

**MATERNAL AND CHILD HEALTH BUREAU (MCHB)
SPECIAL PROJECTS OF REGIONAL AND
NATIONAL SIGNIFICANCE (SPRANS)**

PROJECT TITLE: Hospital to Medical Home

PROJECT NUMBER: H17MC11289

PROJECT DIRECTOR: Pamela J. Oatis, MD, FAAP

GRANTEE ORGANIZATION: Mercy St. Vincent Medical Center

ADDRESS: 2213 Cherry Street
ACC Building, Suite 307
Toledo, OH 43608

PHONE NUMBER: (419) 251-8069

E-MAIL ADDRESS: pamelaoatis@mhsnr.org

HOME PAGE: www.mercyweb.org

PROJECT PERIOD: March 1, 2009 through February 28, 2014

TOTAL AMOUNT OF GRANT AWARDED: \$50,000/year for 5 years = \$250,000

ABSTRACT

PURPOSE: Community medical practices often do not meet AAP criteria as qualified medical homes. Children and youth with special health care (CYSHCN) needs who do not have a qualified medical home have more health care needs and less health care than those who do. The goal of the Project is to maximize the health status CYSHCN in a 17-county northwest Ohio region by implementing a model for their safe transition from the acute care hospital setting to a qualified medical home.

GOAL/OBJECTIVES: The project 1) provided at least 100 pediatric palliative care hospital consultations annually; 2) referred 95% of patients to a qualified, accessible medical home; 3) enabled 75% of patients/families to effectively utilize their community medical home; 4) improved the capacity of 25 community practices to serve as qualified medical home providers to children and youth with special health care needs; and 5) improved the quality of communication between the patient, family, medical home and hospital providers.

METHODOLOGY: The Project provides care planning, coordination and community referral to patients and families to facilitate effective transition to the community medical home; trains and consults with hospital and community practice clinicians and with families on the importance and use of the medical home, works with the Ohio Chapter of American Academy of Pediatrics to identify qualified medical homes and mentor novice medical homes, and provides training to improve the effectiveness of communication between families, hospital clinicians, and medical homes.

EVALUATION: The evaluation documents project outcomes in comparison to stated measurable, time-framed objectives. Results are reported and utilized for continuous improvement of the project and potential replication.

RESULTS/OUTCOMES: The Project met its goals and served 852 families of which an average of 93% kept their first appointment with the medical home and 83% effectively utilized the medical home by keeping all or most of their appointments.

FINAL REPORT

1. PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS:

The purpose of the Mercy St. Vincent Medical Center / Mercy Children's Hospital *Hospital to Medical Home Project* was to maximize the health status and quality of life of children with life limiting and/or life threatening special health care needs by implementing a model for their safe transition from the acute care hospital setting to a qualified medical home. This project fits the "mission of MCHB to work in partnership with communities, public-private partners, and families to assure the availability of medical homes, and build the knowledge and human resources, in order to assure continued improvement in the health, safety, and well-being of the MCH population. The MCH population includes all America's women, infants, children, adolescents and their families, including fathers and children with special health care needs (CSHCN)."

The MCH program priority under which the project was funded is the Individuals and Families program's Implementation of the Medical Home Program.

(<http://mchb.hrsa.gov/programs/medicalhome/index.html>) The Ohio Chapter of the AAP has been supportive of this project from inception recognizing the need of the population in rural and urban settings and providing us with a variety of programmatic and family resources.

One need this project addresses is for children and youth with special health care needs (CYSHCN) to receive their medical care from a medical home (MH). Data continue to reinforce the substantial benefits of medical home based care as defined in the AAP policy statement on the medical home. The 2009 national Survey of Children with Special Health Care Needs revealed that children who do not have a medical home experience significantly delayed

or unattained care as well as significantly more needs for health care and family support services. This same survey reported that while most CYSHCN have a usual source of care, the crucial medical home elements of care coordination and family-centered care are lacking. In 2009 only 43% of CYSHCN in the United States received coordinated, ongoing, comprehensive care within a MH; 34% of CYSHCN with public only insurance had a MH compared to 51% with private insurance. We have worked closely with the Ohio Chapter of the AAP who have provided resource materials and information about practices in our region. As a result of her work in this and other related projects, Dr. Oatis the project director, was named the Elizabeth Ruppert Pediatrician of the Year by the Ohio Chapter for 2011-2012.

The second need was for improved communication between the medical team and parents. We were awarded a 2005 CATCH grant from the AAP to study the need of physicians and parents of CYSHCN (life limiting or life threatening). Parent perceptions were studied through a qualitative analysis of interviews designed to identify the needs and barriers faced by families. The interviews revealed the strong desire that the medical team provide complete honest information and then listen to ideas and feelings.

