

MCHB/ AIM Webcast
Medical Homes for Children

April 21, 2009

AUDREY YOWELL: Good afternoon, everyone. I'm Audrey Yowell, the program director for the alliance for information on Maternal and Child Health known as AIM at the U.S. Department of Health and Human Services health resources and services administrations and Maternal Child Health Bureau. Before we get started I'll review the ways you can use your computer interface during this webcast.

Slides will appear in the central window on your screen and will advance automatically. The slide changes are synchronized with the speaker's presentations so you don't need to do anything to advance them, although you may need to adjust the timing of the slide changes to match the audio. You can do this by using the slide delay control at the top of the messaging window. We encourage you to pose questions for the speakers at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the drop down menu and hit send. If your question is intended for a particular speaker please include that information in your message as well as your state or organization so we'll know from where you're participating. If time allows, the speakers will address your questions near the end of the webcast. But if there isn't sufficient time an email response will be sent to you after the webcast. Again, we encourage you to submit questions at any time during the broadcast. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast, the interface will

close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple minutes to do so, since your responses will help us plan future broadcasts and improve our technical support. Our webcast today will focus on a collaborative effort among several grantees funded by HRSA's Maternal and Child Health Bureau addressing medical homes for children as part of their work to improve the health of women, children and families.

Next slide, please. These two organizations participate in the AIM program, which is a collaborative of Maternal and Child Health Bureau grantees.

Next slide. AIM grantees are all national membership organizations representing those professionals responsible for making decisions affecting the health of women, children and families. Together they include organizations of state and local government officials, Maternal and Child Health professionals, foundations, legal professionals, the health insurance industry and large businesses, as well as family advocates. AIM grantees work with the bureau on two levels. First each is funded individually to educate its constituents and promote dialogue among them about Maternal and Child Health issues and each individual grantee participates in the AIM collaborative.

Next slide. The purpose of the individual grants is to promote two-way communication. First by making new research findings and policy information accessible to professionals to help them make clearly informed decisions affecting public health policies and programs for women, children and families. And secondly, by creating a channel for these professionals in the field, to alert the bureau to emerging concerns and issues that they're facing.

Next slide. On the second level of the AIM program each grantee organization participates in the collaborative. The AIM collaborative was formed when all these individual grantees began meeting together initially to share information and ideas but later also to partner in improving Maternal and Child Health. The partners meet twice annually but also work together on specific issues in smaller groups between meetings.

Next slide. The 16 grant funded AIM partners are listed on the slide you see on your screen. The Maternal and Child Health Bureau is the 17th and equal partner in this collaborative. From the list you can see the diversity among the types of organizations participating in the AIM collaborative.

Next slide. So beyond the value of the individual grants there is an added value from convening their representatives together as this provides opportunities for these organizations with very different perspectives to share expertise and concerns and also to educate one another as well as the bureau about emerging issues and promising Maternal and Child Health practices.

Next slide. More information about AIM or any of our webcasts, all of which will be archived at [The Community mchcom.com](http://TheCommunity.mchcom.com) feel free to contact me. The contact information is on the slide on your screen. You can email me or phone me at 301-443-4292.

Next slide. The medical home has long been demonstrated as a model for managing the healthcare of children with special healthcare needs. It is the discussion of the medical home has moved to the national landscape much of the focus has been on the value of the medical home for adults of chronic conditions. As the medical home concept continues

to be piloted and implemented across various settings it is important not to lose sight how children benefit. I'm pleased to announce Kathryn Santoro who will begin today's discussion to support the implementation of medical home across multiple stakeholder groups. Kathryn.

>> Thank you, Audrey. I'm the program manager for the national healthcare foundation one of the AIM grantees and I chair the AIM medical home interest group which planned this webcast today.

Next slide, please. This slide lists the interest group members who helped participate and plan this webcast today.

Next slide, please. The purpose of our interest group is to share organizational and constituent efforts in support of a medical home for all children. We also aim to understand the various stakeholder perspectives related to the medical home and we also are focus is on disseminating information on the medical home to the AIM collaborative, the broader Maternal and Child Health community as well as our respective constituent groups.

Next slide, please. The goals for today's webcast are to highlight the importance of how children uniquely benefit from the medical home, to share current efforts and support of the implementation of the medical home across multiple stakeholders groups and to spur future collaborative efforts in support of the medical home. At this time I'm pleased to introduce Dr. Santy with the American Academy of Pediatrics.

FAN TAIT: Thanks so much, Kathryn. I'm Fan Tait from the American Academy of Pediatrics and one of the associate executive directors here and over the community of specialty pediatrics.

Next slide, please. I have no disclosures other than to say how passionate I am about medical home. It is my privilege and pleasure to be on this call with you all and the other panelists and my opportunity to set the stage speaking to some of the national medical home activities, not just of the AAP, the American Academy of Pediatrics but of our other partners.

Next slide. We should be on slide 15 now. It was actually in -- it's hard to believe, but 1967 when the word medical home started being used. Over 40 years ago. And back years ago when it started with a doctor out of Hawaii. Dr. McPhearson from MCHB. Family voices and AAP, when we were talking about it years ago, it really was speaking to the need for children and youth with special healthcare needs. And it is critically important when we're talking about children and youth with special healthcare needs. You'll hear a little bit more today from Eva who will address some of the issues that are important for children who are in foster care in medical home.

