Keys to Success: Accountable Care Trends and the Medical Home

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PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

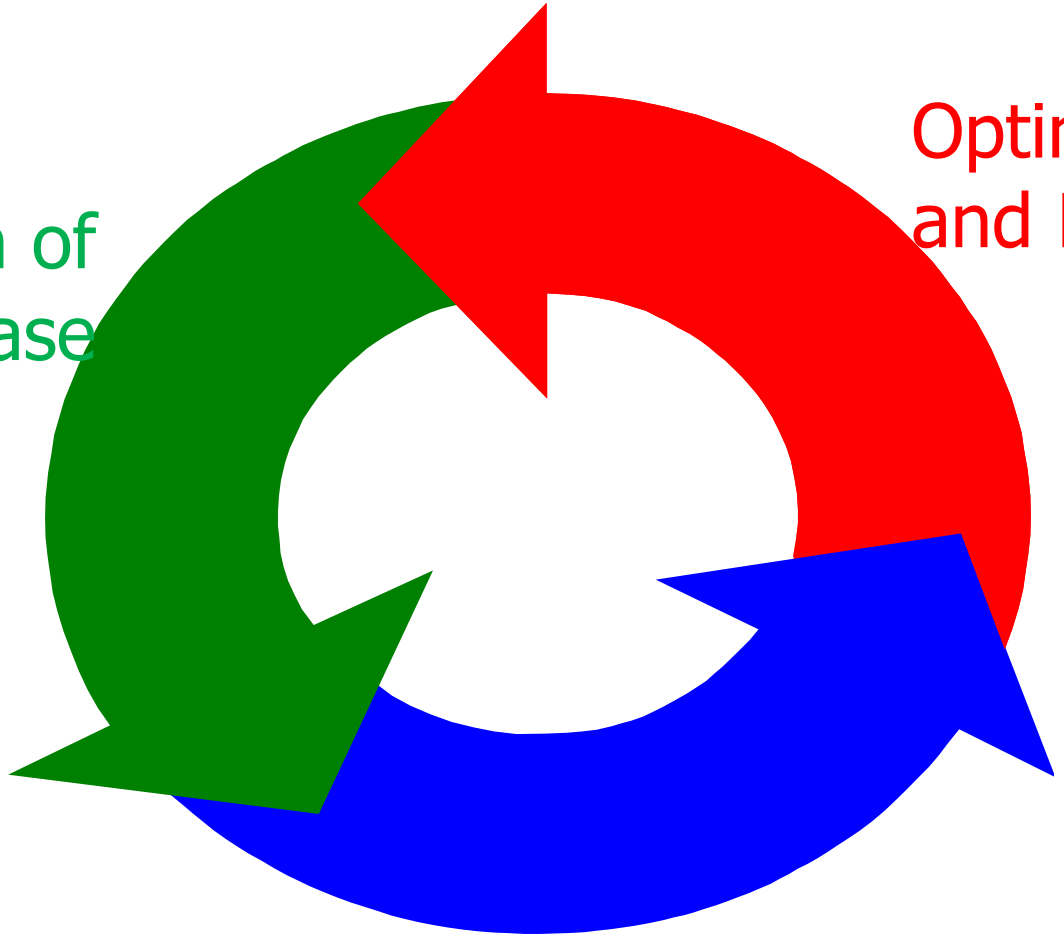
Health Network by Cincinnati Children's

Integrated Care Delivery in the Pediatric Medical Home

Colleen Kraft, M.D., FAAP

The kids "in our backyard"....

