

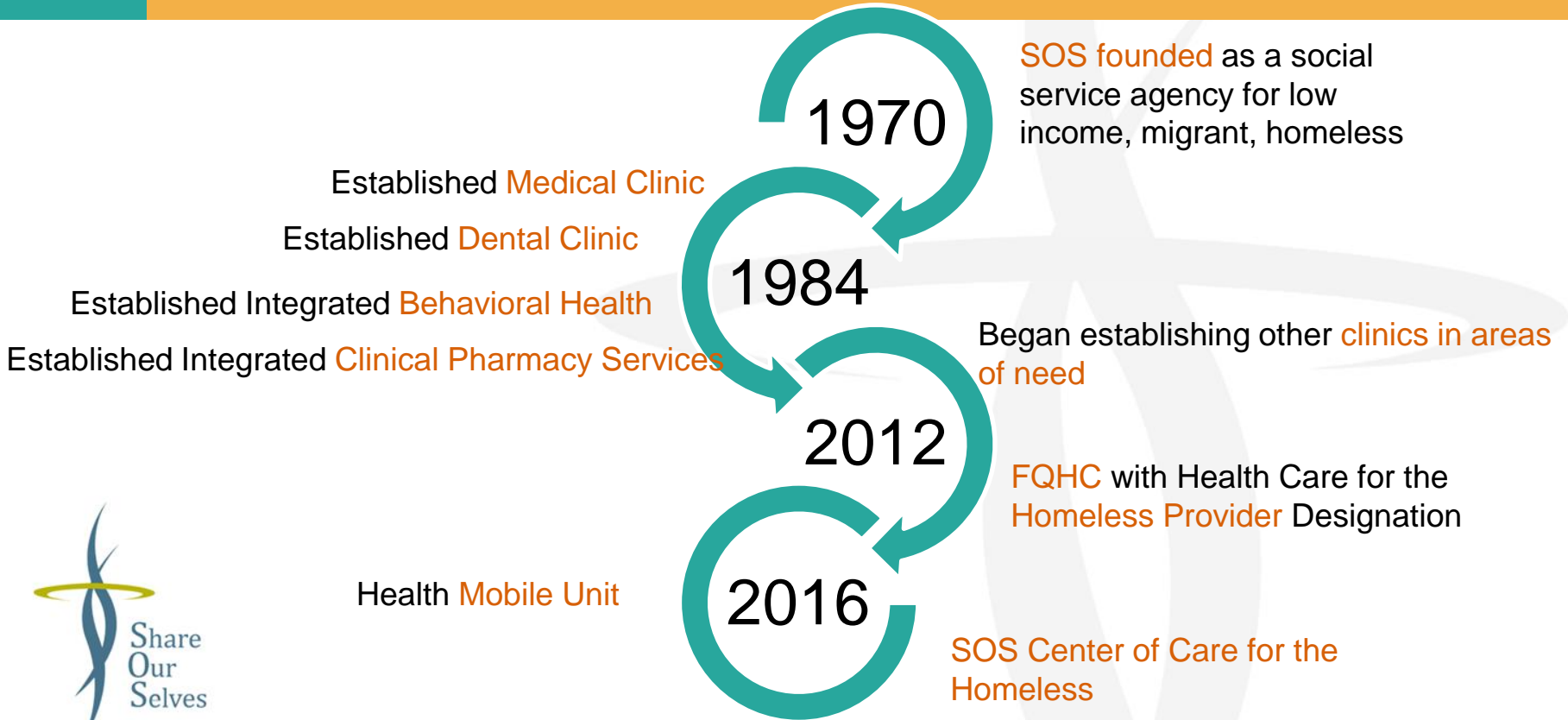
Using PCMH to Radically and Audaciously Care for Those Experiencing Homelessness

Share Our Selves Corporation, Costa Mesa California

Karen McGlinn, CEO

Mary Ann Huntsman, Director of Clinical Pharmacy

Integrated Care Agency



Integrated Care Agency

An Integrated Care Agency is a person centered, personalized partnership that takes into consideration the full range of body, mind, spirit, and community that are necessary to create a state of well-being for each person.



