CARE CONFERENCES: THE FAMILY CENTERED APPROACH

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Objectives

- Understand why family centered care is important to families, community and practice
- How to identify the need for a care conference
- Learn step by step techniques to run an effective care conference
- Learn strategies to keep an open, unbiased mind in problem solving discussions

The Waterman Family

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

Antonelli, McAllister, Popp. **Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework**. The Commonwealth Fund, May 2009

Our Medical Home

- Three pediatricians: Dr. Hagan, Dr. Rinehart, Dr. Connolly
- Two pediatric nurse practitioners: Maryann Lisak and Ashley Boyd
- One main Care Coordinator (RN) Kristy
- Office manager, accounts manager, 2 front desk people
- Six additional part time nurses, two medical assistants
- ~4000 active patients
- Insurance mix: 40% Medicaid, 55% private ,<5% uninsured

Care Conferences

- Introductions/Contacts
- Set Agenda
- Set Roles: Facilitator
- Start with Strengths
- Ecomap if available
- Discussion
- Minutes Recorded
- Update Plan with Next Steps & Accountability
- Next Care Conference Date (if needed)
- Care plan is shared at end of meeting

A Framework for Highly Performing Pediatric Care Coordination

Care Coordination Competencies

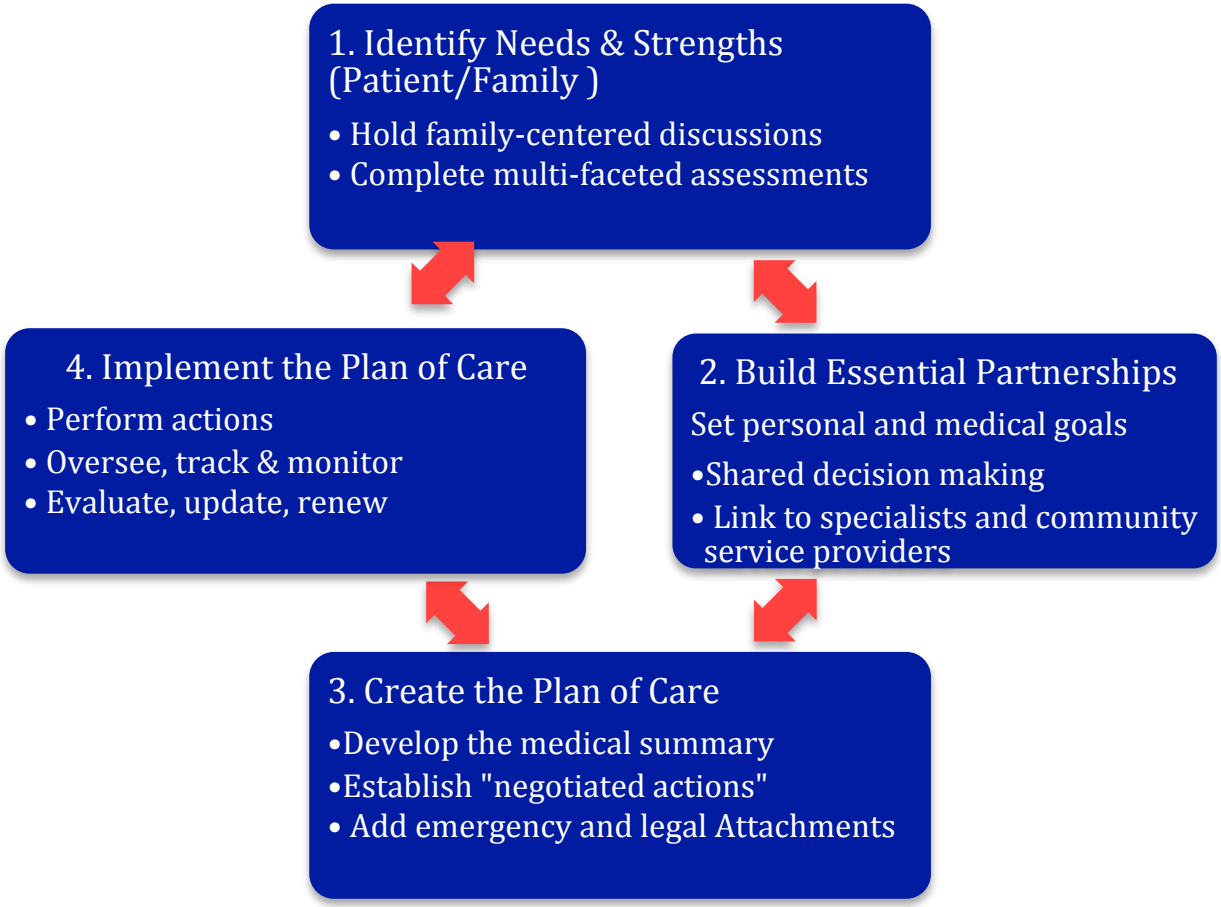
1) Develops partnerships
2) Proficient communicator
3) Uses assessments for intervention
4) Facile in care planning skills
5) Integrates all resource knowledge
6) Possesses goal/outcomes orientation
7) Approach is adaptable & flexible
8) Desires continuous learning
9) Applies solid team building skills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

