CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome
PCMH Kids Practices and Key Stakeholders

PCMH KIDS STAKEHOLDER MEETING 6-04-20

PAT FLANAGAN MD & BETH LANGE MD, PCMH KIDS CO CHAIRS

Agenda

- Welcome & Opening Remarks

  Patricia Flanagan, MD, FAAP, PCMH Kids Co-Chair

  Elizabeth Lange, MD, FAAP, PCMH Kids Co-chair

- Pediatric IBH Status Update

  Liz Cantor, PhD – Pediatric IBH Practice Facilitator

- Review of 2020 Programs

  Patricia Flanagan, MD, FAAP, PCMH Kids Co-Chair

  Elizabeth Lange, MD, FAAP, PCMH Kids Co-chair

PCMH Kids Cohort 2
Completing 3 year Contract

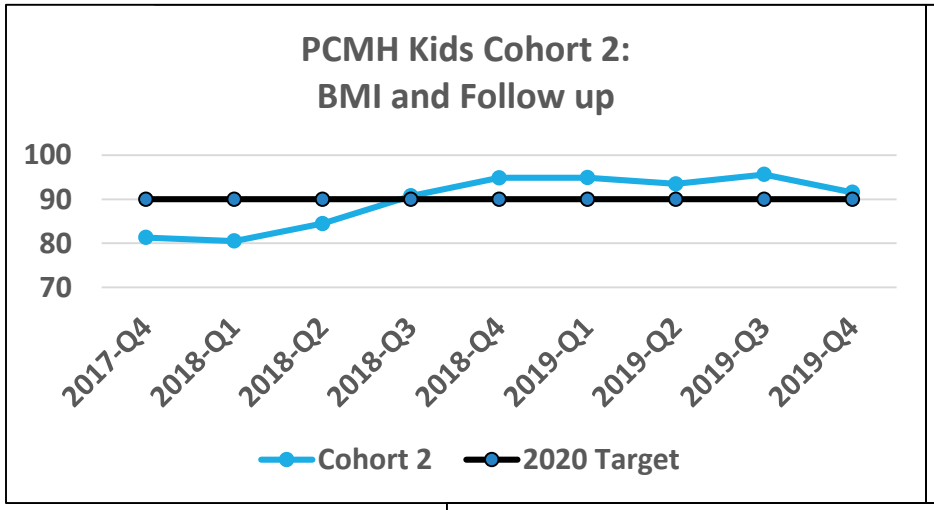
- Aquidneck Pediatrics
- Barrington Family Medicine
- Barrington Pediatrics
- Children's Medical Group
- Coastal Medical – Bald Hill
- Coastal Medical – Toll Gate
- Cranston Park Pediatrics
- East Side Pediatrics
- Kingstown Pediatrics
- Northern RI Pediatrics

