



## Primary Care Modernization and Pediatrics

November, 2018

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# Agenda

- Introductions 5 minutes
- PCM Goals 5 minutes
- Purpose of this Group 15 minutes
- Vision for Pediatric Primary Care 20 minutes
- Capabilities Discussion 70 minutes
  - Diverse Care Teams
  - Oral Health Integration
- Next Steps 5 minutes
- Adjourn

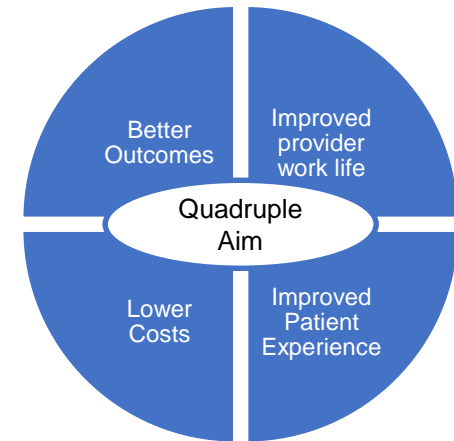
# Goals of Primary Care Modernization

The Practice Transformation Task Force identified primary care redesign to achieve the Quadruple Aim

1. Expand care and diversify care teams
2. Support non-visit based care, patient support and engagement
3. Double investment in primary care over five years through more flexible payments
4. Reduce total cost of care while protecting against underservice.

## Questions Stakeholders are Discussing Now:

- What new capabilities and services will primary care need to provide?
- How will primary care providers be paid for these in a way that supports achieving the goals and is fair to consumers, providers, employers and health plans?



connecticut state innovation model

## Primary Care Payment Reform

*Unlocking the Potential of Primary Care*

June 14<sup>th</sup>, 2018

# Capabilities Under Consideration

Increasing Patients' Access and Engagement	Expanding Primary Care Capacity	System Supports and Resources
<ul style="list-style-type: none"> <li>✓ <u>Diverse Care Teams</u> DG</li> <li>• Community health workers</li> <li>• Pharmacists</li> <li>• Care coordinators</li> <li>• Navigators</li> <li>• Health coaches</li> <li>• Nutritionists</li> <li>• Interpreters</li> <li>• Nurse managers</li> </ul> <p>2. <u>Alternative Ways to Connect to Primary Care</u></p> <ul style="list-style-type: none"> <li>✓ Phone/text/email</li> <li>✓ Home Visits</li> <li>✓ Shared visits</li> <li>✓ Telehealth</li> </ul>	<p>1. <u>Capacities</u></p> <ul style="list-style-type: none"> <li>✓ Genomic screening DG</li> <li>✓ Subspecialists as PCPs</li> <li>✓ Practice specialization               <ul style="list-style-type: none"> <li>✓ Infectious diseases</li> <li>✓ Pain management and MAT DG</li> <li>✓ Older adults DG</li> <li>✓ Persons with disabilities DG</li> </ul> </li> <li>✓ Pediatrics considerations DG</li> <li>✓ Functional Medicine</li> </ul> <p>2. <u>Health Information Technology</u></p> <ul style="list-style-type: none"> <li>✓ E-consults</li> <li>✓ Remote patient monitoring/Patient generated data</li> </ul>	<ul style="list-style-type: none"> <li>✓ BH Integration (adult) DG</li> <li>✓ BH Integration (pediatric) DG</li> <li>✓ Community Integration DG</li> <li>✓ Oral Health Integration</li> </ul>

DG = Design Group

# Purpose of this Group

**Purpose:** Make recommendations to the Practice Transformation Task Force about what core (required) and elective (optional) capabilities pediatric practices should have

**Consider:** As we discuss capabilities for pediatric primary care practices:

- What are we trying to achieve?
- How do we envision pediatric primary care and how can PCM capabilities support this vision?

# Pediatric Primary Care Vision

Potential Starting Point: Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents

Bright Futures Mission: “promote and improve the health, education, and well-being of infants, children, and adolescents, families, and communities”<sup>1</sup>

## Bright Futures Health Promotion Themes

1. Promoting lifelong health for families and communities (Social determinants of health)
2. Promoting family support
3. Promoting health for children and youth with special healthcare needs
4. Promoting healthy development
5. Promoting mental health
6. Promoting health weight
7. Promoting healthy nutrition
8. Promoting physician activity
9. Promoting oral health
10. Promoting healthy sexual development and sexuality
11. Promoting the health and safe use of social media
12. Promoting safety and injury prevention

<sup>1</sup> American Academy of Pediatrics: [https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4\\_Introduction.pdf](https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Introduction.pdf)

