

# Wisconsin Medical Home Learning Collaborative: A model for implementing practice change

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## Abstract

A child with special health care needs is defined as having, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition that requires health and related services of a type or amount beyond that required by children generally. In Wisconsin nearly 14% of children are identified as having or being at risk for special health care needs. *Healthy People 2010* and the federal Maternal Child Health Bureau have challenged each state to “assure access to ongoing comprehensive health care through a medical home” for all children with special health care needs. A medical home is defined as “an approach to providing continuous and comprehensive primary pediatric care.” States are challenged to translate the concepts of medical home to clinical practice activities. This article discusses Wisconsin’s participation in a national Medical Home Learning Collaborative and Wisconsin’s replication of the Collaborative as a means to develop practical strate-

gies for practice implementation of a medical home.

## Introduction

A recent national survey concluded that nearly 13% of children in the United States and nearly 14% of children in Wisconsin have a special health care need.<sup>1,2</sup> As defined by the US Maternal and Child Health Bureau (MCHB), children with special health care needs (CSHCN) have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required by children generally.<sup>3</sup> With improved technologies and increased survival rates, this group of children has grown by 30% over the past 20 years. It is estimated that CSHCN account for 80% of pediatric health care expenses nationally. CSHCN have 2.5 times greater the number of school absences, twice as many unmet health needs, and almost 2.5 times as many contacts with physicians.<sup>4</sup> Health care professionals and families are faced with the challenge of managing complex health care for CSHCN in a system that is ill equipped to provide chronic care management.

Policy makers, health care professionals, and families recognize that finding ways to better coordinate care, minimize duplication of services, reduce hospitalizations,

and improve quality of care is critical. The federal MCHB along with the American Academy of Pediatrics (AAP) have identified a medical home for children with special health care needs as a core health outcome and model approach to providing care.<sup>5</sup> The Future of Family Medicine also includes a personal medical home among its recommendations.<sup>6</sup> A medical home is defined by the AAP as “not a building, house, or hospital, but rather an approach to providing continuous and comprehensive primary pediatric care from infancy through young adulthood, with availability 24 hours a day...from a physician whom families trust.”<sup>7</sup> *Healthy People 2010*, the 10-year agenda for meeting the nation’s health needs, includes a specific goal that all CSHCN have access to a medical home.<sup>8</sup> Each state Title V Maternal Child Health and CSHCN Program is challenged to achieve this goal.

In 2001-2002 the Wisconsin Maternal and Child Health Advisory Committee in collaboration with the MCHB and AAP developed the document Medical and Dental Home: Wisconsin’s Plan to meet the goal that “all CSHCN have access to ongoing comprehensive health care through a medical home.”<sup>9</sup> In developing the plan, the advisory committee identified a number of barriers. Families and health care professionals are not al-

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ways familiar with the concepts of medical home; in fact, for some the term “medical home” is equated with out-of-home placement or the provision of medically complex care in the home. Because health care professionals are not familiar with community resources, they are unable to link CSHCN and their families to resources. Care coordination is a critical aspect of providing a medical home, but the reality for many health care professionals is a limited amount of time and a lack of reimbursement for coordination services. Practices need a practical method to become a medical home that includes a means to determine current practice, a mechanism to change or improve, and a way to measure this change.

## Methods

In 2003 Wisconsin was 1 of 11 states selected to participate in a National Medical Home Learning Collaborative sponsored by MCHB, the National Initiative for Child Health Quality (NICHQ), the Center for Medical Home Improvement (CMHI), and the National Center for Medical Home Initiatives for Children with Special Needs at the AAP.<sup>10-12</sup> The Collaborative utilized the Institute for Healthcare Improvement’s “Breakthrough Series” model as a means of accomplishing its goals to improve care for CSHCN. The Wisconsin team included the medical director and health educator from the CSHCN Program, the chief medical officer for Long Term Care, Division of Health Care Financing, and the special needs coordinator, Children’s Hospital of Wisconsin. Statewide, 3 geographically diverse primary care practices were asked to form a 3-person team (lead physician, care coordinator or key non-physician staff member, and a parent of a child with special needs). Teams attended 3 face-to-

face learning sessions and conducted quality improvement changes at the practice level over the course of the 12-month period. Faculty with expertise in process improvement and measurement, primary care or general pediatrics, research, finance, health policy, principles of family-centered care, care coordination, and other topics essential to providing a medical home assisted teams. Dr Carl Cooley, Center for Medical Home Improvement at Children’s Hospital at Dartmouth Hitchcock Medical Center, chaired the Medical Home Learning Collaborative.

