Center for Health Care Strategies
Better care where it's needed most

Family-Centered and Team-Based Care Models that Drive Health Equity Across Generations

Association of Clinicians for the Underserved (ACU) Conference Session

Tuesday July 25th, 11:30 am-12:30 pm

Made possible through support from the Robert Wood Johnson Foundation

Financial Disclaimer

The presenters have no relevant financial relationships to disclose

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field's best thinking and practices to meet critical needs.
- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.
- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.

Center for Health Care Strategies

Agenda

- Welcome
- Advancing Integrated Models Initiative
- Primary Care Pediatric Population Health: Asthma & Maternal Mental Health
- Accelerating Child Health Transformation Initiative
- Centering Family Advocacy as a Tenet of Anti-Racist Care
- Panel Discussion and Q&A

The Advancing Integrated Models Initiative

Center for Heath Care Strategies
Karla Silverman, MS, RN, CNM
Associate Director, Complex Care Delivery

Center for Health Care Strategies

About the Advancing Integrated Models Initiative

- 2-year, multi-site initiative funded by Robert Wood Johnson Foundation
- Targeting populations with low incomes and people with complex health and social needs
- Goal of supporting health systems and providers in their efforts to strategically integrate and align person-centered approaches to care, including:

→ Complex care management

→ Trauma-informed care

→ Physical and behavioral health integration

→ Mechanisms that address health-related social needs

AIM Pilot Sites

Boston Medical Center: Center for the Urban Child and Healthy Family
Johns Hopkins HealthCare
Maimonides Medical Center
Denver Health
Hill Country Health and Wellness Center
OneCare Vermont
Bread for the City
Stephen and Sandra Sheller 11th Street Family Health Services

Building Integrated Care Models: Keys to Success

- Shared definitions and language across partners
- Alignment in priorities from leadership, to front line staff, to patients and their families
- Centering equity and patient voice in planning and decision-making
- Organizational commitment to soliciting and responding to feedback from the people being served
- Relationship-centered care as a guiding principle
- Healing trauma includes focus on caring for patients and staff

