The Missing Piece:
Medical Homes for California’s Children with Medical Complexity
Overview

- Care for Children with Medical Complexity
- Case Study: AltaMed Children’s Hospital Los Angeles
- Recommendations for a Systems Approach
- PCMH Learning Collaboratives: Primary Care – Title V Partnership
- Discussion about Next Steps
Care for Children with Medical Complexity
Participants

- Lucile Packard Children’s Hospital Stanford
- Mattel Children’s Hospital UCLA
- LA Children’s Hospital (Children’s Hospital of LA)
- Rady’s Children’s Hospital
- Children’s Hospital of Orange County
- UC Davis Children’s Hospital
- Children’s Hospital of Central California
- Miller Children’s Hospital
- Children’s Hospital & Research Center Oakland
- UCSF Benioff Children’s Hospital
- Loma Linda University Children’s Hospital
• 5.8% of all children covered by Medicaid account for 34% of Medicaid spending on children*

About 270,000 Children in California

$3.6 Billion of Medicaid Spending

Interviews with clinic directors and CMOs revealed the most frequently cited issues with current models of care.

<table>
<thead>
<tr>
<th>Barrier and Challenge</th>
<th>Description/Explanation</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Financial models</td>
<td>Fee-for-Service and Relative Value Units system seen as inappropriate</td>
<td>11</td>
</tr>
<tr>
<td>System development</td>
<td>No overarching strategy</td>
<td>9</td>
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<tr>
<td>Care models</td>
<td>Patient-centered medical home/care coordination lacking</td>
<td>9</td>
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<tr>
<td>Data and quality</td>
<td>Relevant real time data needed</td>
<td>6</td>
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<tr>
<td>Mental health</td>
<td>Major issues/lack of providers</td>
<td>6</td>
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<td>Workforce</td>
<td>Lack of providers and training</td>
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Suggested Improvements to Current Models of Care

Through interviews, clinic directors and CMOs suggested new capacities that would be helpful in providing care.

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<thead>
<tr>
<th>Idea</th>
<th>Description/Explanation</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Sufficient Resources</td>
<td>Financial models that support care management, prevention and comprehensive care</td>
<td>9</td>
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<tr>
<td>Care Coordination</td>
<td>Staffing and support for this essential service</td>
<td>7</td>
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<tr>
<td>Patient-Centered Medical Home Model</td>
<td>Development of PCMH as the standard of care</td>
<td>5</td>
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<tr>
<td>Dedicated Clinic/Program</td>
<td>Focused strategy applied</td>
<td>5</td>
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Care Coordination Benefits

• Utilization and Satisfaction Benefits
  – Reduce ED use, hospitalizations and number of hospital days from 30-50 percent¹
  – Improve patient and family satisfaction²

• Financial Savings
  – Comprehensive care reduces total hospital and clinic costs per child ($16,523 vs. $26,781)³

¹ Gordon, 2007; Klitzner, 2010; Leff, 2009, Mosquera, 2014
² Martseller, 2013; Boult, 2013
³ Mosquera, 2014
Case Study: AltaMed Children’s Hospital Los Angeles
AltaMed Children’s Hospital Los Angeles
Outpatient General Pediatrics

Pediatric Patient Centered Medical Home for
Children with Special Healthcare Needs (CSHCN):
Program Review

Mona Patel, MD, FAAP
Medical Director
January 6, 2015
• **Children’s Hospital Los Angeles + USC Keck School of Medicine**
  
  – Academic General Pediatrics and Subspecialty Care
  – Teaching facility—Subspecialty fellowships, Pediatric residency and Medical student education

• **AltaMed Health Services**
  
  – Largest Federally Qualified Health Center in US
  – Serves >81,000 children <0-18yrs
  – Mix of pediatricians, family practitioners and mid-level providers (PA) providing pediatric care in the community of Los Angeles
• FQHC model started September 2005

• >70,000 patient encounters annually
• >17,000 children (ages 0-24 years)
• ~90% MediCal insurance
• >3500 patients in MediCal 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)
  – 1/3 of these patients have at least 1 CCS condition
AltaMed CHLA Pediatric Patient Centered Medical Home for Children with Special Healthcare Needs

- **Priority**: Children with Special Health Care Needs
- **Pilot Surveys**: September 2009-March 2010 (Dr. Larry Yin)
  - Modified Alameda Risk Assessment Survey Tool
- **Launch of PPCMH**: July 2010
  - 1 physician program director (Dr. Mona Patel)
  - 4 full time Clinical Care Coordinators (with 2 RN case managers)
  - 1 full time Medical Assistant
- **Current enrollees**: 824 patient families with CSHCN
  - One hour intake scheduled with each family (Care plan creation)
    - Initial 10 minutes - self-empowerment
    - Care plan creation
    - Goal setting
  - Follow up at least every 6 months (or more depending on situation); 3 month follow up phone calls
  - M-F 8a-7p access to Case Management
Patient and Family are seen by their Pediatrician

The Family contacts their assigned coordinator who works with the Pediatrician for all patient needs

A Referral is made to PPCMH based on Family’s Needs/Request—Modified Alameda Risk Assessment Completed

Primary Care Based Model for CSHCN

An individual care plan is created and All About Me notebook is created

The Clinical Care Coordinator contacts the family and schedules a one hour intake appointment
Role of Coordination of Care

