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AN INNOVATIVE CARE COORDINATION DELEGATION MODEL TO STRENGTHEN THE MEDICAL HOME & IMPROVE OUTCOMES

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Disclosures

- We have no actual or potential conflict of interest in relation to this program/presentation.

"…the ideal model of effective clinical care for Children with Medical Complexity (CMC) is encapsulated by the medical home of the American Academy of Pediatrics. First described in 1967, it is the "go-to" place where the child can get, theoretically, all of the care that they need….

Care that is *accessible, continuous, comprehensive, coordinated, compassionate, culturally competent, and family –centered*."

American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. March 2007

The Child With Medical Complexity (CMC)

- Have complex and chronic health conditions that often involve multiple organ systems and severely affect cognitive and physical functioning.
- 1% of all children they account for nearly one-fifth of all pediatric admissions and one-half of all hospital days and charges in the United States. [1]

1. Berry JG, Hall M, Hall DE, et al. Inpatient growth and resource use in 28 children's hospitals: a longitudinal, multi-institutional study. JAMA Pediatr. 2013;167(2):170–177.

Fragmentation, Disintegration

- Care designed based on diagnosis instead of common experience
- Information silos force every entity to conduct redundant assessments and develop separate care plans

Access Barriers

- Unsure who to call for which problem
- Unable to get in touch with the right person at the right time.
- Increasing delays in care causing morbidity and increased unnecessary care utilization

Children's Comprehensive Care (CCC)

- Established in 2012, A primary care medical home dedicated to the care of CMC
- A cohesive family-centered care delivery system to provide wraparound care for children with challenging medical needs.
- The foundational premise to this approach is the understanding that in pediatric care, contextual needs are as important as physical needs, remembering that a child lives in the context of family – to support the family is to support the child.
- **CCC Vision:** To increase the number of well-days for families of children with medical complexity.
- **CCC Mission:** To provide relationship-based, timely, comprehensive care to families of children with medical complexity, and empower families by providing the tools, knowledge, and collaborative support to identify strengths in themselves and their community for living the best life possible.

Nurse Case Management is the backbone of Complex Care Medical Homes

- Relationship building, knowing the longitudinal narrative
- Continuity across disciplines, providers, settings
- Parent support and advocacy
- Access, 24/7, by phone, text, video, pictures
- Bandwidth to manage the care justification workload
- Systems Based quality improvement

A Struggle for Sustainability

- Initial funding by the 1115 Waiver - Delivery Service Reform Incentive Payment (DSRIP 1.0)
- Complex medical needs value high cost subspecialties and weaken the medical home model
- The current payment structure is insufficient to fund longitudinal, supportive, relationship-based care between the health home and families. No health home can sustain the costs; providers and healthcare systems are set up to fail.

STAR Kids Managed Care: an Opportunity

- November 2016, Managed Care Organization (MCO) provision of Medicaid Benefits to children and adults with disabilities
- An investment in case management and QI initiatives at the MCO level
- Parental pushback and a need for robust oversight
  - The Star Kids Advisory Committee
  - Statewide aggregated assessments, the Star Kids Screening and Assessment Instrument (SAI) and Individualized Service Plans (ISPs)

