CHILD HEALTH TRANSFORMATION: FOCUS ON MEDICAL HOMES

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Prepared for the National Academies of Sciences, Engineering, and Medicine (NASEM) study on

Improving the Health and Wellbeing of Children and Youth through Health Care System Transformation

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Select Key Questions from Study

- Why it is important to invest in the health and well-being of children and youth?
- What is the purpose of health care system transformation? Desired outcomes?
- What are the gaps and barriers related to public coverage, and what are potential solutions to overcome them?
- What have been identified as key levers of change to guide innovation and transformation within systems?
- What are promising policies and practices that incorporate lived experiences, build trust and relationships, support family-centered care, promote protective factors and prevention, and help address systemic inequities and disparities in access to and use of high-quality child and adolescent health care?

My main questions related to transformation

- Since 95% of children have health coverage, how do we **leverage coverage for transforming the health care** delivery system to ensuring access, quality, and equity?

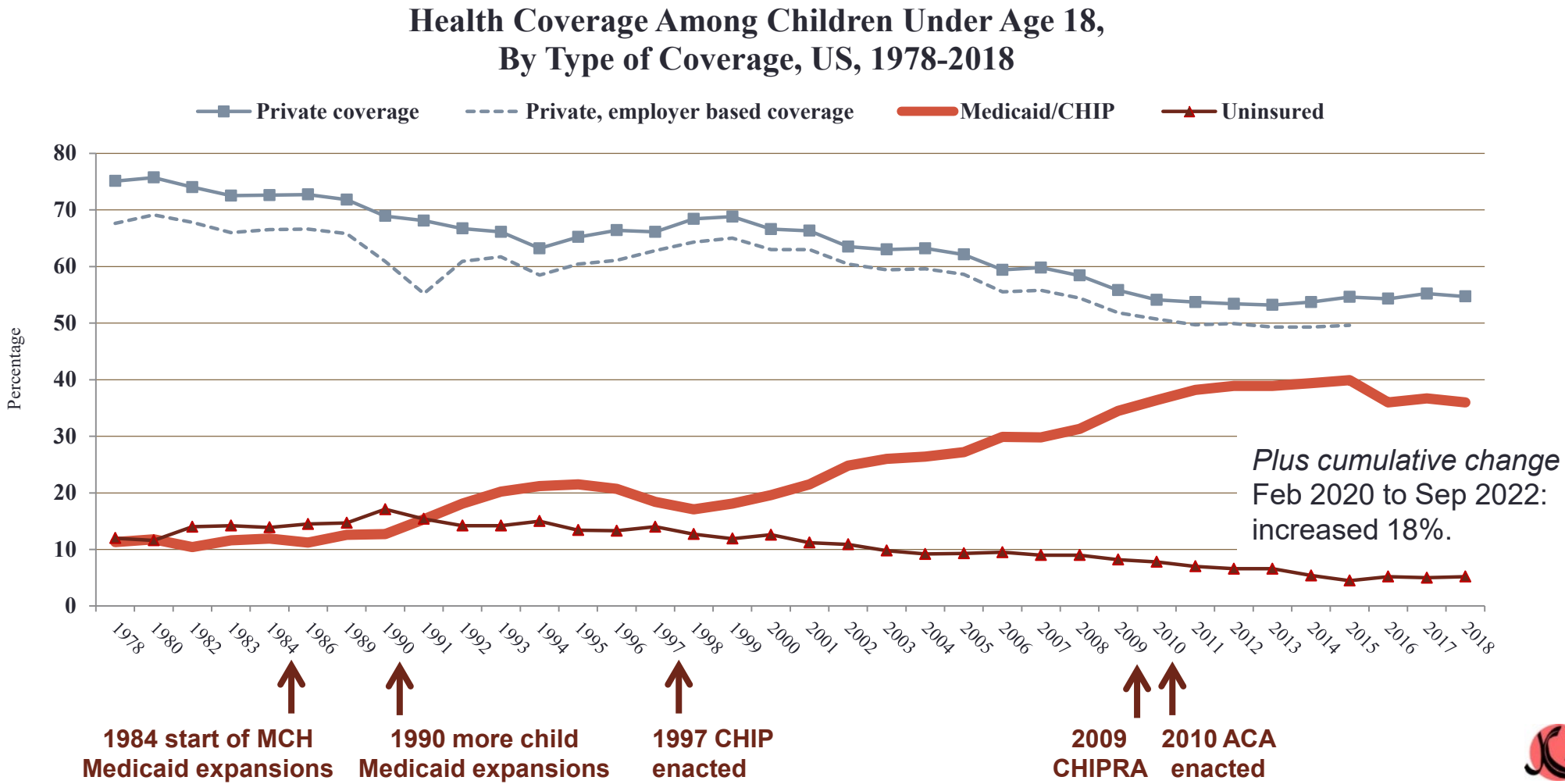
- Since more >90% of young children are seen by the health system, how to maximize **opportunities to promote optimal development**?

