

**PEDIATRIC SUBSPECIALTY EXPERT WORK GROUP  
MEETING SUMMARY  
FEBRUARY 15-16, 2006**

**Background**

The Federal Expert Work Group on Pediatric Subspecialty Capacity, established in 2004 by the Maternal and Child Health Bureau and comprised of leaders affiliated with federal and state government agencies, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Board of Pediatrics, Association of American Medical Colleges, Child Health Corporation of America, Family Voices, National Association of Children's Hospitals, Shriner's Hospitals, and various academic and health policy institutes, met for the third time in February 2006. The Work Group's mission is to develop strategies to improve access to pediatric subspecialty care within a comprehensive, community-based medical home. The Maternal and Child Health Policy Research Center is providing staff support to the Work Group.

**Introduction**

Merle McPherson, formerly of MCHB and now with the Office of Disability at the Department of Health and Human Services, welcomed back the group, which last met in November 2004. She apologized for the funding delay and assured the group that funding has been secured for the group to meet once more this year and twice in 2007. She outlined the work group's 4 objectives for the meeting: 1) to review the plan for developing a commentary article defining pediatric subspecialty problems; 2) to review the draft report on promising practices for improving the interface between primary and specialty care; 3) to learn about North Carolina's statewide initiative to improve access to pediatric subspecialty care; and 4) to consider promising practices in the areas of financing, continuing education and training, and state/regional delivery systems.

**Commentary**

Harriette Fox led the discussion on the commentary article. The group began by considering the most appropriate venue for publication. *Pediatrics* and *Health Affairs* were both considered but ultimately not chosen because of a recently published pediatric subspecialty workforce article in *Pediatrics* by Ethan Jewett and others in November 2005 and because of concerns that the topic of pediatric subspecialty capacity would likely be perceived as too narrow for the *Health Affairs* readership. There was consensus the *JAMA* would be an excellent venue for publication because of its large and diverse readership and because its articles are often picked up by local and national media outlets. There was also a suggestion for having a series of *JAMA* articles on this subject, writing a piece for the *Wall Street Journal*, and producing a special supplement to *Pediatrics*.

The Work Group noted that the commentary must be framed to address broader health policy issues. Several suggestions were made – e.g., looming shortages of adult specialists to care for children, medical home/chronic care model cannot be accomplished without access to specialists, quality/value/efficiency/cost issues, transition to adult services, and national specialty physician workforce crisis. Caution was raised, however, that we not lose focus on children and

the medical home, articulating our vision of a community system of services for children that is organized in ways for families to access them easily.

The group made several suggestions for defining the access problem, its causes, and consequences:

- Clearly articulate the magnitude of the problem, noting the increasing prevalence and severity of children with disabling conditions.
- Highlight changes in demand for services (diabetes, LBW) and the very small number of pediatric subspecialists (e.g., neurosurgeons).
- When discussing inadequate reimbursement, focus on the consequences for children not just for the subspecialist (e.g., the endocrinology clinic cannot support a dietician). Include GME financing as a factor (e.g., inadequate funding has caused psychiatry programs to close).
- Include market competition as a cause; too many health systems in an area make it impossible for any one to have enough pediatric subspecialists.
- Explain the consequences of the pediatric subspecialty shortage in terms of costs, lost productivity, and increased mortality and morbidity (e.g. double the rate of mortality for children treated in adult trauma centers).
- Eliminate discussion of gender differences in practice patterns.

The Work Group recommended that the commentary include bold policy directions. There was an acknowledgement that although the group has not yet articulated its strategic plan, we can nonetheless begin to suggest far-reaching strategies for improving subspecialty capacity and primary care interface.

### **Promising Approaches Report**

Peggy McManus led the discussion on the draft report, *Promising Approaches for Strengthening the Interface between Primary and Specialty Pediatric Care*. The report identifies promising practices that represent a continuum of collaboration -- 4 deal with referral, 3 with consultation, and 3 with collaborative management. These have been selected from more than 100 examples that were submitted. Innovative examples were solicited through various AAP, Title V, and Family Voices listservs.

The Expert Work Group concurred that the report examples are great. The following suggestions were made for strengthening the document and for continuing to identify other promising interface approaches.

- Clarify that consultation is a component of the pre-appointment management of referrals.
- Distinguish first-time referrals from ongoing referrals (in referral management and shared management examples).
- Emphasize the appropriateness of referrals not only from the subspecialist's standpoint, but also from the PCP's and family's standpoints.
- Note the burden on families when sufficient information is not transmitted between PCPs and pediatric subspecialists.
- Continue to identify more real-life strategies for PCPs about effective ways they use to get their patients into a pediatric subspecialist in a timely manner.
- Add an example of pediatric subspecialty consultation in the PCP's office.

