Care Integration
What Is It?
Can It Be Measured?

One Care Implementation Council

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TEACHING HOSPITAL

Disclosures

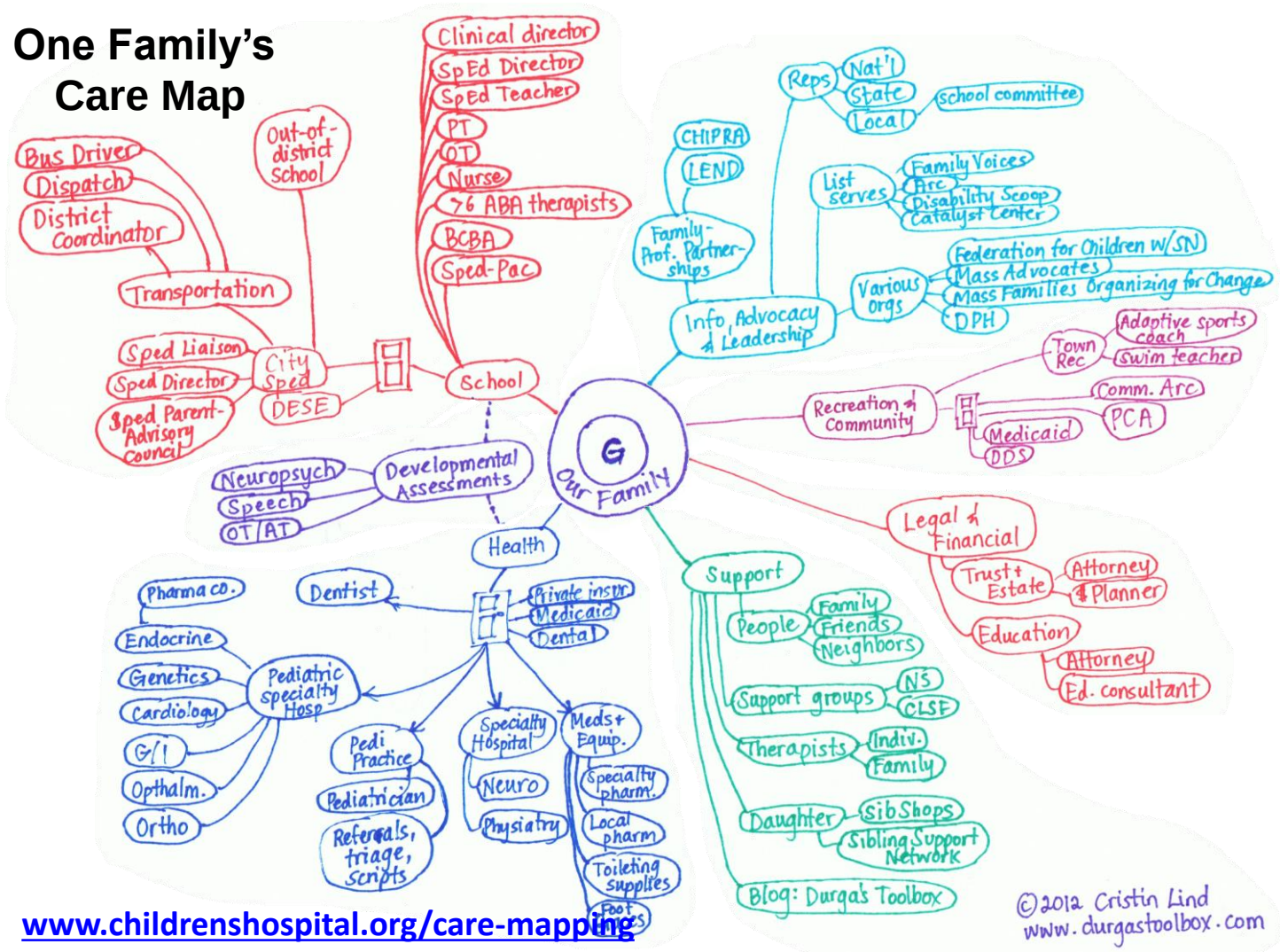
- No financial disclosures
- No conflict of interest

Learning Objectives

- Open Discussion: These are my own views!

