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Well-Child Care Practice Redesign for Low-Income Children: The Perspectives of Health Plans, Medical Groups, and State Agencies

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Abstract

Objective—The aim of this study was to examine the views of key stakeholders in health care payer organizations on the use of practice redesign strategies to improve the delivery of well-child care (WCC) to low-income children aged 0 to 3 years.

Methods—We conducted semistructured interviews with 18 key stakeholders (eg, chief medical officers, medical directors) in 11 California health plans and 2 medical group organizations serving low-income children, as well as the 2 state agencies that administer the 2 largest low-income insurance programs for California children. Discussions were recorded, transcribed, and analyzed using the constant comparative method of qualitative analysis.

Results—Participants reported that nonphysicians were underutilized as WCC providers, and group visits and Internet services were likely a more effective way to provide anticipatory guidance and behavioral/developmental services. Participants described barriers to redesign, including the start-up costs required to implement redesign as well as a lack of financial incentives to support innovation in WCC delivery. Participants suggested solutions to these barriers, including using pay-for-performance programs to reward practices that expanded WCC services, and providing practices with start-up grants to implement pilot redesign projects that would eventually become self-sustaining. State-level barriers included poor Medicaid reimbursement rates and disincentives to innovation created by current Healthcare Effectiveness Data and Information Set measures.

Conclusions—All stakeholders will ultimately be needed to support WCC redesign; however, California payers may need to provide logistic, design, and financial support to practices, whereas

state agencies may need to reshape the incentives to reward innovation around child preventive health and developmental services.

Keywords

patient-centered medical home; practice redesign; well-child care

A fundamental question addressed by pediatric literature is whether a redesigned well-child care (WCC) delivery system can improve the provision of services to children without increasing costs. Although child health care expenditures represent just 13% of total US personal health care expenditures,⁷ the delivery of more efficient and effective WCC may result in outsized benefits. First, WCC uses a substantial proportion of pediatric workforce time, creating ever-larger opportunity costs as the demands of caring for children with chronic and complex health needs increase. Second, WCC may be the only opportunity before a child reaches preschool to identify and address important social, developmental, behavioral, and health issues. Early attention to these issues may have substantial long-term benefits for health and health care costs. In our current WCC system, opportunities for early and aggressive action through these preventive services are often missed—many children either do not receive these important services or receive services of low quality^{8,9}; moreover, these deficiencies in care are often greatest for children in low-income families who have fewer resources to independently meet their unaddressed preventive and developmental needs.^{10,11} The delivery of high-quality WCC to low-income families, therefore, represents an important challenge for pediatric primary care.

Researchers and clinicians have proposed various ways to redesign WCC delivery to improve effectiveness and efficiency, including using nonphysicians to provide services (pediatricians play a much more prominent WCC role in the United States than in other developed nations)^{12,13}; providing some services via alternative formats, such as by Internet, phone, or through group visits; and providing some WCC services in more convenient community locations outside of the clinical setting.^{14–18} These practice redesign tools are central to broader redesign efforts such as the patient-centered medical home,^{19,20} and in previous studies, many of these have been endorsed by 2 key WCC stakeholder groups: pediatricians and parents.^{16,21–23}

These redesign tools are not new; they have been discussed in the literature and implemented in pediatrics at relatively small scale through various comprehensive models of care for decades.^{24–29} However, we do not know if payers (ie, health plans, state agencies) will support broad use of such innovation in primary care. It is unclear whether payers will view such innovations as feasible and potentially more effective and efficient than our current system. Payers' views may have important implications for widespread and sustainable practice redesign. As efforts continue to increase the rolls of Medicaid/Children's Health Insurance Program–insured children,³⁰ the strain of WCC on the pediatric workforce serving this high-need population will continue to increase, making the rationale for a redesigned WCC delivery system especially compelling for these public insurance programs. We are not aware of any published studies that have examined the perspectives of payers on WCC practice redesign.

The objective of this study was to rigorously examine the perspectives of administrative and clinical leaders in California health care industry organizations on WCC redesign for publicly insured children aged 0 to 3 years, focusing on new delivery models, obstacles, and solutions for organizations in implementing such changes. We focused on ages 0 to 3 years since that is when WCC visits are most frequent.

Methods

We focused on the 2 largest California health insurance programs for low-income children: Medi-Cal (Medicaid) and Healthy Families (HF; Children's Health Insurance Program). Children from households up to 250% of the federal poverty level are eligible for these programs.

