

Improving Managed Care for Children with Special Needs



toolkit

Best Clinical and
Administrative Practices

CHCS

Center for
Health Care Strategies, Inc.

Improving Managed Care for Children with Special Needs

A Best Clinical and Administrative PracticesSM Toolkit

About the Center for Health Care Strategies

The Center for Health Care Strategies promotes high quality health care services for low-income populations and people with chronic illnesses and disabilities. We achieve this objective by providing training, technical assistance, and grant making to state purchasers of publicly financed health care, health plans, and consumer groups. CHCS' program priorities are: improving quality, reducing racial and ethnic disparities, and increasing community options for people with disabilities.

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Improving Managed Care for Children with Special Needs

*A Best Clinical and
Administrative Practices
Toolkit*

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Preface and Acknowledgements

The Center for Health Care Strategies thanks the many people who assisted in the production of this toolkit. CHCS acknowledges Carol Tobias, Director of the Health & Disability Working Group, Rhonda Johnson, MD, Medical Director, Medical Management Services at Highmark BlueShield, and Alison Croke, former Program Officer at CHCS, for their guidance and stewardship of the workgroup. CHCS also recognizes Susanne Salem-Schatz, ScD, for her role as the workgroup improvement advisor. We are grateful for Rosa Marquez of CHCS, who provided administrative support; Nina Verma, a former intern at CHCS, for her initial research and development for this toolkit; and to Michael B. Rothman, formerly of The Robert Wood Johnson Foundation, Richard J. Baron, MD, of Healthier Babies, Healthier Futures, Inc. who serves as CHCS' Senior Medical Consultant, and Stephen A. Somers, PhD, of CHCS, for their leadership.

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FOREWORD:

Who are Children with Special Needs?



American medicine is at a crossroads. The technical capabilities available to patients are beyond anything that could have been imagined even 20 to 30 years ago. Babies less than a pound at birth now routinely survive and generally thrive. Life-saving therapies bring children with metabolic disorders back from the brink of death time after time. Adolescents whose kidneys fail receive the reprieve of a renal transplant. While the most sophisticated medical and surgical capabilities are now available for children with special health care needs (CSHCN), the health care delivery services to assure access to this care have not always kept pace. This toolkit addresses the gap between what can be delivered to children with special health care needs and what is actually received.

CSHCN are those who “have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.”¹ The best prevalence estimate for this population of children is 12.8 percent.² This figure comes from the recently completed Centers for Disease Control and Prevention State and Local Area Integrated Telephone Survey national random household survey. CSHCN have a wide range of disorders including congenital anomalies, severe physical disabilities, complex organ system disease such as cystic fibrosis or sickle cell anemia as well as more common conditions, including depression and severe asthma. About half of these children and adolescents (nearly six million) are limited in their ability to function. Some of these children literally shuttle back and forth between home and hospital.

Because of their complex conditions and the impact that their disabilities have on everyday functioning and family life, CSHCN require comprehensive, coordinated, and continuous health services as described by the American Academy of Pediatrics’ Medical Home statement.³ These children also need ready access to appropriate specialists and therapists. They do best if the community-based services they receive at school and through local agencies are coordinated with the primary and specialty care they receive in the office, the clinic, and at the hospital. An individualized care plan is a tremendous help in outlining the child’s current interventions and medications, and the family’s goals, aspirations, and plans for the child’s future health and development. A care coordinator can assist the child’s primary physician to make sure that all the plans are carried out. Experimentation around the country is documenting that with such a system in place, unnecessary and expensive emergency room visits and hospitalizations can be avoided.⁴

¹ McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck PW, Perrin JM, Shonkoff JP, Strickland B. “A New Definition of Children with Special Health Care Needs.” *Pediatrics*, 1998; 102 (1):137-140.

² *The National Survey of Children with Special Needs Chartbook*. United States Department of Health and Human Services. Health Resources Services Administration. Maternal and Child Health Bureau, Forthcoming 2004.

³ National Center for Medical Home Initiatives for Children with Special Needs. American Academy of Pediatrics. <http://www.medicalhomeinfo.org/about/cshcn.html> as viewed on February 1, 2004.

⁴ Tonniges T, Palfrey JS, Mitchell M. “Introduction to The Medical Home.” Supplement to *Pediatrics*, 2004; 113 (5): 1472.

To insure the highest level of services for CSHCN, the Maternal and Child Health Bureau set the following as Healthy People 2010 goals:

- All children with special health care needs will receive regular and ongoing comprehensive care within a medical home.
- All families of CSHCN will have adequate private and/or public insurance to pay for the services they need.
- All children will be screened early and continuously for special health care needs.
- Services for children with special health care needs and their families will be organized in ways that families can use them easily.
- Families of CSHCN will participate in decision making at all levels and will be satisfied with the services they receive.
- All youth with special health care needs will receive the services to make appropriate transitions to all aspects of adult health care, work, and independence.⁵

Managed care plans, particularly those serving Medicaid and providing care for a significant number of the nation's CSHCN, can make a major difference for these children by focusing attention and resources to improve their care. With the sophisticated data systems available to managed care plans, there are wonderful opportunities for identifying CSHCN in the plan and offering physician incentives for providing care that corresponds with the medical home guidelines. Managed care plans can assist providers with enhanced care coordination aimed at preventing emergency room visits, hospitalizations, and days of work lost to parents.

This BCAP Toolkit on *Improving Managed Care for Children with Special Needs* provides resources for policymakers, health plans and other insurers, and clinicians to assure that children with special health care needs and their families move forward along the best path that American medicine and health care delivery can achieve.

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⁵ US Department of Health and Human Services. *All Aboard the 2010 Express: A 10-Year Action Plan to Achieve Community-Based Services Systems for Children and Youth with Special Health Care Needs and their Families*. Maternal and Child Health Bureau, 2001.

Improving Quality for Children with Special Needs



As health plans across the country increase enrollment of Medicaid and SCHIP beneficiaries, the challenges of providing consistent, high quality care and the need for defined and measurable quality improvement expand significantly. The Best Clinical and Administrative Practices (BCAP) initiative was created by the Center for Health Care Strategies (CHCS) to develop, document, and spread best practices among Medicaid health plans. This toolkit reflects the experiences of the *Improving Managed Care for Children with Special Needs* workgroup, a group of 11 health plans and a primary care case management (PCCM) program that collaborated over 24 months to develop, pilot, and refine best practice models for serving this population.

We commend these 12 teams because they chose to participate in a BCAP workgroup to improve care for children with special needs even when a clear return on investment was not evident. It is our hope that the lessons herein prove to institutions interested in enhancing Medicaid managed care that there is indeed a business, social, and economic case for quality for improving care for children with special needs.

In creating this workgroup, CHCS saw the opportunity to test and apply the BCAP Quality Framework, a methodology to improve quality within Medicaid managed care, to complex populations. This toolkit offers a discussion of the BCAP Quality Framework and its application to children with special needs.

The Challenge of Serving Children with Special Needs

CSHCN are a diverse group with a wide variety of clinical conditions that periodically require intensive utilization of health services, including subspecialty care, hospitalization, mental health care, home health services, private duty nursing, and prescription drugs. Many CSHCN have multiple health conditions or disabilities. Many children on Medicaid have special needs that may or may not be addressed through the child's existing system of care. They may be enrolled in Medicaid managed care, have commercial insurance, be eligible for Supplemental Security Income (SSI), and/or participate in various waiver programs. In addition to public or commercial health insurance, they may receive services from public health departments, schools, early intervention programs, state Title V programs, the Juvenile Justice System, and departments of mental retardation, developmental disabilities, and mental health.

It is no wonder that the task of identifying these children, coordinating their services, and communicating with their families in a systematic and compassionate manner frequently falls short. Although extensive resources are spent for the care of these children, they often do not receive the right treatment at the right time in the right setting.

Online Toolkit

Visit www.chcs.org for additional resources and tools developed by the *Improving Managed Care for Children with Special Needs* workgroup.

KATIE'S STORY:

The Challenge of Assuring Continuity of Care

Katie*, age 15, was in South Carolina's foster care system and originally enrolled in the Medically Fragile Children's Program (MFCP) in 1998 at age nine. MFCP, a unique managed care program in Columbia, South Carolina, serves children with special needs in a full-time day health center.

Katie's primary diagnosis was Fetal Alcohol Effects. Her secondary diagnoses included enuresis, failure to thrive, and visual impairment. Through MFCP, she received speech and occupational therapies, nutritional counseling with calorie supplements, therapy for enuresis, as well as psychotherapy for behaviors related to past physical and sexual abuse. Katie was adopted by her foster family in

early 2000. At that point, Katie was discharged from MFCP because she no longer met the medical criteria for participation: her enuresis was resolved and she was on no medications, plus her growth was stabilized at the 5th percentile for weight and at the 10th percentile for height.



Leaving the coordinated care safety net of MFCP was difficult for Katie. Three years after discharge, Katie had a significant growth setback with her weight far below the 3rd percentile and her height at the 3rd percentile. She also was exhibiting disruptive behaviors at home and school. MFCP staff members believe that many children like Katie suffer setbacks after discharge because the general medical community is not equipped to handle children with complex needs.

To help children transition from full-time day health services to traditional health services, MFCP created the Step-Down Program. This program provides transition and support care for children who are discharged from MFCP when they lose eligibility (because they age out or their medical situation stabilizes). As a Step-Down Program participant, Katie now receives nutritional counseling, weekly psychotherapy, and growth monitoring, and she was fitted for new glasses for a diagnosed astigmatism. Her goals are to improve eating habits, increase her growth, better understand and control her disruptive behaviors, and become self-sufficient with activities of daily living. As part of the Step-Down Program, she and her family participate in bi-annual meetings to monitor progress and set additional goals.

Katie's roller-coaster health care journey — from fragmented, sporadic care to a well-coordinated care plan and back and forth again — is a common experience for children with complex medical needs. While diagnoses vary substantially, the constant element for all children with special health needs is the necessity of extensive, personalized health and health-related services to improve day-to-day functioning, avoid hospitalizations, reduce costs for families and the health care system, and ultimately, improve the quality of life for the children and their families.

*Name changed for privacy.



Among the challenges of serving children with special health care needs are the following:

- The absence of a common diagnosis makes it difficult to easily and consistently identify CSHCN.
- Complex co-morbidities make it difficult to evaluate and assess severity levels and long-term prognosis.
- Families may lack adequate support structures and be disconnected to social services provided in the community. They may end up assuming significant coordination and medical care management responsibilities.
- The child may have many health care providers, but no real “medical home” that provides comprehensive review and oversight of all the child’s primary and specialty care needs. Additionally, access to pediatric subspecialists and mental health providers is often limited and not coordinated with the child’s primary care provider.

Opportunities to Enhance Services for Children with Special Needs

With limited established evidence or clinical practice guidelines specific to serving children with special needs, organizations must explore new territory to find effective strategies for reducing costs and improving quality for this population. The structure and accountability of managed care can help design solutions to these challenges. Some strategies available to health plans include:

- Using administrative, claims, and interview data to identify CSHCN.⁶
- Stratifying CSHCN to identify those most at risk and potentially prevent acute exacerbations of chronic conditions.
- Reaching out to families to provide up-to-date clinical information and create social case management programs that foster links to social service programs.

Health Plan Efforts for Special Needs Populations: Do They Count Toward Accreditation or Regulatory Requirements?

When this BCAP workgroup began in 2001, many states did not monitor health plan activities for children with special needs. Since implementation of the Balanced Budget Act quality requirements, many states are now building these performance measures and activities into contractual requirements with health plans.⁷

In 2003, Health Net of California was awarded a contract by the California Department of Health Services to expand its service area from five to seven counties. Representatives from Health Net indicated that the health plan’s participation in the BCAP workgroup and the lessons learned from its pilot project enhanced its bid significantly.

Throughout this workgroup, CHCS heard repeatedly from health plans that their efforts to improve care for CSHCN did not count toward NCOA accreditation or re-certification. While pieces of their CSHCN strategy may apply (e.g., efforts to improve asthma, diabetes, or ADHD), NCOA does not currently recognize efforts that focus on chronic populations generally. At the final meeting of the workgroup, a representative from NCOA expressed interest in working with health plans to develop effective quality measures for CSHCN.

⁶ While clinical guidelines exist for some conditions, they do not exist for all conditions and general guidelines may not have been adapted for pediatric populations. In addition, most children with special needs on Medicaid have multiple physical, behavioral, and cognitive needs that clinical guidelines are often not designed to address.

⁷ The Identification chapter, page 19, has a more detailed discussion of the Balanced Budget Act requirements for identifying children with special needs.

- Providing care coordination services to children and their families and working with providers to establish and enhance medical home programs.

Most health plans and PCCM programs have an infrastructure that can be used to identify service patterns and use, improve access to health care, strengthen care coordination, and monitor quality of care and health outcomes. Well-designed managed care programs offer more comprehensive health services than fee-for-service systems and can work with providers to create a medical home, to arrange for and coordinate specialty care, and to act as an advocate on behalf of the child's needs.

Table 1: Improving Managed Care for Children with Special Needs Workgroup

Health Plan	Location	Workgroup Participants	Number of Medicaid/ SCHIP Enrollees	Estimated Number of CSHCN
Access II Care of Western North Carolina	Asheville, NC	Carol Long, MD Christine Collins	22,020	2,002
Community First Health Plan of Texas ⁸	San Antonio, TX	Maurine Porto, MD* Susan Lomba	9,469	58
Community Health Network of Connecticut	Meriden, CT	Elizabeth Smith, MD* Lynn Childs	55,804	6,488
Health Net of California	Woodland Hills, CA	Bruce Chernof, MD Ana Ruiz Clark	690,639	45,328
Health Services for Children with Special Needs	Washington, DC	Margaretia Jackson, MD* Son Park	3,152	3,152
Keystone Mercy Health Plan	Philadelphia, PA	William Chodoff, MD Kyle Holsinger*	270,000	5,630
Lovelace Community Health Plan	Albuquerque, NM	Jeannette Velarde, MD Patricia Kehoe	68,500	11,675
Maryland Physicians Care	Baltimore, MD	Acquenetta Wheeler, MD* Camille Dobson	87,607	1,381
Medically Fragile Children's Program	Columbia, SC	Ronald Porter, MD Patricia Votava	102	102
Molina Healthcare of Washington	Bothell, WA	Richard Tompkins, MD Lynn Barker	125,621	16,452
Neighborhood Health Plan of Massachusetts	Boston, MA	James Glauber, MD Pamela Gossman*	116,000	Not available
Partnership HealthPlan of California	Suisun City, CA	Chris Cammisa, MD Cheryl Lockhart Cindi Ardans	81,042	5,436
Total Medicaid Membership			1,529,956	97,704

*No longer with the health plan, see the online toolkit at www.chcs.org for an updated list of health plan contacts.

⁸ Community First Health Plan of Texas focused its BCAP pilot efforts solely on its SCHIP population. Therefore, the numbers presented are SCHIP only.

The BCAP Quality Framework



The BCAP Quality Framework, developed by CHCS, is a proven method to address the complexities of improving health care services and delivery for people covered under Medicaid managed care. Since April 2000, more than 120 health plans and PCCM programs, representing nearly 14 million Medicaid beneficiaries in 34 states, have applied the BCAP Quality Framework to improve publicly financed health care.

