MIPCT Opening Remarks

- The purpose of this webinar is to prepare for the face to face meeting on September 17, 2014. We want to use our time together in September to learn from each other. So background information will be presented in webinar format to minimize lecture time on September 17.

Gearing up for September 17

Jane Turner, MD

August 15, 2014

Presenter Introductions

- **Jane Turner, MD**
  - Professor, Pediatrics and Human Development, Michigan State University
  - Assistant Medical Director, Office of Medical Affairs & Chief Medical Consultant, Children's Special Health Care Services, Michigan Department of Community Health
  - **Pediatric Gadfly of MiPCT**

Objectives

- Describe key components of the AAP policy on Family-Centered Care Coordination
- Discuss the continuum between population health and individual health and the role of the care manager in promoting both
- Connect our own experiences to the 5 Ds of pediatrics and see how the 5 Ds are reflected in MiPCT
- Prepare for September 17

Lynn's story

- 12 year old broke both ankles
- No surgery but no weight bearing for 6 weeks
- Braces, crutches, shower chair, walker, elevated toilet seat, wheelchair, walker and temporary ramp
- Couldn't bend his legs – hard to get in and out of car
- In-home PT, OT and home-schooling

CM intervention

- Authorizations for durable medical equipment
- Advice about the medical condition – red flags of complications
- Emotional support for mother
- He became depressed due to isolation – missing school, sports and friends
- Lynn suggested to mother that she talk to his teacher about his sadness
- Teacher and students arranged a schedule for visiting

Outcome

- Engagement in school work and therapy improved
- Good healing, braces removed at six weeks
- He continues to work with PT and OT

Is this an example of care management?

AAP policy statement

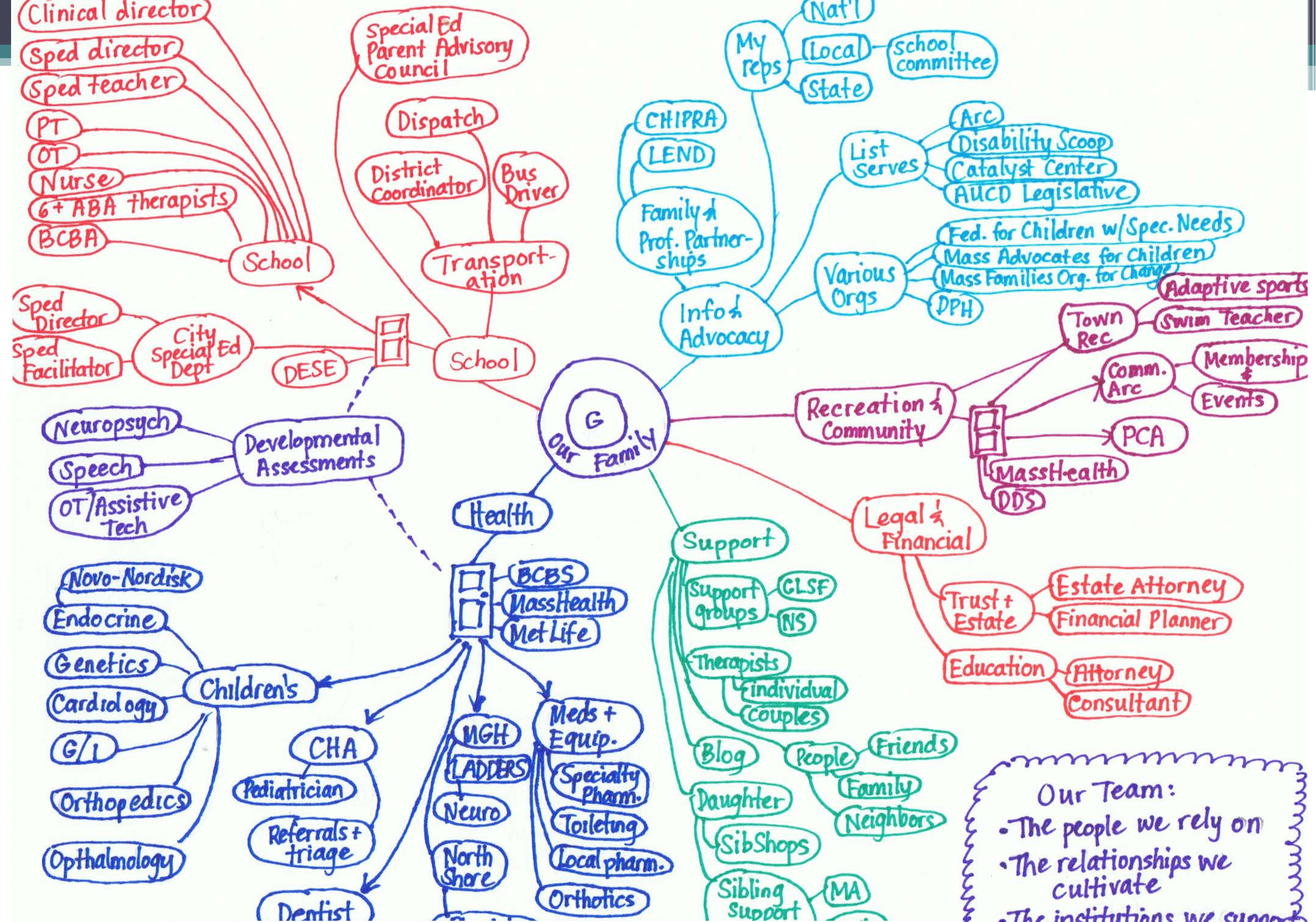
- Published in *PEDIATRICS* in May 2014
- Authors include Richard Antonelli who also authored the "Pediatric Care Coordination Curriculum"
- Emphasis on integrating care across multiple systems.