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

Antonelli, McAllister, Popp. **Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework**. The Commonwealth Fund, May 2009.

Care Planning Model



McAllister, J., et al., *Achieving a Shared Plan of Care for Children and Youth with Special Health Care Needs: An Implementation Guide*. 2014, Lucille Packard Foundation for Children's Healthcare: Lucille Packard Foundation for Children's Healthcare.

Is Being a PCMH Good Enough?

"Comparison of Individual –Level Versus Practice –Level Measures of the Medical Home"

- Each practice had an NCQA level (2 at Tier 3, 3 at Tier 2)
- Of 180 parents only 52% had MH according to NSCH
- No significant association between family perception of medical home and being a practice wide medical home

Long & Garg 2015

Patient and Family Centered Care

Family centered care is about meeting families where they are, and helping them get where they want to go…

In Patient and Family Centered Care:

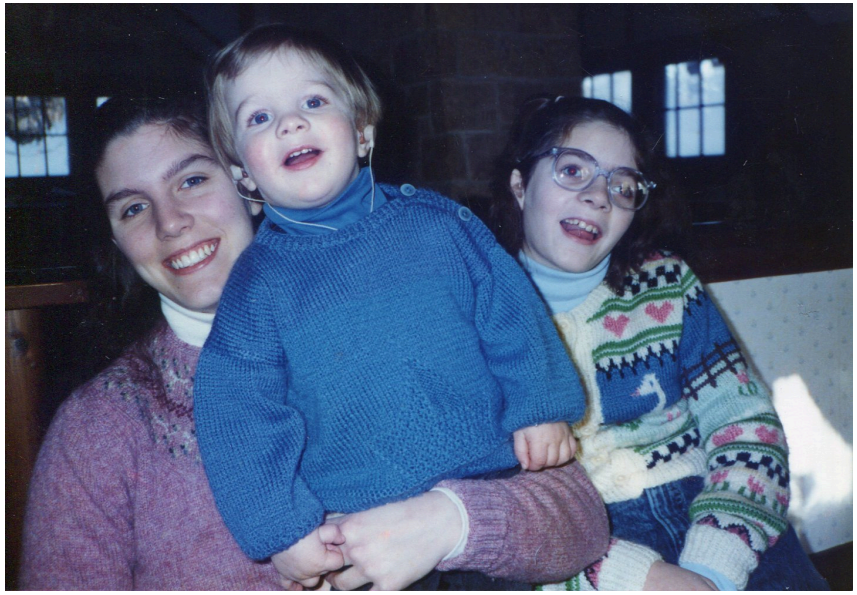
- People are treated with dignity and respect
- Health care providers share information that is useful and affirming
- Plans and experiences build on individuals and families strengths
- Collaboration extends beyond care to include policy change, on

Johnson (2000)

Care Partnership Support

- A meaningful collaboration between families and the care team to ensure effective and quality care for the patient.

