Part Two

High Performing Medical Homes for Young Children: Covering Well-Child Care to Meet *Bright Futures* Guidelines
Child health practice is undergoing a transformation, broadening its focus from treating disease and managing existing health conditions to promoting healthy development. This transformation is based on a much more ecological and family-centered approach to providing primary and preventive services through well-child visits. The definition of health is now generally considered as a state of physical, mental, and social well-being, not merely the absence of disease or disability. Thus health care services, particularly for children, must be broadened to include responses not only to bio-medical factors but also to address social determinants of health that can have negative impact on health across the life span. While the health care system is not responsible for addressing all social determinants, and certainly not through clinical services, it has a key role to play, often in initiating responses. For young children, it is particularly important that primary care respond to social determinants of health that reflect family and community environments that can jeopardize healthy and development.

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents provides evidence-based guidelines for well-child and preventive care. Led by the American Academy of Pediatrics (AAP) and supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Bright Futures has been designated as the standard of care for pediatric preventive services in public and private plans in federal law. The Bright Futures guidelines outline the content for 31 age-specific, well-child, preventive health visits from birth to 21. Its most recent edition has expanded emphasis on using well-child visits to promote overall health and well-being and to respond to social determinants of health, including themes such as family support and healthy development, as well as physical, mental, developmental, and oral health.

A growing array of primary care practices is responding to this broader definition of what determines health. Some exemplary practices in the Child and Family Policy Center’s Health Equity Initiative (Pri-
mary Health Care Iowa, Maricopa Health Systems, The Children’s Clinic) have developed systemic approaches within existing health systems, while others have adopted and built on new evidence-based program models (e.g., Help Me Grow, HealthySteps, and Project DULCE) (see Appendix D). Such practices have recognized that ensuring the safety, stability, and nurturing in the home environment is foundational to healthy child development. In most instances, these efforts extend beyond the primary health setting, connecting families with services and supports to promote all areas of child development (i.e., physical, cognitive, social-emotional, and language). They start, however, with the pediatric primary care setting extending beyond what often is the routine practice of a physical examination, vaccinations, and primary attention to any medical issues. They augment with screening, care coordination/case management, staff focused on development, and other approaches to better serve children from low-income, higher-risk communities.

To move from exemplary sites to widespread implementation will require states to develop Medicaid payment approaches, benefit definitions, provider requirements, and other processes that support this new standard of care. Where states have established contracts with managed care or accountable care organizations for delivering Medicaid services, states must establish contract requirements, guidelines, and incentives to advance this work. Under Bright Futures guidelines and Medicaid’s EPSDT provisions, states have both the authority and the responsibility within their Medicaid programs to accelerate this transformation across the country. The first step is to define and sufficiently finance the pediatric medical home.

### Seven Core Features of the Medical Home

**Personal Physician** — each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

**Physician-Directed Medical Practice** — the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Whole Person Orientation** — the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals.

**Care is Coordinated and/or Integrated** — across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

**Quality and Safety** — are hallmarks of the medical home. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

**Enhanced Access** — to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

**Payment Reform** — appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Defining and Financing a High Performing Medical Home

Pediatric primary care providers (e.g., pediatricians, family physicians, nurse practitioners, etc.) are the professionals most likely to see and serve young children (particularly those under 3). With 9 out of 10 young children seeing a health provider for a well-child, preventive visit at least annually (and more frequently in the earliest years), such visits offer opportunities for improving health outcomes during childhood and for a lifetime. The pediatric medical home is the ideal context for this to occur.

The AAP, HRSA-MCHB, and CMS all recommend that each child have a patient/family centered medical home. An increasing body of research identifies the key characteristics of a medical home. According to the AAP and HRSA-MCHB, a pediatric medical home provides health care must be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In 2007 the AAP, American Academy of Family Practice, American College of Physicians and American Osteopathic Association developed the “Joint Principles of the Patient-Centered Medical Home (PCMH)” and adopted the National Center for Quality Assurance (NCQA) — PCMH criteria as standards for practices. The shared principles are to deliver primary care that is: person and family centered, continuous, comprehensive, equitable, accessible, coordinated and integrated, team-based and collaborative, and high value. Quality and safety are integral parts of the medical home model.

