



**Department
of Health**

**Office of
Health Insurance
Programs**

Preventive Pediatric Care Clinical Advisory Group:

A Recommendation from First 1,000 Days

July 10, 2018

Welcome and Introductions

Dennis Z. Kuo, MD, MHS, Associate Professor, University at Buffalo; Chief, Division of General Pediatrics

Mary McCord, MD, MPH, Director of Pediatrics, Gouverneur Health

Agenda

- Welcome and Introductions
- High-level Summary of Preventive Pediatric Clinical Advisory Group Meeting 1
- Review of First 1,000 Days Recommendations
- Other States' Experiences with Transformation
- The Path to Pediatrics 3.0
- Discuss Questions
- Homework
- Next Steps

Participants

Name	Organization	Name	Organization
Margaret Adeigbo	DOH, Office of Health Insurance Programs	Diane Ferran	Community Healthcare Association of New York State (CHCANYS)
Jeanne Alicandro	DOH, Office of Quality and Patient Safety	Douglas Fish	DOH, Office of Health Insurance Programs
Susan Beane	HealthFirst	Vito Grasso	American Academy of Family Practice, Deputy Executive Director
Winter Berry	Upstate Medical Center, Syracuse	Tochi Iroku-Malize	Prof & Chair Family Medicine, Northwell Health
Rahil Briggs	Montefiore	Liz Isakson	Docs for Tots; Council on Children and Families ECCS
Suzanne Brundage	United Hospital Fund	Michele Juda	Chair of Parent to Parent
Rebecca Butterfield	Albany Medical Center, Medical Director for Better Health for Northeast NY PPS	Marilyn Kacica	Office of Public Health, Division of Family Health
Anne Campagna	Assistant to Dr. Kuo	Jeff Kaczorowski	URMC and Medical Director with Finger Lakes PPS
Carmelita Cruz	OASAS	Paul Kaye	Chair of Schuyler Center's Board, Hudson River Healthcare (FQHC)
Denard Cummings	DOH, Office of Health Insurance Programs	Shantrise Keller	Advocate

Participants

Name	Organization	Name	Organization
Dennis Kuo	University at Buffalo	Paige Pierce	Families Together of NY State
Christopher Kus	Office of Public Health, Division of Family Health	Andrew Racine	Chief, Division of General Pediatrics at the Children's Hospital at Montefiore & Professor of Pediatrics at the Albert Einstein College Medicine
Kallanna Manjanuth	Albany Medical Center, Medical Director for Better Health for Northeast NY PPS	Talya Schwartz	MetroPlus
Mary McCord	Gouverneur Health Services (Gotham)/NYU	Kalin Scott	DOH, Office of Health Insurance Programs
Daniel Miller	Hudson River HealthCare, Inc.	Warren Seigel	FAAP District II Chairperson
Maria Morris	OASAS	Constantina Spiropoulos	NYS Association- Infant Mental Health
Jonathan Nasser	Crystal Run HealthCare	Paul Thompson	New York State Education Department
Alda Osinaga	DOH, Office of Health Insurance Programs	Lauren Tobias	DOH, Office of Health Insurance Programs
Michela Paniccia	DOH, Office of Health Insurance Programs	Elie Ward	American Academy of Pediatrics District II, NYS
Matthew Perkins	OMH	Fern Zagor	Staten Island Mental Health Society, Inc.

Department of Health Charge to Preventive Pediatric Care Clinical Advisory Group

Douglas Fish, MD, Medical Director, OHIP – DOH

Christopher Kus, MD, MPH, Associate Medical Director, DFH, OPH – DOH

Charge of Preventive Pediatric Care CAG

- 1) To develop a framework/model for how to best organize well-child visits/pediatric care in order to implement the *Bright Futures* Guidelines
- 2) To identify barriers, incentives, and new system approaches for doing what is expected of providers of children's health care
- 3) The group will make recommendations to the New York State Medicaid program on how to work with managed care organizations and providers to turn *Bright Futures* implementation guidance into routine practice.

Timeline

- *Meeting 1 (5/29/18)* Background, Defining the Problem & Charge
 - Reviewing available models
 - Developing initial sketch/outline of a model
- *Meeting 2* Model Refinement
 - Implementing Bright Futures
 - Beginning of recommendation development for how to move from where practices are today to the new model
- *Meeting 3* Continued Development of Recommendations
- *Meeting 4* Finalize Model and Recommendations

Summary of Preventive Pediatric Clinical Advisory Group Meeting 1

Douglas Fish, MD, Medical Director, OHIP – DOH

Christopher Kus, MD, MPH, Associate Medical Director, DFH, OPH – DOH

Preventive Pediatric Clinical Advisory Group Meeting 1 Summary

- Discussion of envisioning what Pediatrics 3.0 might look like.
- Better care coordination and closing of referrals loop is needed.
- Critical need to address Behavioral Health, to include mental health.
- How do we best address the social determinants?
- Desire support for both the child and the family.
 - Family voice in defining what support is prioritized
 - Include fathers
- How do we build on the fundamental principles described in Bright Futures?

Recommendations from May 29, 2018 Meeting

- Include Managed Care Organizations in the discussion.
- Include Family Practice in the discussion.
- Continue conversation with State Education Department.
- Where does this Advisory Group fit among the other First 1000 Days' Recommendations?
- Come back to the group with a draft model for practice transformation to move toward Pediatrics 3.0.
- We asked you to bring 3 ideas for key components of what an “Advanced Pediatric Primary Care” practice should look like in NY State in 2018.
 - What are we missing?

Questions on background materials?

First 1,000 Days Recommendations

Kalin Scott, Director, Medicaid Redesign Team Project Management Office; Deputy Director, Bureau of Medical, Dental and Pharmacy Policy

10-Point Plan

Final Rank	Proposal Description
1	Proposal 17 – Braided Funding for Early Childhood Mental Health Consultations
2	Proposal 10 – Statewide Home Visiting
3	Proposal 1 – Create a Preventive Pediatric Clinical Advisory Group
4	Proposal 4 – Expand Centering Pregnancy
5	Proposal 2 – Promote Early Literacy through Local Strategies
6	Proposal 14 – Require Managed Care Plans to have a Kids Quality Agenda
7	Proposal 5 – New York State Developmental Inventory Upon Kindergarten Entry
8	Proposal 20 – Pilot and Evaluate Peer Family Navigators in Multiple Settings
9	Proposal 18 – Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy
10	Proposal 16 – Data System Development for Cross-Sector Referrals

#14 Require MCOs to have a Kids Quality Agenda

- Under this proposal, DOH would develop a two-year effort to improve managed care plan performance on children and perinatal health care quality measures.
 - Develop a two-year common PIP for all Medicaid managed care plans called the "Kid's Quality Agenda."
 - Each plan would be required to develop, implement, and evaluate a supplementary intervention that aims to address the three focus areas; each PIP would be evaluated by the External Quality Review Organization, which would publish a compendium of PIP abstracts per CMS requirements.
 - To encourage Medicaid managed care plans to adequately invest in the Kid's Quality Agenda PIPs, DOH would provide an extra one measure's worth of points (currently 3.03 points) in calculating the Quality Incentive program results, for any plan that was in the 90th percentile on all three of related measures in that program (well-child visits first 15 months, timeliness of prenatal care, and postpartum care).
 - An additional one bonus point in the Quality Incentive program calculation would be available to any plan that effectively engaged non-health sector community based organizations in its intervention (as validated by the External Quality Review Organization).
- Project team is in the process of designing PIP approach, will be engaging with MCOs in the near term, and will also consult on design with the Preventive Pediatric Care Clinical Advisory Group

#20 Pilot and Evaluate Peer Family Navigators in Multiple Settings

- This proposal would develop implement, and evaluate a total of nine pilots that would provide peer family navigator services.
 - The first set of sites would evaluate the use of peer family navigator services in community settings outside of the acute care physical health system.
 - An additional pilot with four sites would focus on family health navigation services in primary care offices.
 - DOH would conduct internally or contract externally for a qualitative and quantitative evaluation of the pilots.
- Project team is interviewing stakeholders working to define pilot scope, funding and evaluation strategy.

