Designing High Value Delivery Systems:

Medical/Health Homes and Integrated Care

Massachusetts Health Policy Commission

Care Delivery and Payment System Reform Committee

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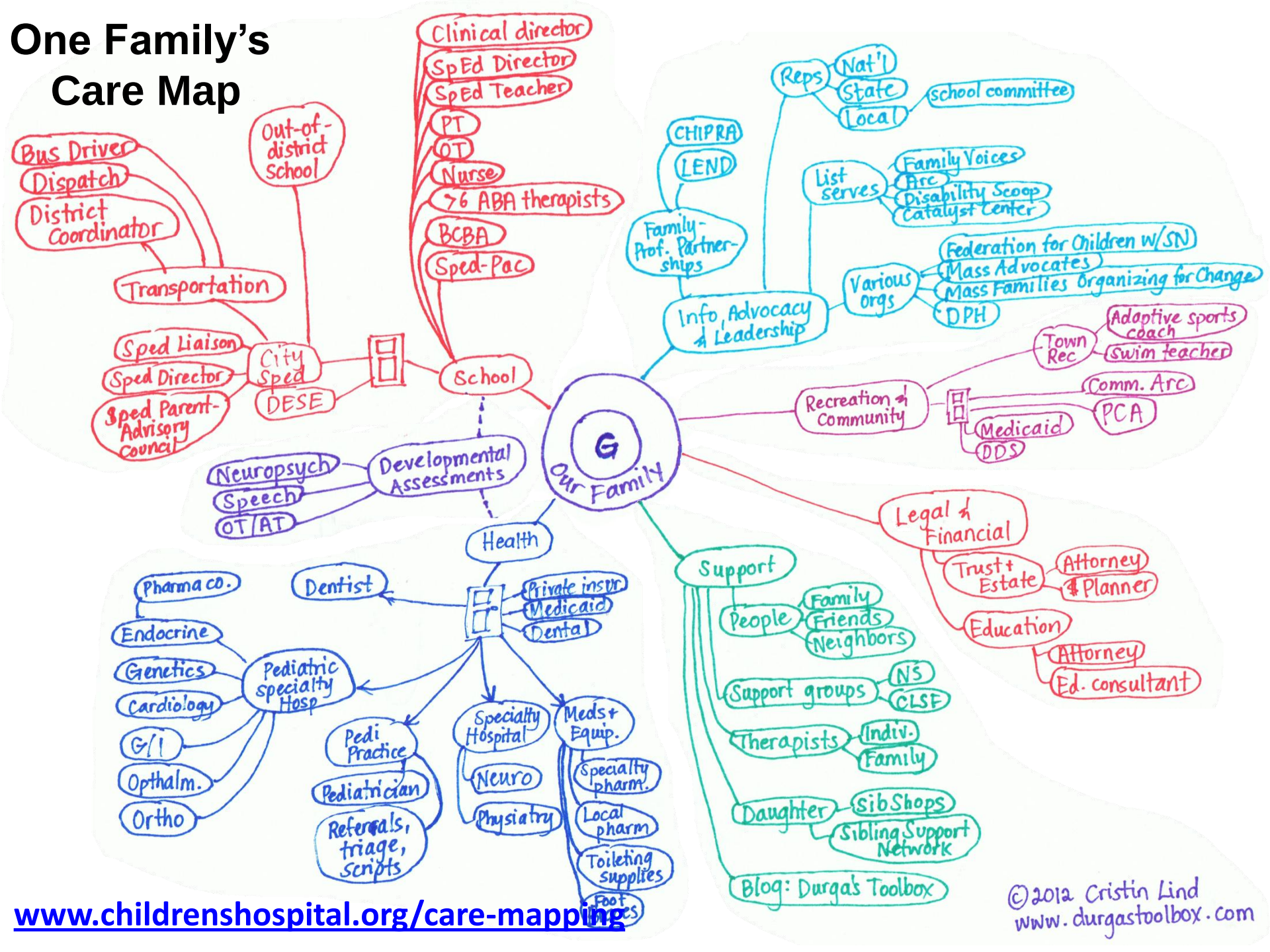
Objectives for Today

- Discuss leveraging integrated care models to promote optimal outcomes
- Strengths of family- and patient-centered Medical Home when part of an integrated system of care
- Special issues for pediatrics, for behavioral health
- Strategic approaches to addressing shared accountabilities, measurement

