

Family-Centered Care Coordination: The Driver for Advancing Pediatric Health Care Quality

Title V MCH Federal/ State Partnership Meeting

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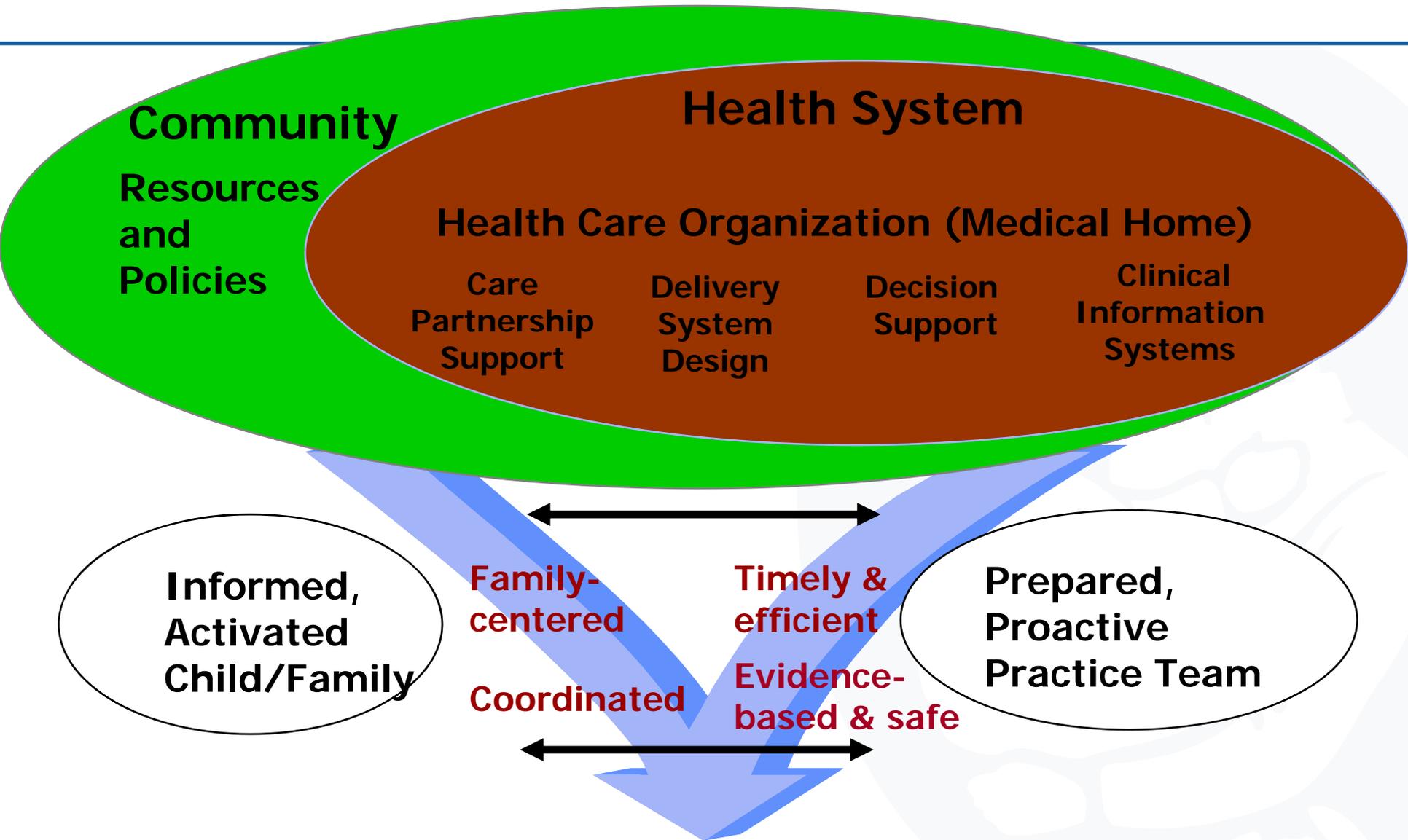


Objectives for Today

- **Understand the benefits of care coordination for families throughout all health care settings**
- **Learn recent developments in the evolution of care coordination that support training and quality improvement**
- **Learn the implications for health system reform of family-centered care coordination**



Care Model for Child Health



Functional and Clinical Outcomes



Definition of Medical Home

- **Care that is:**
 - **Accessible**
 - **Family-centered**
 - **Comprehensive**
 - **Continuous**
 - **Coordinated**
 - **Compassionate**
 - **Culturally-effective**
- **And for which the primary care provider shares responsibility with the family.**

AAP/ AAFP/ NAPNAP/ ACP/ AOA



CLOSING THE DIVIDE: HOW MEDICAL HOMES PROMOTE EQUITY IN HEALTH CARE

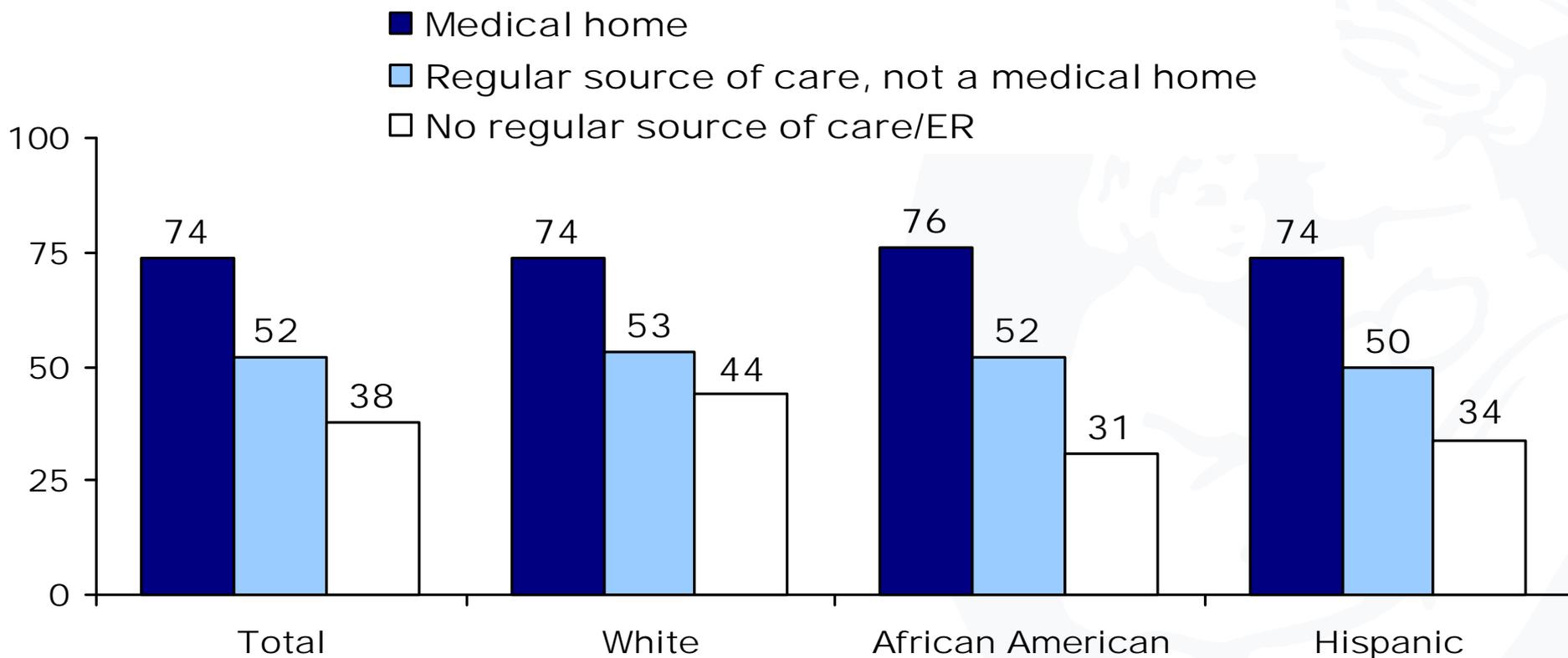
*Results from the
Commonwealth Fund 2006 Health Care Quality Survey*

*Anne C. Beal, Michelle M. Doty, Susan E. Hernandez,
Katherine Shea, and Karen Davis*

June 2007

Figure ES-4. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18-64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Is Medical Home Enough?

- **Medical Home demands system re-design:**
 - **Financing**
 - **Quality measurement**
 - **Regulatory support**
 - **State and Federal policy support**
- **Medical Home is NOT Sufficient!**
- **Integrated Care is Essential**



What Are Elements of an Integrated Health System?

- **Family-Centered**
- **Shared Quality Goals**
 - Clinical outcomes
 - Reduced variation in service delivery
- **Shared Fiscal Accountability Across all Stakeholders**
- **Patient Receives the Right Care at the Right Time in the Right Place**
- **Value= quality/ cost per unit time**
- **IOM Quality: STEEEP**
- **Health Information Technology**

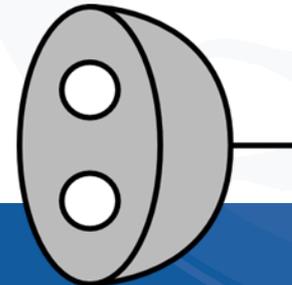
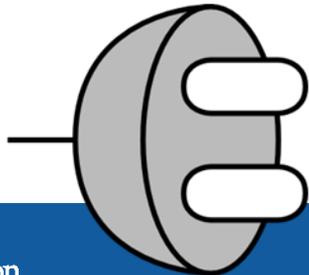


MEDICAL HOME

(Typically, PCP;
may be sub-specialist)

- Accessibility
- Care Coordination
- Tracking & Registry
- Linkage to Community Based Organizations
- EMR

- Clinical Communications
 - Care Plans
 - Structured Referrals
- Optimal Models of Care
 - Disease Specific Care Pathways
 - Collaborative Care Models
- Interoperable IT Infrastructure for IP and OP settings:
 - E-prescribing
 - Test & Referral Tracking
 - Personal Health Record (PHR)
- Utilization Management
- Performance Reporting
 - Quality/Outcomes
 - Finance



What Constitutes CC in a Pediatric Medical Home?



National Study of Care Coordination Measurement in Medical Homes

Antonelli, Stille, and Antonelli, 2008

Focus of Encounter – Aggregate Data –

<u>Primary Focus</u>	<u>% Encounters</u>
Clinical / Medical Management	67%
Referral Management	13%
Social Services (ie. Housing, food, clothing...)	7%
Educational / School	4%
Developmental / Behavioral	3%
Mental Health	3%
Growth / Nutrition	2%
Legal / Judicial	1%



National Study of Care Coordination Measurement in Medical Homes

Outcomes Prevented – Aggregate Data

(32%) of total 3855 CC encounters had something prevented

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

<u>Outcome Prevented</u>	<u># CC Encounters</u>	<u>Percentage</u>
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**



PCMH-PPC: NCQA, AAFP, ACP, AAP and AOA Medical Home Qualifying Criteria

Potential for Linkage to Reimbursement



NCQA

<p>Standard 1: Access and Communication</p> <p>A. Has written standards for patient access and patient communication**</p> <p>B. Uses data to show it meets its standards for patient access and communication**</p>	<p>Pts</p> <p>4</p> <p>5</p> <hr/> <p>9</p>	<p>Standard 5: Electronic Prescribing</p> <p>A. Uses electronic system to write prescriptions</p> <p>B. Has electronic prescription writer with safety checks</p> <p>C. Has electronic prescription writer with cost checks</p>	<p>Pts</p> <p>3</p> <p>3</p> <p>2</p> <hr/> <p>8</p>
<p>Standard 2: Patient Tracking and Registry Functions</p> <p>A. Uses data system for basic patient information (mostly non-clinical data)</p> <p>B. Has clinical data system with clinical data in searchable data fields</p> <p>C. Uses the clinical data system</p> <p>D. Uses paper or electronic-based charting tools to organize clinical information**</p> <p>E. Uses data to identify important diagnoses and conditions in practice**</p> <p>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</p>	<p>Pts</p> <p>2</p> <p>3</p> <p>3</p> <p>6</p> <p>4</p> <p>3</p> <hr/> <p>21</p>	<p>Standard 6: Test Tracking</p> <p>A. Tracks tests and identifies abnormal results systematically**</p> <p>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</p>	<p>Pts</p> <p>7</p> <p>6</p> <hr/> <p>13</p>
<p>Standard 3: Care Management</p> <p>A. Adopts and implements evidence-based guidelines for three conditions **</p> <p>B. Generates reminders about preventive services for clinicians</p> <p>C. Uses non-physician staff to manage patient care</p> <p>D. Conducts care management, including care plans, assessing progress, addressing barriers</p> <p>E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities</p>	<p>Pts</p> <p>3</p> <p>4</p> <p>3</p> <p>5</p> <p>5</p> <hr/> <p>20</p>	<p>Standard 7: Referral Tracking</p> <p>A. Tracks referrals using paper-based or electronic system**</p> <p>Standard 8: Performance Reporting and Improvement</p> <p>A. Measures clinical and/or service performance by physician or across the practice**</p> <p>B. Survey of patients' care experience</p> <p>C. Reports performance across the practice or by physician **</p> <p>D. Sets goals and takes action to improve performance</p> <p>E. Produces reports using standardized measures</p> <p>F. Transmits reports with standardized measures electronically to external entities</p>	<p>PT</p> <p>4</p> <p>4</p> <hr/> <p>Pts</p> <p>3</p> <p>3</p> <p>3</p> <p>2</p> <p>1</p> <hr/> <p>15</p>
<p>Standard 4: Patient Self-Management Support</p> <p>A. Assesses language preference and other communication barriers</p> <p>B. Actively supports patient self-management**</p>	<p>Pts</p> <p>2</p> <p>4</p> <hr/> <p>6</p>	<p>Standard 9: Advanced Electronic Communications</p> <p>A. Availability of Interactive Website</p> <p>B. Electronic Patient Identification</p> <p>C. Electronic Care Management Support</p>	<p>Pts</p> <p>1</p> <p>2</p> <p>1</p> <hr/> <p>4</p>

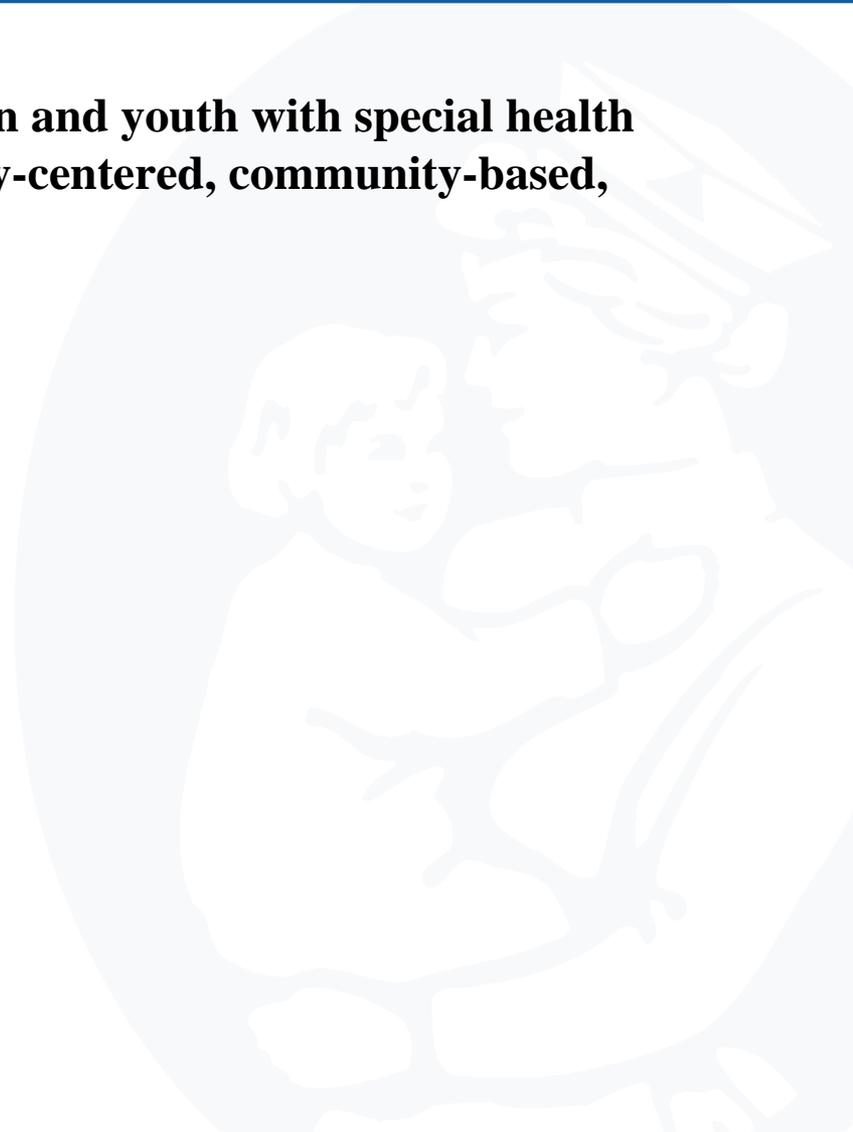


Who Are Critical Partners?



The Role of Title V

- **Title V funds support programs for children and youth with special health needs to facilitate the development of family-centered, community-based, coordinated systems of care**
- **Can influence system integration**
- **Focus on CYSHCN is broad**
- **“Bully Pulpit”**



Logical (But Not Necessarily Traditional) Teammates

- **Public Health**
 - **Including dental**
- **Mental Health**
- **Public and Private Payers**
- **Purchasers (eg, PCPCC)**
- **Education**
- **Family to Family Support**



Where Can We Look For Advocacy and Examples?



State Policy Implementation

- **Introduced Legislation in 2008**

Iowa

Kansas

Massachusetts

New Hampshire

New York

Oklahoma

Minnesota

Washington

Maryland

Maine

Vermont

Utah

- **Enacted Legislation in 2007 and 2008**

Colorado

Louisiana

Minnesota

New York

Washington

Oklahoma

Maine

Iowa



How Do We Develop Integrated Care Systems?

Corollary:

How Do We Develop, Support, and Measure Care Coordination?



Defining 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

Richard C. Antonelli, Jeanne W. McAllister, and Jill Popp

The Commonwealth Fund, May 2009



Components of Care Coordination

Family-centered and Community-based

Proactive, Providing Planned, Comprehensive Care

Promotes the Development of Self Management Skills (Care Partnership Support) with Children, Youth and Families

Facilitates cross-organizational linkages and relationships

Source:

MAKING CARE COORDINATION A CRITICAL COMPONENT OF THE PEDIATRIC HEALTH SYSTEM:
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Care Coordination Functions

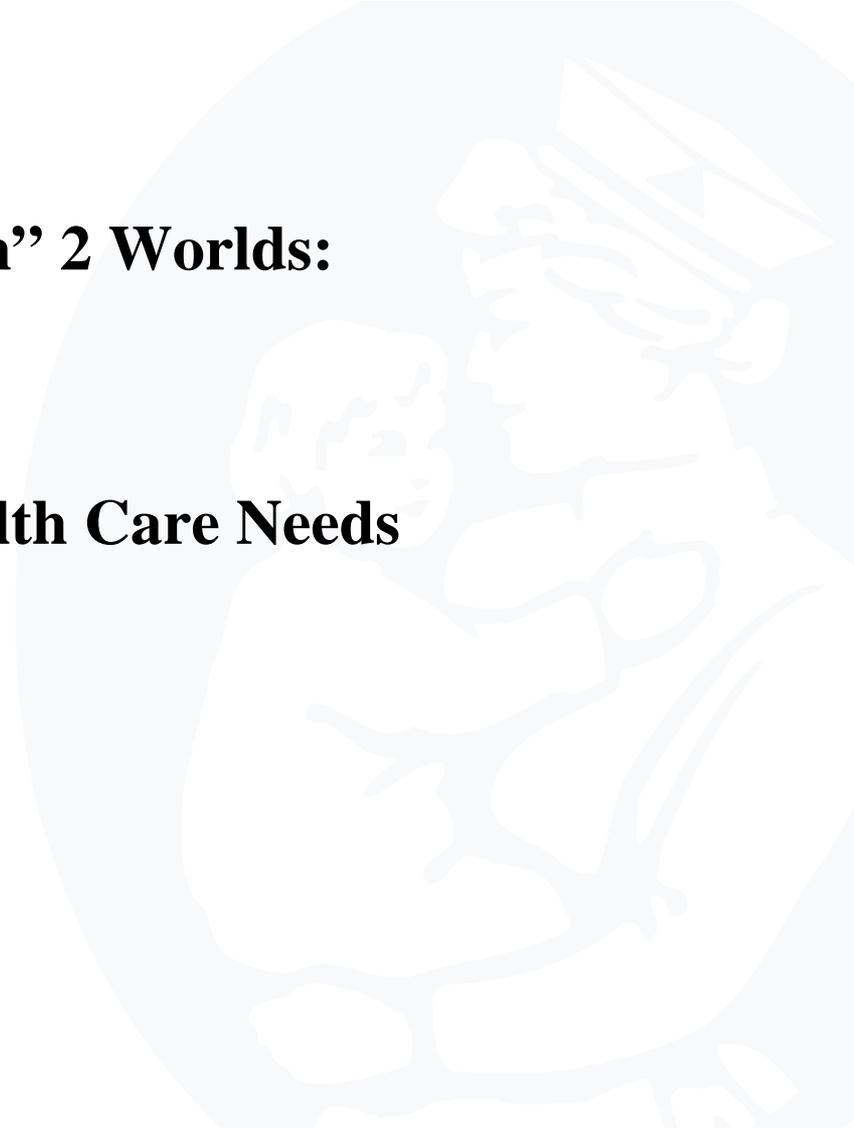
- Provides separate visits and care coordination interactions
- Manages continuous communications
- Completes/analyzes assessments
- Develops care plans with families
- Manages/tracks tests, referrals, and outcomes
- Coaches patients/families
- Integrates critical care information
- Supports/facilitates care transitions
- Facilitates team meetings
- Uses health information technology



You Think This is Challenging?

The Cohort “Between” 2 Worlds:

Youth with Special Health Care Needs



**What about youth with special health care needs?
What is it like transitioning from pediatric to adult
systems of care?**



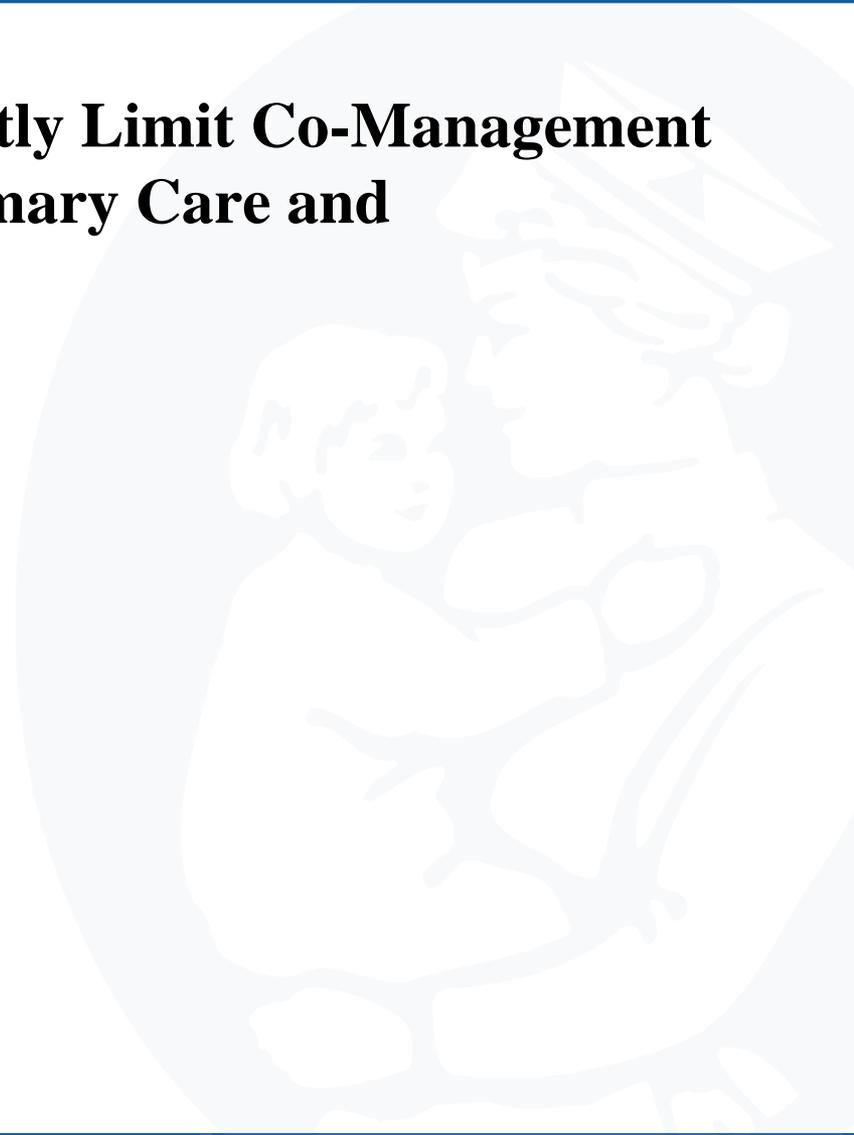
Outcome Realities

- **Nearly 40% cannot identify a primary care physician**
- **20% consider their pediatric specialist to be their 'regular' physician**
- **Primary health concerns that are not being met**



How Can We Address this Disparity?

- **Administrative Barriers Currently Limit Co-Management Among Pediatric and Adult Primary Care and Subspecialty Care**



Where Can the System Generate “ROI”?

- **The “other” transition!**



Why Is Hospital Discharge Such a Driver of Cost and Inefficiency?

Hospitals Pay for Cutting Costly Readmissions

By [REED ABELSON](#)

PUBLISHED: MAY 8, 2009

It is one of the biggest avoidable costs on the nation's medical bill.



What About Transitioning Care from In-Patient to Out-Patient?

- **The greatest opportunities for improving care transitions center around improving communication, building cross-setting relationships, and redesigning our workflow."**
~ Eric A. Coleman, MD, MPH
- **3 Questions Administered at Discharge that Highly Correlate with Risk of Readmission– geriatric focus**
- http://caretransitions.org/ctm_main.asp
- **It applies to pediatrics as well!**



What Can We Do Now to Transform the System?



1 Care Plan Utilization

- Integrated Care plan can document “transactions” in the health care system!
- can be the template for any encounter
- family retains a practical plan designed to address most pressing current concerns
- should include emergency care plan elements
- **THIS IS HOW WE WILL SUPPORT TEAM-BASED CARE!**



Needs Assessment

- **Develop a Standard Tool for Assessment**
(**HINT: create in conjunction with practice family advisory partners**)
- **Prioritize concerns of child/family.**
- **Clarify goals and values.**
- **Assist in linkages for the child/family.**
- **Categories should include health, mental health, financial, education, support groups, developmental needs, and social services.**



Care Plan Elements

Medical Home-Based Care Plan

Prepared for:

Primary Care Provider PCP:

Prepared by: Care Coordinator

Date Plan Prepared:

Problem	Activity	Who will do	By When	Expected Outcome	Follow-Up

2 Access to What?

- Team-based Care in Family-Centered Medical Home
 - Families/ youth, MD, NP/ PA, RN, MA
 - Care Coordinators
 - Family-to-Family
 - Social Work
 - Nursing
 - Education
- Co-Management and Collaborative Care Models



TABLE 1: Patient, Provider, and Community Characteristics as Determinants of Models of Co-Management for CYSHCN

Model	Access to Primary Care	Access to Subspecialty Care	Complexity of Condition	Access to Specialized Services
PCP as Primary Manager	adequate	adequate or limited	low-moderate	limited or adequate
PCP/SP Co-Management	adequate	adequate	moderate-high	adequate
SP as Primary Manager	adequate or limited	adequate	high	adequate

