Achieving Optimal Outcomes of Care: Supporting the Medical Home Team

Innovations in Primary Care Pediatrics: Models of Collaborative Care Between Primary and Subspecialty Providers

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Disclosures

- Richard Antonelli has no financial relationships to disclose or conflicts of interest to resolve.
- There will be no discussion of unapproved or off-label, experimental or investigational use.
Objectives for Today

- Describe the basis for the observation that the Family and Patient-Centered Medical Home is necessary—but not sufficient—to achieve optimal outcomes.
- Demonstrate how the F/PCMH can implement care integration with specialists.
Chronic Conditions
– Enhancing F/PCMH performance
– Enhance Subspecialty "Access"

Collaborative Care Models
• More timely access to actionable information
• More timely access to appointments
• Virtual access to referring providers
• Virtual access to patients/families

– Enhance Patient Self-Management Skills
Neither Obama nor Romney was first!
Hammurabi Care 1780BC

• If a physician make a large incision with an operating knife and cure it, or if he open a tumor (over the eye) with an operating knife, and saves the eye, he shall receive ten shekels in money.
  – Bundled payment

• If a physician make a large incision with the operating knife, and kill him, or open a tumor with the operating knife, and cut out the eye, his hands shall be cut off.
  – Pay for performance
Achieving Optimal Value

• Common, Chronic Conditions
  – Enhancing F/PCMH performance
  – Enhance Subspecialty “Access”
    • Collaborative Care Models
    • More timely access to actionable information
    • More timely access to appointments
    • Virtual access to referring providers
    • Virtual access to patients/ families
  – Enhance Patient Self-Management Skills
Building a System that Supports Care Coordination for this Population Across the Continuum of Care

• Measures of “Complexity”
  – Medical
  – Care Coordination
    • Psychosocial and socioeconomic
• Proactively Identify patients and families
• Define locus of accountability for CC
  – Subspecialists
  – PCP’s
  – Community Health Workers
  – Others
• Information available on as needed basis to all care providers
• Team-based care
• Multidisciplinary, dynamic care plan—follows the patient
• Transparency to patients and families
Medical Homes will not be successful in achieving optimal value unless there is integration of care across the continuum, from the perspective of the patient and family.

IN OTHER WORDS, MEDICAL HOME IS NECESSARY BUT NOT SUFFICIENT.
Integrated care
is the seamless provision of health care services, from the perspective of the patient and family, across the entire care continuum. It results from coordinating the efforts of all providers, irrespective of institutional, departmental, or community-based organizational boundaries.

Distribution of Pediatric Medical Expense

<table>
<thead>
<tr>
<th></th>
<th>% of population</th>
<th>% of spend</th>
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</thead>
<tbody>
<tr>
<td>Complex</td>
<td>0.5%</td>
<td>25%</td>
</tr>
<tr>
<td>Chronic</td>
<td>25%</td>
<td>70%</td>
</tr>
<tr>
<td>Healthy, Preventive</td>
<td>74.5%</td>
<td>5%</td>
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</tbody>
</table>
Children with “special needs”
-- Behavioral (ADHD, depression, anxiety, PTSD)
-- Constipation, GERD
-- Headache
-- Concussion

Children with complex needs
-- Neurodevelopmental (Autism, etc.)
-- Behavioral/Psychiatric
-- Oncology
  • Sickle cell
  • Hemophilia
-- Technology dependent
Who benefits from PCMH?

PCMH largely focuses on support of entire patient populations and only a few of the activities actively start to address the needs of those with highly complex diseases.

The 2014 NCQA PCMH Must Pass Elements are represented above.

1A: Patient – Centered Appointment Access
2D: The Practice Team
3D: Use Data for Population Management
4B: Care Planning and Self-Care Support
5B: Referral Tracking and Follow-up
6D: Implement Continuous Quality Improvement
The changing medical home model

- Specialist or PCP comfortable with high risk patients as the medical home. Patient's specialists highly connected and identified patient coordinator supports the patient and/or family.

- PCP as the medical home + the patient’s specialists. PCP care team support care coordination with the patient and/or family.

- PCP as the medical home and specialist visits as needed. Most care coordination is conducted by the patient and/or family.

