Arkansas
Department of Human Services

ARKANSAS DEPARTMENT OF Health
Keeping Your Hometown Healthy

Arkansas Early Childhood Comprehensive Systems Initiative

Medical Home Work Group – January 18, 2005, 2:30 – 4:30 p.m.

Members Present: Jan Cox, Virginia Lancaster, Dick Nugent, Delores Pinkerton, Martha Reeder, Belinda Sanders, Paula C. Watson, and Lisa Weaver (for Sip Mouden).

Regrets: Gil Buchanan, Stevie Cherepski, Rhonda Sanders, and Eldon Schulz.
Martha introduced Dr. Richard Nugent as the new co-chair of the work group. Self-introductions were made by others attending. Lynn will remain on the group.

Agenda Item #1: Update – Remarks by Martha Reeder and Dick Nugent

Discussion: Martha Reeder provided Dick Nugent with an overview of the work of the Medical Home Work Group to date. Dick responded by indicating that he was aware of the AECCS grant before becoming a co-chair, and he is very interested in it. He discussed the changes in the role of the Department of Health over the past three or four years with regards to early childhood.

The Health Department services that were once performed directly by the Health Department have dwindled. Medicaid has moved to a PCP concept and streamed children into a medical home. The Health Department now depends on the Medicaid data system to keep track of the child. The number of medical homes has been growing. There are a lot of physicians in the Medicaid Program. There are some 500 Primary Care Physicians for children.

The Health Department is interested in seeing what is happening with children. DOH links immunization data with birth certificates. Children are served by a vast array of services. There are a number of different organizations dealing with caring for kids.

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The Health Department moved from direct clinical services to the role of insuring that children receive services. The challenge becomes how does the Health Department work with all other agencies to make sure that children receive what they need? How does the Health Department make sure that children with special needs have access to the mental services needed?

Some decisions are currently being made concerning the allocation of MCH Block Grant monies that redirect money that was formerly spent on direct services. Some of these are: public awareness issues, combined statewide conferences, pulling community people in, hometown health improvement issues—This is a brand new way of doing business. What's on the plate is so large there is no way it can be done without linking arms with others—agencies, people, churches, etc.

TASKS:

Agenda Item #2 – Update - Strengthening Families

Discussion: The Strengthening Families information was available with the agenda. Martha made a report on the project.

One of the things that has come our way because of the AECCS initiative is the strengthening families program that Arkansas is going to be involved. This is an opportunity that Arkansas has, not directly targeted at the Division of Child Care, but it is the prevention of abuse by working with child care providers.

There was a very quick turnaround on the application, and the AECCS partnerships that are already in place actually made it possible to take advantage of this opportunity. The grantor is a partnership between the Center for the Study of Social Policy and the Doris Duke Foundation. They issued an invitation seeking model programs that reach out to families where signs of abuse are there and work directly to prevent such from happening. About 20 programs were selected as model programs.. They investigated what these programs are doings and came up with Five protective factors:

- Parental Resilience
- Social Connections
- Knowledge of Parenting and Child Development
- Concrete Support in Times of Need
- Social and Emotional Competence of Children

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Underneath each area, they assigned different indicators for a way to make this happen. Martha suggested that the work group visit the web site for more information: http://www.cssp.org/. Seven states were invited to Albuquerque, New Mexico, in December to meet with representatives from the Center on Public Policy. Jacqueline Gorton and Sherry Jo McLemore represented the group in Albuquerque. These seven states were then chosen to participate in the pilot project.

This is a technical assistance grant. One of the ways we hope we can receive the technical assistance is with the tool kit that the family support group is interested in creating. There are other ways they can assist with the AECCS Initiative.

Looking forward to what it is going to mean, we need to create a stronger linking between child care and family services so we may be able to come at the foster care situation differently. We need to make sure that foster children are in quality child care situations.

We have some partners from DCHS that are participating in the program. The leadership team for AECCS will be consolidated with the SFI leadership team in order to create a seamless purpose for the two.

Result: In March a facilitator from the Center for the Study of Social Policy will come to Arkansas to meet with the joint Steering Committee.

