Knowing and Managing Your Patients

(KM Competency B, E and F)

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Community Health Solutions

Community Health Solutions

Knowing and Managing your Patients (KM)

The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

Knowing and Managing your Patients (KM)

- KM A: Problem lists, Comprehensive Health Assessments, Depression Screening
- KMB: Diversity, Language
- KM C: Proactive Outreach
- KM D: Medication Reconciliation, Medication lists
- KM E: Clinical Decision Support
- KM F: Community Resources

KM – Competency B

The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 09 (Core)	**Diversity:** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.	*Report*	*2C1*
KM 10 (Core)	**Language:** Assesses the language needs of its population.	*Report*	*2C2*
KM 11 (1 Credit) ***(A) is new** ***(C) is new**	**Population Needs:** Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two): A. Target population health management on disparities in care. B. Educates practice staff on health literacy. C. Educate practice staff in cultural competence.	*Evidence of implementation* (or QI 05 **AND** QI 13 for A ONLY)*	*KM 11B aligns with 3C10*

Note: KM 11B was revised 9.30.17

KM 09 (Core)

Diversity: **Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.**

- The practice collects information on how patients identify in **at least three areas** that include:
  1. Race.
  2. Ethnicity.
  3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence.

- Assessing the diversity of its population can help a practice identify segments of the population with specialized needs or subject to systemic barriers leading to disparities in health outcomes. Data may be collected from all patients directly or the practice may use data about the community served by the practice (such as inputting data from zip code analysis or accessing census data from their specific community).

KM 10 (Core)

Language: Assesses the language needs of its population.

- The practice documents in its records whether the patient declined to provide language information, that the primary language is English or that the patient does not need language services. **A blank field does not mean the patient's preferred language is English**.
- Documenting patients' preferred spoken and written language helps the practice identify the language resources required to serve the population effectively such as materials in prevalent languages, translation services, and availability of bilingual staff. Data may be collected by the practice from all patients directly or may be data about the community served by the practice.

Diversity and Language

KM 09-10: Example

Date Range: January 1, 20[redacted] - December 1, 20[redacted]

Race

Asian	African American	Native American	Caucasian	More than one Race	Refused to Report
5	25	289	1603	29	6

Ethnicity

Hispanic	Non-Hispanic	Refused to Report
162	1697	99

Veterans

Veterans
39

Date Range - January 1, 20[redacted] - December 31, 20[redacted]

Patients better served in a language other than English

Patients	English	Spanish
1957	1858	99
100%	94.9%	5.1%

KM 11 (1 Credit)

Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two):

A. Target population health management on disparities in care *New

B. Educates practice staff on health literacy.

C. Educate practice staff in cultural competence *New

- The practice recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs.

KM 11 (1 Credit) Continued

The practice:

A. **Identifies disparities in care and implements actions to reduce the disparity**. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population. ***New**

B. **Builds a health-literate organization** (e.g., apply universal precautions, provide health literacy **training for staff**, system redesign to serve patients at different health literacy levels, utilize the AHRQ or Alliance for Health Reform Health Literacy toolkit). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes.

C. **Builds a culturally competent organization** that **educates staff** on how to interact effectively with people of different cultures. It supports practice staff to become respectful and responsive to the health beliefs and cultural and linguistic needs of patients. ***New**

Health literacy resources

- **Institute of Medicine: Ten Attributes of Health Literate Health Care Organizations** http://nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf
- **Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit:** https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html
- **Alliance for Health Reform Toolkit:** http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf
- **Iowa Health Literacy Collaborative:** https://www.ihconline.org/additional-tools/initiatives/health-literacy/

Population Needs - Health Literacy

KM 11:B Example

Example of assessing health literacy at the patient level using a standardized assessment embedded in the EHR.

Health Literacy Score = 1: Patient never needs help reading instructions from doctor or pharmacist.

Example of training materials used to educate staff on topics related to health literacy.

Teach-back:

A Health Literacy Tool to Ensure Patient Understanding

Educational Module for Clinicians

from the

Iowa Health System Health Literacy Collaborative

Teach-back is…

- Asking patients to repeat **in their own words** what they need to know or do, in a non-shaming way.
- **Not** a test of the patient, but of how well ***you*** explained a concept.
- A chance to check for understanding and, if necessary, re-teach the information.

KM Competency B - FAQs

How does NCQA define "another characteristic of diversity"? (KM 09)

- The standards and guidelines state, "Diversity is a meaningful characteristic of comparison for managing population health that accurately identifies individuals within a non-dominant social system who are underserved." Examples include, but are not limited to, first ancestry, age, marital status, employment status, education level, housing status and income.

Are statewide data acceptable for documenting race and ethnicity? (KM 09)

- No. Data must reflect the local community served by the practice.

KM Competency B - FAQs

How can we best collect language needs information from all patients in our large population? (KM 10)

- Practices can use two methods to collect language need information:
  1. Collect data from all patients and their families to create a report showing language needs.
  2. Obtain data from an external source (e.g., data about the local community or its patient population).
- Patients who do not speak English and patients from racial/ethnic minority groups may be less inclined to provide this information. Care should be taken to request the information using methods that respect multi-cultural differences.
- Resource: *NCQA's 2010 Multicultural Health Care Standards (Abbreviated) E-Pub*

Questions?

