

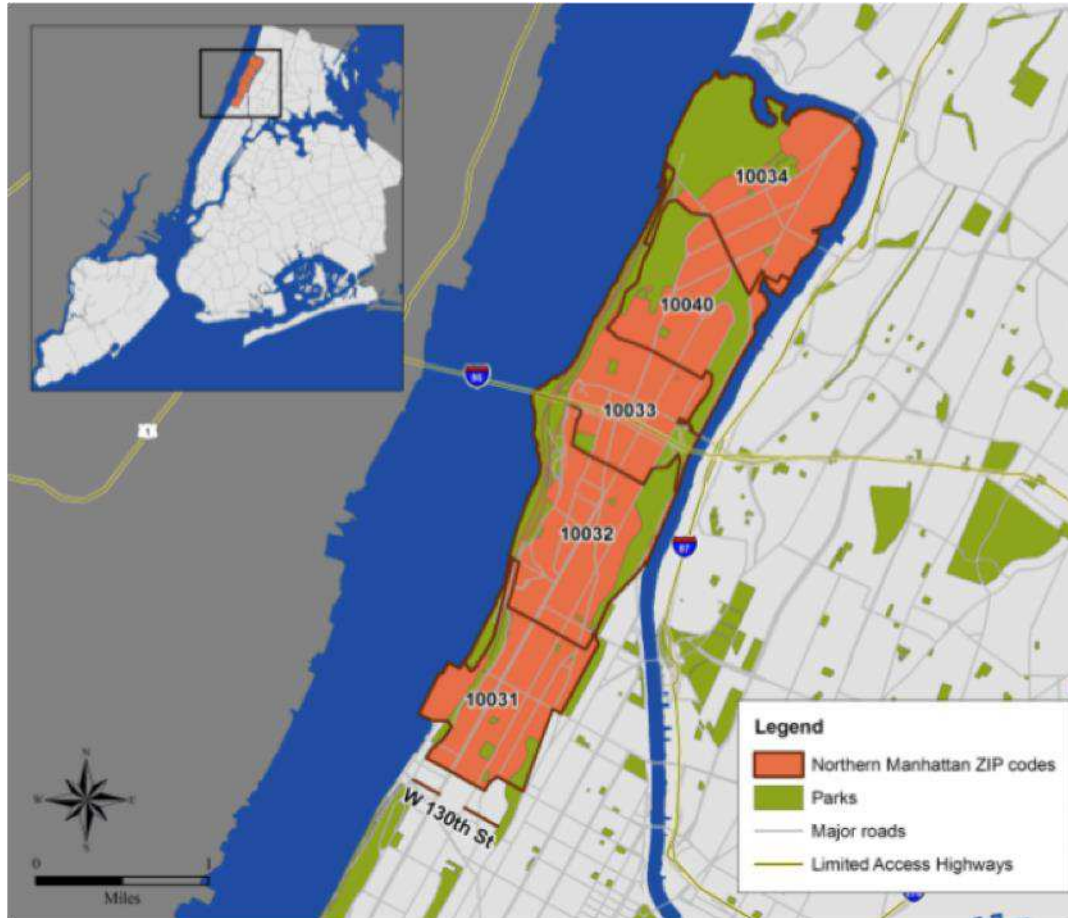
A MEDICAL HOME MODEL FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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Our Community Northern Manhattan

