

Medical Home Examples and Suggested Training / Technical Assistance Resources

Introduction:

This document has been prepared by the Iowa Medical Home Initiative (IMHI) ¹ It is a table intended to suggest examples and useful training and technical assistance web-based resources for primary care practices interested in providing a medical home quality of care.

In the table below, resource suggestions cover a range from general, comprehensive medical home training content to specific guidance or tools applicable to a single quality improvement area. Although many of the resources were designed for a pediatric population, most can be generalized and adapted for any age patient.

This is intentionally not an exhaustive list of resources. Rather, it is a select list of good quality resources felt to be useful, practical, and effective for accomplishing medical home-related quality improvement. Practices are encouraged to seek resources – these or others – they feel will be useful for their own improvement efforts.

New training resources are constantly being developed and disseminated. All organizations – practices, health systems, public health programs, and family advocates – are invited and encouraged to review and recommend newly emerging training and technical assistance resources.

General Quality Improvement (QI) Areas	Suggested Training and Technical Assistance Resources to Achieve Quality Improvement
<p>The following three major web-based resources are for practices desiring to learn about the quality improvement potential of the medical home concept and, if favorably disposed, to incorporate medical home attributes within their own practices. The following three major resources have a wealth of information, resources, and links applicable to most or all of the eight general quality improvement areas.</p>	

<p>Multiple General Quality Improvement Areas</p>	<ul style="list-style-type: none"> • <i>The National Center of Medical Home Initiatives</i> website contains a compilation of facts, resources, tools, and training materials relevant to the medical home concept. The training materials comprise a comprehensive, multi-component training approach that can be presented in a centrally located 1-day program, or in smaller modules over time in local meeting settings. The flexible design enables organizations and practices to customize training program length and target audience. The following webpage contains downloadable faculty and participant curriculum materials. (http://www.medicalhomeinfo.org/training/materials.html) • <i>The Medical Home Primer for Community Pediatricians and Family Physicians</i> is a monograph offering primary care physicians a menu of suggestions that can be incorporated into their practice to improve the quality of care provided to patients and their families. This Primer’s road map provides a naturally evolving, flexible approach to building a medical home. A practice need consider only those options that are most appropriate to its practice setting. An initial assessment helps guide a practice through the menu options to determine how best to proceed. (http://internet.dsc.uic.edu/forms/medicalhome/MedHomeCMEMonograph.pdf) • The <i>Center for Medical Home Improvement (CMHI)</i> offers a practice-based model of quality improvement. The model blends parent insight, professional knowledge, and care coordination to build primary care medical homes. CMHI promotes the medical home as a family-centered “way of doing things” for children with special health care needs. The CMHI website offers a medical home toolkit with assessment and measurement tools; quality improvement strategies; chronic condition management; care coordination; and other topics. (http://www.medicalhomeimprovement.org/)
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The following examples and suggested resources are distributed according to the quality improvement area to which they most contribute. These resources can be used to supplement any of the more comprehensive resources suggested above. They may also have information and links applicable to quality improvement areas other than the one in which the citation is placed.

Continuity of Care

EXAMPLES:

- The care team (including primary care physician, staff, and patient/family) collaboratively develops a care plan ² that identifies needs for services/referrals and assures communication between primary care provider (PCP), patient/family, and other care providers (e.g., specialists, cross-coverage providers, and emergency providers).
- The care plan is shared with the patient/family and placed in the chart, along with documentation of where and to whom the care plan has been distributed.
- The plan of care is reviewed, updated, and re-documented at least twice per year (at six month intervals) by the care team.

