Patient- and Family-Centered Medical Home: Necessary Component of High Value Delivery Systems

National Health Policy Forum
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Harvard Medical School
November 08, 2013
Dedication
Barbara Popper
Objectives for Today

• Understand the potential strengths of family- and patient-centered Medical Home when part of an integrated system of care

• Leverage F/PCMH model to achieve optimal outcomes

• Discuss measurement strategies which support the development of integrated care in era of health system reform
One Family’s Care Map

http://www.childrenshospital.org/care-mapping
Medical Neighborhood

• Improving CC and family-centered care could result in higher quality of care for all children and adolescents, and specifically for disadvantaged adolescents and those with mental health conditions.


• Since Medicaid “ACO’s” might encourage integration across continuum of care, they offer a promising policy solution to improve the integration of community health centers into “medical neighborhoods.”

  Neuhausen, Grumbach, et al, Health Affairs, 2012

• “Health Neighborhood” includes community-based, non-medical services. Must include basic needs assessment, facilitation of referrals, care coordination, co-location.

  Garg, Sandel, J Peds, 2012
Medical Neighborhood

• To include innovative forms of interaction that do not depend on traditional office visits, but for which there are clear incentives
  – care coordination agreements must be better standardized for the sake of practicality
    
    Yee, Ann Int Med, 2011

• Foster models that rely upon community partners
  – churches and schools
  – care teams to include community health workers
  – additional collaborations between providers and their patients/families from less cohesive neighborhoods.

  Aysola, Orav, Ayanian, Health Affairs, 2011
Medical Home
is a necessary component of a
High Performing Health Care System

But it is not sufficient
to deliver optimal value outcomes for all populations
## Expenditures for the five most costly conditions in children (2006, national data)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Expenditures ($ bil)</th>
<th># of children (millions)</th>
<th>Avg total expenditures per child ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental Disorders</td>
<td>8.9</td>
<td>4.6</td>
<td>1,931</td>
</tr>
<tr>
<td>2. Asthma/COPD</td>
<td>8.0</td>
<td>12.9</td>
<td>621</td>
</tr>
<tr>
<td>3. Trauma</td>
<td>6.1</td>
<td>6.7</td>
<td>910</td>
</tr>
<tr>
<td>4. Acute Bronchitis &amp; URI</td>
<td>3.1</td>
<td>12.8</td>
<td>242</td>
</tr>
<tr>
<td>5. Infections Diseases</td>
<td>2.9</td>
<td>4.5</td>
<td>658</td>
</tr>
</tbody>
</table>

**SOURCE:** Center for Financing, Access, and Cost Trends. AHRQ. Household Component of the Medical Expenditure Panel Survey (MEPS) 2006
Distribution of Pediatric TME

- **Healthy, Preventive**: 74.5% of population, 5% of spend
- **Chronic**: 25% of population, 70% of spend
- **Complex**: 0.5% of population, 25% of spend

Total population: 100%
Matching Services to Complexity

**Children with complex needs**
- Neurodevelopmental (Autism, etc.)
- Behavioral/Psychiatric
- Oncology/ Hematology
  - Sickle cell
  - Hemophilia
  - Cancer
- Technology dependent

**Children with chronic conditions**
- Behavioral (ADHD, depression, anxiety, PTSD)
- Asthma
- Diabetes

**Healthy, Preventive**

**Chronic**

**Complex**
Costs Per Member are What You Might Expect Based on Complexity

Per member

Relative Cost

HEMATOLOGY
MALIGNANCY
METABOLISM and...
COMPLICATION of...
RENAI and UROLOGY
CONGENITAL...
GI NON-SPECIFIED
CRANIO-FACIAL FX
CARDIOVASCULAR
DENTAL
PULMONARY
HEALTH
NEUROLOGY
NEONATAL
ENDOCRINE
BENIGN NEOPLASM
BONE and JOINT
ORTHOPEDICS
INFECTION
GI MEDICINE
GENETIC
OB.GYN
ORL
MISC
TRAUMATIC INJURY
OPHTHALMOLOGY
DERMATOLOGIC
V.Codes - MISC
Costs Across Population Reflect Prevalence and Service Needs/Utilization
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.

