A note about this month’s AMCHP Pulse:

This issue of AMCHP Pulse is a special joint edition with our friends and colleagues at the American Academy of Pediatrics (AAP). AMCHP and AAP have a long history of collaboration at the national level and that partnership is mirrored in the states among public health leaders, pediatricians, and families in Title V agencies and AAP state chapters. This issue highlights the shared commitment that AMCHP and AAP have to promoting child health and improving health systems that serve children and their families. We hope you enjoy hearing about our shared successes and are inspired to join AMCHP and AAP in the work that is yet to come.

From the Presidents

The Medical Home: Where We’ve Been, Where We Are, Where are We Going

By Phyllis J. Sloyer, RN, PhD, FAHM, FAAP

No single concept evokes such a powerful calling in me for a national response that moves individuals, communities, and states to get it right for children as does the term medical home. The values that medical home embodies: family-centered care, trusting relationship, continuity of care, comprehensiveness of care are so pivotal to quality child health care and a child’s future that I consider it to be one of the central themes of child health policy.
I have been asked to speak about where we have been, what’s happening now, and where we are going. I know that this issue will be full of interesting information from national experts in medical home with past, present and future perspectives, so I will touch on some personal and professional experiences about medical homes.

As a child growing up in rural northern Indiana, my physician made home visits, an idea that shocks most people today. As a young pediatric nurse in Pensacola, Florida, I was quite used to interacting with primary care pediatricians who managed a great deal of chronic illness. It was typical for me to see the primary care provider look at all the specialists’ recommendations and give a very thorough overview of the child’s care and treatment to the families. I also watched families turn to the pediatrician for more than just the care and treatment of their children. Several young adults who were “chronic visitors” to Sacred Heart Children’s Hospital returned to their pediatricians because there wasn’t an adult provider who felt comfortable with the children I knew who had cystic fibrosis, rare bleeding disorders, spina bifida, congenital anomalies, etc. So, in essence, my childhood experiences and my professional career exposed me to physicians who provided medical homes before the term was in vogue. How grateful I was to have had those experiences because my professional foundation was based on the principles we use to frame medical homes of today and tomorrow.

It is not surprising to me that the American Academy of Pediatrics coined the term medical home in 1967, decades before the adult world promoted patient-centered primary care. The focus was on a central medical record or complete information about the child; something we strive for today and promote technology as a potential solution to the centralization of medical information and the exchange of information to enhance continuity and coordination of care.

But the concept of medical home would not reappear for a couple of decades. During the 1970s and 80s, we witnessed the development and organization of highly specialized services into multidisciplinary programs, regional programs, or “centers of excellence.” Children with chronic or complex problems were surviving past childhood and the need for on-going specialized services grew. If you follow the evolution of crippled children’s programs into children with special health care needs programs, you can easily understand why communities and states focused on the development of specialty programs. However, it was not the norm to talk about the coordination of all of these services with a medical home until the late 1980’s and into the 1990s.

Others will address the evolution of the Title V Programs and the shifting focus from specialty care to medical homes, including the shift to coordinated systems of care in this issue; however, I want to recognize Dr. Cal Sia, who first implemented the medical home concept in Hawaii. I am not sure he had any idea at the time that these early programs would grow into a national movement focusing on adults and children. Dr. Merle McPherson and families joined forces to establish the charge for Title V Children with Special Health Care Needs Programs. They created many firsts; including a set of six national performance measures around comprehensive systems of care and the promotion of medical homes for children with special health care needs that would spread to all children.

I have said many times that we must break down the silos between public health and health care. There is no better example of the need for a strong linkage between public health and health care than the development and implementation of medical homes. Look at the work in Illinois between the Title V Children with Special Health Care Needs Program, the Illinois Chapter of the American Academy of Pediatrics in developing medical home
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criteria and quality improvement initiatives. The states of Colorado and Minnesota have strong partnerships between their Title V agencies and their Medicaid agencies in the development of medical homes. You can look at Washington and many of the northeastern states and see similar progress. The New York Title V Program works with the private sector and health care purchasers to develop quality measures.

Each of us work in different organizational structures, face different political and policy environments, live in challenging economic times, have varying degrees of capacity to perform certain functions, are required to meet certain state mandates, and have varying skill sets. However, each of us are charged with promoting comprehensive and coordinated systems of care and if we truly believe that the quality of children’s health care is significantly affected by the current chaos in our delivery systems, then we have our future charter in front of us.

Take a look at where we are: According to the national children’s health and children with special health care needs surveys, in 2007, approximately 58 percent of all children have a medical home as compared to 47 percent of children with special health care needs (2005 data). We live in a nation with children who are not insured or whose families don’t have the means to provide those services not covered by insurance. We are creating electronic health records, however, some of these systems operate in silos and the much needed specialty note hasn’t made its way to the medical home. We are just beginning to look at the quality of care from a population or provider perspective using a common set of measures.

We have witnessed the development and evolution of the term medical home. We know that it is much more than a usual source of care and it can be provided by physicians and other qualified health providers. States are moving forward with implementation of the concept of “medical home” although the actual definition and implementation activities vary from state to state. Commercial insurers know it is the right way to deliver care and are beginning to promote medical homes through a variety of incentives. The term medical home has evolved to patient-centered primary care and it has blazoned new paths in the adult community, including the maternal health field.

The concept of medical home will not disappear. The National Committee on Quality Assurance has developed criteria for the patient-centered medical home and I suspect it will not be long before it becomes a measurable and institutionalized concept with most payers. A word of caution: While insurance is important, insurance is not a provider of care and it is the relationship between the provider and the patient that creates the necessary environment for quality and cost-effective care.

