

Summary of Medical Home Initiatives in Louisiana  
For ECCS meeting 12/13/04

Susan Berry, MD, MPH, Medical Director, Children Special Health Services (CSHS)  
State of Louisiana, Office of Public Health, Department of Health and Hospitals

**I. Intro:** Louisiana has been a national leader in medical home initiatives, which first began in Louisiana in 2000. At that time, Dr. Gary Peck, who was president of the Louisiana American Academy of Pediatrics (AAP) chapter, proposed that Louisiana host a medical home training for pediatricians, families and allied health professionals based on training materials that he had received from the national AAP office. And, we did. This was the **first medical home training** held by a state that was not led by a Shriner's Hospital.

-Was held in New Orleans in March of 2001

-Was a collaborative effort of Louisiana CSHS of the Office of Public Health, Louisiana AAP chapter, Children's Hospital, and Family Voices.

-Training emphasized the medical home concept (that a medical home is not a building, but an approach to providing high-quality services in a cost-effective manner).

-It was interdisciplinary and comprehensive, addressing each of the six characteristics of a medical home with practical suggestions for practices, such as flagging charts of CSHCN that may need longer appointments, obtaining feedback from families for practice improvement, providing information about community resources for family support, such as Families Helping Families, how to access Department of Health and Hospital programs such as Women, Infants and Children (WIC), Medicaid, and Office for Citizens with Developmental Disabilities (OCDD) services, and coding for maximal reimbursement for CSHCN encounters, identifying a care coordinator in the office to meet with families of CSHCN to identify needs and resources, and transitioning issues to consider for young adults with special health care needs working to achieve independence.

-130 people attended: families, allied health professionals and physicians.

-Received excellent feedback from the national AAP office based on evaluations received.

**II. Participation in Hawaii conference:** Because of our success, we were one of 10 states selected to participate in an AAP Medical Home Training held in Hawaii, in April 2003. Our core team consisted of Dr. Peck, Linda Pippins, CSHS Administrator, Phyllis Landry from Family Voices, Dr. Jean Takenaka, Medical Director for CSHS, and Dr. Keith Perrin, a pediatrician at Children's Hospital and in private practice who is our current Louisiana AAP chapter president.

- In this conference the 10 selected states presented their experience, successes and frustrations with medical home training, and developed plans for implementing the medical home concept in their states.

-The Promise to Louisiana that came from that conference is provided as a handout. This was the game plan for future medical home initiatives.

- III. Development of Regional Teams:** Our next step was to form a **Core Medical Team in Louisiana**, which consisted of all of the regional medical directors and administrators as well as central office leaders. There was a 1 day training held for the regional leaders, and each region then formed its own medical home team including family members, AAP partners, Community Care partners and other identified partners. This formed an infrastructure for future trainings around the state.
- IV. Subsequent trainings occurred in the Monroe, Shreveport, and Houma-Thibodeaux regions.** This garnered significant support from community partners including Shriner's hospital in Shreveport, Louisiana State University and Tulane University, Nichol State University, OCDD, Lieutenant Governor Mitch Landrieu who donated \$10,000 to the effort, and other community partners.
- V. Need for change in training model:** In spite of the excellent participation of physicians associated with CSHS, and the provision of CME for attendance, conferences as a whole were not well attended by pediatricians. However, Louisiana was not the only state that had this experience, but it was decided that other training models might be more successful for reaching and engaging Louisiana physicians.
- VI. Medical Home Learning Collaborative:** In 2003 Louisiana participated in the Medical Home Learning Collaborative sponsored by Maternal and Child Health Bureau (MCHB), National Initiative for Children's Healthcare Quality (NICHQ), and the AAP.

-To participate, states had to identify pediatric practices that were willing to devote themselves to becoming model medical homes. Office teams from each practice attended three 2-day training sessions focusing on incorporating the medical home principals into clinical practices.

-To facilitate the process, **CSHS would provide a care coordinator to the practice** who would meet with each family of a CYSHCN to determine the family's needs, assist with health education, link families with community resources, address educational and psychosocial concerns, and coordinate the child/youth's medical care. The model was to be implemented through Family Voices who would oversee the care coordination activities with the help of a medical home coordinator.

-In Louisiana **two very large pediatric practices were chosen** and have had care coordinators for the past year. The two are: Napoleon Pediatrics located in New Orleans, with lead pediatrician Keith Perrin, the current president of the Louisiana state AAP chapter; and, Dr. Tony Palazzo's practice in Bogalusa Louisiana, a pediatric clinic practicing in a rural community. Care coordinators for each practice are Louisiana Registered Nurses who not only developed knowledge of community resources, but could help with practical medical needs such as Gastrostomy tube care,

intermittent catheterization issues, medication questions, patient health education, and the like.

A third care coordinator will begin shortly at TigerCare Pediatrics, the LSU faculty practice clinic located in New Orleans. This is one of the clinic sites where pediatric medical students and residents receive their training. Not only will this locale provide a service to those families of CSHCN, but it will introduce faculty to the medical home concept as well as residents and medical students. By creating model practices with residents in training, it is hoped that the medical home model will be carried throughout the state as these residents start their own practices.

**Future model:** Finally, a third model was developed where instead of holding additional regional interdisciplinary conferences for physicians, the CSHS regional teams will develop one hour lunchtime presentations on the medical home to individual pediatric offices. By introducing the medical home concept to pediatric practices and bringing CSHS expertise regarding services available through the Office of Public Health and in the community, pediatricians will become aware of resources available to help them meet the needs of CYSHCN and their families'. Teams will consist of a CSHS social worker, physician, nurse, administrator and a parent liaison. Once the model is developed it can be adapted for each region throughout the state.

## **VII. What are the opportunities and barriers to linking to other areas in ECCS?**

Ideally, the medical home should ensure the coordination of all medical, educational, and psychosocial services that a child might need. It doesn't mean that they have to be the sole coordinator, thereby not taking advantage of other care coordination activities that may exist. However the medical home has to ensure that all of the family's needs are addressed concerning their CYSHCN. Currently, it is frequently up to the family to navigate the entrance into each service delivery system that they may need. Ideally, the systems should collaborate to provide a single point of entry. **Physicians need to know about ECCS, and our medical home trainings are the perfect opportunity for this education to occur.** Policies and procedures need to ensure access to all public health resources with a **single point of entry** thereby avoiding duplication of service, and further increasing comprehensive access to needed services.

**VIII. What one thing would I change that would have the greatest impact on health outcomes, other than this?**

Clearly, it would be increased Medicaid funding for the Medical Home and Care Coordination activities. In the present environment, a pediatrician in private practice has much more financial incentive to do procedures, such as ear piercing and wart removals, than to return parent phone calls, to take the time to do an ADD work-up, provide appropriate asthma education, or to coordinate the complex care of a child with special health care needs.

CPT codes such as E/M-25 modifier for extra work in a preventive visit, time spent counseling the family without the child present, codes for telephone calls to parents, schools, or other health professionals for filling out forms involved with making referrals, and other care coordination activities should be reimbursed by Medicaid and private insurers alike. The \$3 monthly care coordination fee does not begin to cover these expenses to a practice for a CSHCN. In fact, one of our model medical homes has decided that even with a care coordinator paid by CSHS, the increased work created for other office staff may not be financially worth it. Until our reimbursement schedules reflect an emphasis on meeting the needs of our families of CYSHCN, it will not be economically feasible for our primary care providers to become true medical homes.