Nemours Children's Health System

Care Models Supporting Contract Populations and Networks and Workflow Options for Value Based Care

NEMOURS CHILDREN'S HEALTH

LEARNING OBJECTIVES

Understand the journey to value for a pediatric health system

Identify the components of a value-based service organization in a pediatric health system

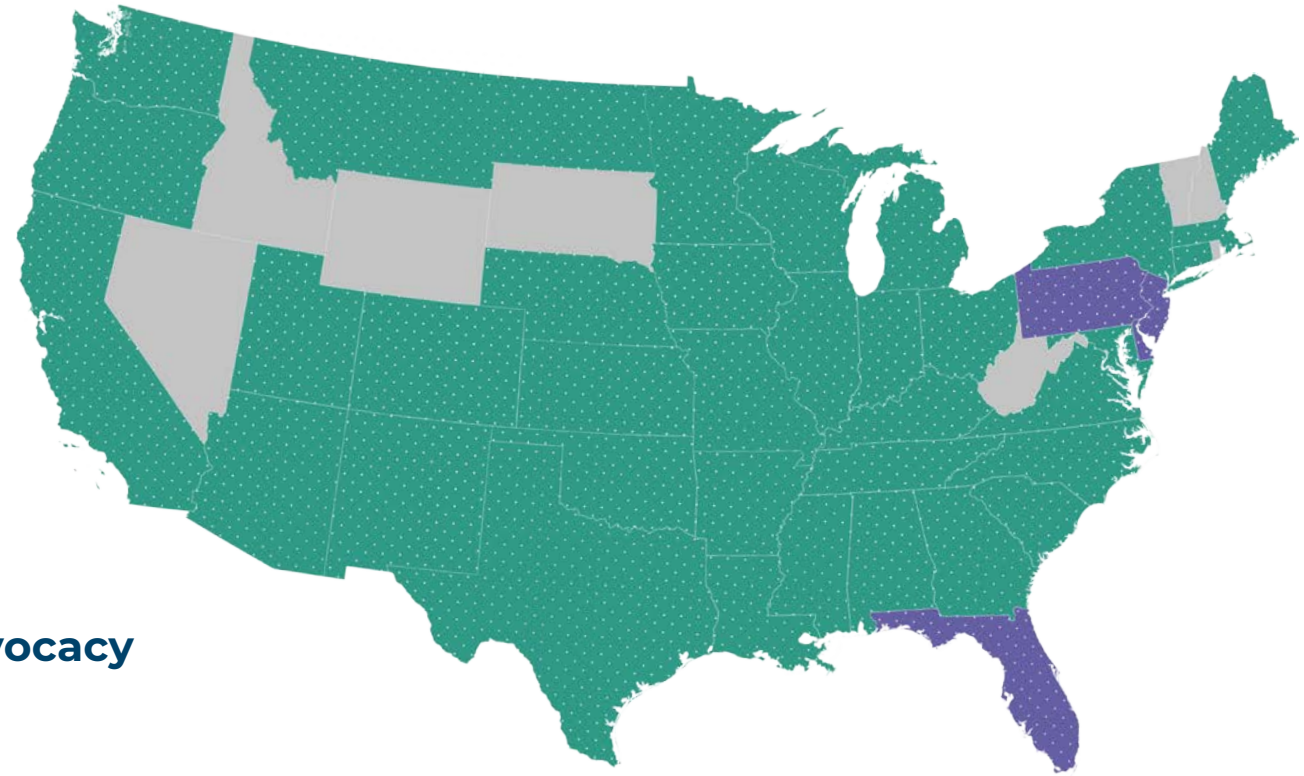
Describe how models of care support value-based care contracting

Illustrate the interconnectedness of the population health initiatives to support care models

Who We Are

Primary, Specialty, Hospital & Urgent Care

- 72 care locations in 4 states
- Value-Based Services Organization
- 35,000 SDoH Screenings
- 1.6 million patient encounters
- 8,600 associates
- 1,130 employed physicians
- 3,900 trainees
- 85,492,310 Radiology Images Reviewed*
- $1.7 billion annual revenue



National Office of Population Health & Advocacy

- Early Childhood Education
- Nemours Children's Reading BrightStart!

