The Patient Centered Medical Home for Children with Special Healthcare Needs

Amanda Ciadella, MPH, CCE
Owner, Patient Centered Solutions

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Session Goals

1. Learn the foundational concepts of a PCMH
2. Dive into complex concepts for chronic management
3. Understand how to align the provider and patient goals

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IMPORTANT

- PCMH might not be for your practice and THAT IS OKAY!
- Examples come from my clients that have passed NCQA PCMH
- NCQA has very specific requirements
- If you have questions, please ask!

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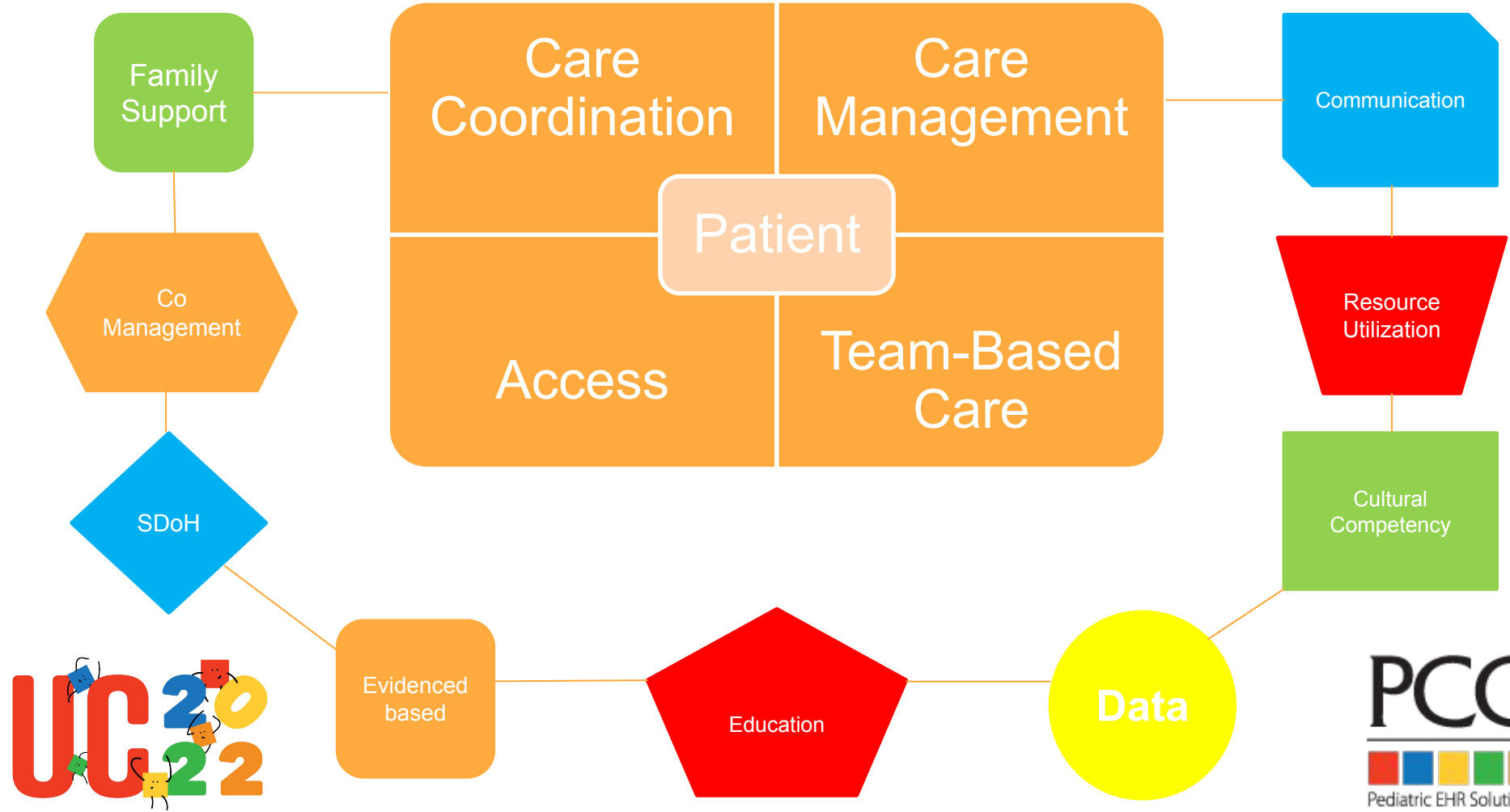
Family Support
Care Coordination
Care Management
Communication
Co Management
Patient
Resource Utilization
Access
Team-Based Care
SDoH
Cultural Competency
Evidenced based
Education
Data
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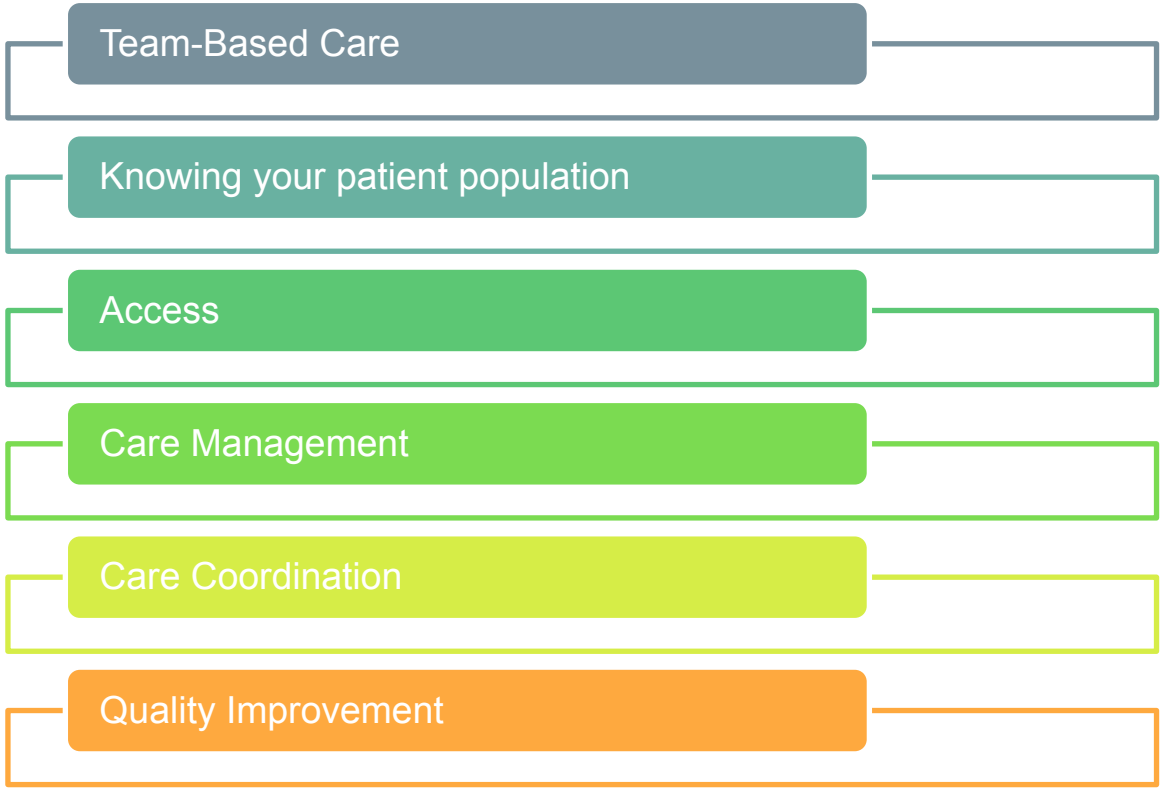
PCMH Concepts



