As a result of federal legislation and a wave of public health and health system initiatives, states now play a key role in helping safety net and other primary care providers navigate the complex waters of health care transformation. At the center of many of these efforts is a fundamental shift in how primary care providers deliver care. Replacing traditional forms of care that often resulted in episodic and fragmented treatment, the Patient Centered Medical Home (PCMH) offers a new model that coordinates health care resources—providers, services and health technologies—to better serve patient and population health needs. Through a marriage of clinical practice improvements and electronic health records, medical homes provide patients with high-quality, evidence-based and seamless care.

Among the various stakeholders, state primary care offices (PCOs) and state and territorial health agencies have an important and emerging role to play. Together with partners in state primary care associations, Medicaid and other state and local public health agencies, PCOs can support health centers and other primary care providers in various ways, which include promoting public health principles in state initiatives, disseminating information about federal and state resources and requirements, convening and facilitating stakeholders, and providing technical and funding assistance.

This report highlights several state examples of collaborations between PCOs and primary care associations to support health centers and other safety net providers’ meaningful use of electronic health records (EHRs) and adoption of PCMH delivery systems. Although the report focuses on strategies that support health centers, many of these initiatives also benefit other primary care providers in private practice and safety net settings. In this document, the term “health center” is used to refer to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended (referred to as “grantees”) and Federally Qualified Health Center (FQHC) Look-Alike organizations, which meet all the Health Center Program requirements but do not receive Health Center Program grants.

I. Overview of Patient Centered Medical Homes and Meaningful Use

Meaningful Use of EHRs. The Health Information Technology for Economic and Clinical Health (HITECH) Act—part of the American Recovery and Reinvestment Act (ARRA) of 2009—provided substantial incentives for health care providers who demonstrate meaningful use of certified electronic health records. The HITECH Act authorizes the Centers for Medicare and Medicaid Services (CMS) to offer incentive payments to eligible providers and hospitals that meaningfully use EHRs to improve quality, patient safety and efficiency of care. Meeting the meaningful use standards requires providers to demonstrate their ability to meet several specific objectives. The final rule announced by CMS in 2010 requires eligible providers and hospitals to select at least one public health objective, which include submitting immunization, electronic laboratory results and surveillance data to public health agencies. A comprehensive list of the meaningful use objectives is available at https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf.
Beginning in 2011, Medicare and Medicaid began providing payments to qualifying providers and hospitals that use EHRs in a meaningful way to improve quality, patient safety and efficiency of care. States have the option of offering the Medicaid EHR Incentive Program to eligible providers and hospitals. As of December 2011, CMS reported that 41 states had established an incentive program.\(^1\) The Medicare and Medicaid EHR Incentive programs provide temporary funding—up to a total of $63,750 for Medicaid providers and up to $44,000 for Medicare providers—to meaningfully use health technology. In addition to using certified EHR technology in a meaningful way (e.g., through electronic prescribing), ARRA requires electronic exchange of health information and submission of clinical quality measures. According to CMS, “Simply put, ‘meaningful use’ means providers need to show they’re using certified EHR technology in ways that can be measured significantly in quality and quantity.”\(^2\)

**Patient Centered Medical Homes.** At the same time that many providers and organizations work toward meaningful use of electronic health records, many are also working to achieve national recognition as a CMH. The federal Patient Protection and Affordable Care Act (ACA) supports medical homes in multiple ways, including enhanced Medicaid and Medicare payments, as well as support for medical home demonstration projects. The ACA also enables states to receive federal reimbursement for health home services for Medicaid populations with chronic illnesses. In other words, health providers that receive PCMH recognition are eligible for financial incentives by health plans and federal and state-sponsored demonstration programs.

