Remodeling Healthcare for Children with NJ FamilyCare:

Care Integration Tools for Complex Health Conditions

NJ InCK Webinar Series

Thursday, September 9th, 2021

New Jersey Chapter
INCORPORATED IN NEW JERSEY
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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NJ Integrated Care for Kids

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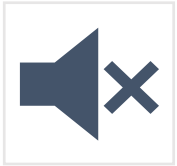

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Utilize the Q&A feature to ask our presenters questions.

Please remain respectful and professional within the Q&A box.

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Presented By:

Steven Kairys, MD, MPH, FAAP

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Co-Principal Investigator, New Jersey Integrated Care for Kids (NJ InCK)
Medical Director, New Jersey Chapter, American Academy of Pediatrics (NJAAP)

Disclosures

Our presenter has NO financial disclosures or conflicts of interest with the material presented in this webinar.

The presentation reflects the viewpoints of the presenter only and does not necessarily represent the viewpoint of the state of New Jersey or other partners.

Learning Objectives

1. Learn about how the Integrated Care for Kids approach meets the medical, behavioral and social needs of children with NJ FamilyCare

2. Detail the Integrated Care for Kids approach to ensuring quality care for children with NJ FamilyCare is achieved through family-centered care integration

3. Have an introductory understanding of the evolving conversation about the role of medical, behavioral and social needs screening in primary care

4. Understand the importance of a medical home and shared plans of care for improved health outcomes in children and families with complex health conditions

5. Identify the Integrated Care for Kids role in identifying and connecting children and families to community resources

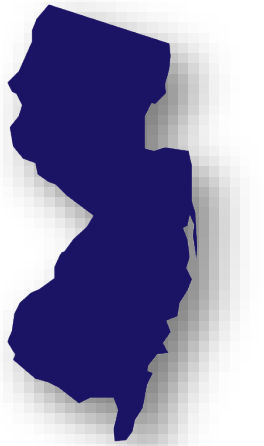
Integrated Care for Kids Approach to Care Management

The When/Where/WHO of InCK

- **Clinical launch is in January of 2022**
- NJ and 7 other sites around the country will be simultaneously launching these projects which are funded to continue **through 2026**
  - **NJ**—Monmouth & Ocean counties
  - **NY**—the entire Bronx (through NYS DOH/Montefiore)
  - **CT**—New Haven (through Clifford Beers Guidance Clinic)
  - **NC**—5 counties in Raleigh-Durham area (through Duke & UNC)
  - **IL**
    - *Lurie Children's Hospital*—2 Chicago zip codes
    - *Egyptian Regional Health Department*—5 rural counties
  - **OH**—Nationwide Children's Hospital—2 rural counties
  - **OR**—5 central OR counties (through OR Health Authority/OHSU)
- All kids 0-20 covered by NJ FamilyCare (Medicaid/CHIP)

Who is making InCK happen in NJ?

- **Co-lead agencies**: Hackensack Meridian Health (awardee), NJ Health Care Quality Institute, VNA of Central Jersey
- **Partnership Council**: Representatives of the CMMI defined Core Child Services
- **Coordinating Council**: Data and Information Sharing Governance
- **Other Key Partners:** New Jersey Chapter of the American Academy of Pediatrics, Central Jersey Family Health Consortium



How does NJ InCK Work?

- After Screening and Diagnosis kids are put in ***risk tiers*** [Service Integrations Levels in CMMI parlance] 1—2—3 (1 being the lowest risk and 2 & 3 being the highest risk)
- NJ InCK sponsored resources are provided to medical providers and the community to connect Level 1 kids to needed resources

NJAAP's Role in the NJ InCK Project

- The NJAAP will provide ***education for healthcare providers and practices*** to understand and engage in the NJ InCK program through American Board of Pediatrics (ABP) approved Maintenance of Certification (MOC) Part 2 credit opportunities and more, such as:
  - Webinar series
  - Quality Improvement (QI) project
  - Project Extension for Community Healthcare Outcomes (ECHO)

- The Psychiatric Care Collaborative will be critical to ***supporting behavioral health care***

NJ InCK: Key Features

- Development of *interoperable electronic platform* for real time sharing of individual child information between agencies and clinicians
- Development of *electronic data base* to track outcomes and metrics
- Advanced Case Management teams:
  - *Care Integration Managers* will serve as the liaison between primary care and the ACMTs
  - Teams will likely include social workers, community health workers, child life specialists, and family support specialists.
  - Teams will work in the community and also meet with the pediatric clinicians.
  - Extent of involvement based on level of Service Integration

