Pediatric Care Coordination: Medical Home Capacity Building for CYSHCN

JIM AEL JOHNSON  
PEDIATRIC MEDICAL HOME PROGRAM MANAGER  
ALASKA DIVISION OF PUBLIC HEALTH  
TITLE V  
OCTOBER 21, 2015

Objectives

- Describe Alaska’s system of care for CYSHCN
- Overview of patient-centered medical home efforts and partnerships to date
- Introduce Principles of Pediatric Care Coordination university-based distance delivery continuing education course
- Discuss lessons learned and next steps
Overview of Alaska’s System of Care for CYSHCN

SIZE AND DISTANCE COMPARISON

Alaska is 586,400 square miles, over twice the size of Texas.
Health Care Environment

- Three distinct health care systems
  - Tribal, Military, Private
- Limited specialty services
- Fee for Service
- New Medicaid Expansion
- Medicaid Redesign (in progress)
- State budget shortfalls
Alaska Medicaid Redesign: Approaches to Coordinated Care and Value-based Purchasing

**Models of Care**

<table>
<thead>
<tr>
<th>Current State</th>
<th>Primary Care Case Management</th>
<th>Patient Centered Medical Home</th>
<th>Health Hubs</th>
<th>Prognostic Advantage Health Plan</th>
<th>Accountable Care Organizations</th>
<th>Full-risk Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Features</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk performance or value-based payment or quality outcomes</td>
<td>Literature review, care coordination, and coordination of care</td>
<td>Provider teams deliver total care, integrated case management</td>
<td>Overview patients with complex needs; behavioral health; inpatient and outpatient care; delivery of care; chronic care; and community support</td>
<td>Risk-based contracts to provide a mix of services to enrolled</td>
<td>Some contracts with health plans for the delivery of services to enrolled beneficiaries</td>
</tr>
</tbody>
</table>

**Payment Mechanisms**

<table>
<thead>
<tr>
<th>Level of Financial Risk Assumed by Providers</th>
<th>Quality Monitoring and Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>HIGH</td>
</tr>
<tr>
<td>Fee for Service</td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
</tr>
<tr>
<td>Per Member Per Month</td>
<td></td>
</tr>
<tr>
<td>Shared Savings</td>
<td></td>
</tr>
<tr>
<td>Shared Losses</td>
<td></td>
</tr>
<tr>
<td>Risk based Contract</td>
<td></td>
</tr>
<tr>
<td>Long-term health and behavior pharmacy plans</td>
<td></td>
</tr>
<tr>
<td>Bundled Payments</td>
<td></td>
</tr>
<tr>
<td>Risk for Global Capitated Payments</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Program Features + Options**

- Private Coverage Option
- Expanded Contributions + Premiums
- Risk-based providers + behavioral incentives

Patient-Centered Medical Home Initiatives
Recent Statewide Medical Home Initiatives

- **Tri-State Children’s Health Improvement Consortium**
  - CHIPRA 2011-2015
- **“D70” Pediatric Medical Home (focus on CYSHCN)**
  - Title V 2011-present
- **Alaska Patient Centered Medical Home Initiative**
  - Alaska Primary Care Assn 2011-present
- **SAMHSA Primary and Behavioral Health Care Integration Grantees**
  - Three clinics awarded since 2010

---

Alaska’s D70 Grant

- **Major accomplishments to date:**
  - Physician Champion Practice engagement
  - Care Coordination pilot in two practices
  - **University-based care coordination training curriculum**
  - Patient-Centered Medical Home focused trainings
  - CAHPS (Patient Experience) survey fielding and learning collaborative
Systems Integration Academy Participation

Three Cross-State Strategy Teams:

- Cross Systems Care Coordination
  - Shared Plan of Care development
- Integration
  - Feedback loop agreement between two or more agencies
- Shared Resource
  - Help Me Grow Alaska planning and implementation

“Principles of Pediatric Care Coordination” Curriculum
Boston Children’s Hospital Curriculum

- MCHB funded, development led by Dr. Rich Antonelli and David Browning
- Extensive four module curriculum authored by families, nurses, social workers, medical providers
- Available publicly as of 2014


Principles of Pediatric Care Coordination
University-based Distance Education Course

Eight Weekly Modules:
1. Introduction and overview of care coordination concepts of PCMH
2. Communication and its impact on care coordination and health of patients and families
3. Understanding social determinants of health – building and connecting community resources
4. Care coordination as a continuous partnership
5. Family partnerships in care coordination
6. What are health-related social services
7. Integrating care coordination into our everyday work
8. Care coordination measurement, outcomes and evaluation

Development Timeline

- **Fall 2012:**
  - Dr. Rich Antonelli of Boston Children’s speaks with stakeholders on PCMH, care coordination & new curriculum
  - Collaboration with University of Alaska and All Alaska Pediatric Partnership begins

- **Spring 2013:**
  - AAP National presents four module Care Coordination curriculum as one day training in Anchorage
  - Feedback from training analyzed; course adaptation begins

- **Fall - Winter 2013:**
  - Family and provider focus groups convened; feedback incorporated

Development Timeline (continued)

- **Spring 2014:**
  - University establishes continuing education course in College of Allied Health
  - Instructional Designer completes Blackboard course shell

- **Fall 2014:**
  - First cohort of students completes 10 week course

- **Spring - Summer 2015:**
  - Course evaluation conducted and modifications recommended
Course Evaluation

- University and external nurse case manager contracted to evaluate pilot course offering
  - Survey course participants
  - Review all course materials and recorded classes
  - Compile recommendations
- Evaluation report will be used to further refine course for future offering

Lessons Learned

- **Partnership** and champions are key
- **Distance-based** format helped ensure sustainability based on cost and accessibility
- Adapt curriculum to “**meet practices where they are**”
  - Supply best practice examples and real-world stories
- Need **local outcome data** to answer “why” care coordination
- **Opportunities** exist in changing political climates
Next Steps

- State Plan for CYSHCN
- Second course offering of “Principles of Pediatric Care Coordination” in Fall 2015
  o Nurse case manager to be course instructor
- Explore curriculum expansion to other populations – lifespan care coordination (i.e. geriatrics, TBI)
- Expand partnerships to build care coordination capacity statewide
- Integrate lessons from State Integration Academy Shared Plan of Care work into curriculum and practice

Thank You

JIMAEI.JOHNSON@ALASKA.GOV
(907) 269-7378
SECTION OF WOMEN’S, CHILDREN’S, AND FAMILY HEALTH
3601 C STREET, SUITE 322
ANCHORAGE, AK 99503