One Family's Care Map



www.childrenshospital.org/care-mapping

Definition of Integrated Care

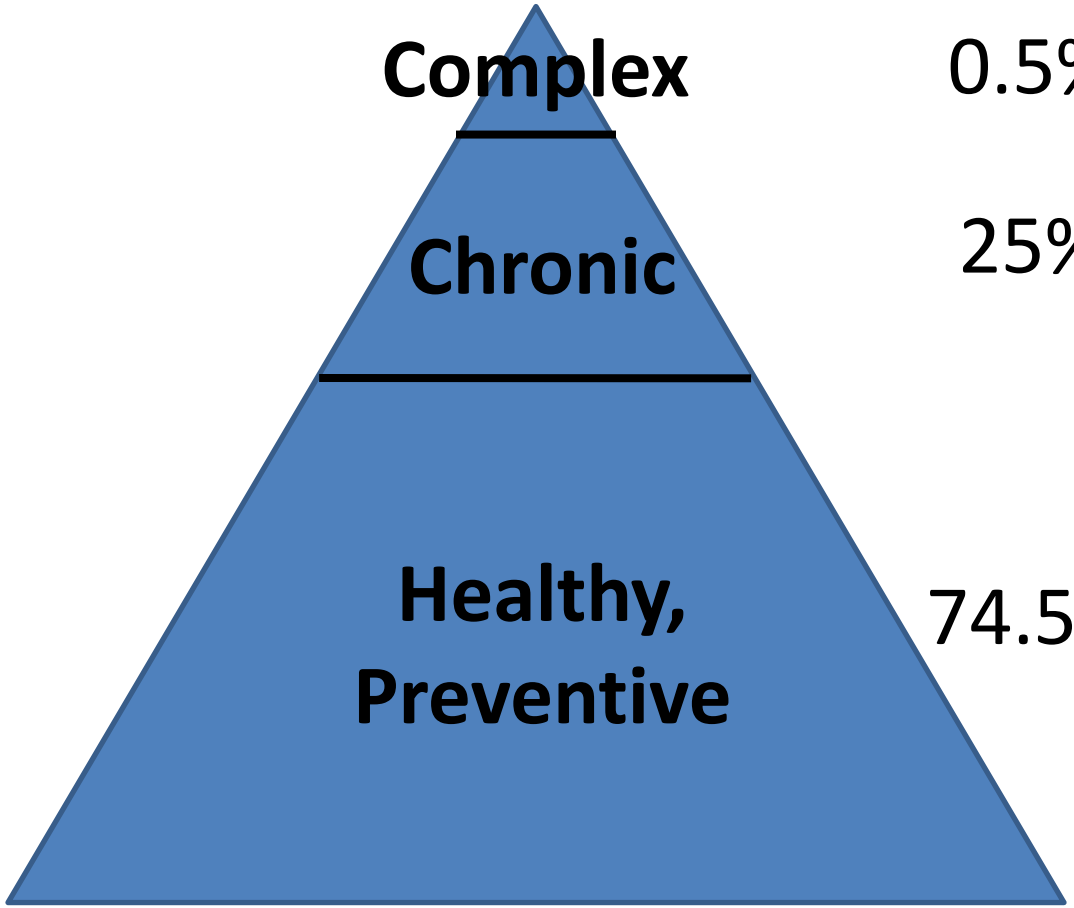
Integrated care
is the seamless provision of health care services, from the perspective of the patient and family, across the entire care continuum.
It results from coordinating the efforts of all providers, irrespective of institutional, departmental, or community-based organizational boundaries.

Antonelli, *Care Integration for Children with Special Health Needs: Improving Outcomes and Managing Costs.*
National Governors Association Center for Best Practices, 2012

