CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

# Pediatric Comprehensive Primary Care

## Care Transformation Collaborative of R.I.

CLINICAL STRATEGY COMMITTEE MEETING
OCTOBER 16, 2020

# Discussion Questions

In addition to general input and feedback, we request your input on the following questions….

1) Slides 4&5 offer provisional principles for pediatric practices participating in Comprehensive Primary Care Capitation. Are these the right principles for Pediatric CPCC practices in RI or what edits would you recommend?

2) Slides 8, 11 and 19-24 offer information on possible members of the care team, a sample care team configuration and tasks for various care team members.
   - Do you agree that care team members do not need to be co-located in the practice?
   - If not co-located, what do you see as necessary to achieve coordination, collaboration?
   - Thoughts on the possible configuration? Right people? Not enough or too much time?
   - Any concerns or suggestions regarding the recommended tasks assigned to care team members in the Appendix?

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRICS
# Provisional Principles for Pediatric CPPC

In 2002, the American Academy of Pediatrics, wrote in a policy statement on the services that should be included in comprehensive health care for infants, children, and adolescents.

These services, edited for space, are provided on the following two slides as “Principles for Comprehensive Pediatric Primary Care.”

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRICS
# Provisional Principles for Pediatric CPPC

- Family-centered care is provided by developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life.
- Care team members share clear and unbiased information with the family about the child's medical care and management and about specialty and community services they can access.
- Primary care, includes but is not restricted to acute and chronic care and preventive services, including 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.
- Ambulatory care for acute illnesses will be continuously available (24 hours a day, 7 days a week, 52 weeks a year).
- Care will be provided over an extended period to ensure continuity. Transitions, including those to other pediatric providers or into the adult health care system, should be planned and organized with the child and family.

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRICS
# Provisional Principles for Pediatric CPPC

- Primary care providers identify the need for consultation and appropriate referral to pediatric medical subspecialists and surgical specialists. (In instances in which the child enters the medical system through a specialty clinic, identification of the need for primary pediatric consultation and referral is appropriate.)

- Primary, pediatric medical subspecialty, and surgical specialty care providers should collaborate to establish shared management plans in partnership with the child and family and to formulate a clear articulation of each other's role.

- Care teams should interact with early intervention programs, schools, early childhood education and childcare programs, and other public and private community agencies to be certain that the health-related social needs of the child and family are addressed.

- Care coordination services should be organized so the family, the physician, and other service providers work to implement a specific care plan as an organized team.

- Care teams should maintain an accessible, comprehensive, central record that contains all pertinent information about the child, preserving confidentiality.

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# Pediatric Expanded Care Teams

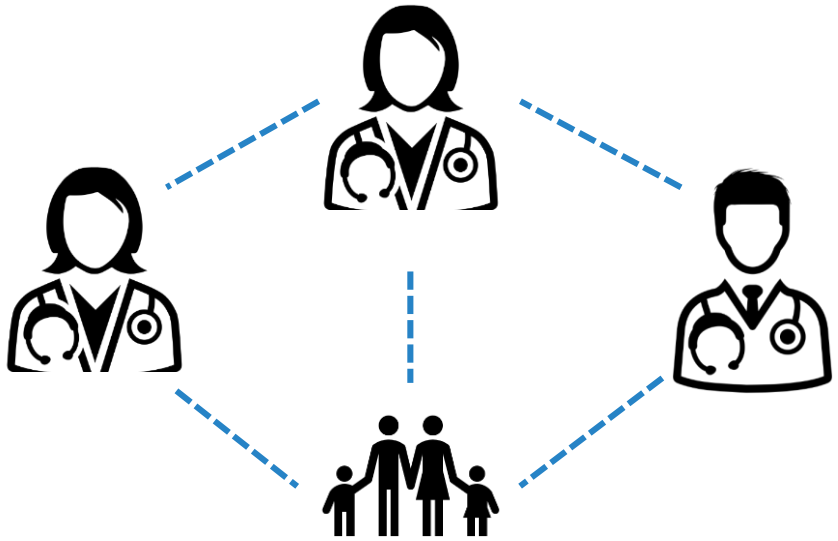
CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS Overview

