AN ACADEMIC MEDICAL CENTER BUILDS A MEDICAL HOME FOR THE SAFETY NET

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Faculty Disclosure

• Mark Weissman, MD has no financial relationships or conflicts to disclose relating to the subject matter of this presentation.
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Washington DC: A Tale of Two Cities

An Academic Medical Center
Builds a Medical Home for the Safety Net
A *Washington Post* analysis of the latest census data shows that more than one third of ZIP codes in the DC metro area rank in the top 5% nationally for income and education.
Washington DC landscape

- DC population: 650,000
  - 1 million during the day
- DC children 0-18 years: 111,000+
- DC Medicaid enrolled children (0-20): 97,000+ *

A Different DC Perspective

• 27% of DC’s children live in poverty
  • 29% children live in areas of concentrated poverty
  • 16% live in extreme poverty

• 42% of DC’s children live in households that lack secure employment
  • 55% in single parent homes

• 2132 (19/1000) children annually reported victims of maltreatment (2013)

• 22% of children live with food insecurity
## DC: Median Income of Families With Children

<table>
<thead>
<tr>
<th>Location</th>
<th>2000</th>
<th>2010</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 1</td>
<td>$38,400</td>
<td>$48,800</td>
<td>$61,133</td>
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<tr>
<td>Ward 2</td>
<td>$47,300</td>
<td>$105,600</td>
<td>$185,878</td>
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<tr>
<td>Ward 3</td>
<td>$195,400</td>
<td>$192,400</td>
<td>$219,921</td>
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<tr>
<td>Ward 4</td>
<td>$74,800</td>
<td>$72,300</td>
<td>$76,141</td>
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<tr>
<td>Ward 5</td>
<td>$44,400</td>
<td>$25,200</td>
<td>$49,730</td>
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<tr>
<td>Ward 6</td>
<td>$39,500</td>
<td>$86,200</td>
<td>$110,753</td>
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<tr>
<td>Ward 7</td>
<td>$33,500</td>
<td>$31,800</td>
<td>$32,178</td>
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<td>Ward 8</td>
<td>$27,000</td>
<td>$26,700</td>
<td>$24,442</td>
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</table>

Data Provided by: DC Action for Children
A Zip Code Should Not Determine A Child’s Future
### Infant Death Rate (per 1000 live births), By Race

<table>
<thead>
<tr>
<th>Location</th>
<th>Race</th>
<th>Data Type</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Columbia</td>
<td>All Races</td>
<td>Rate</td>
<td>7.4</td>
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<tr>
<td></td>
<td>White, Non-Hispanic</td>
<td>Rate</td>
<td>1.5</td>
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<tr>
<td></td>
<td>Black, Non-Hispanic</td>
<td>Rate</td>
<td>11.7</td>
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<tr>
<td></td>
<td>Hispanic</td>
<td>Rate</td>
<td>5.2</td>
</tr>
<tr>
<td></td>
<td>Other, Non-Hispanic</td>
<td>Rate</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Community Care: Then & Now

- Founded 1870: Civil War “foundlings”
- 1950: First “well baby” clinic
- Today- largest primary care provider for children in the District of Columbia
Children’s National Health System: Primary Care

- Children’s National Health System is Washington, DC’s children’s hospital and regional health system for children
- Goldberg Center for Community Pediatric Health
  - Dedicated Center of Excellence
  - Operates 7 primary care health centers at main campus and underserved neighborhoods across DC and mobile health program
  - All recognized as NCQA Level 3 PCMH (2011 and 2014)
- Almost 40,000 attributed patients
  - Largest primary care provider and largest primary care provider for children in DC
  - 100,000 annual visits and growing
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Children’s National: Medical Home to DC’s Most Vulnerable Children

- “Medical Home” is not a place-better way of delivering care
- Team-based care
- Puts patient at the center of the health care system
- Provides primary care that is:
  - Accessible
  - Comprehensive
  - Coordinated
  - Culturally effective
  - Continuous
  - Family-centered
  - Compassionate
- Coordinated with community partners and resources
Building the 21st century Medical Home
“Medical Home” : Origin in Pediatrics