- **How does your clinic asses the diversity of your patients?**

- **How does your clinic asses the language needs of your patients?**

KM – Competency E

The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 20 (Core)	**Clinical Decision Support:** Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate **at least four** criteria A-G): A. Mental health condition. B. Substance use disorder. C. A chronic medical condition. D. An acute condition. E. A condition related to unhealthy behaviors. F. Well child or adult care. G. Overuse/appropriateness issues.	*Identifies conditions, source of guidelines **AND** Evidence of implementation*	*3E*

KM 20 (Core) Clinical Decision Support:

- The practice utilizes systems in its day-to-day operations that integrate evidence-based guidelines (frequently referred to as clinical decision support [CDS]). CDS is a systematic method of prompting clinicians to consider evidence-based guidelines at the point of care.
- CDS encompasses a variety of tools, including, but not limited to:
  - Computerized alerts and reminders for providers and patients.
  - Condition-specific order sets.
  - Focused patient data reports and summaries.
  - Documentation templates.
  - Diagnostic support.
  - Contextually relevant reference information.
- Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS.

KM 20 (Core) Clinical Decision Support:

A. Mental health

- The practice uses evidence-based guidelines to support clinical decisions related to **at least one** mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's) in the care of patients.

B. Substance use disorder treatment

- The practice uses evidence-based guidelines to support clinical decisions related to **at least one** substance misuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism) in the care of patients.

KM 20 (Core) Clinical Decision Support:

C. A chronic medical condition

- The practice has evidence-based guidelines it uses for clinical decision support related to **at least one** chronic medical condition (e.g., arthritis, asthma, cardiovascular disease, COPD, diabetes) in the care of patients.

D. An acute condition

- The practice uses evidence-based guidelines to support clinical decisions related to **at least one** acute medical condition (e.g., acute back pain, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis, urinary tract infection) in the care of patients.

E. A condition related to unhealthy behaviors

- The practice uses evidence-based guidelines to support clinical decisions related to **at least one** unhealthy behavior (e.g., obesity, smoking) in the care of patients.

KM 20 (Core) Clinical Decision Support:

F. Well child or adult care

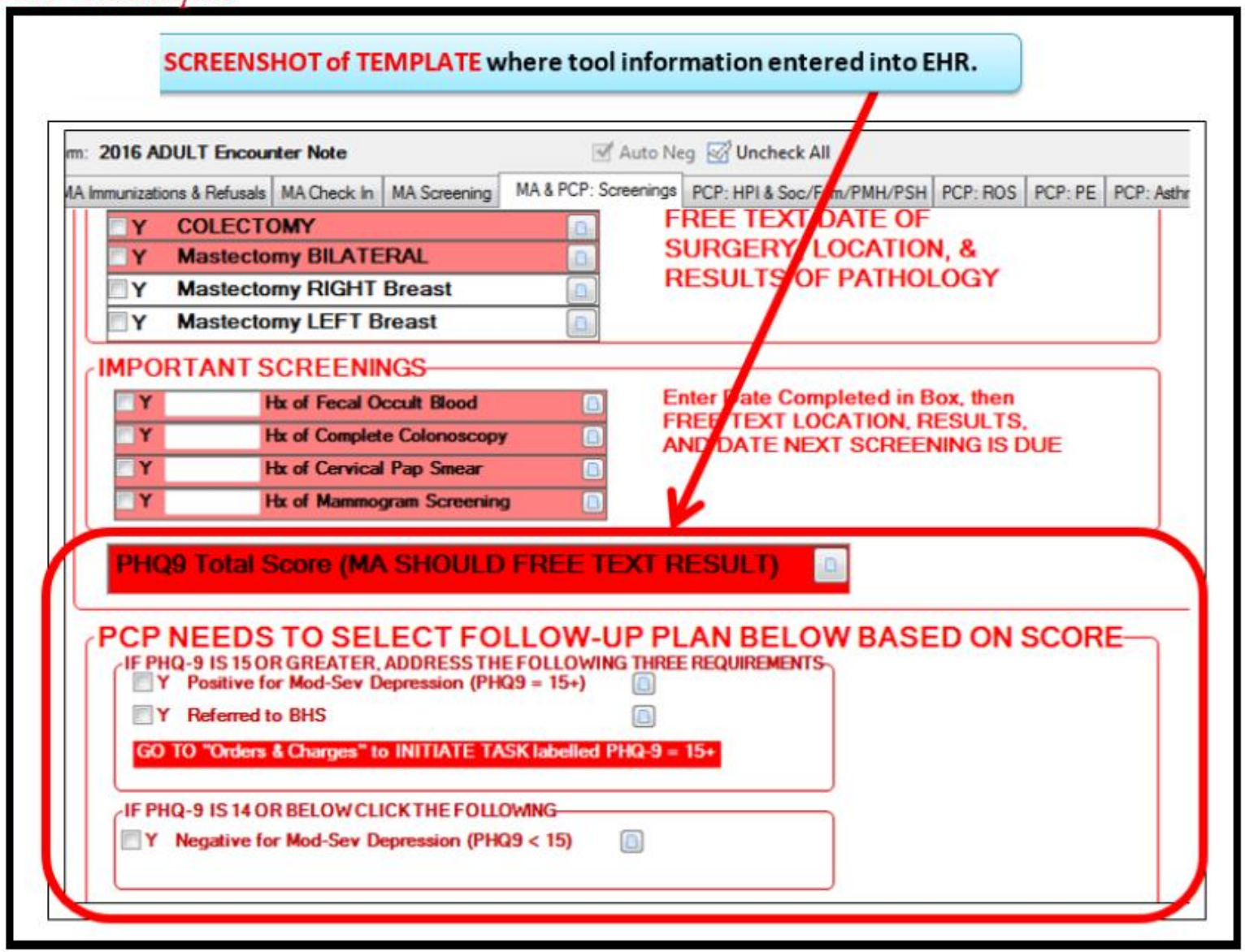
- The practice uses evidence-based guidelines to support clinical decisions related to well-child or adult care (e.g., age appropriate screenings, immunizations) in the care of patients.