Center for Health Care Strategies

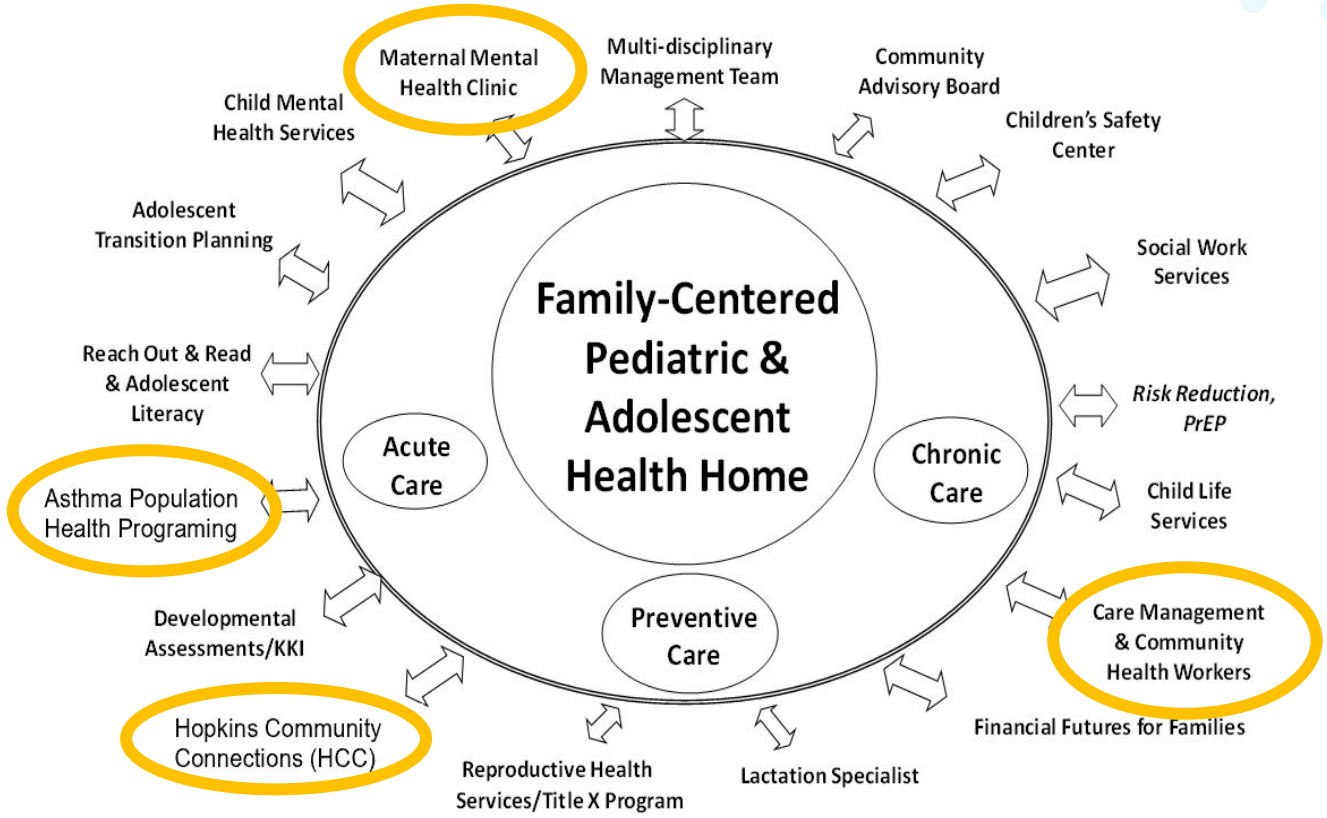
Primary Care Pediatric Population Health: Asthma & Maternal Mental Health

Johns Hopkins School of Medicine
Megan M. Tschudy, MD, MPH
Associate Professor, Pediatrics

Center for Health Care Strategies

Harriet Lane Clinic

- **Primary outpatient pediatrics training site**
  - → 80+ Pediatric Residents
  - → Fellows, Nurses, Nurse Practitioners, Social Workers
- **Primary Care Programs**
  - → Resident Continuity & Acute Care
  - → Adolescent Primary Care & Specialty
  - → Adolescent & Young Adults with HIV
- **Medical Home**
  - → 10,000 patients, 18,000+ annual visits
  - → Low-income: 90% Medicaid/SCHIP
  - → Medically complicated
    - > 40% with ≥ 1 chronic condition
    - Asthma, ADHD, depression



Cheng TL, Solomon BS. Translating Life Course Theory to clinical practice to address health disparities. *Matern Child Health J*. 2014 Feb;18(2):389-95.

