National Performance Measure 11: Medical Home

Resources for State Title V Programs to Achieve National Performance Measure 11 (medical home)

Created by the National Center for Medical Home Implementation (NCMHI), a cooperative agreement between the American Academy of Pediatrics (AAP) and the Maternal and Child Health Bureau (MCHB)

General Resources

- National Center for Medical Home Implementation Web site
- National Center for Medical Home Implementation e-Newsletter and Listserv
- Building Your Medical Home: An Introduction to Pediatric Primary Care Transformation

Technical Assistance and Support

Medical_home@aap.org

Contact the National Center for Medical Home Implementation for resources, support, connection to medical home experts, and other technical assistance requests.
**Resources to Support Family-Centered Medical Home Implementation**

The National Center for Medical Home Implementation (NCMHI) provides practical, evidence-based and evidence-informed resources for Title V programs to enhance components of the family-centered medical home, as identified through the National Survey of Children with Special Health Care Needs.

<table>
<thead>
<tr>
<th>Access to Usual Source of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies to Enhance Access to Care for Hispanic Children, Youth, and Families</strong>&lt;br&gt;This fact sheet provides practical lessons learned for clinicians, states, and community based organizations to increase access to care for Hispanic children and youth.</td>
</tr>
<tr>
<td><strong>Innovative and Promising Practices in Pediatric Medical Home Implementation</strong>&lt;br&gt;This collection of evidence-based and evidence-informed promising practices in pediatric medical home implementation presents numerous strategies to enhance access to usual sources of care for children and youth.</td>
</tr>
<tr>
<td><strong>Annual Webinar Series</strong>&lt;br&gt;The NCMHI hosts an annual webinar series that focuses on increasing access to care through enhanced cultural competence, care coordination, family-centered care, and other practical strategies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obtaining Needed Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family-centered Care Coordination Questionnaire</strong>&lt;br&gt;A customizable form families can complete to inform pediatric primary clinicians of needed referrals and services.</td>
</tr>
<tr>
<td><strong>Co-management Letter and Agreement</strong>&lt;br&gt;A customizable form which allows primary care clinicians to establish care coordination/co-management agreements with specialists for children and youth with special health care needs.</td>
</tr>
<tr>
<td><strong>Community Resource List</strong>&lt;br&gt;Suggestions for resources within states and communities that pediatric practices can use to educate families and coordinate successful referrals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family-centered Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementing Family-centered Care</strong>&lt;br&gt;Practice-based resources Title V programs can use to support implementation of family-centered care in pediatric practices.</td>
</tr>
<tr>
<td><strong>Fostering Partnership and Teamwork in the Pediatric Medical Home: A “How-To” Video Series</strong>&lt;br&gt;Instructional videos on how to implement care partnership support, shared decision making, family advisory councils, and team huddles in practice.</td>
</tr>
<tr>
<td><strong>Positioning the Family and Patient at the Center: A guide to Family and Patient Partnership in the Medical Home</strong>&lt;br&gt;A monograph showcasing replicable family-centered care strategies from 17 pediatric practices across the country.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Coordination and Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Center for Care Coordination Technical Assistance</strong>&lt;br&gt;Part of the NCMHI, this National Center provides technical assistance and support to Title V programs, clinicians, and families around the utilization of the following resources:&lt;br&gt;  - Pediatric Care Coordination Curriculum&lt;br&gt;  - Care Coordination Measurement Tool</td>
</tr>
<tr>
<td><strong>Care Coordination Webinar Series</strong>&lt;br&gt;A three-part recorded webinar series that provides practical strategies for implementation, sustainability, and measurement of cross-care coordination activities.</td>
</tr>
<tr>
<td><strong>Implementing Care Coordination</strong>&lt;br&gt;States can download customizable forms to facilitate cross-system care coordination in pediatric practices.</td>
</tr>
</tbody>
</table>
Evidence-Based/Evidence-Informed Strategies

The NCMHI can assist Title V programs in implementing evidence-based and evidence-informed strategies to increase performance on National Performance Measure 11, medical home.

### FAMILY ENGAGEMENT

Support practices and programs with technical assistance to develop and implement family engagement activities and programs.

**Overview**

Family engagement is a key component of family-centered care and medical home implementation. Title V programs can assist pediatric practices in their states to enhance family engagement. The National Center for Medical Home Implementation (NCMHI) is currently implementing a Family Engagement Quality Improvement Project that focuses on assisting 10 primary care pediatric practices in improving family engagement through shared decision-making and connection of families to appropriate supports and services.

