Your Speaker

R.W. “Chip” Watkins, MD, MPH, FAAFP
Medical Director, CCWNC
Senior Physician Consultant, CCNC
Associate Medical Director, High Country Community Health, Boone, NC
NCQA Foundational Concepts of the Medical Home Faculty
NCQA Physician Review Oversight Committee
Objectives

- Brief Background
- Preparing for assignment, engagement, and operations
- Barriers to engagement and treatment
- Outreach to assigned members
  - Previously un-engaged members
  - Current members
- Engagement case studies
The PCMH is a model of primary care re-design intended to improve the quality and efficiency of primary care delivery.
TennCarePCMH Program Overview

Key Components:

- **Patient-centered access** (e.g., providing same-day appointments for routine and urgent care)
- **Team-based care** (e.g., holding scheduled patient care team meetings or a structured communication process focused on individual patient care)
- **Population health management** (e.g., using data for population management to address chronic and acute care services)
- **Care management support** (e.g., identifying high-risk patients for care management and care plans with self-care support recommendations for each)
- **Care coordination and care transitions** (e.g., referral tracking and follow-up and coordinating care transitions)
- **Performance measurement and quality improvement** (e.g., measuring and tracking performance on quality and efficiency measures)
Features of PCMH

Four common features in successful demonstration projects

- Dedicated care managers
- Expanded access to clinicians
- Data-driven analytic tools
- Use of incentives
Benefits of the PCMH Model

Quality – Outcomes for seven medical home demonstrations

- Fewer ER visits (15%-50%)
- Fewer hospital admissions (6-24%)
- Lower mortality rates
- Better preventive service delivery
- Better chronic disease care
- Higher patient satisfaction

Benefits of the PCMH Model

Efficiency – **Cost**

- Lower total costs of care - (6.5-22%)
- Shorter patient wait times
- Less staff burnout/turnover (10% vs. 30%)
- Higher staff satisfaction/productivity

This is a No-Brainer! Right?

• So Why Aren’t Organizations **RUNNING** to implement PCMH for themselves?!?
  1. Time
  2. Resources
  3. Consultants are expensive
  4. Fear
     a) Gov’t interference
     b) Loss of control/independence
     c) Change
You are not alone in the Brave New World of Pay-for-Value
You now have a partner to work with you in your practice’s transformation
The TennCare PCMH Program is a Win-Win-Win

<table>
<thead>
<tr>
<th>Members</th>
<th>Practices</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Better access to primary care providers</td>
<td>- Support for performance improvement</td>
<td>- Higher quality care</td>
</tr>
<tr>
<td>- Tailored care for those most in need</td>
<td>- Direct financial support for care coordination</td>
<td>- Reduced total cost of care</td>
</tr>
<tr>
<td>- Care coordination services leading to improved quality and outcomes</td>
<td>- Specialized training for practice transformation</td>
<td>- Reduced utilization of secondary care through better management of</td>
</tr>
<tr>
<td>- Greater emphasis on primary and preventative care</td>
<td>- Access to outcome payments</td>
<td>chronic conditions</td>
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<tr>
<td>- Improved care coordination with behavioral health providers</td>
<td>- Input from other members of care delivery team</td>
<td>- Reduced utilization of unnecessary procedures and visits (e.g.,</td>
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<tr>
<td></td>
<td>- Access to better information with which to make decisions</td>
<td>unnecessary emergency room visits)</td>
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<tr>
<td></td>
<td>- Improved work flows and processes that positively impact productivity</td>
<td>- More cost conscious referrals</td>
</tr>
<tr>
<td></td>
<td>and efficiency</td>
<td>- System shift towards greater coordination and information sharing</td>
</tr>
</tbody>
</table>
Barriers to Engagement and Treatment

CORE DETERMINANTS OF HEALTH

- Financial and social status
- Culture
- Biology and genetic endowment
- Healthy child development
- Social environments
- Personal health practices and coping skills
- Social support networks
- Physical environments
- Education and literacy
- Employment/working conditions
- Gender
- Health services
Barriers to Engagement and Treatment

• What gets in OUR way??

