Washington State Medical Home Newsletter

Summer 2009

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Issue Focus: Medical Home Activities 2008-09

Medical Home Leadership Network (MHLN) teams

This issue of the WA State Medical Home newsletter shares some of the work being done by Medical Home Leadership Network (MHLN) county resource teams and communities. Teams have been especially active in the areas of :

* Early diagnosis of autism spectrum disorders
* Care coordination for children with epilepsy, especially from Spanish speaking families
* Outreach to primary care providers and others through formal presentations and the use of Child Health Notes
* Developmental screening
* Quality improvement activities in the clinic
* Improving coordination between mental health services and medical homes

Medical Home Team Activities

Outreach to Primary Care Providers

The **Kitsap County MHLN team** has outreach as a primary component of their activities and does regular lunchtime presentations to staff at community hospitals and clinics. The team adapted a "Menu for Building a Medical Home" from the New England SERVE physician brochure. The team has found the handout very helpful in explaining the medical home concept to audiences.

Kathy Avery, team coordinator and Lead Family Resource Coordinator, reports that going back to a site more than once seems to be helpful in increasing the awareness and understanding of clinic staff about medical homes. She reports that audiences have been especially interested in how to refer to and navigate community services, as well as and ensure ongoing case management for their children with special needs. The team recently presented to a new audience– hospital social workers– who were very interested in the information the team had to share.

The Kitsap team, through the Kitsap County Health District, distributes Child Health Notes to local primary care providers on a quarterly basis. On the advice of their team physician, **Dr. Al-Agba**, they mail printed copies to providers. The team shares appropriate CHNs with additional audiences as well. **Lori Zumwalt**, CSHCN Coordinator, adapts some of the CHNs for child care centers and sends each one a laminated copy (the team is considering doing the same for each health care clinic as well). **Sherry Charlot**, Parent to Parent Coordinator, also distributes some of the CHNs to Parents as part of the local P2P newsletter.

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Three WA Pediatric Clinics Awarded 2009 CATCH Planning Funds

Congratulations to the three WA Pediatricians awarded 2009 Community Access to Child Health (CATCH) Planning-Grants from the American Academy of Pediatrics. All three pediatricians are affiliated with clinics participating on MHLN teams (Skagit and Lewis).

Frances Chalmers, MD– Skagit Pediatrics- Mount Vernon, WA
"*Personal Health Records for Children in Foster Care*"

"Children in foster care are often medically complex. They need a medical home but their increased mobility and multiple changes in health care providers challenge the proper delivery of medical home services. Doctors who care for them are faced with little access to their past medical history (PMH), thus services can be omitted or duplicated. Personal health records (PHR) offer a solution to this problem as a "virtual medical home." For this project, a network of community professionals will be surveyed and asked to participate in focus groups to determine the scope of the health information gap and the potential for an electronic personal health record PHR to help fill that gap. A PHR will be developed that will include a basic health information system tailored to the needs identified by the focus groups. An implementation grant proposal will be developed to pilot the PHR with children at risk of entering the foster care system".

Jennifer Polley, MD– Northwest Pediatric Center—Centralia, WA
"*Lewis County Childhood Obesity Action Coalition*"

"Our community seeks to form a sustainable, multi-disciplinary coalition to assess and ultimately determine local promising practices to address the childhood obesity trends in our county. A community assessment will be conducted, which will be invaluable in informing the coalition's decision making process regarding appropriate interventions. In addition, forming stronger partnerships will help us to broaden community support for this issue".

Isaac Pope, MD, MPA—Centralia, WA -"*Autism Learning Center*"

"Children who exhibit aggressive/destructive behaviors (kicking, biting, punching, etc) associated with autism spectrum and related disorders cause many problems in the home and the community. At school, such behaviors create disruption and can lead to injuries. Pediatricians have limited treatment options including psychotropic medications or behavioral approaches. Yet children with autism-like behaviors have difficulties interacting with communication and social contacts. The Autism Learning Center project will create an innovative environment with quiet private places and small workstations (individualized learning units) where children with autism-like behaviors can acquire skills calmly and safely. Project activities include task force development and meetings, community presentations, interviews with families and teachers, program development and grant writing. The project will align its work with the AAP Washington Chapter and Bright Futures' focus on developmental and autism screens".

