

# CMS Transition to FQHC Medical Home

## PanhandleHATS Coalition

### **Health Navigation Model for CMS Transition Clients to Escambia Community Clinic/Santa Rosa Community Clinics (FQHC)**

#### **Eligible Clients**

Transition clients Ages 18-21; uninsured and Medicaid enrolled, who consent to be referred to FQHC for their Primary Care Medical Home

#### **Partners**

Escambia Community Clinics, Inc. (FQHC)  
Children's Medical Services (Pensacola)

# CMS to Escambia Community Clinic (ECC) FQHC Referral Process

**Step 1: CMS Transition client counseled on medical home options. Client consents to FQHC referral**



**Step 2: Referral made to CMS social worker if client agrees or requests assistance. Client may transition without assistance. CMS Social Worker or nurse coordinator makes contact with ECC.**



**Step 4: Assigned ECC Transition Social Worker will make contact with Patient/Family**



**Step 3: Referral will be called to assigned ECC Transition Social Worker.**

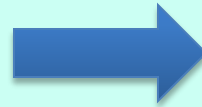
**Step 5: Referred CMS client will be entered into FQHC electronic medical records system and assigned to appropriate PCMH provider support team. Client will be contacted and appointment will be scheduled.**



**Step 6: Once patient arrives at ECC/FQHC for appointment, client will be greeted by designated social worker and walked through check in process.**



**Step 7: ECC/FQHC social worker will remain with CMS transition client through visit**



**Step 9: Designated social worker will continue to be the client's contact, liaison and advocate (FQHC Case Management Model).**



**Step 8: All additional referrals and resources will be provided and coordinated through designated social services staff and PCMH provider support team referral specialist.**

# ***PATIENT CENTERED MEDICAL HOME (PCMH) PROVIDER SUPPORT TEAM ESCAMBIA COMMUNITY CLINIC/FQHC***

**PROVIDER**  
Leader

**PROVIDER NURSE**  
Direct nursing care of patients,  
follow-up with no-shows, same day  
requests, etc. Serves as a Backup to  
Rest of Support Team

**REFERRAL SPECIALIST**  
Manages and tracks all patient referrals  
for diagnostic testing and specialty care.  
Serve as a backup for rest of support  
team.

**SCHEDULER/DOCS MANAGEMENT**  
Manage Provider schedule, ensure outside records are  
scanned into the chart and ready for Provider review  
prior to patient appointment, manage support team  
phone calls.

**RECEPTIONIST**  
Manage Provider Check-In, Insurance Verification,  
Financial Counseling, Collection of Payments,  
Coordinate Patient Flow with Rest of Team