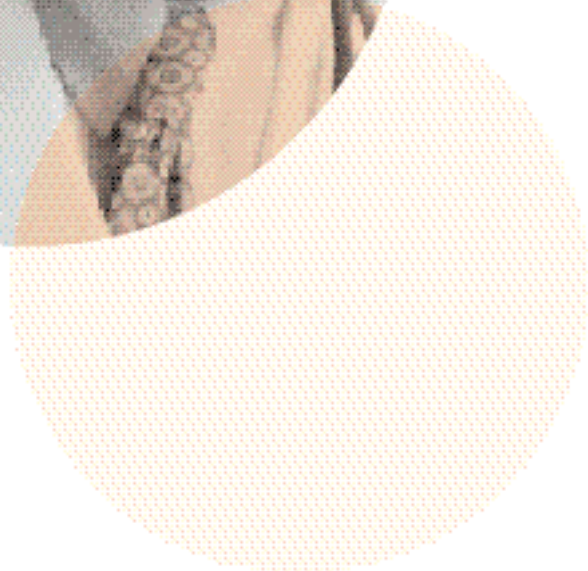


**THE NATIONAL  
MEDICAL HOME  
MENTORSHIP NETWORK  
AT THE AMERICAN  
ACADEMY OF PEDIATRICS**





**IN 1999, THE FEDERAL MATERNAL AND CHILD HEALTH BUREAU (MCHB)** entered into a cooperative agreement with the American Academy of Pediatrics (AAP), forming the National Center of Medical Home Initiatives for Children with Special Needs (National Center). The mission of the National Center is to work with physicians, health professionals, families, and other individuals to meet the objectives set forth in The President's New Freedom Initiative and Healthy People 2010, with a special emphasis on creating access to medical homes. This is accomplished through the provision of educational materials and resources; recommendations for overcoming barriers; facilitation of training programs and conferences on the medical home; as well as, guidance in the formulation of plans to create access to medical homes on the state and local level.

It was soon recognized that providing technical assistance to individuals on a case-by-case basis alone was not sufficient to create the larger change toward global access to medical homes. Individuals needed a more structured system in place at the state-level that would support their mission. As a result, twelve teams were chosen in January 2001 to constitute the National Medical Home Mentorship Network. These states included California, Hawaii, Illinois, Louisiana, Massachusetts, Minnesota, New Mexico, North Carolina, Oregon, South Carolina, Utah, and Washington. The core team members from each state represent pediatricians, family physicians, families, Title V Children with Special Health Care Needs programs, Medicaid programs, and other state and public agencies. Their mission was to develop a strategic plan that would allow every child with special health care needs (CSHCN) in their state access to a medical home by the year 2010.

As the National Medical Home Mentorship Network continues to grow, states are given the task of developing and implementing a plan to improve access to medical homes as well as serving as a mentor for local communities and individuals in their state on how medical homes are created and sustained. Four of the original 12 teams were designated as mentors to new state teams and participated in the second National Medical Home Conference (NMHC) in January 2002. These four teams were chosen based on their exceptional diligence and dedication to the implementation of their state plan. The mentor states are Illinois, Massachusetts, South Carolina, and Washington. These teams have demonstrated success in their efforts through collaboration between public and private entities; strong commitments to partnerships between physicians, families, and state agencies; and the pursuit of stated goals beyond that which "typical" funding mechanisms allow.



In addition to the mentor teams being chosen to attend the 2002 NMHC, 4 new states were brought into the National Medical Home Mentorship Network. Teams from Arizona, Arkansas, Iowa, and Wisconsin were brought to the NMHC to begin the development of their statewide plan to improve access to medical homes for CSHCN. At the end of the conference, new state teams were asked to report on six-month goals that would begin the implementation process of their plan.

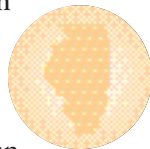
## STATE MENTOR TEAMS

**THE CALIFORNIA TEAM** began their medical home efforts in Los Angeles in 1998 when they received a grant from the MCHB to develop a training program to educate physicians and allied health providers about medical homes and how to enhance care coordination in physician practices in the Los Angeles area. As the training program was rolled out, significant barriers to accessing medical homes arose that project staff were determined to overcome. Workgroups in Southern and Northern California were formed specifically to address ways to breakdown these barriers. In 2001, individuals from across the state of California created a core medical home plan and were invited to attend the NMHC. As part of the development of the comprehensive state plan, members of the team approached the California HealthCare Foundation to finance implementation of a comprehensive multi-site program to increase access to medical homes for CSHCN and their families. The California HealthCare Foundation agreed and provided them with a significant grant to support the medical home team's activities, as well as funding for 7 community-based coalitions to develop mechanisms to improve local access to medical homes. Now, a statewide coalition exists composed of individuals from the public and private sectors that serve children with special health care needs and their families, parents, and other experts. This diverse team has formed to examine obstacles and opportunities for model development, address broad policy issues, and identify and mentor new and established local coalitions interested in implementing medical home models.