Team Based Care

• Working Together Effectively Sometimes Requires New Alliances!
Achieving Optimal Value

Integrated Care for Children with Chronic Conditions
- Team-based care—Patient/Family driven
- Enhancing F/PCMH performance
- Leverage Technology
  - Telehealth
  - Patient-held tools
  - Provider-based tools
- Enhance Subspecialty “Access”
  - Collaborative Care Models
  - More timely access to actionable information
- Enhance Patient Self-Management Skills
- Administrative challenges—many children receive care across states; this is a problem in Medicaid
Integrated Co-located Behavioral Health Care in Primary Care Pediatrics

• The Promise
  – An opportunity to “prevent” illness and de-compensation
  – Better clinical outcomes by leveraging the medical home’s team resources and patient knowledge

• The Barriers
  – Absent clinical model of true integration versus co-located services or a new silo
  – Absent business model to manage payor contract access, revenue cycle and costs of care coordination
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

• USMCHB supported CC Curriculum (work force)
  – MI, OR, FL, CO, AK
Framework for High Performing Pediatric Care Coordination

Defining Characteristics of Care Coordination
1. Patient and family-Centered (PFC)
2. Pro-active, planned, & comprehensive
3. Promotes self-care skills & independence
4. Emphasizes cross-organizational relationships

Levels of Care Coord: Needs and Activities
- Level 1: Basic
- Level 2: Moderate
- Level 3: Extensive

## A Framework for High Performing Pediatric Care Coordination

### Care Coordination Competencies:

1. Develops partnerships  
2. Proficient communicator  
3. Uses assessments for intervention  
4. Facile in care planning skills (PFC)  
5. Integrates all resource knowledge  
6. Possesses goal/outcome orientation  
7. Approach is adaptable & flexible  
8. Desires continuous learning  
9. Applies solid team/building skills  
10. Adept with information technology

### Care Coordination Functions:

1) Provide separate visits & CC interactions  
2) Manage continuous communications  
3) Complete/analyze assessments  
4) Develop care plans (with family)  
5) Manage/track tests, referrals, & outcomes  
6) Coach patient/family skills learning  
7) Integrate critical care information  
8) Support/facilitate all care transitions  
9) Facilitate PFC team meetings  
10) Use health information technology for CC

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### MA Child Health Quality Coalition Care Coordination Framework

**Count: # measures identified**

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>Existing</th>
<th>Potl</th>
<th>Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Needs assessment, continuing care coord engagement</td>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2) Care planning and coordination</td>
<td></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3) Facilitating care transitions</td>
<td></td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>4) Connecting with community resources/schools</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5) Transitioning to adult care</td>
<td></td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
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*MA Child Health Quality Coalition CC Task Force Working Draft*  
*Contact: grogers@mhqp.org*  
*Funded by the Centers for Medicare and Medicaid Services (CMS) through grant funds issued pursuant to CHIPRA section 401(d)*
<table>
<thead>
<tr>
<th>Levels of Accountability</th>
<th>Measures</th>
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</thead>
<tbody>
<tr>
<td>Child/Family</td>
<td></td>
</tr>
<tr>
<td>Community/Schools</td>
<td></td>
</tr>
<tr>
<td>Group Practice/Medical Home (Primary Care) Individual Providers</td>
<td></td>
</tr>
<tr>
<td>Psychiatric and Other Specialty Practices Individual Providers (Sub-specialists)</td>
<td></td>
</tr>
<tr>
<td>Community-Based Organizations Community Service Agencies (CSAs), Other Service Providers (EI, CSA, rehab)</td>
<td></td>
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<tr>
<td>Inpatient Facilities</td>
<td></td>
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<tr>
<td>Health Systems/ACOs</td>
<td></td>
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<tr>
<td>Health Plans</td>
<td></td>
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<tr>
<td>State</td>
<td></td>
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<tr>
<td>National/Regional</td>
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</table>
Strategic Approach to Measurement

