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Medical Home: A Guide for Professionals

Module 3 in a series of 5

North Dakota Center for Persons with Disabilities
Minot State University

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Medical Home: A Guide for Professionals

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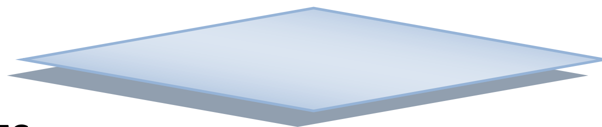
INTRODUCTION

The *Medical Home Module* is an overview of the components that are needed to build a Medical Home in any physician practice or clinic setting that provides primary care. The approach is a quality improvement tool that is beneficial for patients of any age with chronic health conditions, including children and youth with special health care needs or any individual that requires a comprehensive method for delivery primary care. The Medical Home concept takes into consideration effective ways of communication that keeps the patient at the center of the care delivery system. Medical home partners with the patient by keeping the patient at the center of the care being delivered by providing the right care at the right time. The needs of the patient are more important than requirements of the delivery system. Acute needs are addressed at the time of the patient visit, but preventative care is not overlooked. Routine health considerations such as immunizations, diet, exercise and overall health habits are addressed at each visit. The patient is encouraged to share the needs he or she has that promote maximum wellness within illness. What to do and when to do it is outlined at each visit, whether routine care or how an emergency situation could be handled, the details are addressed by your primary care physician and care coordinator which makes chronic illness much easier to manage.



MODULE OBJECTIVES

1. Participant will be able to verbalize characteristics of a medical home.
2. Participant will articulate how to identify patients that would benefit from having a medical home.
3. Participant will be able to verbalize understanding of how to implement the medical home concept for children with special health care needs in the clinic setting.
4. Participant will be able to verbalize how to implement medical home in the clinical practice setting.
5. Participant will be able to state review tools that can be used in the medical home setting.
6. Participant will be able to define patients with chronic health conditions and children and youth with special health care needs.

OVERVIEW OF A MEDICAL HOME

What is a medical home?

The American Academy of Pediatrics (AAP) describes the ideal medical home as one that provides ***accessible, continuous, comprehensive, family centered, coordinated, compassionate,*** and ***culturally effective*** care (www.medicalhomeportal.org).

Accessible	Clinic offers more hours or flexibility. Patients have access to their provider through various means that might include a nurse, care coordinator, telephone, fax or email.
Continuous	Care is ongoing. Annual exams are a must.
Comprehensive	The provider looks at the whole person, not just a specific “part”.
Family-Centered	The family and patient are equal partners in care. The family knows the patient best and is a trusted expert.
Coordinated	The care coordinator or provider works with other providers of care for the patient. Examples: Specialists, Schools, Service Agencies, Employer, Daycare
Compassionate	Provide a caring and comforting environment to patients and families.
Culturally Effective	Understand and support patients’ cultural differences: Beliefs, values, family structure, geographic situation, race, ethnicity, language and so on.

A Medical Home is not a place; it is a quality improvement approach to healthcare. It is a partnership between the patient/family, the provider(s) and other stakeholders that enables the best quality of care for patient.

The medical home model is the model for the 21st century. The primary care practice has the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner (www.pediatricmedhome.org).

Medical Home Model is nationally endorsed by:

- *American College of Physicians*
- *American Academy of Family Practitioners.*
- *American Osteopathic Association.*
- *American Academy of Pediatrics.*

General information about medical home:

- *www.medicalhomeinfo.org*
- *www.medicalhomeimprovement.org*
- *www.pediatricmedhome.org*
- *www.aap.org*

CYSHCN-Children and youth with special health care needs are those who have or at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services beyond the amount required by children general.(Maternal and Child Health Bureau,1995).

A medical home does **not** change your health insurance coverage
http://internet.dscc.uiu.edu/medhome/familyprimer/FamilyMHPrimer.asp

What are benefits of a Medical Home?