Next slide, please. So when we're thinking in terms of the medical home definition, what I've done in some of these slides, because I think most of the people on the phone really have an understanding already of what a medical home means, I've highlighted some of the issues that have changed over the last few years. One of the things that I want to highlight in addition to the care that we all know and believe in, which is accessible and family centered, coordinated, compassionate, continuous and culturally effective, it is also when we're talking about medical homes we're really talking about community based and

it is an interdisciplinary team based approach to care. And as opposed to what we were talking about years ago, when we're talking in terms of medical homes now, we're talking about preventive care, acute care and chronic care. It is truly the kind of care that we all want for ourselves and our children and our families. And from my perspective and from the academy's perspective medical home is all about quality improvement. How do you make care better?

Next slide, please. So the other piece of the medical home definition is that a true medical home works within an integrated healthcare system. It is about patients and families and primary care physician. It is also about specialists and sub specialists when we think in terms of medical homes we're looking at co-management. It is about hospitals and healthcare. It is about public health and it is all about community-based care.

Next slide, please. One of the things that we'll be talking more about today is just what is happening with respect to healthcare reform. There are many forces that are active in primary care and healthcare reform and the medical home. So this is just one way the think about that. I did highlight to the left on your slide the cultural, social, environmental and demographic forces, particularly speaking to -- and reminding us all of the many changes that are going on from not just an economic but from environmental changes.

Next slide, please. And this is slide 19. So when we're thinking in terms -- we've been talking about a pediatric perspective about medical care for many years. It was in 2007 and with the help of some of you on the phone and particularly Dr. Rich Atonally who you'll be hearing more from. With the American Academy of Pediatrics, the internists or college of physicians and the Osteopathic Association. From a pediatric perspective we have a preamble to those principles. We wanted the highlight the critical piece of family

centeredness in a medical home and what I mentioned a few minutes ago, the community-based system of care. Another piece that's important for transition to pediatrics is the whole issue of transitioning from pediatric care to adult care. And then just speaking in terms of the value, the quality piece of a medical home.

Next slide, please. So we're now on slide 21. This just lists -- it doesn't describe it all but certainly on all of our websites we have a description of the medical home joint principles. When you take a chance -- when you have a chance, take a look at that. One of the things that we'll be hearing more again from rich will be what care coordination means and how that is critically important in any medical home.

Next slide, please. It was when we started working particularly with the adult providers that people started, I think, in a more global sense started talking more about medical home and we're very grateful for that collaboration again from you all but also from the other associations.

Not only are we talking medical home in journals like the "New England Journal of Medicine", next slide, but we're also talking about medical home from a health affairs perspective.

Next slide, please. Some of you, hopefully many of you, are part of a new collaborative, relatively new called the patient centered primary care collaborative. This is really a coalition of major employers, of consumer groups, primary care physicians, of health plans, of advocates, of partners with the mission to actually advance the patient-centered medical home.

Next slide. This is number 25. The PCPCC membership has grown to more than 400 members in the last two years. And I just listed a few of the examples. You'll hear more from Amy from the National Business Group on Health. There are many other members, obviously.

Next slide. Number 26. The PCPCC collaborative has centers and committees and there are four or five conference calls per week, sometimes more, from all of these centers and anyone can be on those conference calls. There is the Center for multi-stakeholder, for public payer, for health benefit redesign. Again you'll hear a little more later when we're thinking in terms of HIT, Health Information Technology and E-health information. One of the ones I highlighted on this slide I'm plead there is a committee now for consumer education, we say family education. And there are many legislative committees also.

Next slide, number 27, please. So when we're thinking about medical home and one of the things that we've talked about in the past is if we have a definition, how do you measure medical homes? And there are many ways to measure how much medical home you are in different practices. One way is through the NCQA, patient-centered medical home recognition. It is the national commit on quality assurance. And a lot of the payers are actually looking to NCQA as the measurement tool that's used in payment and reimbursement. We'll hear a little more again about care management and what that means from Rich but stay tuned because we're working from a pediatric perspective we're working with them but also looking at other ways to measure medical homeness.

Next slide, slide 28. So there are many national and Federal medical home activities. Hopefully many of you are on the phone. MCHB has facilitated meetings with HHS Federal organizations. We work with the national academy for state health policy looking

at Medicaid and SCHIP, the council on state governments. This is just a few examples. If we're looking at what is happening nationally, one of the things that we're really interested in and we feel it's critical is that we don't lose sight of what is happening from a pediatric perspective. We had one of the leaders from IBM come and meet with our board and one of the things that we said is that a lot of the patient-centered medical home pilots now, the multi-payer pilot activities are adult pilots. There are pediatric pilots and we're working daily with many of you to help increase the number of pediatric pilots. But one of the things that a person from IBM said. If you're not looking at the pediatric piece of medical home and the prevention piece of it it's like building a skyscraper and leaving out the first ten stories. So we're anxious to move this forward.

Next slide, number 30. So not only are we looking at these pilots from multi-payer pilots but certainly we're very anxious to be involved from a Medicaid and SCHIP perspective. And you can see what's happening nationally on that. Some of the states that are not highlighted here actually have some medical home initiatives. When they were evaluating different states they had a set of criteria they used. If your state is not highlighted it doesn't mean that there aren't activities that are actually going on. This was specifically working with the Medicaid and SCHIP providers and leaders in the states.

