Caring For Children With Special Health Care Needs In The Context Of Health Care Reform

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Components of reform

- Delivery redesign
- Payment reform
- Data and analytics
Delivery Redesign

- Health Care Home to...
- Behavioral Health Home (and Health Home) to...
- Accountable Care Organizations to ...
- Accountable Communities

Increasing levels of integration
The Patient and Family Centered Health Care Home

Access
- Health care for all
- Same day access
- After hours access
- Race/Language Data
- Preferred Communication

Community Partnerships

Prepared practice team

Quality
- Evidence-based practice
- “Triple Aim” Quality Plan
- Quality improvement Team, includes patients/families
- Learning Collaborative

Care coordination
- Collaborative Team
- Dedicated time for care coordinator
- Panel management
- Community resources
- Care transitions

Care Plan
- Patient Centered Goals
- Emergency After Hours Plan
- Wellness promotion
- Patient self management
- Family Involvement
  - “Refrigerator Ready, Living Document”

Registry
- Population Management
- Electronic Registry
- Prevent GAPS in Care
- Pre-Visit Planning
What Makes Minnesota’s HCH Approach Unique?

- Statewide approach, public/private partnership
- Standards for certification all types of clinics can achieve
- Support from a statewide learning collaborative
- Development of a payment methodology
- Integration of community partnerships to the HCH
- Outcomes measurement with accountability
- Practice level quality improvement
- Statewide HCH Evaluation supported by legislation.

Focus on patient- and family-centered care concepts
# Certified Clinics: 290+ 38% of Primary Care Clinics in Minnesota (6 in border states)

- Applicants are from all over the state.
- Variety of practice types such as solo, rural, urban, independent, community, FQHC and large organizations.
- All types of primary care providers are certified, family medicine, pediatrics, internal medicine, med/peds and geriatrics.

Certified Clinicians: 2900

Approximately 2.8 million patients receiving care in a certified HCH.
Workforce Capacity

- Nurse practitioners
- Advanced dental therapists
- Medication therapy management pharmacists
- Community Health Workers
- Community Paramedics
- Doulas
- Behavioral health aids
- Peer counselors (mental health)
Health Care Home As Foundation to ACO’s or Total Cost of Care Payment Methods

Accountable Care Organizations / TCOC defined by population management and financial risk/benefit sharing with payers

Health Care Home Components - An organization that cannot do these things is unlikely to succeed as an ACO
Payment reform

• Opportunities
  • Tiering by complexity
  • Increased payment for greater integration
  • Payment for outcomes
  • Driving integration

• Challenges
  • Provider burden
  • Billing mechanisms
  • Defining outcomes
  • Realigning inside provider systems
Data and analytics

- Measurement
- Risk Adjustment
- Attribution
Measurement

A Paradigm

- Structural measures (e.g. clinic based quality improvement)
- Process measures (e.g. number of children with special health care needs with care plans)
- Health care outcomes (e.g. rate of asthma ED visits/admits)
- Health/well-being outcomes (e.g. parental days work missed, healthy days rating)
Risk adjustment

- Medical complexity
- Social determinants/complexity
HCH Population Based

HCH is Your Entire Clinic

TIER 0
HCH Participants
No chronic conditions or less complex conditions.

TIERS 1-4
HCH Participants: More Complex Severe Conditions

TIERS 1-4
HCH Patients Need: More intensive care coordination by a care team.

TIER 0
HCH Patients Need
Routine Panel Management & Preventive Care

HCH CERTIFICATION AND OUTCOMES MEASUREMENT
Children as compared to adults

- **Children**
  - 31% Neurological
  - 15% Pulmonary
  - 12% Skeletal
  - 12% Psychiatric
  - 9% Developmental

- **Adults**
  - 27% Cardiovascular
  - 23% Psychiatric
  - 17% Skeletal
  - 17% Neurological
  - 16% Pulmonary

CDPS Frequency % in disabled beneficiares
Developing a Social Complexity Model

Project Objective

- Develop a method for Medicaid agencies to identify children who have significant family and environmental risk factors
Social Complexity Data

- Uses administrative data only:
  - Claims and encounter data
  - Enrollment data
  - Cash assistance data
  - Child protection data
Administrative Data

Advantages:
• Cost-effective
• Feasible to implement

Disadvantages:
• Likely undercount on indicators taken from medical claims (e.g. mental illness diagnoses)
• Instability of some data (e.g. income)
• Unreliability of data when self-report indicators are not defined well (e.g. homeless indicator)
Social Complexity Indicators among Children on a Public Health Care Program (N=306,723)

Risk factors of children on Minnesota Public Health Programs who have at least one parent also enrolled

- Family’s income is <125% FPL 83%
  - <$30,000 for family of 4
  - Parent is unmarried 59%
- Parent has high need for medical care: 32%
- Medically complex child in family 16%
- Parent has chemical dependency dx 15%
- Parent has Serious Mental Illness dx 13%
- Parent indicated they were homeless 2%
Next steps: Improve services to our participants

The social complexity data will allow us to:

- Guide our efforts to identify regions, populations, and risk factors that require immediate attention
- Identify particular children and families who would benefit from various services
- Implement a social complexity risk-adjustment indicator to stratify our populations for ACO gain-share payments
Next Steps: Research

- December 2013: Complete telephone surveys with parents (done by SCRI) and with those children’s providers to validate the administrative set of social complexity indicators
- March 2014: Report validation study results to AHRQ, along with the description of how to identify children who would benefit from care coordination
- May 2014: Report differences in health care utilization and cost among children with different levels of social complexity
Support for Research

- Funded by AHRQ through the Center of Excellence on Quality of Care Measures for Children with Complex Needs
- PI: Rita Mangione-Smith, Seattle Children’s Research Institute
- Purpose of Center of Excellence work: Develop new and improve existing indicators of quality pediatric care for children with complex needs
- Purpose of the social complexity project is to develop a method to identify children who would benefit from care coordination