# Tri-state Children's Health Improvement Consortium

## CHIPRA QUALITY DEMONSTRATION GRANT

## ALL GRANTEE CALL

## APRIL 17, 2012

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# Presentation Objectives

- Overview of the Tri-state Children's Health Improvement Consortium or T-CHIC
- Approaches to identifying children with special health care needs (CSHCN) including preliminary policy and practice level implications
- Highlight Oregon, West Virginia and Alaska's efforts around care coordination and identification of children with special health care needs
  - Focus on how states are working to operationalize these activities, including similarities, variations and potential implications

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# T-CHIC Overview

- Consortium is an alliance between the Medicaid/CHIP programs of Alaska, Oregon, & West Virginia
- Consortium, with varying levels of experience and expertise in each category is:
  - Measuring the quality of children's health care, using a variety of indicators to drive quality improvement
  - Demonstrating unique and combined impact of patient-centered care delivery models and HIT on the quality of children's health care
  - Facilitating ongoing cross learning at the state- and practice-level to inform state and national policy
- Outcome will be to develop a comprehensive framework for quality measurement, HIT, and delivery system models to markedly improve children's health care quality; achieving the goals of CHIPRA

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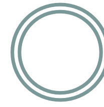
# Integration of CHIPRA Categories



**A**
Quality measurement

Measures enable ongoing, flexible tracking of PCMH impact →

← PCMHs provide data on feasibility, cost, and value of measures

**C**
Patient-centered medical homes

← HIT enables timely tracking and use of quality measures

Measures inform and evaluate impact of HIT ↘

HIT supports PCMH functions (e.g. care coordination) ↗

↙ PCMHs drive service-oriented development of HIT

**B**
HIT systems

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# Children with Special Health Care Needs

- The Maternal and Child Health Bureau defines CSHCN as:
  - *"Those 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."*
- CHIPRA legislation
- T-CHIC working to identify methodologies to inform state- and practice-level systems and process to ensure appropriate identification of CSHCN for enhanced care coordination and planning

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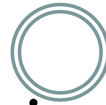
# T-CHIC Baseline Assessment



## Stratification Capacity

| | | Special health care needs |
|---|---|---|
| **Administrative** | Ability to Stratify | *OR* |
| | Written Specifications | *OR* |
| | Validity | *Moderately, Slightly* |
| **Medical Chart Review** | Ability to Stratify | -- |
| | Written Specifications | -- |
| | Validity | *Not at all, Slightly* |
| **Parent/Patient Survey** | Ability to Stratify | *OR, WV* |
| | Written Specifications | *OR* |
| | Validity | *Very, Very* |

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# Children with Special Health Care Needs (CSCHN)

- Practices benefit from use of standardized tools to identify CSHCN, so that there is consistency across different practice types, and more effective care coordination for CSHCN
- T-CHIC is supporting practices in developing methods to identify CSHCN –that are non-condition specific, feasible and sustainable, and involve some level of family engagement and partnership
- Oregon's practice sites -
  - Initial Lessing Session and QI efforts focused on implementing a standardized system
  - Learning Curriculum developed in partnership with the Oregon Center for Children and Youth with Special Health Needs (Title V)
- Alaska practices are evaluating tools for adoption, receiving technical assistance from CAHMI
- West Virginia's practices are utilizing the state Office of Maternal Child and Family Health to refer CSHCN (generally disease specific to a care team)

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- Practices needed support in developing systems
  - Processes in place to identify condition specific groups, but none focused on how to operationalize MCHB definition
  - Why for children this is imperative (see attachment)
  - Developed curriculum goes from identification to care coordination (see attached)
  - Majority of practices are using the Child and Adolescent Health Measurement Initiative (CAHMI) screener to identify CSHCN
- Key findings
  - Requires a "mind shift"
  - EMR's are very limited in this regard, don't provide registry functions
  - Patient engagement requires work flow analysis
  - Processes vary depending on how screener results are used (by PCP vs. by Care Coordinator)
  - Approach implications with payment incentives underway in Oregon anchored to ACA

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# Spotlight of Learning in Oregon: Policy Level Implications

- Medicaid/CHIP CYSHCN
  - Current data sources available: Claims & Enrollment
    - Exploring options for how parent report could become part of enrollment, provider attestation of CYSHCN
  - Current definition anchored to dual-eligibles
  - Exploring enhancing approach based on practice-level learning and learning from CAHPS PCMH implementation
    - For the CAHPS PCMH developing a sampling strategy to identify CYSHCN using Medicaid/CHIP claims and enrollment information
    - Include CAHMI screener in the CAHPS PCMH

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# Care Coordination: T-CHIC

- T-CHIC care model(s) will provide insights into which characteristics of medical home have greatest impacts on patient's experience of care and health outcomes
  - Examples:
    - Oregon: facilitation of a Learning Collaborative around the goals/outcomes and sharing practice-level innovation to achieve goals
    - West Virginia: supported Care Coordinators in each of the 10 practices to bridge the gap between patients, family members and providers and will facilitate communication among patients, family members, and healthcare providers
- T-CHIC exploring attributes of PCMH models, including implementation and evaluation, that are viable and replicable in multiple environments

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# Care Coordination: West Virginia

- Defining care coordination
  - Care Coordinators:
    - Are clinical extenders that work with patients, are familiar with the community, and understand the population
    - Coordinate care through investigation, diagnosis, and treatment from multiple providers and across one or more providers
    - Are “barrier busters”
    - They are not clinicians

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# Care Coordination: West Virginia

- Who are the care coordinators
  - One in each  of the ten practices
  - Full time employee
  - Various educational backgrounds
  - Someone who is compassionate, sensitive, culturally attuned to the people of the community
  - Knowledgeable about the environment and healthcare system
  - Have previously worked in advocacy roles

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# Care Coordination: West Virginia

- Care Coordination is Proactive verses Reactive
  - Facilitate communication among patients, family members, survivors and healthcare providers
  - Coordinate care among providers
  - Assist with financial support and assist with paperwork when appropriate
  - Arrange transportation and child care
  - Ensure that appropriate medical records are available at medical appointments
  - Facilitate follow up appointments
  - Community outreach and build partnerships with local agencies and groups

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# Care Coordination: Alaska

- 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 caregiving capabilities of families
  - Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes
- Care coordination activities
  - All sites are now hiring or assigning staff to increase care coordination
  - Exploring CAMHI screener for CYSHCN
  - Learning collaborative on care coordination - January, 2012
  - Challenges of remote sites - nearest specialized care is 3-hour plane flight away

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# Care Coordination: Alaska (Nuka Model)

- Southcentral Foundation "Nuka" system of care
- Nuka is AK Native word used for strong, giant structures and living things
- Patients are empanelled customer/owners
- Each customer/owner is served by an Integrated Care Team (ICT) to proactively manage their health
- ICT is non-hierarchical and consists of
  - Provider (Physician, NP, PA)
  - RN Case Manager
  - Certified Medical Assistant and
  - Administrative support staff member
  - BH consultant or dietitian when needed

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# Care Coordination: Alaska (Nuka Model)

- Locations convenient for customer/owners with minimal stops to get all their needs address
- ICT comes to the patient
- Emphasis on relationships between customer/owner, family, provider
- Wellness of the whole person, family and community
- Access optimized and waiting time limited
- Integration of services throughout SCF-no more islands
- Development of Nuka model has led to significant reductions in ER visits and admissions

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# Referenced Materials

- T-CHIC overview document
- Oregon ECHO Learning Collaborative & CSHCN
- Learning curriculum for practice sites & identification of CSHCN
- Childe and Adolescent Health Measurement Initiative (CAHMI) CSHCN Screener fast facts
- Alaska
  - Southcentral Foundation Nuka system of care: http://scf.cc/nuka
  - State of Alaska T-CHIC site: http://hss.state.ak.us/dph/healthplanning/tchic
  - Alaska care coordination definition from Commonwealth Fund report, May 2009 by Richard Antonelli, Jeanne McAllister, and Jill Popp

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