

Navigating the Healthcare Journey – Pediatric Patient Centered Medical Home

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What is Patient Centered Medical Home (PCMH)?

The Partnership and Neighborhood

Medical Home Portal

The Medical Home is “the model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner.”

-American Academy of Pediatrics

Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. - NCQA

Medical Home: A model that describes an approach to enhancing care that focuses on patient- and/or family-centered care, improving the quality of and access to care, coordinating care and collaborating across specialties and disciplines.

-CHIC/MCH Team

Key Terms



Children with Special Healthcare Needs

- Children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Quality of Care

- Everyone is doing their own job, while collaborating about the patient

Access to Care

- Appointments to specialty care, tests, labs with high quality care
- New options for communication: patient portals, email

Coordinated Care

- Referrals are accurate, appropriate and timely
- Integration between the patients community and medical care

Collaboration

- Care teams, community resources, schools



Let's talk about it; what does that really mean?

A model that describes an approach to enhancing care that focuses on *patient- and/or family-centered care*, *improving the quality of and access to care*, *coordinating care* and *collaborating* across specialties and disciplines.

- Patient and family centered care –
 - staff works at the top of their expertise and licensure
 - improves family-centered quality outcomes
- Access to care –
 - identifies patient populations (registries) to manage patient care
 - more than office visits (patient portals, email, phone)
- Coordinated care –
 - education on prevention strategies
 - allow for appropriate services and tests
 - connects patients/families with appropriate resources and support services

Information is shared between you and your child's doctors, creating an alliance for care.

Improved follow-through when the care plan is developed collaboratively with families.

Greater understanding of the family's strengths and caregiving capacities by the provider.

More efficient use of healthcare resources

- care managed at home through care plan,
- decrease in hospitalizations and emergency department visits,
- effective use of preventive care

Many practices in the state are working on the journey to certifications and recognitions. The leading body of recognition in Idaho is the National Committee for Quality Assurance (NCQA.org).

Organizations helping practices transform into PCMH:

- Idaho Primary Care Association (IPCA)
- Medicaid - Health Homes
- Children's Healthcare Improvement Collaboration (CHIC)
- Family Medicine Residency of Idaho (FMRI)
- St. Alphonsus Health System

NCQA Recognized Patient Centered Medical Home Sites



Clinic	Address	Certification	Dates
366 MDG Mountain Home Family Health and Pediatric Clinics	90 Hope Dr, Bldg 6000, Mountain Home AFB, ID 83648	PCMH Level 3	6/16/14-6/16/17
CHAS - Lewis and Clark Health Center	338 6th St., Suite 101, Lewiston, ID 83501	PCMH Level 2	11/13/13-11/13/16
Clearwater Valley Hospital and Clinics, Inc.- Orofino Medical Clinic	301 Cedar, Orofino, ID, 83544	PCMH Level 3	1/22/14-1/22/17
Coeur d'Alene Pediatrics - Coeur d'Alene	700 W Ironwood Dr, Suite 102, Coeur d'Alene, ID, 83814	PCMH Level 3	3/13/13-3/13/16
Coeur d'Alene Pediatrics - Hayden	9095 N Hess St, Coeur d'Alene, ID, 83835	PCMH Level 3	3/13/13-3/13/16
Coeur d'Alene Pediatrics-Post Falls	1300 E. Mullan Ave., Suite 1000, Post Falls, ID, 83854	PCMH Level 3	3/13/13-3/13/16
Dirne Community Health Center	1090 W Park Place, Coeur d'Alene, ID, 83814	PCMH Level 1	7/18/14-7/18/17
Family Health Center Sandpoint	606 N. 3rd Ave., Suite 101, Sandpoint, ID 83864	PCMH Level 3	3/7/14-3/7/17
Family Medicine Residency of Idaho, Inc - Fort Street	121 E Fort St, Boise, ID, 83712	PPC-PCMH Level 3	9/4/12-6/25/15
Family Medicine Residency of Idaho, Inc - Meridian	2321 E Gala St, Meridian, ID, 83642	PPC-PCMH Level 3	9/4/12-6/25/15
Family Medicine Residency of Idaho, Inc - Raymond	777 N Raymond, Boise, ID, 83704	PPC-PCMH Level 3	9/4/12-6/25/15
Glenns Ferry Health Center, Inc. - Glenns Ferry Health Center	486 W. First Ave., Glenns Ferry, ID 83623	PCMH Level 2	9/24/13-9/24/16
Health West, Inc - Aberdeen Clinic	330 N Main, Aberdeen, ID, 83210	PPC-PCMH Level 3	5/23/12-5/23/15
Health West, Inc - American Falls Clinic	823 Reed St, American Falls, ID, 83211	PPC-PCMH Level 3	6/6/12-6/6/15