Healthy, Preventive

Chronic

Complex
Strategic Approach to Care Integration

- Care Coordination is the set of activities which occurs in “the space between”
  - Visits, Providers, Hospital stays
- Care Coordination is Necessary but not Sufficient to Achieve Integration
- Only way to succeed is to engage all stakeholders— including patients and families— as participants and partners
States Using/Considering Pediatric Care Coordination Curriculum

As of May 1, 2014
Care Coordination Curriculum

Pediatric care coordination is a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the family’s caregiving capabilities. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health and wellness outcomes. Key activities of Care Coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family.

This curriculum was developed to support the patient and family-centered care.
Approach to Measurement
## CC Framework: Linking to Measures

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>Measures</th>
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| **(1) Needs assessment for care coordination and continuing engagement**  
  - Family-driven, youth-guided needs assessment, goal setting  
  - Use a standard process to assess care coordination needs (differs from clinical needs  
  - Engage team, assign clear roles and responsibilities  
  - Develop authentic family-provider/care team partnerships; requires family/youth capacity building, professional skill building | |
| **(2) Care planning and communication**  
  - Family and care team co-develop care plans  
  - Ensure communication among all members of the care team  
  - Monitor, follow-up, respond to change, track progress toward goals  
  - Workforce training occurs that promotes effective care plan implementation | |
| **(3) Facilitating care transitions (inpatient, ambulatory)**  
  - Family engagement to align transition plan with family goals, needs  
  - Use Implement components of successful transitions (8 elements of a family-driven/youth guided care transition, including receiving provider acknowledging responsibility)  
  - Ensure information needed at transition points is available | |
| **(4) Connecting with community resources and schools**  
  - Facilitate connection to MA family-run org or Family Partner  
  - Coordinate services with schools, agencies, payers  
  - Identify opportunities to reduce duplication of efforts in building knowledge of available community services | |
| **(5) Transitioning to adult care**  
  - Implement Ctr for Health Care Transition Improvement’s Six Core Elements  
  - Teach/model self-care skills, communication skills, self-advocacy | |

Source: MA CHQC CC TF
<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Study Code and Age</th>
<th>Patient Level</th>
<th>Focus</th>
<th>Care Coordination Needs</th>
<th>Activity Code(s)</th>
<th>Outcome(s)</th>
<th>Time Spent*</th>
<th>Staff</th>
<th>Clinical Comp.</th>
<th>Initials</th>
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### Patient Level

<table>
<thead>
<tr>
<th>Level Description</th>
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<tbody>
<tr>
<td>I Non-CSHCN, Without Complicating Family or Social Issues</td>
</tr>
<tr>
<td>II Non-CSHCN, With Complicating Family or Social Issues</td>
</tr>
<tr>
<td>III CSCHN, Without Complicating Family or Social Issues</td>
</tr>
<tr>
<td>IV CSCHN, With Complicating Family or Social Issues</td>
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### Focus of Encounter (choose ONE)

1. Mental Health
2. Developmental/Behavioral
3. Educational/School
4. Legal/Judicial
5. Growth/Nutrition
6. Referral Management
7. Clinical/Medical Management
8. Social Services (e.g., housing, food, clothing, etc., trans.)

### Care Coordination Needs (choose all that apply)

1. Make Appointments
2. Follow-Up Referrals
3. Order Prescriptions, Supplies, Services, etc.
4. Resolve Discrepancies
5. Coordination Services (schools, agencies, payers, etc.)

### Activity to Fulfill Needs (choose all that apply)

1. Telephone discussion with:
   a. Patient
   b. Parent/Family
   c. School
   d. Agency
2. Electronic (E-Mail) Contact with:
   a. Patient
   b. Parent/Family
   c. School
   d. Agency
3. Contact with Consultant:
   a. Telephone
   b. Meeting
4. Form Processing (e.g., school, camp, or complete record release)
5. Confer with Primary Care Physician
6. Written Report to Agency (e.g., Medicaid)
7. Written Communication
   a. E-Mail
   b. Letter
8. Chart Review
9. Patient-focused Research
10. Contact with Home Care Personnel
    a. Telephone
    b. Meeting
11. Develop/Modify Written Care Plan
12. Meeting/Care Conference