• **Lack of reimbursement** methods for:
  ▫ coordinated care
  ▫ health education
  ▫ support and family services

• **Inadequate services** to support self-management

• **Poor coordination** between physical and behavioral healthcare systems

• **Staff concerns**

• These are **difficult patients**!
Your Organization’s Vision and Plan
Preparing for Assignment, Engagement, and Operations
Are You and Your Organization Prepared?
Be Prepared...

- Making sure you understand, believe in and are **committed to PCMH** for your practice
- **Build a PCMH Team** within your practice
  - Need a PCMH Champion
- Understand becoming a PCMH is an “**expensive**” proposition
  - Time
  - Disruption
  - Staff time (money)
- Staff Buy-in Is the “Key to Life”
Be Prepared...

- Know that there will be changes and **challenges for the staff** when adopting a PCMH model
  - “One more thing to do…”
  - “Doc must have gone away to a weekend meeting…”
- Try to schedule **regular staff meetings** to discuss how the staff is adjusting
  - Many things vie for your time – **don’t let this one slip**
- Leadership: **THIS IS A TIME TO LISTEN**
- Realize **TRANSFORMATION TAKES TIME**
  - This is a **CULTURAL** change
Be Prepared...

- Do you have a clear vision of what a “transformed practice” will look like?
- Are you **submitting your quality metrics** to CMS (PQRS, MU, VBPM) and are you ready for MACRA?
- Have you read your **latest QRUR**?
- Are you **managing patient populations** or are you managing your patients by crisis?
- Your **practice assessment** will help both of us to understand where you are and in what direction you need to head.
# Practice Assessment Tool

## Section 1: Support Systems and Capacity

<table>
<thead>
<tr>
<th>#</th>
<th>Criteria</th>
<th>Question</th>
<th>Low (1)</th>
<th>Medium (2)</th>
<th>High (3)</th>
<th>Score (1-3)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Commitment of senior leadership</td>
<td>Can you tell me about the commitment that senior leadership has made to the project?</td>
<td>No designated leader or, if designated, not actively engaged.</td>
<td>Senior leadership supports project but may not actively provide resources and/or enthusiasm.</td>
<td>Senior leadership (including physician champion) supports project, is actively engaged in the project and provides resources and enthusiasm.</td>
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<tr>
<td></td>
<td></td>
<td>i. Do you have a designated leader(s) including a physician leader(s), physician champion, QI champion, and person or group responsible for designation of time, finances and resources?</td>
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<td></td>
<td></td>
<td>ii. Will leadership support the efforts of this project with both resources (i.e., time and cost) and enthusiasm?</td>
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<td></td>
<td></td>
<td>iii. Does your administrator or office manager support this effort?</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Commitment: Financial Resources</td>
<td>How do the leader and the QI team fit QI work in with their other responsibilities in the organization?</td>
<td>No time budgeted for QI PCMH activities. No specific funding to support QI leadership.</td>
<td>Insufficient amount of FTE allocated for QI PCMH activities and/or limited/small amount of funding for QI activities.</td>
<td>Sufficient amount of dedicated FTE and funding allocated to QI PCMH activities.</td>
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<td></td>
<td></td>
<td>i. Are they paid for working on a QI PCMH project or is it volunteer work?</td>
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<tr>
<td></td>
<td></td>
<td>ii. Is time budgeted for and QI PCMH activities?</td>
<td></td>
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<td></td>
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<tr>
<td>3</td>
<td>Level of Physician Leader Support</td>
<td>Do you have a physician leader who supports this effort?</td>
<td>Physician leader has not been engaged in discussions regarding QI PCMH initiatives</td>
<td>Physician leader has started to engage in discussions regarding QI PCMH initiatives</td>
<td>Physician leader has and will continue to engage in discussions regarding QI</td>
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</table>
## Practice Assessment Tool

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Possible Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1: Support Systems and Capacity</strong></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td><strong>Total Possible Points</strong></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td><strong>Total Points Accrued</strong></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Score (%)</strong></td>
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<td>0%</td>
</tr>
</tbody>
</table>