Advantages of Medical Home Case Management

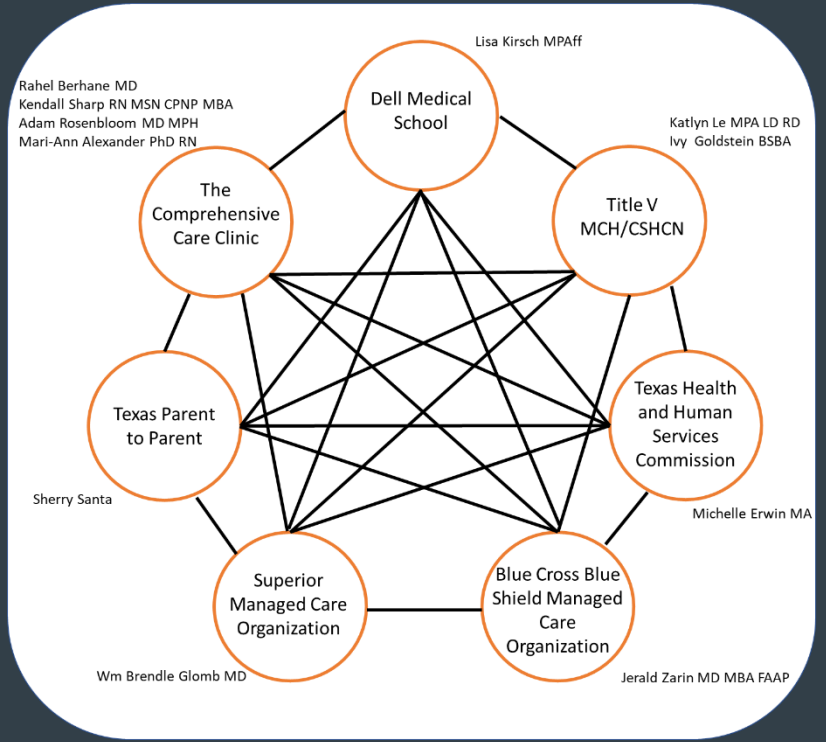
- Access to families means increased touchpoints
- Single point of contact
- Access to the medical home means context through continuity of narrative
- Brings quality work to the medical home, where it is more valuable

Advantages of Medical Home Case Management

- Funds non billable services at a Medical home through a capitated model, allowing robust complex care medical homes to be more solvent (but not completely)
- Integration of assessments reduces burden on families.
- Integration of oversight processes reduces the burden on medical homes

A Framework for Collaboration

- The Collaborative Improvement and Innovation Network (COIIN) to Advance Care for Children with Medical Complexity
- Funded by HRSA Maternal and Child Health Bureau



An MCO Medical Home Partnership

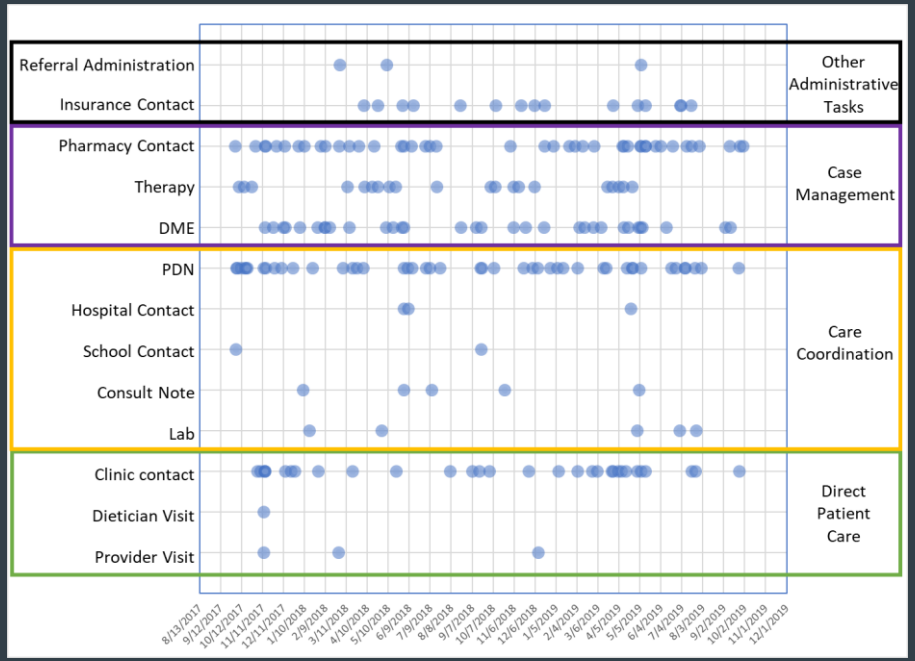
- 2015: Before STAR Kids went live, managers at Blue Cross Blue Shield, were receptive to a delegation of the RNCM responsibilities to the Medical Home
- 2018-2020: A $35 PMPM was negotiated for care coordination
- January 2020: Texas Medicaid Approves the delegation service coordination responsibilities from BCBS to the Comprehensive Care Clinic (CCC)