The PCMH Team

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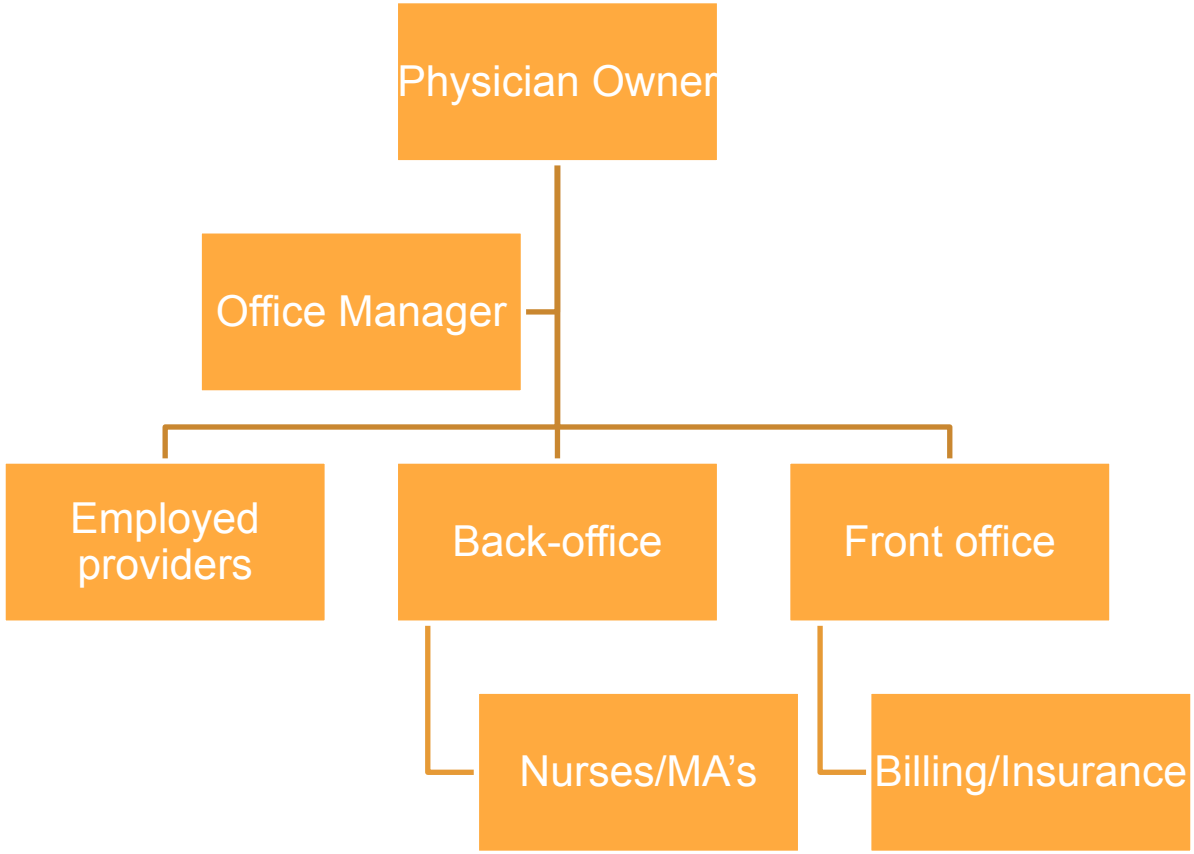
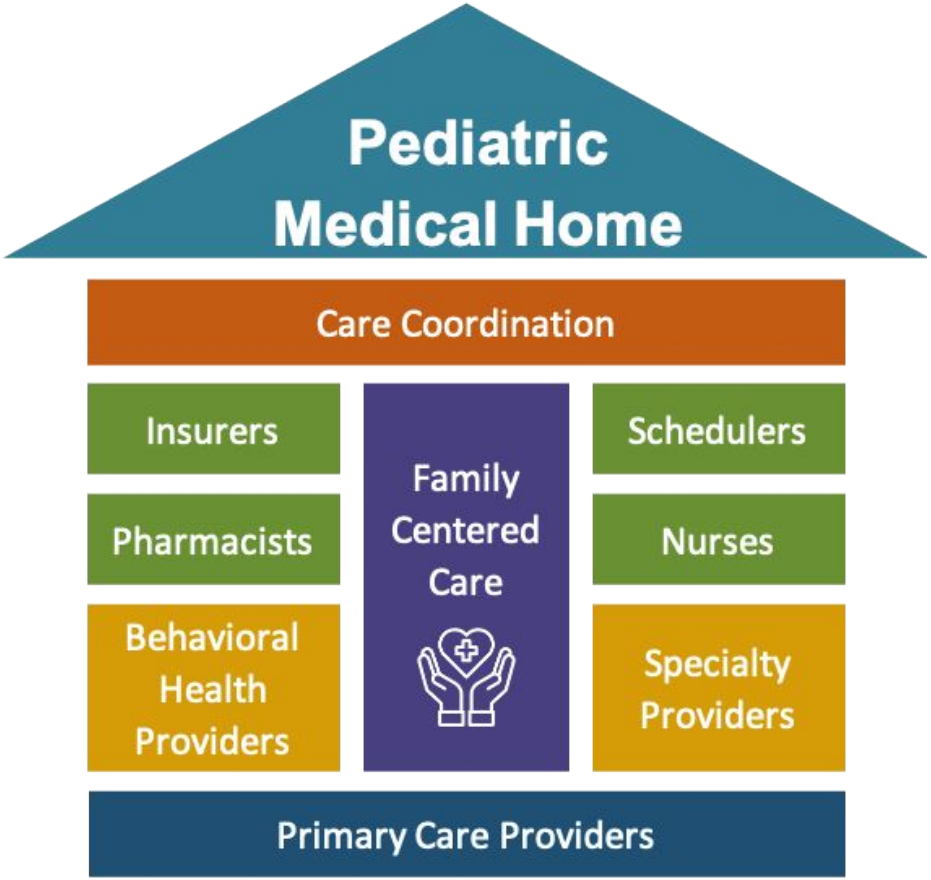

Physician Owner
Office Manager
Employed providers
Back-office
Front office
Nurses/MA's
Billing/Insurance



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PCMH Advantages

Improve	Patient access & care coordination
Manage	High-risk patients
Increase	Patient & staff satisfaction
Reduce	Workplace silos
Lower	Overall healthcare costs

