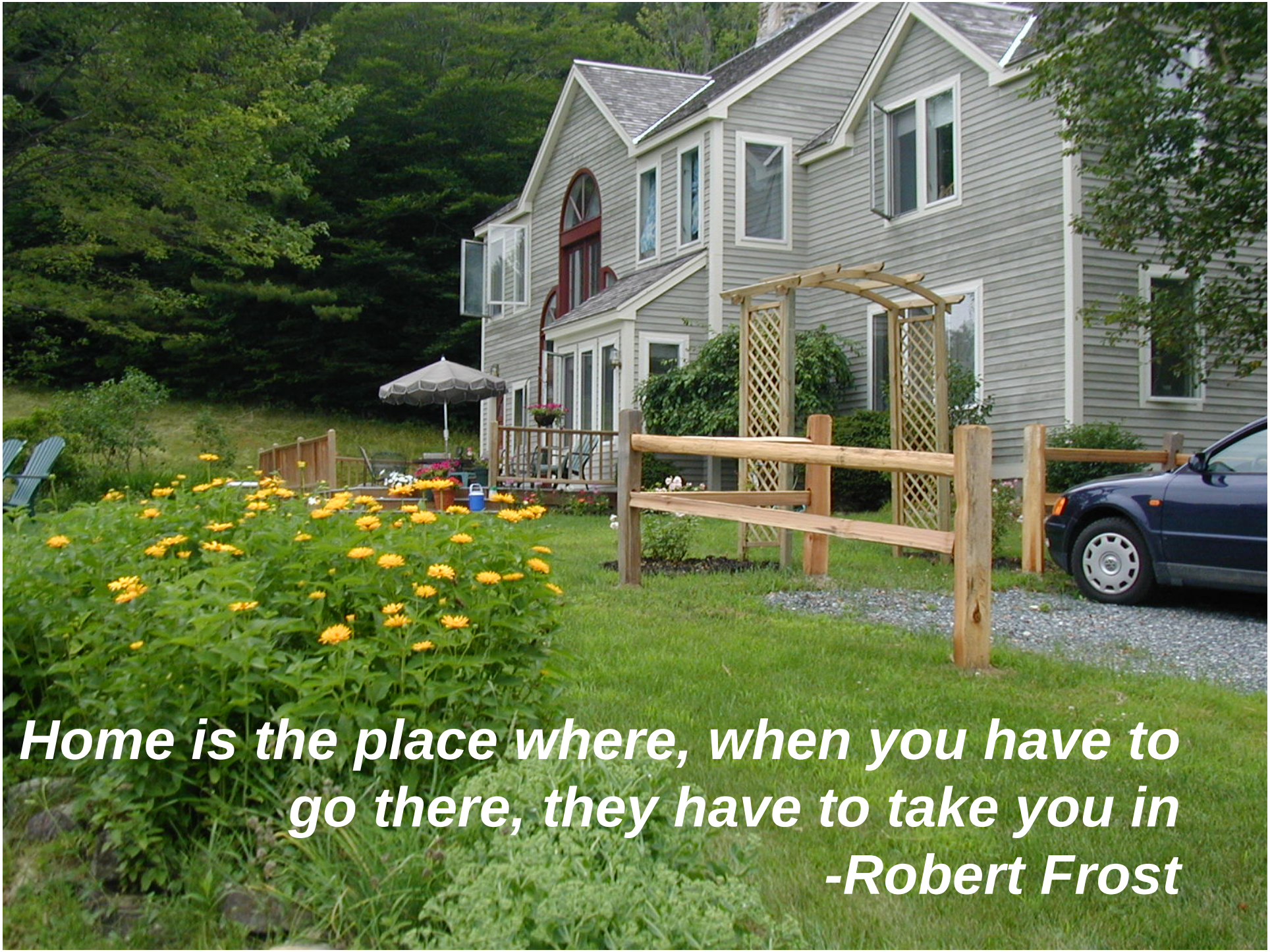
Home is the place where, when you have to go there, they have to take you in
-Robert Frost

Learning Session #1

Utah Medical Home
Integrated Services Project

April 7, 2006

Jeanne McAllister, Co-Director
Center for Medical Home
Improvement (CMHI)
Crotched Mountain Foundation,
Greenfield, New Hampshire

Welcome

(To Your
Medical Home)

Learning Goals

- What is a Medical Home?
- Where to Begin?
  - Medical Home Improvement
    - Self assessment
    - Aim statement
    - Clear plan for next steps

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Are you familiar with / knowledgeable of the ***medical home*** concept?

