Getting to "*Transformation*" in the Pediatric Medical Home

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Children's Health Services Research

Or "getting to sustained "planned, coordinated care" in the medical home

A few parallels

- **Tomatoes**
- **Pilgrims**
- **& Medical Home Transformation**

"Animal, Vegetable, Miracle", Barbara Kingsolver Some Medical Home Parallels

Local Tomato Grower	Medical Home?
Part of the local community	
"Barter" or exchange assets	
Value health, quality products, and safety	
Sell "product" directly to customers	
Livelihood is *mission* as well as business	
Customers show up week after week, at a community gathering place	
First names common; open door/welcoming policy	
Name of the heirloom tomato she is growing? { ? }	

Local Tomato Grower	Medical Home?
Part of the local community	✓
"Barter" or exchange assets	✓
Value health, quality product, and safety	✓
Sell "product" directly to customers	✓
Livelihood is ***mission*** as well as business	✓
Customers show up week after week, at a community gathering place	✓
First names common; open door/welcoming policy	✓
Name of the heirloom tomato? She is growing { ***"TRUST"*** }	

The Mayflower and the Medical Home?

Quote from "The Mayflower"…. *Interdependency one upon the other*

Goals Today

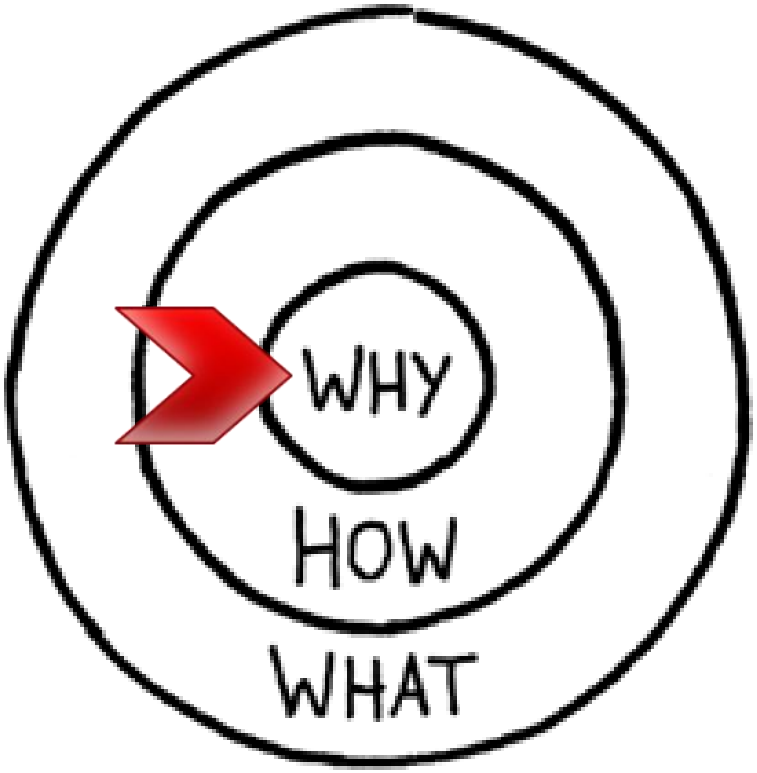
1) ***Identify*** 3 crucial (& feasible) drivers of continued medical home improvement

2) ***Link*** 4 key attributes of highly performing medical homes to the literature, and to your own reflections on improvement

3) ***Prioritize*** (at least) 3 core care assumptions linking medical home activities to goals of the Triple Aim (thereby maximizing benefits)

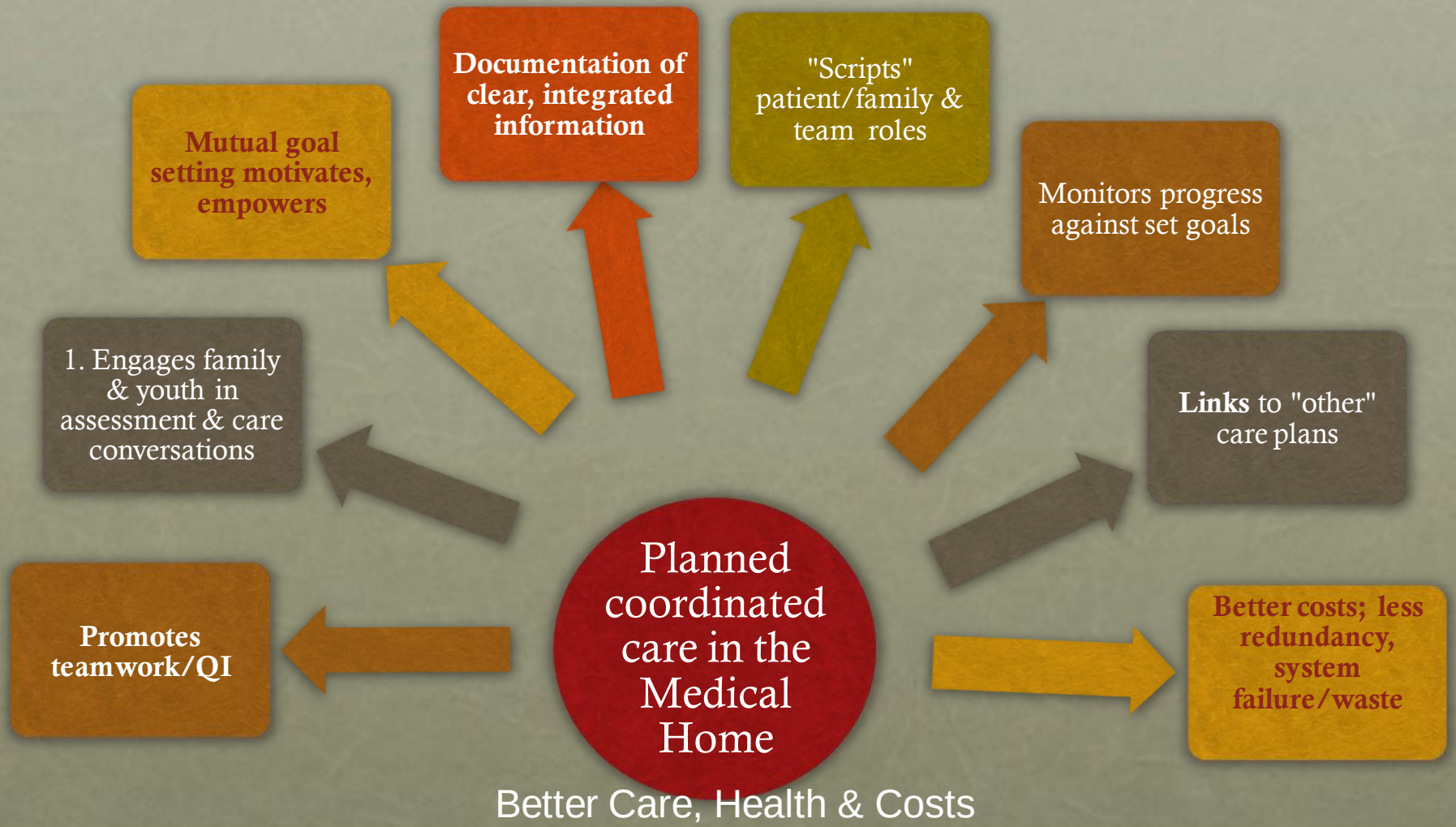
4) ***Describe*** the Comprehensive Integrated Care Plan (CICP); the people, processes and tools which must coalesce to realize optimal outcomes

