Rhode Island
State Innovation Model (SIM)

Leveraging Innovation to Transform Health Systems and Improve Population Health

PCMH Kids Initiative
Care Transformation Collaborative of Rhode Island
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Beth Lange, MD, FAAP, PCMH Kids Co-chair

SIM Liaison: James Rajotte, RIDOH
Marea Tumber, OHIC

Project Start Date: April 2016
Months Implementing: 36 Months
Total Budget: $500,000 (SIM)
$129,628 (Rhode Island Foundation)
$205,000 (Tufts)*
$834,628 Total Budget

Formally Evaluated: Yes

*IBH - ADHD, Maternal Depression & Adolescent SBIRT
SIM Transformation Wheel

Rhode Island State Innovation Model (SIM): A Healthcare System Transformation Initiative

as of Jan 11, 2017

RI SIM THEORY OF CHANGE—
Rhode Island’s payment system is changing to focus more on value and less on volume. IF SIM makes investments to support providers and empower patients to adapt to these changes, and we address the social and environmental determinants of health, THEN we will improve our Population Health and move toward our vision of the Triple Aim.
PCMH-Kids is a multi-payer, multi-provider primary care payment and delivery system reform initiative focused on the unique needs of children and families.

Health plans financially support and engage with PCMH Kids practices under common agreements built around practices progressively implementing service delivery requirements and becoming patient centered medical homes.
# Health Plan Estimated Total Investment

## PCMH Kids Cohort 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate**</th>
<th>Est Annual Payout</th>
<th>Incentive Payout*</th>
<th>Est Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$3.50 pmpm</td>
<td>$1,511,622</td>
<td>$1,511,622</td>
<td>$1,511,622</td>
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<tr>
<td>Year 2</td>
<td>$2.50 pmpm</td>
<td>$1,144,950</td>
<td>$170,298</td>
<td>$1,315,248</td>
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<tr>
<td>Year 3</td>
<td>$2.50 pmpm</td>
<td>$1,030,740</td>
<td>TBD</td>
<td>$1,030,740+</td>
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<tr>
<td>Total</td>
<td></td>
<td>$3,687,312</td>
<td>$170,298</td>
<td>$3,857,610+</td>
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* Incentive Payment is based on quality, customer experience and utilization performance vs targets

** CTC-Adult rate is $5.50 pmpm x 3 years (compared to $3.50/$2.50 pmpm in PCMH-Kids). At the adult rate, the pediatric infrastructure investment would be $7,161,924. **

A difference of $3,474,612
Main Takeaways

Building a strong foundation for children's health is an investment. The value proposition in high quality pediatric care is about investment, not rapid return and shared savings.

Practices need support (time, infrastructure payment, coaching assistance, learning from others, team model, on-going data reporting and QI activities) to make and sustain culture changes needed to thrive in value based payment systems.

To achieve maximum health and well being, families raising children depend on robust, integrated, resourced programs at the community and state level.
Results to Date: Improved BMI and Developmental Screening Rates

Quality Measures
PCMH Kids Cohort 1 & 2

<table>
<thead>
<tr>
<th></th>
<th>Q2 '16</th>
<th>Q3 '16</th>
<th>Q4 '16</th>
<th>Q1 '17</th>
<th>Q2 '17</th>
<th>Q3 '17</th>
<th>Q4 '17</th>
<th>Q1 '18</th>
<th>Q2 '18</th>
<th>Q3 '18</th>
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<tbody>
<tr>
<td>BMI Target</td>
<td>55%</td>
<td>64%</td>
<td>72%</td>
<td>77%</td>
<td>80%</td>
<td>86%</td>
<td>81%</td>
<td>85%</td>
<td>86%</td>
<td>93%</td>
</tr>
<tr>
<td>BMI</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>90%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Developmental Screening Target</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>77%</td>
<td>77%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>42%</td>
<td>45%</td>
<td>52%</td>
<td>68%</td>
<td>72%</td>
<td>78%</td>
<td>77%</td>
<td>77%</td>
<td>81%</td>
<td>86%</td>
</tr>
</tbody>
</table>
Results to Date:
Improved Customer Experience

Patient Experience Survey Results PCMH Kids Cohort 1 & 2

Access

Communication

Office Staff
## Results to Date: Improved ED Utilization

PCMH Kids Cohort 1 & Kids Comparison
Rate per 1,000 Member Months (Excluding ERISA Members)

