AltaMed Children's Hospital Los Angeles Outpatient General Pediatrics

Pediatric Patient Centered Medical Home for Children with Special Healthcare Needs (CSHCN): A Primary Care Model

Mona Patel, MD, FAAP and Matt Keefer, MD, FAAP

CCS Redesign Stakeholder Advisory Board Meeting

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AltaMed CHLA General Pediatrics

- AltaMed Health Services + Children's Hospital Los Angeles Medical Group – 9/2005
- Community-based, Federally Qualified Health Centered, Outpatient General Pediatrics clinic located within a Tertiary Medical Center
  - >17,000 children (ages 0-24 years)
  - >70,000 patient encounters annually
  - ~90% Medi-Cal insurance
  - >3500 patients in Medi-Cal complex category (SPD)
    - Children with Special Health Care Needs (CSHCN) with 3 or systems involved (Tier 3)
    - ~20% of clinic population (**compared with 3-4% in leading academic centers*)
    - 3/4 of these patients have at least 1 CCS condition

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AltaMed CHLA Pediatric Patient Centered Medical Home for Children with Special Healthcare Needs: Program Review

- Pilot Surveys: September 2009-March 2010 (Dr. Larry Yin)
  - Modified Alameda Risk Assessment Survey Tool
  - *Defined priority*: Children with Special Health Care Needs
- Launch of PPCMH: July 2010
  - 1 physician program director (Dr. Mona Patel)
  - 4 FTE Clinical Care Coordinators 2 RN/2 LVN); 1 FTE MA
- Current enrollees: 882 patient families with CSHCN
- PCMH Program:
  - *Primary care pediatrician refers a family in need of coordination*
  - One hour intake scheduled with each family (Care Plan creation)
    - Initial 10 minutes –self-empowerment; Care plan creation; Goal setting
  - Care plan review q6mo; Phone check-in q3mo; appts as needed
  - M-F 8a-7p access to Case Management; 24 hr./7day access to access to live telephone triage (Licensed nurse/MD) with EMR documentation in patient charts
  - Evaluation: Medical Home Family Index; Provider Surveys

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Role of Coordination of Care

- Primary care coordination: Nutrition, Social Work, Occupational therapy, Physical Therapy, Speech Therapy, Pediatric subspecialists, Community and state agencies, behavioral/mental health, foster system, DME/formula supplies; school systems; inpatient care coordination
- Multidisciplinary Rounds: Biweekly conference with case management team, PMD, nutrition, SW and palliative medicine
- Development of Care Management Score system: Review and create a system based on multifactorial needs of case management to efficiently stratify case coordination needs since resources are limited
  - 6 category scale: Primary care, specialty care; utilization rate; psychosocial factors; agency involvement; DME
  - Algorithm to allocate level of care coordination need for each patient
- IT Coordination: Documentation of visits; calls; referrals; ancillary staff coordination with EMR (tasks); access to inpatient charting, outpatient subspecialty charting/radiology/labs

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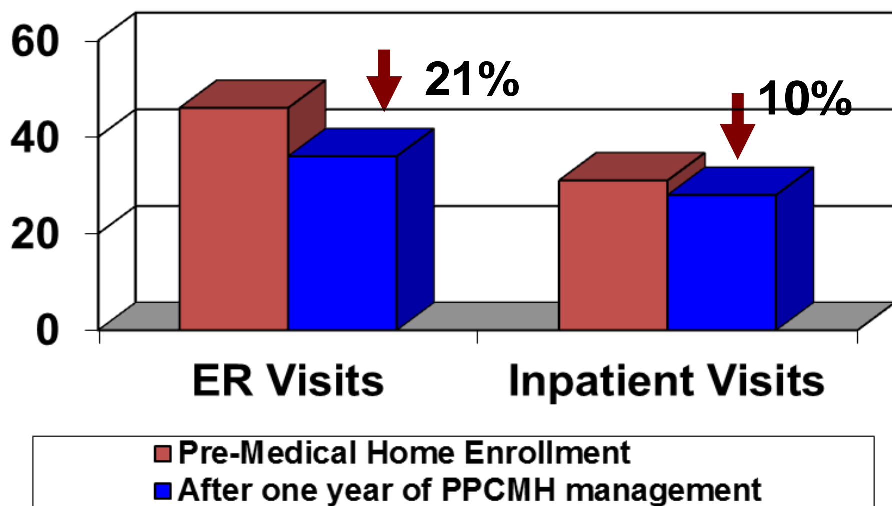
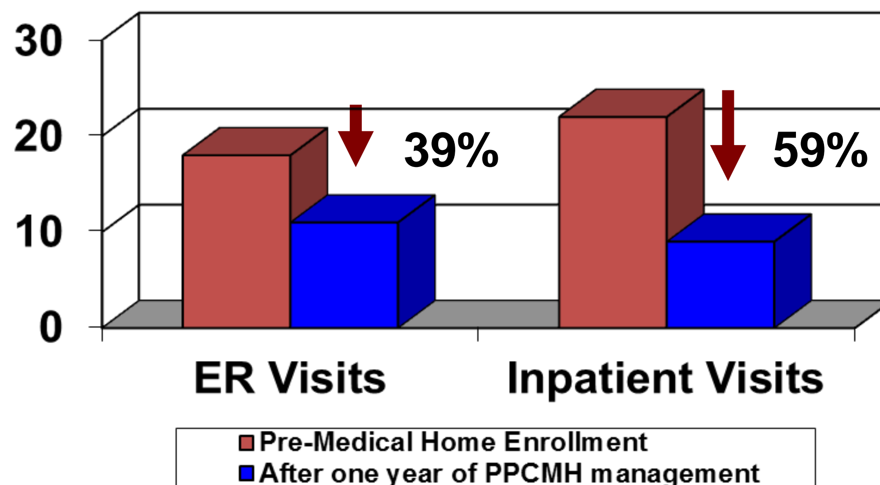
Preliminary Data Review

