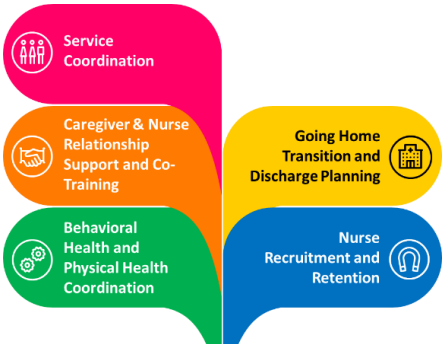
Background and White Paper Summary

The Office of Medical Assistance Programs (OMAP) within the Pennsylvania Department of Human Services (DHS) provides oversight of the managed care delivery system that serves children and adolescents who receive pediatric home health care (i.e., in-home shift nursing or home health aide services). In the past three years, there has been a fluctuating number between 7,600 and 8,000 unduplicated children and adolescents annually who receive these pediatric home health care services. In 2019, OMAP began a special initiative to re-envision how pediatric home health care was delivered to these children and their families and how they were supported in that process. Across a series of collaborative large-scale workshops and smaller workgroup meetings, OMAP along with home health agencies, managed care organizations, family members, and advocates, developed a public white paper with 13 recommendations across 5 areas to improve the system of care – Service Coordination; Going Home Transition and Discharge Planning; Caregiver and Nurse Relationship and Co-Training; Behavioral and Physical Health Coordination; and Nurse Recruitment and Retention.



5 Workgroup Areas

This update to the white paper summarizes how the collaborators within the pediatric shift care initiative have moved from 13 visionary recommendations to on-the-ground changes within Pennsylvania's managed care delivery system. The efforts continue to focus on improving Pennsylvania's pediatric shift care model to better serve patients, families, home health care workers, and managed care organizations.

Implementation Phase 1: Strategic Planning

The 13 recommendations from the stakeholder-developed white paper received support from DHS executive leadership in early 2021 and OMAP was charged with implementing the recommendations. OMAP team began to conduct strategic planning on how to implement each of the recommendations, including brainstorming and prioritizing based on several factors, such as monetary resources needed, scope of OMAP control, and timeframe. The implementation team also conducted research on peer-states to determine if programs or initiatives like those recommended were delivered in other states. Lastly, the team also reached out to subject matter experts that were both part of and not part of the workgroups to gain additional insight on how best to operationalize some of the white paper recommendations within the existing Pennsylvania system. The initial efforts focused largely on establishing a Patient-Centered Medical Home program that was focused specifically on children with medical complexity (CMC) and connecting nursing schools with home health agencies to improve the local workforce pipelines. This groundwork of moving from visionary recommendations to on-the-ground implementation proved to be invaluable for what came next.

Implementation Phase 2: American Rescue Plan Act of 2021 (ARPA) Initiatives

Within a few months of conducting the initial implementation planning, the Centers for Medicare and Medicaid Services (CMS) announced the opportunity for enhanced funding for home and community-based services (HCBS) for Medicaid members through the American Rescue Plan Act of 2021 (ARPA). As part of the larger spending plan across all DHS program offices, OMAP was able to incorporate items into the spending plan that addressed nearly all the white paper recommendations, with multiple strategies for some of the recommendations (see Pennsylvania Department of Human Services-Quarterly Update-HCBS). The spending plan was vetted through the stakeholders of the collaborative initiative through an open comment period and received CMS approval. The OMAP implementation team pivoted and focused their efforts on implementing the items within the spending plan, keeping in contact with the original stakeholders involved in the initiative. Below is a summary of the ARPA-related initiatives that align with one or more of the recommendations from the white paper.

Medical Homes for CMC

The new Patient Centered Medical Home (PCMH) Pediatric Nursing Care (PNC) program began January 2023 and is being delivered through managed care organizations. It leverages the American Academy of Pediatrics medical home applied to CMC to improve comprehensive coordination of care for children receiving pediatric shift care by providing existing PCMH providers (typically primary care providers) start-up funds and enhanced rates to establish and deliver whole-person, family-centered case management and team-based care planning.

Caregiver Support and Training Hubs

The new Pediatric Complex Care Resource Center (PCCRC) program is expected to launch early 2024 and will support families of CMC and their healthcare providers, such as home health agencies. The regionally based centers will provide education and training for specific needs and help families and providers navigate the various systems and resources that are available to support them. PCCRC services will be delivered through the existing regional network of eight Health Care Quality Units (HCQUs). The services will include:

- **Pediatric Coach**: A new position at the HCQU will have three core functions:
    1. ***Caregiver Support and Intervention:*** The Pediatric Coach will provide personalized support and intervention for caregiver teams as they work together and collaborate around the needs of the child. This may include providing problem solving, conflict resolution, and negotiating the bridge between meeting familial, social, and medical goals. They may also work individually with family members to empower them to successfully advocate and communicate needs, priorities, and concerns to the larger team.
    2. ***Learning Customization and Facilitation:*** The Pediatric Coach will provide education and training support to the caregiver team that will be targeted to meet each child's specific needs in a way that empowers each child's team to support them in the best way possible. They will facilitate training courses by leveraging PCCRC curriculum developed for the MyODP learning platform (described below) and customize course

content where applicable. Course instruction will be provided in a variety of modes including classroom-based, small group, and individualized training in the home.

