Texas Medical Home Workgroup (MHWG)

Five Year Strategic Plan

MISSION & VISION

MISSION To enhance the development, and promote the principles of the Patient-Centered Medical Home model within the state of Texas for all children and youth including those with special health care needs.

VISION All children and youth in Texas, including children with special health care needs (CSHCN), will have a medical home that provides accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent services.

STRATEGIC ISSUES

1. Families, providers and other key stakeholders need education, resources, and support for medical home development activities
2. The statewide promotion and focus of medical home implementation needs to continue to be expanded
3. To improve outcomes, best practices related to medical home should be collected and disseminated in practice
4. Partnerships between providers, families and other key stakeholders need to be strengthened
5. Support, education, and advocacy are needed regarding reimbursement for services provided within the context of a medical home
6. Youth without medical homes are less likely to successfully transition to adulthood

BEST PRACTICES* & THEORETICAL FRAMEWORKS

- Joint Principles of the Patient-Centered Medical Home[1]
- Standards for Systems of Care for Children and Youth with Special Health Care Needs (CYSHCN)[2]
- Life Course Framework
- National CLAS Standards[3]

FOUNDATIONAL ACTIVITIES

- Engagement
- Education
- Assessment
- Promotion of medical home best practices
- Supporting value-based payment principles
- Building strategic partnerships
- Collaboration

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[1] American Academy of Family Physicians. (2008). Joint principles of the Patient-Centered Medical Home. Delaware Medical Journal, 80(1), 21.

[2] http://www.amchp.org/programsandtopics/CYSHCN/Documents/Standards%20Charts%20FINAL.pdf

[3] https://www.thinkculturalhealth.hhs.gov/content/clas.asp

* Best practices include but are not limited to the resources and references listed under *Best Practices & Theoretical Frameworks*

GOALS	OBJECTIVES	STRATEGIES
1. Engage CYSHCN, their families, physicians, and other stakeholders to promote medical home implementation in Texas Strategic Issues Addressed: 2) The statewide promotion and focus of medical home implementation needs to continue to be expanded 4) Partnerships between providers, families and other key stakeholders need to be strengthened 5) Support, education, and advocacy are needed regarding reimbursement for services provided within the context of a medical home	▪ Annually, engage CYSHCN and/or their families to complete a survey to assess barriers to obtaining care within a medical home ▪ Annually, engage physicians to complete a survey to assess barriers to implementing medical home services	▪ **Assess** barriers to obtaining care within a medical home for CYSHCN and their families ▪ **Assess** barriers to implementing medical home services for physicians
	▪ By 2020, increase CYSHCN participating in the MHWG by 2 members ▪ By 2020, increase family members of CYSHCN participating in the MHWG by 2 members ▪ By 2020, increase physicians participating in the MHWG by 8 members ▪ By 2020, increase payers represented on the MHWG by 4	▪ **Identify and recruit** CYSHCN, their families, physicians, payers and other stakeholders interested in participation in the MHWG
	▪ By 2020, increase the percentage of families who receive family-centered care within a medical home ▪ By 2020, increase the percentage of medical home providers who are supported in medical home activities	▪ **Connect** families, physicians, other providers, payers and other key stakeholders ▪ **Promote family professional partnership** by empowering families and professionals through education

GOALS	OBJECTIVES	STRATEGIES
2. Educate CYSHCN, their families, physicians, and other key stakeholders on the medical home model <u>Strategic Issues Addressed:</u> 1) Families, providers and other key stakeholders need education, resources, and support for medical home development activities 3) To improve outcomes, best practices related to medical home should be collected and disseminated in practice 5) Support, education, and advocacy are needed regarding reimbursement for services provided within the context of a medical home	▪ Annually, engage CYSHCN and/ or their families to complete a survey to assess care coordination ▪ Annually, engage physicians to complete a survey to assess understanding of medical home best practices	▪ **Assess** CYSHCN, family, and physician understanding of medical home best practices
	▪ By 2020, increase the percentage of CYSHCN and their families who are provided education about receiving care within a medical home by 2% ▪ By 2020, increase the percentage of physicians who are provided education about medical home by 2%	▪ **Educate and reach out** to CYSHCN and/or their families and physicians to increase understanding of medical home best practices ▪ **Promote** the implementation of medical home best practices*

GOALS	OBJECTIVES	STRATEGIES
3. Increase statewide medical home capacity to provide health care transition services for CYSHCN in collaboration with the TTVTW <u>Strategic Issues Addressed:</u> 6) Youth without medical homes are less likely to successfully transition to adulthood	▪ Annually, engage CYSHCN and/ or families to complete a survey to assess level of medical home and transition services ▪ Annually, engage physicians to complete a survey to assess understanding of health care transition and medical home	▪ **Assess** CYSHCN and/or their families and physician's understanding of health care transition services within a medical home
	▪ By 2020, increase the number of CYSHCN and their families who are provided education on health care transition by 2% ▪ By 2020, increase the number of pediatricians caring for adult patients provided education on health care transition best practices by 5% ▪ By 2020, increase the number of physicians caring for adult patients provided education on health care transition best practices by 5%	▪ **Educate and reach out** to CYSHCN, their families, physicians, and other stakeholders to improve understanding of health care transition ▪ **Support** the implementation of health care transition best practices within a medical home setting
	▪ By 2020 increase the number of physicians who are provided support in medical home transformation by 5%	▪ **Support** initiatives increasing medical home capacity