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PEDIATRIC CIN: NEXT STEPS FOR QUALITY

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Faculty Disclosures

- We work for Children's National and its new CIN
- We are very general pediatricians
- We have no financial disclosures

Health care delivery & payment shifting to value

Early healthcare networks & payment models primarily adult-focused

- Medicare/adult care driving early models
  - Growth of Medicare Shared Savings Programs & Next Generation ACOs
  - Medicaid expansion- primarily to adults
  - Health systems' vertical integration is often focused on Medicare Advantage
  - MACRA / MIPS reform- providers paid increasingly on quality performance
- ACOs often include pediatricians but focus on adult care (that's where the $$$ are)
- Pediatricians need to prepare for shift: Medicare ⇨ Medicaid & commercial alternative payment models (coming soon…)

We Need a Better Model for Pediatricians

Meanwhile, in pediatric practices

- Payment models not designed for pediatric utilization and care providers
- Pediatricians involved in adult-focused value-based networks but in the back seat
  - Limited control as a single practice
  - Limited resources to develop clinical & operational infrastructure
  - Critical mass of pediatric patients & providers distributed more broadly
  - Limited long-term investment in children (& pediatric providers)

Adult care & payment models don't fit children - or pediatricians

A Pediatric CIN?

- Adult care payment models don't crosswalk well to pediatrics
- Much of pediatric utilization & expense is outside the walls, resources (and easy reach) of independent community based pediatric practices
  - Today's pediatric morbidity, utilization & expense:
    - Asthma, obesity, mental health, development/ADHD
  - Children with chronic pediatric conditions
  - Medically-complex super-utilizers
- Need to develop care delivery & payment models that aggregate & align providers *across the pediatric care continuum* and reward appropriate care, outcomes, expense

Introducing: Pediatric “CIN” Clinically Integrated Network

- Draw My Story (CIN video)
- https://www.youtube.com/watch?v=i76vKvhKl0E

Background: What is a Pediatric-Focused CIN?

A **pediatrician-led** network of providers who collaborate to **improve quality**, **reduce costs**, and demonstrate data-driven results.

Clinically Integrated Network

PRIMARY CARE

SPECIALISTS

AMBULATORY

INPATIENT

Collaborative Activities

1. **Pediatrician-led governance model** – significant involvement of community practices
2. **Infrastructure to share and track data** related to network-wide quality and cost metrics
3. **Quality & cost reporting to measure & improve effectiveness** of clinical programs
4. **Value-based programs & contracts** that are meaningful and appropriate to pediatricians
5. **Analytics** to monitor population risk and programs to effectively coordinate care

The FTC allows for networks of independent providers to contract as a group as long as they are clinically integrated and focused on improving quality and cost outcomes. Networks are typically non-exclusive.

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Pediatric Accountable Care Networks are Forming & Entering into Risk Across the Nation

P4P/Shared Savings

- Ann & Robert H Lurie Children's Hospital of Chicago
- Phoenix Children's Hospital
- Children's Healthcare of Atlanta
- Children's National Health System
- Seattle Children's Hospital · Research · Foundation
- Rady Children's Hospital San Diego
- Children's Hospitals and Clinics of Minnesota

Downside Risk Arrangements

- Partners For Kids
- Cincinnati Children's change the outcome
- Children's Mercy Hospitals & Clinics Kansas City
- Phoenix Children's Hospital
- children'shealth
- Ann & Robert H Lurie Children's Hospital of Chicago
- CHOC Children's

Provider Sponsored Health Plans

- Driscoll Health Plan A friend of the family
- Texas Children's Health Plan
- children'shealth
- CookChildren's
- Children's Hospital of Wisconsin

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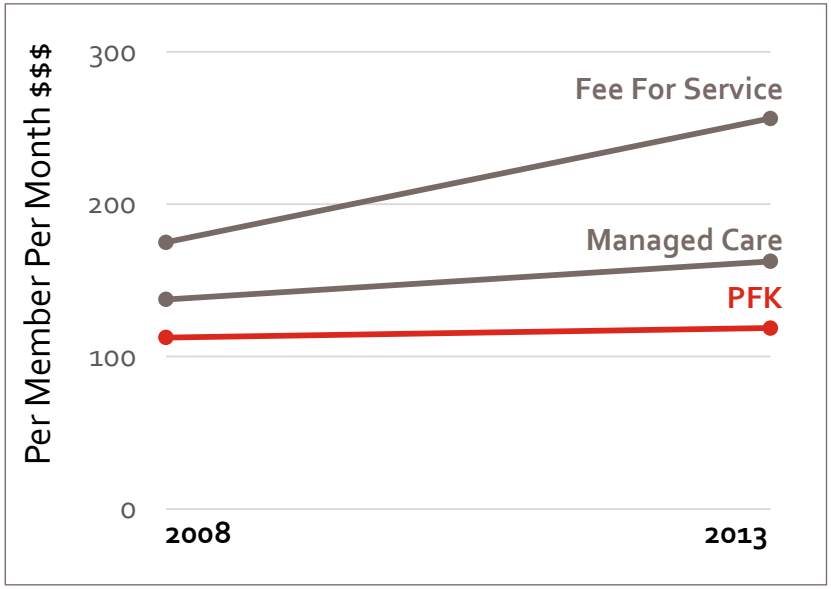
Pediatric Accountable Care Can Impact Costs

Partners for Kids (Ohio)

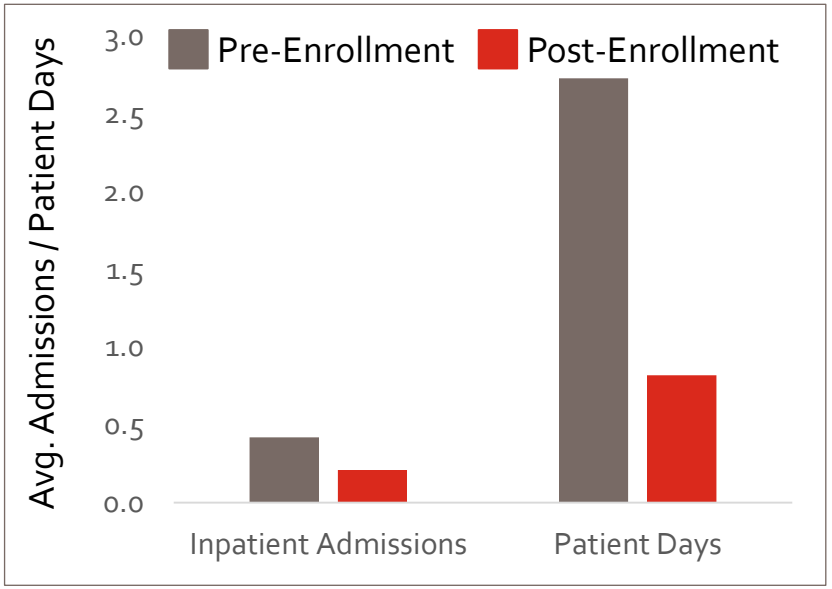
Founded in 1994 | 300,000 Medicaid lives | Full risk & delegated medical management | Well published

Slower Growth in Medicaid Costs



- Between 2008 – 2013, PFK member monthly costs grew at $2.40 per year
- Managed Care and Fee For Service costs grew at $6.47 and $16.15
- Showed improvement in 3 of 4 network quality initiatives over same time period

Impact of Care Management Program



- Analysis of enrollees in PFK's care management program between 2013-16
- Compared utilization 12-months before enrollment to 12-months after

Weier, Gardner, Conkol, Pajer, & Kelleher. "Partners for Kids Care Coordination: Lessons From the Field." *Pediatrics* 2017, 139, S109.
Kelleher, Cooper, Deans, Carr, Brilli, Allen, Gardner. "Cost Saving and Quality of Care in a Pediatric Accountable Care Organization." *Pediatrics* 2015; 125;e582.