The vast majority of Medi-Cal child enrollees who do not have serious medical conditions and do not live in rural areas are enrolled in Medi-Cal Managed Care (MMC); the remainder are enrolled in fee-for-service Medi-Cal.³¹ All HF enrollees are in managed care plans. Preventive visits are a covered benefit in both programs. Both the state MMC and HF programs contract with health plans on a capitated (per member per month) basis, and most contracting plans pay providers on a capitated basis.

The Healthcare Effectiveness Data and Information Set (HEDIS) was frequently discussed by our interview participants; it is used by Medi-Cal and HF to evaluate health plan performance on important dimensions of care and to inform decisions about future contracts. Relevant HEDIS measures include the percentage of enrolled children who 1) are up-to-date with immunizations by age 2, 2) are up to date with WCC visits by age 15 months, 3) have had a visit with a primary care provider during the year of assessment, and 4) have had a WCC visit during the third year of life.

Recruitment and Data Collection

We sent letters of invitation to all California health plans (8 commercial and 14 public) offering Medi-Cal and HF^{32,33} and completed interviews with 11 plans. Because large medical groups in California often participate in risk sharing with plans through capitation and management, we also included 2 medical group organizations (or their medical service organization if responsible for medical management and/or quality improvement); these 2 are among the largest California groups in terms of enrollment and Medi-Cal share.³⁴

An invitation was sent to the chief medical officer (CMO), medical director, or a similar leader of each organization; he/she was asked to participate in an interview or to select another administrative and/or clinical leader who was knowledgeable about the structure and/or reimbursement of the organization's ambulatory child preventive health services. For some organizations 1 person was selected for the interview; for others, 2 individuals with different job titles filled this need and were interviewed jointly or separately. Interviews with 10 organizations were face-to-face, and interviews with 3 were conducted via phone.

Each 60-minute interview was conducted by T.R.C. using a semistructured interview guide (Appendix). Participants discussed WCC practice redesign in general, as well as the use of

1) nonphysician providers, 2) alternative formats of care (non–face-to-face, non–one-on-one), and 3) nonoffice locations for care. Respondents described their perspectives on each topic in terms of 1) feasibility; 2) financial, managerial, and logistic barriers; and 3) potential solutions to these barriers.

After completion and analysis of the 11 health plan and 2 medical group interviews, we conducted interviews with the directors/chiefs of the quality monitoring or policy-related divisions at the 2 California state agencies that administer MMC and HF to obtain their perspectives on barriers to redesign that emerged from the health plans and medical group interviews.

The study was approved by the University of California, Los Angeles, Office for the Protection of Research Subjects.

Statistical Analysis

The interviews were digitally recorded, transcribed, and imported into qualitative data management software (Atlas.ti 6.0, ATLAS.ti Scientific Software Development GmbH, Berlin, Germany). T.R.C. and R.D. read samples of text and created codes for key points within the text. The codes were developed into a codebook using an iterative process, where 2 experienced coders independently and consecutively coded the transcripts, discussing discrepancies and modifying the codebook with T.R.C. We calculated a Cohen's κ ³⁵ using a randomly selected sample (33%) of quotes from each of the major themes, to measure consistency between coders. Kappa scores ranged from 90% to 96%, suggesting excellent consistency.^{36,37}

We performed thematic analysis of the 506 unique quotations pertaining to the topics described above (430 from health plans, 76 from medical groups), and after ongoing and iterative analyses, reached consensus among multiple investigators with respect to thematic saturation (when no new themes emerge from further interviews).³⁸ We identified the most salient themes; these were the specific concepts and ideas that emerged in interviews with at least 10 of the 13 organizations. These are the major themes presented below; dissenting views (ideas contrary to our major themes that emerged in a minority of interviews) are presented in the tables. The analysis was based in grounded theory and performed using the constant comparative method of qualitative analysis.^{39,40} Interviews with the 2 state agencies (67 unique quotations) were analyzed using similar methods, but separately from the health plan and medical group data.

Results

Interviews were conducted with 6 public plans, 5 commercial plans, and 2 medical groups (category includes medical groups, independent provider associations, medical service organizations); we interviewed 8 medical directors/executive vice presidents, 2 directors/executive vice presidents, 2 CMOs, and 1 clinical quality director. In 4 organizations, we interviewed an additional participant (concurrently or separately from the director or CMO) recommended by the organization's leadership. To ensure privacy, we do not provide organization-specific job titles, location, or enrollment data.

Theme 1

There are several nontraditional methods for WCC delivery that may be more efficient and effective than our current system of care (Table 1).

