Health Home Series:

Patient-Centered Medical Home and Meaningful Use

Presenters:

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March 27, 2012, 2:00 – 4:30PM

Learning Objectives

By the end of the workshop, participants will be able to:

1. Describe the difference between Patient-Centered Medical Homes (PCMH) and Health Homes (HH) and how they are aligned.

2. Identify the main areas of PCMH alignment with Meaningful Use (MU).

3. Describe Stage 1 Meaningful Use and summarize key changes of Stage 2.

4. Access resources for further information and technical assistance.

Agenda

- **Alignment of HH, PCMH and MU**
- **PCMH**
- **Meaningful Use**
- **Resources**

PCMH and Health Homes Alignment

Patient-Centered Medical Home

A model for care that seeks to strengthen the physician-patient relationship by replacing episodic care with coordinated care. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranges for appropriate care with other qualified physicians and support services.

Health Home

A model of service delivery expands on the PCMH model to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses or significant behavioral conditions.

PCMH and Health Homes Alignment

Health Homes and PCMH

Require health information technology to coordinate patient care

e.g., patient portal, provider-to-provider portal, RHIO

Health Homes:

1. attest to participation in a RHIO/Qualified Entity,
2. exchange of interoperable clinical information, certified EHRs,
3. clinical decision support, and
4. follow statewide policy guidance for interoperable HIE by 18 months of program initiation.

PCMH and Health Homes Alignment

Health Homes (6 core services)	PCMH 2011 Standards	Meaningful Use/ HIT - selected examples
Comprehensive care management	Standard 1 Enhance Access/Continuity Standard 2 Identify and manage patient populations Standard 3 Plan and manage care Standard 6 Measure and improve performance	Searchable electronic system CPOE; ePrescribing Clinical decision support systems; Active medication list; medication allergy list; up-to-date problem list
Care coordination and health promotion	Standard 4 Provide self-care and community resources Standard 5 Track and coordinate care Standard 6 Measure and improve performance	Provider-to-provider portal RHIO Electronic system for patient reminders for preventive or follow up care
Transitional care, including follow-up care	Standard 5 Track and coordinate care Standard 6 Measure and improve performance	Transition of care summary Medication reconciliation between care settings RHIO
Patient and family support	Standard 4 Provide self-care and community resources Standard 6 Measure and improve performance	Provide patients with access to their health information
Referral to community and social support services	Standard 4 Provide self-care and community resources	Using EHR technology for patient-specific resources
Use of HIT to link services	Standards 1 – 6	P2P; RHIO; Using EHR technology for patient-specific resources

Meaningful Use & NCQA PCMH 2011

	Core Set	Menu Set
Meaningful Use Objectives	15 core objectives	5 of 10 menu set objectives
Clinical Quality Metrics	3 core metrics, or 3 alternate core metrics	3 of 38 menu set metrics

- **All fifteen core objectives map to NCQA PCMH 2011 scoring**
- **All ten menu objectives map to NCQA PCMH 2011 scoring**
- **Depending upon a practice's choice of NCQA clinical conditions, preventive & chronic services- many of the MU quality metrics will fulfill NCQA PCMH 2011 requirements**

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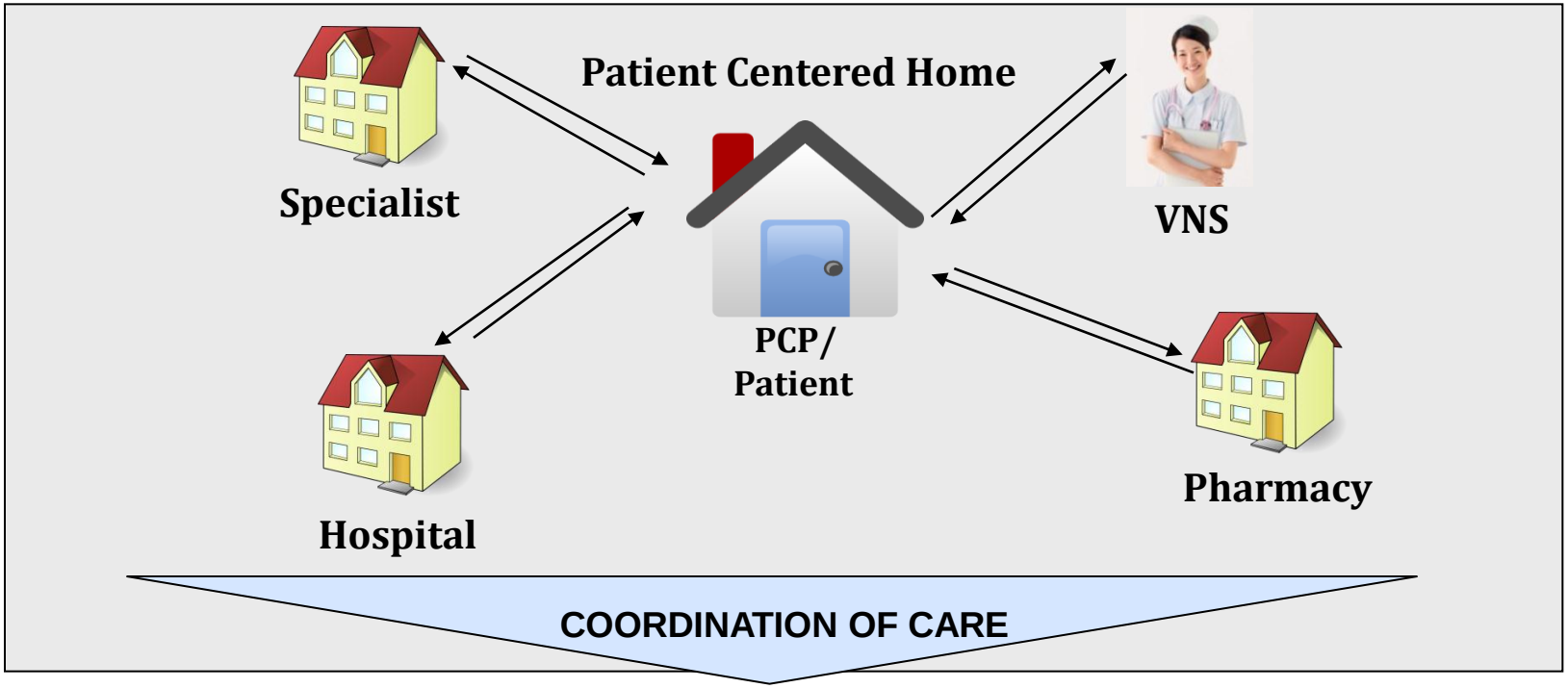
Agenda

