NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION

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A Collection of Strategies Used to Support Innovative and Promising Practices in Pediatric Medical Home Implementation

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This publication of the National Center for Medical Home Implementation—a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA) of the United States (US) Department of Health and Human Services (HHS) (Grant Number U43MC09134)—focuses on innovative and promising practices in pediatric medical home implementation. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS, or the US government.

INTRODUCTION

A medical home is an approach to providing comprehensive and high-quality primary care. It is not a building or place; it extends beyond the walls of a clinical practice. A pediatric medical home should include the following seven components of care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. There is an association between access to and utilization of pediatric medical homes to improved health outcomes for the population, increased satisfaction for children and families, and decreased cost of care. As a result of receiving care provided in the context of medical home, children and families are more likely to receive increased provision of preventive services, decreased missed workdays and parental worry, and decreased hospitalizations.[1, 2, 3, 4, 5, 6]

Many initiatives are underway across the country that focus on implementing innovative strategies to address the various components of pediatric medical home. To capture these strategies and promote them broadly, the National Center for Medical Home Implementation (NCMHI or National Center) launched the ***Innovative and Promising Practices in Medical Home Implementation Initiative*** (Promising Practices) in 2015. The initiative provides opportunities for pediatric medical home projects, programs, and practices from across the United States to share implementation strategies. These strategies enhance the delivery of primary care services for children and youth, particularly those with special health care needs and those living in medically underserved communities.

For the purposes of this project, "innovative and promising practices" refer to techniques, strategies, and/or interventions used by pediatric health professionals that show some evidence or expectation of effectiveness of enhancing the medical home model. These techniques, strategies or interventions have been evaluated using methods that may range from less rigorous (single-group designs, exploratory study, and anecdotal or needs assessment) to most rigorous (randomized controlled trials, meta-analytic review, and quasi-experimental designs).

Applications are reviewed by National Center staff and an expert review panel, including representation from pediatricians, families/caregivers, Maternal and Child Health Title V program staff, and other pediatric clinicians. Promising Practices are selected for evidence-informed, exemplary, and replicable strategies in any four of the seven components of pediatric medical home. The selected submissions comprise a resource database of medical home implementation models at the practice, community, state, and national levels that are available to the public to support their medical home implementation efforts. A total of 21 promising practices are currently featured on the National Center Web site.

This summary report includes an overview and highlights from 14 best practices and strategies. It is organized around each of the seven components of medical home. An overview of each component is provided, followed by examples of practical strategies used to accomplish the promising practice.

The summary report is for pediatric clinicians, Maternal and Child Health Title V / Children and Youth with Special Health Care Needs (MCH Title V / CYSHCN) programs, family/caregivers, and other pediatric health stakeholders interested in innovative and replicable strategies in pediatric medical home. Tools and resources from the National Center and partner organizations are also listed to support implementation efforts.

ACCESSIBLE CARE

Children and youth with special health care needs (CYSHCN) and children who are medically underserved/vulnerable utilize primary care and specialty services more frequently than typically developing children.[7, 8, 9, 16]

Accessible care ensures that CYSHCN and their families are receiving adequate care. **Accessible care is care that is easy for the child and family to obtain, including geographic access, access to care that accept their insurance, and access to insurance that allows the family to get care at a reasonable cost.** Below are various strategies to enhance accessible care in the pediatric medical home.

Category	Implementation Strategies	Resources
Commonly utilized implementation strategies	• 24-hour telephone service • Telemedicine consultations • Connecting with families electronically • Expanded clinic appointments by increasing clinic hours	*Strategies to Enhance Care for Hispanic Children, Youth, and Families Fact Sheet*
More complex implementation strategies	• Assist families enroll in health plans/ insurance • Located clinic within a school setting • Conduct a needs assessment or mapping to determine best location for clinic • Co-locate services for children and youth and families within partner entities, such as a women's health clinic	

Accessible care: Enhancing accessibility of the pediatric medical home can greatly increase the number of children and families who are able to receive comprehensive, coordinated pediatric care. One strategy being implemented by Kids Count Pediatrics involves **expanded clinic appointments allowing patients and families to schedule visits later in the evenings or on weekends.** To reach patients and families outside of the clinic, Weiss Pediatric Care and ReadNPlay for a Bright Future both **connect with families electronically** by utilizing a practice Web site, blog, social media sites, and follow-up phone calls. This allows the practices to keep their respective communities updated on services, initiatives, and support being offered.

