



Pediatrics Design Group Meeting 2

October 31, 2018

DRAFT FOR DISCUSSION ONLY

Agenda

- Introductions and Purpose of the Meeting 10 minutes
- Recap from Session 1 5 minutes
- PCM and Pediatric Primary Care Payment Reform Study Group Recommendations 15 minutes
- Capabilities Discussion 85 minutes
 - Diverse Care Teams
 - Pediatric Behavioral Health Integration
- Next Steps 5 minutes
- Adjourn

Pediatrics Design Group Session 1 Recap

- During session 1, discussed community integration, home visits, diverse care teams
- Feedback from group
 - Need to understand how primary care capabilities fit into system and are applied in practice to think about these
 - Make connection between Health Enhancement Communities and Primary Care Modernization
 - Build off of the work that the Pediatric Practice Reform Study Group has already developed
 - Leverage existing pediatric programs in CT
 - Pediatrics is distinct from adult primary care and needs specific approaches that are tailored to pediatric practices

Opportunities for Pediatric Practice Transformation

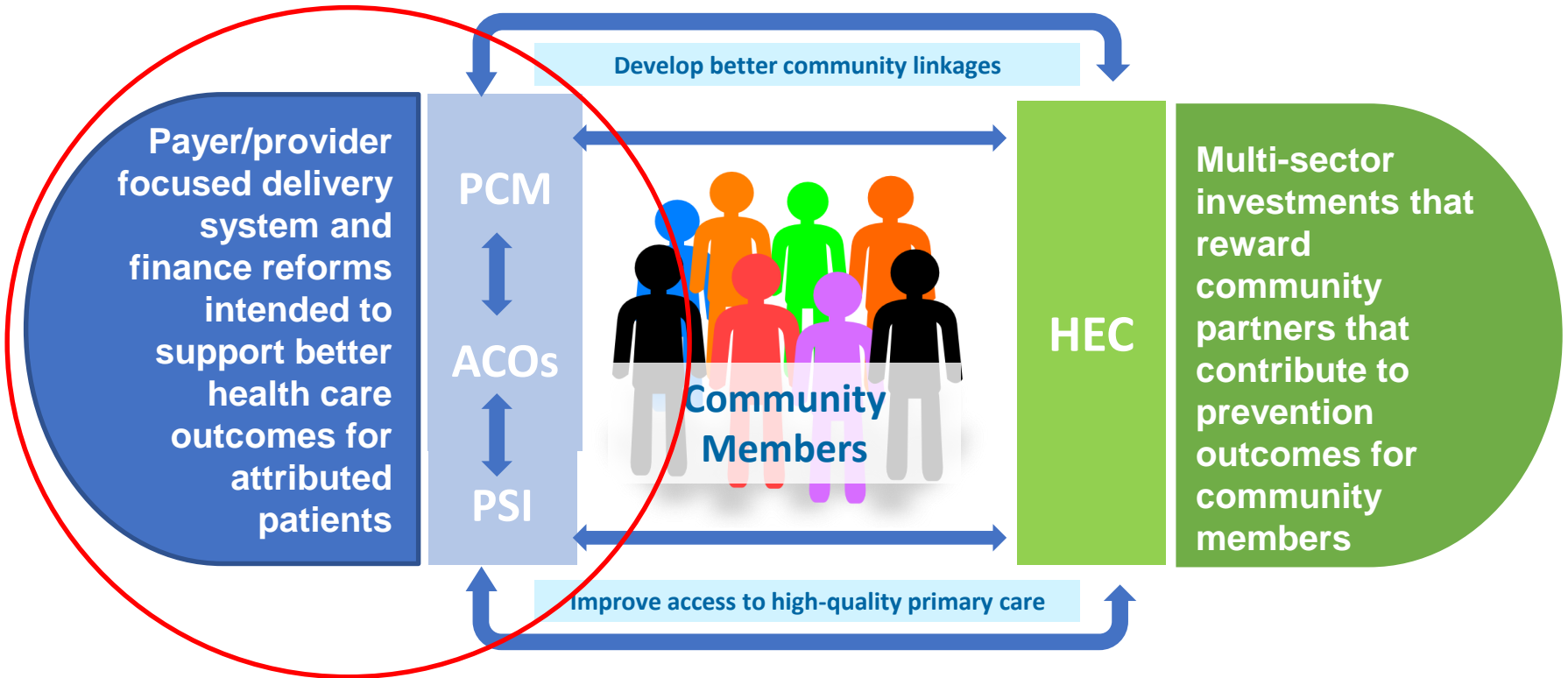
Findings from Pediatric Primary Care Payment Reform Study Group Report

