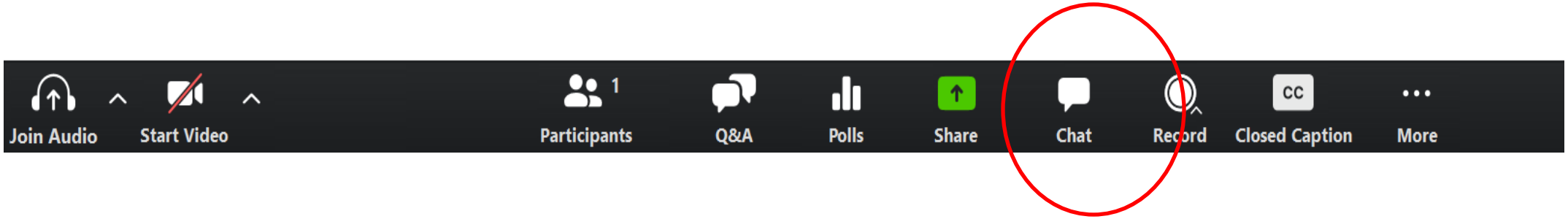
Building pediatric ecosystems of care

May 22, 2023

Housekeeping

- This event will be recorded and sent out with the slides
- Put your organization in the chat – send it to all participants
- Put your questions in the chat throughout
- Please keep yourself on mute while not talking (by phone or on the Zoom platform)



Introductions

Holly Henry
Program Director, Programs & Partnerships

Lucile Packard Foundation for Children's Health

Rhonda Sparr-Perkins
Director of Care Management and Clinical Redesign

Rady Children's Hospital San Diego

Michael Harris
Director

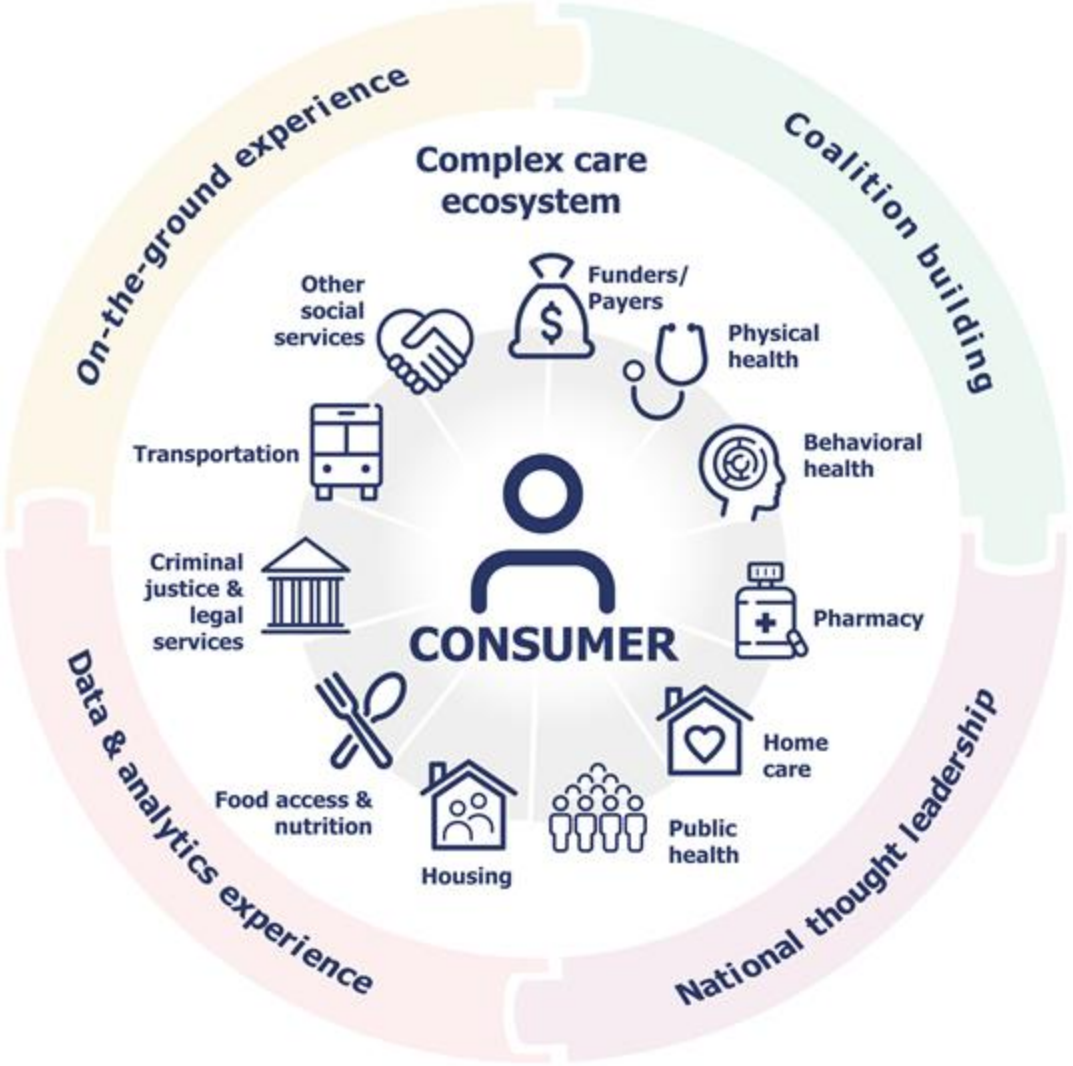
Novel Interventions in Children's Healthcare (NICH), Oregon Health & Science University

Rachel Bensen
Medical Director

Novel Interventions in Children's Healthcare (NICH), Stanford Medicine Children's Health

THE CAMDEN COALITION APPROACH

We leverage our strengths to build ecosystems of care with a diverse set of stakeholders to better serve the needs of patients and practitioners



Strengthening ecosystems of care

- Alignment, coordination, and collaboration of local healthcare and social care systems, community organizations, government agencies, and people in the communities being served.
- They co-design, implement, and lead new or improved programs, systems, and policies that bridge organizations and sectors to better serve the health and well-being of individuals and communities.

How to build an ecosystem of care

Identify community needs

Define your population

Define your aim

Identify partners and allies

Continuous process and quality improvements

Create an intentional structure with a focus on sustainability

Our kids

Children with Special Health Care Needs (CSHCN)

Physical, developmental, behavioral, or emotional conditions that require additional services

18% of children in US

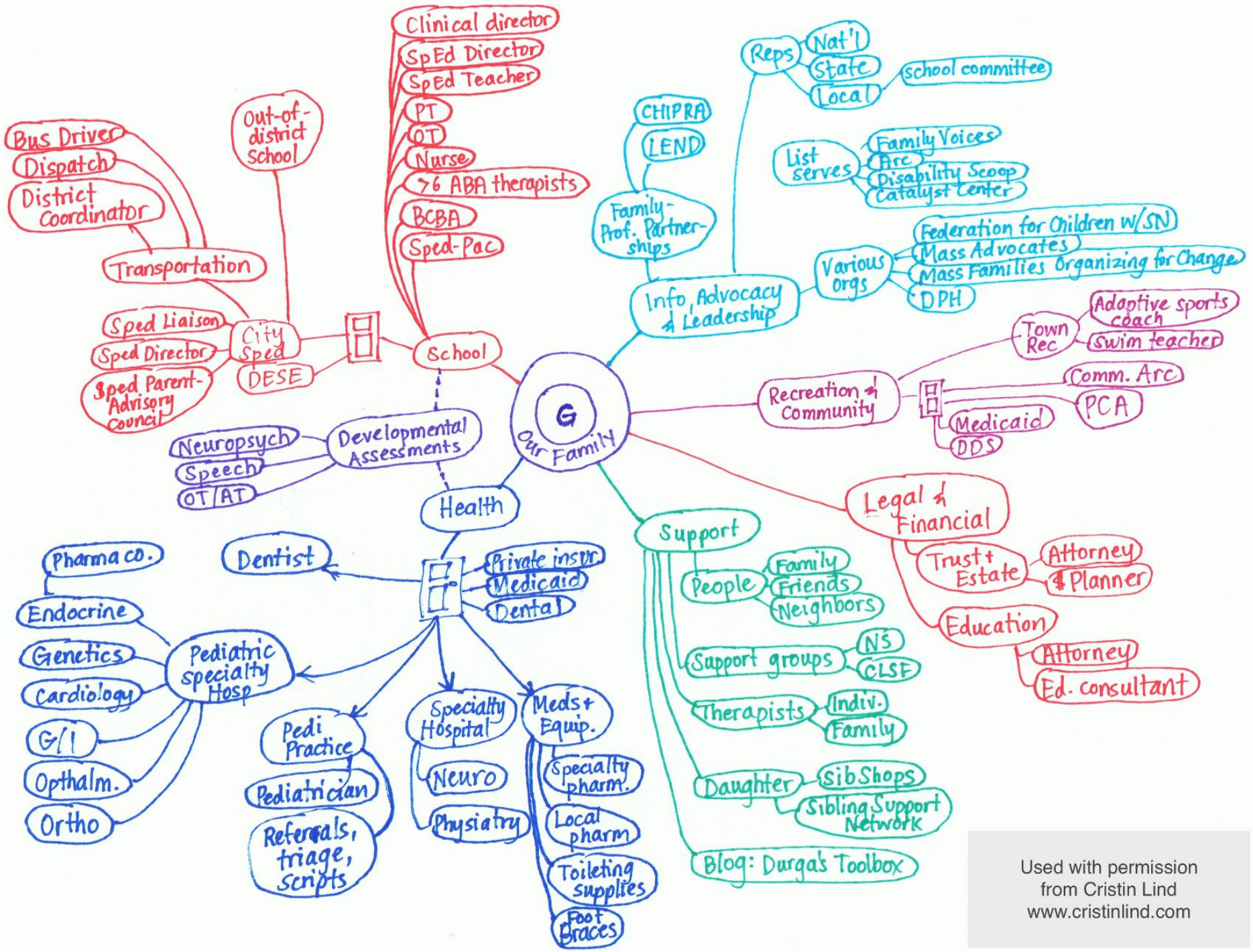
1.3M children in CA

Children with Medical Complexity (CMC)