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS MEDICINE

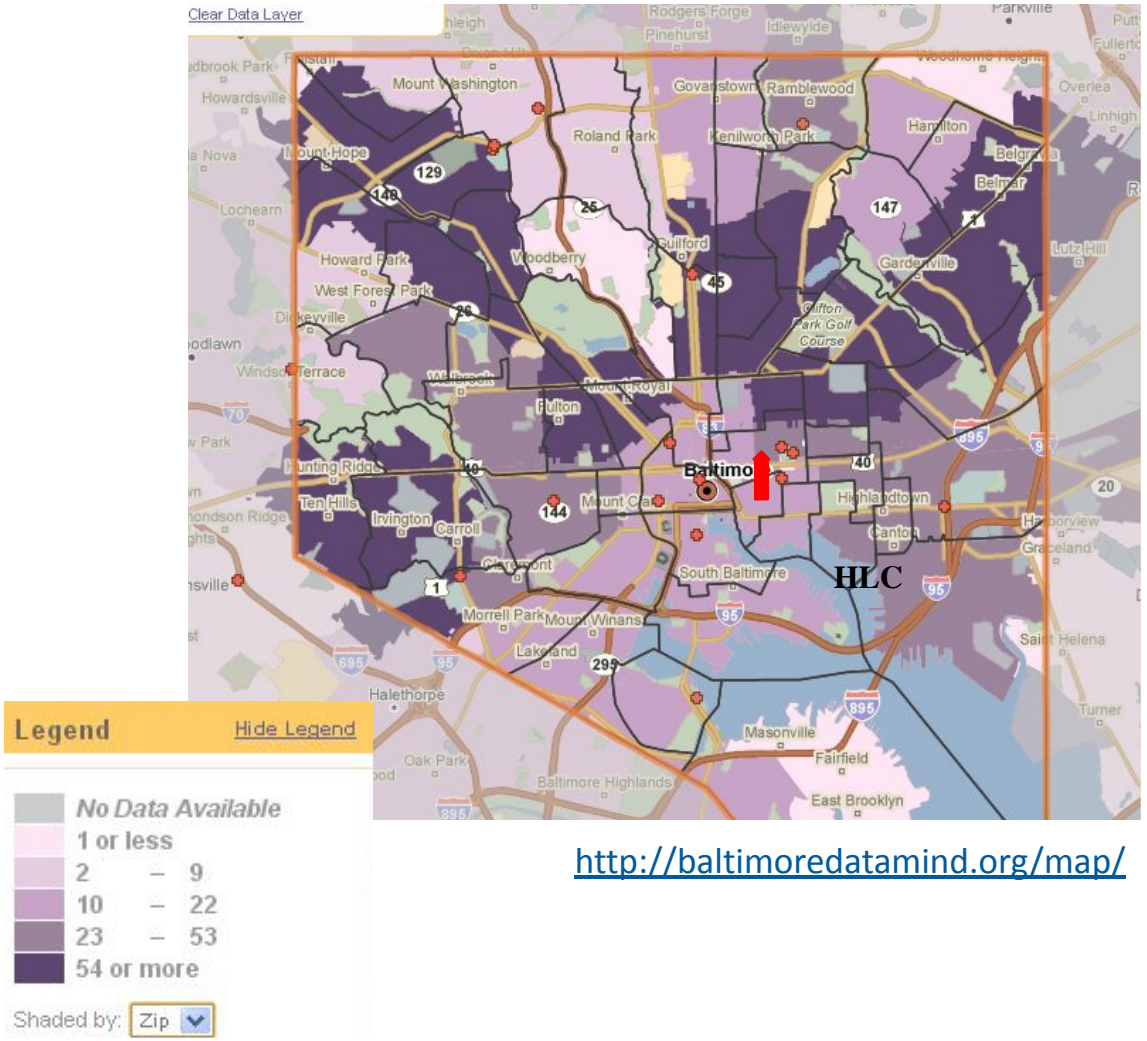
Pediatric Population Health: ASTHMA

Shantia Alderman (HLC CHW)

Helen Hughes, MD, MPH (HLC Site Lead)