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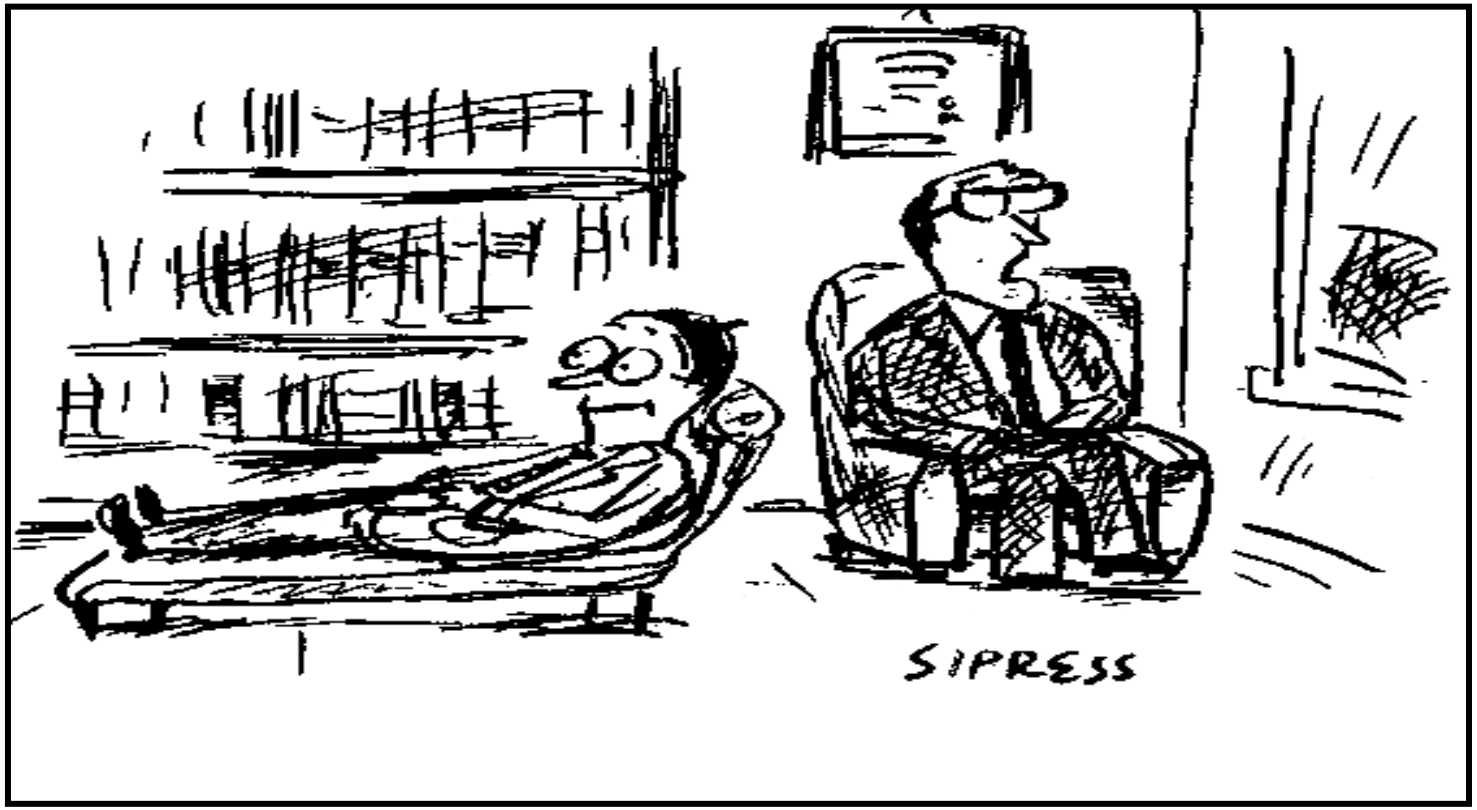
