

HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING

Building Blocks for Promising Practice Models

October 14 - 17, 2007

Partners in the Medical Home for Children and Youth with Special Health Care Needs (CYSHCN)

RENEE M. TURCHI: I want to say what a pleasure it is to be here today and this entire meeting. It's the first time I've been to the MCH meeting. It's been really interesting and great to network and meet folks.

I want to take a minute to acknowledge our funders: Maternal Child Health Bureau; Bernie Mann and Bonnie Strickland, and the Pennsylvania Department of Health, Melita Jordan and Michelle Connors.

And also very importantly to me are the medical home team in Pennsylvania. Truly, Molly Gato and Deb Walker, who is our special programs manager, really are -- the program would not be in existence without them, as well as Suzanne Younghans, who couldn't be here with us today, who is the executive director of the PA chapter.

Today in our session we wanted to go over from the Pennsylvania perspective how we've implemented Medical Home, a little bit about the data collection we've done and some results. Molly is going to talk a little bit about parent partners and Michelle is going to talk about the cultural competency, access to care in some of our state partnerships.

So to start with, this MCHB definition of children with special healthcare needs I know people have seen this in multiple times. It's a broad definition that looks at children who have and are at risk of -- and I know many of you know this definition, how is it operationalized what does it mean. When we look at numbers we know from many of the folks that have done national survey work that anywhere from 13 to 18% of children have special healthcare needs across the United States.

And when we break that down to Pennsylvania, nearly 400,000 children when deploying that definition have special healthcare needs.

And again I wanted to sort of start with and briefly touch on if any of you are in Charlie Homer's session earlier, in talking about medical home you really need to take sort of a look at the theoretical sort of background what's been presented to us from the AAP and others and the whole idea of medical home being this approach and process to care, not a building. But a place where patients and families have centralized mechanism for care. They feel recognized and supported and where they get linked to other services, not just medical services.

And many of us have seen some of these slides. I feel like, from Charlie's presentation. It's like have you seen this before you can raise your hand if you recognize anything that's similar.

But again I think look at the AAP, people often talk about the seas of medical home. And as Charlie talked about earlier today, many of these seas they're all critical elements. But when I reflect on a lot of these and when we worked in the Pennsylvania with Molly and Deb, we've talked about how all of these are essential ingredients, but really how do you operationalize them? And we're working with practices it's all, these are all very, very critical elements. And they really are meant to be omnipresent. So when you talk about family-centered care, yes, parent partners are a critical element but it's not the only piece of delivering family centered care it has to be from the second a patient walks into your office to every time you answer the phone. Again culturally competent care and all the components we talk about in a theoretical framework need to be omnipresent.

I sort of think about -- I was thinking about this last week thinking about this presentation and was thinking about with my own children, how I sort of talk to my daughter about do unto others as you would are have them do unto to you or wash your hands. It's tenets of living your life but it's not like very specific implementation or very specific steps.

So we also in thinking about some of, sort of getting to how we operationalize this, I wanted to just highlight one of the joint statements that has been put out this past we're. And I think the joint statement that came out is an interesting one to mention because not only was the AAP at the table, but some of the adult folks were as well.

Folks from internal medicine and family medicine and from the osteopathic association, and we talked a little bit about in the earlier session if you were there with Dr. Homer, about this issue of medical home now being brought to the forefront in the adult arena how that may really be an opportunity for those of us in pediatrics. And how we really can converge on some interests and alignment but how we can also sort of keep our children and our interest in pediatrics still forging that ahead.

And the joint statement is available on line, but really they talk about, and again it's a brief statement. But talks about things it takes it down to a little more -- little less theoretical but talks a lot about folks having a personal physician and how that should be a physician directed medical practice. But really that translates to more this idea of a team. It's not just a doctor but that there's this whole team that implements medical home.

And that the whole person orientation. So looking at children from birth through chronic illness, acute emergency crisis and also end of life care.

Looking at care coordination across multiple systems. We've heard that many times. Quality and safety on many levels with families and how we deliver care. And enhance access with things like where offices are located, their hours, and also appropriate payment for services.

