

Promoting Medical Home for CYSHCN through Strengthened Partnerships

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Washington Department of Health

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Goals of presentation

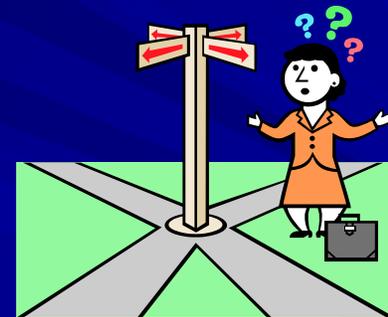
- Share methods to assure children with special health care needs are included in statewide medical home activities
- Show how medical home is spread beyond children with special health care needs
- Identify activities that strengthen partnerships between state CSHCN programs and new medical home partners.

What you will learn...

- Brief History of Medical Home in WA
- Brief History of Learning Collaboratives in WA
- WA State Legislative mandates
- Current medical home learning collaborative
- The role of CSHCN Program
- How it all ties together

Life is really simple, but we insist on making it complicated.

Confucius

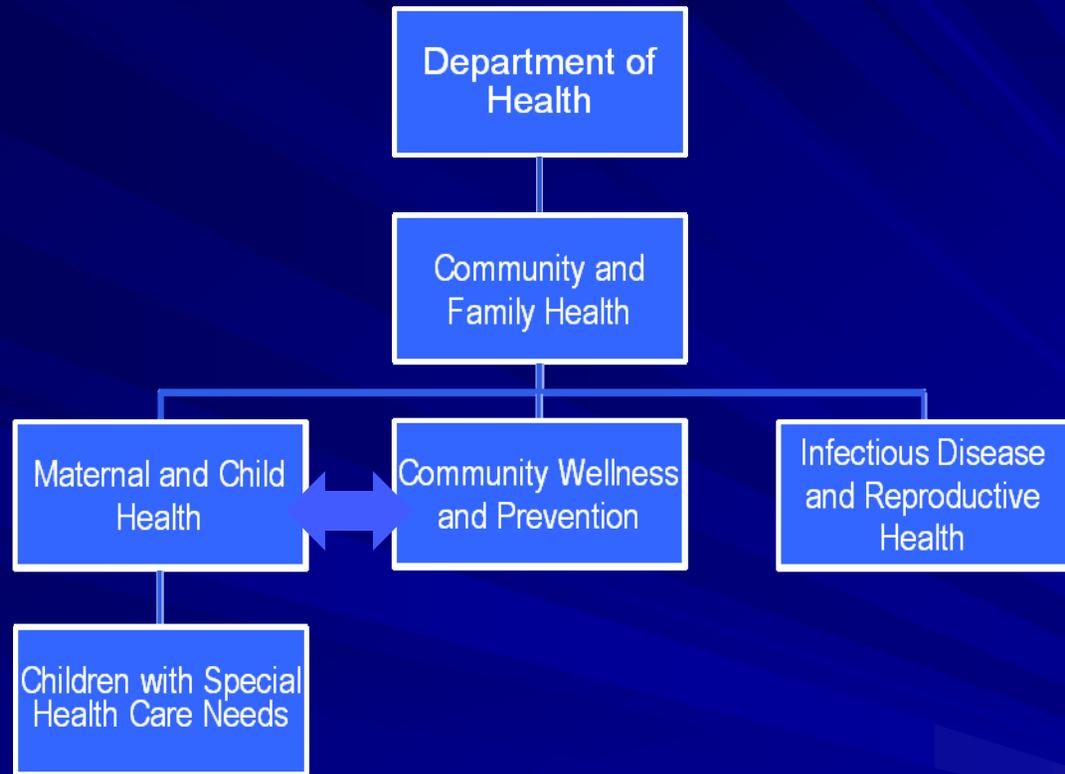


What you won't learn...