The communication findings were especially pertinent to our Hospital to Medical Home project. Parents described how the way medical information was presented and how they were included in decision making either gave them the courage to advocate for their child or made them feel alienated, uninformed and fearful. They were clear that a critical component of competent medical care was the medical team listening to them, their thoughts, ideas, and feelings. They wanted the medical team to provide correct, consistent, direct information, and they wanted them to listen to the full range of their responses with respect and understanding. Parents said, “Doctors and nurses should listen to us, first of all” and “of course we are going to

be emotional. You should know that and stay open and try to keep in mind what we have to say.”

A child’s illness can threaten the foundation of family life. Families suffer when faced with a child’s illness. Suffering is exacerbated when care demands are intense, finances are threatened, and the needs of other family members go unmet. Communication that is respectful, clear and repetitive was requested and valued in virtually every parent interview. It was the listening portion of communication that was especially appreciated, particularly when deep feelings needed to be felt and expressed as parents faced the implications of the diagnosis, prognosis and treatment options.

2. GOALS AND OBJECTIVES:

The goal of the Project was to maximize the health status and quality of life of children with life limiting and/or life threatening special health care needs in a 17-county northwest Ohio region by implementing a model for their safe transition from the acute care hospital setting to a qualified medical home. The project was to:

- 1) provide at least 100 pediatric palliative care hospital consultations annually with special attention to care coordination, and transition to a qualified medical home;
- 2) refer 95% of patients to a qualified, accessible medical home;
- 3) enable 75% of patients/families to effectively utilize their community medical home;
- 4) improve the capacity of 25 community practices to serve as qualified medical home providers to children with special health care needs; and
- 5) improve the quality of communication between the patient, family, medical home and hospital providers by providing and teaching them Listening with Connection, a listening based communication tool based in theories and practice of Hand in Hand Parenting.

3. METHODOLOGY:

The Hospital to Medical Home project is carried out by a hospital-based Medical Home Liaison, utilizing an innovative listening based communication model, a continuously-curated list of MHs in northwest Ohio and southeastern Michigan, and distribution of a care notebook we developed. This is a consultation service for CYSHCN. The consultation team consists of the Medical Home Liaison, a primary care pediatrician with specialty in palliative care and a counselor.

The CYSHCN, who have various levels of severity, are identified as needing assistance by nurses, social workers and/or physicians who are involved with their care. Patients include those in the neonatal intensive care unit (NICU), pediatric floor, intensive care unit (ICU), emergency department (ED), subspecialty clinics, and rarely well-infant nursery who do not have a medical provider, are underutilizing their current medical provider and/or have extenuating psychosocial co-morbidities.

After a patient is identified, the Medical Home Liaison meets with the patient's family and establishes that this service is free and voluntary. The Medical Home Liaison offers a safe environment to understand the child's medical history and current needs with respect to a MH. Over the course of one to several visits, the Medical Home Liaison builds a relationship with the family. Non-judgmental, respectful listening is critical to the service. This is based on Listening with Connection, a listening based communication model which focuses on appreciation, connection, listening, warmth and firmness. (Details at <http://www.handinhandparenting.org>; and booklets) The project director developed this model in 2008-2009 as a participant in Harvard's six-month competitive application Palliative Care Education Program. She developed participatory learning opportunities that were well received and the Harvard faculty encouraged

her to develop trainings and expand the use of Listening with Connection. The Hospital to Medical Home project is part of that expansion.

The Medical Home Liaison listens to the family's upsets and the emotional overload that accompany having a CYSHCN (termed 'listening time'). During the listening time, the Medical Home Liaison does not judge, criticize, analyze, tell the family what to do or how to feel or act, but rather listens. The theory, and our experience, is that as families offload the emotions they think more clearly and function more responsibly so they are better able to make decisions and follow through with care for their child(ren) and themselves.

The Medical Home Liaison educates the family about MH including the qualities and benefits of a MH. She coaches the family on how to build a MH with their current provider or a new provider. The Medical Home Liaison empowers the family to come to appointments informed, respectful, on time and to have the relevant information. This education and coaching focused on preparing and empowering the family to be knowledgeable engaged advocates and shared decision-makers.

Every family in the program is offered a care notebook to organize and track their child's relevant information (e.g. tests results, appointments, consultations, diet input/output, medications, observed signs/symptoms). We developed a care notebook in Year 2 of the project and continue to improve it. Our experience is that although an electronic version of this information sounds logical, it has not yet proven to be workable for our families.