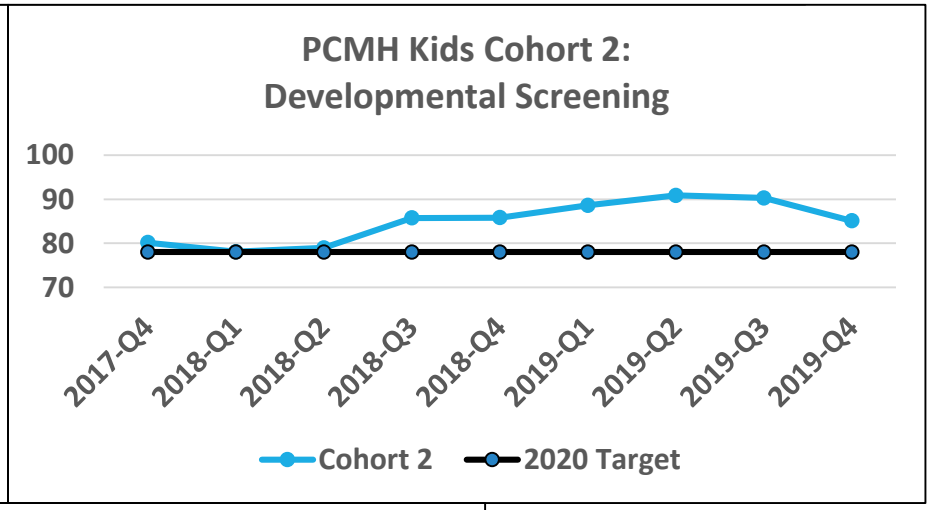
All NCQA recognized

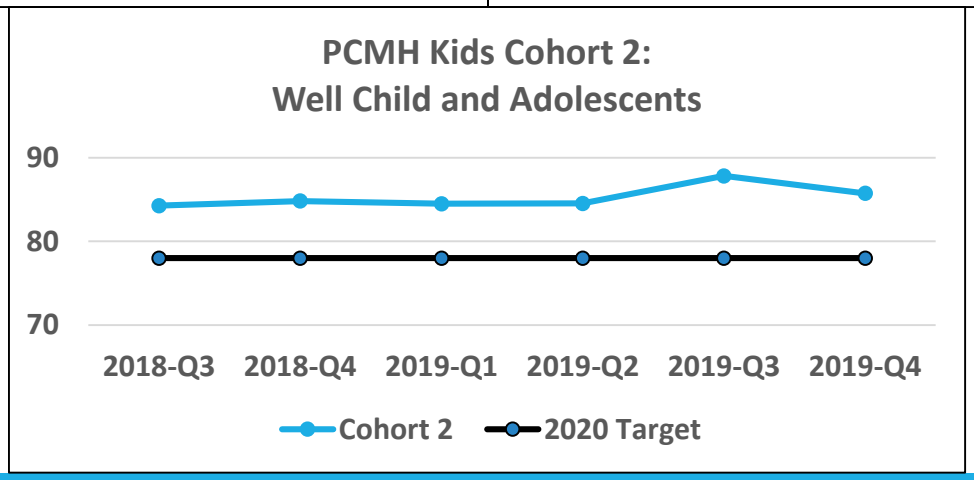
We couldn't have done this without you!
(and had so much fun)

$125K in Incentive Payments to be paid out in 2020

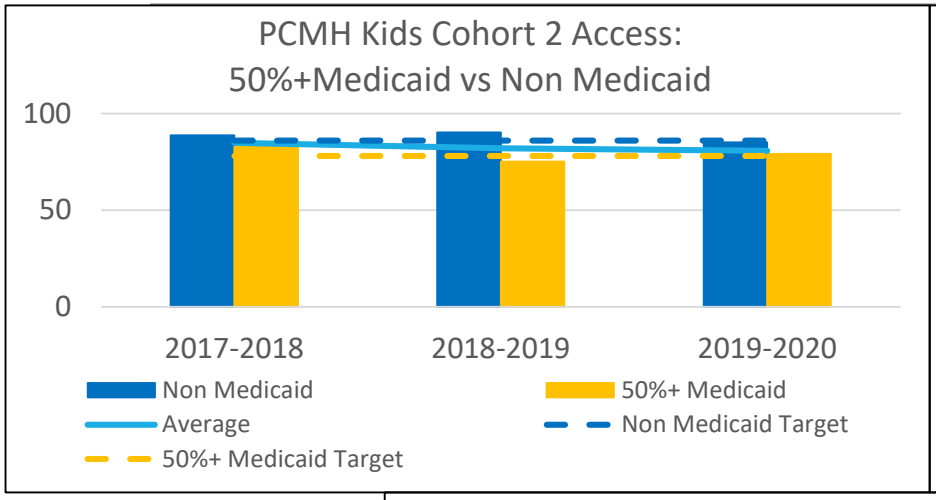
PCMH Kids Cohort 2
Quality Performance Over Time