- Increased patient and family satisfaction
- Establishment of a forum for problem solving
- Improved coordination of care
- Enhanced efficiency for children, youth and families
- Efficient use of limited resources
- Increased professional satisfaction
- Increased wellness resulting from comprehensive care

A Medical Home is a provision of care through a primary care physician through partnerships with allied health care professionals and the family. (www.medicalhomeinfo.org)

Stakeholders may include:

- Primary care physicians
- Family
- Child/youth
- Allied healthcare professionals
- Community
- Pediatric Office staff
- If necessary, pediatric subspecialties

An **Advocate** is a person who provides support or protects your rights.

Respite Care is temporary or periodic care provided by someone else so caregiver can rest or take time off.

Access means ability to get needed medical care and services.

"The Medical Home approach takes us back to the way medicine was practiced years ago, when physicians and patients had long–standing relationships."
-Kim Kiser (Kim is a contributing writer for the Minnesota Medical Home project newsletter).

HOW TO IMPLEMENT MEDICAL HOME

Building or implementing a medical home refers to improving quality and integrating partnerships with families and other health care providers (www.medicalhomeportal.org). If action steps are taken to make a primary practice more patient-centered, principals that would improve on patient-centeredness would be:

- Allowing patients free choices of physicians (when possible).
- Providing prompt appointments, reducing waiting times (same day scheduling is ideal).
- Delivering evidence based care that is clinically effective
- Empowering patients to partner with their personal physicians on decision-making
- Providing care in a culturally and linguistically appropriate manner (www.pccc.net/pediatric).

Keep in mind the list above is recommendations from the Medical Home Portal website. Each practice has variables that may not have been accounted for. The recommendations can be used as a framework for change or improvement.

Clinics might use varying approaches for implementing medical home. Not all clinics are the same. It is important to understand key characteristics of the clinic to identify methods for a more successful beginning. Factors to consider before implementation are:

- Geographic location
- Staff capacity
- Opinions of clinic staff that would be involved in implementation
- Patient population needs
- Clinic facility

"Coming together is a beginning; keeping together is progress; working together is success."
- Henry Ford, auto maker

Illinois Medical Home Project, Information retrieved from http://internet.dscc.uic.edu/medhome/qit/qiteam.asp

Core Steps in Continuous Improvement

- Form a team that has knowledge of the system needing improvement.
- Define a clear aim or aim statement.
- Identify and define measures of success.
- Brainstorm potential change strategies for producing improvement.
- Plan, collect, and use information for facilitating effective decision making.
- Apply the scientific method to test and refine changes.

FORMAT USED BY THE NORTH DAKOTA MEDICAL HOME PILOT SITE

Below is an outline of a format adapted from the Center for Medical Home Improvement.

1. Make the Commitment and Start the Work
   a. Allow yourself enough time
   b. Schedule a regular time to meet
   c. Don't do this alone
   d. Secure funding if possible
   e. Gain support from administration and other key clinic staff members
   f. Identify roles needed on your team

2. Form a Team
   a. Primary Care Provider
   b. Care Coordinator
      i. Nurse
      ii. Social Worker
      iii. Non-physician staff person
      iv. Experienced parent
      v. Family support coordinator
   c. Two Consumer Advisors

3. Write an AIM Statement
   a. Where are you now? (Medical Home Index, Medical Home Family Index, Parent Perception Survey)
   b. Where do you want to be? (Repeat above surveys periodically)
   c. Develop measurements to evaluate your improvements

4. Ensure Productive Meetings
   a. Clarify objectives
   b. Review Roles (leader, recorder, facilitator)
   c. Review and work through agenda items
   d. Review meeting decisions, action steps, and responsibilities
   e. Plan next agenda

A Model for Improvement.

- Improvement is based on building knowledge (of what works and does not work) and applying it appropriately.

