Overview of Technical Assistance (TA) Opportunities for CCOs on Use of Children's Health Complexity Data

Offered by the OHA Transformation Center with TA activities provided by the Oregon Pediatric Improvement Partnership (OPIP)

January 31, 2019
12:30-1:30 p.m.

Agenda

- High-level overview of the broader goal for OPIP technical assistance to CCOs on **use of** the children's health complexity data

- Tracks of technical assistance and support:

  1. Using **population-level findings** regarding children's health complexity to **engage community-level partners and facilitate community conversations**

  2. Using health complexity data to **develop models of best match care coordination and case management for children** with various levels of health complexity

  3. Using children's health complexity information to **guide efforts with front-line health care providers**

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Children with Health Complexity

- **Medical** **Complexity**
  - Uses the Pediatric Medical Complexity Algorithm (PMCA)
    - o Takes into account: 1) Utilization, 2) Diagnoses, 3) Number of body systems impacted
    - o Assigns child into one of three categories: a) Complex with chronic conditions; b) Non-complex, with chronic conditions; or c) Healthy.
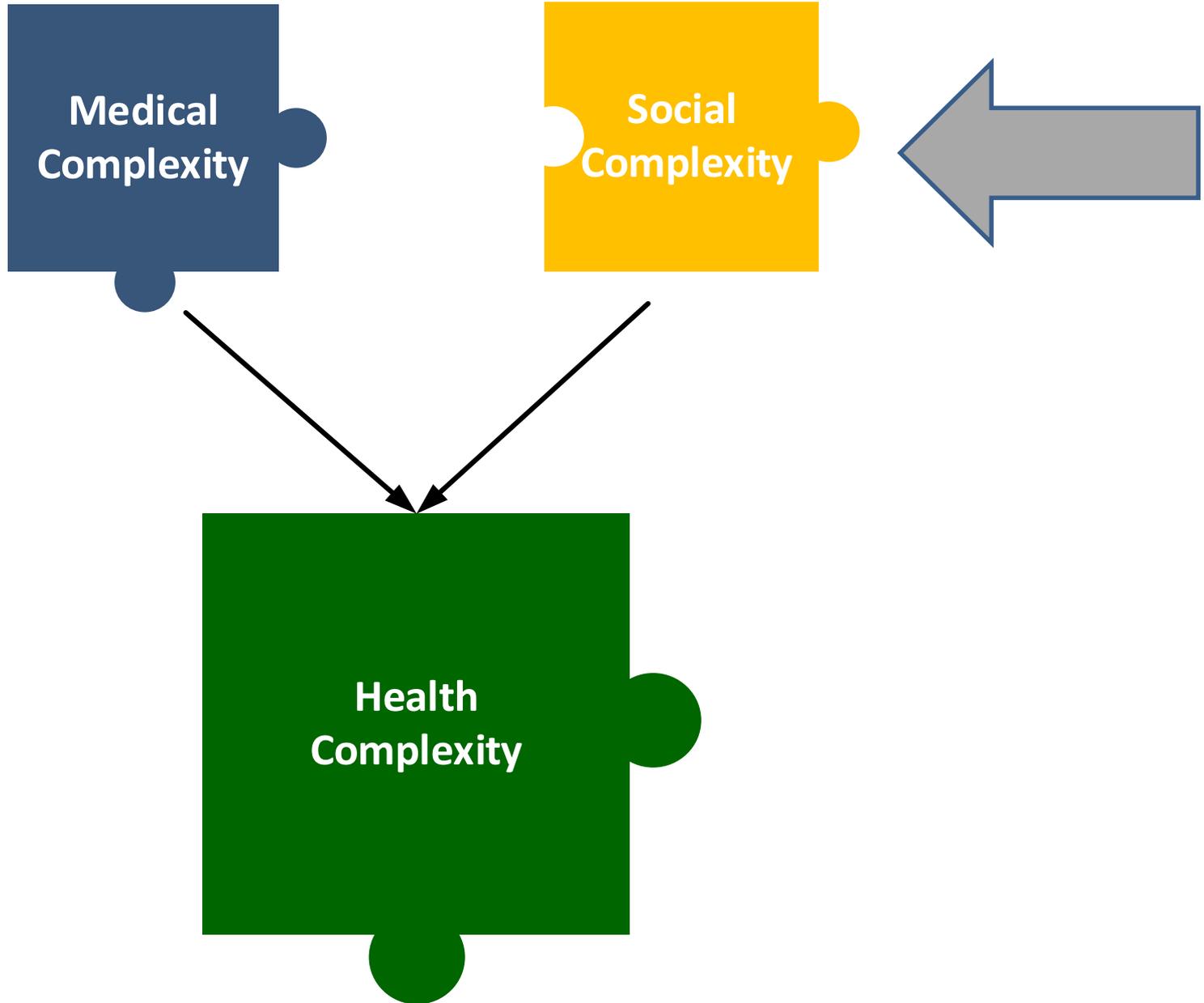- **Social** **Complexity:**
