

Central Maricopa



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CENTRAL MARICOPA REGIONAL PARTNERSHIP COUNCIL FUNDING PLAN SUMMARY

Regional Allocation: \$7,264,206

Allocation includes population and discretionary emergency response allocations

Prioritized Needs	Proposed Strategies	Portion of Regional Allocation	Recommendation to the Board
Well-educated early childhood development workforce	Strategy 1 Tuition-based college scholarships	\$880,000	Approved 12/08
Well-educated early childhood development workforce	Strategy 2 High Quality Professional Development	\$520,000	Approved 12/08
Access to health care through a medical home model.	Strategy 3 Care Coordination and Physician Training and Outreach	\$1,180,000	Recommend for Approval 8/09
Access to preventative dental care through a medical home model.	Strategy 4 Access to Dental Home	\$200,000	Approved 12/08
Limited access to quality early care and education	Strategy 5 Expand Quality First Centers	\$678,000	Approved 12/08
Limited access to quality early care and education	Strategy 6 Child Care Health Consultation	\$100,000	Approved 12/08
Limited access to quality early care and education	Strategy 7 Financial Incentives to increase access to high quality infant/toddler programs	\$772,000 \$417,000 Moved \$355,000 to emergency scholarships	Approved 12/08
Retention of highly qualified early childhood development workforce	Strategy 8 Wage Incentive Program	\$200,000	Approved 12/08
Limited knowledge and information about the importance of early childhood development and health	Strategy 9 Community Awareness Campaign	\$325,000	Hold
Lack of family support services to ensure children are healthy and well prepared to succeed in school	Strategy 10 Family Support Programs	\$720,000	Approved 12/08
Lack of coordination of existing resources and services for young children and their families.	Strategy 11 Coordination of services with other regions	\$75,000	Approved 3/09
Supporting families facing financial hardship	Emergency Response Plan: Child Care Scholarships	\$1,868,070	Approved 2/09
Supporting families facing financial hardship	Emergency Response Plan: Food boxes	\$21,136	Approved 2/09
	Regional Needs and Assets and Evaluation	\$80,000	HOLD
	Subtotal of Expenditures	\$7,264,206	
	Fund Balance	\$0	
	Grand Total	\$7,264,206	



FIRST THINGS FIRST

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August 10, 2009

Chairman Lynn and Members of the Board
First Things First
4000 N. Central Avenue, Suite 800
Phoenix, AZ 85012

Dear Chairman Lynn and Members of the Board:

The Central Maricopa Regional Partnership Council is pleased to present our updated Health Strategy for your consideration. This strategy is from our original funding plan presented to you at the State board meeting on December 4, 2008, but was held for further development by the Council.

The Council and staff convened a workgroup meeting on June 2, 2009 with community members from the health care professions to further develop our medical home health strategy. The Central Maricopa Regional Partnership Council voted to approve Health Strategy # 4 on July 15, 2009.

We are pleased to submit the following strategy for your consideration: **Increase children's access to preventive health care through a medical home model by:**

- a. Participation in the First Things First statewide Strategy of Physician Outreach and Education – the region will identify and select five (5) additional practices to participate in this strategy.
- b. Provide service coordination through Care Coordinators to provide linkages for children and their families with appropriate services and resources.
- c. Support physicians and practices to achieve certification from the National Center for Quality Assurance in being a Medical Home.

Sincerely,

Jacqueline Garner, Chair
Central Maricopa Regional Partnership Council
Joanne Floth, Coordinator

Strategy 3

Increase children's access to preventive health care through a medical home model

According to the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association (2007), the key elements of the medical home are: a physician who has an ongoing relationship with patients and arranges care with other qualified professionals; the implementation of evidence-based medicine, quality improvement measures, information technology, and patient participation in care decisions; improved access to care that includes open scheduling, expanded hours, and new options for communication with patients; and a payment system that recognizes the medical expertise, administrative requirements, and time demands of providing a personal medical home.

