

## **HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING**

### **Building Blocks for Promising Practice Models**

October 14 - 17, 2007

#### **Home is where the Heart is -- The Medical Home Model:**

#### **Caring for Children with Special Health Care Needs - State, Healthcare Providers and Families as Partners**

CHARLES HOMER: Thank you, Bonnie. So, the good news is Bonnie just gave most of my talk. So that's --

BONNIE STRICKLAND: That's what you said about me at the last conference.

CHARLES HOMER: Thanks a lot. What I do want to do today is review a bit of where we've been on the work with the implementation and spread of the Medical Home and talk in a little more detail about where we -- also the work we've done on both epilepsy and hearing screening follow-up and then where we are trying to go going on.

Now, looking around the room and seeing so many familiar faces, I know that there is a lot of expertise in the room, and really what -- what my prepared remarks or slides, really, are just a reflection, me reflecting on what I think we've learned and what's worked and perhaps where we have room to go over the next couple of years.

And rather than just hearing my reflections, I do hope we'll do just what Bonnie said, which is I'll try to keep pausing, and if I don't make lots of remarks or gesticulations to me, to make sure that we get your input. Because really what I want to do is wrestle with some issues together with you about how we can both spread the Medical Home even more extensively than we have before, and even more particularly, how -- what's the best strategy for engaging Title V in the process. That's to me is something that we've been working on for probably four years now, we are going to be working on for the next three years. I think we've learned some things, but I don't think we have it yet. And if we could have some dialogue about that, I would view today's discussion as very helpful.

Now, I don't know everyone in the room, I'm assuming not all of know each other. Do you all know each other?

Okay. So if we could quickly go around, maybe say your name, where you are from and maybe quickly what your role is and maybe should we just -- this microphone is hardwired and I don't think we have a wireless, so maybe if we could speak up, that would be great.

(The audience members introduce themselves.)

CHARLES HOMER: Welcome, and thank you for doing that. It was very helpful for me, one, because I'm so bad at names for you to just remind me of the people that I've met before, but also to meet and find out where you're from.

Linda -- When Linda and I reviewed some of these slides, she suggested that not everyone was as deeply familiar with NICHQ, the National Initiative with Children's Healthcare Quality as I am so, it might be worth spending a few minutes saying who we are and what we do. So I'm going to start off with that as a brief orientation.

We're in -- a non-profit organization. We're based in Cambridge, Massachusetts. Our mission is to eliminate the gap between what is and what can be in healthcare for all children. We emphasize lots of different words; the gap, a very optimistic, but also the all children. So we really focus on the issues of disparities on children, particularly vulnerable populations like kids with special healthcare needs.

We are a hard to describe non-profit. People say, well are you policy? Well, sort of, not really. Are you -- I mean we are, say, an action-oriented organization. Our focus really is driving change within the healthcare system. We focus, as Bonnie said, only on quality of children's healthcare. We seek to be a resource for many, including the direct delivery organizations, healthcare improvements organization, foundations and obviously government, which represents lots of you.

We are national in scope, which distinguishes us from others in the field. We are based in Cambridge. We are cheering for the Red Sox. And -- but even though we are based in Cambridge, we actually have staff and faculty that we draw on from all across the country.

Our -- not so much mission or even a vision statement, but really a statement of success is very similar to what the bureaus' statement is. That is, we acknowledge that if our focus is to help children achieve their greatest potential and to keep the healthcare system from causing needless harm, that is, injury, pain, suffering, and death, we also need to pay attention to the family context so that families are optimally able to provide for, promote and support their child. The communities, this is the wrong wording again, are best able to support the health of children and families, whether -- and also that we work on this at a societal level to achieve these results, both with equity and to eliminate waste in the healthcare system.

So it is a very broad, multi-tiered system which is no surprise to those of you with the deep public health background which recognize you need to pay attention to context.

Now, this is my 43rd attempt to explain to my mother what we do, which I still haven't quite gotten there yet, nor my wife. And this is our current -- let me see if this one works, which is how do we actually go about trying promote change in the healthcare system? And three things that I think we try to do, the first thing we try to do is innovate. So we try to discover or invent or really identify from elsewhere and bring in good ideas into the healthcare system that are ready for use in children's healthcare.

