Washington State Medical Home Newsletter

JUNE/JULY 2008

The Washington State Medical Home Project

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AAP Gives Dr. Phyllis Cavens National Award

Phyllis Cavens, MD, FAAP, Medical Director and founder of the Child and Adolescent Clinic in Longview, WA was one of two pediatricians honored nationally by the American Academy of Pediatrics' as a "Local Hero" at the 2007 Annual American Academy of Pediatrics meeting. The AAP Council on Community Pediatrics established the Local Heroes Award to recognize pediatricians who demonstrate exceptional leadership through community action and advocacy for children. The award is presented to individuals who epitomize the "community pediatrician" committed to using community resources to achieve optimal accessibility, appropriateness, and quality of services for all children, to advocate especially for those who lack access to care.

Dr. Cavens is a member of the Cowlitz County Medical Home Leadership Network (MHLN) team. She leads the Child and Adolescent Clinic, a private practice of nine pediatricians, four pediatric nurse practitioners, and 55 employees serving as a medical home for 20,000 children and youth in Southwest Washington. The clinic provides access for all children regardless of insurance status. Dr. Cavens has led community-wide initiatives to address school readiness and mental health of children, youth and families. She is currently, with the help of her practice partners, mobilizing the community to address adolescent transitions, including transitioning youth in foster care. (www.candac.com/index.htm)

WA State Medical Home Learning Collaborative Underway

Medical practices in the 2008-09 Washington State Collaborative to Improve Health are pioneering new approaches to improving medical homes for children with special health care needs. Seven pediatric and family medicine practices are participating as teams.

The medical home teams have determined their pilot populations of children and youth with special health care needs whose care they will track in the new Washington State Medical Home Learning Collaborative. Teams are targeting practice changes to improve the quality of care. Examples include initiation of pre-visit planning and care coordination activities. Pre-work began in January with establishing a patient registry within a current electronic medical record or with the free CDEMS (Chronic Disease Electronic Management System—Microsoft Access database—www.cdems.com).

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County Medical Home Teams Activities

County Medical Home Leadership Network (MHLN) teams across Washington are improving care for children and youth with special health care needs through a variety of strategies. The examples below from the 2007-08 team workplans showcase some of the creative approaches teams are taking.

Improve screening - The *Adams County* team has purchased an ASQ set and is training a local practice on how to use the ASQ to screen infants and young children for developmental delay . *Pierce County* is focusing on autism screening and will train primary care providers and clinic staff how to administer and score the MCHAT.

Develop and distribute materials - *Clark County* is developing a community resources flip chart for providers. *Kittitas County* has integrated their MHLN team and Oral Health Coalition and is focusing on access to preventive and therapeutical dental services for two groups: children with special health care needs and pregnant women. They have developed dental reminder cards (English and Spanish) and oral health information for these groups to be distributed through local OB/GYN, medical and pediatric clinics. *Grant County* has developed 25 local resource notebooks to distribute to providers.

Change office practice – *Odessa Brown Children's Clinic in King County* is a medical home team for both the MHLN and as one of the pilot sites in the WA State Learning Collaborative medical home track. They are identifying children with complex medical conditions/care issues, entering them in a registry and tracking the outcomes of improved care for these children. The team will pilot strategies to improve care coordination and provide planned chronic disease management visits. They are also looking at how to increase parent participation in team activities. The Kitsap team has been doing outreach to local practices and is interested in developing written material with simple, practical tips for practices to improve their "medical homeness."

Organize the community to improve targeted services – *Walla Walla* has facilitated enthusiastic countywide collaboration to improve children's mental health services. The team and partners are working on identifying existing community mental health resources to post on the web, identifying options to expand services including telehealth consultations and training, exploring grant opportunities to fill gaps and improve stability of resources. *Whatcom County* has also mobilized the community through meetings and planning activities to maintain continuation of pediatric specialty outreach clinics in Whatcom as well as supported activities of the early Childhood clinic in promoting early ID and intervention for kids 0-3.

Develop a model community medical home for children in foster care – Cowlitz County is working with community partners to improve care for children in foster care and will develop a training program so that all foster care caseworkers and pediatricians understand the needs of medical home for children in foster care, deadlines for obtaining initial health evaluation and well child exam, plus obtain all needed release of information documents for full exchange of information. MHLN team member Dr. Phyllis Caven's Child and Adolescent Clinic is one of three pilot Centers of Foster Care Health in WA (The other two are Sacred Heart in Spokane and Harborview in Seattle).

Increase provider awareness through Child Health Notes – A growing number of teams are customizing and distributing CHNs locally. Lewis County distributes 4000 CHNs electronically through their monthly Parent to Parent newsletter to providers, parents and school districts. Many other teams are also using CHNs (or will begin this year) and send them send electronically or by mail primarily to local primary care providers and other service providers. These counties include *Clark, King, Kitsap, Adams, Benton-Franklin, Garfield, and Whatcom.*

Increase family awareness and use of resources – *Skagit County* received a grant from their local Division of Developmental Disabilities to purchase four 26" monitors and DVD players which they will program with materials for early childhood information and education. The equipment will be displayed in the waiting rooms of 3 medical clinics and 1 state agency. *Grant County* will program electronic picture frames with information for families that can be hung in doctors' offices.