- No knowledge of concept
- Some knowledge/ not applied
- Knowledge of concept/ sometimes applied
- Knowledge/concept regularly applied in practice

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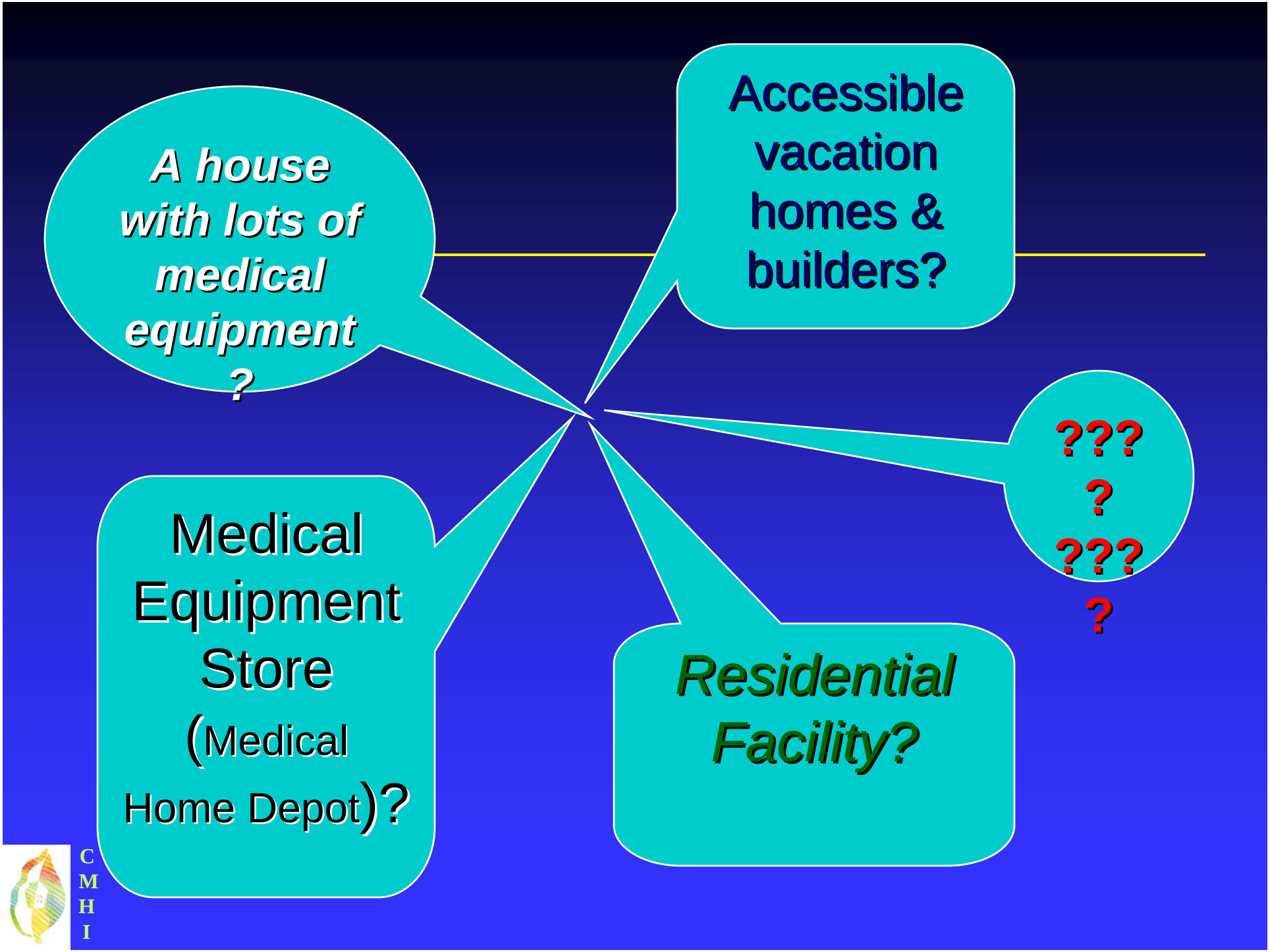
… American Academy of Pediatrics… a medical home provides care that is:

- **Accessible**
- **Family-Centered**
- **Continuous**
- **Comprehensive**
- **Coordinated**
- **Compassionate**
- **Culturally Effective**

When you hear "*medical home*" what image comes to mind?


A house with lots of medical equipment ?
Accessible vacation homes & builders?
???
?
???
?
Medical Equipment Store (Medical Home Depot)?
Residential Facility?

