Coordinating Care in an Uncoordinated World

Rebecca Baum, MD

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Objectives

1. Analyze a potential financial model for care coordination
2. Describe the role of the shared plan in facilitating effective care coordination
3. Illustrate the importance of families in developing a shared plan of care

2009

2018

Overall Goals for Today

1. Share unique successes and challenges pertinent to our organization
2. Identify cross cutting themes applicable to any organization

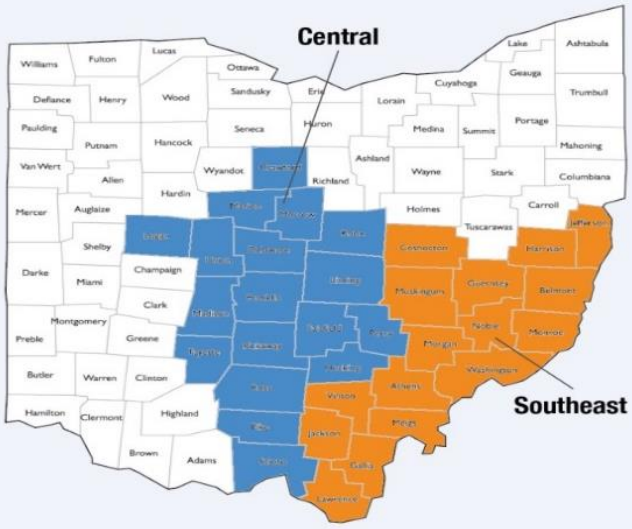
Our financial model

Partners For Kids

- Responsible for improving the quality of care and lowering costs for >320,000 children
- Partnership between NCH and >1,000 physicians caring for children
- Full financial risk through the 5 managed Medicaid plans as an “intermediary organization”

Ohio Market

Contracted with 5 Medicaid Managed Care Plans covering over 330,000 lives in urban and rural Ohio (34 counties)



5 Statewide Health Plans

Buckeye | CareSource | Molina
Paramount | UnitedHealthcare Community

Flow of Funds

Ohio Department of Medicaid

ODM pays the Medicaid Managed Care Plans a set amount per member each month

Plan A	Plan B	Plan C	Plan D	Plan E

Plans pass capitation fee to PFK

PARTNERS FOR KIDS

PFK provides:

- care coordination
- population health initiatives
- network management

High Risk Case Management

As a parent, it can be hard to get your child the health care he or she needs.

The Partners for Kids Care Navigation Program is here to help!

What Are We Going to Change?

- **Single point** of contact for care coordination
- All care coordinators in same **job description**
- Implement **EPIC documentation tools** for care coordination referrals, assessment, and goals/interventions

2017-2022

JOURNEY TO BEST OUTCOMES

Through best people & programs

One Team Values

CORE STRATEGIES

Growth & Partnerships

Operational Excellence

Education

GOAL

Pre-eminent Clinical & Research Programs

ACCELERATORS

Quality, Safety & Service

Behavioral Health

Genomics

Wellness/ Population Health

VISION

BEST OUTCOMES

for Kids Everywhere

NATIONWIDE CHILDREN'S

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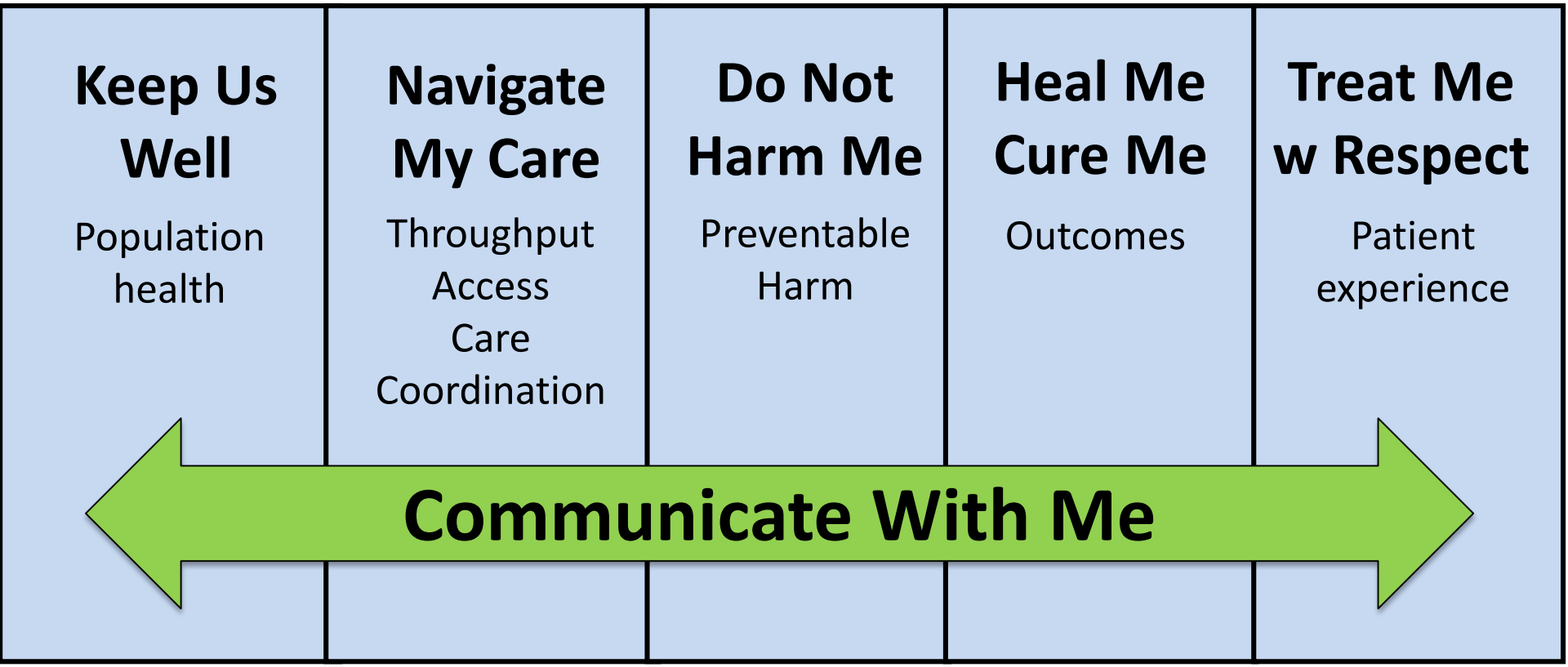
Nationwide Children's Hospital

Patient/Family Centered Quality Strategic Plan



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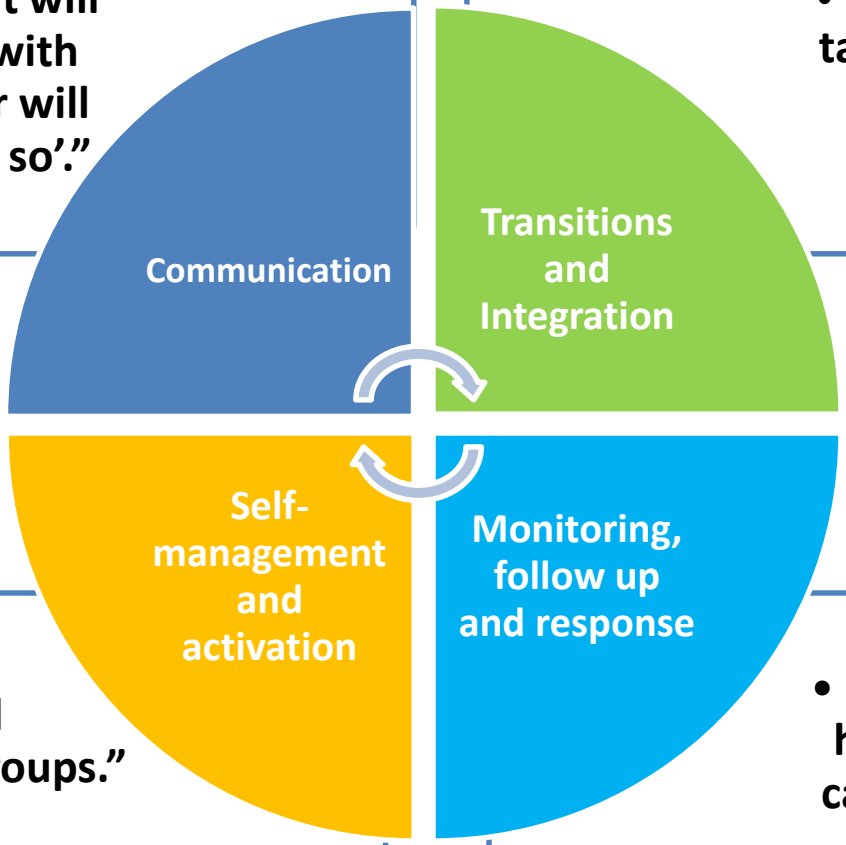
What is Navigate My Care?

