

Medical Home Care Coordination and Family Involvement Resources

- *The National Center of Medical Home Initiatives* website contains a compilation of facts, resources, tools, and training materials relevant to the medical home concept. The training materials comprise a comprehensive, multi-component training approach that can be presented in a centrally located 1-day program, or in smaller modules over time in local meeting settings. The flexible design enables organizations and practices to customize training program length and target audience. The following webpage contains downloadable faculty and participant curriculum materials. (<http://www.medicalhomeinfo.org/training/materials.html>)
- *The National Center of Medical Home Initiatives* website contains extensive materials on care coordination. (<http://www.medicalhomeinfo.org/tools/coordinating%20care.html>)
- *The Center for Medical Home Improvement (CMHI)* offers a practice-based model of quality improvement. The model blends parent insight, professional knowledge, and care coordination to build primary care medical homes. CMHI promotes the medical home as a patient and family-centered “way of doing things” in pediatric and adult primary health care. The CMHI website offers a medical home toolkit with assessment and measurement tools; quality improvement strategies; chronic condition management; care coordination; and other topics. (<http://www.medicalhomeimprovement.org/>)

<p>Care Coordination</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • The primary care provider (PCP) intermittently, but deliberately, asks any patient/family with a chronic condition what additional care supports they need. • The PCP or a staff member helps patients/families obtain resource information and coordinate appointments. • If not provided directly by the PCP, the practice assumes responsibility to connect patients/families needing care coordination with other available care coordination resources. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • The <i>Medical Home Practice-Based Care Coordination Workbook</i> is a downloadable resource from the Center for Medical Home Improvement. Tools included in this resource are: a definition of care coordination in the medical home; a care coordination position description; a framework for care coordination services including structures and processes; strategies for the protection of devoted staff time; and a logical sequence of care coordination improvement ideas. (http://www.medicalhomeinfo.org/tools/Tools/PDF_Final_PracticeBasedCC-Workbook7-16-07.pdf) • The <i>Utah Medical Home Portal</i> website provides a concise overview of care coordination in the context of it being a vital component of the medical home. Care coordination builds essential trust between families and providers by responding to needs in a timely and organized manner. Toolkit links are provided. (http://www.medhomeportal.org/about/care-coordination)
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<p>Family Involvement</p>	<p><u>EXAMPLES:</u></p> <ul style="list-style-type: none"> • “Perceptions of care” feedback from patients/families with chronic conditions is systematically gathered (e.g. using surveys, focus groups, or interviews of ≥10 families) at least every six months. • There is an established process for practice staff to review this feedback and, based on the feedback, to plan and implement change. • Over time, the primary care provider builds a peer-to-peer partnership with selected patients/families who act as trusted advisors to the practice. <p><u>RESOURCES:</u></p> <ul style="list-style-type: none"> • According to the <i>Wisconsin Title V Program Medical Home</i> website, “engaging families as partners in both care planning and practice decisions can be rewarding and introduce enormous efficiencies to the practice.” The site’s “Tips for Providers” lays out simple steps to take before, during, and after the appointment. The tips help integrate family and patient input into health decision-making and coordination of effective appointments. (http://wimedicalhometoolkit.aap.org/engage/index.cfm) <hr/> <ul style="list-style-type: none"> • The <i>Institute for Family-Centered Care</i> is a non-profit organization providing leadership to advance the understanding and practice of patient- and family-centered care. By promoting collaborative, empowering relationships among patients, families, and health care professionals, the Institute facilitates patient- and family-centered change in all care settings. The website’s FAQ section may be particularly helpful. (http://www.familycenteredcare.org/index.html)
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