



Medical Homes for Children and Youth with Special Health Care Needs— Making it Happen in Washington State 2006-2010

*A **Strategic Plan** to achieve medical homes for all children and youth with special health care needs by 2010*

Washington State Partners in Medical Home Strategic Planning

Washington State Department of Health
Children with Special Health Care Needs Program
Child and Adolescent Health Section
Washington State Department of Social and Health Services
Infant Toddler Early Intervention Program
Health and Recovery Services Administration
Washington State Medical Home Leadership Network
Washington State Chapter of the American Academy of Pediatrics
Docs for Tots
Washington State Parent to Parent
Washington State Fathers Network
Center for Children with Special Needs, Children's Hospital & Regional Medical Center
Health Services, Office of Superintendent of Public Instruction
Washington Health Foundation
Group Health Cooperative
Molina Healthcare of Washington
Family Voices of Washington
Spokane County Children with Special Health Care Needs Program
Public Health Seattle-King County Children with Special Health Care Needs Program
Clark County Children with Special Health Care Needs Program
Washington State Medical Home Teams

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For more information:

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Children with Special Health Care Needs Program
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Who are children with special health care needs (CSHCN)?

"Children with special health needs include all children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally." Definition of children with special health care needs from the Maternal Child Health Bureau <ftp://ftp.hrsa.gov/mchb/factsheets/dschsn.pdf>

Fourteen percent of children and youth in Washington State have special health care needs. Source: 2001 National Survey of Children with Special Health Care Needs

Benefits of medical homes

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

Definition: The Medical Home for CSHCN is a model of primary health care that is: (Source: <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;110/1/184.pdf>)¹

Components of a Medical Home

Accessible

- Care is provided in the child's or youth's community.
- All insurance, including Medicaid, is accepted and changes are accommodated.
- Families and youth are able to speak directly to the physician when needed.

Family Centered

- Recognition that the family is the principal caregiver and the center of strength and support for children.
- Complete information is shared on an ongoing basis.
- The family is recognized as the expert in their child's care, and youth are recognized as experts in their own care.

Continuous

- Same primary care providers are available from infancy through adolescence.
- Assistance with transitions, including those to other pediatric providers or into the adult health care systems, are planned and organized with the child and family.

Comprehensive

- Health care is available 24 hours a day, 7 days a week.
- Preventive, primary, and tertiary care needs are addressed.
- Information is available about private and public resources.

¹ The American Academy of Pediatrics, American Academy of Family Physicians, National Association of Pediatric Nurse Practitioners, Family Voices, and United States Maternal Child Health Bureau endorse the medical home as the model for 21st century primary care. (<http://www.medicalhomeimprovement.org>)

Coordinated

- A plan of care is developed by the physician, child or youth, and family and is shared with other providers, agencies, and organizations involved with the care of the child.
- Information is centralized.
- Families are linked to support, educational and community-based services.

Compassionate

- Concern for the well-being of both child and family is expressed and demonstrated.
- Efforts are made to understand and empathize with the feelings and perspectives of the family as well as the child or youth.

Culturally effective

- Family linguistic and cultural background is recognized, valued, and respected.
- All efforts are made to ensure the child or youth and family understand the results of health encounters and the care plan.

Who's involved in promoting medical homes?

- children and youth with special health care needs
- parents
- primary care providers and their office staff
- health and human service providers
- insurers
- public and private organizations
- employers
- philanthropists
- community organizations
- health plans

Washington State Medical Home Strategic Plan for Children and Youth with Special Health Care Needs

Strategic Plan Framework

- Partners developed this 2010 Strategic Plan to build upon the 2000 “Promise to the State”, Washington’s original “road map” for achieving medical homes for children and youth with special health care needs.
- Action Steps in this plan are designed to increase the percent of children and youth with special health care needs (CSHCN) who have a medical home.
- Partners involved in implementing the plan acknowledge that strategic planning is a process—that the goals, objectives, and activities of this plan might change over time based upon evolving vision and environment.

