Take Action on Care Coordination

Wednesday, April 13, 2016
10:30-11:30 PT, 1:30-2:30 ET

Sponsored by
Lucile Packard Foundation for Children's Health
Catalyst Center
PANELISTS

Sara S. Bachman, Ph.D.

Meg Comeau, MHA

Lisa Rossignol, MA

Kelly Kelleher, MD

Matt Lanphier, MPH

Regina Fetterolf, MS
• Please enter questions into the GoToWebinar chat box. Q&A with all speakers will take place at the end of the webinar.

• All attendees will be muted for the duration of the webinar.

• Webinar slides will be posted on the Foundation website and shared with all registrants.
INTRODUCTION

Edward Schor, MD
Senior Vice President
Lucile Packard Foundation for Children's Health
The Care Coordination Conundrum: An Overview

Sara S. (Sally) Bachman, PhD
Meg Comeau, MHA
The Catalyst Center
Boston University School of Public Health
The Care Coordination Conundrum

• What is care coordination?
• Who is eligible to receive care coordination?
• Who provides care coordination?
• How is care coordination financed?
• How is care coordination reimbursed?
Methods

- Comprehensive literature review
- Expert interviews
  - Interviews were conducted over the telephone, directed by a semi-structured interview guide
- Policy analysis
- Methods reviewed and approved by the Boston University Institutional Review Board
Key findings

- No consensus about what care coordination is, who should provide it, who should receive it, and how to pay for it
- Care coordination return on investment (ROI) has not been determined
- CPT billing codes for care coordination are not catching on
- Current models will not support a high-quality, sustainable care coordination system
- Care coordination falls to the child’s family – can be a financial, labor intensive burden
Recommendations

- Pool resources and use population-based financing and reimbursement models
- Establish the evidence base for care coordination, including return on investment (ROI)
- Develop comprehensive payment models that include risk-adjustment
Recommendations

- Identify key care coordination services that should be part of a bundled/capitated payment
- Link bundled or capitated payments to quality indicators and health outcomes
- Provide care coordination in teams that include licensed and non-licensed staff, and family, who share responsibility
It’s Not Enough to Have a Sick Kid

Lisa Rossignol, MA
FFHIC, Parents Reaching Out, Albuquerque, NM
The majority of care coordination activities that are carried out on behalf of children with special health care needs are done by family members.
Cost on Families

• Credit card debt
• My peers are now all Directors—even ones with typical kids—and I have been unable to professionally grow past being a program manager
• I haven’t worked a full 40-hour week since my husband got a full-time job in September
• I neglected my own health needs at times
• I have to prioritize health concerns without the benefit of formal medical training: Can the legs wait while we work on the skull? What about the hand? Is the behavior segregating her from friends? When do I get to just be “Mom”?
Contact us:

1920 B Columbia Dr. SE
Albuquerque, NM 87106

Phone 505-247-0192
Toll-free 1-800-524-5176
Fax 505-247-1345

Website:
www.parentsreachingout.org
What is Partners for Kids?

- Partnership between NCH and >1,000 physicians
- Responsible for >320,000 children
- Full financial risk through the 5 managed Medicaid plans as an “intermediary organization”
PFK’s Place in the System

Partners For Kids Flow of Funds

Partners For Kids receives funds for each child in the program for the child’s medical care.

Ohio Department of Medicaid → Pediatric Medicaid Managed Care Plans → Partners for Kids → Medical Care Providers → Surplus are reinvested into Child Health Programs

Nationwide Children’s
When your child needs a hospital, everything matters. PARTNERS FOR KIDS
Partners for Kids Population

In 2014, PFK was responsible for 333,354 children, broken down into the following groups:
What is Care Coordination (CC)?
High Risk Care Management

1. Identify and Assess
2. Diagnose the Gap
3. Plan for Goals
4. Implement Solutions
5. Evaluate
Staffing Model

Intensive, Engaged  1:25

Intensive, Passive 1:50

High, Engaged 1:75

High, Passive 1:100
# Staffing Model

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Enrolled</th>
<th>FTE</th>
<th>Teams</th>
<th>Enrolled patients per team</th>
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<tr>
<td>1</td>
<td>2,625.00</td>
<td>53.67</td>
<td>10.73</td>
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<td>82</td>
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<tr>
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<td>2.76</td>
<td>0.55</td>
<td>245</td>
<td>82</td>
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<tr>
<td><strong>TOTALS</strong></td>
<td><strong>4860.00</strong></td>
<td><strong>99.36</strong></td>
<td><strong>19.87</strong></td>
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</table>
Workflow

- Children identified by one or more sources
  - Claims based queries
  - Provider and community agency referrals
  - Predictive models
  - EMR data mining
Dashboard Tool to Review Utilization

Patient Name

Total Charges $10,683.97
Total Length of Stay 0.4 Days
Total Active Referrals 1

EMERGENCY 1	URGENT CARE 20	INPATIENT 0	SPECIALTY CLINIC 15

Last 12 Months
CSN	HAR ID	Admit Dt	Disch Dt

Chief Complaint	Dept
Crying	PERIOPERATIVE SERVICES
Arm Injury	URGENT CARE WESTERVILLE
Head Injury	URGENT CARE WESTERVILLE

