



Patient-Centered Medical Home: How Are California School-Based Health Centers Relating to This New Model of Care?

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Introduction

Patient-centered medical home (PCMH) is a model of primary care delivery in which patients receive well-coordinated services, evidence-based care, and enhanced access to their providers. The PCMH model has a few basic features that distinguish it from the traditional care delivery model: integration of health information technology, greater engagement of patients in their own care, and a team-practice approach. In 2007, leading primary care medical associations released the Joint Principles of the Patient-Centered Medical Home that define PCMH as having the following characteristics:¹

- Personal physician – linking patients to a personal medical provider.
- Physician directed medical practice – establishing a medical team directed by the medical provider.
- Whole person orientation – taking responsibility for the comprehensive health needs of patients.
- Coordinated/integrated care – helping patients navigate their health care needs across a complex health care system and access any required community services.
- Quality and safety – using evidence-based practices, establishing QI plans, ensuring patient satisfaction, using information technology, accountability, etc.
- Enhanced access – ensuring patients can get the care they need when needed.
- Payment – should reflect the unique elements of the PCMH model and include incentives for outcomes and benchmarks.

This paper addresses the question of how school-based health centers (SBHCs) fit into the patient-centered medical home (PCMH) model of care. The goals of the paper are to describe what SBHCs across California are doing with respect to PCMH recognition, review best-practices that help SBHCs move closer to the PCMH model, and offers recommendations for SBHCs looking to strengthen their PCMH practices. This paper focuses specifically on SBHCs run by a Federally Qualified Health Center (FQHC). Of the 226 SBHCs in California, half are operated by FQHCs. There are several different ways in which FQHCs structure their SBHCs, with variations related to hours of operation, services provided, and populations served. Some SBHCs are fully licensed clinics, operating five days a week during the entire calendar year. Other SBHCs are satellite clinics, operating less than 20 hours per week and only open during the school year. Twelve FQHCs were interviewed, that together run a total of 36 SBHCs. Six of the organizations were located in Southern California, and six were located in Northern and Central California. One of the organizations did not yet have an operational SBHC, and planned to open their first SBHC in July 2013.

¹ American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA), “Joint Principles of the Patient-Centered Medical Home”, March 2007

The Relevance and Importance of the PCMH Model for SBHCs

Across the nation, PCMH is being recognized as a new standard of care. There are several provisions within the Affordable Care Act that promote this model. The Centers for Medicare and Medicaid Services launched a demonstration project targeting FQHCs, and the Health Resources and Services Administration has several PCMH initiatives, both providing incentive payments aligned with PCMH activities. In July 2013 the House Energy and Commerce Committee released a proposal that identifies the medical home as an effective, value-based primary care model indicating that the PCMH model may be used in federal payment reform. Additionally, health plans, state, and federal agencies are recognizing the value of PCMH in reducing costs, and many have developed programs to provide monetary incentive for practices to achieve patient-centered benchmarks.

As a result of the rising interest in PCMH, several organizations, such as the National Committee for Quality Assurance (NCQA), have developed standards and provide accreditation to health care organizations that meet their standards (see Appendix A). While California has not yet adopted payment incentives for PCMH, many providers are seeking PCMH recognition from NCQA in anticipation of these incentives.

These changes in the health care landscape have implications for the future of SBHCs. SBHC practices and systems will need to evolve if they are to maximize their potential to contribute to the goals of health care reform. The PCMH model offers an opportunity for SBHCs to build upon their clinical operations to respond to the changing demands of health care reform and to prepare for possible payment reform tied to PCMH accreditation.

Perspectives on SBHCs and PCMH

The national School-Based Health Alliance has issued a position statement on “School-Based Health Centers and The Patient-Centered Medical Home.” Their position statement contends that SBHCs have historically included key components of patient-centered care into their models and state, “At its core, the ideal SBHC model represents many key attributes of an advanced patient-centered primary care system for children and adolescents.”² Below are a few of the specific PCMH components referenced in the position statement:

- SBHCs enhance access to high quality primary care by situating services in the most accessible location for young people: their schools.
- Because of their proximity and routine access to children and adolescents, SBHCs serve as the first (and sometimes only) contact or access point for continuous and comprehensive care for young people with complex medical, behavioral, and social needs.
- SBHCs utilize an interdisciplinary team approach to deliver coordinated primary care across physical, behavioral, emotional and social dimensions of health – and within the context of family and community, as appropriate.

