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

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Faculty Disclosure

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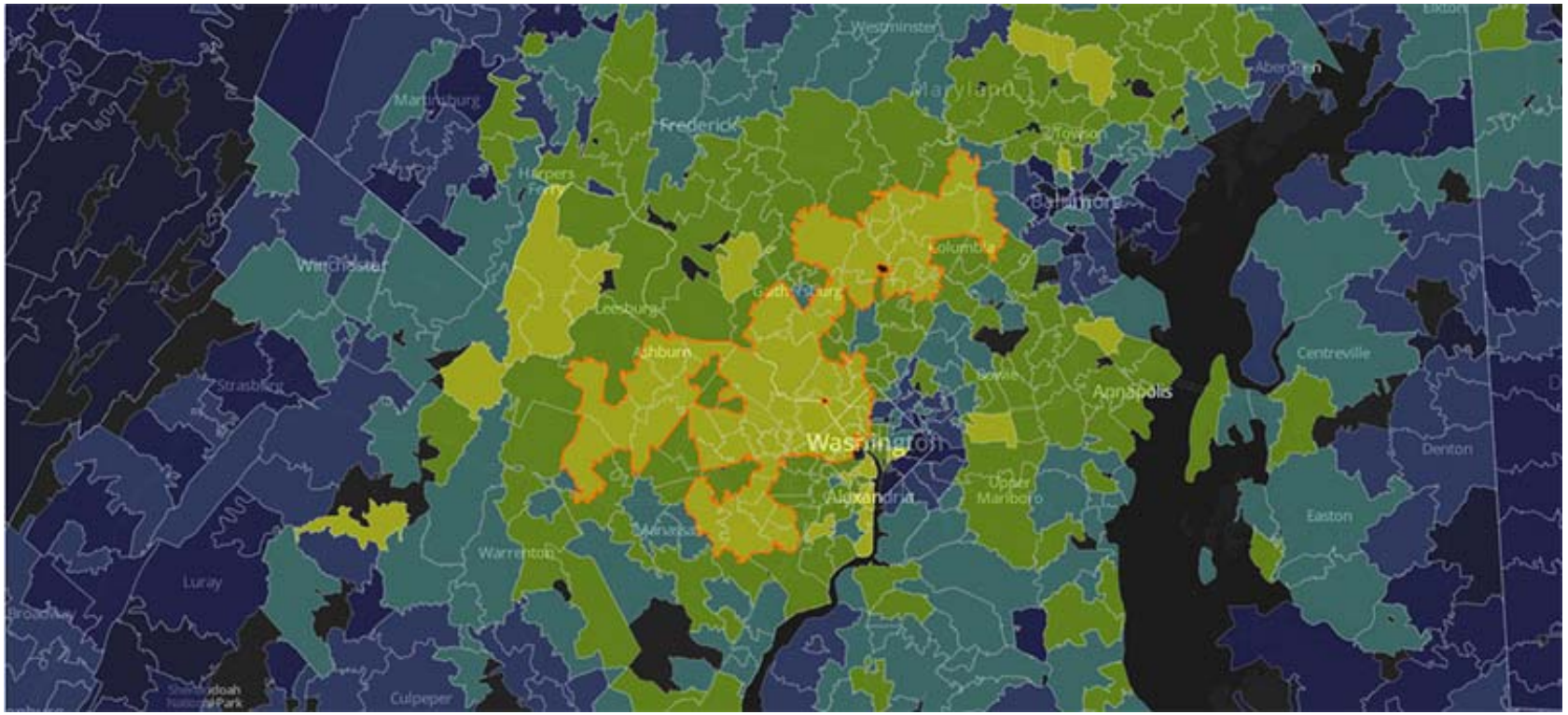
Washington DC: A Tale of Two Cities

Super Zip Codes: Washington DC Region #1



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

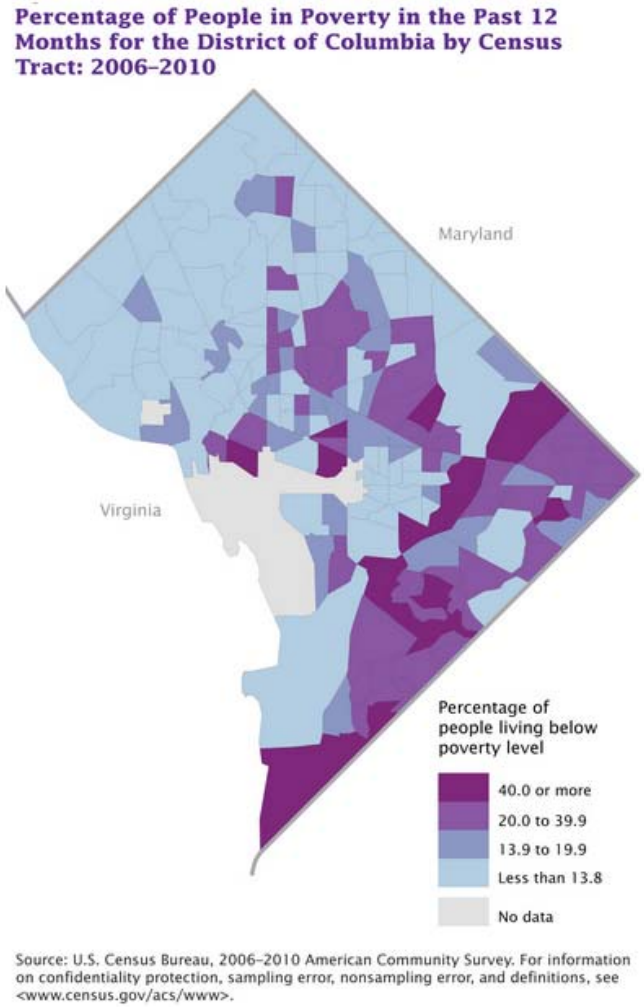
Washington DC landscape

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

Source: United States Census Bureau, State and County Quick Facts ,District of Columbia. http://quickfacts.census.gov/qfd/states/11000.html
*DC Department of Healthcare Finance, Data Snapshot – Children's Coverage. http://dhcf.dc.gov/node/791852

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

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

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

Location	Race	Data Type	2011
District of Columbia	All Races	Rate	7.4
	White, Non-Hispanic	Rate	1.5
	Black, Non-Hispanic	Rate	11.7
	Hispanic	Rate	5.2
	Other, Non-Hispanic	Rate	5.0