Characteristics of an Integrated Health System

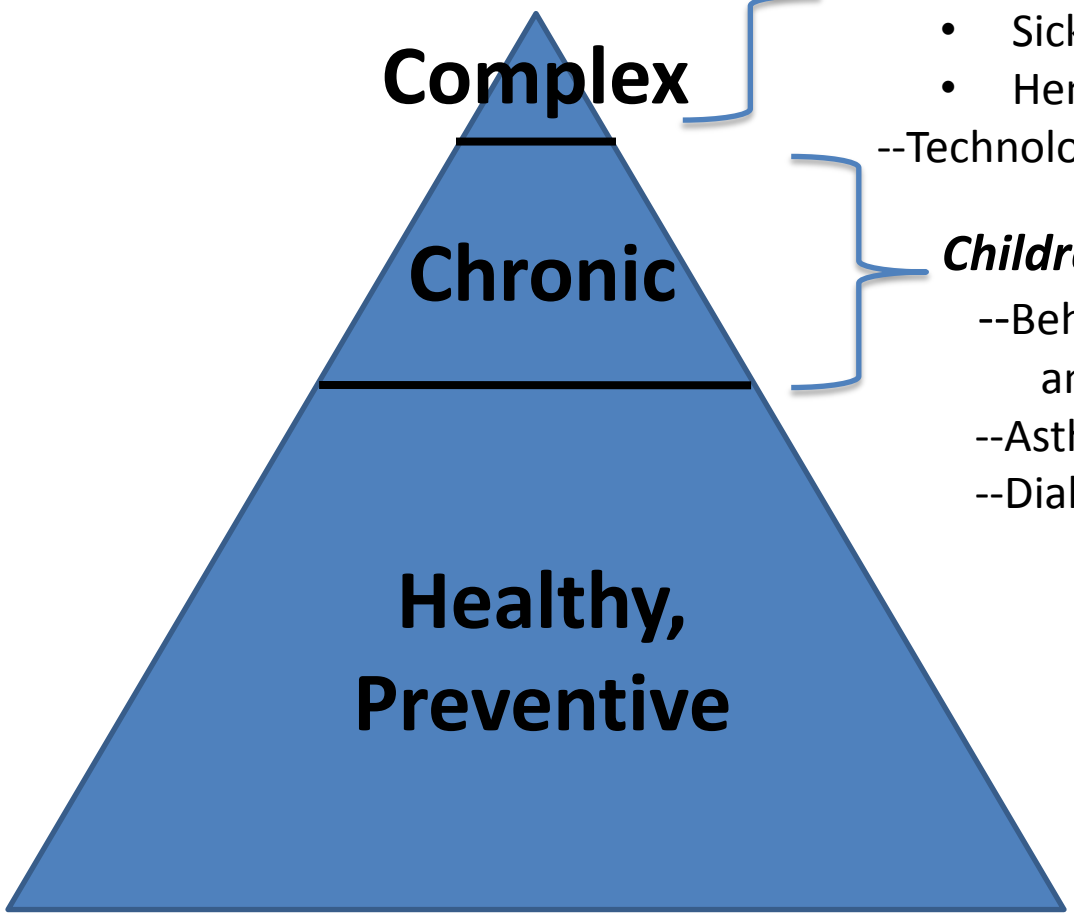
- Patient- and Family-Centered
  - Integrated care plan and transparent communication linkages
- Shared Quality Goals
  - Clinical outcomes aligned across providers
  - Reduced variation in patterns of service delivery
- Shared Fiscal Accountability Across all Stakeholders
  - Community-based
  - Hospital-based
- Patient Receives the Right Care at the Right Time in the Right Place
- Success Requires New Care Models– Integrated Care

Distribution of Pediatric TME



	% of population	% of spend
Complex	0.5%	25%
Chronic	25%	70%
Healthy, Preventive	74.5%	5%

Matching Services to Complexity



Children with complex needs

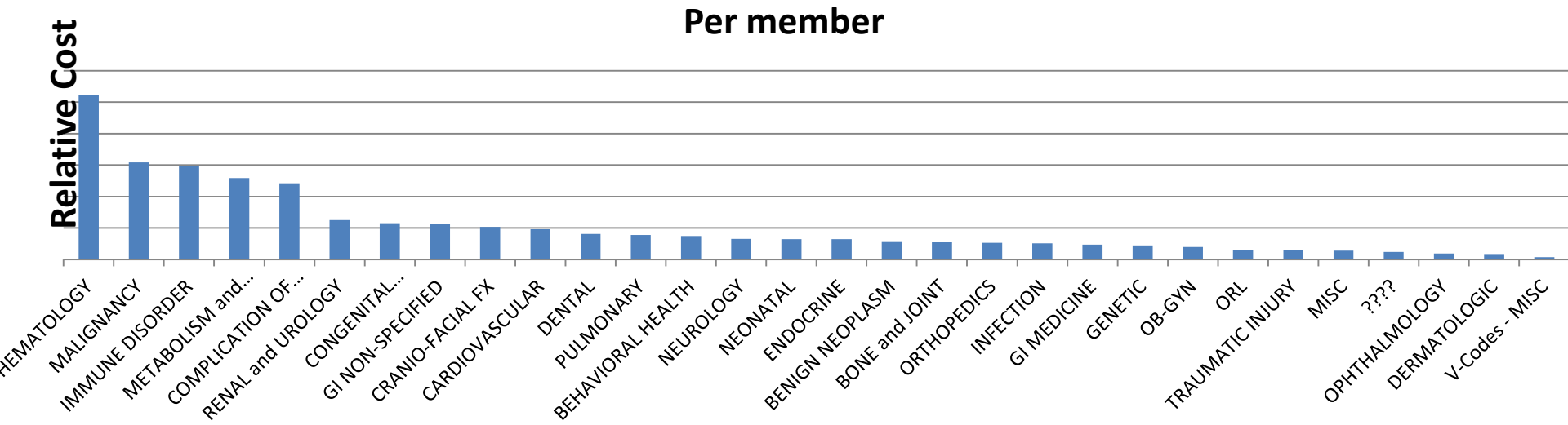
--Neurodevelopmental (Autism, etc.)
--Behavioral/Psychiatric
--Oncology
- Sickle cell
- Hemophilia