² School-Based Health Alliance, “Position Statement: School-Based Health Centers and The Patient-Centered Medical Home, Washington, DC.

The national Alliance encourages SBHCs to pursue PCMH recognition and to communicate and coordinate care with other providers caring for the patient.

The American Academy of Pediatrics (AAP) discusses SBHCs and the medical home model in their Policy Statement on “School-Based Health Centers and Pediatric Practice.” The AAP acknowledges that SBHC help improve access by eliminating barriers to care such as transportation and finances. However, the AAP notes that some pediatricians are concerned that SBHCs do not support the medical home model. Specifically, the concerns center on the SBHCs that are only open during school hours and the potential for duplicative services due to lack of coordination with the patient's primary care provider.

The AAP states that SBHCs can meet the definition of PCMH for their patients in collaboration with their sponsoring agencies by:

- Ensuring linkage so that services are available 24 hours per day, 7 days a week, and 52 weeks per year, even when schools are closed.
- Encouraging parental participation and providing education about the health care needs of the youth they serve.
- Working collaboratively with primary care practices, school districts, and community agencies.
- Coordinating all specialty and subspecialty consultations, referrals, and collaborations.³

SBHCs in California and PCMH

Given the diversity of SBHCs in California, there will be wide variation in SBHCs’ ability to meet specific accreditation criteria. Those sites that are not open year round and which have rotating providers, may find it difficult to meet the PCMH standards of any of the accrediting bodies. Similarly, SBHCs that focus primarily on family planning or those that do not provide primary care services, would not meet most of the PCMH recognition criteria. However for many SBHCs, recognition as a PCMH is an important and realistic goal.

Of the eleven FQHCs with SBHCs interviewed for this project, many are actively working on PCMH transformation in their organizations, but only one had received formal accreditation. This organization received The Joint Commission accreditation and Primary Care Medical Home (PCMH) certification for all of their clinic sites, which includes two SBHCs.

The other 10 FQHCs are seeking NCQA PCMH recognition and are in various stages of the recognition process. The NCQA PCMH Recognition program is a site-specific program, and an organization can decide to include or exclude sites in its applications. The table below shows the recognition status of the SBHCs represented by the organizations interviewed. Time frames were estimated based on responses from the organization and status of Electronic Health Record (EHR) implementation.

³ *Pediatrics* 2012; 129:387; originally published online January 30, 2012; DOI: 10.1542/peds.2011-3443.

PCMH Accreditation Status	# of SBHCs	Notes
Currently Certified (Joint Commission)	2	Two SBHCs are certified through Joint Commission through their FQHC. Joint Commission does not recognize by site, but rather across the entire organization.
NCQA Recognition expected in 3–6 months	7	These SBHCs have been included in the FQHC initial NCQA application for PCMH Recognition.
NCQA Recognition expected in 7–12 months	4	These SBHCs have been identified by their FQHC organizations to be included in the second round of NCQA applications to be submitted for PCMH Recognition. They were not included in the first round primarily due to the FQHC desire to keep the initial application more manageable.
NCQA Recognition expected in > 1 year	16	Fifteen of these SBHCs do not feel prepared to seek immediate PCMH recognition, because they are either in the early stages of EHR use, have yet to fully implement their EHR system, or have simply not engaged in the PCMH planning process. The other SBHC in this category is set to shift their scope of services from just serving the school, to serving the larger community. After this is done they feel it will be more reasonable to pursue PCMH recognition.
No Recognition expected	7	These seven SBHCs are not open year round and therefore do not currently meet PCMH recognition standards around continuous primary care.
Total	36	

Strengths and Challenges for SBHCs in meeting NCQA PCMH Standards

The findings and recommendations below are based information gathered during the interviews and are structured based on the six current NCQA PCMH Recognition Standards:

