



# Medical Home: Opportunities for Pediatricians

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# Future of Primary Care in the US

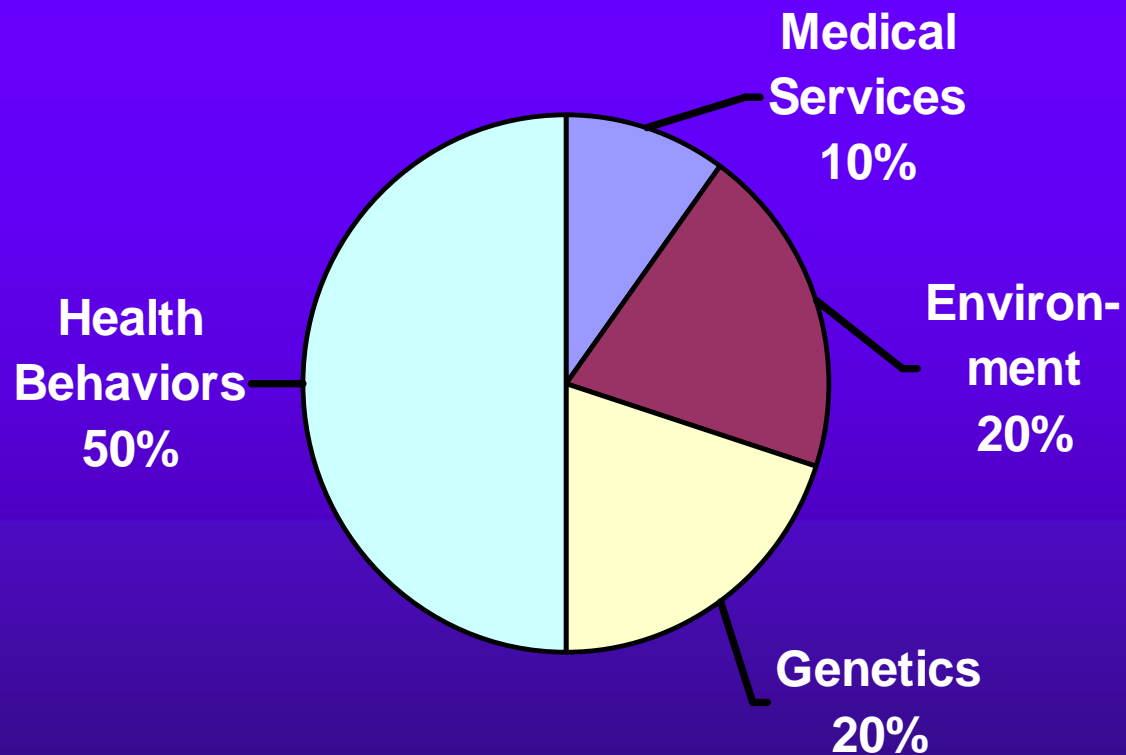
- ◆ Shortages of family medicine and general internal medicine physicians
- ◆ Payment system that rewards “proceduralists” and punishes doctors who spend a lot of time coordinating the care of complex medical patients and providing preventive health services



# Future of Primary Care in the US

- ◆ Currently more than half of medical students are women
- ◆ Many young physicians are not interested in working full-time
- ◆ Neonatologists, hospitalists, retail-based health centers having negative effect upon perceived value of primary care physicians to their communities and payors

# Factors Affecting Child Health



SOURCE: Healthy People 2010, US Department of Health and Human Services, 2000.



