

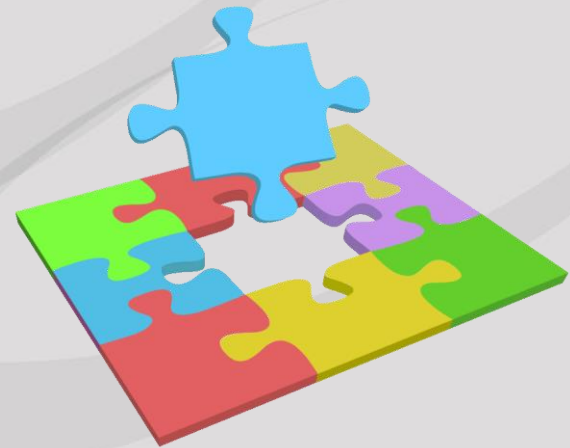


ITH Institute for Transforming
HealthCare LLC



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



Children with Medical Complexity on Medicaid

- 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



Issues & Barriers with Current Models of Care

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

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



Suggested Improvements to Current Models of Care

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

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



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; Boulton, 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

Background Information



- 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

AltaMed CHLA General Pediatrics

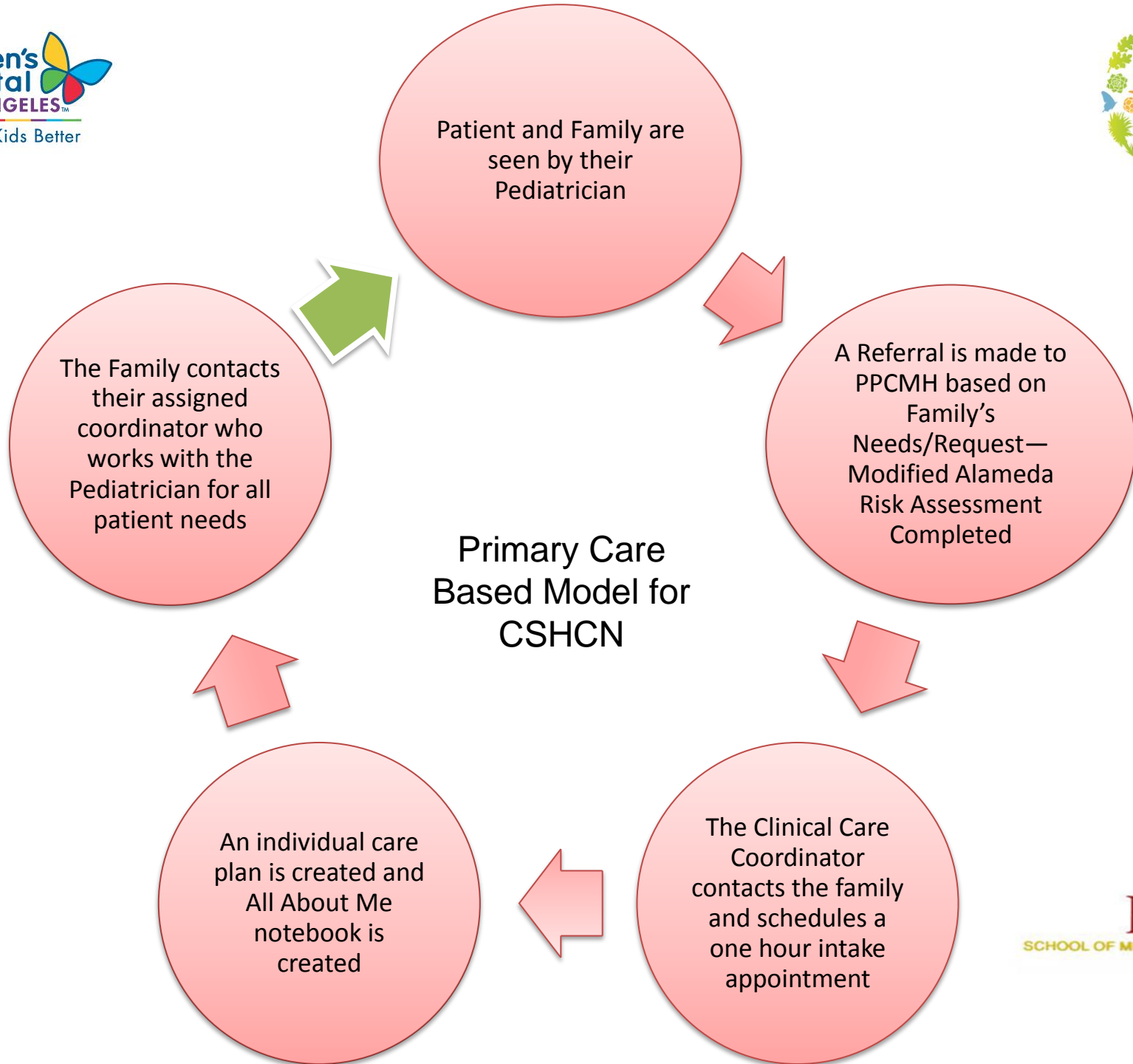


- FQHC model started September 2005
- >70,000 patient encounters annually
- >17,000 children (ages 0-24 years)
- ~90% MediCal insurance
- >3500 patients in MediCal complex category (SPD)
 - Children with Special Health Care Needs (CSHCN) with 3 or systems involved (Tier 3)
 - ~20% of clinic population (**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