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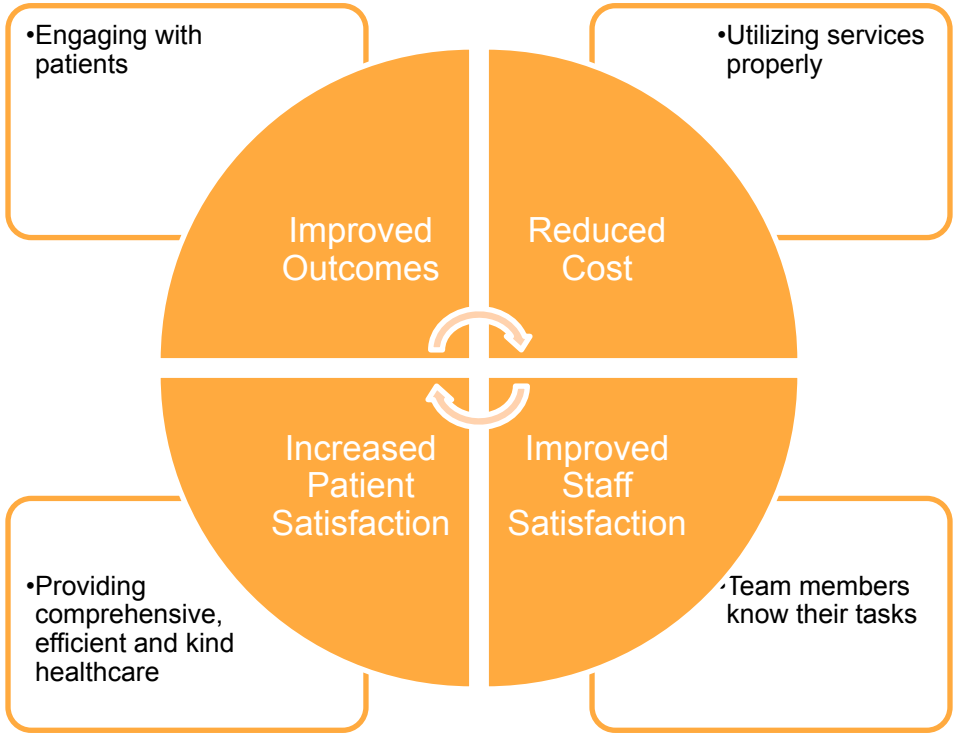
Quadruple Aim of PCMH



States with PCMH Incentives

- Florida: MPIP for Managed Medicaid Payers
- Alabama: Medicaid & BCBS
- South Carolina: BCBS
- Connecticut: Husky [Medicaid]

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Successful PCMH Projects

FQHC PCMH: NCQA sites were associated with reductions in all-cause inpatient admissions.

HRSA PCMH Sites: Recognized PCMH health centers were associated with higher rates for colorectal cancer screening, diabetes control and hypertension control.

PCMH Literature Review: ACOs that had higher rates of PCMH primary care practices were more likely to generate savings.

NCQA PCMHs cut the growth in outpatient ED visits by 11% over non-PCMHs for Medicare patients.

VT Medicaid PCMH Program: 21% lower inpatient use

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Practice Barriers

- Staffing shortages
- Financial/ economic limitations
- Technical challenges
- Physician buy-in
- Resistant patient population

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Create a PCMH Culture

Build a team

Provide them with the tools they need to be successful

Create positive experiences

Meaningful work – working to the top of their license

Encourage staff to discuss concerns

Allow autonomy with patients, role and other staff members

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Overcoming Barriers with Patients

- Ask for feedback
- Be open to trying a new approach
- Follow through and be transparent
- Don’t be afraid to ask the patient to try something new

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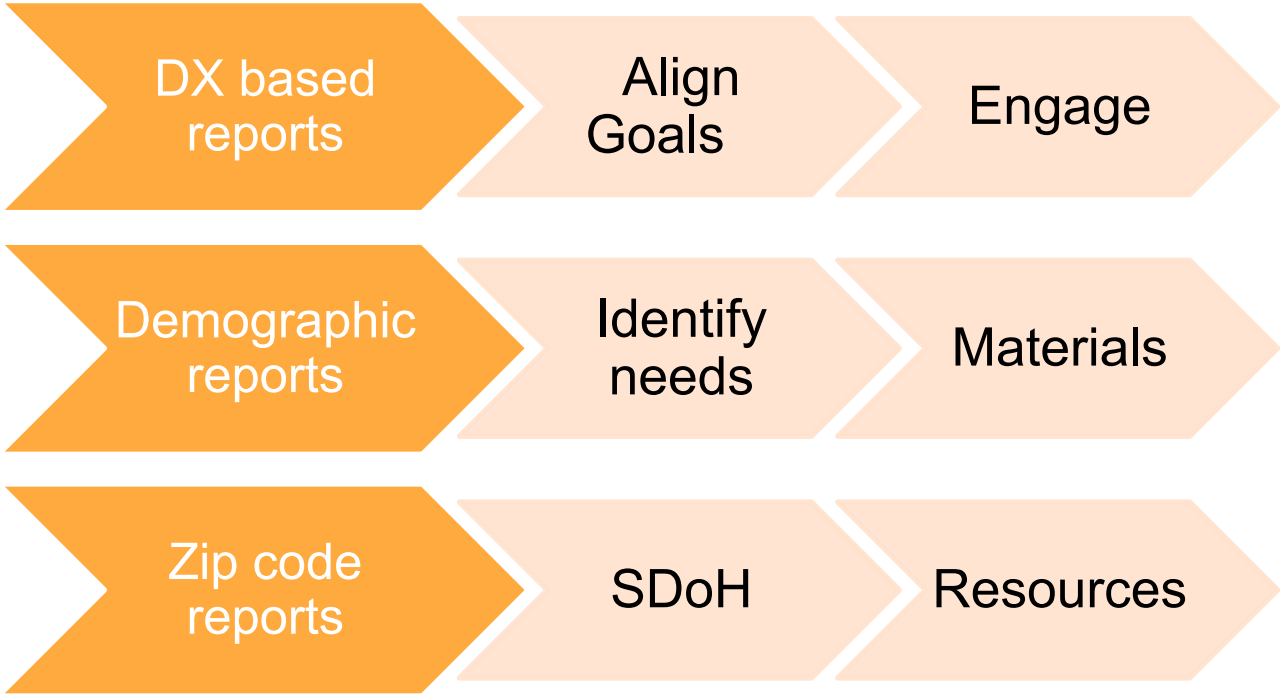
Assessing your patient population



PCMH Client Example

A client wants to use asthma as a chronic measure for PCMH. We run a report to identify severe persistent asthmatics. Hardly any children come up. Why?

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Documenting for PCMH

At least once a year…

- Patient medical, family & social history
- SDoH
- BH/developmental assessments – depression assessment has an 80% expectation

At least once a year or as needed

- Problem list
- Medication allergy list
- Medication list –has an 80% expectation

Every encounter/situation

- Medication reconciliation for care transitions - has an 80% expectation
- Closing referral loops
- Staff meetings

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05/2019:UMC:Pulmonology: Spirometry was performed with pt standing. Configuration of the flow-volume curve is steep with slight concavity at low lung volumes. FVC is mildly decreased. FEV1 is mildly decreased, FEV1/FVC ratio is wnl's. FEF25-75 is WNL's.

05/2019: Pt admitted for Pneumonia... Radiology LB: Assuming that the films are indeed labeled correctly this pt indeed demonstrates situs inversus totalis.Kartagener syndrome is likely. Recommend follow up with pulmonology. Trace inferolateral left sided pleural efusion.

06/2019: Pt seen by [redacted]. Pt seen for pulmonary function test spirometry, oscillometry. Started Qvar

09/12/19: UMMC Cardio. No specific cardiac restrictions. No need to cardiac followup.

09/23/1[redacted]. Decrease Metformin to 500mg daily. Follow puberty and growth closely. RTC 6mos.