- Designed to address family and patient access to quality care and effective communication.



Cultural Humility

*"**Cultural competency** implies that one can function with a thorough knowledge of the mores and beliefs of another culture; **cultural humility acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own**…Cultural humility requires us to take responsibility for our interactions with others beyond acknowledging or being sensitive to our differences."*

http://www.uniteforsight.org/cultural-competency/module12

Cultural Humility

"Humility has traditionally connoted a kind of meekness and humbleness, but it can also be used to denote a willingness to accurately assess oneself and one's limitations, the ability to acknowledge gaps in one's knowledge, and an openness to new ideas, contradictory information, and advice…"

http://www.uniteforsight.org/cultural-competency/module12

Competence

- Self Awareness Allows Progression From:

Unconscious Incompetence

Conscious Incompetence

Conscious Competence

Unconscious Competence

Why a Care Conference?

- Getting team members on the same page
- Uncertain who is involved in care
- Specific problem solving agenda
- Need to share critical information (new diagnosis)
- Transitions (educational, facility, life stage)
- To set Goals and Next Steps with Accountability

Work Flow for Care Planning

Team Person/Roles	Pre-Visit→ Preparation	Visit→ Caring Partnership interactions	After Visits→ Accountable follow through
Care Coordinator	Gathers recent information (recent labs, subspecialist notes, community provider updates) Identifies goals	Updates Care Plan Family/Personal Goals Medical Goals	Negotiate Next Steps
Youth/Patient/Family	Bring Questions? Share ideas Referrals?	Participates in Goal Setting	Negotiate Next Steps
Health Care Professional	Reviews communications Asks about goals Follows up w/ referrals	Assesses Needs Updates Care Plan	Negotiates Next Steps

McAllister, Jeanne, et. Al, "The Comprehensive, Integrated Care Plan (CICP): How Patients, Families and Providers Achieve Better and Continuous Communication, Collaboration and Coordination," The Lucille Packard Foundation for Children's Health, 2013

Pre-Visit Planning

- Care Coordinator sets an agenda with the patient/family
- Confirm attendance and participants and make sure family acknowledges and accepts all attendees
- Identify key problem solving agenda items
- Establishes an Agenda
- Ascertain if any issues family/patient does not want to discuss with the whole team

Physicians/Nurse Practitioners

- Prepare them!
- Tend to want to “fix” things
- Specific questions they should try to answer for the team?
- Subspecialists—orient them to concept

Care Conference: The Space

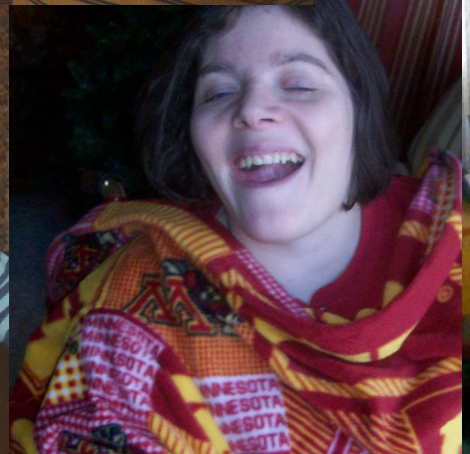
- Enough room for everyone to be at the table
- Family should be seated in central position next to supportive person
- Privacy is important –windows, interruptions to a minimum
- Space should establish comfort and sense of safety
- Priority for all team members to **be on time**
- Accessible, comfortable to needs of the family
- For pediatric care conferences we recommend child not be present unless they are an active participant (if possible)

