The Medical Home and Bright Futures-
What does that have to do with
teenage sexuality and pregnancy
anyway?

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Plan
March 12-14, 2012
Expanding Our Experience and Expertise: Implementing Effective Teenage Pregnancy Programs
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Educational Objectives

• After this session attendees will:
  – Know the components of a medical home
  – Be familiar with Bright Futures Guidelines
  – Understand how these concepts can benefit participants in teen pregnancy prevention projects through an example of youth in foster care
  – Buzz Activity
We need to stop thinking outside the box and begin to think in a whole new box.
Healthy **People 2020-Six Core Outcomes**

- Children/youth with Special Health Care Needs (CYSHCN) will be screened early and continuously for special health care need
- Families of CYSHCN will participate in decision making at all levels and will be satisfied with the services they receive
- CYSHCN will receive regular ongoing comprehensive care within a medical home.
Healthy People 2020-Six Core Outcomes

• Families of CYSHCN will have adequate public and/or private insurance to pay for the services they need.
• Community-based service systems will be organized so families/youth can use them easily.
• Youth with special health care needs (YSHCN) will receive the services necessary to make transitions to all aspects of adult life.
A Medical Home

• Is a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion and prevention, acute illness care, and chronic condition management — across the lifespan.
  – Care in a medical home is rewarding for clinical teams to provide and satisfying for patients and families to receive

  – American Academy of Pediatrics
A MEDICAL HOME IS...

- Accessible
- Family-centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally competent
The Primary Care Medical Home
At the Crossroads Integrating:

Vertically – among health care systems/specialists/PCPs/patients & families
Horizontally – among patients & families/community agencies/schools, etc...
Continuously – with continuity of clinicians and medical home team members
Longitudinally – over time with anticipatory guidance
Accountable Care Organizations

Key Elements

• **Primary Care is foundational-Medical Home**
• Define Roles of Subspecialists
• Define Role of Hospitals
• Governance
• Define Population

Challenges

• Risk Adjustment
• Time Horizon for Outcomes
Leveraging Opportunities

Affordable Care Act
• Quality primary care, extended age to remain on family plan, no charge preventative care

Medical Home – standards for recognition
• Reimbursement potential for population care/registries, care plans, coordination, population, registries, care plans, etc.
• Youth/family involvement, partnership and leadership
• Professional Organizations (AAP, AAFP, ACP, AANP etc.)
  – Resources/toolkits
  – Education, skills, proficiencies
  – Clinical training/residencies
  – MCO

Accountable Care Organizations
• Primary Care is foundational
Families Want and Need a Medical Home

- Offers a collaborative family-centered, team approach
- Develops a written summary of critical care information
- Has a developed process to integrate and coordinate care across multiple services
At the heart of the medical home is the relationship between the clinician and the family or youth
History of the Bright Futures Guidelines

Supported and funded by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA), Department of Health and Human Services

- First published in 1994
- Updated in 2000—2nd edition
- In 2002, AAP selected by MCHB to implement the next phase of the initiative
- 3rd edition released in October 2007
- In 2007, the AAP was awarded a second cooperative agreement to address implementation.
Development of
The Bright Futures Guidelines, 3rd Ed.

The Mission

- Develop one set of uniform guidelines for the health supervision/well care of infants, children, adolescents and young adults
- Address biopsychosocial issues impacting on child health
- Strengthen medical homes
- Use interventions which are *evidence driven*
- Include recommendations on immunizations, routine health screening, and anticipatory guidance
...is a set of principles, strategies and tools that are theory-based, evidence-driven, and systems-oriented, that can be used to improve the health and well-being of all children through culturally appropriate interventions that address the current and emerging health promotion needs at the family, clinical practice, community, health system and policy levels.
Development of
*The Bright Futures Guidelines, 3rd Ed.*

• Our process
  – 4 Multidisciplinary Age-Stage Expert Panels
    • Infancy
    • Early Childhood
    • Middle Childhood

