

## Strengthening Health Care for Children: Primary Care and the Medical Home



**National Business Group on Health**

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### Overview

Employers have good reason to be concerned about the decline in children’s health in the United States. About a third of large employers’ health insurance beneficiaries are under the age of 25.<sup>1</sup> With 56% of large employers’ employees receiving health care coverage for dependents,<sup>2</sup> employers provided health care coverage to about 58% of all U.S. children and adolescents in 2005.<sup>3</sup> Because of the ever-increasing cost of health care, employers should be more invested than ever in preventing chronic diseases in their health plan participants.

Children’s illnesses can also result in reduced productivity among their caregivers. Working parents with young children in child care typically miss 9 days of work annually due to their children’s illnesses, and parents of elementary-school-aged children miss up to 13 days.<sup>4</sup> These illnesses can also result in parents being late to work, having difficulty concentrating at work (sometimes called “presenteeism”), and in extreme cases, quitting their jobs to care for children.

Employers, as purchasers of health benefits, are well-positioned to make changes that will improve the quality of children’s health care and expand access to it. It is especially vital that employers emphasize the importance of primary care for children and work to ensure that all children have a usual source of continuous and comprehensive care.

### **The State of Children's Health**

The number of children and youth with health problems has increased dramatically in recent years. Obesity is just one example. In 2005-2006, 30% of children and adolescents aged 2 to 19 years were overweight or obese, with 16% in the obese category.<sup>5</sup> This is a dramatic jump from 1971-1974 when only 5% of children and adolescents were obese.<sup>6</sup> Obesity and overweight are major risk factors for chronic diseases; for example, one in six overweight adolescents is pre-diabetic.<sup>7</sup>

The prevalence of asthma (now 9% of children and adolescents)<sup>8</sup> has more than doubled since the 1980s.<sup>9</sup> Children are increasingly being diagnosed with attention-deficit/hyperactivity disorder (ADHD). Between 1997 and 2006, the rate of diagnosis increased by an average of 3% per year. More than 8% of school-age children are now diagnosed with ADHD.<sup>10</sup>

A study of the use of medications for chronic diseases in children showed remarkable percentage increases between 2002 and 2005. This was particularly striking in the case of diabetes:<sup>11</sup>

- Diabetes: 103.3%
- Asthma: 46.5%
- ADHD: 40.4%
- High Cholesterol: 15%
- Hypertension: 1.8%
- Depression: 1.8%

## **Current Problems in Health Care for Children**

### **Continuity of Care**

Despite the fact that most children have a usual place of health care, only about half of all children have a specific clinician—even among children who receive care in a private group practice.<sup>12</sup> This is troubling because the basis for effective pediatric primary care is the ongoing relationship with a provider who can recognize changes in a child and provide guidance about appropriate child development to parents. Parents also tend to associate a single continuous provider with higher quality care, and those with greater continuity of care are more likely to report feeling that they were listened to and respected and that things were explained well.<sup>13</sup> Conversely, lower continuity of primary care is associated with higher risk of emergency department use and hospitalization.<sup>14</sup>

It is especially important that families have a usual source of primary care for their well-child visits, where guidance about appropriate child development and what parents should expect is provided. Assessment and guidance on health topics are most effective when there is an ongoing relationship between the parent and the provider.<sup>12</sup>

### **Time and Reimbursement Barriers**

The preventive services recommended for children by the U.S. Preventive Services Task Force require an estimated average of 37 minutes per patient per year.<sup>15</sup> However, pediatricians report that an average visit lasts only about 15 minutes, and following the increasing number of recommendations for evidence-based services takes far longer.<sup>16</sup> However, because primary care providers (PCPs) are paid per service and payments are lower than for specialists, PCPs are forced to try to fit in as many patients per day as possible.<sup>17</sup> PCPs also report that treating the increasing number of patients with chronic conditions makes their job more difficult, even as they are being reimbursed at lower rates for the care they provide.