- Alignment of HH, PCMH, and MU
- Patient-Centered Medical Home
- Meaningful Use
- Resources

Patient Centered Medical Home



"There is a clear consensus that primary care needs to be at the center of a reformed US health care system. The Patient-centered Medical Home (PCMH) has emerged as the key strategy for the redesign of primary care. The PCMH model builds upon the core concepts of primary care that include accessible, accountable, coordinated, comprehensive, and continuous care in a healing physician-patient relationship over time. Added to these basic primary care concepts are features that improve quality of care, improve patient centeredness, organize care across teams, and reform the payment system to support this enhanced model of primary care."

doi: 10.1370/afm.1087

What is the Patient-Centered Medical Home (PCMH)?

First described by American Academy of Pediatrics in 1967 in the context of coordinating care for children with special needs

A medical home is a health care delivery system that:

- Encourages patients to be active participants in their own health and well-being
- Is overseen by a personal physician who leads a medical team that coordinates all aspects of the patient's preventive-, acute-, and chronic-care needs

Joint Principles*

Key Elements of a Medical Home

- Personal clinician
- Clinician-directed medical practice
- Whole-person orientation
- Care is coordinated & integrated
- Quality & safety are hallmarks
- Enhanced access
- Payment reform

***Adopted March 2007 by American Academy of Family Practice (AAFP), American College of Physicians (ACP), American Academy of Pediatrics (AAP), and American Osteopathic Association (AOA)**

PCMH 2011 Goals

1. Increase patient-centeredness
2. Align the requirements with processes that improve quality and eliminate waste
3. Increase the emphasis on patient feedback
4. Enhance the use of clinical performance measure results
5. Integrate behaviors affecting health, mental health and substance abuse
6. Enhance coordination of care

Variations on Description and Measurement*

Assessment entities include:

- **AAAHC**
- **AAFP**
- **CMS**
- **Joint Commission**
- **NCQA**
- **URAC**
- **Various state departments of health**
- **Other**

NCQA is the most relevant to New York

- Focus mainly on structure (policies, procedures, technical capability) and process
- Tell us what you do, show us how you do it
- Clinical focus on three self-selected conditions & practice-defined group of high-risk patients

*Burton, RA, Devers KJ, Berensen RA, ***Patient-Centered Medical Home Recognition Tools: A Comparison of Ten Surveys' Content & Operational Details.*** Urban Institute, May 2011

NCQA PCMH 2011 Structure

Achievement levels

Level 1: 35-59 points; Must-pass elements = 6 of 6, with performance of at least 50%

Level 2: 60-84 points; Must-pass elements = 6 of 6, with performance of at least 50%

Level 3: 85-100; Must-pass elements = 6 of 6, with performance of at least 50%

IT requirements

- **Basic**: Requires electronic practice management
- **Intermediate**: Requires EHR or e-prescribing
- **Advanced**: Requires interoperable IT capabilities

Steps for evaluation

1. Practice conducts self-scoring assessment
2. Practice completes on-line Survey Tool
3. NCQA evaluates all data and documents & provides score
4. At least 5% of practices receive additional, onsite audit by NCQA
5. NCQA provides final information to the practice
6. NCQA reports information on the practice, the providers and level of performance to NCQA & data users (health plans & physician directories) for practices that pass a level

Pricing charged by NCQA

Initial fee Survey Tool license -$80

Initial Application fee

- $450-$2700 for 1-6 non-sponsored provider
- $360-$2700 for 1-6 sponsored providers

Standard 1: Enhance Access and Continuity

Intent of Standard	Corresponding Meaningful Use Measures
• Access during Office Hours (must pass) • Requires availability of advice after hours* • Electronic access to health information • Culturally and Linguistically Appropriate Services • Team-based care; trained staff	Core 12: Electronic Copy of Health Information Core 13: Clinical Visit Summary Menu 5: Timely Electronic Access to Health Information

Standard 2: Identify and Manage Patient Populations

Intent of Standard	Corresponding Meaningful Use Measures
• Electronic systems have searchable fields for demographic and clinical data; (not chart review) • Patients receive comprehensive health assessments • Use data for population management (must pass) • Identify patients who need services	Practice has searchable electronic system: Core 4: Race/ethnicity/preferred language Core 5: Maintain up to date problem list Core 6: Active medication list Core 7: Active medication allergy list Core 8: Record vital signs Core 9: Record Smoking Status Menu 3: Generate lists of patients by specific condition Menu 4: Send reminders for preventive/follow-up care