### Section 2: QI Optimization

<table>
<thead>
<tr>
<th>QI Team</th>
<th>Description</th>
<th>QI Team</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QI Team</strong></td>
<td>Do you have a QI team?</td>
<td>No QI team in place</td>
<td>QI Team meets regularly and regularly uses data to track progress</td>
</tr>
<tr>
<td>8</td>
<td>i. Do they meet regularly?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii. Do they use data to track progress?</td>
<td></td>
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</tr>
<tr>
<td>Prior Experience Executing QI Projects</td>
<td>What improvement work has your organization done in the past? What kind of experience do the members of the QI team bring to the effort?</td>
<td>Organization has not been involved in any improvement projects (putting out fires does</td>
<td>Previous improvement projects pursued using a formal QI method.</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Improvement projects pursued; but no formal QI method used (Model for Improvement, data,</td>
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</tbody>
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**Note:** Adjustments may be needed based on the specific context and criteria for each section.
## Practice Assessment Tool

<table>
<thead>
<tr>
<th>Section 5: Direct Clinical Support Scoring</th>
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<tbody>
<tr>
<td>Total Possible Points</td>
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<tr>
<td>Total Points Accrued</td>
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<tr>
<td>Total Score (%)</td>
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</table>

### SECTION 6: DIRECT ADMINISTRATIVE DEVELOPMENT

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<tr>
<th>38</th>
<th>Does your organization have the resources to commit to organization transformation?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Taking into consideration all of the above information: Do you have organization resources to provide direct administrative support in development policies, processes and changes in workflow?</td>
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<tr>
<td></td>
<td>There are no current resources to provide administrative support in the development of policies, processes or evidence of QI initiatives or running member registries.</td>
</tr>
<tr>
<td></td>
<td>There are limited resources to provide administrative support in the development of policies, processes or evidence of QI initiatives or running member registries.</td>
</tr>
<tr>
<td></td>
<td>There are adequate resources to provide administrative support in the development of policies, processes or evidence of QI initiatives or running member registries.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 6, Direct Administrative Development Scoring</th>
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</thead>
<tbody>
<tr>
<td>Total Possible Points</td>
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<tr>
<td>Total Points Accrued</td>
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<tr>
<td>Total Score (%)</td>
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</tbody>
</table>

<table>
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<tr>
<th>Final Score Scale</th>
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<tbody>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>Q2</td>
</tr>
<tr>
<td>Q3</td>
</tr>
<tr>
<td>Q4</td>
</tr>
</tbody>
</table>
Be Prepared...

- Know that EHRs have a long way to go in terms of population management capabilities
- You may not be able to pull the report that you want or need
- Document what you are doing
  - Develop a **Policy and Procedures manual**
  - Can help with cross-training
- **Care Coordination Tool** will be helpful – get your training!
  - They are archived if you miss the first one or two
Assignment, Engagement, and Outreach

Who, What, When, Where and How
Engagement

Develop a **process and workflow** for the practice:

- Will need a process for **previously unengaged** patients (folks new to your assignment list)
- Will need process for **already established members** on your assignment list

**Incentives**

- PMPM
- Outcomes – quality improvements in the health of your population AND $$
Develop a **process and workflow** for the practice:

- How do we **identify** potential participants?
- **Who** will engage members?
- **How** will they engage them?
- Who will **follow up**?
- **What available resources** are available for help?
Engagement – Identifying PCMH members

• The Care Coordination Tool (CCT) will display all of your PCMH members

• Training on CCT began this week and all of your members should be loaded within the next month

• You will be able to run lists of these members to help engage certain groups

• You can then export lists to Excel and share lists with other care team members
Engagement – Identifying PCMH members

• Thinking about workflow, who will run the list and how often?
• How do you want to aggregate your data?
• What is to be done with the list?
• What should be done with the data?
  ▫ How can you use it?
  ▫ Which data metrics will your practice look at?
  ▫ Can you re-purpose it?
Reaching Out

Who, What, When, Where and How
Engagement – How? Phone

• Will you use the phone?
• Do you have an “elevator” speech? (committed to memory)
  ▫ Short, targeted and simple
  ▫ About your practice?
  ▫ About the PCMH program?
• What is the goal?
  ▫ Connect with them
  ▫ Inform them
  ▫ Are they willing to set up an appointment?
Engagement – How? Mail?