Nonphysician Providers—Health plan and medical group participants reported that nonphysician providers are underutilized in WCC and could be best utilized in a team-based approach to care. They were seen as at least equally effective as physicians at providing many WCC services, and possibly more efficient. Many participants reported that a range of nonphysician providers, including nurse practitioners (NPs), physician assistants (PAs), registered nurses (RNs), and medical assistants could be a useful part of a team-based approach to care. One participant said, “It would result in more efficient, more satisfying care from both the patient side and the doctor side... it means less touch by the highly trained, highly paid doctor, who may not be as good at some of this stuff [anticipatory guidance, behavioral screening/counseling] that patients really need and want.” Participants also reported that nonphysician providers could be best utilized within a multidisciplinary team-based approach to care that included the use of standardized protocols for many services.

Alternative Formats—Participants reported that much of WCC could probably be done more effectively and efficiently by providing some services via phone, Internet, and in group visits. Many viewed the use of phone and Internet as a way to provide more expansive anticipatory guidance and behavioral/developmental services. About group visits, one participant remarked, “There’s no question that the group visits are much more effective,” and another said, “It is more efficient... it keeps the patients more engaged.” With respect to Internet services, one participant said, “You could probably get both, sort of the traditional medical things but also some of the behavioral and risk assessment that we don’t [do now].”

Alternative Locations—In contrast to their views on nonphysician providers and alternative formats, most participants did not see many alternative locations as feasible, efficient, or effective in delivering WCC services. Home visits were generally seen as a targeted service for the highest-risk families only, if at all, due to their costs. Visits at day care centers were seen as a potentially useful option, but logistically difficult because children would be insured by a variety of plans. Retail clinics were the one venue many participants wanted to explore for standardized preventive and minor acute care services. A lack of communication between the retail clinic and the patient’s primary care provider was a key obstacle to their usefulness: “I think that [retail clinics] could actually be an asset to the community as long as they’re really aggressive about getting people back into primary care.”

Theme 2

Although these alternative methods may be more efficient and effective, plans and practices face significant obstacles to implementing such changes (Table 2).

Nonphysician Providers—Health plan and medical group participants noted several barriers to the use of nonphysicians. Participants reported that provider roles (particularly for

non-MD/NP/PAs) are determined more by state policies regarding scope of practice than by what would maximize efficiency and effectiveness: “It’s [scope of practice] that really guides the services that are provided by each level of individual.” They reported that state policies would require all children to be examined in-person by a physician, NP, or PA during each visit: “We can’t have an RN performing physical exams, immunizations, doing a whole visit—without seeing a physician.” Participants described having a mix of both small and larger practices, and many reported that the cost of hiring additional provider types for a team-based approach to care could be an obstacle for smaller practices, even though it may be more cost-efficient long-term. One participant remarked, “Our private docs, the solo practitioners—none of them [even] have nurses anymore. They can’t afford them.” Another participant said, “In the long-run it’s going to be better, but coming up with that initial money to pay the different players on the team would probably be a challenge.”

Alternative Formats—Participants noted major logistical barriers to using alternative formats (phone, Internet, group visits), including office space and scheduling for group visits, information technology investment, and provider and parent capacities for Internet and phone services; in general, the time, start-up costs, and maintenance costs involved in implementing redesign for alternative formats seemed potentially prohibitive.

Theme 3

Few incentives for redesign exist for plans or providers (Table 3).

Plan-Level Incentives—Health plan and medical group participants reported that plans were incentivized to improve performance on HEDIS measures that focus mainly on immunizations and the number of WCC visits rather than on the quality of services that could be targeted with practice redesign, such as anticipatory guidance and behavioral/developmental screening: “You have to link [practice redesign] to what the health plan gets something for. We get 5 measures we get measured on in the state. And if we do well on those, we get a certain number of other people that the state will allocate to us for enrollment. That’s the reward you get for doing well in those numbers. So if it’s not linked to some kind of reward like that on the other end... I mean from the standpoint of a corporate return on investment we have to look at it that way.”

Participants from the public plans also reported that a major nonfinancial incentive to improve care was their organization’s public mission to provide high-quality care to low-income communities. One public plan participant noted, “You have a Medicaid health plan... there’s a real mission-driven focus... we want to do it because it’s the right thing.” This organizational mission was not discussed by commercial plan participants.

Participants reported that practice redesign incentives for health plans needed to be addressed at the state level. In addition to the perceived restrictive MMC and HF requirements regarding provider type and visit format, payment rates were another obstacle to substantive improvements to care: “Medi-Cal is woefully under-funded. So I’m trying to create quality and access to care with about 25% of the premium dollar that they see in the commercial world. How do you do that?”

