

Implementing Effective Integrated Care Management for Children and Youth with Special Health Care Needs

Generalizable Lessons

International Society for Social Pediatrics and Child Health

Richard Antonelli, MD, MS

Medical Director of Integrated Care

Boston Children's Hospital

Harvard Medical School

Boston, USA

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Objectives

- Understand a framework of care integration that can be implemented at level of delivery system, communities, regions
 - Applicable for all ages
 - Relevant to all aspects of service delivery
- Be able to develop strategies to promote integrated care potentially relevant in resource-limited and resource-sufficient settings
- Discuss evidence on outcomes of integrated care

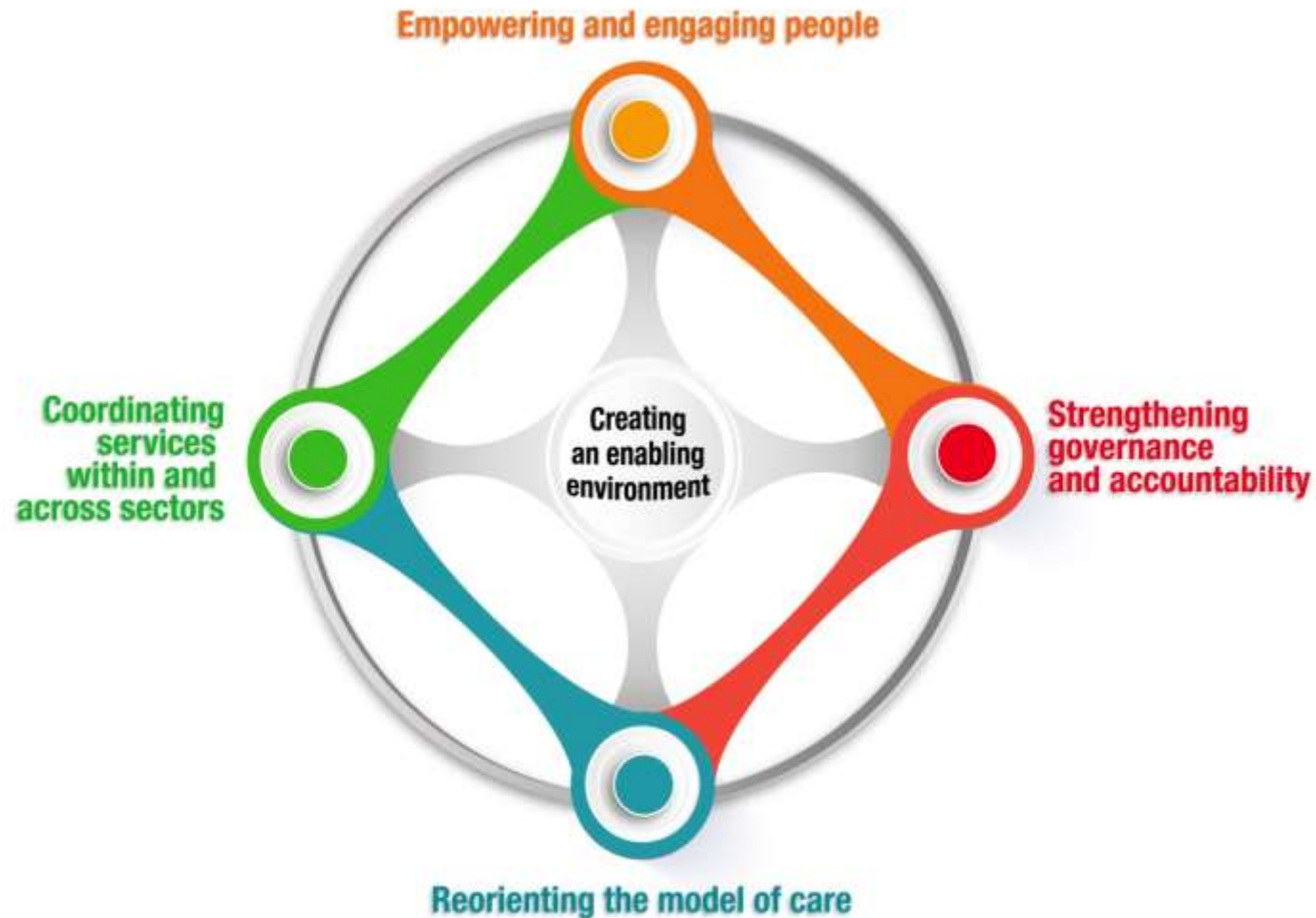


Why Important?

