Practice Transformation Task Force

December 18, 2018

Meeting Agenda

1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of Minutes	5 min
4. House rules refresh	5 min
5. Purpose of Today's Meeting	5 min
6. Pediatrics Capabilities	35 min
7. Recap of Adult Capabilities	20 min
8. Continue Payment Reform Discussion	30 min
9. Next Steps	5 min
10. Adjourn	

Introductions/ Call to Order

Public Comment

Approval of the Minutes

House Rules

House Rules for PTTF Participation

1. Please identify yourself and speak through the chair during discussions
2. Be patient when listening to others speak and do not interrupt a speaker
3. 'Keep comments short (less than 2 minutes if possible) and to the point/agenda item (*the chair will interrupt if the speaker strays off topic or talks longer than 2 minutes*)
4. *Members should avoid speaking a second time on a specific issue until every PTTF member who wishes to speak has had the opportunity*
5. *Members should take care to minimize interference (please mute all phones, turn off cell phones, limit side conversations or loud comments)*
6. Please read all materials before the meeting and be prepared to discuss agenda/issues
7. Please participate in the discussion—ALL voices/opinions need to be heard
8. *Participation in the meetings is limited to Task Force members and invited guests; all others may comment only during the initial public comment period*
9. After the meeting, please raise any concerns with meeting process/content or other issues with members of the Executive Team (Elsa, Garrett, Lesley)

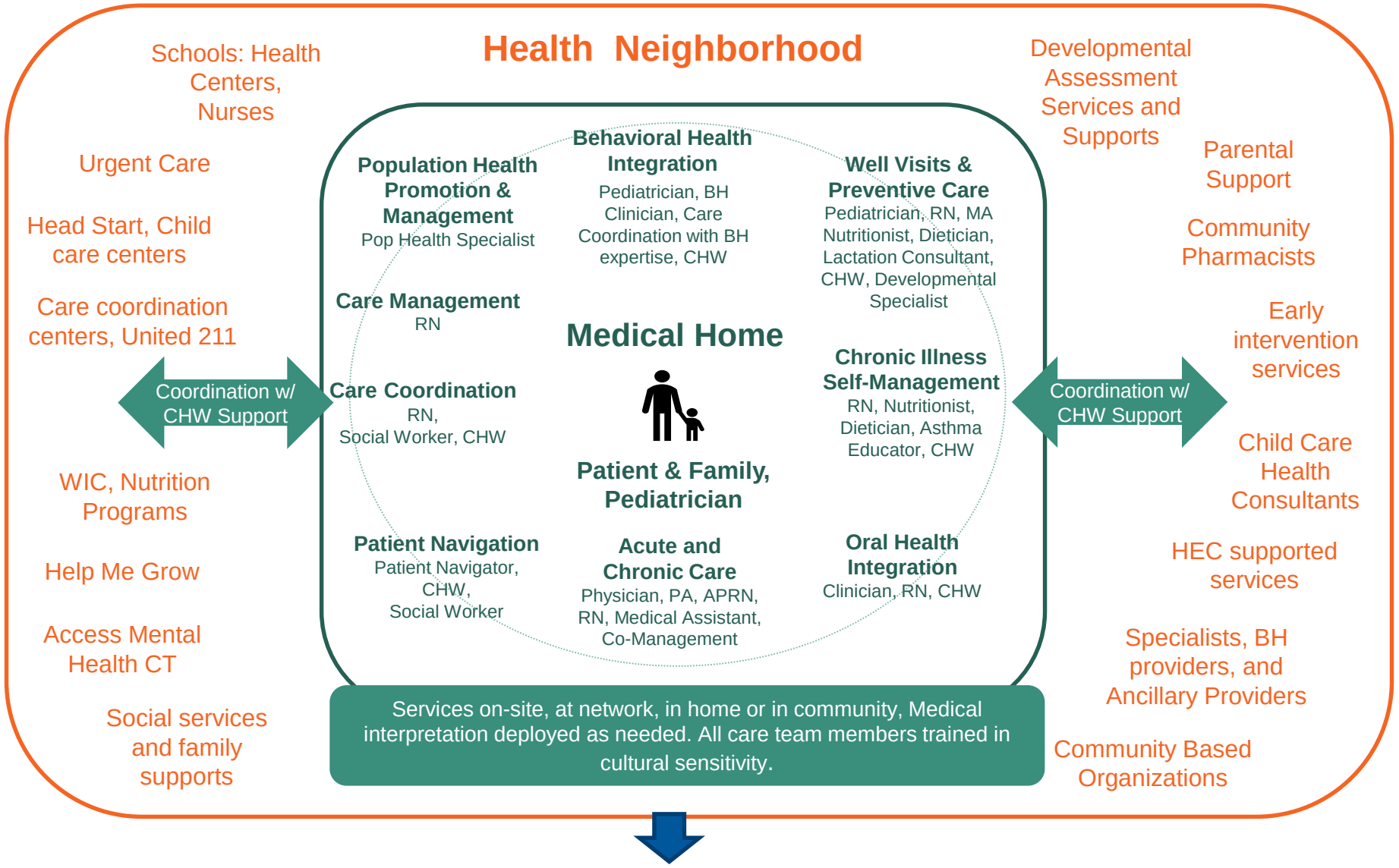
Purpose of Today's Meeting

Purpose of Today's Meeting

- Review Pediatric Capabilities
- Review Recommendations on Adult Capabilities and Alignment with the Payment Model
- Continue Review of Payment Reform Council Work to Date

