YIKES!
I CAN’T TAKE ON
ONE MORE NEW
THING IN THIS
PRACTICE

Improving Care Coordination
in Primary Care Pediatrics
Presenters/Objectives

• Miriam Sheehey, RN
  Coordination of the learning collaborative
• Beth Ann Maier, MD
  What is care coordination and why is it important?
• Kristy Trask, RN
• Marinell Newton, LICSW
  Strategies for implementing care coordination
Logistics of the Learning Collaborative

- Timing
- Funding
- Recruitment
- Maintenance of certification
- IRB Approval
- Faculty
Who are we and where are we going?

• University Pediatrics (Burlington)
• Middlebury Pediatrics and Adolescent Medicine
• Green Mountain Pediatrics (Bennington)
• CHCRR Pediatrics (Rutland)
• Rainbow Pediatrics (Middlebury)
• Hagan, Rinehart and Connolly Pediatricians
• Ottaquechee Health Center
• St. Johnsbury Pediatrics
• Barre Pediatrics
• Associates in Pediatrics (Berlin)
Care Coordination Definition

- Patient- and family-centered
- Assessment-driven
- Team-based
- Meets the needs of children and youth
- Enhances the care-giving capabilities of families

Care Coordination

Addresses interrelated needs:
• medical
• social
• developmental
• behavioral,
• educational
• financial

Goal:
To achieve optimal health and wellness outcomes for the patient...

TO THRIVE

Care Coordination

- Is the set of activities that happens between Office Visits, Hospital Stays, and Providers
  - E-mails, phone calls
  - prior authorizations
  - communication between providers (especially subspecialists)
  - Communication between community partners (school, social services)
  - insurers
  - prescriptions
  - equipment needs
  - in home care providers
This graphic is a model of high-performing care coordination in a patient/family-centered medical home, with all of its key components, which we will review one by one.
Care Coordination: Heart of the Medical Home

- Transforms a house into a home
- Promotes efficiency and continuity of care
- Focuses on helping those in the home get their needs met (immediate and ongoing)
- Makes coming in and going out easier
- Creates a friendly, supportive environment for patients and families and each other
- Prepares patients and families for the future
NO CARE COORDINATION

• “There was no continuity. We would call the primary care office with a concern and they would say “Oh, you need to talk to your specialist about that.” We would call the specialist and they would say “Oh, you need to talk to your primary care doctor about that.” It was just back and forth all the time and the concerns never got addressed.”

WITH CARE COORDINATION

• “Now there is a sense that I’m being listened to – that his medical needs are being addressed. We have a plan with where we are headed, especially with the school, we know where we are going.”

Parent interviews, March 6, 2014
### PARENTS’ VOICES

#### NO CARE COORDINATION

- I would be on hold for an hour, and then they would tell me to go to the hospital. *We* were going to the ER pretty much every other week.

- Don’t get me wrong, I love Dr_, but it was the structure, the organization, that was the problem.

#### WITH CARE COORDINATION

- Now, someone immediately picks up. They are always calm and responsive and find the right person to talk to me. Now, there is always a plan. I know what steps to take, and when to call back.

- Now, *(the doctor)* is able to network better and is proactive. There is more of a holistic view, why are the symptoms happening, what to do to figure out the bigger picture...we have only been to the ER once in the last six months”.

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Parent interview, March 6, 2014
### PARENTS’ VOICES

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<thead>
<tr>
<th>NO CARE COORDINATION</th>
<th>WITH CARE COORDINATION</th>
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<tbody>
<tr>
<td>“I wanted my focus to be my child, not making 32 phone calls a day.”</td>
<td>“Now, I shoot an email to (the care coordinator) - Done - Taken care of.” “I felt I could relax. I didn’t feel the pressure that I was doing it all myself.”</td>
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<td>“The doctor said: “You know it’s a band-aid. We’re just keeping him alive.” I want something more – some quality of life.”</td>
<td>“Now there is a sense that I’m being listened to... We have a plan with where we are headed...we know where we are going.”</td>
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Parent interviews, March 6, 2014
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<th>NO CARE COORDINATION</th>
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<tr>
<td>• “Before, we were always treating symptoms...I always felt that I was leading the</td>
<td>• “I don’t have to be advocating and pushing all the time. Every visit, even sick</td>
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<tr>
<td>conversation, like: “Don’t you think we should consider doing___?”</td>
<td>visits, at the end, we look at where we want to be and how we will take baby steps</td>
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<td>• “I guess I was kind of a problem parent for them.”</td>
<td>to get there, even when there are setbacks, and there are always setbacks, but I don’t</td>
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<td>get as discouraged, because we have a plan, we know where we are headed.”</td>
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Parent interview, March 6, 2014
I feel like I am often playing Wac-A-Mole. I just put out one fire and another starts. There is no vision of where we are headed.

I have good relationships with my patients and families, but may not always be aware of their goals. I sometimes communicate with other community care providers. There is no integrated care plan.

