Overview of Interagency Care Coordination

Senate Select Committee on Children with Special Health Care Needs

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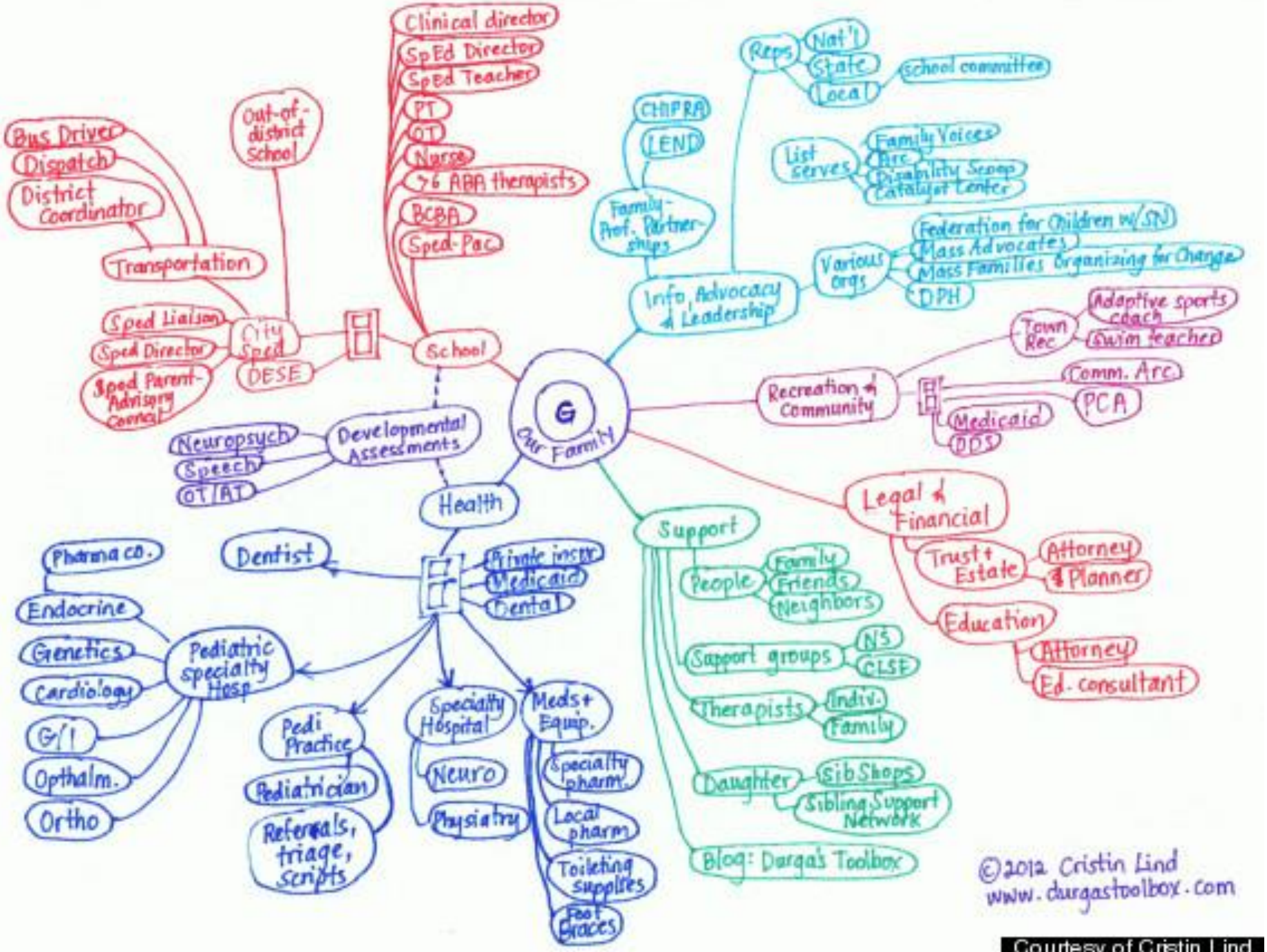
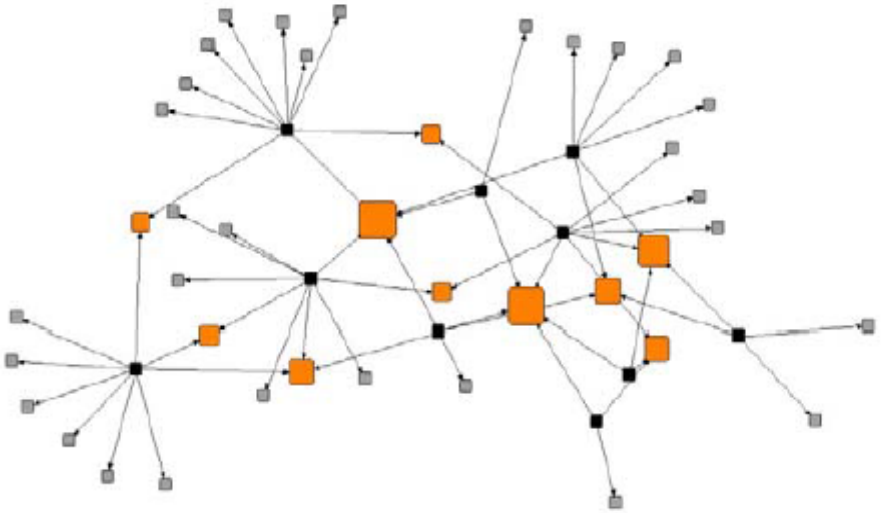
A Parent's Story