Medical Home and Planned Coordinated Care



Source: TED.com
Simon Sinek, The Golden Circle

Why Planned Coordinated Care using a Comprehensive Integrated Care Plan Is So Important



Forward, back, and forward again
Relating a chronology of my work to topic…

- Office Based Systems Change 1993
- Medical Home 1997
  - Medical Home Index 2001, (MHI-RSV 2011)
- More Medical Home Projects 2001-2013
  - Family engagement, Care Coordination
- Medical Home Learning Collaboratives 2003
- **Medical Home Research 2005, 2010 (outcomes, transformation)**
- Health Care Transition, 2010
- **Comprehensive Integrated Care Plan, 2012-13**

AHRQ - Transforming Primary Care
Study of 12 Highest Performing Pediatric Medical Homes (of 50 in MHLC)

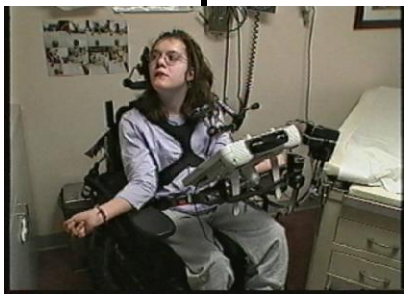
- Medical Home learning Collaborative (12 months)
- Lead Clinical Champion, Parent Partners (2), Care Coordinators
- Chronic Care Model/Care Model for Child Health in a Medical Home
- Medical Home Index – (*physiology* of medical home)

7 years later, mixed methods study:

- Medical Home Index – validated self-assessment tool
- Adaptive Reserve Scale
  - – ability to make and sustain change
- Semi-Structured Interviews
  - Clinician, families, care coordinators
  - ~6000 quotes counted and coded

DEER in the HEADLIGHTS!

2003-2004 50 Primary Care Teams with newly identified family partners and Sponsoring Title V Leadership – "You want us to do what?"

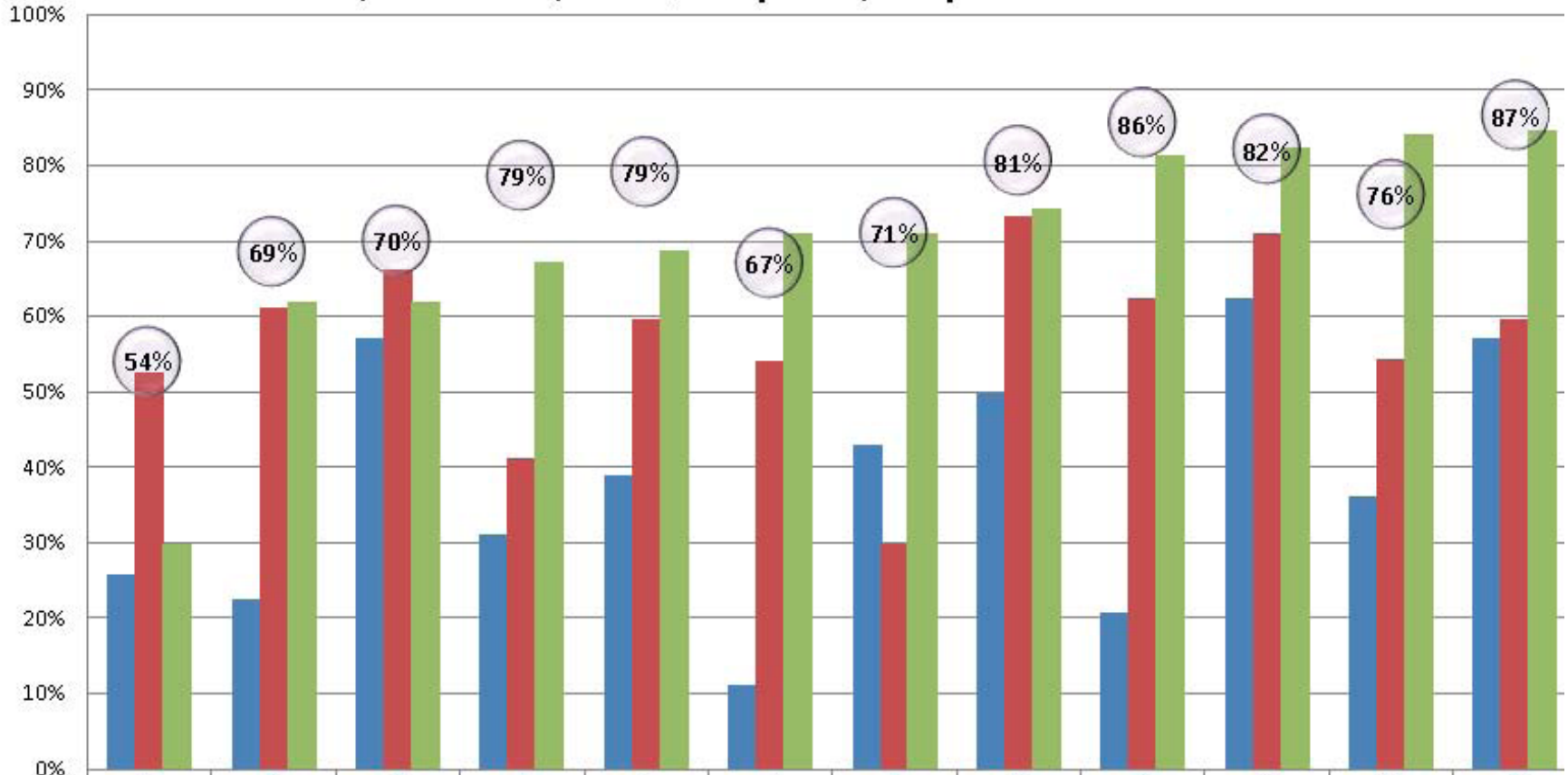


MEDICAL HOMES: LIVING, BREATHING, COMPLEX ORGANIZATIONS

CMHI: Studying Medical Home Transformation in Pediatric Primary Care (AHRQ) 2010-2012

Medical Home Index and Adaptive Reserve for Scores 12 Transformed Practices

MHLC Pre, MHLC Post, AHRQ Study 2011, Adaptive Reserve 2011



	1 512	2 728	3 854	4 262	5 853	6 265	7 582	8 438	9 359	10 815	11 404	12 546
Pre LC	26%	22%	57%	31%	39%	11%	43%	50%	21%	62%	36%	57%
Post LC	53%	61%	66%	41%	59%	54%	30%	73%	62%	71%	54%	59%
AHRQ	30%	62%	62%	67%	69%	71%	71%	74%	81%	82%	84%	85%
% Adaptive Reserve	54%	69%	70%	79%	79%	67%	71%	81%	86%	82%	76%	87%

CMHI - Center for Medical Home Improvement

MHLC - Medical Home Learning Collaborative

Adaptive Reserve Scores

Three Primary Data Elements: "Four Essential MH Attributes"	I. Medical Home Index (MHI)	II. Adaptive Reserve (AR) Transformed Clinician Staff Questionnaire	III. Semi-Structured Informant Interviews (~6000 Coded Quotes-NVivo Analysis)
1) "Quality Improvement"	X	X	X
2) Family-Centered Care	X	X – CMHI ADD ON (&community)	X
3) Team Based Care / Teamwork	X	X	X
4) Care Coordination	X	X	X

(1) Quality Improvement

"Medical home is a process, I don't think it's an endpoint. It should be a way of {practice} life."

