Family and Professional Partnerships: A Cornerstone of Medical Home Transformation

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Agenda

- Welcome and Introductions
- Goals of the Oregon, Alaska, and West Virginia CHIPRA Quality Demonstration Grant
- Overview of Family and Professional Partnerships
  - Data-Driven Focus on Family and Professionals Partnerships
  - Why Family Partnership is Different from Engagement
- Lessons Learned
- Questions

Tri-state Children's Health Improvement Consortium (T-CHIC) CHIPRA Quality Grant Goals

- State-to-state partnership among Medicaid/CHIP programs in Alaska, Oregon, and West Virginia
- State and not-for-profit partnership (3 states, 4 non-state partners)
- Practice-to-practice partnership (21 Medicaid/CHIP practices)
- Tri-state learning collaborative promotes innovations and activities that support CHIPRA goals (diffusion of innovation, active learning network, and rapid cycle improvement)
  - Learning collaboratives
  - Data and analytics
  - Technical assistance and infrastructure support
  - Annual conferences, communications, online repository, outreach and networking

T-CHIC Continued

- Multi-faceted set of strategies to demonstrate the impact that different ways of delivering health care and health care information can have on a child's health by:
  - Improving children's health and health care quality measurement
  - Integration of Health Information Technology (HIT) systems
  - Developing the best models of health care delivery for children and their families
- Participating states are working to improve children's health in their own state, as well as in the other consortium states

T-CHIC Medical Home Efforts

- Working with 21 Medicaid/CHIP practices to transform and improve care in a way that meets the goals of a pediatric medical home
  - Alaska: 2 practices, 1 large health system
  - Oregon: 8 practices
  - West Virginia: 10 practices
- Different medical home and care coordination models to stimulate improvements in health care delivery for children and their families
  - Alaska: Practices applied to RFP, monthly calls to share learning
  - Oregon: Learning collaborative with monthly practice facilitation and group conference calls
    - Facilitation led by Oregon Pediatric Improvement Partnership (part of the National Improvement Partnership Network)
  - West Virginia: Care coordinators in each practice, monthly calls with care coordinators

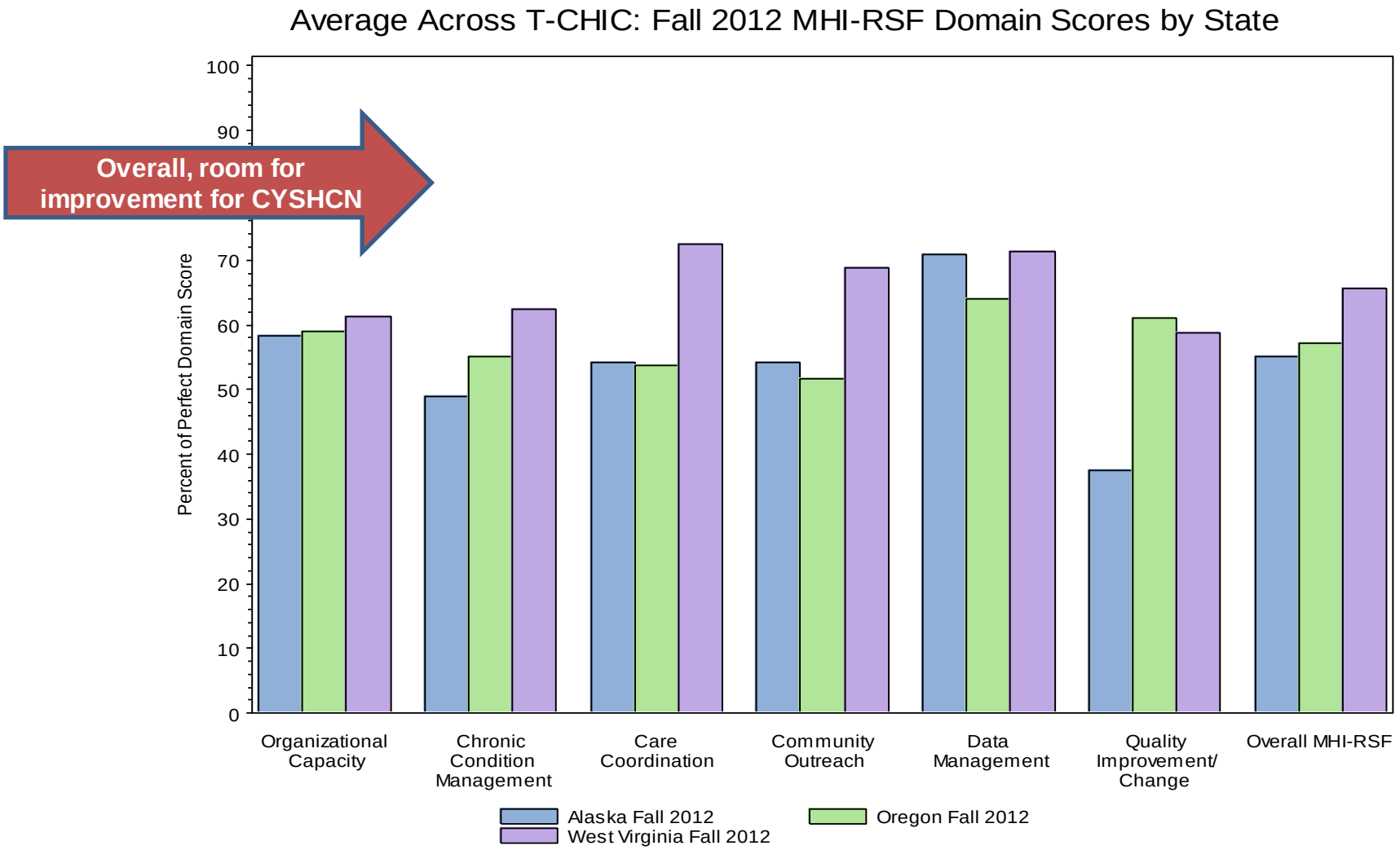
Methods T-CHIC Uses to Assess Medical Home & Identify Priorities for Improvement

