

The University of Illinois  
Division of Specialized Care for Children

in collaboration with

The Illinois Academy of Family Physicians,

The Illinois Chapter of the American Academy of Pediatrics

and

Illinois Health Connect

A Program Sponsored by The Illinois Department of Healthcare & Family Services

**A Medical Home Primer  
for  
Community Pediatricians  
and Family Physicians**



**The Roadmap to  
a Medical Home**

### **Target Audience**

All physicians who provide primary care for children, adolescents, and their families in Illinois, including children with special health care needs.

### **Objectives**

After completing this monograph, physicians will be able to:

Define the medical home concept and its core elements as it relates to the primary care setting involving all children including children and youth with special health care needs (CYSHCN).

Recognize the importance of partnering with families.

Evaluate the “medical homeness” of their practice using available assessment tools. Assess office practices with the philosophy that the Medical Home is the basis to care for all children including CYSHCN.

Identify practical methods of improving quality health care in their practices including physical and procedural changes.

Understand the key characteristics that should guide physicians in providing coordinated care to CYSHCN and their families.

Be familiar with contracting with payers and some of the coding and reimbursement issues specific to the medical home model.

Understand how to implement a continuous quality improvement process in their practice.

### **Preface**

The purpose of this monograph is to offer busy primary care physicians a menu of suggestions that can be incorporated into their practice to improve the quality of health care in the medical home they provide to patients and their families. This Road Map will provide a naturally evolving approach to building a medical home, but, as a practice, you will need to consider only those options that are most appropriate to your practice setting. An initial assessment should help guide you through the menu options to determine how you will proceed. Many suggested changes are simple to adopt and most are not costly.

The Table of Contents has a brief summary for each chapter with a description of the many activities that you can integrate into your practice to build a medical home based on a strong foundation of quality health care. The soul of the medical home model is the relationship that you have with families. Read this chapter carefully and understand it thoroughly before proceeding, as every change you make in your practice relates to the families and their children whom you serve.

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### **DSCC Medical Home Provider Approval**

Successful completion of the Medical Home Primer activity and exam is an OPTIONAL step in becoming an approved DSCC Medical Home Provider.

**Note:** The material in this monograph is also available on the [DSCC website](#). The references at the end of this monograph are embedded into the text online for easier access to the links.

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The Medical Home Primer exam and evaluation can also be completed and submitted electronically. It is available online at: <a href="http://internet.dsccl.uic.edu/forms/medicalhome/MedHomeCMEMonograph.pdf">http://internet.dsccl.uic.edu/forms/medicalhome/MedHomeCMEMonograph.pdf</a>	

# **Introduction**

## **The Road Map to a Medical Home**

### ***What is a Medical Home?***

*“Taking care of a medically complex, chronically ill child is extremely challenging. The most difficult aspect of this life is getting all the caregivers on the same page when an acute situation or even a planned surgery or procedure is done. (...) The coordination of care between specialties is difficult. Everyone cares but time is so sparse for the doctors as well as the families. I would love to see a specialty developed just for the medically complex child/adult so there could be a central location where the specialists and families could go to keep current”.*

“DSCC Family Survey: What Families Said”, 2005

The term “medical home” is becoming more commonly used but frequently has different connotations to people as they see it used in various venues. For some it refers to a special program for children with special health care needs. For others, it refers only to the primary care doctor. Some organizations promote specific components of the medical home model by focusing only on care coordination, written care plans, care notebooks or quality improvement efforts. In fact, the medical home model applies to ALL CHILDREN. A medical home is a community-based primary care setting that integrates quality and evidence-based standards in providing and coordinating family-centered health promotion in wellness, acute and chronic condition management.

A medical home revolves around a family-professional partnership that is the foundation for wellness, acute and chronic condition management. Medical home is not a program adopted by a practice for children with special health care needs. Although some of the aspects of a medical home are specifically for children with special health care needs, a medical home actually represents quality health care that focuses on family-physician partnerships for all children. "All children deserve a medical home" is one of the Healthy People 2010 national objectives.

**Family-Professional Partnerships**  
are essential for  
effective and meaningful  
**Acute, Preventive and Chronic Condition**  
**Primary Care Management**

Regardless of whether a family brings their child to see a physician for acute health care, preventive care or for management of a chronic health condition, they want to have a trusting collaborative relationship with their child’s doctor. This family-professional partnership should prevail in whatever type of care they are seeking. This partnership is the foundation of the medical home model. Without this trusting collaborative partnership, the family does NOT have a medical home. Beyond this partnership, the medical home model provides a blue print for practices to incorporate best practice models and evidence-based medicine as much as possible. This means knowing community resources, communicating effectively with sub-specialists, implementing professional policy guidelines like developmental screening, immunization schedules and Bright Futures Guidelines in well child care.

Though the group of children with special health care needs is broad in scope and needs, a coordinated, comprehensive, and integrated system of health care is needed for all children. The basic elements of accessibility,

continuity, comprehensiveness, coordination, family-centeredness, compassion and cultural effectiveness are critical to the medical home concept.

**Accessibility** is often a major challenge for children with special health care needs and their families. Accessibility does not just refer to the hours that an office is open and the provision of after hours coverage, but also to geographic location and transportation availability. For instance, a child may only live a few miles from their physician's office, but not be able to get there because public or private transportation is not available. A family may also have difficulty with access because providers enrolled in their health plan are not available in their community. The provider's role in ensuring care is accessible is not limited to maintaining appropriate office hours or adapting facilities to accommodate patients with mobility disorders; health care providers must advocate for appropriate ancillary services, insurance coverage, and transportation assistance. Local and state initiatives, such as the All Kids Program available to physician offices in Illinois, help to address the access issue overall. The All Kids program includes a primary care case management (PCCM) component, called Illinois Health Connect<sup>2</sup>, which seeks to strengthen medical homes by ASSISTING ALL ELIGIBLE PATIENTS TO CHOOSE ONE PCP AS A MEDICAL HOME (assigning patients to specific providers) and providing an incentive (\$2 per PEDIATRIC patient per month) to those providers to coordinate care. An estimated 1.2 million children are eligible to be served by this program. Many of those children will have special needs; based on fiscal year 2005 data prior to the All Kids expansion, the Illinois Department of Healthcare and Family Services (HFS) served approximately 108,000 children 18 and under with specified diagnoses of disabilities or special needs. (Nearly 60,000 of those children had attention deficit disorder or were diagnosed with prematurity, while the remaining 50,000 had more severe medical needs.)

**Continuous care** is important for children with special health care needs who often rely on emergency departments for their episodic care. All too often, their chronic care and wellness needs frequently never get addressed. Continuity of care not only includes the scheduling of sick visits, but also chronic care coordination and preventive care visits. Children with asthma have been chronically underserved in this area. Many physicians are providing asthma education and preventive care for these children and their families, as well as chronic and acute care coordination plans. This model has been shown to improve both medical and psychosocial outcomes and decrease overall health care costs. In the medical home, the physician will provide such care to children with a wide range of health care conditions. Continuity of care also provides opportunities to assist families at times of change and transition.

**Comprehensive care** is another important concept in the medical home. It not only refers to the management of primary, chronic, preventative, and tertiary care but also to education, mental health, and community referral needs. Having a working knowledge of local, state and federal programs for children with special health care needs as well as community resource directories helps a great deal toward being able to provide a medical home. For instance, having a working relationship with the local early intervention office (i.e., Child and Family Connections in Illinois) can help a family who recently had a baby with Down Syndrome get off to a healthy start. A physician that knows key local school administrators and other staff can help a child with newly diagnosed diabetes adjust to a school routine while managing their illness.

**Coordination of care** is key to the medical home.<sup>3</sup> All services can be in place for a child, but if they are not linked through communication, much will be lost. Information needs to be shared freely with the family's permission among all professionals involved with the child. For instance, if a child is receiving early intervention services, efforts must be made to assure the primary physician receives the initial evaluation and progress reports so that appropriate medical decisions can take place. The medical home serves as a centralized source of information about the child and facilitates coordination of services.

**Family-centered values** in the delivery of health care are essential to the success of the medical home. Family-centered care is a philosophy of care that is based on the following principles<sup>4</sup>: In family-centered health care...

- People are treated with dignity and respect.

- Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.
- Individuals and family members build on their strengths by participating in experiences that enhance control and independence.
- Collaboration among patients, families, and providers occurs through policy and program development and professional education, as well as in the delivery of health care.

Family-centered health care systems recognize that the child and family are at the center, and the system is there to provide for them. Embracing a family-centered approach means believing that families want the best for their children and are their constant. Finding and recognizing family strengths is of the essence, as problems are often easy to find but solutions are not.

**Compassionate care** and family-centeredness go hand-in-hand. Breaking bad news to a family is one of the most challenging things a physician must do on a daily basis. Families remember how they felt when they were told the bad news and whether the giver of the news was compassionate in their approach. They remember little of the specific medical details. The main thing they remember is if the physician cared.

**Cultural effectiveness** may be the most challenging aspect of care in the multicultural society of the United States. Increasingly, children and families come from other countries and often do not speak English well. Awareness of one's own cultural heritage and values is the first step in recognizing and respecting other cultures and their values. Culturally effective care requires ongoing assessment of the often-changing demographics of a community and attention to the specific cultural and ethnic customs of each population. Resolution of issues can only take place with mutual respect and learning. Interpreters and translation services must be available as well as the provision of multi-language materials.

### **Advancing the Medical Home Model**

When reviewed, most primary care practices are providing excellent care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. But, like the human body or any mechanical device, a commitment to continuous review to maintain state-of-the-art quality standards is important. Beginning in 2010 primary care physicians, both pediatricians and family physicians, will be required to demonstrate quality improvement for direct patient care in order to meet board recertification requirements.

The Medical Home Model has been actively promoted by the American Academy of Pediatrics (AAP) in partnership with the Maternal and Child Health Bureau (MCHB) since 1998. This partnership has now expanded to include the American Academy of Family Physicians, the American College of Physicians and the American Osteopathic Association. Their consensus statement<sup>5</sup> articulates how families and patients identify a primary care practice to provide accessible, continuous, and coordinated care.

*“My (child) sees so many doctors that if a problem arises in one area from a medication stand point, I have to try and reach the other doctor to see if a different medication can be used to treat one problem because the current medication has side effects that are creating another problem. I really wish sometimes that his doctors could just call each other to discuss these issues without me always having to be the middle man relaying information back and forth from doctor to doctor. It gets very frustrating to have to contact a doctor and have to leave a voice mail, then have to wait for a call back so that you can relay this information to the other doctor to see how we should proceed with my (child’s) treatment. It seems like I’m always waiting on a call back from one doctor or another”.*

“DSCC Family Survey: What Families Said”, 2005

# Chapter 1

## Parent Partnerships: The cornerstone of the medical home

*“To give a parent’s perspective (and have a doctor listen) is invaluable.”*

-Diana Lee, Medical Home Quality Improvement Team parent partner-

Seeking input from families who have a child with special health care needs provides valuable first-hand experiences that primary care physicians would otherwise not realize. Practice staff can learn a lot from families when they engage them in discussing the day-to-day issues, barriers, and challenges they face in caring for and meeting the many needs of their child and family.

Physicians need to reach out and actively encourage parents to become “parent partners” with the practice. This can be done as part of an organized Quality Improvement (QI) Team or through family surveys, focus groups or simply through everyday communication with families. Impromptu communication is a good tool, but planned communication efforts are more consistent and meaningful over time.

Practices often recognize the value but fail to elicit family input. Families understand the “little things” that make a visit to the physician effective and beneficial. This can include such things as how the practice has trained staff to answer an initial phone call, or how the practice can schedule additional time to treat children with special health care needs. Asking families “what could be done better,” or “what can we do to make your appointment more beneficial,” can provide opportunities for families to help improve the quality of health care delivery within the practice.

Practices that have incorporated family involvement have seen changes that have enhanced the quality of care. Numerous practices across Illinois have made changes as a result of family involvement. Some of these changes include:

1. Use of specific phone scripts at the point of initial contact to help make the appointment go smoothly for the family. These scripts often ask for family input on accommodations needed to improve their visit experience such as waiting in the waiting room versus being placed immediately in the exam room.
2. Assistance getting into and out of the office, when needed.
3. Extended appointment times for children with special health care needs.
4. Routinely asking for family feedback in the form of surveys or questionnaires.
5. Providing resources in the practice such as internet access or distributing specific health related materials.
6. Providing parent-to-parent connections by way of support groups, after hours informational meetings, or phone trees of parents in the practice whose children have a chronic health condition and wish to become resources to newly diagnosed families.

Why is family involvement the cornerstone of the medical home in your practice? Because each partner - the family, the primary care provider and other office staff - brings their unique perspective to the process. Each partner has important viewpoints to contribute to the process, so each has uniquely meaningful ways to enhance the delivery of quality health care.

*“Having a child with special needs can be very life consuming. It is nice to know that our docs and staff (at ...) understand our struggles and triumphs. They help us to coordinate care for our special kids and to help them reach the maximum potential of their abilities. Not only is there concern for the child, but the family as a whole”.*

-Cheryl Noll, Medical Home QI Team parent partner-

## Chapter 2

### Practice Assessment: Using data to determine where to begin

One of the quickest and easiest ways to determine where to begin is to objectively assess your practice's model of health care delivery using a standardized assessment tool. Assessment tools can be very comprehensive or very general, look at process outcomes or procedural detail and other possible variables that define optimal care. Some are lengthy and time consuming to administer while others are concise and can be quickly completed.

#### Practice Assessment

The Medical Home Index (MHI)<sup>6</sup>, developed by W. Carl Cooley, MD and Jeanne McAllister, MS, MHA of the Center for Medical Home Improvement (CMHI), is a nationally validated primary care self-assessment tool designed to translate the broad indicators defining the medical home into observable, tangible behaviors and processes of care within any office setting. The MHI is based on the premise that medical home is a work in progress rather than a fully realized status for most practice settings. The 25-item MHI measures a practice's quantitative progress in this process and can be used to periodically assess improvement efforts.

The CMHI has developed a Medical Home Index-Short Version<sup>7</sup>, which is available on their website. The 10-item short version was derived from the original MHI. The short version can be used as an interval measurement in conjunction with the original MHI, or it can be used as a quick “report card” or snapshot of practice quality for periodic measurement and/or when it is not feasible to use the full MHI.