The BCAP Quality Framework draws on learning models developed by the Institute for Healthcare Improvement and others focusing on chronic disease such as the Improving Chronic Illness Care program at the McColl Institute for Healthcare Innovation. It offers a unique focus on the challenges specific to serving enrollees in Medicaid managed care and has consistently been applied by Medicaid health plans and PCCM programs to effectively target quality improvement resources and produce documented results.

BCAP QUALITY FRAMEWORK

COMPLEX
MEDICAID = POPULATION
& SYSTEM

NEEDS ASSESSMENT

Evaluate the needs of members, providers, and the managed care organizations to target quality improvement activities.

TPOLOGY FOR IMPROVEMENT

Structure quality improvement activities consistently, addressing barriers unique to serving Medicaid enrollees. The categories are:

Identification:	How can the health plan identify children with special needs?
Stratification:	How is the identified population of children with special needs stratified by different levels of need or risk?
Outreach:	How does health plan staff effectively reach children with special needs and their families?
Intervention:	What changes are effective to improve outcomes for children with special needs?

RAPID CYCLE IMPROVEMENT

Test changes in each of the BCAP Typology categories using the Model for Improvement.⁹ Measure progress early and often to make “real-time” refinements to quality efforts based on preliminary successes or setbacks.

MEASUREMENT AND EVALUATION

Build realistic measures into quality initiatives to establish baseline data, set goals, guide improvement efforts, and demonstrate the success of change strategies.

SUSTAINABILITY AND DIFFUSION

Promote tools to preserve and spread best practices to ensure the long-term success of quality efforts.

⁹ Langley G, Nolan K, Nolan T, Norman C, and Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. Jossey-Bass, 1996.



The following section discusses how the BCAP Quality Framework can be applied to design and evaluate pilot projects to improve health care services for children with special needs.

Needs Assessment

Needs assessment was a critical starting point for this BCAP workgroup because of the complexity of designing programs for this population. Most health plans have data on where they spend money for high-cost children, but data does not help a health plan determine unmet needs or barriers to care experienced by children and their families. Nor does this data help identify children who are stable now, but may need extensive case management in the future.

Health plans in this BCAP workgroup found the needs assessment process useful to evaluate existing initiatives and gauge member and provider needs prior to launching their quality improvement projects. In several cases, workgroup teams significantly revised or enhanced their planned projects based on feedback from needs assessment surveys or focus groups.

Applying the BCAP Typology to Children with Special Needs

The BCAP Typology categorizes quality improvement activities and addresses barriers to serving Medicaid enrollees. It offers a template for designing quality initiatives that can be customized for clinical and administrative improvement projects. While the BCAP Typology is useful to provide structure in designing a quality improvement initiative, there also can be overlap between typology categories. For example, a successful effort to improve identification can often promote activities in stratification, outreach, and intervention. This toolkit is meant as a guide to help organize ideas, but also is designed to allow flexibility for creative planning and design of new initiatives.

The four categories of the BCAP Typology are:

Identification — How can a health plan effectively define the criteria to select children with special health care needs and use its resources to determine which children meet the definition?

Defining exactly who children with special needs are and identifying these members is necessary to focus outreach, health risk screening, care coordination, network management, and quality improvement efforts. Workgroup teams used several different definitions of children with special needs, such as the Maternal and Child Health Bureau (MCHB) definition,¹⁰ and then developed mechanisms to identify children who met the definition.

Stratification — How do health plans determine which children could benefit from structured interventions?

Once a cohort of CSHCN has been identified, how does the plan determine which children can benefit most from care coordination or enhanced support? After developing a stratification method that addresses the above challenges, how does the health plan validate that the selected criteria are effective?

Toolkit Guide

Sections three through seven offer highlights of pilot projects implemented by the *Improving Managed Care for Children with Special Needs* workgroup. For detailed descriptions of pilot projects implemented by Access II Care of Western North Carolina, Health Net of California, Lovelace Community Health Plan, and Partnership HealthPlan, see “Section 8: Applying the BCAP Quality Framework: Health Plan Case Studies,” beginning on page 39.

¹⁰ The Maternal and Child Health Bureau definition of children with special needs is discussed in the Identification chapter, page 19.

Outreach — How does the health plan reach out to members, their families, and providers?

Determining how to effectively communicate with members, their families, and providers is a key step for an effective intervention. Fortunately, many parents of CSHCN are eager participants in their child’s health care and have learned to be vocal about their child’s needs. On the flip side, for those children whose parents are not available to be effective advocates, the urgency for outreach is magnified when a CSHCN has been identified but is hard to find.

Intervention — What interventions are effective in improving care?

Once the health plan has identified and stratified the target population of children with special needs and has made contact with these children, their families, and their providers, the health plan can focus efforts on enhancing services delivered to the population. The needs assessment conducted at the initial stages of pilot development provides value in highlighting what services and interventions are most valuable to members, their families, and providers. Some children may benefit from more comprehensive clinical evaluation and assessment while others may only need reliable transportation to improve adherence to care regimens.

Using Rapid Cycle Improvement

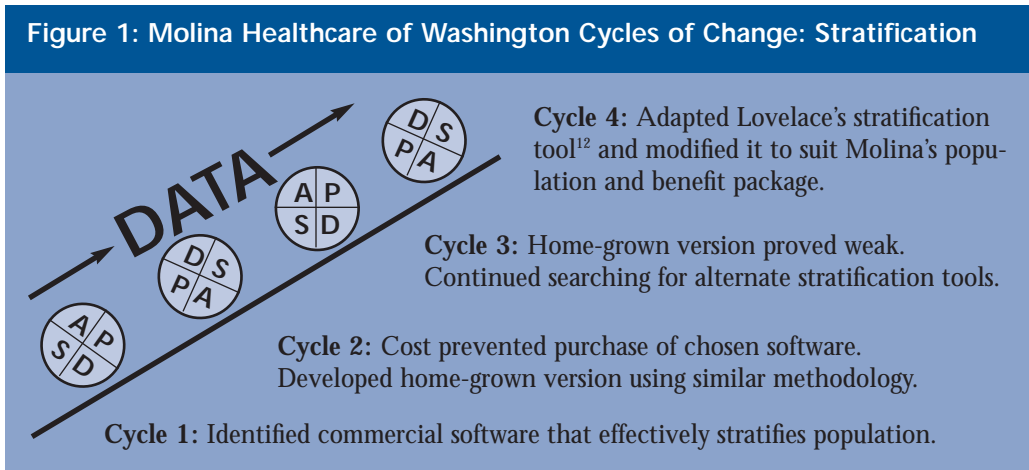
Measuring progress early and often provides ample flexibility to refine projects based on preliminary successes and/or setbacks. BCAP uses the Model for Improvement,¹¹ which employs PDSA (Plan, Do, Study, Act) cycles to test changes in systems and processes. The PDSA cycles guide teams through a quick-turnaround analysis and improvement process. The Model for Improvement encourages organizations to identify an aim, measure, and change strategy for each pilot effort by asking:

AIM	What are we trying to accomplish?
MEASURE	How will we know that a change is an improvement?
CHANGE	What changes can we make that will result in improvement?

Typically, the health plan establishes an overall aim for the project and then develops specific aims, measures, and changes for each BCAP Typology category. This method helps BCAP participants divide large quality improvement projects into manageable pieces and tests specific components of the typology separately.

¹¹ Langley, op. cit.

Figure 1 shows the PDSA cycles applied over an 18-month period by Molina Healthcare of Washington during its participation in this workgroup. Molina Healthcare set an aim to develop a tool that would effectively stratify children with special needs into low, medium, and high risk. Molina Healthcare started by testing small changes, monitoring them, evaluating outcomes, and then making the necessary modifications to meet its goal.



Measurement and Evaluation

Demonstrating the success of any quality improvement initiative requires consistent and frequent data collection. Three categories of measurement are used in the BCAP Quality Framework to evaluate short- and long-term successes:

PILOT MEASURES	Describe individual team results in each BCAP Typology category and reveal where changes are working and where adjustments are necessary.
COMMON MEASURES	Create normative benchmarks that are aggregated across several organizations. The measures also allow BCAP participants to compare their progress against baseline.
CAPACITY MEASURES	Examine team capabilities, organizational processes, and systems changes. ¹³

Establishing baseline data for each of these measures and collecting data in frequent intervals are critical to demonstrating the success of an initiative.

¹² Discussion of Lovelace's stratification tool is on page 51.

¹³ Earlier BCAP workgroups, including *Improving Managed Care for Children with Special Needs*, used common measures to compare each plan against its own baseline. As of 2003, CHCS added capacity measures and changed common measures to allow for benchmarking.



Sustainability and Diffusion

BCAP promotes sustainability and diffusion of best practices to ensure the long-term success and institutionalization of quality efforts.

Sustainability

Sustainability means ensuring that a successful pilot project is institutionalized so that it will continue after the improvement team has been disbanded. This means moving from a pilot project to a permanent program.

Securing additional funding can help to sustain the pilot project as it moves into normal operation. Several of the plans in the *Improving Managed Care for Children with Special Needs* workgroup obtained funding to either expand or support their pilot project. Based on its successful use of the BCAP Quality Framework, the Medically Fragile Children's Program received \$700,000 from the Duke Endowment to support expansion and to develop a web-based data system to monitor cost, service utilization, and outcomes.

Partnership HealthPlan of California received funding from The California HealthCare Foundation to form a local coalition to expand the medical home concept, develop a Parent Resource Notebook, and implement the Center for Medical Home Improvement medical home model.¹⁴ The grant supported completion of provider and member needs assessments. Molina Healthcare of Washington sought and received funding from a pharmaceutical firm to purchase training materials for providers and educational materials for members with attention deficit hyperactivity disorder.

In today's tight budgets, however, new or additional funding is not always possible. Another way to embed the pilot project into normal operations is to gain internal buy-in to make a long-term institutional change. A permanent change in any of the following areas can make the pilot project an enduring program — structure, process, regulation, policy, or staffing. For example, Health Services for Children with Special Needs (HSCSN) changed its EPSDT policy for CSHCN. HSCSN now builds EPSDT performance standards into its contracts with physicians as a way to boost its EPSDT participation rates.¹⁵ Other health plans, such as Lovelace and Health Net, institutionalized processes and procedures developed during their BCAP participation and created a permanent structure for serving children with special needs.

Diffusion

Diffusion is the spread of both the best practice proven by the pilot project and the application of the BCAP Quality Framework methodology to other quality improvement projects.

¹⁴ The Center for Medical Home Improvement is discussed in more detail on page 17 and in the Partnership HealthPlan of California case study beginning on page 54.

¹⁵ For more discussion of Health Services for Children with Special Needs EPSDT program, see page 36.

Access II Care is spreading its success across all 13 networks within North Carolina's PCCM-based Medicaid program. The North Carolina Foundation for Advanced Health funds a web-based case management application for these networks. Access II Care, through its BCAP pilot, added a section containing Medicaid-funded case management codes to enhance this web-based tool. This allows any case manager across North Carolina's PCCM program to quickly identify if there are case managers for agencies outside of the PCCM program billing for case management services (e.g., mental health case management).

The Medically Fragile Children's Program developed a diffusion model to spread the BCAP Quality Framework across its internal operations and into its expansion sites. Because all MFCP members are CSHCN, the plan was initially skeptical about the application of the BCAP Quality Framework to its population. In particular, identification and stratification did not seem critical. However, MFCP has found identification tools, such as the CSHCN Screener, useful in screening potential enrollees at its expansion sites. MFCP not only uses the BCAP Quality Framework consistently within its original program but also has used it in its expansion sites. The BCAP Quality Framework was a key component of the previously mentioned grant from the Duke Endowment.

Finally, other plans have adopted the BCAP Quality Framework as a guide to design plan-wide quality improvement activities beyond improving care for children with special needs. Health Net in California, for example, is using the consistent structure provided by BCAP for improvement activities around diabetes, asthma, and child and adolescent weight management.

Needs Assessment



The Challenge:

How do health plans determine where to focus efforts to improve care for children with special needs?

Needs assessment is a first step to determine priorities for quality improvement. During this stage, health plans can:

- Assess their organizational capabilities.
- Evaluate the primary care and/or specialty network.
- Determine the needs of families of CSHCN.
- Explore potential partnerships with community agencies.

BCAP Solutions

to the Challenges of Effective Needs Assessment

To better understand barriers to care or unmet needs, several health plans in the BCAP workgroup surveyed members, providers, and/or community organizations. Other health plans conducted member focus groups in addition to, or as a substitute for, member surveys. Finally, a few health plans focused efforts internally by assessing existing programs and determining if expansions or modifications were appropriate.

Generally, workgroup participants were successful in implementing needs assessment evaluations with members and community affiliates. Provider needs assessment surveys were not particularly effective for the participants in this BCAP workgroup because they were time-consuming and yielded a low response rate. Visits to provider groups proved a more useful strategy for identifying provider needs.

Member Needs Assessment

Lovelace Community Health Plan

Getting member input can be challenging and time consuming, but provides valuable feedback on effective ways to serve complex populations.

Lovelace Community Health Plan used focus groups to discuss ways to improve barriers to service. These focus groups evolved into an ongoing Consumer Advisory Board that serves as a sounding board on barriers to care and identifies opportunities to improve services for children with special needs.

During one focus group with members in western New Mexico, it was determined that there were not enough network physicians in their area. Lovelace now contracts with additional providers and physician assistants in New Mexico, as well as providers in the states that border New Mexico, including Arizona, Colorado, and Texas.

Partnership HealthPlan of California

Partnership's needs assessment goal was to better understand care coordination barriers from the provider and member perspectives. The plan formed a local coalition to improve medical homes for CSHCN with funding from The California

Partnership believes that the level of success achieved would not have been possible without the involvement of its practice sites and the strength of its coalition. During monthly meetings, coalition participants worked toward quality improvement, discussing all aspects of the Partnership program, from needs assessment to pilot project conception. This mutual respect and understanding fostered a positive environment for all coalition participants to voice their opinions and develop effective projects for Partnership.

HealthCare Foundation. The coalition members included parents, Family Resource Centers, a representative from the local American Academy of Pediatrics chapter, California regional centers, California Children's Services, providers, and a nurse from the county Office of Education. Funding included support for a parent needs assessment survey and an evaluation of practices selected to serve as medical homes.

Partnership conducted a parent/caretaker survey in November 2002. The parent needs assessment survey indicated that most parents felt their doctors understood their child's medical needs.¹⁶ About a third of parents indicated

that they had problems getting prescriptions, counseling, therapy, or medical equipment. Additionally, while 55 percent of parents indicated they did not use a log or diary to record their child's medical or dental visits, 87 percent of those said they would use a diary if it was provided to them. Seventy-eight percent of parents indicated that they did not have a written care plan from their child's doctor and 73 percent said they would like one. These responses guided the coalition to create a parent resource notebook that helps families to record questions, concerns, and information about their child's health status. Partnership worked with the provider groups to help them assess written care plan tools. One practice engaged parents to help select a care plan model.

Community Needs Assessment

Several workgroup participants conducted community needs assessments to determine gaps in services and how the health plan might close those gaps.

Medically Fragile Children's Program

The Medically Fragile Children's Program analyzed what happens to members who are disenrolled because their medical conditions improve and they no longer meet the eligibility requirements. The analysis was designed to assess the transition needs for existing enrollees and determine gaps in the system.

