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Health Homes Policy Brief

Child-Centered Health Homes in California:

An Opportunity to Better Coordinate Care and Improve Outcomes for the State's Most Vulnerable Kids

February 2014

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Executive summary

Too many California children are failing to get the well-coordinated mix of health care services that they need to thrive. This represents a huge area of opportunity to improve outcomes for kids and the state as a whole, given healthy children and families are more productive.

Fortunately, a new twist on an old idea is poised to provide the better, more holistic care for kids and their families that's needed: health homes. A health home is a team-based model for delivering a comprehensive range of health care services in a personalized and coordinated manner, including medical, dental, and mental health, and support services.

While all children can benefit from the health home approach, the greatest returns health homes offer to individuals, families, communities and the state are expected to come from serving those with complex health and living conditions, such as children with special health care needs and foster youth.

Successful child-centered health home models already exist in California as does the statewide infrastructure that can be leveraged to serve these populations. However, the state has not yet taken advantage of opportunities, provided in part by the Affordable Care Act to support and expand access to health homes. Statewide efforts can take advantage of lessons learned from existing models in California and other states.

The opportunity to expand health homes is within reach

We're closer than ever before to ensuring that every child in California has affordable health insurance coverage but an insurance card alone does not guarantee quality health care or a healthy child. Often times, children with health coverage still lack access to high-quality health care. Their access may be limited because (1) care is not available where they live or at a time that works for their families, (2) it is not culturally or linguistically appropriate and/or (3) care may be incomplete, lacking the coordination needed for follow up with different providers. Without adequate access to health care, children are less likely to establish healthy developmental trajectories and more likely to acquire diseases and chronic conditions that can last a lifetime.

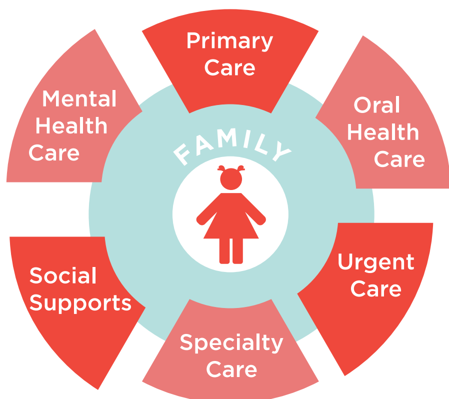
Well-coordinated, accessible health care is critical for whole-child development and well-being. Children with access to health care have generally better health throughout their childhood and into their teen years. They get preventive care to keep them well, can see a doctor when they are sick, and receive well-child care so they can attend school and participate in activities. Healthy students can more easily focus on school work and have a better chance at succeeding in life. Children's health care builds on itself over a lifetime; by providing high-quality preventive and early-onset disease management, we make an investment in a healthy future.

Moreover, the historic federal health care reform law, the Patient Protection and Affordable Care Act (ACA), and accompanying major state reforms in health care delivery provide significant opportunities to develop and expand the health homes model, which has been increasingly used as a vehicle to improve health care quality and control costs. Access to a health home can be one of the most effective methods to provide the high-quality health care and social supports that California's children need to thrive.

This brief defines the health home model and provides examples of existing child-centered health homes in California. It also covers the potential for child-centered health homes to improve health outcomes and care quality while, at the same time, lowering costs to the state , particularly when it comes to children with special health care needs and foster youth. Finally, an assessment of the opportunities provided by the ACA and other policies to create a child-centered health homes program is followed by a set of recommendations.

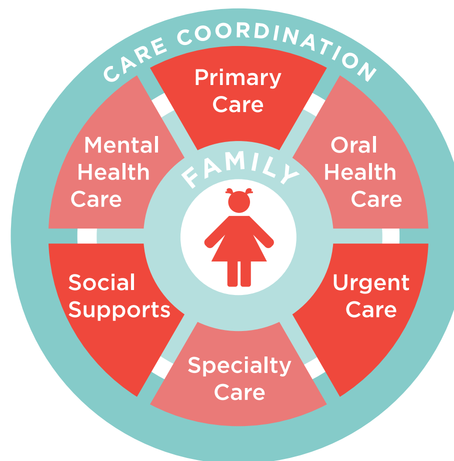
Without a Child-Centered Health Home

Families navigate a fragmented health care system where care by different providers is often uncoordinated and families are unsure where to turn for help.



With a Child-Centered Health Home

Families know where to go for their health care and an explicit emphasis on care coordination helps ensure that children receive all needed services in a timely fashion.



What exactly is a health home?