Chronic health conditions, multiple subspecialists, and high service utilization

<1% of US children

40% of pediatric health care costs



40%

of families receive no care coordination

20%

of parents either cut back hours at work or stop working

86% of CSHCN receive care below federal minimum quality standards

Source: Kidsdata.org

Our areas of focus

Care Coordination

Systems & Standards

Family Engagement

Rady Children's Hospital San Diego

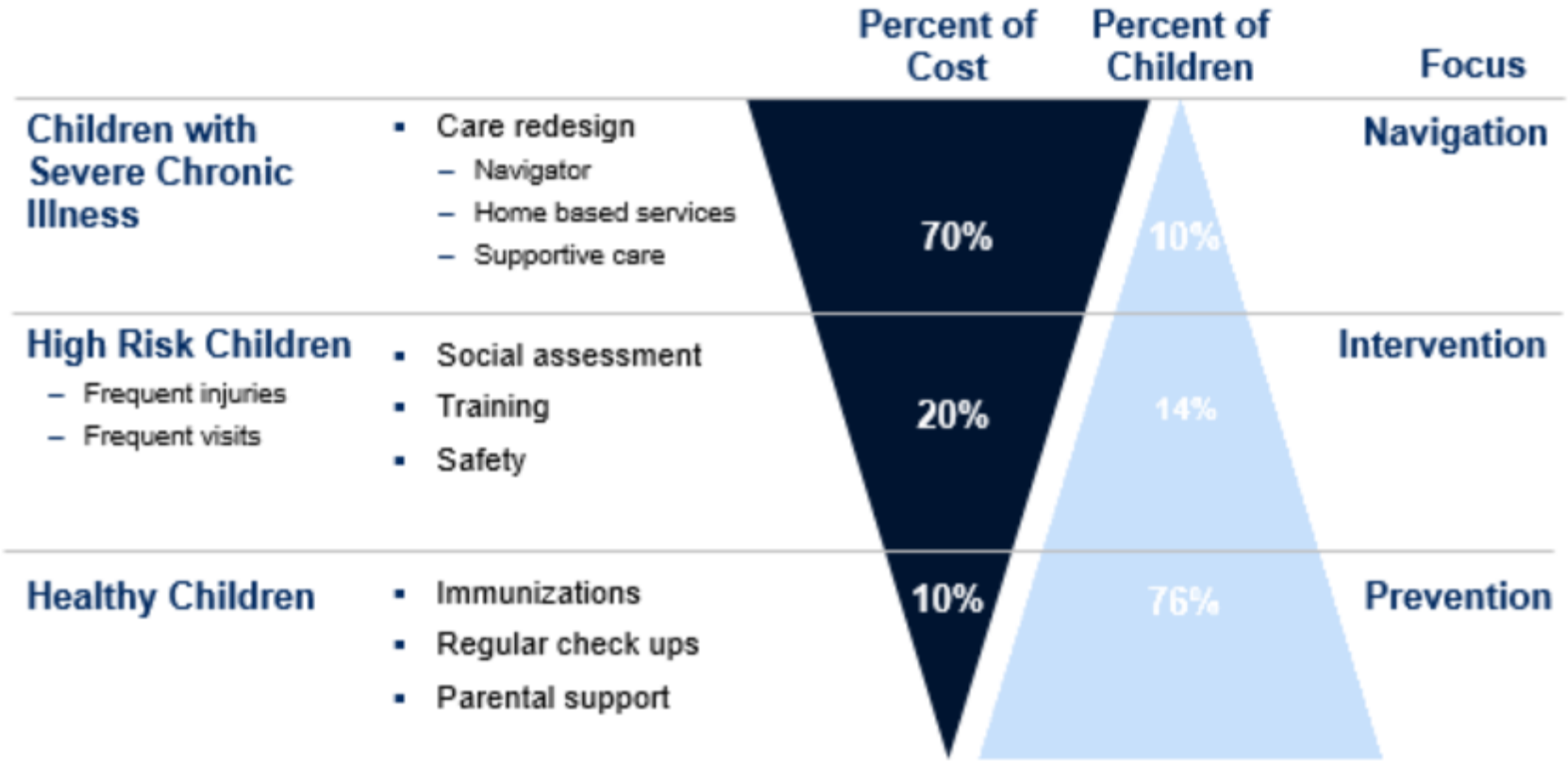
An Ecosystems Approach to Achieve Equitable Health Outcomes for Children

Rhonda Sparr Perkins, MBA, RN

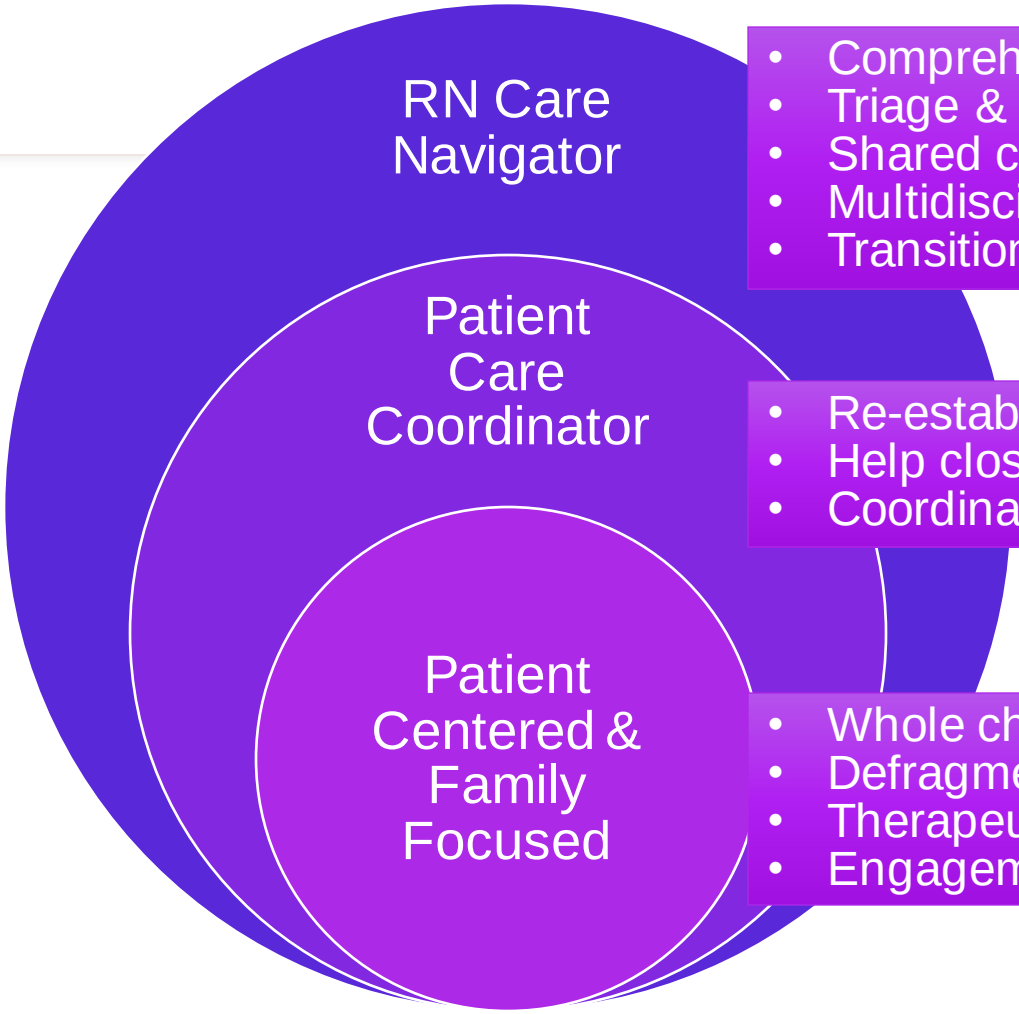
Rady Children's Health Network

Care Redesign

- Improve quality/outcomes
- Improve patient and family satisfaction and empowerment
- Improve cost



Whole Child Model



- Comprehensive needs assessments
- Triage & coordinate needs
- Shared care plans
- Multidisciplinary team liaison
- Transition support

- Re-establish medical homes
- Help close care gaps
- Coordinate resources

- Whole child model
- Defragmented care
- Therapeutic relationships
- Engagement & satisfaction