The primary target population for this proposed project is the approximately 150,000 children who receive services from California Children's Services (CCS), the Title V CSHCN Program. These children are the main focus of the statewide and local medical home coalitions' efforts toward building and sustaining a medical home infrastructure. However, since most providers do not limit their practices to those children enrolled in the CCS program, it is expected that, ultimately, other CSHCN, whether enrolled in CCS or not, will benefit from project activities.

**THE ILLINOIS STATE TEAM** began laying the foundation for its medical home initiative well before the 2001 NMHC. Early planning was necessary in that implementation of their plan resulted in sweeping changes in the Title V CSHCN program. In the past, the Illinois Title V CSHCN program only reimbursed for specialty care. There was no mechanism in place that provided for reimbursement to primary care physicians for any of the care they provided. This was changed as a result of the Illinois state plan. The Title V CSHCN program made provisions to reimburse primary care physicians for care coordination activities, such as developing a comprehensive care plan, telephone case management, participating in Individualized Education Plans, etc. Typically, physicians are not reimbursed for providing these services by Medicaid programs or managed care organizations. In order to educate community-based physicians about the Title V program, a training program was created (based on the National Center's *Every Child Deserves a Medical Home* training program) as well as an accompanying curriculum. All physicians who wish to take part in the new Title V CSHCN program must attend a training program or complete the self-guided curriculum to become an "approved" provider. As an "approved" Title V CSHCN provider, physicians will be eligible for



enhanced reimbursement as well as technical assistance. This technical assistance will help practices to identify ways in which they can improve the level of services provided to families of CSHCN, based on the model designed by the Rural Medical Home Improvement Project (RMHIP). Trained Title V CSHCN staff and physician volunteers will assess community-based practices on their capacity to provide medical homes. As a result of the technical assistance the CSHCN program offers practices, three staff members focus their activities solely on the medical home. Materials developed to support these activities include physician and family brochures, a physician fee schedule, a CME medical home monograph, and a family newsletter with an insert on the medical home.

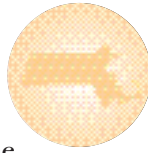
The Illinois team has also conducted several medical home trainings/presentations throughout the state that include Grand Rounds at several hospitals, the Family Physician CME Conference, IL Primary Health Care Association Conference, the National Family Conference, and at several physician practices. As a result of the Illinois teams' effort on medical home education, then Governor George Ryan proclaimed 2002 "The Year of The Medical Home in Illinois."

## THE MASSACHUSETTS STATE TEAM

was established in January 2001 when they were invited by the AAP to attend the first national medical home conference.

Upon returning they expanded their team and formed collaborative relationships with a number of agencies while working to get the message out to key stakeholders about the need to provide medical homes to CSHCN. The Massachusetts Chapter of the AAP formally endorsed the principles of the *AAP Medical Home Policy Statement* as well as the outcome objectives of *Healthy People 2010 for Children with Special Health Care Needs*. A formal presentation on medical home development was made to the Public Health Executive Council, which is composed of members of the Massachusetts Medical Society and senior leadership from the Department of Public Health. A presentation was made to senior leadership of the Massachusetts Family Court system, including the Chief Justice, highlighting the importance of medical homes for children in foster care. Efforts were also made to obtain endorsement for medical home principles of care from the MA Chapter of the American Academy of Family Physicians.

Information on medical homes has also been made available to parents and professionals at the Family TIES/ Federation for CSHCN Annual Conference; the MA Early Intervention Consortium conference; and, a daylong parent leadership conference held by Family Voices in May. Over 1000 people attended these events. An article about medical home, written in family-friendly language, appeared in the Spring Issue of the Federation for CSHCN newsletter, "*Newsline*", which reaches 20,000 people, most of them families of CSHCN. On October 26, 2001, there was a Family Voices Forum on Managed Care and CSHCN entitled *Partnerships for Quality*.



The medical home team now operates through the Consortium, which is a centralized home for creating and improving systems of care for CSHCN in Massachusetts. The consortium was established in 1999 and went from 15 to 100 members. Members include parents (25), physicians (22), researchers (14), primary care sites or provider groups (13), health plans (8), public agencies (5), advocates (8). The consortium operates under the leadership of New England SERVE, an independent health policy and planning organization. There are a variety of funding sources for the Consortium that include the Deborah Monroe Noonan Foundation, MCHB, AAP, and the Massachusetts Department of Public Health.

In May 2001, New England SERVE hosted the New England Regional Policy Leadership Team, bringing together all six New England state Title V CSHCN programs with representation of the AAP, families, and state CATCH facilitators. The title of the conference was "*Implementing Quality Medical Homes for CSHCN: Challenges, Opportunities, and Partnerships*". A new collaboration focusing on CSHCN enrolled in managed care is being developed by the New England Serve and the MA Department of Public Health (DPH). The Alliance for Health Care Improvement, a coalition of the five largest non-profit HMOs in the state that represents over 80% of the commercial insurance market and the largest Medicaid HMO, has agreed to make CSHCN a priority in the coming year. This initiative will identify CSHCN and the focus of quality improvement efforts for these payers.