• Adolescence
  – Numerous AAP Leadership Groups
Development of
*The Bright Futures Guidelines, 3rd Ed.*

• The process
  – Evidence Panel
    • Nominated and Selected
    • Worked with each age/stage panel
  – Children and Youth With Special Health Care Needs Panel
    • Nominated and Selected
    • Worked with each age/stage panel
Developing the Guidelines

• Structure
  – Part I—Themes
  – Includes 10 chapters highlighting key health promotion themes
  – Emphasizes “significant challenges”—mental health and healthy weight
  – Part II—Visits
  – Provides detailed health supervision guidance and anticipatory guidance for 31 age-specific visits
  – Lists 5 priorities for each visit
  – Includes sample questions and discussion topics for parent and child
Sexual Development

- Anticipatory Guidance throughout all ages
- Sexual development and key data and statistics
- Sexual development and the promotion of healthy lifestyles for all ages
- How to teach about health related issues, eg. intercourse, pregnancy, and STI’s
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## Bright Futures Quality Measures Crosswalk

<table>
<thead>
<tr>
<th>Topic Areas</th>
<th>Examples</th>
<th>AAP Bright Futures Measure</th>
<th>Hedis Measure</th>
<th>CHIPRA Core Quality Measure</th>
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<tbody>
<tr>
<td>Preventive Services</td>
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<td><strong>Age Appropriate Risk Assessments</strong></td>
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<td>Medical</td>
<td>(lead, vision, hearing, TB, etc)</td>
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<td>BMI</td>
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<td>oral health</td>
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<td>Chlamydia screening if sexually active</td>
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<td>Parental/dev</td>
<td>Developmental Screening</td>
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<td>Autism Screening</td>
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<td>Maternal Depression</td>
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<td>Anticipatory Guidance</td>
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<td>Parental Concerns</td>
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<td>Parental Strengths</td>
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<td>Developmental surveillance for teens</td>
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<td>Systems</td>
<td>Identify CSHCN</td>
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<td>Track referrals</td>
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<td>Track and remind patients behind schedule</td>
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<td>Well Child Visits (frequency)</td>
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<td>Immunizations</td>
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<td>shared decision-making</td>
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Health Care Reform

• “With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).”

• Recognizes that Bright Future Health Supervision Visits are the guidelines referred to as “Recommended Guidelines”
Burden of Chlamydial Infection

- Most commonly reported nationally-notifiable disease
  - Over 1.2 million cases reported in 2008
  - Many infections not detected
- Estimated 2.8 million cases occur each year
- Direct medical costs: $678 million/year

Weinstock H, Berman S, Cates W Jr. Perspect Sex Reprod Health 2004
Chesson HW, et al. Perspect Sex Reprod Health 2004
Chlamydia Case Report Rates by State, 2008

VT 192
NH 160
MA 271
RI 314
CT 357
NJ 258
DE 447
MD 439
DC 1177

Rate per 100,000 population
- ≤300.0 (n=12)
- 300.1 - 400.0 (n=16)
- >400.0 (n=23)

Sexually active people aged 14-24 have about 3x the chlamydia prevalence of sexually active adults aged 25-39.
Large Racial Disparities In Chlamydial Infection

NHANES, National Health and Nutrition Examination Survey, 1999-2008
Analysis of sexually active 14-39 year-olds; Sexual activity = “yes” response to “Have you ever had sex?” Sex = vaginal, anal, or oral sex
Minors’ Rights to Consent for Confidential STD Care in US

• All 50 states and the District of Columbia allow minors to consent for STD diagnosis and treatment
  – ~25% of states require that minors be a certain age to consent for their own STD care
  – **No** state requires parental consent for STD care or that providers notify parents that an adolescent minor has received STD service
    • Exception in limited or unusual circumstances
    • Some states give physicians discretion to disclose to parents
# How Compliant Are Providers With Annual Chlamydia Screening?

