Walking before Running:
Developing Care Coordination Capacity to Achieve High Value Outcomes for Patients with Behavioral Health Needs

Presenter:
Richard Antonelli, MD, Medical Director, Integrated Care and Physician Relations and Outreach
Boston Children's Hospital
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Key topics to be addressed include:

- Principles of care coordination in relation to different models of integrated care
- Key care coordination activities and core competencies
- Methods for measuring care coordination and associated outcomes
- Issues and opportunities related to how care coordination is financed in both Fee For Service and alternative payment models

Why is this important?

Case Study
Behavioral Health
Care Fragmentation

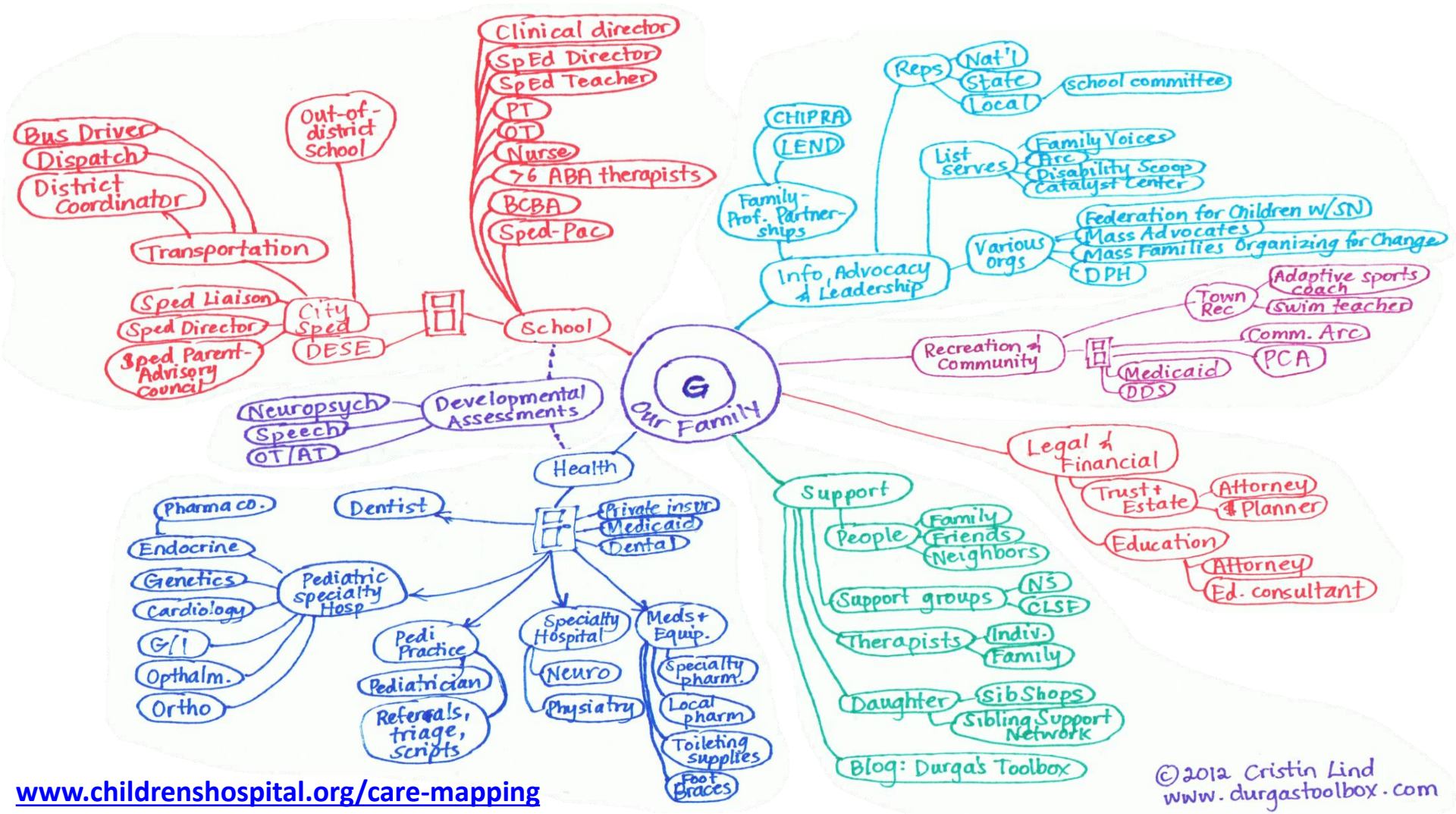
4-year-old Hispanic boy with developmental delay, initial visit for well child care

Triple Aim

- Improving the patient experience of care
- Improving the health of populations
- Reducing the per capita cost of health care

Source: Institute for Healthcare Improvement. [http://www.ihi.org]. 2014

One Family's Care Map



www.childrenshospital.org/care-mapping

National Statistics

Societal Impact

- 30% of American health care spend is ineffective, inefficient, harmful, or inappropriate care

Family Impact*

Nearly 1 in 5 CSHCN have health conditions which have caused financial problems for the family.

Daily activities are greatly impacted for the nearly half of CSHCN with emotional, behavioral, or developmental problems.

One-quarter of all CSHCN have families who cut back or stopped working due to their child's health needs.

Nearly a quarter of CSHCN have families who spend 5+ hours per week providing and/or coordinating their child's health care.

Multi-disciplinary, team-based care*

Nearly 1 in 3 CSHCN experience some emotional, behavioral, or developmental health problems in addition to other health conditions.

Co-morbidity of health conditions is common—29.1% of CSHCN have 3 or more conditions asked about in the survey.

*Data Resource Center for Child & Adolescent Health, a project of the Child and Adolescent Health Measurement Initiative, http://cshcndata.org

Principles of care coordination in relation to different models of integrated care

Medical Homes

will not be successful in achieving optimal value unless there is integration of care across the continuum, from the perspective of the patient and family.

IN OTHER WORDS…
MEDICAL HOME IS NECESSARY BUT NOT SUFFICIENT.

