



U.S. Department of Health and Human Services



Agency for Healthcare Research and Quality

Advancing Excellence in Health Care • www.ahrq.gov

An Exploration of AHRQ's PCMH Resource Center (and Beyond!)

Janice Genevro, PhD, MSW
PCPCC Monthly Briefing

May 21, 2015



Session Overview

- Acknowledgements
- Quick primer on the Agency for Healthcare Research and Quality (AHRQ)
- AHRQ's resources for primary care transformation
 - Implementation
 - Quality Improvement
 - Research and Evaluation
- Additional AHRQ resources



Contributors to this work

AHRQ

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- Cindy Brach
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- Hannah Burak
- Jay Crosson
- Kristin Geonnotti
- Tricia Higgins
- Lyndee Knox (LA Net)
- Dana Petersen
- and many others



AHRQ's Mission Statement



- To produce evidence to make health care:
 - ✓ safer
 - ✓ higher quality
 - ✓ more accessible, equitable, and affordable

- To work with HHS and other partners to make sure that the evidence is understood and used.



AHRQ Priorities

- Improve health care quality by accelerating implementation of Patient-Centered Outcomes Research
- Make health care safer by preventing HAIs and reducing other harms and accelerating patient safety improvements
- Increase accessibility by evaluating Affordable Care Act coverage expansions
- Improve health care affordability, efficiency, and cost transparency



Revitalizing the nation's primary care system is foundational to achieving AHRQ's mission of improving the quality, safety, accessibility, equity and affordability of health care for all Americans



AHRQ Resources for Primary Care Transformation

Resources developed specifically for primary care

- ▶ PCMH Resource Center web site
- ▶ Primary Care Measures databases
- ▶ Improving Primary Care Practice – Information for Health Professionals

Other useful AHRQ resources

- ▶ Innovations Exchange
- ▶ Health IT
- ▶ Clinical Decision Support
- ▶ National Quality Measures Clearinghouse (NQMC)
- ▶ National Guideline Clearinghouse (NGC)


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PCMH Home

- Defining the PCMH
- Evidence and Evaluation
- Tools and Resources
 - Comprehensive Care
 - Patient-Centered
 - Coordinated Care
 - Accessible Services
 - Quality and Safety
 - Foundations
- Implementing the PCMH
 - Practice Facilitation
 - PCPF Resources
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- Federal PCMH Activities
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Welcome to the PCMH Resource Center

The Agency for Healthcare Research and Quality recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The primary care medical home, also referred to as the patient centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care. This web site provides policymakers and researchers with access to evidence-based resources about the medical home and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of U.S. health care.



Defining the PCMH



PCMH Evidence



PCMH Tools & Resources



What is a Medical Neighborhood?

Highlights

- [Papers, Briefs, and Other Resources](#) provides access to all of AHRQ's resources on the PCMH
- [For Policymakers](#)
- [For Researchers](#)
- [New Case Studies of Primary Care Practice Facilitation Programs](#)
- [A How-to Guide on Developing and Running a Primary Care Practice Facilitation Program](#)
- [New PCMH Research Methods Series](#)



Implementing the PCMH – Transforming Primary Care

The screenshot shows a web browser window displaying the AHRQ Patient Centered Medical Home Resource Center. The browser's address bar shows the URL www.pcmh.ahrq.gov/page/implementing-pcmh. The page header includes the U.S. Department of Health & Human Services logo and the AHRQ logo with the tagline "Advancing Excellence in Health Care". A search bar is present with the text "Enter your keywords" and a "Go" button. The main content area features a navigation menu on the left with categories like "PCMH Home", "Defining the PCMH", "Evidence and Evaluation", "Tools and Resources", "Implementing the PCMH", and "Federal PCMH Activities". The central content area is titled "Implementing the Patient-Centered Medical Home" and includes a list of five attributes: Comprehensive Care, Patient-Centered Care, Coordinated Care, Accessible Services, and Quality and Safety. A "Highlights" sidebar on the right lists various resources such as "Papers, Briefs, and Other Resources", "For Policymakers", "For Researchers", and "New Case Studies of Primary Care Practice Facilitation Programs". The footer of the page contains the text "Working with experts who have developed and implemented successful practice implementation programs, AHRQ". The Windows taskbar at the bottom shows several open PDF files and the system clock indicating 1:07 PM on 5/20/2015.



What is a Practice Facilitator?

- ▶ Practice facilitators are specially trained individuals who work with primary care practices “to make meaningful changes designed to improve patients’ outcomes. [They] help physicians and improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment” (DeWalt, Powell, Mainwaring, et al., 2010)

Developing and Running
a Primary Care Practice
Facilitation Program:
A How-to Guide