Integrated Services



<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

Why do we do this

We are Mission driven:

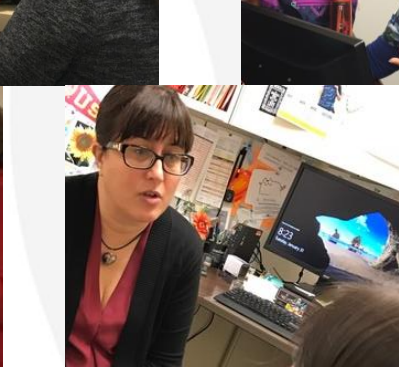
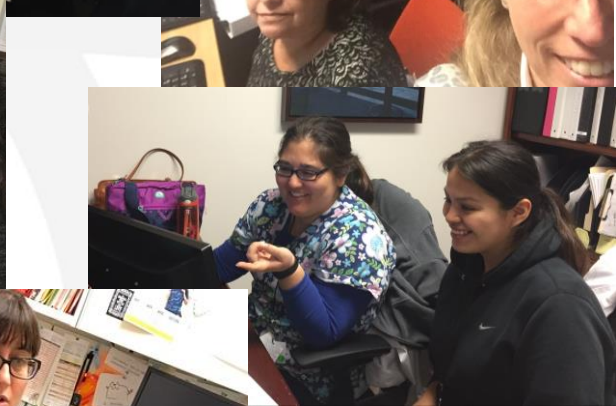
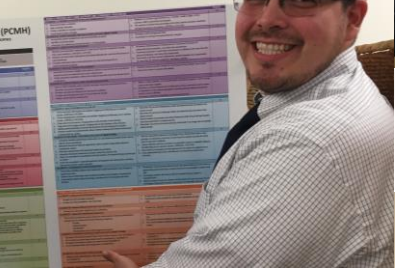
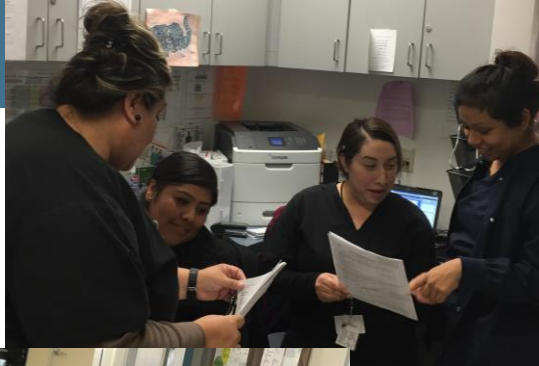
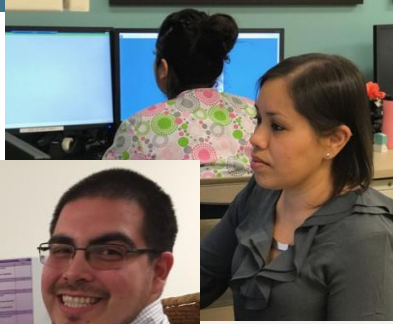
- We are Servants who provide care and assistance to those in need and act as advocates for systemic change
- Personalized care for the Orange County community



We are driven to audaciously advocate for systemic change:

- because it is not easy, but it is right
- because it is sound and we must lead

Who, What , Why, When.....



Tell Your Story

This is our story
This is who we are

- Gold Standard
- Broad support from Private Sector
- Broad support from Government



Recognition Levels	Required Points	Multiple Elements
Level 1	25-50	1-5 of elements are required for each line. Score for each "Qualifying element" must be a 20%.
Level 2	60-84	1-10 of elements are required for each line. Score for each "Qualifying element" must be a 20%.
Level 3	85-100	11-15 of elements are required for each line. Score for each "Qualifying element" must be a 20%.

PCMH 1: PATIENT CENTERED APPROACH	POINTS
ELEMENT A: PATIENT CENTERED APPROACH ADDRESS (INIST PASS)	4.5
1. Providing services, appointments for routine and urgent care (CRITICAL FACTOR)	A. Availability of appointments
2. Providing routine and urgent care appointments outside regular business hours	B. Offering extended hours
3. Providing alternate types of clinic encounters	C. Using an identified opportunity to improve access
ELEMENT B: 24/7 ACCESS TO CLINICAL GUIDANCE	1.5
1. Providing clinical or health care information for use and advice when office is closed	A. Providing clinical advice using a secure, interactive electronic system
2. Providing timely advice via telephone (CRITICAL FACTOR)	A. Documenting Clinic advice in patient records
ELEMENT C: ELECTRONIC ACCESS	2
1. Give 80% of patients free online access to their health information	A. A secure message box sent to more than 80 percent of patients
2. Not include a link or other information to access or practice more than 20% of patients free and one practice has the capability to download their health information or patients that health information to a third party	B. Patients have online communication with the practice
3. Critical summaries are provided within 3 business days for more than 80% of office visits	C. Patients can request appointment, prescription refills, referrals and test results

