OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization and Pediatrics

December 10, 2018

Agenda

- Introductions — 5 minutes
- Refresher: Vision & Purpose — 5 minutes
- Recap of Recommendations to Date — 5 minutes
- Capabilities Discussion — 100 minutes
  - Revisit Medical Home Care Teams
  - Oral Health Integration
  - Community Integration
  - Access to Specialty Care: Co-management, Project Echo
- Next Steps — 5 minutes
- Adjourn

Recap: Vision of Pediatric Primary Care

Based on December 4th Session's Discussion

See Appendix for Medical Home Characteristics

Purpose of this Group: Refresher

Purpose: Make recommendations to the Practice Transformation Task Force about what core (required) and elective (optional) capabilities pediatric practices should have

Payment Reform Council considers Task Force recommendations and makes recommendations for payment model options. The Council and Task Force will reconcile recommendations in January.

Consider: As we discuss capabilities for pediatric primary care practices:

- How do PCM capabilities support this vision of pediatric primary care?

Recap of Recommendations: November 29th

- Discussed Diverse Care Teams
  - Team based approach is needed, with PCP and patient/family guiding direction
  - All functions of the care team are interrelated and overlapping
  - Care coordination across the practice and health neighborhood is critical
  - Community Health Workers are critical and support care coordination
  - Add to health neighborhood: child health care consultants, parent supports, developmental assessments and services for children not eligible for birth to 3

Recap of Recommendations: December 4th

- **Universal Home Visits for New Parents:** Required capability with the necessary resources from the network and expanded care teams in the medial home
- **Partnerships with Home Visiting Services in the Community**: Optional capability, with strong coordination between the medical home and the community
- **Telemedicine (provider to patient):** Required capability within the medical home, infrastructure provided by the network, only used in appropriate clinical scenarios
- **Phone, Text, Email Encounters**: Required capability with appropriate workflows established. Recommended getting input from consumers
- **Group Well Child Visits**: Optional capability for primary care providers and patients and families who want to participate
- **eConsults (PCP to specialist):** Required capability with infrastructure provided by the network

Capabilities Discussion

Medical Home Care Teams

Feedback from Previous Session

- Care team focus is promoting strengths of families and best health for all children
- Desire for payment model to support evidence-based interventions for integrating other professionals into pediatric practice care team
- Strong coordination between practice-based care team and community, especially with schools
- Data sharing between the practice and services provided in the health community
- Functions of care team are overlapping and connected
- Population health and health promotion are overarching across the practice and community
- Community Health Workers are critically important for supporting all practice functions and connecting children and families to the community
- Add to health neighborhood: child health care consultants, parent supports, developmental assessments and services for children not eligible for birth to 3

Health Neighborhood

Schools: Health Centers, Nurses

Urgent Care

Head Start, Child care centers

Coordination w/ CHW Support

WIC, Nutrition Programs

Care coordination centers, United 211

Social services and family supports

Population Health Promotion & Management
Pop Health Specialist

Behavioral Health Integration
Pediatrician, BH Clinician, Care Coordination with BH expertise

Well Visits & Preventive Care
Pediatrician, RN, MA Nutritionist, Dietician, Lactation Consultant, CHW, Developmental Specialist

Care Management
RN

Medical Home

Chronic Illness Self-Management
RN, Nutritionist, Dietician, Asthma Educator, CHW

Care Coordination
RN, Social Worker, CHW

Patient & Family, Pediatrician

Oral Health Integration
Clinician, RN

Medication Prescribing & Management Functions
Pediatrician, Pharmacist, RN, MA

Patient Navigation
Patient Navigator, CHW, Social Worker

Acute and Chronic Care
Physician, PA, APRN, RN, Medical Assistant

Services on-site, at network, in home or in community, Medical interpretation deployed as needed. All care team members trained in cultural sensitivity.

Developmental Assessment Services and Supports

Parental Support

Early intervention services

Coordination w/ CHW Support

Child Care Health Consultants

Specialists, BH providers, and Ancillary Providers

Community Based Organizations

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
- **Medication Prescribing & Management Functions**: Medication reconciliation, monitoring and coordination, comprehensive medication management, medication therapy
- **Behavioral Health Integration**: BH and developmental screenings, assessments, brief interventions, medication, episodic care, referrals to complex and extended treatment, and follow-up

Key Questions

- Do these expanded care team functions and roles support our goals?
- Which, if any, of these functions should be required in every practice?
- Should the full array of expanded care team functions be available in the practice? The network?
- Should expanded care teams to support these functions be a core or elective capability?