- Our goals
  - Reduce avoidable care
  - Improve the patient/family experience across our health care system
- Informed by
  - Organizational successes and challenges
  - Family feedback

Focus Groups

- "One department will say 'we're done with you, and another will say 'I don't think so'."

- "The providers aren't talking to each other."



- "I was never told about support groups."

- "It would be nice to have a social worker call to make sure we got it right."

Definition of Care Coordination

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Navigate My Care

Project Champions: Becky Baum, MD; Kimberly Conkol, RN

Specific Aim

By December 31, 2018, achieve the following amongst 1000 medically complex patients/month*:

- **ED visits: 77 to 70**
- **Inpatient admissions: 62 to 56**
- **Bed Days: 750 to 675**
- **7-day readmissions: 7 to 6 /1000 pts/mo**
- **30-day readmissions: 12 to 11**
- **↑ PICS composite score by 20 % from baseline of 54 to 65**

Strategic Goal

Improve integration and coordination of care for medically complex patients

Key Drivers

Communication
- Interpersonal
- Information transfer

Transitions & Integrated Care
- Specialty ↔ specialty
- Inpatient ↔ outpatient
- NCH ↔ non-NCH
- Primary ↔ specialty

Follow-Up, Monitoring, & Response
- Post-discharge follow-up
- Troubleshooting
- Help at home

Self-Management & Activation
- Education resources
- Support systems

Projects/Interventions

- Collaborate with related groups (Treat Me With Respect, Inter-professional Committee, Diversity and Inclusion, Comprehensive Primary Care & Health Literacy)
- Optimize Epic tools to foster communication (see PFK IT monthly project list)
- Standardize and integrate existing care navigation programs (BCMH, BH and select PFK)
- Implement CRG risk stratification
- Develop & implement activities to support transitions from IP ↔ OP, NCH ↔ Non-NCH
- Develop & implement activities to support transitions from pediatrics ↔ adult
- Develop & implement activities to support transitions from primary ↔ specialty
- Develop strategies to coordinate appointment scheduling for complex patients
- Evaluate care conference process
- Develop funding & marketing plan to continue Complex Care notebook
- Implement Daily Goals (whiteboards) for inpatients
- Expand availability of parent mentors

Fully implemented

Implementation in process

not implemented, not working on it

planned for 2019

*Patients in Tier 3 on the NCH pyramid

Care Coordination Competencies

Patient Stratification

Risk Assessment

Care Planning

Self Management Support

Transition Management

Facilitation Communication & Collaboration

Monitoring & Follow-up

Clinic A : Baseline Results

Care Coordination Assessment Scorecard

6/12/2018

	Score	Comments	
Patient Identification & Risk Stratification (20% of Total Score)			
List of criteria for identifying high risk patients (1)	1		
Criteria exists and patients are identified within criteria (1)	1	per social work assessment	
Identified List of High Risk patients that are followed on an ongoing basis (1)	0	no actual list but discussion and awareness with the team of high risk patients	
List is stratified by risk (2)	0		
Patients in different risk tiers receive different levels of support (3)	3	tiers are not formalized but discussed and known within the group	
Sub-Total	5	*Weighted Total*	12.5
Risk Assessment (5% of Total Score)			
Includes barriers to healthcare access - physical, cultural, language, knowledge deficits or functional abilities (1)	1		
Includes educational needs (1)	1		
Includes caregiver support (1)	1		
Includes assessment of benefits: community resources, Government benefits, school benefits, payer benefits (1)	1		
Includes home needs (durable medical equipment, home health) (1)	1		
Includes readiness to change, parent preferences, primary concerns (1)	1		
Includes wellness and prevention activities (1)	1		
Sub-Total	7	*Weighted Total*	5
Care Plan (20% of Total)			
Documents Care Team (2)	0	Team does not use formal care plans. Much of this information is documented in the providers' note but not in other formal manner	
Care team list includes role and responsibilities assignment (1)	0		
Care Team list is comprehensive and extends beyond physician and medical providers; includes school, board of directors, home care and DME providers (1)	0		
Goals are documented for each need identified in the assessment (2)	0		
Goals interventions address barriers identified in assessment (2)	0		
Progress on goals is tracked routinely (1)	0		
Sub-Total	0	*Weighted Total*	0
Facilitation, Collaboration, Communication (20% of Total)			
Troubleshoots issues such as: benefit or payer, clinical/medication, caregiver support, etc. (3)	3		
Schedules Care Conferences (1)	1		
Routinely provides update to members of the care team (1)	1		
Functions as a single point of contact for which patients have direct access (3)	3		
Sub-Total	8	*Weighted Total*	20

Total Score

/28

Expanding Care Coordination

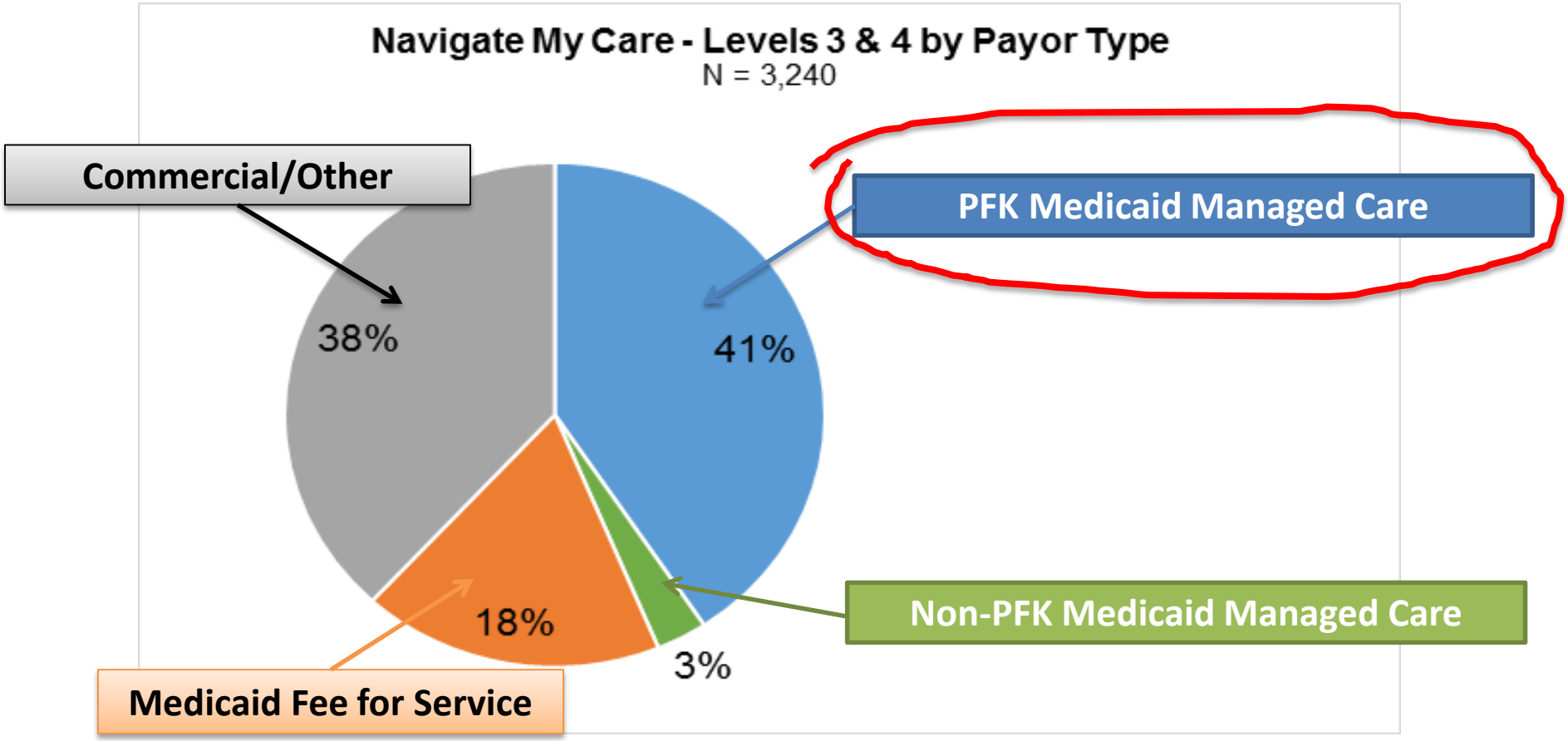
- **2017**
  - Add FTE in 11 specialty clinics not currently providing care coordination
- **2018-19**
  - Standardize activities in specialty clinics already providing condition-specific care coordination (includes Title V services)

