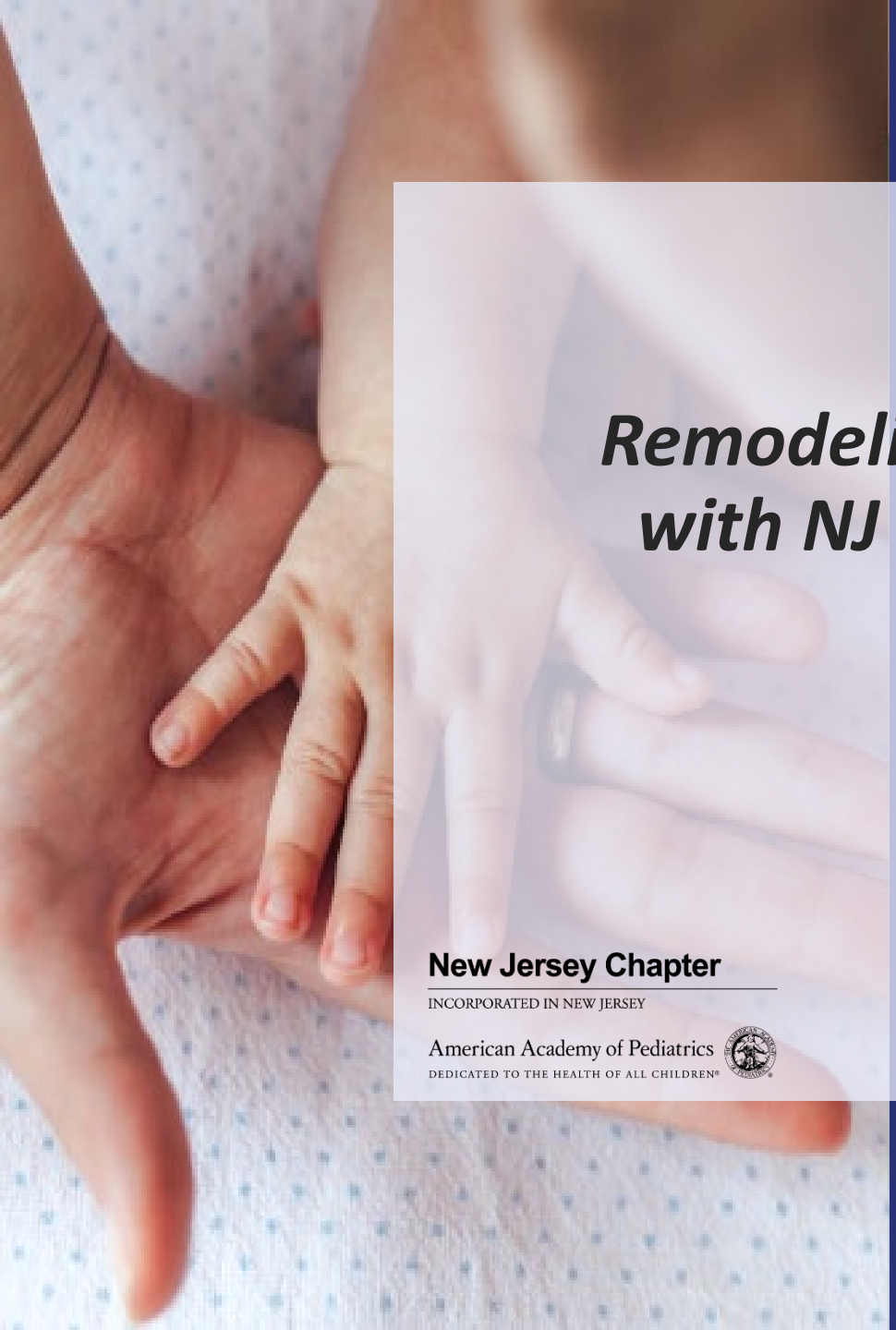

Remodeling Healthcare for Children with NJ FamilyCare: *Transforming Whole Child Care*

NJ InCK Webinar Series

Thursday, May 13th, 2021

New Jersey Chapter
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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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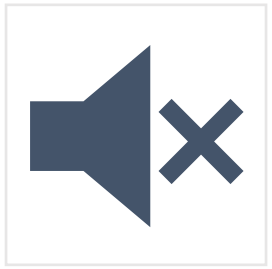
This NJ InCK project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $2.9 million with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Participant Reminders



All participants will be muted throughout the duration of the session to minimize any disruptions.

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

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

Continuing Medical Education Disclosure

Accreditation Statement for 5/13/21 Webinar:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Society of New Jersey through the joint providership of Atlantic Health System and the American Academy of Pediatrics, New Jersey Chapter. Atlantic Health System is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians.

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Successful completion of this CME activity, which includes participation in the activity, with individual assessments of the participant and feedback to the participant, enables the participant to earn 1.0 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit. Disclosure Statement: The presenters have nothing to disclose.

Nursing Contact Hours:

The New Jersey Board of Nursing (NJAC 13:37-5.3) states: *"A registered professional nurse or licensed practical nurse may obtain continuing education hours from the following: (d)3. Successful completion of continuing medical education courses recognized by the American Medical Association, the American Osteopathic Association or the American Podiatric Medical Association: one hour for each 60 minutes of attendance."* Nurses should claim only the credit commensurate with the extent of their participation in the live activity.

Presented By:

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Disclosures

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

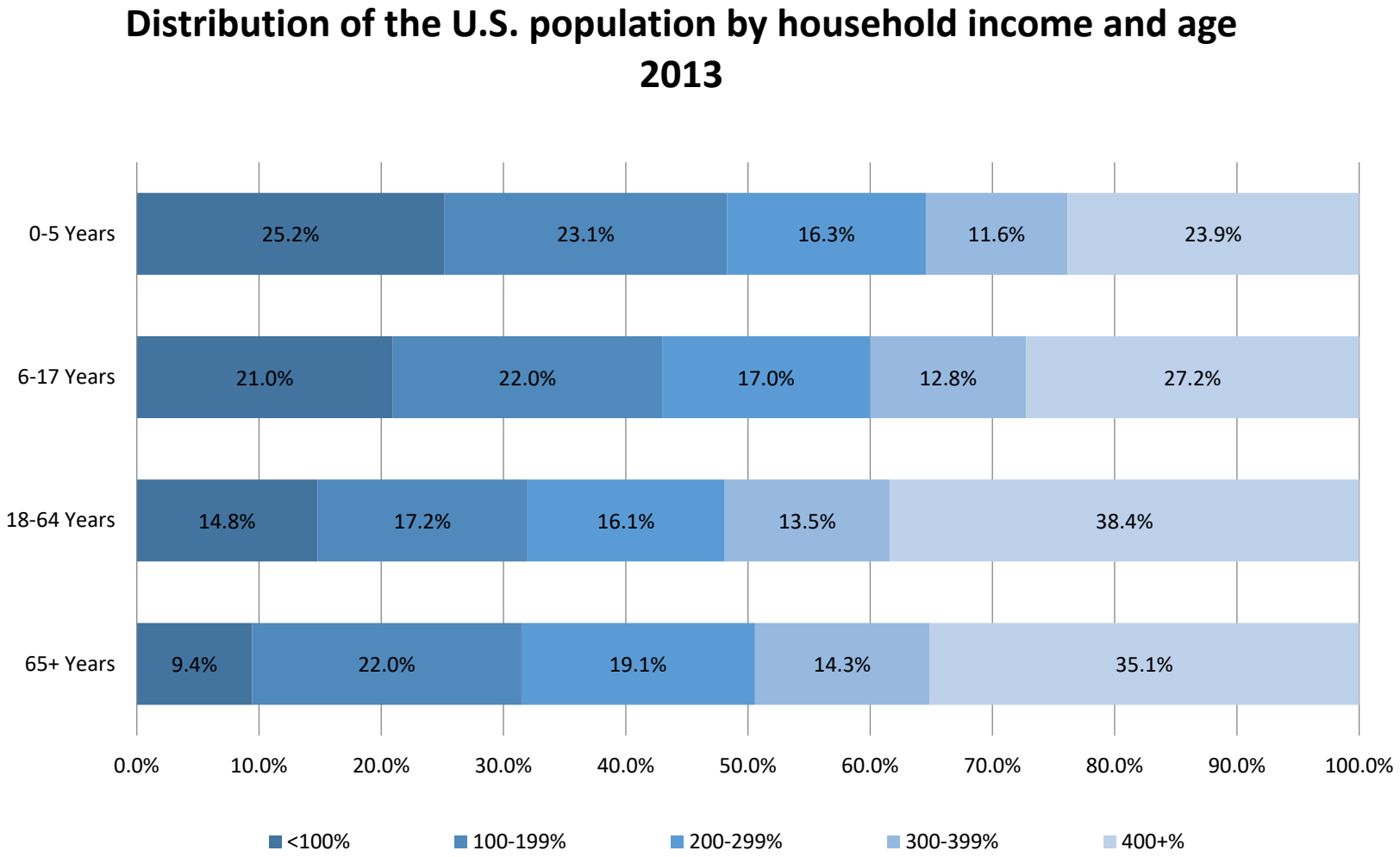
The presentation reflects the viewpoints of the presenters only and does not necessarily represent the viewpoint of the state of New Jersey or other partners.