Perverse incentives existed in both capitated and fee-for-service payment systems. One participant noted that, under capitation, “What incentive does that pediatrician have? Even if he already has a NP or PA, he’s got them busy doing stuff, he can’t afford to pull them away to do screening.” Another participant remarked, “That’s the problem with the fee-for-service basis... it’s based upon physician visits... Sometimes physicians have to see people getting routine shots just because the reimbursement is higher.”

Practice-Level Incentives—Participants also reported that providers and medical groups were generally not incentivized by health plans to implement practice redesign to improve care: “I don’t see Medi-Cal–focused independent provider associations jumping up and down for delivery system redesign because it’s not the way their business incentives [work] today... They make their money regardless. Payers have not done as good of a job of aligning financial incentives.”

Pay for performance was discussed as one way that health plans could incentivize providers to implement redesign; however, there was concern that in capitated systems, the capitated amount to providers would have to be reduced to implement a robust pay-for-performance program: “We really try to get [the providers] all of the dollars we can on Medi-Cal over there to take care of these kids. If we do pay for performance, it means pulling some dollars back from that, and that just stresses [providers] even more... so it’s tough.”

MMC and HF Interviews

When presented with these themes citing regulatory policies as barriers to redesign, both MMC and HF administrators responded that, under their rules, health plans and medical groups actually had substantial flexibility. For instance, midlevel medical professionals (NPs, PAs) could provide WCC visits, assuming they worked under physician supervision. Although other nonphysicians (RNs, health educators) could not be the primary care provider, they could provide a variety of services as part of WCC.

Neither agency had specific policies barring plans or providers from using alternative formats of care; the agencies did not even know the format or location of the visit: “We would have no way of knowing if it was over the phone or in-person because it just came in as that encounter.” However, they acknowledged that providers were required to report visits using Current Procedural Terminology (CPT) codes that are included in the WCC-related HEDIS measures—these CPT code definitions explicitly describe an in-person visit. One participant said, “[Plans and providers would have to] find a way to bill for the codes that are in the HEDIS specs... that’s the key to being able to use phone visits and non–face-to-face visits in order to improve HEDIS rates.”

Finally, both agencies reported that although pay for performance to encourage innovation in delivery system design was desirable, the agencies themselves had no capacity to provide additional financial incentives to health plans as an incentive: “It’s all about money and we just don’t have any to do that right now.”

Discussion

Administrative and clinical leaders in health plans and medical groups reported that nonphysicians were underutilized as WCC providers, and that alternative formats such as group visits and Internet services may be a more effective way to provide anticipatory guidance and behavioral/developmental services. There are, however, major barriers to implementing these innovative changes, most notably a lack of incentives for plans and practices to invest in redesign. Although state agencies allow alternative providers, formats, and locations, they also require organizations to report performance on a narrow set of HEDIS measures, which may lead to the avoidance of non–face-to-face formats and specifically reward organizations for the number of face-to-face visits.

A fundamental way that practice redesign is conceptualized is that it has the potential to improve the quality of care while controlling costs.⁴¹ However, the cost savings from WCC innovations that improve preventive and developmental services (relative to cost savings from innovations that improve acute or chronic care) are likely more long-term, difficult to measure, more likely to benefit other or even nonmedical organizations, and more difficult to link to primary care improvements.²⁰ Given these inherent challenges in measuring WCC cost-effectiveness, organizations will need compelling incentives to encourage investments of time, staff, and money in creating WCC delivery innovations. For example, although pay-for-performance is becoming an increasingly important tool to incentivize practices toward providing higher-quality care, there are few similar “pay-for-innovation” programs that incentivize plans and practices to develop, test, and implement innovative ways to deliver care. Innovation incentives could conceivably be provided when organizations implement practice redesign efforts that have the potential to improve care, or as research and development funding to help them develop and test innovations.

Many participants reported that state regulations were an important barrier to practice redesign; in the state agency interviews, we found this barrier to be related to the state HEDIS reporting requirement. The CPT code definitions for WCC-related HEDIS measures describe an in-person visit (including a physical examination),⁴² creating a major barrier to the use of non–face-to-face formats. One exception is telehealth; this non–face-to-face visit format can include a physical examination, and currently at least 35 states, including California, allow for some reimbursement for telehealth services.^{43,44}

Adjustments to state reporting requirements that expand the definition of a visit to allow a certain number in other non–face-to-face formats and an emphasis on quality reporting beyond visit frequency and immunizations, including measures of quality (eg, receipt of standardized developmental screening), may help to encourage and reward practice innovation and could serve as a way to assess the delivery of care. Since Medicaid managed care plans are required to report HEDIS in at least 22 other states, this could have a significant impact on delivery system design innovation.⁴⁵ Alternatively, providing states with solid evidence that non–face-to-face formats are more cost-effective may be another strategy to address this barrier.