Pediatric Triple Aim

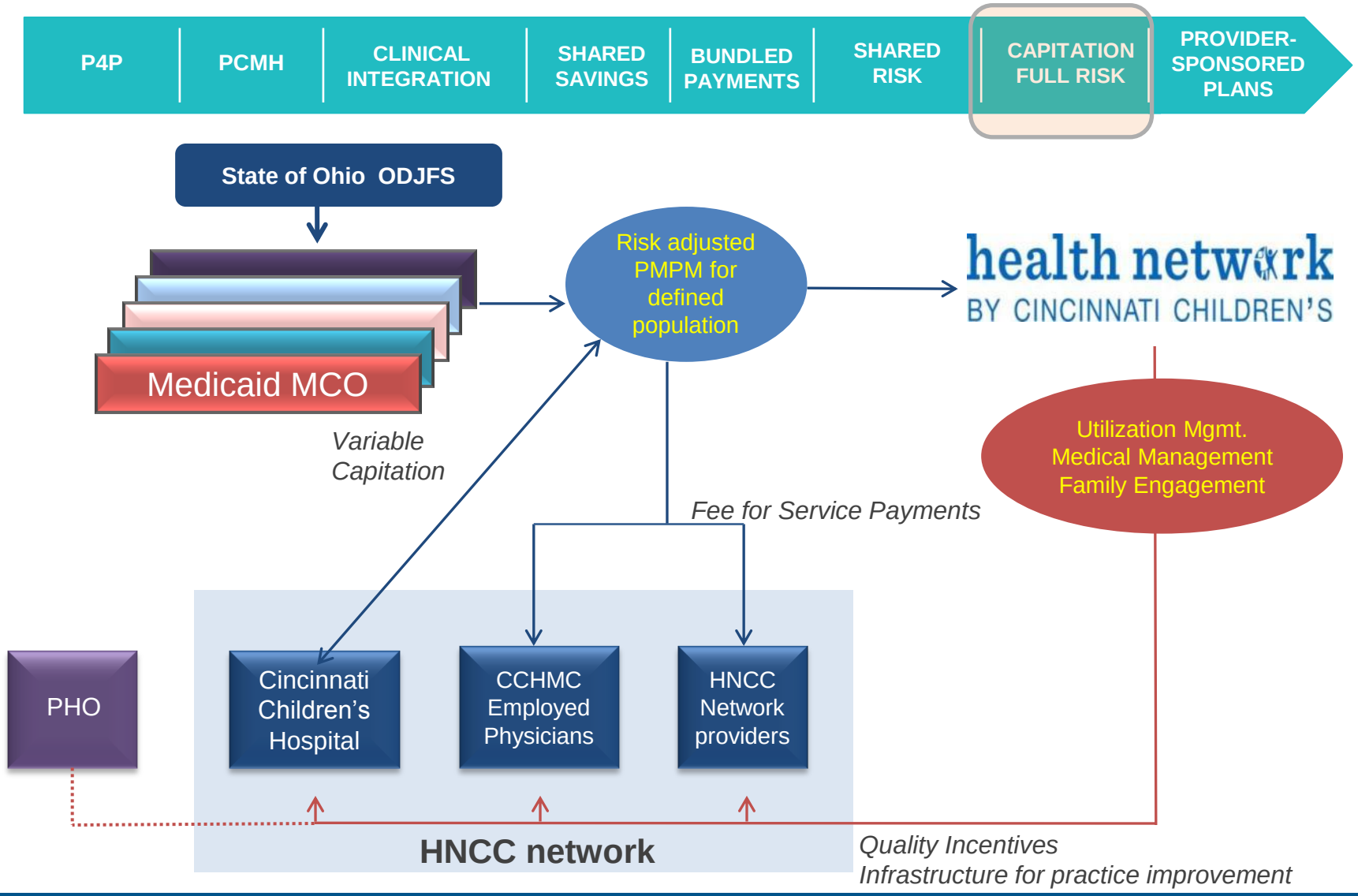


Healthcare payer payment mechanisms

Direction payers are heading

* Medical homes that receive extra dollars for patient management.
† P4P = pay for performance.

Health Network by Cincinnati Children's



HNCC Care Team Roles

RN Case Manager

- **F**acilitate and manage the care coordination and case management across the continuum of care for HNCC patients
- Provide ongoing support and expertise through comprehensive assessment, planning, implementation, and overall evaluation of individual HNCC patient needs
- Responsible for utilization review and discharge planning
- Promote continuity of care and effective resource management

Social Worker

- Perform psychosocial assessment and intervention
- Maintain a liaison with the community to ensure continuity of care for patient
- Partner with families and care team to manage resources, promote interdisciplinary collaboration and continuity of care

Community Health Worker

- Participate as part of the healthcare team in the coordination, referral, and support of HNCC members
- Build trusting and therapeutic relationships to provide communication, empathy, and collaboration between patients, families, and care teams
- Act as a link between HNCC members/families and community resources, events, programs, and information

Shared Team Members

- Diabetic Educator
- Mental Health Specialist
- Internal & External Provider Liaisons
- Community Relations
- Data Analyst
- Quality improvement

Building a robust primary care platform

- How would we define a robust primary care platform?
- What would key drivers be?
  - Patient/Family Centered Medical Home
  - Enhanced access to care,
  - Integrated data systems, EHR/IT resources
  - Effective community partnerships
  - Community based QI support

AIM

For the patients served by CCHMC General Pediatrics, we will redesign the system of care delivery to improve health promotion and prevention, outcomes for children with chronic disease, and patient and family experience, while decreasing the cost of care at a population level.

GOALS (by June 30th, 2013)

Cost of Care for Populations

- Decrease ED visits for low acuity problems by 50%
- Decrease ED visits for asthma by 20%
- Decrease inpatient admissions for asthma by 10%

Health Promotion and Prevention

- Increase the % of patients receiving ALL routine services by 12 months of age (immunizations, influenza vaccine offer, risk factor screen, ASQ, and lead screen) to 95%

Children with Chronic Disease

- Increase % of patients with asthma control score > 19 to 60%

KEY DRIVERS

- Patient care is evidence-based and coordinated
- Patient receives care when, where, and how they want
- Urgent care is "seamlessly integrated" with primary care
- Care is patient-centered – focused around parent concerns and expectations
- Community resources are integrated and accessible from all care sites
- Information technology solutions support, foster, and enforce coordinated/integrated care

INTERVENTIONS

- Preventive Services Bundle Delivery
- Burnet Urgent Care
- PPC Open Access for Acute Illness
- Asthma Care Coordination
- Population and CCO Asthma Registry with Outreach Tools