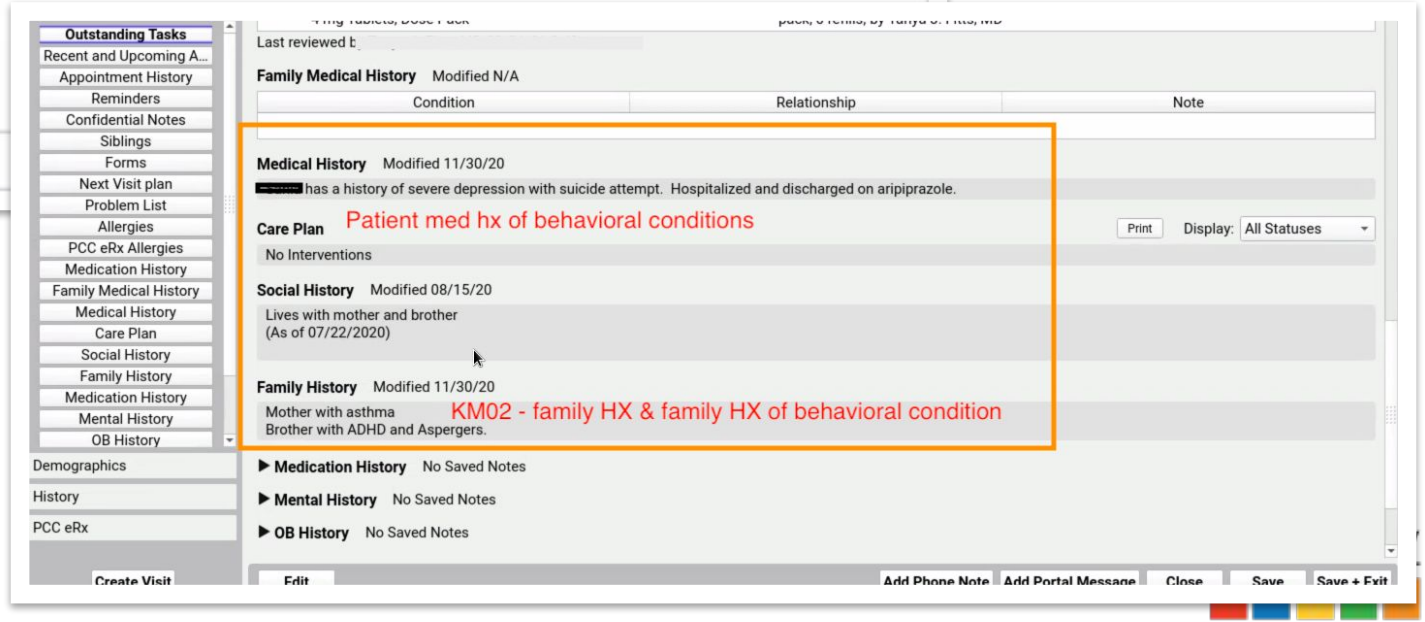
11/27/2019: [redacted] headache clinic:<FONT color=#000000>Pts migraines have improved since hydrating better, No imaging needed. F/u in 6 months. Keep a headache journal. Stay hydrated,

02/25/2020[redacted], No specific cardiac restrictions noted; 24 hr Holter monitor set up during this clinic visit; Does not require SBE prophylaxis; Recommend annual administration of the influenza vaccine unless contraindicated from a medical standpoint - no cardiac contraindication; Instructed patient and parent to contact Children's Cardiology with any questions or concerns; Will request medical records from hospital where Pedro was admitted and treated for pneumonia during Christmas holiday; F/U in 1 month for repeat clinical evaluation.

5/18/2020: [redacted] - here for F/U - no new concerns from cardiac standpoint; reportedly admitted for pneumonia in Arizona - no documentation to verify as of yet; no specific cardiac restrictions or medications indicated at this time; no routine cardiac f/u needed at this time; will see [redacted]
(As of 06/08/2020)
[Physicians Computer Company]
[Last Reviewed for this visit by T

Family History (Chart-wide)
Father's family with multiple members with epilepsy.
Had a sister to die soon after birth

Family History (Chart-wide)
Father's family with multiple members with epilepsy.
Had a sister to die soon after birth



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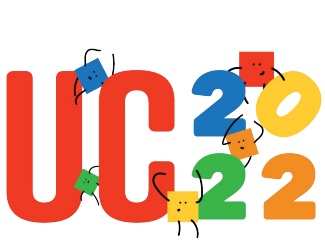
Patient Centered Access

- Office hours to accommodate patients
- Provide basic clinical advice without an appointment
- Offer telehealth appointments
- Accessible by telephone after-hours
- Respond in a timely manner



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Coordinating Patient Care

- PCP Specialist PCP
- PCP Emergency Department—>PCP
- PCP Hospital Admissions PCP
- What if the PCP does not send the patient?

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Documenting Care Coordination

- Encounter note
- Telephone encounter
- Create a care plan
- Past medical history
- If you do not document, it did not happen

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Successful PCMH Client Example

- Have a designated care coordinator for complex patients
  - Call to check on new medication changes
  - Assist with scheduling referrals & outside orders
  - Follow-up if patient misses appointments
  - Handle any forms
- Ask specialists to do a co-management agreement
- Use your tools

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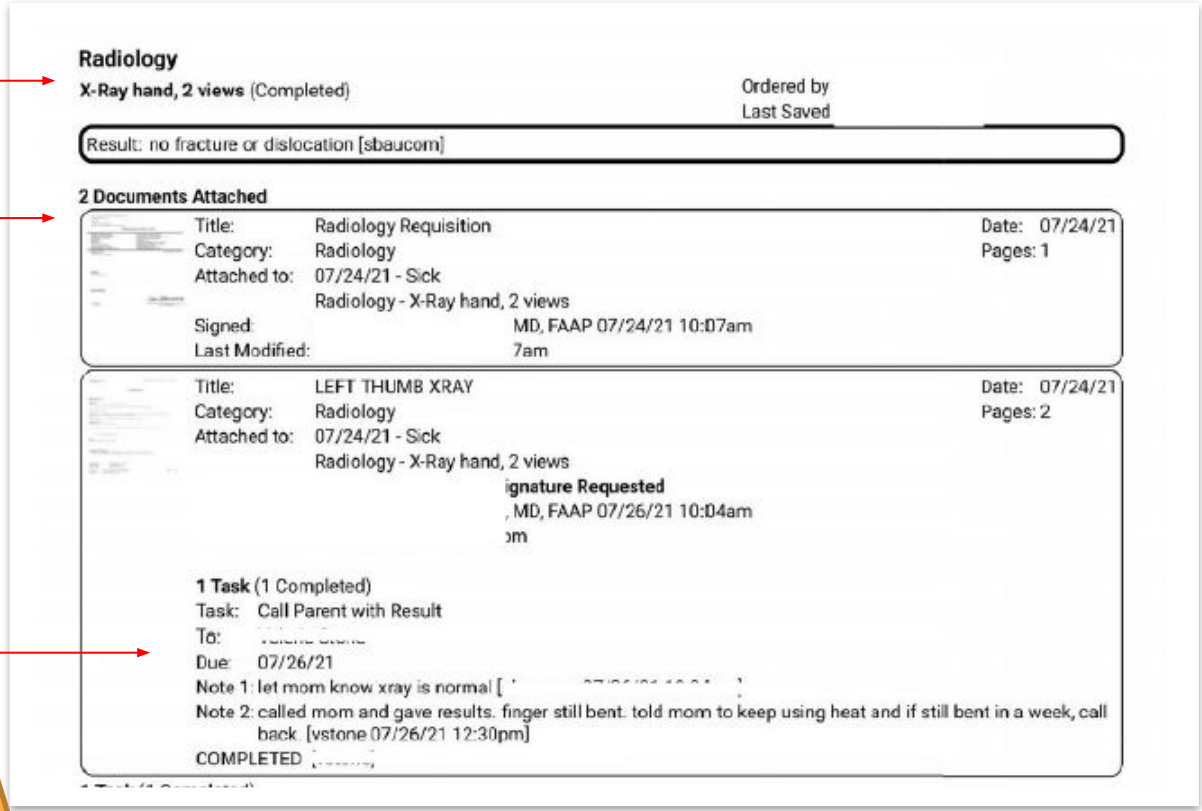
Order in encounter

Results attached

Using tasks to communicate



Radiology

X-Ray hand, 2 views (Completed)

