There is no place like (the medical) home for children and youth. The medical home has historical context in pediatrics dating from the mid-1960s. Its evolution has had a profound influence on contemporary models of healthcare delivery. In the past few years, our adult primary care colleagues have endorsed medical home, and it has become a recognized standard for delivering primary care to children and adults. The notion of a medical home is not intended to signify that the medical establishment will assume primacy over the family’s domicile, nor does it imply that there should be a strong focus on the “bricks and mortar” that comprise institutions. Rather, it has become synonymous with being a process of care delivery in a primary care setting. A key aspect of the medical home, accessibility, was beautifully articulated by Robert Frost: “Home is the place where, when you have to go there, they have to take you in.”

One of us can recall in training that pediatricians routinely provided care for up to 60 patients per physician per day. This drove revenue into the practice. Some trainees, learners, and aspiring pediatric providers at that time struggled with how personally rewarding that pace of work would be. Would one have time to develop family-professional relationships based on true familiarity? Would one be able to ask how family members were doing, and be able to wait for — and listen to — the response? What about taking the time to understand a child, youth, and family’s cultural values and customs? What about school performance, developmental, behavioral, and mental health issues? What about food security?

Primary care providers (PCPs) were reimbursed for being available for “office visits.” For certain needs, face-to-face encounters are exactly what families tell us they want from their primary care pediatrician. However, that is not always the case. Research has shown that many activities encompassing care coordination in primary care have traditionally been provided outside of the examination room, and consequently, reimbursement for these services was non-existent. This presents a paradoxical business dilemma: non-reimbursable activities that support care coordination and improve the quality of care delivered enable families to avoid office visits. However, this ultimately prevents revenue flow into the practice. This is an unsustainable model. As some authors have stated, “Health care is a sacred mission. It is a moral enterprise and a scientific enterprise but not fundamentally a commercial one.” Yet healthcare providers find themselves in the quagmire of endeavoring to fulfill this mission.

Rigorous research efforts in the United States and internationally demonstrate that the quality of health outcomes and of cost-effectiveness are directly related to the proportion of healthcare resources dedicated to primary care. Why is the American system of healthcare not measuring up? As our authors demonstrate in this issue of Pediatric Annals, with a few exceptions, primary care in the United States is not generally configured to provide the services that families, payers, purchasers, and policymakers are demanding. Homer, Cooley, and Strickland trace the cause for the current deficiencies in the system and point out the necessary strategies to support transformation to the patient- and family-centered medical home. It is remarkable to note that the engagement of the purchaser community, as represented by the Patient-Centered Primary Care Collaborative, has been associated with a significant drive toward multilateral discussions on a national scale, which
addresses transformational change in the way care is delivered.

A core element of the medical home model is its family-centeredness. This is often provided through the family-professional partnership, empowering families and patients to self-manage their care and to advocate for their needs. This notion has a long tradition in pediatrics, but is just catching on more broadly in national discussions of health system re-design. In order to include families as partners, we must value and embrace their diversity and look at health and medical care from a strength-based perspective instead of the historical view of a deficit-based approach. Goode, Haywood, Wells, and Rhee present a powerful framework for designing systems of care that is integrally culturally competent and family-centered.

How do we transform systems that are missing key elements? In order to close the “quality chasm,” it is essential to create systems for delivering care coordination services. But what is care coordination, and how does it differ from case management? What about the roles of families, nurses, social workers, physicians, and others in providing care coordination? McAllister, Presler, Turchi, and Antonelli make the case that a family-centered, multidisciplinary approach to care coordination is critical. They present a framework, which includes competencies, functions, and outcomes for care coordination. In order for the medical home to be high performing, it requires links to community-based organizations that support the needs of families, children, and youth. The work does not have to be done by primary care providers alone, but by teams of which they are a part, and over which they have accountability in the medical home. The framework for care coordination must develop, nurture, and continuously improve the functionality of those relationships within the health care setting as well as across the broader community. In short, care coordination must develop organically from the community, building on assets and supporting needs broadly. The roles of federal, state, and community partners become apparent when the necessary linkages and expected outcomes are defined.

As we build the system of care, the medical home must serve as a hub for communications about the patient and family. Stille eloquently informs the discussion by demonstrating methods and tools that can be used to improve how information is transferred among families, primary care, and subspecialty providers. Transforming the way “consultations” are managed will be a critical driver of re-design. Utilizing care plans to delineate roles and responsibilities for families, PCPs, and subspecialists will introduce measurable accountability to the system. Developing mechanisms that define frameworks for different models of consultation will be essential. Will a referral be a one-time consult, with the subspecialist providing a focused opinion back to the PCP who will maintain primary responsibility for the care of the patient? Will the referral be structured as a comanagement model in which PCP, subspecialist, and family share explicitly delineated responsibilities? Will the subspecialist assume total responsibility for the care of the child, in essence, becoming the Medical home provider? And will the patient and family be participants in making the decision about which of these models will pertain? Will family-held care plans become universal tools that will document transactions and accountability throughout integrated care systems?

What about youth transitioning from pediatrics to adult systems of care? Transition is a process. It is not an event. The percent of youth with special healthcare needs who receive structured services preparing them for transition to adult systems of care continues to rise with advances in medicine, but also persists as the lowest performing measure with respect to children with special healthcare needs in Healthy People 2010. There are many reasons for this, but it is urgent that this population and their caregivers be properly prepared for the process of transition. White and Hackett make the compelling case and offer tools and strategies for enabling this as a core component of the medical home.

While we continue to encourage the implementation of the medical home model with the current workforce of practitioners, it is essential to fuel this fire in our learners and trainees. Incorporating medical home concepts into training programs for residents and
medical students ensures its sustained success, similar to the way that other standard practices such as developmental screening or immunizations are taught. Narayan describes the landscape for this educational platform and the current role of pediatricians actively working to build on existing residency competencies to ensure the future of the family-centered medical home for children and youth.

Business leaders often cite: “No margin, no mission!” How can we transform healthcare, optimizing value for all stakeholders, if the appropriate resources are not committed to the work? Wegner and Antonelli make the case that although there is no single, universally endorsed model for financing the medical home, we do know that the current scheme is untenable. They provide an overview of potential policy directions and offer some practical tips for the primary care pediatric provider. It is encouraging that policy and political discussions are all addressing the need for payment reform, with movement away from volume-based financing and toward paradigms, which reward outcomes and support accountability.

Pediatricians have always advocated first and foremost for the well-being of children and families. The national conversation on health system transformation has now firmly placed the family-centered medical home model as a critical element of the value proposition. Although the evidence is mounting that high-performing medical homes can play a key role in enhancing patient-centered outcomes, there is much more to be done. Just as Frost tells us an inspiring definition for “home,” he also reminds us of next steps for health system transformation: “The woods are lovely, dark and deep, But I have promises to keep, And miles to go before I sleep, And miles to go before I sleep.”

REFERENCES
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Dr. Antonelli has also published work defining mechanisms for integration and coordination of care across systems including the development of strategies and interventions to improve collaborative efforts between families, primary care providers, and subspecialists. He serves on the Steering Committee for Care Coordination at the National Quality Forum and as an advisor to the Patient-Centered Medical Home measurement tool work group at the National Committee for Quality Assurance (NCQA). In conjunction with researchers and policy representatives from internal medicine and family medicine, he represents the Academic Pediatrics Association in the current national initiative Establishing a Policy Relevant Research Agenda for the Patient-Centered Medical Home: A Multi-Disciplinary Approach. Most recently (May 2009), he co-authored Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework, supported by The Commonwealth Fund.

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