NC Project LAUNCH

Elements of the Family Centered Medical Home Model

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How did things start changing with the addition of the Team?

- Sorting out the supports the Team could provide
- Determining appropriate referrals
- The Teams exploring work flow issues with nurses, doctors, and support staff different ways of identifying appropriate referrals, how to introduce the Team, discovering the process of a warm hand off, the “language” used when offering the support of the Team, management of time spent in exam rooms
- Less referrals sent out for mental health assessments
- Resource availability became more clear
Burlington Peds: % of families referred to the ECMH Team who received each type of service

- % who received any type of service
- % who received any type of TP3
- % who received lactation consults
- % who received any type of TP4
- % who received care coordination
- % who received short-term therapy
Kernodle Clinic: Percent of families referred to the ECMH Team who received each type of service

- % who received any type of service
- % who received any type of TP3
- % who received lactation consults
- % who received any type of TP4
- % who received care coordination
- % who received short-term therapy

Data points from Oct-Dec 2012 to Apr-Jun 2015.
How we use Triple P to help families

- Encouraging normal development
- Establishing a positive parent child relationship
- Promote behavior management in a non-hurtful way
- Based off of good communication and positive attention to help the child develop
  - Level 3 Primary Care
  - Level 4
  - Stepping Stones Primary Care for children with disabilities
  - Seminar
  - Discussion Groups
Warm Handoffs

Nurse ➔ Health Navigator ➔ Physician

Nurse ➔ Physician ➔ Health Navigator

Health Navigator ➔ Physician

Nurse ➔ Physician ➔ Health Navigator ➔ Clinician
ECMH Tool Kit

Triple P
Health Coaching
Lactation Support
Care Coordination
First Pediatrician Appointment

- All new babies meet with Health Navigator even if only just to pop in and say hello
- This helps families realize that this support is available from the beginning, a place for asking questions, and normalizing the variety of needs that may arise during the child's development
Intake

Partnering with the family is the key to success! The Navigator:

- Engages and supports the parent
- Learns about child/family needs and addresses those as a first priority
- Works with the parent to complete an intake to help inform other members of the care team (physician, etc.) about the child/family’s health, strengths, needs
- Transfers key information into the medical record
- Arranges next steps with the family
Access to Care

- 50 – 75% of children who need mental health services “never have contact with them or drop out prematurely” (Kazdin, 1993)

- Barriers: inaccessible locations, stigma, lack of information about services, unresponsive service providers, previous negative experience with service providers

- The NC LAUNCH FCMH model reverses these trends – children and families do return for care, receive and act upon assistance
Families Return for Care

- Families use the teams as an ongoing, periodic resource
  - Most return for additional services after a break of 3-mo. or more (91% at Burlington Peds, 80% at Kernodle)
- Families who initially declined services come back for them later
  - 80% at Burlington Peds, 72% at Kernodle
- Families come back for multiple visits
  - 33% at Burlington Peds and 45% at Kernodle Clinic came back 4 or more times

Families will use behavioral health services and family supports when they are easy to access and when they are free to decide what they need and when to get it

The ECMH teams are becoming more entrenched as a ‘normative service’ in the practices
### Referral outcomes for child and parent mental health referrals to community agencies
(Oct 2012 through June 2015)

<table>
<thead>
<tr>
<th></th>
<th>Burlington Pediatrics</th>
<th>Kernodle Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child (n =72)</td>
<td>Parent (n = 12)</td>
</tr>
<tr>
<td>Services successfully completed</td>
<td>39%</td>
<td>50%</td>
</tr>
<tr>
<td>Services successfully initiated, in progress</td>
<td>21%</td>
<td>0%</td>
</tr>
<tr>
<td>Services scheduled, but not yet received</td>
<td>1.5%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Services initiated, but discontinued</td>
<td>4%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Services not appropriate</td>
<td>1.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Not eligible for service</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Services not obtained</td>
<td>8%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Outcome unknown</td>
<td>22%</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Total successful completion, initiation and scheduling**

|                              | 61.5%                  | 58.4%           | 70%            | 67%             |
Questions

Thank you for your participation in our webinar.

We will now have a time to answer all of your questions!!

Thank You,
Participants in the Alamance County NC LAUNCH team