- Standard 1: Enhance Access and Communication
- Standard 2: Identify and Manage Patient Populations
- Standard 3: Plan and Manage Care
- Standard 4: Provide Self-Care Support and Community Resources
- Standard 5: Track and Coordinate Care
- Standard 6: Measure and Improve Performance

Standard 1: Enhanced Access and Communication

Access

Definition

Enhanced access means the patient gets the care they need when they need it. That care may be in the form of a phone call about their care or a clinic visit during office hours. It may also include talking to a member of their care team after hours in order to avoid unnecessary use of the Emergency Room. Enhanced access and communication also includes ensuring all encounters are recorded in the EHR so that the care team has easy access to important clinical information at all times. Best practices include offering same day appointments and providing timely clinical advices either during or after office hours, and using an answering service that located a member of the patient's care team who has remote access to the patient's electronic health information.

Patient portals are another way to provide access to the care team through bidirectional secure messaging. However, there is some concern with use of a patient portal in the adolescent population, primarily due to minor consent services and the need to keep that information confidential. While a parent may have a right to view their child's medical information, there are limitations related to the minor consent services. Some EHRs and patient portals are not sophisticated enough to separate the information.

Strengths and Challenges for SBHCs

The majority of the SBHCs identified patient access as a strength, mainly because of their location on the school campus. It is widely recognized that adolescents have a low clinic encounter rate in primary care. However, the ability to provide same day appointments, along with their unique outreach and educational strategies, make SBHCs effective at establishing trusted relationships and bringing students in for needed care. Several interviewees mentioned the value of setting up these trusted relationships with the expected payoff of "training" a lifelong consumer of health care.

A critical access-related limitation evidenced by the interviewees included limited hours of operation. Several SBHCs are not open year round or are only open during school hours and are therefore unable to provide the patients with the care they need when they need it. This limited schedule will preclude an organization from meeting the intent of the access requirement, and is consistent with the AAP concerns mentioned above. Some SBHCs meet this PCMH criteria by directing patients to other clinic locations which have extended hours, when the SBHC is closed.

One of the organizations discussed access limitations due to school policies. Specifically the school administrator did not want students leaving the classroom for clinic appointments. In this situation, students had to make appointments for after-school hours and often missed these appointments because of conflicts with transportation schedules after school.

Only one organization mentioned a patient portal. Their patient portal is in development at this time. This is typical of many organizations across the country that are in the planning phases of implementing patient portals in anticipation of the Stage 2 Meaningful Use Requirements.⁴

Recommendations for Moving SBHCs Toward a PCMH Model

- Ensure same day appointment slots are embedded in the SBHC schedule.
- Make sure patients/families at all of the FQHC's clinics are aware of the convenience of SBHCs locations.
- Expand hours to include year round clinic schedules in order to assure enhanced access.
- Work with FQHC leadership to identify a strategy to provide after-hours support to the SBHCs.
- Work with the FQHC's IT department to determine how a patient portal can be implemented to support the adolescent population, understanding the sensitive nature of some of the services that may be provided.
- Enable students to access care easily. This might include establishing a pass system for students to leave class for appointments, permission to call students out of class for missed appointment, and ensuring that teachers are held to confidentiality standards.

Continuity of Care

Definition

PCMH promotes continuity of care, realizing that a continuous healing relationship between provider and patient is positively linked to improved clinical outcomes. One best practice is to establish a consistent provider staff. Some organizations have historically staffed clinics with a rotating schedule for providers, with a different provider each day or even each half-day clinic session. This practice creates instability in the clinic and impedes continuity of care. When providers rotate from clinic to clinic, their availability to patients is limited in each setting that they serve. The best practice is to assign providers to a "home clinic", and have them only see patients from that location.

A second best practice is Empanelment. Empanelment is the thoughtful and deliberate assignment of each patient to a Primary Care Provider (PCP), and is the cornerstone of continuity. Best practices include the patient having the ability to choose their provider (if multiple providers are available), documentation of that choice in the EHR, and a policy that ensures the patient sees their own personal provider the majority of the time. Empanelment reports are periodically run that show how often a patient was seen by their personal provider.

