

## What Families Need to Know About a Medical Home

When a family brings their child to DSCC and is asked if they would like to participate in a “medical home”, what does that mean? Will I now have to receive my child’s health care at a “medical home”? Does it cost more money? Do I have to fill out a long application? What am I expected to do? What will DSCC do? Will it affect my health insurance benefits? Will I need to change doctors? The questions can be endless, but let me try to explain “medical home”.

“Medical home” is not a place, a house, or a building. It is not a place where you can go. “Medical home” is a special relationship that you have with health care professionals and how they provide health care for your child. There are no additional applications to fill out; every family whose child is eligible for DSCC services can participate in a “medical home”. There are no special fees you have to pay. A “medical home” does not change your health insurance coverage. Then you might say, tell me what will a “medical home” do for my child and family?

“Medical home” is a relationship between you and the health care professionals who take care of your child. We call this a “family-professional partnership”. In this partnership all the health care professionals respect the parent’s understanding of their child’s needs and the priorities the family has for meeting those needs. A “care coordination plan” to meet your child’s needs and good communication between the health care professionals caring for your child are additional important elements in a “medical home”.

In the 13 Regional Offices throughout the state, the DSCC staff who serve your child are called “care coordinators”. They will help you develop a “care coordination plan” for your child. This plan is based on what you explain are the “needs” of your child and the “priorities” you feel need to be addressed. In other words, what needs to be worked on first, then second, and so on. You and your child, plus the DSCC care coordinator, create the beginning of this “family-professional” partnership.

The next professional to become involved in this “family-professional partnership” is your child’s “primary care provider”, a family physician or a pediatrician are the two most common primary care providers for children. They take care of your child for such common problems as head colds and earaches; and they give immunizations and advice on routine health care problems. Your child’s “primary care provider” will work with you, your child, and the DSCC care coordinator to add the “medical details” to your child’s “care coordination plan”. In other words, for each health care need you identified for your child, the “primary care provider” will suggest how that need can be met. For example, you may be concerned that your child has a “seizure problem” and needs help. Your child’s seizures may be causing learning problems in school, school absence, and behavior problems at home. The “primary care provider” may order some blood tests, a brain wave test and refer your child to a pediatric specialist, called a pediatric neurologist, and a behavior specialist, called a psychologist.

The “family-professional partnership” is growing and now includes a pediatric neurologist and a psychologist. All the people making up the “family-professional partnership” can also be called the “medical home team” for your child. These two additional “team members” will add their areas of expertise to the “care coordination plan”. Your DSCC “care coordinator” can help you understand who the members of your child’s “medical home team” might be.

The degree to which all members of the “team” provide a “medical home” can be called “medical homeness”. Let’s look at what adds to “medical homeness”.

- A primary care provider (your child’s pediatrician or family physician) is available 24 hours a day, 7 days a week. That means you can call your doctor and arrangements are made that your child can be seen or questions answered 24 hours a day, 7 days a week.
- You have a trusting and good working relationship with all members of the “team”. You feel comfortable sharing your concerns about your child and know that the team members respect you.
- The “care coordination plan” that is developed by the DSCC care coordinator with all other team members is comprehensive; the “plan” includes all your child’s needs and how they are going to be taken care of.
- Your child’s “care coordination plan” should contain a timeline so that immediate needs are addressed as well as future needs, like transition to adulthood. You and your child may need to think about things like health insurance, employment, education (college or vocation), living in the community (by themselves, in your home, etc) and community recreation.
- Communication occurs among all members of the “team”. Here is where the DSCC care coordinators can help to make sure that all reports and other information from “team members” are shared with your permission.
- All members of the “team” need to show compassion for your child’s problems and be sensitive to your individual cultural background.
- Health care providers (your pediatrician or family physician and pediatric specialists like the psychologist and pediatric neurologist) need to have offices that are accessible by wheelchair, have office staff who are aware of your child’s special needs, and give you appointments that allow you to express your concerns and have your questions answered.

All of the above make up a “medical home”. The degree to which they are practiced determine the amount of “medical homeness” that you and your child experience. DSCC wants to work with the professionals who make up your child’s “medical home team” so that you experience the maximum “medical homeness” in a “medical home”.