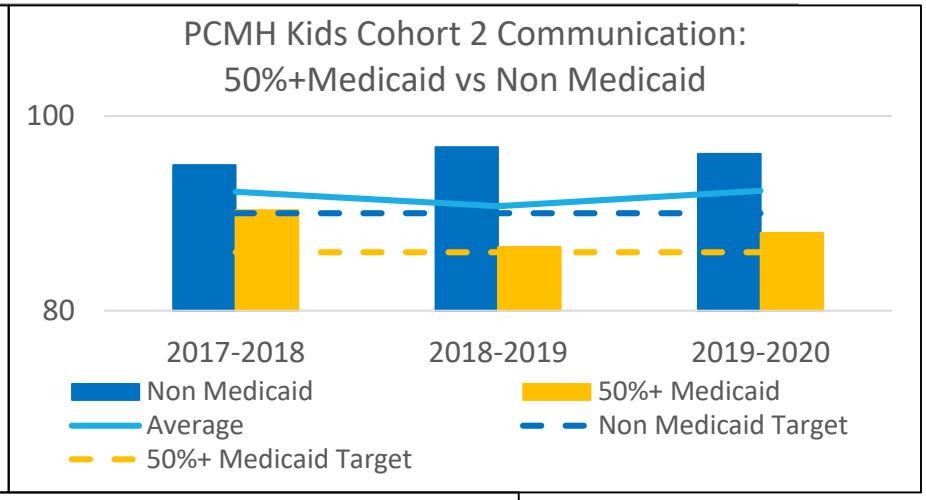


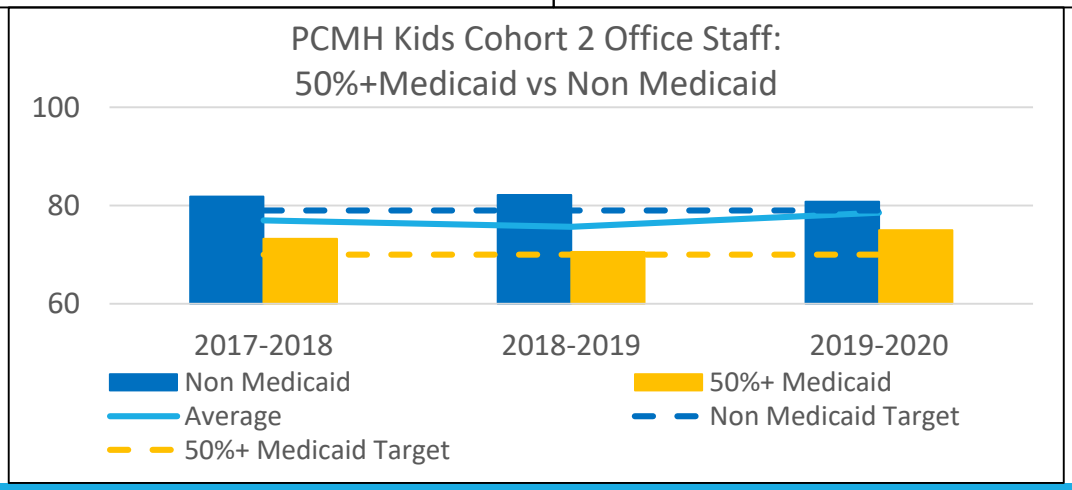




PCMH Kids Cohort 2
Customer Experience Over Time







Financial Sustainability

- PCMH Kids Cohort 1 and 2 should continue to receive **PMPM sustainability payments without interruption** post completion of the CTC/PCMH Kids Contract.
- Health Plans will be contacting practices/SOC for **contract conti**nuation - Reach out to health plan if you do not hear from them (health plan contacts)
- **365-day Rule**
- **Provider Relief Fund**
- CMS
- CTC/PCMH Kids Policy Report to **Governor's COVID-19 Task Force** - requesting short term financial stability of practices, special attention to community pediatric practices as well as Medicare/Medicaid rate parity going forward

