Disclosures

• I have no conflicts to disclose
• I will not be discussing the off-label use of pharmaceuticals
Objectives

• **Quality** – What does this mean for busy clinicians?

• **Innovation** – How to think differently and effect change in our processes?

• **Network Opportunities** – What are the benefits of participating in a network for enhancing the care we provide?
A Day in the Life – Dr. Rose

• Large suburban group practice
• New participant in care management incentive program
• Knows Max has poorly controlled ADHD and asthma

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Photo credit: Shutterstock
A Day in the Life – Max

- 12-year old
- Moderate persistent asthma
  - Interferes with soccer
- ADHD
  - School suspension
- Family stressors
  - Paternal alcohol abuse
- Depressive symptoms
Quality Improvement
Measure what matters
Quality Improvement

• Distinct from measurement in research
  – Bring new knowledge into daily practice
  – Gather just enough data to learn
  – Small tests of significant changes (PDSA)

Institute for Healthcare Improvement, www.ihi.org
Example: Clinical Navigation

- Sufficient staff to implement program
- Proportion of patients screened
- Proportion of cases completed
- Asthma management
- Adolescent depression
- Needs met
- Total cost of care
- Increased visit time
- Provider and patient satisfaction

Burghardt, Barany, Milam, Gunn. The Impact of Screening for and Addressing Social Needs in Pediatric Clinical Settings on Child Health and Cost of Care. *AJPM*. Submitted for publication.
Quality Improvement

• Many of you likely already have some of these in place:
  – Well-child visits first 15 months (*process*)
  – Effective asthma management ACT/TRACK (*outcome*)

• Max, process and outcome measures:
  – Asthma and ADHD management
  – Adolescent depression screening

• How would you know about dad’s drinking?
Quality Improvement

• **Why:**
  – Clinically and socially relevant for Max’s well-being
  – Difficult to improve outcomes without addressing root causes

• **How:**
  – Implement two-generation approach

• **What:**
  – Standard screening for all patients/caregivers, inclusive of substance use
  – E.g., *Would you like help addressing substance use for yourself or your child?*
Innovation

The power of “What if?”
Innovation Example: Failure to Thrive
Innovation Example: Failure to Thrive

Current state
• Admit to hospital
• Parent education
• Potential referral to protective services
• Adversarial experience
• Does not address root causes

Pilot
• Admit to home
• Clinical, social and environmental assessments and supports
• Skill-building experience
• Addresses root causes

“What if these children never needed to be admitted to the hospital?”
Innovation Example: Failure to Thrive

• Clinical assessment performed by RN
• Developmental assessment and supports provided at home
• Cost savings for hospital and payer
• Supports “quadruple aim”:
  – Better health outcomes
  – Enhanced patient experience
  – Lower total cost of care
  – Improved provider satisfaction
Innovation – Questions to Consider

• **Why** do we do this?
• **How** might we approach this differently?
• **What** are key steps to accomplish the goal? What would we measure?
• **Who** needs to do what? (i.e. what is each person’s/organization’s role?)
Innovation – Max

What if Max and his family could access resources in a timely way to reduce the risk of escalation?

• **How**: Via a web-based portal accessible to patient/family and community-based providers (role-based access)
• **What**: Access to educational materials, screening tools, tele-psych visits, referrals to community-based resources, etc.
• **Who**: Providers and patient/families surface ideas, system provides technical support, CBOs provide access to services
Community Pathways Hub

- Web-based integrated system of service delivery
- Portal data entry by patients, clinicians and community-based service providers (E.g., CHWs)
- Facilitates service coordination across multiple sectors
- Case studies: Ohio, Wisconsin

https://carecoordinationsystems.com/
Network Opportunities

Partners in population health management
The Pediatric Health Network ("PHN") will transform the health of our region’s children through highly coordinated and collaborative care among pediatric primary care, specialists, hospitals and community partners.
Network Opportunities

• Facilitating measure development across groups and with payers
  – Incentives align with what matters most

• Enabling shared learning opportunities
  – Patients accessing care at different points along care continuum receive the same high quality care

• Foundational in your ability to address many non-clinical influences on health outcomes
Pediatric Obesity Pilot

- Focus area for large MCO
- Primary care concerned about ability to impact
- Designed collaborative approach to screening and referring to community-based resources for nutrition and physical activity
- Pooled MCO and primary care coordination and outreach resources
- Data sharing across entities

Photo credit: <http://www.drsharma.ca>
Network Opportunities – Max

• Enables testing and “spread” of innovative ideas
  – One clinic tests implementation of social health screening; another tests two-generation screening for substance use
  – Insights learned are shared across the network

• Network and system resources support collection of actionable data

• Network leaders collaborate with community organizations to ensure access to necessary services for referred patients
Parting Thoughts

• It is possible to improving patient care and maintain joy in practice
  – Strategic engagement in quality improvement practices
  – Embracing innovation
  – Utilizing your PHN network resources

• Learn from others – you are not alone
For More Information

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