



Medical Home Newsletter

Medical Home 101 A Family Professional Partnership

Volume No. 10

<http://www.medhomeportal.org>

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Welcome

The purpose of this publication is to support health care providers in the establishment and maintenance of Medical Homes for their pediatric patients by providing tools and information for use in their practices.

To offer comments, or suggest ideas for future newsletters, contact the Project Coordinator Barbara Ward, RN BS bward@utah.gov.

Copies of newsletters may be found on the Utah Medical Home web portal: <http://www.medhomeportal.org> (click on Newsletters/Conf. Calls)

Medical Home 101

A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

In a medical home, a pediatric clinician 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 that are important to the overall health of the child/youth and family.

The Foundation of a Medical Home is the Family-Professional Partnership

Families of children with special health care needs are among the most knowledgeable people about what is working well and not so well in the system. They can be essential sources of information and support to providers in helping to improve policies, procedures and programs, and important allies in more general efforts to create better systems of services and care. (Gina Polamoney)

Barriers to providing a Medical Home

- Knowledge about chronic health condition management, the role of community and state agencies, and school-related issues.

- Lack of reimbursement and practice management strategies.

Benefits of providing a Medical Home

- Increased satisfaction with your role as a provider.
- A closer relationship with the families you treat.
- Increase patient and family satisfaction

The primary care physician and other health care providers:

- Know the child's health history
- Listen to the parents' and child's concerns and needs
- Work in partnership with families to ensure that the medical and non-medical needs of the child and family are met
- Create a trusting, collaborative relationship with the family
- Treat the child with compassion and understanding
- Develop a care plan with the family for their child when needed

What a Medical Home means to families:

- I can get care for my child 24 hours a day, 7 days a week.
- I am a valued and respected member of my child's medical team.
- I get the same doctor or office staff with every visit.
- My child's doctor never gives up on meeting my child's needs.
- I can easily receive referrals to specialists or specialty care when my child needs it.
- My child's providers are familiar with who my child is and his/her health condition(s).
- My child and I are treated with genuine concern and compassion.

Steps to providing a medical home

Step 1: Identify an office medical home team

- Recruit a parent advocate (one who has a child with special needs) to give input on office procedures and provide support to other parents.
- Identify a team member as a Care Coordinator
- Include the practice business manager to help with practice changes
- Schedule regular team meetings
- Recognize that the patient and their parents are part of the team

Step 2: Look at office procedures and anticipate special needs

Appointment scheduling

1. Identify patients with special needs in the scheduling system
2. Use a special sticker or different colored chart
3. Include critical needs at front of chart such as allergies, best way to weigh and measure etc.

Reception and Waiting Area

1. Ask family to fill out a brief form listing issues they would like to address during the visit
2. Be aware of parental concerns such as infection issues. Offer alternate space if possible
3. Use the waiting room to share information on programs and resources (summer camps etc)

Step 3: In the Exam Room: Use Family as Experts

Adjust Routine Procedures

1. Ask “What works best for your child”
2. Address urgent needs first
3. If child is seen frequently you may not need to weigh and undress at each visit, sparing the family and child some difficulty.
4. Some routine screenings, such as the ASQ, may not be appropriate once a disability has been identified.

Assess unmet needs

1. Review identified concerns of the day
2. Ask about impact of child’s condition on family and siblings.
3. Assess support systems
4. Explore other areas of child’s life such as recreation, education, socialization etc.

Develop and use a written plan of care

1. In partnership with the family develop a medical care plan (see resources for examples)
2. Set short and long term goals and include non-medical needs
3. Allows for parents and staff to efficiently communicate with other medical providers
4. Update at each visit

Step 4: After the Visit: Help Coordinate Care

Help Find Resources

1. Have identified Care Coordinator assist with appointments to specialists
2. Care Coordinator identifies and refers to community resources
3. Provide information on local resources and support groups
4. Use web sites, including the MedHome Portal (www.medhomeportal.org) to find resources

Maintain communication with specialists

1. Identify a staff member to obtain reports from specialists.

2. Help families understand the recommendations of other providers
3. Participate in care conferences with other providers

Paying the Bills

1. Identify a staff member to help with payment issues
2. Have information on and refer to the public insurance programs.