There are numerous types of medical home initiatives, including public (e.g., Medicaid PCMH programs), private and multipayer initiatives. According to a December 2011 report issued by The Commonwealth Fund and the National Academy for State Health Policy, public programs have taken the lead with medical homes, especially among individuals with chronic disease. “Public payers, especially Medicaid, have been leaders in these efforts, with the hopes of preventing illness; reducing wasteful fragmentation; and averting the need for costly emergency department visits, hospitalizations and institutionalizations.”\(^3\)

Although delivering patient-centered, coordinated care has been a hallmark of the health center approach, meeting the requirements of PCMH recognition and meaningful use adoption is a daunting challenge for many safety net providers. According to a 2010 report from the Safety Net Medical Home Initiative, “Like private practices, most community health centers (CHCs) will need to engage in significant practice redesign before achieving the high-performing, patient-centered, medical home status required by most enhanced payment


Health centers and other providers must meet specific and measurable criteria, which include communication between providers and patients, electronic prescribing, tracking and registry functions and a team-based care approach.

**Tying it Together: How PCMH and Meaningful Use Relate.** For primary care providers, the two efforts—meaningful use and PCMH—go hand in hand. Because of the need to integrate health IT into medical home practice, the pursuit of meaningful use coincides with medical home efforts. In fact, there is considerable overlap and alignment between the two initiatives. The ACA’s PCMH initiatives coincide with the Office of the National Coordinator’s efforts to promote meaningful use of electronic health records. Health IT is a requirement for national recognition by the National Committee on Quality Assurance (NCQA). Moreover, the 2007 Joint Principles of Patient Centered Medical Homes, an agreement among four major physician groups, articulated the importance of EHRs in a medical home. According to the Joint Principles, a key element of the PCMH is that “information technology (IT) is utilized appropriately and in a meaningful way to support optimal patient care, performance measurement, patient education, and enhanced communication.” While PCMH is much more than meaningful use of EHRs, it is a critical first step. Moreover, health centers can use EHR incentive dollars to meet meaningful use requirements and advance their work towards PCMH designation.

**PCO Roles and Opportunities**

PCOs play an important but varying role in supporting adoption of meaningful use and recognition as a PCMH. According to the National Association of Community Health Centers, “These two efforts—meaningful use and patient-centered medical home—will help define the new environment in which health centers must function.” Neither approach is new for health centers, which have a long history of delivering patient-centered primary care. However, meeting the requirements of PCMH recognition and meaningful use adoption is a daunting challenge for many safety net providers.

Primary care offices can help safety net providers cross the divide through various roles. For example, primary care safety net providers benefit from information and resources to help them enroll in Medicaid EHR Incentive programs. Primary care offices routinely share information about emerging opportunities and connect communities and organizations to technical assistance and consulting services through the state Primary Care Association and regional extension centers. In addition, primary care offices can play an important role in ensuring health center participation in statewide medical home pilot programs and other initiatives, such as Health Center Controlled Networks, that advance adoption of EHRs. As illustrated by the state examples that follow, PCOs—working in tandem with the Primary Care Association, State Department of Health and other public and private partners—are an important state partner in this rapidly changing environment.

**III. Up Close: Examples of State Engagement**

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ASTHO interviewed several state PCO directors to explore current and potential areas of collaboration between PCO, PCA and other state and local entities to support adoption of medical homes and meaningful use. The first case study highlights one state’s approach, and the second provides a continuum of PCO activities, as illustrated through various state examples.

**Rhode Island: Integrating Health IT into Patient Centered Medical Homes**

Rhode Island has pursued multiple, aligned health care delivery and health information technology (HIT) interventions to improve the state’s health and reduce health care costs. Among them is a shift to PCMHs—a care delivery approach in which the patient’s primary care provider coordinates care among the patient’s various health care professionals. Under the PCMH model, patients have improved access to information and high-quality, coordinated care. PCMHs rely on the meaningful use and application of electronic health records to provide clinicians with evidence-based decision support tools, access to patient health records and automated systems for delivering high-quality care.