Role of Coordination of Care



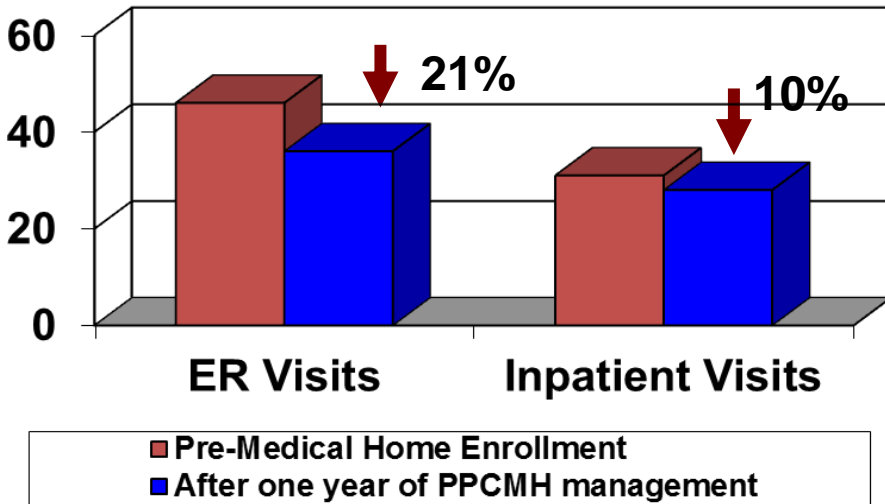
- **Coordination of care:** Nutrition, Social Work, Occupational therapy, Physical Therapy, Speech Therapy, Pediatric subspecialists, Community and state agencies, behavioral/mental health, foster system, DME/formula supplies; inpatient care coordination
- **Multidisciplinary Rounds:** Biweekly conference with case management team, PMD, nutrition, SW and palliative medicine
- **Development of Care Management Score system:**

	Level 1	Level 2	Level 3
Primary Medical Care *Well child visits *Immunizations *Developmental Screening	1		
Subspecialty Medical Care *Management of diagnosis *Coordination of subspecialty		2	
Acute Care *Hospitalizations *ED visits *Readmissions *Clinic Visits	1		
Psycho-Social *Home environment *Parental understanding of complex care *Socioeconomic Issues/FSP involvement/DMH *POLST	1		
Agency (CCS, Insurance, DCFS, School system, Regional Center)	1		
Equipment (DME, Formula, Incontinence supplies, etc)		2	

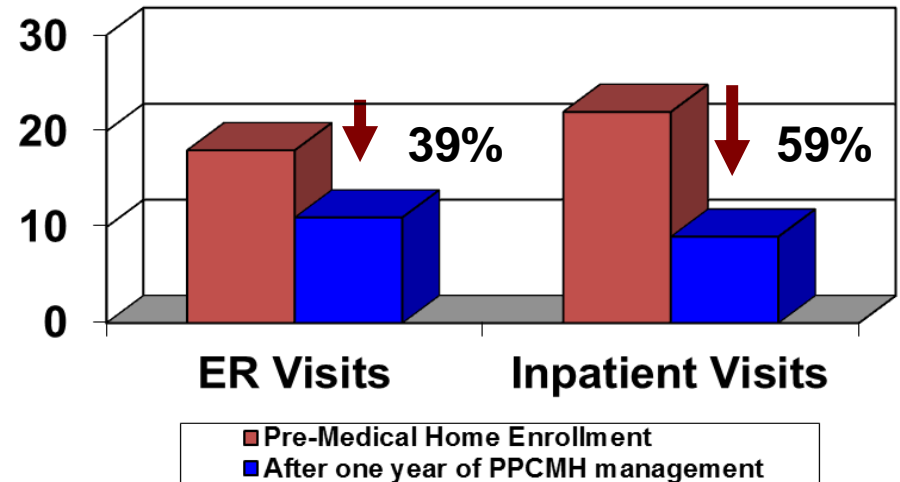
Preliminary Data Review



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*



- *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:

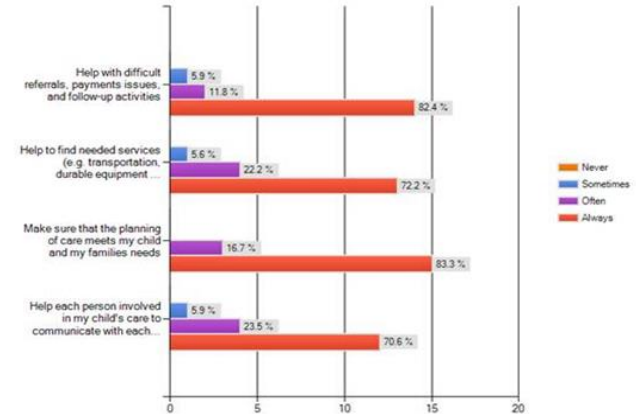
“I love the medical home program - it really helps my patient’s families”

“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”

My PCP has a staff person(s) or a “care coordinator” who will:



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



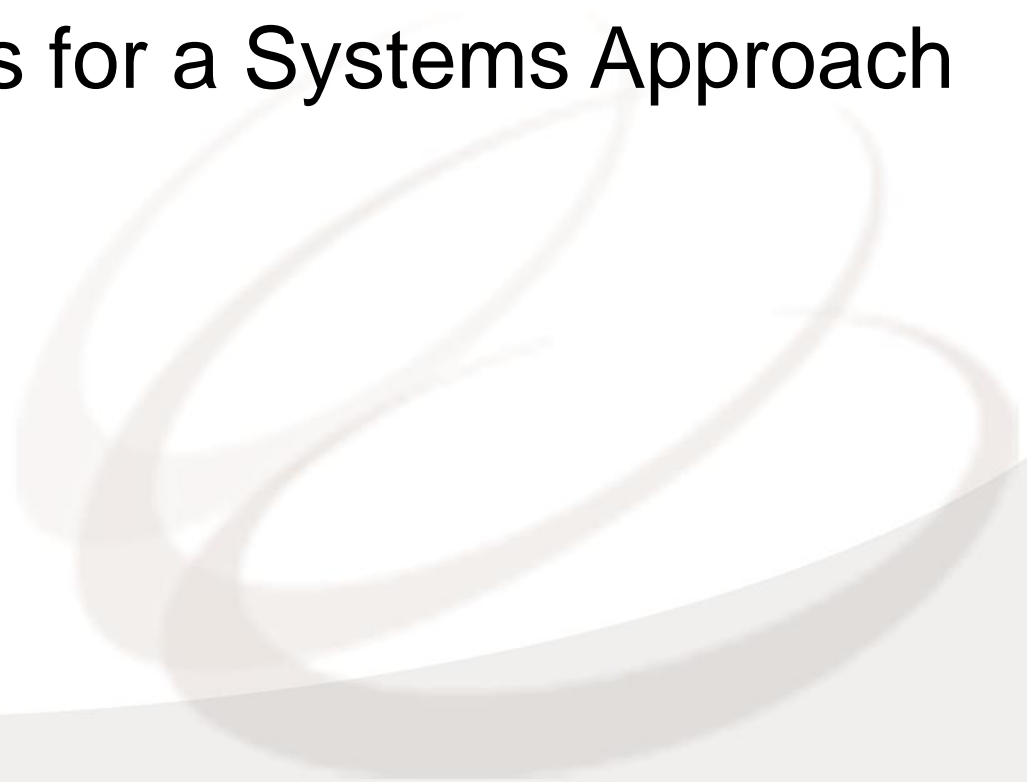
- Matt Keefer, MD, Deputy Division Head and Head of AltaCHLA IPA
- Robert Jacobs, MD, Division Head, General Pediatrics
- Division of General Pediatrics, CHLA
 - Larry Yin, MD
