Massachusetts
Child Health Quality Coalition
October 21, 2013
CHQC Goal Framework

• **Improve care coordination for children** by:
  – Supporting the implementation of the set of standard elements of Care Coordination and associated measures;
  – Supporting the use of a resource guide to support communication strategies necessary for effective care coordination;
  – Contributing to the ability to measure coordination through the development of at least one new measure of care coordination for children with behavioral health issues.

• **Support access to medical homes for more Massachusetts children** by spreading lessons learned from the CHIPRA Medical Home Learning Collaborative, fostering continued collaboration among practices, and facilitating policy, systems and environmental change.

• **Develop and begin implementing a plan for sustaining the CHQC** following the grant-funded period.

• **Support building capacity and create opportunities for families to be active partners** in all CHQC activities and support CHQC organizations in partnering with parents in their work.

• **Inform state and national health policy on issues specific to children’s healthcare and measurement** by identifying and following through on opportunities.
Connecting to Community Resources in the Medical Home Learning Collaborative

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October 21, 2013

National Initiative for Children’s Healthcare Quality
Today’s Objectives

- Provide brief update on CHIPRA Medical Home Learning Collaborative
- Review practice teams’ progress towards build systems to integrate community resources into medical home
- Identify practices’ needs in improving connections to community resources
- 2 goals
  - Deepen existing connections to community resources – focus on systems building rather than individual referrals
  - Make new connections that support families and improve outcomes
Where we are in the collaborative

**Action Period 1**
- LS One Oct 2011
- LS Two Jan 2012
- LS Three May 2012

**Action Period 2**
- LS Four Nov 2012

**Action Period 3**
- LS Five Feb 2013

**Action Period 4**
- LS Six Sept 2013

**MA CHIPRA Medical Home Learning Collaborative**
- October 2011 – December 2013

**Evaluation, final report, plan for spread**
- January 2014 – September 2014
<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Location</th>
<th>Mass Health enrollment (includes adults)</th>
<th>Providers (FTE)</th>
<th>Practice Specialty (as reported by practice)</th>
<th>EHR capacity</th>
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<td>Cambridge</td>
<td>1,856</td>
<td>4.75 MD</td>
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<td>100% EHR, registry</td>
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<td>P/ FP</td>
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<td></td>
<td></td>
<td></td>
<td>Adolescent: 3 MD/ 1.5 NP</td>
<td></td>
<td></td>
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<td></td>
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CHIPRA Learning Collaborative Driver Diagram

Outcomes

Create Pediatric Medical Home

Improved:
1. Clinical outcomes;
2. Family experience;
3. Team experience;
4. Efficiency & reduced costs

Primary Drivers

- Family & Youth Centered Care
- Continuous Medical Home Care Team
- Comprehensive Coordinated Care
- Community
- Systems Improvement
- Engaged Leadership

Secondary Drivers

- Treat family as equal partner in care
- Co-create care plan
- Provide access to information
- Include family members on improvement team
- Develop cultural competency

- Define roles and responsibilities for each member of the care team
- Enhance internal communication
- Prepare in advance for visits
- Streamline office flow
- Ensure continuous care team

- Provide preventive care and anticipatory guidance
- Coordinate primary care, specialty care & other services
- Support timely transition into adult life planning

- Link family to community support
- Create support systems with community programs, service agencies, and public organizations including Title V, schools, AAP & AAFP chapters, Family Voices

- Implement quality improvement methods and training
- Leverage HIT: use registry, visit management, EBC at point of care
- Improve access
- Secure appropriate payment

- Set the direction and display curiosity about Medical Home
- Plan for sustainability and spread
- Foster a culture of partnerships
- Develop alliances and cooperative relationships, advocacy
- Align policy and procedure
- Use data transparently
Community Resources in the Learning Collaborative

Any organization outside of traditional healthcare that supports:

a. Developmental health
b. Behavioral and oral health
c. Clinical outcomes for children with chronic conditions
d. Educational outcomes
e. Transition to adulthood