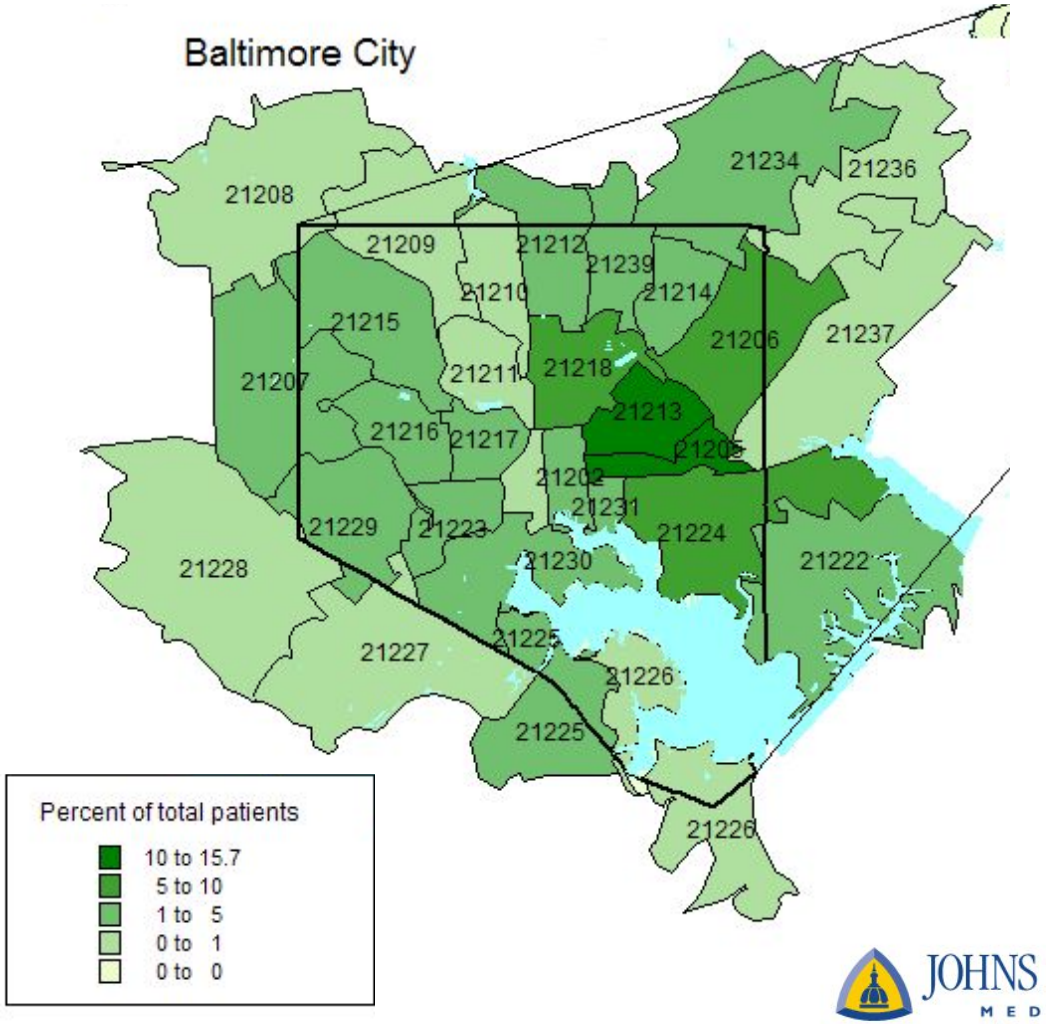
Megan Tschudy, MD, MPH (Program Lead & Evaluation)