Some of you may wonder if you have any role to play in the development and implementation of medical homes. Remember a successful medical home relies on the multitude of supports we bring to the service delivery system that surrounds the family and community. We certainly will have varying roles in each of our states and communities, but I believe we have 75 years of experience as a maternal and child health profession that successfully forges partnerships between public and private practice on behalf of women, children and families.

Enjoy this issue of Pulse and I hope that it fuels the passion inside of you to be a part of making medical homes a success in your state and communities.

Medical Home: Getting Long-Deserved Recognition

By Judith S. Palfrey, M.D., FAAP
President, American Academy of Pediatrics

As I begin drafting this article with the knowledge of the passing of the Patient Protection and Affordable Care Act endorsed by the American Academy of Pediatrics (Academy) — I cannot help but reflect on what an exciting time in history this is!

In 2010 — even beyond the health care reform discussions — it seems that everybody is talking about the medical home. And for good reason. The medical home is the system best suited to meet the health care concerns of all our citizens.

The origins of the medical home go back to the 1960s...
From the Presidents CONT.

Medical Home: Getting Long-Deserved Recognition

When pediatricians in the Academy wanted to develop a single repository for all health information on their patients, the medical home was really the forerunner of a personal health record and included information on a child’s history, physical findings, immunizations, consultations, medications, therapies and anything pertinent to the patient’s health status.

Over time, largely as a result of a partnership between visionary Calvin C.J. Sia, M.D., FAAP, and leaders at the Maternal and Child Health Bureau, the medical home grew into a system of care that is accessible, continuous, comprehensive, coordinated, compassionate and culturally effective (see the Academy’s desirable characteristics of a medical home here).

Families can trust that there is one place where their child is seen as a whole, where all aspects of physical, mental and emotional health are addressed over the long haul of the child’s life. Not a building or a designated space, the medical home is a 24/7 system of care that is well-resourced with primary care, subspecialty care, emergency department and hospital-based care to which the child has ready access.

The doctors, nurses and staff of the medical home know the child and family well. They do not need to go back to the beginning every time they see a child because health information, including recent consultations, medication changes and lab values, is at hand. Getting appointments for tests and consultations is handled in a coordinated fashion. When the consultations are completed, the information comes back to the primary care physician and the family in real time so that timely interventions can take place. Importantly in the medical home, children with special health care needs have access to community-based care coordination.

Today, the medical home is the gold standard for medical care and includes the entire framework of practical elements necessary to assure patients experience optimal outcomes. The AAP is the home for the National Center for Medical Home Implementation — through a cooperative agreement funded by the federal Maternal and Child Health Bureau, Health Resources and Services Administration. The National Center has developed outstanding materials to help practices implement each of the medical home components.

The most recent accomplishment is the Building Your Medical Home toolkit, which was designed to assist pediatricians in meeting the National Committee for Quality Assurance (NCQA) Physician Practice Connections® Patient-Centered Medical Home™ (PPC-PCMH) recognition program requirements. It includes the specific components each practice needs to incorporate to meet the gold standard the Academy has set. Check it out!

Excerpts taken from the February 2010 AAP News.
From the CEO’s Strategies to Achieve Medical Home Implementation

By Mike R. Fraser, PhD

It is a pleasure to introduce this issue of *Pulse*, featuring the work of our members, and share the pages with colleagues and friends from the American Academy of Pediatrics, one of AMCHP’s long-standing and most important partners. This issue of AMCHP *Pulse* features the topic of medical home. The “medical home” concept is powerful: it is about building systems and supporting practices to be more efficient, more effective, and more comprehensive. It is also simple – nothing makes more sense than a coordinated, family and patient-centered approach for providing care. Why then do 42 percent of U.S. children not experience care within a medical home? What do we need to do to get every child access to a medical home?

If our goal is 100 percent access to a medical home, our first strategy should be partnership building. Effective medical homes are not necessarily physical structures but rather specific approaches to comprehensive, coordinated care. Medical homes involve and network pediatricians, family physicians, families, state maternal and child health leaders, community stakeholders, specialists, and key agencies in supporting the health of children, including children with special health care needs. The only solution to fixing uncoordinated care is stepping back, untangling the different systems and silos that make coordination difficult, and then partnering to braid activities in support of patients and their families. Creating braided systems is a hallmark of Title V and a strength that state maternal and child health leaders bring to these critical partnerships. This issue exemplifies the importance of partnership, as highlighted by the inspiring comments from Drs. Alden, Palfrey and Sloyer that introduce it.

Our second strategy should be programmatic. We need to share what is working, replicate best practices and encourage innovation where feasible throughout the states. That is core to the work we do at AMCHP and is the theme of this issue. Also note that AAP’s National Center for Medical Home Implementation is a tremendous resource for all of us and will help us accomplish our programmatic goals. AMCHP is also seeking best practices for our Innovation Station that we can share with state and local health departments that build on the great work of AAP’s National Center, the work of state Title V programs, and other program partners.

Our third strategy includes public policy change that supports medical home development and implementation. Passage of health reform offers the opportunity to do just that and includes many opportunities to move and expand medical home programs in the states. We need to continue to work with AAP and other key partners to identify the policy levers that will move medical home implementation further and continue to evaluate what families, states, and providers need to ensure that all children have access to a medical home.

AMCHP is committed to supporting the medical home concept, and working to support the Title V role in medical home implementation and expansion. As you can see from the content of this issue, there is a lot going on across the country on medical home. We want to continue to share and support this great work, and work with you to reach our goal of all kids having access to comprehensive, coordinated, and culturally appropriate care in a family-centered medical home.

