CHILD HEALTH QUALITY COALITION ACTIVITIES
CARE COORDINATION KEY ELEMENTS
TASK FORCE

Rich Antonelli, MD
WHAT ARE WE DOING?

- Developed Care Coordination (CC) Framework
- Key elements of CC linked to measures
- Companion accountability framework/measure bundles
- Outreach for input and to provide visibility on importance of effective care coordination
- Leveraging framework with policymakers in defining services and accountabilities in new programs and payment models
- Supporting stakeholder programs and implementation opportunities to use the CC key elements framework
STAKEHOLDER OUTREACH

**Payers**
- Commercial: BCBSMA, Harvard Pilgrim Health Plan & Tufts Health Plan
- MassHealth MCOs: BMC HealthNet, Network Health (and their behavioral health partners: Beacon and MA Behavioral Health Partnership)

**Providers**
- Yogman, CHA, PCHI, PPOC
- Synergies with CHIPRA/NICHQ Learning Collaborative (13 practices)

**State/Local and Policy**
- MassHealth, DMH, DPH, MCPAP
- PCPR, Behavioral Health Integration Task Force, Health Policy Commission, Health Homes
## FRAMEWORK FOR HIGH PERFORMING PEDIATRIC CARE COORDINATION

<table>
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<tr>
<th>Key Elements</th>
<th>Measurement concepts</th>
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| 1) Needs assessment, continuing care coord. engagement | Use of structured CC needs assessment tool  
Ask family: did you get what you wanted? |
| 2) Care planning and coordination | Family participation in process  
Care team on same page |
| 3) Facilitating care transitions | Track “closing the loop”  
Some existing HEDIS, patient survey measures  
Resource use |
| 4) Connecting with community resources/schools | Link to family partner  
Referral connections made |
| 5) Transitioning to adult care | Acquisition of self-management skills |
WHY DOES IT MATTER?

- Systems are needed for structured care coordination
- Fundamental to improving pediatric care quality
- Environments for feasibility testing and implementation of the CC framework are needed
- Important to explore solutions, like measure bundles, that recognize that no one player can be held accountable for the outcome
MEASURE DEVELOPMENT WORKGROUP (MDW)

Ayesha Cammaerts
WHAT ARE WE DOING?

• Identifying measurement gaps in care coordination for children with behavioral health diagnoses and proposing a set of measures for the CHQC and federal healthcare agencies

• In order to develop specifications for at least one new measure to fill the gaps in pediatric care quality, 32 measure templates have been developed and are under review by a measure selection committee.
MEASURE OF PATIENT AGREEMENT TO SHARE PHI

**Measure Description:** The percent of patients whose behavioral health chart contains a signed release or refusal to share information with primary care provider that was active during the measurement year.

**Numerator Statement:** Number of patients who have a signed release or refusal, documented in their behavioral health care provider’s chart. The absence of a release is considered a failure on the measure. Refusal is counted in numerator.

**Denominator Statement:** Patients 0-21 years of age, currently receiving behavioral health care, with at least 2 claims for outpatient behavioral health services or 1 emergency department or inpatient claim with behavioral health as the primary diagnosis and/or service code

Sub-group A) Those in the denominator that also have a chronic medical condition, defined as a physical, developmental, or mental health condition that is expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, **OR** an episodic chronic condition, defined as physical, developmental, or mental health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years).

Sub-group B) Those in the denominator that also have Serious Emotional Disturbance (SED) defined by Individuals with Disabilities Education Act (IDEA) as follows:

As defined by IDEA, emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

**Data Source:** Behavioral Health Chart Review/Administrative Claims
WHY DOES IT MATTER?

- The absence of quality measures of care coordination for children with BH needs is problematic for the effective implementation of accountable care.

- Pediatric care-coordination (CC) measures and tools for CC quality measurement are needed as more CC programs are implemented in the emerging accountable care environment.
COMMUNICATION AND CONFIDENTIALITY TASK FORCE

Val Konar
WHAT ARE WE DOING?

Supporting effective communication between and among those who make up the child’s “coordination network,” while addressing issues of confidentiality

Activities:

• Submitting input on communication and privacy to policymakers
• Producing a Communication and Confidentiality Guide
EXAMPLES FROM GUIDE ON PRIVACY

• Summary of 28 privacy related laws and regulations including links: HIPAA, FERPA, Title 42

• Disclosure and Consent
  - Release of information often serves as written consent. A parent/guardian must sign the consent that is dated and has a duration no longer than is reasonably necessary.
  - When a youth turns 18, the youth becomes responsible for record distribution and consent. Youth can give consent for parents or anyone else to see their records at age 18.
Since those with legal custody are the decision makers, it is important to determine who is the legal guardian for a child/youth. The first step is **Ask the Family**.

- We have described some general terms below to help define who has custody or guardianship of a child…
  - **Guardianship of a minor** is a legal process for a child under the age of eighteen not under a parent’s care.
  - **Guardianship for adults** is a legal process for adults (18 and over) who have a clinically diagnosed medical condition and are unable to make or communicate effective decisions about their everyday self-care, health, and safety.

- Typical members of the child/youth and family group you may communicate with are…
EXAMPLES FROM GUIDE ON TIPS FOR COMMUNICATING WITH SCHOOLS

What questions should the PCP ask school staff, to get needed information?