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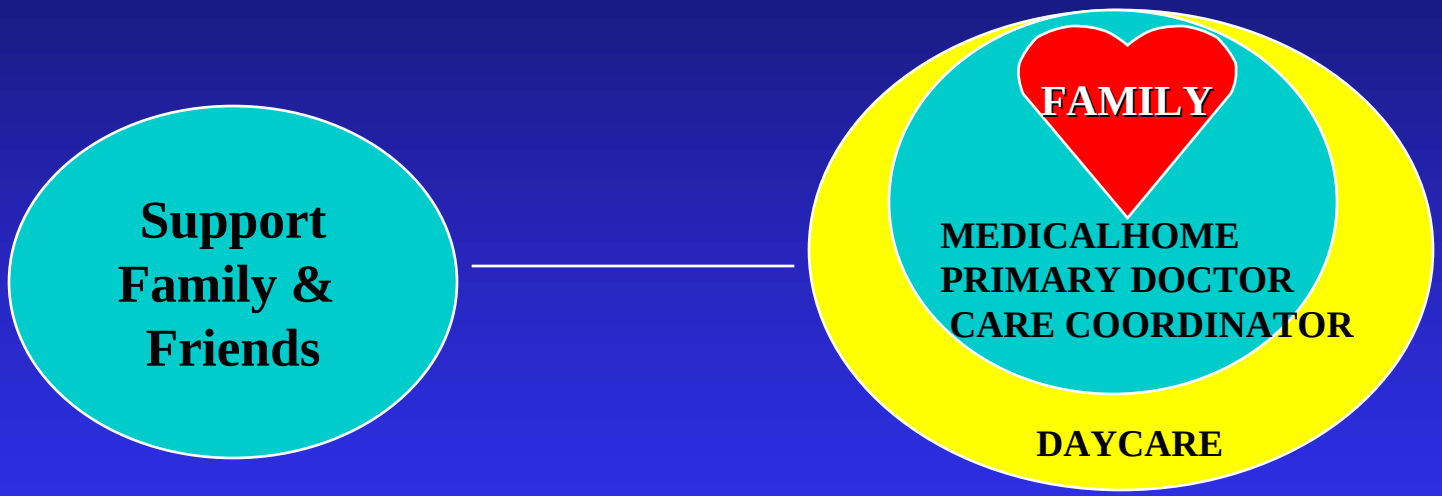
Our Medical Home Until 1:30 p.m. 2/15/01



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And Then… Along Came The Amazing Miss Kate

- **Congenital Hydrocephalus**
- **Multiple revisions, infections, complications**
- **Cerebral Palsy, Epilepsy**
- **Downright remarkable**

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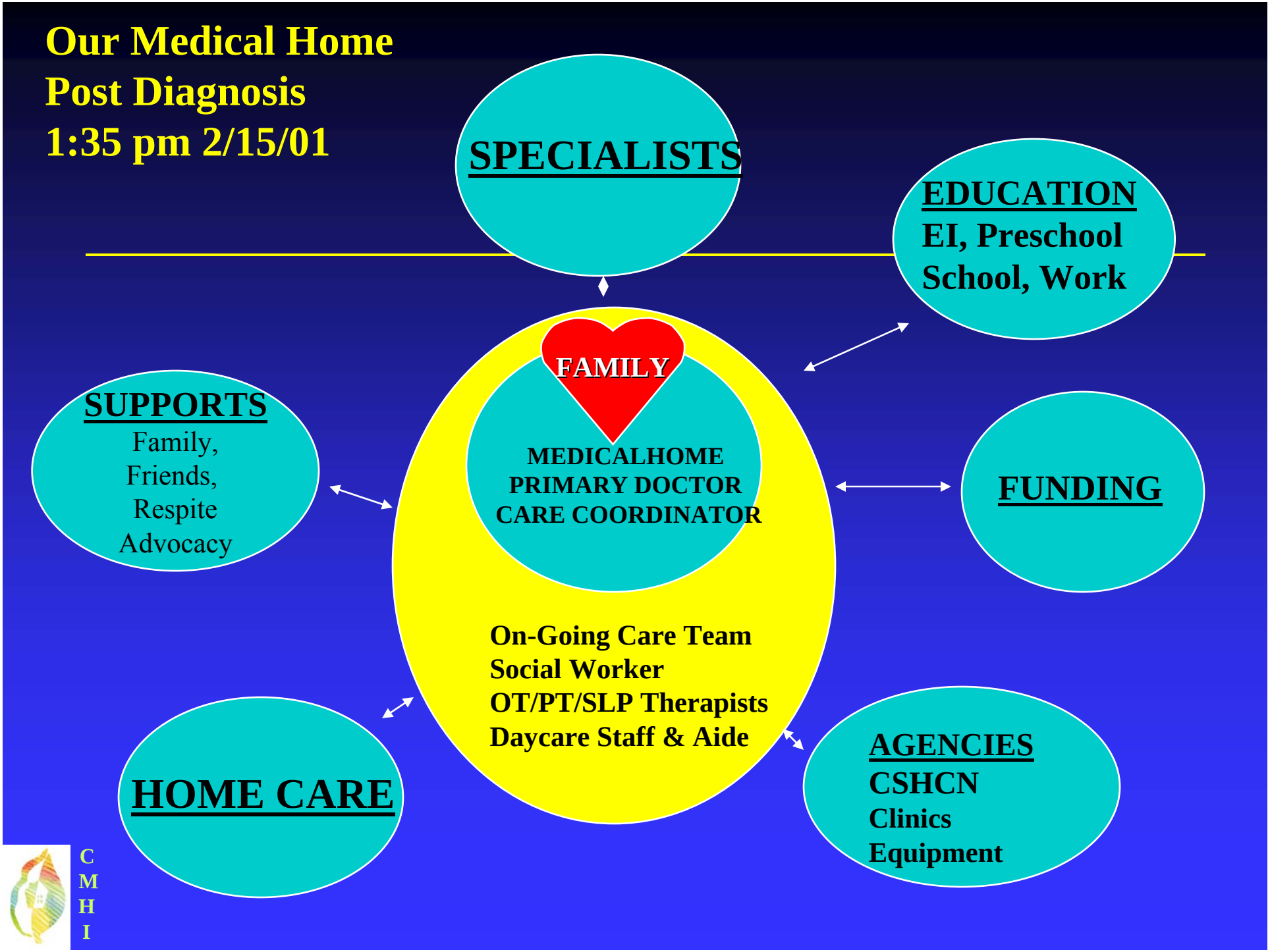
Our Medical Home
Post Diagnosis
1:35 pm 2/15/01
SPECIALISTS
EDUCATION
EI, Preschool
School, Work
FAMILY
SUPPORTS
Family,
Friends,
Respite
Advocacy
MEDICALHOME
PRIMARY DOCTOR
CARE COORDINATOR
FUNDING
On-Going Care Team
Social Worker
OT/PT/SLP Therapists
Daycare Staff & Aide
HOME CARE
AGENCIES
CSHCN
Clinics
Equipment
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Explaining the Medical Home