As a result of various clinical improvement and HIT strategies, combined with political support to advance medical homes, Rhode Island has reached an important tipping point. Per capita, more Rhode Island physicians participate in a nationally-recognized PCMH than any other state. Rhode Island’s vast network of medical homes is supported by a statewide health information exchange, a secure network that enables participating providers to access and share patient health information. With a coordinated investment of public and private resources and backing from state policymakers—who in 2011 passed legislation to recognize the all-payer patient-centered medical home model as instrumental to the future of the state’s primary care delivery system—Rhode Island has emerged as a leader of state health care delivery transformation.

**Overview of Rhode Island’s Medical Home Initiatives**

As shown in Table 2, Rhode Island’s public and private stakeholders have developed several initiatives that support adoption of Patient Centered Medical Homes.

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**Table 1. Rhode Island’s PCO and PCA**

| The Rhode Island Primary Care Office is located in the Department of Health’s Office of Primary Care and Rural Health. The PCO fulfills its mission of “increasing access to high-quality, comprehensive, coordinated, culturally appropriate care for underserved Rhode Islanders” through various activities, including needs assessments, collaboration with health system partners and community capacity-building.
| The Rhode Island Primary Care Association supports the state’s 10 community health centers that operate in 29 locations statewide. Health centers provide primary care and dental services to over 125,000 residents annually.

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### Table 2. Examples of Rhode Island’s Public and Private Medical Home Initiatives

<table>
<thead>
<tr>
<th>PCMH-Related Initiative</th>
<th>Initiative Overview</th>
<th>Examples: How Initiative Supports Health Center Adoption of PCMH</th>
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| **Chronic Care Sustainability Initiative (CSI-RI)** | The Office of the Health Insurance Commissioner convened the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) in 2006 to develop a sustainable model of primary care to improve the care of chronic disease and lead to better overall health outcomes. CSI-RI includes several medical practice sites, including health centers throughout the state. A list of participating practices is available at [http://www.pcmhri.org/csi-ris-medical-home-practices](http://www.pcmhri.org/csi-ris-medical-home-practices). | • Participating providers receive additional per-member, per-month fee for active members.  
• Payments from health plans support nurse care managers in every participating practice.  
• Practices receive training and technical assistance (e.g., on collecting and reporting data).  
• Data sharing between practices and health plans. |
| **Rhode Island Chronic Care Collaborative** | The Chronic Care Collaborative, established in 1999, grew out of a health disparities collaborative between the Department of Health’s Diabetes Prevention and Control Program and a Rhode Island health center. Twenty-three physician teams from health centers, private practice and academic hospital-based practices participated in the collaborative. | • The Rhode Island Department of Health and partners provide technical assistance to help health centers integrate diabetes, asthma, heart disease and cancer standards into a medical home model of care.  
• The collaborative provides opportunities for participating physician teams to learn from one another through learning sessions, conference calls and networking. |
| **Beacon Community Program** | The Office of the National Coordinator for Health Information Technology selected Rhode Island as one of the nation’s 17 Beacon Communities. Beacon funds are being used to enrich Rhode Island’s medical homes with effective use of health IT. | • The Department of Health partnered with the Rhode Island Quality Institute (RIQI) to develop a health information exchange system, currentcare, to enable participating providers to access and share patient health information.  
• RIQI and its partners support practices in various ways, including assistance with practice redesign, enhanced coordination between hospitals and primary care providers, and developing common quality metrics and procedures for reporting. |
| **Other Public and Private Initiatives** | Rhode Island’s health centers, as well as public and private payers, such as Medicaid and Blue Cross Blue Shield of Rhode Island, have adopted medical home initiatives, often to address the complex needs of individuals with chronic disease. | • Rhode Island’s two Health Center Controlled Networks provide resources and support to help health center members adopt EHRs and improve quality of care and clinical outcomes.  
• Medicaid’s Connect Care Choice Primary Care Case Management Program was established in 2007 to provide health homes for select high-risk adults with chronic disease. Participating providers are required to meet “advanced medical home” standards (e.g., incorporating |
the chronic care model, and implementing e-prescribing and computerized evidence-based clinical decision guidelines at the point of care).
State Health Agency and Primary Care Office Roles

The Rhode Island Office of Primary Care and Rural Health plays varying, and often supporting roles in the multiple facets of state reform. In a process characterized by many moving parts—a function of multiple funding streams, stakeholders and activities—the public health role assures that health IT and medical home strategies reflect population health practices and tools.

