CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

PCMH Kids: A Patient Centered Medical Home Community that Works for Children and Families

CityMatCH • PROVIDENCE, RI • SEPTEMBER 24, 2019

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PROJECT WEBSITE: WWW.CTC-RI.ORG

PCMH Kids Background Info

- Under auspices of RI Office of Health Insurance Commission and RI Medicaid
- Multi-payer pediatric primary care payment and delivery system reform initiative
- Health plans provide infrastructure and incentive payments
- Practices meet service delivery requirements
  - ❑ Hire care coordinator to engage with “at risk” children
  - ❑ Become NCQA PCMH
  - ❑ Actively participate in on-site and peer learning
  - ❑ ‘ove quality, customer experience and ER utilization

Blue Cross Blue Shield of Rhode Island

UnitedHealthcare

Neighborhood Health Plan OF RHODE ISLAND™

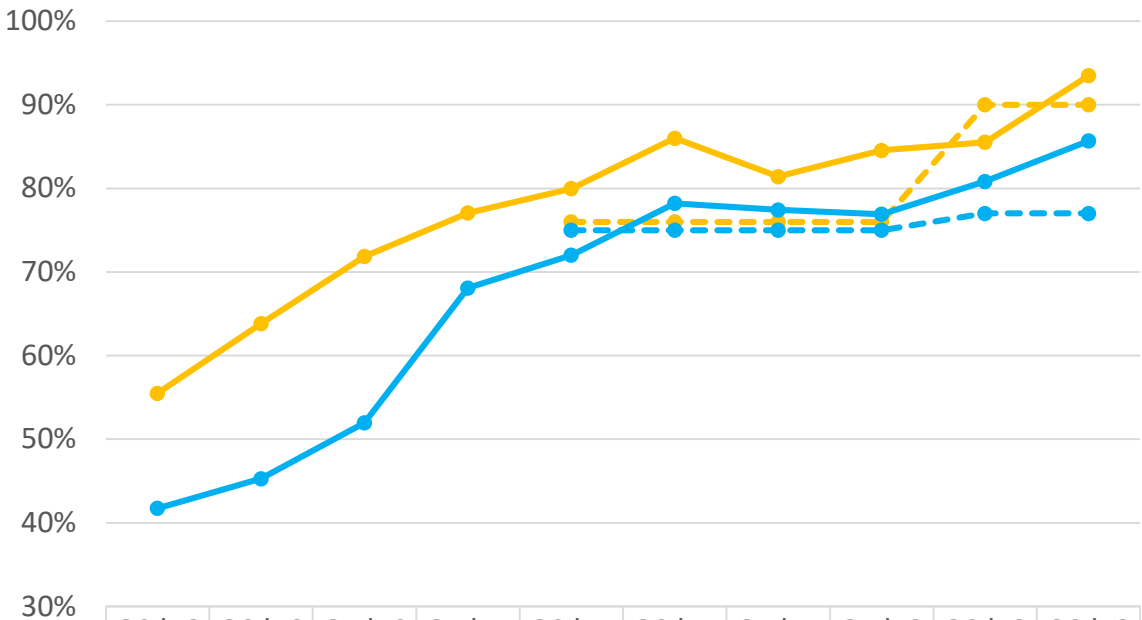
TUFTS Health Plan

Successful Practice Transformation

- Practices achieved the highest level of NCQA patient centered medical home recognition
- Health plans supported 2 additional expansions based on results (now 37 practices, ~200 providers)
- ***PCMH-Kids represents more than 50% of the children in RI and nearly all of the state's pediatric Medicaid population.***
- Medicaid and Commercial payers support on-going sustainability payments
- Increased opportunities for state-wide efforts and grants

