

**MEDICAL HOMES FOR ARIZONA'S CHILDREN WITH SPECIAL HEALTH CARE
NEEDS
A Preliminary Plan of Action for Developing the Arizona Network of Medical Homes**

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SUBMITTED BY

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MEDICAL HOMES FOR ARIZONA'S CHILDREN WITH SPECIAL HEALTH CARE NEEDS

A Preliminary Plan of Action for Developing the Arizona Network of Medical Homes

HISTORY

Arizona is one of the fastest growing states in the nation. In 2001, our population exceeded 5,000,000. The state is highly diverse with remote rural populations of American Indians, border populations of Mexican immigrants, and ethnically and racially diverse urban populations. An estimated 26 percent of the State is Latino; while 260,000 American Indians from 21 tribes live on reservations (18%) and in urban/suburban areas (82%). Health care to the American Indian population is primarily provided by Indian Health Services through three sites: Phoenix, Tucson, and the Navajo Area.

Based on the federal definition, the estimated 300,000 CSHCN in Arizona face an unusual set of factors. The families of CSHCN have had to assume primary responsibility for seeking and coordinating services fragmented between specialty care providers and primary care providers. In addition, significant numbers of Arizona families of CSHCN report having encountered serious difficulties in locating a primary care provider, dental services, obtaining medicine and special services, locating respite services, child care and information on children's behavior; and difficulty paying basic expenses (Family Voices, 1999). Services are often exceedingly difficult to access in rural and border communities. In sum, too many children are receiving less than optimum care, too many families are experiencing unwarranted stress, while health care providers struggle with inefficient and duplicated services and inequitable cost reimbursement.

In 1984, a collaboration of parents, physicians, hospital administrators, and representatives of allied health professions serving children with special health care needs planned and implemented a three-day conference facilitated by James Perrin, MD. and colleagues from Vanderbilt University. The purpose of the "Gold Canyon Summit" was to identify barriers to coordinated family-centered care for children with "chronic conditions" and to open communication between parents and professionals for improving statewide services for

our children. The outcome of the conference was the formation of the Arizona Consortium for Children with Chronic Illnesses (ACCCI). Since that time, Arizona has recognized the importance of family-centered care that focuses on a concept, later to be known as the Medical Home.

Coincidental with the recognition of the needs of children with special health care needs and their families, Arizona developed the nations first wide range managed care model of service. This experiment grew to become the Arizona Health Care Cost Containment System. As a result, the vast majority (90%+) of Arizona's individuals enrolled in Medicaid have been served in this managed care system, as compared to 42% nationwide.

In 1997, researchers from Arizona State University and a large urban private pediatric medical practice were awarded a model demonstration project grant from the federal Maternal and Child Health Bureau. This project convened two focus groups, one of parents and one of parents and medical professionals for the purpose of participating in Participatory Action Research (PAR) thus identifying and testing indicators of the Medical Home. Across four years, the focus groups examined the physical environment, communication strategies during the medical encounter, the parent-physician partnership, parent assessment of children's health status, reimbursement strategies, and model benefit packages. Further, each topic was reviewed for cultural competency.

Presently, a team of parents and professionals including the coordinator of Arizona Family Voices, the chief of the State Title V bureau, private pediatricians, the Arizona AAP Chapter CATCH coordinator, and research faculty from Arizona State University have committed to expanding the lessons learned from the Medical Home Project to the diverse populations of Arizona.

Anticipated Accomplishment

The purpose of our team is to promote the availability and accessibility of medical homes for Arizona's CSHCN, by developing the Arizona Network of Medical Homes, which will systematically bring together teams of parents, primary and specialty care providers, clinical care coordination, and ADHS' direct care services and administration.

Arizona is committed to building an infrastructure of healthy communities. However, we recognize the cultural and ethnic diversity of our state and that no single model will fit all geographic and demographic areas; hence, we propose that communities be supported to identify their own needs. This may be accomplished in numerous ways. The team will explore the potential for sharing tested, practical, replicable, and sustainable models. These models are responsive to American Academy of Pediatrics (AAP) guidelines for Medical Homes, to *Healthy People 2010* and to measures of 4 and 6 Performance Indicators of the Arizona Block Grant Application (ADHS).