- Examine AAP's NCE meeting last year to identify examples of collaboration between primary and mental health care -- Connecting for Children's Sake: Integrating Physical and Mental Health Care in the Medical Home.
- Gather more information about Kaiser's and Group Health's (Seattle) referral patterns and methods for managing referrals.

Other issues were raised about the importance of electronic medical records and telemedicine. Also discussed was the potential for developing referral templates.

The Work Group made several suggestions for dissemination, noting that practice managers are a more appropriate target than practicing physicians. Several groups were identified.

- Association of Administrators in Academic Pediatrics
- Medical Group Management Association
- Child Health Corporation of America and NACHRI
- AAP's Section on Practice and Ambulatory Management (includes listserv of 135 office managers)
- AAP's Council on Sections
- National Initiative on Children's Healthcare Quality
- State Title V Programs/ Association of Maternal and Child Health Programs
- Practice managers

### **Financial Incentives: Identifying Promising Practices**

Peggy McManus, Don Lighter, and Lise Youngblade were the discussants on financial incentives. Peggy reviewed financing strategies related to coding and pay for performance programs. With respect to coding, the AAP's coding expert, Linda Walsh, sent correspondence about potential coding opportunities for referral, consultation, and shared management from 5 of our promising interface practices. Her review revealed the challenges inherent in relying exclusively on CPT codes for reimbursing these innovative practices. Also reviewed was a broad set of codes pertinent to consultation, referral, and shared management. The Work Group noted that almost all private and public insurers fail to recognize codes pertaining to communication, coordination, multidisciplinary care, and education.

Pay-for-performance (P4P) initiatives were also reviewed, focusing in particular on the Bridges to Excellence (BTE) program. This multi-state, multi-employer coalition rewards quality through bonuses for practices (mostly primary care practices) in compliance with selected NCQA HEDIS measures. BTE's 3 key program areas are on diabetes care, cardiac care, and office practices. Of particular relevance to the Work Group is their Physician Office Link program. Physician practices are rewarded with up to \$50/year per eligible patient or up to \$20,000 per physician per year or \$50,000 over the life of the BTE initiative if they have in place specific systems for access and communication (practices can score up to 8 points), patient tracking and registry functions (up to 20 points), care management (up to 20 points), patient self management (up to 6 points), electronic prescribing (up to 11 points), test tracking (up to 12 points), referral tracking (7 points), performance reporting and improvement (up to 12 points), and interoperability (up to 4 points).

Don Lighter, of Shriner's Hospitals, noted that the NCQA's measures for the Physician Office Link are all process measures. One significant issue will be auditing compliance. The Work Group noted that it does not appear at this time that the P4P initiative has been widely introduced into pediatric care.

Lise Youngblade, from the University of Florida's Institute for Child Health Policy (IHP), discussed their MCHB-funded TeleHealth Connections project. Florida's Title V Program for Children with Special Needs made over a \$2 million commitment in infrastructure -- for telemedicine equipment and training. They are not, however, reimbursing telemedicine services. IHP is working with Florida's Medicaid program to encourage them to reimburse for these services, noting the savings that can be accrued in transportation and emergency room costs. With the exception of a few states, Title V Programs are not funding telemedicine infrastructure; they might, however, support some equipment or training modules. Lise also reviewed the results of a 50-state Medicaid survey on reimbursement policies. Half of states (24) currently reimburse for telemedicine services, with 4 more planning to in the future. The most common reimbursable services are medical and behavioral health diagnostic consultations or treatment. Don Lighter noted that all of the 28 Shriner's Hospitals use telemedicine. In most states, they have found that BCBS, but not Medicaid, will reimburse for telemedicine services. Russ Chesney also noted the use of telemedicine in the MCHB-funded LEND program.

The Work Group made the following suggestions.

- Continue to explore the potential of P4P. Also examine Tennessee's P4P plan for children in state custody and also Texas' StarPlus Program.
- Explore state Title V investments in capacity building activities related to pediatric subspecialty access and medical home collaboration.
- Identify examples of insurers' recognizing a broad set of codes. (Check with AAP's Private Sector Advocacy Committee and Dr. Hirsch of Arizona),
- Examine NACHRI's asthma project.

### **State and Regional Delivery System Networks: North Carolina**

Steve Wegner, president and medical director of AccessCare, Allen Stiles, chair of UNC's Department of Pediatrics and the physician-in-chief of NC Children's Hospital, and Olson Huff, senior fellow of NC's Child Advocacy Institute, presented on their statewide efforts to improve access to pediatric subspecialty care in NC's Medicaid program. This initiative was selected as a model because it has brought multiple partners together to address pediatric subspecialty access problems, including Medicaid, academic medical centers, private funders, and medical home providers. Its goals are to improve 1) the ability of medical homes to care for children with complex conditions, 2) communication between the medical homes and specialists, 3) education of families, and 4) financial incentives to facilitate access and collaboration.

