Take Action!

Champion a Medical Home Approach for CSHCN

How to Use?

This MCH Action Guide was created in order to assist local MCH programs with developing their MCH plan. The *"Medical Home"* Action Guide is intended to help local health agencies and community partners develop evidence-based Specific Measurable Achievable Realistic Time-framed (SMART) goals and good objectives. This guide identifies strategies and action steps to strengthen a Medical Home approach for Children with Special Health Care Needs (CSHCN) in your community.

MCH Action Guides are divided into four (4) sections:

- **"How to Use"** – includes special instructions;
- **"What's at Stake"**- contains background information & data;
- **"What Works"-** outlines best practices or promising strategies;
- **"Resources and Tools"-** lists resources and tools to assist with implementation of Medical Home and write SMART objectives.

MCH consultants are available to provide technical assistance to incorporate Action Guide information into local MCH operational plans and consult on specific content material. To contact an MCH consultant about this Action Guide call 303-692-2370 or go to the HCP website at www.hcpcolorado.org and/or MCH website at www.mchcolorado.org.

Tip!

Find local data and experts

Contact Your MCH Consultant Today!

What's at Stake?

How Colorado's CSHCN population compares with 2005-2006 National Data

Usual Source of Care

- 6.5 percent of CSHCN report not having a personal doctor or nurse both nationally and in Colorado.
- 6.5 percent of CSHCN report not having a usual source of care that is not the ER (sick care and well care) compared with 5.7 percent nationally.

Unmet Health Care Services

- 20.0 percent of CSHCN have unmet needs for specific health care services compared with 16.1% nationally.
- 24.9 percent of CSHCN need referrals and have difficulty getting them compared with 21.1% nationally.

Family Support Services

- 5.0 percent of CSHCN have unmet needs for family support services compared with 4.9 percent nationally.

Health Insurance

- 12.7 percent of CSHCN were without insurance at some point in past year compared with 8.8 percent nationally.

Specialty Care

- 53.7 percent of CSHCN needed specialty care compared with 51.8 percent nationally.

Systems of Care Easy to Use

- 87.8 percent of CSHCN report services are organized in ways that families can use them easily compared with 89.1 percent nationally.

Questions to Ask:

✓ *How are CSHCN identified in your community?*
✓ *Do CSHCN in your community have access to primary care providers?*
✓ *Do providers accept children with Medicaid and CHP+?*
✓ *Do families have access to family support services?*
✓ *How does the local health care system work for CSHCN?*

What Works?

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Strategy #1: Provide Care Coordination

Care Coordination is an important component of a Medical Home Approach. Local primary care providers need to understand and be engaged in utilization of Health Care Program for Children with Special Needs (HCP) Care Coordination and available community resources for CSHCN. Contacting Primary Care Providers (PCP) to inform, educate, assist and engage them with HCP and community resources has been shown to improve care for CSHCN and their families.

- Send HCP **Care Coordination letters** to PCPs/Specialty Care providers.
- Provide **outreach/education to PCPs** on community and statewide services.
- Develop a local **description of HCP Care Coordination services** for PCPs.
- Inform PCPs about **HCP Care Coordination**.
- Encourage **Specialty Care Providers** to communicate with child's PCP.
- Discuss development of **child's health care plan** with PCP.
- Utilize health fairs to **inform families about HCP** and community services.
- Engage **culturally diverse families** to help with program planning.
- Promote family members as **mentors to encourage** timely and appropriate health care services for CSHCN.
- **Utilize parents** for their unique perspective of challenges in coordination of care for CSHCN.
- Encourage and educate providers to **value parent partnerships for family centered care**.
- Identify/use **evaluation tools** to assess PCPs and Family Satisfaction with:
    - Parent/Professional Partnership
    - HCP Care Coordination
    - HCP Specialty Clinics

Questions to Ask:

✓ *Which community PCPs utilize HCP Care Coordination?*
✓ *Are new PCPs informed about HCP and community resources?*
✓ *How does HCP Care Coordination assist PCPs?*
✓ *How can HCP improve the ability for practices to coordinate care?*
✓ *What other agencies provide case management, service coordination or care coordination?*
✓ *How might services and referrals be better coordinated for families?*
✓ *What other agencies/programs can assist families with insurance?*
✓ *What training or resources do staff need for care coordination?*
✓ *How is care coordination supporting youth transition to adult health?*
✓ *How can family leaders assist other families with coordination of care?*

What Works? *(continued)*

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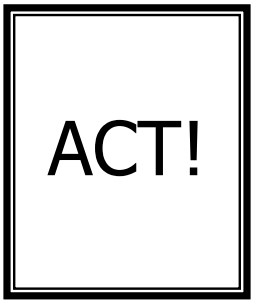
Strategy #2: Collaborate with Community Partners for Easy to Use Services

Families with CSHCN need services to be organized so they can use services easily. By collaborating with community partners we can help assess the access and organization of community services for families. Involving the HCP Family Coordinator and/or community Family Leaders is critical with these collaborative efforts. By engaging multiple partners in this effort across different sectors of the community, resources and solutions can be identified to improve community services for families with CSHCN.

