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

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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
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
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
What we did

1. Literature Search
2. Review of Data
3. Development of Issue Brief/other products
4. National Dissemination
5. Telephone Interviews with Key Informants
6. Development of Key Questions (Delphi process)
Working group (n=19)

• Pediatric practice, research, policy experts

• Quality/measurement experts

• Payment experts

• Family experts
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?
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?
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)
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
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
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
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
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
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
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
Team Care in the Pediatric Medical Home

- Early Brain and Child Development
- Practice Leader
- Chronic Care Coordination
- Mental Health Treatment and Support
- Linking Families and Community Services

Parents as Partners Throughout Team Care
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
SPEAKERS

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Questions?

*Today’s webinar slides and recording will be posted online*

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