PA Consortium for CYSHCN
Background Brief
Medical Home

This background brief presents an overview of the status of **medical home** for children and youth with special health care needs (CYSHCN) in Pennsylvania.

The federal Maternal and Child Health Bureau identified six core outcomes as critical indicators of success in implementing community-based systems of services for all CYSHCN in accordance with Healthy People 2010 and the President's New Freedom Initiative. This background brief relates to Core Outcome #2:

CYSHCN receive coordinated ongoing comprehensive care within a medical home.

Background

A medical home is not a building, house or hospital, but rather an approach to providing health care services that embraces family centered principles, care coordination, and high-quality health care. All children deserve a medical home, and the American Academy of Pediatrics (AAP) defines core medical home components as: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally competent care.[1]

In 2007, a Joint Principles Statement, developed by several adult and pediatric medical constituents, embraced the concept of a patient and family-centered medical home. Central tenants of this statement include: ongoing relationship with a personal primary care providers, a physician-directed medical practice; a whole person orientation to care; care that is coordinated and/or integrated across all elements of the complex health care system and the patient's community; quality and safety, enhanced access to care, and payment that appropriately recognizes the added value of a patient and family-centered medical home.[2]

Medical Home in Pennsylvania

National Survey of CSHCN 2005-06[3]

The National Survey of CSHCN is a national telephone survey that collects data on families' experiences with services, providers, and unmet needs.

The following are the indicators used to measure Core Outcome #2 on the NS-CSHCN:

Indicator	Pennsylvania %	Nation %
Core Outcome #2: CYSHCN receive coordinated, ongoing, comprehensive care within a medical home.	45.8	47.1
CYSHCN ages 0-17 who have usual source(s) for both sick and well care.	95.1	92.9
CYSHCN ages 0-17 who have a personal doctor or nurse	94.4	93.5
CYSHCN ages 0-17 who have no problems obtaining referrals when needed	22.7	26.0
CYSHCN ages 0-17 who receive family-centered care from health providers	63.4	62.4
CYSHCN ages 0-17 who receive effective care coordination	49.8	46.0

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NOTE: PA has a higher percentage of Hispanic (13.6 PA vs. 8.3 National) and Black, non-Hispanic (18.1 PA vs.15 National) CYSHCN than the national average. Also, PA has a higher percentage of Spanish language households (8.2 PA vs. 4.6 National) [4]

Medical Home Programs in Pennsylvania

- In 1992 the first Medical Home meeting took place in PA. This movement was inspired by a grant from the Shriner's Hospitals to the national American Academy of Pediatrics. Selected states had the opportunity to bring key stakeholders together to discuss improving care for children with special needs and improving communication with and services for families.

- **PA Medical Home Program-Educating Practices in Community Integrated Care (EPIC IC).** This program, housed at the PA Chapter of the American Academy of Pediatrics, works with pediatric practices on medical home adoption, implementation, and quality-improvement and practice transformation. Key components include: family-centered care and parent partners, transition, care coordination (practice and community based) and community resource development. Since its inception in 2001, the EPIC IC team has worked with over 80 practices across the Commonwealth of Pennsylvania.

- **PAFP-Medical Home Project (MHP) Educating Medical Professionals in the Community (EMPC).** This program, housed at the PA Chapter of Family Physicians, began in September, 2005. Since then 23 facilities (either private practice or residency programs) have become involved, 284 people have received improved health services, and 4,263 people have been introduced to the Medical Home concept through trainings and presentations. The goal of the program is to educate medical professionals in the transition process for children and youth with special health care needs who are aging out of the pediatric facilities so that as adults, they have safe, comforting, and reliable medical facilities to call home.

- **Governor's Chronic Care Initiative/Improving Performance in Practice (IPIP).** The Governor's Chronic Care Initiative/Improving Performance in Practice (IPIP) effort embraces the Wagner Chronic Care Model and addresses two chronic conditions: adult diabetes and pediatric asthma. Great strides have been made in practice quality improvement and positive changes have been realized in outcomes for asthma and diabetic patients.

Care Coordination and Outreach Services

- The Elks Home Service Program provides statewide community-based care coordination to children, youth, and adults. Their services are provided at no cost to families and include, but are not limited to: assistance with school issues and placement, assistance obtaining needed medical equipment, support finding resources for families with financial constraints, and assistance with transition to adulthood and adult-oriented services.

- The Department of Health's regional Family Health Nursing Services Consultants, formally known as the Maternal and Child Health nurses and Special Needs nurses, as part of their community outreach efforts, promote the concept of medical home among local pediatric providers and parents.

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- In Pennsylvania, the mandatory managed care program for Medical Assistance recipients is called HealthChoices. HealthChoices consists of seven Managed Care Organizations in three zones [South West (SW), Leigh/Capital (L/C) and South East (SE)]. Each health plan houses a Special Needs Unit that is responsible to assist special needs members/families to navigate the health care system to ensure access to care and community resources, to make referrals for physical and behavioral health issues, to coordinate care with other agencies and to advocate on behalf of Special Needs members. Social workers, nurses, and case managers with social work or medical backgrounds staff these units.

Reimbursement

- In 2008, Department of Public Welfare released a bulletin increasing E/M codes for high-level, high-complexity visits for practices in fee for service counties.

- In 2008, McKesson included care plan development and oversight as a pay for performance option for providers in participating counties.

- In 2008, the Department of Public Welfare included obesity and several codes relating to reimbursement.

References

1. American Academy of Pediatrics Medical Home Initiatives for Children with Special Health Care Needs Advisory Committee. Policy Statement: The Medical Home. Pediatrics. 2002; 110: 184-186.

2. Joint Principles of the Patient Centered Medical Home. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). March, 2007. http://www.medicalhomeinfo.org/Joint%20Statement.pdf accessed 3/10/07.

3. http://mchb.hrsa.gov/cshcn05/

4. www.cshcndata.org. Accessed 5/22/09.

Questions for Discussion

1. Do we have capacity to provide the needed services for medical home?
2. Are medical homes available in a way that people can access them?
3. Are medical homes available in enough quantity so as to be accessible to everyone?
4. Does insurance cover the needed services in provision of a medical home?
5. What is the appropriate level at which to solve these problems - local, state, federal?
6. Where do people go for support/education/resources on medical homes?
7. How can we best expand medical homes to work with Federally Qualified Health Centers and Rural Health Centers?

8. What opportunities and lessons learned are there for us certifying Medical Home practices, or having sustainable mechanisms for medical homes from other states?
9. How can Medical Home teams maintain involvement with parents, youth and Family/Professional Youth Forums? Can we have regional leaders who work with practices and provide coaching?
10. How can Family Health Nurse Consultants become engaged and involved with Medical Home Practices across PA?
11. What is missing from this brief with respect to medical home data or services?

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