Important systems and services for families with CSHCN are:

- Pediatric and Family Practice Primary Care
- Pediatric Specialty Care
- Behavioral Health Care
- Dental Care
- Education Services (Preschool/Schools)
- Early Intervention Services (Birth to 3)
- Hospital In-Patient and Out-Patient
- Public and Private Insurance
- Cultural and Ethnic Support
- Faith Based Services
- Family Support
- Youth Transition



- ✓ Survey families to ask if **community health care systems and services** are easy to use.
- ✓ Participate on coalitions, **community action groups** and existing medical home efforts.
- ✓ Engage family members and/or youth on **community task forces** and work groups.
- ✓ Assess the need for **Pediatric Specialty Care** in your Region.
- ✓ Define a **health care referral system** for families with CSHCN.
- ✓ Identify and Utilize **community resources** to help families with needed services.
- ✓ Promote **community outreach** to **identify/enroll** children in SSI, Medicaid and CHP+.
- ✓ Assess availability of systematic developmental **screening and follow up.**
- ✓ Define **community partner roles and responsibilities** in early identification, referral, and follow up systems.
- ✓ Commit to making **family leaders visible** with co-presentations or sharing responsibilities.
- ✓ **Evaluate community systems** for effectiveness and needed modifications.
- ✓ Develop **community network of family leaders** for boards, councils and advisories.
- ✓ Promote **compensating family leaders** for their time, consultation, and commitment.
- ✓ Engage family leaders for **faith based community organizations**.
- ✓ Identify/use **evaluation tools to asses** PCP and Family satisfaction with:
  - o Current Community Resources
  - o Community Health Care Referral System

Questions to Ask:

- ✓ *How can community partners be identified and engaged?*
- ✓ *What community providers do families identify as their consistent source of care?*
- ✓ *What are the available supports and barriers that families experience?*
- ✓ *What is one way to work in the community to support a medical home approach?*
- ✓ *If you achieve your goal, how will community systems change?*
- ✓ *What tangible results will mean the community is utilizing a medical home approach?*
- ✓ *What has a community group identified as planned outcomes?*
- ✓ *How does the community continue to evaluate health referral systems?*
- ✓ *Is there a "medical home champion" in the community?*

Resources and Tools

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Data Resources

- HCP CHIRP Database

Database to document HCP Care Coordination. Contact: HCP State Office (303-692-2370) for data request.

- Colorado Child Health Survey

An annual survey of households to assess health risk and behavior for children ages 1-14.
http://www.cdphe.state.co.us/hs/yrbs/ChildHealth.html

- Child and Adolescent Health Measurement Initiative (CAHMI)

Tools and strategies to assess Preventive Services for Young Children, Standardized Developmental Screening, Children with Special Health Care Needs and Data Resources.
http://www.childhealthdata.org/content/Default.aspx

- National Child Health Survey (National Health Interview Survey (NHIS)

Data for specific diagnoses and selected measures of health care access/utilization for children under 18.
http://www.cdc.gov/nchs/fastats/children.htm

- National Survey of Children with Special Health Care Needs Data

State health care data for CSHCN.
http://www.cdc.gov/nchs/about/major/slaits/nscshcn_05_06.htm

Medical Home Resources

- American Academy of Pediatric Medical Home

Provides Care Coordination tool kits, educational materials for both professionals and families.
http://www.medicalhomeinfo.org/

- Colorado Medical Home Initiative

A statewide effort with state and local partners to build systems of quality health care based on the core components of a medical home as endorsed by the AAP.
www.medicalhomecolorado.org

- The Center for Medical Home Improvement

Provides guidance, tool kits and resources for CSHCN and Medical Home Approach.
http://www.medicalhomeimprovement.org/

- Utah Collaborative Medical Home Project

Tools, assessments/resources of parent/professional teams.
http://medhomeportal.org/

- Washington State Medical Home for CSHCN

Provides useful tools and information for CSHCN and Medical Home Programs.
http://www.medicalhome.org/

Technical Assistance

- To develop goals and S.M.A.R.T. objectives, visit this interactive website:
http://apps.nccd.cdc.gov/dashoet/writing_good_goals/page002.html

SMART!
Specific
Measurable
Achievable
Realistic
Time- framed