• Promote measures of care integration–
  – Experience, not just patient satisfaction
  – Patient and family-reported– Sara Singer; adult
  – Child health in development (recent Lucile Packard Foundation for Children’s Health grant)

• Promote testing and implementation of disruptive measures
  – “close the loop” looking at each side of “hand-offs”
Implications for Accountability

• Measure at all Levels of the System
  – MA CHIPRA measure development of CC for children with BH needs

• Transparency of Performance

• Incentives Supporting Activities in “Space Between”
  – Education of work force– multidisciplinary
    • Nursing, social work, Community Health Workers
  – Support for performing Care Coordination which results in value

• Support both short and long term ROI capture for pediatric innovation grants
No more hurting people.
Peace
References

AHRQ Care Coordination Atlas (McDonald Nov 2010) and companion document Care Coordination Accountability Measures for Primary Care Practice (McDonald Jan 2012)

Commonwealth/Antonelli Pediatric Framework (May 2009)

System of Care/Wraparound Framework

NCQA Meaningful Measures of Care Coordination

National Quality Forum (NQF), National Priorities Partnership (NPP) – Measure Application Partnership (MAP) Care Coordination Family of Measures (request for public comment August 10, 2012)
Appendix
<table>
<thead>
<tr>
<th>Key Elements</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(1) Needs assessment for care coordination and continuing engagement</strong></td>
<td></td>
</tr>
<tr>
<td>• Family-driven, youth-guided needs assessment, goal setting</td>
<td></td>
</tr>
<tr>
<td>• Use a standard process to assess care coordination needs (differs from</td>
<td></td>
</tr>
<tr>
<td>clinical needs</td>
<td></td>
</tr>
<tr>
<td>• Engage team, assign clear roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td>• Develop authentic family-provider/care team partnerships; requires</td>
<td></td>
</tr>
<tr>
<td>family/youth capacity building, professional skill building</td>
<td></td>
</tr>
<tr>
<td><strong>(2) Care planning and communication</strong></td>
<td></td>
</tr>
<tr>
<td>• Family and care team co-develop care plans</td>
<td></td>
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<tr>
<td>• Ensure communication among all members of the care team</td>
<td></td>
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<tr>
<td>• Monitor, follow-up, respond to change, track progress toward goals</td>
<td></td>
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<tr>
<td>• Workforce training occurs that promotes effective care plan implementation</td>
<td></td>
</tr>
<tr>
<td><strong>(3) Facilitating care transitions (inpatient, ambulatory)</strong></td>
<td></td>
</tr>
<tr>
<td>• Family engagement to align transition plan with family goals, needs</td>
<td></td>
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<tr>
<td>• Use Implement components of successful transitions (8 elements of a</td>
<td></td>
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<tr>
<td>family-driven/youth guided care transition, including receiving provider</td>
<td></td>
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<tr>
<td>acknowledging responsibility)</td>
<td></td>
</tr>
<tr>
<td>• Ensure information needed at transition points is available</td>
<td></td>
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<tr>
<td><strong>(4) Connecting with community resources and schools</strong></td>
<td></td>
</tr>
<tr>
<td>• Facilitate connection to MA family-run org or Family Partner</td>
<td></td>
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<tr>
<td>• Coordinate services with schools, agencies, payers</td>
<td></td>
</tr>
<tr>
<td>• Identify opportunities to reduce duplication of efforts in building</td>
<td></td>
</tr>
<tr>
<td>knowledge of available community services</td>
<td></td>
</tr>
<tr>
<td><strong>(5) Transitioning to adult care</strong></td>
<td></td>
</tr>
<tr>
<td>• ImplementCtr for Health Care Transition Improvement’s Six Core Elements</td>
<td></td>
</tr>
<tr>
<td>• Teach/model self-care skills, communication skills, self-advocacy</td>
<td></td>
</tr>
</tbody>
</table>

Source: MA CHQC CC TF
## MA Child Health Quality Coalition TF References: Alignment Across Constituencies