**DEFINTION AND GOALS**

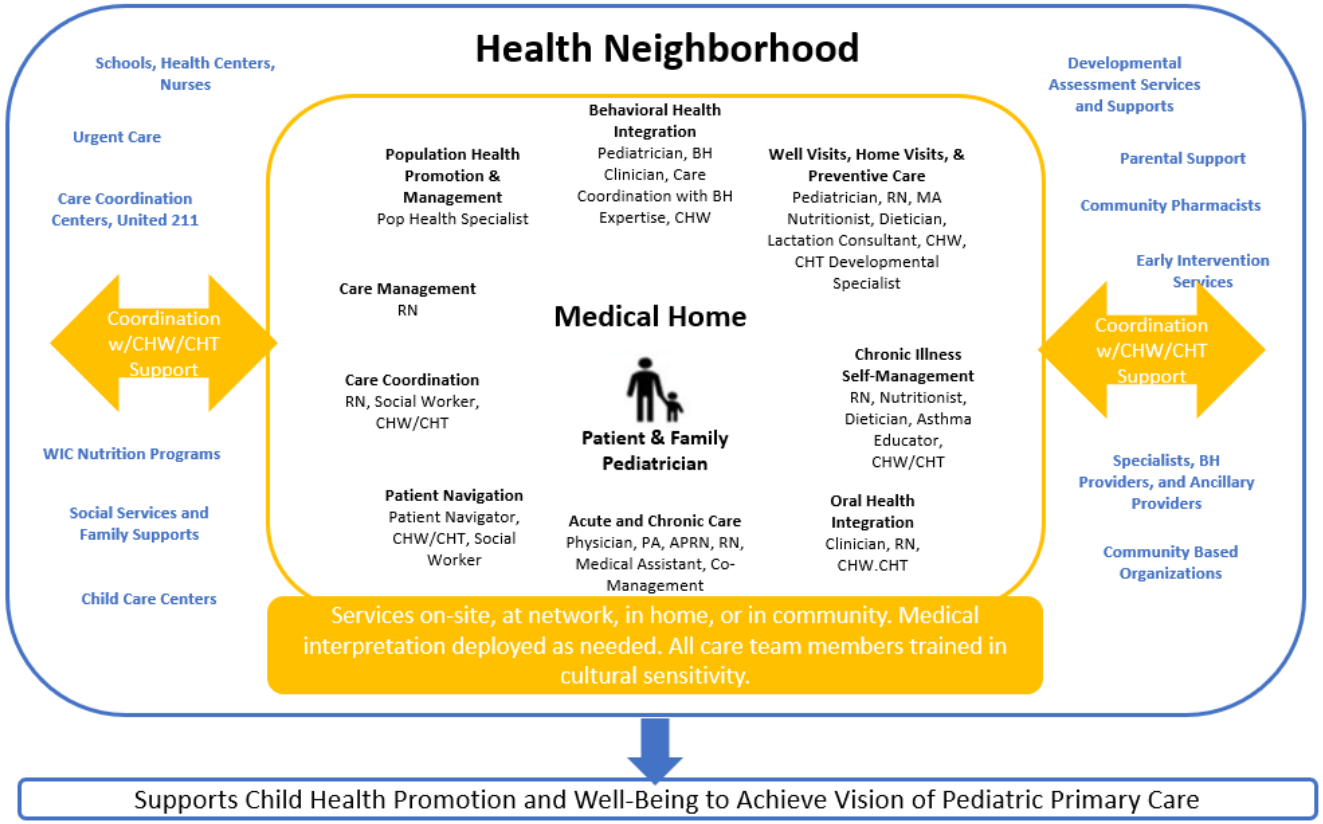
Practices establish care teams within the pediatric medical home that are guided by the primary care clinician in collaboration with the patient and family, integrate other professionals, and coordinate with community supports.

Care teams promote the strengths of families and best health for all children by making primary care more comprehensive and accessible, better meeting the diverse needs of patients and families, improving care coordination, efficiency, effectiveness and increasing patient/family and provider satisfaction.



CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Who is on the team?




