Potential Barriers and Suggested Ideas for Change

Key Activity: Develop a Highly Functioning, Cross-disciplinary Improvement Team*

Rationale: Evidence shows that the results of medical home improvements, including family-centered care, occur as a product of teamwork.

Teamwork involves a set of skilled, cross-disciplinary interactions that are learned, practiced, and improved to provide better care delivery management, promote safety, and enhance outcomes. Highly functioning teams, made up of front-line caregiver representatives and fully engaged family partners, have the capacity to test ideas quickly and have the resilience to deal with the complexities of primary care. Therefore, teams are able to gain practice-wide buy-in for innovations and procedural changes and, thereby, ensure success. Working in effective teams may be a cultural change from the traditional hierarchical system of practice organization. Effective teamwork is a fundamental skill set underlying successful medical home improvement.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: A medical home quality improvement team has not been formed.		
You do not know enough about the medical home model to begin making improvements toward its implementation.	Familiarize yourself with these and other resources on what constitutes a medical home: • The National Center for Medical Home Implementation Web site, including the State Pages for a description of local medical home contacts and initiatives • The American Academy of Pediatrics National Center for Medical Home Implementation. *Building Your Medical Home*: An introduction to Pediatric Primary Care Transformation. • The Center for Medical Home Improvement Web site, including talking points for explaining the concept of medical home to others in your practice • NCQA (National Committee for Quality Assurance) Standards and Guidelines for Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH) • The AAP medical home video from Child Health Day 2009, a compilation of pediatricians and families across the country describing what a medical home means to them • **National Center for Medical Home Implementation YouTube channel** • Investigate opportunities for support in Medical Home development within your health system, State or your largest insurers.	Check with your local AAP chapter to inquire about medical home activities in your state; chapter representatives may know of colleagues from whom you can learn about team experiences. Veteran medical home practices may be willing to provide some coaching or mentoring to your efforts.

*See Appendix for definition.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
You have not formed an improvement team because you do not know what a highly functioning, cross-disciplinary (medical home) improvement team consists of or how to form one. Or, you are uncertain about the steps involved to engage parents on your team. Or, the team hesitates to involve parents because team members do not want to expose deficiencies in their practice.	Prepare for and form a medical home improvement team by doing the following: 1. Familiarize yourself with these and other resources on forming quality improvement (QI) teams: • The EQIPP Quality Improvement in Pediatric Care (QI Basics) course for tips on forming a QI team • The Team content of this EQIPP course and the resources for teamwork provided in Learning EQIPPment • The "From a Medical Home Improvement Team" section of the National Center for Medical Home Implementation *Building Your Medical Home*: An introduction to Pediatric Primary Care Transformation. • The Institute for Healthcare Improvement Web site, ihi.org, for information on assembling teams for QI 2. Review the importance of including family members on your team and the benefits for families and providers: • The Parent Partner Guide and "Do You Have a Medical Home?" article available from the Center for Medical Home Improvement Web site, http://www.medicalhomeimprovement.org. • The article, Improvement in the Family-Centered Medical Home Enhances Outcomes for Children and Youth With Special Healthcare Needs. McAllister JW, Sherreib K, Cooley WC. *J Ambul Care Manage.* 2009; 32(3): 188–196 • The Family Focus Group fact sheet from Building Your Medical Home • Resources such as Partnering With Patients and Families to Design a Patient and Family-Centered Health Care System: Recommendations and Promising Practices from the Institute Patient and Family Centered. 3. Take a first step at forming your team, practice good habits, and use the resources and tools provided in this EQIPP course to guide you as you develop and gain proficiency. 4. Consider the need for transparency and the benefits of looking at change through the lenses of the people closest to understanding the need for improvement. Review *Total Quality in Healthcare: From Theory to Practice* by Gaucher and Coffey with your team (Gaucher EJ, Coffey RJ. *Total Quality in Healthcare: From Theory to Practice*. San Francisco, CA: Jossey-Bass Publishers; 1993).	Consult AAP-affiliated pediatric advisory groups such as the Chapter Alliance for Quality Improvement (CAQI) and Quality Improvement Innovation Network (QuIIN). These groups serve as practical working labs for pediatricians to test how improvements can be implemented in everyday pediatric practice. They also provide QI strategies, tools, "webinars," and "listservs" to share comments and ideas for change. Invite guest speakers from other practices or parent groups to share their insights and to provide encouragement.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: The team for medical home quality improvement is inexperienced, ineffective, or lacks vision.		
A team has been formed, but it is inexperienced with QI.	• Have all team members review the EQIPP QI Basics course. As suggested in this course, an effective team requires leadership at the organizational level, at the clinical or subject level, and from staff working day-to-day on the front lines of care. • Move to declaring an aim and/or revisit an existing aim. Review the purpose of your team, such as to identify needed change ideas, test them to help fit into the practice, and, when refined and acceptable to your colleagues, implement them throughout the practice.	Identify/tap facilitation support from your practice organization, network, department of health and human services, or chapter or state QI initiatives.
The team has not formulated or communicated a clear vision for the practice's medical home.	• Develop a clear purpose or aim for your practice's medical home. (See the Team content of this EQIPP course for an example.) Or, develop a practice mission statement that includes the intention to provide a primary care medical home. • Identify the areas your practice feels must be addressed to perform as a Medical Home • Create a letter or brochure for patients and families that explains the practice's philosophy of being a patient- and family-centered medical home and outlines the methods to access physicians, staff, and resources within the practice. Review the example provided in the AAP's National Center for Medical Home Implementation *Building Your Medical Home:* An Introduction to Pediatric Primary Care Transformation. • Invite a practice who is further ahead on their Medical Home journey to present their work to you; attend a State AAP MEETING THAT ADDRESSES MH ISSUES.	Talk with AAP chapter leaders and other practices, and consult with CAQI, QuIIN, and listservs for ideas and resources about formulating a vision for your medical home. Contact the National Center for Medical Home Implementation to connect with medical home leaders and best practices: e-mail **mailto:medical_home@aap.org**.
Your practice lacks a QI champion, someone who will obtain the necessary support of senior management to drive improvement and spread it throughout the practice.	• Have the team discuss the kind of leadership necessary for success and that is needed to share, spread, and implement successfully tested ideas throughout the practice. Consider the leadership skills needed to ensure that organizational and clinical leadership are "in sync" and/or determine where this guidance might be obtained. • Formulate a plan to meet with leaders, gain their support, and/or invite them to join or visit the team.	Use the voices of patients, literature, and data to demonstrate the value of the medical home. Request or suggest that full medical home implementation become a part of the strategic plan of the organization. Visit the National Center for Medical Home Implementation Web site for literature and data resources.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The team is not functioning with full and active participation of all members. Or, the team leader lacks the facilitative skills to draw out all members.	Brainstorm with your team to determine why the team is not fully engaged, and suggest and implement ideas to overcome obstacles. For example, make sure the team: • Obtains senior leadership support and participation to drive improvements. • *Assures adequate time for team members to participate without ignoring other work* • Clearly defines team roles and responsibilities and articulates a time commitment. • Chooses a designated team leader to facilitate the meeting by actively seeking input from all members of the team. Rotates leadership within the team to empower all members with an equal voice. Reserves time on the agenda for an assessment of the group's team process. This discussion should attempt to draw out what is going well and what could be better. • Uses minutes to assign homework; designates individual team members to follow up with and support completion of assignments. • Reviews the elements needed for a true learning community (or organization); goes back to the aim statement to reflect on progress and/or reaffirm direction. • Checks in with each member regarding his or her experience, interest, and any changes.	Ask your team to review the team content in this EQIPP course and the team content available in the Form a medical home improvement team section of the National Center for Medical Home Implementation *Building Your Medical Home*: An Introduction to Pediatric Primary Care Transformation.
The team is unable to find time to meet because staff time is devoted to patient care or parent time requires meeting before or after office hours and flexibility.	• Engage senior leadership, and discuss the importance of medical home improvements while stressing the importance of successfully integrating parents and families into the medical home improvement team.*Investigate opportunities for Pay-for-Performance incentives or certifications associated with being a Medical Home* • Brainstorm obstacles and ideas for establishing a workable meeting time with your team. Be creative with your solutions and prepared to test several ideas to see what works. For example, you may want to: ✔ Form subgroups within the team for various tasks so work can be divided and conquered by persons with shared schedules and then brought back to group. ✔ Set up phone conferencing, and allow persons to dial into meetings from remote locations when necessary. (Try not to make this the norm, but an option.) ✔ Record meetings for later playback/review. ✔ Help the team to support parents and one another's participation, eg, by providing juice, coffee, and bagels with early morning meetings, box lunches during the lunch hour, and snacks or sandwiches in the evening. • Keep team enthusiasm high by planning and running well-organized meetings, with no wasted time, and a strong sense of accomplishment; share and note successes.	Ask senior leadership for a protected block of time to devote to medical home improvement work and for the ability to use data to show progress.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Team meeting time is not used effectively.	• Establish meeting ground rules such as those found in Seven Basic Steps for Conducting a Good Meeting. • Review the purpose of each meeting, and set a realistic time frame. • Have a mutually agreed-on agenda, and assign the roles of a facilitator, timekeeper, and scribe to help the group stay focused. Ensure that all meetings start and end on time.	Engage the help of a meeting facilitator to walk you through efficient meeting steps. If you are unfamiliar with persons in this role, consider consult other practices or the National Center for Medical Home Implementation at medical_home@aap.org. for recommendations.
There is inadequate reflection on lessons learned from previous plan, do, study, act (PDSA) cycles.	• Revisit the PDSA model with the team, and discuss the importance of each element of the PDSA process. In particular, stress the importance of the study component of the model. Discuss obstacles, and brainstorm ways to overcome them. • After a period of improvement, schedule a block of time to review data and progress; review accomplishments with an eye to future needs; celebrate!	Consider a family/community focus group or forum, and invite comments on what works well in the practice and what could be improved and how.
The team is not sharing progress made with the rest of the practice. Or, the team is not cultivating a culture for change within the practice.	• Set aside time to share effort, success, or failures throughout the practice; ask for all staff input. • Invite other staff members to share how successful team changes improved outcomes or made work easier. • As a team, brainstorm ways to make QI fun and contagious in your practice. Consider fun ways to communicate the team's efforts, eg, offer rewards to the staff member who enrolls the most children in a registry, hold a contest related to naming a project, or recognize staff members, patients, or families for adding improvement ideas to a "master" list.	Post improvement progress in a prominent place in the office. Contact the National Center for Medical Home Implementation at medical_home@aap.org to share your specific dilemma for cultivating change, and invite ideas from others who may have had a similar experience.
Gap: The team is uninformed about its functional strengths and opportunities for development.		
The team is uninformed about its functional strengths and opportunities for development.	• Take the EQIPP Medical Home Practice Survey periodically throughout the medical home improvement process to help you determine areas of strength and opportunities for team development. Then, use the opportunities you identify for reflection, problem solving, and planning team innovations.	Invite guest speakers from other practices to share their insights concerning medical home improvement teams and provide encouragement.

