

Medical Home for Iowa Children and Youth



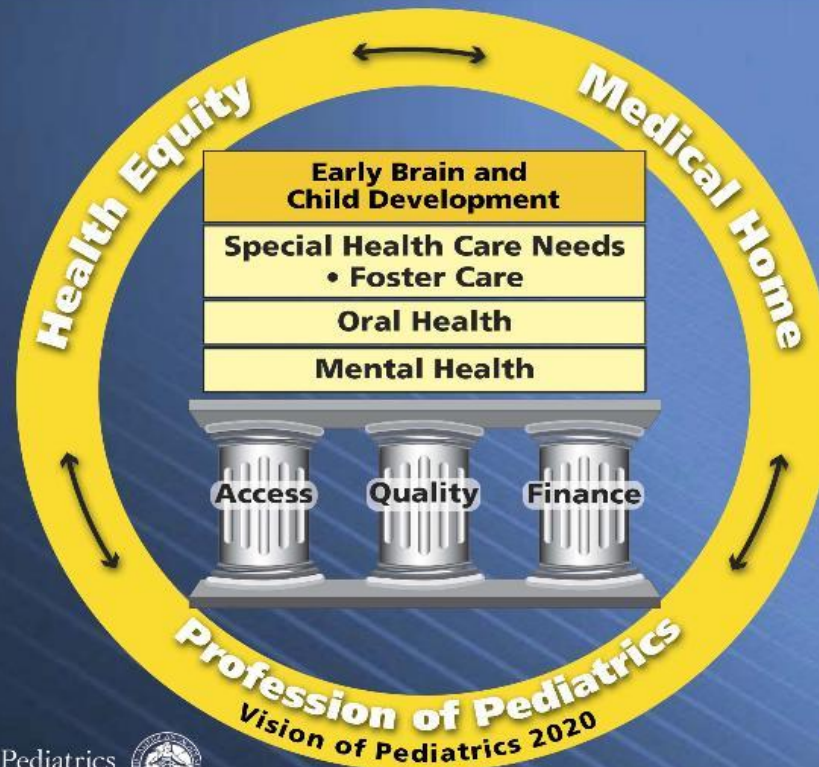
**MEDICAL HOME ADVISORY COUNCIL
JUNE 30, 2010**

IOWA CHAPTER AMERICAN ACADEMY OF PEDIATRICS

AAP STRATEGIC PLAN

AAP Agenda for Children 2009-2010

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- Planning
- Implementing
- Integrating

Goal: Improved health outcomes for all Iowa children and youth.



Objectives:

1. All children and youth have access to appropriate, quality health care within a medical home.
2. Medical practices utilize quality measures and quality improvement methodology to achieve optimal outcomes (e.g. health status, family satisfaction)

Certification for all medical homes for children and youth will be through the national committee for quality assurance (NCQA)

Special Attention to Children and Youth with Special Health Care Need

1. A screen must be done on all children to identify CYSHCN.
2. A care plan must be developed for any CYSHCN in coordination with a care coordinator from the community utility.

Overview

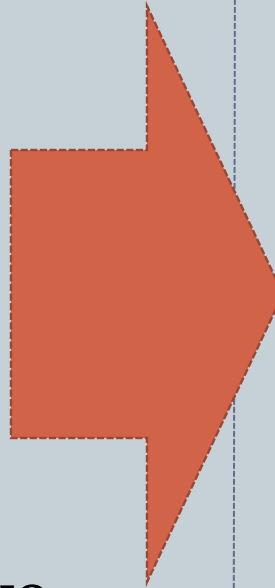


A Medical Home delivers patient centered care where a provider strives to insure **timely, accessible, continuous care.**

The patient centered goals are formed in partnership with the care provider to enhance **care co-ordination** of services and health outcomes that are **safe, equitable and culturally sensitive.**

Medical Home provides care which is:

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



- **Safe**
- **Effective**
- **Efficient**
- **Patient Centered**
- **Timely**
- **Equitable**

Fully developed medical homes offer



Chronic Condition Management (primary care process) which is designed to:

- Serve children and families who use the health care system most often (CSHCN)
- Expand services to include:
 - ✦ Care coordination
 - ✦ Advocacy
 - ✦ Information exchange & family education
- Respond to family & community needs

Planned Care in the Medical Home

PDSA in each "unit"



Microsystem *Walkthrough* throughput



Orientation
To Practice

Appointment
& Visit

Chronic
Condition Care
(& well/acute)