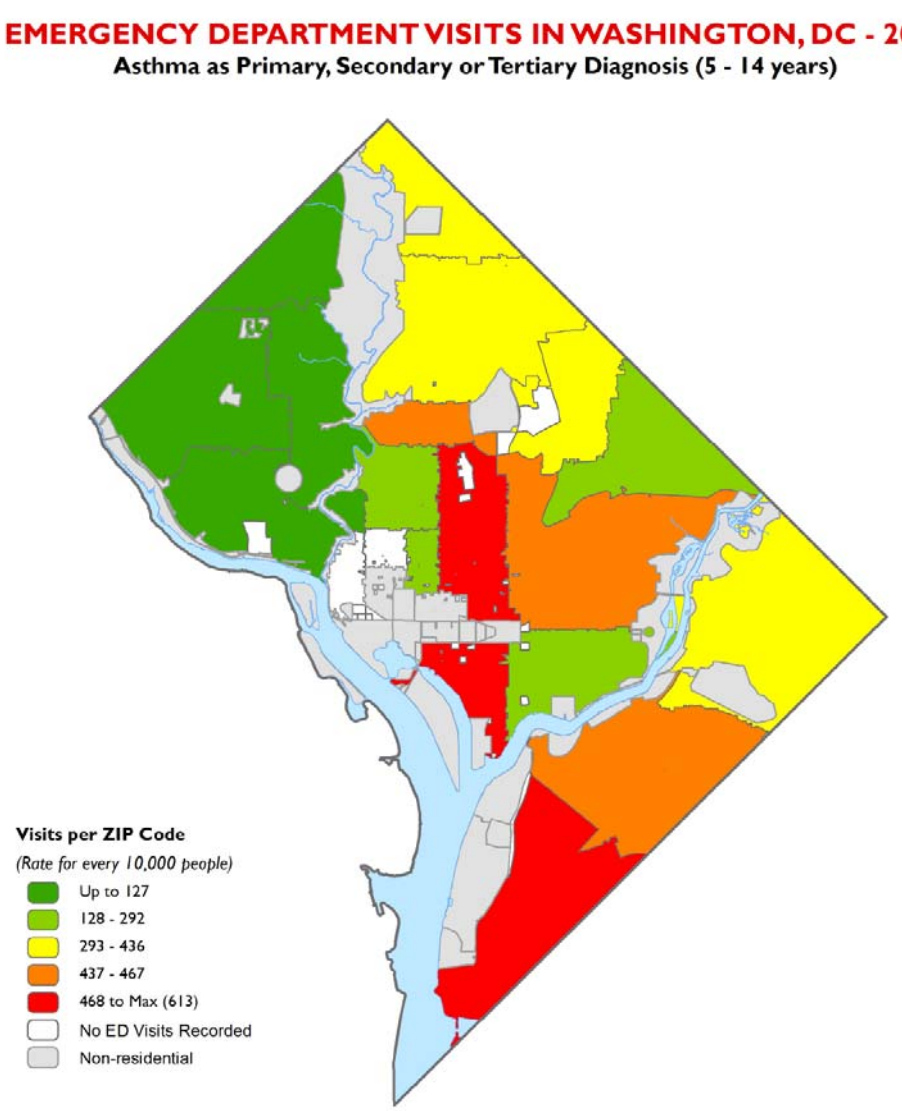
Children's Hospital of the District of Columbia

Community Care: Then & Now

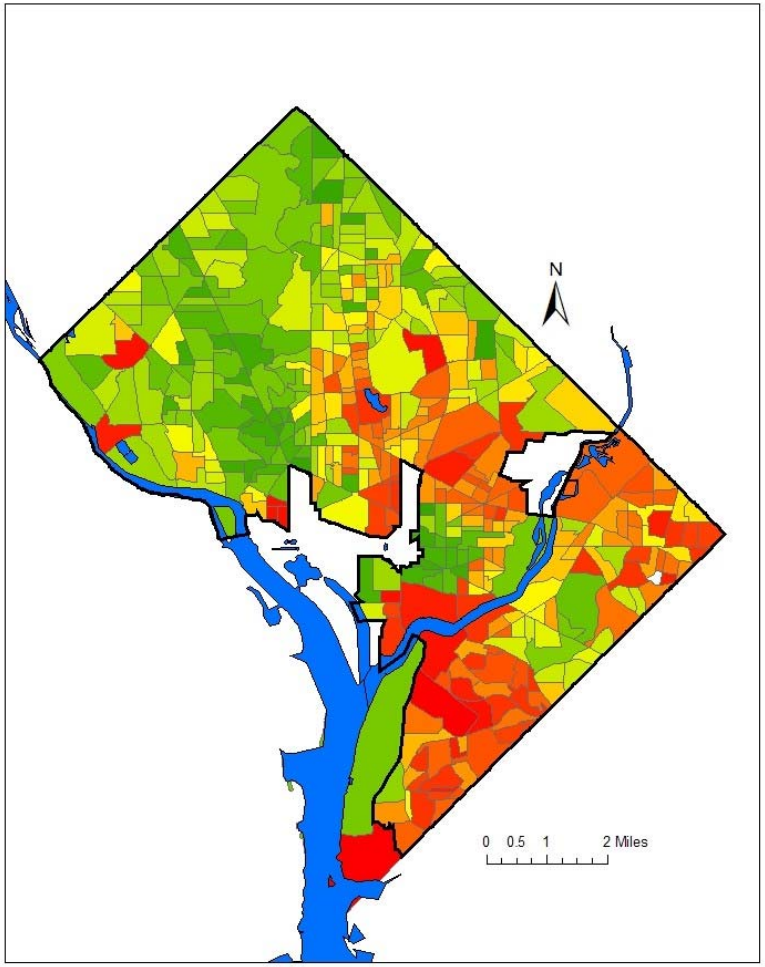
- Founded 1870: Civil War "foundlings"
- 2015: U.S. News and World Report "top 10" children's hospital
- 1950: First "well baby" clinic
- Today- largest ***primary care*** provider for children in the District of Columbia