### **Pediatric Subspecialists**

While there are a sufficient number of pediatricians in the United States, there are shortages of certain pediatric subspecialists (e.g., pediatric heart specialists, pediatric surgeons, pediatric gastroenterologists, pediatric urologists). There is decreasing access to pediatric subspecialty care — it is not unusual to wait six months or longer for an appointment.<sup>18</sup> As a result, children often risk foregoing care and/or suffering adverse health consequences because of lengthy wait times for appointments and delays in obtaining diagnoses and interventions. Their family members may have increased stress and anxiety, which in turn can affect work productivity. The shortages of subspecialists also increase health care system costs. For example, when children are unable to get appointments with pediatric subspecialists, there may be an increased reliance on emergency room services.<sup>19</sup>

Among the primary causes of these problems are:<sup>19</sup>

- The insufficient number of pediatric subspecialists
- The dramatically increasing demand for pediatric subspecialist care due to the increasing frequency of chronic conditions
- A fragmented and inefficient system of pediatric primary and specialty care

### **Screening**

The keys to early detection of disabilities and chronic diseases are surveillance and screening. Developmental delays in babies and young children serve as an early-warning system for later developmental problems such as autism, intellectual disability, hearing or vision impairment, cerebral palsy, speech and language disorders, and learning disabilities. When such conditions are

identified early, treatment can begin as soon as possible, which may lead to better outcomes for children. Unfortunately, these conditions are not identified in many children until kindergarten or later, beyond the period in which early intervention is most effective.<sup>20</sup> Research shows that \$13 is saved for every dollar spent on early intervention services for children with disabilities.<sup>21</sup>

It is important that providers use standardized tools to identify and pinpoint any risks observed during the physical exam.<sup>22</sup> However, most pediatricians use informal observational methods that have limited validity, and pediatric practices identify only about one third of the 12%-16% of children with developmental problems.<sup>23</sup>

### **Coordination of Care**

Families of children who are ill or who have chronic conditions often experience a great deal of stress related to coordinating their child's care. For example, the parents of children with autism use an average of six different services over a six-month period, have an average of eight providers involved in their child's care and spend approximately 37 hours in interventions each week. With these extreme time demands, it is not easy for parents to take the initiative to ensure collaboration and communication among service providers.<sup>24</sup>

The United States often lacks comprehensive and collaborative care.<sup>25</sup> Specifically, parents of children with chronic health problems identify the lack of coordination of care as a major unmet health care need. The problem includes lack of communication with providers, difficulty coordinating care between providers, disconnects between services and being excluded from decision-making.<sup>26</sup> Not surprisingly, families who feel that their child has unmet health care needs often experience a greater sense of burden than other families.<sup>25</sup>

**Children with Special Health Care Needs**

Approximately 13% to 15% of children (22% of all households)<sup>27</sup> in the United States have special health care needs.<sup>28</sup> Children with special health care needs are defined as “those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”<sup>29</sup> Employers cover the majority of children with special health care needs. In 2005, 66.5% of children with special health care needs were covered by private insurance.<sup>30</sup>

The demands of caring for a child with special health care needs (CSHCN) can affect an employee’s health and workplace performance. In one recent study, 30% of parents of CSHCN reported missing one to four weeks of work per year to care for their child, and 18% missed more than four weeks. In addition, 41% of these parents said that in at least one instance in the last year, they did not miss work even though they believed they needed to because of their child’s illness.<sup>31</sup> The worry associated with not being able to care for a sick child almost certainly leads to reduced productivity during working hours.

Parents of children with special health care needs also spend a significant amount of time coordinating their children’s care. In fact, 10% of families of CSHCN report spending more than 11 hours per week arranging care and providing health care to their children (e.g. administering medication or therapies, transporting them to appointments, maintaining equipment). Almost a quarter of parents of CSHCN report having to stop work or cut back their hours at work because of their child’s needs.<sup>29</sup>

Approximately one third of families of children with special health care needs who have insurance report that it is not always adequate to meet their child’s needs, either because the benefits do not meet their needs, the charges are not reasonable, or they do not have access to the providers they need.<sup>29</sup> Health care expenses related to CSHCN are great: children with special health care needs have three times the medical costs of those without special health care needs.<sup>32</sup>

## The Importance of Primary Care

Primary care is crucial to ensuring the health of children and reducing health care costs. PCPs emphasize preventing, detecting and managing chronic disease and injuries. They provide continuous and comprehensive care and serve as the entry point to the health care system. Their offices are also a natural place for surveillance and screening for developmental disorders to begin, because providers who have an ongoing relationship with the patient and family are more likely to notice subtle changes in behavior or health status. PCPs (particularly pediatricians) are especially important in providing well-child care—the foundation of health care for children. Well-child care requires multiple visits for screenings, counseling, immunizations and other services.