- **Coordination of care:** Nutrition, Social Work, Occupational therapy, Physical Therapy, Speech Therapy, Pediatric subspecialists, Community and state agencies, behavioral/mental health, foster system, DME/formula supplies; inpatient care coordination

- **Multidisciplinary Rounds:** Biweekly conference with case management team, PMD, nutrition, SW and palliative medicine

- **Development of Care Management Score system:**

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<thead>
<tr>
<th>Category</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
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<tbody>
<tr>
<td><strong>Primary Medical Care</strong></td>
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<td><em>Well child visits</em></td>
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<td><em>Immunizations</em></td>
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<td><em>Developmental Screening</em></td>
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<td><strong>Subspecialty Medical Care</strong></td>
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<td><em>Management of diagnosis</em></td>
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<td><em>Coordination of subspecialty</em></td>
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<td><strong>Acute Care</strong></td>
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<td><em>Hospitalizations</em></td>
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<td><em>ED visits</em></td>
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<td><em>Readmissions</em></td>
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<td><em>Clinic Visits</em></td>
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<td><strong>Psycho-Social</strong></td>
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<td><em>Home environment</em></td>
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<td><em>Parental understanding of complex care</em></td>
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<td><em>Socioeconomic Issues/FSP involvement/DMH</em></td>
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<td><em>POLST</em></td>
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<tr>
<td><strong>Agency (CCS, Insurance, DCFS, School system, Regional Center)</strong></td>
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<tr>
<td><strong>Equipment (DME, Formula, Incontinence supplies, etc)</strong></td>
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Reductions in Utilization after one year enrollment into PPCMH

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

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

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

- Ten (10) patients in the analysis accounted for 70% and 72% of all ER and inpatient admissions (respectively)

- Among this group, ER visits were reduced by 39% in the first year of the medical home and inpatient admissions were reduced by 59% in the first year of the medical home
Evaluation of our PPCMH program

• **Family Feedback: Medical Home Family Index**

  “The service given to my family is great”

  “The case coordinator is always there for us”

  “A great program that helps me get care for my child”

  “My care manager is an angel-- a person that uses heart and her personality demonstrates this”

• **Provider Feedback:**

  “I love the medical home program - it really helps my patient’s families”

  “I think that Medical Home has been a valuable service for our patients, especially with those who have significantly complex medical problems with multiple specialty needs. Majiney and Wendy are a joy to work with, and they are always willing to help whenever possible, even if they are busy with another task at the time”

  “The program has been wonderful to help with the management of our complex patients. We clearly need several more case managers in order to serve our patients and providers more completely”

  “This is arguably the most comprehensive, successful, helpful ongoing care program we have in our clinic...We all love Majiney and Wendy. Their commitment to patients is impeccable and should be rewarded”
Future of PPCMH at AltaMed CHLA

• Tiered system of care—review and create system based on multifactorial needs of case management including risk assessments
  – Efficient stratification of case management since resources are limited

• AltaMed Corporate office MI (medical informatics) team assisting with financial data on ED visits and inpatient hospitalizations
  • Drs. Patel, Keefer, Yin, Jacobs and Deavenport writing collaborative paper on our complex PPCMH model and ED/Inpatient Utilization

• Continue surveys of families and staff to help modify program/ expansion of case management hours; review results

• Development of parenting skills classes integrated with Promotora model of care
  – Identified strong family advocates to help guide families in care of children with complex needs
Thank you

- Matt Keefer, MD, Deputy Division Head and Head of AltaCHLA IPA
- Robert Jacobs, MD, Division Head, General Pediatrics
- Division of General Pediatrics, CHLA
  - Larry Yin, MD
  - Alex Van Speybroeck, MD
  - 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
Recommendations for a Systems Approach
Model of Care for Children with Medical Complexity

A Medical Home for Children with Medical Complexity

- Data & Quality
- Financial Policy and Models
- Models of Care
- CSHCN & Complex Care
- Workforce Development
- State & Federal Policy
- System Design & Regionalization
- Mental Health
Regional Systems as a Model of Care

Patient Centered Medical Home
- Specialty Care Network
- Regional CMC Primary Care Clinics
- Primary Care Network

Patient
- Care Coordination
- Population Medicine

Children’s Hospital
- Research & Development
- Quality and Performance Improvement

Community Resources
- Health Plan
PCMH Learning Collaboratives: Primary Care – Title V Partnership
Iowa’s CSHCN Program

- University of Iowa
- State of Iowa
- MCHB
- Phase 1- Expert
- Phase 2- One on one coaching
- Phase 3- Collaboratives
LC Content

PCMH Content

- Standardization
- Project Management
- Variation
- Rapid Cycle Change
- PCMH 101
- Quality and Outcome
- Care Coordination
- Population Health
Timeline

- JAN
- FEB
- MAR
- APR
- MAY
- JUNE
- JULY
- AUG
- SEPT
- OCT
- NOV
- DEC

FACE TO FACE DIDACTIC

COACHING CALLS

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Discussion and Questions

Contact Information
Jeff Lobas, MD, EdD: jlobas@ithc.org (949) 706-7511
Laura Kramer, MPP Candidate: lkramer@ithc.org (612)414-6966
Mona Patel, MD, FAAP: mpatel@chla.usc.edu (323)361-2990