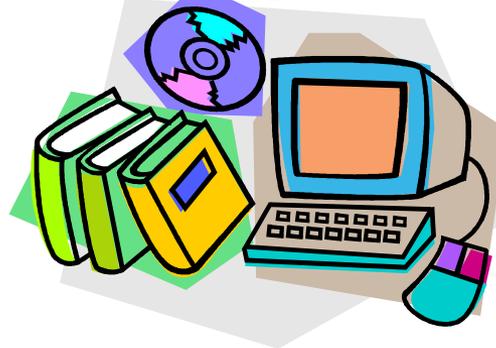
How to
Guide

Support for
organizations
interested in
starting PF
programs

Competency-based
curriculum for
training entry-level
practice facilitators

Model
Curriculum

*Coming summer
2015*



**The Practice Facilitation
Handbook**

Training Modules for New Facilitators
and Their Trainers



PF
Handbook

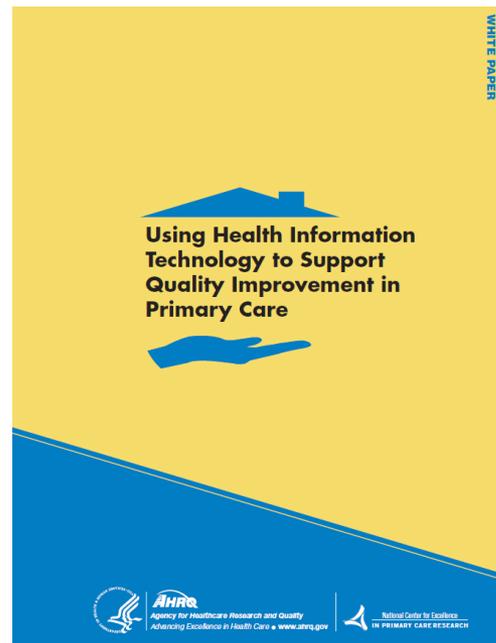
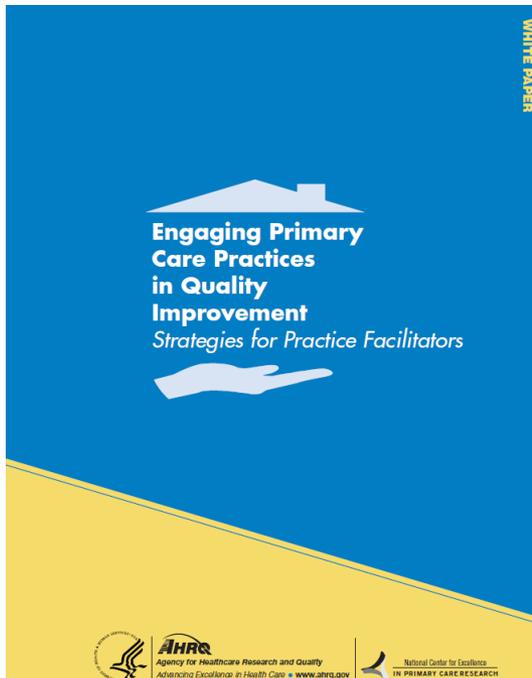
Essentials for
teaching and
learning the
knowledge and
skills for a new PF



Development of a Model Curriculum for Training Practice Facilitators

- Objective
 - ▶ Provide entry-level training for PFs to assist primary care practices in achieving their quality improvement and transformation goals
 - ▶ Builds upon AHRQ's Practice Facilitation Handbook
- Key Characteristics
 - ▶ Links with competencies and includes specific learning objectives
 - ▶ Instructor's guide including guidance for assessment
 - ▶ Student materials and other supporting information
- Available Summer 2015

Two New Resources



- ✓ Companion resources for QI paper
- ✓ Webinar on Health IT paper
www.pcmh.ahrq.gov/page/pcf-webinars
- ✓ Webinar on QI paper coming soon!

Lessons Learned about Transformation

- A strong foundation is needed for successful redesign
- The process of transformation can be a long and difficult journey
- Approaches to transformation vary
- Visionary leadership and a supportive culture can ease the way for transformation
- Contextual factors are inextricably linked to outcomes

Lessons Learned From the Study of Primary Care Transformation

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Agency for Healthcare Research and Quality



Ann Fam Med 2013;15(1):25. doi:10.1370/afm.1548.

The Agency for Healthcare Research and Quality (AHRQ) believes that a robust primary care system is the foundation for an American health care system that delivers high-quality, affordable health care to all Americans.¹ There is recognition, however, that the current primary care system is struggling.^{1,2} The patient-centered medical home (PCMH) model is one transformative way of organizing and delivering primary health care whereby practices deliver care that is patient centered, comprehensive, coordinated, and accessible, with a systematic focus on quality and safety.⁴ Although the PCMH holds promise as a solution to improve health in America, it remains largely an aspiration, a type of care not currently found in most clinical practices or experienced by most patients in the United States.³ Before the promise of primary care can be achieved, more robust information is needed about the actual change process and the lessons learned by successfully transformed practices.⁵⁻⁸

In the summer of 2010, AHRQ awarded 14 grants to better understand the processes and determinants of transformation.¹⁸ The grants provided funds for retrospective analysis of the process of becoming PCMHs from systems and practices that had already demonstrated successful transformational activities. Successful efforts at substantive redesign were demonstrated by improvements in care quality as reflected in quantitative processes, outcome measures, or both. AHRQ is especially interested in the evaluation of transformation efforts that have been in progress long enough to generate measurable changes in patient-level outcomes. After validating these improvements, investigators studied in detail the actual change process and evaluated its impact on patient and clinician experiences and satisfaction. In addition, they systematically assessed the practice culture, context, and conditions within which change occurred. AHRQ is interested in identifying the approaches and methods for transforming the structure, characteristics, and function of primary care that are likely to be successful in a wide variety of practice types and settings. This knowledge will be used to facilitate wider efforts in practices across the United States with the goal of improving quality, reducing cost, and better satisfying the needs of patients and families.

In this commentary, we summarize the characteristics of the practices and interventions studied by the 14 grantees and highlight our impressions, as the funding agency, of the lessons learned on the process of transforming to a PCMH that cut across all the projects. The wide variety of study designs, practice types, and geographic locations means at least one in this group of articles is likely relevant to any given primary care practice in the United States. The lessons learned demonstrate that true transformation to the PCMH model is not only possible but desirable, although not without its challenges. These lessons provide valuable insight that will likely be helpful to other practices considering or beginning this transformation.

Conflicts of interest: authors report none.

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Evidence and Evaluation

Evidence and Evaluation x
 www.pcmh.ahrq.gov/page/evidence-and-evaluation
 Apps AHRQ Intranet HealthPolicy.tv Mission, Vision ... Home Page | C... Log In Chartres Labyrin... Serious Illness C... iCatalog Home ... AHRQ Views | A... Institute for He... PA-14-001: Expl... PAR-10-168: A...

