Position Statement on Pediatric Health Care/Medical Home: Key Issues on Care Coordination, Transitions, and Leadership

The National Association of Pediatric Nurse Practitioners (NAPNAP) affirms that the delivery of children's health care should be family-centered, accessible, comprehensive, coordinated, culturally appropriate, compassionate, and focused on the overall well-being of children and families. All qualified pediatric health care providers should collaborate in providing health care services for children in pediatric health care/medical homes. Interventions must address the concepts of family-centered partnerships, community-based systems, and transitional care from pediatric to adult services.

The pediatric health care/medical home is a model of care that promotes holistic care of children and their families where each patient/family has an ongoing relationship with a health care professional. Children accessing services in a health care/medical home receive management of both their acute and chronic health issues. They and their families also benefit from motivational and anticipatory guidance in health promotion, reinforcement of positive parenting behaviors, parent education, behavioral consultation, nutrition and safety education, developmental assessments, and referrals to community resources. Children and youth with special health care needs (CYSHCN) who receive health care within health care/medical homes have better health outcomes than do those who receive health care in non–medical-home settings (American Academy of Pediatrics, 2014). The outcomes demonstrated with CYSHCN strongly suggest that all children receiving health care services would benefit if they were served using the same health care/medical home model as is recommended for CYSHCNs.

Transition planning to adult health care providers needs to be a standard part of the care received by CYSHCN once they reach young adolescence (Betz, Lobo, Nehring, & Bui, 2013). An individualized transition plan should be developed in partnership with the youth and family with consideration for emotional and cognitive development and social supports. Within health care/medical homes, adolescents and young adults require a gradual transition process that includes coaching and scaffolding youth to become self-directed and increasingly independent in their health care (Fegran, Hall, Uhrenfeldt, Aagaard, & Ludvigsen, 2014).

Pediatric nurse practitioners (PNPs) have the education, knowledge, and skills to successfully lead, coordinate, and manage care within health care that focuses on care coordination, holistic care, and family well-being. PNPs deliver a variety of pediatric health-related services: health promotion, health maintenance, acute illness and chronic condition management, and specialty care. While providing these

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All regular position statements from the National Association of Pediatric Nurse Practitioners automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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services, PNPs create partnerships for family empowerment that support the physical and behavioral needs of children and adolescents and promote family strengths and well-being. Studies support outstanding outcomes of PNP care coordination within comprehensive care delivery teams for children with complex conditions (Adams et al., 2013; Gresley-Jones, Green, Wade, & Gillespie, 2015). Randomized clinical trials (Harris & Samuels, 2015; Mosquera et al., 2014) of coordinated care by two PNPs found striking reductions in children's serious illnesses and health care costs. In another study, PNPs played key roles in a health care/medical home intervention, demonstrating improved parent satisfaction, child health, and caregiver strain (Farmer, Clark, Drewel, Swenson, & Ge, 2011).

Studies where PNPs played key roles in health care/medical home interventions support a model by Looman and colleagues (2013), the Value Model of Care Coordination, that describes the "dose" of PNP care. The "dose" of PNP care is determined by the child and family needs and complexity and is a concept described by many scholars (Brooten & Youngblut, 2006). "Nurse dose" or, in this case, PNP dose, is the quantity of PNP nursing delivered to a child and family. This Value Model of Care Coordination is further described in a study that found positive outcomes of PNP telehealth-delivered care coordination for families of children with medical complexity, including fewer emergency department services and increased family knowledge of how to treat their children's illnesses (Cady, Kelly, Finkelstein, Looman, & Garwick, 2014).

It is imperative that all legislation and policies related to the health care/medical home include PNPs as reimbursable providers and full participants in demonstration projects, reimbursement strategies, and incentive programs. It is essential that legislation and policies be written with provider-inclusive terminology. NAPNAP acknowledges the need for additional research on the impact of pediatric health care/medical home models (Lindeke, 2015.