--Technology dependent

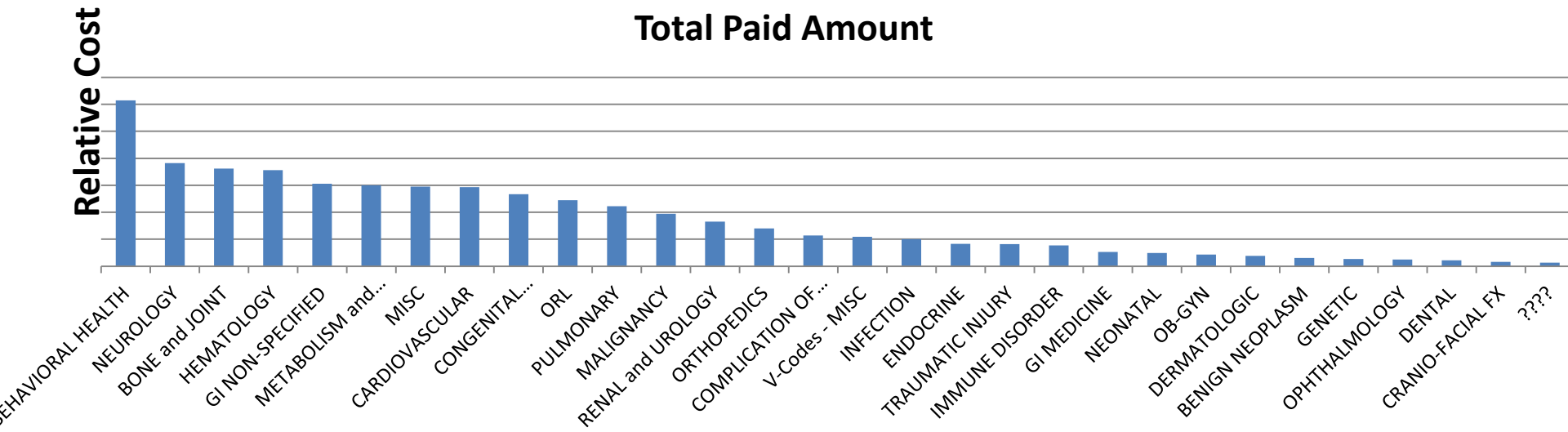
Children with chronic conditions

--Behavioral (ADHD, depression, anxiety, PTSD)
--Asthma
--Diabetes

Costs Per Member are What You Might Expect Based on Complexity



Costs Across Population Reflect Prevalence and Service Needs/ Utilization



Team Based Care
Rethinking Roles

Achieving Optimal Value

Integrated Care for Children with Chronic Conditions

- Team-based care– Patient/ Family driven
- Enhancing F/PCMH performance
- Leverage Technology
  - Telehealth
  - Patient-held tools
  - Provider-based tools
- Enhance Subspecialty “Access”
  - Collaborative Care Models
  - More timely access to actionable information
- Enhance Patient Self-Management Skills

Special Emphasis: Primary and Behavioral Health Care Integration

Integrated Co-located Behavioral Health Care in Primary Care

- The Promise
  - An opportunity to “prevent” illness and de-compensation
  - Better clinical outcomes by leveraging the medical home’s team resources and patient knowledge
- The Facilitators
  - Co-location not sufficient
  - Must support (and measure) CC
  - Engage families in design
  - Engage existing community BH providers
- Challenges
  - Work force training
    - PCP’s, Care Coordinators, Navigators
  - Payor arrangements
    - access, revenue cycle, and costs of care coordination

Care Coordination Improves Care Integration

- CC-- set of activities in “the space between”
  - Visits, Providers, Hospital stays
- CC-- necessary but not sufficient to achieve integration
- Success-- engage all stakeholders– including patients and families– as participants and partners
- USMCHB supported CC Curriculum (work force)
  - MI, OR, FL, CO, AK

Outcomes of CC Measurement

32% of total 3855 CC encounters had something prevented

Of the 1232 CC encounters where prevention was noted as an outcome:

Outcome Prevented	# CC Encounters	Percentage
Visit to Pediatric Office / Clinic	714	58%
Emergency Department Visit	323	26%
Subspecialist Visit	124	10%

62% of RN CC Encounters prevented something

33% of MD CC Encounters prevented something

Non-revenue-generating office nurses drive the most system-level cost savings: avoidance of ED and office visits

National Study of Care Coordination Measurement in Medical Homes
Antonelli, Stille, and Antonelli, 2008

Massachusetts CHIPRA Quality Demonstration Grant Funding

Funded by the Centers for Medicare and Medicaid Services (CMS) through grant funds issued pursuant to CHIPRA section 401(d)

MA Child Health Quality Coalition Care Coordination Framework

Count: # measures identified

Key Elements	Existing	Potl	Gaps
1) Needs assessment, continuing care coord engagement		3	4
2) Care planning and coordination		3	2
3) Facilitating care transitions	6	4	2
4) Connecting with community resources/schools		2	2
5) Transitioning to adult care		3	2

MA Child Health Quality Coalition CC Task Force ***Contact: grogers@mhqp.org***

Funded by the Centers for Medicare and Medicaid Services (CMS) through grant funds issued pursuant to CHIPRA section 401(d)

Implications for Accountability

- Measure at all Levels of the System
  - MA CHIPRA measure development of CC for children with BH needs
- Transparency of Performance
- Incentives Supporting Activities in “Space Between”
  - Education of work force– multidisciplinary
    - Nursing, social work, Community Health Workers
  - Support for performing Care Coordination which results in value
  - Need “Safe Space” for testing CC measures
- Support both short and long term ROI capture for pediatrics

Accountability Framework Pediatric CC

Levels of Accountability	Measures
Child/Family	
Community/Schools	
Group Practice/Medical Home (Primary Care) Individual Providers	
Psychiatric and Other Specialty Practices Individual Providers (Sub-specialists)	
Community-Based Organizations Community Service Agencies (CSAs), Other Service Providers (EI, CSA, rehab)	
Inpatient Facilities	
Health Systems/ACOs	
Health Plans	
State	
National/Regional	

Lessons from
Pediatric Medical Home Pilots

MA MH Learning Collaborative Lessons Learned

- Med Home LC aligning three key system components
  - Primary care (first contact, comprehensive)
  - AAP Med Home (family centered, culturally competent, community based)
  - Chronic care model (primary care practice as part of a system
    - team based care
    - population management
    - Collaborative care (links PCP's and subspecialists)
      - decision support
- Systems based on primary care have better outcomes and lower cost.
- Principles of chronic care management (including behavioral health issues such as depression) also have better outcomes and lower cost.

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MA MH Learning Collaborative Lessons Learned

- Our CHIPRA MH effort has:
  - Built the capacity of team-based care
    - Need QI skills, culture for team-based care
    - When practices challenged with meaningful measures, found them valuable to drive change
  - Enhanced capabilities to screen for behavior and developmental concerns, make referrals and measures to track that the referrals took place—no mean feat.
  - Enhanced ability of primary care practices to assess and manage common behavioral health concerns, e.g., ADHD.

Addressing Transitions

- Identify elements of “high quality” referrals
  - including information needed at transition points
  - timely transmission of information back to the PCP setting
  - family participation
- **Tracking “closing the loop”** with referrals to outside behavioral health entities a high-priority gap
- Addressing **transitions in and out of programs** (e.g. aging out of Early Intervention services, moving from DMH residential services back into community) a significant issue
- **Transitioning to adult care** a special issue in pediatrics: importance of teaching self-care and communication skills early. Shared accountabilities for transition with adult providers.

What Is Needed in MA?

- Community-Based Solutions (Strengthening the "Neighborhood"
  - Info Line 211 Help Me Grow
- Technology
  - Telehealth
  - Resource directory (eg, Help Steps)
- Payment models which support care integration
- Family engagement as system designers
  - Especially vital in our CHIPRA BH work
- Training and support for all stakeholders

Strategic Approach to Measurement

- Promote measures of care integration–
  - Experience, not just patient satisfaction
  - Patient and family-reported– Sara Singer; adult
  - Child health in development (recent Lucile Packard Foundation for Children's Health grant)
- Promote testing and implementation of disruptive measures
  - "close the loop" looking at each side of "hand-offs"

Payment Models

- Fee-for-Service does not encourage shared accountability
  - Generally does not value care coordination efforts (especially by non-MD providers)
- Global budgets have potential, but must be risk adjusted for both medical and non-medical determinants of health outcomes
- Fee-for-service, adjusted global budgets, monthly care coordination (pmpm) showing some promise