Reductions in Utilization after one year enrollment into PPCMH



Reductions in Utilization Among the Top 10 Utilizers as a Result of the Medical Home Program*



- *5 year review (1/1/2010 – 12/30/2014): Top Ten Utilizers**
  - *ED Visits: Pre-PCMH: 1.0 ED visit/mo → Post-PCMH: 0.3 ED visit/mo; (*Seizure, GJT malfunction, respiratory distress/cardiac); average 6 subspecialty*
  - *Admissions: Pre-PCMH: 0.43 admit/mo → Post-PCMH: 0.53 admit/mo (*→ most Post-PCMH were unpreventable surgical admits); average 9 subspecialty*

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CCS Redesign Goals

- Implement Patient and Family Centered Approach
  - Patient and Family engagement at every level
- Improve care coordination through an Organized Delivery System
  - True medical home with primary care and subspecialty care provided at same location; integrated resources including behavioral health
- Maintain Quality
  - PCP and specialists are all CCS-paneled and maintain the same level of excellence expected by those caring for this population
- Streamline Care Delivery
  - Large population of patients with CCS, we are very familiar with the CCS system and work closely with the CCS medical directors and nurse managers.
- Build on Lessons Learned
  - Co-pilot with LA CCS; embed and share care coordination resource
- Cost Effective
  - Inclusion of IPA insurance model allows better coordination of referral needs and oversight of utilization patterns

Reproducibility of our PCMH model

- Reproducible at facilities dedicated to taking care of the population that qualifies for CCS who are largely sick and poor
- Challenges in setting up a similar model at sites with limited Medi-Cal exposure

- Urban: Unique connections with CCS-paneled subspecialists
- Rural: Create rural area partnerships with Rural Health Centers (RHCs) to help with funding models

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Summary of Triumphs and Challenges of AltaMed CHLA PCMH

Triumphs

Greatest success: We are an actual medical home where we coordinate primary care, subspecialty care, as well as community resources and mental health

*Care of the whole child and their family rather than qualifying condition which are narrowly defined

*Creation of a central access point for management of complex patients with integrated subspecialty, nutrition, behavioral health, care coordination and primary care

*Offer same services to patients who have exact needs as those who qualify for CCS but do not meet eligibility criteria

* Negotiated FQHC rate to allow model building as low capitation rates in managed care are insufficient to provide care for the complex needs patients

Challenges

*Full and accurate data on utilization patterns to improve our ability to better study costs

*Large geographic area our patients come from since they often have difficulty obtaining services close to their homes

Thank you

- Robert Jacobs, MD, Division Head, General Pediatrics
- Division of General Pediatrics, CHLA
  - Larry Yin, MD
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  - Suzanne Roberts, MD
  - Michelle Thompson, MD
  - Fasha Liley, MD
  - Alexis Deavenport, PhD
- Kathryn Smith, RN, DrPH
- AltaMed Health Services Medical Informatics Team
- Heydeh Khalili, Clinic Administrator
- Care Coordinators:
  - Wendy Parson, LVN
  - Majiney Eulingbourgh, LVN
  - Jose Arreguin, RN
  - Lindsey Nicholsen, RN
  - Gracie Corona, MA
- Multidisciplinary Team
  - Helene Morgan, Palliative Medicine
  - Muriel Barton, SW
  - Nutrition team
  - PPCMH case management team
  - Primary care pediatricians
  - Pediatric Subspecialists

*****Thank you to our patients and families who allow us to care for them*****

mpatel@chla.usc.edu

mkeefer@chla.usc.edu