# Traditional Morbidities of Children

- ◆ Infectious diseases
- ◆ Prematurity
- ◆ Birth defects
- ◆ Chronic medical illness
- ◆ Developmental disabilities
- ◆ Unintentional injury
- ◆ Sudden Infant Death Syndrome (SIDS)

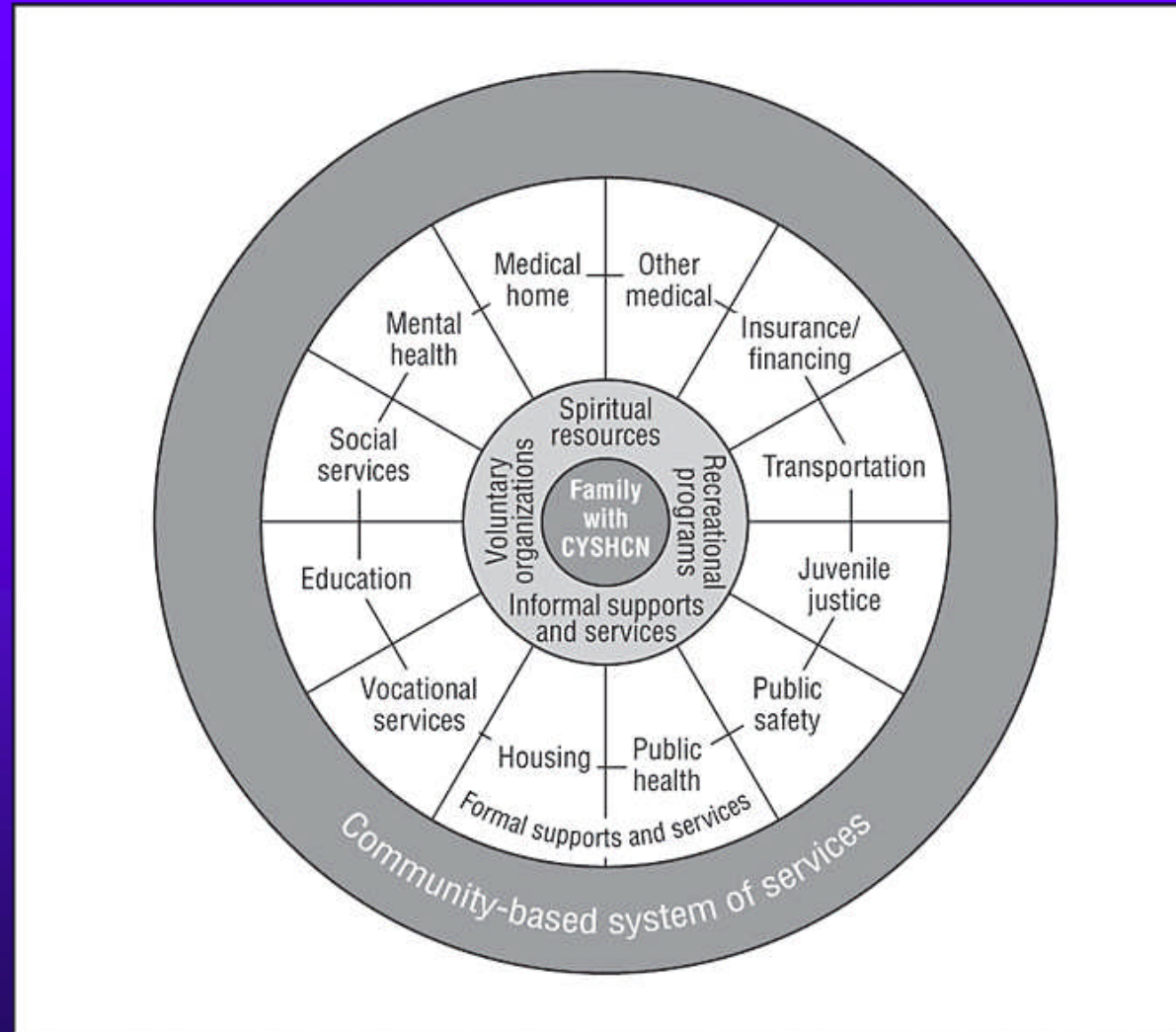


# New Morbidities of Children

- ◆ Child abuse and neglect
- ◆ Early dental caries
- ◆ Obesity
- ◆ Mental health disorders of children
- ◆ School failure
- ◆ Adolescent pregnancy
- ◆ HIV and AIDS
- ◆ Substance abuse including tobacco
- ◆ Juvenile crime/violence