• Will you use a mailer? – post card, tri-fold pamphlet
• Who is responsible on your team for development of the mailer?
• Will it be available somewhere in the office waiting room or will check-out folks or check-in folks be instructed to give one to each patient? Each NEW patient?
Engagement – How? E-transmissions

• Will you use a blast **email? text with link?** (for folks with phones or computers)

• Will you add a **page to your website** or add info on your **patient portal**?

• Is it time to build a website or add a portal?

• What to include?
Engagement – How? Get Creative!

- Practice could be a vendor at **community functions** – set up a booth with info on the program
- Office staff may want to put an “ad” out in the **faith-based community** – church bulletins
- Do an outreach to a **local school** – educate about PCMH
- Ask your **MCO representatives** if they can support the practice in the endeavor
- What other ways can you think of??
Engagement – How?

- Will there be someone designated to receive new calls?
- Are you set up to receive all the calls? Or emails?
- Does your schedule have adequate access currently?
- Where will these PCMH patients go in the schedule?
  - Is there a PA or NP that you will designate for say new well checks, etc.?
Stakeholder Map

Stakeholder Map—what matters to whom regarding your integrated behavioral health program?

*Appeal to what already matters*—and find out what that is.

1. Ask yourself who the stakeholders are in your program—the ones who are depending on you for results, have a stake, and will benefit.
2. Then ask yourself if you know what matters most to each stakeholder. *If you don’t know, find out.*
3. Then ask yourself how your integrated behavioral health program appeals to what matters to those stakeholders. If there are major gaps where your program does not appeal to what matters most, consider changing or featuring things to create a better match.
4. Finally, ask how the stakeholder’s own role and “job” can help bring success—what part they can play that will help them get the benefits.

<table>
<thead>
<tr>
<th>Stakeholder 1</th>
<th>How (and how well) your program addresses what matters to that stakeholder</th>
<th>How the stakeholder’s own role and “job” can help make your program a success—their part to play</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder 2</td>
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<tr>
<td>Stakeholder 3</td>
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<td>Stakeholder 4</td>
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<tr>
<td>Stakeholder 5</td>
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</tbody>
</table>

Common examples of stakeholders in an integrated behavioral health program:

- Your patients and the public
- Your PCPs and staff
- Your organization’s leaders
- County/State human services
- Local specialty mental health clinicians
- Your payers—health plans
- QI reporting/convening folks
- Your hospital or ACO partners
- Behavioral health community resources
- Local or state policy people

Identify the stakeholders you must need to know, understand, and do something for. Be specific, e.g., which payers you actually have. Start with these and go from there. *Don’t make up what you think* matters to people *(or what _should_ matter)—go find out and verify this instead.*

Engaging Current Patients

- Marketing experts tell us it is 50% **harder to get new customers** than to retain old ones – same thing applies to patients.
- It’s all about the **relationship** (or it will be)
- More “**positive touches**” with patients is better!
  - Goal setting
  - Shared decision making
  - Patient Surveys
  - Advisory Board and Patient Advocates
Engaging Current Patients

“I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

Maya Angelou
Patient Engagement Strategies

Evidence-Based Framework

Motivational Interviewing (MI)

Goal setting (BAP)
Self-Management Tool Kit
Patient Education
Patient-Centered Care Plan
Teach Back
Patient Engagement Strategies

*What is Motivational Interviewing (MI)?*

It is a person-centered (empathic), goal-oriented method of communication that enhances people’s intrinsic motivation to change by helping people explore and resolve their own ambivalence.

Rollnick, Miller, and Butler (2008)
Biomedical Model of Health and Illness

- Assumes the patient is or *should be* motivated by illness to *obey (our) instructions*
- Offers treatments to patients *who are not ready to follow them*
- Is focused on treating the disease and *fails to address the needed behavioral change*
- Is *unlikely to cause sustained changes in compliance* even after treatment and intervention

Patient Engagement

Definition:

Patients taking an active role in managing their own health care outcomes.

