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
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
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
Preliminary Data Review

Reductions in Utilization after one year enrollment into PPCMH

- 21% reduction in ER Visits
- 10% reduction in Inpatient Visits

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

- 39% reduction in ER Visits
- 59% reduction in Inpatient Visits

• 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
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
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

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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**

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