Strengths and Challenges for SBHCs

Several of the SBHCs were fairly advanced in their thinking around empanelment and have a defined corporate empanelment strategy, providing for a high level of care continuity. A few SBHCs reported a provider structure that included rotating providers, temporary providers, or residents, which would limit the organization's ability to provide a consistent provider.

⁴ Meaningful Use is a federal program that incentivizes providers to use certified electronic health information in a meaningful way. There are three stages, each with progressively more difficult and technical requirements. Stage 2, which begins in 2014, requires providers to provide patients with electronic access to health information through a patient portal.

Several of the SBHCs noted that they are unable to become the PCP for some of the students they serve. For example, some students are members of other health insurance programs (e.g., Kaiser Permanente), in which case the student has a PCP assigned through the Kaiser administrative process. Similarly, PCP assignments by managed care plans can also inhibit a SBHCs ability to become a PCP. Students may be assigned to a nearby health care provider, but use a SBHC that is operated by a different agency. SBHCs operated by FQHCs are required by law to intake and treat these students, regardless of their PCP assignment. When the SBHC is not the PCP, it is serving as an alternative access point for primary care, which raises questions about the impact on receiving continuity of care from one PCP, and concern about how these services will be coordinated with the services provided by the PCP.

Recommendations for Moving SBHCs Toward a PCMH Model

- Develop a continuity of care plan for the SBHC. Consider assigning clinicians to permanent positions in the SBHC, rather than having clinicians rotate between sites within the organization.
- Develop an empanelment strategy to assure patients are able to see the same provider for the majority of their visits.
- Expand services and obtain contracts with health plans to serve as a PCP, or improve communication with patients' assigned PCP.

Team Based Care

Definition

The team based approach to care is paramount to the PCMH practice. The care team is responsible for comprehensive and coordinated care for everyone on the provider's panel, whether or not the patient comes into the practice. The shift to team based care is often difficult for providers because they are called upon to organize the activities of multiple support staff into a coordinated team. A core patient care team consists of the provider and a medical assistant or other clinical support staff person into a "teamlet." Typical primary care sites supplement this "teamlet" with staff members such as RNs, social workers, chronic disease managers, nutritionists, pharmacists, and others. A PCMH practice has formally defined roles and responsibilities for each care team member.

Strengths and Challenges for SBHCs

In SBHCs, the "teamlet" often already exists because of the small size of the clinic. SBHCs rely on a few key staff to run the day-to-day operations. Even the most robust SBHC "teamlet" may only include a medical provider, site coordinator, medical assistant, financial eligibility clerk, health educator, and mental health professional. This more intimate clinical setting allows for a higher degree of cross-training and role sharing, thereby strengthening the team model. For example, in a SBHC it is not uncommon for the health educator to conduct tasks that would otherwise be handled by medical staff, such as recording patient vitals. Additionally, a smaller number of staff requires team members to support each other where gaps in staffing exist, such as appointment or reception staff. In addition, the smaller setting means the provider has more time to mentor the support staff and often develops greater confidence in their skills.

One FQHC interviewed developed a formal team structure. They have divided their clinic into physical "pods" or work areas. Each "pod" has its own team structure and panel of patients. Most other health centers have

loosely defined teams augmented with case managers or health educators, but the teams do not support a defined panel of patients.

Recommendations for Moving SBHCs Toward a PCMH Model

- Develop formal care teams with clearly defined roles and responsibilities, with job descriptions to support the roles. Provide training and support as needed to ensure that all team members are functioning at their highest level allowed by their licensure, credentials, legal scope of practice, and competencies.

Standard 2: Identify and Manage Patient Populations

Definition

This standard encourages the use of health information technology to systematically record patient information in order to support patient care. Best practice includes effective use of the EHR to record demographic, financial, and clinical information. Reports are then generated to identify patients who have not been seen in a while, need preventive care, follow-up services, or medication monitoring.

Another component of this standard is the completion of a comprehensive health assessment that documents key information about the patient's history, communication needs, immunizations, health behaviors, and depression screenings.

Strengths and Challenges for SBHCs

SBHCs operated by FQHCs are generally reliant on their parent clinic to determine the timing and selection of an EHR, as well as to establish the processes for using the EHR to generate patient data and reports. Sixty-four percent of the SBHCs assessed for this report, had fully implemented an EHR system. Several SBHCs are very good users of their EHRs and were the "early adopters" in their organizations.