Ordered by
Last Saved

Result: no fracture or dislocation [sbaucom]

2 Documents Attached

Title: Radiology Requisition — Date: 07/24/21
Category: Radiology — Pages: 1
Attached to: 07/24/21 - Sick
Radiology - X-Ray hand, 2 views
Signed: MD, FAAP 07/24/21 10:07am
Last Modified: 7am

Title: LEFT THUMB XRAY — Date: 07/24/21
Category: Radiology — Pages: 2
Attached to: 07/24/21 - Sick
Radiology - X-Ray hand, 2 views
ignature Requested
, MD, FAAP 07/26/21 10:04am
om

1 Task (1 Completed)
Task: Call Parent with Result
To:
Due: 07/26/21
Note 1: let mom know xray is normal [
Note 2: called mom and gave results. finger still bent. told mom to keep using heat and if still bent in a week, call back [vstone 07/26/21 12:30pm]
COMPLETED

Care Management

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Care Management Terminology

Care Management

Activities performed to improve patient outcomes

Care Coordination

Organizing patient care between clinicians & facilities

Care Plans

Individualized instructions given to the patient

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Complex Concerns

- Severe persistent asthmatics
- Diabetes
- Genetic disorders
- Premature infants
- Developmental delays
- Autism
- Congenital heart disease
- Patients with a behavioral diagnosis & medication
- Chronic condition + a SDoH layer [ADHD in foster care]

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Quick Guide to Complex Care Management Patients

YES

- Food allergies + asthma with EpiPen & medications
- In need of home health or medical equipment
- Cardiac patient with specialist coordination
- Adolescent with depression + ADHD & multiple medications

NO

- One-time constipation
- One-time ear infection
- Acne
- Eczema
- Well-controlled intermittent asthmatic
- Acute illness [e.g., flu, COVID, strep, stomach virus]

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Complex Care Management

Assess	Engage	Plan
• Physical health • Mental/behavioral health • SDoH • Challenges/barriers	• Specialists • BH team • Payer [payer care management team] • PATIENT	• Create care plan that is individualized to patient • Have patient/family participate in identifying goals • Timeline for meeting goals • Give care plan to patient

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What Makes a Good Care Plan?

YES

- Specific to child & concern
- Goals
- Barriers & ways to overcome
- Care team contact info
- Relevant resources
- Given in the preferred modality
- Educational/self-management materials

NO

- Medical jargon & acronyms
- Providing only the clinical summary
- Including old information/concerns
- Not involving the family in creating care plan
- Completing 1 care plan when there are multiple concerns/DX

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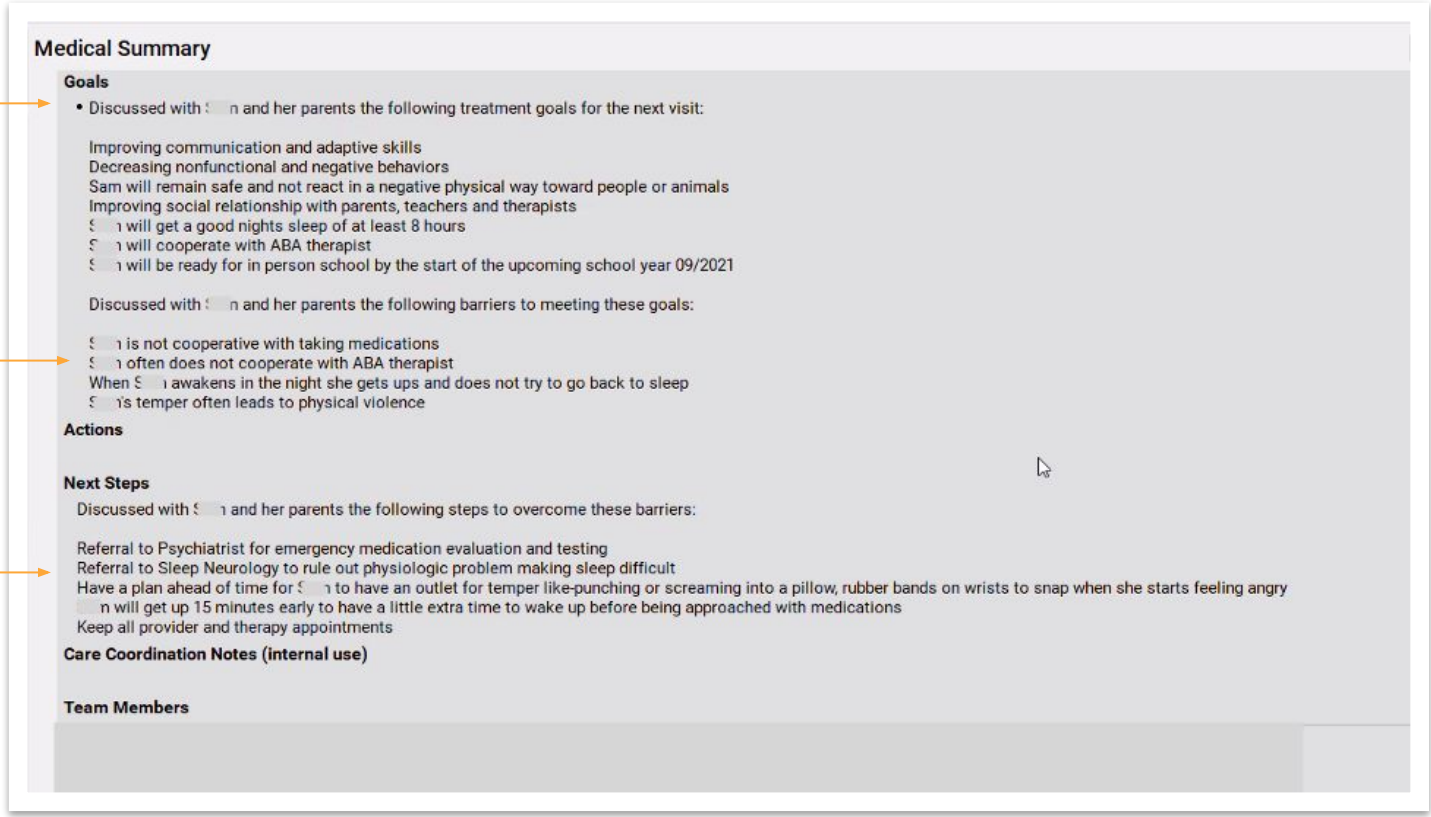
Patient goals

Barriers to achieving goals

Overcoming barriers



Medical Summary

Goals

- Discussed with S n and her parents the following treatment goals for the next visit:

Improving communication and adaptive skills
Decreasing nonfunctional and negative behaviors
Sam will remain safe and not react in a negative physical way toward people or animals
Improving social relationship with parents, teachers and therapists
S n will get a good nights sleep of at least 8 hours
S n will cooperate with ABA therapist
S n will be ready for in person school by the start of the upcoming school year 09/2021

Discussed with S n and her parents the following barriers to meeting these goals:

S n is not cooperative with taking medications
S n often does not cooperate with ABA therapist
When S n awakens in the night she gets ups and does not try to go back to sleep
S n's temper often leads to physical violence

Actions

Next Steps

Discussed with S n and her parents the following steps to overcome these barriers:

Referral to Psychiatrist for emergency medication evaluation and testing
Referral to Sleep Neurology to rule out physiologic problem making sleep difficult
Have a plan ahead of time for S n to have an outlet for temper like-punching or screaming into a pillow, rubber bands on wrists to snap when she starts feeling angry
n will get up 15 minutes early to have a little extra time to wake up before being approached with medications
Keep all provider and therapy appointments

