A Case for the Pediatric Medical Home

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AAP Overview

• Professional membership organization of 60,000 pediatricians, and pediatric medical and surgical subspecialists
• Dedicated to the health of all children
• AIM Collaborative Partner organization along with NIHCM and others
  – AAP grant focused on maternal and child health services delivered in the medical home (ie. Bright Futures, oral health, mental health/post-partum depression screening, breastfeeding promotion)
AAP Medical Home Depth of Experience

1967
• The first known documentation of the term “medical home” appears in Standards of Child Health Care, published by the AAP and written by the AAP Council on Pediatric Practice.
• Book defines a medical home as one central source of a child’s pediatric records and emphasized the importance of centralized medical records to children with special health care needs.

1970s
• (1977) “Fragmentation of Health Care Services for Children” clarifies for third parties the concept of one medical home for every child.
• (1979) “Children Having Care from Multiple Sources” reiterates the importance of the medical home concept.

1980s
• MH concept begins to evolve from a centralized medical record to a method of providing primary care from a community level recognizing the importance of addressing the needs of the total child and family.
• Hawaii pediatrician, Dr Cal Sia, successfully led a campaign to have the MH concept adopted in Hawaii giving birth to the medical home concept as we know it today.

1990s
• (1992) Publishes its first policy statement defining the medical home.
• (1993) Establishes the Division of Community Pediatrics; CATCH program which embraces medical home concept as its core.
• (1994) Receives a five-year MCHB grant for the Medical Home Program for Children With Special Needs.
• (1999) Is awarded a 5-year cooperative agreement with MCHB to implement the National Center of Medical Home Initiatives for Children With Special Needs (National Center).

2000s
• (2000) Future Of Pediatric Education II recommends all children should receive primary care services through a medical home.
• (2002) Updates original MH policy statement and provides operational definition of MH.
• (2007) Partners on Patient-Centered Medical Home Joint Principles with the AAFP, ACP, and AOA.
• (2008) Receives 5-year cooperative agreement from MCHB for the National Center with a focus on medical homes for ALL children and youth. Reaffirms 2002 MH policy and joins the PCPCC as an executive member.
Key Differences: PCMH vs. FCMH

- Family-centered vs. Patient-centered
- Healthier population – focus on prevention

2003-2008 National Ambulatory Medical Care Survey (MD office visits for children 0-21 yrs)

- 29.1% preventive care
- 48.6% acute conditions
- 18.1% chronic conditions
- 2.5% pre/post-surgery care

- Different epidemiology of chronic conditions
- Childhood is the time during which foundation for health is built (eg. Healthy lifestyles, prevention of chronic illness in adulthood)
The Medical Home: Health Care Access and Impact for Children and Youth in the US

• Results of 2007 National Survey of Children’s Health
• 56.9% of US children ages 1-17 years had a medical home
• These children are less likely to have unmet medical and dental needs, and more likely to have preventive health visits

Improved Outcomes Associated with Medical Home Implementation in Pediatric Primary Care

- 6 conditions studied (asthma, diabetes, CP, epilepsy, ADHD, and autism).
- Results: some medical home measures correlated with lower hospitalization rates.
- Higher chronic-condition management scores were associated with lower ER usage.

Colorado Medicaid and SCHIP PCMH for low-income children

- Median annual costs $785 for PCMH children compared to $1000 for control
- PCMH children in Denver with chronic conditions had lower median annual costs ($2,275) than those not enrolled in a PCHM practice ($3,404)
- 72% of children in PCMH practices had well child visits, compared to 27% of controls

Community Care of North Carolina

• Cumulative savings of $974.5 million over 6 years (2003-08)
• 40% decrease in hospitalizations for asthma. 93% of asthmatics received appropriate maintenance medications
• 16% lower ED visits

Despite the benefits of pediatric medical home, there are not many pilots or demonstration projects that have focused on pediatric populations.