Pediatric Capabilities

Medical Home Care Teams



Supports Child Health Promotion and Well-Being to Achieve Vision of Pediatric Primary Care

SIM connecticut state innovation model

Expanded Medical Home Care Team Functions

Population Health Promotion & Management: Assess health promotion and outcome measures, establish targets, identify patients/populations not achieving targets or who require specific services due to age, develop and implement action plans at patient and sub-population level

Acute and Chronic Care: Routine acute and chronic care provided by clinical team

Well Visits and Preventive Care: Child well visits and prevention according to the Bright Futures health promotion themes and activities

Care Management: Family-centered process for providing care and support to children with complex health care needs

Care Coordination: Patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families (AAP definition)

Patient Navigation: Helps families effectively and efficiently use the health care system, identify and address barriers to care; social, emotional, practical, familial, and other needs

Chronic Illness Self-Management: Helps prevent disease from developing (primary prevention) or progression of an existing disease (secondary prevention) through health coaching, nutritional counseling, education and self-management

Behavioral Health Integration: BH and developmental screenings, assessments, brief interventions, medication, episodic care, referrals to complex and extended treatment, and follow-up

Medical Home Care Team Recommendations

- Team-based approach is key characteristic of the medical home, with PCP and patient/family guiding direction
- Care team focus is promoting strengths of families and best health for all children
- All functions of the care team are interrelated and overlapping. While all functions have value, every practice may not need all of them.
- Care teams within the medical home coordinate with and are supported by resources in the Health Neighborhood (e.g. Help Me Grow, Access Mental Health CT)
- Payment model supports evidence-based interventions for integrating other professionals into pediatric practice care team
- Networks support practices in building the infrastructure and training needed to support expanded care teams and functions within the practice
    - Networks may take on certain functions like population health promotion and management, especially for smaller practices
- Need accountability measures to determine functions are provided (to be recommended by the Payment Reform Council)

Care Coordination Recommendations

- Care coordination should be provided within the medical home with connections to the community
  - Community Health Workers support practice-based care coordination by linking patients and families to culturally appropriate community resources within the Health Neighborhood and tracking follow up
  - CHWs and care coordinators may also provide patient navigation functions
  - Community-based organizations play a large role in supporting care coordination and connecting children and families to services
  - CHWs in the community should be supported by financial resources to assist the practice

- Practice-based care coordination is an opportunity to better coordinate care between the Medical Home and:
  - Health Neighborhood, supported by Community Health Workers
  - All other places the child is receiving care (school, urgent care, child care center, etc.)
  - School Health Centers and School Nurses (as permitted by law)

Care Coordination Recommendations (cont.)

- Practice-based care coordinators should be encouraged to use centralized care coordination resources (Medicaid Integrated Care Management Program, United 211, DPH CYSHCN care coordination centers), depending on the family's preferences
  - Support families when connections are needed to the community
  - May connect families with Medical Homes if they do not already have one
  - Medicaid Integrated Care Management program provides coordination support when not available within the practices
  - Ensure that care coordination services are not duplicated through communications and information exchange between the medical home and the centralized care coordination group
- Ideally data is shared* (through HIE or shared EHR) between practices and community settings (schools, urgent care, child care centers, etc.)
- Recommendation beyond PCM: Policy change is needed to allow for communication and exchange of information between pediatric care teams and school nurses.

