

MCH/CSHCN Director Webcast

September 8, 2005

CHRIS DeGRAW: Good afternoon, welcome to the webcast coming to you from HRSA Maternal and Child Health Bureau in Maryland. I'm Chris DeGraw filling in for Dr. Van Dyck who is tied up with meetings related to Hurricane Katrina and cannot be with us. The topic of today's webcast is innovative care coordination models for children with special health care needs. We have an interesting program. First I will, before I introduce today's speakers I would like to review technical information about the webcast. Please note that in response to your suggestions the speakers power point presentation is now available on the website so you can download the slides before the webcast.

Slides will appear in the central window and should advance automatically. Slide changes are synchronized with the speaker's presentation. You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the message window. We encourage you to ask the speakers questions at any time during the presentation. Type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state and organization and message so we know where you are participating from. The questions will be relayed on to the speakers at the end of the webcast. If we don't have the opportunity to respond during the webcast we'll email you afterwards. We encourage you to submit questions at any time during the webcast. On the left of the interface is the video window.

Adjust the volume of the audio using the volume control slider that you can access by clicking on the loud speaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the webcast, the interface will close automatically and you'll have an opportunity to fill out an online evaluation. It will help improve our technical support. Now I would like to introduce you to Lynda Honberg and Lynda will serve as moderator for today's panel and introduce the rest of our speakers. Lynda.

LYNDA HONBERG: Good afternoon. First I want to acknowledge and I know I speak on behalf of everyone that our thoughts are with MCH family in Mississippi, Louisiana, and Alabama. I want to welcome you to today's webcast. You will see the images on the TV from Hurricane Katrina, even more obvious about the importance of care coordination for children with special health care needs. Services for children with special health care needs from 44 state implementation grants. A core component of improving is helping families and develop services for the children.

Today's webcast will present an overview of the role of these grants in developing innovative care coordination models for those children and present the work funded by the divisions. Our first speaker is Nancy Kasen, John Snow, Inc. Including different models, key attributes and components, family involvement, cultural competency. Our next speakers are Dr. Ardis Olson and Beth Pearson. They have worked with Anthen Blue

Cross to provide care coordination. Our last speaker is Beth Allen. [Inaudible] We will turn to our first speaker, Nancy Kasen.

NANCY KASEN: Thank you, Lynda. Good afternoon, everyone. I would like to reiterate our hearts are with everyone in Louisiana, Alabama and Mississippi. Now on to the presentation. A quick overview of the methodology. Initially this began as an initiative with the health insurance and financing and implementation grantees for children with special health care needs. As they had expressed an interest in examining coordination models. Insurance and financing, through our discussions with the grantees we recognized that there was definitely a national relevance and we expanded this to include Allstate implementation grantees funded through the division. We developed the survey collaboratively for care coordination for various models, and conducted phone discussions by the 44 grantees identified by the division. You might ask why review care coordination now. We recognize there are some core components of children for services and health care needs that require a coordination and systems development.

There is a wide range of definitions that are out there and I talked about some of the challenges and barriers that will come up. And there has really been no previous review of state I am -- implementation activity. There has been a study on the role of title 5, and a literature review by the MCH information resource center on outcomes of care coordination primary care. But not specifically has anyone looked at the widespread activity of the state implementation grantee towards an involving care coordination.

Moving right along, there are four major areas that I'll be highlighting today. They include direct care coordination, system development of care coordination, care coordination components and attributes, and as I mentioned before, successes and challenges. So let's discuss the direct care coordination. Direct care coordination as we have defined it and sort of the theme defined it through the phone discussions that we had with the 44 grantees, 13 of the 44 grantees are providing what would in essence be client level care coordination. That means that they have medical home care coordination of two types. Medical home care coordination, primarily clinical and medical care coordinated and then there's also a type of care coordination that we term community-based care coordination, which is primarily being delivered or overseen by family professional partnership grantees, and healthy and ready to work grantees. Community based care coordination is helping on families navigate the system. The difference between the two approaches include the definitions of the goal of staffing, eligibility, and the medical home care coordinations, the financing.