Several of the SBHCs also use an electronic patient tracking database, known as a registry, to manage patient populations and support patients with chronic diseases. Virtually all of the SBHCs reported outreach efforts and diligent tracking of immunizations. Most use the California Immunization Registry to determine what immunizations are needed and to report immunizations given.

Two FQHCs felt that population management was better at the SBHCs than at their other primary care sites. This is attributed to several factors. First, the SBHCs reported using an adolescent risk assessment and depression screening to help identify the needs of their patients. Tools such as the H.E.A.D.S.S.⁵ Assessment help SBHC staff identify patient needs and connect them to additional support services.

⁵ Home and environment, Education and employment, Activities, Drugs, Sexuality, and Suicide/depression Assessment developed by Eric Cohen, Richard G. MacKenzie, and Gary L. Yates in 1988.

The fact that SBHCs often serve a more defined patient population, i.e. students at a specific school or families in the community immediately surrounding the school, also makes it easier for the health center to stay connected to their patients and follow-up with those in need of services.

Finally, the SBHCs have implemented evidence-based clinical processes to identify and manage high risk patients, as a result of funding opportunities. For example, many SBHCs receive grants to conduct universal screening for sexually transmitted infections, implement protocols for rapid treatment, and track patients at risk for re-infection. One SBHC did such a great job managing patients at-risk for Chlamydia infection, that the clinical protocols they established were replicated at the FQHC's main clinic.

Despite these successes, SBHCs still face challenges in maximizing their EHR and health IT tools. These tools were theoretically designed to support patient population management by making it easier for health centers to run reports identifying their target patient groups, and sharing patient population with care-team members for follow-up. However, many of the standard EHR templates adopted by health centers are designed to measure the health of the general population and are not appropriate for adolescent care. For example, most templates do not include fields to record screening around education, social activities, or sexuality; all important developmental areas for school-aged youth. As a result SBHCs either face losing the comprehensive screening and follow-up that they do so well, or have to establish parallel systems (electronic and paper documentation), in order to identify their specific patient populations and coordinate services with other team members.

Recommendations for Moving SBHCs Toward a PCMH Model

- Review EHR clinical templates to ensure they are appropriate for the adolescent population. Modify or create new template with an adolescent focus as needed.
- Invest in the reporting capabilities of the health information technology utilized at the FQHC. This can be done by sending staff to vendor training, working with the vendor to develop meaningful reports, and making sure those who develop/work with the reports in the organization understand where the data comes from, and how and when it gets entered into the system.
- Improve the use of health information technology to identify patients that need well-child visits, flu shots and immunizations.
- Improve the use of health information technology to identify patients and reach out to patients who have chronic conditions, such as asthma or diabetes and need periodic services.

Standard 3: Plan and Manage Care

Definition

This standard recognizes that patients receive the highest value from a medical office visit when the staff is prepared for the visit, anticipates the patient's needs, and is efficient and organized in care delivery. This requires that staff engage in the activities of pre-visit planning, including reviewing the patient's record, gathering all outstanding information needed for the visit (lab test results, imaging studies results, consultation notes from specialty providers, and review of preventive and chronic care needs). With this information, the "teamlet" can get organized around the daily schedule and anticipate the care needs of each patient to be seen.

In addition to organizing and delivering care efficiently, the PCMH model requires providers to adopt and implement evidence-based guidelines. Evidence-based guidelines are emphasized because they are associated with clear protocols to manage specific patient needs, e.g. HIV prevention with high risk populations, thereby ensuring that these patients receive the same level of care.

Providing the same level of care, based on the specific needs of the patients, allows health centers to adopt standardized measures for each group of patients. The health centers can then track clinical outcomes overtime, based on the clinical services provided. Current NCQA Standards require that these evidence-based guidelines be adopted for three conditions that are important to the patient population, including one behavioral health condition.

Other components of this standard involve systematic identification of high risk patients and diligent medication management, including ePrescribing.