Next slide. I'll be wrapping up in just a minute. If we think in terms of -- so we have the multi-payers, we have Medicaid and then we have legislation.

So on slide 31, what we're talking about is just that in many of the states we're actually introducing legislation. Now, that's wonderful but it also gets to be somewhat interesting when you're thinking in terms of what is the true definition of medical home, how are these pilots and activities measured and how do we go from there?

Next slide, this is slide 32. So just briefly I would like to summarize some of the medical home initiatives that are going on not just with AAP but with many of our partners. So we are fortunate here at the academy to the recipient of medical home implementation and that center helps fund some of the activities that we're working on now. A pediatric medical home toolkit, we're actually looking at maintenance certification, MOC. And quality improvement medical home model. There are family-centered care tools that we'll talk a little bit about.

Next slide. Health Information Technology critically important not only within practices but also when we're thinking about the whole system of care and interconnectivity. Implementation in the states and some public policy guidance.

Slide 34, please. So The National Center for medical home implementation as I mentioned is a cooperative agreement funded by MCHB. It is a significant collaboration with public health, particularly Title V. Children with special healthcare needs.

Next slide. Within the next couple months the academy will put out a toolkit that practices and partners could use. This toolkit will be online and accessible and will really speak to this is like medical home 101. It is how do you basically begin the medical homework in your practices and how does that speak to quality improvement? When we're looking at that piece of it we're crosswalking with NCQA so there actually can be some measurement of how you're moving forward in the practice.

Next slide. As I mentioned earlier, transition is the critical piece of pediatrics but it is critically important for youth the special healthcare needs recurrently have a task force

and you can see the members of the task force working on support for medical home from that perspective.

Next slide, 32. Many of you are familiar with the leadership, education and neurodevelopmental disabilities. I mentioned earlier that medical home is a team approach. And that team is an interdisciplinary team. Some of the disciplines from the -- are on the slide. What we're doing for the LIN program. Is looking at different competencies for disciplines with respect to medical home.

Next slide. The equip model. We hope that will help our members to move forward both from a see and need perspective but maintenance and certification.

Next slide. Family voices, as I mentioned, has been with us from the beginning on medical home and they've actually developed family-centered care tools that speak to measurement of family centeredness and these tools are up on their website and ours.

Next slide. The head of our section and steering committee on quality improvement is this man. This is -- he started looking in his own practice as to how he thought in terms of medical homes and I put this in because with his permission to speak to the things that we've talked about, the clinical information system, the patient and family being at the center and the source of control with the community and health system and the practice team. Next slide. What we're hearing from our states -- from our state chapters and from many others are can you give us some help and guidance from a public policy perspective? And so soon within the next six weeks or so we hope to have out some guidance for anyone who is actually working on medical home activities to say here is how

you might consider the definition and care coordination and quality and payment and infrastructure and all the things that are listed here.

Next slide is 42 and there is just one more slide here. So are we done? Are we there with respect to medical home? Obviously the answer is not quite yet. But it's an exciting time. It's a wonderful time. I think we're really moving forward from a medical home perspective. Some of the ongoing issues are on this slide and the next one. Just the definition of medical home and what that means. Again, I don't like consumer so much but family and patient knowledge and involvement within the medical home. One of the things we're concerned about is how do you evaluate the pilots. If there are all these pilots going on, how should we really make sure there is some consistency of the pilots so we can get the right information? Health Information Technology still a challenge. We think in terms from a pediatric perspective from practices should be recognized for what they do. Others speak to certification. We think in terms of if you are in primary care, you are a medical home, how do you get better at what you're doing? That speaks to training and education and the last slide speaks to the issues of measurements and performance standards. How do we really work with sub specialists? What about healthcare reform and how do we continue to work with all of you on these issues as well as employer and purchaser attitudes? So I will stop now. Later we'll have some time, hopefully, for questions and I would like to turn the microphone over to my friend and colleague and mentor, Dr. rich ANTONELLI. I want to acknowledge everything I've learned from families through this process and I want to make a point even on my title slide. You'll notice the joint principle statement came out as the patient-centered medical home. In the parent/child health arena we thought it was a family-centered model. I want to call your attention to that. In addition to being an MCHB grantee and developing a network of primary care pediatric medical homes in central Massachusetts, I'm also the medical director of integrated care

at Children's Hospital, Boston now and also am the project advisory committee at the National Center for medical home initiatives at the AAP.

The next slide, please. These are the objectives for today's talk. Understand the role of the family-centered medical home and a transformed healthcare system. Understand the critical importance of care coordination in supporting high-quality family centered care and to learn about a multidisciplinary framework and definition of pediatric care coordination. Want to knowledge the many people that have had input into the evolution of my thinking from my days as a full-time community-based primary care pediatrician to somebody that informs policy.

Next slide, please. So what are some of the challenges to implementing family-centered medical home? From the trenches we hear this from primary care providers, their staff and even from families, this constraint of time. Also a lack of organized systems of care with well-defined rules. Who is going to do what at what point in the workflow? Inadequately developed family/patient/professional partnerships. Gaps in knowledge about care pathways. Gaps in knowledge about how to change and transform and to continuously measure and improve systems of care. Lack of care coordination functionality in the system. Lack of awareness of community resources and programs and I'm putting the term reimbursement in quotes. Everybody keeps citing reimbursement as than issue. It's clear the issue is much broader than that. It includes a significant financing perspective as well.

