Managing Chronic Conditions in a 'Medical Home'

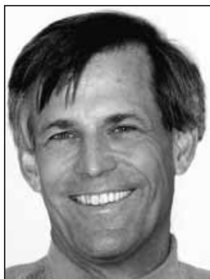
'[It's] not simply a program within a primary care practice ... for children with special health needs.'

BY HEIDI SPLETE
Senior Writer

A "medical home" for children means primary care as a combination of the place where care is provided, the process of care in that place, and the team of people delivering the care.

A medical home is not only about improving health and health care, but also about improving the experience of receiving and providing health care, said Dr. W. Carl Cooley, codirector of the Center for Medical Home Improvement in Greenfield, N.H.

"A medical home is not simply a program within a primary care practice, nor is it only for children with special health needs," Dr. Cooley said. Creating a medical home for children is about practice-wide improvement that depends on being open to change and committed to listening to families and working with them to improve care. That said, children with special health issues account for about 80% of pediatric health care costs.



Creating a medical home is about practice-wide improvement and being open to change.

DR. COOLEY

The model that has emerged in 21st century health care involves chronic condition management as the third leg of a primary care stool, along with preventive care and acute illness management, said Dr. Cooley. An efficient and effective process of chronic condition management in the general practice will benefit all patients in terms of office organization and quality of care.

The first step in providing chronic condition management in a medical home is to identify children with chronic conditions and special needs. If a practice creates a registry of these patients and flags their charts, their conditions are known each time the child comes in or a parent or caregiver calls. Some practices stratify patients by the severity and complexity of the child's condition. For example, on a scale of 1 to 4, 1 might be a child with mild asthma, and 4 might be a child with multiple system complications or home care services.

This type of structure ensures that children with chronic conditions are scheduled for separate visits to discuss specific issues related to chronic conditions. These visits create an opportunity to plan comanagement of the child with specialists and coordinate other aspects of care and services. The visits in the medical home might complement visits to a specialist and reinforce patient education and care strategies, Dr. Cooley said.

For example, a child with diabetes might visit a general practice regularly, alternating with visits to a diabetes clinic every 3 months. Data from the regular medical home visits could be forwarded to the specialty clinic.

In addition, a planned chronic condition management visit creates time for a nurse or nurse coordinator to update the medical history, which makes other preventive and acute visits more useful and productive.

These chronic care visits are among the easiest to bill, Dr. Cooley noted. The visit is a prolonged encounter with an established patient, and codes 99214 and 99215 are almost uniformly accepted as long as the documentation is consistent with this type of visit. "Many pediatricians underutilize the longer visit codes," he said.

Scheduling longer visits can be difficult in a busy practice accustomed to rapid patient flow. Dr. Cooley recommends gradually blocking out certain times, such as the first hour or two after lunch on certain days, for chronic care visits. "Start with two or three patients a month and enroll them in a chronic conditions management program," he suggested.

Grants are available to help general practices become more efficient as medical homes for children. Grantors include the Maternal and Child Health Bureau (MCHB) (www.mchb.hrsa.gov/grants/default.htm) and Community Access to Child Health (CATCH) grants from the American Academy of Pediatrics (www.ntlf.com/html/grants/122256.htm).

Dr. H. Garry Gardner and his colleagues received a CATCH grant in 2004 for their primary care pediatric practice. The CATCH grants are geared toward physicians who are interested in community pediatrics. Physicians develop proposals for how they might make their practices become more community oriented and serve as medical homes for patients.

An important part of Dr. Gardner's grant proposal was the inclusion of the cost of a facilitator from the Division of Specialized Care for Children (DSCC), which is administered by the University of Illinois at Chicago, to help organize a program of caring for children with special needs. DSCC is the Title V federally funded Illinois state program for children with special health needs and disabilities. Similar programs exist under other names in other states.

The definition 'chronic conditions' is for problems such as diabetes, cerebral palsy, and autism.

DR. GARDNER

"We learned through working with the facilitator that many of our patients qualified for Title V funding and they didn't know it," Dr. Gardner said. After receiving the grant, Dr. Gardner, a pediatrician in private practice in Darien, Ill., formed an office quality improvement team. He serves as the physician representative on behalf of the physicians in the practice. The office manager, a nurse, a receptionist, and two patients' mothers complete the team, which meets monthly to discuss ways to improve the quality of care in the office.