Medical Home: The Standard of Care for All

By Errol R. Alden, M.D., FAAP

*Executive Director/CEO, American Academy of Pediatrics*

The American Academy of Pediatrics has a long history of collaboration with the HRSA Maternal and Child Health Bureau and Title V. Indeed, it was through the collaboration of MCHB, Family Voices, and the AAP that the initial concept of “medical home” for children with special health care needs was developed. Medical homes have since expanded to include acute, preventive and chronic care. More recently, the AAP in collaboration with the American College of Physicians, the American Osteopathic Association and the American
Academy of Family Physicians developed the Principles of the Patient Centered Medical Home in 2007. Over the last 30 years, medical homes have moved from a remarkable, visionary concept to becoming the standard of care for all of us — children and adults.

As documented in the 2004 AAP Policy Statement on The Medical Home, medical care of infants, children and adolescents should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. The 2007 Joint Principles also address the personal physician, whole person orientation, care coordination, quality of care, enhanced assess and appropriate payment. Our pediatric preamble stresses the importance of family-centeredness in a community based system of care. The medical home and the physician must be known to the child and family, in a partnership of mutual responsibility and trust. According to the policy statement, “With the collaboration of families, insurers, employers, government, medical educators, and other components of the health care system, the quality of life can be improved for all children through the care provided in a medical home.”

A medical home operates within or develops, then utilizes, a seamless system of care for children, youth and their families. The unique role that state Title V and the AAP chapters can play is in the development of appropriate systems of care which may include other health care providers, specialists and subspecialists, interdisciplinary partners, hospitals and healthcare facilities, public health and the community. Title V has years of expertise in the evaluation and development of systems of care. The collaboration among pediatricians, Title V, and families garners the strength to make the changes necessary to optimize the care of the children within the medical home.

There are still challenges in the full implementation of medical homes. Some of these challenges include: the appropriate definition of medical home; appropriate payment for services; health information technology and interoperability; family knowledge and involvement; knowledge of community resources and services; measurement and performance standards; and subspecialty involvement including co-management.

With the recent historical passage of health care reform legislation, the stage is truly set and the timing is critical for collaboration with our partners in disseminating and implementing medical homes. There is a great opportunity for pediatricians and Title V to capitalize on the current momentum to enhance the spread of “medical homeness.” With the aim of improved health outcomes for children and youth, the goal is simple — and possible: all children must have access to appropriate, quality health care within medical homes.

Feature

State Medicaid, CHIP, and Title V Collaborating to Build Medical Homes

By Michelle Alletto, MPA
Senior Manager, Public Policy & Government Affairs, AMCHP

On Wednesday, March 10, AMCHP, in partnership with the National Academy of State Health Policy (NASHP), the Maternal and Child Health Bureau, and the American Academy of Pediatrics held a meeting in conjunction with AMCHP’s annual conference to explore the topic: “Making Connections: State Medicaid, CHIP, and Title V Collaborating to Build Medical Homes.”

This meeting brought together Medicaid and Title V/CYSHCN teams from six leading states (Colorado, Iowa, Illinois, Minnesota, Pennsylvania, and Texas) to understand ways that these agencies are collaborating to build medical homes and link all children and youth through policy and systems change. State teams were comprised of Title V representatives, Medicaid representatives, and either a provider or family member who plays a key role in the state’s medical home implementation. Federal partners Marie Mann from the Division of Services for Children with Special Health Needs, MCHB, HRSA and Krista Drobac from the Office of the Director, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services were also on hand to share their agency’s perspectives on medical home implementation.
Collaborating to Build Medical Homes

There was a robust discussion in which state teams shared best practices on improving Medicaid and Title V relationships within states as well as posed ideas for improving medical home programs. The key role that Title V plays in being a catalyst for medical home implementation for CYSHCN and in providing resources for care coordination emerged throughout the day’s discussion. Another highlight of the conversation was the role of family engagement and leadership, which were illuminated by family representatives Carolyn Allshouse of Minnesota, Carol Harvey of Texas, and AMCHP Board Member, Eileen Forlenza of Colorado. Particularly good working relationships between Title V and Medicaid, in addition to provider leadership, in Pennsylvania and Illinois provided best practices in partnering to build medical homes and improving systems for CYSHCN. Jane Borst, RN, MA, Chief, Bureau of Family Health for the Iowa Department of Public Health shared the multiple strategies that Iowa is implementing to build medical homes and said that “convening key partners like Title V, Medicaid, insurers, and providers is essential to expanding and improving medical homes for all children.”

NASHP experts will be producing a paper highlighting best practices using the discussion from the March 10th meeting and other research. Title V and Medicaid programs in each state will benefit from hearing the experiences of their peers in Colorado, Iowa, Illinois, Minnesota, Pennsylvania and Texas, and learn from NASHP’s discussion of potential policy changes needed to improve collaboration.

MCHB: An Update and Next Steps on Medical Homes

By Marie Y. Mann, MD, MPH

Genetic Services Branch, Maternal and Child Health Bureau (MCHB)

Not unlike the tortoise in the fable “The Tortoise and the Hare,” we are moving steadfastly toward the goal of optimal child health and development within a comprehensive, integrated system of care for all children, including those with special health care needs. We believe achieving this goal will rely on adoption of the patient/family centered medical home (P/FCMH) model, which combines the central focus on the patient and family with core tenets of primary care and continuous quality improvement. This model broadens the traditional focus on acute care to include prevention and well care as well as chronic care management. It provides a framework for addressing health in the context of social, behavioral, psychological and environmental influences as expressed by the Life Course Perspective.

Successful implementation and evaluation of the P/FCMH model requires continual collaboration at the family, provider, community and state level. Such efforts may involve clinicians partnering with patients and families to conduct quality improvement in the clinical settings or state agencies providing support to sustain the desired changes at the practice level.