So we aren't necessarily the researchers ourselves who develop them, although if we do, that's a beautiful thing, but we are perfectly happy to identify them from other areas within

healthcare, other areas outside of healthcare and bring them into the healthcare system. So we innovate and then we demonstrate. So we identify in a small set of areas, a small set of practices, a small set of states, can we actually produce results in a way that is worthy of replication? But we don't stop there. So we work substantially on accelerating the adoption. And this is where policy comes in. It's where spread practice comes in. So where we can not only do innovation, not only demonstration, but actually accelerate the broader adoption of better practices. Let me know afterwards whether this works or not. But I kind of like it. It at least rhymes. Innovate, demonstrate and accelerate.

A couple of years ago, actually about two years ago, we had been and we continue to actually work at a very broad array of child health topics. I tried to narrow it a little bit and say, what are the things that NICHQ really wants to focus our efforts on, and, in fact, where do we suggest that the healthcare delivery system in particular focus their efforts? So we identified four areas that have been the focus of our programmatic attention for the last several years. The first is really focused on the prevention, and to be frank, the management and treatment of childhood obesity. And I'm happy to talk with you at great lengths about what we are doing in that area in trying to bridge the healthcare, public health community divide in that area and using the internet and all kinds of fun stuff.

The second is obviously the focus of what we are going to be talking about here, which is providing seamless evidence based family centered care for children with special healthcare needs or chronic conditions as you choose to term them.

The third is a significant focus on purging harm from children's healthcare, the main activity we are doing there has been to coordinate the pediatric affinity node of the hundred thousands slash five million lives of the IHI's various campaigns. And I'm happy to talk to you about what that specifically means.

And the last is to promote equity in care where we produce some recommended practices and really tried to integrate through all the rest of our work activities on promoting equity and eliminating disparities.

We have a whole set of programmatic activities and ways we do our work. We'll talk more about our best known product and service which is the learning collaborative. With our obesity work, we are trying to move that into what we call an action network, again trying to do the accelerating adoption process.

We have an annual meeting for those of you who haven't been there, it's great fun. Last year we had about 700 attendees. I'll show you a slide in a minute; it will probably be March 19th to 21st in Miami.

We also produce some tool kits. We have courses on quality improvement, both introductory to advanced level.

Since Lisa Simpson has been working with us over the last couple of years we have become more involved in the policy arena, obviously with the SCHIP reform, we've been

fairly active in trying to incorporate a quality improvement frame into that work. And we can talk more about what that is.

And then really, this work with Title V as well as I know Judy Shaw spoke yesterday about Bright Futures, but her VCHIP model and a variety of other efforts we have done has been -- we recognize there's only so much you can do nationally, and there's a lot that needs to happen locally and regionally, that's why we are partnering with Title V, because we think -- we believe that you are one of the local recourses that can support and drive improvement and practice, and that's one of the models that we seek to work on.

Here is just a little blurb for our forum. If you would like information, certainly ask me, and it's also on our website.

We work with everyone, their brothers and their sisters. They include, of course, the Maternal and Child Health Bureau and many parent and patient organizations including the Epilepsy Foundation which we are pleased to have here, and Family Voices, and there are many others that aren't on the list and its fun.

Anyway, so that's sort of the five-minute spiel on NICHQ. Let me take a breath.

Questions sort of about who we are, what we do, reactions, thoughts? How do you like accelerate, innovate and -

UNIDENTIFIED PERSON: Can you say a little more about the Jump Start and the Jump Ahead programs, what those are all about?

CHARLES HOMER: Sure. So those courses are really kind of QI 101. So I'll briefly show a slide later on for the Model for Improvement which is the framework we use for our quality improvement work. Many people use other ones like Six SIGMA or Lean and things like that, their similarities and generally, I think they are all pretty similar, but we happen to use the Model for Improvement.

So the Jump Start course is really a fundamentals course. If you wanted to launch projects and you wanted to train the staff either within your organization or within practices that you are working with or within a hospital, train them in the fundamentals of how do you do a PDSA, plan-do-study-act cycle, how do you do an AIM, that's what the Jump Start course is.

The Jump Ahead course is sort of the next level if you were to lead a project, if you were -- you were trying to identify project leaders, that's sort of who that course is targeted for. We either run those as free standing courses, so you just pay your tuition and attend. We prefer to run those actually on a contract basis. So, for example, we've had a wonderful contract with the State of New York's Department of Health for the last couple of years where we provide training through them to the leaders and members of all their community asthma coalitions around the State. So they have a CDC funded activity where they have asthma coalitions around the State. And so we run this course

where we actually do the Model for Improvement and we also bring in some asthma faculties. So it is condition specific in that case.