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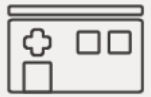
Children's Hospitals are developing CIN's to offer a new way to support pediatric collaboration

Pediatric Physician-Led CIN Entity

- **Joint-governance** with significant participation from community pediatricians in leadership structure
- **Larger network** that supports a comprehensive pediatric-focused continuum of care
- **Amplified voice** that advocates for appropriate & meaningful payment for pediatricians
- **Collaborative approach to** priority health concerns (e.g. ADHD, asthma, autism, mental health, obesity)
- **Quality & care management capabilities** to increase coordination, quality and efficiency of care
- Forums for **education and support** to prepare for increasingly sophisticated risk payment models



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What Clinical Infrastructure Can a CIN Provide?

Increasing CIN Maturity →

Data Exchange

Network-wide view of patients
Quality reports & gaps in care

Advanced Analytics

Identify impact opportunities using population data & algorithms

Quality Initiatives

Collaborative development of best practices & practice tools

Quality Metrics

Measure & improve clinical performance across the network

Care Coordination

Resources to facilitate access & a team-based approach for high-risk patients

Access the right care at the right time & place
Supports & rewards care in PCMH

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Think differently about patients and population

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Expand focus beyond individual patient

Manage care & cost outcomes for ALL patients

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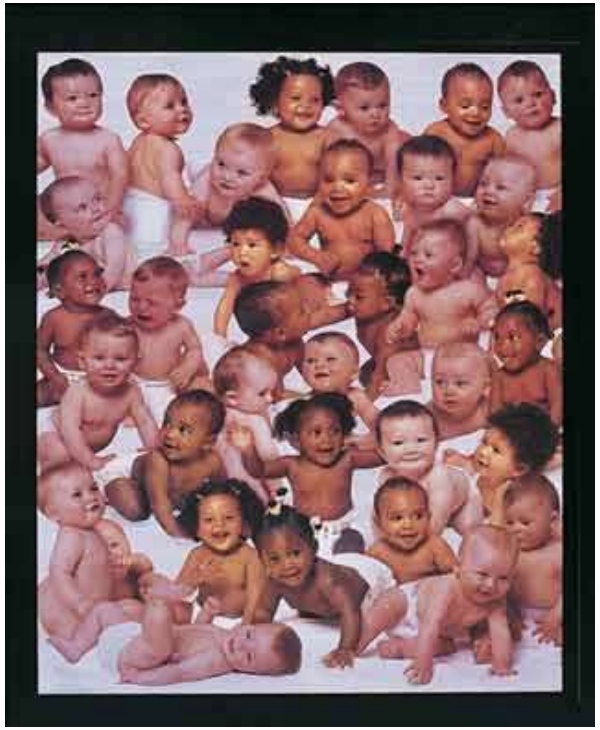
A is for Attribution

ATTRIBUTION

Population health focus: Improve quality & lower total cost

- ALL “attributed” patients in a:
  - PCP panel
  - Practice
  - Defined region (city, state)
  - Payor contract
    - Shared savings global contract
    - Evolve to “full risk” (opportunity)
- ALL attributed patients includes:
  - patients you see
  - *patients you don’t see*
    - who utilize services outside your practice or hospital or health system



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Risk stratification of attributed patients
Targeted interventions at practice or CIN level

Childhood Chronic Health Conditions: Old Conditions and New Epidemics

Next 5 slides courtesy of James Perrin, MD

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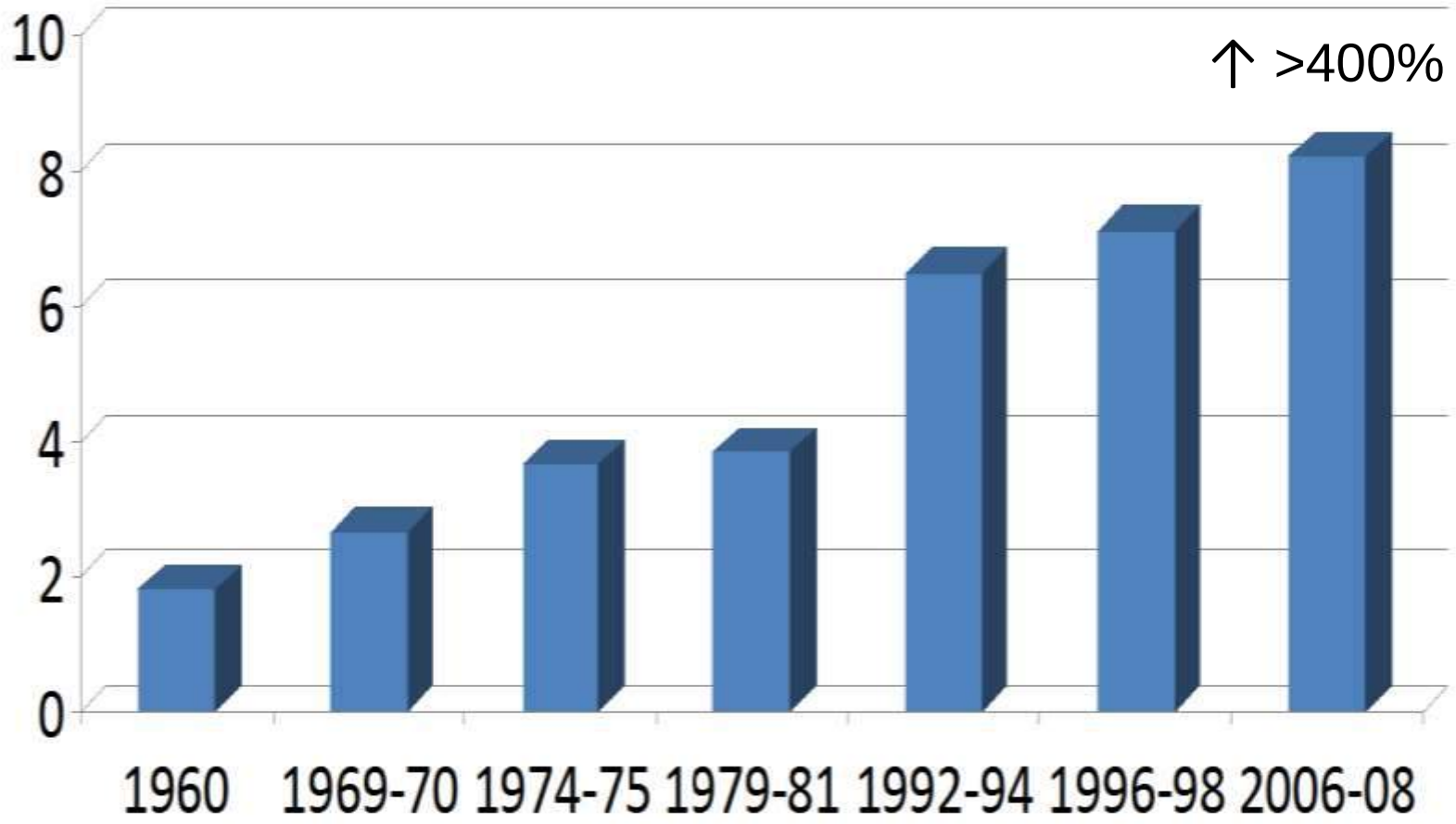
Activity-Limiting Chronic Conditions



Newacheck, NHIS Analyses; IOM analyses

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Grouping Childhood Chronic Conditions

- Very complex, multisystem conditions (0.5%)
  - Trach, g-tube, mobility assistance, etc.
- Low prevalence, (usually) high severity (2.5%)
  - Substantial involvement of pediatric subspecialists in care
  - CF, spina bifida, leukemia, arthritis, diabetes …
- Common, high prevalence, wide spectrum of severity (7.5-10% - including only activity limiting conditions)
  - Asthma
  - Obesity
  - Mental health conditions (anxiety, depression, ADHD)
  - Developmental conditions (incl. autism spectrum disorders)