Pain Points

Financing the program

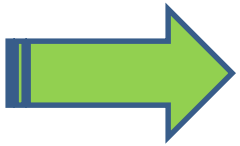
- Leverage capitation and delegated care coordination arrangements
- Proof of concept in Medicaid population then expand to commercial payers

Cohort Payor Mix



Pain Points

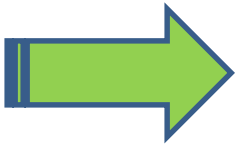
Transitioning from condition-specific to whole child/family perspective



- Proof of concept in PDSA clinics
- Provide additional resources when possible

Pain Points

Coordinating the care coordination



- Implement tools in EHR
- Standardize the definition of care coordination across the organization
- Identify the “quarterback”

The lessons here…

Take advantage of

- The strengths of your organization
- What's important to your organization

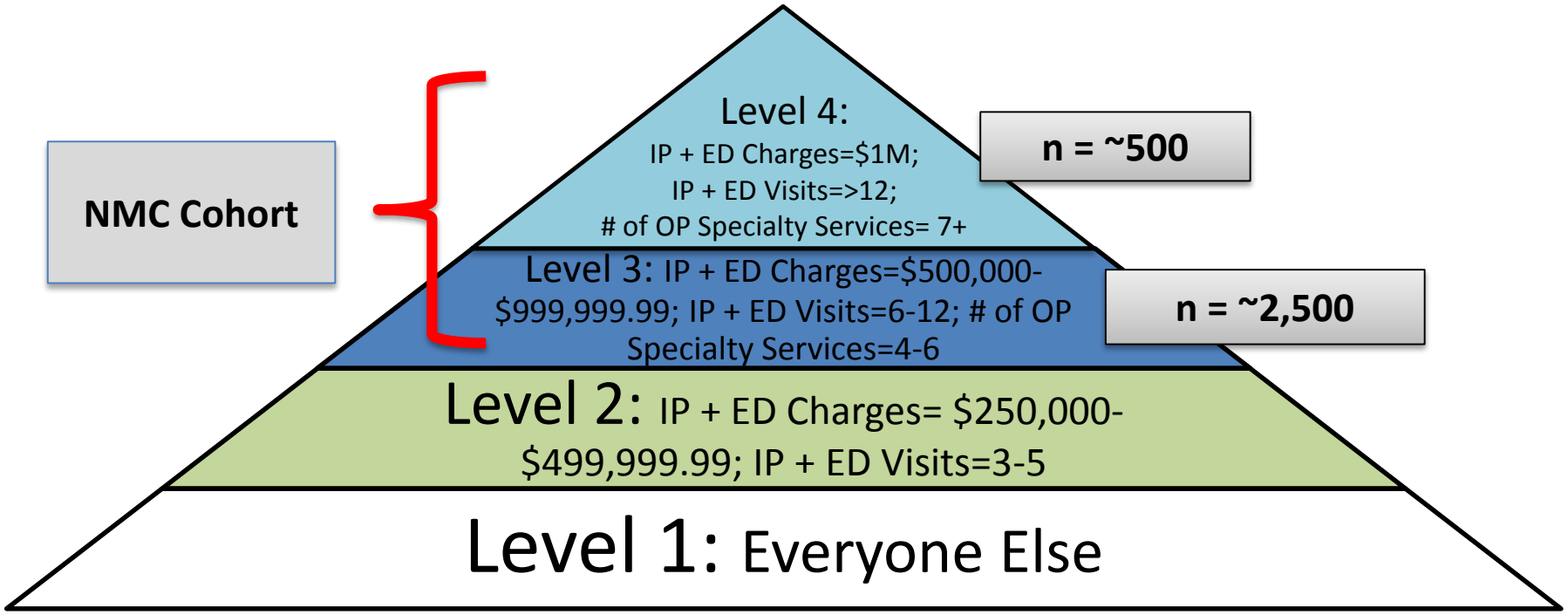
Anticipate and effectively manage the impact of change

- More on this in the breakout session!

Defining the population

The Global Care Coordination Algorithm

A retrospective model where NCH *charges, visits, and specialty clinic utilization* are used to stratify patients into levels of care coordination



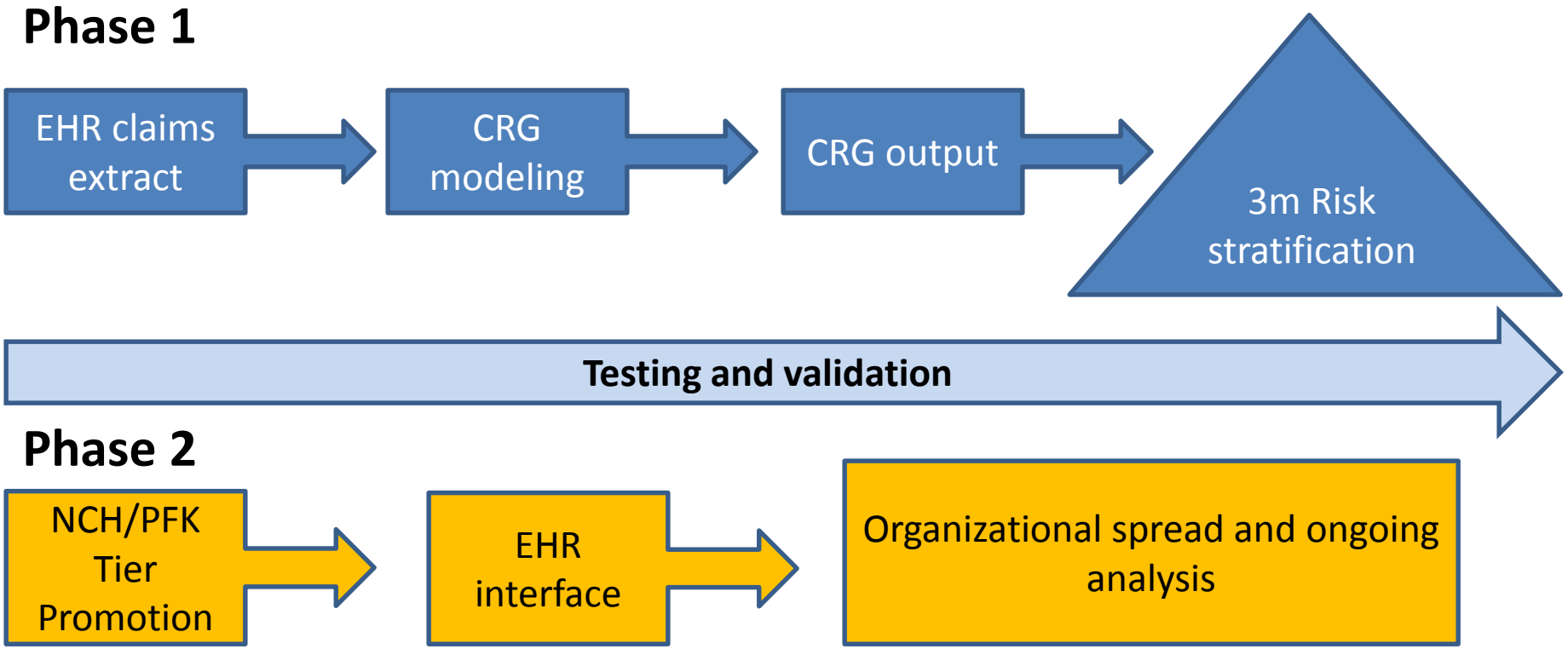
All utilization is based on the last 12 rolling months

Clinical Risk Grouping

Broadest level of aggregation in CRGs, based on the presence or one or more chronic conditions in different body systems, or recent treatment of significant acute condition

Health status	Description
9	Catastrophic Conditions
8	Malignancy under active treatment
7	Dominant Chronic Disease in Three or More Organ Systems
6	Significant Chronic Disease in Multiple Organ Systems
5	Single Dominant or Moderate Chronic Disease
4	Minor Chronic Disease in Multiple Organ Systems
3	Single Minor Chronic Disease
2	History of Significant Acute Disease
1	Healthy/Non-user

