Optimizing Health Reform to Integrate Service Delivery Systems for Women, Children and their Families

Webinar

In partnership with and supported by The Commonwealth Fund

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Creating Shared Resources to Improve Child Health & Well-Being in Communities

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A utility is a resource shared by multiple community services providers or practices in order to achieve efficiencies in operation and management and improvements in quality.
Individual Medical Homes Can Be Inefficient
Care Coordination in Pediatric Practices

Designated Care Coordinator

- Yes: 39%
- No: 57%

Pediatric Practices Receiving Payment for Care Coordination

- All Payers: 1%
- Some Payers: 9%
- None: 86%

Commonwealth Fund IHP Survey 2009
Shared Clinical Service
Help Me Grow Model

Diagram with circles labeled 'Primary Care' and 'CC' connected with arrows.
Shared Resources

- Care coordination
- Health education
- Information technology
- Quality improvement technical assistance
- Home visiting
- Mental health consultation
- Universal Forms
Shared Resources for Practice Support

• Technical assistance & coaching
  – Online support
  – On-call technicians (who can visit service sites and provide support)

• Shared services on- and off-site
  – Community-based shared clinical services
  – Community-based shared wrap-around services
  – Embedded clinical services/co-location
Why would professionals want to share resources?

- Saves money
- Makes practicing easier, less stressful
- Is professionally rewarding
- Improves quality of care
- Achieves required quality standards
How might shared resources be financed?

- Privately, publicly, or shared public-private
- Per member per month payments
- Stone soup (blended funds)
- Shared savings
The Future: Virtual Integration Through Shared Resources

- Community Health Centers
- Public Health
- Hospitals & Institutions
- Specialty Care
- Community Family Support Services

- HIT
- QI
- Pt Ed
- CC
- MH
- 24/7
Additional Resources

• Abrams JK, Schor EL, Schoenbaum SC. How physician practices could share personnel and resources to support medical homes. Health Affairs, 2010; 29(6):1194-1199


• A Tale of Two Large Community Electronic Health Record Extension Projects. Mostashari F, Tripathi M, Kendall M. Health Affairs, March/April 2009, 28(2): 345-356


Medical Home: The Who

Colorado’s Children- The numbers:

– Birth rate: Approximately 70,000 births/year
  • 1/3 covered by Medicaid and CHP+

• Early Intervention/Part C population
  – 4,900 enrolled and receiving EI services (9/1/09). A 36% increase from FY07-08
  – Approximately 2.16% of birth to three population.

• Estimated that 17.6 % of all children in Colorado ages 1-14 have a special health care need
  • That is 162,000 children

* 2008 data from State Demography Office with Colorado Department of Local Affairs
Colorado’s Medical Home Definition per Legislation
(SB 07-130)

“An appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care and related services for a child. ..If a child’s medical home is not a primary medical care provider, the child MUST have a primary medical care provider to ensure that a child’s primary medical care needs are appropriately addressed.”
Medical Home in Action in Colorado

- Legislation (SB 07-130)
- Integration of efforts
- Shared partnership – HCPF and CDPHE
  - Shared - Developing standards (completed 2008)
  - HCPF – Reporting to JBC, Legislative body and Governor’s Office (ongoing every 6 months)
  - HCPF - Increasing access for children who are covered by public programs to have a Medical Home
Lesson Learned

• Connect with family driven community organizations (Family Voices/F2F)
• Let everyone know what you are doing even if you are not making progress
  – *Colorado did not need a bill to do what we are doing – it was already being done*
• Don’t assume everyone knows your language or understands it
  – What is a family centered medical home
  – What is a patient centered medical home
  – What is a primary care program
• Talk to your funders
Medical Home in Action in Colorado

Legislation:

- HCPF – Practice Transformation including Parent Practice Partnerships
- HCPF - Quality Improvement
- HCPF – Measurement of the success of SB -07-130
- HCPF – Reduction in ED utilization by finding children a Medical Home provider
- CDPHE focus on Systems
- CDPHE niche with Family Leadership
Three Legged Stool

Government

Community/Family

Provider/ Private
Medical Home in Colorado

• Health Care Policy & Financing-lead agency per the legislation (SB 07-130)

• CDPHE/Public Health

• Colorado Medical Home Initiative (CMHI)
  – Developed well before legislation – based off learning collaborative by Dr Carl Cooley and NICHQ