As discussed above, many pediatric medical home providers are augmenting their services or increasing linkages with other community providers to better address risks and concerns related to child development, emotional-behavioral factors, or social determinants of health. Others have adopted a pediatric primary care bundle and used quality improvement approaches to achieve significant improvements in practice — for instance, one effort showed an improvement from 58 percent to 92 percent of visits where full bundle of preventive services was received for patients 0 to 14 months of age, with sustained the improvement for over one year. Such efforts require time and resources to establish and maintain in clinical practice and within the office setting, but they are particularly important for assuring the health and development of children in Medicaid and reducing long-term costs in health, education, and social services.

By transforming their practice and operating as a high performing medical home, pediatric primary care providers can better achieve the quality and experience of care for the young child and family.

By transforming their practice and operating as a high performing medical home, pediatric primary care providers can better achieve the quality and experience of care for the young child and family, improving the health trajectories of young children as a result, and reduce the incidence of preventable health conditions across the lifespan that currently are the source of many health care costs. A high performing medical home for young children in Medicaid would carry out the functions beyond what is in standard practice today, and in particular give more focus to the needs and risks of low-income young children and their families. Exemplary pediatric primary care practices for low-income young children share important characteristics related to their approaches and functional components that define high performance. Specifically, they:

1. Provide comprehensive well-child visits and preventive services based on Bright Futures and EPSDT standards, including screening, anticipatory guidance and parent education. This includes engaging with families to screen for, identify, and discuss issues (anticipatory guidance) that extend beyond
the physical/bio-medical well-being of the child to the social and environmental factors that affect healthy child development (e.g. family stress and adversity, maternal depression, food insecurity), with a two-generation emphasis on improving child health.

2. Provide care coordination/case management at appropriate levels (low, moderate, and more intensive levels), depending on child and family presenting concerns. This includes supports for an effective, warm “handoff” from the health practitioner to a care coordinator (based inside the medical home and/or in the community) to identify concerns, strengths, and needs, and to ensure referral and follow-up that connects families with resources and supports that meet needs and build strengths. A part of this care coordination is to identify and network with other resources in the community to facilitate effective care coordination and ensure completed referrals, connecting young children and their families to services and supports in their communities.

3. Increase use of other supports for healthy development. This can include augmented services located within the primary care setting, such as integrated behavioral health, developmental specialists, or community health workers to support families. Primary care practices also should link to or integrate with other services such as home visiting, dyadic therapies to improve children's healthy development, early intervention for developmental delays and disabilities, early childhood mental health therapy, or parenting programs.

Figure 12 illustrates these different characteristics of high performing pediatric medical home, reflecting best practices and approaches identified in the field and based on the goals and guidelines set in Bright Futures. Medicaid can finance services in each of the three areas.
Aiming for Quality in Well-Child Visits

In many respects, the diffusion of innovation in pediatric primary care is in an early stage, with opinion leaders calling for change and early adopters undergoing transformation. Most practices offer traditional medical care for young children but have not adopted approaches to address social determinants of health or accelerated efforts to identify and address developmental and behavioral concerns. Risks and conditions that may not yet meet a clinical threshold of disease or illness or developmental delay often remain unaddressed. Time available to spend with children and their families is limited, and it may seem impossible to add anything new to their responsibilities. At the same time, most pediatric primary care providers recognize there would be value to doing more, particularly if compensation and staff with expertise are available (e.g., for intensive care coordination, augmentations).

The following scenarios describe good current practice for primary care addressing bio-medical issue (scenario one) and practices that extend beyond that (based on exemplary program experience) to be a truly high performing medical home (scenario two).

Scenario one: 1-Year-Old Well-Child Visit

A mother and child come into the office and are sent into an examination room, where a nurse comes in, measures and weighs the child, and informs the mother of the immunizations the child will receive. She asks the mother to unclothe the child and says that the doctor will be in shortly for the examination. The doctor comes in and does a thorough, full-body examination of the child, sharing with the mother that while the child has no medical abnormalities, the child is in the 85th percentile for her age in weight and the 50th percentile for height. He asks about the child’s eating patterns and cautions against giving more than four ounces of juice per day. He also asks the mother if she has any concerns about her child’s physical development and speech. Although he notices the mother looks stressed and does not appear to pick up on the child’s cues for attention, he doesn’t see anything medical to address. He concludes the visit by assuring the mother her child is healthy but again encouraging her to watch the child’s weight and nutrition and says he looks forward to the next visit.

