Preventive Pediatric Care
Clinical Advisory Group:
A Recommendation from First 1000 Days

May 29, 2018
Agenda

Morning
• Welcome and Introductions
• Introduction of Co-Chairs
• Context for First 1000 Days and Children’s VBP
• Problem Statement
• Charge from NYS Department of Health
• Framework for Implementation toward Pediatrics 3.0

Afternoon
• Discussion Questions
• Homework
• Next steps
Welcome and Introductions
First 1000 Days on Medicaid
Context for Preventive Pediatric Care
Clinical Advisory Group

Suzanne Brundage
Director, Children’s Health Initiative
United Hospital Fund
Context—Children in NY Medicaid

- Medicaid covers 43% of all children under age 21 in New York State.
- Children account for 37% of all NYS Medicaid Enrollees.
- Most, but not all, children are in managed care.
- VBP only applies to children in managed care.

<table>
<thead>
<tr>
<th>Enrollment Aug 2017</th>
<th>2,259,071</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care</td>
<td>2,037,665</td>
</tr>
<tr>
<td>Fee For Service</td>
<td>221,406</td>
</tr>
</tbody>
</table>

Age Breakdown

- > age 1: 6%
- 1-4: 22%
- 5-9: 26%
- 10-13: 18%
- 14-17: 17%
- 18-20: 11%

Sources: New York State Medicaid Program Enrollment by Month – Health Data NY; Census Bureau American Fact Finder ACS Demographic and Housing Estimates; United Hospital Fund Understanding Medicaid Utilization for Children in New York State.
Context—Delivery and Payment System Reform

2011: Governor Cuomo created the Medicaid Redesign Team (MRT) reforms.

2014: Delivery System Reform Incentive Payment Program (DSRIP).

2015: As part of DSRIP, NYS working towards 80% value based payments.

2016: Children & Adolescent VBP Advisory Group is formed & makes payment reccs.

2017: First 1,000 Days announced as additional MRT focus, building on VBP advisory group discussions.

Additional State Efforts
- Children’s Health Homes
- State Innovation Model (SIM) and NYS PCMH
- NYS Office of Mental Health: Healthy Steps Pilot
- NYS Early Childhood Comprehensive Systems (ECCS) grant

Regional Efforts
- Multiple “collaborative impact” initiatives
- NYC maternal depression collaborative
- NYC Partnerships for Early Childhood Development grant program
Impotrance of First 1,000 Days of Life

A child’s brain develops rapidly in the first 3 years of life, and we now know what kinds of interventions can help or hinder this process.

Early experiences’ effect on the brain and body partially explain significant disparities in health and learning by school entry – especially for children living in poverty.

Synapses (Connection between brain cells) at birth, 3 months, and 2 years
Long-Term Perspective

40% of children enter kindergarten not ready*

42% of 3rd Graders are Proficient in Reading

24% of 8th Graders are Proficient in Math*

80% of High Schoolers Graduate in 4 Years

65% of graduates enroll in post-secondary

50.5% of SUNY 4-yr students complete in 4 years; 67% complete in 6yrs
Healthcare Uniquely Positioned for Impact

<table>
<thead>
<tr>
<th>Ages 0-1</th>
<th>Ages 1-2</th>
<th>Ages 2-3</th>
<th>Ages 3-4</th>
<th>Ages 4-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Healthcare touches/yr (well-child visits)</td>
<td>4 Healthcare touches/yr</td>
<td>2 Healthcare touches/yr</td>
<td>1 Healthcare touch/yr</td>
<td>1 Healthcare touch/yr</td>
</tr>
</tbody>
</table>

Healthcare Sector

Education Sector

Child care in formal educational settings is voluntary; shortages in care supply exist

Early pre-K opportunities limited; voluntary

Pre-K opportunities growing; voluntary
Medicaid’s Role

- 51% of all births are covered by Medicaid
- 48% of New York’s children 0-18 are covered by Medicaid
- 59% of children 0-3 in NYS are covered by Medicaid

Pediatricians and family physicians play an important role in the early years. Over 80% of publicly insured children in New York make 5 or more well-child visits in the first 15 months of life.
First 1,000 Days on Medicaid: Charge

Develop a 10-point plan for how Medicaid can improve health/development of children ages 0 to 3 that is:

- **Affordable** – Reasonable cost to state Medicaid
- **Cross-sector** – Collaboration beyond health care
- **Feasible** – Able to be implemented in near term through Medicaid levers
- **Evidence-based** – Proposed interventions or approaches are backed by strong evidence
- **High Impact** – Likely to improve outcomes for children, reduce disparities, and encourage systems change
# First 1,000 Days on Medicaid: 10-Point Plan

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

- Developed three core Advisory Group “products.”