Title V programs can use this project’s aim, measures, resources/tools, and strategies to provide technical assistance to pediatric practices within their states.

**Tools, Resources, and Strategies**

- **Family Engagement Practice Assessment Survey**
  A 6-question family survey that can be used to assess family engagement practices within a particular primary care practice. The survey is written in plain language and available in English and Spanish.

- **Change Package**
  A comprehensive change package (resource list) is under development and will include resources that can be used in practice to improve family engagement.

- **Family Engagement Quality Improvement Implementation Toolkit**
  As a result of this project, the NCMHI will create a comprehensive online toolkit that can be used by states to implement similar quality improvement projects. The toolkit is tentatively scheduled for release in January 2017.

### CROSS-SYSTEM CARE COORDINATION

Support and facilitate cross-system care coordination; create a comprehensive shared plan of care template that can be used practice-wide and across systems of care for children and youth with special health care needs (CYSHCN).

**Overview**

States can support implementation of cross-system care coordination between families, primary care practices, specialists, community resources, schools, and other systems of care for children and youth. In particular, states can support the creation of a comprehensive shared plan of care that can be used across systems of care for CYSHCN.

**Tools, Resources, and Strategies**

- **National Center for Care Coordination Technical Assistance**
  The National Center for Care Coordination Technical Assistance (NCCCTA) is a partnership between the NCMHI and Boston Children’s Hospital Integrated Care Program. The mission of the NCCCTA is to support the promotion, implementation and evaluation of care coordination activities and measures in child health across the United States. The following resources are available through the NCCCTA:
    - [Pediatric Care Coordination Curriculum](#)
    - [Care Coordination Measurement Tool](#)
    - [Technical Assistance](#)
• One hour of introductory technical assistance regarding the Pediatric Care Coordination Curriculum, Care Coordination Measurement Tool and the Pediatric Integrated Care Survey.
• Two additional hours of technical assistance in the adaptation, implementation and evaluation of the aforementioned tools.
• Assistance and support through email, as necessary.

• Creating Shared Plans of Care
  
  o Implementation Guide: Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs
    Published by the Lucile Packard Foundation for Children’s Health, this comprehensive guide describes the process of creating a shared plan of care in partnership with families.
  
  o Care Plan Template
    Created by the National Institute for Children’s Health Quality, this interactive care plan can be used as a template by pediatric primary care practices.
  
  o Creating a Shared Plan of Care From the State Perspective (Coming June 2016)
    The NCMHI, in partnership with the National Academy for State Health Policy (NASHP), will be publishing a fact sheet focused on how states are supporting implementation of shared plans of care for CYSHCN.

OUTREACH TO COMMUNITIES AND FAMILIES

Outreach to communities and families about the availability and benefits of the pediatric medical home model of care.

Overview

Communicating about the medical home model of care to communities and families is an important strategy to promote implementation of the model.

The National Center for Medical Home Implementation conducted a community-based project that focused on the provision of education, outreach, and capacity building related to pediatric medical home access and utilization in a Hispanic community.

Tools, resources, evaluation strategies, and lessons learned from this project are available to state Title V programs for utilization and replication.

Tools, Resources, and Strategies

• Strategies to Enhance Care for Hispanic Children, Youth, and Families
  This fact sheet provides practical lessons learned for clinicians, states, and community based organizations.

• Training-of-Trainers Curriculum
  This curriculum was used to build capacity among family leaders to improve community outreach, family advocacy and engagement in pediatric medical home activities.

• Skills-building Scenarios
  Based on real events, these scenarios were used to train family leaders in family advocacy and community outreach skills related to pediatric medical home.
From the National Center for Medical Home Implementation, supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS).