*Appropriate consent and confidentiality maintained

Oral Health Integration Recommendations

All practices are required to integrate oral health into care team functions

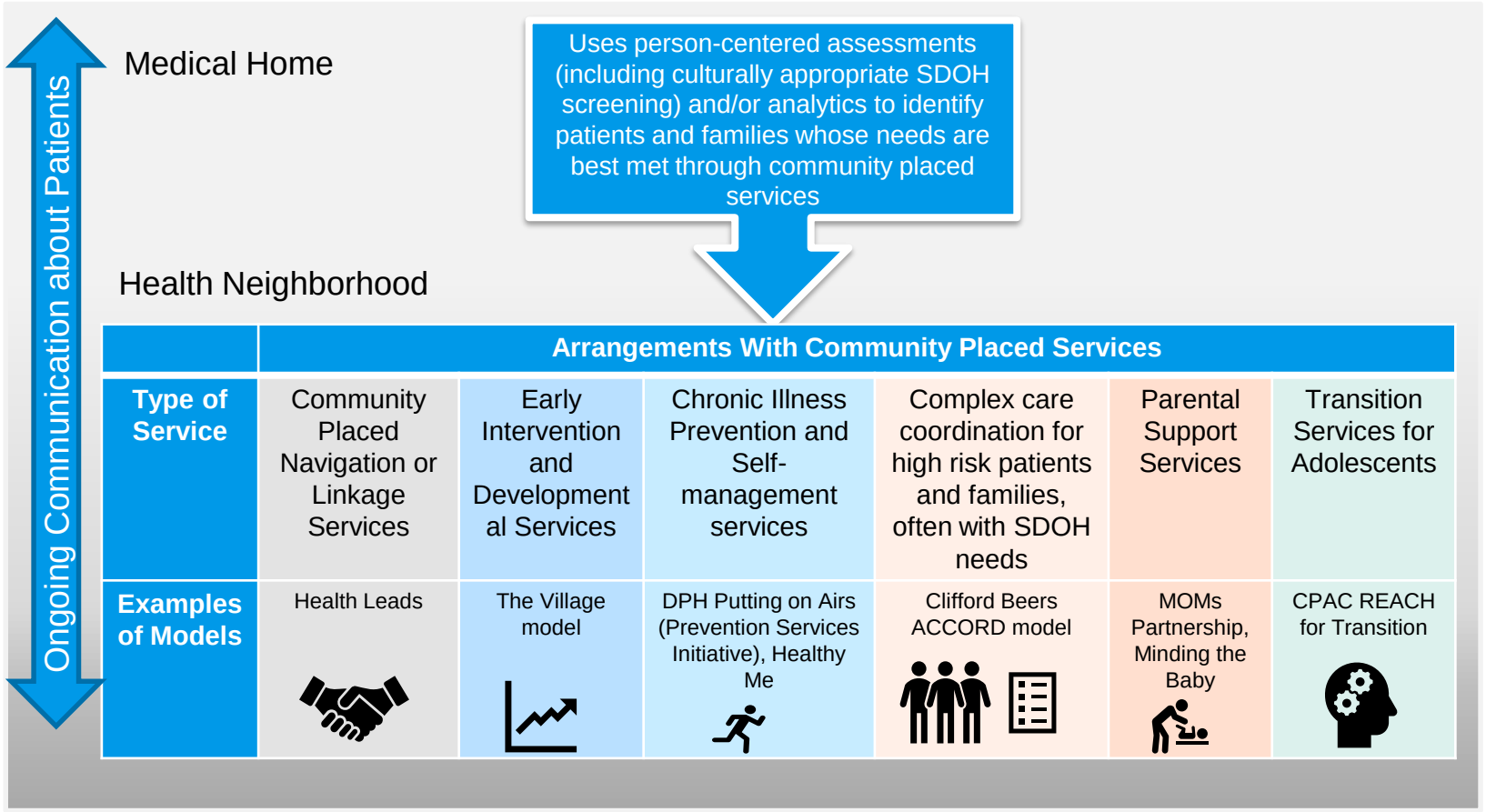
Oral Health Integration Activities

- Oral Health Screenings for oral health and active conditions
- Preventive interventions
  - Apply fluoride varnish for babies and children birth to 5 years
  - Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride as appropriate.
- Communication and education about importance of good oral health and practices to maintain it
- Referral to dental home at age one or when first tooth comes in, tracking outcomes
  - Referral list include dentists who work with children with special needs who have sensitivity issues.

Community Integration

Community Integration

Advanced networks or Federally Qualified Health Centers (FQHCs) will facilitate arrangements with community-placed services on behalf of practices that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services



	Arrangements With Community Placed Services					
Type of Service	Community Placed Navigation or Linkage Services	Early Intervention and Developmental Services	Chronic Illness Prevention and Self-management services	Complex care coordination for high risk patients and families, often with SDOH needs	Parental Support Services	Transition Services for Adolescents
Examples of Models	Health Leads	The Village model	DPH Putting on Airs (Prevention Services Initiative), Healthy Me	Clifford Beers ACCORD model	MOMs Partnership, Minding the Baby	CPAC REACH for Transition

Community Integration Recommendations

- SDOH screening needs to be culturally appropriate and ideally conducted by a care team member the patient and family trusts.
- Pediatric practices will be able to coordinate with services under Health Enhancement Communities (invests in community-based services for Child Well Being and Healthy Weight).
- Care coordinators can make connections on behalf of patients and their families with community-placed supports and services that are generally available to members of the community in addition to those arranged by the network.
- Individual practices should not be burdened with contracting, yet one-size-fits-all network solution won't work.
- Some members of the group recommended that purchasing community-placed services should be an elective capability at the network level. Other members of the group felt that this should be a practice-based core service.

Recommendation: Community integration is a core, practice-based service that is facilitated by the network, which makes arrangements with certain community-placed service on behalf of practices to help them meet patient and families' needs.

Alternative Ways to Access Care

Alternative Ways to Access Care: Required Capabilities

- **Universal Home Visits for New Parents:**
  - Network provides the necessary resources to conduct home visits.
  - PCPs are supported by expanded care teams in the medical home.
  - In-home parenting support should be peer-to-peer and culturally appropriate by using Community Health Workers who connect families to community based organizations and resources

- **Telemedicine visits between patients and providers:**
  - Delivered within the medical home
  - Network provides infrastructure and technology
  - Only used in appropriate clinical scenarios and with established patients

- **Phone, Text, Email Encounters:**
  - Practice establishes appropriate workflows

- **eConsults between PCPs and subspecialists:**
  - Network provides infrastructure and arrangements with specialists

Alternative Ways to Access Care: Optional Capabilities

- **Partnerships with Home Visiting Services in the Community (e.g. Minding the Baby):**
  - Optional depending on needs of practice and patient population
  - Requires strong coordination between the medical home and the community

- **Group Well Child Visits**: Families are seen for well-child visits in a group with similarly aged children
  - Optional capability for primary care providers and patients and families who want to participate

Expanding PCP Expertise

- **Telementoring guided practice learning program to expand health care provider expertise in specific areas**[1]
  - The American Academy of Pediatrics and American Board of Pediatrics, among other, sponsor quality improvement learning experiences. Examples include but are not limited to pediatric ECHOs such as child abuse & neglect, childhood obesity, school based mental health, trauma and resilience.