Nemours KidsHealth – available in 50 states and worldwide

- 250 million annual visitors
- 300 million page views

**Services provided nationally*

NEMOURS CHILDREN'S HEALTH

Value Based Care

Nemours Achievements in Value

- **14 value-based partnerships** with expected 2022 value-based care revenue anticipated >$8 Million
  - Pay-for-Performance (P4P), Care Coordination, Shared Savings since 2016 across Commercial, Medicaid Lines of Business (LOB)
- **More than 60%** of children in Delaware are attributed to a primary care provider participating in DCHN
- **Actuarial support and claims analytics** across > 30 metrics
- Top performer in quality
- First **downside risk** contracts with our **statewide CIN**
  - 3 active downside risk across DE Valley & Florida

Nemours Value Strategy

- Build Data Analytics team and capabilities to support Population Health and Cost Management
- Build Medical Management team to support Care Coordination and intensive Care Management programs to improve utilization and health behaviors
- Build a multi-disciplinary Population Health management team with QI expertise
- Enhance our Patient-Centered Medical Home (PCMH) and Population Health capabilities in Primary Care
- Engage community pediatricians in a Clinically Integrated Network
- Engage payors in innovative Alternative Payment Models to incentivize VBC
- Develop Social Determinants of Health strategy
- Develop strategy for *culture change* to Value

Model

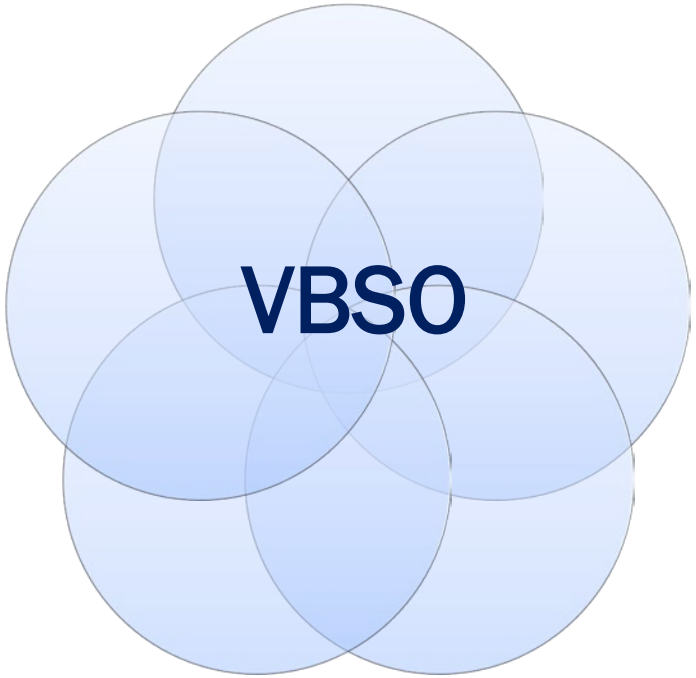
VBSO STRUCTURE

Primary Care

- PCMH
- Preventative QI
- Clinical Pathways

Data Analytics & Technology

- Predictive Analytics
- Clinical Risk Scoring
- Registries and Dashboards
- External Data
- Digital Strategy



Medical Management

- Care Coordination embedded in every practice
- Inpatient Case Management
- NCQA accredited Care Management programs
- Community Health Workers
- Complex Scheduling Team
- Pharmacist support
- Community Health Education
- Children with Medical Complexity

Delaware Children's Health Network (DCHN)

- Includes 13 independent primary care practices and all Nemours specialists and primary care
- ~60% of the kids (under 18) in Delaware

Population Health Management

- Social Determinants of Health
- Trauma Informed Care
- School Health
- Reading Bright Start!
- Quality Improvement
- Practice Transformation

Successful whole-child care requires a community-based care ecosystem with children and families at the center

INTEGRATED CARE ECOSYSTEM

Healthcare facilities

Acute care
Deliver excellent, evidence-based "bedside" care

Primary & specialty care
Enable long-term, trusting provider relationships for preventative care and chronic condition management

Home

Virtual care & home health
Bring care to the patient to enable greater access and convenience

Community

Built environment
Improve interpersonal connectivity and wellness through community environment and facilities

Early childhood & K12 schools
School based care programs to offer clinical and emotional support where children learn

Community organizations
(e.g., CBOs, faith-based orgs)
Partner to expand access to care delivery and address SDoH

Government agencies
(e.g., CPS, Juvenile Justice)
Partner to ensure high quality services for at-risk children and families

Full continuum of physical and behavioral care and support

Key enabling elements

Expanded care team
(e.g., PCP's, Urgent care physicians, nurse practitioners, doulas, community health workers, school mental health, etc.)

Care coordination
(linking primary and specialty care across sites and to other pillars in the care ecosystem)

SDoH programming
(e.g., non-emergency medical transportation, Medical Legal Services, medically tailored meals)

Family & caregiver support
(e.g., parenting education, mental health support)

Data, analytics, IT
(rigorous measurement of outcomes, data sharing across entities)

NEMOURS CHILDREN'S HEALTH

MEDICAL MANAGEMENT CARE TEAMS

- Clinical Care Coordination
- Complex Scheduling
- Community Health Education
- Community Health Workers
- Inpatient Nurse Case Managers
- Opt-in Care Management
- School-Based Health
- Pharmacy
- PCP offices

Populated Segments Delegated Services

Care Management

THE TOP 5% & WALKING WOUNDED

- Opts into Care Management/has Care Plan for disease self-management
- Multiple chronic or acute exacerbations
- May have significant/complex psychosocial issues/multiple SDoH and complex ongoing care or other drivers of high utilization