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



Poverty in DC, 2000



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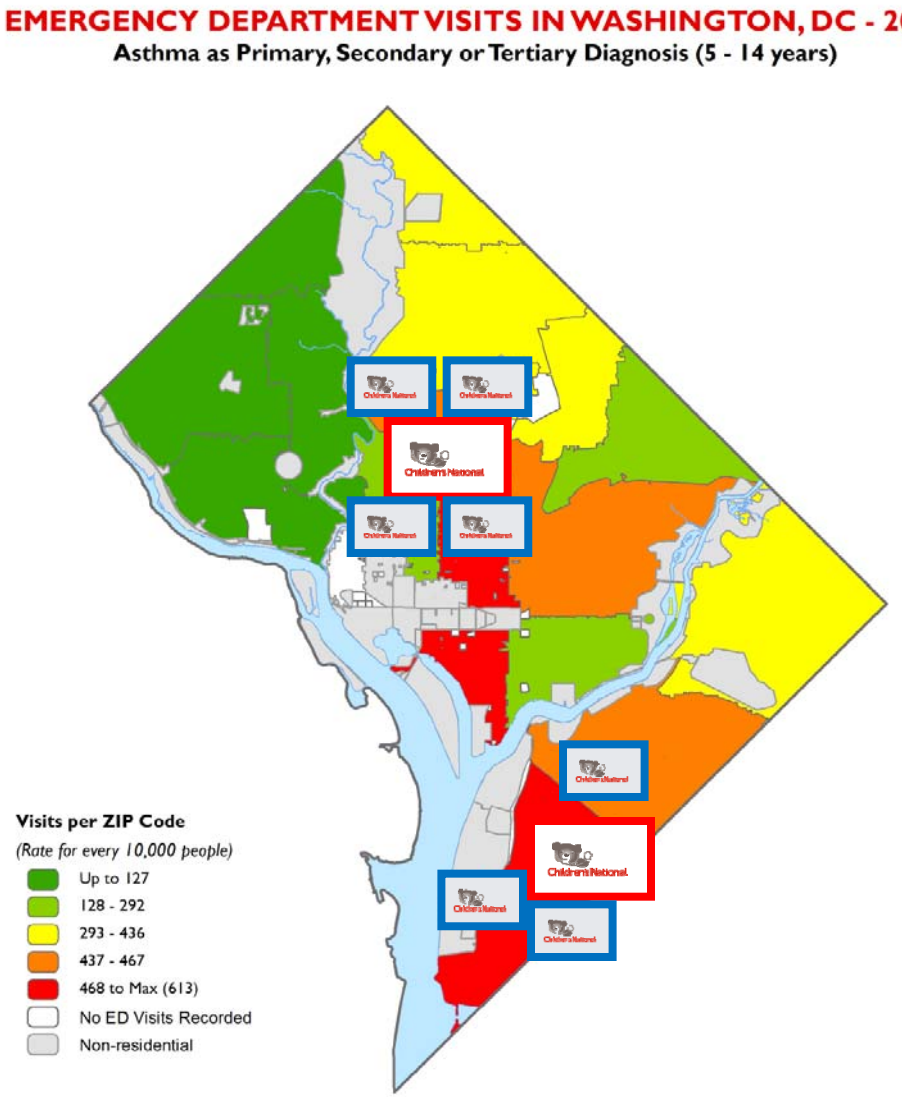
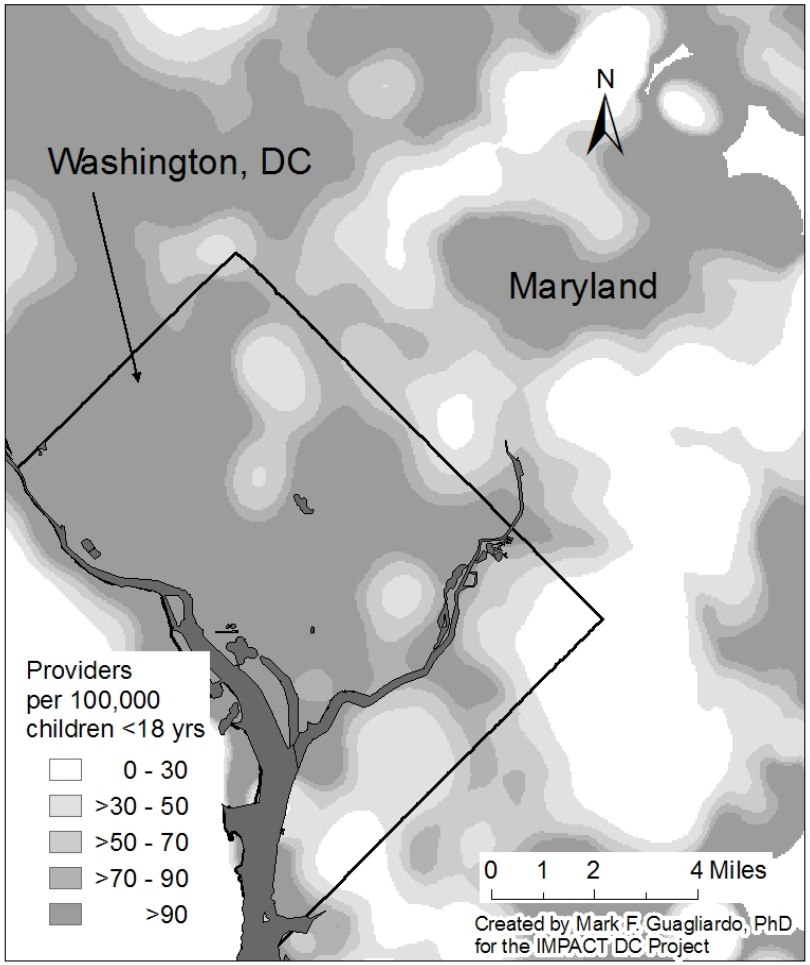
An Academic Medical Center
Builds a Medical Home for the Safety Net



Primary Care Access, 2005



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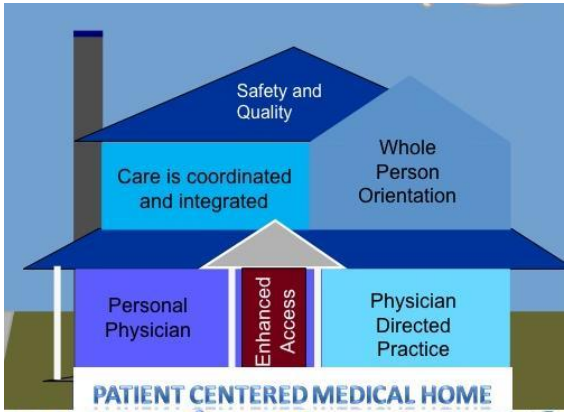
Children's National: Medical Home to DC's Most Vulnerable Children

- **"Medical Home" is not a <u>place</u>- better <u>way</u> 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**