- AAP: “Every Child Deserves a Medical Home” (1978)
  - Calvin Sia, MD (AAP)
- CSHCNs ⇒ All children
- Medical Home expands to all Primary Care
  - Endorsed by AAP-AAFP-ACP
  - Emerging as payment model to achieve “triple aim”
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Think differently about patients and population
Expand focus beyond individual patient
Manage care & cost outcomes for ALL patients

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From teaching clinic to medical home

• Historic academic “teaching clinic” model
  • Evolved based on priorities & needs of:
    • Faculty
    • Residents, students & other learners
    • Nursing & hospital administration
  • NOT needs of patients & families
Rationale for PCMH redesign

• It’s the RIGHT thing to do!
  • For our patients and families
  • For modeling and training the next generation of healthcare providers

• Aligns our practice with emerging models for primary care delivery and reimbursement

• Building the primary care practice of the future as we plan, design, and move into a new ambulatory environment
  • New practice facility design
Challenges for our Academic Practice

Patient Demographics
• 15% of children live with head of household without HS diploma; 50% with head of household have high school diploma
• 77% of fourth grade public school children do not read at level*
• 1550 children in the district are in foster care

Medicaid payment
• 85-90% Medicaid enrolled through Managed-Care Organizations
  • ~10% commercial or uninsured
• No immediate state or payer incentives for PCMH transformation or NCQA certification

Staffing Model
• Mixed model: attending and resident
• 67 faculty (attending physicians)
• >60 resident trainees cycle through each year
• Hospital siloes: Medical/physician, nursing, administration/operations
Continuity

**Challenge:** Establishing continuity in a mixed staffing model (intermittently present faculty and residents)

- Focus on care teams, pods & team-based care

- Smaller practice sites and teams can establish continuity more easily
- Larger sites with rotating providers/residents have a greater challenge defining and documenting continuity
  - Faculty/preceptor-resident continuity teams
- Helping families understand the “academic model” of care
  - “Why do so many people come into my visit?”
  - “What is a teaching hospital?”
- Allowing families to decide who is their PCP; encouraging them to tell us
  - “Families are the captain of the ship”
Redesigning the pediatric academic medical home
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Enhanced Academic Medical Home Blueprint

ENHANCED “MEDICAL HOME”
(Will build to suit - No “clinics” allowed - NCQA PCMH recognized)

Enhanced Primary Care (10,000 – 12,000 patients)
Small practice team focus/accountability + large center resources/efficiency

Small Practice Team
(5000-6000 Patients)
3-4 FTE
Providers
4 Residents/Day
(20 Residents/Week)

Community Health Support Services
Social Work
Health Education
Care Coordination
Parent Navigators
Family Help Desk
Children’s Law Center
WIC

Clinical Programs
Adolescent Generations (Teens & Tots)
Complex Care (CSHCN)
ImpactDC (Asthma)
Obesity
Specialty:
Developmental Peds
Sickle Cell Program
Sports Medicine

Small Practice Team
(5000-6000 Patients)
3-4 FTE
Providers
4 Residents/Day
(20 Residents/Week)

CO-LOCATE: LAB, RADIOLOGY, DENTAL, BEHAVIORAL HEALTH, URGENT CARE?

Goldberg Center “Call Center” ⇒ Advanced Health Management Center
Appointments, Triage/Advice, Refills, Results, Referrals, Outreach/Reminders/Clinical Compliance
Care Coordination, Patient Education and Self-Management, Disease Management
Technology enabled: eCW Web Portal (Required for EMR Meaningful Use Funding)

FTE = full-time equivalent; WIC = Women, Infants, and Children; CSHCN = Children with Special Health Care Needs; eCW = eClinicalWorks; EMR = electronic medical records.
Commitment at all levels