Another tool that provides an objective approach to self-assessment is the Practice Assessment Checklist (PAC)<sup>8</sup>, developed by the Illinois Medical Home Project<sup>9</sup> (IMHP). The PAC is an instrument developed by the Illinois Chapter of the American Academy of Pediatrics for the IMHP. The PAC provides a baseline and follow-up assessment of the practice’s medical home characteristics as defined in the AAP Medical Home policy statement. It was pilot tested with two primary care practices in 2004 and field tested with six primary care practices at baseline in 2004 and follow up in 2006. The instrument was then revised based upon the results of the field test. The PAC is designed to measure pre- and post- medical home quality improvement outcomes at a practice and can be administered by an independent evaluator during a site visit to the practice. The Domains 1-8, as indicated in the table below, may be completed by interviewing the lead physician and one or two key office staff about various aspects of the practice. Domains 9 and 10 may be evaluated by an evaluator for assessing the physical structure of the office, accessibility for children with disabilities, and resources available in the waiting area and exam rooms.

DOMAIN	OVERVIEW OF QUESTION CONTENT
1. Patient Accessibility	Insurance plans accepted, accessibility of medical records, accessibility of physicians by phone and off-hours, proximity to public transportation, availability of computer resources for families on-site.
2. Family-Centered	Use of patient satisfaction surveys, ability to see provider of choice, special considerations made for CYSHCN prior to and during office visit.
3. Continuous	Support for transition care (adulthood), participation in hospital & rehabilitation discharge planning, responsiveness to families leaving practice, etc.

4. Comprehensive	Use of periodicity schedule, in-office developmental assessments, vision screening, anticipatory guidance, handouts about public resources, clinical practice guidelines, resource library for families, etc.
5. Coordinated	Identification of special needs population, care coordinator for CYSHCN, use of chronic condition management care plans, communication with specialists, handling of referrals to Early Intervention, etc., information about support groups, community resources, etc.
6. Compassionate	Staff awareness of AAP policy statement on medical home, ability to provide proactive support for families in turmoil
7. Culturally Effective	Use of bilingual staff/translators, translation of written information given to families.
8. Quality Improvement	QI process, goals, objectives, measures
9. Physical Accessibility	Wheel chair accessibility, bathroom accessibility, elevator accessibility.
10. Other Environmental Issues	Bulletin board content; culturally appropriate pictures, posters, magazines, printed material, toys and other material in waiting area.

There are a number of other measurement tools developed to help objectively assess where you stand and help you to begin contemplating how to proceed. You can find more examples of these measurement tools on the National Center for Medical Home Initiatives web site, on the Medical Home Measurements page in the Tools section<sup>10</sup>.

If you are interested in assessing your practice's cultural diversity and cultural competency, you can utilize the Self-Assessment Checklist for Personnel that is found on the Medical Home Measurements web page listed above. Or, for more information and resources on cultural competence, go to the Georgetown University Center for Child and Human Development - National Center for Cultural Competence<sup>11</sup>. The Center web site contains, among other things, many online resources and tools including a web-based practice assessment tool<sup>12</sup> and a downloadable practice self-assessment checklist<sup>13</sup>.

The American Academy of Family Physicians has developed a web-based training program<sup>14</sup> entitled “Quality Care for Diverse Populations” to assist physicians and other health care professionals in becoming more culturally proficient in the provision of care to their patients. The program includes five video vignettes depicting simulated physician-patient visits in an office setting as a means to explore ethnic and socio-cultural issues found in today's diverse health care environment.

Another good reference for cultural competence is the Department of Health and Human Services, Office of Minority Health<sup>15</sup>. This site offers the latest resources and tools to promote cultural competency in health care. You may access free online courses accredited for continuing education credit as well as supplementary tools to help your practice promote respectful, understandable, and effective care to your increasingly diverse patients.

Bright Futures has developed a Cultural Competence Assessment tool<sup>16</sup> that can be used to get feedback from families. This tool provides families the opportunity to share their experiences and perceptions about the health care received within your practice.

## Family Feedback

In a survey reported by Liptak and Revell<sup>17</sup>, parents and physicians were both asked what services families most needed. Families who participated in the survey listed "information about community resources" as their number one need, whereas, physicians listed "respite care" as a family's greatest need. The study revealed that although families identified information as their greatest need, physicians believed their greatest need to be services. The important point to remember is that without family involvement, a practice may focus on changes that represent different priorities than those of the parents they actually serve.

Regardless where you choose to begin, parent involvement is essential to successful improvement. Parents can be involved in providing feedback about service delivery, office hours, access to the office, or a variety of other aspects of care delivery.

The Medical Home Family Index, developed by the CMHI, is intended to be used in conjunction with the MHI, described above. This tool uses 25 questions to capture the family's perspective about the practice's health care delivery system. In Illinois, we have adapted the Medical Home Family Index (MHFI) to correlate more closely with the Medical Home Index completed by the practice. This MHFI-IL version<sup>18</sup> has reorganized the instrument into 4 of the 6 domains defined in the MHI, so that analysis of both instruments more easily leads to identifying correlation and/or discrepancy. Family feedback can then be more easily compared to your practice's self-assessment, outlining areas where both were in agreement, as well as areas where responses were discordant. These discrepancies in perspective can provide opportunities to consider action for future improvement.

Another measurement tool developed by the CMHI is the Family/Caregiver Survey<sup>19</sup>. This extensive assessment of family needs looks at the impact of chronic health conditions, satisfaction with care, utilization of services, and unmet needs. Gaining this feedback from families provides a comprehensive profile of needs and can assist in identifying priority areas for improvement.

The Illinois Medical Home Project has combined the Medical Home Family Index with the Caregiver Survey to create the Illinois Medical Home Family Feedback Tool<sup>20</sup>. This tool is being used to provide more comprehensive feedback and input from families on their perceptions about the care received within their primary care medical home.

## **Chapter 3**

### **Consumer Awareness:**

### **Ways to help spread information about Medical Home**

Now that you are interested in establishing a medical home, you may wonder "what can I do to get everyone on board?" One of the best ways to help expand your medical home is to share educational materials with others in your practice and with the families you serve.

There are a number of quick and easy ways to get the message out to families that your practice is providing a medical home for all children. Many of these efforts will also help to enhance your practice staff's support for change. Here are a few ways to expand awareness about medical home:

1. Utilize the medical home visit card, developed by the Illinois Medical Home Project, to help families learn more about preparing for office visits and managing their health care afterwards. The 2-sided card is available in both English<sup>21</sup> and Spanish<sup>22</sup>. Contact the University of Illinois, Division of Specialized Care for Children (DSCC) at 1-800-322-3722 to receive a free supply of the medical home visit cards printed on heavy stock glossy card paper.
2. Have a supply of the DSCC medical home information brochure for families<sup>23</sup> in your waiting room. Contact DSCC to receive a free supply of these brochures.
3. Develop a practice newsletter to inform families about practice efforts to expand medical home, upcoming events, resources, support groups, and highlight health promotion and prevention. Sample newsletters have been developed by several Illinois medical home practices: Children's HealthCare Associates Newsletter<sup>24</sup> and Sterling Rock Falls Pediatric Center Newsletter<sup>25</sup>.
4. Create posters to place in your waiting room and exam rooms to increase family awareness of the medical home concept. The Illinois Medical Home Project has developed medical home poster templates in both English<sup>26,27</sup> and Spanish<sup>28,29</sup> for practices to use. Contact DSCC for assistance in customizing and creating posters for your office. Our staff will work with you to design free electronic files of medical home posters that meet your specific needs and can be printed at local printing facilities on legal size paper.
5. Establish a medical home bulletin board and/or a reference library in the waiting room where families can find information about diagnosis-specific information, current events, local resources, and support groups. Provide access to a current copy of the Exceptional Parent Annual Resource Guide<sup>30</sup>. Include books such as those published by DisAbilities Books<sup>31</sup> in your reference library.

The Special Addition family newsletter<sup>32</sup>, developed by the state Title V program for children with special health care needs, is another resource to help inform families about current issues and helpful resources. Many states publish a version of this newsletter that includes information about national as well as state and local issues and resources.

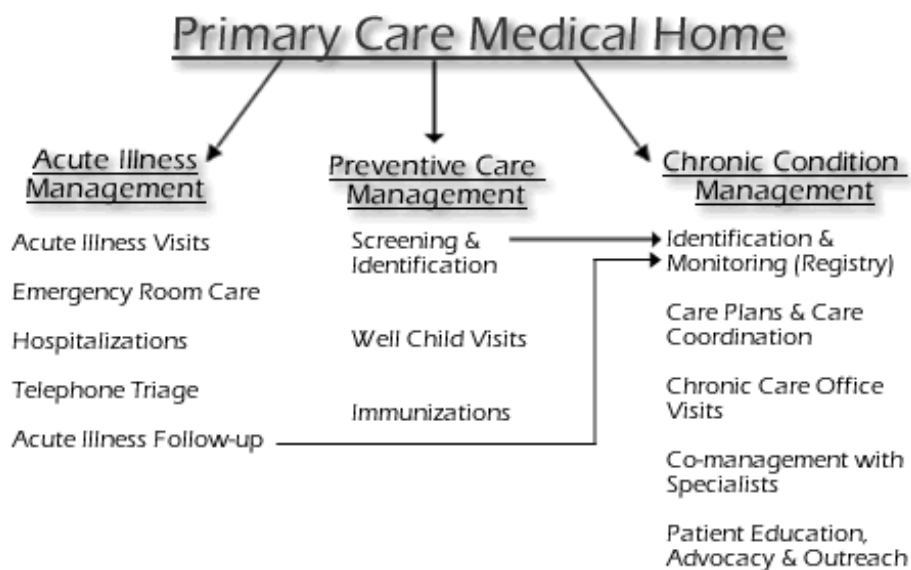
You can find more suggestions and ideas for marketing your medical home on the American Academy of Pediatrics National Center of Medical Home Initiatives for Children with Special Needs website<sup>33</sup>.

# Chapter 4

## Practice Improvements: Easy Ways to Enhance Care Delivery for Acute Illness, Preventive Care & Chronic Condition Management

“...(they seem to forget that I am the professional on my child). It's not just about the child w/disability, it's about the family”.  
 “DSCC Family Survey: What Families Said”, 2005

The process of quality improvement is a self-directed process in partnership with families. Determining which activities will have the most benefit for the practice, and the families served, is an important step to improving care. This chapter emphasizes the Primary Care Medical Home Model as it applies to acute illness management, preventive care management and chronic condition management. For each of the three components, this chapter will describe a variety of activities to enhance quality health care following the principles of the medical home model. Bright Futures provides quality guidelines for well child care. Policies and best practice models provide further guidance for improving care in all three components of the Primary Care Medical Home Model. In addition, some practical strategies developed by medical home practices are also described in this chapter.



Integrating Health and Related Systems of Care for Children with Special Health Care Needs<sup>34</sup> outlines an important role for primary care physicians in the process of care coordination, in concert with the family. Medical homes for children with special health care needs incorporate the same elements of health supervision, community-based preventive care, developmental surveillance, and anticipatory guidance used in the ongoing care of all children. Care should be accessible, comprehensive, continuous, compassionate, culturally effective, and family-centered. The medical home reinforces care coordination activities by the primary care practice team: the primary care physicians in collaboration with nurses, families, and support staff. In pediatrics, family-centered care<sup>35</sup> is based on the understanding that the family is the child’s primary source of strength and support. Further, this approach to care recognizes that the perspectives and information provided by families, children, and young adults are important in clinical decision making.

## **Practice Accommodations**

The following three subsections of this chapter use the Primary Care Medical Home Model to describe suggestions for practice change based on 1) practical strategies, including educational programs provided by professional organizations and 2) AAP/AAFP-endorsed policies and best practice guidelines. The goal in developing practice accommodations is to facilitate a more family-centered approach to primary care in a practice along with organizing office procedures to proactively provide care for CYSHCN. Families with CYSHCN have many challenges in their daily lives, and obtaining appropriate health care and related services for their child should not be one of them.

In addition to a practical strategies approach for change, a practice might consider using policies and best practice guidelines to structure change. In 2005, the AAP developed the Partnership for Policy Implementation (PPI). “A growing body of research continues to demonstrate the distinct role of health information technology (HIT) in facilitating quality improvement efforts and putting standards of care into practice. It is the AAP’s belief that in order to meet this growing trend, AAP statements must be “operationalized” to provide HIT standard-developing groups and software designers with specific, unambiguous content. The PPI aims to ensure that HIT implementations are designed to meet the specific needs of child health professionals by facilitating creation of some of the fundamental building blocks of electronic health record (EHR) systems during the process of statement development”.<sup>36</sup> As of 2007 three policies have been developed using the PPI approach and are referenced in the following sections. The policies are Developmental Screening, Bronchiolitis and Flu Shots. As more policies are converted to the new PPI standards, they will be identified.

## Practice Accommodations for Acute Illness management

Referring to the Primary Care Medical Home Model, this section describes how quality improvement efforts in your practice can impact acute illness management. The medical home model promotes high quality health care in all aspects of the primary care practice, which also includes acute illness management. First, practical strategies that have been tried and proven beneficial in medical home practices will be described. Then, examples of several professional policies and best practice guidelines are presented as a guide to develop standard protocols in the management of several acute health conditions. Less than 50% of policies and best practice guidelines are implemented by primary care practices. Utilizing these policies and guidelines will result in better patient outcomes, more efficient management, and ultimately will reduce health care costs.

### Practical Strategies

**Bulletin boards in the waiting area** - to share educational information with families as well as post information about helpful community resources. Suggested topics could include information about ear infections, upper respiratory infections and how to treat the flu. Educational handouts on these issues may also be helpful.

**Internet access for families** - to support those families that do not have internet access. Some practices have placed a computer in the waiting area, so families are able to obtain diagnosis-specific information, family support networks, and additional state and local resource information. Web sites could be saved as favorites on topics related to many of the illnesses that occur in children.

**Visit preparation** - to assist families in preparing for the child's office visit provides benefits for the child and family as well as the practice staff. The primary benefit is improved communication to promote proactive primary care. Practices gather individualized information about the strengths and needs of families at office visits to better meet these needs and more effectively coordinate services.

### Available Tools for this Preparation

1. **Medical Home Visit Card** - a handout for families that addresses important points to prepare for the child's medical appointment, "Make each doctor's appointment work for you!" (one side in English<sup>21</sup> and one side in Spanish<sup>22</sup>)
2. **Pre-visit questionnaire**<sup>37</sup> - this questionnaire is given to patients and families to complete in the waiting room prior to the appointment. It lists areas of concern and or discussion. Office staff can review the survey before the child sees the physician so that they can prepare for specific needs/concerns such as the need for care coordinator assistance or educational materials. Families are asked if assistance is needed in completing the form. This sample was developed by Exeter Pediatrics, Vermont and is included in the Medical Home Improvement Toolkit created by the Center for Medical Home Improvement.
3. **Today's Visit Form**<sup>38</sup> - another tool to help families share their concerns and issues about the child's health (changes in medication, referral needs, updated therapy or specialty visits, etc).
4. **Post-visit questionnaire**<sup>39</sup> - a companion to the pre-visit questionnaire allows families the opportunity to provide feedback on the office visit and how well the needs and concerns were addressed. This sample was developed by Exeter Pediatrics, Vermont and is included in the Medical Home Improvement Toolkit created by the Center for Medical Home Improvement.