Example Measures

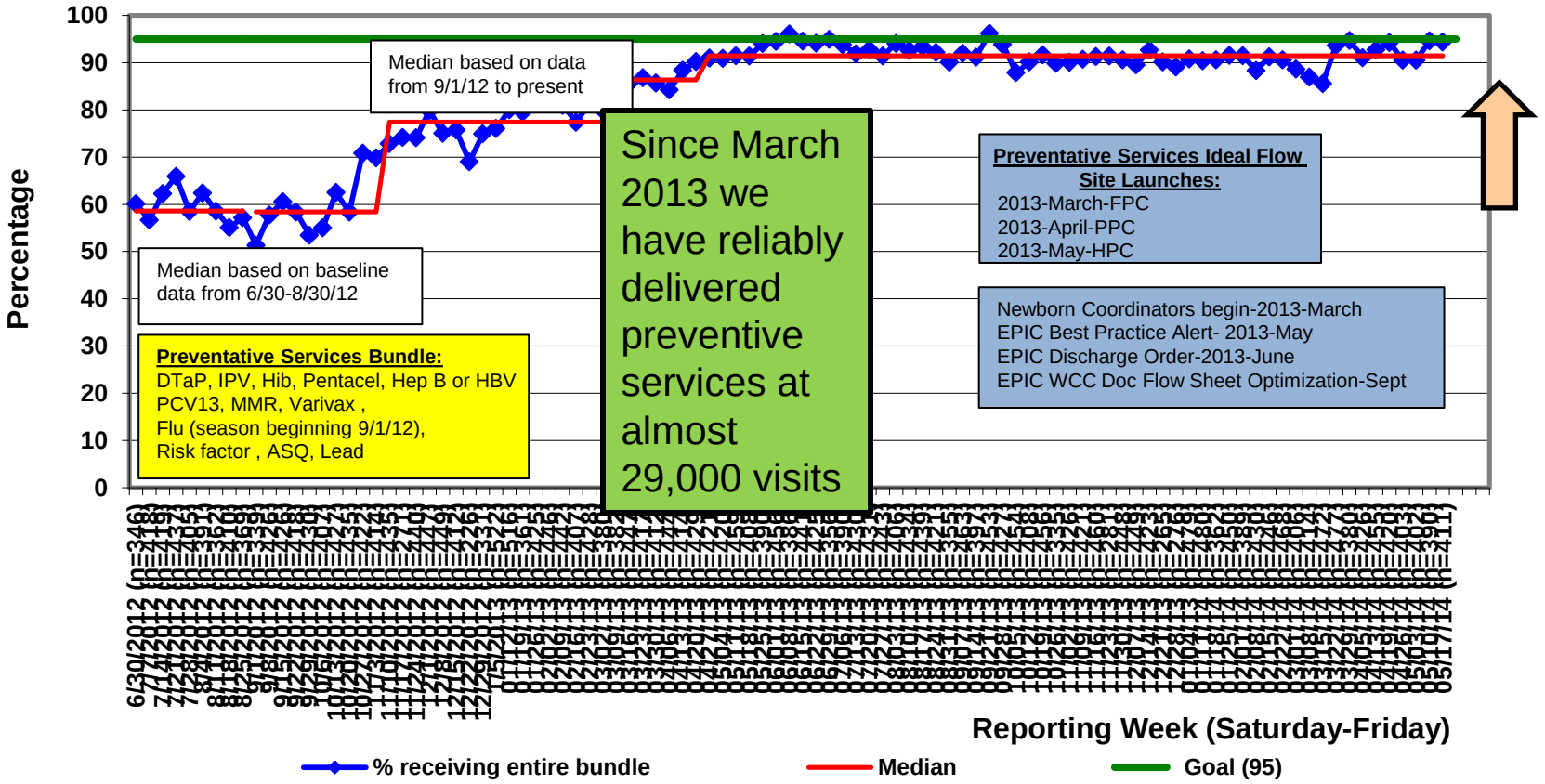
Outcomes:
-Missed school/workdays
-All cause under 18 mortality/infant mortality due to SIDS
-Prevalence of obesity, prevalence of well controlled ADHD, incidence
of injury, substance abuse, STI, suicide
-Functional status/QOL for kids with asthma

Care Delivery:
-Compliance with national quality standards (HEDIS, NCQA)
-Proportion of children with complex/chronic disease co-managed
-Adherence to evidence based guidelines
-Same day PCP access for acute illness
-Third next available appointments for WCC, sub specialty, psychiatry
-Incidence of ED psychiatric evaluation