Community
Linkages &
Resources



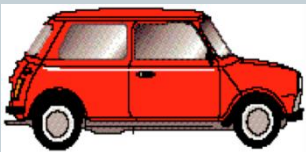
Orientation
letter →
Medical Home

**ID CSHCN
Mini-Survey
Of Needs?**

**Care
Coordination
Care Plan**

Care
Conferences

Measured Improvements



Improvement Strategies for CSHCN & Families

Medical Home **Teamwork**



- **New roles and responsibilities**
 - Everyone functions at the top of their license
- **New work flow**
 - Team meetings for planning and improvement
 - Continuous training, learning, and improvement
 - Non-visit “touches” deliver pro-active, planned, coordinated, and integrated care
 - Data driven work – not visit driven work
- **New Approach to quality and safety**
 - Eliminate re-work
 - Eliminate duplicated effort
 - Eliminate work-a-rounds

Physician Practice Connections Patient-Centered Medical Home (PPC-PCMH)



- Measures evaluate:
 - Use of systems
 - Effectiveness in prevention
 - Management of chronic illness and patient safety
- Measures are “actionable” at physician practice level
- Measures are validated by relating them to performance
- Recognition is based on:
 - Responses in Web-based Survey Tool
 - Supporting documentation attached to Survey Tool
 - Each element specifies type of documentation
 - Reports; documented processes; records or files

Tool Time



- PDSA worksheet, Lean
- Walkthrough throughput
- Integrate information technology, use meaningfully
- Benchmarks, Worthy Goal, Dashboards for populations of Special Needs
- Practice Guidelines and Templates
- Databases of risks, sensitivities and specificities of clinical tests or diagnostic procedures
- Contracts to enhance Care Plans
- Resources: IHC, AAFP, AAP
- NCQA

Suite: Well Child Care



Developmental screen

- **Process Measure** ----percent of well-child visits of children younger than 5 years in which a structured developmental assessment is used.
- **Outcome Measure** ---number of children younger than 5 years referred for developmental assessment

Immunizations

- **Process Measure**—percent of children “up to date” using Composite 3 (see handout)

Suite: Oral Health



Oral Health Screening

- **Process Measures:** --percent of well-child visits of children younger than 8 years in which an I-Smile™ approved oral health risk assessment protocol is used
- **Outcome Measure**—number of children younger than 8 years at-risk or with suspected dental disease referred to Iowa's I-Smile™ program via the I-Smile™ Coordinator assigned to the practice's region of the state

Suite: Mental/Behavioral Health



ADHD

- **Process Measure**—percent of patients who were provided with patient education on disease management and health behavior changes during one or more visits
- **Outcome Measure** —number of children receiving appropriate follow up care when prescribed medication (continuation and maintenance phase)

Suite: Chronic Condition



Asthma

- **Process Measure-**percent patients with written asthma management plan
- **Outcome measure-** Annual number of asthma patients (>1 year-old) with >1 asthma-related ER visit

Change Potential



Score 1-5	
Relative Advantage	
Simplicity	
Compatibility	
Trialability	
Observability	

Bringing Home the Medical Home



- The AAP Division of Children with Special Needs and the National Center for Medical Home Implementation are available to offer assistance to anyone involved in ensuring all children and youth have access to a medical home
- A plethora of information and resources can be found on the new National Center Web site:
www.medicalhomeinfo.org

The Building Your Medical Home Toolkit

▶ **BUILDING YOUR
MEDICAL HOME
TOOLKIT**

National Center Web site



**NATIONAL CENTER FOR
MEDICAL HOME
IMPLEMENTATION**

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Site Search

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ABOUT US

HOW TO IMPLEMENT

TRAINING

STATE PAGES

NATIONAL INITIATIVES

PARTNERS

WELCOME to the National Center for Medical Home Implementation. This resource is for health professionals, families, and everyone interested in creating a medical home for all children and youth.

WHAT IS A FAMILY-CENTERED MEDICAL HOME?



A family-centered medical home is a trusting partnership between a child, a child's family and the pediatric team who oversees the child's health and well-being within a community-based system that provides uninterrupted care with appropriate payments to support and sustain optimal health outcomes.

Medical homes address preventative, acute, and chronic care from birth through transition to adulthood. A medical home facilitates an integrated health system with an interdisciplinary team of patients and families, primary care physicians, specialists and subspecialists, other health professionals, hospitals and healthcare facilities, public health and the community.

The American Academy of Pediatrics (AAP) developed the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to every child and adolescent.

- > Family-centered medical home FAQs
- > Subscribe to our monthly e-Newsletter
- > View current and past e-Newsletter issues



Every child and youth deserves a medical home.