TASKS: Visit the web site for more information on Strengthening Families: http://www.cssp.org/.

Agenda Item #3: Update – Other Work Groups

Discussion: **Early Care and Education Work Group and Review of Suggested Performance Standards from Monica Miller, R.N.**

In Arkansas there is a quality approval program. There is a list of regulations, mostly based on the environmental rating scale. There is a separate one for child-care providers and one for school age children. AR decided to modify the quality approval program and base it on the rating scales. There are consultants who go out and observe and assist programs that want to work towards quality. There is only a small percentage at this time of quality centers. There are thousands of child-care programs in the state.

The Early Care and Education Work Group is looking at instigating a tier quality strategy so that there are some in-between steps, basic health and safety standards. Presently, facilities are visited four times a year. As far as monitoring basic compliance, our licensing specialists work very hard. A lot of technical assistance is supplied through Arkansas State University (ASU). Centers can apply for enhancement grants to help them satisfy some of the requirements. There are many programs that DHS tries to make available.

We are hoping that the tier strategy will be like a path to get from here to there. One of the things the system looks at is how does the child care center support a medical home.

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Attached to the agenda is a listing of essential items that Monica Miller, R.N., from Head Start provided related to what she does for Head Start. This information was sent out prior to the meeting to every member of the work group. One of the things that the Head Start system looks at is how does the child care center support a medical home. This is part of Head Start. There is not always a component to that addresses the medical home in other child care plans. In Arkansas, we do not have a person like Monica (child care health consultants) in the regular child care arena. (See Page 4)

Monica sent 12 Head Start Standards that could relate to the tier program. The group reviewed them and thought this might be a basis for starting our discussion. Eldon Schulz, who could not be here today, felt that the first, second, and third are the most important and the rest would fall into place. After discussion, the group felt that twelve might be too many, but the twelve could probably be combined into five or six standards important for the tier program.

For information purposes, copies of the tier program design was distributed. On the second page under "parent, family, community" under the tier quality sheet, you can see the medical home section. The licensing specialist would have a checklist. That's why there is the need for concrete recommendations from the group.

We may need to condense in some kind of checklist.

We agreed to use this list as the starting point.

TASKS: We recommend that everyone take the list and come up with your own list based on these suggestions. Everyone should attempt to condense the Miller recommendations into five or six direct, concise recommendations and bring back to the next meeting. Review Early Care and Education Minutes on the Web Site for more information about tier systems-- http://www.state.ar.us/childcare/aeccs.html. This may provide a better understanding of tier systems.

Suggested Performance Standards from Monica Miller, R.N.

1. Assess child's access to health insurance and assist as needed to improve enrollment in some form of insurance.

2. All children in group setting child care should have an initial physical to assess their well-child status and be supported in staying on the EPSDT schedule.

3. For all children over three, teeth should be brushed after all meals with an ADA approved toothpaste; if less than three, provide oral cleaning after bottles or meals.

4. All children in child care should receive a dental screening.

5. Provide information and assistance in access to follow-up care.

6. Daily health checks should be done upon arrival with guidelines for exclusions and procedures to guide caregivers.

7. Provide parent education opportunities on Immunization, Lead Exposure, CPR/First Aid, Baby Bottle Tooth Decay, SIDS, Effects of Substance Abuse, Smoking Cessation, Child Abuse, etc.

8. "Appropriate" Mental Health Activities should be provided for children and families.

9. Communicate with parents regularly about their child's behavioral milestones.

10. Track successes and outcomes of services provided in early child-care settings.

11. Initiate routine hand-washing education for children and parents in all child-care settings.

12. Assess existence and provide assistance and information to overcome barriers to access, such as transportation, language, and child care for other sibling children during medical or follow-up appointments.

Agenda Item #3, Continued: Update – Other Work Groups

Discussion: CATCH Grant

In order to meet the goals/objectives in the original logic models, as different opportunities appear on the horizon, we must take advantage of them. That is how we make progress. The implementation grant is not a very large grant, and we must be prepared to secure grants from other sources to implement our work.