North Carolina is a state with a long history of cooperation between Medicaid, physicians, and safety net programs. The state has no HMOs and developed its delivery system around an enhanced primary care case management (PCCM) model where every Medicaid patient has a medical home and every physician receives a case management fee (\$2.50/month) and is reimbursed at fees that are about 95% of Medicare rates. North Carolina's enhanced PCCM model uses a combination of critical components -- local control and physician leadership, disease management initiatives, quality improvement programs, case management support,

utilization feedback to providers, fiscal incentives, and shared state/local responsibility for education and support. Thirteen enhanced PCCM networks operate throughout North Carolina. Unlike other PCCM networks in the state, AccessCare is a physician-owned, not-for-profit managed care organization that consists predominantly of large pediatric practices. It includes over 250 primary care practices with more than 1,000 physicians and serves almost 200,000 Medicaid enrollees, most of whom are children.

Access to pediatric subspecialty care in North Carolina is fragmented, with each of the 6 tertiary centers missing at least one and sometimes as many as 7 subspecialties. Only 2 centers have the full complement of both medical subspecialties, but no center has the full complement of medical and surgical specialties. Likewise, there are long wait times for appointments – as much as 45 weeks for rheumatology, for example. In addition to these access difficulties, there has been a disconnect between the state’s tertiary care centers and medical home providers. Over time, North Carolina’s tertiary care centers have been taking on more of a role in managing the care of children with complex conditions with less referral back to medical home providers.

Various partners -- the chairs of teaching programs in all 6 medical centers, the president of AccessCare, AAP chapter officials, state Medicaid officials, and funders from the Duke Endowment and the North Carolina Foundation for Health Care Improvement have come together in response to these problems and developed a strategy using a case management (CM) program and financial incentives. “Super” CMs will be placed in the tertiary medical centers and all will devote a portion of his/her time to diabetes and one or more other conditions which will be selected by each center. Specific aspects of the “super” CM program are as follows: 1) performing and coordinating the initial assessment and ongoing reassessment of the patients status; 2) documenting patient case information into a dedicated CM database; 3) performing chart reviews and audits monthly or as needed; 4) participating in monthly case conferences for each patient by providing information pertinent to patient’s needs and goals; 5) partnering with program directors to develop and review each patient’s individualized coordination of care plan; 6) ensuring patients medical needs are addressed, including consulting with the patient’s PCP, coordinating the care plans, and advocating for the family; 7) promoting understanding of medical factors affecting diabetes; 8) assisting families in accessing public programs and other community resources; 9) participating in quality assurance and utilization review activities; 10) fostering intra- and inter-facility communication; 11) acting as a liaison between PCP, specialists, and families; 12) following the guidelines for the nurse CM program; 13) participating in outreach; and 14) recommending service changes to fill the gaps.

Financial incentives are being designed to support consultation between pediatric subspecialists and PCPs. The program will be tested initially among infectious disease specialists. Telephone and e-mail consults will be reimbursed based on 15-minute increments. AccessCare will track information on diagnosis, content of call, and results.

Although Medicaid children are the primary focus of this statewide initiative, SCHIP children under 5 have recently been enrolled in Medicaid. In the future, they plan to work with state employees. In response to the question about involving private insurers, while interested, they noted that private insurers have typically invested in their own CM systems. However, “if you put dye into the water, it is going to spread.”

The Expert Work Group commended the North Carolina group for their important efforts and made the following comments and suggestions.

- Consider ways to strengthen the involvement of families in the project.

- Consider ways to incorporate behavioral health.
- Continue involvement in the state's Title V CSHCN program.
- Disseminate information about North Carolina's experience to other states, the federal Center for Medicare and Medicaid Services, and policymakers.

### **Continuing Education and Training**

The next meeting of the Expert Work Group will devote more time to the topic of continuing education and training, considering additional promising practices. The group heard 2 presentations -- from Laura Kavanagh of MCHB's Training Branch and Jim Stockman of the American Board of Pediatrics.

Laura Kavanagh presented information on MCHB's training program, which has a budget of \$38 million. She described 2 specific examples of promising programs -- Collaborative Office Rounds (COR) and Leadership Education in Neurodevelopmental and Related Disabilities (LEND). The COR project provides \$15,000 a year to each of 12 pediatric practices (in California, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, Ohio, South Carolina, Virginia and Washington) to bring together community pediatricians, child and adolescent psychiatrists, developmental-behavioral pediatricians, and pediatric and social work trainees to address the mental health aspects of pediatric practice. The providers meet once a month to discuss a particular case or hear a presentation on an important issue. Although the program is time-intensive, it has resulted in practice pattern changes and the development of stronger relationships between psychiatrists and community pediatricians.