QUICK LINKS

- [Building Your Medical Home toolkit](#)
- [Upcoming Conferences](#)
- [Children and Youth with Special Health Needs](#)
- [Marketing Materials](#)
- [Emerging Issues](#)



FOR FAMILIES

- [Building Your Care Notebook](#)
- [Family-to-Family Health Information Centers](#)
- [How to Partner with Your Physician](#)
- [Title V](#)
- [HealthyChildren.org](#)



Building Your Medical Home toolkit



- Launched June 2009
- Supports primary care pediatricians' development of a pediatric medical home
- Includes free tools that help practices assess and improve their medical home capacity
- Tools crosswalk with 'must pass' elements of NCQA PPC-PCMH
- Six building blocks toward implementation; progress tracking functionality
- www.pediatricmedhome.org



The Medical Home is the model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner.

How can this Toolkit help your practice?

The Toolkit supports your development and/or improvement of a pediatric Medical Home. It also prepares you to apply for and potentially meet the National Committee for Quality Assurance (NCQA) Physician Practice Connections- Patient Centered Medical Home (PPC-PCMHSM) Recognition program requirements. The AAP created a crosswalk between each of the Toolkit building blocks and the NCQA PPC-PCMH Recognition Program 'must pass' elements.



Why it is important to measure Medical Home at your practice?

Patient care associated with the Medical Home improves outcomes, such as health status, timeliness of care, family centeredness and family functioning. The NCQA PPC-PCMH standards provide a way to qualify and quantify care in the Medical Home. In some practices, scoring at NCQA higher levels has resulted in enhanced payment to the practice.



Sign In

Doctors Lail and Tayloe improved their practice and patient outcomes by implementing the Medical Home approach.



Dr. Jennifer Lail, MD
Chapel Hill Pediatrics
and Adolescents
North Carolina



Dr. David Tayloe, MD
Goldsboro Pediatrics
North Carolina

How to Begin

The Toolkit is organized into six building blocks that provide guidance for Medical Home implementation with links to downloadable tools.

- 1 Care Partnership Support
- 2 Clinical Care Information
- 3 Care Delivery Management
- 4 Resources & Linkages
- 5 Practice Performance Measurement
- 6 Payment & Finance



HOME	START BUILDING	MEDICAL HOME STANDARDS (NCQA)			QUALITY IMPROVEMENT BASICS		PROGRESS SUMMARY
Introduction	1. Care Partnership Support	2. Clinical Care Info & Organization	3. Care Delivery Management	4. Resources & Linkages	5. Practice Performance Measurement	6. Payment & Finance	

[Sign Out](#) | [Contact](#)

1 Care Partnership Support

Addresses family access and communication

Step 2: Assess how you promote patient access and quality communication within your medical home.

Communication Checklist

✓ Check the communication standards that your practice currently employs

<input type="checkbox"/>	Assignment of patients/families to a personal physician and/or consistent clinical care team
<input type="checkbox"/>	Coordination of visits with multiple clinicians or multiple tests on one day
<input type="checkbox"/>	Triage process to determine the timing and urgency of visits
<input type="checkbox"/>	Schedule patients on the same day that they call
<input type="checkbox"/>	Schedule same day appointments using practice triage
<input type="checkbox"/>	Schedule same day appointments based upon patient request
<input type="checkbox"/>	Offer physician, nurse or other clinical telephone advice during office hours
<input type="checkbox"/>	Provide urgent phone advice within a specified time (call back)
<input type="checkbox"/>	Physician phone support is available 24/7
<input type="checkbox"/>	Provide secure email consultation with specified hours/response time
<input type="checkbox"/>	Offer a website with all practice information and policies (Is it interactive?)
<input type="checkbox"/>	Provide language support services for patients with limited English
<input type="checkbox"/>	Identify health insurance resources for uninsured patients

Save Progress

1 Care Partnership Support

Addresses family access and communication

Step 3: Can you quantitatively document the following results?

1. Visits with assigned personal clinician for each patient
Example: % of patients seen in last month who saw their personal clinician
2. Appointments scheduled to meet the standards in the communication checklist
Examples: Coordinated visits or % patients seen in last month on same day called
3. Response times to meet standards for telephone, email requests (per above)
Examples: Time tracking for last weeks emails and average response time
4. Language services offered for patients with limited English proficiency
Example: % patients assessed for language barrier receiving translation service in last month

Can you quantitatively document the results above?

- Not at All Partially Yes, all of them


Step 4: Overall, score how well your practice addresses the Communication standards (listed in the [checklist](#) from step 2) and note areas for development and necessary action steps.

