Improving Care for Pediatric Populations

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Disclosures

- I have no conflicts to disclose
- I will not be discussing the off-label use of pharmaceuticals

Objectives

- **Quality** – What does this mean for busy clinicians?
- **Innovation** – How to think differently and effect change in our processes?
- **Network Opportunities** – What are the benefits of participating in a network for enhancing the care we provide?

A Day in the Life – Dr. Rose

- Large suburban group practice
- New participant in care management incentive program
- Knows Max has poorly controlled ADHD and asthma

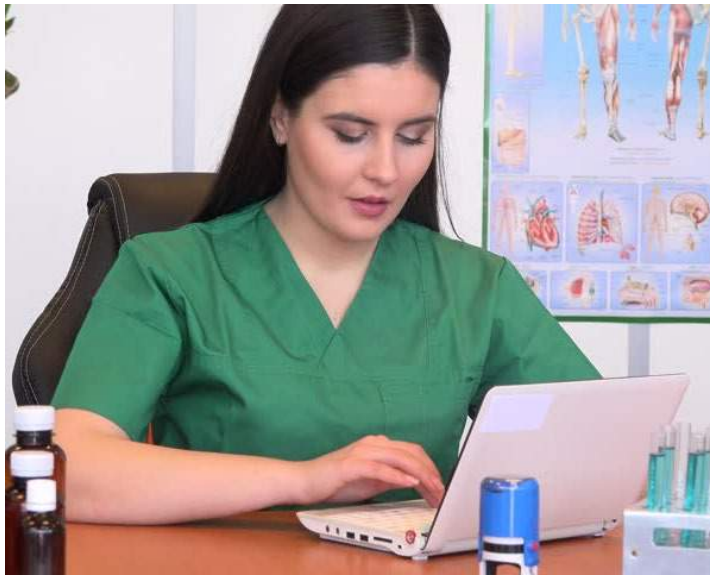

Photo credit: Shutterstock

A Day in the Life – Max

- 12-year old
- Moderate persistent asthma
  - Interferes with soccer
- ADHD
  - School suspension
- Family stressors
  - Paternal alcohol abuse
- Depressive symptoms

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Quality Improvement

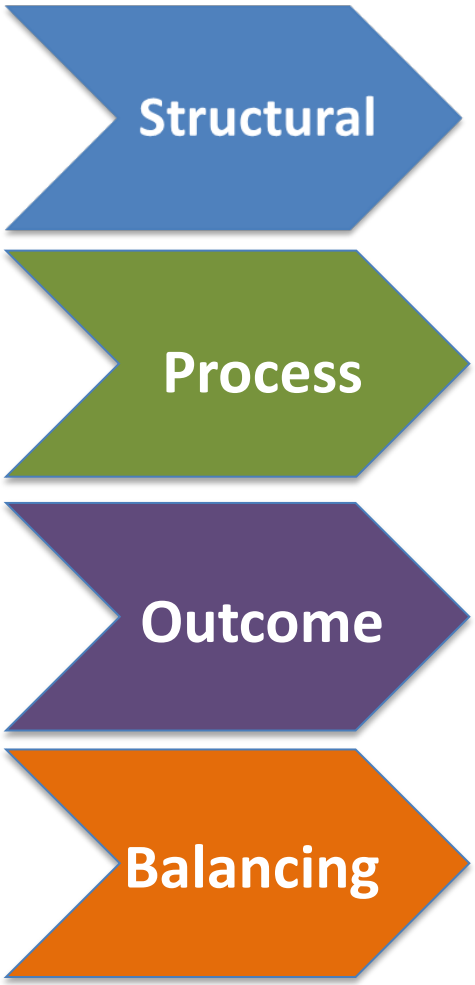
Measure what matters

Quality Improvement

- Distinct from measurement in research
  - Bring new knowledge into daily practice
  - Gather just enough data to learn
  - Small tests of significant changes (PDSA)

Institute for Healthcare Improvement, www.ihi.org

Example: Clinical Navigation



- Sufficient staff to implement program

- Proportion of patients screened
- Proportion of cases completed

- Asthma management
- Adolescent depression
- Needs met
- Total cost of care

- Increased visit time
- Provider and patient satisfaction

Burghardt, Barany, Milam, Gunn. The Impact of Screening for and Addressing Social Needs in Pediatric Clinical Settings on Child Health and Cost of Care *AJPM*. Submitted for publication.

