

Medical Home for Iowa Children and Youth

Goal: Improved health outcomes for all Iowa children and youth.

Objective:

1. All children and youth have access to appropriate, quality health care within a medical home.
2. Medical practices utilize quality measures and quality improvement methodology to achieve optimal outcomes (e.g. health status, family satisfaction)

Background:

Based on HF 2539, the first population Iowa will target to spread the Patient Centered Medical Home (PCMH) is children enrolled in Medicaid. There needs to be a focus and emphasis on key elements of PCMH, but with a stronger pediatric perspective for the 0-21 year population.¹

- Family centered partnership (trusting, collaborative, working partnership with families, respecting diversity)
- Community based system (goes beyond medical home concept by working with the community surrounding the child: family, agency coordinators, education system, and social support systems)
- Transitions (developmentally appropriate services that continue uninterrupted as individual moves along and within system from adolescence through adulthood)
- Value based (appropriate payment to support and sustain pediatric medical homes that promote quality care and optimal health outcomes, family satisfactions, and cost efficiency)

Based on the needs for children and youth with special health care needs, it is our recommendation that the Medical Home for Iowa Children and Youth pilots be divided into two categories. One for well-child care that is based on best practices for providing care for children and youth (Bright Futures) and one for children and youth with special health care needs (CYSHCN) that will focus on the two most prevalent chronic conditions for children (asthma and behavioral/mental health.)²

¹ American Academy of Pediatrics. Accessed May 22, 2010 @ www.medicalhomeinfo.org

² <http://cshcndata.org/Viewdocument.aspx?item=153>

Certification:

Certification for all medical homes for children and youth will be through the national committee for quality assurance (NCQA) and achieved through use of the National Center for Medical Home Implementation's (NCMHI) medical home toolkit. The toolkit is located here: <http://www.pediatricmedhome.org/> Primary care providers wishing to participate in the pilots must become NCQA certified within 12 months of participating in the pilots.

Two tools will be required for all practices wishing to participate.

1. A screen must be done on all children to identify CYSHCN. The screener is available here: <http://cahmi.org/ViewDocument.aspx?DocumentID=115>
2. A care plan must be developed for any CYSHCN in coordination with a care coordinator from the community utility. Examples are available through the NCMHI toolkit.

Use of these tools will be audited by IDPH (or IME) with assistance by IA-AAP on an annual basis for continued participation in the Medical Home for Iowa Children and Youth pilots.

Payment System Methodology:

Well-Child – Title V/MCH Utility Pilot

The well child pilot will be designed with certified medical practices working in coordination with a local Title V/MCH agency as the community utility. Achievement of benchmark levels on the outcome measures will result in a shared savings/pay for performance incentive for the practice and community utility. No PMPM payment will be made for participation in this pilot.

Pay for performance will be based solely on meeting benchmarks for outcome measures. Process measures will be reviewed as a basis for being medical home certified.

Table 1: Well Child Incentives Upon Application Submitted to NCQA

Practices can only be paid according to Table 1 for 12 months, unless a delay in processing NCQA recognition that is caused wholly or in part by NCQA (e.g. backlog, etc.)

EPSDT Screening	Developmental Screen	Oral Health Screen	Immunization
Process Measure	X	X	
Outcome Measure	X	X	

Table 2: Once NCQA Certified

EPSDT Screening	Developmental Screen	Oral Health Screen	Immunization
Process Measure	X	X	
Outcome Measure	X	X	

CYSHCN State Plan Pilot

The CYSHCN pilot will require all practices to become certified medical homes through NCQA. Payment will be through a per member per month care coordination fee to the certified practice. Iowa’s Title V program for CYSCHN-Child Health Specialty Clinics will function as the community utility, through a contract with IME. (See addendum for more information on role of the community utility.) Performance based incentives will be available to practices that meet performance benchmarks.

Table 3 CYSHCN Payment Upon Application Submitted to NCQA

Practices can only be paid according to Table 3 for 12 months, unless delay in processing NCQA recognition that is caused wholly or in part by NCQA (e.g. backlog, etc.)

	Practice Monthly Care Coordination/PMPM	Performance Based Reimbursement	Potential Total Cost/PMPM
All same level	X	X	X

Table 4 CYSHCN Once NCQA Certified

Level of Certification	Practice Monthly Care Coordination/PMPM Payment	Performance Based Reimbursement	Potential Total Cost/PMPM
Level 1	X	X	X
Level 2	X	X	X
Level 3	X	X	X

Additional Incentive Considerations for both pilots:

- Reimbursement for transition related collaboration with adult health care provider
- Reimbursement for specialty consultation with primary care provider
- Reimbursement for services delivered by telemedicine technology (telephone, electronic, webcam)

See addendum for payment data/background

Performance Reporting and Outcome Measures

Both outcomes and process measures will be used for each category.

Well Child - Title V/MCH Utility Pilot

ESPDT

Screening/Using Bright Futures Framework (see Appendix A)

Immunizations/Using AHRQ criteria (see Appendix B)

a. Developmental screen

- **Process Measure** ----percent of well-child visits of children younger than 5 years in which a structured developmental assessment is used.
- **Outcome Measure** ---number of children younger than 5 years referred for developmental assessment

b. Oral Health screen

- **Process Measure** --percent of well-child visits of children younger than 8 years in which an I-Smile™ approved oral health risk assessment protocol is used
- **Outcome Measure**—number of children younger than 8 years at-risk or with suspected dental disease referred to Iowa's I-Smile™ program via the I-Smile™ Coordinator assigned to the practice's region of the state

c. Immunization

- **Process Measure**—percent of children “up to date” using Composite 3

CYSHCN State Plan Pilot Using AHRQ criteria (see Appendix B)

a. Asthma

- **Process Measure**-percent of patients with written asthma management plan
- **Outcome measure**- Annual number of asthma patients (>1 year-old) with >1 asthma-related ER visit

b. Mental Health/ADHD or ASD

- **Process Measure**-percent of patients who were provided with patient education on disease management and health behavior changes during one or more visit(s).
- **Outcome Measure** –number of children receiving appropriate follow up care when prescribed medication (continuation and maintenance phase).