  - Defined by The Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN) as *"A set of co-occurring individual, family or community characteristics that can have a direct impact on health outcomes or an indirect impact by affecting a child's access to care and/or a family's ability to engage in recommended medical and mental health treatments".*
  - Operationalizing factors identified by *COE4CCN* as predictive of a **high-cost health care event** (for example, emergency room use).
- **Health** **Complexity:** Combines **medical** and **social complexity** to create a global score.
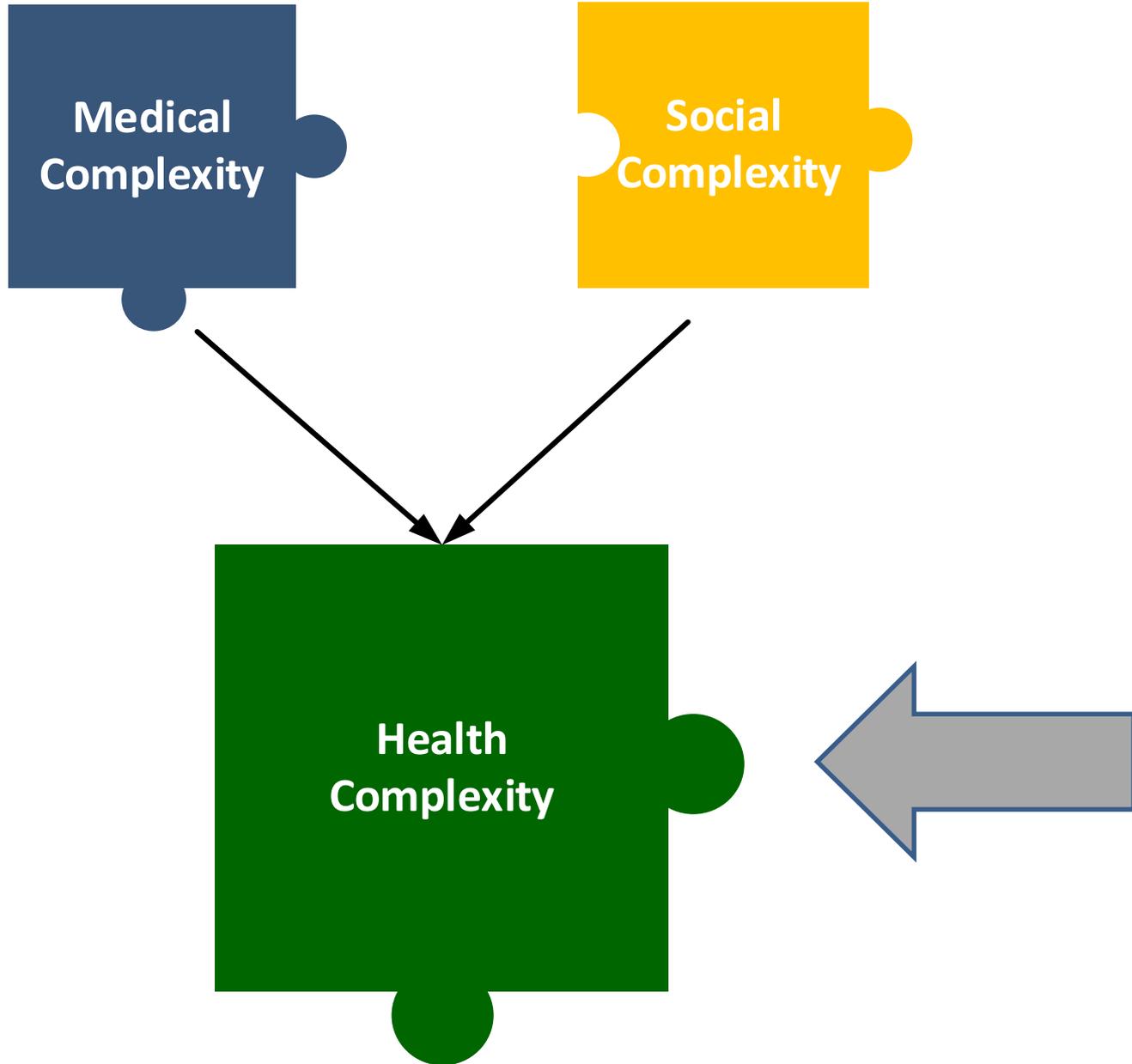
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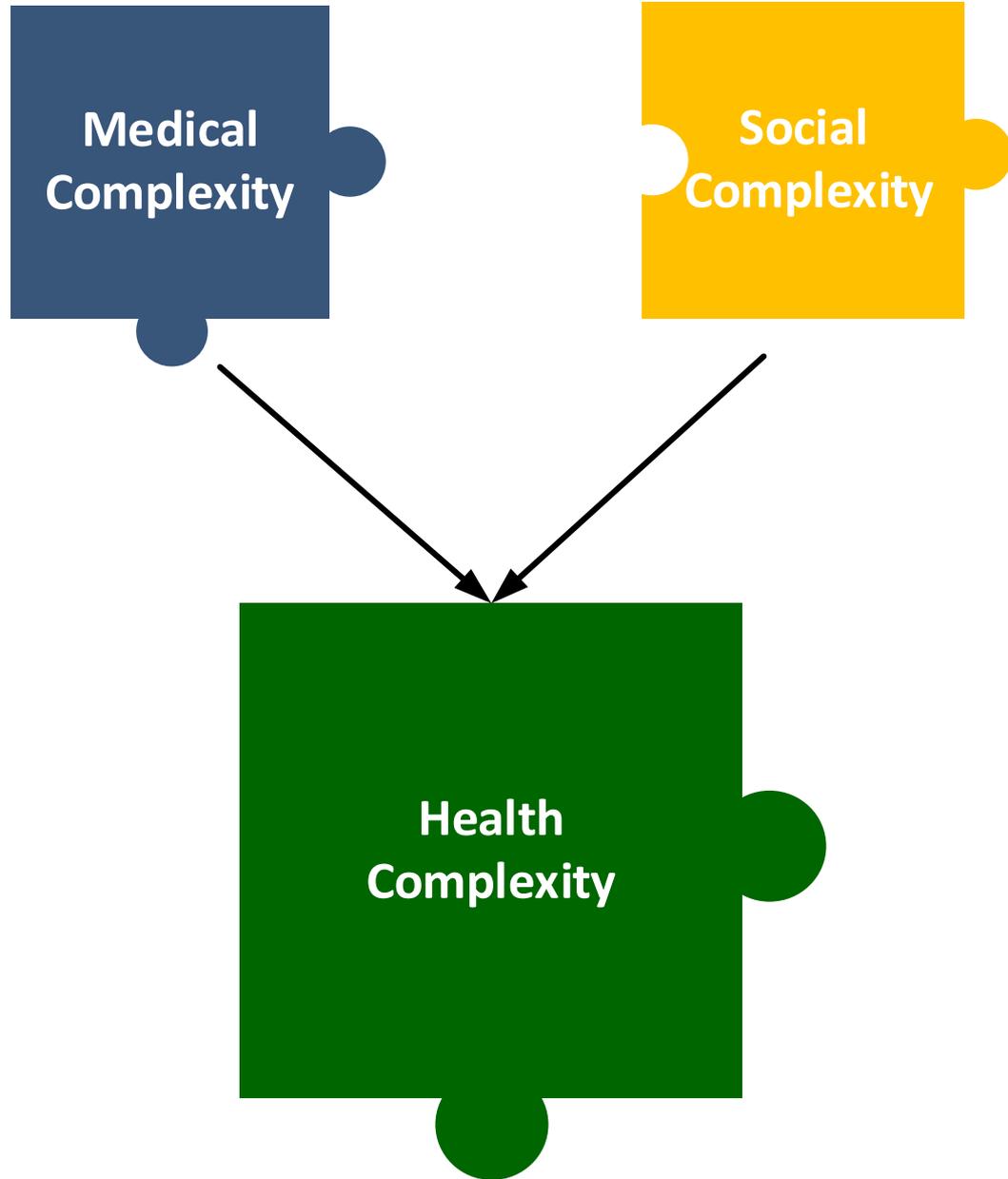
Pediatric Medical Complexity Algorithm