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AHRQ Agency for Healthcare Research and Quality
 Advancing Excellence in Health Care

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PCMH Home

Defining the PCMH

Evidence and Evaluation

Tools and Resources

- Comprehensive Care
- Patient-Centered
- Coordinated Care
- Accessible Services
- Quality and Safety
- Foundations

Implementing the PCMH

- Practice Facilitation
- PCPF Resources
- PCPF Webinars

Federal PCMH Activities

Citations Collection

Contact Us

PCMH Patient Centered Medical Home
Resource Center

Home → Evidence and Evaluation

Evidence and Evaluation

About the Evidence:

Policy decisions concerning the PCMH must rest on sound evidence about whether this model of care helps achieve the Triple Aim of improved patient outcomes, improved patient experience, and improved value. In this section, explore information and resources for PCMH researchers, evaluators, and decision makers.

New! Practical Resource for Evaluators

A Guide to Real-World Evaluations of Primary Care Interventions: Some Practical Advice

This guide presents practical steps for designing an evaluation of a primary care intervention. It answers the questions: Do I need an evaluation? What do I need for an evaluation? How do I plan an evaluation? How do I conduct an evaluation and what questions will it answer? How can I use the findings? What resources are available to help me?

[Go to the Evaluation Guide \(PDF Version, 363KB\)](#)

PCMH Research Methods Series

The **PCMH Research Methods Series** was commissioned by AHRQ and developed under contract by Mathematica Policy Research, with input from other nationally recognized thought leaders in research methods and PCMH models. The series is designed to "expand the toolbox" of methods used to evaluate and refine PCMH models and other health care interventions. This toolbox of novel and underused methods can equip evaluators and implementers to better assess and refine PCMH models and to meet the evidence needs of PCMH stakeholders more effectively. Each of the briefs describes a method and how PCMH researchers have used it or could do so, discusses advantages and limitations of the methods, and provides resources for researchers to learn more about the method.

Title	Brief Description	PDF	HTML
Expanding the Toolbox: Methods to Study and Refine Patient-Centered Medical Home Models	This overview provides an introduction to the PCMH Research Methods Series and introduces methods or approaches that have the potential to expand and refine understanding of the PCMH as a complex health care intervention and innovation.	(PDF - 813.06 KB) PDF Help	HTML

Highlights

[Papers, Briefs, and Other Resources](#) provides access to all of AHRQ's resources on the PCMH

[For Policymakers](#)

[For Researchers](#)

[New Case Studies of Primary Care Practice Facilitation Programs](#)

[A How-to Guide on Developing and Running a Primary Care Practice Facilitation Program](#)

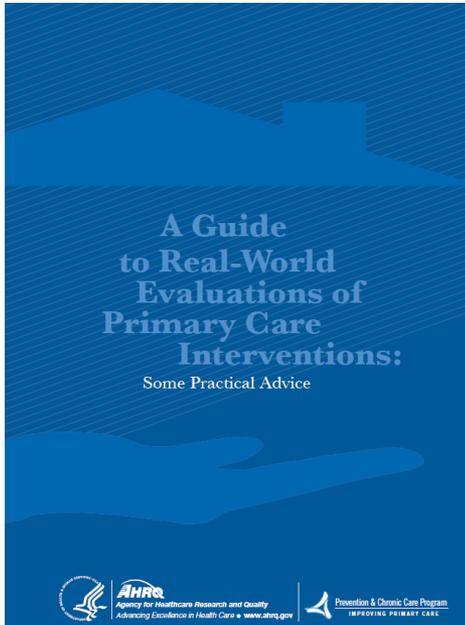
[New PCMH Research Methods Series](#)

QI-strategies-p...pdf | pcmhqi1_0.pdf | practicefacilitat...pdf | Developing_an...pdf

Show all downloads...

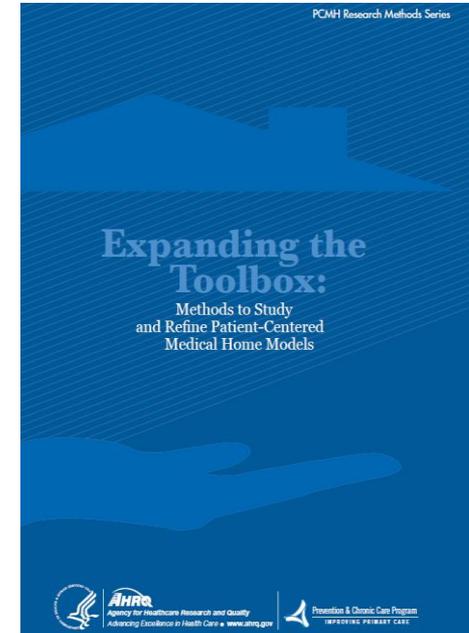
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Improving PCMH Research and Evaluation



- Practical advice
- Information about novel methods
- Guidance for decision makers