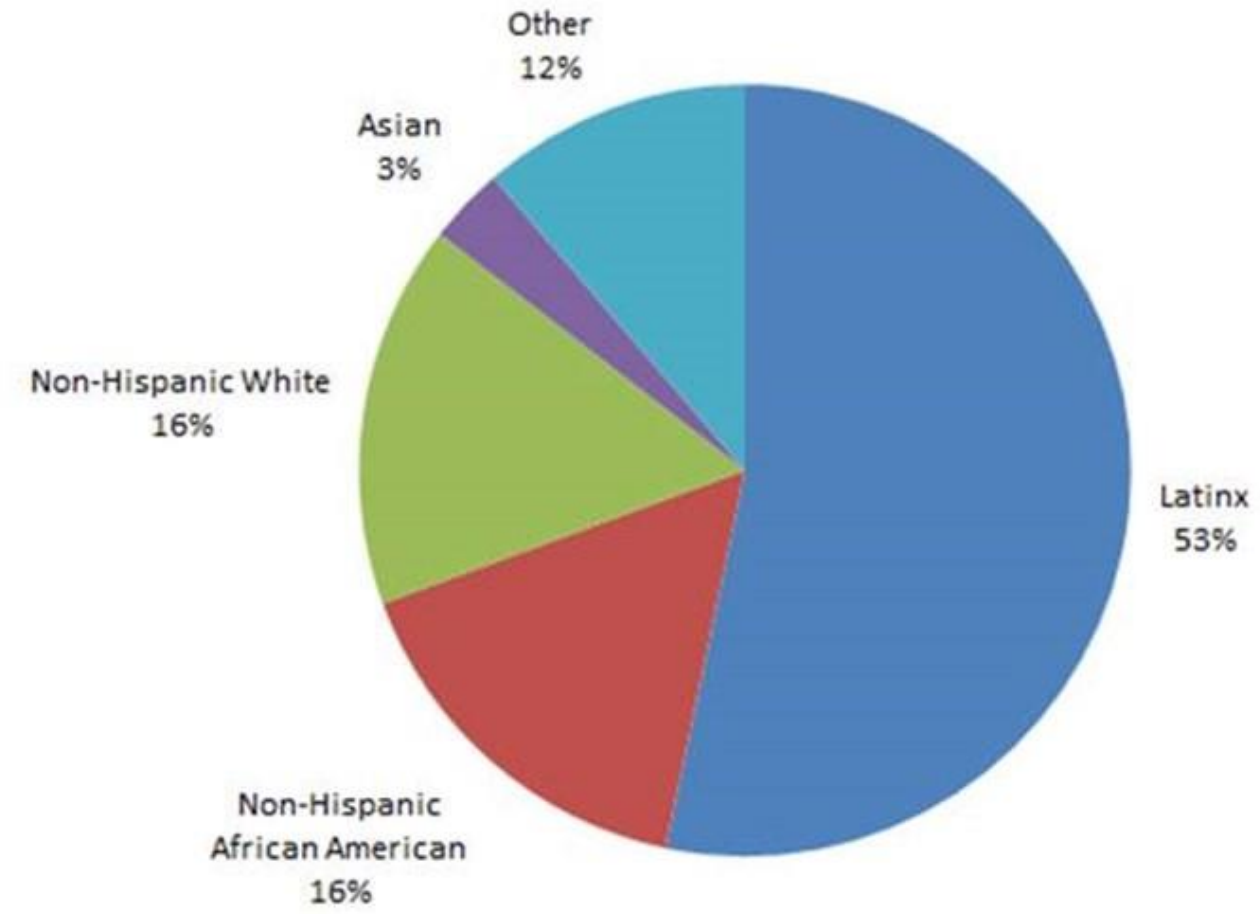
California Kids Care
a program of Rady Children's Hospital-San Diego

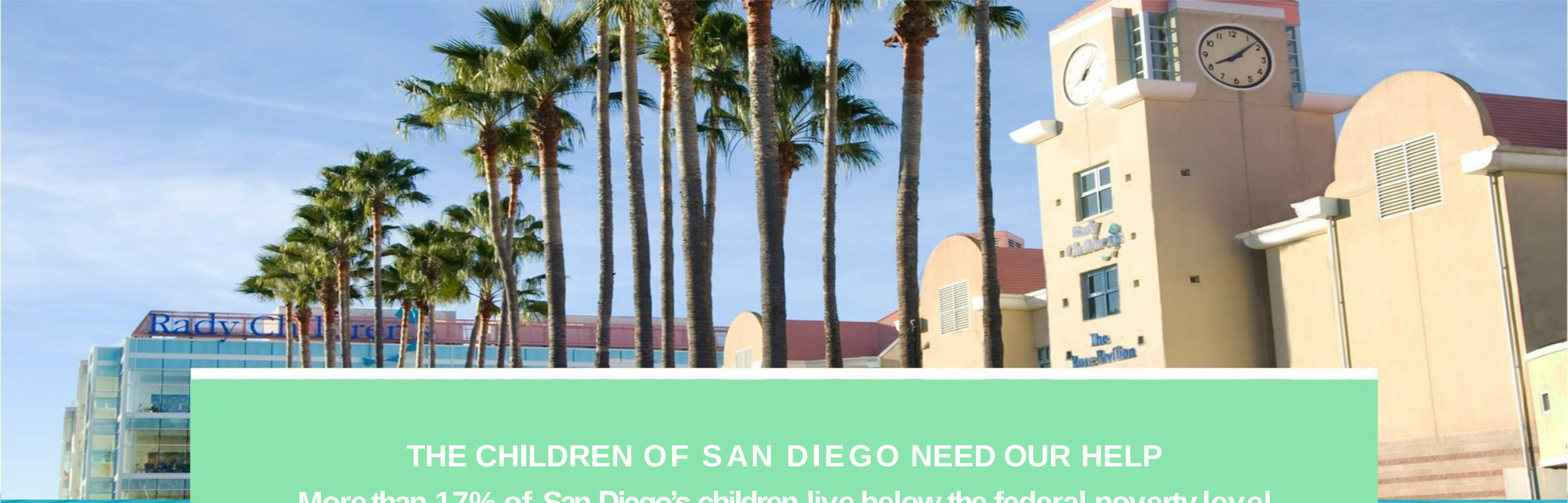
Person Centered Care: Team Training

- Health Literacy
- Teach Back
- Shared Care Planning
- Motivational Interviewing

Our Pilot Patient Population 2018-2021

- 383 children enrolled
  - Ages 0-20 years old
- 100% on Medicaid
- 100% chronic diagnosis
  - Cystic Fibrosis
  - Diabetes
  - Hemophilia
  - Leukemia
  - Sickle Cell Disease





THE CHILDREN OF SAN DIEGO NEED OUR HELP

More than 17% of San Diego's children live below the federal poverty level

Social determinants of health affect the lifelong well-being of thousands of our region's children

All children deserve access to high-quality,

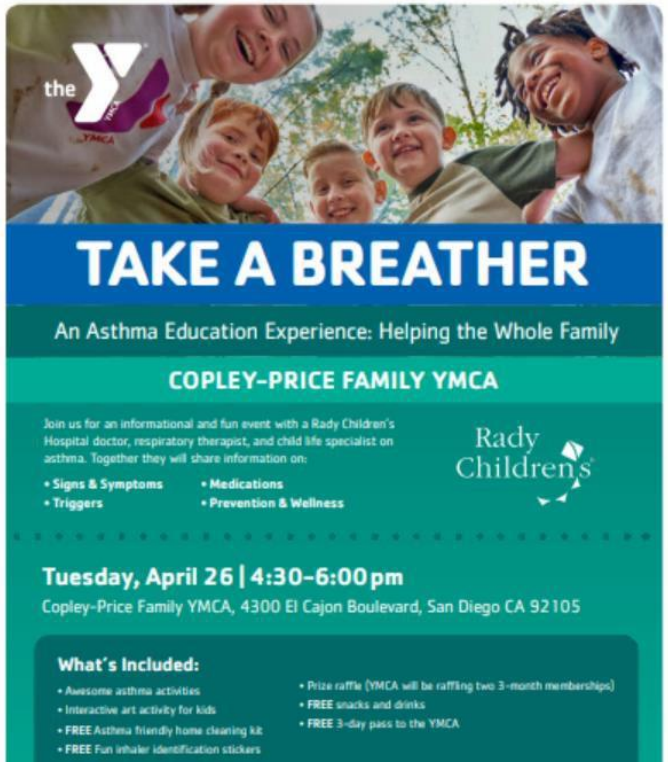
comprehensive, personalized services

A Focus on Health Equity

- Social determinants of health screening
- Measurable root causes
- Resource connection
- Community ecosystems
- Geomapping
- W hole child approach

The Whole Child Ecosystem: Community Partners

- Camden Coalition
- California Kids Care
- Center for Healthier Communities
- San Diego Hunger Coalition
- UCSD Mas Fresco
- YMCA
- Anderson Dental
- Urban Collaborative
- SD Public Library



Culturally Sensitive Community Health Education

- Families able to meet 1 on 1 with healthcare providers
- Family friendly local setting
- Skill building
- Connected over 100 families to community services while addressing social drivers of health, food insecurity, and health literacy

Food Navigation Outreach

Closing Care Gaps

California Kids Care
a program of Rady Children's Hospital-San Diego

Indicator	FY19 Baseline	Goal	FY21 Results
Annual Comprehensive Clinic Visit	54.6%	60%	92%
Annual Well Child Visit (young child)	28%	50%	52%
Annual Dental Screen	9%	70%	85.7%
Annual Vision Screen	23.7%	60%	85.7%
Annual Depression Screening	89.9%	90%	80.4%
Food Security Screening	0%	30%	59.7%
Transportation Screening	0%	40%	85.7%
Immunizations (up-to-date)	35.7%	50%	64.4%
Annual Influenza Vaccine	66.7%	80%	64.1%
My Chart Enrollment	53.8%	65%	82.5%
Medication Possession Rate (MPR)	N/A	80%	82.0%