The CATCH grant is a small grant. The Abstract reads:

"The Arkansas Early Childhood Comprehensive Systems Initiative, sponsored by the Maternal and Child Health Bureau, is working to create a statewide plan to improve the quality of all aspects of child care in our state. A gap exists in the training of child care professionals to support a child's medical home. This project will formalize the medical component of training for child care professionals by creating a training module that can be "plugged in" to existing required trainings. The training module will include printed, video and/or computer materials that will facilitate more effective communication between parents/child's physician/child care professionals."

If funded, this grant will be used to develop a training module, probably in the form of a video with a few written materials. Beginning with the Arkansas Better Chance (ABC) programs, this resource would be part of their training. The administrators of the ABC programs come together twice a year for various training and updating opportunities. It is a requirement that the administrators must show up for the training. The ABC Coordinators have agreed to make this part of their training meetings. This resource must be capable of being used in lots of training applications. This group will have some impact on how the model will come out.

The training will be provided in regional areas by a variety of people. Every ABC administrator is expected to participate in this training and then take the training back to classroom teachers.

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Result: When talking in the Early Care and Education group about the possibility of child-care providers discussing the medical home with parents, there were some private providers who felt that it was invasive to the parents. After listening to Monica, the Medical Home group felt that it was possible to do.

If we have a five-minute video, the development of it must be methodical. It does not need to be "Hollywood" but must be well thought out.

This group must decide what is the most important information. Like most plans, we need to think large and start small. The ABC population is a great place. There are other venues that actually have classroom teachers in training for ABC.

Family Support Work Group

Family Support is looking at a way to get information out across the state related to resources for families. Currently, they are discussing using AR Access (Handout). They are looking at the site to see if it is compatible with our needs. Jackie Gorton and Susan Underwood are co-chairs of Family Support.

Family Support is asking each work group to look at the materials to determine/identify missing links (agencies) and notify the AECCS office or the agency or the chairpersons of Family Support. They are also requesting that you check out the website to determine how "user friendly" you think it is and whether you think other items should be included. Web site address: www.araccess.org. AR Access is amenable to making some changes in the web site to address our needs.

Family Support anticipate that one of their projects is to actually put in place a web site for family support, hopefully using AR Access, or developing their own. There will be a calendar of events included on the site.

Utah has a program, called Utah Clicks, where families go in and answer some basic questions, and it will direct them to the site(s) that they need.

TASKS: Look at the AR Access material and make suggestions for improvement. Also, go the web site, review the site content to see how "user friendly it is, and make improvement suggestions for discussion at the next meeting.

Agenda Item #4: Other Information

Discussion: Martha reported on one other thing that may happen. DHS/DCCECE was contacted by the magazine, Health and Safety Ideas for the Young Child. This magazine covers some basic child care issues. We have contracted to send it out to all child-care facilities. The last two pages would be personalized for Arkansas. This would be a way for information about training to be disseminated. Pediatricians could be invited to write a column. It would go directly to child-care facilities. It would be paid for from the Block Grant. We will try to post this news magazine on the web for you to view.

The license may be for the facility or for the person. There are safety requirements that must be enforced, percentage of staff to child ratio, etc. It is facility oriented.
In some states it is actually the person who owns the facility. There are different credentials that child care folks have to have. There are lots of facilities without a license. There are a lot of family day-care centers that are underground. They are not registered or licensed

There are many family child-care associations that are not licensed. We are trying to help them maintain a level of quality. HIPPY goes into homes to educate parents in order for them to educate children. Services.

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are pretty well distributed in the state. There are still some needs in the state program.

It was suggested that the definition of Medical Home be sent out with the minutes. (Attachment at end of minutes.) It was stated that the Medical Home has more to do with comprehensive health needs. The communication is between the provider, parent, and physician.

There is a mental health initiative that came together about three years ago to discuss the mental health needs of young children. They came up with a training module for community mental health centers that included in the contract they would have a professional designated as an early childhood person. Last February they invited two representatives from each community health center and brought in two mental health professors from Georgetown to talk about early childhood mental health.

There are three pilot projects that include a mental health worker relating to three to six child-care facilities. They have instituted a series of conference calls, occurring on a monthly basis, for all the mental health facilities to discuss some of the issues relating to their facility. There are ongoing series of training and other programs relating to the early mental health of children.