The CATCH program supports pediatricians who work with communities to ensure that all children have medical homes and access to other needed health care services. CATCH provides training, technical assistance, peer support, networking opportunities and funding opportunities for project development. The program offers funding up to $12,000 to pediatricians and up to $3,000 to pediatric residents to plan or implement a community project. Applications for CATCH implementation grants are received November through January. Applications for CATCH planning grants are accepted May through July. . For more information, please visit www.aap.org/catch.

Previous WA State CATCH grantees on MHLN teams include: Dr. Phyllis Cavens (Cowlitz- "Community Medical Home for Child Psychiatry 2006, "Creating Greater Clinical Involvement in Signing Up Children for Medical Insurance" 2001, and "Returning Medical Dropouts to Their Medical Home" 2000), **Dr. A. Chris Olson (Spokane**- "Establishing a Spokane ADHD Care Model"), **Dr. Katherine TeKolste (MHLN Staff**- "Partners in Child Psychiatry"2005), **Dr. Diane Liebe (Yakima**- "The Learning Clinic" 2001 and "Behavioral Assessment Team" 1996), **Dr. Benjamin Danielson (King**– "ADHD in Urban Population– Access to Care, Regional Resources and Community Perception" 2000), and **Dr. Ken Gass (Whatcom**– "Healthy Children Project" 1996).

Medical Home Teams Activities cont….

The **Cowlitz** Child and Adolescent Clinic is collaborating with the Progress Center, their local early intervention center, to screen all children under age 5 with the Ages and Stages Questionnaire in a project they call TLC (Tracking Learning Children). Questionnaires are mailed out by the Progress Center. Items with parent concerns or scored outside norms are given to the clinic nurse to review and follow up on. (TLC brochure in Word) Hilary Gilette Walch, RN presented on the developmental screening work of Dr. Phyllis Cavens and their Cowlitz medical home colleagues this spring in two conference calls to MHLN teams and Medical Home Learning Collaborative teams. www.medicalhome.org/leadership/presentations.cfm.

The Adams County MHLN team continue their interest in developmental screening. They are ordering the ASQ3, the newest version of the Ages and Stages Questionnaire to share with the largest medical practice in Adams. The CSHCN program already uses the ASQ when children are referred to the program.

Walla Walla has used their MHLN team to organize well attended monthly county meetings focusing on promoting mental health of children ages birth to five. Their new focus for 2009-10 will be on exploring options for bringing a multidisciplinary autism spectrum disorder diagnostic team to Walla Walla.

Members of the **Yakima** and **Benton Franklin** MHLN teams have been very involved in the pilot sites for the Dept of Health's Epilepsia en Washington grant. The primary target group has been rural children and youth with a seizure disorder from Spanish-speaking families. The project has involved focus groups with parents and with youth who have a seizure disorder, collaboration with school nurses, other care coordinators, and neurologists. They have also collaborated with the Center for Children with Special Needs on identifying and adapting care coordination tools such as a seizure action plan and wallet-sized medication list. Free Epilepsy Care Organizers are available for children in WA with a seizure disorder.

The Odessa Brown Children's Clinic (Seattle) MHLN team participated in the WA State Medical Home Learning Collaborative track this year. Their work included developing a registry of children with complicated health care needs, scheduling longer appointments for these children, and beginning to do previsit planning in preparation for chronic care visits. The top conditions in their registry of more complex kids included were first sickle cell, then autism. Also included in the registry were children with minor medical issues but very difficult social situations.

The **Spokane** MHLN team provided outreach to community providers by hosting the AAP medical home webinar series locally and distributing CHNs. Dr. Chris Olson and his clinic also participated in the (*See page 6 for more*)….