PCP

(2) Family-Centered Care

"I have a partner in the complex care of my child; the team here, they have our backs; this practice saved my life."

Parent Partner

(3)Team based care / teamwork

"Our eyes have been opened to better care and to a broader definition of patient and family health."

PCP

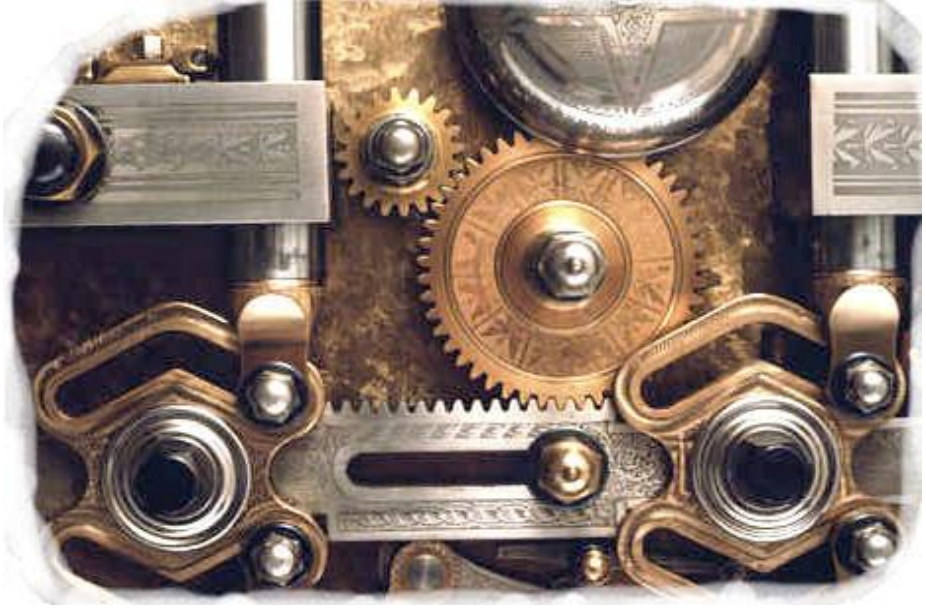
"We are a factor now in our community and we help families make the necessary connections."

PCP/CC/Team

(4) Care Coordination

"We saved that family unnecessary visits and tests - so that was a result of just having someone here (CC) to help right the ship a little bit." *PCP*

"The care coordination support is so helpful; care coordination is all I would do. Our family has benefited, I can be a parent now." *Parent Partner*



What Drives Change?

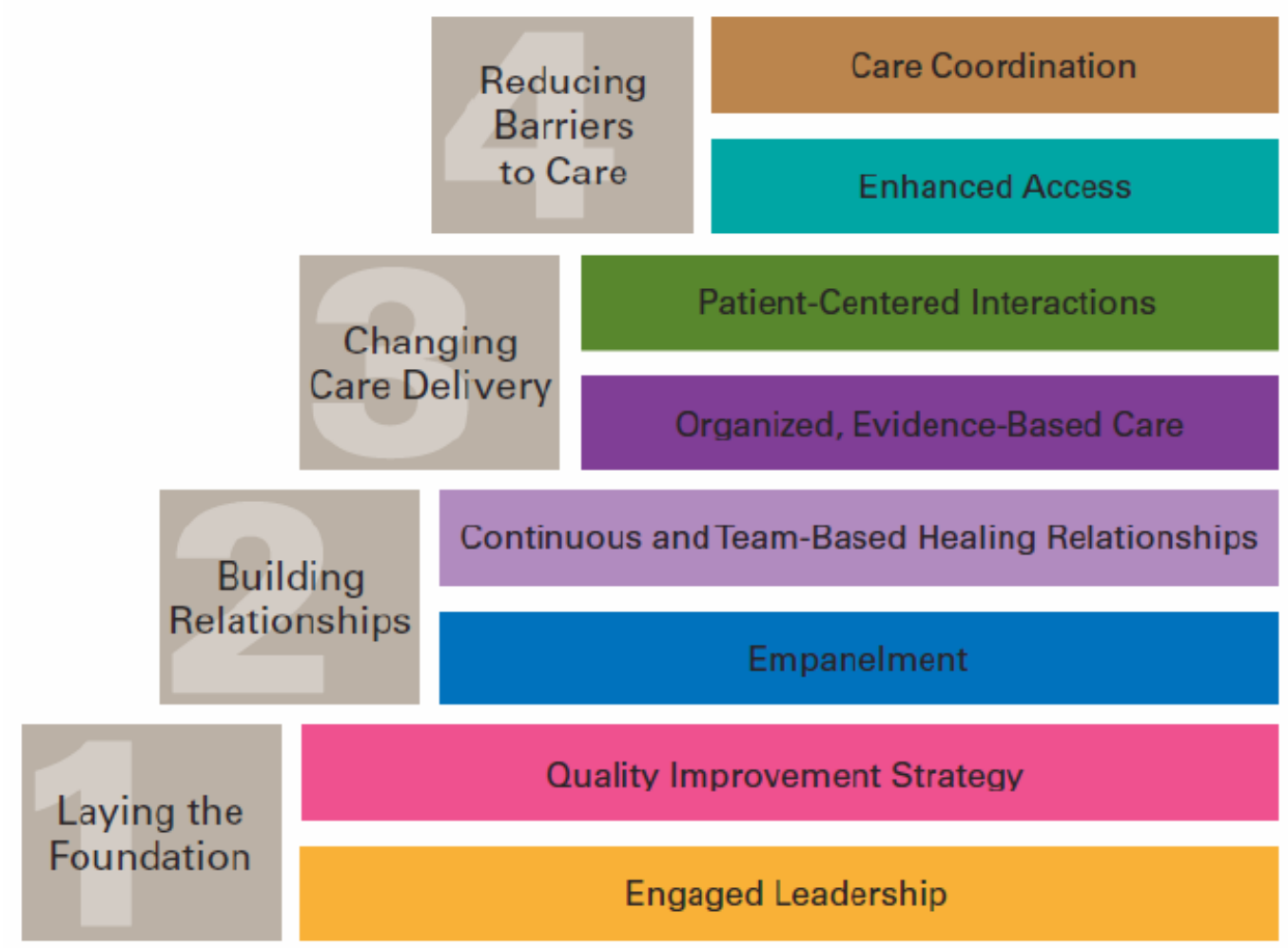
★ **Transformation did not resonate; care improvement did**

Mixed Methods: **Triangulated data across MHI, Adaptive Reserve, and Interviews with 4 emergent essential attributes:**

1) **Quality Improvement**
2) **Family Centered Care**
3) **Teamwork/team approach to care**
4) **Care Coordination**

★ **Physician and staff satisfaction was strong/high**

Change Concepts for Practice Transformation



Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice*. 2012; 39:241-259.

