Using Shared Plans of Care for Effective Care Coordination

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American Academy of Pediatrics-VT, Chapter President
Physician's Computer Company User's Conference
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Objectives

- Define “Effective Care Coordination”
- Why Shared Plans of Care?
- Achieving Shared Plans of Care
- PCC Care plan function
- Future ideas?

hagan
rinehart
connolly
pediatricians PLLC

Check out our new location
128 Lakeside Ave. Suite 115 Burlington,VT
t: (802)860-1928

welcome to our new medical home!

Doctors Hagan, Rinehart and Connolly are happy to announce our new location in Burlington's South End. New patients and transfer patients are welcome. We hope to see you soon!

FAMILY CENTERED CARE IN A MEDICAL HOME

Our Medical Home

- Three pediatricians: Dr. Hagan, Dr. Rinehart, Dr. Connolly
- Two pediatric nurse practitioners: Maryann Lisak and Ashley Boyd
- One main Care Coordinator (RN) Kristy
- Office manager, accounts manager, receptionists
- Six additional part time nurses, two medical assistants
- ~4000 active patients
- Insurance mix: 35% Medicaid, 55% private ,<5% uninsured

Care Study #1

- 13 year old boy with autism, non-verbal, self injury, polydipsia
- Parents struggling with bolting, overall safety
- Middle school unable to educate or keep safe
- Medical issues of skin infections, enuresis, sleep dysfunction, puberty, growth
- Family above and beyond capacity of most families to deal with this at home

Coordinated Care??

Mind the Gap

- Proactive
- Timely
- Accurate
- Problem Solving communication

Family Centered Care

Family centered care is about meeting families where they are, and helping them get where they want to go…

Why is A Family- Centered Medical Home Important to *family*?

- Opportunity for the family to build a trusting and collaborative relationship with the pediatrician and office staff.
- Care coordination provides smooth facilitation among all members of the child's care team including family, specialists, pharmacy staff, community and school services.
- Comprehensive source of complete patient medical history

Victoria Garrison, "Innovations in Medical Home," VFN annual conference, April 2013

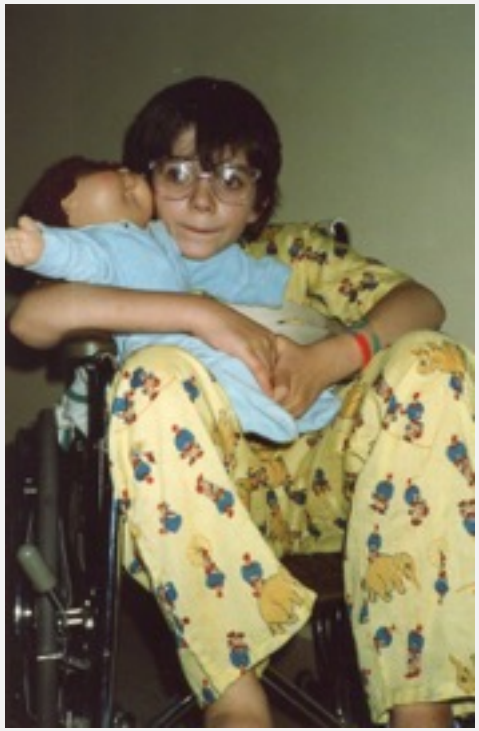
Care Coordination

- Is the set of activities that happens between
  - Visits, Providers and Hospital Stays

  E-mails, prior authorizations, communication between providers (community and subspecialists), insurers, prescriptions, equipment needs, in home care providers, access to community resources

Care Coordination

"Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while *enhancing the care giving capabilities* of families…"



Making Care Coordination A Critical Component of the Pediatric Health System: A Multidisciplinary Framework, Antonelli, McAllister, and Popp, The Commonwealth Fund, May 2009

Why? CMHI National Outcomes Study Cost/Utilization

Medical Home Index:
43 Practices, 7 plans/5 states

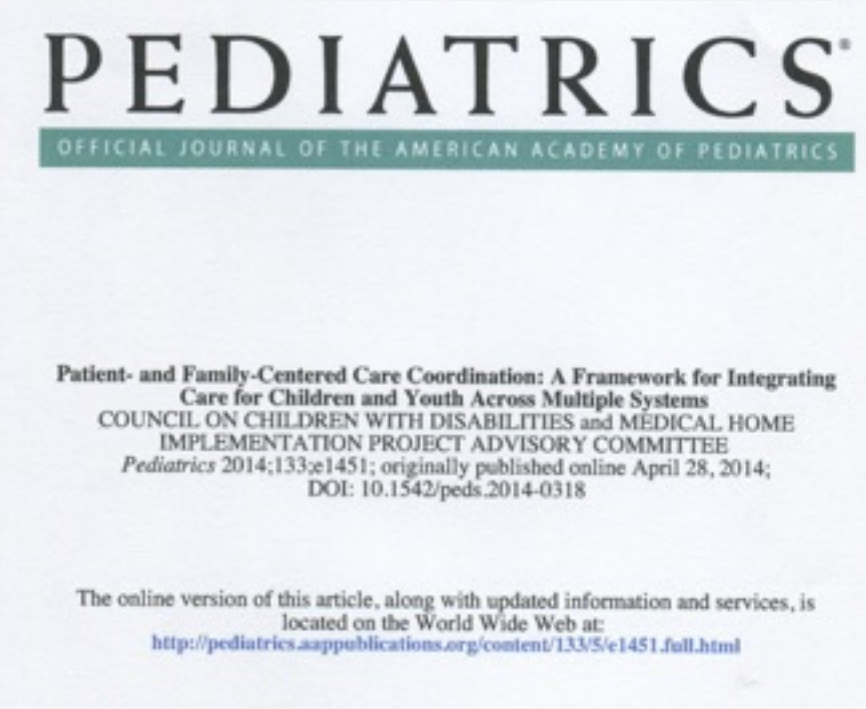
- Higher overall MHI score or higher domain scores for care coordination, chronic condition management, office organizational capacity
  -Lower hospitalization rates

- Higher Chronic Condition Management domain scores
  -Fewer ER visits

Cooley, McAllister, Sherrieb, Kuhlthau, *Pediatrics,* July 2009

Patient and Family Centered Care Coordination:

A Framework for Integrating Care for Children and Youth Across Multiple Settings



PEDIATRICS
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems

COUNCIL ON CHILDREN WITH DISABILITIES and MEDICAL HOME IMPLEMENTATION PROJECT ADVISORY COMMITTEE

Pediatrics 2014;133;e1451; originally published online April 28, 2014;
DOI: 10.1542/peds.2014-0318

Medical Home for Non-CSHN

"The Value of the Medical Home for Children Without Special Health Care Needs,"*Pediatrics*, December 2011

- Decreased outpatient sick visits
- Decreased emergency department sick visits
- Increased odds of "excellent/very good" child health
- Increased health promoting activities such as being read to daily, reported helmet use, and decreased screen time

Foundation of Medical Home

- AAP policy statement (reaffirmed, 2008)
- Provision of family-centered care through developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life
- Acknowledge family stories and information at every step along the way
- Quality improvement, practice transformation and the AAP includes family and consumer perspectives

5 Key Elements of Highly Effective Care Coordination

The Concept

1. Needs assessment for care coordination and continuing care coordination engagement
2. Care planning and communication
3. Facilitating care transitions
4. Connecting with community resources and schools
5. Transitioning to adult care

Antonelli et al (2009); Rinehart (2014)

The Person

PFCC Principles

Dignity & Respect

Providers listen to and honor patient and family perspectives, choices and incorporate their values, beliefs into care delivery.

Collaboration

Patients, families and providers collaborate in policy, program development, implementation and care delivery.

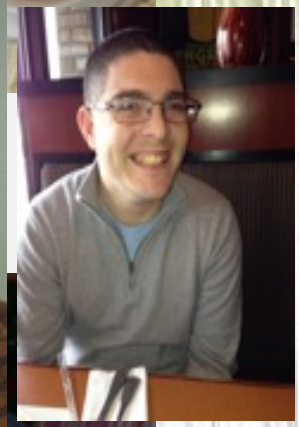
Information Sharing

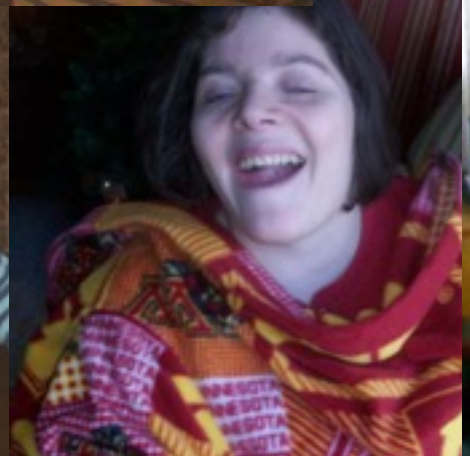
Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making

Participation

Patients & Families are encouraged and supported to participate in care and decision making.



"Care Plans"-recommended

Organization	Care Plan Specifics/Called for Recommendations
National Committee for Quality Assurance (NCQA)	Develop individual care plan includes treatment goals reviewed and updated at each visit
Centers for Medicare and Medicaid (CMS) Meaningful Use	"Visit summary of care" Mandates (ACA) care planning components "Continuity of Care Record"
National Quality Forum (NQF)	Plan of Care: Actively tracks up-to-date progress towards patient goals
AAP Care Coordination Policy Paper, 2002	Plan of care developed by family, youth, physician shared with other providers, agencies, and organizations involved with that patient's care
IHI Care Coordination Model	A "planned visit" contains assessment, review of therapy, review of medical care, self-management goals, problem solving and a follow-up plan

Jeanne McAllister, et.al, "Achieving a Shared Plan of Care for Children and Youth with Special Health Care Needs," supported by Lucille Packard Foundation for Children 2014

PCMH cross-walk

- PCMH 2 Team-based care
  Element B - Medical Home Responsibilities
  2.B.1 - The practice is responsible for coordinating patient care across multiple settings
  Element D - The Practice Team (Must Pass Element)
  2.D.2 - identifying the team structure and the staff who lead and sustain team based care
  2.D.3 - Holding scheduled patient care team meetings or a structured communication process focused on individual patient care (Critical Factor)
  2.D.5 -Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change

PCMH cross walk

- PCMH 5 Care Coordination and Care Transitions
  Element C:1 - Proactively identifies patients with unplanned hospital admissions and emergency department visits
  C:2 - Shares clinical information with admitting hospitals and emergency departments
  C:3 - Consistently obtains patient discharge summaries from the hospital and other facilities
  C:4 - Proactively contracts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit
  C:5 - Exchanges patient information with the hospital during a patients' hospitalization
  C:6 - Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners
  C:7 - Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care