An Innovative Capitated Payment Model

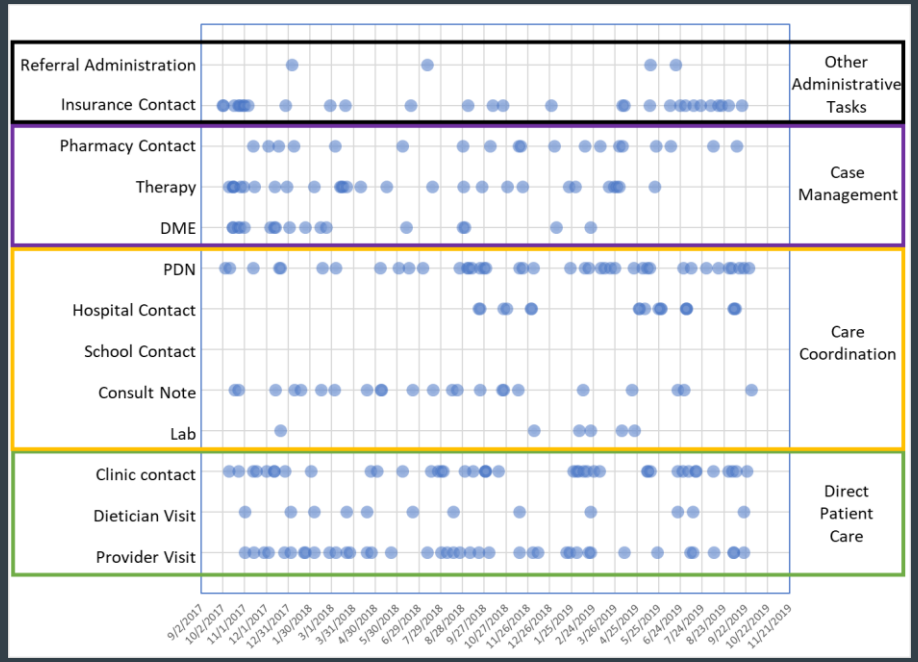
- Payment model based on a per member, per month rate agreement for service coordination between BCBS and the CCC
- Around $200-$300 depending on level
- The CCC hires 16 clinic nurses to provide enhanced care coordination and a dedicated nurse case manager for each CMC, to hit a ratio 50:1 (based on a complexity score) RNCM to patient ratio.

Illustrating the Work

16-year-old female with spastic quadriplegia, scoliosis, acute on chronic respiratory insufficiency on BIPap at night, seizures, dysphagia, gastrostomy dependent