#16 Data System Development for Cross-Sector Referrals

- Under this proposal, Medicaid would direct competitive grant funds to at least 3 communities for the purchase of a Medicaid–determined hub–and–spoke data system that would enable screening and referrals across clinical and community settings.
 - Create data infrastructure to support service referrals and document connections.
 - New York Medicaid would direct competitive grant funds to purchase a Medicaid–determined hub–and–spoke data system that enables screening and referrals across clinical and community settings for at least 3 communities (if fiscally feasible, grants would ideally be available to two urban, two suburban and two rural communities)
- Project team is researching existing, community-level efforts in NYS and working with related Social Determinants of Health and VBP efforts to align pilot design strategy.

#17 Braided Funding for Early Childhood Mental Health Consultations

- This is a proposal for OHIP to convene a design committee with colleagues in the Office of Mental Health, Office of People with Development Disabilities, Office of Alcoholism and Substance Abuse Services, Office of Child and Family Services, and potentially the State Education Department (Adult Career and Continuing Education Services) to explore a braided funding approach for paying for mental health consultation services to early childhood professionals in early care and education settings.
 - Identify potential funding sources.
 - Identify a strategy for allocating revenues and expenditures by categorical funding source.
 - Test feasibility of new funding approach.
 - Coordinate with OMH's Project TEACH.
- Project team is currently researching existing models and identifying agency partners for a design committee.

#10 Statewide Home Visiting

- This proposal is for New York Medicaid to take several significant steps to ensure the sustainability of home visiting in New York so every child and pregnant woman who is eligible and desiring of the services receive them.
 - Convene a workgroup to identify opportunities for increased Medicaid payment for evidence-based, evidence-informed, and promising home visiting programs.
 - Engage the NY State Education Department to explore scope of practices that would allow non-clinician home visits to be billable.
 - Design and launch a pilot project in 3 high perinatal risk communities to scale up evidence-based home visiting programs using a risk stratification approach to match families to a home visiting program (or potentially other community-based health supports) that best fits their needs and eligibility.
- Project team is working with state agency partners on identifying high perinatal risk communities; cataloguing existing efforts statewide; researching models in other states; identifying work group membership and meeting dates.

#1 Create a Preventive Pediatric Care Clinical Advisory Group

- This proposal is to convene a clinical advisory group charged with developing a framework model for how best to organize well–child visits/pediatric care in order to implement the Bright Futures Guidelines (the American Academy of Pediatrics standard of care).
 - Identify barriers, incentives, and new system approaches for doing what is expected of pediatricians as identified by Bright Futures.
 - The group would make recommendations to the New York Medicaid program on how to work with managed care organizations and providers to turn its implementation guidance into routine practice.
 - The end goal of addressing these structural components of well–child visits/pediatric practice is to ensure that all children visiting primary care receive the most effective care possible.
- First work group meeting held 5/29; meetings to work toward final recommendations will continue through the fall.

#4 Expand Centering Pregnancy

- This proposal is for Medicaid to support a pilot project in the neighborhoods/communities of poorest birth outcomes to encourage obstetrical providers serving Medicaid patients to adopt the Centering Pregnancy group-based model of prenatal care, which has shown dramatic improvements in birth-related outcomes and reductions in associated disparities.
 - The model is designed to enhance pregnancy outcomes through a combination of prenatal education (gestational development, healthy behaviors) and social support.
 - The state would contract with the Centering Healthcare Institute (CHI) to provide both training workshops for providers as well as on-going implementation support and technical assistance.
 - The state should also ensure that implementation of the model includes screening and referral for social determinants of health (environment, housing, educational attainment, etc.).
- Project team has engaged with Centering Healthcare Institute and existing state sites, identified potential areas for implementation/expansion based on poor health outcomes, and is working with state agency partners on program design for implementation

#2 Promote Early Literacy through Local Strategies

- This proposal is for Medicaid to launch one or more three–year pilots to expand the use of Reach Out and Read (ROR) in pediatric primary care and foster local cross–sector collaboration focused on improving early language development skills in children age 0 – 3.
 - NY Medicaid would provide three-year pilot funding to any interested mainstream managed care organization sufficient to conduct pilots covering up to 1,500 children age 0-3 per year.
 - Primary care providers participating in the pilot would be required to complete the national ROR online, CME training course and share data with national organization and managed care organizations.
- Project team will meet with national Reach Out and Read organization and existing New York sites in June to support program design for implementation.

#5 NYS Developmental Inventory Upon Kindergarten Entry

- Under this proposal, the State Education Department, Medicaid, and other partners would agree upon a measurement tool to assess child development upon Kindergarten entry.
- A standardized measure took at kindergarten entry would enable:
 1. population–level tracking of trends over time in child development;
 2. assessment of how policy and programmatic changes are possibly affecting child development; and
 3. identification of areas (e.g. whether regions of the state, areas within child development) in need of improvement, investment, and policy change.
- During week of 5/29, SED project team distributed short survey on current screening/assessment usage across NYS – information collected will guide stakeholder discussions and next steps to determine need and scope of Statewide Development Upon Kindergarten Entry; stakeholders to be convened in Fall 2018.

#18 Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy

- This proposal is for Medicaid to allow providers to bill for the provision of evidence–based, parent/caregiver–child therapy (also called dyadic therapy) based solely on the parent/caregiver being diagnosed with a mood, anxiety, or substance use disorder.
 - Develop list of evidence-based, dyadic treatment models eligible for payment.
 - Issue guidance to plans and providers explaining expanded eligibility criteria for dyadic therapy.
- Project team is working with the Medicaid policy team to research similar policies and approaches in other states and design an approach for implementation in New York.

Questions on First 1,000 Days Recommendations?