# Family-Centered Community-Based System of Services for Children and Youth





EQUATION

CHILD

+

RESOURCES

PEDIATRICIAN (CATALYST)

=

MEDICAL HOME



# Patient-Centered Primary Care Collaborative ([www.pcpcc.net](http://www.pcpcc.net))



Coalition of:

Major employers

Consumer groups

Primary care physicians

Mission: To advance the patient-centered medical home



# PCPCC Membership

- ◆ More than 300 members in 2 years
- ◆ Executive Leadership:  
AAP, AOA, AAFP, ACP
- ◆ Examples of membership:  
National Business Coalition on Health  
IBM, Exxon Mobil, Kraft, Boeing  
National Partnership for Women and Families



# Medical Home Definition

- ◆ Primary care
- ◆ Family-centered partnership
- ◆ Community-based, interdisciplinary approach to care
- ◆ Care that is: accessible, family-centered, coordinated, compassionate, continuous, and culturally effective.
- ◆ Preventive, acute and chronic care
- ◆ Quality improvement



# Integrated Health *System*

- ◆ Patients and families
- ◆ Primary care physicians
- ◆ Specialists and subspecialists
- ◆ Hospitals and healthcare facilities
- ◆ Public health
- ◆ Community



# Medical Home Forces

- ◆ Quality preventive, acute and chronic care
- ◆ Financing all components of medical homes
- ◆ Appropriate payment for medical home activities (care coordination, telephone, email, data collection, etc.)
- ◆ Impact of physicians' employment setting on locus of decision-making



# Medical Home Forces

- ◆ Meeting the expectations of patients and families
- ◆ Transitions of care delivery
- ◆ Barriers to QI activities
- ◆ Co-management of patients by primary care and subspecialists
- ◆ Complexity of overlapping systems and competing priorities





# Joint Principles of the Patient-Centered Medical Home

- ◆ American Academy of Pediatrics
- ◆ American Academy of Family Physicians
- ◆ American College of Physicians
- ◆ American Osteopathic Association



# Medical Home Joint Principles

- ◆ Personal physician
- ◆ Physician-directed medical practice
- ◆ Whole person orientation
- ◆ Care is coordinated and/or integrated
- ◆ Quality and safety are hallmarks of a medical home
- ◆ Enhanced access to care
- ◆ Payment appropriately recognizes the added value



# Medical Home Joint Principles: Pediatric Preamble

- ◆ Family-centered care
- ◆ Community-based system of care
- ◆ Transitions
- ◆ Value



# Unique Features of the Medical Home for Children

- ◆ Oral Health
- ◆ Health education – human sexuality
- ◆ Children have special health care needs
- ◆ Parental anxiety and after-hours care
- ◆ Pediatric subspecialty care
- ◆ Nutrition and obesity



# Unique Features of the Medical Home for Children

- ◆ Perinatal care
- ◆ Psychosocial/family issues
- ◆ Child development
- ◆ Child care
- ◆ School-based/linked health services
- ◆ Adolescent mental health
- ◆ Transition to adulthood