- Key principles for why pediatric practice transformation is needed and recommendations for moving forward:
- Why redesign pediatric care?
 - “Transforming pediatric primary care has the potential to bring large benefits to population health in the long term by promoting health and development and more directly addressing non-medical determinants of lifelong health for all children”
 - Impact equity by promoting health among all children, identifying problems early, and linking children and families to services. Because disparities start early in life, early health promotion strategies and identification of risks are necessary.
- What transformation is needed?
 - “Primary care payment system should support pediatric primary care in promoting **population health, mitigating health disparities, and better integrating health care with other services that children and families use.**”
 - Access to and coordination with new care team members
 - Bring to scale existing CT services that support children’s optimal development
 - Integration of medical care with physical, mental, developmental, and oral health services, and schools, Head Start, WIC, the Women, Infants, and Children nutrition programs
 - Developmental promotion and early detection of family concerns, connections to community services for parents, caretakers, and siblings
 - Allow for behavioral health and developmental intervention for children and families before the child has a diagnosis

“What is missing is a model for connecting child health services to such a system and a way to finance pediatric care so that it can make an optimal contribution to lifelong health and well-being.”
(Pediatric Primary Care Payment Reform Study Group report)

PCM and HEC: Aligned and Complementary Reforms

Connecticut's augmented strategy to incentivize quality and prevention



For example, HEC supports a local community center providing free exercise classes and a community garden for children, while PCM payments supports a Community Health Worker who provides healthy weight education and links families to these community services.

PCM Payment Model Options

Payment model options for pediatrics that 1) increase flexibility, 2) recognize the contribution pediatric primary care can make to children and families' health and well-being, 3) make primary care more convenient, community-based and responsive to the needs of patients; and 4) ensure a return on investment in the long-term.

PCM Payment Model Options

Pediatric Primary Care Payment Reform Study Group Recommendations

Basic Bundle



Supplemental Bundle



Fee for Service



Participation of all payers, improve measurement, accountability



Support service innovations that would ordinarily not be covered within traditional fee-for-service payment



Reduce physician burden and expand practice capabilities by accommodating innovative staffing



Provide up-front funds to support practices in developing infrastructure needed for practice innovations

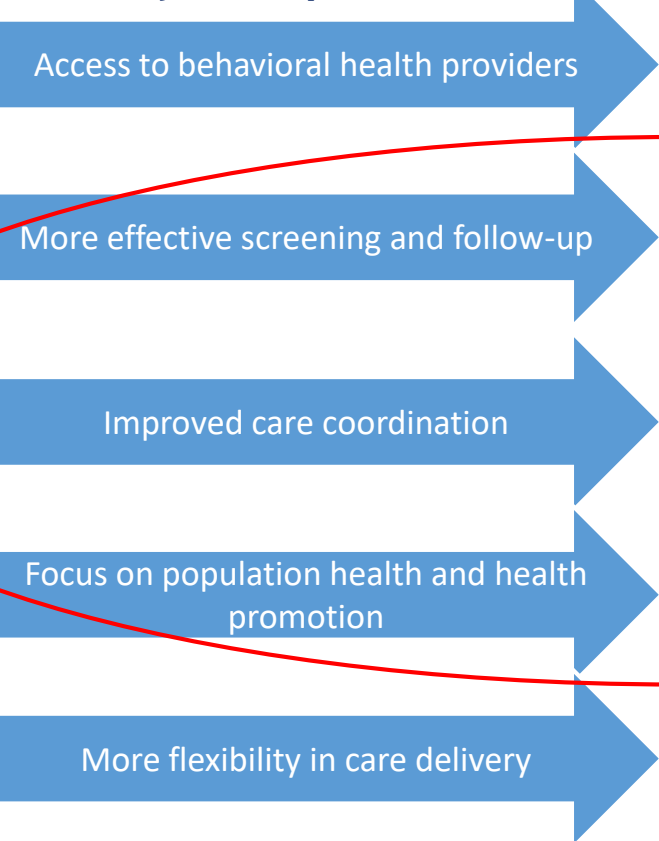
Today's Purpose: Define Pediatric Capabilities Supported by PCM Payment Model