PCMH crosswalk

- PCMH 6 Performance Measurement and Quality Improvement
  Element B - Measure Resource Use and care coordination
  6.B.1 - At least two measures of care coordination
  Element C - Measure Patient/Family Experience
  6C: 1 - The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:

  * Access

  * Communication

  * Coordination

  * Whole person care/self-management support

  Element D - Implement Continuous QI (Must Pass Element)
  6D:3 - Set goals and analyze at least one measure from Element 6:B
  6D:4 - Act to improve at least one measure from Element 6:B
  6D:5 - Set goals and analyze at least one patient experience measure from Element 6:C
  6D:6 - Act to improve at least one patient experience measure from Element 6:C
  Element E - Demonstrate Continuous Quality Improvement
  6.E.3 - achieving improved performance on one utilization or care coordination measure

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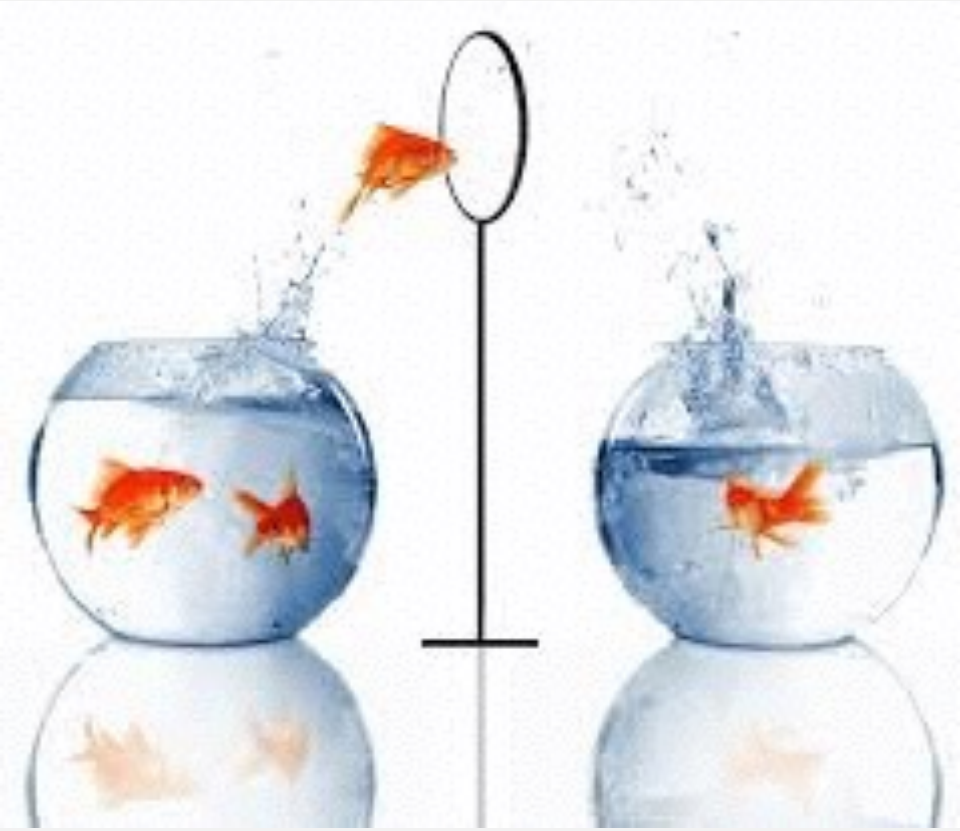
Hoop Jumping



Is Being a PCMH Good Enough?

"Comparison of Individual –Level Versus Practice –Level Measures of the Medical Home"

- Each practice had an NCQA level (2 at Tier 3, 3 at Tier 2)
- Of 180 parents only 52% had MH according to NSCH
- No significant association between family perception of medical home and being a practice wide medical home

Long & Garg 2015

Change Concepts for Practice Transformation

Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice*. 2012; 39:241-259.

Straddling 2 worlds

- Old World: Fee-for-service
- New World: Get paid enough PMPM
- Old World: 99215, prolonged service
- New World: Care coordination supported by funds directed toward the practice
- Old World: Physician: patient dyad
- New World: Team based, integrated care

Pediatric Care Coordination Learning Collaborative

Achieving a Shared Plan of Care

Following the guidelines of the Lucille Packard Foundation's

"Achieving a Shared Plan of Care Implementation Guide"

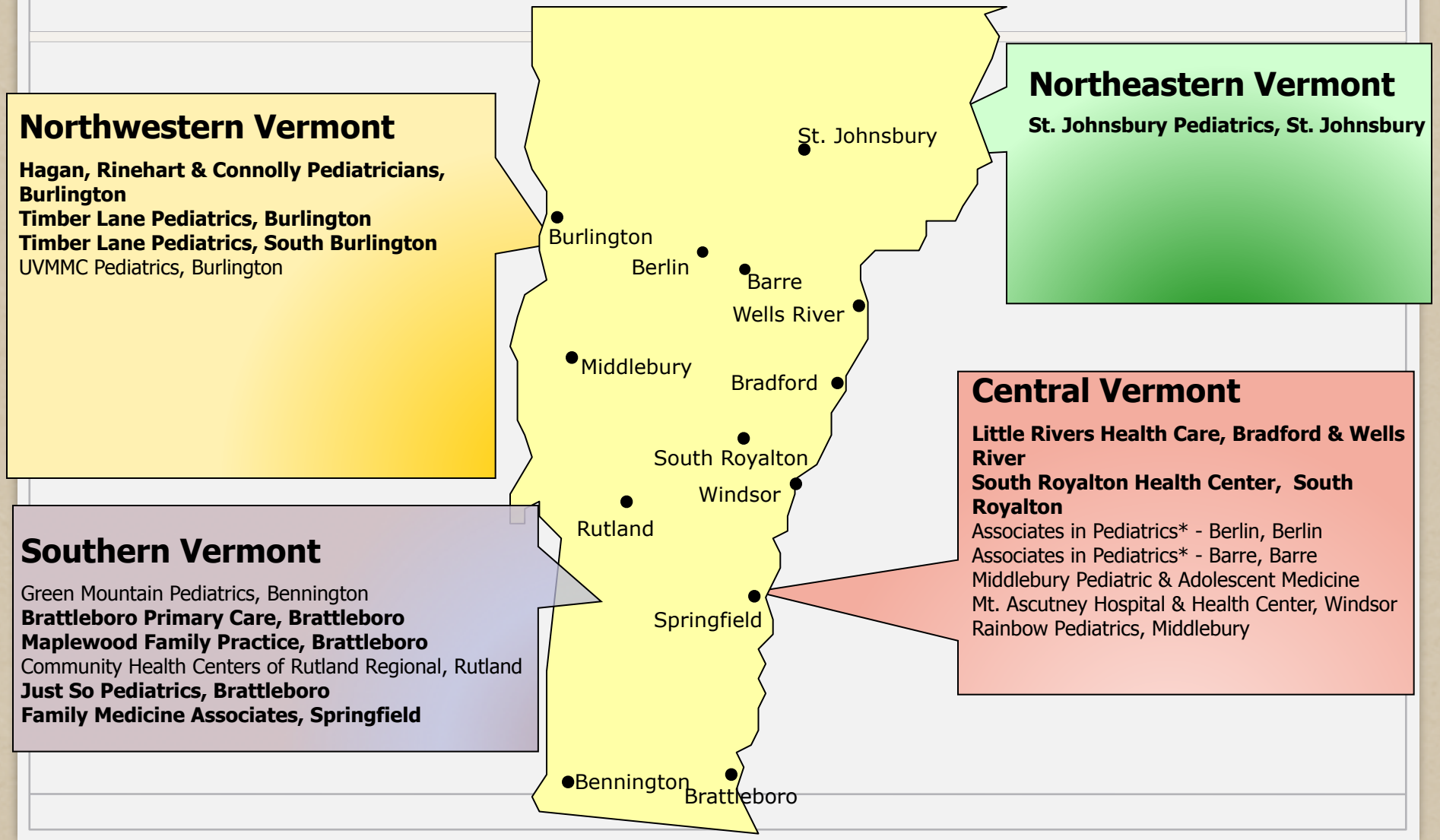
Purpose

Plan, implement and evaluate the impact of effective care coordination by working with

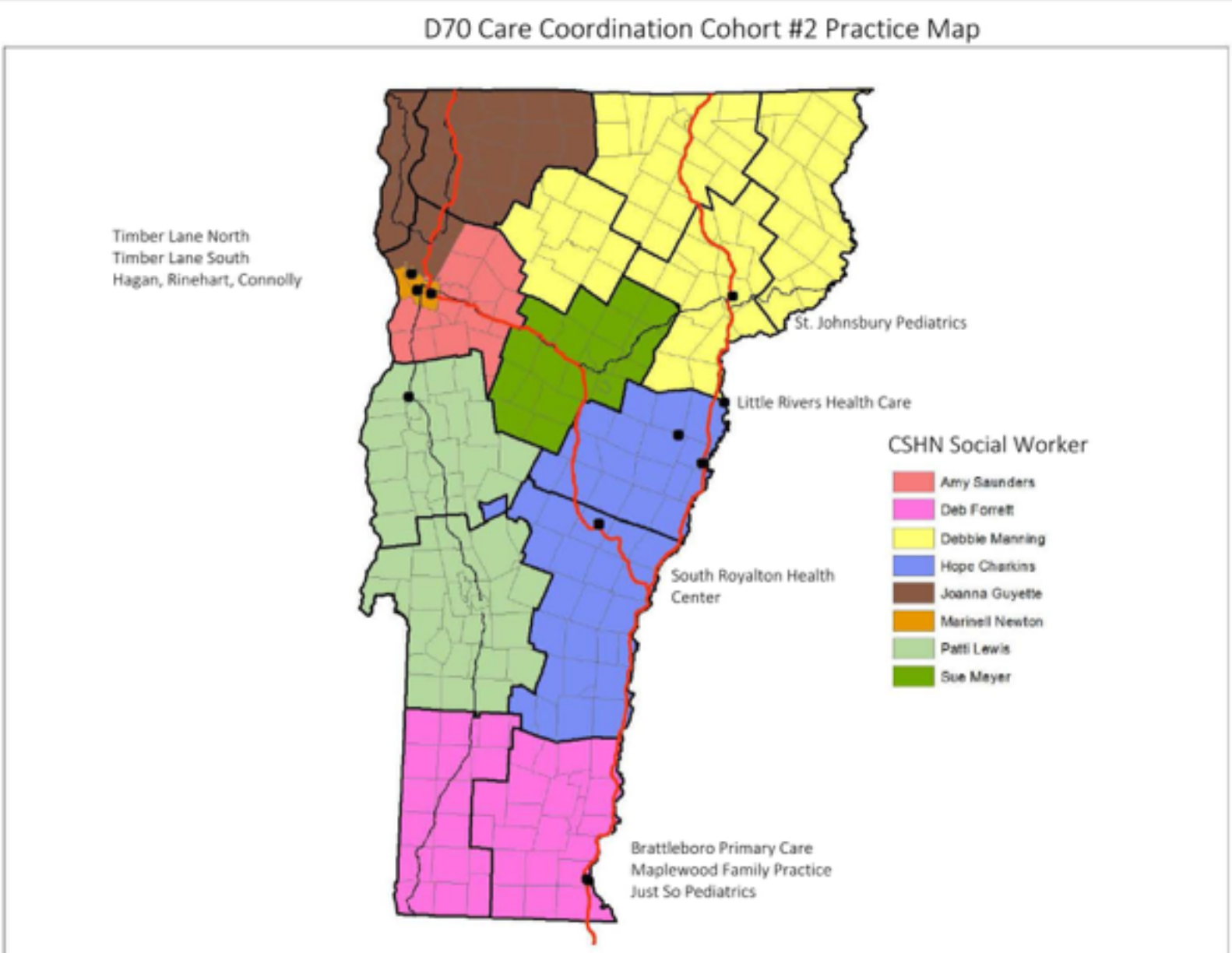
- Vermont's primary and specialty health care professionals
- Patients and their families
- Community-based, child-serving agencies and organizations

