Patient-Centered Medical Home Recognition—It’s Possible!

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Today’s Presenters

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Objectives

1. The participant will learn about the comparison of the various PCMH recognition processes.

2. The participant will be able to identify benefits and challenges for SBHCs in the various PCMH recognition processes.

3. The participant will be able to describe the PC-SBHC recognition designed specifically for SBHCs.
PCMH Models of Care

1. **AAAHC** Medical Home Accreditation and On-site Certification
2. **NCQA** PCMH Recognition Program
3. **Joint Commission** Primary Care Medical Home Certification
4. **PC-SBHC**
5. **State-specific** standards
POLL QUESTION
Comparing Recognition Processes

1. Cost
2. Scope
3. Eligibility
4. Process
5. Accreditation Requirement
6. Levels of Recognition
7. Cycle
The Puzzle: Piecing Together Patient Centered Medical Care and School-Based Health Centers

No matter the challenges of earning patient-centered medical home (PCMH) accreditation, the careful documentation of policies, procedures, and practices that constitute high-quality primary care is beneficial to SBHCs. Such a comprehensive assessment can foster better quality improvement processes, clinical
Questions to Ask When Selecting A Recognition Model to Pursue

1. Is staff willing to commit?
2. Has EHR been functioning at least 6 months?
3. Is recognition a requirement of payers, regulatory agencies, and/or MCO in your state?
4. Has your medical sponsor already pursued PCMH recognition for its community clinics?
5. What is the cost versus benefit?
“Achieving Patient Centered Medical Home (PCMH) Certification using Accreditation Association for Ambulatory Health Care (AAAHC) Standards”

Presented by:
Janelle Dunn, MHA, CMPE – Chief Operations Officer
Deana Montella, BSN, RN – Director of Nursing
“Within the patient-centered medical home, patients are empowered to be responsible for their own health care. As used in these standards, a ‘Medical Home’ is the primary point of care for the patient.”

Excerpt from: 2017 AAAHC Manual, Chapter 25 which outlines the standards required by AAAHC to attain PCMH status
Operations

- Policies and Procedures
- Staff Education
- Facilities Management
- FAQ Sheet
Clinical

- Policies and Procedures
- Clinical Facility Check-List
- Skills Assessment
- Quality
- Documentation
Staff Buy-In

Understand - Why accreditation and PCMH is important for your organization.

Communicate - How PCMH impacts your employees and your patients.

Prepare - What to expect during a survey.

Educate - Explain the expectations of each department.
School-Based Health Alliance Webinar
NCQA PCMH 2014 & 2017 Standards

Richard Lyn-Cook, MD, MPH
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Why is NCQA redesigning the PCMH Recognition program?

The redesign responds to requests to improve the process, to cut back the paperwork, and to simplify reporting. Respondents wanted more time to concentrate on care.

Recent changes in federal law—the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—will change payments to reward value-based care. Our redesigned process aims to align reporting requirements with expected MACRA changes, to eliminate duplication of work.

Changes to NCQA PCMH Certification

2014 Standards>>Elements>>Factors

2017 Standards>>Competencies>>Guidance-Evidence

Process is less onerous (DNV versus Joint Commission example)
- Commit-self assessment
- Transform-gradual transformation
- Succeed-building upon successes with assistance from NCQA
2014 Standards

1. Patient-Centered Access
   The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

2. Team-Based Care
   The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.

3. Population Health Management
   The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

4. Care Management and Support
   The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

5. Care Coordination and Care Transitions
   The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

6. Performance Measurement and Quality Improvement
   The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

2017 Standards

Patient Centered Access and Continuity
- Access to practice and clinical advice
- Care continuity
- Empanelment

Team-Based Care and Practice Continuity
- Practice leadership
- Care team responsibilities
- Orientation of patient/families/caregivers

Knowing and Managing Your Patients
- Data collection
- Medication reconciliation
- Evidence-based clinical decision support
- Connection with community resources

Care Management and Support
- Identifying patients for care management
- Person-centered care plan development

Care Coordination and Care Transitions
- Management of lab/imaging results
- Tracking and managing patient referrals
- Care transitions

Performance Measurement and Quality Improvement
- Collecting and analyzing performance data
- Setting goals
- Improving practice performance
- Sharing practice performance data
Patient Centered – School Based Health Care Standards

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School-Based Health Alliance Webinar
Poll Question:
Common Challenges
Solution: Create Our Own

History:

2012-2014  Gathered stakeholders to write standards
2014-16    Standards piloted (2 states)
1/2017      Met with NCQA to hammer out the
            edges and create new standards for SBHC in alignment
            with NCQA 2017 standards

Current status:

June 2017  Standards go to NCQA board for approval
CROSSWALK NCQA/ PC-SBHC STANDARDS
Challenge: PCP status

SOLUTION:

SBHC

• Is a member of the Primary Care team and provides
  – Comprehensive Primary Care
  – Coordinated Primary Care
  – Minimal Primary Care (Episodic care)

• Has a system to identify level of care provided
Team Based Care and Practice Organization

Challenge: Small staff and limited admin support

SOLUTION:

Core Criteria

• Clinician lead is embedded at site
• Administrative lead can be shared across sites

Elective Criteria

• Behavioral Health manager can be provider of care as long as doing case management.
• Informing patients about role of medical home for SBHC includes informing adolescents about confidentiality for behavioral and reproductive health services.
Knowing and Managing Your Patient

Challenge: Recognition of Presence in school/population

SOLUTION:

For core credit:

- Engages with school or intervention agencies in community

For Elective Credit

- School as Population
- Reproductive Health Needs assessment
- Classroom based or school wide resources
- Case conferencing with PCP and neighborhood/health system as a member of the primary care team
Patient-Centered Access and Continuity

Challenge: Extended hours and summer coverage

SOLUTION:

Core Criteria

• Extended hours includes before 9 am
• After hours care and summers can be documented linkage to sponsoring organization
Care Management and Support

Challenge: Students often seek care without parent present

SOLUTION:

Core criteria

• Identifying patients who may benefit from care management may include patients referred by school personnel
Care Coordination and Care Transitions

**Challenge:** Communication is PCP centered

**SOLUTION:**

**Core criteria**

- **Focus on communication and coordination with PCPs**
  - Set expectations for information sharing and patient care
- **Co-located, integrated Behavioral Health**
- **Process to coordinate communication re hospital admissions/ED use with PCP**

**Elective Criteria**

- Written care plan to transition complex patients included transitions out of the school (practice)
Performance Management and Quality Improvement

Challenge: Core measures, access to data reporting

SOLUTION:

Core Criteria

- Use SBHA Core Quality measures
- Use SBHA patient experience survey (in development)

Elective Criteria

- SBHA indicators will be benchmarked
Poll Question:
Benefits
Next Steps for SBHCs for all Recognition Programs

Prepare:

• Comprehensive Written Policies and Procedures
• Documented Clinic Workflows (Process Maps)
• Maximize EHR Functionality
  – Data extraction and reporting
  – Bi-directional communication w/ PCPs
  – Care Plan Templates
• Population Management
  – Empanelment
  – Targeted Services
  – Proactive Outreach
  – Point of Care Reminders
• Continuous Quality Improvement program
Questions?

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Evaluation Poll Questions
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Additional Questions? Contact us at: info@sbh4all.org