System Level*	Personal Network Level*
	
Top Ten Key Actors in the Systems Network State Part C Health Care Program for CSHCN Developmental Screening Initiative State Part B Department of Human Services Local Early Childhood Councils Family Advocacy State Department of Education State Health Department Primary Care Providers	**Top Ten Key Actors in the Personal Networks** - Pediatricians - Schools - Other Families - Extended Families - Friends - Online Support Groups - Local Disability Services Agency 1 - Local Disability Services Agency 2 - Immediate Family - Other Healthcare Providers

Who Are the Player in Regional Care Coordination

- CCS
- Regional Center
- County Mental Health Center
- Hospitals
- Pediatric subspecialty clinics
- Managed Care Organizations
- Home Care agencies
- Day care, pre-schools and schools

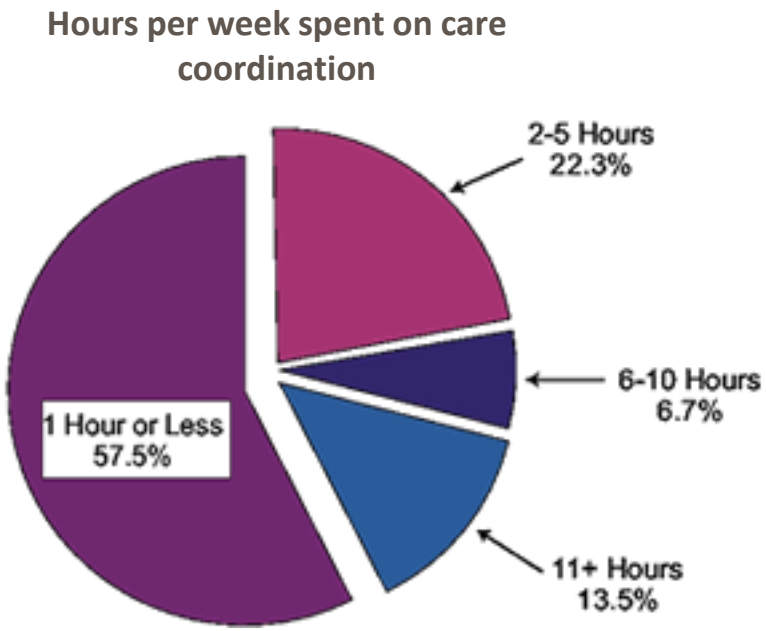
There is no single child centered entity that is responsible for care coordination for the CSHCN

“We need a care coordinator for all of our care coordinators”

Parent of a child with special health care needs

Caring for children with complex conditions equally challenging for family members

- 14% spend 11 hours per week spend on care coordination
- 57% experience financial problems
- 54% had a family member stop working to care for their child
- 49% needed additional income for medical expenses



National Survey for Children with Special Health Care Needs 2010-11

Source: Kuo, DZ, et al. (2011, Nov). *A national profile of caregiver challenges among more medically complex children with special health care needs.* Archives Pediatric Adolescent Medicine; 65(11):1020-6.