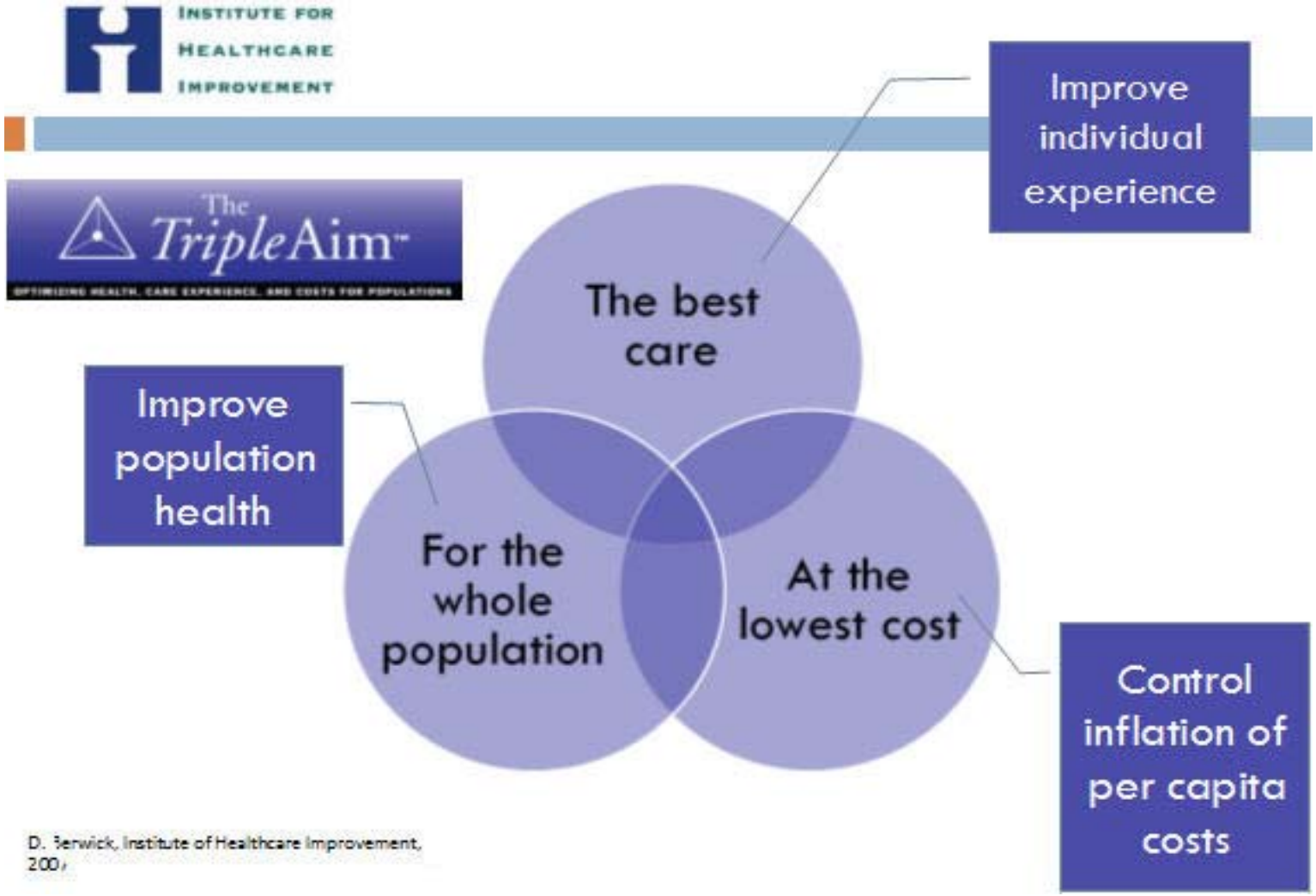
Building the 21st century Medical Home

“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”



Triple Aim Requires New Academic Model



Think differently about patients and population

Expand focus beyond individual patient

Manage care & cost outcomes for ALL patients

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

Enhanced Academic Medical Home Blueprint

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

Small Practice Team	Community Health Support Services	Clinical Programs	Small Practice Team
(5000-6000 Patients) 3-4 FTE Providers 4 Residents/Day (20 Residents/Week)	Social Work Health Education Care Coordination Parent Navigators Family Help Desk Children's Law Center WIC	Adolescent Generations (Teens & Tots) Complex Care (CSHCN) ImpactDC (Asthma) Obesity **Specialty:** Developmental Peds Sickle Cell Program Sports Medicine	(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.

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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