Less Common Chronic Conditions

- Cystic fibrosis 22,500 (3:10,000)
- Spina bifida 60,000 (7.5:10,000)
- Sickle cell anemia 37,500 (5:10,000)
- Hemophilia 7,500 (1:10,000)

80,000,000 children/youth in US

New Epidemics: Mainly Among School-age Children and Youth

• Obesity	13,440,000(16.4:100)*
• Asthma	7,200,000 (9:100)
• ADHD	4,800,000 (6.4:100)
• Depression/Anxiety	3,200,000 (4:100)
• Autism Spectrum Disorder	900,000 (1:100)

**Population estimates, late 2000s*

80 million children/youth in US

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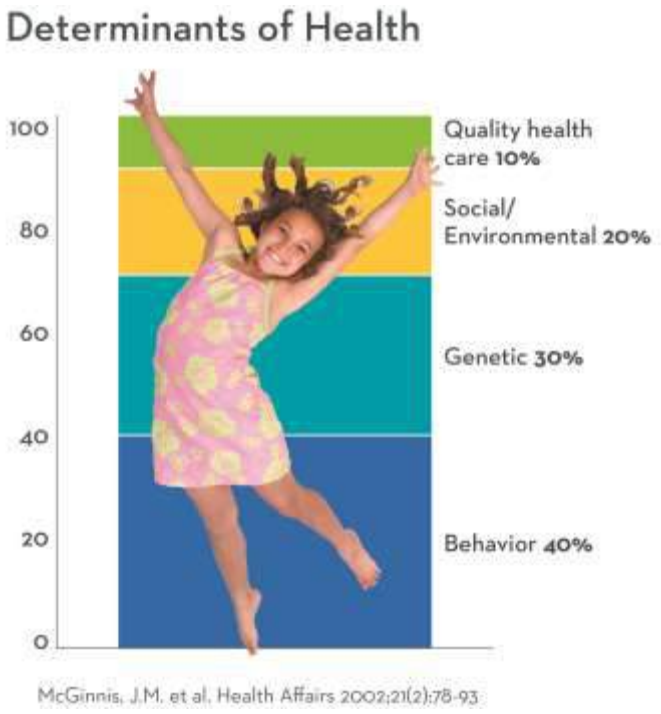
Children with chronic conditions have high rates of mental health comorbidity

- 1 in 5 of general population experience mental or behavioral health concern
- Rates of mental health disorders (measured in several ways) about 2-3 X more common in children with chronic physical conditions
- Expenditures for children with comorbid physical and mental health conditions about 3X those for children with chronic physical conditions alone
  - Most increased expenses appear to be in medical visits and treatments
  - Studies do not account for variations in chronic condition severity
- Implications for behavioral health integration

Social determinants of health (SDOH)

- Increasing awareness that health care utilization, spend & outcomes are influenced by factors outside the exam room or hospital
- As CIN's evolve from early "upside" quality contracts to increased or full risk- need to address social determinants of health at practice, hospital and community level to impact utilization & outcomes
- Require community resources & partners outside CIN practice, children's hospital & payer



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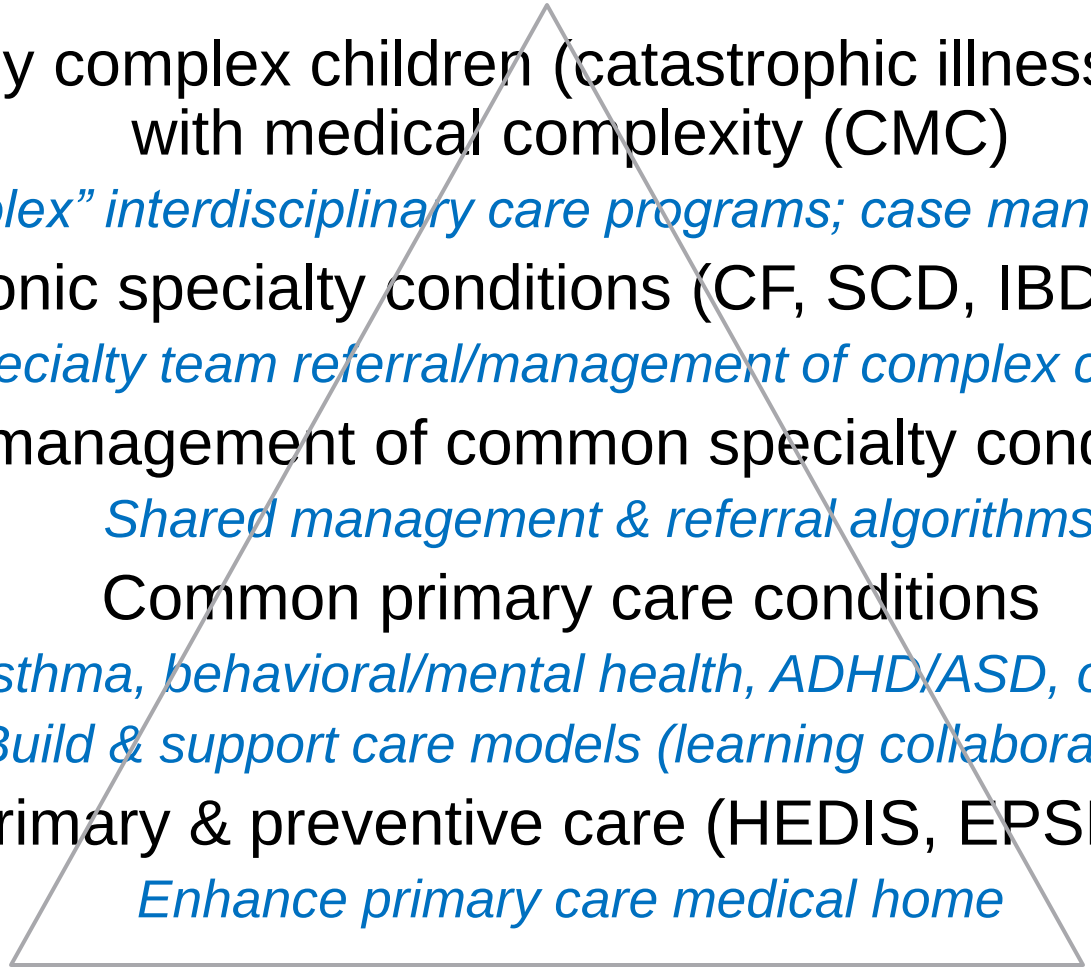
Pediatric CIN: Right care at right place & time (with right resources)



Medically complex children (catastrophic illness; children with medical complexity (CMC)

"Complex" interdisciplinary care programs; case management

Chronic specialty conditions (CF, SCD, IBD, etc.)