Standard 3: Plan and Manage Care

Intent of Standard	Corresponding Meaningful Use Measures
• Practice implements evidence-based guidelines • High-risk patients identified • Care team performs care management through pre-visit planning, developing plan and treatment goals	Core 1: CPOE Core 2: drug-drug, drug-allergy interaction checks Core 3: eRx Core 6: Maintain active medication list Core 10: Use clinical decision support Menu 1: Drug formulary checks Menu 7: Perform medication reconciliation between care settings

Standard 4: Provide Self-Care Support and Community Resources

Intent of Standard	Corresponding Meaningful Use Measures
• Develop and document self-management plans/goals • Provide self-care tools and support to patients • Practice identifies and refers patients to community resources	Menu 6: Use EHR to identify patient-specific education resources

Standard 5: Track and Coordinate Care

Overview of 2011 Standards	Meaningful Use Measures
• Track, flag and follow up on labs and imaging results • Track and follow-up on referrals • Coordinate care received at hospitals and other facilities/care transitions	Core 14: Capability to exchange key clinical information Menu 2: Incorporate clinical lab test results into EHR as structured data Menu 7: Medication reconciliation performed for patients coming from other care settings or provider Menu 8: Provide summary of care record for patients referred or transitioned to another provider or setting

Standard 6: Measure and Improve Performance

Intent of Standard	Corresponding Meaningful Use Measures
• Measure preventive, chronic, and acute care; utilization affecting costs; patient experience and report performance • Use and monitor effectiveness of quality improvement process • Report performance	Core 11: Report clinical quality measures to CMS Menu 9: Capability to submit electronic data to immunization registries Menu 10: Submit electronic syndromic surveillance data to public health agencies

New York State Medicaid Incentives for NCQA PCMH Recognition

Level	Fee-for-service (Institutional providers)	Fee-for-service (Professional providers)	Managed Care
1*	$5.50 per visit	$7.00 per visit	$2.00 pmpm
2	$11.25 per visit	$14.25 per visit	$4.00 pmpm
3	$16.75 per visit	$21.25 per visit	$6.00 pmpm

Also Medicare and a number of NYS commercial insurance pilots provide additional dollars to clinicians who attain NCQA PCMH recognition. Current range is $2 to $7 per member, per month.**

*Medicaid payments for level 1 will end December 2012

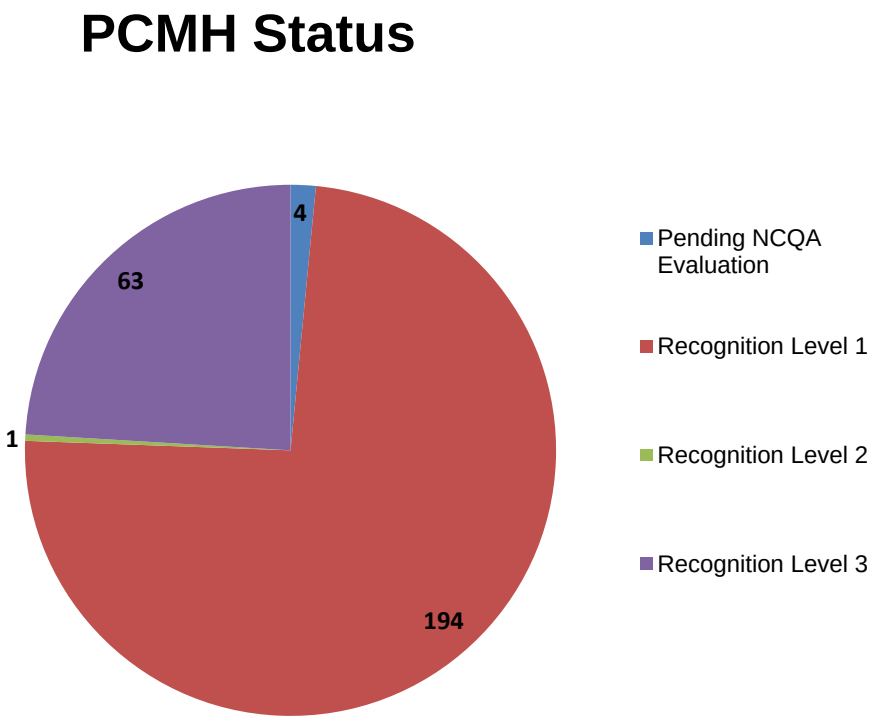
** Burke G. The Patient-Centered Medical Home: Taking a Model to Scale in New York State. 2011. United Hospital Fund

Patient Centered Medical Homes

PCIP practices
258 sites recognized

Level 1: 194
Level 2: 1
Level 3: 63

- 4 pending NCQA evaluation (anticipated level 3)
- Approximately **1 million** cared for at these sites



Agenda

- Alignment of HH, PCMH, and MU
- Patient-Centered Medical Home
- Meaningful Use
- Resources

Overview of Meaningful Use

The American Recovery and Reinvestment Act (ARRA) authorizes CMS to offer financial incentives to physician & hospital providers who demonstrate “meaningful use” of an electronic health record (EHR).