LEND is a multidisciplinary training program involving up to 14 disciplines, including administration, audiology, dentistry, genetics, health, nursing, nutrition, occupational therapy, pediatrics, physical therapy, psychology, social work, special education, and speech-language pathology. Families are also included both as paid faculty and trainees designed to improve the health of children with neurodevelopmental disabilities. There are 37 programs nationally. Each consists of about 300 hours of didactic training and a required leadership and research project. Short-term training and distance education are also available.

The Work Group commented on the need for more LEND programs in states located in the middle of the country. However, because of the requirement to have a variety of disciplines involved as faculty, states that do not have medical schools generally cannot participate in the LEND program. Another issue that was raised is the importance of preparing health professionals for community-based settings.

Jim Stockman, President of the American Board of Pediatrics, discussed a variety of continuing education and training models relating to the interface between generalists and specialists. He noted that educating physicians about effective practices for collaboration between generalists and subspecialists is a complex issue. Similarly trained doctors sometimes have a 10-fold difference in referral patterns. Explaining this variation has to deal with not only knowledge of subspecialty disorders, but also the care system, societal and parental expectations, and reimbursement roadblocks. Several education and training models were reviewed.

- Traditional continuing medical education (CME) is rarely an effective model. The CME Accreditation Council has said that the lecture model is passé.

- Interactive or contextual CME (e.g., case protocols) are more effective, such as those used by Kaiser and Group Health, allowing doctors in a practice to learn from one another and compare practice styles using a shared database.
- Mini-fellowships for practitioners involving only targeted clinical training without the requirement for scholarly activity are limited. These fellowships are not popular because of difficulties in leaving practices, families, and getting coverage.
- Interactive programs between subspecialists and generalists (e.g., LEND, COR, North Carolina model) that include subspecialists working, teaching, and seeing patients in a generalist group practice are important. These approaches are more systems-based.
- Programs at the resident level are being considered to provide greater depth around the top diagnoses referred by generalists to subspecialists.
- Residency redesign efforts are examining tailored training of residents in the circumstances of the future environments in which they anticipate practicing (e.g., in a rural areas).
- Using Maintenance of Certification, major educational themes of importance to the pediatric community can be synchronized to deal with specific issues of relevance. ABP and the AAP could focus on a particular topic, such as mental health or access to care, for 2 to 3 years and have specific requirements for recertification on this topic.

The Work Group noted the significance of considering education along a continuum from medical school to residency to practice. Of particular interest to this group were models that influence practice and system changes. Also noted was the significance of addressing family demand for specialty care.

### Next Steps

The Work Group made several recommendations for next steps, including strategies for working within their own organizations. There was a general consensus that at the next meeting we should go through a strategic planning process to develop a common vision, goals, plan of action, and communication strategy. Other suggestions were as follows.

#### Defining the Problem

- Articulate 2 problems -- small numbers of pediatric subspecialists and the primary/specialty interface problem.
- Seek family stories and make sure that the family piece is central, building systems around where children live.
- Discuss different epidemiology of children's chronic conditions from that of adults. Also, discuss subsets of children with special needs.
- Consider differences in subspecialty needs and implications for PCPs in rural versus urban areas.
- Gather more information on surgical specialties, noting major changes in practice patterns.
- Discuss the negative impact that competition often has in creating comprehensive systems of pediatric subspecialty care.
- Solicit more input from subspecialty groups about common and unique issues and concerns.
- Work with ABP on fact sheets.

### Addressing Demand/Referrals

- Gather more information on existing PCP referral practices, identifying the most common conditions and reasons for inappropriate referrals. Note: North Carolina is planning to conduct a study on referral patterns to provide a baseline for their CM initiative. Also, examine Kaiser's efforts aimed at managing referrals.
- Obtain more information on families' referral patterns and decisions to seek specialty care. Also, it is critical to consider what role families can play in collaboration and communication between the medical home and pediatric subspecialists.
- Incorporate education on referral practices as part of the Maintenance of Certification Programs and AAP's education programs.

### Other Strategies

- Examine what is working and what is not; where there is evidence of change, and develop recommendations for where new information and analyses are needed. Consider examples of trauma and surgery, where regionalization and triage are more common. Also, examples of Web portals that both primary and specialty doctors and families have access to (e.g., Cincinnati Children's Hospital liver transplant program).
- Payment strategies are central to achieving access and interface improvements.
- MCHB to consider ways to work with 7 leadership states to strengthen the interface between medical homes and pediatric subspecialists. Also, MCHB to consider emerging education models to improve their continuing education and distance education programs.
- Consider another session at the Pediatric Academic Societies meeting and also at the AAP's NCE.
- Develop better intra-group communication mechanisms and have more frequent contact and discussion.
- Disseminate information about North Carolina's statewide efforts.