NAPNAP affirms that:

- All children (infants through young adults) must have access to comprehensive pediatric health care services rendered by qualified pediatric health care providers of the family's choice to ensure optimal health for U.S. children and youth (NAPNAP, 2012).
- Professional partnerships with families are the foundation of pediatric health care/medical homes.
- Services should be provided in pediatric health care/medical homes where children's health records and plans of care are centralized, integrated in electronic health records, and accessible to families, with the capacity to be shared across systems with provision for patient privacy.
- From childhood through young adulthood, care must be comprehensive, continuous, culturally responsive, and focused on the overall well-being of children and families.
- PNPs are proficient care coordinators in pediatric health care/medical homes and are qualified to lead health care/medical homes, provide direct primary health care, advocate for children and families, and make appropriate referrals.
- Provider-inclusive language should be used in all legislation and policies regarding any health care/medical home issues.
- PNPs and pediatric nurse scholars are urged to lead and participate in pediatric health care/medical home research and quality improvement projects.

In summary, NAPNAP is an organization whose mission is to empower PNPs and their health care partners to enhance child and family health through practice, leadership, advocacy, education, and research. NAPNAP remains committed to pursuing the vision that all children and their families will have access to comprehensive, high-quality health services within a pediatric health care/medical home from qualified pediatric health care providers.

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REFERENCES

Adams, S., Cohen, E., Mahant, S., Friedman, J., MacCulloch, R., & Nicolas, D. (2013). Exploring the usefulness of comprehensive care plans for children with medical complexity (CMC): A qualitative study. *BMC Pediatrics, 13*, 10.

American Academy of Pediatrics, Council on Children With Disabilities, Medical Home Implementation Project Advisory Committee. (2014). Patient- and family-centered care coordination: A framework for integrating care for children and youth across multiple systems. *Pediatrics, 133*(5), e1451-e1460.

Betz, C. L., Lobo, M. L., Nehring, W. M., & Bui, K. (2013). Voices not heard: A systematic review of adolescents' and emerging adults' perspectives of health care transition. *Nursing Outlook, 61*(5), 311-336.

Brooten, D., & Youngblut, J. (2006). Nurse dose as a concept. *Journal of Nursing Scholarship, 38*(1), 94-99.

Cady, R., Kelly, A., Finkelstein, S., Looman, W., & Garwick, A. (2014). Attributes of advanced practice registered nurse care coordination for children with medical complexity. *Journal of Pediatric Health Care, 2*(4), 305-312.

Farmer, J., Clark, M., Drewel, E., Swenson, T., & Ge, B. (2011). Consultative care coordination through the medical home for CSHCN: A randomized controlled trial. *Maternal Child Health Journal, 15*(7), 1110-1118.

Fegran, L., Hall, E. O., Uhrenfeldt, L., Aagaard, H., & Ludvigsen, M. S. (2014). Adolescents' and young adults' transition experiences when transferring from paediatric to adult care: A qualitative metasynthesis. *International Journal of Nursing Studies, 51*(1), 123-135.

Gresley-Jones, T., Green, P., Wade, S., & Gillespie, R. (2015). Inspiring change: How a nurse practitioner–led model of care can improve access and quality of care for children with medical complexity. *Journal of Pediatric Health Care, 29*(5), 478-483.

Harris, T., & Samuels, C. (2015). Comprehensive care for high-risk chronically ill children utilizing pediatric nurse practitioners in an enhanced medical home: A randomized control trial. *Journal of Pediatric Health Care, 29*(4), 312-313.

Lindeke, L. (2015). A call to action for care coordination research and pediatric implementation science. *Journal of Pediatric Health Care, 29*(5), 474-477.

Looman, W., Presler, E., Erickson, M., Garwick, A., Cady, R., Kelly, A., … Finkelstein, S. (2013). Care coordination for children with complex special health care needs: The value of the advanced practice nurse's enhanced scope of knowledge and practice. *Journal of Pediatric Health Care, 27*(4), 293-303.

Mosquera, R., Avritscher, E., Samuels, C., Harris, T., Pedroza, C., & Tyson, J. (2014). Effect of an enhanced medical home on serious illness and cost of care among high-risk children with chronic illness: A randomized clinical trial. *Journal of the American Medical Association, 312*(24), 2640-2648.

National Association of Pediatric Nurse Practitioners. (2012). NAPNAP position statement on access to care. *Journal of Pediatric Health Care, 26*(2), 21A-23A.