Integrating the new 2011 NCQA Patient Centered Medical Home (PCMH) Standards and Meaningful Use Criteria to Enhance your HCH Practice

Table Exercise #1

Standard 3: Plan and Manage Care

Getting Started:

Table Introductions: Please share your name and the name of the organization with which you are affiliated. Very Briefly Describe your health center (size, scope of services, # of staff)

Instructions for Exercise

The purpose of these exercises is to help you evaluate your practice within the context of a patient centered medical home.

- Review the NCQA PCMH 2011 Standard 3: Plan and Manage Care segment below, and then review and answer the specific questions.
- Note your progress: If you have already begun the process of becoming a medical home, jot down your progress, how you achieved it and any barriers and roadblocks you encountered.
- Discuss: Talk about your answers to the questions with others at your table, focusing on areas of strengths and areas of challenge.
- Report: We will ask for a representative from each table to report a summary of your discussion with the large group.

Standard 3: Plan and Manage Care

- The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems.
- Care management emphasizes:
  - Pre-visit planning
  - Assessing patient progress toward treatment goals
  - Addressing patient barriers to treatment goals
- The practice reconciles patient medications at visits and post-hospitalization
- The practice uses e-prescribing
- The practice collaborates with the patient/family to develop and manage a plan of care
- The practice reconciles medication with the patient/family

Questions to Review

1. Describe your health center's use of evidence-based guidelines or practices for specific conditions, including behavioral health (unhealthy behaviors, mental health, substance abuse)? Or another way: How have you embedded the guidelines into the workflow, including outreach, new patient assessment, care reminders?

2. How does your health center identify high risk/complex patients? What is your determinant of when they get care/case management?

Adapted exercises with permission from Health Team Works www.healthteamworks.org.

3. What is your health center's current process for planning and managing care of patients?

    - How do you provide "whole person orientation" not condition by condition?

4. How are patient barriers assessed relating to the patient's ability to follow through on the plan of care?

5. How is patient education about management of chronic conditions provided?