



Medical Homes in Idaho: Three Lessons Learned

MATERNAL AND CHILD HEALTH PROGRAM | DIVISION OF PUBLIC HEALTH
IDAHO DEPARTMENT OF HEALTH AND WELFARE

The Idaho Maternal and Child Health (MCH) Program first launched the Medical Home Demonstration in 2013 in partnership with the Medicaid Children's Healthcare Improvement Collaborative (CHIC). The goal was to determine if a medical home coordinator could effectively introduce the patient-centered medical home (PCMH) model to family and pediatric practices in rural communities and improve care for children with special health care needs. While the MCH Program funded the project, CHIC provided the quality improvement coaching and ongoing support to the medical home coordinators.

The Medical Home Demonstration came to a crossroads in December 2015. When the CHIC project ended, the MCH Program agreed to continue funding and technical assistance if the participating public health districts could find a way to provide the coaching and support. One of the districts, Eastern Idaho Public Health, took an innovative approach. The district leveraged in-house staff expertise from the Statewide Healthcare Innovation Plan (SHIP) to continue the demonstration and support the medical home coordinator.

CURRENT STATE

The Eastern Idaho Public Health District has a medical home coordinator currently serving two clinics—one rural and one urban—totaling 12 providers. Using PCMH as the foundation, the clinics are focusing their efforts on improving care and screenings related to adolescent depression, autism, Down syndrome, childhood immunizations, and well-child exams. These clinics have expressed the intention of hiring their own medical home coordinators to sustain their success once participation in the project is over.

THE SUCCESSES

Overall, the demonstration has realized increased collaboration between primary care practices and local public health districts, improved population health management and care coordination for complex and chronic health conditions among pediatric patients, and established guided quality improvement projects to improve clinic processes.

Since March 2016, the medical home coordinator has supported clinics in screening 1,119 adolescents for depression, with nearly 13% resulting in positive screens. Almost one-thousand children have been screened for autism, with 2.6% screening positive. Additionally, the rural clinic has more than quadrupled their up-to-date immunization rate for children.

THREE LESSONS LEARNED

Choose a Medical Home Coordinator who is Flexible and Persistent. In the Idaho model, a single coordinator works with two to three clinics. The coordinator helps implement the pediatric medical home through quality improvement, patient education, referral coordination, and workflow management. It's important for the coordinator to be flexible to meet the unique needs of the clinic, understand the communities they work with, and to take initiative and be persistent when working with clinics and families.

Maintain Continuous Communication. The clinic and the medical home coordinator need to work together to understand the patient population and customize the coordination to patient's needs.

Conduct Readiness Assessments. Recruiting clinics that value and are engaged in the project is critical. To maximize success, potential participating clinics should be open to change and view medical home transformation as a path to improving the health of their patient population.