1. Conceptual “North Star” framework intended to guide the State’s future deliberations about children enrolled in Medicaid;
2. Draft recommendations pertaining to a child-specific VBP model, measures, and future work focused on children with complex needs; and
3. Measure set which could be applied to VBP arrangements for children in 2018 and proposed expansion of some maternity measures for other VBP arrangements beginning in 2019.
Value Based Payment (VBP) Recommendations

1. **VBP Principles and Payment Models** – Creating an additional, voluntary Level 3 Pediatric Primary Care Capitation (PPCC) VBP arrangement focused on generating health improvements for the 90 percent of children who are considered “low-cost” in Medicaid.

2. **Quality Measures** – Creating a Universal Child Measure Set applicable to Total Care for the General Population (TCGP), Integrated Primary Care (IPC), and PPCC arrangements, drawing heavily on existing TCGP and IPC measures. Encouraging the Maternity CAG to consider an additional measure and recommending the inclusion of four existing maternity measures in the TCGP arrangement due to their applicability to child health.

3. **Additional Work / Deliberations** – Supporting further work by DOH and appropriate advisory bodies on: VBP appropriateness and opportunities for vulnerable subpopulations of children and adolescents; continued development and refinement of the North Star Framework and child-specific measures; and developing pilots towards the **broader goals of pediatric system transformation** and cross-system accountability.
### Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

#### Preterm to 1 Month

**Optimal birth outcomes for mother and child**
- Birthweight <2500 grams
- Preterm births
- Severe maternal morbidity

**Key Indicators**
- On-target developmental and social-emotional screen
- Reported cases of abuse and neglect

**High-Value, Often Underutilized Primary Care Strategies**
- Early and regular prenatal care visits including:
  - Birth spacing/contraceptive use counseling
  - Breastfeeding encouragement
  - Care transition plan for use by obstetrician, newborn nursery and primary care doctor
  - Screening/treatment for preterm birth risks and tobacco/substance use
- Co-located/integrated behavioral health services
  - Screening/referrals for:
    - Adverse Childhood Experiences (ACEs)
    - Social determinants of health
    - Domestic violence/personal safety
    - Maternal depression
  - Enhancing parental skills through evidence-based education/home visitation programs
  - Seamless information exchange between women’s health and child health providers

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#### 1 Month to 1 Year

**Overarching “North Star” Goals**
- Optimal physical health and a secure attachment with a primary caregiver
- Optimal physical health and developmentally on track at school entry

**Key Indicators**
- On-target developmental and social-emotional screen
- Reported cases of abuse and neglect

**High-Value, Often Underutilized Primary Care Strategies**
- Regular well-child visits including:
  - Developmental screenings in four domains: motor, language, cognitive, and social emotional
  - Weight/nutrition/physical activity counselling
  - Early Intervention referral
  - Co-located/integrated behavioral health services
    - Screening/referrals for:
      - ACEs
      - Social determinants of health
      - Domestic violence/personal safety
      - Maternal depression
    - Enhancing parental skills through evidence-based education/home visitation programs
    - Seamless information exchange between women’s health and child health providers (when mother is primary caregiver of child)

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#### 1 Year to 5 Years

**Overarching “North Star” Goals**
- Optimal physical health and a secure attachment with a primary caregiver
- Optimal physical health and developmentally on track at school entry