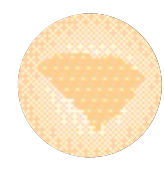
Through the Title V CSHCN agency the Massachusetts Medical Home Project was awarded an MCHB grant to begin implementing their plan to ensure that all children have access to a medical home by partnering care coordinators from the Department of Public Health with primary care pediatricians in the community. Not only were they able to secure funding for implementation, they were also able to secure a Medical Homes for CSHCN Planning grant through the AAP Community Access to Child Health (CATCH) Program. In addition, they hosted the *Every Child Deserves a Medical Home* training program in November 2001 and have completed six more medical home training programs. They are currently planning for their western state medical home conference for the central MA area in fall, 2003. The training is for the existing network of professionals, community based private agencies, DPH care coordinators and their practice partners.

Through funding from the MCHB grant, DPH has held six statewide meetings of its care coordinators to support their transition from regional office to practice-based care coordination. DPH has established MACCLIST (MA Care Coordination LISTSERV) via the Institute for Child Health Policy to facilitate information sharing among practice based care coordinators statewide. They have also expanded their state team to include both parent and physician communities from the Family Initiatives Program at Children's Hospital, Boston, Health Education Centers, and Chief of the Ambulatory Pediatrics at Children's Hospital, Boston. This has provided a critical link to a major network of health education and training resources in the state.

**THE SOUTH CAROLINA TEAM** has worked on several projects aimed at providing outreach to individuals about medical homes. Shortly after developing their state plan at the 2001 NMHC, the team identified the need for a practical tool that would help physicians connect families to community-based services for their children. As a result, a local resource guide was created for physicians and families. The condensed, one-page guide was designed as a quick reference that physicians could post in their office examination rooms, along with a brochure that families could take home with them. The guide has also been designed as a larger poster for physicians to post in their waiting rooms.

The MCHB Grant they were awarded in 2001 specifically targets goals of the SC Promise to the State. The main goal set forth is to increase by 10% the number of CSHCN who receive ongoing, comprehensive care coordinated through a medical home, utilizing a multi-pronged strategy of educating physicians and families, strengthening medical home data baseline and tracking capability, and creating mentor medical home sites. Activities include the *Every Child Deserves a Medical Home* training program in Greenville, SC (Spring 2002) and multiple presentations and trainings have since been done throughout the state to other pediatric practices, at the annual AAP and AAFP chapter conferences, to the Physician's Advisory Committee of the Department of Health and Environmental Control (DHEC), Grand Rounds' statewide satellite broadcast to medical school residents and Grand Rounds attendees at all hospitals in the state, Children's Rehabilitative Services and BabyNet regional coordinators.

Objective Two under Goal One calls for strengthening medical home data baselines and tracking capability. The team developed a methodology for measuring medical home



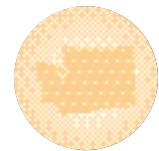
activities using secondary ORS data available. ORS houses all Uniform Billing data (hospitalizations, outpatient surgeries, home health services, and emergency room visits), Medicaid, and service databases from virtually all state agencies. There was consensus to measure improvements in the health of CSHCN by tracking a group of Medicaid children at mentor sites through this database. Mentor site activities are not limited to Medicaid children, although they are the focus until more secondary data sources are available.

The team secured a grant through Sound Partners in 2002 to create a one-hour broadcast on CSHCN and the medical home concept that was broadcast statewide through public television in April, 2003. It was then streamlined on the Internet for one-month and archived for six months. The broadcast will be used for conferences and training programs in the state. Other medical home education and training projects include a ten-minute training video and a broad-based education and public relations campaign. This statewide effort is designed to reach health care providers and families.

The team also applied for and received a Medical Homes for CSHCN Planning Grant through the AAP CATCH Program. This has allowed the team to hire an individual whose time is devoted to writing for larger grants to provide the necessary resources to implement the state plan. This staff person is now funded through the MCHB grant. Other publications and materials the South Carolina team developed are:

1. 16 Defined Outcome Measures for Analyzing Medical Home Sites
2. Baseline Data: Utilization Rates for Emergency Room Use, Hospitalizations and Preventable Hospitalizations at Mentor Sites
3. General Information Packet on State Medical Home Team and Grant
4. 4 Power Point Presentations for Physicians and Grant Staff
5. CSHCN Medical Home Pilot and Public Health Client Assessment forms adjusted for project use
6. Job Descriptions for a social worker in a mentor site and parent support person
7. A brochure entitled, "If Your Child Has Special Needs, So Do You!" More than 50,000 brochures have been distributed
8. 2 medical home assessment questionnaires—one for office staff and one for professional staff.
9. A plan for measuring medical home outcomes that includes tips on what data should be used and how that information can help to improve outcomes.

**THE WASHINGTON STATE TEAM** chose to expand and support their Medical Home Leadership Network (MHLN). This network, originally formed in 1996 through a grant from the MCHB, was developed using a "train-the-trainer" model in which teams are educated about medical homes and sent to train individuals in their local communities. The MHLN consists of over 21 teams across the state of Washington comprised of primary care physicians, school representatives, oral and mental health representatives, families, managed care plans, specialists, and public health representatives. The MHLN has received additional funding from the MCHB to continue developing and implementing plans to improve access to medical homes and serve as a resource for individuals in their local communities.



