Title V <u>Medical Home</u> Strategic Action Plan for CMSN

National Performance Measure (MCHBG #13): Percent of children with and without special health care needs having a medical home.				
National Performance Measure Goal (MCHBG #13): To increase the number of children with and without special health care needs who have a medical home.				
CYSHCN System Standard (National Consensus Framework for Systems of Care for CYSHCN Project): CYSHCN will receive family-centered, coordinated, ongoing comprehensive care within a medical home.				
Priority from Needs Assessment	**Objectives**	**Strategies**	**Activities**	**Performance Measures**
Enhance medical home participation in the state of Florida, especially for CYSHCN.DOH could play a role in this through CMSN. <u>Issue narrative</u> A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, and compassionate medical care. The PCMH is especially advantageous for children with special health care needs as they typically require	I. Increase the number of pediatric providers in the State who identify with a level of medical "homeness," as outlined by one of the current models.	A. Convene a stakeholder group that will define levels of medical "homeness" and method(s) for assessing pediatric providers along that continuum.	1. CMSN to establish Medical Home Stakeholder Group, comprised of internal stakeholders representing care coordinators, families/youth, ICS and primary care network personnel, as well as external stakeholders such as FPS/AAP, CHIPRA workgroup, AHCA (Year 1). 2. Review current medical home assessment tools such as NCQA, Medical Home Index, Joint Principles of the Patient-Centered Medical Home and define levels of medical "homeness" at Level 1, 2, 3 (Year 1). 3. Recommend methodology for how levels will be assessed and at what timeframes. Perform pilot testing of the process (Year 2). 4. From baseline: Create targets for CMSN-enrolled CYSHCN (Year 3). Create targets for all CYSHCN in the State (Years 4-5).	a. Using stakeholder-recommended methodology, assess pediatric providers in the State in order to establish baseline data for each level. Numerator: number of providers at level Denominator: total number of providers

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coordination of care between primary care and specialists.	II. Increase the number of CYSHCN in the State assigned to a provider who is practicing at a higher level of medical "homeness."	A. CMSN, whose statutory charge is to "Provide to children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care, " will partner with other leaders in the State to • Promote and improve CYSHCN being assigned to primary care providers who achieve some level of medical "homeness." • Provide support and education to pediatric providers in achieving higher levels of medical "homeness" from baseline.	1. CMSN to explore collaboration opportunities with the Florida Pediatric Medical Home Leadership (FPMHL) group and to encourage the FPMHL and its existing mission (Year 1). 2. CMSN to also work with FPMHL to promote medical home to all providers (Year 2). 3. Provide educational material on CMSN website: Create external links to medical home resources that all providers can access (Year 2). 4. CMSN will track the level of medical "homeness" for all CMSN-credentialed providers (Year 3).	a. Track these activities through feedback from FPMHL on tasks assigned and completed. b. Track metrics from the websites such as number of hits, number of downloads. c. Use assessment and tracking outputs from the Stakeholder group.

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	III. Increase the number of CMSN enrollees who are assigned to a CMSN provider who is practicing at the highest level of medical "homeness."	A. CMSN will ensure that all CMSN-credentialed primary care providers identify with some level of medical "homeness."	1. CMSN to create internal Medical Home Focus Group (MHFG) of CMSN-credentialed pediatric providers to seek understanding of the education and training needs of providers in medical home (Year 1). 2. Medical Home Focus Group can seek to understand barriers to providers moving from lower to higher level of medical 'homeness" (Years 2-3). 3. CMSN will provide education and training to its providers so that CMSN-credentialed providers can move from lower to a higher level of medical "homeness" (Years 3-5) 4. Create internal website links for CMSN-credentialed providers to access resources that target medical home for CYSHCN enrolled in the CMSN (Years 2-5).	a. Medical Home Focus Group meeting minutes; completed tasks. b. Record/rosters of training activities. c. Track providers attending with begin/end level of medical home. d. Track metrics from the website.
		B. CMSN to provide Care Coordination support to CMSN-credentialed primary care providers who have CMSN-enrolled children assigned to them as a standard resource to achieving a higher level of medical "homeness." Care Coordination includes but is not limited to	1. CMSN will ensure that all CMSN-enrolled children and youth are assigned to a Care Coordinator. CMSN will encourage coordinators to incorporate letters of introduction, provider office visits, and family visits during appointments (Year 1). 2. CMSN will explore options for Care Coordinator co-location within those practices that wish to achieve the highest level of medical "homeness" (Years 2-4).	a. Monitored according to CMSN Care Coordination Guidelines through quarterly QA review of electronic health records. b. CMSN Provider Satisfaction Survey. c. CMSN Customer Satisfaction Survey.