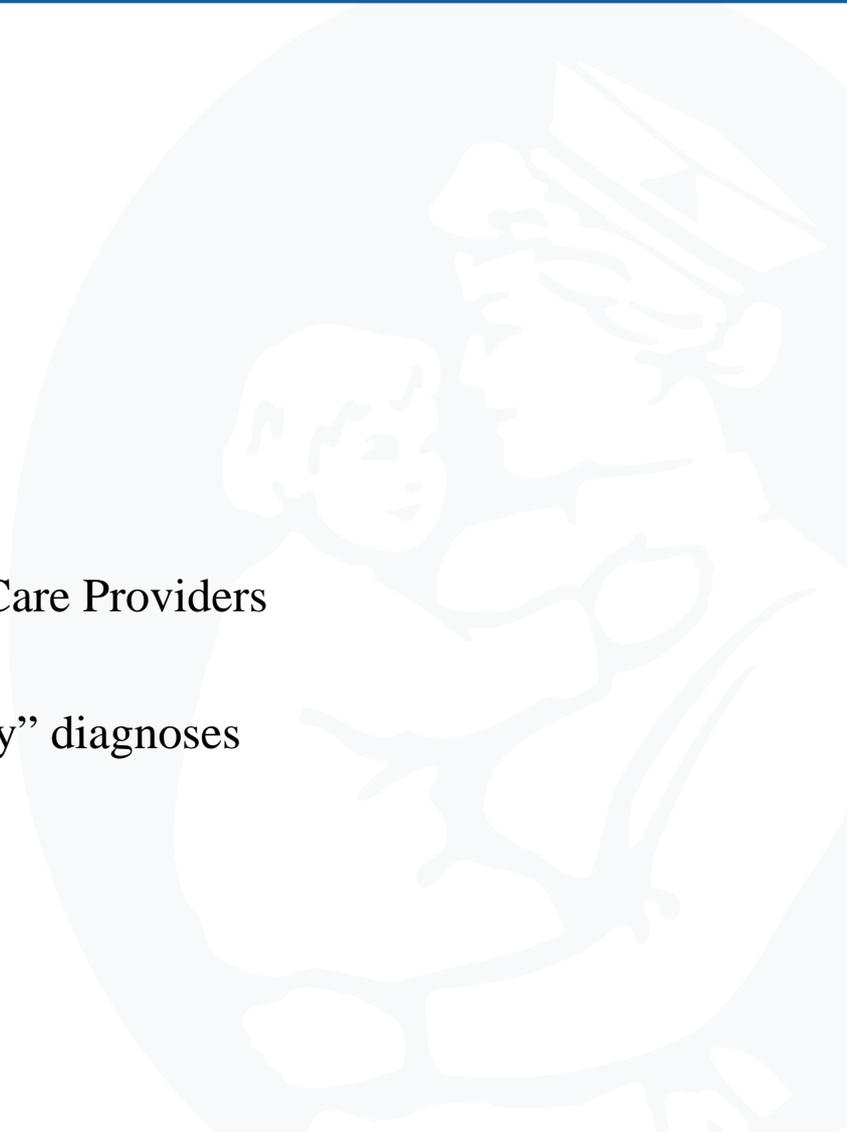
PCP = primary care provider; SP = subspecialist

from Antonelli, Stille, and Freeman, 2005



#3 Aligning Incentives and Goals

- How Do We Finance Care Coordination?
 - Document Competencies
 - Benchmark Process Indicators
 - Care Plans
 - Registry Use
 - Track Outcome Indicators
 - Family Engagement and Satisfaction
 - Access to Primary and Subspecialty Care Providers
 - Emergency Department Utilization
 - In-Patient Utilization for “Ambulatory” diagnoses



Next Steps for Care Coordination

- **Building on framework in The Commonwealth Fund Brief**
 - Develop multidisciplinary family-centered, CC curriculum
 - Pilot the curriculum and evaluate efficacy
 - Link CC to outcomes
- **Continue to work with Federal and State Policy Partners**
 - Build CC framework into state and federal legislation and regulatory language
- **Continue Collaborations with NCQA and with National Quality Forum to incorporate performance and outcome measures into system designs**



References

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- **Lotstein DS, Ghandour R, Cash A, et al. 2009. Planning for health care transitions: Results from the 2005-2006 National Survey of Children with Special Health Care Needs. *Pediatrics* 123(1):e145-e152.**



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
- <http://www.hrtw.org>: tools and resources to support youth transition to adult systems