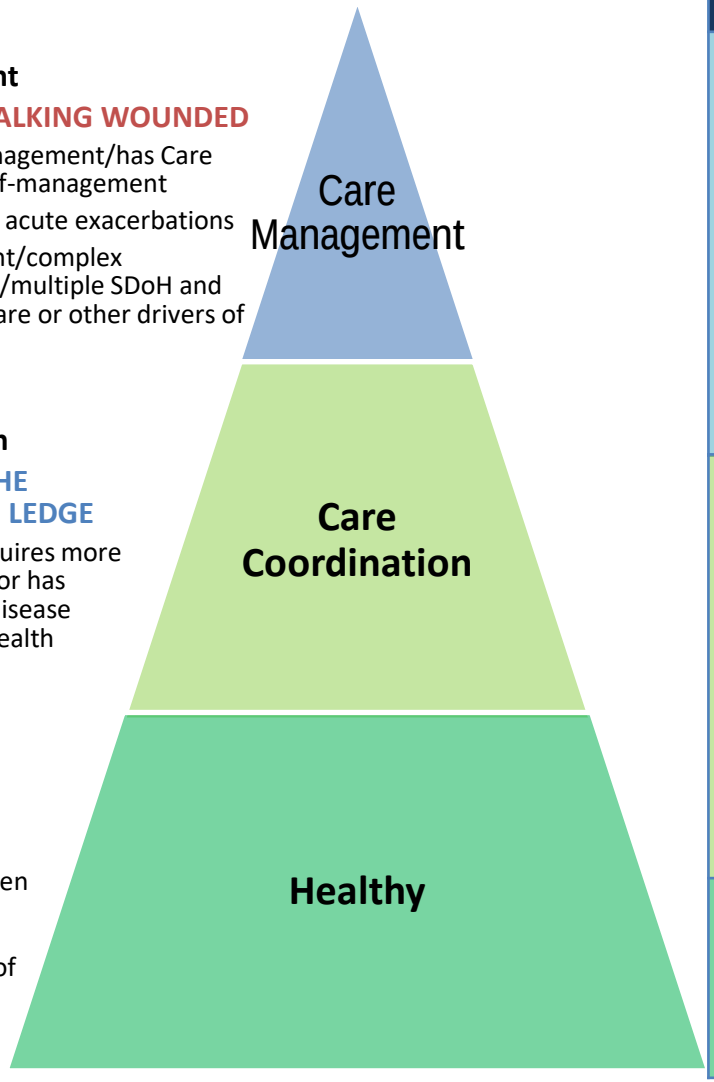
Care Coordination

20-15% UNDER THE RADAR & ON THE LEDGE

- Diagnosis that requires more frequent services or has other barriers to disease management or health

75-80% HEALTHY

- For example, children who have mild asthma diagnosis, with no indication of noncompliance or other significant SDoH



Role Examples of Clinical Care Coordination/Care Coordination Functions
Care Managers provide: • Support across the health care continuum, both when seen at Nemours and between visits (home, school, work) • Patients that opt into care management are given a comprehensive assessment and provided a care plan that monitors progress of goals towards disease self-management **Nemours Hospital Case Managers provide:** • Support during inpatient admissions • Assistance in planning for discharge, including post discharge care and services **Community Health Workers provide**: • Program specific support • Home visits that include assessments for triggers • Resource coordination **Complex Scheduling** Assistance in making multiple and/or complex appointments
Care Coordinators for this level provide: • Reminders for routine well-child visits & immunizations as well as scheduling one additional visit with PCP and/or specialist per year. • Follow up on referrals and diagnostic testing results required for conditions and acute illness • Follow up on ED/Admissions to ensure management of disease **Nemours Hospital Case Managers provide:** • Support during inpatient admissions • Assistance in planning for discharge, including post discharge care and services **Community Health Workers provide**: • Program specific support • Home visits that include assessments for triggers • Resource coordination **Complex Scheduling** • Assistance in making multiple and/or complex appointments
Care Coordinators for this level provide: • Reminders for routine well-child visits and immunizations • Follow up on referrals and diagnostic testing results for routine acute illnesses • ED Follow up **Complex Scheduling** • Assistance in making multiple and/or complex appointments

Care Coordination Teams

Care Coordination Team Embedded in Primary Care

- Nurse Care Coordinators – LPNs and RNs
- Social Work Care Coordinators
- Non-licensed Care Coordinators

Centralized Care Coordinators

- Remote/telephonic - support patient needs and embedded Care Coordination staff

Delegation Intake Care Coordinator

- Aligns patient need with appropriate level of coordination/management

Other community resources

- Community Health Workers
- Community Education

School-based Health Centers

- Team Overseen by APRN
- Foster chronic care management in school setting

Care Coordination

Several roles to meet the coordination needs of the healthy base:

- Centralized Care Coordinators:
  - Review gaps in care
  - Assist in follow-up of Avoidable Emergency Department visits
  - Bulk Outreach

- Clinicians are licensed to provide higher level and targeted support/guidance

- Social Workers support those with high needs surfaced from Social Determinants of Health (SDOH) assessments:
  - Community resources
  - Behavioral health issues

- LPNs/RNs support medically-focused issues:
  - Assist with Letters of Medical Necessity
  - Education around diagnoses
  - Follow up ED and hospital admission

Community Health Worker

Goal of Community Health Workers:

As trusted member of the patient's community, Community Health Workers help families navigate the health care system in the following ways:

- Educating and empowering families around specific disease self-management
- Linkage to community resources and supports for the child and family
- Performs field visits /home assessments to identify barriers to care
- Coordination of Care between Home, School, and Primary Care Office
- Works closely with Care Coordination and Care Management to support patient care
- Utilizes unique methods to outreach to members

Pediatric Home Assessment Survey

Indoor Pollutants					
Mold and Moisture		❑Use dehumidifier ❑No damage	❑Use vaporizer or humidifier	❑Musty odor evident	❑ Visible water / mold damage
Pets	Presence	❑No pets	❑Cat #_____	❑Dog #_____	❑Other: _____
	Management	❑Kept strictly outdoors	❑Not allowed in patient's bedroom	❑Full access in home	❑ Sleeping location: _____
Pests	Cockroaches	❑None	❑Family reports	❑Evidence seen	Present in ❑kitchen ❑bedroom ❑other
	Mice	❑None	❑Family reports	❑Evidence seen	Present in ❑kitchen ❑bedroom ❑other
	Rats	❑None	❑Family reports	❑Evidence seen	Present in ❑kitchen ❑bedroom ❑other
	Bedbugs	❑None	❑Family reports	❑Evidence seen	Present in ❑bedroom ❑other
Lead-based Paint		❑Tested and passed	❑Tested, failed, and mitigated	❑Not tested	❑Loose, peeling, or chipping, paint
Asbestos		❑Tested – None present	❑Tested, failed, and mitigated	❑Not tested	❑Damaged or friable material
Radon		❑Tested and passed	❑Tested, failed, and mitigated	❑Not tested	❑Failed test but not mitigated
Health and Safety Alarms		❑Smoke alarm working and well placed	❑CO alarm working and one on each floor	❑CO alarm does not log peak level	❑No smoke or CO alarm
Environmental Tobacco Smoke		❑No smoking allowed	❑Smoking allowed outdoors	❑ Smoking allowed indoors ❑ bedroom ❑ playroom	❑Total # smokers in household: _____ ❑Mother smokes
Other Irritants		❑None	❑Air fresheners	❑Potpourri,	❑Other strong odors:

Care Management

GOALS

- Early recognition, intervention, education, and treatment
- Self-management of chronic disease

CARE MANAGEMENT:

- Nemours Children's Health Care Management is NCQA Case Management accredited
- Care Managers are located throughout the state of Delaware
    - They can meet families at providers offices
    - They are available to meet with families while they are in patient at Nemours Children's Health Delaware
- Care managers meet regularly with the Nurse Case managers (discharge meetings), Care Coordinators and Community Health Workers
- Patients are identified from several sources
    - Referrals from Providers, Care Coordinators, Nurse Case Managers, Community Health Workers
    - Multiple reports include high utilization reports, disease reports, high risk Asthma

Case Management

Case Management is a team of RNs who work with multidisciplinary care teams to ensure timely progression of care through a safe, successful and sustainable transition of care from an acute care setting.

- Anticipate barriers, develop countermeasures for these and escalate issues in the moment
- Assist families in effectively transitioning their care to the next level through collaboration with post discharge teams, such as Care Coordinators, Community Health Workers, Care Managers and any home care agencies
- Creates effective connections with/for individual patients to other care teams, initiating referrals for outpatient care coordination/care management and community support.

Care Management/Care Coordination Process Flow

REFERRAL → **EVALUATION TRIAGE** → **HIGH LEVEL RISK CARE MANAGEMENT** (Criteria=High Cost, High Risk, Chronic Care) → **CARE MANAGER PERFORMS OUTREACH TO PATIENT/FAMILY CAREGIVER**

- Explains program and offers care management services

REFERRAL SOURCES:

- PROVIDER
- Case Managers
- Care Coordinators
- Patient/Family Caregiver

DATA SOURCES:

- Claims Data
- Behavioral Health Claims
- Pharmacy Claims

Via

- electronic
- telephone
- fax
- email

LOW LEVEL RISK

- Refer to CARE COORDINATOR: (Criteria=gaps in care, planned visits, registries)

MODERATE LEVEL RISK

- Refer to CARE COORDINATOR: (Criteria=chronic disease management which includes self management support and medication management, care coordination, patient education)

ACCEPTENCE

- Opt In
- Assessment completed (within 30 days)
- Care Plan initiated

(goals developed, problem solving, chronic disease management which includes self management support and medication management, patient education, community resources, transitional care).