- Since more than half of children under age 18 are covered by Medicaid and CHIP, how do we **accelerate transformation using public program levers**?

CRITICAL IMPORTANCE OF MEDICAID TO CHILD HEALTH TRANSFORMATION

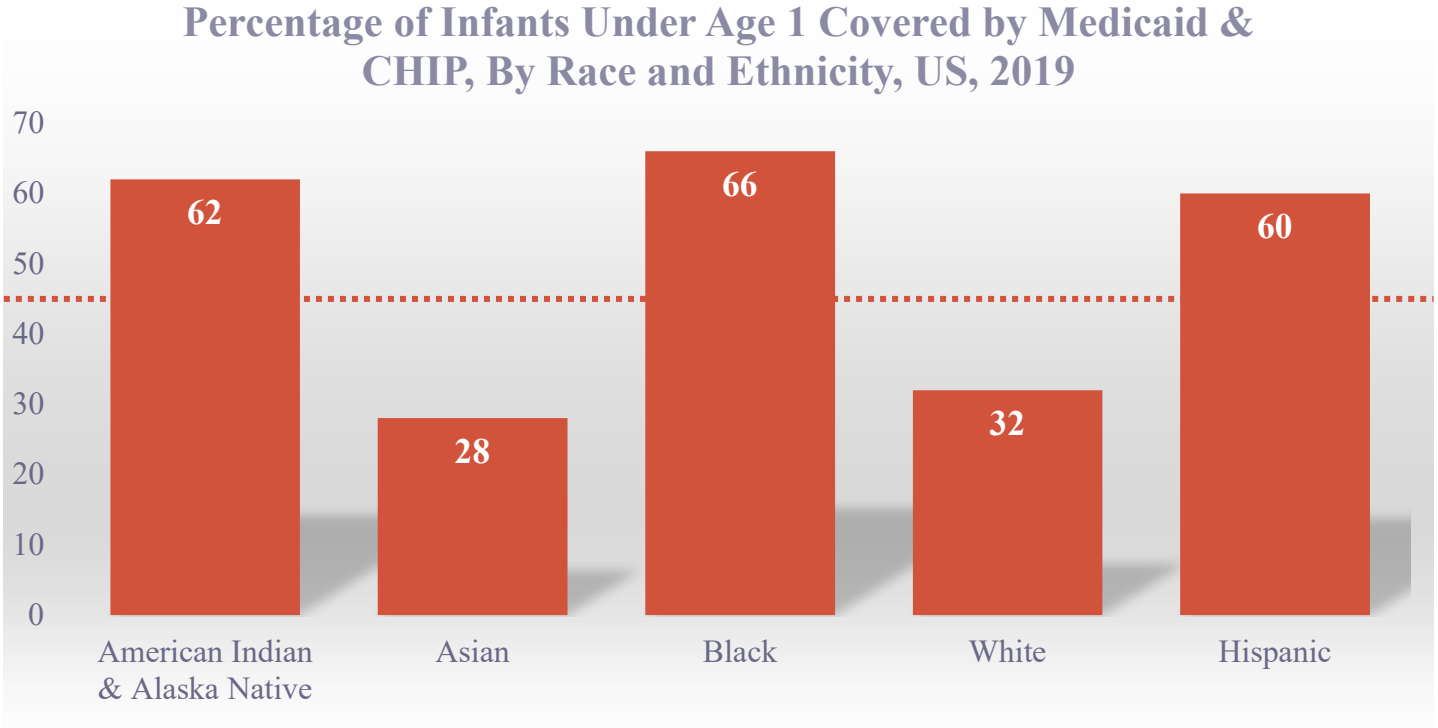
We cannot achieve health equity or transform child health care without leveraging Medicaid and CHIP.