Public Health Coordination and Planning. The PCO fulfills several public health coordination functions for the state’s various medical home initiatives.

- The PCO coordinates quarterly meetings with health department and Primary Care Association staff to discuss emerging primary care issues and opportunities.
- The PCO Director participates in a steering committee that governs both the Beacon Community and CSI-RI initiatives. The steering committee includes a diverse stakeholder group representing the Rhode Island Department of Health, Quality Partners of Rhode Island, Rhode Island Quality Institute, the Massachusetts League of Community Health Centers, select physician practices, health centers, health plans and others. Stakeholder participation ensures that major HIT and medical home strategies reflect primary care and population health tools and resources.
- Through the Chronic Care Collaborative, the Department of Health contracts with health centers to support integration of disease management standards of care.

Supporting Medical Homes through Rural Systems Grants and Technical Assistance. Rural communities in Rhode Island face several access-to-care challenges, including insufficient dental and mental health services, inadequate public transportation and lack of knowledge about community resources. To address these challenges, the Office of Primary Care and Rural Health awarded 11 minigrants of about $5,000 each, between 2009 and 2011, to community-based coalitions and networks in nonmetropolitan areas. The grants supported community needs assessments and strategic planning to improve rural health systems, with an emphasis on enhancing medical homes and maternal and child health services.

Following the needs assessment and strategic planning, the Office of Primary Care and Rural Health awarded two Health Systems Building Grants in 2011 to help communities implement their strategic plan. The two-year grants of approximately $75,000 support efforts to strengthen the primary care systems through increased access to care, reduced disparities and adoption of patient-centered medical homes. Grantees were required to address disparities and maternal and child health services. In November 2011, the PCO released a report, “The Health of Rhode Island Non-Metropolitan Communities” outlining recommendations to address rural health care access barriers.

Moving Forward: Addressing Challenges and Opportunities

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Despite the progress, the state’s primary care safety net struggles to keep up with the rapid pace of innovation. According to PCO Director Carrie Bridges, public-private medical home partnerships tend to target private practices more than safety net providers. “There’s a misconception that there are enough resources already going to health centers.” As early adopters of medical home principles, however, health centers play an important role. “Everyone’s on a different place on the learning curve,” Bridges said, “so we can learn a lot from health center experiences.” For example, the experience of the state’s Health Center Controlled Networks and other early adopters of medical homes offer important lessons and best practices that can inform the broader primary care safety net.

Rhode Island’s experience demonstrates the importance of building effective primary care health systems, one layer at a time—from the foundational technology that enables exchange among providers, to the practice level where providers use data to deliver better care to their patients. Through planning and development and partnerships with other public and private stakeholders, the PCO ensures that these systems encompass primary care and public health priorities and approaches.

Other State Strategies to Support Meaningful Use and Patient Centered Medical Homes

PCO roles vary in meaningful use and PCMHS. In addition to having different funding and staff resources to support their work, various factors, such as the state’s economic or political environment, shape the PCO’s role. Rhode Island offers a useful case study on the PCO role in one set of circumstances: where public and private investments are aligned to support a comprehensive and unified strategy. However, many state health departments and PCOs function in a different environment where lack of resources or other challenges require a different approach that focuses on aligning existing resources and political will to achieve targeted goals. As one PCO director said, “we focus on achieving what’s doable.”