PCMH 2: TEAM BASED CARE	POINTS
ELEMENT A: COORDINITY	3
1. Assigning responsibilities to team members and documenting the health plan practice roles	A. Having a process to monitor team practice
2. Documenting the members of practice with shared roles on chart	B. Documenting with the primary care team to development a written care plan for conditions, team practice, care to each other
ELEMENT B: MEDICAL HOME RESPONSIBILITIES	2.5
1. The practice is responsible for providing patient care across multiple settings	A. The scope of services across sites (practice, home, behavioral health) needs are addressed
2. Instructions for sharing care and critical advice during acute and other office visits	B. The practice provides advice to all of their patients regardless of source of care
3. The practice functions most effectively as a medical home if patients receive a complete medical history and information about care obtained outside the practice	C. The practice gives unshared patient information about planning, coordination or transferring services to the practice, including a copy of a patient's chart
4. The care team provides access to evidence based clinical guidelines	D. The practice gives unshared patient information about planning, coordination or transferring services to the practice, including a copy of a patient's chart
ELEMENT C: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES	1.5
1. Assessing the primary language	A. Providing interpretation or language services to meet the language needs of its population
2. Assessing the language needs of its population	
ELEMENT D: THE PRACTICE TEAM (INIST PASS)	3
1. Creating time for clinical and non-clinical practice	A. Training and ongoing members of the care team to support patient-centered care (e.g. self-management, self-advocacy) and behavior change
2. Identifying team structure and the staff mix and sustain team based care	B. Training and ongoing members of the care team to manage the patient population
3. Having scheduled patient care team meetings or a structured communication process focused on medical, patient care (CRITICAL FACTOR)	C. Having scheduled team meetings to address practice functioning
4. Using ongoing shared feedback	D. Conducting team based on performance, performance evaluation and quality improvement activities
5. Training and ongoing members of the care team to coordinate care for individual patients	E. Documenting, reviewing and acting on patient-centered activities or on the practice's primary strategy

PCMH 3: POPULATION HEALTH MANAGEMENT	POINTS
ELEMENT A: PATIENT INFORMATION	2
1. Date of birth	A. Collection (via any practice preferred)
2. Sex	B. Date of previous clinic visit
3. Race	C. Date of last lab test
4. Ethnicity	D. Primary diagnosis
5. Insurance coverage	E. Insurance coverage (via any practice preferred)
6. Health conditions	F. Medication
7. Social address	G. Home and contact information of other health care professionals involved in patient's care
ELEMENT B: CLINICAL DATA	4
1. An up-to-date primary care visit history and active diagnoses for more than 80% of patients	A. Screen rates and records (prior to care and 800 patients)
2. At least 80% of patients have a documented history of hypertension for more than 12 years and/or for more than 20% of patients	B. Screen of tobacco use for patients 13 years and older for more than 80% of patients
3. At least 80% of patients have a documented history of diabetes for more than 12 years and/or for more than 20% of patients	C. Use of immunization records for a representative 10% (or for those with no diagnosis)
4. At least 80% of patients have a documented history of asthma for more than 12 years and/or for more than 20% of patients	D. Use of immunization records for a representative 10% (or for those with no diagnosis)
5. At least 80% of patients have a documented history of depression for more than 12 years and/or for more than 20% of patients	E. Documenting screening for adults and adolescents using a standardized tool
6. At least 80% of patients have a documented history of substance use disorder	F. Assessment of patient history
ELEMENT C: COMPREHENSIVE HEALTH ASSESSMENT	4
1. Use and prior review of immunization and coverage	A. Screen for smoking history
2. Family reproductive preferences	B. Screen for substance use history of patients and family
3. Communication needs	C. Screen for depression, anxiety, and a standardized tool (via for patients with no diagnosis)
4. Patient history of patient and family	D. Document screening for adults and adolescents using a standardized tool
5. Advance care planning (via for patients preferred)	E. Assessment of patient history
ELEMENT D: USE DATA FOR POPULATION MANAGEMENT (INIST PASS)	4
1. Assess how different practice care services	A. Patients not meeting care by the practice
2. Assess how different practitioners	B. Population trending by age
3. Assess how different conditions	
ELEMENT E: IMPROVING EVIDENCE BASED DECISION SUPPORT	4
1. A practice health or substance use screen (CRITICAL FACTOR)	A. A condition screen or performance results with practice
2. A chronic disease condition	B. The onset or acute care
3. An acute condition	C. One or more appropriate issues