BONNIE STRICKLAND: That's important.

CHARLES HOMER: But that's, for example, the kind of thing we could do for you.

At our forum this year, we will have a -- the Jump Start course really is about two and a half days, but we'll sort of have a boiled-down version of a one-day essence of that during the day before our forum, so on the 19th if you're interested. Okay. Yeah?

UNKNOWN SPEAKER: In terms of also the annual forum, I think it's more than just filling the sessions and then you really learn, it really becomes a learning community --

CHARLES HOMER: Yes.

UNKNOWN SPEAKER: -- in terms of meeting people from all different organizations and not just government, and really learning what a lot of people are doing for quality improvement.

CHARLES HOMER: First of all, it's very -- I can advertise for it a little since Linda -- it's very energizing.

UNKNOWN SPEAKER: Right.

CHARLES HOMER: So people come and just get a lot of positive energy. Because making change, which is what we are all about, is hard. And you go out there with good ideas, you come back from this conference, you hear two days or 3 days of wonderful ideas, you want to go home and, you know, you're going back to the old environment.

So the nice thing about the forum is it has lots of high energy, you hear lots of ideas, which is very good. And we work very good to make it cross-disciplinary and cross-sector. So yes, there is, I would say, there is probably a plurality of hospital-based folks, but by no means universality. So we have public health, state, regional public health, we have early childhood, we've been working very hard to increase the participation of families. I think last year we had about 30 parent advocates there. We are working on getting funding to bring that even more this year. We've worked hard to bring public health community in, and we have community doctors. So it's a broad cross-section of people whose main common interest is how do you drive change in the system?

It's organized around the themes that I mentioned, the obesity, special healthcare needs, safety, and disparities theme as well as a theme on innovation and improvement. So a lot of, kind of, methods course.

This year we are really going to work on innovation. How do you come up with new out-of-the-box ideas and move them into practice. Thanks Linda.

So now I'm going to move into this sort of Medical Home, changing systems work and we heard a little about that. As I said at a meeting we were at before, this gets pretty abstract and it gets kind of hard pretty quickly. So for me, it was helpful when I start thinking about putting this session, similar session together, as I was getting lost in the how do you change, get Title V involved, and gosh, this is hard, and it hasn't gone as fast as I wish it had, it was helpful for me as a pediatrician to think back about specific patients. I guess that's a luxury those of us who have been in the clinical world have.

For me, I kept thinking when I was particularly at a community health center, and I thought of this -- most of my patients were Cambodian refugees, and I thought about a very complex child who had a very unusual genetic discord who required multiple specialist involved, very difficult system, needed interpreters, needed geneticists, needed me bridging the gap between our community and the referral hospital, ended up being a foster care setting, and it's that kind of difficult case and child and thinking really how ultimately we were able to help that family, help that child, that mother, both the biologic and the foster mother care for the very complex child. And how having a system that -- I mean, how I wish you knew then what I know now about what a system should look like. To me it was very important. Are people able to hear or not?

UNKNOWN SPEAKER: Just set it right there.

CHARLES HOMER: Thank you. I realized that when you were walking up.

And I'm sure many of you can think of other families like that, but to me thinking about those kind of families and realizing how important it is for any child and any parent to know that they are going to get what they need as a matter of default. I mean, when I think of these cases, I think of the heroic efforts, you know, the nights that I spent thinking about it, the social worker, how I brought them in, the nurse in our practice, and, you know, it was a heroic effort that we were able to provide sort of pretty good care most of the time.

And really what we are trying to do is design a system so that it doesn't happen heroically, it happens by default. And that's what we are trying to create by the Medical Home and by systems of care and it's helpful for me to think about that.

So let me tell you a little about what we did, but more importantly I want to move to what you're doing, and what we've been learning.

So you all know, except those of you who are brand new to the field, kind of what a Medical Home is. You know the attributes of a Medical Home, accessible, family centered, continuous, comprehensive, coordinated. And I like the clarification as we think about coordinated as being three dimensional. It's coordinated horizontally, that is between the healthcare setting and other community resources. It's coordinated vertically

between a primary care and secondary and tertiary care. And it's coordinated longitudinally through the predictable transition from early childhood to school age to adolescents to adulthood. It's compassionate. It's culturally effective. So these are the sort of well-known attributes, we'd all love to have them.

