Kids First Health Care

Formerly Community Health Services

Care Coordination in SBHCs

Presented by:

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Kids First Health Care

Background on Kids First Health Care

- Private, non-profit organization
- 6 School-Based Health Centers in Adams County
- Our SBHCs are staffed with 1-2 NPs and 1-2 MAs
- Pediatrician serves as our Medical Director (part-time)
- Certified Children's Medical Home
- Participating in Accountable Care Collaborative (ACC) since February 2011
- Added Clinic Manager to take on staff supervision and project management (including the ACC) in August 2012

Accountable Care Collaborative

Colorado: Accountable Care Collaborative

- Through Regional Care Collaborative Organizations (RCCOs)
- 7 geographic regions
- Locally organized and locally led
- 3 possible ways to handle care coordination
  - RCCO Based Care Coordinators
  - Community Based Care Coordinators
  - Primary Care Based Care Coordinators

Care Coordination

- What is Care Coordination?
  - Person and family-centered
  - Assessment-driven
  - Team activity
  - Addresses interrelated needs
  - Enhances care
  - Improves outcomes

- SBHCs regularly do Care Coordination

5 Key Elements

- Actively engaging the student
- Maintaining a relationship
- Data/information sharing
- Mutual benefit/shared mission
- Formal processes in place

Care Coordination Practices:

- Review our monthly data from the state (SDAC)
- Stratify Patients (High Needs, Medium Needs, Low Needs)
  - High ER usage and high cost imaging services
  - Complex Chronic and Critical (ADHD, epilepsy, med changes)
  - At Risk, Simple Chronic and Stable (Asthma, Obesity, WCC)
- Track patients monthly on Excel spreadsheet
- Update patient charts with comments, tasks, care plans, etc.

SDAC Data

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KIDS FIRST HEALTH CARE - 04000188 (Claims paid through 7/31/2016)

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COSDAC Dashboard 2016

RCCO KPI Measures

Key Performance Measure	Rolling 12 months 05/2015-04/2016	Program YTD 07/2015-04/2016	
% Difference ER Visits PKPY	(5.6) %	(5.0) %	Member List
% Complete Postpartum Care	50.0 %	--	Member List
% Complete Well-Child Checks (3-9)	57.7 %	--	Member List

RCCO Program Measures

Performance Measure	Rolling 12 months 05/2015-04/2016	Program YTD 07/2015-04/2016	
% Complete Well-Child Checks (0-21)	50.4 %	--	Member List
% Difference 30 Day Readmits PKPY	44.4 %	77.8 %	Member List
% Difference High Cost Imaging PKPY	(8.6) %	(2.2) %	Member List
Adult Clients with Diabetes and annual HbA1c	0.0 %	--	Member List
% Complete Prenatal Care	50.0 %	--	Member List
% Complete Chlamydia Screening in Women	27.5 %	--	Member List

Budget Basis

Base risk score	1.067
Current risk score	0.592
Base budget	$272.66
Current budget	$151.24

Population Data

08/2015-07/2016

All Members: 2,347

9.54%	Non User
56.67%	Healthy
8.48%	Stable
6.77%	At Risk
16.32%	Simple Chronic
1.70%	Complex Chronic
.51%	Critical

Reports

Care Management Patient List

Care Management Spreadsheet:

	A	B	C	D	E	F	G	H	I
1	Client ID	Client Name	Client DOB	Client Age	Site	Phone Number	Comments	Category	Current Clinical Risk Group
2	Y000000	Doe John	?/?/?	14	KMS	303-000-0000	2-13-14 Asthma visit. Contaced KMS to see if patient has ever been seen by us for ADHD.	At Risk	Attention Deficit/Hyperactivity Disorder Level - 2
3	Y111111	Mouse, Mickey	?/?/?	14	n/a	-	Name in Aprima but No visits	Complex Chronic	Diabetes and Hypertension Level - 3
4	G000000	Fairy, Tinkerbell	?/?/?	8	n/a	-	Name not in Aprima	Complex Chronic	Chromosomal Anomalies Level - 1
5	N000000	Grownup, Georgie	?/?/?	52	n/a	-	Name not in Aprima	Complex Chronic	Diabetes and Hypertension Level - 1
6	Y333333	Doe, Jane	?/?/?	11	Commerce City	720-000-0000	**Seen on 3/28 -WCC & Asthma follow up, 3-31 - blood work + Vaccines ,4-3 - arm pain**	Simple Chronic	Asthma Level - 1
7	J000000	Grownup, Gloria	?/?/?	35	n/a		Name not in Aprima	Simple Chronic	Psychiatric Disease Level - 3
8	G333333	Hook, Captain	?/?/?	5	Commerce City	720-000-0000	**3-24-14 Asthma recheck - follow ups have been consistant**	Simple Chronic	Asthma Level - 1
9	Y444444	Pan, Peter	?/?/?	14	ACMS	303-000-0000	Several well exams, obesity. **Delegated task to MA bc Spanish only, April 8th 2014.**	Simple Chronic	Obesity, Level - 1
10	G222222	Mouse, Minnie	?/?/?	13	Commerce City	720-000-0000	11-26-13 - no show // **attempted to call patient - no answer -unable to leave message**	Simple Chronic	Disruptive Behavior Disorders Level - 2
11	Y555555	Trouble, Tommy	?/?/?	12	Commerce City	720-000-0000	**Made trips to ER due to not being able to schedule an appointment with clinic in less than 5 days**	Simple Chronic	Asthma Level - 2
12	Y666666	Woman, Wonder	?/?/?	14	KMS	303-000-0000	Last appt was in 5/20/13. **Do not have working phone number for patient as of April 8, 2014**	Simple Chronic	Obesity, Level - 1
13	G444444	Man, Super	?/?/?	8	Commerce City	720-000-0000	Last visit on 4/18/13 // **spoke MOC and she advised me that he has been going to Salud for last 6 months**	Simple Chronic	Developmental Delay Level - 2
14	Y666666	Zebra, Zoey	?/?/?	11	ACMS	303-000-0000	**Patient has moved schools, suggested she make an appt at the Commerce City Clinic, provided the phone number to make appts. April 8, 2014.**	Simple Chronic	Obesity, Level - 1

Care Coordination Practices:

- Complete monthly/quarterly metrics for RCCO
  - New patients identified for care coordination
  - Total care coordination patients
  - Risk assessments completed
  - Patient contacts
- Attend monthly meetings with other delegated practices

Care Coordination Practices:

- Assign staff members to manage the care for these patients (Providers, MAs, Patient Navigators, etc.)
  - Part time patient navigator (Obesity grant from Kaiser)
  - Full time SBHC patient navigator (CDPHE Expansion Funding)
  - AmeriCorps members (small fee)
  - Morph Health Coverage Guide(s) into Patient Navigator(s)
  - Money from our RCCO and increased visits helps sustain these positions
    - $6.50 PMPM as delegated practice
    - Current attribution 2347
    - Enhanced Primary Care status gets extra bump

Practice Transformation:

- Evaluate changes in data monthly (improvements, set-backs)
  - ER Visits
  - WCCs
- Modify care coordination and data management practices
  - Merge data from previous months to reduce duplication efforts
  - Look into WCC coding practices
- Engage staff in cycles of rapid improvement (PDSAs)
  - Educate the providers on who these patients are
  - Come up with action plans
- Spread Best Practices

QUESTIONS?