- **Key Features**
  - Aims to improve quality, reduce variety, and standardize best practices
  - Multidisciplinary partnerships that increase access to care and reduce health care costs.
  - Case-based learning under guided practice to provide specialized care to provider's own patients
  - Technology to promote face-to-face mentorship and sharing of knowledge and experience by experts and peers
  - Complements provider licensing and board certification requirements

- **Outcomes:** Data suggests outcomes are the same or better than those treated at specialized referral hospitals, due to leveraging the patient-centered medical home model

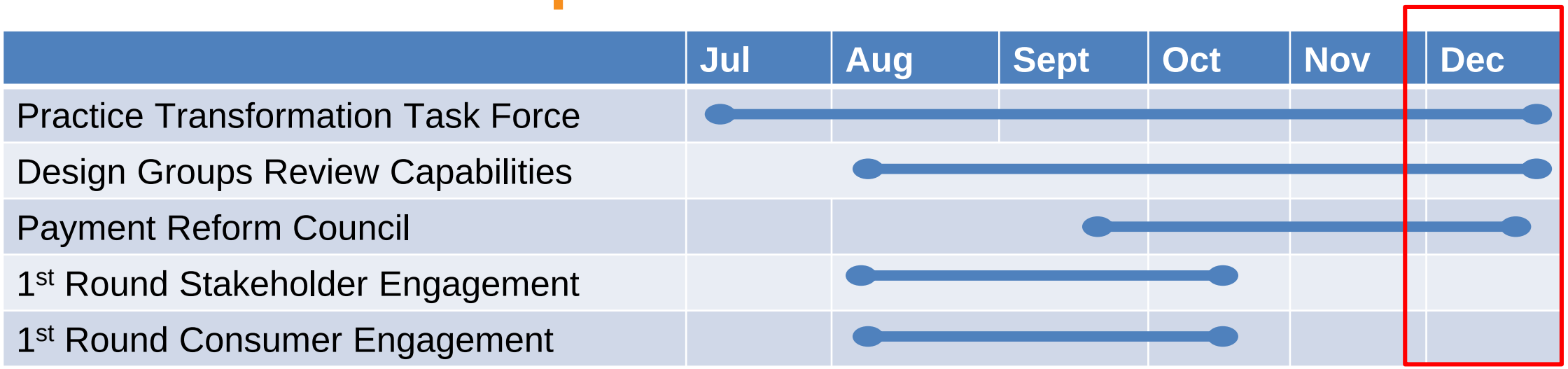
[1]https://www.aap.org/en-us/professional-resources/practice-transformation/echo/Pages/About-Project-Echo.aspx

Pediatric Capabilities Summary

	At the practice or the Network	Core or Elective
Medical Home/ Expanded Care Team: (includes co-management)	Practice- based with facilitation by the network	Core
Community Integration	Practice- based with facilitation by the network	Core
Behavioral Health	Practice-based	Core
Universal Home Visits with Families of Newborns	Practice- based with facilitation by the network	Core
Telemedicine and Phone/text/email	Practice-based	Core
E-consults	Practice- based with facilitation by the network	Core
Partnerships with home visiting services in the community	Network	Elective
Group well child visits	Practice	Elective
Telementoring	Practice	Core, part of continuing education

Aligning Capabilities and Payment Model

PCM Work Plan Update – Our Work to Date



- Practice Transformation Task Force: Complete review of capabilities by January
- Design Groups: Complete design groups in December
- Payment Reform Council: Meeting October – early January

PCM Work Plan Update – The Work Ahead

Recommended Capabilities for Adults

Team-based Care	Provide Expert Care	Support and Engage Patients in Alternative Ways
• Behavioral health integration • Expanded care teams • Community integration • Oral health	• Older adults with complex conditions • Persons with disabilities • Pain management and medication assisted treatment	• Econsult • Phone/text/email • Remote patient monitoring • Shared medical appointments • Telemedicine

Team-based Care

Capability	Core or Elective	Where implemented	Included in Basic Bundle	Included in Supplemental Bundle
Behavioral health integration	Core	All practices	PCP time	Behavioral Health Clinician Care Coordinator Community Health Worker
Expanded care teams	Core	All practices	PCP time	Other care team members' time, e.g. RNs, pharmacists, nutritionist, patient navigators, community health workers, social workers
Community integration	Elective	If elected, all practices or in the network	PCP time	Contracts with community placed services
Oral health integration	Elective	All practices	PCP time	Other care team members' time

Provide Expert Care

Capability	Core or Elective	Where implemented	Included in the Basic Bundle	Included in the Supplemental Bundle
Older adults with complex conditions	Core	Subset of practices specialize	PCP time	Other care team members' time, equipment for home visits, Project Echo
Persons with disabilities	TBD	TBD	TBD	TBD
Pain Management, MAT	Core	Subset of practices specialize	PCP time	Other care team members' time like pharmacists, CHWs, Project Echo consults, training

Support and Engage Patients in Alternative Ways

Capability	Core or Elective	Where implemented	Included in Basic Bundle	Included in Supplemental Bundle
Econsult	Core	All Practices	PCP time Phone & internet	
Phone/text/email	Core	All Practices	PCP time Phone & internet	Other care team members' time
Remote patient monitoring	Core for certain conditions w/ efficacy and cost savings	All Practices	PCP time	Other care team members' time Device fees and connectivity
Telemedicine	Core	All Practices	PCP time	Other care team members' time
Shared Visits	Elective	If elected, at the practice	Outreach, space set up, RN/NP at visit	Other care team members' time (Facilitator, Health coach, Nutritionist)

Discussion

Do we have the capabilities right (core v. elective, all practices v. some)?