Scenario two: 1-Year-Old Well-Child Visit

Prior to coming into the office, the mother received notifications of the upcoming visit, was mailed a pre-visit information sheet for this age group from Bright Futures, and was encouraged to complete the online Well-Visit Planner and an Ages and Stages Questionnaire (screening tool about development). When she comes in, the front desk staff checks to see any results (in this instance there are none, as the mother did not complete the planner or questionnaire) and provides the mother with a parent survey that asks questions about the child’s development and family concerns. The staff person highlights for the doctor several responses, including that the mother has had a change in her life (housing move), reports she is under significant stress, and is concerned with her child’s “acting out.” While she waits, the mother is given a handout that briefly describes developmental expectations and milestones for a 1-year-old and some tips on eating, exercise, bedtime and sleep patterns. As with scenario one, the mother and child are sent to an examination room and the nurse reviews the immunization schedule and informs the parent what the examination will cover.
When the doctor comes in, he immediately asks the mother how she and the child are doing and how the move has gone. The mother indicates that it has been hard, she has moved in with a friend in order to save money, there isn’t much space for her and her child, and they likely will have to move again. Following queries, the mother expresses frustration at managing her child’s temper tantrums, particularly at bedtime, and that she herself is often exhausted. While completing the child’s physical itself, the doctor indicates that the child is healthy but has nutrition concerns and would like to go over the information on the handout about nutrition. The doctor also says he would like to call-in part of his team, a HealthySteps specialist, to spend a little more time discussing child behavior management and development. First, however, the doctor brings out a book and hands it to the mother and asks her to share the book with the child. He watches the mother doing this, and comments on how, even at this age, reading and showing pictures to a child is a good activity. The doctor mentions he would like to have another check-up in a month or six weeks, so he can see how the nutrition and reading are going, and if the nighttime routine is getting easier.

The doctor then leaves and confers briefly with the HealthySteps specialist, who comes in for a 20-minute session with the mother and child. The specialist provides advice, guidance, and modeling on parenting and answers a number of questions the mother now asks. The worker also compliments the mother on the way she holds her child and responds when the child smiles. The specialist learns that the mother does not have a crib for the child to sleep in and that the housing situation is temporary. The worker is able to connect the mother with a paralegal, through a clinic relationship with legal services under the practice’s Medical-Legal Partnership, which helps provide housing leads. The mother also receives a voucher that can be used to get a safe, portable crib through the local health.

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<tr>
<th>Core function for high performing pediatric medical home</th>
<th>Medicaid mechanism</th>
<th>Reimbursement and fiscal sustainability</th>
<th>Quality and value measures for incentives and accountability</th>
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<tr>
<td>Well-Child Visit and Prevention Practices</td>
<td>• Well-child (EPSDT) visit payment</td>
<td>• Reimbursement for visits (which document core functions achieved) cover costs — 15-minute and 30-minute visits @ $100+ and $150+ (e.g., payment for a high performing medical home for young children above that for current well-child visits)</td>
<td>• Medicaid-CHIP core measures on primary care access and preventive services, including: well child visits, developmental screening, immunizations, and access to primary care.</td>
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<td>• Child physical examination</td>
<td>• Separate payments (where approved by state) for screening of child development (general and social-emotional) and social determinants (material, personal, social, and parenting, and screening for maternal depression)</td>
<td>• Screening payments (e.g., $25+ per screen, with more than one screen allowed)</td>
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<tr>
<td>• Developmental surveillance and screening</td>
<td>• Required referrals for other services, including: vision, hearing, and dental</td>
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<tr>
<td>• Screening for social determinants of health and family risks</td>
<td>• Anticipatory guidance</td>
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<td>• Care coordination</td>
<td>• Care coordination</td>
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<tr>
<td>• Required referrals for other services, including: vision, hearing, and dental</td>
<td>• Other referrals as needed for nutrition, housing, income, and other family support services</td>
<td>• Referrals and appointments made for follow up on identified risks</td>
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Table 3. Financing Core Functions in a High Performing Pediatric Medical Home
department. The mother leaves with a general handout on children’s developmental expectations at age 1, a picture book, an appointment schedule for an interperiodic EPSDT visit in six weeks, and several additional resources provided by the HealthySteps specialist about what they had discussed.