Meaningful Use is using a certified EHR technology to:

1) Improve quality, safety, efficiency, and reduce health disparities
2) Engage patients and families in their care
3) Improve care coordination
4) Improve population and public health
5) All the while maintaining privacy & security

Five Pillars of Meaningful Use

1. Improve quality, safety, efficiency, and reduce health disparities
- Provide access to comprehensive patient health data for patient's health care team
- Use evidence-based order sets and CPOE
- Apply clinical decision support at the point of care
- Generate lists of patients who need care and use them to reach out to patients

2. Engage patients and families
- Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health

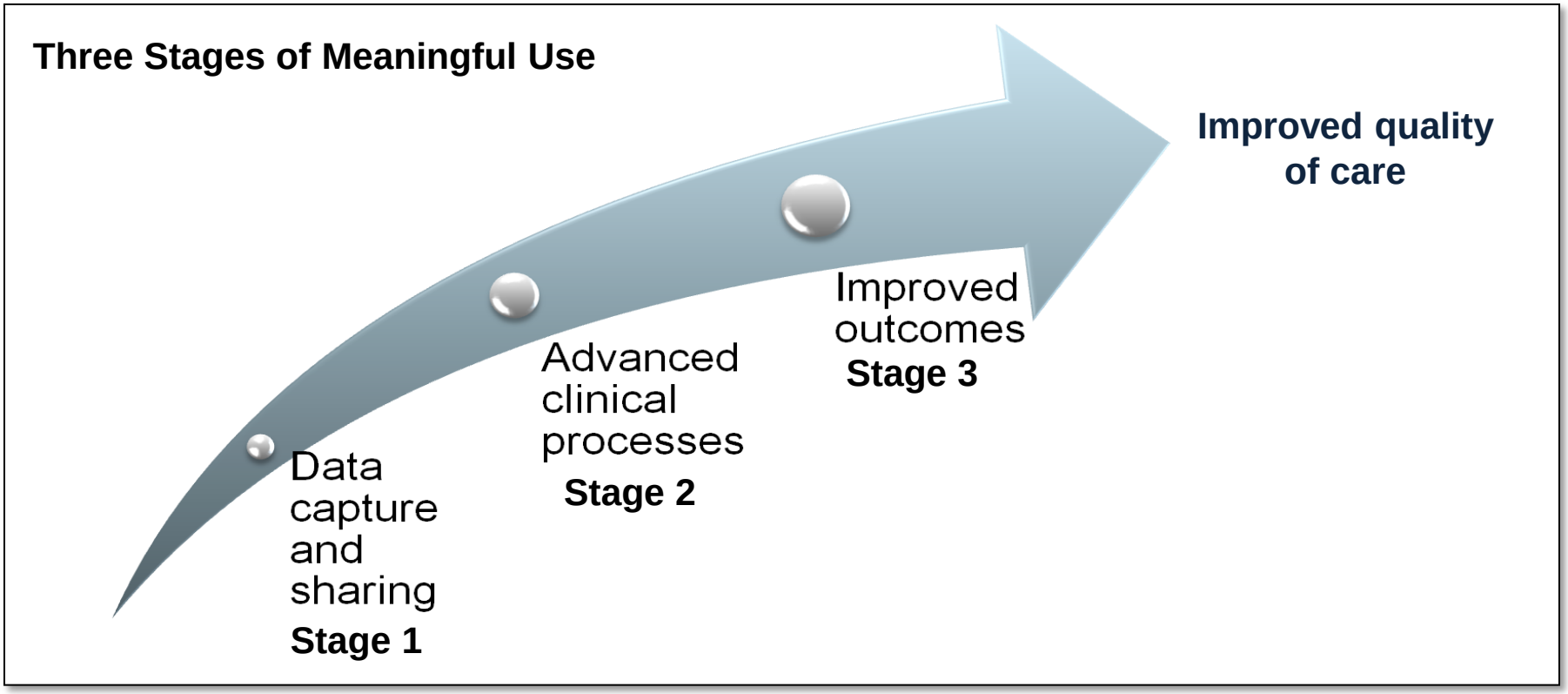
3. Improve care coordination
- Exchange meaningful clinical information among professional health care team

4. Improve population and public health
- Submit immunization, syndromic surveillance and reportable disease data to public health agencies

5. Ensure privacy and security protection for personal health information
- Protect confidential information through policies, procedures, and technologies
- Provide transparency of data sharing to patient

The Vision for Meaningful Use

Each stage gets progressively harder to drive toward the ultimate goal



~520,000 providers will be eligible nationwide to apply for Meaningful Use and receive incentives

Stage 1 Meaningful Use Measures

Overview

<u>Meaningful Use Objective Measures</u> divided into a "core set" and a "menu set."

"Core set" has 15 measures- must do all 15

"Menu set" has 10 measures- must choose 5

- Must choose at least one population or public health measure

As part of the "core set," providers will be required to report <u>Clinical Quality Measures</u> to CMS

Need to report 6 quality measures

- 3 core (or use the alternate core quality measures) plus
- 3 specialty measures from a set of 38 additional measures

