Medical Home Competencies for LEND Trainees was created through a partnership with the American Academy of Pediatrics and the Association of University Centers on Disabilities. These competencies were created out of a perceived need for trainees in Leadership Education in Neurodevelopmental and Related Disabilities (LEND) programs to receive additional training regarding their future role(s) in medical home as part of the medical home team.

Judith Holt, PhD
Co-Director, Utah Regional Leadership Education in Neurodevelopmental Disabilities Program
University of Utah
Utah State University

Michelle Esquivel, MPH
Director, National Center for Medical Home Implementation
American Academy of Pediatrics

Crystal Pariseau, MSSW
Director, Materials Development & Special Projects
Association of University Centers on Disabilities
Creating the Competencies

*Medical Home Competencies for LEND Trainees* was created in 2009-2010 through a partnership with the American Academy of Pediatrics and the Association of University Centers on Disabilities. These competencies were created out of a perceived need for trainees in Leadership Education in Neurodevelopmental and Related Disabilities (LEND) programs to receive additional training regarding their future role(s) in medical home—as part of the medical home team.

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, compassionate, and culturally effective. *It should be delivered or directed by well-trained physicians who provide primary care 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.”

Related to the interdisciplinary work that LEND trainees will be engaged in, the following is at the foundation of this effort—provision of care coordination services in which the family, physician, and other service providers work to implement a specific care plan as an organized team. The ultimate goal of this initiative is to ensure better coordination of care, via participation of an interdisciplinary team, within the medical home. It is essential for trainees to understand the core tenets of medical home and how they apply to their respective fields of expertise to ensure high-quality work as part of the medical home team.

LEND curriculum and the medical home model intersect in many areas, namely interdisciplinary teamwork and service provision, family-centered care, cultural competency, and leadership in policy and advocacy. These are concepts all LEND trainees are well versed in, regardless of their discipline, area of emphasis, or degree level. Because these areas are also the core areas of a medical home, many LEND trainees use the basic concepts of a medical home model in their careers—because they often overlap with the values used in providing other health care related services—even though it may not have been labeled “medical home training” during their coursework.

But there is more to a medical home than these four areas. Medical home competencies were written in order to ensure that LEND trainees have an understanding of, appreciation for, and experience in the medical home model of practice. Specifically, these competencies focus on the parts of a medical home that do not overlap with general LEND instruction.

With the support of the Maternal and Child Health Bureau (MCHB), a group of LEND Directors, in partnership with staff from the American Academy of Pediatrics and the National Center for Medical Home Implementation, began working on the development of medical home competencies in January 2009. After examining LEND curricula, existing LEND competencies in Maternal Child Health Leadership,
and AAP documentation on the medical home, the group was confident that through basic LEND instruction, LEND trainees are able to achieve a high level of understanding and competency in the areas of greatest conceptual and curricular overlap: (1) interdisciplinary teamwork and service provision, (2) family-centered care, (3) cultural competency, and (4) leadership in policy and advocacy. Setting these areas aside, the group found three competency areas that are unique to the medical home and where they felt trainees would benefit from additional instruction. These areas are (1) the Basic Principles of the Medical Home, (2) Organizational Capacity for CYSHCN and Families, and (3) Transition.

Each of the three competency areas is divided into individual competencies. Each competency includes recommended activities for trainees in both primary health care and allied health tracks to acquire the skill or knowledge. Recommended resources for completing the activity and for further learning are included for each competency.

**Continuing Development of the Competencies**

Medical home experts from the AAP, the National Center for Medical Home Implementation, and LEND directors will be surveyed to examine the competency areas for gaps and overlap. They will be asked to suggest activities that will ensure trainees in both primary health care and allied health professions understand and demonstrate the ability to implement medical home concepts in their career. The authors will then synthesize the suggested activities and complete this document. Beginning in the fall of 2010, the “Medical Home Competencies for LEND Trainees” document will be available to all LEND programs to test and pilot locally. Suggestions will be requested in the summer of 2011, and revisions will be made accordingly. It is the workgroup’s goal that a final set of medical home competencies for LEND trainees will be available in the fall of 2011.

**LEND Programs**

Leadership Education in Neurodevelopmental and Related Disabilities (LEND) programs provide long-term, graduate, and post-graduate level interdisciplinary training as well as interdisciplinary services and care. The purpose of the LEND training program is to improve the health of infants, children, and adolescents with disabilities. They accomplish this by preparing trainees from diverse professional disciplines to assume leadership roles in their respective fields and by ensuring high levels of interdisciplinary clinical competence.

LEND programs operate within a university system, often as part of a University Center for Excellence in Developmental Disabilities (UCEDD) or children’s hospital, and collaborate with local university hospitals and/or health care centers. This arrangement offers the expert faculty facilities and other resources necessary to provide exceptional interdisciplinary training and services.

There are currently 39 LEND programs in 32 states and the District of Columbia. Collectively, they form a national network that shares information and resources and maximizes their impact. They work together to address national issues of importance to children with special health care needs and their
families, exchange best-practices, and develop shared products. They also come together regionally to address specific issues and concerns.

The LEND program grew from the 1950s efforts of the Children's Bureau (now the Maternal and Child Health Bureau) to include children with disabilities as a Title V program priority. LEND programs are currently funded under the 2006 Combating Autism Act and are administered by the Health Resources and Service's Administration's (HRSA) Maternal and Child Health Bureau (MCHB).

While each LEND program is unique with its own focus and expertise, they all provide interdisciplinary training, have faculty and trainees in a wide range of disciplines, and include parents or family members as paid program participants and staff. They also share the following objectives:

- advancing the knowledge and skills of all child health professionals to improve health care delivery systems for children with developmental disabilities;
- providing high-quality interdisciplinary education that emphasizes the integration of services from state and local agencies and organizations, private providers, and communities;
- providing health professionals with skills that foster community-based partnerships; and
- promoting innovative practices to enhance cultural competency, family-centered care, and interdisciplinary partnerships.