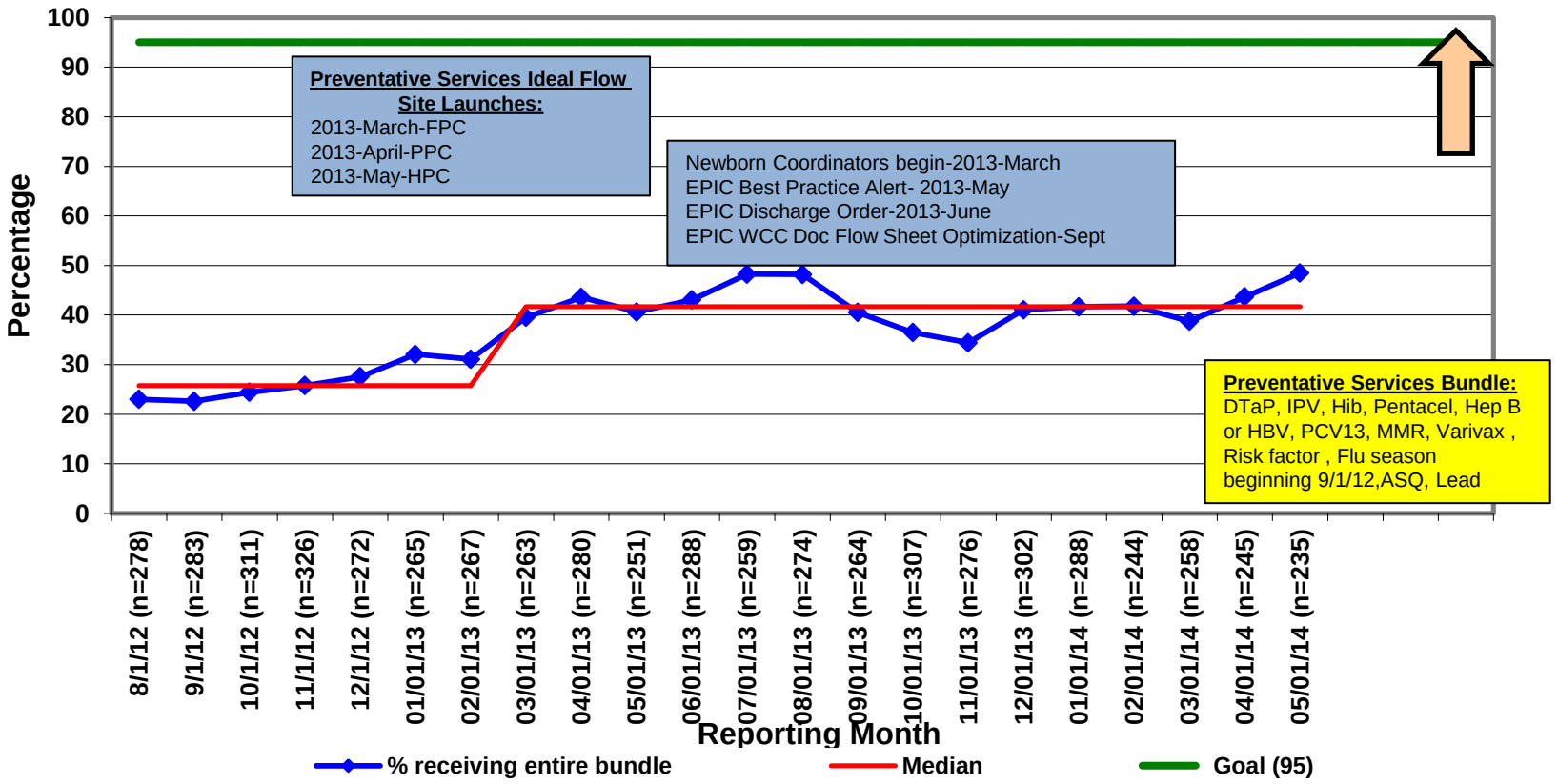
Patient Experience:
-Peds CAHPS

Cost and Utilization:
-Total inpatient days; inpatient admission/readmission rates; ED utilization
-Sub specialty referral rates
-Total per capita cost of care