Next slide. So I don't want to spend much time on the slides. Fan has alluded to it but it's based on Ed Wagner's chronic care model and the Center for medical home improvement in a national medical home learning collaborative. What is important to note on this slide is

that the health system sits within a broader array of community resources and policies. The medical home can be very effective if it just focuses on care partnership support delivery system design, decision support and clinical information systems but that recognition especially in the pediatric world that kids don't spend the majority of their time living at the doctor's office but that in fact children and families rely on the -- it's part of what the medical home is. What is critical is that it's an empowerment model, not a dependency model. So our final common pathway is to develop and inform, activate and child and family and a prepared proactive practice team. It is moving away from that reactive crisis of healthcare transaction and driving toward families being able to self-manage with the appropriate resources and supports.

Next slide, please. Within the next week or two the common law fund will be publishing work that it did in conjunction with Gene Mc-- it became clear to me several years ago that states were making significant financial commitments in terms of paying for care coordination services. And there were some definitions that were specific to the provider community, to the case management community, to the nursing community but there really hadn't been an effort to bring all of these stakeholders together to try to define what care coordination is. This slide really speaks to that. We convened a group of national key informants and expert panelists, the majority of whom were physicians, also included the nursing community, social work community, both pediatric and general social work. Public and private payers and purchasers and we came up with a model that I hope you see is not physician centric. Though it deals with medical issues, is also an attempt not to medicalize children's health. It is a component but doesn't necessarily and shouldn't be focusing exclusively on medical issues and disease. Pediatric care coordination this group is proposing is a patient and family centered team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care

coordination addresses interrelated medical/social, developmental, educational and financial needs in order to achieve optimal health and wellness outcomes. Particularly want to acknowledge Ed Shore our project officer at the Commonwealth fund for his support and vision in this.

Next slide, please. What are some of the fundamental components of a multidisciplinary framework? Family centered, community based. It should be proactive, moving away from the reactive crisis oriented model. Promoting the development of self-management skills based on care partnership support with children, youth and families and facilitating cross organizational linkages and relationships from the medical realm to education to family support, etc., etc.

Next slide. These are some of the core functions of pediatric care coordination. Providing separate visits and care coordination interactions. Managing continuous communications. They can be done asin con isly as in an email platform but the communications need to extend between the face-to-face visits which are the much more typical approach to pediatric or for that matter any healthcare. Completes and analyzes assessments. A standard assessment of needs that is specific to a community. Developing care plans in conjunction with families. Managing and tracking tests, referrals and outcomes of those referrals. Coaching patients and families to help them to become as self-sufficient as possible but having them be empowered and knowing how to navigate systems of care. Coaches, providing coaching support. Integrating critical care information as it arises during and between visits. Supporting care transitions. The handoff that occurs from an in patient setting to an out patient setting. From a primary care setting to a specialty setting. Facilitating team meetings. They should become the norm rather than the anomaly and utilizing Health Information Technology which is a necessary but not sufficient component

of care coordination.next So slide. What constitutes care coordination in a pediatric medical home?

Next slide. MCHB supported us to look at half a dozen practices across the country. We looked at -- we stratified these practices both on the basis of what their payer mix was and also the model of care coordination from practice to practice. Some practices actually had an identified and funded care coordinator in a very specific role. Other practices the work of care coordination was done by whoever was available, what we call an ad hoc model. Some interesting themes arose from this analysis. We asked these practices to record non-reimbursable care coordination activities in relatively realtime. We found that about 2/3 of the time these care coordination encounters were driven by needs that were typically medical or clinical, if you will. Next significant was the referral management. Getting a child from one setting to another. Social services, educational and school, developmental, behavioral, mental health, growth and nutrition and legal and judicial issues. These were non-reimbursable encounters. What's significant is that it is the majority that were medical driven but certainly a significant number of the remainder were non-medical and in some -- one could argue these would be activities that would go unsupported in a strictly medical approach to pediatric medical home. Next slide, please. What is the efficacy of care coordination? We use our care coordination measurement tool and asked because of this non-reimbursable encounter what was the result of your intervention. And we looked at over 3800 care coordination encounters and found that fully one-third of them prevented something. Come down into the middle of that slide and you'll see that 58% of the time because of telephone-based management like guiding a family through a care plan for asthma, for example, the 58% of the time an office visit was not necessary. This was non-reimbursable service provision. Emergency department visits could be avoided because of telephone-based non-reimbursable care coordination

encounters. A third physician care coordination encounters -- the way the healthcare system is currently configured that office space, nurses don't generate revenue. They don't fit into any current available fundable paradigms of care. So consequently we are stuck with a rather perverse business model which is to say if you want to generate revenue, you've got to do something that drives revenue like bringing families in for something that could be accomplished in a non-face-to-face encounter. So the notion and Dr. Tait referred to this and we'll be bringing that up next week at the PCPCC meeting is what can we do to develop teams of care to enhance access and improve outcomes? And this study to my knowledge was one of the first that showed the very highly efficacious outcomes of office-based RN activities for pediatric care coordination.