Patient Centered Medical Home (PCMH) Transforming primary care practices into medical homes

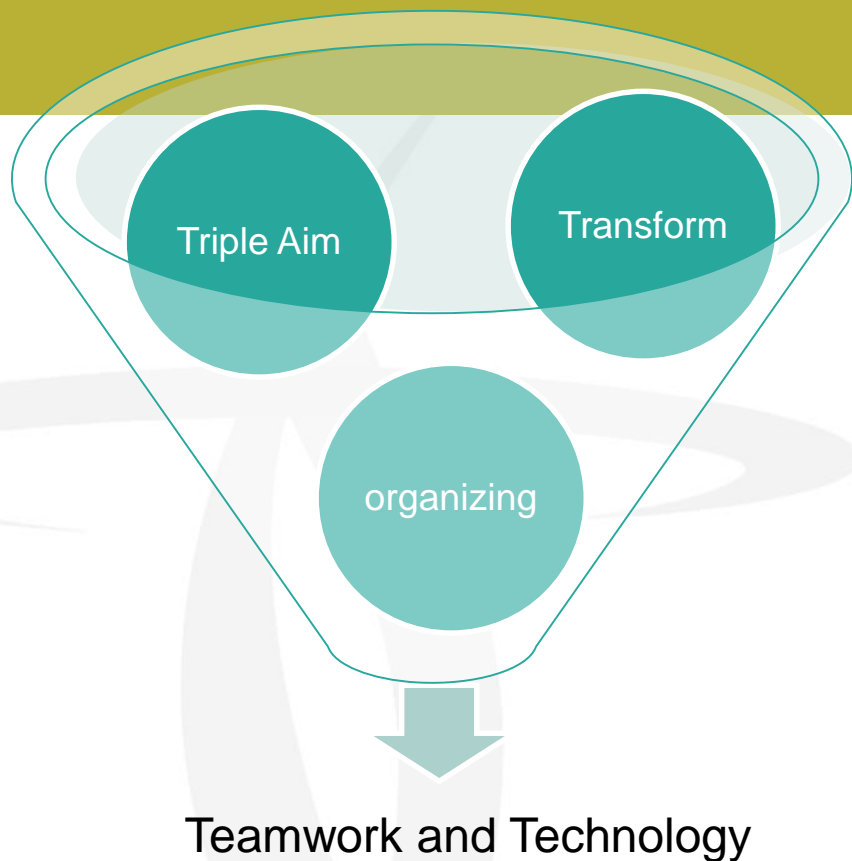
PCMH 4: PROVIDE SELF-CARE SUPPORT AND COMMUNITY RESOURCES	POINTS
ELEMENT A: IDENTIFY PATIENT'S SELF-CARE MANAGEMENT	4
1. Screen for self-care	A. Screen by survey, questionnaire (e.g., surveys, health system, ACO), decision tool or patient/family engagement
2. High cost/high utilization	B. Many identified in-person conditions
3. Screen for self-care readiness	C. Social determinants of health
ELEMENT B: CARE COORDINATION AND SELF-CARE SUPPORT (INIST PASS)	4
1. Increase patient preferences and functional/active goals	A. Include a self-management plan
2. Increase patient goals	B. Increase patient goals
3. Assess and address potential barriers to meeting goals	C. Increase patient goals
ELEMENT C: USE ELECTRONIC PRESSURING	2
1. Use less than 30 percent of eligible practitioners within the practice are compared to find barriers and electronically sent to patients	A. Assessing readiness of practitioners for more than 30 percent of patients to receive care
2. Create electronic medication orders in the medical record for more than 80 percent of medications	B. Assessing readiness to medication and barriers to adherence for more than 80 percent of patients and track the assessment
ELEMENT D: SUPPORT SELF-CARE AND DECISION MAKING	5
1. Use an 80% to identify, demonstrate, education, resources and provide them to more than 10 percent of patients	A. Assessing readiness of practitioners for more than 30 percent of patients to receive care
2. Provide educational materials and resources to patients	B. Document a patient response to the topic or to community service based on importance to the patient population including services offered outside the practice and in practice
3. Provide self-management tools to record before care	C. Offer to other patients to evaluate health education programs, such as group classes and peer support
4. Develop shared decision making tool	D. Assess readiness of practitioners for more than 30 percent of patients to receive care
5. Offer to other patients to evaluate health education programs, such as group classes and peer support	E. Document a patient response to the topic or to community service based on importance to the patient population including services offered outside the practice and in practice
6. Assess readiness of practitioners for more than 30 percent of patients to receive care	F. Assess readiness of practitioners for more than 30 percent of patients to receive care