- A **medical home** combines place, process, and people -
  - the central place where primary care is provided
  - the process and scope of care in that place, and
  - the team of people delivering and coordinating care

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Explaining the Medical Home

- Patients and families expect that their **medical home** staff will:
  - know and remember them
  - respect their ideas, customs and beliefs, and
  - help them coordinate care and information among multiple professionals and services

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Explaining the Medical Home

- The primary care **medical home** strives to improve health outcomes and quality of life for patients and families - while improving the experience of providing healthcare for its office staff

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Explaining the Medical Home

- Care received in a **medical home** can be *good*, *better*, or *great* depending upon the openness to change and commitment to partner with families/consumers to make things better

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Explaining the Medical Home

- Improving care for children or adults with more complex health needs enhances the **medical home** experience for all patients; ***medical home*** is about practice-wide improvement - not a special, separate primary care

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- A "great" **medical home** *declares* itself to be a medical home, and
  - knows its patients and patient populations
  - partners with and learns from youth and families
  - uses a proactive team approach to chronic condition care
    - planned visits
    - coordination of complex services
    - co-management with specialists &
    - assistance with transitions - especially to adult services
  - connects with other community-based organizations
  - offers safe, efficient care while preventing unnecessary or duplicative services, thus reducing health care costs

Who endorses the ***medical home*** as the model for 21st century primary care?

- The American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- National Association of Pediatric Nurse Practitioners (NAPNAP)
- Family Voices
- American College of Physicians
- United States Maternal and Child Health Bureau (USMCHB)
- Others . . .

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Children with Special Health Care Needs are those who have chronic:

- physical
- developmental
- behavioral, or
- emotional conditions, and
- require health & related services of a type or amount beyond that required by children generally

- About 12-15% of all US children
  - (USMCHB, 97)

Health care experiences of CSHCNs

	CSHCN	Typical	Average
Annual school absences	**7.4**	2.8	3.6
% with health insurance	**88.8**	86.4	86.8
% with usual source of care	**94.4**	93.2	93.4
% not satisfied with care	**17.9**	13.6	14.7
% with unmet health needs	**12.9**	6.4	7.6
Annual MD contacts	**6.4**	2.6	3.3
Annual hosp days/1000	**691**	122	225

From Newacheck et al. Pediatrics, 102, July 1998

The medical home is best represented by a primary care office…

- Annual reminders for well child visits w/ a consistent clinician
- contract phone service translation for all potential language barriers

Or

- Paper or electronic system to help staff recognize a child who needs to use the practice frequently
- tools or memory aides help capture the child's history, strengths, assets, any prior special requests and family expertise

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. . . a primary care office:

- A. Prepares for the annual visit by ensuring that all age related comprehensive forms are on the front of the chart

Or

- B. Completes with the family and shares a care plan for children with more complex issues that consolidates information, treatment, actions & ownership, & to do's in an emergency.