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Pediatric Care Coordination Participating Practices



Family Health Partners



PARENTS' VOICES

NO CARE COORDINATION

- "There was no continuity. We would call the primary care office with a concern and they would say "Oh, you need to talk to your specialist about that." We would call the specialist and they would say "Oh, you need to talk to your primary care doctor about that." It was just back and forth all the time and the concerns never got addressed."

WITH CARE COORDINATION

- "Now there is a sense that I'm being listened to – that his medical needs are being addressed. We have a plan with where we are headed, especially with the school, we know where we are going."

Maier, Parent interview, March 6, 2014

Faculty All-Stars

Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs

- Jeanne McAllister, BSN, MS, MHA
- Supported by Lucille Packard Foundation for Children's Health-Children with Special Health Care Needs

Medical Home and Care Plans – they go together, you can't have one without the other! **-*Family***

Shared Care Planning Model

McAllister et al, 2014

What is a Shared Plan of Care?

- A guide for moving care forward using a clear summary of information and a collaborative approach.
- Requires a family-centered, team-based, relational course of continuous action. The family has a clear contact point and access to their plan.

McAllister et al 2014

What is in a Shared Plan of Care?

- Includes: (as a comprehensive and integrated, concise and user-friendly set of information and set decisions)

- •**A Medical Summary**– which details child/ family demographic information; current medical care facts; lead team members and contacts; and core child and family knowledge including their personal preferences and goals.

- •**Negotiated Actions/Next Steps/Accountability:** highlights personal and clinical goals and joint strategies to address and /or achieve goals with timelines, responsibilities and accountabilities

McAllister et al 2014

Why Shared Care Planning?

- Care is fragmented
- Lacking coordination
- Information sharing across providers falls on the parents
- Families asking for:
  - Resource and system navigation
  - Team based care
  - Problem solving discussions

Principles for Successful Use of a Shared Plan of Care

Best results occur when:

1. Children, youth and families are actively engaged in their care.
2. Communication among their medical home team is clear, frequent and timely.
3. Providers/team members base their patient and family assessments on a full understanding of child, youth and family needs, strengths, history, and preferences.
4. Youth, families, health care providers, and their community partners have strong relationships characterized by mutual trust and respect.

Jeanne McAllister et.al, "Achieving a Shared Plan of Care for Children and Youth with Special Health Care Needs," supported by the Lucill Packard Foundation for Children, 2014

Principles for Successful Use of a Shared Plan of Care

5. Family-centered “teams” can access the information they need to make shared, informed decisions.

6. Family centered care teams use a selected plan of chare characterized by shared goals and negotiated actions; all partners understand the care planning process, their individual responsibilities and related accountabilities.

7. The team monitors progress against goals, provides feedback and adjusts the plan of care on an on-going basis to ensure that it is well implemented.

McAllister, 2014

Principles for Successful Use of a Shared Plan of Care

8. Team members anticipate, prepare and plan for all transitions (e.g.early intervention to school; hospital to home; pediatric to adult care)

9. The plan of care is systematized; as a common, shared document; it is used consistently, by every provider within an organization, and by all providers across organizations.

10. Care is subsequently well coordinated across all involved organizations/systems

McAllister, 2014

The Tools

Identify Population

- Youth with one complex chronic condition: Asthma, ADHD, Anxiety/Depression
- Children with complex medical needs
- Registry

HOMES score

Category	Criteria	Score
H-ospitalizations, ER visits, Subspecialty Visits (past yr)	1= 1 hospitalization,ED, specialist 2= 2 or >Hosp, ED, specialist	
O-ffice Visits, Phone calls, prolonged time for visits	1= 1-2 OV or MD/RN calls 2= 3 or more OV or MD calls	
M-edical Condition(s) (One or more diagnoses)	1= 1-2 conditions (no complications) 2= 1 or 2 conditions with complications or 3 or more conditions	
E-xtra Care and Services at MH, home, school, community setting	1= One service from list below 2=Meds, technology, therapeutic assessments/treatments/procedures, care coordination	
S-ocial Concerns	1="At risk" family/school/community concerns 2=Current/urgent complex social need	

Reminders

Medical Summary — **Pebbles Flintstone 10 yrs, 1 mo 5/21/06**

Recent and Upcoming Appointments

Last Visit: 07/17/16 (2d ago) Crusher
Diagnosis: none
Last Physical: 05/29/15 (1y 1m ago)
Next Physical Due: 06/03/16 (6w 4d overdue)
Scheduled Appointments: none

Siblings

Open Chart Dino Flintstone 4 yrs, 3 mos 03/29/12 M

Reminders Modified 06/10/16

Headed to regional soccer championships 10/11.

Lost best friend to a neighborhood house fire in 12/10.

Problem List Modified 06/10/16 Display: All Statuses

Status	Problem	Problem Note	Onset	Resolved
Resolved	Urinary Tract Infection (599.0)			03/12/10
Active	Obesity Exogenous (278.00)			
Active	Asthma Mild Persist (493.00)			

Allergies Modified 06/10/16 Display: All Statuses

Status	Allergy	Reaction	Onset	Resolved
Active	Allergy Cat Hair (477.8)			

PCC eRx Allergies Updated 07/19/16 10:11 AM

Drug	Reaction	Onset

Where to Start? Engaging Families:

During a Visit

Previewing the Week Schedule

Phone Calls (discharges, family, community)

Condition Specific

Wow! This problem list is a mess!

Doc, you may not want to come in on Tuesday…

My son is being discharged tomorrow from Children's after neurosurgery…

My child's teacher says his behavior is out of control…

This family hasn't responded to calls from visiting nurses for the past month

I'm taking control of Asthma!

I'm taking control of Behavioral Health!

Can Begin with:
Family, Patient, Community Partner, or Health Care Professional

Implementing the Shared Plan of Care: Pre-Visit Planning

- Before you enter the room…

- Already have recent, relevant information
- Screening tests (ACT,PHQ9)
- An agenda from the family for today's visit
- Labs, radiology, specialist visit reports
- Follow up from community members (Vanderbilt's, therapists, subspecialists)

Work Flow for Care Planning

Team Person/Roles	Pre-Visit→ Preparation	Visit→ Caring Partnership interactions	After Visits→ Accountable follow through
Care Coordinator	Gathers recent information (recent labs, subspecialist notes, community provider updates) Identifies goals	Updates Care Plan Family/Personal Goals Medical Goals	Negotiate Next Steps
Youth/Family	Bring Questions? Share ideas Referrals?	Participates in Goal Setting	Negotiate Next Steps
Pediatric Clinician	Reviews communications Asks about goals Follows up w/ referrals	Assesses Needs Updates Care Plan	Negotiates Next Steps

McAllister et al, 2014

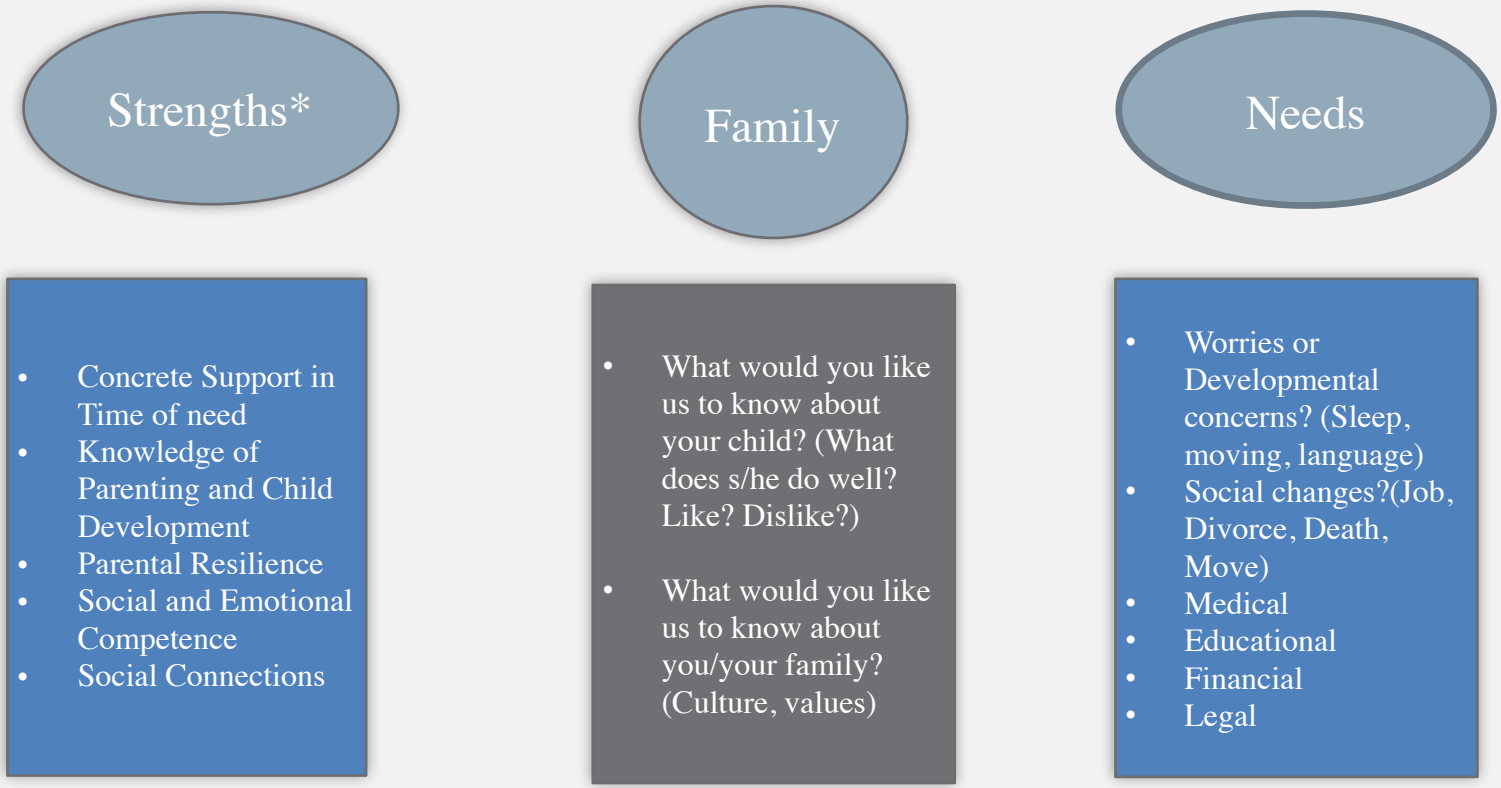
Family Centered Assessment Tool

"No one has ever asked me these questions before…"