- Details of Patient-Centered Medical Home Collaborative
- Details of Learning Collaborative methodology, Change Package, or Chronic Care Model

New Partnerships

- Within WA State Department of Health
 - Community and Family Health Division
 - Maternal & Child Health
 - Community Wellness & Prevention
- With outside partner
 - Washington Academy of Family Physicians



History

- Medical Home in Washington
- Learning Collaboratives in Washington
- Legislative activities for medical home



WORKING TOGETHER

Individuals play games, but teams win championships.

Who are CSHCN?

- MCHB defines children with special health care needs as *“those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally”*



National Performance Measures for CSHCN

- All children will be screened early and continuously for special health care needs
- All families will have adequate private and/or public insurance to pay for the services they need
- All CSHCN will receive regular ongoing comprehensive care within a medical home

National Performance Measures

- Families will participate in decision making at all levels and will be satisfied with the services they receive
- Services will be organized in ways that families can use them easily
- All youth will receive the services necessary to make appropriate transitions to all aspects of adult life

Medical Home



CSHCN will receive coordinated ongoing comprehensive care within a medical home

History WA State Medical Home

- MCHB funded demonstration project
Started in 1994 as collaborative effort with UW, CSHCN, WC AAP, Seattle Children's
- UW "Medical Home Training and Resource Project" now Medical Home Project funded by CSHCN
- Statewide medical home activities

UW Medical Home Project

- Medical Home Leadership Network
- Tools for providers
- Tools for families
- Sharing information to communities and providers about medical home

Statewide Medical Home Activities

■ Medical Home Strike Team

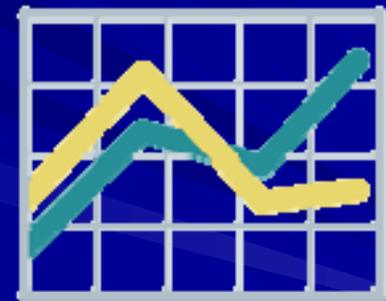
- Response to WA Governor's health care reform
- Broad stakeholder representation including health care organizations, families
- Organized larger committee to develop a Strategic Plan



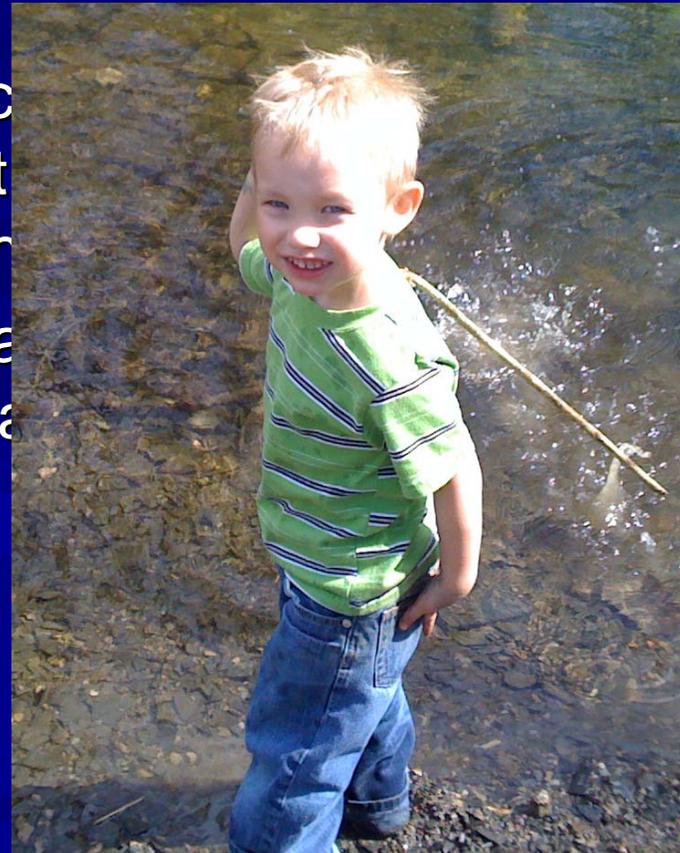
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History WA Chronic Disease Learning Collaboratives