- Provide input on opportunities for Primary Care Modernization capabilities supported by bundled payments to pediatric practice transformation
 - Pediatric Team-Based Primary Care
 - Existing programs to be leveraged
 - Expanded care team members within the pediatric practices
 - Pediatric Behavioral Health Integration Design Group Recommendations
- Next Sessions
 - Alternative ways to connect to pediatric care
 - Phone/text/email
 - Telemedicine visits
 - Home visits (revisit discussion from first session)
 - Shared visits
 - Chronic pain management for children and adolescents
 - Genomic screening
 - Other capabilities as identified

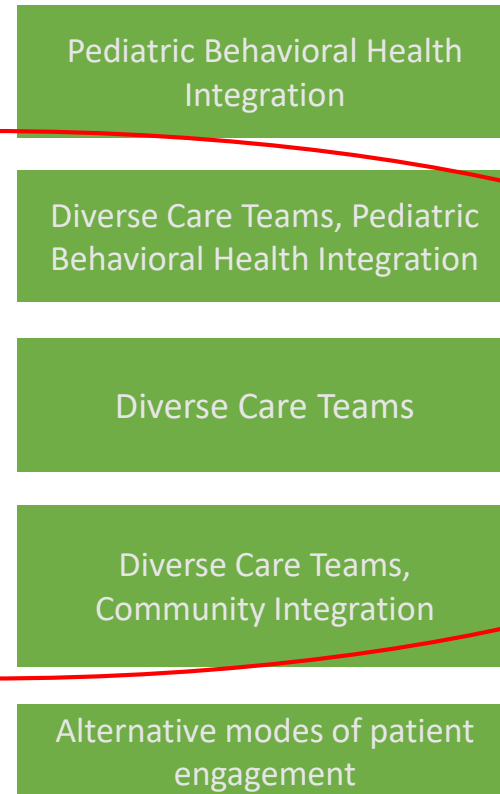
Diverse Care Teams

Pediatric Payment Reform Study Group and Primary Care Modernization Synergies

Pediatric Payment Reform Study Group Priorities



Reflected in PCM Capabilities



Bringing Existing CT Services to Scale: CYSHCN Care Coordination Collaboratives

DPH Children and Youth with Special Health Care Needs (CYSHCN) care coordination centers as shared resource for practices¹

- CYSHCN are those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and require health and related services beyond that required for children in general (CT PCMH+)
- Five regional care coordination centers to support pediatric primary care providers in linking children to health and community services
- Convenes care coordination collaboratives to:
 - Learn from local and state providers about available services and how families access them
 - Review challenging cases to maximize resources available to address the identified needs;
 - Develop and advocate for policy level solutions in connecting families to services
 - Support pediatric providers in meeting the care coordination needs of families
- Access to regional care coordination centers is available through United Way's 211 Child Development Infoline (CDI)
 - Allows pediatric practices to link children and families to developmental services (IDEA Early Intervention Services & Preschool Special Education Services, Help Me Grow Services)
- Can current collaborative be expanded to support children other than CYSHCN to support pediatric practices with care coordination functions?
- Is there a need to establish standards for care coordination services that support practices?

¹<https://cdi.211ct.org/for-providers/care-coordination-collaborative/>

Integration with other Services: School-Based Health Centers

Connecticut: Comprehensive primary care facilities located in or on the grounds of schools, licensed by DPH as outpatient or hospital satellite clinics

Reduce barriers to care, including stigma, difficulty accessing care, parental loss of work time and long wait times for appointments

- Behavioral health screening (including depression and suicide risk)
 - Identify and monitor healthy weight in young children and adolescents; access to counseling
 - Asthma medication management
 - HPV Immunization for adolescent females
 - Smoking cessation
 - Adolescent well care visits
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- How can school-based health centers be strengthened and leveraged to support pediatric care teams?
 - How do we avoid duplication of services and ensure coordination between pediatric practices and school-based health centers?

