

# Medical Home and Pediatric Primary Care Utilization Among Children With Special Health Care Needs

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## ABSTRACT

**Introduction:** The medical home model seeks to improve health care delivery by enhancing primary care. This study

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examined the relationship between the presence of a medical home and pediatric primary care office visits by children with special health care needs (CSHCN) using the data from 2005-2006 National Survey of Children with Special Healthcare Needs.

**Method:** Survey logistic regression was used to analyze the relationship.

**Results:** When CSHCN age, gender, ethnicity/race, functional status, insurance status, household education, residence, and income were included in the model, CSHCN with a medical home were 1.6 times more likely to have six or more annual pediatric primary care office visits than were children without a medical home [odds ratio = 1.60, 95% confidence interval = (1.47, 1.75)]. Female CSHCN, younger CSHCN, children with public health insurance, children with severe functional limitations, and CSHCN living in rural areas also were more likely to have a larger number of visits.

**Discussion:** By controlling for child sociodemographic characteristics, this study provides empirical evidence about how medical home availability affects primary care utilization by CSHCN. *J Pediatr Health Care.* (2013) 27, 202-208.

## KEY WORDS

Medical home, primary care, children with special health care needs

Approximately 10.2 million children ages 0 to 17 years in the United States (14%) have special health care needs. Children with special health care needs (CSHCN) are a diverse group characterized by a variety of physical, mental, and behavioral health conditions (Strickland et al., 2011), and they usually require more health-related services than generally are needed by children of similar ages (Blumberg et al., 2007;

Newacheck, 2007; U.S. Department of Health and Human Services, 2007). Overall, CSHCN account for more than 42% of all medical expenditures for children (Newacheck & Kim, 2005). This high cost of care was recently supplemented by a finding that CSHCN health expenditures were on average three times higher and hospital expenses were four times higher than those of healthier children (Cohen et al., 2010).

Some studies found that CSHCN made a significantly higher number of physician office visits than did children without special health care needs (Houtrow, Kim, Chen, & Newacheck, 2007; Martin, Crawford, & Probst, 2007). Weller, Minkovitz, and Anderson (2003) noted higher rates of hospitalizations and emergency department (ED) visits among CSHCN with severe functional limitations but found no differences in the number of pediatric primary care (PPC) office visits. According to the 2008 National Survey of Children's Health, children with special needs had more well-child visits than did other children (Cooley, McAllister, Sherrieb, & Kuhlthau, 2009). Nageswaran, Roth, Kluttz-Hile, & Farel (2007) reported higher rates of health care needs among CSHCN with greater functional limitations but found no increase in preventive or health assessment office visits. Similarly, a 2004 study found no difference between children with and without special health care needs in terms of preventive care (Bethell, Read, & Brockwood, 2004). Some evidence indicates that CSHCN receive less preventive and well-child care than their healthy peers because their health care needs may dominate the time and conversation during PPC office visits (Ayyangar, 2002).

In recent years, an increasing emphasis has been placed on improving health care delivery for CSHCN in the context of the family and community (American Academy of Pediatrics, 2009; Coker, Rodrigues, & Flores, 2010; National Association of Pediatric Nurse Practitioners, 2009). The American Academy of Pediatrics defined medical home not only as the central location for receiving medical services but also a source of preventive care and a resource for community information and support (American Academy of Pediatrics, 2002). The National Association of Pediatric Nurse Practitioners (2009) supported the approach and proposed to expand the medical home concept to all children and their families in the United States. The Patient Protection and Affordable Care Act (2010) emphasized the need for strong primary care based on the medical home model. The Law also stipulates medical home provisions for persons with chronic medical conditions (Sec. 2703).

The presence of a medical home is associated with a number of positive patient outcomes. Research indicates that availability of the medical home has a considerable potential to reduce emergency and urgent care use for all children (American Academy of Pediatrics,

2002; Antonelli, Stille & Antonelli, 2008; Cooley et al., 2009). In fact, a 2008 study found that having at least the recommended number of early periodic screening, diagnostic, and treatment visits might shift some health provision from the ED to the PPC office (Rosenbaum, Wilensky, & Allen, 2008). Strickland, McPherson, and Weissman (2004) found that children without a medical home were more than twice as likely to have unmet health care needs than were those with a medical home. Unmet child health care needs have been linked to a number of socioeconomic factors such as poverty, minority status, lack of health insurance, and lower parental education (Inkelas, Raghavan, Larson, Kuo, & Ortega, 2007; Mayer, Skinner, & Slifkin, 2004; Singh, Strickland, Ghandour, & van Dyck, 2009).

The purpose of this study was to examine PPC utilization for CSHCN with a medical home and CSHCN without a medical home. When medical homes provide comprehensive health care services and community information to CSHCN and their families, it is reasonable to assume that more visits to the PPC provider would be needed to address CSHCN acute and chronic conditions in addition to well-child examinations. Thus we hypothesized that having a medical home would be associated with a higher number of PPC office visits. We also posited that some CSHCN sociodemographic characteristics would be associated with a higher number of PPC office visits.

## METHODS

### Population and Sample

Data collected by the 2005-2006 National Survey of Children with Special Healthcare Needs (NS-CSHCN) were used in this study. The NS-CSHCN is a random-digit-dial telephone survey of parents or guardians in households with children younger than 18 years. The national overall response rate for the 2005-2006 NS-CSHCN was 56% (American Academy of Pediatrics, 2009). A total of 363,183 households were screened for CSHCN. Interviews were completed for 40,723 CSHCN; these data were used in this study ( $N = 40,723$ ). All results reported in this study are survey weighted according to the NS-CSHCN guidelines to compensate for a selection bias or cluster sampling. Because the data did not permit us to examine sick visits alone, this study included all PCP visits including sick, preventive, and well-child visits. The study was approved by the corresponding Institutional Review Board.

### Measures and Analyses

The outcome variable—that is, the number of PPC office visits by the CSHCN in previous 12 months—was measured by one NS-CSHCN question: “In the past 12 months, how many times has your child been for a doctor visit?” Two categories were created to examine this outcome: (a) no visits to five visits (the low PPC visit category) and (b) six or more visits (the high PPC visit category).

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