- Understand the critical role of care integration in improving care
- Distinguish Care Integration from Care Coordination

One Family's Care Map



www.childrenshospital.org/care-mapping

Complexity Includes Social, Medical, Behavioral

analysis by R. Antonelli

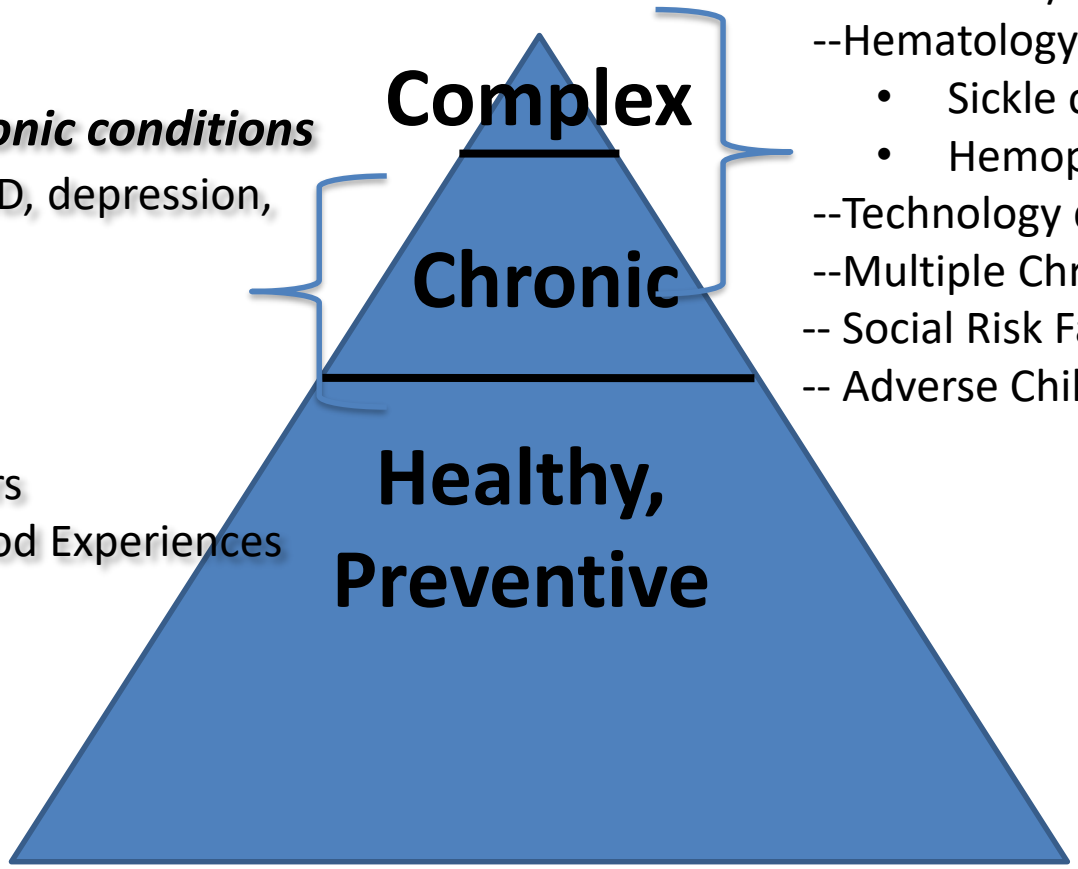
Children with complex needs

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

--Technology dependent
--Multiple Chronic Conditions
-- Social Risk Factors
-- Adverse Childhood Experiences

Children with chronic conditions

--Behavioral (ADHD, depression, anxiety, PTSD)
--Asthma
-- Obesity
--Diabetes
-- Social Risk Factors
-- Adverse Childhood Experiences