Care Coordination Feedback from Previous Session

- Medical home should provide care coordination services
  - Practice-based Care Coordinator and CHW present opportunity to better coordinate between practice and all other places child receives care
  - Opportunity for increased coordination between schools and practices
- Require that care coordinators work within a larger system of available resources
- Ideally data is shared* between practices and community settings (schools, urgent care, child care centers, etc.)
  - Shared EHR would be ideal but not there yet, HIE once established presents an opportunity
- Pediatric practice needs to be aware of all the services in the community
  - Opportunity for care coordinators and CHWs to close gaps in services if payment model supports this function
- Community-based organizations play a large role in supporting care coordination and connecting children and families to services
  - Need way to fund CBOs for this
  - CHWs in community need to be able to bill for this in coordination with the practices

*Appropriate consent and confidentiality maintained

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

Is this the right definition? What's missing?

[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
  - 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

What else is missing?

Should practice-based care coordinators be required to work with a centralized care coordination resource (i.e. DPH CYSHCN care coordination centers, United Way 211)?

Oral Health Integration

US Preventive Services Task Force Grade B recommendations:

- Primary care clinicians apply fluoride varnish for babies and children birth to 5 years
- Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.

Oral Health Integration Activities

- Oral Health Screenings for oral health and active conditions
- Preventive interventions (fluoride varnish and supplementation)
- Communication and education about importance of good oral health and practices to maintain it
- Referral to dental care as needed and tracking outcomes

Should oral health integration be a required capability for pediatric practices?