Quality Improvement

- Many of you likely already have some of these in place:
  - Well-child visits first 15 months (*process*)
  - Effective asthma management ACT/TRACK (*outcome*)
- Max, process and outcome measures:
  - Asthma and ADHD management
  - Adolescent depression screening
- How would you know about dad's drinking?

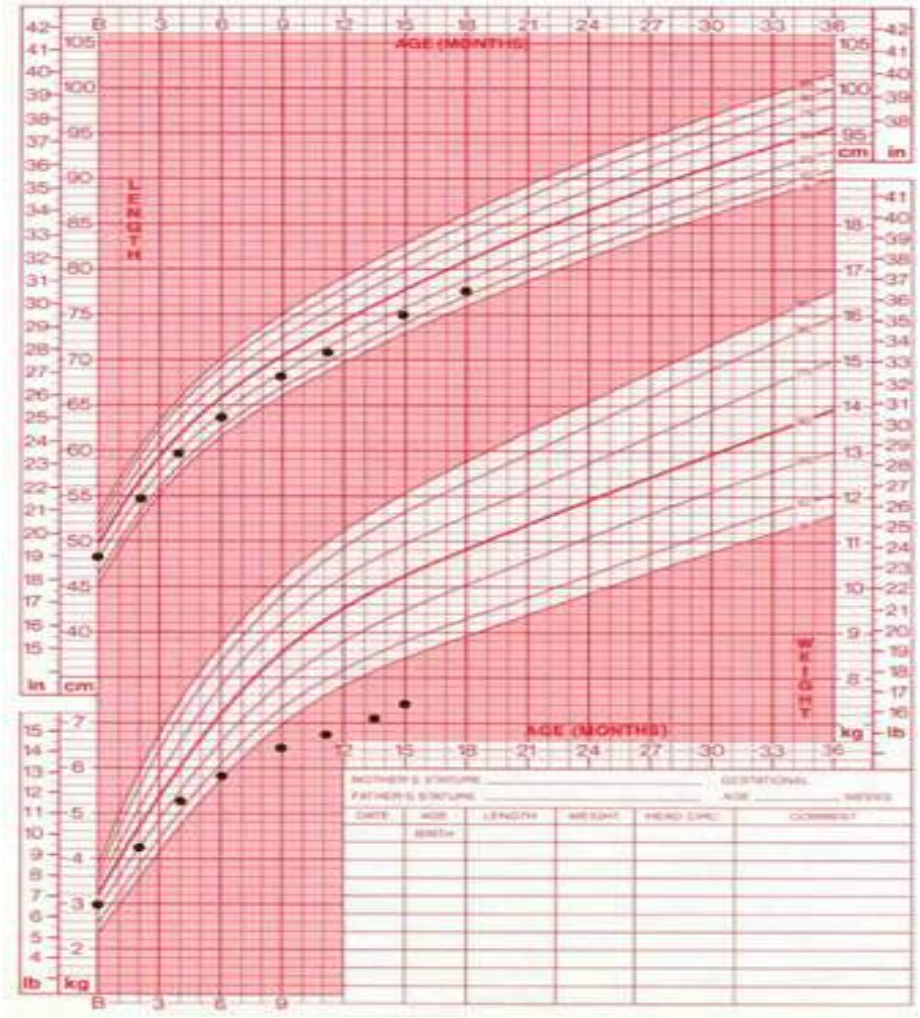
Quality Improvement

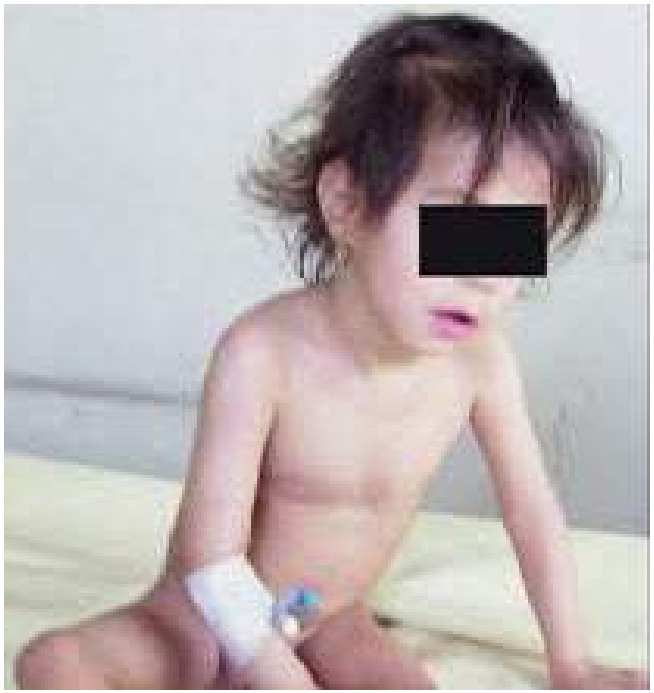
- Why:
  - Clinically and socially relevant for Max's well-being
  - Difficult to improve outcomes without addressing root causes
- How:
  - Implement two-generation approach
- What:
  - Standard screening for all patients/caregivers, inclusive of substance use
  - E.g., *Would you like help addressing substance use for yourself or your child?*

Innovation

The power of “What if?”

Innovation Example: Failure to Thrive





Innovation Example: Failure to Thrive

Current state

- Admit to hospital
- Parent education
- Potential referral to protective services
- Adversarial experience
- Does not address root causes

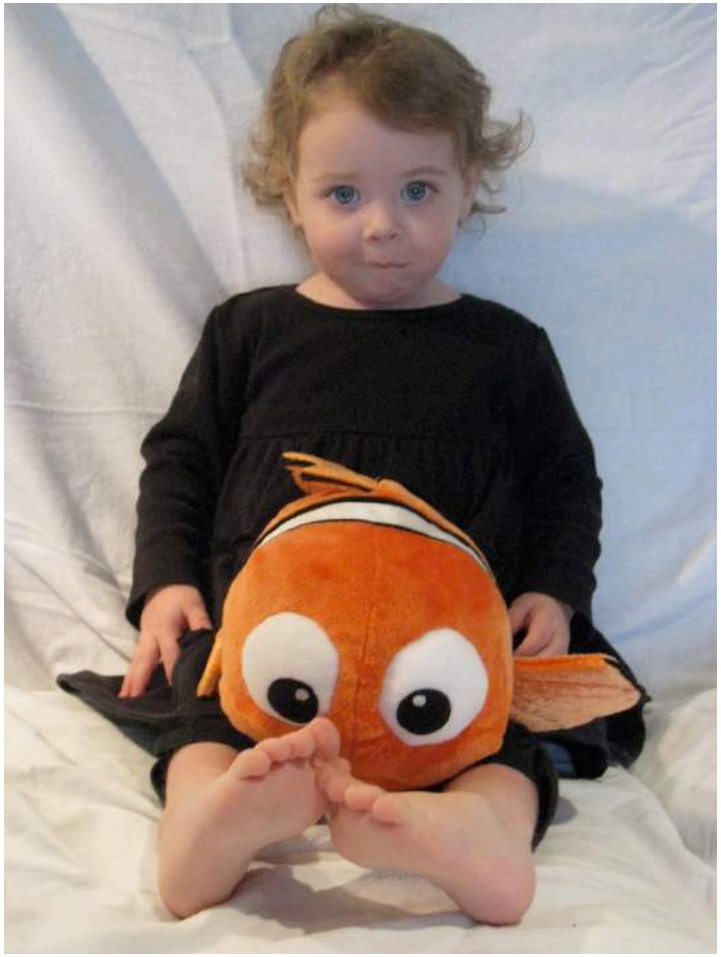
Pilot

- Admit to home
- Clinical, social and environmental assessments and supports
- Skill-building experience
- Addresses root causes

"What if these children never needed to be admitted to the hospital?"

