

**Project Title: Utah Collaborative Medical Home Project**

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Project Period: Three years From: 3/31/01 to 3/30/04

**Organizational Setting:** The Utah Collaborative Medical Home Project (Project) will be co-directed by Vera F. Tait, M.D., Director of the state's Bureau of Children with Special Health Care Needs and Chuck Norlin, M.D., Chief of the University of Utah, Division of General Pediatrics. Additional collaborators include: Family Voices, Utah State University's Early Intervention Research Institute, Medicaid, primary care physicians, and the Spencer S. Eccles Health Sciences Library.

**Purpose:** The purpose of this Project is to develop and implement a statewide system to support medical homes for children with special health care needs (CSHCN) in primary care settings. The major components of the Project include: A) Development of a web-based Medical Home resource to facilitate access to information about the Medical Home and family-centered care, medical literature on chronic conditions, practice guidelines, and information and links for a broad range of resources. B) Phase 1 implementation will establish a Medical Home Facilitator (Facilitator) and Family Advocates in four disparate pediatric offices across the state to integrate family-centered care and Medical Home services into the practices. Project Directors, staff, and the Family Advocate Coordinator will work closely with the practice-based personnel during training and to provide ongoing support. C) With Medicaid as a partner, we will identify and implement existing mechanisms for reimbursing medical home services. We will develop strategies for long-term sustainability and funding of primary care medical homes with Medicaid, other third party payers, and provider organizations.

**Challenges:** The Project addresses needs identified nationally and locally. The National Agenda for Children with Special Health Care Needs selected six performance outcomes for efforts on behalf of CSHCN. The AAP defined the Medical Home, emphasized the importance of coordinated management, and provided recommendations for care coordination. The Association of Maternal and Child Health Programs recommended that care coordination be available at the physician's office. A recent survey identified 13% of Utah's children as having special health care needs. The state's population will grow 60% by 2020. Utah's ethnic and racial minority populations' growth rate is twice that of the general population. An AAP study ranks Utah 48<sup>th</sup> in the country for "child health MD's" per 100,000 children. Access to pediatric subspecialty care is limited by geography and by the number of subspecialists available. Primary care physicians (PCPs) face common challenges: accessing medical knowledge about the many uncommon conditions in CSHCN; having time to assess the needs of CSHCN and to coordinate the array of professionals and services needed; and trying to provide this level of care without adequate reimbursement. A survey of Utah PCPs identified three major needs relative to CSHCN: having a "case manager" for their practice; access to resources for their patients; and practice guidelines for children with

chronic conditions. Information and care coordination needs also are validated by families. Development of innovative approaches to compensation is critical to sustainable support of medical home services.

**Goals and Objectives:** Goal 1: Using a participatory model, design, implement and evaluate medical homes through the provision of readily accessible supportive materials and resources. Objective 1.1: Educate families, providers and allied health professionals about the medical home concept and its components. Objective 1.2: A comprehensive list of local, state and national resources is used by families, providers and allied health professionals. Objective 1.3: Web-based clinical practice modules are developed, readily accessible and used by families, providers and allied health professionals.

Goal 2. Design, implement, and evaluate a statewide model of Medical Home Facilitation beginning in four sites that reflect the geographical, cultural, and socioeconomic needs of the state. Objective 2.1: Informed physicians will understand and implement the Medical Home Facilitation Model. Objective 2.2: Facilitators will understand family needs and use appropriate resources to meet those needs. Objective 2.3: Family Advocates will educate and support families and providers. Objective 2.4: Families report satisfaction with services received.

Goal 3: Design and develop mechanisms to enable replication and sustainable support of the Medical Home Model statewide. Objective 3.1: Distinct processes, services, and outcomes associated with providing a comprehensive Medical Home will be identified and quantified. Objective 3.2: Led by our PAR Team, a broad consensus on strategies for ongoing support of Medical Home services provided through primary care practices will be developed. Objective 3.3: Through key partnerships, maintenance of the vitality and accuracy of the Project Website will be assured. Objective 3.4: Using the strategies identified in Objective 3.2, at least 6 primary care practices will be prepared to implement the Medical Home Model in Phase 2.

**Methodology:** The Project's Medical Home Website will offer physicians, families, and others ready access to information about CSHCN and available resources. Numerous methods for providing feedback will be built into the Website. CME offerings will further promote usage of the site by physicians.

The Project Directors, and the Family Advocate Coordinator will work closely with the Facilitators, Family Advocates, and physicians to train them in family-centered care, use of the web resources, and enhanced communications. Facilitators will be trained in care coordination for CSHCN. Physicians and Coordinators will be trained in use of CPT codes for billing related services. Ongoing education and support will be provided through site visits, annual retreats, and distant communications. Twenty children with the target conditions will be selected and their care studied to identify the Project's impact.

The Project Directors will work with Medicaid to identify medical home services that meet current criteria for funding. A working group including Medicaid, other payers, and provider organizations will collaborate to develop long-term, sustainable strategies to support the Medical Home Facilitation Model.

**Evaluation:** Outcomes will be assessed at the Family, Physician, and Systems levels. Family satisfaction with the child's health care, organization of services in a coordinated fashion, their role in decision making and utilization of support services will be assessed using tools to be developed in collaboration with the Early Intervention Research Institute. Billing data will reflect implementation of medical home services and CPT education. Physicians will be evaluated regarding satisfaction with serving CSHCN, knowledge regarding targeted conditions, and coordination and communication with specialty providers. Systems impact will be reflected by: facilitators' knowledge and coordination of community resources and supports; family involvement in decision making; Medicaid compensation for

care coordination activity; and development of strategies for broad-based reimbursement for medical home services.

**Text of Annotation:** Primary care physicians face many challenges in providing a Medical Home for CSHCN. These challenges include: accessing and maintaining current medical knowledge of the many uncommon conditions of CSHCN and the resources available for them; having sufficient time to assess their needs and strengths and to coordinate the many services and professionals involved; and trying to provide these comprehensive services with inadequate reimbursement. The Utah Collaborative Medical Home Project will provide ready access to important knowledge through a web-based resource. Care coordination will be provided by Medical Home Facilitators in primary care offices. Family partnerships will be enhanced by Family Advocates. Long-term strategies for sustainable support for Medical Homes will be developed in collaboration with Medicaid, payers, and provider organizations.

**Key Words:** children with special health care needs, medical home, care coordination, chronic illness, primary care, family-centered care, Internet, World Wide Web, CPT, reimbursement.