Learning Objectives

1. Understand the complex needs of children who receive medical care through NJ FamilyCare (Medicaid)
2. Review the current care in primary care, and the current community system of care for children with NJ FamilyCare who have special health and social needs
3. Recognize emerging national models of providing whole child care to children with special health and social needs
4. Detail the Integrated Care for Kids approach to care managing children with NJ FamilyCare who have health and social needs

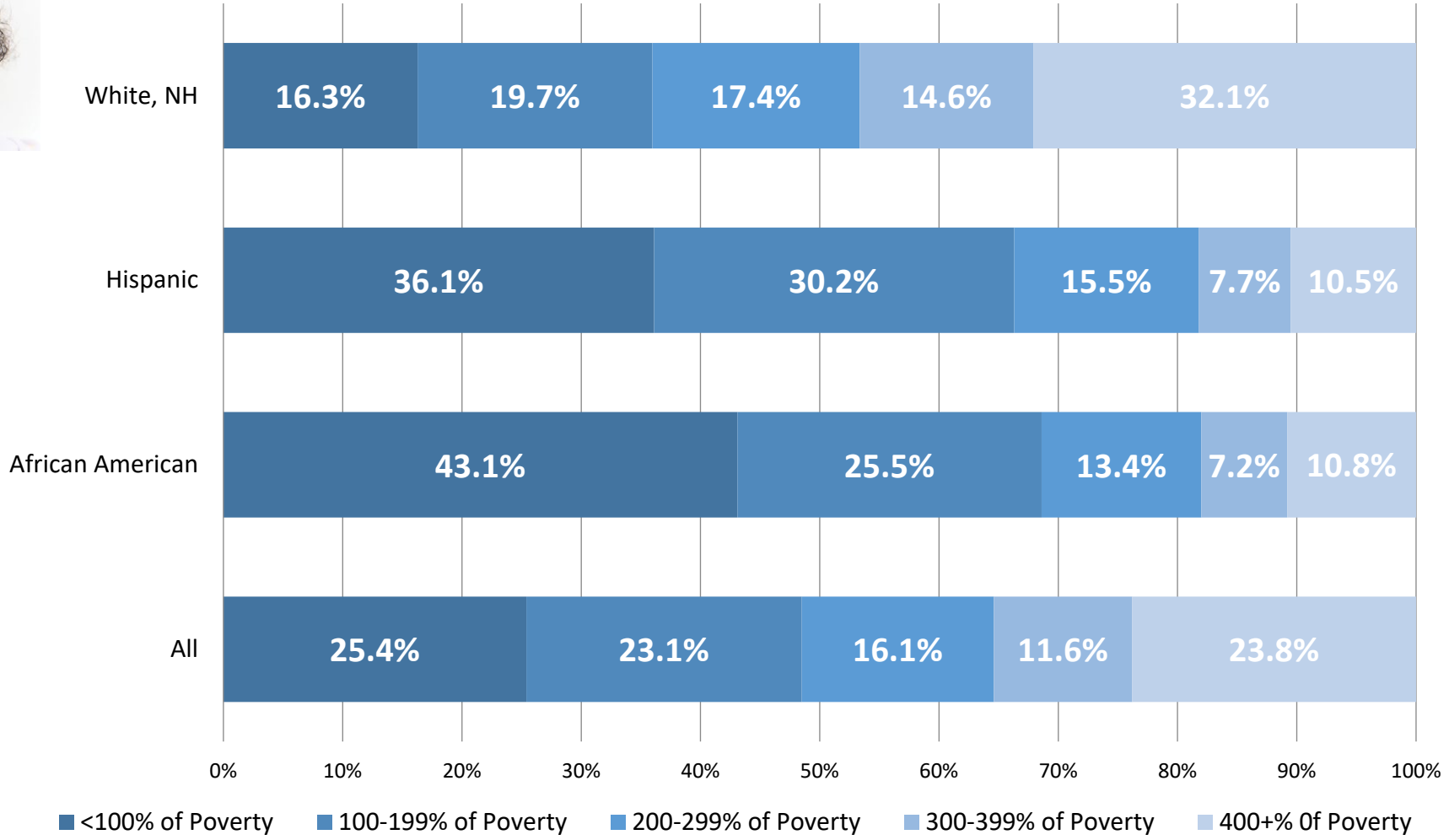
The Complex Needs of Children Living in Poverty