A medical home is not a place. It is an approach and process to healthcare in the primary care setting. It emphasizes a partnership among the patient, physician, practice staff, and, if present, the primary care giver. The practice becomes the place (or home) where patients are known, recognized and supported; where they find a centralized base for medical care and connection to other medical and supportive community services.

Piecing together health services and supports for any family is daunting, it is especially challenging for the families and service providers that serve children who are facing complex or crisis situations, including children with special health needs, children in families experiencing domestic violence, and families who are homeless.

The Needs and Assets report for the region shows there is a real need for the use of a medical/dental home model in the region. The research from both the medical/dental home model is promising. It is the Central Maricopa Regional Partnership Council's desire to dedicate a large proportion of its funding toward this strategy.

Strategy Components

A: The Central Maricopa Regional Partnership Council will collaborate with the State Board Health Strategy to conduct Physician Outreach and Education. Funding will be provided to conduct physician outreach, technical assistance and coaching to ten medical practices throughout the Central Maricopa region, including pediatric practices, family medicine, Federally Qualified Health Centers (FQHC), Community Health Centers, Indian Health Services and Tribal Health facilities.

Physician outreach and education is a quality improvement strategy with the goal of assisting physicians in identifying the health system and practice procedures that need to change or be implemented that would result in consistent quality care for children. Physicians involved in a quality improvement strategy engage in activities that includes assessment of their delivery systems and development of a plan for improvement. They will receive technical assistance and coaching as well as materials to support clinical practice improvement. Additional support may also be provided through the formation of collaborative learning groups that commit to the quality improvement process.

First Things First, at the state level, will seek proposals through the RFGA process for a three year, statewide Physician Outreach and Education Initiative to include:

- Practice assessments and implementation plans to improve the delivery of preventive service such as immunizations, lead screening, anemia risk screening, tobacco risk exposure, sleep position risk identification, dental screening, and vision screening in accordance with standards of preventive care.
- On site education and coaching on enhanced use of parent assessments, parent education and

establishment of medical homes.

- Onsite technical assistance and coaching on establishing systems to track referrals to early intervention services based on level of delay.
- Information about referral pathways and intervention services when delays are identified.
- Development of collaborative learning groups to identify barriers to quality practice and develop plans and strategies to achieve practice-based quality improvement activities.
- Integrate lessons learned and best practices in physician continuing education programs.

Year One includes outreach to build physician practice involvement and will be managed by a Practice Management Advisor. The Statewide strategy targets 50 practices in year one throughout the state, 100 practices in year two and 100 practices in year three.

The Central Maricopa Regional Partnership will fund the participation of an *additional* ten practices within the Central Maricopa Region. Attempts will be made to include a minimum of two practices for each of the communities in the region (Tempe, Chandler, Ahwatukee, Guadalupe and Southeast Phoenix).

B. The Central Maricopa Regional Partnership Council will establish Medical Home Care Coordinators for the practices chosen to participate in the Physician Outreach and Education project mentioned in part A of this strategy.

The medical home represents a standard of primary care where children and their families receive the care they need from a family physician, pediatrician or healthcare professional that they trust. Healthcare professionals in partnership with the family work with appropriate community resources and systems to achieve the child's maximum potential and optimal health. A medical home addresses well-child care, acute care, and chronic care for all children from birth through their transition to adulthood

An important component of a medical home is service coordination and case management to provide linkages for children and their families with appropriate services and resources in a coordinated effort to achieve good health. According to the Medical Home Practice-Based Care Coordination workbook (McAllistar, Presler, Cooley); "It has been suggested that you cannot be a strong medical home without the capacity to link families with a designated care coordinator.