- Started with diabetes 1999
- Results showed improved outcomes
- DOH reputation: successful learning collaboratives



- 2008 CWP branched out to include UW Child Health Improvement home (6 practices), asthma, ch
- Gave CWP opportunity to expand management to include medical



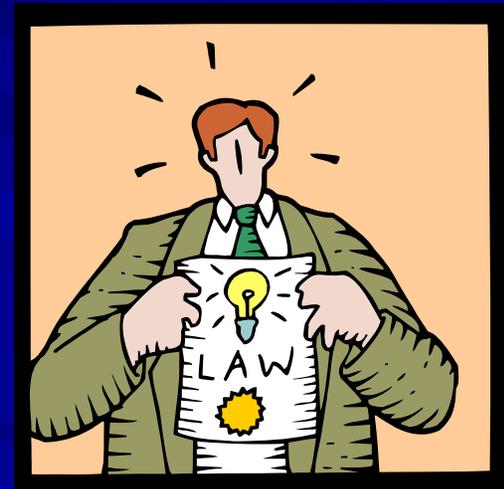
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How do collaboratives work?

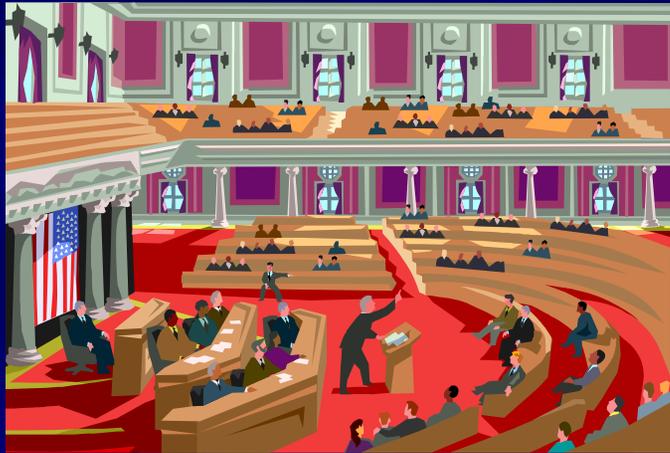
- Bridge gap between evidence and practice
- Offer learning sessions with multiple teams for support from peers, staff, coaches, faculty
- Opportunity for quality improvement projects

WA State Legislation

- Blue Ribbon Commission on health care costs and access (2007)
- Concerning access to health care services for children (2007)



More legislation



- Establishing a patient-centered primary care (medical home) collaborative program (2008)
- Reimbursement pilots for medical home (2009)

Washington Primary Care Medical Home Collaborative

- No state funds appropriated
- Combined federal CDC grants for diabetes, asthma, tobacco cessation, heart disease and cancer
- WAFP grant to “Improve Performance In Practice” targeting diabetes & asthma in primary care practices
- Decision to “join forces” to maximize resources: Washington Patient-Centered Medical Home Collaborative

Data being collected

- Baseline data include MH Index, patient experience, provider experience, staff satisfaction
- Clinical (preventive) measures: Diabetes (IPIP), cancer screening, *well-child checks*

Current Collaborative

- 33 primary care practices
- Urban and rural, small and large practices
- Commitment is 5 learning sessions over 2 years
- About one-third of patients in collaborative are under 18

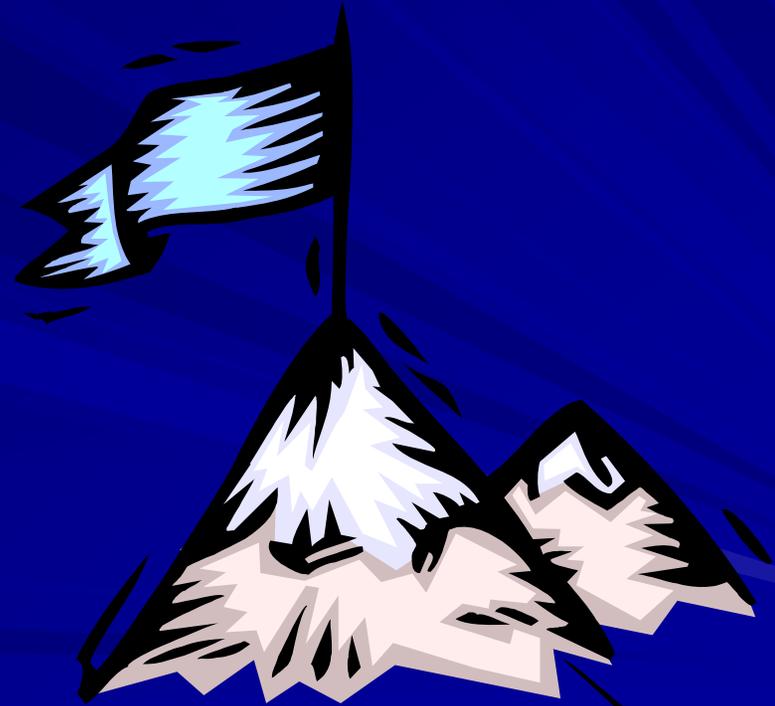
Similar descriptions...but not the same

- WPCMHC: Patient Centered Medical Home (PCMH): An approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.
- The American Academy of Pediatrics describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Medical Home

■ Preaching to the choir?

■ OR not as easy we thought...



What's the difference?

WPCMHC

- Physician-centered
- Family inclusion is muddy, no real language for “family” that works across the life span
- Joint Principles of medical associations

Pediatric focus

- Family-centered
- Understands the role of community
- CSHCN Performance Measure

Lessons Learned (or a work in progress)...

- At the end of the day, it's relationships that matter
 - Hiring the right person to manage the WPCMHC
 - Having the right collaborative planning team: MCH, rural health, chronic disease
- Conducting regular “temperature checks”, i.e. who's missing from the planning team?
- Establishing credibility with faculty, coaches

Keep your eye on the prize

**“A family is a unit composed not only of children but of men, women, an occasional animal, and the common cold.”
Ogden Nash**



Where did CSHCN influence the collaboratives?

- Offer staff time and medical home expertise by:
 - Participating on Planning Committee to interject CSHCN and AAP Medical Home components whenever possible
 - Going on coaching visits to clinics

- Help clinics go an “extra step”, ask how what they do for Quality Improvement might affect patient/family
- Suggest a “walk through” as family member/consumer
- Participate in Collaborative Learning Sessions
- Recommend consumer/family member for advisory board

Resources brought to the planning committee

- cshcndata.org
- medicalhomeinfo.org
- AAP guidelines for well child visits
- Medicalhome.org
- Materials such as decision tree
- Expertise and resources on care coordination
- Partners through our CSHCN Communication Network

Great discoveries and achievements
invariably involve the cooperation of many
minds. Alexander Graham Bell



MHLN Activities

- 18 active teams
- PCP/PHN/FRC/parent
- Examples of activities:
 - Implementing ASQ developmental screening
 - Participating in autism council to improve care for autism
 - Assure families are part of medical home team



Other medical home project activities



Website



Child
health
notes



Teaching residents

Medical Home Key Messages

What is a Medical Home?

A Medical Home is an approach to delivering primary health care through a 'team partnership' that ensures health care services are provided in a high quality and comprehensive manner.

Who can provide a Medical Home?

A primary care provider (physician or nurse practitioner) leads the medical home with the support and direction of the patient, the patient's family, clinic staff, community agencies, and other specialty care service providers.

What are the core components of a Medical Home?

Accessible & Continuous

- Care is provided in the community.
- Changes in insurance providers or carriers are accommodated by the medical home practice.

Coordinated & Comprehensive

- Preventive, acute care, specialty care, and hospital care needs are addressed.
- When needed, a plan of care is developed with the patient, family, and other involved care providers and agencies.
- Care is accessible 24 hours a day, 7 days a week.
- The patient's medical record is accessible, but confidentiality is maintained.