A health home is a team-based model for delivering a comprehensive range of health care services in a way that is personalized and coordinated across many areas including medical, dental, oral, and mental health, in addition to social support services. Even though it is called a "health home," it is not a physical location, but rather an approach to health care delivery. We define a child-centered health home to be a health home that focuses on children and their families.

The concept of a health home arose from the "medical home" concept, which the American Academy of Pediatrics developed to address the problem of duplicative records and gaps in services resulting from inadequate communication and care coordination, but has since been adapted to additionally be patient- and family-centered, accessible and compassionate. The health home approach expands on the medical home model by aiming to provide "whole person" care that focuses on prevention and follow-up services to minimize acute disease episodes, delivered in community settings, when possible, to maximize community connections and social supports while minimizing the disruption of routines (for more, see box on "Why health homes?")[1]

While there is no single accepted definition of a health home, the way it is defined in the Affordable Care Act (ACA) has important implications – discussed further below – for the growth of the model in California. The ACA definition is: "*…comprehensive and timely high-quality services… that are provided by a designated provider, a team of health care professionals operating with such a provider or a health team.*" [2] Services included in the ACA definition are:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- Patient and family support (including authorized representatives);
- Referral to community and social support services; and
- Use of health information technology to link services.[3]

Why health homes?

Due to a fragmented health care system, most Americans must navigate a complex web of health care providers and payers to get the care their children need. This fragmentation contributes to the inefficiency and high cost of our health care system, and also is a barrier for families to effectively coordinate their children's health care. The health home model, with its emphasis on care coordination and family empowerment, addresses these problems.

The design of health homes reflects how children actually live. Just as a child's life exists in the context of a family and community, so too does a child's health. Scientists have found that the conditions in which we live, learn, work and play have enormous health impacts before we ever seek medical attention.[5] Health homes can contribute to our seeing and addressing health issues in this broader context by focusing on education and prevention, the integration of mental and physical health, and the identification and provision of needed social supports. By adding a focus on how to improve factors outside the traditional health care system, the health home concept broadly benefits the health of the community.[6]

A health home team can include anyone who provides coordinated services and support, such as hospitals and health plans; physicians, nurse practitioners, social workers, community health workers and other health professionals; clinical practices, group practices, community clinics, community health centers and school-based health centers.

The child-centered health home model of care can include other "family friendly" components like enhanced and increased access to care providers through techniques including open scheduling, expanded hours and more communications options (e.g., email). In addition, health homes include families as health team members – often making them the center of the team. Family engagement, education and empowerment give families greater opportunities to participate in key decisions about the health care of their children.[4]