)ptions, not
equirements

his graphic is based
)n our work
lsewhere and
djusted slightly to
eflect work in RI

)ifferent practices
nay require different
:are team
:ompositions

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# EXPANDED CARE TEAMS
# What Drives Success

Perspective from “Complexity Science”

**RELATIONSHIP DRIVEN**

Care team members connect outside of formal meetings

**EFFECTIVENESS INCREASES WITH**

- Number & quality of interactions
- Information flow
- Cognitive diversity

**SUCCESS SUSTAINED WHEN**

Care team members mutually adjust behaviors to achieve goals

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Best Practices in Implementation

- ✓ Hire care team members to provide functions defined by the American Academy of Pediatrics, including: well visits and preventive care; acute and chronic care; care management; care coordination; patient navigation; behavioral health integration; oral health integration; and chronic illness self-management
- ✓ Flexible funding supports expanding and diversifying care teams to fulfill recommended functions. Care team members may be onsite in the practice, centralized at the system of care or accessed through community partnerships.
- ✓ Deploy care team members in the practice, virtually, in the community or patient homes
- ✓ Utilize Community Health Workers and Community Health Teams to link patients and families to culturally appropriate community resources, track follow-up, and provide peer support. Coordinate or partner with community services and other places where patients receive care (e.g. schools, childcare centers);
- ✓ Train team members to deliver effective team-based care including workflows and communications. Ensure care team members apply their skills to the top of their training, but do not exceed their qualifications

# PEDIATRIC EXPANDED CARE TEAMS Possible Configuration

| CARE TEAM MEMBER | % FTE | PATIENT CARE ASSUMPTIONS | SALARY, BENEFITS | PMPM |
|---|---|---|---|---|
| **RN Care Manager** | 0.24 | 15% of children with a chronic condition; 49% participate; 100 newborns, 2 hrs/patient/yr | $20,043 | $1.19 |
| **Health Coach/Educator** | 0.12 | 25% children obese; 25% of obese children participate (1.5hrs coaching/yr) | $5,800 | $0.24 |
| **Nutritionist** | 0.12 | 25% children obese; 25% of obese children participate (1.5hrs coaching/yr) | $10,145 | $0.42 |
| **Community Health Worker** | 0.87 | 20% of children have at least two ACEs; 25% of children with ACEs participate (1.5 hr per month with the CHW including admin and travel time), ~.10 FTE reaching out to families who decline | $39,789 | $1.66 |
| **Asthma Educator** | 0.63 | 10% of children have asthma each child/family receives a half hour every 2 weeks | $53,868 | $2.24 |
| **Lactation Consultant/CHW** | 0.23 | Babies under 1 are 10% of the pediatric population; half will participate in home visit program; another 25% will receive additional lactation services | $10,389 | $0.43 |
| **BH Clinicians (LCSW)** | 0.71 | 20-25% of children have a BH condition; 25 percent of those will receive support; 1 hr/month plus admin time | $64,772 | $2.70 |
| **Total Care Team Units** | 2.88 | | | |
| **Total Cost** | | | $204,806 | $8.53 |

Assumes 2,000 patient pediatric practice with expanded care team members shared via Community Health Teams and/or across a system of care

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Integrated Behavioral Health

**DEFINTION**

Provide additional resources and capacity for the pediatric practice to unify pediatric behavioral health and primary care to focus on developmental, socio-emotional, and mental health promotion, prevention and early identification for child and family. This model does not intend to enable pediatric primary care to treat individuals with serious behavioral health conditions, although it does aim to enable primary care to better address these individual's preventive and medical care needs. Care team members may be onsite in the practice, at the system of care or in the community, such as through a Community Health Team.

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Integrated Behavioral Health

## BEST PRACTICES IN IMPLEMENTATION

**Practice Level:**

- ✓ Specific screenings assess developmental and socio-emotional health, behavioral health and health behaviors and social and environmental factors that affect the child/family
- ✓ BH clinician offers brief treatment and interventions; referral for further treatment if needed
- ✓ When feasible, practices prioritize on-site availability of BH services and use common EHR platform; otherwise provided via partnership with system of care or Community Health Team.
- ✓ Dedicated care coordinator with expertise in behavioral health who coordinates within the practice/system of care and community for child and family; establishes two-way information flow between community and practice.

