

A Statewide Pediatric Care Transformation Journey

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INTRODUCTION

United States (US) healthcare payment and delivery reform are rapidly changing the practice of primary care medicine. Population health, quality performance metrics and care coordination accountability can improve health (1) but adult models for care transformation do not fit the needs of children, families and pediatric practices. (2) We developed a process to create a pediatric-relevant care transformation project in Rhode Island. Patient-Centered Medical Homes for Kids (PCMH-Kids) is a multi-practice, multi-payer initiative through which practices share a common contract with all the payers. The contract supports transformation through technical support, collaborative learning and per-member, per-month payments to practices. Since 2015, the PCMH-Kids Initiative has involved a total of 20 pediatric practices in two enrollment cohorts, with one more expansion phase planned for 2019. These 20 pediatric practices include 120 providers and 85 pediatric residents, covering nearly 100,000 lives (about half the children in the state).

The vision of the PCMH-Kids Initiative and its many committed child- and family-focused stakeholders is that all the state's children and youth will grow up healthy and reach their optimal potential. The mission of PCMH-Kids was to engage providers, payers, patients, parents, purchasers and policy makers to develop high quality family and patient-centered medical homes for children and youth that will assure optimal health and development, be committed to quality measurement, accountable for costs and outcomes, focused on population health, and dedicated to data-driven system improvement.

BACKGROUND

Rhode Island is a leader in using multi-practice all-payer contracts for supporting care transformation. The Chronic Care Sustainability Initiative (now The Care Transformation Collaborative or CTC-RI) began in 2008 with five adult practices. (3) By 2015, CTC-RI included 73 adult practices. This adult model of transformation is driven by more effective

chronic disease management and fueled by cost savings from decreasing the need for higher levels of care. No pediatric practices were included in the CTC-RI model as the anticipated return on investment for pediatrics was small and children do not fit the adult chronic care medical models. After provider-led advocacy, PCMH-Kids was chartered in 2013 by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS) to help pediatric practices garner support for transformation, family-centered care coordination, meaningful performance metrics and value-based payment. In 2015, the PCMH-Kids Initiative came under the auspices of CTC-RI. CTC-RI has provided logistical support, data aggregation and analysis, and convening and collaboration support through grants from the Rhode Island Foundation and the RI State Innovation Model (SIM).

PROCESS AND TIMELINE

Beginning in February 2013, a small steering committee laid the groundwork for the project. The PCMH-Kids stakeholder group gathered in September 2013 and met monthly until June 2015. Convened by RI Medicaid and the RI Office of the Health Insurance Commissioner, the stakeholders included pediatricians, family doctors, payers, child-serving community organizations, the Rhode Island Dept. of Health (RIDOH), the Rhode Island Dept. of Children, Youth and Families (RIDCYF), parent and patient voices and child health advocates from across the state. This richly talented and dedicated group developed PCMH-Kids Guiding Principles, Mission and Vision Statements as well as identified specific areas of need for ideal pediatric care – integrated pediatric behavioral health, pediatric care coordination that included social worker and family-focused support. From the stakeholder members, two committees were formed – the Quality Measures Committee and the Practice Selection committee. The Quality Measures Committee researched local and national standard practice and process measures, ultimately choosing measures for the PCMH-Kids Initiative based on statewide measure alignment and meaningfulness for child health improvement. Three measures were chosen: Healthy Weight and Activity Monitoring; Counseling, Developmental Screening, and Emergency Department Utilization. Additionally, family experience was tracked annually.

The Selection Committee created a pediatric practice-specific application, cultivated interested practices, reviewed applications and finally chose 9 pilot pediatric practices for the first PCMH-Kids cohort. By design, the pilot practices represented a diverse payer mix, with a specific focus on Medicaid-serving practices and a diversity of experience with National Committee for Quality Assurance (NCQA) recognition. Ultimately, the 9 pilot practices served 48,480 children (24.8% of RI's children), 48% of whom were insured by Medicaid. All 9 PCMH-Kids practices signed a 3-year common contract with our state's four commercial and two managed Medicaid insurers. In year one of the contract, practices received a per-member per-month payment to fund practice transformation (work flow changes, quality and data management) and care coordination (nurse, parent consultant or social worker.) In years two and three, a portion of the payment was withheld, to be earned by attaining benchmarked quality metrics. The PCMH-Kids pilot practice cohort started their three-year common contract program on January 1, 2016.

