CoIIN to Advance Care for Children with Medical Complexity

Pediatric Academic Societies Meeting
Complex Care Special Interest Group

April 27, 2019

Boston University School of Social Work
Center for Innovation in Social Work & Health

BOSTON UNIVERSITY

Speakers

- **Meg Comeau, MHA**
  - Senior Project Director, Center for Innovation in Social Work and Health, Boston University
  - Principal Investigator, CoIIN to Advance Care for CMC
- **Bethlyn Houlihan, MSW, MPH**
  - Project Director, Center for Innovation in Social Work and Health, Boston University
  - Project Director, CoIIN to Advance Care for CMC

The Collaborative Improvement and Innovation Network (CoIIN) Model

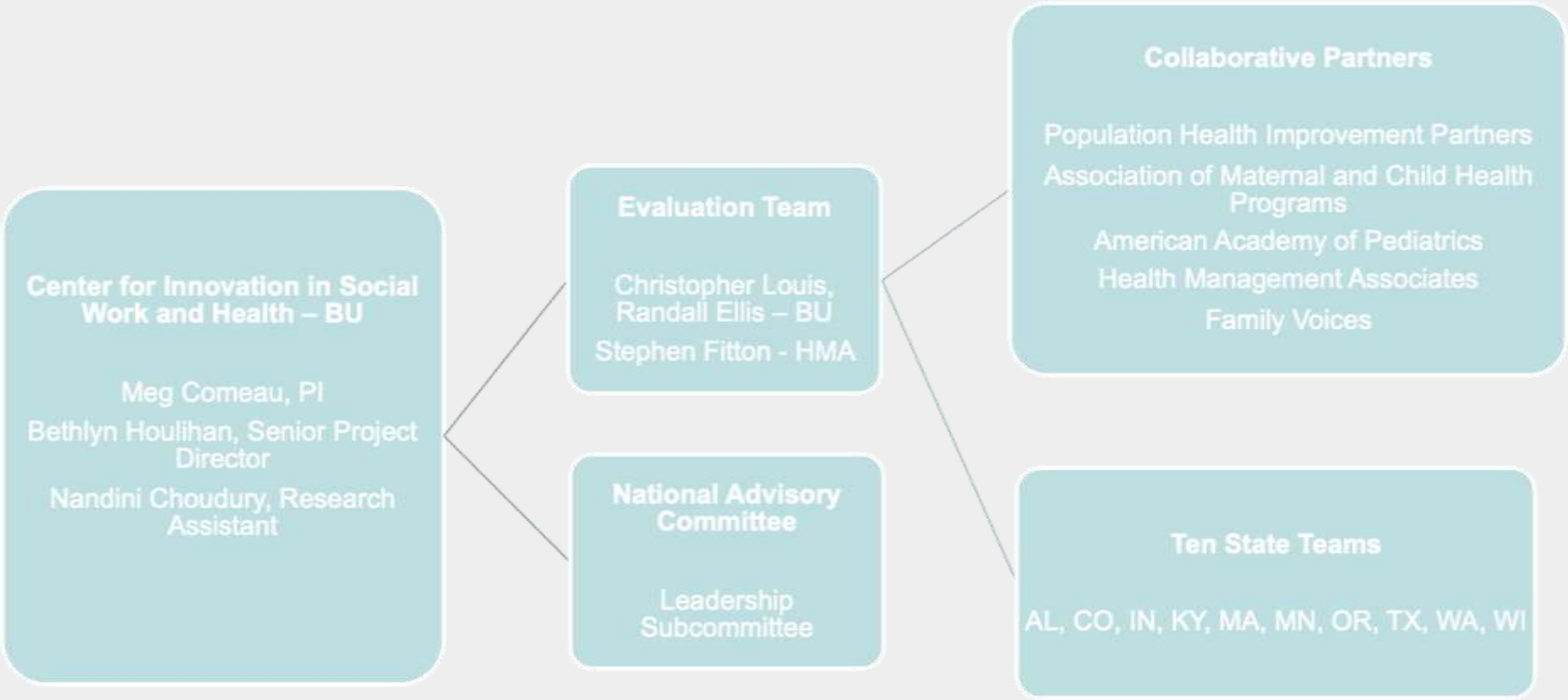
- Evidence-based strategy for addressing complex, persistent challenges in healthcare
- Key elements:
  - Collaborative learning
  - Collaborative innovation networks
  - Quality improvement methods