RESOURCES:

- The *Wisconsin Title V Program Medical Home* website contains helpful tips on creating and using care plans. Patients with special health care needs, their families, physicians, practice teams, and community providers benefit from a basic plan of care, a clear written medical summary, and an emergency treatment plan – all components of a Comprehensive Care Plan. (<http://wimedicalhometoolkit.aap.org/careplans/>)
- The *National Center of Medical Home Initiatives*, sponsored by the American Academy of Pediatrics, provides a webpage with several useful examples of care plans – from short care plan summaries to larger, comprehensive documents integrating medical, emergency, and action plans. (<http://www.medicalhomeinfo.org/tools/assess.html>)

<p>Care Coordination</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • The primary care provider (PCP) intermittently, but deliberately, asks any patient/family with a chronic condition what additional care supports they need. • The PCP or a staff member helps patients/families obtain resource information and coordinate appointments. • If not provided directly by the PCP, the practice assumes responsibility to connect patients/families needing care coordination with other available care coordination resources. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • The <i>Medical Home Practice-Based Care Coordination Workbook</i> is a downloadable resource from the Center for Medical Home Improvement. Tools included in this resource are: a definition of care coordination in the medical home; a care coordination position description; a framework for care coordination services including structures and processes; strategies for the protection of devoted staff time; and a logical sequence of care coordination improvement ideas. (http://www.medicalhomeinfo.org/tools/Tools/PDF_Final_PracticeBasedCC-Workbook7-16-07.pdf) • The <i>Utah Medical Home Portal</i> website provides a concise overview of care coordination in the context of it being a vital component of the medical home. Care coordination builds essential trust between families and providers by responding to needs in a timely and organized manner. Toolkit links are provided. (http://www.medhomeportal.org/about/care-coordination)
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<p>Cultural Competence</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • The primary care practice (PCP) attempts to address obstacles of language, literacy, or personal preferences by having resources and information available for the most common diverse cultural backgrounds in the PCP's catchment area. • When useful for care, individual patients/families are assisted through efforts to obtain interpreters or to access culturally-relevant information from outside sources. • Culturally-related accommodation needs are documented for future clinic visits. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • The <i>National Center for Cultural Competence (NCCC)</i> provides an excellent selection of useful guides, models, tools, and other resources to help a practice increase its cultural and linguistic competence. The mission of the NCCC is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. (http://www11.georgetown.edu/research/gucchd/nccc/) • Two in-state resources – the <i>Office of Multicultural Health</i> at the Iowa Department of Public Health and the <i>Iowa Center on Health Disparities</i> at the University of Northern Iowa – have useful information for practices about culturally and linguistically diverse populations within their geographic service areas. This information can help practices be more knowledgeable, effective, and culturally competent in their service delivery. (http://www.idph.state.ia.us/hpcdp/mh_default.asp) and (http://www.iowahealthdisparities.org/data.php) • Health literacy is an important component of cultural and linguistic competence. Studies show that limited health literacy skills are a stronger predictor of an individual's health status than age, income, employment status, education level, and racial or ethnic group. Although ethnic minority groups are disproportionately affected by low literacy, the majority of those with low literacy skills in the United States are white, native-born Americans. The <i>American Medical Association</i> has been working to raise awareness of this pervasive problem. On their web site is a toolkit for providers, as well as patient safety tip cards. (http://www.ama-assn.org/ama/pub/category/8115.html) <p>A concise review of health literacy was recently published on the <i>Medscape</i> website (registration is required, but free). Learners will gain awareness of the prevalence and consequences of limited health literacy; health literacy assessment strategies; and health literacy-related strategies for successful communication with patients. (Assessing Health Literacy in Clinical Practice)</p>
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Transition³ Support

EXAMPLES:

- PCP providers, on an intermittent basis, initiate and document age and situation-relevant discussions with patients/families about transition issues.
- The primary care provider or a staff member assists patients/families to obtain resources useful for planning successful life transitions.