**Medical Home**

According to the American Academy of Pediatrics⁷, a medical home is not a building, house, or hospital, but rather an approach to providing comprehensive high quality health care services. Pediatric health care professionals partner with families in a medical home to achieve care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

A medical home, as defined by the American Academy of Pediatrics, the American Academy of Family Physicians, the American Osteopathic Association, and the American College of Physicians, includes:

- A partnership between the family and the child's/youth's primary health care professional
- Relationships based on mutual trust and respect
- Connections to supports and services to meet the non-medical and medical needs of the child/youth and their family
- Respect for a family's cultural and religious beliefs
- After hours and weekend access to medical consultation
- Families who feel supported in caring for their child
- Primary health care professionals coordinating care with a team of other care providers

Through this partnership, the pediatric health care professional can help the family/patient access and coordinate specialty care, educational services, in and out of home care, family support, and other public and private community services that are important to the overall health of the child/youth and family.
It is important to recognize that while medical home is an approach to providing primary care services, the values are universal. When beginning to work on achieving these competencies, it is strongly encouraged that trainees discuss with their LEND faculty mentor possible placement with clinics, people, and sites that have received training and technical assistance regarding medical homes. Practices receiving state training and technical assistance as a medical home have begun to appropriately employ the medical home concept, and staff has received formal state training in doing so. These practices have implemented the accepted best-practice principles of the medical home and are excellent resources in assisting trainees to accomplish the below objectives. Trainees (and their LEND programs) should also initiate interactions with the state’s pediatrics association, state medical home improvement grant staff, and other appropriate resources to enhance learning as they proceed through these activities.

**Resources and References**

Following are select resources and references in this document which may assist LEND programs and trainees in further teaching and learning about the concept of the medical home. Additional resources to assist trainees in completing suggested activities are listed throughout this document.

**National Center for Medical Home Implementation**
The mission of the National Center for Medical Home Implementation 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 and youth 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 and youth. [http://www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)

**Medical Home State Data Portal/Website**
The Child and Adolescent Health Measurement Initiative (CAHMI), the Data Resource Center—funded by the Maternal and Child Health Bureau, Health Resources and Services Administration—has partnered with the National Center for Medical Home Implementation and the American Academy of Pediatrics to help state and family leaders quickly access data on how children and youth in each state experience receiving care within a medical home. [http://medicalhomedata.org/content/Default.aspx](http://medicalhomedata.org/content/Default.aspx)
Measuring Medical Homes
The *Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home* monograph presents various tools available and in use to identify, recognize, and evaluate a practice as a pediatric medical home. Because no one tool is recognized as the *de facto* tool to assess pediatric practices, a review of the relative merits of existing tools will help inform purchasers, payers, providers, and patients in evaluating pediatric practices.

www.medicalhomeinfo.org/downloads/pdfs/MonographFINAL3.29.10.pdf

Building Your Medical Home Toolkit
The *Building Your Medical Home* toolkit supports development and/or improvement of a pediatric medical home in practice. It also helps to prepare providers to apply for and potentially meet the National Committee for Quality Assurance (NCQA) Physician Practice Connections® Patient-Centered Medical Home™ (PPC®-PCMH™) recognition program requirements. The AAP created a crosswalk between each of the toolkit building blocks and the NCQA PPC-PCMH Recognition Program 'must pass' elements. The toolkit is organized into six building blocks that provide guidance for medical home implementation with links to downloadable tools. [http://www.pediatricmedhome.org/](http://www.pediatricmedhome.org/)

Measuring Medical Home for Children and Youth

Physician Practice Connections® - Patient-Centered Medical Home™
The 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. [http://www.ncqa.org/tabid/631/default.aspx](http://www.ncqa.org/tabid/631/default.aspx)

Author’s Note: A number of important policies and useful websites will be available soon. As these become available, we will update the competencies. Please visit [www.aucd.org/template/news.cfm?news_id=5908&id=17](http://www.aucd.org/template/news.cfm?news_id=5908&id=17) for the most updated version of the LEND Medical Home Competencies.
COMPETENCY AREA 1: Basic Characteristics of the Medical Home

Show knowledge of the medical home principles, understanding of reasons to implement those principles, and comfort in implementing those principles by completing activities that demonstrate competence in understanding each area of the principles. Select activities are suggested below, or trainees may come up with alternate activities with LEND faculty mentor(s).