Parent

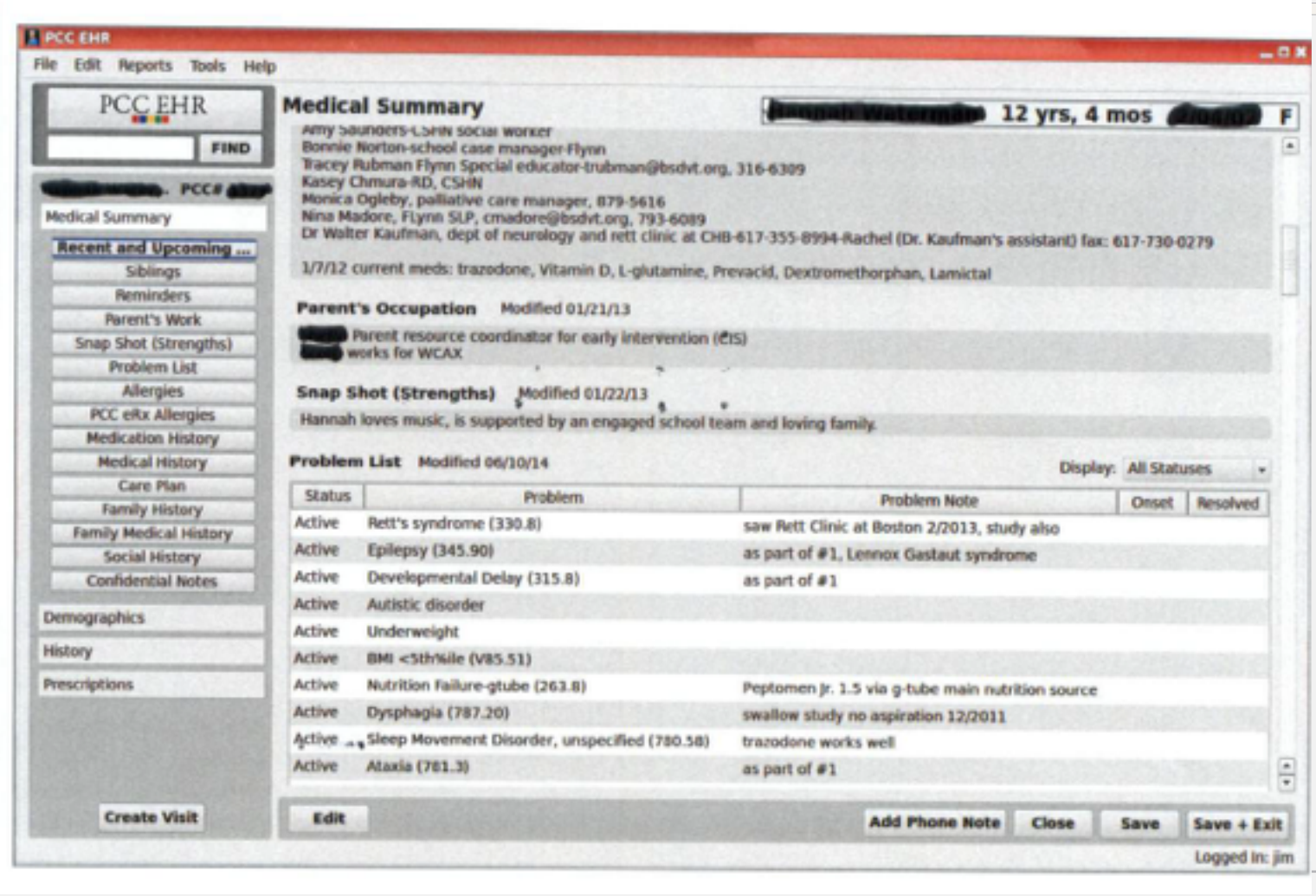
National Center for Medial Home Implementation: http://www.pediatricmedhome.org/pdfs/3_Assessment_of_Care_Needs.pdf

Understanding Needs & Strengths

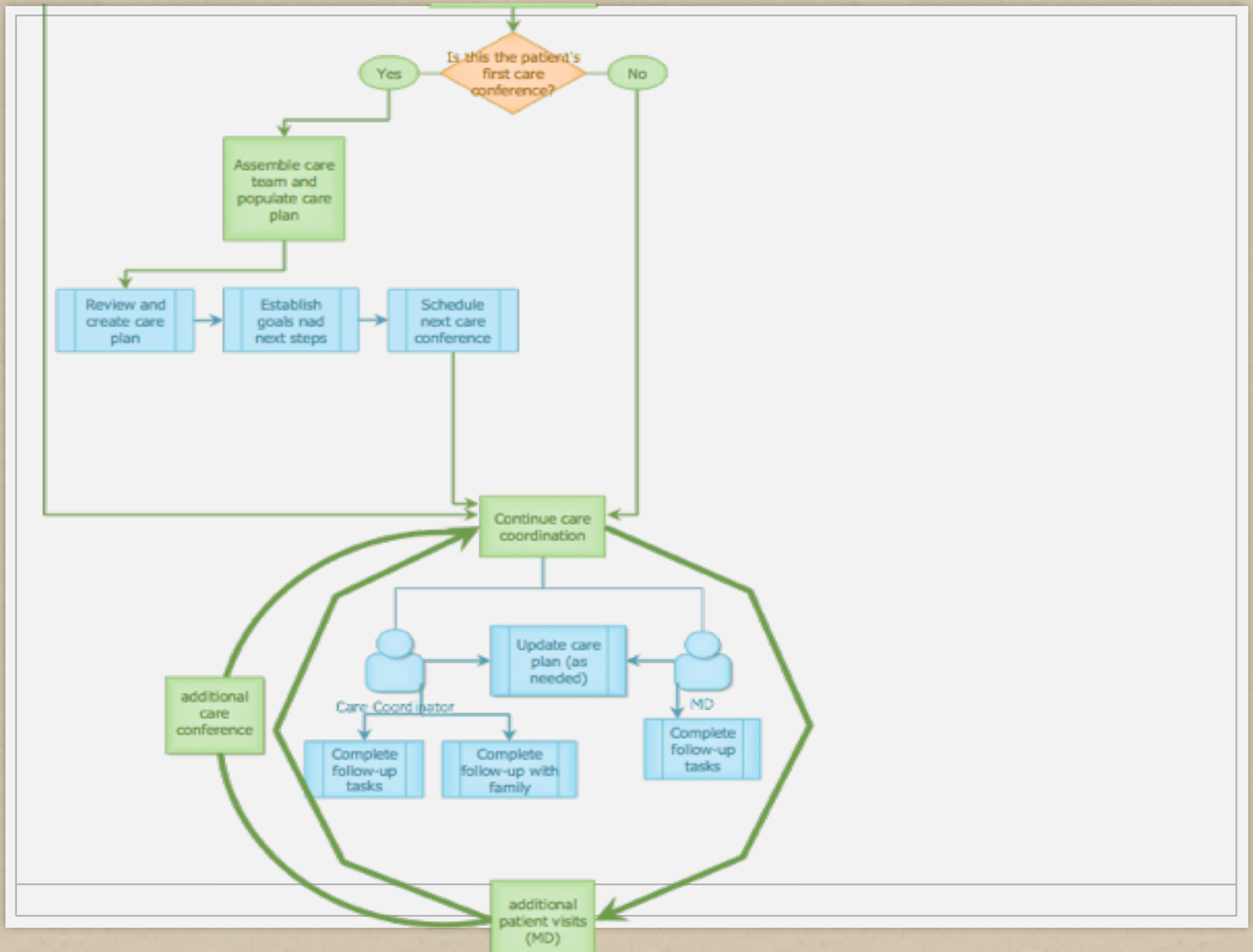


Browne 2014

Strengths Based



HRC Care Coordination Workflow Draft


Is this the patient's first care conference?
Yes
No
Assemble care team and populate care plan
Review and create care plan
Establish goals nad next steps
Schedule next care conference
Continue care coordination
Update care plan (as needed)
Care Coordinator
MD
Complete follow-up tasks
Complete follow-up with family
Complete follow-up tasks
additional care conference
additional patient visits (MD)