<http://www.pcmh.ahrq.gov/page/evidence-and-evaluation>

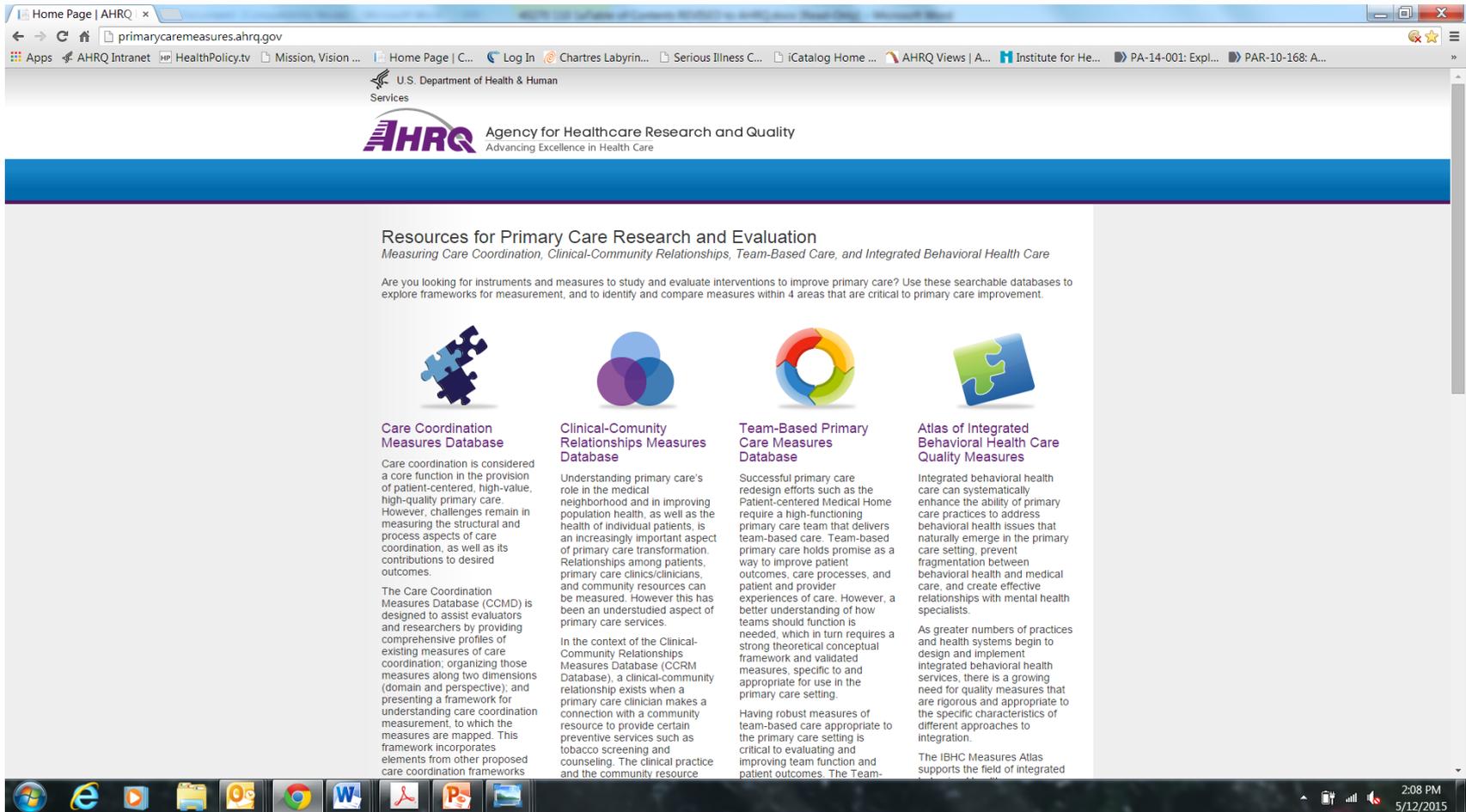


- Methods Webinar Series

<http://www.ahrq.gov/professionals/systems/system/advanced-methods/index.html>



PCMH Citations Database



Home Page | AHRQ x
primarycaremeasures.ahrq.gov

U.S. Department of Health & Human Services
 Agency for Healthcare Research and Quality
 Advancing Excellence in Health Care

Resources for Primary Care Research and Evaluation

Measuring Care Coordination, Clinical-Community Relationships, Team-Based Care, and Integrated Behavioral Health Care

Are you looking for instruments and measures to study and evaluate interventions to improve primary care? Use these searchable databases to explore frameworks for measurement, and to identify and compare measures within 4 areas that are critical to primary care improvement.



Care Coordination Measures Database

Care coordination is considered a core function in the provision of patient-centered, high-value, high-quality primary care. However, challenges remain in measuring the structural and process aspects of care coordination, as well as its contributions to desired outcomes.

The Care Coordination Measures Database (CCMD) is designed to assist evaluators and researchers by providing comprehensive profiles of existing measures of care coordination; organizing those measures along two dimensions (domain and perspective), and presenting a framework for understanding care coordination measurement, to which the measures are mapped. This framework incorporates elements from other proposed care coordination frameworks



Clinical-Community Relationships Measures Database

Understanding primary care's role in the medical neighborhood and in improving population health, as well as the health of individual patients, is an increasingly important aspect of primary care transformation. Relationships among patients, primary care clinicians/clinicians, and community resources can be measured. However this has been an understudied aspect of primary care services.

In the context of the Clinical-Community Relationships Measures Database (CCRM Database), a clinical-community relationship exists when a primary care clinician makes a connection with a community resource to provide certain preventive services such as tobacco screening and counseling. The clinical practice and the community resource



Team-Based Primary Care Measures Database

Successful primary care redesign efforts such as the Patient-centered Medical Home require a high-functioning primary care team that delivers team-based care. Team-based primary care holds promise as a way to improve patient outcomes, care processes, and patient and provider experiences of care. However, a better understanding of how teams should function is needed, which in turn requires a strong theoretical conceptual framework and validated measures, specific to and appropriate for use in the primary care setting.

Having robust measures of team-based care appropriate to the primary care setting is critical to evaluating and improving team function and patient outcomes. The Team-



Atlas of Integrated Behavioral Health Care Quality Measures

Integrated behavioral health care can systematically enhance the ability of primary care practices to address behavioral health issues that naturally emerge in the primary care setting, prevent fragmentation between behavioral health and medical care, and create effective relationships with mental health specialists.

As greater numbers of practices and health systems begin to design and implement integrated behavioral health services, there is a growing need for quality measures that are rigorous and appropriate to the specific characteristics of different approaches to integration.

The IBHC Measures Atlas supports the field of integrated

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5/12/2015



Improve research and build evidence in 4 key areas

Separate resources for care coordination, team-based care, integration of behavioral health, and clinical-community linkages

Database features:

- ✓ Include conceptual models
- ✓ Comprehensive measure profiles
- ✓ Searchable by multiple characteristics
- ✓ Search results can be saved and downloaded

The screenshot shows the AHRQ website's search interface for the Team-Based Primary Care Measures Database. The page includes a navigation bar with links for Home, Search, Conceptual Framework & Definitions, Example Scenarios, About the Atlas, and Help. The main content area features a 'Measure Search' section with a table of results. On the left, there are filters for 'Choose Categories' (Constructs, Type of Instrument, Degree of Adaptation, Number of Items, Setting, Respondent Type), 'Search Settings' (Show measures that relate to any of my selections, Only show measures that relate to all of my selections), and 'Export Options'. The table lists several measures with their IDs, descriptions, and actions.

