Aligning Services with Needs:
Complexity Tiering for Children with Chronic and Complex Conditions

Wednesday, February 28, 2018

11-12 p.m. PT; 2-3 p.m. ET

Sponsored by:

MODERATOR

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HOUSEKEEPING

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SPEAKERS

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Children's Hospital Colorado

Project overview

- 9-month project, funded by LPFCH
- Collaborating sites:
  - University of Colorado
  - Family Voices
  - MassGeneral Hospital for Children
  - Boston Children's Hospital
- Goal: Characterize the state of "risk tiering" for children, and make recommendations for policy and practice

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Why do this?

- Children and youth with special health care needs are a growing population (19% and increasing)
- Children with the 1% of most complex needs account for 1/3 of pediatric health care costs
- New practice and payment models need to predict and plan for **resource needs** and **costs**

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Tiering

- Working definition: use of **risk stratification** methods to group children according to intensity of health care utilization and care coordination needs
- Groups children using past data about utilization (diagnoses), predicted needs
- Beginning to be used by clinical systems, in adults more than children
- Use by payers is likely soon

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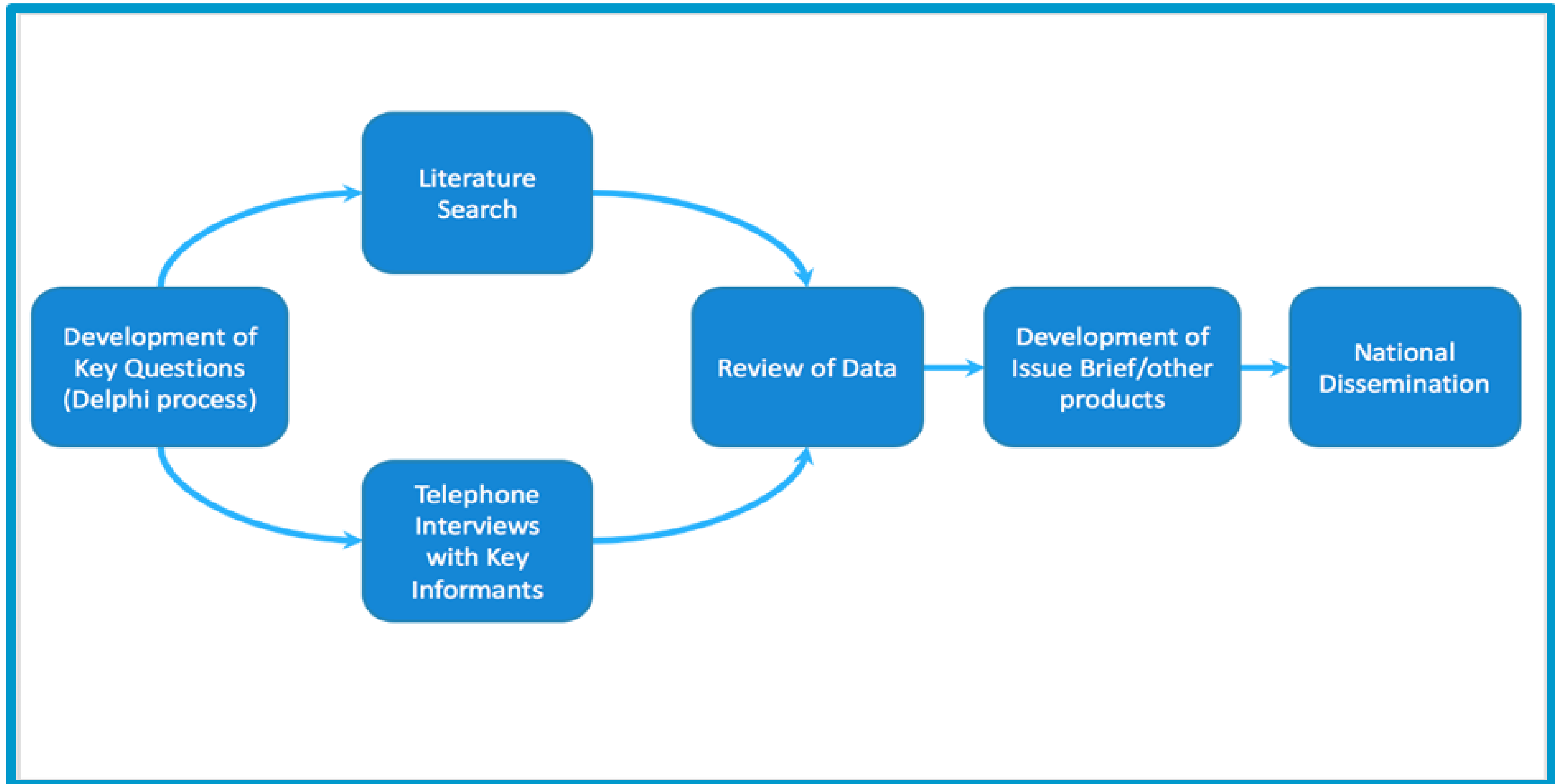
What we did