PARENT VOICES

NO CARE COORDINATION

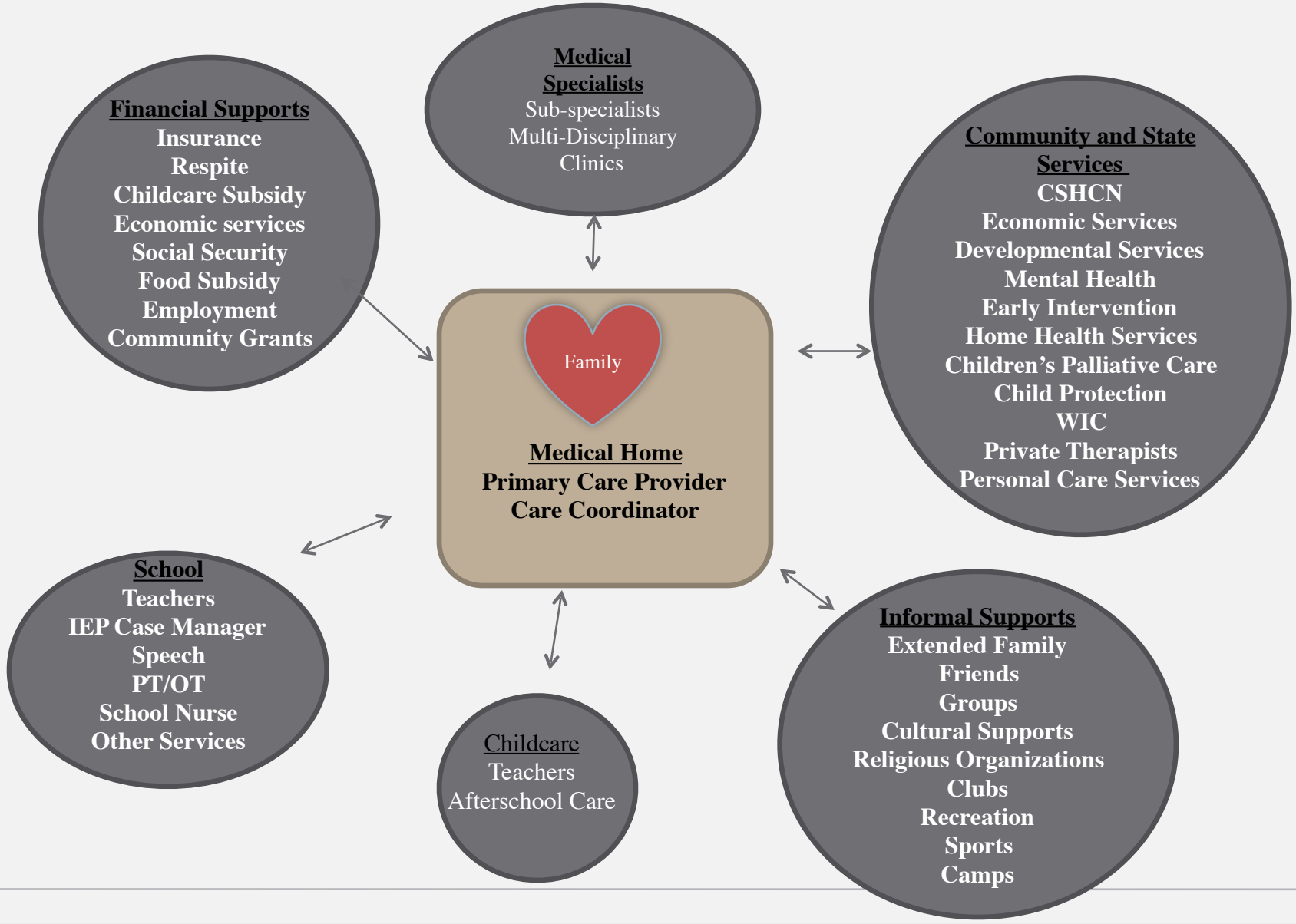
- "Before, we were always treating symptoms...I always felt that I was leading the conversation, like: "Don't you think we should consider doing___?" I guess I was kind of a problem parent for them."

Maier, Parent interview, March 6, 2014

WITH CARE COORDINATION

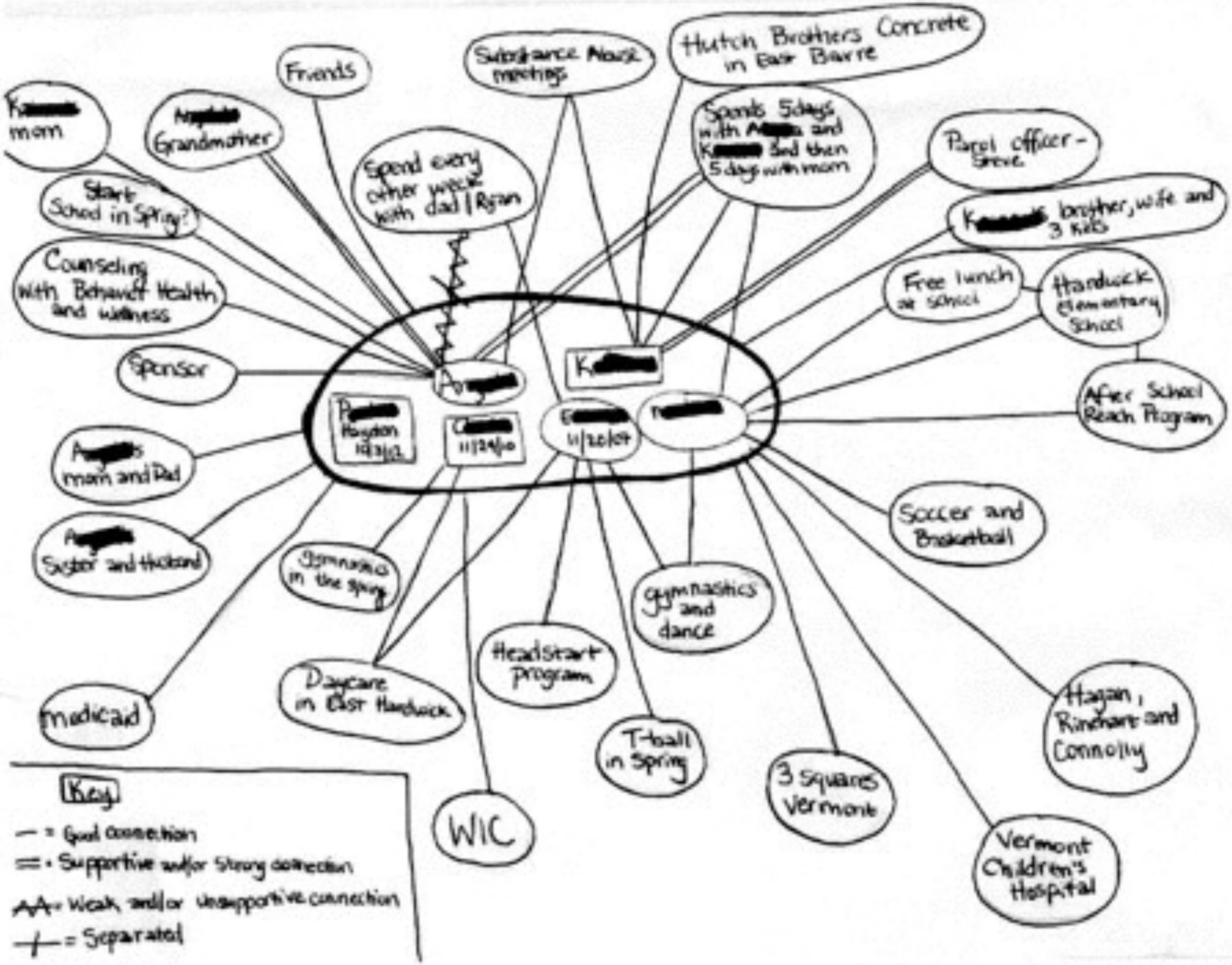
- "I don't have to be advocating and pushing all the time. Every visit, even sick visits, at the end, we look at where we want to be and how we will take baby steps to get there, even when there are setbacks, and there are always setbacks, but I don't get as discouraged, because we have a plan, we know where we are headed."

ECOMAP

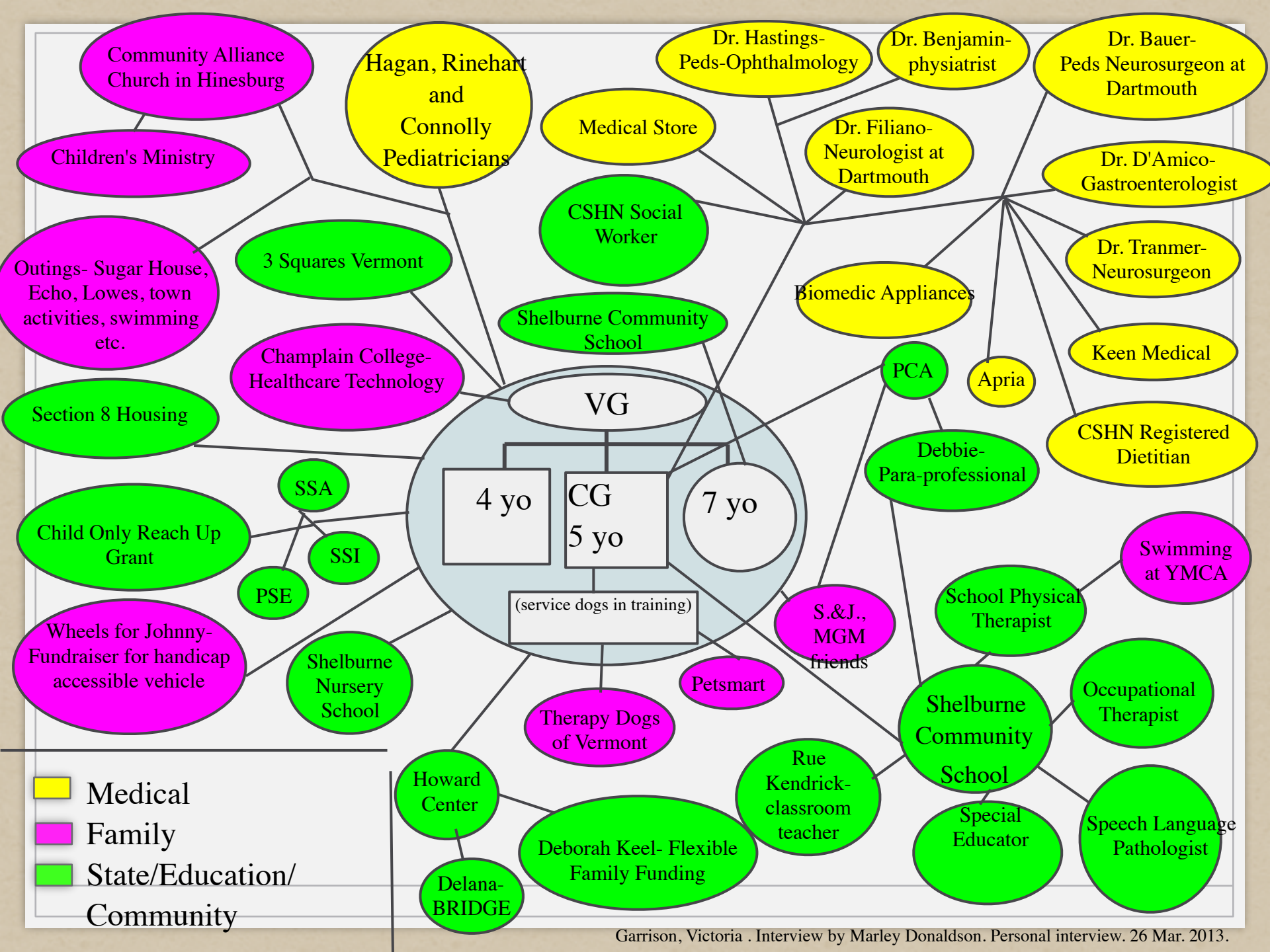


Newton, Marinell, McAllister, Jeanne, et. Al, "The Comprehensive, Integrated Care Plan (CICP)," The Lucille Packard Foundation for Children's Health, 2013