**Key Indicators**
- On-target developmental and social-emotional screen
- Reported cases of abuse and neglect

**High-Value, Often Underutilized Primary Care Strategies**
- Regular well-child visits including:
  - Developmental screenings in four domains: motor, language, cognitive, and social emotional
  - Weight/nutrition/physical activity counselling
  - Early Intervention referral
  - Co-located/integrated behavioral health services
    - Screening/referrals for:
      - ACEs
      - Social determinants of health
      - Domestic violence/personal safety
      - Maternal depression
    - Enhancing parental skills through evidence-based education/home visitation programs
    - Seamless information exchange between women’s health and child health providers (when mother is primary caregiver of child)
  - Management/treatment of chronic conditions

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*Department of Health*  
*May 2018*
### Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

<table>
<thead>
<tr>
<th>6 Years to 10 Years</th>
<th>11 Years to 14 Years</th>
<th>15 Years to 21 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overarching “North Star” Goals</strong></td>
<td><strong>Key Indicators</strong></td>
<td><strong>Staying healthy and able to succeed in the world of work, school, and other adult responsibilities</strong></td>
</tr>
<tr>
<td>Staying healthy and strengthening social, emotional and intellectual skills</td>
<td>Staying healthy and coping effectively with challenges of early adolescence</td>
<td>Management/treatment of chronic conditions</td>
</tr>
<tr>
<td>- Average daily school attendance</td>
<td>- Algebra 1 Regents passing</td>
<td>- Weight/nutrition/physical activity counseling</td>
</tr>
<tr>
<td>- Hospitalization for asthma</td>
<td>- Hospitalization for asthma</td>
<td>- Health care self-management/health literacy education</td>
</tr>
<tr>
<td>- Obesity</td>
<td>- Obesity</td>
<td>- Vaccinations</td>
</tr>
<tr>
<td>- Positive screens for depression/anxiety</td>
<td>- Positive screens for depression/anxiety</td>
<td>- Co-located/integrated behavioral health services</td>
</tr>
</tbody>
</table>
| - Grade progression | - Tobacco/substance use | Screening/counseling/referrals for:
| - Standard 3rd-grade reading scores | - Co-located/integrated behavioral health services | - ACEs |
| **High-Value, Often Underutilized Primary Care Strategies** | **Screening/counseling/referrals for:** | **Screening/counseling/referrals for:** |
| Regular well-child visits including: | - ACEs | - ACEs |
| - Weight/nutrition/physical activity counseling | - Social determinants of health | - Social determinants of health |
| - Dental screening/treatment | - Behavioral health risks | - Behavioral health risks |
| Co-located/integrated behavioral health services | Enhancing parental skills through evidence-based educational programs | Enhancing parental skills through evidence-based educational programs |
| Screening/referrals for: | Management/treatment of chronic conditions | Management/treatment of chronic conditions |
| - ACEs | | - Social determinants of health |
| - Social determinants of health | - Behavioral health risks | - Behavioral health risks |
| - Behavioral health risks | | |
Summary

• State-level recognition of importance of earliest years of life in shaping long-term health and well-being

• State-level recognition of unique role played by Medicaid and children’s primary care providers, *along with other sectors*, during those critical years

• Pathway in place for reforming payment to better support children’s primary care, including behavioral health integration

• Widespread consensus on need to improve structure and capacity of pediatric primary care to more fully deliver on its potential to improve child health and development
Problem Statement

Mary McCord MD MPH Director of Pediatrics, Gouverneur Health
Dennis Kuo, MD, MHS, Associate Professor, University at Buffalo; Chief, Division of General Pediatrics
• Pediatrics 1.0:
  • Effectively addressed infectious disease and nutrition-related morbidity

• Pediatrics 2.0:
  • Added chronic disease management and developmental/behavioral morbidity as a focus

• Pediatrics 3.0 ????
Well-Child Visit Guidelines: Trend in Book Weight

Robert Needleman 2011
Drowning in a Sea of Advice

• 57 AAP policies with 192 discrete advice directives

• 96% created 1993-2002

• 41% required a screening question to identify target population (~78 questions).

• None offered evidence that office-based intervention was effective.
Our Objective

• Outline NY State vision for Pediatrics 3.0

• Bright Futures as the backbone

• Consider practice level

• Consider reimbursement
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
First and Foremost!

• Thank you for agreeing to participate!