How children benefit from health homes

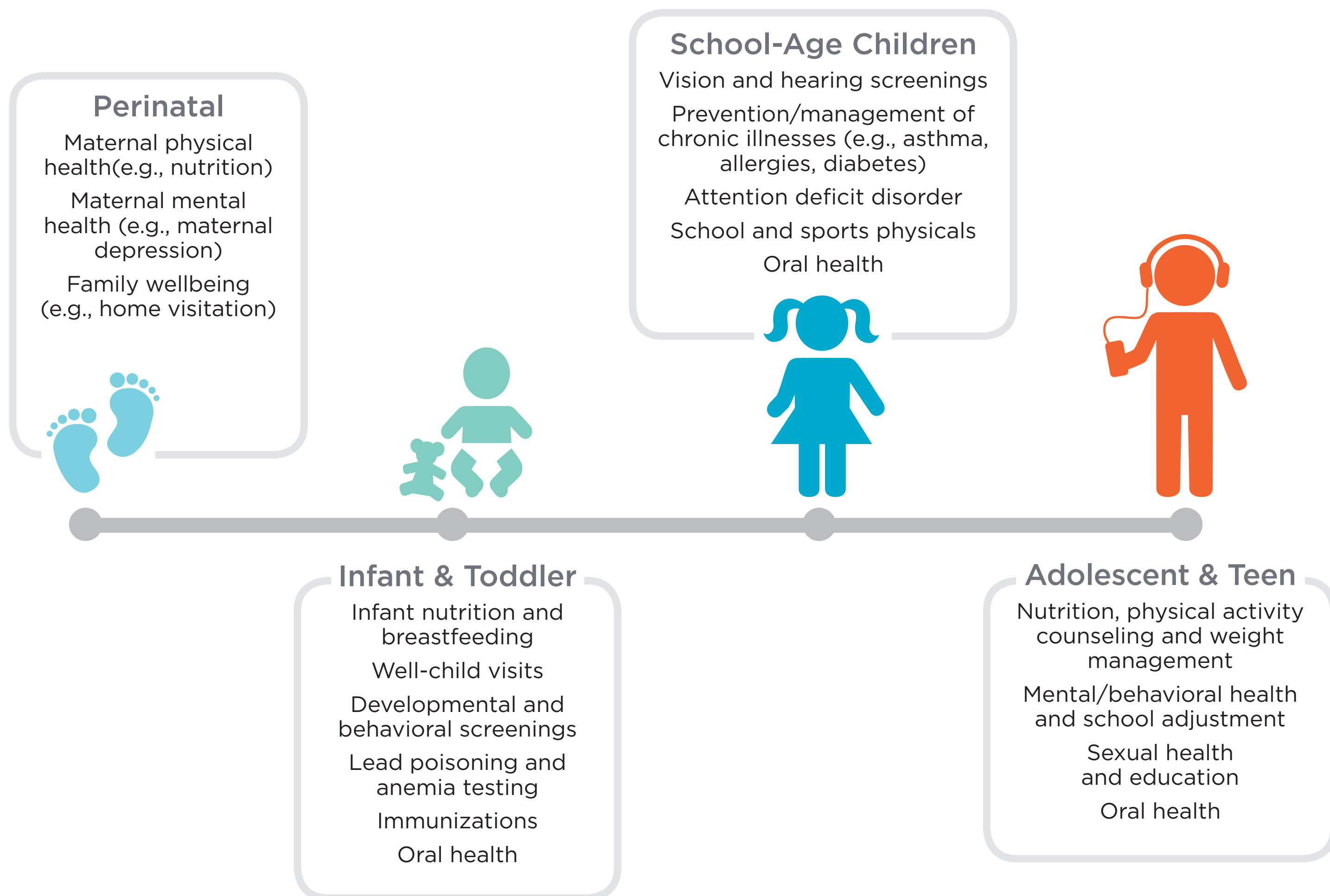
Health homes can offer improved quality of care compared to alternate models through stronger cross-provider coordination and information-sharing. This means that primary care doctors and specialists as well as other service

providers can coordinate and take a more holistic approach to care for an individual, more effectively addressing interrelated health and wellness needs comprehensively.

Additionally, by improving communication and coordination within the health care system, a health home can reduce the access to care hurdles many families face – a benefit that is especially valuable for families with children with special health care needs who are uniquely vulnerable to falling through the cracks. These families often need help accessing and integrating services from a complex system of providers, specialists, hospital and community services and supports, and a wide variety of disjointed programs.[7] According to a recent report from the Commonwealth Fund, "A child's health, ability to participate fully in school and capacity to lead a productive, healthy life depends on access to preventive and effective health care – starting well before birth and continuing throughout early childhood and adolescence"[8] (for more, see box on "Examples of benefits of health homes across a child's development").

While all populations can potentially benefit from receiving care in a health home,[9] the benefits of the model for vulnerable children and their families are paramount. This is due to the following reasons. First, any improved health outcomes and corresponding cost savings associated with inclusion in a health home will accrue over a longer period of time for a child than for an adult. Second, children are not independent and therefore stand to particularly benefit from the health home model's focus on caregiver supports and empowerment. Ample evidence indicates that child outcomes can be improved by attending to the capacity and needs of their caregivers.[10] Third, since children are developing, they have more complex and changing needs that need to be coordinated among primary care providers and specialists, and even across sectors. States such as Colorado and Rhode Island have recognized these benefits, are leveraging the opportunities of the health homes model to both improve the quality of children's health care and lower costs, and can serve as useful models for California (for more, see box on "Health homes in other states".)

Examples of benefits of health homes across a child's development



Health homes in other states

The Colorado Medical Home Initiative provides a compelling example of a program that aims to serve all children in a state. Currently, all health and medical practitioners serving children and youth enrolled in the state's Medicaid program and Children's Health Insurance Program are required to meet a set of standards that was developed by a broad coalition of agencies, families, hospitals, organizations, policymakers and other stakeholders and has been endorsed by the state through legislation as well as by state and national professional organizations such as the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).[11] Among other requirements, practices must provide care coordination, have 24/7 access to a provider or trained triage service, and have systems for families to obtain information and referrals about insurance, community resources, non-medical services, education and transition to adult providers in order to be eligible for extra pay-for-performance payments that are indexed to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) metrics. An evaluation of the program revealed a dramatically positive quality outcome: 72 percent of children in Colorado's medical home practices had had well-child visits, compared to 27 percent of children in control practices.[12] The Initiative has also proven to be cost effective: an evaluation of the program found a 21.5 percent reduction in median annual costs for children with a medical home ($785, compared to $1000 for non-medical home children) in 2009. The subpopulation of children with chronic conditions also showed cost savings, with lower median annual costs for children in medical homes ($2,275) than for those not enrolled ($3,404).[13]