Adequate insurance coverage is a major barrier to accessible care.[10, 11] West Haven Child Development Center reduces this barrier by **helping families to enroll in health plans and health insurance.** Within their office, West Haven Child Development Center **hosts professionals who can assist and educate families about enrolling in public insurance.**

Geographic location of services also stands as a barrier to accessible care. Children's Care Network **co-locates services in partner entities** to allow clinicians to see patients in other commonly accessed health service locations such as the local health department, the Supplemental Nutrition Program for Women, Infants, and Children (WIC) office, and/or within a women's health clinic. This allows patients and families access to care in a location that is convenient for them. This strategy is also particularly useful in communities where public transportation is not easily accessible or available.

FAMILY–CENTERED AND COMPASSIONATE

According to the American Academy of Pediatrics, patient- and family- centered care **is an innovative approach to planning, delivery, and evaluation of health care that is grounded in a mutually beneficial partnership among patients, families, and providers that recognizes the importance of the family in the patient's life.**[12] Family-centered and compassionate care recognizes and acknowledges that families/caregivers are the primary supports for children and **ensures that all medical decisions are made in true partnership with the family/caregiver.** Below are various strategies to implement and enhance family-centered and compassionate care.

Category	Implementation Strategies	Resources
Commonly utilized implementation strategies	• Engage families/caregivers as members of project advisory committees • Seek and implement family feedback through family satisfaction surveys and family support groups • Implement "teach-back" methodology with families/caregivers • Motivational interviewing	*Family Engagement Quality Improvement Project Implementation Guide* *Enhancing Family Engagement Through Quality Improvement Fact Sheet* *Teach-back Toolkit* *Building Your Medical Home: Implementing Family-Centered Care* *Webinar Series: Meaningfully and Effectively Engaging Families in Pediatric Practices and Systems* *Shared Decision Making Clinical Report* *Fostering Partnership and Teamwork in the Pediatric Medical Home: A "How-To" Video Series* *Building Your Care Notebook on the Web page for Families* *Motivational Interviewing: Promoting Healthy Behaviors in Pediatrics*
More complex implementation strategies	• Hire/volunteer parent peer-support • Provide health care services and support groups for siblings of CYSHCN	

Family-centered and compassionate: Families and caregivers are essential in supporting the health of children and youth, particularly those with special health care needs. Families and caregivers have the most experience and interaction with children and provide important, first-hand perspectives. Therefore, it is critical for families/caregivers to be an integral part of their child's care team. Family-centered and compassionate care can be implemented by **engaging families and caregivers as members of advisory committees to guide decision making for the clinics/practices,** as is done in the Empowering Mothers Initiative. Providing opportunities and support for families and caregivers in leadership positions offers a platform to integrate family/caregiver ideas into the practice.

Another method used by Building Healthy Families to obtain family feedback from a broad number of families/caregivers in the practice is **through family satisfaction surveys and family support groups.** This mixed-methods approach to collect family feedback allows for inclusion of diverse and well-rounded perspectives. By implementing family comments and suggestions, practices improve patient and family experience in the medical home.

Columbia University Medical Center implements the "teach-back" methodology. **The "teach-back" method involves the clinician asking the patient or family/caregiver to repeat the plan of care in their own words.**[13] This methodology is used to ensure that information and action plans are truly understood by the parent/caregiver. It also provides families/caregivers with an opportunity to discuss whether action plans are realistic for the patient and family's lifestyle.