I borrowed this slide from Jeannie McAllister that she and Carl are using in their presentation. It's a little different spin than the flavor I just gave it. For one, she says a Medical Home, they are differentiating that every primary care practice is a Medical Home, but some are basic, some are good, some are better and some are great. So the idea of using that framework to overcome the hostility that really confronts us if we go out and say, "Well, we would like to you be a Medical Home." And they say, "I am a Medical Home. I've been in practice 20 years. My patients love me. I care about the kids I've been working with." So this gives you an idea of differentiation.

And when Carl and Jeannie talk about it, and this is a matter for discussion, for example, when we talk about our epilepsy collaborative, does it need to be a primary care -- I mean, the Medical Home terminology is clearly wrapped up with a primary care framework, certainly when we talk about the patient centered Medical Home in a minute. But we heard when we did focus groups from the patients of children with epilepsy, they said "You know, I hear what you're saying, but that neurologist or that epileptologist is really the person or the setting that I view as the center of my care, and you can talk until you're blue in the face, we are not going to change it."

You know, what we said is that every child needs a Medical Home, so as long as that setting is providing accessible, continuous, comprehensible, family centered, community based care, that child gets it, you can put those components together, we can talk about that. Does it need to always be, you know, the traditional image of the community doctor, the community health center. But it does have to provide coordinated, high quality, planned, family centered health promotion and chronic condition management.

Again, this is a slide I borrowed from Carl and Jeannie that just uses a nice graphic image of what I said before, that coordination vertically, that coordination horizontally, that coordination longitudinally. It's much more attractive than what I did.

So when Carl and Jeannie and Bonnie and Merle and I started talking about this a couple of years ago, you know, the concept of the Medical Home had been out for a long time. You know, this isn't new idea. And we just scratch our head and say, so if this is such a great thing and all the focus groups say family want it, you're not going to find a pediatrician or family physician who doesn't say they want to provide all those attributes, why did we find that, in fact, most children who have a special healthcare needs, wouldn't say they were in a Medical Home and most family practices and family medicine practices if you ask them to describe what they are doing, you wouldn't call that a Medical Home?

So we came up with a couple of thoughts and I would like to get your idea if there are other ones. We said, first of all, people aren't aware of that. It's a term at least when we

were talking about it, hard to imagine, people weren't aware of what a Medical Home was. They thought it was a building, they -- you know.

The next was those lovely attributes that we talked about are not very operational. In other words, you say well be culturally competent, be comprehensive, be compassionate. Well, yeah. So what do I do tomorrow that's different than what I do today. How do I hire, create a job description that's going to make that happen. So we felt there was limited operationalization.

The pragmatic barriers that always come up the first time you ask anybody to change or do something different or provide comprehensive care, time right? Time is obviously linked to the one that's -- well, it comes in there. Time is always linked to money. I use the term reimbursement here as the euphemism for money.

It was interesting, I was on a call briefly, I was on a call on another project with some people from the National Business Group on Health and I used that term, reimbursement, and they said right off the bat that that's a loaded term because reimbursement implies you're being paid for services delivered as opposed to payment or payment levels or as opposed to benefits, you know, which doesn't necessarily mean you're reimbursing for services delivered. So even using the term reimbursement actually suggests a certain perspective.

But time and money clearly were barriers, knowledge, role definition, limited skills and the methodology of changing practice. That's what we thought and designed our programs for.

So before I go on to describe what we did, and many of you participated in it, did we capture them? Are there other reasons you think this Medical Home idea hasn't caught on or at least hadn't caught on over the last couple of years the way all of us would have liked it to?

UNKNOWN SPEAKER: I think one thing that is sort of embedded in some of the points but I think needs to be a separate point is parents. The parents need to be involved because they can help drive the change. So parent education work is -- or having a higher expectation of the services they are receiving, perhaps. And also helping the practice who may want to do better know what they need to be doing.

CHARLES HOMER: So parents need to be involved. Good. Great.  
Jeff?

UNKNOWN SPEAKER: First I want to say (Inaudible.) I really enjoyed last night.