Medicaid/CHIP Improved Children's Coverage, Reduced Uninsured



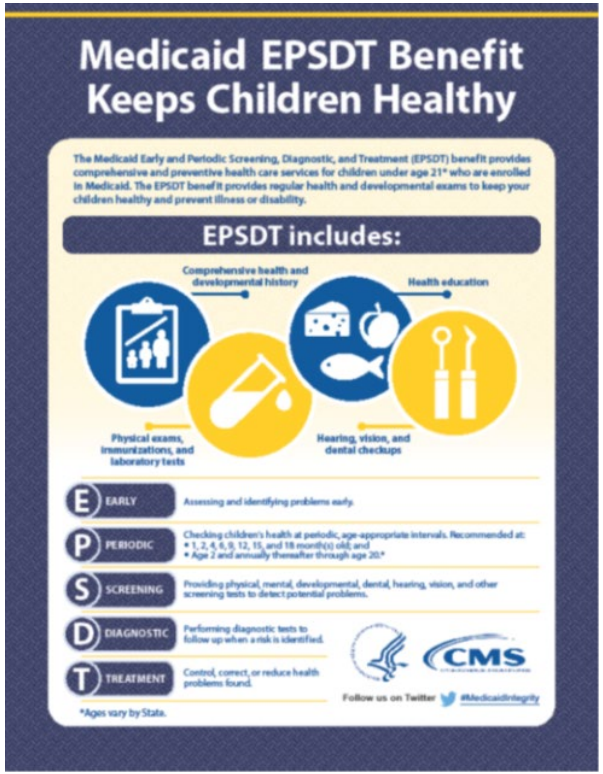
Performance of Medicaid/CHIP Matter for Child Health & Equity

- More than half of all babies—2.1 million infants enrolled in Medicaid.[1]
- 6 in 10 Black, Indigenous, and Latinx infants.[2]
  (46% of total)
- About half (54%) of all children ages 0-18.[3]



Kaiser Family Foundation analysis of American Community Survey Data.

1. Johnson analysis of EPSDT 416 data from Centers for Medicare and Medicaid Services, FFY 2020.
2. Artiga et al. *Medicaid Initiatives to Improve Maternal and Infant Health and Address Racial Disparities*. Kaiser Family Foundation, 2020.
3. Alker and Osorio. *Child Uninsured rate Could rise Sharply if States Don't Proceed with Caution*. Georgetown University Center for Children and Families, February 2023. https://ccf.georgetown.edu/2023/02/01/child-uninsured-rate-could-rise-sharply-if-states-dont-take-care/

