

**Implementing the Medical Home Model in Minnesota:
A Case Study**

**Prepared by a Joint Committee of the
Association of Teachers of Maternal and Child Health (ATMCH)
and the
Association of Maternal and Child Health Programs (AMCHP)**

**Supported by the Maternal and Child Health Bureau, HRSA
February 2008**

Table of Contents

| | |
|--|-----------|
| Introduction and Use of the Guide..... | 4 |
| Case Study: Implementing the Medical Home Model in Minnesota | |
| Introduction | 5 |
| Minnesota’s Children with Special Health Care Needs Program: 2003-2006..... | 5 |
| The importance of parents..... | 7 |
| The importance of physicians..... | 8 |
| The leadership team..... | 9 |
| The importance of funding..... | 11 |
| The Future..... | 11 |
| Use of the Case | |
| Goals and Objectives..... | 13 |
| Key Problems..... | 13 |
| Discussion Questions..... | 14 |
| Role Playing Opportunities..... | 15 |
| Assessing Student Progress..... | 15 |
| Appendices | |
| Appendix A: Medical Home Defined | |
| Appendix B: Medical Home Learning Collaborative Methodology | |
| Appendix C: Minnesota Data from the National Survey of CSHCN | |
| Appendix D: Minnesota Medical Home Grant Development Project Abstract | |
| Appendix E: Minnesota Medical Home Practice Recruitment Letter | |

Authors and Contributors

Deborah Allen, ScD
Director of Child, Adolescent and Family Health, Boston Public Health Commission

Martha Coulter, DrPH, MSW
Professor, University of South Florida College of Public Health

Eugene Declercq, PhD, MS, MBA
Professor, Maternal & Child Health, Boston University School of Public Health

Ellen Daley, PhD
Assistant Professor, University of South Florida College of Public Health

Anita Farel, DrPH, MSW
Associate Chair for Graduate Studies, Maternal and Child Health
University of North Carolina School of Public Health

Monique Fountain, MD, MPH, MBA
Director Medical Home and HRTW Initiatives
Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. DHHS

Loretta J. Fuddy, ACSW, MPH
Chief, Family Health Services Division, Hawaii Department of Health

Holly Grason, MA
Associate Professor, Johns Hopkins Bloomberg School of Public Health

Laura Kavanagh, MPP
Training Branch Chief, Division of Research, Training and Education
Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. DHHS

Captain Audrey M. Koertvelyessy MSN, RN, FNP
Project Officer, Schools of Public Health, Division of Research, Training and Education
Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. DHHS

Charles Onufer, MD
Director, Illinois Title V Program for Children and Youth with Special Health Care Needs

Kalpana Ramiah, MSc, MPH, CHES
DrPH Candidate, George Washington School of Public Health & Health Services

This case is not copyrighted. Anyone may use the case study for teaching or related purposes. The authors ask that if modifications or updates are made to the case, or if new tools or resources are developed based on the case study, that these updates and/or materials be made publicly available through ATMCH.

Introduction and Use of the Guide

This study guide has been developed through a collaborative effort between the Association of Maternal and Child Health Programs (AMCHP) and the Association of Teachers of Maternal and Child Health (ATMCH). It involves an extensive data-based case study of Medical Homes for Children with Special Needs in the state of Minnesota, and is the first in a series of Maternal and Child Health case studies. It is intended as a tool for teachers of public health, maternal and child health, health policy, evaluation and health education.

The case study can be used in a variety of ways in the classroom:

- The entire case study can be handed out at the beginning of a class and read in its entirety, allowing the students to prepare responses to it in either a single or a series of response papers
- It can be utilized throughout the course in sections, where each portion of the case study is taken as a whole, and builds upon previous discussions
- Data can be revised and used within a series of exercises

It is important to note that there is no “right answer” in the use of a case study, and that students should be evaluated (see Assessing Student Progress on page 23) in a variety of ways that extend far beyond their knowledge of the medical home model.

Since the first discussions among the joint committee members, when medical homes for children with special health care needs was identified as the topic that might be most appropriate for the premier ATMCH/AMCHP case study, much more data have become available that show that the medical home is an effective setting for delivery and coordination of services needed by CSHCN and their families. We welcome your feedback on the use of this study guide, and hope that you find the **Medical Homes for Children with Special Health Care Needs** case study a useful teaching tool.

Medical Homes for Children with Special Health Care Needs

Introduction

John Hurley is a preternaturally nice man. He is warm, self-effacing, quick to laugh, quick to give credit to others, slow to criticize. It is not surprising that John is Director of the Title V Children with Special Health Care Needs program for the state that is home to Lake Wobegon. It might be surprising that the first word he mentions when asked about his state's effort to assure a medical home (Appendix A) for every child with special health care needs is "leadership." The question of how to lead his state's effort in this area engages him deeply.

John has clearly figured out some important answers to the question. Over the past four years Minnesota has developed a network of more than 30 pediatric practices engaged in implementation of a medical home approach to care for children with special health care needs. Starting from 2002, when John received a federal grant to promote medical homes but had only a vague sense of what to do with it, to the present, he has led an effort that puts Minnesota out in front, among the few states that have engaged more than a handful of practices in medical home implementation. It also puts Minnesota at a crossroads. Where does John go next to sustain and build on that progress? Once you've signed up all the "early adopters," to borrow a term from quality improvement science, how do you engage the more cautious majority?

Minnesota's Children with Special Health Care Needs Program: 2003-2006

John Hurley became the director of the Minnesota Children with Special Health Care Needs program (MCSHCN, pronounced "mission" by its staff) in 2000. He came to the job with eight years experience in child health policy and 15 years before that in health planning.

When he took over, a big part of MCSHCN's work was direct service. The agency contracted with clinicians to staff a network of child diagnostic and treatment clinics across the state. MCSHCN regional staff managed these clinics, which served 2,100 children at a cost to the state of \$1.5 million per year. MCSHCN saw its role as filling in gaps in the pediatric infrastructure in the state through the clinics.

Minnesota measures up pretty well compared to other states on most health service parameters. State data from the National CSHSN Survey indicate areas of relative strength and weakness of the state's system compared to other parts of the country.¹ While Minnesota ranks high generally, these data do not reveal variability within the state. The Twin Cities, St. Paul and Minneapolis, are home to the state capital, state university and to the university's tertiary medical center. The Mayo Clinic in nearby Rochester, Minnesota is another center of pediatric specialty care. Outside the urban Southeast, however, Minnesota is rural, and pediatric resources are sparse.

MCSHCN's clinics were seen as filling in where resources were lacking, offering diagnostic and treatment services to children with a range of physical disabilities. John Hurley and his staff were proud of the clinics; they felt the network filled an important gap and provided high quality care.

That was not enough, however, to protect the clinics when a \$4 billion budget shortfall hit the state in 2002. The newly elected governor had made “no new taxes” a campaign promise, leaving, John says, nowhere to get the money other than programs.² The \$1.5 million budget of the clinics was cut sharply. MCHSCN closed its treatment clinics. The diagnostic clinics, which were left in place, played a more limited role in the lives of families. MCHSCN was left with limited links to communities and a very lean staff. It had 13 administrative, program and data people divided between the Department of Health central office in St. Paul and regional sites, six former clinic staff, five nurses and one public health social worker, in regional offices, and 5 vacant positions.

Loss of the clinics hit hard. Aside from what John perceived as a loss to families, it created a programmatic dilemma – how to fulfill his mandate to create a “statewide system of care” for children with special health care needs in the state without a statewide framework from which to proceed.

John faced another dilemma at the same time. He was, he says frankly, floundering on how to make progress on a grant awarded to MCHSCN by the federal Maternal and Child Health Bureau in 2002. The grant stated its objective clearly: to increase the percentage of primary care practitioners implementing the medical home model by 75% over three years of funding. It was less clear in discussing how to get there.³ The distractions entailed in dealing with budget cuts and subsequent staff freezes didn’t help. And John was worried.

A serendipitous event began to suggest a way out. “I don’t know,” John says, “how you put a timeline on being hit by an insight.” John’s insight was the result of a chance encounter with a colleague who had attended an Institute for Healthcare Improvement (IHI) “learning collaborative” on diabetes care.⁴ She came back and described how IHI used a structured collaborative process to promote rapid change in the provision of clinical care. Through her contact with IHI, she had also learned that the National Initiative on Children’s Healthcare Quality (NICHQ), the pediatric affiliate of IHI, had plans for a similar program around medical home.⁵

It was also pure chance that Jane Taylor, one of NICHQ’s quality improvement experts, lived in Minneapolis. Once the acute period of dealing with budget cuts was over and the hiring freeze was lifted, John hired Ann Ricketts as the project coordinator for his grant. He immediately pointed her towards NICHQ’s Jane Taylor to learn about what it would take to build a learning collaborative around medical home in Minnesota.

As it unfolded under the leadership of John and Ann, with help from Jane Taylor, the Minnesota Medical Home Learning Collaborative replicated the “breakthrough series” approach used by the National Initiative on Children’s Healthcare Quality (NICHQ) around medical home at the national level. Practices participated as teams, each involving a physician, a second staff member (often, whoever served as care coordinator in the practice) and two, then later three required parent partners. The learning collaborative, which was carried out over two years, entailed three face-to-face meetings called “learning sessions.” During “action periods” between the three learning sessions, participant practice teams tested small changes in procedure, aimed at moving them incrementally towards operation as a medical home.

The strategy of using “small tests of change” to move incrementally towards larger system change is a basic element of the breakthrough series. The idea is to implement changes on a small scale both to test feasibility and efficacy and to create a body of data documenting the benefits of change. These data gave the teams the chance to see for themselves whether in NICHQ’s terms, “a change is really an improvement” and to document the improvement for others in their practices. Jane Taylor instructed them on the “plan, do, study, act,” or “PDSA” cycle that defines the steps involved in conducting small tests of change. With those words as the mantra of the Minnesota medical home learning collaborative, she taught the members of a state leadership group to help practices put the breakthrough series to work. (For details of the Minnesota effort, see Appendix B.) Each learning session featured reports by participating practices on their PDSA cycles

Each learning session also featured a report on data gathered by all of the practices to track progress on the “Medical Home Index,” one of the tools developed by the Center on Medical Home Improvement.⁶ Jane often gave these improvement data reports in the first of Minnesota’s two learning collaboratives. As the resident expert on the breakthrough series she was a consistent cheerleader for data collection, alternately haranguing and cajoling practices to submit monthly statistics reflecting utilization and parent feedback on a regular basis. John was a skeptic about this part of the model at first. Through the first learning collaborative the impact of data showing their own progress on participating practices made John a convert. “We motivated them,” he says, sounding surprised. “I’m not a person who usually inspires other people. The use of data to motivate was an eye opener.” As John became aware of the impact of data on participants he too became a cheerleader. “I like to pull the country boy, and say I’m not a data guy by training, genetics or any other form of proclivity, but I do recognize the importance of this kind of feedback in maintaining day-to-day investment.”⁷

Aside from the luck of happening on the learning collaborative as a strategy to engage practices in change and finding Jane as a local expert on the breakthrough series, several additional factors played a role in Minnesota’s medical home progress. The first of these was the active involvement of parent leaders in the process. The second was the explicit commitment of pediatric leadership in the state to the effort. The third was the enthusiastic buy-in of state agencies other than the Department of Health around medical home and, to a lesser extent, the learning collaborative process.

The importance of parents

John Hurley sees family involvement as almost a secret weapon for Title V programs; both a modus operandi and a habit of mind that enhances Title V effectiveness and clout in everything it does. He speaks fervently about the role of families in his own program and in shaping services generally. “I think that one of the things that really differentiates us is the link to families. It distinguishes us from the Maternal and Child Health program across the hall.⁸ My own history went from me just mouthing the words to the point where I would look at a committee we set up to interview candidates for a position and say ‘Why isn’t there a parent on this?’” John places partnership between parents and providers at the heart of what it means for a practice to be a medical home. “When you look at the things we can do to assure quality in a medical home, the

one thing I really want to maintain as a principle is the role of the parent as partner. Otherwise you end up with a good practice; just a good usual and customary practice, but not a medical home.”⁹