• You are the experts on the front lines of pediatric care

• How do we support Primary Care Practitioners in all setting types to be able to better care for the children in their practices?
Charge 1 (of 3)

• To develop a framework/model for how to best organize well–child visits/pediatric care in order to implement the Bright Futures Guidelines (the American Academy of Pediatrics standard of care).

https://www.health.ny.gov/health_care/medicaid/redesign/1000_days/2017-12-01_proposal_desc.htm
Charge 2 (of 3)

• To identify barriers, incentives, and new system approaches for doing what is expected of pediatricians as identified by *Bright Futures*.
  • Children ages zero to three are expected to make at least thirteen recommended preventive pediatric care (well–child) visits during that time period.
  • Each of these visits is an opportunity to identify risks to health and development and to strengthen the capacity of families to promote a child’s developmental trajectory.

https://www.health.ny.gov/health_care/medicaid/redesign/1000_days/2017-12-01_proposal_desc.htm
Charge 3 (of 3)

• The group will make recommendations to the New York Medicaid program on how to work with managed care organizations and providers to turn *Bright Futures* implementation guidance into routine practice.

https://www.health.ny.gov/health_care/medicaid/redesign/1000_days/2017-12-01_proposal_desc.htm
Considerations (1 of 2)

- How to risk stratify families and match families to a practice’s available supportive resources;
- How to work collaboratively with a parent/guardian’s health providers and health supportive community partners;
- Use of care coordination tools and protocols;
- Review and selection of proposed models for the integration of maternal and child mental health into pediatric primary care;
- Selection and timing of specific early childhood screening tools, including developmental screeners and social determinants of health screeners;
- How to incorporate trauma–informed care into practice, including how to identify and address Adverse Childhood Experiences (ACEs);
Considerations (2 of 2)

• Use of multi-disciplinary teams for delivering evidence-based programs;
• How to integrate behavioral health care for children into primary care settings;
• How to incorporate vision, hearing, and dental screens and/or interventions;
• Development of systems to receive follow-up after screening and referral to offsite programs, including to Early Intervention providers;
• Delivering culturally and linguistically appropriate care; and
• Integration of primary prevention programs, particularly those that support families with parenting skills.
Goal

• 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.
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*
Delivery System Reform Incentive Payment (DSRIP) Program Objectives

- DSRIP was built on the CMS and State goals in the Triple Aim:
  - Improving quality of care
  - Improving health
  - Reducing costs

- 25 Performing Provider Systems (PPS) were recognized by New York to lead Medicaid’s health care transformation efforts.

VBP Transformation: Overall Goals and Timeline

**Goal:** To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

Acronyms: NYS = New York State; PPS = Performing Provider System; MCO = Managed Care Organization
VBP Arrangements

There is no single path towards Value Based Payments. Rather, there are a variety of options from which MCOs and providers can jointly choose:

Arrangement Types

- **Total Care for the General Population (TCGP):** All costs and outcomes for care, excluding MLTC, HARP, HIV/AIDS, and I/DD* subpopulations.
- **Episodic Care**
  - **Integrated Primary Care (IPC):** All costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs.
  - **Maternity Care:** Episodes associated with pregnancies, including delivery and first month of life of newborn and up to 60 days post-discharge for mother.
- **Total Care for Special Needs Subpopulations:** Costs and outcomes of total care for all members within a subpopulation exclusive of TCGP.
  - **HARP:** For those with Serious Mental Illness or Substance Use Disorders
  - **HIV/AIDS**
  - **Managed Long Term Care (MLTC)**
  - **I/DD***

VBP Contractors can contract TCGP as well as Subpopulations as appropriate; nothing mandates that the Roadmap-defined arrangement types must be handled in standalone contracts.

*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is moved to managed care.