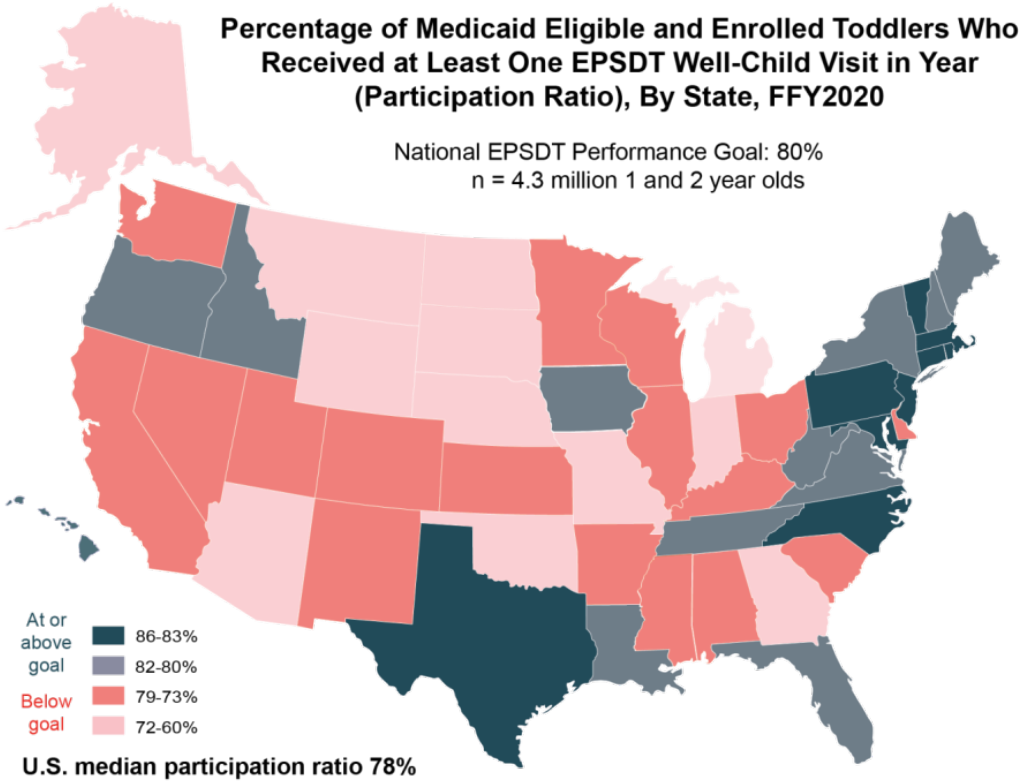


Early Periodic Screening, Diagnostic, and Treatment (EPSDT) exists as the comprehensive child health benefit package for half of all children.

- EPSDT can and should finance and leverage child health transformation.
- EPSDT requires financing for:
  - Comprehensive well-child visits, preventive services
  - Full array of treatment and interventions for children when medically necessary.
  - Support for families to gain access to care.
- Congressionally mandated review of EPSDT underway

Sources: Centers for Medicare and Medicaid Services (CMS). Early Periodic Screening, Diagnostic, and Treatment. [Website]. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html and Health Resources and Services Administration (HRSA), Early Periodic Screening, Diagnosis, and Treatment (EPSDT). [Website] https://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs/early-periodic-screening-diagnosis-and-treatment; CMS. *EPSDT- A Guide for States: Coverage in the Medicaid benefit for children and adolescents*. 2014. https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf; Mann C et al. *Keeping Medicaid's Promise for Children with Special Healthcare Needs.* Manatt Health. 2019. https://www.manatt.com/insights/newsletters/manatt-on-health-medicaid-edition/keeping-medicaids-promise-for-children; National Academy for State Health Policy. EPSDT Resources to Improve Medicaid for Children and Adolescents [Website]. https://nashp.org/resources-improve-medicaid-children-and-adolescents/; Rosenbaum S. When old is new: Medicaid EPSDT benefit at fifty, and the future of child health policy. *Milbank Quarterly*. 2016;94(4),716-719

Medicaid/EPSDT Gaps and Weaknesses



Today, many states are **not**:

- Achieving 80% goal for well-child (screening) visits.
- Financing the full range of prevention and treatment services covered.
- Paying adequate rates.
- Holding MCOs and providers sufficiently accountable.
- Reporting reliable data.

❖ ***All of these can be remedied.***

Sources: Map prepared by Johnson based on Center for Medicare and Medicaid Services (CMS) Form 416 data on EPSDT participation for Federal Fiscal Year (FFY) 2020. Updated from: Schor EL & Johnson K. Child Health Inequities Among State Medicaid Programs. *JAMA Pediatr*. 2021;175(8):775-776. doi:10.1001/jamapediatrics.2021.
Also see: CMS-Funded project to assess EPSDT https://www.norc.org/Research/Projects/Pages/cms-early-and-periodic-screening-diagnostic-and-treatment-benefit-epsdt.aspx
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IMPROVING ACCESS TO MEDICAL HOMES FOR CHILDREN

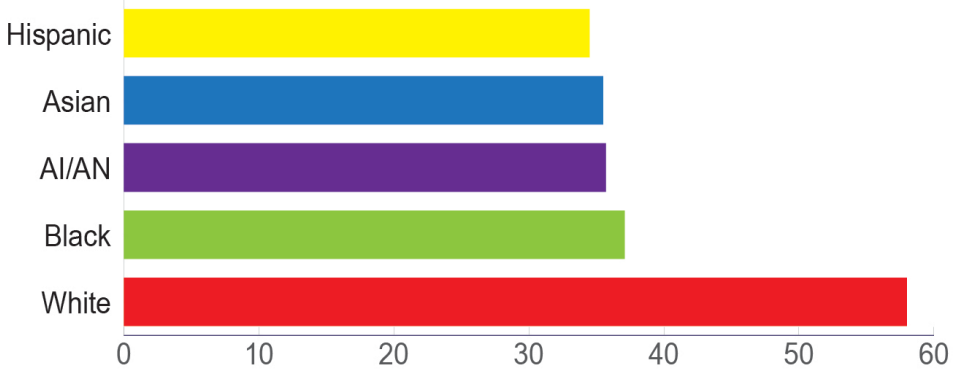
Advancing team-based, holistically focused, family-driven, equitable, and high performing medical homes for children