Family-Centered

- Families and individual clients are involved at all levels of decision-making.

Compassionate and Culturally Effective

- The patient's and family's cultural needs are recognized, valued, respected, and incorporated into the care provided.
- Efforts are made to understand and empathize with the patient's and family's feelings and perspectives.

What are the benefits of a Medical Home?

Promotes Health through Prevention

- Preventive services such as annual physical exams, developmental screening, health education, immunizations, well-child care, and other medical and community-based services help maintain optimal health.
- Women who have a regular source of health care are more likely to access prenatal care.¹
- Regardless of age, sex, race, or socioeconomic status—all people can receive an array of acute, chronic, and preventive medical care services through a medical home.²

Healthier Children and Families

- Among children with special health care needs (CSHCN), children with a medical home have less delayed care, less problems getting care, fewer unmet health needs, and fewer unmet needs for family support services.³
- In a study of medical home among CSHCN, parents reported improved care delivery, a decrease in the number of missed work days, and a decrease in hospitalizations.⁴

Reduce Health Care Costs

- Children who receive care in a medical home are half as likely to visit an emergency room or be hospitalized.⁴
- Having health care access through health insurance is not enough to avoid acute care and treatment costs – other issues such as quality of care and the relationship with a primary care provider also influence the use and cost of health care services.⁵

¹ Braveman, P., Marchi K., Egert S, Pearl M, Neuhaus J, Barriers to timely prenatal care among women with insurance: the importance of pregnancy factors. *Obstetrics and Gynecology*. 2000; 95:874-880

² Kahn, Norman (2004). The Future of Family Medicine: A Collaborative Project of the Family Medicine Community.

³ Strickland, B., et al. (2004). Access to the Medical Home: Results of the National Survey of Children With Special Health Care Needs. *Pediatrics* 113:5 (1485-1992).

⁴ Palfrey, J., et al (2004). The Pediatric Alliance for Coordinated Care: Evaluation of a Medical Home Model. *Pediatrics*. 113:5 (1507-1516).

⁵ Starfield, B & Shi, L. (2004) The Medical Home, Access to Care and Insurance. A Review of Evidence. *Pediatrics*. 113: 1493-1498

Care Coordination within a Medical Home

What is Care Coordination Within a Medical Home?

Care Coordination for children within a medical home is a service that connects children and their families to comprehensive health care and community resources.¹

What Are the Key Elements of Care Coordination?

Key Elements:

- Identified lead coordinator
- Partnership with the family that meets the child's needs
- Collaborative, coordinated, with ongoing process
- Culturally competent at every step
- Assures smooth transitions between systems and services

Care coordination within a medical home is essential to effectively and efficiently manage the medical needs of children and families.² The components of a medical home (comprehensive, coordinated, family-centered, continuous, culturally-effective, accessible, and compassionate) support effective care coordination.

How Does Care Coordination Help Families?³

Care Coordination:

- Helps families understand the possible health outcomes for their children.
- Identifies and builds on child and family strengths.
- Reinforces families' skills and abilities.
- Validates parents' participation in their children's care.
- Understands children's conditions and involves children, when appropriate, in their care.
- Transitions care tasks to children whenever possible.
- Reduces stress and identifies parents' and families' self-care needs.
- Assists with finding financial support.
- Assists with finding support for parents and siblings.

What Are the Benefits of Care Coordination?

There are many benefits of effective care coordination including:⁴

- Reduced hospital admissions.
- Reduced length of hospital stays.
- Reduced inpatient charges.
- Reduced emergency department visits.
- Improved patient satisfaction.
- Enhanced opportunities for clinical improvement.

Who Can Provide Care Coordination?

A variety of professionals such as nurses, social workers, or medical assistants can provide care coordination in a medical home. Parents who receive special training may also act as care coordinators. All rely on community partners such as Early Intervention Family Resources Coordinators, public health nurses, school nurses, and health plans to ensure

¹ This statement was developed in July 2007 in partnership with the Department of Health (DOH), the Washington State Financing Care Coordination Workgroup, and the participants in the May 2007 Washington State Medical Home Leadership Network conference. Comprehensive health care includes medical, dental, mental health and other needed health services.

