Housekeeping Details

• All lines are muted throughout the webinar.

• Have a question?
  • Use the available pods and we will facilitate a discussion at the end of the presentation.

• This meeting will be recorded.

• The recording and presentation slides will be posted to the CHA website a few days following the presentation.
Engaging Community in Care Coordination: Two Member Experiences

Member Highlights
June 6, 2017
Welcome

Lowrie Ward, MPH, CPH
Manager, Practice Transformation
Children’s Hospital Association

Champions for Children’s Health
Children’s Hospitals: Creating Health

• Commodity-driven health care system is not generating the optimum health for children.

• Much of health care is not curing factors that decrease life quality/expectancy. Majority of spend treats symptoms.

• Need to understand populations, subpops and what drives cost and health
Engaging Communities to Optimize Care Coordination

Rosemary Frasso, PhD, MSC, CPH
Public Health Program

Jillian L. Baker, DrPH
Assistant Professor

Jefferson College of Population Health
Today’s Presenters – Boston Children’s

Richard Antonelli, MD, MS
Medical Director Integrated Care

David K. Urion, MD
Director of Behavioral Neurology Clinics and Programs
Partnering with Families to Redesign Care at Boston Children’s Hospital: Care Integration to Improve Outcomes for Patients with Complex Needs

CHA Webinar: Engaging Community in Care Coordination

Richard C. Antonelli, MD, MS
Medical Director of Integrated Care, Boston Children’s Hospital
Assistant Professor of Pediatrics, Harvard Medical School

David K. Urion, MD, FAAN
Director, Behavioral Neurology Clinics and Programs, Boston Children’s Hospital
Charles F. Barlow Chair in Neurology
Associate Professor of Neurology, Harvard Medical School

June 6, 2017
Objectives

• Describe current innovations in integrated care for patients with complex needs
• Understand that the tools and measures of care integration are scalable across populations
• Describe challenges and opportunities in health care reform that may impact care delivery and care integration
The Project Team

**Family Partners**
Irene Gladstone  
Rett Syndrome Association of Massachusetts

Richard Robison  
Massachusetts Federation for Children with Special Needs/ Family Voices

**Integrated Care Program**
Richard Antonelli, MD, MS, Medical Director

Casey Fee, SM, Program Manager

Hannah Rosenberg, MSc, Project Manager

Sonja Ziniel, PhD, Senior Survey Methodologist

**Department of Neurology**
David Urion, MD  
Director, Behavioral Neurology Clinics and Programs

David Lieberman, MD, Physician, Rett Clinic

Jennifer McCrave, RN, BSN, CNRN  
Nurse Clinical Coordinator

Mildred Mejia, RN, Rett Clinic

Lindsay Swanson, MS, Genetic Counselor

Christine Monterio, MSW, Social Worker

One Family’s Care Map

www.childrenshospital.org/care-coordination-curriculum/care-mapping
MIND THE GAP
Care Coordination
the set of activities in “the space between”- Visits, Providers, Hospital Stays

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 Integration for Children with Special Health Needs:
Improving Outcomes and Managing Costs.
National Governors Association Center for Best Practices, 2012
Domains of Integrated Care
Achieving the Quadruple Aim

- Person, Patient, Family, Caregiver Experience
- Care Coordination-- Co-creation and implementation of elements of a care plan
  - High Quality Handoffs
    - transfer of pertinent knowledge between members of a patient’s care team, irrespective of location and discipline, leading to maximize utility of every patient interaction
  - Care Tracking
  - Care Planning
- Utilization and Financial Outcomes
  - Admissions, readmissions, emergency department
- Provider Experience

*All these processes constitute Care Management:* achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.
Some Interventions to Date

• Shared Care Coordination Training with Families and Staff
• Pediatric Integrated Care Survey (PICS)—how do families feel we are doing?
• Improved Care Coordination Processes
  • Tracking Labs, Procedures, Consultations
• Post-Encounter Action Item Grid
Care Coordination Curriculum

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 family’s caregiving capabilities. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health and wellness outcomes. Key activities of Care Coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family.
Integrated Care Framework


- Integrated Care
  - "Holistic Care"

  - Team-Based Care
    - Team Configuration
    - Communication
    - Knowledge Sharing

  - Connection to Life/Community
    - (Connecting Medical Care and Other)
      - Information
      - Family Impact

  - Future (Care Planning)
    - Long-Term Plan/Roadmap
    - Goals
Pediatric Integrated Care Survey (PICS)

Five Domains of Integration
Access to Care
Communication with Care Team
Family Impact
Care Goal Creation/Planning
Team Functioning/Quality
Family Reported Experience of Care Integration

Pediatric Integrated Care Survey (PICS)

Treated you as a full partner in your child's care?