(Laughter.)

UNKNOWN SPEAKER: With that said, you know, we just have had these discussions in Iowa, and I agree with all of those things, but what we don't have (Inaudible) at the State level is some kind of a (Inaudible) infrastructure, because this all takes training, it takes culture change, and, you know, we swoop in, we get a grant and then (Inaudible) or Charlie swoops in and -- (Inaudible) But until we have an institutionalized infrastructure, whether it's the Health Department or Title V, it's really doesn't catch on at the level of the state and we haven't invested in those (inaudible.)

CHARLES HOMER: Although Title V could at least be a partner in creating that.

UNKNOWN SPEAKER: It really could. That's one of my goals is that Title V as for can provide that.

CHARLES HOMER: I agree. Phyllis.

UNKNOWN SPEAKER: Actually, we heard from a couple of people. The concern is that the term Medical Home is going to be used by the payers to drive what Medical Home really means, and from a payer perspective that it will be usual source of care. So while we all talk about the -- you know, the Title V could do and state systems could do, there's a reality out there and that's the payers who are really are the providers and payers of care.

CHARLES HOMER: Thank you.

UNKNOWN SPEAKER: What would be beneficial, what we lack in Indiana, is a champion to help push this implementation.

UNKNOWN SPEAKER: What about the State chapters of the American Academy of Pediatrics? At one point, Medical Home was sort of seen as a self-serving concept for pediatrics, just pediatrics, not primary care. But how about -- how viable is it to look to state chapters for that champion.

UNKNOWN SPEAKER: In Indiana, we are just starting to have our foot in the door and they may consider that. They have the committee on innovative practices on the Medical Home, but we are trying to get that in the (inaudible) as a practice. So it's not a done deal.

CHARLES HOMER: I think of Jeff Schiff, for example, from Minnesota who is now a Medicaid medical director, but was a state chapter leader and certainly championed this.

UNKNOWN SPEAKER: I have a couple of things. One is, I think there's a mind-set, a dilemma. I think you want medical college, primary care practice physicians to take on this role. And there's some physicians that say, "Oh, I do it all because that's my job." But they can't do it all so it fails. And then there's physicians that say, "Well, I'm not a social worker, so I won't do this role." But where is the sort of acceptance or mind-set to say, "This needs to be done, and maybe we can't do it all," and recognize the legitimacy of the

care coordinator role in the practice or the need for something to partner to make the practice able to do it and not say, "I have to be in this role as a physician, I have to do it all." That's a hurdle because I've seen it expressed by physicians when they see for example Bright Futures. It's like, "Oh, well, I'm not a social worker." But how do you get it done?

CHARLES HOMER: Right.

UNKNOWN SPEAKER: The next thing is something I've thought about is we don't really pay -- I think we should think about this, pay for quality improvement actions within practices. So, for example, if a practice brings together a team including a family that time spent is recognized by the reimbursement structures, and all those steps improve the quality we want to encourage or actually reimburse in some fashion.

CHARLES HOMER: So while I wrote that, I hope I'm liberally interpreting what people say. One is I wrote, the doctor is hero and the problem is they come in thinking they have to do it themselves.

The model I was thinking, as you all know, within healthcare, the hot topic for the last couple of years in the policy arena is pay for performance. That is we pay you more if your outcomes or processes are better. A variation on that, it's actually sort of an earlier step, is payment for participation. That is rather than simply if you participate in a quality improvement activity, we will pay you more. And there are a number of plans around the

country that have found that to be more effective and certainly more palatable to the clinician.

UNKNOWN SPEAKER: I just -- I want to comment on a couple -- I want to comments that everyone made and back to Bonnie's comment about do we just -- could we use the local chapters of ADP as champions? In Colorado, that was not successful because we wanted to bring mental health, rural health and medical care altogether.

CHARLES HOMER: Uh-huh.

UNKNOWN SPEAKER: We have all those providers in five organizations at the table, and that crafted the definition that went just beyond the primary healthcare (Inaudible.) And that capitalizes on the original AEP definition that a Medical Home is a team approach. And if you look at a team approach, then you're not talking about as much increase in reimbursement to provide this competence of coordinated medical care. So I think those are important characteristics.