TRANSFORMATION

Each participating practice was paired with a transformation coach who assessed the practice and, with the office team, crafted a work plan to facilitate practice transformation. Plans included clarification of roles/job descriptions, team building, data capturing and reporting systems, behavioral health integration plans and care coordination needs and capabilities. All practices reported their quality metrics quarterly, uploading their data to a shared data repository. Additionally, all practices participated in collaborative learning, sharing best practices and lessons learned in quarterly meetings for care coordination, data reporting, integrated behavioral health and practice transformation.

CARE COORDINATION

One of the most exciting, innovative and rewarding aspects of the PCMH-Kids Initiative involved care coordination. Early in the program-design work of the stakeholders group, we had robust discussions about care coordination in pediatrics. The group felt strongly that the adult model of a nurse care manager who focused on specific disease entities such as hypertension or diabetes was not as helpful to pediatrics. We recognized that many of the care coordination needs were connecting with parenting supports, schools, with DCYF, and with mental health providers. While most practices used some of their care coordination resources to hire nurse care managers, most invested in social workers and family consultants to better match the needs of families. In addition, CEDARs (4), the state's intensive care coordination service for children receiving Medicaid, was a critical resource. We were able to embed these valuable

care coordinators in the practices. Each practice site implemented a care coordination team that best reflected their individual practice's needs.

HIGH-RISK LISTS

In the adult CTC model, insurers produce lists of patients who are (or are at risk for becoming) high-resources utilizers for which practice care coordinators are accountable. There was agreement among the stakeholders, including the insurers, that most high-risk algorithms did not accurately produce meaningful lists for child populations. The common contract included a commitment to work together to define meaningful high-risk identification for pediatrics. Together we developed a three-domain framework for determining which families would benefit most from intense care coordination. Each practice was able to tailor its parameters according to its patient needs and office resources. The first domain addresses high utilization of health resources. Most practices chose to include children who had two ER visits in 6 months or 1 hospitalization for behavioral health in 6 months. The second domain included poorly controlled or complex conditions – Attention Deficit Hyperactivity Disorder (ADHD) plus another complicating behavioral diagnosis such as anxiety, children with asthma who had required oral steroids in the last 6 months, for example. The third domain included children who are at risk based on social, family, or environmental factors, such as high lead levels, homelessness, or gaps in care. While interventions with patients who fit in this category do not immediately bend the insurance cost curve in the near term, investments in patients who are at risk for social reasons may produce the best cost savings in the longer term. (5) The three-domain PCMH-Kids high-risk screening framework has seen many iterations, piloted in a few diverse practices, informed by their experiences and insurer feedback. We continue to refine this work and it has been a collective effort with clinicians and insurers.

INTEGRATION OF BEHAVIORAL HEALTH

The stakeholders group felt strongly that a fundamental need for pediatric transformation included integrating behavioral health into primary care. Here again, the needs of children dictate a different approach to behavioral health integration (BHI). BHI for children requires including attention to mental health issues in parents and caregivers and also to the developmental emergence of social-emotional challenges in young children, school and learning issues and anxiety, depression, and substance use among adolescents. Because of this framework, many of the PCMH-Kids practices incorporated social workers in their care teams. Additionally, screening for social-emotional competencies and family challenges was an important component of the developmental screening that was a key quality metric

for practices (6). Along with these critical changes to practice-based resources and thanks to a separate dedicated insurer grant, PCMH-Kids has sponsored three year-long learning collaboratives, each dedicated to a pediatric-relevant behavioral health topic. Each learning collaborative starts with a half-day seminar that includes a content expert speaker, group discussion and facilitated group work to write aim statements and goals. In the ADHD collaborative, practices developed and implemented improved office protocols for treatment and management, wrote and implemented medication management contracts and one practice developed an ADHD packet, including documents to interface with the child's school, and resources for parents. Seven practices completed a second learning collaborative which addressed Postpartum Depression and Screening, representing 65 providers and 36,000 patients. This collaborative effected a statewide culture shift to the importance of screening for postpartum depression and referring for treatment; the screening is covered by all Rhode Island health insurers including Medicaid. Screening and referral rates improved from 28% to 77% among the participating practices. Sensitive to the opioid epidemic, eleven practices enrolled in this year's Screening Brief Intervention and Referral to Treatment (SBIRT) learning collaborative, representing 75 providers and 34,000 pediatric patients. To date, the practices are reporting on their baseline screening measure, sharing best practices of screening work flows, with special attention to the teen confidentiality that substance screening requires, and continuing motivational interviewing training via an online resource as well as Rhode Island content experts.