Appendix

Highly Functioning, Cross-disciplinary Quality Improvement Team

A highly functioning, cross-disciplinary quality improvement team:

- Practices habits of highly functioning teams (makes the commitment, gains and demonstrates leadership, uses ground rules for communication, secures facilitation skills and support, sets an agenda as a team, keeps minutes, assigns and completes homework, and follows through with plans).
- Includes, at a minimum, physician leadership with senior leader support, patient and family representation, and 1 or 2 key members of the primary care practice (such as a practice manager and a nurse who can develop the practice capacity for care coordination). Invite ad hoc members or others expressing interest.
- Articulates a clear vision for medical home improvement, and experiments with tests of change, performing multiple PDSA cycles.
- Measures the results and progress of the tests of change, and reports results to colleagues; over time, reporting to external entities such as insurers may be valuable to document your improved care. Continuously evaluates and improves the management and facilitation of practice care processes related to the medical home.
- Meets regularly for reflection, problem solving, and to plan for practice innovations (eg, 60 to 90 minutes twice a month).
- Engages and shares ideas with all staff members for their input and participation and, when ready, practice-wide implementation.
- Continually reports progress to the entire practice, creating a culture of teamwork and improvement.
- In larger practices, encourages and supports formation of multiple improvement teams targeting specific improvement goals.

Potential Barriers and Suggested Ideas for Change

Key Activity: Know and Manage your Patient Population

Rationale: The ability to identify and manage your practice's patient population by age, sex, chronic condition, or other characteristic is essential to the medical home's ability to:

- Support the core functions of primary care and the management of chronic conditions of individual patients, including coordination of care.
- Examine groups and subgroups of patients to discern patterns and trends in patient care over time.
- Establish a proactive patient reminder system for health maintenance visits, immunizations, screenings, laboratory tests, imaging studies, referrals, medication refills, and other services.
- Track laboratory tests and imaging studies ordered and their results.
- Track referrals to specialists and therapists and their reports and recommendations.
- Measure your Quality Improvement efforts and progress.

In addition, knowing and managing your patient population can help you make informed financial and operational decisions by helping to predict revenues, costs, and operating efficiencies. This knowledge will enable you to form strategic and operational plans for your medical home and to set priorities.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: A system of accessible and clinically useful information for your patient population, such as a registry, is not available in your practice.		
You do not have or know how to create/organize a patient registry.	To build and implement a patient registry: 1. Obtain leadership buy-in. Building and using a registry involves change. It is best to have someone with influence endorse and support the registry creation and use. 2. Start small, and choose one area or specific condition that your registry will address. Involve your whole staff, and come up with a plan that everyone accepts. 3. Define the Population of patients who will be in your registry. Whose care are you trying to impact? 4. Brainstorm data sources and data collection ideas with your team. 5. Review sample registry and resources to help practices create registries in the Managing Your Patient Population Section of *Building Your Medical Home*: An Introduction to Pediatric Primary Care Transformation. 6. Decide how you will store the data—on paper or electronically. The latter can provide enhanced readability, availability, and data quality. For example, a structured data entry application can prompt for completeness and provide better search and retrieval capabilities and reporting features. 7. Develop a registry that meets your practice's needs with simple or more extensive fields. If using a spreadsheet or database to track patient data, consider adding some	Consult with other practices and coalitions to see the registries they are using and adapt for your purposes. Review commercially available registry products. Conduct library/Internet research to find articles on the subject. Discuss possible registry functions for your electronic health record (EHR) with the information technology staff of your organization or with EHR vendor representative.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	conditional formatting that flags when patients need certain laboratory tests and other preventive services. Initially, build your registry to track information you will use actively to improve patient care. A ready-made diabetes registry, Using a Simple Patient Registry to Improve Your Chronic Disease Care, available on the AAFP Web site, includes conditional formatting that alerts when a service is overdue (Ortiz DD. Using a simple patient registry to improve your chronic disease care: Who needs an EHR? Software you already have can help you make sure your patients get the care they need. *Fam Pract Manage.* April 2006. http://www.aafp.org/fpm/2006/0400/p47.html. Accessed February 7, 2010). The paper-based example card file registry can be used to monitor condition prevalence, treatment and outcomes using different colors of cards for sex and stickers for condition. 8. Identify individual(s) who will maintain the registry and reliable processes for how data is entered into the registry. Educate your staff on the tools and processes they will need to provide accurate and reliable information into the registry. Decide how you want to use your registry: eg, to schedule and plan patient visits?, to contact patients/families for follow-up care?, to track recommended services?, or to report on the status of care for the patient population?. 9. Collect and enter existing patient information. Your billing system or electronic medical records are good sources for pulling retrospective information. Chart audits and patient screenings are other sources for identifying patients to include in the registry. 10. Establish procedures to keep the registry up-to-date with prospective data.	