Through contractual agreement with the Department of Health, the Children's Hospital and Regional Medical Center (CHRMC) will work with the MHLN to organize a think tank to identify strategies to reach target groups, and assemble and/or develop materials that will describe the medical home concept and essential elements. Many collaborative relationships, though, have already been established. Initial discussions to develop a strategic plan to include families' full participation in their children's medical homes have taken place with family leadership organizations in the state such as Parent-to-Parent, Father's Network, Family Voices, and the Family Leadership Council of the State Interagency Coordinating Council.

A new relationship with Molina Health Care of Washington, one of the largest Medicaid managed care plans in the state, has also been developed as a result of funding from the MCHB. The Medical Director and Health Care Services Director of Molina are participating in monthly grant meetings and helping to identify ways to work more collaboratively. One practice within the Molina Health Care system is working to identify CSHCN in their practice in order to review the cost and utilization data related to providing care for these children. Children's care plans are also being developed and monitored for the purpose of reducing utilization costs. The pilot project continues into 2003 to also look at improved outcomes related to care coordination services. A second health care plan has also expressed interest in joining network activities. The MHLN has also enhanced their collaboration with the Washington Chapter of the AAP.

Another goal of the team was to develop a model for measuring outcomes for CSHCN with a medical home. To begin, the Washington Title V CSHCN program, through a contract with FACCT, developed a composite of questions in the Consumer Assessment of Health Plans Survey that matches the AAP definition of a medical home. They first determined that 68.2% of CSHCN are in Medicaid managed care and they are now taking the next steps through a DOH contract with Center for CSHCN to measure outcomes.

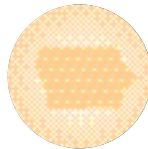
The largest barrier to creating a medical home is the lack of information and resources, thus a primary objective of the team was to reach patients, families, and providers on multiple levels. Through funding from the National Center of Medical Home Initiatives, they developed a Web site with an emphasis on diagnoses and information for regional teams. The Leadership Network held its annual conference in conjunction with the *Every Child Deserves a Medical Home* Training Program in November 2002. Since the training, multiple resources and information for teams have been added to their Web site. This includes a medical home brochure, Families and Providers Working Together. This brochure provides definitions, benefits and tips for families about having a Medical Home for their child in Washington State. They have also developed a brochure, Building Early Intervention Partnerships with Your Child's Doctor. This brochure includes practical tips from and for parents on how to choose, partner and talk with your child's doctor, how to be an advocate for your child in early intervention, and how to involve your doctor in early intervention services for your child. A calendar of events that includes speakers and training programs is also available on their Web site.

## MCHB MEDICAL HOME GRANTEEES

In 2001 states were awarded grants through the federal Maternal and Child Health Bureau to help fund projects related to the statewide promotion and creation of medical homes to children with special health care needs. Grants were awarded to Washington and Massachusetts, two National Medical Home Mentor Teams, as well as New Hampshire, Oregon, Utah, Pennsylvania, and New Mexico. One of the goals of the National Medical Home Mentorship Program is to assure ongoing collaboration between Medical Home State Teams and MCHB Medical Home Grantees. Even though not all MCHB grantees are formal members of the Mentorship Program, their goals remain one and the same – 100% access to medical homes for children with special health care needs in their state by the year 2010.

### THE IOWA TEAM

The medical home project in Iowa is a collaboration of the various public and private providers of health care and other services to CSHCN. This is a comprehensive project that developed a collaborative, centralized leadership as well as active work teams to initiate the project and assist with the replication of the project throughout Iowa. The structure of the Iowa medical home project involves a medical home steering committee, a core advisory group, a work group and a facilitation team.



**THE MEDICAL HOME STEERING COMMITTEE** meets regularly primarily, to direct and review the Work Group and Facilitation Teams progress as well as communicate issues to the Core Advisory Group that the initiative needs assistance with.

**THE CORE ADVISORY GROUP** is comprised of representatives from various community organizations as advisors in this project. The group's primary responsibility is to advise the Steering Committee on the most effective methods to implement the medical home initiative in Iowa. The Advisory Group will also assist the Steering Committee in advocating for the medical home initiative with their respective organization and the community.

**THE WORK GROUP** is comprised of leaders and staff from the partners of the project. The work group's primary responsibility will be to develop the implementation and measurement program for the Medical Home Initiative.

**THE FACILITATION TEAM** is the group of physician advisors and various consultants and staff who work with the clinics. The team facilitates the adoption of the medical home elements in primary care clinics throughout the state.