Utilization Impact

Decreased ED visits by 44%

Decreased Inpatient Admissions 44%

Decreased Median Length of Stay 23.5%

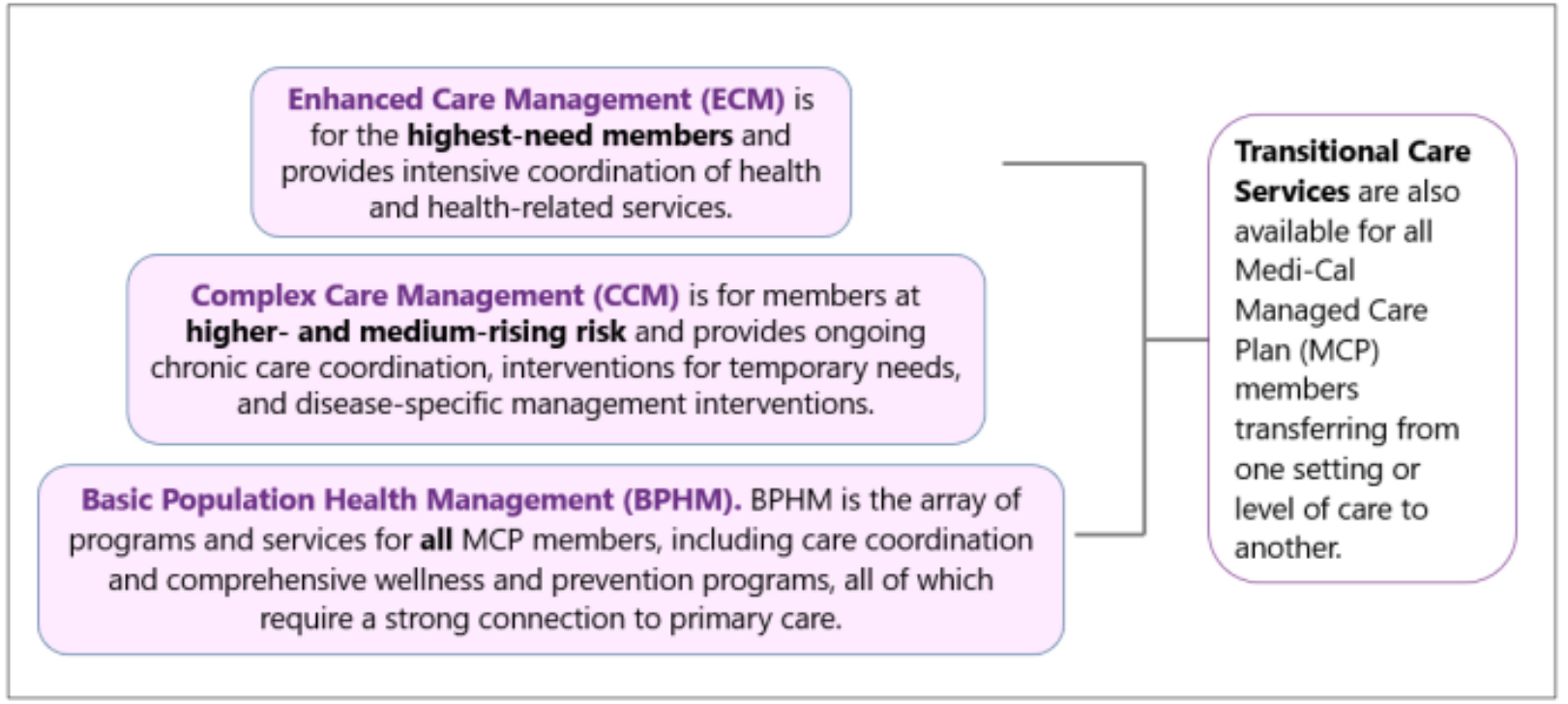
CalAIM
California Advancing and Innovating Medi-Cal

DHCS initiative to improve the quality of life and health outcomes of Medi-Cal Members by implementing delivery system, program and payment reforms across the Medi-Cal program.

A key feature of CalAIM is the statewide introduction of an ECM benefit and a menu of Community Supports authorized by MMCPs in close collaboration with their network of community-based Providers.

CalAIM PHM Continuum

Figure 1: CalAIM Care Management Continuum



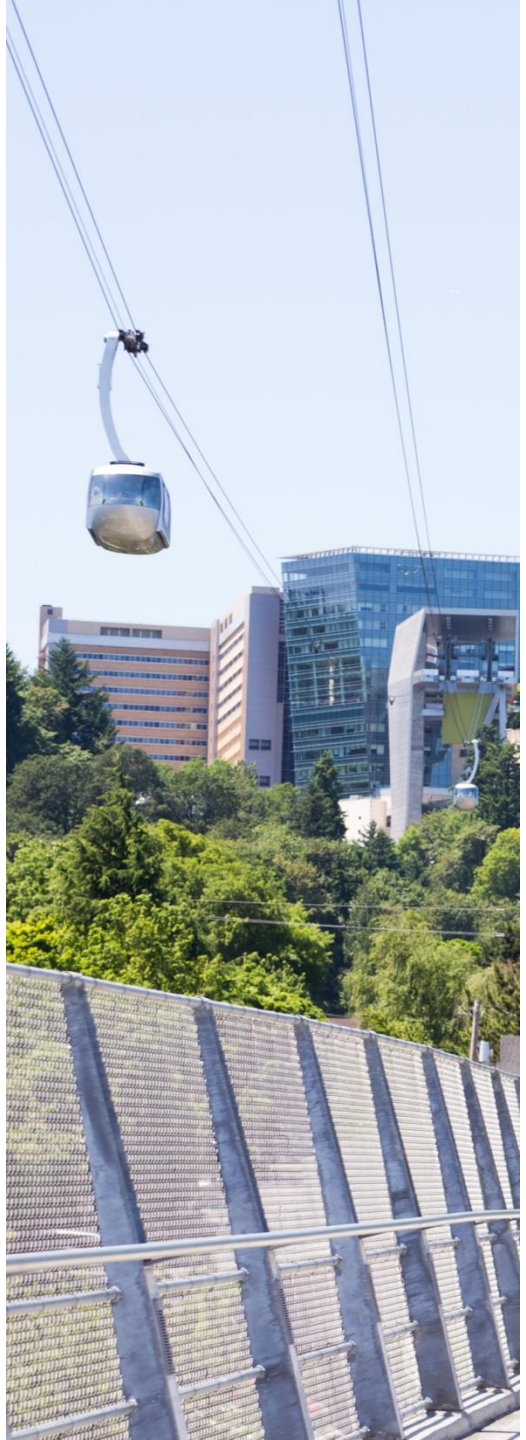
CA Bridge Health Navigator Program

- Providing access and improve the delivery system of care for patients with substance use disorder
- Care Navigation to meet the needs for immediate and ongoing care
- Connecting to services such as shelters and community treatment programs

Afghan Care Navigator

- Addressing health and social needs through care coordination using a whole child/family approach for Afghan children living in San Diego County

Refugee HEALTH UNIT
UC SAN DIEGO CENTER FOR COMMUNITY HEALTH



NICH

Novel Interventions in Children's Healthcare

Michael A. Harris, PhD
Doernbecher Children's Hospital at Oregon Health & Science University

Rachel Bensen, MD
Stanford Medicine Children's Health

*The Problem

- 279 youth were hospitalized 2x
- 82 youth were hospitalized 3x
- 148 youth were hospitalized 4x
- **230 youth (4.5% of all patients)**
  - **3+ hospitalizations**
  - **27% of hospital charges or $67,000,000**
  - **20% of admissions**
  - **Disproportionate number Medicaid**
  - **Disproportionate people of color**

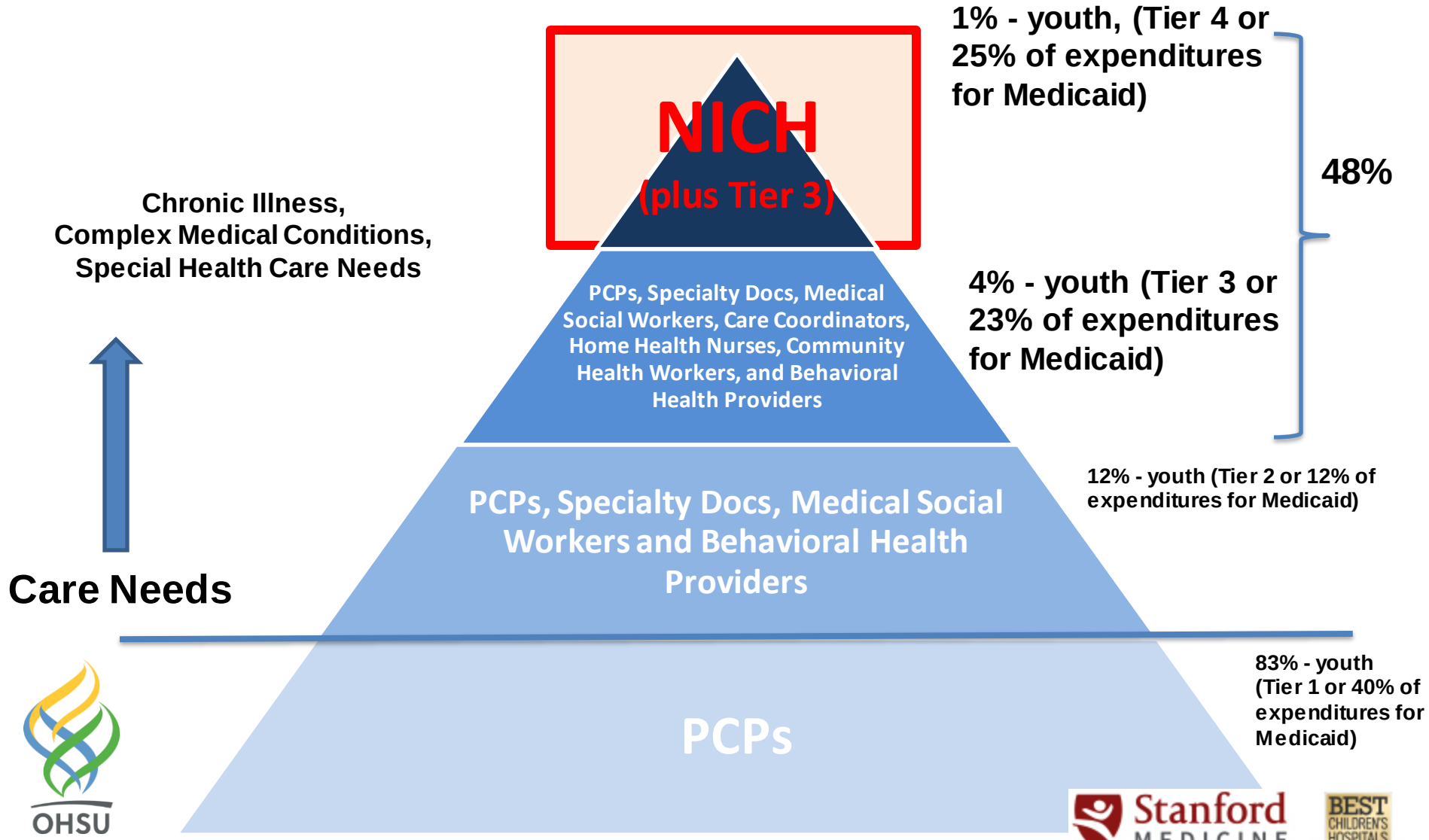
OHSU

*data from Doernbecher Children's Hospital 2008-2011

Stanford MEDICINE Children's Health

BEST CHILDREN'S HOSPITALS U.S.News HONOR ROLL 2022-23

NICH in the Context of Existing Resources



What is NICH?