Other States' Experience

Dennis Z. Kuo, MD, MHS, Associate Professor, University at Buffalo; Chief, Division of General Pediatrics

Child Health & Demographics Are Changing

- Demographic factors
 - Increasingly majority-minority
 - Almost half of children live in or near poverty
 - Infant mortality and vaccine preventable diseases are at historic lows
 - Chronic conditions are increasing – now 20% of children (25% of adolescents)
- The nature of outpatient pediatric visits appear to be changing
 - More behavior health visits, medical complexity, and older patients
 - More patients with Medicaid insurance
 - Reduction in acute visits – and this reduction is not being made up by increases in ED or urgent care

The View From Other States

- Medicaid is a federal-state partnership, which can cultivate innovation
- System transformation is happening around the country
- Some valuable lessons from other states
 - Change CAN happen
 - Begin to address the questions “how can we do all of this” and “who’s going to pay for it”
 - Models and approaches are vastly different
- What can we learn?
 - Arkansas – provider-led model
 - Ohio (Columbus) – ACO-focused model
 - Both states had CMMI support

Lessons Learned From Arkansas

- Physician-led system transformation – enhanced primary care model
 - Providers responsible for entire patient panel
 - 24/7 access for all individuals / networked EMRs
 - Coordinated integrated care across multidisciplinary provider teams
 - Focus on chronic disease with avoided progression
- Monthly fees support care coordination and transformation
- Support for practice transformation
 - Smaller practices pooled patients
 - Larger patients generally handled their own
- **Upside-only** shared savings model rewards providers for controlling costs while maintaining or improving quality

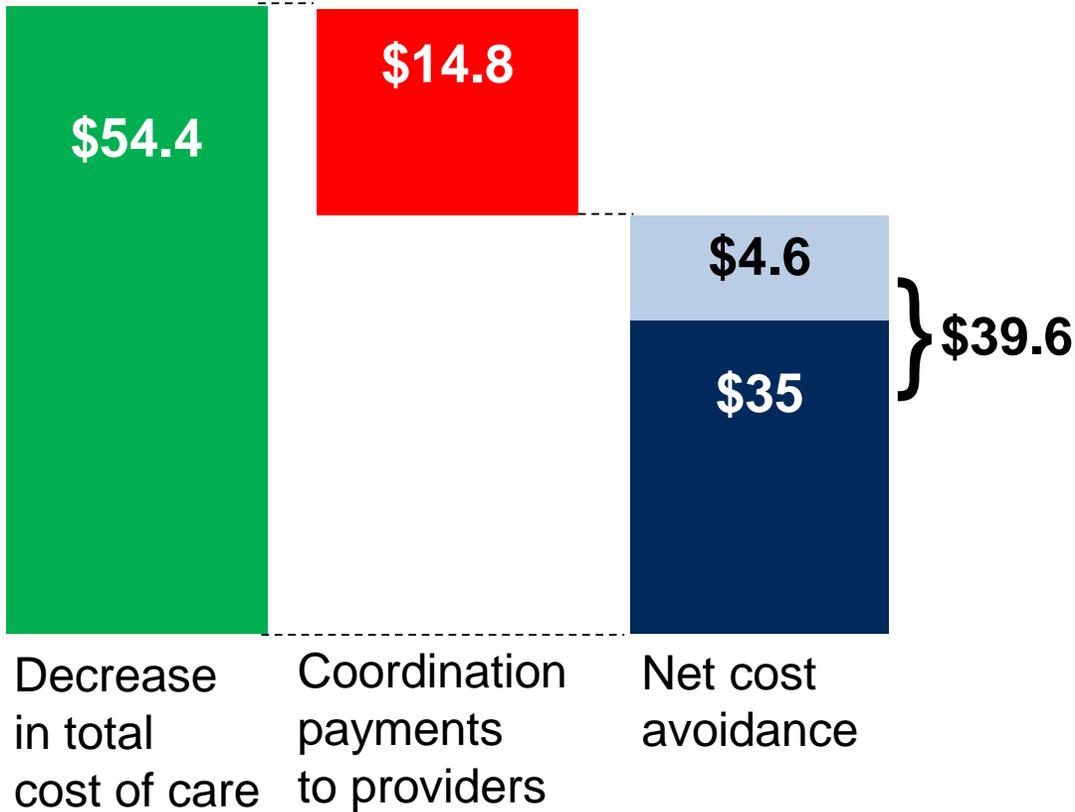
Arkansas PCMH Framework for Transformation

2018 Activities	3 MO	6 MO	12 MO
Identify top 10% high-priority patients	●		
Provide 24/7 access to care		●	
Document approach to expanding access to same-day appointments		●	
Document capacity to receive e-messaging from patients		●	
Enroll in Arkansas Prescription Drug Monitoring Program (PDMP)		●	
Childhood/adult vaccination practice strategy			●
Join SHARE or network that delivers discharge info within 48 hours			●
Incorporate e-prescribing			●
Create care plans for high-priority beneficiaries			●
Assess patient health literacy			●
Document ability to receive patient feedback for improvements			●
Create and share care instructions with high-priority patients			●
Medication management in EHR: Document method			●
10-day follow-up after an acute inpatient hospital stay			●

● Completion of activity and timing of reporting

2015 PCMH Medicaid Cost Avoidance

Millions



Of the \$660.9M predicted total cost of care:

- \$606.5M is the actual cost
- \$54.4M is the generated cost avoidance

Of the \$54.4M in cost avoidance:

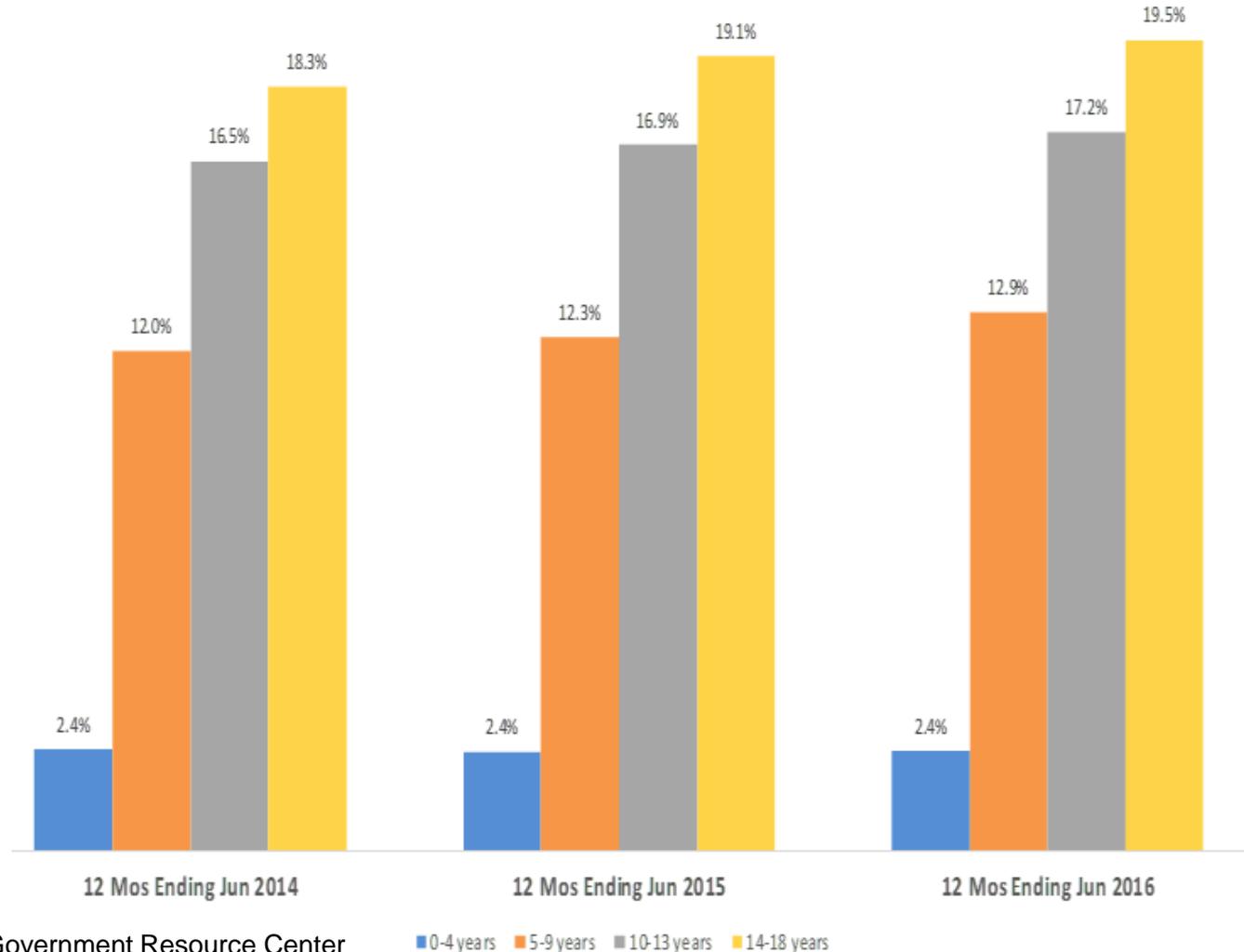
- \$14.8M has been reinvested back into the provider community
- \$39.6M represents total net cost avoidance
- \$12.8M shared savings payments to providers for CY2015