This also looks familiar. I hope you were paying attention earlier. But this is the model that Wagner and Carl Cooley and Charlie Homer worked on, which I really think, when you think about a framework, again trying to distill down to how we took some of these tenets to really explain what we were doing, I think this model really emulates a lot of the pieces that we employ.

And I think not to belabor, because I recognize many of the faces from this morning with Dr. Homer's presentation, but I think the key part of this schematic is that the health system is sort of nestled in the community resources and policies. Really implying that there's sort of this marriage that you can't divorce yourself. In the health system, we can't just operate in a silo.

And that within that healthcare organization, the medical home, that we recognize that clinical information systems, things like EMR and decision support for families, including them in care, as well as how we design our delivery system. So your practice teams, what the components are of care coordination and how that is coordinated with our community and our folks in Title V and our states and commonwealths.

And again sort of looking down, what are some of the results of that. So looking at a very, a quality healthcare delivery system within an informed family and an integrated community and practice team.

So taking this down really to Pennsylvania. So what have we done? What is our program? We always, Molly and I upon affectionately call ourselves the Pennsylvania medical home program because EPIC seems to be the acronym that predates our involvement. But the EPIC stands for Educating Practices in Community Integrated care. It's based on the EPIC model. Many of you may have heard of, maybe not. But it's the idea of educating physicians in their communities. And different states or programs used the EPIC model to roll out other quality initiatives around things like obesity, immunizations. So it took a quality improvement model and applied it to rolling out medical home.

And basically the idea at its inception about seven years ago was to work with pediatric practices across the Commonwealth of Pennsylvania and really working with them on implementing medical home principles within their practices while working with community resources and the state, the commonwealth of Pennsylvania while doing this.

So what do our practices do? Well, many of things. I mean what we really wanted to list some very tangible things. One of the things we do where we have monthly quality improvement teleconferences where we describe a variety of issues from things like medical topics, like when the HPV vaccine how folks were dealing with reimbursement to things like transition or coding or when we worked on PDS cycles, we talked about those.

We also have biannual quality improvement conferences that provide networking opportunities and I'll talk about one of our most recent ones that was two weeks ago a little later when we talk about cultural competency. But again these forums, we typically provide some speakers that we bring in. We often solicit from our practices about what they're interested in hearing about, but we do a range of things we often try to include coding or usually have one medical topic, maybe on a disease specific issue, but we particularly always offer breakout sessions for the practices either work in team or with other practices on working on quality improve issues and how they're going to translate some about what they've talked about or what some of our guest lecturers have talked about into practice, what they're going to bring back in real time and what are some of the systems changes they're going to do, anticipated challenges, barriers, those kinds of things.

We work with practices on identifying the children and youth with special healthcare needs. We'll talk about that in a minute, via Registry. Parent partner recruitment which Molly will talk about in more detail, how we utilize those parent partners; that it's not just identifying them but how are they going to form change and what the practice does.

We also talk about coding and time management and there's many, many topics, and we really sort of get back to some of those theoretical constructs that were mentioned earlier. But I think that one of the things that I wanted to share this map of Pennsylvania and highlight several points. One was thinking a little bit about how Dr. Homer mentioned I think Carl and Jeannie talked about, the good, better, best, I think many of

us have done this with practices have struggled with how I sort of think about it as the many faces of medical home.

I think one of the things that Molly Deb and I have talked a although about is we're working with practices, seems as if there's never really the one thing. It's not like Curly and there's not one thing. There really isn't for many folks there's either multiple things and for different practices it's different things.

And often I think the real key is figuring out what it is that's most beneficial to the practice and what it is they want to change. So looking at the commonwealth of Pennsylvania here, this is a county level map. You can sort of see one of the ways we've tried to operationalize how long and how active different practices are, by talking them adopters where they're currently active in the program, meaning they go to all of our conferences or participate in our telephone conferences. We have those that have fully achieved implementation. And maybe those that we call trainees that have actually received training that are maybe a little less active. And those that are sort of more fresher in the implementation process.

And we also have some practices that have multiple sites sometimes in different counties.

And when we look at that map, it really in total today we've had 62 practices across Pennsylvania that we've trained in medical home principles. And we've worked; we also have 20 practices that have received funding for care coordination activities.