Next slide, please. I was also asked by the planning group here to talk a little bit about what is going on in other states with respect to medical home and in the State of Connecticut legislation was passed creating a child health improvement partnership modeled after the Vermont CHIP program. I've given you a link if you want to learn a little bit about V-CHIP and it is what led to the Connecticut CHIP. It provided a potential system for accountability.

Next slide. From the title five perspective the Department of Public Health is the Title V agency create and convene a medical home advisory council that includes families, youth, clinical providers, the business community, public and commercial payers, education and policy leaders. The council was supported by these work groups that focus on family experience, financing and quality and family representatives on the council are supported by reimbursement for their time and input as well.

Next slide. What is striking is a little bit about the outcomes in terms of these -- I would call these process outcomes early on. The growth in the number of children and families served has could on sided from moving from an institutional-based approach to a regional approach and this broad community-based approach. Unts the institutional model where there were two ternary care pediatric center about 800 children were served per year. Then the state went to a regional model where five different centers were providing care coordination services and about 2,800 were served. The next iteration of this model was one in which care coordination was delivered across multiple primary care settings throughout the state and the number jumped to 5,900 and then the current fiscal year the State of Connecticut expects that about 7,000 children will be receiving care coordination services across the community.

And next slide, please. What can you do with a medical home infrastructure? Interestingly you can add additional elements to enhance integration by being responsive to public health needs.

Next slide. What does that mean exactly? Well, as I alluded to at the beginning, I am the principal investigator on an MCHB project now in central Massachusetts to develop a medical home network of primary practices. We're at the end of our funding. There was significant interest, what is the access like for families of children with mental health needs? And because we already had an existing infrastructure we were able to ask a question that was arguably somewhat outside of the medical silo. So we asked families about their access to services that are currently being offered. What is the need beyond those services. They already -- given to their children for integrated mental and behavioral health and feelings about communication between the child's medical and mental health provider.

Next slide. We ran five focus groups and had these preliminary findings and we're doing additional deployment of this at this time. Families play a crucial role in the communication of the care plan whether they want to or not, if one exists. The system needs to move beyond blaming the parent. All families benefited from or wish they had parent to parent support. Parents who had walked the path with their own child. Information is extremely difficult for families to find, locate and use because of an existing medical home infrastructure in central Massachusetts we were able to get this project done very quickly and start to address these transdisciplinary issues. Measuring and reporting Massachusetts health quality partners is a multidisciplinary group that looks at quality of care and the experience of care in the primary care setting or helping consumers take an active role in making informed decisions about their own healthcare. This group includes families, the provider community and the purchaser/payer community as well. This is all publicly reported so that families can be highly informed and make appropriate choices.

Next slide, we need to re-examine the traditional office space interaction. Much of care coordination happens outside the exam room. The patient centered and family centered medical home must include care coordination. The service union must value non-face-to-face care supporting care coordination, use care plans to drive and to monitor care provision quality and outcomes. All family centered medical home team members function at the top of their license, that includes family and community partners, medical assistants, nurses, nurse practitioners, physician assistants and physicians. It provides what an element of a care plan can be, the nature of the problem. What the activity is that will be used to address it, who is going to do it so there is a clear delineation of accountability. What is the time frame, expected follow up? My proposal and dream is that every healthcare transaction will have a care plan documenting it almost as a receipt as the

transaction on a business environment. I've given you some websites here, given you some references and I'm going to hand over the microphone to my colleague, Amy Reagin from the National Business Group On Health. Thank you everybody.

AMY REAGIN: Thank you. I'm Amy Reagin. The program analyst at the National Business Group On Health. It's a membership organization of large public and private employers representing 300 member companies that provide coverage for at least 55 million Americans. And we represent 64 of the fortune 100 companies. It's primarily large employers. We consider ourselves the voice of large employers in healthcare. Today I'll talk to you about three primary topics. The first is the National Business Group on Health stance on primary care and things based on primary care. I'll talk about the importance of the patient centered medical home especially for children. And finally I'm going to list some potential steps public and private employers may want to take when they're considering implementing the medical home model.

Next slide, please. What we're really dealing with here is a weak primary care system in the United States. When compared with other developed countries, the U.S. ranks fairly low in its primary care functions and low in health outcomes but still high in healthcare spending. Our healthcare system is really based more on specialty care which is a problem. Studies have shown that care for common illnesses such as community acquired pneumonia are higher when provided by specialists than primary care practitioners with no different outcomes. We're paying more for specialist care for these common illnesses when we could be getting the same kind of care in medical home more comprehensive care as a lower cost. The current medical delivery system also provides no incentives for physicians to coordinate test procedures or patient healthcare generally and it puts very