- Integration reduces waste associated with fragmentation in medical delivery systems
- Inter-professional integration essential to reduce disparities due to Social Determinant Risks– housing, food, poverty, violence
 - Behavioral Health
 - Substance Abuse and Dependence
 - Mental Health
 - Developmental Disabilities



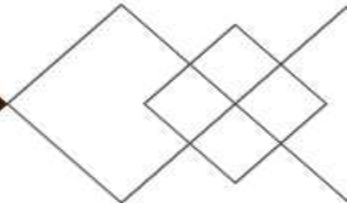
Integrated People-centred Health Services



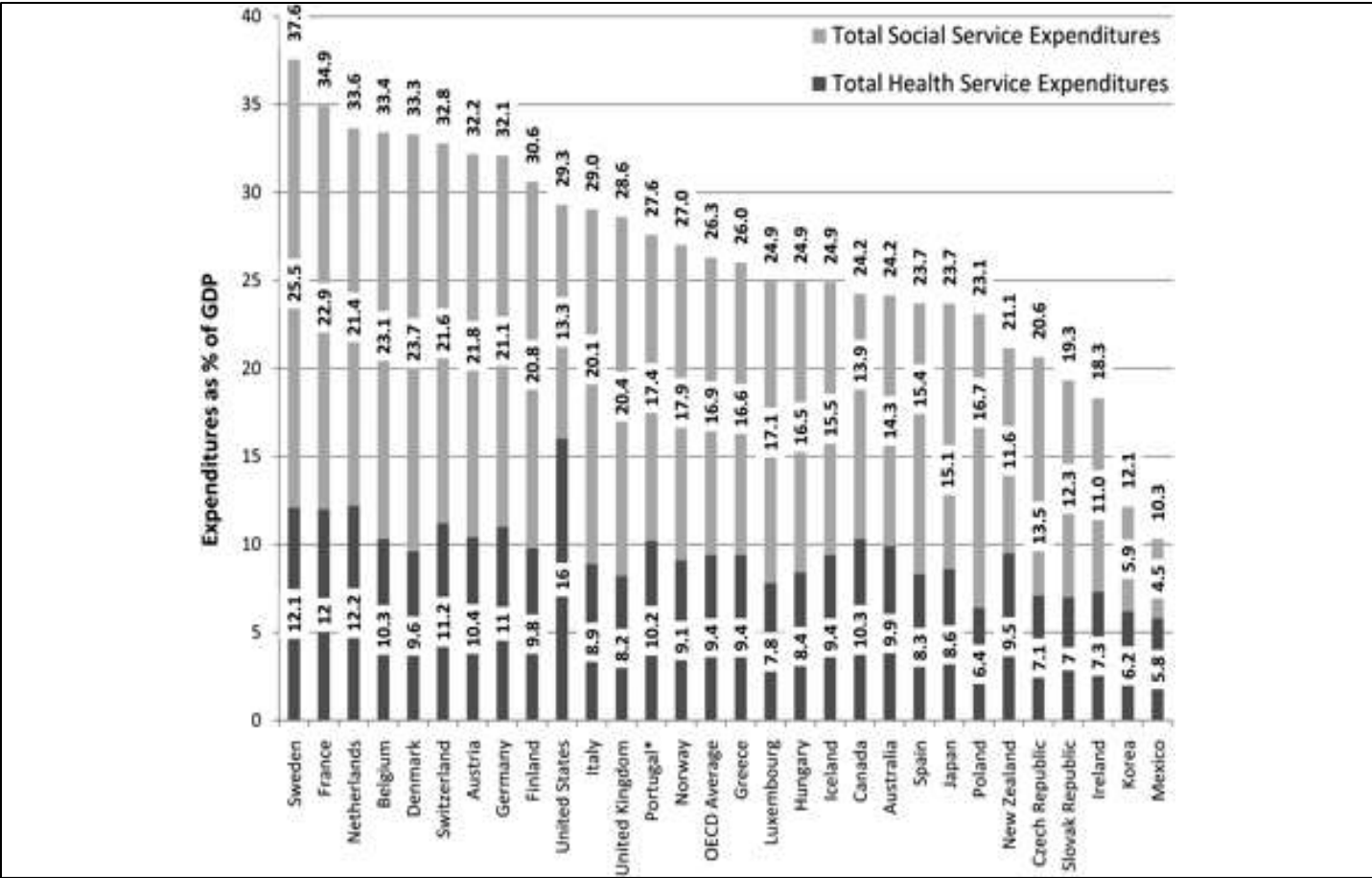


Continuity and coordination of care

A practice brief to support implementation
of the WHO Framework on integrated
people-centred health services



Health & Social Service Spending Combined



Source: EH Bradley et al. *Health and social services expenditures: associations with health outcomes.* *BMJ Qual Saf*; 2011;20:826-831.