3. ***Family Advisory Workgroup Facilitation:*** The Pediatric Coach will develop, schedule, and host ongoing regional family advisory workgroups aimed at supporting families caring for CMC. The purpose of the workgroups is to give families an opportunity to provide insight and feedback on services being utilized.

- **Teleconsulting**: A toll-free telephone line operated by a call center will be available 7am-9pm, seven days a week (excluding Federal Holidays) that will help caregivers (parents, family members, home health aides, nurses, etc.) to receive answers to non-medically-related questions, such as navigating the service system, insurance, peer family support, supporting the child in the home environment, and service referrals. Warm hand-offs will be made as often as possible to referred resources (i.e., the caller can be transferred to a resource without hanging up).
- **Family Facilitator:** An extension of an existing program within the Office of Developmental Programs to support children's transitions from facilities/hospitals to community settings and to support the diversion of children's placements in congregate care settings. The expansion of the program will increase capacity from one position severing the entire Commonwealth to six regionally based positions.
- **Online Training Platform:** Development of new self-paced learning courses on various home-care topics targeted for CMC caregiver teams (e.g., family members, medical personnel, home health agency staff, managed care organizations). OMAP is collaborating with the University of Pittsburgh to develop curricula and deliver through the existing MyODP online learning platform. The process for developing and deploying the courses will follow recognized principles of effectively addressing disparity, equity, inclusion and belonging (DEIB). Courses will focus on fundamentals of supporting CMC receiving in-home care, including education focused on supporting behavioral health needs; using durable medical equipment (DME) in individual home environments; improving advocacy efforts through inclusion in family/community systems; ensuring safe and efficient life transitions; and improving collaboration through relationship building amongst caregiver teams.

Strengthen the Home Health Workforce

- **Shadow Training Payments:** Home health agencies are now reimbursed for new in-home nurses to shadow and train with nurses currently assigned to an in-home case. Directed payments made to managed care organizations to pay these nurses while they train improves the quality of training and prepares nurses to more competently and confidently staff cases, thus improving retention and quality of care.
- **Retention Payments:** Home health agencies are now reimbursed to provide retention bonuses to in-home nurses who remain with an agency and provide in-home nursing for a year. Payments are direct through managed care organizations. This addresses workforce deficits by attracting and retaining qualified nurses.
- **Pay-for-Performance:** Managed care organizations are developing programs to make incremental improvement incentive payments to home health agencies and primary care providers who serve CMC with uncovered, authorized shift care hours and meet goals related to improved clinical and social outcomes.

- **Parents/Families as Paid Family Caregivers:** Managed care organizations have revised their home health aide authorization procedures to ensure that legally responsible relatives (LRRs) of CMC who meet home health aide qualifications and are employed by an enrolled home health agency can be paid for services delivered.

Expand Health Information Technology

- **Health Information Exchange Onboarding Grants for Home Health Agencies:** One-time onboarding grants were made available to connect home health agencies to the Pennsylvania Patient and Provider Network, the Commonwealth's Health Information Exchange (HIE), which allows for sharing of patient information among providers. These grants delivered to Health Information Organizations allowed 37 home health agencies to onboard and represents an investment in technology infrastructure that will enhance care coordination.
- **Electronic Health Record Grants for Home Health Agencies:** One-time grants were made available to home health agencies to obtain interoperable electronic health record (EHR) technology that will allow them to connect their EHR to the Pennsylvania Patient and Provider Network and afford the opportunity to use these EHRs in a meaningful way to improve care for CMC.
- **HIE Care Plan Module and Incentives:** The new Pennsylvania Patient and Provider Network was enhanced with a Care Plan Module to improve care coordination and care management activities by increasing the ability to share care plans across providers. Key elements in shared care planning are person-centered goal setting and engaging caregivers in the creation and maintenance of a comprehensive care plan.

Looking Forward

The efforts of numerous individuals and organizations involved in the pediatric shift care initiative over the past four years has resulted not only in collaborative and innovative strategic planning but has also resulted in real-world changes to Pennsylvania's pediatric shift care delivery model to better serve patients, families, home health care workers, and MCOs. With implementation of several of the above efforts well underway, OMAP is turning to tracking outcomes and executing evaluations of how these efforts have made impacts. The initiative continues to grow as OMAP welcomes additional partners to the collaboration who bring new ideas and expertise to improve care to the CMC living in Pennsylvania, with a continued focus on the primary areas of concern and associated recommendations made within the collaboratively developed white paper.

Appendix: Alignment with Recommendations

The below graphic summarizes how ongoing OMAP efforts align with the 13 original recommendations developed by the five workgroups that were made public in the white paper. Many efforts are addressing recommendations across the five topic areas and the efforts listed here are not exhaustive.