

# Achieving Change in Tough Times

## Statewide, Comprehensive Care Coordination for CYSHCN in Massachusetts

Presented to the MA Consortium for  
Children with Special Health Care Needs  
*-- June 2, 2005 --*  
**Deborah Allen, ScD**  
**Kathy Ryan**

# Agenda

- History and background
  - Consortium financing grant
  - Care Coordination Work Group
- Part I
  - Care coordination definition and principles
  - Care coordination outcomes
  - Stages of care coordination
- Part II
  - Parameters of a statewide system
- Part III
  - Panel presentation: Examples for Inspiration
    - EI
    - Hearing screening
    - CommonHealth
  - Respondent
- Part IV
  - Next steps
    - Work Group plans
    - What we need from you

# Massachusetts Health Care Financing Initiative FY 2003-2006

- 1 of 7 state grants - MCHB \$
- Followed Consortium brief on “*Adequacy of Health Care Financing*”- November 2001, January 2002
- Adopted specific strategies to improve adequacy of health care financing:
  - Support for Consortium
  - 3 target areas for improvement: family participation; understanding medical benefits decision-making; care coordination

# Activities in 2 other Target Areas

- Family Participation Work Group
  - adopted policies on family participation
  - surveyed family leaders and family groups
  - June 2004 Consortium meeting: *Promising Practices*
  - November 2005: launched Family Partners Initiative 6 sites
- Medical Benefits Decision-Making
  - in collaboration with health plans and families, developed 7 vignettes detailing CYSHCN examples
  - surveyed nine health plans on decision-making processes
  - February 2005 Consortium meeting:  
*Health Insurance & CSHCN*
  - June 2005: develop informational tools

# Care Coordination Work Group

- Three part plan
  - Build consensus
  - Describe system
  - Build political will
- February 2003 Summit
- Data collection
  - Key informants
  - Literature review
- Site visits
- Analysis of findings

## Part I: Definition of care coordination

- Central to an effective system of care
- Ongoing
- Engages family in creation of plan of care
- Principles reflect central role of family
- Activities vary but reflect full range of family strengths and needs
- Key outcome is enhanced family capacity

## Broad principles for a care coordination system

- A. Accessible
- B. Individualized
- C. Allied with family in its interactions with broader community
- D. Focused on systems change as well as family support

# Outcomes of care coordination

- Child satisfaction, well-being, autonomy
- Family satisfaction, well-being
- Provider satisfaction and capacity
- Effectiveness and efficiency of systems

# Stages of care coordination

- Community environmental scan
- Child screening and identification
- Family needs assessment
- Collaborative development of IFSP
- Implementation and monitoring of plan
- Review and revision of plan
- Feedback to and engagement with community systems

## Part II: Parameters of a statewide system

- Financing
  - How the system is funded
  - How the system pays for services
  - How much \$\$\$ are we talking about
- Structure
  - Medical home
  - Vendors
  - State
- Operational components
  - Enrollment and service
  - Planning, systems development and oversight
  - Management and financing

## Part IV: Next steps

- Work group plans
  - Elicit input from Consortium
  - Refine definition, principles, stages
  - Refine preliminary description of parameters
  - Elicit input from constituents
- What we need from you
  - Your input
  - Input from your colleagues/organization
  - Suggestions for reviewers