

# Pediatrics Looks Ahead to the Medical Home

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BY MARK CRAWFORD

**A**ccess and affordability for pediatric care, in-hospital or outpatient, continues to be a challenge across the country. The burden extends beyond primary care and wellness to providing quality care for a growing number of children with chronic health conditions such as diabetes and asthma. Advances in the treatment of serious diseases are allowing these children to live longer lives. Often, however, they live with serious and significant health needs that require ongoing, specialized care.

Specialized children's health care increasingly is consolidating into large children's hospitals and pediatric programs. "This trend has been happening for at least a decade, well before the current economic downturn or health care reform," noted Christine Hartwell, vice president of Health Strategies & Solutions, a management consultancy in Richmond, Va., that works with a number of Catholic hospitals and health systems. "This consolidation is the result of smaller community hospitals that are downsizing their pediatric programs, as well as the overall lack of pediatric specialists."

These hospitals are downsizing pediatrics because they don't have enough patient volume to maintain staff and systems, a situation that doesn't attract pediatric specialists looking for jobs. Inpatient pediatrics can be extremely seasonal, with high admissions during flu season and low admissions during the summer months. Meanwhile, demand for health services for the aging Baby Boomers is growing, so some hospitals are converting pediatric space.

Medicaid and low reimbursement rates are another huge issue in pediatrics — the vast majority of patients in children's hospitals are covered by Medicaid. According to Hartwell, more than half of all Medicaid spending goes for children. It is not uncommon for large pediatric hospitals to depend on Medicaid for two-thirds or more of

their revenues.

"Children in poverty tend to be sicker and use more health care services than children living in families with private insurance," said Hartwell. "Families with chronically ill children may exhaust their resources paying for their child's care and eventually end up on Medicaid. Because our mission is to serve the sick and underserved, Catholic health care has a critical role in providing affordable and sustainable pediatric care."

## IN-HOSPITAL CARE

There are two types of pediatric health care — general care provided by private practitioners in

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the community and pediatric specialty care provided by hospitals or academic institutions. General care tends to exist closer to patients' homes, with relatively short wait times for appointments; specialty care is concentrated in large regional centers and provided by scarce pediatric specialists who can be far more inaccessible.

Only about 5 percent of kids need hospital care. For the typical child, an inpatient hospitalization is a rare occurrence. "For every 1,000 children in the U.S., only about 15-20 are admitted to the hos-



pital in a given year,” said Hartwell.

Of these, “most are infectious diseases, with flu or respiratory syncytial virus [RSV] often leading the way” said Susan Walsh, director of pediatrics for Saint Elizabeth Regional Medical Center in Lincoln, Neb., which is part of Catholic

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Health Initiatives. “Kids are usually admitted for dehydration, a need for oxygen or treatment for pneumonia.”

These kinds of hospital stays tend to be short (often a day or less), and children who are discharged are likely to require additional care at home. “This can be a challenge because there may be inadequate numbers of home health providers with expertise in pediatrics,” said Elizabeth Hawkins-Walsh, clinical associate professor and assistant dean for clinical affairs and community partnerships at Catholic University of America, Washington, D.C. “Most home health agencies are more comfortable providing care to adults and elderly. There may also be inadequate or no reimbursement for pediatric care.”

### THE MEDICAL HOME

The future of robust pediatric care depends on the medical home. That’s the conclusion of the American Academy of Pediatrics’ *Report of the Task Force on Vision of Pediatrics 2020*. The report stated, “Essential transformations are needed to thrive in 2020 and beyond, [including] pediatric primary care practices that are true medical home practices.”

According to the American Academy of Pediatrics, “a medical home is the model for 21st-century primary care, with the goal of addressing and integrating high-quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner.” The medical home model for delivering integrated care can be adopted by any practice.

“The move away from hospitalization has been going on for a long time,” said David Zipes, MD, director of pediatric hospitalist services at Peyton Manning Children’s Hospital at St. Vincent, Indianapolis. St. Vincent is part of the Ascension Health system. “Patients are discharged ear-

lier and receive more outpatient therapies. This is driven by cost and the fact that most patients would rather be at home.”