## 2008 Chlamydia Screening HEDIS Rates

<table>
<thead>
<tr>
<th>Age</th>
<th>Commercial (%)</th>
<th>Medicaid (yrs)</th>
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</thead>
<tbody>
<tr>
<td>16-20</td>
<td>36.4</td>
<td>48.8</td>
</tr>
<tr>
<td>21-26</td>
<td>39.2</td>
<td>54.2</td>
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</table>

The State of Health Care Quality, 2008
National Center for Quality Assurance at: [http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf](http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf)
Buzz Activity

• Discuss how you have related to health professionals in your projects/programs?
• Discuss possible ways that you can use the medical home and/or Bright Futures to advance your projects/programs?
• What has been working well in achieving this connection?
• What has not worked?
• How do we replicate these successful strategies?
Boys Town Healthy Tomorrow’s Clinic
We Need To Provide Different Care For Children and Teens Foster Youth

- Children and teens in foster care cost 3-4 times the cost of other children
- Children and teens in foster care are at risk of going off insurance, e.g., Medicaid, within months of going out of the system
- Children and teens in foster care need extra time for their visit

- Healthy Foster Care America
We Need To Provide Different Care For Children and Teens In Foster Care

• First and foremost - children and teens in foster care have special health care needs
  – 60% have a chronic health care condition
  – 25% have 3 or more chronic health care problems
  – 70% have moderate to serve mental health problems
  – 40-60% have at least on psychiatric condition

• Healthy Foster Care America
Trajectory of Life Course Health and Development

Children's Health vs. Age

- Optimal
- Impaired
Determinants of Child Health

• Poverty
• Parental education

– And these are impacted positively or negatively by social capital
– Foster Children and Youth most often get both
Foster youth need to have addressed all of these determinants of health

- Socioeconomic Status
- Physical Environment
- Social Environment - social capital
- Genetics
- Biologic Influences
- Access to primary care - Barbara Starfield’s work
Comprehensive Review of Systems

- Dental/Oral Health
- Mental Health
- School Needs
- Social Needs
- Reproductive History
- Medication History
- Permanency Discussion
- What Do I Want To Be When I Grow Up
I have their name

Friday June 25th 1993

with Mrs. Johnson,

the pleasure of informing you that your daughter Jill has achieved placement in Lincoln Middle School Honor Roll this term.

ake the time to congratulate your daughter on her achievement.

but they’re not my parents.
Developing the Life Course Health Plan empowers youth by asking them to envision their future lives as parents (or choosing not to parent) and helping them determine strategies to achieve their vision.
Life Course Health Plan:

They are asked questions such as:

- Ideal age for having a child
- Whether or not they plan to be married when they have a child
- Plans for education, career, health care and housing when parenting
- When and how they plan to be financially responsible for a child
What types of health information do youth need to “take with them”?

- General Physical & Mental Health
- Reproductive Health
- First aid/addressing minor health problems
- When to go to the doctor/importance of a medical home (how to talk to a doctor)
- When to go to the ER
- Personal Medical Records
Keys to Impacting Foster Youth

• Give them a sense of power
• 4 C’s of messages: clear, concise, consistent, concrete
• Tell teens the truth
• Keep things positive
• Life does have do-overs (generally)
• Assume ability to understand-push to the limit
• Motivate caregivers to talk early & often
• Don’t make assumptions
The Primary Care Setting:

By connecting pregnancy prevention education with a primary care setting, we create an environment where teens:

- Feel comfortable seeking advice and medically accurate information about reproductive health care
- Learn how to establish relationships with primary care providers
- Accept greater personal responsibility for their own health into adulthood
- Receive information in a more consistent place of care
Why Breastfeed?


“Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries”

9,000 Abstracts reviewed:
43 primary infant outcome studies
43 primary maternal outcome studies
29 system. Reviews/meta-anal (400 studies)
# Did You Ever Wonder What's in...?