A collection of tools and resources for pediatric clinicians, state agencies, and family advocates looking to implement care coordination. Look for the National Center for Care Coordination Technical Assistance (NCCCTA) under the "Technical Assistance and Support" heading. Contact us for technical assistance and support related to care coordination.

https://medicalhomeinfo.aap.org/tools-resources/Pages/Care-Coordination.aspx
Measurement

- **Care Coordination Measurement Tool**
  Created by Boston Children’s Hospital with support from the Maternal and Child Health Bureau, this value capture tool tracks care coordination activities and outcomes that are currently being done but are not being tracked or reimbursed.
  - Data collected by the tool assesses the amount and type of resources needed to adequately provide care coordination services to a patient population and the outcomes that both occur and that are prevented from performing these care coordination activities.
  - The tool reflects the true cost and value of care coordination activities. It allows care coordination staff to quantitatively demonstrate how successful care coordination leads to cost-savings and better outcomes for patients and their families.
  - The tool can be used by any individual, program, and/or organization providing care coordination services.
  - The core tool can be adapted to fit the needs of various entities including the following:
    - Pediatric primary and specialty care
    - Adult primary and specialty care
    - Research facilities and projects
    - Title V programs
    - Family advocacy and leadership programs

Additional Tools and Resources

- Additional tools and resources to assist with care coordination implementation include the following:
  - Care Coordinator Job Description
  - Parent Consultant Job Description
  - Special Needs Consultation and Care Coordination Program Job Description
  - Care Coordination Webinar Series
  - Enhancing Care Coordination through Patient- and Family-Initiated Telephone Encounters: A Quality Improvement Project
  - Building Your Medical Home: Coordinated Care
  - Care Coordination Resources for Practices

Technical Assistance and Support

- **National Center for Care Coordination Technical Assistance**
  The National Center for Care Coordination Technical Assistance (NCCTA) is a partnership between the National Center for Medical Home Implementation and Boston Children’s Hospital Integrated Care Program. The mission of the NCCTA is to support the promotion, implementation and evaluation of care coordination activities and measures in child health across the United States.
  - The following technical assistance and support is available to individuals interested in implementing care coordination:
    - One hour of introductory technical assistance regarding the Pediatric Care Coordination Curriculum, Care Coordination Measurement Tool and the Pediatric Integrated Care Survey.
    - Two additional hours of technical assistance in the adaptation, implementation and evaluation of the aforementioned tools.
    - Assistance and support through email, as necessary.

- **Contact us for technical assistance and support.**
- **View a comprehensive poster describing the National Center for Care Coordination Technical Assistance.**
- **To learn more about these care coordination tools, please visit the Boston Children’s Hospital Coordinated Care Web site.**

Community of Learners

- The National Center for Care Coordination Technical Assistance is developing an interactive listserv that will foster a virtual community of those interested in and focused on care coordination activities and measures. If you are interested in joining the listserv, please email Hannah Rosenberg at Hannah.Rosenberg@childrens.harvard.edu.
Lessons learned from a community-based project from the National Center for Medical Home Implementation in partnership with the Rhode Island Parent Information Network and the Rhode Island Department of Health, Office of Special Needs.

Only 33% of Hispanic children and youth with special health care needs (CYSHCN) in the United States receive and have access to high quality primary care.

Results from the “Salud Para Todos” project identified strategies to do the following:
- Effectively engage culturally and linguistically diverse Hispanic families in their child’s care
- Increase the number of Hispanic children and youth who have access to and receive care within a medical home

**Practices and Clinicians**

**Strategies to Enhance Care for Hispanic Children, Youth and Families**

**Support Family Readiness**
Be aware of varying levels of readiness and ability to participate in shared decision-making by culturally and linguistically diverse Hispanic families. Some families, particularly recent immigrants, may be unfamiliar with shared decision-making as a strategy in provision of care. Provide tools and resources to families to ensure they are able to make informed decisions based on their own knowledge, beliefs, and personal readiness.

**Use Cultural Brokers**
Bicultural peer navigators, parent partners, community health workers, or care coordinators can play an important role in enhancing care for culturally and linguistically diverse families.

**Avoid Jargon**
Families, caregivers, and even practice staff may not be familiar with and intimidated by medical home jargon such as family-centered care and care partnership support. Frame the medical home model in terms of relationship building, using words and exhibiting actions that exemplify trust and respect.

**Use Patient Education Tools and Resources that Take Culture into Consideration**
Language and culture varies from region to region, even within the same country of origin for Hispanic patients and families. Ensure that bicultural community members help with the development and/or review of patient education materials to enhance cultural competency.

**Offer Accessible Resources**
Offer patient and family educational materials in multiple formats, including hard copies, electronic, and illustration-based formats for families with low literacy skills. Whenever possible, consult with interpreters to enhance language access of resources and materials offered.

**Encourage Team-based Care**
Involve all practice staff in family engagement activities through lunchtime discussions, team meetings, and team huddles. Whenever possible, include interpreters as members of the health care team.