Care Coordination Notes (internal use)

Team Members

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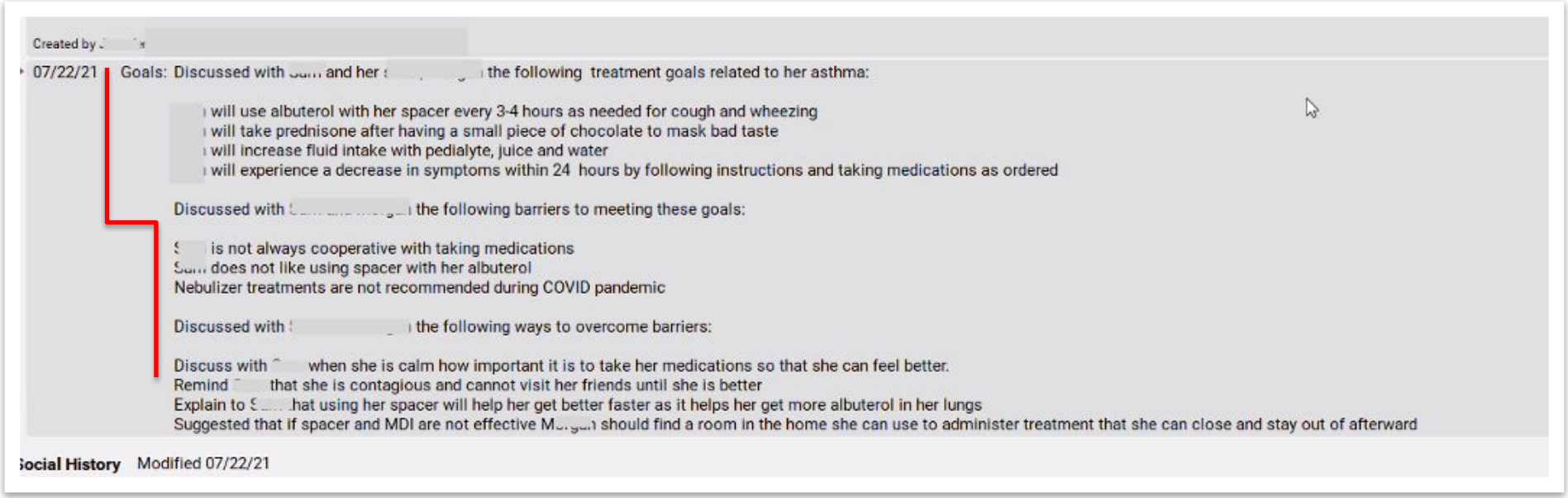

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Did you know that PCC can share protocols from other clients?

EPPA asthma plan

- ✓ Medication changes:
  none [redacted]
- ✓ All patient/ parent questions answered.
- ✓ Reviewed severity of asthma, control as reported by symptom history and exam
- ✓ Reviewed medications wth patient/parent
- ✓ Discussed need for compliance with daily controllers and avoidance of triggers as much as possible
- ✓ Discussed use of spacer if applicable
  yes he use it daily
- ✓ Reviewed and addressed barriers to medication compliance
- ✓ Asthma Care Plan (including Asthma Action Plan) developed with AND printed copy given to patient/parent
- ✓ Notify office if acute respiratory symptoms are noted or if patient needs to use rescue inhaler more than twice weekly on a regular basis or if nighttime symptoms or exercise intolerance is noted
- ✓ Contact office with change in status and/or symptoms requiring initiation of yellow/red zone medications.

Asthma Action Plan

Asthma Severity

- ✓ *(Blank Item)*
  Mild Persistent |

Asthma triggers

- ✓ *(Blank Item)*
  weather changes, URI's, exercise |

GREEN ZONE

- ✓ (No cough, wheeze, chest tightness or shortness of breath during the day or night. Can do usual activities.)
- ✓ Use albuterol 2 puffs 20 minutes prior to exercise as needed
- ✓ Other:
  maintain use of controllers [redacted]

YELLOW ZONE

- ✓ (Cough, wheeze, chest tightness, or shortness of breath. Waking at night due to asthma. Can do some, not all, usual activities.)
- ✓ Other:
  start with 2 puffs of his 220 mcg Flovent for 5 days for prevention of worse exacerbation [redacted] MSN, FNP]
- ✓ *(Blank Item)*
  use albuterol with spacer as needed [redacted]

RED ZONE

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PCC Care Plans

- If the patient has a portal account, the care plan is available
- No need to print and scan back into the patient chart as proof of giving to family
- Care plans can be configured into your encounter visit
- Snap-text can be configured to help reduce free-text
- If part of the care plan is a specialist, the professional contacts can be pulled right into the care plan
- PCC education feature allows you to attach applicable educational content
- Patient can have multiple care plans viewable in the same area
- Care plans by date report is pulled directly from care plans

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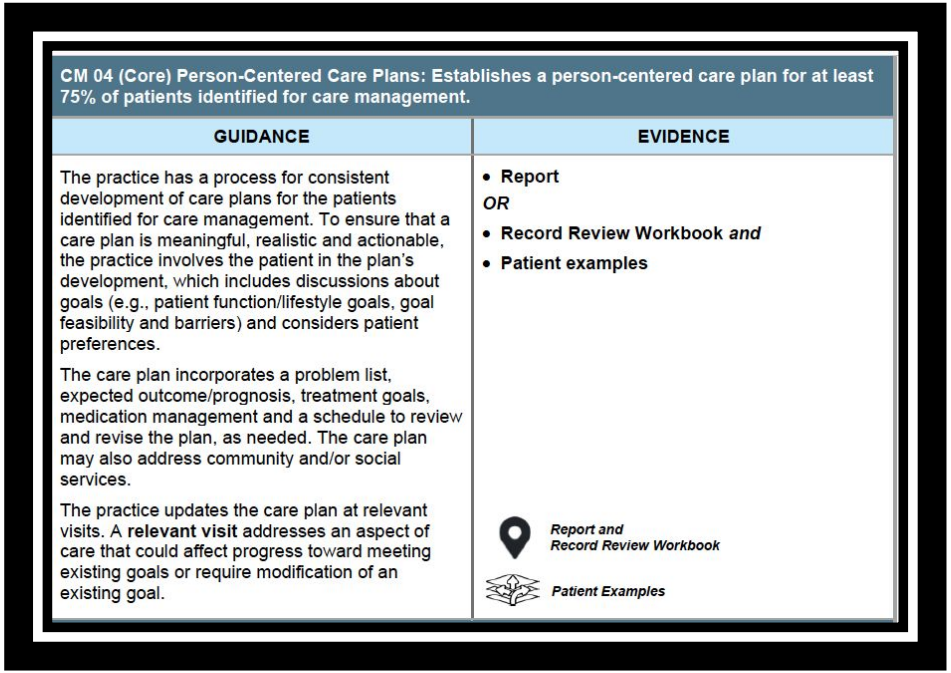
All the extras…..

- You can resolve/remove a child from care management and in PCC inactivate their care plan
- Care plans should be done once a year or if the condition changes
- NCQA ONLY – care plans can be done by any team member
- If you're billing for care management services, look to your payer requirements on care plans
- CM04/CM05 are the only core items of the NCQA program Do CM04-CM08



CM 04 (Core) Person-Centered Care Plans: Establishes a person-centered care plan for at least 75% of patients identified for care management.