Sources: PCPCC Pilots and Demonstrations at: http://www.pcpcc.net/pcpcc-pilot-projects and, Blue Cross Blue Shield Association, BCBS Plan Pilots (June 2010)
Why Pediatric Medical Home Demonstrations?

- Multiple PCMH demonstrations and pilots have proven the effectiveness of the medical home model of primary care in improving clinical outcomes and generating financial benefits to payers.
- PCMH pilots and demonstrations to date have primarily focused on delivering medical home services to adults—especially Medicare.
- Some PCMH pilots serve pediatric patients.
Why Pediatric Medical Home Demonstrations? Cont’d

- The time has come to harvest these medical home best practices and apply them to pediatric populations for a variety of reasons including:
  - An investment in patient- and family-centered care for children today will lead to healthier adults tomorrow
  - Parents receiving care in a medical home will begin to expect these services for their children
  - Employers will begin to use pediatric medical homes as a selection criterion for their benefit plan purchase decisions
  - Investment in the pediatric medical home enhances the relationship with the member/family and provider network which supports value proposition of insurers
What is New in System Design?

• Focus on Integration of Care
• Optimizing Linkages Between PCP’s and Subspecialists
  – Optimal utilization of subspecialists
• Include Community Partners in holistic approach to health care
• Integrated Systems don’t necessarily need to be Accountable Care Organizations (ACOs)
• ACOs should be Integrated
Integrated Care

Integrated care is the seamless and coordinated provision of health care services, from the patient’s perspective, across the entire care continuum, irrespective of institutional and departmental boundaries. The characteristics of integrated care include:

1. A well-defined locus of responsibility for patient care at all points of contact

2. Well-defined mechanisms to engage and empower families as partners in their own care: this component of integrated care treats patients/families as integral to and equals in the care process.

3. Information available among providers so that the right care can be delivered to the right patient at the right time and in the most cost-effective location.
Integrated Care Cont’d

4. *Shared accountability* and transparency by all providers for patient outcomes, resource utilization, and cost of care.

5. *Care coordination, which is integral to the design of the care delivery System:* families are the ultimate coordinators of their care, and when utilizing services across the care continuum, need care coordination across all providers, from the family and the PCP, through ambulatory subspecialty and in-patient settings.
The Medical Director’s Dilemma
Community Asthma Model

- Nurse case management and home visits
  - Individualized asthma plan (English/Spanish), family centered
  - Asthma education, medication management
  - Connect to PCP, Allergy evaluation, insurance, housing
  - HEPA vacuum
  - Integrated Pest Management (IPM)

- Community education for families and consciousness about asthma
  - Community-based educational workshops, events

- Advocacy local, regional, national
  - Family Advisory Board and collaborators

- Team: Elizabeth Woods, MD; Shari Nethersole, MD; many others
Doing the Right Thing!

- Community Asthma Initiative significantly decreased emergency room visits 60% - Admissions 80% - Reduced missed school days - Reduced missed work days

- Successful model of enhanced asthma care and education can be replicated nationally

- BARRIER: financing!!

- Policy changes are essential to support enhanced asthma care, home visiting, and affordable medications
Supporting PCMH practices

• To support transformation, the following services should be supported:
  – Permit physicians to bill for care plan oversight services, telephone calls, and online consultations to ensure comprehensive and continuous care for vulnerable children when direct patient contact is unnecessary.
• Support for disease management and care coordination
• Support for IT infrastructure in the practice setting
Broad Issues for Child Health/Pediatrics

- Vulnerable populations could be at increased risk as systems evolve
  - With focus on adult care, children generally could become “vulnerable”
- Lack of pediatric quality measures in general
- Poor risk adjustment methodologies for pediatrics
- Strong emphasis in ACO pilots on in-patient and adult care
- Determinants of “health” are often not simply medical
  - Poverty
  - Linguistic, literacy, educational barriers
  - Housing
  - Food Security
  - Mental and Dental Health
- Should children be in ACO’s by themselves?
  - What about CYSHCN?
- Time Horizon for Return on Investment
  - months versus years versus decades
PCMH is a foundation for effective ACOs
Key Elements of Accountable Care Model

