

Special Articles

Primary Health Care in the USA: The Medical Home Concept

CCJ SIA

Abstract

The health needs of children must be addressed in the context of the family and community. Primary care pediatricians should recognize the general needs of children and the risk factors that are early predictors of "rotten outcomes" of adolescence. A paradigm shift is indicated towards prevention and early intervention. An integrated system of care based on health, education, and family support is essential in each community to foster optimal growth and development of the child. The Medical Home concept has been promoted for primary health care in the USA. This offers accessible, family centered, community based, coordinated, comprehensive, continuous, culturally effective, and compassionate care. The American Academy of Pediatrics supports "every child deserves a medical home" and "one pediatrician can make a difference in his/her community."

Key words

Delivery of Health Care; Pediatrics; Primary Health Care

Our American Academy of Pediatrics was founded in June 1930 by 35 pediatricians, based on the idea that children have special developmental and health care needs and are not simply "miniature adults". Our membership has grown to 57,000 Fellows with the majority in primary health care. Preventive health practices such as immunizations and regular health examinations assume an integral part of primary pediatric health care. These practices support our Academy's commitment to attain optimal physical, mental, and social health for all infants, children, adolescents, and young adults.

A Task Force to study the Future of Pediatric Education was first established in the late '70s. This consisted of ten major pediatric organizations, including the American Academy of Pediatrics, whose purpose was to review pediatric education based on what is best for children. In

their Report in 1978, they noted that the general needs of children were:

- To be valued by parents and by society
- To be born well
- Optimal growth and development
- To learn skills necessary for success
- A nurturing environment
- Health assessment, maintenance and anticipatory guidance
- Health education for self-care
- To share in advances made possible by biomedical and biosocial research

Child Health problems were noted to be closely associated with poverty, deteriorating physical environment, changing family structures and other social and psychological factors.

In 1988 Lisbeth Schorr, in her book *Within Our Reach: Breaking the Cycle of Disadvantage*, wrote about the "rotten outcomes" of adolescence: school age childbearing, school dropout, inadequate employment skills, increased criminal activity, and long-term welfare dependency. Yet, Schorr points out that these "rotten outcomes" or risk factors are

School of Medicine, University of Hawaii, 656 Paikau Street,
Honolulu, HI 96816-4406, USA

CCJ SIA MD, FAAP

Correspondence to: Prof CCJ SIA

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preventable. Early identifiable predictors are: growing up in a family with an income under the poverty line, having untreated childhood health problems, being born unwanted or to a teen mother, lacking an early trusting relationship with a caring protective adult, being born at low birth weight, and lacking adequate language, reasoning, and coping skills at school entry. In other words, if we reach these children early, we can help make a change in their distressing course of their lives. There is sufficient scientific evidence that early problems are related to later problems. Our role as primary health care pediatricians is to assist in "breaking the vicious cycle of rotten outcomes" during infancy and toddler and early childhood years. The relationship of unplanned adolescent pregnancy, poor prenatal care, low birth weight, child abuse and neglect, lack of nurturing, and other such factors will often lead towards injuries and hospitalizations, developmental lags, lack of school readiness, school failure, school dropout, lack of job skills, unemployment, substance abuse, and crime and vandalism.

In 1978-79 in Hawaii, I gathered a group of pediatric leaders from the University of Hawaii School of Medicine, Hawaii Chapter American Academy of Pediatrics, Hawaii State Medical Association, state Department of Health, and practicing pediatricians to develop a Child Health Plan. In studying needs assessment and available child health programs in our state, a fundamental need was that every child deserved a "medical home" that focused on the *whole child* and began in early childhood. We concluded that there was a need to design an *integrated system of services* that focused upon the well being of the child, within the context of the *family*. A "medical home" would provide primary health care services, which would be comprehensive in addressing the needs of the whole child. Top priority in developing this system would be in early childhood, due to the extremely rapid physical, emotional, cognitive and social growth rate of the first several years of life. The young child is most vulnerable and has special needs, which, if not met, can result in less than optimal development or permanent damage. Prevention and early intervention programs were emphasized, and families should be at the center of service delivery systems that are designed to serve them. The ultimate goal is to empower families at the center of the system and help them through the linkage of the "medical home" to navigate the system of family support, health, and educational services. The multiple and pervasive nature of risk factors, challenging today's families require *comprehensive solutions and integrated programs*.

Partnership and collaboration with families and community agencies, public and private, were essential. The "medical home" could not do it alone.

As all Child Health Plans are written, implementation was slow. However, in 1984, an incremental start was initiated with Hawaii's Healthy Start, a home visitors program for at risk families for child abuse and neglect based on Dr. Henry Kempe's Denver, Colorado program. Lay home visitors, supervised by professionals, offered follow-up family support services for the at-risk infant identified following birth. This Hawaii Healthy Start pilot project was expanded throughout the state for at-risk families. And in the '90s the model was replicated in our nation as Healthy Families America. The program goals were to identify all families of at risk infant from target areas, provide home-based supportive services, promote positive family functioning, promote healthy child development, ensures safety at home from child abuse and neglect, and link to "medical home" and other community resources.

