

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Through the Assuring Better Child Health and Development (ABCD) III learning collaborative, Arkansas, Illinois, Minnesota, Oklahoma, and Oregon have developed and tested models to improve care coordination for children with or at risk of developmental delay. These states have leveraged the medical home as a key mechanism in their improvement efforts. This *State Health Policy Briefing* draws from the ABCD III states' experiences to outline opportunities, options, and lessons for state policy makers to consider in order to strengthen medical home initiatives by explicitly addressing the needs of children in four ways: including pediatric criteria in medical home qualification standards; creating pediatric learning collaboratives for medical home providers; educating non-medical providers about the patient-centered medical home; and using child health and development data to help medical home providers track progress and drive improvement. ABCD III experience is that by using these strategies, states can help advance healthy child development through medical homes.

ABCD III is funded by The Commonwealth Fund and administered by NASHP. For more information about ABCD III and previous ABCD initiatives, please visit: <http://nashp.org/abcd-history>

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Supporting Healthy Child Development through Medical Homes: Strategies from ABCD III States

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Across the country, policy makers and providers seek ways to promote healthy child development by facilitating early identification and amelioration of developmental delays. Appropriate and timely developmental screening and follow-up services are essential to this goal, as are seamless coordination among providers of pediatric health care and community-based services. Through the current Assuring Better Child Health and Development (ABCD III) learning collaborative, Arkansas, Illinois, Minnesota, Oklahoma, and Oregon have developed and tested models to improve care coordination for children with or at risk of developmental delay. These states have leveraged the medical home as a key mechanism in their improvement efforts. This *State Health Policy Briefing* draws from the ABCD III states' experiences to outline opportunities and options for state policy makers to consider to strengthen medical home initiatives by explicitly addressing the needs of children.

With support from The Commonwealth Fund, the National Academy for State Health Policy (NASHP) launched ABCD III in 2009 to help participating states identify, implement, test and then spread ways to improve coordination between pediatric primary care providers (PCPs) and community-based providers of services needed to optimize child health and development, such as Early Intervention, mental health,

and Head Start agencies. With a specific focus on low-income (e.g., Medicaid-eligible) children, Arkansas, Illinois, Minnesota, Oklahoma, and Oregon have:

- changed policy to maximize the use of personnel to improve care coordination;
- implemented initiatives to improve data sharing and the use of technology among various providers or organizations, and monitor overall quality of care coordination; and
- supported cross-systems planning.¹

ABCD III STATES' STRATEGIES FOR SUPPORTING HEALTHY CHILD DEVELOPMENT THROUGH MEDICAL HOMES

The five states participating in ABCD III have pursued the following four strategies to support healthy child development through medical homes:

- Including pediatric-sensitive or pediatric-specific criteria in medical home qualification standards;
- Creating pediatric learning collaboratives for medical home providers;
- Educating non-medical providers about the patient-centered medical home and its value to ensuring healthy child development; and
- Using child health and development data to help medical home providers track progress and drive improvement.

THE ABCs OF MEDICAL HOMES

The American Academy of Pediatrics (AAP) pioneered the concept of a medical home nearly 50 years ago.² Today, the patient-centered medical home (PCMH) is defined as “an approach to providing comprehensive primary care for children, youth and adults...a health care setting that facilitates partnerships between individual patients, and their personal physicians, and

when appropriate, the patient’s family.”³ The nation’s four major primary care physician societies (The American Academy of Pediatrics (AAP), the American College of Physicians, the American Academy of Family Physicians and the American Osteopathic Association) have jointly endorsed the following seven principles of the patient-centered medical home: ⁴

- **Continuity:** every patient has an ongoing relationship with a personal physician;
- **Team-based care:** the personal physician leads a team of individuals who share responsibility for the patient’s care;
- **Whole-person orientation:** the physician-led team provides (or arranges for) care for all of the patient’s health needs throughout the patient’s life course;
- **Coordinated and/or integrated care:** the team organizes the patient’s care across all health care settings and the patient’s (non-medical) community to ensure indicated care is timely and culturally/linguistically appropriate;
- **Quality and safety:** the team uses evidence-based medicine, engages in continuous quality improvement, actively involves the patient and patient’s family in these activities to form a true partnership, and uses information technology wherever appropriate;
- **Enhanced access:** the team uses systems such as open scheduling and extended hours to ensure enhanced access to care; and
- **Payment:** the team operates within a payment structure that recognizes the added value to patients with (and additional investments required to provide) care as described above.