Value–Based Payment Models for Medicaid Child Health Services
Michael Bailit and Marge Houy, *United Hospital Fund – July 12, 2016*

Integrated Care

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

Care Coordination

activities in “the space between”- Visits, Providers, Hospital Stays that co-create (with patient and family) and implement a plan of care

2014 AAP Policy Statement: Patient-and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems

Domains of Integrated Care

Align with Quadruple Aim– Better Health, Better Care, Less Cost Per Capita

- Person, Patient, Family, Caregiver Experience
- Care Coordination
  - Closing the Loop
  - High Quality Handoffs
  - Care Tracking
  - Care Planning
- Utilization and Financial Outcomes
  - Admissions, readmissions, Emergency Dept utilization
- Provider Experience

Family Experience Measurement: Integrated Care Versus Care Coordination

PICS vs FECC

PICS: Care Planning Domain	FECC: Protocols/Plans Domain
1. In the past 12 months, how often have your child's care team members talked with you about specific goals for your child's health care? 2. In the past 12 months, has a member of your child's care team documented these goals in the form of a written care plan? 3. Did you and/or your family members contribute to the content of this written care plan? 4. In the past 12 months, was this written care plan easily accessible to you? 5. Was this care plan written in a way that you could easily understand? 6. In the past 12 months, has someone on your child's care team regularly updated this written care plan to reflect changes and progress?	1. Child has shared care plan. 2. Child has written transition plan. 3. Child has emergency care plan. Source: AHRQ FECC Measure Set

2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

- National Core Indicators (NCI) Survey. This survey assesses the experience and outcomes of individuals with intellectual and developmental disabilities and their families

Patient Perception of Integrated Care- PPIC
https://www.hsph.harvard.edu/ppic/ppic-resources/the-survey/

Patient Perceptions of Integrated Care Items by Psychometrically-derived Constructs

Item #	
Provider knowledge about the patient	
9	In the last 6 months, how often did you have to repeat information that you had already provided during the same visit?
10	In the last 6 months, how often did this provider seem to know the important information about your medical history?
17	How would you rate this provider's knowledge of your values and beliefs that are important to your health care?
46	In general, how often does the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?
47	In general, how often did you have to remind the provider named in Question 1 about care you received from specialists?
Staff awareness of information about the patient	
21	In the last 6 months, how often did these other staff seem up-to-date about the care you were receiving from this provider?
22	In the last 6 months, how often did these other staff talk with you about care you were receiving from this provider?
23	In the last 6 months, how often did these other staff seem to know the important information about your medical history?
Provider communication with the patient	
4 & 5	Some offices remind patients about their appointments. Before your most recent visit with this provider, did you get a reminder from this provider's office about the appointment? Before your most recent visit with this provider, did you get instructions telling you what to expect or how to prepare for the visit?
8	In the last 6 months, when you missed an appointment with your provider, how often did someone from his or her office contact you to make a new appointment?
11	In the last 6 months, how often did this provider ask about things in your work or life at home that affect your health?
18 & 19	In the last 6 months, did this provider talk with you about setting goals for your health?In the last 6 months, did the care you received from this provider help you meet your goals?
29 & 30	In the last 6 months, did this provider or someone in his or her office ask you about these things that make it hard for you to take care of your health? In the last 6 months, did you and this provider or someone in his or her office come up with a plan to help you deal with the things that make it hard for you to take care of your health?
31	In the last 6 months, how often did this provider or someone in his or her office help you identify the most important things for you to do for your health?
33	In the last 6 months, how often did this provider or someone in his or her office help you get these services at home to take care of your health?
34 & 36	In the last 6 months, did this provider or someone in his or her office give you instructions about how to take care of your health? In the last 6 months, how often did the instructions you received help you take care of your health?
39	In the last 6 months, how often did this provider or someone in his or her office talk with you about how you were supposed to take your medicine?
41	In the last 6 months, how often did this provider or someone in his or her office talk with you about what to do if you have a bad reaction to your medicine?
42	In the last 6 months, how often did this provider or someone in his or her office contact you between visits to see how you were doing?
49	In general, how often does the provider named in Question 1 talk with you about the medicines prescribed by these specialists?
Integration post visit	
25	In the last 6 months, when this provider or someone in his or her office ordered a blood test, x-ray, or other test for you, how often did this provider or someone in his or her office follow up to give you those results?
26	In the last 6 months, how often did you have to request your test results before you got them?
27	In the last 6 months, how often were these test results presented in a way that was easy to understand?
Integration with specialists	
50	These questions ask about care you received from the specialist you saw most often in the last 6 months outside of the office of the provider named in Question 1. When you see this specialist, does he or she seem to know enough information about your medical history?

