Innovations in Primary Care Pediatrics:
Models of Collaborative Care Between Primary and Subspecialty Providers
Collaborative Care Models To Enhance Access for Patients with Common Neurological Problems

David K. Urion, M.D.
Director of Behavioral Neurology Clinics and Programs
Director of Education and Residency training Programs in Child Neurology and Neurodevelopmental Disabilities
Charles F. Barlow Chair
Department of Neurology
Boston Children’s Hospital
Disclosures

- I have no financial disclosures
Access to Child Neurology care is problematic at this moment

- Length of wait varies across the US, but is usually measured in months, not weeks
- A variety of schemes have been tried to improve access
- Most involve increasing capacity in tertiary/quartenary care site
- Most involve some form of triage or rationing
BCH example

• Despite a massive expansion of service providers over the last decade (60 MD’s, 10 full-time NP’s in independent outpatient practice), time to next third appointment hasn’t improved commensurate with this.

• We have created systems that make ready access for urgent (same day/next day), semi-urgent (within 72 hours), and within 1 week routine.

• In part, this has been at the expense of routine referrals.
How could we improve this?

- Concept: find the most common referrals, and see why this was occurring
- Internal audit of ten most common referrals
Two most common referrals

- ADHD
- Headache

In both instances, > 90% referrals were primary - i.e., PCP had attempted no evaluation or treatment
Incentivized system

- With a select group of frequently referring practices, we made an offer.
- If a patient had ADHD diagnosis established by questionnaires or better, had been treated with 2 stimulants unsuccessfully, or had certain co-morbid medical conditions, we would be seen within 14 days.
- Otherwise, they would wait for next available (9 months).
Modest success

- In the first six months, 25% of the referrals now had well-established diagnosis, and met the above-noted criteria.
And then

- Nothing changed for four years
Back to the drawing board

- Concept of transfer of knowledge and information to PCP settings
- Multiple sets of seminars with PCP’s, case-based reviews, and paradigms that could be followed were developed
- These also led to options for two types of consultation with neurology before patient sent
Informational Consultations

- Asynchronous: Secure email exchange, neurology agrees to answer in 3 business days
- Synchronous: Phone call to assigned number, neurologist calls back in 30 minutes
Campaign launched

- Hours of educational time for PCP’s in the above-noted seminars
- Paradigms tailored for the groups in question
- Monitoring of neurology performance in consultations just noted
- Willingness of neurology to forego part of its revenue stream (and contribute all these hours of intellectual effort) in the expectation that it would free up space in our schedules
And then?

- Six months in, 25% practices engaged as designed
- Other practices either do not use, or use asynchronous and synchronous consultations as a means of rapid referral
Lessons learned

- A coalition of the willing
- We all need to have skin in the game
- Once ACO’s truly take effect, those willing to engage in this sort of model are likely to be advantaged
Next steps

- A substantial portion of our patient population are Children and Youth with Special Health Care Needs.
- When we monitor, roughly 1/3 of our outpatient nurses’ time is occupied with primary care issues.
- Another metric of variable engagement of PCP’s in the care of CYSHCN.
How could we make the care of these families better coordinated

- We have some data from an experience in a CHC that we can reduce costs, improve outcomes, and enhance family engagement with robust care coordination.

- We are moving this out of the CHC and into our outpatient offices.
Care Coordination Project

- Developing a model wherein every patient has a care map, with aspects of care accountably assigned to members of the team - neurologists, PCP, families

- Any PCP can engage as much (or as little) as they want, so long as we are clear and we are all held accountable for the job we signed on to do

- We will evolve capacity by having everyone on our team working at the top of their paygrade

- This model uses extant resources and repurposes them
Care Coordination Project

- Document will exist in a cyberlocation that BCH specialists, PCP’s and families can all access
- Some day, we hope there is an app for that
Implications for Training

- ACGME milestones require education in care coordination
- One could pay lip service (a lecture here or there), or engage residents in building out new capacity
Care Coordination Information

For more information on Care Coordination or to review slides, please visit:

http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement

For additional questions, please email:

Richard.antonelli@childrens.harvard.edu