This year we will celebrate “All Aboard the 2010 Express,” our ongoing plan to achieve coordinated systems of services for children and youth with special health care needs and their families. The P/FCMH has been, and will continue to be, a key element of our plan. One of the most significant developments during the decade has been the widespread recognition that medical home is the model of care that all children and youth deserve. We also know, from the National Survey of Children’s Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN) that only about half of children and youth in the United States currently have access to this model of comprehensive health care. We will continue to sponsor initiatives and implement funding strategies that will support innovations and measurement-based efforts fostering collaboration, as well as promote evidence-based and culturally effective services, and dissemination of promising practices, lessons learned, and successful policy strategies.

The Health Reform legislation contains provisions that are relevant to advancing the P/FCMH model, particularly for the Medicaid and CHIP populations. State Title V agencies can take this opportunity to partner with their state’s Medicaid agencies, Primary Care Organizations, family and child health professional organizations to share resources and expertise for achieving the vision. Join us in October 2010, along with the 75th Anniversary of Title V, as we celebrate “All Aboard the 2010 Express,” and plan for the next decade.
New PCPCC Center: A Focus on Consumer Involvement & Leadership

By Christine Bechtel
Vice President of the National Partnership for Women & Families

The primary objective of the newly established Patient Centered Primary Care Collaborative’s (PCPCC) Center for Consumer Engagement (CCE) is to ensure the medical home model is truly patient-centered. The CCE will accomplish this by facilitating consumer involvement and leadership in the design and evaluation of the Patient Centered Medical Home (PCMH), strengthening the consumer voice in the PCPCC, and developing a set of “Best Practices” for consumer engagement in PCMH. The CCE partners with consumer groups in their existing efforts.

The following are the initial goals and related activities to be addressed via the CCE:

Task 1:

- Identify and make recommendations on ways to ensure a strong consumer voice in the PCPCC, including ensuring coordination across existing centers and with the Board of Directors. Communicate recommendations to PCPCC Board and Center leadership.
- Develop a set of “Best Practices” for consumer engagement in PCMH demonstrations and pilots by surveying existing PCMH pilots regarding how they are currently engaging consumers in the design, ongoing practice and evaluation of current PCMH initiatives, at both the patient level and the systems level.

Several key resources are available via the CCE, including the recently published consumer guide; a Participatory Engagement Framework; and more!

The CCE is co-chaired by Christine Bechtel who is the Vice President of the National Partnership for Women & Families, a non-profit consumer advocacy organization based in Washington DC.; Julie J. Martin, Communications Manager, The John D. Stoeckle Center for Primary Care Innovation in Boston; and Dr. Warwick Charlton, who is the Chief Medical Officer for Medfusion, the nation’s leading provider of patient-to-provider communication solutions, based in North Carolina.

To register to receive email notifications of the CCE monthly call schedule, agendas, and other information, visit here. The CCE conference calls occur on the last Friday of the every month at Noon (EDT).

Real Life Story

Title V: Giving Families Strength - Q & A with Nicole Schomberg

Nicole Schomberg is the Project Director at Family TIES of Nevada for the Nevada State Implementation Grant for Improving Systems of Services for Children and Youth with Special Health Care Needs. She also is a board member for the Down Syndrome Network of Northern Nevada, and a parent representative on Nevada’s Title V Advisory Committee. Nicole and her husband have three children – Roman, 23, Heather, 21, and Becky, 18. Soon after Heather was born, she was diagnosed with Down syndrome and two holes in her heart, requiring intensive
Real Life Story CONT.
Title V: Giving Families Strength - Q & A with Nicole Schomberg

care and services from a variety of healthcare providers. Please read on to learn more about Nicole, her family and how Title V supported their health care journey.

How did you first become aware of Title V?

My husband and I were a young, married couple and we didn’t have health insurance when our daughter, Heather, was born. When she was two weeks old, we started her in early intervention services. After six months of monitoring Heather’s condition, our pediatric cardiologist told us that Heather would need open heart surgery, and early intervention services referred us to Title V and their children with special health care needs services. Title V was a payer of last resort for parents without health insurance and fortunately, we were connected to them, because they paid for Heather’s surgery and medical bills when she was hospitalized for two months following her surgery because of complications – she had a blood clot and her heart doubled in size. It was great to know that there were services like Title V out there to help us, because it was a really hard time for us.

What is something that occurred through your work with Title V that you didn’t expect?

Before Heather was born, I didn’t know services like Title V were out there – that they had put money aside to help families with children with special needs and provide services for them. The process was simple and easy – we had an initial meeting with Title V staff and they helped take care of everything we needed and helped with our medical care and bills.

What would you want other families to know about Title V?

One of the big things is that they [Title V] do care about families and they do have many programs, including those for pregnant women. Title V also has advisory committees that families can participate on. It’s important for parents to know that Title V also partners with family organizations, like Family TIES of Nevada, to understand their needs and then provide services to meet those needs.

Please describe the strengths and value that families bring to Title V?

Families need to tell their stories and talk about their challenges. In Nevada, Title V helped organize the Families First conference and they surveyed families at that meeting, to get their feedback on what specialized health services they need. Getting this information from families helps get doctors into their communities and more services for children.

What advice would you give to Title V Directors and staff that want to work more with families in their state?

Having families on advisory committees is very helpful and it’s also important to partner with family organizations and agencies to reach out to and connect with families and learn about what they need.

How has your experience with Title V impacted you and your family to this day?