For 10 years, St. Joseph’s Children’s Hospital in Tampa, a ministry of the Franciscan Sisters of Alleghany, has operated a medical home for chronically ill children called the Chronic-Complex Clinic (CCC). It was established as an alternative to “bouncing children from emergency room to emergency room because general pediatricians were not comfortable treating them in their practices,” said Keri Eisenbeis, director of child advocacy and ambulatory care for St. Joseph’s.

The Chronic-Complex Clinic assembled a team of physicians and clinicians to treat a large number of children with a variety of conditions at a similar level of medical complexity. Over the past decade, they have demonstrated that comprehensive care coordination across multiple specialists, both in and out of the hospital, saves money and keeps the most medically fragile and expensive children healthier and happier. “Located steps from our hospital and ER, the CCC takes ownership of these kids’ treatments and facilitates the multiple services they need, including navigating Medicaid,” said Eisenbeis.

Home-based health care is a natural extension of the medical home model.

Children often are more comfortable recovering at home, where the environment is more conducive to healing and recovery. Caregivers also are able to provide some of the latest technologies on an outpatient basis today that weren’t available 10 or 15 years ago. “More complicated therapies that can be done at home include chronic ventilators, home oxygen and intravenous treatments,” said Zipes. “The advent of PICC [peripherally inserted central catheter] lines has been a big boost to home intravenous treatments, especially antibiotics.”

To take pediatric services deeper into the community, St. Joseph’s Children’s Hospital works with five area pediatric clinics to provide primary and specialized pediatric care on an outpatient basis.

“Hospitals need to work closely with their physicians to illustrate the importance of covering clinics and how that outreach benefits the com-

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munity and the mission of the children's hospital," said Eisenbeis. "Creating accessible, child-appropriate clinic experiences allows us to increase the number of children with better-managed health care and decrease the number of children with minor health concerns that can escalate into serious health problems."

St. Joseph's also sends out a mobile medical bus to provide services to hard-to-reach children in rural areas. Immunizations, developmental screenings and well child-type visits can quickly diagnose serious problems that might otherwise go undetected. "This outreach gives the mobile clinical staff the opportunity to review with families basic nutritional, sleeping and hygienic standards that are age-appropriate," said Eisenbeis.

School-based health care is actually one of the earliest versions of the medical home model.

Created about 20 years ago, there are now almost 2,000 school-based health centers operating in the U.S. Centers typically have a multidisciplinary team including a social worker, pediatric nurse practitioner, psychologist and community health worker who can make home visits, as well as a physician. "They are more likely to have easy access and knowledge of community resources available to families, such as obesity and healthy-living programs that are likely to be culturally sen-

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sitive," said Hawkins-Walsh.

The Montgomery County Department of Health and Human Services in Maryland, for example, operates eight school-based health centers. The centers provide a comprehensive range of services including health, mental health, social services and other services that promote positive youth development and support families and students. Parents sign written consents for their children to receive the full scope of services provided at the centers. On-site health services offer physicals, mediations, lab tests and guidance designed to support students in making the best choices and avoiding risky behaviors. Physicals help to keep children well by identifying and resolving potential health problems before they progress to conditions that are more serious.

"In this way, students remain healthy, and visits to the emergency room and hospitalizations are reduced," said Judith Covich, director of school

health services in Montgomery County. "Importantly, national data shows that adolescents — who have the lowest rate of receiving health care — have easy access to preventive and sick care right down the hall from their classroom, and then return to their class."

### **HEALTH CARE REFORM AND KIDS**

Health care reform shows promise for pediatric providers who welcome the incentives to provide prevention that is more robust and education services to their patients. Extended coverage for young adults is a key part of the legislation, especially for those still living with chronic childhood diseases.

"I'm excited about parts of the health reform bill for families and children," said Walsh. "There are many young families who have limited money or insurance, so they use ER services or urgent care instead. The health care law reduces or eliminates financial barriers and will go a long way toward promoting wellness and developing relationships with primary care physicians."

From a payment perspective, the Affordable Care Act provides the first-ever federal payment standard for Medicaid. From 2013-2014, pediatric primary care doctors will be reimbursed at the same rate as their adult-care counterparts for the same Medicare service. "Because of the gross disparity between Medicaid and Medicare payments, this is a huge and symbolic step in the direction of providing more fairness and parity between the respective

pediatric and adult-focused medical communities," said Eisenbeis.