Specialty team referral/management of complex cases

Co-management of common specialty conditions

Shared management & referral algorithms

Common primary care conditions

Asthma, behavioral/mental health, ADHD/ASD, obesity

Build & support care models (learning collaboratives)

Primary & preventive care (HEDIS, EPSDT)

Enhance primary care medical home

Measuring & improving quality

Measuring (and rewarding) care at practice level

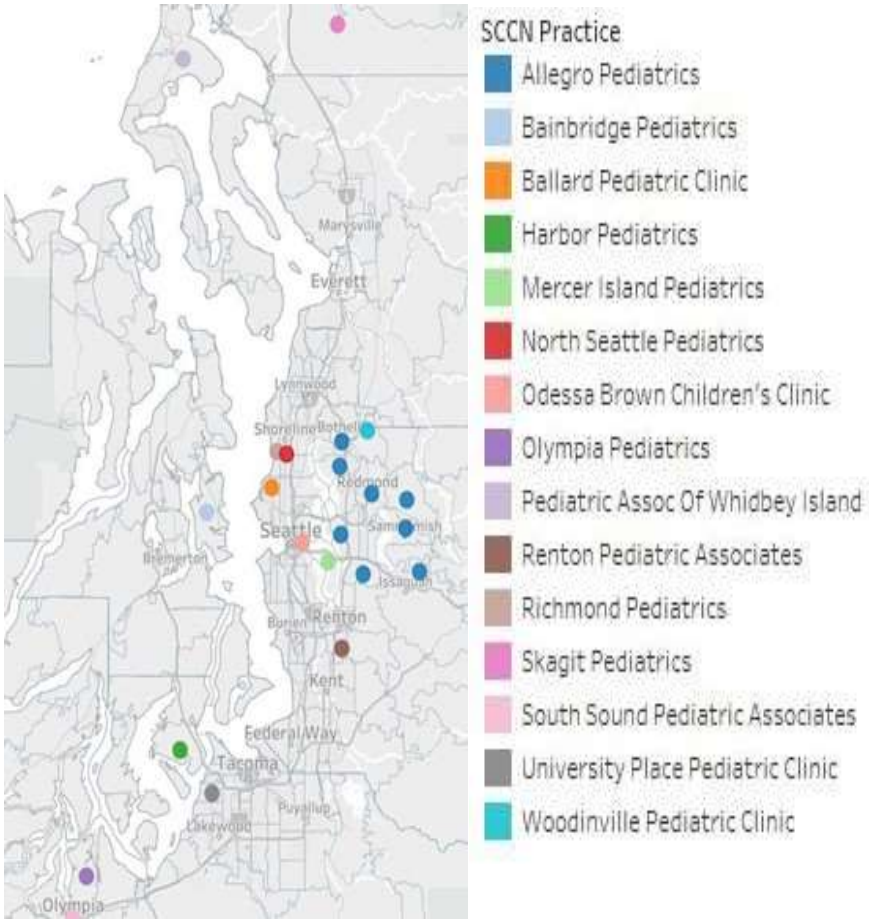
- Pediatric CIN's collaboratively develop meaningful pediatric metrics to measure and improve quality
- Typically start with pediatric HEDIS measures
  - Industry standard & benchmarked
  - Commercial vs Medicaid
  - Claims-based; some hybrid measures require chart/EMR audit
- Many CIN's link enhanced PCP quality payments based on practice performance vs CIN/practice benchmarks
- Practice can learn & improve quality performance from local "best practice" champions & CIN coaching/support
- Pediatric CIN's now beginning to benchmark HEDIS performance across markets to validate & share best practices

HEDIS: Preliminary CHA Pediatric Core Set

- Childhood Immunization Status Combo 10 (CIS)
- Immunization for Adolescents (IMA) (MCV, Tdap, HPV)
- Weight Assessment and Counseling for Nutrition and Activity for Children/Adolescents (WCC)
- Lead Screening in Children (LSC)
- Well-child visits in the first 15 months of life (W15)
- Well-child visits in the third, fourth, fifth and sixth years of life (W34)
- Adolescent Well-Care Visits (AWC)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Asthma Medication Ratio (AMR)
- Appropriate Testing for Children with Pharyngitis (CWP)

Case Examples:

Seattle Children's Care Network



Proud member Seattle Children's Care Network

urac ACCREDITED Clinical Integration Expires 04/01/2021

- 200+ MD/NP PCP's
  - 15 community practices
  - 5 university primary care sites
- 600 specialists
- Seattle Children's Hospital
- URAC accredited

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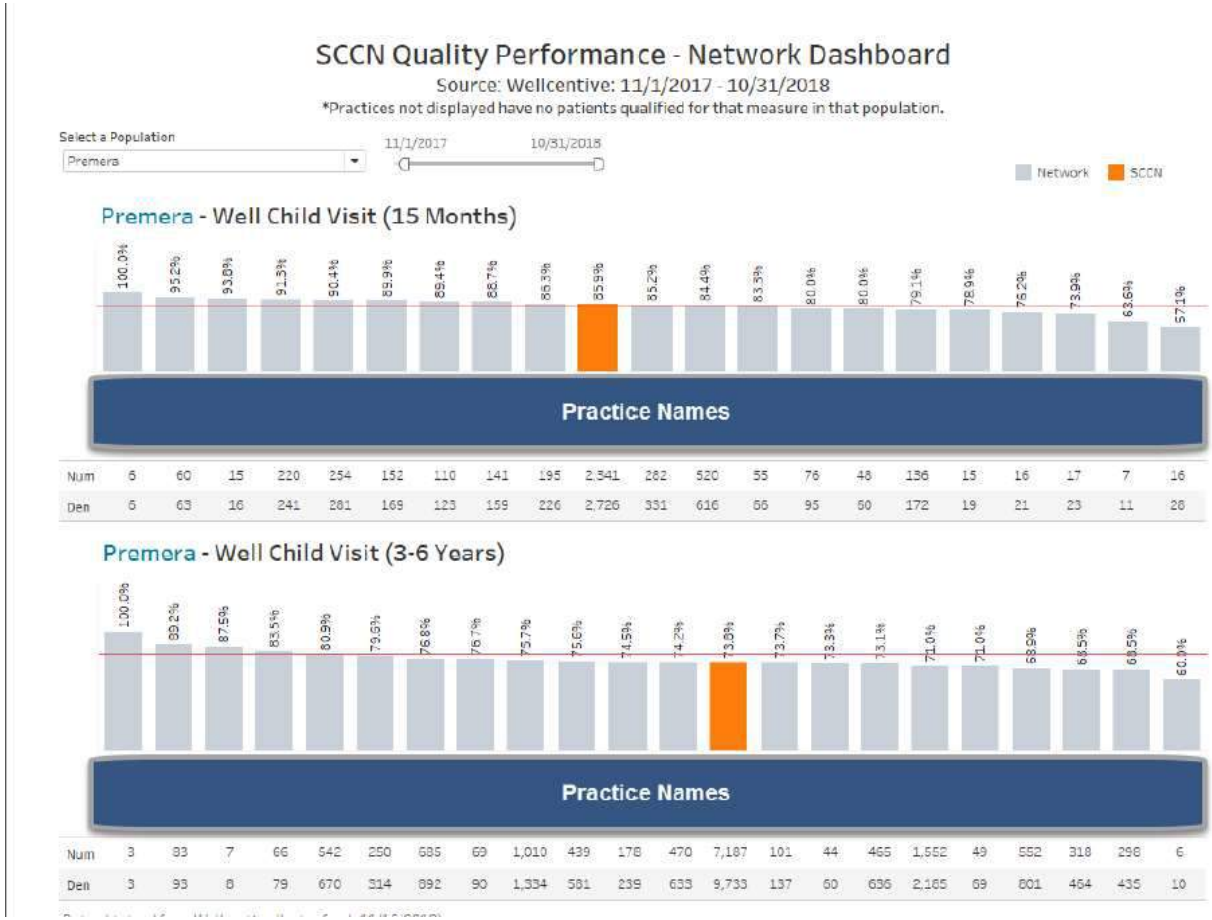
SCCN Quality Dashboard