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Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: The registry you have in place is not optimally functional.		
You are uninformed about your system or registry's functional strengths and opportunities for development.	• Take the EQIPP Medical Home Practice Survey periodically throughout the medical home improvement process to help you determine areas of strength and opportunities for system or registry development. Then, use the opportunities you identify for reflection, problem solving, and planning innovations.	Invite guest speakers from other practices to share their insights concerning registry development. Use this information for reflection, problem solving, and planning innovations.
The registry is not being kept up-to-date.	• Be sure you have a registry "champion". Registries require maintenance to identify patients who have left the population or do not belong in it. While many staff may provide information to the data base, especially if it is electronically populated from your EHR, processes and training for accurate data entry are essential. Brainstorm obstacles and solutions for keeping the registry up-to-date. Consider a scheduled "purge" date to remove patients who are no longer in the population. Create a visual or electronic reminder to enter new patients into the registry while in the process of care. If patient entry is based on coding, be sure your practice is using the proper code. If the obstacle is a staffing issue and there is not enough time to update the registry and perform other duties, a workload assessment may be in order. • Seek information technology or vendor advice about how registry fields can be populated directly from your EHR or administrative database system.	Ensure that staff members understand the value of the registry and have appropriate buy-in. Discuss and assign specific roles and responsibilities for registry update, review, and reporting.
The registry is not being used to support organized clinical care.	• Identify what population information will help you improve a selected care process—for example, do you need to know which premature babies might qualify for Synagis? • Be sure someone with influence oversees the creation of the registry and its use and that the medical home improvement team helps direct the integration of the registry into the day-to-day workflow. • Establish and use processes in evaluate and improve the effectiveness of the registry that ensures all voices in the practice are heard. Make your measures available to the practice; "89% of Dr. X's patients received their MCHAT screening". • Make sure the registry contains fields to track the appropriate protocol, best available practice, or clinical measure suggested by scientific evidence for the condition for which your registry was developed. • In a team meeting, brainstorm ways the registry can be used to support organized care for a particular population group. Develop consensus among leaders about standards for care within your practice. Set priorities, and implement procedures for arranging the	Provide opportunities for physicians, nurses, and other staff to share how they have found the registry helpful, making their jobs easier and improving patient care. Consult with other practices and coalitions to see the registries they are using and adapt for your purposes. Consult AAP-affiliated pediatric advisory groups such as the Chapter Alliance for Quality Improvement (CAQI) and Quality Improvement Innovation Network (QuIIN). These groups serve as

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	agreed-on clinical care. If using a spreadsheet to track patient data, consider adding conditional formatting that flags when patients need certain laboratory tests or other preventive services. • Discuss ways to use the registry to monitor and report on the quality of care delivered. Establish and use appropriate reporting and follow-up procedures. • Create a regular process of sharing registry data with the entire staff to highlight successes or shortcomings in clinical care. Use registry data to inform discussions among staff about improvements in care.	practical working labs for pediatricians to test how improvements can be implemented in everyday pediatric practice and also provide quality improvement strategies, tools, "webinars," and "listservs" to share comments and ideas for change.
Staff members believe the registry has limited value, eg, it does not consider the entire patient population.	• If you started small, consider expanding the registry with one chronic condition at a time based on the priorities of your practice. Note that NCQA recognition requires you to identify, monitor, and track tests, referrals, and key outcomes for children and youth with 3 conditions of concern for your practice. Remember that many chronic conditions in childhood are high in severity and low in frequency, so evidence-based guidelines of care may not be available. • Consider expanding the registry to include the entire patient population with a limited scope, eg, to track immunizations, developmental screening, or implementation of transition support services from adolescent health care to adult care.	Consult with other practices and coalitions to see the registries they are using and adapt for your purposes. Review commercially available registry products.

Potential Barriers and Suggested Ideas for Change

Key Activity: Enhance Access to Care

Rationale: For a practice to function as a patient-centered medical home, patients and their families need access to the practice as their first contact for new and ongoing health concerns. In addition, it is important to cultivate a personal and ongoing relationship between the patient and the personal pediatrician or physician-led care team to provide continuous and comprehensive care. Greater accessibility can help families avoid harmful delays and obtain needed care with greater ease, less stress, and reduced time away from work and school. It is important for the practice to communicate the manner and means through which it can be accessed so families can partner effectively in their child's care. This communication helps reduce unplanned utilization and helps promote continuity of care.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Patient/family satisfaction with your practice's access to care and quality communication is unknown.		
You do not know how well your practice meets the needs of patients and families in your practice in terms of access to care or communication.	• Take the EQIPP Medical Home Practice Survey periodically throughout the medical home improvement process to determine areas of strength and opportunities for development, particularly in the area of access and communication. Then, use the opportunities you identify for reflection, problem solving, and planning innovations. The following are some additional assessment tools to consider: o National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition Program 2011. Standard 1: Access and Continuity o AAP's website for Building Your Medical Home: An Introduction to Pediatric Primary Care Transformation site, Building Your Medical Home. • Implement a Family Advisory Group to get patient/family feedback on access and communication. See the National Center for Medical Home Implementation (NCMHI) video and webinar. Video: Building a Stronger Pediatric Medical Home: Family Advisory Groups (9 minutes). Webinar: http://www.medicalhomeinfo.org/training/cme/2014.aspx	Consult the resources provided here, and then develop your own office visit survey to assess how your practice promotes patient access and quality communication. Choose 1 week each month to randomly ask 30 patients and families to complete your survey.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Patients' primary care pediatrician or physician-led care team is not the first contact for new or ongoing health concerns.*		
Patients see multiple physicians (within or outside of the practice) because they do not have an ongoing relationship with a primary care pediatrician. As such, they may not be receiving optimal continuous and comprehensive care. Staff cannot identify the pediatrician who knows the patient the best when scheduling the patient for new or ongoing health concerns.	• Identify the name of the primary care pediatrician or physician-led care team in the patient's medical record. Use this "information match" as the first step toward ensuring that each patient in the practice can develop an ongoing relationship with a personal physician able to provide first contact and continuous and comprehensive care. • Once identified in patient's medical record, schedule the patients to receive their health supervision visits from their primary care pediatrician or physician-led care team to help ensure continuous, comprehensive care.	With your staff, review the consensus statement on medical home principles developed and jointly endorsed by the American College of Physicians, American Academy of Family Practice, American Osteopathic Association, and AAP. This statement describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.
Staff members are unclear about their role for responding to patient needs or unaware of the function of their role.	• Discuss the roles, responsibilities, and appropriate workflow for responding to patient and family needs in a physician and all-team staff meeting. Brainstorm obstacles to responding quickly and thoroughly and ways to overcome them. • Develop and implement a medical home assessment questionnaire that specifically addresses the role of staff in improving access to care such as the following SC Greenwood medical home self assessments. Tabulate assessment results, and discuss them in a staff meeting. With your team, brainstorm obstacles and strategies to overcome them. o Health Care Office Staff Version o Health Care Professional Version • Implement team huddles every morning to organize the day, patient visits, and team member roles. The NCMHI recently produced a how-to video about team huddles: o Creating Efficiency: Team Huddles (8:30 minutes)	Review literature about the successful outcomes of open-access scheduling with staff. The AAP Practice Management Online provides a variety of resources on improving your scheduling system, including the following: • Open Access Scheduling: Decrease waiting times and delays in the pediatric office • Making the Best Use of Your Office Hours

* For information on closing this gap and the associated measures provided in this EQIPP course, see *Ideas for Closing Gaps and Measures: Enhance Access to Care*.

