

## **Medical/Dental Homes and Networks of Care for Children under Medicaid**

Eight out-of-state speakers and three panels of Texans discussed the health of children eligible for Medicaid, under the Frew Settlement, for a standing room audience at The University of Texas J. Jake Pickle Research Campus in Austin on November 26-27, 2007. There was a general consensus among the statements of the participants and the surveys returned at the conclusion of the meeting, that the Frew Settlement offered a critically important opportunity to address the health needs of children for the future. There was general agreement that successful programs would require well-planned integration of services, provide primary care dentists and physicians, working closely with nurses, psychologists, psychiatrists, pediatric and dental specialists, schools, teachers, patients and families. In addition, there was consensus that it was critical to start health care early to have a positive long-term impact on disease prevention.

Several speakers reiterated that, in spite of Frew Settlement increases in reimbursement rates for dentists and physicians, these providers were “stretched thin” by the demands upon their time and that reimbursement rates continue to be inadequate. Also, some of the rules and regulations associated with Medicaid were challenging to incorporate into the practice setting and were deterrents from participation. There was in general agreement on several points:

- Improved health would depend upon systems of care which have the following attributes:
  - Accessible
  - Evidence-based family/patient focused
  - Equitable with well-defined standards of practice.
  - Measurable outcomes and managed through relevant and timely access to data.
  - Comprehensive

- Care should be organized so that it is consistent whether a child is “in or out of a particular system”, i.e. whether covered by Medicaid or some other system of care.
- Success would depend on methods for consultations, and close collaborations between primary care and subspecialty providers including telephone and telehealth consultations.
- Reimbursement for time spent on such consultations (including telephone consultation) would be an essential feature of a successful program.
- Electronic tools, including a registry of children, electronic health records, standardized risk assessment, methods for drug utilization, monitoring and the use of office “tablets” were among the tools required.
- Services should be co-located in so far as possible. This includes dental, medical, social, psychological, and related-services which are integral components of the “health care home”.
- Successful outcomes will depend upon partnerships between physician and non-physician providers, including care-coordinators. The DART Model of psychologists between mental health referrals and the role of dental hygienists or other oral health care providers were specifically described.
- Systems of care should include regional networks with methods to enhance coordination, collaboration and personal interaction between primary care providers, specialists, community school, academic health centers, business and health plan leaders.
- These regional networks of care would need to be carefully monitored for high quality and equitable care throughout the state.
- Outcome assessment and performance measurements are important to determine if we are making a difference and by how much.
- A population health paradigm should be considered in which the important roles of patient databases, and patients and families related to groups of providers in multiple disciplines was noted.

- Networks of care require bi-directional communications between primary care providers and specialists and viscera versa. This includes an important role for academic health centers in the networks.
- A long term vision for innovation would be required. Dr. Neal Halfon described this as a move from 2.0 to 3.0 in analogy to computer software packages.
- A medical/dental home and a care coordinator are particularly critical for children with chronic illnesses, with a special emphasis for co-location of needed services.
- Some well crafted periodic screening tools in the field of mental health could be very effective in identifying children at risk and in need of intervention (e.g. for ADHD, depression, anxiety).
- Some specific recommendations included:
  - An institute for learning which would provide opportunities for continuing education of primary care providers in dealing with mental health, dental and other complex problems and a mentor system for primary providers.
  - A regional or statewide obesity treatment center.
  - A focus on maternal-child health was needed to be successful.
  - A combined Department of Education Medicaid health program based in public schools.
  - An easily accessible telephone or web-based consultation resource that is well-informed about ancillary services available in Texas for care/management of children with complex medical problems.
  - Incorporation of standards of care for certain medical conditions (e.g. for asthma) already developed for networks elsewhere.
  - The initial training of health care providers needs to be better integrated among the various schools for a more seamless transition into practice and the community. Grants for innovative teaching and training approaches among health care providers should be made available to address this issue.

- The role of requests for proposals with specified characteristics emphasizing systems of care networks and integrated programs. (The attached figure prepared by Dr. George Lister captures this concept graphically.)

# Texas Comprehensive Network of Pediatric Medical, Mental Health, and Dental Care