Instrument ID	Instrument	Number of Items	Actions
AHRQ (2008)	Medical Office Survey on Patient Safety To obtain providers and administrators' opinions about issues that affect the overall safety and quality of the care provided to patients in their office. Measure Profile (PDF File, 72KB) Measure Instrument	31+	Add to My List
Anderson & West (1998)	Team Climate Inventory (TCI) To assess the climate for innovation within groups at work. Measure Profile (PDF File, 79KB)	31+	Add to My List
Aubé & Rousseau (2005)	Untitled (Aubé & Rousseau 2005) To assess the relationships between team goal commitment and three criteria of team effectiveness (i.e., team performance, quality of group experience, and team viability). Measure Profile (PDF File, 55KB)	11-20	Add to My List
Batorovica & Shepherd (2008)	Team Decision Making Questionnaire (TDMQ) To evaluate the advantages and disadvantages of a trans disciplinary team model on the quality of the teamwork process. Measure Profile (PDF File, 79KB)	11-20	Add to My List



Improving Primary Care Practice: Information on ahrq.gov for Health Care Professionals

The screenshot shows a web browser window displaying the AHRQ website. The address bar shows the URL: www.ahrq.gov/professionals/prevention-chronic-care/improve/index.html. The page header includes the AHRQ logo and the text "Agency for Healthcare Research and Quality Advancing Excellence in Health Care". The navigation menu includes "Health Care Information", "For Patients & Consumers", "For Professionals", "For Policymakers", "Research Tools & Data", "Funding & Grants", "Offices, Centers & Programs", and "News & Events". The breadcrumb trail is "Home > For Professionals > Prevention & Chronic Care > Improving Primary Care Practice".

The main content area is titled "Improving Primary Care Practice". It features a sidebar on the left with a tree view of topics: Clinicians & Providers, Education & Training, Hospitals & Health Systems, Prevention & Chronic Care (selected), Capacity Building, Care Coordination, Clinical-Community Linkages, Health Care/System Redesign, Behavioral and Mental Health, Self-Management Support, and Resources. The main content area contains the following sections:

Improving Primary Care Practice

Primary care is the cornerstone of health care that is effective and efficient and meets the needs of patients, families, and communities. Our primary care system currently has significant—and perhaps unprecedented—opportunities to emphasize quality improvement (QI) and practice redesign in ways that could fundamentally improve health care in the United States. To ensure these efforts are successful, there is a need to build and sustain the ability of primary care practices to engage in QI activities in a continuous and effective way.

Capacity Building

These AHRQ publications describe the need for external infrastructure to help primary care practices develop quality improvement (QI) capacity and describe approaches and supports that could develop and support QI capacity in primary care.

Care Coordination

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

Clinical-Community Linkages

Clinical-community linkages help to connect health care providers, community organizations, and public health agencies so they can improve patients' access to preventive and chronic care services.

Health Care/System Redesign

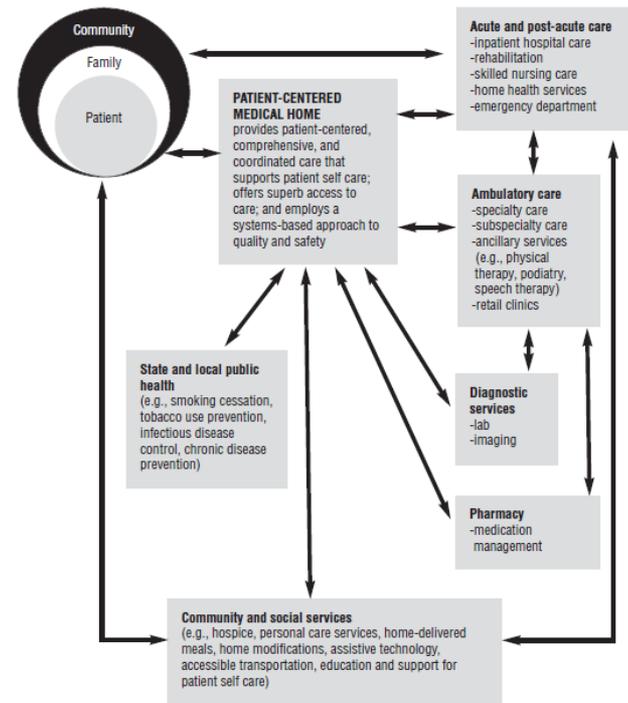
Health care/system redesign involves making systematic changes to primary care practices and health systems to improve the quality, efficiency, and effectiveness of patient care.

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/index.html>

Care Coordination and the Medical Neighborhood

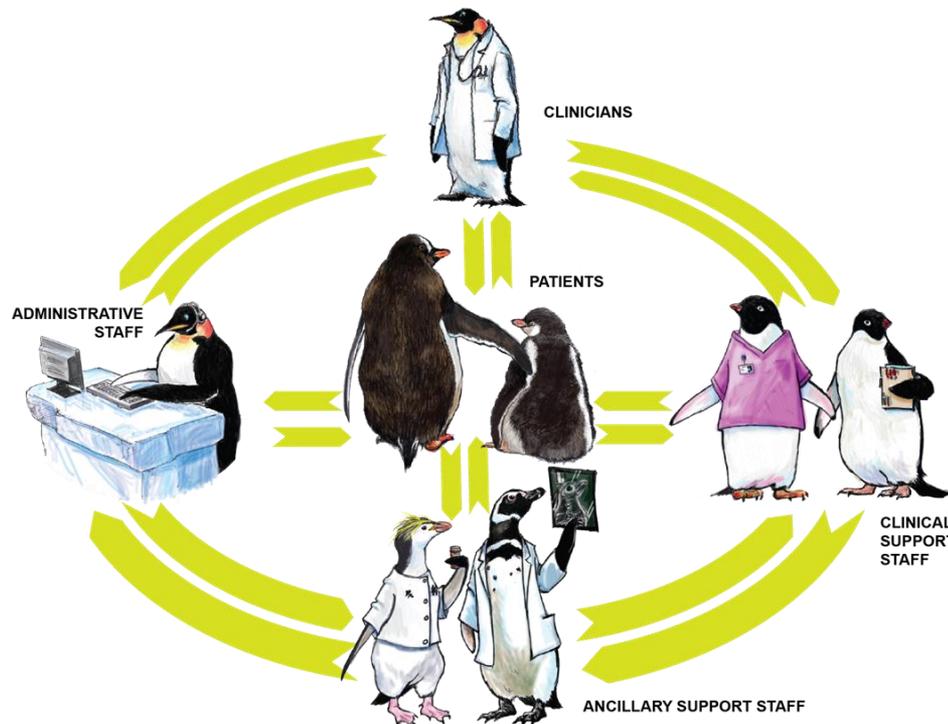
- Information to support systems redesign to improve referral processes between primary care, specialty care practices, and community services
- Improving research and the evidence base – measure development work