They really helped us to truly have health services. My husband lost a lot of work, and we almost lost our daughter. Title V gave us strength. It also helped Heather’s siblings to understand the importance of health insurance and making their own health a high priority. Becky, our youngest daughter, is in a mentorship program at the hospital and going into nursing – her focus is the pediatric intensive care unit. We’re big advocates for all of our children to grow up to be independent, have self-determination, and be able to live lives like everyone else. When we were close to losing Heather, that changed our attitudes and our family’s major goal became making her happy and being a part of the community and do whatever anyone else can do. We don’t know what would have happened if we didn’t have the support from Title V.

Interviewed by Angela Tobin, AM, LSW, Manager, Technical Assistance, American Academy of Pediatrics.
Member to Member

What opportunities are there for Title V and chapters of the AAP to collaborate at the state level?

Iowa

Debra B Waldron, MD, MPH
Director & Chief Medical Officer
Iowa Child Health Specialty Clinics

The American Academy of Pediatrics (AAP) is an organization of 60,000 pediatricians committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. Each state has a local chapter of the AAP that is focused on the unique health concerns of its pediatric population. There are many examples of collaborative efforts between state AAP chapters and state Title V agencies. These have included topics such as early hearing detection, child nutrition, and injury prevention.

In Iowa (IA), establishing a “medical home” is a major component of our health reform legislation. The state AAP chapter is involved in the state’s Medical Home System Advisory Council that is developing the plan for a statewide patient centered medical home system. One specific collaboration between the IA-AAP and IA-Title V is centered on care coordination for children with special health care needs. The clinical expertise of pediatricians in conjunction with the population focus of public health practitioners is providing an opportunity to use community resources to achieve improved health outcomes for a larger number of CYSHCN. It is hoped that this clinical-community partnership will be instrumental in IA’s future efforts in identifying, assessing and addressing social and environmental determinants of health.

Ohio

James A. Bryant, MD
Chief, Bureau for Children With Medical Handicaps, Ohio Department of Health

It is my honor to participate actively in two great organizations, AMCHP and the AAP. At the national level these organizations partner to improve the health of all children and especially children and youth with special health care needs. At the state level Ohio has a long history of the Title V program partnering with the Ohio Chapter of the AAP. Our most conspicuous collaboration is in the state’s joint committee for children and youth with special health care needs. As the state’s Title V CYSHCN director, I co-chair this committee with Dr. Roberta Bauer, M.D. from the Ohio Chapter AAP. The committee is a true partnership and collaboration and is the lead for our state’s medical home and transition activities.

The Ohio Chapter AAP has also been a strong partner in Ohio’s efforts to spread quality improvement activities in our state. This started with our medical home activities and is continuing with the state’s activities to incorporate structural developmental screening into pediatric and primary care physician medical practices in Ohio. This includes screening for autism at the appropriate ages. This effort is spreading to screening for the social/emotional needs of children in Ohio and including screening for maternal depression. These efforts could not be successful without our partnership.

Even more important is connecting those identified with the services they need. This effort is a partnership between the Ohio Chapter AAP, the Ohio Title V agency and the Ohio Office of Medicaid. I could say much more but I will close by saying how much I appreciate the opportunity to work with Ohio Chapter AAP as we pursue our common goals.

Success Stories

The Pennsylvania Medical Home Initiative (EPIC-IC)

By Renee Turchi, MD, MPH; Deborah Walker, M.Ed.; and Molly Gatto, MHA

Educating Practices in Community Integrated Care (EPIC-IC) has provided training to over 100 practices in all six regions of Pennsylvania since its inception in 2001. EPIC-IC is a collaborative effort of the Pennsylvania Department of Health (PA DOH), family organizations, and
Success Stories CONT.
The Pennsylvania Medical Home Initiative (EPIC-IC)

the Pennsylvania Chapter of the American Academy of Pediatrics. The Maternal and Child Health Bureau founded the initiative in 2001 and continued to support medical home through 2009. Title V funding through the PA DOH has supported the initiative from 2002 to the present.

Some highlights of the PA Medical Home Initiative:

• EPIC-IC has successfully integrated the medical home model into diverse types of practices including pediatric/family practices, specialty practices, private practices, health system and hospital-owned practices, school-based clinics, Federally Qualified Health Centers and Rural Health Centers.

• EPIC-IC practices have cultivated a network of parent partners that also work with the EPIC-IC program statewide (n=68). A social networking site further supports parent-to-parent learning, sharing and support.

• Collaboration with Title V and the Department of Public Welfare has resulted in policy changes such as reimbursement for care plans, increased reimbursement for higher complexity visits, and reimbursement of transition-related collaboration with adult health care providers.

• During the course of the initiative, EPIC-IC has sought to assess the value of the Medical Home through the collection of outcome-based evidence. EPIC-IC practices (n=20) participated in a time tracking study in which over 80,000 encounters involving care coordination activities were analyzed. Results demonstrate a statistically significant number of emergency department visits, unplanned hospitalizations, missed parental work days, and missed school days were prevented due to care coordination activities.

• EPIC IC practices are currently participating in a survey project in which families of CYSHCN are asked about health care utilization, satisfaction, unmet needs, care coordination, sources of care, family centered care and cultural competency. Results from the survey will be linked to other data providing a detailed view of the impact that care in a medical home has on the lives of patients from the perspectives of families, providers and payors.

To learn more about EPIC IC, visit their website and watch a video, in which participating health care providers and families describe their experiences with the PA Medical Home Initiative. Join “Especially for Parents,” the web community for parents of CYSHCN. If you have questions, please contact Program Director Dr. Renee Turchi.