[redacted]

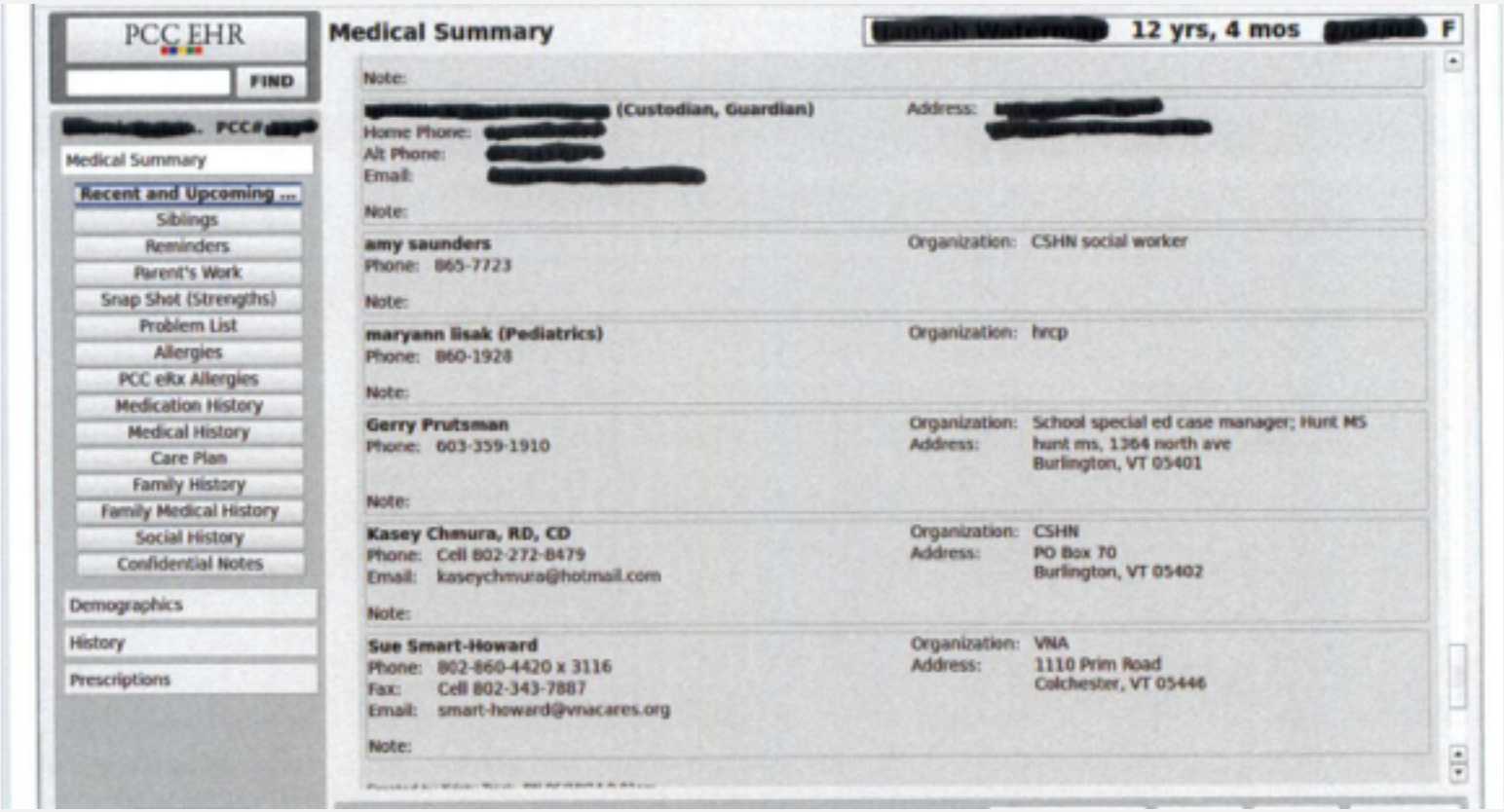


[redacted] mom
[redacted] Grandmother
Friends
Substance Abuse meetings
Hutch Brothers Concrete in East Barre
Spends 5 days with [redacted] and [redacted] and then 5 days with mom
Parol officer - Steve
[redacted] brother, wife and 3 kids
Start School in Spring?
Spend every other week with dad/Ryan
Counseling with Behavior Health and wellness
Free lunch at school
Hardwick Elementary School
Sponsor
[redacted]
[redacted]
[redacted] Hayden 10/3/12
[redacted] 11/24/10
[redacted] 11/20/07
[redacted]
After School Reach Program
[redacted] mom and Dad
[redacted] Sister and Husband
Gymnastics in the spring
Soccer and Basketball
gymnastics and dance
Headstart Program
Daycare in East Hardwick
medicaid
T-ball in Spring
3 Squares Vermont
Hagan, Rinehart and Connolly
WIC
Vermont Children's Hospital
Key
— = Good connection
= = Supportive and/or Strong connection
AA = Weak and/or unsupportive connection
-/- = Separated



Garrison, Victoria . Interview by Marley Donaldson. Personal interview. 26 Mar. 2013.

Contact List



Contacts

Demographics — **Pebbles Flintstone 10 yrs, 1 m**

No Preference

Home Address
Wilma Flintstone
15 Quarry Lane
Winooski,VT05404

Phone
Home Phone: 802-555-0194
Work Phone: 802-555-0197
Cell Phone: 802-555-0161
Emg Phone: 802-555-0168

E-mail: stones@HannaBarbera.com

Account Flags: CONFIDENTIAL

Billing Address
Fred Flintstone
1400 Rock Road
Winooski,VT05404

Phone
Home Phone: 802-555-0105
Work Phone: 802-555-0146
Cell Phone: 802-555-0112
Emg Phone:

E-mail: stones@HannaBarbera.com

Account Flags: Billing Problem

Relation to Bill Payor: Child

Personal Contacts

Barney Flintstone (Uncle)
Phone: 802-564-2039

Address: 1 Main Street
Winooski, VT 05404

Note: Watches Pebbles after school.

Betty Rubble (Registered Nurse, Other)

Organization: Bed Rock School
Address: 1245 Bed Rock Ave
Winooski, VT 05404

Note: School Nurse

Care Conferences

- Introductions, share contact information
- Set Agenda
- Set Roles: Provider and Family facilitate meeting
- Start with Strengths
- Discussion following the Agenda
- Minutes recorded (by Care Coordinator)
- Update Plan with “Next Steps, Accountability
- Next Care Conference Date (if needed)
- Care plan is shared at end of meeting

Coordinated Care??

- Mind the Gap

Shared Care Planning

Patient/Family/Team Goals	Negotiated Actions	Process and Outcome measures
Less Self- Injury	Psychiatry Assessment Co-management In-home behavioralist	Keeping family together Less need for police and Crisis support
Improve school attendance Improve education supports	Same behavior plan across settings Explore alternative school placement	Clear communication btwn home/school/providers Alternative program found
Repetitive behaviors	Improved psychopharm Improved wrap around services Improved behavior plans	Innovation: across silos of mental health, developmental disabilities, CSHN and school

Care Story 2

- Mary is a 4 year old with tuberous sclerosis whose self-injurious behaviors, tantrums, sleep dysfunction-- heading towards inpatient psychiatry hospitalization
- Despite having a VT developmental services waiver, respite care and a team of multidisciplinary medical experts at Mass General
- Intractable seizures seemed the least of her concerns in comparison to behaviors
- Strengths: strong parent involvement and expertise, loving respite family, Mary engaging, verbal with cognitive strength (can anticipate seizures)

Patient/Family/Team Goals	Negotiated Actions	Process and Outcome measures
Less need for "crisis" intervention	Co-management from psychiatry, medical home and subspecialists In-home behavioralist	Less need for police, mental health crisis support
Improve Sleep	Same behavior plan across settings	Less communication errors about medications Improved work attendance
Increase Home Safety-of Mary and family	Improved psychopharm CSHN SW: Waiver allowed for enhanced access to in-home behavioralist	Innovation: region contracted with vendor outside of network Less Crisis Need
Mary to attend school Improve social relationships	Communication opened between school, behavioral plans, family, medical home	Making academic gains Attendance improved Cannot pick her out from peers

PARENTS' VOICES

NO CARE COORDINATION

- I would be on hold for an hour, and then they would tell me to go to the hospital. We were going to the ER pretty much every other week.
- Don't get me wrong, I love Dr_, but it was the structure, the organization, that was the problem.

Maier, Parent interview, March 6, 2014

WITH CARE COORDINATION

- Now, someone immediately picks up. They are always calm and responsive and find the right person to talk to me. Now, there is always a plan. I know what steps to take, and when to call back.
- Now, (the doctor) is able to network better and is proactive. There is more of a holistic view, why are the symptoms happening, what to do to figure out the bigger picture…we have only been to the ER once in the last six months"