Yavapai Pediatrics has **recruited a parent/caregiver volunteer to their practice.** Yavapai Pediatrics provides early screening, diagnosis, and treatment of children and youth with Autism Spectrum Disorder (ASD) in the context of the pediatric medical home. **The parent/caregiver volunteer provides peer support and guidance to families who have children diagnosed with ASD.**

Another popular implementation strategy utilized by Texas Children's Health Plan is motivational interviewing. **Motivational interviewing includes conversation techniques that support clinicians in helping patients identify how, when, and what behaviors they can change to improve their own health.** Motivational interviewing encourages family engagement by creating collaborative patient-centered goals.

CONTINUOUS CARE

Care within the pediatric medical home should be continuous. Continuity of care in a pediatric medical home setting includes the **consistency with which a patient and their family see a specific pediatric clinician or small core of pediatric clinicians.**[14] **This small core includes nurses, physician's assistants, care coordinators, social workers, pediatricians, and others.** Below are strategies to implement continuous care.

Category	Implementation Strategies	Resources
Commonly utilized implementation strategies	• Implement empanelment—assigning individual patients to primary care clinicians based on patient and family preference. • Daily team huddles	*Empanelment Executive Summary* *Empanelment: Establishing Patient-Provider Relationships* *Got Transition Web site* *Transition to Adult Care Resources on the Web page for Families and Caregivers*

Continuous care: Continuous care within the pediatric primary care setting enhances physician and patient relationships. **Patients and families visit the same pediatrician and pediatric practice over the course of the child's life,** which builds trust and **provides clinicians with increased knowledge about the patient.** It enhances preventive services and further supports transition to adult care. Children's Care Network, which includes a team of pediatric clinicians, assigns primary care clinicians to patients and families and utilizes a team-based care model.

Team-based care used by Children's Care Network supports continuous care in the pediatric medical home. According to the American Academy of Pediatrics, **team-based care is a health care model that "endorses the partnership of children and families working together with one or more health care providers and other team members across multiple setting to identify, coordinate and address shared goals that meet the needs of the whole child."**[15] One way this can be implemented is by conducting daily team huddles, or short meetings to prepare the clinical team for the day ahead.

COMPREHENSIVE CARE

Pediatric medical home care should be comprehensive, meaning that **preventive, primary, and specialty care—in addition to other services—are provided to the child and youth.**[16] Comprehensive care ensures that the health needs of the child/youth are met and improves health outcomes for children and youth with special health care needs (CYSHCN). Below are various strategies to implement comprehensive care.

Category	Implementation Strategies	Resources
Commonly utilized implementation strategies	• Provide interactive child development curriculum • Offer parenting and nutrition classes • Communicate Bright Futures recommendations to the community through innovative, family-friendly resources • Integrate a multi-disciplinary team approach which may include on-site behavioral and mental health, speech therapy, occupational health services and more and utilize joint electronic health record system	*Bright Futures Web site* *National Center Web page for Families and Caregivers* *Co-Management and Transitions Resources* *Letter Template to Engage a Specialist in Co-management of a Specific Child*
More complex implementation strategies	• Provide targeted interventions for families with frequent emergency department visits • Invite local community agencies and specialists serving children and families to attend team meetings at the practice • Conduct an annual "Health and Service Evaluation" meeting for each patient seen by the practice to develop comprehensive care plans	*Building Your Care Notebook on the Web page for Families and Caregivers* *Care Plan Templates from National Institute for Children's Health Quality*

Comprehensive care: CYSHCN often require a variety of health care services that are rarely be met by just one clinician or health care provider. Therefore, it is **essential the treatment CYSHCN receives is comprehensive and addresses the various complexities of care often faced by CYSHCN.** There are a number of strategies that can be utilized to enhance comprehensive care.

Preventive care can be provided to youth and families during group and individual visits and often takes the form of **education and information/resource sharing.** For example, the Empowering Mothers Initiative utilizes group visits to implement an interactive child development curriculum focused on educating caregivers on issues such as nurturing and attachment, discipline, stress management, nutrition, and safety. By providing education on various topics, mothers will be better equipped to implement prevention strategies or respond appropriately in certain situations.

