
Learning to Implement the Medical Home in Communities

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Abstract

Practicing the Medical Home within communities is prefaced by university training through pediatric residency programs. Through collaboration experiences, future and practicing pediatricians can learn skills to form effective interprofessional relationships, thereby supporting families and children. Seeing parents as enabled partners and creating interdependent relationships with community members and professionals, enhances the medical home's broad base of support for families.

"A medical home is not a building, house or hospital, but rather an approach to providing health care services in a high-quality, cost-effective manner. Pediatricians and parents act as partners in a medical home to... access all the medical and non-medical services needed to help children and their families achieve their maximum potential."¹

As we approach the 21st century, children are increasingly being affected by what pediatrics calls the "new morbidity".² The new morbidity refers to the developmental and behavioral problems which pediatricians are seeing exhibited in their patients within the last two decades.³ As a tragic example of the new morbidity, the Colorado school shooting raises immediate questions as to the role of the family and the pediatricians in communities. Increasing social and behavioral problems—e.g., AIDS, child abuse and neglect, substance abuse, teen sexuality and school failure—plague our communities.

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Research indicates that parents and children today are at higher risk for negative outcomes in both physical and social-emotional health arenas. In *Health Trends in Hawaii*,⁴ the data show increases in the number of incidences for abuse and neglect for younger children (birth to 5). It also notes that low birthweight, associated with smoking and drug use during pregnancy, often leads to poor development. Unintentional injury was the highest cause of deaths for four to five year olds. Childhood asthma continues to be the most prevalent condition occurring in child health. The primary care pediatrician is often the central point between the family and the larger community. How then do pediatricians advocate and contend with the contemporary challenges of practice in communities?

National and Local Movements

Perhaps pediatricians can be assured that they are not going it alone. These new challenges are being addressed at the federal, state and local levels. In 1987, U.S. Surgeon General, C. Everett Koop, M.D., ScD. called for a national agenda for children and their families, emphasizing commitment to family-centered, community-based, coordinated care. Historically, in 1986 the Hawaii Medical Association (HMA) led the first pilot of the medical home with primary care pediatricians, under the leadership of Calvin C.J. Sia, MD. The medical home has since been recognized nationally by the American Academy of Pediatrics (AAP) and the federal Maternal and Child Health Bureau (MCHB). Over ten years later, MCHB has expanded its federal commitment to promoting medical home and integrated services in University education and training programs. HMA received one of only three federal demonstration grants funded to promote family-centered care and interprofessional collaboration among students in medicine, social work and education through University programs. The three grant programs were HMA's Health and Education Collaboration Project (HEC), Partnerships for Change from the University of Vermont and the Higher Education Curricula for Integrated Service Providers from Western Oregon State University.

Families, too, have organized nationally. Core support for families across the country, as well as parent-professional collaboration, have been provided through national organizations such as Family Voices,⁵ a grassroots network of families and friends speaking on behalf of children with special health care needs. Josie Woll is one of the national founders of Family Voices. She lives in Hawaii and supports their mission both nationally and locally.

Communities have become the focus of a national effort to strengthen families. The Carnegie Corporation of New York alerted the nation of the "quiet crisis"⁶ particularly for those families with children birth to three. The report made four recommendations: 1) Promote responsible parenthood, 2) Guarantee quality child care

choices, 3) Ensure good health and protection and 4) Mobilize communities to support young children and their families. The fourth recommendation highlighted infusing community building strategies as a way to strengthen the health and well-being of families and communities. Carnegie, committed to this effort, funded promising states (10) and cities (6) to work with government and communities. Hawaii was selected and is working in three communities, Koolauloa, Ewa and Hilo/Puna, through the HMA and the Good Beginnings Alliance (GBA), a statewide, non-profit early childhood coordinating mechanism and community-based organization. For the past year, HMA and GBA in collaboration, have worked with the Hawaii State government to adopt the shared outcome that all children are healthy, safe and ready to succeed in school.

Under the newly created Community Pediatrics Division, the American Academy of Pediatrics (AAP) has adopted a 1999 policy statement highlighting that "the role of the pediatrician is to promote the health and well-being of *all* children in the communities they serve." Pediatricians must have a perspective that enlarges [their] focus, recognizes the family within the larger community, enables a practice and public health synergy, and commits to using community-based services in collaborations with significant key members involved in the child's care.⁷ The AAP promotes such programs as Community Access to Child Health (CATCH), which offers funding to pediatricians who are willing to work in their communities. The Hawaii Chapter AAP was recently awarded funds to support collaboration between the community pediatricians, pediatric residents and child care centers.