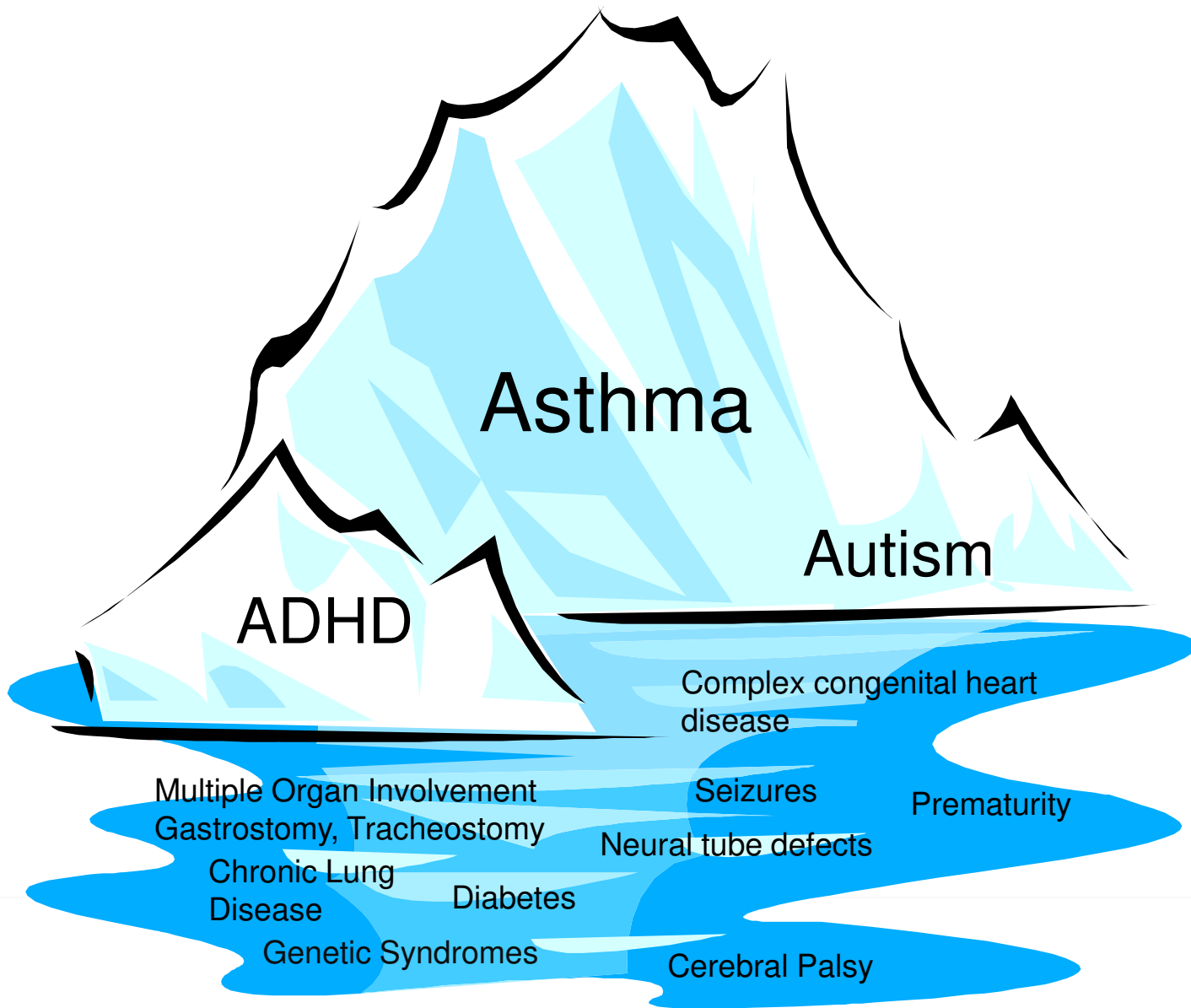


Community Data- Census 2015

- 66% Hispanic
- 54% foreign-born
- 52% Spanish-only
- 56% Low acculturation score
- 43% have a household income <\$20,000 USD

Children with Special Health Care Needs (CSHCN)

“those who have or are at increased risk for a chronic physical, developmental or emotional condition and who also require health and related services of a type or amount beyond that required by children generally”



Asthma

ADHD

Autism

Complex congenital heart disease

Multiple Organ Involvement
Gastrostomy, Tracheostomy

Seizures

Prematurity

Neural tube defects

Chronic Lung Disease

Diabetes

Genetic Syndromes

Cerebral Palsy

WHY?

- CSHCN comprise 15-18% of all children in US (12.5 million)
- CSHCN account for 80% of pediatric health care expenses
- CSHCN have grown by 30% in the past 20 years due to improved medical care and testing
- Account for >2.5 times the number of school absences, 2x as many unmet health needs, >5 times as many hospital days/ 1000 children

Latino Children in the US



America's Hispanic Children: Gaining Ground, Looking Forward

David Murphey, Ph.D. | Lina Guzman, Ph.D. | Alicia Torres, Ph.D.
9/24/2014



- Fastest growing minority population in the US (16%-2011)
- Multiple health disparities, health access and socioeconomic challenges
- Patient and family-centered care can help to address health disparities and improve population health

