Assessing and Promoting Title V’s Role in Addressing Gaps in Care Coordination for CYSHCN

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Ask me about:

✓ Children and Youth with Special Health Care Needs/Medical Complexity
✓ Autism and other Developmental Disabilities
✓ Early Childhood Data Integration
✓ Systems of Care
✓ Developmental Monitoring & Screening
✓ Zika response
Agenda

• Who is AMCHP?
• What is Title V?
  • Performance measurement framework
• The role of Title V in improving systems of care for CYSHCN
• Three Impact Points to Increase Population-Based Approaches to Care Coordination
• Session Evaluations
Learning Outcomes

1. Demonstrate understanding of the role of Title V programs in promoting high quality, cross-systems care coordination.

2. Identify future implications for Title V CYSHCN programs as they continue to promote the spread of effective care coordination strategies.

3. Discuss practical examples of applying care coordination strategies to improve systems of care for CYSHCN.
AMCHP is national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.
What is Title V?

The nation’s longest standing public health legislation focused solely on improving the health of all mothers and children, including children with special health care needs (CSHCN).

Appropriates funds to states to:

• Ensure access to quality health services
• Promote the health of children by providing preventive and primary care services
• Provide and promote family-centered, community-based, coordinated care for children with special health care needs

At least 30% of funds
Title V MCH Services Block Grants

Every 5 years, states conduct a needs assessment to prioritize MCH needs.

Each year, states submit a block grant application outlining their strategic priorities for the year.

With each block grant application, states select 5 National Performance Measures (out of 15), 3-5 state priority measures, and one or more state outcome measures.

Next stop: 2020!
Title V Performance Measurement Framework

National Outcome Measures
Population-level measures that reflect the ultimate health outcomes to be improved

National Performance Measures
Process and/or program measures shown to affect the national outcome measures

Evidence-Based/Informed Strategy Measures
Accountability measures for improving quality and performance of state efforts related to the National Performance Measures
National Performance Measure 11
Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

National Performance Measure 12
Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

National Performance Measure 15
Percent of children, ages 0 through 17, who are continuously and adequately insured
National Performance Measure 11

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Despite advances, the care of 57.3% of children and youth with special health care needs (CYSHCN) DOES NOT meet medical home criteria.
National Performance Measure 11

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Yet, 86.2% of children and youth with special health care needs (CYSHCN) DO NOT RECEIVE CARE IN A WELL-FUNCTIONING SYSTEM
The Challenge

61.8% of CYSHCN receive needed care coordination.

For CYSHCN, coordinated care by their care team, including family members, and primary, specialty, and service providers, is essential to their health and well-being.

Unfortunately, communication and coordination across systems of care is often fragmented.

According to The National Standards for Systems of Care for CYSHCN, a plan of care should be jointly developed, shared, and implemented among the CYSHCN and their family, primary care provider and/or the specialist serving as the coordinating physician and members of the health care team.

Three Impact Points to Increase Population-Based Approaches to Care Coordination

- Interagency Partnership Development
- Strengthening Infrastructure
- Systems Assessment & Action Planning
Rhode Island Title V and Medicaid agencies worked together to understand the state’s current care coordination system by reviewing the care coordination domain of the National Standards to gain insight on what an ideal, well-functioning care coordination system offers.

Rhode Island identified care coordination providers for CYSHCN and invited key stakeholders to attend monthly meetings to review the current status of care coordination services, identify available resources, and share experiences.

The state identified numerous barriers to providing care coordination, including: 1) limited communication between care coordinators, 2) lack of official designation for some care coordinators by Medicaid which prevents reimbursement, and 3) an inability for care coordinators to authorize services, which caused delays in care.
Improving Population-Based Continuity of Care & Case Management for CYSHCN

Abridged Case Study: Kentucky

As Kentucky’s CYSHCN program shifted some of their activities away from direct service to more population-based efforts, the National Standards were used as a resource to inform Kentucky’s Title V Block Grant action plan(s) and Needs Assessment.

While Kentucky CYSHCN continues to provide traditional gap-filling direct services, the agency strengthens its infrastructure through strategic planning and continuous quality improvement strategies, framed by the National Standards.

To advance access to care in partnership with existing providers whenever possible, Kentucky CYSHCN services strive for a “hybrid clinic” model of collaborating with community and state partners to not only augment care, but to limit duplication and fragmentation of services.
Minnesota assessed statewide provision and receipt of care coordination services by using the National Standards as a mechanism to define how to achieve a coordinated system of care and identify needs that helped develop a statewide care coordination framework.
In Conclusion...

✓ Successful Care Coordination for CYSHCN involves many systems working together, so Title V programs must work in partnership with Medicaid, state health policymakers, health care systems, etc. to improve care coordination outcomes.

✓ Central to the National Standards is the importance of high-quality systems of care coordination, thus they can be used as a framework for convening stakeholders and identifying barriers and complexity of care for CYSHCN.
Resources to check out:

✓ Access the National Standards for Children and Youth with Special Health Care Needs as well as accompanying tools and resources, learning modules, and state examples.

✓ Check out the full National Standards online toolkit

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