Lessons Learned From Ohio

- ACO-led model: Partners for Kids and Nationwide Children's Hospital
- "Patient-Centered Medical Neighborhood" – less change in practices

OLD	NEW
PCMH	PCMNeighborhood
Anticipatory Guidance Visit	Group Well Care, Online Care
Physician Care	Team Care
Physician Focused Practice	Retail/Consumer Focused Care
Child Wellness	Social Determinants of Health

Percentage of PFK-Enrolled Members with Community Mental Health Claims



Source: MITS data from the Government Resource Center

■ 0-4 years ■ 5-9 years ■ 10-13 years ■ 14-18 years



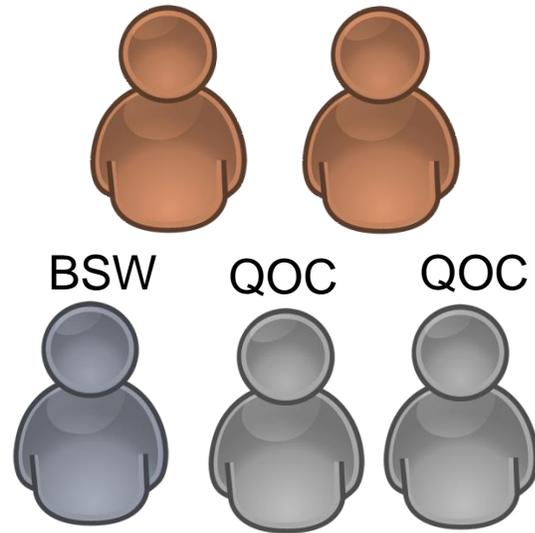
Department of Health

Primary Care Team

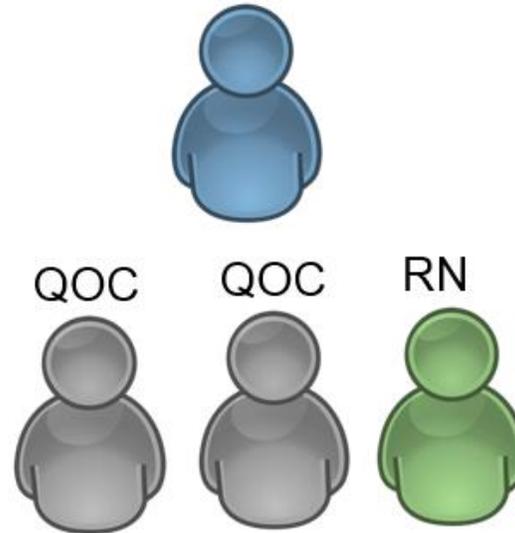


Care Coordination Staffing Model

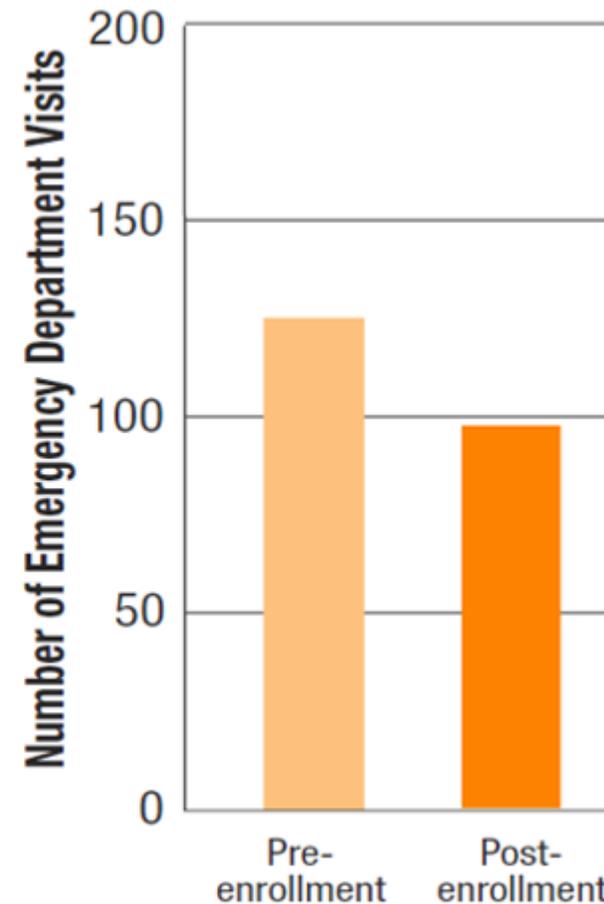
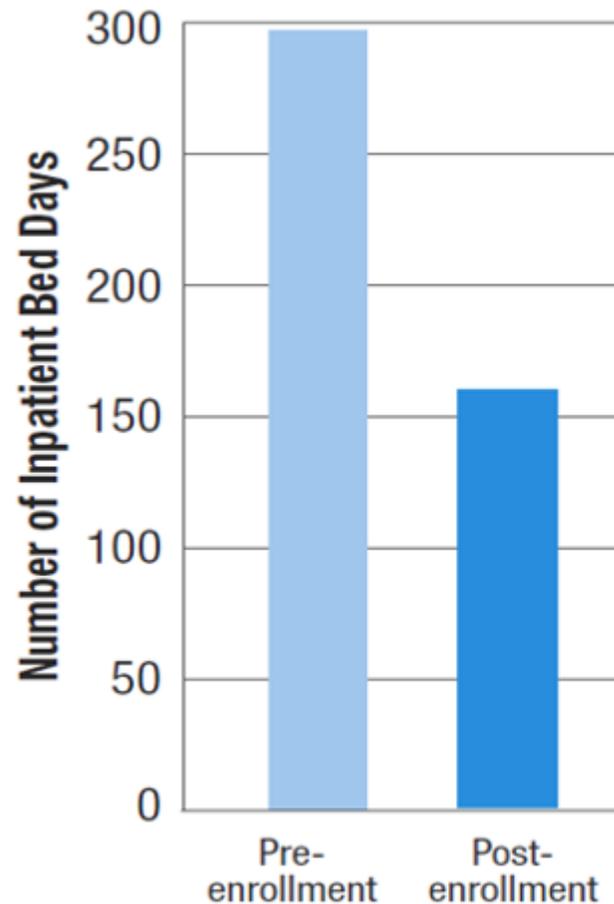
RN Care Coordinators



