

## Center for Medical Home Improvement Using the Care Model for Child Health in a Medical Home

The change package for Medical Home is based on a conceptual framework, the Care Model for Child Health in a Medical Home, outlining features of the ideal system for Medical Home and a set of evidence-based strategies that have been proven to be effective in achieving improvements (“change concepts”).

The ability to develop, test, and implement changes is essential for any practice that wants to improve. Practices should establish a process for quality improvement, such as the Model for Improvement, to implement the change concepts. After selecting specific changes, practices should run Plan-Do-Study-Act (PDSA) cycles to test a change or group of changes on a small scale to see if they result in improvement. If they do, practices may expand the tests and gradually incorporate larger samples until they are confident that the changes can be adopted more widely across the practice.

The following *short list* of high-leverage strategies are adapted from the Care Model for Child Health based on the experience of the Center for Medical Home Improvements and the NICHQ Medical Home Learning Collaborative I & II (2004 & 2005). The highlighted areas (**#1, #2, #3 and #4**) are recommended strategies, in order of importance, most effective when implemented early on in the improvement process.

<b>Care Model for Child Health in a Medical Home - Improvement Ideas</b>	
<b>Areas of Improvement</b>	<b>Improvement strategies (start up top three are numbered)</b>
Community	<ul style="list-style-type: none"> <li>• Meet with community partners (e.g. “lunch &amp; learn” time)</li> <li>• Catalog (dynamically) community resources and contact persons</li> </ul>
Health System	<ul style="list-style-type: none"> <li>▪ Gain commitment of health care system senior leadership to have quality standards in place for meeting the needs of CYSHCN &amp; families</li> <li>▪ Establish plan to maximize reimbursement for medical home visits</li> </ul>
<b>Care Partnership Support</b>	<ul style="list-style-type: none"> <li>• <b>#1 Engage parents as partners at the practice level</b></li> <li>• Develop a care planning process and plan with families</li> </ul>
<b>Delivery System Design</b>	<ul style="list-style-type: none"> <li>• <b>#4 Develop strategy and identify specific roles for care coordination and communication at the practice level</b></li> <li>• <b>#3 Use planned visit encounters</b></li> </ul>
Decision Support	<ul style="list-style-type: none"> <li>• Co-manage care with specialists and choose information exchange method (fax-back, email, web-based systems)</li> <li>• Select and use evidence based practice guidelines</li> </ul>
<b>Clinical Information System</b>	<ul style="list-style-type: none"> <li>• <b>#2 Identify CYSHCN {flu list, computer runs, memory, prospectively)</b></li> <li>• Build and use a registry to enroll identified CSHCN, use visit reminders, to support care planning process and monitor care needs</li> </ul>
Jeanne McAllister Co-Director © Center for Medical Home Improvement, 2005	

The recommended measurement tools for evaluating the successful integration of Medical Home in clinical practice are the: 1) Medical Home Index; 2) CAMHI Screener; and 3) CMHI’s Medical Home Family Index and Survey.