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Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: The practice has limited access points for communication or patients and families are unaware of them.		
Patients and families are unaware of ways to access the practice when they need care, information, or referrals.	• Develop multiple access points for communication, including in-person visits, phone, e-mail, and the Internet. Formulate a plan to communicate your practice's accessibility and response expectations to patients and families to help reduce unplanned utilization and promote continuity of care. • Create a brochure and/or Web site to explain a medical home, expectations, responsibilities, and the different ways families can communicate with members of the practice. Also spell out options for emergencies and urgent situations. The following are some resources for this purpose: o The AAP/MCHB Building Your Medical Home toolkit sample brochure o The National Partnership for Women and Families patient brochure explaining the medical home, A Medical Home Is about You.	Post brochures in the waiting room, and make copies available at the patient check-in/check-out desk. Create a refrigerator magnet with office hours and access information and distribute to patients. Place "Did you know…" posters in examination rooms that provide information about medical home and practice access. Review key messages of your practice's accessibility during the appointment time.
Gap: Patients are turning to alternative health services because they cannot get a needed or convenient appointment.		
Patients and families are using the services of an urgent care facility or emergency department for acute illnesses or when they cannot get an appointment soon enough to meet their needs.	• Provide phone access to your practice with physician support 24 hours per day, 7 days per week. • Calculate appointment supply and demand by using an appointment tally sheet. If the appointment demand is greater than appointment supply, brainstorm with your team to implement strategies to work down the backlog. • Educate patients and families about the different ways they can communicate with your practice after hours, and discuss options for emergencies and urgent situations. Create a brochure or Web site for your practice that spells out these options. The AAP/MCHB *Building Your Medical Home* toolkit offers *a* sample brochure for this purpose.	Review key messages about your practice's accessibility during the appointment time.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Patients are unable to see their pediatrician of choice and must accept an appointment with another member of the practice to meet their care needs. Or, there is dissatisfaction with care continuity.	• Calculate appointment demand and supply for physicians in your practice. If demand consistently exceeds supply, find ways to adjust your appointment schedule. For example: o Are there enough examination rooms available to maximize physicians' time? o Are appointments conducted as efficiently as possible? For example, if some physicians have 30-minute slots for well-child visits and others see patients efficiently in 20 minutes, determine what is different between the ways each conducts the visit. o Can certain tasks be delegated, eg, having the nurse practitioner oversee all immunizations? o Can you be creative with standardizing the length of appointments for sick and well-child visits, eg, a 15- or 20-minute time slot with short appointments given 1 slot and longer appointments given 2 or more slots? o Do you have enough staff to prepare the room and patient for the physician's visit without any down time? o Can you define limits for the number of patients under the care of a specific pediatrician for your practice? (This is also referred to as limiting "panel size.") Use information from your practice management system to measure the patient panel for all pediatricians in the practice. As a team, brainstorm ways to level the patient panel among them while considering the needs and preferences of patients. Examples: Prevent physicians who exceed the panel size from accepting new patients, or assign a part-time physician to team up with an "overused" one.	Hire another physician or nurse practitioner. Or, do not accept new patients for a period.
Patients and families must take time away from work and school to meet an appointment.	Brainstorm ways to expand office hours and implement strategies to accommodate patients' and families' work and school schedules.	Hire another physician, full- or part-time, to cover the extended hours. Consider a part-time nurse practitioner or physician assistant with telephone backup by a physician to provide a 2-hour evening clinic and/or Saturday morning clinic.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Patients are experiencing long office wait times.	Calculate office wait time and with your team, brainstorm obstacles for keeping appointments on schedule, and implement strategies to reduce office wait time. Consider the following ideas: • Make sure the first morning and afternoon appointments start on time with all team members poised and ready to go. • Huddle with your staff at the start of the day to go through the schedule and ensure clear roles and responsibilities. • Insert a morning and afternoon "catch-up" slot into the schedule for unforeseen delays. • Set and communicate appointment standards to staff, patients, and families, enabling all parties involved to contribute to achieving these goals. For example, communicate that patients who arrive on time will be seen on time. Patients who arrive late will have the option to reschedule or be fit into that day's schedule on an "as available" basis. In the same way, define your practice's policy for "no shows" and chronic no shows. Courtesy should extend both ways. Make it a habit to call patients when your practice is running late and give them the option of coming in today at an adjusted time or rescheduling. Also make sure the process is easy for patients to phone in to cancel an appointment or to report a delay. • Cross-train office staff. Ensure that clinical staff members know how to make appointments and check-in patients. Ensure that clerical staff members know how to escort a patient to a room and obtain basic information, including vital signs. • Colocate staff to enhance work and communication flow. Physicians, nursing staff, and clerical staff should be in proximity to each other to enhance interactions and communication. • Complete patient registration by phone. • Dictate or type your notes during the visit rather than stacking all charts to be completed at the end of the day. • Consider nurse triage services to empower families to make informed choices about the need for an in-person visit. A simple phone call can provide immediate symptom assessment, health information, and advice from a registered nurse and	Consult AAP-affiliated pediatric advisory groups such as the Chapter Alliance for Quality Improvement (CAQI) and Quality Improvement Innovation Network (QuIIN). These groups serve as practical working labs for pediatricians to test how improvements can be implemented in everyday pediatric practice. They also provide quality improvement strategies, tools, "webinars," and "listservs" to share comments and ideas for change.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	help families choose the most appropriate time and place for care. • Critically look at your electronic health record what tasks can be done by non-physician staff (ie, med reconciliation, med refills, recording chief complain scoring of screening instruments (PEDS, MCHAT, Vanderbuilts, ACT etc.). Work with your venders to help you with this. • Are personnel working to the top of their qualifications can the MA or Nurse do asthma education or PFT's. • Do you have protocols and standing orders for flu shots? • Can you protocol a work up for common conditions like a sore throat ie, rapid strep obtained prior to the physician arriving in the room or dysuria obtain a sterile urine and have it dipped prior to the physician arrival, or wheezing can you switch to MDI's vs a nebulizer that can tie up an office for longer periods of time?	
Gap: Families are unable to pay for services.		
The patient does not have insurance to help pay for needed services.	Refer families who need to apply for assistance from Medicaid, Children's Health Insurance Program, and Title V Block Grant to States to the list of current organizations funded as Family-to-Family Health Information Centers (F2F HICs) on the Family Voices Web site. The list includes contact and funding information. • The AAP provides resources for families regarding getting insurance. See What Your Family Needs to Know.	Consider offering a discount for cash payments made on the day of service.

Potential Barriers and Suggested Ideas for Change

Key Activity: Provide Family-centered Care

Rationale: There is increasing evidence that the care experience, which encompasses how health care practitioners communicate with patients and families and invite their active participation in clinical care, affects outcomes. The better the experience—relationship and communication with the provider—the better the outcome.[1]

The family is the principal caregiver and the main support network for children. Health care practitioners who listen to and honor patient and family knowledge, perspectives, and choices communicate dignity and respect. They take into account the patient's and family's values, beliefs, and cultural background. They share complete, unbiased, transparent information with the patient and family on an ongoing basis to help families make informed decisions, to be valued as partners in their child's care, and to promote a continuous relationship.

The "family-centered medical home" is a model of care provided by a physician practice that emphasizes readily accessible, comprehensive, coordinated care and active involvement of the patient and family in health care decisions. It embraces 9 key principles of family-centered care to guide care delivery and to regularly identify ways to improve the quality of care.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Changes needed to become a family-centered practice are unclear.		
Changes needed to become a family-centered medical home, ie, pediatricians and teams changing how they deliver care and new systems and processes put in place, seems an overwhelming task.	• Identify internal and external resources that can assist you with practice transformation. For example, if your practice is affiliated with a hospital, there may be quality improvement (QI) resources that you can readily tap into. • Also check the AAP Chapter Alliance for Quality Improvement (CAQI) in your state or the Quality Improvement Innovation Network (QuIIN). These groups provide resources and networking opportunities to advance quality improvement efforts within member practices.	Invite guest speakers from other practices, parent groups, or members of your local AAP Chapter to share insights about the medical home QI process and provide encouragement.