To ensure safety at home from non-violent injuries, an Emergency Medical Services for Children bill was introduced in Congress through our initiative to develop a system of care from the "medical home": injury prevention to stabilization, transport, and upgrading the emergency departments, intensive care, and rehabilitation services in a sequence of management for children. Primary care pediatricians, or the "medical home", with the child and family, became the axle of the wheel around which emergency medicine revolves. The primary care provider interprets all services and provides for a continuum of care.

Having established a family support home visiting program for at-risk children for child abuse and neglect and emergency medical services for children system, in 1986 we initiated a physician involvement-training program through a grant from our federal Maternal Child Health Bureau to help train our primary care pediatricians on the challenges of change for children with special health care needs. We noted that physicians are traditionally disease-deficit oriented, have problems working with difficult families, received low reimbursement for the time spent with these at-risk children, and had few training opportunities to adapt to the new patterns of health care. Our six-hour course emphasized preventive health care, collaborating with family support and other related services for children with special needs. We successfully increased reimbursement from our state Medicaid/EPSDT program for service delivery to the poor and at-risk children.

The "medical home" concept embodies family centered care, the recognition that family is the child's source of strength. It supports parents as the experts of their own children that care for the child is a shared responsibility or partnership between the pediatrician and family, and that coordinated care means *facilitation* of community-related services for the child. Thus, the "medical home", child, and family relate to Medical Specialists, educational services including early intervention, mental health services, financial assistance, parent support services, and religious/spiritual support. In 1992, our Academy defined the "medical home" in a policy statement. A medical home is care that is accessible, family centered, comprehensive, continuous, coordinated, culturally effective and compassionate. A recent revised Academy policy statement has expanded the description of this medical home definition, published in July 2002 *Pediatrics*.

In 1987, early intervention services from a federal Educational Act, Part H of PL 99-457, created Hawaii Early Intervention Coordinating Council with Individualized Family Support Plan (IFSP) for Children with special health care needs and resources with computerized tracking. This became a state law to cover early intervention services for developmentally delayed, biologic at-risk and environmentally at-risk infants, toddlers and children from birth to three, called our Zero to Three program. This helped broaden our developing integrated system of care to include health services, family support and special educational services to children with special needs.

By 1989, National Educational Goals were articulated with the first goal being "all children will be healthy and ready to learn". From early intervention program based on family centered, community-based, coordinated care for children with special health care needs, inclusiveness of all children was promoted. By 1994, Carnegie Corporation of New York published "*Starting Points: Meeting the Needs of our Youngest Children*". Experts from family support, health, and early childhood education recognized that a "Quiet Crisis" was occurring from birth through three years of age in United States and recommended the following broad action points:

- Promote responsible parenthood
- Guarantee quality child care choices
- Ensure good health and protection from violent and non-violent injuries
- Mobilize communities to support young children and their families

Carnegie Corporation of New York proceeded to give grants in 1995 to over 10 states and 5 cities to implement these principal action points over a four-year period.

These sequences of historical changes in care for children has reflected a challenge for pediatricians to reexamine training of pediatricians and the role of primary health care in United States. Primary care pediatricians reported that there was a noticeable decline of infectious diseases through effective childhood immunizations programs, and an increase in children with special health care needs and chronic diseases. Allergy and asthma, and psychosocial, behavioral, and mental health problems were increasing challenges in the office practice. Hospitalization days were shortened and the majority of care was being performed on an ambulatory basis. Thus, a second Task Force for the Future of Pediatric Education (FOPE II) was established by all the major pediatric organizations in 1997 to re-evaluate pediatric education, manpower, and the future role of pediatricians. Two relevant recommendations FOPE II made for pediatric generalists of the future workgroup was that "*all children should receive primary care services through a consistent Medical Home, and that pediatric medical education at all levels must be based on the health needs of children in the context of the family and community*".

Access to child health care or "every child deserves a medical home" has become a top priority for our American Academy of Pediatrics. It is strongly promoted by our CATCH (Community Access to Child Health Care) program. For the uninsured and underserved, there has been strong interest in enlarging the scope of "Community Pediatrics", recognizing the importance of the *environment and the communities* relating directly or indirectly to the health and welfare of our children. Community pediatricians have become advocates for children and the medical home and are forming strong partnerships with families and other providers. "Community pediatrics is a recognition that family, educational, social, cultural, spiritual, economic, environmental, and political forces act favorably and unfavorably, but always significantly, on the health and functioning of children." Under the Anne E. Dyson Foundation Initiatives, ten major University pediatric residency program in the United States are training pediatric residents in community pediatrics.

The US Department of Health and Human Services *Healthy People 2010* goals and objectives state that "all children with special health care needs will receive regular on going comprehensive care within a medical home. This

has also been reiterated in the New Freedom Initiative - Delivering on the Promise - a report to President Bush on March 25, 2002 recommending HRSA's Maternal and Child Health Bureau take the lead in developing and implementing a plan to achieve appropriate community-based services systems for children and youth with special health care needs. Development and dissemination of models of the medical home is recommended.

Primary health care pediatricians in the United States are facing the challenges of change in delivering pediatric health care in their offices or clinics. By adopting the Medical Home concept, collaborating and developing partnership with families and Communities, they can enhance the quality of life for children in the coming decade!

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