

Families Partner with Pediatric and Family Medicine for Quality Improvement in a Medical Home



The Medical Home Learning Collaborative is an Indiana Community Integrated Systems of Services (IN CISS) Project, funded through a grant to the Indiana State Department of Health from the federal Maternal and Child Health Bureau

Dr. Nancy Swigonski
Mary Jo Paladino
Angela Paxton
Dr. Mary Ciccarelli

Dr. Judy Ganser
Kim Minniear
Shirley Payne
Rylin Rodgers
Meredith Edwards



INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Children's Health Services Research

Overview

- Background
 - Patient Centered Medical Home
 - Medical Home Learning Collaborative
- The Family / Provider Partnership
 1. What is a family provider partnership?
 2. How does this relationship improve healthcare?
 3. How does the relationship help strengthen the Medical Home?

What is Medical Home?



- More than just a building or a place to receive health care
- It is the partnership between you and your physician or health care provider

AAP, AAFP, ACP, AOA 2007 Joint Principles of the Patient-Centered Medical Home (PCMH)

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks of a medical home
- Enhanced access to care
- Payment appropriately recognizes the added value

***“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
www.pediatricmedhome.org/

What Does a Medical Home Look Like?

- Good communication before, during and after office visits
- Coordinating with specialists and other health professionals
- Sharing of health education, family support and community resources
- Avoiding the ER for unnecessary visits
- Preparing for transitions and future health needs

Medical Home Learning Collaborative



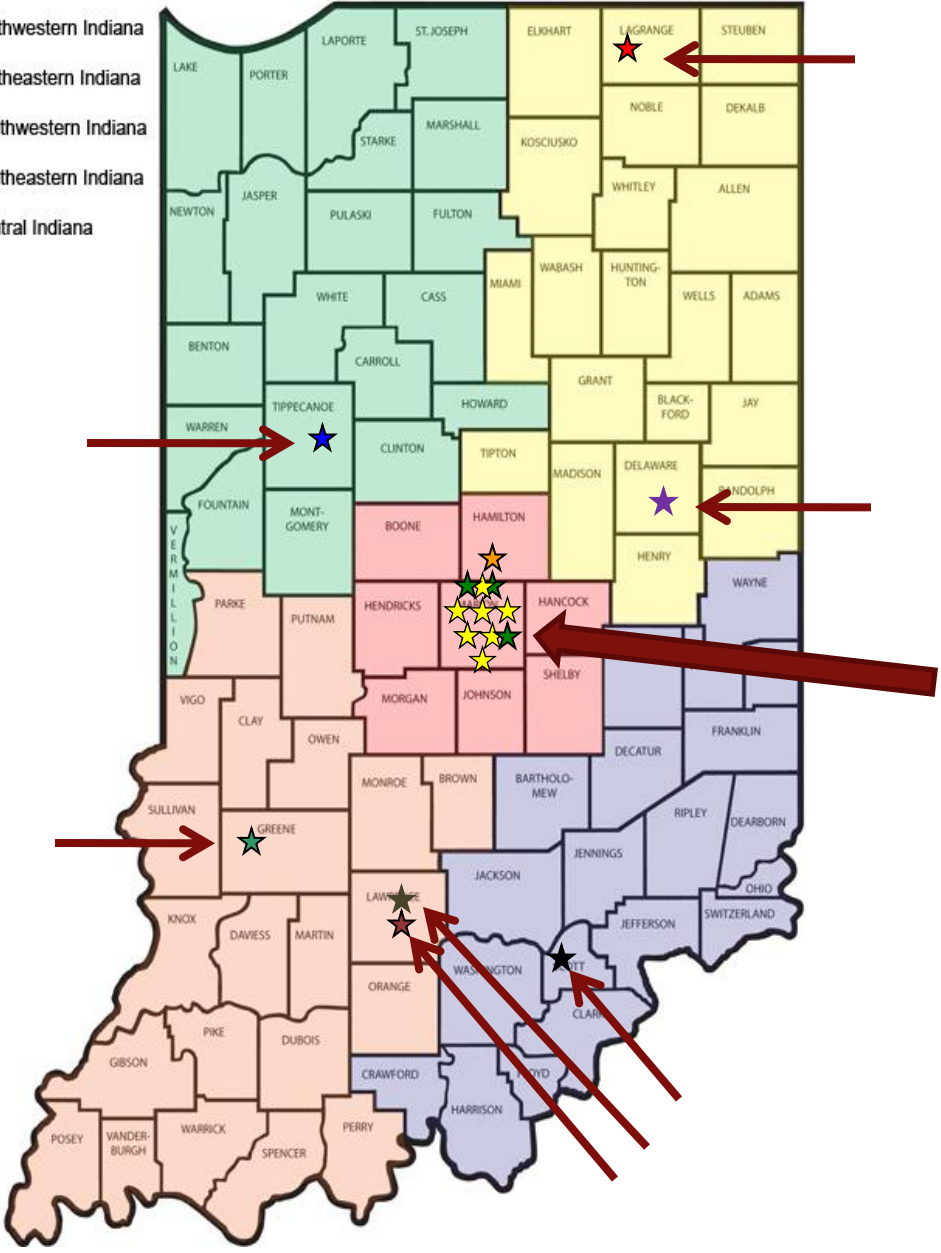
- An example of Medical Homes in action
in our state