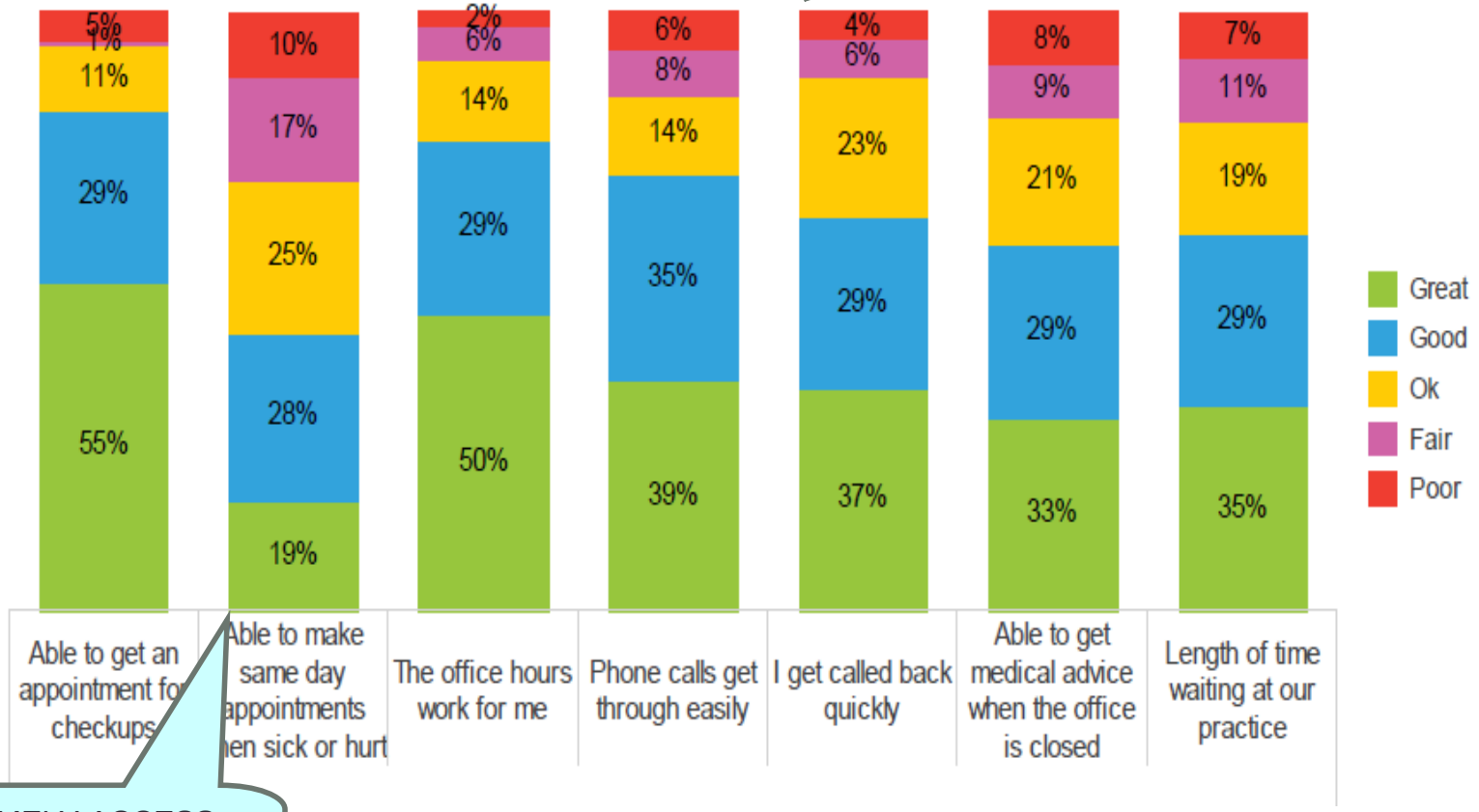
Family experience & engagement

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 Satisfac
Timely Access

EXT HOURS & ADVANCED CALL CENTER:
ADD APPTS, CENTRALIZED ADVICE NURSES



TIMELY ACCESS FOR ADVICE OR APPTS

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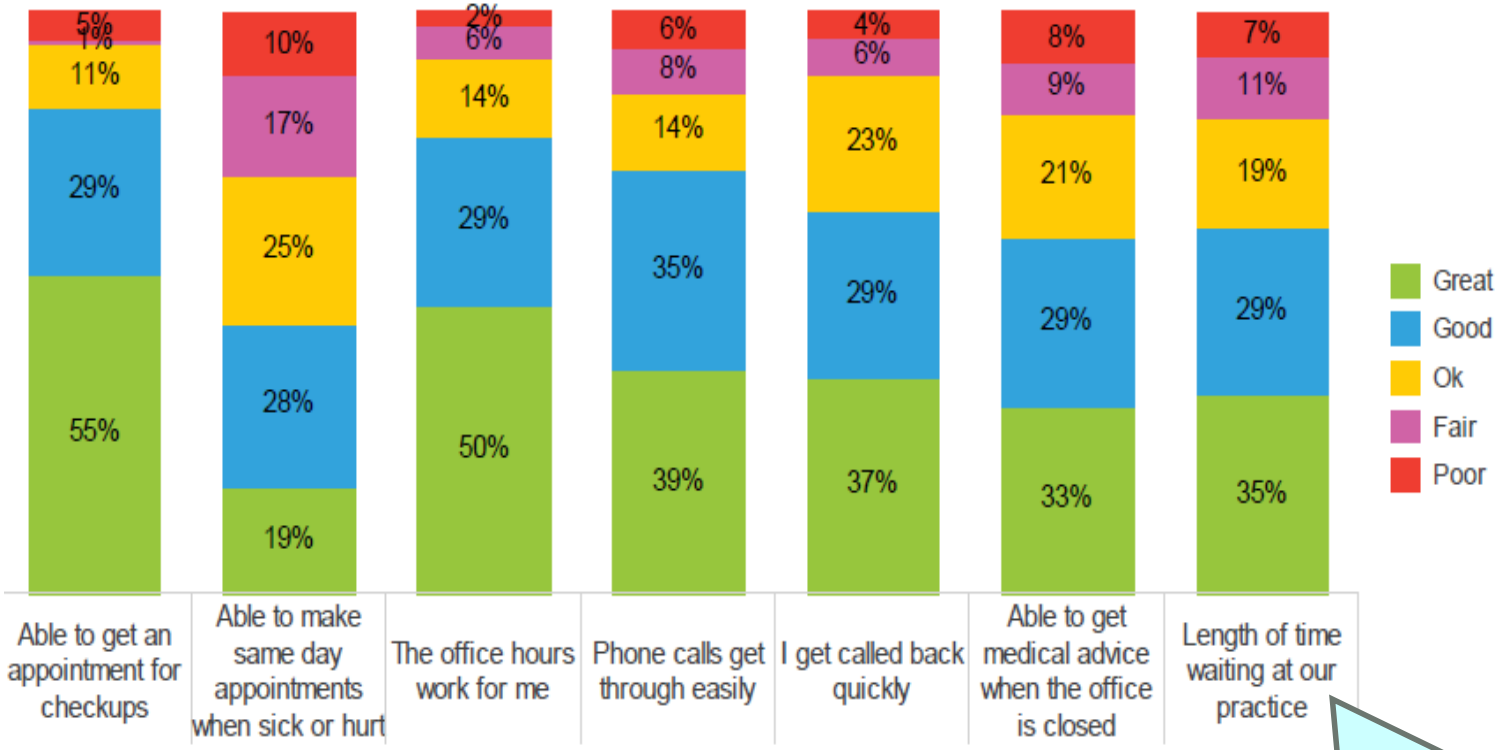
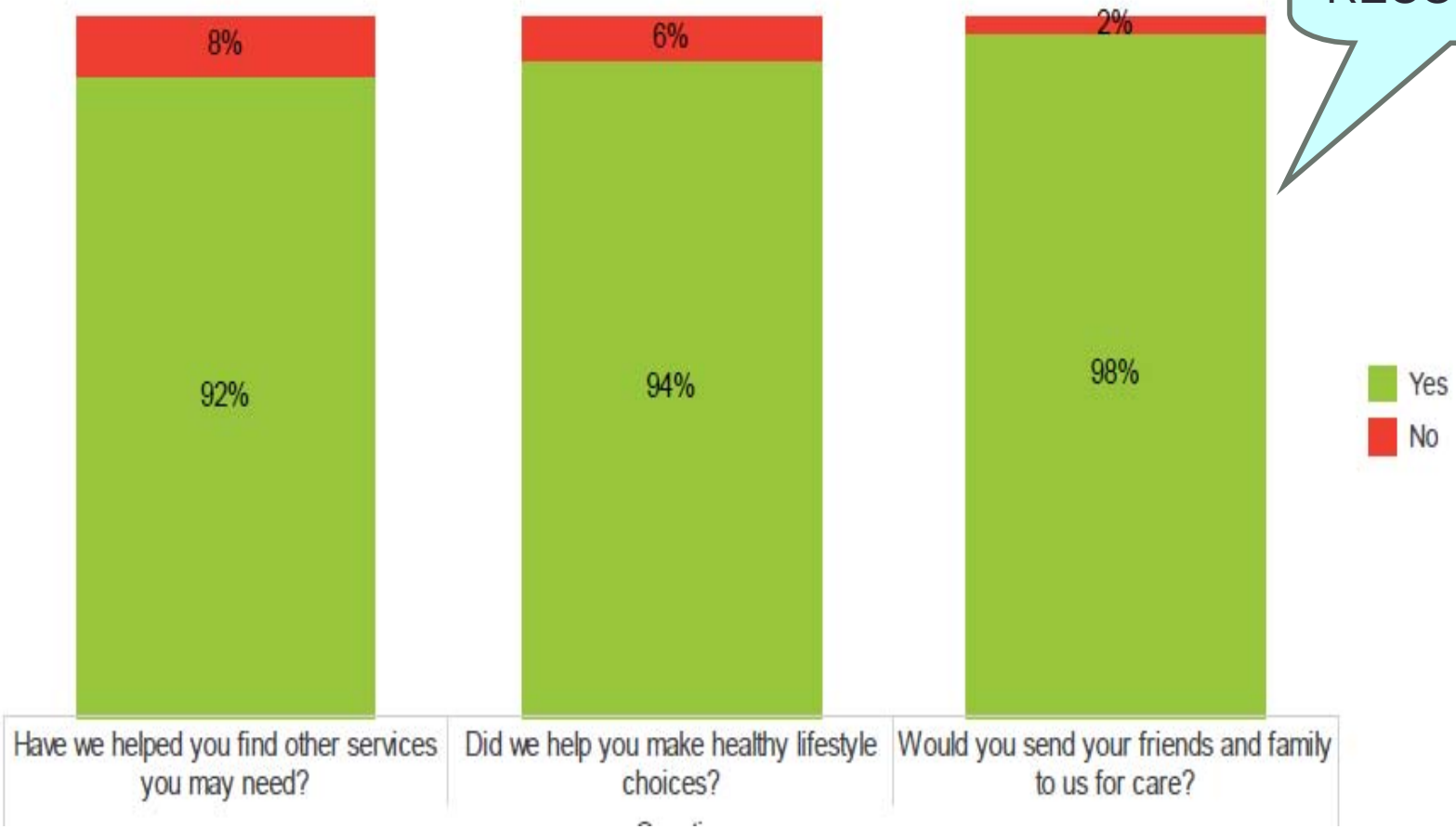
Primary Care Patient Satisfaction Wait Times