Cross-Cutting University Collaborative Education

Pediatric residency programs across the country are meeting the new challenges to prepare future pediatricians to work in communities. Recently, the American Council on Graduate Medical Education (ACGME) Residency Review Committee recommended, in its program requirements, increasing time spent in Ambulatory Pediatric Training to as much as 50%, including time spent in Community Pediatrics.⁸

Through the HMA's HEC Project, the University of Hawaii Manoa (UHM) John A. Burns School of Medicine (JABSOM) Pediatric Residency Program, has achieved a major accomplishment in learning to implement the medical home in communities. Over four years, 46 medical residents field tested a collaborative curriculum as they rotated into the training and all program sites, Healthy and Ready to Learn Center (HRTL) in Ewa⁹ was formed as a result of a partnership with the Consuelo Zobel Alger Foundation, Child and Family Service, Kapiolani Medical Center for Women and Children and the HMA. Staffed by a team of professionals—a nurse practitioner, social worker and early childhood educator, HRTL provided prenatal and postpartum care, routine well child care, child development information, parent-child activities, supportive counseling and referral services. Both pediatric and ob-gyn faculty rotated residents into HRTL to work with staff and families. In its fourth year, two new community sites — Parents and Children Together (PACT) in Kalihi-Palama and Waipahu Elementary School/Head Start, an early childhood, special education collaboration — agreed to work with the University and HEC to host a rotation for an interdisciplinary student team, comprised of a pediatric resident and

social work and education graduate students.

Prompted by the critical thinking processes of the project, the HEC Project team evaluated their traditional roles. UHM School of Social Work faculty Ron Matayoshi adapted existing pediatric resident training for use with the "Ho'opili" team of students during their practicum at PACT. Working with the HEC faculty team, Louise Iwaishi, MD, Director of Ambulatory Pediatrics, instituted an innovative community health rotation.¹⁰ Her openness to the other disciplines, a win-win attitude and a "just do it" style enriched the development of the new rotation. As a sustaining outcome of this project, the community health rotation incorporated interactive techniques drawn from the other disciplines. The residents participate in home visiting and journal writing, as influenced by the school of social work, develop portfolios, as modeled by the college of education, and experience guided learning, a school of medicine component. Dr. Iwaishi has also demonstrated how partnerships with community enriches resident education. As Haggerty points out:

The university possesses some but not all of the knowledge, skills and manpower. Partnership with other institutions—hospitals, health departments social and educational services, businesses, and community foundations—and with private practitioners as well as local citizens groups is necessary.¹¹

The HEC faculty team supported this community partnership by securing a commitment from their department Deans — College of Education, Schools of Medicine, Social Work, and Nursing, and the College of Tropical Agriculture and Family Resources — to promote the concept of interprofessional collaboration. The Deans also provided representation at the February 1999 "University and Community-Based Partnerships in Early Childhood" conference.¹² Leaders from the community, philanthropic, medical, educational and human service sectors met for a one-day conference surrounding the needs of communities and families of children with special needs, and promoting partnerships like those so successfully demonstrated in Dr. Iwaishi's Community Health Rotation.

Many lessons learned during these four years, through team development, training and evaluation,^{13,14,15,16} point out the need to build on interpersonal capacities, and to learn collaborative skills critical to creating more effective partnerships with diverse families. The most important lessons highlighted the need for increased capacities in areas such as building trusting relationships, fostering commitment, and negotiating. These skills are key to sustaining the relationships. The greatest community challenge is finding community-based staff as competent role models for family-centered interprofessional collaboration. Many institutional barriers exist that keep students in discipline-specific settings, i.e., hospitals for physicians, classrooms for teachers. This is understandable. Physicians must learn the practice of medicine and teachers must learn to teach. However, if new ways of working with families and communities are to be developed, the format for educating the new practitioner must change. Resistance to change is a common phenomenon. Change disrupts the status quo and may cause disequilibrium. Yet the University faculty and the community program site, PACT, were willing to meet the challenge, experience the stress and imbalance of change, and still continue the collaboration. All are

enthusiastically seeking resources to sustain the effort. They have demonstrated that a strong commitment to community partnership is needed to break the “hidden ceiling on scale”¹⁷ or risk succumbing to the towering bureaucracy that allows little leverage to University “rock climbers”.

Family-Centered Interprofessional Collaboration A Two-Module Pediatric Resident Curriculum

Pediatric resident training was based on the seven principles of family-centered interprofessional collaboration. (see Table 1) The project produced a training manual¹⁸ with two modules, containing activities designed to promote the attitudes, skills and knowledge required to provide services that empower families and encourage collaboration among professionals. The two modules are: Part I: Family-Centered Care and Part II: Interprofessional Collaboration. Each part is separated into four sections.

