

Is your health
center certified as a
Patient-Centered
Medical Home?

Yes

No



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Health centers that are designated as Patient Centered Medical Homes aim to connect primary care, private practice providers, specialists, hospitals, outreach, and behavioral health, along with relevant community-based organizations, to not only deliver care but to support healthy lifestyles and safe environments for the community. Studies suggest that implementing an effective Patient Centered Medical Home framework will increase patient acceptance and satisfaction while reducing the total costs. In [one study](#), PCMH recognition was associated with 4.9 percent less total Medicare spending per beneficiary. [Another study](#) concluded that the longer a practice had been transformed, and the higher the risk of the patient pool in terms of comorbid conditions, the more significant the positive effect of practice transformation, especially in terms of cost savings.

Visit [HRSA Accreditation and Patient-Centered Medical Home Recognition Initiative](#) webpage to get started.

Download HITEQ's [PCMH Self-Assessment Tool](#) to gauge your health center's readiness for meeting the NCQA 2017 PCMH Requirements.

Back

Forward



**Are your clinic sites that
serve special populations
like mobile agricultural
workers also PCMH
certified?**

Yes

No



The majority of health centers have achieved PCMH at one or more of their sites. Many health centers, however, have not brought PCMH to the clinics that serve their most vulnerable, and at times most challenging, patients. Yet, these patients, like mobile agricultural workers, may benefit the most from PCMH processes, if the processes are adapted for the barriers the patients may face.

Here are some resources to get you started:

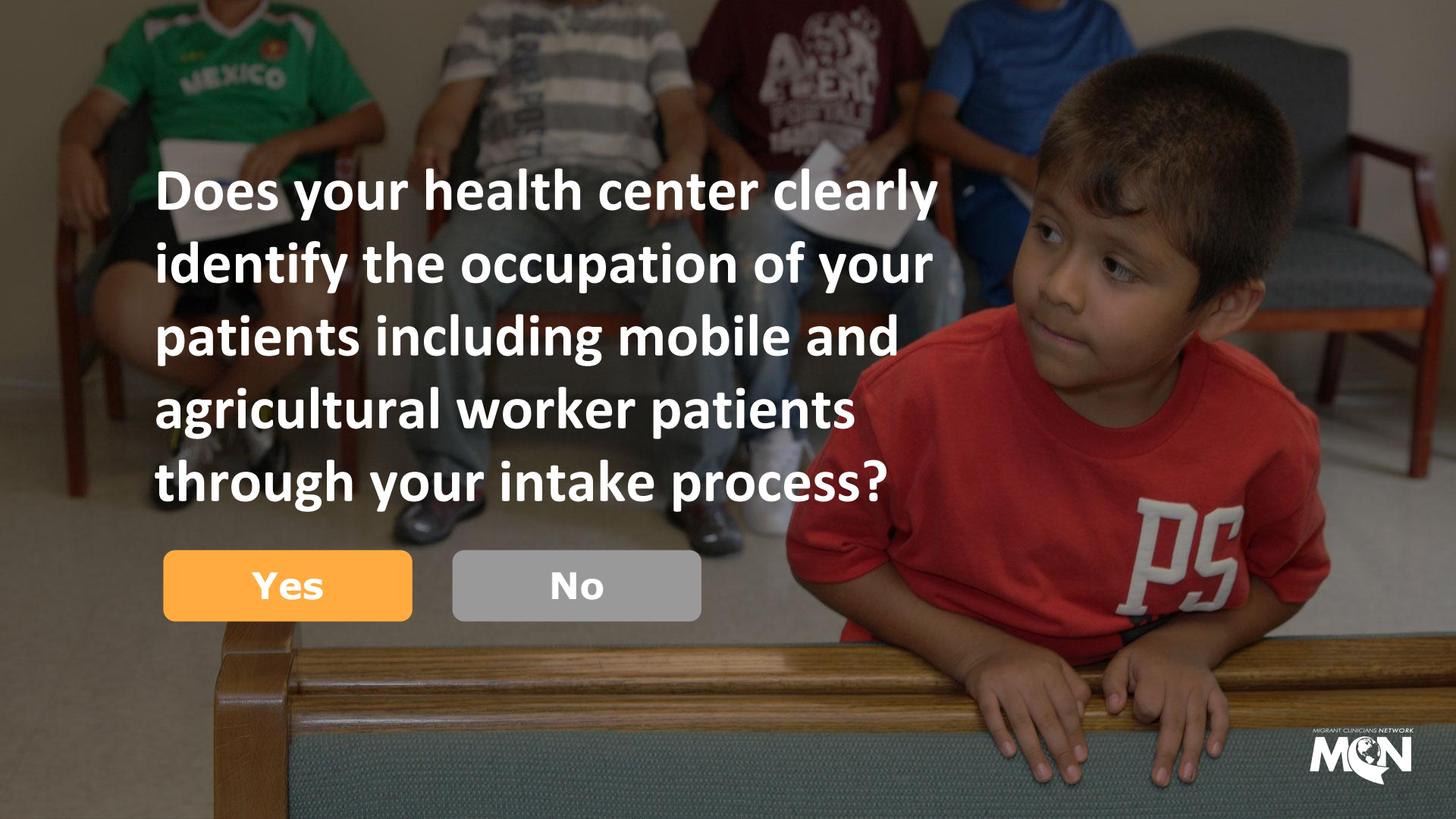
Read “[Approaches for Establishing a PCMH for Mobile Patients](#),” an article from MCN’s in-print quarterly clinical publication, Streamline.