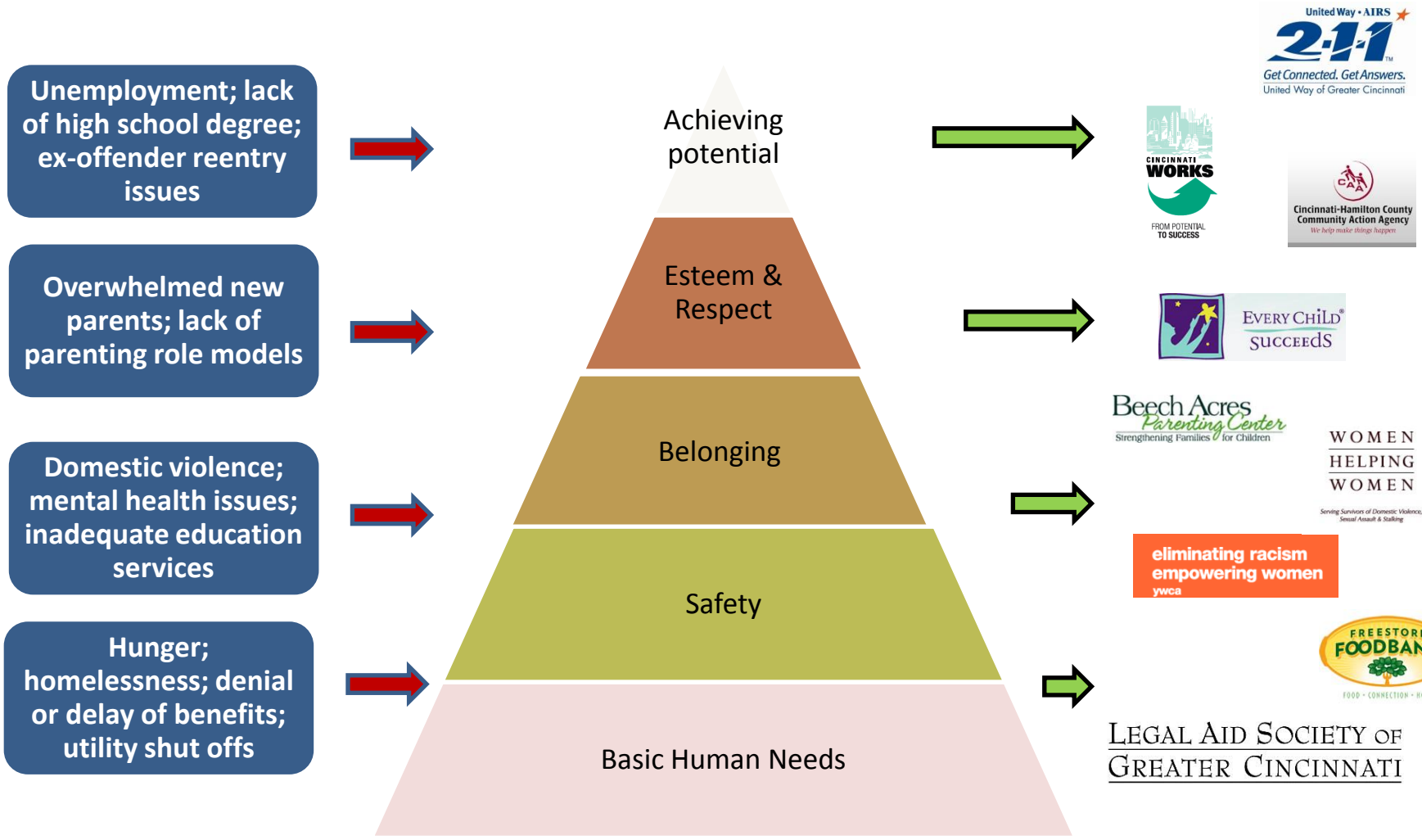
% of Primary Care Patients Seen 14 months and younger who have received the entire Bundle of Preventive Services for which they are Eligible



% of the CCHMC Primary Care Population turning 14 months old who have received the entire Bundle of Preventive Services

