



Pennsylvania Medical Home Initiative



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Pennsylvania Chapter

Objectives

- 1. Improve understanding of the role of a statewide program addressing medical home
- 1. Review data demonstrating change and impact of care coordination and family centered care.
- 2. Provide strategies and tools for improving communication among care providers and lessons learned

Medical Home and Multiple Players



PA Medical Home Initiative EPIC IC

- · Quality improvement initiative since 2001
- · EPIC framework and Chronic Care Model
- PA AAP Chapter

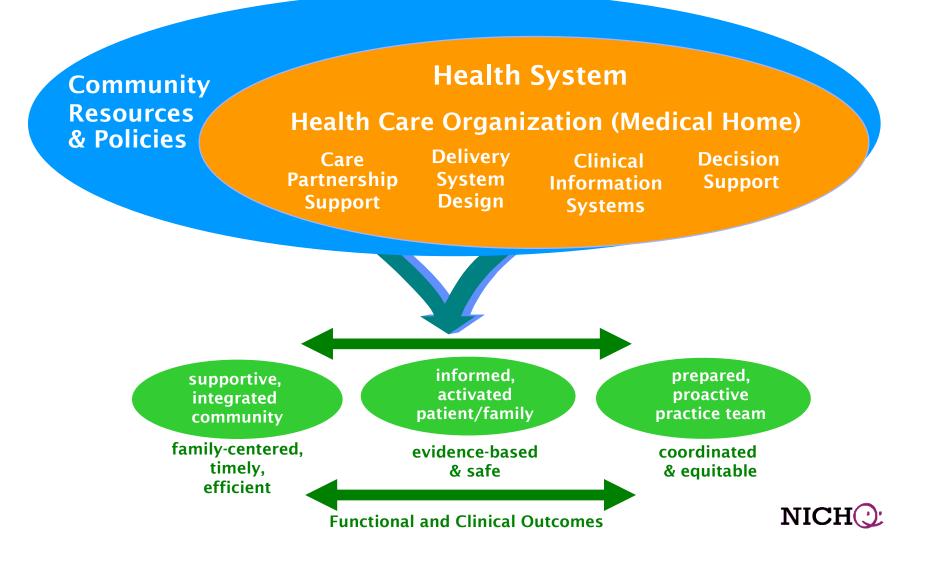


PA Medical Home Initiative

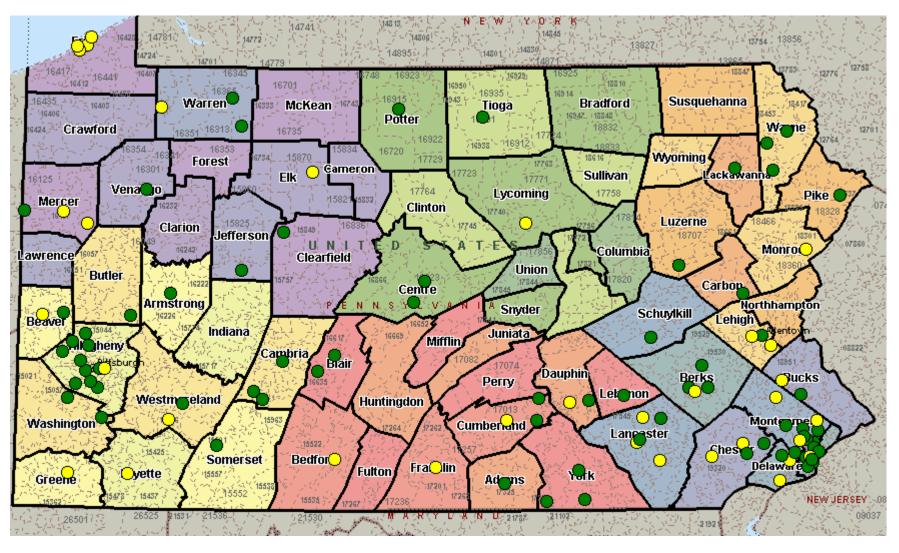
· Goals:

- Support quality improvement/practice transformation
- Incorporate family centered care
- Promote care coordination
- Develop data collection methods
- Ensure financial viability
- Foster high quality, efficient health care delivery

Chronic Care Model for Child Health in a Medical Home



EPIC IC Medical Home Sites



Participated in Medical Home implementation

Has received Medical Home Outreach/Education

There are 97 sites that have participated in implementation (green dots) and 28 sites (yellow dots) that have received education marked on this map dated 1/19/12. Some pushpins may overlap when sites are in close geographical proximity.