Vision All children and youth with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home.

Washington State: 54% of children with special health care needs received coordinated comprehensive care within a medical home. (2001 National Survey of CSHCN)

Strategic Areas	Individuals or Organizations Involved		
	System	Family, Youth, Child	Primary Care Providers
Understanding and Promotion Goal People understand and promote the concept of medical home.	Objectives 1-2	Objective 3-4	Objective 5-6
Performance and Quality Goal All involved actively strive to create medical homes for children with special health care needs and their families.	Objectives 7-9	Objectives 10-11	Objectives 12-16
Financing Goal Financing for medical homes is adequate.	Objectives 17-20	Objective 21	Objective 22

Strategic Area: Understanding and Promotion

Goal People understand and promote the concept of medical home.

5 Year Goal Policymakers understand the medical home concept and take action to promote it.

Strategies

- Create a Marketing Plan to promote awareness of the medical home concept.
- Assure the Marketing Plan includes methods for reaching varied audiences, including materials that can be adapted to multiple audiences.
- Include selection and dissemination of materials in the Marketing Plan.
- Collaborate with partners to promote the medical home concept using the Marketing Plan and materials.
- Seek endorsement of the medical home concept from appropriate entities.

Objective 1

Policymakers, state agency staff and those serving children and families will understand and promote the concept of medical home.

Action Steps

- a. Explore a plan for Early Childhood providers, School Nurse Organization of Washington, School Nurse Corps, the Elementary Schools Principals Association, professional teacher groups, First Steps to understand and promote medical home.
- b. Provide training about benefits of medical homes to a wide range of audiences, including the EPSDT Improvement Workshop.
- c. The CSHCN Program will collaborate with CHILD Profile to routinely include medical home information in mailings.
- d. Give a presentation about medical home benefits to Medicaid health plans and providers at a quarterly HRSA meeting.
- e. Define how medical homes for children and CSHCN relate to medical homes for all people.
- f. Use an existing, or develop a logo or “visual brand” for Washington State Medical Homes to facilitate recognition and acceptance of the concept.
- g. Develop one promotional piece for all stakeholders that describe the concept of medical homes for children and youth with special health care needs.
- h. Assure promotional materials clarify the difference between “medical home” and “health home”.
- i. MHLN staff will create and disseminate a bookmark advertising the MHLN website. Disseminate the bookmark through MHLN teams, conferences, the medical home website and other appropriate venues. Initial production will be done by May 2006.
- j. Identify and obtain endorsement statements of Medical Homes from key people or groups such as the Governor, Washington Chapter of AAP and AAFP.
- k. Not for profit organizations can carry out a Medical Home Day with the legislature where physicians and parents together educate legislators about Medical Homes.

<p>Objective 1, cont.</p>	<ul style="list-style-type: none"> l. Identify and coordinate promotion of medical homes with existing initiatives such as Medical Homes for All Children, Early Learning Department and Thrive by Five. m. The Infant Toddler Early Intervention Program (ITEIP) will share information about the benefits of medical homes with local and state level partners with whom they work by disseminating uniform information in person, via newsletters, at conferences, or the ITEIP web site. n. The Washington Health Foundation can share promotional materials about medical homes with people in the business community and hospitals. o. Identify colleges and universities in the state that have medical and allied health professional training programs, and work with curriculum developers in these schools to include training about medical homes as a routine part of the curriculum. p. Develop a sustainable plan for writing and disseminating “<i>Your County</i>” or <i>Washington State Child Health Notes</i> (e.g. a Spokane Public Health newsletter) around the state and include information about Medical Homes in each issue. q. Build work into contracts to promote medical home definition and concept. r. The Child and Adolescent Health Section of Washington State Department of Health will promote an understanding and endorsement of medical homes among early childhood providers and school based clinics in the state. s. Children with Special Health Care Needs (CSHCN) Coordinators will identify and contact primary care providers in their jurisdiction area to offer information about the role of the CSHCN Coordinator in fostering medical homes.
<p>Objective 2 A culturally and linguistically appropriate Washington State Medical Home Marketing Plan will be in place to promote medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. The CSHCN Program will integrate this objective into the overall promotion of medical homes for all children. b. Seek counsel to assist in promoting Medical Home concept among national and ethnic minority and non-English speaking populations. c. Seek counsel on how to partner with cultural leaders from diverse communities to help promote Medical Home concept. d. Allocate funding to organizations that represent linguistic and cultural minorities so those organizations might consult on developing a Medical Home Marketing Plan that will reach as wide an audience as feasible. e. Coordinate with Washington State Native American tribal leaders to promote medical homes within tribal health organizations.