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Improvement Strategies in Primary Care… Why are they needed?

Medical Home Improvement
Why now?

- More children with chronic conditions
- Home and community-based services preferred

- Fragmented care
  - Institute of Medicine report

- Healthy People 2010 goal:
  - “All CSHCNs will receive coordinated, comprehensive care in a medical home”

"We're running a little bebind, so I'd like each of you to ask yourself, 'Am I really that sick, or would I just be wasting the doctor's valuable time?'"

TIME STRATEGIES

Intervention elements

- QI team in each practice
  - Lead physician
  - Care coordinator/staff member
  - Parent Partners (at least 2)
- QI process
  - Redesigned Care/Changes
  - Metrics
- Facilitator/consultant
- Learning collaboratively

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Building a Medical Home - Step by Step Quality Process:

1) Team Establishes starting point
   - ☼ Measurement; Brainstorming; Prioritization

   Focus area & aim statement

   Plan Do Study Act –
   - ☼ Small tests of change

2) Learn, logical next steps, momentum

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Measurement

Not everything that can be counted counts,

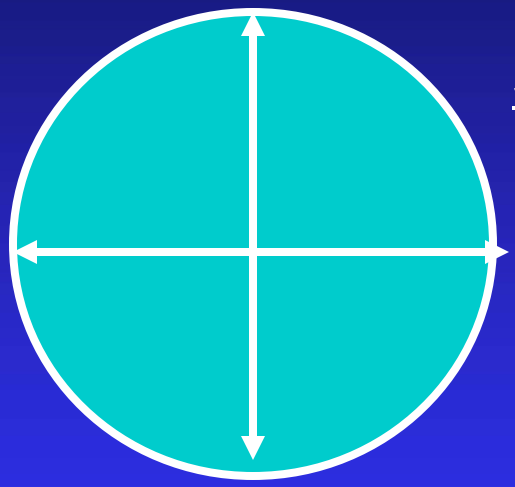
and not everything that counts can be counted.

Albert Einstein

Clinical Value Compass
Child, Family & Practice
Medical Home
Outcomes

Functional:
↓ stress/worry
↓ school absence
↑ dx/rx information access
↑ family care giving competence
↑ quality of life

Clinical:
↑ preventive services for CSCHN
↓ illness episodes
↓ acute encounters



Satisfaction:
↑ communication
↑ office CCM
↑ care plan/continuity
↑ family involvement

Cost:
↓ ER, hospital visits
↓ unnecessary specialty & office visits
↓ lost parental work time
↑ care coordination activities received

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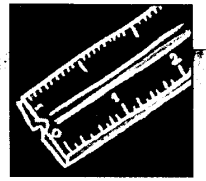
Center for Medical Home Improvement - Outcomes, 2005

Achieving “medical homeness”

- MHI measures movement toward a stronger medical home

- 6 Domains, 25 indicators; scale of 1-8
  - 1) Organizational Capacity
  - 2) Chronic Condition Management
  - 3) Care Coordination
  - 4) Community Outreach
  - 5) Data Management
  - 6) Quality Improvement