Stage 1 Meaningful Use Measures

Meet all 15 CORE SET Measures

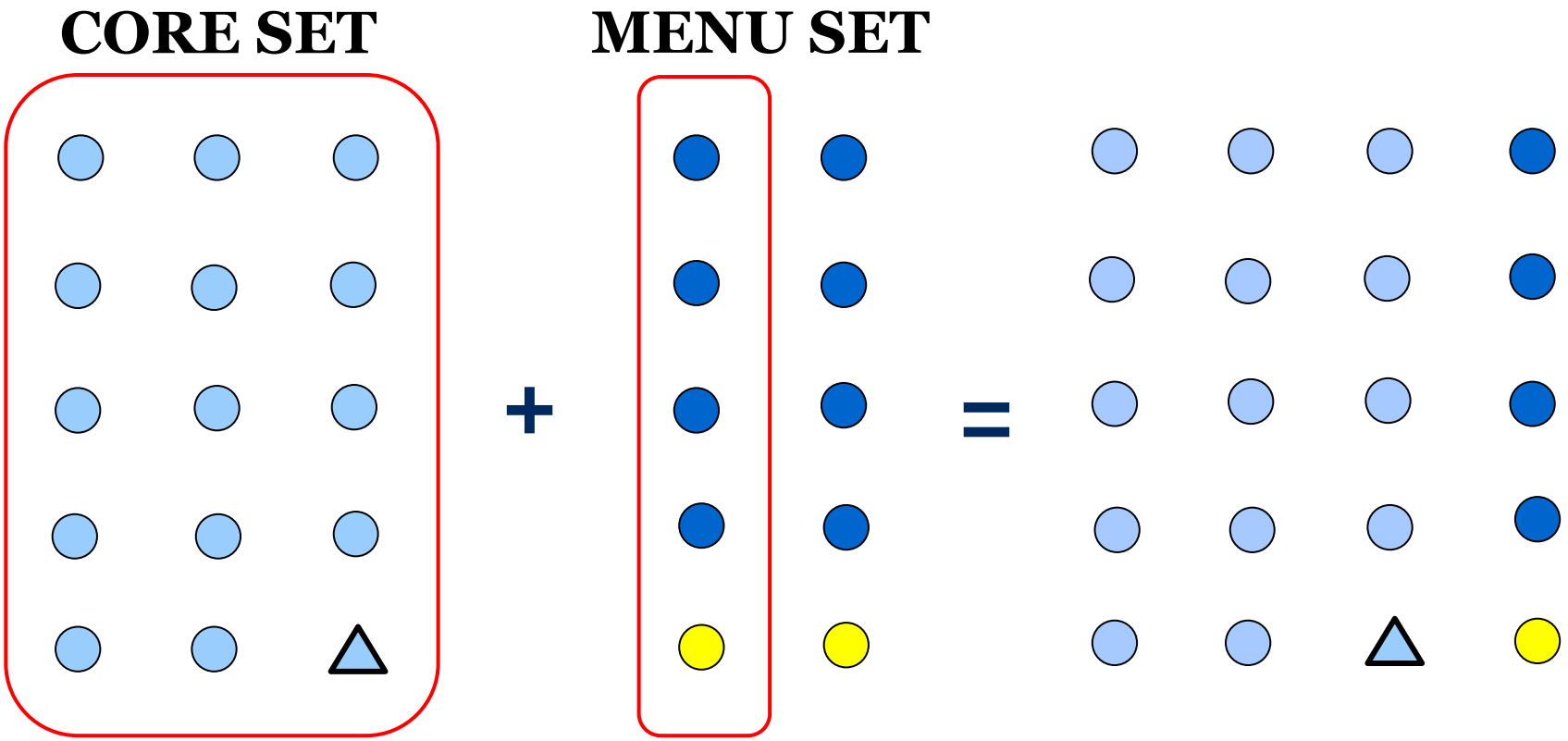
Objective	Measure
Record patient demographics (sex, race, ethnicity, date of birth, preferred language)	More than 50% of patients' demographic data recorded as structured data
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data
Maintain up-to-date problem list of current and active diagnoses	More than 80% of patient have at least one entry recorded as structured data
Maintain active medication list	More than 80% of patient have at least one entry recorded as structured data
Maintain active medication allergy list	More than 80% of patient have at least one entry recorded as structured data
Record smoking status for patients 13 years of age or older	More than 50% of patients 13 years of age or older have smoking status recorded as structured data
Provide patients with clinical summaries for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies)	More than 50% of requesting patients receive electronic copy within 3 business days
Generate and transmit permissible prescriptions electronically	More than 40% are transmitted electronically using certified EHR technology
Computer provider order entry (CPOE) for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE
Implement drug-drug and drug-allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR's capacity to electronically exchange information
Implement one clinical decision support rule and ability to track compliance with this rule	One clinical decision support rule implemented
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures

+

Submit 5 of 10 MENU SET Measures

Objective	Measure
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period
Incorporate clinical laboratory test results into EHRs as structure data	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10% of patients are provided patient-specific education resources
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50% of transitions of care
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50% of patient transitions or referrals
PH Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
PH Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20% of patients 65 years of age or older or 5 years of age or younger are set appropriate reminders
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR

Meaningful Use Objective Measures



At least 1 public health measure

LEGEND: △ Clinical Quality Measure ○ Public Health Measure

Clinical Quality Measures

Eligible Professionals– Core Set CQMs

NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0013	Hypertension: Blood Pressure Measurement
NQF 0028	Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow-up

Eligible Professionals – Alternate Core Set CQMs

NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older
NQF 0038	Childhood Immunization Status

Clinical Quality Measures

Additional Set CQM– EPs must complete 3 of 38

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
11. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b)Effective Continuation Phase Treatment
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
18. Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
19. Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