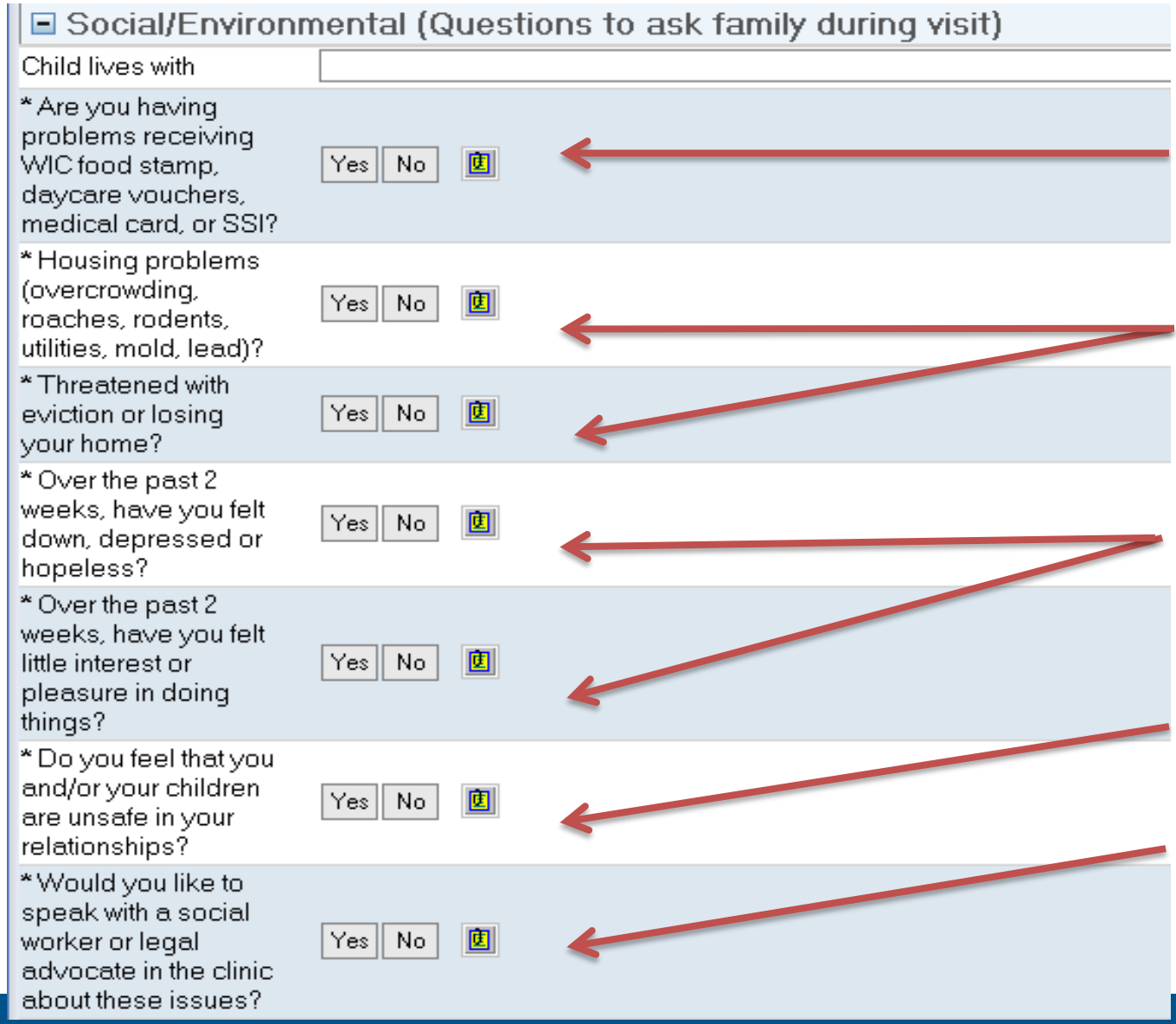


What A Well-Trained Clinic Will Detect	Maslow's Hierarchy of Needs	Potential Collaborations

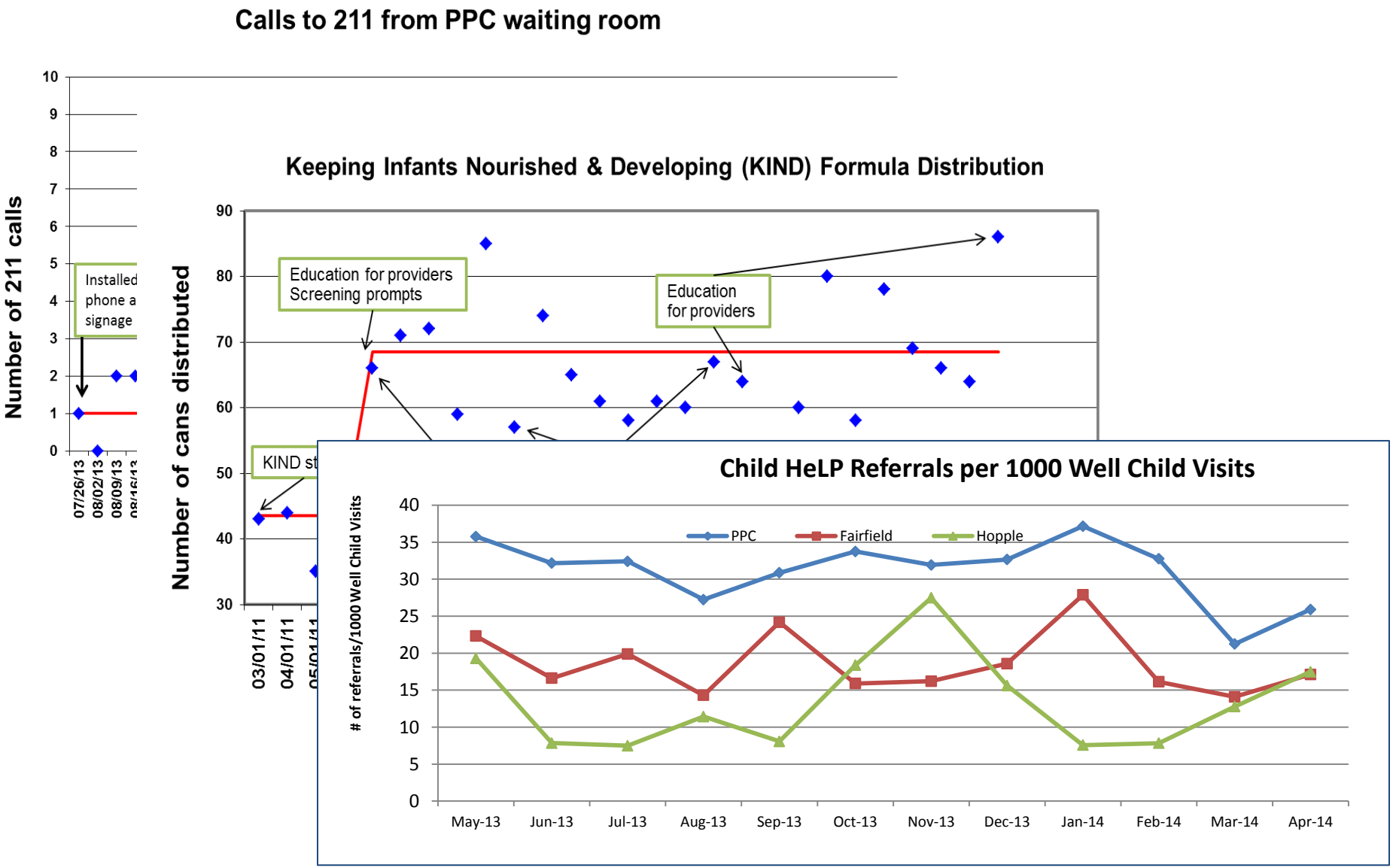


Henize, Kahn (2013)