To help connect the family with a MH, the Medical Home Liaison provides a list of qualified MHs that matches the family's insurance coverage and geography. Not all MHs on the list are certified or credentialed, but they possess many MH qualities. Families are also given a set of questions from the American Academy of Pediatrics that we encourage them to ask

prospective MHs in order to find a practice that fits their family's needs. Regardless of the MH the family chooses, they receive the same coaching, education and follow-up from the Medical Home Liaison. Once the family has chosen a MH, the Medical Home Liaison ensures that before discharge they schedule their first outpatient appointment.

Some families need more than a MH. When the Medical Home Liaison learns about family needs requiring a social worker, she makes that referral. When families and children need listening time beyond what the Medical Home Liaison can offer to offload emotional upsets, the Medical Home Liaison refers them to a part-time on-site licensed counselor hired for this program and the hospital's bereavement service.

After discharge, based on clinical judgment, the Medical Home Liaison calls the family to confirm that they are ready for their child's first MH appointment. She calls all families after the appointment to ensure that they kept the appointment and discuss how it went. If they didn't keep the appointment, then the Medical Home Liaison works with them to reschedule. If it didn't go well, then the Medical Home Liaison starts again and works with them to find a new provider.

The Medical Home Liaison maintains contact with the family after discharge to ensure they are well-connected. If the patient is re-hospitalized, then the Medical Home Liaison reassesses the patient and family, reeducating and reinforcing the MH concepts.

The Medical Home Liaison, physician and counselor provide Listening with Connection to families per the family's needs and interest. All families receive respectful; strength focused listening, without judgment or criticism. Our team hosts a weekly lunch and our counselor leads a support group for interested families. She also provides individual, family, and child counseling utilizing the Listening with Connection model. We have conducted Listening with Connection trainings for 209 health care providers in pediatric practice, resident trainees, nurses

and social workers to improve the effectiveness of communication between families, hospital clinicians, and medical homes.

We established a mentoring group of six pediatricians experienced in the care of infants and children with complex medical needs. We gave their contact information to less experienced physicians in the region so they could be in touch to discuss patient management questions over the phone. We did not track these calls but do know the mentors were very willing and the newer practitioners were appreciative. Since we started 5 years ago, the group of capable physicians to whom we refer patients has grown from 20 to over 50 in the 17 county region.

The program has three innovations through the course of the grant period: 1) We further developed and utilized Listening with Connection, our listening based communication tool; 2) We expanded our service to outpatient subspecialty clinics; and 3) We expanded our service to less complex CYSHCN in the NICU, PICU, pediatric floor, and well infant nursery.

The Listening with Connection tool is utilized by our entire team, both as the basis upon which we approach our families, as well as for self-care. We interact with all families from a basis of respect, no judgment, no criticism or advice, focused on their strengths and challenges. We expect them to have upsets, fears, grief, and to cry and talk enough to offload the emotional content of their experience as care givers. As we listen with relaxed kindness, they clear their minds of confusions and unburden their minds to free their attention to think more clearly. As we listen to any needed offloading, our goal is to foster their strengths, get them needed information and backing to meet and solve their challenges so that they can be credible, informed respected advocates for their own and their children's physical and emotional health. The Medical Home Liaison and physician who meet with families utilize this approach. We also have access to a Licensed Professional Clinical Counselor who utilizes this methodology and tool with her clients

who need more resource than the RN and MD can provide.

Our Mercy Family Care Team of seven (data entry, spiritual care, mission and values, RNs, another grant coordinator and MD) meet weekly as a group and additionally in pairs or threes to use Listening with Connection for self-care. We find we can be more relaxed and pleasant with our patients and each other if we have a time and place for ourselves to talk with kindly faced listeners, without judgment, blame, criticism or advice and an agreement of confidentiality. When feelings and confusions cloud our thinking we are less effective. The listening times help clear those fogs and relieve tensions so we too can think more clearly thus function more effectively on behalf of our patients.

We expanded our service to outpatient subspecialty clinics. Several of the groups have asked us to be involved with patients who have not required hospitalization but who have need of our services regarding a medical home. The families often need a provider who can handle their medical complexity and for many the care notebook is a key resource to organize material to keep appointments and be an informed prepared shared decision maker whom the physicians respects.