[1] MacKean, G. L., Thurston, W. E., Scott, C. M. (2005). Bridging the divide between families and health professionals' perspectives on family-centered care. *Health Expectations, 8*, 74-85.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
You do not know how well your practice is communicating with patients and families and inviting families to actively participate in their child's clinical care.	• Develop and implement a patient and family satisfaction survey yourself, or use an existing survey such the Center for Medical Home Improvement (CMHI) Family/Caregiver Survey to measure and assess the "medical homeness" of a primary care practice from the family perspective. These tools can help you determine a starting point for improvement. • Take the EQIPP Medical Home Practice Survey periodically during your medical home improvement process to help you and your staff determine areas of strength and opportunities for development. Then, use the opportunities you identify from your answers to questions about family-centered care for reflection, problem solving, and planning innovations.	Talk to members of primary care QI teams in your state to find out what has worked for their practices. Invite guest speakers/parent partners from other practices to share their insights concerning family-centered care development. Use this information for reflection, problem solving, and planning innovations. See the Team content in this EQIPP course for help forming a QI team.
Gap: Individual patient and family concerns are unknown or are not addressed at the visit.**		
You are not inviting patients and families to actively participate in their child's clinical care. Or, you are more in the habit of addressing concerns when they are expressed versus specifically inviting conversation on this topic. Or, you do not have a process in place to elicit individual concerns.	• Establish a process to elicit patient and family concerns at every visit, for example, put prompts on the intake form or hang a poster in the examination room that urges patients to express their concerns. • Develop a post visit process that queries patients and families whether their concerns were addressed at this visit or if plans were made to address them. Or, check for understanding and satisfaction about the plan made to address them.	Establish a "check and balance" procedure – perhaps conducted by another staff person – that asks patients if all of their questions were answered before they leave the office. Consider a group model of care (as advocated in Osborn LM, Woolley FR. Use of groups in well child care. *Pediatrics.* 1981;67(5):701–706). This model gives parents time to ask questions and to learn from those other parents ask.

* For information on closing this gap and the associated measures provided in this EQIPP course, see *Ideas for Closing Gaps and Measures: Provide Family-centered Care*.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Patients and families are not engaged as true, active partners in improving the quality of care they receive.		
Families do not feel valued as true partners in their child's care, or they do not feel their voices are being heard by the practice.	• Conduct informal or formal discussions or interviews with families to brainstorm ideas for opening the lines of communication. • Establish focus groups for collaboration based on specific needs within the practice. • Clearly post office procedures for handling patients' and families' recommendations, complaints, and questions. • Add a suggestion box in the office waiting room. • Involve families in QI activities in the practice. Make every effort to maintain and sustain their involvement.	In a staff meeting, review the key principles of family-centered care to guide care delivery and to regularly identify ways to improve the quality of care. Include family members as part of your QI team. Listen to what they have to say, and ask them questions about how they would like to use their medical home. Over time, consider establishing an advisory board that includes family membership.
Gap: The practice does not actively invite families as true, active partners in their child's care and/or in QI activities.		
Individual patient and family concerns are unknown or not addressed.	• Establish a process to elicit patient and family concerns at every visit, for example, put prompts on the intake form or hang a poster in the examination room that urges patients to express their concerns. • Develop a post-visit process that queries patients and families whether their concerns were addressed at this visit or if plans were made to address them. Or, check for understanding and satisfaction about the plan made to address them.	Establish a "check and balance" procedure – perhaps conducted by another staff person – that asks patients if all their questions were answered before they leave the office.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: The practice has limited access points for communication or patients and families are unaware of them.		
Patients and families are unaware of ways to access the practice when they need care, information, or referrals.	• Provide multiple access points for communication, including in-person visits, phone, e-mail, and Internet. Formulate a plan to communicate your practice's accessibility and response expectations to patients and families to help reduce unplanned utilization and promote continuity of care. • Create a practice brochure and/or Web site to explain what a medical home is, any expectations and responsibilities, and the different ways families can communicate with physicians and office staff in the practice. Also spell out options for emergencies and urgent situations. The AAP/Maternal and Child Health Bureau *Building Your Medical Home* toolkit offers *a* sample brochure for this purpose.	Post brochures in the waiting room, and make copies available at the patient check-in/check-out desk. Review key messages of your practice's accessibility during the appointment time. See the Enhance Access to Care content in this EQIPP course for more information and improvement ideas.
Gap: Special accommodations are not offered or arranged for patients and families who need them.		
There is no system within the practice to identify special accommodation needs when an appointment is made.	• Develop and implement a phone script to identify special accommodation needs and ways to make the appointment go smoothly for the family, for example, the need for extended appointment times, the need to be placed immediately in the exam room vs the waiting room, or help getting into and out of the physical office. • Use a previsit contact form to collect information, and identify ways to help the practice prepare for the patient's visit. The AAP/Maternal and Child Health Bureau *Building Your Medical Home* toolkit offers a previsit contact form that can be adapted for this purpose.	Develop and use a registry that identifies and alerts when patients with special accommodation needs phone for an appointment. Update your computer system to flag patients with special needs, including primary and secondary diagnoses and any special accommodations. Train reception staff to use the computer system or pull patient charts when scheduling appointments so they know if a patient has special needs. Note special accommodations needed where they can be easily seen and honored.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: The office is not physically accessible for all patients.		
Your practice may have some accessibility limitations that need to be identified and addressed.	• Navigate through your office in a wheelchair or using a walker or crutches to learn which rooms are accessible for patients with special needs. Use these rooms for patients with special needs. If problem areas are found, such as bottlenecks, confusing aspects of care, or physical inaccessibility, take measures to resolve the problems.(Wheel chair scales, mechanical tables that adjust height for easy transfer, exam rooms large enough to accommodate equipment and wheel chairs.)	Navigate your office with patients and families with and without special needs. Find out from the patient's perspective what works and what does not. Then, take appropriate measures.
Gap: The practice's cultural awareness, knowledge and skills needs improvement.		
Your practice is unaware of its cultural and linguistic competencies or is seeking ways to improve them.	• Take a systematic assessment of your organization's cultural and linguistic attitudes, practices, structures, and policies using the Cultural Competence Health Practitioner Assessment. Use the results of the assessment to plan for and incorporate cultural and linguistic changes in your practice.	See the CCHPA Web site for more information and resources.
Gap: The practice does not have a ready source of community resources for families that need them.		
Families lack information, skills, and resources necessary to improve health outcomes and promote family well-being.	• Become aware of community-based resources in your area, and provide families with information about how to access these services and supports. • Develop a protocol in your practice that designates a representative of your practice, eg, a care coordinator, to review key educational messages with patients and families at every visit. • Provide information on parent support groups for specific medical conditions or for parents of children with special health care needs. • Foster parent-to-parent connections by way of support groups, after-hours informational meetings, or a referral to a local Family-to-Family Health Information Center.	Locate family educational materials to share with families, such as those mentioned in this EQIPP course. Use the Maternal and Child Health Community Services locator to provide families with state Title V and Title XIX information and resources.

Appendix

Family

Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. As family members, we nurture, protect, and influence each other. Families are dynamic and are cultures unto themselves, with different values and unique ways of realizing dreams. Together, our families become the source of our rich cultural heritage and spiritual diversity. Each family has strengths and qualities that flow from individual members and from the family as a unit. Our families create neighborhoods, communities, states, and nations.

— Developed and adopted by The Young Children's Continuum of the New Mexico State Legislature

June 20, 1990

Principles of Family-centered Care

A family-centered medical home:

1. Develops an interdisciplinary team to guide care in a continuous, accessible, comprehensive, and coordinated manner;
2. Takes responsibility for coordinating its patients' health care across care settings and services over time, in consultation and collaboration with the patient and family;
3. Provides patients with ready access to care;
4. "Knows" its patients and provides care that is whole-person oriented and consistent with patients' unique needs and preferences;
5. Partners with patients to make treatment decisions;
6. Encourages open communication between patients and the care team;
7. Supports patients and their caregivers in managing the patient's health;
8. Fosters an environment of trust and respect; and
9. Provides care that is safe, timely, effective, efficient, equitable, patient-centered, and family-focused.

Source: Adapted from the National Partnership for Women and Families. Principles for Patient-and Family-centered Care: The Medical Home from the Consumer Perspective. http://www.nationalpartnership.org/site/DocServer/Advocate_Toolkit-Consumer_Principles_3-30-09.pdf?docID=4821. Accessed February 17, 2010.