CRG Project Steps

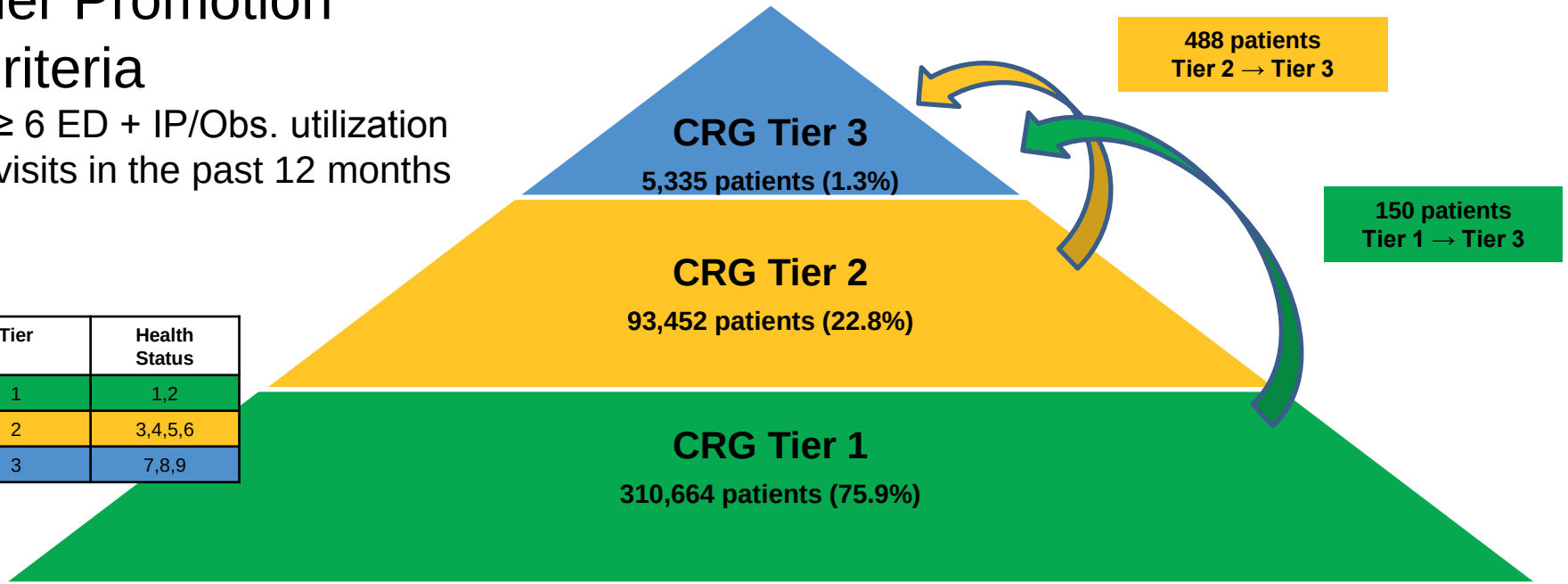


CRG Tier Distribution

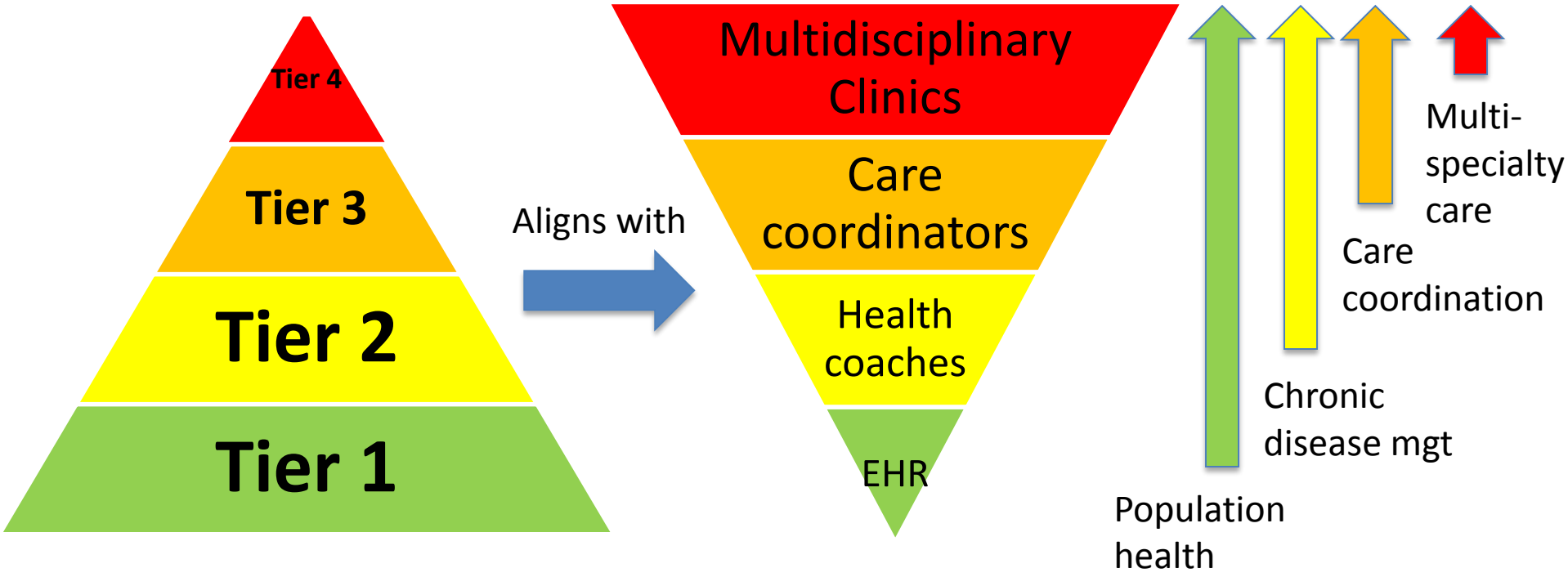
Tier Promotion Criteria

- ≥ 6 ED + IP/Obs. utilization visits in the past 12 months

Tier	Health Status
1	1,2
2	3,4,5,6
3	7,8,9



Risk modeling informs the resources



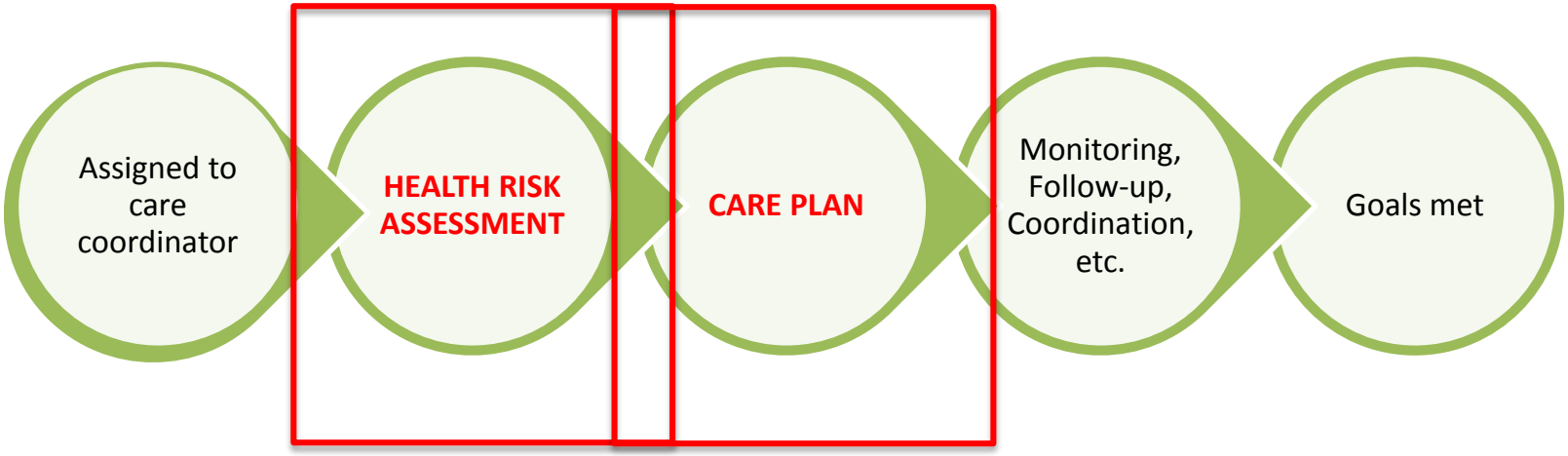
The lessons here…

We can't provide high risk case management to everyone

- Choose a strategy to identify your population
- What's important to your organization and to your families?