Clearly, both visits have value for the child’s overall healthy development, but the second does much more around probing the stability and nurturing the child is likely to receive that are foundational for optimal physical, cognitive, social, and emotional development. The first scenario meets the periodicity schedule for well-child care set out in *Bright Futures* and checks off specific required medical examination boxes, but the second scenario embodies the overall *Bright Futures* guidelines for well-child care, including its emphasis on identifying and responding to social as well as bio-medical determinants of health.

Operating a practice that provides well-child visits that conform to scenario two has greater costs than visits that reflect scenario one. At heart, “value-based payment” systems are intended to provide differential payments that recognize these different values. If the current well-child visit as provided in scenario one is reimbursed $75 (the typical payment by Medicaid, although subject to very large variations across states), it is easy to argue that scenario two has a value of double or triple that and should be reimbursed accordingly. It may be possible for a practice to maintain itself doing well-child visits with a reimbursement of $75 for scenario one for its Medicaid patients, but certainly not for scenario two. If practices are to be incented to adopt scenario two, their reimbursement must be substantially greater.

This is true whether operating within a fee-for-service or a managed care environment. In most instances, the actual Medicaid reimbursement is similar under managed care payments and under fee-for-service ones (see part five for a detailed discussion of opportunities to reimburse high performing medical homes under different payment systems and models).

In addition to providing reimbursement for the office visit, Medicaid also may provide separate reimbursement for screens that are performed. Currently those primarily involve child-specific screens (e.g., Ages and Stages, autism screens) but also have extended in some instances to screens related to the family

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<th>Table 4. Measuring High Performing Pediatric Medical Homes for Young Children in Medicaid</th>
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<td>High rates of access to care*</td>
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<td>High percentage of children receiving well-child visits*</td>
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<td>High rates of children who are up-to-date on immunizations*</td>
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<td>High performance on developmental screening measure*</td>
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<td>Satisfaction with the experience of care as measured with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H*</td>
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<tr>
<td>Use of validated CSCHN screening tool</td>
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<td>Use of SDOH screening tool, including maternal depression</td>
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<td>Low rates of unnecessary emergency department visits*</td>
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<td>Family engagement demonstrated through use of recommended Bright Futures pre-visit tools and/or the electronic Well-Visit Planner</td>
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<td>Documentation on rates of referrals, follow up and completed referrals</td>
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<tr>
<td>Documentation of augmented resources and supports provided in practice (e.g., integrated mental health, Healthy Steps, Project DULCE, Reach Out and Read)</td>
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<tr>
<td>* Measures are part of CMS Medicaid-CHIP Core Child Set.</td>
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environment (e.g. maternal depression, ACEs, and screens around material and social risks). Again, states vary widely in the degree to which they enable practices to bill separately for screens, particularly screens for broader social determinants as opposed to child-specific behavioral and developmental screens, and what they pay for it. The greater the payment practices receive for both the practitioner’s visit and screens that are conducted, the more the office can be structured to operate in the manner described in scenario two. Current payment rates for such office visits vary substantially across states (see Appendix E for description of variations across states both in office reimbursement and for screening). States need to look at what services they can reasonably expect practices to provide under current rates and what reimbursements will be needed to structure the office to practice as a high performing medical home.

In developing differential payments for high performing medical homes, it is important that the financing system distinguish between this enhanced, high performing medical home and regular well-child visits. Making such distinctions requires the development of metrics and measures, which may include measures incorporated into electronic medical records but also other measures based on chart reviews or assessments of office organization and practice. Increasing the use of metrics and developing monitoring and measurement systems will help to ensure payment accountability and assist in quality improvement.

Beyond improving rates of use of well-child EPSDT visits and screens, states also need to develop measurement systems for high-quality well-child visits in the context of a high performing medical home. Table 4 shows measures that reflect key characteristics of high performing medical homes for young children in Medicaid.

References