The assessment found that existing community transition programs have different eligibility criteria and the scope and quality of services offered varies greatly. None of the programs that MFCP analyzed offered complete services for children with moderate or severe health needs. Additionally, there was no precedent for a child to access services across multiple systems, yet have one agency act as the child's lead advocate to assure that the child's needs are met.

¹⁶ Partnership HealthPlan's needs assessment survey is available in the online toolkit at www.chcs.org.



The needs assessment exercise was useful because it led to the creation of MFCP's Step-Down Program to address transitional needs. The Medically Fragile Children's Program worked with its state Medicaid agency to create a program that provides ongoing transitional care for children in the MFCP catchment area who were disenrolled from the full service program.

Health Net of California

Health Net assessed gaps in services and unmet needs within the carve-out systems of care for its CSHCN. The plan analyzed results from screenings conducted by a large multi-specialty group practice that served as the plan's medical home pilot site. The analysis showed that

43 percent of CSHCN had not been referred to appropriate programs prior to participating in Medicaid managed care. These services include mental health, dental care, Local Education

Health Net's needs assessment analysis within a large multi-specialty group practice identified that 43 percent of CSHCN had not been referred to appropriate programs prior to participating in Medicaid managed care.

Agencies, and regional centers that care for people who are developmentally disabled. This analysis was critical to developing an intensity of service/acuity tool to help providers identify the full range of services available for CSHCN.

Provider Needs Assessment

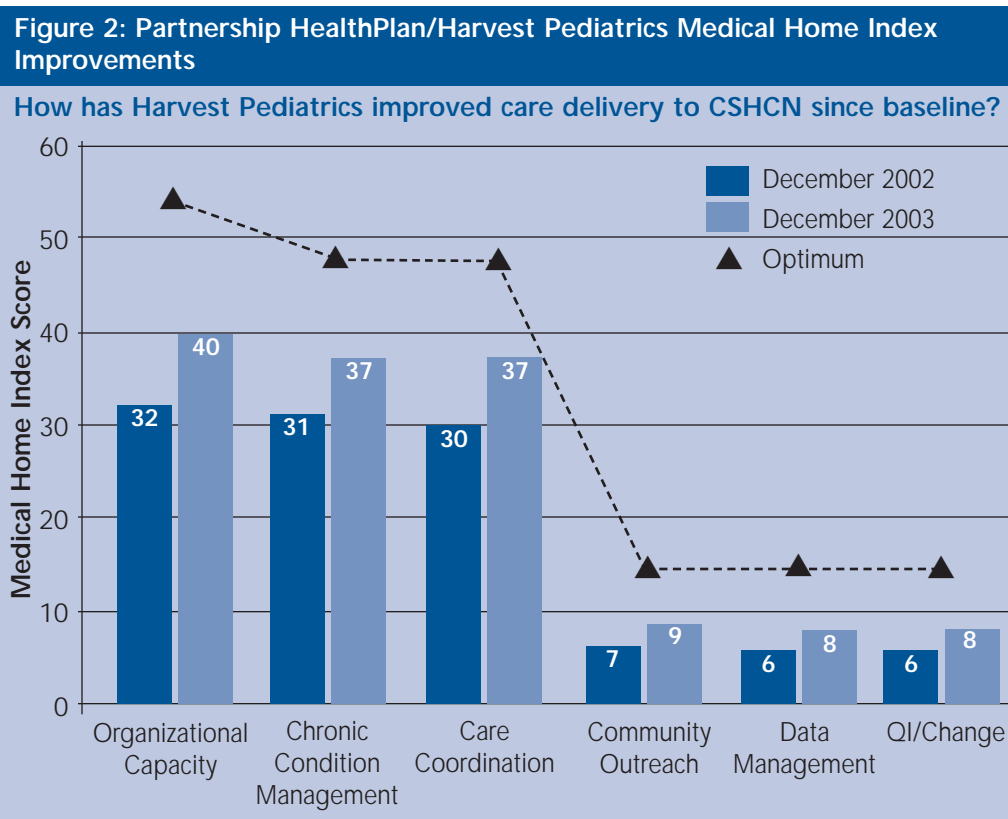
Several health plans, including Community First of Texas, Community Health Network of Connecticut, and Partnership HealthPlan of California conducted provider needs assessment surveys. Results from these surveys proved useful in educating health plan staff on the readiness of practices to serve children with special needs and also highlighted opportunities for provider education on serving children with special needs. One of the most common concerns expressed by providers was the need for more information about available community resources and local referral contacts. Many health plans in this workgroup responded by developing community resource directories for their providers.

Partnership HealthPlan of California

Partnership's parent/caretaker survey demonstrated that parent/caretakers were not satisfied with continuity and coordination of care for CSHCN. As a result, Partnership set a goal to improve parent/caretaker satisfaction with continuity and coordination of care to 80 percent and collaborated with a group of network providers to improve capacity of their sites to serve as medical homes. To do this, Partnership's Medical Home coalition reviewed the Center for Medical Home Improvements' (CMHI) resources, including the Medical Home Index (MHI) and Medical Home Family Index assessment tools, and adopted them as the model for practice-based quality improvement.¹⁷ The Medical Home Index measures practice sites against six measures: organizational capacity; chronic condition management; care coordination; community outreach; data management; and quality improvement/change. Three practice sites participated in a pilot project to implement the

¹⁷ The Center for Medical Home Improvement, formerly part of Dartmouth Hitchcock Medical Center, has relocated to the Crotched Mountain Foundation. For additional information, see the Center for Medical Home Improvement's website at <http://www.medicalhomeimprovement.org>.

CMHI model. The practice sites that measured their progress using the MHI assessment tool found that their organizational capacity to provide support and services to children with special needs improved between one and eight percent over the course of a year. An example of one site's improvement, Harvest Pediatrics, is shown in the graph below.



Identification The Challenge:

How can health plans identify children with special needs?



Most health plans identify children with special needs through eligibility codes assigned by the state upon enrollment. These eligibility codes identify many children included in the Balanced Budget Act of 1997 (BBA) definition of children with special needs. Yet most of the health plans in this BCAP workgroup found that although eligibility codes capture a significant number of children with special needs, these codes are not exhaustive of all children needing special services. These plans have found that other data sources are needed to give the health plan a true picture of its entire pediatric special needs population. Plans also found that while the MCHB definition is comprehensive, it is hard to effectively build into operations because of the broadness of the criteria.

Commonly Accepted Definitions of CSHCN

The Centers for Medicare and Medicaid Services requires states to use the Balanced Budget Act of 1997 definition of children with special needs in their Medicaid contracts. States often require health plans to identify children who meet the definition and to offer specific services to these children. Some states have chosen to use the broader Maternal and Child Health Bureau definition in place of the BBA definition.¹⁸ Following are both definitions:

Balanced Budget Act of 1997

According to the BBA, a child is defined as having special health care needs through participation in one of the following five programs:

- Supplemental Security Income under the Social Security Act (SSA).
- The Katie Beckett state plan option (a discretionary Medicaid eligibility category that covers children living at home who would be eligible for Medicaid if they were institutionalized) under Section 1902(e)(3) of the SSA.
- Maternal and Child Health Services Title V Block grants for CSHCN.
- Federal foster care or adoption assistance services under Title IV-E of the SSA.
- Foster care or other out-of-home placement.

US Maternal and Child Health Bureau

Children with special health care needs are defined as those who “have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”¹⁹

When this BCAP workgroup began in 2001, it was estimated that 13-18 percent of all children in this country had special health care needs,²⁰ with approximately one-quarter of the children covered under Medicaid estimated to have special health care needs.²¹ Prevalence varies based on a variety of factors, including regional differences, demographics, and whether or not a plan serves SSI-eligible children. Given SSI and other eligibility criteria for Medicaid, it is likely that the percentage of children with special needs in Medicaid is even higher. A soon-to-be released survey estimates that 12.8 percent of all children have special needs.²²

¹⁸ For more information about state requirements for serving CSHCN under the BBA, see: HB Fox et al., 1999, *An Analysis of Safeguards for Children with Special Needs in States' Medicaid Managed Care Contracts*, at www.mchpolicy.org/publications/medicaid.html.

¹⁹ McPherson, et al., op. cit.

²⁰ Newacheck P, Stickland B, Shonkoff J, et al. “An Epidemiologic Profile of Children with Special Health Care Needs.” *Pediatrics*. 1998;102(1):117-121.

²¹ *Identifying Children with Special Health Care Needs in Managed Care Plans*. Synopsis of the April 2001 Maternal and Child Health Bureau Expert Work Group Meeting, Health Resources and Services Administration, 2001.

²² *The National Survey of Children with Special Needs Chartbook*, op. cit.

Workgroup participants began their pilot projects by evaluating whether existing lists of CSHCN were accurate and exhaustive. By comparing the percent of CSHCN identified in the health plan with other health plans in the workgroup and with national benchmarks such as those based on the Maternal and Child Health Bureau’s definition of CSHCN, most of the BCAP participants concluded that their lists were not comprehensive.²³ Because early identification of children with special needs is critical to enhancing quality for these members, most of the BCAP workgroup participants focused initial pilot project efforts on increasing identification of children with special needs. In some situations, this meant using a broader definition than required to capture children who might otherwise remain unidentified until a traumatic event led to a costly intervention.

Populations Served Lead to Drastically Different Prevalence Rates among Health Plans

The challenges of identifying potential CSHCN in Medicaid managed care are magnified by the vast differences among the populations served. So while the MCHB definition may indicate that 13-18 percent of the pediatric population has special needs, a specific health plan’s prevalence rate may vary depending on the specific populations they serve.

Table 2: Populations Served by BCAP Workgroup Health Plans

Health Plan Name	TANF	SCHIP	SSI	Other Aid Codes
Access II Care of Western North Carolina		X	X	
Community First Health Plan of Texas ²⁴		X		
Community Health Network of Connecticut	X	X		
Health Net of California	X	X		
Health Services for Children with Special Needs			X	
Keystone Mercy	X			
Lovelace Community Health Plan	X	X	X	X
Maryland Physicians Care	X			
Medically Fragile Children’s Program				X
Molina Healthcare of Michigan	X	X		
Neighborhood Health Plan of Massachusetts	X	X	X ²⁵	
Partnership HealthPlan of California	X		X	X

²³ Two workgroup participants, Health Services for Children with Special Needs, and the Medically Fragile Children’s Program, only serve CSHCN. Therefore, they did not need to address identification issues.

²⁴ Community First Health Plan of Texas serves the Medicaid population, but only focused its BCAP pilot efforts on its SCHIP population.

²⁵ Neighborhood Health Plan of Massachusetts enrolls children on SSI, but only at select provider sites.



BCAP Solutions to the Challenges of Effective Identification

The health plans in this BCAP workgroup generally used state aid codes for CSHCN as a starting point and enhanced their capacity to identify children by applying various tools, including the CSHCN Screener,²⁶ software packages, or developing patient registries using lists of appropriate ICD-9 codes. Plans created data algorithms that identified children in plan case management or community-based case management services. Some plans examined utilization data from pharmacy, durable medical and adaptive medical equipment, nutritional supplements, private duty and home health nursing services, and/or therapies (speech, physical, and occupational). Approaches often required coordination across several departments, including information systems, member services, case management, medical management, and quality improvement. The techniques used by workgroup members are discussed below in two broad categories: diagnostic codes and screening tools.

Use of Diagnostic Codes

Several health plans developed lists of ICD-9 codes as a starting point to identify CSHCN. A few plans used an ICD-9 prescreen sampling code list developed by the Child and Adolescent Health Measurement Initiative (CAHMI). This list of codes was designed to be used in conjunction with the CSHCN Screener and the CAHPS Child Survey to oversample for pediatric populations that meet the Maternal and Child Health Bureau's definition of special health needs. Several BCAP plans found this prescreen list to be a helpful starting point for identifying a group of potential CSHCN.²⁷

Lovelace Community Health Plan

Prior to participating in BCAP, 12 percent of Lovelace's pediatric population was identified as CSHCN using the list of ICD-9 codes developed by CAHMI. Lovelace compared the ICD-9 list with CIGNA's²⁸ high-risk pediatric codes and a list provided by California Medicaid. A claims query revealed that more than 50 percent of Lovelace's high-cost pediatric cases were not identified by using just the ICD-9 codes. Subsequently, Lovelace added V-codes, which are a subset of ICD-9 codes that generally refer to a history of illness.²⁹ Additionally, Lovelace now collects data on other potential CSHCN who are identified through referrals, member services, case management, utilization review, health risk assessment forms, etc. Use of these various identification mechanisms increased Lovelace's identification from 12 percent in 2000 to 21.3 percent in 2004.³⁰

²⁶ The Children with Special Health Care Needs Screener (sometimes referred to as the CAHMI Screener) was developed through the Living with Illness Task Force of the Child and Adolescent Health Measurement Initiative (CAHMI). CAHMI is a national initiative formerly part of the Foundation for Accountability and now based at Oregon Health and Science University. For more information, visit www.cahmi.org.

²⁷ CAHMI's prescreen sampling code list can be found in the online toolkit at www.chcs.org. Representatives from CAHMI do not promote using the ICD-9 code list as an identification tool because of its high false positive rate.

²⁸ Lovelace's parent company at the time was CIGNA.

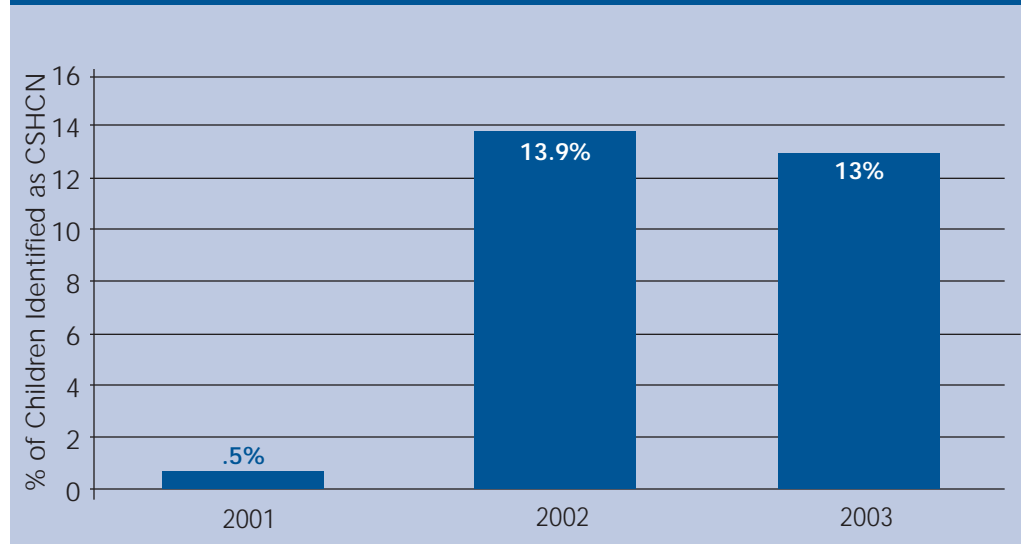
²⁹ V-codes are a supplementary classification of factors affecting health status and/or contact with health services. Most doctors do not code with V-codes, but some may. Lovelace found that its most costly cases of CSHCN were missing from its database until V-codes were added to the algorithm.

³⁰ While 21.3 percent is higher than the MCHB definition prevalence of 13-18 percent, Lovelace indicates that their prevalence rate is consistent with other Medicaid health plans in New Mexico.