Rhode Island also has created a statewide health homes program, using federal funds under the ACA to provide for its population of children with special health care needs. To do so, the state took advantage of an existing model of care delivery called Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation (CEDARR). At CEDARR centers, a variety of licensed clinicians coordinate children's care to ensure they are receiving appropriate, family-centered and community-based medical and support services, including the provision of an Initial Family Intake and Needs Determination and the development and regular review of a Family Care (or Treatment) Plan with specific child goals. Goals of the program include improved care coordination, decreased emergency department use and preventable admissions, and improved quality of transitions from inpatient/residential care to the community. Turning the CEDARR model into a health home model required adjustments to structures for communication and information sharing among service providers, and its success can prove instructive for other states facing similar hurdles.[14]

Particular sub-populations of children stand to benefit the most

Children with special health care needs

"Children with special health care needs" is a term used to describe individuals under age 18 who have chronic physical, developmental, behavioral and/or emotional conditions, and need health care and related services beyond those required by children generally. Examples of chronic conditions include asthma, attention deficit disorder, sickle cell disease, cleft palate or cerebral palsy. Approximately 1 million children in California – or 1 in 10 – have special health care needs.[15]

The need for a health homes program for this population is underscored by a series of recent reports by the Lucile Packard Foundation for Children's Health that examined how well California's health care system is serving children with special health care needs. These reports found that the state has considerable room for improvement. For example, nearly half of California children with special health care needs do not receive effective care coordination, ranking the state 46th in the nation on this measure. The state fares even worse in the percentage of these children that have problems getting needed referrals for specialty care: it ranks last among the states.[16]

A survey of the California Advocacy Network for Children with Special Health Care needs identified improving care coordination as the most pressing issue among members, with the top three barriers to improvement being California's fragmented health care system, inadequate communication among health care providers and inadequate payment for care coordination.[17] For these children who face serious health problems, a regular source of care like that

provided by a child-centered health home can dramatically improve treatment outcomes, mitigating the impact of chronic conditions. For example, the American Academy of Family Physicians (AAFP) has found that health homes particularly improve the management of chronic illnesses such as asthma, preventing episodes of acute illnesses and unnecessary ER visits.

In contrast, children without a regular source of professional, family-centered treatment and care coordination are less likely to receive high-quality asthma care and more likely to use inhaled bronchodilator medications rather than control medications, to be treated by general providers rather than asthma specialists and to have irregular medical follow-up.[18] Since research shows that asthma is the leading cause of school absences due to a chronic disease and accounts for three times more lost school days than any other cause – an estimated 1.9 million missed days of school in California in 2005 – health homes can potentially improve both health and educational outcomes.[19]

Foster youth

In 2012, over 55,000 children and youth under age 21 were in foster care in California.[20] These children have significant health care needs and poorer long-term outcomes compared to peers who have not been in foster care. Nearly 90 percent of young children entering the foster care system have physical health issues such as asthma, anemia, malnutrition and manifestations of abuse. More than half have two or more chronic conditions.[21]

Moreover, removal from the home and the preceding abuse and/or neglect are traumatic experiences that create toxic stress, which interferes with healthy brain development and emotional well-being. Examples of conditions that are linked to early trauma include heart disease, obesity, alcoholism and drug use.[22] For these reasons, the American Academy of Pediatrics (AAP) has defined children in foster care as children with special health care needs and recommended that they be provided with health homes.[23]

Foster care is an incredibly complex system and foster youth face unique barriers stemming from the diffusion of responsibility among multiple parties such as caseworkers, courts, agencies, foster caregivers and parents. In the context of health care provision, challenges include obtaining consent for health care, obtaining health information, coordinating care, sharing information across systems, obtaining timely referrals and health care workers needing to navigate the child welfare system.[24] For these children, the intensive case management, care coordination and social supports of a child-centered health home can be especially beneficial. Evidence suggests that enhanced care coordination in a health home model may increase access to services and decreased emergency room visits for foster youth.[25]

Examples of existing child-centered health homes in California

The following innovative and nationally-recognized programs highlight the diversity of health home models – in terms of services provided, populations served and geography – and how health homes are already positively impacting the lives of California's children and families.