Introductions & Roles

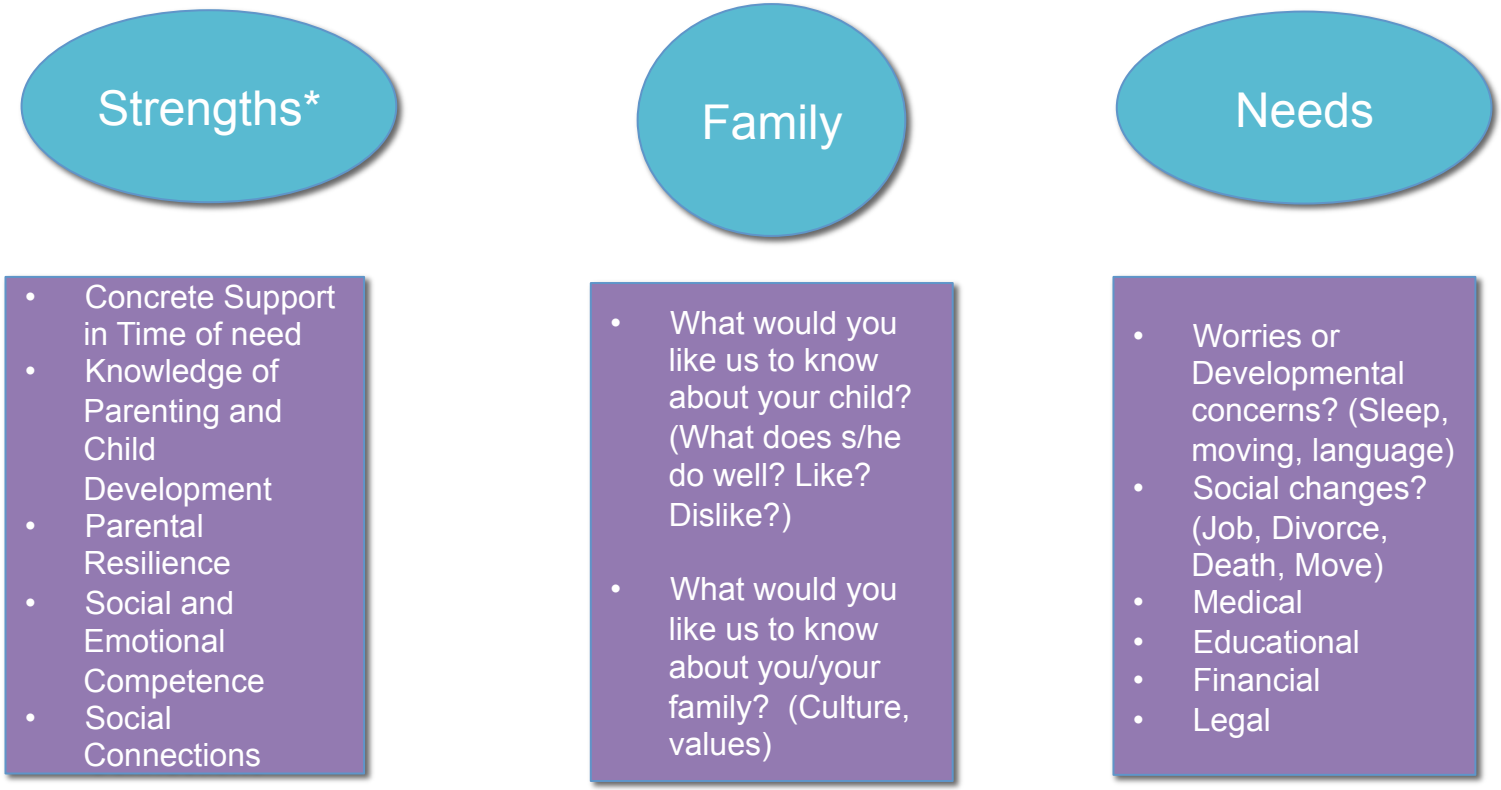
- Establishing the ground rules
- Identify who will be the facilitator?
- Facilitator leads introductions—each introduces themselves
- Share contact information
- If people call in, it is important for voices to be identified
- Facilitator sets roles:
- Who will take minutes?
- Time keeper?
- Jargon Buster?
- Capture goals and next steps?