Strengths and Challenges for SBHCs

Most FQHC's struggle with this standard during PCMH transformation. This is a distinct shift from the more traditional model of reacting to the patient when they arrive for a visit, to planning for their needs and assuring they get evidence-based care at the time they need it.

Not surprisingly, only a few of the SBHCs interviewed were able to describe the use of evidence-based guidelines and any degree of chronic care management. Most sites indicated that they were using the "same standards of care" as the parent organization but were unclear if these were evidence based. The most commonly tracked data among the SBHCs interviewed included adolescent risk assessments, asthma patient tracking, BMI, immunizations, and Chlamydia screens. While these are all important data points to track, most did not have a formally defined set of conditions being tracked and managed using evidence-based guidelines and care management support.

Recommendations for Moving SBHCs Toward a PCMH Model

- Adopt evidence-based guidelines for at least three conditions important to the school health center population.
- Work proactively to make sure patients with these conditions get the services they need when they need them.
- Develop and implement medication management policies and workflows.
- Implement care team "huddles". Huddles provide a time for the care team to meet before the start of clinic in order to review the clinic schedule, discuss particular needs of each patient, and develop a plan to address these needs. In the smaller setting of the SBHC, it is often beneficial to include every staff member in these huddles.

Standard 4: Provide Self-Care Support and Community Resources

Self-Care Support

Definition

It is well-known that patients respond more favorably to community and peer support than to general health care messaging or “you should” statements from clinicians. The PCMH model incorporates requirements for staff to understand how patients learn and how they are best motivated to make lifestyle changes that will have a positive impact on their health status. Helping patients learn how to manage their chronic conditions with confidence is a key care management role in patient-centered care. It is especially important to ensure that children and adolescents with a chronic disease understand how they must participate in the management of their care. Techniques in providing self-management support include the use of motivational interviewing or “teach-back” techniques to verify that the patient understands the treatment plan.

Strengths and Challenges for SBHCs

Each of the SBHCs interviewed conduct regular health education as a way to encourage self-care support with patients. The type of health education provided varies by site and can include nutrition education, tobacco cessation, pregnancy prevention, academic support, as well as other healthy decision making topics. SBHCs are also creative in the way they engage patients around self-care support, using both individual and group health education visits, but also going beyond the walls of the health center by implementing peer health education in classrooms, on the school campus, or in the community.

SBHCs have integrated strong health education elements into their care delivery model because it also helps build strong provider-patient relationships. Relationships are important when working with patients in general, but they are particularly critical when working with children and adolescents since they are still developing social skills around trust and communication. One FQHC identified this process as reaching tomorrow’s health care consumer, and reported it as one of their biggest value propositions. The staff from the FQHC stated that educating health care consumers at an early age will help them learn to take care of their health and to live healthier lifestyles. Another organization reported that they actively teach kids and their parents about when they need to come in to see a provider.

Although SBHCs have demonstrated strengths in providing self-care support, there are areas for growth. None of the SBHCs interviewed identified using specific self-management tools suitable for adolescents as a part of their health education services. Documentation of self-management support provided to patients is also inconsistent across SBHCs, and can even vary at each site depending on the staff providing the services. The lack of evidence-based tools and proper documentation makes it difficult for SBHCs to demonstrate how current health education services support the self-care element of the PCMH model

Recommendations for Moving SBHCs Toward a PCMH Model

- Select self-management tools suitable for adolescents and establish a mechanism for providing and documenting their use in middle and high school SBHCs.
- Develop a standardized approach to (and method of documenting), self-management support, goal setting, patient-centered care planning, and motivational interviewing.
- Involve all team members in supporting patients’ self-management efforts. Train all staff members on self-management support, define roles and responsibilities, and update job descriptions to include this activity.

Community Resources

Definition

A PCMH connects patients with appropriate community resources such as medical services, weight management resources, parenting classes, transportation information, or any other service appropriate to the patient population. A key component of this standard includes arranging or providing treatment for mental health and substance abuse disorders. A PCMH can either provide these services in-house, contract to have the services done on-site, or refer to external agencies.