Integration with other Services: Head Start and WIC

Head Start: Promotes school readiness for children birth to age 5 in low-income families by offering educational, nutritional, health, social, and other services.

- Services include health and development screenings, nutritious meals, oral health and mental health support, connecting families with medical, dental, and mental health services, parental and family support for social determinant needs
- Shown to improve school readiness, increase immunization rates, increase number of families with health insurance, medical and dental homes¹

Women, Infants and Nutrition Program (WIC): Safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk

- Provides nutritious foods, nutrition education, breastfeeding promotion and support, and referrals to health and other social services
- Shown to improve infant health and survival, support more nutritious diets and better infant feeding practices, improve access to healthy foods, increase access to preventive medical care²

How can PCM support pediatric practices in better coordinating with these program to supplement care team functions?

¹https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/hs-program-fact-sheet-2017_0.pdf

²<https://www.cbpp.org/research/food-assistance/wic-works-addressing-the-nutrition-and-health-needs-of-low-income-families>

Supporting New Care Team Members within the Pediatric Practice

American Academy of Pediatrics Definition: “Team-based care is a health care model that endorses the partnership of children and families working together with one or more health care providers and other team members across multiple settings to identify, coordinate, and address shared goals that meet the needs of the whole child...The medical home focuses on building a team of professionals responsible for coordinating a patient’s care across the health care continuum and through the changing health care needs that occur from early infancy to adulthood.”

PCM support for team-based pediatric care

- Upfront payments in the form of a supplemental bundle support new staff and functions for care team members other than the pediatrician
- ANs/FQHCs determine how to meet core competencies through care team compositions at the network and practice level
- Care team members may be deployed at the practice site, a network hub, in the home or in the community
- Care teams members fulfill functions based on stated roles and their training, qualifications and skills

Successful Models of Pediatric Team-based Care

- Vermont Blueprint for Health Patient Centered Medical Home for Pediatrics
- Healthy Me: Childhood Obesity Program, Primary Care Coalition of CT
- Project Dulce
- Healthy Steps

See Appendix for details

Pediatrics Diverse Care Teams DRAFT Concept Map

Network Level

Population Health Promotion and Management



Identify sub-populations with modifiable health/developmental risk and clinical targets; predictive analytics



Assign patients, patient registries, action plans



Performance tracking, data sharing, child & family engagement

Informs

Practice & Community Level On-site, central hub, home or community

Comprehensive Care Management
RN

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

Health Promotion
Pediatrician, RN, Nutritionist, Dietician, Lactation Consultant, CHW, Developmental Specialist

Care Coordination
RN, Social Worker, Medical Assistant, CHW, Family/Developmental Specialist

Team-based Care



Patient & Family, Pediatrician

Patient Navigation
Patient Navigator, CHW, Social Worker

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

Disease Management
RN, Nutritionist, Dietician, Asthma Educator, CHW

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

Coordinates

Medical interpreters deployed as needed. All care team members trained in cultural sensitivity.

Health Neighborhood



School-based Health Centers



Specialty Care
Pulmonologists, neurologists, etc.



Community Care Extenders
Home care providers, Head Start, WIC, etc.



Community Resources
Food, housing support, legal assistance, etc.



