



Washington State Department of
Early Learning

Practice Guide: *Medical Homes and Primary Care*

**Department of Early Learning/Early Support for Infants and Toddlers
and
Department of Health/Healthy Starts and Transitions**

June 23, 2016





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What is your role in early intervention?



Washington State Department of
Early Learning






Today's Webinar

- ❑ We will be recording today's webinar
- ❑ All attendees are muted
- ❑ If you have a question or comment, please use the question box
- ❑ We will answer questions at the end



Objectives

Objectives:

-  Understand the importance of the medical home model of care for infants and toddlers with disabilities
-  Review the new Practice Guide on Medical Homes and Primary Care
-  Learn how to share this information with parents

Great LINCS Goals

❑ Three year HRSA (Health Resources and Services Administration) grant- aimed to integrate services that work with CYSHCN

❑ Goals:

🔺 Create a state-wide shared resource for CYSHCN

🔺 Increase the use of shared plans of care within a sub-population

🔺 Increase the amount of children who have a medical home

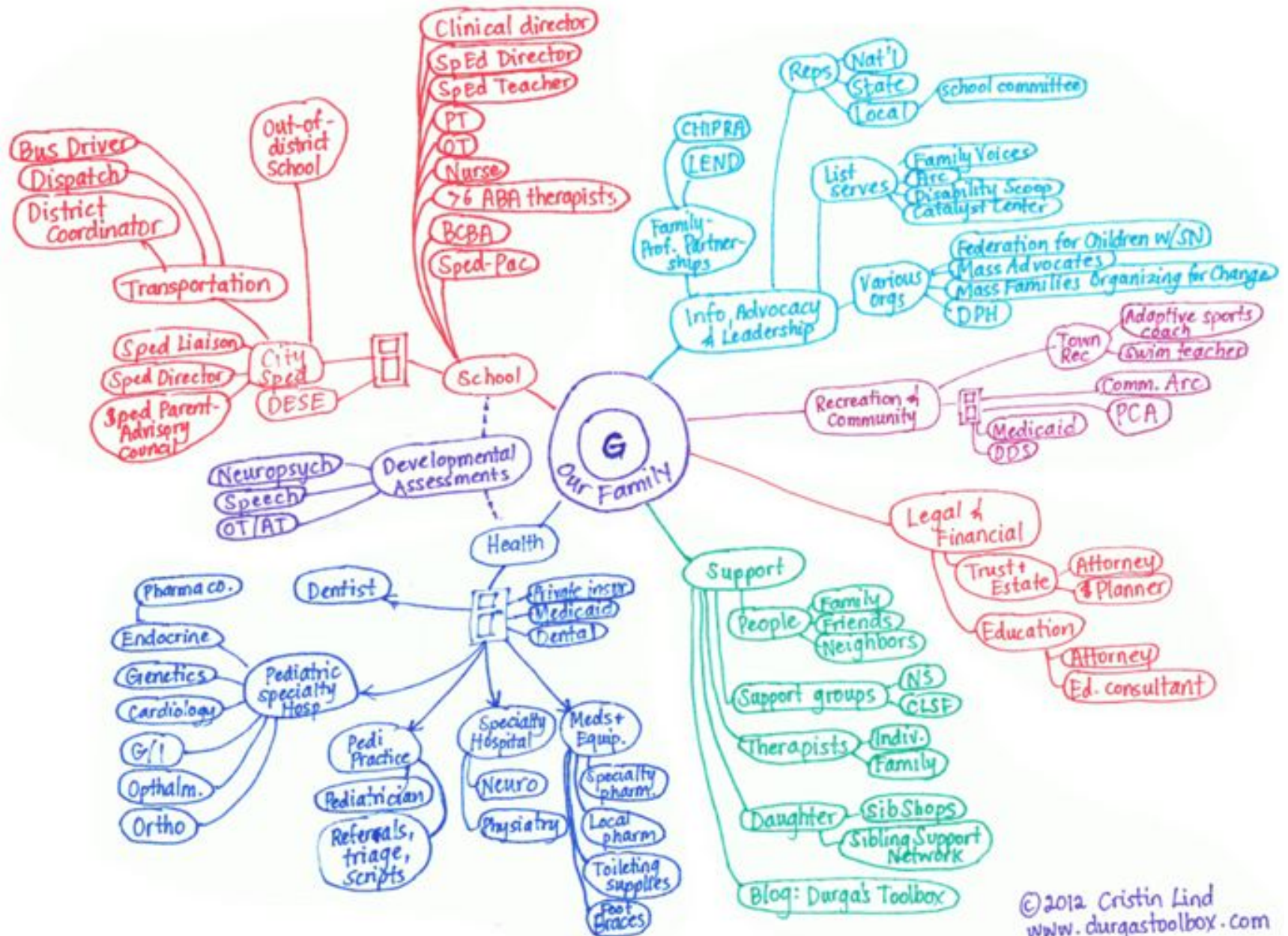


Who are Children with Special Health Care Needs?