Acronyms: MLTC = Managed Long Term Care; HARP = Health and Recovery Plans; I/DD = Intellectually/Developmentally Disabled
<table>
<thead>
<tr>
<th>Children’s Transition Timeline</th>
<th>Health Home Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone</strong></td>
<td><strong>Implementation Dates</strong></td>
</tr>
<tr>
<td>Current 1915c Waiver Care Manager Transitioning to Health Home Care Management</td>
<td>Beginning 10/1/2018</td>
</tr>
<tr>
<td>VFCA 291 Licensure</td>
<td></td>
</tr>
<tr>
<td>Licensure of all VFCA’s</td>
<td>November 15, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Applications Due</td>
<td>July 31, 2018</td>
</tr>
<tr>
<td>VFCA contract and claims test with Managed Care Plans</td>
<td>January 1, 2019 – June 30, 2019</td>
</tr>
<tr>
<td><strong>State Plan Services</strong></td>
<td></td>
</tr>
<tr>
<td>Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports (OLP, PSR, CPST)</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>Family Peer Support Services (FPSS)</td>
<td>July 1, 2019</td>
</tr>
<tr>
<td>Youth Peer Support and Training &amp; Crisis Intervention (YPS, CI)</td>
<td>January 1, 2020</td>
</tr>
<tr>
<td><strong>1915c Waiver(s) Transition to 1115 Waiver</strong></td>
<td></td>
</tr>
<tr>
<td>Authority for the following six 1915c Children’s waiver(s) will transition to 1115 Waiver:</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>• OMH SED</td>
<td></td>
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<tr>
<td>• DOH Care at Home (CAH) I/II</td>
<td></td>
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<tr>
<td>• OPWDD CAH</td>
<td></td>
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<tr>
<td>• OCFS Bridges to Health (B2H) SED</td>
<td></td>
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<tr>
<td>• OCFS B2H Developmentally Disabled</td>
<td></td>
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<tr>
<td>• OCFS B2H Medically Fragile</td>
<td></td>
</tr>
<tr>
<td>HCBS will be part of Managed Care benefit</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>OMH SED, DOH CAH and OPWDD Care at Home will transition to Managed Care</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>A child that is in B2H, receiving HCBS services and that is no longer in Foster Care will transition to Managed Care and receive their HCBS from the plan</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>B2H transitioning children in Foster Care will receive HCBS through fee-for-service</td>
<td>January 1, 2019 through June 30, 2019</td>
</tr>
<tr>
<td>B2H children in Foster Care will transition to Managed Care</td>
<td>July 1, 2019</td>
</tr>
</tbody>
</table>
| **Note:** Children transitioning to 1115 that are currently receiving crisis intervention, family peer supports, and youth peer supports and training under a 1915c waiver will continue to receive these services under the 1115 authority; this ensures no break in service for these children.
Summary

- The Medicaid program is transforming to a value based system of care.

- Children are now the focus of many efforts in Medicaid.

- Wise investments in the early years of life will have benefits in healthier and more productive communities.

- We are grateful for your wisdom, expertise, and experience to help New York continue to be a leader in these national transformation efforts.
Framework for Implementation toward Pediatrics 3.0

Mary McCord MD MPH Director of Pediatrics, Gouverneur Health
Dennis Kuo, MD, MHS, Associate Professor, University at Buffalo; Chief, Division of General Pediatrics
Pediatric Primary Care Patient Centered Medical Home

• Well Child Care
  • Health Promotion and Disease Prevention
  • Managing Childhood stages to optimize outcomes

• Illness Care
  • Chronic Conditions
    • Mental Health (ADD, Depression, Maternal Depression)
    • CSHCN – Diverse group
    • Asthma – Small group, adult model applicable

• Acute illness care
Argument for First 1000 Days Focus

• 90+% of children attend Well Child Care (WCC) multiple times in first 3 years.

• No other system interacts systematically with 0-3 age group.

• Brain science says this is where the population health impact opportunity is for Pediatric primary care.
Early Childhood – Opportunity for Long-term Impact
Toxic Stress

Three Levels of Stress Response

Positive
Brief increases in heart rate, mild elevations in stress hormone levels.

Tolerable
Serious, temporary stress responses, buffered by supportive relationships.

