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TO: Julie Hamos, Director Healthcare and Family Services
FROM: Art Dykstra, Trinity Services, Inc.
DATE: June 29, 2011
SUBJECT: RESPONSE TO COORDINATED CARE POLICY QUESTIONS

The following comments and observations are submitted in response to the June 2011 invitation to provide input to the Key Policy Issues outlined in the Coordinated Care Program document.

The efforts that DHFS staff members have made in seeking to capture the many facets of managed / integrated care are appreciated. It is apparent that this is an area of public policy where questions are more apparent than solutions.

It is recognized that many of the questions included in the June 2011 paper are "high elevation" questions and may, indeed, be determined by the federal government. The intent of this comment memorandum is to focus on the more immediate and practical aspects of coordinated care rather than enter the debate regarding such matters as medical loss ratios. Such issues, while important, typically depend on other decisions that are being made with respect to risk based payments.

1. How comprehensive must coordinated care be?

As noted in the Issues Paper, "coordinated care" entities could be organized by hospitals, program groups, FQHC's or social service organizations.

Trinity Services, as a social services provider, would be interested in providing care coordination service to persons with disabilities whether physical, developmental/intellectual or behavioral. It is recognized that other populations might also be served within this model.

Trinity would propose to offer such services within the framework of a medical and/or health care home utilizing the services and leadership of a primary care physician.

In terms of coordinated care, it is suggested that such an approach begin with a base set of requirements that could be expanded over time. A preferable approach promotes care coordination across multiple providers.

In our present thinking, medical homes would, indeed, serve as the hub of coordinated care and also reach out to relevant "neighborhoods." Operational parameters would be outlined as a function of the decisions regarding a medical home for specialized populations.

It seems reasonable to have medical homes attain NCQA certification. These standards as they currently exist, however, may not be sufficient with respect to achieving the highest quality of personal outcomes. Further, it is likely (based on previous history) that medical homes must be granted sufficient time to achieve NCQA certification and it is suggested that reasonable benchmarks be built into the proposed integrated care model.

It is perhaps obvious that incentives should be a critical part of care coordination networks – the nature and extent of such incentives might vary in terms of geography, scope of service, population served, measures utilized, and outcomes realized.

In summary, it is suggested that those providers who know the persons served the best might be the most appropriate entity to provide comprehensive care coordination services.

2. What should be appropriate measures for health care outcomes and evidence-based practices?

As recognized in the Key Issues paper, there is an emerging body of research with respect to evidence based practices and health or wellness outcomes. What is being noted here is that such matters with respect to specialized populations also be recognized in efforts to achieve optimal health at the lowest cost.

The measures selected must indeed reflect the priority of the outcomes being pursued.

In struggling with the issues of metrics and measurement, the observation of David Boyle in The Sum of our Discontent might be noted. "Counting is always about power, it means definition and control. It is also about paradox. If we don't count something, it gets ignored. If we do count it, it gets perverted."

3. To what extent should electronic information capabilities be required?

It is reassuring to note the observation in the Key Issues paper that it "would be unrealistic to require these (electronically communicated information) capabilities initially, even though we expect national progress from the current situation by 2013."

There are many instances across the United States where individual providers have spent considerable monies in the development of electronic records only to discover that their system was not compatible with the approach being developed by others including possible "neighborhood" members.

It is recommended that the Department of Healthcare and Family Services host a forum of non-profit providers and together develop a grant proposal to one of the primary charitable foundations in Illinois in order to fund the development of an appropriate electronic health record system that could be shared across the system to other providers.

Perhaps individual ARRA grants could be pooled by participant providers and serve as a match to the foundation.

4. What are the risk-based payment arrangements that should be included in care coordination?

It is recognized that capitated systems may "under-serve" individuals and that fee for service models may typically "over-serve" individuals, hence the importance of having well defined outcomes.

Other stakeholders are probably more experienced and qualified to address some of the specific policy issues such as "stop loss" and "reinsurance" or such factors as risk adjustment.

5. What structural characteristics should be required for new models of coordinated care?

Our primary recommendation for new models is that arrangements be made to allow social service providers to provide care coordination to specialized populations.

It is recognized that many individuals with disabilities might be characterized as "high users" and do reflect patterns of service difficulty and significant expense.

It is for this reason that care coordination should be undertaken by those who have the most intimate service relationships, have the necessary skill sets, and who express a desire to participate in this undertaking.

6. What should be the requirements for client assignment?

The platform of thoughts represented in this comment paper is that specialized care coordination services may be the preferred model for addressing individuals with complicated life issues whether it be physical, developmental/intellectual or behavioral disabilities. The advantage being offered is knowledge of the disability and related medical conditions as well as potential cost savings.

This option is seen as being practical if a sufficient number of enrollees are included in the medical home. Matters of choice should be governed by naturally occurring geographic boundaries. With this approach, services might be limited to a sufficiently sized neighborhood. The assignment of clients who have not selected a care coordination entity should be done on the basis of the best service match and cost considerations.

7. How should consumer rights and continuity of care be protected?

Continuity of care in terms of the proposition that provider entities may "come and go" should be dependent upon the development of a performance monitoring system that includes agreed upon service outcomes and client satisfaction measures.

Monitoring mechanisms such as "watch lists" should be utilized as well as such tools as dashboard indicators. Consumer rights should be protected through the establishment of voluntary oversight review committees and the availability of an independent appeals structure.

8. What is your organization's preliminary anticipation of how it might participate in coordinated care?

As indicated previously, Trinity Services is interested in providing care coordination services either in the context of the model forwarded to HFS by AFSCME Council 31 and Trinity, or as a separately contracted social service provider.

Trinity Services is interested in developing medical homes or, if created, healthcare homes, for the mentally ill. Such services as care coordination would be undertaken for the clients currently enrolled in Trinity Services' day and residential programs. Trinity would also seek to collaborate with other non profits that are providing similar services.

Finally, Trinity would welcome dialogue with HFS staff concerning the ideas expressed in this memorandum. Trinity is also interested in serving the newly identified populations that will become eligible for Medicaid services in the near future.

Thank you for the opportunity to provide feedback with respect to this important issue.