Results to Date: Improved Quality: BMI and Developmental Screening Rates

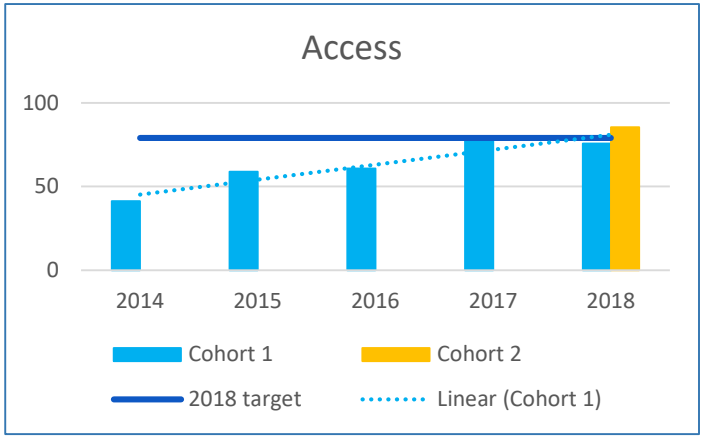
Quality Measures
PCMH Kids
Cohort 1 & 2

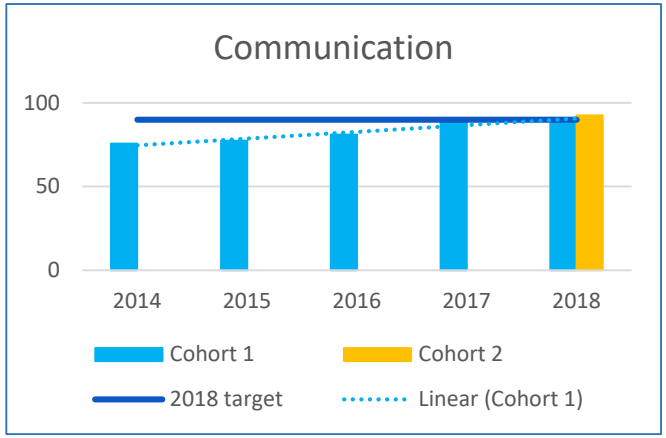


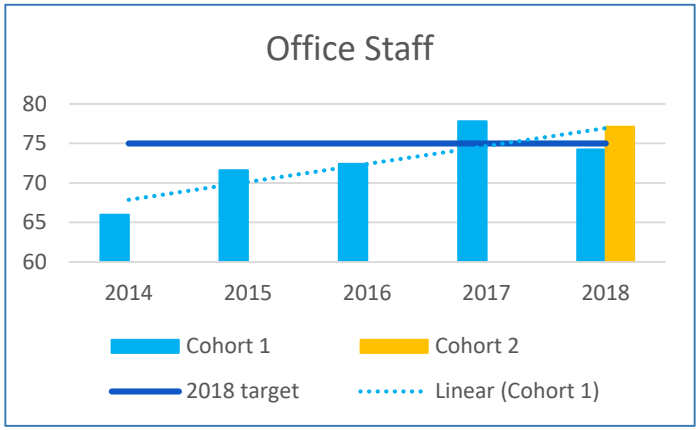
	Q2 '16	Q3 '16	Q4 '16	Q1 '17	Q2 '17	Q3 '17	Q4 '17	Q1 '18	Q2 '18	Q3 '18
BMI Target					76%	76%	76%	76%	90%	90%
BMI	55%	64%	72%	77%	80%	86%	81%	85%	86%	93%
Developmental Screenng Target					75%	75%	75%	75%	77%	77%
Developmental Screenng	42%	45%	52%	68%	72%	78%	77%	77%	81%	86%

Results to Date:
Improved Customer Experience

Patient Experience Survey Results PCMH Kids Cohort 1 & 2







CAPHS survey data

Results to Date: "At risk" children and families identified and linked with care coordination services

- Developed and implemented a 3 domain pediatric sensitive high-risk framework to identify children and families that could benefit from care coordination services:
  - High cost/high utilization
  - Poorly controlled/complex conditions
  - "at risk" based on gaps in care and/or family social environmental issues
- Practices hired care coordinators who worked with "at risk" children and families