little emphasis on preventive services and health maintenance. Our payment methods
wore worsen the problem. We don't place as much value on prevention and early
management of health problems, care coordination or efficient use of technology. Finally
our primary care physicians supply is fairly weak and declining. The center is studying
health system change says only 37% of doctors specialize in primary care. A much lower
percentage than other industry allied nations. The special business group on health
believes primary care is for an efficient healthcare system. We've developed certain
primary care capabilities that we believe employers should look for when purchasing and
evaluating their health benefits. You may notice some of these are very similar who what
we were talking about with the medical home. First contact and access. Primary care
should be the initial point of care for medical needs and patients should have access to
primary care on days, nights and weekends and they should be able to get timely
appointment with their primary care practitioner or team. It should be comprehensive,
address preventive, acute and chronic needs. And be able to meet the clinical needs of
the patient. There should be a sustained relationship between patients and their providers
for their primary care team and the team should be able to facilitate referral and services
to other providers such as specialists and when patients are referred to specialists the
primary care team should be involved in their care still. We believe in the importance of
Health Information Technology and clinical tools such as electronic medical records, E-
prescribing, E-visits. Online schedule and consultations. We believe primary care should
be patient centered, patient education is very important. There should be supports for
patients to manage their own chronic illnesses when they can to make decisions about
their care. Providers should respect the beliefs, preferences, psychological and physical
needs of the patient and should engage family and community resources when possible. It
should be transparent. There should be disclosure of price and of performance.

Next slide, please. We should be on slide number 70 now. We have committees of employers who are working on some of these issues. The first is the primary care workgroup. The primary care workgroup proposed a multi-year path to payment reform that is being discussed with major health plans. Secondly we have the national committee on employer and health plan solutions and they are working on physician payment reform and implementation of patient safety policies. We have the national committee on evidence-based benefit design. They're working on an employer action agenda for improving healthcare efficiency and erasing waste and including a focus on prevention and primary care in our national health reform principles. Each one of these activities the National Business Group On Health is raising an awareness of the importance of primary care in the medical home. Why is the medical home so important when we're talking about primary care? If our goal is patient centered comprehensive care provided over time, the coordinated across service settings this facilitated by Health Information Technology and informational and clinical tools the patient centered medical home embodies these characteristics. Hallmarks of the medical home model include an ongoing relationship with a physician, disease management, coordination of care and focus on prevention and risk factors. This is really important because research shows that patients with an ongoing physician relationship have better health outcomes and lower cost. And when managed effectively by primary care physicians patients with chronic diseases have fewer complications and avoidable hospitalizations. In fact, the Commonwealth fund reports that it's organized its entire Health Care Center around patient centered medical homes achieving the highest patient satisfaction in the world in Denmark. They're supported by health information system that assists them in coordinating care. Among western nations Denmark has some of the lowest per capita health expenditures and highest primary care rankings. The U.S. the results and pilots are encouraging. Reductions in ER visits and hospitalizations. Blue Cross-Blue Shield in North Dakota expanded their medical home

nationwide. After a three year analysis showed a 6% decrease in hospital admissions and a 24% decrease in emergency room visits for patients with chronic conditions. That resulted in a savings of \$500 per member per year.

Next slide, please. This should be slide number 72. We think the medical home concept is especially important for children. We pay close attention to the health of children because employers provided healthcare coverage to more than half of the children in the United States. In fact, one out of every \$5 that employees spend on healthcare is for Maternal and Child Health services. Employer claims cost were for children and adolescents.

Children's health problems -- we think it's important the get children started in the medical home early and get them started on the right path to be healthy because many employers provide coverage to dependents of adolescence. 43% of our employers responded that they provided coverage through age 25 for dependent children who were enrolled in school. We're trying to keep them healthy into adolescence and young adulthood. When we talk about the medical home it can help insure that children are up to date on preventive services. Children, the American Academy of Pediatrics recommends 26 visits between birth and age 21. When a child has special needs, complex medical conditions and research shows that children in medical homes receive more on time vaccinations than children seen in other care delivery models. Medical homes promote timeliness of care by keeping up to date records and reminding parents of their children's immunization needs. Medical homes are good for children because there is fragmentation of care for children. This can be due to changes in their parents' employment, changes in health plan options or changes in levels of coverage. Parents add or eliminate dental coverage. They need the continuity of care about a medical history. Medical homes are essential then.

Finally, 8.6% of employees provide care for a child with a special healthcare need.

Employees spend a significant amount of time organizing and coordinating healthcare.

Parents with special healthcare needs in children spend more time. This can be the point of access for that child and it's really crucial. Slide number 73. What can we do to start implementing these medical home models? A strong need for payment reform. Primary care physicians are significantly undercompensated compared to specialists and not paid for many services such as coordinating care across settings and practitioners. Primary care delivery and payment models need to be restructured to provide more value to patients. It contains -- for medical care and can increase involvement between the patient and physician. There are three different models I'll speak of briefly. One is reimbursement. A fee-for-service model with fees for care coordination and other enhanced services and pay performance. This is actually what the Center for Medicare and Medicaid services will be doing beginning in 2009. A three year medical home demonstration project and develop and evaluate care fees and there are also pilots using this time of reimbursement. Payment methods include monthly pay management fees. Targets, quarterly bonuses and fee schedule enhancements. There is also global fee for care episodes. We know employers working to develop with other organizations and with primary care practices to develop care packages which are specific services such as care for asthma, bundled into one package and fee-for-service enhancements. This is just a way of enhancing the current fee-for-service model to provide things like nurse-based management. Integrated into the primary care system with an enhanced fee-for-service payment.