### Basic Characteristics Competency 1: Demonstrate an understanding that the medical home is family-centered.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| 1.1 | Identify the principles of family-centered care in a medical home model. | • Read the *American Academy of Pediatrics Preamble to Patient-Centered Medical Home* Joint Principles and the *Joint Principles of the Patient-Centered Medical Home*. Develop a brief reflection paper comparing and contrasting a situation in your training where one or more of the Joint Principles was or was not applied. | • Read the *American Academy of Pediatrics Preamble to Patient-Centered Medical Home* Joint Principles and the *Joint Principles of the Patient-Centered Medical Home*. Develop a brief reflection paper comparing and contrasting a situation in your training where one or more of the Joint Principles was or was not applied. | • [American Academy of Pediatrics Preamble to Patient-Centered Medical Home Joint Principles](http://practice.aap.org/content.aspx?id=2063&nodeID=8002)  
• [Joint Principles of the Patient-Centered Medical Home](http://practice.aap.org/content.aspx?id=2063&nodeID=8002)  
• [Contacts for State Title V (CSHCN) Directors](https://peridata.hrsa.gov/mchb/mchreports/link/state_links.asp)  
• State Medicaid Directors: [www.nasmd.org/contact/contact.asp](http://www.nasmd.org/contact/contact.asp) Click on Home on the left side then select “Members” from the drop down list |
|   | For Primary Health Care Providers | • Attend a meeting or training session with your state’s Title V (CSHCN) coordinator; the state AAP chapter director, staff or leaders; or state Medicaid staff to identify progress toward implementing the principles of family-centered medical home across pediatric practices in state. | • Attend a meeting or training session with your state’s Title V (CSHCN) coordinator and/or the state AAP executive director, staff, or leaders, or the state Medicaid staff to identify progress toward implementing the principles of family-centered care and medical home concepts across pediatric practices in the state. | |
|   | | • In the medical home setting (where the LEND program has a working relationship) meet with the care coordinator(s) to better understand their responsibilities and roles with both the primary care provider and the families. Discuss with your Discipline Coordinator both the benefits and the challenges of this position in a medical home. | • In the medical home setting (where the LEND program has a working relationship) meet with the care coordinator(s) to better understand their responsibilities and roles with both the primary care provider and the families. Discuss with your Discipline Coordinator both the benefits and the challenges of this position in a medical home. |
| 1.2 Demonstrate the ability to apply the philosophical constructs of family-centered care and use these constructs to critique and strengthen clinical practices. | • Conduct an interview with a medical home team and identify the challenges and barriers they face in implementing the joint principles.  
• Observe a medical home team and provide a written review including a set of recommendations to strengthen clinical practices consistent with family-centered care. | • Invite a medical home team to present a seminar and write a reaction paper identifying the challenges and barriers faced in implementing the joint principles. | • Medical Home Portal: [www.medicalhomeportal.org/clinical-practice/building-a-medical-home](http://www.medicalhomeportal.org/clinical-practice/building-a-medical-home) |
### Basic Characteristics Competency 2: Demonstrate an understanding that the medical home includes family/professional partnerships.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| 2.1 | Discuss the principles of family-centered care and how to implement them so as to assure the health and well-being of children and their families through a respectful family-professional partnership. | • Review *Building a Medical Home Partnership: A Wisconsin Toolkit* and describe strategies that can be utilized when providing information on services and supports to families, to ensure that family’s ability to access these is considered.  
• Interview a representative from the state Family Voices organization or another family organization to identify the activities designed to strengthen family-professional partnerships within medical homes. | • Review *Building a Medical Home Partnership: A Wisconsin Toolkit* and describe strategies that can be utilized when providing information on services and supports to families, to ensure that family’s ability to access these is considered.  
• Interview a representative from the state Family Voices organization or another family organization to identify the activities designed to strengthen family-professional partnerships within medical homes. | • Video: *Building a Medical Home Partnership: A Wisconsin Toolkit*  
[http://wimedicalhometoolkit.aap.org/toolkit/video1.cfm](http://wimedicalhometoolkit.aap.org/toolkit/video1.cfm) |
| 2.2 | Display the ability to assess needs and mutually develop care plans using available scientific evidence, and patient and family preferences. | • Describe your approach to working with a family and creating a plan of clinical care with the family that ensures the plan of care is acceptable (medically does no harm and addresses the family’s goals) to both the patient/family and practitioner. Discuss with your faculty mentor and the family faculty.  
• Review several types of care plans and discuss their family-friendliness as well as usefulness with families and practitioners. Make recommendations for modification/improvement. | • Review several types of care plans and discuss their family-friendliness and usefulness with families and practitioners. Make recommendations for modification/improvement. | • Care plan example:  
• Care plan example:  
[www.medicalhomeinfo.org/downloads/pdfs/PediatricCarePlan-EFOF.pdf](http://www.medicalhomeinfo.org/downloads/pdfs/PediatricCarePlan-EFOF.pdf)  
• Talking with your Doctor:  
Basic Characteristics Competency 3: Demonstrate an understanding that the medical home provides coordinated services.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| 3.1 | Discuss strategies that address the needs of the child and family (e.g., medical, educational, developmental psychosocial, etc.) | • Develop a care plan (using one of the example plans at right or one used by the medical home team) with a mentor family that will facilitate coordination of services across various domains. | • Review examples of care plans at right and identify how they do (or do not) provide a structure for coordinating services across various domains. | • Care plan examples: [www.medicalhomeportal.org](http://www.medicalhomeportal.org) /clinical-practice/building-a-medical-home/care-coordination; and [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)/downloads/pdfs/PediatricCarePlan-EFOF.pdf
  • Care Notebook examples: [http://www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)/for_families/care_notebook/#examples

<p>| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |</p>
<table>
<thead>
<tr>
<th>3.2 Describe knowledge of resources within the community and state and the requirements to access them.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Find out more about your state’s Family-to-Family Health Information Center (F2F) and how that organization can assist families. Consider coordinating a conference call with the F2F in your state to learn more about the needs of families and the resources and supports provided by the F2F. Share this resource with others in your discipline.</td>
</tr>
<tr>
<td>• Visit your state page on the National Center for Medical Home Implementation website. Explore what is going on in your state related to medical home and how that might relate to better understanding of state/local resources.</td>
</tr>
<tr>
<td>• As you meet with families in clinical settings, ask if they would like to link with local and state resource and support groups for families and provide those resources as requested.</td>
</tr>
<tr>
<td>• Examine the categories of services listed at various sites or hotlines (e.g. support services, community services, specialty services, insurance, etc.) and areas of potential family need (e.g. food, shelter, safety, legal aid, etc.). Be aware of how a hotline resource list is updated and how you can assist in that process.</td>
</tr>
<tr>
<td>• Find out more about your state’s Family-to-Family Health Information Center (F2F) and how that organization can assist families. Request an in-person or virtual presentation by the F2F director for your program. Share information about this resource with others in your discipline.</td>
</tr>
<tr>
<td>• Visit your state page on the National Center for Medical Home website. Explore what is going on in your state related to medical home and how that might relate to better understanding of state/local resources.</td>
</tr>
<tr>
<td>• Identify and discuss at least five additional resource websites with relevant statewide information for families.</td>
</tr>
<tr>
<td>• As you meet with families in clinical settings, ask if they would like to link with local and state resources and support groups and provide those resources as requested.</td>
</tr>
<tr>
<td>• Complete a case study to practice identifying available resources for a family. Contact each of the identified resources to verify the resources information and how to access it.</td>
</tr>
<tr>
<td>• List of Family-to-Family Health Information Centers: <a href="http://www.familyvoices.org/info/nacfpp/grantees.php">www.familyvoices.org/info/nacfpp/grantees.php</a></td>
</tr>
<tr>
<td>• National Center for Medical Home Initiatives &amp; Resources by State: <a href="http://www.medicalhomeinfo.org/state_pages/">www.medicalhomeinfo.org/state_pages/</a></td>
</tr>
<tr>
<td>• State or local resource lines/websites (e.g. 211 call centers)</td>
</tr>
</tbody>
</table>
3.3 Develop a care plan with a child or youth and family that involves other providers, agencies, and organizations included in the care of the individual.