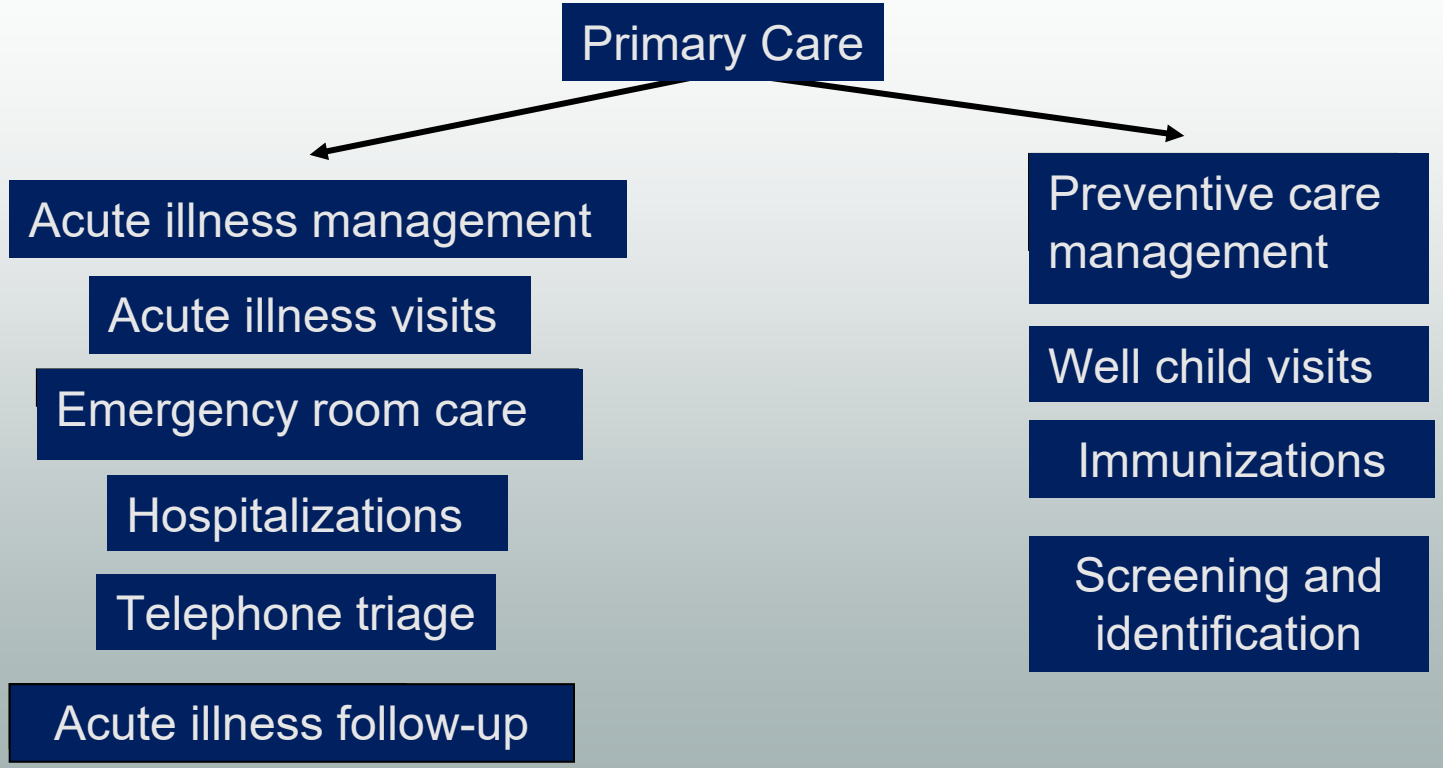
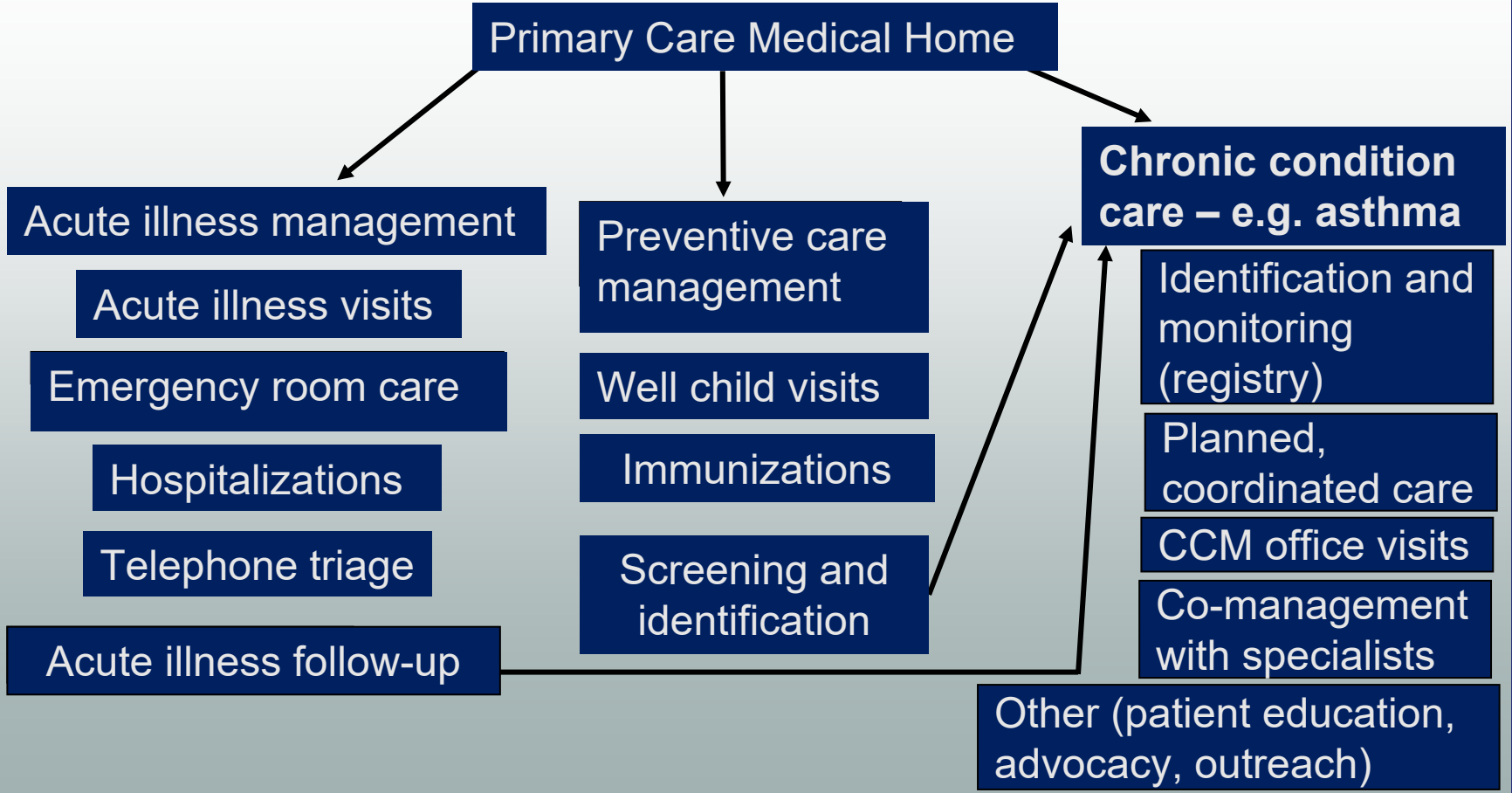