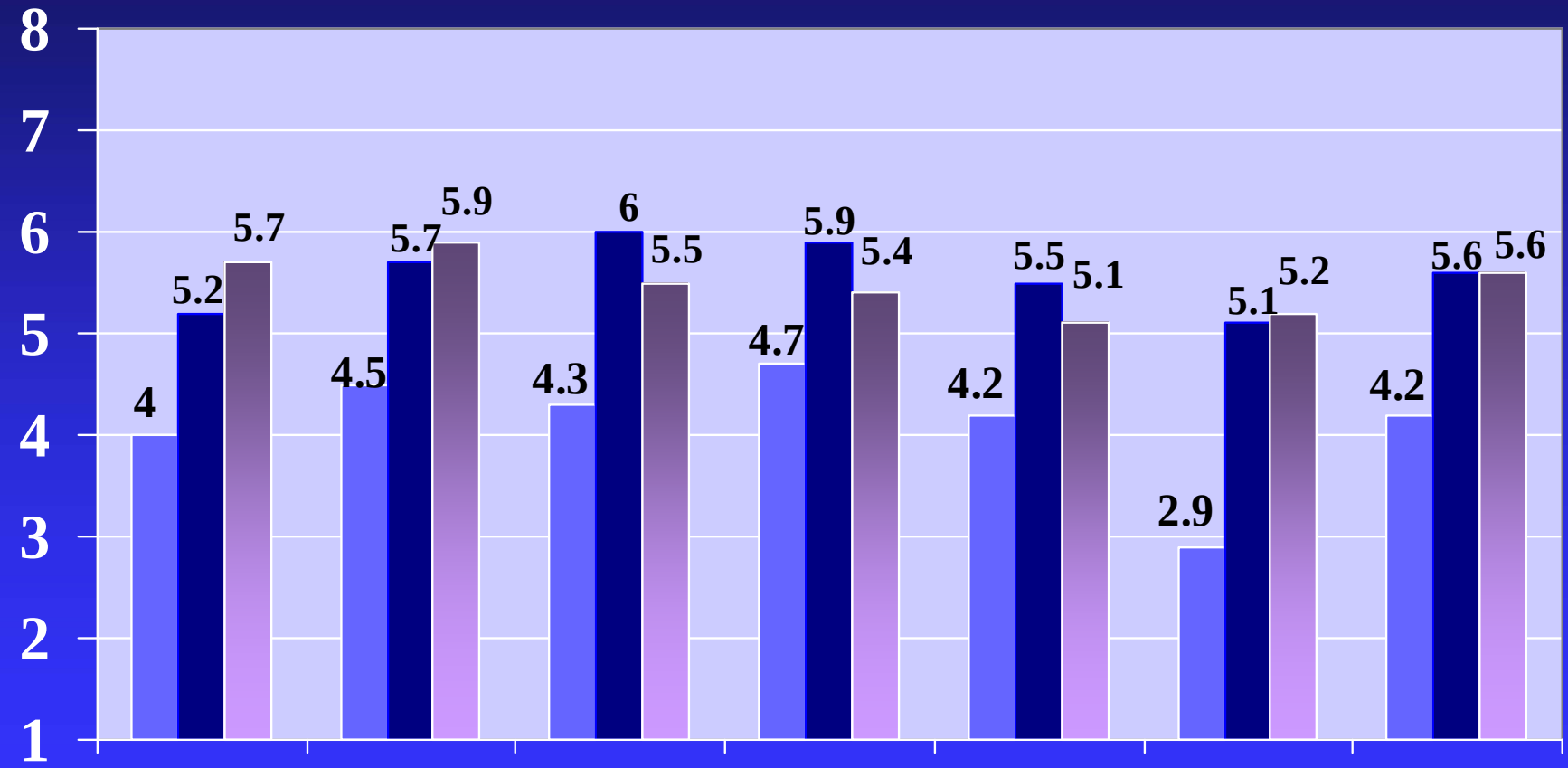
Center for
Medical Home
Improvement



Domain 1 Organizational Capacity (continued): For *CSHCN* and Their Families

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#1.4 Office Environment *Requires both MD & key non-MD staff person's perspective.*	Special needs concerning physical access and other visit accommodations are considered at the time of the appointment and are met if possible. ❒ PARTIAL ❒ COMPLETE	Assessments are made during the visit of children with special health care needs and the needs of their families; any physical access & other visit accommodation needs are addressed at the visit and are documented for future encounters. ❒ PARTIAL ❒ COMPLETE	In addition to Level 2, staff ask about any new or pre-existing physical and social needs when scheduling appointments; chart documentation is updated and staff are informed/prepared ahead of time ensuring continuity of care. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, key staff identify children scheduled each day with special health care needs, prepare for their visit and assess and document new needs at the visit; an office care coordinator prepares both office staff and the office environment for the visit; s/he advocates for changes (office/environmental) as needed. ❒ PARTIAL ❒ COMPLETE
#1.5 Family Feedback *Requires both MD & key non-MD staff person's perspective.*	Family feedback to the *practice* occurs through external mechanisms such as satisfaction surveys issued by a health plan; this information is not always shared with *practice* staff. ❒ PARTIAL ☑ COMPLETE	Feedback from families of *CSHCN* is elicited sporadically by individual *practice* providers or by a suggestion box; this feedback is shared informally with other providers and staff. ❒ PARTIAL ❒ COMPLETE	Feedback from families of *CSHCN* regarding their perception of care is gathered through systematic methods (e.g. surveys, focus groups, or interviews); there is a process for staff to review this feedback and to begin problem solving. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, an advisory process is in place with families of *CSHCN* which helps to identify needs and implement creative solutions; there are tangible supports to enable families to participate in these activities (e.g. childcare or parent stipends). ❒ PARTIAL ❒ COMPLETE
#1.6 Cultural Competence	The *primary care provider* (*PCP*) attempts to overcome obstacles of language, literacy, or personal preferences on a case by case basis when confronted with barriers to care. ❒ PARTIAL ❒ COMPLETE	In addition to Level 1, resources and information are available for families of the most common diverse cultural backgrounds; others are assisted individually through efforts to obtain translators or to access information from outside sources. ❒ PARTIAL ❒ COMPLETE	In addition to Level 2, materials are available and appropriate for non-English speaking families, those with limited literacy; these materials are appropriate to the developmental level of the child/young adult. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the *practice* uses these encounters to assess patient & community cultural needs. ❒ PARTIAL ❒ COMPLETE