• Family Voices CO
Medical Home in Colorado

Concepts leading to integration of Family Leaders into Medical Home Efforts

• Understand that families are a valuable resource and human capital
• Supports emerging family leaders to attend national and state conferences
• Provides equitable compensation
• Employs a systems approach to leadership development
Lesson Learned

- Families have been providing their own care coordination for the past 10 to 15 years – even with managed care
  - Perspective is unique and valuable
  - Why would you develop a care coordination model without asking the people currently doing the job what works and what doesn’t?
- Listen to what they need and get their buy in now
  - Family Voices CO, AARP, etc willing to be at the table in your area, too
Lesson Learned

• Don’t reinvent the wheel
  – Use what is already available and paid for by others (Family to Family Centers in your state)
  – Tie into existing programs and you don’t need to ask for a waiver or state plan amendment
• Colorado tied Medical Homes to EPSDT based on NICHQ learning collaborative model
  – Built in measurements
    » EPSDT 416
    » HEDIS
    » Medical Home Index for provider and family satisfaction
Free Support Services

Family Centered Medical Home Providers utilize current Federal and State programs

- Nurse Advice Line/After Hours Coverage
- Infant Immunization Program
- CIIS
- ABCD Program
- EPSDT
- HCP
- Part C
- Part B
Medical Home in Colorado

CDPHE/Public Health

• Case Management/Care Coordination programs:
  – Health Care Program for Children with Special Needs (HCP), PreNatal Plus (PNP), Nurse Family Partnership (NFP)

• Immunization, newborn hearing, and newborn metabolic screening integrated data systems including PCP offices and health clinics (continuous)

• Birth Registry calls for CDC

• ABCD project – developmental and other screenings
Medical Home Process

1. Identify the practice (CCHAP)
2. Orientation
3. Medical Home Index with staff (no < 80%)
4. Family Survey
5. Follow up share data
6. Improvement Process
7. MHI repeated in one year
   1. Now certifying year 2 practices
Colorado Medical Home to Date

• MHI’s in 180 practices (33 counties)
  – 23 Family Practice, Pediatric, 22 Mental Health & School based
• Over 3200 family surveys
• Average Family Survey Satisfaction 3.7
• 22 Mental Health Clinics (come on slowly)
• 3960 staff/providers MHI surveys
• 10-13% Families of CSHCN
• Tie data together-community resources
Free Support Services

• Practice supports from the Department and CCHAP (Colorado Child Healthcare Access Program) include:
  – Enrollment Specialists and access to Presumptive Eligibility
  – Technical Assistance for business processes related to Medicaid and CHP+ (Billing)
  – Social Services Support
  – Transportation Support
  – Case Management and Care Coordination
  – Practice Redesign
Free Support Services

• Practice supports from CCHAP include:
  – Practice Administrators Network
  – Mental Health Services (on call providers who specialize in children)
  – Diversity Training
  – Medical Spanish Interpretation Courses
  – LCSW Support
  – Continuous Quality Improvement with
  – a Quality Improvement Coach
Contact Info

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BEACON
Best Evidence for Advancing Childhealth in Ohio NOW!

AMCHP Webinar
Integrated Service Delivery Systems

October, 12 2011
BEACON

• Statewide collaboration

• Encourage & support initiatives that achieve measurable improvements in children’s health & outcomes through improvement science

• 21 Stakeholder groups/supporters; inc. universities, researchers, advocacy groups for children’s issues, children’s hospitals & state departments
Mission of BEACON

The mission of BEACON is to **improve the quality and outcomes** of health for children in Ohio, with a special **emphasis** on Medicaid eligible children, youth and their families. To do so requires **initiatives targeted** to important health issues; the establishment of **sustainable, quality improvement** infrastructure; and **public private collaboration**.
BEACON is built on the IHI Triple Aim Initiative...

