Parent Navigators: A New Care Team Member in Your Medical Home or Specialty Practice

Faculty Disclosure:
We have no financial relationships to disclose relating to the subject matter of this presentation.

Learning Objectives

• Describe the role of the parent navigator in the healthcare team
• Discuss the emerging concept of patient-centered specialty practices
• Explore how parent navigators can be integrated into medical homes and ambulatory specialty practices
Parent Navigators:
Bridging the gaps between patients and families and the healthcare system

Who are Parent Navigators?
- Parents of children and youth with special health care needs (CSHCN)
- Hospital employees
- Members of the health care team in our primary care medical homes and the Complex Care Program

What do our Parent Navigators do?
- Mentorship
- Resources
- Navigation
Potential Patient and Family Benefits

• Learn about community resources
• Make contact with other families of children with special healthcare needs
• Be more involved in their child’s health care
• Influence care at physician’s office
• Feel less isolated
• Become better advocates for their child with special healthcare needs

Potential Practice Benefits

• Feel more effective in caring for children with special health care needs
• Learn about community resources and opportunities for patients and families
• Help to empower families
• Develop systems of care that best meet the needs of patients and families
• Ensure patients and families feel they are a respected member of their child’s care team
• Support office staff in caring for children with chronic conditions
• Change the way YOU care for children with special health care needs

Challenges: Creating and Sustaining a Navigator Program

• Identifying and securing continued funding
• Building and maintaining infrastructure
  — Data systems
  — Staffing schedules
• Standardizing parent navigation services hospital-wide
  — Specialty clinics with different versions of navigation
• Maintaining professional boundaries
• Overcoming communication barriers
  — Ineffective language interpretation
  — Lack of staff sensitivity to literacy levels and unique dialects
  — Cultural differences
• Maintaining employer flexibility
• Identifying certification programs
• Integrating social media
Parent Navigator: A Key Member of the Medical Neighborhood

What is the Patient-Centered Medical Home (PCMH)?

“The PCMH puts patients at the center of the healthcare system and provides primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”

(American Academy of Pediatrics)

Rationale for PCMH Certification

- Do the RIGHT thing:
  - for patients and families
  - in training the next generation of healthcare providers
- Align your practice with emerging models for primary care redesign and reimbursement
- Build the primary care practice of the future
Children’s National Primary Care Medical Home

**Enhanced “Medical Home”**

*Will build to suit - No “clinics” allowed - NCQA PCMH recognized*

**Enhanced Primary Care (10,000 – 12,000 patients)**
Small practice team focus/accountability + large center resources/efficiency

**Small Practice Team**
- Partners
- 1 FTE Provider
- 1 FTE RN
- 1 FTE Receptionist/Secretary

**Community Health Support Services**
- Social Work
- Health Education
- Case Coordination
-4201 Friendship Blvd
- Children’s Care Center
- Washington, DC

**Clinical Programs**
- Admission
- Care Coordination
- Inpatient Care
- Specialty
- Translational Pediatrics
- Special Care
- Family Navigation
- Nutrition

**Goldberg Center “Call Center”**
- Advanced Health Management Center
- Appointments, Triage, Advice, Refills, Results, Referrals, Outreach/Reminders/Clinical Compliance
- Technology enabled - eCW Web Portal - Required for EMR Meaningful Use Funding

**Patient-Centered Specialty Practice (PCSP)**
- Designed to improve quality & reduce waste and poor patient experiences
- Focuses on coordinating and sharing information between primary care & specialists
- Organizes care around patients
- Includes patients & families as partners in planning care

**Patient-Centered Specialty Practice: Standards for Recognition**
- Track & Coordinate Referrals
- Provide Access & Communication
- Identify & Coordinate Patient Populations
- Plan & Manage Care
- Track & Coordinate Care
- Measure & Improve Performance
PCSP: An Emerging Opportunity

District of Columbia
No specialty practices with PCSP Recognition

Texas
11 Practices with PCSP Recognition (including 5 satellites from one specialty group)
Cardiology, Nephrology, Oncology, Maternal/Child Health

Why Consider Parent Navigators or PCSP Certification?

- Increased Patient Satisfaction Scores
  - New transparency with provider-specific scores
  - Impact on referring providers and patients/families
- Enhanced provider and staff satisfaction
  - Multidisciplinary team-based care: “top of license”
  - Systems support coordinated care
- Improved Performance on Quality Measures
  - Pay for Performance Contracts
  - National Rankings: US News and World Report
- Changing reimbursement models
  - Value vs. fee-for-service
  - Global risk contracts

Let’s Discuss ...

Parent Navigators in your Medical Home or Specialty Practice
Contact Information

Karen Fratantoni, MD, MPH
Medical Director, Complex Care Program
kfratant@childrensnational.org

Cara Biddle, MD, MPH
Medical Director, Parent Navigator Program
Medical Director, Children's Health Center
cbidlle@childrensnational.org

Michelle Jiggetts, MD, MBA
Program Administrator, Parent Navigator Program
mjiggett@childrensnational.org