Rhode Island's Development of a Pediatric Health Home

Introduction

The Affordable Care Act (ACA) affords states an opportunity to establish a health home, an innovative care delivery model in Medicaid designed to coordinate care and improve outcomes for patients with complex medical needs. Rhode Island, home to an existing community-based care coordination model for children with complex health needs, has taken up this option and created—alongside a program for adults—a health home geared specifically to children and youth with special health care needs. This paper provides background on care coordination and information about the provision—Section 2703 of the ACA—as well as a description of the Rhode Island pediatric health home model, to inform other states that might be considering implementing the health homes option.

Background: Origins of the Health Home Concept

Health care industry stakeholders have long advocated for ways to streamline communication and service delivery to improve patient care and, ultimately, health. In 1967, the American Academy of Pediatrics defined a medical home as "one central source of a child's pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination."[1] Over time this definition was adapted to convey that, in addition to reducing failures in care delivery, the medical home would be coordinated, patient- and family-centered, accessible, and compassionate. In 2004, other organizations called for Americans of all ages to have access to a medical home.[2] This expansion and interest in medical homes opened up the concept to a larger patient population and also allowed for the model to serve patients across their lifespan.

Over time, ideas have evolved about the goals of health services and the most effective ways to provide care. While the goal of health systems was once to find and deliver the most appropriate remedies for sick people, health care providers and policymakers now work toward effective health maintenance, treatment, and disease management for both individuals and populations. In conjunction with this change in our conception of health care's aims, we have also expanded our ideas about the most appropriate ways to achieve them. We look for ways to keep individuals in their homes and communities, rather than relying on hospitals as the only places to provide a broad range of services.

[1] Centers for Medicare and Medicaid Services. State Medicaid Director Letter # 10-024, Health Homes for Enrollees with Chronic Conditions. November 16, 2010. http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

[2] Ibid.

Health Homes in the ACA

Two aspects of care delivery transformation—providing services that prevent acute disease episodes and delivering these services in the community—gave rise to the health home model. Similar to the medical home definition throughout its evolution, the health home is a model of service delivery that provides coordinated, person-centered care, including a broad range of physical and mental health services, to improve patient outcomes and experience. When possible, providers offer these services in a community-based setting to keep the patient and family connected to their community, minimize disruption to the patient's and family's routines, and keep them connected to their social supports. Additionally, stakeholders including policymakers and providers hope this model will simultaneously reduce per capita cost of care among participants—largely through decreased acute care use—to drive down overall health care costs and make this model sustainable for states.

As defined in the ACA, health homes serve a specific population of Medicaid enrollees who meet one of three health status criteria:[3]

- Two or more chronic conditions, including mental health conditions
- One serious and persistent mental health condition
- One chronic condition, including a mental health condition, and high risk for another

If a state chooses to adopt the health home option, that state is eligible for a 90 percent federal matching rate for health home services during the first eight quarters (two years) of the program. After that introductory period, federal matching will continue at the state's normal Medicaid matching rate.[4]

In order to determine if these programs are effective, the Department of Health and Human Services (HHS) will survey participating states' data by January 1, 2014 and make an interim report; subsequently, HHS will arrange for an independent evaluation of health homes to be completed by January 1, 2017. These reports will explore the use of health information technology (HIT), continuous quality improvement methodologies, and outcomes measurements, as well as emphasizing cost savings, reductions in emergency department use, and decreased institutionalizations (both hospital and skilled nursing facility admissions).[5]

Rhode Island's Basis for Health Homes

Rhode Island is home to a model of complex care delivery called Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation (CEDARR), a program for children and youth with special health care needs. At CEDARR centers around the state, licensed clinicians such as registered nurses, licensed clinical social workers, and psychologists coordinate children's care to ensure they are receiving medical and supportive services that are clinically appropriate, family-centric, and based in the community whenever possible. With this program in place, state policymakers saw an opportunity to match their model to the health home option

[3] Kaiser Family Foundation (KFF). Focus on Health Reform: Medicaid's New "Health Home" Option. January 2011. www.kff.org/medicaid/upload/8136.pdf
[4] Ibid.
[5] KFF. Focus on Health Reform: Medicaid's New "Health Home" Option.

in the ACA to strengthen the program and bring additional federal dollars into the state. As a state with 12,000 children and youth with special health care needs and 7,000 adults with serious and persistent mental illness, policymakers recognized a need for effective care for these populations.

Developing the State Plan Amendment

In applying to the Centers for Medicare and Medicaid Services (CMS) for health home designation, state officials combined both CEDARR centers and an adult-focused program (Community Mental Health Organizations (CMHOs)) into their initiative; this tactic was important to ensure the health home would serve the needs of all eligible Medicaid enrollees. To do this, officials developed an overarching definition of the health home that applies to both CEDARR centers and CMHOs, which is similar to a vision statement and describes the overall goal of the program; then, within that larger definition, each setting is defined with a description of the way services are delivered in that part of the program. This unified superstructure with distinct pediatric and adult programs underneath it met CMS' requirements that the state make these services accessible to all, regardless of age, while simultaneously allowing them to tailor service delivery to be as effective as possible for both children and adults.