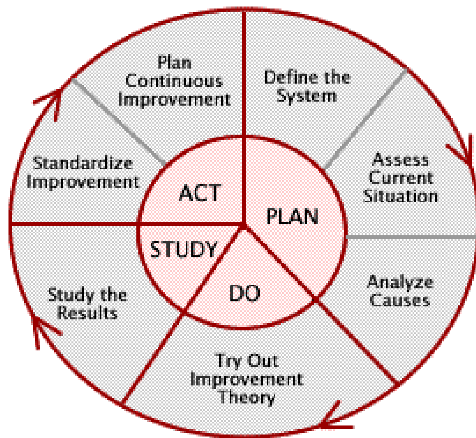
AIM statements:
Very specific declarations of what a team will be focusing on as they strive to improve a process or a system.
http://truesimple.com/2008/12/13/developing-clear-aim-statements/

Medical Home Index: The Medical Home Index (MHI) is a validated self-assessment and classification tool designed to translate the broad indicators defining the medical home (accessible, family-centered, comprehensive, coordinated, etc.) into observable, tangible behaviors and processes of care within any office setting (Center for Medical Home Improvement 2001).

Medical Home Family Index: The Medical Home Family Index uses twenty-five questions to capture the family perspective (Center for Medical Home Improvement 2001).

Parent Perception Survey: A survey conducted by the practice periodically that quantifies how families perceive the practice. It also contains insurance and demographic information.

- The model offers a ***trial and learning*** approach that helps reveal the outcomes of change.
- Test a change on a *small scale* using **PDSA** (small 2 or less; large would be more than 2).



P=Plan
D=Do
S=Study
A=Act

Plan the change strategy including ***who*** will be involved, what data will be collected, ***how*** and ***when*** the data will be collected, and **when** the data will be considered adequate to study.

After the test is complete, determine if you will adapt the change, abandon the change, or adopt the change.

- **Adapt:** This means that the teams still feels the change is an improvement: Some adjustments are needed for the change to work effectively in the practice.
- **Abandon:** This means that the change was ineffective or will not result in an improvement: The change is discontinued.
- **Adopt:** This means that the change was an improvement: The change and will be adopted by the practice and become *the standard of practice.*

What to do if the change is *successful:*

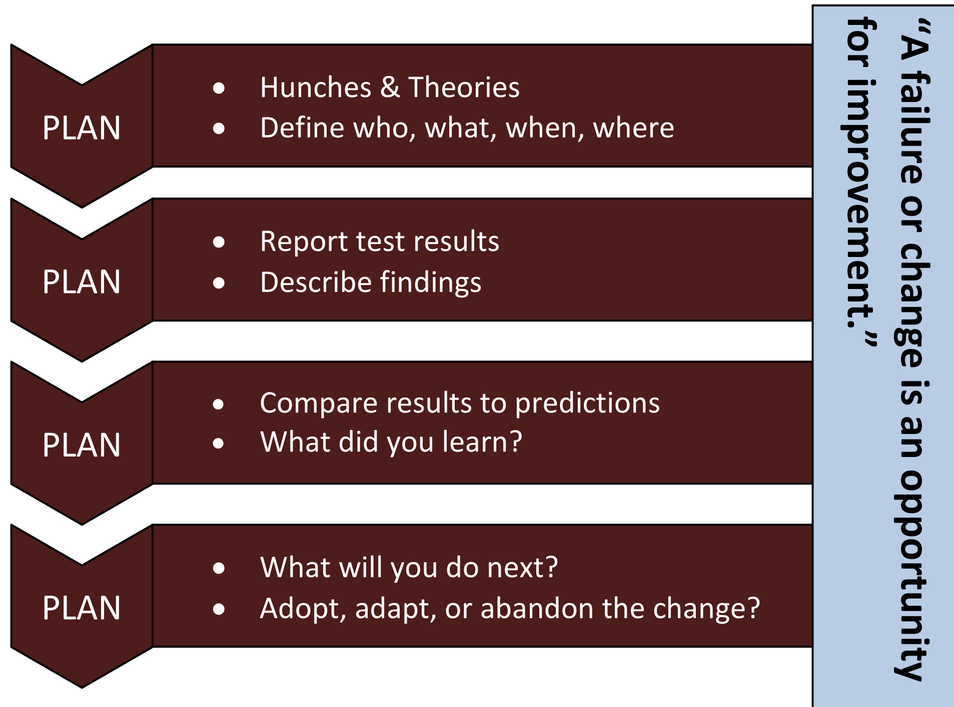
- ***Expand*** to the rest of the system
- ***Establish*** systems to support it
- ***Identify*** ways to further improvement