Molina Healthcare of Washington

Prior to participating in BCAP, Molina Healthcare used the state's list of children in the Title V program to identify children with special needs. Less than .5 percent of Molina Healthcare's population was identified as CSHCN based on this criterion. To improve its identification rate, Molina Healthcare adopted the MCHB definition of CSHCN and analyzed claims and encounter data using the identifier codes for children with special needs developed by CAHMI. Since implementation in 2002, Molina Healthcare has consistently identified between 13-14 percent of children in the health plan as children with special needs.

Figure 3: Molina Healthcare of Washington: Identification Improvements



Using Diagnostic Codes to Apply the BBA Definition

Community Health Network of Connecticut

Community Health Network of Connecticut (CHNCT) worked with the state Child Health Council to identify diagnoses that are indicative of CSHCN. CHNCT developed a quarterly claims data report to identify CSHCN. The plan's enrollment broker also identifies CSHCN as defined by the Balanced Budget Act. Additional identification sources include a daily inpatient census and referrals from the disease management program, the high-risk prenatal program, and the health plan's pharmacy benefits manager for children using high-end injectable medicines and nutritional supplements. Using these techniques, CHNCT has increased its identification of CSHCN from 7.7 percent of its pediatric population in 2001 to 16 percent in 2003.



Partnership HealthPlan of California

Partnership uses multiple criteria that feed into a general database to identify CSHCN. These criteria include:

- Children identified using the BBA definition.
- Diagnosis-based criteria for a chronic physical, developmental, behavioral, or emotional condition.
- Selected service use or authorization criteria, such as durable medical equipment, pharmacy utilization above and beyond a set standard over six months, or the number of hospitalizations over a set period of time.

Using these multiple sources of data, Partnership increased its identification of CSHCN from 10 percent in August 2001 (3,614) to 15 percent in 2004 (5,825).

Using Diagnostic Codes to Apply the MCHB Definition

Maryland Physicians Care

Maryland Physicians Care (MPC) previously used the state's CSHCN definition, which consisted primarily of eligibility codes for certain state programs. For the BCAP pilot, the plan used the MCHB definition and developed a database to capture all children with special needs. Over time, MPC has used a variety of data sources to assist with the identification and stratification of children with special needs, including:

- Eligibility codes for children in foster care.
- Health risk assessments for CSHCN.
- Members who participated in the state's Rare and Expensive Management program.
- Authorizations for substance abuse treatment for children under 21.
- Referrals for children needing specialist treatment.
- Follow-up to state hotline reports.
- School-based health reports.
- Medication and durable medical equipment utilization.

This database helped the plan increase its identification of CSHCN from 5.8 percent in 2001 to 12 percent in 2002.

Use of the CSHCN Screener

The CSHCN Screener is widely recognized as a tool for identifying children with special needs. The tool is unique because it asks parents whether or not they consider their child to have needs that are different from other children of a similar age.³¹ Prior to BCAP, only one of the 12 workgroup teams had experience using the CSHCN Screener. To provide workgroup participants with more background, the tool was presented at the first meeting of this BCAP workgroup. Since few tools exist to help health plans broadly identify CSHCN, most of the workgroup teams decided to test the CSHCN Screener's utility within their health plans.

³¹ A sample of the CSHCN Screener is included in the online toolkit at www.chcs.org.

BCAP workgroup plans reported mixed success with the CSHCN Screener. Most of the plans that used the CSHCN Screener conducted screenings through outbound calling initiatives. The biggest hurdle was purely logistical: Since the tool is paper based, incorporating it into existing process flows at the health plans proved challenging. For instance, Keystone Mercy found the assessment tool too burdensome and abandoned use until late 2003, when it was able to integrate the screener into its information system. Other workgroup teams found some success using the CSHCN Screener with provider sites.

Several health plans found the CSHCN Screener enhanced their existing identification methods and implemented it more broadly. Health Net automated the tool early in its pilot project and continues to find it useful as a broad-based screening tool. Generally, health plans found it most helpful to use as an initial screen administered by non-clinical staff with positive screens routed to clinical staff for follow-up. Plans that used the screener to broadly identify children eligible for enhanced services found the tool more useful than health plans that wanted a tool to identify severely ill children in need of case management.

Access II Care and Health Net modified the tool to assign scores to the answers to stratify children into low-, medium-, and high-risk levels. Health plans used this stratification to target outreach and intervention efforts to those with higher scores. The health plans reporting the most success with the CSHCN Screener modified it to accommodate specific needs within the plan (automation, scoring, etc.) and built the CSHCN Screener into their daily operations. These plans also found that the CSHCN Screener is not effective as the sole means of identifying children with special needs, but can be an important component of an identification strategy that uses multiple resources to identify children with special needs. A key benefit of the CSHCN Screener is that it can be used to identify CSHCN upon enrollment, long before claims data are available.

Use of the Screener within Pediatric Practices

Access II Care

Access II Care implemented the CSHCN Screener with Medicaid enrollees within a pediatric practice. Approximately 20 percent of children screened were identified as CSHCN. Over the course of the pilot project, Access II Care expanded use of the CSHCN Screener to two additional provider sites, but ultimately discontinued use of the screener in favor of a less resource intensive claims profile.

Access II Care used results from the CSHCN screener to develop member profiles. These profiles were compared to claims data and an algorithm was created to identify children with characteristics similar to an expected claims profile of a CSHCN.

Medically Fragile Children's Program

MFCP's social workers initially attempted to use the CSHCN Screener during the intake process for new enrollees. However, because MFCP only serves children with complex medical needs, this was not effective because these children were already accepted into the program based on complex medical needs. MFCP instead found the screener was helpful during the application process to identify children potentially eligible for the program.



Use of the Screener by Health Plan Staff

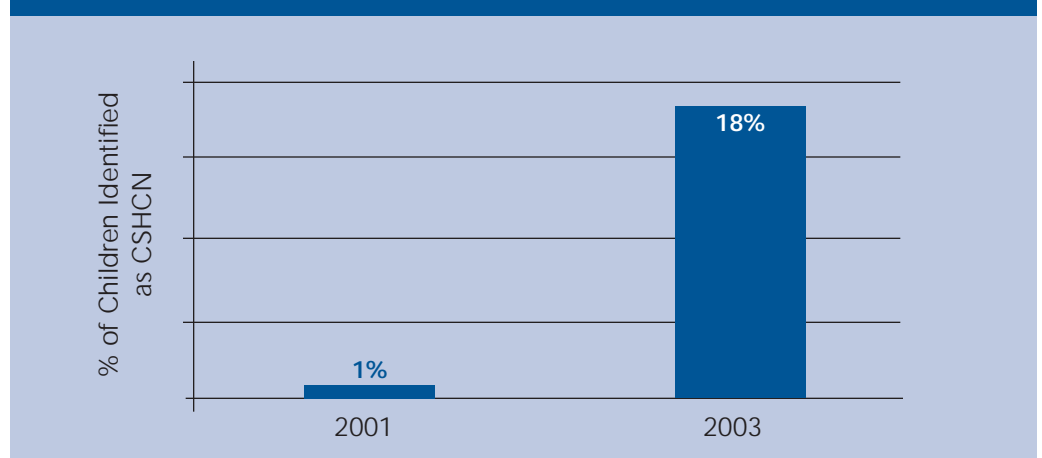
Community First Health Plan of Texas

Community First Health Plan of Texas (CFHP) has used the CSHCN Screener since its participation in the BexarCare pilot program in 1999.³² Use of the CSHCN Screener was mandated by the SCHIP program of Texas. In the BexarCare pilot, the state required the health plan to use clinical staff to use the screener when conducting outreach to children identified as CSHCN. CFHP has since found it more effective to have non-clinical staff do the initial assessment using the CSHCN Screener and have clinical staff follow up on positive screens.

Health Net

Health Net sought to increase identification of CSHCN by 10 percent through an outbound calling program to new members. State-provided Medicaid eligibility and demographic data do not provide information on CSHCN since most of the services for CSHCN are carved out of managed care in California. To more effectively identify CSHCN, Health Net implemented an automated version of the CSHCN Screener. Children found eligible for carve-out services still remain enrollees of the health plan, but gain access to extensive state services for CSHCN.

Figure 4: Health Net of California: Identification Improvements



Lovelace Community Health Plan

Lovelace developed an outbound calling program to remind new members about its welcome packet and incorporated the CSHCN Screener into these calls. The outbound calling program, combined with Lovelace's identification strategies, helped increase Lovelace's identification of CSHCN from 12 percent in 2001 to 21.3 percent in 2004.

³² See *A Model for Integrating Children with Special Health Care Needs into Medicaid Managed Care* in CHCS' online Resource Library at www.chcs.org.

Stratification



The Challenge:

How do health plans determine which children can benefit from interventions?

Stratification of children with special needs is challenging, in part because the children do not have a single disease or medical diagnosis and in part because the potential interventions vary widely. Some BCAP participants stratified CSHCN based on severity of illness to target them for intensive case management. Other plans used stratification to assess whether children, who often receive intense acute services, also were receiving EPSDT services or well-child care. Still other plans designed stratification systems to assess specific service needs for children, such as transportation services, transition services, or eligibility for additional services through publicly funded programs.

BCAP Solutions

to the Challenges of Effective Stratification

Several workgroup health plans experimented with existing clinical management software, while others developed home-grown stratification systems. A key theme that emerged was that stratification systems must carefully consider the demographics of the target population.

Workgroup participants generally found that using pre-packaged stratification systems, such as one developed for their commercial population or one that included SSI enrollees who were not enrolled in the health plan, often produced meaningless results. One of the reasons that adapting commercial software did not work for BCAP participants is that while most of these programs evaluate severity of illness from a clinical perspective, they often do not take into account all of the social issues that put some CSHCN at “higher risk” for adverse health outcomes due to poverty or family dysfunction.³³

In the end, most workgroup participants developed their own tools to stratify their special needs populations. During workgroup meetings, they shared criteria, borrowed ideas from colleagues, and modified stratification systems developed by their peers to suit the needs and demographics of their own organizations.

³³ Neighborhood Health Plan of Massachusetts had preliminary success with a commercial software package, but found that it generally captures more adults with special needs than children.



Stratification for Appropriate Case Management Assignment

Several health plans either developed algorithms or modified existing algorithms to stratify CSHCN into low-, medium-, and high-risk levels to determine appropriate case management assignments.

Maryland Physicians Care

Maryland Physicians Care revised its stratification of CSHCN to assign children to case management more effectively. MPC previously used claims data and case assessment questionnaire responses to stratify CSHCN. MPC found that these criteria missed children with chronic illness who might not be high users of services, but might need help in accessing primary care or school-based services. MPC created a new algorithm that stratifies members into three risk levels based on:

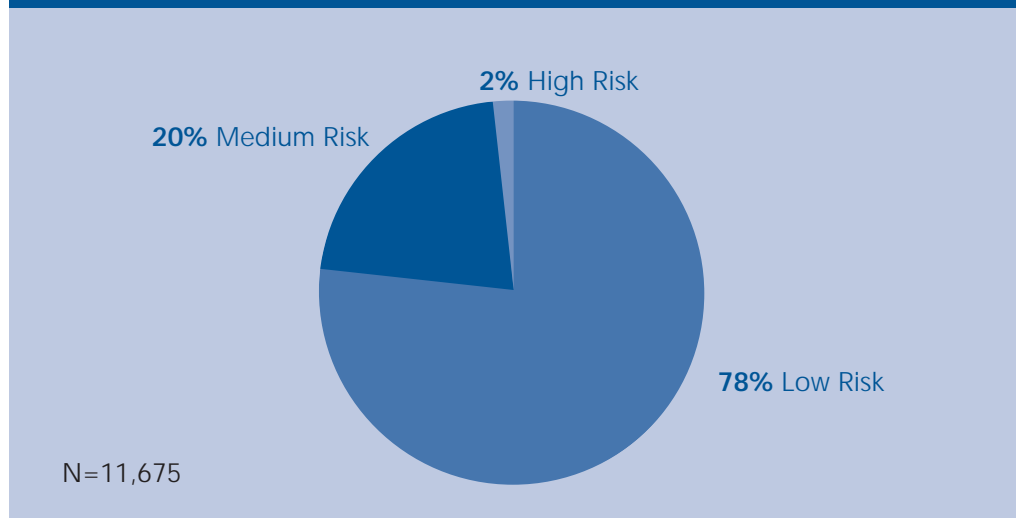
- Health status.
- PCP/specialist relationships.
- Access needs.
- Emergency room/inpatient utilization.
- Educational needs.

MPC incorporated a scoring system for ease of administration. In testing the new criteria on a pilot population, MPC found that some children were reassessed at a higher level. The tool has proven effective for appropriately assessing MPC's population.

Lovelace Community Health Plan

Lovelace originally used a stratification tool developed by its corporate affiliate for the commercial population. The plan found this tool was not sensitive to the severity of needs, particularly psychosocial needs, among its Medicaid members. Lovelace then developed an algorithm based on eight criteria designed specifically to enhance sensitivity to severity of illness within the Medicaid population. To date, out of 11,675 CSHCN, 78.1 percent are classified as low-risk, 19.7 percent as medium-risk, and 2.1 percent as high-risk. Overall, 2,452 children, those identified as medium- or high-risk, were referred to case management. Lovelace has used the algorithm for more than 18 months and believes that it accurately stratifies its Medicaid children into appropriate risk levels. Several of the other health plans in this BCAP workgroup, including Partnership HealthPlan of California and Molina Healthcare adapted modified versions of Lovelace's algorithm for their populations.

Figure 5: Lovelace Community Health Plan: Stratification of CSHCN



Stratification in Special Needs Plans

Two participants in this BCAP served only CSHCN. Because their members were pre-selected based on special needs status, identification of the population was not challenging for these plans. However, stratification of the population proved useful in determining the service needs of the population.

Medically Fragile Children's Program

The Medically Fragile Children's Program had a complexity of care stratification tool prior to BCAP participation.³⁴ This tool was unique in that it measures the complexity of care provided by parents in the home. MFCP sought to improve the tool and compare the results to service use. To do this, they tested the complexity tool with another special needs plan's population and found the results concordant with its own results. Conversely, MFCP tried applying the stratification criteria developed by other BCAP health plans to its population, but found that these tools were not effective since MFCP serves many more children with complex needs than other health plans.

To further enhance their efforts to compare the stratification tool with service use, and ultimately, outcomes, MFCP created an electronic database to track and analyze these parameters. The Medically Fragile Children's Program was awarded a grant from the Duke Endowment to support expansion efforts and to develop a web-based system to monitor cost, service utilization, and outcomes data.

Health Services for Children with Special Needs

HSCSN had two stratification goals: to assess the number of children in its program in need of EPSDT services and to enhance identification of members with active co-morbidities and assign them to the appropriate level of care management. The plan developed a stratification system that evaluates use of EPSDT services by members to identify children in need of these preventive services.

³⁴ The Medically Fragile Children's Program Level of Care Assessment tool is available in the online toolkit at www.chcs.org.

Outreach



The Challenge:

How does a health plan successfully reach members, families, and providers?

Communication with CSHCN, their families, and their providers is a critical component of an effective intervention. The need for effective communication is enhanced given the challenges of reaching the Medicaid population. Financial pressures can lead to housing instability or loss of telephone service. Frequent address or telephone number changes complicate health plan efforts to find and educate members.