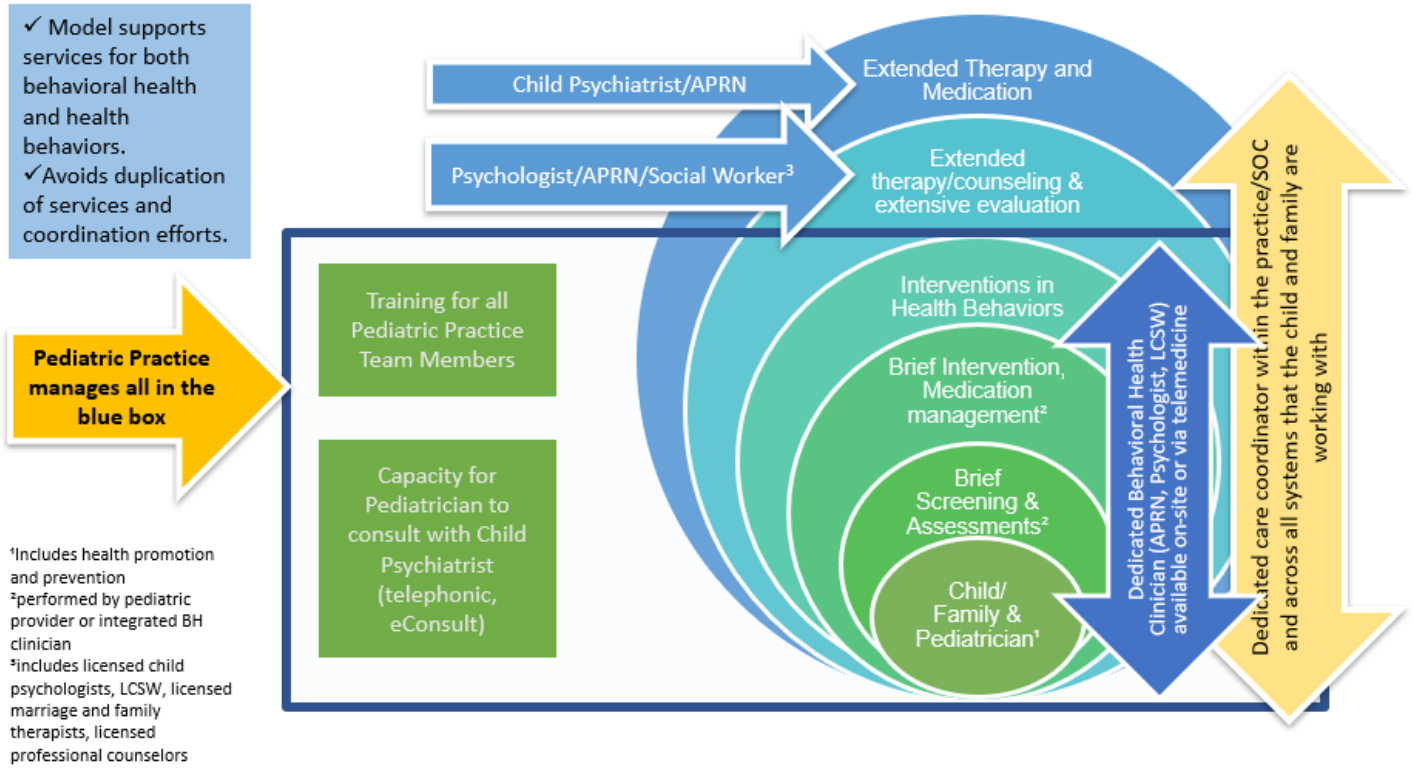
**Practice/System of Care/Community:**

- ✓ Medication management expertise within the practice and access to consultations with child psychiatrists
- ✓ Patient-to-clinician video visits (especially for adolescents)
- ✓ Tracking outcomes in EHRs
- ✓ Training for clinical staff on BH teaming and BH issues and for BH staff on chronic illness
- ✓ Referral and coordination with community-based BH specialists for extended therapy, counseling, evaluation and medication

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Integrated Behavioral Health