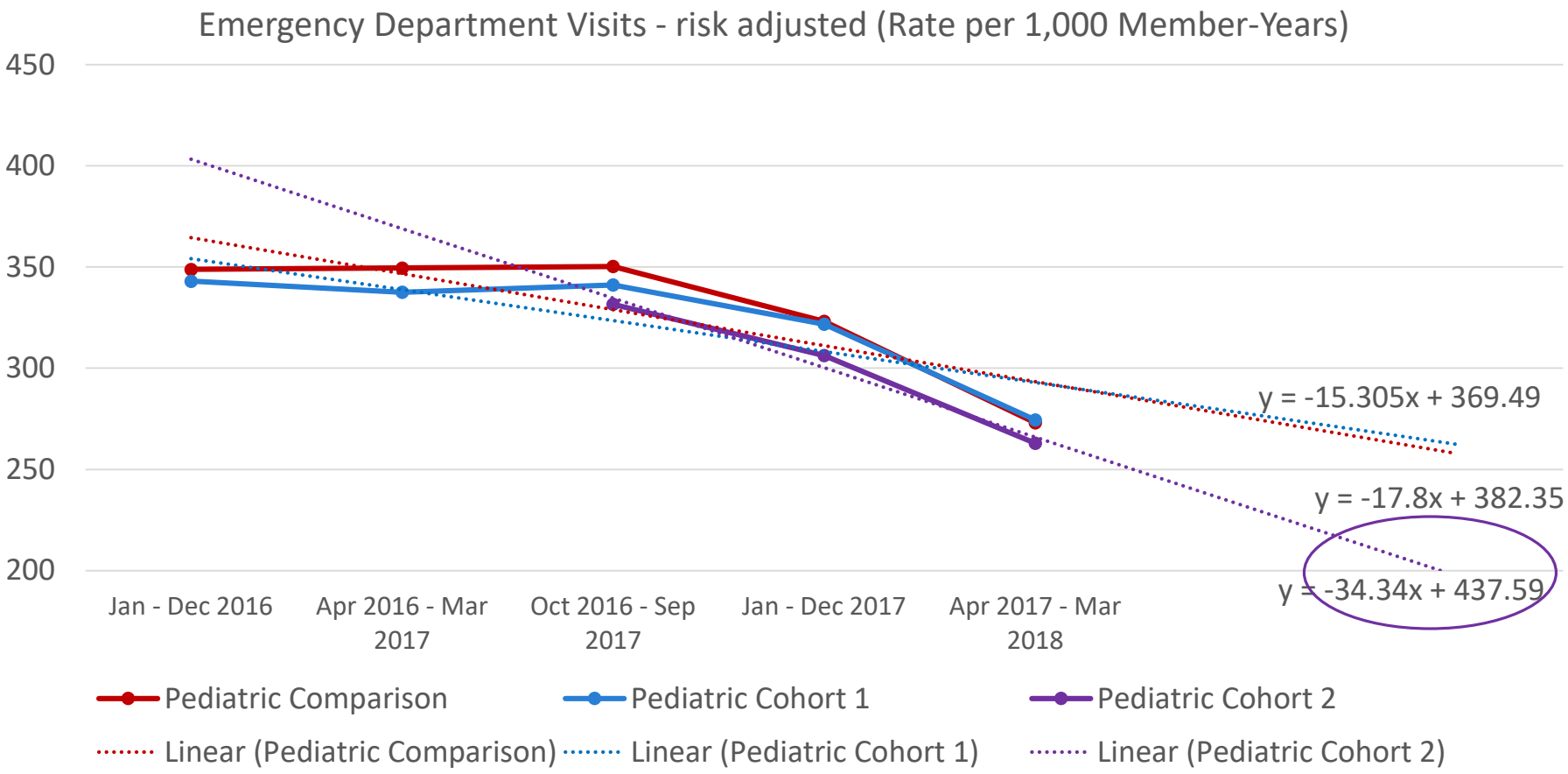
Results to Date: Improved ED Utilization

PCMH Kids Cohort 1 & Pediatric Comparison
Rate per 1,000 Member Months (Excluding ERISA Members)