PCMH 5: CARE COORDINATION & TRANSITIONS	POINTS
ELEMENT A: TEST TRACKING & FOLLOWUP	6
1. There is one individual within the practice tracking and following up on medical results (CRITICAL FACTOR)	A. More than 30 percent of laboratory tests are electronically received in the patient record
2. Track imaging tests and results are available, flagged and following up on medical results (CRITICAL FACTOR)	B. More than 30 percent of radiology (work as electronically) received in the patient record
3. Flag abnormal test results, bringing them to the attention of the clinician	C. Electronically received more than 30 percent of all critical lab test results into electronic health in medical records
4. Flag abnormal imaging results, bringing them to the attention of the clinician	D. More than 10 percent of tests and tests that result in an image are available electronically
5. Follow up with appropriate facility about retest/review and reason for repeat	
ELEMENT B: REFERRAL TRACKING & FOLLOWUP (INIST PASS)	6
1. Create a written performance information on coordination activities when referring patients	A. Have the capacity for electronic transfer of the critical information and sharing recommendations
2. Maintain formal and informal agreements with a select of specialists based on coordinated care	B. Track referrals and the completion or non-completion of a referral is available, flagged and following up on outside referrals
3. Maintain agreements with behavioral healthcare providers	C. Document a patient response to the patient's referral needs
4. Increase behavioral healthcare referrals to the practice and practice site	D. Also patient/family about self-referrals and returning reports from specialists
5. Give the specialist or specialist contact demographic and clinical data including test results and current care plan	
ELEMENT C: COORDINATE CARE TRANSITIONS	6
1. Proactively identify patients with upcoming, routine admissions and emergency department cases	A. Proactively contact patients/families to appropriate follow-up care when an appropriate patient following a hospital admission or emergency department
2. Share critical information with admitting hospitals and emergency departments	B. Document a patient response with the hospital during a patient's hospitalization
3. Consistently obtain patient discharge summaries from the hospital and other facilities	C. Create a prior consent for release of information and have a process for secure acquisition of information and for coordination of care with continuity, practice

PCMH 6: PERFORMANCE MEASUREMENT & QUALITY IMPROVEMENT	POINTS
ELEMENT A: TRACK AND MONITOR PERFORMANCE	2
1. At least two performance measures	A. At least two chronic or acute care clinical measures
2. At least two other practice care measures	B. Performance data available for vulnerable populations (to assess disparities in care)
ELEMENT B: MEASURE RATIONALE AND CARE COORDINATION	2
1. At least two measures related to care coordination	A. At least two utilization measures affecting health care costs
ELEMENT C: MEASURE PATIENT/FAMILY ENGAGEMENT	4
1. The practice conducts a survey (long or short cycle) to measure patient/family experiences in at least three of the following categories:	A. The practice uses the PCMH version of the CHPS, Clinician & Group Survey
- Access	B. The practice shares feedback on experience of vulnerable patient groups
- Communication	C. The practice shares feedback from patients/families through qualitative means
- Coordination	
- Continuity	
- Understanding of self-management (INIST PASS)	
ELEMENT D: IMPROVE CONTINUOUS QUALITY IMPROVEMENT (INIST PASS)	4
1. Set goals and evaluate at least three cycle quality measures from SUBJECT A	A. Set goals and evaluate at least one patient experience measure from SUBJECT C
2. At least 10 percent of all care team quality measures from SUBJECT A	B. At least 10 percent of all care team quality measures from SUBJECT C
3. At least 10 percent of all care team quality measures from SUBJECT B	C. Set goals and evaluate at least one patient experience measure from SUBJECT C
4. At least 10 percent of all care team quality measures from SUBJECT E	D. Set goals and evaluate at least one patient experience measure from SUBJECT C
ELEMENT E: DEMONSTRATE CONTINUOUS QUALITY IMPROVEMENT	3
1. Measuring the effectiveness of the action to improve the measure selected from SUBJECT D	A. Achieving improved performance on the action or care coordination measure
2. Achieving improved performance on at least one chronic quality measure	B. Achieving improved performance on at least one patient experience measure
ELEMENT F: REPORT PERFORMANCE	2
1. Publish chronic or performance results with the practice	A. Publish chronic or performance results with patients
2. Performance performance results with the practice	