NCQA Recognized Patient Centered Medical Home Sites



Clinic	Address	Certification	Dates
Health West, Inc - Downey Clinic	79 N Main, Downey, ID, 83246	PPC-PCMH Level 3	7/13/12-7/13/15
Health West, Inc - Lava Clinic	85 South 5th, Lava Hot Springs, ID, 83246	PPC-PCMH Level 3	7/13/12-7/13/15
Health West, Inc - McCammon Clinic	204 Center St, McCammon, ID, 83250	PPC-PCMH Level 3	7/13/12-7/13/15
Health West, Inc - Pocatello Clinic	845 West Center St, Suite 200, Pocatello, ID, 83204	PPC-PCMH Level 3	4/1/12-4/1/15
Primary Health Medical Group - Pediatrics	6348 Emerald St., Boise, ID 83704	PCMH Level 3	1/22/14-1/22/17
Saint Alphonsus Medical Group - Eagle Health Plaza	323 E. Riverside Dr., Suite 224, Eagle, ID, 83616	PCMH Level 2	6/23/14-6/23/17
Saint Alphonsus Medical Group - McMillan	12273 W. McMillian Rd., Boise, ID 83713	PCMH Level 2	6/26/14-6/26/17
Saint Alphonsus Medical Group - Overland Clinic	10255 W. Overland Rd., Boise, ID 83709	PCMH Level 2	6/23/14-6/23/17
Terry Reilly - Boise Clinic	300 S. 23rd St, Boise, ID, 83702	PPC-PCMH Level 3	7/11/12-7/11/15
Terry Reilly - Caldwell Clinic	2005 Arlington, Caldwell, ID, 83605	PPC-PCMH Level 3	7/11/12-7/11/15
Terry Reilly - Homedale Clinic	108 E Idaho Ave, Homedale, ID, 83628	PPC-PCMH Level 3	7/11/12-7/11/15
Terry Reilly - Marsing Clinic	201 W Main, Marsing, ID, 83639	PPC-PCMH Level 3	7/11/12-7/11/15
Terry Reilly - Melba Clinic	150 2nd St, Melba, ID, 83641	PPC-PCMH Level 3	7/11/12-7/11/15
Terry Reilly - Nampa Clinic	211 16th Ave. N, PO BOX 9, Nampa, ID 83653	PPC-PCMH Level 3	7/11/12-7/11/15
Valley Family Health Care - New Plymouth	300 N. Plymouth Ave., New Plymouth, ID 83665	PCMH Level 2	12/19/13-12/19/16



The Family Component

What Matters to the Family



- Patients are allowed input about their own healthcare
- The entire family unit is considered
- Better health outcomes
- Patients see the same primary care provider
- Provider spends enough time with the family, listen carefully to their concerns, are sensitive to their values and customs, provide any information they need, and make the family feel like a partner in their child's care

Activity

Goal: Identify Medical Home Neighborhood

Roles: Healthcare, School, Legal/Financial, Support, Recreation/Family time

Activity: Identify organizations, groups, resources that would be helpful in caring for children with special healthcare needs.

The Other Side...



Physicians and the
Practice

- What is the commitment from the practice?
- Why it is important to know?
- How do they make changes?

