



HomeBase

A Case Study of South Carolina's First Medical Home Mentor Site

The Project

A series of mentor medical home sites are being developed by the South Carolina State Medical Home Team under the leadership of the Title V program located in the South Carolina Department of Health and Environmental Control. The majority of project activities are funded by a three-year grant from HRSA that began in 2002. Key members of the State Medical Home Team include representatives of the state chapter of the American Academy of Pediatrics, Family Connection of South Carolina, Inc., the state's Medicaid agency, and the University of South Carolina School of Medicine.

Delivery Model

Through a partnership with the local health district, a licensed, master's level social worker with significant experience in coordinating care for children with special health care needs was placed in the practice of pediatricians Dr. Gratin Smith and Dr. Lyle Pritchard in September 2002. The practice is affiliated with Self Regional Healthcare in Greenwood and offers residency training in family medicine. Approximately 75% of the patients are Medicaid eligible, and the majority have been diagnosed with special health care needs.

The social worker, Ms. Lenora Talley, LMSW, was placed in the practice to serve as a care coordinator for a pilot group that ranges from 65 to 85 children with special needs. Ms. Talley remains an employee of the local health district, allowing her to bill Medicaid for Family Support Services, and sustain her position through revenue generated by billing. This model is a shift from the traditional public health model to an integrated public/private partnership.

Ms. Mary Gambrell, parent of a child with special health care needs, works with Ms. Talley on a part-time basis, offering parent to parent support to families in the pilot group. Approximately 27 residents are exposed to this project yearly, with their experiences supported by educational offerings on the medical home approach on a quarterly basis.

Criteria for Participation in HomeBase

Dr. Smith, Dr. Pritchard, and the practice's medical home team identified selection criteria for inclusion in the pilot group, named HomeBase. The selection criteria is as follows:

- Children with a medical need characterized by a complex illness, dependent upon technology to thrive, or requiring complex medications,
- Families of project enrollees demonstrating some risk including problems with care compliance, financial or ongoing transportation problems, and other family stressors
- School needs related to serious behavioral problems or management of attention deficit disorders and related conditions
- Mental health conditions present, in conjunction with any of the other criteria

Framework of Project

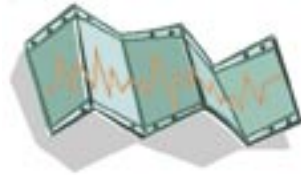
The framework used for project implementation was based on a program developed by the Center for Medical Home Improvement under the leadership of Dr. Carl Cooley. The Center asserts that the following six domains are defining concepts for a medical home: organizational capacity, chronic care management, care coordination, community outreach, data management, and quality improvement.

Medical Home Strategies

- (a) A licensed social worker was hired to serve as a full-time care coordinator.
- (b) The practice's medical chart forms were revised to reflect a comprehensive, coordinated care plan that promoted preventive as well as specialty care for children with special health care needs.
- (c) Changes to the medical record that facilitated the core service characteristics of a medical home were made.
- (d) The parent support person's role was enhanced to include conducting interviews with families of children with special health care needs on thoughts and concerns about their children's care.
- (e) A comprehensive resource manual containing updated information on specialists, community-based resources, school programs, family support services, state agency-sponsored services, and wellness programs has been developed.
- (f) Care coordination team members meet routinely with representatives from the state Title V program and the local health department. During the care coordination team meetings, specific cases are discussed so that a comprehensive care plan can be appropriately developed and managed for each child.
- (g) The project staff is also working to develop a closer relationship with the school districts by providing useful educational programs for teachers and parents.
- (h) Emergency management plans have been developed that involve partnerships with the local EMS.
- (i) Continuing education for office and clinical staff is provided on state and federal policies, various diseases and conditions, as well as the availability of community-based services.



Evaluation



Through a primary data collection effort, family satisfaction surveys have been conducted annually, with an initial

assessment occurring before the intervention. The most recent assessment using a tool developed by Cooley demonstrated that families of HomeBase were most satisfied with the following project components:

- (a) care coordination services,
- (b) relationship with the family,
- (c) advocacy work,
- (d) assistance in finding adult services, and
- (e) commitment to quality and family support.

Physicians and office staff are also surveyed annually to capture their unique perspective on how they view their practice as a medical home. Using a tool adapted from the AAP, providers and office staff recently indicated they were very satisfied with how HomeBase is providing compassionate and comprehensive care.

A secondary data analysis is used to evaluate the service utilization side of the medical home.



Specifically, Medicaid data is used to examine office visits, inpatient hospitalizations, emergency room visits, pharmacy

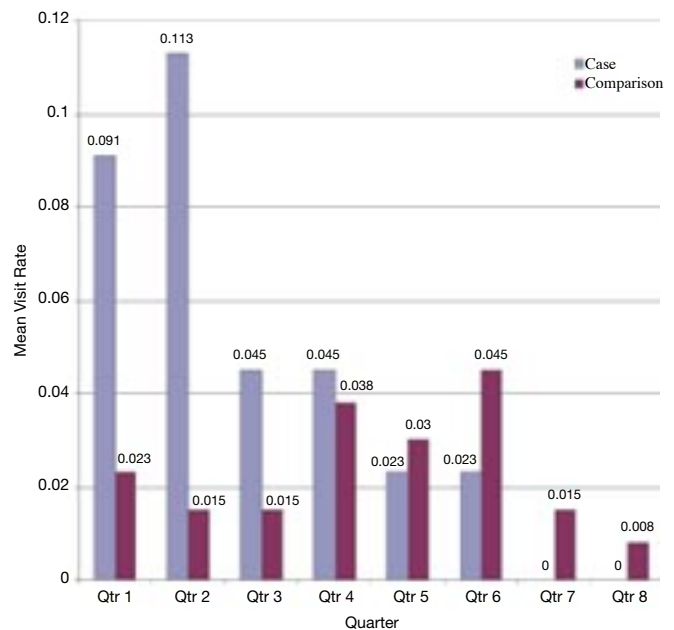
claims, and dental services. A comparison group matched on demographic, diagnostic, and health service utilization descriptors was created. The case group's service utilization was compared against themselves before the intervention and after 6-months into the medical home. The case group was also compared against the comparison group. After only 6 months in the medical home, the mean emergency room visit rate for the case group decreased over time and at greater rates than the comparison group. The case

group had significantly fewer emergency room visits resulting in inpatient hospitalizations than the comparison group.



The most dramatic difference, which was statistically significant, was the rate of emergency room visits resulting in inpatient hospitalizations for the case group from the pre-medical home quarters (1-4) to the medical home year quarters (5-8). The figure below illustrates the mean visit rate per quarter for emergency room visits resulting in inpatient hospitalizations. The case group's mean paid claims rate for emergency room visits declined at a comparable rate. Additionally, EPSDT visit rates increased over time for the case group and at a greater rate than the comparison group. No demonstrable changes were noted in inpatient hospitalizations. More participation time in the medical home may be necessary to affect changes in hospitalizations. A comprehensive cost of care model is being developed based on the HomeBase experience and will be available for review in May 2004.

Mean Rate for Emergency Room Visits Resulting in an Inpatient Hospitalization Per Child by Group and Quarter



The State Medical Home Team and Title V at the South Carolina Department of Health and Environmental Control have created educational materials on the medical home concept for children with special health care needs. Request medical home brochures for families or for physicians; resource brochures and posters; or a copy of an eleven minute training video on this concept. Contact information for requests is provided below.

Printed with the support of the S. C. State Medical Home Team and Champions for Progress at Utah State University. For more information contact betsywolff@aol.com or call 803-782-0238.

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