² November 2005 AAP Policy Statement, Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs

³ Adapted from Washington State Medical Home portal: http://www.medicalhome.org/physicians/coordinating_care.cfm

⁴ November 2005 AAP Policy Statement, Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs

Medical Home Translation Project





MEDICAL HOME DATA MONOGRAPH

Medical Homes for Children in Washington State

Washington State Department of Health, Office of Maternal and Child Health, May 2007

BACKGROUND:

About Medical Home

*"A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is **accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.**"*

American Academy of Pediatrics

A medical home is not a place; it is an approach to providing high quality, comprehensive primary health care services. Medical homes promote efficient use of limited health care resources. For the past 20 years, the focus of Medical Home has been on the population of children with special health care needs. It is now expanding to include all children and adults.

Studies show that children with special health care needs who have a medical home have less delayed care, less forgone care, fewer unmet health needs, and fewer unmet needs for family support services.¹ When children with special health care needs have a medical home parents report improved care delivery, fewer hospitalizations for their children, and a decrease in the number of days parents are unable to work.² In addition, children who qualify for the Vaccines for Children program were more likely to receive vaccinations on time if they had a medical home.³

The medical home approach is supported by the American Academy of Pediatrics, the American Academy of Family Physicians, National Association of Pediatric Nurse Practitioners, American College of Physicians, American Osteopathic Association, Family Voices, and the US Maternal and Child Health Bureau. A national Healthy People 2010 goal is that all children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home.

METHODS:

Measurement of Medical Home

The components of a medical home are numerous. The American Academy of Pediatrics identified 37 qualities that make up a medical home.⁴ The Child and Adolescent Health Measurement Initiative (CAHMI) developed a uniform measure of medical home to be used in population-based surveys such as the National Survey of Children's Health (NSCH).⁵ For the purpose of measurement,⁶ a child must have the following characteristics to be considered as having a medical home:

1. Have a personal doctor or nurse.
2. Have had preventive care in the past year.
3. Get needed care.
4. Receive family-centered care.
5. Have easy access to specialists or equipment.
6. Have follow-up care after receiving specialist care or equipment.

Medical Home

December 2007



What is a Medical Home?

A medical home is an approach to delivering primary health care through a team partnership that ensures health care services are provided in a high quality and comprehensive manner.

History of Medical Homes in Washington State

- In 1994, the Washington State Department of Health (DOH) Children with Special Health Care Needs (CSHCN) Program was part of a collaborative effort to develop and fund the Medical Home Training and Resource Project.
- The purpose of the Medical Home Project was to provide training and support to community teams of physicians and public health nurses who served children with special health care needs. The Medical Home Training and Resource Project became the Medical Home Leadership Network (MHLN).
- In 2000, DOH and the MHLN joined a group of key stakeholders to develop a "Promise to the State", a document outlining a plan to provide medical homes to all children and youth with special health care needs by 2010.
- This plan became the basis of a successful Maternal and Child Health Bureau (MCHB) grant application that led to the expansion of community teams involved in the MHLN.
- In 2000, MCHB released a 10-Year Action Plan to Achieve Community-Based Service Systems for Children and Youth with Special Health Care Needs and their Families. Coordinated, ongoing comprehensive care within a medical home became one of the six National Performance Measures for Title V (CSHCN) programs across the country. The CSHCN Program reports on this National Performance Measure.
- DOH continues to contract with the University of Washington's Center on Human Development and Disability (CHDD) to maintain the MHLN and promote medical homes for children with special health care needs throughout the state.
- In 2006, the CSHCN Program convened a group of key state and community partners to develop a new Washington State Medical Home Strategic Plan for children and youth with special health care needs, building on the success of the 2000 "Promise to the State".