We expanded our service to less complex CYSHCN in the NICU, PICU, pediatric floor, and well infant nursery. As our Medical Home Liaison's interventions and success with families became known, she was asked to see patients who did not have a serious life limiting illness but maybe was admitted for a medical problem such as asthma that was not well controlled. As time allowed she has expanded her services to those families as well. We have also trained another non-medical member of our team, not on this grant, to provide this service to families with a newborn in the well infant nursery. Our Medical Home Liaison backs her up handling situations that require her expertise. Even families who have a physician appreciate

knowing what a medical home is, the advantages, and how to come prepared for appointments so they can be respected shared decision makers.

The cost of the full program includes staffing (Medical Home Liaison who is an RN, Secretary/data entry, Listening with Connection Specialist who is masters prepared counselor, and Project Director who is a physician), incentive and educational materials. The bulk of the costs are in our human resources and direct care. We served 852 families and had 5,411 touches averaging 6.35 contacts per family. Our total costs over the five year grant period was \$760,405 with means the total cost per family was \$892.50. We did obtain support from the Mercy Foundation and United Way Funding to provide additional funding for staffing. Those additional hours are not included because these funding sources had different target population, but it did provide us the opportunity to employ staff at full time levels.

4. EVALUATION:

The project evaluation was supervised by the Project Director. Data was collected by the Medical Home Liaison and recorded by the Secretary/Data Specialist. The evaluation measured project results related to the Maternal and Child Health Bureau Performance Measures as well as the outcomes of the project compared to stated objectives, providing feedback for continuous improvement and data to support replication.

OBJECTIVES	OUTCOMES MEASURES
<p>1. Provide at least 100 pediatric palliative care hospital consultations annually, offering comprehensive, family centered care focuses on acute curative care integrated with quality of life, care coordination, and transition to a qualified medical home.</p>	<ul style="list-style-type: none"> • Number of pediatric palliative care referrals recorded monthly/annually • Number of pediatric palliative care patients readmitted to the hospital • Present one physician grand round and one nursing grand round annually (10 total over 5-year project period); • Lead 12 case conferences annually; • Family members involved in 30% of all in-services; • Family members will comprise 20% of Advisory Board members.

<p>2. By 2014, 95% of pediatric palliative care patients will have a referral to a qualified, accessible medical home at the time of hospital discharge.</p>	<ul style="list-style-type: none"> • 100% of parents who do not have a medical home for their child will receive a listing of medical home providers in their community • Referral to medical home documented in discharge plan; • Completed teaching materials about benefits and appropriate use of medical home by end of year 1 • Number of medical home teaching materials distributed annually • Listing of qualified medical homes can be located on acute care units by more than 60% of unit staff
<p>3. By 2014, 75% of palliative care patients/families will utilize their community medical home for primary care and as triage for specialty needs.</p>	<ul style="list-style-type: none"> • 100% of all family conferences will have conference outcomes documentation in the medical record • Percent of families who keep first appointment with medical home following discharge • Annual survey of families will document medical home utilization
<p>4. By 2014, improve the capacity of 25 community practices who are novice medical home providers to serve as qualified medical home providers to children with special health care needs.</p>	<ul style="list-style-type: none"> • Number of new medical homes identified annually • Number of mentored medical homes • An annual telephone survey of qualified and mentored medical homes will report being “very satisfied” with collaborative medical home model for children with special health care needs
<p>5. Improve the quality of communication by improving the listening skills between the patient, family, medical home and hospital providers.</p>	<ul style="list-style-type: none"> • Number of acute care providers completing program each year • Number of medical home providers completing program each year • Number of families completing program each year

Evaluation results are reported to the Advisory Board, staff, Mercy St. Vincent Medical Center / Mercy Children’s Hospital administration, and funding agency. All of the information collected for evaluation purposes is documented without personal identifiers and is coded in the database and for reporting purposes. No confidential information can be connected to the child’s name for evaluation purposes. The secretary/data manager worked with the project team to design a database (in Microsoft Access or SPSS) for data entry, and develop documentation for the database. Data is summarized primarily with descriptive statistics.