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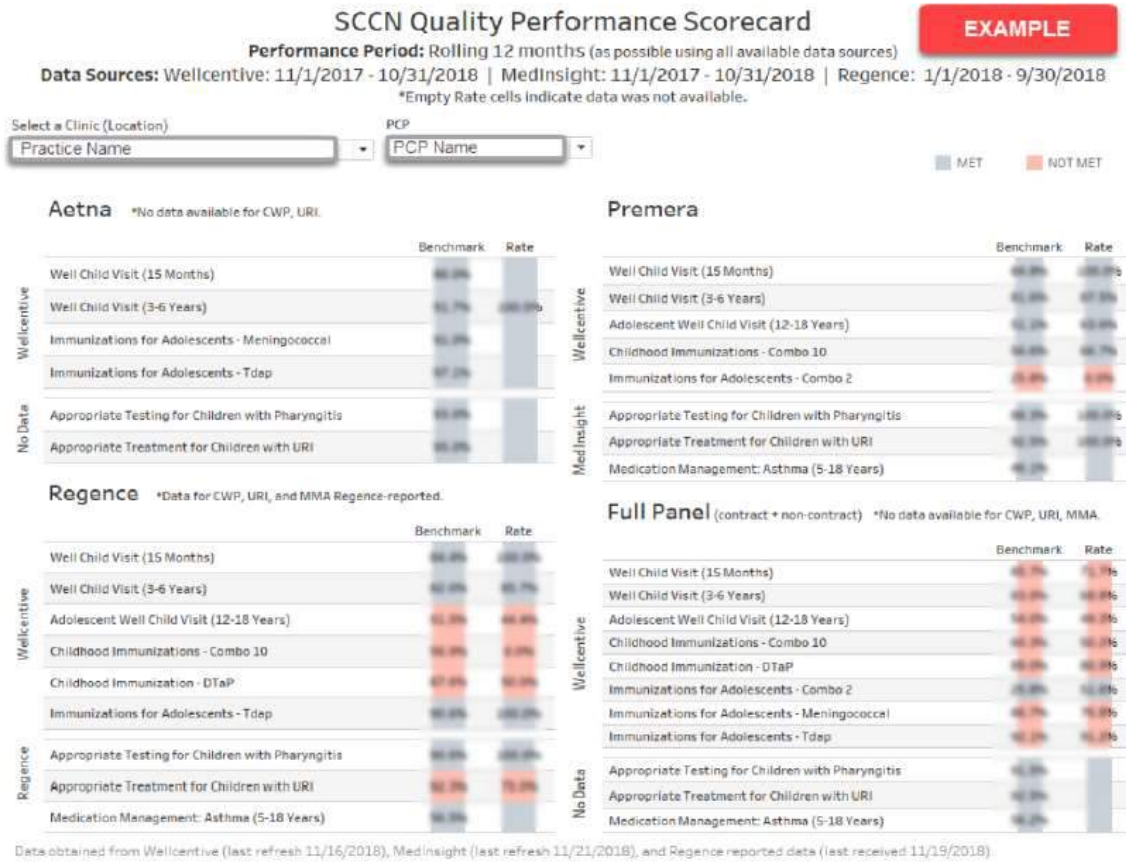
SCCN Quality Scorecard Page 1



SCCN Quality Performance Scorecard

EXAMPLE

Performance Period: Rolling 12 months (as possible using all available data sources)

Data Sources: Wellcentive: 11/1/2017 - 10/31/2018 | MedInsight: 11/1/2017 - 10/31/2018 | Regence: 1/1/2018 - 9/30/2018

*Empty Rate cells indicate data was not available.

Select a Clinic (Location): Practice Name

PCP: PCP Name

MET NOT MET

Aetna *No data available for CWP, URI.

		Benchmark	Rate
Wellcentive	Well Child Visit (15 Months)		
	Well Child Visit (3-6 Years)		
	Immunizations for Adolescents - Meningococcal		
	Immunizations for Adolescents - Tdap		
No Data	Appropriate Testing for Children with Pharyngitis		
	Appropriate Treatment for Children with URI		

Premera

		Benchmark	Rate
Wellcentive	Well Child Visit (15 Months)		
	Well Child Visit (3-6 Years)		
	Adolescent Well Child Visit (12-18 Years)		
	Childhood Immunizations - Combo 10		
	Immunizations for Adolescents - Combo 2		
MedInsight	Appropriate Testing for Children with Pharyngitis		
	Appropriate Treatment for Children with URI		
	Medication Management: Asthma (5-18 Years)		

Regence *Data for CWP, URI, and MMA Regence-reported.

		Benchmark	Rate
Wellcentive	Well Child Visit (15 Months)		
	Well Child Visit (3-6 Years)		
	Adolescent Well Child Visit (12-18 Years)		
	Childhood Immunizations - Combo 10		
	Childhood Immunization - DTaP		
	Immunizations for Adolescents - Tdap		
Regence	Appropriate Testing for Children with Pharyngitis		
	Appropriate Treatment for Children with URI		
	Medication Management: Asthma (5-18 Years)		

Full Panel (contract + non-contract) *No data available for CWP, URI, MMA.

		Benchmark	Rate
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	Appropriate Treatment for Children with URI		
	Medication Management: Asthma (5-18 Years)		

Data obtained from Wellcentive (last refresh 11/16/2018), MedInsight (last refresh 11/21/2018), and Regence reported data (last received 11/19/2018)

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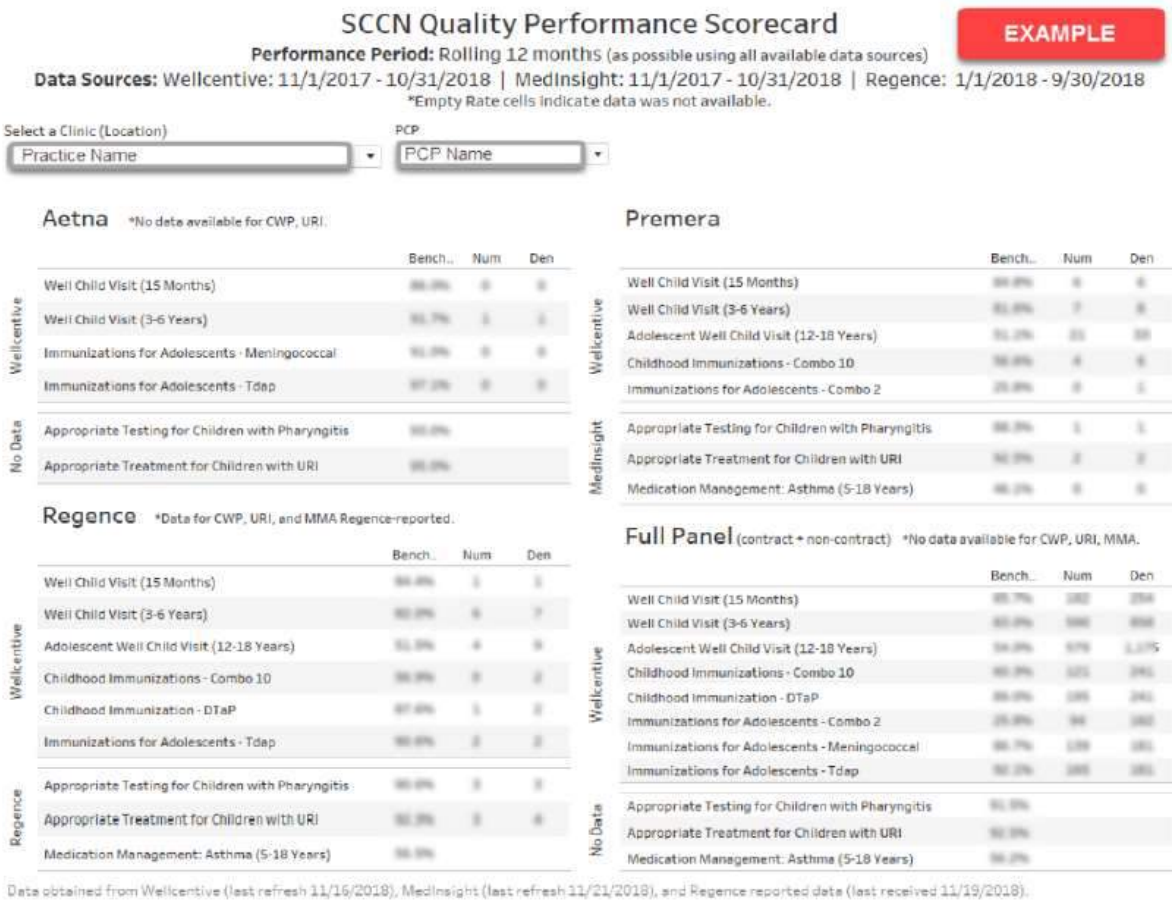
SCCN Quality Scorecard Page 2



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Phoenix Children's Care Network: Practice Scorecard

PCCN Vision Measure Quality Scores

Hello PCCN Members:

This performance dashboard illustrates your provider and overall practice performance against the PCCN Vision Quality Agenda. Below you will find the overall performance of your practice against the quality measures: your numerator and denominator for all patients, your compliance scores, and how you scored against the network. Know that PCCN is available to discuss any of the information that has been presented to you in this report. Please contact PCCN at 602-933-7226 or by email at pccn@phoenixchildrens.com should you have any questions or concerns.