What to do if the change is *not an improvement:*

- ***Adapt*** the change
  - Make adjustments and conduct more PDSA cycles
- ***Abandon*** the change
  - Discontinue efforts if the change is not an improvement.

Hints for improvement efforts:

- Before you try to solve a problem, **define it.**
- Before you try to control a process, **understand it.**
- Before trying to control everything, find out what is important.
- Most important issue or on the process having the biggest impact.
- Recognize that we can learn from failures, so respect meaningful failures.



ADDITIONAL BUILDING BLOCKS

Further information for medical home implementation is available online. A medical home toolkit can be found at www.pediatricmedhome.org. The building blocks of the medical home toolkit are divided into ***six areas***.

1. ***Care Partnerships***
   - This section addresses family access to care and communication. For example, the roles of the clinicians and office staff are explained to patient and family.
   - How are appointments scheduled? Can a patient plan to be seen the same day that he or she needs to see the clinician?
   - Family-friendly communication is outlined. For example how do the patient and family prefer to be communicated with, such as internet, face to face or by phone? Sharing your medical home brochure at this point would be valuable. A template of a communication checklist can be found at www.pediatricmedhome.org.

2. ***Clinical Care Information.*** This section addresses standards of practice and use of clinical information. Office specific information such as the medical record, coding issues, progress notes and medication records are outlined.

"A specific attribute of a Medical Home is a registry. The registry can be as simple as cards in a shoebox or as advanced as an Electronic Health Record (EHR). A registry helps manage a population of patients and individual patients. It can track goals, track those patients who are due for services and whether their measures are within an acceptable range. It can provide reminders for tests, procedures, and preventive services. It also assists in monitoring lab values and test results and allows providers to observe improvement over time."
-Jane Taylor, Medical Home Quality Improvement Advisor

A well-designed registry for Individual Care Planning …

- Prints patient summaries and are made available at the visit
- Track self-management goals
- Generate care plans
- Graph key clinical data
- Share data electronically in a secure and confidential manner with specialist and other members of a patient's care team.

A well-designed registry has report functions that …

- Generate condition population reports
- Generate provider-level reports with comparators
- Provide data analysis around reports
- Easily query ad hoc data so that providers may monitor sub-groups of patients
- Aggregate data across sites or provider and leadership feedback.

From Child/Chronic Model Clinical Information Systems Registries presentation by Jane Taylor.

3. ***Care Delivery Management***
This section encourages evidence-based care that is consistent with patient and family preference. Additional forms and tools are also available such as:
- CYSHCN screener
- Family-Centered Care Coordination
- Youth-Centered Care Coordination
- Pre-visit contract form
- Co-Management letter and agreement
www.pediatricmedhome.org/section3/step1

4. ***Resources and Linkage***
This section addresses linking patients and families to resources within the community. An example of a resource checklist is found at www.pediatricmedhome.org/section4/step1/index.asp . State and local resources may be found by contacting the Department of Health, Department of Human Services state, county social services offices, churches, non-profit organizations and civic groups.

5. ***Practice Performance Measurement***
This section provides information to help evaluate the clinical practice in two areas: physician performance and patient/family perspective regarding quality of care. Related tools and checklists are found at (www. Pediatricmedhome.org/section5/step1/index.asp).

6. ***Payment and Finance***

This section refers to the standards of NCQUA PPC-PCMH. Included in this section is a link to *Building Your Medical home and Getting Paid* (www.pediatricmedhome.org/pdfs/payment.pdf).