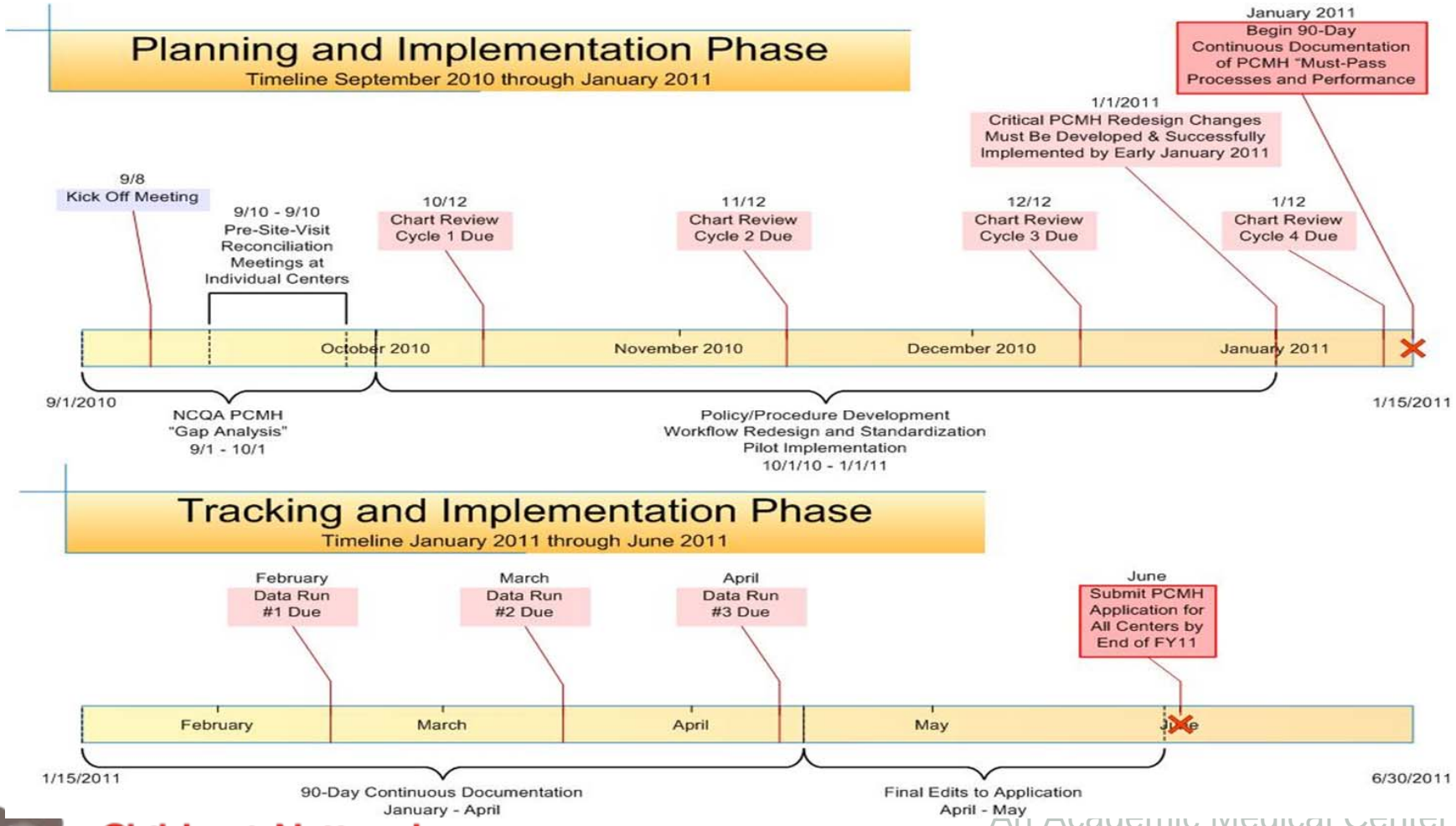
LONG WAITS: WAITING ROOM, EXAM ROOM, IMMUNIZATIONS LEAN REDESIGN, POD TEAMS, ADDED MA's & RN's

Primary Care Patient Satisfaction Overall- likelv to recommend

>95% WOULD RECOMMEND!