Outreach is a crucial part of the BCAP Typology because work done in other typology categories depends heavily on successful outreach strategies. For example, Lovelace's outbound calling program demonstrates the use of an outreach technique to enhance identification of potential CSHCN among new members. Lovelace members were sent health risk assessment forms in the welcome packet. Lovelace then conducted follow-up calls to welcome new members to the health plan. During this call, Lovelace completed the health risk assessment and if the member identified any concerns, Lovelace routed the member to case management.

BCAP Solutions to the Challenges of Effective Outreach

Workgroup teams spread their messages through common vehicles such as newsletters and mailings, but also created innovative mechanisms for reaching the target population.³⁵

Member and provider outreach techniques used in this BCAP workgroup include:

- Surveys (discussed in Needs Assessment chapter).
- Outbound calling/inbound call tracking (discussed in Identification chapter).
- Use of enhanced member navigation tools.
- Enhancement of traditional provider outreach such as medical office visits, newsletters, or fact sheets to spread information about clinical needs and programs available for children with special needs.

Enhancing Member Navigation

Participants in this BCAP workgroup focused significant energy on enhancing member and provider navigation of services for CSHCN through the following outreach strategies:

- Creation of resource guides.
- Parent consultant serving as an advocate within the health plan.
- Distribution of parent notebooks (discussed in the Intervention chapter).
- Medical home initiatives (discussed in the Intervention chapter).

³⁵ Previous BCAP toolkits provide a variety of outreach strategies that can be adapted for multiple populations. These toolkits are available online at www.chcs.org.

Resource Guides

The participants in this BCAP workgroup found that one of the most needed services for members and providers was a list of resources available for CSHCN.³⁶ Parent surveys and focus groups indicated that families experienced difficulties accessing services. Similarly, providers often did not always know the extent of community resources available to CSHCN or how to access them.

Health Services for Children with Special Needs

HSCSN hired a former member to develop and create a community resource directory, which is online in a searchable database.³⁷ The directory contains a comprehensive list of agencies and community-based organizations across 44 categories of services or programs. A print copy of the directory was sent to key community partners. HSCSN received grant funding to print an abridged, user-friendly version of the directory for parents and additional funding from the District of Columbia Department of Health (its Medicaid agency) to produce all three versions (print, online, abridged) in Spanish. A survey of members and community partners revealed that 80 percent of survey respondents have used the directory and more than 90 percent of users rated the directory either good or excellent. Respondents indicated that the most useful resource listings were:

- Before and After School Care.
- Education/Tutors/Mentors.
- Mental Health.
- Day Care.
- Shelter/Housing.

Neighborhood Health Plan of Massachusetts

Neighborhood Health Plan of Massachusetts (NHPMA) built a “Smart Neighbor” resource guide on its website. Included in the searchable database are resources for CSHCN. Smart Neighbor provides brief descriptions of the resources listed and links to appropriate websites.³⁸ Since the Smart Neighbor site went live in 2002, it has received more than 25,000 hits and has a monthly average of 1,500-2,000 hits.

Parent Consultant

Neighborhood Health Plan of Massachusetts

NHPMA employs a parent consultant to more effectively serve CSHCN and their families. The parent consultant, a multi-lingual parent of a CSHCN, provides families with educational materials on the child’s illness, peer support, assistance in navigating health plan protocols, advocacy support for special education programs, and connections to community resources. The consultant also can help identify appropriate services and help the family navigate health plan policies regarding payment and utilization.³⁹ Referrals to the parent consultant typically come from health risk assessments, case managers, or the health plan medical director. Members also can self-refer or be referred by their providers. Participation in the program is voluntary for families.

³⁶ Workgroup health plans generally defined resources broadly and included information on health service providers, social service providers, educational programs, legal services, etc.

³⁷ The directory can be found at www.hscfoundation.org

³⁸ Smart Neighbor can be found at www.nhp.org.

³⁹ The parent consultant has no influence or involvement in benefit or coverage decisions.

The parent consultant demonstrates the value of having a non-clinician and a parent of a child with special needs as a member of the clinical team. A total of 143 families have benefited from the services of the parent consultant over the past three years. Parents have been open about their emotions and problems in caring for their child and the consultant has provided constructive assistance in dealing with educational issues.

An Advocate Who Knows the System: The Parent Consultant

Five-year-old Ben*, a member of Neighborhood Health Plan of Massachusetts participated in Massachusetts' Early Intervention Program (EIP). Ben has Pervasive Developmental Delay, which is considered one of the more mild and treatable forms of autism. When the state eliminated speech and occupational therapy services within EIP, NHPMA used a benefit exception to continue these services for a short period of time.



Unfortunately, when Ben was placed in a classroom for severely autistic children — an inappropriate setting for him — his verbal abilities declined and his mother withdrew him from the school after one month. While Ben's mother tried to find him a more appropriate school placement, she asked NHPMA to cover speech and occupational therapy services so that his skill levels would not deteriorate further. Ben's nurse case manager questioned why he was not receiving these services through the education system and referred the mother to the parent consultant for support.

Ben's mother told the parent consultant about her feelings of rejection and her perception that her child was not valued. She was overwhelmed with the stress of caring for a special needs child, of fighting for services for Ben, and coping with his diagnosis. The parent consultant concluded that the mother felt powerless and that her knowledge was inadequate to meet Ben's needs. The parent consultant worked with NHP's medical director to grant Ben a benefit exception for speech and occupational therapy until he was placed in an appropriate school setting. She helped the mother set goals for Ben, including getting the right school placement and scheduling a diagnostic re-evaluation. The parent consultant armed the mother with information about Ben's disorder, enlisted the help of a previously uninvolved father in Ben's care and education, and scheduled a Department of Education hearing to appeal the incorrect school placement.

Outcomes Include:

- The mother successfully appealed to change Ben's school placement to an appropriate school selected by both the mother and the father.
- The mother can run errands while Ben is at school and the father picks Ben up from school and is involved in his care.
- The mother is familiar with how to manage Pervasive Developmental Delay.
- Ben's primary care physician is re-evaluating his diagnosis of Pervasive Developmental Delay.

*Name changed for privacy.

Provider Outreach

Pediatricians or family practitioners may encounter challenges in serving children with special needs, such as reimbursement levels that are not adequate, or fears that if they become known for serving complex populations, they may end up with a large number of resource-intensive patients in their practice. Therefore, it is essential for health plans to reach out to providers and find out what they might need to better serve CSHCN. BCAP workgroup health plans found that surveying providers helped to pinpoint their concerns and identify appropriate resources to serve children with special needs.

Community First Health Plan of Texas

Community First conducted a survey of providers to determine their knowledge, skills, and desire to care for children with special needs. Based on the survey results, Community First implemented several outreach strategies to educate providers about issues related to caring for CSHCN, including:

- Placing articles about CSHCN in provider newsletters.
- Creating and distributing a generic care plan.
- Disseminating updates and assessments of the CSHCN program to designated PCPs.
- Revising provider manual to incorporate information on serving children with special needs.
- Developing an abridged community resource list (one-page, front to back) of available services for CSHCN and distributing it to providers.

Lovelace Community Health Plan

Lovelace used its provider relations staff to distribute fact sheets about CSHCN during routine provider office visits. These fact sheets also were placed in the provider newsletter. Lovelace's medical director also frequently met with provider groups across the state about available services for CSHCN, and created other venues to reach providers, such as participation in the New Mexico Medical Home Initiative.

Intervention



The Challenge:

What interventions can help improve care for CSHCN?

Ultimately, the purpose of the intervention is to improve the delivery of services to CSHCN and determine whether the changes implemented affect the child's outcomes or enhanced quality of life. This section outlines four types of interventions implemented by BCAP workgroup teams:

- Distribution of system navigation aids, including parent notebooks.
- Improvement of preventive care for children with special needs.
- Creation of comprehensive medical homes within provider practices.
- Creation of enhanced case management programs.

BCAP Solutions

to the Challenges of Effective Intervention

Parent Notebook Distribution and Education

While community resource guides provide contact information for external programs that might benefit CSHCN, a parent notebook helps families capture important information specific to their child's illness, medication, and hospitalization history. Because the complex array of services that CSHCN may need can be overwhelming, several health plans in this BCAP workgroup created, purchased, or adapted parent notebooks to distribute to families of CSHCN.

Access II Care

Access II Care created a parent notebook called *All About My Child*. The child's case manager meets with the parent and helps the parent complete the notebook with information from the child's medical record. The notebook allows parents to track the child's medical history, treatment plans, immunization history, and medication lists.⁴⁰

Having the special needs notebook has empowered me as a parent to be more involved in my child's medical care. I take the notebook with me to all of his medical appointments since the information is right there and organized, and it speeds up the time we spend at doctors' visits. It has prevented him from having duplicate tests several times.

— Tonya Proffitt, Parent of an Access II Care Member

⁴⁰ This parent notebook is available in the online toolkit at www.chcs.org

Lovelace Community Health Plan

Lovelace's parent notebook, a binder that the plan refers to as a personal medical record, is sent to all CSHCN who are considered high risk. It allows the caregiver or provider to complete information sheets that track emergency visits, specialist and PCP visits, immunizations, allergies, and vital signs.

Health Net of California

Health Net's parent notebook was distributed to parents of CSHCN at the provider group practice that was the pilot for Health Net's medical home initiative. Health Net used a parent notebook developed by the Los Angeles County Medical Home Project for CSHCN.⁴¹ This parent notebook, which is available in both English and Spanish, is divided into sections to organize information about the child's medical history, care coordination, medical home, and school. It also provides information on the regional center for children with developmental disabilities and community resources.

Partnership HealthPlan of California

Partnership developed a parent notebook that is available online in both English and Spanish.⁴² It includes a summary form to provide a brief overview of the child's diagnoses, allergies, medications, and developmental history. It also includes a section to record the child's health history as well as an encounter form for parents to take to the doctor's office to prompt questions and discussion.

Strategies to Improve Well-Child Care for CSHCN

While it is important to ensure access to specialists and appropriate tertiary care for children with special needs, it also is essential that health plans and providers ensure that CSHCN are receiving appropriate well-child and primary care. Several health plans in this BCAP developed interventions to improve well-child care rates.

Lovelace Community Health Plan

Lovelace developed an outbound calling program for CSHCN who need EPSDT exams. If the child was not scheduled for an EPSDT visit, health plan staff initiated a three-way conference call with the member and the provider's office to schedule an appointment. The outbound calling program made approximately 800 EPSDT calls per month.

Health Services for Children with Special Needs

HSCSN wanted to ensure that eligible children were receiving EPSDT visits and that providers were documenting EPSDT services appropriately. A review of 2001 utilization data revealed that more than 50 percent of members did not have EPSDT visits based on claims. HSCSN then conducted an outreach survey and concluded that 40 percent of these members had received EPSDT services.

⁴¹ This parent notebook can be found at: http://www.medicalhomela.org/all_about_me.htm

⁴² This parent notebook can be found in the online toolkit at www.chcs.org.



HSCSN approached the problem of poor documentation by enhancing provider contracting requirements for EPSDT documentation. In the third quarter of 2003, HSCSN built EPSDT performance standards into provider contracts. To date, 35 percent of provider contracts have been revised to require that 85 percent of a physician's panel have a documented EPSDT visit. These providers deliver 77 percent of all EPSDT services. A recent study by Mercer Consulting found that HSCSN members are getting more EPSDT visits than members of other Medicaid health plans in the area.⁴³

Partnership HealthPlan

Partnership's Health Plan Employer Data Information Set (HEDIS) goal was to achieve compliance for its well-infant, well-adolescent, and childhood immunization rates for CSHCN. Partnership monitored preventive care for CSHCN annually, emphasized the importance of preventive care to provider groups, and built in HEDIS monitoring as a key component of its medical home initiative. Partnership saw improvement in all three measures between 2002 and 2003: the plan's HEDIS rates for well-infant improved from 34 to 40 percent, well-adolescent from five to 27 percent, and childhood immunizations from 54 to 69 percent.

⁴³ This information was published in September 2004 in a report developed by Mercer Human Resource Consulting for the District of Columbia's Medical Assistance Administration.

Medical Home Initiatives

The Center for Medical Home Improvement defines a medical home as “a process of care offered by primary care providers in partnership with families of children with special needs. Children and families are recognized, welcomed, and supported by their community-based medical homes.”⁴⁴

Several BCAP participants developed medical home initiatives at pilot provider sites. Because CSHCN have multiple providers that manage particular aspects of their care, it is important for these children to have a medical home with a designated provider responsible for evaluating whether all of the child’s needs are being met appropriately.

Health Net found that implementation of its medical home was so successful that the original medical home site continued to fund the care coordinator even after grant funding from Health Net ended. Additionally, Health Net successfully replicated the medical home initiative with another provider office where 73 percent of the PCPs and office staff participated in training on the identification of CSHCN and referral to carve-out programs.

Health Net, Partnership HealthPlan of California, and Lovelace each implemented medical home initiatives. These initiatives are described in more detail in the case study section beginning on page 39.

Serving High-Risk Children with Special Needs

Medically Fragile Children’s Program

To assess needs, MFCP surveyed enrollees who either “aged out” of the program (upon reaching 21) or were discharged because they no longer met the medical criteria for the program. This evaluation revealed a significant need for community transition services. MFCP developed an intermediary care program for children with special needs who are disenrolled once their health stabilizes. This “step-down” approach assures continued quality of care for children who have left the plan. MFCP collaborated with several stakeholders, including the state Medicaid agency, to develop and implement a Step-Down program that includes primary care, lab tests and x-rays, medications, emergency care, case management, and durable medical equipment. MFCP contacted 100 percent of former enrollees about the program: 42 percent chose to enroll in the Step-Down Program.

⁴⁴ For more information about the Center for Medical Home Improvement, see www.medicalhomeimprovement.org.

Applying the BCAP Quality Framework: Health Plan Case Studies



The previous sections highlight this BCAP workgroup's leadership in advancing health care quality improvement initiatives for CSHCN. The workgroup's successes demonstrate that a quality improvement framework that works well for homogeneous populations (e.g., pregnant women) can be effectively adapted for complex populations. The efforts of the 12 workgroup teams resulted in the development of more effective tools for:

- Screening their pediatric population and determining risk and severity levels of their children with special needs.
- Engaging parents and families of children with special needs.
- Coordinating complex health and social services.
- Working with providers to develop comprehensive medical homes for children with special needs.
- Identifying appropriate interventions for children with special needs and getting children services in a timely manner.

An important component of the BCAP Quality Framework is tying the pieces together to create effective change. This chapter features case studies detailing pilot project activities from Needs Assessment to Intervention for the following health plans:

- Access II Care of Western North Carolina
- Health Net of California
- Lovelace Community Health Plan of New Mexico
- Partnership HealthPlan of California

I

Access II Care of Western North Carolina

Access II Care was formed to enhance Carolina ACCESS, North Carolina's primary care case management program. It is one of 13 provider-led community networks that collectively manage approximately 513,000 Medicaid enrollees. Access II Care serves seven (rural and urban) counties in Western North Carolina and has approximately 20,000 members. As a member of the BCAP workgroup, Access II Care's main objectives included streamlining case management services for CSHCN, designing a risk assessment tool for identifying high-risk CSHCN, incorporating community-based services into a medical home model, and providing interventions on proven case management techniques.

► NEEDS ASSESSMENT

Some CSHCN receive overlapping case management from multiple agencies, while other CSHCN lack case management assistance. To address this fragmentation, Access II Care conducted a needs assessment survey of existing state- or federally-funded community agencies that provide case management within its counties.