G. Overuse/appropriateness issues

- The practice uses evidence-based guidelines to support clinical decisions related to overuse or appropriateness of care issues (e.g., use of antibiotics, avoiding unnecessary testing, referrals to multiple specialists) in the care of patients. The American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support (http://www.choosingwisely.org).

Clinical Decision Support – Mental Health

KM 20 A: Example



KM 20 Evidence Based Guidelines

Clinically important condition #1/ Diabetes:

Screening: Based upon recommendations from the American Diabetes Association, all patients greater than 45 years of age are screened for diabetes. Patients are screened by obtaining either random blood glucose or, preferably, a fasting blood glucose. However patients at risk for developing diabetes are screened when they are < 45 years of age. These risk factors for diabetes include:

- BMI > 25
- Family history of DM
- Habitual physical inactivity
- Race- African Americans, Hispanic Americans, Asian Americans, and Pacific Islanders
- Previously identified impaired fasting BG
- BP >140/90
- HDL <35
- Polycystic ovarian disease
- History of vascular disease

Diagnosis: Based upon American Diabetes Association (ADA) recommendations, patients are diagnosed with Diabetes Mellitus if they have, on two separate occasions, a fasting blood glucose >126 mg/dL or a 2 hour postprandial blood glucose > 200mg/dL.

Treatment goals:

Based upon ADA American Association of Clinical Endocrinologist (AACE) recommendations:

1. pre meal BG <120
2. fasting BG >80, <100
3. HgBA1c <6.5%
4. BP <130/80
5. LDL <100
6. Annual eye exam
7. Routine foot exams and neuropathy screenings
8. Routine microalbuminuria screenings

KM 20 – Example Diabetes Flowsheet (showing evidence of implementation)

Diabetes Flowsheet

	Frequency	Date	Date	Date	Date
History & Physical					
Blood Pressure	Every Visit				
Check Weight (BMI)	Every Visit		40.1	40.6	
Retinal Screening	Annually				
Inspect feet	Every Visit				
Comprehensive Lower Extremity Exam	Annually				
Dental/Oral health assessment	6 Months				
Kidney Assessment	Annually			Y	
Labs & Tests					
A1c	3 Months	7.7		7.3	
Triglycerides	Annually	218		206	
HDL	Annually	36		47	
LDL	Annually	25		35	
Total Cholesterol	Annually	147		173	
Estimated GFR	Annually	<- 60			
Medications & Immunizations					
Aspirin Use	Every Visit			Y	
Assess Need For ACE/ARB	Every Visit		Y	Y	
Assess Need For Statin	Every Visit		Y	Y	
Influenza Vaccination	Annually		Y		
Pneumococcal Vaccination	5 Years				
Lifestyle & Counseling					
Set Self-Management Goals	Every Visit		Y	Y	
Diabetes Patient Education / Nutrition / Exercise	Every Visit		Y	Y	
Tobacco Use/Exposed to 2nd hand smoke	4 Months		N	Y	
Smoking/Second Hand Smoke Counseling	Every Visit		Y	Y	
Depression / Mental Health Screening	Every Visit		Y	Y	
Review blood glucose log	Every Visit		Y	Y	

KM Competency E - FAQs

What type of tool is not acceptable as an example of demonstrating implementation of clinical decision support? (KM 20)

- Copies of guidelines and empty templates or flow sheets do not demonstrate implementation of clinical decision support. These items show the guideline, but do not show its use at the point of care. In addition to the condition and source of the guideline used for clinical decision support, the practice must provide a patient example demonstrating the guideline is used at the point of care.

KM Competency E - FAQs

Does use of the PHQ-2 or PHQ-9 meet the requirements for KM 20-A?

- The intent is that the provider is alerted when a specific service or action is needed at the point of care, based on evidence-based guidelines. Practices that use an evidence-based tool that is built into the EHR or is part of a workflow and used according to clinical guidelines can meet the requirements **if** they provide the guideline and an example of the guidelines implementation (i.e., the tool's use). Use of PHQ-2/PHQ-9 meets the requirement **if** practices provide the evidence-based guideline for its use in monitoring depression treatment they use **and** an example of the tool's implementation in clinical care and decision making. **The intent of this factor is to monitor progress during treatment, not for screening or diagnosis.**

KM Competency E - FAQs

What qualifies as an overuse or inappropriateness issue for KM 20-G?

- Practices must implement evidence-based guidelines via a clinical decision-support tool for each factor. KM 20G requires evidence-based guidelines on appropriate use of services (e.g., appropriate laboratory test ordering, avoiding the use of MRI as a first-line diagnostic test for back pain, appropriate use of antibiotics).
- NCQA encourages practices to look at ABIM's Choosing Wisely Web site for information on overuse/ appropriateness (www.choosingwisely.org). Examples include use of antibiotics for pediatric ear infections and referral to an orthopedist for acute, uncomplicated low back pain.

Questions?

- **What is one** evidence-based **point of care reminder your clinic has imbedded in your EHR?**

KM – Competency F

The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 21 * (Core)	**Community Resource Needs:** Uses information on the population served by the practice to prioritize needed community resources.	*List of key patient needs and concerns*	*No equivalent*
KM 22 (1 Credit)	**Access to Educational Resources:** Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	*Evidence of implementation*	*4E2,3,5*
KM 23 * (1 Credit)	**Oral Health Education:** Provides oral health education resources to patients.	*Evidence of implementation*	*No equivalent*
KM 24 (1 Credit)	**Shared Decision-Making Aids:** Adopts shared decision-making aids for preference-sensitive conditions.	*Evidence of implementation*	*4E4*

KM 21 (Core) Community Resource Needs

Uses information on the population served by the practice to prioritize needed community resources.