## Policies and Best Practice Guidelines

The following is a brief list of the more pertinent clinical policies and best practice models that can be used as a guide to make change and improve quality of health care in the three components of a primary care medical home practice. Recognizing that practices are already busy providing care and that change is challenging, choose one at a time and slowly integrate the recommendations into your practice setting.

### **Bronchiolitis<sup>40</sup>**

Bronchiolitis is a disorder most commonly caused in infants by a viral lower respiratory tract infection. It is the most common lower respiratory infection in this age group. It is one of the first policies to be converted by the PPI process.

### **Febrile Seizures**

*Long-term Treatment of the Child with Simple Febrile Seizures<sup>41</sup>* is a practice guideline designed to assist pediatricians by providing an analytic framework for the treatment of children with simple febrile seizures. *Technical Report: Treatment of the Child with Simple Febrile Seizures<sup>42</sup>* provides pertinent evidence on the individual therapeutic agents studied including study results and dosing information.

*The Neurodiagnostic Evaluation of the Child with a First Simple Febrile Seizure<sup>43</sup>* is a practice parameter designed to assist pediatricians by providing an analytic framework for the evaluation and treatment of this condition including interventions of direct interest: lumbar puncture, electroencephalography, blood studies, and neuroimaging.

### **Otitis Media**

In May 2004, the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) jointly released the first national clinical practice guideline on appropriate *Diagnosis and Treatment for Acute Otitis Media<sup>44</sup>* (AOM). The guideline outlines steps for more accurate diagnosis, encouraging pain relief, reducing antibiotic-related adverse effects, and targeting antibiotics for children likely to receive the most benefit.

The clinical practice guideline on *Otitis Media with Effusion<sup>45</sup>* (OME) was also released in May 2004 by the AAP, AAFP, and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) to provide evidence-based recommendations on diagnosing and managing OME in children. The OME guideline emphasizes appropriate diagnosis and provides management options including observation, medical intervention and referral for surgery for children who are not at risk.

The follow-up care of children in whom tympanostomy tubes have been placed is shared by the pediatrician and the otolaryngologist. Guidelines<sup>46</sup> are provided for routine follow-up evaluation, perioperative hearing assessment, and the identification of specific conditions and complications that warrant urgent otolaryngologic consultation. These guidelines have been developed by a consensus of expert opinions.

### **Urinary Tract Infections**

Practice Parameter: *The Diagnosis, Treatment, and Evaluation of the Initial Urinary Tract Infection in Febrile Infants and Young Children<sup>47</sup>* provides strategies for the diagnosis, management, and follow-up evaluation of infants and young children with unexplained fever, who are later found to have a diagnosed UTI. Accurate diagnosis is extremely important for two reasons: to permit identification, treatment, and evaluation of the children who are at risk for kidney damage and to avoid unnecessary treatment and evaluation of children who are not at risk, consequently, negating the need for interventions that are costly and potentially harmful but provide no benefit.

## Practice Accommodations for Preventive Care Management

Referring to the Primary Care Medical Home Model, this section describes how quality improvement efforts in your practice can impact preventive care management. The medical home model promotes high quality health care in all aspects of the primary care practice, which also includes preventive care management. First, practical strategies that have been tried and proven beneficial in medical home practices will be described. Then, several professional policies and best practice guidelines are presented as a guide for developing standard protocols in the provision of preventive health care in your practice. Less than 50% of policies and best practice guidelines are implemented by primary care practices. Doing so will result in better patient outcomes, more efficient management, and ultimately will reduce health care costs.

This section concludes with applicable educational programs on preventive care management. Both the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and the Illinois Academy of Family Physicians (IAFP) provide opportunities for ongoing educational training. In addition to professional development experience, participation in these educational programs allows practices to promote healthy patients and families and also instructs families on your commitment to quality care.

### Practical Strategies

**Bulletin boards in the waiting area** - to share educational information with families as well as post information about helpful community resources. Suggested topics could include information about immunizations, flu shots during the season, diet and exercise related to obesity prevention, TV viewing, and information about screening for developmental problems and autism spectrum disorders. Educational handouts on these issues may also be helpful.

**Internet access for families** - to support those families that do not have internet access. Some practices have placed a computer in the waiting area, so families are able to obtain diagnosis-specific information, family support networks, and additional state and local resource information. Web sites could be saved as favorites on topics related to immunizations, screening for developmental disorders and autism spectrum disorders, healthy diets, and obesity prevention.

**Visit Preparation** - to assist families in preparing for the child's office visit provides benefits for the child and family as well as the practice staff. The primary benefit is improved communication to promote proactive primary care. Practices gather individualized information about the strengths and needs of families at office visits to better meet these needs and more effectively coordinate services.

### Available Tools for this Preparation

1. **Medical Home Visit Card** - a handout for families that addresses important points to prepare for the child's medical appointment, "Make each doctor's appointment work for you!" (one side in English<sup>21</sup> and one side in Spanish<sup>22</sup>)
2. **Pre-visit questionnaire**<sup>48</sup> - this questionnaire is given to patients and families to complete in the waiting room prior to the appointment. It lists areas of concern and or discussion. Office staff can review the survey before the child sees the physician so that they can prepare for specific needs/concerns such as the need for knowing about specific community resources or wanting some educational materials about diets to prevent obesity. Families are asked if assistance is needed in completing the form. This sample was developed by Exeter Pediatrics, VT and is included in the Medical Home Improvement Toolkit created by the Center for Medical Home Improvement.
3. **Today's Visit Form**<sup>49</sup> - another tool to help families share their concerns and issues about the child's health (developmental issues, diet, concerns about autism, etc).

4. **Post-visit questionnaire**<sup>50</sup> - a companion to the pre-visit questionnaire allows families the opportunity to provide feedback on the office visit and how well the needs and concerns were addressed. This sample was developed by Exeter Pediatrics, VT and is included in the Medical Home Improvement Toolkit created by the Center for Medical Home Improvement.

## Policies and Best Practice Guidelines

This section addresses the many choices a practice has to improve quality health care based on Policies and Best Practice Models<sup>51</sup> developed by professional organizations, like the AAP and the AAFP. Such guidelines represent the best judgment of a team of experienced clinicians and methodologists addressing the scientific evidence for a particular clinical topic.

Primary care practices implement less than 50% of their professional organization's policies and best practice models. The reason is lack of time during a visit. Some claim that a well child visit would have to last at least 45 minutes or longer in order to include all policies and best practice models. The following is a brief list of the more pertinent clinical policies and best practice models that can be used as a guide to make change and improve quality of health care in the preventive component of a primary care medical home practice. Recognizing that practices are already busy providing care and that change is challenging, choose one at a time and slowly integrate the recommendations into your practice setting.

### Immunizations

The annual recommended immunization schedules for children and adolescents in the United States reflect current recommendations for use of vaccines licensed by the US Food and Drug Administration. The following schedule and guidelines outline the current recommendations for children and adolescents.

- Recommended US Immunization Schedule<sup>52</sup>
- Guidelines for Use of Rotavirus Vaccine<sup>53</sup>
- Recommendations on Combination Vaccines for Childhood Immunization<sup>54</sup>
- Recommendations for Use of Only Inactivated Poliovirus Vaccine for Routine Immunization<sup>55</sup>
- Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis (Tdap) Vaccine<sup>56</sup>
- Recommendations for Influenza Immunization of Children<sup>57</sup>
- Recommendations for Use of Meningococcal Vaccines in Pediatric Patients<sup>58</sup>
- Varicella Vaccine Update<sup>59</sup>

### Developmental Surveillance and Screening

*Identifying Infants and Young Children with Developmental Disorders in the Medical Home*<sup>60</sup> provides an algorithm as a strategy to support health care professionals in developing a pattern and practice for addressing developmental concerns in children from birth through 3 years of age at every well-child preventive care visit. This is an example of another one of the first policies to be converted by the PPI process. The Developmental Surveillance and Screening Policy Implementation Project (D-PIP)<sup>61</sup> selected 17 pilot primary care pediatric practices to implement the AAP policy statement to determine if the use of the policy, specifically, the algorithm, changes the delivery of developmental surveillance and screening. In particular, the project aims to determine if the algorithm is efficiently and effectively implemented into pediatric practice, recognize strategies for implementing the algorithm, and examine outcomes of implementing the algorithm. To obtain free copies of the whole policy statement, including the algorithm, contact [screening@aap.org](mailto:screening@aap.org).

## Bright Futures<sup>62</sup>

Initiated by the Maternal and Child Health Bureau (MCHB) over a decade ago, Bright Futures is a philosophy and approach that is dedicated to the principle that optimal health involves a trusting relationship between the health professional, the child, the family, and the community. As part of this initiative, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* was developed to provide comprehensive health supervision guidelines, including recommendations on immunizations, routine health screenings, and anticipatory guidance.

A good resource is the *Bright Futures Well-Child Care Curriculum*<sup>63</sup>, a series of 10 modules that address the content and delivery of well-child care, the core competencies of health promotion and disease prevention, and documentation of health care services. Each module is augmented with supplementary materials and resources. Users may concentrate on one particular subject, choose several related topics for a tailored training, or progress through the entire curriculum module-by-module.

The following is a brief list of additional pertinent medical situations where policies and best practices models can be used as a guide to improve quality of health care in the preventive component of a primary care medical home practice. Recognizing that practices are already busy providing care and that change is challenging, choose one at a time and slowly integrate the recommendations into your practice setting.

### Lead Screening

In 1993, state-mandated screening for childhood lead poisoning in children 6 years of age and younger began. Federal mandates and Illinois Department of Healthcare and Family Services policy recommend that all children enrolled in the department's Medical Programs<sup>64</sup> be considered at risk for lead poisoning and receive a screening blood lead test at 12 and 24 months. Children over the age of 24 months, up to 7, for whom no record of previous screening blood lead test exists, should also receive a screening blood lead test. All children enrolled in the department's Medical Programs are expected to receive a blood test regardless of where they live. Physicians and other health care providers have conducted 2.4 million lead tests and reported about 270,000 children with elevated lead levels. The numbers of elevated and normal test results<sup>65</sup> are used to identify areas where effort is needed to combat lead poisoning. Every physician licensed to practice shall screen children 6 months through 6 years of age for lead poisoning (Section 6.2 of the Lead Poisoning Prevention Act [410 ILCS 45]), using a blood lead measurement for children residing in high risk areas. Children residing in low risk areas shall be assessed for their risk for lead exposure by providing the information contained in the *Childhood Lead Risk Assessment Questionnaire*<sup>66</sup>.

### Autism – Screening and Diagnosis

*The Pediatrician's Role in the Diagnosis and Management of Autistic Spectrum Disorder in Children*<sup>67</sup> policy statement serves to familiarize the pediatrician with currently accepted criteria defining the spectrum of autism, strategies used in making a diagnosis, and conventional and alternative interventions.

*Screening and Diagnosis of Autism*<sup>68</sup> reviews the available empirical evidence and gives specific recommendations for the identification of children with autism. This approach requires a dual process: 1) routine developmental surveillance and screening specifically for autism to be performed on all children to first identify those at risk for any type of atypical development, and to identify those specifically at risk for autism; and 2) to diagnose and evaluate autism to differentiate autism from other developmental disorders<sup>69</sup>.

The Centers for Disease Control and Prevention's *Learn the Signs. Act Early*<sup>70</sup> campaign is encouraging physicians to reach out to communities to help raise awareness of the importance of monitoring a child's developmental milestones.

## Obesity

Documented trends in the increasing prevalence of overweight children and, correspondingly, the lack of physical exercise and activity mean that pediatricians must focus preventive efforts on childhood obesity with its associated co-morbid conditions in childhood and likelihood of persistence into adulthood. These trends pose an unprecedented burden in terms of children's health as well as present and future health care costs. The following practice guidelines and policies outline strategies to foster prevention and early identification of overweight and obesity in children.

- Dietary Recommendations for Children and Adolescents<sup>71</sup>
- Identifying and Treating Eating Disorders<sup>72</sup>
- Prevention of Pediatric Overweight and Obesity<sup>73</sup>
- Prevention of Childhood Obesity Through Increased Physical Activity<sup>74</sup>
- Promotion of Healthy Weight-Control Practices in Young Athletes<sup>75</sup>

An Expert Committee on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity, made up of representatives from the AAP and 14 other health professional organizations, was convened by the AMA to develop strategies to help physicians more effectively work with families, school health professionals, public health organizations and community groups to reduce overweight and obesity and to eliminate racial and ethnic disparities in childhood obesity. In June 2007, the committee released 22 recommendations for health care professionals to apply in their practices<sup>76</sup>.

## Educational Programs

The Illinois Chapter of the American Academy of Pediatrics provides office-based educational programs on developmental screening, autism recognition, immunizations, maternal depression, medical home, oral health, social-emotional health, and tobacco cessation. In following the recommendations set forth in these programs, it sends a message to families that these are important screenings and protocols. For more information about these programs, refer to the ICAAP website<sup>77</sup>.

## Oral Health<sup>78</sup>

*Bright Smiles from Birth* is the newest of ICAAP's educational and technical assistance programs. The program is focused on improving the oral health of infants and young children. Participating practices receive a 90-minute in-office program that trains providers and office staff to incorporate oral health screenings into their well-child exams. The program also assists providers in taking appropriate steps once high-risk patients are identified, which may include patient education, referral to dental homes, and application of fluoride varnish. There is no cost for the program and participating practices are provided with a resource kit containing professional and patient education materials as well as continuing medical education (CME) credit. Practices in Cook County that complete the training receive a "starter kit" for fluoride varnish application and are eligible for reimbursement through Medicaid for fluoride varnish application. Physicians will be paid for providing this service to any patient in All Kids (formerly Medicaid and KidCare) – including those in capitated managed care plans. To schedule a *Bright Smiles from Birth* program presentation for your practice, refer to the ICAAP website<sup>79</sup> on educational programs.

Illinois Academy of Family Physicians provides CME programs throughout Illinois and with the national American Academy of Family Physicians. The IAFP's website provides a listing of all IAFP meetings, including many CME opportunities, the AAFP courses and conferences, and CME meetings around the state. For more information about these programs, refer to the IAFP website<sup>80</sup>.

## **Practice Accommodations for Chronic Condition Management**

Referring to the Primary Care Medical Home Model, this section describes how quality improvement efforts in your practice can impact chronic care management. The medical home model promotes high quality health care in all aspects of the primary care practice, which also includes chronic care management. First, practical strategies that have been tried and proven beneficial in medical home practices will be described. Then, examples of several professional policies and best practice guidelines are presented as a guide to develop standard protocols for health promotion and screening. Less than 50% of policies and best practice guidelines are implemented by primary care practices. Doing so will result in better patient outcomes, more efficient management, and ultimately will reduce health care costs.