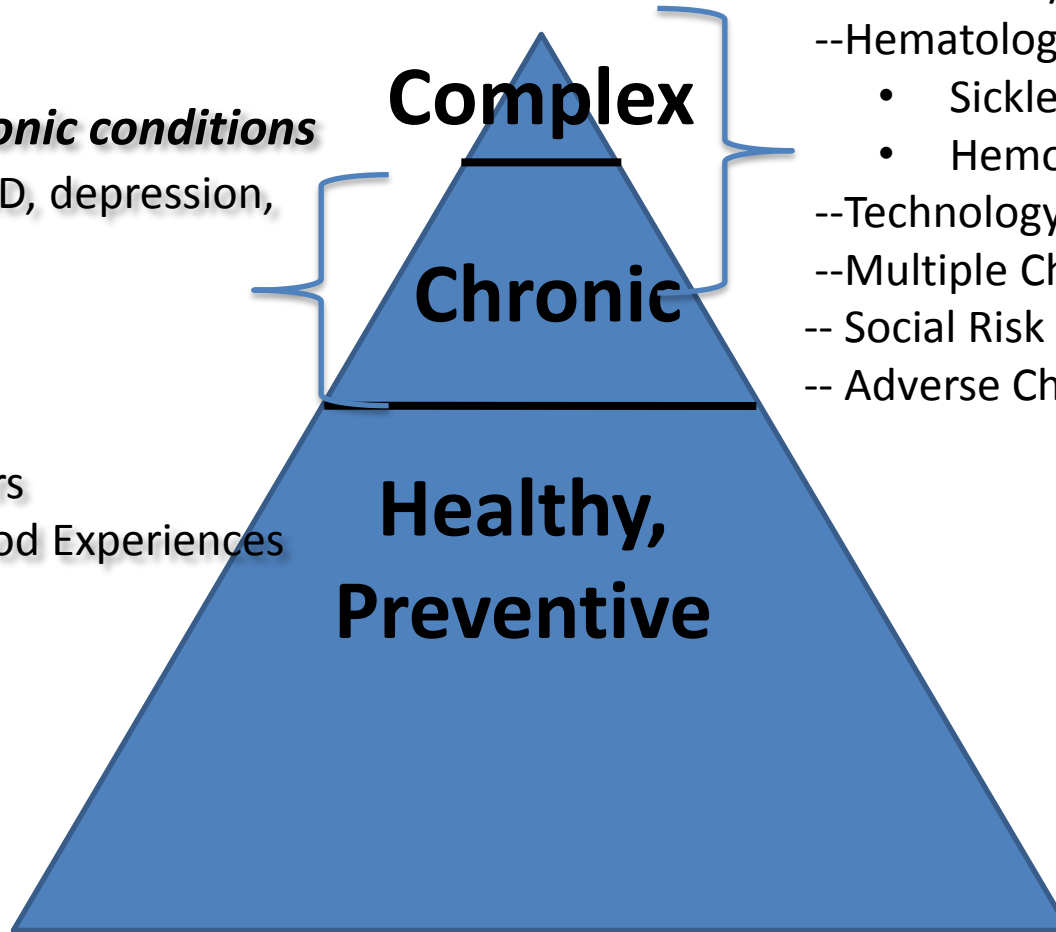


Matching Services to Complexity— Including Social, Medical, Behavioral

analysis by R. Antonelli

Children with chronic conditions

- Behavioral (ADHD, depression, anxiety, PTSD)
- Asthma
- Obesity
- Diabetes
- Social Risk Factors
- Adverse Childhood Experiences



Children with complex needs

- Neurodevelopmental (Autism, etc.)
- Behavioral/Psychiatric
- Hematology/ Oncology
 - Sickle cell
 - Hemophilia
- Technology dependent
- Multiple Chronic Conditions
- Social Risk Factors
- Adverse Childhood Experiences