- The practice identifies needed resources by assessing collected population information. Practice may assess social determinants, predominant conditions, emergency department usage and other health concerns to prioritize community resources (e.g. food banks, support groups) that support the patient population. ***New**

KM 22 (1 Credit) Access to Educational Resources

Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs. Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy.

- The practice provides **three examples** of how it implements these tools for its patients.

KM 22 (1 Credit) Access to Educational Resources

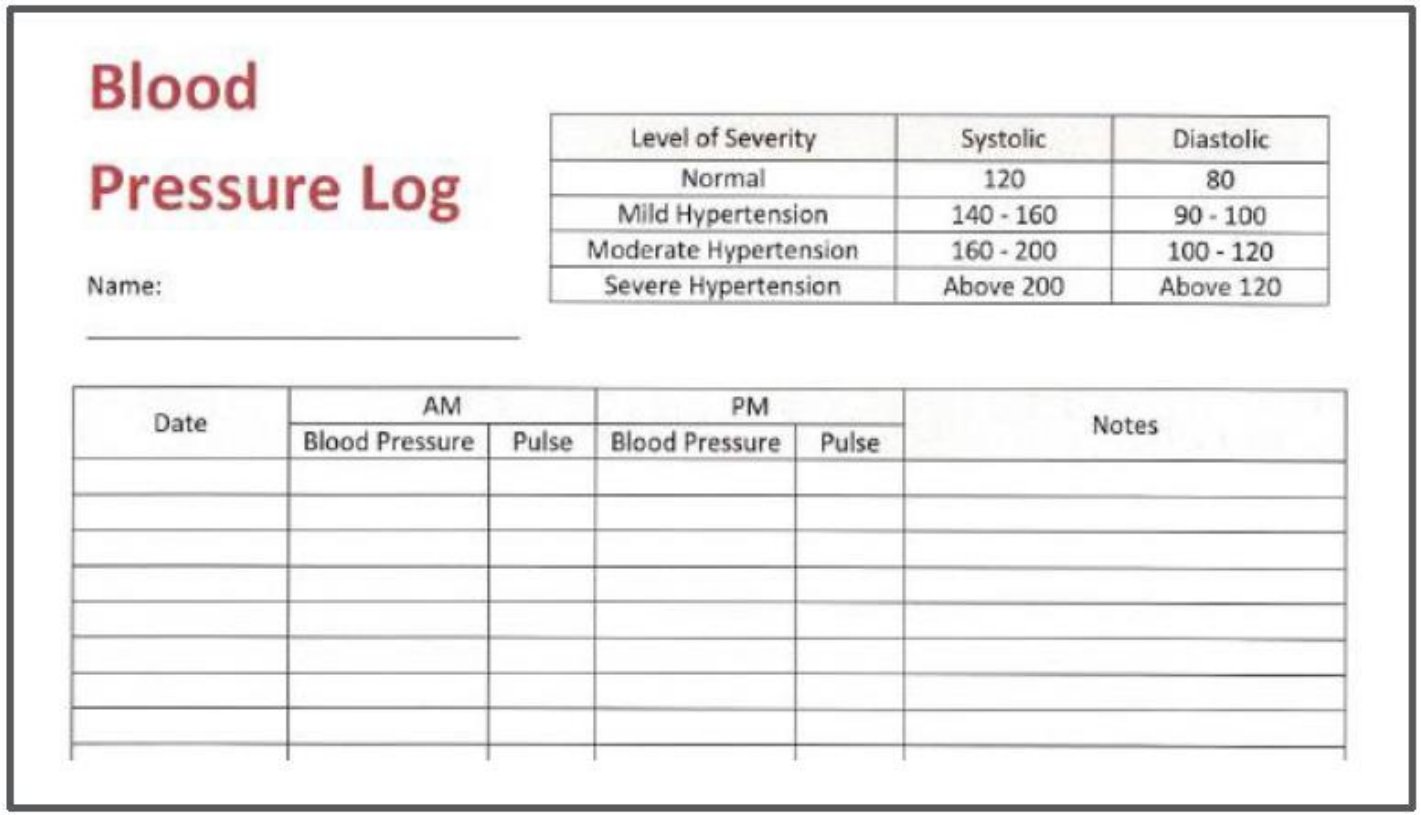
- **Educational programs and resources** may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups).

- **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings

The practice provides or shares available **health education classes,** which may include alternative approaches such as **peer-led discussion groups** or **shared medical appointments** (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and facilitate

Access to Educational Resources

KM 22: Example



Blood Pressure Log

Name: _____

Level of Severity	Systolic	Diastolic
Normal	120	80
Mild Hypertension	140 - 160	90 - 100
Moderate Hypertension	160 - 200	100 - 120
Severe Hypertension	Above 200	Above 120

Date	AM		PM		Notes
	Blood Pressure	Pulse	Blood Pressure	Pulse	

KM 22 – Example Diabetes Self Management Tool

Diabetes Health Record

	Frequency	Common Goals	Individual Goals	My results	My results	My results
Review blood sugar records Pre-meal target: After meal (1 to 2 hours) target:	every visit	 less than 130 less than 180				
Blood pressure	every visit	less than 140/80				
Weight (set realistic goals)	every visit					
Foot exam	every visit					
Hemoglobin A1C	every 3 to 6 months	less than 7.0				
Urine microalbumin/ creatinine ratio	yearly	less than 30				