Medical homes are important in connecting children and their families to community-based supports and services that can support healthy development. A 2007 AAP policy statement emphasizes the role of the pediatric health care provider and the medical home in ensuring that at-risk children receive appropriate early intervention services.⁵ As of January 2012, 41 states are advancing medical home policies within their Medicaid programs.⁶ With Medicaid covering nearly 31 million children nationally,⁷ the spread of state Medicaid

medical home initiatives means states are working to improve delivery of care for low-income children. Some states are targeting specific populations, such as children with special health care needs (CSHCN).⁸ With guidance from organizations such as the National Initiative for Children’s Health Care Quality, and through collaboration among state maternal and child health (Title V) agencies,⁹ Children’s Health Insurance Programs (which, with Medicaid, cover one-third of all children), and family support organizations, states have established initiatives to ensure that CSHCN have medical homes.¹⁰

At the national level, recent legislation related to health reform and reauthorization of the Children’s Health Insurance Program have created a number of opportunities for states to implement medical homes for children. Table 1 summarizes a few examples of state implementation of medical homes to advance healthy child development.

Like many others across the country, states participating in ABCD III have policies and programs that support this enhanced primary care delivery model of “accessible, continuous, comprehensive, family-centered, coordinated, and compassionate” care.¹⁷ Anecdotal evidence from ABCD III indicates that the enthusiastic uptake of PCMH in many state Medicaid programs provides a great opportunity to improve care coordination for children. Furthermore, the collaboration improves the overall design and structure of the state’s PCMH program, since children are the majority population in Medicaid.

Currently, there are 24 states that offer enhanced payment to providers that qualify as medical homes and provide services to children (individuals under age 18).¹⁸ Although the payment is available for pediatric practitioners, state Medicaid PCMH programs in fact often seem to focus on adults. For example, states such as Pennsylvania¹⁹ have focused on asthma care

Table 1: Examples of Initiatives that Use Medical Homes to Advance Healthy Child Development

INITIATIVE	EXAMPLE
<p>Affordable Care Act Health Home State Plan Amendment Option</p>	<p>Under section 2703 of ACA (P.L. 111-148) states can implement “health homes” for Medicaid beneficiaries with chronic conditions and receive 90 percent federal matching for health home services (e.g., care coordination, family support) for the first two years. CMS has approved six health home SPAs, including two in Rhode Island.¹¹ Through Rhode Island’s first SPA, approved November 2011, CEDARR (Comprehensive Evaluation Diagnosis Assessment Referral and Re-Evaluation) Family Centers, which serve children and youth with special health care needs, are the eligible health home providers. The SPA adds to existing CEDARR Family Center services and processes by, for example, enhancing their information sharing with Medicaid managed care plans and requiring certain child screenings.¹² Electronic case management is provided using KIDSNET, a statewide, integrated child health information system.</p>
<p>CHIPRA Demonstration Grants</p>	<p>In 2010, the federal government awarded 10 demonstration grants as part of the Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). These grants support efforts in 18 states to improve child health quality, for example, by enhancing medical home initiatives, which several of the grantee states are pursuing.¹³ For example, as part of its CHIPRA grant with Alaska and West Virginia, Oregon is implementing and evaluating medical home and care coordination models.</p>
<p>State Pediatric Medical Home</p>	<p>Twenty-four state Medicaid programs offer enhanced payment to medical home providers for services to children.¹⁴ However, only a few states have pediatric-specific medical home criteria to qualify primary care sites as PCMH. One example is Colorado’s medical home initiative, which includes a pediatric medical home definition from 2007 state legislation (SB 130).¹⁵ The state’s initiative is grounded in partnership among Medicaid, Title V, and other child health agencies and stakeholders. Recognized medical home providers receive enhanced reimbursement rates from Medicaid and CHIP for developmental screening.¹⁶</p>

for pediatric populations, yet education and guidance to medical home providers tends to emphasize management of diseases found in adult populations. According to ABCD III state team members, children are not often explicitly included in state PCMH program or policy discussions. However, the ABCD III state teams have worked closely with their state medical home programs to address healthy child development. This brief outlines several ways to address the unique developmental needs of children within existing (and emerging) medical home initiatives.