In order to weave a sometimes patchwork of health and social services into a coherent and comprehensive system of services, the Central Maricopa Regional Partnership Council will provide care coordination through the use of Medical Home Care Coordinators. Effective care coordination enhances access to needed services and resources, promotes optimal health and functioning of children, and supports improved quality of life. Data shows that primary care physicians struggle to fulfill the care-coordination needs of children, youth, and families. Care is coordinated and/or integrated across all elements of the complex health care and social services systems (e.g., subspecialty care, hospitals, home health agencies) and the patient's community (e.g., family, schools, childcare, public and private community-based services.). Care coordinators will enhance the abilities of the physician and practice to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. It is the desire of the council that physicians and

Responsibilities of the care coordinators working with the identified practices may include, but are not limited to assisting in:

1. scheduling
2. assessing patient (and families') needs
3. planning and implementation of care
4. assurance of access to care (insurance or social services)
5. authorization of services
6. service monitoring
7. reporting to the physician regarding the coordination of care.
8. tracking referrals
9. brokering or obtaining resources
10. family support and education.
11. provide service coordination with other community resources, to make an effort to minimizing duplication and to ensuring that families receive comprehensive services as needed

Medical Home Care Coordinators will NOT be responsible for performing medical procedures or treatments, giving medical advice, writing reports generally prepared by physicians or nurses and performing routine bookkeeping, clerical or billing functions.

It is also the desire of the Central Maricopa Regional Partnership that there will be collaborative working relationships between the practices identified above, the Medical Home Care Coordinators, Quality First Child Care centers and the Child Care Health Consultants located in the region. In addition, the practices involved in the Physician Outreach and Education and Medical Home Care Coordinators will be required to actively participate in the cross regional coordination strategy of both the Central Maricopa and Southeast Regional Partnership Councils. It is through this strategy that a Family Support Network will be established to provide mechanisms to coordinate a cross-system of family support, early childhood development, early care and education, health care and parenting education programs. The Family Support Network will provide Resource Management, Network Coordination for both regions. The Medical Home Care Coordinators will work closely with the Family support Network staff to ensure the coordination of service providers.

C. Support physicians, practices and clinics involved in the learning collaborative identified in part A to fund specific activities that will increase children's access to medical homes by making necessary changes within a practice or clinic that will enhance their ability to achieve certification from the National Center for Quality Assurance in being a Medical Home.

Patient Centered Medical Homes are health care settings that facilitate partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by networks, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

The National Center for Quality Assurance offers certification in being a Medical Home. The Physician Practice Connections – Patient-Centered Medical Home (PPC®-PCMH™) program reflects the input of the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA) and others in a revision of Physician Practice Connections® to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC®-PCMH™ standards emphasize the use of systematic, patient-centered, coordinated care management processes.

Many private and public health plans and employers are considering projects to recognize and compensate

practices as patient-centered medical homes. Many large health plans, as well as Medicare and Medicaid, are planning demonstration projects to learn more about how practices can become medical homes. The quality and cost advantages of doing so will allow physicians to help families with young children address health issues in preventive care such as screening measures in vision, hearing, physical and developmental growth as well as acute care. Children with special health care needs will also benefit.

The council recognizes that many practices and clinics may not have the resources necessary to achieve certification or to implement necessary changes in order to function as a medical home. Participating practices and clinics will have support in making necessary improvements and achieving the three different levels of certification from The Physician Practice Connections – Patient-Centered Medical Home (PPC®-PCMH™).

Grants of up to \$4,000 - \$10,000. will be awarded each year to practices and clinics involved in the learning collaborative in part A of this strategy to make the necessary changes within the practice or clinic in order to achieve the nine PPC®-PCMH™ standards for medical practices to meet, including use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions and performance reporting and improvement. These changes should lead to activities that must be sustained after grant implementation.

Patient care associated with the Medical Home improves outcomes, such as health status, timeliness of care, family centeredness and family functioning. The NCQA PPC-PCMH standards provide a way to qualify and quantify care in the Medical Home.

The Central Maricopa Region will join the state board strategy in seeking proposals through the RFGA process for a three year, statewide Physician Outreach and Education Initiative for Part A of the strategy. Parts B and C will be implemented through a Regional RFGA process. Grantees must provide a clear and realistic sustainability plan following this three year funding opportunity. Proposals must also clearly demonstrate coordination with community resources to ensure that existing efforts are not duplicated.

Lead Goal: FTF will build on current efforts to increase the number of health care providers utilizing a medical and dental home model.

Goal: FTF will lead cross-system coordination efforts among state, federal and tribal organizations to improve the coordination and integration of Arizona programs, services, and resources for young children and their families.

Key Measures:

1. Total number and percentage of children with health insurance
2. Total number and percentage of children receiving appropriate and timely well-child visits
3. Total number and percentage of health care providers utilizing a medical home model
4. Ratio of children referred and found eligible for early intervention

Target Population:

Target population will include physicians, practices and clinics who currently do not use a medical home model or do not have the resources to implement a medical home model.

	SFY2010	SFY2011	SFY2012
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Proposed Service Numbers	July 1, 2009 – June 30, 2010	July 1, 2010 – June 30, 2011	July 1, 2011 - June 30, 2012
	A: 10 Practices (average 4 physicians/practice) B: 10 Care Coordinators	A: 10 Practices (average 4 physicians/practice) B: 10 Care Coordinators	A: 10 Practices (average 4 physicians/practice) B: 10 Care Coordinators

Performance Measures SFY 2010-2012

1. % of medical health care professionals that use a medical home model/Strategic target.
2. # of children with health insurance/proposed service #.
3. # of children with health insurance under 150% - 200% poverty level/proposed service #.

- How is this strategy building on the service network that currently exists:
The Regional Partnership Council intends to increase the number of families and physicians using a medical/dental home model. There are many opportunities to work with existing family resource agencies in community-based settings. Within the region there are several community-based clinics, such as the Chandler Care Center and Mountain Park Health Center and the Las Fuentes Clinic in Guadalupe. These programs have expressed interest in participating in the physician outreach and education strategy.

- What are the opportunities for collaboration and alignment:
There are opportunities to coordinate with resources already in place and build partnerships with clinics, community resources and programs to guide families and physicians to use a medical home model. Networking and collaboration of grantees and existing resources is essential. To maximize effectiveness and efficiency of training efforts, the Regional Council believes such efforts should be coordinated with professional associations such as the Academy of Pediatrics, as well as area hospitals and clinics.

The Central Maricopa Regional Partnership and the Southeast Maricopa Regional Partnership have a Coordination strategy in which the regions will develop a mechanism to provide all families with a comprehensive system of family support, early care and education, health care and parenting education programs that ensures all families have access to the information and support they need to be effective parents. Participants in this strategy will be required to participate in the network of resource providers. Having access to and the use of a Medical Home will ensure families have access to comprehensive medical care and the coordination of needed social services.

SFY2010 Expenditure Plan for Proposed Strategy

Population-based Allocation for proposed strategy	Total: \$1,180,000.
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Budget Justification:
A: Physician Outreach and Education: 10 practices @ 6,500. /yr. = 65,000.
B: Cost for ten full-time Medical Home Care Coordinators is estimated at \$80,000 each (inclusive of salary, ERE, supplies and mileage reimbursement) for a total of 800,000. The administrative entity that will employ, possibly house and supervise the Medical Home Care Coordinators will be determined through a competitive RFGA process. Medical Home Care Coordinators could be housed within the administrative agency or within specific clinics or practices depending on the determination of how best to deliver their services. A realistic sustainability

plan must be submitted with the grant proposal for these services. Examples of this may include a cost share by the Physician/Practice for the funding of the Care Coordinator in years two and three. Example: Year One: Grantee funds 100% of the FTE Care Coordinator. Year Two: Grantee funds 80% and Physician/Practice funds 20%. Year Three: Grantee funds 60% and Physician/Practice funds 40%

C. 10 practices X up to 10,000. = \$100,000. Grants from \$4,000 to \$10,000 for practices or clinics (depending on size of practice) involved in the Physician Outreach and Education Learning Collaborative to implement changes necessary to be a medical home model.