

PROMISE TO THE STATE

Oregon

The following document describes our promise to the state of Oregon to create a system of health care in which all children with special health care needs will receive their care through a medical home. A medical home is care that is accessible, comprehensive, continuous, coordinated, family-centered, compassionate, and culturally- competent, in which the primary care physician shares responsibility. This document outlines the steps that will be taken to make the provision of medical homes for children with special health care needs a reality by the year 2010.

Overview

Our goal is to ensure the provision of comprehensive services to CSHCN through a Medical Home in local communities by establishing a statewide network of community-based Resource Teams and by educating primary care providers on the Medical Home. The Resource Teams will provide direct supports to families and medical office staff and will facilitate a process of continuous quality improvement (CQI) in practices and communities in all regions of the state. The primary care office will be part of a local network of comprehensive services for children and families of CSHCN will have comprehensive services available through a local system of care which recognizes cultural differences.

1. The Resource Teams will be present in 20 Oregon communities located in all regions of the state. Nurses from the Care Coordination (CaCoon) program of the Child Development and Rehabilitation Center (CDRC) will partner with local parents and paraprofessionals to form the Resource Team. Care coordinators of managed care plans will work with the Resource Team depending on their availability in each region. Physicians and staff of CDRC's Community Connections Network will provide support and consultation to the Resource Teams and technical assistance to medical offices as needed. Additional support to the Resource Teams and medical offices will be provided as needed by staff of the Portland and Eugene CDRC offices.
2. A common procedure for the identification of CSHN in the primary care office and managed care plan will be implemented statewide. CSHCN identified by this procedure will be referred to the Resource Teams by primary care office staff. All families of CSHN will receive an initial contact and information on community services from the Resource Team as needed. Resource Team staff will work directly with medical office staff to implement CQI procedures and subsequently transfer some or most of the activities of the Resource Team to office staff.
3. Care coordination and related activities in the primary care office will be reimbursed from a combination of sources including Title V, Medicaid, managed care plans and commercial insurance plans.
4. All families seen in Shriners and CDRC clinics will be asked if they have a primary care physician (PCP). If they do not have a PCP, they will receive assistance in finding a PCP in their local community. If they have a PCP, they will be referred to the Resource Team in their area to receive information on the Medical Home and community resources. The

child's PCP will be notified that the child has a special health care need, will receive information on the Medical Home and community resources, and will receive a questionnaire to identify the supports that would be helpful in that office to enhance the services for CSHCN.

5. Families with newborn children will be asked if they have a PCP at the time of neonatal hearing screening. If they do not have a PCP, they will receive assistance in finding a PCP in their local community. All families will receive information on the Medical Home and referral to the local Resource Team as needed.

Plan of Action

January-July, 2001

1. Initiate the Medical Home survey of parents of CSHN who attend Shriners and CDRC clinics.
2. Provide information to Pediatric residents and University Affiliated Program trainees on the Medical Home training program and the CATCH program.
3. Personal physician to physician contact to health care providers in rural areas (physicians who work in CDRC's Community Network) to encourage their attendance.
4. Conduct the "Every Child Deserves a Medical Home" training program in Portland, OR, March 31, 2001.
5. Provide information on the Medical Home to families and professionals who attend Oregon's Parent Training Initiative statewide Wagon Wheel conference, April 2001.
6. Disseminate information on the Medical Home and available resources through a variety of methods including announcements at professional conferences and the newsletters of the Oregon Pediatric Society (OPS) and Association of Family Physicians (OAFP).
7. Initiate planning to implement the procedure of asking families who attend Shriners and CDRC clinics about their child's PCP and contacting the PCPs.
8. Meet with the new Medical Director of the Oregon Medical Assistance Program (OMAP) to reconvene the task force on CSHN.

July-December 2001

1. Initiate the Medical Home provider survey with the PCPs of children and families who attend Shriners and CDRC clinics.
2. Follow-up the Medical Home training program with presentations to local medical staff meetings and family workshops.
3. Provide information on the Medical Home on the OPS, OAFP and CDRC web sites.
4. Convene meeting of stakeholders to initiate the discussion on a common procedure to identify of CSHN.
5. Healthy Start staff will incorporate the procedure for asking families about a PCP and related activities into their contact to families with firstborn children.
6. Convene meeting with staff of the Oregon Health Division to develop procedures to contact families about their newborns' PCP and provide information on the Medical Home at the time of hearing screening.
7. Meet with the training directors of the Oregon Health Sciences University's Family Practice residency and Area Health Education programs to incorporate training on the concept of the Medical Home.

2002-2003

1. Convene meeting of stakeholders to initiate the discussion of reimbursement for care coordination and related activities in the primary care office.

2. Identify parents and paraprofessionals to partner with CaCoon nurses to form the Resource Teams (the rate of development of specific teams will depend on identification of on-going fiscal support)
3. Pilot the use of a procedure to identify CSHN in primary care offices refer families of CSHN to the Resource Team.
4. Implement the procedure to ask families who attend Shriners and CDRC clinics about their PCP and contact PCPs.
5. Pilot a procedure to ask families about their child's PCP and contact PCPs at the time of neonatal hearing screening.
6. Initiate planning to disseminate information about the Medical Home through other agencies including WIC, child care providers, Head start and schools.

2004-2005

1. Expand the capacity of Resource Teams to serve families and primary care offices.
2. Pilot a program for reimbursement of care coordination and related activities in primary care offices.
3. Replicate the procedure to identify CSHN in primary care offices.
4. Replicate the procedure to contact families and PCPs at the time of neonatal hearing screening.

2006-2010

1. Expand the number of Resource Teams to 20 sites.
2. Implement the reimbursement for care coordination and related services in the primary care office statewide.
3. Expand the procedure to identify CSHN in the primary care office and referral of families to CSHN to the Resource Teams statewide.
4. Expand the procedure to contact families and PCPs at the time of neonatal hearing screening statewide.

METHOD OF EVALUATION

The evaluation plan will include both process and outcome measures. Specific issues that will be addressed will include the quality of services in the primary care office (medical home index), the number of children with a Medical Home, cost-benefit analysis of care coordination services in the primary care office and Resource Teams, child health outcomes, and the impact on the family and on the health care practice.

STATE RESOURCES

CDRC, Shriners Hospital, Medicaid (OMAP), Oregon Pediatric Society, Oregon Family Practice Society, Family Voices, COPE, managed care plans (HMO-OR, Care Oregon etc), Oregon Department of Education, Oregon Health Division, Commission on Children and Families, Oregon Department of Human Resources, (Children's Unit, DD services, Mental Health, SCF), Department of Vocational Rehabilitation, SDS, Lifespan Respite Program/Childcare Coalition Developmental Disabilities Council.