Care Coordination

Care Coordination is the set of activities in “the space between”- Visits, Providers, Hospital Stays

Turchi RM, Antonelli RC et al. Patient- and Family-Centered Care Coordination: A Framework for Integrating Care For Children and Youth Across Multiple Systems. *Pediatrics*. May 2014.

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.

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

A Core Element of Integration: Care Coordination

Pediatric care coordination is a patient- and family centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families.

Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

Source:
MAKING CARE COORDINATION A CRITICAL COMPONENT OF THE PEDIATRIC HEALTH SYSTEM: A MULTIDISCIPLINARY FRAMEWORK
Antonelli, McAllister, and Popp, The Commonwealth Fund, May 2009

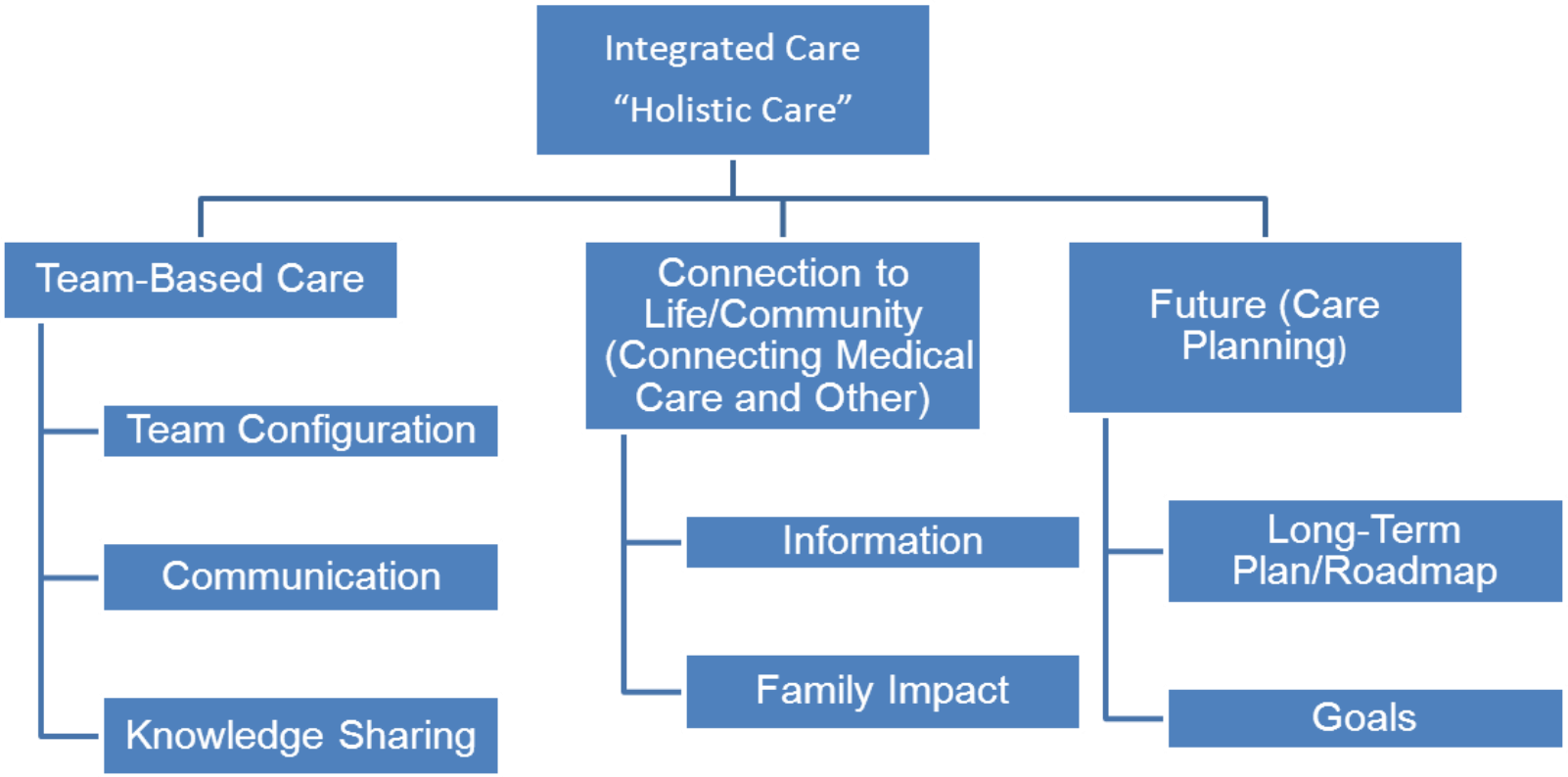
A Qualitative Study of Families with Children Seeing Multiple Health Care Providers

Aims were to:

- Gather experiences of parents/guardians with Children and Youth with Special Health Care Needs (CYSHCN)
- Explore and define how families who have children with multiple care providers perceive care integration and assess how well their child's care is integrated

Funded by Lucile Packard Foundation for Children's Health

Parent-reported “integrated care” domains



Funded by Lucile Packard Foundation for Children’s Health

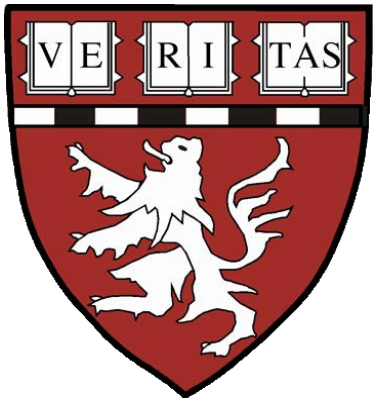
Results of study

- The majority of families reported that they don't perceive their child's care to be as integrated as they would like it to be.
- Families described the role of the integrator as a central point of contact for a child, his/her family and his/her care providers.
- Based on our operational definition of integrator, families report that the PCP does not always play the role of the integrator.
- Different models work for different families.