Fever	URGENT CARE WESTERVILLE
Crying	URGENT CARE WESTERVILLE
Bar Drainage	URGENT CARE WESTERVILLE

Partners For Kids

Nationwide Children's
When your child needs a hospital, everything matters.
Manager Dashboard
Staff Performance Metrics

• Care Coordinator caseload by week

<table>
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<tr>
<th>Care Coordinator</th>
<th>1/11/2016</th>
<th>1/18/2016</th>
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<tbody>
<tr>
<td>Smith, Carey</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Jones, Sandy</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>White, Lori</td>
<td>38</td>
<td>43</td>
</tr>
<tr>
<td>Brown, George</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Green, Betty</td>
<td>38</td>
<td>40</td>
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• Initial Outreach Call Volumes and Outcomes

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<thead>
<tr>
<th>Number of Outreach Calls by Staff Member</th>
<th>Outcome of Outreach Calls by Staff Member</th>
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<tbody>
<tr>
<td>White, Lori</td>
<td>Week of 12/14</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>White, Lori</td>
<td>26</td>
</tr>
<tr>
<td>Red, Jenny</td>
<td>27</td>
</tr>
<tr>
<td>Yellow, Rachel</td>
<td>14</td>
</tr>
<tr>
<td>Orange, Joe</td>
<td>31</td>
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Enrollment Statistics

Average Enrollment by Quarter

<table>
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<tr>
<th>Quarter</th>
<th>Enrollment</th>
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<tr>
<td>2014 Q1</td>
<td>284</td>
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<tr>
<td>2014 Q2</td>
<td>273</td>
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<tr>
<td>2014 Q3</td>
<td>405</td>
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<tr>
<td>2014 Q4</td>
<td>550</td>
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<tr>
<td>2015 Q1</td>
<td>601</td>
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<tr>
<td>2015 Q2</td>
<td>566</td>
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<tr>
<td>2015 Q3</td>
<td>514</td>
</tr>
<tr>
<td>2015 Q4</td>
<td>620</td>
</tr>
<tr>
<td>2016 Q1</td>
<td>915</td>
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</table>
Keeping Complex Patients Home

Desired Direction of Change

Care Coordination

Care Coordination Expanded

Med. Dir. of Comprehensive Health Care Service (CCHCS) Starts HCIA Grant Awarded/Feeding Tube Task Force Formed Dietician & RN Join CC Team

Census Patient Days per 100 Feeding-Tube Patients

Chart Type: Run Chart

Patient Days per 100 Feeding-Tube Patients

Monthly Compliance  Baseline Median(s)  Baseline Periods  Control Limits (N/A)  Goal(s)

Census Inpatient Days

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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<tr>
<td>2011</td>
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</table>

Feeding Tube Cohort

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
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<td>724</td>
<td>725</td>
<td>726</td>
<td>727</td>
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</table>
Pre- and Post-enrollment Utilization Characteristics of Selected Patients Enrolled in Care Coordination 2014

Number of Inpatient Bed Days

<table>
<thead>
<tr>
<th></th>
<th>Pre-enrollment</th>
<th>Post-enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>300</td>
<td>150</td>
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</tbody>
</table>

Number of Emergency Department Visits

<table>
<thead>
<tr>
<th></th>
<th>Pre-enrollment</th>
<th>Post-enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>200</td>
<td>100</td>
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</table>
Cost Comparison

Cost Per Member Per Month: PFK Compared to Medicaid

- Green dots: Fee for Service
- Orange dots: Managed Care
- Blue dots: Partners for Kids

Year:
- 2008
- 2009
- 2010
- 2011
- 2012
- 2013

Per Member Per Month ($):
- 0
- 100
- 200
- 300

Graph showing the cost comparison over the years.
Patient Experience

Care Navigation: How the Program Helps Patients and Families
The Accountable Care Collaborative

Presented by: Matthew Lanphier & Regina Fetterolf

Mar-16
Care Coordination Strategies

• Every member has a Primary Care Medical Provider (PCMP)

• All ACC members and PCMPs belong to a local Regional Care Collaborative Organization (RCCO)

• Unprecedented access to data from the Statewide Data and Analytics Contractor (SDAC)

• Gradual introduction of payment strategies to reward outcomes instead of volume
ACC Components

Statewide Data and Analytics Contractor (SDAC)

Regional Care Collaborative Organizations (RCCOs)

Primary Care Medical Providers (PCMPs)
RCCOs

• Ensure a medical home for every member
• Develop and manage a network
• Support providers
• Ensure medical management and care coordination
• Report on progress and outcomes
• Accountable for health outcomes and costs
Seven RCCOs

RCCO 1

RCCO 2

RCCO 3

RCCO 4

RCCO 5

RCCO 6

RCCO 7
RCCO Payment Model

- Per-member-per-month payment (PMPM)
- Incentive payment for meeting Key Performance measures (KPI)
- May delegate care coordination duties to providers
PCMPs

