Keys to Success: Accountable Care Trends and the Medical Home

Blair Childs, Premier

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Integrated Care Delivery in the Pediatric Medical Home

Colleen Kraft, M.D., FAAP
The kids “in our backyard”...
Pediatric Triple Aim

Prevention of Adult Disease

Optimize Health and Development

Reduce High Cost Care
Healthcare payer payment mechanisms

Direction payers are heading

THE RISK CONTINUUM ASSOCIATED WITH EXISTING AND PROPOSED REIMBURSEMENT STRUCTURES

Fee-for-Service
Medical Home*
P4P
Bundled Payment
Payment for Episodes of Care
Gain Sharing
Global Payment with Performance Risk & P4P
Global Payment with Financial Risk

> Consumers
> Employers
> Health Plans
> Government Payers

> Physicians
> Medical Groups
> Hospitals
> Other Providers

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

- Facilitate 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

- 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

- 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

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

RN Case Manager
Social Worker
Community Health Worker
Shared Team Members
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%
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
Since March 2013 we have reliably delivered preventive services at almost 29,000 visits.

Preventative Services Bundle:
- DTaP, IPV, Hib, Pentacel, Hep B or HBV
- PCV13, MMR, Varivax
- Flu (season beginning 9/1/12), Risk factor, ASQ, Lead

Preventative Services Ideal Flow
Site Launches:
- 2013-March-FPC
- 2013-April-PPC
- 2013-May-HPC

Newborn Coordinators begin-2013-March
EPIC Best Practice Alert- 2013-May
EPIC Discharge Order-2013-June
EPIC WCC Doc Flow Sheet Optimization-Sept

Since March 2013 we have reliably delivered preventive services at almost 29,000 visits.
% of the CCHMC Primary Care Population turning 14 months old who have received the entire Bundle of Preventive Services

Preventative Services Bundle:
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Preventative Services Ideal Flow Site Launches:
2013-March-FPC
2013-April-PPC
2013-May-HPC
What A Well-Trained Clinic Will Detect

Maslow’s Hierarchy of Needs

Potential Collaborations

Unemployment; lack of high school degree; ex-offender reentry issues

Overwhelmed new parents; lack of parenting role models

Domestic violence; mental health issues; inadequate education services

Hunger; homelessness; denial or delay of benefits; utility shut offs

Achieving potential

Esteem & Respect

Belonging

Safety

Basic Human Needs

Henize, Kahn (2013)
Using EPIC to drive social history screening

<table>
<thead>
<tr>
<th>Social/Environmental (Questions to ask family during visit)</th>
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</thead>
<tbody>
<tr>
<td>Child lives with</td>
</tr>
<tr>
<td>* Are you having problems receiving WIC food stamp, daycare vouchers, medical card, or SSI?</td>
</tr>
<tr>
<td>* Yes No Options</td>
</tr>
<tr>
<td>* Housing problems (overcrowding, roaches, rodents, utilities, mold, lead)?</td>
</tr>
<tr>
<td>* Yes No Options</td>
</tr>
<tr>
<td>* Threatened with eviction or losing your home?</td>
</tr>
<tr>
<td>* Yes No Options</td>
</tr>
<tr>
<td>* Over the past 2 weeks, have you felt down, depressed or hopeless?</td>
</tr>
<tr>
<td>* Yes No Options</td>
</tr>
<tr>
<td>* Over the past 2 weeks, have you felt little interest or pleasure in doing things?</td>
</tr>
<tr>
<td>* Yes No Options</td>
</tr>
<tr>
<td>* Do you feel that you and/or your children are unsafe in your relationships?</td>
</tr>
<tr>
<td>* Yes No Options</td>
</tr>
<tr>
<td>* Would you like to speak with a social worker or legal advocate in the clinic about these issues?</td>
</tr>
<tr>
<td>* Yes No Options</td>
</tr>
</tbody>
</table>

- **Benefits**
- **Housing**
- **Depression**
- **Domestic Violence**
- **All others**
Connecting to Community Services

Calls to 211 from PPC waiting room

Keeping Infants Nourished & Developing (KIND) Formula Distribution

Child HeLP Referrals per 1000 Well Child Visits

- Education for providers
- Screening prompts
- Education for providers

Number of calls to 211

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

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

8/22/2014
ED Visits and Percent Low Acuity (Triage Level 4 & 5) by Month

Since July 2013 there have been almost 4500 less ED visits by PPC patients

All ED visits are included in this measure, regardless of whether the patient was admitted from the ED or went home.

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

Number of ED Visits (scale on left)      Percent of Visits Low Acuity (scale on right)
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
  o Physician interest and engagement

• Detailed value proposition to include:
  o On-site Care Managers
  o Learning collaborative opportunities
  o Behavioral Health—Primary Care initiatives
Core Set Shared Goals for Cincinnati Children 0-17

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

CCHMC Primary Care Core

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

Population Health

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

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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