For more information about well-child care, see *Recommended Wellness Visits Charts for Children, Adolescents and Women* at [http://www.businessgrouphealth.org/pdfs/NBGH\\_WellChild\\_final.pdf](http://www.businessgrouphealth.org/pdfs/NBGH_WellChild_final.pdf).

An increasing emphasis on primary care leads to lower per capita health care costs, better health outcomes and increased patient satisfaction.<sup>33</sup> Countries with stronger primary care systems have lower overall mortality and morbidity rates than countries that place less emphasis on primary care. In particular, countries with a strong primary care focus have better outcomes for health during early childhood (e.g., lower rates of low birth weight, post-neonatal mortality, infant mortality and child mortality).<sup>34</sup> Primary care services are also less costly than specialty care, and areas of the United States with more available primary care doctors report lower health care costs than other areas.<sup>35</sup> Unfortunately, the health care system in the United States is not oriented toward primary care.<sup>36</sup>

Regular preventive and primary care is associated with<sup>37</sup>

- Lower per-person costs
- Fewer emergency room visits
- Fewer hospital admissions
- Fewer unnecessary tests and procedures
- Less illness and injury
- Higher patient satisfaction

It is projected that if a metropolitan statistical area with a population of 775,000 increased its proportion of primary care physicians by 5% — from 35% to 40% of total physicians— it could have approximately 2,500 fewer inpatient hospital admissions per year. If the city's average hospital admissions charge was \$9,000, this would save nearly \$23 million in health care costs. The increase would also mean a projected 15,000 fewer emergency room visits and 2,500 fewer surgeries.<sup>38</sup>

## Potential Models for Improvement and Employer Strategies

Ill and injured children are a source of increased direct and indirect costs to employers. For example, a substantial portion of employees' lost work time can be attributed to children's health problems. Furthermore, children are the workforce of the future. It is imperative that employers find effective strategies to improve the health of children and adolescents.

### The Medical Home

The American Academy of Pediatrics (AAP) introduced the medical home model (also known as the "health home") in 1967; the term initially referred to a central "home" for a child's medical records. Since then, the model has grown in popularity and has been expanded to represent a partnership between a patient, his or her family, and their primary health care provider, who provides first contact and continuous, comprehensive care.

The goals of the medical home include increased access to higher quality care, a focus on preventive services, and early identification/management of health problems.<sup>39</sup> The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, together representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the medical home:<sup>40</sup>

- Personal physician: each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician-directed medical practice: the physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation: the personal physician is responsible for meeting all of the patient's health care needs or appropriately arranging care with other qualified professionals.
- Coordinated and/or integrated care: care is coordinated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchange and 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:** including the use of a care planning process, evidence-based medicine, clinical support tools, continuous quality improvement, patient feedback and participation in decision making, and information technology.
- **Enhanced access to care:** through systems such as open scheduling, expanded hours and new options for communication between patients, their physician, and office staff.
- **Appropriate payment:** payment that recognizes the added value of a patient-centered medical home, including reimbursement for patient-centered care management that falls outside the face-to-face visit; services associated with coordination of care; adoption and use of health information technology; enhanced communication access; and remote monitoring of clinical data. Separate fee-for-service payment should be offered for face-to-face visits, and payment structures should recognize case mix differences in the patient population being treated.

### **Benefits of the Medical Home**

People with medical homes are more likely to report better access to care, better coordination of care, improved communication with their primary care providers and fewer medical errors.<sup>41</sup>

The medical home model is a means of strengthening the primary care system in the United States. It has been shown to improve the quality and cost-effectiveness of care for patients with chronic diseases, which are a huge cost-driver in our current system.<sup>37</sup> Medical homes are also associated with better preventive care. For example, 42% of those with a medical home have their blood pressure checked regularly, compared to 20% of those without a medical home.<sup>45</sup>

Unmet health care needs and the lack of a regular source of care are associated with lower overall health-related quality of life in children and adolescents.<sup>42</sup> Of those with a medical home, 74% always get the care they need, compared to 52% of those without a medical home.<sup>34</sup> A medical home provides a regular source of preventive and primary care that results in lower per-person costs through reduced emergency room use, fewer unnecessary tests and procedures, and fewer hospital admissions. It also increases the quality of care—specifically, by reducing rates of illness/injury and increasing reported patient satisfaction.<sup>39</sup>

The medical home may be of increased benefit to children with special health care needs. Parents of CSHCN who have a medical home also report significantly less delayed or foregone care than parents of CSHCN who do not have a medical home.<sup>43</sup>

**Case Study: Community Care of North Carolina**

In 1998, the state of North Carolina began a medical home project with the goal of managing Medicaid patients in rural areas by linking small practices with a local hospital and other safety net providers. The program is now statewide and includes approximately 3,000 physicians and 13 insurance networks.