This section highlights a wide range of PCO partnerships to promote medical homes and support meaningful use adoption among primary care providers. Many of the states discussed here are implementing a comprehensive statewide medical home initiative as well—and their inclusion here does not imply a piecemeal or incremental approach—but they are included here to present an array of options that could be adopted in other states.

Aligning Work with PCO Core Functions

PCO directors engage with meaningful use and Patient PCMH strategies on different levels. Although some states provide direct assistance (through funding or services) to help primary care providers adopt meaningful use of EHRs, many PCO directors expressed that the PCO core functions, as defined by Health Resources and Services Administration (HRSA) (see Table 3), support engagement that focuses on sharing information with primary care safety net providers, communicating with the primary care associations and other entities about emerging issues and challenges, and serving as a “hub” of information and resources, as noted by one PCO

<table>
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<th>Table 3. PCO Core Functions</th>
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<td>1. Organizational Effectiveness and Fostering Collaboration</td>
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<td>2. Technical Assistance to Organizations or Communities</td>
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<td>3. Needs Assessment and Data Sharing</td>
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<tr>
<td>4. Workforce Development</td>
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<td>5. Shortage Designations</td>
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Source: HRSA Program Guidance,
director. As demonstrated in the state examples that follow, PCOs play myriad roles in supporting primary care providers as they transform their practices into high-quality, comprehensive and “connected” medical homes.

**Fostering Collaboration.** PCO directors frequently participate in steering committees and advisory councils that focus on specific dimensions of federal and state reforms. Even if they are not in a leadership role, participation in these planning entities fosters collaboration and communication and provides a valuable opportunity to embed public health tools and priorities into primary care practice reforms.

Several states rely on regular PCO and primary care associations meetings to exchange information and address problems and opportunities as they arise. The **Colorado** Primary Care Office Director attends Colorado Community Health Network’s (the state’s designated primary care association) quarterly board meetings, as well as meetings with FQHC operations and medical staff. In addition to staying informed about health center issues, the meetings provide an opportunity for PCOs and primary care associations to examine the impact of primary care policies and initiatives on safety net providers.

PCOs also convene primary care stakeholders to foster dialogue and strategic planning on a particular issue, such as electronic medical records or PCMH implementation. In November 2011, the **Nevada** Health Division and Medicaid Office hosted a meeting that connected state partners with national and state experts in medical home implementation. By bringing together partners from Medicaid, the Office of Rural Health and the primary care association, the PCO created an opportunity to examine the state’s medical home initiatives and develop strategies for supporting health centers.

In addition to one-time meetings, PCO can also play an important role in longer term statewide strategic planning. In November 2011, the **New Jersey** Primary Care Association was selected to participate in the National Association of Community Health Center’s Patient Centered Medical Home Institute, a national PCMH learning collaborative. The primary care association invited the PCO director to participate in the New Jersey team as its state partner. Through this partnership, the PCO will contribute to statewide PCMH planning and capacity building and serve as liaison for the New Jersey Department of Health and Senior Services.

**Providing TA and Sharing Information to Support Meaningful Use /PCMH Adoption.** Although primary care associations tend to take the lead in providing direct assistance to safety net providers, some of them support organizations and safety net providers by providing technical or funding assistance to help support meaningful use or PCMH adoption. As described in the **Rhode Island** case study, the primary care office provides technical assistance for health centers that participate in the Chronic Care Collaborative. **New Jersey’s** support for health center adoption of electronic medical pre-dates the federal meaningful use guidelines. The PCO distributed state funds to help three FQHCs move toward implementation of electronic medical records. In addition to providing funds for feasibility studies and implementation, the PCO also provided or arranged technical assistance to support FQHCs and ensure that the electronic systems were able to capture and report state-required information.