It has not always been clear to John how to translate this commitment into action at the state level. A parent advisory group for MCSHCN set up four years ago has never taken off. John’s view is that the group lacks a real mission. “It’s the difference between an elected school board and a parent-teacher advisory committee. The School Department has to listen to the former, but nods and does what it wants in relation to the latter.” Lack of mission has not plagued MCSHCN in regard to parent involvement in the learning collaborative process. John hired Carolyn Allshouse, an experienced parent leader, as coordinator of a second grant from the Maternal and Child Health Bureau, now in place through 2008. This second grant builds on the earlier medical home grant, supporting a second learning collaborative but in the context of efforts to advance the state’s progress on all six elements of the national 2010/New Freedom Initiative agenda. Between the two grants, Minnesota has involved 32 pediatric practices in medical home learning collaboratives. Carolyn took the job in 2005 after working at Minnesota’s parent-run Pacer Center, where she managed parent involvement in the initial medical home effort through a contract with the state. She now oversees that contract, working closely with John Hoffman, another experienced parent who replaced her at Pacer. One example of their joint leadership: while the national medical home learning collaboratives have required practices to work with at least one parent as part of their medical home teams, Minnesota has required that each practice design roles for at least three parents, and, Carolyn emphasizes, “We are not flexible about it.” Carolyn feels this has paid off in real leadership for change. She comments:

*The very successful teams got parents involved from the start and got them to sit down to say what really needed to be improved. That discussion identified totally different priorities from the doctors’, like having an automatic door to get into the clinic. The doctor in one clinic said, “We do.” The parents said “No. The building does but the individual clinic itself does not.” The doctors didn’t know it because they come in the back door.*¹⁰

The importance of physicians

Jeff Schiff moved last year from practice as emergency room physician to a new role as Medical Director of Minnesota’s Medicaid (Title XIX) program. Like Carolyn, his state role grew out of a personal history as a leader. Jeff was first involved in the medical home effort as chair of the Minnesota chapter of the American Academy of Pediatrics. His initial interest was partly pragmatic: Minnesota had the nation’s largest unstaffed American Academy of Pediatrics chapter. Jeff found this mortifying, but without funding the chapter could not afford a staff position. One attraction of the medical home effort for Jeff was that he saw medical home grant funding as a possible source of funds for the chapter. A history of collaboration with Title V in the state (he had worked with Title V staff on an ongoing Maternal and Child Health Bureau-funded effort to improve emergency medical services for children) made him comfortable with the prospect of close collaboration on this project. And, by coincidence he had gotten to know Carolyn Allshouse after taking care of her child on several occasions. So when John invited his participation, Jeff knew and trusted both Title V and the Pacer Center’s family leadership of the

project and willingly signed on for the American Academy of Pediatrics. But his commitment to medical home really came with involvement. He was particularly impressed by the central importance of parent partnership to the model.

Jeff ties his interest in the parent role in medical home practice to a broader view of the importance of consumer voices in health care generally.

I realized in medical home that there's a gigantic amount of energy that comes from parents. Berwick [the President of the Institute for Healthcare Improvement] has talked about how we don't make use of patients as a resource. In the medical home, parent energy is more important for the doctor than financial reimbursement. At the first learning collaborative meeting I went to, doctors were in one room while parents were in the next room. But when we all got together there was tremendous amount of energy. The sea change is the parents being involved in how the practice runs. It's Toyota versus GM. GM told you what kind of car you wanted, while Toyota brought you in and asked.

John Hurley sees Jeff's early buy-in as critical. John and Ann Ricketts, the director he hired to manage the 2002-2005 medical home grant, decided the best way to recruit practices to the first learning collaborative was a convincing letter from what doctors were likely to perceive as credible sources. The letter that went out was cosigned by the then-Commissioner of Public Health and Jeff, as the American Academy of Pediatrics chapter chair. Asked which signature made the greater difference, John unhesitatingly says it was Jeff's. Ultimately, 18 practices signed on to participate in the first collaborative based largely on that letter.¹¹

The leadership team

Jeff Schiff works on medical home now in his new capacity as Medical Director to Minnesota's Medicaid program. Medicaid's Director of Children's Health Policy and representatives of the state's Departments of Education and Human Services have worked with MCSHCN along with Jeff as part of a leadership team for the medical home effort. This team has a different role from the practice teams that comprise the collaborative's membership: it plans the learning sessions, identifying topics for plenaries and workshops and suggesting guest faculty to cover topics outside the team's own expertise and that of practice participants. It also tracks progress through the three action periods of the collaborative, reviewing practice team data on a regular basis.

Members of the leadership team benefited from Jane Taylor's presence in the group during the first collaborative. In addition to coaching leadership team members on the breakthrough series so they could, in turn, coach practices, she put them in touch with national experts who served as faculty for Minnesota learning sessions on several occasions.

Glenace Edwall, the Director of Children's Mental Health Services in the Department of Human Services, has been both a faculty member and a member of the leadership team. Glenace's presence on the faculty carries the important message that medical home is not a sectarian preoccupation of public health in Minnesota and nationally, but a strategy for serving children with all types of special health care needs. Glenace speaks enthusiastically both about medical

home and about ongoing collaboration with MCSHCN. She traces her alliance with MCSHCN to shared commitment to children and families and her conviction that primary care is important for children with mental health needs to her own background as a mental health clinician in primary care settings. Her comments about the importance of the medical home model for children with mental health problems are forceful:

We have been wrong headed about kids' mental health nationally and at the state level for a long time. We've thought of it as a stepchild of child welfare. That does a terrible disservice to families. It also means we've substituted social services for real treatment. ... We are at a place where we need to reconceptualize our public responsibility for mental health; to understand mental illnesses as medical conditions. Given that, I am outrageously enthusiastic about medical home. That doesn't mean medical home doesn't have a long way to go about mental health. But the idea of family and professional partnerships, the importance of coordination and planning -- it's exactly what we need.¹²

Ralph McQuarter oversees community programs for the Department of Human Services. His focus is on traditional social services programs – those that Glenace so carefully distinguishes from clinical mental health care. He shares her enthusiasm for the medical home model, but emphasizes its potential for children in families at social risk, who are of greatest interest to him. His feeling is that the medical home model is conducive to early and ongoing risk assessment and intervention, preventing or at least ameliorating long-term disability. Ralph, like Glenace, has been on the state's medical home learning collaborative leadership team.

One final collaborator with a unique role in current efforts to expand medical home implementation is **Susan Castellano**, who is responsible for children's health policy in the Minnesota Medicaid program. Susan is, as she herself notes, oddly placed: while most of her colleagues with responsibility for particular areas of Medicaid policy are housed in a general policy unit, historical happenstance has placed her in the agency's Performance Measurement and Quality Improvement Unit. That gives her room, she says, to think about the big picture rather than just about benefit packages and reimbursement rates. Certainly those issues are concerns for her, but her placement promotes a focus on outcomes. Susan's background promotes big picture thinking as well; she came to Minnesota from the Children's Defense Fund, a nationally known children's advocacy group in Washington. Susan sees her role on the medical home leadership team as part of a broader partnership that is, in turn, evidence of shared values.

I think it's personal. The personalities involved here see the value in collaboration. I don't mean 'personal' in the sense that we go out for drinks. But we place a shared value on improving the health of kids in the state. You could have someone in my role that didn't see the job that broadly, but the feds require that Title V and Title XIX work together and we've taken that to heart. ¹³

Values notwithstanding, Susan laughs when she describes how she got recruited to the leadership team for the MCSHCN medical home initiative, "That was John," she says. "When they put the team together they invited me because they wanted Medicaid at the table. John was unobtrusive

about the fact that he wanted Medicaid dollars for medical home spread.” And certainly the dollars do matter to John. In fact, they are central to his strategy for moving forward from here.

The importance of funding

John’s view, which is shared by Title V leaders in many other states, is that Medicaid funding could persuade doctors who are on the fence about medical home – those who are drawn to aspects of the model but concerned about the time required to identify children with special health care needs, provide enhanced care coordination, work with family partners, and increase engagement with community agencies, key elements of the model – to embrace it. The trick, of course, is persuading Medicaid to move in that direction.

In the hope of generating data that will permit Susan and encourage other Minnesota Medicaid officials to support reimbursement for medical home practices, John has allocated funds from his current grant to support an MCH epidemiologist at Medicaid. The medical home leadership team is now collaborating on the design of a study aimed at assessing the cost effectiveness of the model, using Medicaid records to identify costs and the Medical Home Index to characterize practices in regard to degree of medical home implementation. The study is just now underway, but team members are already excited about the information it may yield. Their hope is that a positive outcome will give them evidence to take to the state legislature for funding. Susan herself is optimistic but cautious, noting that cost saving may be shown only for children with more significant special health needs whose utilization, absent good care coordination, is costly to the system. “I don’t expect we will be reimbursing care coordination for children with mild asthma,” she says, even as she expresses hope that the study will impel reimbursement onto the policy agenda.

The Future

With or without data, however, winning state commitment to medical home at the policy level will be a challenge. John has gone as far as any state Title V director using the resources under his direct control. His boss, **Carol Woolverton**, the Assistant Commissioner of Public Health in charge of the Family and Community Health Promotion Bureau (in which MCSHCN is housed) acknowledges the value of the medical home model.¹⁴ In her view, it is linked to health department strategic priorities around elimination of disparities and health care reform. Central to her view of the model is that it is based, as she puts it, on “the fundamental belief that no one should be siloed; that clients should be able to move through services smoothly, based on an overarching understanding of their needs.” Having said that, though, she is direct about what it would take to put medical home near the top of the department’s agenda. “There’s going to have to be an indication of how much this will save the system, that there’s an avoidable cost. And on the other side, what are the positive outcomes: what will this do for quality of life.” In her view, data are more important than anecdotal evidence in making that case, but she acknowledges that the voices of constituents are very important as well.

They need, I think, to enhance the grassroots buy-in by the professions: physicians, nurses, social workers. That whole gamut of people need to get on the bully pulpit and say it’s a good thing and why. You need disability groups

involved. Get that grassroots foundation and then build the case. Carol says, “This is what’s hardest for me: the people in the programs are so passionate about what they do. And God bless them. But they have to understand the state’s role and think about what it takes. Legislators hear a lot of “no-brainers.” They have to hear, “Here’s the facts, here’s the data. Here’s what you lose if you don’t do it. Here’s the grassroots support.”

1 See Appendix C. Additional Minnesota data and data on other states are available at: <http://www.cshcndata.org/>

2 Direct communication, August 22, 2006

3 See proposal abstract, Appendix D

4 Chin, et al. Evaluation of Bureau of Primary Healthcare (HRSA) 1998 Diabetes Health Disparities Collaborative. *Diabetes Care* 2004;27:2-8. For a basic description of the breakthrough series method and the use of learning collaboratives, see: Institute for Healthcare Improvement. *The Breakthrough Series: IHI's collaborative model for achieving breakthrough improvement*. Institute for Healthcare Improvement, Innovation Series. 2003. For a general introduction to IHI, see <http://www.ihl.org/ihl>

5 <http://www.nichq.org/nichq>

6 Current versions of the data collection tools used in the MN Medical Home Learning Collaboratives are available from the Center for Medical Home Improvement, at <http://www.medicalhomeimprovement.org/assets/pdf/MHIK-II-A.pdf>

7 Personal communication, August 15, 2006

8 Note that state Title V programs often distinguish between “MCH programs”, those that serve pregnant women, mothers, children and youth without special needs, and “CSHCN programs” like John’s. While both are funded by the federal Maternal and Child Health Block Grant they have generally been distinct. Even today they are housed in different agencies in some states.

9 Personnel communication, August 15, 2006

10 Carolyn Allshouse, personnel communication, August 25, 2006

11 See recruitment letter, Appendix E

12 Personal communication, August 24, 2006

13 Personal communication

14 Personal communication, August 24, 2006

Use of the Teaching Case

A. Case Study Goal

Prepare students to serve as effective change agents working within the framework of Title V at national, state and community levels.

B. Case Study Objectives/Teaching Purpose:

- Provide grounding in policies which currently drive Title V program efforts for CYSHCN at national, state and local levels.
- Demonstrate the opportunities to effect change open to a Title V leader.
- Illustrate the constraints which confront a Title V leader who seeks to effect change.
- Demonstrate the importance of mentorship as a leadership development tool.
- Explore the impact of qualitative and quantitative data on state policy change efforts.
- Demonstrate the importance of collaboration as a strategy towards achievement of change.
- Indicate the importance of person-to-person relationships as facilitators to effective collaboration at the state level and as a tool of leadership.
- Indicate the limitations of person-to-person relationships as a tool of leadership.
- Display the motivations which shape behavior of potential collaborators in change efforts.
- Demonstrate the complementary roles of different participants in collaborative public health efforts.

Key Problems:

- Limited understanding of Medical Homes both in the clinical field and in the policy arena.
- Lack of consensus on the benefit of Medical Homes and less data to support the benefit of Medical Homes.
- Low interest amongst the physicians due to inadequate reimbursement.
- Reduced funding support for Medical Homes.

Discussion Questions

1. Who are the key players around medical home in Minnesota? What brings each of them to the table?
2. Study the Minnesota summary page from the National Children with Special Health Care Needs Survey.
 - a. What do you see as the strengths and weaknesses of Minnesota's system of care based on these data?
 - b. What would you highlight if you were a state official reporting on these data?
 - c. A parent?
 - d. An advocate?
3. What are the factors that have promoted progress in relation to medical home in Minnesota? What is the relative significance of those factors?
4. To what extent can those factors be brought into play through conscious effort of Title V or other leaders in the state? To what extent are those factors the result of chance or the unique history of Minnesota?
5. Will strategies that have promoted progress to date in Minnesota be adequate to push the medical home model further? What more is needed? Could new strategies to achieve progress pose any threats to the collaboration that has characterized efforts in Minnesota to date?
6. Several of John's collaborators have different viewpoints about what medical home means and how it stands to benefit children in Minnesota. Do you see any potential conflicts among those viewpoints? Do those differing viewpoints pose any risks to interagency collaboration?
7. John and others in Minnesota see Medicaid funding as an important component in spread of the medical home model beyond "early adopter" practices. Do you share that view? How could Medicaid funding play a role in spread? Is there any risk entailed in enhanced Medicaid funding for medical home practices?
8. The medical home leadership team is now planning to participate in a research project to determine the cost effectiveness of the medical home model. How would you design a study with that purpose? What challenges confront a researcher charged with design of the study?

9. John and other team members are, of course, optimistic about what a cost effectiveness study that is now underway will show. They are aware, however, that the study may not yield the results they hope for. Are there any steps they can take now to minimize the impact of negative or inconclusive findings?
10. If you were John, what would your next steps be to promote medical home in Minnesota?
11. Do you see any opportunities for national support to Minnesota and other states? What outside resources could strengthen in-state efforts?
12. How would you address the following issue in relation to this case study: the American Academy of Pediatrics supports and defines medical home in the context of *all* children; the Children with Special Health Care Needs does not. Is one approach better than the other?

Role Playing Opportunities

Role playing opportunities include, but are not limited to:

- Medical Home Task Force: Stakeholders from state, federal organizations and professional associations develop a strategic plan for promoting Medical Home model.
- Groups developing lobbying brief from various organizations:
 - American Academy of Pediatrics (AAP)
 - American Public Health Association (APHA)
 - Association of Maternal and Child Health Programs (AMCHP)
 - Family Voices

Assessing Student Progress

As noted in the Introduction of this study guide, case teaching does not have only one correct answer. A student should be evaluated based on his/her ability to:

- Identify key stakeholders (even the ones not mentioned in the case study);
- Understand issues surrounding the case;
- Strategize around the development and implementation of a medical home program;
- Formulate a plan for strengthening the program;
- Utilize current research and data regarding CSHCN;
- Communicate the issue and options to policy makers; and,
- Display leadership skills during role play.