Next slide, please, slide number 74. Other potential solutions that private and public employers can consider. They can participate in a medical home pilot provided by the patient center primary care cooperative in geographic locations where they have employees. Partner with health plans to work on preventive services equalization, well child visits, prescriptions and E-visit and chronic illness management. They can pay for non-face-to-face meeting such as telephone and online services. These services can

provide patients with greater access to their physician. Also important they encourage employees to select a primary care provider for their child. Most employees don't understand the value of medical home. They should know that having a primary care physician for themselves and children is associated with less ER and hospital use. Better preventive care and higher satisfaction with care. More of our patients can get the best possible specialty care by having a primary care physician who can be sure the specialist has the right information to deliver the right care for the patient. It is crucial that you allow the employee also to choose their primary care provider if possible. This helps them establish trust in the physician or provider for recommendations and achieve a high level of care satisfaction.

Next slide, please. Slide number 75. It can also develop benefit design options that encourage employee selection of a primary care physician or medical home when that's an available option. For example, employers can offer a premium reduction or another financial incentive or a recognized medical home and also reduce cost sharing for primary care visits. They can also integrate communications of primary care into their existing programs. Employers can add messages about the value of primary care into these programs. Along with supports to help employees choose a provider, prepare for a visit. Use preventive service and follow treatment regimens and work with health vendors to integrate these messages. Reach out to employees that don't have primary care providers and encourage them to use provider services and offer them assistance in choosing a provider. Customer service calls to a third party vendor can trigger a question about whether the patient has a primary care provider and then deliver the message about the primary care relationship and offer help in choosing a provider. Case managers can also contact anyone who doesn't have a primary care provider and assist them in choosing one. They can ask if a child has a primary care physician. Talk about the parents about

the value of primary care and help them choose one. Finally it's important that employers advocate for primary care and physician payment reform in public policies. For example try public policies that might support medical students who choose primary care residency. Scholarship programs and low interest loans.

Next slide, please. Slide number 76. So today I've talked to you about what we believe is important in primary care, what activities we're doing with our employers, to help strengthen the primary care system. The importance of the medical home and some suggestions for employers. If you need any more information please feel free to contact me. You can also visit our website. This concludes my presentation. I'm now going to turn it over to Eva Klain with the ABA center on children and the law.

EVA KLAIN: Thank you, Amy. My name is Eva Klain, director of child and adolescent held at the ABA center on children and the law. Our center has two HRSA-funded grants one under the AIM program, which is the health of infants, toddlers and pre-schoolers grant and other is one for adolescent health. We work under both grants to raise awareness among legal professionals and to improve the legal and judicial practice in primary child welfare cases but also in other court cases involving children and we work specifically to raise awareness about health-related issues and how judges, what important roles judges and attorneys have to play in ensuring that the healthcare needs of children who are in foster care are met. So as part of this work under our AIM grant we're in the final stages of producing a guide for judges on how to ensure that the physical, mental and dental health of infants, toddlers and pre-schoolers specifically receive the attention that it requires for better well-being outcomes for children who are in the foster care system and the use of medical homes for all children in foster care clearly falls within what we hope to achieve through our efforts.

Next slide, please. Slide 78. Many children enter foster care with complex medical needs. They may have acute illnesses or compromised systems from either the maltreatment that brought them into care in the first place or from the inadequate healthcare that they may have received prior to placement. Once they're in care they may experience multiple placements though certainly we work very hard to try to limit the number of placements, work to make the first placement the last placement. But in reality we know that often children do experience multiple placements and that can have a clear impact on the healthcare that they receive. They may also experience lack of access or availability of needed services for specialized services that they require. Very often their medical histories aren't known when they come into care and so for all these reasons and because the children are -- once they're placed in care are adjusting to separation from their homes and their families, a single healthcare provider is essential for this population. A knowledgeable medical home provider can get to know the child well over successive visits and therefore can see changes in the child over time that others may not notice or perhaps others may not notice because the caretakers may change and so again, one of the reasons why it's crucial for this population to have a medical home. A medical home can also help the care gives whether they're foster parents to understand what they need to do to support the child's health and well-being. As part of the care that children who are in foster care need, the American Academy of Pediatrics recommends a schedule of enhanced or increased preventive care. For instance, from birth to six months they recommend that children are seen monthly from six months to 12 months they recommend that children are seen every two months. So it is definitely an enhanced preventive care schedule.

Next slide, please. They recommend supplemental visits at critical child welfare junk terse. Many maltreated children haven't had adequate healthcare or even previously seen a doctor. Placement transitions, again we try to keep placements stable but a single medical home provider can provide consistency during a placement transition. Significant changes in home environment that might impact health. Significant issues related to visitation which also may affect the child's mental health or behavior. Clearly any signs of abuse or neglect while in care should be examined and a dear tier oration in behavior. And when the child is discharged from the child welfare system.