TASKS: Martha to have posted, Health and Safety Ideas for the Young Child, on the web site for review by the work group.

Agenda Item #5: New Meeting Date and Adjournment

Discussion: Dr. Nugent would prefer that we not meet on Mondays and Tuesdays. Stevie Cherpski cannot meet before 2:30 because of the school system—she is a school nurse. It was suggested that future meetings be held on Wednesday afternoon.

There being no further business, the meeting was adjourned.

Result: Next meeting Date: Wednesday, February 9, 2005, 2:30 – 4:30 p.m.

Note: Meeting site—
Old Choctaw Railway Station
Clinton School of Public Service
William J. Clinton Presidential Center and Park
1200 President Clinton Avenue
Little Rock, AR 72201
501-683-5200

TASKS: Martha and Paula are to send out the notice for the next meeting and locate a meeting site.

Medical Home Initiatives for Children With Special Needs Project Advisory Committee

ABSTRACT

The American Academy of Pediatrics proposed a definition of the medical home in a 1992 policy statement. Efforts to establish medical homes for all children have encountered many challenges, including the existence of multiple interpretations of the "medical home" concept and the lack of adequate reimbursement for services provided by physicians caring for children in a medical home. This new policy statement contains an expanded and more comprehensive interpretation of the concept and an operational definition of the medical home.

INTRODUCTION

The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated,[1] compassionate, and culturally effective.[2] It should be delivered or directed by well-trained physicians who provide primary care[3] and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the "medical home." In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective. Although inadequate reimbursement for services offered in the medical home remains a very significant barrier to full implementation of this concept,[4,5] reimbursement is not the subject of this statement. It deserves coverage in other AAP forums.

Physicians should seek to improve the effectiveness and efficiency of health care for all children and strive to attain a medical home for every child in their community.[6] Although barriers such as geography, personnel constraints, practice patterns, and economic and social forces create challenges, the AAP believes that comprehensive health care for infants, children, and adolescents should encompass the following services:

1. Provision of family-centered care through developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life.
2. Sharing clear and unbiased information with the family about the child's medical care and management and about the specialty and community services and organizations they can access.
3. Provision of primary care, including but not restricted to acute and chronic care and preventive services, including breastfeeding promotion and management,[7] immunizations, growth and developmental as-

sessments, appropriate screenings, health care supervision, and patient and parent counseling about health, nutrition, safety, parenting, and psychosocial issues.

4. Assurance that ambulatory and inpatient care for acute illnesses will be continuously available (24 hours a day, 7 days a week, 52 weeks a year).

5. Provision of care over an extended period of time to ensure continuity. Transitions, including those to other pediatric providers or into the adult health care system, should be planned and organized with the child and family.

6. Identification of the need for consultation and appropriate referral to pediatric **medical** subspecialists and surgical specialists. (In instances in which the child enters the **medical** system through a specialty clinic, identification of the need for primary pediatric consultation and referral is appropriate.) Primary, pediatric **medical** subspecialty, and surgical specialty care providers should collaborate to establish shared management plans in partnership with the child and family and to formulate a clear articulation of each other's role.

7. Interaction with early intervention programs, schools, early childhood education and child care programs, and other public and private community agencies to be certain that the special needs of the child and family are addressed.

8. Provision of care coordination services in which the family, the physician, and other service providers work to implement a specific care plan as an organized team.

9. Maintenance of an accessible, comprehensive, central record that contains all pertinent information about the child, preserving confidentiality.

10. Provision of developmentally appropriate and culturally competent health assessments and counseling to ensure successful transition to adult-oriented health care, work, and independence in a deliberate, coordinated way.

Medical care may be provided in various locations, such as physicians' offices, hospital outpatient clinics, school-based and school-linked clinics, community health centers, and health department clinics. Regardless of the venue in which the **medical** care is provided, to meet the definition of **medical home**, a designated physician must ensure that the aforementioned services are provided (see Table 1 for more details).

TABLE 1. Desirable Characteristics of a Medical Home

Accessible

Care is provided in the child's or youth's community.