Go on to the next slide regarding medical home care coordination. As I said, this is care coordination that is based in medical practices. There are sort of a common theme or a grouping that began to sort of come together as far as the, as when we began to talk to the grantees and so the definition has been defined as assisting families with obtaining medical and specialty care, appointments, referrals, dealing with insurance issues and linking with resources. As I said, I just want to be clear that folks understand this is a definition that we took out as a result of the discussions we had with the 44 grantees. This

is not a definition that is set in stone, and as I mention and have mentioned one of the challenges is in defining care coordination. But for this presentation please keep in mind the medical home care coordination will be using this definition. The goal of care coordination is really quite simply to reduce the utilization by preventing unnecessary hospitalizations or emergency room visits.

The staffing for the medical home care coordination model was really mostly nurses, mostly clinical nurses that were working part-time, and that part-time was defined in any number of ways, whether it was someone that was in the office, FTE, full-time equivalent, or someone specifically hired to do care coordination, and it ranged across the board as far as the number of hours and it was obviously based, these individuals were definitely based at the clinic site or practice site, they were on-site. Activities at the care coordination medical home, in-person meetings with the families, child or youth of special health care needs during regular office visits as well as phone consultations. The eligibility was usually they had specific criteria within the practice, or the medical home for identifying children with special health care needs that would be eligible for care coordination, and largely was based on diagnosis, so they went mainly with major diagnosis as defined by the ICD9 code, or potentially a chart review. In addition, they also looked at high utilizers of medical care, especially emergency room utilization. The folks that were coming into the office a lot, folks that were accessing or using resources extensively or who were potentially having unnecessary emergency room visits for eligibility, and then obviously some combination, often times they go hand-in-hand. And then as I said, they used the chart review, and sometimes there were specific models or

methods within the practice that they might use for identifying and for determining eligibility for children and youth with special health care needs who might benefit from care coordination.

On the next slide, we talked about financing and one thing on this was a significant area of concern for grantees who were providing medical care coordination. Most of the practices that we spoke with had attempted and to not be necessarily successful in billing for care coordination. They bill private insurance using as one would expect CPT codes, as well as also Medicaid, but there were a number of noted barriers. None of the grantees reported immediate success with billing, particularly with Medicaid. Part of that Medicaid issue is the budget issue. The other issue is that physicians did not have time to bill, and billing for care coordination was a bit more complicated, or in figuring out a way to be successful than standard or regular billing for office visits or other procedure codes. And once again, care coordination did not always fit within the parameters of existing codes. So they might bill for the initial assessment using codes such as 99244, 99255, but billing for follow-up or billing for meetings or education plan development or care plan development or involvement with that became particularly difficult. So they did not have much success like that.

On the next slide I'm going to talk a little bit about community-based care coordination. As I mentioned when I began the presentation, this is a, once again these are sort of themes that came out of our phone discussions with the 44 state implementation grantees, so therapy no means set in stone definitions but they are a way to categorize the themes that

we were able to identify. So the community-based care coordination was really conducted mainly by family professional partnership grantees, as well as healthy and ready to work or the transition guarantees. And once again, the categorical definition that came out of our discussion was that services, community-based care coordination and services that helped families and adolescents access and manage a wide range of services as determined by the family. So this is a bit different than the medical home care coordination in that it is more of navigational and not necessarily specific to medical care and medical service delivery. The goal of community-based care coordination is to help families learn how to navigate the health care system, give them information, develop skills, build skills, help them deal with insurance issues, to help them communicate better and more effectively and to help them also better manage the care or better interact with clinicians and ask the right questions. It was somewhat empowering but focusing on navigating and the health care system.

Healthy and ready to work grantees, their goal of this type of care coordination to help adolescents secure employment, higher education. I will highlight throughout the presentation a couple examples where adolescents going through transition faced some additional challenges or obstacles where care coordination might better be suited or was being developed to help meet those jobs in need. The staffing was significantly different than the medical model in that staffing for community-based care coordination where parents or persons with disabilities. All the grantees that were providing this type of care coordination and community-based care coordination were, all were based -- the care coordinators were based out of family support or parent advocacy groups, so there was a

significant link to the community. The eligibility was unlike the medical home counterpart who use exclusive criteria, the eligibility was much more inclusive. And all children or adolescents with some type of special health care needs, for a special or chronic condition were eligible. Interestingly enough, families professional partnership often relied on referrals from the community and from title 5. Okay.

Moving on to the next slide. What I would like to talk about is system development. And the system development sort of encompasses their categorization of the remaining grantees. We, as I said, we interpreted and had discussions with 44 grantees with certainty really had a direct, direct care coordination and then the remaining grantees did care coordination system development. So they were working to improve, strengthen and increase access to the system of care coordination by focusing on both eligibility and financing initiatives. Eligibility, they were identifying children with special health care needs who could benefit and who they thought needed care coordination and with financing, in addition to the medical home grantees, there were actually three other grantees focusing on financing and policy issues related to care coordination. So the eligibility they used a variety of strategies to identify children in need of care coordination.

Many of the organizations and grantees that were doing the system development had grassroots connections within and to the community, and they were doing outreach using lay health workers to really reach out to families of children and use special health care needs to ensure they were being linked to the services. And then there's a financing. System development or policy issue that would be tackled among the remaining grantees,

preventing further cuts in care coordination services and they accomplished this by looking at Medicaid and other things to increase funds for care coordination, exploring innovative ways to bill Medicaid, to use federal statutes to ensure that the state paid for it, or one grantee allowed for, was working with Medicaid implementing federal regulations and the categorization of case management. But basically they were also working at the systems level to develop operational definitions of care coordination that could be used for analyzing costs, and I think Ardis will talk about her state implementation of that at the specific practice level.

Moving on to the next slide, I would like to talk about the key components and attributes. We ask all of the state implementation grantees to describe the specific aspect of care coordination, and there were is being provided. A family member may be assisting a practice to make the practice more user friendly, and that might be changing the way receptionists speak with families. You know, others are, others are using parents to best define how to use care coordination and to educate other parents to access care coordination and what their expectation -- what is realistic as far as their expectations of care coordination. Several grantees are using families as staff. Often where direct care coordination is being provided, a medical home practice might hire a staff, a family member to be a liaison to the medical home practice. They may also hire family members to be a care coordinator or evaluator. This is also happening with regard to healthy and ready to work where adolescents who had completed transition were being, were, their expertise were drawn upon.

And the last one, adolescents and care coordinator, healthy and ready to work grantees relied on often a person-centered care coordination where they allowed the adolescent to guide the care planning so therefore they empowered the adolescent to develop and in some ways their own care coordinator, to advise others in the care process. Often they were advisors to the medical home in healthy home once again, be more acclimated to the transition process.

The next slide we have key partners, and the key partners were, there were a variety of key partners. Primary were Medicaid, American Academy Of Pediatrics, title 5, and then others such as the Head Start program, schools, pediatric residency training programs, disability organizations and family organizations. Linguistic and cultural competency was also another component that influenced care coordination. It was one of the most challenging areas that was noted by many of the grantees. It didn't only depend on race and ethnicity and language, it also was dependent on the area, the geographic area and the target population that was being served, or being targeted by the grantee. Some strategies for addressing linguistic and cultural competency, and particularly the challenges were that many of the grantees were offering translation services. Most were offering Spanish but many had very creative, had drawn upon very creative resources within the community to address this issue, and to make sure that language was not a barrier to accessing care coordination. Another strategy was to hire staff who were representative of the community and in fact, one grantee was actually allowed families to choose their own care coordinator, which I know has sort of pros and cons, but it was one creative strategy that had been working for the grantee in allowing them to address the

linguistic and cultural aspects of the family. And then obviously providing targeted outreach and that ties into what I spoke about before in that they are using lay outreach people.

So, the successes and challenges. There are many. Successes are that there is increased family satisfaction. Care, families are reporting care is going more smoothly. Parents are becoming empowered and more readily able to actively participate in the care and coordination of their childhood use with special health care needs. Interestingly, staff is also reporting more satisfaction. Care coordination, care coordinators are individuals who are hired to prepare care coordination, higher levels of job satisfaction and grantees were also reporting sites that were doing care coordination or involved in care coordination had less turnover of staff. There was also a ripple effect which was interesting to note is that non-care coordination staff were actually reporting higher levels of satisfaction. For instance, physicians were spending less time on tasks that could be done by a care coordinator freeing them up to do other types of clinical care.

There was a ripple effect. It wasn't just reserved to clinicians, but clinicians in general. Also care coordination resulted invaluable partnerships within the community, in that they were able to identify resources or build additional resources through the relationships so care coordination became more accessible and other resources and linkage in the community were readily available. Some selected examples of successes that were not necessarily as widespread, meaning they didn't go across all the grantees, but I do note that they are worth noting. Some, as mentioned before, were able to, some medical home

practices or direct care coordination were able to bill for the time spent doing care coordination.

Although they may not have always been successful in being reimbursed, it did create a feeling of validation, and that they were not necessarily working for free or, or working and doing a lot and not It also, especially for medical home grantees, placed an importance on developing a care plan and what folks recognized is that by developing and using the care plan and providing that to the family, it made it easier for children and youth with special health care needs, as well as the parents, to be seen outside of the practice site, whether they were being referred or accessing other types of services, and also it avoided unnecessary hospitalizations and [inaudible] when parents have could continuously repeat and reiterate what the treatment is and what the plan is over and over again, they have a written document that allows for easy -- facilitated communication. And it also, care coordination was, it highlighted the need for a team approach as it underscored that children and youth with special health care needs handling a child with -- handling a child with special health care needs is a lot for families to handle on their own. And so a team approach helps bear that burden and make it a bit easier.

Now, the challenge is, these are challenges that were encountered and were reported by the 44 grantees. As I mentioned at the very beginning of this presentation, the definition of care coordination is problematic. Overall, we lack a widely acceptable standard definition of care coordination. Folks are not using the same language. People have very different expectations about care coordination. What services it involves, who is providing it, what it

is in general, and where it should be provided. So this creates barriers as far as communication, as far as seeking financing, because there is no one clear operational definition of care coordination. And that also often prevents further program development and sustainability and spread of the care coordination model. So it is, that's a huge challenge. The other challenge is family and parent utilization, which somewhat relates to the definition of care coordination in that families and parents often don't understand what care coordination is, what it is about, and what it can do for their children. So they often do not seek it, seek out care coordination. They don't know to ask for it. As I mentioned also previously throughout the presentation, financing is also a huge challenge, and this relates once again to the issues of sustainability and spread with regard to the need for demonstrating cost savings and I think that Ardis can talk to that a little bit more specifically. Then there are issues which relate to, there's a fragmentation of care coordination. Often times grantees –

LYNDA HONBERG: Nancy. I think we have to move on to the next speaker.

NANCY KASEN: Okay. Sorry.

LYNDA HONBERG: Ardis.

ARDIS OLSON: I'm going to pick up and talk specifically about the model she has in New Hampshire. Can we turn to her slides?

ARDIS OLSON: Thank you, Nancy.

NANCY KASEN: Sure. Sorry about that. Lost track of time.

ARDIS OLSON: Nancy has been a wonderful introduction to what went on in our project, partners of chronic care. Our project sought to use many of those principles Nancy was talking about and determine how can you talk about them in a medical home practice setting. How can you take the care coordination aspect of medical home and help families have those where they have practice. And towards that end, we developed a family team model in the primary care pediatric practice and how to [inaudible] -- we provided a lot of slides that are more traditional reading. I'm going to turn to Beth Pearson, my project manager who has been working very directly and the things you'll see in the next slide, how to read [inaudible]

BETH PEARSON: ...structure training and helping with unique partnership with the insurance case manager and a practice care mapping out the strengths and weaknesses and the need based on what the family tells us.

But looking at the big picture rather than just one thing. Now the kids in our practices and in our programs, we have had kids with 70 different diagnoses. Most of them have two, three diagnoses. Right now the only thing that is an exclusionary criteria [inaudible] and if you look at the slide, what are the important differences in this model, one big important difference is we are partnered with Anthem Blue Cross/Blue Shield and we have the benefit of their trained pediatric case managers who partner in person in terms of case

finding, training, and then they go together to the family visits, they work hand-in-hand in a team meeting and in follow-up. The biggest difference I think is this really goes in and changes the prospective of the practice from a reactive chair coordination to anticipatory chair coordination. The basic components of what we do are, we go in, help the practice identify potential children in their practice. We use a bunch of different things. We have reports generated by Anthen based on codes, and then that is often helpful as a first level. But we use referral. A lot of times when we go in and meet with the entire practice, between the docs and the people who answer their phones they can generate a list of 12 to 15 families that they know could probably use care coordination help. And then we also look at utilization of ER and inpatient, and we know that we make a big difference in their costs, and we can talk about costs in a few minutes. But those areas are where we have a big difference.

The family team meetings, the assessment goes out to the home, it's the slide that starts family visit. And we do a comprehensive assessment, and that's looking at the big picture, using the approach and then from that family visit we end up with a listing of needs that the family identifies and who they would like to include in the family team meeting. This meeting is different than most meetings that people attend in a couple ways. Number one, includes the primary care doc and other people who are sort of in the universe of the family working with them, with their child. And we invite them, they come and it's a brainstorming session, and it's, it gives you, it has a structured agenda. We brainstorm. It's a chance for the team to be more than they would be separately. And thinking outside the box, because a lot of these families have unique needs that fall between the cracks that

they don't really fit into a normal either referral pattern or resources. And so we, we come up with new solutions and this is all put into a care coordination plan. And it's a very simple plan that maps out who, what and when.

Then the follow-up is where a lot of the work takes place. We have an active six-month period we are working directly with someone teaching them how to do the follow-up, and they use the team. This does not mean the care coordinator in the office does all the work. We monitor their progress, and we do that in-person and through weekly contact with the care coordinators. We help them maintain contact with the family to make sure the needs are met. The needs change over time. Team meeting is really a jumping off place. The case manager works directly with the care coordinator on a regular basis and really fosters a partnership between the practice and the case manager that then benefits other kids in the practice that they share.

ARDIS OLSON: Thanks, Beth. In the interest of time, we have provided some nice examples of specific cases and what happened when people really thought outside the box, and I think you can look at our slides about Andrew and Mary's team meeting and see a very specific care plan. And I think the key element that we end up doing at the end you'll see summarized is training for really delivering approach rather than having practices struggle on how to do the approach one case at a time. In the interest of time, I'm going to let you look at some of the slides later about how it benefits the families and we can talk with questions about the benefits for partners. Handing back to you, Lynda.
Hello? Lynda.

LYNDA HONBERG: Thank you, Ardis and Beth. Our final speaker is Debbie Allen, and she's going to be talking about the system approach that Nancy highlighted and what they are doing in that.

DEBBIE ALLEN: Greetings, everybody. I'll wait 'til you get to my slides. The first couple –

LYNDA HONBERG: They are up already.

DEBBIE ALLEN: They are, okay. I'm not seeing them. The first couple are just introductory, who I am. I'm at Boston University and I'm part of a broad consortium focused on children with special health care needs in Massachusetts and it's really the work of that consortium I'm going to be talking about. The second overhead is an outline of my presentation. I'll give a little background about the consortium, and then talk about where its work has taken us in the development of a proposal to fund a state-wide system for care coordination in Massachusetts that has actually many of the elements that were just described in the model in New Hampshire and Maine. So moving right into the backgrounds, the third slide, consortium financing grant, the work of this consortium has in part been funded by a grant from Maternal and Child Health Bureau, financing grant, one of the ones Lynda mentioned, that has three components looking at financing in three very different ways that were defined by this broad consortium in the state.

The three issues that were identified by the consortium were financing of care coordination, it's really sort of the critical element in service that lacks financing and is, therefore, not available to kids Massachusetts. It's a state in which, as people are probably aware, there's a pretty rich supply of medical resources and it's creating a system on a family basis and then on a statewide basis, really the critical gap that we face. So financing care coordination, just so you have a sense of context. The other two issues being addressed are how to increase family understanding of health care system financing generally. So that's a separate project funded under the same grant as part of the financing agenda of the consortium. And the third is looking at how definitions of medical necessity affect the financing of care in Massachusetts. So very diverse, broad agenda, looking at financing of care and my work groups that I chair is the one focused on paying for care coordination.

Next overhead, next slide. The vehicle for carrying out the work is a work group that comprises, I co-chair it with a parent who in a sense is the co-author of this presentation, because we present it together very frequently and Kathy Ryan could not be on the call. And other members are parents, there are several care coordinators who come from managed care organizations in the state. Three different ones are represented currently. There have been some personnel changes. The state health department, there have been representatives in and out of other state agencies as well. So pretty broad representation and critically in the state, work groups. Early on in the planning and I think this is sort of most critical, the work group made a decision that even though it was supposed to come up with a system of financing that wasn't going to talk about financing for a couple of

years, it came to the conclusion that if we started talking about how to pay for care coordination, that people would run the other way. Unless we were much clearer about what it was we wanted to pay for and that we really needed to build some consensus and win some buy-in about the service and what it needed to look like and what the value would be before we started talking about how to fund it. Most of the work we have done to date has really focused on two things. Initially developing a clear picture of what the model of care coordination we wanted to implement was, and then more recently beginning to talk about how we thought it ought to be funded, and that's what I'm going to now.

The bottom of the fourth slide, one that says care coordination work group, gives you a sense of some of the activities we engaged in to develop our proposal about how care coordination should look, and I would be glad to talk about those if there's time later. But I would like to get to the actual proposal. The slide that says definition of care coordination hits some of the key points of the definition we developed. I should say that for a while we waited thinking that a national definition would emerge that rather like the definition of who is a child with special health care needs and that we didn't want to sort of work in the parallel universe. So we felt off for a while but felt we needed this step as part of our process. I'll read you the full definition while you have in front of you the highlights from it. Care coordination is a central component of an effective system of care for children with special health care needs and their families. It engages families in development of a care plan and links them to health and other services that address the full range of their needs and concerns.

Principles of care coordination reflect the central role of families and the priority in effective care of children with health care needs. It may vary from family to family, start with identification of children child and family needs, strengths and concerns, and simultaneously and meeting family needs, building family capacity, and improving systems of care. Obviously, you know, could use a little trimming but we hope it captures what we felt were the key ideas. And then on the next slide broad sense principles for care coordination system, first among them we felt the system needed to be accessible. It reflected a lot captured in that if a lot of debate about where the system ought to be housed.

We ultimately came to the conclusion that if there were going to be a system that were acceptable to kids all over the state, that it needed to have, it needed not to be the kind of patch work that exists now, but individual agencies might want to continue their own care coordination systems. But we agreed that we were working towards a system that would be universally available. That meant there were only a few options where it could be housed. Basically we came down to it could be in primary care offices, it could be in schools, or it could be in the community. And after a lot of debate with parents weighing in very heavily about their concerns about placing it in the schools, because of issues of trust and confidentiality, or placing it in the community because of concerns about whether or not any community setting could make it accessible to all families, pretty strong support for the notion that care coordination is not just a care coordination as part of the medical home model, but the medical home made sense to our group as site for location of a universal system of care coordination, and that was true for a whole list of reasons.

Interestingly, though, I'll come to this in a second, also a very strong sense as a principle, the fourth of those listed here it ought to focus on systems change as well as individual family support. One of the consequences of that principle was the idea that although it should be housed within the medical home, the individual care coordinator needed to be tied to some statewide network, and not just be an employee of a particular practice. There is a real concern that if you, for example, provided funding and the doctor went out and hired someone that worked for them, that you would, with no sort of strings attached to the state or some system, there was a real risk of the person becoming a Jack of all trades within the practice rather than having the families needs the primary issue.

Next overhead. With that notion in mind, we defined what we agreed on four outcomes we thought a system needed to have, the first of which was the child's own well-being, both satisfaction and health within the parameters of the child's special health needs. And autonomy. The system ought to aim at promoting the child's healthy development towards adulthood. Second, and clearly following closely related to the child well-being was family satisfaction and well-being. And we talked a lot about what each of these meant. Third we felt was provider satisfaction, that we would not be able to sustain a system unless it also made the processes delivering the care to families more worthwhile and gratifying to provide certainly on a personal level and not more of the man did it financially, even though we weren't particularly interesting in making it less costly in delivered care. And fourth, the system needed to contribute to the overall effectiveness of an assistance, didn't

want each individual care coordinator to deal with problems in the approval process, but we wanted the knelt -- we wanted it to be floated to the statewide level.

Working in the practice we envisioned, starting with the individual care coordinator, having some broad knowledge of what is available in the community based on a scan of the environment and then honing in on the individual family working with the family to develop a care plan very similar to the discussion about the New Hampshire and Maine model, and described that as we defined that as an individualized family service plan using the early intervention term rather than something more focused on the child or on health in a narrow sense. Then you'll notice the last stage again emphasizing this notion of relationship to assistance of care is feedback to and engagement of community systems. That proposal, as I have described it so far in terms of the definition of care coordination, the sense of what the model would look like. The parameters we are dealing with are, first of all, how do you pay for it.? And we are envisioning it not as a reimbursable service that was a big discussion. The feeling was that the cause of the strong system level components we would like to have as part of it, and also very importantly because of the lack of experience that to go to a reimbursable kind of unit rate early in the process would probably not be feasible so we were thinking about how you pay for it on sort of a broad system wide rate, a flat rate for the role to be done, rather than reimbursement being attached to the individual child.