The implementation strategy is to start with a group of partnering clinics to develop the systems first, and then replicate the model throughout the state. The partnering clinics will likely become additional advisors for subsequent clinics. The facilitation team is currently working with 5 partner clinics. The goals are:

1. Work with the major health systems in Iowa
2. Develop outcome measures
3. Complete baseline study
4. Develop a data repository for the outcomes
5. Develop additional tools to collaborate with families, specialists, schools, and community programs
6. Develop a community resource database for easy access in the clinics
7. Teach the clinics how to establish care coordination in their office

8. Work with carriers to obtain alternative reimbursement methods for the initial patients
9. Assist the initial clinics in the development of the Medical Home Model (actual care coordination will be completed by the clinic).
10. Maintain the sustainability of the Project

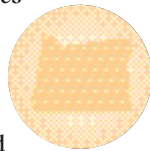
### THE OREGON MEDICAL HOME TEAM

began their plan for increasing access to medical homes in the state during the planning process for the *Every Child Deserves a Medical Home* training program at the Shriners Hospital in Portland. The planning committee not only discussed how they would design a training program that would educate health care professionals and families about medical homes and resources in the community, but also how to improve collaboration between the multiple health care agencies in the community and state. To assess the educational needs of families and physicians around medical homes, a survey was created. Plans were made to distribute the survey to families whose children receive services at Shriners Hospitals and their community-based primary care physician in Fall 2001. Another activity of the planning committee was to design a comprehensive resource guide for families and professionals to distribute at the training program. This guide contains a listing of all the services and resources in Oregon that might potentially benefit a family of a child with special needs.

At the 2001 NMHC, the Oregon Team created a plan for the state that built upon the work and efforts of the Medical Home Training Program's planning

committee. Knowing that dissemination of a local resource guide was not sufficient to improve a physician's capacity to coordinate services among the various state agencies for children in their practice, they developed a plan that would partner physicians with a family member and an expert in care coordination. This is the plan that was ultimately funded by the MCHB. One of the primary objectives of the grant is to partner a care coordination nurse (CaCoon Nurse) from the Oregon Children's Development and Rehabilitation Center (CDRC) with a local parent to form a "Resource Team." Six regionally based Resource Teams were then created that will then go into physician practices to provide training on how to create medical homes by utilizing resources in the community.

In addition to the formation of the Resource Teams, other successes of the Oregon State



Team over the last year include:

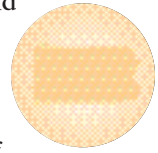
- Convening a meeting of experts and key stakeholders to establish an operational definition of CSHCN in the state of Oregon
- Making the local resource guide developed for the Medical Home Training Program available through the CDRC Web site
- Providing multiple educational opportunities on medical home to health care professionals and families across the state

Since the start of the grant, the Oregon team has completed trainings and program evaluation of each pediatric practice. This included a month of screening all clients and the completion of the parent medical home index and Processes of Care Survey. Practices also participated in presentations to special education leaders. New medical home materials were developed: maps for all teams as they carry out medical home improvement plans and develop into viable resource teams; and a brochure that describes the community services provided by Title V. A face validity test of the Medical Home Parent and Provider Survey is also being conducted.

Currently the team is working on the Oregon medical home Web site, which involves the collaboration of the practice teams and the state advisory panel. Products in development include Guidelines for care and care plans, Tips for communicating with families, Tips for communicating with educational staff, Transition to adult services; links to resources, & Coding, billing and reimbursement. These items will soon be available on the Oregon Medical Home Web site.

**THE PENNSYLVANIA MEDICAL HOME PROJECT** began to carry out activities related to medical homes for CSHCN in 1999 with the planning process for the Every Child Deserves a Medical Home training program that was held at the Shriners Hospital in Philadelphia in March 2000. From the beginning of their planning, they developed a train-the-trainers model to bring an educational program on medical homes across the entire state. This model is known as Educating Physicians in Community Integrated Care (EPIC IC) This is the model that was funded by the MCHB.

The purpose of the Pennsylvania Medical Home Initiative is to improve the quality of life for CSHCN and their families by building sustainable medical home teams in primary care practices. Led by the Pennsylvania Chapter of the AAP, "Regional Education and Quality Improvement (REQUI)" teams will be trained to disseminate information on medical homes based on a modified version of the *Every Child Deserves a Medical Home* training program to individuals across the state. Each REQUI team will include representatives from families, health care professionals, the Title V CSHCN and/or Early Intervention programs. The REQUI teams will have the capacity to provide training in large group settings or to individual physician practices. Physician office staff that complete the training will be assessed in their capacity to provide medical homes, and will also receive resources to help them improve their practices. Practices that complete the program and demonstrate adoption of medical home principles will receive a "Medical Home" certificate.



Twenty-one practice teams across the state have been recruited to engage in a process of quality improvement in the care of their special needs patients. Teams are comprised of a clinician, staff member and a family representative. These teams attended a two-day training conference and participate in monthly conference calls on a medical home concept or topic that the practices want to address. Each practice team has developed and started to implement a quality improvement cycle based on needs identified by the practice.

As part of the quality improvement process, eleven practices now have care coordinators, and multiple office tools have been developed to help with the identification of CSHCN, documentation and billing for services, and communication with families. Tools include: evaluation and management codes (CPT), progress note template, fax back referral form, tip sheet for parents, and a list of state and national web sites/resources.

**THE UTAH STATE TEAM** had just completed two *Every Child Deserves a Medical Home* training programs in Salt Lake City when they applied to attend the 2001 NMHC. After these training programs, the training planning committee continued to meet to establish statewide goals. The committee expanded to include members from all state agencies and organizations serving CSHCN, then was divided into workgroups on funding, community resources, education, transitions, and clinical practice modules. The MCHB chose Utah as a funded medical home project based on activities stemming from this committee.