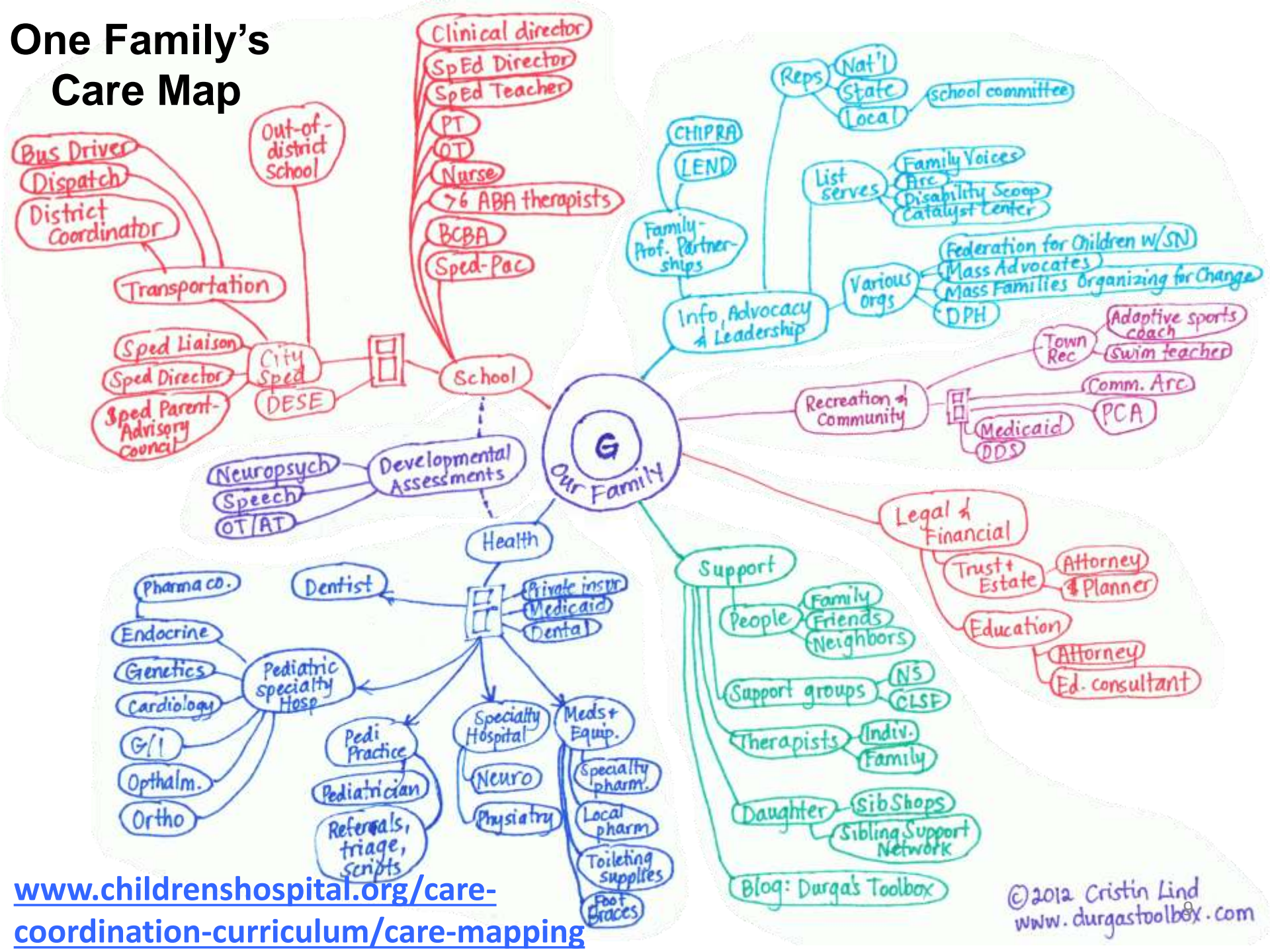


Miguel

- 4 year old Hispanic boy; he and mother immigrated from Guatemala
 - diagnosed-- asthma by PCP at 9 months
 - referred for “poor attention”
 - ED visit 3 times in prior year for asthma
 - no assessment/ intervention for attention
 - All care quality measures were met
 - Referrals made
 - Care Coordination measures require completing a loop



One Family's Care Map



N5642



MIND THE GAP

Domains of Integrated Care: the Quadruple Aim

Better Quality, Less Cost Per Capita, Improved Experience for Patients/ Families and Providers

➤ Person, Patient, Family, Caregiver Experience

➤ Care Coordination

- High Quality Handoffs
- Care Tracking
- Care Planning

➤ Utilization and Financial Outcomes

- Admissions, readmissions, Emergency Dept utilization

➤ Provider Experience



Pediatric Integrated Care Survey (PICS)

Five Core Domains

Access to Care

Communication with Care Team

Family Impact

Care Goal Creation/ Planning

Team Functioning/Quality

***Validated Assessment of
Experience of Integration for
Medical, Behavioral, Social,
Educational, Family Support***

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



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For permissions to use the Pediatric Integrated Care Survey, please contact
Dr. Richard Antonelli (Richard.Antonelli@childrens.harvard.edu)

