Patient-Centered Medical Home: Extending Beyond the Medical Clinic using Information Technology

Albuquerque Health Care for the Homeless

Mission/Vision

Albuquerque
HEALTHCARE
for the homeless

VISION

To live in a world that is just and without homelessness

MISSION

Provide caring and comprehensive health and integrated supportive services, linking people experiencing homelessness to individual and collective solutions

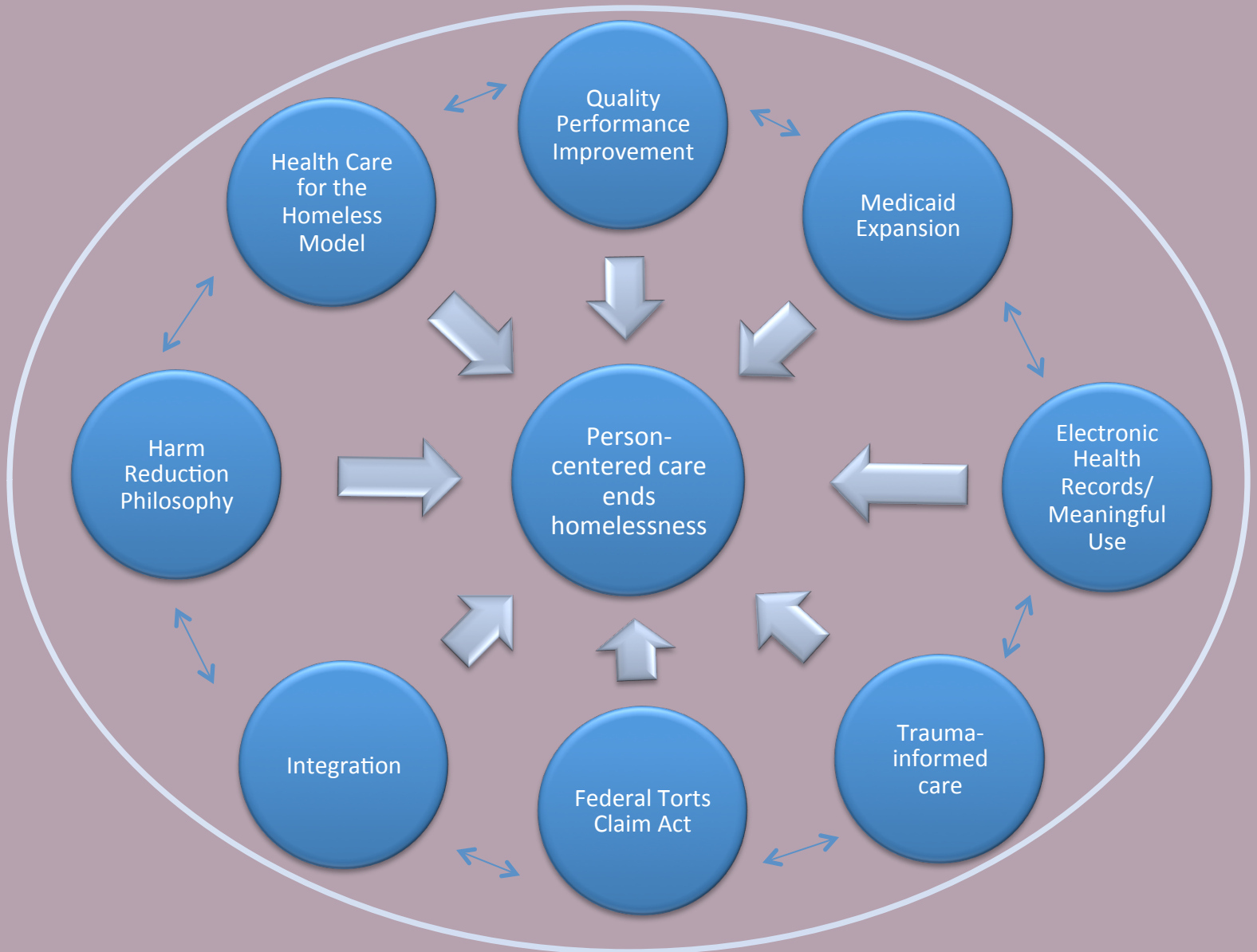
and

Be a leader in implementing innovative service models and a catalyst for solutions to homelessness

and

Uphold a commitment to diversity and equity

Patient-centered Health Home Quality Recognition



2011 Patient-Centered Medical Home Level - 2

- Albuquerque Health Care for the Homeless Evaluation Option:
  - Overall Score: **84.50 out of 100.00** (85/100 or .5 of a point away from achieving level – 3 recognition).

