PRIMARY CARE MODERNIZATION

Community Purchasing Partnerships

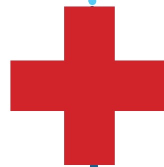
ELECTIVE CAPABILITY

Advanced Networks or FQHCs facilitate arrangements for home and community-placed services on behalf of pediatric practices that extend the reach of primary care to better meet the health needs of diverse communities, address social determinants of health (SDOH), or fill gaps in services.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Get help from your pediatric provider's office to find community resources to help your family achieve your health goals
- Get help supporting your child's health from organizations in your town or neighborhood
- Get help parenting or managing your child's chronic illness in your home or your community, possibly with others who have similar issues
- Get help coordinating your child's care with services in your community
  - Connect to services such as early intervention, developmental supports and transitional services for adolescents that are important to strengthening your family and supporting your child's long-term health



PEDIATRIC CARE TEAMS CAN...

- Engage community resources such as schools, childcare centers, and recreation centers to undertake population health interventions
- Offer connections to community organizations that can more effectively engage and support patients and families experiencing barriers to preventive and chronic illness care
- Enhance your ability to manage patients with special health care needs by partnering with community care coordination resources and home visiting programs
  - Reduce the burden on the primary care team by creating effective solutions for addressing health disparities and populations at risk for poor outcomes

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

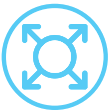
Nathan is twelve years old and was diagnosed with Dyslexia at age six. In elementary school, he worked with a reading specialist and tutor. Since transitioning to middle school this year, he has been acting out in class and getting poor grades.

Nathan's parents take him to his annual checkup at his pediatrician's office. They share that he is really struggling in school and doesn't seem to get enough support. Nathan starts crying because he says he "feels dumb" in class.

The pediatrician refers Nathan's family to the care coordinator, who connects them to a program that provides transition support services and works with their school system.

Nathan and his parents meet with the transition program's support specialist. She explains what services his middle school are required to provide and offers to meet with his parents and the school to develop a support plan for Nathan.

HOW



Care Team and Network Requirements

- Identify service gaps and needs for community-placed services:
  - Evaluate performance on health promotion, preventive screening, chronic illness management, care transitions, and management of patients with complex health and SDOH needs
  - Segment the evaluation based on population characteristics such as race, ethnicity, country of origin, language preference, health literacy, SDOH risk, sexual orientation and gender identity status, and disability status
- Contract for community-placed services to address identified service gaps, such as evidence-based navigation and coordination, early intervention and developmental services, chronic illness prevention and self-management services, complex care coordination for high-risk patients and families, parental support services, and transition services for adolescents
- Clinical protocols and analytics to support identification of patients and families that require these services
- Referral management protocols including determining whether families were successfully linked to and served by community-placed services
- Outcomes tracking including the impact on patient/family experience, healthcare outcomes and cost

Health Information Technology Requirements

- Electronic health record (EHR) that captures above population characteristics
- Analytics that enable performance analysis with respect to such characteristics
- EHR configuration or software to support referral management with respect to community-placed services
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved provider communication and medical home ratings such as "explained things in a way that was easy to understand" and "asked you if there were things that make it hard for you to take care of your child's health"

★ Quality

- Improved preventive and well-child care (e.g. immunizations, developmental and BH screenings)
- Improved chronic illness and behavioral health outcomes (e.g., asthma control)
- Reduced preventable hospital admissions for asthma

$ Cost

- Reduced emergency department visits and hospital admissions

Access

- Faster, more convenient connection to local, culturally effective health resources

IMPROVING HEALTH EQUITY

Patients and families experience barriers to care that result in health disparities. Health disparities start early and can be reduced through interventions in childhood. Access to culturally appropriate community-placed care can reduce disparities in the following ways:

✓ **Address health and preventive care needs in the home** or in a convenient, culturally appropriate and trusted community setting.

✓ **Better address social and environmental risks**, language preference and health literacy gaps.

✓ **Support pediatric practices** by filling gaps in services for patients and families experiencing barriers to care.

LEARN MORE!
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PEDIATRIC COMMUNITY PURCHASING PARTNERSHIPS

MEDICAL HOME

Uses person-centered assessments (including culturally appropriate SDOH screening) and/or analytics to identify patients and families whose needs are best met through community placed services. [See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Developmental Services	Chronic Illness Prevention and Self-Management Services	Complex Care Coordination for High Risk Patients and Families, Often with SDOH Needs	Parental Support Services	Transition Services for Adolescents
EXAMPLES OF MODELS	Health Leads	The Village Model	DPH Putting on Airs (Prevention Services Initiative), Healthy Me	Clifford Beers ACCORD Model	MOMs Partnership, Minding the Baby	CPAC REACH for Transition