Children Hospitalized for Asthma or Asthma-Related Illness



http://baltimoredatamind.org/map/

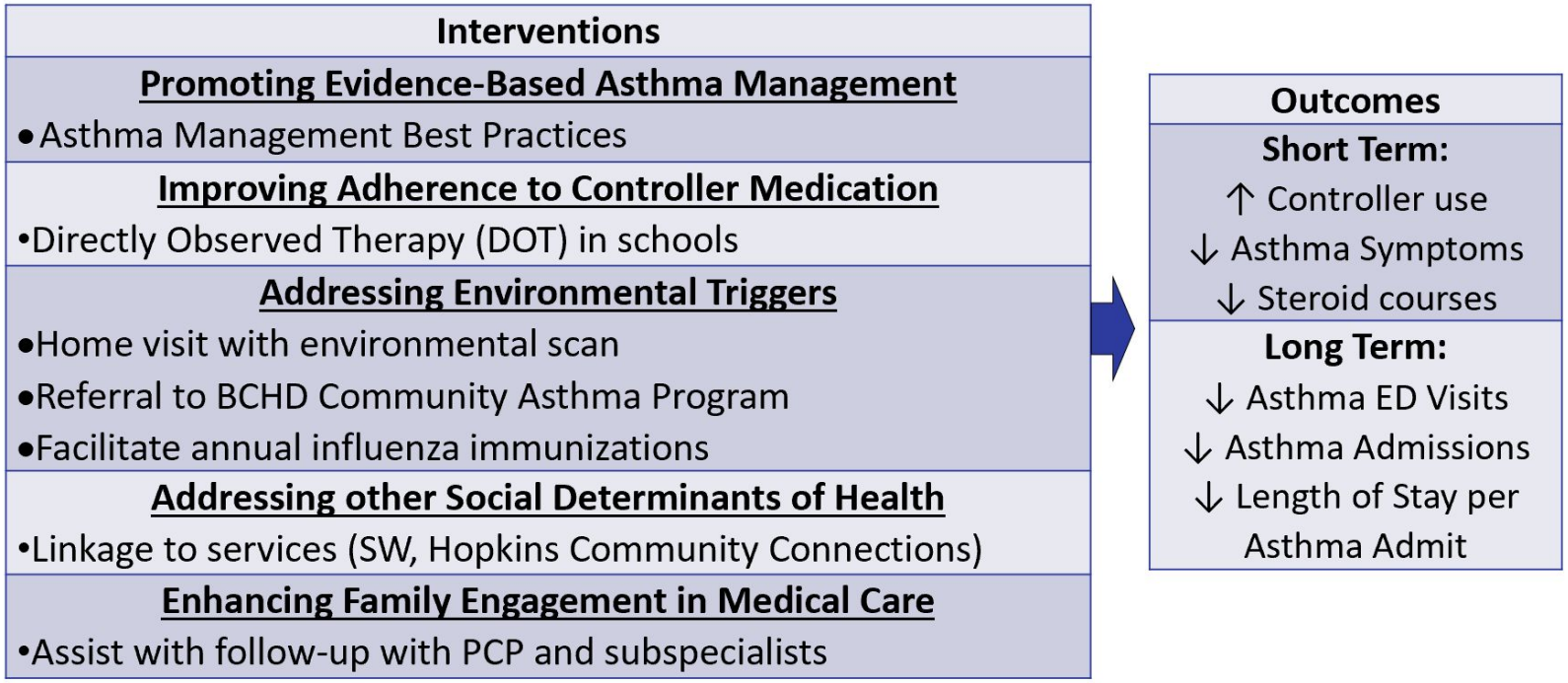
Harriet Lane Clinic Patient Catchment



JOHNS HOPKINS MEDICINE

Asthma: Aims & Intervention

- Integrate Community Health Workers (CHWs) into a comprehensive pediatric asthma program
- Improve asthma control through increased asthma controller medication use & addressing environmental triggers and social determinants of health (SDoH)
- Decrease asthma exacerbations - fewer emergency department (ED) visits and hospitalizations
- Develop and refine best practices to spread asthma population-based initiatives



JOHNS HOPKINS MEDICINE

Asthma: Successes

- **CHW Program Integration**
  - → CHWs integrated with clinic
  - → CHWs providing navigation to address SDoH
  - → Demonstrated CHWs can facilitate & deliver asthma controller medication to school
- **Best Practices**
  - → Disseminated asthma best-practices to 100+ pediatric clinicians
- **Community Benefits**
  - → Sustained relationships with families
  - → Improved family health
  - → Built relationships with schools
  - → CHW career development
- **Spread**
  - → Expanding locally

PROCESS MEASURES

Total Outreach Contacts:
- 1000+

Total Children Enrolled:
- 65+

Home visits completed:
- 35+*

CHW "touches" per enrolled participant:
- Avg: 38 (Range 9-107)

In School DOT therapies delivered:
- 42 controllers delivered*

*Home Visits and School-based care were suspended from 3/2020-9/2021 due to the COVID-19 pandemic