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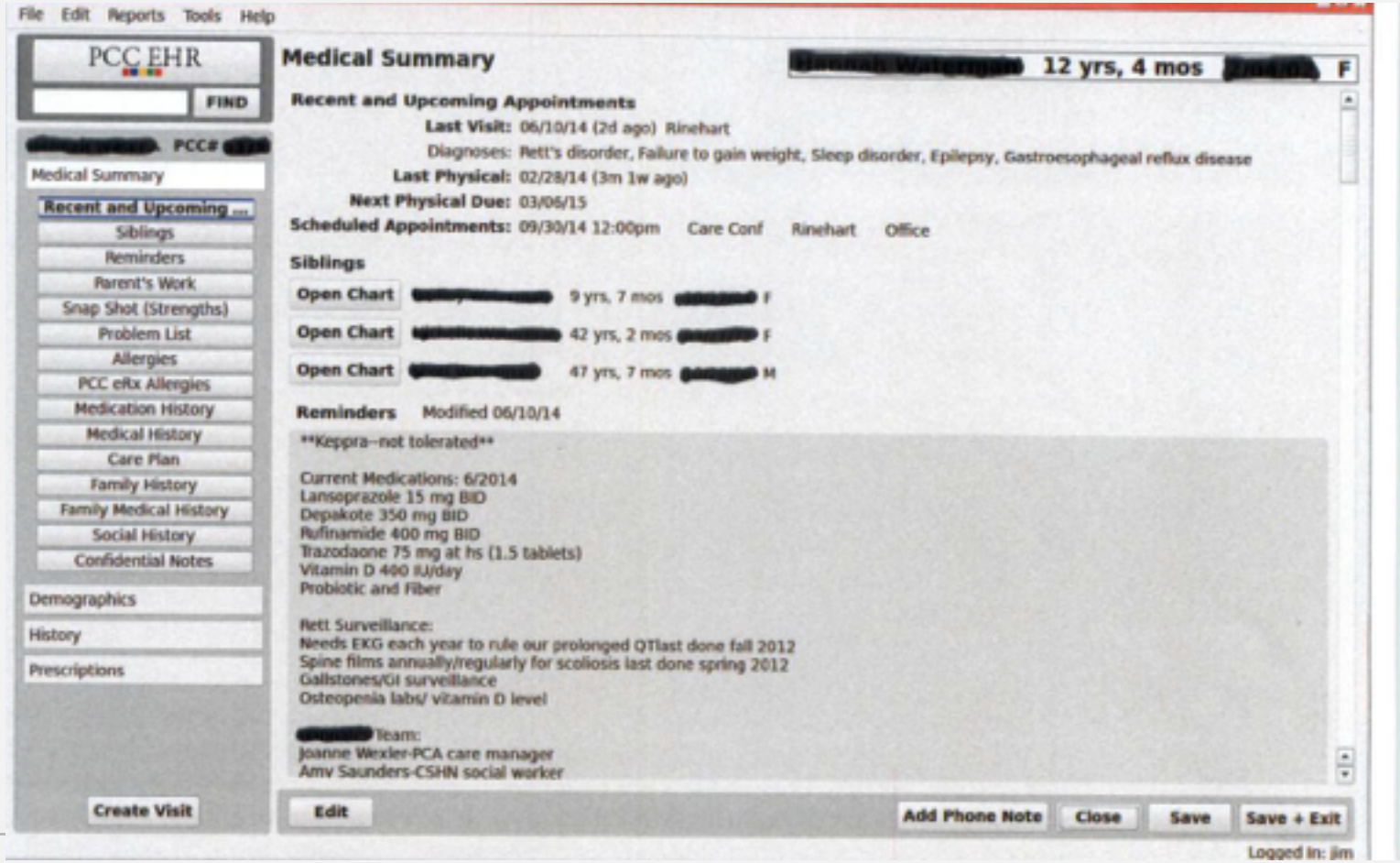
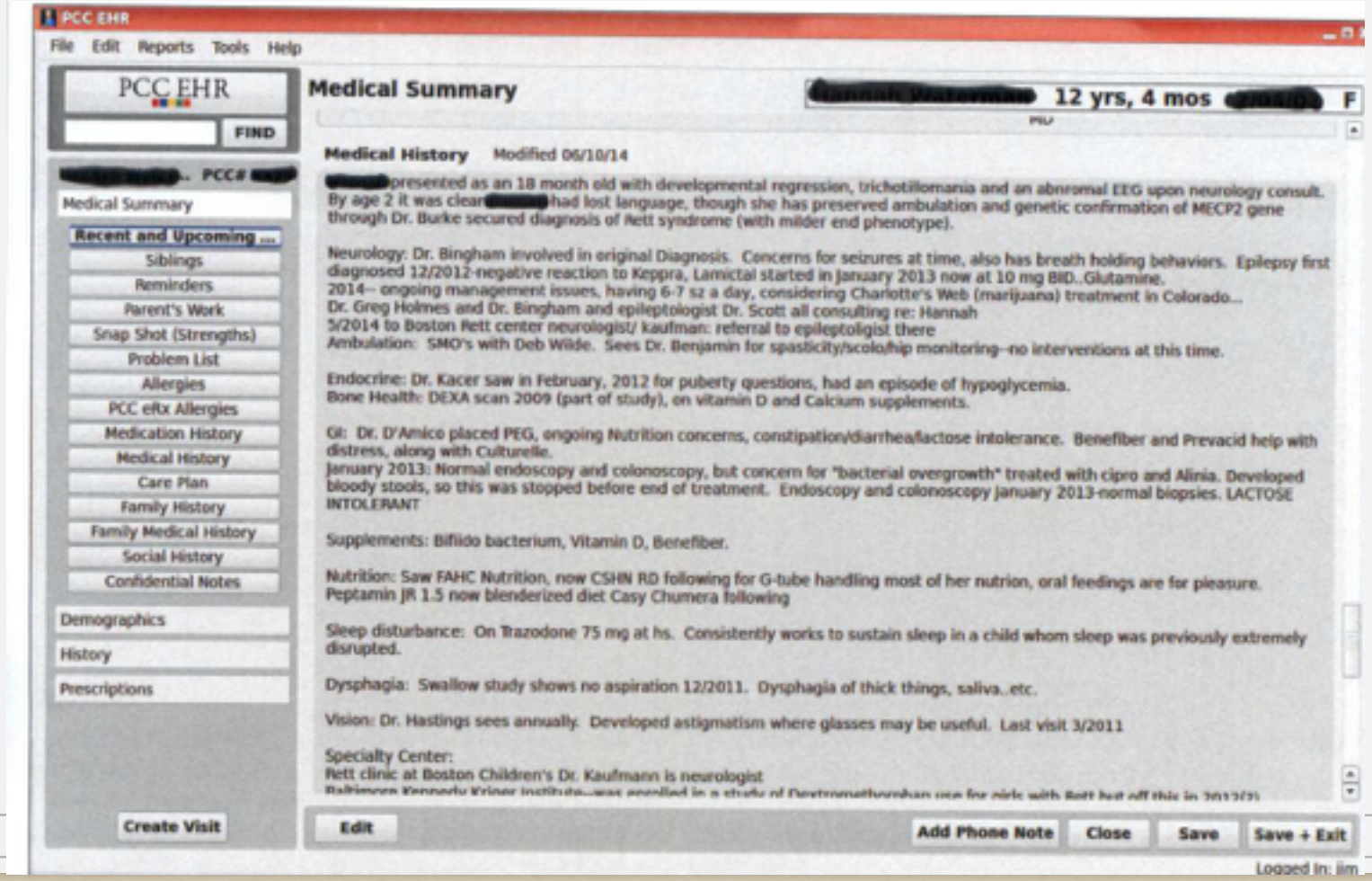
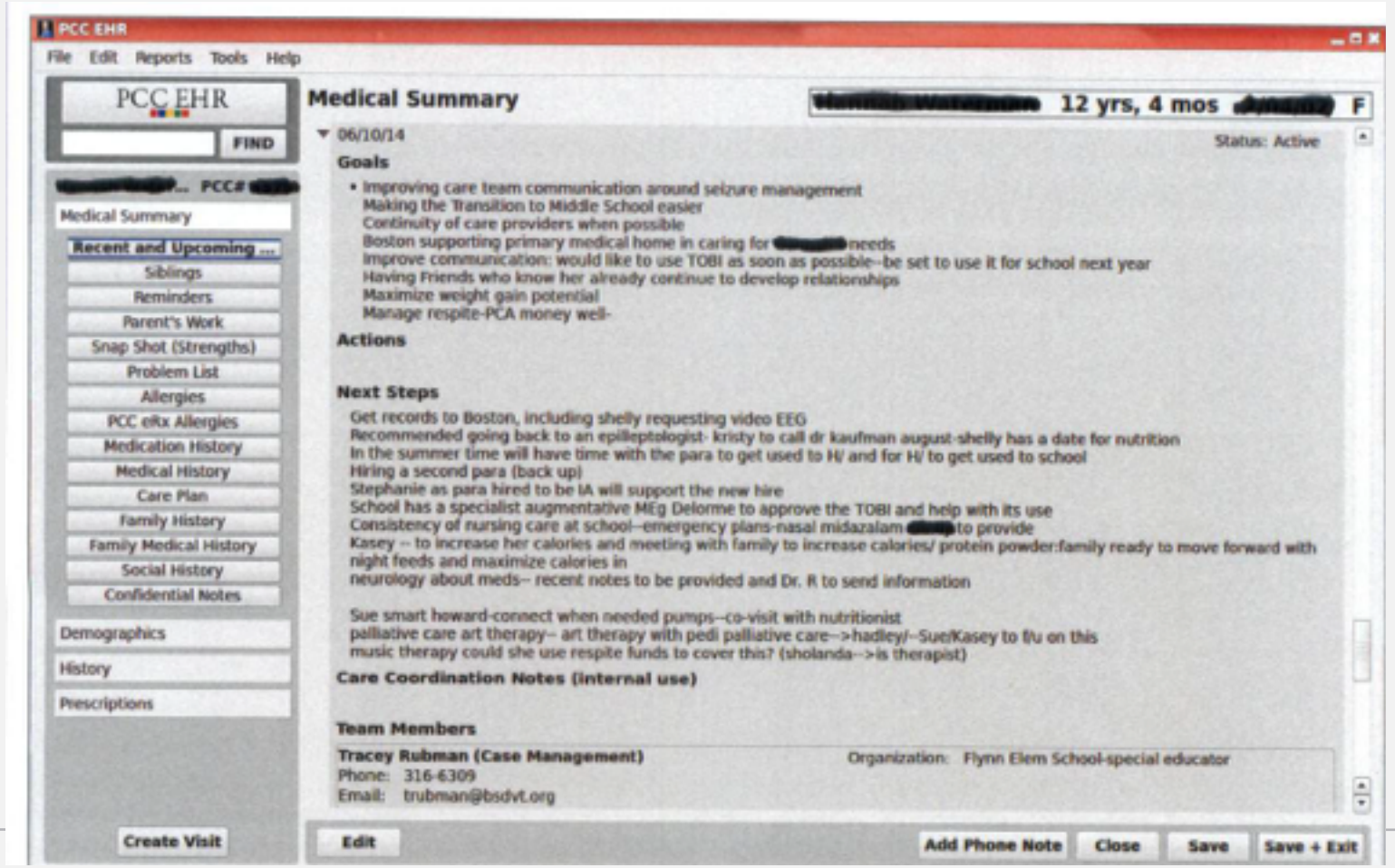
Medical Summary



Important Synopsis



Negotiated Next Steps



Care Plan

Medical Summary — **Pebbles Flintstone 10 yrs, 1 mo 5/21/06**

PCC eRx Allergies Updated 07/19/16 10:11 AM

Drug	Reaction	Onset
amoxicillin	mouth swelling	

Medication History Updated 07/19/16 10:11 AM — Display: All Statuses

Active	Drug	Formula	Details
✓	Adderall XR (dextroamphetamine-amphetamine)	capsule,extended release 24hr 20 mg	Take 1 capsule by mouth twice a day Dsp. 60 capsule by Mark Williams, M.D.
	cefadroxil (cefadroxil)	suspension for reconstitution 500 mg/5 mL	Take 0.5 teaspoon dissolved in water twice a day Dsp. 50 ml (last 06/19/16 stop 06/29/16) by Mark Williams, M.D.

Care Plan — Print — Display: All Statuses

07/19/16 — Status: Active

Goals

- Control Asthma
- Start soccer with asthma controlled

Actions

Next Steps

Pebbles will start taking a new medication for her asthma and will also have her inhaler for physical activity. We will follow up with the school nurse and her PE teacher and coach to assess Pebble's progress on the new medication. We will schedule follow up appointments with Pebbles every three months to check vital signs and check-in on her medication use and overall health.