Toxic
Prolonged activation of stress response systems in the absence of protective relationships.
The Often *Hidden* Driver: Adverse Childhood Events

**ACE Score** = 1 point each for positive responses to 10 questions inquiring about exposure to:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Divorce/separation
- Domestic violence in the home
- Parent that used drugs or alcohol
- Parent that was incarcerated
- Parent that was mentally ill

From: www.acestudy.org
Managing Early Childhood to Optimize Long-term Outcomes

• Early Childhood Focus – strong science tells us there is an opportunity for long-term impact

• Maximize Public Health Impact of Pediatric WCC
  • Population Health Outcomes

• 2 Generation Care – Attending to parent needs will help children

• PCMH and DSRIP Program resources should be focused on Early Childhood care
2 Generation Care – Vision Mother is Your Patient, too

• Address Maternal Depression

• Support positive parenting with focus on trauma-exposed mothers

• Prevent unintended pregnancy for mothers of young children

• Address Social Determinants of Health (SDH) (poverty needs)
Screening for Development and Social Determinants of Health
Link to Community Resources

- Maternal ACEs
- Specific needs – food, housing
- Maternal Depression
- Specific risks – Domestic violence, Substance Use, other mental illness, homeless
- Child behavior and development
- Geo-mapping to high risk census tracts
Apply Chronic Disease Model to Support Early Childhood

- Risk Stratify
- Define Care Bundles for different risk levels and follow with registry
- Develop systematic linkages with Community-based EC services
- CHWs to work closely with high risk mothers
- Make Positive Parenting the focus of “Anticipatory Guidance”
- Practice re-design and Quality Improvement focused on this agenda
Challenges

- Screen effectively
  - ALL patients
  - Risk Stratify
  - Reliable follow-up

- Resources needed
  - Allocate PCMH and DSRIP resources to Pediatric care
    - Care Coordinators
    - QI data resource

- Maternal care documented in infant chart
Challenges (continued)

• Too much to do, too little time
  • Prioritize this agenda
  • Team approach
    • Link to OB/GYN – don’t do double work
    • MAs and nursing roles in health education

• Limit required items and focus on outcomes – Focus Quality Agenda here
Early Childhood – Opportunity for Long-term Impact

“Brains continue to be built after birth, primarily through interactions with family members and other important adults in a child’s life. …it is not commonly accepted by the scientific community that individuals are shaped through a dynamic interplay between their genetic makeup and the environments in which they live. This theory of gene-environment interaction has been described as ‘nature dancing with nurture’.”

Jack Shonkoff, Harvard Center for the Developing Child, Neurons to Neighborhoods
References

• Coker et al.
  • Does well-child care have a future in pediatrics? *Pediatrics*. 2013;131:S149–S159
  • A Parent Coach Model for Well-Child Care Among Low-Income Children: A Randomized Controlled Trial *Pediatrics* 2016;137, 3

• Halfon et al.
  • The changing nature of children’s health development: New challenges require major policy solutions. *Health Affairs*, 33(12) 2014

• Zuckerman

• Brundage
  • Seizing the Moment: Strengthening Children’s Primary Care in New York. United Hospital Fund 2016

• Olin et al
  • Can Postpartum Depression Be Managed in Pediatric Primary Care? *J Womens Health* Nov 2015

• Samaan ZM et al.
Lunch
Discussion Questions
How do we move from Pediatrics 1.0 to 3.0?
What goals should lead model development (e.g. adoption of North Star goals, other goals)?
Based on the models presented today (or other models out there), what are the best features or components on which NY should focus?
What does the evidence suggest is most important to include in the model?
How do we effectively integrate behavioral health care for children into primary care settings?
Homework

• Review articles sent out with meeting notice, if you haven’t already.

• Bring 3 ideas for key components of what an “Advanced Pediatric Primary Care” practice should look like in NY State in 2018.
Next Steps

• *Meeting 2* – Model refinement/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* – Model and review of recommendations
Meeting Dates

• July 10 for Meeting #2

• Sept. 11 for Meeting #3

• October 30th for Meeting #4

• Proposal is to convene #2 & 3 as WebEx meetings, with Meeting #4 again in person
Resources

• First 1000 Days
  • https://www.health.ny.gov/health_care/medicaid/redesign/1000_days/2017-12-01_proposal_desc.htm

• Bright Futures Guidelines Summary

• DSRIP Program
  • https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

• VBP Resource Library
  • https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/