PCMH Kids Cohort 3 Accomplishments

- Submitted baseline & quarterly **quality measures**
- Participated in **CAHPS** as baseline year
- Submitted **budget & staffing plans**
- Submitted **NCQA** recognition/renewal **work plans**
- Submitted **OHIC** quality measure information
- **Hired NCM or Care Coordinator**
- Developed **High Risk Registry**
- Submitted **Transition of Care Policies**
- NCM/cc participates in **xGLearn or ECHO** learning programs
- Submitted **After-Hours Protocol**
- Enrolled in Pedi-PRN
- Submitted **BH Compact**
- Registered for **Q Pass**

- Children First Pediatrics
- Hasbro Adolescent Medicine
- Drs Concannon & Vitale LLC
- North Providence Pediatrics
- Ocean State Pediatrics
- Partners in Pediatrics
- Providence Community Health Center - Capitol Hill
- Providence Community Health Center - Central
- Providence Community Health Center - Chafee
- Providence Community Health Center - Olneyville
- Providence Community Health Center - Prairie Ave
- Providence Community Health Center - Randall Sq
- Santiago Medical Group - North Providence
- Santiago Medical Group - Pawtucket
- Tri-County Community Action Agency - Johnston
- Tri-County Community Action Agency - North Providence

PCMH Kids Cohort 3
NCM/CC Completed GLearn

- Started January 2020-June 2020
- Blended educational learning experience
- Web based interactive modules
- Weekly Pediatric NCM facilitated telephone consultations
- Earn up to 18.58 CEU's
- Occurred during COVID-19 crisis with NCM/CC still saying "sorry it ended"
- Pediatric learners will present capstone case studies at 6/16/20 NCM meeting
- Funded by UnitedHealthcare

OHIC 2020 and PCMH Kids Transformation Plan

- Clinical Quality Measures: Report Only including Lead Screening
- PCMH Kids Cohort 3: Incentive Payment
  - **Health plans currently considering an alternative Incentive Payment option**
  - Components of the Alternative Incentive Payment option
    - Following OHIC's guidance, practices continue to report clinical quality measures (with no incentive targets to meet) and deliver on other deliverables outlined on the CTC-RI/PCMH Kids milestone document.
    - In lieu of CAHPS survey & ED Utilization, PCMH Kids Cohort 3 would receive performance improvement incentive ($0.50 pmpm) based on developing, implementing and meeting deliverables identified in the Quality Improvement Immunization Work Plan.
    - Incentive payment 75% upfront; 25% for meeting goal
    - Goal: MMR immunization for school age children with 10% prior year by December 31, 2020*. Adolescent Medicine may need to target adolescent immunizations for incentive payout.

*may need to be adjusted based on Governor's Task Force.

Immunization Proposal to Governor's COVID Task Force

- Statewide Immunization Learning Collaborative
- Utilizing KIDSNET data
- Providing Practice Facilitation Services
- Recommending $3PMPM fro 3 months or $9 per member with at least 2/3 upfront and 1/3 towards meeting goal
- Goal: TBD

Pediatric Integrated Behavioral Health Pilot Program

RHODE ISLAND FOUNDATION
Lead, Transform, Inspire

Blue Cross Blue Shield of Rhode Island

TUFTS Health Plan

UnitedHealthcare

- **3-year pilot program with 2 waves of 4 practices**
- **Kickoff Meeting was in July, 2019**
- **Key Program Components:**
  - Support culture change, workflows, billing
  - Universal Onsite IBH Practice Facilitation: Screening 3 out of 5: Depression (adolescent), Anxiety (adolescent), Substance use (adolescent), Middle childhood, or Postpartum depression
  - Embedded IBH Clinician : warm hand offs, pre-visit planning, huddles
  - Quarterly Best Practice Sharing: data driven improvement, content experts