## Breastmilk

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<thead>
<tr>
<th>Water</th>
<th>Carbohydrates (energy source)</th>
<th>+</th>
<th>Fat</th>
<th>+</th>
<th>Proteins</th>
<th>+</th>
<th>Vitamins</th>
<th>+</th>
<th>Minerals</th>
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<tr>
<td>Alkaline</td>
<td>Triglycerides</td>
<td>Long-chain polyunsaturated fatty acids</td>
<td>Desiccated milk solids (DM)</td>
<td>Important for brain development</td>
<td>Leucine</td>
<td>Glutamic acid</td>
<td>Serine</td>
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<td>Neutrophil granulocytes</td>
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<th>+</th>
<th>Vitamins</th>
<th>+</th>
<th>Minerals</th>
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<td>Lactose</td>
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## Development

- **Basic factors**: Glucocorticoids, insulin, progesterone, estrogen, testosterone, and IGF-1 (insulin-like growth factor 1) and IGF-2 (insulin-like growth factor 2).
- **Early growth factors**: IGF-1 and IGF-2.
- **Neonatal growth factors**: IGF-1 and IGF-2.
- **Postnatal growth factors**: IGF-1 and IGF-2.

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Developed as a student project for the Broadening Course for Health Care Practitioners, Douglas College, New Westminster, BC, Canada © 2007 by Carla T. Peterson, 2007 is a trademark of the University of British Columbia.
If a woman missed her period, starts to have an enlarged abdomen, and experiences some nausea and vomiting, what is very likely true about her?

- She may have the flu (Admit: 4, Discharge: 2)
- She may have a venereal disease (Admit: 4, Discharge: 1)
- She may be pregnant (Admit: 81, Discharge: 91)
- She may need to see a psychotherapist (Admit: 3, Discharge: 2)
Healthy Tomorrows
Pre-Post Comparison Graphs
(August 2011)

When I visit a doctor for the first time, I need to bring:

- A list of vaccines and immunizations I have had
  - Admit (n=90)
    - 3
  - Discharge (n=92)
    - 1

- Dates of any previous surgeries or injuries
  - Admit (n=90)
    - 3
  - Discharge (n=92)
    - 3

- A list of medications I am taking
  - Admit (n=90)
    - 3
  - Discharge (n=92)
    - 4

- All of the above
  - Admit (n=90)
    - 76
  - Discharge (n=92)
    - 90

- None of the above
  - Admit (n=90)
    - 5

- None of the above
  - Discharge (n=92)
    - 5
Healthy Tomorrows
Pre-Post Comparison Graphs
(August 2011)

Why do you need to share your family's medical history with your doctor?

- To help my doctor choose the best treatment plan for me: 40 (Admit), 49 (Discharge)
- To alert my doctor to all the health problems I'm going to have: 40 (Admit), 36 (Discharge)
- So my doctor knows which family members are still living: 10 (Admit), 4 (Discharge)
When should you see your primary doctor?

- **Admit (n=93)**
  - Once per month: 24
  - Every 6 months: 44
  - Once per year: 19
  - Every other year: 2
  - Only when sick: 6

- **Discharge (n=93)**
  - Once per month: 12
  - Every 6 months: 60
  - Once per year: 16
  - Every other year: 3
  - Only when sick: 3

Healthy Tomorrows
Pre-Post Comparison Graphs
(August 2011)
Genogram
Relationship graphing
Date: ______________  [ ] Initial  [ ] Follow Up

Referring physician name: ____________________________________________

Address:  ________________________________________________________

Fax: ( )  Phone: ( )

Patient’s name: ____________________________________________________

DOB: __________________  Phone: ( )

Parent’s name: ____________________________________________________

Address:  ________________________________________________________

Date(s) patient seen: ______________________________________________

Reason(s) for referral:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Any specific questions or requests:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Referring physician’s printed name / signature
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Thank you for evaluating this patient. To facilitate communication and treatment, please mail or fax this document (both pages) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.
Health Care Transition Planning Algorithm for All Youth and Young Adults Within a Medical Home Interaction