SELECTED POLICIES AND PRACTICES FROM ABCD III STATES

This *State Health Policy Briefing* focuses on four types of policies and practices that ABCD III states have identified and/or undertaken to help ensure medical homes meet the developmental needs of children. As the following sections describe, these strategies are:

- Incorporate pediatric-sensitive or pediatric-specific criteria in standards that qualify primary care sites as medical homes;
- Create pediatric learning collaboratives for medical home providers;
- Help non-medical providers understand PCMH and its value to ensuring healthy child development; and
- Use child health and development data to help medical home providers track progress and drive improvement.

INCORPORATE PEDIATRIC CRITERIA IN STANDARDS THAT QUALIFY SITES AS MEDICAL HOMES

Every PCMH program articulates its expectations of the participating medical homes through the criteria or standards used to qualify those sites for the initiative.²⁰ As experience from Oklahoma, Oregon and Minnesota shows, the first strategy ABCD III states have identified and/or pursued to ensure medical homes meet the developmental needs of children is developing and incorporating medical home criteria that specifically reference children or services provided predominantly to children. These criteria are part of (or in addition to) the states' medical home criteria for the general Medicaid

population. Examples include optional or required services for medical home qualification, recertification, and medical home measures.

Required or optional services for qualification

States can require that primary care providers be qualified as a medical home in order to treat Medicaid-eligible and enrolled children, establish qualification standards for the medical home, and reimburse practices based on meeting these criteria.

Oklahoma's SoonerCare (Medicaid) Choice Medical Home program has three medical home tiers; each tier requires a minimum set of services (e.g., care coordination such as tracking tests and referrals) and some optional services that result in additional payment. As is the norm, higher tiers have more requirements and are eligible to receive higher payments.²¹ As a result of ABCD III, Oklahoma is pursuing changes to the current criteria to explicitly require developmental screening and follow-up for children in all three tiers. (Currently, medical home providers are required to conduct a health assessment of patients, for which a developmental screening *could* count). Oklahoma would like developmental screening and follow-up to apply to all three tiers, since most practices are in tier one. The addition will require review of language by an advisory taskforce, followed by contractual notification to practices (with 60 days before the change becomes effective). Screening and follow-up then will become part of medical home compliance reviews. The language will be crafted based on language for an existing requirement that resembles developmental screening; a specific age range for children may or may not be specified. Oklahoma plans to integrate these changes at the end of 2012, and the requirement for developmental screening and follow-up for children will be effective from that point forward.

Based in part on feedback from state ABCD III team members, **Oregon** modified its medical home ("patient-centered primary care home" or PCPCH) standards to reflect the developmental needs of children. A core attribute of PCPCHs is "comprehensive, whole person care:" and the PCPCH implementation guide includes provision of recommended preventive services according to Bright Futures periodicity guidelines as an optional element of this attribute.²² All PCPCHs must attest to

having a documented screening strategy for mental health, substance abuse, or developmental conditions along with local referral resources. One example provided of how practices can meet this is through evidence of “formal screening instruments for autism or other common developmental conditions in children” in patient charts.²³ Tier three PCPCHs also must track referrals and coordinate care with community-based settings. A PCPCH guidance document offers examples of settings where providers might coordinate care and referrals; examples include educational and foster care settings.²⁴ Another relevant PCPCH attribute is “person- and family-centered care.”²⁵ The reference to family recognizes that for children (as well as the elderly and other populations), the family unit is involved in and responsible for care decisions. In other words, for certain populations, the patient is the family. Oregon’s initiative reflects this by expecting PCPCHs to assess family satisfaction and document family education.