DOH Activities to Expand Medical Homes

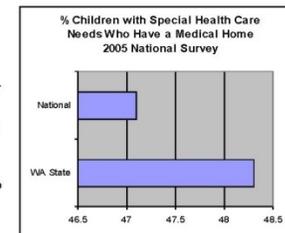
- In November 2005, Governor Gregoire released her *Five Point Strategy for Improving Health Care*. The Healthy Washington/Prevention Workgroup formed and supported a Medical Home Initiative for all children.
- DOH created the "Medical Home Strike Team" with representatives from other state agencies and community partners to (1) build a common understanding of the concept of medical home and (2) create a plan for policy development to promote the medical home approach for all people, with an initial focus on children.
- The "Medical Home Strike Team" adopted the Medical Home Strategic Plan to use as a roadmap for promoting medical homes beyond children and youth with special health care needs to all children.
- DOH is directed to implement the Washington State Learning Collaborative on Medical Home through HB 2549. The Learning Collaborative is a quality assurance activity designed to improve patient care outcomes in primary care practices.

2007 Legislation related to Medical Homes

- Senate Bill 5093 passed, increasing the number of children eligible for Medicaid. In addition, 5093 increased reimbursement for physicians caring for children on Medicaid and calls for performance measures related to the rate increase that indicate if a child has a medical home.
- Senate Bill 5930 also passed, requiring the Department of Social and Health Services (DSHS) to collaborate with DOH in the design and implementation of medical homes for clients who are aged, blind, and disabled.
- DOH participates on DSHS cross-agency task forces related to 5093 and 5930 to (1) develop pay-for-performance measures for medical home reimbursement, and (2) increase the number of medical homes for the aged, blind, and disabled DSHS clients.

Medical Home Data

- All people can receive an array of acute, chronic, and preventive medical care services through a medical home.¹
- Children who receive care in a medical home are half as likely to visit an emergency room or be hospitalized.²
- The 2003 National Survey of Children's Health showed 49% of children and youth aged birth to 17 years old have a medical home.
- 2005 National Survey of CSHCN shows 48.3% of children with special needs in Washington have a medical home compared to 47.1% nationally.



¹ Kahn, Norman (2004). The Future of Family Medicine: A Collaborative Project of the Family Medicine Community.

² Palfrey, J., et al (2004). The Pediatric Alliance for Coordinated Care: Evaluation of a Medical Home Model. *Pediatrics*, 113:5 (1507-1516).

Future – Lots Brewing!



Washington Contacts

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CSHCN Public Health Nurse Consultant
- **Website**
<http://www.doh.wa.gov/cfh/mch/cshcnhome2.htm>

PUBLIC HEALTH

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Partnering with your Doctor: the Medical Home Approach

Presenters: Bob Cook & Jane Turner, M.D.

Moderator: Cynthia Cameron, Ph.D.



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History of the Regional Collaboratives

Established under Title XXVI of the Children's Health Care Act of 2000, "Screening for Heritable Disorders"
"....The Secretary shall award grants to eligible entities to enhance, improve or expand the ability of State and local public health agencies to provide screening, counseling or health care services to newborns and children having or at risk for heritable disorders..."





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Role of the Regional Collaboratives

- Ensure that children with heritable disorders and their families have access to quality care and appropriate genetic expertise and information in the context of a medical home that provides accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective care.
 - To strengthen communication and collaboration among public health, individuals, families, primary care providers, and genetic medicine and other subspecialty providers.
 - To quantitatively and qualitatively evaluate outcomes of projects undertaken to accomplish their goals.





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Our Vision

- All newborns will receive state-of-the-art newborn screening and follow-up; children and youth with heritable disorders will have access to genetic expertise and coordinated care in the context of a medical home.





