Abstract:
Pediatric acute care delivery has changed dramatically in the last 20 years. While acute care options were once limited to only primary care and the emergency department, additional options now include retail based clinics, urgent care centers, and telehealth. These alternate settings have proliferated because of convenience, low relative cost, and the appeal of a patient-centric model aimed at customer service and efficiency of care.
The patient-centered medical home has been slow to accept these changes with concerns about fragmentation of care and disruption to the medical home.
Specialized pediatric urgent care centers may bridge the gap in the medical neighborhood offering acute care when access to a primary care physician is unavailable and the emergency department isn't required. This article discusses the evolution of pediatric urgent care and how acute care sites can work together with the medical home and maintain high quality of pediatric care.
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Keywords:
acute care; medical home; medical neighborhood; patient centered medical home; pediatric urgent care; retail based care; urgent care

*PM Pediatrics, New Hyde Park, NY; †Division of Urgent Care, Children's Mercy Medical Center, Kansas City, MO; ‡University of Missouri-Kansas City School of Medicine, Kansas City, MO; §University of Kansas-School of Medicine, Kansas City, KS.
Reprint requests and correspondence: Toni Clare Hogencamp, MD, 1 Hollow Lane, Suite 301, New Hyde Park, NY 11042.
thogencamp@pmpediatrics.com

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The New Medical Neighborhood – Where Does Pediatric Urgent Care Fit in?

Toni Clare Hogencamp, MD*, Amanda Montalbano, MD, MPH†‡§

Over the last 2 decades, changes in health care economics have necessitated renewed interest in the patient centered medical home (PC-MH). The concept of the medical home for children was first introduced by the American Academy of Pediatrics (AAP) in 1967.[1] At the time, the concept was quite simple, a repository for medical information for children with complex medical needs. In 2002, with renewed interest in the medical home model, the AAP expanded its concept. According to the AAP, a medical home should be accessible and provide continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.[2] In 2007, a joint statement from several healthcare organizations was released providing guiding principles for the medical home (Figure 1).[3]

While the medical home is important for families, it can be difficult to meet the needs of all patients, all the time, within the 9-to-5 timeframe of a traditional office. Balancing patient needs for all stages of life—acute care, chronic care, preventive services, and end of life care—remains a challenge for the medical home. The inherent episodic and unpredictable nature of acute care poses challenges to be managed during business hours while competing with well-exams and chronic care coordination. Further, care delivery disruptors including Retail Based Care, Urgent Care, and telemedicine have posed new challenges, adding a level of convenience with which most medical homes now need to compete. This may be especially true in pediatrics where parents perceive many needs as acute and the family is unwilling to wait for

- Personal physician - ongoing relationship with an individual physician
- Physician directed medical practice – physician leads a team to collectively care for patients
- Whole person orientation – the physician provides or arranges for care of all patient needs for all stages of life - acute care, chronic care, preventive services, and end of life care.
- Coordinated care – care is coordinated and/or integrated across all elements of the health care system and the patient's community. Care is facilitated by electronic or other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- Quality and safety – these are hallmarks of the medical home including use of evidence based medicine, clinical decision support and continuous quality improvement.
- Enhanced access to care – access is available through systems such as open scheduling, expanded hours and new options for communication between patients, the personal physician, and practice staff.
- Payment for complex care – reimbursement should incorporate care coordination, patient medical and social complexity and efforts toward continuous quality improvement.

Figure 1. Principles of the patient-centered medical home. Adapted from Joint Principles of the Patient-Centered Medical Home, March 2007. Available at: http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf. Accessed 12–01–2016.

next-day availability within the medical home.[4] Primary care providers have tried multiple strategies to keep patients from seeking acute care outside of the medical home, including: extended ambulatory hours, designated after-hours practices within a call group, better availability for after-hours phone triage, and expanded walk in visit capabilities. Many of these strategies prove costly and may still not be centered on the patients' needs, highlighting the importance for the PC-MH to communicate with and understand local acute care offerings.[5]

The term "medical neighborhood" expands on the concept of the medical home. The medical neighborhood is comprised of specialists, hospitals, acute care facilities, and local resources including social services, physical therapy, and other community health services. With the focus on value-based care and the advent of Accountable Care Organizations, there is more pressure on the medical home to develop strong relationships with their medical neighbors, but to also better understand the value they provide. This article will discuss the various types of acute care facilities, highlighting the place for urgent care within the medical neighborhood.

ACUTE CARE NEIGHBORS—A BRIEF HISTORY

Traditionally, patients have had 2 choices for acute care—their primary care provider and the emergency department (ED). However, these 2 options are relatively divergent in scope and leave incomplete solutions to the many "on-demand" needs of patients. In the 1960s, house calls were a mainstay for physicians to provide after-hours or convenient care. As health care delivery models evolved, home visits became less financially feasible for physicians.[6] As EDs began to grow and home visits declined, new approaches to acute care delivery developed. A timeline of the evolution of acute care delivery models is discussed below and shown in Figure 2.

In the 1960s, physicians began to standardize care and staffing of hospital based emergency wards, leading to the formation of the American College of Emergency Physicians in 1968. While EDs managed the highest acuity patients with life-threatening illness and injury, they also provided a safety net for medical care. While this open-access provided critical resources for a community, it simultaneously led to ED overcrowding, highlighting the desire of patients to have access to care