

# 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 maximum 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 an approach to providing health care services in a high-quality and cost-effective manner.
- Medical Home is as much an attitude as it is a way of delivering care: families are recognized as the principal 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 chronic or disabling conditions is rising. Advances make it possible for persons of all ages to be cared for in the home and community, but this requires new approaches to care and new systems of supports.
- All primary care physicians who care for children have some children with special health care needs in their practice.
- Purchasers are increasingly using patient satisfaction measures as an indicator of quality care.
- Breakdown in communications and connections between patients and their physicians are among the primary reasons why consumers change providers and, in severe cases, take legal action.

# RESOURCES FOR BUILDING MEDICAL HOME PARTNERSHIPS IN MASSACHUSETTS

Learn about Medical Home activities across the country:

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](mailto:medical_home@aap.org)  
website: [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)

Learn about the Massachusetts Care Coordination Project and other state resources:

Massachusetts Department of Public Health  
Office of Family & Community Support  
Division for Special Health Needs  
250 Washington Street  
Boston, MA 02108  
phone: 800-882-1435  
website: [www.state.ma.us/dph/fch/famsupport.htm](http://www.state.ma.us/dph/fch/famsupport.htm)

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

Massachusetts Chapter  
American Academy of Pediatrics  
Committee on Disabilities  
P.O. Box 9132  
Waltham, MA 02454  
phone: 781-895-9852  
website: [www.mcaap.org](http://www.mcaap.org)

Join others working to promote Medical Home partnerships in Massachusetts:

Massachusetts Consortium for Children with Special Health Care Needs

New England SERVE  
101 Tremont Street, Suite 812  
Boston, MA 02108  
phone: 617-574-9493  
email: [info@neserve.org](mailto:info@neserve.org)  
website: [www.neserve.org](http://www.neserve.org)

Find resources to support Family Centered Care:

Institute for Family-Centered Care  
7900 Wisconsin Avenue, Suite 405  
Bethesda, Maryland 20814  
phone: 301-652-0281  
email: [institute@iffcc.org](mailto:institute@iffcc.org)  
website: [www.familycenteredcare.org](http://www.familycenteredcare.org)

Find Tools for Medical Home Improvement:

Center for Medical Home Improvement  
Hood Center for Children & Families  
Children's Hospital at Dartmouth-Hitchcock  
Medical Center  
One Medical Center Drive  
Lebanon, New Hampshire 03756-1479  
phone: 603-653-1480  
website: [www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org)



## SMALL STEPS... BIG DIFFERENCES

THE MEDICAL HOME PARTNERSHIP\*

Practical Tips for Physicians Caring 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.



101 Tremont Street  
Suite 812  
Boston, MA 02108  
[www.neserve.org](http://www.neserve.org)

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# 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 and 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 or home care.
- Maintain telephone numbers of public agencies, including the Massachusetts Family TIES program and the care coordinators based in Department of Public Health regional offices.

### 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 Department of Public Health, Division of Medical Assistance (Medicaid), Massachusetts Commission for the Blind, 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 in your community 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 health needs including ADHD and mental health conditions; and physical disabilities such as cerebral palsy, spina bifida, or muscular dystrophy. Recent survey data from the National Center for Health Statistics, Centers for Disease Control and Prevention estimate that 13% of children nationwide have special health care needs that meet this definition.