- Medical Home Office Report Tool
  - Practice characteristics
  - Pediatric Medical Home Index: Revised Short Form (MHI-RSF)
  - National Committee for Quality Assurance Patient-Centered Medical Home 2011(NCQA PCMH)
  - State-specific items
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Clinician and Group (CG) PCMH survey:
  - Included additional items focused on care coordination
  - Oversampled for Children and Youth with Special Health Care Needs (CYSHCN)

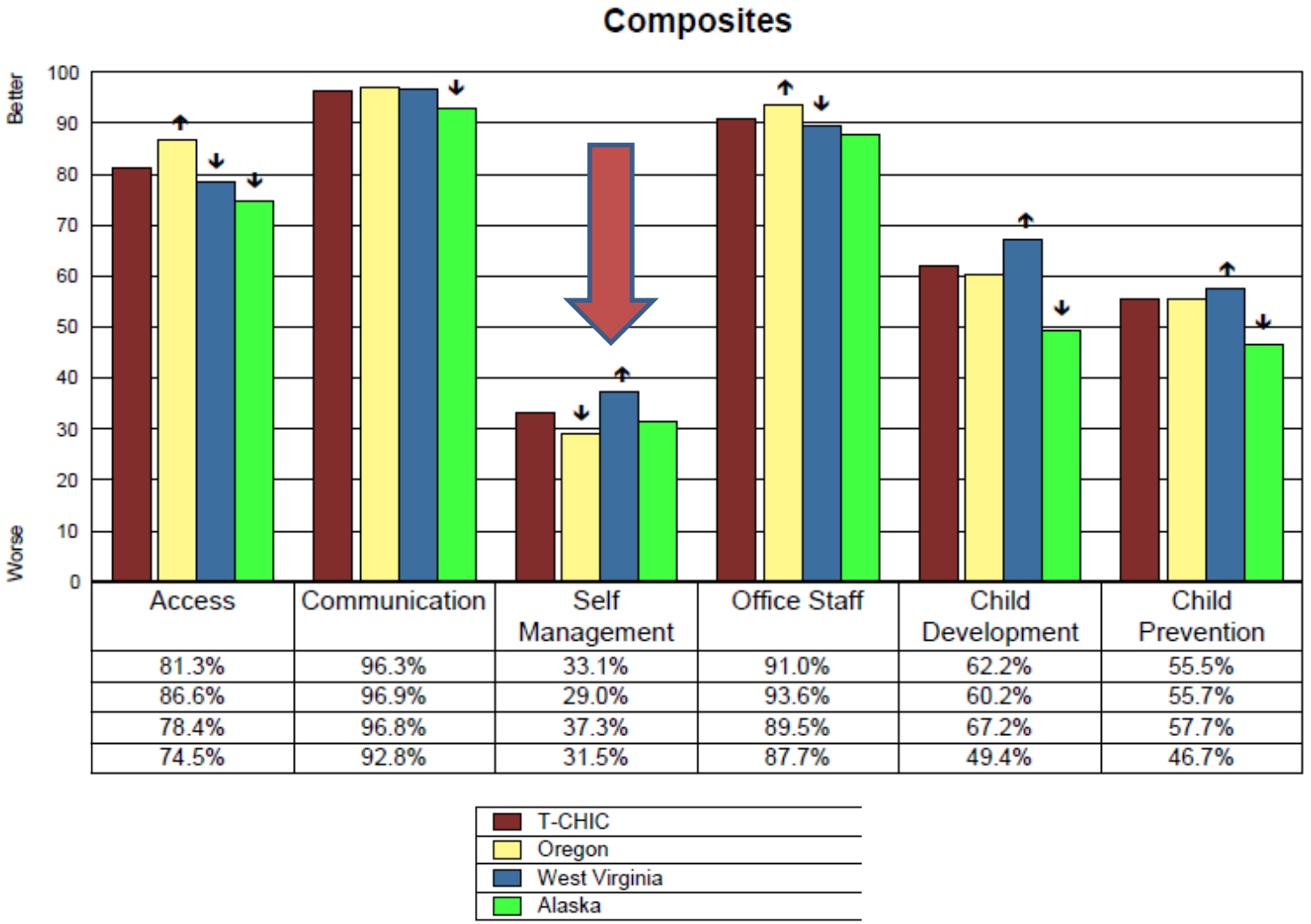
NCQA PCMH Findings:
Areas Needing Most Improvement Related to Family Partnerships