Renewed focus on pediatric medical home

- **Need focus on access, design, and financing of medical home to better serve all children and families**.
  - Advance demonstrated elements of transformation
  - More team-based care and relational care coordination
  - Support for families and family engagement, including SDOH and equity
  - Embed approaches for promotion, prevention, and continuum of intervention
  - Emphasis on cross-system coordination and linkages
- Opportunities that to build support similar to NCQA recognition process
  - e.g. financial incentives, support for transformation, learning collaboratives, MOC credit, performance measurement, align with payer goals, etc.

Children and Medical Homes: *Underperforming*

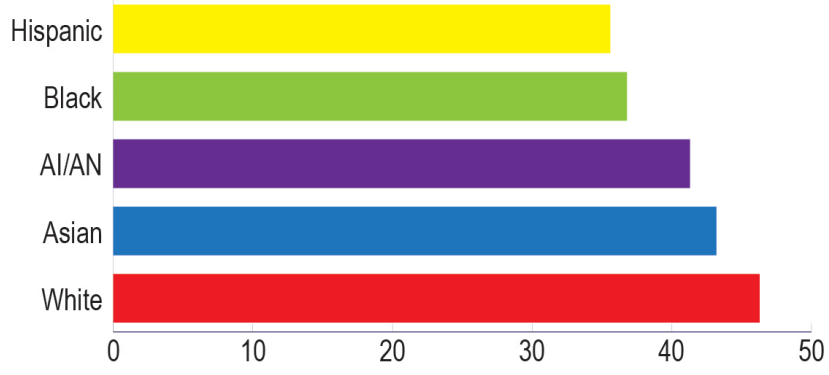
Percent of Children without Special Needs Ages 0-17 Who Had a Medical Home, By Race/Ethnicity, US, 2020-21



Proportion of children with public insurance (Medicaid/ CHIP) who had a medical home. **36%**

Only half of all children under age 18 have care that meets criteria for medical home.

Percent of Children with Special Health Care Needs (CSHCN) Ages 0-17 Who Had a Medical Home, By Race/Ethnicity, US, 2020-21



Proportion of children who had a medical home reported, by age group.

Age 0-5: 48%

Age 12-17: 45%

Data Source. Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administraton (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 3/22/23 from www.childhealthdata.org

Practice Transformation State of the Field

- State-of-the-field reviews and research have identified exemplary practices that point to value of:
  - Restructuring and enhancing practice, particularly well-child visits
  - Using relational approaches, care coordination, whole child/family focus, and cultural and linguistic responsiveness (e.g., reduce bias, build trust, etc.)
  - Embedding evidence-based models and linking to other services

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Bruner C, Johnson K, Hayes M, et al. Young child health transformation: What practice tells us evidenced-based and promising programs. Working Paper InCK Marks Child Health Care Transformation Series. April, 2020. https://www.inckmarks.org/webinars/InCKMarksPracticeTransformationComponentfinalpdf.pdf
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High Performing Medical Homes for Young Children

Redesigned Well-Child Visits

- Holistic, **team-based care**
- Comprehensive **well-child visits** based on Bright Futures guidelines and EPSDT
- Family-centered, **relational**, **strengths-based,** and whole child / family approaches
- **Recommended screening** for development, social-emotional health, maternal depression and social determinants of health (SDOH)

Relational Care Coordination

- **Routine** care coordination as part of medical home
- **Intensive care coordination** for more complex medical conditions or social risks
- **Relational care coordination staff** (e.g., community health workers)
- More **effective responses, completed referrals,** and **linkages** to community

Other Services and Enhanced Supports

- **Co-locate programs in primary care** to promote ERH and development (e.g., DULCE, HealthySteps, Reach Out and Read, VIP)
- **Integrate mental health**
- **Refer and/or link** to other services (e.g., home visiting, early intervention, dental, early care and education, parent-child mental health therapy, nutrition programs)

Adapted from: Johnson K, Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing high performing medical homes and improving lifelong health.* Child and Family Policy Center. 2018. https://www.inckmarks.org/docs/pdfs_for_Medicaid_and_EPSDT_page/SourcebookMEDICAIDYOUNGCHILDRENALL.pdf
Willis DW, Paradis N, Johnson K. The paradigm shift to early relational health: A network movement. *Zero to Three*. 2022;42(4):22-30.