Center for Youth Wellness, San Francisco[26]

Nadine Burke Harris, MD, FAAP, MPH, Founder and CEO: "The Center for Youth Wellness is a health organization embedded with a primary care pediatric home serving children and families in Bayview Hunters Point, San Francisco. We were created to respond to a new medical understanding of how early adversity harms the developing brains and bodies of children. This is not just an issue for kids in Bayview, but across the state and around the world. Our integrated pediatric care model allows us to screen every young person we see for adverse experiences that we know can lead to toxic stress and poor health outcomes in life. We heal children's brains and bodies, piloting the best treatments for toxic stress and sharing our findings nationally. We're seeing first-hand that this integrated approach—one that takes the whole child into account and addresses children's physical and neuro-developmental needs—is hugely beneficial to the children and families that we treat."

Pediatric Medical Home Program at Mattel Children's Hospital, University of California, Los Angeles[27]

Thomas Klitzner, MD, PhD, Director: "The Pediatric Medical Home Program at UCLA serves medically complex children and is designed to deliver care that is accessible, family-centered, continuous, comprehensive, coordinated, culturally sensitive and compassionate. Currently, the Program serves over 200 children. Many of the families are poor, come from minority or immigrant backgrounds, live in overcrowded apartments and have limited access to transportation. They often miss medical appointments and tend to use emergency rooms to get their care, when their children become too sick to wait to see a doctor. The program helps these children and their families manage care and cope more effectively, and has demonstrated significant reductions in emergency room utilization. The mother of a 12-year-old patient with a rare chromosomal abnormality says, 'The Medical Home Program offers hope and kindness to my son. It gives him hope to feel better and kindness to help him feel better. My son has very special needs, and now we have a wonderful doctor and a home for his care. They say it takes a village, and we say it takes a Medical Home! There is no place like home!!!'"

University of California, Davis' Pediatric Telemedicine Program, Sacramento[28]

James Marcin, MD, FAAP, MPH, Director: "UC Davis' pediatric telemedicine program was the first of its kind in the United States. We provide real-time remote specialty consultations and evaluations using video conference technology for children throughout California. UC Davis emergency medicine physicians, neonatologists, critical care specialists, geneticists, cardiologists, neurologists and others connect directly to remote hospital emergency departments, newborn nurseries, inpatient wards and outpatient clinics to provide care and consultation for infants, children and adolescents who experience traumatic injuries, life-threatening infectious diseases or other critical illnesses. By leveraging telemedicine technologies, the Program serves children who do not have access to specialty care and has thus positioned itself to be a critical member of pediatric health home teams across the state. Children are receiving their specialty consultations in their primary care providers office or their local hospital with all providers present, making it a true team approach. Ample research has demonstrated the benefits of the Program in terms of parent satisfaction of care, provider satisfaction of care, health outcomes, patient safety, and cost savings."

Family Outreach and Support Clinic, Children's Hospital Research Center, Oakland[29]

Peggy Pearson, MFT, Director: "The FOSC is a collaboration of the Primary Care Center and case managers from the Center for the Vulnerable Child of Children's Hospital Research Center Oakland, serving the San Francisco Bay area. Our mission of over 25 years has been to provide comprehensive and culturally sensitive medical care and case management to children in foster or kinship care, as well as to those in the adoption or reunification process. Many areas of need are addressed including sub-specialty care, dental care, developmental assessments, mental health and psychiatric care, foster parent continuing education and care giver support. The children range from infants to teens and the services have no time limit. The children are referred by foster parents, kinship care givers, child welfare workers, doctors and public health nurses. A similar model was created for homeless families in our community with the Encore Medical Clinic in 2006 at the same site."

California can benefit from child-centered health homes

Many policymakers, health care delivery organizations and advocates have embraced the "Triple Aim" health care goal of improving the individual experience of care, improving the health of populations and reducing the per capita costs of care to populations. This concept recognizes the need for "integrator" entities – individual organizations that recognize and respond to patients' individual needs and preferences, and link health care, public health and social service organizations.[30] Health homes fulfill these requirements and can thus significantly contribute to advancing the Triple Aim.

California is already benefiting from the aforementioned nationally-renowned programs that provide or contribute to creating child-centered health homes and have proven to be effective at advancing the Triple Aim. For example, a comprehensive study of the Pediatric Medical Home Program at Mattel Children's Hospital, UCLA, found a

55 percent reduction in Emergency Department (ED) utilization for children – a phenomenal result that reflects an improvement in care quality and a reduction in costly crisis intervention services.[31] Likewise, studies of the UC Davis Pediatric Telemedicine Program have demonstrated impressive improvements in care quality measures, clinical outcomes and cost savings,[32] including a significantly reduced risk of physician-related ED medication errors among seriously ill and injured children in rural EDs[33] (for more, see box on "Examples of existing child-centered health homes in California").