"You know, Martin, when a primary care physician tells me he's happy, all my alarm bells go off."

The Primary Care Model



The Medical Home Model



Lone Doctor Model

- The current primary and specialty care model is a lone doctor model
- The doctor is responsible for everything
- The doctor doles out tasks to other team members but they do not share responsibility or pride for patient outcomes
- Many patients view the doctor as the only person who can solve their problems

Tool Box for Integrated Care for Kids

Expanded Primary Care

- Treating the Whole Child
- Centering Care/Group Care
- Two Generation Care
- Early Relational Health
- Strength Based Focus

The Patient Centered Medical Home

- Medical Home Index
- Patient Engagement
- Population Health
- Synchronizing the Pediatric Office

Menu of System Innovations for Improving Well Child Care

- Advanced access scheduling
- Reminder and recall systems
- Pre-visit prompts
- Structured screening prior to encounter
- Preventive services summary forms and provider prompts
- Office team approach
- Reinforcement patient education materials
- Group well childcare
- Negotiated care priorities and management
- Structured referral to community resources
- Web-based patient education

“Tis Better to Screen than Not”

	Identified With Screening	Not Identified Without Screening
Children with Developmental Disabilities	70-80%	70%
Children with Mental Health Problems	80-90%	80%

Expanding Primary Care

Treating the Whole Child

- Using Evidence based screening and assessment
- Assessing for Social Determinants
- Recognizing the high prevalence of trauma in the lives of the children in your practice

Two generation care

- Maternal Depression
- Trauma informed care

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New Jersey Pediatric Psychiatry Collaborative Overview

FUNDING:

- Original and continued funding by NJ DCF

THE PROGRAM:

- The program is open to any pediatric provider serving children up to age 18 (or as long as patient is under physician's care)
- Child psychiatrist available to pediatric providers for diagnostic clarification, medication consultation, and a face-to-face evaluation with a patient, if needed, free of charge
- Licensed social workers and psychologists available to facilitate referrals to appropriate services in the community

NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE

https://njaap.org/mental-health/njppc/

NJPPC Benefits

- A child and adolescent psychiatrist available for consultative support through the Child Psych. consult line
- *A psychologist/social worker available to:*
  - Assist the pediatrician with diagnostic clarification and medication consultation.
  - Speak with a referred child's family regarding the child's mental health concerns and to assist in providing diagnostic clarification.
- One-time *evaluation by a Child and Adolescent Psychiatrist (CAP) at no charge to the patient* when appropriate.
  - Based on the recommendation of the CAP, the NJPPC Hub staff will work with the family to develop the treatment and care coordination plan.
- *Continuous education opportunities in care management and treatment* in the primary care office for the common child mental health issues: ADHD, depression, anxiety, etc.

New Jersey Pediatric Psychiatry Collaborative Regional Hubs

- Atlantic Health Hub @ Newton Medical Center
- Atlantic Health Hub @ Goryeb Children's Hospital
- Hackensack Meridian Hub @ Hackensack University Medical Center
- Hackensack Meridian Hub @ Palisades Medical Center
- Hackensack Meridian Hub @ Middlesex and Mercer
- Hackensack Meridian Hub @ Jersey Shore University Medical Center
- Cooper Hub @ Cooper University Medical Center
- Cooper Hub @ Pennsville
- Essex County served by Rutgers University Behavioral Health Care.