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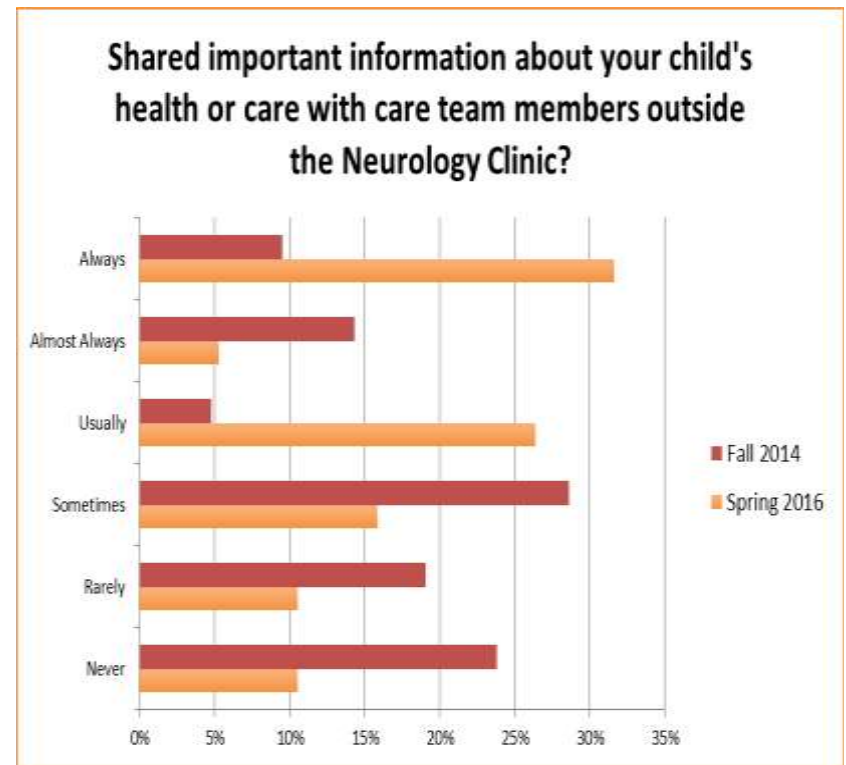
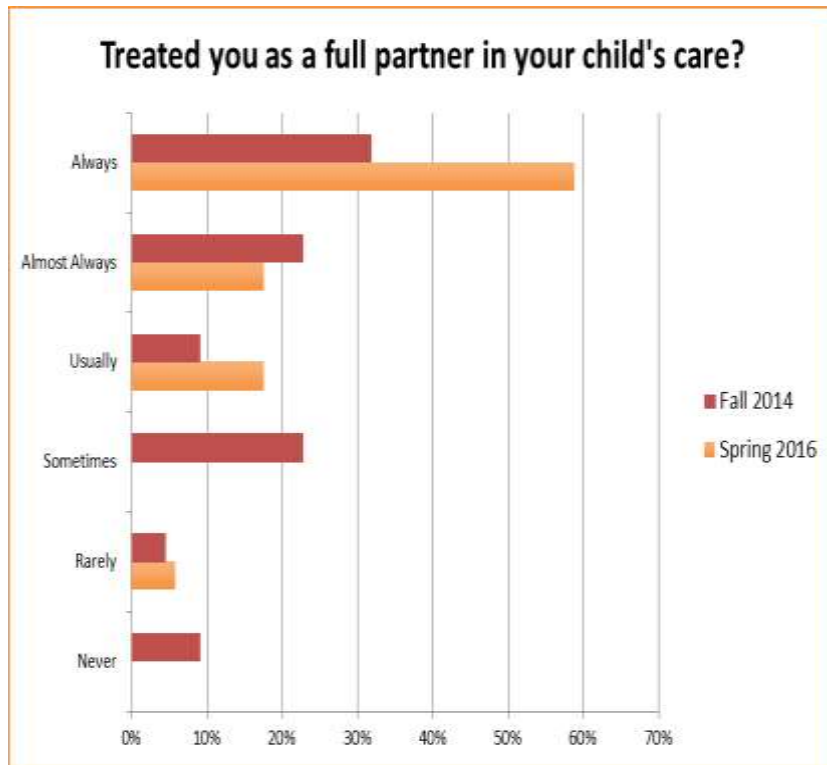
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Until every child is well™



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Family Reported Experience of Care Integration

Pediatric Integrated Care Survey (PICS)



Boston Children's Hospital Dept. of Neurology



Warm Handoffs to Subspecialty Care and Use of Care Coordinators

Courtesy Daniel Slater, MD, Chair of Pediatrics, Atrius Health

I am referring John Doe (DOB: 10/9/1998; Atrius # 123456) to you for further evaluation.

Purpose of the upcoming patient visit: {28571}

Requested Referral Relationship: {28572}

Relevant clinical information includes: ***

Relevant psychosocial concerns include: ***

You may find the following relevant material available through the Atrius Portal: {26983}.

If more information is needed, please feel free to call 617-972-5570 or to contact me with feedback regarding this referral.

If you'd like any further lab or imaging studies, **I could arrange for them at Atrius Health and have results and images viewable to you through the Atrius Portal.** I'd also be happy to discuss any referrals to other specialists that you feel would be helpful.

Patient Active Problem List:

ADHD (attention deficit hyperactivity disorder), inattentive type [F90.0]

Atypical nevi [D22.9]

Current Outpatient Prescriptions:

methylphenidate (METADATE CD) 40 mg capsule, ER multiphase 30-70, Take 1 capsule by mouth every morning

Purpose of the upcoming patient visit: {28571}

Requested Referral Relationship: {28572}

Relevant clinical information includes: ***

Acute clinical concern: ***
Chronic condition needing specialty input: ***

Requested Referral Relationship: {28572}

Relevant clinical information: Co-management/shared care
Subspecialty-based management (All care under direction of subspecialist)
Relevant psychosocial: To be determined as evaluation proceeds

You may find the following relevant material available through the Atrius Portal: {26983}.

