



Community Partners

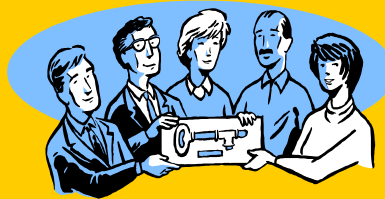
An Essential Component of Medical Homes

Educational and Community Based Services for Children and Adolescents

A Medical Home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. Community partners are an essential component. A medical home is defined as primary care that is accessible, continuous, family centered, coordinated, compassionate, and culturally effective. In a medical home, a pediatrician, family practice physician or other primary health provider works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services (Community Partners) that are important to the overall health of the child/youth and family.

Benefits of a Medical Home

- ♥Increased child/youth and family satisfaction
- ♥Establishment of a forum for problem solving
- ♥Improved communication and care coordination
- ♥Enhanced efficiency for children and families
 - ♥Efficient use of limited resources
 - ♥Increased professional satisfaction
 - ♥Increased wellness resulting from comprehensive care



Care Coordination: is a process that links children with special health care needs and their families to services, resources and Community Partners in a coordinated effort to maximize the potential of the children and provide them with optimal health care. This can be complicated because there is no single point to multiple systems of care, and complex criteria determine the availability of funding and services among public and private payers. Economic and socio-cultural barriers to coordination exist and affect families and health care professionals. With this in mind, communication among Community Partners is vital to the physician to provide coordination, in concert with the family.

Examples of Coordination with Community Partners:

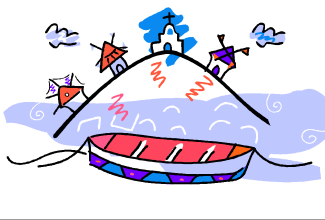
- ♥ A plan of care is developed by the physician, child or youth and family and is shared with Community Partners such as: providers, agencies, education and organizations involved with the care of the child/youth.
- ♥ Care among multiple providers is coordinated through the medical home.
- ♥ A central record or database containing all pertinent medical information, including hospitalizations, and specialty care is maintained at the practice. The record is essential, but confidentiality is preserved.
- ♥ The medical home physician shares information among the child or youth, family and consultant and provides specific reason for referral. This consultant may be one of the Community Partners mentioned above.
- ♥ Families are linked to family support groups, parent to parent groups and other family resources.
- ♥ The plan of care is coordinated with educational and Community Partners and organizations.

Examples of Coordination with other Medical Community Partners:

- ♥ When a child or youth is referred for consultation or additional medical care, the medical physician assists the child, youth and family in communicating clinical issues.
- ♥ The medical home physician evaluated and interprets the consultant's recommendations for the child, youth or family and in consultation with them and subspecialists, implements recommendations that are indicate and appropriate.
- ♥ The plan of care is coordinated among providers.



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Medical Home Community Partners

Educational and Community Based Services for Children and Adolescents

Children and adolescents with chronic diseases and disabling conditions often need related services. As medical home professionals, physicians can assist children, adolescents and their families with the complex federal, state, and local laws and regulations and systems associated with these services.

Because of the complex range of services and systems for special education and related services for children and adolescents partnership in the Medical Home process is critical. Community Partners, families and physicians together can navigate what is available to meet a child's specific needs.

Related services such as speech therapy, occupational therapy, physical therapy, and nursing care are provided to students in school because they are related to the student's education. Health care professionals frequently view these related services as medically necessary or helpful for children and adolescents with chronic diseases and disabling conditions. Although this is appropriate in the health care setting, it is not the standard for services that are mandated to be provided by public systems. The difference is perspective and interpretation by physicians and families often leads to misunderstandings, frustrations, conflicts and problems in the development and implementation of related services. To best serve children with special health care needs, community providers, families and physicians need to work together to assure complete communication. **This is a key function of the medical home provider for children.**

Similar to the IEP process, a multidisciplinary approach is required in the initial evaluation of children to determine their eligibility of services within the educational system. It is also necessary to maintain a comprehensive multidisciplinary approach in the provision of these services, which must be coordinated with the child's medical home professional. The developmental, educational, and medical needs of the child or adolescent should be determined first. Issues of who provides the appropriate services and how payment is to be made must be resolved in the context of maintaining the child in the appropriate educational and community environment.

It is necessary to be a part of a Medical Home Community by: Educating ourselves, learn the laws, be an advocate, focus on the child's needs, coordinate care, be proactive, and get involved at the systems level.

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