- Through the LEND program or the F2F, request contact with a family mentor willing to partner to develop a care plan for their child. After the plan has been completed, request their feedback on the process, the content, and if they were treated as a full partner.

- Through the LEND program or the F2F, request contact with a family willing to partner to develop a care plan for their child. After the plan has been completed, request their feedback on the process, the content, and if they were treated as a full partner.

- Care plan example: [www.medicalhomeinfo.org/downloads/pdfs/PediatricCarePlan-EFOF.pdf](http://www.medicalhomeinfo.org/downloads/pdfs/PediatricCarePlan-EFOF.pdf)

3.4 Better understand the care coordinator’s role in the practice and as a member of the team by demonstrating the ability to collaborate with a care coordinator to assist the family.

- Discuss with the medical home team how they determine which families are offered care coordination.
- What happens when a family and care coordinator are not working together effectively?
- Assist a care coordinator in supporting the family to achieve the best outcomes for their child.
- Identify one 'connection' that the care coordinator has made for a patient/family that was of benefit to them in some way (medically or otherwise) and discuss why the family felt it was a benefit.

- Using role play, ask a family to identify their care coordinator(s). Consider such options as a family requesting a new care coordinator or stating they are unhappy with their current coordinator. Consider the ethical considerations of these conversations.
- Identify one 'connection' that the care coordinator has made for a patient/family that was of benefit to them in some way (medically or otherwise) and discuss why the family felt it was a benefit.
# Basic Characteristics Competency 4: Demonstrate an understanding that the medical home is comprehensive.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| 4.1 | Understand the need to address the full range of child’s and family concerns including preventive, primary health care, and non-medical needs and work with the care team to address them. | • Evaluate a primary care clinic for standard procedures that are used for referring patients to services from other providers including but not limited to behavioral, mental, and oral health. Discuss in a small group setting, with a family member of the team, what does and does not work for families seeking to obtain referrals.  
• Meet with the medial home team and the special education coordinator/liaison in your area to better understand how the medical home can interface with the school district.  
• Discuss with families the areas where medical home and the school system need to interface for their children and how to best accomplish this. | • Identify where families might access assistance for non-medical needs in your local area using 2-1-1 or a web-based resource. Select an area (e.g. housing, transportation, utilities, food, etc.). Determine the accurateness and appropriateness of the resources listed in a specific area (e.g. housing, transportation, assistive technology, etc.). | • United Way 2-1-1 Information & Referral Search: [www.211.org/](http://www.211.org/)  
• United Way: [www.liveunited.org](http://www.liveunited.org)  
| 4.2 | Describe the importance for care to be available for ongoing and acute illnesses 24 hours a day, 7 days a week, and 52 weeks a year. | • Register to use the *Building Your Medical Home* toolkit. Review the core building blocks on Care Partnership Support and Care Delivery Management.  
• Compare and contrast the level of coverage (preventive, acute and chronic services available to patients) in a medical home with coverage provided by subspecialists and allied health clinics.  
• Assess how you promote patient access and quality communication within your medical home including the provision of urgent and emergency care. | • Register to use the *Building Your Medical Home* toolkit. Review the core building blocks on Care Partnership Support and Care Delivery Management.  
• Compare and contrast the level of coverage (preventive, acute, and chronic services available to patients) provided by specialists and allied health clinics. | • *Building Your Medical Home* toolkit. Building Block 1: Care Partnership Support. See Steps 1 and 2: [www.pediatricmedhome.org/sign_in/](http://www.pediatricmedhome.org/sign_in/) |
<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| 5.1 | Demonstrate the influence of culturally competent health care practices on individuals’ access to health services, participation in health promotion and prevention programs, adherence to treatment plans, and overall health outcomes. | • Identify a resource to access translation services for common and uncommon languages used by families.  
• Identify barriers to health care services by families who have a variety of cultural/ethnic backgrounds in your community.  
• Review the article *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs* with your supervisor/mentor, describe how the model is used/could be used/could be used more effectively in clinical settings including medical homes. | • Identify a resource to access translation services for common and uncommon languages used by families.  
• Ensure that information for community resources includes resources for families whose primary language is not English.  
• Review the article *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs* with your supervisor/mentor, describe how the model is used/could be used/could be used more effectively in clinical settings including medical homes. | • *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs*: [nccc.georgetown.edu/resources/brokering.html](http://nccc.georgetown.edu/resources/brokering.html)  
• National Center for Cultural Competence: *Cultural Competence Health Practitioner Assessment (CCHPA)*: [nccc.georgetown.edu/features/CCHPA.html](http://nccc.georgetown.edu/features/CCHPA.html) |
| 5.2 Assess the strengths of individuals and communities and respond appropriately to their needs based on sensitivity to and respect for their diverse cultural and ethnic backgrounds and socioeconomic status. | • Read the National Center for Cultural Competence data vignettes. Discuss their implications for your practice with a small group or your mentor.  
• Complete the *Promoting Cultural Diversity and Cultural Competency: Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth with Special Health Needs and their Families* and make recommendations for a self-improvement plan.  
• Discuss the role of a cultural navigator when working with families and ways in which the medical home or other organization has utilized this strategy. | • Read the National Center for Cultural Competence data vignettes. Discuss their implications for your practice with a small group or your mentor.  
• Complete the *Promoting Cultural Diversity and Cultural Competency: Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth with Special Health Needs and their Families* and make recommendations for a self-improvement plan.  
• Discuss the role of a cultural navigator when working with families and ways in which the medical home or other organization has utilized this strategy. | • National Center for Cultural Competence Data Vignettes: [www11.georgetown.edu/research/gucchd/nccc/data_vignettes/index.html](http://www11.georgetown.edu/research/gucchd/nccc/data_vignettes/index.html)  
• *Promoting Cultural Diversity & Cultural Competency: Self-Assessment Checklist for Personnel Providing Services & Supports to Children and Youth with Special Health Needs & their Families*. Select the title under: [nccc.georgetown.edu/resources/publicationtype.html](http://nccc.georgetown.edu/resources/publicationtype.html)  
## Basic Characteristics Competency 6: Demonstrate an understanding that the medical home is accessible.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| 6.1 | **Promote patient access and quality communication.** | • Register to use the *Building Your Medical Home* toolkit. Review Building Block 3, Step 1 and Building Block 4, Step 1.  
• Identify in your current setting access and communication challenges; recommend strategies to address these concerns. | • Register to use the *Building Your Medical Home* toolkit. Review Building Block 3, Step 1 and Building Block 4, Step 1.  
• Identify in your current setting access and communication challenges and recommend strategies to address these concerns. | • *Building Your Medical Home* toolkit:  
[www.pediatricmedhome.org/sign_in/](http://www.pediatricmedhome.org/sign_in/) |
6.2 Show the ability to define and discuss aspects of accessibility to health care including financial, geographic, physical, and communicative access.