Across T-CHIC: Average NQCA Fall 2012 Scores

MHI-RSF Findings: Family Professional Partnership for CYSHCN Needs Improvement



CAHPS CG PCMH Findings: Area Most Needing Improvement Related to Self-Management



Access	Communication	Self Management	Office Staff	Child Development	Child Prevention
81.3%	96.3%	33.1%	91.0%	62.2%	55.5%
86.6%	96.9%	29.0%	93.6%	60.2%	55.7%
78.4%	96.8%	37.3%	89.5%	67.2%	57.7%
74.5%	92.8%	31.5%	87.7%	49.4%	46.7%

↑↓Statistically significantly higher/lower than T-CHIC score.

Shared T-CHIC Medical Home Priorities

1. Patient engagement
2. Care coordination (5 specific functions)
   a. Utilizes standardized systems/process for identifying CYSHCN
   b. Provides patient education and engagement materials defining medical home and assessing the patients' needs from the medical home, overall, and specifically relating to care coordination
   c. Develops care plans with families
   d. Manages and tracks tests, referrals, and outcomes
   e. Coaches patients/families
3. Support of adaptive reserve in practices to ensure sustainability

T-CHIC Tracking Tool: Progress on Medical Home Priorities

- Tracking sheet mapping to each of the priorities with state indicators and practice level indicators related to processes and systems

T-CHIC Medical Home PRIORITY AREA #1: Family Engagement	TOTAL (n=21)
State-Level Project Indicators:	**#yes (%)**
Parents and/or Youth participate in in-person meetings in with the practices	**2 (67%)**
Parents and/or Youth are part of the state-team guiding the improvement efforts	**3 (100%)**
Practice-Level Project Indicators:	**#yes (%)**
Practice has an advisory committee of their patients/patient families that includes a focus on their input and guidance on the quality strategy within the practice and improvement efforts	**1 (5%)**
Parents and/or Youth are part of the practice-level team focused on the T-CHIC project	**1 (5%)**
Parents and/or Youth, served by the practice, are engaged by the practices to provide feedback to specific parts of the QI efforts (e.g. to review a shared care plan)	**2 (10%)**
Parents and/or Youth meeting 10% Improvement OR Level 3 Complete/ Level 4 on MHI-RSF© Item 1.5 **Family Feedback**	**12 (57%)**
Practice designs a QI project based on results from patient experience of care survey	**2 (10%)**

Family and Professional Partnerships: Lessons Learned with Family Engagement

- Engaging families in the quality improvement process is powerful
  - Families are keynote speakers at in-person learning sessions
  - Families serve on the Oregon project team
  - Families are engaged in the QI effort at the practice level
  - Examples:
    - Focus group on shared care plans
    - Paid parent member of the practice team
- Culture shift for both practices and providers
  - Requires time and communication

Hearing from Families to Ensure our Approach is Patient Centered

- Wanted to learn from families what it means to be engaged – positive and negative experiences
- Oregon Center for Children and Youth with Special Health Needs conducted interviews and created a video of 12 parents of CYSHCN from urban, rural, frontier, and coastal areas with varied levels of education and experience
- Video presented at annual T-CHIC Learning Session and state-specific learning sessions with the practices
  - http://www.ohsu.edu/edcomm/flash/flash_player.php?params=1%60/cdrcfinal.flv%60vod&width=640&height=360&title=Interview%20Segment

Family and Professional Partnerships: Tools and Strategies Being Used by T-CHIC Practices

- Identification of CYSHCN
  - Includes understanding the child/youth and family needs and health consequences
    - Need to ask the child/youth and family
  - Not all CYSHCN need care coordination
  - Not all children with a diagnosis have complex special health care needs
  - Some children with complex special health needs do not have complex diagnoses
- Care coordinators
  - Recognize additional staff are needed do this well
  - All 21 practices now have a care coordinator
  - Use of tools to understand and gauge families' strengths and needs (complexity scales)

Family and Professional Partnerships: Tools and Strategies Being Used by T-CHIC Practices

- Shared Care Plans
- Emphasis on shared, collaboratively developed plans vs. action plans
- Significant learning about how to feasibly and meaningfully implement these
  - Requires pre-visit planning and care coordination team
  - Time intensive
  - Anchor to child/family needs; not specific to a diagnosis
  - Care coordinators needs to be versed in techniques like motivational interviewing
  - Cumbersome to build and manage in electronic health records

Questions

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