Must Pass Elements Passed: 6

Standard	Element	Your Score	Minimum Score Required	Unit Of Assessment Affected	Passed
PCMH1	Element A	**100.00%**	50.00%	All	Yes
PCMH2	Element D	**75.00%**	50.00%	All	Yes
PCMH3	Element C	**75.00%**	50.00%	All	Yes
PCMH4	Element A	**75.00%**	50.00%	All	Yes
PCMH5	Element B	**75.00%**	50.00%	All	Yes
PCMH6	Element C	**100.00%**	50.00%	All	Yes

AHCH Critical Factors Results

Element	Critical Factor	Met	Condition Not Met
PCMH1A	Providing same-day appointments	Yes	
PCMH1B	Providing timely clinical advice by telephone when the office is not open	No	None
PCMH3A	The third condition, related to unhealthy behaviors or mental health or substance abuse.	Yes	
PCMH3D	Reviews and reconciles medications with patients/families for more than 50 percent of care transitions	Yes	
PCMH3E	Generates at least 75 percent of eligible prescriptions	Yes	

AHCH Critical Factors Results

Element	Critical Factor	Met	Condition Not Met
PCMH4A	Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families	Yes	
PCMH5A	Tracks lab tests until results are available, flagging and following up on overdue results	Yes	
PCMH5A	Tracks imaging tests until results are available, flagging and following up on overdue results	Yes	

PCMH1: Enhance Access and Continuity View Points

- ELEMENT A - Access During Office Hours
- ELEMENT B - After-Hours Access
- ELEMENT C - Electronic Access
- ELEMENT D - Continuity
- ELEMENT E - Medical Home Responsibilities
- ELEMENT F - Culturally and Linguistically Appropriate Services
- ELEMENT G - Practice Team

PCMH2: Identify and Manage Patient Populations

- ELEMENT A - Patient Information
- ELEMENT B - Clinical Data
- ELEMENT C - Comprehensive Health Assessment
- ELEMENT D - Use Data for Population Management

PCMH3: Plan and Manage Care

- ELEMENT A - Implement Evidence-Based Guidelines
- ELEMENT B - Identify High-Risk Patients
- ELEMENT C - Care Management
- ELEMENT D - Medication Management
- ELEMENT E - Use Electronic Prescribing

PCMH4: Provide Self-Care Support and Community Resources

- ELEMENT A - Support Self-Care Process
- ELEMENT B - Provide Referrals to Community Resources

PCMH5: Track and Coordinate Care

- ELEMENT A - Test Tracking and Follow-Up
- ELEMENT B - Referral Tracking and Follow-Up
- ELEMENT C - Coordinate With Facilities and Care Transitions

PCMH6: Measure and Improve Performance

- ELEMENT A - Measure Performance
- ELEMENT B - Measure Patient/Family Experience
- ELEMENT C - Implement Continuous Quality Improvement
- ELEMENT D - Demonstrate Continuous Quality Improvement

Referral Tracking

Hire referral coordinator

System wide referral tracking

Track through EHR system

Use of alerts

Referrals sit as open orders – Pre-visit clinical review

Review a set of queries – waiting for a response, monthly referral follow-up

Challenges Other Innovative Ideas

- Setting clients up with an email account
- Patient Portal – make appts, view labs, dialogue with providers via computer – 76% usage, able to leave a message into the portal and attach letters for the client
- Americorps volunteers – escort, computer work, help with paperwork
- Computer access for the clients? Library, shelters/day program
- Letters in the EMR – generate letters for clients that are signed by the provider
- Text messaging – reminders & lost to care
- Students – help with data integrity, chart reviews

After Hours Access

- Answering service and providers on call
- Nurse navigator system
- Urgent Care/Express clinics
- 11hrs/day, Saturday & Sunday
- After hours contract with hospital
- Ask a nurse - triage

Follow-up with clients that haven't been seen in ???months

- Baseline? 6 months, 3 months, match to QM matrix
- Tie to utilization, decrease the number of months based on the data
- Clients not seen within a month – PCMH
- Contact no-show same day
- Every visit verify cell # & contact info.
- Coord with mental health

Documenting Self Management Techniques

- Run multidisciplinary groups – referrals tracked in the EHR
- EHR has a self management – quick text templates, quick note favorite
- Built in EHR templates – chronic conditions
- Case Managers – follow-up & notes

Follow-up with clients who need tests or lab results

What are you struggling with?

- Time
- Community Psylos
- Needing more staff
- What is the perfect staffing ratio?
- How do you work smart?
- Maintaining honest & integrity
- Philosophy of care – alphabet soup
- Self care & burn out – set of core values that includes life balance