<table>
<thead>
<tr>
<th>Task</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete at least two modules of the Public Health Communication’s health literacy course and discuss with your mentor</td>
<td></td>
</tr>
<tr>
<td>Read the requirements of physical access in the Americans with Disabilities Act (ADA). Evaluate and discuss in a small group setting a specific clinic or community resource in compliance with ADA.</td>
<td></td>
</tr>
<tr>
<td>Read benefits and procedures information for one or two representative medical insurance plans especially state Medicaid or similar programs, in order to assist families in understanding coverage provided. Be prepared to discuss topics such as referral procedures and medical necessity with other professionals as well as family members.</td>
<td></td>
</tr>
<tr>
<td>Research utilization requirements or incentives for primary care in one or two common medical insurance plans or federal benefits programs.</td>
<td></td>
</tr>
<tr>
<td>Understand the principles of universal design. How will structuring all areas of the medical home site assist all families in better accessing services?</td>
<td></td>
</tr>
<tr>
<td>Catalyst Center: explore strategies to address financial access barriers:</td>
<td><a href="http://www.hdwg.org/catalyst/">www.hdwg.org/catalyst/</a></td>
</tr>
<tr>
<td>Building Block 6 of the Building Your Medical Home toolkit:</td>
<td><a href="http://www.pediatricmedhome.org/sign_in/">http://www.pediatricmedhome.org/sign_in/</a></td>
</tr>
<tr>
<td>Public Health Communication’s course on health literacy:</td>
<td><a href="http://www.hrsa.gov/publichealth/healthliteracy/">www.hrsa.gov/publichealth/healthliteracy/</a></td>
</tr>
<tr>
<td>The Center for Universal Design:</td>
<td><a href="http://www.ncsu.edu/www/ncsu/design/sod5/cud/">http://www.ncsu.edu/www/ncsu/design/sod5/cud/</a></td>
</tr>
</tbody>
</table>
### Basic Characteristics Competency 7: Demonstrate an understanding that the medical home is community centered.

<table>
<thead>
<tr>
<th></th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| ✓ | 7.1 Describe the relationship between the medical home and the community to which it belongs. | • Review the current mission statement of the practice you work in and identify its relevance to the community in which the practitioner provides care.  
• Discuss with the medical home team how the practice is reflective of the needs of the community.  
• Meet with family members to discuss what they need from a medical home. | • Find the mission statement of your current practice environment or potential future practice. Discuss how this mission does/does not address the needs of the community.  
• Meet with family members to discuss what they need from a medical home. | • Building Your Medical Home toolkit - Building Block 5, Step 1 Medical Home.  
Domain 1 (Theme 1.1): [www.pediatricmedhome.org/sign_in/](http://www.pediatricmedhome.org/sign_in/) |
|   | 7.2 Describe the importance of maintaining a strong partnership between families and providers and broad based community involvement by the medical home team. | • Through discussion with the medical home team, assess the extent to which the practice uses community resources and reaches out to the community.  
• Meet with a practice family advocate, family advisory committee, or other family representatives to discuss the effectiveness of the practice’s use of community resources including those utilized by culturally diverse communities. | • Discuss the medical home team’s approach to community outreach, including methods, goals, and outcomes. Include in the discussion the outreach activities to underserved/unserved communities.  
• Meet with a practice family advocate, family advisory committee, or other family representatives to discuss the effectiveness of the practice’s use of community resources including those utilized by culturally diverse communities.  
• Discuss (with a care coordinator, family advocate, family advisory group) the ways feedback is obtained from families on both what they need in the community as well as what they are using its effectiveness. | • Building Your Medical Home toolkit -Building Block 5, Step 1 Medical Home.  
Domain 3 (Themes 3.5 and 3.6) and Domain 4 (Themes 4.1 and 4.2): [www.pediatricmedhome.org/sign_in/](http://www.pediatricmedhome.org/sign_in/) |
### COMPETENCY AREA 2: Organizational Capacity for Children and Youth with Special Health Care Needs and Their Families

Demonstrate an understanding of the Organizational Capacity of a medical home for CYSHCN and families, the different aspects involved in providing quality medical home care from an organizational perspective, and ability to implement policies and procedures consistent with that Organizations Capacity by completing activities that prove competence in understanding each area of Organizational Capacity. This competency area relates directly to primary health care providers; hence no activities are suggested for allied health provider trainees. Select activities are suggested below, or trainees may come up with alternate activities with LEND faculty mentor(s).