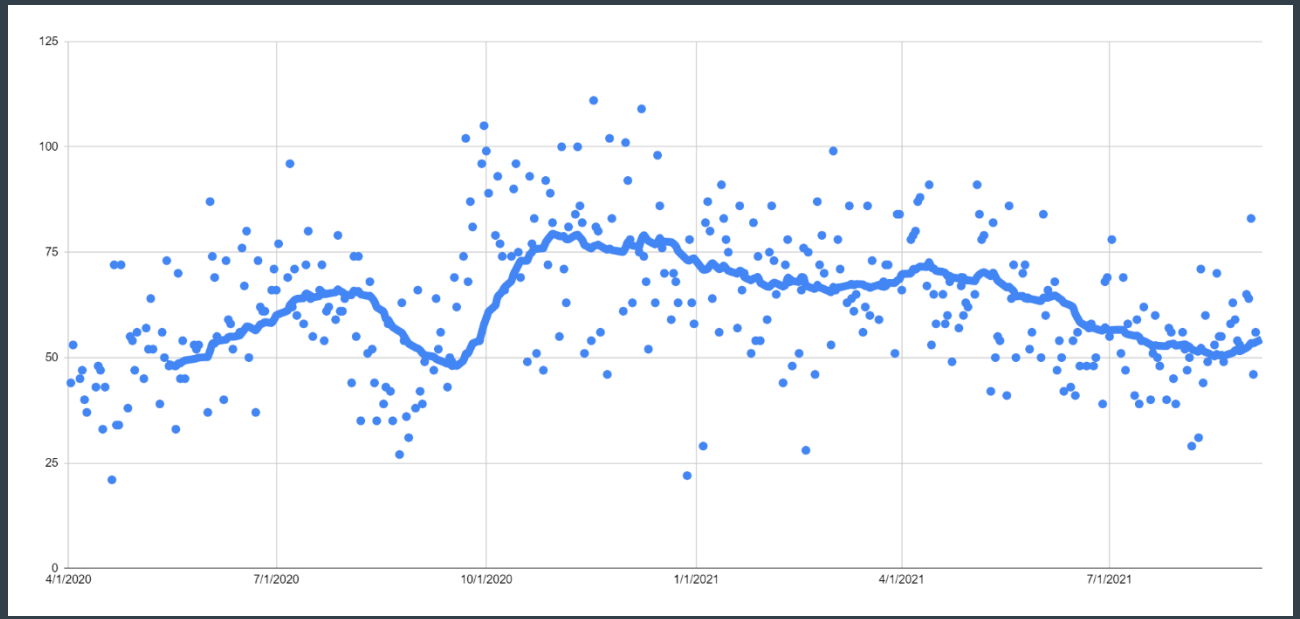


3-year-old male with Spina Bifida, neurogenic bowel, gastrostomy dependent, neurogenic bladder, catheterization dependent, hydrocephalus with a ventriculo-peritoneal shunt, Obstructive Sleep Apnea, Tracheostomy dependent.