When families and their doctors work together to make comprehensive care in the community a reality, the partnership is called a Medical Home.

Physicians’ and Parents’ Ranking of Services

This grid below is from a survey that asked physicians and parents to rank the importance of services for families of CSHCN. The responses show that physicians' responses were not reflective of families' needs to help coordinate and manage their child's care. It also demonstrates the importance of partnering with families, asking them what their needs are instead of assuming what they are.

Ranking Service	Physicians	Parents
Respite	1	9
Day care	2	21
Parent support groups	3	3
Help with behavior problems	4	10
Financial info	5	2
After School Child Care	6	20
Assistance with physical/household changes	7	15
Vocational counseling	8	6
Psychological services	9	5
Homemaker Services	10	22
Recreational opportunities	13	4
Info on community resources	14	1
Dental Treatment	16	8
Summer camps	19	7

From Liptak G. and Revell G. Community physician's role in case management of children with chronic illnesses. Pediatrics, Sep 1989; 84: 465 - 471. [Abstract](#)

Billing for Medical Home Activities

Healthcare services provided to children with special health care needs (CSHCN) often exceed the typical services provided to most patients in primary care settings. Most of these services are described by existing CPT codes. The following are examples of CPT codes for services that are provided within Medical Homes but that are often not coded for correctly or compensated properly:

- Central Nervous system Assessments (developmental testing) (96110-96111)
- Special Reports (99080)
- Care plan oversight, home (99339-99340)
- Telephone calls (99371-99373)
- Home visits (99341-99350)
- Prolonged physician services (99354-99359)
- Team Conferences (99361-99362)
- Telephone calls (99371-99373)
- Care plan oversight services (99374-99380)
- Counseling and/or risk factor reduction intervention for individuals (99401-99404) or for groups (99411-99412)
- -25 modifier, used when the service significantly exceeds the usual service provided for that code (e.g., billing a preventive medicine visit, 99381-99397, plus a 99214-25 for the added time dealing with the child's spasticity, seizure disorder, and feeding problems)

For a complete list of codes go to the MedHome Portal click (Optimal Coding under About Medical Home) or the AAP medical home website listed below.

Utah Medical Home Resources

Utah Collaborative Medical Home Website

www.medhomeportal.org

This website provides **Information, Tools, and Resources** to aid **Primary Care Physicians** in caring for **Children with Special Health Care Needs (CSHCN)** and providing a **Medical Home** for all of their patients. Care plans, coding, management information, Utah community resources, and more are available at this site hosted by the Department of Pediatrics at the University of Utah

Utah Collaborative Medical Home Project at the Bureau of Children with Special Health Care Needs at the Utah Department of Health

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For office support:

Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) www.upiqhome.org

UPIQ Quality Improvement Specialist: Sandra Debry
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Monthly practice support phone conferences (topic oriented) Contact Barbara Ward (801-584-8584) for more information

Utah Family Voices Provides health information resources and support to families of CSHCN.
1-800-829-8200 or 801-584-8236

Utah Parent Center Provides information, training and referral for families of children with disabilities.
801-272-1051, 800-468-1160, **Español:** 801-272-1067
www.utahparentcenter.org/

National Resources

The American Academy of Pediatrics: The National Center for Medical Home Initiatives for Children with Special Health Care Needs. This site provides information on providing medical homes, tools, materials, brochures, screening information, coding information and more. 847-434-4000

Medical_home@aap.org

www.medicalhomeinfo.org

Medical Homes e-newsletter: from the AAP An E-newsletter dedicated to providing medical home info and resources for children with special needs. To sign up or view go to the above AAP website.

Institute for Family Centered Care: The Institute for Family-Centered Care provides leadership to advance the understanding and practice of patient- and family-centered care in hospitals and other health care settings.
301-652-0281

institute@iffcc.org

www.familycenteredcare.org

Center for Medical Home Improvement: Crotched Mountain, Greenfield, New Hampshire . Provides improvement strategies in primary care for Children with Special Health Care Needs 603-547-3311 ext. 272

www.medicalhomeimprovement.org

Attachment: Emergency Medical Form is a standardized emergency care plan that will be implemented statewide in 2007 for CSHCN to provide EMS providers and ER's with current health information on a chronically ill child.