For other states considering a state plan amendment to implement health homes and interested in focusing on the pediatric population, the Rhode Island example is instructive. Although the Rhode Island model is inclusive of patients of all ages—thereby maintaining compliance with the law—the division of the program into settings that are age-specific enables policymakers to connect patients with the most appropriate providers.

Adjusting CEDARR into a Health Home

Working from an existing model presented both advantages and challenges in establishing a health home option. The transition into health homes required adjustments to the CEDARR model, including changes to the structures for communication and information sharing among service providers. In particular, the state worked to improve its data-sharing to comply with the health home definition. Additionally, physician buy-in was integral to the success of the program, as pediatricians had in the past expressed a desire to serve the population of children and youth with special health care needs more effectively, but felt constrained in their ability to do so. Because state officials and CEDARR staff made the case that health homes would bring additional resources to these children, pediatricians supported the model. Additionally, pediatricians appreciated the opportunity to gain a better understanding of the services their patients receive outside of their practices.

Provider Reimbursement

As the health home model matures, program leaders are evaluating the care coordination activities and the way providers are reimbursed for these services. As of August 2013, CEDARR staff who conduct care coordination services are reimbursed for this work based on 15-minute units of time. Administrators are considering a shift to per-member-per-month (PMPM) reimbursement; they believe that this change would reduce the burden on providers to document

every small increment of work they perform. To reflect the fact that children with more complex needs require more intensive care coordination, PMPM rates would be tiered based on the child's level of need, as demonstrated on an assessment tool developed within one of the state's health homes. The tool takes into consideration family needs—including medical and psychosocial needs—and assigns a score that correlates to an estimated amount of care coordination effort over a year. Program leaders are conscious that families could attempt to overstate their needs and are currently testing the tool's validity by conducting the assessment and comparing its results to subsequent claims related to the child's care. One feature of the tool leaders believe increases the tool's validity is its strengths-based perspective: rather than asking a family about their child's deficits, it asks about the child's strengths, which primes the family members to provide a true picture of what their child can do and helps the person conducting the assessment identify the child's needs.

Data Collection and Reporting

The transition to the health home model required CEDARRs to change their data collection, both in terms of practices and metrics. One aspect of new data collection requirements has been a success: the introduction of more outcome measures, which the state introduced to CEDARR and CMHO sites before the formal health home project began. Policymakers use these measures to track progress on the goals set at the state level.

Program leaders now measure several patient-rated outcomes measures, which allow patients and families to assess their health and the effectiveness of their care. Although these measures are still relatively new, leaders are already seeing some encouraging trends associated with increasing length of enrollment. Families respond to seven questions related to self-reported stress level, knowledge of the patient's condition, ability to advocate for their child, and normalcy (their ability to do things that families with usual health care needs can do); these are measured using a Likert scale rating between 1 and 7. Analysts look at these ratings not only at a given point in time but also longitudinally for a given patient and family. They have observed that, as a patient's enrollment continues, his or her outcome scores improve. This trend suggests—although it is early to draw conclusions and other factors might be involved—that access to CEDARR is helping kids and families.

Program leaders continue to face challenges in planning to adapt their data to fit CMS reporting requirements. CMS has not yet requested much data from the state on the initiative, but program leaders know they will need to find a way to fit their data to CMS core measures, which are largely targeted toward adults. With very few program participants over the age of 18, Rhode Island will have only a small number of CEDARR participants whose outcomes they can report. Moreover, some of the measures CMS requests—such as how many times patients' medication lists are communicated from inpatient to outpatient providers—do not fit well with the CEDARR model of community-based care and are difficult to report without conducting a chart review.

Perpetuating the Health Home Model

Policymakers in Rhode Island are pleased with the performance of the health home model to date, having launched in October 2011. The transition into formal health homes has allowed the

state to enhance its existing model and has led to some important developments. For example, one of the goals of the CEDARR health home was to remedy a disconnect between the physical health and mental health sides of patient care. In particular, policymakers thought it was imperative to monitor body mass index (BMI), as the CEDARR population is at high risk of developing other conditions, including obesity and the conditions that stem from it. However, screening revealed that a significant number of children were below a healthy weight and needed intervention to boost their BMI to a healthy level. A similar initiative to screen for depression has led to several diagnoses of depression as an underlying condition in a child with other mental health needs.

Additionally, the model of linked child and adult health homes has proven effective for the state. Even before the state plan amendment was in place, policymakers worked to ensure that children aging out of the CEDARR health home and into the CMHO health home experienced a smooth transition process. As advances in HIT capabilities continue, these transitions should become increasingly seamless.

Rhode Island's enhanced matching for CEDARR will stop at the end of September 2013, and services provided through the health home will be reimbursed at the state's standard FMAP rate. However, although the program was initially considered a temporary money-saving measure to ride out a difficult fiscal situation, state leaders are now committed to continuing the program. Moreover, the state is exploring the option of submitting additional state plan amendments to expand the program to other populations, such as individuals in opiate treatment.

In general, program leaders have seen positive changes to the CEDARRs and believe that the program enables providers to view children and youth with special health care needs more holistically and evaluate their needs more effectively than before. There are several entities in Rhode Island providing services to children and youth with special health care needs—including the behavioral health system, the child welfare system, schools, and the health care system—and state leaders have seen immense benefit from the CEDARR's role as the single entity bringing all these services together to ensure they are meeting children's needs.

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