Optimizing Pediatric Health Care Delivery for Underserved Populations

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Speaker Disclosure

Neither I nor my spouse have any relevant financial relationships with the manufacturer (s) or any commercial product (s) and/or provider of commercial products or services discussed in this CME activity.

I do not intend to discuss unapproved/investigative use of commercial product (s)/devices (s) in my presentation.
Learning Objectives:

a. Describe the evolution of the AltaMed/CHLA partnership

b. Illustrate 2 innovative health care delivery models which fulfill the Quadruple Aim

c. Recognize the impact of disparities in health care access and socioemotional determinants of health (SEDOH) on child health outcomes for vulnerable populations

Background Information

• AltaMed Health Services Corporation
  – Largest Independent Federally Qualified Health Center (FQHC) in US
  – Serves population of >300,000 underserved, uninsured patients in Los Angeles and Orange County
    • 67,000 children served in Los Angeles County by AltaMed
    • Mix of pediatricians, family practitioners and mid-level providers providing pediatric care

• Children’s Hospital Los Angeles + University of Southern California (USC) Keck School of Medicine + CHLAMG
  – Academic General Pediatrics and Subspecialty Clinical Care
  – Teaching Facility- Subspecialty fellowships, pediatric residency, medical student education
  – Research infrastructure with Saban Research Institute, CTSI, USC
Phases in the Relationship Between AltaMed and CHLA/MG

Phase I: CHLAMG Pediatricians Consult in AltaMed Community Clinics

Phase II: AltaMed CHLA General Pediatrics Outpatient Clinic

Phase III: AltaCHLA IPA

Phase IV: Pediatric Services Joint Venture

1995 | 2005 | 2011 | 2018

Phase I: Growth of CHLAMG in AltaMed Community Sites

<table>
<thead>
<tr>
<th>ALTAMED CLINIC SITE</th>
<th>PEDIATRIC FTES</th>
<th>CHLAMG PHYSICIANS</th>
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<tr>
<td>1 BOYLE HEIGHTS</td>
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<td>2 GOODRICH</td>
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<td>3 EL MONTE</td>
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<td>4 PICO RIVERA</td>
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<td>5 SOUTH GATE</td>
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<td>6 WEST COVINA</td>
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<td>7 3RD &amp; ALVARADO</td>
<td>6.5</td>
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Phase II: Establishing an FQHC within CHLA

– Establishment of General Pediatrics Outpatient Clinic at CHLA
– >27k pediatric lives; 14% complex needs population; >92,000 visits FY 17-18
– Clinical, Education, Advocacy and Research services in primary care
– Expansion and integration of onsite specialty care
– Enhancement of ancillary support services

Phase II: Expansion of Services in Primary Care

Community Based, Federally Qualified Health Centered, Outpatient General Pediatrics Clinical Located within a Tertiary Care Medical Center

AltaMed CHLA Clinic Hours:

• 7 days per week access
• 24/7 live person access to nurse/physician triage for all patients

Ancillary Support Programs:

• Patient Centered Medical Home
• Family Support Department
• Childhood Obesity Group Classes/Lifestyle Redesign & Nutrition Services
• Newborn Services
  • Lactation Services
  • Home Phototherapy Program
  • Circumcision Clinic
  • Prenatal Classes
• Incredible Years Parenting Group
• Immunization Clinics

Onsite Subspecialty care

• Allergy & Immunology
• Optometry
• Developmental Behavioral Pediatrics
• Oral Health
• Gastroenterology
• Neurology
• Orthopedics
• Dermatology
• Cardiology
• Pulmonary
• Genetics
• Pediatric Dentistry
Phase III: Shared Risk between FQHC Partner and Hospital Medical Group: AltaCHLA IPA

- Risk Arrangement:
  - Professional fee: ED/IP
  - Non capitated labs
  - Subspecialty visits
  - Medications (until stop loss)
  - Non-CCS DME (Title V) program
Quadruple Aim Standards in Health Care

- Care Team Wellness as a prerequisite for Triple Aim = Quadruple Aim
  - 46% of practicing physicians report burnout\(^1\)
  - Principal driver of provider satisfaction = ability to provide quality care\(^2\)

- How can we move health care delivery systems towards achieving the Quadruple Aim?
Model #1: Patient Centered Medical Home (PCMH)

PCMH

A partnership between pediatric health care professionals and patient families to identify, access and coordinate medical and non-medical services to help a child achieve their maximum potential.