The team established a complexity score to define children with special needs. They opted not to designate all children with ADHD or asthma as having chronic conditions. Instead, they reserved this definition for more severe problems, including diabetes, cerebral palsy, and autism.

"We literally labeled the kids by putting a sticker on the front of the chart, and an identifier on the computer screen that comes up when the name is entered," he explained. "That identification process was important because it helped us know who the child was whenever the parent called with a question or to make an appointment," he added. Dr. Gardner's practice currently includes 90 children with chronic conditions for whom they serve as a medical home.

Another successful project was creating a telephone script for use by the receptionist when the parent of a special needs child calls. The receptionist has a specific set of questions to ask, such as whether the visit will take extra time, or whether the child prefers to wait in a quiet exam room rather than a crowded waiting room. The office manager of the practice serves as a "care coordinator," for these patients, and helps manage referral letters, letters of medical necessity, and insurance coverage, which removes some of the paperwork burden from the physicians.

Feedback from the parents on the quality improvement team in Dr. Gardner's practice led to the creation of two additional features.

First, the office has a picture guidebook available for nonverbal patients, which includes pictures of the front door, the waiting room, the different doctors, and the different pieces of equipment. Pictures in this format, also known as picture exchange cards, are often used by parents of nonverbal autistic children, and such pictures have been shown to reassure children who might be anxious about the office visit, Dr. Gardner explained.

Second, children with chronic conditions or special needs have a written care plan, condensed to both sides of a single sheet of paper, that lists all of the child's diagnoses, medications, recent hospitalizations, therapist visits—"everything that goes on with this child," Dr. Gardner said. "We put this page in the front of the chart, and parents have a copy that they can keep with them."

For more information about the medical home concept and ideas for incorporating its strategies into your practice, visit www.medicalhomeimprovement.org. ■

ABP President Reviews Pediatric Subspecialty Career Trends

BY DOUG BRUNK
San Diego Bureau

LAS VEGAS — A medical student approaches you for some advice. She is seeking a career choice in pediatrics and has been thinking about becoming a pediatric gastroenterologist, but she's heard rumors that interest in training in the pediatric subspecialties has declined.

What should you tell her?

"This young lady needs to understand that she can get a job," Dr. James Stockman III said at a meeting sponsored by the American Academy of Pediatrics' California Chapters 1, 2, 3, and 4 and the AAP. Factors that influence the work force, he said, include the supply of trainees, the number of international medical school graduates, the increasing number of women coming into pediatrics, the impact of managed care, the increasing number of children that need to be cared for, and the "delicate interface between what a generalist does and what a subspecialist does."

According to data from the American Board of Pediatrics, the bulk of pediatric subspecialists certified through January 2005 were in neonatal-perinatal medicine (4,136) followed by hematology/oncology (1,884) and cardiology (1,870).

"There are some subspecialties such as sports medicine where there are just a [few] people certified in the discipline," said Dr. Stockman, who is president of the ABP. "We tend to see what looks like large numbers of neonatal/perinatal people, but these numbers actually are not huge. In fact, if you added up [all pediatric subspecialists] in the United States they would equal about half the number of adult cardiologists. So there are relatively few pediatric subspecialists in the United States."

He noted that the percentage of pediatric residents going into subspecialties dropped to 18% by the late 1980s, largely as a result of the emphasis on gatekeeping in primary care. "Fortunately these numbers have turned around," Dr. Stockman said. For example, 664 residents chose a subspecialty fellowship in 1997-1998, compared with 1,121 in 2004-2005.

To ensure enough people are being trained in specific subspecialties, the ABP tracks their average age. "We look at the people who are currently in the field who are age 50 or older, add up those numbers and [infer that] in 10-15 years they're not likely to be seeing patients," he said.

Using pediatric gastroenterology as an example, he explained that almost half of diplomates in that subspecialty are aged 50 and older, "so this whole cohort needs to be replaced in the next 15 years," said Dr. Stockman, also of the pediatrics departments at the University of North Carolina and at Duke University. ■