CALL TO ACTION MEETING
SEPTEMBER 13-14, 2006

Medical Home - What's Working

- Talking to providers at new provider training to let them know that clients will be referred to them.
- Define what a 'medical home' is.
- Educate the community.
- Conducting surveys.
- Opening dialog and referring clients to a medical home. Creating a collaboration with doctors.
- Educating the clerks-next visit to medical home for immunizations (medical staff, parents).
- Do medical home survey at large immunization clinics.
- Referring to medical home.
- Immunization clinic is used as primary care facility.
- Educating providers at tool kit training.
- Nurses ask parents about having a physician or medical home.
- Medical home provided by state for those not eligible for Medicaid/CHIP in every area for the uninsured. Travis County is doing it (MAP).
- School nurses-Could they become the medical home in underserved areas?
- Travis County school partnership well-clinic (Dell county).
- DSHS funded preventive health grant.
- HD primary health program. Send info to schools and child will be seen for anything for $10. Nurse practitioner on staff. School nurse can send sick or well child.
- Other clinics refer to this clinic.
- FQHC acts as a medical home (same copay).
- United Way call center.
- Private providers refer to LHD for immunizations.
- Education for providers who refer and own staff.
- 'Walk in' clinic at LHD.
- Challenge-Its not working. Private providers biggest obstacle. Send child to provider, try to encourage parents, but providers send them back.
- Medicaid provider went to LHD asking if they could refer to health department.
- Work on provider compliance.
- Nurse only visits.
- Challenge-Outreach health service center providing some vaccines, send to health department for ones they don't have.
- Co-location WIC and LHD means one or other will bring up to date when needed immunizations-one record.
- Some LHDs are a medical home.
- Sometimes a Medicaid provider will send a child to the local health department just for shots.
- The LHDs that do serve as a medical home provide 24 hour service at least on-call.
- Sometimes the client will come to the LHD for shots because they like getting their shots at the LHD.

- It's hard to refer to a Medical home because it conflicts with the sense of trust we are building.
- There is a lack of medical homes available.
- Hard to refer to a medical home if you don't feel that the patient will be properly taken care of.
- In some counties, some providers don't even want to deal with VFC so they don't provide compassionate services.
- Parents will take the child to their doctor only when they are sick but will bring them to the LHD when they need shots.
- Helps when you are able to develop a rapport with the Medical home.
- We use the VIS-thoroughly go over it and let them know how this vaccine works with others.
- Many barriers to actually promoting medical home.
- LHD creates a list of potential physicians who accept new patients and/or accept CHIP and/or Medicaid.
- Provide patients with CHIP info but no staff to help with that.
- Try to approach the physicians re: talking about missed revenue-and targeting them during the 'slow' time of year.
- Developed relationships during Hurricane Katrina needs (a time of crisis).
- Have a list of providers in area; WIC offices do the same.
- Educate clients of who their provider is and encourage them to contact them.
- Excel file of providers available sent to schools and daycares.
- The LHD is some of these people's medical home.
- Educate parents to not use the emergency room for care.
- Send a memo to providers that they can give all the shots needed.
- Educate.
- Get provider centrally-close to them. Ask where they live? Provide list. Ability to change provider.
- Screening questionnaire.
- Educate parents to use the emergency room as provider.
- So many uninsured children (undocumented) can not get Medicaid. There is nothing for them except public health.
- What can we do? Improve usage of medical home.
- OK to give immunization if they have a runny nose.
- Access to care.
- What you need to look at when a provider-where they live when assigning.
- Medicaid should educate up from-what to do. Make sure they want who they have. Work better with their clients. Bilingual.
- Educate office manager (staff turnover).
- Reimbursement rate for well visits.
- Offer info on CHIP. Assess if they have a medical home. Refer to clinic or another community resource.
- Do outreach clinics.
- Encourage Medicaid and CHIP (but not all eligible).
- Issue-Undocumented; don't take new patients.
- List of charitable clinics.

- Have a list for prenatal patients.
- Issue-Uninsured.
- Refer to FQHC.
- Increase TVFC provider enrollment.
- Medical home issue-Tried to refer clients to MH but missed appt (late, not at time client could make it)-good for middle to upper class but not lower class.
- Medicaid doesn't condone referrals-do direct follow-up with docs that do refer; inform them of the violation & warn that if they continue will inform Medicaid on the issue. (stress in educational efforts).
- Stress medical home philosophy with TVFC providers during enrollment.
- Survey (June) of providers to see who is accepting patients; provide list to schools and others to use as referral source; work with them to promote medical home concept.
- Need educational materials to promote medical home for parents.
- Work to make the LHD a pediatric clinic (HRSA grant)-issue is finding a doctor.
- Use MH for sick child but not wellness check.
- Try to observe record, who have they been with.
- Give list of the providers in area.
- Provide a sheet of paper..allergies, ask if they have a medical home.
- Pre-natal program; will be going to private provider.
- Referrals.
- FQHC.
- Direct services.
- Some MDs do not take new patients.

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