# How Do We Get There?

- Challenge: Current payment model and care delivery system doesn't support pediatric primary care practices in achieving the Bright Futures mission
  - Not enough time during visits
  - Pediatricians are overburdened and burnout is increasing
  - Historic focus on acute episodes and disease rather than prevention and health promotion
  - Lack of support for integrated and coordinated care
- Capabilities aim to help pediatric practices (*based on feedback from previous sessions*):
  - Promote children and families' health and well-being
  - Expand access and equity
  - Make primary care more convenient, community-based and responsive to the needs of patients
  - Increase flexibility for providers to allocate necessary resources where truly needed
  - Ensure a return on investment in the long-term

# Vision: Key Questions

- Is this the vision of pediatric primary care we should aim for? What are we missing?
- How can new capabilities help pediatric primary care practices achieve this vision? be supported to achieve these goals?



# Capabilities Discussion

# Diverse Care Teams

# Diverse Care Teams Key Questions

- Do diverse care team functions and roles support our goals?
- Which, if any, of these functions should be required in every practice?
- Should the full array of diverse care team functions be available in the practice? The network?
- Should diverse care teams be a core or elective capability?

# Diverse Care Teams

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

### Network Level

**Population Health  
Promotion and  
Management**

Informs

**Comprehensive  
Care Management**  
RN

**Care Coordination**  
RN,  
Social Worker, CHW,  
Family/Developmental  
Specialist

**Oral Health  
Integration**  
Clinician, RN

**Patient  
Navigation**  
Patient Navigator,  
CHW,  
Social Worker

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

### Team-based Care



**Patient & Family,  
Pediatrician**

**Acute and Chronic  
Care**  
Physician, PA, APRN, RN,  
Medical Assistant

**Prevention &  
Health Promotion**  
Pediatrician, RN, MA  
Nutritionist, Dietician,  
Lactation Consultant,  
CHW, Developmental  
Specialist

**Chronic Illness  
Self-Management**  
RN, Nutritionist,  
Dietician, Asthma  
Educator, CHW

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

Coordinates

### Health Neighborhood

**School-based  
Health Centers,  
Community  
Placed Services,  
Community  
Resources,  
Specialists and  
Ancillary  
Providers**

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

# Prevention and Health Promotion Activities

Based on Bright Futures Guidelines

- Solicitation of parental and child concerns
- Surveillance and screening
  - Measuring growth parameters including BMI, blood pressure
  - Sensory screening of vision and hearing
  - Developmental and behavioral health screenings
  - 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
- Anticipatory guidance for each well child visit organized around 5 priority areas:
  - Bicycle helmets
  - Children, adolescent, and media
  - Cardiometabolic risk of obesity
  - Motivational interviewing and shared decision making for enhancing a patient's motivation
  - Tobacco smoke exposure and tobacco use cessation
  - Weight maintenance and weight loss
- *Expanded care team members to support these functions: Medical Assistant, Nurse, Nutritionist, Dietician, Lactation Consultant, CHW, Developmental Specialist*
- What other prevention and health promotion activities are needed?
- How can pediatric primary care practices be supported to improve prevention and health promotion?

# Integrating Existing Programs into Practices

Interventions Identified by CT Pediatric Practice Payment Reform Study Group

Examples of evidence-based programs that integrate additional care team members into pediatric primary care practices:

- Early childhood development and parenting: *Healthy Steps*: Child development professional “HealthySteps Specialist” connects with families during well-child visits, provides screening and support
- Strengthening families: *Project Dulce*: Team of pediatrician and family specialist provide information on child development and support for the family from birth to six months
- Obesity Prevention: *Healthy Me*: Team-based pediatric prevention and treatment program with PCP and Registered Dietician on site at pediatric practice
- How can the payment model options support integration of interventions like these in pediatric primary care?

# Coordinating with Prevention & Health Promotion Services within the Community

Other medical and health services in other sectors provide prevention and health promotion services in the community:

- School-based Health Centers
- Head Start
- WIC
- Child Nutrition programs
  
- How can pediatric practices coordinate with these programs?
- How can the payment model support this coordination?

# 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
- What other care management activities are needed?
- How can pediatric primary care practices be supported to improve care management?



# Care Coordination

Definition: “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...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). Connects children and their families to specialty services and community supports (Child Health and Development Institute of CT).

Outcomes (Child Health and Development Institute of CT)<sup>1</sup>:

- Ensure optimal health and development
- Address social determinants of health needs
- Provide culturally and linguistically appropriate health promotion and self-care management education

<sup>1</sup> <https://www.chdi.org/our-work/health/medical-home/care-coordination/>

# Care Coordination Activities

- 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
  - Specialists
  - Hospital and ED settings and discharge coordination
- Facilitate communication between providers and families
- Connect children and families to timely interventions
- Link to community supports and resources
- Support care recommendations of pediatric practice

*Expanded care team members to support these functions: RN, Social Worker, CHW, Family/Developmental Specialist*

- What other care coordination functions are needed?
- Should there be a dedicated care coordination resource within every practice?
- How can pediatric primary care practices be supported to improve care coordination?

