

The Massachusetts Medical Home Initiative: An Interagency Strategic Plan for the Development of Medical Homes for Children with Special Health Care Needs, 2001-2010

Overview

The Commonwealth of Massachusetts is committed to ensuring access to a medical home for every child with special health care needs. A medical home is care that is accessible, comprehensive, continuous, coordinated, family-centered, compassionate, culturally-competent, and in which the primary care physician shares responsibility. We are dedicated to the achievement of the six core outcomes for children with special health care needs (CSHCN) outlined in Achieving and Measuring Success for Children with Special Health Care Needs by 2010, promulgated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau in **Healthy People 2010**. These include:

1. All children with special health care needs will receive ongoing comprehensive care within a medical home;
2. All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need;
3. All children will be screened early and continuously for special health care needs;
4. Services for children with special health care needs and their families will be organized in ways that families can use them easily;
5. Families of children with special health care needs will participate in decision making at all levels and will be satisfied with the services they receive; and
6. All youth with special health care needs will receive the services necessary to make appropriate transitions to all aspects of adult life, including adult health care, work, and independence.

Studies performed throughout the 1990's indicated that families with CSHCN in Massachusetts were not consistently receiving care within a medical home for several major reasons: lack of information about services; limited access to resources; lack of care coordination; and lack of mental health and family supports such as respite and flexible funding for family needs. In response to these findings, partnerships were created bringing together all major stakeholders in health care delivery systems for children in Massachusetts. The Massachusetts Consortium for CSHCN is a broad coalition of children's health care leaders, representing state agencies, managed care organizations, family advocates, physician leaders and university-based researchers. This Consortium provides a unique forum for assessing system level barriers to creating medical homes and coordinating system level advocacy. Many of the care elements of a medical home model already exist in our Commonwealth. Many of our current efforts are targeted at linking these programs and services in a seamless, accessible, continuous,

comprehensive, coordinated, culturally-competent fashion that recognizes the central and essential role that the family plays in the life of its children and identifies the family as the principal source of strength and support for its children.

By the year 2010, our medical home model will be administered through a statewide network of appropriately trained, supported, and funded community-based practices. Providers will have access to training, support for care coordination services, and technical assistance consistent with principles outlined and endorsed by the American Academy of Pediatrics (AAP) National Center on Medical Home Initiatives for Children with Special Needs (CSHCN). They will also receive mentoring support for the establishment and on-going maintenance of local medical homes. Children will be screened early and continuously for special health care needs. This will include newborn metabolic screening, hearing screening, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protocols, and preschool vision screening. A broad, non-categorical definition of special needs will apply. All children will have access to insurance coverage via a broad Medicaid program, the CommonHealth program (which permits families that are over-income to purchase full or partial Medicaid coverage on a sliding scale), private payers, or the state's Children's Medical Security Plan. The Massachusetts Medical Home Initiative will monitor and advocate for access to adequate insurance benefits and appropriately trained pediatric primary and subspecialty care providers. These services will be organized, coordinated, and facilitated through their medical homes. A specific family-centered care plan will be created for each CSHCN within the medical home. Responsibilities for implementing the elements of the care plan will be precisely defined. Access to care coordination services and linkages to community-based services will be available at the level of the practice.

CSHCN and their families will receive educational, developmental, and family support services through their medical home by referral to Early Intervention, Head Start, special education and a broad array of community programs. CSHCN will have access to quality childcare through linkage to our Healthy ChildCare America grantee network via the medical home.

Families will receive education, support, and training through parent-to-parent resources such as Family Voices, Family TIES, and the Federation for Children with Special Needs. Other family-professional linkages will be encouraged and supported, such as practice-level parent advisory groups.

All medical home providers will be familiar with transition rights under the Individuals with Disabilities Education Act (IDEA). These providers will work with youth and families to develop a plan for obtaining services and supports necessary to make the transition to all aspects of a productive and fulfilling adult life including health care, vocation, and independence.

Goal 1: Development and Endorsement of the Massachusetts Medical Home Initiative

Objective 1: Creation of the Massachusetts Medical Home Initiative at the National Medical Home Conference by the MA State Team	1/2001
Objective 2: Collaborative endorsement by the leadership of the MCAAP	2/2001
Objective 2.A.: Seek endorsement of full membership of MCAAP	2001
Objective 3: Collaborative endorsement from MA Title V CSHCN program	2001
Objective 4: Collaborative endorsement from MA Family TIES and Family Voices leadership and membership	2001
Objective 5: Collaborative endorsement from the MA Consortium for CSHCN	2001
Objective 6: Seek endorsement from Massachusetts Medical Society	2001
Objective 7: Seek endorsement from Mass Chapter of Family Practitioners	2001-2003
Objective 8: Seek endorsement from all public and private payers in MA for the Initiative	2002-2003

