Treating the Whole Child: Integration of Home Visiting and Pediatric Medical Homes
Sally Baggett
Director of Parent and Family Support
Carolina Health Centers, Inc.
The Children’s Center

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.
HV Triage at The Children’s Center

First Time Families

Parental Assessment of Risks

Yes

Low income prior to 28 weeks

Yes

Special circumstances

No

Nurse-Family Partnership

Yes

Healthy Families

No

All Families with a Newborn

Birth Assessment of Risks

Yes

Tier 1 Risks

Healthy Steps for Young Children

No

Yes

Tier 2 Risks

Edgefield, Saluda, McCormick, Laurens Co.

Yes

Greenwood or Abbeville County Resident

Yes

Reach Out and Read

No

Chart provided by Carolina Health Centers, Inc.
## Common Outcomes ▸ Improved Outcomes

<table>
<thead>
<tr>
<th>Measure</th>
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Chart adapted from Carolina Health Centers, Inc.
Preventive Oral Health

Healthy Birth Outcomes

School Readiness

Reduction of Maternal Depression

Social Emotional Health
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

Shared In-basket with EHR

Oral Health Ed, Fluoride, dev scr

Anticipatory Guidance reinforced in-home

Child and Family

Health Concierge; Screening, risk id

Medical or social needs, refer to CHIP

CYSHCN, refer to CCC, Special Families
## Health Concierge: Social History Screening

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**Benefits**

**Housing**

**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

Colleen Kraft, MD
Medical Director
Health Network by Cincinnati Children’s Hospital Medical Center

Colleen.Kraft@cchmc.org

513-803-6806
Treating the Whole Child: Integration of Home Visiting and Pediatric Medical Homes
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>
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<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>
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<tr>
<td>Quality is felt, not measured</td>
<td>Quality is measured and continuously improved</td>
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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

Katy Sides, Director of Research and Grants, Institute for Child Success
102 Edinburgh Court
Greenville, SC 29607
ksides@instituteforchildsuccess.org
(846) 467.4802
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### Categories
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  – Health Outcomes
  – Reduced costs
Home Visiting Intervention Pilot

Pregnant Women: Average Claims per Member per Month
- PnP/CHIP Intervention Group: Total = $432.26
- Control Group: Total = $413.24

Babies: Average Claims per Member per Month for first year (birth to 12 months)
- PnP/CHIP Intervention Group: Total = $538.84
- Control Group: Total = $922.91

Pregnant Women: Inpatient Days per 1,000
- PnP/CHIP Intervention Group: 4,302
- Control Group: 4,477

Babies: Inpatient Days per 1,000
- PnP/CHIP Intervention Group: Total = 4,382
- Control Group: Total = 7,808

- Other Inpatient Days
- NICU Days
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