Key Issues in Regional Care Coordination

- Who needs care coordination? - Identification and eligibility of children who are in most need of intensive care management
- What is good care coordination? –Components of evidenced based care coordination
- How do you pay for care coordination? –Aligning incentives for high quality care

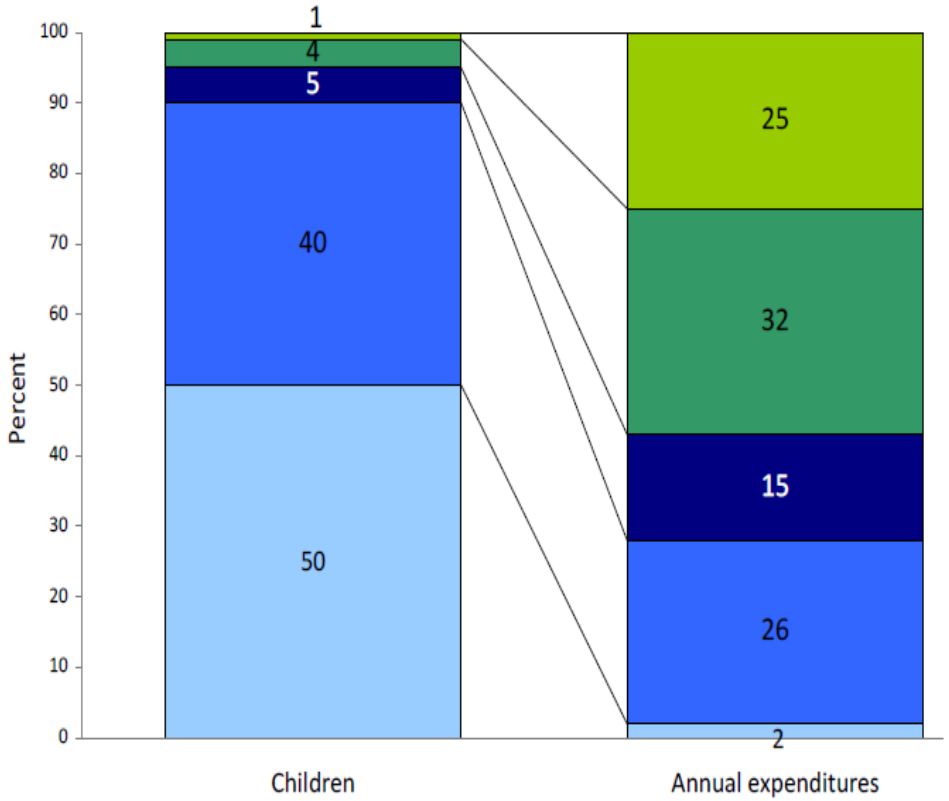
Who Needs Care Coordination?

- Big spenders?
- Children with specific diagnoses?
- Children with behavioral problems and social determinants of health care?

Who Needs Care Coordination: Big Spenders

- They account for a large proportion of health care costs

Exhibit 1: Distribution of Annual Expenditures by Children enrolled in California Children Services