Funded by Lucile Packard Foundation for Children's Health

Family Experience
of CC Supporting Behavioral Health Needs

Parent / Professional PPAL Advocacy League



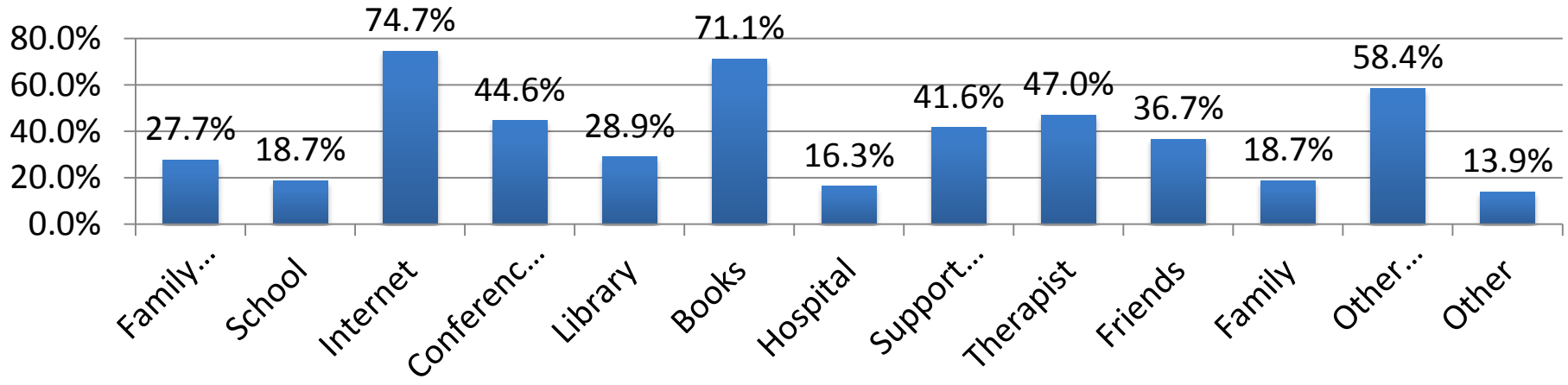
Family Experience of CC Supporting Behavioral Health Needs

Domain	Question	Responses*
Care Coordination/ Communication	Do you have help with communication and coordination of care amongst your child's medical & mental health providers and non-physician providers?	Yes: 34.2% No: 59.5% Don't Know: 6.3%

Family Experience of CC Supporting BH Needs

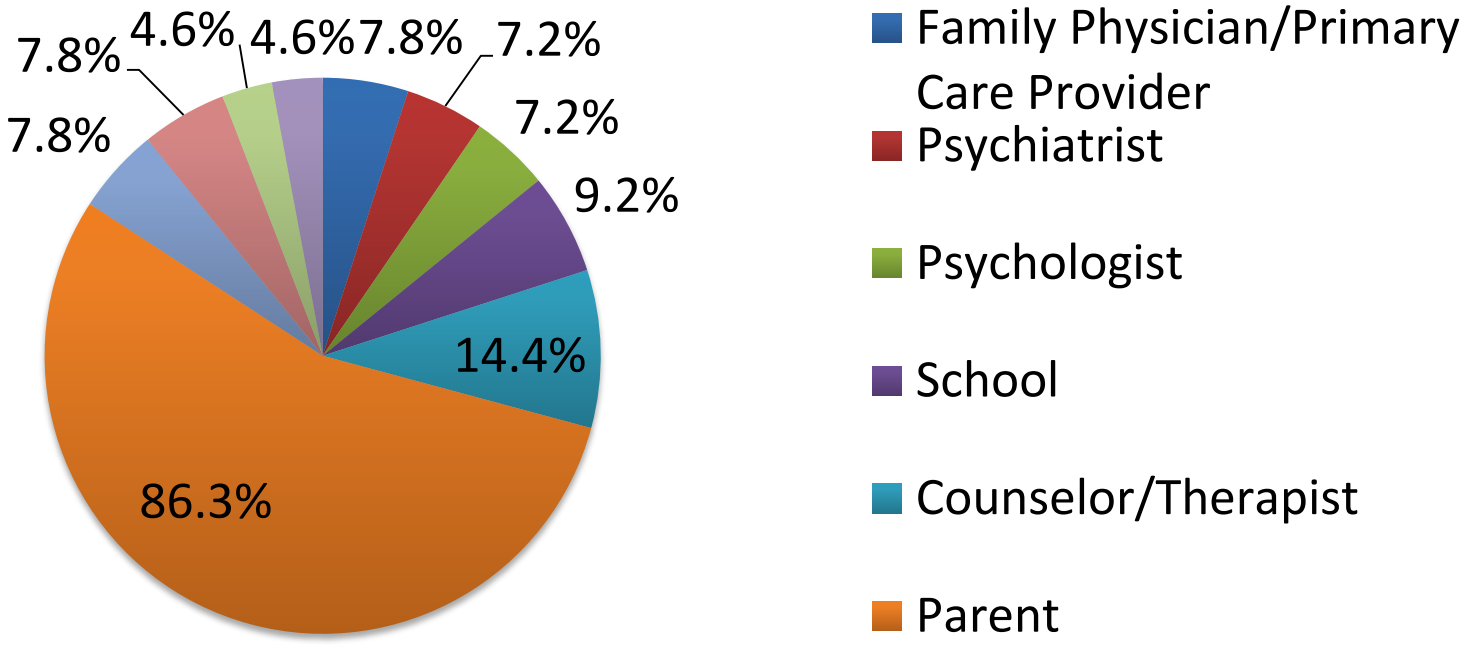
Parent / Professional PPAL Advocacy League

What has helped you, past or present, in gaining knowledge and understanding about your child's Mental Health needs?