LEAP – Learning Effective Ambulatory Practice (30 adult sites)

- **Saw in all sites:**
  - **New ambulatory care roles for nursing**
  - **Teamwork – top of license and who and how to hire and use (for attitude!)**
  - **Planned, coordinated care (follow up, self management, hospital discharge, resources,**
  - **Efforts to integrate services (mental health, etc.)**
- **Saw in some sites:**
  - **Bright young lay people in different roles (CC, IT, etc.)**
  - **Proactive efforts (scrubbing charts for prevention, no shows etc.)**

Your prediction about responses?

- Medical Home:
  - For Children and Families
  - For Adults

  - Differences articulated?

Pediatric Practice Perceptions

- We care for the whole family We are interested in the success of *families*
- We integrate with community partners/resources
- ***My observation:***
  - ***Effective use of care plans with families***
  - ***And…***

Emphasis on partnerships with families

Continuum of ways to engage patients & families, as:

Providers of Feedback

- Suggestion box
- Surveys

Experience of Care Tutors

- Diaries
- Focus Groups
- Practice walk thru

Teachers

- About their family
- Topical/review panel experts
- Workshop speakers

Partners for Improvement

- Advisory group
- Practice team partners

TIPS: 1) Practice 8 ways 8 times, times 8 !
2) Turn to families for focus when get confused

Consensus Standards for Care Planning and Care Plans –

Comprehensive Integrated Care Planning/Plans (CICP)

Funded by the:
Lucile Packard Foundation for Children's Health

Our Purpose:
"Quality Standards; Flexibly Applied"

Create and gain endorsement *for comprehensive, integrated care plan* (**CICP)** consensus standards

Link comprehensive, integrated, care planning to the Triple Aim:

1. **Better individual experience of care,**
2. **Better health of the population, and**
3. **Better cost implications**

Care Plan Policy Recommendations

Pediatric

- NCQA
- AAP
  - Toolkit
  - CC Policy Paper
- NASHP/Medicaid CC Reports
- CMHI (research)
- NICHQ
- ACA
  - Essential benefits
  - Medical/health home

Adult

- NCQA
- Care Transitions (E. Coleman U. Colorado)
- Guided Care - (J. Hopkins)
- Grace Program (IUPUI)
- Institute for Healthcare Imp
- Accountable Care Act (ACA)
  - Essential benefits
  - Medical/health home

Care plans are the solution!
(to what?)

Clarify: What do you want care plan to do, and for whom? Disparate responses:

I want that critical medical information right in front of me; what's the problem & what's the solution…

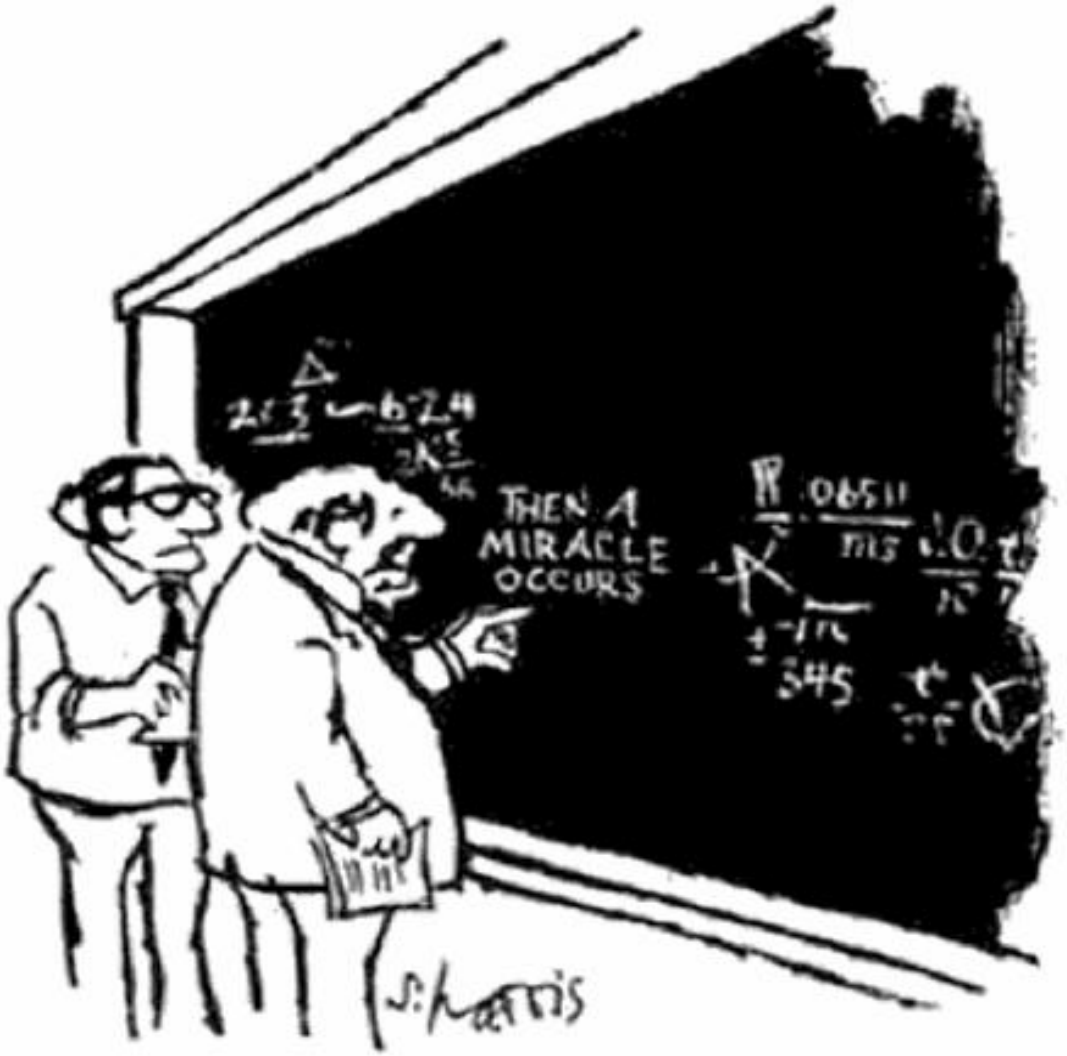
PCP

I want the doctor or nurse to know who my child is, what pleases her, our family strengths . . .

