Treating the Whole Child: Integration of Home Visiting and Pediatric Medical Homes
Katy Sides
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Introduction to the Patient-Centered Medical Home

The Joint Principles of the Patient-Centered Medical Home (PCMH)

• Personal physician
• Physician-directed medical practice
• Whole-person orientation
• Care is coordinated and/or integrated
• Quality and safety
• Enhanced access
• Payment

Graph adapted from National Committee on Quality Assurance
### Differences Between Traditional Primary Care and the Medical Home

<table>
<thead>
<tr>
<th>Today’s Care</th>
<th>Medical Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care is provided to patients who come to the clinic</td>
<td>Care is provided to all patients registered in the medical home</td>
</tr>
<tr>
<td>Care varies by clinician experiences</td>
<td>Care standards are evidence-based</td>
</tr>
<tr>
<td>Care is provided by a single clinician</td>
<td>Care is provided by a multidisciplinary team of medical professionals</td>
</tr>
<tr>
<td>Patients schedule specialty visits and are responsible for informing clinicians about content of those visits</td>
<td>Care is coordinated and tracked by the care team</td>
</tr>
<tr>
<td>Quality is felt, not measured</td>
<td>Quality is measured and continuously improved</td>
</tr>
</tbody>
</table>

Graph adapted from Qualis Health
Key Elements of a Medical Home for Children

• Population-based approach
• Chronic condition supports
• Coordinated care
• Parental involvement
• Clinical practice standards
• Newborn screening
• Child and family education
• Community agency involvement
Home Visitation and PCMH Collaboration

Benefits of Collaboration:

• Information sharing
• Care coordination
• Referral facilitation
• Community needs
• Assisting transition
• Assisting parent communication
• Reinforcing advice
• Monitoring well health
• Fostering cultural competence
• Performing environmental and safety assessments
• Parental depression identification
• Meeting the needs of complex health care in the home
Contact

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Carolina Health Centers, Inc.
Home visitation as a component of primary care
Care coordination as a component of primary care
Behavioral health as a component of primary care
Home Visitation Programs at TCC

Nurse-Family Partnership
Helping First-Time Parents Succeed

healthy families america®

Healthy Steps for Young Children®

Carolina Health Centers Inc.
Common Outcomes → Improved Outcomes

<table>
<thead>
<tr>
<th>Measure</th>
<th>MIECHV</th>
<th>HEDIS</th>
<th>CHIPRA</th>
<th>NCOA-PCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Screening</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connection to community resources</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI assessment</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Culturally/linguistically appropriate care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead screening</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Birth weight &lt; 2500 grams</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Timeliness and frequency of prenatal care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Postpartum care</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Immunization Status</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>ED Utilization</td>
<td>X</td>
<td></td>
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<tr>
<td>Access to Primary Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Behavioral/Mental Health</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well child visits in first 15 months</td>
<td>X</td>
<td>X</td>
<td></td>
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</tr>
</tbody>
</table>

Chart adapted from Carolina Health Centers, Inc.
Preventive Oral Health

Healthy Birth Outcomes

School Readiness

Social Emotional Health

Reduction of Maternal Depression
Sustainability

TCC current strategies:
- PCMH incentives
- Substitution linked to productivity
- Pay for performance incentives
- Enhanced grant opportunities
- Managed care pilot potential

National conversations:
- Social Impact Bonds
- CMS Waiver Process
- Payment reform inclusive of hv as team based care
- Enabling services status within FQHC
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Medical Home: Pediatric “Extensive” Care

Child and Family

- Shared In-basket with EHR
- Health Concierge; Screening, risk id
- Oral Health Ed, Fluoride, dev scr
- Anticipatory Guidance reinforced in-home
- CYSHCN, refer to CCC, Special Families
- Medical or social needs, refer to CHIP
# Health Concierge: Social History Screening

## Benefits
- **Are you having problems receiving WIC food stamp, daycare vouchers, medical card, or SSI?**
  - Yes
  - No

## Housing
- **Housing problems (overcrowding, roaches, rodents, utilities, mold, lead)?**
  - Yes
  - No
- **Threatened with eviction or losing your home?**
  - Yes
  - No
- **Over the past 2 weeks, have you felt down, depressed or hopeless?**
  - Yes
  - No
- **Over the past 2 weeks, have you felt little interest or pleasure in doing things?**
  - Yes
  - No
- **Do you feel that you and/or your children are unsafe in your relationships?**
  - Yes
  - No
- **Would you like to speak with a social worker or legal advocate in the clinic about these issues?**
  - Yes
  - No

## Depression

## Domestic Violence

## All others
Care Management Design

• Home Visiting Contract
  – Paid per member/per month

• “High Touch”, in-person, in-home

• Data Collected in home
  – HEDIS metrics
  – Health Outcomes
  – Reduced costs
Results

100% families receive early childhood education
90% 2yr olds UTD on well visits and immunizations
100% children are screened for lead, Hgb, development

97% children have a Dental Home
66% of children have had a dental visit by age 3
97% have had an oral health assessment and fluoride varnish

145 children in program 2011-2012
84% well controlled
84% minimal inhaler use
90% decrease in ED visits
82% decrease in school absence due to asthma
Key Policy Considerations

• The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) should be reauthorized to provide a strong base of funding for innovative approaches;

• Integration requires flexible funding that can be braided with other federal, state, and private funding streams, including Medicaid;

• Funding sources should be aligned to incentivize collaboration and integration of services;

• This innovative model is new and evolving and is breaking down traditional silos between health, early learning and social services. We want to be a resource as we further develop these models of care.
Contact Information

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