Implementing Bright Futures for All Children: Oregon Perspectives

R.J. Gillespie, MD, MHPE, FAAP
Pediatrician
The Children’s Clinic – Portland, OR

Learning Collaborative on Improving Quality and Access
to Care in Maternal and Child Health

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Bright Futures in Oregon: Policy Efforts

• Patient-Centered Primary Care Home (PCPCH) Standards
• Coordinated Care Organization Performance and Incentive Metrics
• Child and Family Well Being Workgroup and Kindergarten Readiness
Spoiler Alert… One of my Top Tips in Implementation:

Use measures to drive behavior

The Framework: AAP-defined Medical Home

Accessible
Continuous
Family-Centered
Comprehensive
Coordinated
Compassionate
Culturally Effective

Recognizing that families play a vital role in ensuring health and well-being of the patient. Acknowledging that emotional, social and developmental support are integral components of health care.

Simultaneously addressing medical, behavioral, and social issues. Treating the whole individual and ALL of his or her needs.
Why Primary Care Homes?

*Goals of HB 2009*

- Improve individual and population health outcomes
- Reduce inappropriate utilization
- Reduce health system costs
- Strengthen primary care
- Encourage prevention and chronic disease management over acute, episodic care
- Stimulate delivery system change

*“Right care at the right time and in the right place”*

Oregon’s Transformation Journey

- HB 2009 mandated the formation of the PCPCH Standards Advisory Committee
- Goal: *to improve the availability and affordability of high quality patient centered primary care to all Oregonians*
- Considered previous medical home models and definitions
  - National Council for Quality Assurance (NCQA)–2007 Standards
  - AAP definition
  - Other state, federal, and private efforts
Oregon’s Transformation Journey

• PCPCH Pediatric Standards Advisory Committee convened Fall, 2010
• Mission: to further refine the standards to ensure the unique needs of children and adolescents were captured
• Revised the work of the previous committee to create a combined report
• PCPCH Standards Advisory Committee convened Fall of 2012 to review and propose updates to standards

PCPCH and Bright Futures

• Access to care: Patients get the care they need, when they need it.
• Accountability: Recognized clinics are responsible for making sure patients receive the best possible care.
• Comprehensive: Clinics provide patients all the care, information and services they need.
• Continuity: Clinics work with patients and their community to improve patient and population health over time.
• Coordination and integration: Clinics help patients navigate the system to meet their needs in a safe and timely way.
• Patient and family-centered: Clinics recognize that patients are the most important members of the health care team and that they are ultimately responsible for their overall health and wellness.
Selected PCPCH Standards

• PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.
• PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources.
• PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.

Practice-based, Bright Futures Aligned Measures in PCPCH

• Childhood Immunization Status
• Adolescent immunizations up to date at 13 years old
• Developmental screening in the first 3 years of life
• Well child care (0 – 15 months)
• Well child care (3 – 6 years)
• Adolescent well-care (12-21 years)
• Screening for clinical depression
What is a CCO?

• Coordinated Care Organization is a network of health providers that work together in a community to serve Medicaid recipients.
• One budget for mental, physical and dental care.
• Held accountable to improve on some metrics (incentive metrics) while holding steady on others (performance metrics).

Incentive Metrics and How they are Chosen

• Metrics used to determine whether CCOs are effectively improving care
• Nine member Metrics & Scoring Committee appointed by director of the OHA
• Committee decides (based on a lot of public input) the measures that CCOs are held accountable to – and get financial incentives for improving or reaching a benchmark
Measures that Connect to Bright Futures

Incentive Metrics
• Adolescent well-care visits
• Alcohol / substance misuse (12+)
• Dental sealants on permanent molars (6-14 yrs)
• Depression screening with follow up plan (12+)
• Developmental Screening
• Effective Contraceptive use (15+)
• Patient-centered primary care home enrollment

State Performance Metrics
• Child and adolescent access to primary care providers
• Childhood immunization status
• Chlamydia screening
• Immunizations for adolescents
• Well-child visits birth to 15 months

Developmental Screening as an Example of Bright Futures in Policy

Statewide, developmental screening continues to improve and is near the benchmark as of mid-2015.
Adolescent Health:
Well, we’re still working on that…

Statewide, the percentage of adolescents receiving well-care visits remained steady between 2014 and mid-2015.

Overlap or Alignment?