- ❑ CYSHCN are kids; kids who also happen to need extra care
 - ⚠️ Have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions
 - ⚠️ Require health and related services of a type or amount beyond that required by children generally
 - ⚠️ All kids that ESIT serves!

What is a Medical Home?

- ❑ NOT a *place*, but rather an *approach* to providing **comprehensive** primary care.
- ❑ **The American Academy of Pediatrics (AAP)** developed the medical home model for delivering primary care that is:
 - Accessible
 - Coordinated
 - Continuous
 - Compassionate
 - Comprehensive
 - Culturally effective
 - Family-centered





Common players in a Medical home for CYSHCN in WA State

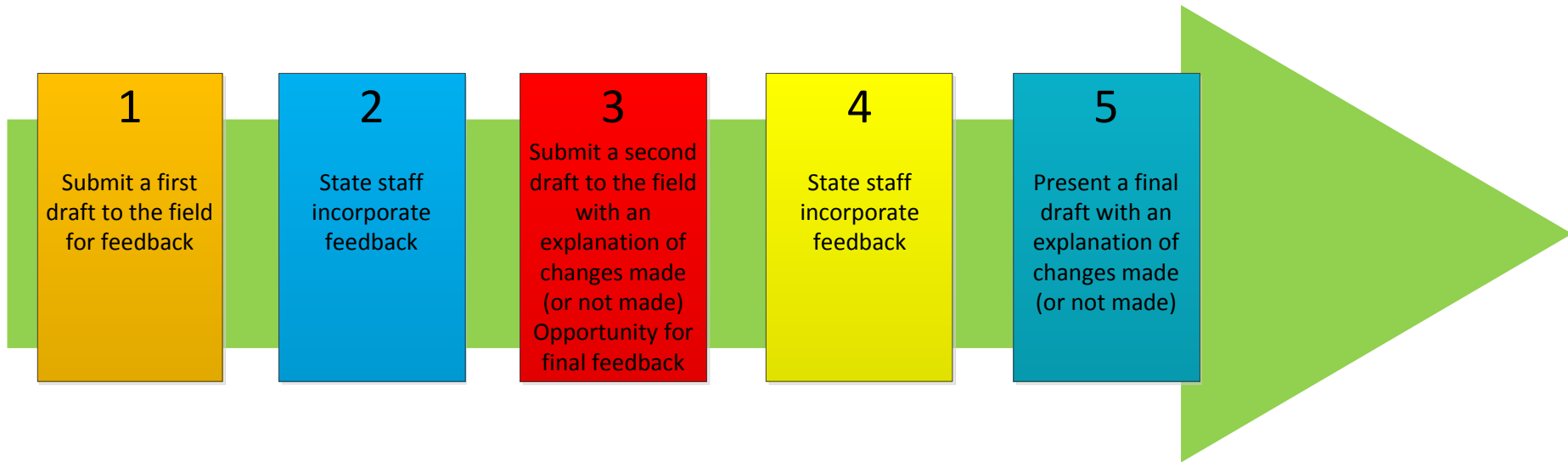
- ❑ ESIT (you!)
- ❑ MCO Coordinators
- ❑ CSHCN County Coordinators
- ❑ Neurodevelopmental Centers (and other specialists)
- ❑ Primary Care Providers



Practice Guide

- ❑ Practice Guide: Medical Homes and Primary Care
- ❑ Appendix 1: Background Information
- ❑ Appendix 2: Parent Information
- ❑ Appendix 3a: Medical Home Brochure- English
- ❑ Appendix 3a: Medical Home Brochure- Spanish
- ❑ Optional form for communication