Since 1995, the Arizona Department of Health Services/ Office for Children with Special Needs (ADHS) has been committed to the process of community development across the state. Currently, nine communities have viable parent leadership teams who serve as the leaders of community advocacy, planning, and information dissemination. These teams are supported professionally and financially by ADHS. They have the services of a professional consultant in community development, meet quarterly for planning retreats, and are connected monthly by conference calls. Arizona has recently developed the capacity for telemedicine with hubs in all areas of the state. Finally, we have four years of a federally funded demonstration of successful medical home management under the direction of David Hirsch, MD, FAAP. This medical home has been operational for over twenty years. Dr. Hirsch and his colleagues at Phoenix Pediatrics,

have a working model of effective and efficient practice. For these reasons, we believe that Arizona is in a unique position to facilitate Medical Homes statewide.

GOAL: By 2010, improve the quality of pediatric health care for CSHCN across Arizona on two levels: 1) on a system-wide level, build upon the existing infrastructure of ADHS/OCSHN Parent Leadership teams to develop a network of medical homes that includes parents, PCPs, specialty care providers and care coordinators who are linked via the internet and the Arizona Telemedicine Project, and 2) on a direct pediatric practice level, identify physicians in population centers across Arizona, train these physicians and their staff, care providers, and families on the Medical Home model.

ACTION PLAN

YEAR ONE

Objective 1. Establish an administrative structure, which will ensure sustainability of the Project across time.

Activity 1.1. Expand and formalize the Medical Home Leadership Team to include membership from the state Medicaid.

Activity 1.2 Identify roles and responsibilities of Leadership Team members.

Activity 1.3. Establish meeting schedule and communication pathways (listserv, mailing list, etc.)

Activity 1.4. Identify key stakeholders across Arizona invested in the care of CSHCN.

Activity 1.5. Key stakeholders identify and commit resources to the Project.

Activity 1.6. Key stakeholders identify extant Medical Home project and resources across Arizona. Resources are mapped by population, community, funding stream, and restrictions.

Activity 1.7. Identify local foundations, funding sources, and resources to support the statewide plan for Medical Home.

Activity 1.8. Identify outcomes by which Project will be evaluated

Activity 1.9 State Bureau of Maternal and Child Health supports two staff (RN, social worker) who provide day-to-day operations and communication across the Leadership Team and with stakeholders and Mentor Team.

Objective 2. State programs that serve CSHCN will have contract language that is responsive to Medical Home.

Activity 2.1 Staff within the State Bureau of Maternal and Child Health monitor contracts for inclusion of language specific to Medical Home.

Activity 2.2 All quality assurance plans will contain measurable indicators by which to evaluate movement toward Medical Home status.

Objective 3. Create statewide awareness of Medical Home. Families, providers, leaders of state initiatives, policy makers, and insurers are informed about medical home.

Activity 3.1. Identify extant materials from AAP, MCHB, and Medical Home Project

Activity 3.2. Locate/secure public relations support for educational campaign

Activity 3.3. Translate materials into Spanish and review for cultural competency

Activity 3.4. Conduct educational blitz in identified nine communities

Activity 3.5. Develop a Statewide Medical Home website for dissemination of information including:

- AAP General medical Home information,
- Arizona Medical Home Project,
- State CATCH grants,
- Related medical home initiatives

Objective 4. Use the Medical Home Project products to produce a Training Package that is flexible, feasible, and culturally competent. The comprehensive Training Package is used statewide to improve all aspects of services for CSHCN. Based on the Medical Home Project, the Manual addresses the following indicators of quality care: a) Medical Home (e.g., 24 hour continuous service), b) Family-Centered Bill of Rights, c) Physical

Environment, d) Staffing/Staff Training, e) Reimbursement Strategies, f) Communication Strategies between families and physicians, g) Children’s Health Status Assessment, a durable, portable medical record used by families to track and report CSHCN health, and h) Systematic Coordination of Care Planning (SCP) (access to and coordination of medical and related services),

Activity 4.1. Identify a cohort of local physicians to test the tools for readability, feasibility and time commitment

Activity 4.2. Produce the training Package in English and Spanish in both print and digital format.

Activity 4.3. Linked to Objective 4: Each identified community develops a resource compendium and links this to the existing system of Arizona Community Information and Referral System (AZ CIFS)

Activity 4.4. Improve medical training to include CSHCN by exploring extant training options for residents, including rotations in chronic illness, family-centered care, developmental pediatrics, grand rounds.