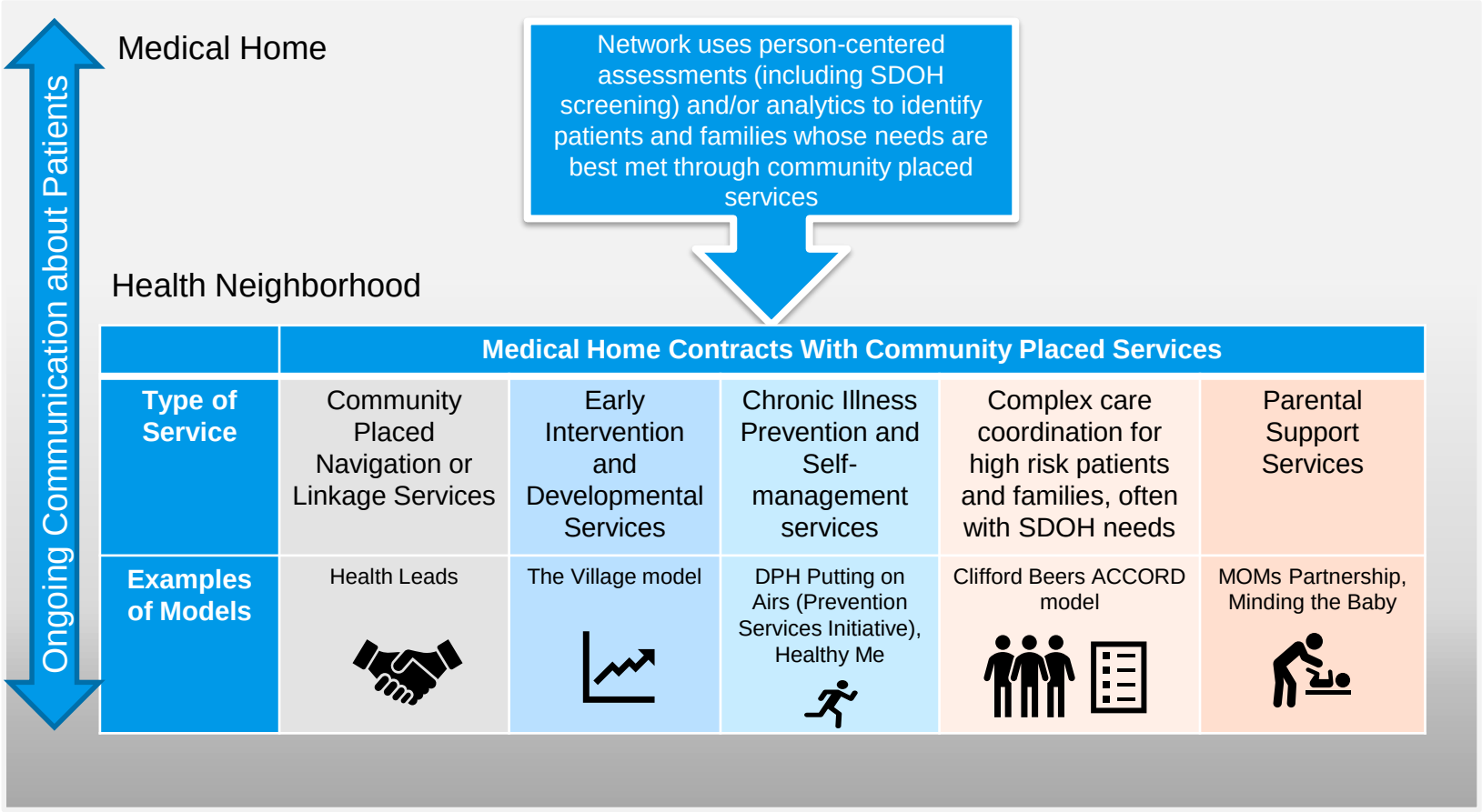
Community Integration

Community Integration: Overview

- Group has emphasized:
  - Importance of pediatric care services within the community (via schools, care coordination services, developmental services, etc.)
  - Importance of medical home coordination with community based services and resources
  - Importance of funding to support these services

- Community Integration supports pediatric care services in the community:
  - Advanced networks or Federally Qualified Health Centers (FQHCs) purchase community-placed services that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services

Community Integration: Types of Services



	Medical Home Contracts 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
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

What other types of services should be included?
Should pediatric practices be required to contract with community-placed services?

Access to Specialty Care

Capabilities from 12/4 Discussion

Access to Specialty Care: Co-Management

"Collaborative and coordinated care that is conceptualized, planned, delivered, and evaluated by two or more health care providers, one being a PCP and the other a subspecialist"[1] for certain conditions

- Outcome: Enables primary care providers to care for patients with certain conditions that otherwise would have been referred to a specialist
- Early evidence: provider satisfaction, increased adherence to guidelines
- Example: Connecticut Children's Medical Center Co-management Programs[2]
  - CCMC medical experts team up with pediatric primary care providers to treat patients with certain conditions (e.g. Lyme, concussions, migraines, etc.)
  - Provide standardized clinical algorithm, referral guidelines, CME co-management trainings, visits templates for providers, and handout for patient and family

Should co-management be incorporated into PCM as a tool for pediatric primary care clinicians?

Is something like the CT Children's Medical Center program a scalable model?

[1]https://www.chdi.org/publications/reports/impact-reports/working-together-meet-childrens-health-needs-primary-and-specialty-care-co-management/
[2]https://www.connecticutchildrens.org/co-management/

Expanding PCP Expertise: Project ECHO

- **Telementoring guided practice learning program to expand health care provider expertise in specific areas**[1]
  - Examples of AAP pediatric ECHOs: 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

- **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

Should primary care practices be required to participate in ECHO guided practice?

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

Next Steps

- Review summary of recommendations electronically
- Practice Transformation Task Force reviews recommendations on January 8th
- Payment Reform Council considers how payment model will support recommendations

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
- Make primary care more convenient, community-based and responsive to needs of patients and families
- Ensures a return on investment in the long-term

Vision is achieved through AAP medical home services and Bright Futures Health Promotion themes

[1]http://pediatrics.aappublications.org/content/pediatrics/110/1/184.full.pdf
https://www.aap.org/en-us/about-the-aap/aap-facts/AAP-Agenda-for-Children-Strategic-Plan/Pages/AAP-Agenda-for-Children-Strategic-Plan-Medical-Home.aspx

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 opportunities

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

[1] American Academy of Pediatrics: https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Introduction.pdf

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

- What other care management activities are needed?
- How can pediatric primary care practices be supported to improve care management?