Is there anything to add or take out?

Which of these capabilities will need a longer lead time to ramp up?

Review Payment Reform Council Work To Date

Context for Reviewing Capabilities Cost Estimates

1. Estimates based on the literature, not actuarial assessments reflecting the specific needs of Connecticut residents. Actuarial assessments will come later.

2. PCM assumes some foundational investments in HIT. The supplemental bundle may not cover all costs for some capabilities for some provider organizations and may cover more than the cost for others. Organizations have made different historical investment decisions.

3. PCM supplemental bundle payments intend to cover the cost of new care team members, new investments in technology directly related to achieving the capabilities and the training and technical assistance necessary to position providers for success.

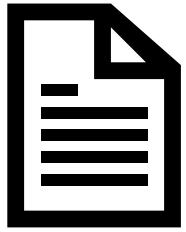
4. Investments in new care teams will look different for different provider organizations depending on the patient needs, practice type (adult v. pediatric), organizational culture and budget.

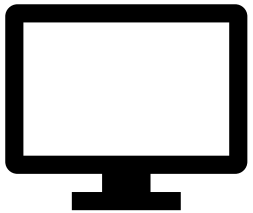
Hypothetical Cost Estimates for Core Capabilities

Core Capabilities	Estimated Cost PMPM	Assumptions (*all cost estimates based on an "average" multi-payer, 1500/per FTE MD panel*)
Phone, Text, Email	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Telemedicine	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Remote Monitoring ***(For conditions where there is proven benefit)***	$.50-$1.50	**One-time Fixed Cost** $20,000 Implementation; $15,000 Integration Fee; $15,000 Training Fee **Annual Fixed Cost** - $175,000 Platform fee **Annual Variable Cost** - $7 Transaction cost per patient Assumes 80,000 covered lives. Costs would vary depending vendor, AN size and the targeted conditions.
eConsult	$2.94	Assumes 12 eConsults per week per PCP ($85 each including specialist time and technology platform)
Expanded Care Teams	$10.00-$15.00	Using CPCI, "fully-enabled" PCM estimates
BH Integration	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Specialized Practices	$2.00-$6.00	Technical assistance, equipment, access to support networks like Project Echo. May include some additional care team members specific to the need of the specialized practice. Recognizes panel sizes may need to be smaller than a standard practice.
Training and Technical Assistance	$3.00	Training in collaboration and leadership for expanded care teams.

How would consumers be protected?

Protecting Against Underservice:

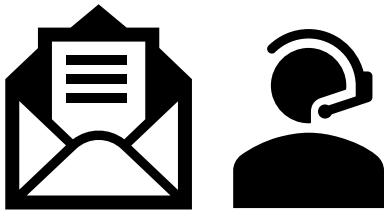




Quarterly claims data and electronic health records capture office and telemedicine visits, other interactions with care team members and hospital stays and readmissions per member

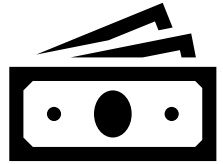
Data is shared publicly through routine provider reports and other sources

Protecting Against Patient Selection:



Patient experience surveys and consumer feedback loop relay patient perspective

Attribution method prioritizes patient selection of provider



Layered risk adjustment recognizes additional cost of social and behavioral needs

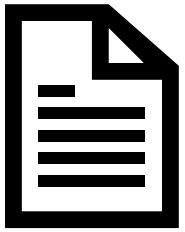
Mystery shopper to monitor access

How is underservice monitored?

A Focus on Level of Patient Support and Engagement

Today

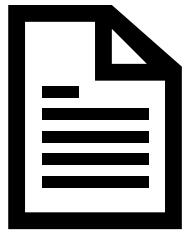
Claims



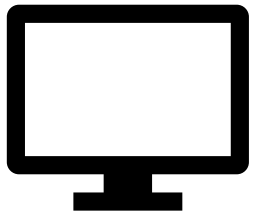
PCP visits/member

Under PCM

Claims



EHR



PCP visits/member

Other PCP contacts/member

Other Care Team
contacts & visits/member

Strawman PCM Accountability Process

AN/FQHC PCM application details approach to capabilities.

State and payer review and approve application.

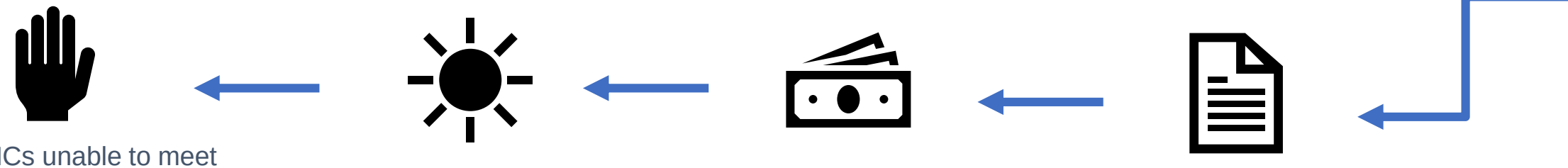
Using state template, ANs/FQHCs develop patient communications.