The use of Internet-based services was viewed by participants as a way to expand the breadth and depth of services provided outside of the in-office visit. However, Internet access in low-income families is an important consideration. In California, access varies by income; 66% of low-income adults compared with 86% of higher-income adults reported having home Internet access in 2010.⁴⁶ This proportion of low-income adults reporting access has increased over time and is up from 49% in 2008.

Under the Affordable Care Act (ACA), Medicaid payment rates for primary care will be increased to 100% of Medicare rates in 2014. The ACA includes a Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMI) that will investigate new service delivery and payment models, and a Prevention and Public Health Fund that provides mandatory funding for prevention and wellness programs.⁴⁷ These and other ACA provisions have the potential to encourage investment in WCC redesign; for these gains to be realized, innovations must be reconciled with quality measurement requirements.

Another question to consider is whether these innovations would actually improve care. Participants cited the use of nonphysicians and alternative formats as a way to improve the effectiveness and efficiency of care. Few studies have examined these claims for WCC, especially among low-income populations. Several studies examining group WCC suggest that it is at least as effective and likely more efficient in disseminating information to parents than individual WCC.^{48–51} In another study, researchers found that e-visits (visits conducted entirely via e-mail) were acceptable to clinicians for providing WCC services⁵²; no data is available on effectiveness. In a randomized controlled trial of a 15-minute newborn anticipatory guidance video (in addition to the newborn WCC visit), parents of newborns who watched the video had fewer additional office visits.⁵³ In a prospective controlled study of Healthy Steps for Young Children (a program using nonphysician providers to improve WCC by enhancing behavioral and developmental services¹⁵), participating families discussed more anticipatory guidance topics, were more likely to have a developmental assessment, and were more likely to comply with WCC visits and immunization schedules.^{15,54} More research is needed to examine both the costs and effectiveness of WCC delivered using practice innovations compared with usual care. A major challenge will be defining the outcomes. Because long-term outcomes are difficult to link to WCC, more short-term outcomes such as receipt of recommended preventive services, timely follow-up for children with identified delays, patient centeredness of care, health care utilization, and parent satisfaction may be important outcomes to consider in future trials, whereas long-term outcomes over the lifespan (eg, health and well-being) might be investigated through alternative techniques such as microsimulation modeling.⁵⁵

This study has several limitations. Our sampling strategy limits the generalizability of our findings; we focused on California organizations serving low-income children. Other states, however, are facing similar challenges to California, including large state budget deficits, an increasing proportion of publicly insured children, and high Medicaid managed care penetration.⁵⁶ Our focus on plans over medical groups may also limit our findings by payer organization type. Next, we asked respondents about specific practice redesign approaches in addition to more open-ended questions about practice redesign. Probing questions and

specific examples are often used in qualitative methods, especially to obtain respondent perspectives on specific items of interest that might not be spontaneously discussed otherwise.⁴⁰ Participant responses were likely shaped by their organizational experiences. For example, although the size of practices that care for Medi-Cal/HF child enrollees statewide ranges from 1- to 2-person practices to much larger practices, each organization has a different mix, and participants may have answered questions based on their own organizational characteristics. In addition, responses may have been shaped by respondents' educational background (eg, pediatric training) or work experiences (eg, prior clinical work with group visits). We do not provide respondent characteristics to preserve respondent privacy; however, our recruitment methods were designed so that respondents had at least some experience and/or knowledge in the area of child preventive health. Finally, participants discussed effectiveness and efficiency without providing evidence related to outcomes or costs.

Despite these limitations, our findings have important implications for WCC practice redesign. To support innovation in WCC delivery, payers will need to provide practices with compelling incentives to invest in practice redesign, including assistance with the logistic, design, and financial support required to develop, test, and implement innovations. State agencies may need to reshape incentives to reward quality regardless of WCC provider type, format, or location. Current reporting requirements do not incentivize organizations toward innovation in WCC delivery, and in some cases may discourage legitimate efforts in quality improvement.