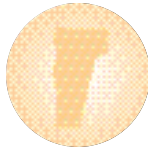
The Utah Team also recognized the importance of working with community physicians to enhance their capacity to provide medical homes to CSHCN. Modifying the practice-improvement model created by the Rural Medical Home Improvement Project, the team

has identified four pediatric and one family practice medical home practice site. They recognized the special importance of family physicians in rural communities, to establish models, document progress and activities and to mentor additional pediatric practices. Medical Home Facilitators and Family Advocates have been identified and trained in each practice. Evaluation tools have been developed and validated using existing AAP, CAHPS, SLAITS, and cultural sensitivity assessment tools. They have targeted practices that serve Navajo and Hispanic communities, and migrant workers due to the multiple challenges these communities endure such as social barriers, isolation, language barriers, as well as the limited number of resources available to these communities.

Having established a method to train physicians in the principles of medical home, the Utah Team decided to build a comprehensive Web-based resource of tools to help these physicians move the medical home approach into their practice. Upon completion, the Web site will contain links to community resources, a listing of physicians and other health care providers in the state, as well as “diagnosis modules” that contain information on specific conditions. These “diagnosis modules” will not only include research-based clinical data on disease processes, but will also contain information for parents related to caring for their child at home. An example of the information contained in a module for cerebral palsy might be how to measure the height of the child, toileting practices, and links to community resources that might provide specialized services for these children. The team has also developed a monthly newsletter to enhance efforts and to support primary care physicians with information they can use in their practice.

In 2003, the Utah Team took the next step in Medical Home development through collaboration with other states nationally in the National Institute for Child Health Quality (NICHQ) Medical Home Learning Collaborative. The Utah goal for the NICHQ project is to expand the number of practice sites actively involved in this effort, and to continue the education, outreach, and knowledge about Medical Home to all primary care practices, families and allied health professionals in the state

**THE VERMONT MEDICAL HOME FOR CSHCN PROJECT** began their project in 2002 through the Vermont Department of Health, CSHCN Program, with significant support from the Vermont Chapter of the AAP, Parent-to-Parent Vermont, and the Center for Medical Home Improvement (CMHI). An advisory committee made up of representatives from the DOH, CSHCN, Part C, Parent to Parent, AAP, Vermont Child Health Improvement Project, and CMHI, the Vermont Office of Health Access (Medicaid), and family and provider representatives guide the implementation of this project. The purpose of this project is to increase the number and capacity of pediatric medical homes throughout Vermont for CSHCN with substantial support from their AAP chapter. Specific technical assistance and supports for systems change are being used to increase practice's collaboration with families, specialists, and community resources.



The Vermont team had to first seek out those practices interested in a quality improvement process by connecting with the 33 pediatric practices in the state. They started with a mailing to each practice to let them know about the project and how to get involved. This included a medical home facilitation packet for practices reviewing the key components to a medical home and how to start a quality improvement process. This packet offered

available resources and tools, and entry in to the Vermont medical home LISTSERV. The LISTSERV can be used to poll practices about interest in services on topics such as coding for CSHCN, family focus groups and care coordination. It is also a mechanism to maintain communication with the various teams and disseminate information on local and state initiatives, and best practices.

The team has started to look at other ways to support the capacity and building of medical homes statewide. A survey was developed and sent out to specialists and primary care physicians serving children in Vermont to assess issues of communication, asking what works and what are the barriers to effectively caring for and coordinating care for CSHCN. They are also discussing with the state agency of human services ways to look at families' needs, resources, and regional services in a collaborative way. This is a huge step, and has potential for really bringing about system changes that support all families and providers in the state.

They are also looking at various ways to educate the physicians in their state on the medical home. This has led them to discussions with pediatric residency programs to look at integrating the medical home approach into the curriculum. The Vermont AAP Chapter spring meeting on office management also included several sessions on the medical home and how to incorporate those ideas and behaviors into a busy office. Other projects include working with public and private payers to increase reimbursement for medical home services. Vermont Medicaid is working to support physicians that are providing medical homes and care coordination for CSHCN. The Medicaid office is openly discussing options to increase reimbursement and decrease duplication of services to better improve the state system of health care.

**THE MEDICAL HOME MENTORSHIP PROGRAM** has expanded its scope to meet the needs of states, communities, and health care professionals at multiple levels. In addition to the state medical home teams, the network now includes practice mentors and promising practices. The Medical Home Mentorship Program offers guidance, resources, and networking opportunities for individuals, communities and states to assist them in achieving increased access to medical homes. The success of the program relies heavily on the continued efforts of state, community, and practice-based medical home teams to share their strategies, lessons learned, tools, and resources designed to improve the delivery of care to CSHCN.

**Practice Mentors** include teams who are working with primary care physicians to create medical homes in the community. Core qualities of practice mentors are: the provision of training to other practices and/or the community; engaging practices in a quality improvement process; and developing and disseminating resources and tools. Most practice mentor activities are funded through MCHB Medical Home Implementation Grants.

**Examples:**  
**Center for Medical Home Improvement (CMHI)** The mission of the Center for Medical Home Improvement is to establish and support networks of parent/professional teams to improve the quality of primary care medical homes for children and youth with special health care needs and their families.