### Organizational Capacity Competency 1: Demonstrate an understanding of the importance of identifying and tracking CYSHCN in a medical home.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Resources For this Objective</th>
<th>Allied Health</th>
</tr>
</thead>
</table>
| 1.1 Exhibit understanding of the need to identify children and youth with special concerns in your practice, and knowledge of strategies to identify and monitor (track) children/youth with particular health conditions including the creation of a practice-wide registry. | • Describe the system of electronic medical records in a current practice or research the movement toward implementing an electronic medical record system in medical home practices within your state.  
• Meet with your state’s Title V (CSHCN) coordinator, the state AAP chapter executive director, staff or leaders, or state Medicaid staff to discuss progress toward implementing electronic medical records across pediatric practices in the state.  
• Describe the system of identifying CYSHCN in your practice or present recommendations for such a system. | • Find contacts for state Title V CSHCN Directors: [https://perfdata.hrsa.gov/mchb/mchreports/link/state_links.asp](https://perfdata.hrsa.gov/mchb/mchreports/link/state_links.asp)  
• Find contacts for state Medicaid Directors: [http://www.nasmd.org/contact/contact.asp](http://www.nasmd.org/contact/contact.asp)  
Click on NASMN Home on the left, then select “Members” from the drop down list  
• National Center for Medical Home Implementation’s Child/Adolescent Health Assessment Screener: [www.pediatricmedhome.org/pdfs/3_CSHCN_Screener.pdf](http://www.pediatricmedhome.org/pdfs/3_CSHCN_Screener.pdf) | |

| 1.2 Demonstrate the ability to describe strategies to ensure that clinical information is centralized and well organized (including use of electronic medical records EMRs). | • Discuss the challenges and possible solutions for ensuring that clinical information is centralized and organized.  
• Review strategies to centralize and organize information using the Building Your Medical Home toolkit, Building Block 3, Step 1. | • Building Your Medical Home toolkit, Building Block 3, Step 1: [www.pediatricmedhome.org/start_building/index.aspx](http://www.pediatricmedhome.org/start_building/index.aspx) | |
<table>
<thead>
<tr>
<th>1.3</th>
<th>Demonstrate the ability to assess care coordination needs and address gaps in coordination.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Utilizing family partners and or family advisory councils, assess the effectiveness of care coordination provided by the medical home. Define both strengths and areas that require strengthening.</td>
</tr>
<tr>
<td></td>
<td>• Review strategies to care coordination using the <em>Building Your Medical Home</em> toolkit, Building Block 3, Step 1.</td>
</tr>
<tr>
<td></td>
<td>• Review ways others have implemented care coordination. Think about how to support a care coordinator at your primary practice site.</td>
</tr>
<tr>
<td></td>
<td>• Indicate three providers you should regularly communicate with to improve the care of a patient with SHCN.</td>
</tr>
<tr>
<td></td>
<td>• <em>Building Your Medical Home</em> toolkit, Building Block 3, Step 1: <a href="http://www.pediatricmedhome.org/start_building/index.aspx">www.pediatricmedhome.org/start_building/index.aspx</a></td>
</tr>
<tr>
<td></td>
<td>• Cincinnati Children's Hospital Center for Infants and Children with Special Needs: <em>The Care Coordination Toolkit</em>: <a href="http://www.medicalhomeinfo.org/downloads/pdfs/CareCoordinationToolkit06.pdf">http://www.medicalhomeinfo.org/downloads/pdfs/CareCoordinationToolkit06.pdf</a></td>
</tr>
</tbody>
</table>
### Organizational Capacity Competency 2: Demonstrate an understanding of the importance of family advocate and/or family input into the practices and procedures of a medical home.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Resources For this Objective</th>
<th>Allied Health</th>
</tr>
</thead>
</table>
| 2.1 | Demonstrate the ability to solicit and use family input in a meaningful way in the design, delivery, and evaluation of the medical home. | • Describe how the family perspective is reflected in your current practice.  
• Discuss the level of involvement of the family partner/family advisory council in your practice—for instance, are they involved in the evaluation of the practice related to the components of the medical home. Review the *Medical Home Family Index* to better understand the multiple roles that families have as partners in a fully functioning medical home.  
• Use the Medical Home Family Index to assess the current level of family centeredness in the medical home and suggest possibilities for improvement. | • The *Medical Home Family Index* survey: [http://practice.aap.org/content.aspx?aid=2050&nodeID=8002](http://practice.aap.org/content.aspx?aid=2050&nodeID=8002) | }
Organizational Capacity Competency 3: Demonstrate an understanding of the importance of quality improvement in a medical home.