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

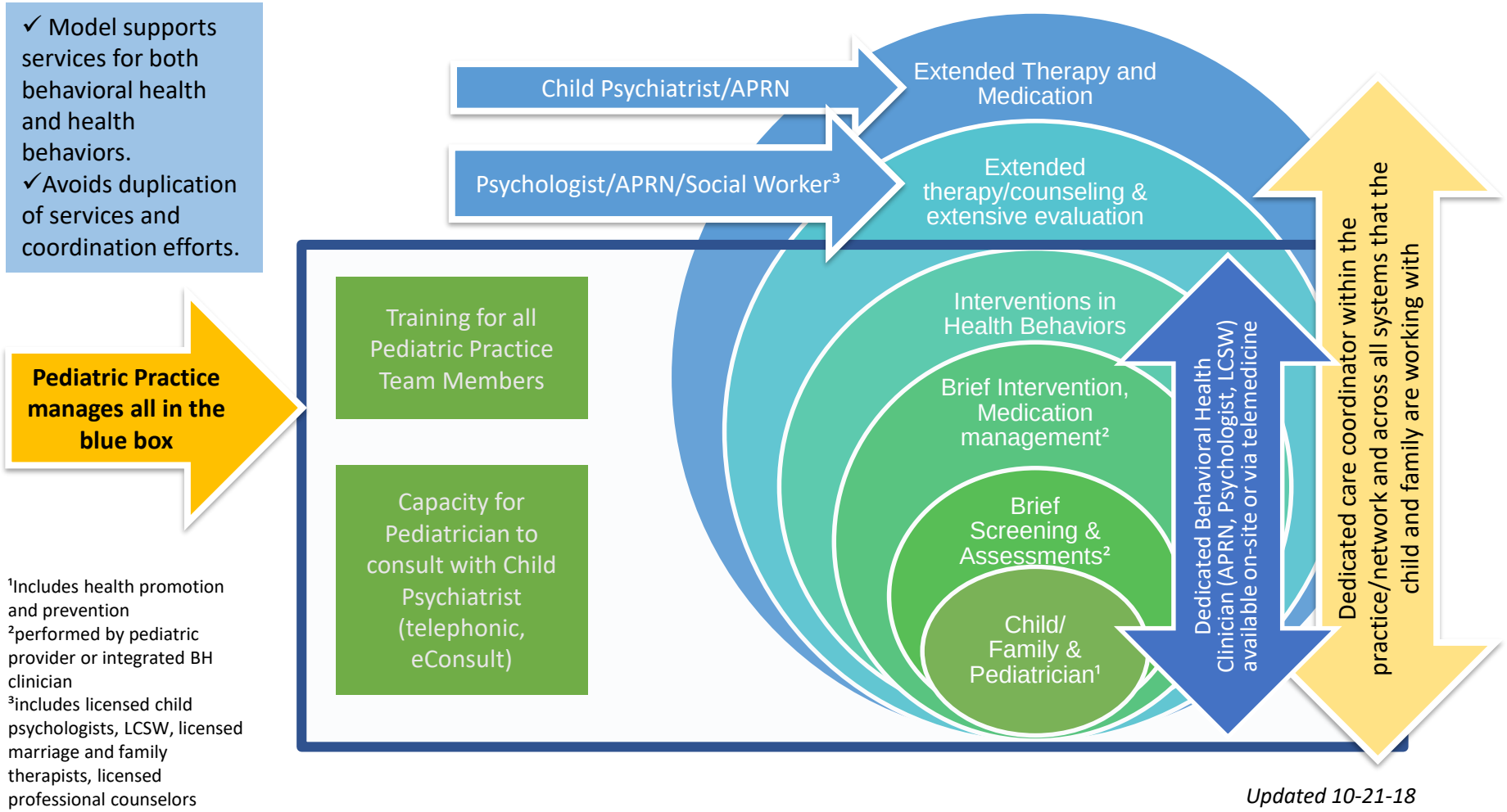
Medication Management and Prescribing Functions

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.



[1]Includes health promotion and prevention
[2]performed by pediatric provider or integrated BH clinician
[3]includes 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)

Community Integration Examples

Community Integration Examples

Community Placed Navigation or Linkage Services

- Health Leads
  - Primary care practices contract with organization that provides on-site aids to connect patients to social services
  - Volunteer advocates screen patients for social determinants of health needs and links patients depending on SDOH needs to basic resources like food, clothing, housing, etc.

Early Intervention and Developmental Services

- The Village, Mid-Level Developmental Assessment
  - Assessment of children struggling within their home and/or school environment, including communication, cognitive, physical, adaptive, social/emotional and parenting
  - Appropriate services are provided before problems escalate, and the child is brought back to a normal developmental trajectory.

Community Integration Examples

Chronic Illness Prevention and Self-management services

- CT DPH Putting on AIRS Program:
  - Asthma education specialist and environmental specialist visit home and review asthma signs and symptoms, identify and remediate asthma triggers and review proper medication administration
- Healthy Me: Childhood Obesity Program, Primary Care Coalition of CT
  - Team-based pediatric prevention and treatment program with PCP and Registered Dietician on site at pediatric practice
  - Provides physical exam, meeting with dietician, referrals to physical therapy and behavioral health clinician as indicated, lactation counseling

Community Integration Examples

Complex care coordination for high risk patients and families, often with SDOH needs

- Clifford Beers Advanced Care Coordination (ACCORD)
  - Children's mental health clinic that helps those with physical, mental, and/or social determinants of health issues.
  - Services are delivered by care coordinators and community health workers backed by an in-house team of psychiatrists, social workers, and medical consultants.
  - Services can be provided in the home and trauma training and professional development in schools are also available.

Parental Support Services

- Yale Child Study Center “Minding the Baby”: Enhance mother-infant relationships for at-risk mothers, children and families[1]
- MOMS Partnership: Program for pregnant women, mothers and female caregivers to address mental health and parenting needs in convenient locations