Baby Steps to Health Program

By Cynthia DeLago, MD, MPH
Director, Pediatric and Adolescent Ambulatory Center
Albert Einstein Medical Center
Philadelphia, PA

The Baby Steps to Health Program is one of 10 Healthy Tomorrows* grants that received funding in 2009. The premise of the Baby Steps to Health Program is to help medically and socially at-risk infants and their families transition health care from the Neonatal Intensive Care Unit (NICU) to the Pediatric Center at the Albert Einstein Medical Center. To do this, a team of physicians, nurses and social workers devised ways to promote easy transitioning, starting with identifying eligible babies in the NICU, scheduling their first appointments in the Pediatric Center, and developing care plans, so the parents know all the upcoming doctor appointments, what to expect, and whom to contact for supplies, equipment and help. The program hired a patient liaison — Mrs. Cassandra Martinez — to be a primary support for the baby's caregiver starting in the NICU and continuing until the caregiver no longer needs her support. Most importantly, she is someone the caregiver can call for questions and help. Her oversight provides a safety-net for these babies.
Success Stories CONT.
Baby Steps to Health Program

Since September 2009, the program has helped 15 babies transition to the pediatric center. The first baby enrolled — Maliq Dargan — was born three months premature and weighed only 590 grams. He was discharged from the NICU when he was three months old. Maliq had a difficult medical course after discharge from the NICU. Mrs. Martinez’s support helped Ms. Taggart keep doctor’s appointments and stay on task with his care. Maliq is now nine months old and has transitioned to the Pediatric Center’s Medical Home. Ms. Taggart has become very self-sufficient and is a wonderful advocate for her son; nevertheless, when it was time to transition Maliq she said, “Maliq, grow young so you don’t have to leave Ms. Cassandra.” The program will continue for at least four more years and we hope to help many more babies like Maliq.

* The Healthy Tomorrows Partnership for Children Program is a collaborative grant program funded and administered by the HRSA Maternal and Child Health Bureau in partnership with the American Academy of Pediatrics. The program supports community-based health projects that improve the health status of mothers, infants, children, and adolescents by increasing their access to health services.

View from Washington CONT.
How Will Health Reform Promote MH?

wanted to provide a quick re-cap of some policy related highlights from AMCHP’s recent Annual Conference. We are thrilled to report that over 60 members, families, and friends made visits to Capitol Hill while in town to advocate for increased funding for the Title V Maternal and Child Health Services Block Grant!

We are so appreciative of all whom helped raise the profile of state MCH programs and made the case for increased funding with elected officials and their staff. An archive of all the materials developed to support this advocacy is available here. While health reform will continue to dominate attention, we are not losing sight of the need to keep pressing on for an increase to Title V MCH Services Block Grant funding and will continue to advocate on your behalf as this year’s appropriations process continues.

On Tuesday March 9 we capped off our annual conference with a spectacular reception on Capitol Hill where we presented our 2010 AMCHP Legislative Champion for MCH Awards. We were joined by Rep. Jesse Jackson, Jr. (D-IL) who accepted an award in honor of his work addressing health disparities, promoting MCH and specifically for championing funding for the Title V MCH Services Block Grant. He provided some poignant remarks about the wisdom he gained from his mother. He also highlighted how our request for an increase to Title V is a heavy lift in this fiscal environment, but committed to continuing to champion our cause.

View from Washington

How Will Health Reform Promote Medical Homes?

By Brent Ewig, MHS
Director of Policy & Government Affairs, AMCHP

Greetings again from our nation’s capital. I will address this issue’s main topic of medical homes in a moment but first
We were also joined at the reception by Rep. Lois Capps (D-CA) who as a former school nurse has been a consistent champion for MCH issues in Congress. She spoke eloquently of the leadership Congress is providing for mothers, children and families, and highlighted her intention to soon introduce legislation to address maternal mortality within the United States.

Finally, on March 10 a small AMCHP delegation joined Sen. Max Baucus (D-MT) to present him with an AMCHP Legislative Champion Award. While acknowledging his overall work on reauthorizing CHIP and leading health reform efforts in the U.S Senate, we specifically celebrated his leadership to place the new Maternal, Infant, and Early Childhood Home Visiting State Grant Program with Title V in the Patient Protection and Affordable Care Act.

Overall, the AMCHP annual conference provided a great opportunity to raise the profile of State Title V MCH programs in our nation’s capital, celebrate the progress we are making, and continue our advocacy efforts on behalf of the women, children, and families we serve. We look forward to building on this momentum next year!

Now, back on to the topic at hand – Medical Home. I first want to extend a word of appreciation to our colleagues at the American Academy of Pediatrics who have been consistent and effective advocates for promoting medical homes. We have been working in partnership for several years now on a shared vision to provide all children with care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. We are appreciative of the strong collaboration between AMCHP and AAP staff members in both DC and Illinois.
Together with AAP and many other partners, AMCHP advocated for many important provisions for MCH populations in health reform.

The following are highlights included in the Patient Protection and Accountable Care Act (PPACA) which present the best opportunities to support the expansion of medical homes:

**Health Homes in Medicaid**

Section 2703 of the PPACA creates a state option to provide health homes for Medicaid enrollees with chronic conditions. The Secretary may award $25 million in planning grants to states to develop a state plan amendment to provide health homes. Health homes are to be provided by a designated provider (physician, clinical group practice, rural clinic, community health center, community mental health center, pediatricians, gynecologists, obstetricians) or team (include physicians and other professionals such as nurse care coordinator, social worker, behavioral health) and must provide comprehensive case management, care coordination and health promotion, transitional care, patient and family support, referral to community services, and the use of Health Information Technology as appropriate.

**Pediatric Accountable Care Organization Demonstration Project**

Section 2706 authorizes participating states to recognize pediatric medical providers as an accountable care organization (ACO) for purposes of receiving incentive payments (states and the Secretary will establish an annual minimum savings level to be achieved by the ACO for services covered under Medicaid or CHIP in order to receive savings). Demonstration project established with the ACO should last three years.