It is important that parents are also aware of pediatric milestones. An **innovative way to communicate these milestones to parents** has been developed by the ReadNPlay for a Bright Future Program. This program developed a book titled "My Baby Book," which contains age-appropriate tips for keeping babies healthy and safe during the first two years of life based on pediatric guidelines, and leaves room for families to document when children are reaching important pediatric milestones. The book is created at a sixth-grade reading level to enhance accessibility for all families. If parents are aware of milestones, they will be able to take early and preventive action if milestones are not being met.

To reduce frequent emergency department visits and unplanned hospital admissions, Premier Pediatrics **trains practice staff to proactively prepare families with preventive strategies, such as a shared plan of care and targeted patient education,** to avoid similar visits in the future.

Many practices also conduct **social determinants of health screenings for all patients.** These screenings allow practices to link patients to community support services, specialist care, or follow-up treatment. For example, Building Healthy Families conducts health risk assessments for all patients. These **assessments are used to guide treatment, consultation with families, and referrals to community services.** Individuals conducting the screenings can range from practice clinical staff, community health workers, or a case worker. If care teams are integrated, referrals and hand-offs can be made with greater ease.

For example, Kid's Count Pediatrics and Texas Children's Health Plan both have **on-site mental health social workers, behavioral health, occupational health, and/or speech therapy professionals within practice.** Integration of services allows for a more comprehensive visit and ensures that clinicians are providing care that is aligned. Kid's Count Pediatrics utilizes a **joint Electronic Health Record system for pediatricians and subspecialists to enhance integrative and comprehensive care.** The Beacon Program and Clinic conducts **annual "Health and Service Evaluation" meetings** for each patient seen by the practice. These meetings involve the entire care team and result in the creation of a comprehensive care plan for the patient and family and further enhance family-centered care.

COORDINATED CARE

The American Academy of Pediatrics defines care coordination as **"a 'cross-cutting system intervention' that is 'the deliberate organization of patient care activities between at least two participants—including the patient—involved in a patient's care to facilitate the appropriate delivery of health care services.'"**[17] Coordinated care is implemented in partnership with the family and communicated with the family, all health care clinicians, and community agencies and organizations, as necessary.

Optimal outcomes for children and youth, especially those with special health care needs, require **interfacing among multiple care systems and individuals,** including the following: medical, social, and behavioral health professionals; the educational system; payers; medical equipment providers; home care agencies; advocacy groups; needed supportive therapies/services; and families.

Coordination of care across settings permits an **integration of services that is centered on the comprehensive needs of the patient and family,** leading to decreased health care costs, reduction in fragmented care, and improvement in the patient/family experience of care. The following are highlights of practical strategies to implement coordinated care.

Category	Implementation Strategies	Resources
Commonly utilized implementation strategies	• Develop a shared plan of care • Hire a care coordinator or designate care coordination tasks to staff. The care coordinator can assist with scheduling appointments with specialists, tracking patient referrals, and conducting appointment follow-ups • Coordinate on-site case managers and licensed clinical social workers who screen for mental health, toxic stress, and domestic violence • Use an electronic medical record system that allows for a multidisciplinary team to edit, view notes, and collaborate	*American Academy of Pediatrics Care Coordination Policy Statement* *Shared Plan of Care Fact Sheet* *National Center for Care Coordination Technical Assistance Web page* *Building Your Medical Home: Coordinated Care* *Care Coordination Resources on Web page For Practices* *Care Coordination Measurement Tool* *Pediatric Integrated Care Survey Tool* *Pediatric Care Coordination Webinar Series*
More complex implementation strategies	• Establish formal care coordination agreements between partners that outline partner duties and responsibilities related to care of patients • Foster connections with local community-based social wellness organizations that recruit, hire, and train community health workers (CHWs)	