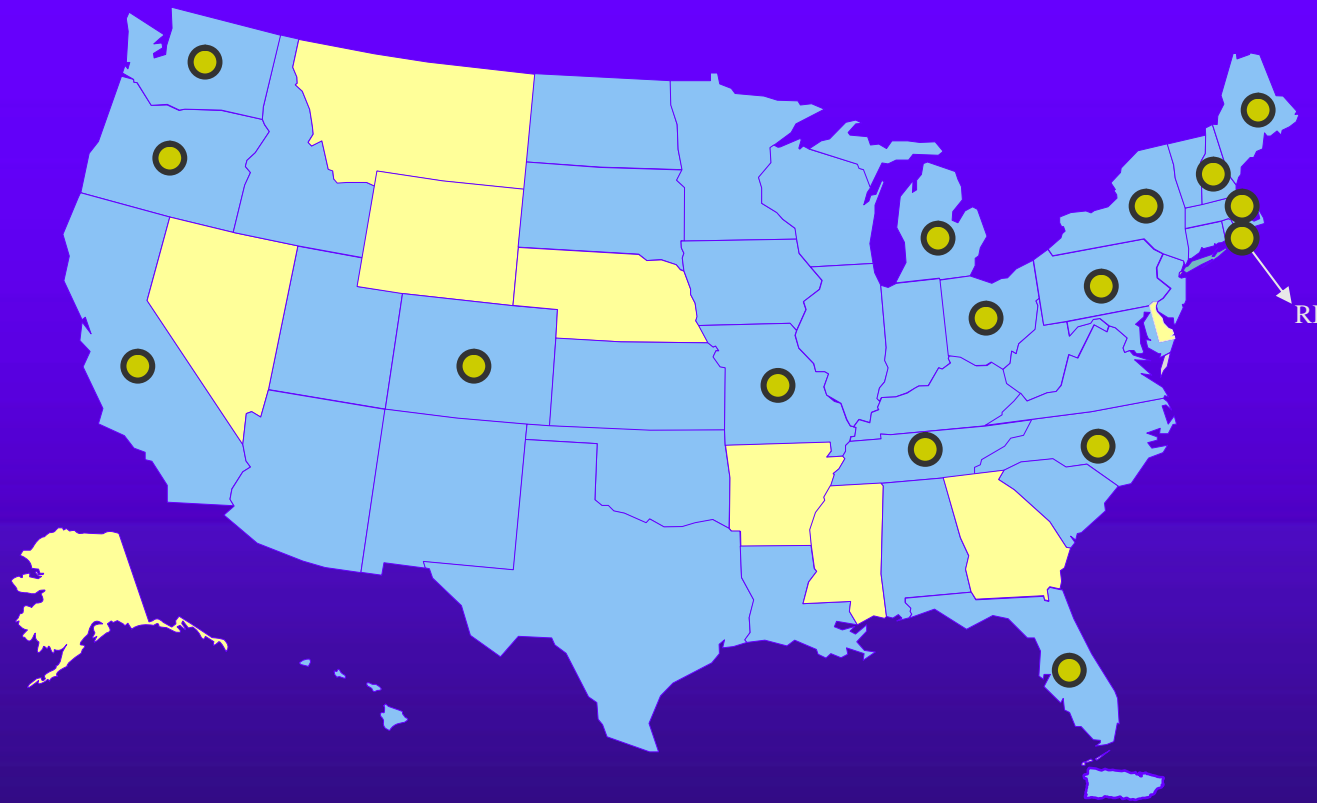
# Multi-payor/multi-player Medical Home Pilots

- ◆ Aetna
- ◆ UnitedHealthcare
- ◆ Humana
- ◆ Blue Cross Blue Shield Association
- ◆ Wellpoint, Inc
- ◆ MVP Health Care
- ◆ Cigna



# Patient-Centered Medical Home

*Overview of Current Pilot Activity and Planning Discussions (as of April 2008)*



- Multi-payor pilot discussions/activity
- Identified pilot activity
- No identified pilot activity