In Part I, Section I, elements of family-centered care are introduced and scenarios of relevant family issues, which impact pediatric care, are presented. Section II explores working with families from different cultures defined by race, religion, ethnicity, and socioeconomic status, and suggests strategies for becoming culturally competent. Section III explores the definition of Children with Special health care needs (CSHCN) and the special health, educational and social needs of children who are biologically or environmentally at-risk for developmental delays. Section IV suggests guidelines for effective communication, including breaking diagnostic news and interviewing families regarding psychosocial problems.

In Part II: Interprofessional Collaboration, Sections I and II look at the need for interprofessional collaboration by addressing the multiple risk factors affecting children. These sections consider the disparate philosophies of the medical home, nurse practitioners, early childhood educators and social worker. Sections III and IV attempt to integrate disparate roles by creating opportunities for participants to understand their communication styles, which may help or hinder their effectiveness.

sity performed the evaluation by collecting data from project documents, conducting in-person semi-structured interviews and observing training activities. The outcome evaluation included interviews of the social work and education graduate students and a self-administered structured questionnaire completed by the pediatric residents of their perceived competence and interest.

Dr. Duggan concluded the following in the formative evaluation:

- 1) Because the underlying philosophy of interprofessional collaboration is innovative and difficult to explain in the abstract, it is extraordinarily difficult to develop a training program and service program in tandem.
- 2) Program development requires buy-in from all collaborating agencies.
- 3) Training program success depends heavily on individuals.
- 4) Varying degrees of faculty buy-in compromise program impact. It can take several years to elicit active participation of faculty across professions.
- 5) Scheduling constraints that limit student exposure to the training program compel faculty to find imaginative ways to make the most effective use of available time.

The Outcome Evaluation revealed that the residents (12) who completed the questionnaire rated their competence in community pediatrics as high. Dr. Duggan reported:

“Ten rated their interest in community pediatrics as high, five with a score of 5 and five with a score of 4. The two residents who rated their interest as low were among those with lower perceived competence scores. Residents rated themselves most highly in communication (Item 6, ability to communicate and establish rapport and Item 8, the ability to communicate with family and others to engage in decision making). They rated themselves lowest in the areas of coordination (Item 9, ability to coordinate the family and professionals to ensure improved services and consultation, and Item 5, being a consultant to a non-health system).”

The outcome evaluation tool, modified from Bradley and colleagues,²⁰ is presented in Table 2.

Implications for the New Primary Care Pediatrician

The concept of *medical home* requires demonstrated competence in seven major areas. As excerpted from AAP policy statement:

The American Academy of Pediatrics believes that the medical care of infants, children and adolescents ideally should be *accessible, continuous, comprehensive, family centered, culturally competent, coordinated and compassionate*. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them.²¹

What does this mean for the new primary care practitioner? The call for community engagement and new practices with families and other professionals suggests four practice strategies.

Respect the Family's Story. In the context of family-centered care, a critical question, again, is learning “What is the family's

Table 1. – Principles of Family-Centered Interprofessional Collaboration
<ul style="list-style-type: none"> • Promotes a relationship in which family members and professionals work together to ensure interagency coordination to provide improved services for the child and family. • Recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship. • Acknowledges that the development of trust is an integral part of the collaborative relationship. • Facilitates open communication so that families and professionals feel free to express themselves. • Creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored. • Recognizes that negotiation is essential in a collaborative relationship. Brings to collaborative relationships the mutual commitment of families, professionals, and communities to meet the needs of children and their families through a shared vision of how things could be different and better.

Evaluation

The evaluation of this training incorporated a formative evaluation process in the first three years and outcome evaluation in the fourth year.¹⁹ Anne K. Duggan, ScD of the Johns Hopkins Univer-

**Table 2. – Community Pediatrics Rotation
Pediatric Resident Self-Evaluation**

Name _____ Today's Date _____
 Month of Rotation _____ *
 *In _____ (month/year) you completed a rotation at _____
 In evaluating this rotation we would be grateful for your impressions and self evaluation.

RANK YOUR COMPETENCY IN THE FOLLOWING AREAS:
 Please circle the number 5 to 1 which best represents your competency with 5 being the highest rank and 1 being the lowest.