Twelve agencies, representing 19 case management programs, responded to the written needs assessment survey. Data gathered from the survey helped Access II Care assess:

- Existing mandates.
- Eligibility criteria.
- Funding sources.
- Case management processes.
- Overlapping services.

Of the 12 agencies, two mainly serve adults and two are no longer funded. The remaining eight agencies agreed to participate in a case management workgroup to create streamlined care processes for CSHCN. Nearly two years after its inception, representatives from all eight agencies still participate in the group.

The case management workgroup reviewed each program's assessment forms with the goal of streamlining paperwork. The workgroup's initial accomplishments included:

- Developing and adopting written case management protocols.⁴⁵
- Developing a web-based case management program that allows Access II Care to cross reference children with available data.

⁴⁵ Access II Care's case management protocols are available in the online toolkit at www.chcs.org.

I

Access II Care of Western North Carolina

► IDENTIFICATION

Access II Care sought to change its method of identification because it had no systematic screening tool to identify or stratify CSHCN to target resources for those at highest risk. Access II Care implemented a modified version of the CSHCN Screener at a pilot PCP site. The modified screener uses a scoring system to identify children at different risk levels. Access II Care set a goal to screen 40 percent of all the PCP's Medicaid pediatric patients.

Access II Care distributed the CSHCN Screener in its pilot PCP office. The parent completed the screening tool while waiting in the exam room. The provider reviewed the screen to assess the child's risk level. Children with a score of 1-7 were considered CSHCN and those with a score of 1-4 were referred to case management.

Access II Care tracked screening rates each quarter and the practice screened 27-28 percent of its assigned Medicaid population each quarter. In 2004, two new practices in the county joined the project and used the screener.

Though Access II Care used the CSHCN Screener for more than two years and spread use to three pediatric practices, the plan ultimately found that the time investment in provider training, data collection, and data entry was prohibitive. Barriers to reaching a higher screening rate include provider buy-in, Medicaid enrollment turnover, and use of emergency rooms rather than the PCP for primary care.

Aim:

To screen 40 percent of all Medicaid pediatric patients, age 0-20, assigned to the pilot PCP site with the CSHCN Screener.

Measure:

of Medicaid patients age 0-20 screened

of Medicaid patients age 0-20 assigned

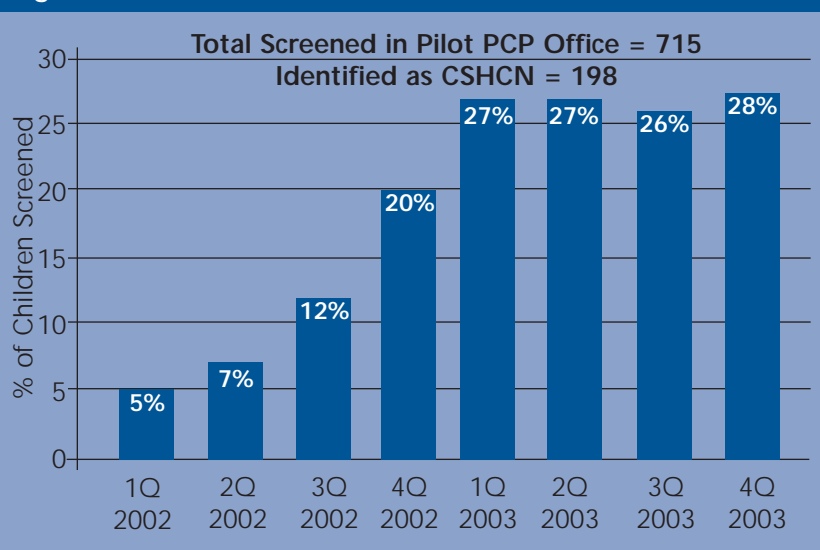
Change:

Access II Care used a modified version of the CSHCN Screener in its pilot PCP office. The tool was modified to incorporate a scoring system of 1-7 (1 is the highest, 7 in the lowest). Children with a score of 1-7 were considered CSHCN, but children with a score of 1-4 have more severe needs and were referred to case management.

Results:

The practice generally screened between 27-28 percent of the pilot PCP's assigned Medicaid population quarterly. The screening initiative spread to two additional provider practices, but was abandoned for a more comprehensive claims profile that identified and stratified CSHCN.

Figure 6: Access II Care Children Screened 2002-2003



► STRATIFICATION

Prior to participating in BCAP, Access II Care used SSI eligibility to identify CSHCN and did not stratify children's risk levels. Access II Care added a scoring component to the CSHCN Screener that stratifies the population based on severity levels. All children receiving a score of 1-4 were considered children with moderate to severe special needs.

Each child screened is entered into a web-based case management program developed by North Carolina's PCCM provider-led community network. This case management program allows Access II Care to cross reference children with the following data:

Aim:

To increase the number of children identified and stratified as CSHCN by assigning a stratification component to the CSHCN Screener and comparing the result to the child's Medicaid program status.

Measure:

$$\frac{\# \text{ of children with a score of 1-4 via the CSHCN Screener}}{\# \text{ of children identified as special needs based on Medicaid SSI criteria}}$$

Change:

Access II Care evaluates the scores of all children identified as CSHCN via the CSHCN Screener and uses a scoring system to stratify them. The plan then compares this result to the number of CSHCN identified based on Medicaid program status.

Results:

Through the pilot modifications, an additional 671 children were identified and stratified (beyond just SSI eligibility). Prior to implementation of the CSHCN Screener, only about 11 percent of these children were previously identified based on Medicaid SSI criteria. The scoring system and cross-reference with other case management systems led to a 300 percent increase in identification of children with special needs.

- The CSHCN Screener.
- State enrollment data that includes Medicaid program category (SSI).
- Claims data.
- Disease management registries for asthma and diabetes.
- Real-time inpatient and emergency room data.

Through the workgroup, the statewide computer system was enhanced to display all paid claims for case management services billed to Medicaid. This feature is now available to all 13 PCCM networks across North Carolina.

Of all the children who have been screened to date, only 11 percent were previously identified as a child with special needs based on SSI eligibility. The remaining 89 percent of identified children with special needs (an additional 671 chil-

dren) represent almost \$3.2 million in Medicaid expenditures per year.

As mentioned in Identification, Access II Care recently abandoned use of the CSHCN Screener because the time investment in provider training, data collection, and data entry was prohibitive. To create an automated stratification system, Access II Care used completed screening forms to develop a claims utilization profile of CSHCN. Claims profiling allows Access II Care to expand screening to its entire network instead of just working with the three pediatric clinics that pilot-tested the CSHCN Screener.

I

Access II Care of Western North Carolina

▶ OUTREACH

To enhance effective coordination and reduce expenditures, Access II Care assigned lead case managers to children who were most in need of services. Access II Care determined that all who scored positive on the CSHCN Screener (score of 1-4) would receive a phone call, home visit, and/or letter from a case manager.

Access II Care identified 198 children in need of an outreach contact. For those identified:

- The case management workgroup met monthly and determined which agency should provide lead case management services based on each child's needs.
- The lead case manager called the family to tell them about services available to the child and assisted them with coordination of services across multiple agencies.
- The case management workgroup assigned lead case managers and contacted families who were not receiving services to offer assistance.

Aim:

To provide an outreach contact to 100 percent of CSHCN identified through the CSHCN Screener with a score of 1-4.

Measure:

$$\frac{\text{\# of CSHCN with case management contact}}{\text{\# of CSHCN identified with a score between 1 and 4}}$$

Change:

To improve outreach to identified CSHCN, Access II Care:

- Provided case management outreach to high-risk CSHCN via a combination of home visits, phone calls, and letters.
- Coordinated care with the different case management organizations to provide a more targeted approach to care.

Results:

A total of 198 children were identified with a score of 1-4 on the CSHCN Screener. Of those, 170 (93 percent) had an outreach contact from their lead case manager.

Access II Care also expanded this program to include children who may not have been identified via the CSHCN Screener, but appeared to be high- or medium-risk based on claims analysis.

To enhance outreach, Access II Care published an article in the local parent support network's quarterly newsletter. This article prompted calls from both providers and parents for a copy of the resource guide, *All About My Child*. Additionally, the lead physician involved in Access II Care's BCAP project wrote an article for the county medical society newsletter to inform local providers about their work serving children with special needs.

I

Access II Care of Western North Carolina

► INTERVENTION

Access II Care's intervention was to ensure that children with the most severe needs have a written protocol coordinating case management with their primary care practice. Based on information received from case managers, providers, parents, and local organizations, the community special needs coordinator created a uniform CSHCN case management protocol for providers and case managers.⁴⁶ The protocol was adopted by seven of the eight agencies in the case management workgroup, including the Buncombe County Health Department and Department of Social Services; Head Start; the regional mental health agency; the Infant Toddler Program; Mission Hospital; and Access II Care.

With the assistance of the case management workgroup, the special needs coordinator at Access II Care also developed *All About My Child*, a resource notebook for parents, PCPs, and care managers to document and track information about CSHCN. The notebook provides detailed information regarding patient history, pharmaceutical information, and resources. Case managers spend significant time with the family gathering the child's medical history and entering it into the notebook.

Parents bring the notebook to office visits and PCPs and case managers write information about the care received by the child. This notebook helps parents stay aware of the child's needs and ensures that providers are updated regarding the child's care.

While only 22 forms have been returned with signed protocols, Access II Care estimates that several hundred notebooks have been distributed via community partners in the case management workgroup. Community partners expressed reluctance in having parents sign and return protocols, so Access II Care allowed these partners to distribute the notebook without collecting the paperwork. Access II Care also reports that case managers in other counties are using the notebook as well.

Aim:

- 1) To ensure that 100 percent of children with the most severe needs (those scoring a 4 on the CSHCN Screener and with an assigned lead case manager) have a case management protocol in their medical record.
- 2) To ensure that 100 percent of CSHCN deemed at highest risk by lead case managers will have a parent resource notebook.

Measure:

$$\frac{\# \text{ of CSHCN with written case management protocol}}{\# \text{ of CSHCN with score of 4 and assignment to lead case manager}}$$

$$\frac{\# \text{ of CSHCN with parent resource notebook}}{\# \text{ of CSHCN with score of 4 and assignment to lead case manager}}$$

Change:

Access II Care developed a case management protocol to assist parents, case managers, and PCPs with documentation and tracking of CSHCN care. Additionally, based on feedback from community organizations, with the assistance of the community special needs coordinator, Access II Care created *All About My Child*, a parent resource notebook

Results:

Measure 1: Forty-five percent (10/22) of children with highest risk have signed protocols in the medical record. As a next step, Access II Care is currently designing a web-based case management care plan. Initially, the protocol will be used by the four state-funded programs in the case management workgroup. With additional funding and appropriate HIPAA protocols, Access II Care hopes to expand use to all agencies involved in serving children with special needs.

Measure 2: Eighty-six percent (19/22) of children with highest risk received a parent resource notebook.

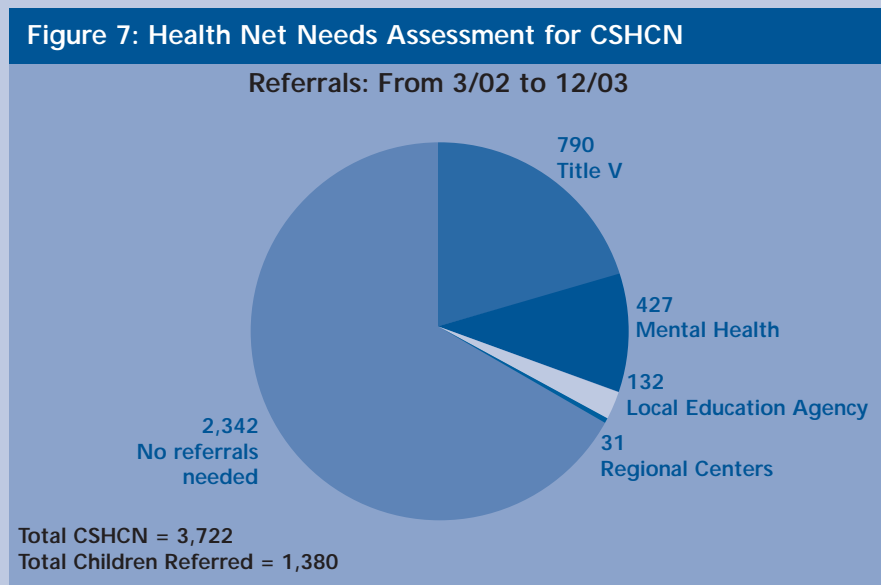
⁴⁶ A copy of the case management protocol and *All About My Child* can be found in the online toolkit at www.chcs.org.

Health Net is California's largest network model health plan, serving more than 2.8 million members, including 690,639 Medicaid and SCHIP members. While children with special needs on Medicaid are included in managed care, the California Department of Health Services carves out the majority of specialized services for these children. These services include mental health, dental care, Local Education Agency services, and California Children's Services, which provides services for children with certain acute or chronic, physically disabling conditions, and regional centers that care for the developmentally disabled. Health Net is responsible for identifying and referring children to these programs. Health Net's overall pilot project objective was to enhance early and complete identification at multiple levels (including health plan, physician group, and doctor's office) and to empower families to use available resources through the creation of a medical home. This case study highlights Health Net's comprehensive program for serving children with special needs.

► NEEDS ASSESSMENT

The vast majority of Health Net's enrollees were in fee-for-service Medicaid prior to enrollment. Very little data is given to the plan upon enrollment about whether the member is connected to carve-out programs. Health Net used its outbound calling program to assess which new enrollees need referrals to these programs or were already receiving services from these carved-out programs. Health Net found that the greatest gaps exist for children with chronic medical conditions and mental health services.

By modifying the outbound calling system with the CSHCN Screener, Health Net identified and referred children to the services that could most appropriately meet their needs. Of the 3,722 children with special needs identified as of December 2003, 1,380 had unmet needs: 790 (21.2 percent) had chronic medical conditions and were referred to Title V programs; 427 (11.5 percent) were referred to mental health programs; 31 (1 percent) were referred to regional centers; and 132 children (3.5 percent) were referred to Local Education Agency services. The additional referrals enhanced care coordination between the plan and the carved-out programs, and decreased fragmentation of care and duplication of services.



► IDENTIFICATION

To improve identification of CSHCN, Health Net implemented the CSHCN Screener as part of a new outbound calling program to new families with children 0 to 21 years of age. Previous identification methods captured less than one percent of children who met the criteria for California's public health carve-out programs. Through its outbound calling program, Health Net set a goal to increase identification of CSHCN by 10 percent within 12 months. Health Net modified the tool to better suit the plan's population and needs by adding questions specific to California's complex delivery system and training bilingual member relations staff to translate the instrument into the member's spoken language. Using the new tool and bilingual staff, Health Net's identification rate of CSHCN was consistently about 18 percent of new pediatric members.

Aim:

To increase identification of CSHCN by 10 percent within 12 months through an outbound calling program.

Measure:

$$\frac{\# \text{ of CSHCN identified via the CSHCN Screener}}{\# \text{ of successful outbound calls to new families with children age 0 to 21}}$$

Change:

Over an eight-month period, Health Net went through the following cycles of change to improve administrative processes to identify CSHCN:

- **Cycle 1:** Health Net added the CSHCN Screener to its existing scripted outbound calling system.
- **Cycle 2:** The CSHCN Screener and Health Net's outbound calling script were modified to serve a broader population.
- **Cycle 3:** The CSHCN Screener was automated using an Access database, allowing for real-time data input and customizable tracking reports for CSHCN. The Access database includes a scoring system based on the caregiver's responses to questions in the CSHCN Screener.
- **Cycle 4:** Database was modified to determine if member needs link to carve-out programs.