Young Children Age Group Most Likely to Live in Poverty



Reference: *U.S. Census Bureau, Public Use Microdata Sample, 2011-2013*

Young Children of Color by Far the Most Economically Disadvantaged



Reference: *United States Census, Public Use Microdata Sample 2012*

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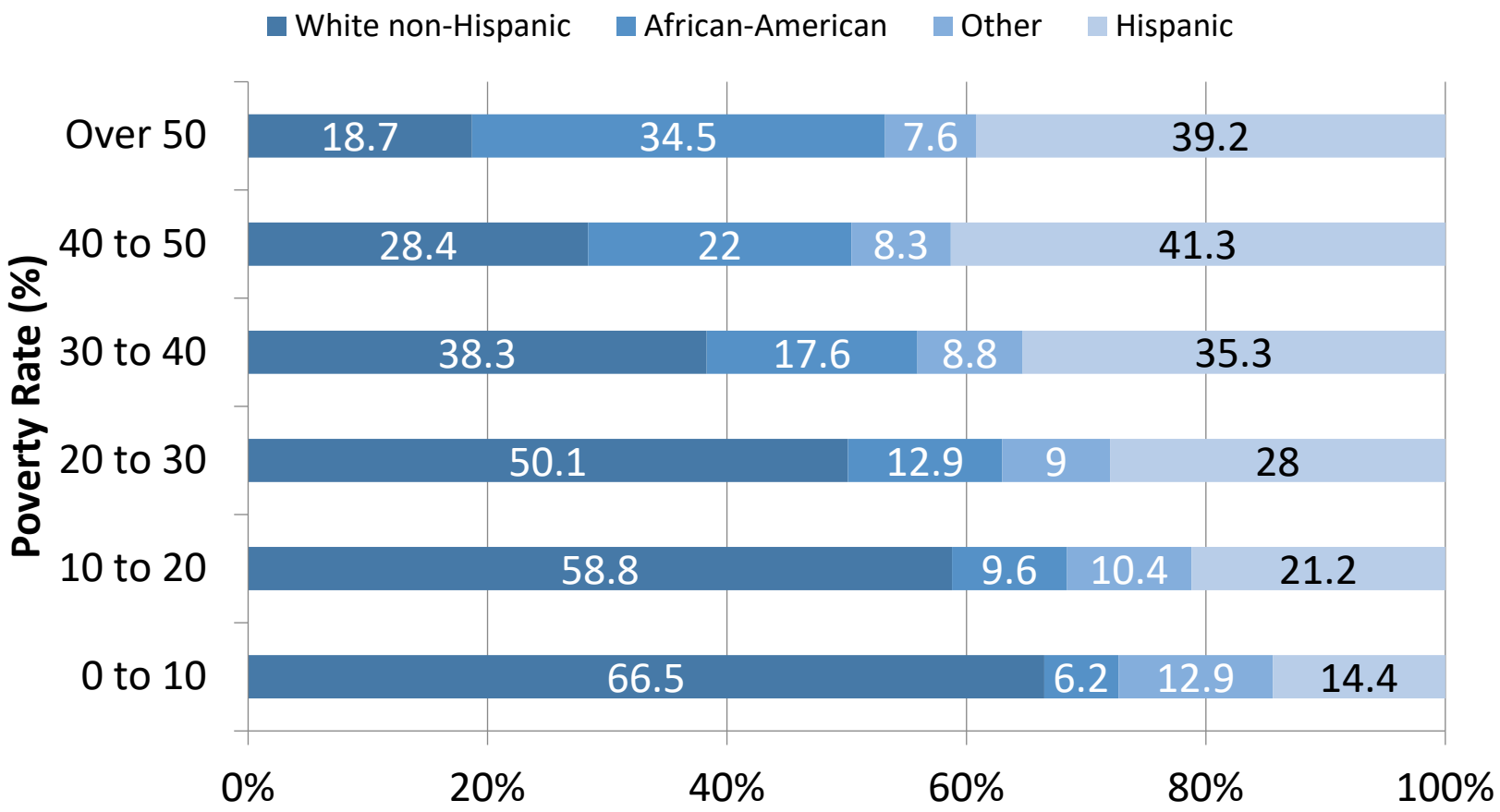
Poorest Neighborhoods: Highly Segregated



Note: While 8.4 percent of White, non-Hispanic children live in census tracts where the poverty rate is above 40 percent, 38.2 percent of African Americans, 31.9 percent of Native Americans, and 28.9 percent of Hispanics do.

Beyond Census Data: Comparing Neighborhoods of Affluence and Poverty

A Tale of Two DCs

	Ward 3	Ward 7
Parent(s) of 0-3 with BA *	97 %	20 %
Two-Parent Households 0-3) *	93 %	15 %
Births to Unmarried Women	7 %	85 %
Percent teens giving birth **	0.2 %	7.8 %
Low birthweight	7 %	15 %
Late or no prenatal care	3.8 %	9.1 %
Infant deaths (0-1)	0.1 %	2.5 %
Substantiated abuse (0-3)	.03 %	3.5 %
EI screenings 0-3 yr. olds	2.7 %	2.4 %
Gold Star Ratings of child care ***	100 %	22 %
Family income under 200% pov. *	28.1%	97.1%

Reference: Child Trends/Bainum Family Foundation (2015). *Infants and Toddlers in the District of Columbia.*

* PUMA data in which Ward 3 and 7 located. ** Ward 2/3 and 7/8 combined. *** Ward 2, Ward 3 has no participating child care centers in QRIS.

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New Jersey Data

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New Jersey Data

- **35%** of 0-3 yo children in NJ live in families with income *less than 200%* of federal poverty threshold
- **35%** of black women and **30%** of Hispanic women receive no or late prenatal care
- Infant mortality per 1000 births: Black babies **9.4**, Hispanic babies **4.8**, white babies **2.7**
- **310,000** children under age 3 and there are 5,459 funded home visitation slots
- **73%** of families likely to need child care do not have access to licensed child care, and this care averages $15,600 dollars a year

Reference: *Pritzer. 2020. Unlocking Potential – A Roadmap to Making New Jersey the Safest, Healthiest and Most Supportive Place to Give Birth and Raise a Family*