RESOURCES:

- Supporting adolescent transition is a major focus of *Wisconsin's Title V Program Medical Home* website. The transition webpage contains resources and practical guidelines for primary care providers who desire to meet the challenges of transition and who assume responsibility for current health care, care coordination, and future health care planning. (<http://wimedicalhometoolkit.aap.org/transitions/>)
- The *University of Washington Center on Human Development and Disabilities* hosts a website with information and resources for health care providers concerned with planning and delivering high quality transition services. The following webpage link is for health care providers. Other resources are listed on other website pages. (<http://depts.washington.edu/healthtr/Providers/intro.htm>)
- Many aging adults confront life-altering questions of if, how, and when to consider transitioning from independent to assisted living. Health care needs are often a major factor in decision-making. The Iowa Department of Elder Affairs website provides valuable transition-related information for providers, families, and aging individuals. (<http://www.state.ia.us/elderaffairs/services/HelpMeStayAtHome.htm>)
- *LifeLong Links* (a project of Iowa's Aging and Disabilities Resource Center) is an excellent web-based resource to help aging people do their own future planning. A selection of available resources plus an easy-to-follow series of planning questions on goals, health, and family provide excellent guidance to transitioning elderly and the providers who serve them. (<http://www.lifelonglinks.org/planning.htm>)
- Many young Iowans, 0-3 years old, with developmental delays are enrolled in *Early ACCESS* (Iowa's Part C early intervention program). The *Iowa Department of Education (IDOE)* website is planning to post a resource notebook of materials and procedures that service coordinators discuss with families throughout the child's Early ACCESS enrollment. Some materials will specifically address transitioning to further services and programs for older children. Check the IDOE website for these materials. (<http://www.iowa.gov/educate/>)