Includes:

a. Community and social service organizations
b. Schools
c. Oral health and behavioral health providers
d. Adult primary care practices
Aggregate % of Preschool Children With Complete Wellness Assessment

Six well visits since birth, primary immunizations developmental screening and screening for autism spectrum disorder (ASD), anticipatory guidance regarding diet, screen time, and physical activity, and oral health assessment and fluoride varnish

N = 13
Aggregate % Completed Healthy Development Referral & Follow Up

Percentage of children who screen positive for ASD, developmental delays, or behavioral health concerns who are referred to and receive follow up with Early Intervention, a specialty provider, mental health provider, or CORE evaluation within 3 months after a positive screen.
Aggregate % Children with Transition Plan Initiated by 14

Documentation of Transition Plans initiated by age 14.

Note: 4 teams reported zero
Aggregate Medical Home Index

- Organizational Capacity
- Chronic Condition Management
- Care Coordination
- Community Outreach
- Data Management
- QI/Change
- Overall Mean Result

LS1
LS2
LS4
Practice Community Connections: Introducing families to community resources, coordinating care

**Basic Level** – Health fairs at community organizations and practices (MEHC)
- Coordinate child mental health care (YP)
- Resource guide that includes local community agencies and support groups (CHA)
- Strengthened relationship with DCF: more frequent and proactive calls to them to discuss patients (HVMA)
- DPH Care coordinator created linkage between Early Intervention and practice-based care coordination (HVMA)
- Coordination of paperwork for ADHD with local schools (HPA)
Practice Community Connections: Building Systems and Organizational Partnerships for the Medical Neighborhood

- Pediatrician for local child care centers and preschools (YP)
- In-service for daycare providers on physical and sexual abuse (SC)
- Meet with school nurses throughout the school year (SC)
- Share asthma and allergy information with Head Start (SC)
- Parent Advisory Council program at local Boys and Girls Club on the nutrition and exercise (SC)
- Early intervention and WIC speak to practice staff at meetings (SC)
- Partnered with organizations that support key ethnic groups in the community (HVMA)
- Fitness & Nutrition collaborations with local schools and community centers (MEHC)
Practice Community Connections: Building Capacity for Better Integrated Systems

- Created a 30 hour social work position to help families access community supports for basic needs (CHA)
- Working with a local mental health agency to provide co-located behavioral health services (HPA)
- Dedicated “community programs” staff (MEHC)
Community Resource Spider Web
Most Common Community Organizations Practices are Connected to

- Early Intervention (12)
- Women, Infants and Children (11)
- Department of Public Health (9)
- Massachusetts Child Psychiatry Access Project (7)
- Family Ties (6)
- Department of Children and Families (5)
Other Community Organizations Practices are Connected to

- To support basic needs:
  - Farmers' markets, farms, food resources
  - Homeless coalitions and shelters
  - Economic resources
  - Legal services

- To support better emotional health:
  - Anti-bullying organizations and youth empowerment organizations
  - Domestic Violence Programs

- To support care of CYSHCN
  - Special Olympics
  - Autism groups and other groups that support children with chronic conditions
  - Respite care
Community Organizations Practices Would Like to Connect to

- Adult PCPs accepting new/complex patients
- After school and out of school programs
- Psychiatry (especially inpatient units)
- Home visiting and visiting nurse programs
- Housing and school advocacy organizations
- Support groups and national organizations for CYSHCN
- Faith based and cultural organizations
- Private insurance carriers
Caring NC

State Agencies:
DDH, DDS, MEB, MCHH, etc.