The shared plan of care

Care Coordinators assist with a journey



Key Stakeholders

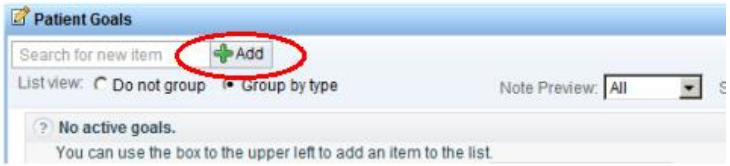
- External
  - Parents and families
  - Payors (Medicaid managed care, Title V)
  - Schools and other agencies
- Internal
  - Hospital administration
  - Clinic staff
  - Practitioners

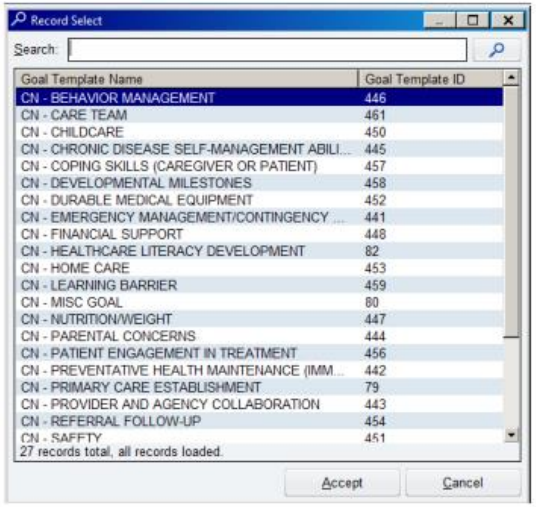
Health Risk Assessment

Category	Examples
Physical health	Communication, cognition, activities of daily living
Medication review	Medication reconciliation, insurance coverage
Condition-specific	Asthma, diabetes, epilepsy, etc.
Nutrition	Formula, type of feeding, etc.
Medical devices	GT, trach, other equipment
Medical services	Home care, therapies, admissions, ED visits, preventive care
Education	School placement, special education services
Social	Financial, family make up, caregiver mental health, legal, health literacy, etc.
Community resources	Early intervention, Title V, behavioral health, SSI, WIC, Board of Developmental Disabilities, faith-based, etc.

Care Plan

- SMART goals
  - Priority level
  - Current state
- Interventions
- Contingency planning
- Self-management plan
- Communication plan





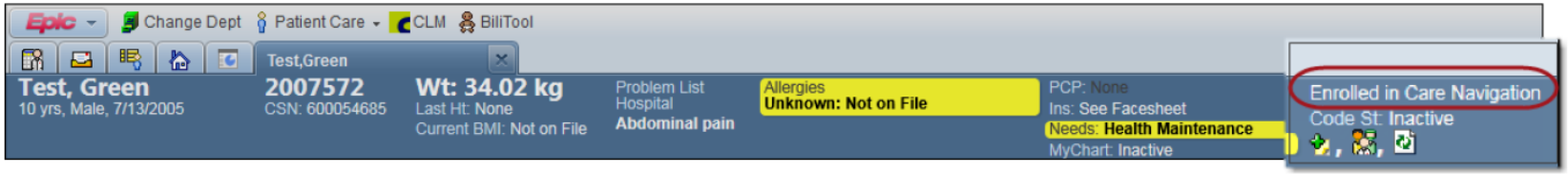
Care Team Table

Role/Specialty	Helps with	Provider	Phone	Address
Care Coordinator	Care plan, follow-up, troubleshooting, Single point of contact			Nationwide Children's Hospital
Primary Care Provider	well child checkups, sick child checkups, immunizations, referrals			
Social Worker	Assist with Care Coordination			Nationwide Children's Hospital
Quality Outreach Coordinator	Assist with Care Coordination			Nationwide Children's Hospital
Developmental Behavioral Pediatrics	Behavioral Management			380 Butterfly Gardens Dr Suite 3D

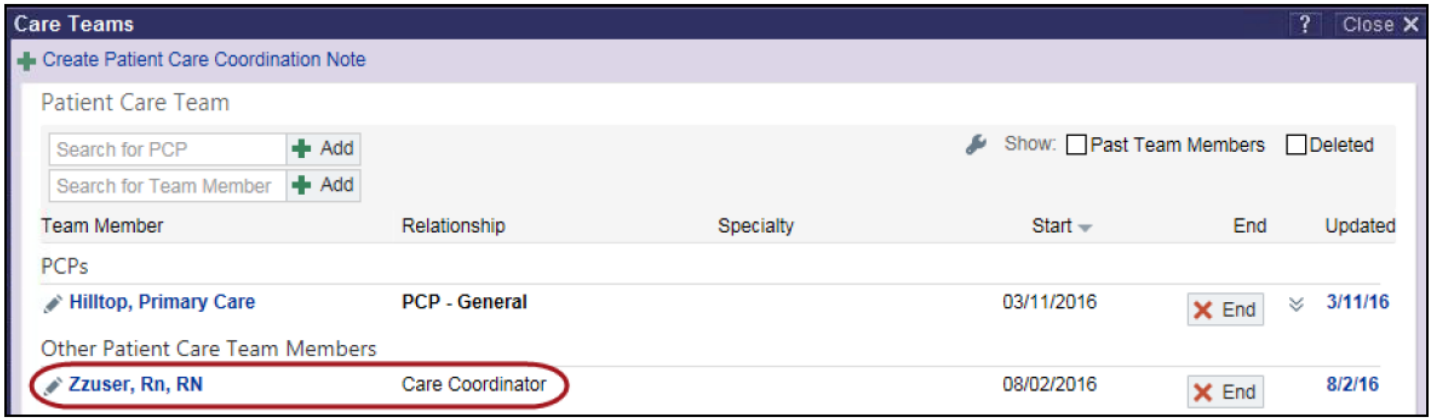
Making it visible

Identifying Patients Enrolled in Care Navigation

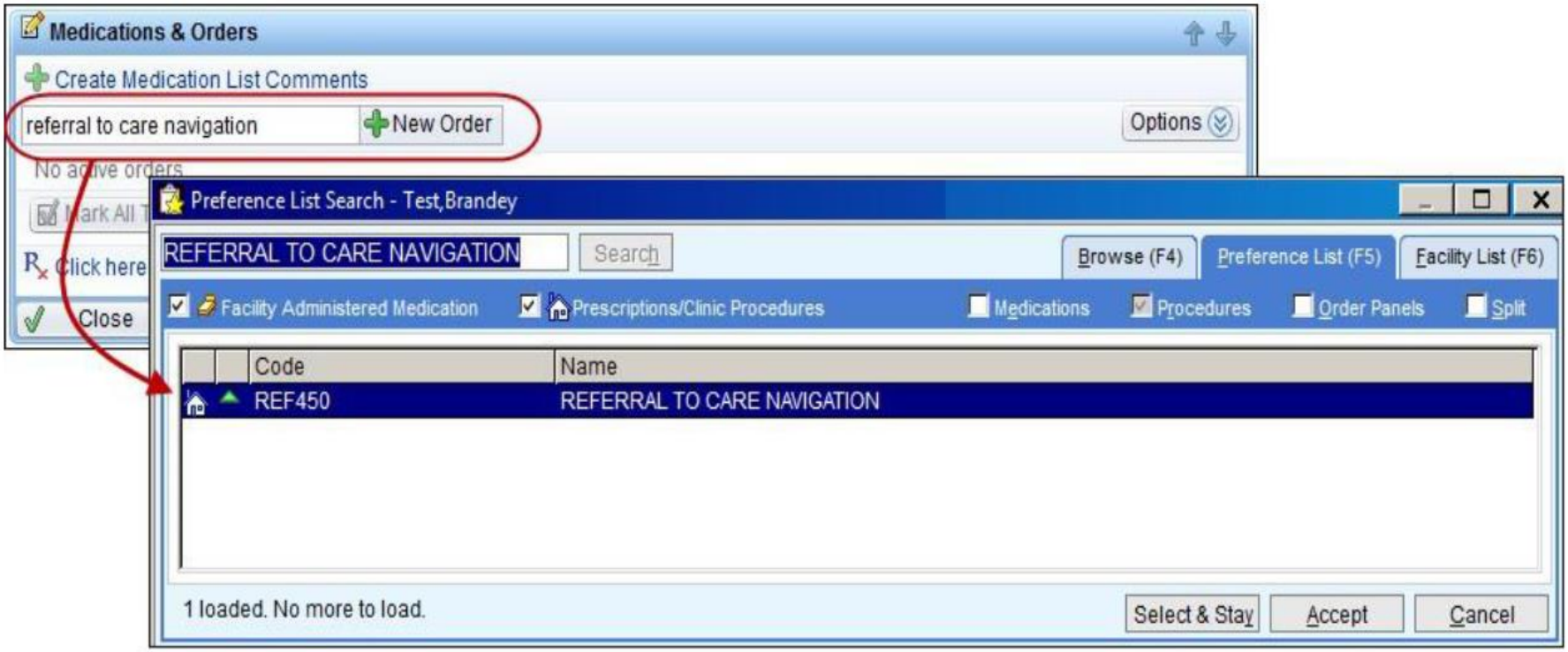
- "Enrolled in Care Navigation" appears on the far right of the header for patients actively enrolled in the Care Navigation program.