• Serve as client-centered medical homes
• Provide accessible, comprehensive primary care
• Coordinate medical care
• Educate clients to promote self-management
• Contract with the State and an individual RCCO
PCMP Payment Model

- Per-member-per-month payment (PMPM)
- Continued fee-for-service reimbursement
- Incentive payments
- Extra PMPM for meeting certain factors
Three publically funded, statewide programs that provide some level of care coordination for children and youth:

• Program for Children and Youth with Special Needs (HCP)

• EPSDT Outreach/Healthy Communities

• Accountable Care Collaborative Program
TEAM 4C: COLORADO CARE COORDINATION COLLABORATIVE

AIM STATEMENT

Using a phased approach, we aim to maximize efficiency and effectiveness of care coordination delivery for the **CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS** (CYSHCN) population funded by state and federal resources.

**POPULATION**

We will impact children and youth with special health care needs enrolled in medicaid, **BIRTH to 21 YEARS**.

**PARTNERS**

COLORADO DEPT. OF PUBLIC HEALTH & ENVIRONMENT
HEALTH CARE POLICY & FINANCING
COLORADO ACCESS
TRI-COUNTY HEALTH DEPT.
OBJECTIVES

To MINIMIZE GAPS, AVOID DUPLICATION and MAXIMIZE the VALUE of care coordination services.

PHASE 1: June - December 2014
- Define collaborative and purpose
- Establish outcomes and a target population for three existing care coordination programs:
  1. EPSDT/Healthy Communities
  2. RCCO
  3. HCP
- Develop care coordination systems map for RCCO region 3

PHASE 2: January - June 2016
- Identify and implement policy/systems change opportunities for each care coordination program
- Develop data sharing agreements, systematize interagency case conferencing and shared plans of care

PHASE 3: November 2015 - 2020
- Replicate Team 4C process
- Develop and administer a readiness tool
- Hold webinars to gauge interest
- Establish replication team(s)
Identified **Strengths to Leverage**

- HCP has an existing **statewide infrastructure** for providing care coordination services for CYSHCN
- HCP has specific **focus** and **expertise** in serving children and youth
- **Healthy Communities** and the RCCO contracts are both administered by the same agency, with opportunity for greater **alignment**
- RCCOs are responsible for assuring that their members have **access to** care coordination services
- RCCO contracts are up for re-bid. **Opportunity to influence** care coordination **standards**
Identified **Challenges** to Address

- Care coordination provided by RCCOs varies by region
- RCCOs and delegated practices have variable *capacity* to provide care coordination to all CYSHCN who might benefit from the service
- There is no *standardized approach* to identifying CYSHCN enrolled in the RCCOs who may benefit from care coordination
- Limited *quality standards/expectations* exist for care coordination at either the RCCO or practice levels
Identified **Challenges to Address**

- Healthy Communities has large staff to client ratios
- RCCOs and Title V HCP do not have a **shared understanding** of one another’s roles across the state
- Wide range of **working relationships** between RCCOs and local public health agencies
- There are no standardized mechanisms and/or statewide platforms to support a **shared plan of care** amongst agencies who serve children and youth
As a result of the process . . .

- Established and/or strengthened relationships between key state and local partners

- Identified over 40 potential programmatic and cross-agency policy/systems change opportunities

- Prioritized areas of focus: data sharing and analysis; developing pathways for interagency communication; and standardized processes for interagency case conferences and shared plans of care

- Developed action plan for prioritized policy/systems change opportunities
What have we learned?

• HCP and the RCCOs can have complementary roles in providing care coordination (swim lanes)

• Need to have the right people at the table (ie: RCCO contract manager)

• Essential to have both state and local staff for each program to ensure alignment & accountability

• Important to engage care coordination managers who are familiar with processes and have the authority to implement change
Contact Information

Matthew Lanphier
Colorado Department of Health Care Policy and Financing
ACC Policy Analyst
Matthew.Lanphier@state.co.us

Regina Fetterolf
Colorado Access
Director, Care Management
Regina.Fetterolf@coaccess.com
Questions?
MORE ON CARE COORDINATION

www.lpfch.org/publications

• The Care Coordination Conundrum
• An Experiment in Local Care Coordination
• Key Elements of Care Coordination for CYSHCN

www.lpfch.org/symposium/webcast

• Webcast and presentation slides from the 2015 Symposium:
  Designing Systems That Work for Children with Complex Health Care Needs
Sara S. Bachman, Ph.D.
Principal Investigator, The Catalyst Center:
Improving Financing of Care for Children and Youth with Special Health Care Needs
Boston University School of Public Health
sbachman@bu.edu
www.hdwg.org

Meg Comeau, MHA
Co-Principal Investigator, The Catalyst Center:
Improving Financing of Care for Children and Youth with Special Health Care Needs
Boston University School of Public Health
mcomeau@bu.edu
www.catalystctr.org

Edward Schor, MD
Senior Vice President
Lucile Packard Foundation for Children's Health
Edward.SchorMD@lpfch.org
www.lpfch.org
www.kidsdata.org