Medical Home Index: Mean Item Scores
(MHIP 8 sites Fall 2001, 2002, and 2003) N=8



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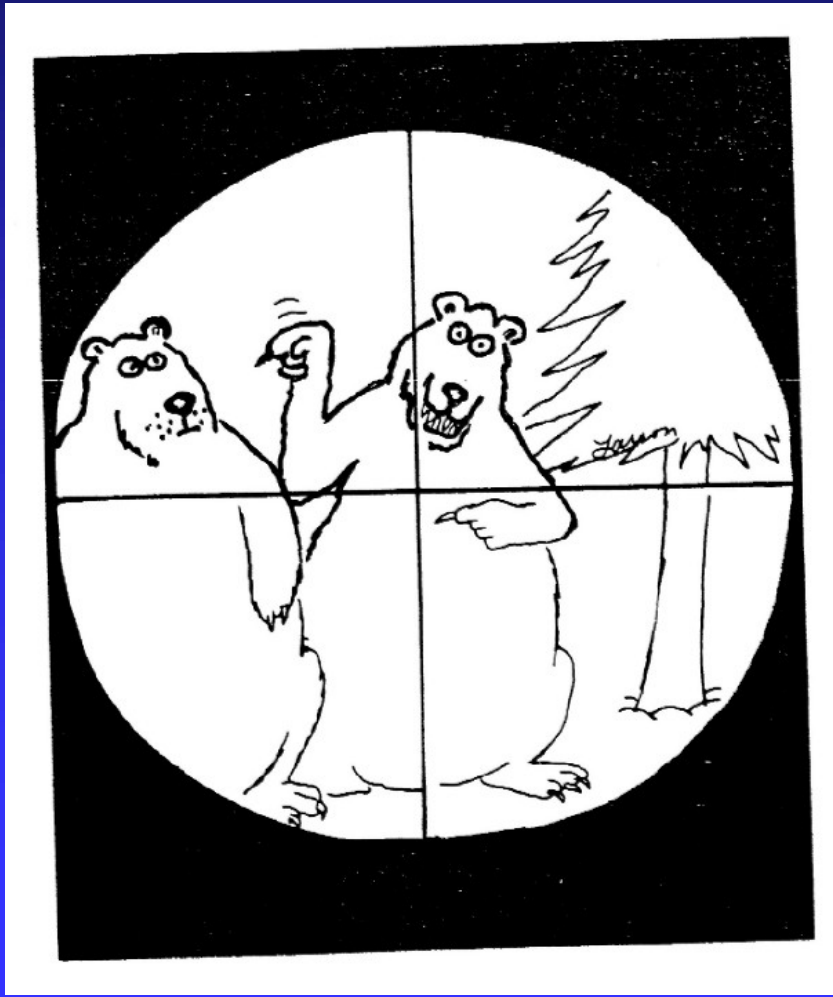
What do your Parent Partners tell you?