And then the reimbursement issue, I think we have to be very articulate about are we talking about reimbursement rates or are we talking about reimbursement practices? Because in Colorado, practices don't know how to code and bill. And once they do, reimbursement rates are not as much an issue. It still is, but I think you really have to separate out reimbursement rates from practices.

And then finally the operationalization of Medical Home components were very close because of our legislation to identifying standards and indicators for those Medical Home components which will help make it more operational at the practice level. But we can't forget, back to Jeff, I think we need to have standards and indicators for the infrastructure, for the system of Medical Home as well. And that's a big one. And if NICHQ can help us out with that, that would be great.

I'm from Colorado, and I was happier last night.

UNKNOWN SPEAKER: I want to know what happened last night.

UNKNOWN SPEAKER: The Rockies.

CHARLES HOMER: The Indians beat the Red Sox and the Rockies are in the world series.

One more comment and then I want to move on because there will be more opportunity for input.

UNKNOWN SPEAKER: We tried to implement a Medical Home in practice, but physicians weren't used to doing their own productivity by the number of patients they see every day. And Medicaid will not reimburse in Louisiana for most care coordination activities, phone calls, anything that really takes time in a Medical Home directly, Medicaid will not reimburse for.

So if the main administrators in this practice is our (Inaudible) and he did not want us to implement the models because he wouldn't make as much money because the practice is not going to be able to break even doing all of these activities that we are expected to do as a Medical Home. We pursued it anyway, and I think we went over, but I think that's the whole issue.

CHARLES HOMER: I think -- I mean, that's a --

UNKNOWN SPEAKER: (Inaudible) had a question.

CHARLES HOMER: Kim.

UNKNOWN SPEAKER: I think (Inaudible.)

(Laughter.)

UNKNOWN SPEAKER: She's got a whole segment.

CHARLES HOMER: I mean, I think these are key points, I think, and we learned some of these along the way and we are learning more as we go forward.

Our hypothesis several years ago when we started the Medical Home collaboratives was that four key concepts, constructs, would accelerate the spread of the Medical Home.

One was developing a more operational model by integrating the Medical Home concept with the Chronic Care Model with what we came up with called the Chronic Care Model for Child Health. The second was the well-known Learning Collaborative Model which I will briefly but not boringly review. The third is the Model for Improvement which is the change model. And the fourth is the Model for Spread which is when you get two or three or four successful medical homes within your state, how do you actually go from that two or three or four to making sure that every child with special healthcare need in fact is in a Medical Home.

Now, we -- our hypothesis was, just to follow up on Jeff's point, the point that others who have articulated, is that this creating a local infrastructure by strengthening the capacity of Title V in partnership with other critical partners in their state would be the core resource that could support both the creation of and spread of Medical Home. So that was actually -- our hypothesis was that that would be the resource that's needed to provide the technical assistance, in a word or an in a way, for the creation and spread of medical homes.

And what I want to get the conversation around, because I think it's really what we are wrestling with now, is what does that really mean? What is the role if you are the state resource, what does that really mean to be the state resource to create and spread Medical Home?

So we'll talk brief -- this is the Care Model, I hope all of you have it committed by heart. I think, again, just some points: I still think it underlies, to me it's helpful because I'm more of a visual learner, it does underlie a lot of the recent financial work that NCQA and the payers are doing about what are the characteristics of better and best Medical Home so that they can get more reimbursement. It includes the creation of registry systems; it includes the availability of specialty consultation such as for example the mental health program that was described. It includes the creation of teams within the practice. And I would say that's one of the subtle distinctions between this Care Model and the way Ed Wagner talks about it and the AAP definition of the Medical Home, which is this really does emphasize the importance of what is the team of people working together within your organization that can accomplish this with the assumption that this is not a doctor-focused activity.

The fourth area is this care partnership support that includes care coordination and the direct involvement of families in the improvement process.

And the last is the connection, not the last, next is the connection with community resources, and the last is the creation of health system policies which includes reimbursement, but also includes things like training of appropriate staff.

So that's this complicated model, too complicated, although more operational than the simple conceptualization model to improve the Medical Home.

This is our Model for Improvement, again, something I suspect all of you have deeply ingrained in your souls as much as I do. But I tell you the truth, we found in all of our collaboratives that the teams that get this, and particularly the teams that A, are clear about what their aim is, what they are trying to accomplish, not vague but specific, and undertake rapid small tests are the teams that make the biggest changes.