Potential Barriers and Suggested Ideas for Change

Key Activity: Provide and Document Planned, Proactive, Comprehensive Care

Rationale: Patients and their families benefit from having continuous, longitudinal, and comprehensive care that considers the "whole" person and identifies, manages, follows up, and documents the patient's preventive, acute, and chronic health care needs while also addressing the patient's educational, developmental and behavioral/psychological needs. Evidence shows that patients who receive most of their care from their medical home benefit from more accurate and earlier diagnosis, fewer emergency room visits, fewer hospitalizations, lower costs, fewer unmet needs, and increased satisfaction (Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. Pediatrics. 2004;113(5 suppl):1493-1498).

Additional Resources:

- Reid, RJ. Spreading a medical home redesign: effects on emergency department use and hospital admissions. Annuls of Family Medicine. May/June 2013 Supplement 1.
- Driscoll, D L. Process and outcomes of patient-centered medical care with Alaska native people at Southcentral Foundation. Annuls of Family Medicine. May/June 2013 Supplement 1.
- Home, C J. A review of the evidence for the medical home for children with special health care needs. Pediatrics 2008.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Patients' primary care pediatrician or physician-led care team is not the first contact for new or ongoing health concerns.		
Patients see multiple physicians (within or outside of the practice) because they do not have an ongoing relationship with a primary care pediatrician. As such, they may not be receiving optimal continuous and comprehensive care. Staff cannot identify the pediatrician who knows the patient the best when scheduling the patient for new or ongoing health concerns.	• Identify the name of the primary care pediatrician or physician-led care team in the patient's medical record. Use this "information match" as the first step toward ensuring that each patient in the practice can develop an ongoing relationship with a personal physician able to provide first contact and continuous and comprehensive care.	With your staff, identify the root cause of why patients are seeing multiple physicians (eg, lack of communication between providers) and then engage in a small "test of change" to fix the problem. Review the consensus statement on medical home principles developed and jointly endorsed by the American College of Physicians, American Academy of Family Physicians, American Osteopathic Association, and American Academy of Pediatrics (AAP). This statement describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Patient visits are not optimally efficient and effective.		
You do not have procedures to maximize the efficiency and effectiveness of patient visits.	• Start your day with a team "huddle," eg, to organize the day's work and staffing needs, to gather laboratory and test results or emergency department records, and to arrange special accommodations. Map out the processes and personnel to determine if there are gaps or bottlenecks. Fostering "team thinking" in this way can help your practice organize and address issues and schedules proactively on a daily basis. Consider "pre-rounding" on charts to make visits more efficient and comprehensive. • Use a previsit contact form such as the one provided in the AAP/MCHB *Building Your Medical Home* toolkit to help track tests, referrals, and changes since the last visit, estimate the amount of time needed for the visit, and identify patient and family concerns. • Write a script for the scheduler that includes asking if additional time (or less) is needed for the visit depending on the parent/family schedule, whether the child or youth has any special needs (ie, interpreter, transportation) that need to be taken into consideration when visiting the office and if the parent/family requests to speak to the pediatrician privately without the child in the room. • Establish office-wide processes to: o Ensure that adequate time is scheduled for the visit o Assemble all consultation reports, laboratory results, and emergency department records since the prior visit o Review the patient's chart before the patient/physician interaction o Identify and address patient and family concerns prior to and during visits. • Maximize each team member's expertise and scope of education/license: o Evaluate tasks to determine who is doing each o Assign tasks to appropriate personnel (eg, nonprovider tasks to nonproviders) o Determine if nonappointment tasks can be batched for maximum efficiency o Have standing orders or protocols, and ensure all understand them (eg, complete a strep screen on all children with a sore throat and fever but without signs of a cold or cough)	Review the TransforMED article, Huddles: Increased Efficiency in Mere Minutes a Day with your team for practical advice to improve efficiencies and put these ideas into practice. Watch the *Fostering Partnership and Teamwork in the Pediatric Medical Home: A "How To" Video Series* video on "Creating Efficiency: Team Huddles." This video describes the strategy, benefits and guidance on implementing teams huddles in the practice setting. Ask parents for recommendations to make the visits go better and share "learnings" with all staff. This can be accomplished via face-to-face inquiries, a survey, suggestion box, or through a parent advisory group. (Click to view a fact sheet on creating a Family Advisory Group in the practice.) Also see the Provide Family-centered Care content in this EQIPP course for more ways to engage families as true partners in their children's care. For information of the use of interpreters in the pediatric practice setting, see the AAP Practice Management Online resource, Balancing Advocacy for Your Patients with Advocacy for Your Practice: Effective Use of Interpreters.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Provide written tips for families to help make the visit go better. Communicate these tips in a variety of ways, including your practice brochure, web site, bulletin board, previsit contact, or patient visit. • If language or cultural barriers exist, consider interpretation services. Local hospitals often have certified medical interpreters. • Enhance your practice's cultural awareness, knowledge, and skills. See the CCHPA Web site for information, resources, and the Cultural Competence Health Practitioner Assessment. • Another resource is the Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services.	
Gap: Documentation standards are not established or adhered to for all care encounters.		
You do not have established standards and processes to document care for all types of care encounters.	• Develop and implement standard paper-based or electronic forms, checklists, or templates to document all encounters: o For **preventive** care encounters, incorporate prompts based on Bright Futures guidelines, including age-appropriate developmental screenings and risk assessments. o For **acute** illness encounters, determine which are prevalent in your practice and incorporate prompts based on evidence-based or consensus guidelines where possible (eg, otitis media or gastroenteritis). o For **chronic condition management** encounters, incorporate condition-specific additions and prompts based on evidence-based or consensus guidelines and linkages to a comprehensive care plan. o For the patient's eventual **transition from adolescence to adulthood**, the AAP recommends that a written health care transition plan is developed together with the youth and family and includes what services need to be provided, by whom, when, and how they will be financed. • For all encounters, implement checks and balances to ensure appropriate follow-up and documentation is complete. Also communicate the results of screenings, assessments, tests, and other assessments and their implications to the patient and family. Make results available via a patient portal, if possible. • Implement processes to ensure every patient encounter is documented, including office visits, phone and e-mail communications, home visits, and hospital visits.	Consult with other practices and coalitions to see the documentation they are using and adapt for your purposes. Also consult with the state chapter of the AAP. Consult with your organization's information technology team or your EHR vendor or Regional Extension Center regarding incorporation of missing elements in the electronic health record. Check the AAP/MCHB *Building Your Medical Home*: An Introduction to Pediatric Primary Care Transformation. Review the Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: An up-to-date *portable* medical summary has not been created/updated/reviewed for all patients in the practice.*		
You do not have a medical summary model to use. You do not routinely maintain or review the summary with the patient and family.	• For **healthy** patients, consider the key elements to include in the patient's portable medical summary as presented in the Document Care content, or review the sample pediatric care plan from the AAP/MCHB *Building Your Medical Home* toolkit and adapt for your purposes. • For patients with **chronic** conditions, consider the elements to include in the expanded portable medical summary as presented in the content or review the sample pediatric emergency plan for children with special needs from the AAP/MCHB *Building Your Medical Home* toolkit and adapt for your purposes. • Implement processes to develop, maintain, and review the plan for every patient in your practice. Provide a copy of the plan to the patient and family (or produce a copy on request). • Utilize an EHR which provides access to the portable medical summary to families.	Consult with other practices and coalitions to see the medical summaries they are using and adapt for your purposes. Consult with your organization's information technology team or your electronic health record (EHR) vendor regarding how to populate the fields of an electronic medical summary based on existing data in the EHR. Consider starting with a selected population of patients with chronic conditions by specific condition or by complexity score to begin testing the use of an expanded medical summary, emergency care plan, and active, explicit plan of care. Consider establishing criteria for the types of patients (eg, which chronic conditions, what types of complications) needing an emergency care plan. Ask appropriate specialists if they have emergency plan templates for the kind of conditions they comanage with you (eg, sickle cell disease emergency protocol). Invite a group of veteran parents of children with chronic conditions (or a group of youth) to discuss their ideas about the comprehensive care plan that would best meet their needs and how it should be used, shared, and updated.