Similar to Oregon, **Minnesota** ABCD III team members have identified “coordination with school-based services” as a service that could be included as a required (or optional) service in medical home (known as “health care home” in Minnesota) criteria. As noted previously, coordination is a hallmark of the PCMH. Calling out coordination with school-based services, especially for states in which the Department of Education is the lead agency for Part C Early Intervention, is another way to help ensure care coordination occurs across medical practices and non-medical settings in which children receive a range of services, such as speech or physical therapy, or behavioral health care.

Required services for recertification

After Medicaid practices or providers have been qualified as medical homes, some states require them to go through a “recertification” process at a defined point to assess their continued functioning as a medical home. In **Minnesota**, the second year of health care home recertification requires community connection; practices must demonstrate they have an ongoing partnership with at least one community resource to which they refer patients.²⁶ One way the state has incorporated child developmental needs is by including schools as a community resource option for practices. The team is working with the regional public health nurses who

support clinics on recertification to make ongoing partnerships with schools and Early Intervention (EI) standard practice in pediatric medical home sites. Other key community partners that serve children and could be listed as options for community partnership include: Women, Infants and Children (WIC), child care, Head Start, home visiting, CSHCN programs, and/or state-specific child screening or early childhood family education programs.

Medical home measures to monitor progress

To ensure medical homes produce intended results (e.g., improved clinical outcomes, patient experience, cost containment), states develop measures for which medical homes must track, report, and/or achieve certain benchmarks of performance.²⁷ Both Minnesota and Oregon’s medical home initiatives include pediatric-specific measures for practices to track and report. Although Minnesota’s measure is not yet defined, Oregon’s PCPCH program includes pediatric measures in two ways, which are outlined below.

Higher-tiered medical homes (PCPCHs) in **Oregon** are responsible for tracking, reporting, and (if in tier three, the highest tier) meeting benchmarks for three measures. The measures come from two different lists, both of which include child measures.²⁸ One list of measures (the “core set”) includes a group of adult measures as well as a group of six pediatric measures from which practices can select. ABCD III team members in Oregon worked with PCPCH policy makers to secure developmental screening as one of the options in this list of measures. The other list of measures (“menu set”) from which practices must select includes pediatric measures such as follow-up care for children prescribed medication for attention-deficit/hyperactivity disorder.

As the number of PCMH initiatives grows, so does the number of evaluations. Recently, the Patient-Centered Medical Home Evaluators’ Collaborative released a limited, core set of standardized measures to assess the impact of the medical home on clinical quality, utilization and cost.²⁹ (Measures on patient experience and clinician/staff experience are reported elsewhere.) The technical quality measures include a core set of pediatric measures for researchers to consider in their future work. This core set does *not* include

developmental screening, which has proven to be an important measure for ABCD states' efforts to support healthy child development. Experience from ABCD III is that developmental screening is an important measure to consider including in medical home initiatives to ensure attention to this critical step in recommended care for children, as well as the enabling assessment of care coordination and "closing the loop" in referrals for children with identified developmental delays.

CREATE PEDIATRIC LEARNING COLLABORATIVES FOR MEDICAL HOME PROVIDERS

A common way that states support practices in meeting medical home criteria is through learning collaboratives.³⁰ ABCD III states seek to ensure medical homes meet the developmental needs of children by addressing pediatric topics in medical home provider education offered, for example through learning collaboratives. **Minnesota** requires its health care home providers to participate in statewide learning collaboratives to share best practices and facilitate practice-level change.³¹ This component came about as a result of the state's success with learning collaboratives in its pediatric medical home learning collaborative initiative (with a focus on children with special health care needs), which ran from 2004-2009.³² Through that initiative, participating practices' main method of transferring knowledge was through quarterly learning collaboratives facilitated by quality improvement experts from the Institute for Healthcare Improvement (IHI).

