

The Enhanced Medical Home for Medically Underserved Children

The Children's Health Fund (CHF) strongly advocates for a medical home for all children, and especially for those who are medically underserved. Medically underserved children have many of the same needs of children with special health care needs (CSHCN). Both have a higher than typical rate of chronic conditions; higher than typical rates of mental health and developmental problems; and often require a range of specialty care from other providers and systems. For example, the asthma rate among New York City homeless children is 31%, more than triple the typical rate for children. Developmental and psychiatric problems far exceed typical rates as does the rate of referral for specialty care -- one patient in four. Care provided in the medical home model that is continuous, comprehensive and coordinated is essential for these children.

The Medical Home Model

The "medical home" model was first proposed by the American Academy of Pediatrics in the 1960's as the standard of care for CSHCN. These children have chronic medical conditions associated with developmental and possibly behavioral, or emotional problems. They need a level of health care and related services that often exceeds that which is typical for other children. The medical home model was proposed as a way to ensure continuity of care throughout childhood and adolescence, and coordination of care from multiple providers and systems.

There are seven key characteristics of the medical home: The medical home model encompasses health care that is 1) accessible; 2) continuous; 3) comprehensive; 4) family-centered; 5) coordinated; 6) compassionate; and 7) culturally effective.

The Enhanced Medical Home

The "enhanced" medical home model takes this standard a step further. In the enhanced medical home, pediatric primary care providers have an expanded scope of practice to include evidence-based protocols for chronic disease management (e.g., for asthma), and on-site access to services that are necessary and often difficult to access, like nutrition interventions, oral health and mental health services, and assistance receiving care from other pediatric specialists when needed.

Why an "Enhanced" Medical Home model?

An estimated 8 million U.S. children go a full year without health insurance; however, nearly 20 million children do not have adequate access to care when we add those children with part-year or limited insurance coverage and those who lack transportation to get to health care sites. Many of these children live in "health professional shortage areas" or "HPSAs" where there are not enough available health providers, and the distance from home to a doctor may be ten miles or more.

The high level of need for pediatric mental health services was demonstrated in the Surgeon General's Mental Health report which found that one in five children show

TABLE ONE: Key environmental determinants of a child being medically underserved and in need of care in an enhanced medical home model

Economic	Geographic	Psychosocial
Family income <200% FPL	Low density rural county residence	Vulnerable population
No or inadequate insurance	High poverty inner city residence	DV, maternal depression
	Residence in a Health Professional Shortage Area (HPSA)	Limited English language proficiency
	Limited /no public transportation	Low health literacy
	Lack of safety net providers including CHCs, MMU and SBHC	Living in an area affected by a disaster

Key
FPL= federal poverty level
HPSA=federally designated health professional shortage area

MMU=mobile medical unit
SBHC=school-based health center
DV=domestic violence
CHC=Community Health Center



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ENHANCED MEDICAL HOME

signs of a diagnosed psychiatric disorder during a year. While poor, minority and rural children have the worst access to mental health care, the problem is more widespread. Federal data show that nearly 80% of children and adolescents (6-17 years old) who need mental health care do not receive it each year. The states with the highest rates of unmet need for child mental health services are California, Florida and Texas.

Medicaid is the principal insurer for poor children, and its low reimbursement rate discourages the participation of dentists. While as few as 15% of dentists accepted Medicaid under the fee-for-service reimbursement system (and not all accepted pediatric patients), now still fewer accept Medicaid as lower managed care reimbursement rates have become the norm.

In rural communities, transportation problems also contribute significantly to poor oral health care access for children. For example, about half of Mississippi's counties are designated oral health HPSAs, with the fewest dentists available in the rural Delta region.

Poor access to pediatric dental care is not exclusively a rural problem. An Illinois study found that the limited supply of dentists who accept Medicaid leads to similar barriers for rural children as for children in urban centers like Chicago. Unmet dental need is highest for children under five years old, especially if poor and on Medicaid. Young children have the highest rates of tooth decay and dental pain but the lowest rate of oral health care visits.

Recommendations

For these reasons CHF advocates for an enhanced medical home model which is responsive to the full range of health care needs affecting medically underserved and other poor and low-income children.

CHF supports measures to institutionalize the enhanced medical home model for all children and encourages Congress to consider pay for performance measures to increase Medicaid reimbursement for health providers whose practice meets enhanced medical home model standards as part of larger health care reform.

CHF also recommends start up funds for integration of health information technology in provider practices located in HPSAs to improve quality and coordination of care, and financial support of innovative efforts to improve access to pediatric specialty appointments.

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