WHAT IS A MEDICAL HOME PARTNERSHIP?

The American Academy of Pediatrics, the American Academy of Family Physicians and the national Maternal & Child Health Bureau are promoting Medical Home partnerships between families caring for children with special health care needs and the physicians they trust. In a Medical Home, families and physicians work together to identify and access all the medical and non-medical services needed to help children with special health care needs and their families reach their greatest potential.

A Medical Home partnership enhances the effectiveness of the patient-family-doctor relationship, not by working harder and faster but by doing things differently.

- Medical Home is not a building, house or hospital. It is a way of providing high quality health care services in a cost-effective manner.
- Medical Home is as much an attitude as it is a way of providing care: families are viewed as the main caregivers and the center of strength and support for children.
- Medical Home is another way of describing a physician's office when it helps families access the full range of services and supports needed to care for a child with special needs.

WHY Invest in Building a Medical Home Partnership?

- The number of children and youth with special health care needs is growing, and families' expectations about the delivery of health care are changing. Continuing to provide quality health care services to these children and their families requires new approaches to care and new systems of supports.
- The formation of active and lasting partnerships with families can improve the experience of providing health care for physicians and their staff.
- Breakdown in communications and connections between patients and their physicians is among the primary reasons why consumers change providers, and in severe cases, take legal action.
- Purchasers are increasingly using patient satisfaction measures as an indicator of quality care.

RESOURCES FOR BUILDING MEDICAL HOME PARTNERSHIPS IN MARYLAND

Learn about Medical Home activities and other resources in Maryland:

Maryland Department of Health and Mental Hygiene

Office for Genetics and Children with Special Health Care Needs
201 West Preston Street
Baltimore, MD 21201
phone: 800-638-8864
website: www.fha.state.md.us/genetics

Join physician leaders working to improve care for children with special health care needs:

Maryland Chapter
American Academy of Pediatrics

Children with Special Health Care Needs Committee
744 Dulaney Valley Road, Suite 12
Towson, MD 21204
phone: 410-828-9526
website: www.mdaap.org

Find family leaders working to promote Parent-Professional Partnerships:

The Parents' Place of Maryland (Maryland Family Voices)

801 Cromwell Park Drive, Suite 103
Glen Burnie, MD 21061
phone: 800-394-5694
email: info@ppmd.org
website: www.ppmd.org

Find Tools for Medical Home Improvement:

American Academy of Pediatrics

National Center of Medical Home Initiatives for Children with Special Needs
141 Northwest Point Blvd
Elk Grove Village, IL 60007
phone: 847-434-4000
email: medical_home@aap.org
website: www.medicalhomeinfo.org

Center for Medical Home Improvement

Crotched Mountain
One Verney Drive
Greenfield, NH 03047
phone: 603-547-3311 ext. 272
website: www.medicalhomeimprovement.org

Find resources to support Family-Centered Care:

Institute for Family-Centered Care

7900 Wisconsin Avenue, Suite 405
Bethesda, MD 20814
Phone: 301-652-0281
email: institute@iffcc.org
website: www.familycenteredcare.org

New England SERVE
101 Tremont Street
Suite 812
Boston, MA 02108
www.neserve.org

MARYLAND
Martin O'Malley, Governor
Anthony G. Brown, Lt. Governor
John M. Colmers, Secretary

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SMALL STEPS... BIG DIFFERENCES

BUILDING MEDICAL HOME PARTNERSHIPS* FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

* When families and their doctors work together to make comprehensive care in the community a reality, this partnership is called a Medical Home.

TIPS FOR PROVIDERS

Department of Health and Mental Hygiene
MARYLAND
Office for Genetics and Children with Special Health Care Needs

ONE STEP at a TIME...

These practical tips for physicians, nurses and office staff can help to improve both family and provider satisfaction. Use them to review current office policies and for training staff. Start where you can; there is no special order for implementation. Build your Medical Home partnership one step at a time.

Step 1: BEFORE THE VISIT – Anticipate Special Needs

Appointment Scheduling & Medical Record

- ☐ Identify patients with special health care needs in the scheduling system.
- ☐ Use a special sticker or different-colored chart.
- ☐ Include critical needs at front of medical record such as: allergies, larger exam room, best way to take height and weight, scheduling when extended visits are possible.

Reception & Waiting Area

- ☐ Greet by name families and patients who call or come to the office frequently, to increase confidence that their needs are recognized.
- ☐ Ask the family to fill out a brief "Concern of the Day" form to identify new issues or pressing needs.
- ☐ Use the waiting room to share information about programs and resources useful to families (e.g., special summer camps, support groups).
- ☐ Be mindful of challenges faced in the waiting room due to equipment or infection concerns. Offer alternate space when waiting time may be extended.

Step 2: IN THE EXAM ROOM – Use Family as Experts

Adjust Routine Procedures

- ☐ Ask for advice before starting any procedure, "Is there anything I should know about your child or what works best for him/her at the office?"
- ☐ Delay more routine aspects of the exam when there is an urgent need until after the physician has attended to the immediate concern.
- ☐ In cases where a child is examined frequently, the physician may decide it is not necessary to weigh or undress the child at each visit. This can spare the parent and child difficulty or discomfort.

Assess Unmet Needs

- ☐ Review the "Concern of the Day" form to facilitate conversation.
- ☐ Ask questions about the impact of the child's condition on the family — on siblings, work, finances, fatigue — and assess the support systems in place.
- ☐ Encourage the family to discuss other facets of their child's life including in-home care, education, recreation and socialization.
- ☐ Offer to help explain their child's medical needs to other health, education or community professionals, if needed.

Use Written Plans for Care

- ☐ Acknowledge the family's need to communicate medical plans and decisions to other providers outside the office.
- ☐ Set short-term (3-6 month) and long-term (12 month) goals with the family, always including non-medical goals.
- ☐ Provide information on recommended medical treatments in writing.
- ☐ Develop a written plan of care with the family and update the plan when regularly assessing progress.

Step 3: AFTER THE VISIT – Help Coordinate Care

Help Find Resources

- ☐ Identify a staff member or community-based care coordinator to help families find needed services and implement care plans.
- ☐ Connect families to community resources, such as specialized transportation, durable medical equipment, home care, or respite.
- ☐ Maintain contact information for public and private agencies that can provide information and referrals, including the Office for Genetics and Children with Special Health Care Needs and your local health department.

Maintain Linkages with Specialists

- ☐ Ensure continuity of care and updated information by working to improve timely communication with medical specialists.
- ☐ Help families make sense of clinical recommendations they may receive from different providers.
- ☐ Organize or participate in team meetings with multiple providers to achieve agreement on plans for care.

Paying the Bills

- ☐ Assign a staff member to help with referrals, payment issues and follow-up activities to assist families to coordinate financial benefits and increase timely reimbursement.
- ☐ Keep a list of how to reach the special case management programs within health plans and insurers that serve your area.
- ☐ Refer families to public programs such as the Maryland Medical Assistance Programs (including Maryland Medicaid and MCHP) and the Children's Medical Services Program, as well as local organizations that may offer financial assistance for medical needs.

Step 4: IN THE COMMUNITY – Work Collaboratively with Families

Family & Staff Participation

- ☐ Seek the input of families in your practice to find ways to make the office more user-friendly and family-centered.
- ☐ Identify potential parent leaders who may be interested in supporting other families.
- ☐ Invite staff members with interest and skills in working with families to help build the Medical Home partnership in your practice.

Parent-to-Parent Support

- ☐ Learn about parent support groups in your community and encourage families to connect with those groups.
- ☐ Post notices about meetings and events in your waiting room.
- ☐ Offer your office facility for evening meetings.

Families as Advisors

- ☐ Include parents on existing practice-based committees that inform office policies and practices.
- ☐ Benefit from the expertise of parents in your practice by creating a Family Advisory Committee.
- ☐ Seek consultation from family leadership groups like The Parents' Place of Maryland when questions arise regarding family-centered care.

WHO ARE CHILDREN WITH SPECIAL HEALTH CARE NEEDS?

All physicians who care for children will have patients and families with special health care needs in their practice. Children and youth with special health care needs are recognized to be those from birth to 21 years old who:

- have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more, and
- need health and related services more than most children,
- may receive these services from various public and private agencies and providers in the areas of health, education, and social services,
- and, as a result of complex conditions and many different providers, may need help in coordinating this care.

This includes children and youth with chronic medical conditions such as diabetes, sickle cell anemia, cystic fibrosis, and heart disease; developmental disabilities such as mental retardation, sensory impairments, and autism spectrum disorders; emotional or behavioral conditions such as depression or ADHD; and physical disabilities such as cerebral palsy, spina bifida, and muscular dystrophy. Recent survey data from the National Center for Health Statistics, Centers for Disease Control and Prevention estimate that over 15% of Maryland children have special health care needs that meet this definition.