

# STEP THREE

## FAMILY TRAINING AND PARTNER ORIENTATION

### Orientation to the medical home

Family Health Partners should be knowledgeable about the medical home concept. A medical home is not a place but a process of care that emphasizes “home” as a headquarters for care where patients and families feel recognized, welcomed and supported. The American Academy of Pediatrics (AAP) developed the medical home model for delivering primary healthcare that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective to all.

### Patient- and family-centered care

**Patient- and family-centered care** is about patients, families, doctors, nurses and other professionals working together. Medical home practice that embraces the patient- and family-centered values described below can achieve high-quality care.

### FOR RESOURCES ABOUT MEDICAL HOME TO SHARE WITH FAMILIES, VISIT

<http://www.nichq.org/sitecore/content/medical-home/medical-home>

- Honoring racial, ethnic, cultural and socioeconomic diversity and its effect on the family’s experience and understanding of care
- Encouraging each child and family to discover their own strengths, build confidence and make choices and decisions about the child’s care even in difficult and challenging situations
- Ensuring flexibility within the practices so services can be created to meet the unique needs, beliefs and cultural values of each child and family
- Sharing honest and unbiased information with families on an ongoing basis and in ways they find useful and affirming
- Providing connections to community supports for the child and family during all stages of childhood including adolescence and young adulthood

“When patient- and family-centered care is practiced it shapes health care policies, programs, facility design, evaluation of health care and day-to-day interactions among patients, families, physicians, and other health care professionals.”

“Patient- and Family-Centered Care and the Pediatrician’s Role,” American Academy of Pediatrics policy statement

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### Orientation to the medical home

Culturally responsive care

In an effective patient- and family-centered medical home, a family's cultural background, including beliefs, rituals and customs, is recognized, valued, respected and incorporated into the care plan. All efforts are made to ensure that the child and family understand the results of the medical visit and the care plan. When needed, **translators or interpreters** should be offered.

Culturally and linguistically appropriate services are defined as “care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals and are increasingly recognized as effective in improving the quality of care and services.”<sup>1</sup>

Keep in mind that family members of a similar ethnic or language group are not all the same, even though within one group or across groups, people might face similar challenges. Ask families about their cultural beliefs, how these relate to their child's plan of care and how they make decisions about care. When providers ask families to define themselves in their own words, authentic partnering is reinforced.

**Cultural humility** encourages providers to constantly self-assess their own views of cultural norms and acknowledge the power imbalance between patients and providers. By exercising cultural humility, providers can more effectively establish partnerships with their patients to let their needs and beliefs inform care decisions.

### Medical home care team

Patient-centered care teams in medical homes deliver care that is guided by patients and families. Care teams might include a primary care physician or nurse practitioner; other nursing staff and a medical assistant. Family Health Partners may also be included along with other professional staff (such as a behavioral health provider, care coordinator, dietician, etc.), depending on the patient's or family's needs. Team roles and responsibilities may vary by practice, so distribute tasks among care team members to reflect their skills, abilities and training.

NICHQ has created a medical home care team builder tool that assists practices in developing care teams within their medical home.

<sup>1</sup> Beach et al., 2004; Goode, Dunne, & Bronheim, 2006

### Orientation to the medical home

#### Care plans

**A care plan** compiles the patient's information—current and past medical history, list of medications, list of doctors and specialists, community resources or services accessed by the family—along with personal preferences of the patient and family regarding a child's health-care, all together in one place. Also known as a portable medical summary, the plan may include medical and social aspects of a child's and family's needs, and any medical equipment the patient uses.

Patients and families can use this summary to convey medical information to other medical providers not familiar with their care history. It can be especially helpful for families in the case of a medical emergency when care providers do not have access to their child's medical record.

A **care notebook** is a tool that patients and families use to keep important medical information organized. Bringing the notebook to appointments and meetings allows families to easily share information with doctors, therapists and school or childcare staff.

#### **A care notebook can help patients and families:**

- Prepare for appointments
- Store information about health history
- Keep track of current medications, including allergies
- Organize contact information (address and phone numbers) for health-care providers and community organizations supporting the families



### Orientation to the medical home

#### Care coordination

**P**ediatric care coordination is driven by identifying the needs of a child and his or her family and connecting them to medical services and community services to meet those needs. In a medical home, the provider and practice staff may help patients and families make contact with other health providers, specialty care doctors, family support organizations or other services that assist families. Care coordination may be a specific role within a practice or it may be a function of the medical home practice.

#### **Patient- and family-centered medical homes aim to deliver care coordination that:**

- Is family-centered and community-based
- Is proactive, planned and comprehensive
- Promotes self-care and management skills for children, youth and families
- Helps patients and families connect with other healthcare providers

Care coordination functions within a medical home by completing **needs assessments** with patient and families, developing a plan of care and tracking referrals to providers and other supports. How care coordination is handled within medical homes varies, but they all share a similar goal of helping children achieve good health and wellness.

#### Linkage to community resources

**M**edical home care teams can assist and guide families in need of more than just medical services. Medical home practices must discover the programs and services in their patients' communities that provide positive assistance to families. Established organizations with experience supporting patients and families can be productive partners in medical home practices looking to improve outcomes.

During visits, care teams can discuss a patient's and family's concerns and any challenges they are facing. Also, consider conducting a survey of all patients and families in the practice; ask them what needs they have that aren't being met and what they think would help. Consider asking what community resources have been useful to families. What better way to learn about beneficial programs and services than through the families who are using them?

### Orientation to the medical home

Linkage to community resources

**A HELPFUL RESOURCE:  
MATERNAL AND CHILD  
HEALTH LIBRARY'S  
COMMUNITY SERVICES  
LOCATOR**

### Here are additional ways to identify community assets and start linking families to necessary resources:

- Network with other medical professionals
- Connect with early childhood programs (e.g., Head Start, Early Intervention, etc.)
- Establish contacts in school districts (elementary and secondary school level)
- Learn of resources available through faith-based organizations
- Check community education, town recreation, YMCA and Boys & Girls clubs
- Look for family support organizations
- Check local and state Department of Public Health
- Review services of State Maternal and Child Health Title V programs

Have reliable information for patients and families catalogued and readily available.

### Established medical homes build community resource knowledge within their medical homes by:

- Creating a practice resource book
- Using waiting room and common area bulletin boards to broadcast information
- Inviting community partners to staff meetings to learn about programs and services they offer
- Hosting resource fairs
- Including community groups' contact information on the practice's website or in the patient portal
- Devoting time during staff meetings for success stories of community linkages

### Orientation to the medical home

Linkage to community resources

#### **Family support organizations**

Peer support (also known as parent-to-parent support) can provide valuable opportunities for families to learn about the systems and services needed to help their children thrive. By sharing a common experience, families often develop a trust that can lead to deeper identification of needs. These relationships allow families to develop community connections while gaining practical knowledge.

#### **Other community resources of value to families:**

- **Family to Family Health Information Centers:** assistance with health insurance questions
- State-funded family relief programs (e.g., food, housing, electricity, transportation, equipment)
- Educational rights and resources, including workshops and trainings
- **Parent 2 Parent USA**
- Employment rights and resources, including resources for those affected by unemployment
- Condition/diagnosis-specific patient education materials/classes
- Adapted recreation
- Patient self-management tools/guidance
- **National Federation of Families for Children's Mental Health**
- Language-appropriate services and resources
- Parent support groups
- External care management assistance
- Home care/respite help
- Title V, schools, **American Academy of Pediatrics (AAP)**, American Academy of Family Physicians (AAFP), **Family Voices**