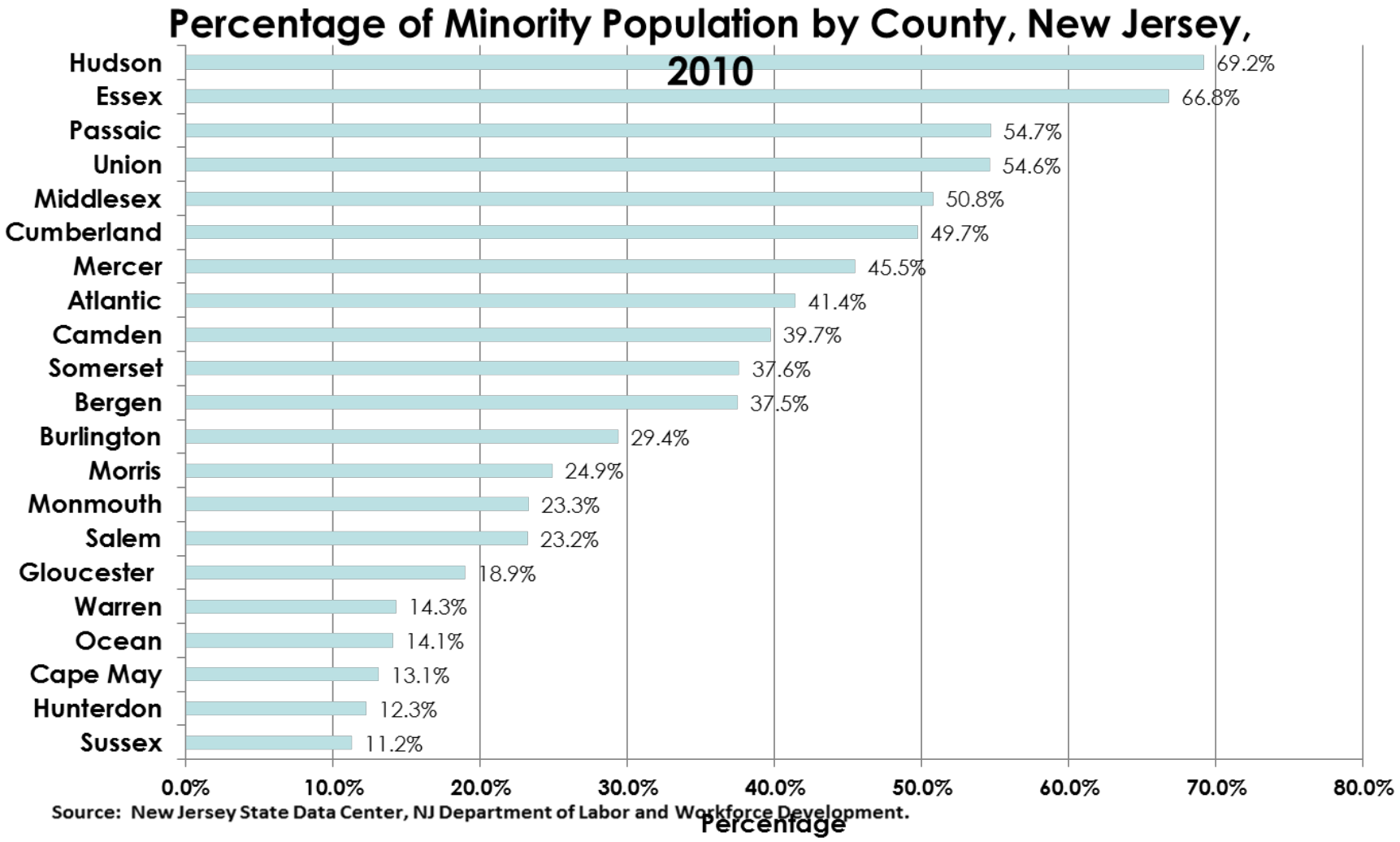
New Jersey Data

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

- **66%** of children by 15 months receive 6 well child visits (compared to 61% nationally)
- **60%** of children 12-21 receive one well child visit (45% nationally)
- **49%** of children 1-20 with at least one preventive dental visit (48% nationally)
- **20%** of female adolescents by 13th birthday receiving 3 HPV doses (40% nationally)

Reference: *American Academy of Pediatrics. EPSDT and Bright Futures: New Jersey (2016 Medicaid Data)*

Minority Population by County



Source: New Jersey State Data Center, NJ Department of Labor and Workforce Development.

Consequences of Poverty: Child Health

- Increased **infant mortality**
- Low **birthweight** and subsequent problems
- **Chronic diseases** such as asthma
- More **food insecurity, poorer nutrition & growth**
- Poorer **access to quality health care and healthy food** (transportation, food deserts)
- Increased **accidental injury and mortality**
- Increased **obesity** and its complications
- Increased **exposure to toxins** (i.e., lead) and pollutants

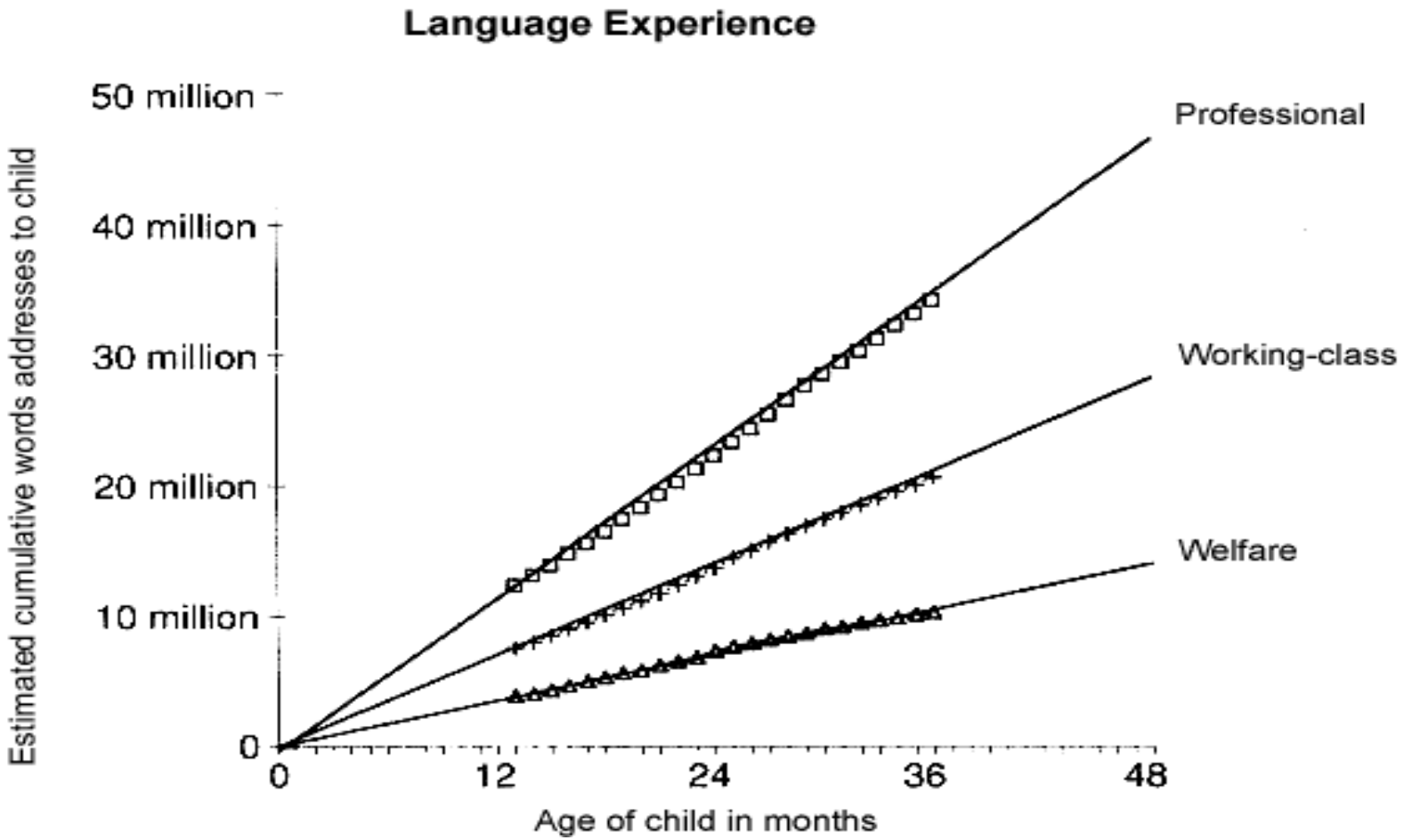
Reference: *Moore KA , et al. Children in poverty: trends, consequences, and policy options. 2009. Child Trends Research Brief*

Consequences of Poverty: Well-Being

- More **toxic stress**
- Poorer **educational outcomes**:
  - poor academic achievement
  - higher rates of HS dropout
- Less positive **social and emotional development**
- More **problem behaviors** leading to "TAEs"
  - Early unprotected sex with increased teen pregnancy
  - Drug and alcohol abuse
  - Increased criminal behavior as adolescents and adults
- More likely to be poor adults
  - **Low productivity and low earnings**
- Especially if deep poverty (<50% FPL), long-term poverty, or poverty in early childhood

Reference: *Moore KA et al. Children in poverty: trends, consequences, and policy options. 2009. Child Trends Research Brief*

30 Million Word Gap



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Linkage to all Levels of Health Care

Old: Acute Model	New: Prevention-Chronic
Patient: **passive**	Patient: **engaged in own care**
Clinician: **delivers visits and procedures**	Clinician: **provides ongoing planned care**
Microenvironment: **supports for visits and procedures**	Microenvironment: **systems for care management over time**
Organization (group): **billing and scheduling**	Organization: **systems support and feedback**
Environment: **medical necessity benefits and pay for procedures**	Environment: **value-based benefits and payment**

Practice of the Future: The Paradigm Shift

- From I to We:
  - From the lone doctor with “helpers” to the high-functioning team
  - From my patients to our patients
- From He/She to They:
  - From a sole focus on individual patients to a concern for the team’s entire panel

- **Different patients have different needs:**
  - Some only need routine preventive services
  - Others need same-day acute care
  - Some have one or two chronic conditions
  - A small number have multiple illnesses and complex healthcare needs
  - Some have mental health/substance abuse needs
  - Others require palliative or end-of-life care

