Fetal Alcohol Spectrum Disorders (FASD):

Facilitation of Community-based Services

Pediatricians can accompany families in their health journey by facilitating access to community-based resources that support children and families. Pediatric medical homes are in the unique position to forge therapeutic alliances, convene community partners and resources, and provide integrated child- and family-centered care to children with Fetal Alcohol Spectrum Disorders (FASD). Pediatricians working closely with community-based providers can increase the health outcomes of children with prenatal alcohol exposure and provide support for families living with risky alcohol use and substance use disorders (SUD).

Three primary care coordination strategies can improve the ability of pediatricians to identify community partners and connect children and families with them. These three strategies can help develop, implement, and monitor shared plans of care: 1) Ecomapping; 2) Care Conferences; and 3) Care Coordination Rounds.

1 Ecomapping Community Partners and Resources

An ecomap requires a 10–15-minute interview, often during an initial patient assessment, and can be updated periodically as needed. The ecomap is a strength-based visual map of the family in the context of their environment that provides a holistic view. The ecomap identifies the biological, psychological, financial, and social environment from the family's perspective that includes birth parents, foster parents, and kinship caregivers. An ecomap identifies community partners and is a primary tool for community resource mapping, care coordination and care rounds.

Ecomapping Benefits to Guide Care Conferences and Care Coordination

- Child and family-centered approach
- Shared decision making
- Increased interventions
- Pediatrician and family collaboration
- Reduced care fragmentation
- Families empowered to seek community resources
- Reduction of duplicative care
- Improved health and better outcomes

Non-judgmental and open-ended questions to solicit information about the family structure and formal and informal support services are used to frame an ecomap. Answers identify significant members of the family and the nature and quality of relationships, gaps in services, financial status, met or unmet needs, family communication tools, family stressors, and contributing factors that affect the child's or adolescent's health.

Sample questions to solicit ecomap detail

Informal supports

- Tell us about who lives in the household.
- Are there any extended family or friends living in the household or nearby?
- What types of activities does the family enjoy together?
- Tell us about neighbors that help the family.
- Who helps with childcare?
- How are family decisions made?

Formal supports

- What types of services does your child receive? Can you easily access them?
- Do other family members receive services?
- Are there any financial concerns?
- Do you ever worry about running out of money or food at the end of the month?
- Tell us about your healthcare plan and how it is paid.

2 Care Conferences

With a completed ecomap, a care conference is a tool to facilitate discussions with family members and the care team. Care conferences have a facilitator (often the pediatrician or nurse) who sets an agenda, prioritizes the confidential discussion around care goals and what is important to the family, and shares the ecomap. Shared problem solving and decision making can bring consensus and resolution to care issues when there are medical care plan changes or updates. Care conferences are billable.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

a program to enhance the health & development of infants & children
Fetal Alcohol Spectrum Disorders Program
A program of the American Academy of Pediatrics in cooperation with the Centers for Disease Control & Prevention

Collaborative for Alcohol-Free Pregnancy
Partnering for Practice Change

3 Care Coordination Rounds

Care coordination rounds engage a multidisciplinary team that share care and involvement to meet regularly and address the health and wellness of a patient or a population of children and families. Care coordination rounds may involve pediatricians, practice coordinators, specialty care managers and community providers. Patient family members can serve in advisory roles during meetings to speak for families and to advocate for systems and promote specific community services. Care coordination rounds can specify patient progress between care conferences for review and discussion with pediatricians.

Major Benefits of Care Coordination Rounds

- Continued progress with shared care plans
- Improved clinical outcomes
- Increased proactive care rather than reactive care
- Lessened service duplication
- Reduced care fragmentation
- Expanded provider knowledge base
- Amplified relationship building across community providers
- Decreased siloed services