Furthermore, the current Administration has embraced the Triple Aim goal and health homes as a means of achieving it. In February 2013, the California Health and Human Services Agency was awarded a State Innovation Model (SIM) Design grant by the Center for Medicare and Medicaid Innovation (CMMI), to be used to develop a State Health Care Innovation Plan (SHCIP) to improve health care quality by changing payment structures. The SHCIP is intended to complement the goals of the Governor's Let's Get Healthy Task Force Report – which outlines a ten-year plan to improve the health of Californians while reducing health care costs – and form the basis for an application for a three-year State Innovation Model Testing award in 2014.[34] The SHCIP, which at the time of publication of this brief was in the form of a working draft, is organized into initiatives that center on care coordination and include a health homes initiative for complex patients. The vast majority of cost savings to the state are estimated to come from the health homes initiative, though only a fraction is presumably attributable to savings from serving children.[35] However, depending on how a health home model is crafted and the extent to which populations are served, there could be considerable cost savings, especially when looked at across sectors and over time.

How can California expand health homes for children?

Given the health benefits and potential cost savings resulting from the health homes approach to care, California should pursue all opportunities to support and expand health homes. One attractive option is to take advantage of the systems changes and opportunities associated with federal health care reform and considerable federal resources for states that wish to move forward with this model. However, California can also move ahead and develop its own health homes model using lessons learned within the state and elsewhere.[36]

Health homes in the Affordable Care Act

The ACA provides an unprecedented opportunity for California to expand the health homes model of care for Medicaid (known as Medi-Cal in California) enrollees with chronic conditions.[37] By pursuing this option, California could receive additional federal funds to test some of the innovative practices designed to improve access to high-quality care that children and their families need, while reducing costs needed to provide expensive and state-funded institutional and crisis-driven care. Specifically, to encourage states to explore this option, the law provides a 90 percent federal matching rate for two years so long as the funding is used to coordinate care service provided in conjunction with a health home.[38] Therefore, by choosing this option, California would only have to cover 10 percent of the costs during the start-up phase of a health homes program.

Through the ACA, the federal government established broad eligibility criteria, which allows states flexibility in the ultimate creation of their health home pilots. While the law is clear that states cannot develop a pilot that limits access to a health home by age or aid category, it allows states to make choices that would enable them to serve many of their most vulnerable children.

States are allowed to choose the type of population to apply the health home option to by selecting patients suffering from two chronic conditions, patients with one chronic condition who are at risk for another and/or patients with one serious and persistent mental health condition. States may also determine what chronic conditions the health home option should be applied to. Examples include mental health conditions, substance abuse disorders, asthma, diabetes, heart disease and being overweight.[39] Therefore, while the ACA precludes a health home option from being tailored just for children, the state could select chronic conditions that affect children, such as asthma, attention deficit disorder and pediatric diabetes, or certify as health home providers those whose licenses allow them to serve children.

While the state has been occupied with large deadline-driven systems changes associated with implementing federal health reform, it is expected to move forward in creating a health home pilot program in 2014. The recent passage of Assembly Bill 361 (Chapter 642, Statutes of 2013), authored by Senator Holly Mitchell, signals the desire of the California legislature and governor to take advantage of the ACA's health homes option.[40] The statute authorizes the California Department of Health Care Services (DHCS) to create a California Health Home Program and submit appropriate applications to the Centers for Medicare and Medicaid Services in order to draw down the available 90 percent federal matching dollars, specifies eligible health home providers and services, and requires DHCS to complete and report on an evaluation of the Health Home Program within two years after its implementation.

Expanding health homes for children with special health care needs

DHCS is assessing how best to explore the ACA's health homes option.[41] One option that was deemed by DHCS's consultants to be both feasible and cost effective is to create a health homes pilot program around the existing California Children's Services (CCS) program.[42] CCS is a state program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to over 150,000 children under 21 with certain diseases or health conditions whose parents are unable to afford these services.[43] CCS-eligible conditions include cerebral palsy, hemophilia, epilepsy, heart disease and chronic lung disease.[44]

Advantages of a health homes pilot program built around the CCS program include (1) the ability to treat children with special health care needs who would benefit the most from the integrated care provided by a health home, (2) an existing statewide infrastructure of CCS Special Care Centers that use multi-specialty teams to evaluate a patient's medical condition and develop a comprehensive, family-centered health care plan and (3) anticipated cost savings to the state General Fund. The ample benefits of pursing such a program were recognized by a recommendation to prioritize a CCS Special Care Center Health Home option over all other health homes options analyzed.[45]