**Refer to Peer Supports**
Refer families and caregivers to peer supports, such as state Family-to-Family Health Information Center(s).

More information available on next page
State and Community-Based Organizations Strategies for Implementing Pediatric Medical Home Projects for Hispanic Communities

**Build Relationships First**
Begin any medical home improvement project by building trust and respect with families, caregivers, and the community. Consider a slow, intentional approach to improvement based on the needs of the community and families, rather than implementing changes immediately.

**Ask “What’s in it for them?”**
Identify a unique need within the community for enhancing the number of children who receive care within and access to pediatric medical home; this need may be different from the need of a state agency or organization.

**Find Motivated Community Members**
Find bicultural community members to lead outreach within the community and explain medical home project implementation goals in a way that is culturally relevant to families and caregivers.

**Engage the Neighborhood**
Identify stakeholders in the community to guide development of the project. These stakeholders may include, but are not limited to, the following:
- Family-to-Family Health Information Centers
- State American Academy of Pediatrics chapters
- Maternal and Child Health programs (Title V)
- Community health centers and Federally Qualified Health Centers
- Schools
- Insurance agencies
- Religious organizations
- Advocacy organizations
- Early education and child development centers (such as Head Start)

**Provide Incentives**
Provide incentives—financial and non-financial—for family members and caregivers to participate in projects and activities.

**Avoid Jargon**
Community members may not be familiar with or may be intimidated by medical home jargon such as “family-centered care” and “care partnership support.” Frame the medical home model in terms of relationship building, using words and exhibiting actions that exemplify trust and respect.

**Offer and Acknowledge Professional Development**
Through formal and informal channels, state and community-based organizations can explore opportunities to offer family members and community members with professional development opportunities and acknowledgements. This may include presenting certificates of participation to family members or distributing letters of gratitude from the organization facilitating the project.

**Use Tools and Resources that Take Culture into Consideration**
Language and culture varies from region to region, even within the same country of origin for Hispanic patients and families. Ensure that bicultural community members help with the development and/or review of patient education materials to enhance cultural competency.

**Offer Accessible Resources**
Offer patient and family educational materials in multiple formats, including hard copies, electronic, and illustration-based for families with low literacy skills.

**Proactively Seek Family and Community Feedback**
Ensure program goals, objectives, and methodology are family-centered and culturally competent by seeking feedback from families throughout the project by using the following strategies:
- Involving families in the development of the project—from the conceptual phase to implementation and evaluation
- Creating meaningful roles and responsibilities for family members
- Creating a comfortable environment for information sharing through the utilization of community spaces and encouraging bicultural facilitators to lead discussions
- Providing information on how family feedback has been utilized to facilitate change or strategic planning
- Asking questions about cultural implications of project goals, objectives, and methodology

---

**Resources**
- Medical Home Data Portal
- Community Tool Box (English and Spanish)
- Sustaining Pediatric Community-based Initiatives
- Growing Your Capacity to Engage Diverse Communities
- Family Engagement in Title V
- iSpeak Cards
- Diversity RX
- Training Materials from “Salud Para Todos” Project:
  - Promoting Child Health in Partnership with Clinicians and Families: Presentation for Pediatric Practices
  - Promoting Child Health in Partnership with Clinicians and Families: Presentation for Peer/Family Navigators
  - Peer/Family Navigator Discussion Scenarios
- The National Center for Medical Home Implementation Web site

---

For additional information about the “Salud Para Todos” project, including evaluation and training materials, contact Alex Kuznetsov (akuznetsov@aap.org).
Overview of the Family Engagement Quality Improvement Project

A project of the National Center for Medical Home Implementation, a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau in the Health Resources and Services Administration.

The Family Engagement Quality Improvement Project aims to improve family engagement in clinical practice through enhanced shared decision-making and connection of families to appropriate supports and services. This quality improvement project is overseen by an Expert Work Group comprised of experts in pediatric primary care, quality improvement, research, and a national recognized family leader with expertise in quality improvement. The project will meet the standards established by the American Board of Pediatrics (ABP) for Maintenance of Certification (MOC) Part 4.

Ten pediatric primary care teams will be recruited to participate in this project in April and May 2016. Each team will include four members: a pediatrician, nursing or non-pediatrician clinical staff, administrative/front desk staff, and a parent/caregiver partner.