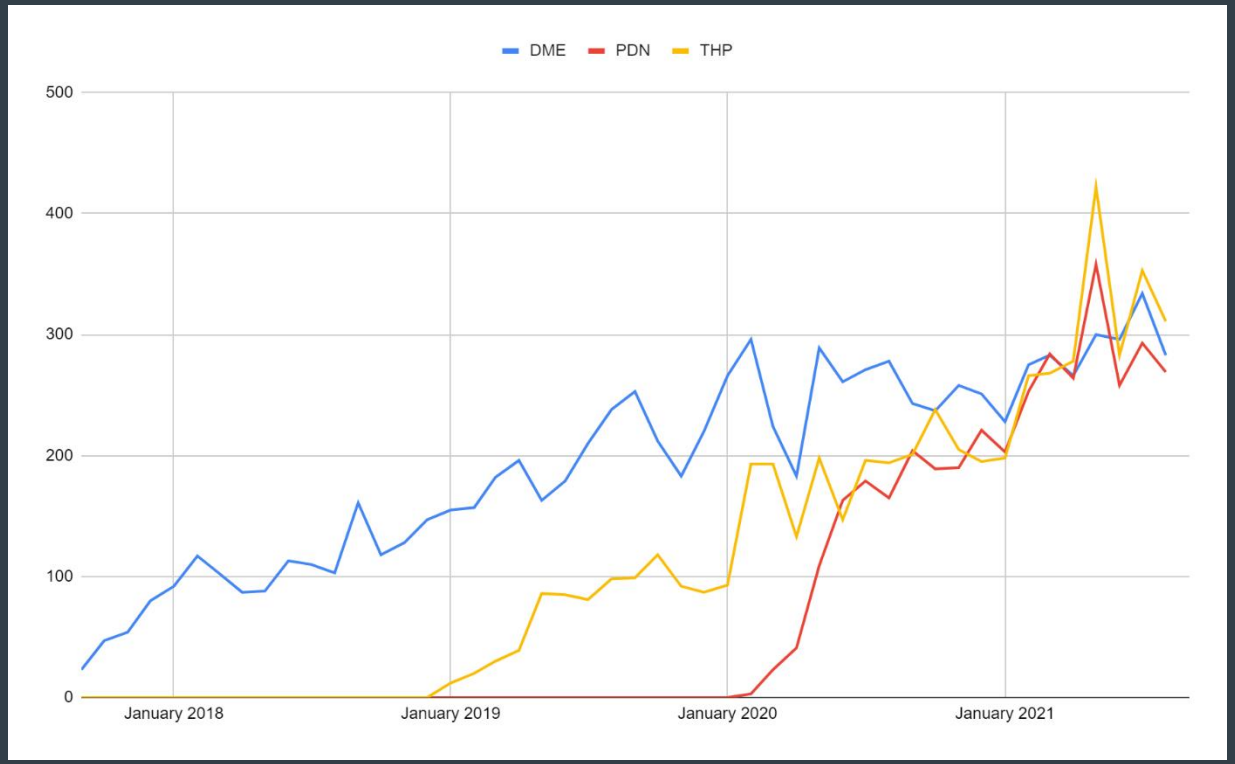
Illustrating the Work

Total number of Patient Engagements in Calls Documented per day over 18 months



23201 Calls
25.3 average calls per unique patient
Max 175 for a single patient
1450 calls per RNCM
80.5 calls per RNCM per month
1289 calls per month
44 average calls per day

Illustrating the Work



2500 DME orders per year
2400 PDN orders per year
2500 Therapy orders per year

Physicians review and sign every order, and all that work is unbillable

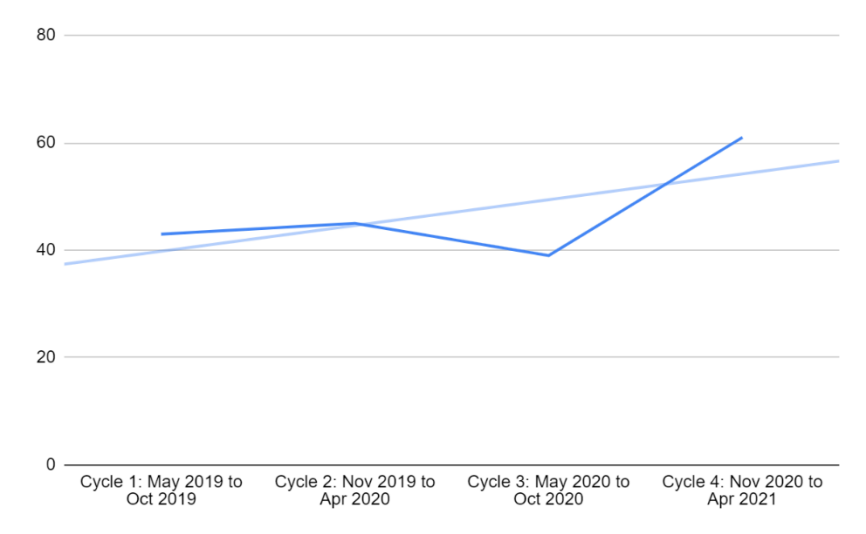
Family Responses

~40 parents surveyed over 4 time cycles:

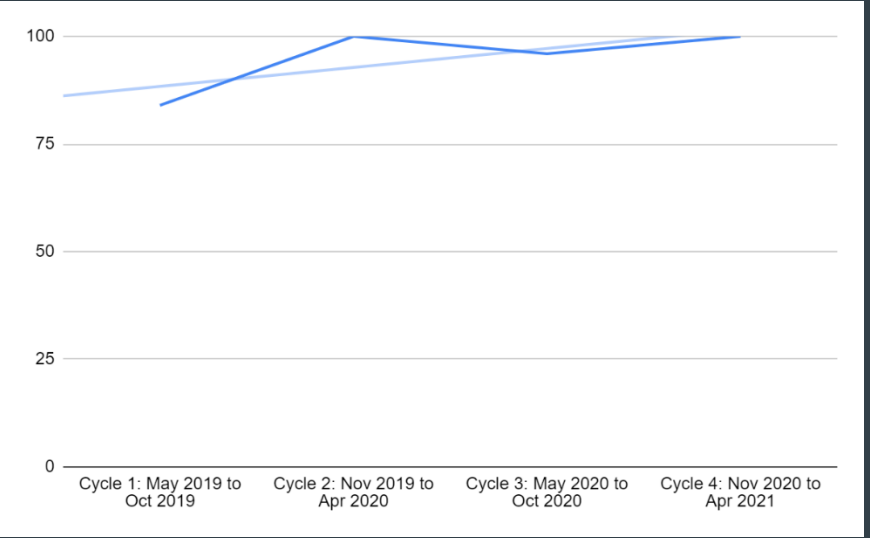
Cycle 1: May 2019 to Oct 2019
Cycle 2: Nov 2019 to Apr 2020
Cycle 3: May 2020 to Oct 2020
Cycle 4: Nov 2020 to Apr 2021