PPAL/BCH Study

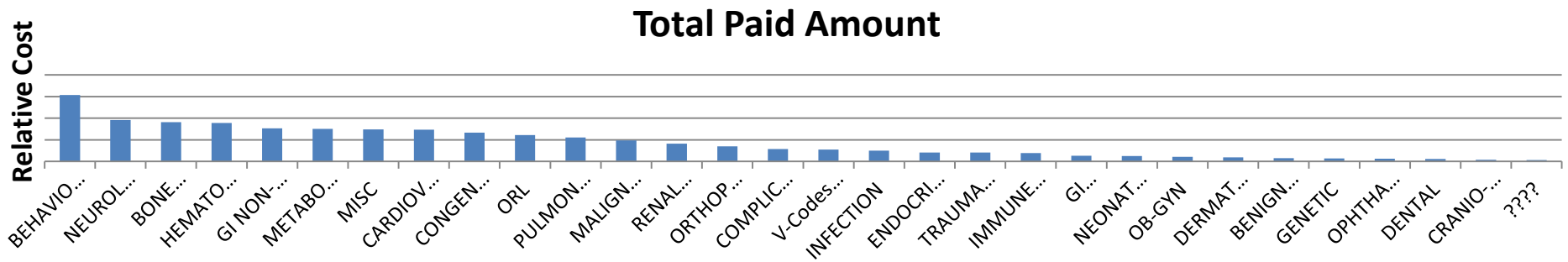
Who is primarily responsible for that communication/coordination of your child mental health needs?



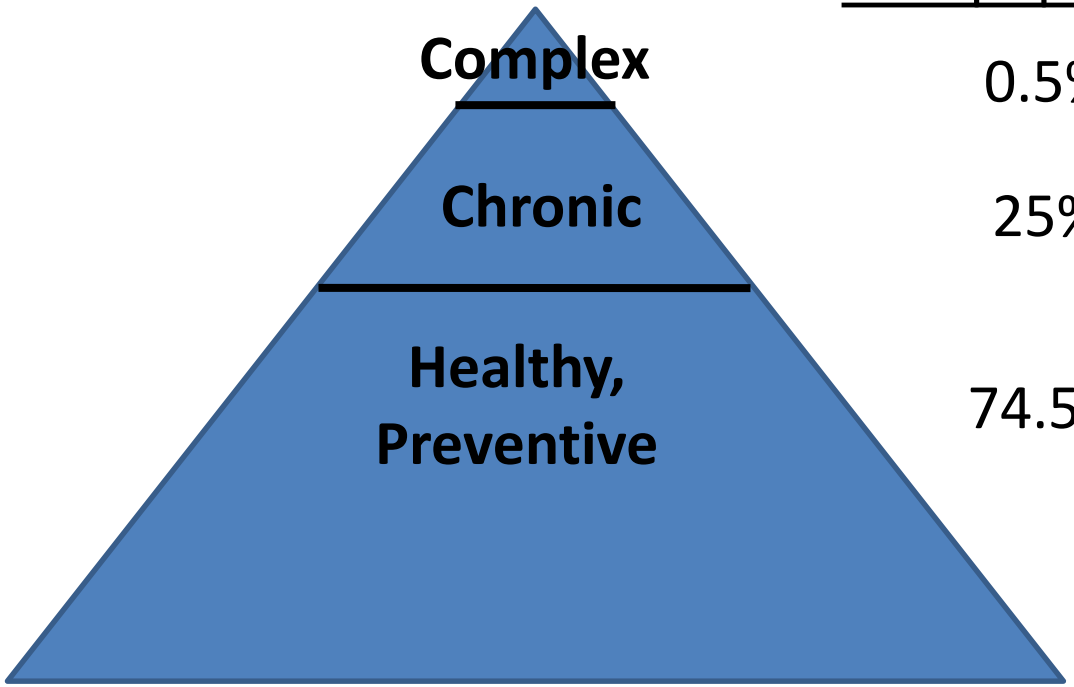
Building a System that Supports Care Coordination for this Population Across the Continuum of Care

- Measures of “Complexity”
  - Medical
  - Care Coordination
    - Psychosocial and socioeconomic
- Proactively Identify patients and families
- Define locus of accountability for CC
  - Subspecialists
  - PCP’s
  - Community Health Workers
  - Others
- Information available on as needed basis to all care providers
- Team-based care
- Multidisciplinary, dynamic care plan– follows the patient
- Transparency to patients and families

Costs Across Population Reflect Prevalence, and Service Needs/Utilization



Distribution of Pediatric Medical Expense



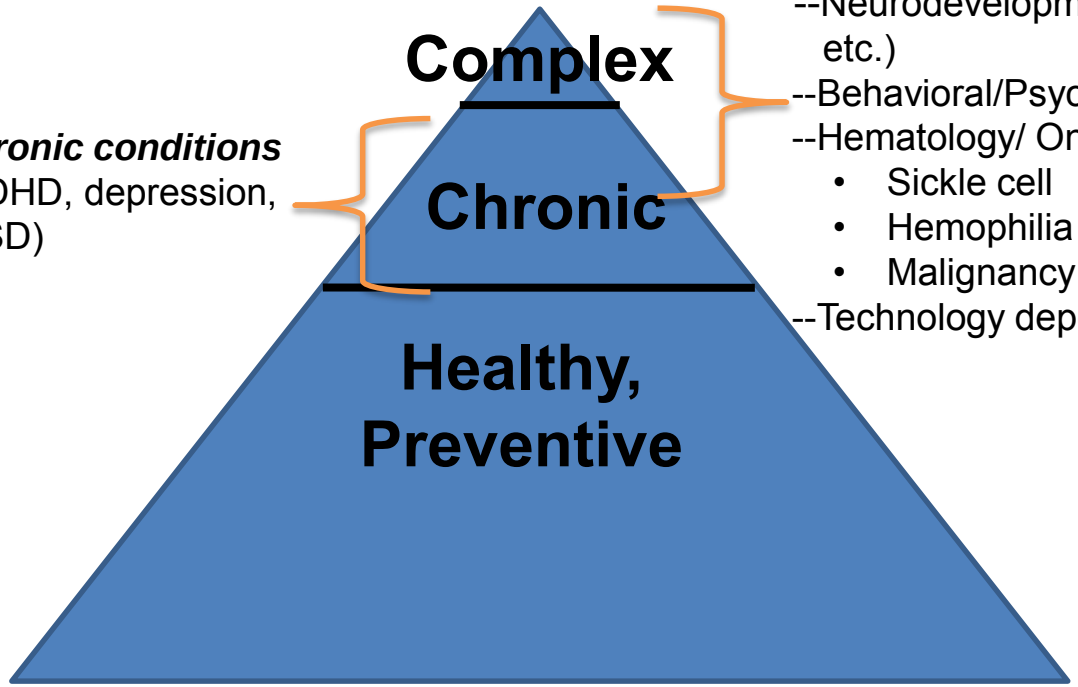
	% of population	% of spend
Complex	0.5%	25%
Chronic	25%	70%
Healthy, Preventive	74.5%	5%