Group	July 2015 – June 2016 (A)	July 2016 – June 2017 (B)	Difference (2015 – 2017) (B-A)	% Difference (2015 – 2017)
Emergency Department Visits				
(1) PCMH Kids Cohort 1	29.2	28.6	-0.7	-2.3%
(2) Pediatric Comparison	29.0	29.0	0.1	0.2%
Difference (1–2)			-0.7	-2.5%
Inpatient Discharges				
(1) PCMH Kids Cohort 1	1.5	1.5	0.01	0.7%
(2) Pediatric Comparison	1.2	1.2	0.01	0.5%
Difference (1–2)			0.00	0.3%

*Data Source: Onpoint

Results to Date: Improved ED Utilization

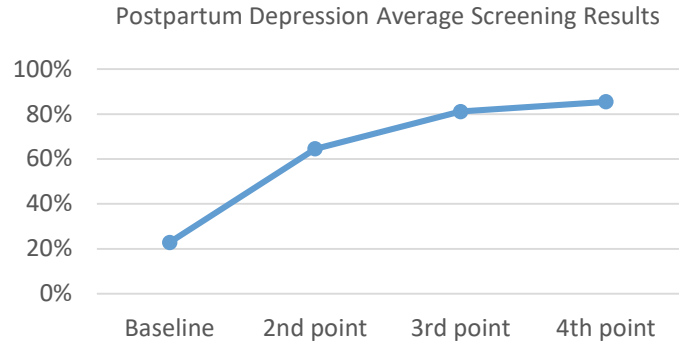


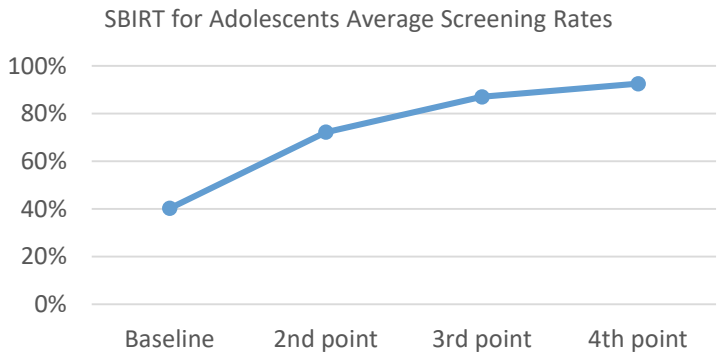
*Data Source: Onpoint

Behavioral Health Successes

Integrated Behavioral Health Services into Pediatric Primary Care through:

- **Universal Screening all infants/toddlers for social emotional wellness, social influencers of health**
- **Annually selected behavioral health topic for 12 month learning collaborative with health plan funded incentive to improve care: Postpartum depression screening, ADHD care, and screening adolescents for SUD/referral to treatment**





Outcomes/Partnerships

KIDSNET (RI Department of Health children's health information system): Provided practices with practice profile based on risk score

Rhode Island Department of Health: Joint application for HRSA "Healthy Tomorrows" Grant

KIDSCOUNT: Collaboration to launch RI 1st 1000 Days Campaign

Tufts Health Plan: Financial support for IBH Pilots

AAP/Rhode Island College: Adolescent SBIRT Program

Rhode Island Foundation: 3 year grant for standardized IBH Pediatric Program

Sustainability Approaches

Learning

- Successfully built a pediatric primary care and integrated behavioral health learning community
- Integrated "pediatric track" in CTC Annual Conference
- Provided joint learning experiences between PCMH Kids and Adult PCMH practices

Sustainability Approaches

Evaluation

- All Payer Claims Data Base Performance Metrics
- Patient Experience (CAHPS)
- Quality Measures
- NCQA recognition
- PCMH Kids Co Chairs: National Recognition Calvin C.J.Sia Community Pediatric Medical Home Leadership Award

Main Takeaways

Building a strong foundation for children's health is an investment . The value proposition in high quality pediatric care is about investment, not rapid return and shared savings.

Practices need support (time, infrastructure payment, coaching assistance, learning from others, team model, on-going data reporting and QI activities) to make and sustain culture changes needed to thrive in value based payment systems.

To achieve maximum health and well being, families raising children depend on robust, integrated, resourced programs at the community and state level.

Any Questions?