This section concludes with applicable educational programs on chronic condition management. Both the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and the Illinois Academy of Family Physicians (IAFP) provide opportunities for ongoing educational training. In addition to professional development experience, participation in these educational programs allows practices to promote healthy patients and families and also instructs families on your commitment to quality care.

### **Managing Chronic Health Conditions<sup>81</sup> for Primary Care Providers**

The role of the primary care physician in providing a medical home is to utilize basic knowledge, professionally endorsed policies, best practice models, and community resources while providing care that is accessible, coordinated, continuous, comprehensive, family-centered, compassionate, and culturally effective. The content in this monograph provides the tools to enable physicians to do just that.

This information elaborates on the medical home model and can be applied to the management of specific chronic health conditions in the primary care setting. The content here is designed to help primary care providers gain valuable information and insight about the on-going care and needs for certain chronic health conditions. This includes an identification registry, clinical assessment information, treatment options, practice guidelines, patient education, and related articles and tools.

### **Practice Identification Registry**

Identifying children that have special health care needs within your practice is a vital step in chronic condition management and the provision of a medical home. Approximately 12 to 15% of patients in a typical primary care setting have special health care needs. Who are the children that will be the focus of enhanced services? The process of identification yields several positive results:

1. Increases knowledge of those children with chronic conditions for all office staff;
2. Improves communication between the family and practice staff;
3. Allows for scheduling specific to the needs of the child and family (longer appointments, time of day and any other special accommodations) ; and
4. Provides a means to “pull” certain high risk populations or diagnoses for chronic condition management such as determining priority for flu shots.

Developing a definition of CYSHCN to use in the identification process helps to get this process rolling. There is a wide array of health conditions that may cause physical and emotional challenges. The US Maternal and Child Health Bureau offers this definition:

“Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”<sup>82</sup>

The definition chosen will guide which patients are included in your special needs group. Those patients then have their charts identified either by a different colored chart, a sticker, or an electronic marker such as “CYSHCN” or an alert box on the computer.

For most practices, the process of identification is ongoing as patients are seen for appointments and complex needs are identified. It is also important to recognize that not all children with chronic health conditions require special services. Some children may have stable health conditions and be functioning very well.

## **Strategies for Developing a Practice Registry of CYSHCN**

### **Staff Recall**

Practices frequently begin with staff recall - a personal recall of patients whom they consider CYSHCN, as a starting point.

### **Computer Generated Lists**

Practices have printed a list of all patients by their primary care physician and asked each doctor to identify those patients that meet their criteria. For practices with computerized systems and scheduling, The Center for Medical Home Improvement provides a list of ICD-9 codes<sup>83</sup> which can be used in the identification process. This list is very comprehensive, and can be overwhelming when first starting this process. Rather than utilize the list in its entirety, practices can “choose” those diagnoses that they feel are more complex and most appropriate to focus medical home services. You can run computer-generated reports for certain codes/diagnoses to identify additional patients.

### **Screening Tools**

The Children with Special Health Care Needs (CSHCN) Screener<sup>84</sup> is an easily administered 5-item parent survey which can be conducted in person or by telephone. An affirmative response on any question identifies a child with special needs.

The Questionnaire for Identifying Children with Chronic Conditions-Revised (QuICCC-R)<sup>85</sup> is a 16-item validated interviewer-administered instrument for identifying children with chronic and disabling conditions. It is available in both English and Spanish and is administered either by telephone or in person to the parents or guardians of children under the age of 18.

### **Complexity Scales**

Some children with chronic conditions may be functioning very well and require few or no special services. Two examples of tools that rate the complexity of a child's chronic condition and related service needs include *The Complexity Index*<sup>86</sup> developed by Dr. David Hirsch of Phoenix Pediatrics in Arizona and *The HOMES Complexity Scale*<sup>87</sup> developed by Exeter Pediatrics in New Hampshire.

These tools can be used to identify the level of complexity/intensity involved in supporting and managing children with special health care needs in your practice, which can then be used for planning proactive care such as scheduling flu vaccinations, etc.

## The Clinical Risk Group Classification<sup>88</sup>

*Clinical Risk Groups* (CRGs) classifies individuals into mutually exclusive categories and assigns each person to a severity level if they have a chronic health condition using enrollment and claims or other encounter level data. The commercial software for CRGs has been developed by 3M Health Information Systems.

The National Center of Medical Home Initiatives for Children with Special Needs<sup>89</sup> also provides additional tools to document the complexity of conditions and related services to help practices determine those children in need of prioritized care.

## Practical Strategies

**Phone script<sup>90</sup>** - to enable staff to better serve families. A simple script can be developed in which families are asked by the receptionist if there are any special needs to consider or special requests which will make the child's visit go more smoothly. This information is documented on the schedule for the day and in the child's record for future appointments.

**"Fast Track" to exam room** - to help those children who do not do well in a waiting room setting (either with other children or with a wait). For example, an autistic child and parent are escorted directly to an exam room to wait for their appointment.

**Longer appointment times** - to promote more effective time management. Knowing that CYSHCN typically require more time, longer appointments are automatically scheduled.

**"Valet" parking** - to improve access for families. A staff member meets the family as they arrive for their appointment and stays with the child while the parent parks the car or parks the car for the parent as they go into the office to sign in their child.

**Referral "scripts"<sup>91</sup>** - to promote family-centered coordinated care. Families are given a referral form that identifies who they will be seeing, why they are being referred and where they need to go. These forms can be used with referrals to community agencies, medical equipment and specialists.

**Fax Back forms<sup>92</sup>** - to facilitate communication between the pediatrician and specialty care providers. They are given to families for appointments with the child's specialist and the specialist then faxes back the recommendations for further care to the pediatrician.

**Bulletin boards in the waiting area** - to share educational information with families as well as post information about helpful community resources including support groups. Suggested topics could include information about asthma, ADHD, diet related to obesity prevention, epilepsy, transition to adult health care, autism and other commonly seen chronic health conditions. Educational handouts on these issues may also be helpful.

**Internet access for families** - to support those families that do not have internet access. Some practices have placed a computer in the waiting area, so families are able to obtain diagnosis-specific information, family support networks, and additional state and local resource information. Web sites could be saved as favorites on topics related to autism, ADHD, epilepsy, diet related to obesity prevention, transition issues and links to the DSCC web site<sup>93</sup> to learn about available services and information (financial assistance, care coordination, home care waiver program, transition assistance, and the principles of medical home).

**Visit Preparation** - to assist families in preparing for the child's office visit provides benefits for the child and family as well as the practice staff. The primary benefit is improved communication to promote proactive

primary care. Practices gather individualized information about the strengths and needs of families at office visits to better meet these needs and more effectively coordinate services.

### Available Tools for this Preparation

1. **Medical Home Visit Card** - a handout for families that addresses important points to prepare for the child's medical appointment, "Make each doctor's appointment work for you!" (one side in English<sup>21</sup> and one side in Spanish<sup>22</sup>)
2. **Pre-visit questionnaire**<sup>94</sup> - this questionnaire is given to patients and families to complete in the waiting room prior to the appointment. It lists areas of concern and or discussion. Office staff can review the survey before the child sees the physician so that they can prepare for specific needs/concerns such as the need for knowing about specific community resources or wanting some educational materials about diets to prevent obesity. Families are asked if assistance is needed in completing the form. This sample was developed by Exeter Pediatrics, VT and is included in the Medical Home Improvement Toolkit created by the Center for Medical Home Improvement.
3. **Today's Visit Form**<sup>95</sup> - another tool to help families share their concerns and issues about the child's health (school learning problems, referrals to community resources, available support groups, diet, concerns about autism, etc).
4. **Post-visit questionnaire**<sup>96</sup> - a companion to the pre-visit questionnaire allows families the opportunity to provide feedback on the office visit and how well the needs and concerns were addressed. This sample was developed by Exeter Pediatrics, VT and is included in the Medical Home Improvement Toolkit created by the Center for Medical Home Improvement.

### Policies and Best Practice Guidelines

The following is a brief list of the more pertinent clinical policies and best practice models that can be used as a guide to make change and improve quality of health care in the three components of a primary care medical home practice. It is not a complete list. Recognizing that practices are already busy providing care and that change is challenging, choose one at a time and slowly integrate the recommendations into your practice setting.

#### Asthma

*Guidelines for the Diagnosis and Management of Asthma in Children*<sup>97</sup> is intended to help pediatricians, primary care physicians, and other clinicians/health care professionals diagnose and manage patients with allergic diseases. It was developed by the Pediatric Asthma Committee, a multidisciplinary and multi-organizational group of US asthma and health care experts. The guide includes the recommendations from the National Heart, Lung, and Blood Institute (NHLBI) "Guidelines for the Diagnosis and Management of Asthma - Update on Selected Topics."

*Pediatric Asthma: Emergency Care for Emergency Care Professionals* is an online<sup>98</sup> slide presentation for nurses, physicians, and prehospital providers developed by the Illinois Emergency Medical Services for Children (EMSC). This educational module provides an overview of the essential components of pediatric asthma management in the emergency department, including patient/family education resources. It addresses evidence-based best practice guidelines, national and local asthma statistics, barriers and misconceptions, patient/family education, and numerous statewide asthma resources. The course has been approved for 2.5 hours of nursing CEU/Category II CME credits.

*Managing Childhood Asthma in Primary Care: A Quality Improvement Program* is an online<sup>99</sup> slide presentation, and podcast for primary care physicians, and nurses developed by the Illinois Academy of Family Physicians for the *Your Healthcare Plus* program, sponsored by HFS. This educational module provides information on the prevalence of diagnosed asthma and asthma symptoms in children and young adults; it discusses the guidelines used for diagnosis of childhood asthma and helps users evaluate appropriate use of pharmacologic agents and non-pharmacologic therapies for acute and long-term therapy in pediatric asthma. This module also

includes information on how to educate patients and caregivers on how to reduce environmental asthma triggers and to improve self-management with action plans. A quality improvement tool is also included for this module to help practices implement and sustain changes in their practice which will improve the care of asthma patients.

### **Attention-Deficit/Hyperactivity Disorder**

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood. ADHD is also among the most prevalent chronic health conditions affecting school-aged children. The core symptoms of ADHD include inattention, hyperactivity, and impulsivity. *Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder*<sup>100</sup> provides recommendations for the assessment and diagnosis of school-aged children with ADHD. *Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder*<sup>101</sup> provides evidence-based recommendations for the treatment of children diagnosed with ADHD. This guideline primarily addresses children with ADHD but without major coexisting conditions. The AAFP has a CME DVD video<sup>102</sup> on “Diagnosis and Management of Childhood ADHD in the Family Practice Setting.”

### **Epilepsy**

The management of epilepsy in the pediatric patient requires careful evaluation, classification, and pharmacologic treatment. *Behavioral and Cognitive Effects of Anticonvulsant Therapy*<sup>103</sup> presents an overview of pediatric studies of antiepileptic drugs and behavioral/cognitive function.

*Managing Pediatric Epilepsy Syndromes with New Antiepileptic Drugs*<sup>104</sup> reviews available case reports and clinical trial data related to the use of newer anti-epileptic drugs in the chronic management of epilepsy syndromes in pediatric patients.

### **Care Coordination**

Care Coordination is a collaborative process that links children and families to services and resources in a coordinated manner to maximize the potential of children and provide them with optimal health care. Care coordination is a vital component of the medical home.

Care Coordination includes assessing, planning, implementing, and evaluating options and services to meet the child and family's individual needs. To learn more about care coordination and how it can be implemented within a practice, please visit the following web sites:

1. The National Center of Medical Home Initiatives for Children with Special Needs<sup>105</sup>  
Provides tools to assist in the coordination of care at the practice, community, and state level.
2. AAP Policy Statement<sup>106</sup>  
Care Coordination: Integrating Health and Related Systems of Care for Children with Special Health Care Needs.
3. Center on Medical Home Improvement<sup>107</sup>  
*The Medical Home Improvement Kit* has detailed information regarding care coordination and much more.
4. Care Notebooks  
A common problem facing the parents of children and youth with special health care needs is keeping records of their children's medical history and current treatment plans so that they can be easily accessible. As a result, the AAP has developed a web site<sup>108</sup> that provides several types of Care Notebooks and gives parents of CYSHCN an opportunity to create a personalized care notebook suited for their family that specifically meets their child's needs.

## Transition

The AAP Policy Statement on the Age Limit of Pediatrics<sup>109</sup> indicates the purview of pediatrics includes the physical and psychosocial growth, development, and health of the individual. This commitment begins prior to birth when conception is apparent and continues throughout infancy, childhood, adolescence, and early adulthood when the growth and developmental processes are generally completed. The responsibility of pediatrics may, therefore, begin with the fetus and continue through 21 years of age. Anticipating this transition point can be accomplished by having signs in examining rooms indicating that your practice wants adolescents to make the transition to adult health care providers by the age of 21 years. There are special circumstances (e.g., a chronic illness and/or disability) in which, if mutually agreeable to the pediatrician, the patient, and when appropriate, the patient's family, the services of the pediatrician may continue to be the optimal source of healthcare past the age of 21 years.

*A Consensus Statement on Health Care Transitions for Young Adults with Special Health Care Needs*<sup>110</sup> has been approved as policy by the boards of the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians-American Society of Internal Medicine. The policy statement represents a consensus on the critical first steps that the medical profession needs to take to realize the vision of a family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent health care system that is as developmentally appropriate as it is technically sophisticated. The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood.

*The Role of the Pediatrician in Transitioning Children with Disabilities and Chronic Illnesses from School to Work or College*<sup>111</sup> is to provide anticipatory guidance and to promote self-advocacy and self-determination. Knowledge of the provisions of the key federal laws affecting vocational education is essential for the pediatrician's successful advocacy for patients. Pediatricians can bring much strength to this transition process, including a longitudinal relationship with the family that offers multiple opportunities for providing anticipatory guidance and constructive interventions.

Research shows that children and youth with special health care needs who make the transition from pediatric health care systems to adult health care systems require more resources and services when compared to the transition of typical adolescents. Transition to adult health care may be difficult. Parents and health care providers need to work in a collaborative team approach with the needs and desires of the child at the center of the plan. Physicians can be proactive in assisting CYSHCN to make the transition to adult health care by age 21 years by arranging consultations with pre-arranged adult primary care physicians beginning at the age of 12 and continuing this process every two years thereafter. Even before that, the pediatrician can direct questions to the child rather than the parent and offer explanations at the child's level of understanding. It gives the adolescent the opportunity to experience adult health care and be a self spokesperson and advocate for themselves.

Transitions involve changes, such as adding new expectations, responsibilities and resources while letting go of others. Transition is an important part of the medical home process. Visit the DSCC Transition web site<sup>112</sup> for more detailed information and valuable tools and resources for successful transitions.