Care coordination definition

Pediatric care coordination is a patient- and family-centered, assessment driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes.

Care coordination

- is to be distinguished from disease or case management which primarily focuses on patients' medical issues.
- 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.



http://live.huffingtonpost.com/r/segment/what-it-takes-to/50f97e3dfe34447bd30002f3

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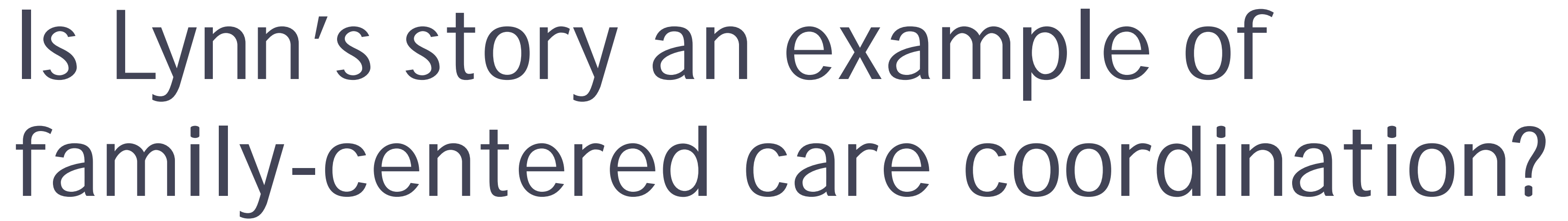

Is Lynn's story an example of
family-centered care coordination?

A Framework for High Performing Pediatric CC

Care Coordination Competencies:

1. Develops partnerships
2. Proficient communicator
3. Uses assessments for intervention
4. Facile in care planning skills (PFC)
5. Integrates all resource knowledge
6. Possesses goal/outcome orientation
7. Approach is adaptable & flexible
8. Desires continuous learning
9. Applies solid team/building skills
10. Adept with information technology

Care Coordination Functions:

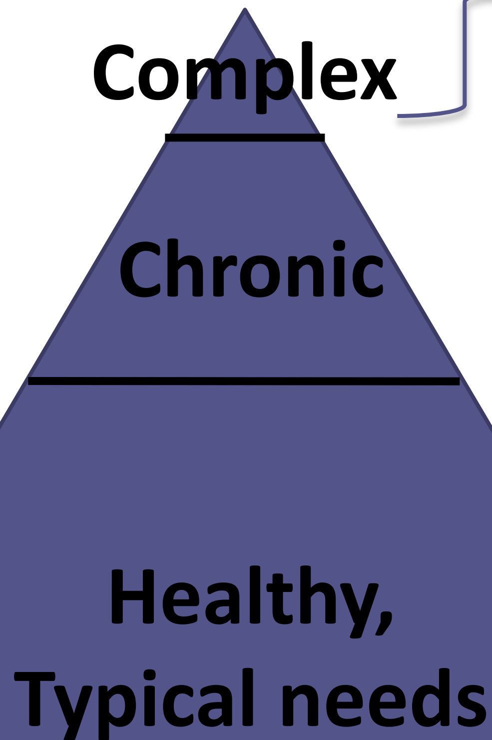
1) Provide separate visits & CC interactions
2) Manage continuous communications
3) Complete/analyze assessments
4) Develop care plans (with family)
5) Manage/track tests, referrals, & outcomes
6) Coach patient/family skills learning
7) Integrate critical care information
8) Support/facilitate all care transitions
9) Facilitate PFC team meetings
10) Use health information technology for CC

Antonelli, McAllister, Popp. **Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework**. The Commonwealth Fund, May 2009

Population health

- "the health outcomes of a group of individuals, including the distribution of such outcomes within the group". American Journal of Public Health 2003 Mar;93(3):380–3. Retrieved 2008-10-12
- Think about the population of children and youth served by your practice – and sub populations within the practice.