Reviewing the Agenda

- Wellness
- Strengths
- Updates/Questions to address today
  - Family updates
  - Medical updates—perhaps historical review
  - Community updates from each team member
- Problem solving discussions
- Goals/Next Steps identified

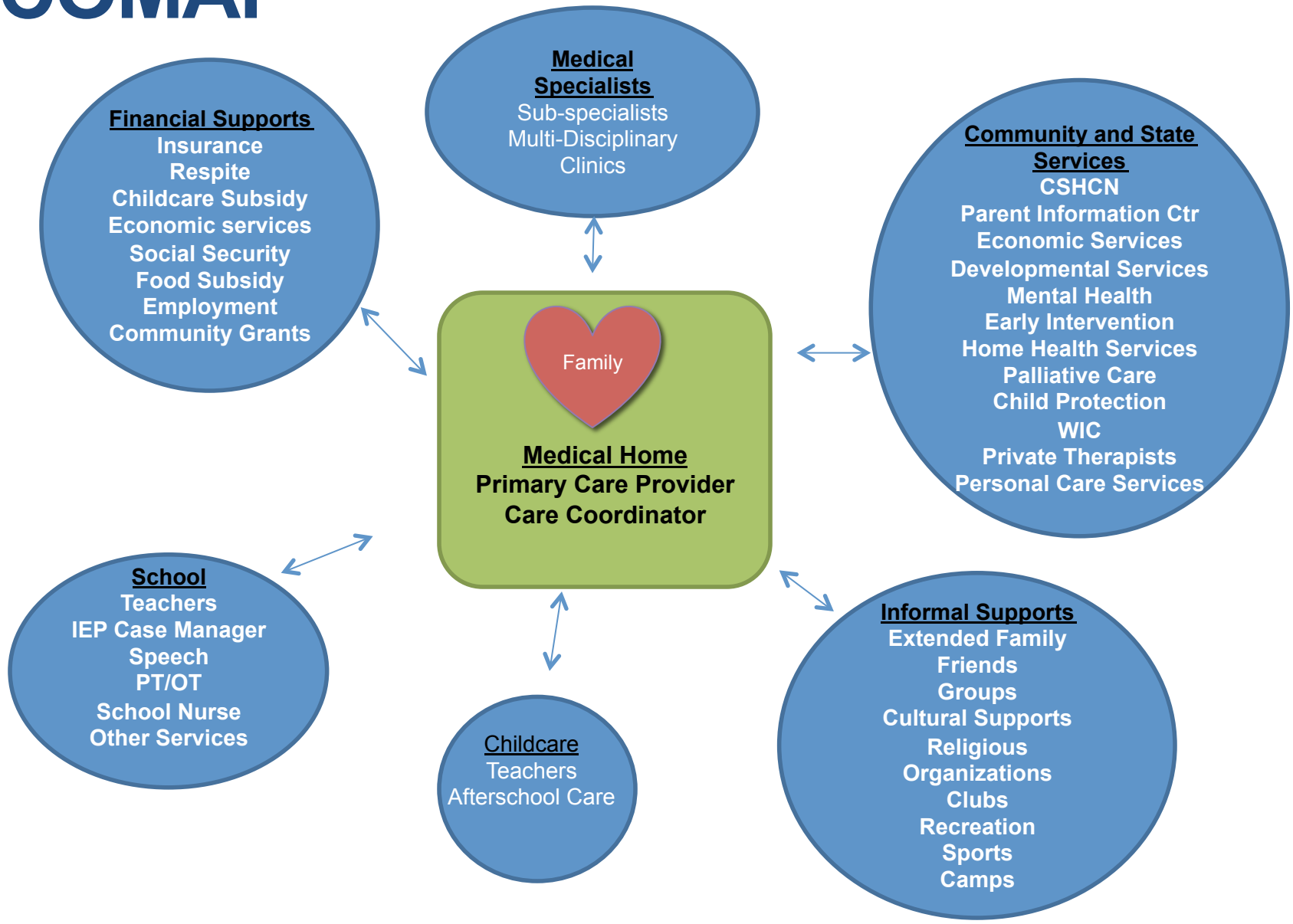


Comprehensive Understanding



Harper Browne, C. (2014, September). *The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper.* Washington, DC: Center for the Study of Social Policy

ECOMAP


Medical Specialists
Sub-specialists
Multi-Disciplinary
Clinics
Financial Supports
Insurance
Respite
Childcare Subsidy
Economic services
Social Security
Food Subsidy
Employment
Community Grants
Community and State Services
CSHCN
Parent Information Ctr
Economic Services
Developmental Services
Mental Health
Early Intervention
Home Health Services
Palliative Care
Child Protection
WIC
Private Therapists
Personal Care Services
Family
Medical Home
Primary Care Provider
Care Coordinator
School
Teachers
IEP Case Manager
Speech
PT/OT
School Nurse
Other Services
Childcare
Teachers
Afterschool Care
Informal Supports
Extended Family
Friends
Groups
Cultural Supports
Religious
Organizations
Clubs
Recreation
Sports
Camps

Eco-Maps

- Share copy with the team
- Members can identify gaps and update resources
- Orients the team to community around the patient
- Patient can identify where strong connections are
- Who is the “main” care coordinator in some instances

Updates

- Family
- Medical (Primary, subspecialty, psychiatry)
- Education updates and access
- Community (Developmental Services)
- Individual Services (Vision, Speech, OT, PT)
- Behavioral Planning

Problem Solving Discussions

- Each of us at the table has a piece of the puzzle
- Keeping an open mind can be challenging
- You may have an idea of how to move from point “A” to “B,” but the team/family/patient may have to go to “C” and “D” first
- Patience
- Kindness
- Humility
- Parking Lot and follow up

Conflict is…

Situation in which the concerns of two or more people/parties appear to be incompatible.