## Newborn Genetic Screening

Illinois, along with 6 other states, is a member of the Region 4 Genetics Collaborative. This collaborative provides a forum for these states to share available newborn screening and genetic resources, an advancement that will result in improved geographic distribution of genetics expertise throughout the region. The Region 4 Genetics Collaborative web site<sup>113</sup> has comprehensive information about newborn screening and providing a medical home for children with genetic disorders in Illinois. Though individually rare, together these disorders affect about 11 in

1000 - 3000 infants. We are confident that the materials on the Collaborative web site will prove invaluable when one of your newborns is suspected of having a disorder identified through newborn screening.

### **Newborn Hearing Screening**

Each year about 500 children in Illinois are born with congenital hearing loss. The technology now exists to detect hearing loss in newborns that are only a few hours old. This simple, non-invasive test can save hundreds of thousands of dollars in special education costs. Research has shown that infants who have congenital hearing loss can have normal language skills and cognitive development by the time they are ready for school if amplification devices and therapy are provided by 6 months of age. Early identification, therefore, is imperative. The Illinois Newborn Hearing Screening Program web site<sup>114</sup> has more information about the program's efforts and the services provided.

### **Educational Programs**

The Illinois Chapter of the American Academy of Pediatrics provides an office-based educational program on asthma. For more information about the asthma program and other available preventive-type educational programs, refer to the ICAAP website<sup>115</sup>.

Illinois Academy of Family Physicians provides CME programs throughout Illinois and with the national American Academy of Family Physicians. The IAFP's website provides a listing of all IAFP meetings, including many CME opportunities, the AAFP courses and conferences, and CME meetings around the state. For more information about these programs, refer to the IAFP website<sup>116</sup>.

The medical home care model has been adapted from the Chronic Care Model<sup>117</sup> for improving chronic illness care in primary care settings. Six domains organize the model; each represents numerous change concepts and innovative action ideas for a strong health care environment supportive of a medical home for all children and youth with special health care needs. The Institute for Healthcare Improvement web site<sup>118</sup> has more information on the Chronic Care Model and methods of improvement.

## **Chapter 5**

### **Community Resources: Helping families find needed services**

*“I really need help to provide my kids everything they need, but I need counseling or more information of places that I could take them so they could receive it”.*  
“DSCC Family Survey: What Families Said”, 2005

When you are seeing patients and want to give them references to local community, perhaps state, or even national resources, you want that information at your fingertips. Maintaining up-to-date listings of resources is very difficult and time consuming.

The Arc of Illinois web site offers the Illinois Life Span Statewide Information Resource & Referral directory with an expansive database of resource information. In collaboration with DSCC, the Illinois Life Span Project is expanding to include many more resources throughout the state for children with special health care needs. This database will soon be populated with the resources known to DSCC’s care coordinators from 13 regional offices. In addition, several other organizations are planning to share resource information with the Illinois Life Span Project. Please explore the Illinois Life Span web site<sup>119</sup> now, so that in the future, as it becomes more populated with resources, you will be knowledgeable about this reference.

Learning more about the resources located within the communities your practice serves can also help you to remain informed about valuable services and resources available for families. One way to elevate your practice involvement within the communities you serve is to develop working relationships with established community-based organizations like the local health departments, Child & Family Connections (CFC) for Early Intervention, social service agencies, and other health promotion organizations. This may sound daunting and unrealistic, but it can be something your practice undertakes over a realistic length of time. It won't happen overnight, but it can happen gradually and within the capabilities and limitations of your practice. Or, you may know of a community association that you could join whose membership is comprised of many health and social service organizations. Such associations can help your practice become knowledgeable and involved in issues affecting those in your community.

Another source of information about community services and organizations is DSCC. DSCC is the Title V Program<sup>120</sup> for Children and Youth with Special Health Care Needs (CYSHCN) in Illinois and is administered through the University of Illinois at Chicago. Over one million families have been served by DSCC since its inception in 1937. Each year over 20,000 families are served through a statewide network of 13 Regional Offices with a care coordination staff having backgrounds in nursing, social work, speech pathology and audiology.

DSCC staff are knowledgeable about the community resources and organizations that assist and serve children with special health care needs, including educational, therapeutic and social service providers. You can use the DSCC web site, “Find an Office” web page<sup>121</sup>, or you can call 1-800-322-3722 to locate the office serving your area.

DSCC provides care coordination for all medically eligible children and financial assistance for medical services to those families with an annual income under 285% of the Federal Poverty Level (e.g., in 2007, \$58,853 for a family of four). Eligible conditions must be chronic, amenable to treatment, require long-term specialty care, and fall within one of the following categories:

- Orthopedic Impairments
- Nervous System Impairments
- Cardiovascular Impairments
- Craniofacial Anomalies
- Genetic & Metabolic Conditions Leading to Disability
- Hearing Impairments
- Organic Speech Impairments
- Cystic Fibrosis
- Eye Impairments
- Urinary System Impairments
- Hemophilia & Disorders of Coagulation

DSCC’s mission focuses on public service, education, and research as a basis to provide, promote, and coordinate family-centered, community-based, culturally effective care for eligible children with special health care needs in Illinois. The programs and services provided by DSCC are described below.

The **Core Program** offers care coordination and cost-supported diagnosis and treatment for children with chronic health impairments determined eligible for program support. DSCC supports non-investigational treatment related to the eligible condition and recommended by physician specialists, such as therapies, medications, specialized equipment, and supplies. Application forms are available on the Core Program page of our website.

The **Home Care Program** offers care coordination and support for in-home nursing care of technology-dependent children who would otherwise have to remain in a hospital or skilled nursing facility. The Division of Specialized Care for Children (DSCC) operates this waiver program on behalf of the Illinois Department of Healthcare and Family Services (HFS). Application forms and more information are available on the Home Care Program page of our website.

The **Children’s Habilitation Clinic**, formerly known as the Center for Handicapped Children, is located on the west campus of the University of Illinois at Chicago, within the Children and Adolescent Section of the Out-Patient Center. The location allows collaboration with other specialists and primary care providers. The Clinic provides comprehensive diagnostic services to children with complex disabling conditions and provides ongoing rehabilitation and developmental management to those children to age 21. There are approximately 1600 patient visits annually.

The **Supplemental Security Income - Disabled Children’s Program** has been administered by DSCC since 1978 to provide rehabilitative services to children less than 16 years of age who are eligible for the Supplemental Security Income (SSI) program. DSCC provides information about and referral to community resources, including referrals to Early Intervention or preschool programs when appropriate, and DSCC Core Services as described above.

The SSI program is a Federal assistance program administered by the Social Security Administration (SSA) that guarantees a minimum level of income for aged, blind, or disabled individuals. For more information about the SSI program for children with disabilities, visit the federal government’s Social Security Administration web site on SSI Benefits for Children with Disabilities.

*“I have found that my care coordinator has been wonderful in the care and services for my (child) these last (number) years. Also, I am finding that they have the ability to also give me other resources to explore for meeting the needs of my child”.*

“DSCC Family Survey: What Families Said”, 2005

## **Chapter 6**

# **Medical Home Reimbursement**

Children with special health care needs comprise between 10 and 15% of a community-based pediatrician's practice. Providing better care for a child with a chronic illness requires more time than is typically spent with other children in your practice, more frequent visits, care coordination with other healthcare professionals and with the child's family. There are many potential financial challenges facing the implementation of the medical home in physician practices. This includes accurate and accountable coding for the extended time and services provided to families and children with special health care needs as well as negotiating contracts with payers to receive maximum revenue for the care and services that your practice provides.

Special attention must be directed to scheduling, coding, and documentation in order to maximize reimbursement for the more complex services that may be needed by children with special health care needs and their parents. Not all payers, including the Illinois Department of Healthcare and Family Services (HFS), recognize and reimburse for all the codes that will be discussed in this chapter. Many office visits for children with special health care needs are routine and require no extra time. Documentation and more precise coding are required to increase practice revenues in those instances when the level of decision-making or planning complexity requires more physician time.

A significant amount of income for your practice comes from successful contracting. Well-negotiated health plan contracts can increase revenue and reduce insurance company hassles by clarifying issues ahead of time. There is a distinct advantage when a practice has at least one partner with good skills in negotiating contracts. It is imperative that physicians carefully review and understand any managed care contract they are considering signing. This is true whether the physician is signing the contract directly or indirectly through a physician network such as an independent practice association (IPA). It is not enough to review a summary of the contract terms. Provisions in the contract that are often glossed over at the time of signing can suddenly spring to life in new and often unpredictable ways when a controversy arises that requires interpretation or clarification. This section of the chapter will address many of the provisions that require your special attention.

The medical home model offers families of children with special health care needs and physicians a new important opportunity for health care partnership. For the primary care physician the professional rewards of providing medical home services are great, but the financial challenges of the medical home cannot be ignored. Careful attention to contract negotiations with payers and scheduling, coding, and billing procedures can help minimize the primary care physician's financial barriers to caring for children with special health care needs. Strategies for minimizing these barriers help the physician make "accessible, continuous, comprehensive, family-centered, coordinated, culturally competent and compassionate care" more feasible.

## **Coding & billing for the care and services provided**

### **Scheduling Strategies**

Parents of a child with special health care needs appreciate the primary care physician who takes the time to listen, advise, collect data, and coordinate care. Most importantly, primary care physicians and families value the opportunity for well child care with a focus on everyday issues of all children beyond the child's special needs.

For children with special health care needs, well and sick visits may require considerable amounts of time. A number of practice management systems allow a scheduler to know when appointments are made for a child with special the child has special needs and therefore a longer appointment is scheduled. Anticipating these visits by scheduling appointments at the end of the day and/or allowing additional time slots for the visit can be another helpful means to effective practice management. For example, it may be more appropriate for the child, and a better scheduling option, to schedule a developmental screening apart from a well child visit. Developmental screening is coded as 96110 for the use of a validated developmental screening tool and 96111 for a more comprehensive developmental assessment.

### **The Down-Coding Dilemma**

Better reimbursement begins with accurate coding—coding that reflects the unique complexity of children with special health care needs. Down coding is the use of a lower code than what is appropriate for the time and complexity of the specific visit. There are several common reasons when down-coding occurs:

- The physician doesn't choose the most precise code to reflect time, history taking or decision making activities that occur during the visit.
- The documentation of the visit doesn't support the use of higher intensity evaluation and management codes.
- Codes that may be used for medical home care coordination activities are under-utilized.

It is important that physicians accurately identify the procedure code that corresponds to the patient encounter to maximize proper reimbursement. Accurate documentation of the visit will potentially allow the use of higher intensity evaluation and management codes (E/M) that more accurately reflect services provided to children with special health care needs. For example, a complex sick visit should be billed and coded as 99214 or 99215. By averting down-coding, physicians can increase revenues through the use of more accurate coding for complex services. Accurate coding and billing is essential to financially support the philosophy and spirit of the medical home: managing and coordinating special health care needs in the context of routine well child care.

### **Coding Strategies for Well Child Care for the Child with Special Health Care Needs**

While parents of children with special needs make frequent visits, often the majority of the visits are to specialists and too frequently preventive health care is neglected. Often, a child's special health care needs are addressed in the context of a routine health maintenance visit (99391-99395). It is appropriate to code the routine visit with a modifier – 25 (significant separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). In addition to the well child health maintenance code, you can include the additional appropriate diagnostic code<sup>122</sup> (i.e., hearing loss, hemophilia, cerebral palsy, Down Syndrome). Document the well child visit and problem-focused assessment and management separately. Third party payers will often reimburse both codes for the additional time and work spent on the same visit.

### **Coding Strategies for Developmental Screening for the Child with Special Health Care Needs**

Developmental screenings may present another coding challenge when providing services to the child with special health care needs. With the understanding that limited developmental screening is an included part of every well child visit, there are instances when developmental screening is more involved and results in subsequent

management plans. For these extensive assessments, use the modifier – 25 and link the diagnosis code 783.4x (lack of expected normal physiological development in childhood) to the office visit. The fifth digit (x) is required: use either 783.40 (unspecified), 783.42 (delayed milestones) or 783.43 (short stature). Use of the full intricacies of CPT and ICD-9 coding, provides a tool to maximize reimbursement for the Medical Home. HFS (Illinois Medicaid) reimburses providers separately for objective developmental screening using CPT code 96110 and 96111.

### **Assessing Your Practice for Accurate Coding**

It is essential that physicians assess billing practices on a continuing basis, which includes the analysis of coding patterns. In Section 3, *Reimbursement Strategies*, from the booklet *Practicing Comprehensive Care*<sup>123</sup>, Michael Ganz advises evaluating a practice’s use of higher intensity evaluation and management codes by:

- Examining CPT code distribution for all children and comparing it to the distribution of CPT codes for children with special health care needs.
- Analyzing any difference between the two populations of children. He says “The distribution should *not* be similar; if they are, the practice is not fully and appropriately utilizing the richness of CPT coding to capture the true nature of services to CYSHCN.”

### **Documentation**

The reimbursement that you receive for a child with special health care needs depends upon proper coding along with documentation of the services provided and the time spent in their care. The rule of thumb in appropriate coding is that if you have not documented service you have not provided a service. By following the CPT guidelines, a physician should receive appropriate reimbursement; and if not, should have grounds for appeal with third-party payers. For outpatient care, services that are provided consist of face-to-face time, which occurs when the physician works directly with the patient or family. Non face-to-face time occurs when the physician provides work before or after a patient visit. This may include review of reports from other physicians and review of test results. Identification of the level of service for evaluation and management codes often includes the following variables:

- Extent of the history of the presenting problem(s)
- Comprehensiveness of the examination
- Decision-making for the presenting problem(s)
- Counseling
- Coordination of care
- Nature of the presenting problem(s)
- Time

Other reimbursement strategies Mr. Ganz suggests for improving reimbursement for services include:

- Investigating codes covered by local insurance carriers to enhance proper reimbursement for billing.
- Billing for care that is typically not reimbursed (i.e., telephone conversation prior to an office visit if the visit is impacted by the telephone conversation).
- Determining if a child may be eligible for All Kids (SCHIP)/Medicaid/DSCC.

The following information, excerpted from an article by Dr. Aris Sophocles, *Coding on the Basis of Time for Physician Services*<sup>124</sup>, outlines some of the important parameters to consider when seeking reimbursement for outpatient chronic condition management.

### **The “Greater than 50 percent” Rule**

The CPT manual provides the following instruction: “the extent of counseling and or coordination of care must be documented in the medical record.” The documentation that you provide should specify the number of

minutes, and that counseling and coordination of care consists of greater than 50% of the visit. The progress note should specify the nature of counseling or coordination of care that you provided.