“The patient is in charge, we are not.”
Meet the members “where they are”...
Teach-back: a Safety Issue

Confirmation that you have explained to the patient what they need to know/do in a manner that the patient understands.

Patient understanding is confirmed when s/he explains it back or demonstrates.
SPECIFICALLY it is...

1. The process of asking the patient to repeat in their own words what they need to know or do. (return demonstration)

2. A chance to check for understanding and, if necessary, re-teach the information.

3. NOT a test of the patient, but of how well the “teacher” explained a concept.

Health Literacy

“The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

Healthy People 2010
Incentives/services can add value

• What additional services (portal, extended access, “boots on the ground”) have the sites or the plans offered?

• Support with member with benefits where possible
  ▫ Transportation
  ▫ Visit accompaniment
  ▫ Help with prescription adherence
  ▫ Help with life skills (e.g., food shopping or budgeting)

• Will there be home visits made available?
Team Approach

• Define your PCMH Team and your Champion
• Clear roles defined for each **person on the team**
• Common data source to track outreach and contacts (decide **who gets access** to levels of patient information)
• Identify key **member** needs and team member best able to address them:
  ▫ Peer support for in-person interactions to increase contacts and early engagement
  ▫ Care manager to support holistic benefits and alignment
  ▫ Care coordinator to gather information from all providers and coordinate care
Tools for Tracking

- Member Record – Care Coordination Plan
- Care Coordination Tool
- Care Alerts for follow-up
  - Attend upcoming appointments
  - Were follow up appointments kept?
  - Were prescriptions filled?
- Disease registries
- Quality measure tracking
- EPSDT tracking (Well Child Visits)
Changing Culture Requires Persistence and Time

- People may not recognize the value when first learning about the model
  - Fine tune message based on experience
  - Use teachable moments to promote the program
    - Benefits applicable to specific situation
    - Avoidable adverse events
- Relationships matter
  - Engaging around member needs
  - Showing interest in more than the clinical needs
Case Studies
Enrollment and Engagement in NC
Supporting Patient Self-Advocacy
Patient Tool Kit Enhances Care

Susan Johnson knows how to put her tools to good use. As a patient of Blue Ridge Medical Center, she met CCWNC Nurse Care Manager Laura Ball who was eager to put tools in her hands. Whether it was medical equipment supplies, updated pocket medication lists, or insurance coverage information, Susan would make the most of these tools to advocate for herself and keep her full medical team informed. "Laura has helped me so much," Susan says. "She has shared with me things that I just didn't know were available."

Susan recounts how she has used her Patient Toolkit, a Care Management educational resource, to track the many important updates in her care. "I keep it right here by my chair. It takes 2 minutes to stick a piece of paper in there so that I can find the information later. I take it with me every time I go to the doctor. Everyone asks, 'Do you have your book with you?'." Susan has repeatedly heard various healthcare workers commend her organizational skills and thank her for keeping her medical history so accurate. Once during a hectic hospitalization when she could not speak up for herself, Susan's Patient Toolkit gave her husband, EMS workers, ICU nurses and doctors helpful information to care for her. "They were amazed," she remembers. CCWNC applauds Susan for being such an engaged patient who uses the tools and resources of a coordinated health system to her benefit.
Putting Patients at the Center of Care

Care Management works when the health care system pulls together around a patient with complex issues, such as it did when Pediatric Care Manager Patty Harte started working with the family of young Garren Haney. Garren is a social and playful toddler with over 16 physicians and multiple hospital systems involved in his care related to a very rare genetic syndrome. Frequent hospitalizations requiring days to stabilize his nausea, vomiting, and dehydration were taking a toll on his mom Shayla as well, who worried that communication as not going as well as she wanted with the number of providers. Dr. Ansley Miller, a pediatric hospitalist with Mission Children’s Hospital, and Garren’s physician team reached out to Patty of CCWNC “in an effort to improve his quality of life,” Dr. Miller said. Patty and Shayla developed a Care Plan together that prompted the involvement of a Palliative Care Physician who helped them create a protocol for how to handle Garren’s symptoms when they began at home, and worked with Garren’s pediatrician, hospitalists, and specialists on a plan for when presenting to the ED became necessary. Patty was able to attend specialty appointments with Shayla and Garren to help with getting all questions answered and debriefing with her after and between appointments.