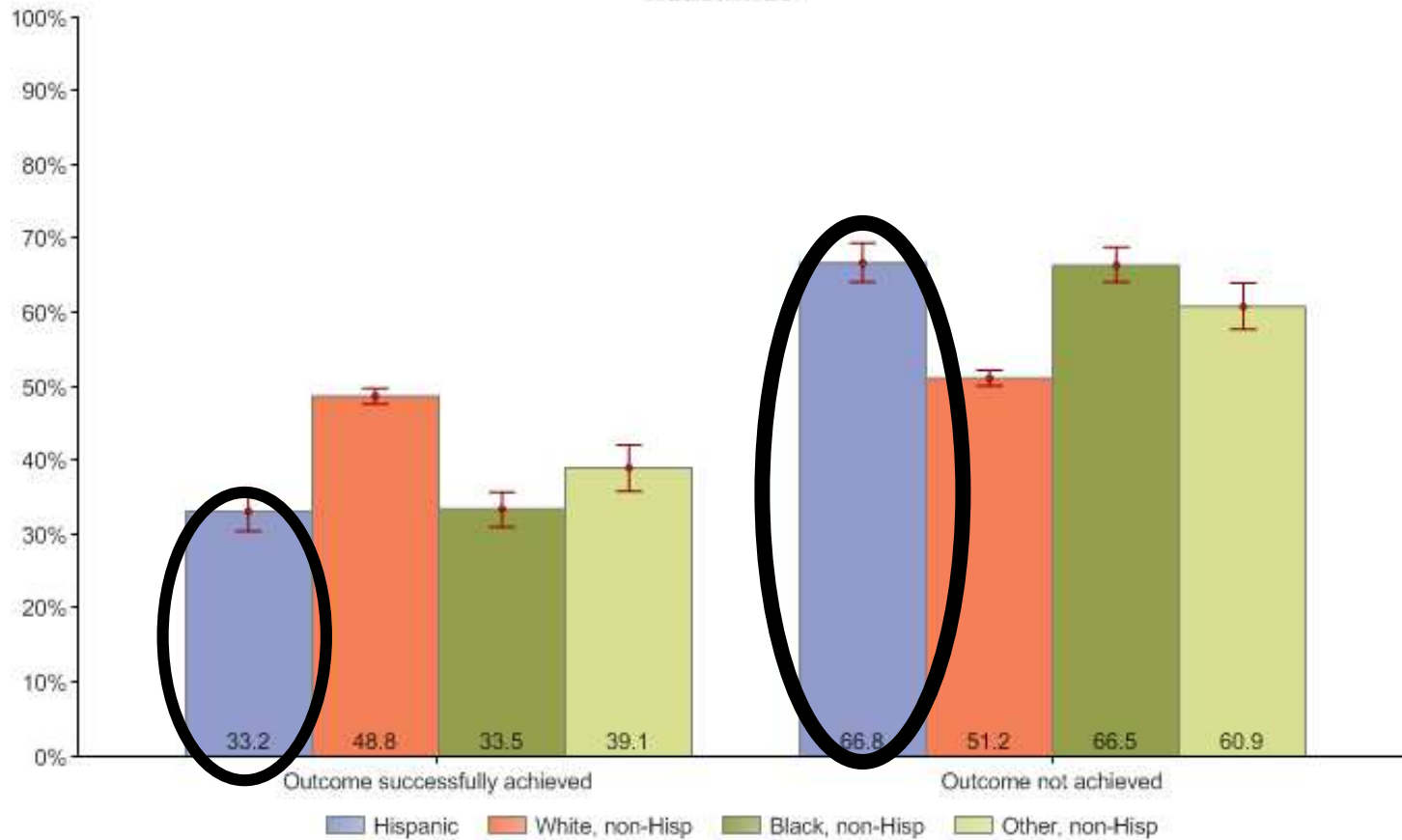


COLUMBIA UNIVERSITY
MEDICAL CENTER

NewYork-Presbyterian
Ambulatory Care Network

National Survey of CSHCN, 2009/2010

MCHB Core Outcome #2: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home
CSHCN age 0 -17 years
Nationwide