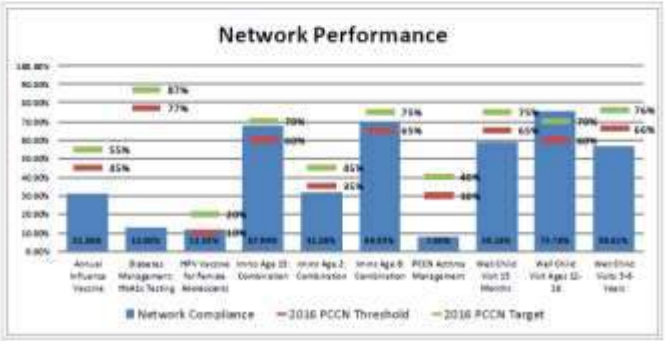
Practice Information

Practice Name	Overall Numerator	Overall Denominator	Overall Compliance Score
[redacted]	12,818	20,204	63.44%

Practice Ranking (67 Practices total)	Quartile
1	4

Practice Scoring

Measure	Numerator	Denominator	Compliance	Network Compliance
Well Child Visits 3-6 Years	2,077	2,847	72.95%	56.61%
Well Child Visit 15 Months	766	1,007	76.07%	59.16%
Asthma Management	65	432	15.05%	7.80%
HbA1c Testing	0	18	0.00%	13.00%
Immunizations Age 13: Combination	504	692	72.83%	67.99%
HPV Vaccine for Female Adolescents	128	531	24.11%	11.55%
Annual Influenza Vaccine	3,676	7,941	46.29%	31.36%
Well Child Visit Ages 12-18	4,671	5,231	89.29%	75.78%
Immunizations Age 6: Combination	544	698	77.94%	69.93%
Immunizations Age 2: Combination	387	807	47.96%	31.56%



Practice Performance vs CIN Performance

Practice Performance

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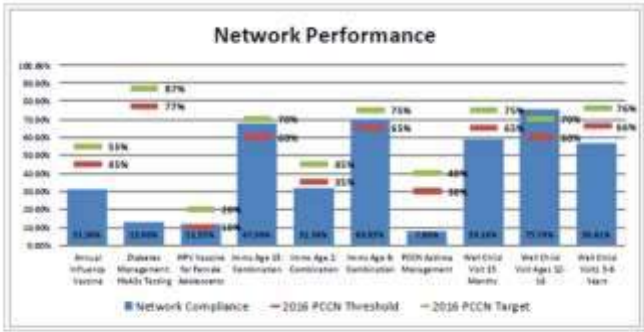
Network Performance



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Have I seen reports cards like that before?

CNHN Asthma QI Practice report cards

Type of Visit			Count of Charts	Percent Response
		Well	4	25%
		Sick	12	75%
		Planned	0	0%

Measures	Number of 'Yes' Responses Recorded	Project % Aim	Practice Average	Distance From Goal
Asthma diagnosis is documented in patient chart on problem list	16	90%	100%	-10%
Asthma severity is documented in the patient chart at this visit or at a prior visit	11	90%	69%	21%
Inhaled corticosteroids were prescribed if asthma classified as persistent	6	90%	75%	15%
Asthma control was assessed at this visit	7	90%	44%	46%
Patient's exposures to allergens and irritants were assessed and addressed	10	90%	67%	23%
Patients have a scheduled or recommended follow-up visit documented in their chart	12	90%	75%	15%
Patient was given a current AAP at this visit	11	75%	69%	6%
Patient's use of asthma inhalation device(s) was/were assessed and proper technique reviewed	2	75%	13%	63%
The influenza vaccine was recommended for the 2012-2013 flu season	12	75%	75%	0%
Patient received influenza vaccine according to CDC guidelines (applies during flu season)	11	75%	69%	6%

Improvement Rating	Percentage	
Measures- Improvement Needed	2	20%
Measures-Within Range	6	60%
Measures-Achieved	2	20%

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Map of Participating Asthma QI MOC Practices

2012

- Children's National Medical Center
- Capital Area Pediatrics
- Children's Pediatrician's and Associates
- Northern Virginia
- Maryland
- District of Columbia

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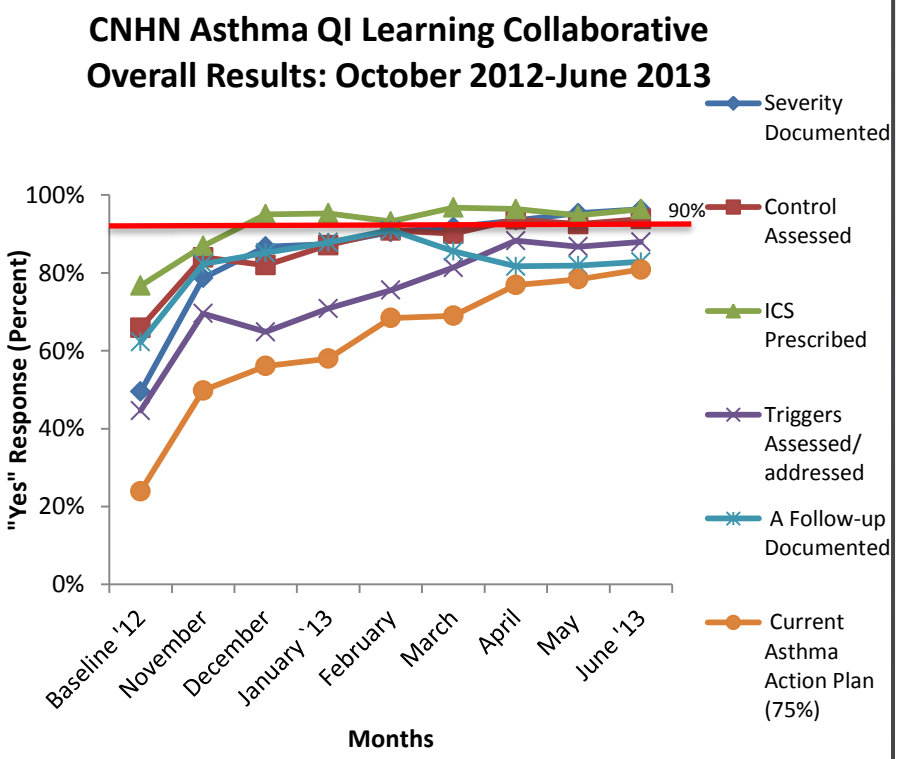
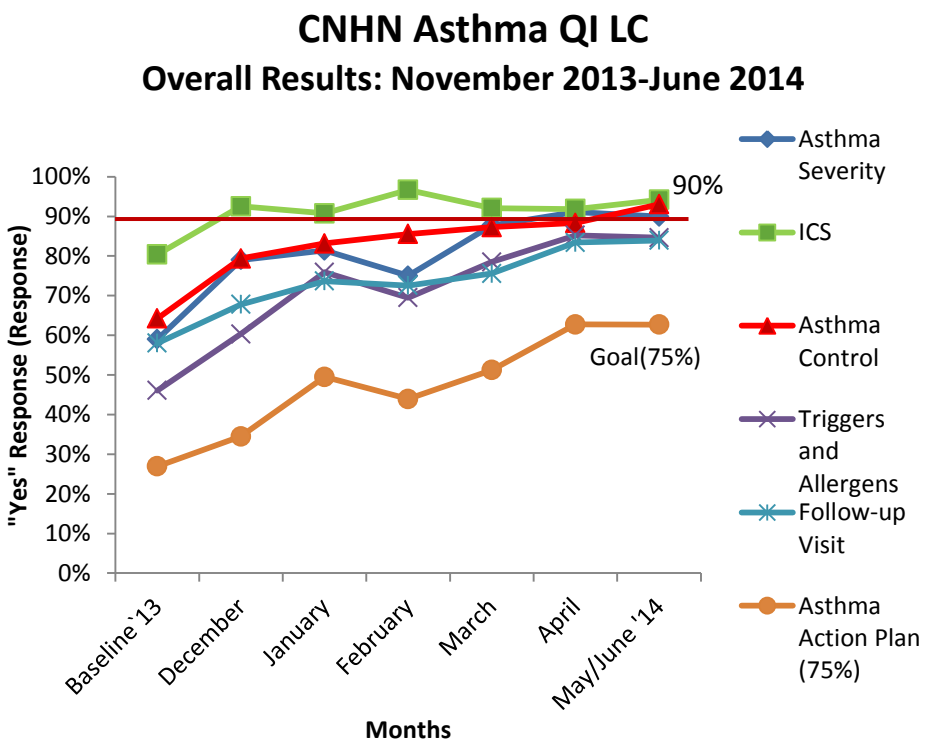
Over 300 providers & 75 practice sites improved care in our two asthma QI LC's