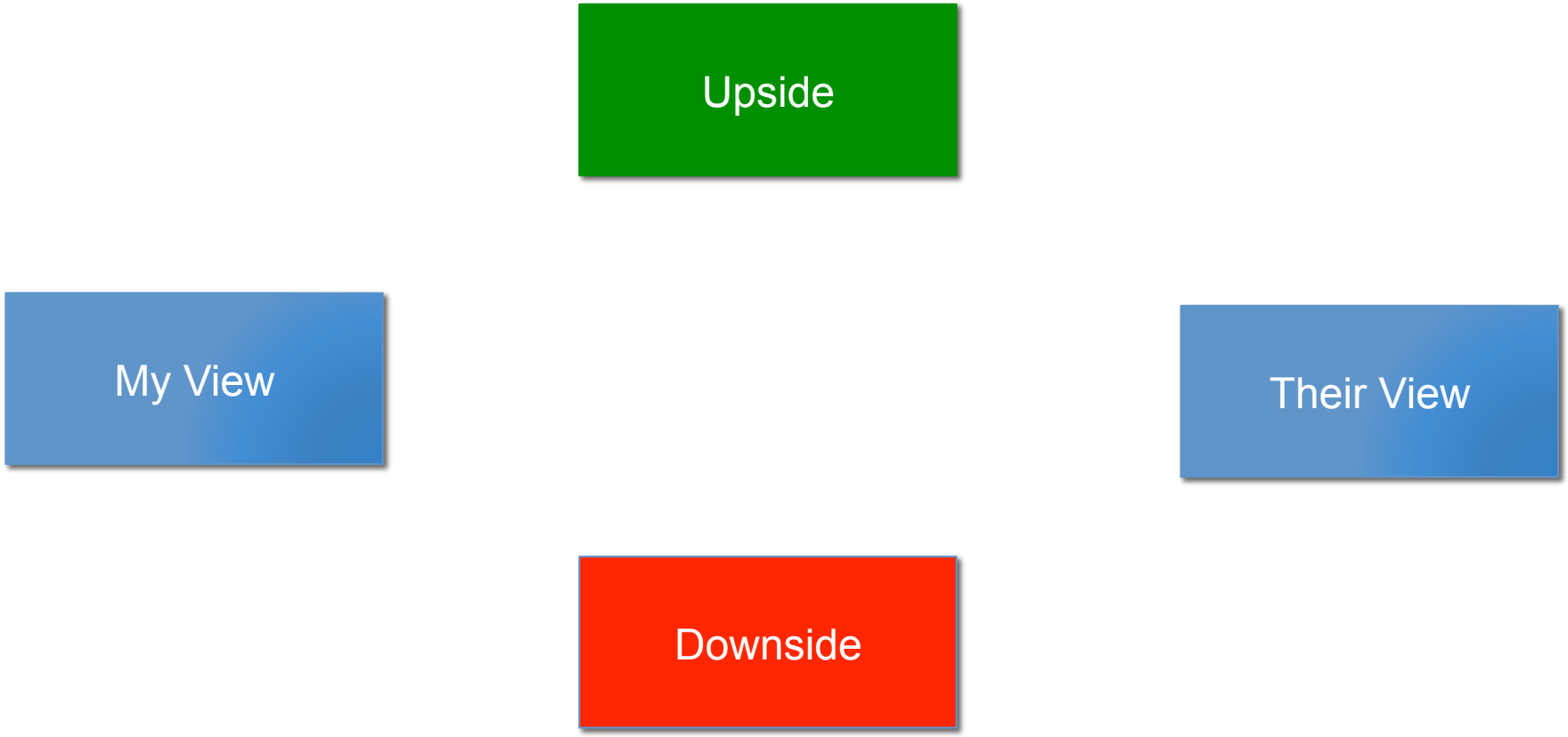
Thomas-Kilmann Conflict Modes

http://www.edbatista.com/2007/01/conflict_modes_.html

Acknowledgement

- Especially when things are tense or heated
- Without acknowledgement conversation much harder
- Opens up listening and liklihood of influencing

Managing Conflict



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Communication Activity

LEARN

- **L**isten: to the person's perception
- **E**xplain: your perception
- **A**cknowledge: similarities & differences
- **R**ecommend: both have ideas on what to do
- **N**egotiate: make a plan WITH (not for) the family

(adapted from Berlin & Fowkes, 1982)

Communication Activity

From BUT to AND…

REFRAIN from using:

- But
- However
- Be that as it may
- Regardless

Kleinman's Questions (1980)

- What do you call your problem?
- What do you think caused it? Why?
- What do you think your sickness does to you?
- How severe is it? Short or long course?
- What do fear the most?
- What are hardest problems this causes you?
- What kind of treatment do you feel you need? What are results you hope for?

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Wrapping Up

- Minutes Recorded
- Update Plan with Next Steps & Accountability
- Next Care Conference Date (if needed)
- Care plan is shared at end of meeting

GOALS/NEXT STEPS

- Medical, Personal
- Accountability
- Review this at the closure of care conference

Care Conference Scenarios

Care Coordination

Care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families…"

Making Care Coordination A Critical Component of the Pediatric Health System: A Multidisciplinary Framework, Antonelli, McAllister, and Popp, The Commonwealth Fund, May 2009

Outcomes of Shared Cared Planning

- Builds community collaboration and communication across services
- Builds knowledge base of services and system of care
- Determines most appropriate referrals, reduces duplication and fragmentation of care.
- Builds the capacity of primary care to provide long term chronic care management
- Addresses systems issues and barriers proactively (i.e. financing, poverty, access to care)