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Our Mission

- Increase access to information about newborn screening and genetic resources, services and family support systems
- Facilitate data collection and analysis to guide decision-making regarding screening cut-offs, diagnosis and long term treatment of heritable disorders
- Support state public health agencies in improving infrastructure for genetic service delivery to children with heritable disorders
- Provide a forum for families, public health, and clinical providers to share best practices and models for improving newborn screening, follow-up and genetic care coordination
- Link Region 4 states with regional and national initiatives for improving the quality of newborn screening and genetic service delivery





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Work Group

- Members for the Medical Home Education work group were recruited in late 2007
- Members included: Region 4 Staff (Project Coordinator and Parent Coordinator); 2 co-leads (one parent/professional and one professional); 5 parents; 1 genetic counselor; 4 professional/public health representatives and 1 pediatrician/primary care provider.
- Members convened the workgroup in December 2007
- Developed workplan and primary goal:



“Identify, review and select existing initiatives and materials to educate Region 4 families and providers”





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Parent partners

- 3 of our parent members are also professionals in the CSHCN departments of their respective states
- Workgroup activities were a part of their full time position duties, allowing them maximum participation
 - Parents were offered an honorarium for their time (\$20/hour)
 - Co-leads were offered compensations for their time and meeting planning (\$150/call)





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Material review & process

- The Work Group identified and research existing resources and materials designed to educate families
- A reviewing tool was developed (See Handout) to guide decision making, and to have a comparable format for all materials
- The Work Group reviewed materials, using the reviewing tool





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Modifications

- Decision to use the Michigan tool “*A guide for Michigan families: Special Care for Special Kids*”
- Began to modify the guide to fit the goal of educating families about care for their child with a genetic condition
 - The concepts and recommendations apply to all families with a child with special health care needs
- Addition of unique features
 - Section on “Advocating for your Child”
 - “Parent-to-Parent Tips!” and tools
 - Resources on Medical Home
- Utilized the AAP definition of a medical home
 - Used component to format the guide
 - Each component of the definition is a separate section of the guide





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Time & effort



- The Work Group met 17 times by phone
- Over 100 administrative hours to create, edit and produce the guide
- Volunteers from the Work Group were utilized to create a webcast for the rollout of the Guide
- Webcast aired December 1, 2009 and can be viewed at:

<http://learning.mihealth.org/mediasite/medicalhome>





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Finalized guide



Partnering with your Doctor *The Medical Home Approach*

A guide for families of children with special health care needs

Work Group completed
modifications and revisions
in August 2009



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Pediatrician's perspective

- I like it!
- Great advice about choosing a doctor and working with the doctor
- “Getting the most out of an appointment” section - great advice on preparing for visits
- Describes ways family members can take active role in child's care
- Though the guide is written for families with children who have a genetic condition, I believe it is also a useful tool to educate members of the health care about the medical home and how we can best serve all the children and youth in our practices.





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Current distribution plans

- Guides are currently being distributed to each Region 4 state (IN, IL, KY, MI, MN, OH, and WI) newborn screening follow-up program
- Many states have direct mailings with families who have received their child's diagnosis and follow-up directly with them
- Other states, such as Michigan, plan to distribute the guides to the follow-up genetic clinics to get them into the hands of parents through that route
- Guides are available for purchase (\$10/guide)
- The guide is available for free download at:
www.region4genetics.org





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Distribution ideas

- Marketing the guide to:
 - Family support and advocacy organizations
 - Children's hospitals and clinics
 - Parent trainings or advisory groups
- Other ideas?





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The guide is designed to:

- Be a source of specialized information for parents to help them care and advocate for their child
- Provide a detailed definition and description of the medical home concept
- Lay the foundation for understanding and advocating for a medical home
- Provide tools and examples for parents to use and learn from while creating and maintaining a medical home with their child's doctor
- Bring attention to the importance of linking families of children with special health care needs to a medical home





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The guide is designed to:

- Provide advice on how to effectively partner with your child's doctor
- Define family-centered care and demonstrate how it benefits families
- Demonstrate how to seek culturally effective, compassionate care
- Assist families through the transition process by providing resources and tips
- Provide a list of resources and links to organizations that support families and the medical home concept





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Parent's perspective



I believe we have provided a very family-friendly guide with useful information and resources that would help **all** families who have a child with chronic health conditions better understand the concept of Medical Home, Partnering with your Doctor.