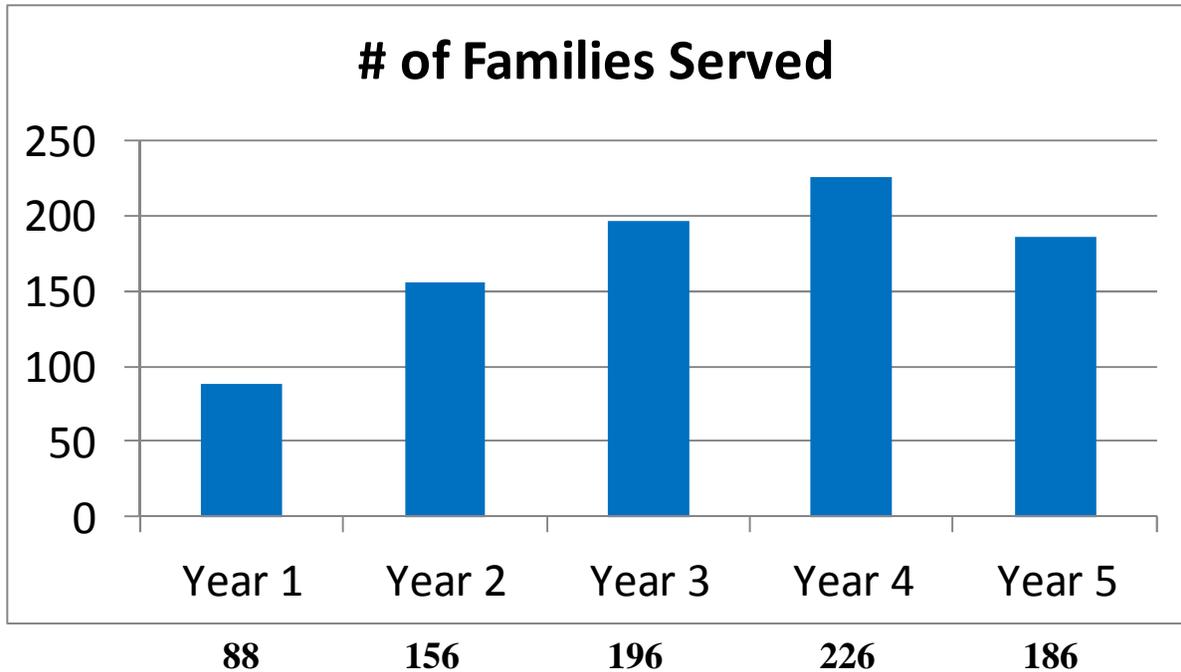
5. **RESULTS/OUTCOMES:**

The goal of the Project was to maximize the health status and quality of life of children with life limiting and/or life threatening special health care needs in a 17-county northwest Ohio region by implementing a model for their safe transition from the acute care hospital setting to a qualified medical home. The project was to

- 1) provide at least 100 pediatric palliative care hospital consultations annually with special attention to care coordination, and transition to a qualified medical home. We provided services to an average of 170.4 families each year.
- 2) refer 95% of patients to a qualified, accessible medical home; 100% of our patients were referred. Impressively, our 5 year average was 93% of patients kept their first appointment. We were above 95% for years 3 thru 5.
- 3) enable 75% of patients/families to effectively utilize their community medical home. The majority of families effectively utilized the MH demonstrated by 84% of families kept all or almost all of your MH/subspecialist/community appointments.
- 4) improve the capacity of 25 community practices to serve as qualified medical home providers to children with special health care needs. We started with 20 practices and finished with over 50 practices who were willing to and capable of caring for our patients.
- 5) improve the quality of communication between the patient, family, medical home and hospital providers by providing and teaching them Listening with Connection, a listening based communication tool based in theories and practice of Hand in Hand Parenting .

The total of families served/taught Listening with Connection is 747, while total sessions with families equals 2277. 209 physicians and other clinicians were taught Listening with Connections.

Between March 1, 2009 — February 21, 2014 the program served 852 CYSHCN averaging 170.4 families annually



The ethnic and cultural makeup of our families:

Total 852 Patients Served From Medical Home Project March 1, 2009 – February 28, 2014	N (%) 852
African American	216 (26%)
Caucasian	488 (57%)
Other	148 (17%)
Medicaid	618 (73%)
Private Insurance	214 (25%)
Self-pay / Other	20 (2%)
Married	305 (36%)
Not married/not living together	363 (43%)
Not married/living together	184 (21%)
Did not have a Medical Home on admission	572 (67%)
Dissatisfied with Medical Home	47 (5%)

The other category includes multiracial, Latino, Asian, and Middle Eastern families. Of the 852 patients served, 545 were referred from the Neonatal Intensive Care Unit and 307 were