Asthma: Outcomes

Utilization

>50% Decrease in ED visits

>60% Decrease in Inpatient Admissions

Closing Care Gaps

100% well visit in past year; increased engagement in subspecialty care

96% met HEDIS AMR (Asthma Medication Ratio)

Cost of Care

Average ED + Inpatient Cost Savings per patient/year = $5,214.64
Avg Annual Cost Savings per patient = $4,961.91
Avg Annual Cost Savings = $74,428.65

[1]Costs do not reflect ambulatory pharmacy costs because pharmacy cost files were not available at time of analysis.
[2]Avg CHW caseload at one time point = 15 patients. Total patients who have been enrolled fully in program is 65. With CHW outreaching to >300 patients.

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS
MEDICINE

Two Generation Approach Supporting Mothers and Children In Pediatric Primary Care

Shannon Adams – Community Health Worker
Tracy Carter –Maternal and Infant Case Manager
Laura Prichett – Data Analyst (BEAD Core)
Barry Solomon – Program Lead

Maternal Mental Health Background

- Maternal depression prevalence as high as 50% in mothers living in low resource communities vs. 10-15% in general population
- Associated with **poor physical health outcomes, higher healthcare utilization** in mothers/children, and **poor developmental and educational outcomes** for children
- **Maternal and child outcomes improve with treatment**
- Pediatric primary care is an opportune venue to identify, support mothers and connect them to treatment

JOHNS HOPKINS MEDICINE

Maternal Mental Health Program: Aims & Interventions

- Building on an existing model of integrated intensive case management and mental health support in pediatric primary care clinic by **integrating CHWs** to:
  - → ***Improve*** attendance to routine well childcare
  - → ***Decrease*** acute care/emergency department visits for mothers and children
  - → ***Increase*** mothers' adherence with postpartum visits, linkage to primary care

Interventions
Universal Screening for Maternal Depression, Trauma, Other Needs Newborn to 12 month well child visits
Case Management +/- Community Health Worker Based on mental health and resource needs of mothers
Linkage to Care and Addressing SDOH Urgent mental health needs triaged to social worker Home/phone/virtual visits for goal setting & ongoing support When ready to engage, connect to mental health treatment Connect to Hopkins Community Connection & other resources
Enhancing Family Engagement in Medical Care Ongoing assessment of medical needs (appointment reminders for primary and specialty care, OB post-partum, family planning, insurance, transportation, medications)

Outcomes
↑ MH engagement
↑ WCC/PP visits
↓ ED visits
↓ Admissions

Maternal Mental Health Program: Successes

- **CHW Program Integration**
  - → CHW integrated with Case Manager and clinic staff
  - → CHW able to connect with mothers experiencing trauma, depression and address SDoH
  - → CHW adapted to virtual environment
- **Best Practices**
  - → Following AAP recommendations for screening and linking mothers with depression to care
- **Community and Family Benefits**
  - → Strengthened relationships with community-based mental health providers
  - → Improved overall family health (connected children, siblings, other relatives to care)
- **Spread**
  - → Shared model with peer academic institutions
  - → Starting local expansion to FQHCs (pediatrics/internal medicine/OB clinics)

Maternal Mental Health Program: Cost Savings

- **Inclusion Criteria**

→ 81 mothers/218 children (enrolled 3/2018 - 3/2019) to capture at least 12 months pre/post enrollment

  - *Excluded children ≤ 1 year since no visit data 12 month pre-enrollment*
  - *Due to COVID19 impact on utilization, limited to enrollment up to 3/2019*

- **Data**

→ PPMCO claims data (3/2017 - 3/2020)

– sions

	Average Savings Per Patient per Year	Total Savings For All Patients per Year (n=409)
Emergency Care Visits	$276.00	$112,884.00
In-patient Admissions	$584.00	$238,856.00
Total Emergency and Inpatient Care	**$860.00**	**$351,740.00**