Progress Notes from {26945}

Outside Records
Lab Reports
XR Reports and Images
EKGs
Growth Charts
No other attachments:

You may find the following relevant material available through the Atrius Portal: {26983}.

Results Primary Care Perspective

- Reductions in emergency department utilization, hospital admissions, and overall total medical expense
 - Sustained beyond 3 years
- Aim to keep care in highest value setting
 - Primary Care



Care Coordination Tracking and Planning

Care Coordination Measurement Tool (CCMT)

- Captures Value of CC activities— For Both QI and Business Planning
 - Supports efforts of all disciplines doing CC
 - Identify Gaps and Redundancies in Care (eg, vulnerable and underserved populations)
 - Rationalization of workforce education and deployment-- functioning at “top of license or scope”
 - More accurate reflection of true cost of care– enables sustainability of move from reactive to proactive care; fee-for-service to value-based care delivery
- Adapted to capture activities/ outcomes in diverse settings (adult, child)
 - Community Health Workers
 - Social Workers
 - Primary Care
 - Subspecialty Care (behavioral, surgical, medical)
 - Home Care
 - Families
- Access BCH website: <http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement>

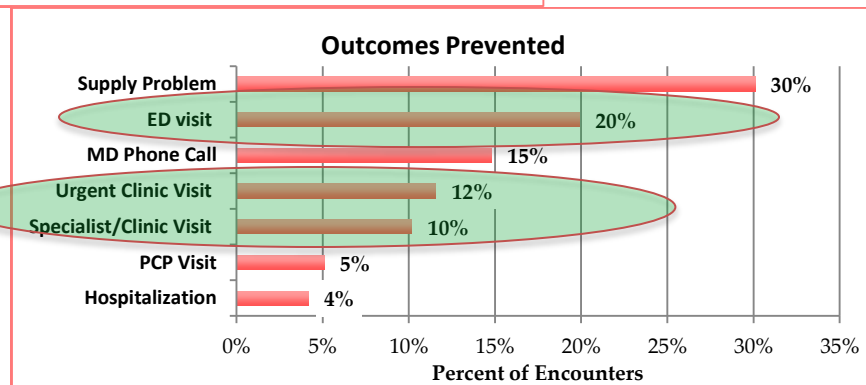
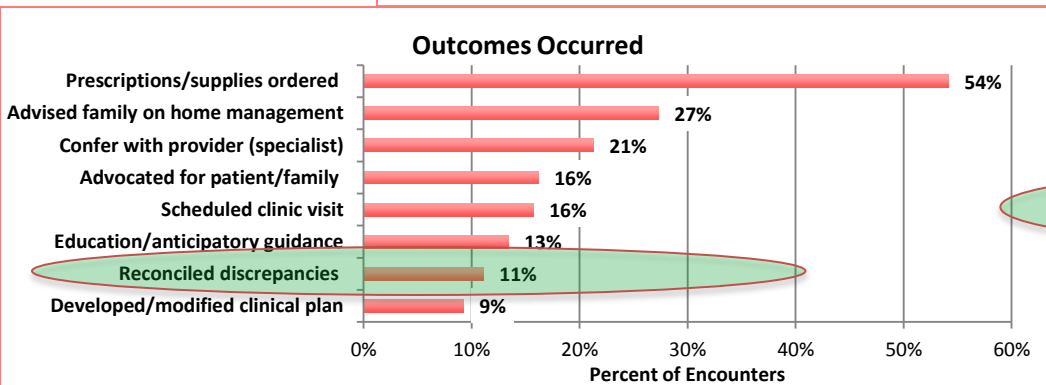
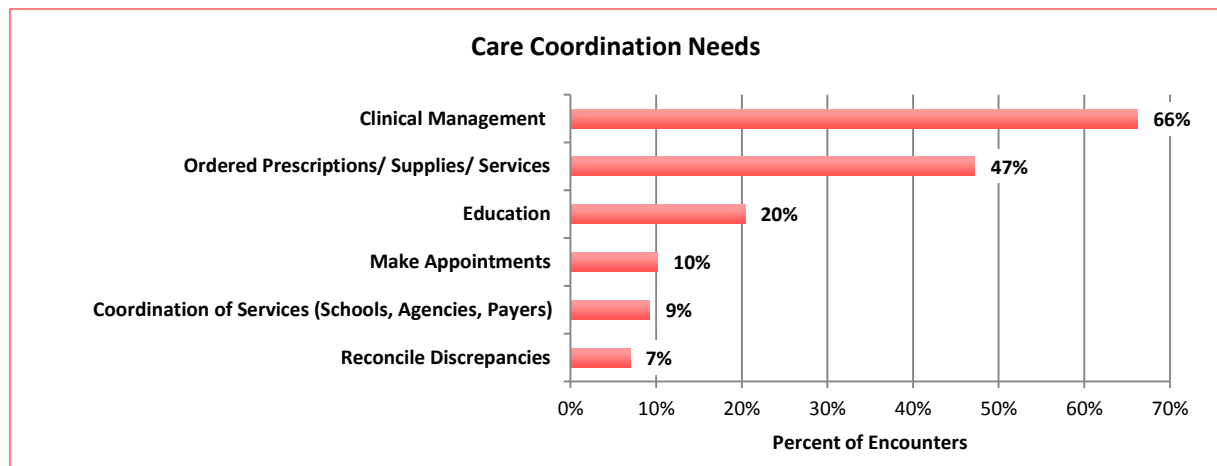


