GRANT MAKERS IN HEALTH

Pediatric Medical Homes:

The What and Why of It All

The "medical home" encompasses the places, people, and processes involved in providing comprehensive primary care services. Medical homes replace episodic patient care with a holistic approach fostering ongoing physician-patient relationships, systematic care coordination, and addressing the "whole person." They also must deliver physician-directed patient care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally effective. The concept was introduced in 1967 by the American Academy of Pediatrics (AAP) to improve comprehensive primary care provided to children with special health care needs (CSHCN) (AAP 2008). Over time, it has expanded to encompass services provided to all children and adults.

In 2007 a partnership between physician societies led to the development of a joint principles statement on patient-centered medical homes (PCMH) (AAP 2007). The statement endorses patient-centered, coordinated care management processes to guide providers and health care teams in decision-making and patient care provision using evidence-based medicine, clinical decision support, and health information technology (HIT) (Honigfeld et al. 2006).

The utility of medical homes as a health care reform feature and model for all primary care services is gaining widespread recognition. PCMH advocates believe it will improve access, quality, coordination of care, and overall patient experiences and satisfaction, as well as the trajectory of escalating costs. Despite broad-based support, disagreements remain over defining and implementing medical homes, as well as which care improvements require prioritization. Most proponents advocate the "patient-centeredness" component, while others emphasize chronic case management or system of care improvements through organizational structures or HIT improvements such as electronic medical record usage (Berenson et al. 2008).

CARE COORDINATION

In 2005 the AAP issued a policy statement on care coordination, a critical component in facilitating children and families' linkage to appropriate services and resources to achieve good health outcomes (AAP 2005). Medical home care coordination activities, particularly important to CSHCN and their families, provide routine planning and facilitation of health promotion and chronic condition management; measure and improve the quality of health outcomes and resource utilization; and promote communication and information sharing between providers, families, and communities.

Substantial time and resources must be dedicated to care coordination activities, including using designated care coordinators as single points of entry to minimize patients' confusion in navigating health care systems. Unfortunately, delivering effective care coordination is often challenging for small or rural practices, which may lack staff capacity, technology infrastructure, or resources and purchasing power to perform necessary services. This is particularly notable because nearly 50 percent of private providers work in practices containing one to two physicians (Bodenheimer 2008).

RECOGNIZING THE MEDICAL HOME MODEL

Numerous collaborations and programs exist to support the medical home model's expansion, recognize high-performing physicians, and set primary care practice standards. For instance, the Patient-Centered Primary Care Collaborative (PCPCC) is a national coalition of major health plans, employer groups, medical specialty societies, and consumer organizations. The PCPCC strategizes and shares information on transforming practices, reforming reimbursement, evaluating medical home demonstration projects, and supporting broader PCMH implementation (PCPCC 2008).

The Physician Practice Connections (PPC) medical home recognition program was created by the National Committee on Quality Assurance (NCQA) to acknowledge physicians who deliver superior quality patient care utilizing PCMH components. Recently NCQA released updated medical practice standards, through the PPC-Primary Care Medical Home program, which align with PCMH joint principles. These standards recognize practices functioning as PCMHs, including measuring specific aspects of care such as patient - self-management support and performance reporting and improvement (AAP 2008).

MEDICAL HOME FUNDING MECHANISMS

The PCMH joint principles statement suggests a reimbursement structure that recognizes the value of provider care management beyond face-to-face patient visits (AAP 2007). A Commonwealth Fund-supported partnership between the PCPCC and the National Academy for State Health Policy (NASHP) is also working to identify strategies and policy solutions for implementing the PCMH model in Medicaid and the State Children's Health Insurance Program (SCHIP) (NASHP 2008). One strategy suggests using an enhanced reimbursement system to integrate case management, or performance-based, fees with traditional fee-for-service payments to providers. This system allows greater flexibility and

creativity for providers, though requiring more time devoted to managing patients' health care.

In addition to fee-for-service payments, a number of states pay Primary Care Case Management fees per member per month for all services to Medicaid and SCHIP beneficiaries (NASHP 2008). Some states offer additional reimbursements for functions such as care coordination or practice-level quality improvement. Others offer capitated primary care reimbursements or financial incentives to managed care organizations providing a comprehensive set of benefits or achieving key performance benchmarks associated with functioning as a medical home.

PHILANTHROPIC INVOLVEMENT

Health philanthropy has long played a role in seeding the development and broader adoption of true medical homes for children. Medical home development in pediatric practices continues to evolve allowing numerous opportunities for philanthropic involvement.

- **Children's Fund of Connecticut**, in partnership with numerous organizations, is funding the demonstration project Health Outreach for Medical Equity, which provides care coordination and outreach services to over 1,200, mostly minority, children and their families in Hartford. The program targets high-risk children who miss appointments, transfer care, or use emergency room services. The fund is currently collaborating with a variety of state agencies and advisory councils to assess broader policy reforms to support the financial sustainability of medical home services.
- **United Health Foundation** provided a grant to the AAP for the Education in Quality Improvement for Pediatric Practice (eQIPP) Web-based quality improvement initiative. This initiative includes activities for practices such as opportunities to earn continuing medical education credits for certifications, participate on-line for collaborative learning and information access, evaluate individual practices and performance against peers, and participate in quality improvement activities.
- Beginning in 2002 the **California HealthCare Foundation** committed funding to support seven local, community-based coalitions through the California Medical Home Project. The project supports the development of a statewide network of family-centered medical homes. The coalitions have aimed to improve access to primary and specialty care for approximately 150,000 CSHCN and their families, as well as promote collaboration between agencies and programs serving CSHCN, professional organizations, and the community at large.
- The **Morris & Gwendolyn Cafritz Foundation** and other funders have provided funding to the Health Services for Children Health Care System for a family-centered medical home project for CSHCN and their families. This quality improvement initiative provides customized training, education, resources, technical assistance, and on-site care coordination to improve primary care practices' efforts to function as better CSHCN medical homes. The creation of a "Guide for Medical Home Implementation Replication" is expected to help expand the initiative to other practices.

FUTURE DIRECTIONS

Functional medical homes require system redesign, quality measurement and performance improvement financing, and state and federal regulatory and policy support. Collaborations across typically siloed and competitive entities should facilitate pooling resources, leveraging staffing and technological improvements, implementing key process changes, and evaluating quality and cost efficiencies within practices (Bodenheimer 2008).

New approaches for reimbursing primary care coordination continue to be explored. Recently medical societies have participated in developing a care management fee code and evaluation to reimburse practices for "personal physician services." This code will be used during an upcoming three-year Medicare Medical Home Demonstration Project beginning in 2009 (AAP 2008).

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