OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization and Pediatrics

December, 2018

Agenda

- Introductions — 5 minutes
- Recap on Pediatric Primary Care Vision — 15 minutes
- Capabilities Discussion — 75 minutes
  - Home Visits
  - Telemedicine
  - Phone, text and email encounters
  - Group Well Child Visits
  - Econsults, Co-management, Project ECHO
- Next Steps — 5 minutes
- Adjourn

What are We Trying to Achieve?
Vision of Pediatric Primary Care

Based on November 29th Session's Discussion

Vision of Pediatric Primary Care

AAP Medical Home Characteristics[1]

- Family-centered partnership with personal PCP relationship
- Addresses preventative, acute, and chronic care from birth through transition to adulthood
- Practice-based care team takes collective responsibility for all of the patient's health care needs
- Care is continuous and coordinated across care settings, disciplines and community resources
- Quality is measured and improved as part of daily work flow
- Enhanced access and communication for patients
- Practices move towards use of EHRs, registries, and other clinical support systems
- Facilitates an integrated health system within a community-based system
- Appropriate payment to support and sustain optimal health outcomes

We Might Add:

- Promotes health equity for all children
- Increase flexibility for providers to allocate necessary resources where truly needed
- Make primary care more convenient, community-based and responsive to needs of patients and families
- Ensures a return on investment in the long-term

[1]http://pediatrics.aappublications.org/content/pediatrics/110/1/184.full.pdf
https://www.aap.org/en-us/about-the-aap/aap-facts/AAP-Agenda-for-Children-Strategic-Plan/Pages/AAP-Agenda-for-Children-Strategic-Plan-Medical-Home.aspx

Achieving the Vision

Based on November 29th Session's Discussion

Pediatric medical homes work towards achieving **this vision through** the Bright Futures Health Promotion themes and AAP Medical Home services (see appendix)

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

Purpose of this Group: Refresher

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:

- How do PCM capabilities support this vision of pediatric primary care?

Flexible Care Delivery

Alternative Ways to Access Care

- Aims to:
  - Promote healthy development and child well-being
  - Free up physician time for in-office care for well visits and patients with complex needs
  - Make care more accessible: avoid unnecessary Emergency Department; address family barriers to care (transportation, getting time off work, finding child care)
  - Increase continuity of care (telemedicine, phone, text, email)
  - Provide comprehensive, team-based care: expand access to specialists as part of team, partner with community-based services

Home Visits: New Parents

Universal home visits for families with newborns to support health promotion

Evidence-based Outcomes[1]

- Evidence suggests improved prenatal and post-natal outcomes including lower infant mortality
- Potential long-term benefits: fewer unwanted pregnancies, reduced maternal criminal behavior, decreased use of welfare, decrease in verified incidents of child abuse and neglect, less maternal behavioral impairment attributable to alcohol and drug abuse

Features of successful programs[2]

- Families consent to visit
- Focus on families in greater need of services
- Intervention beginning in pregnancy and continuing through second to fifth year of life
- Flexibility and family specificity
- Active promotion of positive health-related behaviors and infant care-giving
- Broad multi-problem focus to address the full complement of family needs
- Measures to reduce family stress by improving its social and physical environments
- Use of nurses or well-trained paraprofessionals

Should there be universal home visits for families with newborns?
If so, should pediatric primary care teams be required to conduct those visits?
Can the practice/AN contract with an external organization to provide this service?

[1]http://pediatrics.aappublications.org/content/140/3/e20172150
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4503253/
https://www.ncbi.nlm.nih.gov/pubmed/27980028

Home Visits: Integration with Community Services

Community-based home visiting services

- Yale Child Study Center "Minding the Baby": Enhance mother-infant relationships for at-risk mothers, children and families[1]
- CT DPH Putting on AIRS Program: Asthma education specialist and environmental specialist visit home and review asthma signs and symptoms, identify and remediate asthma triggers and review proper medication administration[2]

Two-generation approaches: Addresses needs of both children and adults

- CT Office of Early Childhood Home Visiting Programs: Home visits help families build on their strengths and provide support for both caregiver and child[3]
- MOMS Partnership: Program for pregnant women, mothers and female caregivers to address mental health and parenting needs in convenient locations

Should primary care practices be required to provide community-based home visits for children beyond a newborn visit?
If yes, can the practice/AN contract with an external organization to provide this service?

[1]https://medicine.yale.edu/childstudy/communitypartnerships/mtb/model.aspx
https://medicine.yale.edu/psychiatry/moms/what/
[2]https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/Asthma/Putting-on-AIRS--Asthma-Indoor-Risk-Strategies
[3]https://www.ct.gov/oec/cwp/view.asp?a=4544&q=556276

Telemedicine

Visits between clinicians and patients through virtual real-time communications

Outcomes:

- Address barriers to in-office visits like transportation or parent time off of work
- Increase consumer satisfaction
- Reduce emergency department visits for non emergency medical care
- Efficient use of provider resources

Typically used for:

- Appropriate urgent care or same day visits outside of a practice's normal business hours, or when an in-office visit is not available.
- Routine care management of chronic conditions (with in-person visits when necessary)
- Warm-handoff to behavioral health clinician
- Adolescent patients (age 12 and up) may prefer remote interaction

**AAP recommends telemedicine be used within a medical home only for continuity of care and efficiency*[1]

Should all pediatric primary care practices be required to use telemedicine?

Are there guardrails on telemedicine that the group suggests (e.g. not appropriate for certain populations or conditions)?

