

Medical Home

Introduction

Meeting the complex health needs of children and their families often requires special assistance in the form of care coordination. In North Dakota (ND), approximately one in seven children (13.9%) have special health-care needs. Mandated services for certain conditions for Children with Special Health Care Needs (CSHCN) assist eligible families with medical costs and helps to provide gap filling services, such as state level care coordination and assistance with providing no cost medical food and low-protein modified food products for children with phenylketonuria (PKU) and maple syrup urine disease (MSUD). ND recognizes the importance of the medical home for all children, including CSHCN. In the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), it was reported that 47.8 percent of children, ages 0 to 18, received coordinated, ongoing and comprehensive care within a medical home.

Purpose

The Division of Children Special Health Services (CSHS) is the designated Title V Children with Special Health Care Needs program for the Title V/MCH Block Grant in North Dakota. The purpose of CSHS is to provide access to services for children and youth with special health care needs and their families and promote family-centered, community-based, coordinated services and systems of health

care. Care Coordination is a proactive approach to obtaining health care whether at well visits or symptomatic treatment. In addition, the care coordinator assists the family and child/youth with navigating the complicated health care system so that health needs are met in an efficient and timely manner at the appropriate level of care. According to (Antonelli, et al, 2009), "The goal of care coordination is to help link patients and families to services that optimize outcomes articulated in a patient-centered care."

Definition

A medical home is not a place, like an office or a hospital. Rather, the family or patient-centered medical home is a team-based approach to care that promotes coordinated acute, preventive and chronic care for all life stages. In a quality medical home, the clinical team partners with the patient or family to assure that all medical and non-medical needs are met. According to the American Academy of Pediatrics, a medical home provides well-child and preventive care. A medical home ensures care for its patients that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. A medical home assists in the early identification of special health-care needs, provides routine primary care and coordinates with a broad range of other related services.



The American Academy of Pediatrics (AAP) describes the ideal Medical Home as one that provides "**accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective care.**" Medical Home components prioritize: 1) accessible (physically, geographically, hours are practical, and the clinic accepts all insurance types), 2) family centered (goals, needs, and preferences of child and caregivers), 3) continuous care (children and families develop relationships and care for by the same team from infancy through young adulthood), 4) comprehensive care (all health care needs of children and youth are met, including well-care, sick-care, and behavioral health needs), 5) coordinated care (multiple providers and community services, including adult providers to assist with transition from pediatric to adult care), 6) compassionate care (well-being of the child and family is explicitly expressed and demonstrated and 7) culturally competent care (child and family culture, beliefs, rituals, and traditions are values, respected, and incorporated into care).

Strategies

Strategies to measure processes and outcomes associated with the Medical Home Model can be demonstrated by a) implementing quality improvement initiatives, b) utilization of measurement and practice-assessment tools such as the Medical Home Index.

Summary

Medical home will increase satisfaction with care, allow better access and improve the health of the individuals participating. The care coordinator is the link that connects the patient and family with services within the practice, with community based services, inpatient and outpatient settings and

between various specialty settings. Effective care coordination functions efficiently when provided in the context of the team setting within the medical home with an identified care coordinator.

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Resources

American Academy of Pediatrics,
medicalhomeinfo.aap.org

ND DoH: Division of Children's Special Health Services. Children with Special Health-Care Needs in ND: Using Data from the 2009-2010 National Survey of Children with Special Health-Care Needs, November 2013.

ND DoH: Division of Children's Special Health Services. Children with Special Health-Care Needs in ND, <http://www.ndhealth.gov/cshs/>

Antonelli R., McAllister JW, Popp J. Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework. The Commonwealth Fund; May 2009.