GUIDANCE	EVIDENCE
The practice has a process for consistent development of care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/lifestyle goals, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A **relevant visit** addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples** ***Report and Record Review Workbook*** ***Patient Examples***

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Surprise!!!
Care Management Billing

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Care Management Services

Disease specific work intended to

- Keep the patient out of the hospital
- Educate them about their condition
- Coordinate services required to treat and/or manage the condition

These services may be provided or overseen by MD/QHCP

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CPT 2022 - Care Planning

Activities: LONG list on page 63 CPT 2022 includes

- Communication and engagement with
  - patient…professionals regarding aspects of care;
  - home health agencies and other community services utilized by the patient;
- patient … education to support self -management, independent living, ADLs
- assessment and support for treatment regimen adherence and medication management;

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CPT 2022 - Care Planning

Activities: LONG list on page 63 CPT 2022 (cont'd)

ID of available community and health resources
facilitating access to care / services needed by patient and/or family
Management of care transitions not reported as part of transitional care management
Ongoing review of patient status, *including review of laboratory and other studies not reported as part of an E/M service*
Development, communication, and maintenance of a comprehensive or disease-specific (as applicable) care plan

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CPT 2022 - Care Planning

Practice Qualifications - Must:

Provide 24/7 access to physicians or other QHCPs or clinical staff including … means to make contact with HCP in the practice to address urgent needs regardless of the time of day or day of week

Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments

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CPT 2022 - Care Planning

Practice Qualifications - Must:

Provide timely access and management for follow-up after an ED or facility discharge
Use an EHR for timely access to clinical information
Be able to engage and educate patients … and coordinate and integrate care among all service professionals, as appropriate
Reporting physician / QHCP oversees activities of care team
All care team members providing services are clinically integrated

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CPT 2022 – NEW: Principal Care Management

New: Services focus on medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least 3 months and include establishment, implementation, revision, or monitoring a care plan specific to that single disease.

Physician or other QHP

- **99424** first 30 mins during calendar month
- **99425** each additional 30 mins during calendar month

Clinical staff time directed by MD or QHP

- **99426** first 30 mins
- **99427** each additional 30 mins during calendar month

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CPT 2022 - Principal Care Management

Documentation

Disease-specific Care Plan details
Development, monitoring, revision
Communication with “relevant practitioners”
Time: Less than 30 minutes not reportable
For minutes 31 and up:
Total minutes spent
How the time is spent (See list of activities CPT p63)
BONUS: Why disease is complex for this patient

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CPT 2022 - Chronic Care Management

Modified

- 99491 Chronic care management, first 30 mins, provided personally by MD or QHCP.
  Required:
  - Two or more chronic conditions expected to last at least 12 months or until death;
  - Chronic conditions that place pt at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Comprehensive care plan established, implemented, revised or monitored
- **Added**
  - 99437 … each additional 30 minutes

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Resources

- Have a current list of relevant community resources
- Educational resources should be available in multiple modalities
- Document you provided a resource
- Interact with your community

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12/01/20 - LPC 2 Mo Well

1 app Topical twice a week
Quantity: 1 x 120 mL bottle, 0 refills

Visit Documents

Title:	EPDS	Date: 12/01/20
Category:	Clinical Documentation	Pages: 1
Attached to:	12/01/20 - LPC 2 Mo Well	
Last Modified:		

Title:	Bright Futures Parent Handout 2 Month Visit
Category:	Patient Education
Attached to:	12/01/20 - LPC 2 Mo Well
Portal:	Available in Portal Documents
Last Modified:	

Title:	Torticollis exercises
Category:	Patient Education
Attached to:	12/01/20 - LPC 2 Mo Well
Last Modified:	

Document Viewer

Document Viewer

Thumbnails

1

2

Community Resources

Abundant Truth Salt & Light Ministries Food Panty
- Nondenominational church that supplies a food pantry in Taylor, MS.
- Contact:

More Than a Meal
- Serves meals at the Stone Center in Oxford
- (662) 426-6826

The Pantry of Oxford & Lafayette County
- Food pantry for eligible Lafayette Country residents located on Molly Barr Rd.
- Contact: (662) 832-8001

Family Crisis Services of Northwest MS, Inc.
- 24-hour crisis intervention, counseling, education, and legal advocacy
- Website: Oxfordadvocacy.org
- Contact:

Page 1 of 2

Community_Resources.pdf 11/30/21 09:29am

Rotate Page | Rotate Document | Fit Width | - | + | Zoom to Fit

Tags

Title:	Community Resources
Date:	11/30/21
Category:	Forms
Pages:	2
Attached to:	11/30/21 -
Portal:	Available in Portal Documents
Last Modified:	

▶ **Communication Preferences**
▶ **Account Demographics**

Add to Portal Message | Print | Sign | Edit | Close

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Engaging with Patients

- Utilize the PCC patient portal to check on patients and have them communicate their progress with you
- Broadcast messages for patients that have fallen off the radar
- Identify overdue services ahead of visit
- Schedule well-visits at check-in
- Schedule follow-up visits at check-out
- Use social media to engage and educate

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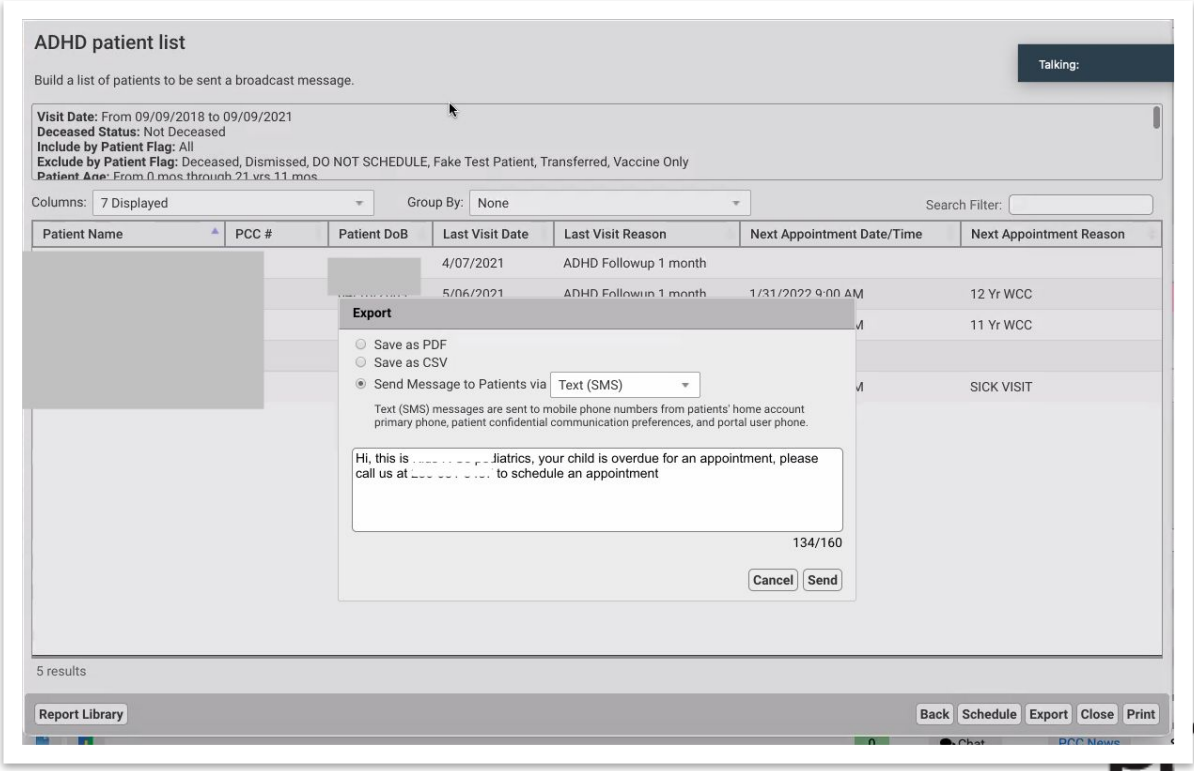
Use tools available to you!