Medical Home Learning Collaborative



- 3 year Indiana Community Integrated Systems of Services (IN CISS) grant
 - Began in October 2009 with a kick off meeting including pediatric and family medicine
 - Nine practices in first year (2009)
 - Nine more joined in October 2010
- Diverse in size, demographics, location and culture

- = Northwestern Indiana
- = Northeastern Indiana
- = Southwestern Indiana
- = Southeastern Indiana
- = Central Indiana



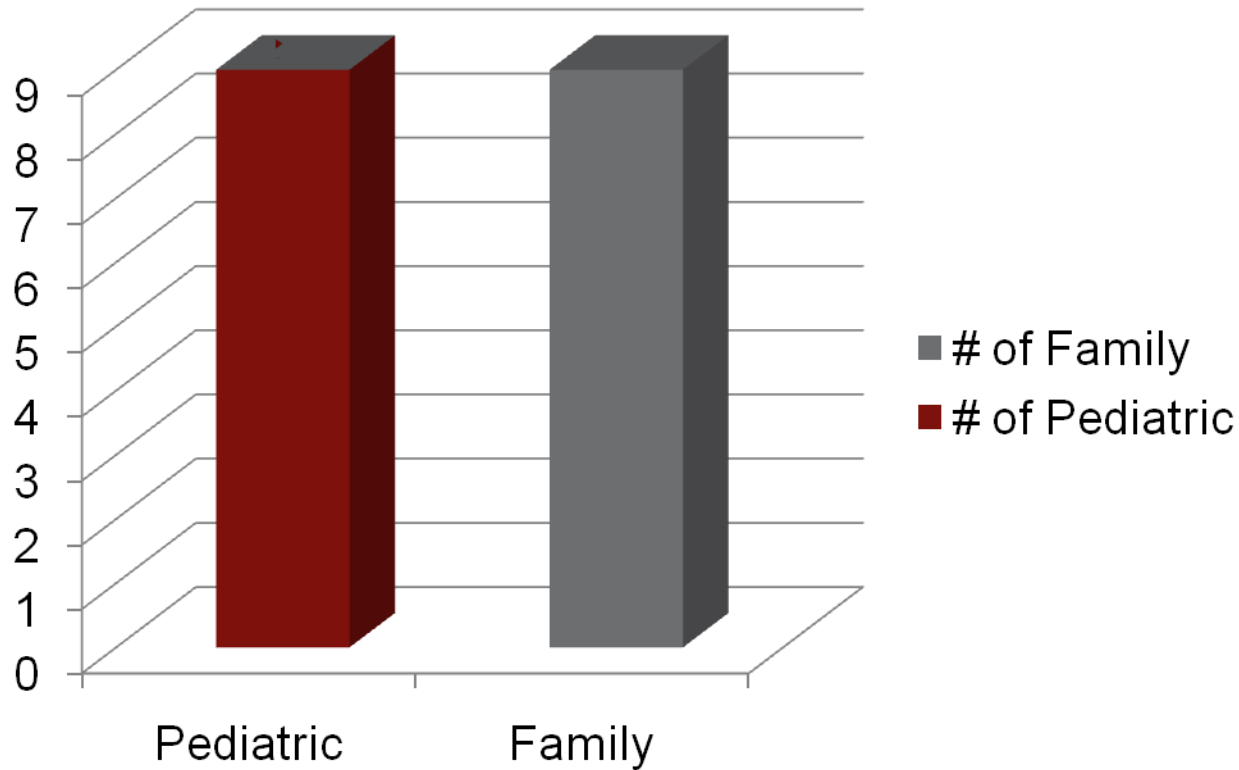
PEDIATRIC PRACTICES

- Blackburn Health Center**
- Clarian Arnett**
- Healthnet Pediatric Adol. Center**
- Linwood Health Center**
- Pecar Health Center**
- Meridian Pediatrics**
- Riley Hospital MSA 1**
- St. Vincent Pediatric Primary Care**
- Wishard Primary Care**

FAMILY MEDICINE

- Ball Memorial Hospital**
- Foundations Family Medicine**
- Ridge Medical Center**
- St. Vincent Faculty Practice**
- St. Francis**
- St. V'S Family Medicine Residency**
- St. Vincent Physician Network**
- Bohon/Craton, MD**
- Lira, MD**
- Shipshewana Family Medicine**

Family Medicine and Pediatric practices learning from each other



Medical Home Learning Collaborative



- AAP's Medical Home free on-line tool kit
<http://www.pediatricmedhome.org/>
- Use quality improvement methodology to make systematic changes within the practice

BUILDING YOUR MEDICAL HOME



HOME	START BUILDING	MEDICAL HOME STANDARDS (NCQA)	QUALITY IMPROVEMENT BASICS	PROGRESS SUMMARY		
Introduction	1. Care Partnership Support	2. Clinical Care Information	3. Care Delivery Management	4. Resources & Linkages	5. Practice Performance Measurement	6. Payment & Finance

[Sign Out](#) | [Contact](#)

Start Building Your Medical Home

Each of the six progressive Medical Home 'Building Blocks' include content and tools available to help you improve care while meeting NCQA Physician Practice Connections®-Patient-Centered Medical Home™ (PPC®-PCMH™) Recognition standards. Tools and related information can be used as they are provided or adapted to meet the needs of your practice.