REFUSAL

- Opt Out
- Referral back to Care Coordinator
- Care Management Closed
- Open to Care Management at any time patient requests

NEMOURS CHILDREN'S HEALTH

Complex Scheduling Team

This is a group of dedicated schedulers (4 non-clinical and 1 RN scheduler) who assist with complex appointment scheduling:

- Work to secure appointments at location closest in the community to the family

- Work to coordinate appointments to promote fewer trips for the family

- Assist with the following populations:
  - Families who require 3 or more appointments (for 1 or multiple children)
  - Families traveling a distance who require 2 or more appointments
  - Children who are medically complex and will be undergoing orthopedic surgery.
  - Inpatient discharging patients who require any number of specialty appointments
  - NICU babies from NCH and partner hospitals who require NICU follow-up and/or specialty appointments
  - Children whose appointments require key questions asked prior to arrival (Feeding Clinic, Gender Wellness Program, etc.)

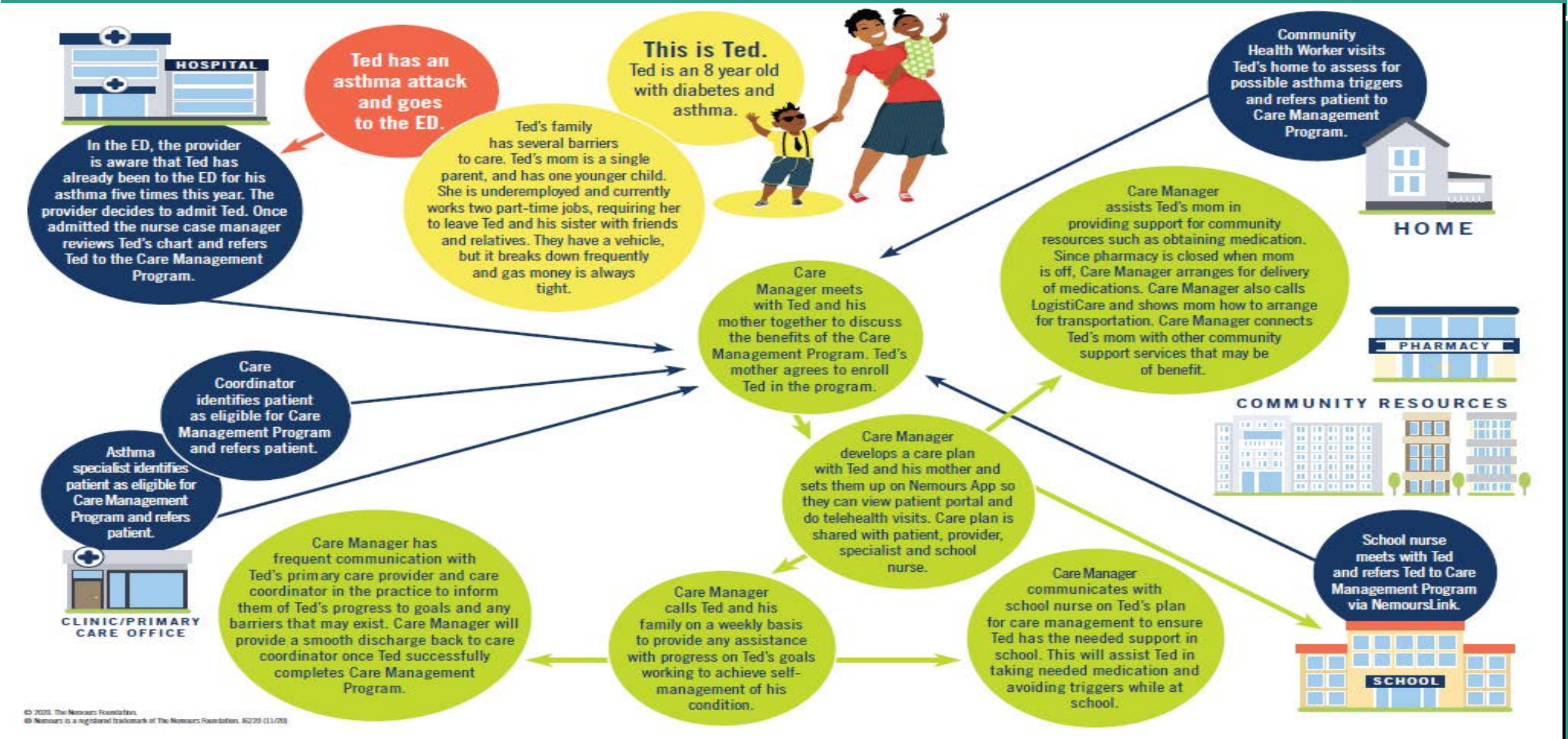
- Receive referrals from referring hospitals, community physicians, PCP offices, Care Coordination teams and from specialty clinics

Pharmacy

- Inpatient to Outpatient - CIN Pharmacy team will collaborate with inpatient pharmacy and medical management teams to ensure children and families go home with the medications prescribed.