 - Alex Van Speybroeck, MD
 - Suzanne Roberts, MD
 - Michelle Thompson, MD
 - Fasha Liley, MD
 - Alexis Deavenport, PhD
- Kathryn Smith, RN, DrPH
- AltaMed Health Services Medical Informatics Team
- Heydeh Khalili, Clinic Administrator
- Care Coordinators:
 - Wendy Parson, LVN
 - Majiney Eulingborough, LVN
 - Jose Arreguin, RN
 - Lindsey Nichol森, 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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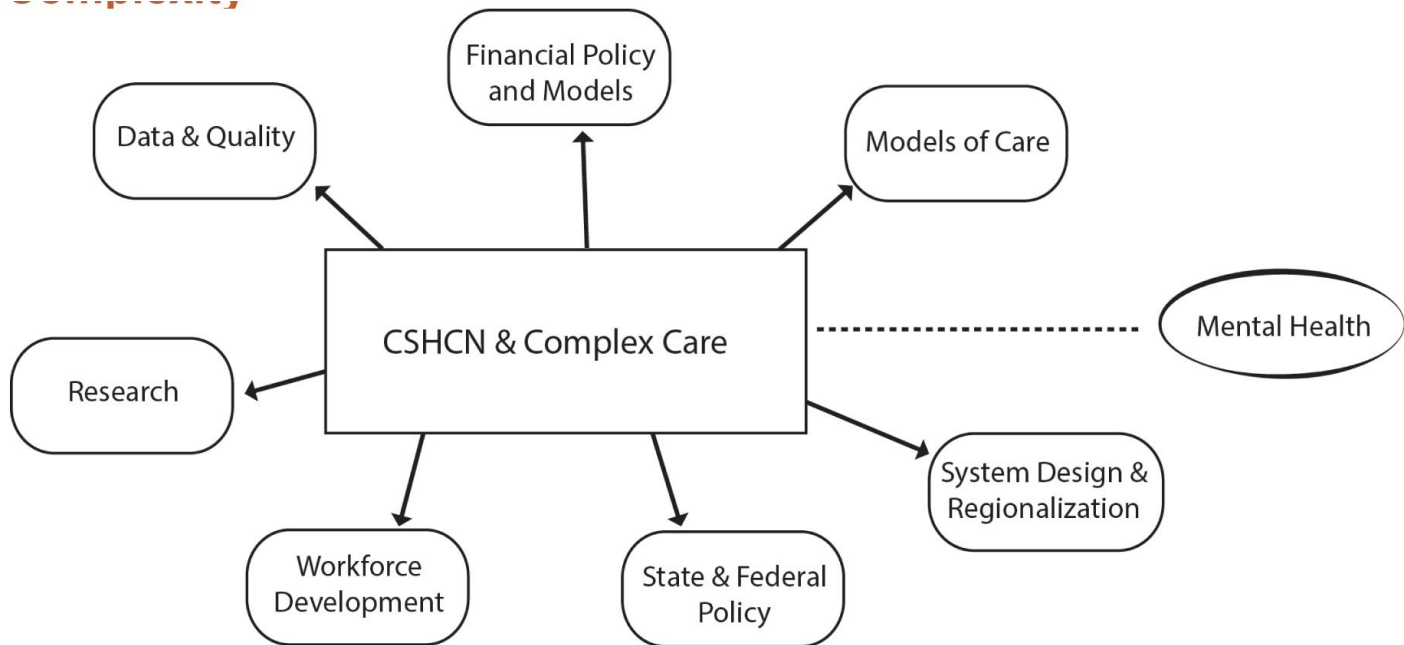
Recommendations for a Systems Approach