- **Each sub-group of a practice's patient panel needs a different set of services by different team members**

Emerging Models of Care for Children with Complex Needs

Primary Care Centered Models (Patient Centered Medical Home)

- Build on long standing relationships
- Proximity to home
- Understanding of culture and family dynamics

→ Disadvantages

- Poor reimbursement to practitioners
- Time needed to coordinate care
- Inadequate knowledge to address complex care acute and chronic issues
- Limited personnel and community resources
- Current model geared to episodic care

→ Emerging solutions

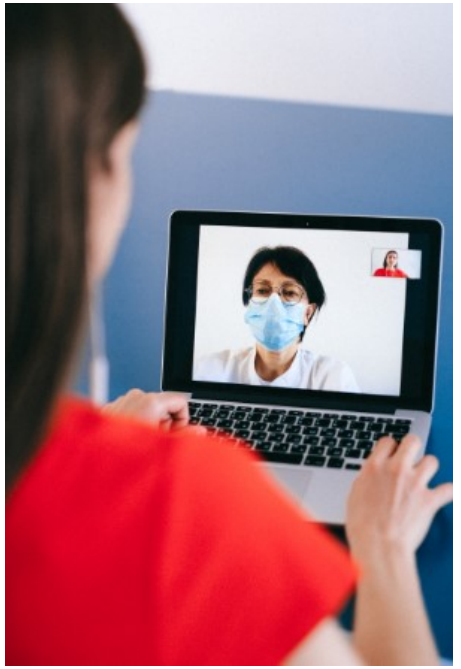
- Standardized coordination protocols with a tertiary center
- Nonphysician care coordinators in the office (Healthy Steps, etc)
- Telemedicine
- Parental advisory groups
- Increased accessibility to the primary care provider

Emerging Models of Care

Consultative Models - Centered at subspecialty programs

→ Advantages

- Well positioned to care for children with complex needs
- Social workers and allied health already at the site
- Better payment models for insurers



→ Disadvantages

- Often geographically far from the family
- Not geared for acute needs
- Disease specific and not connected to community resources

→ Emerging Solutions

- Telemedicine
- Co-management with primary care
- Face to face services by regular co-management care coordination clinics staffed by primary care and a tertiary care nurse practitioner

Medicaid Innovations in Other States

- **New York**
  - Health Homes - per member per month support for attributed children
  - Two or more chronic conditions and prioritizes children with social risks

- **California** – Whole Child Care
  - Ties together Medicaid and Department of Health
  - Single point of care coordination

- **Colorado**
  - Requires PCMH to establish relationships with community organizations
  - Requires screening for and addressing social determinants

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Integrated Care for Kids Approach to Care Management

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The When/Where/WHO of NJ 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 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

New Jersey 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

How does NJ InCK Work?

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

[More on this in August and September]

Capacity Building at the Primary Care Office

- The NJAAP will *support primary care practices* in responding appropriately to the things they find when screening the Tier 1 kids
- They will become more active in making *community referrals*—get ready to receive!
- The Psychiatric Care Collaborative will be critical to *supporting behavioral health care*

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Care Integration Managers

Air Traffic Controllers

- Reviews the claims history and the needs assessment
- Reviews the current care management the family is receiving
- Works to ensure that all current management is now coordinated and that one agency becomes primary care coordinator with the family
- Assigns care coordinator from the InCK Advanced Care Management Teams of community health workers and social workers for those families with additional needs and those that stratify into levels two and three
- Ensures that the ACMT connects and meets regularly with the primary care medical home

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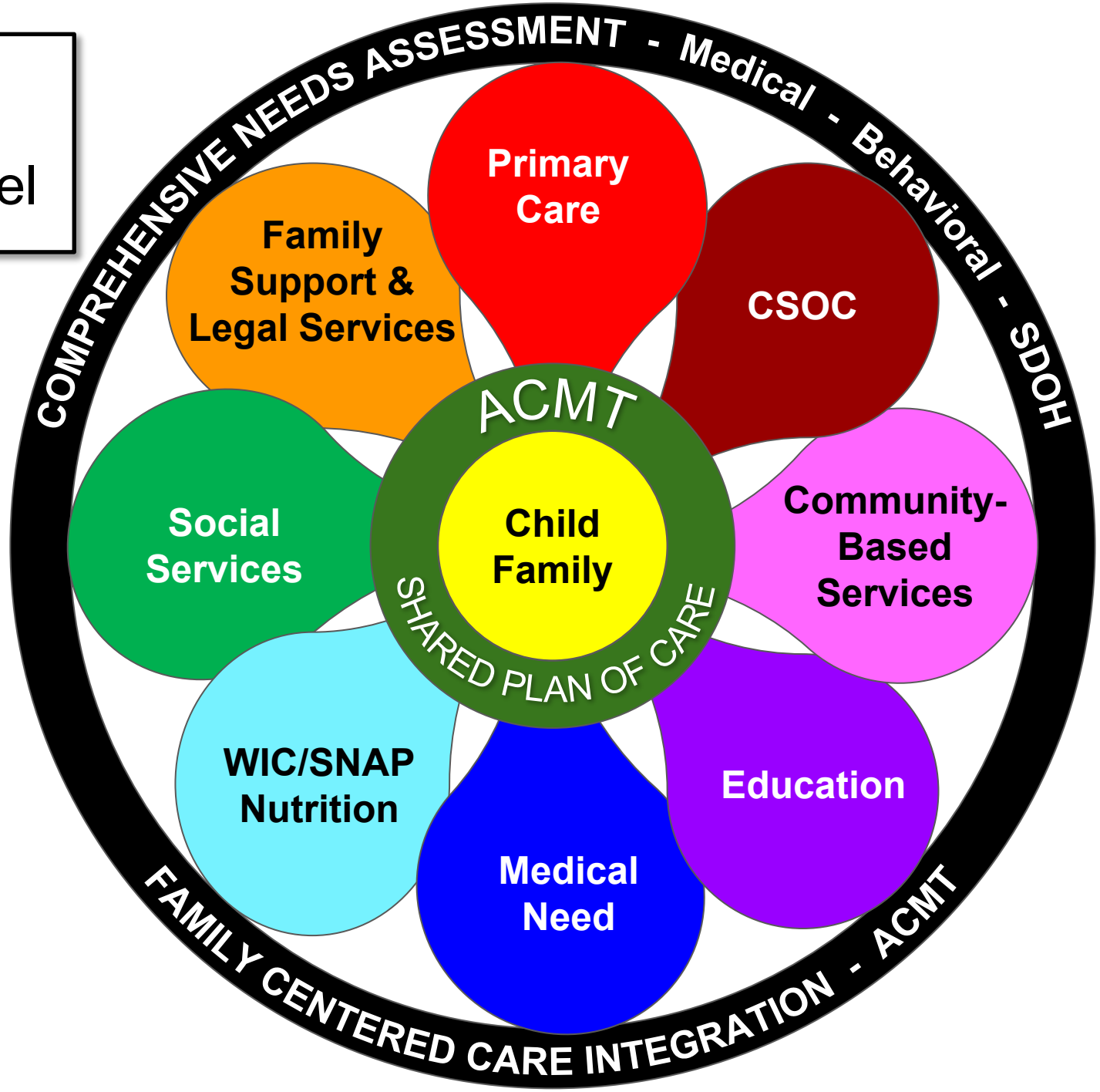
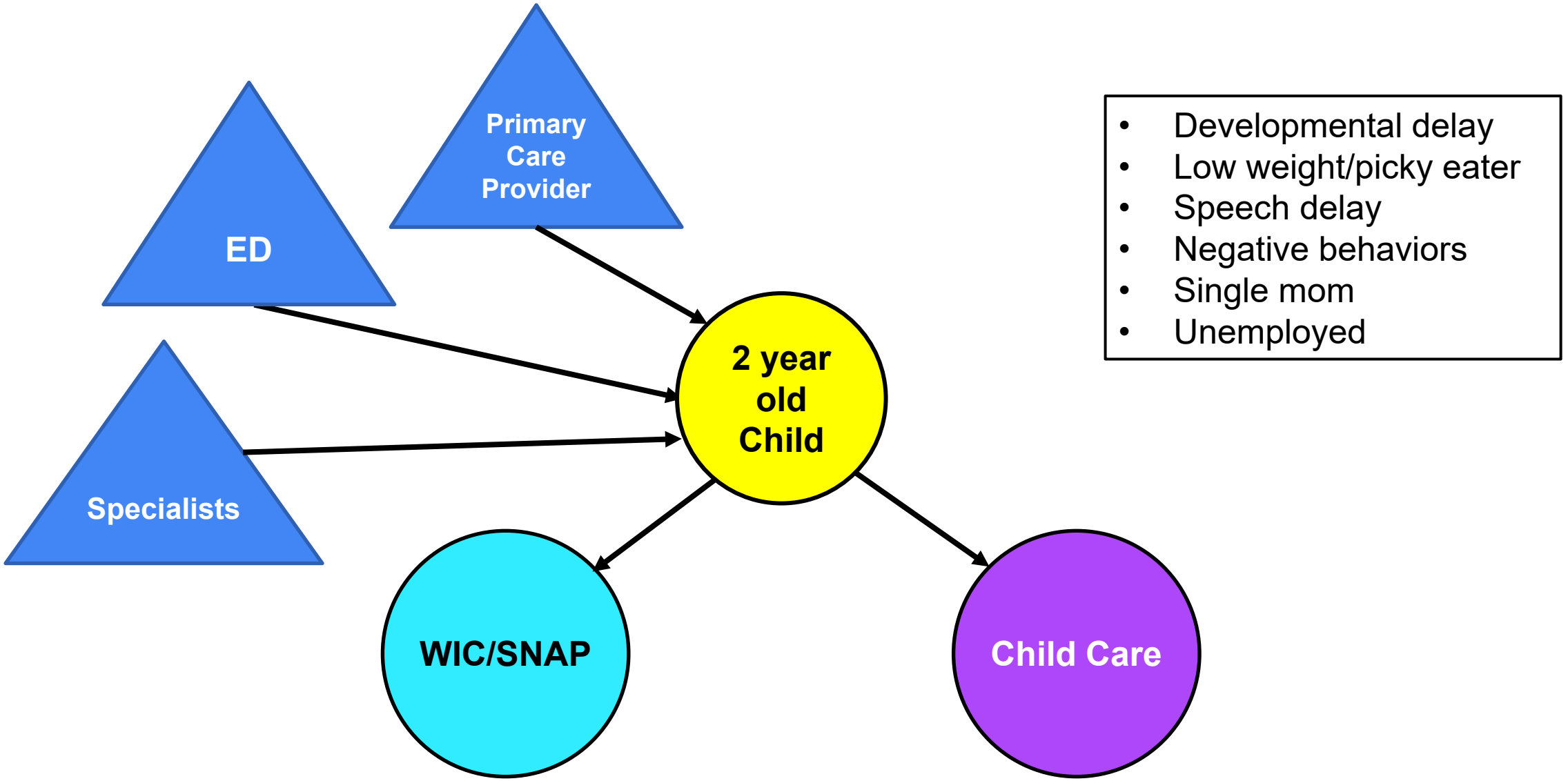
Whole Child Model