PCO directors typically expressed that serving as the conduit of information for primary care providers—disseminating information and connecting primary care providers to important federal, state and local resources—was one of their most significant roles related to meaningful use and medical home.
• Missouri’s Office of Rural Health disseminates information about meaningful use and the EHR Incentive Program through its Rural Spotlight blog and Rural Spotlight. Missouri’s Primary Care Association provides direct assistance to help providers achieve meaningful use of EHRs and provide meaningful data to the state’s data warehouse. The PCO disseminates information, encourages partnerships and connects safety net providers to partners and resources.

• The Massachusetts Medicaid Office is participating in a Massachusetts League of Community Health Centers webinar about the Massachusetts Medicaid EHR Incentive Program. The primary care association and state Medicaid agency are partnering to inform providers in FQHCs and Rural Health Clinics about the incentive program and requirements for participation.

In addition to linking health centers to resources and information, PCOs also benefit from the experiences and innovations taking place in the state’s health centers. Given the common challenges they face, health centers have pursued partnerships with other health centers to share resources and address common HIT and other challenges. In Rhode Island, Colorado and other states, for example, health centers have formed Health Center Controlled Networks to implement meaningful use of electronic health records. In addition, these networks pool resources to fulfill a wide range of other common functions, such as provider education, quality reporting, human resources and clinical quality improvement. With funding from HRSA, Health Center Controlled Networks offer efficiencies for participating organizations by supporting information systems, clinical improvement, finance, administration and managed care.\(^9\) These networks have a significant role in supporting adoption of meaningful use among collaborating organizations, and as a result, they represent important resources for state PCOs and the state’s safety net providers.

Workforce Development. The Massachusetts' Community Health Center Steering Committee—which involves representatives from the Massachusetts Department of Public Health, the Massachusetts League of Community Health Centers and the Massachusetts Area Health Education Center—provides a forum for stakeholders to examine the impact of federal guidelines and requirements, such as meaningful use of EHRs on the primary care workforce.

IV. Conclusion

Together with their partners in the primary care association and other public and private entities, PCOs have assumed an important role in the process of health care transformation. The role is different in every state, but the PCO’s core functions support various activities aimed at fostering collaboration, providing technical assistance, sharing data and information and strengthening the primary care workforce capacity to incorporate meaningful use of electronic health records into their clinical practice. Sometimes described as “behind the scenes,” PCOs play a critical role by supporting public health safety net providers as they transform their health care delivery systems.

PCOs fulfill these functions through activities that align with their core public health functions, such as public health coordination and planning, technical assistance and serving as liaison between safety net providers and

other public and private stakeholders. Moving forward, partnerships and a strong PCO role will take on even
greater importance as states and safety net providers manage the many moving parts related to federal health
reform implementation.

VI. Resources

Meaningful Use:

ASTHO HITECH and Meaningful Use Resources
http://www.astho.org/Programs/e-Health/HITECH-Act-and-Meaningful-Use/Main/

HHS, Office of the National Coordinator for Health Information Technology

HRSA Primer on Meaningful Use for Critical Access Hospitals

HRSA Web Resources on Health Center Controlled Networks

NACHC Meaningful Use Resources for Health Centers
http://www.nachc.com/meaningfuluseofhit.cfm

Centers for Medicare and Medicaid Services (CMS), Meaningful Use Overview
https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp

CMS Website on Medicaid and Medicare EHR Incentive Programs
http://www.cms.gov/ehrincentiveprograms/

Meaningful Use OneSource
http://www.himss.org/ASP/topics_meaningfuluse.asp

Patient Centered Medical Homes:

National Committee for Quality Assurance, “Patient-Centered Medical Homes” 2011
http://www.ncqa.org/LinkClick.aspx?fileticket=ycS4coFOGnw%3d&tabid=631

Patient Centered Primary Care Collaborative
http://www.pcpcc.net/

Joint Principles of the Patient Centered Medical Home (2007)
http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

Agency for Healthcare Research and Quality, PCMH Resource Center
http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483
Patient Centered Medical Home, Building Evidence and Momentum: A Compilation of State PCMH Pilot and Demonstration Projects


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