MSW Care Coordinators



Pre- and Post- Enrollment Utilization Characteristics of Selected Patients Enrolled in Care Coordination 2014

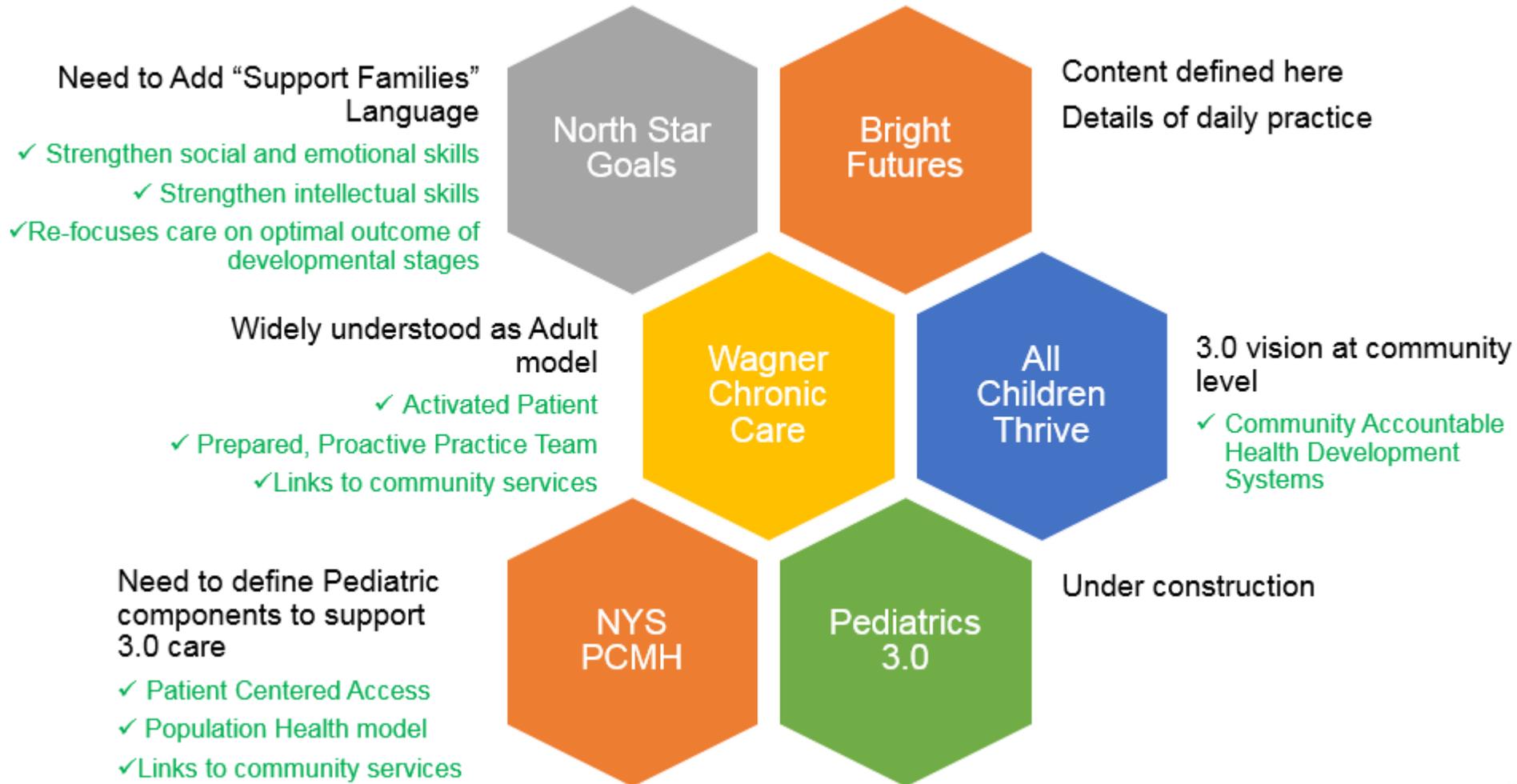


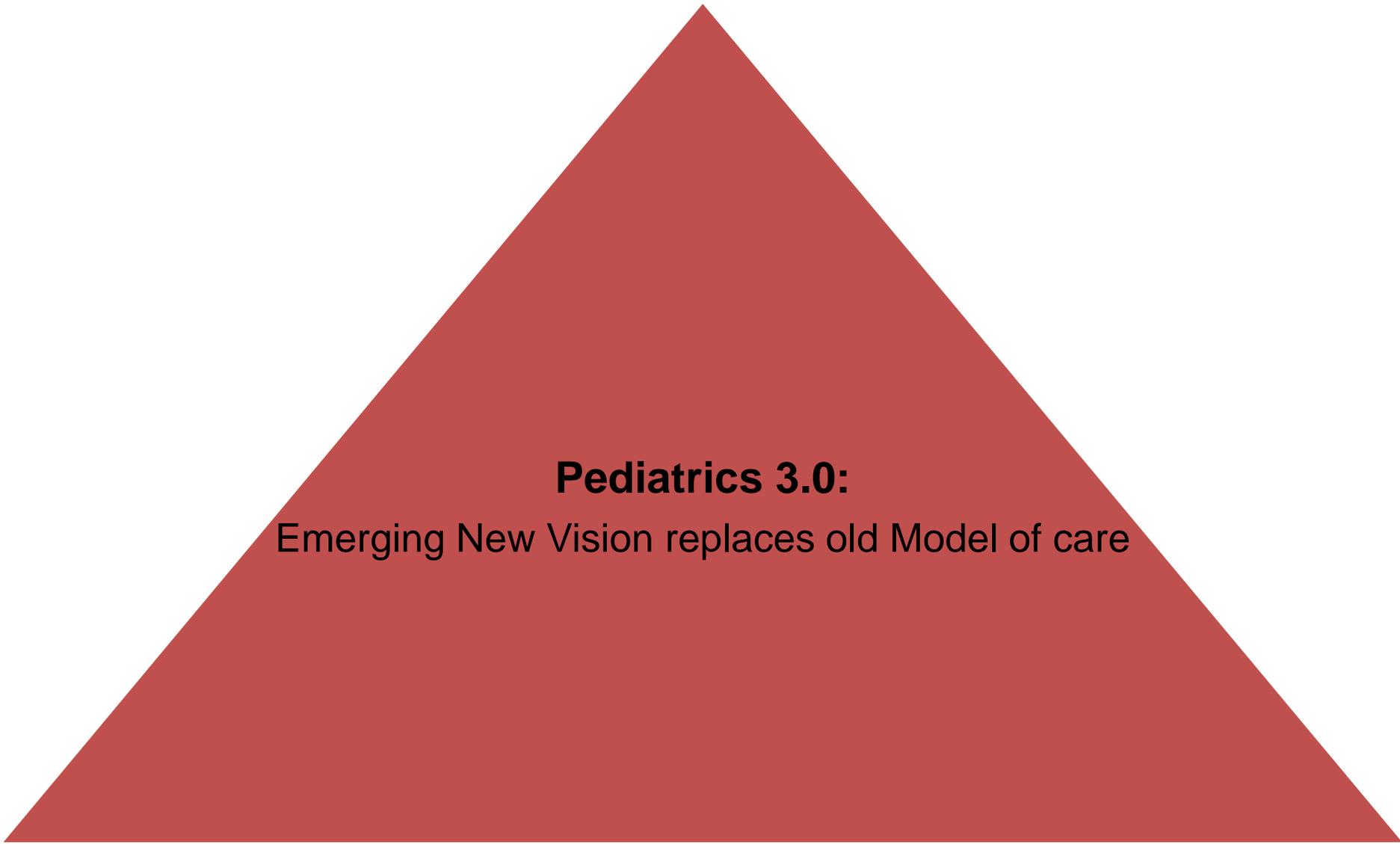
Questions on other States' experience?