Model of Care for Children with Medical Complexity

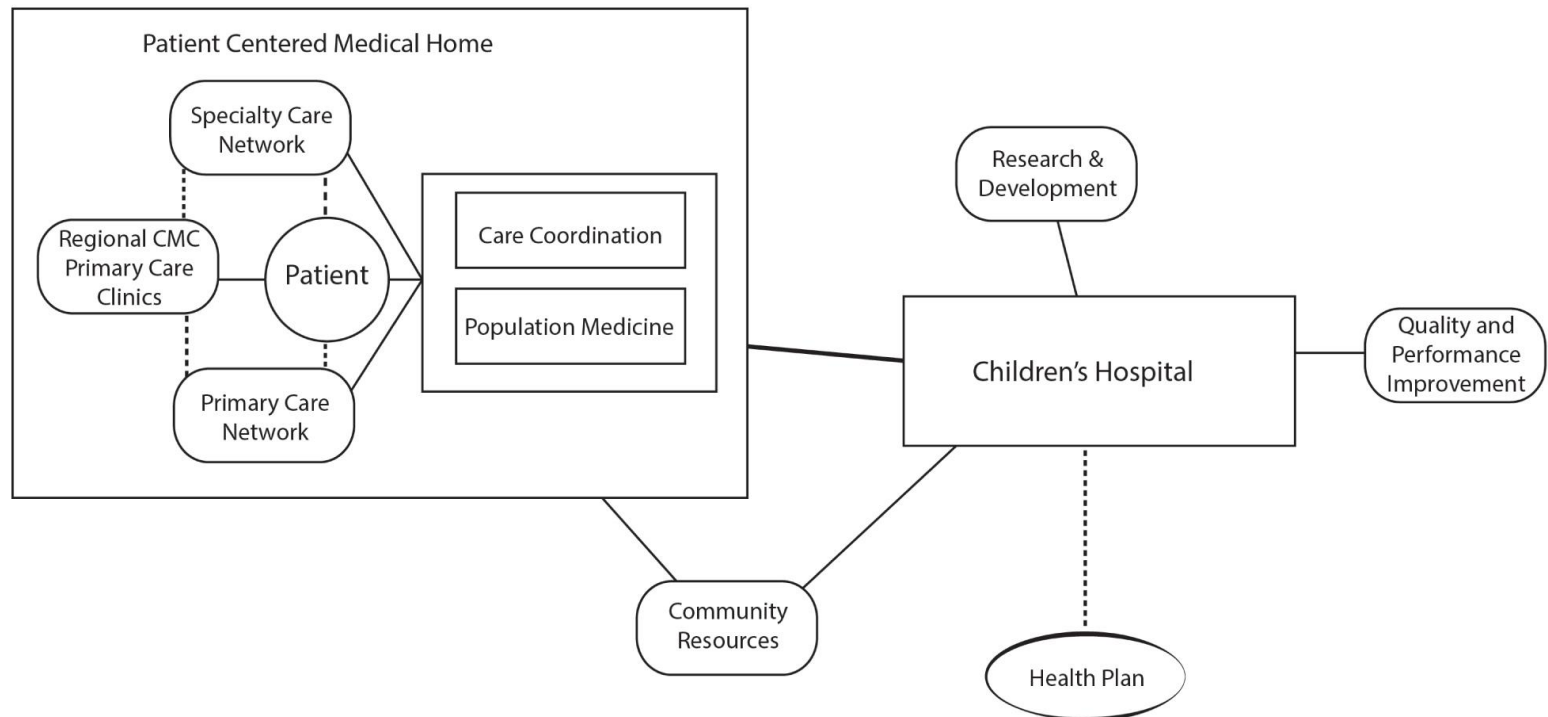
A Medical Home for Children with Medical Complexity





