

## The History of the Medical Home Project in South Carolina

South Carolina's State Medical Home Team was established in 2001 as a partnership between the state chapter of the American Academy of Pediatrics, Children's Rehabilitative Services at the S. C. Department of Health and Environmental Control, the state chapter of the American Academy of Family Physicians, Family Connection of S. C., Inc., and the S. C. Department of Health and Human Services. CATCH funding from the AAP supported the team's development activities which included setting goals for children with special health care needs.

### Goals

- All children with special health care needs (CSHSN) will have an identified medical home by 2010 where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, culturally competent and cost-effective.
- These medical homes will result in improved health status, function and quality of life for CSHCN and their families.
- Medical home teams will promote early identification and screening of CSHCN.
- There will be a plan for transition of care at the end of childhood to adult-oriented resources.
- All children will have health care insurance that covers health care costs.

In April 2002, The CRS Division of DHEC (Title V) received a three-year grant from the Maternal and Child Health Bureau of HRSA to build upon the initial goals of the State Medical Home Team. Grant priorities include a broad-based education campaign on medical homes, mentor medical home sites to develop and share strategies to improve care and strategies to strengthen the linkages between providers and community organizations.

## Getting Started

The State Medical Home Team can provide curricula for training, trainers, and speakers; and basic brochures targeted to the family and to the health care provider.

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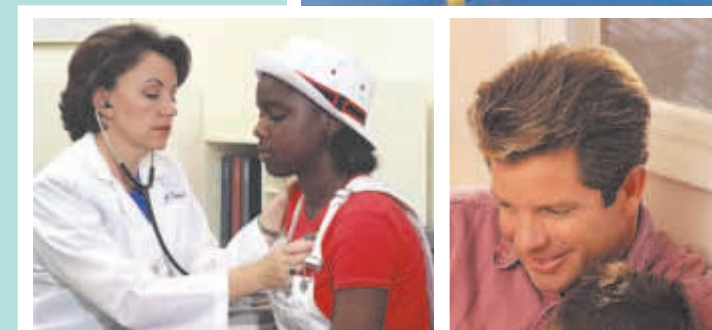
Children's Rehabilitative Services at DHEC  
S. C. Chapter, American Academy of Pediatrics  
S. C. Chapter, American Academy of Family Physicians  
S. C. Department of Health and Human Services  
Family Connection of South Carolina, Inc.

*Learn more about medical homes at the following web sites:*

[www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)

[www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org)

## A Provider's Introduction to Strengthening Medical Homes For Children with Special Health Care Needs



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## What is a Medical Home?

A medical home is not a building, house or hospital. It is an approach to providing health care services to children with special health care needs in a high-quality and cost-effective manner. Children and their families in a medical home setting receive the care they need from a pediatrician or family physician. Physicians, families, and allied health professionals are partners in a medical home. This team identifies and accesses medical and non-medical services needed to help children achieve their maximum potential. This approach builds upon and expands the traditional medical home concept.



What defines Children with Special Health Care Needs (CSHCN)?

CSHCN have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond that required by children in general. In South Carolina, more than a third of a million children are identified as having special health care needs.

## Why is this approach important?

There are more children with special health care needs than ever before. National data shows that roughly 15% of all children fall into this category and that these children account for 80% of pediatric health care expenditures. A stalled economy, changes in insurance and health delivery systems, and funding reductions in many governmental programs contribute to fragmented care for this growing, vulnerable population.

In response, linking all children with special health care needs to a comprehensive medical home has become a priority of the Healthy People 2010 objectives and the American Academy of Pediatrics.

Traditional pediatric primary care is designed to provide well-child preventive care services and acute illness management to the majority of children who do not have special health care needs. The challenge is to build upon this traditional approach in ways that improve care for the children who use the health care system most often.



## What are the obstacles to improving primary care for CSHCN?

- Offices lack systemic approaches to care for CSHCNs
- Care roles for primary care providers, specialists, parents, and others are not explicitly defined
- Practices lack systematic processes for change or improvement
- Reimbursement is inadequate and linked to well-child care and acute care of healthy children
- Patient and family involvement is limited or non-existent

## What does this new model emphasize?

- Improved access to care at all levels, including better coordination with sub-specialists
- Family-centered care that results in true partnerships with families
- Primary care-based care coordination that includes sub-specialists and community helping programs
- Continuous improvement process
- Improved office systems that:
  - Identify CSHCN
  - Track and monitor progress
  - Evaluate health and systems outcomes

## What are the benefits of this approach?

- Increased provider, patient and family satisfaction
- Improved coordination of care
- Improved linkages to sub-specialists and community organizations
- Establishment of a forum and system for problem solving
- Efficient use of limited resources
- Increased wellness resulting from comprehensive care