Building Your Medical Home Toolkit– Clinic Resource

The American Academy of Pediatrics Medical Home Toolkit supports your development and/or improvement of a pediatric Medical Home. It also prepares you to to apply for and potentially meet the National Committee for Quality Assurance (NCQA) Physician Practice Connections® Patient Centered Medical Home (PPC-PCMH™) Recognition program requirements. The AAP created a crosswalk between each of the Toolkit building blocks and the NCQA PPC-PCMH Recognition Program 'must pass' elements. The Toolkit is organized into six building blocks that provide guidance for Medical Home implementation with links to downloadable tools:

- Care Partnership Support
- Clinical Care Information
- Care Delivery Management
- Resources and Linkages
- Practice Performance Measurement
- Payment and Finance

The Lead Toolkit Consultant was Jeanne McAllister, BSN, MS, MHA. Director of the Center for Medical Home Improvement and co-author of the Medical Home Index. **Dr. A. Chris Olson,** Spokane MHLN team, provided input to the project through his participation on the AAP Medical Home Implementation Project Advisory Committee.
www.pediatricmedhome.org/

MHLN Team Workplans 2008-09

MHLN teams have been busy this past year with a variety of activities to improve medical homes for children and youth with special health care needs! Many teams distribute Child Health Notes to primary care providers and others serving children. Teams that submitted a simple workplan received an honorarium to help support their local activities. Below is a list of the primary activities of teams across the state as detailed in their workplans.

As of July 1, 2009 teams can submit new workplans for 2009-10 and receive $200 to help support this coming year's activities. For more information, contact Kate Orville (oville@u.washington.edu or 206-685-1279).

Team	2008-09 MHLN Team Workplans—Primary Focus
Adams	Screening children for developmental delay by purchasing the new ASQ for use in the largest medical practice in the county and through the CSHCN program upon referral
Benton-Franklin	Improve understanding of local PCPs of medical home concept and their roles in medical homes, as well as the needs of CYSHCN. Explore electronic distribution of Child Health Notes to providers.
Clark	Improved connection between parents, providers of services to CYSHCN and community resources with the use of a flip chart style community resource guide
Cowlitz	Training to mental health providers on the role of the medical home in mental health service delivery
Garfield	Increase knowledge of MHLN team of medical home in order to share information in county
Grant	No workplan submitted for 2008-09
King	Explore options for expanding team and work activities in County; email Child Health Notes to King County providers, Sea-King Public Health Providers, Community clinics, pediatric hospitals, and health plans quarterly
King - Odessa Brown	Participate in the Medical Home track of the WA Learning Collaborative and develop systems to better provide care including care coordination for CYSHCN at Odessa Brown clinic.
Kitsap	Training to PCPs via Child Health Notes, presentations, information packets. Will also develop a plan to increase awareness of children's mental health issues and available resources
Kittitas	Increased access to early intervention and support for families with children with special needs through outreach to medical clinics and other agencies about 0-3 and CSHCN programs and outreach to KVCH about assistance available to families of infants with hearing loss.
Lewis	Increase public awareness and collaborative effort of doctors to provide medical homes for CYSHCN
Pierce	Improved early identification and diagnosis for children with ASD by continuing to develop ASD diagnostic and treatment program at Mary Bridge Children's Hospital; collaborate with state Combating Autism Advisory Council to improve diagnosis and treatment in WA; develop and produce prototype diagnostic process pyramid.
Skagit	Prepare slides for broadcast and utilize public access TV station to broadcast EIs, CSHCN , Parent to Parent and other Contact information
Snohomish	No workplan submitted for 2008-09 but will submit in 2009-10
Spokane	Increase provider knowledge of medical home resources and strategies for CSHCN by hosting AAP medical home webinar series spring 2009 and distributing at least one CHN to community providers
Walla Walla	Continue monthly medical home team meetings which improve coordinated care for CYSHCN in the community and remain advocates for increased service to children
Whatcom	CHNs, support activities of the Early Childhood Evaluation Clinic in promoting early ID and intervention for children 0-3, and promoting ongoing collaboration between agencies serving CSHCN with a focus on maintaining continuation of Pediatric Specialty Outreach Clinics in Whatcom County.
Yakima	Early identification, diagnostic and intervention programs for children with Autism Spectrum Disorders

Recent Medical Home Publications of Interest

New Evidence Supports the Pediatric Medical Home

A team of child health researchers developed a 2 page brief regarding evidence about the pediatric medical home entitled "Medical Home for Children with Special Healthcare Needs -A Review of the Evidence." This report shows how medical home implementation leads to improvements in important outcomes for children and youth with special healthcare needs (CYSHCN) and their families. This work was carried out for the Maternal and Child Health Bureau and represents a collaboration among the MGH Center for Child and Adolescent Health Policy, NICHQ, and the Child and Adolescent Health Measurement Initiative.

www.nichq.org/CYSHN/index.html

Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework

May 21, 2009 | Volume 110 .