### Key References for Care Coordination Frameworks and Measures

<table>
<thead>
<tr>
<th>Frameworks</th>
<th>Inventory of Measure Sets</th>
</tr>
</thead>
</table>
| **AHRQ Care Coordination Atlas** (McDonald Nov 2010) and companion document **Care Coordination Accountability Measures for Primary Care Practice** (McDonald Jan 2012)  
- Chapter 3. Care Coordination Measurement Framework, Table 1. Mechanisms for Achieving Care Coordination (Domains)** | **NCQA Healthcare Effectiveness Data and Information Set (HEDIS)** (selected measures applicable to pediatric care coordination)  
- NQF-Endorsed 12 Care Coordination measures (August 2012)  
- NQF-Endorsed Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination (NQF 2010)  
- Physician Consortium for Performance Improvement (PCPI) (AMA-convened) Care Transitions Measurement Set (2009) and STAAR  
- Medicaid Meaningful Use Measures (Stage 1) (for incentive payments for EHR adoption)  
- NCQA’s Patient-Centered Medical Home (PCMH) and new Accountable Care organization (ACO) Accreditation Programs  
- MA Statewide Quality Advisory Committee (SQAC) recommended measure sets; MassHealth Comprehensive Primary Care Payment Reform potential list of metrics (p. 5-6) |
| **Commonwealth/Antonelli Pediatric Framework** (May 2009)  
- Medical Home Care Coordination Measurement Tool (CCMT)  
- Center for Medical Home Improvement (CMHI) Medical Home Index (MHI)  
- Primary Care Assessment Tool (PCAT-PE, PCAT-PE)  
- Medical Home Health Care Transition Index (HCTI)  
- Behavioral Health Integration Needs Assessment (survey developed for the MA Patient-Centered Medical Home Initiative) |
| **System of Care/Wraparound Framework**  
- Stroul, Blau, Friedman. **Updating the System of Care: Concept and Philosophy**. Georgetown Center for Child and Human Development. 2010. System of care components and 13 guiding principles: Table 1 (p 6)  
- Wraparound Fidelity Index (WFI), Team Observation Method (TOM), Child and Adolescent Needs and Strengths (CANS) | Family/patient experience surveys  
- National Survey Children w/ Special Health Care Needs (NS-CSHCN)  
- MHQP Ambulatory Patient Experience Survey (PES)  
- NQF-Endorsed 3-item Inpatient Care Transition Questions (CTM-3)  
- Families and Communities Together (FCT) Parent Satisfaction Svy  
- Medical Home Family Index (MHFI), companion to CMHI  
- Family-Centered Care Self-Assessment Tool (Family Voices/MCHB)  
- Patient Activation Measure (PAM) (Hibbard et al)  
- The Right Question Effective Patient Strategy™ |
| **NCQA Meaningful Measures of Care Coordination**  
- Scholle SH. **Care Coordination Measurement Approach. Meaningful Measures of Care Coordination**. NCQA National Committee on Vital and Health Statistics. October 13, 2009. | **Framework**  
- Health Care Improvement Authority (HCIA)  
- National Quality Measures Clearinghouse (NQMC)  
- National Quality Forum (NQF) Quality CHART Guide  
- [http://www.qualityforum.org](http://www.qualityforum.org)  
- [http://www.ncqa.org](http://www.ncqa.org)  
- [http://www.ahrq.gov/index.jsp](http://www.ahrq.gov/index.jsp) |
| **National Quality Forum (NQF), National Priorities Partnership (NPP) – Measure Application Partnership (MAP)**  
- Care Coordination Family of Measures (request for public comment August 10, 2012)  
- Sample Measurement Cascade/Accountability Framework: p. 20 in NQF/NPP. The Role of Performance Measurement. ldjhealththeeconomist.com/media/janet_corrigan_slides.pdf | **Source**  
- American Academy of Pediatrics (AAP)  
- American College of Physicians (ACP)  
- American Quality Institute (AQI)  
- National Institute of Health (NIH)  
- [http://www.aap.org](http://www.aap.org)  
- [http://www.acponline.org](http://www.acponline.org)  
- [http://www.aqi.org](http://www.aqi.org)  
- [http://www.aap.org](http://www.aap.org) |
Key Actors and the Flow of Information in the Medical Neighborhood