Matching Services to Complexity

Children with complex needs

--Neurodevelopmental, neuro-cognitive, etc.)
--Behavioral/Psychiatric
--Hematology/ Oncology
- Sickle cell
- Hemophilia
- Malignancy

--Technology dependence

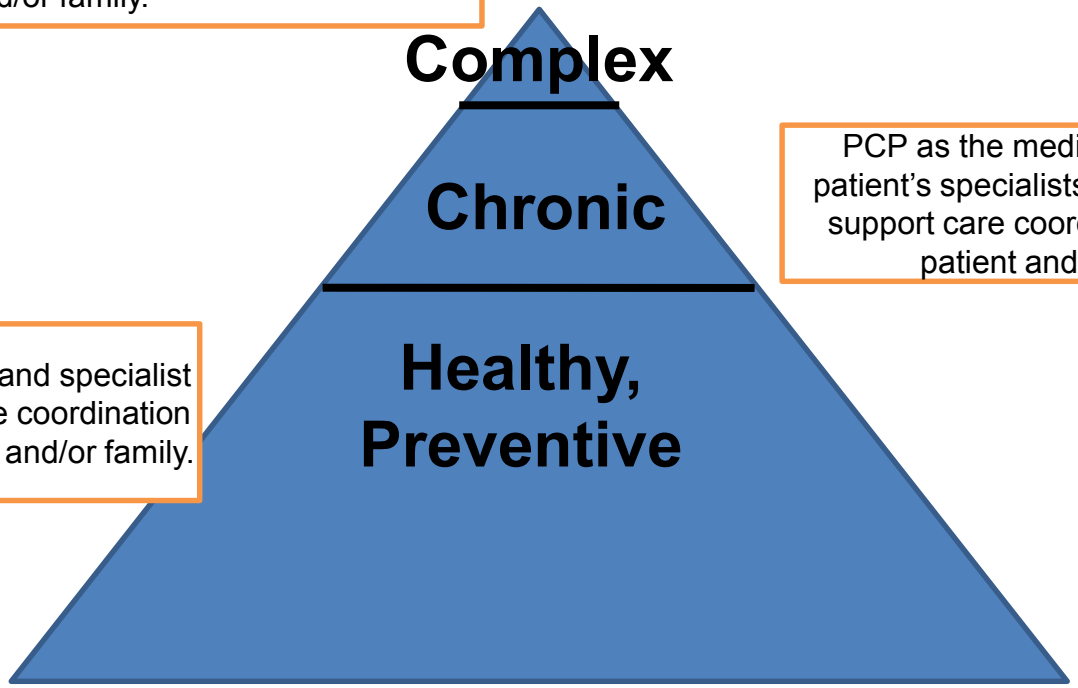


Children with chronic conditions

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

The Evolving Medical Home model

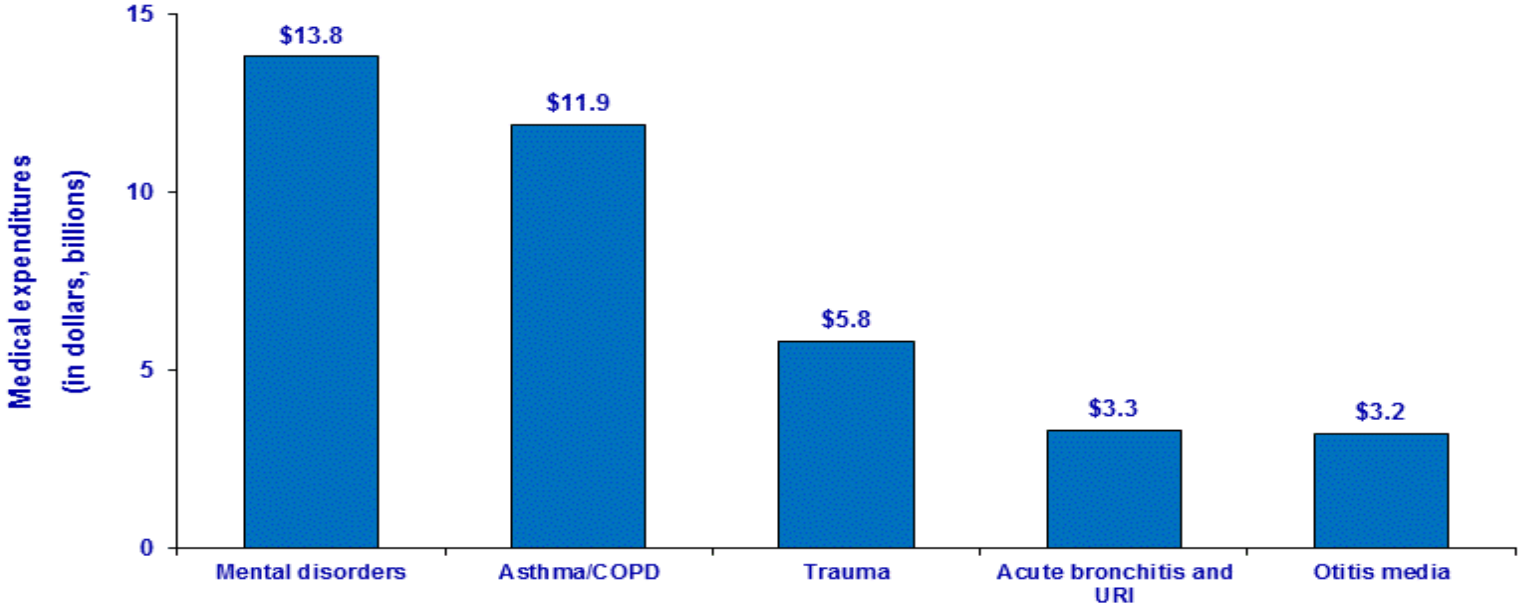
Specialist or PCP comfortable with high-risk patients as the medical home. Patient's specialists highly connected and identified patient coordinator supports the patient and/or family.