Using EPIC to drive social history screening



Connecting to Community Services



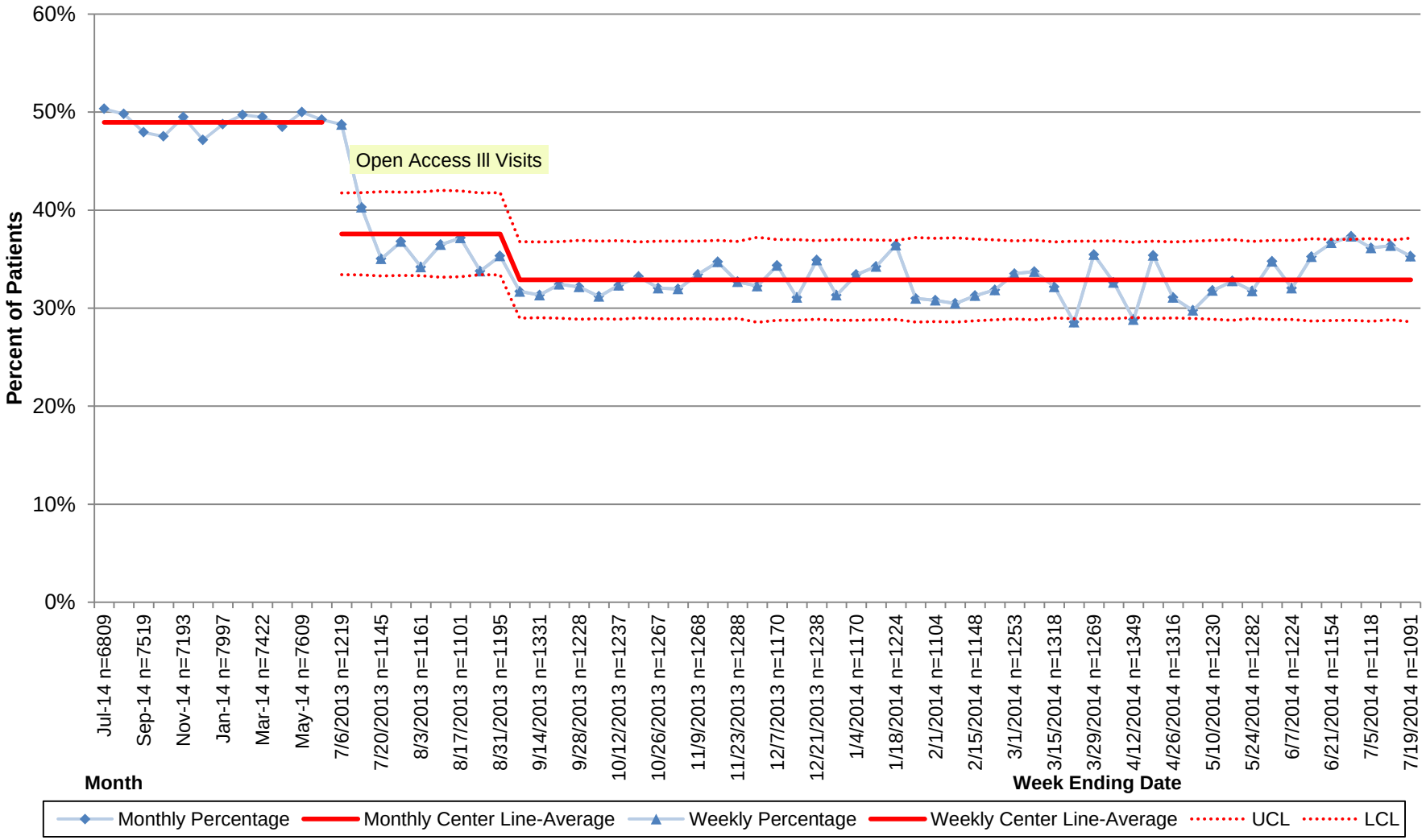
Cincinnati Children's

Preventive services use among children receiving free formula (KIND) vs. who did not (Klein)

	KIND (%)	No KIND (%)	P
Lead complete	81	75	<.01
ASQ complete	27	20	<.01
≥5 well visits in first 14 months	42	29	<.01
Social risks identified			
Food insecurity	57	10	<.01
Parental depression	11	5	<.01
Housing issues	15	6	<.01
Benefit issues	24	14	<.01
Domestic violence issues	5	2	<.01
Referrals to social work	29	18	<.01
Referrals to MLP	15	6	<.01