Results:

The implementation of the CSHCN Screener has helped Health Net maintain an average monthly identification rate of 18 percent.

Health assessment coordinators, who have clinical pediatric backgrounds, followed up with positive screens. This model was extremely effective, allowing clinical staff to devote attention to children who were pre-screened by member services staff. Health assessment coordinators also initiated care coordination between the medical home provider and the carved-out program's providers and case managers.

► STRATIFICATION

Health Net's goal was to develop an intensity of service/acuity tool to help providers determine appropriate services for CSHCN. Health Net worked with a pilot provider site to test a secondary screening and referral tool. Use of the tool helped Health Net track referrals to carve-out services. The tool catalogues unmet needs by type of carve-out and can be used to identify patterns of under-utilization.

Stratification also was tracked through monitoring of referrals generated by the out-bound calling program. Health Net stratified into the following categories to determine appropriate referrals to carve-out programs:

- **Chronic Physical Conditions** were carved out to California Children's Services Program.
- **Developmental Disabilities** were carved out to regional centers.
- **Behavioral or Emotional Conditions** were carved out to the local mental health plan and/or substance abuse treatment programs.
- **Additional Services** were provided from the Local Education Agency.

Aim:

To stratify at least 50 percent of CSHCN at the pilot sites and make appropriate referrals by applying the secondary screening and referral tool.

Measure:

$$\frac{\# \text{ of CSHCN referred to carve-outs based on stratification with secondary screening and referral tool}}{\# \text{ of CSHCN at the pilot site}}$$

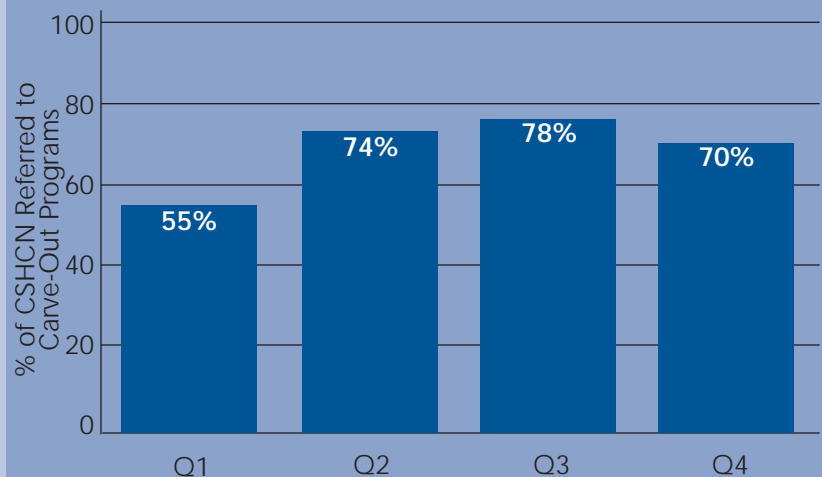
Change:

Health Net pilot tested the tool for five days at a pediatric site. They then began implementing it regularly and expanded its use to a second provider site.

Results:

More than 1,000 children were screened in 2003 using the secondary screener at the two pilot provider sites. A large portion of the children screened had unmet needs and were subsequently referred to carve-out programs. The most frequent unmet need was behavioral health.

Figure 8: 2003 Stratification of CSHCN at Two Provider Sites Using Secondary Screener



► OUTREACH AND INTERVENTION

Health Net's outreach and intervention components are tightly linked. Health Net piloted a project to offer an enhanced medical home to CSHCN at one of its largest provider sites, which provides health care for more than 48,000 Health Net Medicaid and SCHIP members. Health Net awarded a grant to the practice to pay for the start-up costs of implementing the medical home. The site hired a health coordinator to provide on-site care coordination, conduct family education sessions, and distribute a parent notebook created by the Los Angeles Medical Home Project for CSHCN.⁴⁷

Outreach Aim:

To provide an outreach contact to at least 75 percent of parents of CSHCN.

Measure:

$\frac{\# \text{ of families successfully contacted}}{\# \text{ of families with CSHCN at pilot sites}}$

Change:

Families were contacted either by phone, mail, or on site during the office visit.

Results:

The initial provider site had an average contact rate of 47 percent in 2003 (the last two quarters were markedly improved from the first two quarters). The second provider site had an average contact rate of 75 percent in 2003.

Intervention Aim:

To provide at least 75 percent of families with CSHCN at pilot sites with parent notebook for CSHCN.

Measure:

$\frac{\# \text{ of parent notebooks given to families}}{\# \text{ of families with CSHCN at pilot sites}}$

Change:

To improve distribution of parent notebooks, Health Net piloted the following changes:

Cycle 1: Family Voices, a national advocacy group for parents of CSHCN, conducted training on the use of the parent notebook at the medical home pilot site.

Cycle 2: Changed from group training to individual parent training by the care coordinator.

Results:

Health Net found it difficult to distribute the parent notebook at the medical home pilot site. During the first seven months, 83 parent notebooks were distributed at this site. Health Net redirected its focus by sending specific program information to each family with an identified CSHCN. Examples of information mailed include materials on Title V, mental health, regional center, and school services.

Although grant funding to the pilot site ceased, the medical group continues to fund the program because it recognizes the value of the health coordinator in facilitating links to carve-out programs and serving as an advocate for CSHCN and their families.

Health Net expanded the pilot to a second provider site. By involving management in the initial planning stages, Health Net found that buy-in and commitment was even higher at the second site than the first one. Health Net also realized the value of hiring an RN with clinical expertise as the care coordinator. At the first site, the care coordinator did not have a clinical background, which made it difficult for families to understand specific medical information related to carved-out services. The first pilot site served 508 children with special needs in 2003, while the second pilot site served 802 children with special needs.

Health Net redirected its outreach efforts based on the lessons learned from the first medical home pilot project. Health Net changed from distributing parent notebooks at the provider site to offering hands-on care coordination at the medical group. Outreach by the medical group care coordinator was a more effective method to conduct outreach with families and provide written materi-

als based on the child's specific needs. At the plan level, the Health Assessment Coordinators conducted outreach to families, provided educational information, distributed materials on available carve-out programs, facilitated connections to community resources, and assisted with appointments and referrals.

⁴⁷ For more information on the LA Medical Home Project for CSHCN see www.medicalhomela.org. Copies of the parent notebook can be downloaded from the site.

Lovelace Community Health Plan serves 68,500 Medicaid and SCHIP enrollees in New Mexico. The goal of its BCAP pilot was to enhance health plan support of CSHCN, their families, and their providers. Lovelace implemented a multi-pronged approach that included gathering feedback from members about the services that Lovelace provides to CSHCN, employing multiple strategies to enhance identification, developing a new stratification algorithm to classify CSHCN by risk levels, and working with the New Mexico Medical Home Initiative to enhance clinical care for this population.

► NEEDS ASSESSMENT

Getting member input can be a challenging and time consuming process. Lovelace Community Health Plan used focus groups to obtain consumer feedback to identify barriers to care and opportunities for improvement. As outlined below, it took several cycles for the health plan to find an effective system for conducting the sessions.

Cycle 1: Hired facilitators to run focus groups. This was not successful because it was time-consuming for health plan staff to educate facilitators about what information was needed. The facilitator only allowed one health plan staff member to attend sessions, and did not allow health plan staff to redirect the focus group if it deviated from the stated purpose.

Cycle 2: Developed focus groups within existing advocacy groups. Although this was helpful for building relationships with community groups, it was difficult to get the group to address problems or challenges that Lovelace could change and improve.

Cycle 3: Developed focus groups facilitated by outreach staff. Although time-consuming, this was the most effective way for Lovelace to get information from members.

Cycle 4: Expanded focus groups statewide and redesigned existing Consumer Advisory Board to function more like a focus group. Lovelace sent three reminders to families prior to each meeting. Child care and transportation were provided, if needed. Participants received a \$10 Wal-Mart gift certificate for participation.

To date, 20 focus groups have been conducted. Out of 400 consumers who attended, nearly 100 percent found the focus groups effective. Lovelace staff believe the reason for the extremely high satisfaction rate was that Lovelace staff spent significant time following up on issues raised. Even if issues could not be resolved as the consumer had hoped, the efforts made by staff were appreciated and consumers felt their voices were heard.

► IDENTIFICATION

Prior to BCAP, 12 percent of Lovelace's pediatric population was identified as CSHCN using the MCHB definition. Yet, the MCHB definition suggests that 13-18 percent of Lovelace's pediatric population should be classified as CSHCN. Lovelace employed multiple strategies to improve its identification.

Lovelace first compared the ICD-9 list developed by CAHMI with its (former) parent company's high-risk pediatric codes and a list provided by California Medicaid. A claims query revealed that more than 50 percent of high-cost pediatric cases were not previously identified using just the ICD-9 codes. Subsequently, additional codes were added to Lovelace's list. Additionally, Lovelace began to collect data on other potential CSHCN as identified through referrals, member services, case management, utilization review, health risk assessment forms, etc.

Aim:

To increase identification of CSHCN to 15-18 percent of the pediatric population.

Measure:

$\frac{\# \text{ of CSHCN identified}}{\text{Total Medicaid enrollment under age 21}}$

Change:

To increase identification of CSHCN, Lovelace used the following strategies:

- Used CSHCN Screener during outbound welcome calls.
- Added member health risk assessments.
- Streamlined referrals of CSHCN from other departments to case management.
- Put CSHCN flag on health plan internal database.
- Added ICD-9 codes to the claims query for CSHCN.

Results:

Lovelace's identification rate increased from 12 percent in 2001 to 21.3 percent in 2004.

Lovelace sent all new members a welcome packet that included a health risk assessment form. If the member completed it and any issues were identified, the forms were routed to case management.

Cycle 1: To increase identification of CSHCN, Lovelace began an outbound calling program to remind new members to complete the health risk assessment. This was not effective because members still did not return forms.

Cycle 2: During the outbound call, member services representatives completed the CSHCN Screener and routed positive screens to case management for follow up.

The outbound calling program, combined with the modifications in Cycle 2, increased Lovelace's identification of children with special needs from 12 percent to 21.3 percent. While this prevalence rate is higher than the MCHB definition, it is consistent with other health plans in New Mexico. All children identified were referred to case management.

► STRATIFICATION

Lovelace used stratification to determine which children with special needs would be most appropriate for case management. The plan implemented an algorithm to stratify children with special needs into low-, medium-, and high-risk.

Cycle 1: Lovelace adapted a case management tool created for its corporate affiliate's commercial product. Medicaid case managers used it for two months and found that it was time consuming and ineffective for the Medicaid population. Additionally, nearly all children identified as children with special needs in the Medicaid population were classified as high-risk when using the tool.

Cycle 2: Lovelace developed an algorithm that reviews claims from the previous rolling calendar year. The algorithm uses the following eight criteria that are sensitive to the Medicaid population:

Aim:

To stratify 100 percent of CSHCN into three groups: high-, medium-, and low-risk to appropriately determine referrals to case management.

Measure:

$$\frac{\# \text{ of CSHCN stratified as high-, medium-, or low-risk}}{\text{Total \# of CSHCN}}$$

Change:

Cycle 1: Adapt commercial case management tool for Medicaid.

Cycle 2: Develop algorithm more appropriate for the Medicaid population that uses eight criteria (each worth one point) to stratify children as follows:

- Children with 0-2 points are low-risk.
- Children with 3-6 points are medium-risk.
- Children with 7+ points are high-risk.
- Children with 3 points and above are referred to case management.

Results:

To date, out of 11,675 CSHCN, 78.1 percent are classified as low-risk, 19.7 percent as medium-risk, and 2.1 percent as high-risk. Overall, 2,452 children have been referred to case management with three points or more.

- Emergency room visits: One or more per quarter.
- Acute hospital stay (behavioral or physical): One or more per quarter.
- Nine or more prescriptions per month.
- Durable medical equipment: More than \$250 per year.
- Residential treatment center admissions based on specific revenue codes.
- High-dollar cases based on reinsurance criteria.
- Private duty nursing based on CPT codes.
- Identified ICD-9 codes.

Each criterion was worth one point. It is possible to be a child with special needs and not have any points (e.g., a child identified through a waiver code but with no identified illness through the ICD-9 code list). All identified children with special needs were run through the criteria each quarter. Lovelace's Medical Economics Department validated the children classified as high-risk and confirmed that the algorithm appropriately captured all CSHCN who were high-risk.

► OUTREACH

Lovelace's outreach goal was to offer frequent educational updates about CSHCN to providers. Fact sheets on children with special needs were created to distill complex information in an easy-to-read bulleted format. Lovelace's provider relations representatives distributed these fact sheets during regularly scheduled meetings. One drawback of the strategy was the lack of face time with physicians – typically Lovelace's provider representatives meet with clinic directors and not individual physicians. The clinic directors received materials, but it was unclear whether information reached physicians. Because of this, Lovelace decided to add a special section of the provider manual focused on CSHCN.

To bolster physician outreach, Lovelace created additional outreach channels to reach providers. For example, the plan began working with the New Mexico Medical Home Initiative. As part of this collaboration, Lovelace's medical director spoke with multiple provider groups on the advantages of becoming medical home providers.

Aim:

To educate 100 percent of pediatric providers on CSHCN.

Measure:

of PCPs who received and read fact sheet on CSHCN
of PCPs visited by provider network representatives

Change:

To enhance its visibility, Lovelace developed a one-page fact sheet that was distributed quarterly during provider representative practice visits and also was published in the provider newsletter and posted on the provider section of the plan's website.

Results:

Lovelace found it difficult to determine whether providers were actually using the information in the fact sheets. As a result, Lovelace created other venues for reaching providers, such as the New Mexico Medical Home Initiative. Additionally, in collaboration with the New Mexico Medical Home Initiative, Lovelace's medical director traveled the state to meet with provider groups about serving children with special needs.

Lovelace indicates a modest improvement in the number of pediatric providers that refer children to case management and use case management for assistance with their CSHCN.

► INTERVENTION

Lovelace's intervention goal was to have all high-risk children with special needs receive a personal medical record. Lovelace assessed various formats for personal medical records, including personal medical record samples from the California Medical Home Project, New Mexico Parents Reaching Out, and other Medicaid health plans. Lovelace ultimately designed its own personal medical record, but incorporated many elements from the other designs. Multiple drafts were reviewed and evaluated and Lovelace used its provider and member focus groups to review the final draft.

The caregiver or provider completes information sheets for the binder that detail the child's medication use, emergency room visits, specialist visits, immunizations, allergies, PCP visits, home care visits, and vital signs. A key feature of the Lovelace personal medical record is a plastic sleeve for storing business cards that helps parents organize provider contact information.

Aim:

To provide 100 percent of children stratified as high-risk with personal medical record for parental use.

Measure:

$$\frac{\text{\# of CSHCN who receive the personal medical record}}{\text{\# of CSHCN stratified as high-risk}}$$

Change:

Lovelace produced 1,000 personal medical record binders to distribute to children with special needs who are stratified at high risk.

