

# 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  
Jennifer Lail, M.D.

Cincinnati Children's Hospital Medical Center  
December 7-8, 2015

# Essential Systems in Primary Care Medical Homes for Co-management in Chronic Conditions

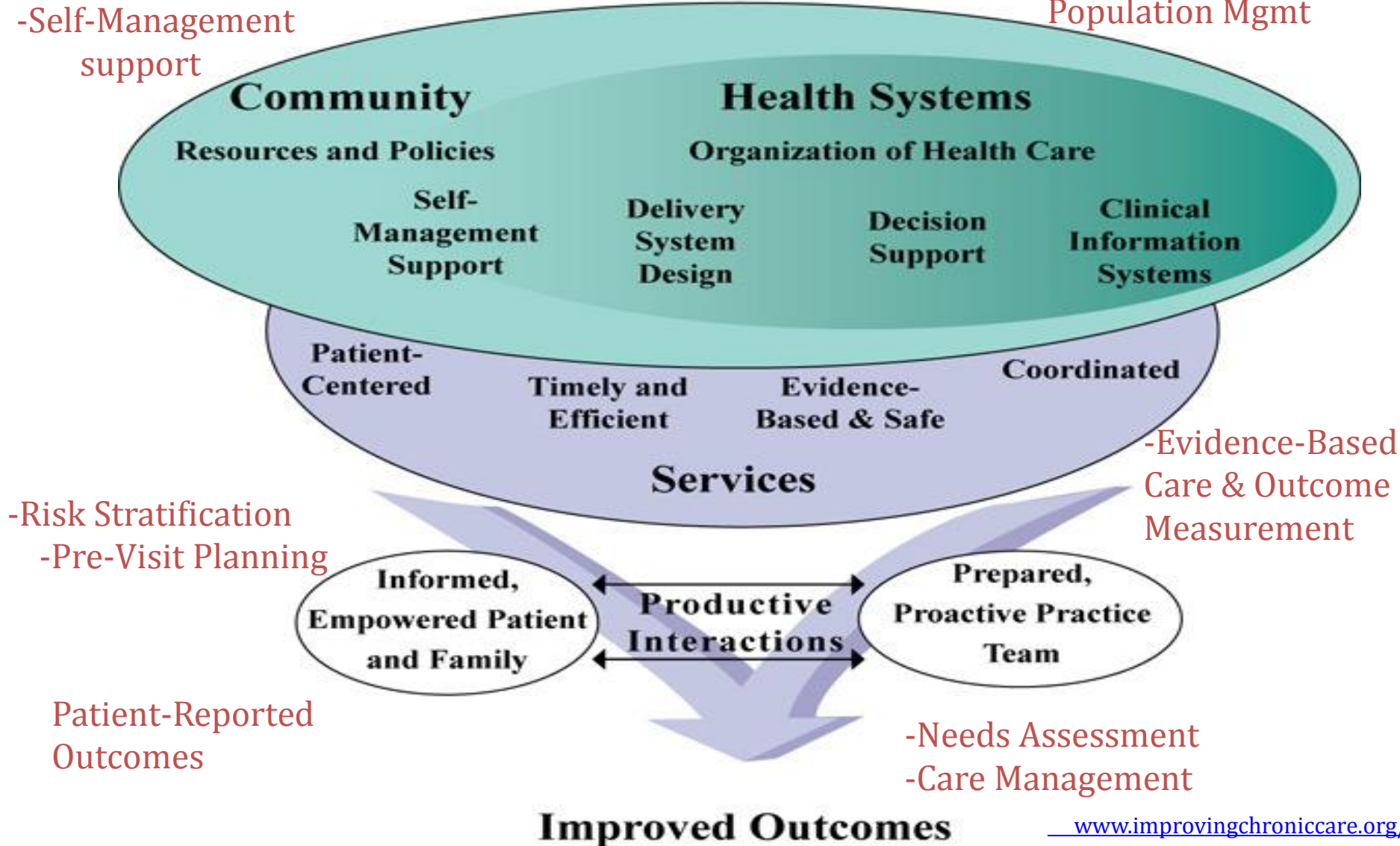
- Relationships
- Ready Access
- Registry, Care Coordination, Planned Care
- Records (Electronic)
- Resources, internal and external
- Reimbursement
- Recruitment