Cohort 1	Anchor Pediatrics
	Comprehensive Community Action Program (CCAP)
	Hasbro Pediatric Primary Care
Cohort 2	Coastal Medical – Bald Hill
	Coastal Medical - Waterman
	Hasbro Medicine Pediatric Primary Care
	Northern RI Pediatrics
	Tri-County Community Action Agency

Pediatric Integrated Behavioral Health Cohort 1 Yr1 Accomplishments

Anchor Pediatrics	• Provided **preliminary self-assessments** • Submitted participative agreements • Developed and implemented a **staffing plan** for patients to be able to access BH assessment/treatment with same day to 48-hour access from an on-site behavioral health clinician; • Identified mechanisms within the **electronic health record** to capture and report screening rates using evidence based screening guidelines for 3 out of 5 populations of focus; • Hired BH staff if not already in place; • Developed **work flows** (including roles/responsibilities/screening and warm hand off protocols/ referrals to external resources) as needed; • Developed **billing systems** to successfully bill for services; • Submitted **baseline** and **quarterly screening rates** on the 3 practice identified populations of focus and are **on target** to meet the Yr1 target screening rates due July 1, 2020; • Participated in **monthly on-site practice meetings** with the IBH practice facilitator and quarterly peer learning network opportunities.
Comprehensive Community Action Program (CCAP)	
Hasbro Pediatric Primary Care	

		EPDS	PSC-35	PHQA/9	GAD7	CRAFFT(N)
Targets:	*YR1/YR 2*	*40/60%*	*40/60%*	*60/75%*	*40/60%*	*40/60%*
Anchor	**2nd Qtr**	**95%**	N/A	**85%**	**4%**	**(85%)**
	1st Qtr	**88%**	N/A	**66%**	**2%**	**(63%)**
	baseline	**95%**	N/A	**75%**	**0%**	**(27%)**
CCAP	**2nd Qtr**	N/A	N/A	**71%**	**42%**	**41%**
	1st Qtr	N/A	N/A	**78%**	**2%**	**21%**
	baseline	N/A	N/A	**88%**	**1%**	**42%**
Hasbro Pediatric PC	**2nd Qtr**	**68%**	N/A	**93%**	N/A	**90%**
	1st Qtr	**39%**	N/A	**89%**	N/A	**87.5%**
	baseline	**45%**	N/A	**85%**	N/A	**44%**

Pediatric Integrated Behavioral Health Cohort 2 Accomplishments

Cohort 2	Coastal Medical – Bald Hill	• Officially started program in April, 2020 • Provided **preliminary self-assessments** • Submitted participative agreements • Developed **staffing plans** for patients to be able to access BH assessment/treatment with same day to 48-hour access from an on-site behavioral health clinician; **Due June 1** • Identified mechanisms within the **electronic health record** to capture and report screening rates using evidence based screening guidelines for 3 out of 5 populations of focus; **Baseline data due June 1** • Will be **hiring BH staff** if not already in place; • Began participating in **monthly on-site practice meetings** with the IBH practice facilitator • Attended quarterly peer learning network opportunities.
	Coastal Medical - Waterman	
	Hasbro Medicine Pediatric Primary Care	
	Northern RI Pediatrics	
	Tri-County Community Action Agency	

… during a pandemic!

Pediatric Integrated Behavioral Health Friendly Reminders of Deliverables Due

Cohort 1	Mid-point Self Assessment **due July 1, 2020**
	Execute MOA with PediPRN (if not already in place) and MomsPRN, **due Aug 1, 2020**
Cohort 2	Staffing plan & baseline data was **due June 1, 2020**
	Hire BH Staff, **due Aug 1, 2020**

Pediatric Integrated Behavioral Health Provider Feedback

- "There are many examples of how having an IBH clinician has helped our office provide **better care to our patients**. This project has been **enormously successful** in helping our patients get services that have been so helpful to them."