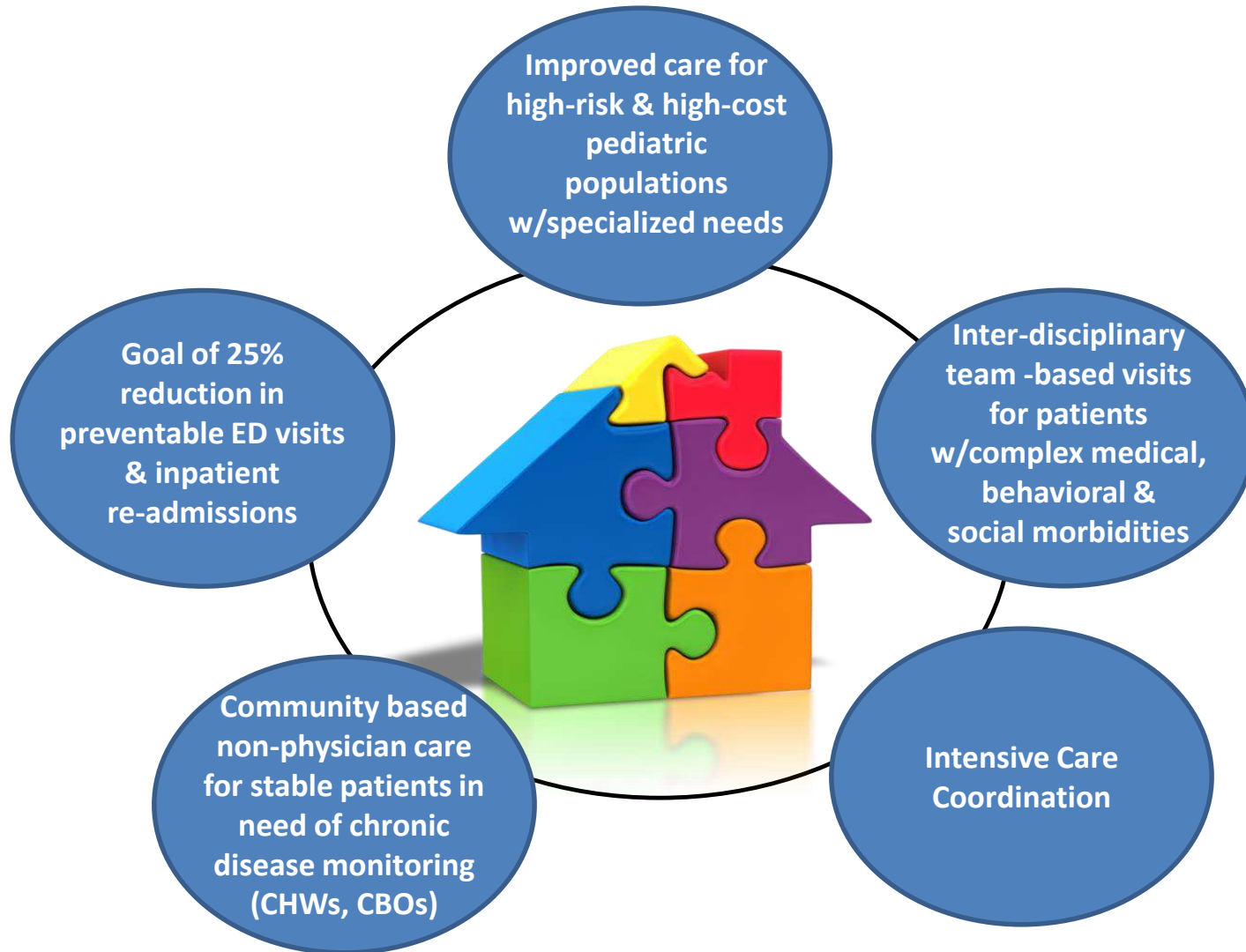


Case

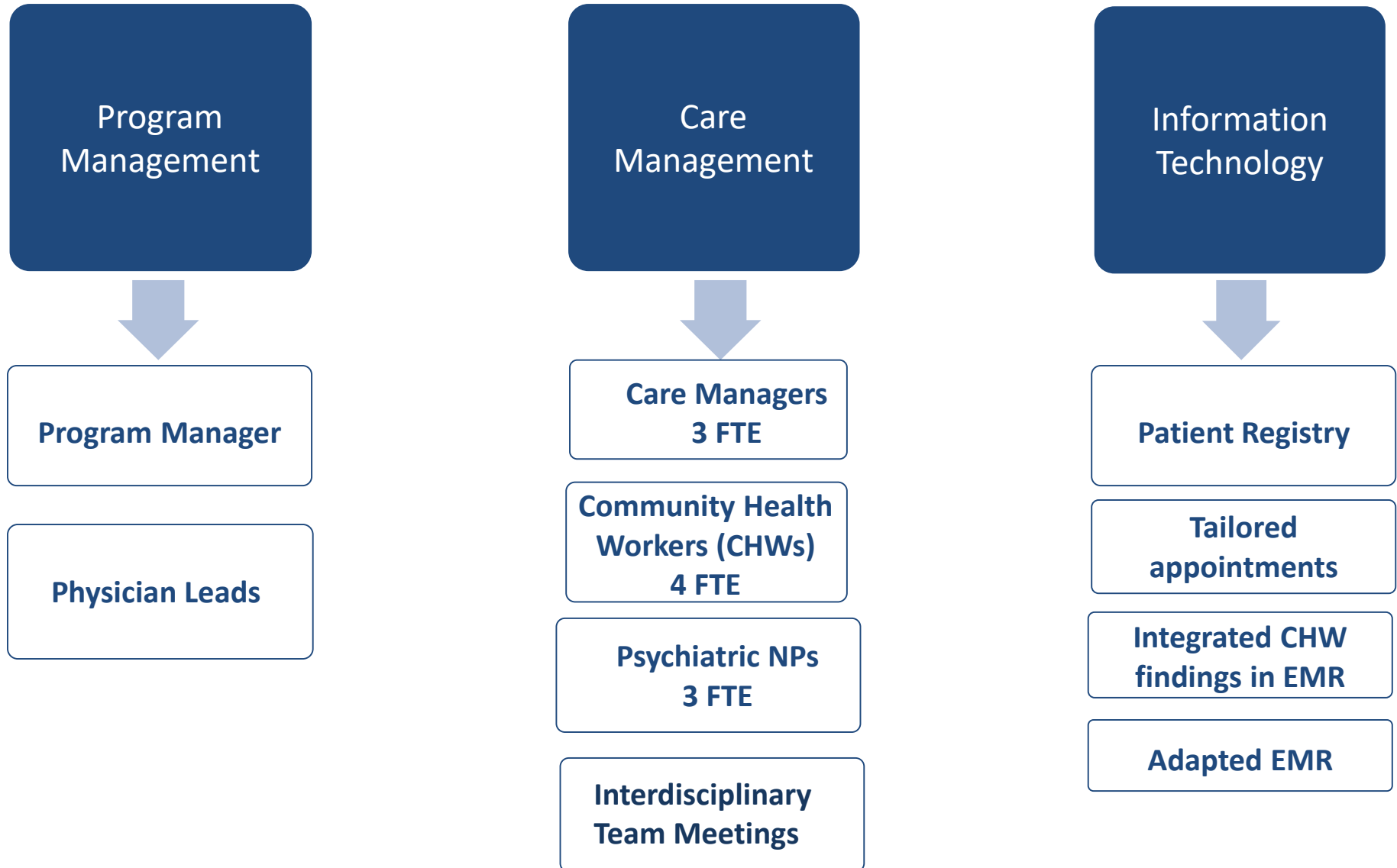
- Patient Y born with prenatally diagnosed TEF, VSD
 - s/p TEF repair and at age 3 mos suffered esophageal rupture
 - subsequent critical course and major complications
 - 9 months admission at Children’s Hospital discharged with:
 - esophageal stricture
 - G tube and J tube
 - chronic lung disease
 - global developmental delay
 - hypertension