referred from the Pediatric floor and Pediatric Intensive Care Unit

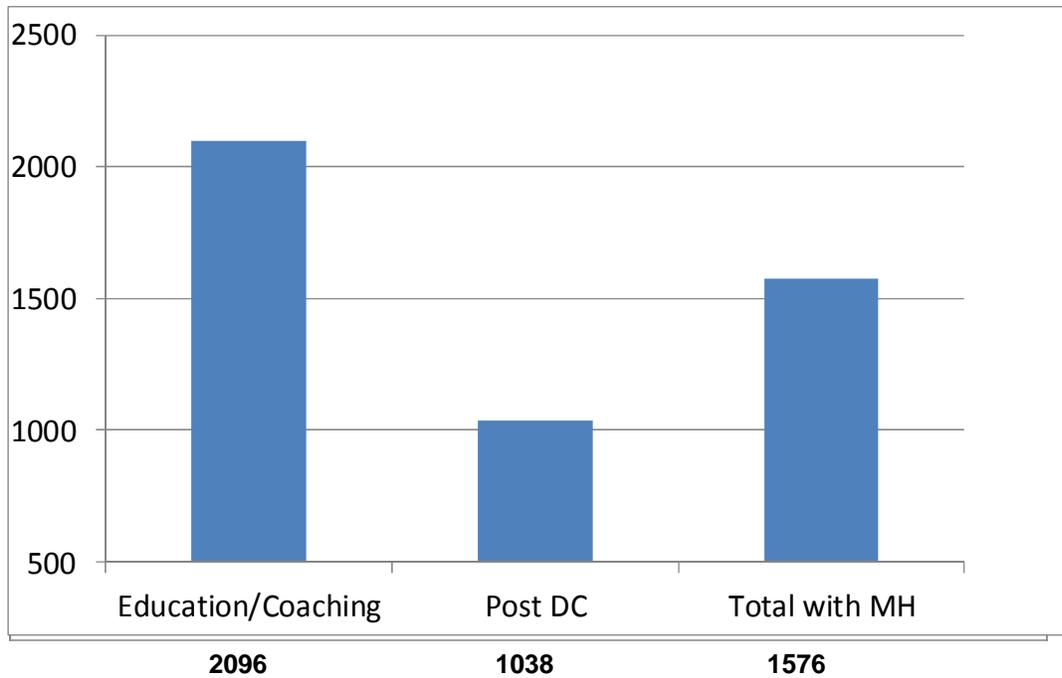
Our families are from the 17county northwest Ohio region ranging from rural to urban with few from suburban areas. They are almost exclusively English speakers, 75% receive Medicaid or are self-pay and 43% face the effects of racism being African American, Latino or mixed heritage. Only 36% of our families are intact and married and 43% are single mothers. The vast majority of them experience all of poverty’s obstacles whether they live rurally or near our central city 125 year old hospital with a mission to serve the underserved.