Youth and Families	
<p>Objective 3 Youth and families play a significant role in planning and promoting medical homes.</p>	<p>Action Steps</p> <ol style="list-style-type: none"> a. Explore a plan for the role of Washington State Father’s Network in promoting medical homes. b. Collaborate with Family Voices and other family organizations, to identify or develop tools, including a one page checklist, that will help families and youth know if they have a medical home. c. Family to Family will include questions about medical home in the Family to Family Health Information Training and Information Survey. d. Explore a plan for how to recruit linguistic and ethnic minority family participation in implementing Washington State’s Medical Home Strategic Plan. e. The CSHCN Program will collaborate with state agency partners to identify funding to reimburse family leaders participating in implementing Washington State Medical Home Strategic Plan. f. The CSHCN Program and the Adolescent Health Transition Project will develop a plan to identify and reimburse youth leaders to participate in planning and implementing the WSMHSP. g. The CSHCN Program will provide medical home in-service training for Washington State Parent to Parent and Washington State Father’s Network. h. Encourage medical home teams to include at least one parent of a child with special needs and a Family Resource Coordinator. i. Collaborate with the Special Olympics to promote medical homes.
<p>Objective 4 Families and youth know how they benefit from medical homes.</p>	<p>Action Steps</p> <ol style="list-style-type: none"> a. The CSHCN Program will collaborate with CHILD Profile to include information about Medical Homes with CHILD Profile mailings to parents by April 2007. b. Design and distribute a printed “bookmark” and magnets about medical homes for families and youth. c. Continue to distribute “Care Organizers” to families.
Primary Care Providers	
<p>Objective 5 Primary and specialty care physicians and their office staff recognize the components of a medical home.</p>	<p>Action Steps</p> <ol style="list-style-type: none"> a. Involve military primary care providers in promotion and endorsement plans. b. Present and share information about medical homes at meetings attended by primary care providers. c. Include information about medical homes in newsletters that primary care providers receive. <p>Use existing, or develop ways for primary care providers to measure whether they provide each component of a medical home.</p>

<p>Objective 6 Primary care providers know how they benefit from medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none">a. Use existing methods for primary care providers to measure whether they are benefiting from providing components of a medical home.b. WMHLN staff will identify and post articles on the WMH website that document the value for primary care providers in providing medical homes, including cost savings physicians experience when providing medical homes.
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Performance and Quality

Goal All involved actively strive to create medical homes for children with special health care needs and their families.

5 Year Goal Medical Home is recognized as a quality improvement strategy.

Strategies

- Implement care coordination.
- Practice family centered care.
- Identify the population of children with special health care needs.
- Implement continuous quality improvement.