Special Kids Achieving Their Everything (SKATE)



Funding from Medicaid Reform in New York



Pediatric Care Managers

- Navigation
 - Coordinate appointments and procedures
 - Home care services
 - Pharmacy and supply needs
 - Connect to child welfare agencies, schools, insurance companies
 - Medication reconciliation
 - Accompany to appointments
 - Coordinate multidisciplinary meetings

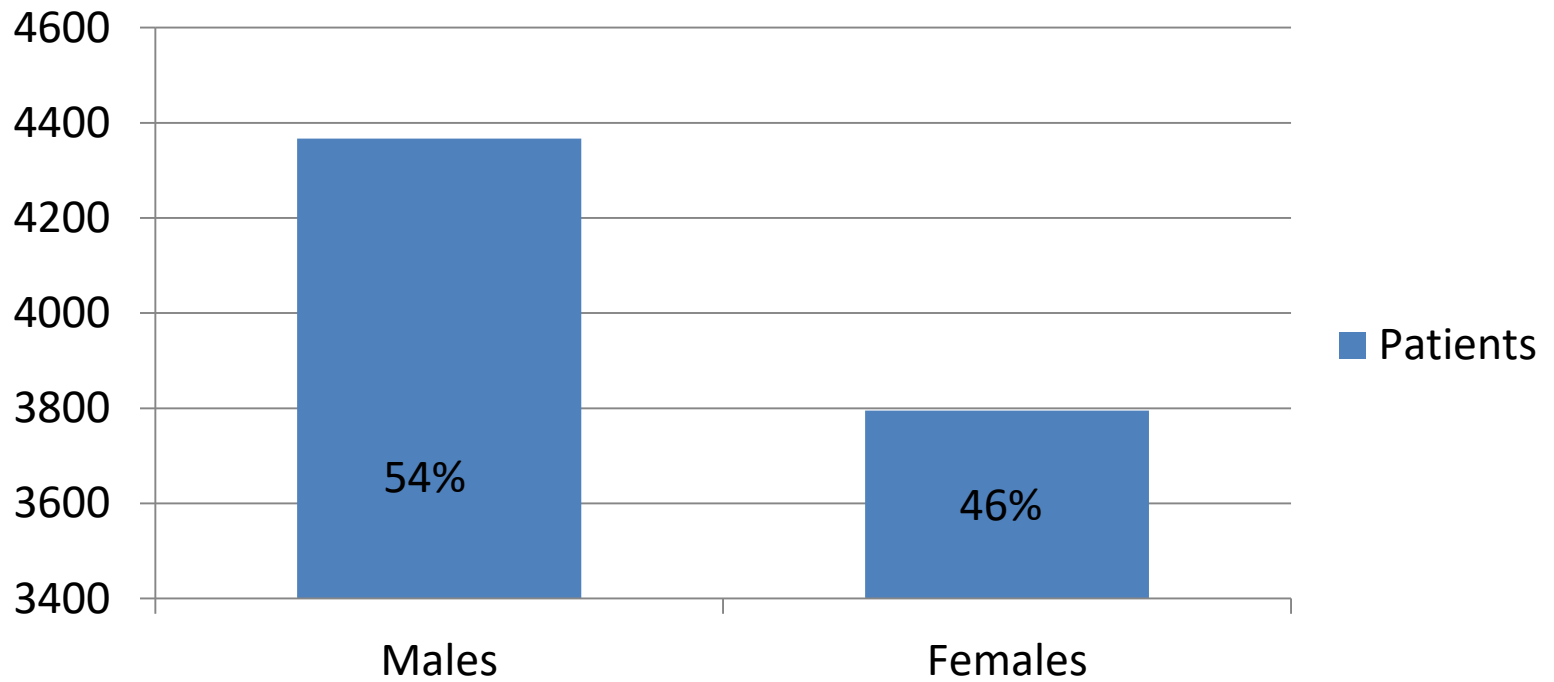
Pediatric Psychiatry Nurse Practitioners