Results:

A total of 235 CSHCN were classified as high-risk and 150 notebooks were distributed. Although this only represents 65 percent of the plan's high-risk children, Lovelace found that most of the remaining families already have a personal medical record or parent notebook from other sources.

Partnership HealthPlan of California is a Medicaid health plan serving 82,500 members in Solano, Napa, and Yolo counties in Northern California. Partnership case manages children classified as “special members,” including those with chronic conditions, children in California Children’s Services (Title V), and out-of-county foster care. Fifteen percent of all children in the health plan are children with special needs and of these, approximately 32 percent are “special members.”

Partnership’s overall BCAP objective was to create medical homes to streamline care for CSHCN and provide comprehensive resources for families of these children.

► NEEDS ASSESSMENT

Prior to participation in BCAP, Partnership did not have a formal process for assessing needs of CSHCN and their families. To address this, Partnership applied for and received a grant from The California HealthCare Foundation to form a local coalition to develop medical homes for CSHCN. Working closely with coalition members, including individuals from practice organizations, medical groups, county health agencies, and many others, Partnership developed a thorough needs assessment survey modeled on the 2002 CAHPS survey.⁴⁸ The parents’ needs assessment survey was translated into Partnership’s most common languages, including Spanish and Russian, and was mailed to 1,429 CSHCN families in November 2002.⁴⁹

Partnership achieved a 19 percent response rate and received valuable information to help shape the Medical Home Project. Approximately 73.3 percent of parents responding indicated that they would like to receive a written care plan from their child’s doctors. The survey also validated the importance of care coordination for equipment, therapy, and pharmacy.

Partnership began routine discussions with medical home coalition members to foster communication between parents and providers. Partnership, its parent partners, and other coalition members, decided that it would be beneficial for parents to have a resource notebook to record their questions, concerns, and information presented by their PCPs. Additionally, PCPs would have the opportunity to provide members with written care plans through this process.

⁴⁸ CAHPS®, developed by the Agency for Healthcare Research and Quality, offers tools to help consumers and purchasers assess and choose among health plans. For more information, visit <http://www.ahrq.gov/qual/cahpfact.htm>.

⁴⁹ Partnership’s needs assessment survey is available in the online toolkit at www.chcs.org

► IDENTIFICATION

Partnership's existing identification and stratification methods were not screening CSHCN adequately. Prior to BCAP participation, CSHCN were identified using the Balanced Budget Act definition. With a baseline prevalence of 10 percent in 2001, Partnership estimated that this only captured 60 percent of CSHCN. In its BCAP project, Partnership aimed to identify 100 percent of its CSHCN population by enhancing its identification mechanisms and by creating a new registry for all of its CSHCN.

Partnership's BCAP pilot developed a registry using the BBA aid codes and Title V children. Partnership added selected diagnoses and information on service utilization to

Aim:

To identify 100 percent of Partnership's CSHCN.

Measure:

Compare the percentage of CSHCN age 0 to 21 with prevalence rate established by the Maternal and Child Health Bureau to determine if Partnership's existing identification methods were adequate.

$$\frac{\# \text{ of children identified using the BBA definition} + \text{select diagnoses} + \text{service utilization criteria}}{\# \text{ of members age 0 to 21}}$$

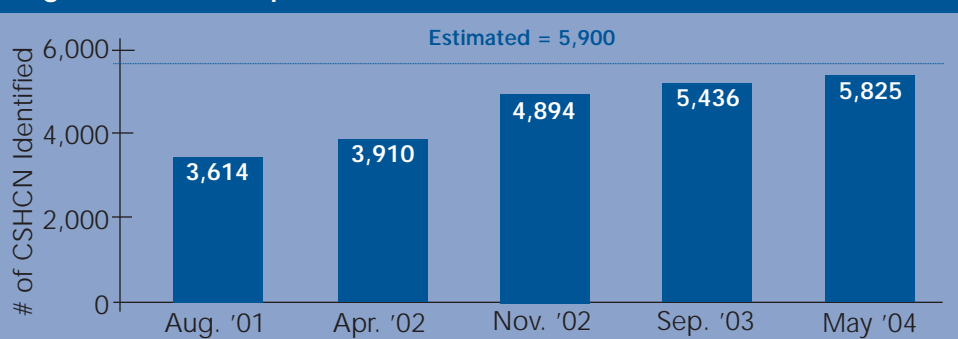
Change:

- Identify all children 0 to 21 who meet the BBA definition and enter into registry.
- Develop a methodology to identify additional children using select diagnoses.

Results:

Initially, Partnership identified 3,614 CSHCN using BBA aid codes and adding California Children's Services (Title V) children, which was a 10 percent prevalence rate. By December 2003, Partnership achieved a prevalence rate of 15 percent, which falls within the Maternal and Child Health Bureau definition.

Figure 9: Partnership CSHCN Identified vs. Estimated



improve identification of CSHCN. Partnership plans to continue revising the registry until it accurately identifies 100 percent of the plan's CSHCN population. Partnership assumes a prevalence rate between 13 and 18 percent based on the Maternal and Child Health Bureau's definition of CSHCN. Improvements have been notable, as Partnership has already identified 5,825 CSHCN members, which is a 61 percent increase from the original baseline figure of 3,614 individuals. As of December 2003, Partnership's registry remains stable with 15 percent of all Partnership children under age 21 identified as having special health care needs.

► STRATIFICATION

Partnership's goal was to validate that 80 percent of CSHCN were stratified accurately using the Burden of Illness (BOI)⁵⁰ system compared to an assessment completed by the medical home provider. This stratification example illustrates the benefit of using rapid cycle improvement to quickly test and modify change strategies.

Partnership determined levels of acuity based on the Burden of Illness scale by examining clinical data for different score levels. A separate assessment tool was created for providers to assign severity and acuity levels.

While the BOI was in the testing phase, it was discovered that the BOI system was not reflective of the total health status of children. A comparison of the two systems found that 56 percent of identified CSHCN had a Burden of Illness score of zero. This was not compatible with claims and utilization data for this population, which indicated a high use of services.

Aim:

To validate that 80 percent of CSHCN are stratified accurately using the BOI scale compared to a provider assessment.

Measure:

of CSHCN stratified at the same level using BOI and provider assessment

of CSHCN stratified using both methods

Change:

Partnership implemented the following cycles of change:

Cycle 1: Incorporate BOI scale.

Cycle 2: Compare to provider assessment.

Cycle 3: BOI does not match provider assessment.

Nearly 60 percent of identified CSHCN had a BOI of zero.

Cycle 4: After hearing Lovelace's presentation on its stratification method, Partnership decided to pursue a similar approach.

Results:

By adapting Lovelace's stratification approach and using utilization data to assign risk levels, Partnership stratified the population with the following results for the 5,825 identified CSHCN:

- Highest risk = 8 percent
- Moderate risk = 26 percent
- Lowest risk = 66 percent

Through this exercise, Partnership concluded that using the BOI system to assign acuity levels was not appropriate for the plan's population. Partnership instead pursued stratification methods based on utilization and ICD-9 codes such as the one created by Lovelace Community Health Plan.

⁵⁰ The Burden of Illness is a summary measure of patient illness severity developed as part of CaseAlert, a case management software developed by MEDecision. For more information, see www.medecision.com.

► OUTREACH

Of the 3,614 CSHCN identified at baseline, 1,156 (32 percent) were not assigned to a PCP. Most of these were Title V children who are not usually assigned to a PCP. Since Partnership does outreach through practice sites by giving them lists of their assigned CSHCN, the outreach goal was to assure that all CSHCN had a primary care selected or assigned. Partnership developed a system to ensure that Title V children receive a designated PCP or medical home provider. Additionally, the Provider Relations department now distributes a monthly report to each PCP listing members who have designated the provider as their PCP. From August 2001 to April 2002, the number of CSHCN with a designated PCP improved from 68 percent to 83 percent. By 2003, 99 percent of CSHCN had a designated PCP.

Partnership also developed a parent notebook⁵¹ to allow parents to record the child's diagnoses, allergies, medical conditions, and other pertinent information.

Aim:

To ensure that 100 percent of CSHCN have a PCP selected or assigned.

Measure:

$$\frac{\# \text{ of CSHCN with a PCP selected or assigned and recorded into database}}{\# \text{ of CSHCN}}$$

Change:

Partnership implemented the following cycles of change to increase the number of CSHCN who are assigned to a PCP:

Cycle 1: Contacted family to select PCP provider for Title V population and recorded selected provider in database.

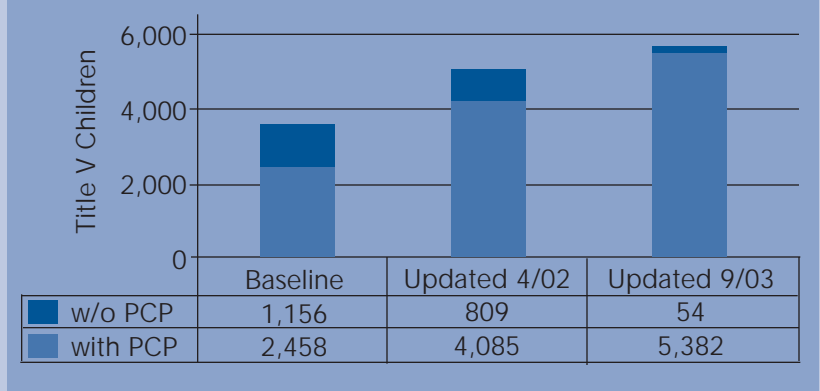
Cycle 2: Developed process to work with California Children's Services to have parent designate a PCP.

Cycle 3: Developed a procedure to ensure that a PCP was entered in its claims/encounter data system. PCPs received a list of members who have chosen them as their designated provider.

Results:

Partnership achieved its goal of linking nearly all – 99 percent – of its CSHCN to a PCP.

Figure 10: CSHCN at Partnership HealthPlan with a Designated PCP



⁵¹ Partnership's parent notebook is available in the online toolkit at www.chcs.org

► INTERVENTION

Partnership set an intervention goal to improve HEDIS rates for childhood immunizations (70 percent), well-infant visits in the first 15 months of life (50 percent), and well-adolescent visits (40 percent).

Aim:

1. To improve HEDIS rates for:
 - Childhood Immunizations—70 percent
 - Well-Infant Visits—50 percent
 - Well Adolescent Visits—40 percent
2. To measure provider progress in improving continuity and coordination of care.
3. To assess family satisfaction with care.

Measure:

1. Attain recommended HEDIS well-child rates for CSHCN.
2. Compare provider site Medical Home Index measures to baseline.
 - Provider site Medical Home Index Follow-Up Measure
 - Provider site Medical Home Index Baseline
3. Survey families to assess satisfaction rate with continuity of care and coordination of care.
 - $\frac{\# \text{ of families satisfied with coordination of care}}{\# \text{ of families responding to survey}}$

Change:

Partnership piloted the following changes to achieve the above goals:

- Monitored preventive care for CSHCN annually and compared to goal.
- Worked with four provider sites to implement the Center for Medical Home Improvement model and collaborated with a core group of network providers to improve the medical “homeness” of their sites.
- Provided parent resource notebook to parents of CSHCN. Offered instruction and education on effective use of the tool to a core group of parents. Pilot tested use of the tool.
- Explored interest and feasibility of support group for parents.
- Developed survey to assess caretaker satisfaction with communication and coordination of care between providers for CSHCN.

Results:

Partnership saw improvements in its HEDIS scores⁵¹ for CSHCN that were comparable or exceeded increases in HEDIS scores for all children in the health plan (Figures 11 and 12). Initial survey results for the practices revealed practice strengths in commitment to quality care and family supports (90 percent) and indicated that improvements are needed in the area of coordination of pharmacy, durable medical equipment, and special therapy services (34 percent). A follow-up survey in 2004 will evaluate effectiveness of interventions.

Based on a provider survey administered in November 2002, Partnership staff realized that providers were not satisfied with continuity and coordination of care. Partnership also set intervention goals to improve provider satisfaction with continuity and coordination of care to 80 percent and to assess family satisfaction with care. Partnership collaborated with a group of network providers to improve the medical “homeness” of their sites. An *ad hoc* work group of Partnership’s coalition reviewed the Center for Medical Home Improvement’s resources, which includes the Medical Home Index assessment tool and the Medical Home Family Index for families. Partnership’s Medical Home Coalition adopted these tools as the model for a practice-based quality improvement project. Four provider sites agreed to participate. Copies of the Medical Home Improvement Kit and lists of children with special needs were delivered to each site.

In April 2003, approximately 191 families were sent the

⁵¹ Partnership’s HEDIS scores are consistent with national means for children on Medicaid. See *The APHSA Medicaid HEDIS Database Project* at <http://www.nasmd.org/research/hedis1999.htm#Table%203> (Table 8) for more information.

Medical Home Family Index, which assesses family satisfaction of how well the PCP cares for the child. Sixty-one families completed the survey, for a response rate of 32 percent. Fifty percent of parents indicated that they had a written care plan for their child and 34 percent of parents indicated that their provider practice is helpful in finding needed services for the child (transportation, equipment, home care, etc.).

Each provider site assessed its own processes using the Medical Home Index and established specific protocols to enhance care management. All provider sites showed improvement in most components of the Medical Home Index, including organizational capacity, chronic condition management, care coordination, community outreach, data management, and quality improvement change. Two of the four sites began using the parent resource notebook to enhance interactions with families and improve family experiences of care.

Provider sites have remained actively engaged in the pilot project. Three sites completed a practice site assessment (Medical Home Index) in December 2002 and again in December 2003. All sites reported improvement in each of the five domains in the medical home improvement model.

Figure 11: Partnership Preventive Care HEDIS Rates — CSHCN

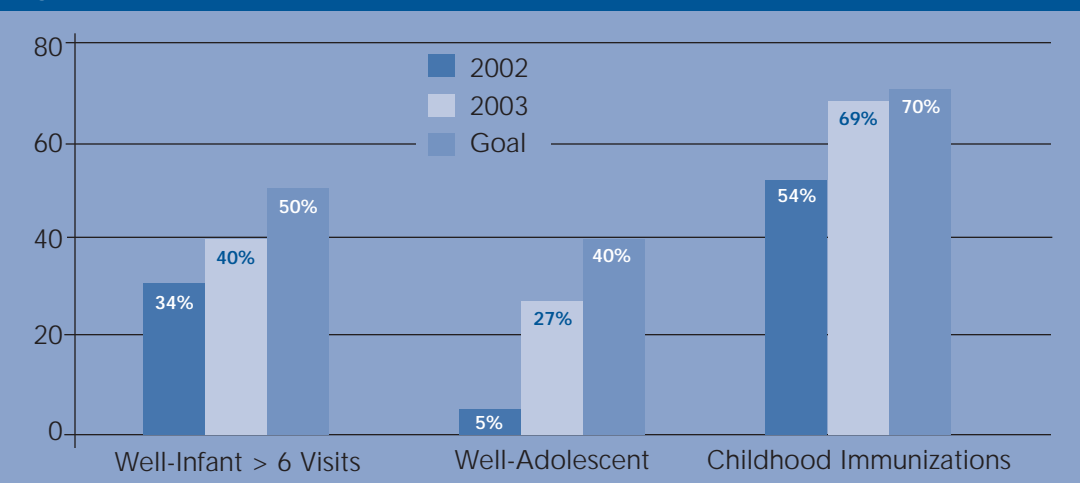


Figure 12: Partnership Preventive Care HEDIS Rates — All Children