System

<p>Objective 1 Policymakers and state agency staff promote Action Steps that support medical homes.</p>	<p>Action Steps</p> <ol style="list-style-type: none"> a. The CSHCN Program will coordinate and maintain an advisory body of stakeholders to sustain implementation of the WSMHSP. b. DOH CSHCN Program will include medical home techniques as a key strategy for improving care for CSHCN within their contracts and interagency agreements. c. Develop a plan that results in pertinent state agencies including language in appropriate contracts that will facilitate implementation of medical homes. d. The CSHCN Program will develop a curriculum about family leadership skills, communication skills, and how primary care providers can use family advisory groups to improve their practice. e. Collaborate with other state agencies, foundations such as the Washington Health Foundation, and other organizations to include presentations on medical homes at conferences attended by policymakers, health and human service providers and families. Emphasize that medical homes are quality care. f. Host a conference on the topic of medical home emphasizing that medical homes are quality care. g. The CSHCN Program will collaborate with partners to design and carry out an evaluation to measure progress on this Strategic Plan.
<p>Objective 2 All who work with children with special needs will know who each other are, understand each other's roles, and know how to communicate among themselves.</p>	<p>Action Steps</p> <ol style="list-style-type: none"> a. Provide training to Child Care Health Consultants on the medical home concept and how child care, early learning, and out of school time providers can play a role in providing medical homes. b. Increase the number of County CSHCN Programs that distribute Child Health Notes newsletters which include information about medical homes on a regular basis.

Objective 2, cont.	<ul style="list-style-type: none"> c. Create a series of “talking points” about medical home from the perspectives of families and people who work with children with special needs. Incorporate the “talking points” in a presentation for conferences. Make these “talking points” available on the Washington Medical Home website for anyone to use in a presentation. d. MHLN staff will create and maintain a “Speakers List” on the Washington State Medical Home website that lists speakers with expertise in medical home who are available for consulting and giving presentations about the roles of various providers in the medical home and continuous quality improvement measures that foster medical homes. e. Post, maintain and advertise the availability of video streams of important conferences such as the Duncan Seminar or other medical home related conferences on the internet. f. Develop a plan for assuring the medical home concept is used in school-based teen health centers.
<p>Objective 3 Those who work with children with special health care needs collaborate to deliver quality, coordinated, culturally appropriate care.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Develop a plan to work with Kids Matter Partnerships, Early Learning Department, Infant and Toddler Early Intervention Program and Office of Superintendent of Public Instruction (OSPI) Health Services Program regarding the coordination of services that occurs as part of a child’s medical home. b. Develop a plan to assure that health care providers receive ongoing continuing education about how to practice in a culturally competent way. c. Maintain and make available to families and health care providers an up-to-date list of health care providers who are bi-lingual and “bi-cultural” and who work with children with special health care needs. d. The CSHCN Program will assure that CSHCN Coordinators and other Public Health Nurses receive training and supervision to deliver intensive care coordination services to families and youth with special health care needs. e. Create plans for how children’s hospitals in Seattle, Spokane and Tacoma can use its telemedicine infrastructure to support medical homes by providing specialty consultations, coordinating care via video-conferencing, and coordinating video-conferences that support medical homes for families and professionals who serve children with special needs. f. Explore developing a plan for using the K-20 video-conferencing system for purposes related to components of medical home.
Youth and Family	
<p>Objective 4 Youth and families have the skills and knowledge to find a medical home and be active partners in a medical home.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Use existing - or create new - action steps for enabling families and youth to be actively involved in a medical home partnership. b. Assure all Public Health Nurses introduce families with children who have a new diagnosis to the concept of medical home and assure all Public Health Nurses link families with a medical home. c. Provide families with tools on how to approach their primary care provider about the medical home concept and what steps to take if dissatisfied.