KM 22 – Example Educational Class Description

Prenatal Care: Steps Toward a Healthy Pregnancy

Prenatal Session #1

PROGRAM: Comprehensive Perinatal Services Program TIME: 1-1 ½ Hours

OBJECTIVES

By the end of the session, the participant will be able to:

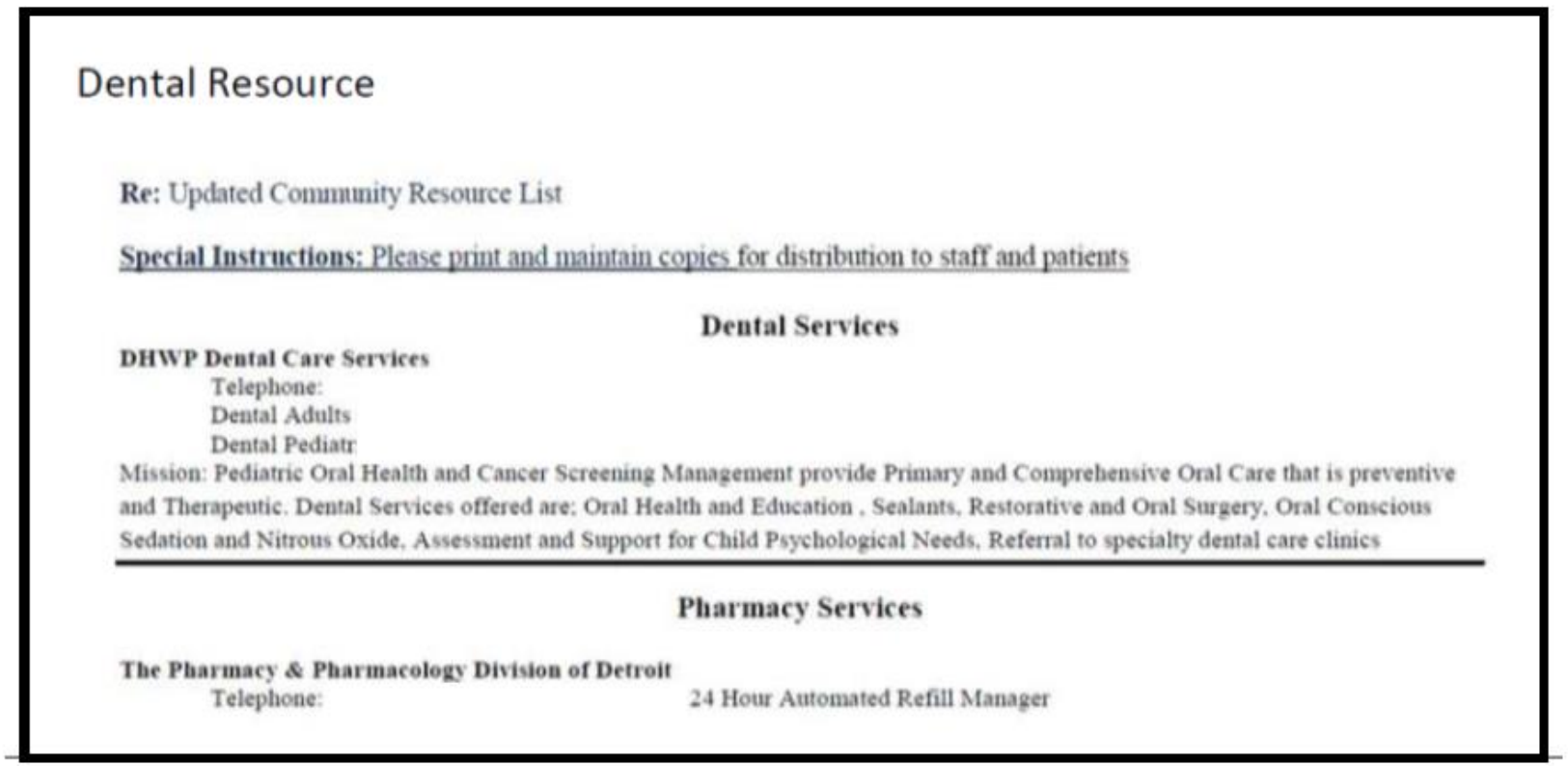
1. **Identify basic anatomy of human reproductive system**
2. **Identify common discomforts of pregnancy including aspects of fetal growth and development.**
3. **Identify danger signs during pregnancy and action to take during complications.**
4. **Identify lab tests including the importance of ultrasound.**
5. **Understand the importance of Oral health during pregnancy**

KM 23 (1 credit) Oral Health Education

- The practice provides an example of how it provides patients with educational and other resources that pertain to oral health and hygiene. Oral disease is largely preventable with knowledge and attention to hygiene. Poor oral health can complicate the care for chronic conditions such as diabetes and heart disease. ***New**

Knowing and Managing Your Patients

KM 23: Example



Dental Resource

Re: Updated Community Resource List

Special Instructions: Please print and maintain copies for distribution to staff and patients

Dental Services

DHWP Dental Care Services
Telephone:
Dental Adults
Dental Pediatr
Mission: Pediatric Oral Health and Cancer Screening Management provide Primary and Comprehensive Oral Care that is preventive and Therapeutic. Dental Services offered are; Oral Health and Education , Sealants, Restorative and Oral Surgery, Oral Conscious Sedation and Nitrous Oxide, Assessment and Support for Child Psychological Needs, Referral to specialty dental care clinics

Pharmacy Services

The Pharmacy & Pharmacology Division of Detroit
Telephone: 24 Hour Automated Refill Manager

KM 24 (1 Credit) Shared Decision-Making Aids

Adopts shared decision-making aids for preference-sensitive conditions.