Figure 1. Key actors and the flow of information in the medical neighborhood



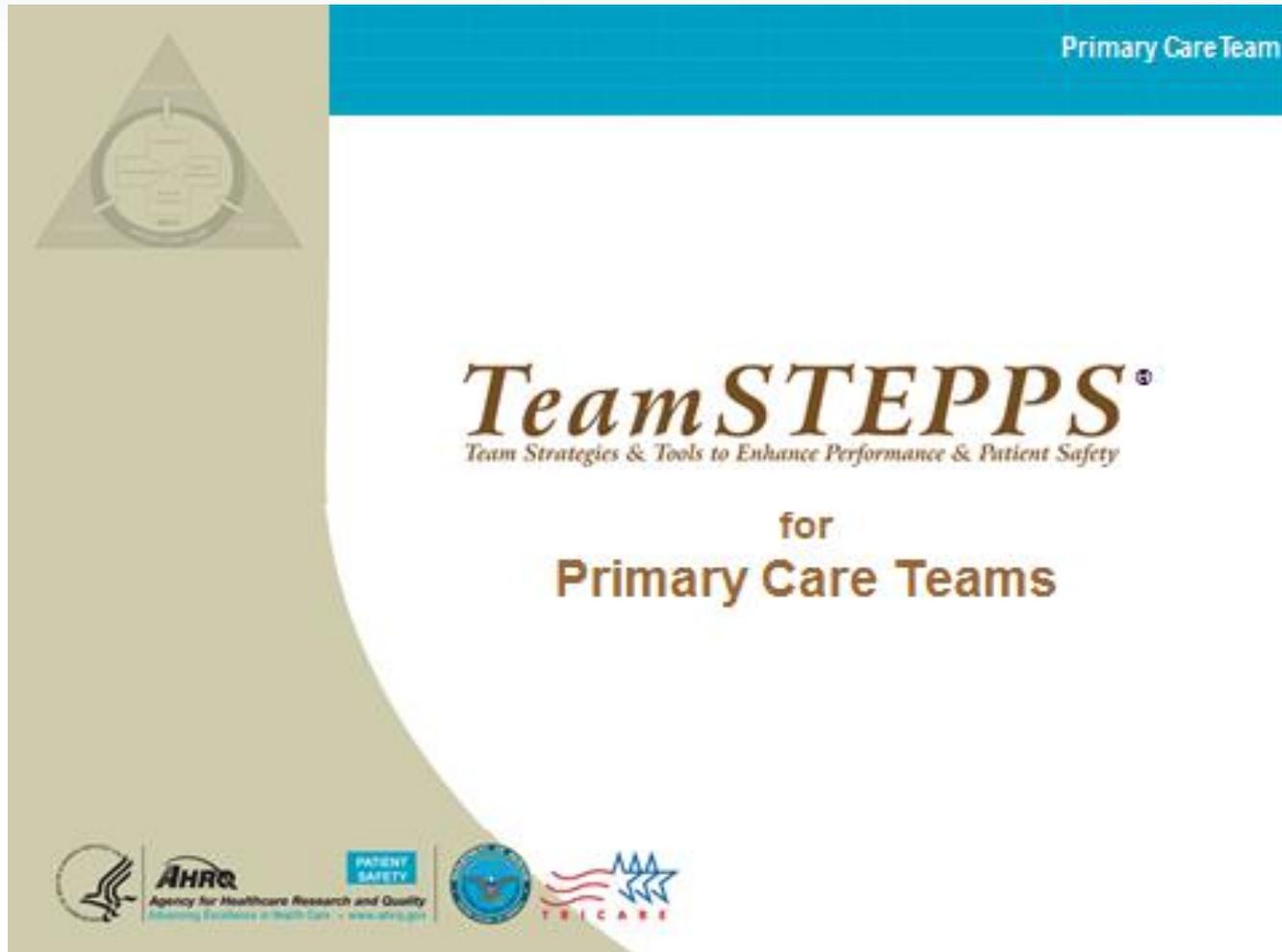
Enhanced Care Delivery Resources

- In order to deliver accessible, coordinated, comprehensive, patient-centered care
 - ▶ It requires a team



Primary
care
teams

Helping Build Teams



<http://teamstepps.ahrq.gov/>



Integration of Primary Care and Behavioral Health

The Academy
Integrating Behavioral Health and Primary Care

Home About Us Research Education & Workforce Policy & Financing Lexicon Clinical & Community Health IT Resources Collaboration

Now Available!
Access the new Atlas of Integrated Behavioral Health Care Quality Measures
[Coming Soon](#)

Vision
AHRQ's vision is that the Academy for Integrating Behavioral Health and Primary Care will function as both a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare.

Welcome to the Academy The AHRQ Academy web portal offers you **resources** to advance the **integration** of **behavioral health and primary care**, and fosters a **collaborative** environment for dialogue and discussion among relevant thought leaders.