**CMS Center for Medicare and Medicaid Innovation**

Section 3021 establishes a new Center for Medicare and Medicaid Innovation within CMS to test innovative payment and service delivery models for Medicare, Medicaid, and CHIP programs. Models should promote payment and practice reform in primary care, including patient-centered medical home models for high-need individuals and medical homes that address women’s unique health care needs. Additional factors for consideration include whether the model places the individual, including family members and other informal caregivers, at the center of the care team and provides for the maintenance of a close relationship between care coordinators, primary care, specialists, and community-based organizations. The law provides an initial mandatory appropriation of $5 million for planning in FY 2010 and then a mandatory appropriation of $10 billion over the next 10 years for implementation.

**State Grants to Promote Community Health Teams that support the Patient-Centered Medical Home**

Section 3502 authorizes grants for community-based interdisciplinary teams which will provide support services to primary care practices, including OBGYN practices. The team may include specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral/mental health providers, and physicians’ assistants. Health teams should collaborate with local primary care and health providers; coordinate disease prevention and management; coordinate transition between health care providers and settings; provide case management for patients, including children; incorporate patients and caregivers in program design and oversight; provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care; establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems; and should provide support for transitional health care needs from adolescence to adulthood.

**Community Health Centers**

Finally, to dramatically expand community based primary care capacity, section 10503 creates a Community Health Center Fund that provides $11 billion in mandatory funding (over five years) for the Community Health Center program, the National Health Service Corps, and construction and renovation of community health centers. Additionally, section 4101 provides $50 million over four years for a new grant program to establish school-based health clinics that provide health services to children and adolescents.

Taken together, these provisions offer substantial resources and opportunities to generate further expansion of medical homes. AMCHP will continue to work with key partners to provide additional information on these opportunities, with a particular focus on the potential roles for state Title V MCH and CYSHCN programs.
The National Center for Medical Home Implementation, funded via a cooperative agreement from the Health Resources and Services Administration, Maternal and Child Health Bureau, has experienced many exciting changes over the past year. The National Center is thrilled to introduce its team — including the following new staff members who contribute all or part of their time to implementing and advancing medical home initiatives, policies and practices on a daily basis:

- **Michelle Esquivel, MPH—Director** (National Center for Medical Home Implementation director; medical home multidisciplinary training and education; financing; policy and program evaluation and analysis; practice implementation; collaboration with other national centers.)

- **Suzi Montasir, MPH—Program Manager** (Medical home Chapter Champions program; state-level policy and practice; asthma; integration of medical home concepts in practice; co-management issues; and the role of the subspecialist.)

- **Heather Stob—Program Coordinator, Technical Assistance** (Medical home e-Newsletter development; website and listserv maintenance; technical assistance; medical school education and residency training; state and local level tools and resources.)

- **Chelsea Fosse—Program Assistant** (Website maintenance; technical assistance to states and communities; medical home data; surveillance and screening; children and youth with special health care needs.)

- **Corrie Pierce—Division Coordinator** (Technical assistance; state, community and practice resources and information; administrative support.)

Additional staff who continue to contribute substantially to the overall goals and objectives of the National Center are:

- **Fan Tait, MD, FAAP—Principle Investigator; Associate Executive Director and Director, Department of Community and Specialty Pediatrics** (Oversees the strategic direction of the National Center and ensures linkages between the National Center, the AAP and other national strategic medical home initiatives.)

- **Angela Tobin, AM, LSW—Manager, Technical Assistance** (Advanced technical assistance; quality improvement; Web site management and direction; health disparities; cultural competency; community connections; practice implementation; continuing education.)

- **Stephanie Skipper, MPH—Manager, Council on Children with Disabilities** (Children and youth with special health care needs; transitions; developmental screening and surveillance; autism.)

The mission of the National Center is to work in cooperation with federal agencies — particularly the Maternal and Child Health Bureau (MCHB) — and other partners and stakeholders to ensure that all children, including children with special needs, have access to a medical home. The National Center provides medical home resources, technical assistance and support to physicians, families, and other medical and non-medical providers who care for children. The National Center is housed in the American Academy of Pediatrics Division of Children with Special Needs.

Contact information for all National Center staff can be found here or by calling (800) 433-9016. We look forward to working with you to ensure that every child and youth has a medical home!

### New MCH Leaders

AMCHP is pleased to recognize the recent promotions of two of our Federal partners. Dr. Ursula Bauer, Director of the CDC’s Chronic Disease Center, selected Wanda Barfield, MD to be the new Division of Reproductive Health’s (DRH) Director. Some people know Wanda from working with DRH’s MCH Epidemiology Program, while others may know of her work in the field of neonatology. Dr. Bauer also announced John Lehnherr will be joining the Director’s office as Dr. Bauer’s Deputy Director. These appointments will become effective June 1, 2010. Congratulations to these two good friends of maternal and child health, and AMCHP!
Who’s New CONT.

New MCH Leaders

The following are new MCH Leaders:

District of Columbia

Anjali Talwalkar, MD, MPH  
Deputy Director of Policy and Programs  
Community Health Administration  
DC Department of Health

Vermont

Breena W. Holmes, M.D.  
Maternal and Child Health Director  
Vermont Department of Health

West Virginia

Christina Mullins  
Director, Division of Infant, Child, and Adolescent Health  
West Virginia Bureau for Public Health

If you know of a retiring MCH leader, please contact Librada Estrada, Associate Director, Workforce & Leadership Development, Family Involvement, AMCHP.