- The care team has, and demonstrates use of, **at least three** shared decision-making aids that provide detailed information without advising patients to choose one option over another.
- The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Engaging patients in understanding their health condition and in shared decision making helps build a trusting relationship.
- More information and resources can be found through the International Patient Decision Aid Standards Collaboration (IPDASC). http://ipdas.ohri.ca/index.html

Shared Decision-Making Aids

KM 24: Example

What is my risk of breaking a bone?

As you get older, your risk of breaking a bone, often through a fall, increases. This increased risk may be due to weakened bones or ***osteoporosis***.

Your risk is estimated primarily by:
Your age: ____
Your Bone Mineral Density (T score): _____

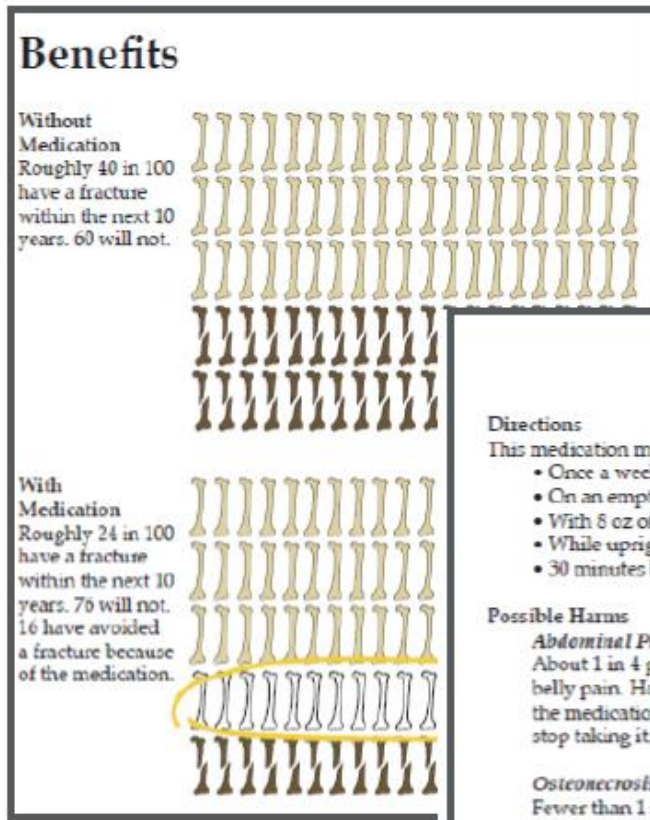
It is also affected by:
- ☐ If you have had a fracture
- ☐ If a parent had a fracture
- ☐ If you currently smoke
- ☐ If you drink more than 2 drinks of alcohol a day
- ☐ If you have taken prescription steroid medications

Based on these risk factors, we estimate your risk is
<10% 10-30% >30%

Your fracture risk can be lowered with medications called ***bisphosphonates***, which work to reduce bone loss. This decision aid will walk you through the benefits and downsides of bisphosphonates, so that we can make an informed choice about whether or not they are right for you.

Prepared for: _____

Benefits



Downsides

Directions
This medication must be taken
- Once a week
- On an empty stomach in the morning
- With 8 oz of water
- While upright (sitting or standing for 30 min)
- 30 minutes before eating

Possible Harms

Abdominal Problems
About 1 in 4 people will have heartburn, nausea, or belly pain. However, it may not be from the medication. If the medication is the cause, the problem will go away if you stop taking it.

Osteonecrosis of the Jaw
Fewer than 1 in 10,000 (over the next 10 years) will have bone sores of the jaw that may need surgery.

Out of Pocket Cost
with insurance $30 | without insurance $70-90

What would you like to do?

KM – Competency F
(continued)

The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
KM 25 * (1 Credit)	**School/Intervention Agency Engagement:** Engages with schools or intervention agencies in the community	*Documented process **AND** Evidence of implementation*	*No equivalent*
KM 26 (1 Credit)	**Community Resource List:** Routinely maintains a current community resource list based on the needs identified in KM 21.	*List of resources*	*4E6*
KM 27 (1 Credit)	**Community Resource Assessment:** Assesses the usefulness of identified community support resources.	*Evidence of implementation*	*4E7*
KM 28 * (2 Credits)	**Case Conferences**: Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).	*Documented process **AND** Evidence of implementation*	*No equivalent*

KM 25 (1 Credit) School/Intervention Agency Engagement

Engages with schools or intervention agencies in the community.

- The practice develops supportive partnerships with social services organizations or schools in the community. The practice demonstrates this through formal or informal agreements or identifies practice activities in which community entities are engaged to support better health.

School/Intervention Agency Engagement

KM 25: Example

The Hispanic Counseling Center

Patient Access	STEP 1 (within 24 hours of visit) ☐ If visit is urgent, PCP office will call The Hispanic Counseling Center office intake line to notify of need for a more expedited appointment and outreach to the patient STEP 2 (within 24-48 hours of visit) ☐ Patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit indicated STEP 3 (on-going management) ☐ If patient does not schedule or is a 'no-show', notification from Specialist office will be sent to PCP office within 30 days via fax or telephone encounter ☐ 609 Fulton Pediatrics Pc Care Coordinators run reports & perform outreach to anyone who has not complete appropriate follow-up	STEP 1 (during patient PCP visit) ☐ If visit is urgent, PCP office will call Specialist office to notify of need for expedited appointment STEP 2 (within 24-48 hours of visit) ☐ Referred patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit STEP 3 (at visit) ☐ If patient needs to be seen for follow up visit - patient will schedule directly with Specialist office
Transitions of Care	STEP 1 (at visit) ☐ Informs patient of need, purpose, expectations and goals of the specialty visit ☐ Patient/family in agreement with referral, type of referral and selection of Specialist ☐ Unless urgent, PCP office provides patient with Specialist contact information and patient calls to schedule appointment STEP 2 (within 24 hours of visit) ☐ PCP office documents appropriate	STEP 1 (at visit) ☐ Reviews reason for visit with patient/family ☐ If patient needs to be seen in ED or Mental Health Facility, arrangements will be made then Specialist office will notify PCP office within 24 hours STEP 2 (within 7-10 days of initial visit) ☐ The specialist office communicates with the PCP regarding the patient's plan of care, up-dated diagnosis, and medication recommendations. ☐ If there is ongoing visits with the