Before You Begin

To have a successful Medical Home requires the participation of all practice staff, think about ways that these materials can help you engage your team. Decide who at your practice should be part of a small team whose job it will be to select and/or adapt medical home tools and ideas. Use the model for improvement outlined in the Quality Improvement Basics section to guide you. Next, strategize how to engage your whole practice in these activities as your prepare for implementation.



How to Navigate

Review each Building Block, preferably in consecutive order. Each Block contains a brief assessment to determine how well your practice currently addresses care in that area. Tools are available in each Building Block section for you to download and use.

How to Navigate

Review each Building Block, preferably in consecutive order. Each Block contains a brief assessment to determine how well your practice currently addresses care in that area. Tools are available in each Building Block section for you to download and use.

Medical Home Building Blocks



- 1 Care Partnership Support**
Empowers children, youth and families to manage their health and healthcare
- 2 Clinical Care Information**
Assures delivery of effective, efficient clinical care & patient self-management support
- 3 Care Delivery Management**
Promotes clinical care that is consistent with patient and family preference and scientific evidence
- 4 Resources & Linkages**
Mobilizes community resources to meet patient and family needs
- 5 Practice Performance Measurement**
Addresses the organization and promotion of safe and high quality care
- 6 Payment & Finance**
Matches quality care and NCQA recognition with payment / solid return on investment

