Home, Home on the Range

Developing the Medical Home Approach in EHDI

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Colorado’s Medical Home Definition

The Colorado Medical Home model is an approach to health care that ensures that all providers of a child’s care operate as a team; that families are critical members of that team; and that all team members understand the importance of quality, coordinated medical, mental and oral health care.
Who’s who locally in the Medical Home for EHDI?

- Primary Care
- Public Health
- Audiologist
- CO-Hear Coordinators
- H&V Parent Guides
- Part C
- Hospital Coordinators
The Role of Public Health

• Develop systems at the local level
  – Hospital/EHDI program ensures PCP has screening results
  – Audiology communicates with CO-Hear, PCP
  – CO-Hear Communicates with PCP, Audiology, Part C
  – Parent Guides are available throughout the process
The Role of Public Health

• Develop systems at the State level
  – Develop Guidelines to address best practices
  – Reporting requirements to State and partners
  – Define a roadmap for parents and providers
  – Analyze, plan and evaluate programmatic needs
Case Study - The Screening

RJ was born after an unremarkable pregnancy. He is their first child. He lives in a state where newborn hearing screening is mandated.
Home from the Hospital

• When RJ was three months old the parents received a letter from the Health Department that RJ had failed his newborn hearing screening and needed to be rescreened.

• RJ’s parents are surprised.

• They don’t remember the hearing screening even being performed.

• They also have seen their pediatrician several times and there was never a mention of the results.
Discussion

• What did not go well in this case so far?
• What would be the ideal scenario for this family?
The Audiology Referral

- The parents contacted the hospital who determined the infant was too old for a rescreen and recommended the talk to their PCP for a referral to an audiologist.
- The PCP referred them to a metropolitan pediatric diagnostic center.
- The Center is several hours from their home.
- The earliest appointment was six weeks out.
The Audiology Evaluation

- RJ was diagnosed with a moderate bilateral sensorineural hearing loss.
- The audiologist ordered hearing aids.
Time Slips By…

• RJ is fit with amplification at 7 months old.
• The insurance would not initially cover the hearing aids and the clinic did not offer loaners.
• At 9 months of age, the audiologist senses RJ is developing normally.
• The family is concerned because they do not know what “normal” is.
RJ’s mother was unable to return to work because of the burden of RJ’s care. Obtaining qualified child care proves difficult. Family members are uncomfortable around RJ. The family is isolated and hurt that the dreams they had for their child are not the realities that they are facing.
Discussion

- What are the ramifications of a new diagnosis for this family?
- What is the role of the audiology clinic?
- What is the role of Early Intervention?
- What is the role of the primary care clinic?
- What is the role of Title V/Public Health?
- What is the role of the community?
The Medical Home Approach

With the assistance of ‘care coordination’ by the Title V program the parents identify their issues/gaps in service.

• Obtaining qualified therapists to work with their son closer to home
• They would like to work on building their circle of support – educating family members, friends, preserving their marriage
• Both of RJ’s parents realize that they are handling their grief differently and would like someone to talk to about these differences.
• RJ’s mom liked her job – she would like to return to work at some point
Mobilizing the Community Team

RJ’s parents, physician, local public health nurse and audiologist prioritize the issues together. They need:

• The pediatrician to be involved so that RJ receives routine pediatric care and services
• Referral to the early intervention program
• Connected with Hands & Voices or a parent advocacy organization in their area

What else would you do?

How might what happens next change if RJ’s parents can’t articulate what they need?
Medical Home: Teamwork

1. Family receives diagnosis
2. Public Health systems engaged
3. Gaps in Services Identified
4. Team works on priority issues
5. Family involved at the practice/clinic level to implement change