Because of the Children's Health Insurance Program Re-authorization Act (CHIPRA) and expanded Medicaid coverage of parents under the ACA,^{30,47} there may be a greater proportion of publicly insured children in the United States. As the demand for primary care increases, perhaps beyond the capacity of our current workforce, the benefits of a redesigned WCC delivery system may become even more apparent, particularly as it has the potential to support the PCMH by creating a system of care that is more comprehensive, family-centered, and accessible.⁵⁷ With the ACA provisions, CHIPRA, CMI, and the PCMH, the time for improving the delivery of WCC may be at a critical tipping point.⁵⁸ Our findings may be critical for WCC redesign research and development as these various forces push delivery system innovation forward in public insurance programs for children.

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Appendix

Table

Selected Questions From Interview Guide (for Health Plans)

The topic of this interview is well-child care redesign. Well-child care includes a wide array of child preventive care services. There have been multiple proposals in the pediatric literature to “redesign” the way we deliver care to families. When thinking about redesign, many proposals have focused on alternative ways to deliver care to young children. I’d like to give you some examples of these, see if you have any other ideas, and find out if and how these alternative methods and modes of delivery could work in your organization.

A PROVIDERS

1. How is well-child care provided within [health plan]? What types of providers can conduct visits?
2. Do you currently use any nonphysician providers to provide well-child care services to your members? (IF YES—Which ones for which services?)
3. Would you consider offering some well-child care services using these nonphysician providers? Which types and for which services?
4. Are there any policy or procedural constraints that you [or health plan] have put in place that would preclude providers from doing this?
5. Would these different types of providers require separate billing (from the usual well-child care billing) for services provided?
6. Would current reimbursement systems support these additions/changes? If not, could they be easily altered to do so?
7. As [title], would you feel comfortable with these possible changes?

C FORMATS

1. Do you currently use any of these alternative formats to provide well-child care services to your members? (IF YES—Which ones for which services?)
2. Would you consider offering some well-child care services using these alternative formats? Which ones and for which services?
3. Are there any policy or procedural constraints that you [or health plan] have put in place that would preclude providers from doing this?
4. Would these different types of formats require separate billing (from the usual well-child care billing) for services provided?

5. Would current reimbursement systems support these additions/changes? If not, could they be easily altered to do so?

6. As [title], would you feel comfortable with these possible changes?

D LOCATIONS

1. Do you currently use any of these off-site locations to provide well-child care services to your members? (IF YES—Which ones for which services?)

2. Would you consider incorporating off-site locations for some well-child services? Which ones and for which services?

3. Are there any policy or procedural constraints that you [or health plan] have put in place that would preclude the use of off-site locations?

4. Would current reimbursement systems support these changes? If not, could they be easily altered to support these changes?

5. As [title], would you feel comfortable with these possible changes?

E OTHER

Are there any other changes or new models that you can think of that would improve the efficiency and effectiveness of well-child care?

Any other innovative changes to well-child care/child preventive services in [health plan]? Any plans for changes?

What's New

California payers reported that several options for practice redesign in well-child care could improve the effectiveness and efficiency of care; however, there were also several barriers to redesign, including a paucity of incentives to reward organizations for well-child care delivery innovation. Well-child care is a fundamental component of pediatric primary care—over one third of outpatient visits for infants and toddlers are for well-child care.^{1,2} The recommended number of visits and range of services provided during these visits have greatly expanded over the last few decades.^{3–5} At the same time, the proportion of children with chronic diseases that require ongoing management has increased over the past 20 years.⁶ This inexorable shift exerts more pressure on clinicians to develop primary care-driven medical homes that meet the needs of children with and without chronic conditions.

Table 1

Theme 1: Nontraditional Delivery Methods for Well-Child Care Delivery Are at Least As Effective and Efficient As Our Current Delivery System

There are several nontraditional methods for delivery of WCC* services that are more efficient and effective than our current system of care.

- A.** Subtheme: Nonphysician providers are underutilized as primary care providers of WCC services, and likely are more efficient and at least equally effective as physician providers.

"I think anticipatory guidance and the developmental behavioral services stuff is part of that. If we figured out how to do it, it could be done by other than the pediatrician... so those parts I think could be done by these other professionals probably more efficiently." (Public plan)

"Nonclinical folks can certainly do a lot of the psychosocial screening, the developmental screening, anticipatory guidance... A lot of the psychosocial and educational things, those programs have demonstrated in the medical literature for many years that lots of different people can do those." (Public plan)

- B.** Subtheme: Much of WCC could be done more effectively and efficiently by providing some services via phone, Internet, and in group visits; however, most alternative locations were generally not viewed as feasible for plans or practices.