ICU and ED for Social Challenges

- **If you have a complex/chronic medical condition you get the *highest level of care.***

- **If you have an equally complex social situation, we tend to start with the *lowest level of care* (telephonic support, home health nurse, community health worker).**

- **NICH matches the intensity of the intervention with the degree of need, thus NICH models it's care for social complexity after the care model in the ICU and ED.**

OHSU

Stanford MEDICINE Children's Health

BEST CHILDREN'S HOSPITALS U.S.News HONOR ROLL 2022-23

What makes NICH different (and so impactful)?

- Intervention in the "lived experiences" of youth and their families.
- Therapeutic support that is proactive.
- Target the true drivers of poor health.
- Outcomes are aligned with the IHI's Quintuple Aim
- Tracks and demonstrates significant ROI, both for the hospital and insurers.

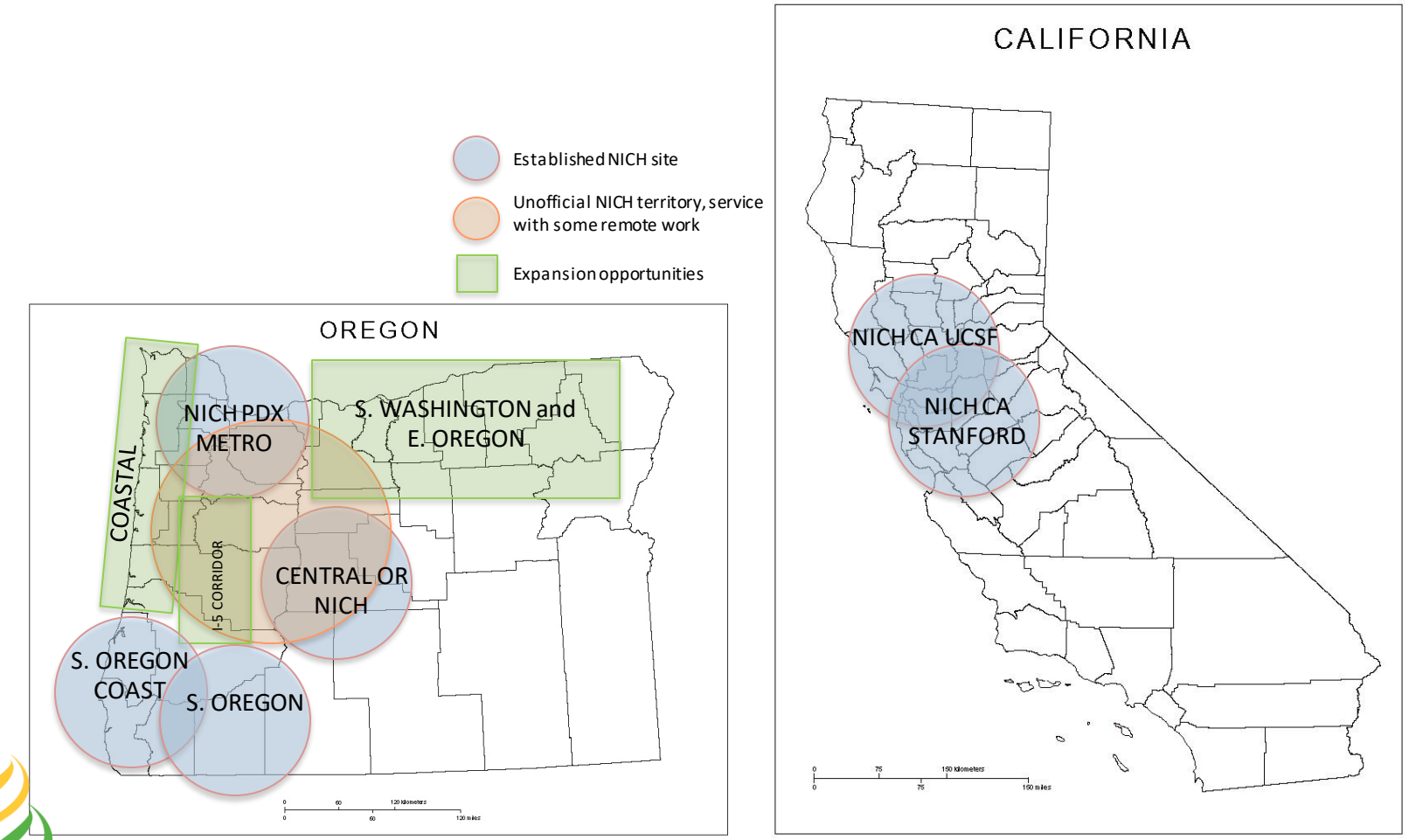
NICH Patient 0

- 14 year-old female
- T1D diag at 5.5 yrs
- 1st DKA at 10 yrs
- 2nd DKA at 14 yrs
- A1c prior to Apr 2011
  - 7.0-8.8%
- A1c since Apr 2011
  - 9.1-10.2%
- **Nov 2011**
  - **22 admits for DKA to our ED/PICU**

SDoH = 12

- Truant
- Maternal chronic illness
- Maternal mental illness
- Houselessness
- Unemployed parent
- Single parent
- Incarcerated parent
- Drug/alcohol issues
- Child abuse
- Limited access to tech
- Unreliable transportation
- CPS involvement - neglect

Service Areas: Oregon & Bay Area



Does NICH . . .

Reduce Costs?

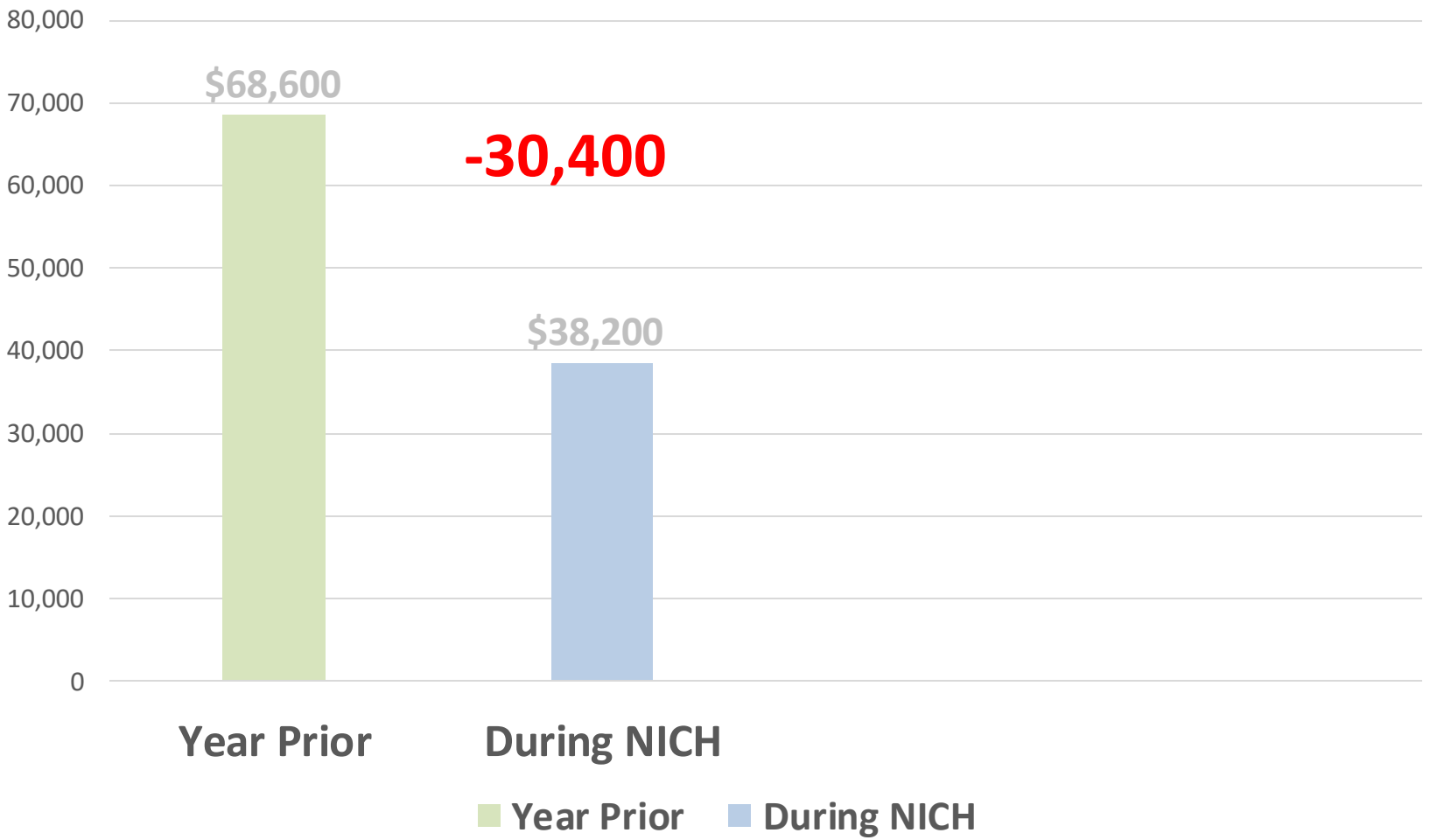
Improve Health?

Improve Care?

