Connecting Children

to Ongoing and Coordinated Health Care

As the health care system stands today, a child may receive immunizations at a community clinic, a check of height and weight at school, and treatment for a respiratory illness in the emergency department of a local hospital, all without a primary care doctor's knowledge. Too many children and families, particularly those without adequate insurance, face a fragmented health care system that leads to unmet needs for care, inadequate use of preventive care, and potentially higher costs to the system.

To improve health outcomes for children, a concerted effort is needed to ensure access to care that is both ongoing and coordinated. In settings providing ongoing and coordinated care, children receive health care from a provider who knows them and their families; and physicians, families, and allied health care professionals work together to coordinate all of the health and health-related needs of the child and family. This kind of care has been linked to better health outcomes for children, as well as lower overall costs (Starfield and Shi 2004).

Although desirable, this approach to pediatric care has not been universally adopted. Among the barriers to adoption are a lack of adequate payment to physicians for the additional time it takes to provide coordinated care and a lack of staff in the primary care office to assist in providing coordinated care. In addition, most physicians are not trained in the skills needed for integrated and community-based pediatrics. Grantmakers can play a valuable role in overcoming these and other barriers to ongoing and coordinated care for children.

THE IMPORTANCE OF COORDINATED CARE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Access to coordinated care is important for all children, but it is especially important for the 12.5 million U.S. children with special health care needs (CSHCN). Compared to the average child, CSHCN have twice as many unmet health needs, about 2.5 times as many contacts with physicians, and account for greater than 5 times as many hospital days per 1,000 (Cooley and McAllister 2004). Since many primary care settings are geared toward acute and well-child care, rather than dealing with chronic conditions, families of CSHCN often deal with fragmented care that is difficult to manage. A more accessible and integrated primary care approach would provide increased information for families, coordination between specialists, and integration of the children into the community, while maintaining chronic condition management.

The federal government is promoting access to ongoing and coordinated care for all children, including CSHCN. *Healthy People 2010* affirms the benefit and need for ongoing, comprehensive care for CSHCN. The federal Maternal and Child Health Bureau has played a key role by issuing policy statements on the benefit of integrated care and by giving grants to states implementing programs related to ongoing and coordinated care.

> For a one-stop source of information regarding medical homes and integrated care, visit the *National Center of Medical Home Initiatives for Children with Special Needs* on-line at www.medicalhomeinfo.org. The site provides access to an extensive collection of educational, resource, and advocacy materials.

OPPORTUNITIES FOR GRANTMAKERS

There are many opportunities for grantmakers to ensure that every child receives ongoing and coordinated care. Some of the approaches available are highlighted below.

➤ ***Improving Access to Medical Homes*** – One method for improving access to coordinated care is to increase the number of medical homes, as well as the number of children enrolled in them. The medical home is a comprehensive primary care model that can lead to better health for all populations, especially children. Contrary to its name, a medical home is not an edifice of any sort, but rather an approach to providing care that emphasizes the partnership between the child, family, and health care staff and utilizes the principles of ongoing and coordinated care.

Care provided in a medical home is family centered, accessible, comprehensive, community based, and culturally effective. Key components of a medical home include:

- sharing clear and unbiased information with the family,
- assuring ambulatory and inpatient care at all times,
- providing ongoing care to ensure continuity,
- coordinating care with specialists,
- interacting with the surrounding community through schools and early intervention programs, and
- maintaining an accessible central record (American Academy of Pediatrics 2002).

The California HealthCare Foundation has launched an extensive initiative to provide medical homes for CSHCN in seven California communities. The foundation is supporting activities such as recruiting physicians, providing training and support to physicians, supplying information and support to the families of the children, and improving coordination among health and social service agencies that serve CSHCN.

➤ ***Coordinating Care for Children with Chronic Diseases*** – Several foundations are funding programs aimed at improving health care for children who suffer from chronic or infectious diseases. These children have much greater interaction with health services, so it is important to help families and physicians coordinate their care. The United Hospital Fund in New York City is working to expand a series of community-based health programs that provide health education, disease management, and prevention programs for inner-city youth suffering from chronic and infectious diseases. Saint Luke's Foundation of Cleveland, Ohio funded an initiative to improve the health status of children ages 0-10 by developing and implementing a community-based model for health promotion and health care delivery. A key component of this program is an asthma detection and intervention program that offers screening, coordination of treatment, and parent education.

➤ ***Educating Providers*** – Since integrated and community-based care are not standard, it is essential to educate providers about the needed skills and strategies. The Dyson Foundation in New York is well respected for its pediatric residency training programs focusing on community-based medicine and advocacy. Ten residency programs have been given funding to incorporate community pediatrics into their residency curricula. In another example, The Blue Cross Blue Shield of Massachusetts Foundation is funding cultural competence training for physicians, interns, residents, and staff of a community health care center. The training will help health providers work with families of all backgrounds so they can stay involved in their children's care.

➤ ***Colocating Services*** – One way to ensure access to ongoing and coordinated care is to colocate health services in places where children and families are receiving other services. For example, The Welborn Foundation in Indiana is funding a school-based program that integrates health, social services, and education through family-neighborhood-school partnerships. Students are provided with physical and mental health care, while families are provided with health education classes and a forum for understanding their children's health. The Wellmark Foundation in Iowa has taken a different approach to colocating services by funding a health center located in a church that also houses a Head Start program. The center provides accessible and culturally sensitive care to women and children who are considered at risk due to socioeconomic status. Services include immunizations, family planning, well-child and well-woman care, and management of chronic illness. Patients are encouraged to return to the clinic to ensure continuity of care and an ongoing relationship with a health care provider.

➤ ***Reducing Emergency Department Use*** – Recent studies have shown that over three-quarters of yearly emergency department visits are for illnesses and injuries that are treatable by primary care providers. Another 7 percent are the result of chronic conditions, such as asthma, that can be treated in primary care settings (The Commonwealth Fund 2004). While access to emergency care is important for those who truly need it, access to primary care can reduce unnecessary emergency department use and help both children and adults achieve optimal health. The Commonwealth Fund recently launched an initiative to test new strategies for reducing emergency department use and connect users with primary care.

Web sites that provide information on family-centered and coordinated care include:

- Family Voices, www.familyvoices.org, which provides information for parents about family-centered care and advocacy;
- Champions for Progress, www.championsforprogress.org, which provides information on improving integrated systems of care for CSHCN; and
- The National Center for Cultural Competence, www.gucchd.georgetown.edu/nccc, which provides information on building culturally and linguistically competent service delivery systems.

SOURCES

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This Issue Focus is supported by a cooperative agreement with the U.S. Department of Health and Human Services' Maternal and Child Health Bureau (MCHB), which administers the Title V Maternal and Child Health Services Program. In partnership with state Title V programs, MCHB works to ensure the health of the nation's mothers and children, including children with special health care needs.