The networks are required to address four quality improvement areas:

- Disease management
- High-risk and high-cost patients
- Pharmacy management
- Emergency department usage

North Carolina providers receive \$2.50 per member per month to work together to create a medical home and give the state their data. Local networks receive \$3.00 per member per month for case and disease management activities and staffing. Medical home and network payments for patients with more complex problems (e.g., those with blindness, deafness, or disabilities) are \$5.00 and \$8.00 per member per month, respectively. The network payments provide resources for networks to improve patient care and coordination by, for example:

- Hiring case managers/care coordinators to work with primary care physicians and patients.
- Reimbursing a part-time medical director and paying for medical management committee meetings of key physician leaders from participating practices.
- Hiring a local clinical pharmacist to assist with complex medication problems.

Even with these additional costs, a 2007 study by Mercer Human Resources Consulting Group showed that the program saved approximately \$218-\$240 million during fiscal year 2005 and \$284-\$314 million during fiscal year 2006. For more information, see [www.communitycarenc.com](http://www.communitycarenc.com).<sup>33, 44</sup>

**How can the medical home potentially address the problems in pediatric care?**

<b>Issue</b>	<b>Potential Medical Home Solutions</b>
Continuity of Care	<p>Identification of a primary provider who serves as first contact and single point of entry into the health care system</p> <p>The same primary provider is available throughout childhood and adolescence</p> <p>When a child is hospitalized or treated by another provider, the primary physician participates in discharge planning</p>
Time and Reimbursement Barriers	<p>Appropriate reimbursement means that providers can spend more time with each patient</p> <p>Higher reimbursement for the time and expertise needed for children with special health care needs</p>
Pediatric Subspecialists	<p>Physician consults with specialists as needed, then refers only when appropriate</p> <p>Primary and pediatric subspecialists collaborate to establish shared treatment plans</p>
Screening and Surveillance	<p>Provider is more familiar with the patient and can recognize developmental problems sooner</p> <p>Greater focus on prevention and early intervention</p>
Coordination of Care	<p>Reimbursement for telephone consultations with other providers</p> <p>Personal physician is responsible for arranging all of patient's care</p> <p>When referring a patient to a subspecialist, the primary provider follows up to communicate clinical issues</p> <p>Care is facilitated by registries and health information technology</p> <p>Families are linked to community support resources when available</p>
Increase in Chronic Diseases	<p>Greater likelihood of receiving preventive care, immunizations and disease/case management</p>

### **Challenges to Adoption**

Despite the advantages of the patient-centered medical home, the model has not been widely adopted. According to the Commonwealth Fund, only 27% of Americans report having a medical home.<sup>45</sup> This is partially due to a lack of resources to support the medical home model. Research shows that it would require a one-time investment of approximately \$100,000 for a primary care physician to establish a medical home, and ongoing expenses would increase by \$150,000 or more.<sup>46</sup> Also, reimbursement structures do not currently support the establishment of medical homes. Payment methods that reimburse providers for various aspects of the medical home model, such as team consultation and e-mail/telephone communication, are needed in order for more primary care doctors to transform their practices. It is also crucial that physicians are given financial incentives and allowed to share in the cost-savings related to the medical home.<sup>41</sup>

In 2003, less than half (46%) of U.S. children and adolescents received care that met the American Academy of Pediatrics' definition of a medical home.<sup>47</sup>

### **How Can Employers Support the Medical Home?**

#### ***Align payment strategy with medical home objectives.***

The key to the success of the medical home initiative is to provide incentives that promote behaviors which strengthen the primary care system. The Patient-Centered Primary Care Collaborative (a coalition of major employers, consumer groups, patient quality organizations, health plans and others) suggests that employers should work with their health plans to provide:

- Compensation for face-to-face consultations as well as those conducted by e-mail or phone
- Compensation for services associated with the coordination of specialist care and the monitoring of test results and procedures performed by specialists
- A hybrid model of payment:
  - Fee-for-service based on hours of contact with the patient
  - Performance-based incentives, including sharing emergency room cost savings, and compensation for achieving measurable and continuous patient health improvements