Child - Current System

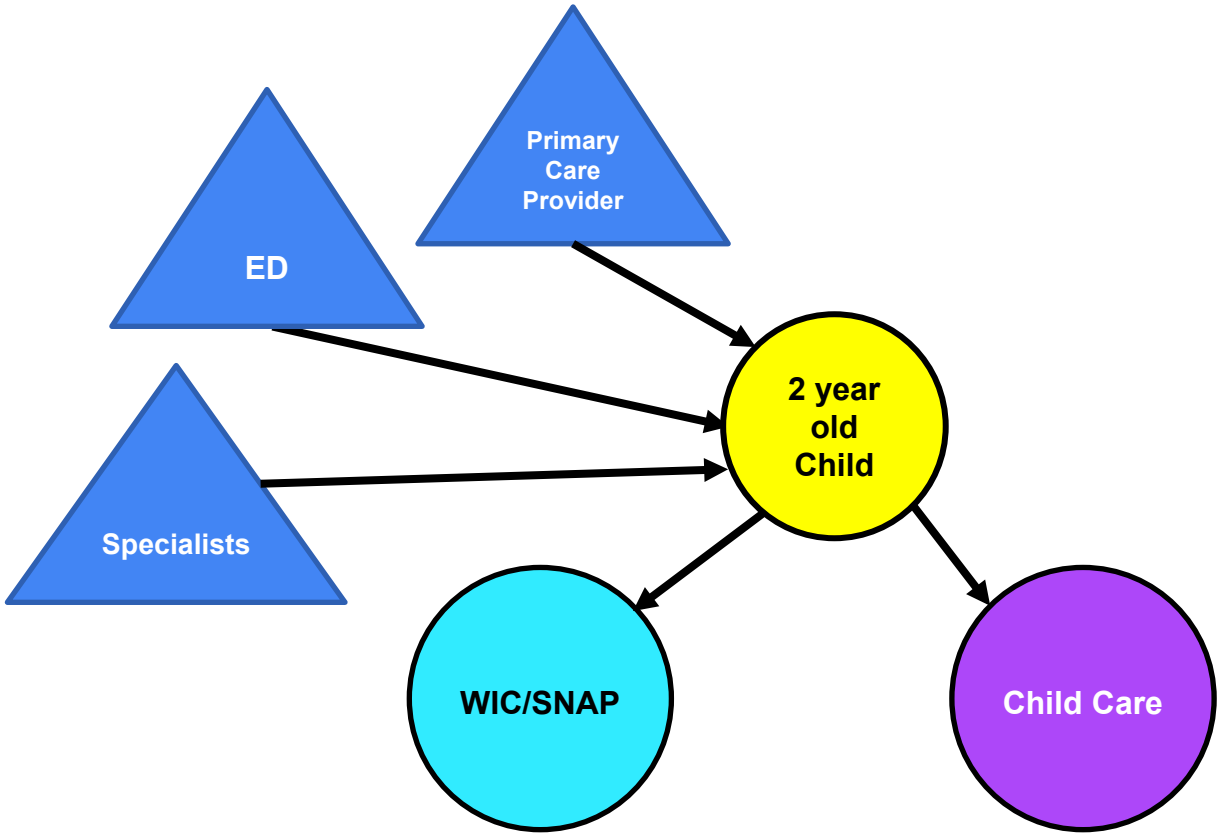
2 year old



- Developmental delay
- Low weight/picky eater
- Speech delay
- Negative behaviors
- Single mom
- Unemployed