Perhaps the most vulnerable children with special health care needs are high-risk infants from birth to three years of age who are experiencing developmental delays or have a diagnosed condition that has a high probability of resulting in developmental delays. In California, nearly 5,000 infants per year are served by the CCS High Risk Infant Follow Up (HRIF)[46] program. Under the program, each CCS-approved Neonatal Intensive Care Unit (NICU) is required to ensure the follow-up of discharged high-risk infants and either have an organized program to provide diagnostic services or a written agreement for provision of services by another CCS-approved NICU.[47] HRIF clinic teams often include collaborations of specialists such as neonatologists, nurse practitioners, pediatric development specialists, dieticians, occupation and physical therapists, and social workers.[48]

Not only are high-risk infants in particular need of care coordination to address their complex health requirements,[49] but (1) a large proportion of high-risk infants who would benefit from early intervention do not receive referrals,[50] (2) a statewide evaluation mechanism is already in place[51] and (3) since high-risk infants are particularly expensive patients,[52] improved prevention efforts would be expected to yield significant cost savings to the state General Fund.

Expanding health homes for foster youth

Just as a health homes program for children with special health care needs can be built around the existing CCS program, health homes for foster youth can leverage existing reform efforts and programs intended to provide and coordinate services for those in the child welfare system. Many existing reform efforts in California intend to change systems to better support foster youth without rotating them through programs and placements while maintaining cost effectiveness. Child-centered health homes are well suited to play a significant role in these efforts.

California's Continuum of Care Reform (CCR) is an ongoing effort to develop recommended revisions to California's current rate setting system, services and programs in order to ensure better outcomes for youth in the child welfare system and to reduce the reliance on group care.[53] CCR, along with other recent and ongoing reforms such as implementation of the Katie A. Settlement Agreement,[54] recognizes that many families in or at risk of entering the child welfare system face mental and behavioral health issues. One national study, for example, showed that while children in foster care represented only three percent of the Medicaid child population, they accounted for 29 percent of total behavioral health spending for children, and that behavioral health expenses for children in foster care were double those of physical health.[55]

Given that care for this population is relatively costly, health homes for foster youth have the potential to provide significant savings to the state. Furthermore, child-centered health homes can link families with substance abuse and mental illness challenges to needed services and supports – a critical feature since healthy child development depends on the availability of responsive and supportive relationships.[56] Another potential benefit of two-generational care is the facilitation of reunification through the coordinated provision of services and supports for children who are reunifying with their parents.

The goals of existing programs that are targets for expansion or reform often converge with those of the child-centered health home model and include a focus on addressing the high rates of behavioral health and service coordination challenges faced by this population. "Wraparound" is a planning process that focuses on providing children in the foster care system with alternatives to group home care by engaging the family to identify their needs and create methods to meet those needs. Funds that would otherwise go to group homes are used to pay for Wraparound services and supports that are intensive, individualized and community-based – the kind of supports and services that child-centered health homes also seek to provide.[57] An example of a service provided through Wraparound is Therapeutic Behavioral Services, one-on-one behavioral mental health services that are Medi-Cal reimbursable under EPSDT and are provided to foster youth with serious emotional challenges. As of February 2012, 47 of California's 58 counties have developed California Wraparound Services Programs and one is actively planning a program.[58]

Recommendations for a child-centered health homes program for California

With the recent passage of authorizing legislation, California is poised to create one or more statewide health home models that can help the state achieve the Triple Aim of improved health outcomes, care quality and cost savings. The following recommendations for a child-centered health homes program arise from an evaluation of the needs of California's children, the capacity of existing state infrastructure,[59] and the efficacy of health home models and related health care delivery reform efforts in other states.

Create a health homes program that includes children with special health care needs. The gaps in care coordination and other critical services for California's children with special health care needs are well documented[60] and a health homes program to serve this population could be designed around the CCS program, just as Rhode Island designed its health homes program around its existing CEDARR program.[61] Among children with special health care needs, medically fragile infants deserve special attention because of their particularly complex and costly health care needs and the well-suited existing state infrastructure of the HRIF program and the California Prenatal Quality Care Collaborative.