- Developed by a team at Seattle Children's, validated by Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN)
  - For children 0 to 18 insured
  - Developed as a way to identify a population, stratify quality metrics, and target patients who may benefit from complex care management
- Based on claims and diagnoses
- Categorizes complexity into three categories:
  1) **Complex Chronic Disease,**
  2) **Non-Complex Chronic Disease, and**
  3) **Healthy**
- Takes into account three main factors:
  - Diagnoses
  - Number of body systems impacted
  - Patient utilization
- The three categories are co-linear with COST (*as complexity increases, so does cost*)

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Medical Complexity

Social Complexity

Health Complexity

Fall 2018: Available and Feasible Social Complexity Indicators Included in a Social Complexity County Variable and Social Complexity Categorical Variable

INDICATOR	CHILD FACTOR	FAMILY FACTOR	TOTAL
Poverty –TANF (For Child and For Either/Both Parent)	X	X	X
Foster care – Child receiving foster care services DHS ORKids (since 2012)	X		X
Parent death – Death of parent/primary caregiver in OR		X	X
Parental incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon.		X	X
Mental Health: Child – Received mental health services through DHS/OHA	X		X
Mental Health: Parent – Received mental health services through DHS/OHA		X	X
Substance Abuse: Child – Substance abuse treatment through DHS/OHA	X		X
Substance Abuse: Parent – Substance abuse treatment through DHS/OHA		X	X
Child abuse/neglect: ICD-9, ICD-10 dx codes related to service	X		X
Limited English Proficiency: Language other than English listed in the primary language field		X	X
Parent Disability: OHA eligibility due to parent disability		X	X
Total Number of Individual Flags Included	5	7	12

7   Look Back Period: Presence of the risk factor in prenatal period (year before birth)-lifetime of the child.

State-Level **Health Complexity** Categorical: Source Variables Related to **Medical** and **Social** Complexity

MEDICAL COMPLEXITY (3 Categories)	**SOCIAL COMPLEXITY (Total Factors Possible in Preliminary Data Shown Here N=12)**		
	3 or More Indicators	**1-2 Indicators**	**None in System-Level Data**
HIGH Medical Complexity (Chronic, Complex PMCA=1)	3% (11,637)	2.4% (9,342)	0.7% (2,702)
MODERATE Medical Complexity (Non-Complex, Chronic PMCA=2)	9.5% (36,908)	7.2% (27,952)	1.7% (6,731)
NO MEDICAL COMPLEXITY (PMCA=3)	26.5% (103,459)	32.6% (127,169)	Neither Medically or Socially Complex 16.6% (64,682)

Data Source: ICS Data Warehouse & Medicaid data sourced from Medicaid Management Information System (MMIS)

DHS Oregon Department of Human Services

Oregon Health Authority

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Child Health Complexity Data to CCOs

Child health complexity data shared in late 2018 – 3 items

A) Population-level data for aggregate data: Population of children publicly insured in 2016-2017 (390582)

  1) Population-level reports, <u>aggregate data report</u>

  – Data shown for the population at state and **county level**

  - At a state and population level, can show prevalence of specific indicators and by race/ethnicity
  - Population of children publicly insured in 2016-2017

  2) CCO population-level report, <u>aggregate data report</u>

  - Data shown for the population attributed to the CCO
  - At a population level, able to show prevalence of specific indicators at a CCO level

B) Children attributed to CCO at the time of the data transfer: Data file sent to people with access to Business Objects.