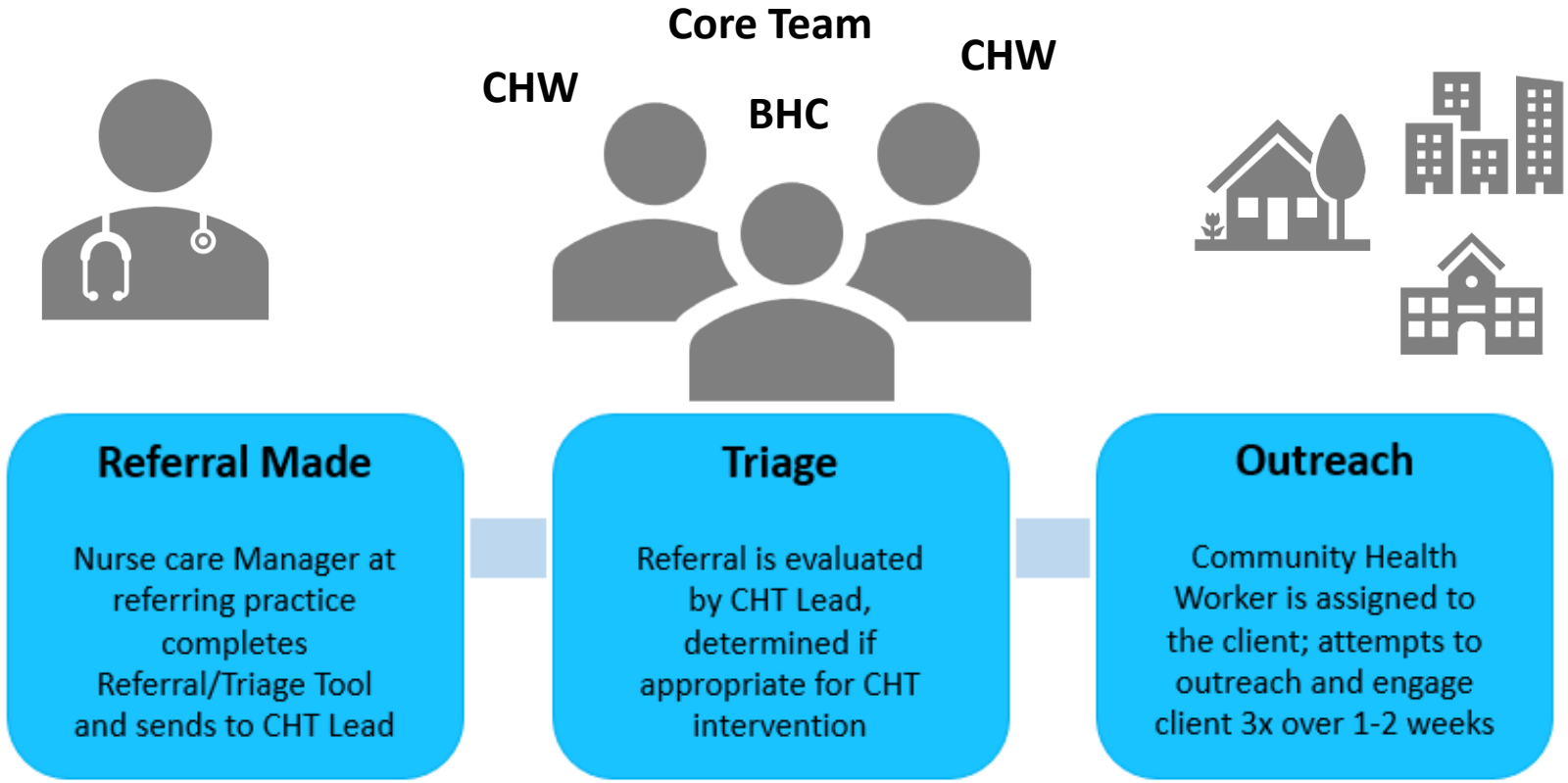
**CONCEPT MAP**




CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Community Health Teams

**IDEAS FOR IMPLEMENTATION**




CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# APPENDIX

***Comments and feedback welcome! Please send to:***

Pano Yeracaris, Chief Clinical Strategist, CTC-RI
pyeracaris@ctc-ri.org
Mary Jo Condon, Senior Consultant, Freedman Healthcare
mcondon@freedmanhealthcare.com