MCN’s [PCMH for Mobile Patients](#) webpage, which includes a recent poster presentation.

The Patient-Centered Primary Care Collaborative 2017 evidence report, “[The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization](#),” found that “the longer a practice had been transformed, and the higher the risk of the patient pool in terms of comorbid conditions, the more significant the positive effect of practice transformation, especially in terms of cost savings.”

Back

Forward



**Does your health center clearly
identify the occupation of your
patients including mobile and
agricultural worker patients
through your intake process?**

Yes

No



Patient-centered means knowing who your patient is and what health risks they may encounter. Simple and effective adjustments to intake methods and a health center's EHR can assure that you understand the special needs of all your patients and that high risk patients such as agricultural workers and their family members are being correctly identified.

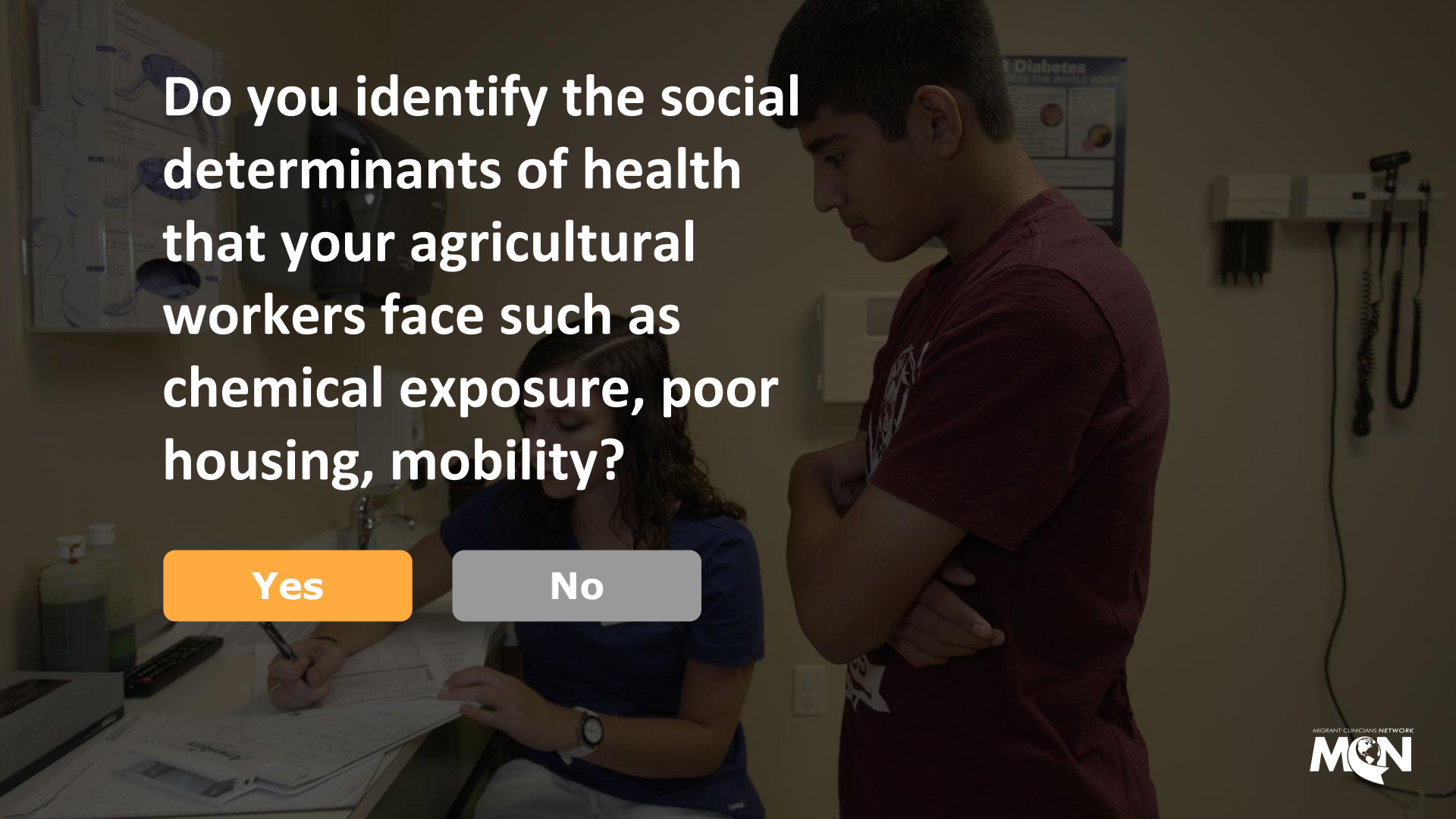
Here are some resources to get you started:

[Identifying Migratory and Seasonal Agricultural Workers in Your Clinic](#): MCN's resource, in English and Spanish, to guide your intake process.

[Ag Worker 2020](#) National Center for Farmworkers Health Campaign calls on every migrant health center grantee to increase by 15% each year over the next five years the number of agricultural workers served.

Back

Forward



Do you identify the social determinants of health that your agricultural workers face such as chemical exposure, poor housing, mobility?

Yes

No

Through a robust PCMH, a comprehensive care team forms to provide coordinated care for patients. By identifying the social determinants of health among a patient population and for an individual patient, care teams can plot a path to health that makes sense for the patient. In general, agricultural workers face numerous obstacles to a healthy life that your overall patient population may manage to avoid. Agricultural workers may suffer health issues or lose health access because of pesticide exposure, mobility, language and cultural differences, transportation issues, and more.

Here are some resources to get you started on identifying and addressing social determinants for agricultural worker patients:

Read the [WHO's page on social determinants](#) and how to address them at "[A Conceptual Framework for Action on the Social Determinants of Health](#)."

MCN's [Environmental and Occupational Health Screening Questions](#) for Primary Care (available in English and Spanish) is EHR friendly.

Read how one health center used [MCN's Centers of Excellence program](#) to integrate environmental and occupational health into its medical practice.

MCN and Farmworker Justice teamed up to create [Clinician Guides for Farmworker Health and Safety Regulations](#).

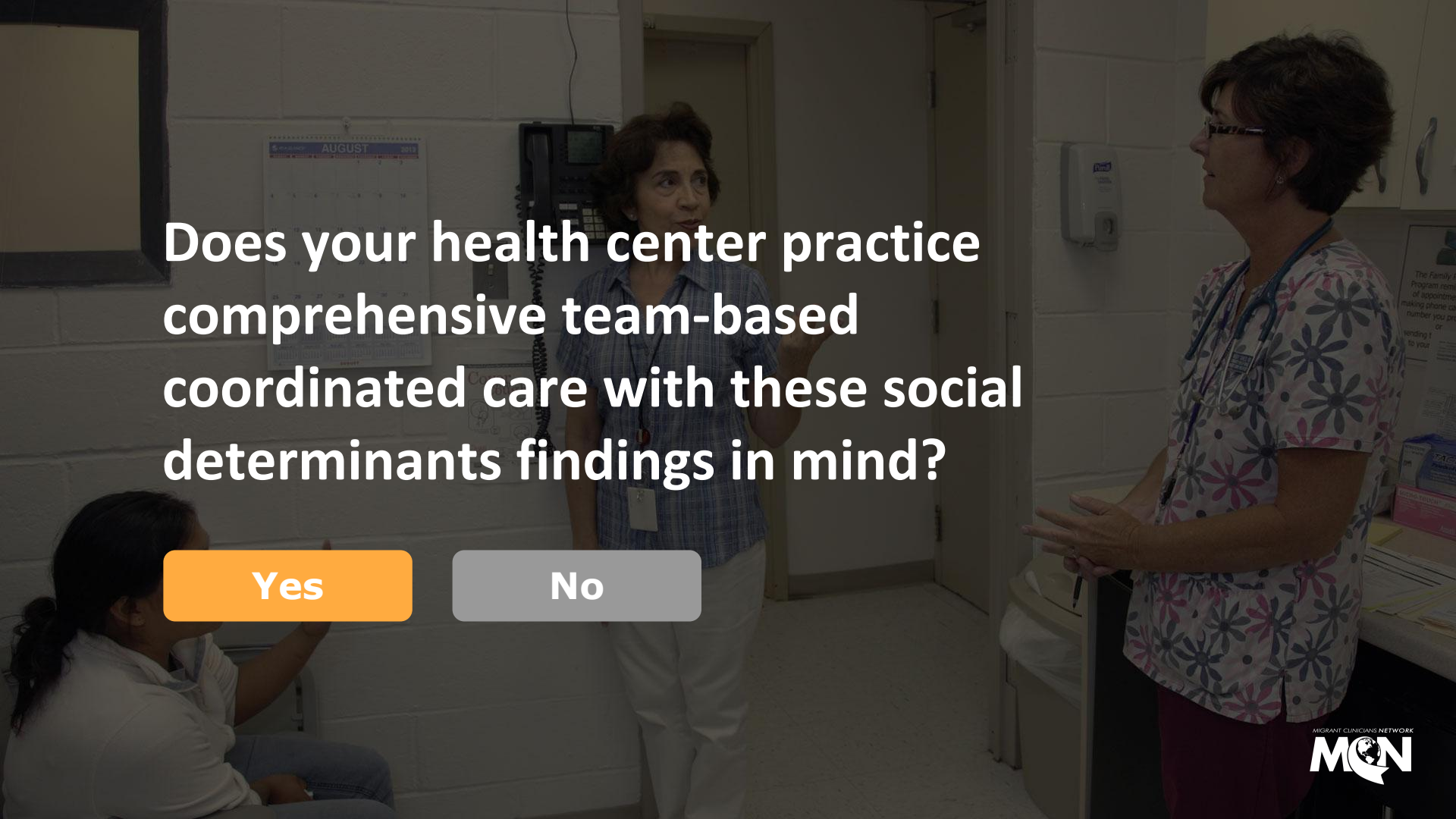
Not all agricultural workers face the same social determinants. Read the summary of 2017 research to hear how subgroups of agricultural workers face different barriers: [Recent Research on Agricultural Workers' Social Determinants of Health and Health Outcomes](#).

