These notes have been excerpted from the drafts of forthcoming resource guides on TCE's Building Healthy Communities outcomes. The notes are designed as an interim tool and meant for internal use for facilitators and site coordinators. – Planning Support Team

Outcome #2
Families Have Improved Access to Health Homes that Support Healthy Behaviors

Health homes are a relatively new and increasingly popular model for organizing and delivering patient-centered health care. Also called *medical homes* or *patient-centered medical homes (PCMH),* the approach typically involves primary care practitioners partnering with the patient and family to provide accessible, comprehensive, coordinated, family-centered, culturally competent, and prevention-oriented care. The *Patient Centered Primary Care Collaborative* has published a compilation of patient-centered medical home pilot and demonstration projects. TCE is promoting a broader model of "health homes" rather "medical homes" because of our emphasis on prevention and on using community assets, which include health care providers other than physicians.

PROMISING PRACTICES AND STRATEGIES

INTEGRATED, COORDINATED, AND COMPREHENSIVE CARE

Strategy	Examples and Resources
Using health information technology to ensure coordination within and between health care settings (i.e. electronic medical records and electronic health records).	• ACCEL El Dorado Care Pathways is a personalized care management program designed to increase access to primary and specialty care for underinsured and uninsured children in El Dorado County. • National Health IT Collaborative for the Underserved • Patient Centered Primary Care Collaborative: IT Resource Guide
Utilizing a team-based primary care model, that requires one or more primary care physicians collaborate with multiple team members to develop and provide comprehensive, individualized and integrated treatment plans.	• Kaiser Permanente/Georgia redesigned its primary care delivery system by developing over twenty primary care teams to improve patient care and satisfaction. • Vermont Blueprint for Health also incorporated Community Care Teams to improve the health care system for Vermonters. • Bodenheimer, T. "Building Teams in Primary Care: Lessons Learned and 15 Case Studies." California HealthCare Foundation. July 2007.
Integrating oral health, mental health and other services into health home service.	• The 11th Street Family Health Services Center (Philadelphia) provides coordinated and integrated services, and offers training for new staff to understand how each of the three clinical areas of the practice relate (primary care, behavioral health, and dental services)
Providing linkages and connections with community organizations that provide services that support health and promote wellness.	• *Help Me Grow* (Connecticut) works in collaboration with other organizations to implement a network of children's services. • The Peninsula Family Advocacy Program Medical-Legal Partnership provides onsite legal services to low-income families and pregnant women in addressing legal barriers to their children's health outcomes.
Utilize community health workers (CHWs) in their roles as trusted frontline health workers.	• Healthy Homes Asthma II Project (Seattle-King County, WA); utilized CHWs to educate families about reducing indoor asthma triggers. • Community Health Worker National Educational Collaborative • Vision y Compromiso: The CHW/Promotora Network (California)

PATIENT- AND FAMILY-CENTERED CARE

Strategy	Examples and Resources
Making Health Home Accessible	• The Second Street Family Practice (Maine) reduced waits and delays in health care delivery service. • TransforMED Resource on improving access to physician offices and implementing group visits.
Engaging Patients and Families Through Shared Decision-Making	• Washington became the first state to explicitly endorse through legislation the use of shared decision-making. • Center for Advancing Health: *Supporting Patient Engagement in the Patient-Centered Medical Home*
Encouraging and Supporting Patient Self-Management	• El Rio Community Health Center's (Tucson, AZ) childhood asthma self-management program. • New Health Partnerships - Partnering in Self-Management Support: A Toolkit for Clinicians
Encouraging the use of Personal Health Records (PHR)	• Mathematica Policy Research, Inc.: "Personal Health Records: What Do Underserved Consumers Want?" May 2007. • Example: Health Shack (Sacramento, CA), a pilot program that designed and implemented PHRs for youth. • Examples of PHR tools: American Health Information Management Assoc. MyPHR, Microsoft's Health Vault and Google Health

CULTURALLY COMPETENT AND LINGUISTICALLY ACCESSIBLE CARE

Strategy	Examples and Resources
Ensuring culturally competent health care systems	• America's Health Insurance Plans: Tools to Address Disparities in Health • Health Resources and Services Administration: Cultural Competence Resources for Health Care Providers
Incorporating language assistance services in health care settings	• California Health Care Safety Net Institute – Straight Talk: Model Hospital Policies and Procedures on Language Access • Medical Leadership Council on Cultural Proficiency: Language Access, Cultural Proficiency and Workforce Diversity
Collecting data on race and ethnicity	• Institute of Medicine: Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement. August 2009.
Hiring a workforce that reflects the diversity of patients and families	• Example: Welcome Back Initiative

HIGH-QUALITY CARE

Strategy	Examples and Resources
Providing Appropriate and Evidence-Based Care	• University of Michigan's Medical School uses an electronic reminder/tracking system designed to support evidence-based quality improvement efforts. • National Guideline Clearinghouse – A resource for evidence-based clinical guidelines.
Embracing concepts and strategies that promote continuous quality improvement	• Building Clinical Capacity for Quality is an initiative designed to enhance the capacity of community clinics to implement quality improvement strategies that are supported by health information technologies. • American Board of Internal Medicine Practice Improvement Modules – Web-based tools that enable physicians to conduct an evaluation of their services.
Investing in technologies and staff training that supports the incorporation of updated and expedited forms of payment and reimbursement.	Development of the health home may require new forms of reimbursement for health professionals and organizations. The American Medical Association offered a framework for thinking about payment in their Joint Principles of the Patient Centered Medical Home. The Patient-Centered Primary Care Collaborative proposed a three-part model for reimbursement for patient-centered medical homes

MEASURES OF PROGRESS

- The American Academy of Pediatrics and TransforMED (a subsidiary of the American Academy of Family Physicians) have developed resources to self-assess an organization's medical home status.
- NCQA has developed a Patient-Centered Medical Home recognition program, which measures access and communication, patient tracking and registry functions, referral tracking, performance reporting and improvements, and advanced electronic communications.
- Consumer Assessment of Healthcare Providers and Systems (CAHPs) that measures patient's experiences and ambulatory and facility level care
- Patient Activation Measure (PAM), a tool that assesses the knowledge, skills and confidence of managing one's health and healthcare.
- Another area of policy development will be the integration of these patient-experience measures in the overall measures and assessments of health homes.