Key Messages

- No magic bullet – a range of models can work; need culture change and workforce development to achieve shared accountabilities, authentic partnerships
- Payment models w/ bundled payments enabling care coordination and other services for identified populations at core of achieving optimal value
- Medical Home is a <u>necessary</u> component of a high performing health care system, but it is <u>not</u> sufficient to deliver optimal value outcomes
- Need to promote testing of measures embedded into QI perspectives that operationalize shared accountabilities
- Don’t ignore the long-term -- benefits from whole family, life course, prevention, population-based strategies

Key Messages

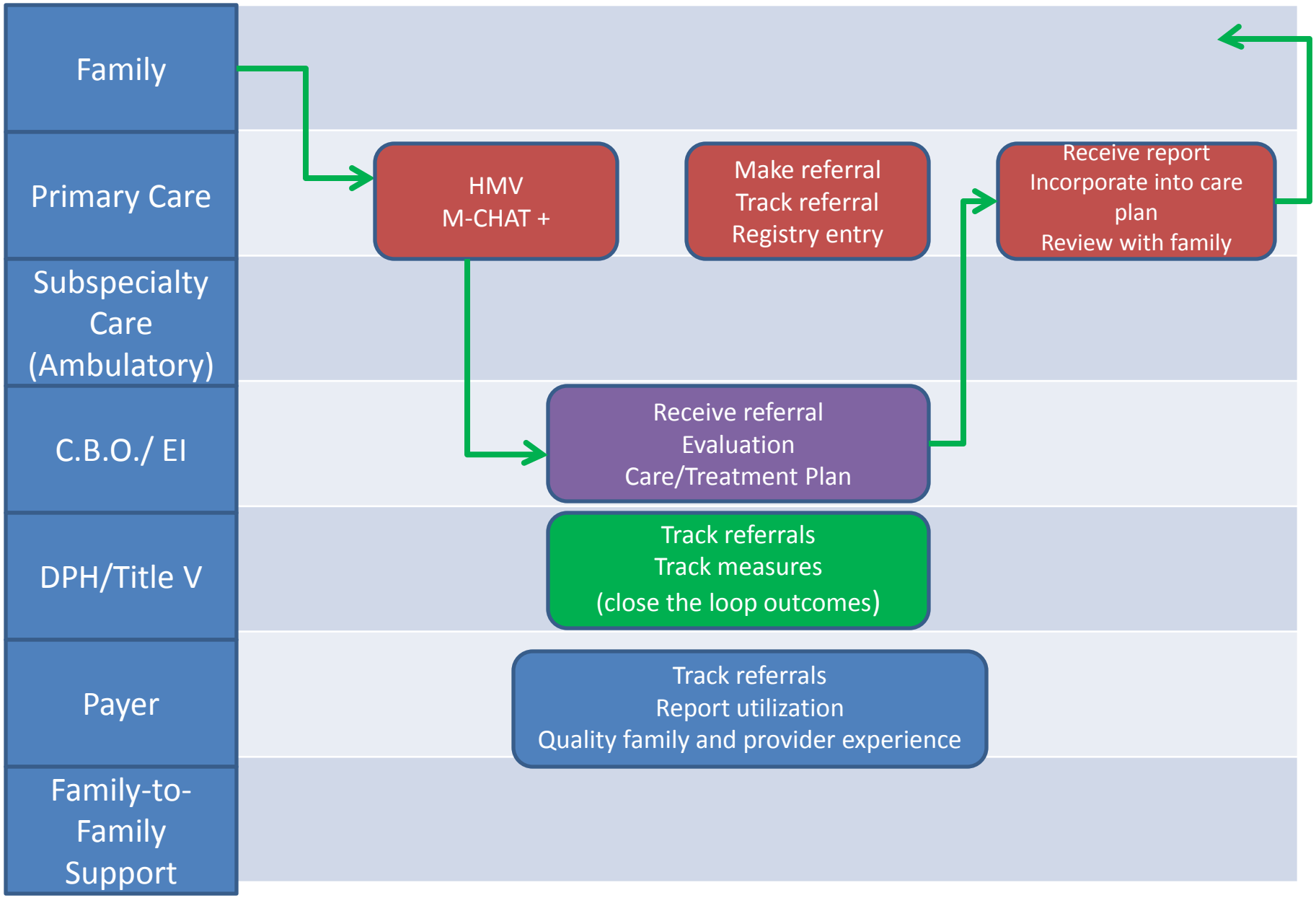
- Families as authentic partners
  - “do with, not to; not for”!
  - “Time to raise the bar!”
- Implement CC Framework (all domains, save #5) are age and organ-system agnostic)
- Promote testing of CC measures
  - Usability and feasibility
  - Pay-for-Reporting/ Participation, before Pay-for-Performance
  - Parity of behavioral and medical care will align public and commercial payer strategies
- Resources to support CC capacity building
  - Care coordination workforce
    - Care coordinators which support primary care and behavioral health integration
    - Community Health Workers, Title V – MA DPH
    - Case management, family partners – MA DMH
  - Community resource and referral center capacity
  - Recognition that CC activities, measures, and accountabilities occur at different foci