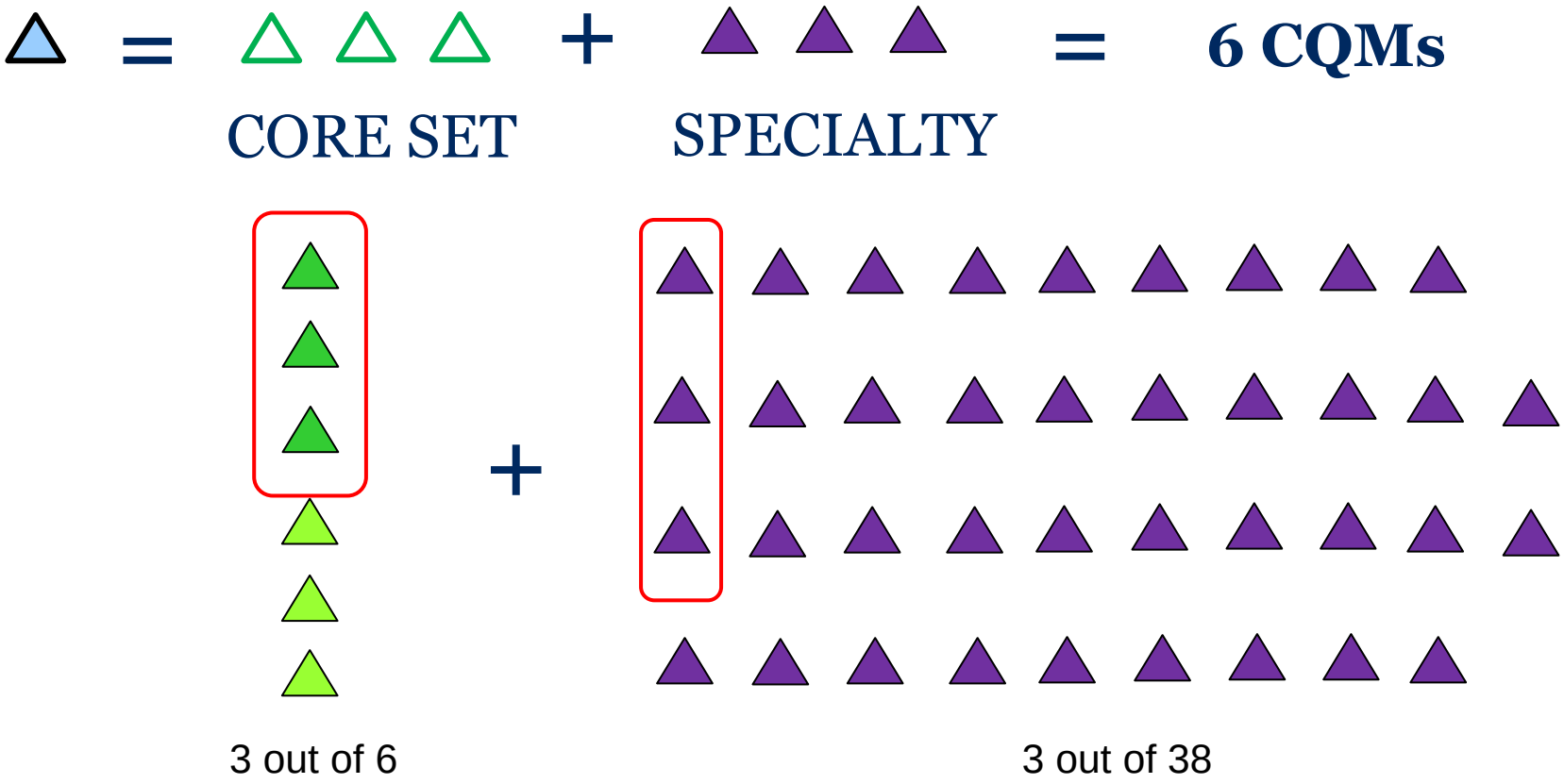
Clinical Quality Measures

Additional Set CQM– EPs must complete 3 of 38 (cont.)

19. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
20. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
21. Diabetes: Eye Exam
22. Diabetes: Urine Screening
24. Diabetes: Foot Exam
25. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
26. Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
27. Ischemic Vascular Disease (IVD): Blood Pressure Management
28. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
29. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
30. Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
31. Prenatal Care: Anti-D Immune Globulin
32. Controlling High Blood Pressure
33. Cervical Cancer Screening
34. Chlamydia Screening for Women
35. Use of Appropriate Medications for Asthma
36. Low Back Pain: Use of Imaging Studies
37. Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
38. Diabetes: Hemoglobin A1c Control (<8.0%)

Clinical Quality Measures (CQMs)

Clinical Quality Measures (CQMs)



Additional Meaningful Use Details

Reporting Period for Meaningful Use Measures

- 90 days for first year of payment
- Entire year for subsequent years

Switching between Medicaid & Medicare

- Meaningful Use measures will be the same for Medicaid and Medicare
- Providers will be allowed to switch one time between the 2 programs

Failing to meet criteria

- For Medicare, if you fail to meet criteria for a year, you lose the incentive payment for that year
- For Medicaid, you can reapply the next year

Overview of Payments

Medicare

- Payments are proportional to Medicare allowed charges (75% of total of allowed Part B charges up to a cap each year)
- Up to $44,000 over 5 years
- Payments increased by 10% for physicians practicing in a Health Professional Shortage Area
- Must participate by 2012 to receive the maximum incentive payment

Medicaid

- Payments are fixed and not proportional to Medicaid billings.
- Up to $63,750 over 6 years
- Meet 30% Medicaid patient volume thresholds
- If pediatricians qualify at 20%, only eligible for 67% (2/3) of payments
- Must participate by 2016 to receive the maximum incentive payment

<u>If you are eligible for both incentives programs, you must select only one.</u>

Meaningful Use Payment: Medicare

- Participation in the Medicare EHR Incentive Program can begin as early as 2011 or as late as 2014. Incentives end in 2016.
- Penalties for not meeting Meaningful Use begin in 2015 (1% in 2015, 2% in 2016, and 3% in 2017)

	First Calendar Year in which the EP receives an Incentive Payment				
Calendar Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
2011	$18,000				
2012	$12,000	$18,000			
2013	$8,000	$12,000	$15,000		
2014	$4,000	$8,000	$12,000	$12,000	
2015	$2,000	$4,000	$8,000	$8,000	$0
2016		$2,000	$4,000	$4,000	$0
Total	$44,000	$44,000	$39,000	$24,000	$0

Meaningful Use Payment: Medicaid

Medicaid EHR Incentive programs are voluntarily offered by individual states and may begin as early as 2011 or as late as 2016. Incentives end in 2021.