- A "Care Coordinator" is listed as an active member of the patient's Care Team.



Making it easier



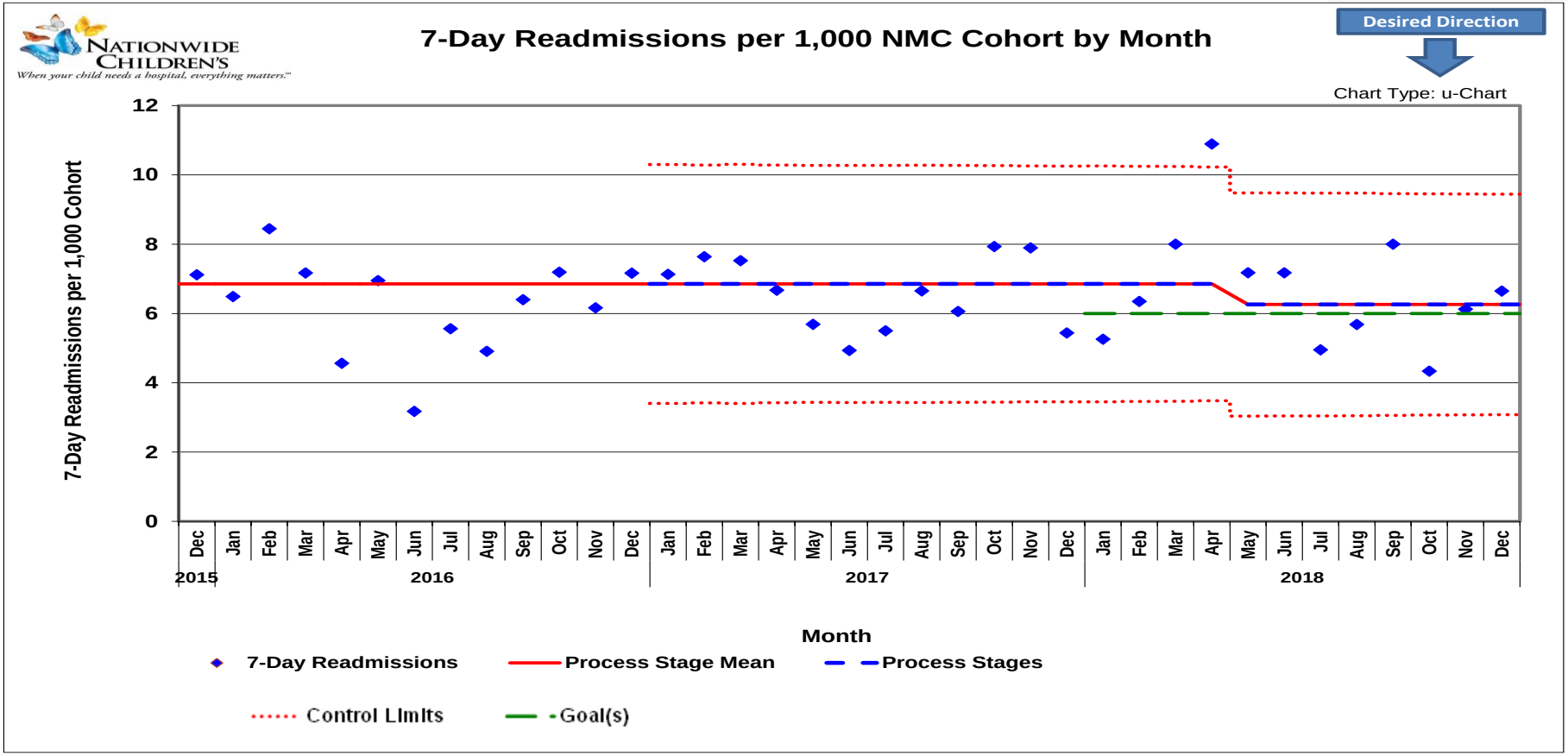
Progress to Date

Goals per 1000 Cohort for 2019				
Metric	**2019**	**2018**	**2017**	**% Improvement**
ED Visits	**71.84**	74.52	77.28	3.6%
IP Admissions	**61.54**	62.09	62.65	0.9%
Bed Days	**668.97**	698.30	729.12	4.2%
7 Day Readmits	**6.10**	6.34	6.59	3.8%
30 Day Readmits	**10.87**	11.38	11.91	4.5%

7-Day Readmissions

***all causes**

Improved by 3.8% - Achieved 96% of Goal

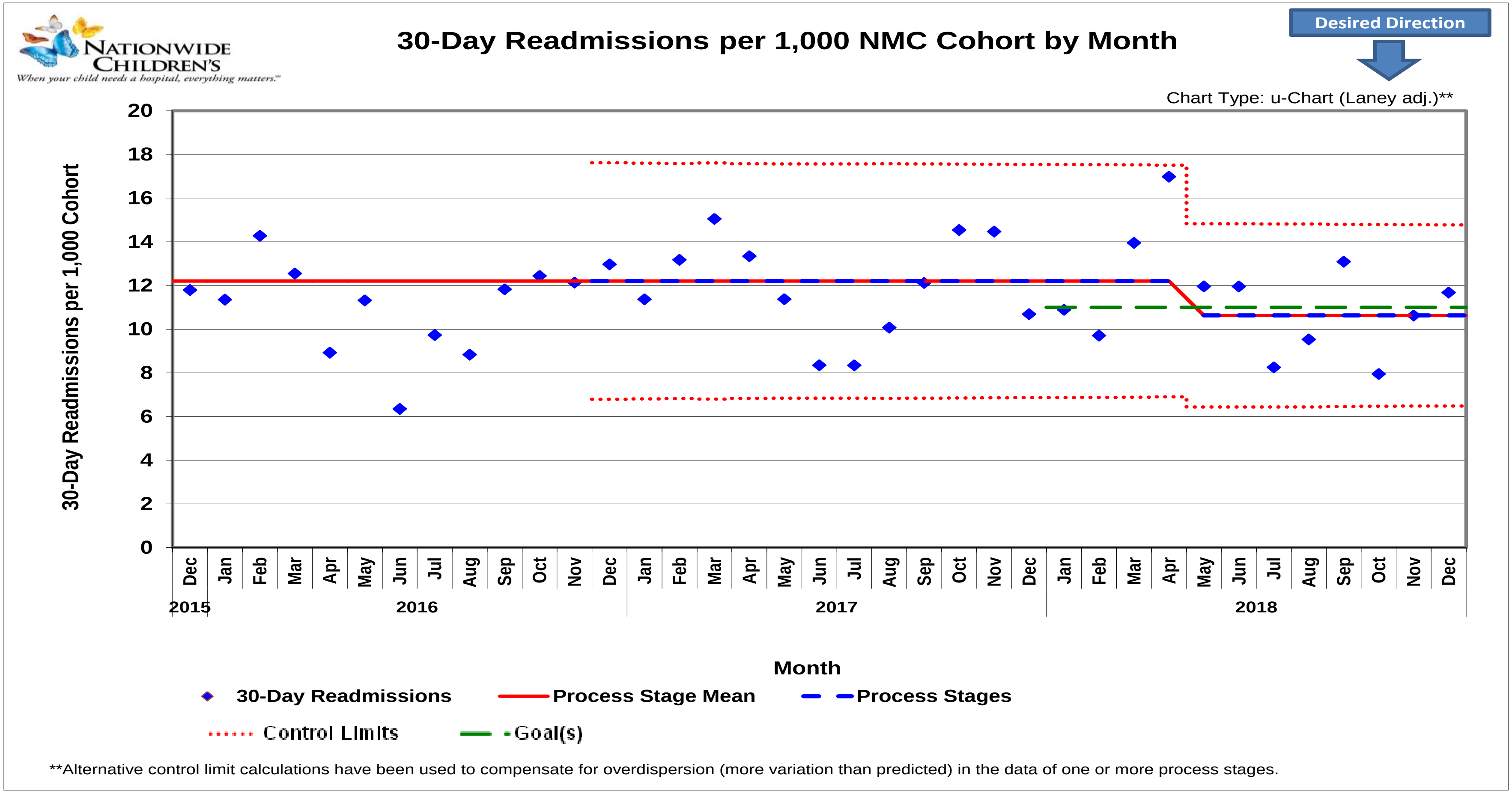


7-Day Readmissions	35	32	42	36	23	35	16	28	25	33	37	32	37	37	40	39	35	30	26	29	35	32	42	42	29	28	34	43	59	39	39	27	31	44	24	34	37
Total Patients	4918	4932	4973	5021	5041	5036	5039	5035	5093	5157	5145	5192	5165	5189	5237	5183	5246	5275	5269	5272	5261	5281	5295	5321	5333	5325	5356	5375	5417	5435	5436	5453	5455	5500	5535	5552	5566

30-Day Readmissions

*all cause

Improved by 4.5% - Achieved Goal!