This Month

Organizations Supporting Integration

This month the AHRQ Academy has updated the Organizations page on the Resources tab to include a more comprehensive list of [organization...](#)
[More ...](#)

Where Integration is Happening

[Learn More...](#)

New & Notable

- Wed, 08/27/14 NIAC Meeting
- Wed, 08/27/14 QUALITY IMPROVEMENT RESOURCES FOR PRIMARY CARE
- Wed, 08/27/14 Get Your Latest News Via the Academy
- Wed, 08/27/14 Delivering Effective Complex Care Management
- Fri, 08/08/14 Get Your Latest News Via the Academy

New & Notable items include highlights of current activities of The Academy for Integrating Behavioral Health and Primary Care, as well as new research findings, Federal initiatives and other public and private activities going on in the field of

Featured Products

[Atlas](#) of Integrated Behavioral Health Care Quality Measures

[Lexicon](#) for Behavioral Health and Primary Care Integration

[Academy Webinars](#): National experts address various topics related to behavioral health and primary care integration

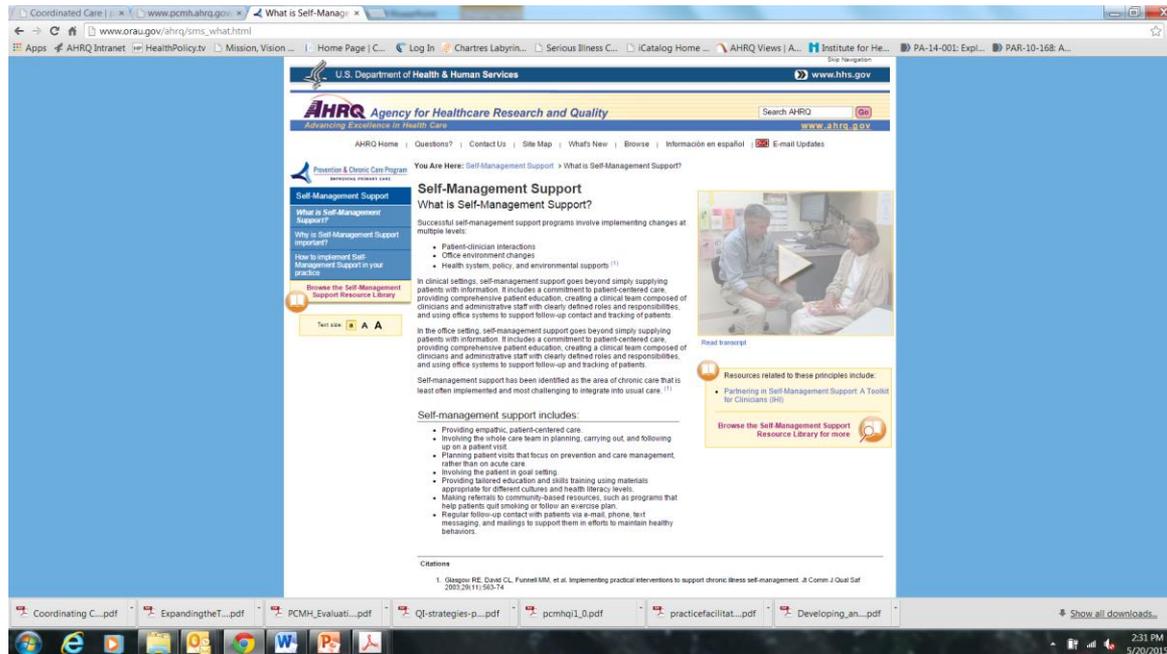
[NIAC Videos](#): Featuring National Integration Academy Council members

Kavita Patel, MD, MSHS
The Academy for Integrating Behavioral Health

<http://integrationacademy.ahrq.gov/>

Self-Management Support

- What is self-management support? Why is it important? How can it be implemented in practice?
- Resources for clinicians, clinical teams, health systems, and consumers





AHRQ Resources for Patient and Family Engagement

- Engaging Patients and Families in the Medical Home
(white paper)
- Strategies to Put Patients at the Center of Primary Care
(decisionmaker brief)

Resources that describe how decisionmakers can encourage a model of care that truly reflects the needs, preferences, and goals of patients and families.

<http://www.pcmh.ahrq.gov/page/patient-centered-care>

- Health Literacy and Cultural Competency Resources

Resources, such as the Health Literacy Universal Precautions Toolkit, to help primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels.

<http://www.ahrq.gov/health-care-information/topics/topic-health-literacy.html>



AHRQ's Innovations Exchange

PCPF Resources | pcm | x | Practice Facilitation | x | AHRQ Health Care In | x

https://innovations.ahrq.gov

U.S. Department of Health & Human Services

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

AHRQ HEALTH CARE INNOVATIONS EXCHANGE
Innovations and Tools to Improve Quality and Reduce Disparities

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Search for Innovation Profiles and QualityTools

Primary Care Innovations To Improve Cardiovascular Health
Clinical practices are finding innovative ways to reduce the risk of cardiovascular disease and improve patient outcomes.

Learning Communities
The Innovations Exchange is expanding efforts to scale up and spread innovations by sponsoring three Learning Communities (LCs) focused on the following high-priority topic areas: "Advancing the Practice of Patient- and Family-Centered Care in Hospitals," "Reducing Non-Urgent Emergency Services," and "Promoting Medication Therapy Management for At-Risk Populations." Participants will work together in a collaborative group setting to adapt and implement innovation "clusters" that address their unique quality improvement needs.

Downloadable Database
The entire Health Care Innovations Exchange collection of Innovation Profiles and QualityTools is freely available for download as CSV and XML files.