KM 26 (1 Credit) Community Resource List

Routinely maintains a current community resource list based on the needs identified in KM 21.

- The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population. The list includes services offered outside the practice and its affiliates. Include a date to demonstrate that the list is regularly updated or otherwise demonstrate how the list is maintained.
- Maintaining a current resource list that prioritizes the central needs and concerns of the population can help a practice guide patients to community resources that support their health and well-being from that additional support.

KM 26 Community Resource List

Community Resources

Teen Pregnancy and Parenting Referral:

- Teen Pregnancy/Parenting Programs: (800) 833-6235
- Garfield Medical Center, 525 N. Garfield Ave. MP, CA (626) 573-2222 (Pico Rivera)
- USC-WCH, 1240 N. Mission Rd, Los Angeles (323) 442-1100
- San Gabriel Perinatology Center. 616 N. Garfield, Monterey Park, CA. 91754.

Medical Choice Referral:

- Health Net Member Service Department: 1-800-675-6110
- AltaMed Assistants: 1-877-GO-2-ALTA
- DPSS 1(800) 660-4066

New Immigrant Resources:

- National Hispanic Prenatal Hotline: 1-800-504-7081
- National Immigration Law Center: (213) 639-3900
- International Rescue Committee Inc (213) 386-6700

Cultural Considerations:

- Local Adult Education Classes, ELA College (323) 233-1283
- ESL Classes, L.A Unified Adult School (323) 262-5163
- Language Line Services: 1 (800) 367-9559

Parenting Stress

- Parental Stress Line Number: (800) 339-6993, or 211
- Elizabeth House: (626) 577-4434

KM 27 (1 Credit) Community Resource Assessment

Assesses the usefulness of identified community support resources.

- The practice assesses the usefulness of resources by requesting and reviewing feedback from patients/families/caregivers about community referrals. Community referrals differ from clinical referrals, but may be tracked using the same system.
- When a practice's patients have unmet social needs, the practice can refer patients to useful community support resources. Meeting the patient's social needs, supports their self-management and reduces barriers to care.

KM 28 (2 Credits) Case Conferences

Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).

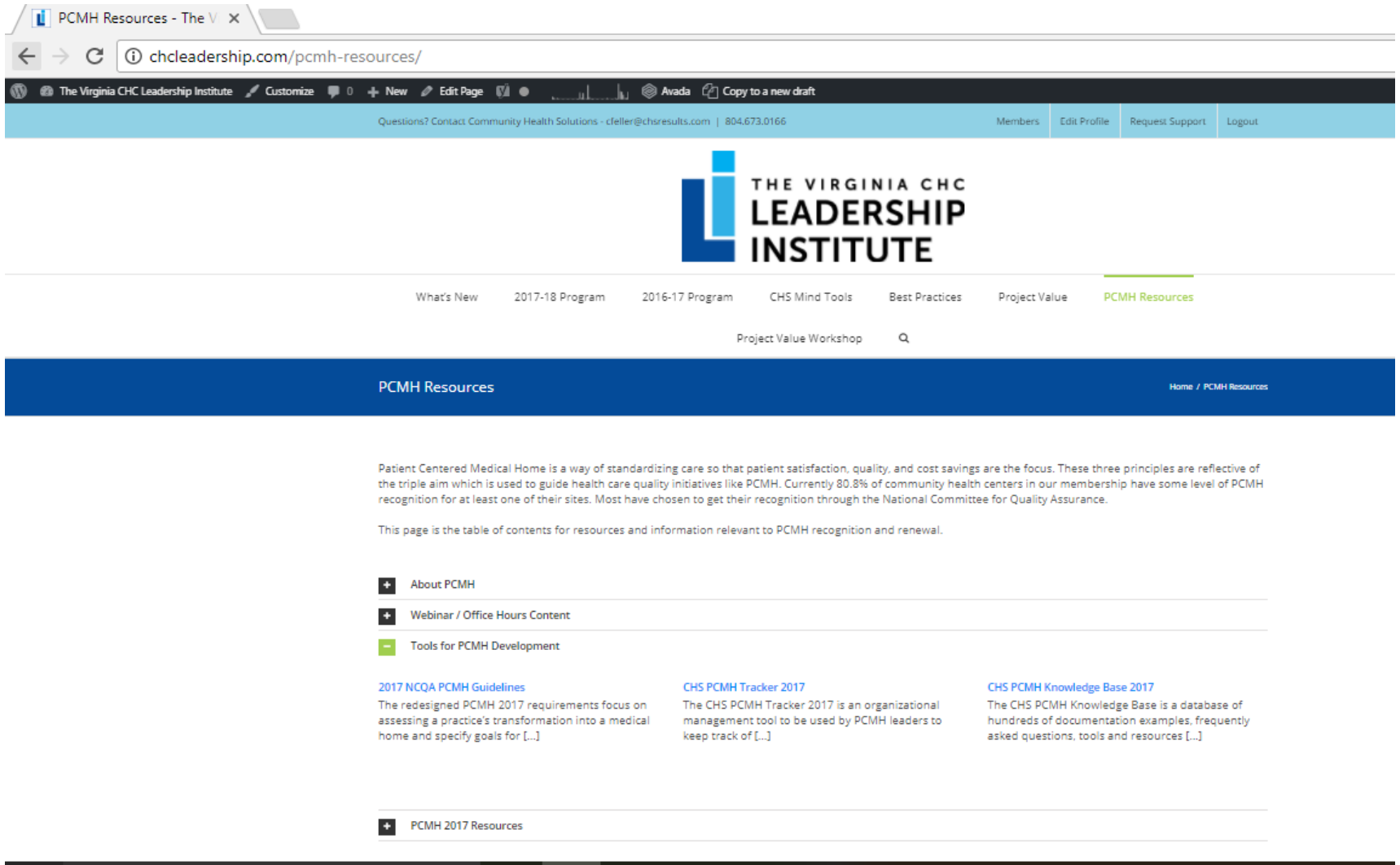
- The practice uses "case conferences" to share information and discuss care plans for high-risk patients with clinicians and others outside its usual care team.
- Case conferences are planned, multidisciplinary meetings with community organizations or specialists to plan treatment for complex patients.

