Patient-Centered Medical Home-Kids (PCMH-Kids): A Conversation with Anchor Pediatrics

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In the following Q&A, pediatrician **JUDITH B. WESTRICK, MD,** a member of Anchor Pediatrics, a group of six pediatricians, one of whom is also a pediatric cardiologist, and four nurse practitioners, describes the group's experiences with PCMH-Kids.

The Lincoln, RI, practice is part of the multispecialty Anchor Medical Associates, which grew from the former Harvard Pilgrim staff model HMO beginning in the year 2000. It is associated with two groups of internists in Providence and Lincoln and a medicine and pediatrics group in Warwick.

1. Why did your group decide to join PCMH-Kids?

Anchor Pediatrics was a National Committee for Quality Assurance (NCQA)-recognized medical home prior to joining the initiative. We joined PCMH-Kids to implement quality improvement (QI) methods to improve patient and family-centered care. In addition, the financial support that we received has enabled us to finance and hire staff to facilitate the QI efforts within our practice.

2. What were the biggest challenges and successes?

The biggest challenge was implementing developmental screening. Most of the other practices participating in PCMH-Kids began using Survey of Wellbeing of Young Children (SWYC) available through Chadis.com and their online questionnaires for the purpose of screening the development of young patients during their well childcare visits. This did not work in our office.

We tried to use tablets provided by PCMH-Kids for children's caregivers to use to complete surveys with little success. They never seemed to be able to complete the surveys properly or promptly. Frequently, passwords were forgotten, toddlers tried to take the tablets away from caregivers to play with them, and young children's need for supervision all impeded timely completion of surveys. Only rarely did caregivers complete the surveys before our visits, and even then the caregiver commonly completed the wrong survey for the child's age.

Working with our QI team, we tried using a different, paper-based validated screen. We now consider developmental screening as a big success of the project since we have switched to the Parents' Evaluation of Developmental Status (PEDS) and continued doing the Modified Checklist for Autism in Toddlers (MCHAT) screens. The caregivers of our patients have been much more successful and efficient at completing paper survey screening tools. The two screens complement each other as the MCHAT asks very specific questions and the PEDS screen asks open-ended questions. The answers to the MCHAT are useful for screening for developmental disorders such as autism and that facilitates our developmental evaluation enormously. The PEDS is useful both for the straightforward answers, e.g., "I am concerned my child is not able to talk as well as he/she should" and also encourages and asks for other concerns from caregivers, e.g., "I am concerned about how my child will react when he/she learns Daddy is moving out" or "I am concerned we will need assistance to pay our rent or electric bill". Certainly, both kinds of responses are extremely helpful when trying to understand how a particular patient and family are doing.

3. How has your practice changed?

Through the PCMH-Kids project we have implemented multiple screenings in our office. This process is largely accomplished by the medical assistant (MA), who presents the questionnaire to the patient or caregiver and then enters the results into our EMR. In so doing, the MAs in our office have been asked to assume much more clinical responsibility and they have done so with attentiveness and compassion for our patients. They are responsible for finding ways to give teens and infant caregivers privacy to complete the CRAFFT substance use screen and the EPDS postpartum depression screen. Since this transition, the MAs in the office are more likely to comment on changes they notice in patient or family attitudes. The help of our MAs was consistent before PCMH-Kids, but as their clinical roles have changed, the MAs are even more involved and helpful.

Also, the availability of a nurse case manager (NCM) in the office has been extremely helpful. Having a clinically trained person who is not busy seeing patients but available to follow up on and guide families of patients with special needs is invaluable. The NCM in our office can check in with families of medically fragile patients and ensure they understand and are able to accomplish and access needed care for their children. She has become the point person for families to communicate with when trouble arises, and who ensures families have the follow-ups, supplies, and support they need.

4. What did you learn from other practices?

It has been extremely helpful to meet as a PCMH-Kids group to discuss how to implement the changes required of our practices. While we all agreed from the start that teens need privacy to complete substance use screenings in an accurate and helpful way, in practice this can be a serious challenge. Initially, our office wanted to screen all teens for substance use. After one of these sessions, we realized that we were more likely to be successful if we started with a smaller group. We chose 16–18 year-olds and developed a specific protocol for them.

Alternatively, when we started screening caregivers for postpartum depression, we realized that we wanted to screen all caregivers, not just biological mothers. Discussion within the group was enormously helpful in deciding how to proceed. We were particularly concerned to include all caregivers, as the incidence of depression is high in many caregivers – including fathers, adoptive and foster parents.

The sessions where we discussed how each office had implemented strategies for accomplishing these tasks were very helpful in the implementation of the project.

5. Has your office used integrated behavioral health and how has that been?

Behavioral health for pediatric patients in Rhode Island remains a very serious challenge. Despite the increased number of pediatric psychiatric beds in Rhode Island, they are almost always full. There is significant overflow of children with psychiatric diagnoses almost all the time to the medical beds at Hasbro Children's Hospital.

At the same time, it is getting harder and harder to find behavioral healthcare for pediatric patients who do not require inpatient level of care. Waitlists are often long and even when a suitable provider of behavioral healthcare can be found, the out- of-pocket costs for families can be prohibitive. In this situation, most pediatricians, including those of us at Anchor Pediatrics, are providing more mental health care to our patients.

Pedi-prn is a program that provides us with a way to speak with a child psychiatrist at a scheduled time later in the day. While this has been very helpful for crisis or co-management of conditions, we still lack the access to counseling resources, in-person psychiatry resources and family supports that our families need.

At Anchor, we have not yet been able to incorporate a behavioral health provider directly into our practice, although we feel this would be of great benefit to our patients. We have tried some other strategies with only modest success. We did come to an agreement with a behavioral health group located about a block from our office, which was very convenient for all. When we mentioned the various types of patients we wanted to refer they agreed wholeheartedly. Shortly thereafter they closed the office near us and moved. With less availability the wait times have increased and our patients are having some difficulty getting to their other offices which are farther away.

For short time, we had the help of a CEDARR (Comprehensive Evaluation Diagnosis Referral and Reevaluation) worker from Rhode Island Parent Information Network (RIPIN) in our office. While not a clinician, she was very helpful in locating behavioral health resources for patents and families. She was able to help patients and families connect with services more quickly and even arranged transportation when possible. As of this writing, RIPIN has a seasoned CEDARR worker who is scheduled to start in our office soon. In addition, Bradley Hospital has announced a training program for pediatric providers interested in learning more about providing more mental health services to our patients. At present they allow one provider per practice to be trained; two of our providers have asked to be included.

We plan to try to network with the practices in PCMH-Kids who have integrated behavioral health and learn how they are financing their behavioral health support.