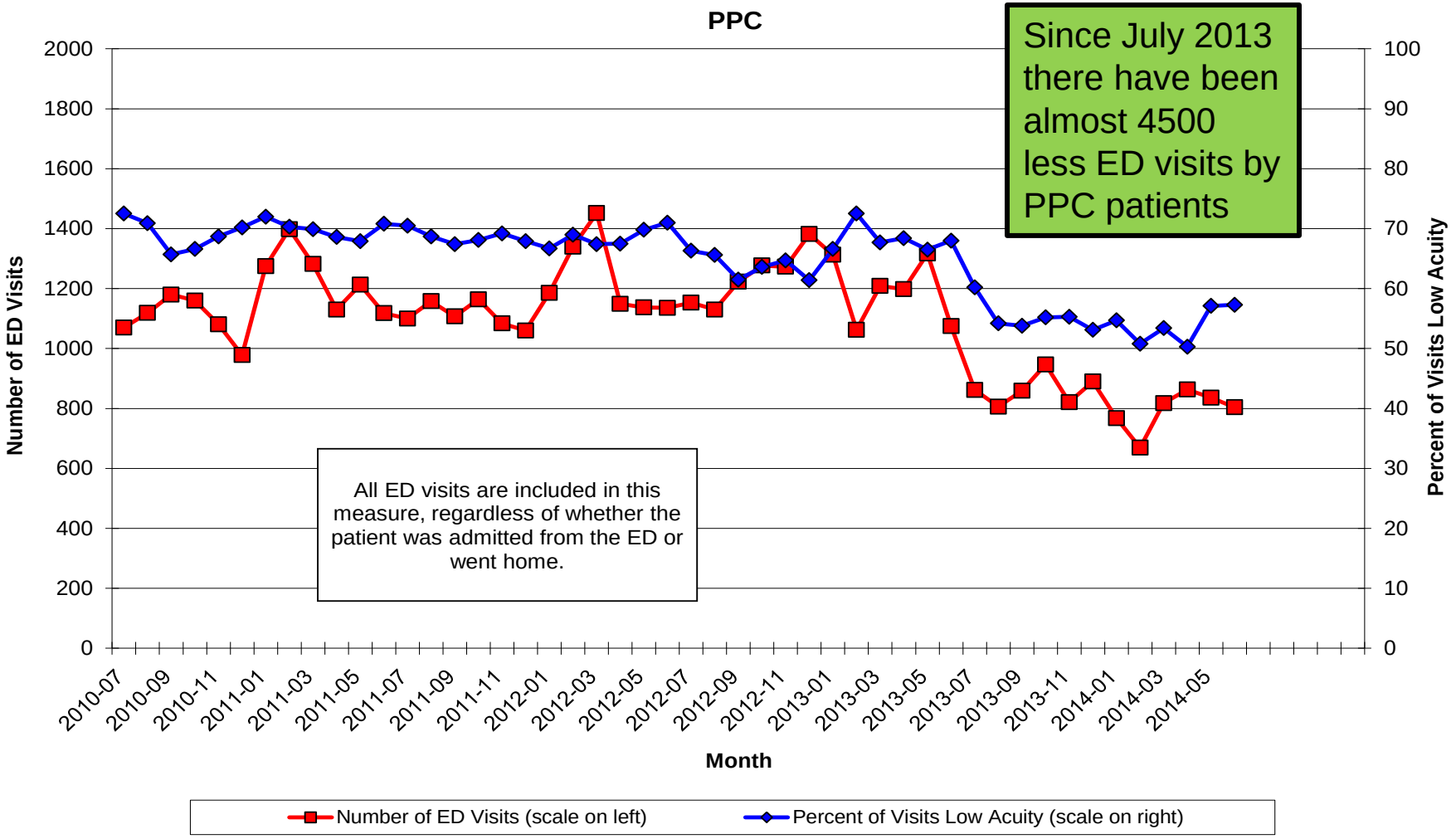
Cincinnati Children's

Proportion of Patients Seen at the Base ED with an Acuity of 4 or 5
p-chart



Created by Kate Rich,
James M. Anderson Center for Health Systems Excellence

ED Visits and Percent Low Acuity (Triage Level 4 & 5) by Month



Last update: 07-25-14 by H. Atherton Data source: EPIC

Dissemination of best practices

- Active relationship building with community physicians who participate with HNCC MCOs.
- Objective criteria for inclusion in first cohort/contract – 20% or 1000 Medicaid member minimum
  - Physician interest and engagement
- Detailed value proposition to include:
  - On-site Care Managers
  - Learning collaborative opportunities
  - Behavioral Health—Primary Care initiatives

Population Health

Core Set Shared Goals for Cincinnati Children 0-17

Matrixed Research, QI, Community Engagement & Advocacy, Health Disparities Training, Community Leaders Inst, Geoanalytics, Recruitment

Outcomes

Peds QL (Functional Status)

Care Delivery

- Compliance with national standard (HEDIS, NCQA)
- Children with Medical / Social Complexity (CMC) with shared plan of care
- Access

Experience

Peds CAHPS

Cost/Value

- Utilization
- Total per capita cost of care

Divisions: Gen & Comm Pediatrics, Adolescent Transition Medicine, Dental, ED, Behav Med & Clin Psych, Psychiatry

CCHMC Primary Care Core

PHO, Batesville

FPC, HPC, PPC, Complex Care

Teen HC, Transition Medicine

Non-PHO: FP/Meds Peds

Community Health Clinics: FQHC, CHD

School Based Health Centers

Urgent Care

Other: Dental, Behavioral

Other: Mobile, Retail, Clinic

HNCC (Reimbursement Strategy/Case Management Expertise)

Organizational Core

Quality Improvement and Clinical Transformation

Measurement Data, EHR, IT

Building Community, Stakeholder Engagement, Advocacy, Policy

Research and Innovation Core – Grants, Publications