- Leadership buy-in
 - Practice champions
 - PCMH teams
 - Physician, care coordinator or RN, office personnel
 - Evidence based quality improvement
 - Identify and lead project

- Competing initiatives
 - What else is going on?
 - Immunization changes, EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) recommendations, corporate changes

- Cost
 - Staffing
 - Adding, changing, education
 - Practice changes (workflows)
 - Documentation, education
 - Meeting time
 - Practices may not meet on a regular basis

Change Concepts



Change concepts "are general ideas used to stimulate specific, actionable steps that lead to improvement. Qualis framework includes eight change concepts in four stages:

Laying the Foundation: [Engaged Leadership](#) and [Quality Improvement Strategy](#)

Building Relationships: [Empanelment](#) and [Continuous and Team-Based Healing Relationships](#)

Changing Care Delivery: [Organized, Evidence-Based Care](#) and [Patient-Centered Interactions](#)

Reducing Barriers to Care: [Enhanced Access](#) and [Care Coordination](#)

Each Change Concept includes three to five "key changes." These provide a practice undertaking PCMH transformation more specific ideas for improvement

Laying the Foundation:

Engaged Leadership and Quality Improvement Strategy

A key role of leaders during PCMH transformation is to identify and allocate resources to best support PCMH transformation needs.

Adopting a stable quality improvement (QI) strategy gives staff confidence, skills and a specific approach to use in making these changes

Building Relationships:

Empanelment and Continuous and Team-Based Healing Relationships

Empanelment is the basis for population health management and the key to continuity of care. A care team is a small group of clinical and non-clinical staff who, together with a provider, are responsible for the health and well-being of a panel of patients

Changing Care Delivery:

Organized, Evidence-Based Care and Patient-Centered Interactions

In a Patient-Centered Medical Home (PCMH) designing each encounter to meet a patient's preventive and chronic illness needs, using planned interactions and ensuring appropriate follow-up care.

Patient-centered interactions encourage patients to expand their role in decision-making, health-related behavior change and self-management. Patient-centered practices respect patients' values and preferences

Reducing Barriers to Care:

Enhanced Access and Care Coordination

PCMH practices are able to create capacity to care for patients in as close to real-time as possible by providing patients with a variety of patient-centered options that also promote practice efficiency (same-day appointments, telephone, email and group visits).

The goal of care coordination is to make the primary care practice the hub of all relevant activity



Care Coordination

Coordinating Care: Pulling it all together

Agency for Healthcare Research and Quality (AHRQ) - Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

Safety Net Medical Home Initiative - The goal of care coordination is to make the primary care practice the hub of all relevant activity. Care must be coordinated not only within the practice, but between it and community settings, labs, specialists and hospitals. The responsibility of the PCMH is not just to be informed by community providers and resources, but to reach out and connect in meaningful ways with other sources of service and link with them, so that information is communicated appropriately, consistently and without delay.

Pediatrics: In a busy medical practice, care coordination fosters improved productivity and efficiency by transferring the mechanics of follow-up care, referrals, equipment acquisition, letters of medical necessity, patient information, transition of care, and previous authorization to care coordinators rather than physicians. As such, efficiency ensues because physicians can spend less time on nonclinical issues for patients. *(Published online April 28, 2014 Pediatrics Vol. 133 No. 5 May 1, 2014 pp. e1451 -e1460 (doi: 10.1542/peds.2014-0318))*

- How can a Care Coordinator help?
 - Link patients with community resources to facilitate referrals and respond to social service needs.
 - Integrate behavioral health and specialty care into care delivery through co-location or referral agreements.
 - Track and support patients when they obtain services outside the practice.
 - Follow-up with patients within a few days of an emergency room visit or hospital discharge.
 - Communicate test results and care plans to patients/families

What a care coordinator doesn't do:

Care Coordination vs. Case Management: Case management, primarily focuses on patients' medical issues. Case managers work with and guide services intrinsic to their specific agency, often within the constraints of eligibility criteria. In contrast, care coordinators work with and guide the team process, which includes and is driven by the needs of patients and families for services across the community.



Medical Home Portal

Medical Home Portal



- Useful tool for families, clinicians, and care coordinators of children with special healthcare needs (CSHCN)
- Approximately 3000 Idaho specific resources and services
- Google translator available in 70 languages
- Templates and forms to help care coordinators advocate for their patients
- Medical information written by physicians
 - Accurate, reliable, and informative
- Easy to [navigate](#)

Wrap up

- Patient Centered Medical Home is a huge commitment from providers and practices
 - Patients are expected to participate in their care
- Patient Centered Medical Home is whole person care
 - Taking care of all of you results in a better health outcome
- Many Idaho practices know what this is, ask for care coordination
 - Resources are available!