Advancing Family-Centered Care Coordination

Promote Family Understanding of Medical Home

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Learning Objectives

• Understand expectations of your selected additional focus area (Promote family understanding of medical home)

• Understand resources to support families on this topic

• Be aware of partners available to support your team in fulfilling these expectations
Participating Sites

- Gerald L Ignace
- Lac du Flambeau
- Sokaogon Chippewa
### Populations selected for piloting Shared Plans of Care

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Patient Focus</th>
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<tbody>
<tr>
<td>Gerald L Ignace</td>
<td>Children diagnosed with ADHD</td>
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<tr>
<td>Lac du Flambeau</td>
<td>Children with chronic special health care needs including behavioral health</td>
</tr>
<tr>
<td>Sokaogon Chippewa</td>
<td>Children with medical complexity/behavioral health</td>
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Promote family understanding of medical home

In collaboration with your Regional Center and WISMHI team, work to educate at least 10 families on concepts of medical home. Communication tools to support this work include:

1. *Training* for parents titled *Care Mapping*
Customizable brochure for parents on the topic of medical home

www.wismhi.org
**Definition of a Medical Home**

A medical home is a trusting partnership between you, your child, and your pediatric health care team. Both families and health care teams have responsibilities.

In a medical home, your health care team can help you and your child access and coordinate specialty care, other health care and educational services, in and out of home care, family support, and other public or private community services that are important to the overall well-being of you and your child.

From AAP's [healthychildren.org](http://healthychildren.org)

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**Family Responsibilities**

- **Before an appointment**
  - Write down important questions and concerns
  - Prepare your child for what may happen at the visit
  - Organize your thoughts using a free online tool such as the Well-Visit Planner [WellVisitPlanner.org](http://WellVisitPlanner.org)

- **During an appointment**
  - Share your concerns openly and directly as you know your child better than anyone
  - Ask the doctor to explain the care your child needs, and write it down. Children with ongoing medical needs may have a written care plan

- **After an appointment**
  - Keep notes on how the care plan is working
  - Contact your doctor or health care team if you have questions or concerns

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**Health Care Team* Responsibilities**

- Knows your child’s health history
- Listens to your concerns and needs (as well as your child’s)
- Treats your child with compassion
- Understands your child’s strengths
- Develops a care plan with you and your child when needed
- Respects and honors your culture and traditions

* A health care team may include a doctor, nurse, front desk staff, and others working at a clinic.

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**TRUSTING PARTNERSHIP =**

**YOU + YOUR CHILD +**

**YOUR CHILD’S HEALTH CARE TEAM**

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"My son’s doctor, nurses and I are a team. They listen carefully to me when I talk about him, and I try to follow their suggestions. We have different roles, but we respect one another. My son’s medical care is better because of this partnership."

Wisconsin Parent

"Medical Home allows me to be the doctor my patients and families deserve. We partner with the family to coordinate their child’s care. We also connect them to other supports and services they want and need."

Wisconsin Pediatrician

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www.wismhi.org
Brochure

Medical Home Resources

Wisconsin Medical Home Initiative promotes family-centered, integrated care with health care teams and families throughout Wisconsin. www.wismhi.org

Wisconsin has five Regional Centers that support families with children and youth with special needs and their providers. dhs.wisconsin.gov/cyshon/regionalcenters.htm

Wisconsin First Step provides an online resource directory and a 24-hour information and referral hotline serving families of children with special needs and professionals. Contact the hotline at 1-800-642-7837. mdh-hotlines.org/mdhhotlines/wisconsin-first-step/

Family Voices is a statewide network of families who have children and youth with special health care needs. Family Voices provides information, training and leadership opportunities to help families learn more and be effective partners in their child’s care. familyvoicesofwisconsin.com

Parent to Parent of Wisconsin supports parents of children with special needs through a one-to-one connection with another parent. j2pwi.org

Next Steps
Consider talking with your child’s health care team about the idea of medical home. If your child does not have a primary care doctor, speak with a person from your health plan about available doctors and their areas of interest.