NCI, https://www.nationalcoreindicators.org/upload/core-indicators/2017_IPS_MA_MAR2020.pdf

Individual Outcomes Domain

Sub-domain	Concern Statement
Work	People have support to find and maintain community integrated employment.
Community Inclusion, Participation and Leisure	People have support to participate in everyday community activities.
Choice and Decision-Making	People make choices about their lives and are actively engaged in planning their services and supports.
Self Determination	People have authority and are supported to direct and manage their own services.
Relationships	People have friends and relationships.
Satisfaction	People are satisfied with the services and supports they receive.

Health Welfare and Rights Domain

Sub-domain	Concern Statement
Safety	People are safe from abuse, neglect, and injury.
Health	People secure needed health services.
Medications	Medications are managed effectively and appropriately.
Wellness	People are supported to maintain healthy habits.
Respect/Rights	People receive the same respect and protections as others in the community.

System Performance Domain

Sub-domain	Concern Statement
Service Coordination	Service coordinators are accessible, responsive, and support the person's participation in service planning.
Access	Publicly funded services are readily available to individuals who need and qualify for them.

Psychiatric Services Taking Issue

Measurement That Matters—Joy in the Village!

Jeffrey S. Schiff, M.D., M.B.A., and Richard C. Antonelli, M.D., M.S.

May 2019https://doi.org/10.1176/appi.ps.70503

Integrated Learning Approach to Measure Selection and Utilization

Opportunity for our CC Academy

- "**Fit for purpose**" implementing measures designed to evaluate the care of an individual child and simultaneously aggregating those scores to evaluate a clinical program, institution, or state system
- "L**earning health systems**" **approach--** de-emphasize data collection burden and focus on what can be learned by comparing outcomes across populations and systems
  - Performance assessment at macro and subsystem levels.
  - Providers judged by rate of collection of the measures and their subsequent response to lessons derived from performance on those measures.
  - The learning systems would generate action steps for interdisciplinary teams, and the results of improvement interventions would be tracked.
- Emphasis would be placed on activities that integrate care across settings and disciplines and on the processes of care that are most likely to yield high-value results.

Opportunities to Transform Care– COVID19

- Broad acknowledgement that disparities are critical to measure and mitigate
- Recognition that Virtual Care MUST be sustained
  - Optimize the implementation to measurably improve Care Coordination and care Integration for CYSHCN and CMC
- Demonstrate Added Value of Virtual Care, not just equivalency
- Document those criteria for which Virtual Care is indicated
  - Behavioral/ Developmental
  - Complex care management and care plan design and execution
  - Rural access