Appendix

Medical Homes: Adults & Children

- It began with children… *Statement of the AAP Ad-Hoc Committee on the Medical Home, 1992*
- More similarities than differences
- Looking to identify special issues for children that can serve as an overlay to work defining high value elements of medical home transformation more globally
  - Lessons learned from pediatric practices participating in the Massachusetts' CHIPRA Medical Home Learning Collaborative

Integrated Model: Accountabilities Across All Stakeholders
New Measurement Approaches, Measure Bundles



MA CHIPRA Quality Demonstration Grant

Support the development and maintenance of an integrated approach to measurement and improvement across all settings of child health care delivery that will lead to transformational gains in children's health and outcomes

- Core Measures: testing a set of pediatric measures with reporting to practices and families
- Medical Home Learning Collaborative: trans-formation support and spread efforts
- MA Child Health Quality Coalition: advocacy, care coordination task forces, measure development

MassHealth | Boston Children's Hospital | MHQP Massachusetts Health Quality Partners *trusted information. quality insights.* | NICHQ National Initiative for Children's Healthcare Quality | Commonwealth Medicine UMASS Medical School *Applied Knowledge in Public Service*

MA Child Health Quality Coalition

- Broad-based public-private partnership
- 60 members representing specific stakeholder groups
- 5 Grant Partners
- Co-Chairs:
  - Carolyn Langer, MD, Chief Medical Officer, MassHealth
  - Andrew Balder, MD, Baystate Mason Square Neighbor-hood Health Center

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CHIPRA Medical Home Learning Collaborative

13 diverse practices across the Commonwealth

Driver Diagram:

- Family and Youth Centered Care
- Comprehensive Coordinated Care
- Linkage to and Mobilization of Community Resources
- Systems Improvement
- Medical Home Care Team
- Engaged Leadership

NICHQ
National Initiative for Children's Healthcare Quality

Funded by the Centers for Medicare and Medicaid Services (CMS) through grant funds issued pursuant to CHIPRA section 401(d)

Linking to Community Resources

- **Heightened priority for children/youth**, including linkages to schools/day care, after school, recreation
- Addressing medical and psychosocial issues; must be **systematic assessment of community referral needs**
- Importance of **connections to family support organizations**: partners to help navigate system, build capacity to participate
- Big **challenges creating two-way communication channels** with community-based organizations
- Identify **opportunities to reduce duplication** of efforts in building knowledge of available community services; promise of centralized resources like
  - 211/Help Me Grow/ Warmlines models

A Framework for High Performing Pediatric Care Coordination

Care Coordination Competencies:

1. Develops partnerships
2. Proficient communicator
3. Uses assessments for intervention
4. Facile in care planning skills (PFC)
5. Integrates all resource knowledge
6. Possesses goal/outcome orientation
7. Approach is adaptable & flexible
8. Desires continuous learning
9. Applies solid team/building skills
10. Adept with information technology

Care Coordination Functions:

1) Provide separate visits & CC interactions
2) Manage continuous communications
3) Complete/analyze assessments
4) Develop care plans (with family)
5) Manage/track tests, referrals, & outcomes
6) Coach patient/family skills learning
7) Integrate critical care information
8) Support/facilitate all care transitions
9) Facilitate PFC team meetings
10) Use health information technology for CC

Antonelli, McAllister, Popp. **Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework**. The Commonwealth Fund, May 2009

CC Framework: Linking to Measures

Key Elements	Measures
(1) Needs assessment for care coordination and continuing engagement • Family-driven, youth-guided needs assessment, goal setting • Use a standard process to assess care coordination needs (differs from clinical needs • Engage team, assign clear roles and responsibilities • Develop authentic family-provider/care team partnerships; requires family/youth capacity building, professional skill building	
(2) Care planning and communication • Family and care team co-develop care plans • Ensure communication among all members of the care team • Monitor, follow-up, respond to change, track progress toward goals • Workforce training occurs that promotes effective care plan implementation	
(3) Facilitating care transitions (inpatient, ambulatory) • Family engagement to align transition plan with family goals, needs • Use Implement components of successful transitions (8 elements of a family-driven/youth guided care transition, including receiving provider acknowledging responsibility) • Ensure information needed at transition points is available	
(4) Connecting with community resources and schools • Facilitate connection to MA family-run org or Family Partner • Coordinate services with schools, agencies, payers • Identify opportunities to reduce duplication of efforts in building knowledge of available community services	
(5) Transitioning to adult care • Implement Ctr for Health Care Transition Improvement's Six Core Elements • Teach/model self-care skills, communication skills, self-advocacy	

