

The Medical Home Initiative for CYSHCN in Connecticut

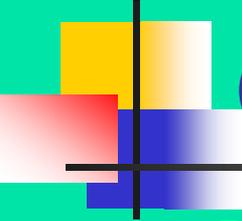
CT Department of Public Health

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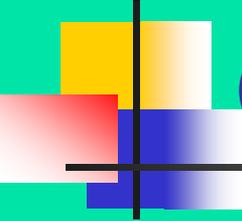
Title V CYSHCN Director





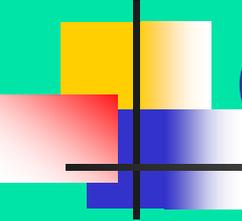
Evolution of Services from Centralized to Community Based

- 2002-2005 Services were centralized through two large tertiary care centers (Yale and Connecticut Childrens'); in 2005 approximately 900 CYSHCN received care coordination services.
- In response to requests by the Office of the Child Advocate and other stakeholders, the Medical Home Advisory Council was established to provide guidance and advice to the Connecticut Department of Public Health in its goal to improve access to community based care for Children and Youth with Special Health Care Needs (CYSHCN) by connecting them (ensuring their connection) to a medical home that is accessible, compassionate, comprehensive, continuous, coordinated, culturally competent and family-centered.



Evolution of Services from Centralized to Community Based

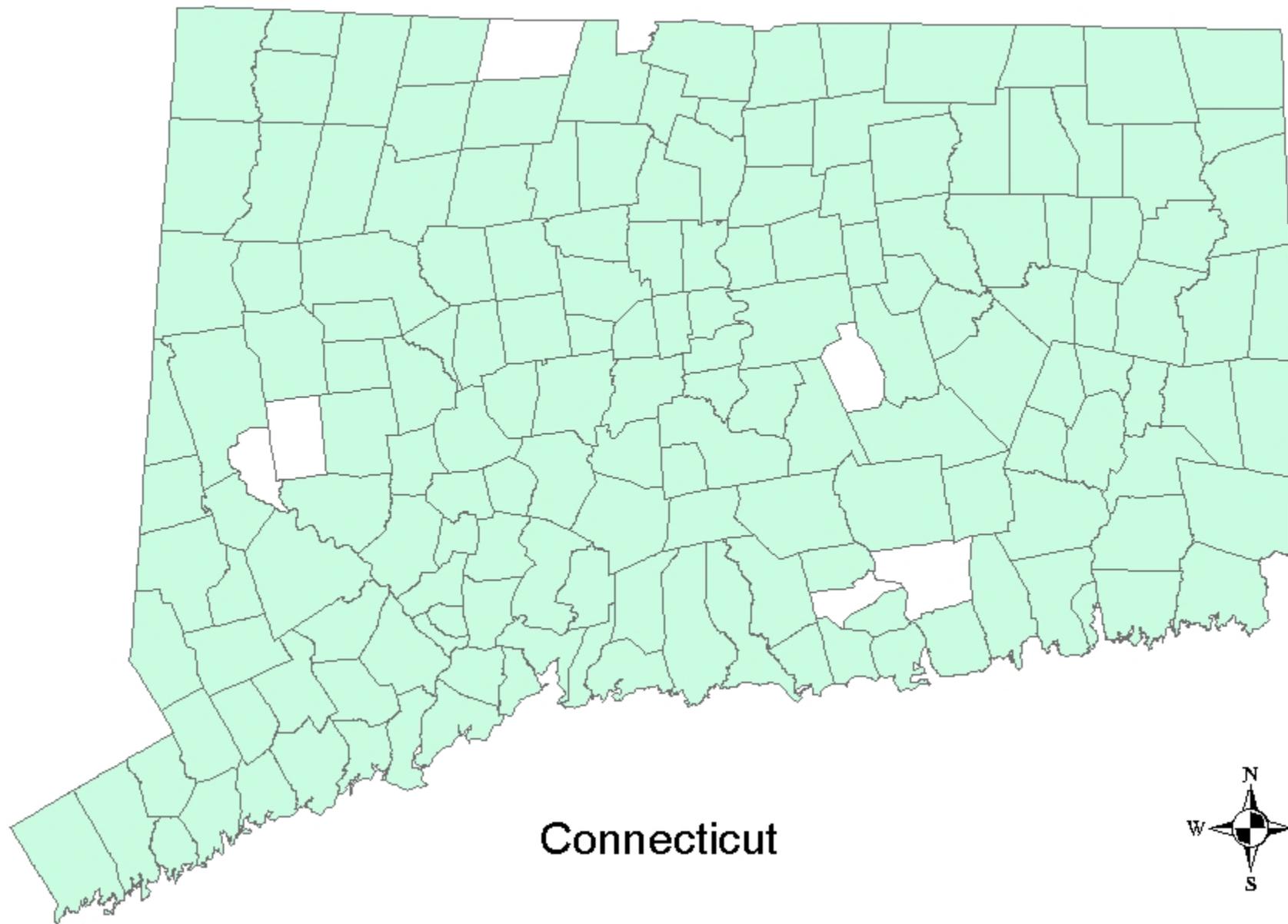
- 2005-2007 Services were regionalized through five Special Needs Support Centers; in 2007 - 2,820 CYSHCN received care coordination services.
- 2007-2009 Services were contracted to five area care coordination networks who provided co-located or embedded care coordination services in pediatric primary care settings. Child Health and Development Institute and the Family Support Network partnered to implement provider and family outreach and education statewide. Child Development Infoline (United Way) served as a statewide single point of entry and referral. CT Lifespan Respite Coalition served as a statewide respite and extended services administrator.



Community Based System

- 6,782 CYSHCN received care coordination services between July 1, 2008 and June 30, 2009
- More than 100 different primary diagnoses
- 40% between Autism, Asthma and ADHD
- Provided in 32 medical homes including community health centers, hospital clinics, pediatric and family practices
- Care Coordination includes assessment, care planning, home visits, family advocacy, linkage to specialists, linkage to community based resources, coordination of health financing resources, coordination with school based services, **chronic disease case management**, family education.

CYSHCN Care Coordination Services 2008





Connecticut Medical Home Initiative for Children & Youth with Special Health Care Needs

Who is eligible?

Children & youth age 0 to 21 who have, or are at increased risk for, a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Services available?

All families of eligible children and youth with special health care needs (CYSHCN), regardless of income, will receive a respectful working partnership with you and your child's medical home; care coordination services and family support referrals.

Uninsured or underinsured families, who fall within income guidelines, can also benefit from payment for limited services (i.e. durable medical equipment, prescriptions, and special nutritional formulas). Contact the Connecticut Lifespan Respite Coalition, Inc. (CLRC) for more information at 877-737-1966.

SOUTHWEST

Stamford Hospital
Stamford

1-866-239-3907
(toll free)

SOUTH CENTRAL

Coordinating Council for
Children in Crisis
New Haven

1-877-624-2601
(toll free)

EASTERN

United Community and
Family Services, Inc.
Norwich

1-866-923-8237
(toll free)

NORTH CENTRAL

Connecticut Children's
Medical Center
Hartford

1-877-835-5768
(toll free)

NORTHWEST

St. Mary's Hospital
Waterbury

1-866-517-4388
(toll free)

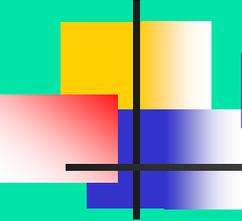
United Way of Connecticut's Child Development Infoline

*The central access point for Connecticut's Medical Home Initiative for CYSHCN.
Provides information about medical, educational and recreational resources*

1-800-505-7000

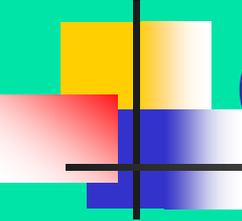
Connecticut Family Support Network

Contact for family support, information and advocacy at 877-FSN-2DAY



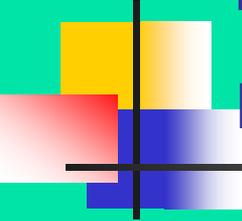
Care Coordination vs Case Management

- **Care Coordination:** focus: patient and family needs
- a holistic approach that ensures needs are met through team process and successful linkages to resources. Coordination includes both medical and non-medical domains and extends to coordination of health financing resources and family education. (complementary to...)
- **Case Management:** focus: resource utilization & benefits eligibility (insurance model)/ or human services - assists with access to supports and services/ **or Medicaid MCO chronic disease case management.**



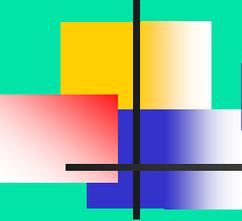
Quality Measures

- **Care Coordination:** Analysis of comprehensive care plans, family involvement in care planning, family satisfaction, screening for special health care needs, successful linkages to resources, EPSDT components. (System Goals and Objectives: MCH Block Grant PMs)
- **Case Management:** Analysis of performance improvement projects, mandatory reporting of data on case management for: high risk pregnancies, asthma, diabetes, cardiac, neurological, NICU babies, cancer, catastrophic illness, other chronic conditions. (System Goals and Objectives: Improve access to care and services – preventative and primary care, improve pre and post-partum care, improve provider network, reduce inappropriate ER use and admissions)



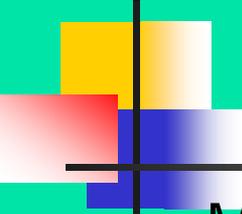
MCO PMPM (Includes Case Management) – Pharmacy, Dental and Behavioral Health are Carved Out

HUSKY A – Rate	Aetna	Ameri Choice	CHNCT
less than 1 yr	\$713.18	\$713.18	\$629.60
Age 1-14 M & F	\$91.41	\$91.90	\$88.15
SSI Age 0-20 M&F	\$479.52	\$479.52	\$472.63
DCF	\$125.25	\$125.25	\$123.45
Age 15-39 F	\$294.00	\$300.40	\$297.19
Age 15-39 M	\$110.15	\$110.15	\$99.85
Age 40+ Female	\$295.52	\$295.52	\$287.40
Age 40+ Male	\$212.95	\$212.95	\$212.95



Primary Care Case Management

- Established at the direction of the Medicaid Managed Care Council (www.cga.ct.gov/ph/medicaid/) as a fourth option to the three MCOs.
- 7.50 PMPM to participating providers for care coordination services in addition to primary and preventive services on a fee for service basis. Also provide case management for diabetes, asthma, depression and childhood obesity.
- Pilot with 59 providers and 211 consumers enrolled. (Approximately 300,000 HUSKY A enrollees)
- Barriers: no additional funds or time to providers for promotion, is not a default option, MCO contracts prohibit direct competition (can not actively promote to change from MCO to PCCM).



Collaboration and Potential

Medical Home Initiative for CYSHCN is collaborating with PCCM providers and MCO Case Managers to.....

- avoid duplication of services,
- maximize limited resources,
- increase care coordination capacity in practices,
- develop strategies for reimbursement of care coordination services, and
- serve more CYSHCN and families.