QUALITY METRICS RESULTS

Through shared learning and practice coaching the cohort 1 practices implemented work flows and data and analysis metrics that address the contracted measures. Supported by strong transformation coaching and support, all practices achieved NCQA 3 recognition within the first contract year. In year two, 100% of the cohort 1 practices met both quality metrics for developmental screening and growth monitoring and counseling and posted improvement over time. [Figures 1 and 2] Patient and family satisfaction was high at baseline and 67% of the practices met the improvement benchmarks for customer service measure for access, communication and office staff. PCMH-Kids practices successfully decreased

Figure 1. PCMH Kids BMI Screening Rates

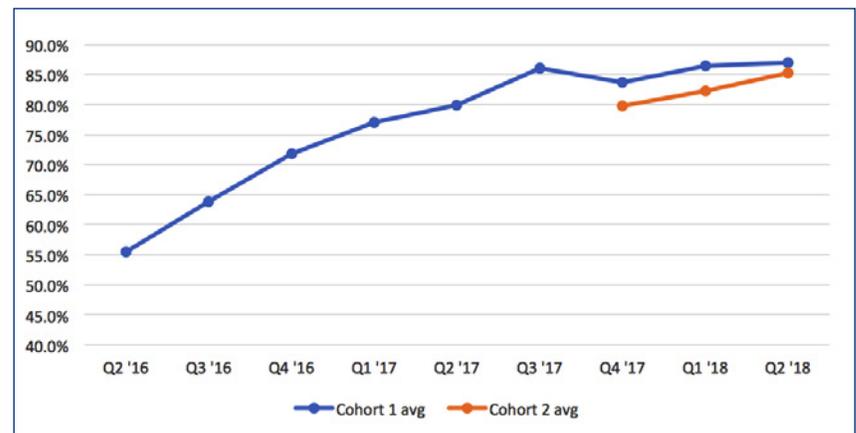
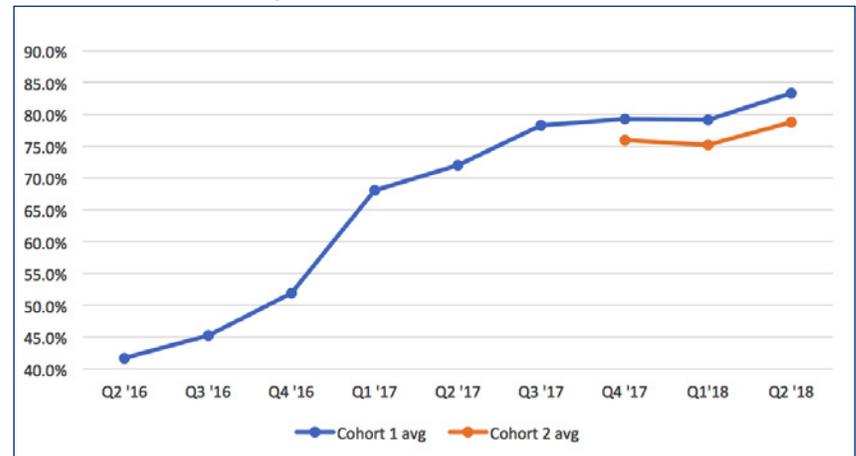


Figure 2. PCMH Kids Developmental Screening Rates



Emergency Department (ED) utilization and had a 2.5% reduction in ED usage compared to the peer group (rate for 1,000-member-months, excluding ERISA members).

EXPANSION

In 2017 PCMH-Kids had the opportunity to expand and 11 new practices joined as cohort 2, representing 45 providers and 28,000 attributed patients and we are planning another expansion in 2019. Given the quickly changing healthcare landscape, the second cohort contract is more individualized by practice based on their Accountable Care Organization (ACO) affiliation.

NEXT STEPS

The project has elevated a number of issues that we continue to grapple with, as so much of the adult-focused insurance infrastructure is not relevant to children and families. There is still work to be done on high-risk definition for children and integration of schools and other community resources.

This project has supported our notion that while nurse care managers still have a role in care coordination for children and families, a multidisciplinary team, including parent consultants and social workers, broadens the traditional care coordination to include the social and school determinants that can significantly affect a child's health and to integrate the behavioral needs of families and children.

Perhaps one of the most exciting results of our PCMH-Kids journey has been the successful creation of a pediatric learning community – a group of practices that now share a common language and a skillset that enables workflow analysis, rapid-cycle improvement, and data-driven change. As the healthcare landscape moves more towards systems of care and value-based payments, the challenge will be to keep the child and family voice at each of these tables to ensure that the financial resources remain available for this important work whose societal dividends and medical-cost savings are longer term than the traditional adult chronic care patient-centered medical care home.

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