Questions?

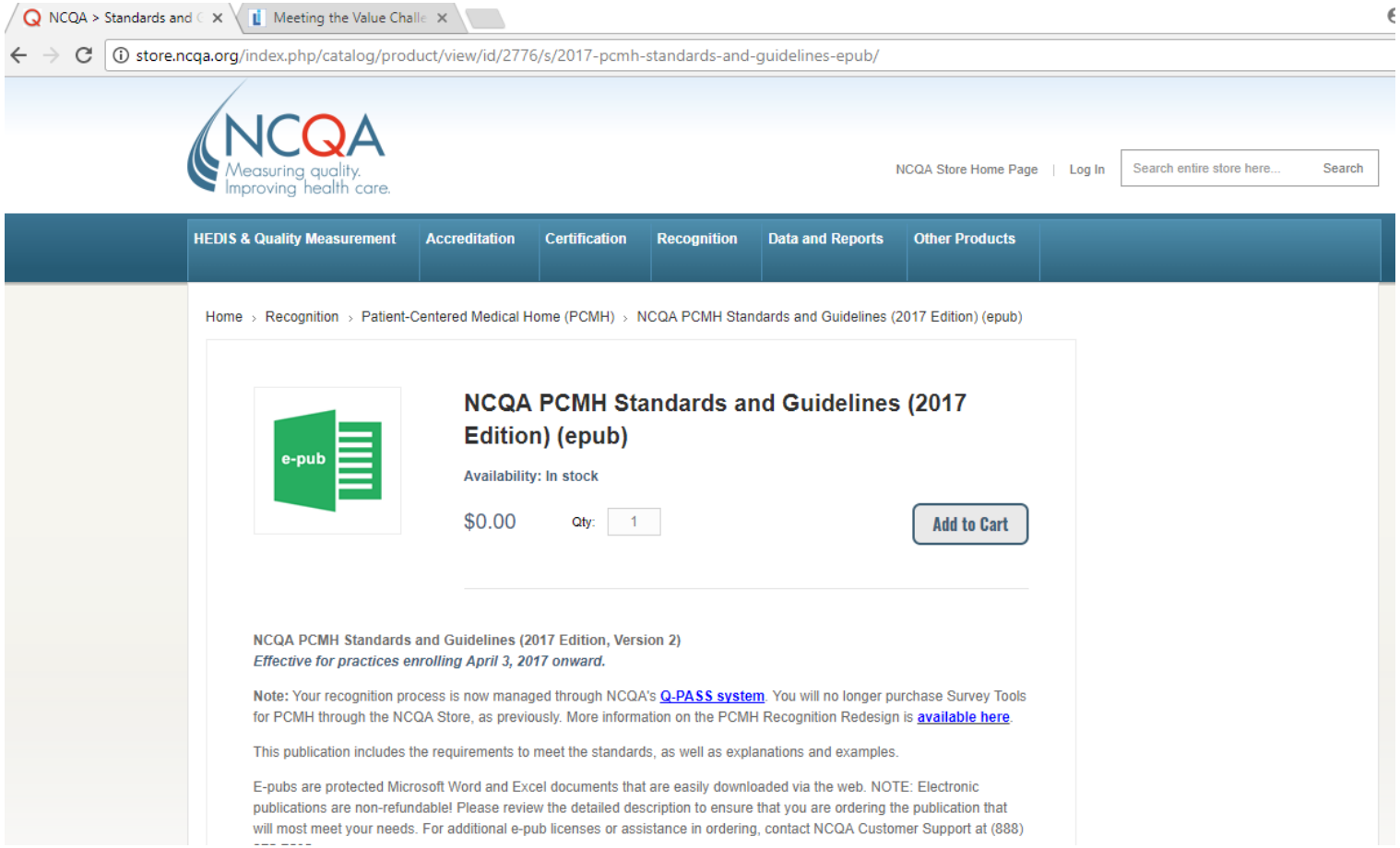
Announcements

- ***PCMH Development webinar schedule:***
  - **January 9th - AC Competency A (Patient Centered Access)**
  - February 13th - AC Competency B and TC Competency C
  - March 13th - CM Competency A and B
  - April 10th - CC Competency A and B
  - May 8th - CC Competency C
  - June 12th - QI Competency A, B and C

http://chcleadership.com/pcmh-resources/



http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/



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