National Association of Community Health Centers [PRAPARE Implementation and Action Toolkit](#)

Visit the Medical-Legal Partnership's [SDOH Academy](#).

Back

Forward

A photograph of three healthcare workers in a clinical setting. One woman is seated on the left, another stands in the center, and a third stands on the right. They appear to be in a discussion. The background shows a white wall with a calendar for August 2019 and a wall-mounted phone.

**Does your health center practice
comprehensive team-based
coordinated care with these social
determinants findings in mind?**

Yes

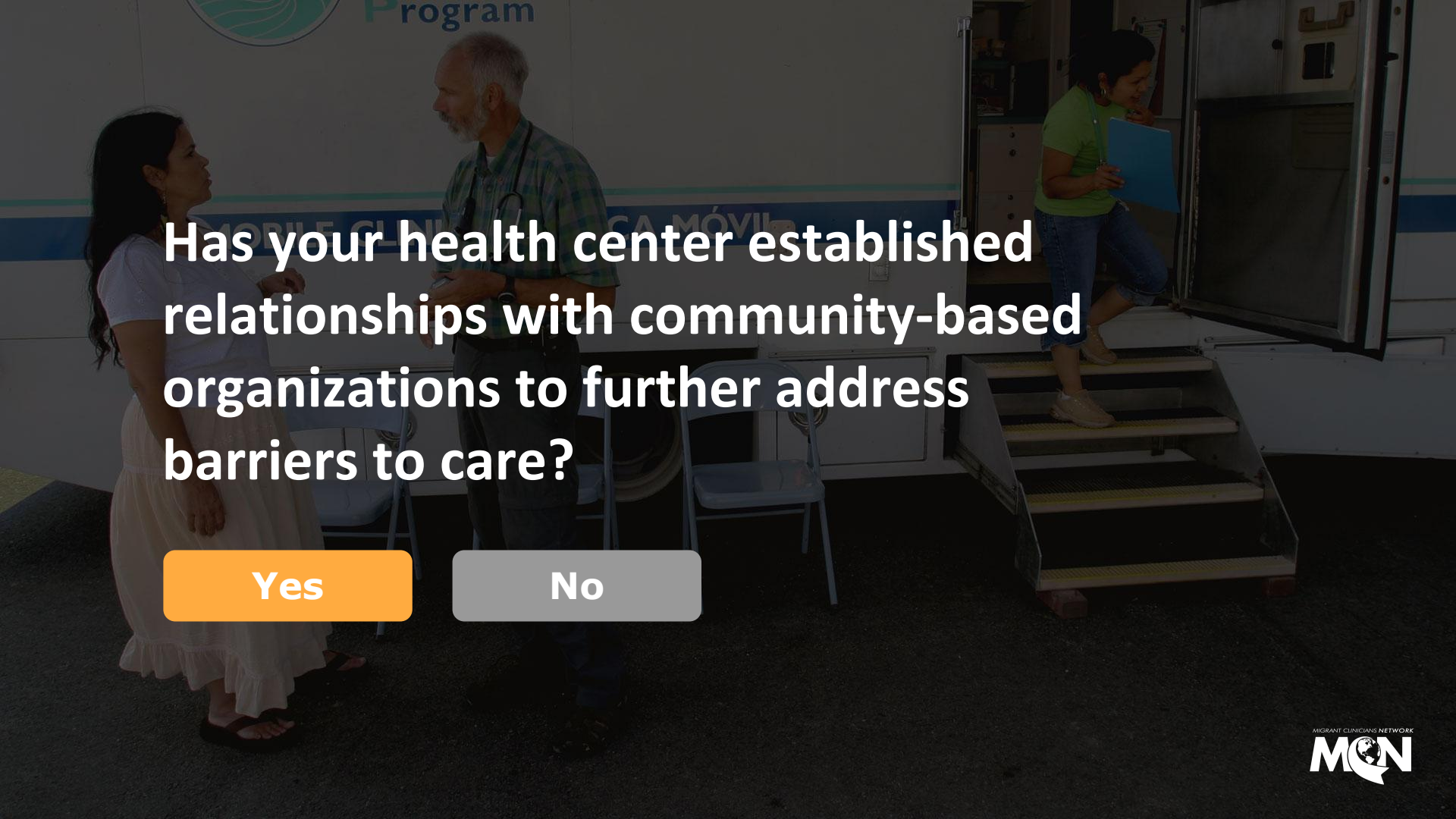
No



Read “[Behavioral Health Integration: Obstacles & Successes](#),” an article by the Patient Centered Primary Care Institute on how Yakima Valley Farmworkers Clinic has built its PCMH to meet the unique needs of its largely agricultural worker population, with a strong emphasis on behavioral health and addressing the social determinants of health.

Back

Forward

A photograph of a mobile clinic van. A woman in a white dress is talking to a male doctor with a stethoscope. Another woman is walking up the steps of the van. The van has text on it, including "program" and "CLINICA MÓVIL".

Has your health center established relationships with community-based organizations to further address barriers to care?

Yes

No



Community-based organizations can help mobile agricultural worker patients tackle many health concerns outside of the clinic's walls.

Consider gathering these types of resources for your area

- Transportation resource
- Food resource
- Legal services?
- Migrant head start?
- Housing Shelter resources

Here are a couple of resources to get you started

[Assistance with Transitional Housing](#)

[Homeless Shelter Directory](#)

Back

Forward

**Does your health center have
systems in place to serve a patient
who intends to leave the service
area before care can be completed?**

Yes

No