Goal 2: Establishment of the MA Medical Home Initiative Model

Objective 1: Implementation of the Title V- initiated MA Medical Home Project	2001
Objective 1.A.: identification of practices to receive care coordinators based on a demonstrated willingness and capacity to deliver care within a medical home model and to undergo appropriate training in medical home principles	2001-2002
Objective 1.B.: training and deployment of practice-based care coordinators	2001
Objective 1.C.: training of families, providers, and office staff in the principles of medical home provision including methodologies for: a) identifying CSHCN; b) care coordination; c) providing family support services; d) linking families to community resources.	2001

Objective 2: Expand the network of family leaders participating in policy development and planning through the Family Advisor Initiative	2001-2005
Objective 3: Establish a strategy and criteria for certifying medical homes	2001-2004
Objective 4: Create a designated network of medical home delivery sites across the state.	2001-2006
Objective 5: Enhance infrastructure for Ma. Consortium for CSHCN in order to support its essential role in:	2001-2003
a) providing a forum for all stakeholders to meet to address the programmatic needs of CSHCN and their families;	
b) identifying barriers to medical home implementation;	
c) developing system-wide solutions to these barriers	
Objective 6: Establish a sub-committee of the Consortium to serve in an advisory capacity to the MA Medical Home Project and to the MA Medical Home Initiative	Spring 2001
Objective 7: Establish the medical home as the standard of care delivery for all CSHCN in MA	2003-2005
Objective 7A.: Disseminate widely the federal performance objectives in Healthy People 2010	2001-2003
Objective 8: Promote medical home availability for all children in MA	2003-2008
 Goal 3: Outreach and Training Activities for statewide medical home network development	
Objective 1: Plan for and present the Shriners/ AAP/ Family Voices/ NACHRI/ MCHB endorsed Every Child Deserves a Medical Home Training Program in Boston	Nov 2001
Objective 2: Develop extensive schedule of presentations of the medical home model at workshops, conferences, grand rounds with intended target audiences of: families, family organizations, medical students and residents, pediatricians, family practitioners, medicine-pediatrics practitioners, and adult primary care providers.	2001-2005
Objective 2.A.: Develop focused outreach to state agencies (Departments of Mental Health, Mental Retardation, Social Services, and Medicaid- Dept. of Medical Assistance)	2001-2005

Objective 2.B.: Deliver outreach and training to health plan personnel at policy and service delivery levels	2002-2005
Objective 2.C.: Training for staff at public and private third party payer organizations	2001-2005
Objective 2.D.: Outreach to legislative staff at the state level	2003-2007
Objective 3: Establish a statewide medical home mentoring network	2001-2008
Objective 3.A.: Identify areas of the state where there is a lack of medical home access and capacity	2001-2006
Objective 3.B.: Identify practices willing to participate in medical home training and able to demonstrate a capacity to deliver these services	2001-2010
Objective 3.C.: Create mentoring teams able to provide on-going training and support for newly developed medical homes:	
a) identify regional medical home providers, family members, and care coordination personnel willing to serve as mentors	2002-2004
b) create a medical home mentoring tool kit	2002-2004
Objective 3.D.: Create AAP-assisted web site featuring medical home tools and resources	2002

Goal 4: Project Evaluation

Objective 1: Identify appropriate outcomes for evaluation of medical home model	2002-2005
Objective 2: In conjunction with Title V Medical Home Project, perform pre-care coordinator-deployment family satisfaction studies	2001-2002
Objective 3: Evaluation of family satisfaction within medical homes after care coordinator intervention	2002-2004
Objective 4: Evaluation of provider knowledge and satisfaction before and after medical home model implementation	2002-2004
Objective 5: Advocate for, and support initiatives for measuring cost and outcome efficacy of medical home implementation	2001-2010
Objective 6: Utilize continuous quality improvement methods to refine our model and services	2003-2010

Goal 5: Program Expansion

Objective 1: Utilizing outcome and evaluation data for justification, extend training and outreach activities targeting all stakeholders to achieve ultimate goal of a statewide network of medical homes for all children in MA by 2010

2005-2010

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Methods of Evaluation

Our program's success will be measured against the outcome objectives outlined in **Healthy People 2010**. We will also utilize quality indicators developed by New England SERVE (a research and policy analysis organization focused on care issues for CSHCN). Subsequent initiatives measuring the appropriateness of medical home care delivery will be assessed using tools currently being developed by the federal Maternal and Child Health Bureau and the Hood Center at Dartmouth College.

A leadership role in program evaluation will be performed by DPH as part of their Massachusetts Medical Home Project initiative. Title V staff will incorporate findings as part of MCH block grant reporting. Patient, family, and provider satisfaction will be measured utilizing appropriate tools. The findings will be used to modify our model of care.

State Resources

The key stakeholders for our statewide Medical Home Network initiative include:

MCAAP-leadership

Eugenia Marcus, MD: President

Sean Palfrey, MD: Vice-President

Richard Antonelli, MD: Chair, Committee on Disabilities

Lynda Young, MD: Chair, Continuing Education Committee

Consortium for CSHCN

Susan Epstein, MSW, Director of New England SERVE

Please see Appendix A for complete listing of Consortium membership.

Family TIES

Polly Sherman, Network Director

Title V CSHCN /DPH

Deborah Allen, ScD

CATCH Representatives

Emily Roth, MD

Bev Nazarian, MD
David Keller, MD

Our Medical Home Initiative will include active participation by many other significant stakeholders, most of whom are already represented at the Consortium for CSHCN. These include:

Family Voices

The Federation for Children with Special Needs

Medicaid Agency (Department of Medical Assistance)

Health plans, both public and private

Early Intervention

The Children's Hospital- based Pediatric Alliance for Coordinated Care Project (PACC)

Tertiary pediatric care organizations throughout the Commonwealth

Pediatric and family medicine training programs in Massachusetts

Healthy Child Care America grantee in MA

Additional Comments

There is currently a demonstration project of the medical home model at Children's Hospital, Boston. Under the direction of Judith Palfrey, MD, the Pediatric Alliance for Coordinated Care is analyzing outcomes of medical home provision for CSHCN. The project has published a valuable document: **Practicing Comprehensive Care: A Physician's Operation Manual for Implementing a Medical Home for Children with Special Health Care Needs**, Silva, TJ, Sofis LA, Palfrey, JS, 2000. Boston, MA: Institute for Community Inclusion/ UAP, Boston. This manual will serve as a keystone reference for the development of medical homes across our Commonwealth.

Our state's medical home model development will be augmented through affiliations linking members of the MCAAP, the Consortium for CSHCN, and highly visible national projects. We have representation on the MCHB/AAP National Center of Medical Home Initiatives for Children with Special Needs Project Advisory Committee. We also participate on expert panels at HRSA/MCHB dealing with issues affecting medical home providers in managed care. We recently began a liaison with the Federal Interagency Coordinating Council addressing issues of medical home partnerships with community resources and programs.

Written by:

Richard C. Antonelli, MD, FAAP, Chair, MCAAP Committee on Disabilities

Susan Epstein, MSW, New England SERVE

Deborah Allen, ScD, MA Dept. of Public Health

Beverly Nazarian, MD, FAAP, CATCH co-facilitator

Polly Sherman, Family TIES/ Family Voices

February 2, 2001

Appendix A: Massachusetts Consortium for Children with Special Health Care Needs

Member List

Name	Organization
Debby Allen	Department of Public Health
Betsy Anderson	Family Voices / Federation for Children with Special Needs
Richard Antonelli, MD	UMassMemorial Pediatrics; MCAAP Comm on Disabilities
Louise Bannister	Division of Medical Assistance
Anne Beal, MD	Massachusetts General Hospital
Kathy Bennett, MD	Upham's Corner Neighborhood Health Center
Kathleen Betts	Department of Social Services
Allen Crocker, MD	Children's Hospital / New England SERVE
Margaret Driscoll	New England SERVE
Susan Epstein	New England SERVE
Diane Erlandson	Maternal and Child Health Bureau, Region I
Sally Fogerty	Department of Public Health
Patricia Gallagher	UMass Boston - Center for Survey Research
Whit Garberson	Department of Public Health
Jane Gardner	New England SERVE / Harvard School of Public Health
James Glauber, MD	Neighborhood Health Plan
Pamela Gossman	Neighborhood Health Plan
Katherine Grimes, MD	NHP, Mental Health Services Program for Youth
Annette Hines	Special Families - Special Care
Ruth Ikler	Division of Medical Assistance
Marcy Karcher-Ghirardi	Division of Medical Assistance
Karen Kuhlthau	Massachusetts General Hospital
Lisa Martin	Family Advisor Initiative
Judy Palfry, MD	Children's Hospital
Jim Perrin, MD	Massachusetts General Hospital
Nicole Roos	Department of Public Health
Josh Sharfstein	Department of Public Health / Boston Medical Center
Polly Sherman	Family TIES / Family Voices
Emily Sherwood	Department of Mental Health
Lisa Sofis	Children's Hospital
Nancy Turnbull	New England SERVE / Harvard School of Public Health
Debbie Walker	Department of Public Health / New England SERVE
Nora Wells	Family Voices / Federation for Children with Special Needs
Ammie White	Neighborhood Health Plan
Yvette Yatchmink, MD	Division of Medical Assistance