A Systems Approach

Regional Systems as a Model of Care





PCMH Learning Collaboratives: Primary Care – Title V Partnership

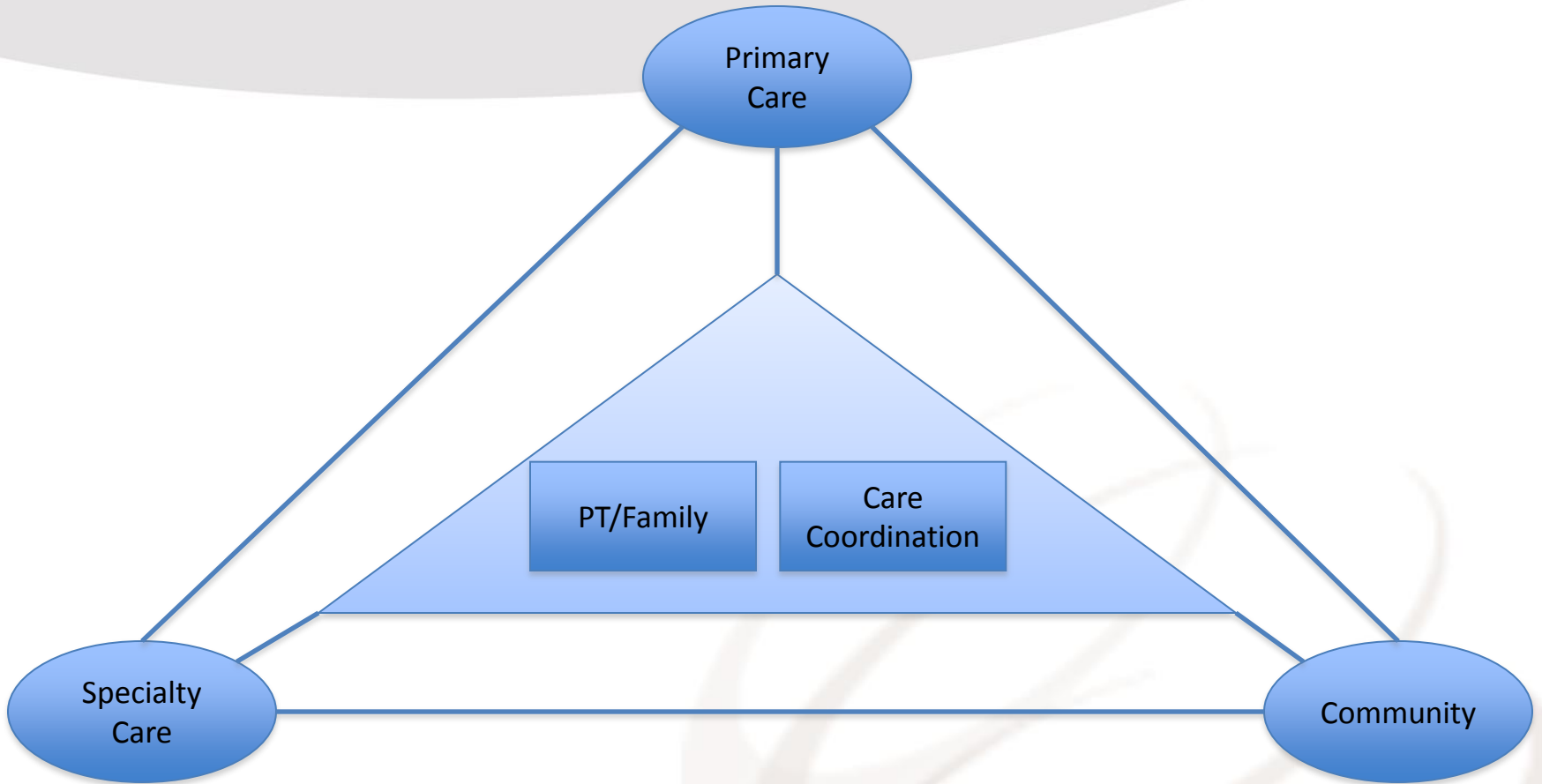


Iowa's CSHCN Program

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



Medical Home