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2011	First Year Medicaid EP Qualifies to Receive Payment 2012	First Year Medicaid EP Qualifies to Receive Payment 2013	First Year Medicaid EP Qualifies to Receive Payment 2014	First Year Medicaid EP Qualifies to Receive Payment 2015	First Year Medicaid EP Qualifies to Receive Payment 2016
2011	$21,250	-	-	-	-	-
2012	$8,500	$21,250	-	-	-	-
2013	$8,500	$8,500	$21,250	-	-	-
2014	$8,500	$8,500	$8,500	$21,250	-	-
2015	$8,500	$8,500	$8,500	$8,500	$21,250	-
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	-	$8,500	$8,500	$8,500	$8,500	$8,500
2018	-	-	$8,500	$8,500	$8,500	$8,500
2019	-	-	-	$8,500	$8,500	$8,500
2020	-	-	-	-	$8,500	$8,500
2021	-	-	-	-	-	$8,500
TOTAL Possible Incentive Payments	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Stage 2 Meaningful Use

Proposed Rule for Stage 2 Meaningful Use

Stage 1 to Stage 2 Meaningful Use

Stage 1	Stage 2
Eligible Professionals 15 core objectives 5 of 10 menu objectives **20 total objectives**	**Eligible Professionals** 17 core objectives 3 of 5 menu objectives **20 total objectives**
Eligible Hospitals & CAHs 14 core objectives 5 of 10 menu objectives **19 total objectives**	**Eligible Hospitals & CAHs** 16 core objectives 2 of 4 menu objectives **18 total objectives**

http://www.cms.gov/EHRIncentivePrograms/

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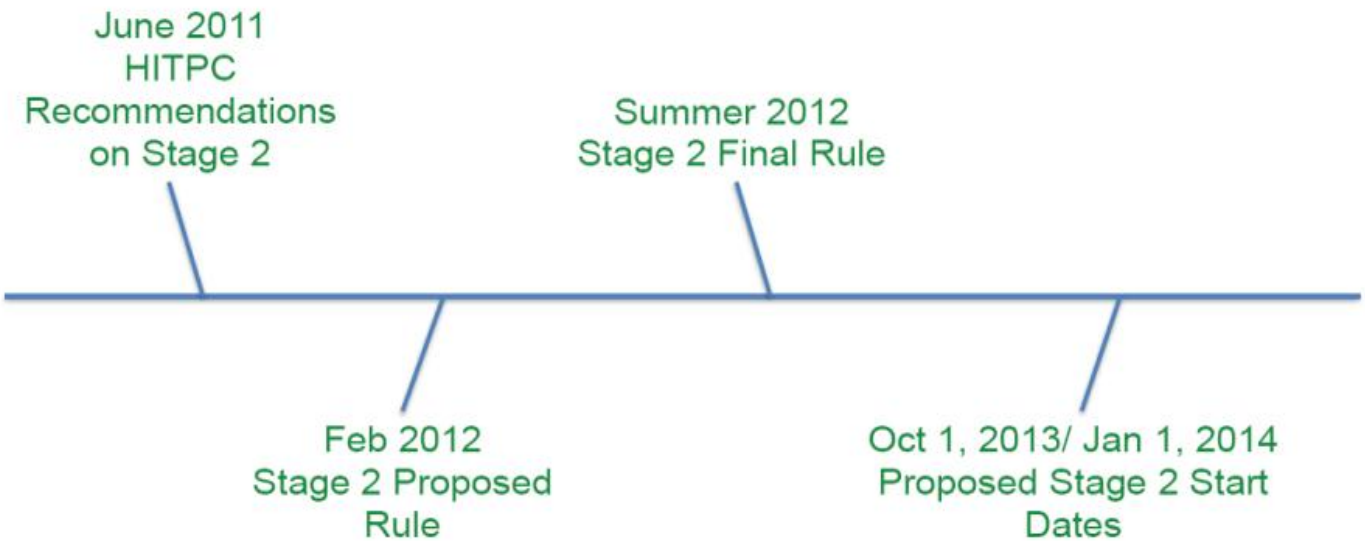
Stage 2 Timeline