In Summary

Lessons Learned

- CHWs can provide vital consistent linkage to the medical home for children with chronic medical conditions and caregivers with behavioral health needs
- Real-time data is critical to identify patients and conduct proactive outreach
- Partnership with primary insurer has been critical to success and ensuring sustainable funding

Success Depends On

- How you define success and who are your key stakeholders
  - → Patients/families, staff, providers, health system, insurers
- Staff with lived experience who connect authentically with patients/families
- Strong partnership with key stakeholders from the beginning
- Sustainable funding (more than year to year)
- Learning from mistakes, making adjustments, and moving forward (continuous quality improvement)

The Accelerating Child Health Transformation Initiative

Center for Heath Care Strategies
Armelle Casau, Ph.D.
Associate Director, Child and Family Health

Center for Health Care Strategies

Key Strategies & Levers for Child Health Transformation

Adopt **anti-racist practices and policies** to advance health equity

Co-create **equitable partnerships** with patients, families and providers

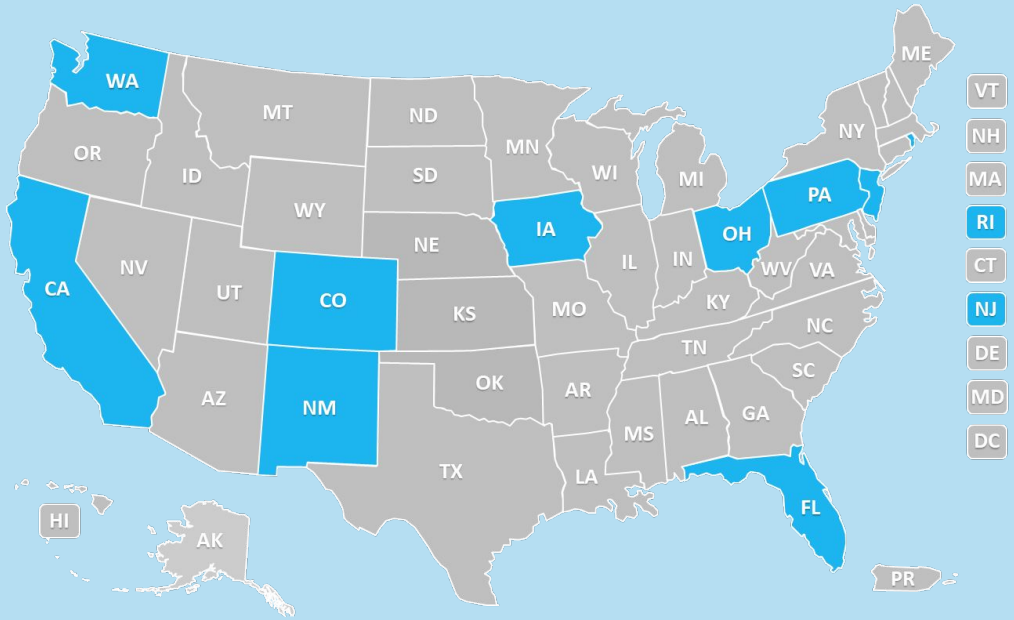
Identify **family strengths** and address **health-related social needs**

Implement **payment and accountability levers** to support and sustain transformation

Center for Health Care Strategies

Supporting a Learning Community for Pediatric Providers

ACHT Pediatric Provider Pilot Sites



Center for Health Care Strategies

- Equity is a process & an outcome
- It’s all about co-creation
- Progress moves at the speed of trust

- Expand care teams
- Foster communities of practice
- Center dignity & abundance
- Support diverse hiring, anti-bias training & retention
- Build capacity of family/patient leaders

Accelerating Child Health Transformation: Centering Family Advocacy as a Tenet of Anti-Racist Care

Hasbro Children's Hospital Pediatric Primary Care
Tosin Ojugbele, MD
Carol Lewis, MD

