A Primary and Tertiary Care View of Co-management—Changing Attitudes and Systems

“Designing Systems That Work for Children with Complex Health Care Needs”

Lucile Packard Foundation, 2015 Symposium
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Cincinnati Children’s Hospital Medical Center
December 7-8, 2015
Essential Systems in Primary Care Medical Homes for Co-management in Chronic Conditions

- Relationships
- Ready Access
- Registry, Care Coordination, Planned Care
- Records (Electronic)
- Resources, internal and external
- Reimbursement
- Recruitment
Implementing Chronic Care Model

- Parent Advisors
- Self-Management support
- Registries for Population Mgmt
- Evidence-Based Care & Outcome Measurement
- Needs Assessment
- Care Management

Patient-Reported Outcomes

www.improvingchroniccare.org/
Changing Attitudes—
“a culture of collaborative care”

- Identify and connect allies and resources
  - personally
  - electronically
  - across domains

- Communicate explicitly - “what do I need to know to care for this child?”

- Clarify roles/responsibilities - Medical Home/Family/Specialists

- Maximize health, quality of life; prevent complications

- Support care beyond the encounter

- Focus on unique needs for Children with Medical Complexity
Changing Systems

- Population registries, stratified by need
- Bi-directional electronic communication
- Caring requires Person-support
- Innovative care (apps, Telehealth, e-visits, phone)
- Collect data on Outcomes/Value/Funding
- Make it easy to do the right thing
  - Standardize common processes
  - Provide decision support
  - Develop algorithmic care for triage and followup
- Commit to accountability
To co-manage care, we must...

- Know our patients, populations
- Communicate explicitly
- Partner with Families
- Work as a team, optimizing all skills
- Make Care Plan -- Choose Plan Leader
- “All teach, all learn”– empower and improve
- Share resources in the Medical Neighborhood
- Give evidence/consensus-based care at most appropriate site
- Measure and Improve Outcomes and Spending
- Innovate to build a patient-centric system
“My family, with all its challenges, is a success story, but part of that success is because we have had a Medical Home”... Libby
References: Chronic Care Model


• Partnership for Solutions: Johns Hopkins University, Baltimore, MD for The Robert Wood Johnson Foundation (September 2004 Update). "Chronic Conditions: Making the Case for Ongoing Care".

• *Health Aff (Millwood).* 2009 Jan-Feb;28(1):75-85. doi: 10.1377/hlthaff.28.1.75.Evidence on the Chronic Care Model in the new millennium. [Coleman K, Austin BT, Brach C, Wagner EH](http://www.jamesmandersandersoncenter.org)

References: Medical Home Model

- Berenson and Doty; Achieving Better Quality of Care for Low-Income Populations: The Roles of Health Insurance and the Medical Home in Reducing Health Inequities, Commonwealth Fund, May 2012