Similarly, the American College of Physicians' proposed hybrid payment structure includes:

- A fee-for-service component
- A monthly fee for care coordination that would be risk-adjusted for the severity and complexity of the patients' illnesses. The fee is meant to cover:

- Care not provided through face-to-face visits
- Implementation of health information technology and other systems
- A pay-for-performance bonus

***Participate in a regional pilot program.***

There are many medical home pilots underway around the country. Employers can encourage or require contracted insurers to participate in a multi-payer pilot program. The Patient-Centered Primary Care Collaborative has a comprehensive list of pilots taking place in various states: [http://www.pcpcc.net/content/pcpcc\\_pilot\\_report.pdf](http://www.pcpcc.net/content/pcpcc_pilot_report.pdf). Employers can find additional information here: <http://www.pcpcc.net/content/center-multi-stakeholder-demonstrations>.

***Work with health plans to implement a pilot program.***

Some large employers are sponsoring their own medical home pilot programs. For example, IBM and UnitedHealthcare recently announced their plan to initiate a patient-centered medical home pilot program in Arizona. Blue Cross Blue Shield of Michigan also just designated more than 1,000 primary care physicians across the state as patient-centered medical home providers, eligible for 10% add-on payments for several office billing codes. They reported that nearly two million people in Michigan might now be recipients of medical home services.

***Partner with health plans and data warehouses to inform primary care practices.***

Employers can work with their health plans to provide information and feedback that will assist primary care providers in evaluating how well their practice meets the criteria for a medical home. Three types of information may be especially helpful:

- Information about their individual patients' needs and use of medical care (e.g., prescription drug use, inpatient care, emergency room visits, patients who are due for preventive care services, etc.)
- Information about their own performance, including comparisons to those of their peers or to objective benchmarks (e.g., an individual profile on their performance in critical areas, such as immunization rates and specialty care visit rates)
- Information regarding best practices and continuing education

***Build or join coalitions in support of the medical home.***

Employers may want to consider partnering with their outside vendors and other interested stakeholders in the regions where they have employees (e.g., primary care pediatric clinics, early intervention and education systems, state and local governments, professional organizations and other community agencies) to build coalitions that advance the adoption of the medical home model. Alternatively, employers may want to join existing coalitions that support the medical home. For example, the Patient-Centered Primary Care Collaborative and the Bridges to Excellence (BTE) organization have joined other organizations representing physicians to develop the BTE Medical Home recognition program. This program provides physicians who meet certain requirements with \$125 per year for each patient who is covered by participating employers.

***Educate employees about the importance of primary care and the medical home.***

Employers may want to consider requiring their employees to choose a primary care provider or giving them incentives to do so. Employers can support medical home initiatives by giving employees information about the care provided in a medical home, written in an easily understandable style. It may also be helpful to provide information about the medical homes that are available in their community (if applicable). Employees who are pregnant should make every effort to identify the child's medical home/primary care provider before the child's birth.

**Other Employer Strategies**

The patient-centered medical home is only one model geared towards strengthening the primary care system in the United States. However, lessons from the medical home principles can serve as a starting point for improving health care services for children. For example, employers can work with their health plans to reward providers who use health information technology, open-access scheduling, enhanced communication techniques and patient reminder systems. They can also work to educate employees about the importance of primary care, encourage employees to keep personal health records for their children, and give medical practices feedback on their performance. Other strategies for improving primary care services for children are listed below.

**Pay-for-Performance**

Pay-for-performance (P4P) programs use financial and non-financial incentives to reward health care providers who achieve a specific level of performance or performance improvement in care delivery. Performance goals can be set in a variety of areas, including utilization management, clinical outcomes, and patient satisfaction. Typically, P4P programs are sponsored by health plans, but large employer groups and coalitions are also providing incentive programs for physicians who care for their employees. Incentives generally fall into the following categories:<sup>48</sup>

- **Threshold bonus payments:** if physicians demonstrate the delivery of required processes/outcomes, they are eligible for a payment.
- **Tiered bonuses:** top tier providers receive the most money, the second tier receives somewhat less, etc.
- **Quality infrastructure grants:** designed to support the investment required to participate in P4P programs (e.g., investment in health information technology).
- **Contract negotiations/at-risk contracting:** the purchaser may make a portion of the annual payment increase contingent on a specified level of performance.

The amount of the incentive often influences whether a physician decides to participate in a particular improvement in the care process. Typically, incentives must at least significantly contribute to the cost of change. For example, the average investment for a practice of three physicians to adopt new clinical information and patient management systems is \$50,000.<sup>49</sup>

### **On-Site Medical Clinics**

Employers can consider opening their on-site medical clinics to dependents in order to encourage increased use of primary care. More than a third of large employers offer a worksite or near-site medical clinic. The largest proportion of these use their clinic for occupational health services (31%), but 24% (and 34% of the largest employers, those with more than 20,000 employees) either currently provide primary care services or are planning on doing so. About one third of employers who offer an on-site or near-site primary care clinic allow retirees, covered dependent adults, and covered dependent children to use clinic services.<sup>50</sup>

### **Reimbursement for Care Coordination**

In a recent study, families who received care coordination services got significantly more preventive and developmental services than families who did not.<sup>51</sup> Employers should consider working with their health plan to ensure that care coordination is funded. This can be done in many different ways, including any or all of the following:

- Encourage pediatric primary care practices to hire a staff member who is responsible for care coordination.
- Reimburse for care coordination CPT codes, including telephone and e-visit codes added in 2008.
- Provide a prospective, per patient, per month bundled care coordination payment to providers. Practices that take care of patients with more complex diseases should receive an appropriately higher care coordination fee for such patients.

### **Get Involved**

The National Business Group on Health is currently working to support the following primary care characteristics:<sup>52</sup>

- First Contact and Access
  - Initial point of care for medical needs
  - Accessible days/nights/weekends
  - Timely appointments, open-access scheduling
- Comprehensive
  - Address preventive, acute and chronic health needs
  - Care team meets clinical needs
- Continuous and Coordinated
  - Sustained relationship
  - Facilitate referral and services to other providers

- Primary care team involvement in care by other providers
- Coordinated patient communications
- Health Information Technology and Clinical Tools
  - Electronic medical record, e-prescribing, registries, clinical decision supports
  - E-visits, secure messaging, online scheduling, telephone communication
- Patient-Centered
  - Support patient education, decision-making and self-management
  - Respect beliefs, preferences, psychological and physical needs
  - Engage family and community resources
- Transparent
  - Price, discount disclosure
  - Performance disclosure

Employer members of the National Business Group on Health can become involved in these efforts by working with the Primary Care Work Group, the National Leadership Committee on Employer and Health Plan Solutions, and the National Committee on Evidence-Based Benefit Designs. For more information, see [www.businessgrouphealth.org](http://www.businessgrouphealth.org).

## **Conclusion**

As health care costs continue to increase and our population ages, the United States needs to put greater emphasis on preventive services. Health care for children—one of our most vulnerable populations as well as the workforce of the future—should be a principal concern when reforming the American health care system and increasing its focus on primary care services.

The medical home model is just one of many mechanisms to be considered in primary care reform. As a proven method of integrating primary care for children and adults, the medical home model may benefit both care providers and recipients. Consequently, employer support of this model and/or other primary care reforms is vital.

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# ISSUE Brief

October 2009

## Strengthening Health Care for Children: Primary Care and the Medical Home



**National  
Business  
Group on  
Health**

**Center for  
Prevention  
and Health  
Services**

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### Acknowledgements:

This issue brief was generously funded by Grant #G96MC04447 from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. All materials are in the public domain.

### About the Center for Prevention and Health Services

Mission: Educate large employers about diseases and health issues in order to protect and promote health and well-being among their employees and beneficiaries as well as control costs.

The Center:

- Identifies strategies and develops tools to address health and benefits issues.
- Translates health research into practical solutions for large employers.
- Provides the national voice for large employers and links them with national expertise and resources.

For more information, e-mail [healthservices@businessgrouphealth.org](mailto:healthservices@businessgrouphealth.org).

### Issue Brief

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### About the National Business Group on Health

The Business Group is the only non-profit organization devoted exclusively to representing large employers' perspectives on national health issues and providing solutions to its members' most important health care and health benefits challenges. The Business Group fosters the development of a safe health care delivery system and treatments based on scientific evidence. Members share strategies for controlling costs, improving patient safety and quality of care, increasing productivity and supporting healthy lifestyles.

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