Family Responses

In the past 12 months, how often had clinical team talked with you about specific goals or other things important to your child/ teen's health?

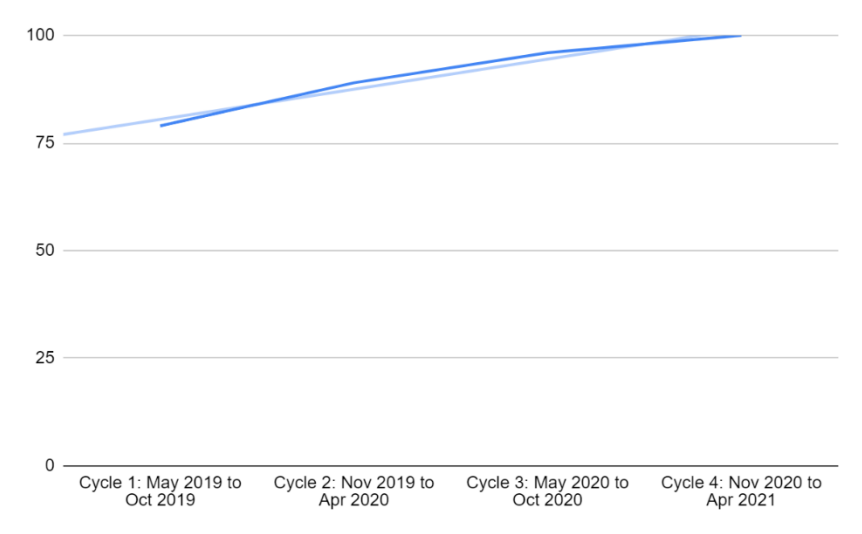


Was this care plan written in a way that you could easily understand?

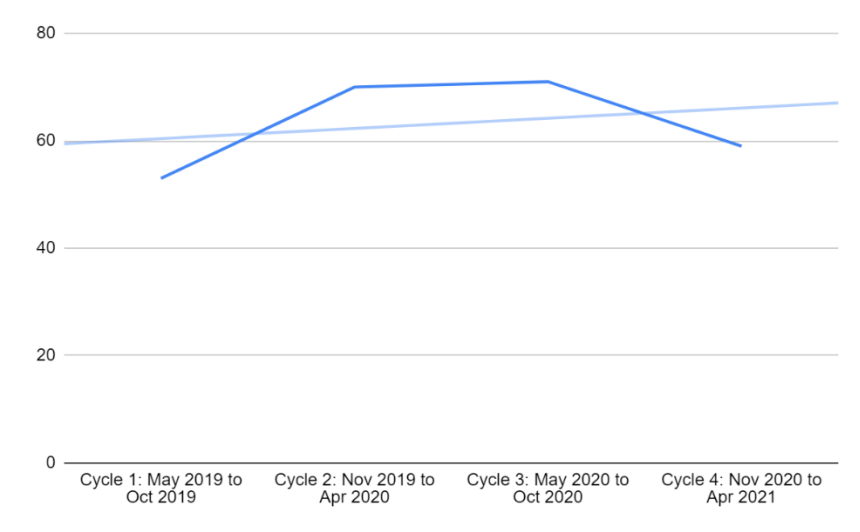


Family Responses

In the past 12 months, was a written care plan easily accessible to you?