CMHI was originally funded by the MCHB as the The Rural Medical Home Improvement Project (RMHP) in 1997 to develop a quality improvement model in which pediatricians, partnered with families from their practice, would be guided through a process of changing their practices over time to create medical homes. This project led to the development of the Medical Home Index. The Index is a validated, self-administered assessment tool that allows the physician to assess the quality of services provided to CSHCN and their families. By completing the Index, physicians also become aware of ways in which they can improve care delivered to CSHCN in their practice. The RMHP has also developed a “toolkit” of resources to accompany the Index, which includes detailed instructions to help practices begin a process of quality improvement.

The Medical Home Index has set the standard across the nation for measuring medical home capacity in physician practices. Nearly all of the Medical Home State Teams and MCHB Medical Home Grantees have adopted the use of this tool in their projects. In 2001, the MCHB continued to fund the CMHI through the Rural Medical Home Expansion Project (RMHEP). The RMHEP has allowed the CMHI to expand the number of practices they work with in rural New England for direct intervention, and continue to train individuals across the country in the use of the Medical Home Toolkit. They have also collected data from physicians and families across the nation to begin to determine a “baseline” of medical home capacity, as well as begin the process of determining the relationship between providing a medical home and improved outcomes for CSHCN.

## EPIC PROGRAM

Educating Physicians in Community Integrated Care (EPIC IC) is a collaborative effort of the Pennsylvania Department of Health, Division of Special Health Care programs (DOH Title V), family organizations (Family Voices, Parent to Parent), and the PA Chapter of the AAP, funded by the MCHB and the Pennsylvania Department of Health. EPIC IC Medical Home project is based on the Educating Physicians In their Communities (EPIC) model. EPIC IC is a statewide health care professional education program using office-based change as the key to improving the care provided to CSHCN.

The mission of the program is to enhance the quality of life for CSHCN through recognition and support of families as the central caregivers for their child, effective community-based coordination and communication, and improved primary health care.

**Promising Practices** include practices that are: engaged in a quality improvement process toward becoming a medical home; developing systems and tools designed to assist in the provision of care to CSHCN; and are advocating for CSHCN in their practice, community, and state. A goal of the Medical Home Mentorship Program is to link practices with similar demographics, geography, state, and community health care systems and resources. Individuals from these practices can provide support to other practices as they work to provide a medical home to CSHCN. Tools created by **Promising Practices** are made available via the medical home web site at [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org) and or by contacting the National Center.

For example, if you are a hospital based clinic with an inner-city population and you need information about care coordination, wrap-around services, and funding stream options, we will send you any available information on different models, tools, and contact information if available of Promising Practices similar to your own. We provide information and examples of practices that are rural and urban, hospital based, university based, community based, based on size, demographic and or the quality improvements that they have implemented for their CSHCN. This can include care coordination models, parent advisory group models, different reimbursement strategies, office organization, etc. For more information or to be connected with a similar practice model through our medical home mentorship network, you can call 1-800-433-9016, ext. 7621, or send e-mail to [medical\\_home@aap.org](mailto:medical_home@aap.org).

**EACH YEAR** the National Center plans to bring new teams that include individual practices, community based initiatives, and statewide initiatives into the National Medical Home Mentorship Network. These teams will be selected through a competitive process based on initiatives already begun in their state around improving access to medical homes for CSHCN. Teams might also be chosen based on their experience as an *Every Child Deserves a Medical Home* training site and/or their expertise in working with physicians to improve care for CSHCN.

## KEYS TO SUCCESS AND POTENTIAL PITFALLS

Through analysis of the State Mentor Teams, several common activities occurred with each one that contributed to their success. Among these are:

- Establishing regular meetings among the Medical Home Team to plan and strategize how they would implement their state plan.
- Expanding the core team to include all of the key stakeholders in the state. All teams discovered that “buy-in” to the state plan was necessary in all state organizations and agencies at all levels.
- Taking advantage of existing groups and/or committees that have shared goals and an invested interest in children with special health care needs to help in the oversight and continued development of the state plan. Oftentimes the Medical Home Team can find a home in an existing multi-disciplinary body as opposed to creating an entirely new entity.
- Establishing a mechanism of outreach whether through a hands-on approach that assists physicians in improving their practice, developing a supportive network of physicians across the state, or finding incentives to provide medical homes through increased reimbursement.

- Providing education or training on medical homes to diverse audiences and through multiple media (one-day training programs, brochures, newsletters, etc.).
- Recruiting individuals from multiple organizations to assist in the implementation of the state plan. The more individuals that are involved and committed the less work and pressure that are placed on the core team members.