- Accessible
- Continuous
- Comprehensive
- Family-Centered
- Coordinated
- Compassionate
- Culturally Effective

- Children with Special Health Care Needs
  - High Utilization of care
  - Largely publicly insured
  - >60% pediatric health care expenditure
  - Poor access to medical home

- AltaMed CHLA IPA Population
  - >27k Lives; 14% complex needs
  - Majority with CCS conditions
AltaMed CHLA PCMH

PCMH: “We just help the patients and families... period”

• Since 2010, model of care which is integrated in primary care

• 1400 actively managed children with complex needs/5 FTE case managers

• Coordination of healthcare, community based services; education; mental health; social needs

• Use of case management score algorithm to allocate appropriate support for patient and their families

• Data analytics integration systems to review utilization
How do the case managers do this?

- 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-S 8a-7p access to Case Management

PCMH: Patient Case OB

4yo male with cerebral agenesis, cerebral palsy, epilepsy, cortical blindness and failure to thrive

Care Plan Intake:
- Diagnoses/Problem List
- Subspecialists
- Medications
- Feeding Regimen
- Services
  - Therapies
  - Schooling, IEP
- Nursing
- Supplies
- Equipment
- Financial - SSI, IHSS, Jobs
- Social Concerns - Immigration Status, Transportation; Language Barriers; health access inequity

Social Challenges:
- **Medical complexity**: Patient not gaining weight, parents refuse G tube, lapse in medical care
- **Patient engagement**: non-compliance, difficulty reading, speak a Indigenous language, poor health literacy
- **Social/legal implications**: open DCFS case
- **Skilled needs**: Home skills, Tube care, home nursing
- **Financial/resource limitations**: unable to access SSI funds, home nurses kept quitting because tiny apartment, father has lost several jobs because of days missed; limited access to transportation
PCMH: Patient Case OB

4yo male with cerebral agenesis, cerebral palsy, epilepsy, cortical blindness and failure to thrive

Multidisciplinary Rounds:

- Integrated outpatient conference: PCMH team, PMD, CCS MTU OT, DCFS case worker with family engagement
- Inpatient admission with FTT workup & GT Placement (6 day admit)
- Inpatient family conference: Inpatient team, community regional center, DCFS, outpatient PCMH case management
- Discharge home coordinated with PCMH case management & PMD along with community service providers (Regional Center; DCFS; CCS MTU)

Case Management Solutions:

- Medical: coordinate appointments for subspecialties and procedures/imaging studies, refill medications, order supplies (formula, diaper, g tube)
- Patient engagement: Find interpretation, create visual medication lists, arrange for patient transport
- Social/Legal: Multidisciplinary meetings, liaison with DCFS, RC, CCS and our team, create supporting documentation for SSI
- Skills Needed: coordinate special teaching by feeding pump company representative, obtain home nursing every time a nurse quits, frequent check-ins with other therapists

PCMH Satisfaction

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”
**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*

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**AltaMed CHLA PCMH DATA: 1/1/2010-12/31/2015; N= 543**

- **Average LOS per year before and after PCMH program implementation**
  - All Patients: Pre-PCMH 26.3, Post-PCMH 35.9
  - High Utilizers: Pre-PCMH 4.5, Post-PCMH 5.6

- **Annual ED Visit Rate Pre and Post PCMH Program**
  - All Patients: Pre-PCMH 1.36, Post-PCMH 6.75
  - High Utilizers: Pre-PCMH 0.81, Post-PCMH 0.51

- **Annual Inpatient visit rate pre and post PCMH program**
  - All Patients: Pre-PCMH 1.86, Post-PCMH 4.88
  - High Utilizers (≥2 visits): Pre-PCMH 0.65, Post-PCMH 1.46

* P<0.001
Value Based Care?!

MACRA (MediCare Access and CHIP Reauthorization Act 2015)
- Replaces Sustainable Growth Formulas with Valued Based Care
  - MIPS (Merit-Based Incentive Payment System)
  - APM (Alternative Payment Method)

Value Based Reimbursement Opportunities
- Quality Programs -> Advanced care improvement
- Transitional Care
  - Reimbursement for coordination of care from outpatient within 2 business days of hospital DC followed by in-person visit 7-14 days
- Chronic Care
  - Reimbursement for incremental time managing patients with chronic disease

*Opportunities for insurers to pay PMPM (per member per month) to health systems building clinically integrated networks (demonstrating coordination of care activities) which can support sustainability of care coordination
Value Based Care?!