1. **Clinical Judgment:** How well could you integrate scientific data, clinical finding, family factors, cultural considerations, social milieu and community resources in making diagnoses and intervention plans for individuals being seen in community (non-clinical) settings?
 5 4 3 2 1
2. **Use of Community Resources:** If you were practicing in a setting without social services or other services linking you to community resources, how would you rate your ability to access and utilize community resources that provide effective, age-appropriate, language-specific, and culturally competent assistance that match the needs of underserved patients/families?
 5 4 3 2 1
3. **Provision of Health Education:** How would you rate your ability to provide groups of children/adolescents/families with age appropriate, understandable health information and assistance with health-related decision-making and skill building?
 5 4 3 2 1
4. **Knowledge Related to Physician's Role in the Community:** How would you rate your ability to differentiate roles for physicians in the community (primary care provider, advocate, and consultant to child-serving agencies)?
 5 4 3 2 1
5. **Being a Consultant to a Child-Serving, Non-Health System:** How would you rate your ability to serve as a consultant or representative for a school system, day care facility, or other child-serving agency in the community?
 5 4 3 2 1
6. **Relationships with Non-Physician Collaborators:** How would you rate your ability to communicate and establish rapport with non-physicians who provide services to children and their families in schools, community agencies and social services?
 5 4 3 2 1
7. How would you rate your ability to convey your recognition of the knowledge, skills, experience, culture and values that families and non-medical professionals bring to the physician/family professional partnership?
 5 4 3 2 1
8. How well can you communicate (i.e. openness, trust and respect) with the family and professionals to engage in a decision-making process for at least one improved child health outcome?
 5 4 3 2 1
9. How would you rate your ability to coordinate the family and professionals you work with to ensure improved services for your patient?
 5 4 3 2 1
10. **Overall Skill:** Please rate the extent to which you now have the skills you need to conduct a community-oriented practice.
 5 4 3 2 1
11. **Overall Interest:** Please rate your overall interest in being active in the community as part of your pediatric practice.
 very interested.....moderately.....not at all
 5 4 3 2 1

story?" Successful implementation of the medical home relies on the pediatrician's skill in learning about the family's unique background and experiences. Family-centered care assumes that "the...role of the family as [care] manager is recognized and respected...parents become experts in their own child, and possess insights that providers of health care lack." Beyond acknowledging the family's role as the child's main caregiver, physicians must recognize the broader social and economic context surrounding the family's life. The medical home relationship draws families to share their story through simple questions from the physician such as "Have there been any major changes in your family since your last visit?". Inquiring about the family's cultural health practices (taking herbs or seeing a traditional healer) may indicate the extent to which the family is willing to follow through with medical treatment.

Recognize the importance of community: Families' decisions regarding health care are largely influenced by their social and institutional experiences living in a community. Though the primary physician provides service to individual patients, they must know how both they themselves and the family influence, and are influenced by, the entities comprising the greater community, from an individual member — a neighbor or colleague — to larger health, human service, business, educational, and religious institutions.

Palfrey acknowledges that "the root causes of many primary and secondary health problems rest squarely within the community."²² Based on a community's strength-based assessment, the physician's aim is to reduce geographical and financial access barriers to child health and to provide medical homes for all children. By asking questions about financial assistance for health care, resource and referrals for services and needs for food and transportation, pediatricians will learn the impact of the social situation on the child's health. The pediatrician should also recommend local resources, such as parent-child groups, that will help the family maintain ties with nearby social or cultural organizations that support family wellness.²³

Collaborate as the child's medical home: Collaboration with other professionals is a vehicle for moving from the traditional deficit model of care to a comprehensive and preventative one. As multiple forms of care and services are provided in locations other than physician's offices, one role of the pediatrician is reaching out to or being contacted by others involved in the community. The family support network may, for example, include the Healthy Start worker, Public Health Nurse, the Head Start teacher or the therapist. This may be accomplished via telecommunication, e.g. phone, e-mail, fax, or video conferencing, with medical specialists, child care providers, care coordinators and social work case managers. At a minimum, "the [pediatrician] becomes the repository for the database on the child's growth and development, strengths and weaknesses, and intervening experiences."²⁴ Developed to its full potential, the medical home provider considers themselves a partner on an interdisciplinary team, attuned to the comprehensive array of services provided to the child and family.

Advocate for quality health care: One of the most critical "hats" the pediatrician can wear is that of the advocate. Professional expertise, reinforced with direct experience in the field, provide a secure platform on which to voice recommendations or support family-centered systems and policies. Advocacy is demonstrated in many forms. The pediatrician can generate or write, fax or present

testimony on legislation. They can provide regular communication clarifying the child's health condition to the social worker for Child Protective Service involved child and family. The pediatrician can advise managed care plans to promote children specialists that truly meet the needs of their patients. Visibility at community health or education fairs, also serves as advocacy. In any form, the role of the pediatrician as an advocate cannot be overstated.

Conclusion

By practicing the Medical Home within communities, the primary care pediatrician acknowledges the family's principal role in using appropriate medical and non-medical resources and supports. Equally through collaboration, primary care pediatricians, no longer alone, can learn skills to form effective interprofessional relationships, thereby effectively coordinating services for families and children. By seeing parents as enabled partners and by creating interdependent relationships with community professionals and community members, the primary care pediatrician strengthens the medical home's comprehensive support for families and children in their home and communities.

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