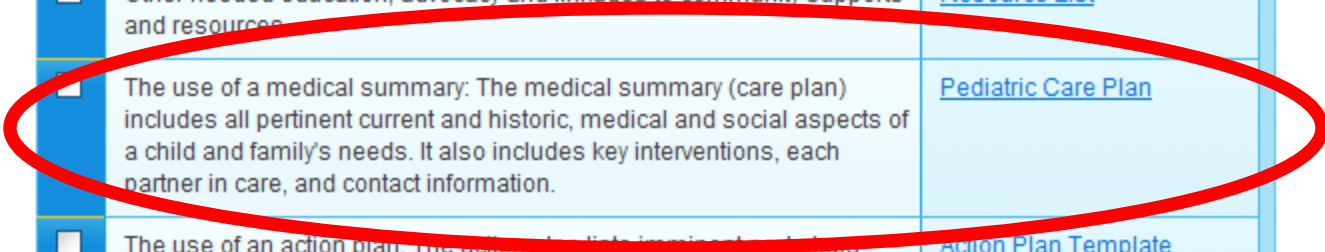
- None are in place Some are in place All are in place

Note areas for development:

Management Strategies Checklist

✓ Check the management strategies that your practice currently uses for each patient

	STRATEGIES	RELATED TOOLS 
<input type="checkbox"/>	Identification, enrollment in a registry, and monitoring of children/youth with particular health conditions or concern or all children/youth with special health care needs (CYSHCN)*	CYSHCN Screener
<input type="checkbox"/>	Assessment of care coordination needs	Family Centered Care Coordination Care Coordination Functions Youth Centered Care Coordination
<input type="checkbox"/>	Tracking of tests and referrals with monitoring of progress	
<input type="checkbox"/>	Planned office visits of appropriate length - matching resources to the needs of children, youth, and families	Pre-visit Contact Form
<input type="checkbox"/>	Co-management agreements establishing shared roles with specialists (these agreements can be faxed back and forth)	Co-Management Letter & Agreement New Patient Referral/Consultation Information Form
<input type="checkbox"/>	Planned outreach and communication with schools and other community partners	
<input type="checkbox"/>	Other needed education, advocacy and linkages to community supports and resources	Resource List
<input type="checkbox"/>	The use of a medical summary: The medical summary (care plan) includes all pertinent current and historic, medical and social aspects of a child and family's needs. It also includes key interventions, each partner in care, and contact information.	Pediatric Care Plan
<input type="checkbox"/>	The use of an action plan: The action plan details imminent and steps while detailing who is responsible for each referral, test, evaluation or other follow up.	Action Plan Template




Pediatric Care Plan Template

Please fill out the following form. You can save data typed into this form. Highlight Fields

Medical Summary Part I

Pediatric Care Plan



Child's Name _____	Nickname _____	DOB _____
Parent <i>Caregiver</i> _____	Relationship _____	
Address _____		
Home Phone _____ <i>Blocked?</i> <input type="radio"/> Y <input type="radio"/> N	Best Time to Reach _____	E-mail _____
Mother Alternate Phone _____	Father Alternate Phone _____	
Emergency Contact _____	Phone _____	Relationship _____
Emergency Contact _____	Phone _____	Relationship _____
Health Insurance/Plan _____	Identification # _____	

Diagnoses	Emergency Plan? <input type="radio"/> Yes <input type="radio"/> No	Complexity Level _____
Primary _____	ICD9 _____	Primary _____ ICD9 _____
Secondary _____	ICD9 _____	Secondary _____ ICD9 _____
Secondary _____	ICD9 _____	Secondary _____ ICD9 _____

Children With Special Health Care Needs (CSHCN)



- Infants or children from birth through the 21st year with special health care needs
 - ✦ health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems
 - ✦ have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that are required by children generally

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System



- State Program Collaboration with Other State Agencies and Private Organizations
- State Support for Communities
- Coordination of Health Components of Community-Based Systems
- Coordination of Health Services with Other Services at the Community Level

Community Utility: Title V CSHCN



Clinician-directed care coordination services

(face-to-face and non-face-to-face)

- Development and revision of a client's written care plan (a formal document or contained in the client's progress notes)
- Coordinating care among multiple providers
- Maintaining a central record or database that contains all pertinent client medical information, hospitalizations and specialty care
- Assisting the client and family in communicating clinical issues when a client is referred for a consultation or additional care
- Evaluating, interpreting, and managing consultant recommendations for the client and family in partnership and collaboration with consultants, other providers, the client, and the family

QUESTIONS