* For information on closing this gap and the associated measures provided in this EQIPP course, see *Ideas for Closing Gaps and Measures: Provide and Document Planned, Proactive, Comprehensive Care*.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
You cannot easily identify which patients may benefit from an expanded portable medical summary.	• Develop a registry or paper-based method to identify children and youth with chronic conditions in your practice. See the Managing Your Patient Population section of t *Building Your Medical Home* for sample registry and resources. • Consider stratifying the registry by complexity to determine which are the low-risk and high risk population of CYSHCN.	See the Know and Manage Your Patient Population content and improvement ideas in this EQIPP course. Consider starting with a limited or selected population of patients with chronic conditions by specific condition to begin testing the use of an expanded medical summary, emergency care plan, and active, explicit plan of care. Consider establishing criteria for the types of patients (eg, which chronic conditions, what types of complications) needing an emergency care plan.
Gap: An up-to-date *comprehensive* care plan has not been created/updated/reviewed for all CYSHCNS at every encounter.*		
You do not have a comprehensive care plan model to use for patients with chronic conditions.	• For patients with **chronic conditions beyond a specified level of complexity**, consider the elements to include in the patient's comprehensive care plan. Review the Comprehensive Care Planning packet from the Medical Home Learning Collaborative for sample forms for recording present medical information, emergency plans, and working (action) care plans and adapt them for your purposes. • Then, develop, with input from the patient and family, a comprehensive care plan for patients with chronic conditions beyond a specified level of complexity. Maintain and review the plan with the patient and family at every visit. • The AAP/MCHB *Building Your Medical Home* toolkit provides examples of a pediatric care plan, an action plan, and an emergency plan for children with special needs, which can be used or adapted for your purposes. • Provide a current copy of the plan to the patient and family.	Consult with other practices and coalitions to see the care plans they are using and adapt for your purposes. Hold a focus group of a few veteran parents of children with chronic conditions regarding their ideas of what sort of comprehensive care plan would best meet their needs and how it should be used, shared, and updated.

* For information on closing this gap and the associated measures provided in this EQIPP course, see *Ideas for Closing Gaps and Measures: Provide and Document Planned, Proactive, Comprehensive Care*.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
You cannot easily identify the children and youth in your practice with special health care needs to ensure that each has a comprehensive care plan.	• Develop a registry or paper-based method to identify children and youth with specific health care needs or conditions in your practice.	See the Know and Manage Your Patient Population content and improvement ideas in this EQIPP course.
A plan is provided or updated at every visit, but it is not always reviewed.	• Develop a protocol that designates a representative of your practice—a care coordinator, for example—to review the care plan with the patient and/or family caregiver at every visit. Reinforce key educational messages, and ensure that the plan is understood.	Allot more time for visits for patients with special health care needs. Provide simple, brief, written materials that reinforce the skills taught. These materials can help streamline key messages and instill confidence that the skills can be duplicated at home.
A plan is developed and provided, but without input from the patient and family	• Identify reasons why the patient and family were not part of the decision-making process (eg, time constraints, cultural or language barriers) and brainstorm ways to overcome this. • Ensure staff members recognize the value of promoting shared decision making and patient/family self-management.	Involve the designated care coordinator with plan development.
The patient and/or family follows the care plan at home, but it is not adhered to during school hours. Or, the plan has not been shared with others providing care to the child or youth with special health care needs	• Encourage parents to provide copies of the care plan to all caregivers, including relevant personnel at the child's school.	Obtain parental permission, and send a copy of the care plan to the school nurse or designee. Include office contact numbers so the school can call the office for clarification, if necessary. For patients with complex conditions, consider holding a "wrap-around" meeting of the family and key stakeholders (some can join by phone) to walk through the care plan, identify responsibilities, and solicit suggestions for improvement.

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Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The plan is presented to the patient and family, but it is not fully understood owing to language or cultural barriers.	• As a general practice, ask all patients and their family to repeat the plan (teach-back method) to check for areas of misunderstanding. • Where there are language or cultural barriers: o Engage an interpreter to explain the plan. o Use materials that explain important concepts in pictures. o Translate the plan into the family's native language. • Consider working with community health workers, promotoras, patient navigators to bridge cultural gaps.	Review the article in Pediatrics, Pediatricians and Health Literacy: Descriptive Results From a National Survey. Consult linkages to health literacy resources regarding the development of materials understandable at a fifth or eighth grade level of education. Establish personal contacts in the cultural community to help you communicate effectively and work collaboratively.
Gap: All follow-up activities are not scheduled, documented, or tracked or their results communicated to patients and families.		
You do not have clear processes for follow-up activities or documentation in the practice. Or, you do not have clearly defined roles and responsibilities for follow-up activities.	Develop protocols in your medical home that include checks and balances to track and follow-up on the following activities. Document results so they become part of the patient's medical record, and communicate the results and their implications to the patient and family. • Track laboratory tests, imaging, and consultations. Communicate results and their implications to patients and families. • Update/monitor the medical summary or care plan. • Provide care coordination services (see the "Coordinate Care" content in this EQIPP course). • Plan outreach/communication with schools and other community partners. • Provide other needed education, advocacy, and linkages to community supports and resources. • Recommend/schedule needed follow-up from time of visit.	Consider the role and functions of care coordination for your medical home as it relates to tracking, follow-up, and documentation. Then, establish roles and delegate functions. Review the article in Pediatrics, Practice-Based Care Coordination: A Medical Home Essential with staff for ideas and principles to adapt for your practice.
Gap: Lack of insurance.		
The family does not have health care insurance.	Provide information to families to assist with insurance enrollment.	Provide staff support to ensure coverage does not lapse.

Potential Barriers and Suggested Ideas for Change

Key Activity: Coordinate Care Across all Settings

Rationale: An effective medical home develops processes for coordinating and comanaging care to ensure timely and optimal communication and information exchange. It communicates with nonmedical providers such as schools and community agencies as needed to share the same goals of care and ensure timely and appropriate services. It implements methods that track the results and follow-through on all laboratory tests, x-rays, consultations, and referrals within the health care system and with other community agencies. It communicates these results and implications to patients and families.

Care coordination is crucial to the provision of planned, proactive care and requires an active partnership among the medical home team, patients and families, and specialists. It is important to work together to clarify and make explicit comanagement expectations for the patient and family, the primary care medical home, and specialists. Comanagement responsibilities may shift between primary and specialty care depending on the complexity, current status, and needs of the patient.

Good coordination and well-documented communication among all stakeholders are essential for all care, but are even more important for chronic condition care. Serious and unsafe gaps in medical care can occur when individual providers act in an uncoordinated manner. To treat the whole patient, the preventive care needs and disease- and condition-specific needs must be met. Optimally delivered comanaged care also addresses local issues such as coordination with schools and linkage to community-based organizations.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: There is no vision for care coordination in the practice.		
You do not know how to define or shape care coordination for your practice.	• Review the Coordinate Care content of this EQIPP, including the discussion on making a case for care coordination. • As a group identify what gaps exist in the practice and reflect on them. • Identify promising models, tools, and best practices for care coordination based in medical homes. • Draft a brief office policy for care coordination, and review with staff and with several patients/parents. • Create a business plan for care coordination, including support for the role of a care coordinator (if your practice is large enough for such a role to be feasible). • Take the EQIPP Medical Home Practice Survey. The questions related to care coordination can help you determine areas of strength and opportunities for development in this area. Then, use the opportunities	• Contact your state's Title V children with special health care needs program for advice and guidance regarding care coordination. • Visit or call a colleague with a practice in which care coordination is well defined. • Review the Commonwealth Fund report on care coordination. • Review the Coordinated Care Section of the American Academy of Pediatrics (AAP)/Maternal and Child Health Bureau (MCHB) *Building Your Medical Home*, which contains many care coordination tools and resources.

