Advancing the Maternal & Child Health VISION

# Parent Professional Partnerships in Medical Homes and Health Reform

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## THE PARADIGM SHIFT

- States and local governments are mandated to ensure access to care that is person/ family-centered, easy to use, culturally competent
- States and local governments are decreasingly direct service providers
- Affecting CHANGE
  - Contracting versus Integrating Parents

RHODE ISLAND DEPARTMENT OF HEALTH → → → → RIPIN

Administered by----------Contract to Provide----------Family Resource Specialist Services

**RI's Medical home Initiative is launched!**

***The Pediatric Practice Enhancement Project (PPEP) was developed to enhance Medical Homes in RI.***

## Where do families go for Information and support?

•Parents/Families with CSHCNs go to their doctor as a trusted source of information
•Parents/families seek each other for information, as those who know resources and have unique knowledge of navigating systems

***The PPEP Model blends the where families go for accurate information and places and pays for trained Family Resource Specialists in Medical Homes throughout RI.***

**2004: 8 practices – primary care**
**2006: 20 practices – primary and specialty care**
**2008: 24 practices – added healthcare centers**
**2013: 30 practices; 15 agency based; 5 resource center**

**Who are the Family Resource Specialists?**
Parents and family members who have CYSHCNs and individuals with SHCNs who have experience in navigating the complex systems of care in Rhode Island. This experience includes knowledge of resources: from information re: basic needs (food, shelter, clothing) to accessing the appropriate insurance plan or specialty evaluation.

**How does the FRS meet families?**
•Referrals from physicians, staff, other families, meet in waiting room, health plan referral, coordinated chronic condition workforce partner referral

**Where are the FRS located?**
•They are located in the physician's offices, at RIPIN or other community based organizations, and at health plans

**What does the FRS do?**
•Addresses the needs of the child and family: education, health insurance, basic needs
•Follow up on referrals to specialists

***We <u>did not</u> create any new services and program – we coordinated and linked to existing supports, services and programs***

## How do we measure success?

Individual Level Evaluation

- Demographics / General Information: Age, Diagnosis, Race, Ethnicity, # in Household, Problems Identified
- Process Measures: Activity Type, Activity Location, Activity Content, Time Spent
- Outcomes: Goal Achievement, CEDARR Referrals, Referrals Made & Type, Utilization Analysis

In 8 years:

√ Served nearly 9000 CYSHCN and their families
√ Had 35,094 contacts with families
√ Addressed 22,020 family concerns
√ Assisted families in achieving 89% of concerns
√ 40 Resource Specialists are currently working on 750 concerns
↑ Understanding of service system
↑ Satisfaction with care
↑ Feel empowered & supported
↔ Change in utilization of health care

√ Categories of Problems Addressed:

**22% Education**
**19% Mental / Behavioral Health**
**17% Specialty Evaluation**
**9% Health Insurance**
**7% Recreation / Social**
**7% General Parenting**
**5% Housing**
**4% Food / Clothing**
**4% Nutrition**
**3% Medical Equipment**
**3% Child Care**



## Practice Level Evaluation:

- Identification of CSHCNs within practice
- Track and monitor CSHCNs
- Practitioner productivity
- Comprehensive service delivery / provision

## Practice Level Results:

**↑ Physician Productivity**
**↑ Patient Satisfaction**
**↑ Physician Satisfaction**
**↑ Comprehensive Care**
**↑ Knowledge of System**
**↓ Family Wait Time**
**↑ FAMILY CENTERED CARE**



## System Level Evaluation:

- Systems Barriers Identified and worked on
- Integrated Service Delivery System for CSHCN and their families
- Practices Buying-In
- Recognition as a Reimbursable Service!

## System Level Results

CEDARR works better
Reduce Wait Lists
Increase in Family Education
Identified Need for Coordinated Information
INTEGRATED SYSTEM OF SERVICES
Peer Navigators in Community of Care
Health Insurance Exchange Partner
Consumer Assistance Program for ACA

## THE EVALUATION of PPEP

- Evaluation Partners: Center for Health Data & Analysis, Brown University, Neighborhood Health Plan of RI
- Conducted a utilization analysis
  - Pre-PPEP
  - PPEP
  - CSHCNs Non-PPEP
- Compared 3 groups of utilization of healthcare by location, outcomes and utilization cost (ED, inpatient, outpatient).

## PPEP Evaluation Summary

| | Total CYSHCN | ED Visit # (%) | Hospital Stay # (%) | OP Visit # (%) | Ave Cost Per CYSHCN |
|---|---|---|---|---|---|
| Pre-PPEP | 355 | 339 (95.5%) | 176 (49.6%) | 5,550 (15.6%) | $23,842 |
| PPEP | 353 | 262 (74.2% | 89 (25.2%) | 4387 (12.4%) | $14,593 |
| Std Care | 2,024 | 1,384 (68.4%) | 1,191 (58.8%) | 20,864 (10.3%) | $19,858 |

## Key Elements to Success

- Families have comprehensive needs that affects utilization of health care.
- Family workers / peer resource workers need to be supported (ie, paid, trained, supervised)
- Need a comprehensive system of care to address needs at all levels:
  - State / policy level
  - Practice / community level
  - Individual / family level

Opportunities for peer support under the ACA

- Consumer Assistance Program
- Patient Navigation
- Community Health Worker
  - Direct patient assistance
  - Attending to the social determinants that interfere with health
- Coordination of training
- System Support

## Questions? Comments

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