Just to give you some sense of what we ended up with, our estimate based on a pretty stingy model said it would cost us about \$18 million to provide that in Massachusetts. And

I say that with humility and caution. Just to give some sense of what we are talking about, that is, it's a big number but it's not an insane number. It's about the cost of 18 houses in the city of Cambridge, you know, for the comparative benchmark here. Our, the structure that we are proposing for it at least initially is that it be a vendor-based model. That it not be money given to individual providers to hire someone for a number of reasons, not least being that the different sizes of different practices might make that very difficult, but there might be a network of care coordinators, some might work in smaller practices part-time and be shared in a community also not totally pieced out, but work within a few practices. And then the other thing we envisioned was an important role for the state in terms of standard setting, the overall organization of the financing and payment for the system, quality management evaluation and so on. And that the state through the vendors would be critical in assuring that the system meets the principles that we had defined and achieved the outcomes.

Just to go to the last slide, the next steps for us having gone this far, and I should say again, really emphasize the purpose of defining those parameters was really to start a discussion, so while the model that I described reflects the end point of a lot of discussion, the parameters really reflect only discussion within the care coordination work group and the beginning of a discussion in the broader consortium. What we envision doing from here on is taking the very, the model that we described, and first sort of tightening it up to provide some real benchmarks that we can use the organizations that comprise the consortium. The other important next step is to, and this is something that my co-chair and I will primarily do, is to take the proposal for financing, the statewide proposal, and meet

with key policy makers, legislators, payers, and importantly leaders of groups in communities of color and immigrant groups to try to craft a proposal for financing on this that we can, to which we can get some buy-in. So that proposal is subject to lots of change, and we see it as something we want to throw out to begin a process that we envision taking a couple of years, at least, perhaps three years, before we really end up with something we want to take to the legislature. I'm going to stop there, since there is almost no left and hope that that will give people a clear enough sense for any questions or discussion.

LYNDA HONBERG: Thank you, Debbie and I think if people wanted to talk to you further about it that they could obviously contact you. We do have time, we do have a couple of questions. One of the questions was whether or not in terms of the care coordinators in the community-based models, whether or not there were more people with disabilities providing those services versus people in the medical home setting. And I believe that in the community-based, we didn't ask that question explicitly but in the community-based models, there were more family members, as they said, and more youth provided services than there were in the medical home model. And Ardis, I don't know if in terms of your experience, Ardis and Beth in New Hampshire, whether or not any of the care coordinators are people with special needs or not.

ARDIS OLSON: We have been able to involve people who are already employed by the office, so in this particular setting we are drawing from nursing staff that's already going to school. We haven't had a chance [inaudible] hired, although we have [inaudible].

LYNDA HONBERG: Another question was regarding the input of the care coordinators in terms of haven't experienced a successful model. So what we find it really has the experience with doing a care coordination team meeting [inaudible] quickly understand how it helps other children [inaudible].

CHRIS DeGRAW: And finally, question, what do you anticipate as the administrative oversight for the \$18 million, I guess this is Debbie Allen that may be expense of support care coordination.

DEBBIE ALLEN: You mean where will it come from?

CHRIS DeGRAW: Yeah, I think that -- they are wanting to know how it will -- who would provide oversight over it.

DEBBIE ALLEN: Well, the model that I think we are working from this date is our early intervention program, in which the state oversees a vendor system. Early intervention here is a mandated benefit so it is a reimbursable service. That differs. The notion the state health department would change its role from being a direct provider of care coordination as it is now to oversight of the system, including both the sort of qualitative technical assistance and training components, a certification part of that. And also, including, I mean I think our vision is both that care coordinators would get certified to be in the role and practices would have to achieve some level of kind of medical home certification to be

the recipient of a care coordinator. So those roles would be part of the oversight of the health department as well as the financing of the system, and we are looking to existing capacity to run a very expensive G.I. System for the basis for conclude it can do that.

CHRIS DeGRAW: Thank you. That's the end of our webcast today. I would like to thank our moderator and our speakers for an excellent presentation. Thank our contractor, the center for the advancement of distance education at the University of Illinois-Chicago School of Public Health. Today's webcast as with all of our webcasts will be archived and available within a couple days on the website MCHCOM.com. We encourage you to let your colleagues know about the website. We like to make them as responsive to your needs as possible. If you have topics you would like addressed on future webcasts or have comments in general with the webcast, email them to us at info at MCHCOM.com. We look forward to seeing you next month.