All practices participating in either pilot must put together a team to participate in the Medical Home Learning Community led by the Iowa Healthcare Collaborative.

Community Utility – Use System of Care Model

Children With Special Health Care Needs (CSHCN) -Infants or children from birth through the 21st year with special health care needs. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

Establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. Program collaborates with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

Emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

Community coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

Community coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Clinician-Directed Care Coordination Services

Clinician (physician or APRN)-directed care coordination services would be a benefit of the CHSC Services Program.

In providing a medical home clinician directs care coordination together with the child or youth and family. Care coordination is a family-centered process that links children or youths with special health needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) would include the following activities, with permission of the patient and/or family:

- Supervising the development and revision of a client's written care plan (a formal document or contained in the client's progress notes) in partnership with the client, family, and other agreed-upon contributors and sharing of this care plan with other providers, agencies, and organizations involved in the care of the client
- Coordinating care among multiple providers
- Maintaining a central record or database that contains all pertinent client medical information, including hospitalizations and specialty care
- Assisting the client and family in communicating clinical issues when a client is referred for a consultation or additional care
- Evaluating, interpreting, and managing consultant recommendations for the client and family in partnership and collaboration with consultants, other providers, the client, and the family

Clinician-directed care coordination services should also include supervision of development and revision of the patient's emergency medical plan in partnership with the client, the family, and other providers to be used by emergency medical services (EMS) personnel, schools, other community agencies, and caregivers.

APPENDIX A:

Working With Practices to Improve Preventive Care Using Bright Futures

Bright Futures training and implementation materials funded by the Commonwealth Fund with support from the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, have been developed to facilitate implementation of *the Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition*, at the practice system level (for tools and resources to use in conjunction with health supervision visits, see the [Bright Futures Tool and Resource Kit](#)).

These training and implementation materials are built on 2 key concepts: the Bright Futures framework and the use of an “office systems” approach in primary care practice. The Bright Futures framework lays out 6 key components of care:

1. Use of a Preventive Services Prompting System
2. Use of structured developmental assessment
3. Evaluation of parental strengths and needs
4. Development of a recall and reminder system
5. Development of linkages to community resources
6. Identification of children with special health care needs

Practices that have systems to support these 6 components are ones that embody the Bright Futures philosophy.

The office systems concept is important as well. All practices have office systems in which staff work together to accomplish a common purpose. Billing is an example of a system in which the entire health care team communicates to ensure that patients receive an accurate bill for services. Applying these office system principles to preventive care helps to overcome the sheer number of recommended services by using tools, training, and data to ensure that appropriate services are provided to patients at every visit.

APPENDIX B

Immunization

Children who received 4 DTaP vaccinations, 3 IPV, 1 MMR, 2 Hib, 3 Hepatitis B, 1 VZV, and 4 pneumococcal conjugate vaccines on or before their second birthday
Composite 3; other composites are available

- Enrolled children who turn 2 yrs of age during the measurement year
- Continuous enrollment for 12 months prior to child's second birthday

Addendum:

Culturally Competent Practice Includes:

- bilingual/bicultural or multilingual/multicultural staff;
- cross-cultural communication approaches;
- cultural brokers;
- foreign language interpretation services including distance technologies;
- sign language interpretation services;
- multilingual telecommunication systems;
- videoconferencing and telehealth technologies;
- TTY and other assistive technology devices;
- computer assisted real time translation (CART) or viable real time transcriptions (VRT);
- print materials in easy to read, low literacy, picture and symbol formats;
- materials in alternative formats (e.g., audiotape, Braille, enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- materials developed and tested for specific cultural, ethnic and linguistic groups;
- translation services including those of:
- legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications)
 - signage
 - health education materials
 - public awareness materials and campaigns; and
- ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals).

Care Coordination Payment data

R. Antonelli and D. Antonelli reported the costs associated with care coordination for special needs children and youth in a primary care practice. Clinic staff recorded all non-reimbursable care coordination activities occurring over a 95-day period. Notably, half of the encounters involved care for nonmedical issues (e.g., follow-through with referrals in managed care networks, conferencing with school officials, and overseeing psychosocial problems). Extrapolating from the cost of practice-based personnel from national benchmark data, the authors concluded that the total cost of non-reimbursable care coordination activities ranged between \$22,809 and \$33,048 per year for a practice of four full-time-equivalent (FTE) physicians and one FTE nurse practitioner. In a follow-up study, Antonelli, Stille, and Antonelli looked at time spent performing non-reimbursable care coordination activities and resulting outcomes in six practice models across the United States.²⁴ Practices representing a diversity of geographic, patient socioeconomic, and payer mix characteristics were selected. The practices used varying models of care coordination, from those with no designated care coordination staff to those with funded staff whose only tasks were related to care coordination. Significantly, care coordination activities delivered by nurses using non-billable telephone-based interventions often led to avoidance of billable office and emergency department visits.

\$7.78/PMPM was the cost from 2008 article in Peds