Aim Statement and Measures

By January 2017, 10 pediatric primary care practice teams will work individually and collaboratively to test, implement, disseminate, and plan to sustain strategies that lead to improved family engagement in clinical practice through enhanced shared decision-making and connection of families to appropriate supports and services.

1. 80% or more patients have documentation in their medical record that patient/family concerns were elicited at the most recent health supervision visit.
2. 80% or more patients have documentation in their medical record that patient/family concerns were addressed at the most recent health supervision visit or a plan to address the concerns was made.
3. 80% or more patients have documentation in their medical record that family strengths were identified and discussed at the most recent health supervision visit.
4. 80% or more patients have documentation in their medical record that a post-visit medical summary or a comprehensive care plan was created or updated/maintained at a most recent health supervision visit.
5. 80% or more patients have documentation in their medical record that a current copy of their post-visit medical summary or comprehensive care plan was reviewed through an active form of family engagement and offered to patient/families at a most recent health supervision visit.
6. 80% or more of patients have documentation in their medical record that families received a follow-up discussion of age-appropriate screening results on the same day as the screening.
7. 80% of parents/families will indicate that they can be honest with their child’s doctors and nurses about the choices they make for their child, as measured by a post-visit family survey.
8. 80% of parents/families will indicate that doctors and nurses explained things about their child’s health in a way that was easy to understand, as measured by a post-visit family survey.
9. 80% of parents/families will indicate that doctors and nurses listened to what the family had to say, as measured by a post-visit family survey.
10. 80% of parents/families will indicate that doctors and nurses gave thoughtful responses to their questions and concerns, as measured by a post-visit family survey.
11. 80% parents/families will indicate that receptions and other clinic staff treated them with respect, as measured by a post-visit family survey.
12. 80% parents/families will indicate that doctors and nurses involved them in decisions about their child’s health, as measured by a post-visit family survey.

Project Components

- **Pre-work Period** (May - June 2016, 1 Month)
  - Baseline medical record review (20 medical records per practice using QIDA)
  - Baseline post-visit family survey collection (10 post-visit family surveys per practice using QIDA)
  - Pre-implementation practice survey
  - “Flipped classroom” orientation call
- **Learning Session 1** (June 2016)
- **Action Periods** (July – December 2016, 6 months)
  - Medical record review (10 medical records entered per practice using QIDA)
  - Monthly progress reports (1 narrative report per practice)
  - Monthly conference call participation and any relevant pre-work associated with same
  - Monthly conference call evaluation survey
  - One-on-one quality improvement coaching calls (two calls per practice team)
  - Monthly post-visit family surveys (maximum of 10 surveys collected per practice per month)
- **Post-Action Period** (January – February 2017, 2 months)
  - Post-implementation survey
- **Learning Session 2** (January or February 2017, in-person meeting)
- **Additional Project Components**
  - Expert Work Group
  - Project work space and email group/listserv
  - Parent/caregiver partner
  - Qualitative interviews with practice teams, including parent/caregiver partners (optional)
## Project Timeline

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Project orientation webinar and QIDA demo to understand data collection system</td>
<td>Submit data monthly on up to 10 patients via medical record reviews and on up to 10 patients via post-visit family surveys using QIDA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submit data on up to 20 patients via medical record reviews and on up to 10 patients via post-visit family surveys using QIDA</td>
<td>Submit data monthly on up to 10 patients via medical record reviews using QIDA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project orientation webinar and QIDA demo to understand data collection system</td>
<td>Submit data monthly on up to 10 patients via medical record reviews and on up to 10 patients via post-visit family surveys using QIDA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submit data on up to 20 patients via medical record reviews and on up to 10 patients via post-visit family surveys using QIDA</td>
<td>Implement interventions using PDSA cycles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project orientation webinar and QIDA demo to understand data collection system</td>
<td>Communicate with other participants via listserv</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submit data on up to 20 patients via medical record reviews and on up to 10 patients via post-visit family surveys using QIDA</td>
<td>Participate in at least two quality improvement coaching calls</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project orientation webinar and QIDA demo to understand data collection system</td>
<td>Participate in at least two quality improvement coaching calls</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submit data on up to 20 patients via medical record reviews and on up to 10 patients via post-visit family surveys using QIDA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project orientation webinar and QIDA demo to understand data collection system</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submit data on up to 20 patients via medical record reviews and on up to 10 patients via post-visit family surveys using QIDA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project orientation webinar and QIDA demo to understand data collection system</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>