All insurance, including Medicaid, is accepted.

Changes in insurance are accommodated.

Practice is accessible by public transportation, where available.

Families or youth are able to speak directly to the physician when needed.

The practice is physically accessible and meets Americans With Disabilities Act[10] requirements.

Family centered

The medical home physician is known to the child or youth and family.

Mutual responsibility and trust exists between the patient and family and the medical home physician.

The family is recognized as the principal caregiver and center of strength and support for child.

Clear, unbiased, and complete information and options are shared on an ongoing basis with the family.

Families and youth are supported to play a central role in care coordination.

Families, youth, and physicians share responsibility in decision making.

The family is recognized as the expert in their child's care, and youth are recognized as the experts in their own care.

Continuous

The same primary pediatric health care professionals are available from infancy through adolescence and young adulthood.

Assistance with transitions, in the form of developmentally appropriate health assessments and counseling, is available to the child or youth and family.

The medical home physician participates to the fullest extent allowed in care and discharge planning when the child is hospitalized or care is provided at another facility or by another provider.

Comprehensive

Care is delivered or directed by a well-trained physician who is able to manage and facilitate essentially all aspects of care.

Ambulatory and inpatient care for ongoing and acute illnesses is ensured, 24 hours a day, 7 days a week, 52 weeks a year.

Preventive care is provided that includes immunizations, growth and development assessments, appropriate screenings, health care supervision, and patient and parent counseling about health, safety, nutrition, parenting, and psychosocial issues.

Preventive, primary, and tertiary care needs are addressed.

The physician advocates for the child, youth, and family in obtaining comprehensive care and shares responsibility for the care that is provided.

The child's or youth's and family's medical, educational, developmental, psychosocial, and other service needs are identified and addressed.

Information is made available about private insurance and public resources, including Supplemental Security Income, Medicaid, the State Children's Health Insurance Program, waivers, early intervention programs, and Title V State Programs for Children With Special Health Care Needs.

Extra time for an office visit is scheduled for children with special health care needs, when indicated.

Coordinated

A plan of care is developed by the physician, child or youth, and family and is shared with other providers, agencies, and organizations involved with the care of the patient.

Care among multiple providers is coordinated through the medical home.

A central record or database containing all pertinent medical information, including hospitalizations and specialty care, is maintained at the practice. The record is accessible, but confidentiality is preserved.

The medical home physician shares information among the child or youth, family, and consultant and provides specific reason for referral to appropriate pediatric medical subspecialists, surgical specialists, and mental health/developmental professionals.

Families are linked to family support groups, parent-to-parent groups, and other family resources.

When a child or youth is referred for a consultation or additional care, the medical home physician assists the child, youth, and family in communicating clinical issues.

The medical home physician evaluates and interprets the consultant's recommendations for the child or youth and family and, in consultation with them and subspecialists, implements recommendations that are indicated and appropriate.

The plan of care is coordinated with educational and other community organizations to ensure that special health needs of the individual child are addressed.

Compassionate

Concern for the well-being of the child or youth and family is expressed and demonstrated in verbal and nonverbal interactions.

Efforts are made to understand and empathize with the feelings and perspectives of the family as well as the child or youth.

Culturally effective

The child's or youth's and family's cultural background, including beliefs, rituals, and customs, are recognized, valued, respected, and incorporated into the care plan.

All efforts are made to ensure that the child or youth and family understand the results of the medical encounter and the care plan, including the provision of (para)professional translators or interpreters, as needed.

Written materials are provided in the family's primary language.

The need for an ongoing source of health care—ideally a **medical home**—for all children has been identified as a priority for child health policy reform at the national and local level. The US Department of Health and Human Services' *Healthy People 2010* goals and objectives state that "all children with special health care needs will receive regular ongoing comprehensive care within a **medical home**"[8] and multiple federal programs require that all children have access to an ongoing source of health care. In addition, the Future of Pediatric Education II goals and objectives state: " Pediatric **medical** education at all levels must be based on the health needs of children in the context of the family and community" and "all children should receive primary care services through a consistent '**medical home**.'"[9] Over the next decade, 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**.

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