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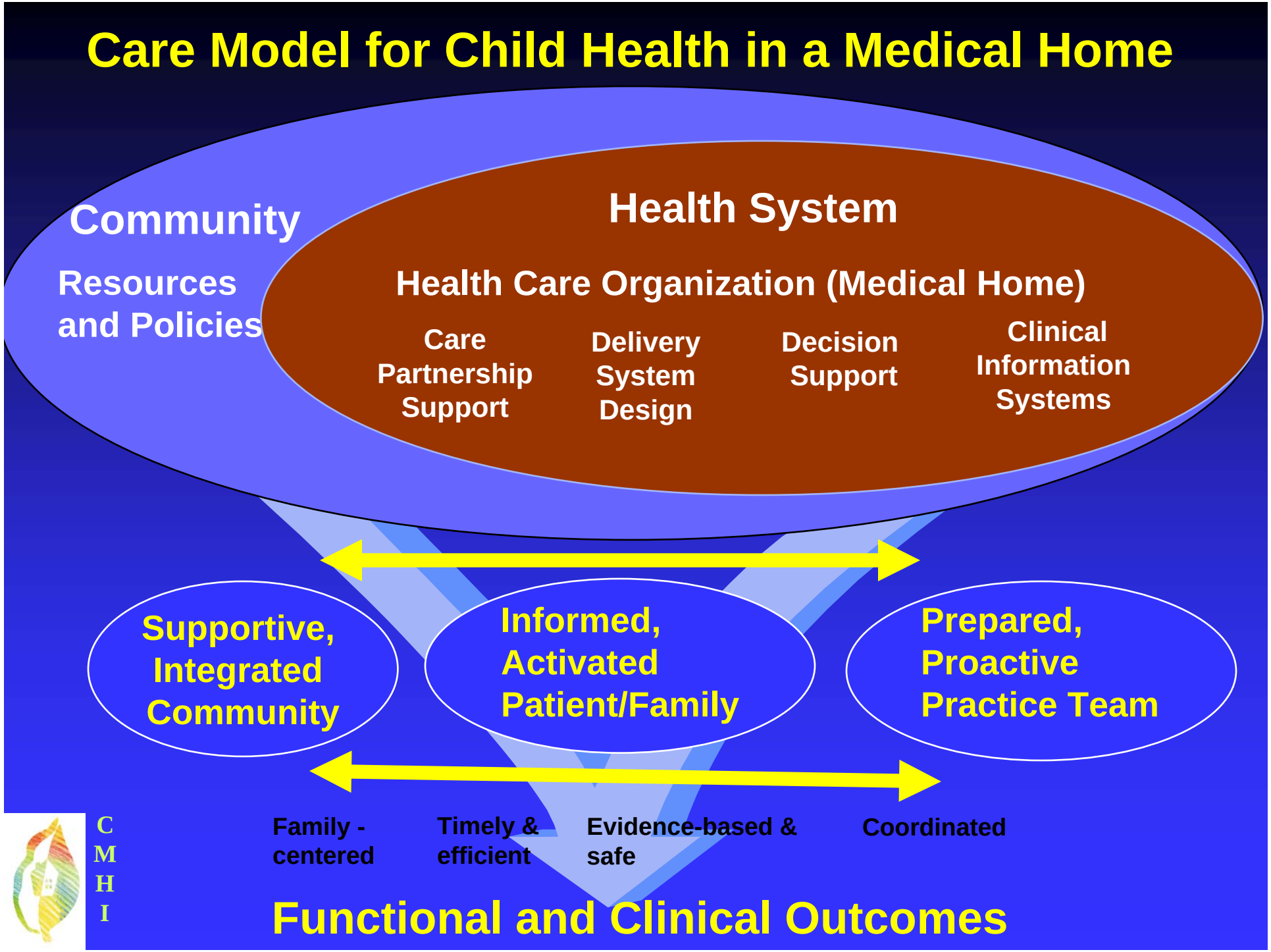
What do your Parent Partners tell you?

"We would like a Medical Home that"

- Develops a written summary of critical information (care plan)
- Offers a collaborative family-centered team approach
- Has a developed process to integrate and coordinate multiple services

The Care Model

Care Model for Child Health in a Medical Home



Care Model for Child/Patient Health in a Medical Home

Community	✱ Meet with and gain knowledge of community "partners" ✱ Catalog community resources; list key contact persons
Health System	✱ Gain/have commitment of health care system senior leaders to establish & institute quality care standards for CYSHCN ✱ Create strategy to negotiate with plans maximizing reimbursement for medical home visits/care delivery
Care Partnership Support	✱ #1 Engage parents as partners at the practice level ✱ Use tools to facilitate youth's access to transition resources and transition to adult life and healthcare.
Delivery System Design	✱ #4 Develop strategy & identify specific roles to ensure practice-based care coordination and team communication ✱ #3 Create and offer planned visits using pre-visit assessments and information organization; select and use care plans and a care planning process with families
Decision Support	✱ Co-manage care with specialists & choose information exchange methods (fax-back, email, web-based systems) ✱ Identify, select and use evidence based practice guidelines
Clinical Information Systems	✱ #2 Identify CYSHCN (definition &/or CSHCN screener) ✱ Build and use a registry to enroll identified CSHCN; use visit reminders, supported care planning delivery, and monitor needs and outcomes

1) Parents
2) Population
3) Planned care
4) Care coordination

Organizations Citing Care Coordination as Crucial to Delivery of Quality Care

- AAP/USMCHB/AAFP (policy papers)
- Family Voices
- **IOM**
  - **Crossing the Quality Chasm & f/u Report**
- Commonwealth Fund
- Future of Children (RWJ)
- Care Model (Improving Chronic Care)
- Individual authors (e.g. Starfield, Antonelli)
- Others…

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Care Coordination in a Medical Home (Definition)

- Practice-based care coordination is a direct, family/youth-centered, team oriented, outcomes focused process designed to:
  - Facilitate access to health care and other resources
  - Ensure ongoing pro-active care planning
  - Build community connections
  - Improve and sustain quality:
    - Of life – for child/youth (patient) and family
    - Of care – within the medical home (system)

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(CMHI, 2005)

Learning Goals

- What is a Medical Home?
- Where to Begin?
  - Medical Home Improvement
    - Self assessment
    - Aim statement
    - Clear plan for next steps

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Cultural Effectiveness

Family Centeredness . . .