YEAR TWO

Objective 5. Build a Statewide Medical Home Network for training and support. Building on the existing infrastructure of Parent Leadership Teams, established by Arizona Department of Health Services Office for Children with Special Needs, develop a support base of parents and physicians in 9 population centers that include Maricopa County, Pima County, three communities that border Mexico, and 3 communities dominated by American Indians in Northern Arizona. Medical practices use the quality indicators to

determine changes needed to become Medical Homes. Staff is trained using the Training Package. The Parent Leadership Teams collaborate using Participatory Action Research (PAR) as a method of ongoing problem solving. The Network communicates through electronic and digital technology, including the Arizona Telemedicine Program. The medical homes and the parent Leadership Teams and Care Coordinators are linked to the Phoenix Pediatrics Medical Home.

Activity 5.1. Identify Community Leadership teams in each targeted community

Activity 5.2. Train Community Leadership Teams on the methods of PAR.

Activity 5.3. Parent Leaders in each targeted area recruit at least 10 parent members who will form Parent Focus Groups. Facilitated by the Community Leadership teams, focus groups identify resources, service needs, and barriers to service access within their communities.

Teams strive to have representation from ethnically and racially diverse members of the respective communities. Parent Leaders Team train/inform local hospitals of the Parent Focus Groups and provide written materials to be given to new families. Raising Special Kids and Pilot Parents of Southern Arizona refer parents in the respective locations to the Parent Leaders or their designee for inclusion in Parent Focus Groups. Information is provided to communities for inclusion in various newsletters authored by Community Leadership Teams.

Activity 5.4. Support Leadership Teams by monthly conference calls from AZ Department of Health Services

Activity 5.5. Conduct leadership training at retreats annually sponsored by the AZ

OCSHN

Activity 5.6. Leadership Teams identify at least one medical practice (med/peds, pediatric, family practice) in each community

YEAR THREE

Objective 6. Expand the number of medical homes in Arizona to 9. Provide training and support to 9 existing pediatric/family care practices in border communities, geographically remote areas, and within American Indian communities.

Activity 6.1. Identify incentives for physicians to participate in medical home training

Activity 6.2. Each physician/group identified by the Community Team and agreeing to participate, self evaluates using the Medical Home Index and Children's Medical Bill of Rights and Measures.

Activity 6.3. After analysis of the results of the Index and Bill of Rights, each practice identifies its strengths and weaknesses with respect to medical home; and identifies those changes that they wish initiate and the resources necessary to make these changes.

Activity 6.4. The Leadership team assists the practice to procure the resources necessary to make change and the technical medical support including hooking practices to the Arizona Telemedicine Project.

Activity 6.5. Participating physicians are linked by a Medical Home listserv. Listserv serves as a forum of medical home questions and is monitored/managed by Medical Home Leadership Team physician members.

Activity 6.6. Participating physicians attend training on AAP principles and Medical

Home Project strategies.

Activity 6.7. Participating physicians are provided with tools from the Medical Home Project such as the Child Health Status Assessment (CHSA),

Activity 6.8. Each quarter, a telemedicine conference is held with all participating physicians. Topics specific to medical management are identified prior to the conference on the listserv.

Objective 7. Support clinical care coordination within each Medical Home.

Activity 7.1. A flexible model of systematic care planning is offered to each identified community/medical home. The care coordination model is dependent on the needs articulated by each Community Leadership Team.

Activity 7.2. A model of systematic care planning, based on the needs of the CSHCN and family and resources available in the community is provided/tailored in each community medical home.

Activity 7.3. Service/Care Coordinators are linked through a listserv and provided access to the AZ CIRS.

Activity 7.4. The Leadership Team and stakeholders explore the potential for electronic archiving of care plans in a central database that is accessible to multiple systems and the family

YEARS 4-10

Objective 8. Evaluate outcomes

Activity 8.1. Monitor outcomes based on Performance Indicators identified in the State Block grant Application.

Activity 8.2. Construct a database of outcome data

Activity 8.3. Analyze data

Activity 8.4. Prepare data results for wide spread dissemination

Objective 9. Propose changes in state policy and procedural

Activity 9.7 Potential proposed changes:

Tax incentives for physicians providing care to CSHCN

Equitable reimbursement rates for CSHCN

Reimbursements for care planning and care coordination services

Electronic central storage and retrieval of care plans and medical records

Models of blended and braided funding across state agencies

Expand family choice of benefit packages within managed care

Institutionalize Medical Home Concept within state budget