The Path to Pediatrics 3.0

Mary McCord, MD, MPH, Director of Pediatrics, Gouverneur Health

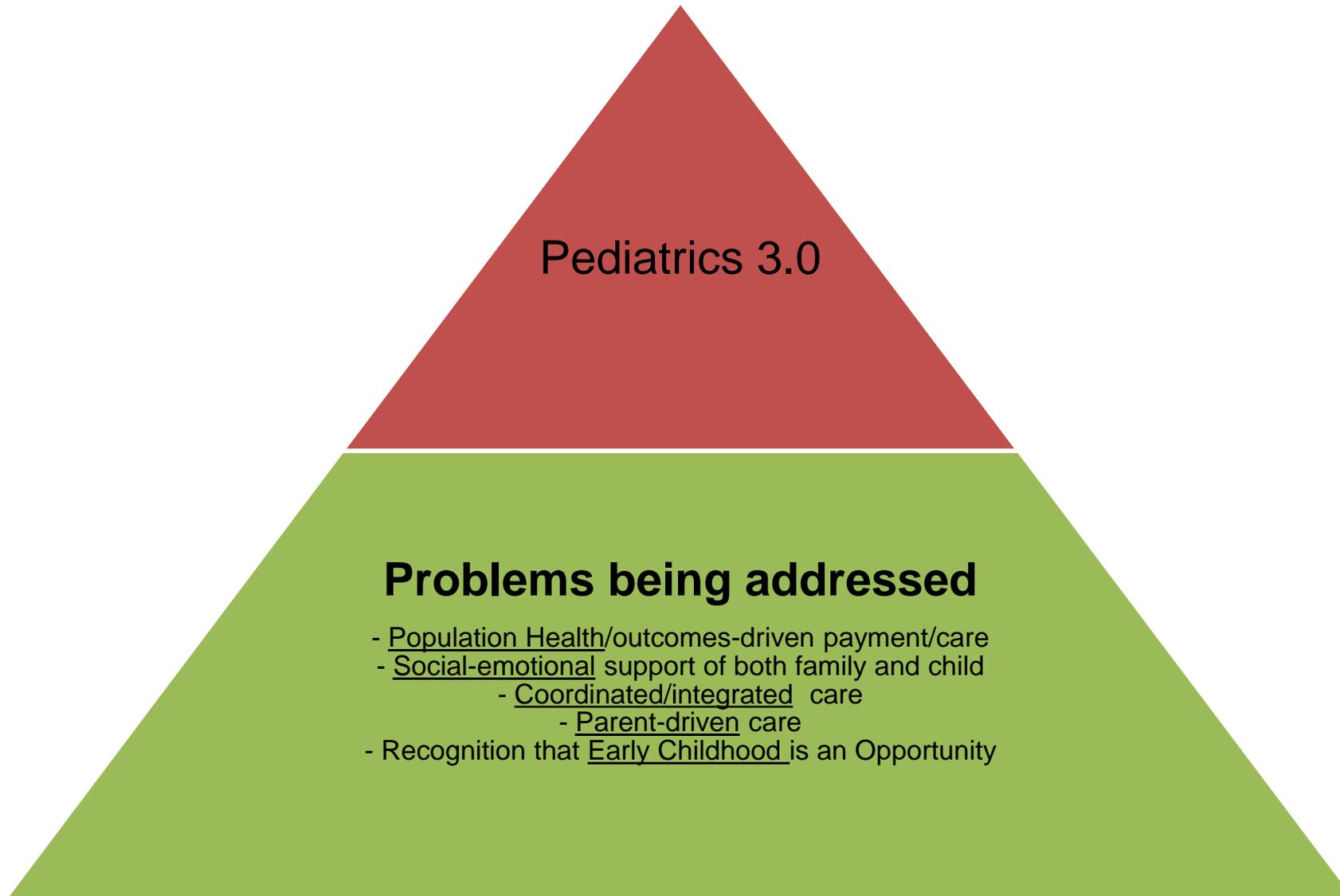
Building Blocks

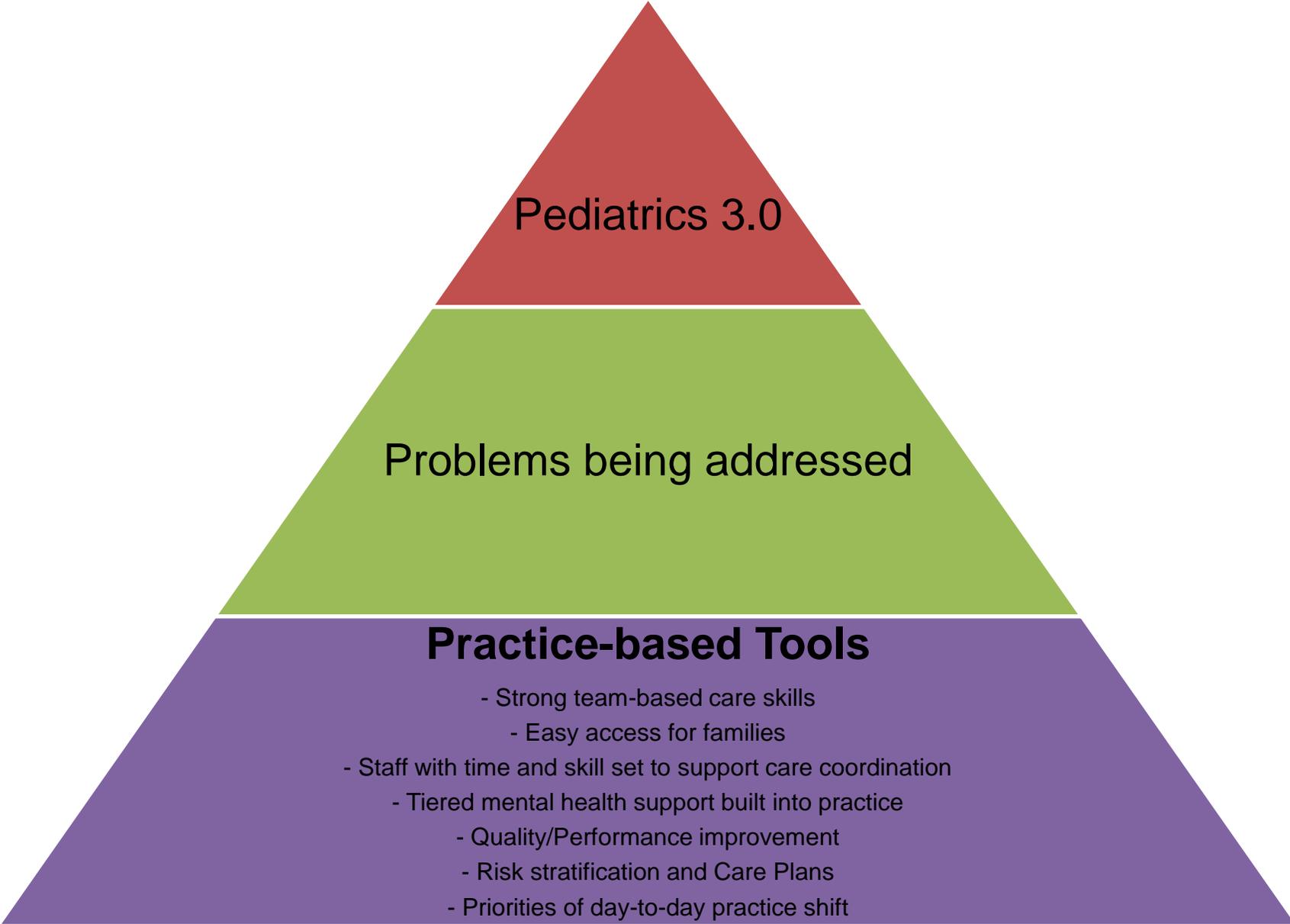


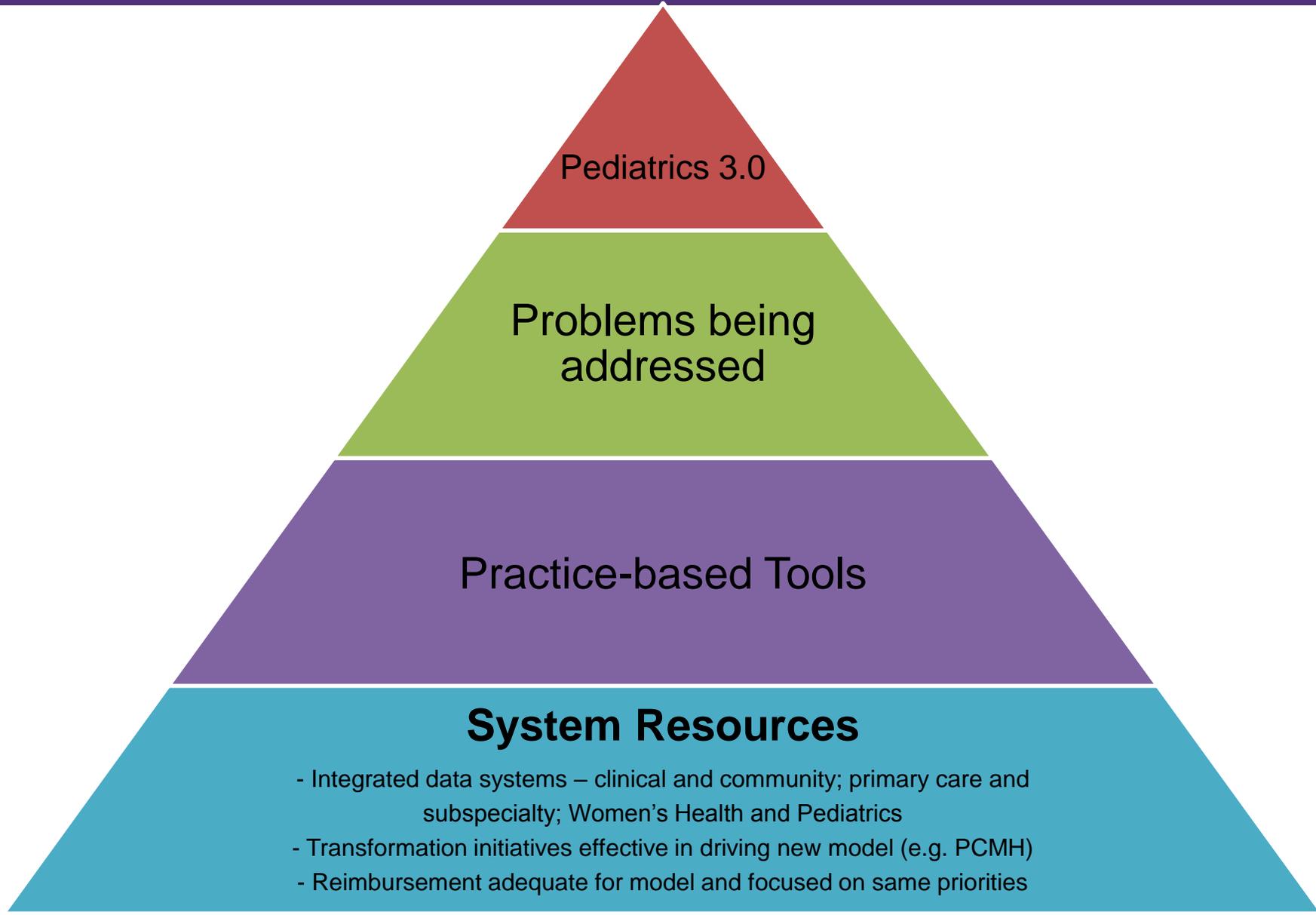


Pediatrics 3.0:

Emerging New Vision replaces old Model of care







Isn't Everything Practices Need Already in Bright Futures?

YES, but...

- Old model of care, driven by acute care visits and narrow and medical vision of health care is prevalent – Old model is not sustainable
- Emerging new vision – Need consensus on vision and a payment model to support it
 - Invest in supporting optimal child development and social-emotional health
 - Chronic illness management
 - Wagner Care Model

What Is The Problem We Are Addressing?