As a result of some of our funding we've been able to translate that to practices to be able to support some of their efforts around care coordination to help them get jump started until that funding is not meant to be long standing but more to help them protect sometime to figure out, do some quality improvement, figure out some system changes and have it be long lasting. The practices that do participate represent all the six public health regions in Pennsylvania and 29 counties and our practices represent urban, suburban, rural areas.

We have all the children's hospitals in Pennsylvania participating. And I think that one of the other big pieces of what we do is Molly talks to the practices a great deal. I do my best to also communicate with them. And we also try to do as much on-site practice visiting.

So even though we see the practices at the conferences, we'll often do road trips or tours where we go out and spend time and really, in real time, it's almost like doing a home visit for a patient where you really get to see what are some of the systems issues, and now that we've seen many practices, not to say that we're the experts, but oftentimes it's just linking another practice with a practice that's like them that may have

experienced similar issues or has similar challenges and really seeing them in their setting as proved to be very fortuitous for both parties.

The other big thing for us I think that we've learned is this whole idea of the medical home team. And that it's really key that even though there is a sort of a lead clinician or project leader in the practices that kind of champions, maybe the person who will always call into the teleconference but will always try to bring the other folks on board or really sort of the jump-starter to maybe bring handouts back but that really everyone across the practice has to buy into this notion that medical home for all children is really an important concept but that you have one real catalyst for it.

And when we look at our practices, the teams are comprised of certainly physicians but the nurses and the social workers, care coordinators, the administrative staff are huge pieces as well as the parent partners.

One of the things we've been working on is really working on an implementation guide. Deb and Molly have really worked hard at -- we find that sometimes we'll go out to practices and we talk to them about what our program is about, how we might be able to help them, what resources we can offer and many folks are pretty excited but they say what can I do tomorrow. They want something very tangible. Many of us are type A how do I get involved or engaged in this. We've been working hard on a tangible step one, two, three, sort of like a road map to get through the program.

And recognizing that it's a journey and that you might not necessarily reach your destination but that there's lots of support in that journey and there's many things that it's just very iterative and not going to just stop one day and be done with medical home. So identifying the team and the practice. Identifying that lead person and who are the folks in the office, particularly for some of the larger, for some of the larger offices maybe figuring out if there's going to be five or ten minutes dedicated to a staff meeting. But really identifying that core team that may meet independent of the staff meeting or however that may look in the practice.

And one of the next things we have them do is identify and engage their parent partners. As I said we'll hear from Molly in a little bit about that. We also really encourage them as they get more immersed to schedule some regularly schedule some team meetings where they can really sit down and hammer through issues, because as we all know, sometimes it can be six months and before you know it it's the next epic conference and maybe we haven't been able to move forward and the idea is we've talked about at the conference before.

We talk a lot and really help them create a process to identify their children with special healthcare needs. We've been finding recently that many of the practices that have been getting involved with our practice already have a registry, and sometimes it's just helping them figure out other ways to add patients or pointing out some of the things they can do with it.

We do have practices complete medical home index and we work with them with identifying community resources, having some of the community and statewide resources come into the office for lunch.

And really creating special relationships with them so they can call on them and have a real reciprocity. And we often work with them on having them plan a special event.

Molly is sort of notorious for it coming out and planning resource nights. At the practice where I am we're doing a big autism event for families that have new diagnoses of autism in north Philadelphia.

It's really important to help and support that, because there's many times where practices are doing things that other practices have done and we don't have to reinvent the wheel.

This is the address for our website, which Deb has designed, and it's really very user friendly. Very colorful. The big thing I'll say you really need to go to the website to check it out but she's done a nice job of sort of making it user friendly for both practices and for parents and the idea is that either and both can access either information but that it's important for it also to be user friendly for parents and caregivers.

So some of our data, collecting data we have found to be a very key element for many reasons. One is it's very important in the quality improvement process to know that

you're doing what you think you're doing to keep an eye on what areas you might need to work harder on.