### Time Spent*

1. Less than 5 minutes
2. 5 to 9 minutes
3. 10 to 19 minutes
4. 20 to 29 minutes
5. 30 to 39 minutes
6. 40 to 49 minutes
7. 50 minutes and greater* (Please NOTE actual minutes if greater than 50)

### Staff

- RN, LPN, MD, INF, PA, MA, SW, Cler

### Clinical Competence

- Clinical Competence required
- Clinical Competence not required

### Outcome(s)

As a result of this care coordination activity, the following was PREVENTED (choose ONLY ONE, if applicable):

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>1a</td>
<td>ER visit</td>
</tr>
<tr>
<td>1b</td>
<td>Subspecialist visit</td>
</tr>
<tr>
<td>1c</td>
<td>Hospitalization</td>
</tr>
<tr>
<td>1d</td>
<td>Visit to Pediatric Office/Clinic</td>
</tr>
<tr>
<td>1e</td>
<td>Lab/X-ray</td>
</tr>
<tr>
<td>1f</td>
<td>Specialized Therapies (PT, OT, etc.)</td>
</tr>
</tbody>
</table>

2. As a result of this care coordination activity, the following occurred (choose all that apply):

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<tbody>
<tr>
<td>2a</td>
<td>Address family/patient on home management</td>
</tr>
<tr>
<td>2b</td>
<td>Referral to ER</td>
</tr>
<tr>
<td>2c</td>
<td>Referral to subspecialist</td>
</tr>
<tr>
<td>2d</td>
<td>Referral for hospitalization</td>
</tr>
<tr>
<td>2e</td>
<td>Referral for pediatric sick office visit</td>
</tr>
<tr>
<td>2f</td>
<td>Referral to lab / X-ray</td>
</tr>
<tr>
<td>2g</td>
<td>Referral to community agency</td>
</tr>
<tr>
<td>2h</td>
<td>Referral to Specialized Therapies</td>
</tr>
<tr>
<td>2i</td>
<td>Ordered prescription, equipment, diapers, taxi, etc.</td>
</tr>
<tr>
<td>2j</td>
<td>Reconciled discrepancies (including missing data, miscommunications, compliance issues)</td>
</tr>
<tr>
<td>2k</td>
<td>Reviewed lab, specialist reports, IEP's, etc.</td>
</tr>
<tr>
<td>2l</td>
<td>Advocacy for family/patient</td>
</tr>
<tr>
<td>2m</td>
<td>Met family's immediate needs, questions, concerns</td>
</tr>
<tr>
<td>2n</td>
<td>Unmet needs (PLEASE SPECIFY)</td>
</tr>
<tr>
<td>2o</td>
<td>Not Applicable / Don't Know</td>
</tr>
<tr>
<td>2p</td>
<td>Outcome Pending</td>
</tr>
</tbody>
</table>

**Supported by grant HRSA-02-MCHB-25A-AB**

And to review slides from this evening’s session, please visit:

http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement

For additional questions, please email:
richard.antonelli@childrens.harvard.edu
References

• Patient- and Family-Centered Care Coordination: A Framework for Integrating Care For Children and Youth Across Multiple Systems. pediatrics.aappublications.org/content/early/2014/04/22/peds.2014-0318.full.pdf+html

• MA CHIPRA Child Healthcare Quality Coalition Care Coordination Task Force Key Elements Framework www.mhqo.org/EmailLinks/CHQC%20CC%20Key%20Elements%20High%20Level%20Framework.pdf

• Care Coordination Curriculum
  http://www.childrenshospital.org/care-coordination-curriculum
References


References


References

Useful Websites

- [http://www.medicalhomeinfo.org](http://www.medicalhomeinfo.org) American Academy of Pediatrics hosted site that provides many useful tools and resources for families and providers
- [http://www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org) tools for assessing and improving quality of care delivery, including the Medical Home Index, and Medical Home Family Index
- Care Mapping [http://www.childrenshospital.org/care-mapping](http://www.childrenshospital.org/care-mapping)