It is not unusual to spend a considerable amount of face-to-face time with a patient reviewing problems, adjusting medication dosages, and counseling or coordinating care only to find that you do not have enough history, exam or medical decision-making elements to support a code that would otherwise be appropriate for a visit of that duration. In other words, you've spent the time, but the points don't add up. This is when the "greater than 50 percent rule" applies. When you devote more than 50 percent of your face-to-face time with the patient for counseling or coordinating care, "time may be considered the key or controlling factor to qualify for a particular level of E/M service," per CPT.

To code these encounters, use the code that relates to the total time spent with the patient. For example, if you spent 25 minutes face-to-face with an established patient in the office, and more than half of that time was spent counseling the patient or coordinating his or her care, you could use the 99214 code even if you lack the history, exam or medical decision-making elements. For example, in a typical 99214 visit, 13 minutes or more are spent in care coordination or counseling. In a 99215 visit, 21 minutes must be spent in care coordination or counseling. As an example in the case of a child with asthma, if you spend more than 21 minutes in reviewing medications and developing care plan for future exacerbations that would justify a higher level of coding, 99215.

### **Use of a -25 modifier**

In the case of a child with a chronic illness, such as cerebral palsy, who comes in for a preventive health visit and has another condition apart from the preventive visit, the use of a 25 modifier may be appropriate either for time spent in the evaluation and management of the new condition or the time spent counseling or care coordination (see above). With the use of a 25 modifier, the documentation must be specific as to the nature of the time spent and/or the additional condition. It is often best to document this on a separate encounter form.

#### **Example 1:**

Annual well check for a 9-year-old girl with quadriplegic cerebral palsy, seizure disorder, reactive airway disease, gastrostomy (status post-Nissen), who is non-ambulatory, in diapers with history of chronic constipation and the family has just lost their after school care. Visit lasts 35 minutes longer than usual preventive medicine visit before charting and other phone calls, etc.

#### **Code:**

99393 Preventive medicine exam (age 5-11)  
99214-25 Sick visit

#### **Example 2:**

Annual well check for a 6-year-old with Type I diabetes. During the visit the mom casually mentioned that her daily glucose levels were a little higher than normal and her diet had not changed. Upon completion of the age-appropriate preventive medicine service, the physician decides to perform a separate E/M service to address the daily glucose levels. He performs an expanded problem-focused history and exam and straightforward medical decision making.

#### **Code:**

99393 Preventive medicine exam (age 5-11)  
99213-25 Sick visit

### **Prolonged Services**

The prolonged service codes in CPT are meant to be reported in addition to E/M codes when the length of time a physician spends with a patient goes at least 30 minutes beyond what is typical for that service. When

physicians provide services that require more time than what is typical, they can submit prolonged service codes that must be used in conjunction with (*in addition*) to the appropriate E/M code. When calculating the number of minutes spent in prolonged service, do not include the average time allotted by CPT for that E/M code; count only the minutes spent beyond the typical service. Use 99354 for the first 30 to 74 minutes beyond the typical time required for that service and 99355 for each additional half-hour. Note that prolonged services are seldom reimbursed by third party payers including state Medicaid.

According to CPT, an example of a prolonged outpatient visit would be the care of an office patient with an acute asthma attack who warrants prolonged face-to-face care by a physician.

CPT also contains two codes for prolonged physician services that are not face-to-face: 99358 and 99359. These are for pre and post-care services provided in either the outpatient or inpatient setting.

- Code 99358 is used for the first 30 minutes to an hour of service, and
- Code 99359 is used for each additional 30 minutes or for the final 15 to 30 minutes on a given day.

The Care Coordination Toolkit<sup>125</sup>, developed by the Cincinnati Children's Hospital Center for Infants and Children with Special Needs, indicates it is equally important for the managing physician to document all phone calls, care conferences, review of old records, subspecialty letters, test results, etc., as well as the time spent on each. Office staff who interact with the patient, family, other offices, and/or the physician should also document what they do and indicate the time spent in discussion and in getting direction for the encounter with the managing physician. Thus, a nurse may spend 1 hour on the phone with the family dealing with a new problem and calling in new meds, but the office can only bill for the time the nurse spent in discussions with or while under the instruction/direction of the managing physician, which might only be 10 minutes.

## **Time-dependent codes**

Physicians provide a number of services with no direct patient contact that are strictly time dependent. The codes are strictly for physician work and time spent. These include the following:

### Case Management Services

- For team conferences lasting approximately 30 minutes, use 99361;
- For team conferences lasting approximately 60 minutes, use 99362.

Evaluation/management before and/or after patient care (review records/tests, communication with professionals, and/or the patient/family)

- 99358 for the first 60 minutes;
- 99359 for each additional 30 minutes (list separately, in addition to code 99358, for prolonged physician services).

### Care Plan Oversight

For services relating to a patient residing at home or in an assisted living facility, use:

- 99339 for 15 to 29 minutes and
- 99340 for 30 minutes or more.

For services relating to home care, use:

- 99374 for 15 to 29 minutes and
- 99375 for 30 minutes or greater.

For services relating to nursing facility care, use:

- 99379 for 15 to 29 minutes and
- 99380 for 30 minutes or more.

## Creating a System for Managing Care Plan Oversight (CPO)

Establishing a monthly routine is the best way to ensure you are paid for your CPO services. Here is one approach: First, create a log of all patients for whom CPO is provided each month. This list will remind you which charts to pull at the end of the month when it's time to submit claims. Second, keep a CPO log in each patient chart and document the date, total time, and a brief description of the services each time you provide them. Be sure to sign the CPO documentation.

At the end of the month, have a staff person collect the logs from the patients' charts, total the time and bill CPO for those patients for whom you provided more than 15 minutes of CPO during the calendar month. Use the start and end dates of the month as the service dates. Finally, return the logs to the charts for use in future months.

An alternative approach is to create a log and place it in the charts of all patients who receive CPO services. When more than 15 minutes of service time have been logged, send the log to the office staff who will manage billing for these services and put a new log in the chart. Staff can then add up the log times for each patient at the end of the month and submit them for reimbursement.

## CPO Billing Form

The Care Coordination Toolkit includes suggestions for developing a billing form<sup>126</sup> to help track and manage documentation of services and time. This form should be easily accessible and can be placed in the front of the patient's chart and all staff involved in the patients care should fill it out but remember it is only for *physician time*. CPT Guidelines indicate: "The complexity and approximate physician time of the care plan oversight services provided within a 30 day period determine code selection." Note: eligibility for reimbursement depends on the diagnosis/ICD-9 you enter on the billing form.

Office tips for successful management of chronic condition management services:

1. Identify eligible patients, if billing to state programs
2. Label charts and identify patients in computer practice management systems
3. Keep billing form in front of chart
4. Train all staff to document care coordination activities
5. Meet with your billing department to discuss strategies on how to bill for these codes. (For example, Title V may not be the payer of last resort in this situation and may be the first designated payer for these codes. Some systems are set up to bill private insurance, and then Medicaid, and then Title V, and you may need to work on a new system to bill this properly.)
6. Design a system for your practice on how to tally and submit billing information.

Information originally developed by Margaret McManus, Alan Kohrt, Joel Bradley, and Linda Walsh has been recently updated and published as the *Index of CPT Codes for Medical Home*<sup>127</sup>. The original document, *Medical Home Crosswalk to Reimbursement*, was developed in collaboration with the Center for Medical Home Improvement, the American Academy of Pediatrics, and the National Institute for Children's Healthcare Quality and funded by the Maternal and Child Health Bureau, US Department of Health and Human Services through the Maternal and Child Health Policy Research Center.

## Additional CPT Coding References

The new 2007 Supplement is available on the Illinois Academy of Family Physicians website<sup>128</sup> entitled "Strategies for Billing, Coding and Getting Paid Appropriately – A Guide for Family Physicians." A total of 645 changes have been made in CPT for the year 2007. While 258 codes have been added, more codes (308) have been

deleted and 79 codes have received some type of revision. Overall, there are 50 fewer CPT codes in 2007 than there were in 2006.

Additional information and resources on coding can be found on the National Center of Medical Home Initiatives for Children with Special Needs web site<sup>129</sup>.

### **Working with DSCC**

DSCC recognizes that serving children with special health care needs is often more complex and time consuming. Chronic health care conditions generally require the expertise of a pediatric specialist. For these reasons, DSCC provides reimbursement to the primary care provider for telephone consultations with specialists and some care coordination activities. These are explained in a DSCC publication (Fee Schedule for Medical Home Services) available by downloading the document from the Provider Section of the DSCC website.<sup>130</sup> The primary care provider needs to be an approved DSCC medical home provider to receive reimbursement, and the patient must be both medically and financially eligible for DSCC support. The process to become a DSCC-approved provider involves completing a basic application (which includes professional training and experience, taxpayer identification and legal status disclosure, and professional insurance verification) and successfully completing the Medical Home Primer Exam and Evaluation.

## A model for negotiating contracts with payers

A significant amount of income for your practice comes from successful contracting. The AAP, AAFP and AMA have developed online educational courses and resources to help pediatricians and family physicians successfully negotiate contracts. Every practice may have 10-20 different health plans they contract with. Well-negotiated health plan contracts can increase revenue and reduce insurance company hassles by clarifying issues ahead of time. There is a distinct advantage when each practice has at least one partner with good skills in negotiating contracts. It's important to review contracts annually, clarifying details and negotiating from the perspective of logic, fairness and need.

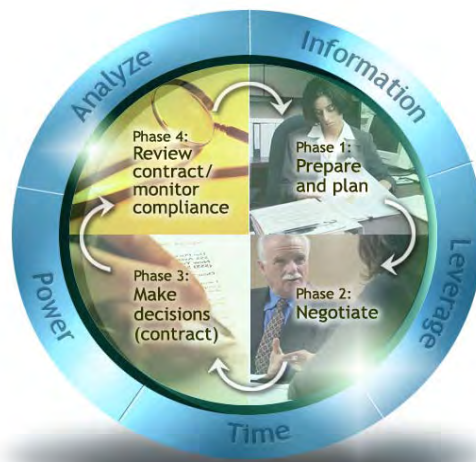
There are five elements that are crucial to successful negotiations.

1. You must have **information** about both partners in the negotiation.
2. You must understand and develop your **leverage**.
3. You must understand the **timing** of the negotiations both in the annual enrollment cycle for managed care plans and in the **time** you have dedicated to this particular negotiation.
4. You must understand the **power** of your organization.
5. You must be able to **analyze** all of the data concerning this process that you can discover and generate.

*Contract Negotiations with Payers* is an online PediaLink Course<sup>131</sup> presenting tools and techniques to help physicians and staff successfully negotiate payer contracts with confidence. This course features a four-step process model to help course registrants plan and prepare, use leverage when negotiating, make informed decisions, and monitor compliance to contract terms and agreements.

### *A Model for Negotiating Contracts with Payers*

This 4-phase model will assist you and your staff to negotiate with payers in more explicit, effective ways through thoughtful planning, organization, and strategizing.



These are the phases of successful negotiations. **Prepare and plan** for the negotiation. Set goals. Be the best **negotiator** you can be. **Make the decisions** to finalize the negotiation. **Review** the final contract in order to understand all of its terms and **monitor compliance** with those terms.

1. The steps of the **Prepare and Plan** phase:

1. Look first at the top 10 CPT codes for which you bill. Define priority contract issues, including provisions/what services are important to you.
2. Identify your goals, desired outcomes, needs, and wants – and reason (s) why you want the outcome.

3. Collect and analyze data about your practice performance. Document the quality of care you offer. Assess the market, different payment models, physician numbers, geography, patient volume, largest area employers, and other areas that relate to your practice.
4. Identify your strengths (niche).
5. Determine who it is that you will be talking to in each step of the negotiation process. Identify the decision-maker representing the payer on your contract.
6. Research payer interests, needs, and wants, including ascertaining what you perceive to be their interests and desired outcomes.
7. Know federal and state antitrust law, as it applies.
8. Plan your strategy and create your agenda... then prepare to work it. Plan your strategy and approach to implement your agenda.
9. Rehearse important parts of your agenda and negotiating position.
10. Set your target based on your goals and identify your options, alternatives, and compromise level.

2. The steps of the **Negotiation** phase:

1. Orient yourself toward a successful negotiation. Implement your planned strategy and approach.
2. Establish rapport in phone and face-to-face meetings.
3. Take an active listening stance and skills into every meeting. Focus on understanding... and on being understood.
4. Reassess your pre-determined negotiation style based on what you observe and perceive early in the meeting (s). Adapt your style, if necessary.
5. Assert your needs clearly. Align your responses and overall path forward with your expectations, goals, outcomes, needs, and wants.
6. Acknowledge the payer's representative as a person and recognize the payer's point of view.
7. Reframe.
8. Ask problem-solving, open-ended questions to gain deeper understanding and encourage dialog. Why? Why not? What if?
9. Review and refine options. Brainstorm possibilities and ideas for solutions.
10. Focus on needs, interests, and concerns. Deal effectively with objections and dishonest tactics. Manage impasses with patience and respect. Clarify issues and feelings. Counter offers, using persuasive and bargaining skills.

3. The steps of the **Make Decisions** phase:

1. Identify signals that could indicate it is time to begin closing the discussion.
2. Restate and evaluate options. Pick a solution (or solutions) from the options, adjust, and work to agree on preliminary outcomes. Build consensus.
3. Decide when to close for agreement, defer/delay, or walk away. If you decided to defer or delay negotiations at this or some other point, evaluate when or if it is reasonable to return to the bargaining table at a later time with new options or explore other payer options.
4. Close for agreement.
5. Recap/summarize to ensure that all parties are clear on agreed upon points.
6. Secure commitment.
7. End the meeting with a mutual commitment to implement determined plans. Build an opportunity to check back with each other to evaluate progress on implementation.

4. The steps of the **Review Contract and Monitor Compliance** phase:

1. Review/evaluate the contract.
2. Conduct a legal review to ensure that the contract is legally binding.
3. Have both parties sign the contract.
4. Evaluate the negotiation process and results.
5. Implement the contract. Ensure that all pediatricians and staff in your practice are fully informed as to all provisions of the new contract.

6. Monitor compliance by the payer and enforce contract provisions.
7. Establish a formal review process to evaluate the overall impact of the contract on your business, patients, practice, and staff.
8. Renew, replace, or terminate the contract. Make your decision based on the payer's performance and the value the relationship brings to your practice.

**Five elements to consider throughout the contract negotiations are:**

1. Analysis is the process of considering something in detail to discover the relationship and meaning of parts to each other and the whole.
 

Give careful thought to your negotiating strategy, proceeding thoughtfully and methodically based on clear goals, positions, and interests. Know your bottom line. Just how far are you willing to go? Determine relevance and usefulness of every point of the agreement and how these points relate to your goals. Break down and study all aspects of the negotiating process before, during, and after each step. Start by determining priority contract issues and examining data related to your practice and the payer in your planning. Keep a clear head to make logical and best decisions, taking time outs to rethink your approach if necessary. Try to figure out the best resolution you can expect.