More information on the Essex Hub can be found here: https://ubhc.rutgers.edu/clinical/community/collaborative-behavioral-health-care-project-essex-hub/collaborative-behavioral-health-care-project-essex-hub/collaborative-behavioral-health-care-project-essex-hub.xml

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Strength based Approaches

- Support mastery
- Identify strengths
- Start with what's right
- If a behavior change is needed, use helping skill or motivational interviewing

G Generosity

Demonstrate honesty and caring; Contribute to family and/or community

I Independence

Be able to get things done independently -- (self-efficacy)

M Mastery

Have completed high school; Have work, learning or other activity they can pursue with enthusiasm

B Belonging

Have connections to friends and family

Brendtro

Group Well Child Care (Centering)

- Clustering well child visits by the age of the child
- While the individual child is seen the group of parents and children engage in interactive discussions on topics such as attachment, safe sleep, nutrition, early literacy, parenting, mindfulness
- Parents are more informed, support each other in an environment that is safe and supportive

https://centeringhealthcare.org/

Family Engagement

Shared Plans of Care

Family Surveys

Shared Plan of Care

- A guide for moving care forward using a clear summary of information and a collaborative approach. Enables family and care team to collaborate and operate from the same page
- Family has a clear contact and access to their plan

Includes two parts

1. A medical summary that includes demographic information, current medical care facts, lead team members and contacts, and core family knowledge including their personal preferences and goals
2. Negotiated Actions- The joint strategies to address goals with timelines and clear accountability

Shared Plan of Care - The Principles

1. Communication with medical team is clear, frequent and timely
2. Assessments based on child and family strengths, history and preferences
3. Medical team and family have mutual respect and trust
4. All partners understand the care planning process and individual responsibilities
5. The team monitors progress and adjusts plan as needed
6. Team anticipates and prepared for all transitions - to school, to hospital, to adult care, etc.
7. Plan of care is used consistently by every provider within the organization and by providers across organizations

Pediatric Integrated Care Survey (PICS)

- The Pediatric Integrated Care Survey (PICS) is a family experience measure of care integration, considered an **outcome measure**

- Used to conduct quality measurement to inform improvement work in the space of pediatric care integration

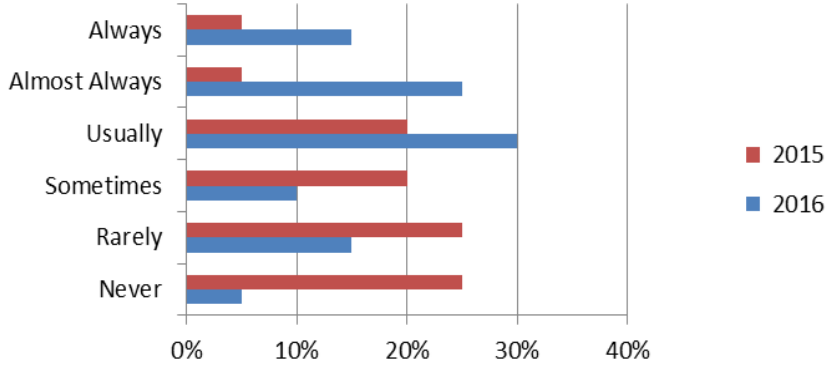
PICS tool consists of:

- 19 validated experience questions, health care status/utilization & demographic questions
- Supplementary and topic-specific modules
- *Spanish version is available*

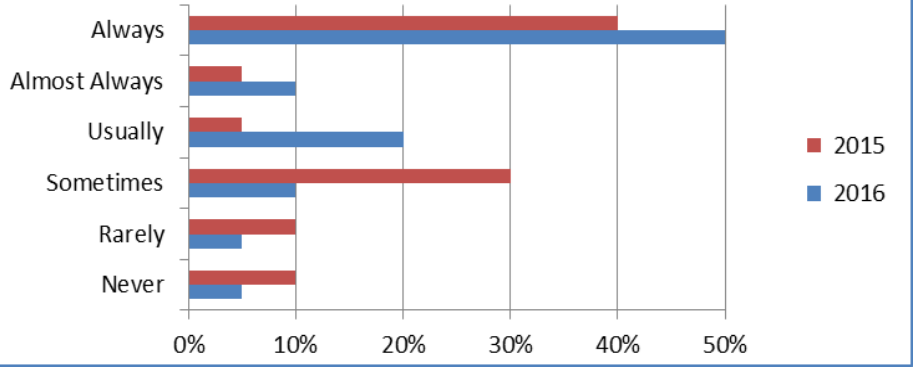
https://www.childrenshospital.org/integrated-care-program/patient-and-family-experience-outcome

