CASE STUDY

Akron Children's Hospital Adopts PCMH Model of Care to Accelerate Transition to Value-Based Care

The Client

Akron Children's Hospital is the largest pediatric provider in Northeastern Ohio and one of the fastest-growing children's hospitals in the U.S. Its two children's hospitals offer a combined 446 beds, and the organization maintains 28 primary care pediatric offices.

In 2017, Akron Children's 150-member primary care medical staff delivered more than 430,500 primary care visits to its approximately 190,000 patients. The organization is in the process of building a foundation of population health throughout its medical neighborhood, ultimately leading to becoming the medical home for the children and families it serves. It is dedicated to creating a continuum of care to help families manage wellness, as well as conditions such as ADHD, asthma, behavioral health, and obesity, in order to help all children reach their full potential.

The Business Challenge

Akron Children's is dedicated to making the transition from fee-for-service (FFS) to value-based care. However, the organization must still maintain revenue as it changes its business model, which means looking for options to enhance reimbursement to aid with the transition. In early 2017, it became an early adopter of Ohio Comprehensive Primary Care (CPC). Ohio CPC is a Patient-Centered Medical Home (PCMH) program, which is a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs.

CPC offers per member, per month (PMPM) payments to support and encourage PCMH activities, with rewards for practices that achieve total cost-of-care savings through shared savings payments. One of Akron Children's primary care offices, which serves a vulnerable population, had already began the transition to PCMH. The organization wanted to move quickly to ensure the other 27 offices met the requirements.

The Board made it an objective to achieve full recognition of all of its primary care pediatric offices in a year, which meant significant changes would need to be instituted from the committee level down to the staff nurse level.

Value-based care programs such as Ohio CPC rely largely on effective population health management and team-based care best practices to improve outcomes and reduce costs. At the time, Akron Children's was heavily focused on an FFS encounter-based system and did not have team care methodologies or care management services in place. It did have a quality program, but it focused solely on providers achieving certain tasks, not on outcomes. When staff members were surveyed about the quality program, few of them could explain it. Additionally, their perception was that they did the work while providers reaped the benefits, which created animosity toward quality/value-based care efforts.

Although the entire health system was on the same instance of Epic and had very consistent practices across their systems, many transformational gaps were still identified, such as conducting transitions-of-care follow ups; using admissions, discharge, and transitions (ADT) transactions; tracking laboratory testing and imaging results; screening for social determinants of health; a risk stratification model; and care management services.

To achieve NCQA PCMH Recognition and meet the requirements of Ohio CPC, Akron Children's primary care offices needed to be able to stratify risk for individual patients as well as populations. They also needed to begin measuring social determinants of health, which meant asking sometimes uncomfortable questions. In the past, physicians were hesitant to ask these questions if social solutions were not available. There was also a culture shift required, as the individual practices would need to take more of a team approach in caring for their patient populations.

Many staff members were skeptical of the changes, fearing they would be asked to do more without any real insights as to why. They were also concerned about even more technology being added that would interrupt workflows and be perceived as getting in the way of the physician-patient relationship. However, since achieving recognition was a Board objective, the organization knew changes would have to be made—and made quickly. What they needed was a partner that could help make the transition smooth and swift.

CTG's Solution

Akron Children's executives were attending an industry conference when they spoke with a director at Children's Hospital of Buffalo, which is part of the same network of children's hospitals. After describing their ambitious plans, the director recommended they meet with CTG.

CTG brought a team of PCMH experts to the initial meeting, and the two sides meshed immediately. CTG understood what Akron Children's needed to do, on both an overall and a day-to-day basis, and demonstrated that they would be onsite with them—going to meetings, diving deeply into their operations, and participating with them every step of the way.

After performing a baseline assessment, CTG's consultants recommended significant transformation across four areas:

- Operations
- IT and Reporting
- Population Health Management
- Quality

For operational improvement, CTG recommended that the practices adopt a team approach to care to build a foundation for moving to the CPC/PCMH model and demonstrate how those changes affect patient care and organizational success. The CTG team also showed how shifting responsibilities would enable all team members to operate at the top of their license and distribute work among the team members. Improvements were implemented to begin pre-visit planning and to use patient-focused huddles to identify care gaps that could then be addressed during patient visits. A program to screen for social determinants of health was instituted to better understand the social risks that patients were facing and use that information to drive better social resources and patient outcomes. CTG conducted an in-depth staff analysis resulting in the development of new skills and redistribution of many key clinical responsibilities. Additionally, 35 full-time equivalents (FTEs) across 28 sites were added to support the additional work, many of them focusing on care coordination, social work support, test and referral tracking, and care transitions.