Get Involved

AAP’s Audio Series on Autism


NICHD Launches Online SIDS Curriculum for Nurses

The National Institute of Child Health and Human Development (NICHD) is now offering an online version of its Continuing Education (CE) Program on SIDS Risk Reduction. The curriculum is designed to inform pediatric, obstetric and neonatal nurses—as well as nurses who educate families and caregivers about caring for infants—of the latest risk-reduction strategies for SIDS. It also helps to increase nurses’ knowledge of ways to communicate SIDS risk-reduction information to parents and caregivers. The curriculum is accredited by the Maryland Nurses Association* and is available free of charge. The online module automatically grades responses to the post-test questions and provides nurses with real-time completion results. To learn more, visit here.

PUSHING FOR CHANGE? HERE’S THE ROAD MAP.

Co-authored by AMCHP keynote speaker Dan Heath

* #1 New York Times bestseller  
* #1 Wall Street Journal bestseller

Read the first chapter FREE at www.heathbrothers.com/switch
Q. Does your chapter have an active working relationship with your state Maternal and Child Health (MCH)/Title V Program Director?
Chapter Officers: N=58; Chapter Executive Directors: N=41.

Source: American Academy of Pediatrics, Department of Community, Chapter and State Affairs: 2009 Chapter Needs Assessment
Resources

New AAP Website Offers Pediatric Health Information for Parents

HealthyChildren.org is a new website designed for families seeking child and adolescent health information consistent with American Academy of Pediatrics (AAP) policies and guidelines. The site contains information on more than 300 topics compiled from AAP parenting books, patient education materials and fact sheets. Content is organized into the following sections: Ages & Stages (prenatal to young adulthood), Healthy Living, Safety & Prevention, Family Life, Health Issues, News, and Tips & Tools. The site is also searchable by keyword, topic, age or gender.

An Ask the Pediatrician corner provides a searchable database of current health issues. The Hot Topics area presents news and guidance on medication safety alerts, product recalls, and information generated by the AAP such as new policies and public awareness campaigns. Parents may also opt to register with the site, customize the view, and receive information specific to their needs. Visit HealthyChildren.org today!

Influence Medical Home Advancement With Data

Brought to you by the Child & Adolescent Health Measurement Initiative (CAHMI), the National Center for Medical Home Implementation and the AAP, the Medical Home Data Portal presents state-by-state summaries and state comparisons on how children are meeting the overall criteria for having a medical home.

As Title V programs engage in policy-level discussions regarding the healthcare of children, this portal can provide state performance data on medical home for all children, including those with special needs. Data for these summaries and comparisons are taken from the National Survey of Children’s Health and the National Survey of Children with Special Health Care Needs, which are sponsored by the federal Maternal and Child Health Bureau and conducted by the National Center for Health Statistics.

The medical home measure used for this data set includes an assessment of whether children and youth:

- Have a personal doctor or nurse
- Have a usual source of care
- Receive care that is family-centered
- Receive care that is culturally sensitive
- Obtain needed specialty care referrals
- Receive needed help coordinating care across multiple providers and types of services

This user-friendly resource has the capability to interactively search and compare measures by important subgroups of children — such as age, sex, race/ethnicity, insurance type and household income. Further, states can be compared to one another or against the nation on the percentage of children who receive ongoing, comprehensive and coordinated care within a medical home.

For more information, contact Angela Tobin or call (800) 433-9016, ext 7621.

New and Improved Medical Home Implementation Website—Available Soon!

This spring, the National Center for Medical Home Implementation will launch a new and improved website! The new site will feature a plethora of resources and information designed to help you learn more about family-centered medical home and how practices, families, and states are implementing and advancing medical home in states, communities and practices. Informational destinations on the website include:

- How to Implement Tools/Resources: The National Center provides an extensive list of user-friendly tools and resources for implementation of medical home in the pediatric practice. Visit the How to Implement section to see how you can adapt these tools to best meet the needs of your child, patient or client.

- Training Resources: A variety of tools and resources targeted towards pediatricians and the medical home care team that may also be of
interest and/or use for families, youth, communities and states are available.

- **State Pages**: Find out what’s going on around the country and in your state by visiting the State Pages section. This section includes information on state pediatric medical home initiatives, key contacts, partners, and related grant activities and initiatives.

- **Quick Links**: The Quick Links section of the site features links to valuable resources and information including the Building Your Medical Home toolkit, upcoming conferences, Children and Youth with Special Health Care Needs (CYSHCN), and marketing materials. A new area in this section focuses on new information and hot topics.

- **For Families**: The For Families section of the site features links to tools and resources aimed at assisting families including the Building Your Care Notebook, Family-to-Family Health Information Centers (F2F HICs), tips for partnering with your physician, Title V and links to the new AAP consumer Web site, www.HealthyChildren.org.

- **Spanish Resources**: A variety of medical home resources are also available in Spanish.

Subscribe to the National Center’s e-newsletter to receive notification of the website’s official launch and more! Medical Homes@Work is a monthly e-newsletter offering implementation tools and resources, training materials, and information about national initiatives, including updates from AAP medical home partners. To subscribe, send an e-mail with “Subscribe” in the subject line.
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**Mike Fraser, PhD**, Chief Executive Officer

**Melody Gilbert**, Program Associate, Program Team
On April 13, March of Dimes hosted a networking event at AMCHP’s offices to share information about their Prematurity Campaign initiatives and the Maryland - National Capital Area’s chapter’s March for Babies kickoff event on April 25.

From Left: Jessica Lindquist, Lauren Raskin Ramos, Mike Fraser, Julio Arguello, Jr., Joshua Brown, Jessica Hawkins, Ellen Schleicher Pliska, Vanessa White, Tania Carroll, Marion McCartney

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