- **Local Accountability**
  - Foster provider accountability for quality and per capita cost for their patient population

- **Standardized Performance Measurement**
  - Increased accountability on the part of providers should be accompanied by improved incentives and information for consumers

- **Payment Reform**
  - Transition payments from rewarding volume/intensity to increasing value
  - Payments should encourage collaboration and shared responsibility among providers and consistent incentives from payers
Clinically-Enhanced Starter Set

**Category I: Diabetes**
- HbA1C Control
- LDL Control
- BP Control
- Eye Exam
- Kidney Disease Screen
- Aspirin Prophylaxis

**Category II: Coronary Artery Disease**
- LDL Control
- Aspirin Prophylaxis

**Category III: Chronic Heart Failure**
- Beta-blocker with LVE< 40%
- BP Control
- LDL Control

**Category IV: Hypertension**
- BP Control

**Category V: Care Coordination**
- Tobacco Use Inquiry or Counseling
- Childhood immunization
- BMI recorded
- Influenza vaccine
- Pneumovax vaccine
- Medication reconciliation
PCMH as part of an ACO

• Carilion Clinic, VA is participating in an ACO pilot project sponsored by the Dartmouth Institute and the Brookings Institution’s Engelberg Center for Health Care Reform.

• Support for IT and care coordination to enhance quality and reduce costs

• Features include quality improvement initiatives such as asthma management, including a care coordinator who ensures children come to asthma maintenance visits.
Joint Principles for Accountable Care Organizations

• Joint statement by AAP, AAFP, ACP and AOA
• Primary care should be the foundation of any ACO and the family-centered medical home is the model that all ACOs should adopt for building their primary care base.
• The 21 principles describe important aspects to consider when building the administrative structure of ACOs, as well as how payment should be facilitated.
AAP Guidance to Pediatricians on ACOs

- Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement
- Addresses organizational structure, clinical and financial performance metrics, and payment methodologies for pediatrics
- [http://aapnews.aappublications.org/cgi/content/full/32/1/1-e](http://aapnews.aappublications.org/cgi/content/full/32/1/1-e)
AAP Medical Home Resources

• National Center for Medical Home Implementation
  – http://www.medicalhomeinfo.org/

• Building Your Medical Home Tool Kit

• Medical Home Chapter Champions Program on Asthma

• AAP Child Health Informatics Center
  – http://www.aap.org/informatics/chic.html
AAP Medical Home Resources Cont’d

- AAP Oral Health Initiatives
  - [www.aap.org/oralhealth](http://www.aap.org/oralhealth)
- AAP Mental Health Initiatives
  - [http://www.aap.org/mentalhealth/](http://www.aap.org/mentalhealth/)
- AAP Breastfeeding Initiatives
  - [http://www.aap.org/breastfeeding](http://www.aap.org/breastfeeding)
- Bright Futures ([http://brightfutures.aap.org/](http://brightfutures.aap.org/))
  - Health promotion /disease prevention in the medical home
  - At the heart of the medical home is the relationship between the clinician and the family or youth
Every state has at least one AAP Chapter

Key, local contact resources on developing a medical home program within the state

Approximately 40 chapters have pediatric councils which meet with payers on pediatric topics
AAP Medical Home Service Portfolio

• To ensure the ongoing health of all children, the AAP is developing a comprehensive portfolio of services to assist payers and providers to effectively operate a patient centered medical home

• The AAP Medical Home Services Portfolio is an integrated service offering enabling pediatric practices to become patient-family centered medical homes

• Service solutions include a Digital Navigator, webinars, workshops and on-line community portal as well as multi-site management and diagnostic solutions to guide the practice transition into a medical home

• Contact Sherry Fischer, Manager, Practice Services Improvement Program, at sfischer@aap.org
THANK YOU!

For more information, please contact:

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