Frequently Asked Questions: Patient Centered Medical Home for Health Care for the Homeless Projects

What should we attain first, Meaningful Use (MU) of EHR or PCMH recognition?

If you have not begun the PCMH recognition process, adopting, implementing and/or upgrading your EHR and attesting for the CMS incentives may provide funding to support the PCMH process. Additionally, meeting MU objectives will help in becoming recognized as a PCMH through NCQA. A successful EHR implementation requires significant review of existing workflows. As such, simultaneously addressing the practice transformation components in the PCMH recognition process in tandem with EHR implementation may be useful as existing practice workflows within each of the components may be impacted. However, the CMS financial incentives for MU are also only available until 2016, so it is important to be aware of the MU timeline and practice capacity when determining if you decide to navigate PCMH or MU independently or in tandem to ensure funding for the organization. The NCQA PCMH website has a crosswalk of the PCMH standards and MU objectives. Strategically outline your workflow processes to include both MU and PCMH objectives and becomefamiliar with the CMS MU incentive website https://www.cms.gov/**EHRIncentivePrograms/** and NCQA PCMH website http://www.ncqa.org and register for their listserves for weekly updates, tips and tools.

How can our organization engage in PCMH implementation without resources for training, staffing, and cost?

In addition to technical assistance available from the Council, many state PCAs have attained funding to provide technical assistance support for MU of EHR and PCMH recognition. HRSA encourages all grantees to get PCMH recognition. The fee for gaining NCQA PCMH recognition are waived for Health Center Program Grantees participating in the Patient-Centered Medical/Health Home (PCMHH) Initiative (PAL 2011-01). HRSA provides training, technical assistance, and mentoring to support practice transformation. The HRSA PCMHH Initiative website outlines guidelines and assistance for PCMH recognition (http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html). Health centers pursing PCMH as part of HRSA's Accreditation Intiative, through The Joint Commission or the Accrediation Association for Ambulatory Health Centers (AAAHC), have the opportunity to receive site specific TA through the Intiative.

It is also useful to identify a PCMH project manager in your staff and build a team that includes a clinician, practice operations manager and IT/reporting team member. Communication strategy for this team and the staff about PCMH process, timeline, and goals is also important, as well as integrating PCMH training into staff meetings and communications. A good PCMH overview video is available at http://www.clinica.org/Clinica_PCMH.html. The Affordable Care Act authorized CMS's Center for Medicare and Medicaid Innovation (http://innovations.cms.gov) to launch a number of medical home initiatives that offer access to learning collaboratives, disease registries, EHR systems, care coordinators, practice coaches and data feedback. There are federal and state financial incentives and payment approaches available for PCMH recognition to help offset the costs involved in the transformation process.

How can we build a PCMH with the homeless population when this population is transitory and often temporary consumers of our services?

The PCMH model is very closely aligned with the key elements of HCH care, especially outreach and engagement, whole person orientation, patient activation, and team based care (http://www.nhchc.org/wp-content/uploads/2011/10/Key-Elements-of-Integrated-Care.pdf). PCMH standards focus on care coordination and management; patient engagement and self management; and access and continuity. These concepts are aimed to support patient self efficacy, an important goal for the homeless consumer. PCMH model promotes team based care, expecting staff to practice at the top of their skill set and license. Outreach and CHWs can help facilitate care coordination, patient self-management goal setting, referral and resource coordination, and care transitions. Population risk stratification can help identify high risk, high resource patients that can be assigned to a case manager or care team to focus more intensive services to help support patients with multiple conditions. The PCMH goal is to improve health care quality and health outcomes, which is a shared goal of HCH care.

For more information and resources contact:

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Access the NHCHC PCMH/MU Resource webpage for tools, resources, webinars
http://www.nhchc.org/resources/general-information/health-care-reform/