- Diagnose
- Short-term therapy
- Coordinate referral to acute service or longitudinal therapy
- Coordinate with school based psych
- Support pediatrician medication management

Community Health Workers (CHW)

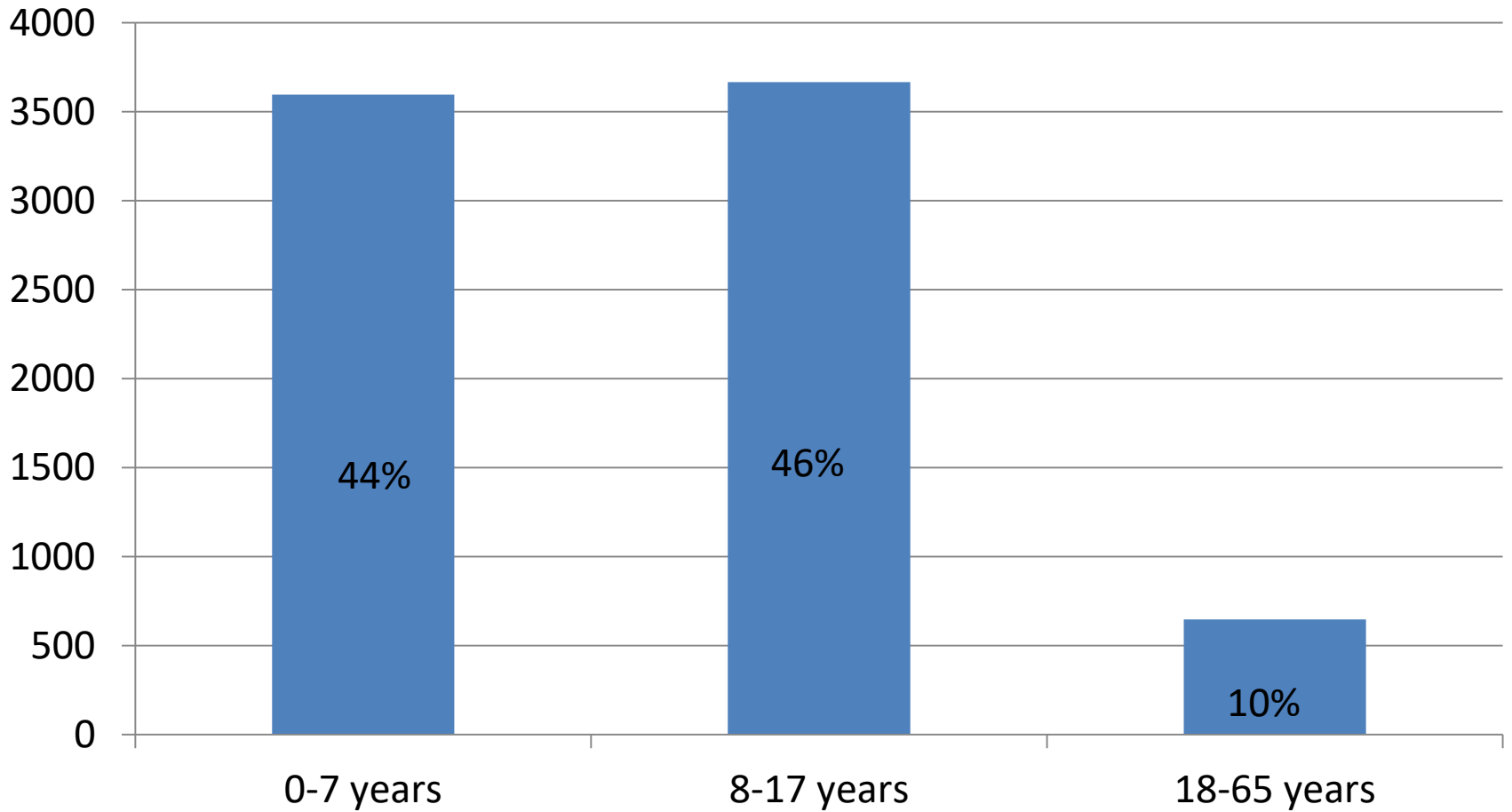
- Hospital-Community partnership model
- Bilingual
- Peer-level culturally-sensitive education and support
- Trained on CSHCN topics
 - Disease based, services (disability resources and special education)
- Social needs which compete with self-management and coordination of care
 - Housing, literacy, food insecurity, immigration