Claims and EHR data generate utilization and quality metrics.

Patient experience surveys; potentially oversample subpopulations.

Consumer feedback loop answers questions and investigates complaints.

Mystery shoppers call practices to confirm equitable access.



ANs/FQHCs produce periodic reports on investments, process milestones and results.

Payers report percent spending on primary care.

Public reports offer transparency to consumers, advocates and employers.

AN/FQHCs unable to meet requirements or who engage in underservice and/or patient selection will be subject to corrective action plans, financial consequences and termination.

Potential Alternative "Risk-lite" Approach:

- Consumer advocates have raised concerns that downside risk options might be intended for Medicaid and that such an approach, if applied to Medicaid beneficiaries, would result in stinting on care.
- If Medicaid participates, we would recommend that Medicaid consider other model options that might address these concerns.
- We would like to review one such model, which might be considered by Medicaid, and which might also be considered by other payers as an entry level option for providers that do not demonstrate readiness to accept and manage risk at the outset of the program.

Potential Alternative "Risk-lite" Approach:

Strawman is based on CPC+ Track 2, which is similar in design and aims to PCM. All numbers are for discussion purposes only.

CPC Plus Track 2	Care Management Fees	Performance-Based Incentive Payment	Medicare Physician Fee Schedule
	$28 average per beneficiary per month (PBPM) including $100 PBPM to support patients with complex needs	$4 PBIP tied to quality, patient experience and utilization performance	Hybrid bundled payment for office visits: Reduced FFS w/ primary care bundle
Potential PCM Adaptation	**Tier 1 Supplemental Bundle Payment**	**Performance-Based Incentive Payment**	**Full Basic Bundle**
	$18-$20 average target, with increased payments for high-needs populations	$4 PBIP tied to quality/patient experience and utilization performance	Full basic bundle payment. Same as other PCM AN/FQHCs.

Risk Adjusting the Supplemental Bundle

Proposed Approach

- Since supplemental bundle funds will largely go toward supporting care management and coordination, behavioral health integration and community integration, ideally these payments should be adjusted to align with the patients' needs in those areas.
- To achieve this, supplemental payments would be adjusted using an approach similar to CPC+.
- All beneficiaries are assigned to tiers based on their risk score **but** some beneficiaries default to higher tiers if they have certain conditions or characteristics. We will call this "secondary adjustment."
- Secondary adjustment conditions and characteristics should be meaningful to primary care, able to be defined using available data, and reasonable to isolate despite increased administrative burden.

Example: MassHealth Social Determinants of Care Risk Adjustment Model

- Risk adjustment methodology was augmented to capture the impact of social determinants of health on medical expense.
- The model predicts costs from DxCG relative risk score and age-sex indicators (leveraging commercially available model).
- Then, it adds markers for unstable housing (3 or more addresses/yr or v-code), disability, agency relationships, severe mental illness and substance use disorders.
- The final component is a summary measure of “neighborhood stress” based upon residence in a census block group.

Source: EOHHS
Model is not commercially available

Which populations should receive a secondary adjustment?

During stakeholder meetings, several populations were identified whose clinical, behavioral and social needs may not be fully reflected in a traditional risk adjustment methodology.

Examples included:

- Individuals with unmet social needs such as lack of stable housing.
- Individuals with behavioral health conditions and substance use disorder conditions.
- Children
- Individuals with dementia

Next Steps

Next Steps

- January 8 meeting materials will be sent December 31
  - Remaining capabilities
  - Payment Reform Council recommendations on Measurement and Accountability, ROI estimates

- Late January/early February
  - Send final capabilities to Health Innovation Steering Committee

Adjourn

Appendix

Vision of Pediatric Primary Care

Medical Home Characteristics (AAP and Design Group)[1]

- Family-centered partnership with **personal Primary Care *Provider* relationship**
- Addresses preventative, acute, and chronic care from birth through transition to adulthood
- **Practice-based care team** takes collective responsibility for all of the patient's health care needs
- Care is continuous and coordinated across care settings, disciplines and community resources
- Quality is measured and improved as part of daily work flow
- Enhanced access and communication for patients
- Practices move towards use of EHRs, registries, and other clinical support systems
- Facilitates an integrated health system within a community-based system
- Appropriate payment to support and sustain optimal health outcomes
- Promotes health equity for all children
- Increase flexibility for providers to allocate necessary resources where truly needed

Achieving the Vision

Based on November 29th Session's Discussion

Pediatric medical homes work towards achieving **this vision through** the Bright Futures Health Promotion themes and AAP Medical Home services (see appendix)

Bright Futures Health Promotion Themes:

1. Promoting lifelong health for families and communities (Social determinants of health)
2. Promoting family support
3. Promoting health for children and youth with special healthcare needs
4. Promoting healthy development
5. Promoting mental health
6. Promoting health weight
7. Promoting healthy nutrition
8. Promoting physician activity
9. Promoting oral health
10. Promoting healthy sexual development and sexuality
11. Promoting the health and safe use of social media
12. Promoting safety and injury prevention