Family

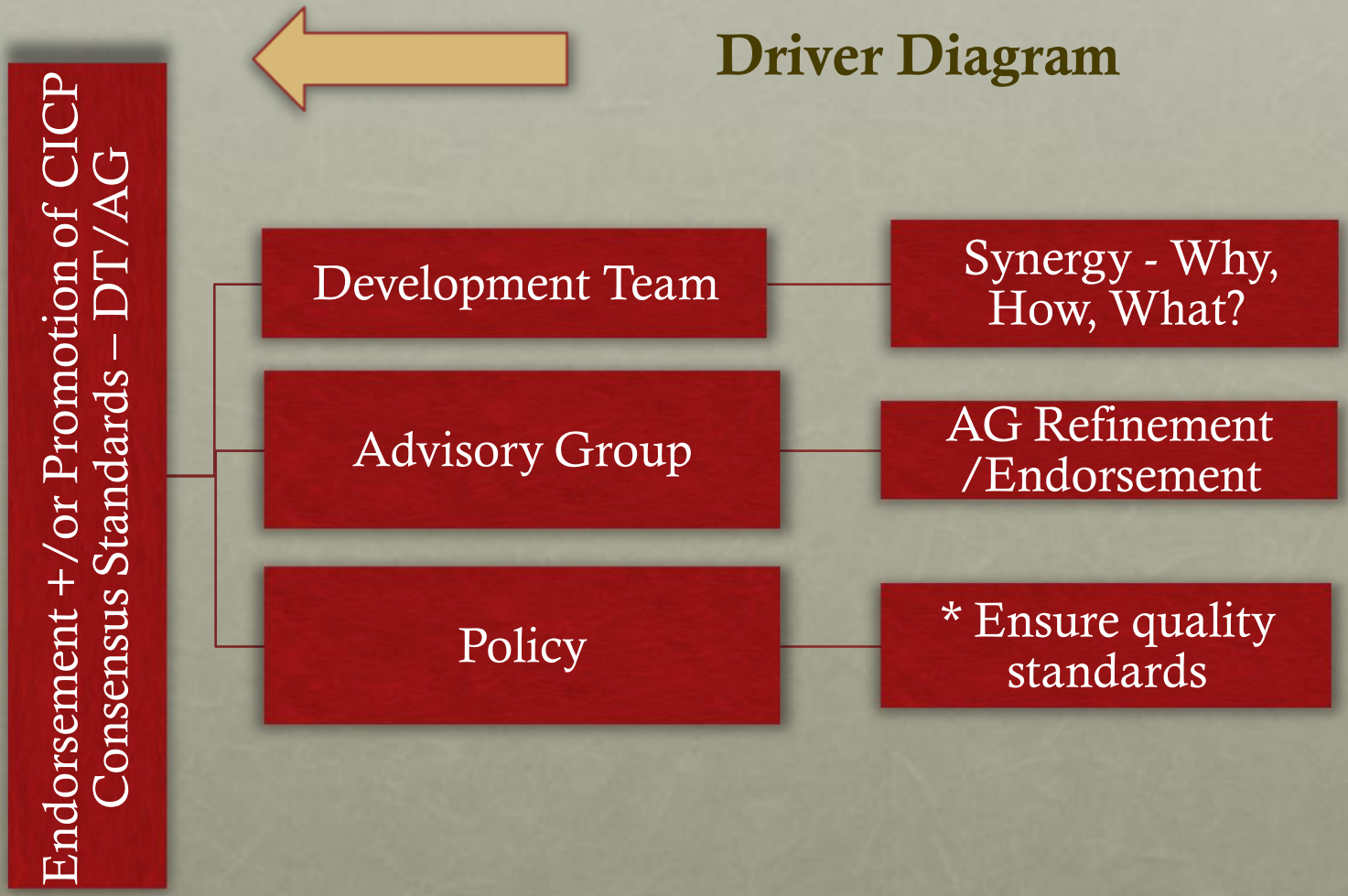
We are "here"… we want to get "there"…

Or, The Why, How and What of Comprehensive, Integrated Care Planning



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

Comprehensive, integrated, care planning (CICP) consensus standards



Development Team

- 2 Family Leaders
- 2 Pediatricians
- 1 Child Psychiatrist
- 1 Pediatric APNP
- 2 Care Coordinators
  - One practice
  - One CSHCN Title V
- 1 Title V Director
- 1 Leader and "Boundary Spanner"
  - (☺ me)

Fundamental Assumptions

Assumptions - A Worksheet

- Review 10 Assumptions
- Pick 1 that you believe will address the Triple Aim the most directly &
  - Helps families, energizes providers
- Share 1:1, Your #1 Pick and Why?
- Then will a few share with all of us?

How to Achieve Benefits of *Better* Care, Health & Cost - Our Assumptions

1. Children, youth and families are actively engaged in their care.
2. Communication among their medical home team is clear, frequent and timely.
3. Providers/team members base their patient/family assessments on a full understanding of child, youth and family needs, strengths, history, and preferences.
4. Youth, families, health care providers, and their community partners have strong relationships characterized by mutual trust and respect.
5. Family-centered care teams can access the information they need to make shared, informed decisions.

Assumptions for How to Achieve Benefits of *Better:* Care, Health & Cost

6. Family-centered care teams use the Comprehensive Integrated Care Plan (CICP) as the plan of care; it includes shared goals with negotiated actions; all partners understand the CICP process, their individual responsibilities and related accountabilities.

7. The team monitors progress against goals, provides feedback and adjusts the CICP, or plan of care, on an on-going basis to ensure that the plan is well implemented

8. Team members anticipate, prepare and plan for all transitions (e.g. early intervention to school; hospital to home; pediatric to adult health care)

9. The CICP is systematized; it is used consistently by every provider within an organization, and by all providers across organizations.

10. **Care is (subsequently) well coordinated across all involved organizations/systems.**

