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

Patricia Flanagan MD FAAP • Elizabeth Lange MD FAAP • Susanne Campbell RN MS PCMH CCE

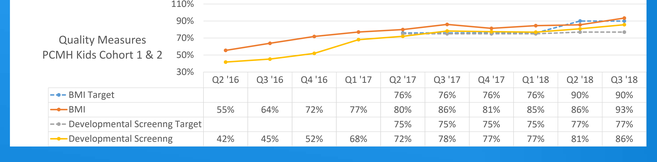
Under auspices of RI Office of Health Insurance Commission and RI Medicaid, in 3 years CTC-RI PCMH Kids created a state-wide, multi-payer pediatric-relevant primary care transformation initiative which now includes 37 practices, covering over ½ the children in the state and 80% of RI Medicaid-insured children. PCMH-Kids practices and health plans enter into a common contract with service delivery requirements and infrastructure pmpm payments to achieve NCQA PCMH recognition, hire a care coordinator, implement population health approach to care management, and participate in on site practice facilitation and learning collaborative initiatives. Incentive payments are provided for improving quality, customer experience and reducing ED utilization.

Pediatric Sensitive Transformation

WHAT WE DID : Planning , Implementing and Evaluating

- A community-driven process obtained commitment from payers and designed common set of service delivery requirements: emphasis on screening, prevention with anticipated longer term ROI
- Created "best practice" sharing committee support (PCMH Kids Stakeholder, NCM/CC, Practice Reporting/Transformation, Breakfast of Champions) and on-site practice facilitation
- "Call for Applications", contracts, payment
- Practices hired care managers (social workers, parent consultants, or nurses) who engage "at risk" children and families

RESULTS : Quality



	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 : Customer Experience

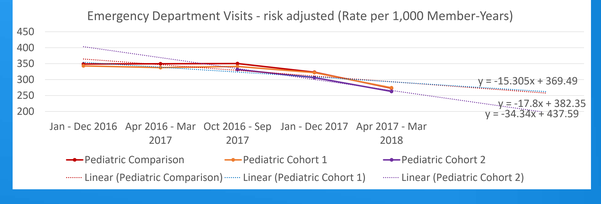
WHAT'S NEXT?

- Medicaid and Commercial Payers are providing sustainability payments through Systems of Care (ACO and AE) and to individual practices

Pediatric High-Risk Framework

Using a population health approach we created 3 domain "At risk" framework for poor health outcomes due to 1) high cost/high utilization 2) poorly controlled, or complex condition 3) "at risk" based on gaps in care and/or family, social, environmental issues. Practices use EHR for population health identification, together with clinical judgment, referral to care coordinator with reporting on successful engagement.

RESULTS:



WHAT'S NEXT?

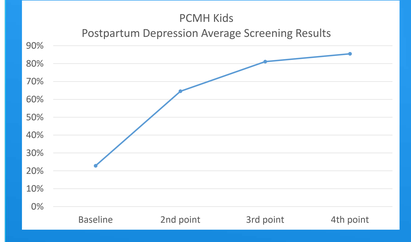
- Sharing birth at risk scores and plans of safe care with Pediatricians
- Integrating Home Visiting Programs
- Connecting with Early Intervention
- Creating child and family Community Health Teams

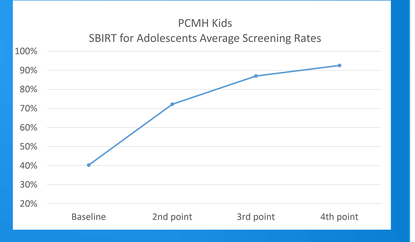
Integrated Behavioral Health

WHAT WE DID: Incorporate social workers into practices

- 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

RESULTS:





WHAT'S NEXT?

- Piloting standardized Integrated Behavioral Health universal screening approach (Depression, Anxiety, Substance Use Disorder, Postpartum Depression and Pediatric Symptom Checklist)
- Hiring and Integrating Behavioral Health Clinician
- Creating meaningful liaison with community resources, such as schools, Pedi PRN