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Population Health Promotion & Management | • Assess health promotion and health outcome measures for the population<br>• Establish appropriate targets for each<br>• Identify patients and sub-populations not achieving the targets and those who require specific services due to age<br>• Develop actionable steps using evidence based or clinical guidelines<br>• Incorporate health outcomes and health promotion measures into patient registries | Pediatrician, APRN, or PA utilize data and collaborate with other members of the care team to identify populations and action steps |
| Care Management | • Identify children with complex health care needs<br>• Conduct Family Centered Assessment<br>• Develop Individualized Care Plan (ICP)<br>• Establish Comprehensive Care Team<br>• Establish annual training to successfully integrate and sustain comprehensive care teams.<br>• Execute and Monitor ICP<br>• Assess individual readiness to transition to self-directed care maintenance<br>• Monitor individual need to reconnect with Comprehensive Care Team<br>• Evaluate and improve the intervention | RN |

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Well Child Visits, Home Visits and Preventive Care | • Activities related to the Bright Futures Health Promotion themes:<br>  • Promoting lifelong health for families and communities<br>  • Promoting family support<br>  • Promoting health for children and youth with special healthcare needs<br>  • Promoting healthy development<br>  • Promoting mental health<br>  • Promoting health weight, nutrition and physical activity<br>  • Promoting oral health<br>  • Promoting healthy sexual development and sexuality<br>  • Promoting the health and safe use of social media<br>  • Promoting safety and injury prevention<br>• Home visits are universally provided to all newborns and their families at least once.<br>• Gain families' consent to visit<br>• Actively promote positive health-related behaviors and infant caregiving<br>• Discuss measures to reduce family stress by improving its social and physical environments | • Primary care clinician (Physician, PA, APRN) supported by RN, MA, Nutritionist/Dietician, CHW, Lactation Consultant, Developmental Specialist as needed<br>• Home visits are conducted by an RN and CHW<br>• Community Health Team members may also support these functions |

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Behavioral Health Integration | • Brief Behavioral health screenings and initial assessments<br>• Brief interventions, medication management<br>• Interventions in health behaviors<br>• Referrals to extended therapy/counseling, extensive evaluation, medication and higher levels of care (day treatment, partial hospitalization)<br>• Dedicated care coordination across all systems that the child and family work with<br>• Linkages to and coordination with community BH specialists, higher level BH services, behavioral supports (e.g., peer support), developmental services and community resources (e.g., housing) | • Psychologist, APRN, LCSW<br>• Care coordination supported by care team member with expertise addressing the child and adult's BH and social determinants of health needs<br>• Community Health Workers and Community Health Teams support linkages to community services |

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Care Coordination | • Provide separate visits and care coordination interactions<br>• Manage continuous communications<br>• Complete/analyze assessments<br>• Develop care plans (with family)<br>• Identify gaps in care and manage/track tests, referrals and outcomes<br>• Coach patient/family skills learning using motivational interviewing techniques<br>• Integrate critical care information<br>• Support/facilitate all care transitions<br>• Facilitate patient and family-centered team meetings<br>• Use health information technology for care coordination (HIE, EHR)<br>• Coordination with other sites of care and care coordinators, especially schools<br>• Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator | PCP, RN or LCSW<br><br>Community Health Workers and Community Health Teams within the medical home or connected to the medical home support care coordination and community linkages, under the direction of the PCP or Care Coordinator.<br><br>Although patients' family members may choose to take on care coordination roles, patients and families should have access to a qualified Care Coordinator to direct and support these activities. |

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Patient Navigation | • Identify family barriers to accessing care, including insurance related barriers to care, understanding how to use benefits and how benefits can impact decisions regarding choice of provider<br>• Address social determinants of health, emotional, financial, practical, cultural/linguistic and/or family needs<br>• Assist patients with pre-visit planning, getting to appointments, and making follow up appointments<br>• Ensure timely follow up and reduce delays in care throughout the continuum of care for a medical episode<br>• Facilitate communication between providers and patients | Social Worker, Community Health Worker, Community Health Team, Patient Navigator (privately credentialed, specific training) |
| Chronic Illness Self-Management | • Identify the population who will benefit from disease management program<br>• Health or lifestyle coaching and patient education<br>• Promote chronic illness self-management<br>• Develop programs that are culturally diverse and remove barriers<br>• Nutritional education and counseling<br>• Basic screenings and assessments | RN, Dietician, Asthma Educator, Nutritionist, Pharmacist, Community Health Worker, Social Worker, Community Health Team |