Ancillary Providers
Physical/occupational therapists, integrative medicine practitioners



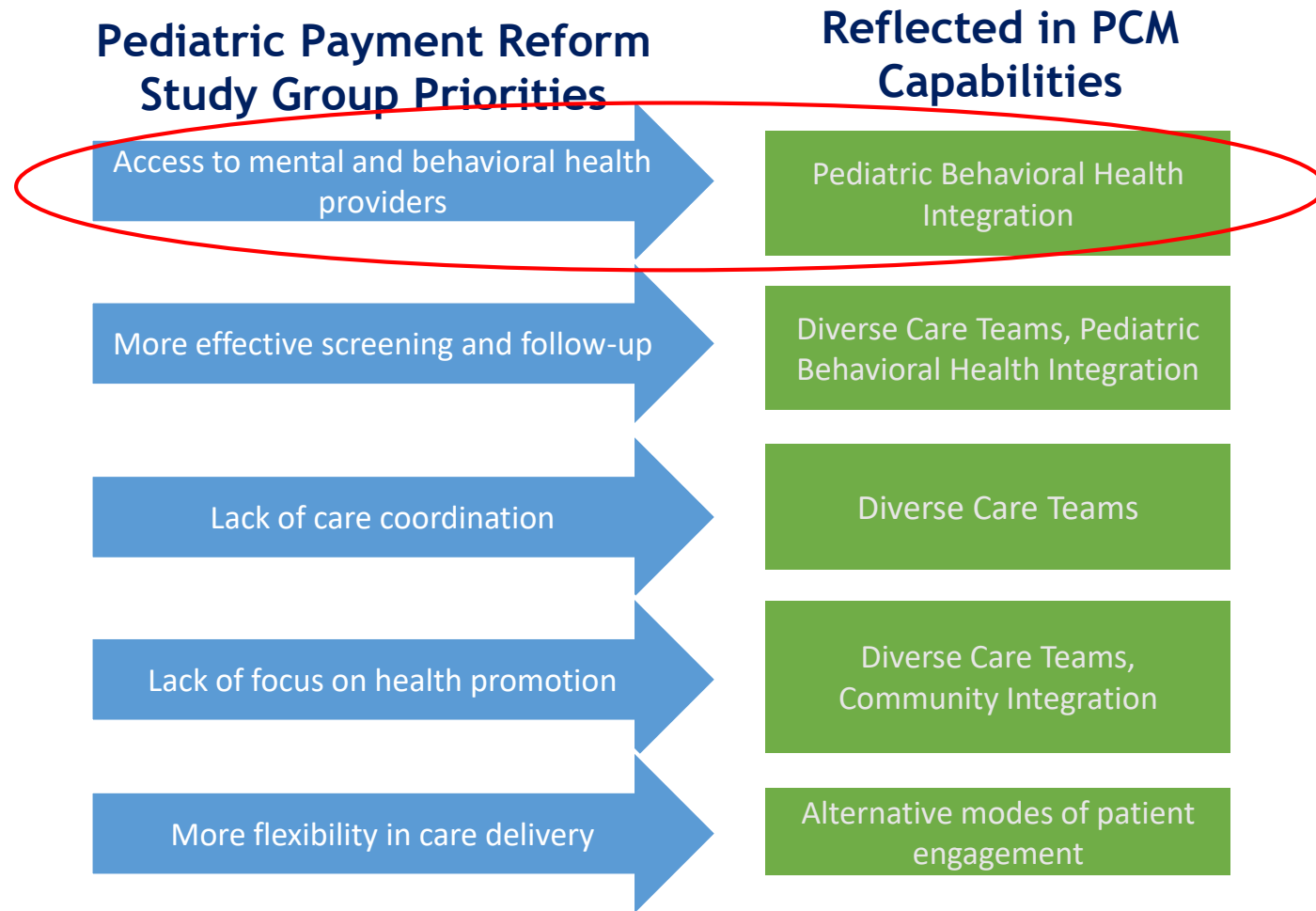
connecticut state innovation model

See appendix for definitions of functions

Questions for Discussion

- What should be added or removed from the diverse care teams concept map? Are these the right functions? Are we missing any or are any unnecessary?
- How do we avoid duplication with potentially multiple care coordinators (PCP, school clinics, specialists)?