- What is the contact information for the school nurse?
- What is the child/youth’s behavior in school?
- What are the child’s/youth’s learning disabilities?
- What can be done to help manage and minimize the student’s learning obstacles?
- Does the child/youth have an IEP? How can I gain access?
WHY DOES IT MATTER?

The Guide will:

- Help you determine with whom to communicate
- Describe laws, regulations and concepts related to privacy
- Offer tips, tools and resources for families/youth, PCPs, behavioral health providers and schools
- Provide a common source of reference for communication in the child’s coordination network.
PEDIATRIC
PATIENT- CENTERED
MEDICAL HOME
SPREAD SUPPORT

Louise Bannister
WHAT ARE WE DOING?

• Facilitating transformation to medical homes by child-serving practices

• Learning from the 13 CHIPRA practices
  – What worked best
  – Challenges and solutions
  – What is most important for child-serving practices to consider when transforming

• Using those lessons to inspire others to transform
  – “How to” for practices and families
  – Engaging payers and policymakers to support transformation
WHY DOES IT MATTER?

Gathering and sharing lessons learned will:

- Facilitate increased visibility of the importance of medical home transformation for children
- Support transformation efforts by other practices, including family partnerships in transformation
- Inform policy and ongoing projects supporting more integrated and coordinated care
WHY THE CHILD HEALTH QUALITY COALITION MATTERS

Karen Smith
CHQC PROMOTES A QUALITY AGENDA FOR PEDIATRICS

Visibility

- A multi-stakeholder body working with policymakers to define the pediatric quality improvement agenda, pediatric care coordination services and accountabilities
- Advance quality measurement with families, providers, payers, and policy makers
- Create a forum for sharing lessons learned and best practices for pediatric health care transformation

Advocacy

- Ensure focus and funding for pediatric priorities, including: medical home spread, quality measurement, care coordination and communication
CHQC FACILITATES COLLECTIVE ACTION

Alignment

- CHQC’s role as a neutral convener facilitates cross-stakeholder engagement and strong family voices
- Integration of family partners and stakeholders advances pediatric quality improvement more effectively through collective effort
Massachusetts Child Psychiatry Access Project

John H. Straus, MD

Massachusetts Behavioral Health Partnership
Take Home Message

MCPAP is an organization that finds the Coalition is an important resource to efficiently develop a cross provider/system solution to an important problem.
MCPAP Services

• Telephonic child psychiatry consultation to PCPs within 30 minutes, Monday thru Friday. Last quarter response time met target for 89% of consultations.

• Face to face consultations (18% of youth served)

• Care Coordination

• Transitional support when youth waiting for behavioral health services

• PCP education - newsletter, practice meetings, CME
MCPAP Overview

- 438 practices with 2,991 individual clinicians
- Over 98% of Commonwealth
- 20,641 encounters, 10,553 youth in FY2013
- Prescriber level care remains with PCP, 70% of time.
MCPAP Developing New Components

• Perinatal/postpartum depression screening and management.

• Improved screening and management of teen substance use.

• Parent training for disruptive behavior in children under 6 using co-located PCP clinicians trained in evidence based practice, Triple P.
An idea that has caught on....

- Alaska
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Illinois
- Iowa
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Nebraska
- New Hampshire
- New Jersey
- New York
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Texas
- Vermont
- Virginia
- Washington
- Washington DC
- Wyoming
- Wisconsin
From Coalition Point of View

• Coalition Care Coordination Task Force has developed key elements.

• Element #3 is “facilitating care transitions”

• Need metric to measure “closing the loop”. Nothing “shovel ready”.
From MCPAP Point of View

- FY13, MCPAP did care coordination for over 7,000 youth.
- Pilot study revealed that only 50% of referrals kept.
- For FY14 MPAP added care coordination/family partner time to provide follow up contact with family.
- Need metrics to measure follow up and report actionable information to PCP.
Perfect Role for Coalition

Coalition Care Coordination Task Force available to help develop questions and answer categories.

Coalition Care Coordination Task Force available to help test with PCPs actionability of information.
Question 1 – Outcome of Referral

- Appointment kept
- Appointment made
- Wait list > 2 months
- No response from family after 3 tries
- Appointment not made
- Service not needed
- Unable to find acceptable time
- Transportation issue
- Connection not made
- Appropriate appointment not available
- Dissatisfied with referral
- Escalated to Crisis
- In process
- Referral provider not responsive
- Estimated wait time error
Question 2
Planning to stay with referral?

• If no, why?
• No additional visits recommended
• Not interested at this time
• Inappropriate match
• Dissatisfied with referral
• Insurance change
• Plan to use alternate referral
• Other

MCPAP
Massachusetts Child Psychiatry Access Project
Informal Results from One Regional Team

134 youth with attempt to follow up care coordination activity.

77 families able to be contacted (57%)

Of 77,

43 kept appointment (56%)

(3 made appointment with different provider because of waiting time or insurance mismatch)
Reasons Appointment Not Kept

- 11 Service not needed
- 6 Appointment not made
- 2 Connection not made
- 5 Wait list
- 1 Provider no longer in practice
- 3 Providers never returned phone calls
- 2 Still in process
- 2 Disliked provider
- 1 Family moved
• Iterative Process that MCPAP and Coalition Care Coordination Task Force will continue.

• Two way street:
  MCPAP helped by Coalition’s expertise
  Coalition helped by MCPAP developing and testing P&P’s for “closing the loop”

• How will this knowledge live on?