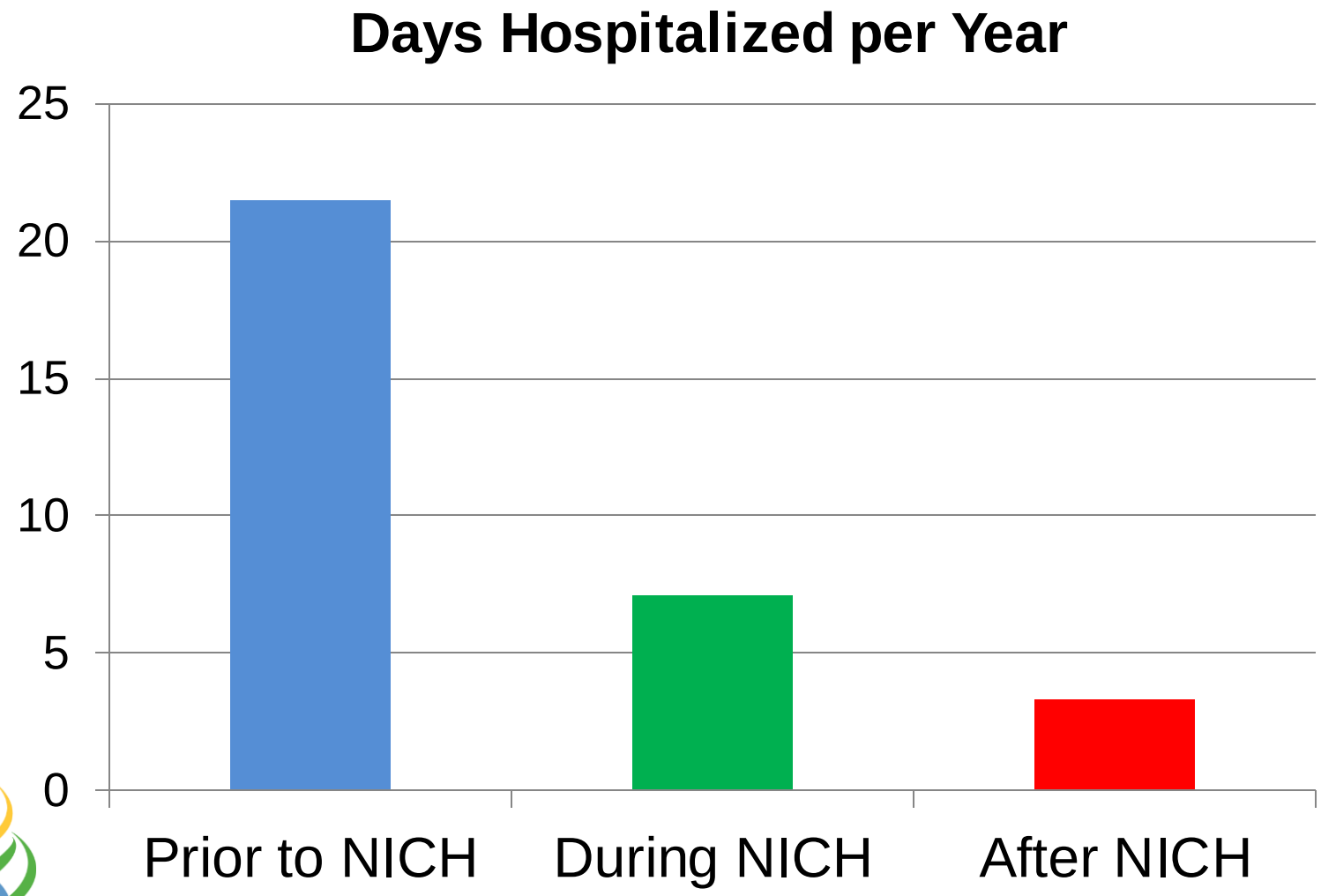
Increase Staff Satisfaction?

Reduce Health Disparities?

Cost Savings



Reducing Hospital Costs



Does NICH . . .

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Improve Health?

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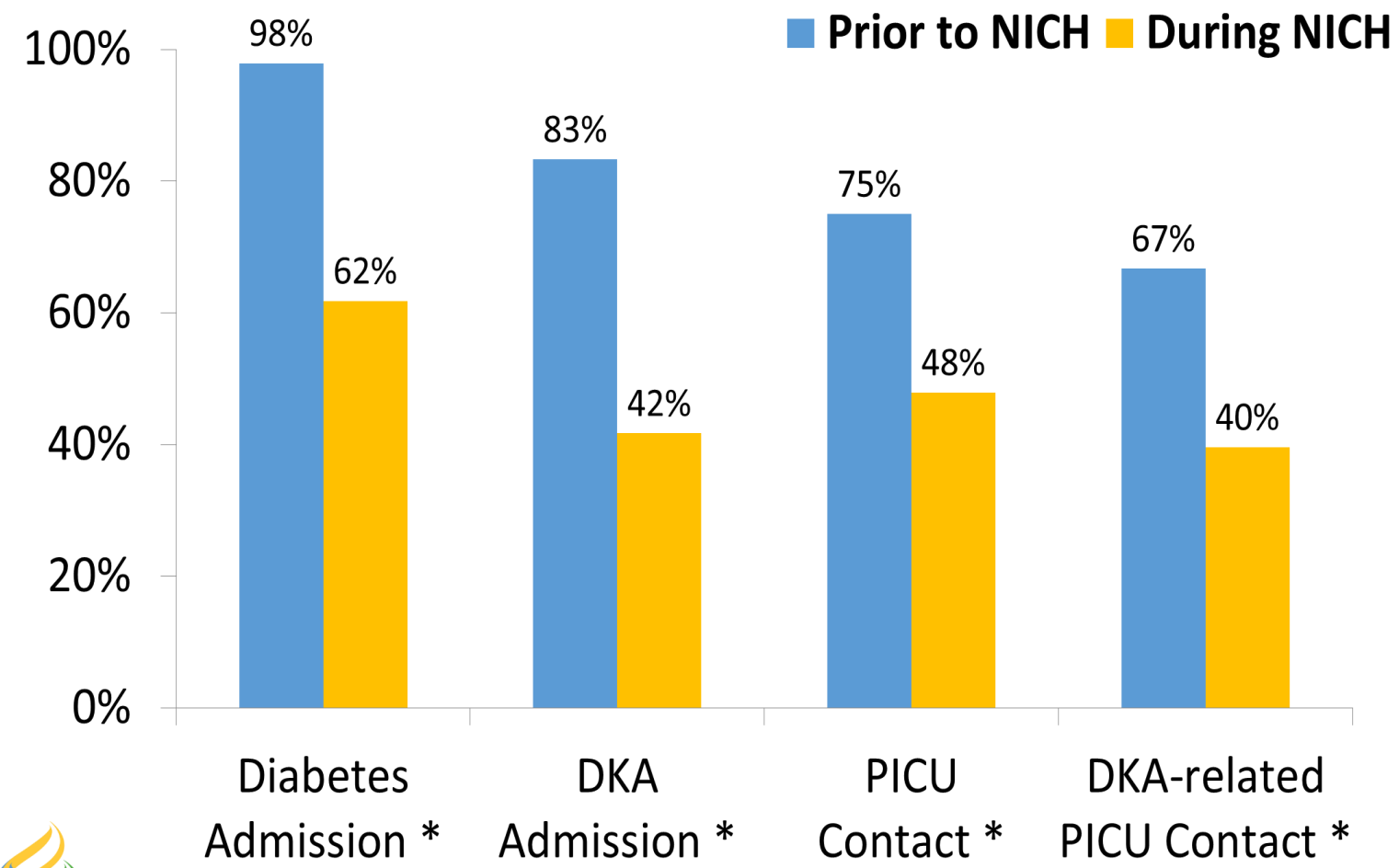
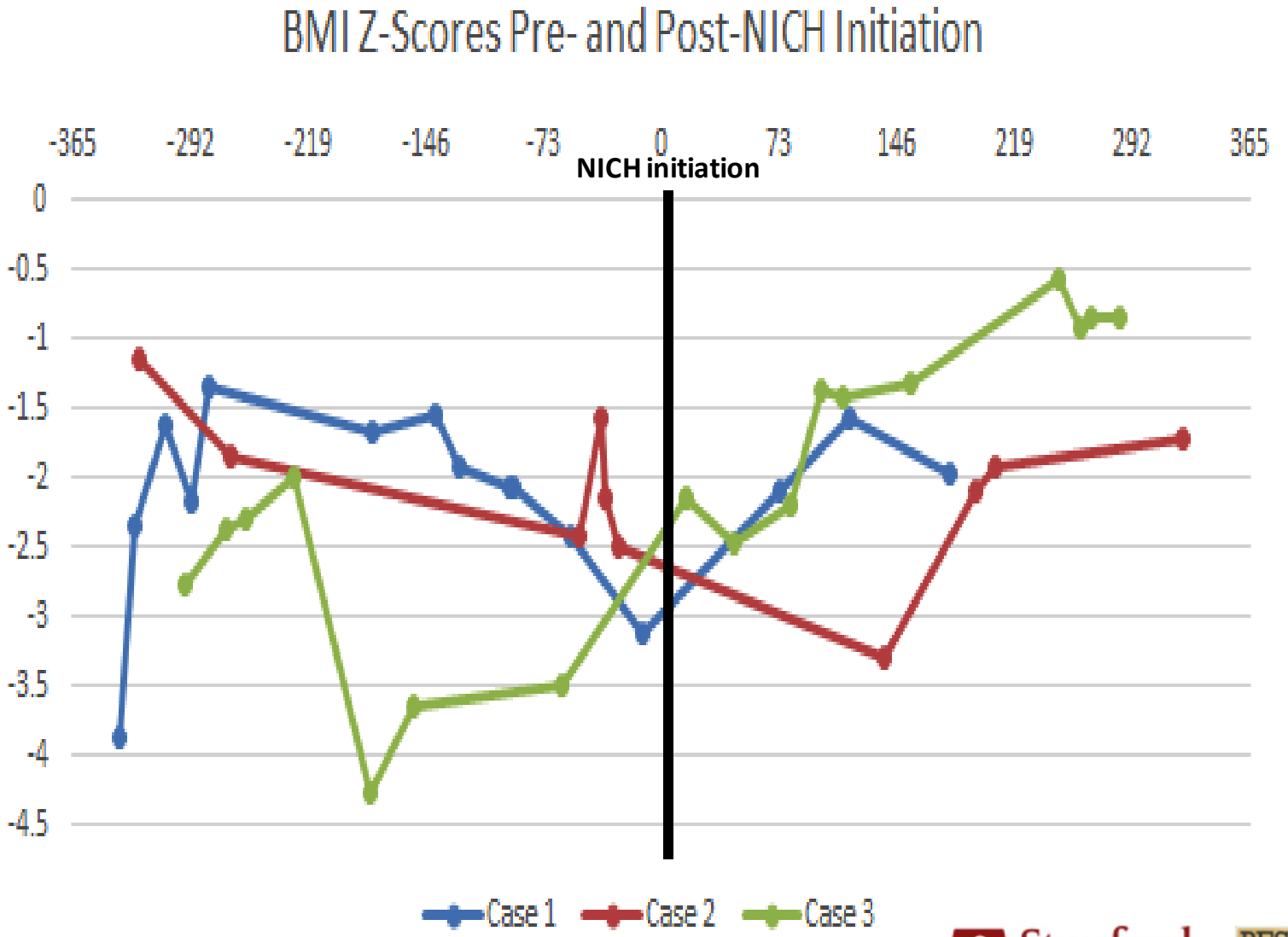
Percent of Youth Who Experienced Acute Events



Improving Health



Does NICH . . .