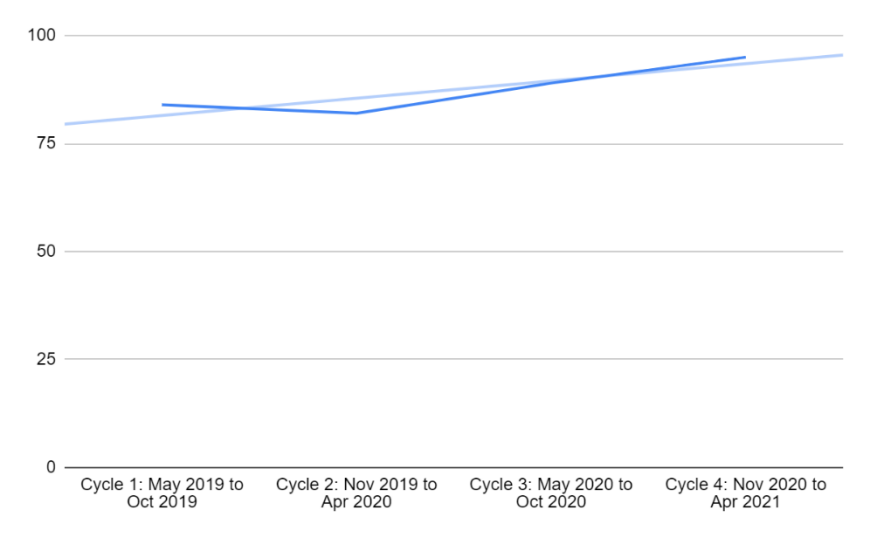


In the past 12 months, how oftern has clinical team documented these goals in a written care plan?

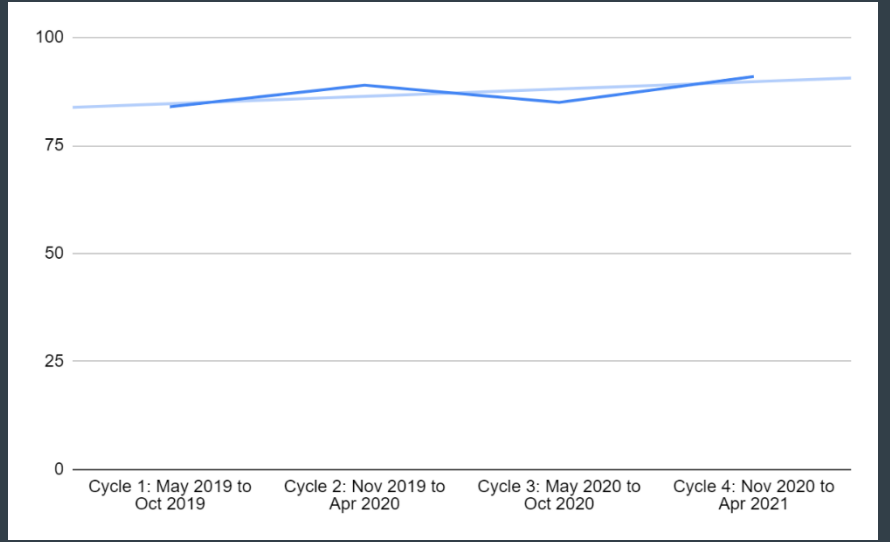


Family Responses

Using my child/ teen's written care plan has helped me better understand my role in managing my child/teen's care