Asthma Yr. 1



Asthma Yr. 2



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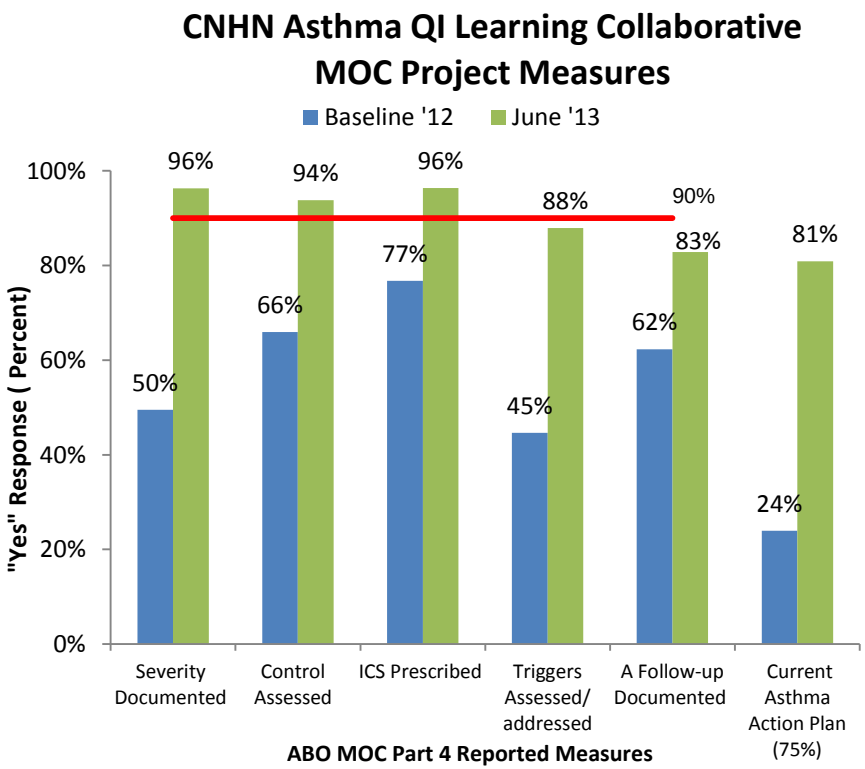
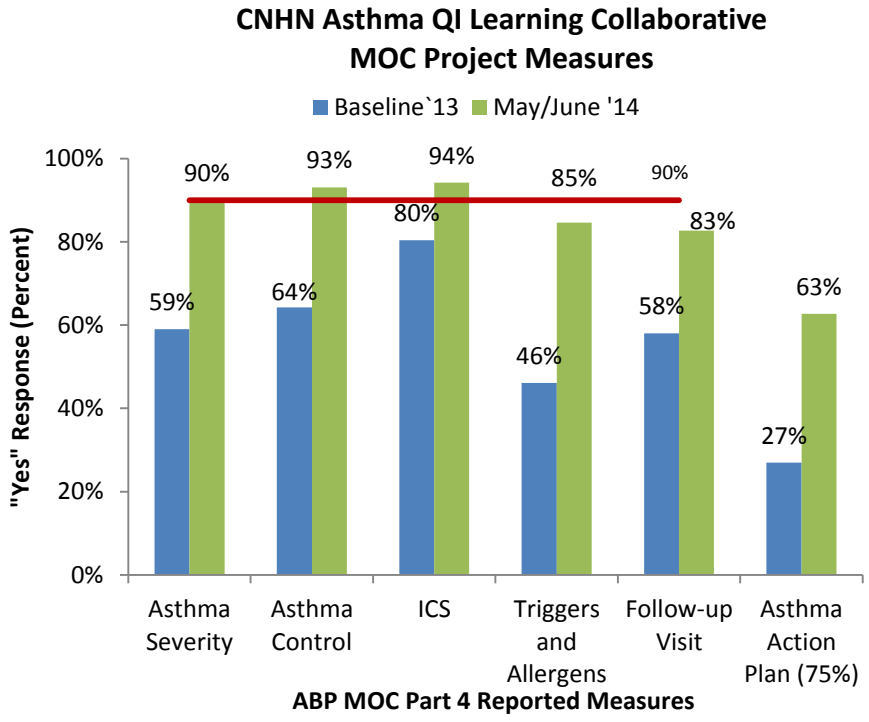
Asthma MOC Part 4 Reported Measure: Overall Results

Asthma Yr. 1



Asthma Yr. 2



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CIN Opportunity

Improve Care

Enhanced Payment

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CIN opportunity for enhanced PCP payment based on measurably improving care

- Pediatricians decide on focus areas & metrics
- Practices are connected and sharing data (claims & clinical)
  - Small scale QI drives population health improvement
  - All attributed patients (vs small reported samples)
- Incentives for improving quality performance
- Shared CIN and “best practice” expertise & resources
- Integrating CNHN QI resources (and MOC Part 4 credit)

Opportunity to reimagine how PCP's and specialists communicate & collaborate on care

- Improve knowledge, comfort & support of PCP's to manage common lower acuity concerns in primary care practice (increase PCP revenue)
- Improve access to specialty care for higher acuity and complexity concerns
- Leverage CIN data connectivity to measure performance, access and utilization and position resources appropriately
- Improve family and provider satisfaction
- Manage attributed population more cost-effectively

Top specialty referral diagnoses

- Opportunities for co-management pilots

- Develop shared protocols/algorithms for PCP management & referral
- Supporting provider and patient education
- CIN Pilot: Acne management & Referral Guidelines (2017-2018)

Allergy (top referral diagnoses)

- Food allergy
- Asthma
- Allergic rhinitis
- Chronic rhinitis
- Atopic dermatitis
- Peanut allergy

Cardiology (top referral diagnoses)