So the teams that say, "We want to think about this for two years and we sort of just want to make life better and we are going to spend six months doing strategic planning and we need to review a thousand charts before we get started," don't get anywhere.

And the teams that say, "We want every child to have, you know, a care plan within six months and we are going to try the one -- pull down one from the web tomorrow and try it on a patient and then learn from that," are the ones that make the most differences. So that's -- that's basically the Model for Improvement.

And again, you know, the Learning Collaborative Model, and that was very funny, Charlie sweeping in to run a learning collaborative. But again, from my perspective, a couple of things I want to emphasize in this Learning Collaborative Model, because it gets to the question of when the grant goes away, does the project? And the point is, it ain't supposed to. And that's -- it ain't supposed to on a couple of levels.

First of all, the way we modified the Learning Collaborative Model in the Medical Home collaborative and to some extent in the epilepsy and adherence collaborative, was that

rather than sort of NICHQ or our faculty doing all the teaching and training, the idea was that we would train Title V leadership and the state team to actually support practices, to support the quality improvement process. So that was the -- that's what made these collaboratives different than any that had ever been done before, because we were not only working with the 30 practices or so that we worked with in these different collaboratives, we were also working with the state team so that the state team would develop the competency to conduct improvement projects and programs on their own.

The idea is also that the practices have developed systems, and by the end of the collaborative having embedded those systems into the way they operate so that it won't go away when the project ends. You know, whether that actually happens or not, we haven't really done enough research to go back to those practices and say.

I can tell you when IHI goes back to the practices they work with the general distinguishing character of practices that stick, there are two, one is ongoing commitment of leadership, and the way that ongoing involvement of leadership is manifested is by continuing collection of data. So organizations that continue to collect and report data, not to us, but to their own leadership about performance tend to sustain the changes.

Teams that tend to say, "Medical Home was fun, that was a nice project, let's move on to Bright Futures, or let's move on to smoking cessation or let's move on to mental health," and not sort of put it altogether, tend to be the ones that don't sustain the changes.

So I already talked about what we did differently was we involved the State Title V. And I'd like to get some discussion about that. We learned in the first Medical Home collaborative that simply bringing Title V, we knew it already, but we were more formal about it in the second. That simply bringing Title V alone to the table is not going to change the practice level, that it needs to be a state partnership effort that includes AAP and AAFP, it includes parents, and we believe it also should include the group that often is the hardest to bring to the table is Medicaid as a key partner, and could be private insurers as well.

The other thing that we did that was different, now it's like ho-hum, but I have a slide, we can look at the video in a minute when we talk about the epilepsy collaborative, was the direct involvement of families on improvement steam on the faculty as leadership, and that made a huge difference in all of our work.

The last model that we talked about, and this is an anguished presentation, you'll hear pain in my voice as I describe this, is the Spread Model, because again, in interest of true disclosure, I think of all the models we did, this was the one that was hardest to communicate, had the least uptake. And I'd like to spend a fair amount of time kind of getting your input on this model. Because the idea -- we have never had the idea in NICHQ that the way to spread the Medical Home is for it to be a thousand learning collaboratives at the State level, each of which has 30 practices, and that's how you're going to get all 30,000 pediatricians and primary care and, you know, 50,000 or 75,000 family docs. I mean, it's just not a scaleable model at that level. At least I don't think so.

So the question -- the whole purpose of a learning collaborative is to create exemplar teams that succeed so that when Dr. Skeptical says, "I don't want to do this and you can't make it happen," you can say, Well, wait a minute, you know, Dr. Innovative here and their team have actually created a Medical Home and they look just like you. I mean, they are rural or they are urban or they have 60 percent Medicaid or 20 percent Medicaid and they did it, so you can do it. And don't listen to me, your state leader or your outside hired, you know, fireman from Boston, you know, look at this local person who's really walked in your shoes, and they've accomplished these result. That's really what the collaboratives are about. And the collaboratives are also about helping you as state leaders really understand what it takes to change practice on a granular level. It's not to teach you the secret handshakes of how do you get people to mail back their PDSA forms and, you know, what's a good lunch to have at a learning collaborative session. I mean, you know, that's really not people -- I think we have been not clear in communicating that. And you know, so the whole role of the Learning Collaborative Model is actually fairly constrained. It's really to create exemplar teams and to help you learn what it takes to drive practice.