Sample PICS Questions

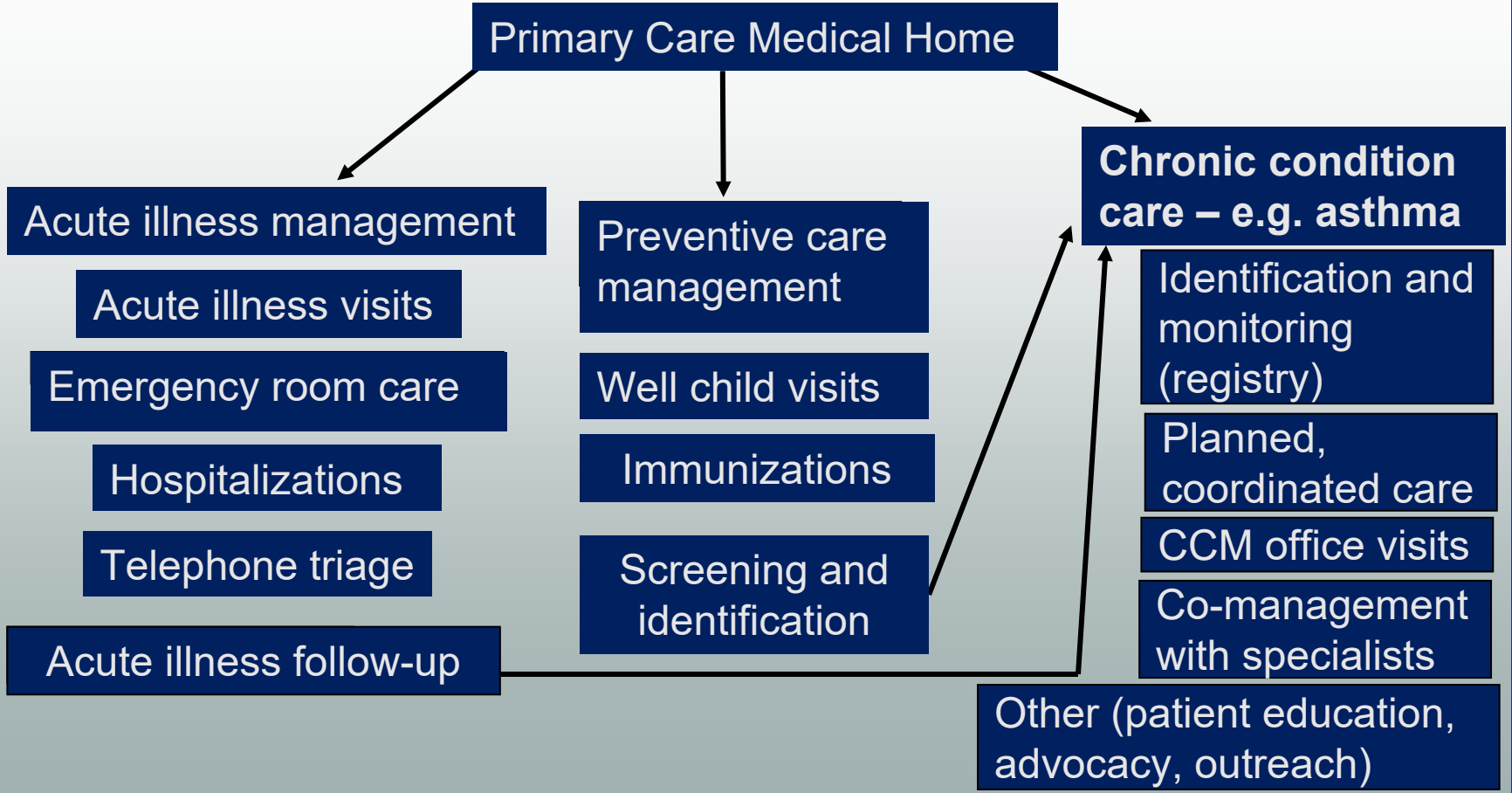
In the past 12 months, how often did you feel that your child's care team members in the Smith Clinic knew about the advice you got from your child's other care team members?



In the past 12 months, how often have your child's care team members in the Smith Clinic treated you as a full partner in the care of your child?



The Medical Home Model



Eight Distinguishing Characteristics

- Proactive planned visits instead reactive
- Tracking patients and their needed care using special software (patient registry)
- Support for self-management of chronic conditions (e.g., asthma, diabetes)
- Patient involvement in decision making
- Coordinated care across all settings
- Enhanced access (e.g., secure e-mail)
- Personal physician (clinician)
- Team-based care

The Medical Home Index Measurement Pre and Post Improvement

6 Domains (25 Themes)

1. Organizational Capacity (7)
2. Chronic Condition Management (6)

[More to come in October]

3. Care Coordination (6)
4. Community Outreach (2)
5. Data Management (2)
6. Quality Improvement/Change (2)

https://medicalhomeinfo.aap.org/tools-resources/Documents/CMHI-MHI-Pediatric_Full-Version.pdf