√ Reduce Costs.

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Improve Care?

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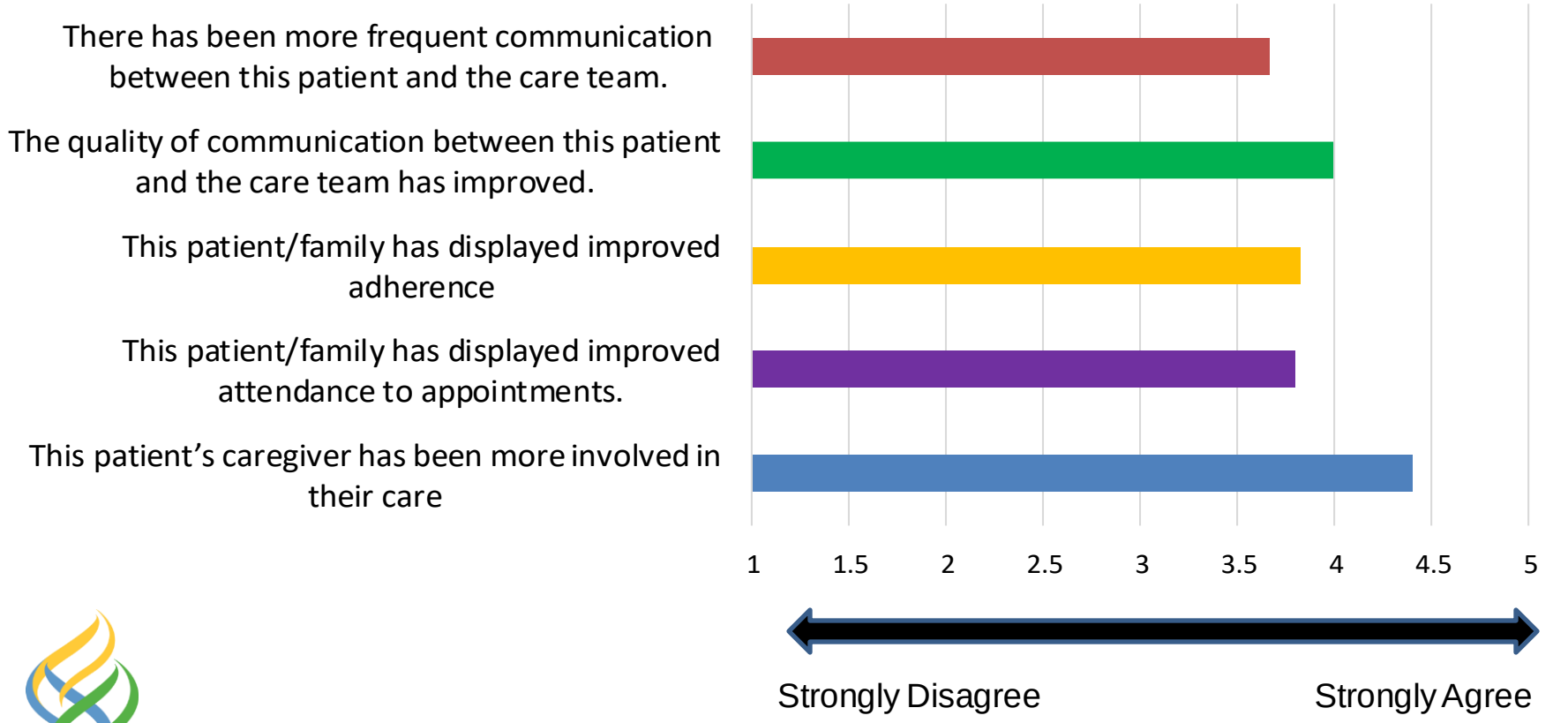
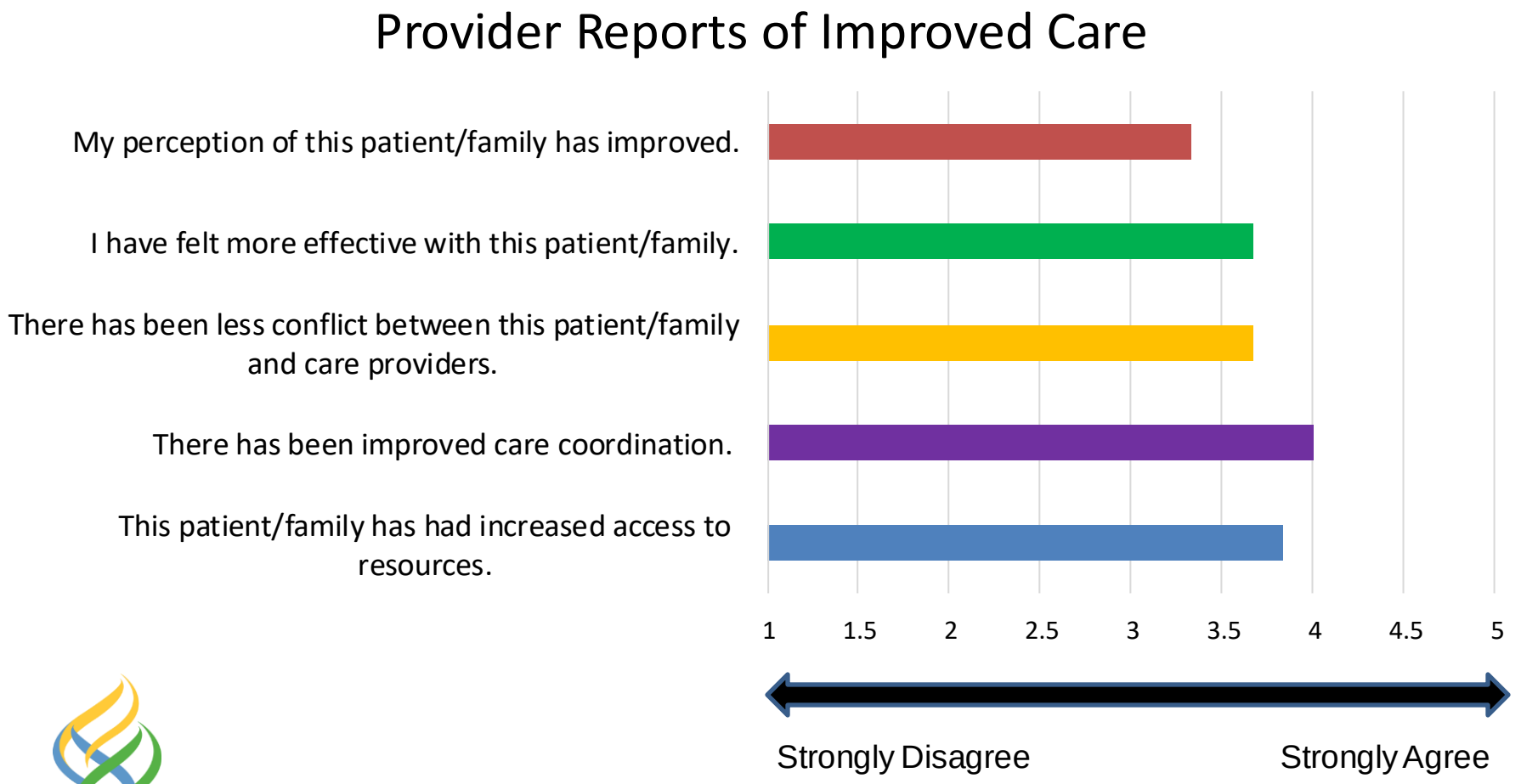
Improving Care

Provider Reports of Improved Care



Improving Care



Does NICH . . .

√ Reduce Costs?

√ Improve Health?

√ Improve Care?

Increase Staff Satisfaction?

Reduce Health Disparities?

Staff Satisfaction

- Providers significantly less frustrated with limitations to help patients/families with NICH.
- Provider QOL improves! Burnout and lack of retention costs the system $$$$.
- COVID-19 has exacerbated burnout; most concerning patients are being successfully managed with NICH.
- NICH reduces provider burnout by improving relationships between medical team and the family.
- NICH makes provider time more efficient; patients more likely to arrive on time, prepared for their appointment, etc.

Does NICH . . .

√ Reduce Costs.