Medical Home for Pediatric Primary Care

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	you identify for reflection, problem solving, and planning innovations. • Consider how you will work with payers to finance care coordination through fee-for-service enhancements, per-member per-month administrative payments, or the use of care plan oversight billing codes.	• Work with team members and parent advisors on strategies for care coordination. • Review Sustaining Your Medical Home from the AAP/MCHB *Building Your Medical Home* toolkit for information on working toward enhanced payments for care coordination services. • Approach the state chapter of the AAP to discuss advocacy opportunities with regards to payers and financing.
You have not identified the target population for which you want to develop—and improve—your practice's care coordination processes.	• Brainstorm with your team to determine the target patient population(s) in your practice that would benefit from linkages to needed services and resources. For example, will it be every patient in the practice or a particular subpopulation such as children with asthma? Or will care coordination services be based on complexity of need above a certain level? How will psychosocial, economic, and cultural factors be taken into consideration? How does the practice define "high risk?" • Prioritize the list, and determine the care coordination services your practice will initially provide. Develop a timetable for your prioritized list that fits your practice's capacity. • Identify individual patients who need these care coordination services. See the coordinated care section of the AAP/MCHB *Building Your Medical Home* toolkit which provides tools to identify children and youth with particular health needs and to assess care coordination needs for families and youth: o Child/Adolescent Health Assessment form to help screen for special health care needs o Family-centered Care Coordination form o Youth Care Coordination, a transition checklist	• Initiate a simple registry listing children with special health care needs prospectively as they come in for visits, and assign a simple complexity score. Target the most complex as the initial care coordination case load. • Consider coordinating and tracking the referral and follow-up process for a specific group of children, such as children with positive screening results for developmental delay or autism at the 18-month checkup. • Review the content in Know and Manage Your Patient Population in this EQIPP course for information on building a registry. • Identify which patients frequent the emergency department or are hospitalized as an initial target group.

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Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The functions of care coordination are complex, time-consuming, and frustrating for you or members of your practice.	• Consider the benefits of having a care coordinator in your medical home and the key competencies required by these professionals. As needed, develop a business plan for a care coordinator for your medical home. (If a full-time care coordinator is not feasible, consider developing these services on a part-time basis with a member of your existing staff.) • Decide how to involve a care coordinator in your practice to help build relationships among all parties, coordinate information and follow-up, and identify community linkages and resources. • Consider writing a job description such as the Care Coordinator Position Description Worksheet available from the Center for Medical Home Improvement care coordination workbook.	• If your practice is not ready for a formally designated care coordinator, identify someone in your practice to take the lead on your office's care coordination activities. • Review a list of care coordination functions (eg, the Commonwealth Fund report) and divide the list between functions that your office currently performs (indicate by whom) and functions that are not performed; prioritize the second group and work on adding functions one or two at a time (including who will perform each function). • Review care coordination functions that you already perform and who performs them for efficiency, appropriateness, and reliability and consider how to improve on the status quo.
Gap: There are no processes in place for comanaging care for patients with particular health needs.		
You do not know how to define or shape comanaged care for patients in your practice. You do not have the tools or resources needed to comanage care for all patients in your practice with special health needs.	Develop processes for comanaging care among the patient/family, pediatric medical home, and specialists by doing the following: • Identify individual child and family needs, strengths, and concerns, and aim simultaneously at meeting family needs, building family capacity, and improving systems of care. See the coordinated care section oof the Medical Home Tookit. o Child/Adolescent Health Assessment form to help screen for special health care needs o Family-Centered Care Coordination form o Youth Care Coordination, a transition checklist • Involve the patient/family in the decision-making process and development of an action plan. (See example action plan.) • Coordinate care using recommended tools such as the following: o Select one subspecialist champion to pilot comanagement with.	• Select one or two specialists with whom you work and communicate well to talk with about improved and more explicit comanagement. • Discuss with senior leaders in your practice the idea of comanagement service agreements between primary care and specialists and hospitalists. • Develop a standard format for referral letters that provide a brief history, state the question or concern, and specify your and the patient's preference for ongoing care/comanagement. • With the care team, review the content that defines comanagement and the articles. cited, particularly Stille CJ, Jerant A, Bell

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Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	o Comanagement letter and agreement with specialists that specify the responsibilities of the medical home and those of the specialist o Referral forms to accompany the patient/family on the visit with the subspecialist that clarify the purpose of the referral, the questions to be answered, and the degree to which you want the specialists help (eg, assume care of the problem, provide initial diagnosis and recommendations, share care according to a specific plan) o Comprehensive care plans to share information that can travel back and forth between primary care and specialty visits with updates added following each visit o A system of planned follow-up visits that alternate between specialty and primary care	D, Meltzer D, Elmore JG. Coordinating care across diseases, settings, and clinicians: a key role for the generalist in practice. *Ann Intern Med*. 2005;142(8):700–708 regarding communication between primary care and specialty care. • Review materials for Pediatric Subspecialists within the Medical Home on the AAP National Center for Medical Home Implementation Web site, featuring news, articles, best practices, resources and links for subspecialty care.
Gap: Your practice's care coordination services are unknown to others.		
Families or other health services are unaware of the care coordination services your medical home provides.	• Articulate how care coordination functions within your medical home. You may want to express this information on your practice's Web site, on a waiting or exam room poster, or in a brochure (see sample brochure template from the AAP/MCHB Building Your Medical Home toolkit). • Communicate the care coordinator role to the following: o All staff members of the medical home o Patients and families o All health system referral contacts o Community agencies • Encourage families to communicate the coordinator role information to all of their health system and community contacts.	• Design a poster for the back of exam room doors or the waiting room describing care coordination in your office and how to access it. • Place information on your Web site regarding care coordination. • Invite patients/families to e-mail your care coordinator with questions or needs. • Ask parent advisors to share benefits with other parents in the practice.

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Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Follow-up visits are not routinely scheduled or recommended.*		
The responsibility for making the follow-up appointment is unclear among members of the care team or practice. The appointment is made or offered, but not documented.	• Develop a protocol in your practice to schedule or recommend follow-up visits for patients with clearly defined roles and responsibilities. (The interval of the next offered appointment is mutually agreed upon by the patient and family.) • Ask patients for best methods and times for follow-up visits. • Put checks and balances in place to ensure follow-up offers are extended and documented before patients leave the office – eg, use a visit checklist to ensure the offer is extended; assign a specific staff person to ensure the appointment or offer is documented; integrate an EMR system reminder to prompt for follow-up at time of patient check out.	• Educate staff on the importance of timely follow-up. • Generate reports from your registry to discover patients in need of follow-up and generate contact lists. Telephone patients to make appointments. • Consult with staff not adhering to established protocol concerning follow-up appointments and brainstorm ways to ensure the appointments are made or offered and documented.

* For information on closing this gap and the associated measures provided in this EQIPP course, see *Ideas for Closing Gaps and Measures: Coordinate Care Across All Settings*.

Appendix

Key Competencies of Care Coordinators

1. Family-centered, culturally effective behaviors supporting family professional partnerships
2. Interpersonal communication proficiencies
3. Care planning that promotes shared decision making and patient/family self-management
4. The integration and use of health knowledge and resource information
5. Team-based patient and family assessments and quality improvement capabilities
6. Goal/outcome-oriented efforts and attitude
7. Role development skills dynamically in step with the health care environment/culture and the needs of families and health care teams
8. Continuous learning and sharing of health, network, and community-based systems knowledge
9. Resourcefulness in information technology operations

Comprehensive Care Plan

For patients with complex conditions, a **comprehensive care plan** includes an expanded, portable medical summary, an emergency treatment plan, and a dynamic, explicit plan of care, also known as an action plan.

Action Plan

An **action plan** is a dynamic, explicit plan of care for patients with active issues, pending actions, and unresolved needs that clearly identifies the issues and concerns, includes agreed-on goals, and identifies actions planned, persons responsible (including nonmedical sources of care), anticipated time frames, and, where possible, resolutions. The action plan may be simple or complex as dictated by patient need and may unfold across multiple visits. View a sample action plan.