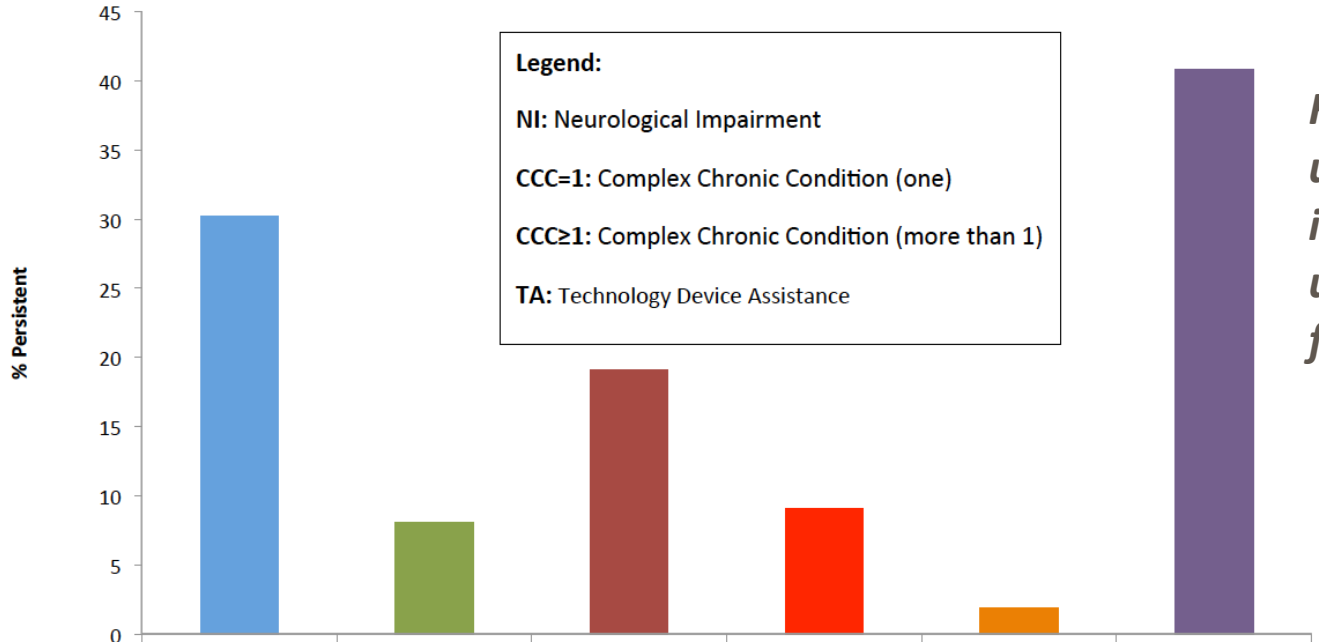
10% of children accounted for 64% of expenditures

1% of children accounted for 20% of expenditures

Source: Center for Health Policy /Primary Care and Outcomes Research, Health Policy Facts, November 2013, Issue 3

Who Needs Care Coordination? Looking Back at Big Spenders Doesn't Work

Percentage of children with persistently high health care use (3/5 years in the top 1%) by clinical category (N=5,780)



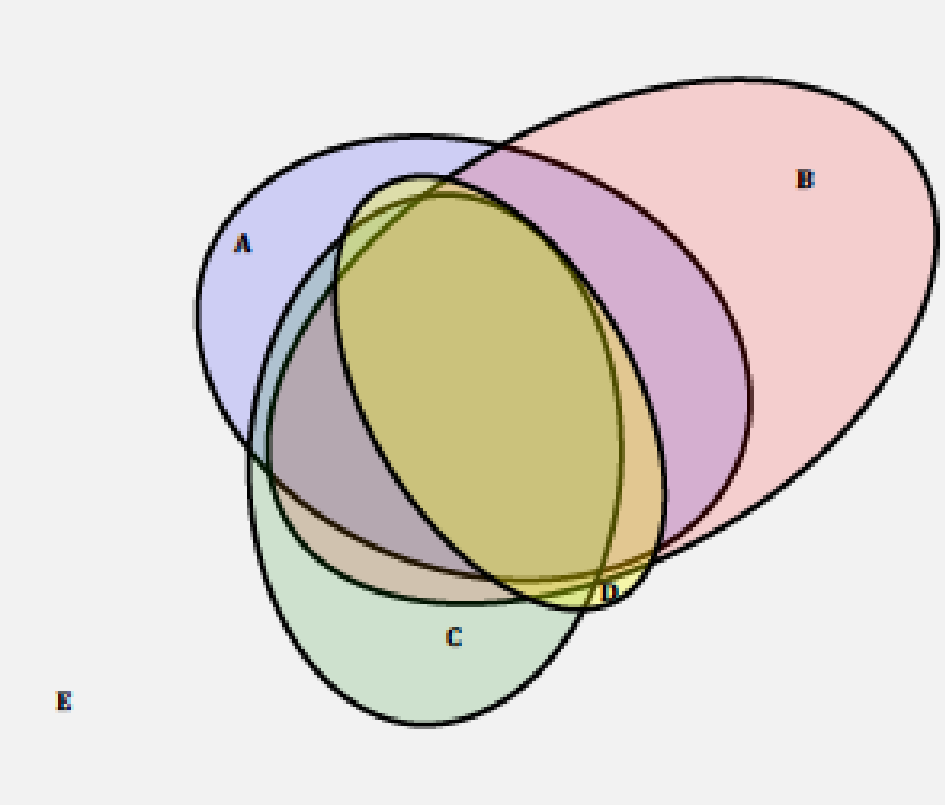
	NI (N=7,214)	CCC 1 (N=9,145)	CCC >1 (N=2,772)	Mental Health (N=3,242)	Asthma or Diabetes (N=34,369)	TA (N=3,879)
% Persistent	30.2	8.1	19.1	9.1	1.9	40.8