# Care Coordination Resources in the Community

## Care coordination resources for pediatric primary care practices

- DPH Children and Youth with Special Health Care Needs (CYSHCN) care coordination centers as shared resource for practices
  - Can assist all children and families
- United Way's 211 Child Development Infoline (CDI) to link children and families to developmental services (IDEA Early Intervention Services & Preschool Special Education Services, Help Me Grow Services)
- How can existing care coordination services be optimally used and strengthened to support practices?

# Diverse Care Teams Key Questions

- Do diverse care team functions and roles support our goals?
- Which, if any, of these functions should be required in every practice?
- Should the full array of diverse care team functions be available in the practice? The network?
- Should diverse care teams to support these functions be a core or elective capability?

# Oral Health Integration

# Oral Health Integration

US Preventive Services Task Force Grade B recommendations:

- Primary care clinicians apply fluoride varnish for babies and children birth to 5 years
- Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.

## Oral Health Integration Activities

- Risk Assessments for oral disease or factors which increase disease risk.
- Oral Health Screenings for oral health and active conditions
- Preventive interventions (fluoride varnish and supplementation)
- Communication and Education about importance of good oral health and practices to maintain it
- Referral to dental care as needed and tracking outcomes

# Oral Health Integration Key Questions

- Should oral health integration be a core or elective capability?

# Next Steps

- Next Session: December 4<sup>th</sup> 6-7:30 pm
  - Flexible Ways to Deliver Care
    - Home Visits
    - Telemedicine, Phone, Text, Email
    - Group Well Child Visits
    - Access to Specialty Care



# Appendix

# Other 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

# 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

# Chronic Illness Self-Management

“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

# Medication Management and Prescribing Functions

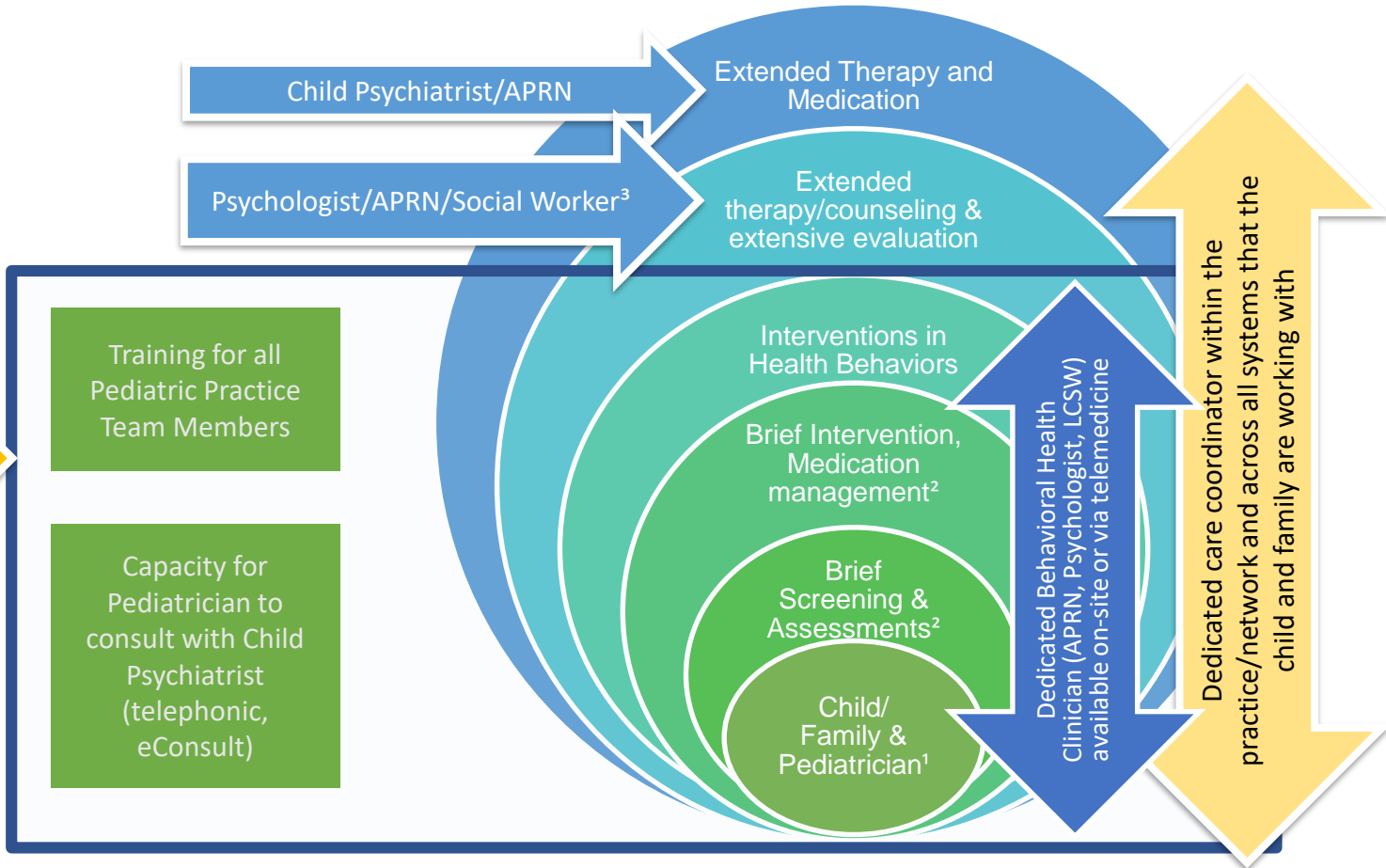
Medication related functions such as medication reconciliation, routine medication adjustments, initiating, modifying, or discontinuing medication therapy and medication monitoring/follow-up care coordination that other care team members can perform to assist the pediatrician