Additional forms and tools that are available on the **Pediatric Medical Home** site that are used by the North Dakota Medical Home Pilot sites are:

- **CYSHCN screene**r: A 5-question survey that helps to identify Children and Youth with Special Healthcare Needs
- **Family and Youth Centered Care Coordination: An a**ssessment of care coordination needs
- **Pre-visit contact form**: Assists in addressing all needs of the patient during the appointment and allows the care coordinator to compile useful resources for the patient
- **Co-Management letter and agreement**: A means of communication with specialists
- **Pediatric Care Plan**: A major component of the Medical Home, this is a summary that includes medical, social, familial, and contact information
- **Action Plan Template**: An outline of action steps for the patient and/or family to follow through on the providers' recommendation (www.pediatricmedhome.org/section3step1)

A Medical Home is an approach to providing health care services that are high-quality, comprehensive and cost effective. A primary care physician develops partnerships with other allied health care professionals and family members in an effort to meeting the needs of individuals with chronic health conditions or children and youth with special health care needs. Various internet resources are available for developing the building blocks of your medical home. Many of the building blocks have been reviewed throughout this learning module and are available to be utilized and customized for each practice and no cost.

Private health plans and state Medicaid programs choose Medical home practice eligibility criteria: many are using the NCQA PPC (www.ncqa.org).

North Dakota Blue Cross Blue Shield currently endorses a program called MediQ Home. The program is offered to physician practices that have at least 1 member that has Blue Cross Blue Shield of North Dakota. The tools and software are not limited to payer source, but can be used for other patients that do not have Blue Cross Blue Shield. Details about the program s can be found at https://www.thorconnect.org/nd/physician.

CONCLUSION

The listing below includes additional resources. The sites can be found online by using Google and typing in the title. The additional resource list is not inclusive but a starting point for finding additional sources that maybe beneficial for developing a medical home in a primary care physician practice or clinic setting. NDCPD does not promote or endorse any of the sources listed.

National Center for Medical Home Implementation. Located at the American Academy of Pediatrics with support from the US Maternal and Child Health Bureau, the National Center for Medical Home Implementation provides a clearinghouse for Medical Home activities, information, and tools. While featuring the pediatric medical home in particular as it relates to children with special health care needs, the National Center provides downloads and links for medical home activities relevant to all children and other national resources for medical home across the lifespan (www.medicalhomeinfo.org).

Children and Adolescent Health Measurement Initiative, National Survey of Children with Special Health Care Needs Data Resource Center. The Child and Adolescent Health Measurement Initiative (CAHMI) developed and maintains a number of quality measurement tools and strategies that assess the quality of care provided to children and young adults. CAHMI created the CAHMI or CSHCN screener providing a non-categorical tool for identifying children with special health care needs. The National Survey of Children with Special Health Care Needs Data Resource Center provides user-friendly access to national and state-level results of the National Survey (www.cahmi.org).

Data Resource Center for Child and Adolescent Health. The Data Resource Center, funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, is partnering with the American Academy of Pediatrics to help state and family leaders quickly access data on how children and youth in each state experience receiving care within a medical home (www.childhealthdata.org).

Family Voices (FV) is a national grassroots network of families and friends. They advocate for access to health care services and provide particularly good information for families with children and youth who have special health care needs. Family Voices is in every state, they make it their mission to have up to the minute resource information. They are also linked to numerous “family to family” resource information centers. FV knowledge can help any family in need; their skills also include connecting and involving families one to another when this is desirable (North Dakota www.fvnd.org or national www.familyvoices.org).

Family-to-Family Health Information Centers are non-profit organizations that help families of children and youth with special health care needs (CYSHCN) and the professionals who serve them. Family-to-Family Health Information Centers are in a unique position to help because they are typically staffed and run by parents. These staff understands the issues that families face and provide advice, offer a multitude of resources, and tap into a network of other families and professionals for support and information (www.familyvoices.org).