>> Section 1: Care Partnership Support

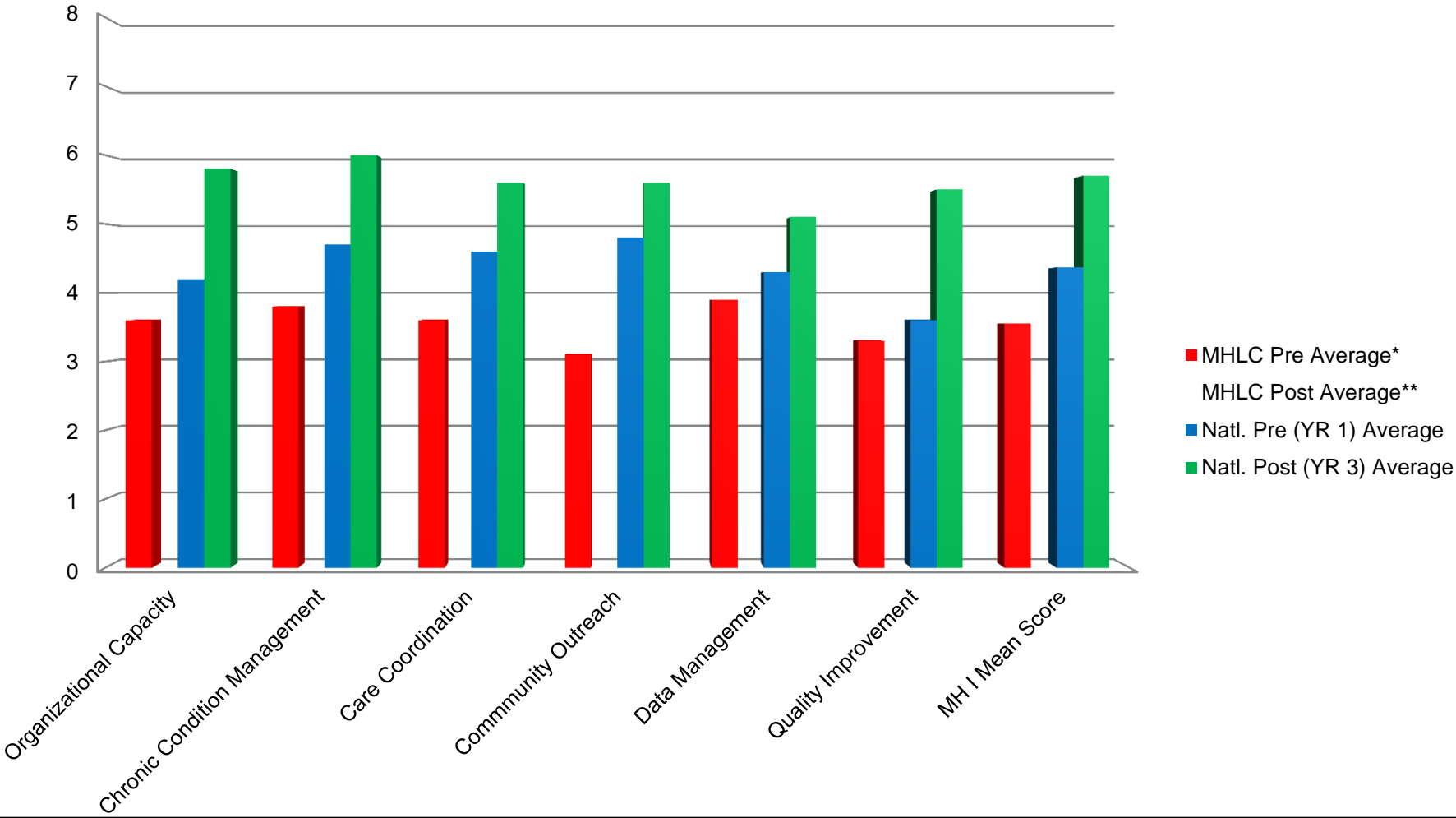
The **Medical Home**... accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care (AAP policy statement 2002, reaffirmed 2008).