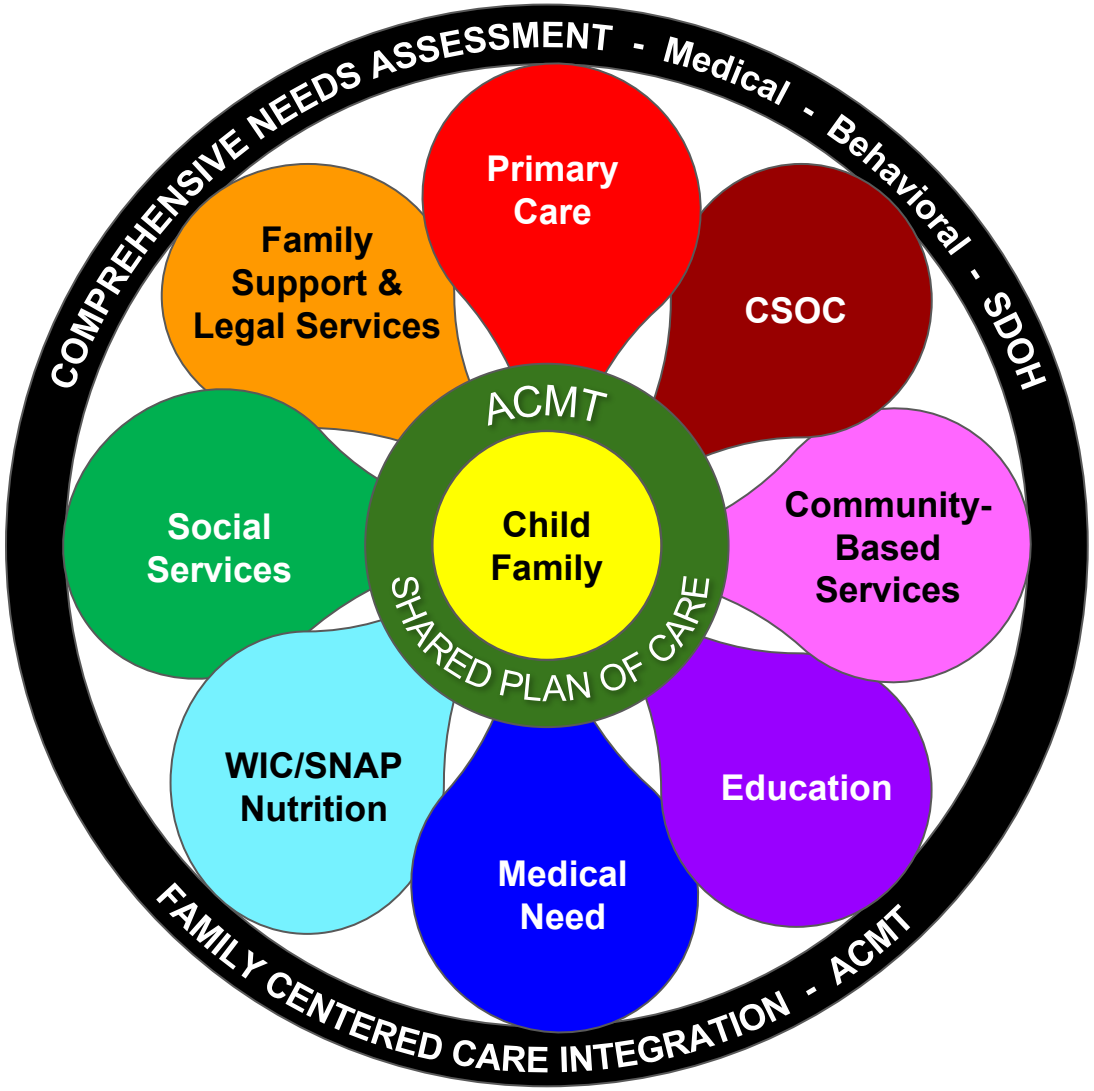
Child - Current System

2 year old



InCK System

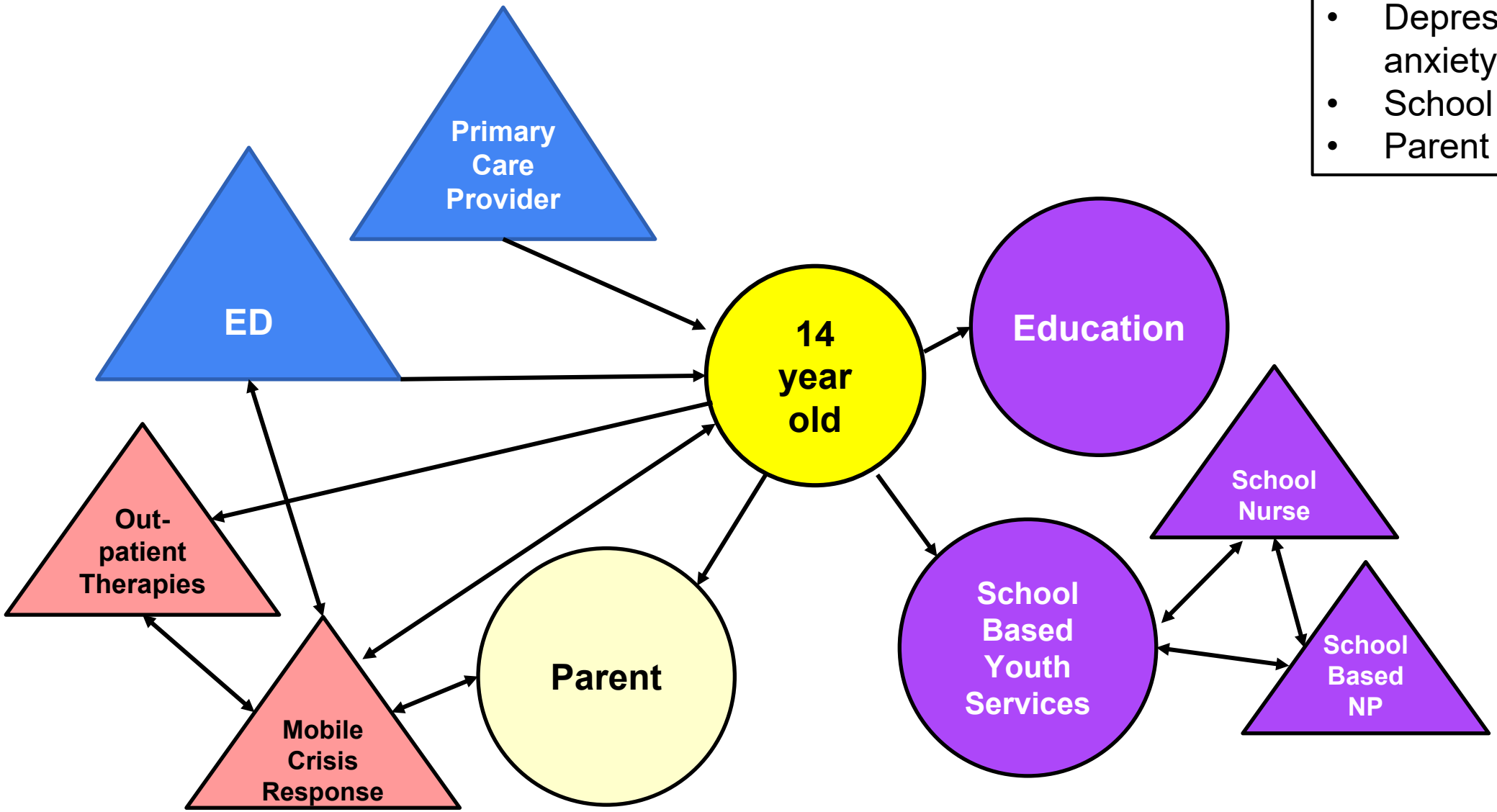
2 year old



Adolescent - Current System

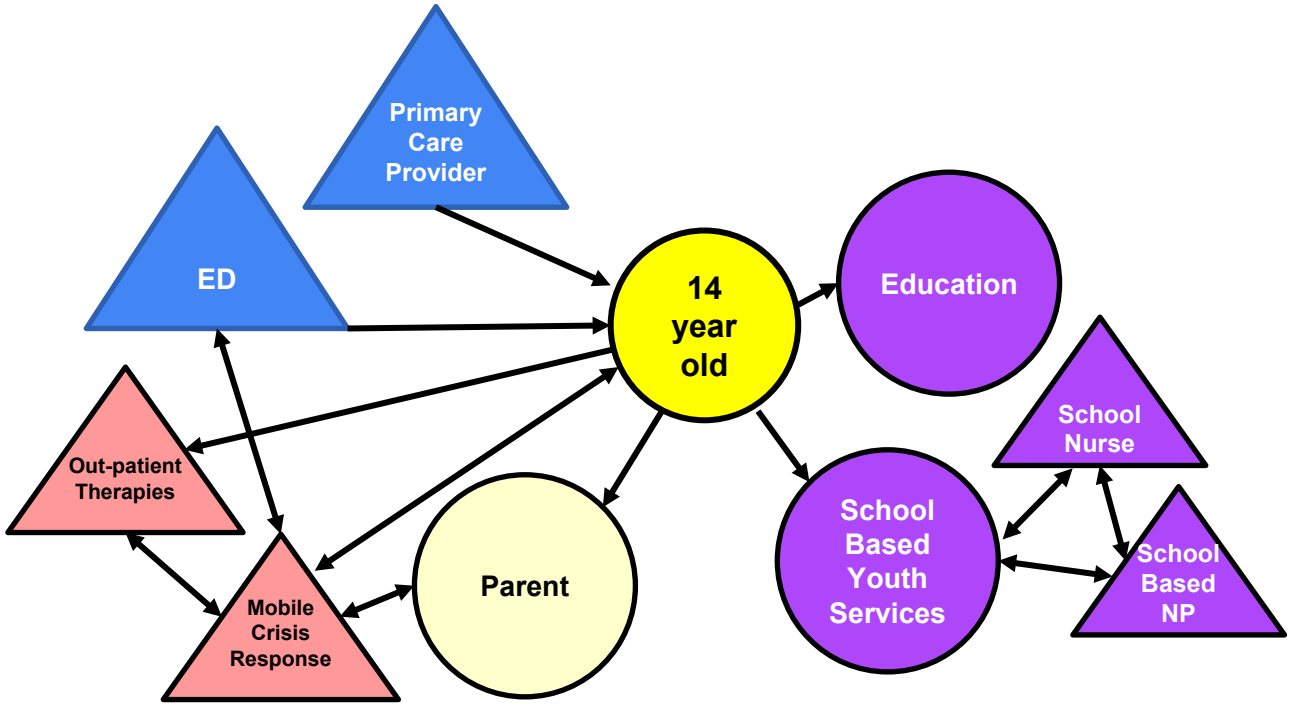
14 year old

- Tourette syndrome
- Depression and anxiety
- School refusal
- Parent depression



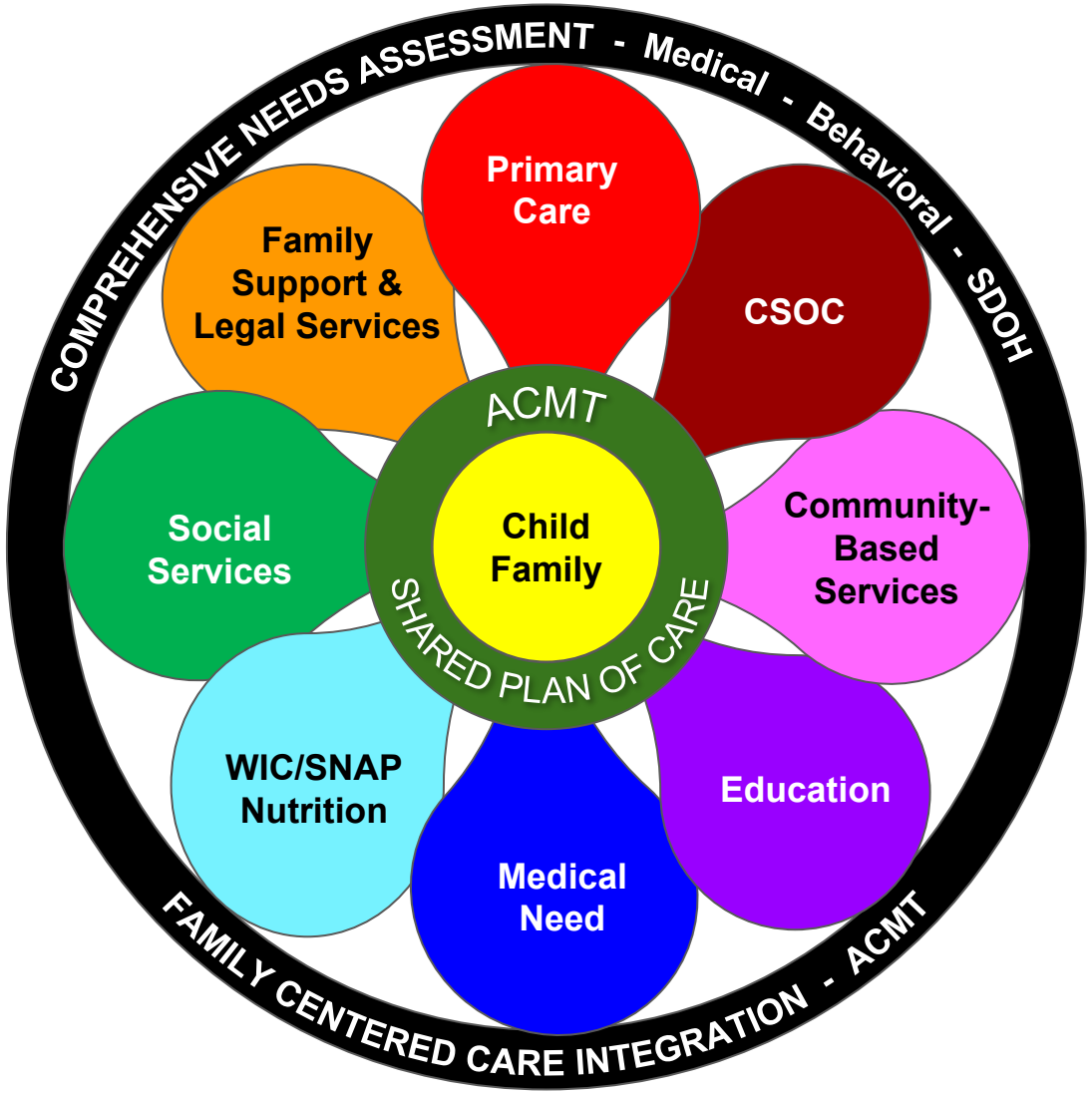
Adolescent - Current System

18 year old



InCK System

18 year old



Questions?

NJ InCK Team

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Join us for our Third Session!

Remodeling Healthcare for Children with NJ FamilyCare:

The NJ InCK Tools for Developmental and Socio-Emotional Assessment

Thursday, June 10th, 2021 from 12-1 PM

Presented By:

Kristine I. McCoy, MD, MPH
Chair, Children & Family Health Institute
Visiting Nurse Association of Central Jersey
Co-Clinical Principal Investigator, NJ InCK

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