• Highest Impact Health Care Delivery Operations Leading to Shared Savings:
  – Nurse/Physician Telephone Triage Line Access
  – Population Health Management Tools
  – Care Managers to Support Patients and Provider
  – Chronic Care Management

• Data Integration & Analytics
  • Collection of data with integration (clinical, patient, hospital, community) to understand practice management

*It is critical to risk adjust based upon clinical + social risk

Quadruple Aim: PCMH

Reduction in Cost
(Decreased ED, IP, LOS, RA, CV)*

Improved Patient Outcomes
(Less utilization; increased social & community support)

Improved Patient Satisfaction
(Press Ganey > 90%; Medical Home Index)

Satisfied Providers
(Less paperwork, improved coordination, allows providers to focus on the medicine)*

*ED = Emergency Department; IP = Inpatient; LOS = Length of Stay; RA = Readmission; CV = Clinic Visit
Model #2: Home Phototherapy

Elimination of disparities in care for private pay vs. publicly insured patients

- Home Lactation & Phototherapy services contracted January 2016
- Pilot: 1/1/2016-11/1/2018 → 57 newborns treated with home phototherapy (mean treatment length of 2.5 days)

- In-home lactation support and daily communication with targeted social screening in an underserved population
Model #2: Home Phototherapy

Growth Data and Cost Implications: 1/1/2016-10/31/2016

Publicly Insured Newborns Receiving Home Phototherapy
N=57

Newborn Phototherapy Cost Models

Quadruple Aim: Home Phototherapy

- Reduction in Cost (Diminished ED, IP)
- Improved Patient Outcomes (Promotes breastfeeding; ACES screening; allows integration of psychosocial support; reduction in kernicterus)
- Improved Patient Satisfaction (report increased satisfaction being home)
- Satisfied Providers (Eliminates disparities in care, improved quality; insight into patient’s home to garner increased services)
11/29/18 at 8am: 14yr & 15yr WCC

Social Emotional Determinants of Health (SEDoH)

Socioeconomic Factors
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

Health Behaviors
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care
- Access to Care
- Quality of Care

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2016)
AltaMed CHLA Partnership: Child Health Outcomes

It is imperative to define measures that track LA County’s most underserved & vulnerable pediatric populations and incorporate innovative strategies into developing pediatric health care delivery models.
AltaMed CHLA Partnership: Child Health Outcomes

Key Categories for Pediatric Services Joint Venture:
*With a priority to develop and use disparities-sensitive health equity measures*

Pediatric Clinical Quality Indicators
Experience of Care
Utilization Management
Access to Care
Population Health Performance Tracking

Innovation in Health Care Delivery

“CMS may allow hospitals to pay for housing through Medicaid” Modern Healthcare
11/14/2018

“The ‘Frequent Flier’ Program That Grounded a Hospital’s Soaring Costs

In Dallas, Parkland Hospital created an information-sharing network that gets health care to the most vulnerable citizens—before they show up in the emergency room”
Politico December 18, 2017

The Healthy Neighborhood, Healthy Families Initiative
Pediatrics September 2018
Community Vital Signs

Step 1: Collect & Organize SDH Data

Step 2: Present & Integrate SDH Data into Primary Care Workflows

Step 3: SDH Data Triggers Automated Support & Action

Community Vital Signs Data
Imported from public data sources about community-level information (e.g., US Census) matched to patient address

Patient-Reported Data
Collected by asking patients direct questions about their individual circumstances (e.g., employment, education, housing)

Panel Management
Population of Patients

Point-of-Care
Individual Patient Care

Improved Health Outcomes

Referrals to social services, medical specialists
Clinical Decision Support
Patient Engagement
Clinical & Social Services Coordination

Achieving Health & Mental Health Equity at Every Level

Transforming the conditions in which people are BORN, GROW, LIVE, WORK and AGE for optimal health, mental health & well-being.

Healthy People
Health Care
Child Development, Education, and Literacy Rates
Food Security/Nutrition
Built Environments
Discrimination/Minority Stresses

Healthy Community
Healthy Environment
Healthy Society

Prevention
Mental Health Services
Culturally/Linguistically Appropriate and Competent Services
Income Security
Housing
Neighborhood Safety/Collective Efficacy
Environmental Quality

http://Letsgethealthy.ca.gov  #CAHealthyTogether
Next Steps

Phase IV: Joint Pediatric Service Venture: CHLA, CHLAMG and AltaMed

Joint Pediatric Venture to invest in caring for underserved populations and strategically collaborating in community settings to optimize care and affect child health outcomes

Expansion and growth of market share opportunities to enhance quality care for the most vulnerable youth

Advocate for improved models of care for our underserved pediatric populations

Thank YOU!

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- Care Manager/Coordinators:
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  - Lindsey Nichoision, RN
  - Beaneet Solorzano, L VN
  - Abraham Gonzalez, L VN
  - Vanessa Games, L VN
  - Gracie Corona Arias, MA
  - Sasha Mckee, RN

- Multidisciplinary Team
  - AltaMed clinic staff
  - Palliative Medicine Team
  - Family Support Team
  - Nutrition team
  - Pediatric Subspecialists
  - Community partner agencies: CCS, regional center; DCF, LAUSD, Family Resource Center, Learning Rights, etc.
  - Government relations/community affairs team

**Thank you to our patients and families who allow us to care for them**