Practice Demographics (n=137)

- Setting
 - Urban...43%
 - Suburban...28%
 - Rural...29%
- Hospital-based
 - Yes...32%
 - No...68%

- Practice Size
 - Smallest practice:1000 patients
 - Largest practice:30,000 patients

Medical Home Team

- Patients
- Physicians
- Nurse Practitioners
- Physician Assistants
- Parent Partners
- Specialty Physicians
- Education partners

- Nurses
- Social Workers
- Administrators
- Office Staff
- Grant Office
- Community Partners

Models of Family Centered Care and Care Coordination



Care Coordination

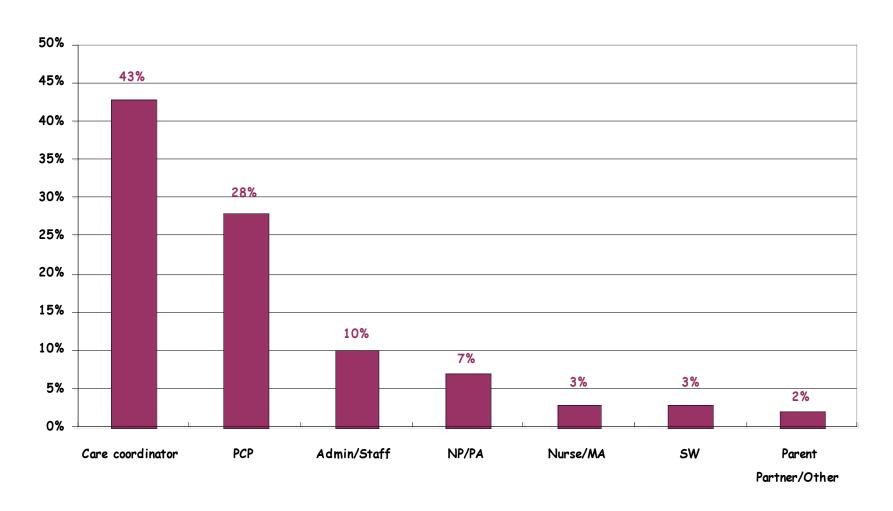
- Essential in medical home
- Cross cutting system intervention
- "Patient and family-centered, assessmentdriven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families"
 - Crossing the Quality Chasm, IOM, 2000
 - Adams et. al., National Academies Press, 2004
 - Antonelli et al. 2009 Commonwealth Fund

Care Coordination Pilot

- 2 ½ year pilot with 20 practices
- Tracked care coordination activities:
 - Focus of care coordination
 - Contact and activity
 - Time spent
 - Outcome of the encounter



Who is Coordinating Care?



What is Focus of Care Coordination?

 Clinical Medical Management

Referrals

Education

Taguag

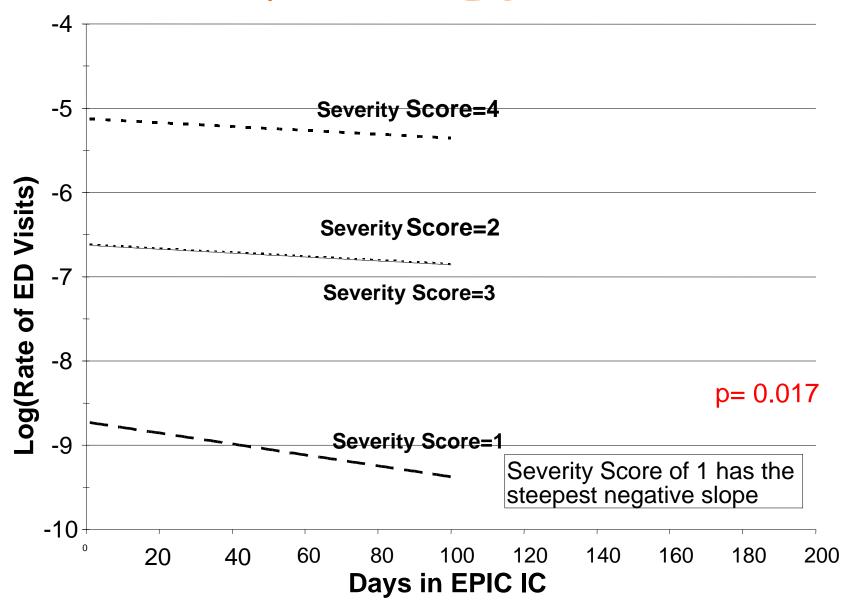
 Mental Health/Behavioral



Care coordination: Activity and Time Spent

Activity	Time spent minutes/encounter
Face to Face*	23
Email*	22
Meeting Conference*	17
Dev./Modify Care Plan *	15
Make Appts. Schedulin g*	12
Telephone *	11
Chart review*	11
Forms/Paper work*	7