Based on lessons such as the value of in-person learning and of creating community from those learning collaboratives, ABCD III team members (some of whom participated in the pediatric medical home learning collaborative) pursued a similar model of knowledge transfer in ABCD III for providers serving children with or at risk of developmental delay. The ABCD III learning collaboratives support participating practices that are pursuing (or have received) health care home certification. There is not currently a statewide pediatric learning collaborative. However, Minnesota is in the midst of reorganizing its statewide health care home learning collaboratives, and in the process, it plans to develop a pediatric learning collaborative curriculum that incorporates a toolkit with lessons, sample forms and referral protocols compiled through ABCD III.³³

HELP NON-MEDICAL PROVIDERS UNDERSTAND PCMH AND ITS VALUE TO ENSURING HEALTHY CHILD DEVELOPMENT

Since childcare and Head Start providers regularly interact with children and families, another strategy ABCD III states are using is engaging childcare providers in medical homes. **Arkansas** is one of 47 states with an Early Childhood Comprehensive Systems (ECCS) grant from the Health Resources and Services Administration's Maternal and Child Health Bureau. These grants support state and community efforts to develop and integrate early childhood service systems to meet the needs of children and families.³⁴ One of the core components and goals of this grant program is to increase access to medical homes for all children. As a result, Arkansas has an ECCS workgroup focused on medical homes. That workgroup has developed educational materials tailored for childcare providers. Informational materials explain the medical home concept and provide Medicaid resources (e.g., contact information) to not only familiarize childcare providers with medical homes, but also enlist their support in connecting children to needed primary care. Tools such as these will be helpful as Arkansas implements medical homes.

SHARE CHILD HEALTH AND DEVELOPMENT DATA WITH MEDICAL HOME PROVIDERS

Routine reporting and feedback of quality data to providers is critical to providing high-quality pediatric care. State Medicaid agencies feed back a variety of information to medical homes to support improvement and ongoing performance assessment. Both Illinois and Oregon are improving data sharing between Medicaid and Early Intervention to facilitate care coordination and inform medical home quality improvement and assurance efforts.

Illinois' primary care case management medical home program, Illinois Health Connect (IHC), serves certain populations covered by Medicaid and other state coverage programs. IHC provides a number of tools to support quality improvement and assurance among participating practices. For example, IHC providers receive a patient panel roster with demographic and clinical information about all patients they serve as the medical home.³⁹ The panel rosters make clear which patients (and what percent of patients overall)

ABCD III IN OREGON: IMPLICATIONS FOR ACCOUNTABLE CARE ORGANIZATIONS

Oregon ABCD III team members are informing not only the state’s medical homes initiative, but also the development of Accountable Care Organizations in the state (known as “coordinated care organizations” or CCOs). CCOs—which must include patient centered primary care homes—are entities meeting state-defined criteria that are accountable for care management and for providing integrated and coordinated health care for their members.³⁵ Through an emphasis on community engagement and inclusion of pediatric measures, CCOs—like the state’s PCPCHs—are ensuring healthy child development.

For ABCD III, Oregon Medicaid contracted with the Oregon Pediatric Improvement Partnership (OPIP) to conduct a Medicaid performance improvement project (PIP) with participating managed care organizations. The PIP is producing an improvement model that integrates care coordination with standardized screening and referrals at the clinical level with supporting metrics. The PIP was shaped and continues to be guided by feedback gathered through a multi-pronged community engagement process that included town-hall style meetings and structured Community Café conversations—all with an array of stakeholders ranging from pediatric primary health care providers, Early Intervention, and community-based service providers, to health plans and parents and families of children with or at risk of developmental delay.³⁶ Through this process, the project team gathered a wealth of information, including identification of strengths, barriers and suggestions for improving care coordination and service linkages for children. Oregon incorporated aspects of this process into expectations for CCOs, which must engage community members and providers from a range of areas and settings (e.g., public health, mental health) to develop a “shared community health assessment process” that results in a community health improvement plan.³⁷ Additionally, based in part on ABCD III team member feedback, one of the proposed first-year measures to be reported at the CCO level is developmental screening. Finally, team members are interested in outcome-based measures for CCOs, such as kindergarten readiness. Kindergarten readiness is currently a key goal of the state’s Early Learning Council;³⁸ CCOs may be another mechanism to help meet this goal.

are due for preventive services such as developmental screenings or well-child visits. Electronic panel rosters are updated every day; IHC providers can access them through an online provider portal via a Medicaid claims-based data exchange system known as Medical Electronic Data Exchange (MEDI).⁴⁰ As part of ABCD III, Illinois is harnessing a number of separate electronic data systems with child data (e.g. MEDI and the EI point-of-entry system) to enable information sharing for care coordination and referral follow up.⁴¹ Once this information sharing system is complete and electronic data exchange is live between the separate child-serving agencies, Illinois will use them to enrich the IHC panel rosters by including EI service claims data; providers will be able to see if a child is eligible for EI, received an EI assessment or currently receives EI services. Having this information available will enable medical homes to better coordinate care and attend to children with risk factors.