Create a health homes program that includes current and former foster youth. Given the complex physical and behavioral health challenges and care coordination needs typically faced by this population, a statewide health homes program should include foster youth and former foster youth at least up to age 26, at which age they are no longer categorically eligible for Medi-Cal coverage. Agencies should collaborate to support more coordination across the child welfare, mental health, juvenile justice and education systems; facilitate the use of blended funding streams; and leverage existing programs such as Wraparound. Coordinated two-generation services can help address persistent substance abuse and mental health challenges that are barriers to healthy child development. Given the high incidence of adverse childhood experiences,[62] all child-centered health homes should provide trauma-informed care.

Develop a provider education and support system as a critical component to the successful development of a health home program. Focusing training and resources of the developing care teams; recruiting parent partners;[63] creating comprehensive patient registries; collaborating with local, community-based organizations; and connecting with relevant statewide efforts and practices will help ensure that providers have the skills, tools and supports necessary to transition from a traditional health delivery system to a true health home.

Support families in their care coordination, in accordance with recommendations made by the AAP for the provision of care for children with special health care needs.[64] This support could come in the form of an initial care coordination needs assessment to determine immediate needs, followed by families being offered tools to coordinate

their child's care in conjunction with the health home team.[65] Home visiting programs that provide supports for new and expectant parents have ample, well-demonstrated benefits that far outweigh the costs.[66] Another valuable support could be provided by the development of a parent/peer navigator model, in which trained parent consultants assist families in accessing community resources, assist physicians and families in accessing specialty services, and help identify barriers to coordinated care.[67]

Close the feedback loop on care coordination to ensure that, at a minimum, when primary care provider (PCP) referrals are made to community service providers, these providers follow up with the child's PCPs to provide feedback and PCPs ensure that these interactions are documented to close the feedback loop in a timely fashion. For example, the results of developmental screenings used to identify children at risk for developmental disorders should be used for referrals to Early Intervention (EI) providers, and EI services provided should be tracked by PCPs. Based on experiences in other states, California would benefit from developing or promoting mechanisms to track closed feedback loops.[68]

Craft payment policies to leverage funding sources and provide desired incentives. To create health homes programs that deliver on their promise to improve health care quality and health outcomes, incentives must be designed to (1) reward more capable and better performing child-centered health homes; (2) enable the delivery of appropriate services to children facing health challenges of varying severity; and (3) foster collaboration among primary care, specialty care and other service providers.[69] To create health homes that are cost-effective for the state, blended funding policies should be designed and the state should offer assistance to enable health homes to make the best use of available funding streams. For example, health homes for foster youth may employ health and social services funds, while school-based health centers could use health and education funds. Payers should be encouraged to create financial incentives for providers to employ cost-effective services such as telehealth, which can help children in under-served communities.

Incorporate a rigorous program evaluation to ensure that the state adequately measures the benefits of a health home program and fosters a culture of evidence-based continuous improvement.[70] A child-centered health home should be evaluated against California- and child-specific standards that are developed by health care providers, state agency staff, advocates and other stakeholders,[71] and that take into account expert recommendations on quality measures.[72] An evaluation would demonstrate program impact and value to the public and decision makers who influence fiscal resources and engage in long-term planning to transform our health care delivery system. An evaluation is also critical for identifying areas where changes such as additional support and training are needed to maximize positive health outcomes, care quality and cost savings.

Conclusion

We know that remedial medical care alone is insufficient to ensure good health; children need preventive care, follow up after illnesses, screenings and access to broader support services. Child-centered health homes can provide children – especially those with special health care needs and those in foster care – with access to effective, child-centered, holistic treatment and health care. While California has been a leader in implementing federal health reform, it has fallen behind in leveraging the health home model to improve health outcomes and care quality for children and families while reducing health care costs. California policymakers must capitalize on current and future opportunities to make significant progress toward the vision of every child in the state having a health home that provides the comprehensive and integrated health care they need needed to grow, learn and thrive.

Footnotes

1 Though the terms "medical homes" or "patient-centered medical home" might seem new to some, the concept actually originated in the 1960's by the American Academy of Pediatrics (AAP) and is experiencing a great resurgence of interest given its strong evidence base of improving care coordination and increasing patient satisfaction. Since the AAP's promotion of the concept, several organizations including the World Health Organization and the Institute of Medicine have endorsed this model of care. In 2010, the Centers for Medicare and Medicaid Services (CMS) issued a state Medicaid Director Letter to bring the "medical home" concept into the Affordable Care Act and rebrand it as "health homes." CMS states that they expect "health homes to build on the expertise and experience of medical home models and when appropriate, to deliver health home services. In this brief, the health home model is considered to be broader and thus encompass the medical home model. In some cases, e.g. when discussing AAP recommendations, the terms are used interchangeably.

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