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Stages of Meaningful Use

1st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

http://www.cms.gov/EHRIncentivePrograms/

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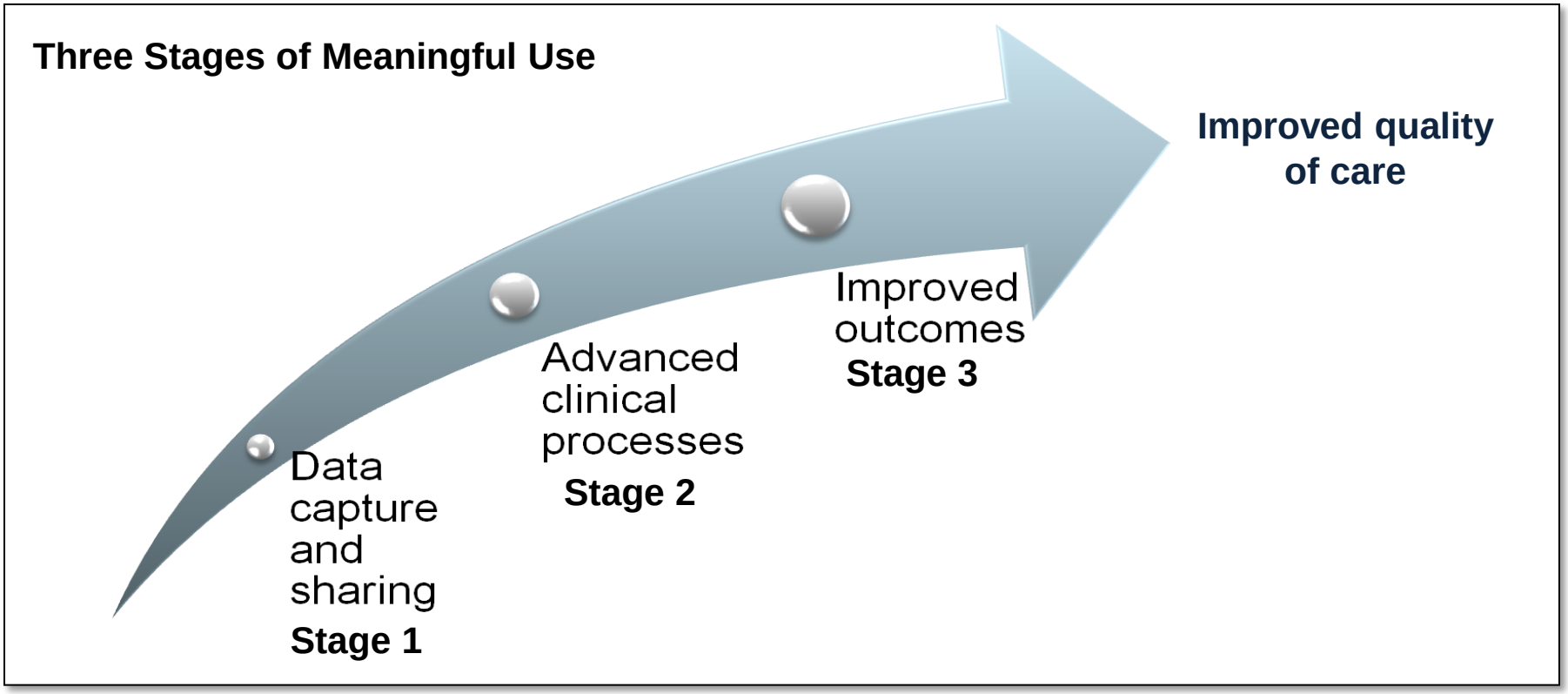
The Vision for Meaningful Use

Each stage gets progressively harder to drive toward the ultimate goal



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In Summary

1. Health Homes, PCMH, and Meaningful Use align for improving:
    - patient outcomes
    - patient experience
    - cost containment

2. Health IT is a required component of all three programs.

3. Additional resources are available from:
    - NYC REACH
    - NYeC
    - IPRO

Agenda

- Alignment of HH, PCMH, and Meaningful Use
- Patient-Centered Medical Home
- Meaningful Use
- Resources

NYC REACH Member Resources

- Resource Library:
  - www.nycreach.org/members/resourcelibrary
  - password protected
- Medicaid MU Registration Assistance: http://www.nycreach.org/request
- PCIP Newsletters
- NYC REACH Digest Emails
- Webinars and Group Trainings: http://emrtraining.eventbrite.com
- On the Record (online forum): http://ontherecord.ning.com/

NYeC – New York eHealth Collaborative Resources- http://www.nyehealth.org

- NYS HIE Operational Plan http://nyehealth.org/images/files/File_Repository16/pdf/nys_hie_operational_plan_2010.pdf
- Meaningful Use http://www.nyehealth.org/index.php/resources/meaningful-use
- NYS Policies http://www.nyehealth.org/index.php/resources/nys-policies
- RHIOs http://www.nyehealth.org/index.php/resources/rhios
- Tools http://www.nyehealth.org/index.php/resources/tools
- Glossary http://www.nyehealth.org/index.php/resources/glossary#page_h_5
- FAQ http://www.nyehealth.org/index.php/resources/faq
- Links http://www.nyehealth.org/index.php/resources/links
- Events http://www.nyehealth.org/index.php/events
- Regional Extension Center http://www.nyehealth.org/rec/
- Newsletter http://www.nyehealth.org/index.php/news/newsletter

Some IPRO-Suggested PCMH Links

- Agency for Healthcare Research and Policy PCMH Resource Center: http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483
- American Academy of Family Physicians: http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html
- American Academy of Pediatrics: http://www.medicalhomeinfo.org and http://www.pediatricmedhome
- American College of Physicians: http://www.acponline.org/running_practice/pcmh/help.htm
- Center for Medical Home Improvement: http://www.medicalhomeimprovement.org/index.html
- Community Care of North Carolina: http://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/
- Emisolutions-TransforMed: http://www.emmisolutions.com/medicalhome/transformed/
- IPRO: http://www.ipro.org/index/patient-centered-medical
- National Committee for Quality Assurance: http://www.ncqa.org/tabid/1302/Default.aspx
- Patient-Centered Primary Care Collaborative: http://pcpcc.net/
- Primary Care Development Corporation: http://pcdcny.org/
- Safety Net Medical Home Initiative: http://qhmedicalhome.org/safety-net/index.cfm

Meaningful Use Resources

Federal/State Websites

- CMS: http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp
- ONC Website: http://www.healthit.hhs.gov
- NYState MU Medicaid Website: https://www.emedny.org/meipass/apply.aspx
- Certified Health IT Product List Website: http://onc-chpl.force.com/ehrcert

Vendors

- Meaningful Use Curriculum
- Meaningful Use Dashboards/Reports

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HH Implementation Session 5: Care Coordination

Presenters: Sara Butterfield, IPRO
Joseph Twardy, VNS of Schenectady & Saratoga Counties

Date & Time: Wednesday April 11,2012 2:30 pm eastern time

Registration Link: https://cc.readytalk.com/r/ksfp878hrtzq

All training sessions (recordings and registrations) will be made available on the Medicaid website.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ohitt_ehr_webinars.htm