Care Team Functions

Population Health Promotion & Management

- "Population health refers to proactively addressing the health status of a defined population including assessing the performance of health promotion activities. Population health management is a clinical discipline that develops, implements and continually refines operational activities that improve the measures of health status and health promotion for defined populations."
- • Assess health promotion and health outcome measures for the population under management and establish appropriate targets for each with the goal of improving the health of the population
- • Identify patients and sub-populations not achieving the targets and those who require specific services due to age
- • Develop actionable steps using evidence based or clinical guidelines to improve the delivery of health promotion activities and health outcomes, especially in sub-populations not meeting targets
- • Incorporate health outcomes and health promotion measures into patient registries. Health analytics are used to identify patients and sub-populations at risk, including primary and secondary prevention

Well Child Visits and Preventive Care

- Well Child visits and preventive services adhere to guidance from Bright Futures health promotion themes and activities

- Bright Futures Health Promotion Themes
- 1. Promoting lifelong health for families and communities (Social determinants of health)
- 2. Promoting family support
- 3. Promoting health for children and youth with special healthcare needs
- 4. Promoting healthy development
- 5. Promoting mental health
- 6. Promoting health weight
- 7. Promoting healthy nutrition
- 8. Promoting physician activity
- 9. Promoting oral health
- 10. Promoting healthy sexual development and sexuality
- 11. Promoting the health and safe use of social media
- 12. Promoting safety and injury prevention

Comprehensive Care Management

- "Complex care management is a family-centered process for providing care and support to children with complex health care needs. The care management is provided by a multi-disciplinary Comprehensive Care Team comprised of members of the pediatric care team and additional members, the need for which is determined by means of a family-centered needs assessment." (adapted from CT SIM Clinical & Community Integration Program)
- Identify children with complex health care needs
- Conduct Family Centered Assessment
- Develop Individualized Care Plan (ICP)
- Establish Comprehensive Care Team
- Establish annual training to successfully integrate and sustain comprehensive care teams.
- Execute and Monitor ICP
- Assess individual readiness to transition to self-directed care maintenance
- Monitor individual need to reconnect with Comprehensive Care Team
- Evaluate and improve the intervention

Care Coordination Definition

- Key function of pediatric medical home
- AAP Framework for high-performing pediatric care coordination within medical home: “Patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes.“[1]
- Defining characteristics
  - Patient and family centered
  - Proactive, planned and comprehensive
  - Promotes self-care skills and independence
  - Emphasizes cross-organizational relationships

- [1]http://pediatrics.aappublications.org/content/133/5/e1451?ijkey=4917e10942a2a1a33c329f76fc1d3689bf1c9c4d&keytype2=tf_ipsecsha

Care Coordination Functions

- Functions (AAP)
  - Provide separate visits and care coordination interactions (including home visits)
  - Manage continuous communications
  - Complete/analyze assessments
  - Develop care plans (with family)
  - Identify gaps in care and manage/track tests, referrals and outcomes
  - Coach patient/family skills learning using motivational interviewing techniques
  - Integrate critical care information
  - Support/facilitate all care transitions
  - Facilitate patient and family-centered team meetings
  - Use health information technology for care coordination (HIE, EHR)

- In addition:
- Coordination with other sites of care and care coordinators, especially schools
- Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator

Patient Navigation

- Patient navigation may be defined as the process of helping children and families to effectively and efficiently use the health care system (Adapted from "Translating the Patient Navigator Approach to Meet the Needs of Primary Care," by Jeanne M. Ferrante, MD, MPH, Deborah J. Cohen, PhD and Jesse C. Crosson, PhD)
- Identify barriers and increase access to care
- Address social determinants of health, emotional, financial, practical, cultural/linguistic and/or family needs
- Help families negotiate healthcare insurance and access decisions
- Improve satisfaction with team communication and increase sense of partnership with professionals