Innovation Example: Failure to Thrive

- Clinical assessment performed by RN
- Developmental assessment and supports provided at home
- Cost savings for hospital *and* payer
- Supports “quadruple aim”:
  - Better health outcomes
  - Enhanced patient experience
  - Lower total cost of care
  - Improved provider satisfaction



Innovation – Questions to Consider

- **Why** do we do this?
- **How** might we approach this differently?
- **What** are key steps to accomplish the goal? What would we measure?
- **Who** needs to do what? (i.e. what is each person's/organization's role?)

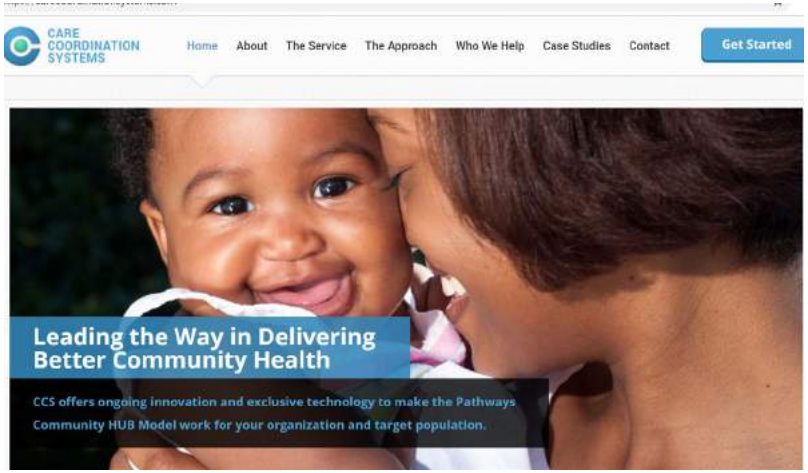
Innovation – Max

What if Max and his family could access resources in a timely way to reduce the risk of escalation?

- **How**: Via a web-based portal accessible to patient/family and community-based providers (role-based access)
- **What**: Access to educational materials, screening tools, tele-psych visits, referrals to community-based resources, etc.
- **Who**: Providers and patient/families surface ideas, system provides technical support, CBOs provide access to services

Community Pathways Hub

- Web-based integrated system of service delivery
- Portal data entry by patients, clinicians and community-based service providers (E.g., CHWs)
- Facilitates service coordination across multiple sectors
- Case studies: Ohio, Wisconsin



https://carecoordinationsystems.com/

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Network Opportunities

Partners in population health management

PHN Vision

The Pediatric Health Network ("PHN") **will transform the health of our region's children through highly coordinated and collaborative care among pediatric primary care, specialists, hospitals and community partners.**

Network Opportunities

- Facilitating measure development across groups and with payers
  - Incentives align with what matters most
- Enabling shared learning opportunities
  - Patients accessing care at different points along care continuum receive the same high quality care
- Foundational in your ability to address many non-clinical influences on health outcomes

Pediatric Obesity Pilot

Photo credit: http://www.drsharma.ca

- Focus area for large MCO
- Primary care concerned about ability to impact
- Designed collaborative approach to screening and referring to community-based resources for nutrition and physical activity
- Pooled MCO and primary care coordination and outreach resources
- Data sharing across entities

Network Opportunities – Max

- Enables testing and “spread” of innovative ideas
  - One clinic tests implementation of social health screening; another tests two-generation screening for substance use
  - Insights learned are shared across the network
- Network and system resources support collection of actionable data
- Network leaders collaborate with community organizations to ensure access to necessary services for referred patients

Parting Thoughts

- It is possible to improving patient care and maintain joy in practice
  - Strategic engagement in quality improvement practices
  - Embracing innovation
  - Utilizing your PHN network resources
- Learn from others – you are not alone

For More Information

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