Measurement for High Performing, Team-Based, Whole Child, and Relational Medical Homes

Access to care *(primary care visit measure in NCQA-HEDIS)*
Receipt of recommended **well-child visits*** (*W30-CH; WCV-CH*)
Up-to-date on **immunizations*** (*CIS-CH; IMA-CH*)
Receipt of recommended **developmental screening*** (*DEV-CH*)
Receipt of all recommended screening, including social-emotional and social needs (*SNS-E in HEDIS*)
Use of the validated **CSHCN screening** tool
Unnecessary **emergency department** visits* (*AMB-CH*)
Family engagement demonstrated (e.g., Bright Futures pre-visit tools and/or Well-Visit Planner)
Satisfaction with the experience of care as measured with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H* (*CPC-CH*)
Documentation on **rates of referrals, follow up and completed referrals** *(perhaps for select topics)*
Documentation of **augmented supports** provided in practice (e.g., integrated mental health, HealthySteps, DULCE, Reach Out and Read, adolescent wellness approaches, transition)

* Measures identified as part of CMS Medicaid-CHIP Core Child Set 2023-2024. Adapted table from Johnson and Bruner. Sourcebook. 2018.

Aligning Measures for Shared Accountability

Updated and adapted from Johnson K & Bruner C. Sourcebook. 2018.

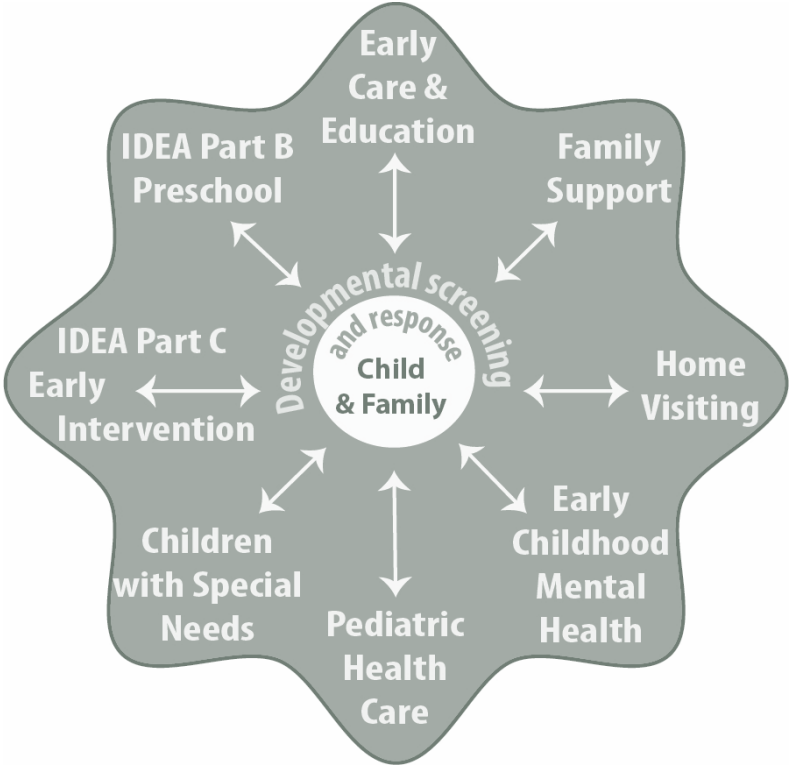
★Directly related to Medicaid EPSDT requirements * Part of CMS Core Set of Child Health Care Quality Measures	Medicaid / CHIP Core Child Health Measures 2023-24	Healthcare Effectiveness Data and Information Set (HEDIS) 2023	Title V MCH Block Grant National Measures	Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
Prenatal and postpartum care visits	✓	✓	✓	Postpartum
Contraceptive care (postpartum) *	✓			
Maternal depression screening & follow up	Behavioral health assessment	✓	Postpartum depression	✓
Well child visits in first 30 months of life ★ *	✓	✓	Medical home	✓
Child and adolescent well care visits ★ *	✓	✓	Medical home	✓
Immunization status of young children and adolescents★ *	✓	✓	✓	
Access to primary care★			Medical home	
Developmental screening★ *	✓		✓	✓
Social need / risk screening		✓		
Lead screening★ *	✓	✓		
Preventive dental / oral exams★ *	✓	✓	✓	
Emergency department visits *	✓	✓		✓ **(injury)**
Weight assessment and counseling★ *	✓	✓	Obesity	
Experience / satisfaction with care – CAHPS *	✓	✓		
Coordination of care ★		✓	✓	✓
Insurance coverage	(assumed)	(assumed)	✓	✓