### **CHALLENGES REMAIN**

There just aren't enough pediatricians — particularly specialists — to go around. Pediatricians and pediatric specialists typically earn less than other types of medical specialists. Meanwhile, chronically or seriously sick children today may suffer from more serious conditions than they did 10 or 15 years ago. According to Zipes, these cases include Methicillin-resistant *Staphylococcus aureus* (MRSA), a highly resistant bacterial infection; premature births; multiple drug-resistant organisms; and such complex medical issues as cardiac disease, genetic abnormalities, cystic fibrosis and cerebral palsy. Modern medicine has helped these children all live longer, and their care is frequently technology-dependent.

The vast majority of pediatric physicians are



generalists — the lack of pediatric surgeons, gastroenterologists, neurologists, endocrinologists, rheumatologists and other specialists is a major problem for pediatric providers. Not only are there not enough of them, the ones that exist are highly concentrated in the top children's hospitals. "There are a dozen states without a single pediatric rheumatologist, but top children's hospitals like Children's Hospital of Philadelphia and Boston Children's have about 10 each," said Hartwell.

This means that primary care pediatricians need to play a greater role in these specialty areas — including mental health, another hugely understaffed segment of pediatric care.

"A major cause of pediatric morbidity is the high number of children with unmet mental health care problems," said Hawkins-Walsh. "Nearly 20 percent of children and adolescents have a mental or behavioral health problem that is interfering with their functioning. Some estimates show that only about 25 percent of these children receive adequate care. Failing to meet the mental health care needs of children will likely lead to more serious problems as they grow."

The U.S. Surgeon General, among others, has called for primary care providers to step in and meet these needs. "Primary care providers have been referred to as 'de facto mental health providers' for this reason," said Hawkins-Walsh. "Both the scarcity of child and adolescent psychiatrists and the stigma often associated with going to a mental health specialist are two powerful reasons for primary care providers to become better trained in attending to many of the mental health concerns being seen in pediatrics."

A medical home model promotes a level of collaboration among caregivers of varying specialties that helps identify and treat under-evaluated conditions such as mental health. Shifting to a medical home model doesn't have to be complicated — the key is having the right balance of clinicians and caregivers for your team and empowering them to deliver patient care. "After all, someone has to coordinate and monitor progress outside the office, and you know that won't be the physician," said Hawkins-Walsh. "It's not cost-effective or a good use of their skills."

Coordination is a better role for a nurse, nurse practitioner or social worker. The person selected will likely be the team member who is best equipped to deal with a patient's key issue.

Doctors will become increasingly dependent on nurse practitioners for delivering efficient medical-home practices in the coming years. According to Hawkins-Walsh, studies have shown

that 90 percent of what primary care pediatricians do can also be done by nurse practitioners (mostly wellness and health management).

"In fact, there actually may not be a need for more pediatricians if the gaps can be filled by nurse practitioners and nurses," said Hawkins-Walsh. "In the near future, a model home system could consist of one physician and half-a-dozen nurse practitioners, with the doctor attending the more serious pediatric cases."

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Medical practices can also be certified as medical homes. Even though this is a costly process with lots of paperwork, being certified may reap insurance benefits from carriers.

"Insurance companies will be more likely to pay higher compensation to a practice that can demonstrate better-managed care," said Joseph Kahn, MD, chairman of the department of pediatrics at Mercy Children's Hospital in St. Louis. "Better outcomes in the pediatrician's office means insurance companies will have to pay less for duplication of care elsewhere in the system or unnecessary ER visits."

Hartwell indicated that, of all the trends and issues discussed above, the one that may affect Catholic providers the most is the pediatric specialty shortage. Pediatric specialists tend to want to be involved in both clinical care and academics and are attracted to freestanding children's hospitals (which tend to be highly academically oriented).

How can Catholic hospitals compete for these pediatrician specialists? One solution is to affiliate more with academic-oriented medical centers and freestanding hospitals and provide the real-life environments for transitional studies, which test in real hospital settings the results from scientific research and clinical studies — a critical step toward final acceptance of new devices and technologies.

"As more [National Institutes of Health] funding is shifted toward transitional studies, there will be good opportunities for Catholic organizations who want to participate in applying this research and strengthening their reputation among pediatric specialists," said Hartwell.

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