  3) To CCOs for their attributed populations: <u>child-level data file</u>

  - Currently attributed population (smaller population)
  - Child-level indicator of:
  - ❖ **Medical** Complexity Categorical Variable (3 categories)
  - ❖ **Three Social** Complexity Count Variable: Child (0-5), Family (0-7) and Total (0-12)
  - ❖ **Health** Complexity Categorical Variable (9 categories that map to slides shown)

Future Data Sharing During Course of Technical Assistance

1) Spring 2019: Updated CCO-level data

2) County-level reports: Timeline TBD, in 2019

3) If significant and demonstrated CCO use, spring 2020 updated CCO-level data

Tracks of Technical Assistance and Support

- Developing guides and tools to support the three "tracks" of data use identified and focused on at the 11/28/18 in-person learning session for CCOs:

    1. Using **population-level findings** regarding children's health complexity to **engage community-level partners and facilitate community conversations**

    2. Using health complexity data to **develop models of best match care coordination and case management for children** with various levels of health complexity

    3. Leveraging the data to support a health complexity informed approach **with front-line health care providers**

- Individual TA to CCOs available 1/1/19 through 6/28/20

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General Opportunity Across the TA Tracks: Additional Analysis from OHA Health Analytics

- Goal of the population level reports was to provide a high-level summary of the data.

- Recognize there may additional and valuable data analysis that is not possible with the child-level data files OR included in the population-level data reports.

- Therefore, to support CCOs in **use of** the data, OHA Health Analytics has agreed to support CCOs who are using OPIP TA to have **up to three requests for data analysis by OHA**
  - Requires an outline of why the data is being requested and planned use
  - OPIP can walk through potential options for this analysis on TA calls

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#1: Using the Population-Level Findings

Tools OPIP is creating to support using the population-level findings to engage community-level partners:

1. Example slide template for CCOs to use in displaying their community-level data and facilitating community-level conversations (April 2019)

2. Document outlining recommended key partners (e.g., CaCoon nurses, directors of early learning hubs) for CCOs to engage in the community-level conversations (April 2019)

3. Learning collaborative meeting on how CCOs have used the aggregate population-level data (late spring/early summer 2019)

4. Written brief summarizing strategies that early-adopting CCOs used, including what CCOs did, how they did it, and lessons they learned (summer 2020)

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Technical assistance to CCOs:

OPIP thinks this is a primary and first step needed by CCOs.

Examples of potential TA from OPIP:

➢ Provide assistance on interpreting CCO-specific data and opportunities, identify priority next step analyses

➢ Present at board meetings, meetings of providers, meeting of consumers

➢ Present to persons working on the community health improvement plan (CHP)

➢ Present and explain data at a meeting of community-level partners

➢ Participate in small-group work sessions with community-level stakeholders that OPIP has experience working with

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#2: Enhanced Care Coordination and Care Management

*Use the population-level and child-level data findings to*

- Support development of new models of best match care coordination and case management using a child- and family-centric lens

- Community-based, centralized supports for children with varying levels of health complexity

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#2: Enhanced Care Coordination and Care Management

Tools OPIP is creating to support care coordination and care management in CCOs:

1. Written brief summarizing the opportunities to use the health complexity information to guide and inform best-match care coordination and care management (fall 2019)

   – Compendium of articles and presentations by national leaders on various models of complex health management and care coordination