Value Capture- Specialty Setting

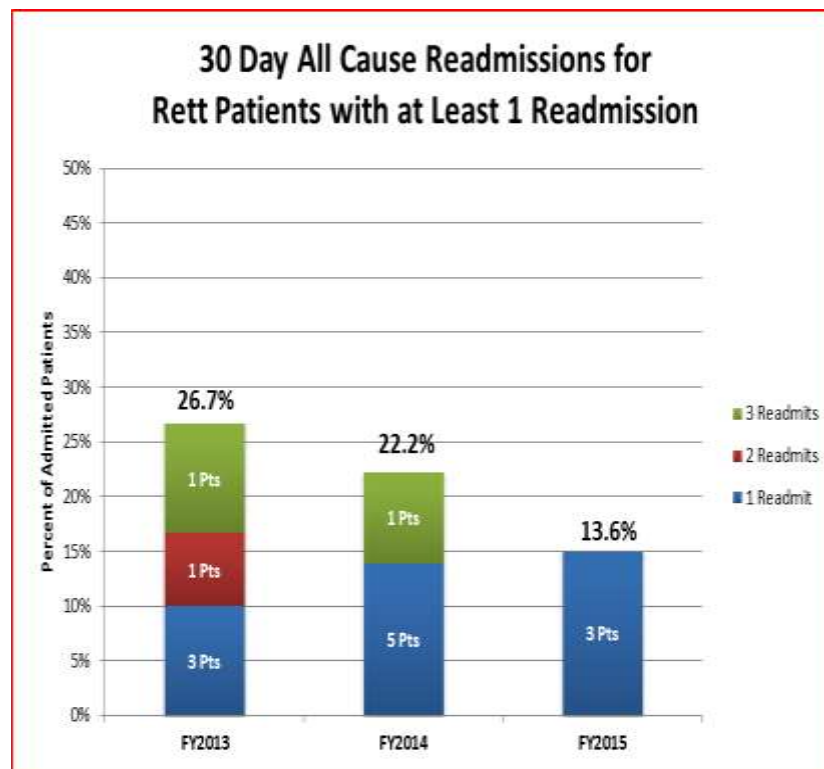
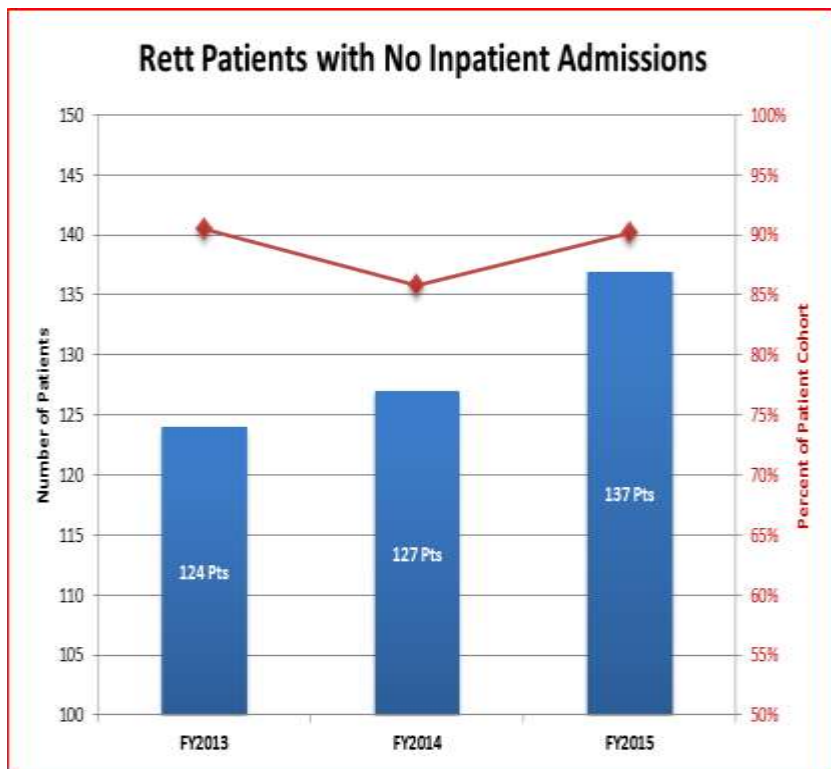
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Division of Gastroenterology CCMT