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Working group (n=19)

- Pediatric practice, research, policy experts
- Quality/measurement experts
- Payment experts
- Family experts

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Key questions

- What are relationships among **medical** costs, **social** determinants (SDH) and **behavioral** health (BH) in tiering?
- How do these **vary** between children and adults, and how can they inform policy recommendations?
- What **measures** currently exist to make tiering effective for care models and payment?
- What are **roles** of care team members, parents and payers in developing service plans guided by tiering?

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Key questions (2)

- How are SDH and BH needs being **integrated** into services informed by tiering?
- How do integrating BH and SDH data into models improve "fit" and **prediction** of need?
- What is the current state of **policy and payment** for providing services and coordination oriented to medical needs, SDH and BH needs?
- How can tiering models be **financed across public coverage** sources? What trends might help or hinder meeting child and family needs?

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What we found

- The field is very new for children
- Key questions difficult to answer given currently available data
- Key informant interviews (n=17) much more fruitful than literature reviews (200+ articles searched, 30 useful articles)

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Current practices

- Many tiering systems based on diagnosis patterns; not in widespread use
- Typically 4 tiers in a pyramid shape:
  - Lowest tier (70%): healthy children
  - Highest tier (>1%): highly complex
  - High variability among those in middle tiers
- Largely unknown to families
- Social determinants and behavioral health diagnoses not typically included
- Adult systems do not work well for kids: differences in epidemiology of chronic conditions

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Current innovations

- Used mainly for care coordination planning within large health systems
- Population-based tiering (1 or 2 centers): tiering groups as opposed to individuals
- Not currently used for payment except at fringes (e.g. PMPM for complex children)
- Few to no measures exist to gauge success of tiering

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Incorporating social and behavioral health

- Data typically separate (BH) or absent (SDH)
- Stakeholders: care coordination and service needs highly dependent on BH and SDH needs
- Great need for integration of data
- Great need for integration of services
  - Service needs are different from those generated by medical conditions
- Conceptual models exist in a few systems; implementation just starting

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Payer perspective

- Tiering most useful in systems where total cost is important
- Needs and costs variable over time: difficult to measure impact of tiering
- Most useful for population resource planning

Family Perspectives

- Families not typically included or informed in discussions of payment approaches such as tiering
- Tiering has most value in matching medical services with needs, but not to create rigid guidelines; individualization is important
- Tiering derives cost data mainly from costs within medical systems (medical, behavioral); not likely to include community based costs (such as home adaptations, respite care, assistive technology) that are essential to whole child/family wellness

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Family Recommendations

- To incorporate family perspectives in tiering discussions – turn to family led organizations
- Discussions at this systems level need family leaders who have systems level experience, peer support, access/capacity to gather perspectives across many families in many parts of the country
- Such family perspectives will provide unique value to designing systems change
- Family-to-Family organizations in every state and DC, connected nationally and designed to train families, can gather broad input and spread information widely

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Recommendations

- Accurate data, integrated across medical, behavioral and social determinants, that reflect children's needs
- Transparency in use of data
  - To inform resource allocation
  - To inform payment
- Engagement of family leaders as full partners at all levels of decision-making
- Measure development to reflect accuracy, usability, and outcomes

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Recommendations

- Periodic reassessment of tiering methodologies
  - To reflect children's needs
  - To reflect needs of "middle tiers"
- Research:
  - How well tiering predicts needs over time, especially at transition points
  - Linkages between methods, use, and outcomes

Growth of Population Health

- Helps:
  - Identification of specific population needs
  - Development of organized teams and provider groups to meet those needs
  - *Examples: Pregnant women, apparently healthy children, CYSHCN, CMC; various adult populations*
- Tiering can be key tool to aid population health
- Growth of teams also aids population health

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Team Care in the Pediatric Medical Home

Early Brain and Child Development

Mental Health Treatment and Support

Practice Leader

Chronic Care Coordination

Linking Families and Community Services

Parents as Partners Throughout Team Care

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Behavioral Health Integration

- High rates of co-morbid mental health and substance use disorders among CYSHCN and CMC
- Current systems that separate mental and physical health
  - Limit access to appropriate services
  - Lower outcomes
- Integration critical
- Tiering systems will be more effective if they include behavioral health co-morbidities

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Questions?

Today's webinar slides and recording will be posted online

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