HEALTHIER KIDS, HEALTHIER CONNECTICUT

A vision for redesigning pediatric primary care

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Child Health and Development Institute of Connecticut, Inc.

The health of **Connecticut** adults is troubling. Nearly two-thirds are overweight or obese.[1] One in 10 Connecticut adults has diabetes,[2] and nearly one in three has hypertension.[3] Connecticut's per-person health care costs are more than 20 percent higher than the national average.[4]

Many of the chronic conditions that burden Connecticut residents have their roots in childhood. This presents an opportunity: **The best way to ensure that adults are healthy is by starting early and keeping children healthy**.

Yet even among children in Connecticut, there are significant inequities and challenges. Among them:

Children of color have worse health outcomes than their white counterparts – disparities that begin early and compound through life. Black infants, for example, are more than **four times** as likely as white infants to die before age one.[5]

Many families – regardless of race or socioeconomic status – struggle to find the right services if their children need behavioral health care, developmental services, or other supports. While many of these services exist, they function within **fragmented systems** that even experts can struggle to navigate.[6]

These are symptoms of a health care system that is not ensuring children are best positioned to reach their full potential. The stakes for addressing the challenges of that system are enormous: The opportunities or barriers children face early in their development play key roles in their lifelong health, educational attainment, and economic prosperity.

Children and families face a wide range of challenges, but many experts now recognize that the way the health care system functions is itself a roadblock to assuring that all children have the best possible start in life and stay healthy through adulthood.

This brief recommends redesigning child health services to allow pediatric primary care providers to play a broader role in the health and well-being of children and families in ways the current system makes virtually impossible.

In a newly envisioned health care system, pediatric primary care providers would continue to provide guidance on development, well-child visits, and medical care when children are sick, but they would also expand their practices to include family support services and connect families with community services such as behavioral health care, assistance with food or housing, help with school issues, and treatment for maternal depression.

Key to this redesign is a health care system that rewards pediatric primary care providers for outcomes that improve children's health and well-being – rather than simply for seeing more patients and conducting more procedures – and that ensures providers have the resources they need to reshape their practices to take on this broader role. Pediatricians and other primary care providers already serve as trusted advisers to families and see children frequently, making them well positioned to serve as a hub to connect families to the supports that can help them thrive.

These recommendations are the result of a study group that brought together experts from across the health care landscape, including some representing organizations that do not typically agree. The group – which includes representatives from parent groups, pediatric primary care providers, hospitals, insurance companies, Medicaid, state agencies, and philanthropy – outlined a series of recommendations for Connecticut to move forward.

The changes outlined in this work are ambitious but achievable. Connecticut already has a wide array of services that support children's optimal development. What is missing is a model for connecting those child health and support services and a way to finance pediatric care to support providers in making the strongest possible contribution to children's lives.

Why investing in children is critical

There are state and national efforts underway to shift health care from a system that pays primarily for treating illness to one that also rewards providers for keeping patients healthy.

These efforts have generally centered on adults, particularly those with conditions that carry the opportunity to achieve significant improvements in care and savings. Children's health gets little attention in health reform efforts, in part because most children are healthy and their care is comparatively inexpensive. Put another way, children's health is not a likely source for big short-term savings.

Yet the potential payoff from focusing on children's health and well-being is tremendous. It is far less costly to prevent conditions that have roots in childhood than to treat them in adulthood. Early intervention – in conditions including autism spectrum disorder, developmental concerns, and exposure to trauma – can change a child's life trajectory. Spending on children's healthy development can produce long-term savings in special education, health care for chronic diseases, and criminal justice, as well as benefits through higher educational attainment and economic productivity.[7] Truly improving the health of Connecticut residents will require starting early in life.

What children need

Children's health is broad: It includes not just whether a child is free from disease today, but whether he or she is on a path to optimal development, ready to learn, with a nurturing family able to meet his or her needs.

Children's health is influenced by the well-being of their families, as well as non-medical factors such as whether they have enough food to eat, stable housing, safe places to play, and adults they can trust.

Pediatric primary care providers recognize the importance of understanding the full picture of their patients' lives, of the role of non-medical stresses in long-term health, and the importance of protective factors in helping families withstand challenges. Yet the way health care and social services are currently structured, and largely separated from each other, can prevent providers from taking action to address the many factors that affect the lives of the families in their practices.

The role of payment

In the current health care payment system, pediatricians and other child health providers are generally paid for each office visit, test, or procedure. Time spent counseling a family on the phone, coordinating with specialists, or trying to find a behavioral health provider for a patient is generally unpaid time.

Similarly, the present system does not allow payment for services such as care that addresses the needs of both the parent and child, group visits with a developmental specialist so families can learn what's typical for kids their child's age, or linking families with resources such as food or housing assistance.