Pediatric Payment Reform Study Group and Primary Care Modernization Synergies



Pediatric Behavioral Health Integration

Addressing Consumer Input, Questions and Concerns

Need training, screenings and awareness:

- All providers in the practice need basic training in BH issues, don't just add a team member
- The shortage of trained mental health providers who can prescribe meds, handle serious cases, have real expertise and can assist in a crisis is so severe that its almost hard to think about how adding someone to a PCP office would really be helpful.
- Providers need to have more compassion, training in trauma

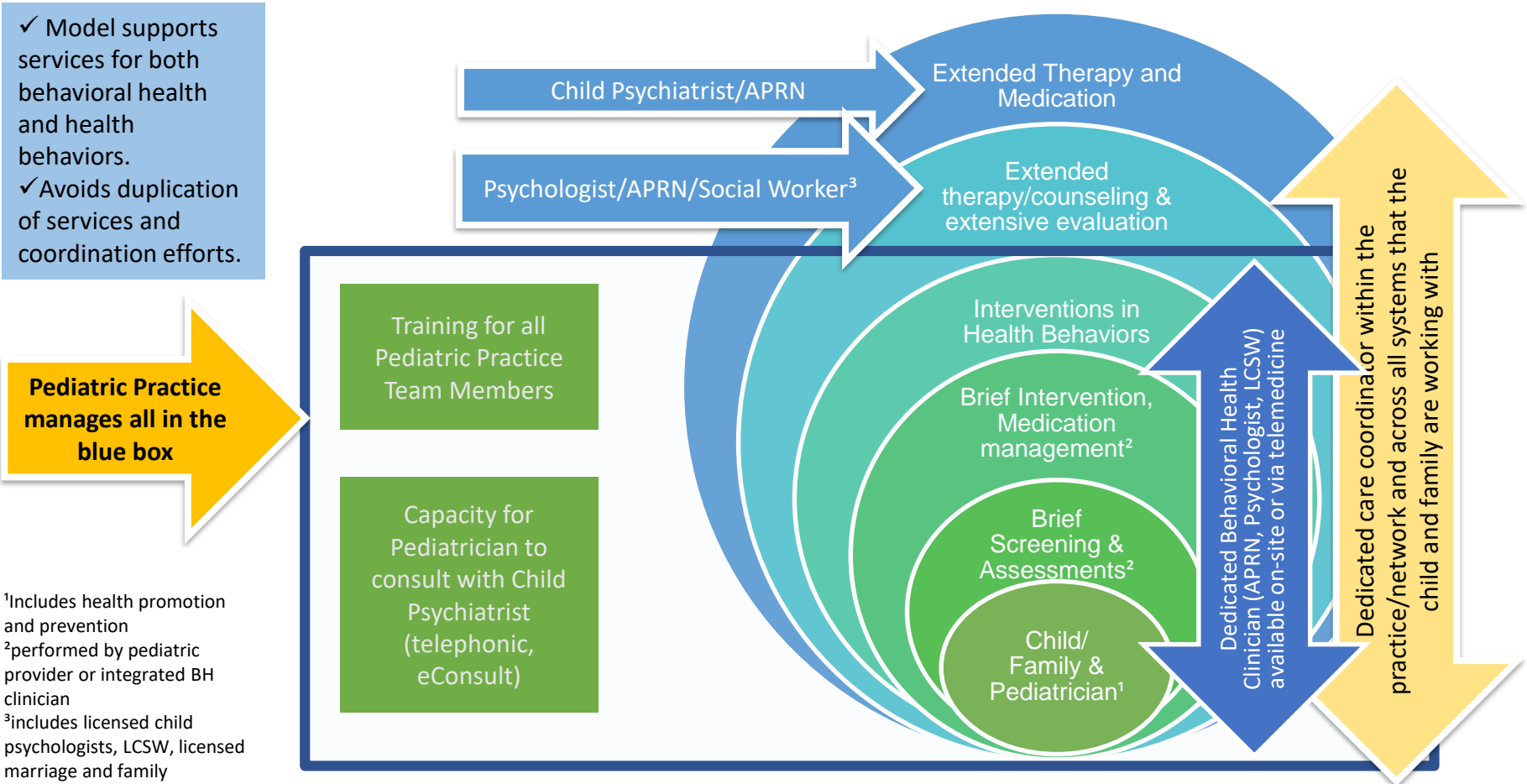
Improve access to care:

- “My school severely lacked in helping me with my mental health issues. School was one of the biggest stressors.”
- “Cannot expect putting one person in a PCP office will solve the problem of access to specially trained behavioral health professionals.”