- Outpatient (PCP office)– CIN Pharmacy team will work in partnership with Primary Care Providers and families to provide support around comprehensive medication management.

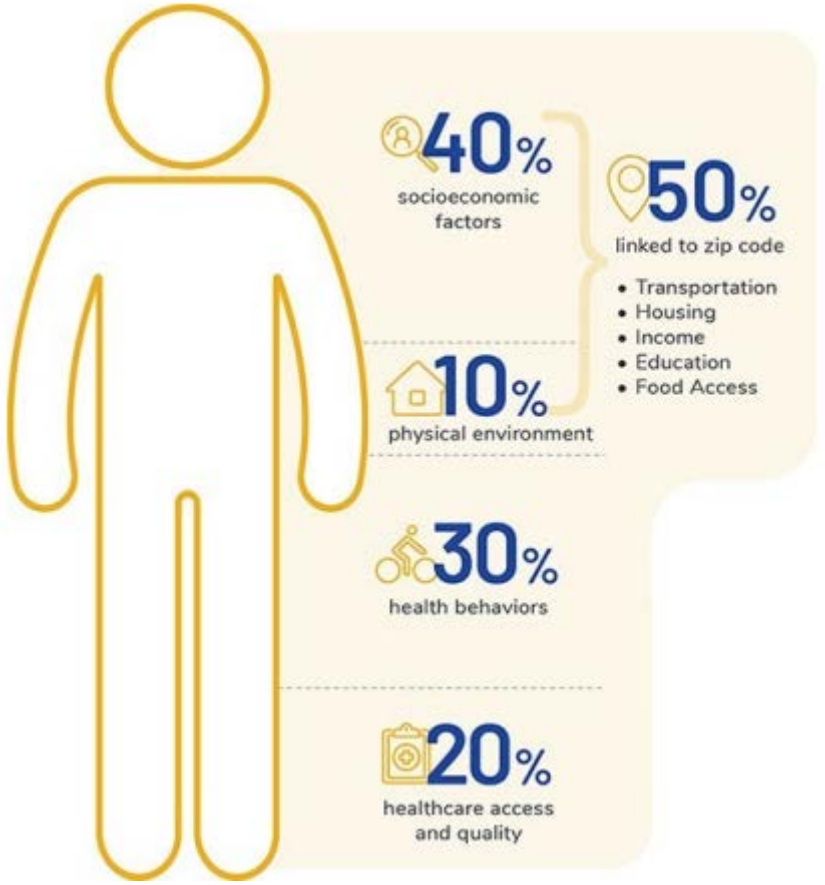
Care Continuum



SDoH Impacts on the Family Unit

SDOH DOMAINS

DOMAINS
Food Insecurity
Financial Insecurity
Transportation
Utility Concerns
Housing
Social Support
Legal Concerns
Personal Safety
Neighborhood Concerns
Health Literacy



Social Determinants of Health Baseline Model

ALL TIERS

- Provider discusses clinical implication of needs – medical lens
- Individual locations continue to utilize existing resources & processes to meet patient needs

Tier 1

Flyer with resources

Tier 2

Requires identification of a point person for escalation needs (social work, care coordinator/manager)

- Connecting patients directly with resources
- Warm handoff

Tier 3

Coordination of Community Services

- Direct connection
- Closed loop
- Greater automation

NEMOURS CHILDREN'S HEALTH

SDoH interventions & community efforts launched as a response to screening insights

- Food Closets and Mobile Food Bank Pilots
- Community Needs Assessment
- Medical-Legal Partnership

Cross-Sector Collaborations

Cross-Sector Collaborators

Food Bank of Delaware

- Food Closets
- Mobile Food Pantries
- Backpack program
- Home delivery through Amazon fresh

Hospital Systems

- Impact ED Utilization rates
- Transition of Care
- Pregnant Teens Pilot

School Based Health Centers (SBHC)

- Ability to align care coordination efforts across primary care practices and community services
- Unique opportunity for preventative care
- Data Access for Student Health (D.A.S.H)

Community Partners

- Health Fairs
- Newly enhanced model to align community partnerships
- Delaware's first Clinically Integrated Network (DCHN)