PCMH NCQA Application Project Timeline

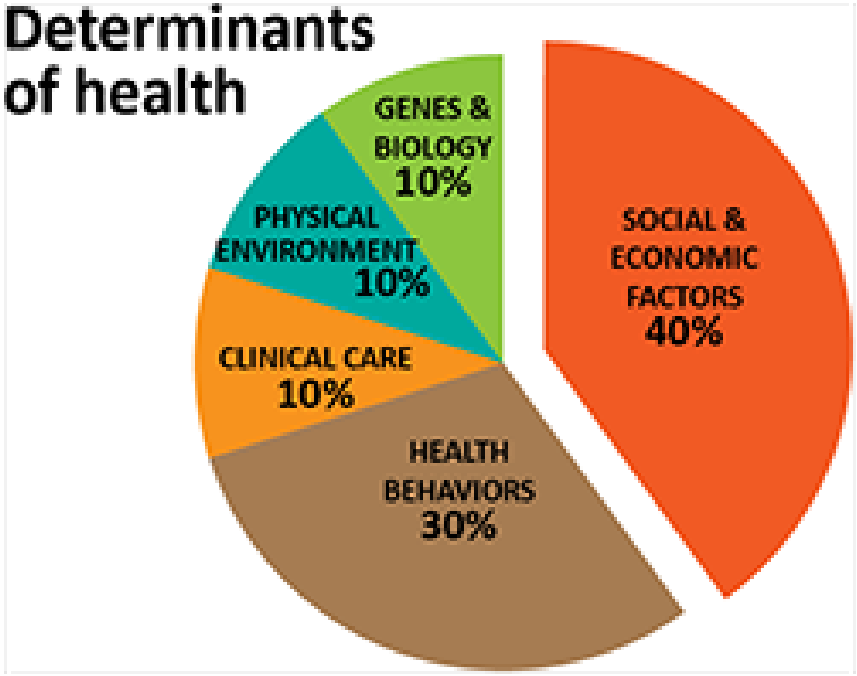


PCMH Results: NCQA Recognition

- 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

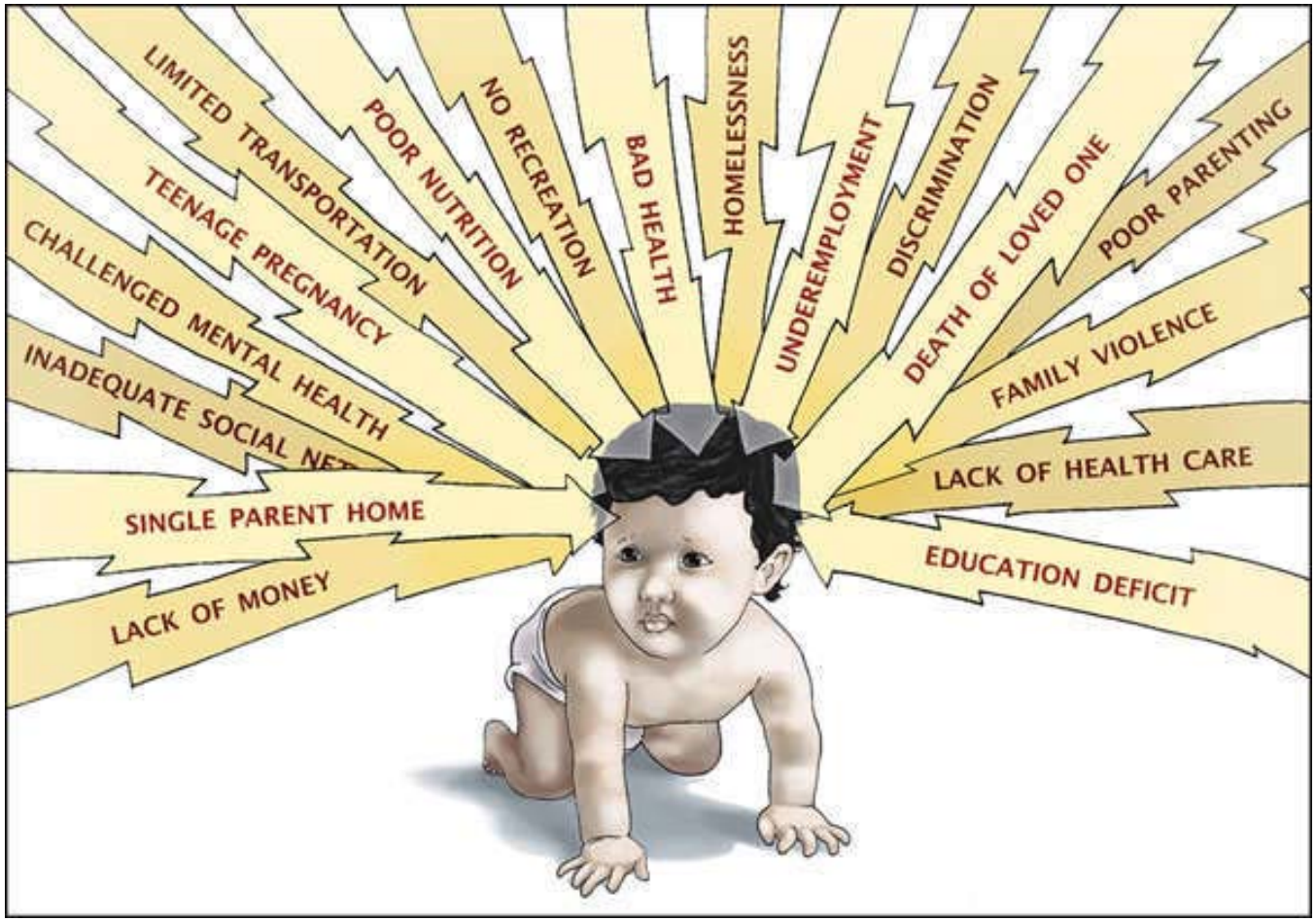
- CAVEAT: Medical Home transformation is ongoing
- NCQA recognition is (mostly) useful framework & metric for organizational change

Social Determinants of Health



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

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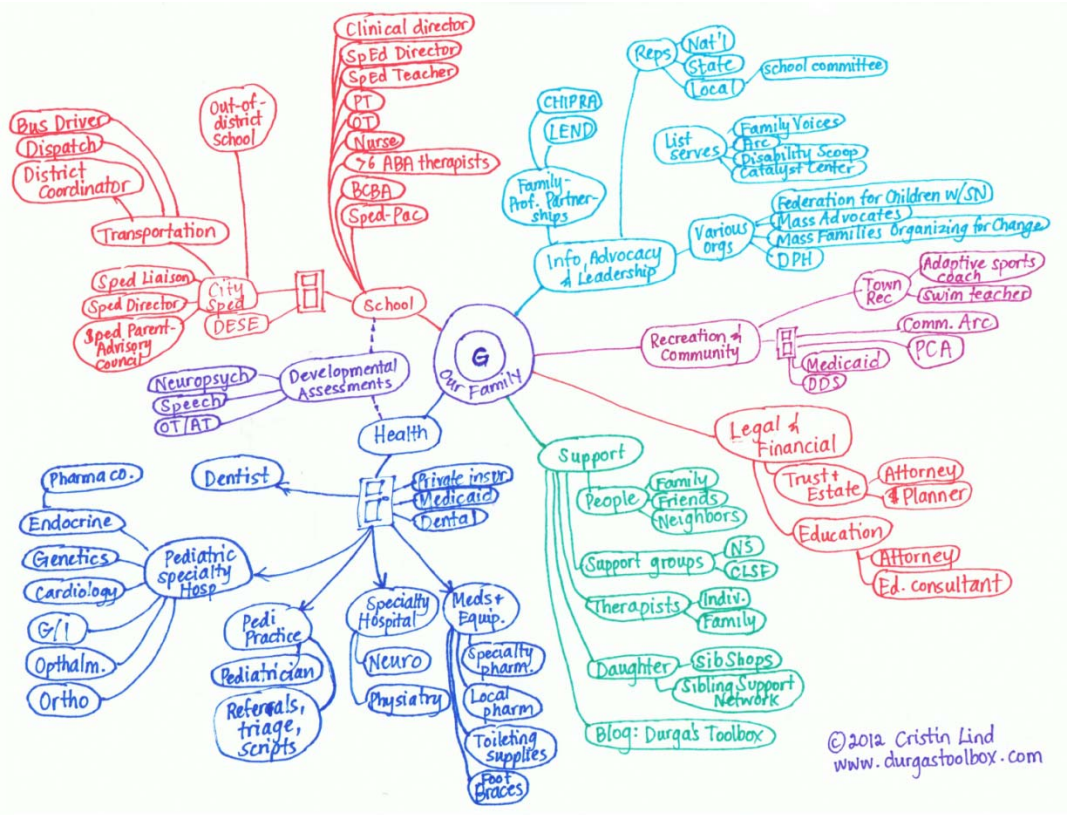
Care Coordination for medically complex children (CSHCN's)