Oregon has a data-sharing agreement between the

state Medicaid and Part C Early Intervention agencies that allows Medicaid to use individual and aggregate EI data for evaluation/quality improvement purposes. As a result of ABCD III, EI began providing Medicaid with monthly aggregated data reports to help the team assess referrals and care coordination between primary care and early intervention providers. New referral data source fields have been added to the EI data system to facilitate this project and enrich the information Medicaid receives. Under managed care plan service agreements and with parental consent, Medicaid is able to share with participating MCOs the EI and claims data of children receiving Early Intervention services. Doing so enables the plans responsible for each child’s care to identify additional services the child may be eligible to receive through the managed care contract; it also enables Medicaid to assess plan progress in ensuring medical homes for all children (which they are required to do), since medical home providers should be aware

of patients' developmental needs and following up to ensure care coordination. The data will make clear if there are children receiving EI services who are not affiliated with a medical home (e.g., have not had a well-child visit).

LESSONS

ABCD III states' experiences integrating a focus on healthy child development into medical homes highlight the following lessons and considerations for other states:

- **Ensure that medical home initiatives and program guidance account for children's unique developmental needs.** Anecdotal experience from ABCD III is that care planning and care coordination processes look different for children than for adults. Care planning for children requires individualization and family/parent input, and therefore more time. By the same token, a single condition, diagnosis or chronic illness in a child requires substantial coordination and carries potentially life-long consequences for development and learning if not addressed in a timely manner. States can acknowledge and address these factors by giving medical home providers guidance, clear examples, and expectations for meeting the developmental needs of children served.
- **Include pediatric providers and/or experts in advisory groups or policy discussions about medical home standards and measures.** Having pediatric voices at the table shapes conversation and policy recommendations. Oregon, for example, convened both a standards advisory committee and a pediatric standards advisory committee, which influenced final PCPCH standards and measures. Including or meeting with representatives from statewide early childhood initiatives or committees is a way to promote alignment with medical homes.
- **Reference school-based services.** Schools and Early Intervention programs are unique and often critical partners in children's care; consistently listing them as examples of

important partners in medical home guidance (e.g., practice self-assessment tools) is one way to incorporate children's needs.

- **Hold family practitioners that serve primarily children accountable to pediatric standards.** If pediatric medical home standards or measures are strictly optional, particularly for family practitioners, it is possible for family practice sites to qualify by demonstrating they are providing supports/services that best meet the needs of adults, even if they primarily serve children.
- **Emphasize family-centeredness and community partnership and leverage these aspects of medical homes.** Medical homes that take into account the family unit in care decisions and quality improvement processes and that partner with community-based providers are particularly beneficial to the vulnerable and at-risk, like children, who depend on caregivers to participate in and help manage their care planning, and who regularly interact with and access non-medical and community-based service providers. States often use National Committee for Quality Assurance (NCQA) standards for state medical home standards;⁴² Oregon ABCD III team members have found the 2011 NCQA standards (updated from 2008) incorporate a community focus that aligns well with meeting the developmental needs of children.⁴³

CONCLUSION

Through ABCD III, five states have pursued and implemented strategies to improve care coordination and service linkages for children with or at risk of developmental delay to ultimately advance healthy child development as part of medical home initiatives. Their experiences provide lessons on how to explicitly address the developmental needs of children in medical homes and highlight important considerations for state policy makers to do so. A focus on patient- and family-centered care and an emphasis on collaboration between primary

care practices and community-based providers establish a strong foundation for advancing healthy child development in medical homes. More specifically, ABCD III experience is that by including pediatric criteria and pediatric provider education, developing medical homes tools for non-clinical, community-

based providers of child and family services, and using child health and development data, states can help advance healthy child development through medical homes.

ENDNOTES

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