In other words, limitations in the current payment system mean that even the most well-informed and motivated pediatric primary care provider would struggle to take on a more comprehensive role in meeting patients' needs. Doing so would run contrary to the system that finances care. In addition, the fragmentation that exists between medical care, behavioral health, social services, education, and other systems makes it difficult for any single pediatric practice to address families in a holistic way.

Designing a better system

The study group focused on ways to create a system that supports this broader conception of child health – one that focuses on the child and family's medical and social needs.

The group has identified three key components that a new model of pediatric primary care must include:

Flexibility: Providers need flexibility to implement innovative practices, such as longer or weekend hours, embedding behavioral health or other practitioners in the practice, or group visits so families can learn from each other.

Focus on outcomes: To ensure the care is improving health, the system must measure and reward providers for achieving specific outcomes. Outcome measures could include infant mortality rates, healthy weight, optimal child development, school measures such as kindergarten readiness or third-grade reading, or healthy lifestyle measures such as rates of tobacco use and exercise.

Payment that supports innovation and health: Moving away from traditional fee-for-service payments would allow providers more flexibility in how they care for their patients. The system must build in elements that deter providers from realizing savings by limiting needed care. This would mean linking payments to a robust set of performance and quality measures that reflect best practices in care delivery for children.

Payment reform itself is not the goal; the health and well-being of children is. The key question is how to pay for care in a way that ensures an integrated, innovative system.

Recommendations for reforming payment in pediatric primary care

1. **Reward health promotion and prevention – not just treating illness – for all children.** A broader view of primary care should include helping families address issues such as healthy weight and nutrition, socio-emotional well-being, and developmental outcomes that ensure school readiness and success.

2. **Develop payment methods that support the restructuring of pediatric primary care in ways that can improve population health, health equity, and care quality, and address costs.**

   These include:

   - flexibility for innovations such as care coordination; flexible office hours; alternative visits such as group or telehealth appointments or e-consults; care that includes both the parent and child; embedded or easy access to behavioral health and other practitioners such as nutritional counselors and pharmacists.
   - use of non-physician professionals and paraprofessionals to reduce physician burden and expand practice capabilities.
   - up-front funds, separate from payment for care and services, to support practices in developing infrastructure for practice innovations.
   - data and documentation to assess new capabilities, activities, and outcomes enabled by the new payment structures.
   - bringing evidence-informed innovations to scale.

3. **Measure outcomes and build a body of evidence** demonstrating the long-term return on investment for pediatric primary care.

4. **Require all payers to participate in the new system.** These changes require providers to adjust the way they work with every patient. It would be infeasible – and inequitable – for providers to practice differently depending on a child's source of insurance.

5. **Efforts to eliminate fragmentation in services must be accompanied by reduced fragmentation in funding,** particularly among the many public sectors – including health, education, social services – that serve children and families.

Underlying these recommendations is the recognition that pediatric primary care is a public good similar to public education, in which spending on children produces long-term benefits across the population.

What's next?

Connecticut is at a crossroads, a time when leaders are setting a course for the future. The study group is continuing its work and testing some of the concepts through pilot projects. As state leaders map out policy and action for the coming years, these recommendations can serve as a framework for moving Connecticut forward in recognizing the role of children's health in health reform, emphasizing the importance of collaboration between the many systems that serve children and families, and supporting pediatric primary care providers in assuring the best possible opportunities for the next generation.

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This brief was written by Arielle Levin Becker. It was based on the report "Transforming Pediatrics to Support Population Health: Recommendations for Practice Change and How to Pay for Them," which can be downloaded at www.chdi.org. The full report was prepared by the Center for Health Law and Economics at the University of Massachusetts Medical School and captures the work of the Pediatric Primary Care Payment Reform study group convened by the Child Health and Development Institute of Connecticut and the Connecticut Health Foundation.

Endnotes

1 Kaiser Family Foundation analysis of the Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2013-2017 Survey Results. https://www.kff.org/other/state-indicator/adult-overweightobesity-rate/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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4 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: Health Expenditures by State of Residence, June 2017. https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

5 Kaiser Family Foundation analysis of data from the United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. https://www.kff.org/other/state-indicator/infant-mortality-rate-by-race-ethnicity/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

6 Child Health and Development Institute of Connecticut, "Connecticut Children's Behavioral Health Plan," Oct. 1, 2014. https://www.plan4children.org/wp-content/uploads/2014/10/CBH_PLAN_FINAL-_2_.pdf

7 Heckman JJ. Skill formation and the economics of investing in disadvantaged children. Science. 2006; 312:1900-2. See also: https://heckmanequation.org/resource/research-summary-lifecycle-benefits-influential-early-childhood-program/

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