What is a fair and reasonable deal – and what is a minimally acceptable deal?
2. Time is the measurable period during which an action, process, or condition exists, continues, happens, begins, or ends.
 

In a negotiation, use time as an asset, resource, and tool to your advantage throughout the entire process. Define the period over which negotiation phases will take place and address factors that relate to time. How long will you allow for initial and follow-up negotiating sessions? What is the most advantageous moment in the relationship to schedule negotiations? You don't want to be rushed or distracted by other activities, so schedule enough time. What is the best time of day to schedule the negotiation? What is your deadline for back and forth proposals? What is your timeframe for having a signed agreement?

Don't be pressured into making decisions in haste. Most negotiations will conclude in the final 20% of time allowed.

Use time wisely – make it your ally.
3. Power is the possession of mental or physical control, authority, or influence over people or situations. Using power to influence people or situations is an important aspect of negotiations.
 

How can you develop power or what can make you feel powerful in a negotiation? It can come in many forms, such as position, knowledge, character/ethics, gender, charisma, and even the appearance of irrationality.

Most importantly, you can gain power in a negotiation through thorough preparation, asserting your needs, educating the payer, and even by dealing effectively with objections or dishonest tactics.

Use power constructively in a negotiation.
4. Information is knowledge, intelligence, or data obtained from investigation, study, or instruction. It can be acquired by telephone, e-mail, hard copy, or in person. Information (facts, statistics, background, past experience, etc.) is critical to have and use effectively in negotiating with a payer.
 

The more information you have on your position and the more you know about the other side, the better you can establish your position.

Research, learn, listen, and ask questions to gain information. What information do you have about your practice and its' relationship to the payer and what do you need? What does the payer need from you? What are the payer's and your competitive advantages and disadvantages?

Information = Power.
5. Leverage is your ability to effectively obtain agreement and achieve a goal on your own terms – your strategic advantage. It is dynamic, based on perception and fact. Leverage is different from power in that leverage is

about situational advantage, not objective power. You can exert considerable leverage under the right circumstances with very little conventional power.

Recognize options (alternatives) on both sides of the table. Appreciate how willing you are to consider those options and know what the bottom line is for you and the payer.

Knowledge and insights into the relative strengths of you and the payer are important to create leverage. Which side has the most to lose? Can you gain control over something the payer needs? Can you commit the payer to terms that favor your practice? For who is time a greater factor?

Data is especially important in creating leverage. Before entering negotiations, gather as much information about your practice as possible, such as quality rankings, patient volume, financial data, patients to be served, geographical needs and coverage, and physician provider panels. Also gather external information such as services provided by other pediatricians in the area and current quality and quantity of pediatric services.

To get a sense of how leverage will play out in a negotiation, ask yourself,

“Who has the most to lose if there is no contract?”

The following is a list of additional resources to assist you in making good decisions in contracting with payers:

- The American Academy of Pediatrics Payer Advocacy Hotline.<sup>132</sup> (Email contact).
- American Academy of Family Physicians: Negotiation Skills Tame Managed Care Contracts.<sup>133</sup>
- American Academy of Family Physicians: Bottom Line Series.<sup>134</sup>
- The Business Case for Pricing New Vaccines developed by the AAP Private Sector Advocacy Advisory Committee.<sup>135</sup>
- AAP Private Payer Advocacy (PPA) Update - shares information that impacts your practice's bottom line and relationships with private payers.<sup>136</sup>
- Medical Association (AMA), Model Managed Care Contract, Fourth Edition, (2005).<sup>137</sup>
- Camp, Jim. Start with No - The Negotiating Tools That the Pros Don't Want You to Know. New York: Crown Business, July 2002.
- Forbes.com: ABCs of Negotiating.<sup>138</sup>
- Hassle Factor Form developed by the American Academy of Pediatrics.<sup>139</sup>
- Healthcare Financial Management Association.<sup>140</sup>
- Managed Care & Ambulatory Surgery: Strategies for Contract Negotiation & Reimbursement.<sup>141</sup>
- Medical Group Management Association.<sup>142</sup>
- National Health Information's Healthcare Management Library.<sup>143</sup>
- Talking to Third Party Payers: Immunization Financing Template: American Academy of Pediatrics Pediatric Council Immunization Toolkit.<sup>144</sup>
- The Negotiation Academy (TNA): Neutralizing Manipulative Negotiation Tactics.<sup>145</sup>
- A Pediatrician's Guide to Managed Care - 2nd Edition. Nelson, Dr. Richard P. and Dr. Maria E. Minon, eds. American Academy of Pediatrics, 2001.
- SAB Negotiation Enterprises -Negotiation Training.<sup>146</sup>
- Shell, G. Richard. Bargaining for Advantage. Penguin Books, 1999.
- Stark, Peter B., and Jane Flaherty. The Only Negotiating Guide You'll Ever Need. New York: Broadway Books, 2003.
- Ury, W. Getting Past No. London: Business Books, 1991.
- Ury, W. Getting to Yes: Negotiating Agreement Without Giving In. Penguin Books, Ltd. Middlesex, England. 1981.
- Warner, Dr. Jon. Negotiating Styles Profile. HRD Press, Inc. and Team Publications, 2004.
- AAP Practice Management Online.<sup>147</sup>
- AAP Private Payer Advocacy Committee.<sup>148</sup>
- AAP Checklist to Assess Carrier Contracts.<sup>149</sup>

## **Chapter 7**

# **Quality Improvement Team: Establishing a Medical Home Through Continuous Quality Improvement**

*“Our Medical Home QI Team has helped our practice reach out to the families and improve the care of our patients with special health care needs. It has been extremely gratifying to be a part of that. We are fortunate to have a team with many dedicated and talented members, including our parent partners who bring fresh and invaluable perspectives (not to mention hard work!) to everything our team does”.*

-Sean McCormick, MD, QI Team Lead Pediatrician-

One effective method that primary care practices can use to establish a medical home is the continuous quality improvement (CQI) process. CQI is a concept that focuses on a team approach to continuous improvement in healthcare. Team members include both practice staff and health care consumers served by the practice. This collaborative approach is the foundation of the process and is essential for successful health care improvement outcomes necessary for creating a medical home.

CQI is a management philosophy which contends that most things can be improved. This philosophy does not subscribe to the theory that “if it isn’t broke, don’t fix it.” It is a set of concepts and methods developed from principles proposed by early quality gurus including W. Edwards Deming. These CQI principles, tools, and techniques have been found to work effectively in manufacturing industries and have recently been found to also work effectively in human service industries, including healthcare. At the core of CQI is serial experimentation applied to everyday work to meet the needs of those served and improve the services offered.

### **Core Concepts of CQI**

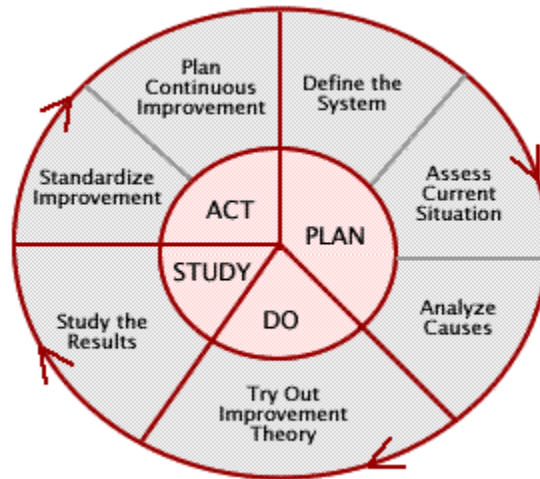
- Quality is defined as meeting and/or exceeding the expectations of customers.
- Success is achieved through meeting the needs of those being served.
- Most problems are found in processes, not in people. CQI does not seek to blame, but rather to improve processes.
- Unintended variation in processes can lead to unwanted variation in outcomes and, therefore, effort is focused on reducing or eliminating unwanted variation.
- It is possible to achieve continual improvement through small, incremental changes using the scientific method.
- Continuous improvement is most effective when it becomes a natural part of the way everyday work is done.

### **Core Steps in Continuous Improvement**

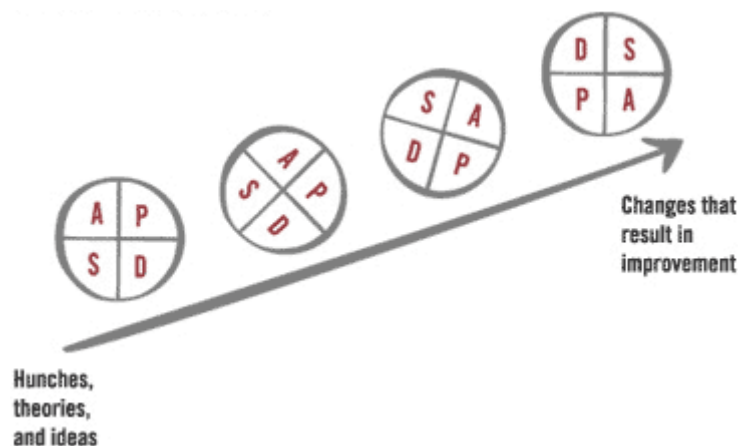
- Form a team that has knowledge of the system needing improvement.
- Define a clear aim.
- Identify and define measures of success.
- Brainstorm potential change strategies for producing improvement.
- Plan, collect, and use information for facilitating effective decision making.
- Apply the scientific method to test and refine changes.

## A Model for Improvement

- Improvement is based on building knowledge (of what works and does not work) and applying it appropriately.
- The model offers a “trial and learning” approach that helps reveal the outcomes of change.
- Three basic questions:
  1. What are we trying to accomplish?
  2. How will we know that a change is an improvement?
  3. What changes can we make that may result in an improvement?
- Test a change on a small scale using PDSA. **P = Plan; D = Do; S = Study; A = Act**



- Plan the “change” strategy; including who will be involved, what data will be collected, how and when the data will be collected, and when the data will be considered adequate to study.
- Plan a small test - one day, 5 records, etc.
- Do the intervention.
- Study the results.
- Act on the knowledge you gain from the data (maintain the plan, modify the plan, add to the plan).  
*Continue with a second PDSA Cycle, and so forth. The process continually builds, fostering improvement efforts.*



If the “change” was successful, solidify it by:

- Expanding it to the rest of the system.
- Establishing systems to support it.
- Identifying ways in which further improvements can be made.

### **Additional thoughts about improvement efforts:**

- Before you try to solve a problem, define it.
- Before you try to control a process, understand it.
- Before trying to control everything, find out what is important, and work on the most important issue or on the process having the biggest impact.
- Recognize that we can learn from failures, so respect “meaningful failures.”

### **Establishing a Quality Improvement Team**

In Illinois, DSCC staff are working with primary care practices throughout the state to establish medical homes. As part of this work, the practice establishes a Quality Improvement (QI) Team that includes practice staff and health care consumers. Ideally, the QI Team includes a lead physician, the staff person(s) who will provide care coordination, staff from the front office involved in scheduling and billing and at least two health care consumers served by the practice (parents and/or teenage children). Contact DSCC to see whether a facilitator can be arranged for your practice. Facilitators are experienced and knowledgeable of group processes and provide the structure for meetings to be effective. They can also be helpful for assisting in future quality improvement projects that will satisfy board recertification requirements.

To initiate the QI Team's work, two assessment tools are utilized to obtain baseline data: the Medical Home Index and the Medical Home Family Index. These nationally validated assessment tools were developed by Dr. Carl Cooley and the staff at the Center for Medical Home Improvement (CHMI)<sup>150</sup>. These tools enable the practice to assess how well they provide comprehensive family-centered care and identify needed changes for providing a medical home for children with special health care needs.

It is highly recommended that a practice obtain no less than 30 completed Medical Home Family Indices to get meaningful results. If you are planning to perform statistical tests, you should consider consulting a biostatistician to determine what sample size would be appropriate to achieve statistical significance for your specific needs. Keep in mind that the number of completed surveys you receive will be less than the number you distributed. The higher response rate you achieve, the more meaningful your results will be. You might aim for a response rate of 35%- 40%, meaning that you should distribute 25% - 50% more surveys than the sample size you are aiming for, but with some patient populations, response rates will be lower.

How do teams assess the results of these tools? The CHMI Medical Home Index (MHI)<sup>151</sup> is divided into 6 domains that define the essential characteristics of a medical home:

1. organizational capacity,
2. chronic condition management,
3. care coordination,
4. community outreach,
5. data management and
6. quality improvement.

The MHI scores reveal the practice's strengths and weaknesses within these areas.

The Medical Home Family Index (MHFI)<sup>152</sup> used by Illinois practices has been adapted so that the questions correlate to the domains of the MHI completed by the practice, thus providing opportunities for the QI Teams to compare the practice results with those from families served by the practice. This comparison generally reveals the practice staff and families often agree on the same strengths and weaknesses. However, this comparison also frequently reveals deviations between the two group's perceptions about practice strengths and weaknesses - these areas are ideal for the QI Team to begin brainstorming about planning improvement changes.

The Illinois Medical Home Project has combined the Medical Home Family Index with the Caregiver Survey to create the Illinois Medical Home Family Feedback Tool<sup>153</sup>. This tool is being used to provide more comprehensive feedback and input from families on their perceptions about the care received from their primary care medical home.

DSCC staff will score and analyze the MHI and MHFI and develop a written report for practices who are interested in establishing a quality improvement team and developing a medical home. Contact DSCC by calling 800-322-3722 or by email at [dsc@uic.edu](mailto:dsc@uic.edu) for more information about medical home quality improvement efforts.

Once the team has reviewed the strengths and weaknesses revealed by the assessment tools, they can begin discussing the processes where improvement would be most beneficial and define specifically the small tests of change they believe will result in improvement. Using the PDSA Cycle, described above, the team can define these small tests of change and begin to think and plan for subsequent larger scale changes.

### **Other Resources**

DSCC staff who serve as QI Team facilitators have developed a *Facilitator's Guide*<sup>154</sup> to help practices who want to independently begin the quality improvement process.

The Illinois Medical Home Project<sup>155</sup> is an MCHB-funded grant and is administered through the Illinois Chapter of the American Academy of Pediatrics (ICAAP) in collaboration with the DSCC. The project establishes medical home QI Teams, utilizing parents as partners, with primary care practices. Experienced project staff help support medical home initiatives utilizing the CMHI Tool Kit, National Initiative for Children's Healthcare Quality (NICHQ) training materials and resources, QI Team facilitators, technical assistance, and funding to support participating sites. Facilitators and technical assistants utilize knowledge of medical home concepts, family involvement, and QI techniques to support office or clinic-based systems level changes to better serve children and youth with special healthcare needs and their families. The project also uses a public relations strategy and hosts meetings to spread implementation of medical homes across Illinois.