I have a clear care plan that addresses my patient’s needs and goals. I have clear communication with the family and all who participate in my patient’s care.
Medical Home Index: 43 Practices, 7 plans/5 states

- Higher overall MHI score or higher domain scores for care coordination, chronic condition management, office organizational capacity
  - Lower hospitalization rates

- Higher Chronic Condition Management domain scores
  - Fewer ER visits

## “Care Plans”-Recommended

<table>
<thead>
<tr>
<th>Organization</th>
<th>Care Plan Specifics/Called for Recommendations</th>
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<tbody>
<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
<td>Develop individual care plan includes treatment goals reviewed and updated at each visit</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid (CMS) Meaningful Use</td>
<td>“Visit summary of care” Mandates (ACA) care planning components “Continuity of Care Record”</td>
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<tr>
<td>National Quality Forum (NQF)</td>
<td>Plan of Care: Actively tracks up-to-date progress towards patient goals</td>
</tr>
<tr>
<td>AAP Care Coordination Policy Paper, 2002</td>
<td>Plan of care developed by family, youth, physician shared with other providers, agencies, and organizations involved with that patient’s care</td>
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<tr>
<td>IHI Care Coordination Model</td>
<td>A “planned visit” contains assessment, review of therapy, review of medical care, self-management goals, problem solving and a follow-up plan</td>
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Our Medical Home Program

- Three pediatricians, Dr. Joseph Hagan, Dr. Jill Rinehart, Dr. Greg Connolly
- Two Pediatric Nurse Practitioners, Maryann Lisak & Ashley Boyd
- One main RN Care Coordinator Kristy Trask
- Business manager, office manager, two office assistants, six additional part-time nurses two medical assistant
- ~4500 Active Patient List
Medical Home Definition

- Accessible
- Culturally Effective
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Family Centered
Why is A Family- Centered Medical Home Important to family?

- Opportunity for the family to build a trusting and collaborative relationship with the pediatrician and office staff.

- Care coordination provides smooth facilitation among all members of the child’s care team including family, specialists, pharmacy staff, community and school services.

- Comprehensive source of complete patient medical history

5 Key Elements of Highly Effective Care Coordination

The Concept

1. Needs assessment for care coordination and continuing care coordination engagement
2. Care planning and communication
3. Facilitating care transitions
4. Connecting with community resources and schools
5. Transitioning to adult care

The Person

## A Framework for Highly Performing Pediatric Care Coordination

### Care Coordination Functions

1. Provide separate visits & interactions
2. Manage continuous communications
3. Uses assessments for intervention
4. Develop Care Plans (with families)
5. Integrate critical care information
6. Coach patient/family skills learning
7. Support/facilitate all care transitions
8. Facilitate care conferences
9. Use health information technology for care coordination

### Care Coordination Competencies

1. Develops partnerships
2. Proficient communicator
3. Uses assessments for intervention
4. Facile in care planning skills
5. Integrates all resource knowledge
6. Possesses goal/outcomes orientation
7. Approach is adaptable & flexible
8. Desires continuous learning
9. Applies solid team building skills
10. Adept with information technology

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Partnership Care Planning Model

1. Identify Needs & Strengths (Patient/Family)
   - Hold family-centered discussions
   - Complete multi-faceted assessments

2. Build Essential Partnerships
   Set personal and medical goals
   - Shared decision making
   - Link to specialists and community service providers

3. Create the Plan of Care
   - Develop the medical summary
   - Establish "negotiated actions"
   - Add emergency and legal Attachments

4. Implement the Plan of Care
   - Perform actions
   - Oversee, track & monitor
   - Evaluate, update, renew

Care Conferences

A facilitated, family-centered meeting (typically 1 hour) among the family, primary care, community providers, schools, formal and informal family supports to facilitate detailed communication about strengths, challenges, current services, and gaps in services. A coordinated plan of care is developed with goals, resources, and work load distribution among providers with family input and consent. Care conferences address communication issues, needs of the family and helps to resolve identified and anticipated needs.
Children with Special Health Needs - Overview

- Care coordination
- **Medical Home Initiative**
- Pediatric Hi-Tech
- Personal Care
- Children’s Palliative Care
- Child Development Clinic
- Cleft Palate Clinic
- Rehab and Neurology clinics
- Respite
- Financial Technical Assistance
- Community Nutrition
- Newborn Screening
- Newborn Hearing Screening

Birth to age 21
Care Coordination Retooled: Integrating with a Statewide System of Care

Children’s Integrated Services (CIS) is a statewide resource for pregnant or postpartum women and families with children from birth to age six. Includes: Early Intervention, Nursing & Family Support, and Children’s Mental Health.

The Vermont Blueprint for Health (Medical Home initiative) is a vision, a plan, and a statewide partnership to improve health and the health care system for Vermonters. The goals are: 1) To implement a statewide system of care that enables Vermonters with, and at risk of, chronic disease to lead healthier lives; 2) To develop a system of care that is financially sustainable; and 3) To forge a public-private partnership to develop and sustain the new system of care.
Care Coordination Rounds

• Regular meetings (typically 1 hour) with practice care coordinator, physicians, CHT social worker, (sometimes other community partners as needed)

• Discussion of patients (who needs more intervention and who is doing what part of the work)

• Systems issues
Outcomes of Shared Care Planning

• Builds community collaboration and communication across services
• Builds knowledge base of services and system of care
• Determines most appropriate referrals, reducing duplication and fragmentation.
• Builds the capacity of primary care to provide long term chronic care management
• Addresses systems issues and barriers proactively (i.e. financing, insurance poverty, access to care)
• What gets measured – gets improved!
• Start small – Do something!
THANK YOU!