- 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)

# Pediatric Behavioral Health Integration Design Group Recommendations

- ✓ Model supports services for both behavioral health and health behaviors.
- ✓ Avoids duplication of services and coordination efforts.

**Pediatric Practice manages all in the blue box**



<sup>1</sup>Includes health promotion and prevention  
<sup>2</sup>performed by pediatric provider or integrated BH clinician  
<sup>3</sup>includes licensed child psychologists, LCSW, licensed marriage and family therapists, licensed professional counselors

Updated 10-21-18

# 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
<b>Universal Screenings</b>		
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"> <li>Ages and Stages Questionnaires, Third Edition (ASQ-3)</li> <li>Parent Evaluation of Developmental Status (PEDS)</li> <li>The Survey of Well-Being of Young Children (SWYC)</li> </ul>
Autism	At 18, 24 or 30 months	<ul style="list-style-type: none"> <li>MCHAT-R/F</li> <li>SWYC 18-, 24-, and 30-month forms</li> </ul>
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"> <li>The Survey of Well-Being of Young Children (SWYC) (2 mos. - age 5)</li> <li>Pediatric Symptom Checklist-17 (PSC-17)(ages 4 -18)</li> </ul>
Depression	At age 12+	<ul style="list-style-type: none"> <li>Patient Health Questionnaire-9 (PHQ-9): Modified for Teens (ages 12-18)</li> </ul>
Substance Abuse	At age 12+	<ul style="list-style-type: none"> <li>The CRAFFT</li> </ul>
Postpartum Depression	At 1, 2, 4, and 6 month well-baby visits	<ul style="list-style-type: none"> <li>Edinburgh Postnatal Depression Scale (EPDS)</li> </ul>
<b>Secondary/Indicated Screenings</b>		
Trauma	6 to 18 years	<ul style="list-style-type: none"> <li>Child PTSD Symptom Scale (CPSS-5) (8+yrs)</li> <li>Child Trauma Screen (CTS) (6+yrs)</li> </ul>
Depression	6 to 17	<ul style="list-style-type: none"> <li>The Center for Epidemiological Studies-Depression Scale for Children (CES-DC)</li> </ul>
Anxiety	8-18	<ul style="list-style-type: none"> <li>The Screen for Child Anxiety Related Disorders (SCARED), particularly the brief version</li> </ul>
ADHD	6 to 12 6-18	<ul style="list-style-type: none"> <li>Vanderbilt ADHD screening tool (includes comorbid disorders) (parent and teacher versions)</li> <li>SNAP-IV Rating Scale – Revised (SNAP-IV-R)(parent and teacher versions)</li> </ul>
Suicide	12+	<ul style="list-style-type: none"> <li>Columbia-Suicide Severity Rating Scale (C-SSRS)</li> </ul>



# Evidence-based Interventions

# Healthy Me

- 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 Dulce

- Project Dulce<sup>1</sup>
  - 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

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

# Healthy Steps

**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](http://www.Healthysteps.org)

# Community Placed Services

# Care Coordination Collaboratives

DPH Children and Youth with Special Health Care Needs (CYSHCN) care coordination centers as shared resource for practices<sup>1</sup>

- 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

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)

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

# 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

# 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 homes<sup>1</sup>

**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 care<sup>2</sup>

<sup>1</sup>[https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/hs-program-fact-sheet-2017\\_0.pdf](https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/hs-program-fact-sheet-2017_0.pdf)

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