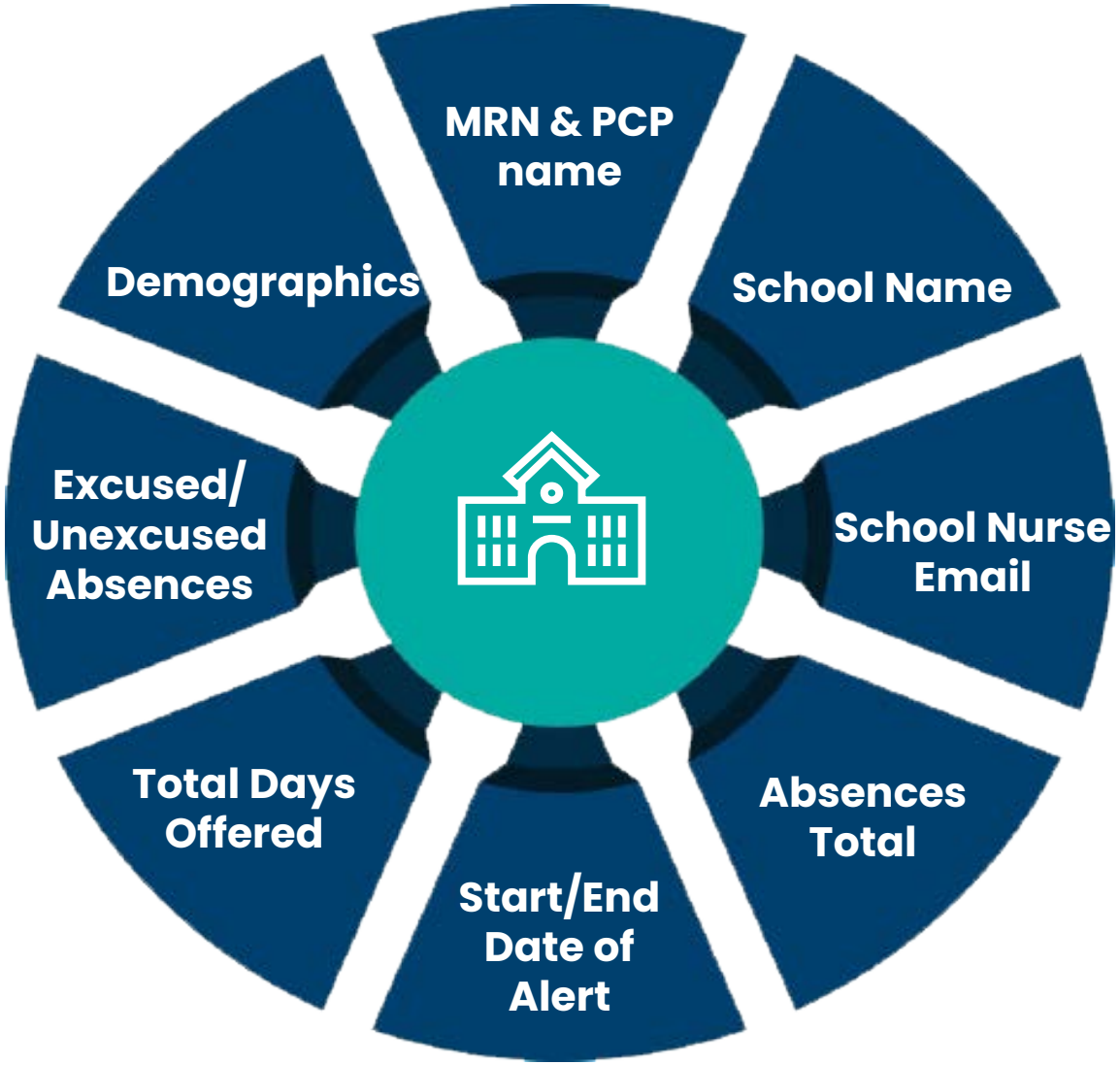
Towe VL, Leviton L, Chandra A, Sloan JC, Tait M, Orleans T. Cross-Sector Collaborations And Partnerships: Essential Ingredients To Help Shape Health And Well-Being. Health Aff (Millwood). 2016 Nov 1;35(11):1964-1969. doi: 10.1377/hlthaff.2016.0604. PMID: 27834234.

DASH

Data Access for Student Health (DASH)

- Modeled after the District of Columbia's Chronic Absenteeism Reduction Effort (CARE)*
- Electronic database system that alerts PCP when child has extended absences.
- PCP receives information on total days missed, total excused/unexcused, IEP/504 plan status

Data coming from school through Dash Initiative



D.A.S.H Outcomes

September 2021-June 2022-first year!

Over 1,940 children have been signed up for the DASH program, with more expected.