Goal for PCMH

The patient-centered medical home is a way of organizing primary care using teamwork and technology to improve quality and patients' experience of care, and to reduce costs



2017 PCMH

Concept

- 6 Concepts

Competency

- Subdivisions within the Concepts

Criteria

- Core (meet all core criteria)
- Elective (earn 25 credits in elective criteria)
- Guidance and Evidence



Structure of PCMH 2017

Team Based Care and Practice Organization

- Communicate roles and responsibilities, and train staff to work to the top of their license

Knowing and Managing Your Patients

- Deliver evidence-based care with culturally and linguistically appropriate services

Patient-Centered Access and Continuity

- 24/7 access to clinical advice and appropriate care

Care Management and Support

- Tracks tests, referrals, and care transitions to achieve high quality and low cost care

Care Coordination and Care Transitions

- Track tests and coordinates care

Performance Measurement and Quality Improvement

- Culture of data-driven improvement on quality, efficiency and patient experience



Resources Provided by PCMH

NCQA
Representative

PCMH
Standards and
Guidelines

Annual
Reporting



Our Journey



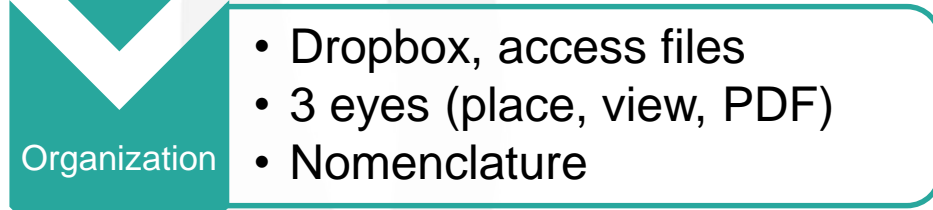
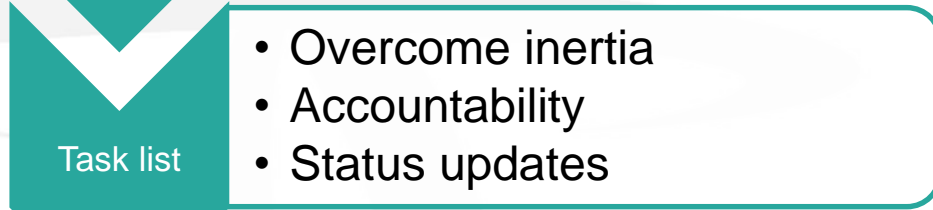
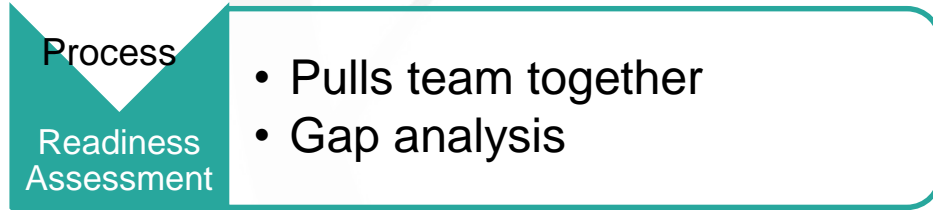
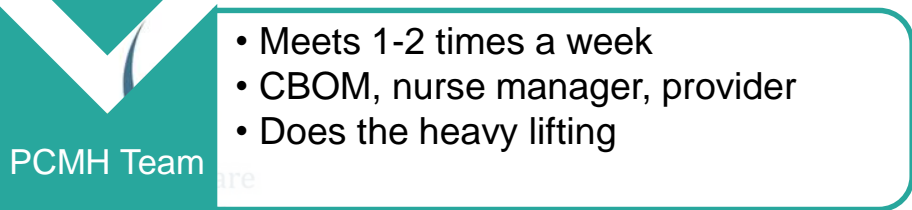
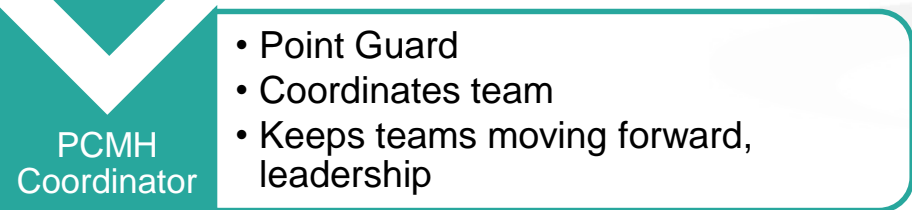
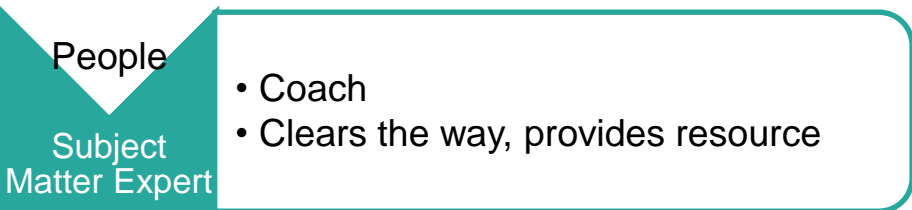
Economies of scale
Best Practices
All teach All learn
Roadmap for
transformation