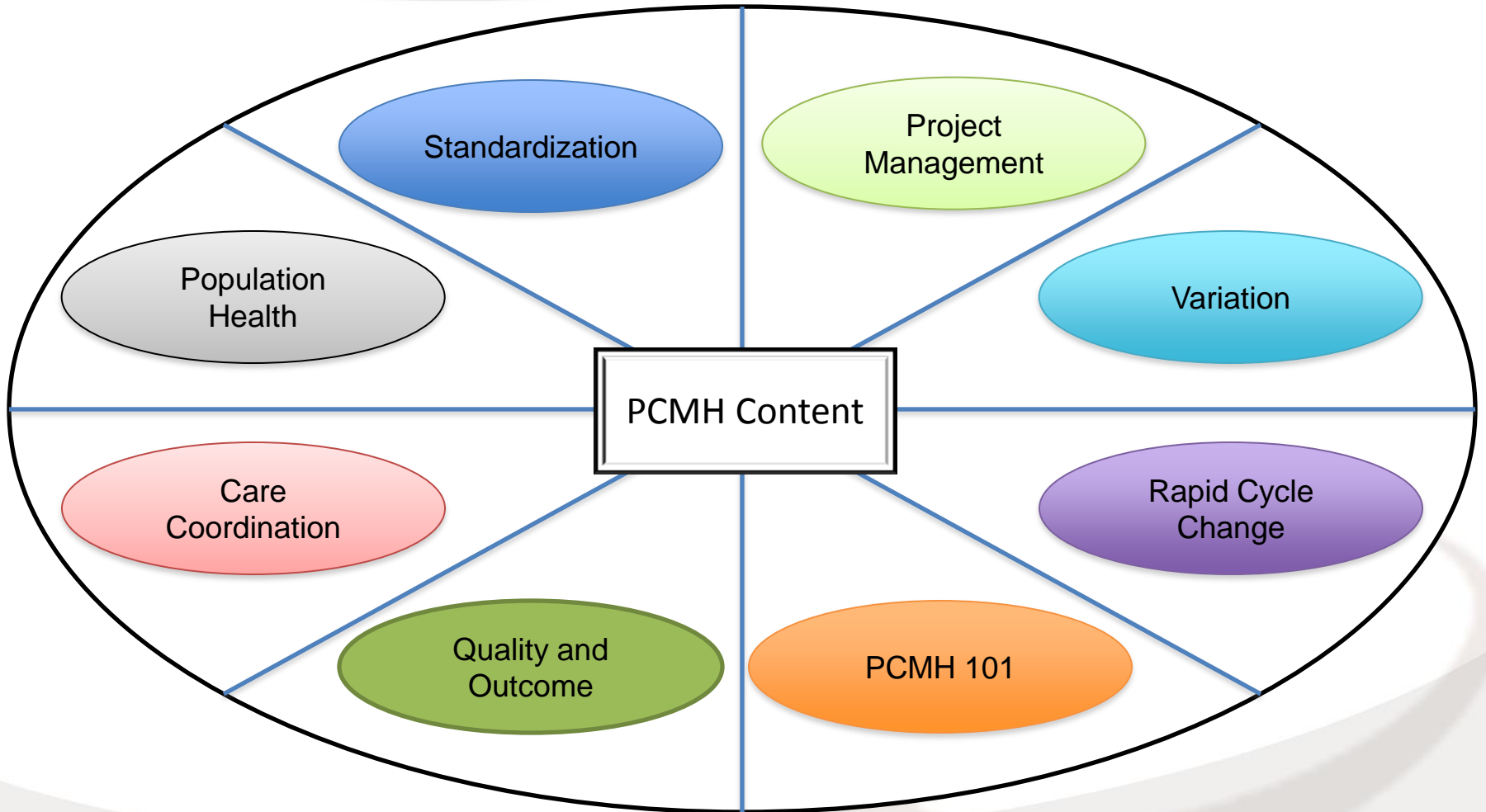
Quality and Population Analytics

Financial Model

Governance

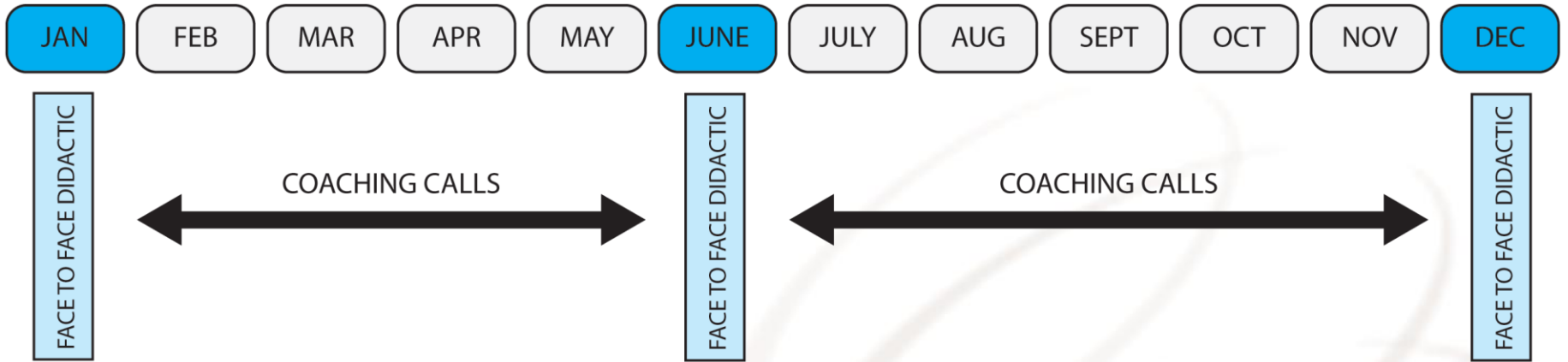


LC Content





Timeline





Discussion and Questions

Contact Information

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