Chronic Illness Self-Management

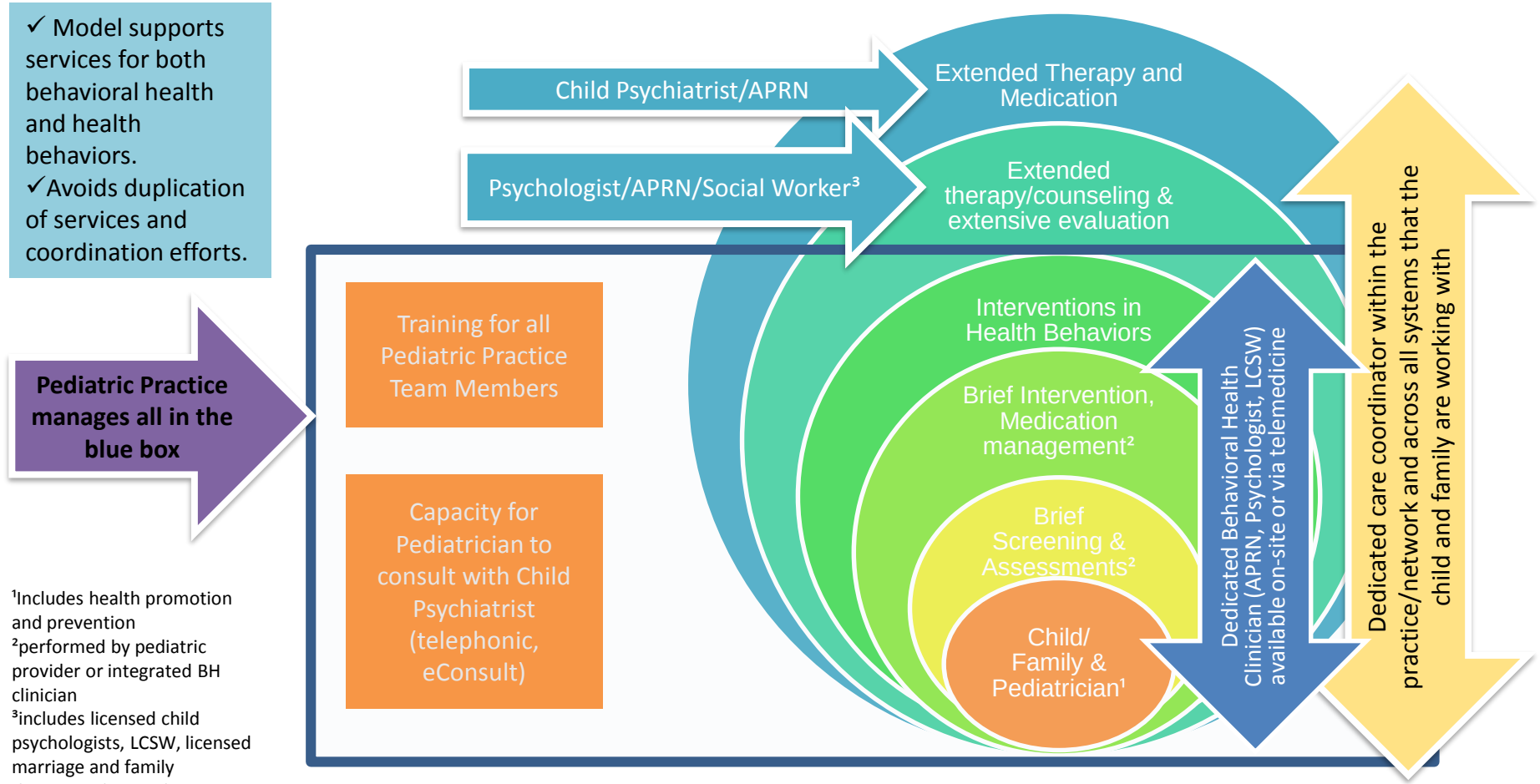
- "Improve the health of persons with specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations." (Bodenheimer, T., 1999)
- Identify the population who will benefit from disease management program
- Health or lifestyle coaching and patient education
- Promote chronic illness self-management
- Develop programs that are culturally diverse and remove barriers
- Nutritional education and counseling
- Basic screenings and assessments

Medication Management and Prescribing Functions

- Medication related functions such as medication reconciliation, routine medication adjustments, initiating, modifying, or discontinuing medication therapy and medication monitoring/follow-up care coordination that other care team members can perform to assist the pediatrician
- Medication reconciliation/ best possible medication list
- Medication monitoring/follow-up care coordination across multiple prescribers and pharmacies
- Medication adjustments under standing order (RN)
- Initiating, modifying, or discontinuing medication therapy (Pharmacist only if under CPA)

Pediatric Behavioral Health Integration Design Group Recommendations

✓ Model supports services for both behavioral health and health behaviors.
✓Avoids duplication of services and coordination efforts.



¹Includes health promotion and prevention
²performed by pediatric provider or integrated BH clinician
³includes licensed child psychologists, LCSW, licensed marriage and family therapists, licensed professional counselors

Updated 10-21-18

Pediatric Specific Screening Recommendations

Based on AAP recommendations, to be implemented in stages and on a defined schedule as PCM rolls out

Domain	Age	Sample Screeners or any standardized screening tool evaluated and recommended by the AAP
Universal Screenings		
Developmental	At a minimum: 9, 18, and 24 or 30 months and additional visits at the discretion of the primary care provider	• Ages and Stages Questionnaires, Third Edition (ASQ-3) • Parent Evaluation of Developmental Status (PEDS) • The Survey of Well-Being of Young Children (SWYC)
Autism	At 18, 24 or 30 months	• MCHAT-R/F • SWYC 18-, 24-, and 30-month forms
Behavioral Health	At ages 5 - 18 years annually during well-child visits and after a high risk developmental or autism screen, or whenever a concern arises	• The Survey of Well-Being of Young Children (SWYC) (2 mos. - age 5) • Pediatric Symptom Checklist-17 (PSC-17)(ages 4 -18)
Depression	At age 12+	• Patient Health Questionnaire-9 (PHQ-9): Modified for Teens (ages 12-18)
Substance Abuse	At age 12+	• The CRAFFT
Postpartum Depression	At 1, 2, 4, and 6 month well-baby visits	• Edinburgh Postnatal Depression Scale (EPDS)
Secondary/Indicated Screenings		
Trauma	6 to 18 years	• Child PTSD Symptom Scale (CPSS-5) (8+yrs) • Child Trauma Screen (CTS) (6+yrs)
Depression	6 to 17	• The Center for Epidemiological Studies-Depression Scale for Children (CES-DC)
Anxiety	8-18	• The Screen for Child Anxiety Related Disorders (SCARED), particularly the brief version
ADHD	6 to 12 6-18	• Vanderbilt ADHD screening tool (includes comorbid disorders) (parent and teacher versions) • SNAP-IV Rating Scale – Revised (SNAP-IV-R)(parent and teacher versions)
Suicide	12+	• Columbia-Suicide Severity Rating Scale (C-SSRS)