1. 
Row 1: Medical Home Interaction

- Medical Home Interaction for Patients ≥ 12 Years of Age

2a. Is the Patient 12-13 Years of Age?
   - No
   - Yes
   - ACTION: Refer to Pediatrics

2b. Is the Patient 14-15 Years of Age?
   - No
   - Yes
   - ACTION: Refer to Pediatrics

2c. Is the Patient 16-17 Years of Age?
   - No
   - Yes
   - ACTION: Refer to Pediatrics

2d. Is the Patient > 18 Years of Age?
   - No
   - Yes
   - ACTION: Refer to Pediatrics

3a. Step 1: Discuss Office Transitions Policy with Youth & Parents
   - Yes
   - No

3b. Step 2: Ensure Step 1 is Complete, then Initiate a Jointly Developed Transition Plan with Youth & Parents
   - Yes
   - No

3c. Step 3: Ensure Steps 1 & 2 are Complete, then Review & Update Transitions Plan & Prepare for Adult Care
   - Yes
   - No

3d. Step 4: Ensure Steps 1, 2, & 3 are Complete, then Implement Adult Care Provider
   - Yes
   - No

4. Step 5: Determine Special Needs
   - Yes
   - No

5a. Incorporate Transition Planning in Chronic Condition Management
   - Yes
   - No

5b. Have Appropriately Transitions Issues Been Addressed?
   - Yes
   - No

5c. Initiate Follow-up Interaction
   - Yes
   - No

Legend:

- Start
- Action/Process
- Decision
- Stop

**The federal Maternal and Child Health Bureau defines children with special health care needs as: "Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services or supports of a type or amount beyond that required by children generally."** (HCFA, P.L. 100-386) A new definition of children with special health care needs.
Rates of Return to Human Development Investment Across all Ages

R 4 6 8
Pre-school Programs
Pre-school  School  Post School
Return Per $ Invested
Pedro Carneiro, James Heckman, Human Capital Policy, 2003

Pedro Carneiro, James Heckman, Human Capital Policy, 2003
The Problem

- Later interventions are economically inefficient.
- We can not effectively deal with disparities unless we approach disadvantage from an equity perspective.
- We currently over invest in remedial skills and under invest in early years.
- America-the great second chance society.
- Best investment.
Early Manifestations of Personality and Adult Health: A Life Course Perspective

• “Conclusions: Associations between child personality attributes with both general self-rated health and number of illnesses in adulthood were maintained after taking account of childhood social environment and child health. Findings indicate that early emerging personality and related processes influence adult physical health, and suggest the potential value of interventions targeting early life development.”

Health Development Process

- Cumulative Impact
- Timing of Exposure
So What Can You Do?

• Talk to youth about the relationship between school attendance and academic performance
• Schedule youth during non school hours
• Always ask the child/youth how they are doing in school-focus on strengths
• Connect every child to highly trained, caring and competent professionals
• Create a robust infrastructure that emphasizes collaboration
So What Can You Do?

• Develop culturally responsive programs that build on the strengths of the child, youth, there caregiver, and the community
• Focus on quality so every interaction is of the highest caliber
• Provide professional development
• Connect to your youth’s primary care health professional
• Start Small
•THINK BIG
What We Can Predict

The needs of transitioning youth in the future will be the same as youth today:

- Loving Adults – we all need at least one
- Integrated & coordinated health system & human services that serve them into adulthood
- Supportive and safe community
- Good school/education
- Transition to a job that provides a living & satisfaction
Children and youth need the force of good and attractive examples.
Children are not philosophers, but they are apt imitators.
They may be easily led to follow where they cannot be driven.
So What Can You Do?

- Make every interaction with every youth count
- Always focus on the youth’s strengths
- During every visit ask how they are doing—if modifiable factors are brought up—act on them
- Create an expectation from your first interaction that you are concerned about their success in life
- Smother the youth & their parent/s with the support they need when they need it
- Educate both females & males about searching for their history
- Educate both about the importance of breastfeeding
Resources

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