- 560 have a Nemours PCP
- 243 students generated 501 alerts for missing 3-day consecutive days
- 66 students generated 71 alerts for missing 10 or more days during the school year

Outcomes

- Increase in patients scheduled for Well Child Visits
- Medication education
- Clearer communication and coordination with school nurse/counselor

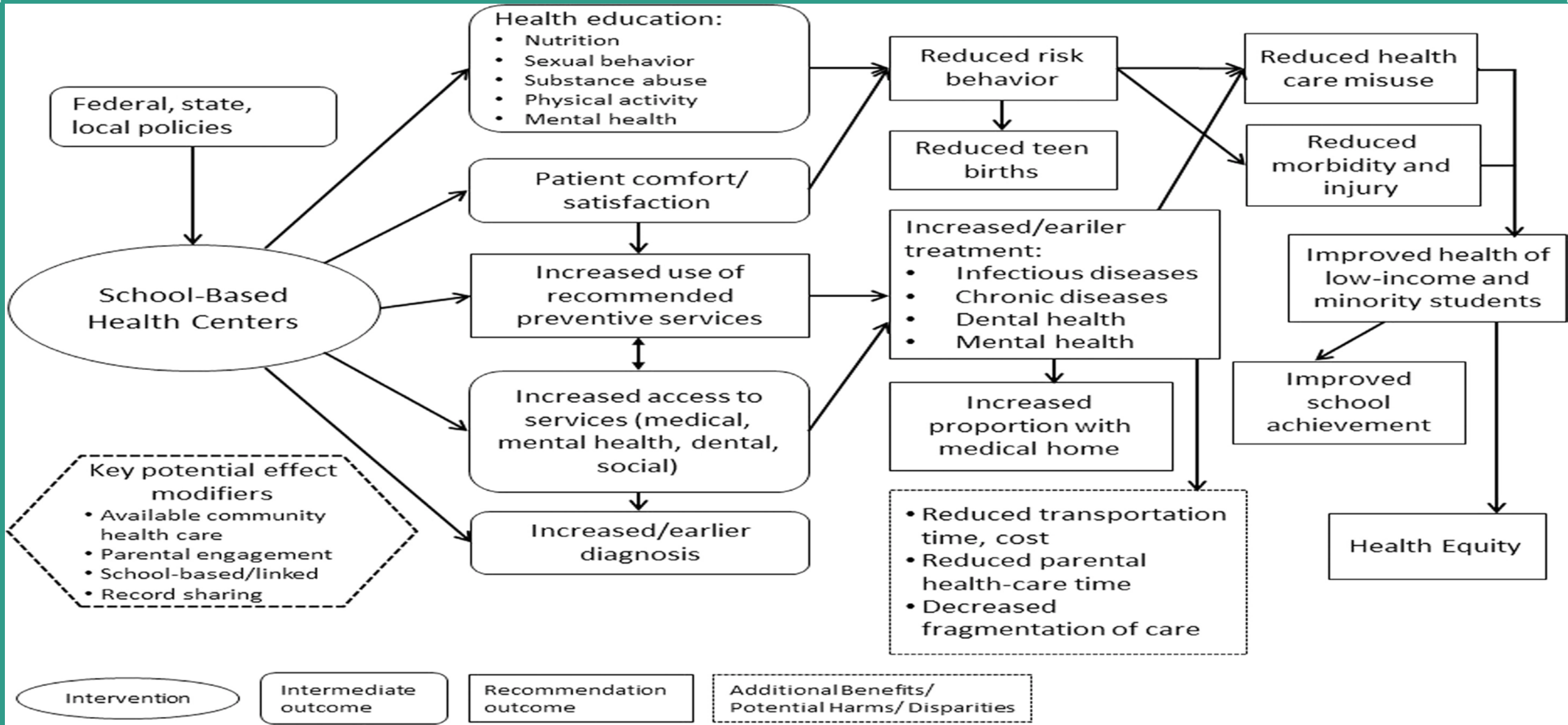
Patient Story

School Based Health Care

What are School Based Health Centers (SBHC)

- Health Center located within a school building
- Funded by the Delaware Department of Health and Social Services, Division of Public Health.
- Nemours currently in partnership with an elementary school district in the State of Delaware with a single Elementary School mid state.
- Provide an array of services for physical and mental health needs
- Removes barriers to learning created by health conditions, exposure to violence/trauma, and instability or stress in home or community.

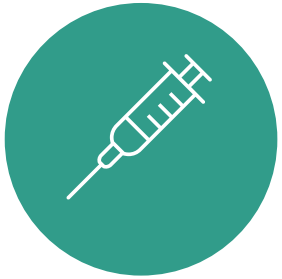
Analytic Framework: School Based Health



School Based Health Care

With Parental Consent-

SBHC patients receive the following services



- Wellness and sick visits
- Preventative Vaccinations
- Medication Education
- SDoH Screener

- Nutrition Counseling

- Behavioral Health Counseling

- Other Health and Social Services
- Assistance to applying for insurance programs

Aspirations for SBHC

Positive impact on absences, dropout rates, and other academic outcomes

Academic Improvements

Improved compliance with wellness and dental check-ups. Decrease ED utilization

Students have higher test scores and a lower dropout rates

Next Steps

What's Next

1

Continue contracting within Delaware, Pennsylvania, New Jersey

2

Develop free-standing care management for key areas in Florida

3

Continue to grow SBHC to meet children and families where they are in their communities

4

Expand health education to families within the community through key partnerships and establishment of Community Health Educators

5

Continue to grow/enhance partnerships to assist families in meeting needs related to SDOH

QUESTIONS