PCPCC



# NCQA: Patient-Centered Medical Home Measurement and Recognition

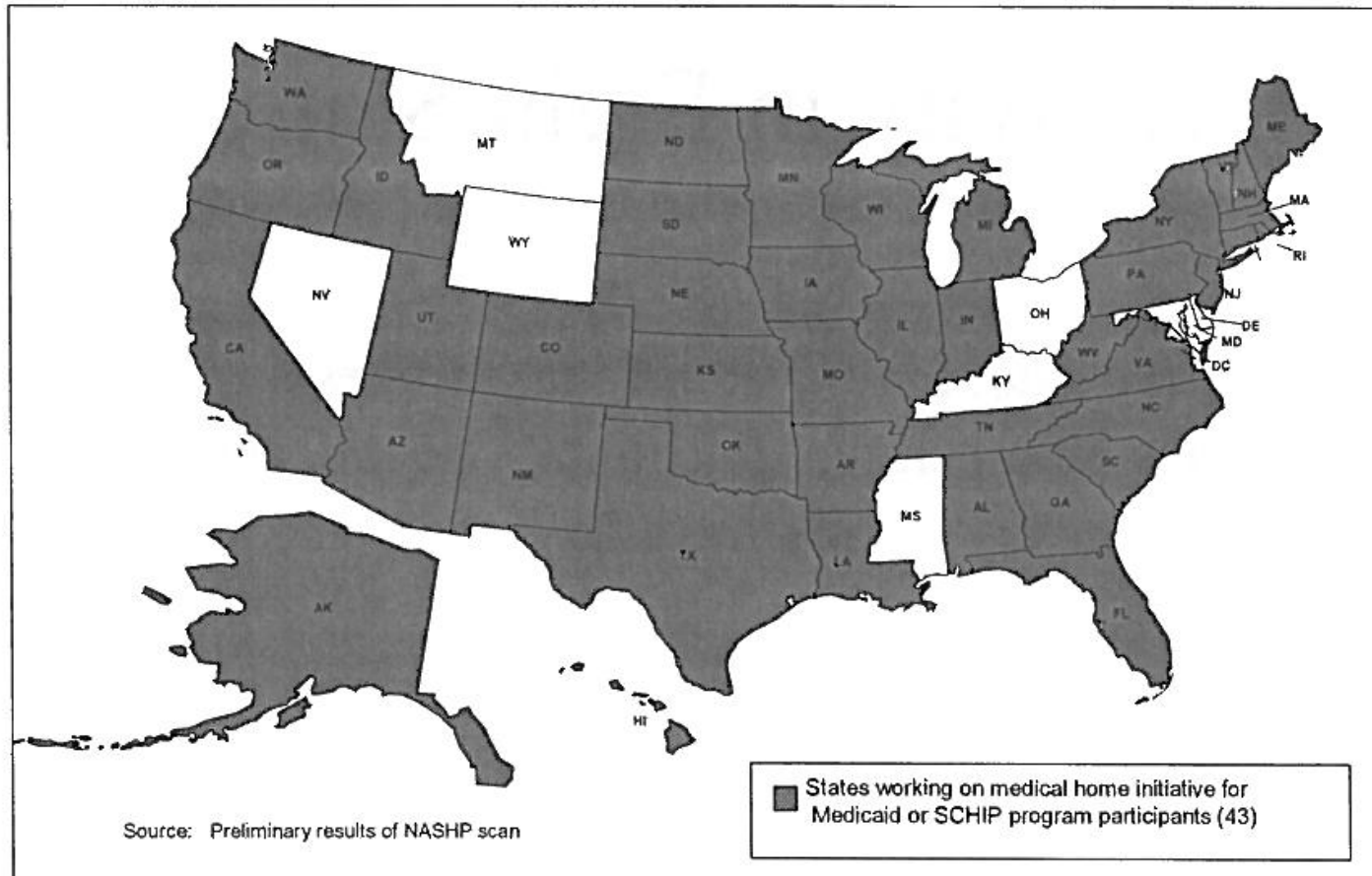
- ◆ Access and communication
- ◆ Patient tracking and registries
- ◆ Care management
- ◆ Patient self-management
- ◆ Electronic prescribing
- ◆ Test-tracking
- ◆ Referral-tracking
- ◆ Performance reporting and improving
- ◆ Enhanced electronic communications



# Payment for the Pediatric Medical Home

- ◆ Fee-for-service based upon equal access
- ◆ Appropriate CPT-based payment for all services provided outside 8-5, M-F
- ◆ After-hours nurse triage/nurse advice line
- ◆ Per-member-per-month (PMPM) for quality assurance/improvement, health information technology (HIT)
- ◆ Grants for HIT start-up
- ◆ PMPM for community-based care coordination
- ◆ Payment for finite number of oral health visits in first three years of life utilizing dental codes