30-Day Readmissions	58	56	71	63	45	57	32	49	45	61	64	63	67	59	69	78	70	60	44	44	53	64	77	77	57	58	52	75	92	65	65	45	52	72	44	59	65
Total Patients	4918	4932	4973	5021	5041	5036	5039	5035	5093	5157	5145	5192	5165	5189	5237	5183	5246	5275	5269	5272	5261	5281	5295	5321	5333	5325	5356	5375	5417	5435	5436	5453	5455	5500	5535	5552	5566

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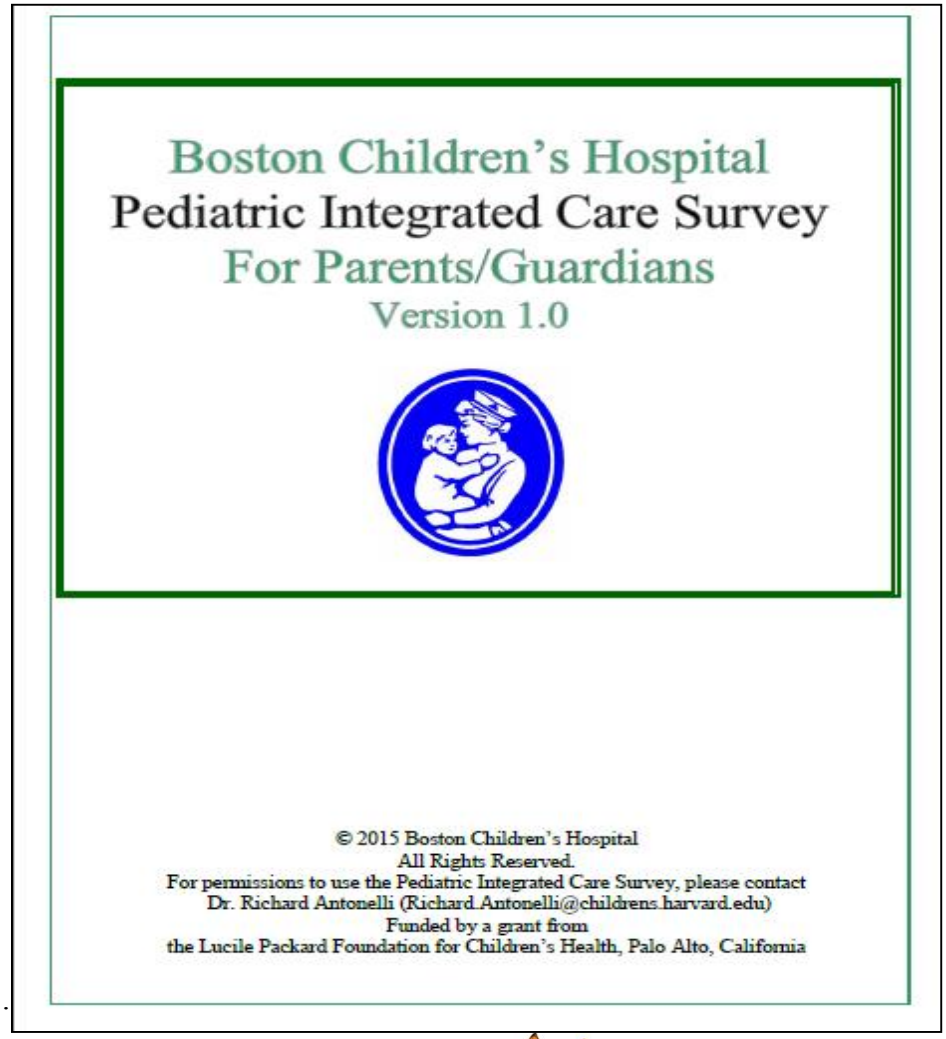
The role of families

Measuring Family Experience


Boston Children's Hospital
Pediatric Integrated Care Survey
For Parents/Guardians
Version 1.0

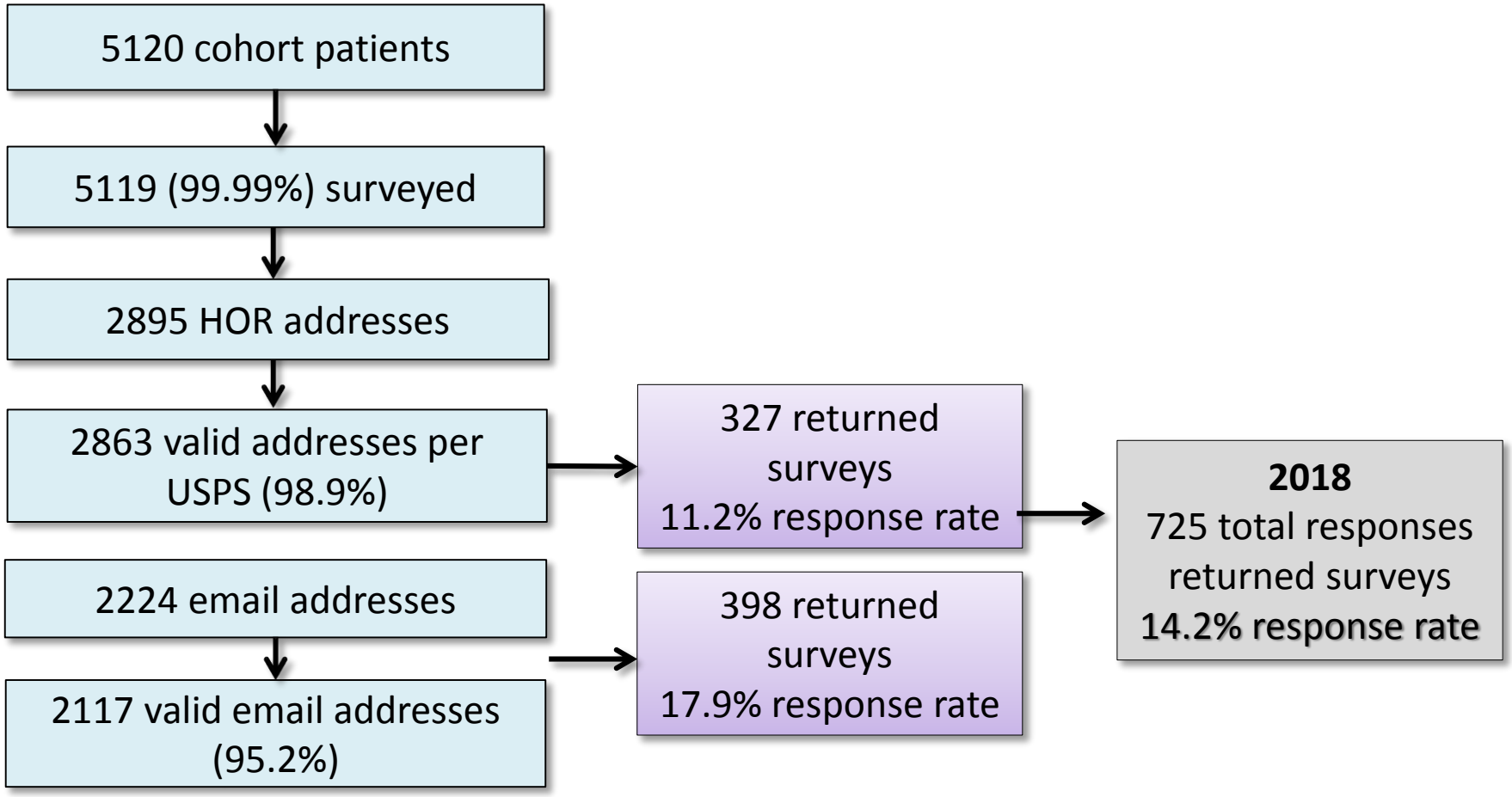
Funded by a grant from
the Lucile Packard Foundation for Children's Health, Palo Alto, California

Pediatric Integrated Care Survey (PICS)

Questionnaire Summary

- Measures the family's experience with care integration
  - Current state
  - Change over time
- Consists of
  - 19 validated experience questions
  - health care status/utilization questions across five domains (access, communication, family impact, care planning, team functioning)