-Parent Advisors  
-Self-Management support

-Registries for Population Mgmt

**The Care Model**



# 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

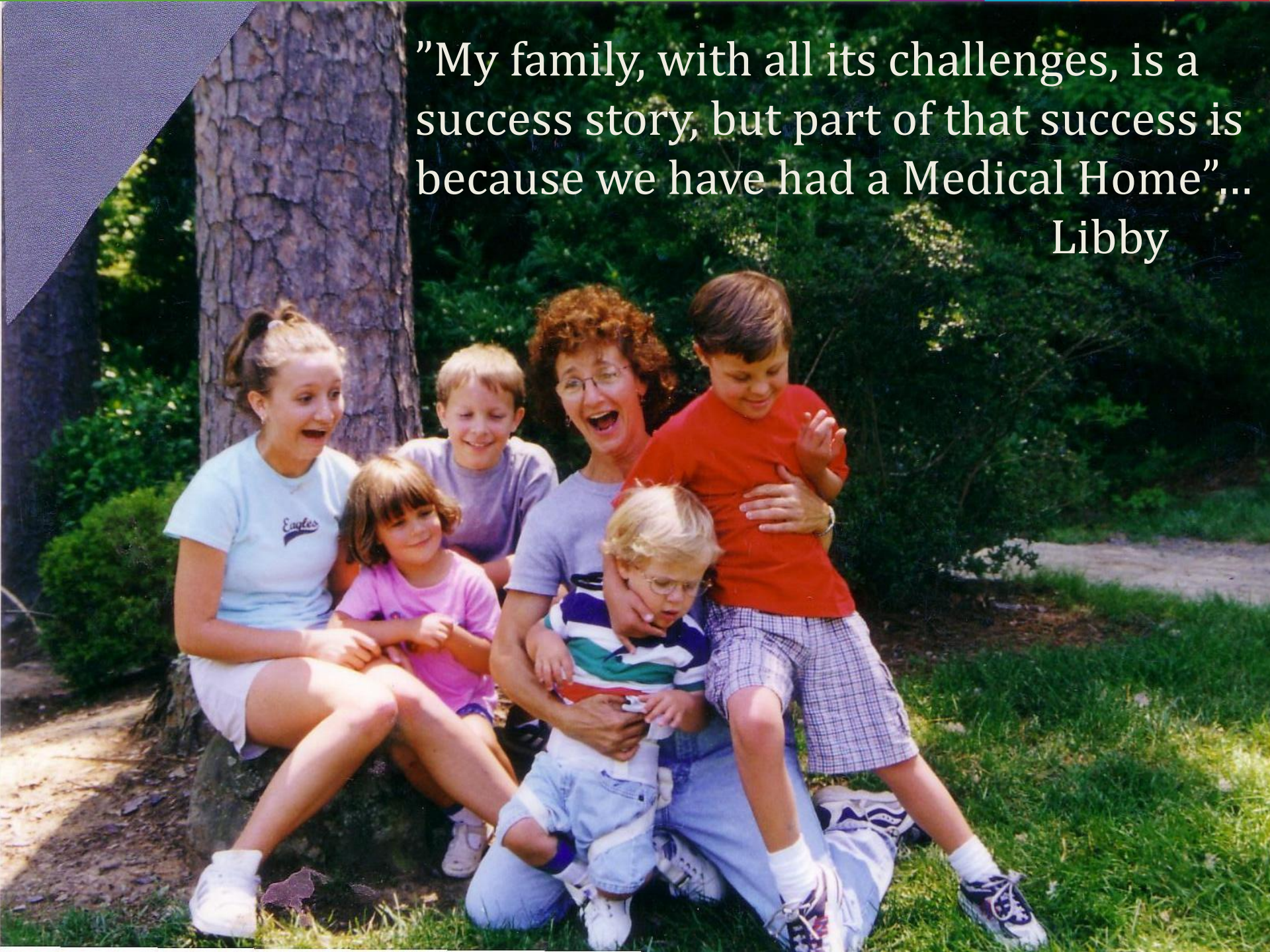
# To co-manage care, we must...

- 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

- Group Health Research Institute:  
[http://www.improvingchroniccare.org/index.php?p=The Chronic Care Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)
- 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](#)
- Ward BW, Schiller JS. Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey, 2010. *Prev Chronic Dis* 2013;10:120203. DOI: <http://dx.doi.org/10.5888/pcd10.120203>.



# References: Medical Home Model

- Palfrey, J.; The Pediatric Alliance for Coordinated Care and Evaluation of a Medical Home model. *Pediatrics*, Vol 118, May 2004
- Mandel, K.; Pay for Performance Alone Cannot Drive Quality. *Archives of Ped. Medicine*, Vol 161, July 2007
- Grant, R.; Healthcare Savings by using Guideline-based Asthma care in Pediatric Medical Home. *Journal of Healthcare for the Poor and Underserved*, Vol 21, May 2010
- Long, W.; Medical Home offers Benefits for Children without Special Needs, *Pediatrics*, Vol 129, Jan. 2012
- Strickland, B.; The Medical Home; Healthcare Access and Impact for Children and Youth in the United States. *Pediatrics*, March 2011
- Rosenthal and Abrams; Recommended Core Measures for Evaluating the Patient-Centered Medical Home: Cost, Utilization, and Clinical Quality. Commonwealth Fund, May 16, 2012.
- 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
- Ranking 37th — Measuring the Performance of the U.S. Health Care System; Christopher J.L. Murray, M.D., D.Phil., and Julio Frenk, M.D., Ph.D., M.P.H., *N Engl J Med* 2010; 362:98-99 [January 14, 2010](#)
- Sullivan, Katie; Fierce Healthcare Report: PCMH model leads to reduced cost of care, improved population health, PCPCC website, January 15, 2014  
<http://www.pcpcc.org/2014/01/15/report-pcmh-model-leads-reduced-cost-care-improved-population-health>