We certainly want to give the feedback to patients and families that we're listening to them. For some of the practices the data we've collected has been helpful for employers in terms of pointing out what they're spending time on, showing the favorable outcomes and impacts of programs.

Certainly with payors, when we talk about getting reimbursement for medical home, data is important. And the altruism is important to help others as we're all trying to move medical home forward.

This is an example of the patient registry. We usually have practices use an Excel spreadsheet if they're adept at Excel or we try to help them. These are the different components that we have them collect data of birth, insurance. We have them calculate a severity score. Home care, whether or not they need home care or durable medical equipment. Diagnoses information and their status. We also have all the practitioners sign up, the parents sign a HIPAA release. And you can see, just as an example, one of the things we've tried to do is pull, for example, close to 9,000 children in our registry currently and we'll look at different diagnoses. We'll do this for the state program but even more importantly try to pull things that are germane and helpful for the practices. While they submit this data to us, Deb has been really instrumental in developing an access a larger database for us that's housed at the academy, and we can -- we're

planning or if the practice, for example, is planning a particular resource right around autism or we for example had done a state, there was a state initiative around fetal alcohol spectrum disorder, so we looked at how many children were identified with that and we're hoping via quality improvement and education perhaps identification and diagnosis would change.

Certainly for things like different obesity or pay for performance issues, the idea of having diagnoses being able to pull out is really key.

It's also helpful for us because we can look at particularly for things like asthma or autism where there's defined guidelines for the prevalence of these disorders, we can look and see if we're sort of on target. And at least with the kids we're looking at are we seeing more or less than what's out there.

This is just a pie chart demonstrating the insurance in Pennsylvania. Again, this points out to me where it's helped us work with practices in terms of identifying issues and how you can use the data to help.

In Pennsylvania, we certainly have Medicaid, folks are eligible based on federal poverty levels but we have a family of one law that children with certain diagnoses are eligible to receive medical assistance regardless of income. So that's where the public and private is.

So about two-thirds of the children in our program receive medical assistance in some form. And we also have a small percentage of children who are uninsured and we went back and looked at those children and we found that the majority of them were residing in areas where there was a large Amish population, the families because of cultural values were choosing not to be insured.

We also did have a practice that was at the time not accepting Medicaid so we kept them as unknown because we felt like that practice, those children could potentially be public and private. That helped us identify a practice they maybe they weren't aware of that family of one law and how looking at some of this insurance data might in fact help improve access to SCHIP and things like that.

This is another example of some of the data we've collected. We talked a little bit about the funding, I mentioned that we've given out to some of the practices for care coordination activities. And one of the things we were trying to look at is who is actually doing a care coordination in these practices? I think that one of the things we learned is that we physicians probably not the best at documenting this all the time, myself included. That a lot of times they think we don't think of ourselves as doing care coordination encounters, but we're doing it.

What we found, what other folks are finding, if there's a designated care coordinator, they're often the ones doing much of the care coordination; but I think it was important for folks -- when we break this down for the practices and give them feedback, to show

the time that their administrative staff or folks are spending on various activities, in terms of job responsibilities, allocation of resources or garnering more resources from their administration.

We've used some of this time tracking we've done and tried to translate it to outcomes. We have about two years of data that we're looking at to look at both the state level and practice level. And this is just a summary of some of what we found.

As I said, we had the practices that were funded really try to look at and track when they spent time on care coordination, what was the focus of that time, and what was the outcome of that. And we tried to really operationalize things around healthcare utilization and quality of life.

So as you can see, looking at we had over 50,000 encounter forms tracked. This is a summary of that. With that we prevented, I should say the program, it was the care coordination that occurred within the program prevented over 400 hospitalizations, over a thousand ED visits, over 700 school absences and over 500 work days missed.

You can see those that also occurred on the other column. I think one of the challenges in looking at some of this and why I think certainly need the help of a statistician is what we found in some of the data collection is it sometimes can be hard to operationalize how you determine if something is prevented or occurred. So we're able to look at this in

a more sophisticated way and controlling for things to make sure to sort of translate this into dollars.