• What strategy would a practice take to improve something like developmental screening compared to:
  – A health plan or CCO?
  – Public health?
  – A community agency?
  – An early childhood system provider?
Implementation Tip

Reach across ALL tables

Child and Family Well-Being Metrics Workgroup

• Oregon Health Policy Board and Early Learning Council collaboration
  – Purpose to ensure alignment and/or integration between health care and early learning system transformation
  – Framed by concept of Collective Impact
• The Child and Family Well-being (CFWB) Workgroup convened to develop recommendations for three related and likely overlapping child and family well-being measure sets:
  – Early Learning Hub accountability measures
  – Coordinated Care Organization accountability measures
  – Community monitoring measures
Who Sat at the Table...

- Medicaid health plans (CCO Medical Director)
- Early Learning System - Family relief nursery, Head Start, Oregon Child Development Coalition
- Early Learning Council
- Oregon Health Policy Board
- Measurement experts / Data Analysts / Epidemiologists
- Pediatricians
- K-12 representatives
- Public Health
- Oregon Center for Children and Youth with Special Health Needs
- Tribal health
- Human Services, United Way
- Oregon Health Authority
- County Commissioner

Measurement Domains

- Family stability and economic well-being
- Community stability
- Health care access, prevention and experience
- Early childhood care and education
- Systems of care – cross-system coordination
Looking toward the future of measurement...

• Kindergarten Readiness is an important outcome for early childhood
• Implies that children arrive in Kindergarten
  – Healthy and safe
  – Developmentally prepared
  – With a supportive and intact family to encourage academic achievement
  
  *And therefore ready to learn*

• Can Kindergarten Readiness serve as a model for cross-system collaboration?

Kindergarten Readiness: Shared Accountability for a Vital Outcome

**Health System Inputs**
- Early identification of developmental delays
- Coordination and management of chronic disease
- Immunizations
- Growth, nutrition and food insecurity monitoring
- General family functioning, risk factor identification

**Early Childhood System Inputs**
- Delivery of developmental services
- Parent and family support networks
- Parenting support groups, classes
- Food, housing insecurity solutions
- High quality preschools / daycares / schools
Social Determinants of Health

• “The social determinants of health are the conditions in which people are born, grow, live, work and age.”

  – Food insecurity
  – Housing insecurity
  – Poverty
  – Unsafe neighborhoods
  – Access to high-quality education
  – Adverse Childhood Experiences

Adverse Childhood Experiences (ACES)

“We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.”

• Abuse
  – Emotional
  – Physical
  – Sexual

• Neglect
  – Emotional
  – Physical

• Household dysfunction
  – Domestic violence
  – Household substance abuse
  – Household mental illness
  – Parental separation / divorce
  – Incarcerated family member

Premature Morbidity & Mortality with ACEs

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Autoimmune diseases
- ER Visits
- Medical Office Visits
- Fractures
- Psychotropic Medications Prescribed
- Early Death from heart attack (myocardial infarction)
“We are the only living species that regularly and predictably maims and destroys its own young.”

Sandra L. Bloom
Creating Sanctuary

Smoking Prevention
Drug Abuse Prevention

Alcohol abuse prevention
Teen pregnancy prevention

Prevention of Early Death From Heart Attacks
Kindergarten Readiness

![Image of a child at a chalkboard]

[Diagram showing the relationship between childhood experiences (Adverse Childhood Experiences) and adverse outcomes throughout the lifespan, including disrupted neurodevelopment, social, emotional, and cognitive impairment, adoption of health-risk behaviors, disease, disability, and social problems, and early death.]
The BIG Questions

If TOXIC STRESS is the missing link between ACE exposure and the unhealthy lifestyles and poor outcomes seen as adults, it raises the following BIG questions:

1) Are there ways to treat, mitigate, and/or immunize against the effects of toxic stress?

2) What are the long term costs due to toxic stress versus the up-front costs to treat, mitigate or immunize?
Why I chose to be a partner

- Ensuring healthy pregnancies and healthy children are key for long term investments in health and ensuring that we don’t create another generation of chronically ill (and therefore expensive) adults.
- Actionability of quality measures is important to front line providers – those with “boots on the ground” know what will work in practice ... can’t all be theory.
- Kids are often left out of the conversation in health care transformation ... or at least woefully under-represented.

How to Find Provider Partners

- State AAP chapters
- Improvement Partnerships (if you have one)
  - National Improvement Partnership Network
- Independent Practice Associations
Oregon Pediatric Improvement Partners (OPIP) General Functions

- Create synergy between partners to develop a common agenda for child health quality improvement and quality measurement
- Catalog successful projects for sustainability and spread of best practices
- Develop new practice-based quality improvement activities
- “Audit” quality improvement projects (External Quality Review)
- Coordinate quality measurement activities
Summary

– Prevention works
– Families matter
– Health is everyone’s business