Thanks to these collective efforts, Garren has had only one unplanned hospitalization in the past 10 months, which Shayla said went very smoothly. Furthermore, Garren has made great developmental progress in that time as well-- walking, signing, and talking more now that he is not so sick and stuck in the hospital. "Patty was like a life-saver to me, because we were at a point where we didn’t know what was going on or which way to go," Shayla said. "She got Palliative Care involved and the nursing care I need for both my sons, and we have an active Care Plan at the hospital. Patty is always there and has helped me so much." Putting Garren and his family at the center of the complex care he needed is the purpose and strength of care management collaborations. As Dr. Miller said, "Garren is a remarkable and joyful little boy with multiple complex medical problems. Keeping him healthy and out of the hospital is a victory for both him and all those involved." This is CCWNC’s goal to do what is right, to do it well, and to do it together.

In February and March 2016, 3,138 unique patients like Garren received 13,326 interventions from our Care Management Team.
Helping Patients Mobilize Resources

Success is a smile, and a home. When the challenges of limited income left Nadine Woods and her son living day-by-day in a motel, their family doctor made a referral to CCWNC. Our care management team joined Nadine in addressing her barriers, from securing emergency assistance and family shelter, to advocating with the Housing Authority, legal aid, and a variety of additional service agencies, including the car repair shop. Stability at home and in school for her son who has autism was the driving motivation for Nadine's persistence in exiting homelessness, and her care team supported her resiliency skills through use of Community Resilience Model (CRM) techniques. Nadine's positive attitude can be heard in the WLOS story where she bravely shares her struggles (and success!) in order to help bring a spotlight to Asheville's affordable housing crisis. "I've met some really, really wonderful people," she is quoted as saying, "so the positive part of this whole transition is that I have made some wonderful friends and I know things are going to get better." "Getting better" is always the goal of CCWNC care management!

Nadine and her son, Tyree

In October and November 2016, 2,043 unique patients received intensive Care Management Interventions
Further Resources
To Improve Enrollment and Engagement
Resources: CCNC Provider Services

Point of Care Resources for Providers

Tools to help providers more effectively manage care

This website was developed by a group of Primary Care Providers (PCPs) consulting with Community Care of North Carolina. Our intent is to provide a compendium of tools and resources designed for use by PCPs at point-of-care. You will find screening tools, decision aides, and algorithms based on current evidence and standards of practice.

If there are tools you would like to see added or deleted, please click here to offer feedback. Our steering committee meets quarterly to review comments and requests.

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<th>Populations</th>
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<td>Advanced Care Planning</td>
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<td>Antipsychotics</td>
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https://www.communitycarenc.org/provider-tools/
Resources: NCQA

Patient-Centered Medical Home (PCMH) Recognition

Learn It, Earn It, Keep It
VIEW OUR START-TO-FINISH PCMH RECOGNITION GUIDE

The Patient-Centered Medical Home (PCMH) is a model of care that emphasizes care coordination and communication to transform primary care into "what patients want it to be".

NCQA PCMH Recognition is the most widely adopted model for transforming primary care practices into medical homes. Research confirms medical homes can lead to higher quality and lower costs, and can improve patients’ and providers’ experience of care.

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Becoming and Staying a PCMH
Resources and Support
PCMH Program Redesign
Education and Training
Payment and Public Policy
Evidence Supporting PCMH
Practice Facilitation Handbook

Training Modules for New Facilitators and Their Trainers

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About This Handbook
How To Use This Handbook

Part 1. Introduction to Practice Facilitation

Module 1 Trainer’s Guide: Practice Facilitation as a Resource for Practice Improvement

Resources: SAMHSA-HRSA Center for Integrated Health Solutions CIHS

http://www.integration.samhsa.gov/
Q and A
THANK YOU