Care Coordination: Coordinated care is an essential element of pediatric medical home and health care transformation. Care coordination emphasizes increased quality, decreased cost, and enhanced partnerships and collaboration.[17] Use of **shared plans of care** facilitates implementation of key functions of the medical home model, including comprehensive, coordinated care. As described by the American Academy of Pediatrics, shared plans of care are **"developed and implemented with input from members of the team caring for a child, including community partners, education specialists, primary care providers, dental providers, medical subspecialists and surgical specialists, and, most importantly, the family and patient themselves."**[17] Shared plans of care support the following: identifying goals, both personal and clinical; developing a care plan and medical summary; and conducting regularly timed multifaceted assessments for the child/youth and family to complete. To ensure that all care team members had access to the shared plan of care, the West Haven Child Development Center team uploaded the shared plan of care to a secure, confidential, computerized system. Much like the West Haven team, many teams utilize a **streamlined, Web-based medical record or communication system.** This allows for constant communication and informed care planning among the care team.

Another common method to ensure care coordination is to **hire a coordinator or delegate care coordination tasks among existing staff members** of the practice. For example, the Little Rock Pediatric Clinic delegated care coordination tasks to various staff. These individuals provided additional care coordination and referral services, including tracking referrals and appointment follow-ups electronically and assisting with developing care plans. Texas Children's Health Plan has also assigned care coordinator duties to an existing member of the staff. The **care coordinator supports the team by leading daily team huddles, maintaining population health registries, and coordinating between primary care and behavioral health services.**

Another implementation strategy to enhance coordination of care is to **invite local community agencies and specialists serving children and families to attend team meetings at the practice.** Weiss Pediatrics utilizes this strategy to enhance awareness of community resources and to increase the provision of referrals. Once partnerships with other care providers and stakeholders have been built, formal care coordination agreements can be established. Providing care for children and youth with special health care needs can be complex and requires partnership and collaboration. This need increases for CYSHCN who are more socially vulnerable, such as youth in foster care. Fostering Health North Carolina maintains the system of care for foster youth by creating a formal Letter of Agreement between the local Department of Social Services, medical home, and

medical home network. **The letter outlines roles and responsibilities of each organization as they pertain to caring for children and youth in foster care.** Establishing formal agreements helps to ensure that the system supporting and caring for CYSHCN is functioning optimally.

The Keeping Families Healthy Program utilizes **partnerships with community health workers (CHWs) to engage in preventive health education, discuss strategies for patient/family engagement, and facilitate families' understanding of clinician recommendations.** The program also developed a referral workflow for clinicians to easily identify and refer patients who are at risk and may benefit from the services of a CHW.

CULTURALLY EFFECTIVE CARE

Caring for increasingly diverse cultures in the United States has implications for provision of care in the pediatric medical home. Diversity impacts utilization of care and acceptance of interventions. Culturally effective care is when the **family and child's culture, language, beliefs, and traditions are recognized, valued, and respected.**[16] Culturally effective care supports bidirectional communication and adoption of care plans that are culturally appropriate and acceptable. Implementation strategies to enhance culturally effective care are described below.

Category	Implementation Strategies	Resources
Commonly utilized implementation strategies	• Employment and partnership with culturally and linguistically diverse staff or community health workers • Provide cultural competence training to all clinic staff • Provide brochures and written resources in multiple languages and at appropriate reading levels	*Resources for Culturally Competent Care on Web page For Practices* *Language Access in Pediatric Primary Care Fact Sheet* *Strategies to Enhance Care for Hispanic Children, Youth, and Families Fact Sheet* *Cultural Competence Self-Assessments from the National Center for Cultural Competence* *Growing Your Capacity to Engage Diverse Communities from Family Voices*
More complex implementation strategies	• Provide toys, books, equipment, and other materials that reflect diversity • Place alerts in patient charts with diverse cultural and linguistic backgrounds providing insight about linguistic needs and cultural preferences	

Culturally Effective Care: Empowering Mothers Initiative **employs and establishes partnerships with culturally and linguistically diverse staff and community health workers.** These staff and community health workers support and facilitate bidirectional communication with patients and families and pediatric clinicians. Bidirectional communication helps facilitate family-centered care and development of appropriate care plans and interventions.