<p>Objective 5 Youth and families play a significant role in assuring high quality and coordinated services in their medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Train CSHCN Coordinators and other Public Health Nurses to counsel families on how to provide feedback to their primary care provider. b. Parent to Parent, PAVE, Family to Family, and the CSHCN Program Family Consultant will meet with the Medical Home Leadership Network to plan ways to bring trained family leaders to Medical Home Teams to give the teams input on the parent perspective. c. The Washington Family to Family Network and Family to Family will develop action steps to continue to meet to implement the Washington State Medical Home Strategic Plan. d. Research existing resources and develop training material on how parents and youth can advocate for quality, coordinated care for their child or themselves. Develop a plan for getting this training to parents and youth. e. Washington State Parent to Parent will connect with State Parent Teacher Association (PTA) to develop a plan for how PTAs can learn about medical homes and share information about medical homes with parents and local school principals and school building staff. Collaborate with the Family Educator Partnership on this effort. f. Washington State Parent to Parent will work with regional Parent to Parent organizations to develop a plan for advising school nurses on issues related to medical home. g. Parent to Parent has trained volunteers helping parents around the state. Develop a plan for how these parents can play a role in promoting and assuring medical homes. h. Parent to Parent and appropriate partners will develop a plan to notify primary care providers about the existence of Parent to Parent and the benefits of parents of children with special needs having access to others parents of children with special needs. i. Create and post on the Internet or have available through one organization, a list of parents and youth who are willing to serve on advisory board related to medical home issues.
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Primary Care Provider

<p>Objective 6 Primary care providers and their office staff have the knowledge and skills needed to partner in medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Develop a plan for a quality assurance professional to consult with primary care practices on a quarterly basis to assist practices in implementing continuous quality improvement measures. b. Use existing, or develop a new scorecard that practices will use to measure whether they have a medical home for children and youth with special health care needs. c. Train practices how to conduct chart reviews to measure percent of patients that receive developmental screening and fluoride varnishes. d. Provide primary care providers with a list of what features of a practice make a medical home, and include the belief the provider or colleague with access to information about the child should be available around the clock to a family.
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Objective 6, cont.	e. Assess what primary care practices currently do to assure coordinated, quality care for children with special health care needs, and maintain a posting of best practices on the World Wide Web.
<p>Objective 7 Primary care providers identify the special needs of children and youth in their practice and assure quality, coordinated, culturally appropriate services in medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Collaborate with Molina health plan to learn more about their medical home tool and how it can be used to sustain quality medical homes. b. Assess how the linguistic and cultural medical home needs of diverse families are met and whether families of children and youth with special needs perceive their linguistic and culture needs are met. Develop a plan to address any gaps in linguistic and culturally relevant medical home services. c. Host and maintain a list serve related to medical home issues for people who want to discuss medical home questions and work on medical home projects. d. Explore what State and County Interagency Coordinating Councils can do to increase the number of medical homes for children birth to five in Washington State. e. Explore what local school boards can do to increase the number of medical homes for school age youth and children.
<p>Objective 8 Primary care providers and their office staff engage youth and parents as partners in the medical home.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Assess how successful teams have developed and utilized their existing Family Advisory Group, what benefits they found, and how other practices might use the same approach to assure they offer medical homes. b. Identify existing activities in regions around the state that relate to medical home and then develop a plan to coordinate work with these existing efforts.
<p>Objective 9 The Medical Home Leadership Network promotes best practices among Medical Home Teams and other physicians.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. MHLN staff and DOH will develop and hold an interactive conference for MHLN teams in collaboration with the DOH-CSHCN program and other partners. b. MHLN staff and the DOH-CSHCN program will identify funding for team stipends to support team activities. c. MHLN staff will survey teams in 2006 for how to best provide support for their team activities and use team survey results to prioritize and focus type of technical assistance and other support given. d. MHLN teams will share at least twice yearly updates with MHLN staff about medical home activities, outcomes and challenges to be compiled and shared with other MHLN teams, DOH-CSHCN Program and interested groups e. MHLN staff will identify teams and/or physicians to profile and publish their medical home Action Steps in newsletters, the medical home website, and other media.

