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# School-Based Health Centers

Patient-Centered Medical  
Homes - A True Community  
Partnership



Oregon  
Health  
Authority

Public Health Division  
Office of Family Health  
Adolescent Health Section

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# Objectives for today...

- The Participant will be able to describe seven basic attributes of a patient-centered medical home.
- The Participant will be able to evaluate their SBHC's readiness to participate in a medical home model of care.
- The Participant will be able to define at least three short-term actions SBHCs must take to become integral member of their student's health care delivery team.

# WHAT IS A MEDICAL HOME & WHY SHOULD AN SBHC CARE?

# History of Medical Home Concept

- Began as a term to describe a place: a single source of all medical information about a patient
- Now: refers to a partnership approach with families to provide primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.

# History of Medical Home Concept

- **1967-** The American Academy of Physicians (AAP) *Standards of Child Health Care* envisioned the medical home as: “one central source of a child’s pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination.”
- **1977-** AAP published policy statement “Quality medical care is also best provided when all the child’s medical data is together in one place, (a Medical Home) readily accessible to the responsible physician or physicians.”
- **Late 1970s-80s:** Evolution towards a model of primary care from a community level that includes complete child and family needs.

# History cont.

- **1980s:** As concept evolved and gained recognition 3 major barriers were identified:
  - Training pediatricians to understand the Medical Home model
  - Communication and care coordination for related services in health, family support, and education/special education
  - Reimbursement for periodic well-child supervision and care coordination.
- **1992:** AAP published first policy statement defining Medical Home:
  - “Medical care of infants, children, and adolescent ideally should be accessible, continuous, comprehensive, family-centered, coordinated and compassionate.”
- **Late 1990s-2000:** AAP expands concept to include all children

# History cont.

- **2002:** AAP further characterized care in a medical home as accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and **culturally effective**.
- **2004:** The Future of Family Medicine Project expanded on the concept by calling for **every American** to have a personal medical home.
- **2006:** Joint Principles of the Patient-Centered Medical Home drafted

# Medical Homes and Health Reform

- Medical Home Provisions in the Patient Protection and Affordable Care Act (ACA)
  - Health Homes in Medicaid (Sec 2703)
  - Center for Medicare and Medicaid Innovation (Sec 3021)
  - State Grants to Promote Community Health Teams that support the Patient-Centered Medical Home (Sec 3502)
  - Community-Based Collaborative Care Network Program (Sec 10333)
  - Pediatric Accountable Care Organization Demonstration Project (Sec 2706)
  - Community Health Center Expansion

# “Health Home”

- Patient Protection and Affordable Care Act (ACA):  
Health Homes in Medicaid (Sec 2703)
  - Expanding on the traditional medical home model
  - Build linkages to community and social supports
  - Enhance integration and coordination of primary, acute, behavioral health, and long-term care services and supports for Medicaid enrollees with chronic conditions
- Allows states to focus on three goals:
  - Improve the experience of care;
  - Improve the health of populations
  - Reduce per capita costs of health care (without harm to individuals or families)

# Medicaid “Health Home” cont.

- Three types of health home providers:
  - Designated providers
  - Team of health care professionals
  - Health team
- Health Home population criteria: individuals who have at least two chronic conditions, as listed in section 1945(h)(2) of the Act, one chronic condition and be at risk for another, or one serious and persistent mental health condition.
- The chronic conditions include: a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25. Section 1945(h)(2) of the Act authorizes the Secretary to expand the list of chronic conditions reflected in this provision.

# Federal Initiatives –

## *Health Homes for Enrollees with Chronic Conditions*

- CMS issued guidance to states on November 16, 2010
- Guidance implements Sec. 2703 of Affordable Care Act
- States can elect to participate through a Medicaid State Plan Amendment
- Goals
  - Build linkages to other community and social supports
  - Enhance coordination of medical and behavioral health care
  - Whole person model
- Provides a 90% Federal Match

# “Health Home” cont.

- Service Definition
  - “comprehensive and timely high quality services,” and includes the following health home services to be provided by designated health home providers or health teams:
    - Comprehensive care management;
    - Care coordination and health promotion;
    - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
    - Individual and family support, which includes authorized representatives;
    - Referral to community and social support services, if relevant; and
    - The use of health information technology to link services, as feasible and appropriate.

# Oregon's Medical Home Journey

- In 2007, Oregon formed the Health Fund Board to develop a comprehensive plan to reform Oregon's health care system
- The Oregon Health Fund Board adopted the “Triple Aim” as its core focus:
  - Healthy Population
  - Extraordinary Patient Care
  - Reasonable Costs
- The Health Fund Board identified the development of Patient-Centered Primary Care Homes as a central strategy for improving the health care delivery system.

# Oregon's Medical Home Journey (cont)

- In 2009, the Health Fund Board's work was incorporated into Oregon's Health Reform legislation, HB 2009
  - The Oregon Health Authority was created
  - The Oregon Health Policy Board was created to oversee health care reform initiatives for Medicaid, the Oregon Public Employees Benefits and the Oregon Education Benefits
- The Oregon Health Policy Board established a Patient-Centered Primary Care Home Program within the Office of Oregon Health Policy and Research (OHPR)
- HB 3418 also required the Oregon Health Authority to study the feasibility of alternative payment models for primary care homes within the Medicaid program
- Two advisory committees formed to assist OHPR to develop standards for Oregon's medical home model.