Authors: Richard C. Antonelli, M.D., M.S., Jeanne W. McAllister, B.S.N., M.S., M.H.A., and Jill Popp, M.A.

www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/May/Making-Care-Coordination-a-Critical-Component-of-the-Pediatric-Health-

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Making Medical Homes Work: Moving from Concept to Practice

Key operational issues facing medical home initiatives include how to qualify physician practices as medical homes; how to match patients to their medical homes; how to engage patients and other providers to work with medical homes in care coordination; and how to pay practices that serve as medical homes, according to a new Policy Perspective from researchers at the Center for Studying Health System Change (HSC) and Mathematica Policy Research (MPR). www.hschange.com/CONTENT/1030/ (Dec, 2008)

Access to the Medical Home: New Findings From the 2005-2006 National Survey of Children With Special Health Care Needs

Bonnie B. Strickland, PhD[a], Gopal K. Singh, PhD[a], Michael D. Kogan, PhD[a], Marie Y. Mann, MD, MPH[a], Peter C. van Dyck, MD, MPH[a] and Paul W. Newacheck, DrPH[b,c]

PEDIATRICS Vol. 123 No. 6 June 2009, pp. e996-e1004 (doi:10.1542/peds.2008-2504)

RESULTS. Results of the survey indicate that (1) approximately one half of CSHCN receive care that meets all 5 criteria established for a medical home; (2) access to a medical home is affected significantly by race/ethnicity, income, health insurance status, and severity of the child's condition; (3) parents of children who do have a medical home report significantly less delayed or forgone care and significantly fewer unmet needs for health care and family support services; and (4) limited improvements have occurred since success rates were first measured by using the 2001 NS-CSHCN.

CONCLUSIONS. The findings suggest that, although some components of the medical home concept have been achieved for most CSHCN, care synonymous with the principles underlying the medical home is not yet in place for a significant number of CSHCN and their families.

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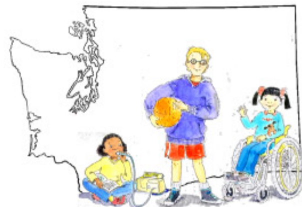

Funded by the Washington State Department of Health
Children with Special Health Care Needs Program
www.doh.wa.gov/cfh/mch/cshcnhome2.htm

Child Mental Health Phone Consultation

The Partnership Access Line (PAL) is a telephone -based child mental health consultation system funded by the state legislature, being implemented now in Washington State. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital to deliver its consultation services. Though PAL is just contracted to provide service to 1/3rd of the state, (DSHS Regions 1 & 6) at this time the PAL team is making itself available to any primary care provider throughout WA.

Washington's primary care providers are encouraged to call the PAL **toll free number 866-599-7257** as often as they would like. PAL provides rapid consultation responses during business hours (M-F, 9-5) for ***any*** type of child mental health issue that arises with ***any*** child.

What does a provider get by calling PAL?

* immediate phone advice from an expert
* free tools to help you and your patient (like patient advice handouts, rating scales, local resource lists tailored to your patient, etc.)
* access for your DSHS or Healthy Options patients to a rapid in- person or telemedicine consultation with a child mental health expert at Seattle Children's Hospital
* For children covered by Medicaid's Fee for Service program, the department will reimburse providers participating in the Partnership Access Line (PAL) program for a peer-to-peer phone contact. This fee is only available to providers who discuss the clinical management of a child, who has a mental health condition, with a PAL pediatric psychiatrist at Seattle Children's Hospital. Participation in the PAL program will be confirmed.

See www.palforkids.org/ for more information.

MHLN Team Activities– Continued from page 3…

medical home learning collaborative as faculty and as a medical home quality improvement pilot site. The practice developed a registry of children with complicated medical needs as well as a process and forms to do previsit phone calls for children on the registry. As a result of the previsit work, the clinic reports improved medical summaries in the charts, more effective visits and greater family and clinician satisfaction with visits. The practice also developed a new website with some patient forms and medical home information. (www.olsonpeds.com/)