Source: ***MA CHQC CC TF***

MA Child Health Quality Coalition TF References: Alignment Across Constituencies

Key References for Care Coordination Frameworks and Measures

Frameworks	Inventory of Measure Sets
• **AHRQ Care Coordination Atlas** (McDonald Nov 2010) and companion document **Care Coordination Accountability Measures for Primary Care Practice** (McDonald Jan 2012) – Chapter 3. Care Coordination Measurement Framework, Table 1. Mechanisms for Achieving Care Coordination (Domains) • **Commonwealth/Antonelli Pediatric Framework** (May 2009) – Antonelli R, McAllister J, Popp J. Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework. The Commonwealth Fund. May 21, 2009. Functions of care coordination: p. 10-11 • **System of Care/Wraparound Framework** – Stroul, Blau, Friedman. **Updating the System of Care: Concept and Philosophy**. Georgetown Center for Child and Human Development. 2010. System of care components and 13 guiding principles: Table 1 (p 6) – National Wraparound Initiative: http://www.nwi.pdx.edu/ –Wraparound Fidelity Index (WFI), Team Observation Method (TOM), Child and Adolescent Needs and Strengths (CANS) • **NCQA Meaningful Measures of Care Coordination** – Scholle SH. **Care Coordination Measurement Approach. Meaningful Measures of Care Coordination**. NCQA National Committee on Vital and Health Statistics. October 13, 2009. • **National Quality Forum (NQF), National Priorities Partnership (NPP) – Measure Application Partnership (MAP)** – **Care Coordination Family of Measures** (request for public comment August 10, 2012) – **Sample Measurement Cascade/Accountability Framework**: p. 20 in NQF/NPP. *The Role of Performance Measurement.* ldihealtheconomist.com/media/janet_corrigan_slides.pdf	– NCQA Healthcare Effectiveness Data and Information Set (HEDIS) (selected measures applicable to pediatric care coordination) – NQF-Endorsed 12 Care Coordination measures (August 2012) – NQF-Endorsed Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination (NQF 2010) – Physician Consortium for Performance Improvement (PCPI) (AMA-convened) Care Transitions Measurement Set (2009) and STAAR – Medicaid Meaningful Use Measures (Stage 1) (for incentive payments for EHR adoption) – NCQA's Patient-Centered Medical Home (PCMH) and new Accountable Care organization (ACO) Accreditation Programs – MA Statewide Quality Advisory Committee (SQAC) recommended measure sets; MassHealth Comprehensive Primary Care Payment Reform potential list of metrics (p. 5-6) **Practice-based surveys** – Medical Home Care Coordination Measurement Tool (CCMT) – Center for Medical Home Improvement (CMHI) Medical Home Index (MHI) – Primary Care Assessment Tool (PCAT-PE, PCAT-FE) – Medical Home Health Care Transition Index (HCTI) – Behavioral Health Integration Needs Assessment (survey developed for the MA Patient-Centered Medical Home Initiative) **Family/patient experience surveys** – National Survey Children w/ Special Health Care Needs (NS-CSHCN) – MHQP Ambulatory Patient Experience Survey (PES) – NQF-Endorsed 3-item Inpatient Care Transition Questions (CTM-3) – Families and Communities Together (FCT) Parent Satisfaction Svy – Medical Home Family Index (MHFI), companion to CMHI – Family-Centered Care Self-Assessment Tool (Family Voices/MCHB) – Patient Activation Measure (PAM) (Hibbard et al) – The Right Question Effective Patient Strategy™

References

AHRQ Care Coordination Atlas (McDonald Nov 2010) and companion document **Care Coordination Accountability Measures for Primary Care Practice** (McDonald Jan 2012)

Commonwealth/Antonelli Pediatric Framework (May 2009)
- Antonelli R, McAllister J, Popp J. Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework. The Commonwealth Fund. 2009

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- Stroul, Blau, Friedman. **Updating the System of Care: Concept and Philosophy**. Georgetown Center for Child and Human Development. 2010. System of care components and 13 guiding principles: National Wraparound Initiative: http://www.nwi.pdx.edu/

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