And then the whole next idea is given some successes at a small level, how do you spread that innovation across the population that you're responsible for as state leaders? And so this -- I'll talk more about this model, I can talk about it until I'm blue in the face. But the idea is, first you have to have a good idea. We think the Medical Home is a good

idea, but we think the ways that we have talked about it make it very hard to spread, so we'll talk about that.

You already mentioned in your comments about the role of leadership, you need both sort of mission-driven leadership, but you also need organizational leadership, people who can remove barriers and make things happen. It's obviously easier in a command and control, I'm in the Veterans Administration and you all work for me approach than it is for you in a public health setting.

And then this whole set up process, working through the social network, are all critical components. So this whole spread idea is much more ephemeral than a specific project, but it needs to work. And that's where I would like to talk a little bit about it.

So we did this collaborative, we had many of you participating. You know what the purpose was. You know, we had all kinds of diverse practices from small little community solos to, you know, the Marshfield Clinic.

We looked at the usual suspects including the Medical Home index which you all know and love, and if you want to look back at some of those other slides -- by the way, I'm late always on my slides. I'll mail them to you. I'll post them on the website.

UNKNOWN SPEAKER: Don't post them.

CHARLES HOMER: Don't post them on the website.

You know, this is Carl and Jeannie's Medical Home index, and more is better and we showed in these collaboratives that all of their scores improved, and what was nice for us was that they improved as much in a year as when Carl and Jeannie were working one-on-one, it took them about two years. So we felt this accelerated the process. And when we ran the collaborative the second time, we basically got the same level of improvement in the Medical Home index which was very nice.

And we had some suggestive data that, you know, not publishable in the New England Journal, but to me suggestive that emergency department visits went down in both first and second learning collaborative as did unplanned hospitalizations.

So, you know, these collaboratives did seem to help create some medical homes and those practices that reported data, now you know why you can't put it in the New England Journal, showed some reductions in some of the outcomes that are important to us.

When we interviewed all of you about what you thought worked in these collaboratives, you said walk-thru's were very important. So going out of, you know, your public health office, going out to the practice and walking in their shoes really made a difference because you understood what the issues were.

Being able to connect teams and practices to the resources that you all know about is very helpful. This care coordination, this providing some core resource in care coordination was very helpful you thought. And training practices how they can work more effectively with families was a particular thing you felt that you were bringing.

And the feedback we heard was that you needed more support in how to actually work with practices. You needed more support in how to learn the Model for Improvement. And there needed to be more infrastructure within your programs to undertake this kind of work. It couldn't just be added on to all your other activities, it really need to have an infrastructure.

And the spread process again was a challenging process. A few states basically did take on this idea of running collaboratives internally, and those that did, actually, have been pretty successful. You've been successful in convincing state legislatures to fund them in some settings, so it's actually been -- so even though that wasn't our initial idea about how it would spread, I think in some settings, if you're trying to create a limited number of sites, perhaps chosen geographically for where they might have the most impact, that's an approach that some of you have done.

Parents certainly were critical, we learned that, for a variety of things for the change process, and parents also found it helpful for them.

And many of the practices felt the collaboratives were helpful for them. This PDSA cycle for those who got it, they found it helpful. But we also heard very clearly that the Medical Home Model, even the way we framed it, was much too complicated and they needed prioritization.

So when we reflected on did the Medical Home two collaboratives we did succeed in overcoming the barriers that we said, and now I need to look back at the ones you just added, how did they -- how effective were they in addressing the barriers? The first question was lack of awareness, and the reality is we at NICHQ and these collaboratives, the purpose wasn't focused on awareness. There was a little bit of local activities that you did. But one thing I would like to hear from you is whether the current brouhaha or attention or focus on Medical Home. I mean, it's now on the Commonwealth Funds website, on the Design for the Future, and, you know, there's -- I have one of Steve Wagner's slides, you know, the family centered -- what's it? The family center -- Patient Centered Medical Home is now out there. There are all these efforts around finance reform; NCQA is developing the performance measure around Medical Home. I mean, what do you guys think? Are you hearing that all these activities are changing the level of awareness and how is that affecting your interest in availability and ability to spread this? I'm seeing some shaking heads. Is that happening in your community?

UNKNOWN SPEAKER: I think it's given for us and the children with the special healthcare needs --

(End of segment.)