Total Medical Home Liaison Contacts

Education/Coaching contacts with families – 2096

Post Discharge Contacts w/ families – 1038

Total contacts w/Medical Homes – 1576

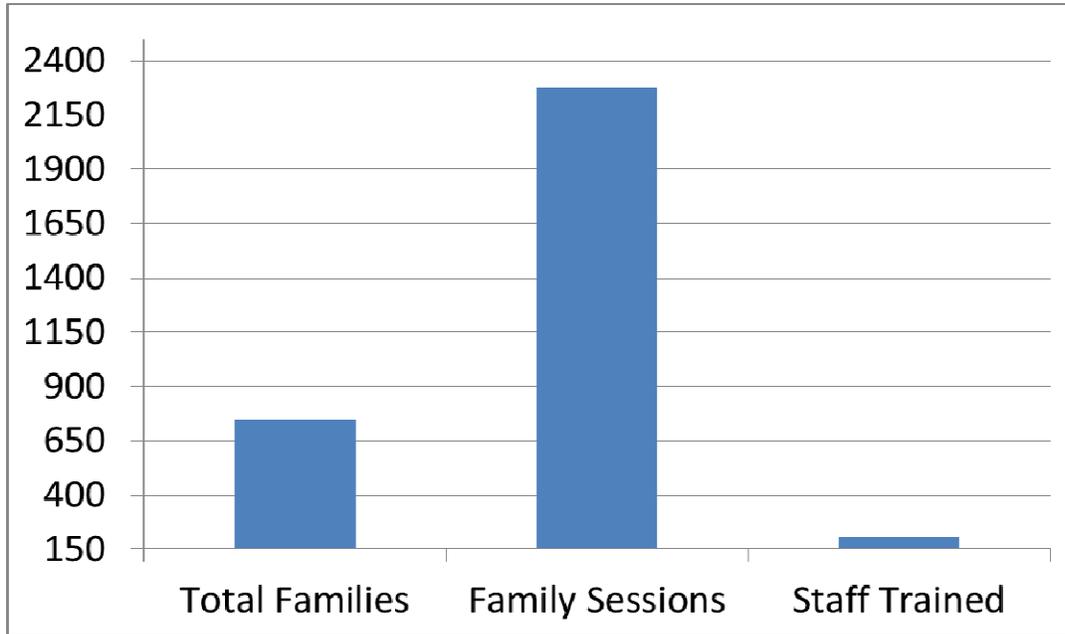


Listening With Connection Totals

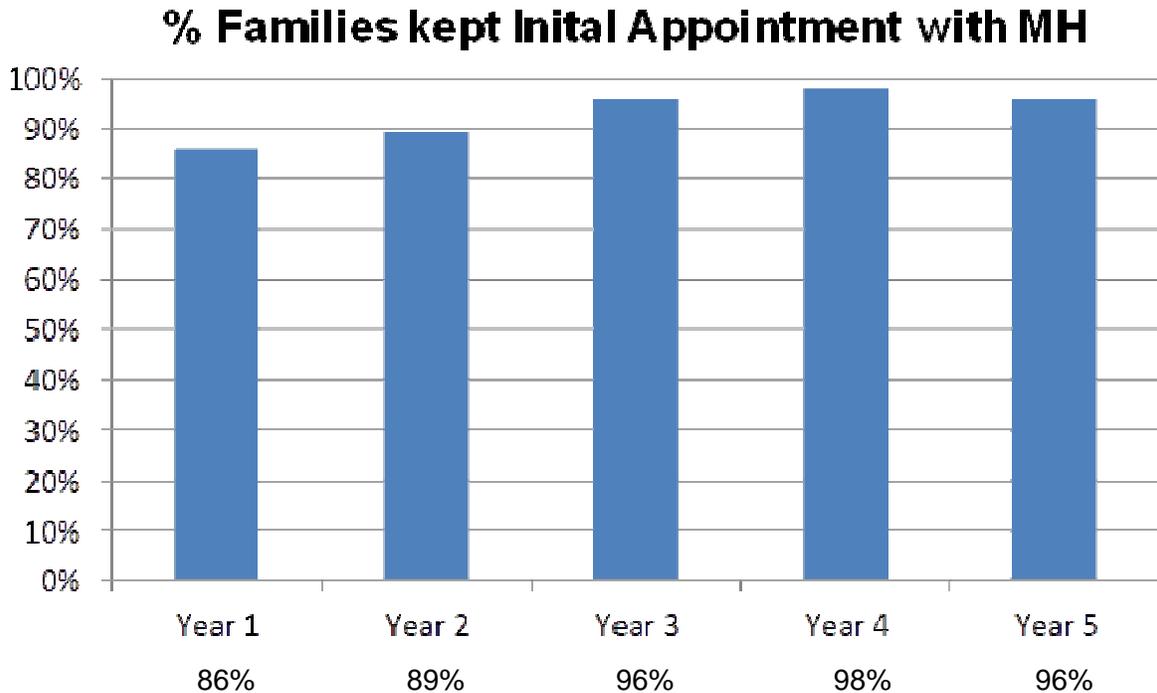
Total families served – 747

Total sessions with families – 2277

Total Staff trained – 209



We tracked families who kept initial appointment with a MH after discharge from the hospital. Our 5 year average was 93% of patients kept their first appointment.



A significant portion of the patients who came into the program without a MH were able to find a MH, keep their first appointment after discharge from the hospital and know their MH and keep appointments up to one year later. We began to evaluate one year after discharge at the end of Year 1 (February , 2010) so they number of families contacted one year after discharge includes patients from years 2-4 only. There were 578 patients during that period but we contacted the 446 who had not died or been transferred.

Total Patients eligible to be measured for contact 1 year after discharge 2/2010 – 2/2014	446
Not able to contact	57 (13%)
Total Patients Contacted	389 (87%)
Can you name your child’s MH provider?	
YES	361 (93%)
NO	28 (7%)
Have you kept all or almost all of your MH/subspecialist/community appointments?	
YES	328 (84%)
NO	61 (16%)
Have you taken your child to the ED over the past year?	
YES	209 (54%)
NO	180 (46%)
Were you sent to the ER by your MD?	
YES	111/209(53%)
NO	98/209 (47%)
Was your child admitted from that visit to the ED?	
YES	76/111 (68%)
NO	35/111 (42%)

We have learned a number of lessons. How we treat our patients is crucial to our success. To the extent we do not judge, criticize or blame but instead are respectful, appreciative of their strengths, have high expectations and listen to their upsets with warmth and compassion they tell us the truth, they learn about MH and become engaged enough to keep appointments. We have also learned that in order for us to be able to consistently treat people this way, we need to off load—stereotypes, confusions, upsets that leak like toxic waste into our interactions with families whether we want them to or not. The precepts of both United to End Racism and Bridges out of Poverty have been tremendous resources which we continue to utilize to teach us how to better

interact with our global majority and economically stressed population. We have learned repeatedly to get multiple phone numbers and email addresses, and to utilize WIC so we can maintain contact with our transient population.