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Emergency Department Visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(1) Kids Cohort 1</td>
<td>29.2</td>
<td>28.6</td>
<td>-0.7</td>
<td>-2.3%</td>
</tr>
<tr>
<td>(2) Kids Comparison</td>
<td>29.0</td>
<td>29.0</td>
<td>0.1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Difference (1–2)</td>
<td></td>
<td></td>
<td>-0.7</td>
<td>-2.5%</td>
</tr>
<tr>
<td><strong>Inpatient Discharges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Kids Cohort 1</td>
<td>1.5</td>
<td>1.5</td>
<td>0.01</td>
<td>0.7%</td>
</tr>
<tr>
<td>(2) Kids Comparison</td>
<td>1.2</td>
<td>1.2</td>
<td>0.01</td>
<td>0.5%</td>
</tr>
<tr>
<td>Difference (1–2)</td>
<td></td>
<td></td>
<td>0.00</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

*Data Source: Onpoint*
Results to Date: “At risk” children and families identified and linked with care coordination services

❖ Developed and implemented a pediatric sensitive high-risk framework to identify children and families that would benefit from care coordination services;

❖ With funding from health plans, practices hired care coordinators who worked with at risk children and families
Results to Date

Integrated Behavioral Health Services into Pediatric Primary Care through:

1. Hired on site social worker care coordinators
2. Improved screening for social-emotional challenges in infants and toddlers
3. Participated in multi-practice IBH learning collaboratives, focused on:
   - ADHD screening, diagnosis and treatment plans;
   - Maternal post-partum depression screening: Improved screenings from a baseline of 22% to 87% and implemented referrals protocols for intervention.
   - Screening, Brief Intervention, Referral, and Treatment (SBIRT) in adolescents: 75 providers, with a total pediatric population of ~34,000, enrolled in the learning collaborative;
Results to Date

Practice Transformation

❖ In its first year, all 9 initial practices achieved the highest level of NCQA patient centered medical home recognition;

❖ Based on the outcomes of PCMH Kids pilot, health plans supported a July 2017 PCMH Kids expansion and a 2019 PCMH Kids expansion.

❖ PCMH-Kids is now comprised of 20 practices, covering over 66,000 lives including 200 pediatricians and trainees caring for more than 50% of the state’s pediatric Medicaid population.

❖ PCMH-Kids 2019 expansion encompasses 17 practices, covering ~44,000 lives including 64 pediatric providers. *With this expansion, PCMH-Kids will now represent more than 50% of the children in Rhode Island and nearly all of the state's pediatric Medicaid population.*

❖ Increased partnerships with KIDSNET and Family Home Visiting programs are improving practice knowledge of at-risk families and collaboration with home visiting staff.
Lessons Learned

Threats – Changing or Unmet Needs
- **CEDAR program** (state’s intensive care coordination resource) which high Medicaid practices had relied upon for MH care coordination is no longer functioning.
- Care coordination services are best serviced in the medical home, only.
- Common contract is at risk of being replaced with multiple systems of care contracts.

**Medical Needs**
- Newborns with NAS
- Behavioral health needs
- Need to link high risk maternal obstetric care to pediatric care setting.

Things to Do Differently
- This program is underfunded, $3 pmpm is not enough to cover costs.
- Change requirement to allow more time to achieve NCQA.

What Would Be Helpful Post-SIM
- Continued **financial commitment** by health plans and systems to support needs of children and families.
- State-wide campaign to improve care during 1st 1000 days.
- **Expand CHT** to include services for high risk/need children and families.
- Increase coordination with home visiting program/EI/DCYF.
- Continue to make connections to the **statewide ecosystem**.
Expected Outcomes/Partnerships

• **KIDS NET**: Provided practices with practice profile based on risk score
• **Rhode Island Department of Health**: Joint application for HRSA “Healthy Tomorrows”
• **KIDSCOUNT**: Collaboration to launch RI 1st 1000 Days Campaign
• **Tufts Health Plan**: Financial support for IBH
• **AAP/Rhode Island College**: Adolescent SBIRT Program
Sustainability Approaches

**Funding**

- Multi-payer infrastructure payments for pediatric practices when contract ends;
- Multi-payer support and funding for PCMH Kids expansions (Cohort 2 and 3)
- Potential for multi-sector funding
- Funding applications to RIF, HRSA
- With robust pediatric community, RI positioned to apply for larger grants
Sustainability Approaches

Partnerships

• Pediatric Primary Care practices
• RIF/SIM/Tufts
• Health plans (BCBSRI, NHPRI, Tufts, United)
• OHIC / EOHHS
• HEALTH, DCYF
• Higher education
• Systems of Care
• ACO / AE
Learning

- Successfully built a pediatric primary care and integrated behavioral health learning community.
- Integrated “pediatric track” in CTC Annual Conference.
- Provided joint learning experiences between PCMH Kids and Adult PCMH practices.
Sustainability Approaches

Evaluation

• All Payer Claims Data Base Performance Metrics
• Patient Experience (CAHPS)
• Quality Measures
• NCQA recognition
• PCMH Kids Co Chairs: National Recognition Calvin C.J.Sia Community Pediatric Medical Home Leadership Award
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Any final questions or comments?
Contact Information

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