[Toolkit Acknowledgements](#) | [site by eostudios](#)

Medical Home Index Report

	Domain	MHLC Pre Average	MHLC Post Average	Natl. Pre (YR 1) Average	Natl. Post (YR 3) Average
1	Organizational Capacity	3.7		4.2	5.8
2	Chronic Condition Management	3.6		4.7	6
3	Care Coordination	3.3		4.6	5.6
4	Community Outreach	2.9		4.8	5.6
5	Data Management	3.7		4.3	5.1
6	Quality Improvement	3.1		3.6	5.5
	MH I Mean Score	3.4		4.4	5.7

Medical Home Index- Pre and Post



What Does it Take to Build a Medical Home?

1. Commit to being a medical home
2. Assess your current performance
- 3. Engage parent, family and patient partners**
4. Assign a care coordinator
5. Establish a registry
6. Begin pre planned visits and care planning



Medical Home Learning Collaborative Structure

- Practices form quality improvement teams with a physician, RN, MA, social worker, and/or front office personnel and a patient or family member
- Annual Spring and Fall Meetings
- Face to face site visits every 8-12 weeks
- Bi-weekly Conference Calls



Conference Call Topics

- **Updates**
- Huddles and Pre-planned Visits
- **Quality Improvement Team Meetings**
- Improved Access
- Buy-In to Medical Home
- National Committee for Quality Assurance (NCQA) Standards
- Registries
- Electronic Health Records
- Medical Home Billing Codes
- **Family / Patient Partner Recruitment and Involvement**

Family/Provider Partnership

What is a Family/Provider Partnership

- Family members & professionals working together to ensure optimal services
- Recognition and respect for the knowledge, skills and experience that families bring
- Trust is a large part of the collaborative relationship
- Open communication so families and professionals feel free to express themselves
- Cultural traditions, values, and diversity of families are respected, acknowledged and honored

Why Include Families?

- Offer unique perspective on how practices work and where there might be opportunities for improvement
- Don't have a vested interest in the practice or status quo
- Can determine what makes the most sense because they are users of the practice

How Does this Partnership Work in the MHLC?

- Participate on quality improvement team
- Attend regular meetings and offer their perspective
- Asked to help with specific projects
- More informal feedback can be received through surveys, direct email or phone calls to patient
- Staff on the MH project are parents of children with special health care needs