Domain 1: Organizational Capacity: For CSHCN and Their Families

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#1.1 The Mission of the Practice	*Primary care providers (PCPs)* at the *practice* have individual ways of delivering care to children with special health care needs (CSHCN); their own education, experience and interests drive care quality. ○ Partial ○ Complete	Approaches to the care of *CSHCN* at the *practice* are child rather than *family-centered*; office needs drive the implementation of care (e.g. the process of carrying out care). ○ Partial ○ Complete	The practice uses a *family-centered* approach to care (see page15), they assess *CSHCN* and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policies (e.g. the way things are done). ○ Partial ○ Complete	In addition to Level 3, a parent/*practice* "advisory group" promotes *family-centered* strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written,visible mission statement reflects practice commitment to quality care for CSHCN and their families. ○ Partial ○ Complete
#1.2 Communi-cation/ Access	Communication between the family and the *PCP* occurs as a result of family inquiry; *PCP* contacts with the family are for test result delivery or planned medical follow-up. ○ Partial ○ Complete	In addition to Level 1, standardized office communication methods are identified to the family by the practice (e.g. call-in hours, phone triage for questions, or provider call back hours). ○ Partial ○ Complete	Practice and family communicate at agreed upon intervals and both agree on "best time and way to contact me"; individual needs prompt weekend or other special appointments. ○ Partial ○ Complete	In addition to Level 3, office activities encourage individual requests for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (e.g. fax, e-mail or web messages, home, school or residential care visits). ○ Partial ○ Complete
#1.3 Access to the Medical Record *Requires both MD & key non-MD staff person's perspective.*	A policy of access to medical records is not routinely discussed with families; records are provided only upon request. ○ Partial ○ Complete	In addition to Level 1, it is established among staff that families can review their child's record (but this fact is not explicitly shared with families). ○ Partial ○ Complete	All families are informed that they have access to their child's record; staff facilitates access within 24-48 hours. ○ Partial ○ Complete	In addition to Level 3, practice orientation materials include information on record access; staff locate space for families to read their child's record and make themselves available to answer questions. ○ Partial ○ Complete

Instructions: A) Please select and circle one level from Levels 1, 2 3, or 4 for each theme above (circle one).
B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).

Domain 1: Organizational Capacity (continued): For *CSHCN* and Their Families

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#1.4 Office Environment *Requires both MD & key non-MD staff person's perspective.*	Special needs concerning physical access and other visit accommodations are considered at the time of the appointment and are met if possible. ○ Partial ○ Complete	Assessments are made during the visit of children with special health care needs and the needs of their families; any physical access & other visit accommodation needs are addressed at the visit and are documented for future encounters. ○ Partial ○ Complete	In addition to Level 2, staff ask about any new or pre-existing physical and social needs when scheduling appoint ments; chart documentation is updated and staff are informed/ prepared ahead of time ensuring continuity of care. ○ Partial ○ Complete	In addition to Level 3, key staff identify children scheduled each day with special health care needs, prepare for their visit and assess and document new needs at the visit; an office care coordinator prepares both office staff and the office environment for the visit; s/he advocates for changes (office/environmental) as needed. ○ Partial ○ Complete
#1.5 Family Feedback *Requires both MD & key non-MD staff person's perspective.*	Family feedback to the *practice* occurs through external mechanisms such as satisfaction surveys issued by a health plan; this information is not always shared with practice staff. ○ Partial ○ Complete	Feedback from families of *CSHCN* is elicited sporadically by individual practice providers or by a suggestion box; this feedback is shared informally with other providers and staff. ○ Partial ○ Complete	Feedback from families of *CSHCN* regarding their perception of care is gathered through systematic methods (e.g. surveys, focus groups, or interviews); there is a process for staff to review this feedback and to begin problem solving. ○ Partial ○ Complete	In addition to Level 3, an advisory process is in place with families of *CSHCN* which helps to identify needs and implement creative solutions; there are tangible supports to enable families to participate in these activities (e.g. childcare or parent stipends). ○ Partial ○ Complete
#1.6 Cultural Competence	The *primary care provider* (*PCP*) attempts to overcome obstacles of language, literacy, or personal preferences on a case by case basis when confronted with barriers to care. ○ Partial ○ Complete	In addition to Level 1, resources and information are available for families of the most common diverse cultural backgrounds; others are assisted individually through efforts to obtain translators or to access information from outside sources. ○ Partial ○ Complete	In addition to Level 2, materials are available and appropriate for non-English speaking families, those with limited literacy; these materials are appropriate to the developmental level of the child/young adult. ○ Partial ○ Complete	In addition to Level 3, family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the *practice* uses these encounters to assess patient & community cultural needs. ○ Partial ○ Complete

Domain 1: Organizational Capacity (continued): For *CSHCN* and Their Families				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#1.7 Staff Education *Requires both MD & key non-MD staff person's perspective.*	For all staff, an orientation to internal office practices, procedures and policies is provided. ○ Partial ○ Complete	In addition to Level 1, the practice supports (paid time/ tuition support) continuing education for all staff in the care of CSHCN (children with special health care needs). ○ Partial ○ Complete	In addition to Level 2, educational information on community-based resources for CSHCN, including diagnosis specific resource information, is available for all staff. ○ Partial ○ Complete	In addition to Level 3, families of CSHCN are integrated into office staff orientations and educational opportunities as teachers or "family faculty"; support for families to take this role is provided. ○ Partial ○ Complete