Strengths and Challenges for SBHCs

This is an area of the PCMH model in which many SBHCs excel. Most of the organizations interviewed either have integrated, on-site behavioral health services or have a well-defined network of resources available to support the behavioral health needs of the SBHC patients. About half expressed that they had more behavioral health services available to their SBHCs than to their main sites. The interviewees also demonstrated strong relationships to community health resources to support the healthcare needs of the student population. These included tobacco cessation programs, teen parenting education, and physical fitness facilities. Most of the organizations have staff available to coordinate care and build bridges to these needed services for their patients.

Recommendations for Moving SBHCs Toward a PCMH Model

- Continue providing information to patients on community resources. Develop a list of community resources and track usage of referrals to those resources. Routinely review and update the list as needed.
- Continue to integrate mental health and substance abuse into the SBHCs.

Standard 5: Track and Coordinate Care

Definition

Care coordination provides the means for a clinic to help patients navigate the often complicated health care delivery system and is a critical component of the PCMH. Part of care coordination is tracking and follow-up activities to ensure patients are getting the necessary care. “Closed-loop” tracking includes following the test or referral from the point of order to the results or receipt of specialty care. Processes that support “closed-loop” test and referral tracking will ensure that patients needing additional care do not fall through the cracks and actually receive the tests and services ordered.

Another key component of care coordination is timely follow-up with patients who have been to the emergency department or admitted to the hospital. This component encourages a formal relationship with local hospitals to notify clinics when a patient has been admitted or discharged.

Strengths and Challenges for SBHCs

The interviewees provided striking evidence of care coordination through the SBHCs. Strong relationships with the parent corporation and other satellite health centers allow efficient coordination with specialists, dental

care, and behavioral health. Many SBHCs have these additional health services co-located within their clinics. The majority offer integrated behavioral health and a growing number of SBHCs are beginning to offer oral health services. Co-locating all of these services in one easily accessible site allows for streamlined coordinated care in the form of warm hand-offs. For example, a medical provider can actually walk a patient to the mental health clinician, adding a personal element to the referral process.

One SBHC reported that they work diligently to keep patients out of the emergency room. They work with their local health plan to get reports of ER and urgent care visits. They follow-up with patients to make sure they receive follow-up care and understand the SBHC hours and services available. Another SBHC reported that they provide fliers during flu season that explain how to access their clinics and how to stay out of the ER.

Recommendations for Moving SBHCs Toward a PCMH Model

- Develop, implement, and monitor processes to track SBHC lab and imaging testing from ordering to resulting. Ensure these processes address what happens when the results are not received and how normal and abnormal results are handled.
- Develop, implement, and monitor processes to track SBHC referrals to specialists from ordering to receipt of the specialist report. Ideally, this would include internal FQHC referrals as well. Ensure these processes address the specific information is sent to specialists so they have the key clinical information needed and what happens when the reports are not received back from the specialist.
- Work with FQHC leadership to coordinate with local hospitals or managed care plans to develop ways to share information on clinic patients who have been seen in the ER, and establish formal policies for obtaining the information and following up with the patients.

Standard 6: Measure and Improve Performance

Definition

A PCMH has a well developed, organization-wide quality improvement (QI) program that uses data to identify opportunities for improvement and uses well tested improvement methodologies to act upon that information to improve quality, efficiency, and the patient experience. An effective QI program is led by a multi-disciplinary committee with a formal operating structure and clear objectives.

A PCMH also has a robust reporting capability, with data shared across the organization down to the provider level, as well as data shared with patients and other external stakeholders.

Involving patients in the quality improvement process is an important element of all of the PCMH accrediting bodies. The recommended process is to regularly measure patient satisfaction. Below are the guidelines from each PCMH accreditation program. For more information on SBHCs and measuring patient experience, please see CSHC's "Measuring Adolescent Patient Experience" report.