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Care Coordination | • Provide separate visits and care coordination interactions<br>• Manage continuous communications<br>• Complete/analyze assessments<br>• Develop care plans (with family)<br>• Identify gaps in care and manage/track tests, referrals and outcomes<br>• Coach patient/family skills learning using motivational interviewing techniques<br>• Integrate critical care information<br>• Support/facilitate all care transitions<br>• Facilitate patient and family-centered team meetings<br>• Use health information technology for care coordination (HIE, EHR)<br>• Coordination with other sites of care and care coordinators, especially schools<br>• Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator | PCP, RN or LCSW<br><br>Community Health Workers and Community Health Teams within the medical home or connected to the medical home support care coordination and community linkages, under the direction of the PCP or Care Coordinator.<br><br>Although patients' family members may choose to take on care coordination roles, patients and families should have access to a qualified Care Coordinator to direct and support these activities. |

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Care Coordination | • Provide separate visits and care coordination interactions<br>• Manage continuous communications<br>• Complete/analyze assessments<br>• Develop care plans (with family)<br>• Identify gaps in care and manage/track tests, referrals and outcomes<br>• Coach patient/family skills learning using motivational interviewing techniques<br>• Integrate critical care information<br>• Support/facilitate all care transitions<br>• Facilitate patient and family-centered team meetings<br>• Use health information technology for care coordination (HIE, EHR)<br>• Coordination with other sites of care and care coordinators, especially schools<br>• Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator | PCP, RN or LCSW<br><br>Community Health Workers and Community Health Teams within the medical home or connected to the medical home support care coordination and community linkages, under the direction of the PCP or Care Coordinator.<br><br>Although patients' family members may choose to take on care coordination roles, patients and families should have access to a qualified Care Coordinator to direct and support these activities. |

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Care Coordination | • Provide separate visits and care coordination interactions<br>• Manage continuous communications<br>• Complete/analyze assessments<br>• Develop care plans (with family)<br>• Identify gaps in care and manage/track tests, referrals and outcomes<br>• Coach patient/family skills learning using motivational interviewing techniques<br>• Integrate critical care information<br>• Support/facilitate all care transitions<br>• Facilitate patient and family-centered team meetings<br>• Use health information technology for care coordination (HIE, EHR)<br>• Coordination with other sites of care and care coordinators, especially schools<br>• Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator | PCP, RN or LCSW<br><br>Community Health Workers and Community Health Teams within the medical home or connected to the medical home support care coordination and community linkages, under the direction of the PCP or Care Coordinator.<br><br>Although patients' family members may choose to take on care coordination roles, patients and families should have access to a qualified Care Coordinator to direct and support these activities. |

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Care Coordination | • Provide separate visits and care coordination interactions<br>• Manage continuous communications<br>• Complete/analyze assessments<br>• Develop care plans (with family)<br>• Identify gaps in care and manage/track tests, referrals and outcomes<br>• Coach patient/family skills learning using motivational interviewing techniques<br>• Integrate critical care information<br>• Support/facilitate all care transitions<br>• Facilitate patient and family-centered team meetings<br>• Use health information technology for care coordination (HIE, EHR)<br>• Coordination with other sites of care and care coordinators, especially schools<br>• Community Health Workers identify social determinants of health needs and link families to services and work with care coordinator | PCP, RN or LCSW<br><br>Community Health Workers and Community Health Teams within the medical home or connected to the medical home support care coordination and community linkages, under the direction of the PCP or Care Coordinator.<br><br>Although patients' family members may choose to take on care coordination roles, patients and families should have access to a qualified Care Coordinator to direct and support these activities. |

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

# PEDIATRIC EXPANDED CARE TEAMS
# Core Care Team Functions

| DOMAIN | TASKS | APPROPRIATE STAFF |
|---|---|---|
| Oral Health | • Oral health screenings for oral health and active conditions<br>• Preventive interventions<br>• Apply fluoride varnish for babies and children birth to 5 years<br>• Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride as appropriate<br>• Communication and education about importance of good oral health and practices to maintain it<br>• Referral to dental home at age one or when first tooth comes in and tracking outcomes. Referral lists should include dentists who work with children with special needs who have sensitivity issues. | • Primary care clinician, RN<br>• Community Health Worker or Community Health Team supports linkage to dental services in the community |

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND