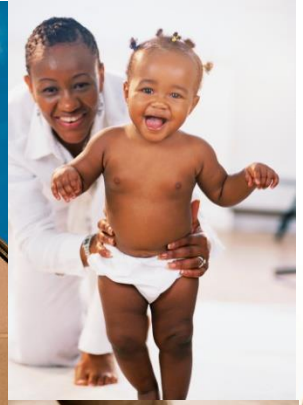
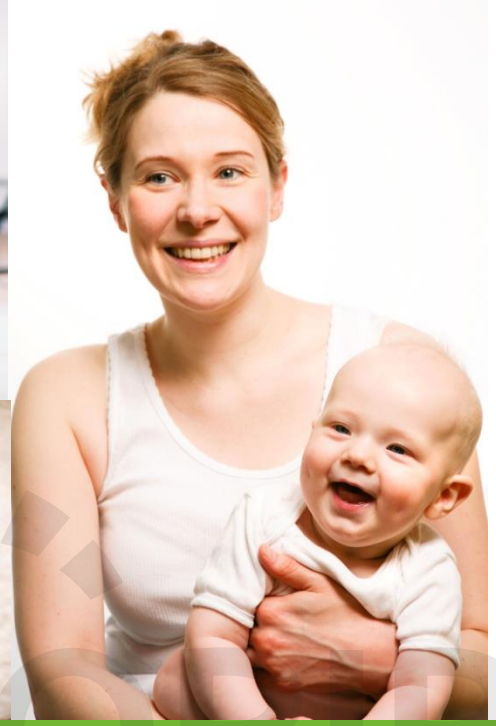






Complex Care Management for Children and Youth with Special Health Care Needs (CYSHCN)

August 11th, 2016

Northwest Health Foundation –

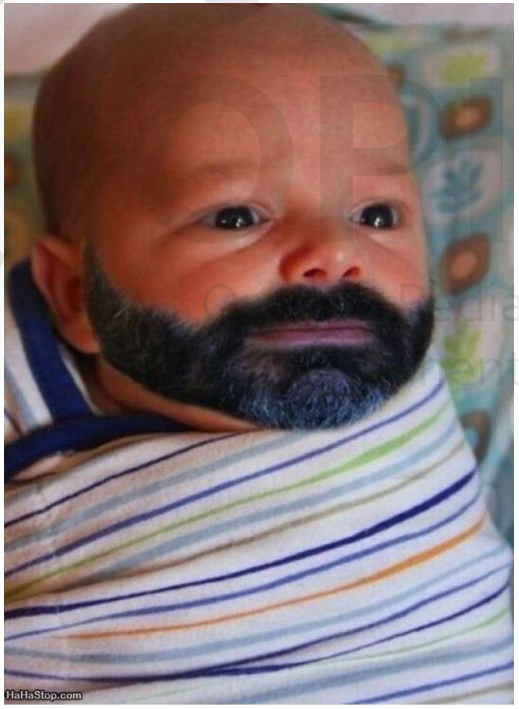
Bamboo Room

OPIP
Oregon Pediatric Improvement Partnership

Agenda

1. **Spotlight** of OPIP efforts with practices and health systems focused on care coordination and complex care management
2. **Keynote** from Rita Mangione-Smith, MD, MPH: Development of Innovative Methods to Stratify Children with Complex Needs for Tiered Care: Assessing Both Medical and Social Complexity
3. **Shared discussion about opportunities** for health systems to obtain and leverage data about children in existing state-level databases to inform complex care management **for children**
    - Input gathered will be used to inform OPIP proposal to Lucile Packard Foundation for Children's Health

Focus for Today is on Children…….
And Children are NOT Little Adults



This meeting will be a success if ……

- **Participants** learn about the important factors to **identifying children and youth with special health care needs (CYSHCN)**… and how it is different than identifying adults with special health care needs
- **Participants** learn about **innovation** occurring within practices and systems focused on CYSHCN
- **Participants** learn about **barriers to this innovation** and potential solutions that participants could help to support focused on:
  - **System-level data** and how it can be used to identify children who could benefit from care coordination
  - Support for **effective complex care management** that meets the needs of children and their families
- **Opportunities are identified among participants for the sharing and use of data** to identify WHO and what **complex care management** program would be most useful to **meet the needs of children**

Confirmed Attendees

State

- **Nancy Allen** – *Intensive Services Coordinator, Addictions & Mental Health Department, OHA*
- **Sarah Bartelmann*** – *Metrics Manager, Health Analytics Department OHA*
- **Margaret Braun** – *Senior Researcher, Oregon Youth Authority*
- **Lisa Bui *** – *Quality Improvement Director, Health Policy & Analytics Department, OHA*
- **Leslie Clement** – *Director, Health Policy & Analytics Department, OHA*
- **Lori Coyner** – *State Medicaid Director, OHA*
- **Angela Long** – *Business Intelligence Director, Oregon Department of Human Services*
- **Alison Martin** – *Assessment & Evaluation Coordinator, Oregon Center for Children & Youth with Special Health Needs*
- **Jeffrey McWilliams** – *Medical Director, Kepro & Oregon Health Plan Care Coordination (OHPCC)*
- **Susan Otter** – *Director & State Coordinator for Health Information Technology, Health Policy & Analytics Department, OHA*
- **Alfonso Ramirez** – *Children & Families Behavioral Health Services Manger, Health Systems Division, OHA*
- **Jim Rickards** – *Chief Medical Officer, OHA*
- **Evan Saulino *** – *PCPCH Clinical Advisor, PCPCH Program, OHA*
- **Sen. Elizabeth Steiner Hayward** – *Senator for District 17: NW Portland/Beaverton*
- **Karen Wheeler** – *Integrated Health Programs Director, Health Systems Division, OHA*
- **Cate Wilcox*** – *Manager, Maternal & Child Health Section, OHA*

CCOs and Health Systems

- **Maggie Bennington-Davis** – *Chief Medical Officer, Health Share of Oregon*
- **Jim Carlough** – *President & CEO, Yamhill CCO*
- **Casey Grabenstein** – *Maternal Child Health Program Manager, CareOregon*
- **Anna Jimenez** – *Medical Director, FamilyCare*
- **Bhavesh Rajani** – *Medical Director, Yamhill CCO*
- **Mindy Stadtlander** – *Executive Director, Network & Clinical Services, CareOregon*
- **Anna Stern** – *Medical Director, WVCH*
- **Joyce Liu*** – *Medical Director of Medicaid, KPNW Region*
- **Dave Wagner** – *IDD Psychology, OHSU (Representing NICH)*

Providers and OPIP Steering Committee Members:

- **Gregory Blaschke*** - *President, Oregon Pediatric Society; Pediatrician, OHSU Department of Pediatrics*
- **Albert Chaffin*** – *Pediatrician, Pediatric Associates of the NW; Children's Health Alliance/Children's Health Foundation*
- **Doug Lincoln*** – *Pediatrician, Metropolitan Pediatrics*

**** OPIP Steering or Partner Committee Member***

Helping to Support Today

- **Oregon Center for Children and Youth with Special Health Needs**
  - http://www.ohsu.edu/xd/outreach/occyshn/
  - Enhancing Systems of Services (SOS) Project: https://www.ohsu.edu/xd/outreach/occyshn/programs-projects/sos.cfm
- **Kaiser Permanente Care Management Institute**
- **Northwest Health Foundation for offering this free space for the meeting**

Some Background:
Why Was OPIP Interested in Holding This Meeting?

1) OPIP Collection, Examination and Use of Quality of Care Data by CYSHCN

- **Disparities by type of health care need**
  - Stratified data by consequences rather than diagnosis
  - Disparities by type of consequence
- **Disparities by family and social factors**
  - Examples: race/ethnicity, language spoken at home, education of the parent, health status of the parent

2) OPIP Support to Front-Line Practices on Medical Home for Children and CYSHCN

- **Enhancing Child Health in Oregon (ECHO) Learning Collaborative**
  - Eight primary care sites (5 pediatric, 3 family medicine; 3 Urban, 2 Suburban, 3 rural)
- **Tri-State Children's Health Improvement Consortium (T-CHIC) Learning Collaborative**
  - 21 sites across OR (ECHO Sites), AK, and WV
- **Patient Centered Primary Care Institute (PCPCI) Learning Collaborative**
  - Five pediatric practices across the state
- **OCCYSHN's Enhancing Systems of Services (SOS) federal grant.**
  - **OPIP Subcontract: Leading Learning Curriculum and Site-Level Coaching** to Pilot Methods to **Improve Access to and Quality of Medical Homes for CYSHCN**
    - One of these sites is Kaiser Permanente Northwest – Work is at a practice AND system-level

Relevant to Today's Discussions: Key Learnings About Complex Care Management in Primary Care

- Identifying CYSHCN requires a **multi-faceted** approach
- Primary care practices have **access to two data sources** (not all) to identify CYSHCN
  - Clinic-level data about diagnosis and use of health care within their practice
  - Parent and patient-reported data
    - Big focus of OPIP's facilitation efforts – largely new to most practices
    - Content focus: 1) Medical complexity; 2) Social complexity; 3) Care coordination needs
    - Practices would benefit from information about health and health services received OUTSIDE of the practice in order to be more effective as the primary care home
- In order to **effectively implement care coordination** and complex care management, **additional staffing is needed**
  - Given current payment, most practices can afford a limited number of staff
  - Given the emphasis on reducing costs, efforts typically look at medical complexity….but those may be the wrong kids to focus on
- Care coordination and **complex care coordination needs differ by child/family**
  - Practices need to use assessment tools to understand care coordination needs
  - Practices observe that **families with social complexity require a different type** of care coordination and would often benefit from different care coordination staffing
- Given **limited resources and staffing**, tools are needed to identify and weight: 1) WHO should receive care coordination, 2) WHAT care coordination team is best for the child and family

OPIP Work with Kaiser Permanente Northwest (KPNW) Via SOS Project

- Region-level activities to impact all children enrolled in KPNW
  - N=93,637 paneled to pediatrician. N= 115,500 in systems (includes FM)
  - 17,254 pediatric Medicaid patients
- Team Based Care (TBC) exists for adults not children
- Initial pilot level activities focused on children in Mt. Scott (MTS) and new pediatric Team Based Care for Complex Care Management, with potential to spread clinics across region

Three Parts to the OPIP Learning Curriculum & Support

#1	#2	#3
Support for Pilot of Complex Care MTS: Developing tools, strategies and care coordination methods	Based on MTS learning, support to develop standardized team-based care tools for CYSHCN that will be spread around KPNW	Develop System-Level Methods to Identify CYSHCN that Would Benefit from Complex Care Management

