


The Medical Home and Palliative Care: Won't you be my neighbor?

Fall Conference
October 5, 2018
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pa pennsylvania

Overview

- Describe changes that have occurred in pediatric palliative care over the past decade.
- Describe the medical home model, in theory and how it is implemented in current practice.
 - PA Medical Home Program
- Analyze the opportunities and barriers to implementing pediatric palliative care via the medical home model.




Medical Home History Timeline

1967	2002	2007	2010	2018
Standards of Child Health Care <i>Repository for patient records Dr. Cal Sia et al.</i>	Medical Home Policy Statement <i>AAP Advisory Committee</i> <i>IOM Report</i>	Joint Principles Statement <i>PA Governor's Chronic Care Commission</i>	Medical Home Recognition <i>20 Bills promoting medical home in 10 states.</i> <i>ACA signed 3/23/10</i>	Family Centered Care Quadruple Aim <i>PCMH Committee</i>
<i>1987- Surgeon Gen Conference</i>	<i>PA Medical Home is born!</i>		<i>Medical home in CMS establishing ACOs.</i>	

Principles of the Medical Home

The medical home is best described as a model or philosophy of primary care that is:

- ◆ Patient and Family centered
- ◆ Comprehensive
- ◆ Team-based
- ◆ Coordinated
- ◆ Accessible
- ◆ Focused on Quality and Safety



Patient Centered Primary Care Collaborative (PCPCC), www.pcpcc.org


Medical Home Care Components

The American Academy of Pediatrics, with support from the Maternal and Child Health Bureau, has defined 9 core elements of the medical home:

- Family-centered
- Comprehensive
- Continuous
- Coordinated
- Compassionate
- Community-based
- Culturally-competent
- Accessible
- Environment of trust and mutual responsibility


-Pediatrics 2002






Pennsylvania Medical Home Initiative

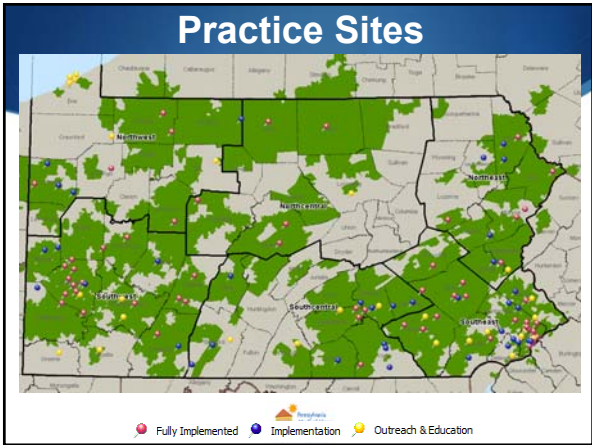
Educating Practices In Community Integrated Care



PA Medical Home Initiative

- ◆ Quality improvement initiative- 2001
- ◆ Funded: PA DOH Title V & HRSA
- ◆ PAAAP Chapter
- ◆ Goals:
 - ◆ Support QI/practice transformation
 - ◆ Incorporate family centered care
 - ◆ Promote care coordination and integration
 - ◆ Develop data collection methods
 - ◆ Ensure financial viability
 - ◆ Foster high quality, efficient health care delivery





Evidence Supporting Medical Home

- ◆ Improves;
 - ◆ Overall patient/family satisfaction
 - ◆ Quality of care
 - ◆ Health care utilization
 - ◆ Medical errors (fewer)
 - ◆ Coordination of care
 - ◆ Efficiency and access to care
 - ◆ Racial and ethnic disparities in care


Schoen et al. 2007; Homer et al. 2008; Cooley et al. 2009; McAllister et al. 2009; Stille 2013; Turchi 2014; Kuo et al 2017



Evidence Against Medical Home

- ◆ Multi-payer Pilot in PA
 - ◆ Asthma and Diabetes
 - ◆ Funding by payers
 - ◆ NCQA certification
 - ◆ Modest if any positive outcomes

JAMA 312 (4):2014



Quadruple Aim




Don Berwick, IHI

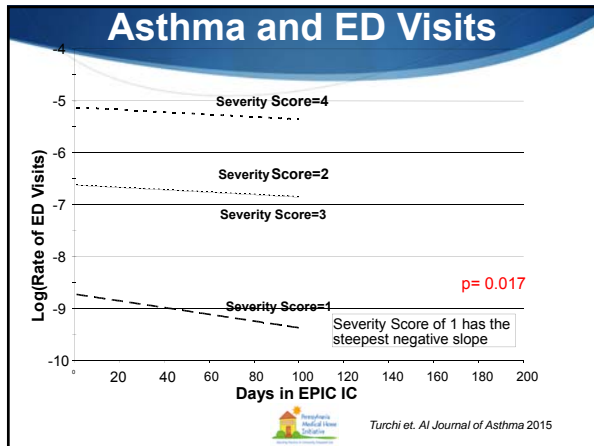


Medical Home Implementation

- ◆ Identify the team in the practice
- ◆ Identify and engage Parent Partners
- Schedule regular team meetings
- Implementation guides and assessments
- Create a process to identify special needs patients
- Huddles
- Care planning/mapping
- Work with community resources/partners
- Care integration
- Policy changes

(Turchi et. al, 2006)





Care Coordination

Care Coordination is the set of activities in "the space between"- Visits, Providers, Hospital Stays
Turchi RM, Antonelli RC et al. Patient- and Family-Centered Care Coordination: A Framework for Integrating Care For Children and Youth Across Multiple Systems. *Pediatrics*. May 2014.