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		• Family needs assessment • Proactive care plan development • Facilitating care transitions • Education, support and coaching to families on disease-specific and general wellness topics • Coordination and tracking of referrals and test results • Use of health information technology to deliver and monitor care coordination and effectiveness of service delivery		d. Total number co-located CMSN Care Coordinators and practice site level of medical home.
		C. CMSN will create an infrastructure to provide leadership in promoting and sustaining medical home for CYSHCN including • Improving access to pediatric providers who identify with some level	1. CMSN to establish Medical Home Stakeholder Group to define levels of medical "homeness" and methodology for tracking (Years 1-2). 2. CMSN to develop internal Medical Home Focus Group to • Understand education and training needs of medical home providers (Years 1-2). • Determine barriers to providers moving from lower	a. Funding devoted to medical home activities in CMSN. b. Number of CYSHCN with a medical home as reported by National Survey. c. Number of CMSN primary care providers who move from lower to

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		of medical "homeness." • Sustaining and improving those providers who wish to move to higher levels of medical 'homeness.'	to higher level of medical 'homeness'(Years 2-3). • Explore ways to match CYSHCN to medical home providers based on acuity and level of medical "homeness" (Years 2-3) • Explore ways to incentivize providers to accept more CYSHCN or higher risk CYSHCN (Years 1-2). 3. CMSN will determine how work groups will communicate progress back to CMSN regional offices and headquarters (Year 1). 4. CMSN will develop a website devoted to advancing medical home and providing education and resources to providers, especially those of CYSHCN. CMSN will keep website up to date (Years 2-5). 5. CMSN will participate in webinars and conferences as soon as possible and regularly to promote medical home (Years 2-5). 6. CMSN will identify necessary resources for key staff to be responsible for promoting and advancing medical home and meeting the national performance measure (Year 1).	higher levels of medical "homeness." d. Record of medical home work group activities/outcomes. e. Record of CMSN attendance at webinars, conferences, and other educational activities related to medical home. f. Website metrics such as number hits and downloads; date of update(s) to site.

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	IV. Increase the number of higher acuity CMSN enrollees assigned to highest level medical home	A. CMSN to utilize acuity score as one criterion for promoting the assignment of children to practices at higher level of medical "homeness."	1. Using CMSN-approved Acuity Tool, CMSN Care Coordinators will provide acuity assessment for all CMSN-enrolled CYSHCN on enrollment and periodically, but no less often than every 6 months (Years 2-3). 2. CMSN MHFG to review this process and determine how it can be operationalized to advance medical home (Years 3-4). 3. CMSN MHFG to determine how to operationalize the match between CYSHCN and their providers based on the Acuity Score/Level (Years 3-4). 4. CMSN MHFG to create rubric to show the match rates and categories of medical home (Year 4).	a. Monitored through CMSN quarterly QA reviews in electronic health record. b. Set target match rates and assess effectiveness every 2 years.

Title V Transition Strategic Action Plan for CMSN

National Performance Measure (MCHBG #14): Percent of children with and without special health care needs who received services necessary to make transitions to adult health care				
National Performance Measure Goal: Increase the percent of youth with and without special health care needs who have received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.				
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Services for CYSHCN transitioning from the pediatric health care system to the adult system **Education and Training** Issue Narrative A systematic approach to accessing and promoting awareness of transition education will enhance the patient/provider planning and readiness process. While numerous transition resources exist, the FloridaHATS	I. Increase the percentage of CMS Care Coordinators who receive transition-specific education and training annually.	A. CMSN Care Coordinators will receive transition education and training.	1. CMSN program office will ensure transition education is added to the DOH education system (TRAIN) (Year 1). 2. Under the CMSN transition program, FloridaHATS will develop a module specific to transition education related to the care coordination process (Year 1). 3. CMSN Care Coordinators will be required to have transition education annually (Year 2). 4. Measurement of the above activities (Years 3-5).	a. Percentage of CMS Care Coordinators who complete the web-based training module on the DOH education website.

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website is a centralized location for transition resources.	II. Increase the percentage of providers and educators who receive information on how to access transition-specific education and training annually.	A. Providers are equipped with resources and education related to transition services and incorporate transition education as part of the annual well-child checkup.	1. The ICS Provider Liaison will provide physicians with information related to transition education, the transition process, and access to the FloridaHATS transition modules to enhance services provided to all youth in transition in their practices (Year 2) 2. Place FloridaHATS link on CMSN and ICS websites (Year 1) 3. CMSN will promote FloridaHATS web-based training modules among pediatric and adult physicians, nurses, social workers, and other allied health professionals (Year 2). 4. Measure all of the above (Years 3-5).	**a**. Percentage of providers who complete the web-based training module for CME credit. b. Percentage of providers who have received transition education information from Provider Liaisons.
		B. Educators are provided with resources and education related to health care transition and incorporate health care self-management skills in Transition IEPs.	1. Provide school-based transition education modules for teachers and other support staff. • Develop materials (Year 1) • Begin distribution (Year 2) • Begin measurement (Year 3)	**a.** Percentage of school-based staff who completed transition education modules. b. Percentage of IEPs of YSHCN that include health care self-management.

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Education & Training cont.	III. Increase the percentage of patients and families who receive transition-specific education and training annually.	A. Youth with and without special health care needs and their families will receive transition-specific, age-appropriate education related to the following aspects of their lives • Work • Health care • Self-determination and self-management ability (power of attorney/guardianship) • Secondary and post-secondary education	1. Place FloridaHATS link to education modules on CMSN and ICS websites (Year 1) 2. Develop anticipatory guidance sheets for specific age groups to be distributed by CMSN Care Coordinators (Year 1) 3. Develop youth ambassador program to promote and provide support for self-determination and self-management skills to youth in transition (Year 1). 4. Under CMSN Transition Program, FloridaHATS will disseminate transition information and curricula to secondary and post-secondary students (Year 2). 5. Measure all of the above (Years 3-5).	a. Percentage of CMSN enrollees who receive education materials. b. Increase in percentage of parents who report on CMSN annual surveys that Care Coordinator discussed transition.

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Services and Models of Care <u>Issue Narrative</u> Transition from youth to adulthood is a vulnerable stage in life, especially for CYSHCN. Often these adolescents and young adults lose some or all of their health care services and support when they transition from pediatric to adult health care. As a result, their care is interrupted and their health may be affected. Transition support is essential to navigating a new complex health care system and other aspects of adult life.	IV. Youth, families, and providers will have access to community-based resources necessary to facilitate and achieve successful health care transition.	A. Transition support will be provided for youth, families, and providers.	1. CMSN will identify navigators to assist providers in the development of transition policy and establishing transition-specific medical homes related to the Six Core Elements of Healthcare Transition for their practices (gottransition.org), and provide assistance with the care coordination process specific to transition assessments, care planning, and resources (Years 1-2). 2. CMSN will provide an individualized, client specific transition staffing for CMSN enrollees ages 18-21 using the existing multidisciplinary staffing model that includes oversight by a regional transition physician (Year 2). 3. Explore utilizing telehealth to provide transition services when necessary (Year 2). 4. Promote utilization of the FloridaHATS web-based Health Services Directory for Young Adults in Florida (Year 1). 5. Leverage the state Memorandum of Agreement between CMSN and the Florida Association of Community Health Centers to establish community-based partnerships between CMSN area offices and Federally Qualified Health Centers (Year 2). 6. Under the CMSN transition program, FloridaHATS will strengthen and continue to build regional transition coalitions throughout the state (Years 1-5).	a. Percentage of youth 18-21 who receive transition support. b. Percentage of CMSN regional offices who have transition navigators. c. Percentage of CMSN area offices who establish a transition team. d. Increase in regional coalition activity and outcomes. e. Increase in use of telehealth to provide transition services. f. Significant increases in transition metrics on CMSN Satisfaction Surveys.

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Infrastructure <u>Issue Narrative</u> Based on the National Performance Measure for transition and Healthy People 2020 Objective 5, transition is a high priority for all youth. Identifying a separate transition program under Title V will provide centralized coordination, advocacy and a standardized approach to transition that encompasses Got Transition's 6 Core Elements (gottransition.org). The development of a strategic plan and specific performance measures will	V. Transition is recognized as a priority for Department of Health's Title V Program.	A. CMSN implements a transition program within the CMSN organizational structure that includes specific programmatic outcomes related to quality improvement, measureable performance expectations, maintaining a transition registry and ensuring provider adequacy.	1. Identify a transition program consultant(s) and staff support for the state that are responsible for the development of the transition program and identify and implement a transition registry to collect information necessary to assess pre- and post-transition data (Years 1-2). 2. Explore more robust documentation and reporting options in the CMS data system to document and track anticipatory guidance and transition readiness based on age (Years 1-2). 3. Establish the Adolescent Health Program as a transition program partner to support transition policy and practice as a process for all youth with and without SHCN (Year 2). 4. FloridaHATS becomes a formal component of the CMSN transition program to develop and maintain (Years 1-2) • Transition registry • Transition provider network database • Webinars/teleconferences for families 5. CMSN will identify necessary resources for transition navigators, youth ambassadors, and programmatic operations (Year 1). 6. Measure above activities (Years 3-5).	a. Transition implemented as a formal priority by CMSN (central consultant and office established). b. Increase in utilization of transition registry and provider database. c. Increase in number of providers listed in database. d. Significant increases in transition metrics on CMSN Satisfaction surveys.

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ensure accountability by holding stakeholders responsible for achieving assigned objectives.				