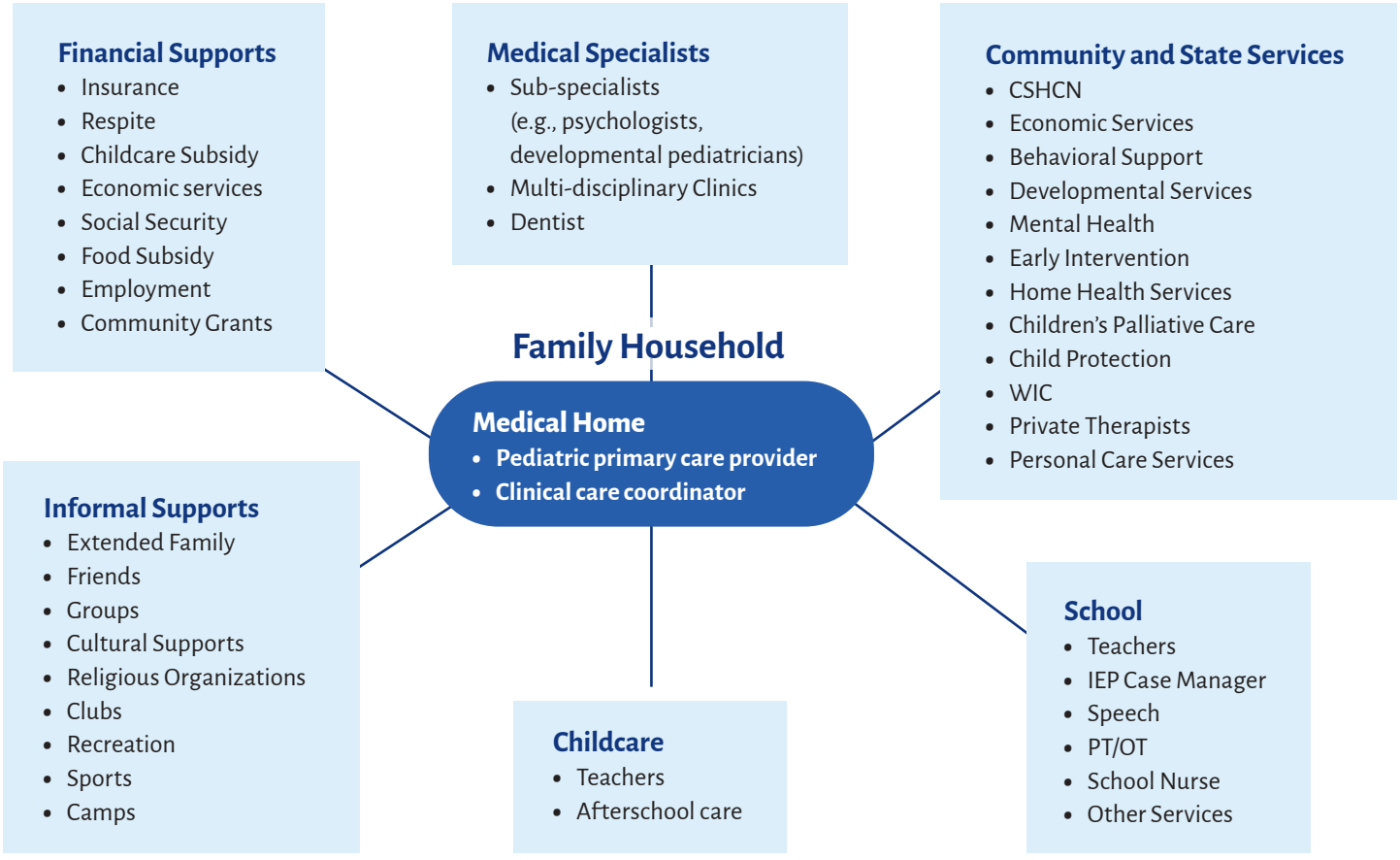
Care coordination rounds center around what is working well, needed system improvements, and strategies for communication and collaboration. Rounds present the opportunity to share key community contacts, found resources, and successful care strategies.

View Additional Information

For additional resources on facilitation of community-based services, please visit www.aap.org/fasd/carecoordination.

Sample Ecomap Template

Formal and informal supports that can be coordinated through the pediatric medical home for interventional care and community support services, are listed.



Newton, Marinell, McAllister, Jeanne, et. Al, "The Comprehensive, Integrated Care Plan (CICP)", The Lucille Packard Foundation for Children's Health, 2013

This resource was supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $500,000 with 100% funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement, by CDC/HHS or the U.S. Government.