- Data represents care coordination encounters for patients with enteral tubes



Complex Patient Admissions – Boston Children’s Hospital Rett Syndrome Clinic



Evidence for Integrated Behavioral Health

- Collaborative Care model (strategic use of psychiatrists to support PCP's) significantly improves depression and anxiety outcomes, compared with standard primary care. J. Archer, P. Bower, S. Gilbody et al., "Collaborative Care for Depression and Anxiety Problems," *Cochrane Database of Systematic Reviews*, 2012, Issue 10



Current Projects Care Integration

Calgary: Children with NDD

- Families reported improved communication across care team, including school
- Decreased ED and in-patient care
- Fewer behavioral issues for children
- Improved child function at home and school

Courtesy V. Nadine Gall, MSc., Manager, NeuroDevelopmental Disorders Integrated Brain Health Initiative, Child Development Services Alberta Children's Hospital



Current Projects Care Integration

- Cincinnati
 - Pediatric Refugee Health Collaborative, an effort to unify and focus community-engaged research with refugees from Syria, has now expanded
 - Document activities used to improve access to clinical and social services

Courtesy of Riham Alwan, MD, MPH, Department of Emergency Medicine, Cincinnati Children's Hospital Medical Center



Current Projects Care Integration

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- Spina Bifida Multidisciplinary Clinic
- Complex Care Service
- Cerebral Palsy Center
- Epilepsy
- Rett Syndrome Clinic
- Home Parenteral Nutrition Clinic
- Enteral Tube Clinic
- Liver Transplant Clinic
- Transition from Pediatric to Adult Care
- Discharge Optimization
- others



Projects Gearing Up

- Chile: Spanish validation of PICS for children and youth with complex care needs
- Native American, Great Plains Tribal Chairmen's Health Board/ Rosebud Sioux Tribe, US SAMHSA/ Partners in Health
- Freiberg, Germany: Improve Care Integration for Patients with Spinal Muscular Atrophy



Integrated Strategies to Achieve Health Equity

AJPH PERSPECTIVES

No Equity, No Triple Aim: Strategic Proposals to Advance Health Equity in a Volatile Policy Environment

Health professionals, including social workers, community health workers, public health workers, and licensed

Geoffrey W. Wilkinson, MSW, Alan Sager, PhD, Sara Selig, MD, MPH, Richard Antonelli, MD, Samantha Morton, JD, Gail Hirsch, MEd, Celeste Reid Lee, MEd, Abigail Ortiz, MSW, MPH, Durrell Fox, CHW, Monica Valdes Lupi, JD, MPH, Cecilia Acuff, MSW, and Madeline Wachman, MSW, MPH



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<http://www.childrenshospital.org/integrated-care-program>

- Integrated Care Program
- Care Mapping
- Care Coordination Curriculum
- Care Coordination Measurement
- Patient & Family Experience Outcome
- High Quality Handoffs
- Multidisciplinary Care Planning

Integrated Care Program

Integrated Care is Important to Everyone!

Problem Statement:

Family/ Patient Perspective

A national sample of parents whose children have special health care needs reported that 37% of the time, their child's care team members rarely or never explained who was responsible for different elements of their child's care¹. Families expect this to be 100%.

Referring Provider Perspective

More effective care could be offered in the primary care setting if consulting subspecialists would give clear and actionable information that addressed their concerns.

Subspecialist Perspective

Knowing why the primary care provider refers the patient to the subspecialty setting would allow them to know what has been done to date, and what is expected from them.

So, What Can We Do Right Now?

- Persist with Compelling, Civil, Global Advocacy
 - Bring Data!
- Build Capacity of Families and Work Force
 - Inter-professional education
- Implement Measures of Integration, CC, and Value
- Form alliances across disciplines, sectors
- Leverage Adult Priorities for Maternal and Child Health
 - Integrated Behavioral Health
 - SDoH



Children and Families FIRST!!



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What's Next?



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**KEEP
CALM
AND
CARRY
ON**



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**KEEP
CALM
AND**

**Measure
Value**



**KEEP
CALM
AND**

**Integrate
Care**



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Contact

richard.antonelli@childrens.harvard.edu

Medical Director of Integrated Care
Boston Children's Hospital
Harvard Medical School



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- **Continuity and Coordination of Care: a practice brief to support implementation of the WHO framework on integrated people-centred health services**. Geneva: World Health Organization, 2018. Licence CC-BY-NC-SA 3.0 IGO.