Practice Guide Feedback





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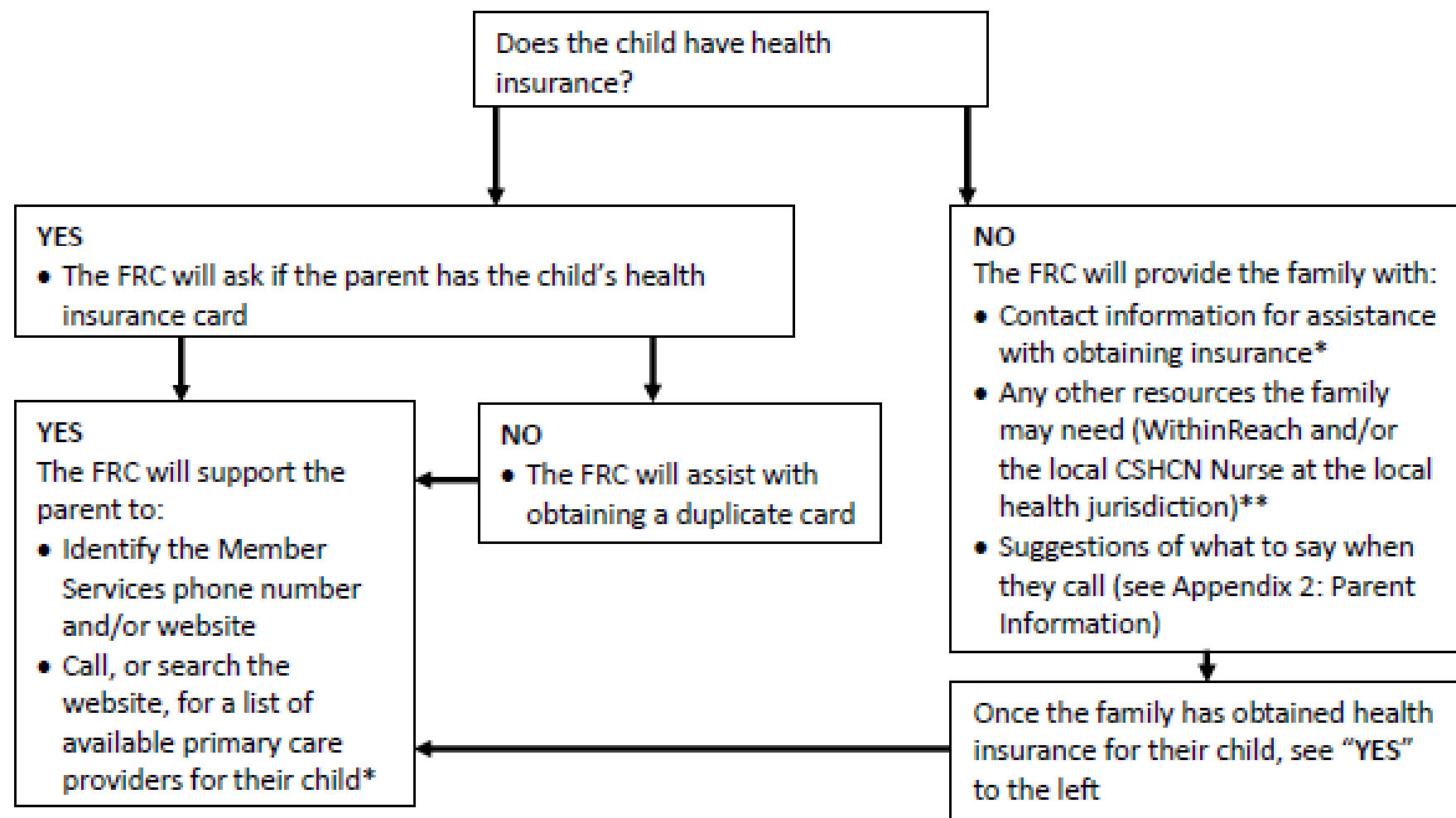
Have you ever helped a family find a primary care provider?

Guidance

One responsibility of the Family Resources Coordinator (FRC) is to help families identify and access community resources and supports that they or their child may need, based on the family's current priorities. During the intake process and/or the initial Individualized Family Service Plan (IFSP) meeting, the FRC must discuss with the family whether or not they have a primary care provider (PCP) for their child.

If the family DOES NOT have a primary care provider, the following are the steps the FRC must take:

1. During the intake process, use the decision tree below to support the family to identify a primary care provider:





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Have you ever written a family/community resource outcome with a family?



2. If a primary care provider has not been identified by the initial IFSP meeting, offer to write an FRC community resources and supports outcome to assist the family. An example outcome for this scenario is below:

Outcome #____ What do we want to accomplish? We want to locate a primary care provider and/or medical home so our family receives comprehensive, coordinated medical care.
Who will do what? The FRC will support the family in exploring options for and obtaining insurance coverage/a primary care provider/medical home. The family will use resources such as WithinReach and CSHCN to find out about local options for providers and assistance with health insurance.
Review Date: _____
Progress code (circle one): Achieved Continue Discontinue Revise
Comments:

3. The family (with FRC assistance as needed), will research the options and make an appointment with the primary care provider they choose. The FRC can help the family understand the medical home concept and prepare for a doctor's visit by offering information to the family on the medical home model of primary care. See Appendix 3 for a printable brochure in English and Spanish; to access the brochures online visit <http://medicalhome.org/resource/support/brochures/> and to access an older brochure in six other languages, visit <http://medicalhome.org/resource/support/resources-by-language/>.

<http://medicalhome.org/resource/support/brochures/>



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How do you share information back with primary care providers?



When the family DOES have a primary care provider, the following are the steps the FRC must take to allow information sharing between ESIT and the primary care provider and to educate the family about the medical home model of primary care and:

1. Offer the family a release of information to communicate with the primary care provider and ask the family to sign the release. With the family's consent, the FRC must:
 - a. Inform the primary care provider of the child's ESIT enrollment status;
 - b. Share the Individualized Family Service Plan (IFSP) with the primary care provider (if the PCP indicates they would like less information send, at minimum, the initial eligibility and summary of services pages from the IFSP or a summary letter);
 - c. Share progress as needed; and
 - d. Inform the primary care provider of changes to the child's ESIT enrollment.

2. Offer information to the family on the medical home model of primary care (see Appendix 3 for a printable brochure in English and Spanish; to access this brochure online visit <http://medicalhome.org/resource-support/brochures/> and to access an older brochure in six other languages, visit <http://medicalhome.org/resource-support/resources-by-language/>).

Optional form for communication



Parent Information





Questions



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Thank you!

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