Population of children



Children with complex needs

--Neurodevelopmental (Autism, etc.)
--Behavioral/Psychiatric
--Oncology
- Sickle cell
- Hemophilia

--Technology dependent

Children with chronic conditions

--Behavioral (ADHD, depression, anxiety, PTSD)
--Asthma
--Diabetes
--Obesity

Individual health to population health

- Physician refers a 14 year old to you because she is depressed.
- Practice screens all youth 11 – 20 years old with the a validated screening at health maintenance visits.
- Medical assistant runs reports to identify youth who have not come for health maintenance and calls family to make an appointment.

Population to individual

- All the youth in the practice 11 years and older come for health maintenance visits.
- Every youth completes the PHQ2;
- Anyone with a score of 3 or above gets the PHQ9
- Physician/NP/PA assesses likelihood of depression based on PHQ and **other cues**
- Youth at risk for depression are referred to CM
- CM works with youth and family to arrange appropriate services
- Physician/NP/PA treats medically if indicated

The difference between the FCMH of pediatrics and the PCMH of adult medicine: The 5 Ds:

- **D**evelopmental trajectory
- **D**ependence on adults
- **D**ifferential epidemiology of chronic disease
- **D**emographics of poverty and diversity
- **D**ollars spent

Developmental trajectory

- Developmental screening using a validated tool
- Referrals to Early On
- Working with schools
- Coordinating care of children with autism spectrum disorders.

Dependence on adults

- Social workers as care managers
  - 20 % of pediatric CM are MSW
  - 9.6% of family medicine CM are MSW
  - 11.4% of adult medicine CM are MSW
- Interest in topics about guardianship, foster care, custody, extended family.

Differential epidemiology

Table 1. Patient and Care Manager Demographics by Practice Type

[CT1] I am going to check these numbers – they look off

	Practice Type		
	Pediatric	Family	Adult
MiPCT Practice and Patient Demographics *			
Total number practices	50	180	128
Total number of patients	114,255	499,834	254,139
High risk patients	**6.5%**	**25.8%**	**39.2%**
Utilization (average visits/member/6 months)			
ED	1.3	1.4	1.4
Hospital inpatient	1.1	1.2	1.3
Top three chronic disease diagnoses **	**ADHD (10.4%)**	**HTN (24.8%)**	**HTN (40.2%)**
	Asthma (10.3%)	**Diabetes (10.2%)**	**Diabetes (15.2%)**
	Obesity (5.1%)	**Obesity (8.4%)**	**CAD (13.1%)**

Demographics

- Children are poor
- About 25% of children in Michigan live in poverty
- More than 50% of children in MiPCT are insured by Medicaid in contrast to 5% of the patients in adult medicine practices. Family medicine is midway with 23% covered by Medicaid.

Dollars

- Overall, we spend less on health care for children than for adults.
- Mean cost per member per year:
  - Pediatric $2000
  - Family practice $4600
  - Adult medicine $6000

September 17 meeting

- Focus on **working in systems**
- Principles of **family-centered care coordination**

Working in systems

- Strategies to work with your practice team
- Working with agencies in your community
  - Community Mental Health
  - Medicaid Health Plans
  - Local Health Department
  - Schools
- Identify those who will benefit most from CM
- Resources to help with transition to adulthood

Family-centered care coordination

- Family/professional partnership
- Resources available to families
- Strategies to work effectively with families
  - Work with families – not to and not for
  - How to negotiate priorities when family and professionals do not agree

Format

- Brief presentations to the whole group
- Small group discussions facilitated by a family representative and a pediatric professional
- Case based learning:
  - Asthma
  - NICU grad with complex issues
  - Autism Spectrum Disorder
  - Depression

Taking care of ourselves

How do we keep our spirits up when there is too much to do in too little time and we work with families with huge needs and a system that is broken in so many ways?

Summary:

- Key components of Family-Centered Care Coordination according to the AAP
- The continuum of population health and individual health and our role in promoting both
- What we have learned from MiPCT about the difference between FCMH of pediatrics and PCMH of adult medicine (those 5 Ds)
- Plans for September 17

Next Webinar: October 17

- There will be no webinar in September since we will have our face to face meeting.
- The topic of the October webinar will be determined after we hear from you in September.

Questions for Dr. Turner

- **At this time we will unmute those with raised hands to provide an opportunity to ask questions or make comments.**