   – Example outreach and communication strategies with families

2. Written brief summarizing key learnings from the CCO efforts (summer 2020)

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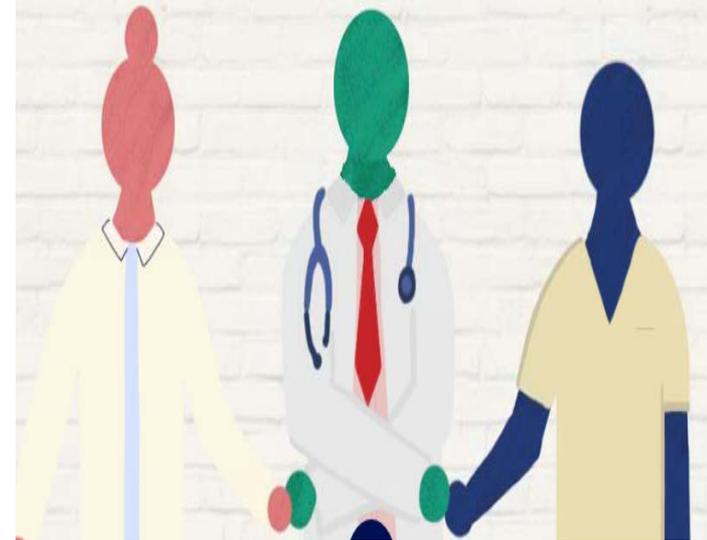
#2: Enhanced Care Coordination and Care Management

Examples of potential TA:

➢ Approaches to using data to design population-based approaches for identifying children who may benefit from further assessments

➢ Strategies to prioritize which children to target for assessments, best match outreach and teams

➢ Strategies for reviewing the data and considering care coordination and care management resources

➢ Outreach and engagement strategies

➢ Tiering patients and identifying best match supports

➢ Care coordination and complex care management models

➢ Parent partners and parent supports

➢ Evaluation tools and example evaluation tools

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#3: Leveraging the data to support a health complexity informed approach with front-line health care providers

Focused on how the population-level and child-level information can be used to partner with and inform activities with front-line health providers who CCOs contract with to serve children with health complexity.

- Part 1: Value of **examining aggregate population-level data** by practice and by **geographic regions** to assess resources and health complexity management needs in the practice and/or in the community

- Part 2: **Sharing the child-level data variable indicators with the primary care practice** to which the child is attributed

#3: Leveraging the data to support a health complexity informed approach with front-line health care providers

Tools OPIP is creating to support work with front-line providers:

1. Written brief summarizing opportunities to use the data to guide and inform efforts with front-line health care providers, uses aligned with the intent of the data, and considerations and processes necessary to ensure a trauma-informed approach (summer 2020)

2. Written brief summarizing key learnings from the CCO efforts (summer 2020)

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#3: Leveraging the data to support a health complexity informed approach with front-line health care providers

Examples of potential TA on using the aggregate data at a practice or region level

- Assistance in reviewing the data for the level of health complexity by region and practice.

- Ways to consider resources/supports that are needed in places that have high proportions of children with health complexity.

- Strategies for using the population-level information as part of work with practices, to stratify metrics, and to inform alternative payment models.

- Strategies for considering supports for children with high medical complexity who may primarily receive care from specialists.

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#3: Leveraging the data to support a health complexity informed approach with front-line health care providers

Examples of potential TA to support sharing the child-level data variable indicators with the primary care practice to which the child is attributed:

- Consultation on systems and processes to put in place before data is shared

- Consultation on strategies that leverage the value and need for primary care input on the strengths and needs of the child and family

- Health complexity aligned approaches to screening within front-line primary care practices

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Next Steps

- OPIP is working on the first set of tools focused on using the population-level data.

- Each CCO has the opportunity to use 10 hours of TA through the Transformation Center.

- The TA hours can be spread over the three focus areas as the CCO chooses.

- TA hours for the first focus area (using data to engage community partners) must be requested by July 1, 2019 – *this may change to October 1, stay tuned!*

- TA hours for the other two focus areas must be requested by October 1, 2019

- Any hours not requested by October 1 may be re-allocated to CCOs already engaged in the TA.

- TA hours may be used through June 28, 2020.

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To request TA hours, contact Liz Stuart at
elizabeth.m.stuart@dhsoha.state.or.us

For more information:
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx