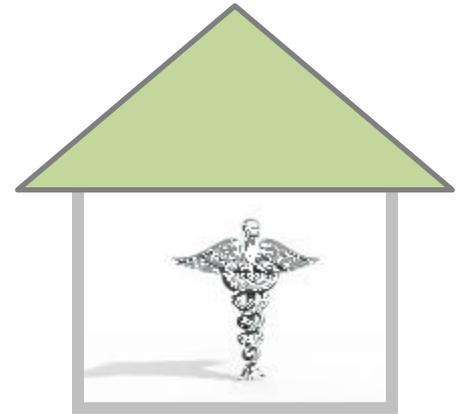


Special Health Services

Medical Home

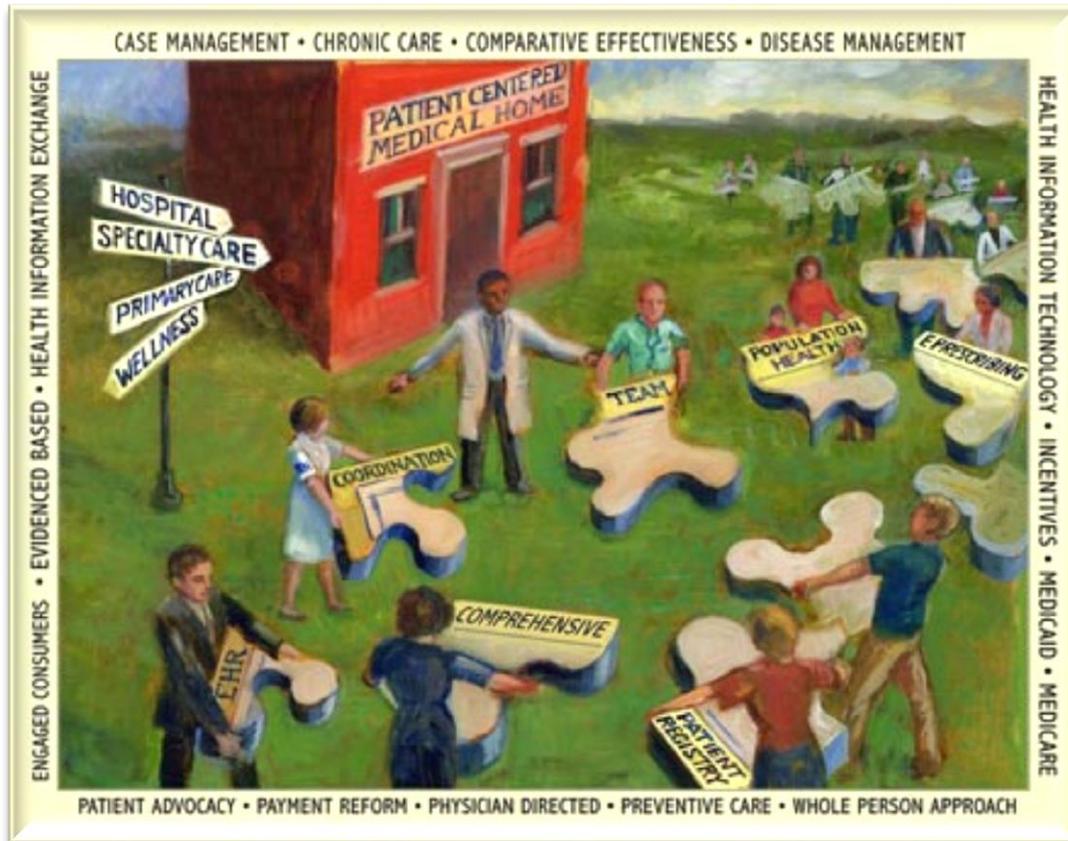


WHY? FEDERAL INITIATIVE

The US Department of Health and Human Services' *Healthy People 2010* goals and objectives state that "all children with special health care needs will receive regular ongoing comprehensive care within a **medical home**"²

² US Department of Health and Human Services, Health Resources and Services Administration. *Measuring Success for Healthy People 2010: National Agenda for Children with Special Health Care Needs*. Washington, DC: US Department of Health and Human Services; 1999

Medical Home Training Objectives



To understand how to:

- assess the presence of a medical home
- enhance the development of the medical home
- demonstrate skills that promote the development of a medical home

A Medical Home is not a:

- Building
- House
- Hospital



What IS a Medical Home?

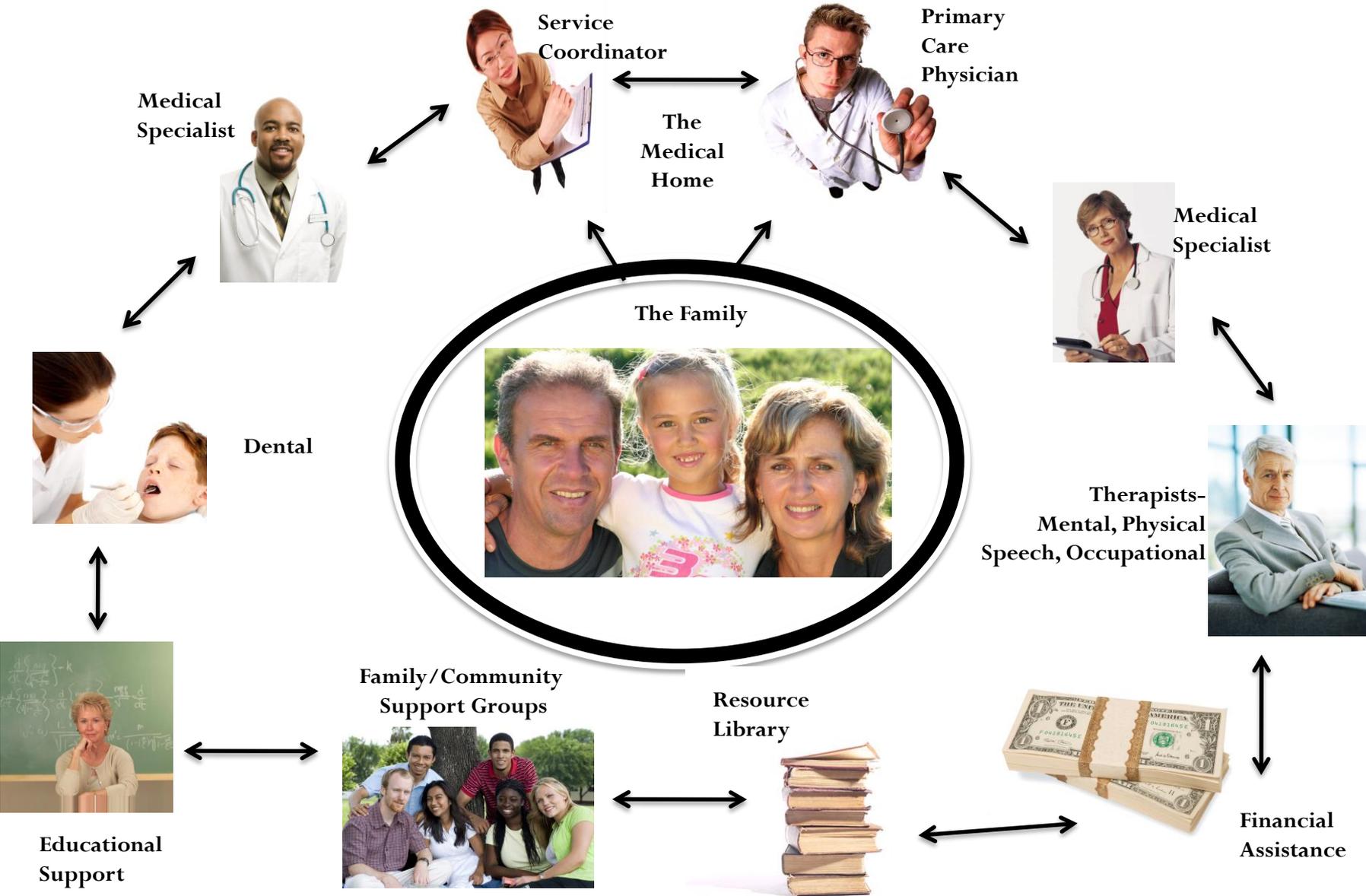
A medical home is not a building, house, or hospital, but rather an approach to providing health care services. In a high-quality and cost-effective manner .

Individuals who have a medical home receive the care they need from a health care provider whom they know and trust. Individuals and their health care providers act as partners in a medical home to identify and access all the medical and non-medical services needed.

A medical home should be accessible, family-centered, continuous, coordinated, comprehensive, compassionate, and culturally competent.

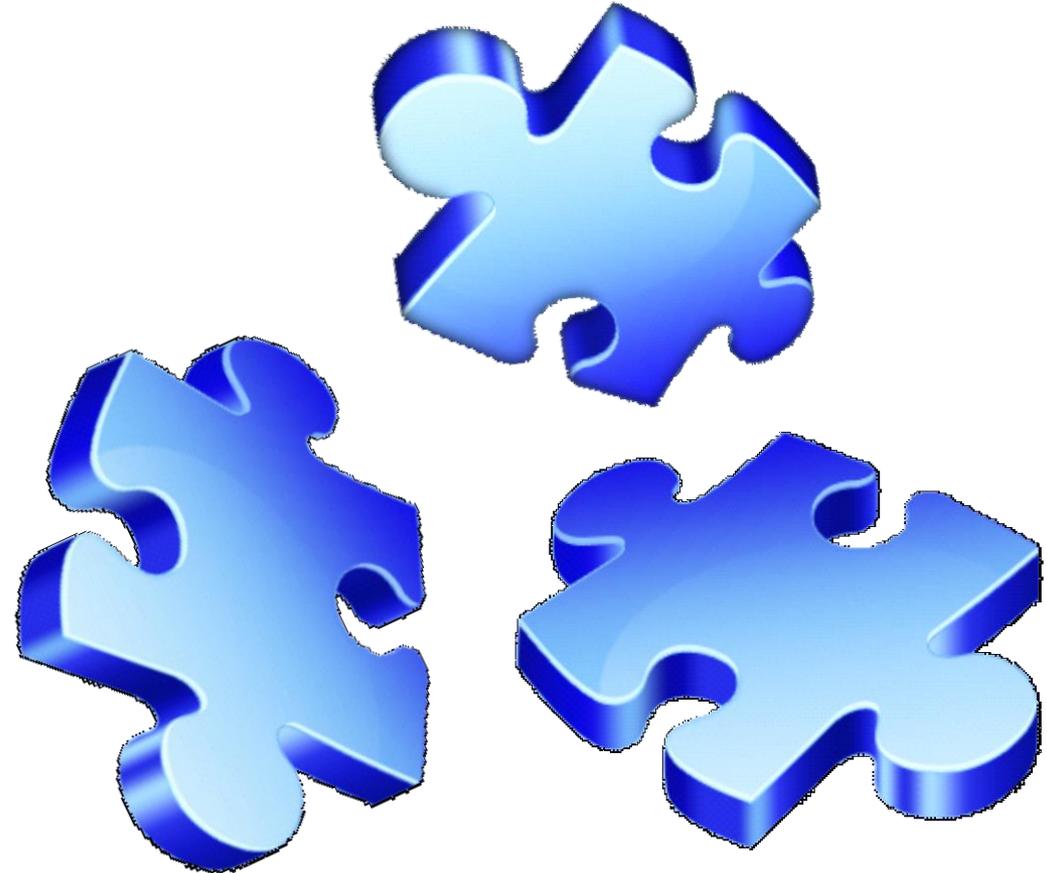


The Medical Home



What are the components of a Medical Home?

1. Accessible
2. Family-Centered
3. Continuous
4. Coordinated
5. Comprehensive
6. Compassionate
7. Culturally Competent



Accessible



Care is

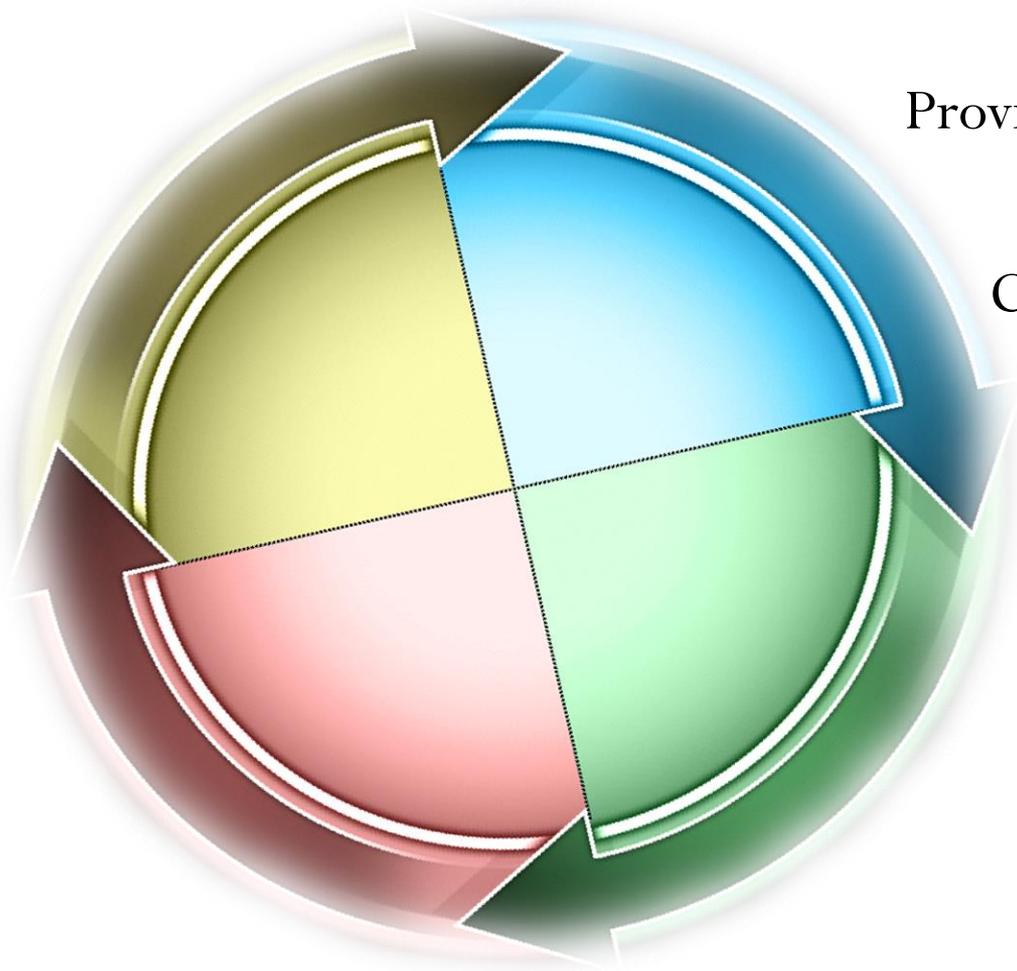
- Personally,
- Geographically, and
- Financially accessible for families.

Family Centered

- Families and providers share responsibility and information
- They know and trust one another
- Families are involved in care coordination.
- Family expertise is acknowledged.



Continuous



Providers are consistent.

Care is provided during wellness and illness.

Providers assist with transitions.

Coordinated



Coordination is established between families, providers, and agencies.

Comprehensive

All aspects of well being are considered and addressed:

- Medical
- Dental
- Developmental
- Educational
- Psychosocial
- Financial
- Family Support Services

Compassionate

Providers:

- respect families
- are supportive
- recognize and assess the need for supportive services
- provide resource information

Culturally Competent



Family values and customs are considered and incorporated into care plans.

Translation or interpreter services are provided when needed.

Written materials are provided in the family's primary language.

Potential Benefits of a Medical Home are:

- Increase individual and provider satisfaction.
- Increase wellness.
- Improve coordination of care.
- The health care system is easier to navigate.
- Efficient use of limited resources.



Building a Medical Home

The Service Coordinator needs to:

- Determine if the participant/family has partnered with medical professional
- Determine if a Medical Home exists and learn how it can be enhanced.
- Develop a written comprehensive care plan.
- Determine if a partnership exists with the medical professional and others involved in the participant's care.



Partner with Participants/Families



- Build rapport
- Identify strengths and unmet needs
- Identify participant/family goals
- Develop a plan
- Connect to information and resources
 - Health/Medical
 - Mental Health & Family Supports
 - Education
 - Interagency Collaboration
- Follow-up as needed

Tool Template

MEDICAL HOME

Individuals with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home.

1. The participant has a usual source for medical care:
 - A. Does the participant have a usual source of medical care when sick?
 - B. Does the participant have a usual source for preventive health care?
2. Physician or a specialist visit in the past year:
 - The participant has seen a physician or a specialist within the past year.
3. Effective service coordination is provided:
 - A. Do the participant's health care providers share information with each other?
 - B. Do the participant's health care providers and other non-medical professionals share information with each other? (e.g., educators, child care providers, therapists, vocational rehab, other agencies)
4. The participant receives family-centered care. Does the physician who sees the participant most:
 - A. Spend enough time with the participant during visits?
 - B. Listen carefully?
 - C. Consider the participant's/family's values and customs?
 - D. Provide needed information?
 - E. Make the participant/family feel like a partner?
5. Community-based services are organized so that they are easy for the participant/family to use:
 - A. Does the participant/family know whom to call when services are needed?
 - B. Can the participant get referrals when they are needed?
 - C. Does the participant receive most services in his/her local community?
 - D. Does the participant have adequate health insurance to pay for needed services?
 - E. Can the participant access language or mobility accommodations needed for provision of services? (e.g., language interpreter is available, office is wheelchair accessible)

Medical Home criteria are met if: questions 1A, 1B and 2 are answered "Yes"; And questions 3, 4 and 5 have at least a total of five "Yes" responses WITH at least one "Yes" response in each question 3, 4 and 5.

If Medical Home criteria are not met, was educational material provided? Yes No

- Questions?
- Comments?

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