As I mentioned we have all the practices complete the medical home index scores. And this is just a snapshot of some of our practices over time. We have them complete them yearly no matter how long they're in the program. It's also very gratifying for them I think to see which areas they need to focus on and work on and how they improve over time. And it really helps them hone in on one or two areas and then see that maybe the score went up or it stayed the same.

And then I'll have Molly talk about parent partners.

MOLLY GATO: Thanks, Renee. Parent partners is one of my favorite topics so I'm privileged to talk to you about parent partners.

We recognized when I came to the program four years ago and Renee came shortly thereafter, that we had some parent partners who were involved in our practices that were working directly with us at the time. But it wasn't what we wanted it to be. There was some gaps that we identified.

We knew all the reasons why we should have parent partners and what they could bring to our program. And we struggled with how to engage more parent partners and keep

them. I'm not going to read this because I think we've all seen and know the value of what a parent can bring to the practice.

As part of family centered care, we promote that the family with the care coordinator, especially the ones in the practices that we have funded, work together to do different things. Identify barriers. We had one practice who had a parent with a child who was autistic, do a walk-through with them. And really help them understand what could help them family when they came in with their child for the visit to make it as easy on everyone as possible.

And so they had an expedited sort of registration process where they would, the child and the parent would arrive. They'd go right back to an exam room. The front desk person, if you will, would go back to the room get all the information and bring it back.

And the same happened when they left. So it was a barrier that really one of the practices took their parent partner and utilized them well to do that.

Identify resources. I think it's sort of a change of mind set that we often think we can provide the resource information to our families. And I think I've come to realize that it's really just the opposite.

Families have wonderful resources and they provide us as the practices or to the practices far more information about local resources and we just need a way to gather

that all and have the parent partners in each practice help us create something that can be provided to the other parents of children with special healthcare needs, especially at their own practice or locally.

We do have some resources that we help the practices learn about so it can be a two-way system. Parents are experts on their child's diagnosis often, especially if they're not newly diagnosed. And especially if a child has a rare condition. Parents are on the Internet a lot as we all know. They're learning a lot and living with it. So they can again provide a lot of information back to the practices, and the practices can share their expertise as well.

I'd really like to think of it as a two-way street with our families and care coordinators work directly with the families on developing a care plan.

This is a slide many of you have probably seen, I hope. And I just love this slide because even though it was studied in 1989, I think it's critical to point out that as practitioners you don't always recognize what a family needs best. This by way of quick explanation is parents and physicians were given a list of services offered and they were asked to rank them in order and physicians obviously had a different idea of what families needed. Then the parents.

And I think it's just good to bring back to you need to communicate with your families about what they need.

Renee talked a little bit about some of the tools that we're using to collect data. And I think that it would be very short sighted of us not to include, which we haven't forgotten this, the parent's position and their perception of services offered.

What we've done is we've created Medical Home Family Survey. We previously had used the family home index, but we wanted specific information. So we looked at the different areas, components of medical home accessibility parent satisfaction and trust of their primary care provider, healthcare utilization, one of the things we found was that families may have taken their children to an emergency department that wasn't where their PCP was on staff. So the PCP may not have known that the child had gone to the ED. Unmet medical needs and why. And also just general demographic information.

And in trying to be culturally sensitive to this, we have offered the family several modes of taking the survey. When we have the families sign off on the HIPAA form in the practice, we figured out that we could print a preferred contact sheet on the other side of the HIPAA. So it's front and back. They have it. It's not another piece of paper for the practices to worry about.

And it asks them if they'd be willing to take the survey, what their primary language spoken at home was, and what method they'd like to take it. We will either send it to them in a hard copy.

We have a parent with a special healthcare need, actually, who isn't able to look any longer helping us call the families at home who want to complete the survey over the phone. And we also have an electronic copy that the parents can take on-line, and we've just finished our linkage so those surveys can go right into our database.

If they speak Spanish, we have the survey translated into Spanish. And we have some folks lined up for people who would like to take it over the phone in various languages.

And it also addressed literacy issues, because even though we may have families who were born and raised in the United States but may have some problems with reading and comprehension, it gave them an opportunity to participate and have a voice without having to say I have literacy issues.