PCP as the medical home + the patient's specialists. PCP care team support care coordination with the patient and/or family.

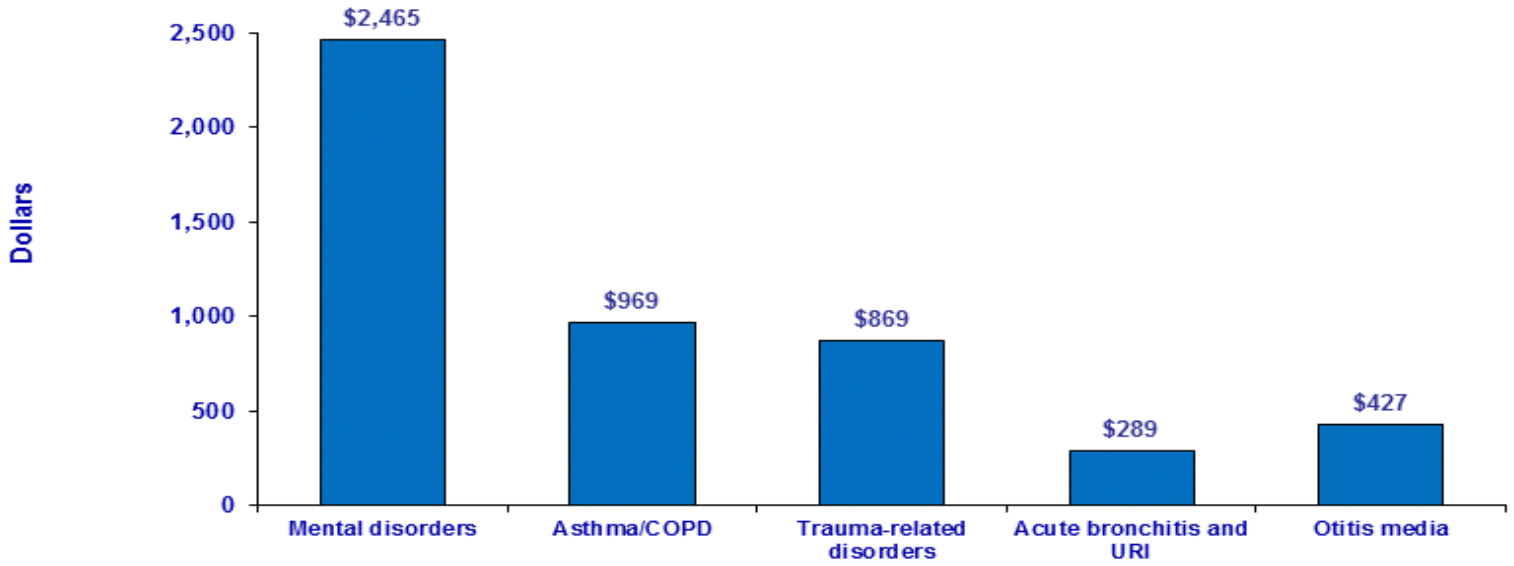
PCP as the medical home and specialist visits as needed. Most care coordination is conducted by the patient and/or family.

Figure 1. Expenditures for the five most costly conditions in children, 2011



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011

Figure 3. Average expenditures per child with expenses for the five most costly conditions, 2011



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2011

Strategic Approach to Care Integration

- Care Coordination is the set of activities which occurs in “the space between”
  - Visits, Providers, Hospital stays
- Care Coordination is Necessary but not Sufficient to Achieve Integration
- Only way to succeed is to engage all stakeholders– including patients and families– as participants and partners

Why Integrated BH Care?

CENTER FOR PRIMARY CARE
HARVARD MEDICAL SCHOOL

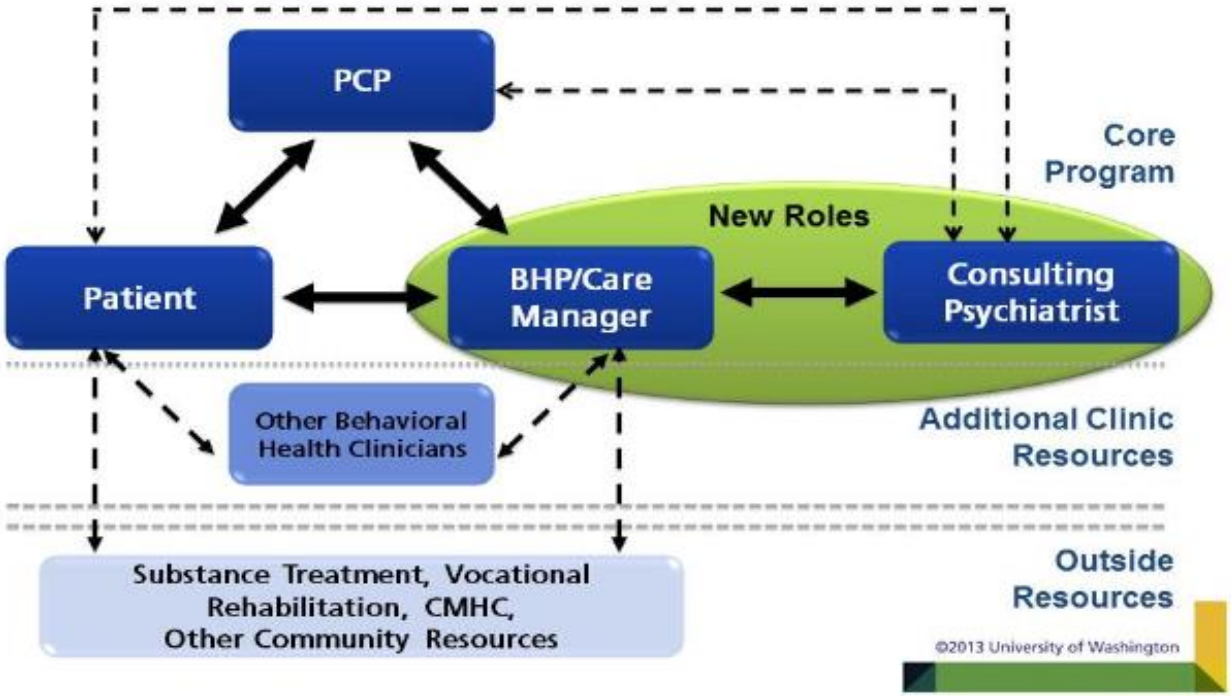
- Need is great
  - 20% of all youth have diagnosable psychiatric disorders
  - 10% of all youth have functionally impairing psychiatric disorders
  - 5% of all youth have severe and persistent psychiatric disorders
- Problems are interwoven
  - Psychological factors affect physical conditions (diabetes, asthma, pain, inflammatory bowel, epilepsy) and vice versa
- Treatment gap is enormous
  - Specialty mental health sector has capacity to treat only 20% of youth with psychiatric disorders
  - Up to 80% of youth with psychiatric disorders receive mental health care in primary care
  - 30% of pediatric visits are for mental health treatment (mainly medication management); another 30-60% of visits include some mention of mental health need
  - On average, 9 years elapse between first symptoms and definitive diagnosis/treatment