The changes required a significant cultural shift, especially around team and population-level responsibilities and social determinants of health screening, but with the support of a cohesive and strong executive team, the changes were implemented on a rapid scale.

On the IT side, many important Epic developments were needed, including test tracking systems, transitions-of-care notifications, work queues, and the creation of a new department for population health, which was essential in managing Akron Children's high-risk, rising-risk, and low-risk groups. A risk stratification methodology was developed for the patient population as the Ohio CPC program requires the implementation of a risk stratification model.

Rather than purchase an outside application, Akron Children's elected to build their own. The organization decided to utilize a model developed by the Children's Hospital of Philadelphia, so CTG worked with the organization's Epic builders to create an application that would identify which patients would benefit from care management based on patients whose care is complex and requires extra coordination rather than cost. A CTG developer and consultant worked with Akron to create new patient registries, new test and referral tracking capabilities, and automated ADT to support work queues and care transitions. CTG also helped Akron Children's develop new quality dashboards to monitor progress and performance in real time, and new success measurements were established in line with PCMH requirements.

The new PCMH capabilities included the creation of more than 25 reports to define the patient population, measure compliance and new metrics, and report on quality outcome performance. CTG helped Akron Children's create a routine of systematic proactive reminders to parents about wellness visits, immunization reminders, health concerns, and more to help ensure their children could be monitored and care gaps filled.

With CTG's help, care coordination services were implemented to help improve transitions of care and encourage greater engagement on the part of patients and their parents. CTG and Akron Children's worked together to build a new Epic department to enable care plan management and high-risk registries. The organization began coordinating with social work services when social determinants of health screening revealed concerns, such as not having enough food, housing challenges, or physical or psychological abuse, so suggested improvements could be made outside of pediatric offices to improve health outcomes.

The initial mandate for population health is to affect the highest-risk-scoring patient of the patient population, then create a longitudinal plan of care to address the needs of the sickest 10 percent—those who require the most care right now.

The long-term goal, however, is not only to help that top 10 percent, but to develop interventions to keep the other 90 percent from moving up from their current level of risk to a higher one.

Results

From a business standpoint, in August 2018, all 28 of Akron Children's primary care offices earned NCQA PCMH Recognition and met the Ohio CPC requirements, making them eligible for PMPM reimbursement under the program. This regular revenue stream is helping support Akron Children's transition to value-based care. It is also yielding improved health outcomes while helping the organization reduce its costs.

The transition has also shaped substantial operational changes. Prior to this project, Akron Children's care was physician centered. This meant the physician was responsible for managing all patient calls in between seeing patients, as well as all follow up. There was no preventive care outreach or tracking of who needed it, nor were orders tracked. All quality metrics were behind the scenes.

Leveraging the team-centered PCMH approach, Akron Children's is now able to offer and measure same-day appointments and care teams have been developed to assist providers with managing patients. Regular patient outreach is now part of the program, and referrals and tests are tracked. High-risk patients are identified and managed by the entire care team with the support of care coordination, while quality metrics are reviewed and celebrated by the whole team.

Clinical result improvements include:

- An increase in developmental screening during 9-, 18-, 24-, and 30-month wellness visits from 20 percent to nearly 100 percent since the drive toward CPC was initiated. This includes the 24-month screening for Autism. The clinical staff was performing these screenings prior to the transition, but there was little enthusiasm around them because they didn't understand the underlying purpose. The move to a team-based approach demonstrated the reasons behind the screenings, elevating performance in this crucial area.
- An increase in depression screening among adolescents using PHQ-9 during wellness visits. Today, 90 percent of patients over age 12 have been screened for depression—an important factor in the overall health of this age group.
- An increase in the percentage of adolescents who receive the HPV vaccine at wellness visits when it is due from roughly 45 percent to more than 50 percent.
- More than 70 percent of patients aged four years or older who have asthma have received asthma control tests at wellness visits, up from just 50 percent the previous year.

While there is still much more work to be done on the journey toward value-based care, Akron Children's has cleared a major hurdle. With CTG's help, the organization can continue the journey using their patient-centered, data-driven model as a foundation, which will benefit providers, patients, and payers alike.

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