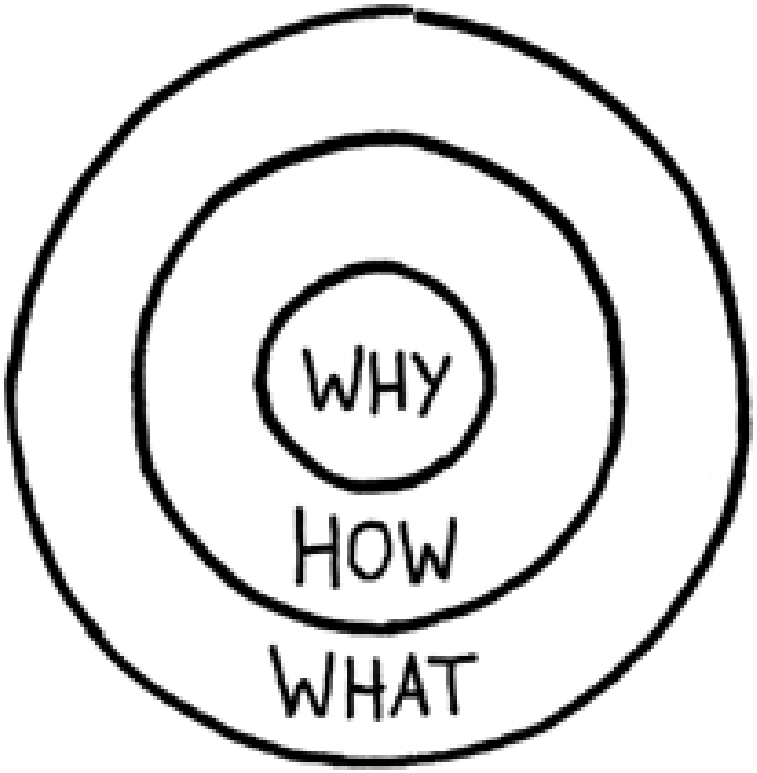


Comprehensive Integrated Care Plans

1) Model 2) Implementation & 3) Measurement & Care Stories



Medical Home and Planned Coordinated Care



Source: TED.com
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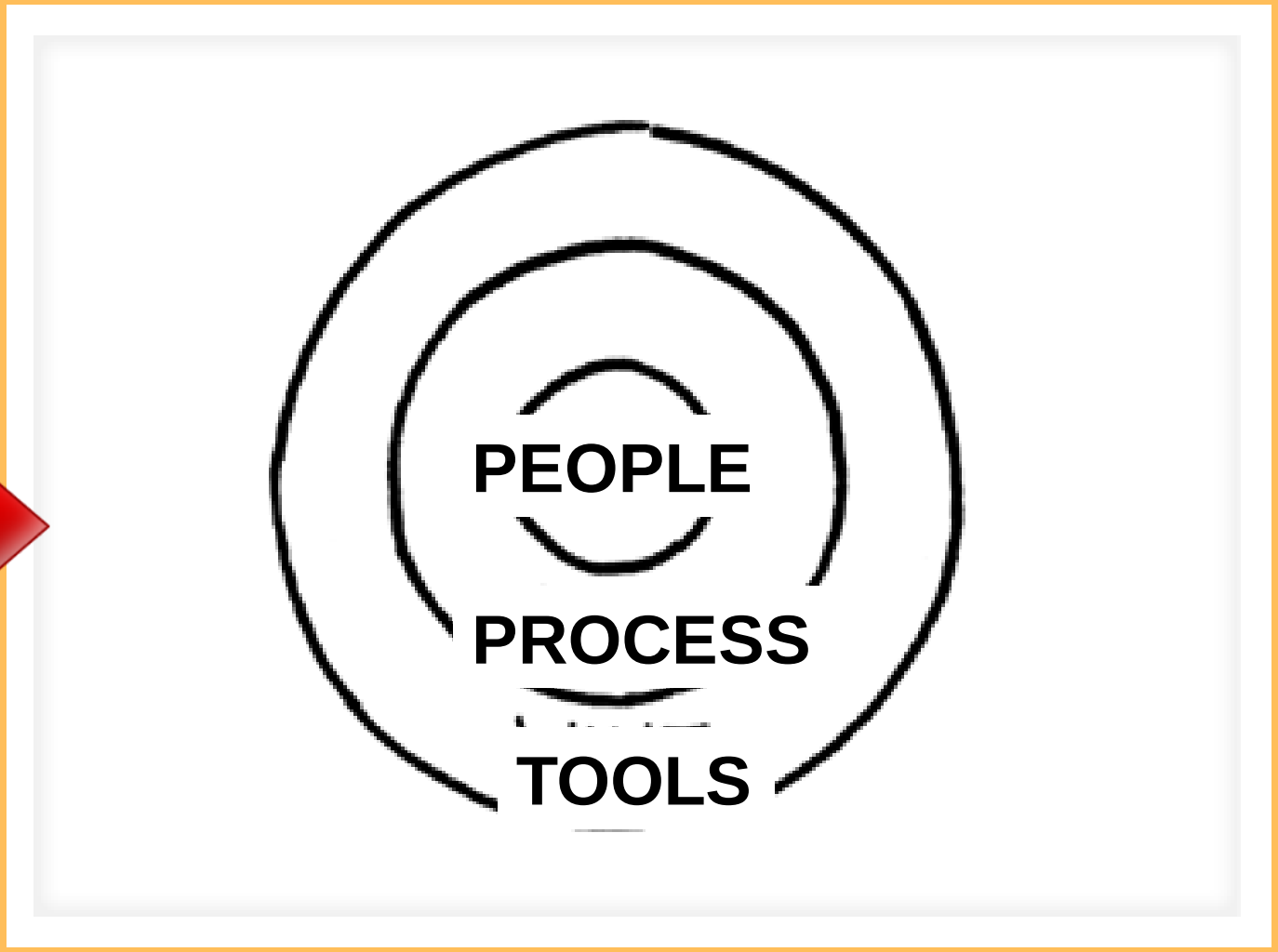
Implementation – People, Process and Tools



Source: TED.com
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Model: People, Process and Tools

1. Identify Needs & Strengths (Patient/Family)

- Family-centered discussions
- Multi-faceted assessments

2. Build Partnership Relationships

- Setting personal & clinical goals
- Shared decision making
- Plan care/link with community

3. Co-create the CICP

- Medical Summary
- Documented & shared Goals with "Negotiated Actions"
- Emergent & Legal Attachments

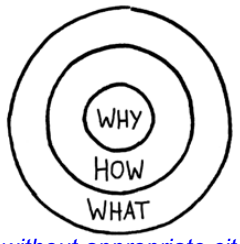
4. Care Jointly with Continuity

- CICP implementation
- CICP oversight; track & monitor
- CICP evaluation; update/renew

Implementation

Why? Led Us to "Core People"

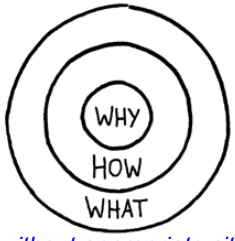
- **Part 1: Core People Children and Youth, Families, Health Providers and Community Partners**
  - CICP Core People 1.1
    - Establish a Partnership to Create and Implement a CICP
  - CICP Core People 1.2
    - Educate clinicians and staff about the CICP
  - CICP Core People 1.3
    - Educate youth and families about the CICP.



How?
Led us to CICP "Core Processes"

CICP Core Processes

- 2.1 Declare and implement a family-centered care planning process.
- 2.2 Identify child, youth and family needs, strengths and preferences.
- 2.3 Guide youth and families to articulate their goals
- 2.4 Use goals to guide the creation, review, updating and revisions of the CICP.
- 2.5 Use the CICP implementation process to deliver continuous team-based *care coordination*
- 2.6 Use the CICP to ensure safe, seamless transitions of care.
- 2.7 Make access to the CICP possible and practical

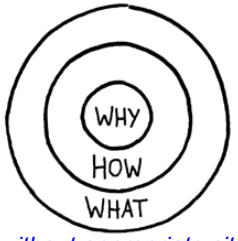


CICP Supported by IT Features (2.8)