- "Emerging from a troubled childhood, this young woman has struggled with anxiety, depression, PTSD, and multiple somatic symptoms and several medical problems for many years. She has not graduated from high school and spends most of her time at home with little energy accomplishing little. My patient has steadfastly refused counseling and feels the many psych medications I have prescribed for her are unhelpful. … My patient finally admitted to our IBH Clinician and now to me that the reason she does not want to go back for her GED or apply for jobs is that she really cannot read much at all. Our IBH Clinician has worked with her on finding literacy resources and we are hoping she can make progress with reading after the pandemic. This patient is more optimistic and **truly benefiting from the IBH input**."

Pediatric Integrated Behavioral Health Provider Feedback

"many parents shared with me that our screening program made them much more comfortable having discussions with their children and adolescents about mental health concerns. As we as providers became more comfortable with these discussions - so did our patients and their parents."

"we developed a reputation in the community as a practice that was able to address the mental health concerns of our patients. We even had new families join the practice because they heard from their neighbors and friends about our screening process and in-office therapy options."

"one introverted teenage boy told me he was actually excited to come to his annual exam because his sister had just had her exam and told him all about the screening process and how the physicians are willing to talk about "everything". He was able to share his anxieties that had increased over the past few years and without this program I don't think he would have revealed his concerns and sought treatment."

Healthy Tomorrow Grant

- Connecting Home Visiting with PCMH Kids Practices Learning Collaborative
- HRSA funded
- 2020 Planning Year

Community Health Team Expansion includes Families & Kids

The enhanced current statewide Community Health Team (CHT) network is bringing an “integrated family health” approach to best serving individuals and families who are “high” or “rising” health risk due to significant social and/or behavioral health needs. We are doing this by:

- Enhancing our connections to Family Home Visiting Teams (i.e. First Connections, Early Intervention)
- Piloting a cross-agency, cross-discipline, intentionally-designed team to serve families (children and adults) with complex medical, behavioral and social needs. The intention is for this pilot to specifically serve families affected by for Opiate Use Disorder (OUD). The Family Care Team brings together people from the different agencies and programs families are working with, in order to facilitate information sharing and provide more streamlined support.

Benefits of CHTs working with Family Home Visiting Programs

Family Benefits

- Improved overall patient and family care
- Decreased gaps in care
- Improved service coordination
- Expedited referral process
- Improved care planning

Staff Benefits

- Streamlined treatment pathways and reduction in duplication of services
- Improved collaboration and communication between providers
- Increased educational opportunities
- Ability to share and learn about valuable community resources
- Decreased staff burnout through collegiate support

Friendly Reminder RIPIN Family Care Liaison

Introducing Rhode Island Parent Information Network (RIPIN) FAMILY CARE LIAISON

As care coordinators, you may need help to identify resources to address child and family needs. The Family Care Liaison is a new resource for care coordinators and nurse care managers at PCMH-Kids practices.

What can the Family Care Liaison do?

The Family Care Liaison will assess the needs and eligibility of the child or children and identify and coordinate with appropriate programs to meet their needs

- Enhanced care coordination through RIPIN's Cedar Family Center
- School supports from RIPIN's special education experts
- Family support from RIPIN Peer Professionals
- Other relevant programs, both inside and outside RIPIN

RIPIN's new Family Care Liaison can help any family with a child

- In need of in-home services
- Whose family is at risk for food or housing insecurity
- Whose parent presents as overwhelmed with their child's needs
- Whose family is affected by Substance Use Disorder (SUD) or at risk for Opiate Use Disorder (OUD)

Families are eligible for referral to the Family Care Liaison **regardless of health insurance type.**

The Family Care Liaison will close the loop with your practice's care coordinator or nurse care manager.

For direct access to the Family Care Liaison, call

401-384-7831 Or call the main RIPIN number, 401-270-0101 ext. 192

RIPIN

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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Health Care Transitions from Pediatrics to Adult Primary Care Learning Collaborative

- RIDOH Title V funded; Looking for additional funding
- Most likely postponed to 2021