3 Clinics with new
submission
1 Clinic resubmitting
Teams formed at
each Clinic site



PCMH Working Structure



Foundational Transformation

EHR

Population
Management

Care
Coordination &
Tracking

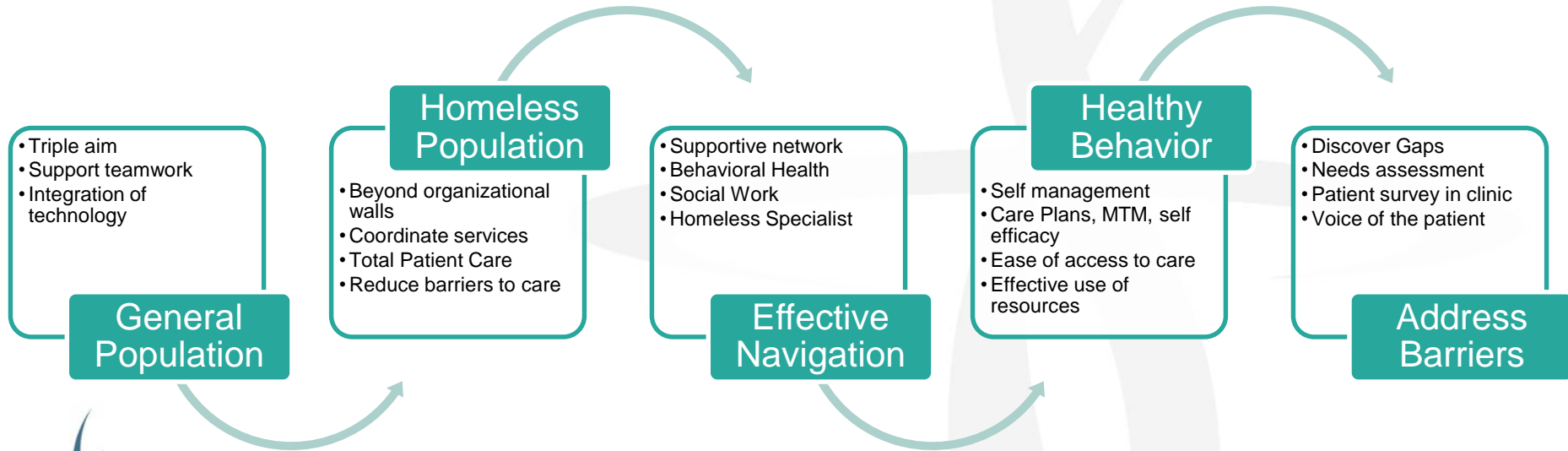
Self
Management
Tool

Data Analytics

Empowerment



PCMH in the Homeless Population



Leadership buy in, **PCMH**
Coordinator, regular meetings

Start early, be systematic, next
steps identified, **empower**

Use your resources, collaborate
with others, **network**

Understand your **data** and **CQI**

Teams and Technology

Lessons Learned