Courtesy Heather Walter, MD

Team Roles and Structure: One Model

CENTER FOR PRIMARY CARE
HARVARD MEDICAL SCHOOL

Collaborative Care Team Structure



Courtesy
Heather Walter, MD

Key care coordination activities and core competencies for practices

Pediatric Care Coordination Curriculum

funded by **U.S. Maternal and Child Health Bureau**

CC Curriculum Foundational Principles

- 80/ 20 Rule: 80% of CC is core activities and functions
  - 20% is specific and must be developed "organically", reflecting Assets, vulnerabilities
  - Culture, language
  - Sociodemographics
  - Geography

- CC training necessary for families, nurses, social workers, trainees, community health workers, MD's

- Currently being implemented at Boston Children's Hospital and in greater Boston Community.

- Can be found at: http://www.childrenshospital.org/care-coordination-curriculum

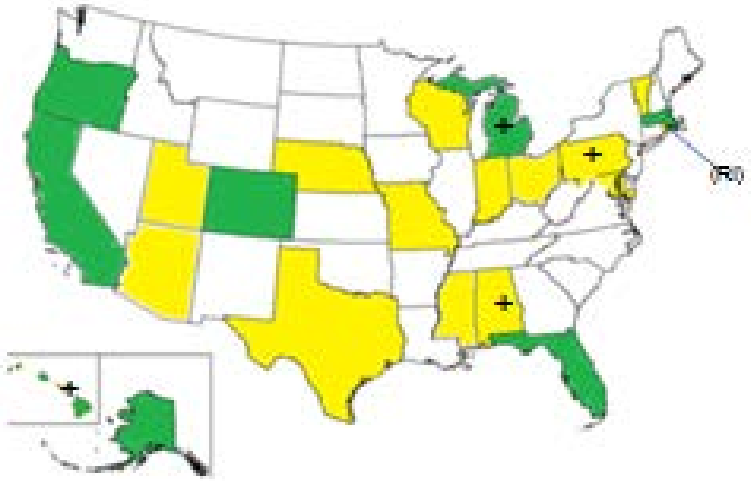
CHQC
MASSACHUSETTS
CHILD HEALTH QUALITY COALITION

CC Framework Key Elements

Key Elements	Sample Measures
1) Needs assessment, continuing CC engagement	Use of a structured care coordination needs assessment tool/process Ask family: did you get what you wanted?
2) Care planning and coordination	Family engagement in co-creation and implementation of care plan Care team members can access, update plan
3) Facilitating care transitions	"Closing the loop": timely communication after referral visit (to PCP/family/others) Measure bundles, adaptations (HEDIS, CTM-P, CAHPS-PCMH/PICS, ABCD)
4) Connecting with community resources/schools	Link to family partner/family-run org/peers Referral connections made Bi-directional communication of results
5) Transitioning to adult care	Acquisition of self-management skills ID adult providers with capacity, expertise

MA Child Health Quality Coalition CC Task Force - www.masschildhealthquality.org/

Pediatric Care Coordination Community of Learners



Legend

- states with entities that are in early stages of engagement. Expressed interest in developing care coordination workforce capacity on level of individual institution and/or state-wide program.*some sites may have implemented since our last communication
- states with entities that have used the Pediatric Care Coordination Curriculum as a resource to implement care coordination workforce capacity building

Across these states, we are aware of over 20 different institutions using the Pediatric Care Coordination Curriculum as a resource

\+ - states engaged in statewide implementation, some partnering with State Title V programs

Boston Children's Hospital

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

As of April 1, 2015

Benefits to developing community:

- Sharing Resources
- Not “re-inventing the wheel”
- Learning from others difficulties and successes
- Potential for collaboration

National Center for Care Coordination Technical Assistance

The mission of the center is to support the promotion, implementation and evaluation of care coordination activities and measures in child health across the United States

Some activities of the National Center for Care Coordination Technical Assistance involve collaboration with the National Center for Medical Home Implementation in the American Academy of Pediatrics, and is supported in part by a contract with National Center for Medical Home Implementation, a cooperative agreement (U43MC09134) with the Maternal and Child Health Bureau, Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Contact Hannah Rosenberg, Manager for National Center for Care Coordination Technical Assistance, to learn more: hannah.rosenberg@childrens.harvard.edu or 617 919 3627.

Medical Home Care Coordination Measurement Tool©

Site Code: ___ Form # ___ of ___

Date	Patient Study Code And Age	Patient Level	Focus	Care Coordination Needs	Activity Code(s)	Outcome(s) Prevented	Outcome(s) Occurred	Time Spent* 1 2 3 4 5 6 7	Staff	Clinical Comp.	Initials

Patient Level

Level	Description
I	Non-CSHCN, **Without** Complicating Family or Social Issues
II	Non-CSHCN, **With** Complicating Family or Social Issues
III	CSHCN, **Without** Complicating Family or Social Issues
IV	CSHCN, **With** Complicating Family or Social Issues

Focus of Encounter (choose ONE)

1. Mental Health
2. Developmental / Behavioral
3. Educational / School
4. Legal / Judicial
5. Growth / Nutrition
6. Referral Management
7. Clinical / Medical Management
8. Social Services (ie. housing, food, clothing, ins., trans.)