# Oregon's Medical Home Journey (cont)

- In February, 2010 OHPR finalized the Standards and Measures for Patient Centered Primary Care Homes
  - The Standards included Pediatric standards that were developed by a sub-committee
  - SBHC's were represented in the Pediatric Sub-Committee
  - The model anticipates coordination among care organizations – so no single entity must meet all the standards independently
- In December, 2010 the Oregon Health Policy Board published Oregon's Action Plan for Health
- In January, 2011 Oregon's legislature formed a Health Care Transformation Team to develop legislation need to implement Oregon's Action Plan for Health
  - The legislation includes the adoption of Coordinated Care Organizations
  - The legislation includes Patient-Centered Primary Care Home
- Oregon is now seeking a Medicaid State Plan Amendment

# Why should an SBHC care?

- The Medical Home Model is being adopted by both public and private payors as a means of providing cost-effective quality care
- Accountable Care Organizations are forming to provide comprehensive care to communities through a variety of medical homes
- SBHCs have focused on cost effective quality and PREVENTIVE health services for a long time
- If an SBHC is not participating within their community's health care delivery system, they will be limited to a first-aid/urgent care model of care

# HOW DO I KNOW IF MY SBHC CAN PARTICIPATE IN THE MEDICAL HOME MODEL?

# Core Principles of Patient-Centered Medical Home

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Coordinated and/or integrated care
- Quality and safety are prioritized
- Enhanced access is available
- Payment appropriately recognizes the added value to patients who have a PCMH

# NCQA Medical Home Criteria

- March 28, 2011 Update
- Can obtain online for free
- NCQA is a private accreditation organization that is recognized by many states
- Standards
  - Access & Continuity
  - Identify & Manage Patient Populations
  - Plan & Manage Care
  - Provide Self-Care Support
  - Track & Coordinate Care
  - Measure & Improve Performance

# CMS Health Home Requirements

- Cost Effective
- Culturally appropriate
- Evidenced-based clinical practice guidelines
- Preventive & Health Promotion services that include mental health & substance abuse
- Comprehensive care management & coordination
- Chronic disease management
- Individual and Family supports and services
- Person-centered care plan
- Use health information technology
- Continuous quality improvement including data collection & analysis

# Oregon Medical Home Criteria

## **Access To Care**

Be there when we need you

## **Accountability**

Take responsibility for making sure we receive the best possible health care

## **Comprehensive Whole Person Care**

Provide or help us get the health care, information & services we need

## **Continuity**

Be our partner over time in caring for us

## **Coordination & Integration**

Help us navigate the health care system to get the care we need in a safe and timely way

## **Person & Family-Centered Care**

Recognize that we are the most important part of the care team – and that we are ultimately responsible for our overall health and wellness



# Participant Exercise & Discussion

Conduct a “Gap” Assessment of your SBHC’s ability to meet the Medical Home standards?

Do you see opportunities?

Do you see challenges?

# Critical Success Factor: *Community Partnerships*

| Core Area                       | SBHC Strategies  |
|---------------------------------|--|
| Access to Care                  | Partnerships with local hospitals and clinics for care during the summer & after hours                                   |
| Accountability                  | Partnerships with specialists to meet all health care needs  |
| Comprehensive Whole Person Care | Partnerships with dental professionals, mental health professionals, social service agencies, educators and youth        |
| Continuity                      | Ongoing meetings with community partners to identify process improvements  |
| Coordination & Integration      | Work with partners to identify roles & responsibilities as a group and for individuals within the medical home community |
| Person & Family Centered        | Involve Youth & Families in the medical home community   |

# Critical Success Factor:

## *Electronic Health Records*

| Core Area                       | SBHC Strategies   |
|---------------------------------|---|
| Access to Care                  | <ul style="list-style-type: none"><li>• Evaluate the EHR system being used by other providers in the service area</li><li>• Determine the current status of Health Information Exchange in the service area</li><li>• Invest in an EHR system that will allow the SBHC to exchange health information with other providers within their service area</li><li>• Develop the EHR functionality to best align with the medical home requirements</li></ul> |
| Accountability                  |   |
| Comprehensive Whole Person Care |   |
| Continuity                      |   |
| Coordination & Integration      |   |
| Person & Family Centered        |   |

# Critical Success Factor:

## *Data Collection & Analysis*

| Core Area                       | SBHC Strategies  |
|---------------------------------|--|
| Access to Care                  | Identify the total number of students that have access to the SBHC and compare that with                     |
| Accountability                  | Adopt Bright Futures as the Standard of Care in your SBHC and develop reports that focus on patient outcomes |
| Comprehensive Whole Person Care | Identify and implement the federal Meaningful Use requirements for EHR                                       |
| Continuity                      | Develop patient-specific data extracts to evaluate the patient's health status over time                     |
| Coordination & Integration      | Implement a referral tracking system that allows for data extracts for number and types of referrals         |
| Person & Family Centered        | Include the patient and family in the analysis of patient-specific data                                      |

# Managed Care vs Medical Home

## Managed Care

- Focused on disease and body parts
- Intended to reduce unnecessary health care costs
- Reactive management of chronic conditions
- Physician-Centered:
  - PCP is “gatekeeper”

## Medical Home

- Emphasis on prevention
- Focused on whole person and patient’s environment
- Proactive management of chronic conditions
- Use of EHR
- Patient-Centered
  - PCP is “navigator” and “coordinator” to support patient
  - PCP tracks ALL care

## For more information...

- Oregon SBHC State Program Office  
[http://www.oregon.gov/DHS/ph/ah/sbhc/  
sbhc.program@state.or.us](http://www.oregon.gov/DHS/ph/ah/sbhc/sbhc.program@state.or.us)  
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