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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

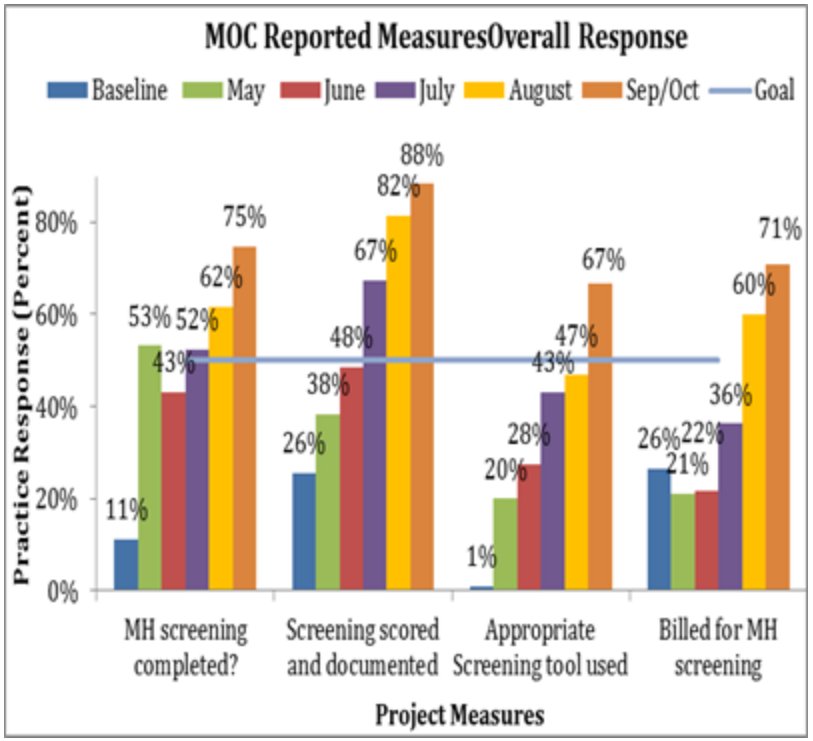
Community Health is population health

Old & New: Medical Homes & Pediatric Population Health

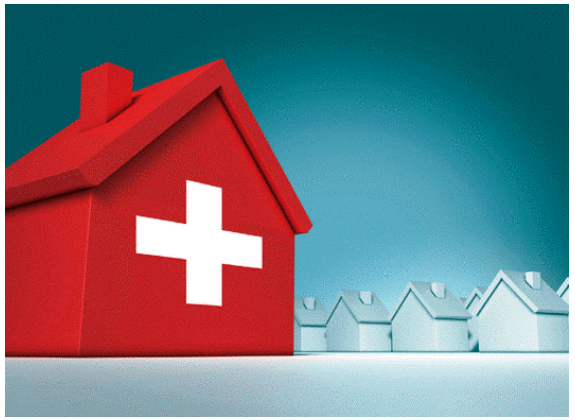
- Annual well-child exams
  - EPSDT screening, immunization rates
  - Adolescent & reproductive health
- ED utilization for low acuity non-emergent (LANE) concerns
- Chronic disease management: asthma, obesity
- Mental health screening & co-located services
- Children with special health care needs
  - 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



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

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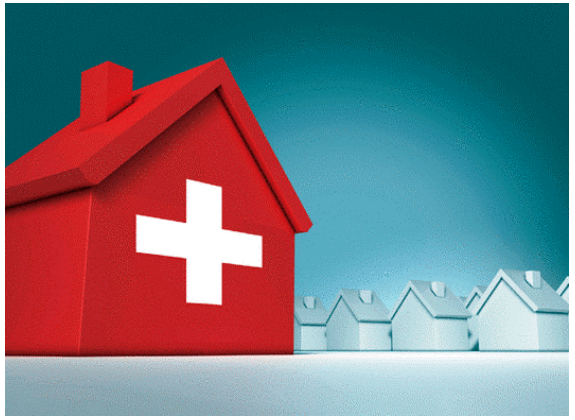
Ar
Builds a Medic

Bus Stops Across SE DC

ED2MH: Early Bending of Curve



First two years ED2MH experience:

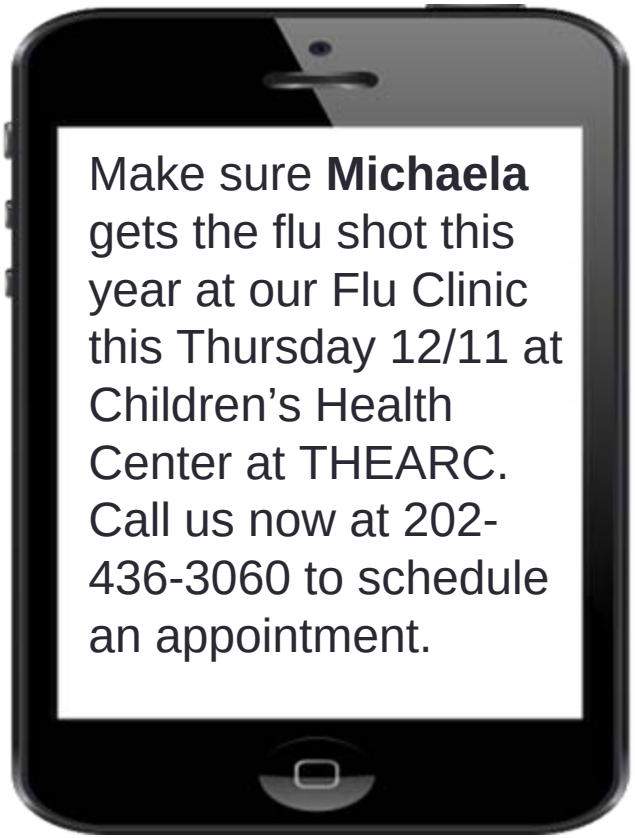
- Overall primary care visits increased 10%
- 15-20% of primary care visits now in extended hours (evenings & Saturdays)
- Overall ED utilization by Medical Home patients down 5%
- Still high utilization for low acuity concerns

Re-imagining patient engagement

- Today's *toddlers* are tech savvy
  - Almost 96% of 1 year olds use mobile device by 1st birthday
  - Most 2 year olds use mobile device daily
  - Most 3 – 4 year olds use devices without help; 1 in 3 multi-task
- H Kabali, et al, *Pediatrics*, October 2015
- Studied inner city population

Patient engagement

Flu vaccines



"Pollen busters"

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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