Some of the areas that we talked about on the survey, this is one slide and I know Carl talked this morning about being a visual person. I don't think there was anything new in this slide that I didn't know but to see it in graph form really just kind of grabbed me.

We asked parents, one of the questions what does having a child with a special healthcare need do to you, personally? What are the effects of that? And we had some of our families who had no effect. They had children who were not very complex. But look at the inadequate sleep. I think of the nights I don't sleep for no good reason other than I can't sleep but I know that the next night might be good. Families that have a

child who are on monitors, who don't have nursing in the evening, whatever, that is huge, I think.

Relationship issues are huge. Either turning down a job, quitting a job, being fired from a job because they have a child with a special healthcare need, that to me really hit home.

I looked this weekend in preparation for the conference at just a couple of the other statistics that we have or percentages. We had 82% of the respondents identify that they have someone that they consider their child's personal doctor or nurse. Which I thought was really good in Pennsylvania.

We looked at some of the transition questions. We had 33% of the people completing the survey who had children over the age of 12. And although I think 52% of them said their primary care physician had talked to them about how the child's healthcare needs would change as they moved into adulthood. 63% of the respondents said they had no formal plan for that, which I thought was interesting.

So it's on the map but it's not on the map. So it's definitely an area we want to work in. And the other thing that I thought was very interesting is we looked at some spirituality questions, which it was sort of a last-minute thing we decided to throw in to see how that would go over. The demographic questions were ones they didn't have to answer.

They could move right to the end of the survey. It was totally up to them what they responded.

We had 83% indicate that they were religious or spiritual in some way, and 66% of those people felt that their spirituality helped them cope with their child's needs, which I thought was very interesting.

Now we're going to have Michelle talk to us about some of the work on the state level and access to care.

RENEE M. TURCHI: I'm going to take literally 20 seconds to talk about what we did to kick off -- Michelle is going to talk about that, I think really emulates the state partnership that's occurring with our medical home program. This is just to introduce the idea of cultural competency as discussed by our good folks at National Center for Cultural Competency. But we had a conference about a week ago in the Mechanicsburg area, where we did a training for practices around cultural competency. We had previously really had been struggling with how to specifically address this issue with our practices.

And so we had done a language screener to really assess and have the practices tell us what languages different families spoke. But we had at this particular conference had (inaudible) Good and Wendy Jones from the National Center of Cultural Competency

help us plan it. But it kicked off with (inaudible) from MCHB as well as the Commonwealth came and they really supported us in more ways than one.

Our Deputy Secretary Torres came and spoke about what the Commonwealth was doing around some issues around health disparities that practices don't often hear and don't know what's always going on at the state level.

Melita Jordan spoke about what's going on at MCH and also linked us to an attorney, a family court judge who is in the Philadelphia area who ultimately spoke.

We had breakout sessions so it really truly I think was an example of how sort of pulling together in a conference for us, and I think it was the first time we ever had formal presentations from folks at MCH as part of our conference really emulated a partnership.

MICHELLE CONNORS: Good afternoon. My name is Michelle Connors, and I'm representing the Department of Health. And I'm going to introduce my boss in the back of the room. If she wants to wave her hand, Melita Jordan, Bureau Director.

Welcome. I'm going to talk a little bit about the state partnerships and I'm very privileged to work with these two ladies. And we talked a lot about our presentation and what we could prepare for you. And in developing our presentation we wanted to talk about how we work together. And we think that's what makes our program special. And in trying to

put this together, I was looking for some quotes as I know Melita, she's always looking for some special things.

And these two things actually brought this home for me, because I think that health is really at the foundation, especially for our children.

And the medical home partnership, that's what I'm going to show new the next couple of slides, is really what we're trying to bring together in all our programs. And many of the programs I manage deal with children with special healthcare needs and what we're trying to do and working with Renee and with Molly is trying to bring together some of those programs through the medical home project and getting them to work together. But I really like these two quotes in particular.

And some of the things that I do in the bureau which I represent is I work with the Department of Education, the Department of Public Welfare and things like the Family Literacy Council, the Family Court Project, those kind of things. Health is at the center. If our children are not healthy, they cannot go to school or work.