Other lessons learned include the importance of building relationships not only with the families we serve but also with the nurses, doctors and social workers both in the hospital and the practices that we also serve. The care notebook we have developed, with input from many sources, has proven invaluable to many families for the patient who was hospitalized as well as for siblings and sometimes parents too. The welcoming presence of our diverse staff both in the office as well as on the wards gives families a safe home base at the medical center. We serve homemade soup and bread on Fridays for our family support group and have a family friendly non clinical space so many families drop by other days to say hello or hang out between appointments with subspecialists in the building. We learned the importance of having specific goals and objectives in a logic model that we have referred to repeatedly for 5 years so that we maintained our focus. Rigorous daily data collection and timely data entry by the same person who is organized and a steadying, exacting force has been crucial to accurately documenting our work and success.

Our methods, lessons learned and outcomes have tremendous potential for transfer and replication not only in other pediatric inpatient settings but also into the adult world.

6. PUBLICATIONS/PRODUCTS:

- Manuscript describing our project in the final editing phase prior to sending for publication
- Quarterly advisory board reports include a power point and hand out of our data and an educational article regarding MH or our Listening with Connection service.

- Care note book based on multiple resources for tracking appointments, test results, letters from consultants, input and output, important contacts, etc.
- Care notebook is basis for a web based resource that the Ohio Department of Health Title V bureau will be posting and updating
- Poster presentation at the 2014 annual AAP NCE conference in Orlando
- Poster presentation in both 2012 and 14 was one of five awarded at the Mercy St. Vincent Medical Center Annual Research Symposium.
- Patient handout describing our service and MH.
- Database format for tracking patient demographics, diagnosis, admission/discharge dates, appointments kept after discharge, one year out data, readmissions, death etc.
- Listening with Connection handouts, multiple training presentations, evaluation tool

7. DISSEMINATION/UTILIZATION OF RESULTS:

- Based on our first 3 years of data we were awarded Ohio's HRSA grant for CYSHCN to teach our methodology of education and coaching utilizing the Listening with Connection model to 700 providers across the state including public health nurses, Early Intervention workers, Head Start teachers and families. The presentations include outcome data from our Hospital to Medical Home project.
- Presented our data to the 2013 Ohio Patient Centered Primary Care Collaborative statewide annual conference
- Presented our data to the Medical Director of the Ohio Department of Health which has resulted in participation in several state wide committees and task forces addressing MH issues
- Manuscript describing this project in final editing phase for publication

- Quarterly advisory board reports include a power point and hand out of our data and an educational article regarding MH or our Listening with Connection service.
- Our care note book we shared with the Ohio Department of Health Title V program and is the basis for a web based resource they are creating.
- Poster presentation at the 2014 annual AAP NCE conference in Orlando
- Poster presentation in both 2012 and 14 was one of five awarded for excellence at the Mercy St. Vincent Medical Center Annual Research Symposium.

8. FUTURE PLANS/SUSTAINABILITY:

Dr. Oatis has been working with Mercy St. Vincent Medical Center and Catholic Health Partners, the Cincinnati based Parent Corporation, which is the largest health care provider in Ohio, to sustain and integrate this model into other pediatric services as well as adult areas. Catholic Health Partners' recently appointed Chief Clinical Officer, has prioritized tracking the rate of patients keeping the first appointment after discharge from the hospital. He and the woman in charge of inpatient case management work and advancing care transitions across the entire system are interested in exploring our model as a basis to improve current processes and replicate in the adult population. Mercy's Chief Operating Officer, President, and Chief Network Integration Officer has set up meetings with the Project Director to discuss including this project into the Clinical Integration Network which encompasses five hospitals and over 400 outpatient practices in Northwest Ohio.

Ohio has applied for a SIM grant to advance the medical home concept into more practices with a focus on pediatrics. Our model of education/coaching utilizing our materials and concepts including Listening with Connection is expected to be part of the training program with practices.

ANNOTATION: The goal of the Mercy St. Vincent Medical Center / Mercy Children's Hospital *Hospital to Medical Home Project* was to maximize the health status and quality of life of children with life limiting and/or life threatening special health care needs by implementing a model for their safe transition from the acute care hospital setting to a qualified medical home.

KEY WORDS: Medical home, children with special health needs, community based health services, parent support services, access to care, patient engagement.