Expand care team/integrate behavioral health

- Pediatricians often don't have a good understanding of specialty medications prescribed
- Many parents of children with BH issues feel pediatricians are too quick to call in department of children services – which they felt made them less likely to share information with the pediatrician's office about behavioral health issues
- Care manager from the pediatrics office should be the ultimate care manager and working to coordinate across systems

PROVISIONAL DRAFT Concept Map: Primary Care Modernization Pediatric Behavioral Health Integration



¹Includes health promotion and prevention

²performed by pediatric provider or integrated BH clinician

³includes licensed child psychologists, LCSW, licensed marriage and family therapists, licensed professional counselors

Updated 10-21-18

Pediatric Behavioral Health Integration

- **Definition:** Provide additional resources and capacity for the pediatric practice to unify pediatric behavioral health and primary care to focus on developmental, socio-emotional, and mental health promotion, prevention and early identification for child and family
- **Goal:** Child, family and pediatric clinician are at the center of a well-coordinated, fully integrated set of services embedded within the practice, available in the network and tied to services and resources in the community.

Pediatric Behavioral Health Integration Capabilities

Practice Level

- Specific screenings to assess developmental and socio-emotional health, behavioral health and health behaviors
- Treatment and brief interventions; referral for further treatment if needed
- Dedicated behavioral health clinician (BHC) for each practice; clinician is on-site at the practice or available via “Warm Handoff” through telemedicine visit
- Dedicated care coordinator with expertise in behavioral health whole family approach, coordinates within the practice/network and other systems for child and family including SDOH needs

Practice and Network Level

- Medication management expertise within the practice and access to consultations with child psychiatrists (through service like Access Mental Health CT)
- Patient-to-clinician telemedicine visits (especially for adolescents)
- Tracking outcomes in EHRs
- Training for clinical staff on BH teaming and BH issues and for BH staff on chronic illness, training for all staff on cultural sensitivity and awareness
- Referral and coordination with community-based BH specialists for extended therapy, counseling, evaluation and medication

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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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+	<ul style="list-style-type: none"> Patient Health Questionnaire-9 (PHQ-9): Modified for Teens (ages 12-18)
Substance Abuse	At age 12+	<ul style="list-style-type: none"> The CRAFFT
Postpartum Depression	At 1, 2, 4, and 6 month well-baby visits	<ul style="list-style-type: none"> Edinburgh Postnatal Depression Scale (EPDS)
Secondary/Indicated Screenings		
Trauma	6 to 18 years	<ul style="list-style-type: none"> Child PTSD Symptom Scale (CPSS-5) (8+yrs) Child Trauma Screen (CTS) (6+yrs)
Depression	6 to 17	<ul style="list-style-type: none"> The Center for Epidemiological Studies-Depression Scale for Children (CES-DC)
Anxiety	8-18	<ul style="list-style-type: none"> The Screen for Child Anxiety Related Disorders (SCARED), particularly the brief version
ADHD	6 to 12 6-18	<ul style="list-style-type: none"> 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+	<ul style="list-style-type: none"> Columbia-Suicide Severity Rating Scale (C-SSRS)

Questions about the Pediatric BHI Capability

- Are the requirements and services in the PCM Pediatric BHI model consistent with the vision of this group?
- Are there any other roles or functions that should be noted to help pediatric practices create an integrated approach?

Next Steps

- Project team will summarize the group's discussion today and incorporate feedback
- Next meeting:
 - Alternative modes of connecting to pediatric care
 - Chronic pain management
 - Genomic Screening

Questions?