Population

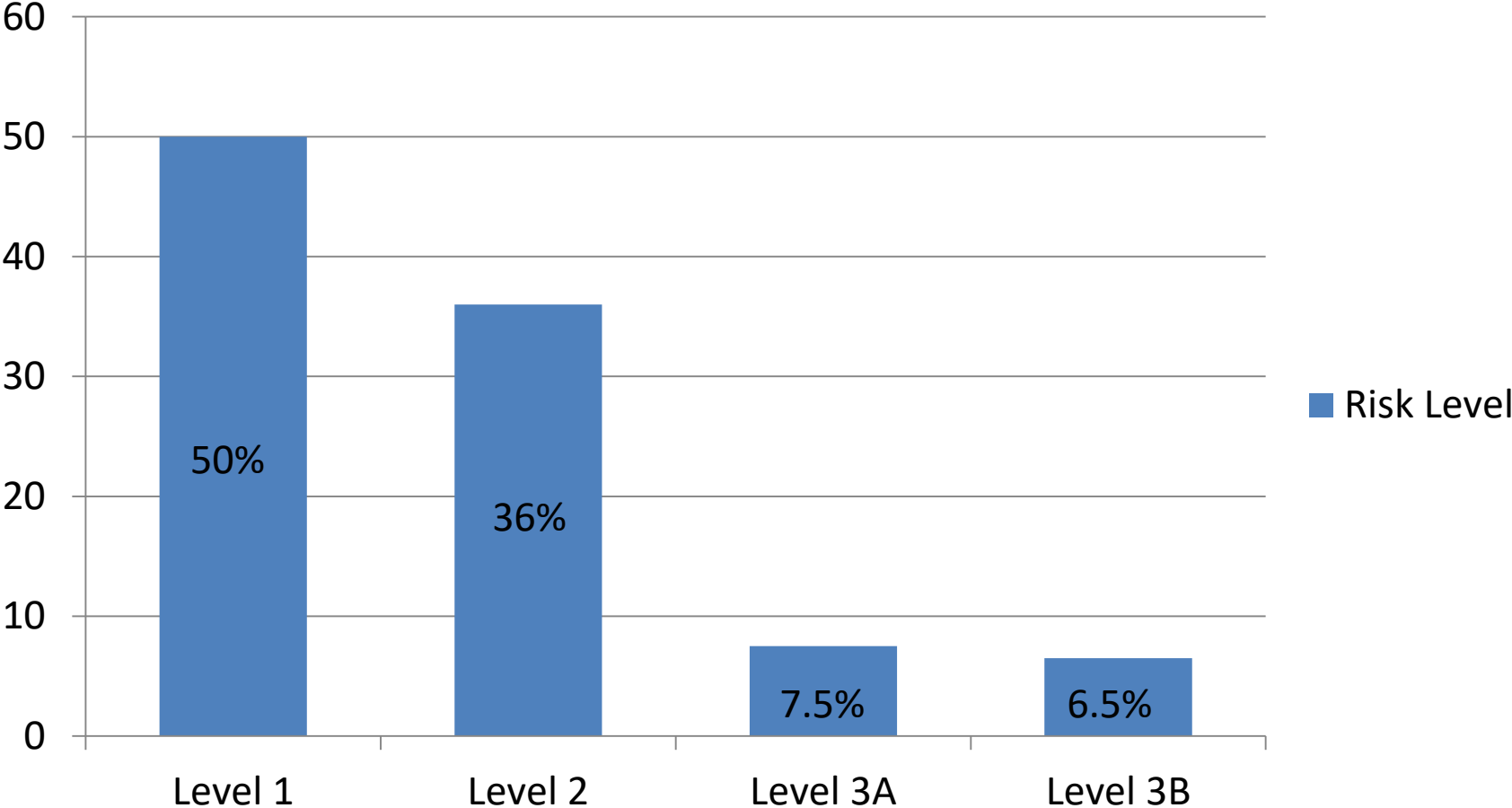


N=8162
March 2017

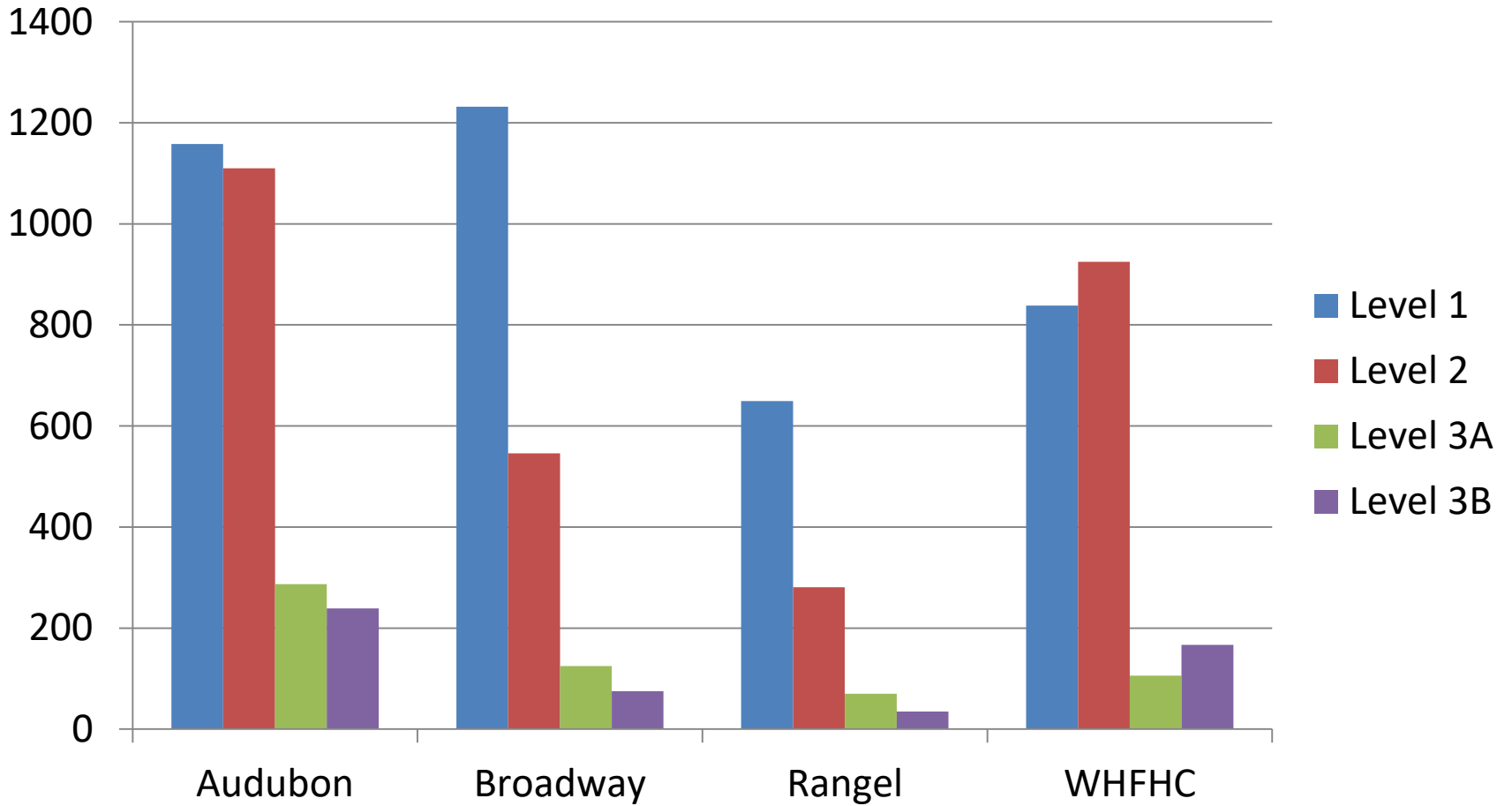
Age Distribution



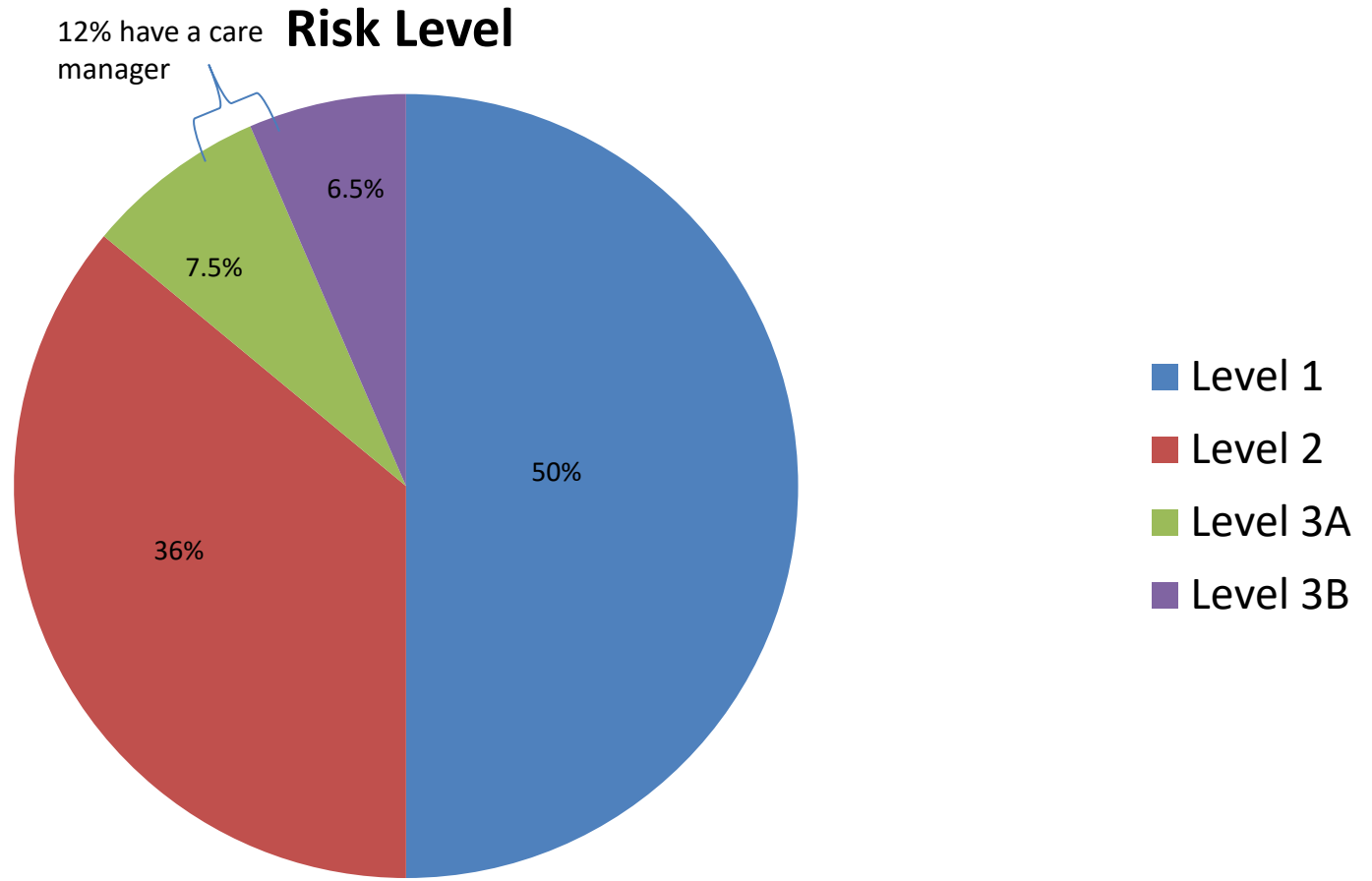
Risk Stratification



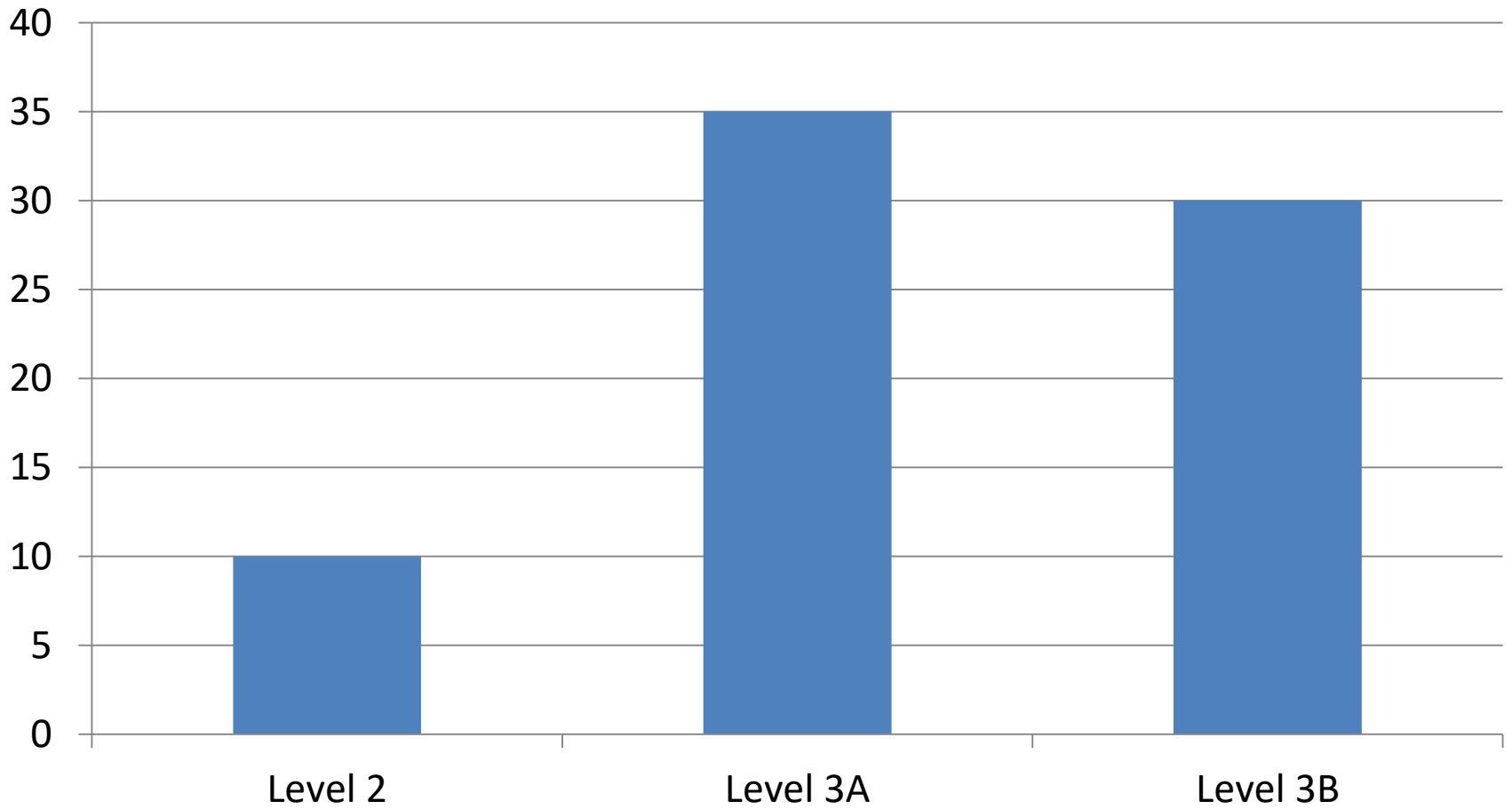
Pediatric Practices



Risk Stratification



CHW Cases



N=76

Metrics

Program

- Social determinants
 - Housing, access to care, food insecurity
- Goal attainment
 - Provider and family
- Social service referrals
- Number of monthly contacts
- ED and hospitalization

Patient/Family

- Diagnosis understanding
- Knowledge on accessing care
- Medication management
- Confidence in self-management
- Level of distress
- School connectivity

Preliminary Outcomes and Next Steps

- RN Care Managers – 160 patients
- CHWs – 76 families
 - 183 service referrals mostly for food insecurity, housing, and English as Second Language classes
- Analyze ED and hospitalizations, primary care visits and subspecialty visits

Lessons Learned

- Identifying and risk stratifying a population is essential to understand their needs and allocate resources.
- CHWs and Practice-based RN care managers support families' experience in the medical home.
- The medical home model needs to be flexible and evolving as it adapts to changing resource opportunities but remain grounded in its core mission to support families.

CONTACT INFORMATION

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