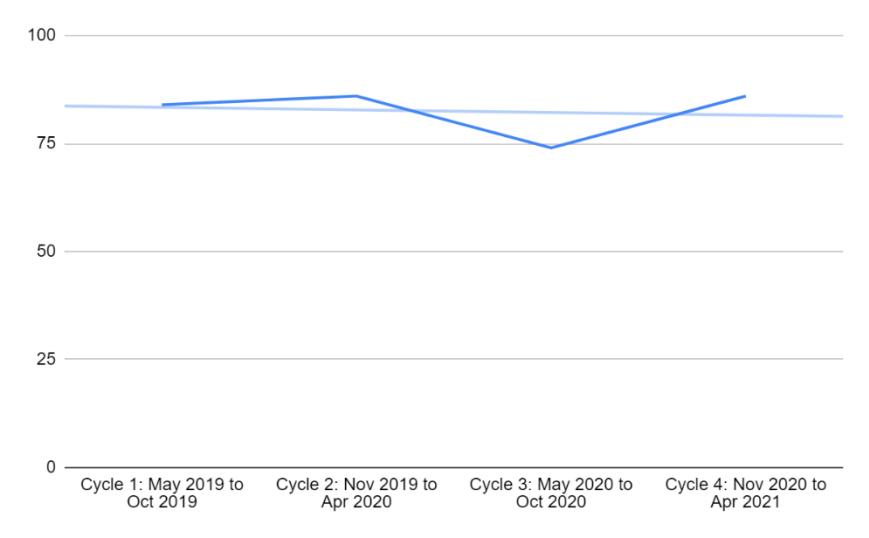


Using my child/ teen's written care plan has helped me make sure my child/ teen's needs are met

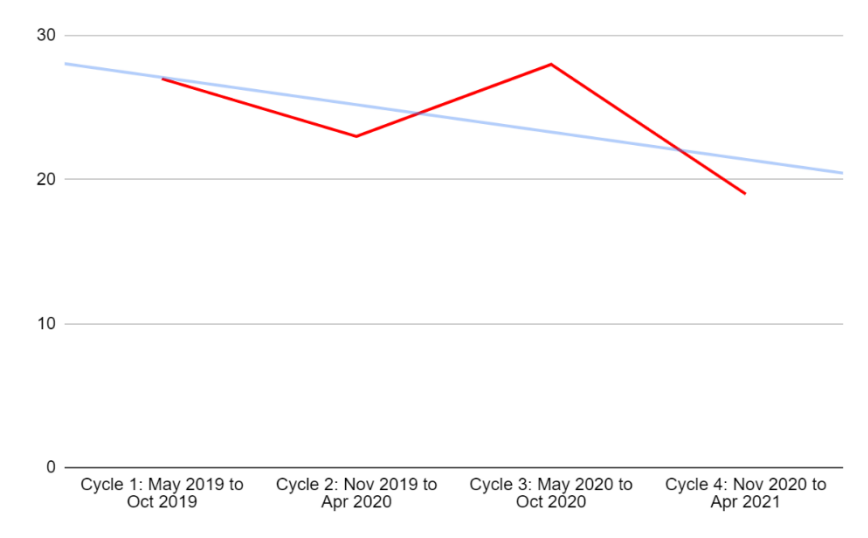


Family Responses

Using my child/ teen's written care plan has helped the clinical team, who take care of my child, communicate better with each other



% of total respondents stating an unmet need



Iterations and Lessons Learned

- Delegation moved the work to make it more valuable but didn't always change the work to make it more efficient.
- Further work required us to build more efficient tools, such as the Cloud Forest Solutions DME, PDN, and Therapy Module
- Iterating on the ISP in a way that made it directly updateable from the EMR, accessible from the cloud with a mobile app
- Up to date system integration with the hospital EMR to monitor ER visits, hospitalization admissions and discharges

Iterations and Lessons Learned

- Dual documentation, redundant work
- Dual management structure and culture
- Started too big, we took all STAR Kids, and should of focused on just MDCP patients. Moving to a capitated model makes you rethink your admission criteria.
  - We have a lot of MDCP eligible patients that do not receive MDCP.
- A likeminded trusting MCO partner is key.
- A strong medical home is key to high quality care for Children with Medical Complexity

Conclusion

- Innovative payment models can fund care coordination and management at the Medical Home Level
- Investing in Care Management and Quality Improvement at the Medical Home Level adds meaningful value
- New innovations are needed to strengthen Medical Homes to change the work.
- Care integration with shared documentation and shared payment will allow Complex Care Medical Homes to become more sustainable and improve care