High resource utilization in one year is a poor predictor of utilization in the following years

Who Needs Care Coordination: Children with Complex Diagnoses

Different Diagnosed based algorithms lead to different populations

A - Clinically identifiable complexity
B - Complex chronic conditions
C - Neurologically impaired
D - Technology dependent



Stone BL and Srivastava R. PAS 2013

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Who Needs Care Coordination: Children with Emotional and Behavioral Problems

CSHCN Subgroup	CSHCN Screener Scoring Criteria	Adjusted Average Medical Expenditure	Potential Relevance of Each Subgroup
CSHCN with less complex needs	Meets *only* criterion 1 on need or use of medication	$2,705	In primary care settings
CSHCN with more complex needs	Meets *2 or more* of any criteria, indicating multiple types of needs	$4,003	For efforts seeking to coordinate or integrate services between primary care and specialist care
CSHCN with limitation in daily activities due to ongoing health conditions	Meets activity limitations criterion in addition to any other criterion (virtually all meet other criteria)	$4,866	For efforts related to transition to adulthood or improving coordination of care with non-medical, health-related community-based services
CSHCN who met 3 or more criteria	CSHCN who meet 3 or more criteria	$6,755	For efforts focused on reducing medical expenditures and overall system integration efforts, including initiatives to reduce hospitalization
CSHCN with more complex EDB	CSHCN meeting EDB criterion (question 5) and at least 1 other criterion	$5,813	For efforts to reduce medical expenditures and integrating primary care and behavioral/mental health care services

Use of Social Determinants to Define the Need for Care Management

Social Complexity and Suboptimal Health Care Utilization: A Marker of Need for Care Coordination? *Kimberly C. Arthur, Barbara A. Lucenko, Irina V. Sharkova, Jingping Xing,* PAS 2015

- Used a literature review and multi-stakeholder consensus to develop a list of social complexity risk factor and used multivariate regression to show in medicaid children < 18yr :
  - An association between timely well child are social complexity risk factors (strongest homelessness)
  - An association between ED utilization and poverty, juvenile justice involvement and child substance abuse treatment as well as other risk factor

Social Complexity Is Associated with Caregiver-Reported Need for Care Coordination *Sheree M. Schrager, Kimberly C. Arthur, Justine Nelson, Anne R. Edwards, J. Michael Murphy, Rita Mangione-Smith, Alex Y. Chen.* PAS 2015

- Examined the association between social complexity risk factors and caregiver-reported need for care coordination and found
  - An association between social complexity and increased perceived need for care coordination with the strongest association for child welfare involvement

We still do not have an effective way to identify children who currently need and in the future will continue to need intensive care management services

What is Good Care Coordination: Key Components

- Care plan and goals
- Defined health care team
- Communication among team members
- Frequent touches with the family
- Family education and self management
- Referrals to needed services
- Support to ensure family receives all services for which they are eligible
- Medication review and reconciliation

Evidence Base for Care Coordination

- Randomized controlled trials show mixed results depending on the population targeted and the intensity of the intervention
- Numerous prospective studies showing impact at the program level on cost and utilization
- Large scale trial underway to assess the impact of care management on patient experience and cost and utilization in children with medical complexity

Paying for Care Coordination: Aligning Incentives

- How do we pay for care coordination
  - Salaried health professionals
  - PMPM reimbursement
  - Unit of service – care coordination codes

  Our current system does not adequately reimburse for care coordination services
- Incentives
  - Quality based
  - At risk for health of a population

  For most providers there is no financial or quality incentive to provide care coordination

Conclusions

- Regional care coordination is complex and challenging
- The work is often shifted to parents
- There is a need to tier CSHCN according to their need for care management to be able to rationally allocate resources
- There needs to be aligned incentives to reward both improved quality and cost saving
- Ideally there should a single child centered entity for care coordination, or at least clear delegation and coordination of tasks among the stakeholders