- Always
- Almost Always
- Usually
- Sometimes
- Rarely
- Never

Shared important information about your child's health or care with care team members outside the Neurology Clinic?

- Always
- Almost Always
- Usually
- Sometimes
- Rarely
- Never

Fall 2014
Spring 2016

Boston Children’s Hospital
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL
Family Reported Experience of Care Integration

Pediatric Integrated Care Survey (PICS)

Talked to you about things in your life that cause you stress because of your child's health or care needs?

- Always
- Almost Always
- Usually
- Sometimes
- Rarely
- Never

Explained who was responsible for different parts of your child's care?

- Always
- Almost Always
- Usually
- Sometimes
- Rarely
- Never
Improving Care Coordination

What do you receive prior to a patient’s visit?

• In general, the clinician’s reason for referral is available less than 10% of the time for ambulatory visits.

• If anything is in the patient’s EHR, our audits find the information:
  o Varies widely by referring provider
  o Most likely is a recent progress note from last PCP office visit
  o Rarely includes expectations for the referring relationship

• These gaps in communication lead to:
  o Frustration and confusion across the care team: PCPs, BCH subspecialists, patients, families
  o Uncommunicated and thus unaddressed objectives
  o Lack of clarity on roles and responsibilities for follow up
Creating High Quality Handoffs

Clinician Reason for BCH Visit

Purpose of the upcoming patient visit:
2 month old female w/ rhythmic jerky movements in sleep lasting 1-2 minutes. Extinguished when awakened, but lasting longer than typical sleep myoclonus. Also w/ low axial tone on exam. Please evaluate for potential seizure disorder.

Relevant clinical and/or psychosocial information:
Normal birth hx. No fhx sz d/o.
Please see progress note from 12/15/2016 and growth charts.

Requested referral relationship:

- One-time consultation
- Co-management/shared care
- Subspecialty-based management
- To be determined

If other, please specify: PCP to resume care unless pt found to have seizure disorder.
Care Coordination Tracking and Planning

*Care Coordination Measurement Tool (CCMT)*

- **Captures Value of CC activities— For Both QI and Business Planning**
  - Supports efforts of all disciplines doing CC
  - Identify Gaps and Redundancies in Care (eg, vulnerable and underserved populations)
  - Rationalization of workforce education and deployment-- functioning at “top of license or scope”
  - More accurate reflection of true cost of care— enables sustainability of move from reactive to proactive care; fee-for-service to value-based care delivery

- **Adapted to capture activities/ outcomes in diverse settings (adult, child)**
  - Community Health Workers
  - Social Workers
  - Primary Care
  - Subspecialty Care (behavioral, surgical, medical)
  - Home Care
  - Families

Care Coordination Activities - Neurology

• Data collected by Jennifer McCrave, RN, BSN, CNRN and Cathy Curro-Harrington, RN, BSN, CPN for 205 encounters between December 2015 and July 2016.
Financial Outcomes for Patients with Complex Needs

BCH Neurology/ Integrated Care Program Collaboration

- Reduced Expense by 10%, primarily by shifting in-patient to ambulatory
- Reduced 30 day, all cause readmissions from 22% to 13%
- Reduced Emergency Department usage
- Not specific to single primary care integration partner
What About Adult Patients?
Problem Statement: Transition/ Transfer of Care to Adult Systems

• Many patients with complex, chronic conditions that begin in childhood “age out” of pediatrics but have challenges finding adult care providers who are accessible and comfortable with their care
  o Medical Homelessness
  o Fragmented Care
    • Low Value (ie, high cost)
    • Reactive care
Hybrid Care Integration Model

- All aspects of care that can be provided by adult providers
- Those requiring on-going “pediatric” care stay engaged
- Integration results from coordination between adult and pediatric providers
<table>
<thead>
<tr>
<th>Goal</th>
<th>Action</th>
<th>Who</th>
<th>When</th>
<th>Contingency</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor weight gain:</td>
<td>Refer to Nutrition at BCH</td>
<td>We will make appointment today</td>
<td>by April 14, 2017</td>
<td>Mother to call Rett Clinic team at 617-355-XXXX if questions</td>
<td></td>
</tr>
<tr>
<td>Nutritional support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquiring adult PCP</td>
<td>Dr. Smith in Chelmsford is able to become your PCP</td>
<td>Parent to call for initial interview/appointment</td>
<td>Call by end of April, 2017. First appointment should be by July 01, 2017</td>
<td>Call Rett Clinic to let us know your decision</td>
<td></td>
</tr>
</tbody>
</table>
| Getting information to Dr. Smith, new PCP | • Patient can [register here](#) for a BCH MyChildren’s Patient Portal account  
• Dr. Smith can [register here](#) for a BCH MyPatients Provider Portal account  
• Patient uses their MyChildren’s account to invite Dr. Smith to view their record in the MyPatients Provider Portal, and Dr. Smith accepts the invitation. | Parent can share this information at initial interview | By July 01, 2017 | Call Rett Clinic if questions |           |
Sustaining Care Models for Patients with Complex Care Needs in Era of Health Care Reform

• Are you in “accountable care arrangement”; ie, ACO?
• Are your complex patients included in financial risk models?
• How does your leadership view the value you contribute to the system performance
  o Cost
  o Quality
  o Experience
• Can your care model reduce cost?
Value-Based Payment Models for Medicaid Child Health Services

Payment Model all Children Except those with Medical Complexity

- Capitated Primary Care Payment (incorporating behavioral health)
- CC Payment (risk adjusted per-patient-per-month)
- Performance Incentive Bonus

Value-Based Payment for Patients with Medical Complexity

- Total Cost of Care-model evolving from shared savings to shared risk
- CC Payment- risk adjusted per-patient-per-month

Conclusions

• Measure each domain of care integration
  o Begin with Family Experience
• Define “Value Proposition” of your Care Model
  o Cost, quality, experience
  o Measurement
• These tools and measures are scalable across populations and ages!
Contact

richard.antonelli@childrens.harvard.edu

Medical Director of Integrated Care
Boston Children’s Hospital
Harvard Medical School
Select References


- **MA Child Health Quality Coalition Care Coordination Framework.** Funded by the Centers for Medicare and Medicaid Services (CMS) through grant funds issued pursuant to CHIPRA section 401(d). Contact: grogers@mhqp.org www.masschildhealthquality.org/work/care-coordination/


- **AHRQ Care Coordination Atlas** (McDonald Nov 2010, June 2014) and companion document Care Coordination Accountability Measures for Primary Care (McDonald Jan 2012).


- **Care Coordination Curriculum and Care Mapping Tool User Guides:** Antonelli, Browning, Hackett-Hunter, McAllister, Risko; Lind. Boston Children’s Hospital; funded thru Family Voices/MCHB HRSA grant. 2012. www.childrenshospital.org/care-coordination-curriculum
Today’s Presenters – HSHS St. John’s

Kim Luz, MS, CHES
Divisional Director of Community Outreach
HSHS St. John’s

Tracey Smith, DNP, PHCNS-BC, MS
Director of Population Health Integration
Southern Illinois University Medicine
Connecting Community to Healthcare For Those Who Are Medically Complex and Socially Fragile

Children’s Hospital Association 2017

Kim Luz, MS, CHES
Divisional Director of Community Outreach, HSHS St. John’s Hospital

Tracey Smith, DNP, PHCNS-BC, MS
Director of Population Health Integration, SIU Family and Community Medicine
Objectives

• Identify 2 ways that we have focused on community engagement for better patient and population health outcomes

• Identify how we have used the concepts of value-based care to develop the foundation for this project

• Identify 2 ways that we have taken a whole person approach to wellness including the integration of mental and behavioral health

• Identify how we are moving the program from a pilot to a practice
# FY17 CHNA Priorities:

<table>
<thead>
<tr>
<th>HSHS St. John’s Hospital</th>
<th>Memorial Medical Center</th>
<th>Sangamon County Department of Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
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<tr>
<td>Pediatric Mental Health</td>
<td>Mental Health</td>
<td>Child Abuse</td>
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<td>Pediatric Obesity</td>
<td>Obesity</td>
<td>Pediatric Asthma</td>
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<tr>
<td>Pediatric Asthma</td>
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Designing the Strategy

Zip Codes 62701, 62702, 62703
- Pop. 68,750
- 35% of county’s population: 59% of Springfield
- Ranked worst on index
Enos Park Neighborhood

Diabetes
Hypertension
Mental Health
Pediatric Asthma
Community Engagement

Four Focus Groups:

- Points of access to health care
- Trust of medical community
- Transportation
- Health literacy
- Health insurance
- Prescription medication
- Other needed services

Outcomes:

- Lack of relationship between patient and provider.
- Unaware of healthcare systems.
- ED provides convenient access: cost, location, hours.
- Transportation.
- Competing priorities: Unmet basic needs.
Community Health Worker (CHW) Model

- Focus on coordination of care
  - Trust
  - Patient-centered
- Clients referred by churches, service agencies, neighbors, schools, hospitals, self-referred, etc.
- Identify and connect resources
  - Healthcare - Establish a Medical Home
  - Social - Decrease isolation
  - Activities of daily living
    - Housing First Model
  - Financial
Who is a community health worker?

“A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.” (2015)

American Public Health Association
Value-Based Care Model

**Why**
- Poor community health / zip code issues (crime, disease, ED use, high school exclusions)
- SDOH (the place)
- No-shows, firing patients, time to first appointment, limited new patient slots/Engagement issues

**What**
- A program to decrease overuse of health care by high-cost, high need patients, to improve patient care experience, enhance population health, and **increase revenue collected**
- Create a family approach to care

**How**
- Get to know and address SDOH, zip code issues through an integrated team/one stop shop
- Goal is to decrease no shows, not fire patients, provide access to needed care/create a family care plan

**Barriers**
- Getting the community around concept of a primary care medical home
- Transportation; Scheduling Patients; Integrated Team; Clinic Session Design; Cost
- “The provider doesn’t listen to me so why should I come in?”
Whole Person Approach: Root Cause Analysis
Case Conferencing: The Family Story

• A high percentage of children with challenging behaviors face adverse experiences including family health, mental health, substance abuse, or domestic violence.

• Conditions of poverty contribute to stress, depression, and other mental health problems. In a national sample of parents of children 0-9 in deep poverty:
  – 25% had no one in neighborhood they could count on for help.
  – 29% said the neighborhood was not safe for their children.
  – 24% were in fair or poor versus good health.

You cannot treat the child without taking into account the adult.

(www.nccp.org) (Ekono, Jiang, Smith, 2016)
“SDOH Map”

https://goo.gl/DdWOC5
From Pilot to Practice: “Who is Cindy”

• 7-year old girl brought to clinic after connecting with CHW.
  – Sensitive: hides and cries; is very emotional.
  – Sleep is reported as okay.
  – Low self-esteem: She is called ‘fat’. Does not like her skin color or hair.
  – Cannot see well when asked to read.
  – Teachers have reported that Cindy does not read at grade level.
  – Parents have shared custody.
  – Cindy states there is a lot of fighting (verbal, not physical) at dad’s house.
From Pilot to Practice: “Who is Cindy”

- PMHx/PSurghx: none
- Meds: none
- ROS: negative
- Growth Chart without abnormality
- Immunizations are up to date
- PE:
  - Vital signs stable
  - No acute distress, well appearing, and well nourished.
  - Neuro: Grossly normal.
  - Psych: Quiet. Good eye contact. Appears shy.
From Pilot to Practice: “Who is Cindy”

• Assessment & Plan:
  – “Crying”, “poor self esteem”
  – Avoiding labels and diagnoses.
  – Referred for Counseling.
  – Encouraged mom to work on positive reinforcement.
  – Recommended follow up in 1 month.
  – Recommended formal eye exam yearly.
  – BUT the CHW is able to help highlight that:
    • Cindy has difficulty with letters and is getting extra help at school.
    • Numerous past referrals (8) from the emergency department for counseling for the children in the family but never completed by the mother.
    • Then when we do an eye exam Cindy will not read letters only symbols
“Cindy” and Family’s Intervention

**Parenting Education**
- Positive Interaction
- Behavior/Chore chart.
- Psychoeducation

**Therapy**
- Weekly in-home therapy.

**Income**
- Supplementing low income.
- Work with community health worker to assist with socioeconomic needs

**Medication**
- Pharmacist Interaction:
  - Medication Management
  - Medication Reconciliation

**Disease Management**
- Regular CHW phone calls.
- Specific care plan education.
- Proactive management of medical symptoms in outpatient setting.

**Transportation**
- Medical appointments for the entire family.
Family Healthcare Service & Financial Utilization

PCMH / PCP Office Visits

Carla

Total Children Visits

- 2015
- Jan 2016 - Aug 2016
- Sept 2016 - March 2017
Family Healthcare Service & Financial Utilization

- **Sept. 2016 – March 2017**
  - (1.2 visits per month)


- **Nov. 2015 – Dec. 2015**
  - (2.5 visits per month)
Outcomes

Reached Special Populations:

- 26 people who were parolees
- 15 people who were homeless (87% now housed)
References


Discussion

Pose questions to “All Participants” using the chat box on the right side of your screen, or simply use the Q/A pod.
UPCOMING 2017 WEBINARS

**Member Highlight: Hospital Collaborations with Schools**  June 19 | 2:00pm ET

**Integrating Mental Health and Behavioral Health**  June 21 | 2:00pm ET

**Member Highlight: Integrating Mental and Behavioral Health**
Children’s Health, Dallas and Children’s Hospital of Wisconsin
June 29 | 2:00pm ET
Thank You; Provide Feedback

• It’s brief!

• When you exit the webinar, the survey will launch on your screen.

• Please take a few minutes to give us feedback.
Contact: Stacy Biddinger  
Manager, Community & Child Health  
Stacy.Biddinger@childrenshospitals.org