Innovative Approaches in Care Coordination and Care Delivery for Children with Special Needs

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The HSC Health Care System

- The System is a nonprofit health care organization, serving families with complex health care needs in the Washington, D.C. area for over 130 years.
- The System combines a care coordination plan, pediatric specialty hospital, home health agency and parent foundation to offer a comprehensive approach to caring, serving and empowering people with disabilities.

A Care Coordination Plan

- Health Services for Children with Special Needs, Inc. (HSCSN) serves children and young adults up to age 26, who live in the District and receive Supplemental Security Income.
- HSCSN's care management network provides a comprehensive set of benefits, including health, long-term care and social support services for members.

HSCSN Today

- HSCSN currently serves over 5,400 children and young adults with disabilities.

- Our members are in foster care, under the guardianship of child protective services
- Organization Structure/Shared Services

Integrated Care Management

The HSC Health Care System
Caring. Serving. Empowering.

Integrated Model Design Overview

The HSC Health Care System
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Network and Clinical Integration Assessment

How well positioned is the health system's existing network to control costs within target populations?

What history, structure and level of collaboration exists with providers in the market to create care efficiencies?

What incentive models are in place currently (or planned) that will align financial incentives across provider network?

Benefit / Engagement Design Assessment

How does the current benefit design support a focus on individual accountability, network control and healthy decisions?

How is the organization structured in a way to facilitate alignment around DHCF beneficiaries health and quality of life?

What is the culture and level of resource currently in place to provide employees with children with special needs with adequate support around their health?

Care Model Design

Where do the greatest opportunities exist to create care efficiencies in the target populations and to what extent?

How are health system employees organized today around managing transitions, filling coordination gaps and addressing access issue? Coordination with Homecare, Pediatric Center?

What infrastructure is in place to provide timely information and resources to providers and patients across the care continuum?

Tech Assessment

What are the sources of information that exist that can be tapped to provide visibility into care activity and opportunities?

What tools are currently in place to manage care efficiency and where/how are they being deployed?

What are the systems used at the point of care and how are these being used to facilitate decisions?

Care Coordination at HSCSN

- HSCSN uses a team approach & embeds care coordination staff with providers
  - Teams that combine staff of different skill sets, background and training in care management teams of up to 15 care managers in order to allow each staff member to draw on the expertise and experience of a deep pool of care coordination staff
  - Co-located at Children's National Medical Center and its specialty clinics and have access to their scheduling system in order to make appointments for enrollees themselves
  - Work with individual practice groups with care coordinators already on their own staff, to collaborate with practices and share information about the plan's care coordination processes, with the goal of ensuring practice and plan staff efforts are aligned

Care Coordination at HSCSN (cont'd)

- Integration of Behavioral Health Care with Other Care – HSCSN co-locates a mental health site with a primary care clinic -
  - High-need neighborhood
  - Helped re-engage approximately 150 members in mental health services who had discontinued care
  - Drives efforts to deliver mental health supports in the community in the most integrated setting possible

Care Coordination at HSCSN (cont'd)

- Supporting Non-Medical Needs of Members and Families
  - Care coordination activities can uncover non-medical needs with a significant impact on the success of health care interventions
  - Respite services to assist caregivers in the challenging, non-stop effort of caring for a child with complex needs
  - HSCSN operates a youth athletic program for members and their siblings; children at all levels participate as much as they can and wish to do so; ensures members are "out in the community" and engaged in community life and activities
  - Member with sickle cell disease with dozens of emergency department visits in just a short three-month span. Upon closer assessment, the plan learned the young woman was homeless and seeking care in the ED in order to find shelter. The plan connected the enrollee with community-based supports to provide temporary housing assistance, which offered the opportunity to stabilize

Leverages system-wide capabilities and assets

- Emphasis on combining the expertise found within the HSC System to deliver health care, care coordination, and coverage for segments of the population starting with HSCSN enrollees
- Offers a service mix of therapeutic services (OT, PT, ST, and behavioral health), home health services, and primary care services through a capitated rate payment model
- Promotes the delivery of convenient and quality care based on identified need, strategic opportunity, and financial sustainability
- Builds upon a wealth of knowledge and expertise in using an integrated approach to care coordination and delivery within the primary care setting
- Promotes transition from a referral-dependent organization to a value-based approach by aligning our expertise in managing chronically ill populations with the community's desire for convenient services that best meet the needs of its members
- Based on the alignment of incentives for primary care, preferred outpatient care and care coordination at the point of healthcare delivery

CoordinationPlus™ Program (cont'd)

Quality measures for members in Coordination Plus

- 5% decrease in ED visits.
- 80% compliance in EPSDT visits.
- 5% decrease in hospital readmission.
- 90% immunization rates.
- 90% lead screening compliance.
- 90% fluoride varnish applications.
- 90% rate of 48 hour newborn visit screen
- Maintain asthma medication HEDIS measures.
- 5% increase in members reaching rehabilitative goals and graduating
- from outpatient services.
- 90% increase in member admits to home care services within 24
- hours of referral

Discussion