Recognition Program	Patient Experience Guidelines
National Committee for Quality Assurance	<p>The patient experience survey should include questions related to three of the four categories:</p> <ul style="list-style-type: none"> • Access • Communication • Coordination • Whole-person care/self-management support. <p>Patient experience data should also be elicited through qualitative means through feedback methods that may include focus groups, individual interviews, and suggestion boxes.</p>
The Joint Commission	<p>The patient experience survey should include four areas:</p> <ul style="list-style-type: none"> • Patient experience and satisfaction related to access to care, treatment, or services, and communication. • Patient perception of the comprehensiveness of care, treatment, or services. • Patient perception of the coordination of care, treatment, or services. • Patient perception of the continuity of care.
Accreditation Association for Ambulatory Health Care	Assesses whether the patient population is surveyed to elicit satisfaction data, however specific content areas to address with patient experience data are not specified.
URAC	Assesses whether the practice seeks feedback from patients/families/caregivers on all aspects of operation. Feedback can be obtained through multiple means; surveys are one option for obtaining feedback. Specific content areas to address with patient experience data are not specified.

Strengths and Challenges for SBHCs

Some of the SBHC interviewees stated that they were involved in the organization's QI work, although there was wide variability in types of involvement. Some were active participants on the QI committee and engaged in review of comparative data across all clinic locations; others simply provided SBCH data to the QI committee on a routine basis.

Measuring patient experience was not discussed during the interviews; however the Federal government requires all FQHC's to perform periodic patient satisfaction surveys at all sites, so all of the clinics have been engaged in the process to some degree.

Recommendations for Moving SBHCs Toward a PCMH Model

- Strengthen the ties of the SBHC to the organization's QI Committee. Identify the clinical process and outcome metrics that are relevant to children and adolescents and advocate that these metrics are

compared across all sites so that they can be included in improvement efforts. Ensure SBHC staff and leadership actively participates on the QI Committee.

- Review the patient experience/satisfaction surveys currently in use by the FQHC to determine if they are appropriate for the adolescent population. Consider the use of student focus groups to develop questions that will resonate with this population. Refer to CSHC's "Measuring Adolescent Patient Experience" report for additional recommendations on instruments, survey tools, and questions relevant to the patient population.

Summary and Moving Forward

The information gathered from our interviews support the idea that SBHCs are well-positioned to either become a PCMH or to participate in the overall organizational transformation effort. Because they excel in areas of access, communication, and integration of healthcare services, many SBHCs have the foundation of the PCMH model. However, moving SBHCs closer to becoming PCMHs will require substantial changes in care delivery and coordination outside of the school, and an emphasis on health outcomes and quality improvement relevant to children and adolescents.

SBHCs are encouraged to review the goals and benefits of the SBHC becoming a PCMH with both the sponsoring FQHC and school administrators, in order to identify and resolve any challenges in implementing the model. If a SBHC is prepared to adapt to the PCMH model, it is important that there is support and dedicated resources from the FQHC. Including the SBHC in the overall PCMH transformation activities early in the process, even if they are not included in initial recognition application, can be a key first step.

If PCMH recognition is not a goal, SBHCs can share their best practices, such as the utilization of community resources and coordination with behavioral health, with other FQHC sites to support the overall PCMH effort. SBHCs can also easily implement some of the techniques and guidelines outlined above to strengthen their patient-centered focus and help better serve their patient populations.

Appendix A: PCMH Accreditation Bodies

National Committee for Quality Assurance (NCQA)

<https://www.ncqa.org/>

6 Standards (Each clinic location must apply separately. There are some elements that may be addressed at an organizational level.)

- Enhance Access and Communication
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- Track and Coordinate Care
- Measure and Improve Performance

URAC

<https://www.urac.org/>

- 7 Modules (Each clinic location must apply separately.)
- Core Quality Care Management
- Patient-Centered Operations Management
- Access and Communications
- Testing and Referrals
- Care Management and Coordination
- Advanced Electronic Capability
- Performance Reporting and Improvement

The Joint Commission

<http://www.jointcommission.org/>

5 Operational Characteristics (The organization applies and the application covers all locations.)

- Patient-centered Care
- Comprehensive Care
- Coordinated Care
- Superb Access to Care
- Systems-based Approach To Quality and Safety

Accreditation Association for Ambulatory Health Care (AAAHHC)

<http://www.aaahc.org/>

5 Main Medical Home Standards (The organization applies and the application covers all locations.)

- Relationship, Communication, Understanding, and Collaboration
- Continuity of Care
- Comprehensiveness of Care
- Accessibility
- Quality