Checklist for Identifying Partners

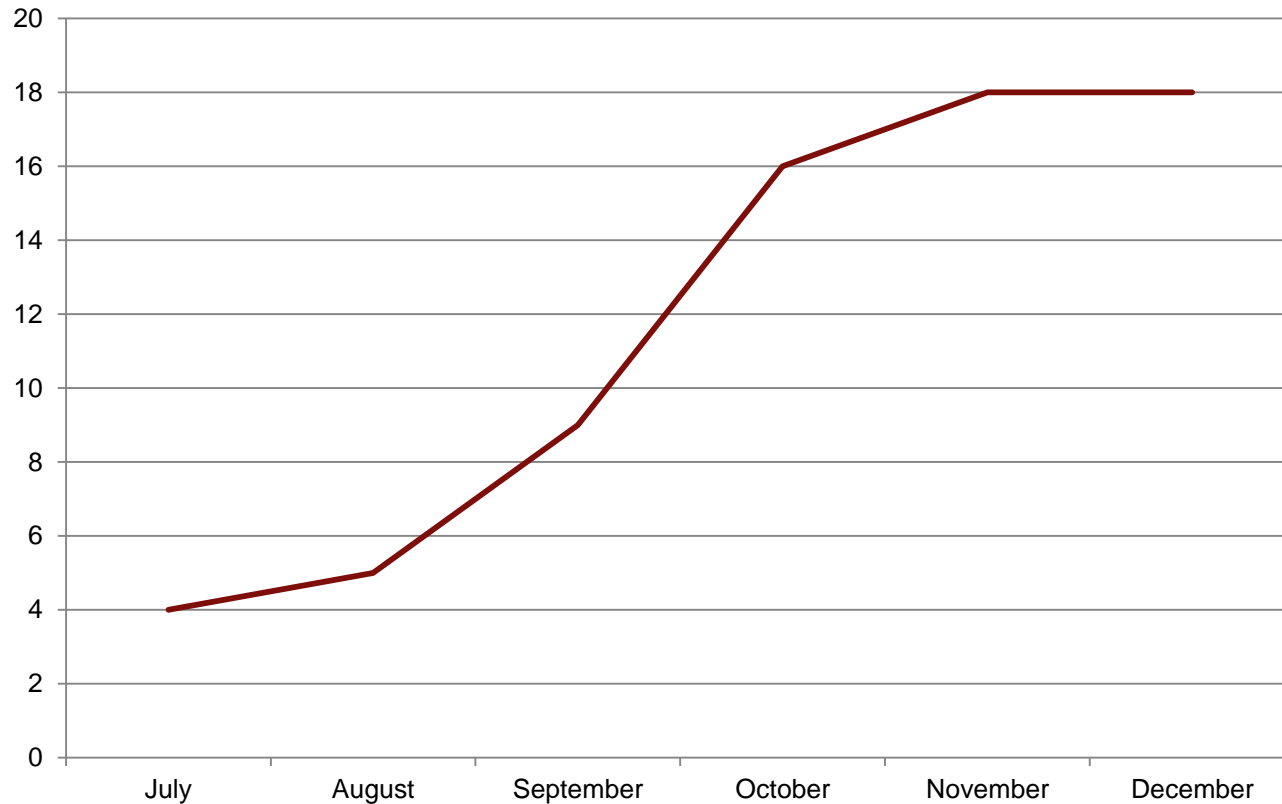
- Parent or family member of a child or youth with special health care needs
- Can they see past the needs of their own child to the needs of other children or youth with special health care needs
- Good communicator – able to speak up in front of a group
- Good advocate
- Responsible – on time and keeps appointments
- Team player

Checklist for Identifying Partners

Other Considerations:

- Member of a support group
- Comfortable sharing their personal story with others
- Good knowledge of community resources
- Experienced with multiple specialists
- Time to commit and access to childcare
- Later on, may want to choose someone who will really challenge your practice
- Get suggestions from fellow staff members
- Invite more than one partner

Number of Family / Parent Partners



Examples of Family Partner Successes

- Better phone triage, dropped calls were reduced by 50%
- Informational brochure was developed for families.
- “Resources for Families” section on practice website.
- Cultural differences in a practice led a physician to invite different parents in the practice to one on one meetings
- Physician wrote a letter to the family’s insurance company requesting the purchase of special medical equipment

Lessons Learned

- How to get started; invite a partner to be on your team from the beginning
- Who do you ask? – Checklist
- Partner and provider unsure of role initially
- Partner turnover and schedule conflicts – invite 3-5
- Consider more informal kinds of family involvement
- The process of partnering takes time
- Create opportunities for everyone involved to express concerns – QI meetings, include all staff and family partner, rotate team roles, e.g. facilitator
- Your annual budget should include payment for meaningful family involvement

How Can You Become a Family Partner with your Medical Home?

- Come to your appointments with a list of your questions and concerns. If you think you will need extra time, let the scheduler know that ahead of time.
- Ask if you could offer a suggestion - be positive, offer kudos as well as constructive criticism
- Ask if they offer focus groups, advisories or need help on projects involving the practice
- Offer your expertise – public health concerns – smoking cessation or obesity prevention and reduction

Summary

- Medical Home
 - The definition of Medical Home
 - The Medical Home Learning Collaborative is an example of how its being done in Indiana
- Family Provider Partnership
 - Why it's important
 - How partnerships are encouraged in Medical Homes
 - You, as a consumer of health care, can advocate as a patient or family partner

- Questions?
- Angela Paxton, Parent Consultant
Medical Home Learning Collaborative,
Indiana Community Integrated Systems
of Services (IN CISS) Project
317-586-0299
arpaxton@iupui.edu