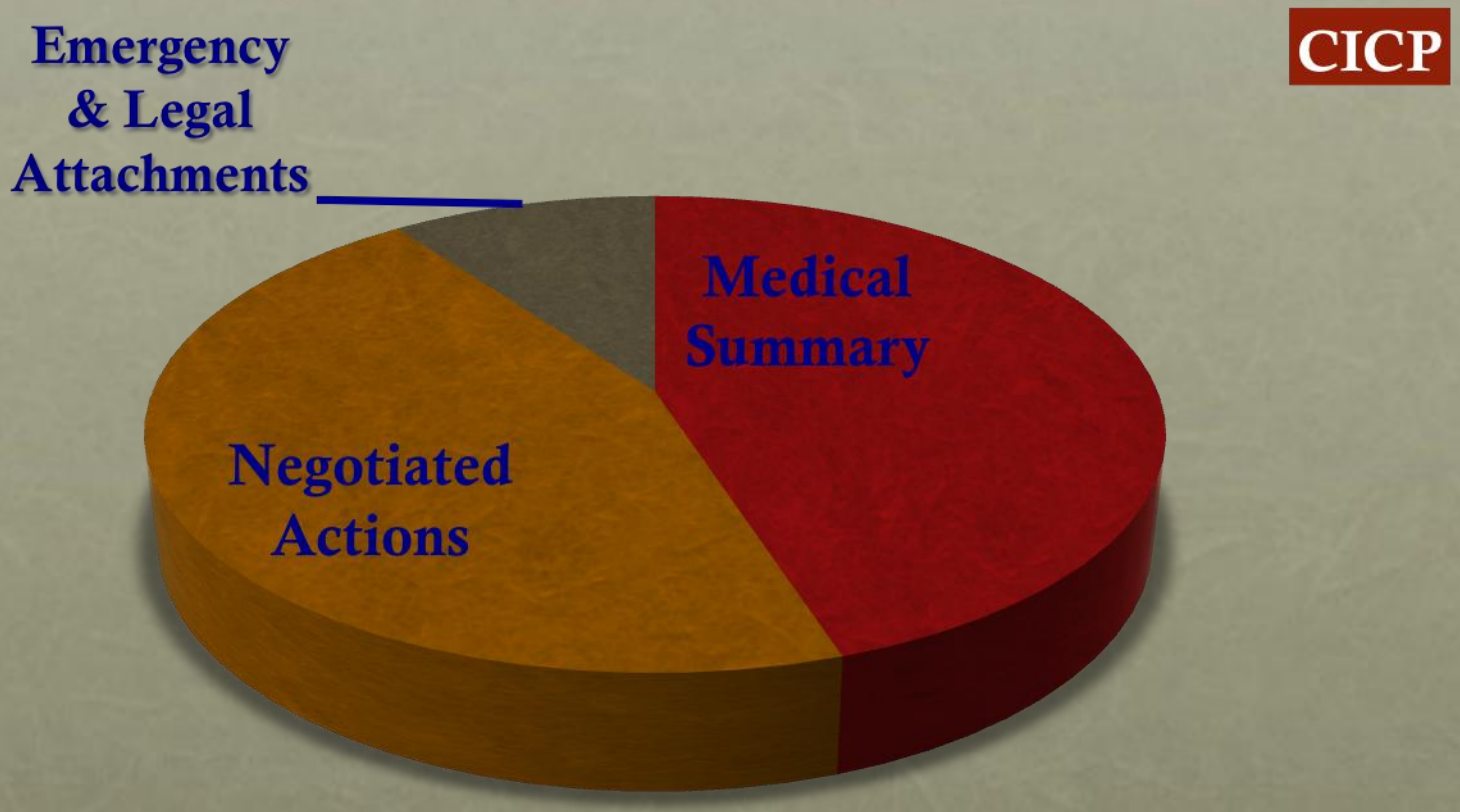
- **Use the full power of health information technology** to proactively
  - a) enable goal setting across multiple persons (including parents and medical providers) and
  - b) support essential care coordination functions.
- The CICP must draw upon electronics to back up the team/family with personalized and timely alerts and information, monitoring of care goals (unobtrusively), and tracking of actions to achieve both personal and clinical goals.

What? Led Us to "Core Tools"

- CICP Core Tools 3.1
  - The Medical Summary
- CICP Core Tools 3.2
  - Negotiated Actions are easily identifiable and extractable within the medical record (electronic preferred).
- CICP Core Tools 3.3
  - Specialty Condition, Emergency and Legal Attachment



Tools = What?
Core Components of the CICP



Supplemental Care Coordination Team Strategies and Supports

- Care Conferences (individual)
- Care Coordination Rounds (population)
- Eco Maps
- Community partnerships/ communication
- Position Descriptions
- Cultural Leader Positions
- **Workflow chart (handout "care loop")**

	Partnership Roles	Pre-Visit Activities *Anticipation*	Visit Activities *Care Partnership Support*	Post Visit Activities *Accountable Follow Through*
Family- Centered Team-Based Partnership Achieves Comprehensive Integrated Care Plan (CICP)	Care Coordination/Care Coordinator	- Reach out to family - Complete a pre visit assessment - Review priorities - Review CICP progress/gaps - Huddle with team - Communicate/share	- Assess and discuss needs, strengths, and priorities - Educate/share information - Inform CICP in real time - Facilitate communication - Set time for next visit/contact	- Update/share CICP and implement accountable tasks - Ensure communication loops, quality access, and resource contacts - Foster care partnership support with the family - Repeat accordingly
	Youth/ Family	- Prepare - review recent events, lessons, expectations, goals, and hopes - Review CICP for progress, gaps, successes/failures, and questions - Prioritize topics for visit	- Share priorities - Discuss care options - Contribute to CICP development/renewal - Acquire any needed care giving/ self care skills - Offer feedback & ideas - Set time for next visit/contact	- Access and communicate with team as want and/or need - Review care information/instructions - Use, share, implement CICP with partners - Complete tasks responsible for - Repeat accordingly
	Pediatric Clinician	- Huddle with team; consider pre-visit assessment data - Review CICP /other data, and/or - Identify the need for CICP - Attend to team readiness for prepared/planned visit	- Meet with family; engage them with the medical home core team - Complete assessments - listen, learn, partner, and plan - Evaluate & recommend for clinical/family bio-psychosocial and functional goals - Develop/update CICP jointly - Link to referrals/resources - Set time for next visit/contact	- Update/implement CICP; complete accountable tasks - Monitor communications - Huddle with team - Help guide team conferences - Supervise continuous care coordination and ensure CICP oversight - Repeat accordingly

Figure 1. Comprehensive Integrated Care Plan (CICP): Practice Workflow *Example*

Team Person/Roles	Pre Visit Activities Anticipation	Visit Activities Care Partnership Support	Post Visit Activities Accountable Follow Through
Care Coordinator	*Pre Visit Activities* ***CICP***	*Visit Activities* ***CICP***	*After Visit Activities* ***CICP***
Youth/ Family	*Pre Visit Activities* ***CICP***	*Visit Activities* ***CICP***	*Visit Activities* ***CICP***
Pediatric Clinician	*Pre Visit Activities* ***CICP***	*Visit Activities* ***CICP***	*Visit Activities* ***CICP***

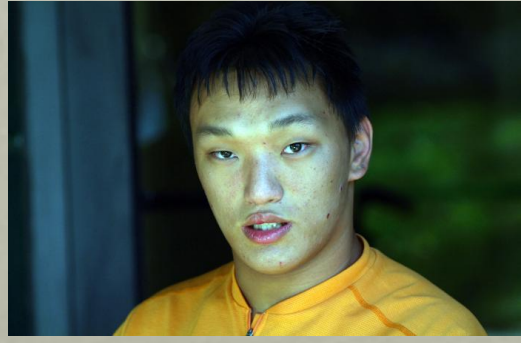
Figure X. Planned Coordinated Care – Defined Workflow Descriptors