Improving Chronic Illness Care (ICIC). ICIC has worked for almost ten years with national partners toward the goal of bettering the health of chronically ill patients by helping health systems, especially those that serve low-income populations, improve their care through implementation of the Chronic Care Model.

Institute for Health Improvement. Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action (www.ihi.org).
Maternal Child Health Bureau. A bureau of the Health Resources and Services (www.mchb.hrsa.gov).

Medical Home Portal. The Medical Home Portal provides access to reliable and useful information for professionals and families to help them care and advocate for children and youth with special health care needs (CYSHCN) as partners in the Medical Home model. Based at the University of Utah, the portal now includes resource information from a number of states as well as downloads and links to useful information, tools and resources related to the medical home model – particularly for children with special health care needs (www.medicalhomeportal.org).

National Committee on Quality Assurance. National Committee on Quality Assurance provides quality assurance measures and information for health plans, health care provider organizations, and physicians. The NCQA Physician Practice Connection recognition tools were recently expanded to include the Physician Practice Connection – Patient-centered Medical Home survey and measurement tool. The PPC – PCMH has emerged as a method of medical home measurement used by commercial health plans in a series of medical home pilot projects to determine eligibility for enhanced reimbursement scenarios for medical home practices (www.ncqa.org).

National Initiative for Child Health Quality (NICHQ). The National Institute for Children's Healthcare Quality (NICHQ) was the child health-focused offspring of the Institute for Healthcare Improvement (IHI). The NICHQ organizes and implements quality improvement projects promoting screening, preventive health care and chronic condition management for children. NICHQ

collaborated with the Center for Medical Home Improvement in the first national medical home learning collaborative in 2004 and has made the promotion of medical homes its primary focus for 2009 and 2010 (www.nichq.org).

North Dakota Center for Persons with Disabilities (NDCPD). The North Dakota Center for Persons with Disabilities is a University Center for Excellence on Development Disabilities (UCEDD) and a member of the Association of University Centers on Disabilities (AUCD). NDCPD is housed on the campus of Minot State University. The website offers information about current projects, upcoming events and resources (www.ndcpd.org).

> **North Dakota Integrated Services (NDIS).** The North Dakota Integrated Services project is housed at the North Dakota Center for Persons with Disabilities. The focuses of NDIS include Medical Home, Healthy Transitions and Family Involvement/Cultural Competence for Children and Youth with Special Healthcare Needs (CYSHCN) and their families. The website contains information about upcoming events, news about the project's activities and contact information for staff (www.ndcpd.org/ndis).

Patient-Centered Primary Care Collaborative (PCPCC). Created as a partnership of corporate purchasers of health care for employees, national primary care professional organizations, insurers, consumer organizations, quality improvement and assurance organizations, and other stakeholders, the PCPCC provides an active forum for medical home advocates while keeping the transformation of primary care visible among policy makers and elected officials in Washington. Through national meetings, a weekly, open conference call, workgroups, and its website, the PCPCC has become one of the hubs of national medical home activity (www.pcpcc.net).

The Commonwealth Fund. Commonwealth Fund is a private foundation promoting a high performing health care system with better access, improved quality, and greater efficiency by supporting independent research on health care issues and making grants to improve health care practice and policy. Through periodic reports and a weekly e-newsletter, the Fund disseminates information important to health care reform and practice transformation (www.commonwealthfund.org).

Your State Maternal and Child Health Services Title V Program. Title V is administered by the Maternal and Child Health Bureau (MCHB) as part of the Health Resources and Services Administration, U.S. Department of Health and Human Services. In partnership with the States and communities, MCHB provides the leadership and resources needed to advance the health and safety of the nation's mothers, infants, children, adolescents, and CSHCN, including those with low incomes, those with diverse racial and ethnic heritages, and those living in rural or isolated areas without access to MCHB's care (www.mchb.hrsa.gov).

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