PICS Response Rate



Most Favorable Responses

Question	2018 Q1	2018 Q4	Trend
Did all of your child's medical providers have ***access to the same medical records***? (Yes/No)	94%	96%	+2
How often did you ***feel comfortable letting your child's care team members know that you had any concerns*** about your child's health or care?	90%	85%	-5
How often did your child's care team members ***explain things in a way that you could understand***?	89%	87%	-2
How often have your child's care team members ***treated you as a full partner*** in the care of your child?	78%	84%	+6
How often did you feel that your child's care team members ***listened carefully to what you had to say*** about your child's health and care?	72%	78%	+6

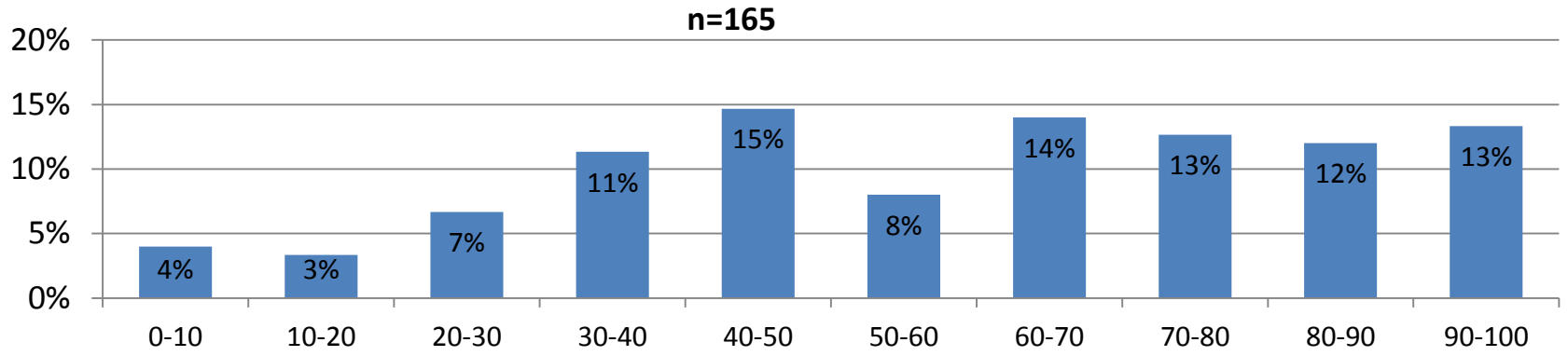
Least Favorable Responses

Question	2018 Q1	2018 Q4	Trend
How often have your child's care team members offered you opportunities to ***connect with other families*** who they thought might be of help to you?	17%	21%	+4
How often have your child's care team members talked to you about ***things in your life that cause you stress*** because of your child's health or care needs?	23%	25%	+2
How often have your child's care team members talked with you about how ***health care decisions for your child will affect your whole family***?	28%	32%	+4
How often have your child's care team members talked to you about ***things that make it hard for you*** to take care of your child's health?	37%	37%	0
How often has someone on your child's care team explained to you who was ***responsible for different parts*** of your child's care?	44%	52%	+8
How often have you had ***to repeat information*** about important events in your child's life or important details about your child's health that you thought care team members should have known?	35%	10%	-25

Distribution of PICS Composite Scores

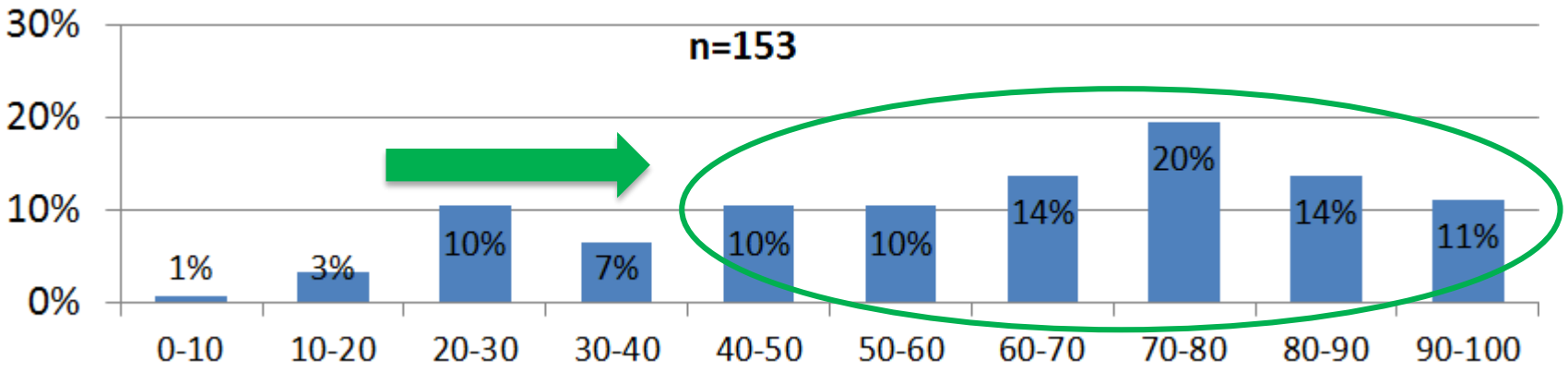
Q1 2018

60% Favorable



Q4 2018

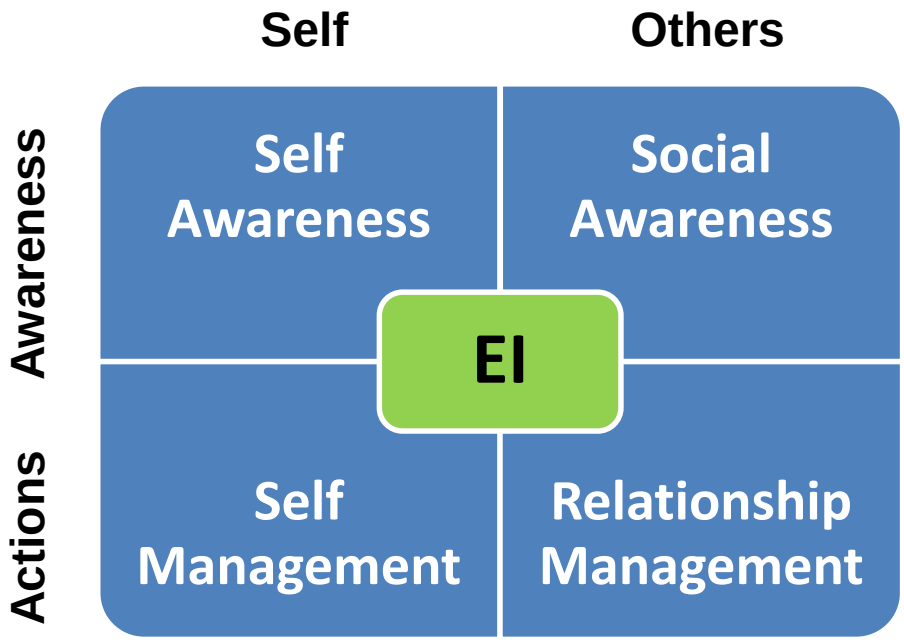
69% Favorable



Emotional Intelligence

Your ability to recognize and understand emotions in yourself and others, and your ability to use this awareness to manage your behavior and relationships

Travis Bradberry



Date: Monday, May 1

Your nurse: Susan

Your doctor: Dr. Smith (Neurology)
Dr. Jones (Cardiology)
Dr. Hernandez (Hospitalist)

Your goal for today:

GET WELL!

The Roadmap Project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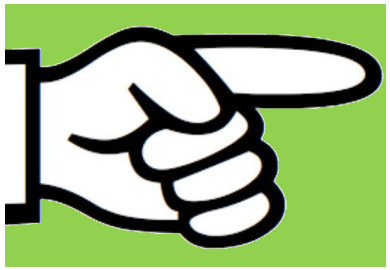
"My only expectation is that our physician understands that living with chronic illness is riddled with stress and burden, but having (and being given) the medical tools and knowledge by a provider, to address mental health from onset, is crucial in reducing those issues. Our ultimate goal should always be to have a happy and healthy child."

- Mother of two daughters with type 1 diabetes



The lessons here…

At the end of the day, families want to be heard and understood

- Use the shared plan of care to make that happen
- Find ways for ALL families to be heard and understood

In summary

1. We can't provide high risk case management to everyone
2. Take advantage of the strengths of your organization and what's important to your organization
3. Anticipate and effectively manage the impact of change
4. At the end of the day, families want to be heard and understood