Care Coordination Notes (internal use)

Team Members

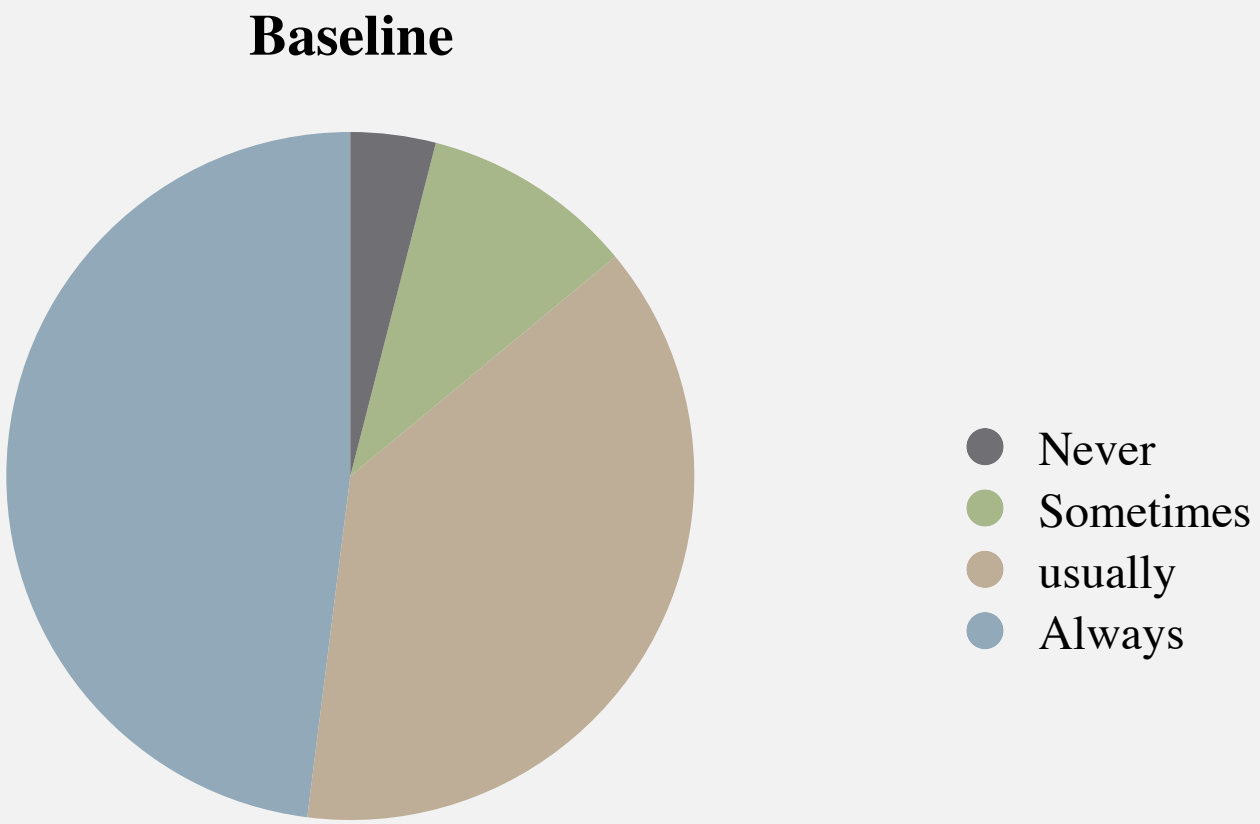
Created by Elizabeth Casey, M.D. 07/19/16 10:09am

All Practice Data

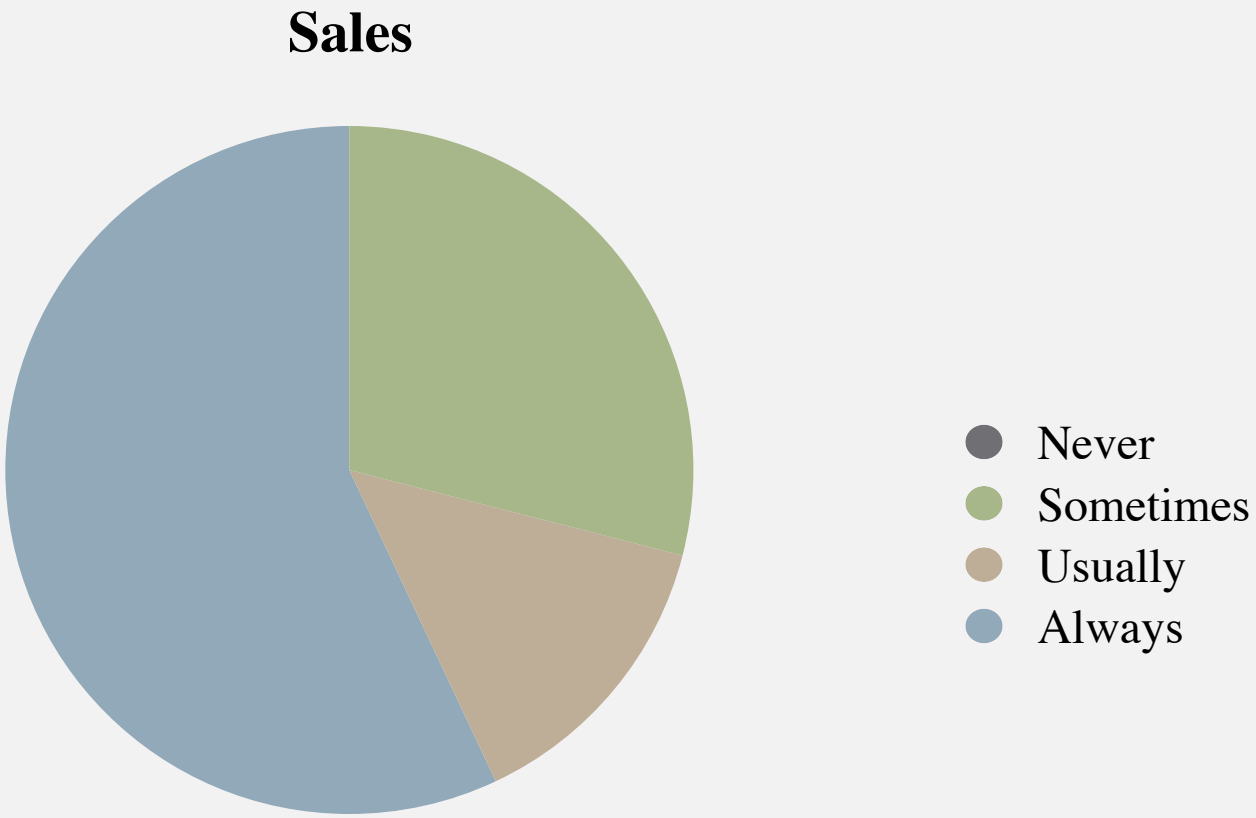
Enrolled: 138	Baseline	6 month follow	
At least one care conference	20	35	
Working with CSHN SW	56	65	
Shared Plan of Care	25	66	

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

How often did the practice help the family get needed family services?



How often did the practice help the family get needed family services?



Complex Care Coordination Codes

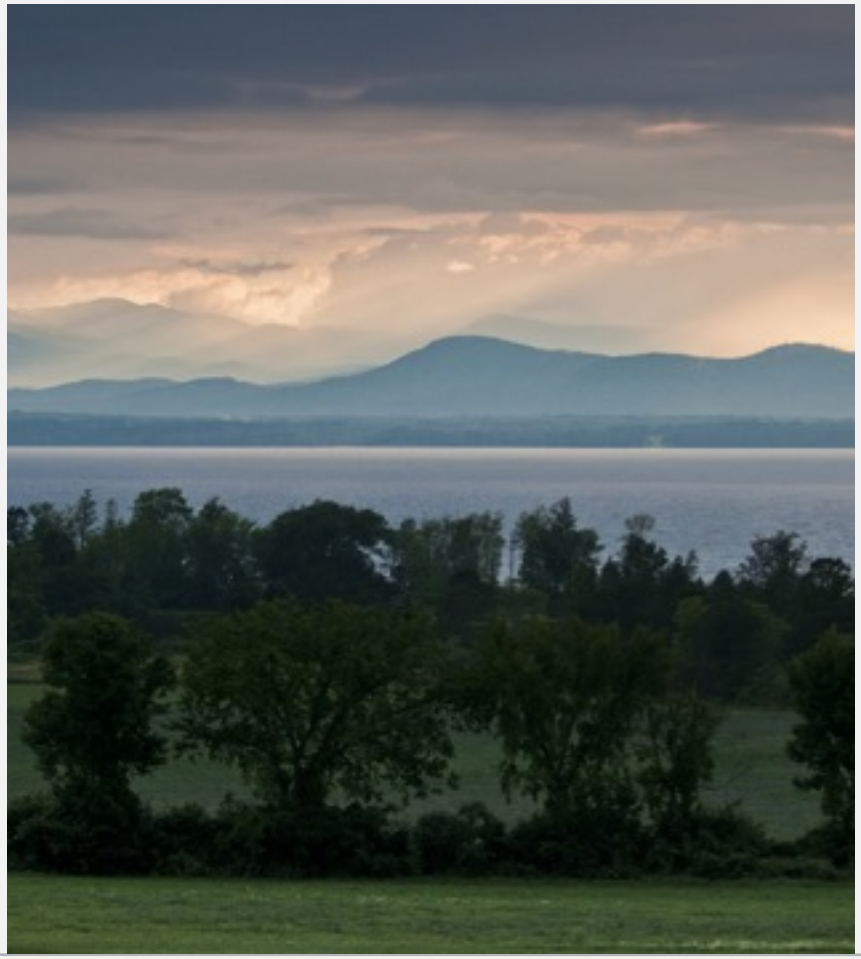
- 99487-9—Clinical Staff Reimbursement Codes, non- face-to-face
- 99488 includes one office visit plus one hour of care coordination services.
- 99487 involves one hour care coordination
- 99489 for each additional 30 minutes for care coordination
- **99215 highly complex office visit-care conferences**
- **Prolonged Visit**

Future?

- Access to the shared care plan from community, families, medical home and subspecialists
- Adequate investment in this primary care system to support care coordination
- 16 states involved in Shared Plans of Care and outcomes measurement
- Care coordination is practice transformation for health care reform
- “App Orchard”

Thank you to our family partners

Crystal Abair
Carolyn Brennan
Tammy Carrol
Victoria Garrison
Liz Metevier LeFebvre
Peggy Mann Rinehart
Theresa Soares
Kate & Michael Stein
Shelly Waterman



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Questions?