- **Population Health**/outcomes-driven payment/care is here to stay
...and we don't have a vision of what Pediatric practice in Pop Health world looks like
- **Social-emotional** support of both family and child most important for pop health impact but not funded
- To improve outcomes support from community and practice must be **coordinated/integrated** but integration infrastructure not there
- **Parent driven** care not wide spread – current payment undermines it in many ways
- Wide understanding of **importance of Early Childhood** support is an opportunity

Pediatrics 3.0 Tools – Practice-Based

- Practices with strong team based care skills
- Easy access for families
 - Includes appts, phone, email, portal-based pre-visit and post visit information exchange
- Staff with time and skill set to support care coordination for children
- Tiered mental health support built into practice (aka Collaborative care) - Early childhood, school age and Adolescent skill sets needed
 - Low risk = anticipatory guidance and routine referral to resources
 - Medium risk = extra support in practice including treatment capacity
 - High risk= link to needed care, support family until they get there
- Quality/Performance improvement supports new model of care

Pediatrics 3.0 Tools – Practice-Based

- Right support to the right family at the right time = risk stratification and Care Plans
 - Limited, high quality screening, with effective process to address identified needs
 - Support provider-patient dialogue as critical tool – other work to other staff
 - Efficient and meaningful links to evidence based services
 - Patient-centered care plans
- Priorities of day-to-day practice shift to:
 - Social/emotional/developmental health
 - Parent voice
 - Population Health = understand and organize practice resources to address needs of entire patient panel.
 - Requires different approach to different patients
 - Links to community services

Pediatrics 3.0 Tools – Outside Practice

- Integrated data systems that genuinely support community service-family-practice integration
- Infrastructure – links to OB/Gyn and to sub-specialists to smoothly communicate care plans
- Reimbursement model that drives care in the right direction and supports services needed
- PCMH – harness the potential for Pediatrics

Challenges

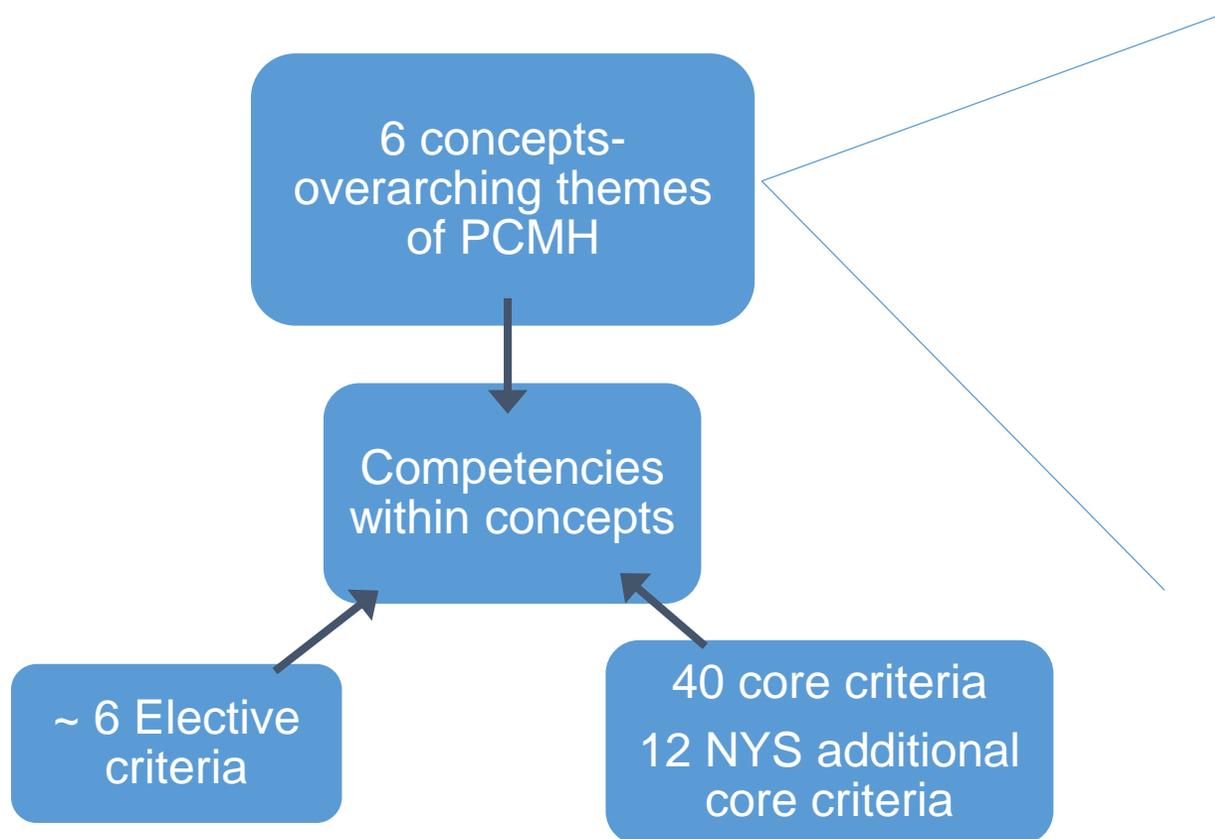
- Reimbursement!!
- No consensus or clarity on vision for Pediatrics 3.0
- Variable competence in new processes (screening, care coordination)
- Lack of community connections and systems
- Transformation costs and upfront costs
- Piecemeal vs. Statewide efforts (e.g. Ohio, Arkansas, Vermont or Oregon)

Questions on the Path to Pediatrics 3.0?

NYS PCMH

Douglas Fish, MD, Medical Director, OHIP – DOH

NYS PCMH Components



- Team Based Care and Practice Organization
- Knowing and Managing Your Patients
- Patient Centered Access and Continuity
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

What Are The Deliverables From This Committee?

- Crisp consensus of what Pediatrics 3.0 really is
- Prioritized recommendations for whom, besides NY State?
 - Managed Care?
 - NCQA for PCMH?
 - Others?
- Anything else?

Questions

- How can we build upon PCMH to achieve pediatric 3.0 transformation?
 - Would decoupling Pediatric PCMH from Adult PCMH help?
 - How has PCMH changed (or not changed) what you do today?
- How do we most effectively move from checking boxes to meaningful transformation?
- How do we best motivate and inspire the culture change needed among Administrators, Clinicians, and Payers to transform to the New Model?

Summary

- Investments will need to be made in children if we are to be successful in achieving meaningful transformation.
- We need to move from the volume and acute care-driven model to one that addresses children within the context of the family unit and sets them on a path to succeed and maximize their potential
- Early investments in children promote later successes in health, education, and over well-being.

Next Meeting & Homework

- **Please send written comments on Pediatrics 3.0 (slides 45 – 48) with either an edit to strengthen the description or a concern you would like to see addressed to Michela.Paniccia@health.ny.gov**
- Next meeting via WebEx Tuesday, September 4, 1 – 3:30 PM
 - Continued refinement of recommendations
 - Will dive deeper into reimbursement options
 - **Please bring 2-3 ideas on messaging to the State concerning reimbursement and transformation models that would support Pediatrics 3.0**
- Final meeting in person, likely in NYC, Tuesday, October 30, 2018

Further Questions or Comments?

Please contact:

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