<p>Objective 9, cont.</p>	<ul style="list-style-type: none"> f. Teach primary care practices and family advisory groups how the <i>Shewhart-Demming Plan-Do-Study-Act Cycle</i> can be used as an approach to creating a medical home within a primary care practice. Use existing Medical Home Teams and parent advisory groups to model this approach and train other practices in its use. g. Maintain a calendar on the Washington State Medical Home web site that lists conferences pertinent to medical home. h. The Medical Home Leadership Network will recruit other primary care provider practices to receive sponsoring and mentoring to learn how to assure medical homes for children with special needs within their practices.
<p>Objective 10 The number of Medical Home Leadership Network Teams will increase each year.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. MHLN staff will identify additional funding for new teams' activities. b. MHLN staff will adapt or develop a toolkit for new teams with suggestions for how to get started. c. At least one new team will be identified and invited to participate in the Spring 2007 MHLN team conference.

Financing

Goal Financing for medical homes is adequate.

5 Year Goal A forum exists for medical home partners to discuss strategies for improving reimbursement and funding for medical homes.

Strategies

- Convene a group of stakeholders to develop an effective strategy for care coordination reimbursement
- Pilot reimbursement and funding strategies developed by the group of stakeholders.
- Use findings from pilots to implement system changes.

System

Objective 1

Reimbursement for health care services is sufficient to allow quality, comprehensive, linguistically and culturally appropriate, coordinated care within a medical home.

Action Steps

- a. DOH CSHCN Program will facilitate and support a workgroup consisting of the Washington Chapter of the American Academy of Pediatrics, Medicaid, health plans, parents and others to develop financing action steps for care coordination within the medical home.
- b. Research the pros and cons of state certification of primary provider practices as “Certified Medical Homes” and apply any beneficial aspects of this practice.
- c. The workgroup will create a plan for assuring primary care providers are reimbursed by insurers for care coordination.
- d. The CSHCN Program will use the \$2,000 Catalyst grant to provide technical assistance as needed to implement WSMHSP action steps via a council that meets on an ongoing basis.
- e. Develop a plan for assuring all health and human service providers who serve families and youth with special needs have cost effective access to interpreters or bi-lingual staff who can communicate with families who do not speak English.
- f. Incorporate Medical Home Leadership Network Teams as part of the public health system.

Objective 2

Public and private financing is sufficient to allow health care providers to coordinate care.

Action Steps

- a. Develop a plan for increasing funding to Public Health Nurses so public health infrastructure has time and personnel to assure medical homes.
- b. Find funding to reimburse Parent to Parent Helping Parents for consulting with both Medical Home Teams and within other primary care practices on how providers can best work with families to make medical homes.

<p>Objective 3 Public and private insurers know how they benefit from medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. The CSHCN Program will contract with local health jurisdictions for public health nurses to routinely work with primary care practices to carry out continuous quality improvement processes using the Shewhart-Demming Plan-Do-Study-Act Cycle. b. Publicize findings from evaluation and research that show quality and cost outcomes of medical home approach (e.g. fewer hospitalizations result). c. Demonstrate to third party payors how medical homes decrease health care costs.
<p>Objective 4 Purchasers of insurance know how they benefit from medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Consult with Aetna health plan on how to work with businesses about how quality control reduces insurance costs for businesses.
<p>Youth and Families</p>	
<p>Objective 5 Families and youth understand health care financing sufficiently to advocate for financing medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Include health care financing to support medical homes as a topic in all strategic plan related venues for families and youth.
<p>Primary Care Providers</p>	
<p>Objective 6 Primary Care Providers and their office staff understand health care financing and practice Action Steps sufficient to promote financing medical homes.</p>	<p>Action Steps</p> <ul style="list-style-type: none"> a. Train primary care providers on the cost and quality effectiveness of conducting patient reviews at one and two years of age, as well as using the technique of sending reminder postcards to families and youth for preventive and needed care. b. Explore the feasibility of a model wherein a facilitator works with many primary care provider practices on a regular basis, consulting in the practices on how to implement continuous quality improvement procedures that lead to medical homes. Do this as part of the work of the workgroup mentioned in this Goal. Molina Health Care has professionals who consult on quality improvement, and they can be studied as a model.