[1]https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Issues-Recommendations-on-Telemedicine-in-Pediatric-Health-Care.aspx

Phone, Text, Email Encounters

Communications between patients and care team via phone calls, text messages, and e-mails:

- For young children: Text, email, phone allows family member to initiate communications without needing to leave work or find transportation
- For adolescents: Subject to consent and parental permission requirements

Should pediatric primary care practices required to enable phone, text, and email for notifications, reminders, information exchanges, and encounters?

What beyond current PCP-parent/guardian phone calls is a must have?

Is confidentiality a concern for adolescent patients in pediatric practices?

Group Well Child Visits

Families are seen for well-child visits in a group with similarly aged children

- **Evidence-based Outcomes[1]**
  - Some studies suggest they are at least as effective as individual well child visits
  - Some studies report fewer sick visits and less advice seeking by parents between well visits
  - Reported benefits to parents include
    - Support from other parents
    - Comparisons to development of peers
    - Learning from other participants' experiences
    - Enhanced parental involvement during the visit
    - More time with provider

Should primary care practices be required to offer group well child visits to all patients? Some patients?

[1]http://pediatrics.aappublications.org/content/131/Supplement_1/S5

Access to Specialty Care: EConsults

Primary care provider (PCP) consultation with a specialist using electronic communications for non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit.

- **Outcomes**[1]
  - Limits overuse of specialists by decreasing need for face-to-face visits
  - Enhance primary care expertise and capacity to care for more complex patients including behavioral health patients requiring medication
  - More timely management of patient problems
  - Fewer specialist visits helps families avoid travel to specialist's office, time away from school/work and anxiety during wait period
  - Limited studies in pediatrics but one study found decrease in face-face-visits and high provider satisfaction

Should all pediatric primary care practices be required to have eConsult capabilities?

[1]https://aap.confex.com/aap/2015/webprogram/Paper31012.html

Access to Specialty Care: Co-Management

"Collaborative and coordinated care that is conceptualized, planned, delivered, and evaluated by two or more health care providers, one being a PCP and the other a subspecialist"[1] for certain conditions

- Outcome: Enables primary care providers to care for patients with certain conditions that otherwise would have been referred to a specialist
- Early evidence: provider satisfaction, increased adherence to guidelines
- Example: Connecticut Children's Medical Center Co-management Programs[2]
  - CCMC medical experts team up with pediatric primary care providers to treat patients with certain conditions (e.g. Lyme, concussions, migraines, etc.)
  - Provide standardized clinical algorithm, referral guidelines, CME co-management trainings, visits templates for providers, and handout for patient and family

Should co-management be incorporated into PCM as a tool for pediatric primary care clinicians?

Is something like the CT Children's Medical Center program a scalable model?

[1]https://www.chdi.org/publications/reports/impact-reports/working-together-meet-childrens-health-needs-primary-and-specialty-care-co-management/
[2]https://www.connecticutchildrens.org/co-management/

Expanding PCP Expertise: Project ECHO

- **Telementoring guided practice learning program to expand health care provider expertise in specific areas**[1]
  - Examples of AAP pediatric ECHOs: Child abuse & Neglect, Childhood Obesity, School Based Mental Health, Trauma and Resilience

- **Key Features**
  - Aims to improve quality, reduce variety, and standardize best practices
  - Multidisciplinary partnerships that increase access to care and reduce health care costs.
  - Case-based learning under guided practice to provide specialized care to provider's own patients
  - Technology to promote face-to-face mentorship and sharing of knowledge and experience by experts and peers

- **Outcomes:** Data suggests outcomes are the same or better than those treated at specialized referral hospitals, due to leveraging the patient-centered medical home model

Should primary care practices be required to participate in ECHO guided practice?

[1]https://www.aap.org/en-us/professional-resources/practice-transformation/echo/Pages/About-Project-Echo.aspx

Next Steps

- Next session: December 10th 8-9:30 am
- Confirm recommendations from previous sessions

Appendix

Challenges with Current System

- Current payment model and care delivery system doesn't support pediatric primary care practices in achieving the vision of pediatric primary care
  - Not enough time during visits
  - Pediatricians are overburdened and burnout is increasing
  - Lack of support for integrated and coordinated care
  - Reimbursement models have historically prioritized paying for acute episodes and disease rather than prevention and health promotion
  - FFS reimbursement puts pressure on clinicians to focus on documentation and keeping up with technology for billing rather than patient care

AAP Medical Home Services[1]

- Provision of family-centered care through developing a trusting partnership with families
- Sharing clear and unbiased information with the family
- Provision of primary care, including but not restricted to acute and chronic care and preventive services (breastfeeding promotion and management, immunizations, growth and developmental assessments, appropriate screenings, health care supervision, and patient and parent counseling about health, nutrition, safety, parenting, and psychosocial issues)
- Assurance that ambulatory and inpatient care for acute illnesses will be continuously available
- Provision of care over an extended period of time to ensure continuity
- Identification of the need for consultation and appropriate referral to pediatric subspecialists
- Interaction with early intervention programs, schools, early childhood education and child care programs, and other community agencies
- Provision of care coordination services in which the family, physician, and other service providers work to implement a specific care plan as an organized team
- Maintenance of an accessible, comprehensive, central record
- Provision of developmentally appropriate and culturally competent health assessments and counseling

[1]http://pediatrics.aappublications.org/content/pediatrics/110/1/184.full.pdf