<table>
<thead>
<tr>
<th>No.</th>
<th>Objectives</th>
<th>Activities</th>
<th>Resources</th>
<th>Allied Health</th>
</tr>
</thead>
</table>
| 3.1 | Exhibit the ability to apply important evidence-based practice guidelines and policies and those of sufficient promise so that they can be used in situations where actions are needed. | • Review the NCQA PPC®-PCMH™ requirements [http://www.ncqa.org/tabid/631/default.aspx](http://www.ncqa.org/tabid/631/default.aspx) and be prepared to discuss them with your medical home mentor.  
• Review the “Key Clinical Activities” and description of the medical home EQIPP course developed by the American Academy of Pediatrics and discuss the approach to quality improvement that it will address. | • NCQA PPC®-PCMH™ (National Committee on Quality Assurance, Physician Practice Connections - Patient-Centered Medical Home) [www.ncqa.org/tabid/631/default.aspx](http://www.ncqa.org/tabid/631/default.aspx)  
• Accreditation Council for Graduate Medical Education (ACGME): [www.acgme.org](http://www.acgme.org) | Health |
| 3.2 | Demonstrate the knowledge necessary to complete a practice performance assessment, obtain feedback from families, and share data with staff to improve quality related to family-centered care, cultural diversity, and care coordination. | • Review how the practice currently assesses performance and make recommendations to improve the flow and possible implementation of feedback, particularly from families.  
• Examine available tools which assess practice performance including the Medical Home Index. | • Center for Medical Home Improvement [Medical Home Index](http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Full-Version.pdf) | Medical Home Improvement |
### Organizational Capacity Competency 4: Demonstrate an understanding of the payment structure for medical services for families.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Resources For this Objective</th>
<th>Allied Health</th>
</tr>
</thead>
</table>
| 4.1 Show the knowledge and ability to advocate and negotiate for improved and appropriate payment for services. | • Discuss the cost of implementing components of a medical home based on current findings.  
• Describe why traditional fee-for-service is an insufficient payment mechanism for medical home.  
• Discuss the importance of accurate coding for medical home reimbursement.  
• Building Your Medical Home toolkit: [www.pediatricmedhome.org/section6/](http://www.pediatricmedhome.org/section6/)  
| 4.2 Demonstrate an awareness of the steps to achieve medical home recognition using a continuous quality improvement approach to position a practice for improved payment. | • Review the NCQA PPC®-PCMH™ requirements and application materials (at right) related to its recognition program and complete the readiness assessment from same.  
• Review and complete the Medical Home Index. | • Physician Practice Connections® Patient-Centered Medical Home™ requirements, National Committee for Quality Assurance: [www.ncqa.org/tabid/631/default.aspx](http://www.ncqa.org/tabid/631/default.aspx)  
• Center for Medical Home Improvement: [http://www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org) |  |
| 4.3 Exhibit an understanding of medical home payment options including: prospective per member per month payment (PMPM); traditional fee for service payments (FFS); payment for infrastructure charges; and payment for quality or performance. | • Review the information found in the *Building Your Medical Home* toolkit on medical home payment options. Contact your state AAP chapter to determine whether the chapter has a pediatric council and determine if that pediatric council has discussed the possibility of work related to medical home.  
• Determine whether your state is involved in a Children’s Health Insurance Program Reauthorization (CHIPRA) program or other medical home demonstration program. Determine whether there is a pediatric focus or pediatric involvement in the state’s CHIPRA grant and what elements of payment/financing are being considered as part of this pilot program. | • *Building Your Medical Home* toolkit: [www.pediatricmedhome.org/section6/](http://www.pediatricmedhome.org/section6/)  
**COMPETENCY AREA 3: Transition**

Transition does not occur at a single point in time, but rather throughout a child’s lifespan. Many transitions can be a challenging time for children and families; this competency focuses solely on the transition from pediatric to adult health care. Show your knowledge of the importance of the Transition process in a successful Medical Home practice and the ability to work with the family and other providers to ensure a successful transition from pediatric to adult health care by completing activities that demonstrate your competence in understanding Transition and the Medical Home. Activities are suggested below, or you may develop alternate activities with your LEND faculty mentor.

A number of important policies and useful websites will be available soon. As these become available, we will update the competencies. Please visit [www.aucd.org/template/news.cfm?news_id=5908&id=17](http://www.aucd.org/template/news.cfm?news_id=5908&id=17) for the most updated version of the LEND Medical Home Competencies.

### Transition Competency 1: Demonstrate a family to youth focus in providing transition services.

<table>
<thead>
<tr>
<th>✓</th>
<th><strong>Objectives</strong></th>
<th><strong>Activities</strong> For Primary Health Care Providers</th>
<th><strong>Activities</strong> For Allied Health Providers</th>
<th><strong>Resources</strong> For this Objective</th>
</tr>
</thead>
</table>
| 1.1 | Demonstrate the ability to discuss the process of partnering with the child and youth as their choices and preferences become more critical in the decision-making process. | - Describe and discuss the strategies needed to address early, middle, and late transitions for youth with special health care needs and their families.  
- Discuss A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs and identify the role you play in implementing the recommendations. | - Read about transition for youth with special health care needs from the Healthy and Ready to Work National Resource Center.  
- Discuss A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs and identify the role your discipline may play in implementing the recommendations. | - GotTransition.org: [http://gottransition.org](http://gottransition.org)  
- A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs: [http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/6/S1/1304](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/6/S1/1304) (a new AAP/AAFP/ACP clinical report is expected in July 2011: link TBA) |
| | Select one of the critical areas below and, with appropriate permission, implement the activity with a youth and their family.  
- Have youth and family complete a health history summary. | Select one of the critical areas below and, with appropriate permission, implement the activity with a youth and their family.  
- Review resources to enhance family and youth skill advancement to prepare for transition in early, mid and late teens. | - Health History Summary: [http://depts.washington.edu/healthtr/healthhistory/default.html](http://depts.washington.edu/healthtr/healthhistory/default.html) |
| 1.2 Demonstrate strategies to support both families and youth in areas of dispute. | - Discuss and determine strategies to ensure young adults are offered privacy from family members for clinical examinations and discussions.  
- When necessary, facilitate communication regarding clinical decisions between families and young adults. Strategize with the interdisciplinary team ways to facilitate interactions when necessary.  
- Read the Transition Timeline for Children and Adolescents with Special Health Care Needs. Reflect on ways to help youth achieve independence in their own health care and in other areas of life as they grow. | - Discuss and determine strategies to ensure young adults are offered privacy from family members for clinical examinations and discussions.  
- When necessary, facilitate communication regarding clinical decisions between families and young adults. Strategize with the interdisciplinary team ways to facilitate interactions when necessary.  
- Read the Transition Timeline for Children and Adolescents with Special Health Care Needs. Discuss ways to help youth achieve independence in their own health care and in other areas of life. | - Transition Information on Health Care for Adults with Specific Diagnoses: [http://depts.washington.edu/healthtr/Providers/adult.htm](http://depts.washington.edu/healthtr/Providers/adult.htm); scroll down to the information for adult providers  
- Transition to Adulthood: Services to Consider: [http://depts.washington.edu/healthtr/](http://depts.washington.edu/healthtr/) - select Transitions, then select the relevant information |
Transition Competency 2: Demonstrate an ability to link children, youth, and families to appropriate adult health care services and supports.