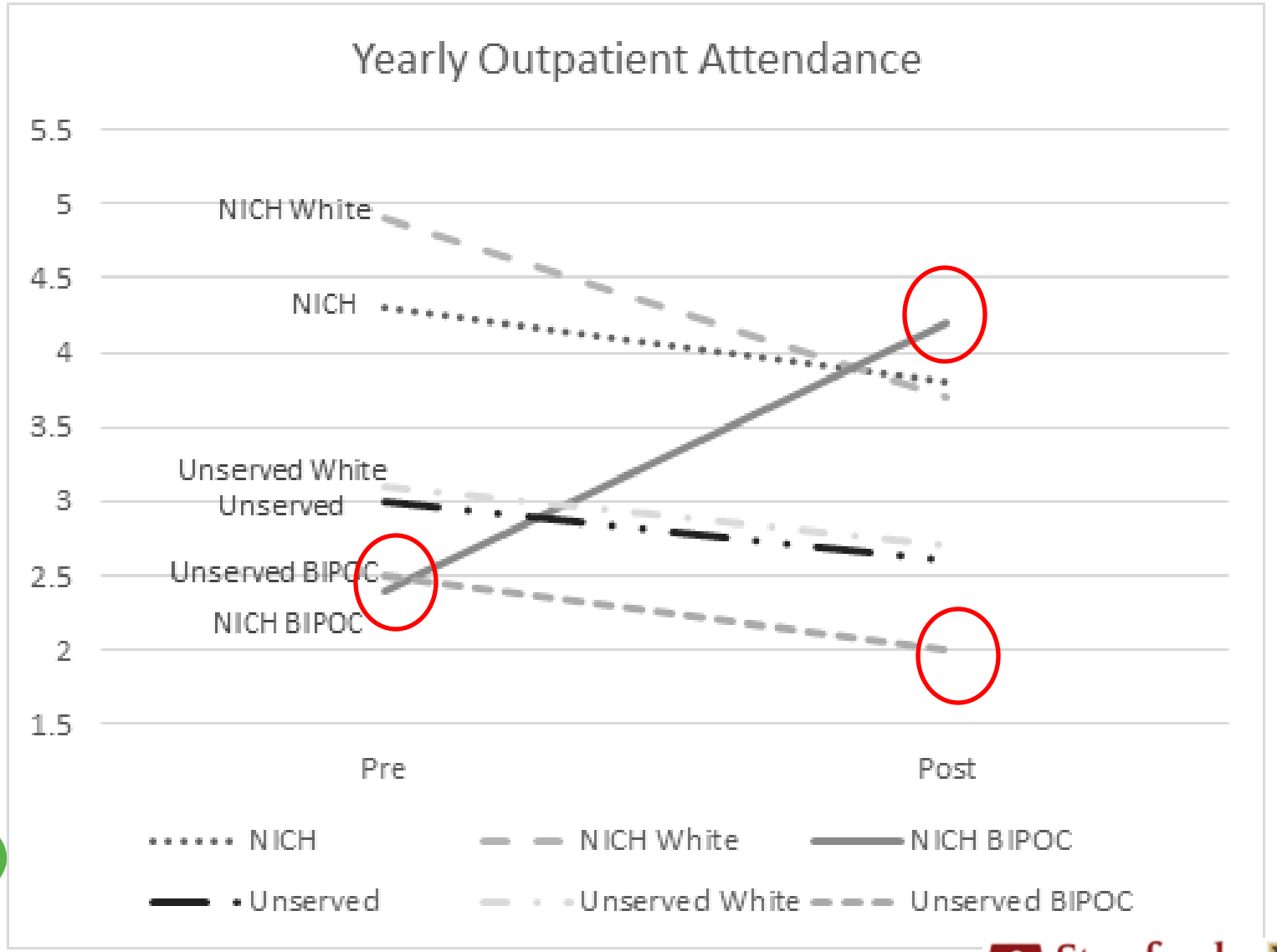
√ Improve Health.

√ Improve Care.

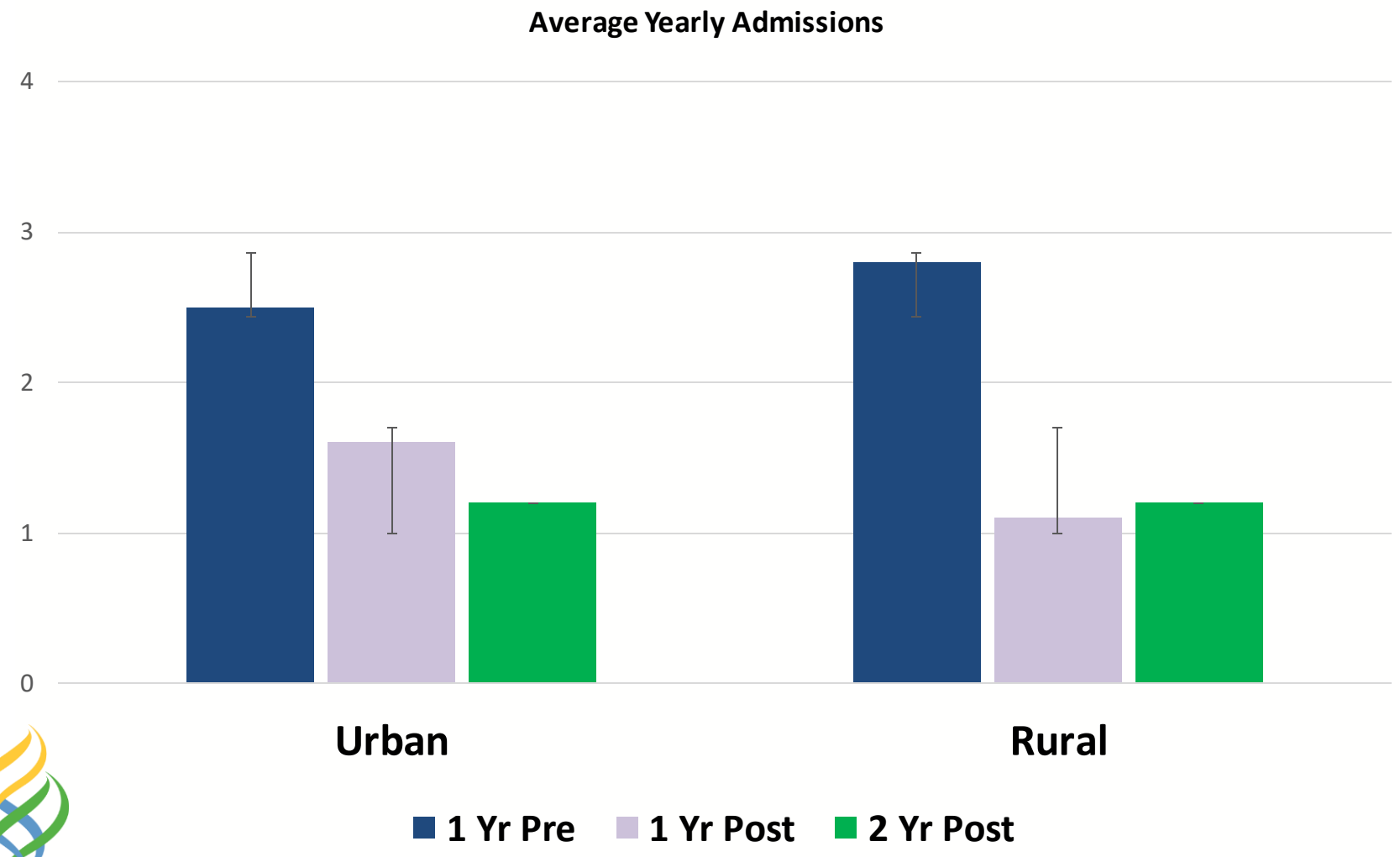
√ Increase Staff Satisfaction.

Reduce Health Disparities?

Reducing Health Disparities



Reducing Health Disparities



Does NICH . . .

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Sustainability Plan: Braided Funding

- Health Innovation Grants
- Case Rates with Payors (APMs)
- Program Contracts with Payors
- Billing Codes – G codes
- Foundation Support
- Research Grants
- Hospital Support – DSH dollars

Financial Sustainability

- Taking pressure of ED/PICU
  - *Keeping patients out of ED/PICU for avoidable reasons*
- Reducing LOS
  - *Freeing up beds for higher acuity patients*
- Decreasing no shows - outpatient
- Billing Codes – G codes
  - *Successfully getting Medicaid to pay for service*
- ↓ Physician Burnout, ↑ Physician QOL
  - Sig costs in turnover (~ $250k-$800k in direct costs)
- Foundation Support
  - *Highly appealing to donors*

Challenges

- No infrastructure for addressing SDoH
- Peds budget dust
- SDoH program siloed
- Ownership and turf over population
- Everyone thinks they already do NICH
- No shortcuts
- More costly
- Not tracking $ or effectiveness of less intensive approaches

THE LEONA M. AND HARRY B.

HELMSLEY

CHARITABLE TRUST

Thank You

Q&A

The PATH Technical Assistance (TA) Marketplace initiative provides funding for California providers, community-based organizations, counties, and others to obtain technical assistance resources to establish the infrastructure needed to implement Enhanced Care Management (ECM) and Community Supports.

- ✓ **Domain 2:** Community Supports: Strengthening Services that Address the Social Drivers of Health
- ✓ **Domain 4:** Enhanced Care Management (ECM): Strengthening Care for ECM 'Population of Focus'
- ✓ **Domain 5:** Promoting Health Equity
- ✓ **Domain 6:** Supporting Cross-Sector Partnerships
- ✓ **Domain 7:** Workforce

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- Virtual access for those unable to travel

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Elevating behavioral health in whole-person care

Learn more → **camdenhealth.org/centeringcare23** | **#CenteringCare23**

Thank you!

National Center for Complex Health and Social Needs

An initiative of the Camden Coalition

www.nationalcomplex.care
@natlcomplexcare

800 Cooper St., 7th Floor
Camden, NJ 08102

Presenter contact:
Jason Turi, jturi@camdenhealth.org
Rhonda Sparr-Perkins, rsperkins@rchsd.org
Holly Henry, holly.henry@lpfch.org
Michael Harris, harrismi@ohsu.edu
Rachel Bensen, bensen@stanford.edu