Contact Information

- Alyssa Harrington, Project Director
aharrington@freedmanhealthcare.com
- Vinayak Sinha, Project Coordinator
vsinha@freedmanhealthcare.com

Appendix

Pediatric Study Group Payment Model Recommendations

- Reward effective health promotion and prevention
- Value-based system using bundled payments to provide flexibility needed to support practice innovations
- Motivate practice restructuring to improve population health, health equity, quality, and address cost
- Support improved health measurement and data
- Payment reform should include all payers to ensure accrual of long-term benefits
- Benefits accrue across sectors, therefore cross-sector collaboration through blended financing, service delivery, and accountability is encouraged

Successful Models of Pediatric Team-based Care

- Vermont Blueprint for Health Patient Centered Medical Home for Pediatrics
 - Community collaboratives identify local health priorities and plan responses
 - Community health teams of multidisciplinary professionals provide support services: nutritional guidance, healthier living workshops, social work, and care coordination to connect child to community services, interact with school and family involvement
- 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
 - Targeted text messages, emails and phone calls at weekly intervals between visits
- Project Dulce¹
 - Team of pediatrician and family specialist work together and offer information on child development and provide support for the family from birth to six months
 - Family specialists are trained by the Medical-Legal Partnership Boston in legal and support services and usually have varying educational backgrounds
 - Family specialist is available during routine pediatric visits, makes home visits and available by phone
 - Identified high-risk families who needed more intensive supports from outside agencies and connected families to those supports
 - Children more likely to have immunizations on schedule

¹<https://www.cthealth.org/latest-news/blog-posts/part-2-getting-value-pediatric-primary-care/>

HealthySteps

HealthySteps is an evidence-based, interdisciplinary pediatric primary care program that promotes nurturing parenting and health development for babies and toddlers.

- Child development professional “HealthySteps Specialist” connects with families during well-child visits, provides screening and support
- Practice works as a team to implement **8** core components that strengthen the relationship between families and the practice and support strong parent/child attachment:

Tier 1. Universal Services:

Child developmental, social-emotional & behavioral screening, screening for family needs (maternal depression, social determinants of health, other risk factors), & child development support line

Tier 2. Short-Term Supports:

All Tier 1 services plus child development & behavior consults, care coordination & systems navigation, positive parenting guidance & information, & early learning resources

Tier 3. Comprehensive Services (families most at risk):

All Tier 1 & 2 services plus ongoing, preventative team-based well-child visits (WCV)

Evidence:

- Children are more likely to attend well-child visits on time and receive timely vaccines and screenings
- Parents are more likely to: receive information on community resources and services; provide infants with age-appropriate nutrition; adhere to child safety guidelines; use positive parenting strategies; and engage in early literacy-enhancing practices with their children
- Parents report higher levels of satisfaction with their pediatric care than non-participating parents
- Physicians report the team-based approach enhances their ability to meet the needs of children and families.

Source: www.Healthysteps.org

Definitions of 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

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

Care Coordination

“Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient” (Agency for Healthcare Research & Quality). Care coordination connects children and their families to specialty services and community supports to ensure optimal health and development, address social determinants of health needs and provide culturally and linguistically appropriate health promotion and self-care management education.

- Conduct Pre-visit Planning
- Develop Care Plans with families and address gaps in care
- Coordinate care across providers and settings and avoid duplication in services
- Facilitate communication between providers and families
- Connect children and families to timely interventions
- Link to community supports and resources

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

Health Promotion

Health Promotion is embedded in health supervision visits as described by the Bright Futures program, which aims to “promote and improve the health, education, and well-being of infants, children, and adolescents, families, and communities”. Care teams use “a set of principles, strategies and tools that are theory based, evidence driven, and systems oriented...to improve the health and well-being of all children through culturally appropriate interventions that address their current and emerging health promotion needs at the family, clinical practice, community, health system, and policy levels.” (AAP Bright Futures Program)

- Solicitation of parental and child concerns
- Surveillance and screening, i.e. measuring growth parameters including BMI, blood pressure, sensory screening of vision and hearing, developmental, behavioral health screenings, tobacco, alcohol, drug use assessment, newborn blood screening tests, anemia, lead intoxication tuberculosis, dyslipidemia, sexually transmitted disease, HIV, cervical dysplasia screening
- Oral health including fluoride varnish and fluoride supplementation
- Immunization administration
- Assessment of strengths
- Discussion of certain visit priorities for improved child and adolescent health and family function over time including anticipatory guidance for each well child visit organized around 5 priority areas

Disease Management

“Disease management programs are designed to 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

Other Medication and Prescribing Support 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)