Domain 2: Chronic Condition Management (*CCM*): For *CSHCN* and Their Families				
THEME:	*Level 1*	*Level 2* (in addition to level 1)	*Level 3* (in addition to level 2)	*Level 4* (in addition to level 2)
#2.1 Identification of Children in the Practice with Special Health Care Needs	Children with special health care needs (*CSHCN*) can be counted informally (e.g. by memory or from recent acute encounter); comprehensive identification can be done through individual chart review only. ○ Partial ○ Complete	Lists of children with special health care needs are extracted electronically by diagnostic code. ○ Partial ○ Complete	A CSHCN list is generated by applying a definition (see pg. 15), the list is used to enhance care +/or define practice activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups). ○ Partial ○ Complete	In addition to Level 3, diagnostic codes for CSHCN are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible practice database. ○ Partial ○ Complete
#2.2 Care Continuity	Visits occur with the child's own primary care provider (PCP) as a result of acute problems or well child schedules; the family determines follow up. ○ Partial ○ Complete	Non-acute visits occur with families and their PCP to address chronic condition care; the PCP determines appropriate visit intervals; follow-up includes communication of tasks to staff and of lab and medical test results to the family. ○ Partial ○ Complete	The team (including *PCP*, family, and staff) develops a plan of care for *CSHCN* which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up/cross coverage providers are informed by these plans. ○ Partial ○ Complete	In addition to Level 3, the practice/teams use condition protocols; they include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes which support children and families. ○ Partial ○ Complete

What is an asthma registry?

- A list of patients with asthma
- A source of data for asthma management
- A tool to incorporate guidelines into practice

How is a registry different than an electronic medical record?

How is our registry used?

- Recalling patients for follow-up
- Identifying patient sub-sets for additional support
- Performance feedback to providers

“System Changes? I have patients to see!”

- One in 5 families has a child and youth with special healthcare needs (CSHCN)
- Survival/complexity among CSHCN is increasing
- Strategic connections with specialists save time and money
- Caring for CSHCN is where pediatricians shine

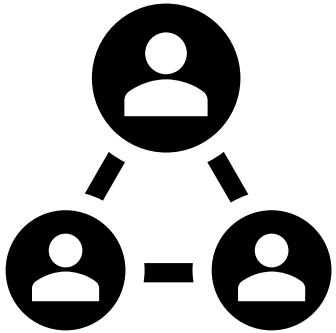
From I to We:
Challenge for Interprofessional Education

- Clinicians have most of knowledge and tell or ask other team members to do isolated tasks for them
  - *Diffuse knowledge* so that all team members become highly competent at the work they do
- *Training* is critical for team formation
- Rather than isolated tasks, team members need area of work for which they feel responsible, proud
- Physicians must learn how to *delegate responsibilities* rather than ordering tasks

Community Services for Children with SHCN and Their Families

Role of Primary Care Practice in Community Services

- Child Welfare
- Social Services
- Early Childhood Services
- Education
- Mental Health
- Community Based Therapies
- Public Health
- Family Support



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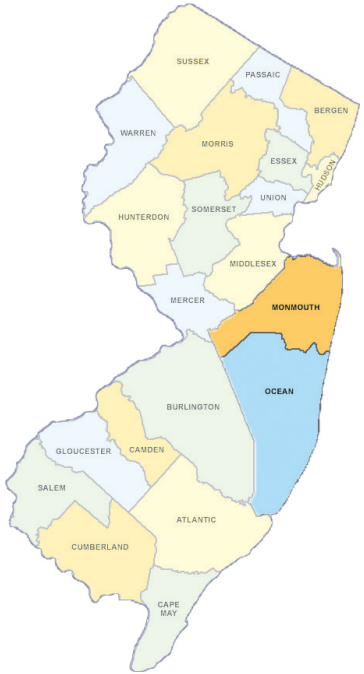
NJ InCK Can Help

NJ InCK staff able to provide support to practices based on the priorities of the practice

- Expanded use of the EMR
- Evidence based screening
- New models of care/ Medical Home
- Team Building
- Care for children with complex issues
- Linking the community

Piloting in Monmouth and Ocean Counties!



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Questions?

NJAAP NJ InCK Team

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Join us for our seventh session!

Remodeling Healthcare for Children with NJ FamilyCare: *Care Coordination*

Thursday, October 14th from 12-1 PM

Presented By:

Mary Remhoff, RN, MSN, APN

Director, Center for Early Childhood Development and Family Support Children and Family Health Institute, VNAHG, Care Integration Director/Clinical Team Supervisor, NJ InCK

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Register Here!

Evaluation

If you are seeking CME/MOC part 2 or CNE credit for your participation, you must complete the webinar evaluation:

https://forms.office.com/r/tG6LLc1P98