- Cardiac murmur, unspecified
- VSD
- ASD
- Chest pain, unspecified
- Tachycardia, unspecified
- SVT
- Syncope or collapse

Dermatology (top referral diagnoses)

- Acne
- Allergic eczema
- Infantile eczema
- Congenital nevus (non-neoplastic)
- Hemangioma
- Molluscum contagiosum

Endocrinology (top referral diagnoses)

- Type 1 diabetes
- Short stature
- Type 2 diabetes
- Hypopituitarism
- Hypothyroidism
- Precocious puberty

Gastroenterology (top referral diagnoses)

- Feeding difficulties
- Constipation
- Abdominal pain, unspecified
- Crohn’s disease
- GE reflux disease without esophagitis
- Failure to thrive
- Vomiting, unspecified

Neurology (top referral diagnoses)

- Epilepsy, general idiopathic
- Convulsions
- Autistic disorder
- Migraine
- Neurofibromatosis
- Encephalopathy, unspecified

Orthopedics (top referral diagnoses)

- Congenital hip deformities, unspecified
- Congenital foot deformities, unspecified
- Scoliosis, unspecified
- Supracondular fracture, displaced simple
- Congenital clubfoot
- Knee pain

ENT (top referral diagnoses)

- Hypertrophy of tonsils and adenoids
- Obstructive sleep apnea
- Snoring
- Other disorders of eustachian tube
- Other chronic nonsuppurative otitis media
- Hypertrophy of adenoids
- Ankyloglossia
- Otitis media
- Epistaxis

Hematology-Oncology (top referral diagnoses)

- Sickle cell disease
- Malignancies- various
- Idiopathic thrombocytopenic purpura
- Neutropenia, unspecified
- Anemia, unspecified
- Iron deficiency anemia, unspecified

Psychology (top referral diagnoses)

- ADHD
- Autistic disorder
- Generalized anxiety disorder
- Adjustment disorder, mixed anxiety and depressed mood
- Major depressive disorder
- Insomnia

Pulmonary (top referral diagnoses)

- Obstructive sleep apnea
- Asthma, moderate persistant
- Other disorders of lung
- Cystic fibrosis
- Cough
- BPD origin in perinatal period
- Sleep apnea
- Chronic respiratory failure
- Snoring

Rheumatology (top referral diagnoses)

- Systemic lupus erythematosis
- Juvenile rheumatoid arthritis
- Joint pain, unspecified
- Other abnormal serum immunological findings
- Juvenile arthritis

Urology (top referral diagnoses)

- Phimosis
- Undescended testicle, unilateral
- Nocturnal enuresis
- Unspecified hydronephrosis
- Urinary tract infection
- Vesico-ureteral reflux, unspecified

CIN Primary Care-Specialty Pilots

- Identify 1 topic area opportunity in key specialty areas
- Identify PCP & specialty champions
- Meet 3x between January – May to develop initial pilot
- Present at 2019 Future of Pediatrics (June) for community practitioners
- Begin pilots in CIN practices

Higher prevalence primary care opportunities

- Mental health screening & treatment
  - PCP management of common lower acuity conditions
  - Co-location/integration of behavioral health into primary care setting
- ADHD
- Asthma
- Obesity
- Medication/antibiotic stewardship
- Reduce low acuity non-emergent ED visits

- Develop CIN metrics, ongoing QI initiatives
- Opportunities to measurably improve care and impact utilization and cost across CIN

Need champions for CIN Clinical Quality Committee and work groups

- Most of our CIN meetings will be web-based
  - We're busy & we're all over the map (VA, DC & MD)

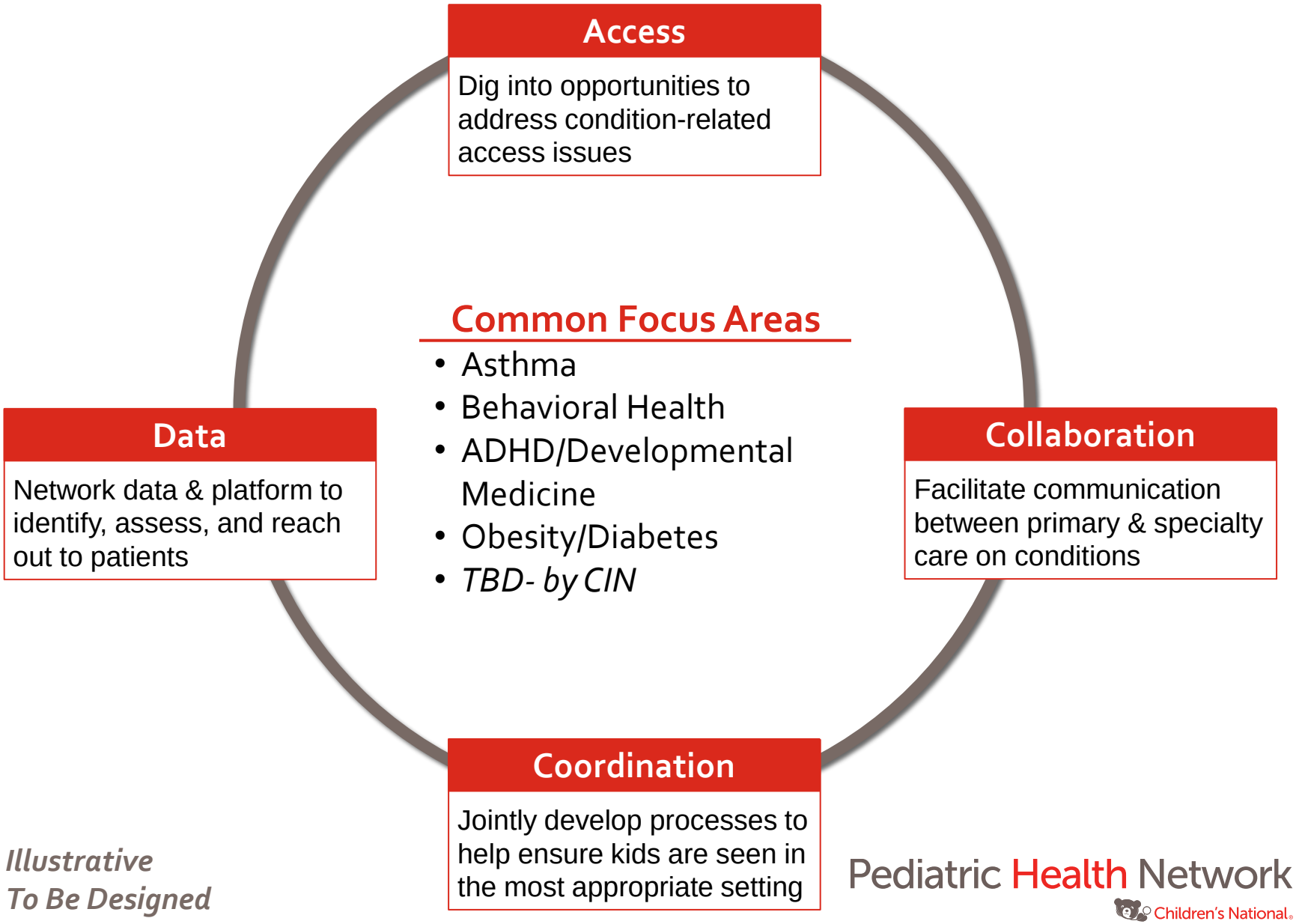
Interested in Participating in the Design of a Primary Care-Specialty Quality Initiative?

- Fill out the form on the PHN table (near registration), OR…
- Email us:
- Dabney@cnmc.org
- Ehamburg@cnmc.org

- And (optional) tell us what commonly referred conditions you favor working on

Discussion

Pediatric Collaboration on Condition-Specific Priorities



Illustrative
To Be Designed

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