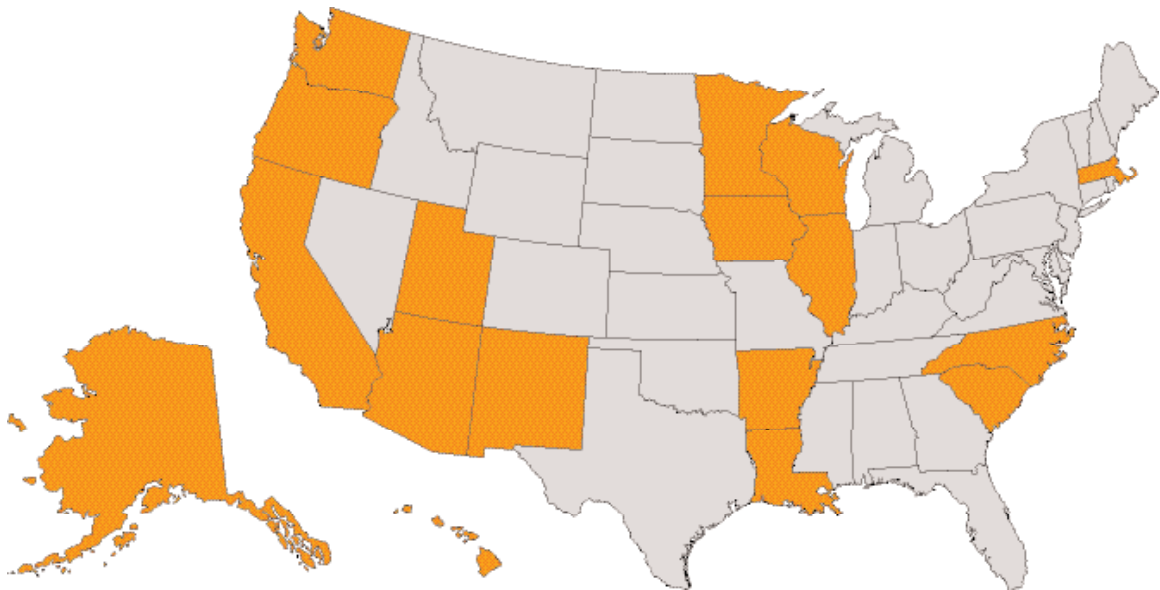
It was determined that teams attending the 2001 NMHC that did not meet early and often after the conference, and tried to “go it alone” were not as successful.



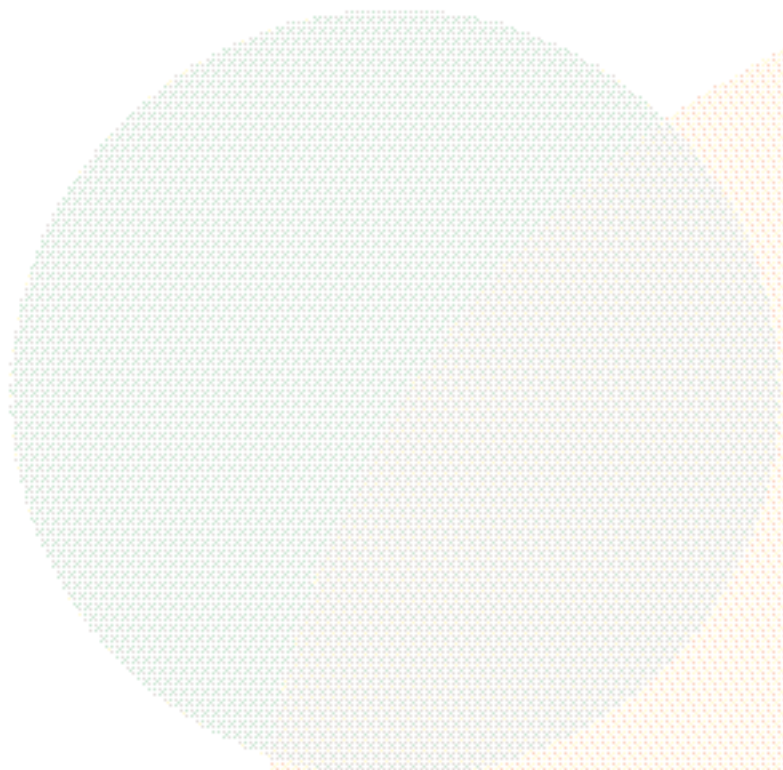
## GETTING STARTED— A PLAN FOR YOUR STATE

The National Center strongly encourages all states to begin the planning process for achieving the goals set forth in Healthy People 2010 for CSHCN as soon as possible. In order to achieve these goals by the year 2010, it is important to get started now. As evident from the successes of the states mentioned above, there are a multitude of activities and methods you can use to engage individuals in your state to make the commitment.

This map shows what states have a strategic plan that would allow all CSHCN in their state access to a medical home by the year 2010 known as a Promise to the State. For more information about the resources offered by the National Center of Medical Home Initiatives for CSHCN, as well as more detailed information on the Medical Home Mentorship Network and MCHB Medical Home grantees, please visit the National Center's Web site at [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org). If you would like more information on how to begin the process of developing a plan for your state, please call 847/434-7621, or send e-mail to [medical\\_home@aap.org](mailto:medical_home@aap.org). As noted throughout the state profiles, many states have taken part in the *Every Child Deserves a Medical Home* training program that has been a catalyst for many of the medical home initiatives. You can download a copy of the training program through our web site or for technical assistance on how you can participate in or plan a training program for your state, please send e-mail to [mhtraining@aap.org](mailto:mhtraining@aap.org).







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