 

**Pediatric High Risk Workgroup Proposal**

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The PCMH high risk sub-committee recommends:

* Using a multi-part framework for high risk children and families that would benefit from care coordinator services
* Having practices use a population based approach and clinical judgment to identify high risk patients per the framework and practice needs.

**High Risk Framework:**

1. Multi-part framework for high risk for kids and families include:
2. At risk for high utilization of hospital services (source of data health plan lists);
3. At risk of negative health outcome due to health condition (e.g. prematurity, moderate-severe asthma)
4. At risk of negative health outcomes due to social, environmental and behavioral and family issues.

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| **High risk category** | **Suggested population health approach/data** | **Data Source** |
| a. High cost/high utilization: At risk for high utilization of hospital services | 2 emergency visits in 6 months;  1 hospitalization for BH in 6 months | Health plan lists  EHR report |
| b. Poorly controlled or complex conditions: At risk of negative health outcomes per complex care condition | ADHD plus other complicating condition such as anxiety  Asthma and required oral steroids in the past 6 month  NICU stay greater than 1 week  Infants with Neonatal abstinence syndrome | EHR report  Health plan lists |
| c. At risk based on gap in care and/or positive risk screen that is suggestive of family/social of determinant of health, environmental concern | Child 9 months with less than 3 prevnar immunizations  2 year old missing 4th Dtap  Positive screen for depression, substance use disorder and or sexually transmitted infection  Positive screen for early childhood dental caries  Post maternal depression screen  Homelessness, (lives in shelter) Food insecurity | EHR  Kids Net  Health plan lists |

**Practice Guidelines:**

**Population Health Identification**

Practices could use the suggested population health approach /data or could identify an alternative population health approach based on practice patient/family panel characteristics. Practices can use practice electronic health record reports recommended in NCQA “Knowing and Managing Your Patients” as a source of reference. Additionally, KIDS NET is in the process of creating Practice Profile information that can also be used as a source of reference.

**High Risk Thresholds:**

Different practices may require different “cutoffs” for the above suggested parameters depending on the practices population- for instance one practice may want to use greater than 2 ed visits in 6 months, another may start with greater than 2 ed visits in past year. This approach is consistent with NCQA PCMH 2017 Care Management and Support guidance: “The practice identifies patient needs at the individual and population levels to effectively plan, management and coordinate care in partnership with patients/families/caregivers”. The framework is additionally consistent with OHIC cost management strategies for developing a high risk registry for patients inclusive of patients with high utilization, patients with complex chronic conditions and patients referred from health plans Additionally , clinicians can self-identify children and families based on other patient/family reported needs and clinical judgment.

Care Coordinator Caseload Guidelines

The PCMH Kids Service Delivery Contract outlines an expectation that the practice hire 1 full time care coordinator for every 3000 attributed patients. The health plans has as an expectation that practices engage with 50% of high risk patients. Review of the literature indicates that a full time care manager can actively engage with 150-170 patients. Practices can use these parameters as they establish thresholds

**Recommended Next Steps: Plan Do Study Act**

1. Practices and practice facilitators can meet to review the PCMH High Risk framework, review practice population health information, practice reporting capacity and discuss and identify 1-2 patient populations from each framework category;
2. Run reports on the selected patient populations of focus, review information and discuss potential thresholds based on staffing capacity
3. Test the practice identified categories and report on engagement with high risk patients;
4. Evaluate framework after testing and refine
5. Be able to report out at the next High Risk Meeting (to be scheduled in June)

* Population of focus per category
* Number of patients identified per condition
* Thresholds set
* Engagement levels with care coordinator and high risk patients
* Lessons learned
* Recommendations

**Background:**

PCMH Kids sub-group efforts to date include:

1. Literature review and best practice sharing presentations
2. Development and testing of a high risk screening tool using a modified version of the CEDAR tool
3. Obtaining EOHHS cost data by age and behavioral health condition
4. Development and testing of potential high risk population health categories of patients (including health plan identified high cost patients and data from EHR and Kids Net;
5. Review of framework and feedback from Nurse Care Managers/care coordinators

**Findings:**

1. It was useful to look at work that is being done nationally and locally as this helped inform efforts. Ideally, it would be helpful to have a state-wide data base system (claims and practice data) that provided actionable, specific patient information. At this point in time, pediatric practices have various electronic health records with varying amount of sophistication and varying levels of practice reporting support.
2. Feedback on the testing of the high risk screening tool: in pediatric practices with high concentration of Medicaid patients, the screening tool was not sensitive enough (“almost all patients screened positive”); in practice with high number of commercially insured patients, there were low number of patients that screened positive. There was not an efficient, effective way to integrate the tool into the work flow.
3. Sub-group asked EOHHS to generate reports on different age groups with cost data in an attempt to identify patterns of children who might benefit from care management
4. Sub-group brainstormed population health categories of children based on risk status. Practices piloted using those categories, which were reviewed using clinical judgment for accuracy and sensitivity. Findings using this approach led to above recommendations.