Slide 80. I want to give an example of a medical home for children that is specifically for children in foster care. So I would like to briefly discuss foster care pediatrics in Rochester, New York. Foster care pediatrics is housed jointly with the Department of Social Services and the Department of Health for Monroe county. About 600 to 700 children enter foster care each year in the county and some of the common healthcare issues that these children come into care with include post traumatic stress disorder, attachment disorders, conduct disorders, ADHD, substance abuse among the older children and feet -- fetal alcohol effects. They provide a medical home for the foster care population in Monroe county. Its mission is comprehensive, high quality primary care. Coordination of services, support and education for foster families and casework staff and this is such an important function because really the caretakers, foster families and care providers are the primary therapeutic intervention for these kids and they need to be educated and supported in what they do for the children on a daily basis. Their mission includes advocacy and development of collaborative efforts to enhance wellness. So the program, foster care pediatrics is designed to provide a medical home, preventive medicine to ensure the well-being of children in foster care and reduce the number of hospitalizations and emergency room visits and provides an opportunity for the responsible agencies to talk to each other

and provide support and education for foster parents and staff alike. Since 1990 foster care pediatrics has served 90% of the children in out of home care Monroe County. The program averages about 4,000 visits per year, providing primary care services on site as well as developmental screening. On site assessment of physical and sexual abuse cases and children receiving psychotropic medications. There is a physician, pediatric nurse practitioner and clerical staff and provides night and weekend coverage through contract nurses to provide assistance to families during off hours.

Next slide, please. As I mentioned earlier, the ABA center on children and the law works with judges to help them understand the importance of healthcare and medical homes and provide them with practice tips and advice on how they can implement some of these best practices and some of these practices tips include simply requiring a medical home. And part of that is also addressing barriers to using a medical home and this can include making sure that placement decisions are made with continuity of medical care in mind. Whenever there is a suggested placement change, that it is looked at in light of continuity of care. We also recommend that judges help each child access a dental home. We tell them that at each hearing they should be asking when the child's last appointment was and when the next one is scheduled and because we feel that frequent court hearings are also helpful in moving cases appropriately through the system, that way the medical appointments are also kept up to date and documented in the case file. Judges should also require that the additional appointments that I mentioned earlier as recommended by the AAP are also kept. And they should ask that the social worker get an update after each medical visit and then incorporate the information in a meaningful way into the case plan so it's not just an addendum somewhere that yes, the child was seen by the doctor, but specifically what needs to be done with that information and who needs to do that. And also we recommend that judges ensure that all current and potential caregivers know the

child's name and number so that if anything does come up, that contact can be made and that continuity continued.

Next slide, please. I would also like to take a few minutes to talk about the fostering connections to success and increasing adoptions act of 2008 signed into law on October 7th, 2008. The foster and connections act is connected to promote permanent families and to improved indication and healthcare for children in foster care. Its provisions extend Federal support for youth in care through age 21. That obviously has implications for improved health, potential for improved health and continued healthcare for children through age 21. Specifically the fostering connections healthcare provisions are designed to help healthcare and appropriate screening, follow up treatment, sharing of critical information and oversight of prescription medications and the provisions to help older youth and improve outcomes for older youth in care include, as I mentioned, an extension of support up to age 21. And equally important a transition plan created within 90 days of the child's leaving care that addresses health-related issues such as insurance coverage, continuing support services, housing and education. Slide 83, please. Fostering connections also requires states to develop a plan for to t coordination of healthcare services including mental and dental health. The state under its title 4B plan under the Social Security act must develop the plan in consultation with pediatricians and other health experts. The plan must describe what initial and follow-up health screening will be provided to children in care, how identified health needs to be monitored and treated and how medical information will be updated and shared appropriately. And significant to our conversation today, fostering connections requires the state plans to detail what steps will be taken to ensure continuity of healthcare services for children in foster care including the possibilities of a medical home for every child in care. Now states were allowed to submit certifications of required state legislation for various sections of the act meaning that they

could not implement those sections until there was some legislative action on the state level and those sections included the healthcare oversight and coordination plans. We'll have to wait and see how many states have submitted for this potential one year delay. In addition, no regulations have been written on the act so we're still waiting for guidance from the children's bureau but we look forward to seeing medical homes take on a new momentum for children in foster care. Last slide, please. And just to conclude I wanted to give you my contact information, which is here on the last slide. Please feel free to call or email me and I invite you to visit our two websites on baby and teen health. We have a lot of resources available there. Audrey, I'll give it over to you.

AUDREY YOWELL: Thanks, Eva. I want to begin by offering an apology and a disclaimer. Due to some mysterious technical glitch Dr.'s slides appeared on the HRSA logo. The disclaimer from HRSA that they weren't HRSA slides. We have one question. A question that came to us from Colorado not addressed to anyone in particular. It says have you worked on getting reimbursement for public health programs to help people find medical homes through different types of home visits? We've just had our Medicaid funding cut for postpartum visits. Do any of our speakers have a comment in response?

>> This is Diane. I can comment briefly. We're looking at ways to identify and develop medical homes early on and from the perspective of home visitation, we know that with you, given what is happening in many of the states, some of those home visitation programs have been cut. So what we've worked through AAP chapters in those states really looking at advocacy to see how we can work together from -- with our public health colleagues to either have reinstatement or look at other ways and options to move forward quickly and early on from a medical home perspective particularly knowing all of the information on early brain and child development and what that means. That's actually one

of our strategic priorities over the next year from an early brain and child development.

Don't have the answers for you yet, though.

>> Any other responses so this question? Well, before we conclude our webcast this afternoon, I have two quick reminders for you. First please fill out the short evaluation online at the end of this webcast. Your feedback really will assist us in planning future webcasts. And finally the webcast will be archived in approximately a week and will be available at mchcom.com. Want to thank all of our terrific presenters today and especially thank all of you who participated in the webcast. For your concern for the health of women, children and families. Have a great afternoon.