Select emerging state efforts

- **Massachusetts**
  - Design proposed for Medicaid financing of advanced medical homes; added preventive behavioral health, social supports, and more
- **Mississippi**
  - HRSA-funded Mississippi Thrive Child Health and Development Project, enhanced pediatric medical home services/bundle and more
- **New Jersey**
  - CMS funded InCK cross-sector collaborative model of integrated care and NJ Seedlings (HRSA-funded Transforming Pediatrics in Early Childhood-TPEC)
- **Rhode Island**
  - Built PCMH initiative (all payer); Medicaid health homes for children with special needs
- **Vermont**
  - Aiming for DULCE sites statewide, including mix of funding and ACO role
- **California**
  - Medicaid EPSDT guidance, financing of preventive dyadic services, and community health workers (CHW); action in children's mental health, and more
- **Oregon**
  - Continuous coverage 0-6; Medicaid data and metrics to drive incentive payments and improvement; plus enhanced medical homes for those with complex needs, TPEC, and more
- **Washington State**
  - Medicaid demonstration with CHW in medical home to promote early relational health and well-being of school-aged children; plus action in children's mental health, and more

Select exemplary local efforts to build systems and advance equity

- Boston, MA
- Bridgeport, CT
- Cincinnati, OH
- New York, NY
- Oakland, CA
- Pittsburgh, PA
- Pierce County, WA
- Portland, OR



How can NASEM transformation study help?

- Report on the evidence in support of transformation toward advanced, team-based, high-performing **medical homes** for all children birth to 18.
- Emphasize role of **Medicaid** in child health transformation and equity in outcomes.
- Describe the failures of states and recommend how to deliver on promise of **EPSDT**.
- Go beyond the rhetoric on **family engagement and equity** to make strong and specific recommendations for action on how to **partner with families and communities**.
- Describe the opportunities and limitations of various **purchasing arrangements** that can support advanced, holistic and team-based care, as well as coordination with community.
- Document successful approaches for **linking** health and building community **systems**.
- Make recommendations for improved **measurement, data collection and reporting** at both the clinical and population levels.

SELECT REFERENCES AND RESOURCES

1. Web-based resources
2. Literature about child health transformation
3. Literature about design and impact of medical homes
4. Literature about equity
5. Literature about evidence-based models
6. Literature and links related to local examples of health care and systems transformation

Key Related Websites and Federal Documents

- American Academy of Pediatrics. National Resource Center for Patient/Family-Centered Medical Home. (Website, 2023) https://www.aap.org/en/practice-management/medical-home
- Data Resource Center for Child and Adolescent Health. (Source for interactive data from National Survey of Children's Health). Child and Adolescent Health Measurement Initiative (CAHMI).(Website, 2023). https://www.childhealthdata.org
- Medical Home Portal. The Patient-Centered Medical Home. (Website, 2019). https://www.medicalhomeportal.org/clinical-practice/the-patient-centered-medical-home
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Select literature about opportunities to transform medical homes

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Select literature about design and impact of medical homes

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- Pierce County, WA (Pediatrics Supporting Parents – PSP – site)
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- Portland, OR (Transforming Pediatrics for Early Childhood –TPEC – site; Building Community Resilience site)
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Also see: Center for Community Resilience. https://ccr.publichealth.gwu.edu/ and https://ccr.publichealth.gwu.edu/bcr/network-sites
Pediatrics Supporting Parents https://www.pediatricssupportingparents.org/
Transforming Pediatrics for Early Childhood. Maternal and Child Health Bureau, Health Resources and Services Administration, US HHS. https://www.hrsa.gov/grants/find-funding/HRSA-22-141