Key Contact for Medical Home:

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<tr>
<th>Name</th>
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<tr>
<th>Phone</th>
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After hours contact

www.wismhi.org
Care Mapping

An interactive session to begin to create a diagram to help support and guide your family and care teams
Learning Objectives for the training:

✓ Better understanding of the value of a care map.

✓ Understand how to use a care map to build a medical home.

✓ Learn potential outcomes of using a care map.

✓ Create your own care map.
Care Mapping

What is a Care Mapping?

- A process which guides and supports the ability of families and care professionals to work together to achieve the best possible health outcomes.
- A family-driven, person-centered process which highlights a family’s strengths and communicates both the big picture and the small details of all of the resources needed to support a child and their family.
Care Mapping
Care Mapping
### Care Mapping

#### Now It's Your Turn

<table>
<thead>
<tr>
<th>Important Family Members</th>
<th>Recreation/Community/Social</th>
<th>Legal/Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family</td>
<td>Special Olympics</td>
<td>Trust/Estate</td>
</tr>
<tr>
<td>Extended family</td>
<td>After School Program/Clubs</td>
<td>Attorney</td>
</tr>
<tr>
<td>Friends like family</td>
<td>Adaptive Classes</td>
<td>Economic Services</td>
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#### Health

- Doctors
- Insurance/Medicaid
- Dentist
- Hospital
- Pharmacy/Medications
- Specialists
- OT/PT/Speech
- Equipment

#### Education

- School
- Transportation
- Special Education
- Regular Education
- School District
- Nurse
- Case Manager
- Lunch / Recess

#### Home Care

- Respite
- Private Duty Nurse
- Personal Care Worker
- Home Health Services
- Guide Dog
- Child Care
- Vacation

#### Social Services

- Case Manager
- Programs
- WIC
- Birth to Three
- Early Intervention
- Waiver Programs

#### Advocacy and Information

- Children & Youth with Special Health Care Needs
- ABC for Health
- Family Voices of WI
- Representatives – local, state, national

#### Support

- Spiritual Community
- Parent to Parent
- Parent Support Groups
- SIBShops
- Blogs
CYSHCN Network of Support

Wisconsin Title V Children and Youth with Special Health Care Needs Program
Why would a family member or provider contact the CYSHCN Regional Centers?

- Information on your child’s condition
- Problem-solving
- Partnering with your doctor in a Medical Home
- Health Transition from child to adult health care
- Health insurance / benefits assistance (e.g. Medicaid)
- Services in the community
- Parent-to-Parent support
- Finding doctors and dentists
- Parent training events
- Communicating with schools
Family Voices of Wisconsin

**Why would a parent contact Family Voices of Wisconsin?**

- To serve in a leadership or advisory role to impact health care or long-term supports
- To join our regional Facebook groups, be added to the Family Action Network and our mailing list
- Register for a training
- Have resources printed from our website
- Have suggestions for a newsletter article, fact sheet, or new training
Why would a parent contact Parent to Parent of Wisconsin?

- To request a “match.”
- To register for a Support Parent training.
- To schedule a Support Parent training in their area.
Why would a family member or provider contact the Wisconsin Medical Home Initiative?

- To learn more about partnering with their child’s doctor.
- To learn more about use of a shared plan of care to facilitate care for CYSHCN.
**Wisconsin Youth Health Transition Initiative**

**WHY WOULD A FAMILY MEMBER CONTACT THE WISCONSIN YOUTH HEALTH TRANSITION INITIATIVE?**

- Visit the YHTI website for information, tools and resources to help prepare and plan for health transition.

- Seek and receive more information through training programs sponsored by partners including things to consider at different ages as well as ways they can support their child to become more involved in their health care.
Discussion Questions

- How might this training benefit families?
- Are there families who come to mind for this training?
- How might understanding these concepts help families better partner with your team?

If you would like access to this PPT, you can find it along with all of the other presentations on the www.WISMHI.org website.
Thank You!