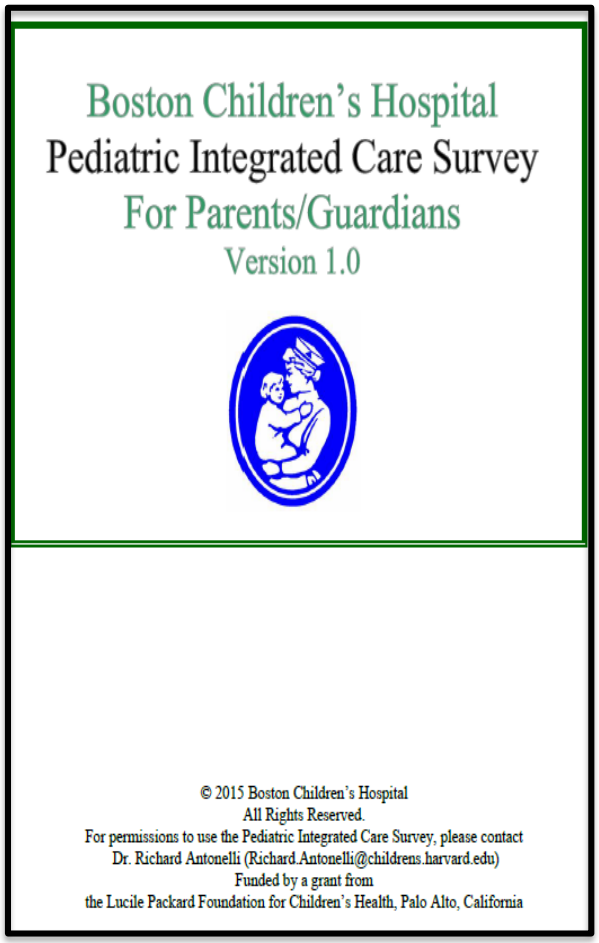
Pediatric Integrated Care Survey (PICS)

Five Core Domains

- Access to Care
- Communication with Care Team
- Family Impact
- Care Goal Creation/ Planning
- Team Functioning/Quality

Validated Assessment of Experience of Integration for Medical, Behavioral, Social, Educational, Family Support

- Core Instrument (48 questions, 19 validated for ranking)
  - Generally takes families 15 minutes to complete
- Modules
  - Module 1: Transition to Adult Care
  - Module 2: Care Plan
  - Module 3: Integrator
  - Module 4: Burden
  - Module 5: School and Services Through IEP
- Supplementary Questions



Boston Children's Hospital Integrated Care Program

www.childrenshospital.org/integrated-care-program

Action Grid– What Does Care Coordination Look Like?

- Used to:
  - Identify goals and actions
  - Delegate tasks and timelines to the most appropriate care team members
- Helps patients and families to have a better understanding of expectations, next steps, and "big-picture" view of how their care is coordinated.

Goal What is action contributing to?	Action What needs to be completed?	Who Who is responsible for completing action?	When What is the timeline that the action needs to be completed?	Contingency If there is an issue or barrier, what are next steps?
Complete necessary genetic testing	Lab orders will be placed for ### Test	Genetics - Dr. Bodamer	One month	Parents should contact Dr. Bodamer's office (123-456-7890) if unable to complete testing within one-month's time
Maintain stable blood sugar	Test blood sugar 3 times per day and control with small, frequent meals	Parents, with guidance from Endocrinology and Nutritionist	Daily, beginning immediately and to continue until reassessed at next Endocrinology appointment	Blood sugars between XXX and XXX should be reported to Dr. Example's office (123-456-7890). If a sugar is over XXX, parents will bring patient to the nearest Emergency Department
Take medication for epilepsy as prescribed	Order for medication will be sent to Longwood Galleria	Neurology, with follow up phone call by Nurse Jane Doe	RX to be started no later than 3/7/2020 and should continue until next appointment unless otherwise noted	Please call Nurse Jane Doe if any problems arise with the prescription at 123-456-7890
IEP documentation request will be updated with school system	Required school documentation and phone call to Teacher Smith	Neuropsychology and Teacher	Two weeks from most recent visit: XX/XX/XXXX	Teacher Smith should contact patient's parents with any noticeable adverse changes in behavior or understanding

Courtesy of Olaf Bodamer, MD, PhD

Take Home Points

- Integration is Essential for Achieving Optimal Value– evidence
- Care Coordination is Necessary but not Sufficient to Achieve Integration
- CC is the set of activities which occurs in “the space between”
  - Visits, Providers, Hospital stays, Agency contacts
- Only way to succeed is to engage all stakeholders– including patients and families– as participants and partners
- Medical Home is a necessary, but not sufficient, component of high performing system