[Health Network](#), MCN's bridge case management system for mobile patients, was specifically designed to assure continuity of care for patients who will be leaving the service area. Patients with any ongoing health concern may be enrolled. Clinicians enroll patients for free, after which MCN's Health Network Associates contact the patient to arrange for the continuation of care and records transfer in the patient's next location, following the patient for as long as that patient is mobile and in need of care.

[Health Network and PCMH together](#) can assure better care for mobile patients. Read how MCN's Ed Zuroweste, MD, Co-Chief Medical Officer, developed a version of [PCMH that worked for mobile patients](#) in his practice.

Here are some additional resources:

[Open Access Scheduling](#) for PCMH

[Standing Lab Orders for Migrant Patients](#)

Back

Forward



**Does your health center regularly
evaluate your systems to assure
program effectiveness?**

Yes

No

A comprehensive evaluation of interventions to improve the provision of PCMH for mobile patients should include a systematic review of four areas that are critical to performance improvement.

1. Identifying the social determinants of the patient

Who are they | What do they do | What are their needs

2. Employing comprehensive, team based coordinated Care

Integration of behavioral health | Continuity and Follow up

3. Establishing clinical-community relationships

4. Evaluating the value

Impact | Quality | Return on Investment

Here are some evaluation resources to assure your efforts continue to meet the needs of your community while best utilizing the center's limited finances.

[A Guide to Real-World Evaluations of Primary Care Interventions: Some Practical Advice](#) from AHRQ

[Measuring Population Health Management Return on Investment](#) from HITEQ Center

[Data for Population Health Management](#) from HITEQ Center

Back

Forward



Thank you!

For full list of resources visit migrantclinician.org/pcmh-resources.html