# Medicaid/SCHIP Programs Already Working to Implement/improve Medical Home





# Medical Home: Public Policy Guidance

- ◆ Definition
- ◆ Care coordination
- ◆ Quality
- ◆ Payment
- ◆ Infrastructure and information technology
- ◆ Practice coaching and education
- ◆ Patient education
- ◆ Community-based systems
- ◆ Care transition
- ◆ Population specifics
- ◆ Medical home advisory committees





# Medical Home Implementation Issues

- ◆ Definition of medical home
- ◆ Payment (pmpm, fee-for-service, infrastructure)
- ◆ Evaluation of pilots
- ◆ Certification vs. recognition





# Medical Home Implementation Issues

- ◆ Measurement and performance standards
- ◆ Consumer knowledge and involvement
- ◆ Training and education
- ◆ Politics/health care reform
- ◆ Employer/purchaser attitudes



# Examples of AAP Medical Home Membership Support

- ◆ National Center for Medical Home Implementation
- ◆ Medical Home Toolkit
- ◆ Medical Home Conference Call Series
- ◆ MOC: eQIPP Medical Home module
- ◆ Family-Centered Care Tools



# Examples of AAP Medical Home Membership Support

- ◆ Health information technology
- ◆ Transition initiatives
- ◆ Payment advocacy
- ◆ Chapter facilitation of medical home implementation in states
- ◆ Medical home public policy guidance

## BUILDING YOUR MEDICAL HOME

brought to you by...



NATIONAL CENTER FOR  
MEDICAL HOME  
IMPLEMENTATION

HOME

START BUILDING

MEDICAL HOME STANDARDS (NCQA)

QUALITY IMPROVEMENT BASICS

MEDICALHOMEINFO.org

**Medical Home** is the model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner.

### What this Toolkit can do for your practice

The Toolkit supports your development and/or improvement of a pediatric Medical Home for your patients and families. It also prepares you to 'score' well in your application process to the [National Committee for Quality Assurance \(NCQA\)](#) Physician Practice Connections®-Patient-Centered Medical Home (PPC-PCMH™) recognition program. Each of the Toolkit building blocks is cross-walked with the NCQA PPC-PCMH recognition 'must pass' elements.

### Why it is important to measure Medical Home at your practice

Patient care associated with the Medical Home improves outcomes, such as health status, timeliness of care, family centeredness, and family functioning. The NCQA PPC-PCMH standards provide a way to qualify and quantify care in the Medical Home. In some practices, scoring at NCQA higher levels has resulted in enhanced payment to the practice.

Here are two vignettes from providers that have improved their practice and patient outcomes by implementing the Medical Home approach: [Dr. Jennifer Lail](#), MD of Chapel Hill Pediatrics and Adolescents in North Carolina; and [Dr. David Tayloe](#), MD of Goldsboro Pediatrics in North Carolina.

### How to begin

To help your practice assess its Medical Home capacity, the Toolkit is organized into six building blocks that provide guidance for implementation; links are provided to downloadable tools. Click the **START BUILDING** button to get started.

### [Toolkit Acknowledgements](#)



The Toolkit is organized into six areas:



**START BUILDING**





# Medical Home Conference Call Series

- ◆ Implementing Medical Home for All Children and Youth - **March 3, 2009**
- ◆ Improving Communication and Co-management Between Specialty Providers and the Medical Home - **March 25, 2009**
- ◆ Implementing Developmental Screening in the Medical Home - **April 20, 2009**
- ◆ The Role of the Medical Home in Family-Centered Early Intervention - **May 21, 2009**
- ◆ Incorporating Family Participation Practices into Your Practice and Project - **June 24, 2009**



## Medical Home eQIPP Module

- ◆ Education and quality improvement
- ◆ CME and Maintenance of Certification
- ◆ Linkage with Medical Home toolkit
- ◆ Initial meeting January 2009





# State Policy Implementation

## ◆ Pending Legislation in 2008

Iowa

Kansas

Massachusetts

New Hampshire

New York

Oklahoma

Minnesota

Washington

Maryland

Maine

Vermont

Utah

## ◆ Enacted Legislation in 2007 and 2008

Colorado

Louisiana

Minnesota

Iowa

Washington

Maine

New York



# Discussion