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Building Medical Homes

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Building Medical Homes for Children with Special Health Care Needs



**A New Millennium
A New Vision**

Every Child Deserves a Medical Home

Role of French Physician (15th Century)

Gurer parfois...

Soulager souvent...

Consoler toujours...

(To cure sometimes...

To relieve often...

To comfort always...)

Family Expectations of Pediatricians in Primary Care

- Most parents would advocate that it is the physician's role to help fit the medical care plan into the overall management of their child with a disability.
- They look for guidance and support in the form of creative problem solving rather than ultimate decision conferring.

Pediatric Primary Care

- Designed for 80% of children who **do not** have special health care needs.
- Designed to provide well child preventative care services and acute illness management.
- Designed to support a single service unit: the provider – patient encounter.

Who are Children with Special Health Care Needs?

Every Child Deserves a Medical Home

Conceptualizing the Population: A Long and Winding Road (Newacheck, 2003)

<u>Era</u>	<u>Terminology</u>	<u>Scope</u>
1930s-60s	Crippled Children	Orthopedic impairments
1970s-80s	Handicapped Children	Above plus developmental disabilities, other physical conditions
1990s-	Children with Special Health Care Needs	Above plus emotional and behavioral conditions

Definition of Children With Special Health Care Needs

Children who have or are at risk for a chronic physical, developmental, behavioral or emotional condition and who also require health related services of a type or amount beyond that required by children generally.

(MCHB July 1998 - adopted by AAP October 1998)



Care Giving for CSHCN: Another Long and Winding Road (Newacheck, 2003)

Paradigm Shifts in Care Giving Approach

Care of Defects



Care of Children



Care of Children
and their Families

Family-Centered Care

- Families are usually constant in the life of CSHCN, while service systems and their personnel change frequently.
- Physicians are accustomed to the role of authority and control and have been slow to accept the change in the family role from grateful recipient to partner in the health care process. This has led to fragmentation of care and paternalism.
- The family is now considered the center of the health care universe, not the physician and or hospital (McPherson, 1989).

How Helpful are Pediatricians in Meeting the Needs of Families with CSHCN?

- In a survey study of parents whose children were entered into early intervention programs, less than half identified their pediatrician as helpful in terms of providing information about support services (O'Sullivan, 1992).

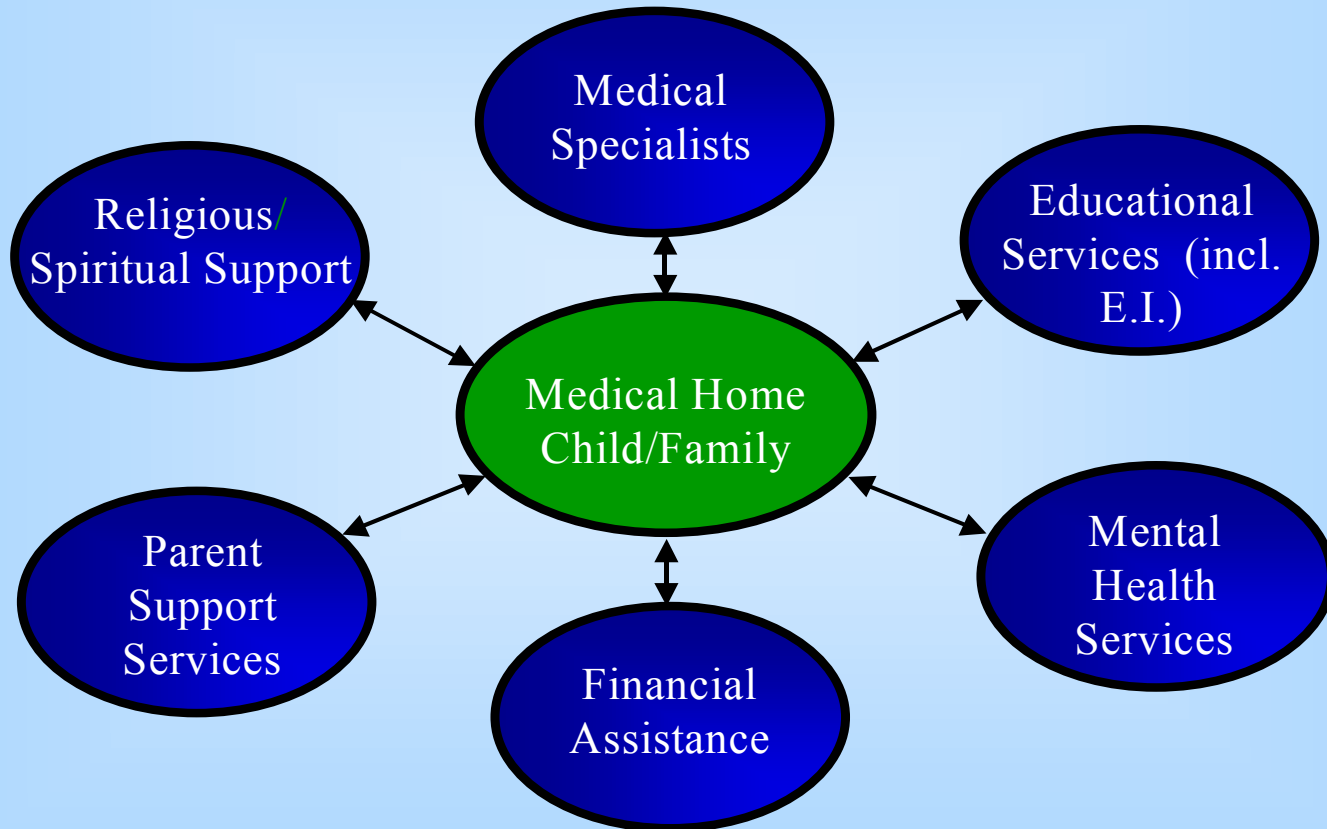
Obstacles to Improving Primary Care for CSHCN

- Offices lack systematic approaches to CSHCN
- Care roles are not explicitly defined among parents, specialists, PCP and others

Obstacles to Improving Primary Care for CSHCN

- Practices lack intrinsic processes for change or improvement
- Reimbursement is inadequate and linked to child care and acute care of healthy children
- Consumer involvement is limited or non-existent

THE MEDICAL HOME CONCEPT



AAP Department of Community Pediatrics

Every Child Deserves a Medical Home

Pediatric Medical Homes

Provide a primary care process of chronic condition management which...

- Serves children and families who use the health care system most often (CSHCN)
- Expands services to include
 - Care coordination
 - Advocacy
 - Information exchange & family education
- Responds to family and community needs

Pediatric Medical Homes

Should be able to...

- Form active partnerships with families
- Identify and monitor CSHCN
- Coordinate care in a systematic manner
- Communicate with other community resources and pediatric specialty services

What Does a Medical Home Look Like?

- Accessible
- Family-centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally-competent



Healthy People 2010 Goals As They Relate to CSHCN

- **Family Participation and Satisfaction**
- **Access to Medical Home**
- **Access to Affordable Insurance**
- **Early and Continuous Screening**
- **Easy-to-Access Community-based Service Systems**
- **Services Necessary to Transition to Adulthood**

Colorado's Health Care Program for Children with Special Needs (HCP)



HCP is the public health agency in Colorado responsible for building family driven, sustainable systems of health services and support.

Through interagency collaboration, we connect culturally respectful community based resources.

We maintain surveillance of chronic health conditions impacting children with special health care needs and seek to provide outcome data that assures meaningful lifestyles for those children.

Every Child Deserves a Medical Home

HCP and the Provision of Pediatric Specialty Care

Since 1935, the federal Title V program has supported states in the initiation of programs for pediatric special needs populations. State Title V programs have fostered the development of specialty clinics and multidisciplinary services for children with a variety of specific chronic illnesses.

HCP and The Medical Home

Few state Title V programs have developed substantial relationships with their state's primary care community, provided direct support or liaison to primary care systems, or actively engaged in the systematic improvement of primary care services.

The Colorado Medical Home Initiative



Medical Home Advisory Board

Kathy Watters- Director of HCP
Don Cook- Past President,
American Academy of Pediatrics

Colorado Medical Home

Practice Development

James Ledbetter- Project Director

Every Child Deserves a Medical Home

Colorado Medical Home Initiative

Goal #1: All children with special health care needs in Colorado will have a medical home.

Goal #2: Families of CSHCN will be able to recognize and advocate for a medical home for their child.

Goal # 3: Primary and Sub-Specialty health care providers will recognize the components of a medical home and will implement medical home practices.

Goals #4: Reimbursement for health care for children with special needs will reflect the level of funding necessary to provide medical homes.

Medical Home Learning Collaborative

The Learning Collaborative provides an opportunity for health care providers of children, interested in implementing Medical Home qualities within their practices, to collaborate with other practices and their state's CSHCN program.

Medical Home Learning Collaborative State CSHCN Team

- **Kathy Watters, Director Health Care Program for Children with Special Needs**
- **Dr. Jim Ledbetter (HCP), Team Leader**
- **Christy Blakely (Family Voices), Parent Consultant**
- **Gina Robinson (EPSDT Outreach), Community Resource Consultant**

Medical Home Learning Collaborative State CSHCN Team

- **Work with Primary Care Practices for children to make incremental changes toward implementing a medical home.**

Medical Home Learning Collaborative

State CSHCN Team

- **Encourage Parent Partnerships with Primary Care Practices for children.**

Medical Home Learning Collaborative

State CSHCN Team

- **Increase awareness of community resources to Primary Care Practices for children.**

Medical Home Learning Collaborative

State CSHCN Team

- **Work with Primary Care Practices for children to implement a systematic approach to the identification of CSHCN within their practice.**

Medical Home Learning Collaborative

State CSHCN Team

- **Develop and assimilate outcome data to support implementation of medical homes for CSHCN within their practice.**

For Further Information Contact:

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