During the Collaborative, Wisconsin teams were asked to complete an assessment of technical assistance needs. In response to this assessment, Wisconsin CSHCN staff conducted a retreat/training for its practice teams. At the meeting, staff discussed “lessons learned” and solicited suggestions from participants regarding a 2004 Wisconsin replication of the learning collaborative process.

## Results

Wisconsin practice teams at the initiation of the Collaborative did not have mechanisms in place to consistently identify CSHCN within their practice. Practices did not have routine access to care coordination services or have care plans in place for even the most complex CSHCN. All practices had limited knowledge of community resources or how to link families to these resources.

During the Collaborative, all practices completed rapid-cycle quality improvement projects aimed at identification of CSHCN, care planning, and resource development. Those teams with a meeting facilitator reported meeting more frequently and accelerated quality improvement project timelines. Practice teams uniformly

identified parent partnerships as a major strength of the team process. Families provided an important consumer perspective to office operations. All practices implemented mechanisms to gather family input either through survey or focus group. To ensure continued parent participation, all teams recommended having more than 1 parent partner as part of the team. Connecting practices to the Wisconsin CSHCN Program’s Regional CSHCN Center helped link families to available resources within their community. Regional CSHCN Center staff also provided training to office support staff on resources and assisted in the spread of medical home concepts to other clinic staff within the practice setting.

Utilizing the model of the National Medical Home Learning Collaborative and based on experiences gained during participation, the CSHCN Program initiated a Wisconsin Medical Home Learning Collaborative. Nine primary care practice teams made up of both pediatricians and family physicians were recruited in spring 2004. All practice teams have at least 1 parent partner and many have 2. The 5 Regional CSHCN Centers serve as facilitators to the Medical Home practice teams located in their regions. In March 2004 all Regional CSHCN Center facilitators and key CSHCN state staff attended a 1-day training conducted by the Center for Medical Home Improvement to learn more about the Collaborative model and practice facilitation. Practice tools were assembled from the National Medical Home Learning Collaborative, the Center Medical Home Improvement, and the National Center for Medical Home Initiatives for Children with Special Needs, along with state-specific resource information, to begin to develop a Wisconsin Medical Home Toolkit.

Prior to the first learning session, all practices completed the Medical Home Index. The Medical Home Index (MHI) is a validated practice level tool developed by the Center for Medical Home Improvement. This tool provides a “point-in-time assessment of the implementation of medical home elements.” The tool has 25 items or themes divided into 6 domains of practice activity thought to be critical to medical home quality of care: (1) organizational capacity, (2) chronic condition management, (3) care coordination, (4) community outreach, (5) data management, and (6) quality improvement.<sup>13</sup> Teams utilized the MHI to identify areas of quality improvement. Practices will complete an MHI at the conclusion of the Wisconsin Collaborative. It is expected that practices will demonstrate an increase in their MHI scores.

Three learning sessions are scheduled for 2004. The first session was held May 7-8 with Dr Cooley as the keynote speaker and meeting facilitator. All practice teams initiated activities related to identification of CSHCN in their practice, care coordination/care planning, and resources/support services for families. Practice teams and Regional CSHCN Center facilitators continue to meet between learning sessions. Future learning sessions will focus on financing issues, communication issues related to primary and specialty care, and transition issues. Each learning session will also continue to promote rapid cycle improvement methodology.

#### Discussion

Medical home implementation requires partnerships between families and health care professionals. Practices need to have tools in place to translate the concepts of medical home into daily clinic operations.

Participation in the National Medical Home Learning Collaborative provided Wisconsin the opportunity to learn from experts in the field, partner with families to test implementation of medical home concepts utilizing a rapid-cycle quality improvement method in the practice setting, and access tools developed by participating practice teams. The Medical Home Learning Collaborative model can be replicated at the state level. As states work to meet the *Healthy People 2010* goal that “all CSHCN have access to a medical home,” a Learning Collaborative model can facilitate practice change and provide some of the support necessary to create medical homes.

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