Group visits

"I think the biggest format for nontraditional providers is the group appointments. Yeah, so if there were really strong curriculums and trainings and standardization and support for those, I think that's definitely something." (Public plan)

"Again, anticipatory guidance is something that's really amenable to group visits, it really is. You could do the group visit...you can lump all your 6-monthers together and then do all the 6-month anticipatory guidance to the whole group. And then see the patients separately and then kick them out a lot faster than your time with each one and they would have all received the right information." (Commercial plan)

Dissenting view: "Unless there is a mechanism inside the doctor's office that can say 'Here are 10 patients, all children under 1 year of age that need to come in for a well-child visit' or something like that, I don't know that they would know how to identify those patients in order to have them come into the office [for a group visit]." (Medical group organization)

Internet and phone services

"We do things all the time based on presentations, live presentations—Meeting Space. You could do the anticipatory guidance and all that like Meeting Space...that would be good. Webinars!" (Commercial plan)

"There are some excellent, especially commercial IPAs,^[7] that are leading the way to help get their solo practice private docs contracted, they're leading the way to help them redesign their practice, use health information technology and alternatives to the face-to-face visit, to achieve this more efficient, more productive better-quality package... If all IPAs were like that we'd be in a lot better shape." (Public plan)

Dissenting view: "Again, the problem though is reaching people by phone these days. Even getting a good phone number, and when to reach them, and if they work then you have to do it at night when they're at home. I know our member services does outreach but it's hard." (Public plan)

Home visits

"I can't see a pediatric setting where it would be cost-effective at all to make a home visit. Now, if the kid was on a ventilator, etc... But, for a well-baby exam and preventive care, I just can't see it." (Medical group organization)

"Home visits are expensive and doctors don't want to do them because they take so much time up... I just think they're on the rare side and I don't see that changing just because of the time constraints... Now see, a lot of these things are predicated on the fact that it's worth your time and money." (Public plan)

Dissenting view: "I think that home visits have opportunity, particularly when people have access issues." (Public plan)

Day care centers

"But if a physician went to a day care center and saw patients who could include our members it would probably be difficult for him to get... compensated because if they're undercapitated services the plan won't cover services that aren't provided by that capitated provider or authorized through that provider. So I don't see day care... I can't bill because I'm capitated already." (Commercial plan)

"Yeah it's really challenging...when you have all these tiny health plans or not even a huge health plan, but everyone just has one little piece of the pie, it's hard for them to say, 'let's transform the care at this one site,' because we can't afford to, we only have a small piece of it." (Public plan)

Retail clinics

"I know they have a different business model and it's not something that they've gone out to do but for us it's an experiment because the clinics are in the locations up where our members live and so it was a natural for us.... during the daytime we are going to try to push them back to their primary care office, but the bottom line is if they can't get to their PCP^[7] we would prefer them to go to [retail clinic name] or one of these retail clinics rather than going to the ER."[§] (Medical group organization)

“I would love to see them expand into well-child care. That’s something that I have supported but that’s not an opinion that I think is supported by our professional society, but I think that I would rather see people in that location than in a hospital location accessing services, personally.” (Commercial plan)

* WCC = well-child care.

† IPA = independent provider association.

‡ PCP = principal care provider.

§ ER = emergency department.

Table 2**Theme 2: Plans and Practices Face Several Obstacles to Implementing Well-Child Care Redesign**

Although these methods may be more efficient and effective, plans and practices face significant obstacles to implementing such changes.

- A.** Subtheme: The costs of using additional providers are too high for most practices, even if it may be a more effective and efficient way of providing care.

“There’s a certain amount of investment that goes into doing this [using a team of nonphysicians]. So, you’re asking the provider to put a lot of money and effort forward to, in the end, get reimbursed for nothing more.” (Commercial plan)

“A nurse educator is going cost \$50 000 a year, so... how many patients do you need in the practice to be able to spread the overhead expenses of that person. That’s why a larger group practice with multiple physicians in the group, you’re leveraging the business to be able to afford that person to do those additional services.” (Medical group organization)

- B.** Subtheme: Logistical barriers exist for use of alternative formats

Internet-based services

“I finally finished fighting with [providers in the practice] over fax machines—I told them you got to have a fax machine and you got to leave it on 24 hours a day or you can’t work with us. So, now the next push is [that they] got to have Internet capability...” (Public plan)