<p>Family Involvement</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • “Perceptions of care” feedback from patients/families with chronic conditions is systematically gathered (e.g. using surveys, focus groups, or interviews of ≥ 10 families) at least every six months. • There is an established process for practice staff to review this feedback and, based on the feedback, to plan and implement change. • Over time, the primary care provider builds a peer-to-peer partnership with selected patients/families who act as trusted advisors to the practice. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • According to the <i>Wisconsin Title V Program Medical Home</i> website, “engaging families as partners in both care planning and practice decisions can be rewarding and introduce enormous efficiencies to the practice.” The site’s “Tips for Providers” lays out simple steps to take before, during, and after the appointment. The tips help integrate family and patient input into health decision-making and coordination of effective appointments. (http://wimedicalhometoolkit.aap.org/engage/index.cfm) <hr/> <ul style="list-style-type: none"> • The <i>Institute for Family-Centered Care</i> is a non-profit organization providing leadership to advance the understanding and practice of patient- and family-centered care. By promoting collaborative, empowering relationships among patients, families, and health care professionals, the Institute facilitates patient- and family-centered change in all care settings. The website’s FAQ section may be particularly helpful. (http://www.familycenteredcare.org/index.html)
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<p>Self-Management Support</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • The primary care provider (PCP) assesses the patient’s/family’s ability to understand and manage their health condition. • Based on the assessment, the PCP assists the patient/family to live with the chronic condition using evidence-based self-management strategies ⁴. • The self-management plan is reviewed and documented at intervals appropriate to patient/family needs. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • The <i>Institute for Healthcare Improvement</i> provides several useful webpages on strategies, tools, and resources to support successful patient self-management. Self-management, implemented by patients and supported by providers, yields improved illness understanding, informed decision-making, and healthier behaviors. http://www.ihl.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport • The <i>Ontario Patient Self-Management Network</i> provides general concepts and resources to help clinicians understand and utilize patient self-management in their practice settings. A link to a paper by Patrick McGowan gives an excellent detailed background on patient self-management, including how it is different from traditional patient education. Another link to a paper by Kate Lorig shows promising research on self-management’s benefits on health status, health behavior, health care utilization, and self-efficacy. http://www.ontpsm.net/self_management.php • This paper from the <i>Stanford School of Medicine</i> reports study results of a patient self-management program showing significant improvements in cognitive symptom management, communication with physicians, self-reported general health, health distress, exercise, fatigue, disability, social/role activities limitations, and number of hospital days. http://patienteducation.stanford.edu/programs/cdsmp.html
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<p>Practice-Based Continuous Quality Improvement</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • The PCP has its own documented systematic quality improvement mechanism for patient care, including use of evidence-based clinical guidelines. • Regular PCP provider and staff meetings discuss how to improve care and treatment, including reflections on the PCP’s use of evidence-based clinical guidelines; status of patient and staff satisfaction; and ease of patient/family access to care. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • “<i>TransformMed: Empowering Medical Practices</i>” is a website affiliated with the American Academy of Family Physicians. The following webpages provide links to a selection of working papers in PDF format and other published resources to guide practices in pursuit of clinic-based best practice quality improvements. (http://www.transformed.com/LLworkingpapers.cfm) and (http://www.transformed.com/resources.cfm) • A good place to browse or search for evidence-based clinical practice guidelines is the <i>National Guideline Clearinghouse</i> (NGC). The NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Dept of Health and Human Svcs. (http://www.guideline.gov/) • Practices can benefit from a sensible, systematic approach to medical home-related quality improvements. The <i>Institute for Healthcare Improvement</i> website presents a useful approach to implementing any kind of practice-based change. This approach includes description of the Plan-Do-Study-Act (PDSA) cycle with examples. (http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove) • For practices interested in measuring their level of “medical homeness,” helpful tips and tools can be found at the <i>National Center of Medical Home Initiatives</i> website. (http://www.medicalhomeinfo.org/tools/med_home.html)
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<p>Special Patient Identification and Data Monitoring</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • A registry list (electronic or otherwise) of patients with special health care needs ⁵ is generated to enhance planning and delivery of quality care. • The registry list is used for flagging and monitoring such things as vaccines; use of other evidence-based clinical guidelines; sequential lab values; or abnormal test results. • Out-of-practice referrals are tracked and documented to assure that a full information picture about the patient/family is available to the primary care provider. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • <i>TransformMed: Empowering Medical Practices</i> is a website affiliated with the <i>American Academy of Family Physicians</i>. The following webpage provides comparative information and additional resources on patient registries, electronic medical records, and chronic disease management systems. (http://www.transformed.com/takeAction/index.cfm) • The <i>Iowa Foundation for Medical Care (IFMC)</i> has a free Microsoft Access registry tool called <i>SECAT (Steps Electronic Collection and Analysis Tool)</i>. SECAT tracks preventive services and diabetes indicators. IFMC is not able to provide SECAT operational support, customization, or updates, but will send a self-loading CD program plus user's manual at no charge. They will provide some telephone help for installation questions. For a free copy of the CD and user's manual, contact Mike Speight at: mspeight@ifmc.org <p>The IFMC is also offering a new registry software product called <i>CareMeasures</i> (recently endorsed by the IAFP) for chronic diseases such as asthma*, CAD, CHF, COPD*, diabetes, hypertension, preventive care and smoking cessation. An annual license fee averages \$1,500/yr depending on number of users in the practice system. IFMC will provide operational support, new features, upgrades, and regional clinical data comparisons. For information on CareMeasures, contact Mike Speight at: mspeight@ifmc.org (* to be developed and available in late 2008)</p> <ul style="list-style-type: none"> • One instrument, more than any other, has been used to identify and flag children with chronic illness, sometimes called children with special health care needs. Developed by the <i>Child & Adolescent Health Measurement Initiative</i>, this easy to administer tool may prove very useful to a practice's medical home development plan. (http://www.markle.org/resources/facct/doclibFiles/documentFile_446.pdf)
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Notes:

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² Suggested elements in the care plan, which is a summary, not a full medical record, include patient's diagnoses; current health issues and treatments, including medications; family and medical history; immunizations; allergies; significant medical test results; possible emergency needs; primary care provider

and specialist(s) involved in care; related school, community, and home concerns; and other useful contacts (e.g. insurance, care coordinator, pharmacy, home nursing agency, dentist, and health-related vendors).

³ Transition is a process that occurs at several major life junctures, especially early childhood to school entry; adolescence to independent adult living and work; and independent adulthood to elderly assisted living.

⁴ Examples of useful self-management strategies include personal goal setting; identification of barriers and challenges; personalized problem solving; and plans to obtain follow-up support.

⁵ A suggested inclusive and non-specific definition of patients with special health care needs is: “those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by patients generally (adapted from the Maternal and Child Health Bureau definition of children with special health care needs, 1998).