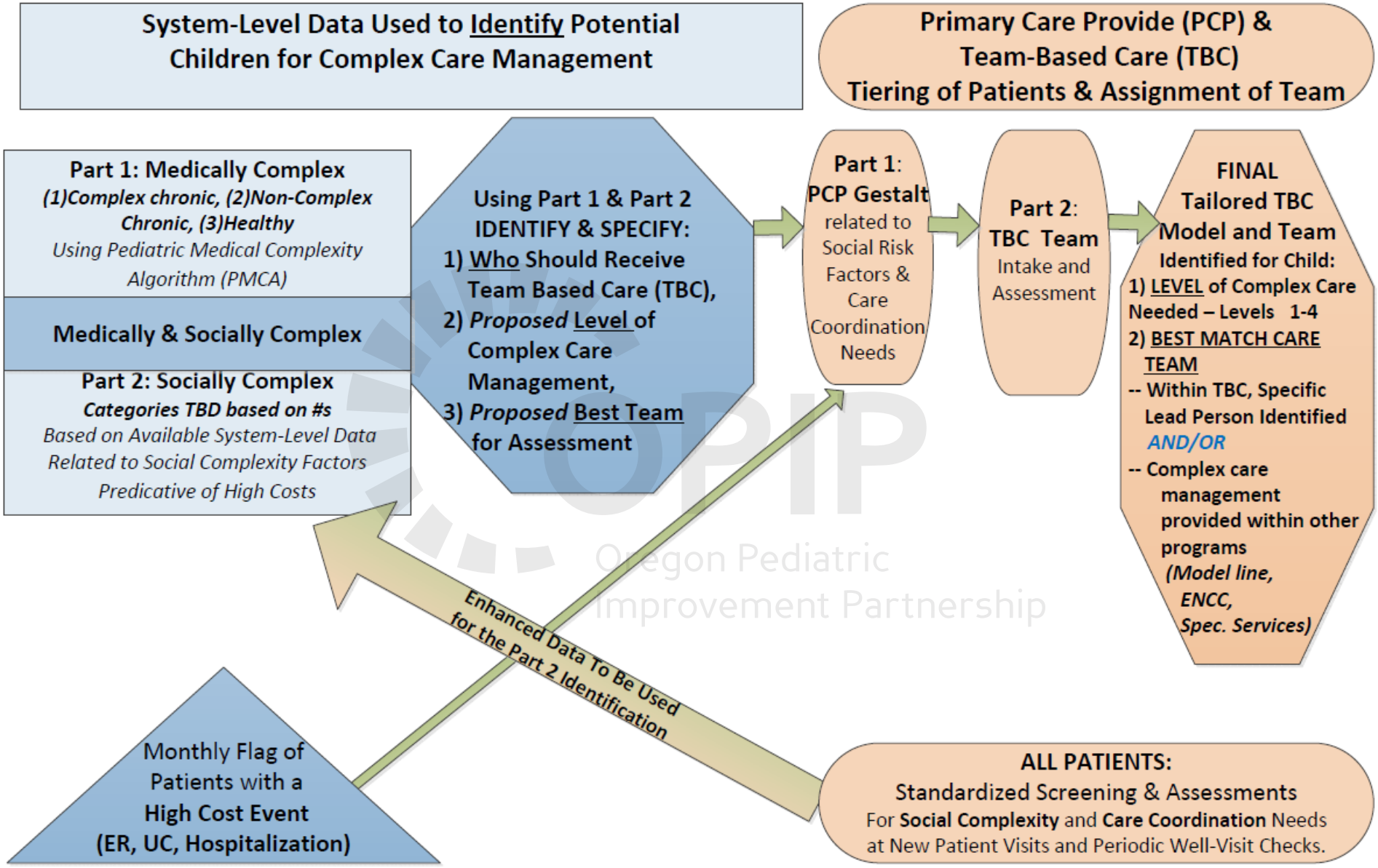
COE4CCN

HOME • COMMUNITY • HOSPITAL

Development of Innovative Methods to Stratify Children with Complex Needs for Tiered Care: Assessing both Medical and Social Complexity

Center of Excellence on Quality of Care Measures for Children with Complex Needs
University of Washington and Seattle Children's Research Institute

DRAFT STRAWMAN of Proposed Stratification and Tiering Model for Children & Youth in KPNW: Version 3



Relevant to Today's Discussions: Preliminary Learnings Related to Identifying and Tiering for Complex Care Management

- Team based care tools developed for adults provide an invaluable start….but much refinement is needed to be meaningful and useful for children & families
  - Refinement by age of child
  - Refinement by family context
  - Methods of engagement and outreach seem to require different approaches than what has worked with adults with chronic conditions/ on hospice
- Even within a "closed" system like KPNW, barriers to being able to access data across payors, by specific services, and about the parent
  - Mental health services, substance abuse services – special requests needed
  - Mental health services provided outside of KPNW for Medicaid insured children (KPNW is only "physical health" provider for children within CCO)
- System wants a focus on highest costs patients, but those may not be the kids who benefit from complex care management that impacts costs
- Missing data on social complexity risk factors that exist within state data systems
- Spotlight Provided at **OPIP Partner Meeting**: oregon-pip.org

PUNCHLINE FROM MEETING: Given this is new and focus on children is new→ Value in starting a state-level conversation to inform the pilot work already underway, inform new pilot work and inform spread

Time for Our Shared Discussion:

Opportunities to Build Off and Leverage These Learnings for Children and Youth in Oregon

Questions for Our Health System and Primary Care Providers Attendees:

- What resonated for you based on the data presented?
- What strategies do you use now to identify children to receive care coordination and/or complex care management?
- Health Systems: How many children within your health systems have parents also in your system?
  - Do you know the percent?
  - Have you already strategized on how you may use information at the family-level to better meet their needs?
- **What risk factors presented do you wish you had access to data about in order to better serve children and families?**
- **Based on the findings presented, what is the most exciting opportunity you think should be explored?**

Questions for Our Partners Within the State

- **Of the social complexity risk factors presented, which ones do you have access to?**
- What would it take to enable data sharing to better support children and families?
  - **Based on the findings presented, what is the <u>most exciting opportunity</u> you think should be explored?**
  - What are learnings from data sharing already occurring about children (e.g. foster care)?
  - What are there the biggest barriers and why?