The Building Healthy Families Initiative **provides training on cultural competence to clinic staff.** Cultural competence training can focus on developing and enhancing skills and knowledge to understand cultural differences, increase awareness of personal bias, and increase awareness of cultural norms. **Trainings can also provide tools and strategies to manage intercultural communication skills and understand potential barriers to care.** In order to share health education and pediatric health resources broadly, Kids Count Pediatrics provides **brochures and written pediatric care resources in multiple languages.**

In order to create an inclusive environment for patients, West Haven Child Development Center **provides toys, books, equipment, and other materials that reflect diversity.** This can include gender, racial, ability, linguistic, or religious diversity, among others. Including and promoting toys, books, and children's materials that reflect diverse characteristics affirms children's identities and provides care that that is culturally effective.

To ensure that pediatric clinicians at Premier Pediatrics are providing culturally effective care, **alerts have been placed in patient charts for patients and families with diverse cultural and language backgrounds.** Once alerted, staff can provide care in the family's preferred language and be more mindful of cultural preferences when creating the plan of care in partnership with families.

CHALLENGES AND RESOLUTIONS

Implementation of pediatric medical home strategies can be challenging. Practices and organizations often have competing priorities and a finite amount of resources. **Overcoming challenges and creating realistic, sustainable, long-term solutions supports longevity of programs and initiatives that advance the pediatric medical home.**[16] Featured Promising Practices have experienced challenges related to funding, sustainability, and culture change and have created several innovative solutions to mitigate these challenges.

The Empowering Mothers Initiative was challenged to expand the project beyond a demonstration to a widely adopted part of regular clinic operations. To do this, the **project utilized evaluation results to demonstrate its impact and enhance leadership buy-in for sustainability.** This is an effective strategy to enhance culture change within an organization. If upper-level management support the project, this may result in buy-in from other members of the organization and also result in sustainability and spread of the pediatric medical home model.

To accommodate funding shortages, leadership of Kids Count Pediatrics **started a nonprofit organization to help raise funds for co-located services within the practice, including further classroom space, an accessible playground, and physical therapy.** Alternatively, West Haven Child Development Center **utilizes volunteers from surrounding universities to assist with projects and initiatives.**

One obstacle faced by Little Rock Pediatric Clinic included difficulty motivating staff and encouraging culture change to support transformation into a pediatric medical home. **The project increased team meetings and staff training and promoted sharing of data to support staff throughout the transformation.** To reduce physician fatigue and burnout during this project, the Little Rock Pediatric Clinic team delegated responsibility to other clinicians and staff within the practice to support physicians.

For practices in smaller, rural communities, it can be challenging to ensure that patients and families have access to adequate services. To overcome this, Yavapai Pediatrics **established relationships with specialty care clinicians and organized teleconferences between specialists, patients, and families to enhance accessibility to services that may not be readily available directly in the community.**

For more information about challenges experienced and resolutions, visit the complete list of Promising Practices.

CONCLUSION

Pediatric medical home implementation requires thoughtful planning and execution, and is critically important for all children and youth, particularly those with special health care needs. Implementation of components of the medical home model has the potential to improve health outcomes for CYSHCN and their families. As such, the practical tools and techniques described in this summary report offer a variety of strategies for others interested in implementing similar components of the pediatric medical home model.

Ensuring sustainability requires consideration of financial factors, access to resources, and management of office culture and personnel morale. Developing creative solutions to challenges is a necessary step in building sustainability. Each practice and organization implementing the medical home model is unique. The challenges and resolutions outlined in this summary report highlight the following important potential solutions: utilizing resources and talent outside of the practice or organization, capitalizing on free resources, and providing training to project staff to build confidence and encourage team work.

TECHNICAL ASSISTANCE AND CONTACT INFORMATION

For more information about the practices/programs discussed in the summary report, contact the National Center for Medical Home Implementation (NCMHI). The NCMHI staff can facilitate introductions to clinicians and staff in the featured practices and are available to answer questions and provide technical assistance.

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