“... [there were] some studies 5 [or] 6 years ago that showed that the Medi-Cal population uses e-mail and the Internet more than people think. And so I think that there are some opportunities in that but there’s kind of a sense ‘well people won’t be using that.’ ” (Public plan)

Dissenting view: “And then you can get creative and certainly use the waiting room, which is what we did for ours, is we just closed down the waiting room...to do fully scheduled group visits. So all those things can be compensated because you can do a group visit with just one MA^{*} who works their way through it, or typically two MAs is more efficient. See I don’t think it takes more staff, it takes being willing to doing something different than you’re used to doing.” (Public plan)

- C.** Subtheme: Barriers to redesign related to financing and reimbursement exist in both capitated and fee-for-service payment systems

“As far as the Internet service it’s really not an issue in Medicaid because I’m not aware that Medicaid, that the regulators in California allow payment for that.” (Commercial plan)

“We don’t have a way at the moment to pay for non-face-to-face visits... our contracts today says, ‘face-to-face visits at this periodicity is consistent with AAP’.”[†] (Public plan)

“[Capitation], it drives that kind of mentality in the doctor’s mind that ‘I’m only getting 15 bucks a month for this patient and if I have to see him 3 times this month I’m losing money.’ So there’s all these perverse incentives and a lot of it depends on how the individual physician sees the relationship and how to work it and do that kind of thing. So I think that’s the thing that capitation, and you know when we want to do something new capitation often gets in the way because the first thing they say is ‘okay, well how much are you going to pay for this?’ And then the health plan’s going ‘well we don’t get any more for this but we’re trying to improve the care.’ But you know the health plan can only finesse that for so long.” (Public plan)

Dissenting view: “So I mean that’s one of the nice things in capitation is if you want to get creative in how you provide services to try to make things either more efficient or better, there’s nothing really stopping you from the financial side.” (Commercial plan)

* MA = medical assistant.

[†] AAP = American Academy of Pediatrics.

Table 3**Theme 3: There are Few Incentives to Encourage Investment in Well-Child Care Redesign**

Few incentives for redesign exist for plans or providers. Pay for performance and start-up grants may be important tools to incentivize practices, whereas health plans will likely require changes at the state level to help incentivize them toward redesign.

- A.** Subtheme: Plans are incentivized to improve performance on narrow set of measures that are generally not related to comprehensive WCC* services.

“And that’s one of the problems with HEDIS[†] because you know we are then incentivized in one way or another to look at things that are under HEDIS... but then we ignore other aspects. That’s the downside.” (Commercial plan)

“It may be that we wouldn’t see a direct return on investment or we may not even get count for HEDIS. ...but we still want to try and promote the care.” (Public plan)

- B.** Subtheme: For public health plans, a major incentive to improve the quality of care and member satisfaction is their organization’s public mission.

“What’s great about working for a plan like [health plan name] is we’re a public entity; we’re a mission-driven plan. Part of our goal is to make Medi-Cal work better for doctors and members and ultimately for the taxpayers that fund the program on behalf of the State. That’s our goal—we’re all about delivery system redesign and better change in payment...” (Public plan)

- C.** Subtheme: Pay for performance to incentivize providers to implement redesign efforts

“And then the private doctors... when they do a well-child check and then they spend some additional time doing some anticipatory guidance, then we give them that little extra money... I can’t figure out any other way for a health plan to support this type of work.” (Public plan)

“Pay for performance though also does create an incentive for that [practice redesign]. So not just us but all of the [the practice’s] other health plans participating in that, they’ve been doing very well on pay for performance and pulling in a lot of bucks from that which helps to support all of this infrastructure as well. It’s not enough to fully support it, but it certainly may, starts to make a business case that they can put themselves out there as being an efficient, high-quality medical system and doing things in ways that it actually can improve member satisfaction too.” (Commercial plan)

- D.** Subtheme: Incentives to practice redesign for health plans need to be addressed at the state level.

“I think that the biggest thing that they have to change is the CPT‡ definitions—because if you look at the CPT definitions they require face-to-face contact. So the first thing that’s got to change is the definition of that. Where there have to be some codes that are handled, that are then reimbursed, that support a non-face-to-face. You’ve got to have the ability... again it comes back to reimbursement... we have got to have our reimbursement infrastructure.” (Commercial plan)

“And you know the whole bottom line for any of this would be if we could make the state be like other states and Medicaid pays the equivalent to Medicare.” (Public plan)

* WCC = well-child care.

† HEDIS = Healthcare Effectiveness Data and Information Set.

‡ CPT = Current Procedural Terminology.