Non-Profit Community-Based

Springfield Housing

WIC

MCPAP

Support Groups

DN Programs

Legal Services - all kinds of need

Family Ties

TPS 

(Teens)

JPS 

(Juveniles)

Special Education

School Projects

Special Needs

YWCA

Recreation

PPAC

FP/HC

Faith-Based

Schools

Head Start

Boys/Girls Clubs and Youth in Service
Practice Perspectives on Working With Community Resources

Jacqueline Johnson
Chief Operations Officer
Caring Health Center
FAMILY PERSPECTIVES ON COMMUNITY RESOURCES

Bonnie Thompson
CHIPRA Grant Family Leader
bthompson@fcsn.org
Mass Family Voices at Federation
for Children with Special Needs
**CHQC Goal:** Find ways to support ‘medical home neighborhoods’ in which practices and community resources work together to support patients and families.

**NICHQ:** Linkage of and Mobilization of Community Resources is one of the five drivers of Quality Improvements in Medical Home Initiative
Family Outreach

Informal survey sent to:

CHQC family leaders experienced in providing peer support; 10 respondents

Family Partners in NICHQ practices; 6 respondents

The following questions were asked...
1. **What community resources are most useful and of greatest benefit to you, your family or the families you work with?**

- parent support groups
- disability specific organizations (mental health conditions, autism support centers, diagnosis specific groups)
- schools
- libraries
- adapted recreation programs
- family run organization call centers (Parent Professional Advocacy League-PPAL, Mass Family Voices, Federation for Children with Special Needs-FCSN, Family Ties of MA)
- Boys & Girls Club
- Children’s Behavioral Health Initiative (CBHI)
- Resources for Community and People (RCAP Solutions)

....continued...
1. …continued…

Community resources most useful to families...

- REGIONALLY LOCATED to get information on resources in or near their community
- Provide information on LOCAL AID (housing, food pantries/bank, fuel assistance, WIC, child care)
- Groups that can LINK PARENTS TO OTHER PARENTS with similar needs and concerns
- If payment required, within families’ HEALTH INSURANCE NETWORK
2. Where did you learn of these resources?

- listserves
- other parents
- PPAL, Family Ties, FCSN
- doctors’ waiting rooms/bulletin boards
- social workers
- internet
- medical home practice
- school collaborative
- state agencies (DDS, DPH, MCB)
- health center outreach team
- hospitals
- conferences and resource fairs
- in-home personal care attendant (PCA)
3. Who coordinates connections to these community resources?

- parents
- patient (youth/young adult)
- therapist
- Autism Support Center
- Family Partners in Children’s Behavioral Health Initiative (CBHI)
- case workers
- pediatricians and their staff
- DPH Care Coordination (limited availability)
- For kids with complex needs, it may be many people coordinating small parts, as many agencies and programs work in silos.
4. What barriers or obstacles hinder connections from being made?

- conflicting demands for family or patient’s time
- cost
- location
- scheduling ease and availability of appointments
- siblings’ competing needs
- parent capacity and wellness
- knowing what is out there
- lack of response from resources contacted
- family readiness to engage
- language barriers
- transportation
- limited time resource (funding ends)
- weather
- many non-profit resources are at capacity; challenged to get out, do outreach and spread the word
5. **What needs to further develop to encourage greater community linkages?**

- Expanding resource knowledge to more staff so information not lost when staff moves on
- Thorough documenting of resources, updated regularly
- More family partners/leaders embedded in clinical practices facilitating connections
- Funding for an independent organization or persons with lived experience to create a family driven/youth guided plan to link resources together
- Need to see kids holistically, not carved out by specialty, system or silo
- To have someone who can look at the gaps and see the opportunities to innovate; how to do better and address unmet needs
- When used, improvements to health insurance case management can work when the assistance is meaningful, otherwise it leaves families frustrated.
- Family-centered care; looking at the whole family relative to the child needs
Discussion Questions

• What community resources have been most beneficial to you or the families you work with? What factors have made those resources stand out (e.g., services provided, consistency of communication, family feedback)?
• What systems have you created or used to ensure that medical and community plans of care are coordinated?
• What barriers or obstacles hinder connections from being made or maintained?
• What systems could be developed or enhanced to overcome these barriers and provide continuous care across the medical neighborhood?
• What is one action that you could take in your role to improve connections between medical homes and community resources?