- PCMH Recognition incorporated into the strategic plans for Children’s National Health System and the Goldberg Center for Community Pediatric Health- leaders, managers, faculty, staff
- Primary care faculty and management incentive goals
- Build into education & training curriculae for students, residents & fellows
- Dedicated PCMH project team
  - PCMH champions at each primary care site
    - Physician, nursing, administrative managers aligned
    - Defined & protected meeting times
- Established at QI/learning collaborative model across all practices
Leveraging improvement tools

- Quality Improvement expertise & infrastructure embedded in academic faculty division
- Prioritize Quality Improvement
  - QI methodologies for implementing change
    - Learning collaborative
    - LEAN
      - Identifying “value” for families, care team, and learners
- Transparent benchmarking, run charts, dashboards for all centers/providers
- On-going patient experience surveys

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Family experience & engagement

**Challenge:** Going beyond patient satisfaction surveys

- We established a robust survey process for ongoing family feedback
  - Over 10,000 surveys collected within the past 5 years
  - Monthly reports targeted goals and interventions
- We gather qualitative feedback
  - Suggestion box
  - Exit surveys
  - Rounding
- Parent partners actively participated in all PCMH project meetings
Primary Care Patient Satisfaction

Timely Access

- Able to get an appointment for checkups
- Able to make same day appointments when sick or hurt
- The office hours work for me
- Phone calls get through easily
- I get called back quickly
- Able to get medical advice when the office is closed
- Length of time waiting at our practice

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Primary Care Patient Satisfaction
Wait Times

LONG WAITS: WAITING ROOM, EXAM ROOM, IMMUNIZATIONS LEAN REDESIGN, POD TEAMS, ADDED MA's & RN's

Able to get an appointment for checkups
Able to make same day appointments when sick or hurt
The office hours work for me
Phone calls get through easily
I get called back quickly
Able to get medical advice when the office is closed
Length of time waiting at our practice
Primary Care Patient Satisfaction
Overall- likely to recommend

- 92% yes
- 6% yes
- 2% yes

- >95% WOULD RECOMMEND!
PCMH NCQA Application Project Timeline

Planning and Implementation Phase
Timeline September 2010 through January 2011

- 9/8 Kick Off Meeting
- 9/10 - 9/10 Pre-Site-Visit Reconciliation Meetings at Individual Centers
- 10/12 Chart Review Cycle 1 Due
- 11/12 Chart Review Cycle 2 Due
- 12/12 Chart Review Cycle 3 Due
- 1/12 Chart Review Cycle 4 Due

NCQA PCMH "Gap Analysis" 9/1 - 10/1
Policy/Procedure Development Workflow Redesign and Standardization Pilot Implementation 10/1/10 - 1/1/11
Critical PCMH Redesign Changes Must Be Developed & Successfully Implemented by Early January 2011

Tracking and Implementation Phase
Timeline January 2011 through June 2011

- February Data Run #1 Due
- March Data Run #2 Due
- April Data Run #3 Due

90-Day Continuous Documentation January - April
Final Edits to Application April - May
Submit PCMH Application for All Centers by End of FY11
PCMH Results: NCQA Recognition

- All seven primary care practice locations received NCQA PCMH Level III Recognition in 2011- and again in 2014
  - Continuous: re-submission planned for 2017
- Only pediatric practices in DC NCQA PCMH III
- CAVEAT: Medical Home transformation is ongoing
- NCQA recognition is (mostly) useful framework & metric for organizational change

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Social Determinants of Health

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Adverse childhood experiences (ACEs)
Chronic adverse childhood experiences are “toxic” & yield poor health and life outcomes.
Primary Care at Children’s National:  
Signature Programs & Services for Vulnerable Populations

- WIC (Supplemental Food Program)
- Social Worker(s)
- Health Leads (Project Health-Community Resources/Referrals)
- Children’s Law Center (Legal Aid for Health, Housing, Education)
- Reach Out and Read (Early Literacy)
- Behavioral/Mental Health (co-located psychologists, psychiatrists)
- IMPACT DC (Community Asthma)
- IDEAL Clinic (Obesity)
- Oral Health: Pediatric Dentistry
- Children’s Health Project (Mobile Health- 3 vans)
- Child & Adolescent Protection Center (Abuse & Neglect)
- Complex Care Program (Medical Home & Care Coordination for CSHCNs)
- Parent Navigators (Children with Special Health Care Needs)
- CSHCN Care Coordinators
- Healthy Generations (Teen Parents & Infants Program)
- HIV Services (Burgess Clinic) (Adolescent Medicine)
- Youth Pride (LGBTQ) Clinic (Adolescent Medicine)