*"The enthusiasm our three parent partners bring to our quality improvement team has been an inspiration. When other issues distract the practice staff, the parent partners have kept the medical home improvements on task".*

-Tim Geleske, MD, QI Team Lead Pediatrician-

### **DSCC Medical Home Primer**

Please be aware that successful completion of the Medical Home Primer activity and exam is an OPTIONAL step in becoming an approved DSCC Medical Home Provider. Physicians who are interested in completing the Medical Home Primer exam and evaluation can access and submit the exam/evaluation form online at the following web address: <http://internet.dsc.uic.edu/forms/medicalhome/MedHomeMonographEvaluation.pdf>

## References

**Note:** The material in this monograph is also available on the DSCC website. The references listed below are embedded into the online text for easier access to the links. Go to:  
<http://internet.dsc.uic.edu/medhome/mhintro.asp>.

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- <sup>1</sup> Electronic version of this monograph: “A Medical Home Primer for Community Pediatricians and Family Physicians”: <http://internet.dsc.uic.edu/forms/medicalhome/MedHomeCMEMonograph.pdf>
- <sup>2</sup> Illinois Health Connect: <http://www.illinoishealthconnect.com/>
- <sup>3</sup> American Academy of Pediatrics, Committee on Children With Disabilities, “Care Coordination: Integrating Health and Related Systems of Care for Children with Special Health Care Needs,” *Pediatrics*, 1999, 104(4), pp. 978-981.
- <sup>4</sup> Institute for Family-centered Care, personal communication, Brazdziunas.
- <sup>5</sup> Joint Principles of a Patient-Centered Medical Home Released by Organizations Representing More Than 300,000 Physicians, March 5, 2007: <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>
- <sup>6</sup> Medical Home Index: [http://www.medicalhomeimprovement.org/assets/pdf/MHI-FullV\\_2006CMHI.pdf](http://www.medicalhomeimprovement.org/assets/pdf/MHI-FullV_2006CMHI.pdf)
- <sup>7</sup> Medical Home Index-Short Version: [http://www.medicalhomeimprovement.org/assets/pdf/MHI-ShortV\\_2006CMHI.pdf](http://www.medicalhomeimprovement.org/assets/pdf/MHI-ShortV_2006CMHI.pdf)
- <sup>8</sup> Practice Assessment Checklist: <http://internet.dsc.uic.edu/forms/medicalhome/PracticeAssesementChecklist.pdf>
- <sup>9</sup> Illinois Medical Home Project: <http://www.illinoisap.org/medicalhomeproject.htm>
- <sup>10</sup> Medical Home Measurements: [http://www.medicalhomeinfo.org/tools/med\\_home.html](http://www.medicalhomeinfo.org/tools/med_home.html)
- <sup>11</sup> National Center for Cultural Competence: <http://www11.georgetown.edu/research/gucchd/nccc/>
- <sup>12</sup> Web-based practice assessment tool: <http://www11.georgetown.edu/research/gucchd/nccc/features/CCHPA.html>
- <sup>13</sup> Downloadable practice self-assessment checklist:  
<http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist.SIDS-ID.pdf>
- <sup>14</sup> The American Academy of Family Physicians Web-based training program entitled “Quality Care for Diverse Populations”: <http://www.aafp.org/online/en/home/cme/selfstudy/qualitycarevideo.html>
- <sup>15</sup> Department of Health and Human Services, Office of Minority Health; Think Cultural Health:  
<http://www.thinkculturalhealth.org/>
- <sup>16</sup> Cultural Competence Assessment Tool:  
[http://www.brightfutures.org/mentalhealth/pdf/professionals/cultural\\_comptnc.pdf](http://www.brightfutures.org/mentalhealth/pdf/professionals/cultural_comptnc.pdf)
- <sup>17</sup> Gregory S. Liptak, MD, MPH and Gail M. Revell, RNC, MS, Community Physician's Role in Case Management of Children With Chronic Illnesses, *PEDIATRICS* Vol. 84 No. 3 September 1989, pp. 465-471:  
[http://pediatrics.aappublications.org/cgi/content/abstract/84/3/465?maxtoshow=&HITS=10&hits=10&RESULTFO RMAT=&author1=Liptak&searchid=1070987182352\\_3983&stored\\_search=&FIRSTINDEX=0&sortspec=relevance&journalcode=pediatrics](http://pediatrics.aappublications.org/cgi/content/abstract/84/3/465?maxtoshow=&HITS=10&hits=10&RESULTFO RMAT=&author1=Liptak&searchid=1070987182352_3983&stored_search=&FIRSTINDEX=0&sortspec=relevance&journalcode=pediatrics)
- <sup>18</sup> Medical Home Family Index-IL Version:  
<http://internet.dsc.uic.edu/forms/medicalhome/MedicalHomeFamilyIndex.pdf>
- <sup>19</sup> Family/Caregiver Survey: [http://www.medicalhomeimprovement.org/assets/pdf/MHIK\\_II-A3.pdf](http://www.medicalhomeimprovement.org/assets/pdf/MHIK_II-A3.pdf)
- <sup>20</sup> Illinois Medical Home Family Feedback Tool:  
<http://internet.dsc.uic.edu/forms/medicalhome/ILMedicalHomeFamilyFeedbackTool.pdf>
- <sup>21</sup> Medical home visit card – English: <http://internet.dsc.uic.edu/forms/medicalhome/MedicalHomeVisitCard1.jpg>
- <sup>22</sup> Medical home visit card – Spanish: <http://internet.dsc.uic.edu/forms/medicalhome/MedicalHomeVisitCard2.jpg>
- <sup>23</sup> Brochure for families: <http://internet.dsc.uic.edu/forms/medicalhome/4016.pdf>
- <sup>24</sup> Children's HealthCare Associates Newsletter:  
<http://internet.dsc.uic.edu/forms/medicalhome/CHANewsletter3.pdf>
- <sup>25</sup> Sterling Rock Falls Pediatric Center Newsletter:  
<http://internet.dsc.uic.edu/forms/medicalhome/SRFNewsletter1.pdf>
- <sup>26</sup> Sample Poster 1 – English: <http://internet.dsc.uic.edu/forms/medicalhome/MHPoster3.pdf>
- <sup>27</sup> Sample Poster 2 – English: <http://internet.dsc.uic.edu/forms/medicalhome/MHPoster5.pdf>
- <sup>28</sup> Sample Poster 1 – Spanish: <http://internet.dsc.uic.edu/forms/medicalhome/MHPosterSpanish1.pdf>

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- <sup>29</sup> Sample Poster 2 – Spanish: <http://internet.dscc.uic.edu/forms/medicalhome/MHPosterSpanish2.pdf>
- <sup>30</sup> Exceptional Parent Annual Resource Guide: <http://www.eparent.com/>
- <sup>31</sup> DisAbilities Books: <http://www.disabilitiesbooks.com/catalog.htm>
- <sup>32</sup> Special Addition family newsletter: <http://internet.dscc.uic.edu/dsccroot/parents/newsletter.asp>
- <sup>33</sup> American Academy of Pediatrics National Center of Medical Home Initiatives for Children with Special Needs: <http://www.medicalhomeinfo.org/tools/Marketing.html>
- <sup>34</sup> Policy Statement: Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children With Special Health Care Needs, PEDIATRICS Vol. 116 No. 5 November 2005, pp. 1238-1244 (doi:10.1542/peds.2005-2070): <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1238>
- <sup>35</sup> Policy Statement: Family-Centered Care and the Pediatrician’s Role, PEDIATRICS Vol. 112 No. 3 September 2003, pp. 691-696: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/3/691>
- <sup>36</sup> Partnership for Policy Implementation (PPI): [http://www.aapcocit.org/PPI\\_overview.doc](http://www.aapcocit.org/PPI_overview.doc)
- <sup>37</sup> Pre-visit questionnaire: <http://internet.dscc.uic.edu/forms/medicalhome/PreVisitQuestionnaire.pdf>
- <sup>38</sup> Today’s Visit Form: <http://internet.dscc.uic.edu/forms/medicalhome/TodaysVisitForm.pdf>
- <sup>39</sup> Post-visit questionnaire: <http://internet.dscc.uic.edu/forms/medicalhome/PostVisitQuestionnaire.pdf>
- <sup>40</sup> Clinical Practice Guidelines: Diagnosis and Management of Bronchiolitis, PEDIATRICS Vol. 118 No. 4 October 2006, pp. 1774-1793 (doi:10.1542/peds.2006-2223): <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/4/1774>
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## Medical Home Exam

The Division of Specialized Care for Children (DSCC) offers the Medical Home Primer activity and exam as a OPTIONAL step in becoming an approved DSCC Medical Home Provider. The Medical Home Primer exam and evaluation can also be completed and submitted electronically. It is available online at:

<http://internet.dscc.uic.edu/forms/medicalhome/MedHomeMonograph.pdf>

### Learning Objectives

- Define the medical home concept and its core elements as it relates to the primary care setting involving all children including children and youth with special health care needs (CYSHCN).
- Recognize the importance of partnering with families.
- Evaluate the “medical homeness” of their practice using available assessment tools.
- Assess office practices with the philosophy that the Medical Home is the basis to care for all children including CYSHCN.
- Identify practical methods of improving quality health care in their practices including physical and procedural changes.
- Understand the key characteristics that should guide physicians in providing coordinated care to CYSHCN and their families.
- Be familiar with contracting with payers and some of the coding and reimbursement issues specific to the medical home model.
- Understand how to implement a continuous quality improvement process in their practice.

### True/False

- True** 1. The medical home model applies to ALL children.
- True** 2. Partnership between parents and professionals is not important in the medical home model
- True** 3. Parent input can be solicited through planned communication, family surveys or focus groups.
- True** 4. Standardized assessment tools are not helpful in assessing your practice’s model of health care delivery.
- True** 5. The Medical Home Index is designed to reduce the cost to managed care organizations.
- True** 5. Establishing working relationships with community-based organization like local health departments and Early Intervention promotes access to valuable community services and resources for a medical home provider.
- True** 6. DSCC reimburses primary care providers for some care coordination activities and telephone consultations with specialists.

### Multiple Choice

- 7. The key elements of the medical home include:
  - a. Accessibility, fiscal responsibility, comprehensiveness, continuity, family-centeredness, and coordination.
  - b. Accessibility, continuity, comprehensiveness, coordination, family-centeredness, compassion, and cultural effectiveness.
  - c. Accessibility, comprehensiveness, continuity, coordination, family- centeredness, and mental health care.
  - d. Accessibility, comprehensiveness, continuity, coordination, family-centeredness, and the provision of all needed services for the family.
- 8. Consumer awareness of medical home can be promoted through:
  - a. DSCC Medical Home Information for Families brochure
  - b. Medical home visit cards and medical home posters
  - c. Medical home bulletin board and reference library
  - d. All of the above

10. The definition of children with special health care needs does not include:
- a. A child with behavior problems who needs to see a counselor.
  - b. A child who is well and has no risk factors for medical, emotional or developmental problems
  - c. Babies who were prenatally exposed to cocaine.
  - d. Children whose parents are mentally ill.
11. Some practice accommodations to promote proactive care for CSHCN may include the following:
- a. Longer appointment times, referral “scripts”, and Fax Back forms.
  - b. Phone scripts, “child friendly” print gowns, and longer appointment times.
  - c. Relaxing “on hold” messages, “valet” parking, and bulletin boards.
  - d. Snacks in the waiting area, internet access for families, and “fast track” to the exam room.
12. All of the following statements are true about DSCC except:
- a. Statewide Title V Program for children with special health care needs.
  - b. Provides financial assistance for medical services and care coordination for medically eligible children.
  - c. Reimburses for school physical examinations.
  - d. Staff is knowledgeable about community resources and organizations to assist children with special health care needs.
12. Coding strategies to more accurately reflect the services provided for reimbursement include all but:
- a. Bill all CYSHCN for prolonged services codes.
  - a. Accurate documentation of the service.
  - b. Medical home care coordination codes are frequently not utilized.
  - c. Code to reflect time, history taking or decision making that occurs during the visit.
13. Quality improvement teams have been effective in:
- a. Promoting parent professional partnerships.
  - b. Creating improvements through small, serial steps.
  - c. Use of the Plan, Do, Study, Act Cycle.
  - d. All of the above.

# Program Evaluation

## “The Road Map to a Medical Home”

The University of Illinois, Division of Specialized Care for Children (DSCC) respects and appreciates your opinions. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few minutes to complete this evaluation form.

Please answer the following questions by circling the appropriate rating:

5=Outstanding 4=Good 3=Satisfactory 2=Fair 1=Poor

### Extent to Which Program Activities Met the Identified Objectives

Upon completion of this activity, participants should be able to:

Define a medical home and its core elements;  
5      4      3 2      1

Recognize the importance of partnering with families;  
5      4      3      2      1

All of the above. Evaluate the “medical homeness” of their practice using available assessment tools;  
5      4      3 2      1

Assess office practices with the philosophy that the medical home is the basis to care for all children including CYSHCN;  
5      4      3 2      1

Identify practical methods of improving quality health care in their practices;  
5      4      3 2      1

Understand the key characteristics that should guide physicians in providing coordinated care to CYSHCN and their families;  
5      4      3 2      1

Understand how to implement a continuous quality improvement process in their practice;  
5      4      3      2      1

Be familiar with some of the contracting, coding, and reimbursement issues specific to the medical home model.  
5      4      3      2      1

### Overall Effectiveness of the Activity

Objectives:

Related to purpose/goal(s) of activity.	5	4	3	2	1
Related to my practice needs.	5	4	3	2	1
Will influence how I practice.	5	4	3	2	1
Will help me improve patient care.	5	4	3	2	1
Stimulated my intellectual curiosity.	5	4	3	2	1
Overall quality of material.	5	4	3	2	1
The activity met my expectations.	5	4	3	2	1

Will the information presented cause you to make any changes in your practice?  Yes  No

If yes, please describe any change(s) you plan to make in your practice as a result of this activity.

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How committed are you to making these changes?  
(Very committed) 5      4      3      2      1 (Not at all committed)

Additional comments about this activity:

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Do you feel future activities on this subject matter are necessary and/or important to your practice?  Yes  No

Your degree:  MD  DO  RN  PA

Mail or fax to the Division of Specialized Care for Children

**You will be notified of your exam results by email.**

### EXAM ANSWER KEY

1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_  
9 \_\_\_ 10 \_\_\_ 11 \_\_\_ 12 \_\_\_ 13 \_\_\_ 14 \_\_\_

Please fill in your name and address and mail/fax this sheet to:

DSCC  
Attn: Medical Home Facilitator  
3135 Old Jacksonville Road  
Springfield, IL 62704-6488  
217-558-0773 (Fax)

Name

Specialty

Street Address

City

State

Zip

Email

Phone

# “Every Child Deserves A Medical Home”



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