<table>
<thead>
<tr>
<th>✓</th>
<th>Objectives</th>
<th>Activities For Primary Health Care Providers</th>
<th>Activities For Allied Health Providers</th>
<th>Resources For this Objective</th>
</tr>
</thead>
</table>
| 2.1 | Demonstrate your knowledge of strategies to support transition from pediatric to adult health care systems. | • Review the joint AAP, AAFP, and ACP clinical report on health care transition and become familiar with the process of the care algorithm that is at the center of that report.  
• Analyze the process of care in a pediatric medical home and consider practical tools that would lead to the appropriate transition from a pediatric to an adult model of care and, where needed, the eventual transfer of care to an adult medical home. Demonstrate the understanding that this can only come about through preparation (of those involved – youth, family, providers), planning, and implementation. | • Compile resources to be included in a directory of physicians and other providers who are capable and willing to treat young adults with special health care needs to avoid gaps in care. Ensure family and young adult feedback.  
• Discuss effective strategies of supporting youth with the Healthy and Ready to Work Youth Advisory Toolkit.  
• Discuss your discipline’s approach to the prevention of secondary conditions. | • American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians-American Society of Internal Medicine: A Consensus Statement on Health Care Transitions for Young Adults with Special Health Care Needs: [http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/6/S1/1304](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/6/S1/1304)  
• GotTransition.org: [http://gottransition.org/](http://gottransition.org/) |
| 2.2 Demonstrate knowledge of what is required to assure a successful transfer of care to adult providers through preparation of the youth/family; effective health care transition planning; advance personal communication with the prospective adult provider; transmission of useful, concise, and well-organization health information; and planning for follow-up until the transfer of care is complete. | • Reflect on how you can work with youth and families to ensure their adult care provider is well informed. Reflect on adequate preparation of the transitioning youth/family for the adult health care system: organized key health care information; physician-to-physician communication prior to the transition; planning for helpful follow-up consultation after the transfer; and reimbursement strategies for the care coordination aspects of a successful transfer.  
  
• Review and demonstrate a familiarity with at least one readiness checklist for transitioning youth and consider how it would be applied in a primary care medical home.  
  
• Demonstrate a familiarity with effective tools for the transfer of health information between pediatric and adult health care providers, e.g., portable medical summary; active care plan; emergency protocol/plan; and condition-specific fact sheets. | • Reflect on how you can work with youth and families including adequate preparation of the transitioning youth/family for the adult health care system: organized key health care information; and a plan for helpful follow-up consultation after the transfer.  
  
• GotTransition.org: [http://gottransition.org/](http://gottransition.org/) |
APPENDIX A

The goal of the EQIPP Medical Home for Pediatric Primary Care course is to help pediatric health care providers create plans for improvement to address gaps identified in key activities of the medical home. Using EQIPP, pediatric health care providers will collect baseline and follow-up data and work to improve care and processes delivered by your medical home through Plan, Do, Study, and Act (PDSA) cycles.

This EQIPP course will focus on the following key activities related to medical home:

- Developing a highly functioning, multidisciplinary quality improvement team
- Knowing and managing your patient population
- Enhancing access to care
- Providing family-centered care
- Providing and documenting planned, proactive, comprehensive care
- Coordinating care across all settings

Objectives

By the end of the EQIPP Medical Home for Pediatric Primary Care course, you will be able to:

**Develop your practice’s “medical homeness” in the following ways:**

- Form a team for medical home improvement.
- Develop a system such as a registry to identify and manage your patient population or one or more subpopulations.
- Cultivate a personal and ongoing relationship with each patient to provide first-contact, continuous, and comprehensive care; enhance access to care to ensure care is delivered when, where, and how it is needed and wanted.
- Develop family-centered partnerships with families, respecting that they are the constant in their child’s life; apply principles of family-centered care.
- Identify ways to plan, manage, document, and follow-up on patients’ preventive, acute, and chronic health care needs, while also addressing their educational, developmental, and behavioral/psychological needs.
- Develop processes to coordinate care across care settings to ensure shared goals of care and timely and optimal communication and information exchange.

---

i Figure reflects the current number as of 08-01-09.
Measure and improve care delivery and processes in your medical home by doing the following:

- Collect and analyze baseline data to establish a starting point for medical home improvement.
- Identify one or more performance gaps in one or more key activities of the medical home.
- Create an improvement plan for closing the performance gap(s) you identified by clarifying the improvement idea to be tested:
  - Aim: What are we trying to improve or accomplish?
  - Measures: How will we know that a change made is an improvement?
  - Changes: What changes can we make that will result in improvement?

Test your ideas quickly, on a small scale, so you can determine if the change leads to improvement:

- Collect and analyze follow-up data to measure the results of your test.
- Determine how to sustain successful changes and how to systematically integrate them into the culture, process, and workflow of your medical home.
- Create additional improvement plans and repeat the change-improvement cycle until you reach your maximum potential of being a high-quality, effective medical home.