Supported primarily through grants & philanthropy
Care Coordination for medically complex children (CSHCN’s)
Parent Navigators

- Parent navigators provide peer-to-peer guidance and support for families of CSHCNs in our primary care medical homes & Complex Care Program
  - Employees of CNHS
  - Partially supported through state (DC & MD) grants
- Active members of Medical Home practice redesign and management teams
Community Health is population health
Old & New: Medical Homes & Pediatric Population Health

- Annual well-child exams
  - EPSDT screening, immunization rates
  - Adolescent & reproductive health
- ED utilization for low acuity non-emergent (LANE) concerns
- Chronic disease management: asthma, obesity
- Mental health screening & co-located services
- Children with special health care needs
  - Children with medical complexity (CMC)
  - Parent navigators
- Leveraging technology & telemedicine
Integrating Mental Health into Primary Care Medical Home

- 1 in 5 children have MH concern in childhood- often under recognized and addressed
- Co-locating psychiatry (PT) and psychology into all primary care settings
- Training and coaching all pediatric providers city-wide
  - Mental Health & ACE screening
  - Initial evaluation & referral
  - Management of common behavioral concerns
- DC MAP: Psychiatry Access Line for PCP’s
- Coordination with early child care & schools
ED2MH: Emergency Department to Medical Home

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Key ED2MH Interventions

- Negotiated enhanced payments and incentives from Medicaid Managed Care Organizations
- Implemented extended hours at primary care health centers (evenings and Saturdays)
- Offered scheduled appointments in extended hours for all visit types
- Acute illness, well-child care, follow-up and chronic disease management, influenza vaccination, immunizations
- Introduced and reinforced extended hours and medical home
Bus Stops Across SE DC

Evening and weekend hours available.


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ED2MH: Early Bending of Curve

First two years ED2MH experience:
• Overall primary care visits increased 10%
• 15-20% of primary care visits now in extended hours (evenings & Saturdays)
• Overall ED utilization by Medical Home patients down 5%
• Still high utilization for low acuity concerns
Re-imagining patient engagement

• Today’s toddlers are tech savvy
  • Almost 96% of 1 year olds use mobile device by 1\textsuperscript{st} birthday
  • Most 2 year olds use mobile device daily
  • Most 3 – 4 year olds use devices without help; 1 in 3 multi-task
  • Studied inner city population
Patient engagement

Flu vaccines

Make sure **Michaela** gets the flu shot this year at our Flu Clinic this Thursday 12/11 at Children’s Health Center at THEARC. Call us now at 202-436-3060 to schedule an appointment.

“Pollen busters”

Spring Pollen is coming. Don’t wheeze or sneeze. Call Children’s Health Center for an appointment or refill. We now have evening and Saturday appointments! 2024363060
Telemedicine extends Medical Home

- Technology moving faster than medicine
- Patients are connected to friends & family…
- Patients and student learners are teaching our medical teams
Medical Homes & Academic Centers: Lessons learned

- Even academic centers can implement and teach change
  - Medical Home model can be implemented successfully in academic settings
  - Children’s National: ongoing journey to redesign primary care delivery and training of current & next generation of pediatric health care providers
- Improved care delivery can generate more volume & revenue to support academic Medical Home model
  - FFS revenue shifting to value/population based payment
- Train next generation:
  - Best care for individual patients & families
  - Medical Home model & team-based care
  - Community and population health models- increased focus on community & social determinants of health
- Challenges continue: particularly re-imagining primary care/Medical Home curriculum and clinical training models that balance family-centered needs and needs of educators/learners
Contact information

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