



Your Extended Family.

Transforming a School Based Health Center into a Patient Centered Medical Home

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Outline

- Molina Healthcare of New Mexico
- Primary Care in New Mexico
- Coordination of Care
- School Based Health Centers (SBHCs)
- Patient Centered Medical Homes (PCMHs)
- SBHCs as PCMHs
- Molina approach to PCMH
- Conclusion



Molina Healthcare of New Mexico

- Manages the healthcare needs of approximately 210,000 New Mexicans covered under government programs
- People younger than 21 are a majority of the members we insure
- NCQA Excellent Accreditation
- Emphasis on helping people navigate the complex healthcare system
- #1 in Top 10 Hispanic Health Care Organizations

Primary Care Providers

- In the United States the PCP to specialist ratio is about 30:70²
- In other developed countries the ratio is 70:30
- In those countries health care costs are lower and outcomes often better
- In New Mexico the ratio is about 20:80
- Currently about 7% of medical students enter office based primary care

Coordination of Care

- Provide efficient and effective care at any given time in illness or wellness
- Establish and guide patient and family expectations
- Manage care proactively at all times and all settings, matching appropriate resources to the patient's condition
- Optimize resource utilization: family, community, and provider resources



Coordination of Care

- Enable patients and their families to become active, informed partners in their healthcare
- Focus on prevention and wellness
- Improve overall healthcare delivery



School Based Health Centers

- Are located in schools or on school grounds.
- Work cooperatively within the school to become an integral part of the school.
- Provide a comprehensive range of services that meet the specific physical and behavioral health needs of the young people in the community.
- Employ a multidisciplinary team of providers to care for the students: nurse practitioners, registered nurses, physician assistants, social workers, physicians, alcohol and drug counselors, and other health professionals.

School Based Health Centers

- Provide clinical services through a qualified health provider such as a hospital, health department, or medical practice.
- Require parents to sign written consents for their children to receive the full scope of services provided at the SBHC.
- Have an advisory board consisting of community representatives, parents, youth, and family organizations, to provide planning and oversight.

School Based Health Centers – Principles

- 1. Supports the School**
- 2. Responds to the Community**
- 3. Focuses on the Student**
- 4. Delivers Comprehensive Care**
- 5. Advances Health Promotion Activities**
- 6. Implements Effective Systems**
- 7. Provides Leadership in Adolescent and Child Health**

The Patient-Centered Medical Home Defined

ACP, AAFP, AAP, AOA Joint Principles – April 2007

Personal physician – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.



School Based Health Centers as Patient Centered Medical Homes

School Based Health Centers	Patient Centered Medical Homes
<p>Provide a comprehensive range of services that meet the specific physical and behavioral health needs of the young people</p>	<p>Provide for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals</p>
<p>Multidisciplinary team of providers to care for the students: nurse practitioners, registered nurses, physician assistants, social workers, physicians, alcohol and drug counselors, and other health professionals</p>	<p>Team of individuals at the practice level who collectively take responsibility for the ongoing care of patients</p>
<p>Provide clinical services through a qualified health provider such as a hospital, health department, or medical practice.</p>	<p>Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).</p>

NCQA Standards

PPC 1: Access and communication

PPC 2: Patient tracking and registry functions

PPC 3: Care management

PPC 4: Patient self-management support

PPC 5: Electronic prescribing

PPC 6: Test tracking

PPC 7: Referral tracking

PPC 8: Performance reporting and improvement

PPC 9: Advanced electronic communications



Standard 1: Access and Communication A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pts 4 5 9	Standard 5: Electronic Prescribing A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with cost checks	Pts 3 3 2 8
Standard 2: Patient Tracking and Registry Functions A. Uses data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system D. Uses paper or electronic-based charting tools to organize clinical information** E. Uses data to identify important diagnoses and conditions in practice** F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pts 2 3 3 6 4 3 21	Standard 6: Test Tracking A. Tracks tests and identifies abnormal results systematically** B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management A. Adopts and implements evidence-based guidelines for three conditions ** B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	Pts 3 4 3 5 5 20	Standard 7: Referral Tracking A. Tracks referrals using paper-based or electronic system** Standard 8: Performance Reporting and Improvement A. Measures clinical and/or service performance by physician or across the practice** B. Survey of patients' care experience C. Reports performance across the practice or by physician ** D. Sets goals and takes action to improve performance E. Produces reports using standardized measures F. Transmits reports with standardized measures electronically to external entities	PT 4 4 Pts 3 3 3 3 2 1 15
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers B. Actively supports patient self-management**	Pts 2 4 6	Standard 9: Advanced Electronic Communications A. Availability of Interactive Website B. Electronic Patient Identification C. Electronic Care Management Support	Pts 1 2 1 4

**** Must Pass Elements**



PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 - 74	10 of 10
Level 1	25 - 49	5 of 10
Not Recognized	0 - 24	< 5

Levels: If there is a difference in Level achieved between the number of points and “Must Pass”, the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 “Must Pass” Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 “Must Pass” Elements are not Recognized.

Community Care of North Carolina

- Goal: Reduce Medicaid costs and improve the health of the patient population
- Setting: Local partnerships of physicians, hospitals, health departments, and departments of social services
- Changes:
 - > After-hours pediatric clinic (6 PM to 10 PM)/365 nights/year
 - > Nurse advice phone line
 - > 1 Case Manager per 3,300/pts, averaging 100 to 200 patients at any given time
 - > Developed disease management tools
 - > Case management fee

Community Care of North Carolina

- Outcomes
 - > 17% decrease in Emergency Department visits by Medicaid patients under age 21 in 1st year (1999)¹
 - Parents and patients appreciated the convenience of Emergency Department alternatives
 - > 17% decline in Emergency Department admissions 2003 to 2006 despite 176% increase in number of patients diagnosed with asthma²
 - > Opportunities for improvement drive change
 - Practice-specific data identifies opportunities

1. Wilson CF. Community care of North Carolina: Saving state money and improving patient care. *NC Med J.* 2005; 66(3):229-33.

2. Asthma Disease Management Program Summary. Community Care of North Carolina, 2007. Available at: <http://www.communitycarenc.com/>

Molina's Approach to PCMHs

- Invite PCP groups to obtain NCQA PCMH accreditation
- Subsidize application fee
- Provide consultative support during process
- Once accreditation achieved provide quarterly incentive payments based on assigned MHNM membership
- Develop outcomes measures
- Measure and report on success of program



Molina's Approach to PCMHs

- Subsidize 50% of application fee for the group at the outset
- Once accreditation is achieved reimburse an additional 25% to the group
- Help groups develop and incorporate components of Medical Home into their work processes
- Pay quarterly incentives for first year
- Develop 3-5 Outcomes measures for subsequent incentives
- Update incentives to achieve desired Outcomes



How to Transform SBHC's into PCMH's?

- NCQA Accreditation
- Reimbursement model
- Outcomes measures
- Patient (and parent) satisfaction
- Others?

Discussion