IMPROVEMENTS in the
• QUALITY: individual experience of care,
• HEALTH: health of the population &
• COST: lower per capita cost of care
Ohio’s BEACON Initiatives

• Ohio Perinatal Quality Collaborative (OPQC)

• Developmental & Autism Screening

• Childhood Obesity

• Solutions for Patient Safety Initiatives

• Early Childhood Mental Health – Pediatric Psychiatry Network (PPN)

• Help Me Grow Home Visiting
BEACON RESULTS - Example

Ohio Perinatal Quality Collaborative (OPQC) & Preterm Births

- Prevention of 8,000 late preterm births, 36-38 weeks
- Resulting in reduced NICU admissions and infant deaths by approx. 150-250
- Time period: 20 months Aug ’08 to March ’10
- Includes 24 hospitals, representing 47% of all Ohio births
- Saving $10 million in total costs. Assume Medicaid is 50% = $5 million savings to Medicaid
Positioning for Health Care Reform

- Quality Improvement
- Identified Metrics
- Systems Reform
- Movement towards Payment Reform
CHILD HEALTH QUALITY MEASURES

Key Participants in the Development and Implementation

• CHIPRA
  – to develop a Pediatric Quality Measures Program (PQMP)
• Centers for Medicare & Medicaid Services (CMS):
• Institute of Medicine (IOM)
• Agency for Healthcare Research and Quality (AHRQ)
• Medicare and Medicaid EHR Incentive Programs:
  – $$
  – adoption “meaningful use” of EHR
  – achieve health and efficiency goals – Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009
• State Medicaid Agencies w/ managed care programs
• National Committee for Quality Assurance (NCQA)
• National Quality Forum (NQF)
BEACON Benefits

- Transformational change
- Public/Private partnership
- Coordinating key quality improvement initiatives with state agencies, providers and external stakeholders
- Outcome metrics/data
- Transparency
- Proven cost savings...return on investment
- Common Infrastructure
For additional information please contact:

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Objectives

- Review Vermont’s history of collaboration among MCH partners in transforming our system of care
- Describe the integration of these existing systems with Blueprint for Health (Vermont’s Health Care Reform Initiative)
Maternal and Child Health Division

- WIC
- EPSDT
- School Health
- Title V
- Children with Special Health Needs
- Injury, Domestic Violence, Family Planning…
... enter, AAP—VT (and AAFP)
And then along came . . .
Mission: to optimize the health of Vermont children by initiating and supporting *measurement-based* efforts to enhance private and public child health practice.

*In partnership with:*
Vermont Department of Health
University of Vermont Department of Pediatrics
Vermont Chapter of the American Academy of Pediatrics
Vermont Chapter of the American Academy of Family Physicians
Office of Vermont Health Access (Medicaid)
Vermont Agency of Human Services
Banking, Insurance, Securities & Health Care Administration (BISHCA)
Three Vermont Managed Care Organizations (BCBSVT, TVHP, MVP)
Vermont Health Care Reform 60+ Discrete Initiatives to:

**Increase Coverage**
- New Coverage Options
- Premium Assistance
- Integrated Marketing and Outreach

**Improve Quality**
- Provider Access, Transparency
- Promote Wellness / Prevention
- Blueprint for Health
  - integrated Medical Home & Community Health Team
- Health Information Technology

**Contain Cost Growth**
*All of Above PLUS*
- Cost Transparency
- Statewide Health Resource Planning and Review
- Prescription Drug Cost Containment
- Administrative Simplification
BP Integrated Pilots: Building an Integrated System of Health

- Integrated Health Service Model
- Payment Reform to support prevention & health maintenance
- Health Information Infrastructure
- Evaluation Infrastructure
- Generalizable (other services)
- Scalable (larger populations)
- Sustainable (financially)
Blueprint for Health: Children

- 2003: Blueprint launched: chronic disease focus
- 2010: Statewide Blueprint Expansion
- 2011: 35 pediatric practices in line for NCQA scoring (3 practices currently “on”)
Blueprint for Health

- Pediatric Expansion
  - Outcome measures
  - Bright Futures

- Frequent meetings and collaboration
  - Vermont Department of Health
  - AAP/AAFP
  - Vermont Child Health Improvement Program
  - Integrated Family Services (Agency of Human Services)
Blueprint for Health: Children

- Bright Futures Guidelines: Data dictionary
  - Clinical care
  - Program planning and evaluation
  - Quality improvement activities
Vermont Health Reform Legislation

- June 2011: Act 48
- Puts state on path to a single payer system
Questions

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Thank You!

For more information about AMCHP’s National Center for Health Reform Implementation or this project, please contact: Carolyn Mullen at cmullen@amchp.org

To view a more extensive overview of this topic go to http://webcast.hrsa.gov/conferences/mchb/amchp2011/optimizing_hcr.htm

We appreciate your participation today and value your feedback. Upon exiting the webinar, you will be directed to a brief evaluation.