Integrated Care

seamless provision of health care services, from the perspective of the patient and family, across entire care continuum.
It results from coordinating the efforts of all providers, irrespective of institutional, departmental, or community-based organizational boundaries.

Antonelli, Care Integration for Children with Special Health Needs: Improving Outcomes and Managing Costs. National Governors Association Center for Best Practices, 2012

Pediatric Medical Home logo at the bottom.

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Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems
COUNCIL ON CHILDREN WITH DISABILITIES and MEDICAL HOME IMPLEMENTATION PROJECT ADVISORY COMMITTEE
Pediatrics; originally published online April 28, 2014;
DOI: 10.1542/peds.2014-0318

Pediatric Medical Home logo at the bottom.

Medical Home Team

- ◆ Families
- ◆ Parent Partners
- ◆ Youth
- ◆ Physicians
- ◆ Nurse Practitioners
- ◆ Physician Assistants
- ◆ Specialty Physicians
- ◆ Nurses
- ◆ Social Workers
- ◆ Administrators
- ◆ Office Staff
- ◆ Grant Office
- ◆ Community Partners
- ◆ Educators




Teams come together as one...

TABLE.

The Interdisciplinary Pediatric Palliative Care Team

Patient, parents, and siblings	Child life specialist
Primary care physician	Pastoral care
Registered nurse/home health nurse	Case manager
Social worker	School tutor
Child psychologist	Physical/speech/occupational therapist
Psychiatrist	Subspecialty physicians

Source: Dripathi SS, et al. Reprinted with permission.



Challenges in Medical Home and Palliative Care

- ◆ Who is the Quarterback (Wentz)?
- ◆ Access and payment
- ◆ Timeliness of referral
- ◆ Medications
- ◆ Shift/home nursing
- ◆ Parent request/goals
- ◆ Many health care providers/ partners
- ◆ Complicated medical history
- ◆ Multiple specialty appointments
- ◆ Communication consistency






Opportunities for Medical Home and Palliative Care....

- ◆ Beyond hospice
- ◆ Meeting patients' and families' needs
- ◆ Meeting families' and patient goals....improved experience
- ◆ Shared plans of care
- ◆ Learning from each other
- ◆ Understand responsibilities
- ◆ Improved patient and family outcomes
- ◆ Better quality of life
- ◆ Address the quadruple aim.....



PA MHI: Family Survey

- Surveyed families from PA MHI Network of 156 practices in PA
- N=3,253 unique parents/caregivers surveyed
- Domains:
 - Access to care
 - Care integration
 - Satisfaction and patient/family experience
 - Health care utilization
 - Family centered care
 - Transition to adult oriented system
 - Cultural & linguistic competence




PEDIATRICS PERSPECTIVES

Incorporating Patient- and Family-Centered Care Into Practice: The PA Medical Home Initiative

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PEDIATRICS Volume 142, number 3, September 2018:e20172453




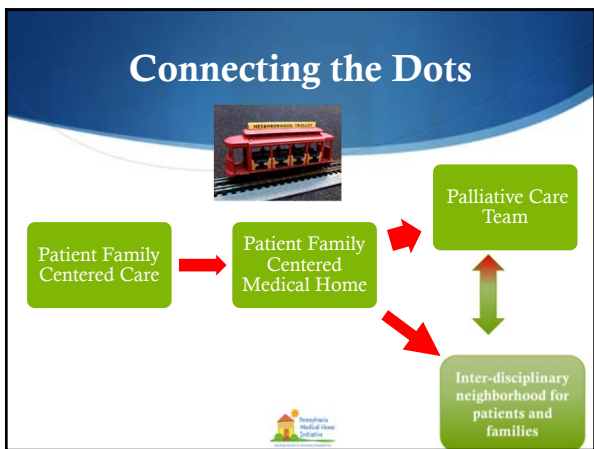
Goals of Team work across Medical Home and Palliative Care

- ◆ High quality care
- ◆ Better patient outcomes
- ◆ Care coordination
- ◆ Patient and family centered care
- ◆ Improved family, provider and staff satisfaction/retention



Families are key members of the team












Our Study



- ◆ Children with special health care needs are at high risk for severe health consequences when disasters strike
 - ◆ Physical disabilities, reliance on assistive technology
 - ◆ Intellectual disabilities, autism spectrum disorders, communication challenges
 - ◆ Chronic illnesses
- ◆ Identify and address unique disaster information needs and preferences
 - ◆ Content needs – what do people need to know?
 - ◆ Trusted sources – from whom?
 - ◆ Preferred ways to get information – how?
- ◆ Develop and evaluate materials for families, providers, emergency response agencies, based on findings, types of disasters

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Respectful Medical Care Initiative

What We Need From You



- ◆ Your perspective on communication needs of patients with special health care needs
 - ◆ Your capacity to provide information to patients before, during, and after disasters ("trusted intermediary" role)
- ◆ Provider Survey
 - ◆ Included in your packets
 - ◆ Please fill out and return to us before leaving today
- ◆ Focus Groups
 - ◆ Conducted this morning during registration
- ◆ Recruiting Patients for Interviews
 - ◆ Flyer included in your packets
 - ◆ Distribute to families with children with special health care needs in your practice

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Respectful Medical Care Initiative

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