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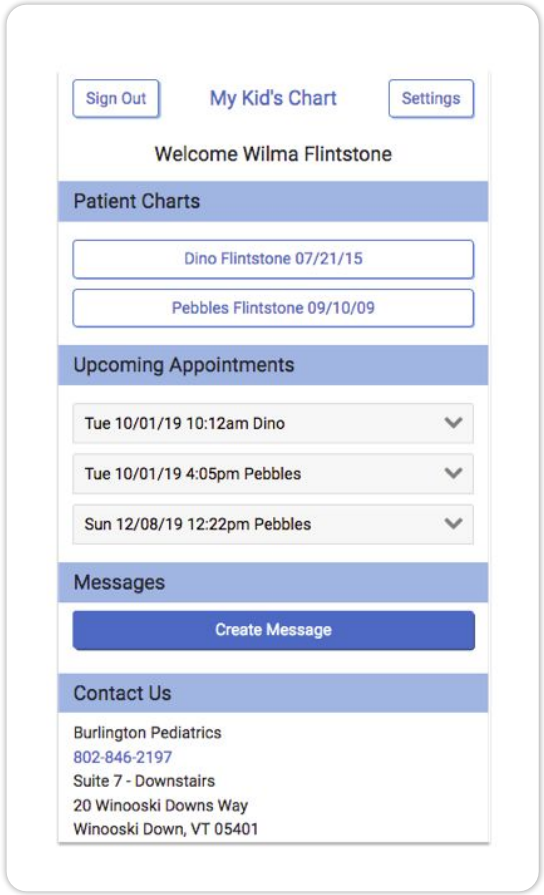
PCC MyChart



- Implement a policy for all chronic patients to have a portal account to request refills and communicate with their care team
- Respond in a timely manner
- Credit item for AC07 & AC08 NCQA PCMH***

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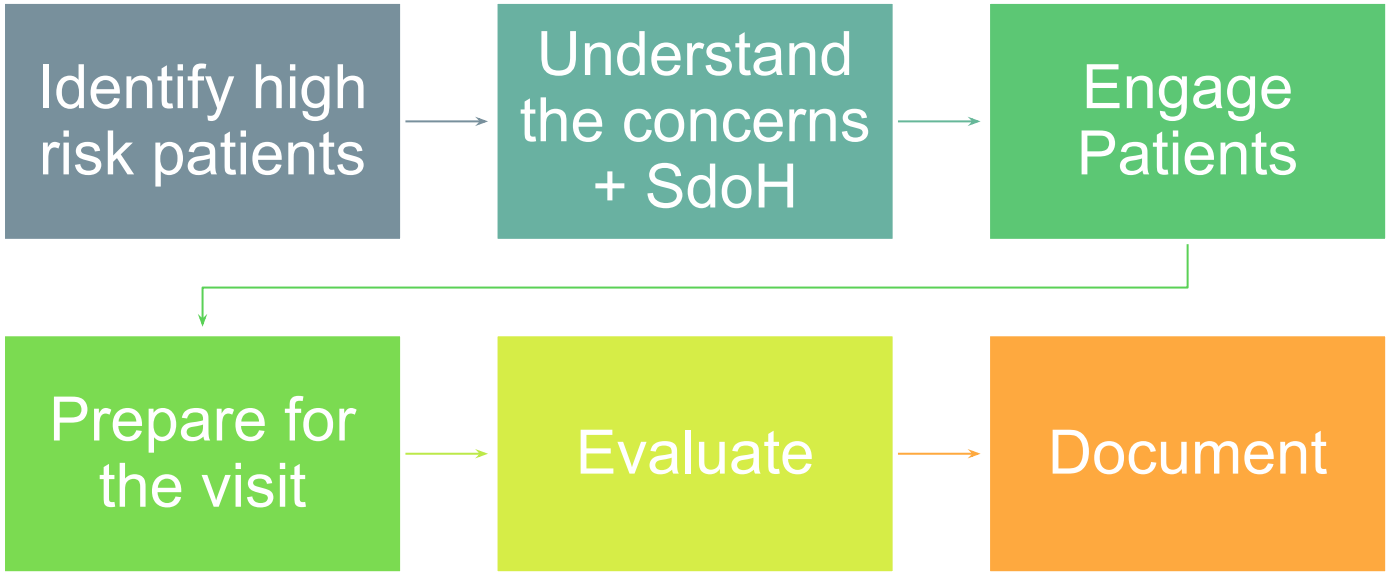
Closing A Care Gap



Aligning Clinical Quality Data

- Align clinical quality measures with patients identified in care management Care management patient (CM01): asthma
  - Assess patient population (KM09/KM10)
  - Clinical decision support (KM20): asthma template/visit note example
  - Recaller (KM12): identified asthmatics in need of a flu shot
  - Quality measure (QI01): asthma (influenza) vaccine
  - By aligning the patients/conditions with multiple sections you're easily able to identify, close care gaps, and improve metrics.

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Quality Improvement/Data Management

- PCC Dashboard is a great tool to see your population high level
- Refreshes once a month
- Read the measure descriptions
- Some measures allow you to drill down to the patient level
- Quickly stratify data by most common factors [provider & insurance are most popular]

- Report library will give you current information
- Build report run chart audits
- Save in your report library to run at another time
- Reports by diagnosis/last visit/codes allow you to build custom complex reports
- Generate broadcast messages [action for improvement]

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Provider Responsibility

Patient Expectations

- **Same day appointments**
- **Engaging when overdue for services**
- **Provider will be knowledgeable on your child's health history**
- **Communication and collaboration with other providers**
- **Knowledgeable staff**
- **Notification of all test results**

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Patient Responsibilities

01
Come to visits prepared

02
Give a full and accurate health history

03
Participate in the care coordination process

04
Include child's PCP/other providers

05
Designate preferred contact method

06
Register for patient portal

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Leverage Software

- Phreesia
  - BH assessments
  - Developmental questionnaires
  - Front office operations
  - Patient surveys
- Patient Portal
- Survey Platforms

- Patient Recaller Systems
- CHADIS
  - BH assessments
  - Developmental questionnaires
  - Chronic care assessments

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PCMH FAQ's

- Is a portal required? **No**
- Can you do PCMH without an EMR or with an older EMR? **It would be very difficult to do without an EMR. We can work around the challenges of an older or low functioning EMR**
- Will I immediately get incentives? **No, it can take a few months for payers to organize their databases**
- Does the doctor have to participate on all calls or in the project? **No, we need someone who is familiar with the system and patient population**
- I recently opened; can I do PCMH? **Yes! It's better to start early.**

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PCMH FAQ's

- Do I have to do care plans? **Yes**
- What options do I have for extended hours if I don't' want to work weekends? **Pick a morning or evening to work an additional hour or two OR do schedule telehealth time**
- I am a small office; can I still do PCMH? **Yes! PCMH isn't about the size of your office, it's how well you're tending to your patients**

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Session Takeaways

1. PCMH is a concept of care and can be an incentive program
2. PCMH transformation can help your practice run more efficiently
3. Use tools and technology available to streamline operations

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What Questions Do You Have?

Questions posted in the Socio will be read aloud by moderator for the presenter to answer. Please post your questions in Socio now.

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Later Viewing

This and all other UC2022 course recordings will be available for later viewing through Socio and PCC's YouTube Channel

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