Outreach to providers – *Lewis County* is planning a provider conference focusing on medical home and other relevant topics and *Pierce* a training on autism. Kitsap and many other teams provide onsite talks to practices (food is always recommended!). Child Health Notes are another popular strategy by many teams to increase provider awareness of resources. *Continued on page 4*

Improving Care for Children and Youth with Epilepsy

The Children with Special Health Care Needs Program has been awarded a new three year federal grant to focus on improving community-based system of services for children and youth with epilepsy. Epilepsy is a challenging condition that affects from 6,100 to 15,000 children in Washington. It can seriously affect their lives by causing severe seizures, injuries, lifestyle restrictions, stigma, and depression, all contributing to a poor quality of life. Children with epilepsy who live in rural, under-served areas of Washington and who speak a language other than English have even more difficulty managing their epilepsy because they have less access to the range of needed health care services. Grant activities are targeting medically underserved and rural areas of central Washington where there is a significant Hispanic population. **Yakima and Benton-Franklin counties** have been selected as initial sites. The grant will focus on five distinct groups within these communities: parents of children with epilepsy, youth with epilepsy, primary care providers, specialty care providers, and care coordinators for children with special health care needs. Activities include organizing focus groups (parents and youth), parent trainings, youth advisory groups, learning collaboratives for providers, and multidisciplinary committees. Work is being done in partnership with the Epilepsy Foundation Northwest, parent organizations, local health departments, community health centers, specialty and community-based providers, and the School Nurse Corps. Medical Home teams in these counties have been involved in helping to recruit children and youth with epilepsy and seizures disorders for focus groups and to be involved in learning collaboratives to strengthen provider partnerships.

For more information, contact Yris Lance at 360-236-3585 or Yris.Lance@DOH.WA.GOV

Medical Home Learning Collaborative (continued)

(Continued from page 1)

While all CSHCN can be added to the registry for tracking of care, teams will follow between 50 and 200 patients as a pilot population of their choosing.

The MHLN is very involved in the Medical Home track. Dr. Chris Olson and Dr. Kathy TeKolste are Faculty and Co-Directors for the track. Kate Orville is helping provide technical assistance to teams.

Three of the participating practices are also involved in MHLN teams—Skagit Pediatrics, Odessa Brown Children's Clinic in Seattle, and Olson Pediatrics in Spokane). Additionally, four family medicine practices in Clark County (2), Grant (1) and King (1) are participating. Additional practices are focusing on asthma, obesity and several adult conditions.

Watch for information about change elements, successes and tools embraced by these early adopter practices!

More information:

www.doh.wa.gov/cfh/wsc/

Health Literacy and More CME Credit!

I. Health Resources and Services Administration has developed a **five module, self-paced course on health literacy** designed to help health professionals improve patient communication skills, increase awareness of factors that affect communication with patients and implement patient-centered communication practices. The five modules take about 5 hours to complete and you can receive CME, CNE, and other credits for completion. See: www.hrsa.gov/healthliteracy/training.htm

II. **Assuring Quality Care for People with Limited Health Literacy— Valid for 0.5 CME credit through 1/25/2009:** A review of the latest information about limited health literacy, communication skills and clinical interventions that may improve health communication for all patients., Available at: www.medscape.com/

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Funded by the Washington State Department of Health
Children with Special Health Care Needs Program

Team Activities continued from page 2

Strengthen and further develop MHLN team– Many MHLN teams have been active for 10 to 13 years. A number of teams are focusing this year on strengthening the team and expanding team membership. This includes Benton-Franklin, Yakima, Garfield, Grant, and Kittitas.

Summary of activities by team: www.medicalhome.org/leadership/the_mhln.cfm

To contact teams see Teams by County or email Kate Orville (orville@u.washington.edu) for a list of MHLN team coordinators.

Foster Care Resources

The June MHLN conference calls with team members identified a strong interest in how to improve health care for children in foster care. Pat Shaw, Parent-Child Health Director of Clark County, reported on a presentation she heard by Moira Szilagiyi, MD, PhD, Medical Director of Foster Care Pediatrics in Rochester, NY. Dr. Szilagiyi has written a book Pat highly recommends called "Fostering Health: Health Care for Children and Adolescents in Foster Care." More information about Dr. Szilagiyi can be found at: www.urmc.rochester.edu/pr/news/story.cfm?id=1702

New Resources— Transition Letters, New Child Health Notes

Adolescent Transition Letters

For youth with milder intellectual impairment or chronic childhood onset disorders (or their parents), the Adolescent Health Transition Project has developed a set of three letters for early, middle and late transition years. These letters highlight issues and resources available to start the process of learning about and managing a youth's health issues and transitioning to an adult health care setting. The letters direct the youth to web resources to improve their knowledge and self-management skills and anticipate needs as they move to adult health care providers.

http://depts.washington.edu/healthtr/

Then go to Transitions section and click on 'Transition Letters'

New Child Health Notes

* Epilepsy: Care Coordination for Children and Youth
* Autism Spectrum Disorders—Early Identification

www.medicalhome.org/leadership/chn_topics.cfm

VISIT OUR WEBSITE!

www.medicalhome.org

Primary Care Collaboration with Mental Health

Examples of innovative collaborative projects between primary care clinicians and mental health providers have been collected by the AAP and are available at:

http://www.aap.org/commpeds/dochs/mentalhealth/mh3co.html