Asthma and ED Visits



Family Centered Care and Parent Partners

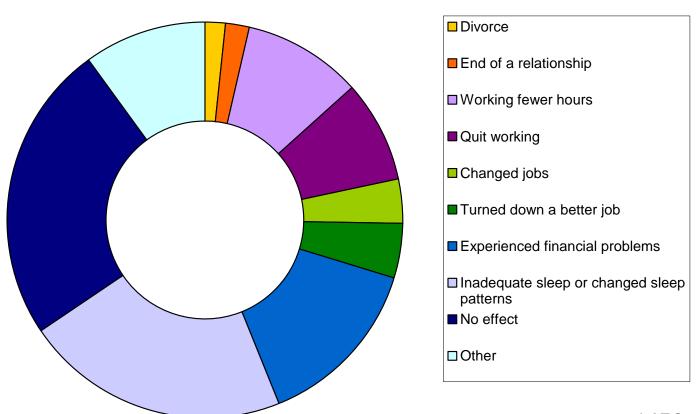
- Listens carefully
- Spends time with the child and the family
- Is sensitive to the values of the family
- Provides needed information
- Makes the parent feel like a partner
- Recognize families are the expert on their child

Return on Investment

- PCP Visits
- Hospitalizations
- ED visits not significant
 - Risk Stratify?

EPIC-IC Family Survey

My child's medical or behavioral condition has affected me and/or my child's caregivers in the following ways:

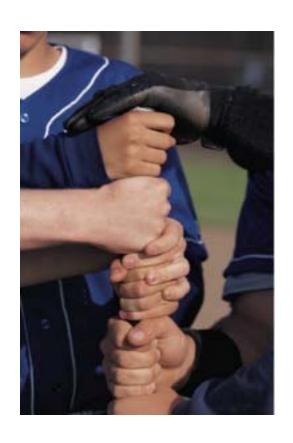


Successful Models for Engaging Parent Partners

- Focus Groups
- Resource Nights
- Individual Invitation



Tools to Enhance the Team



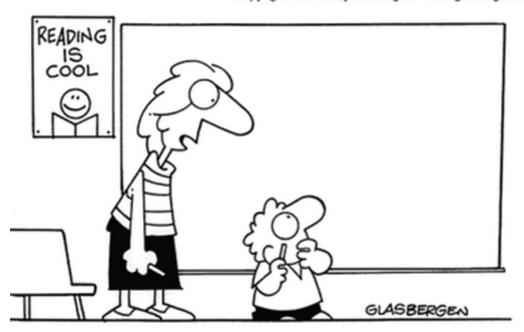
Tools for Fostering Family Centered Care and Parent

- Care Plans Partners
- Resource Nights
- Contracts for Parent Partners
- Advertisements
- Newsletters
- Family Faculty/Advisory Councils
- Community Liaison

Technology and Family Centered Care

- Social Networking
- Facebook
- Electronic Health Records and patient portals
- Appointment/referral requests

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"There aren't any icons to click. It's a chalk board."

Tools to enhance Communication

- Patient Registry
- Pre Visit Contact
- Pre Appt. referrals
- Fax Back Referrals
- · Email
- Care plans
- Data reports
- Family Survey
- · EMRs



Benefits of Care Plans

- Empowers the family
- Improves communication among care providers
- Provides information if family not present
- Family does not have to repeat history
- Allows salient and rapid information exchange during an emergency

Key Partners

- PA AAP Chapter and National AAP
- Community partners
- MCHB
- Families
 - F2F and P2P
- Youth (PA youth Leadership Network)
- Commonwealth Partners
 - Department of Public Health and Title V
 - Department of Public Welfare
 - Governor's Office

Sustainability in PA and Success

- NCQA recongition
- Care Plan reimbursement
- Transition overlap payment
- Increase in E & M codes
- Patient care conference/phone calls

New Grants on Transition

- Innovation Grant MCHB
- PA DOH Transition Grant

Grants will overlap enabling the EPIC IC program to:

- 1. Identify additional pediatric/adult practice partnerships
- 2. Disseminate family practice survey statewide
- 3. Test Opp's memo
- 4. Collaborate with PAFP on educational opportunities

Pennsylvania Medical Home Initiative

Educating Practices in Community-Integrated Care





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Thank you

- · Grant support
 - Maternal Child Health Bureau
 - PA Department of Health
- · PA AAP
- Pediatric Practices in EPIC IC
- · Children/youth and their Families

Contact information

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