Workflow

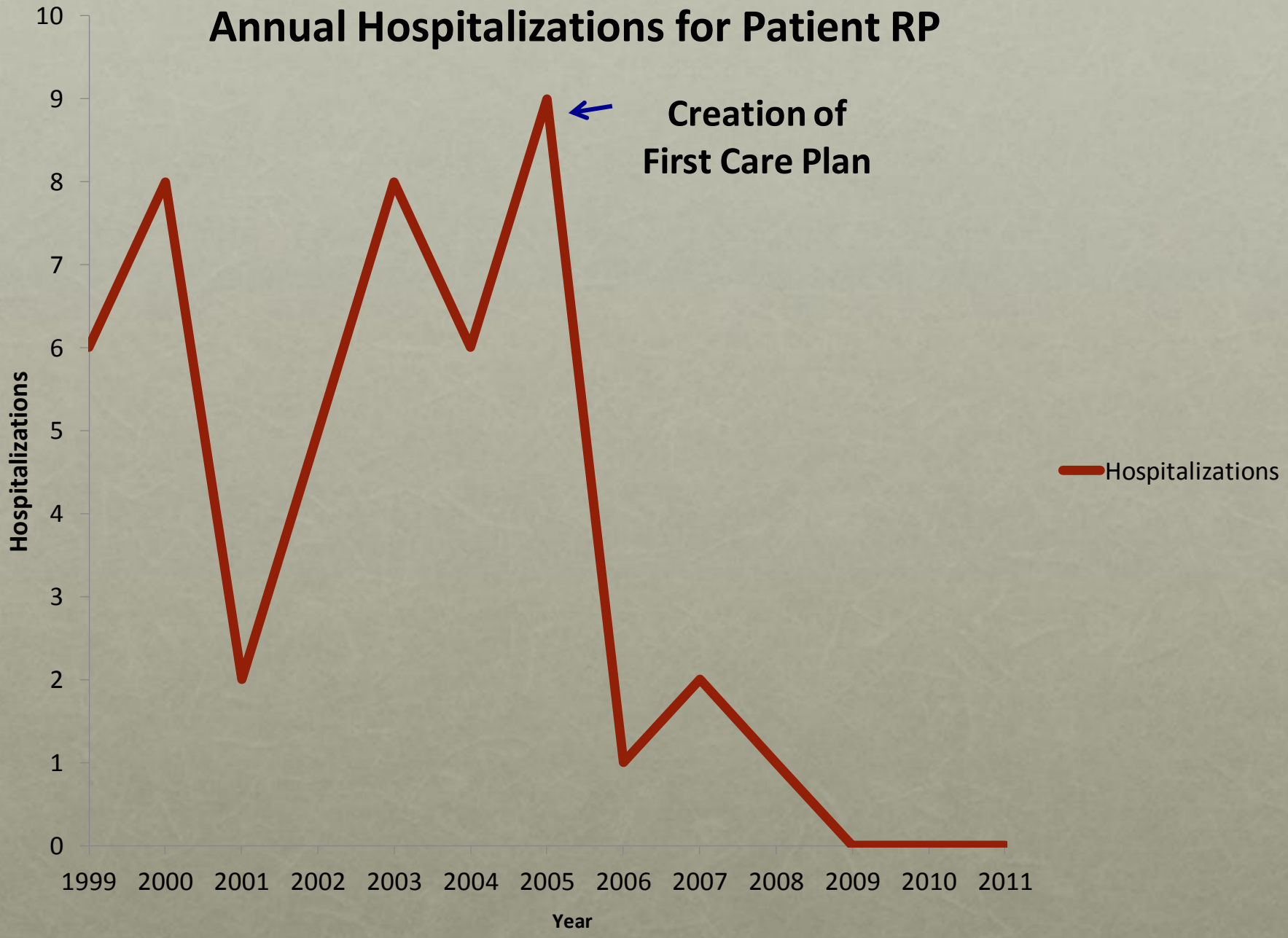
- Is your workflow clear now for the team?
- Why/how would you integrate CICP process into your workflow?

Triple Aim Metrics Goals:	Measures	Tools
Better Care		
Better Population Health		
Better Per Capita Cost		
Enhanced Family Outcomes		
Enhanced Provider Outcomes		

RP'S STORY



- Severe intractable epilepsy
- Failed medical and vagus nerve stimulator therapy
- Not a candidate for epilepsy surgery
- Creation of Care Plan, including Emergency Care Plan, marked the beginning of seizure control
- Last seizure 4/18/08, with pneumonia



Whitney is a 15-year-old female, who on her best days dreams of getting her drivers license.

- She presented to the emergency room with a history of longstanding, uncontrolled Type1 Diabetes. Compounding social factors also contributed to numerous school absences and truancy charges.
- During the 6-month period (prior to switching to an medical home equipped (including care coordination, care conferences and CICPs), Whitney had 9 ER visits and 7 hospitalizations for ketoacidosis.
- *The table summarizes the interventions, shared goals, and mutual actions of her team identified team (teen, family, medical home team, specialist and school/community partners); and also reveals outcomes 10 months later.

Patient, Family and Team Goal	CICP Negotiated Actions Discussion	Process and Outcome Measures
Overall Aim: •Effective control and management of Type 1 Diabetes •Improved communication, collaboration coordination among teen, family, clinicians & school team.	• Support of teen and family to achieve goals • Enroll in a highly functioning medical home • Engage with the care coordinator • Hold/attend care conferences • Develop a CICP; include endocrinologist input in the emergency plan (when and when not to admit teen to hospital according to need and/or blood glucose levels) • Align all coordinating partners with CICP goals • Increase contact between medical home and school with frequent communications and collaboration • Overcome (persistent) communication and transportation barriers to establish regular counseling	✔ Access to medical home care ✔ Actively engaged with a care coordinator ✔ Care conference regular attendance ✔ Accessible shared CICP with medical summary, goals with negotiated actions and emergency action plan attached. ✔ Increased contacts for regular communication ✔ Teen receiving regular counseling
1) Transition to insulin pump (pending Diabetes control) 2) Obtain a drivers license 3) Improve school attendance/performance	• Work with Diabetes educator every other week • Work with Dietician every other week	1) A1C and overall glucose "drastically improved" 2) Pump still pending 3) Decreased school absenteeism, school nurse office visits reduced, and classroom time increased.
Reduce Utilization of ER and Hospital: #ER visits # Hospitalizations	**Results:**	During 6 months prior to onset of care coordination, there were 9 ER visits and 7 hospitalizations for DKA. For 10 months following creation of the CICP and onset of care coordination, 2 ER visits and 0 diabetes related hospitalizations occurred.

Medical Home - Easy?

Getting there day by day with:

- **Quality Improvement**
- **Family Centered Care**
- **Teamwork**
- **Care coordination with CICP**

Patient & Family-Centered Medical Home

Across the life course for children, youth and adults

To keep you going remember - drivers, assumptions, 4 key attributes, CICP and … Tomatoes, Pilgrims and the Mayflower