McPherson, M., Gloor, P. and Smith. L. (2015). Using Collaborative Improvement and Innovation Networks to Tackle Complex Population Health Problems. JAMA Pediatrics, Vol. 169, Number 8

CollN to Advance Care for CMC – Timeline and Funding

- Four-year cooperative agreement with MCHB
- Launched in August 2017
- Funding
  - $2.7 million per year
  - 50% goes to state teams for project work, divided equally among them

CMC CollN Project Structure



CMC CoIIN Project Goals

- Improve
  - The quality of life for children with medical complexity
  - The well-being of their families
  - The cost-effectiveness of their care

CMC CoIIN Project Objectives

- Increase by 50%
  - Cohort-enrolled CMC who have a single locus of care in a medical home and a shared plan of care
  - Families of cohort-enrolled CMC who report family engagement on the individual clinical level
- Increase by 25%
  - Families of cohort-enrolled CMC who report previously unmet needs being met
- 25% of state teams will have piloted an innovative payment model

CMC CoIIN – Activities to Date

- Consensus definition of CMC for state teams
- Consensus list of project topics
- Work with states to determine target population, intervention(s) to test and outcomes
- Development of family and staff experience surveys, and accompanying focus groups
- QIDA construction
- Creation of an evaluation plan that includes state and network outcomes as well as cost data

CMC CoIIN National Advisory Committee and Leadership Subcommittee Membership

Rishi Agrawal>	Rita Mangione- Smith
Jay Berry>	Jeannie McAllister
Eyal Cohen>	Marlene Miller
Eileen Forlenza*>	Garey Noritz>
Amy Houtrow	James Perrin
Michelle Jarvis*>	Rylin Rodgers*>
Alisha Keehn	Edward Schor
Dennis Kuo>	Christopher Stille>
Jacqueline Kueser	Renee Turchi
Jennifer Lail>	Cara Coleman*>

*indicates parent of a child/youth with medical complexity
>indicates member of leadership subcommittee

CMC CoIIN Family Engagement

- Guiding values: equity, accountability, transparency
- Multiple modalities to access the diversity of skill set/experience/expertise available
  - NAC and leadership subcommittee membership
  - Measurement workgroup (QoL, well-being +)
  - QoL and well-being focus group planning committee
  - Articles/essays in monthly enewsletter
  - Monthly project update summaries – published in enewsletter
  - Participation on state teams: design, implementation, evaluation, improvement
  - Family leader peer mentoring calls
  - Honoraria in BU and state team budgets

CMC CoIIN State Team Project Examples

Kentucky

1) Creating a comprehensive, multidisciplinary aero-digestive clinic.
2) Improving and facilitating care of CMC, especially in rural areas, by utilizing teleconferencing technology for patient centered care planning services.
3) Improving the care and quality of life for children on home ventilators and their families by working with Medicaid and other agencies to improve the system of care.
4) Creating a comprehensive clinic for young children recently discharged from the NICU, with medical complexity

Texas

1) Engage and support patients/families in meaningful ways to promote shared decision-making.
2). Integrate required assessments to minimize duplication and guide development of individualized care plans that inform service delivery.
3) Utilize technology-based tools such as a patient-controlled care coordination platform to promote a shared plan of care.
4) Identify patterns of service/supply usage in the areas of therapy, durable medical equipment, private duty nursing and subspecialist utilization in various subpopulations to maximize efficiency.

Indiana State Team Project - Overview

- IUSM model of tertiary-primary care integrated care coordination

Engagement of Indiana State Medicaid

- Using COIIN funding as leverage
- Negotiating a demonstration project
- Planning for sustainability with ACE Kids Act and/or Health Home funding

Team IN: Care Coordination

- Plan for care coordinator training – including Boston Children's curriculum +

Team IN: Tools for Collaboration

- Telehealth for visits – business agreements across different health systems
- Cross system communication platform, registry and documentation of CC activities – pMD

Team IN: Work with Parent-to-Parent Organizations

- Planning program
- Developing family advocacy at practice level
- Consulting on cases of families needing help with being a parent of a CSHCN

CMC CoIIN Next Steps

- Finalize vision for what constitutes “innovation” in payment models; support states in negotiations
- Finalize evaluation design, including cost-effectiveness analysis and comparison group
- Work with state Medicaid programs to obtain data
- Monitor data collection and reporting by state teams
- Support state teams in QI activities
- Dissemination and sustainability

Questions and discussion

Thank you!

Contact information

Meg Comeau, MHA
Principal Investigator
mcomeau@bu.edu
302-329-9261

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Anna Maria Padlan, HRSA/MCHB Project Officer