This is actually at the center of their existence. These are simply just definitions. This is our mission. Secretary Johnson is our secretary. Pediatrician by background. I just included in here our mission statement. Some of our goals and objectives, elimination of disparities.

We all talk about linguistically effective healthcare. And as Molly talked about, the culturally competent workshop that we had just recently was excellent. We talked about many different things. The minority groups, imagine being in a pediatrician's office and not being able to understand if a pediatrician spoke to you, gave you a form and you could not understand, you could not read. It was not of your language and you were asked to fill that out or you were asked to follow someone's instructions.

These are just issues in public health. Factors that simply affect your health. Your income. Your educational background, where you live in a particular community. And what this is the Pennsylvania Department of Health. What we feel a child with a medical home certainly with the assistance of a care coordinator, they receive better preventive care. They're much more likely to take that appropriate medication and find it easier that child, their parents find it easier to navigate that system.

Healthcare is not a privilege. But it's a right.

This is something I want to focus on, and we all certainly know we do a five-year needs assessment. That's something we all have to do. Pennsylvania did it in '05. It identified strengths and weaknesses. Some things that we could be proud of. Many things we could be proud of. Some things that we needed to take a look at.

Some things that we needed to take a look at as far as children with special healthcare needs.

And one thing that it said was Pennsylvania you've got a lot of programs out there for children with special healthcare needs, but you know what, your public doesn't know about all of them.

So we've done a couple of things. And one thing I think we've done even better now is we're starting to collaborate. We're starting to work better with our other agencies. And one thing we've done is we've worked with our websites and one thing these ladies have just talked about is the medical home website has done a great job in advancing information to parents, to providers.

We also have a system of care program that is a field program that works out with the community in developing partnerships. They have a website. And we were the lucky award winners of a family to family grant. They are developing a website. So we're trying to collaborate and say we know that we have many partnerships across the state. We have many services across the state. We need to talk.

Because we have many things that we support with Title V dollars, but you know what we're not doing a good job about telling our public about them. And many times our parents have to stumble across the services or stumble over the services.

One thing I failed to mention, the bullet above, is our health and human services call center. It's our mini 211. Pennsylvania wants to have a 211 system. Hopefully some day soon we're going to get there.

But what this is an interagency concept. And it's a toll-free system. We currently have seven lines and it's a cross trained system where people can call and they can access information from prenatal care to long-term care information. But this system also has a website and a data system that has over 15,000 resources. That system is talking. But all this we're hoping to bring resources together. This is something I want to show you. This system is actually part of that call center, and this is an ad we developed for one of those lines. (Commercial).

This is what we feel all kids deserve. Thank you.

MICHELLE CONNORS: I'm going to finish up and I'm going to transform and be Suzanne Younghans for a minute since she couldn't be here today and talk to you briefly about the Pennsylvania chapter of the American Academy of Pediatrics. Listed at the bottom here are the eight programs that we house at the academy. Of course we put ours first since we're here today.

We have a traffic injury program. We work with them for children with special healthcare needs and appropriate restraints. The child abuse and neglect program, we also work with them. We're lucky because I think our program covers all of these in some way.

The newborn hearing screening. Clean Air for Healthy Children which does a lot with asthma. Early Childhood Education Linkage System which we've worked with for working with day-care centers for children with special healthcare needs to be fit into.

The immunization education program and the Pennsylvania child death review. Some of our collaborations are listed here. And Suzanne wanted me to tell you that the PA chapter of the AAP is involved in a long-standing coalition with the academy of family physicians and the college of the PA chapter of the college of physicians, and at 10,000 strong the coalition is a powerful voice for primary care medicine as well as the patients they serve.

Recently that coalition was awarded an improving performance and practice grant from the American Board of Medical Specialties to work on quality improvement initiatives in Pennsylvania.

Together we can make a difference. Our role at the AAP is as a collaborator to improve lives for children in any way we can. We look for partnerships and opportunities to enhance the work by expanding our network of professionals we work with. We have many, many people that we collaborate with at the moment and hopefully will continue to do that.

And we work on various issues. And we really can and we have made a difference in our advocacy efforts. Thank you very much.

(Applause)

[END OF SEGMENT]