Rev-09/10

Care Coordination Needs
(choose all that apply)

1. Make Appointments
2. Follow-Up Referrals
3. Order Prescriptions, Supplies, Services, etc.
4. Reconcile Discrepancies
5. Coordination Services (schools, agencies, payers etc.)

Time Spent

1 – less than **5** minutes
2 – **5 to 9** minutes
3 – **10 to 19** minutes
4 – **20 to 29** minutes
5 – **30 to 39** minutes
6 – **40 to 49** minutes
7 – **50** minutes and greater*
(*Please NOTE **actual minutes** if greater than 50)

Staff

RN, LPN, MD, NP, PA, MA, SW, Cler

Clinical Competence

C= Clinical Competence required
NC= Clinical Competence not Required

Activity to Fulfill Needs
(choose all that apply)

1. **Telephone discussion with:**
   a. Patient e. Hospital/Clinic
   b. Parent/family f. Payer
   c. School g. Voc. / training
   d. Agency h. Pharmacy
2. **Electronic (E-Mail) Contact with:**
   a. Patient e. Hospital/Clinic
   b. Parent f. Payer
   c. School g. Voc. / training
   d. Agency h. Pharmacy
3. **Contact with Consultant**
   a. Telephone c. Letter
   b. Meeting d. E-Mail
4. **Form Processing**: (eg. school, camp, or complex record release)
5. **Confer with Primary Care Physician**
6. **Written Report to Agency**: (eg. SSI)
7. **Written Communication**
   a. E-Mail
   b. Letter
8. **Chart Review**
9. **Patient-focused Research**
10. **Contact with Home Care Personnel**
    a. Telephone c. Letter
    b. Meeting d. E-Mail
11. **Develop / Modify Written Care Plan**
12. **Meeting/Case Conference**

Outcome(s)

As a result of this care coordination activity, the following was **PREVENTED** (choose **ONLY ONE**, if applicable):

1a. ER visit
1b. Subspecialist visit
1c. Hospitalization
1d. Visit to Pediatric Office/Clinic
1e. Lab / X-ray
1f. Specialized Therapies (PT, OT, etc)

2. As a result of this care coordination activity, the following **OCCURRED** (choose **all that apply**):

2a. Advised family/patient on home management
2b. Referral to ER
2c. Referral to subspecialist
2d. Referral for hospitalization
2e. Referral for pediatric sick office visit
2f. Referral to lab / X-ray
2g. Referral to community agency
2h. Referral to Specialized Therapies
2i. Ordered prescription, equipment, diapers, taxi, etc.
2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
2k. Reviewed labs, specialist reports, IEP's, etc.
2l. Advocacy for family/patient
2m. Met family's immediate needs, questions, concerns
2n. Unmet needs (**PLEASE SPECIFY**)
2o. Not Applicable / Don't Know
2p. Outcome Pending

Supported by grant HRSA-02-MCHB-25A-AB

Boston Children's Hospital

Integrating Care: From Evidence to Operations

Second Annual Statewide Forum on Integration

CC Strengths/Needs Assessment Tool Domains

MA Child Healthcare Quality Coalition Template and Accompanying resources

http://www.masschildhealthquality.org/work/care-coordination/

Medical	Referrals needed, medications, blood/lab tests, functional status, self-care, DME, managing special health problems (sleep, growth/nutrition, etc), oral health, transition to adult care if >14
Behavioral	Help managing behavioral issues, meeting child's emotional needs, behavioral issues/risky behaviors as barriers to care Connect to resources for support: need an IEP eval? in-home therapy? after school support?
Social	Making/keeping friends, family support network/caregiver needs, family issues (siblings, divorce, etc.), parenting groups/recreational programs/other community resources
Educational	Learning/school performance, IEP/504/ADA/Individual Health Plans, educational advocates/lawyers
Other	Financial (insurance, income assistance), housing and food assistance, independent living, child care/transportation/other assistance programs, legal (guardianship, wills/trusts, immigration)

Format for Action Items on the Care Plan

Action	Goal	Person Responsible	Time Frame	Status
1.				
2.				
3.				
4.				
5.				

Implications for Accountability

- Measure at all Levels of the System
- Transparency of Performance
- Incentives Supporting Activities in “Space Between”
  - Education of work force
  - Support for those activities
  - Support for measurement

Issues and opportunities related to how care coordination is financed

Fee-for-Service (FFS)

FFS plus per member per month(pmpm) allowance

Global Budget

Caveats:

Know TRUE costs of care

Document CC activities and outcomes

Affordable Care Act: Opportunities in Accountable Arrangements

Take Home Points

I. Medical Home is an essential component of high performing system, but it needs

- Financing
- Work force development
- Resources which align with integrated care structures (i.e., subspecialties)
  - Technology
  - Collaborative Care Models

II. Integration is Essential for Success– evidence exists

III. Care Coordination is Necessary but not Sufficient to Achieve Integration

III. CC is the set of activities which occurs in "the space between"

- Visits, Providers, Hospital stays, Agency contacts

IV. Only way to succeed is to engage all stakeholders– including patients and families– as participants and partners

Web Links

Care Coordination Curriculum: [http://www.childrenshospital.org/care-coordination-curriculum]

Care Coordination Measurement Tool: [http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement]

Care Mapping: [http://www.childrenshospital.org/care-coordination-curriculum/care-mapping]

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Useful Websites

- http://www.medicalhomeinfo.org American Academy of Pediatrics hosted site that provides many useful tools and resources for families and providers
- http://www.medicalhomeimprovement.org tools for assessing and improving quality of care delivery, including the Medical Home Index, and Medical Home Family Index
- MA Child Health Quality Coalition http://www.mhqp.org/collaboration/chqc.asp?nav=063700