Center for Health Care Strategies

Hasbro Children's Hospital Pediatric Primary Care

- Primary Care for about 10,000 children and their families
- 86% Medicaid insured
- Residency and medical student training site for Brown University
- 21% have preferred language other than English
- 30.5 % identify as Black or African American
- Special programs to provide primary care for refugees, children in foster care and children with complex medical needs exist within HCH primary care
- Part of a very large System of Care with inpatient and adult focus

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
Lifespan. Delivering health with care.®

Our Dilemma

Administrative Structure

Bureaucracy

How do we transform pediatric primary care within our **academic medical center** to be **anti-racist, patient & family centered** most *efficiently and expediently*, while keeping an eye to making the process *integrative of a multidisciplinary faculty and staff, representative of the diverse body of patients we look to serve, and sustainable?*

Culture

Inexperience with Family-Centered Care

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
Lifespan. Delivering health with care.®

Family Advocates!

- Have experience with and enthusiasm for family-centered care
- Can be a source of representation and diversity on staff
- Have a clearly defined focus on delivering and improving family-centered care
- Have been effective in other settings (ex. HCH Oncology Parent Consultant)

Accelerating Child Health Transformation (ACHT) Pilot Site Team

- Conducted a baseline assessment of our level of family-centered care
- Introduced the role of Family Advocates to the primary care clinic
- Recruited and hired 1-2 Family Advocates
- Conducted an evaluation of the project from the perspective of clinic faculty and staff, the Family Advocates themselves, and patients
- Reviewed Family Advocate journal entries
- Conducted a post-project assessment of our new level of family-centered care

Data Informed Action Items Summary

- Have a process to amplify strengths of each family, link families with similar life experiences, and provide peer mentoring for families and caregivers
- Help youth develop a portable medical record and meet with older youth as role models
- Share successes with families and clinic staff
- Ensure families can access, understand, and add to their medical record (demographics)
- Easier process and more accessibility for longer appointments and special appointment types (ex. “no wait” appointments) when needed
- Ensure consistent and accessible ways for patients to provide feedback on clinic practices
- Share information with families regarding delivering Family-Centered Care and allow patients to share their expertise with clinic staff

Why the Family Advocate Role is Essential

- Participates in direct patient interactions → allows patient voices to be heard and their specific needs to be addressed
- Helps to create a warm, approachable, welcoming environment for patients and families
- Assists patients and families in confidently navigating the clinic space
- Helps to diffuse difficult situations when they arise
- Provides feedback and suggestions for the clinic to improve

Evolution of the Family Advocate Role

- **Differences between old and new job description**
  - → More active role (ex. making initial contact w/ community resources, connecting with families in the waiting room)
  - → Resource training and helping to update community resource lists
  - → Monthly peer-to-peer support groups for patients and families
  - → Collecting and documenting patient interactions in a daily journal to help provide QI suggestions
- **Integrating the Family Advocate Role into the Primary Care Clinic**
  - → Avenues for mentoring
  - → Opportunities to connect with Family Advocates outside of Hasbro
  - → Attending department meetings to help increase understanding of clinic roles and programs
- **New funding opportunities for CHW in Refugee Health Program**

Panel Discussion and Q&A

Center for Health Care Strategies

Thank You!

Presenter Contacts

- Karla Silverman ksilverman@chcs.org
- Megan Tschudy mtschud1@jhmi.edu
- Armelle Casau acasau@chcs.org
- Tosin Ojugbele Olutosin.Ojugbele@health.ri.gov
- Carol Lewis carol_lewis@brown.edu

CHCS Resources

- https://www.chcs.org/project/advancing-integrated-models/
- https://www.chcs.org/project/accelerating-child-health-transformation/
- https://www.traumainformedcare.chcs.org/
- https://www.chcs.org/project/the-better-care-playbook/

Center for Health Care Strategies