QI-strategies-p...pdf | pcmhq1_0.pdf | practicefacilitat...pdf | Developing_an...pdf

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<https://innovations.ahrq.gov/>



AHRQ's Innovations Exchange

- Building Relationships Between Clinical Practices and the Community to Improve Care
<https://innovations.ahrq.gov/scale-up-and-spread/building-relationships-between-clinical-practices-and-community-improve-care>
- Award-winning series of 3 videos on Vermont's Blueprint for Health program
<https://innovations.ahrq.gov/videos/blueprint-health-working-together-better-care-1-3>



Getting Health IT to Work for You

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AHRQ NATIONAL RESOURCE CENTER

HEALTH INFORMATION TECHNOLOGY

Best Practices Transforming Quality, Safety, and Efficiency

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[-](#) [A](#) [A+](#) [YouTube](#) [in](#) [t](#) [f](#)

- HEALTH IT HOME
- PROGRAM OVERVIEW
- EVENTS
- AHRQ-FUNDED PROJECTS
- HEALTH IT TOOLS AND RESOURCES
- KEY TOPICS
- FUNDING OPPORTUNITIES
- CONTACT US
- STAY INFORMED

Findings and Lessons From

AHRQ's Clinical Decision Support Demonstration Projects

[Previous](#) [Pause](#) [Next](#)

AHRQ [report](#) summarizes findings and lessons for designing, implementing, and evaluating clinical decision support (CDS). Teams from Yale University ([video](#)) and Brigham and Women's Hospital ([video](#)) demonstrate novel approaches for CDS implementation to improve care.

- Events
- AHRQ-Funded Projects
- Findings and Lessons From AHRQ's Clinical Decision Support Demonstration Projects
- New Success Stories Highlight Ways that Health IT Improves Care and Satisfaction
- 2012 Health IT Annual Report
- Robust Health Data Infrastructure Report

About AHRQ's Health IT Portfolio

AHRQ's Health IT Portfolio develops and disseminates evidence to inform policy and practice on how health information technology can improve the quality of health care. AHRQ's Health IT Portfolio has invested in research grants and contracts awarded to over 180 distinct institutions in 47 States and the District of Columbia.

[Learn more about AHRQ's Health IT Portfolio](#)

Latest News

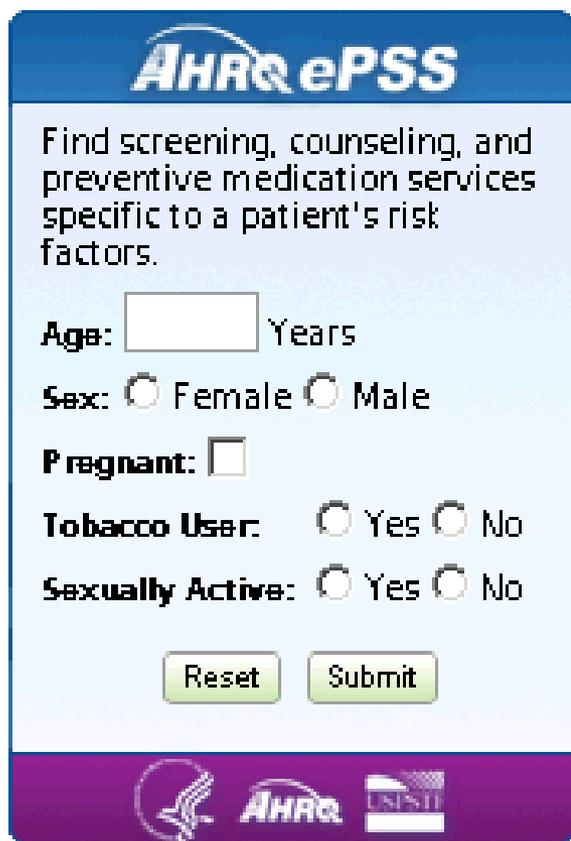
Events

There are no upcoming events. Please check back soon.

[View more events...](#)

<http://healthit.ahrq.gov/>

Preventive Services Recommendations



AHRQ ePSS

Find screening, counseling, and preventive medication services specific to a patient's risk factors.

Age: Years

Sex: Female Male

Pregnant:

Tobacco User: Yes No

Sexually Active: Yes No

www.epss.ahrq.gov



 **myhealthfinder**

Find health advice for you or someone you care about.

Age: Sex: M F

Pregnant?

healthfinder.gov 
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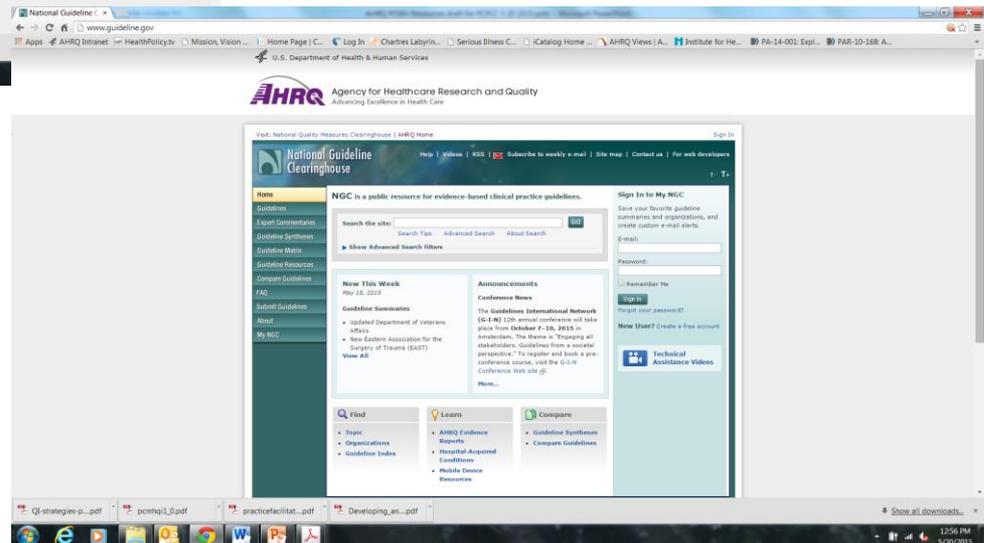


Additional resources for Quality Improvement and Evidence-Based Care



National Quality Measures Clearinghouse

<http://www.qualitymeasures.ahrq.gov/>



National Guideline Clearinghouse

<http://www.guideline.gov/>



AHRQ's Resources for Primary Care Transformation

Questions?



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Thank you!

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