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
- Ottaqueechee 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

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

Care Coordination

Addresses interrelated needs:

- medical
- social
- developmental
- behavioral,
- educational
- financial

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

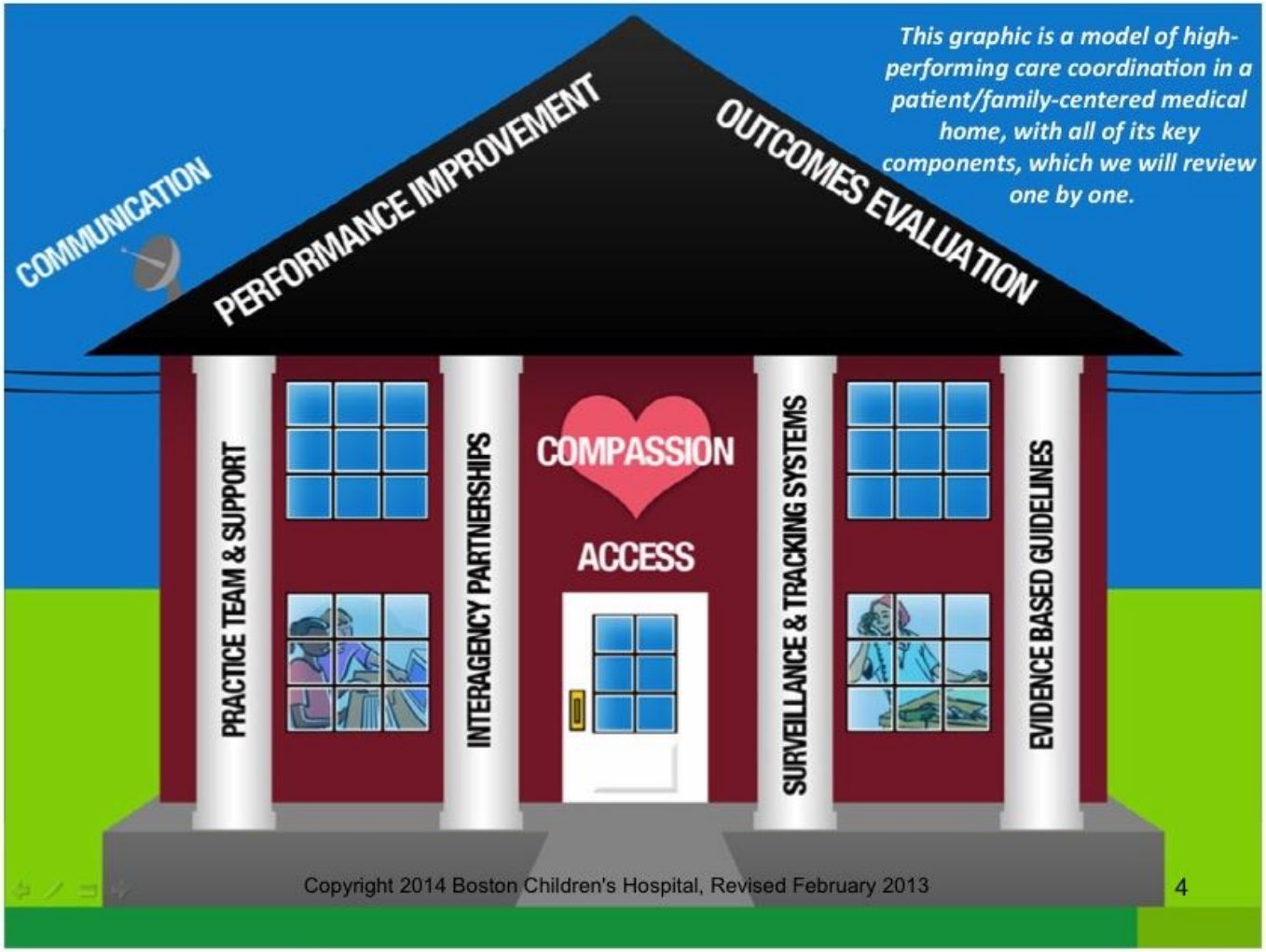
Goal:

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.
COMMUNICATION
PERFORMANCE IMPROVEMENT
OUTCOMES EVALUATION
PRACTICE TEAM & SUPPORT
INTERAGENCY PARTNERSHIPS
COMPASSION
ACCESS
SURVEILLANCE & TRACKING SYSTEMS
EVIDENCE BASED GUIDELINES
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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

PARENTS' VOICES

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.

Parent interview, March 6, 2014

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"

.

PARENTS' VOICES

NO CARE COORDINATION

- "I wanted my focus to be my child, not making 32 phone calls a day."
- "The doctor said: "You know it's a band-aid. We're just keeping him alive." I want something more – some quality of life."

WITH CARE COORDINATION

- "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."
- "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."

Parent interviews, March 6, 2014

PARENT VOICES

NO CARE COORDINATION

- "Before, we were always treating symptoms…I always felt that I was leading the conversation, like: "Don't you think we should consider doing___?"
- "I guess I was kind of a problem parent for them."

Parent interview, March 6, 2014

WITH CARE COORDINATION

- "I don't have to be advocating and pushing all the time. Every visit, even sick visits, at the end, we look at where we want to be and how we will take baby steps to get there, even when there are setbacks, and there are always setbacks, but I don't get as discouraged, because we have a plan, we know where we are headed."

WHICH PROVIDER VOICE ARE YOU ?

- ❑ 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.

CMHI National Outcomes Study Cost/Utilization

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

Cooley, McAllister, Sherrieb, Kuhlthau, *Pediatrics*, July 2009

"Care Plans"-recommended

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

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

Our Medical Home Program

- Three pediatricians, Dr. Joseph Hagan, Dr. Jill Rinehart, Dr. Greg Connolly
- Two Pediatric Nurse Practicioners, 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

Victoria Garrison, "Innovations in Medical Home," VFN annual conference, April 2013

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

A Framework for Highly Performing Pediatric Care Coordination

Care Coordination Competencies

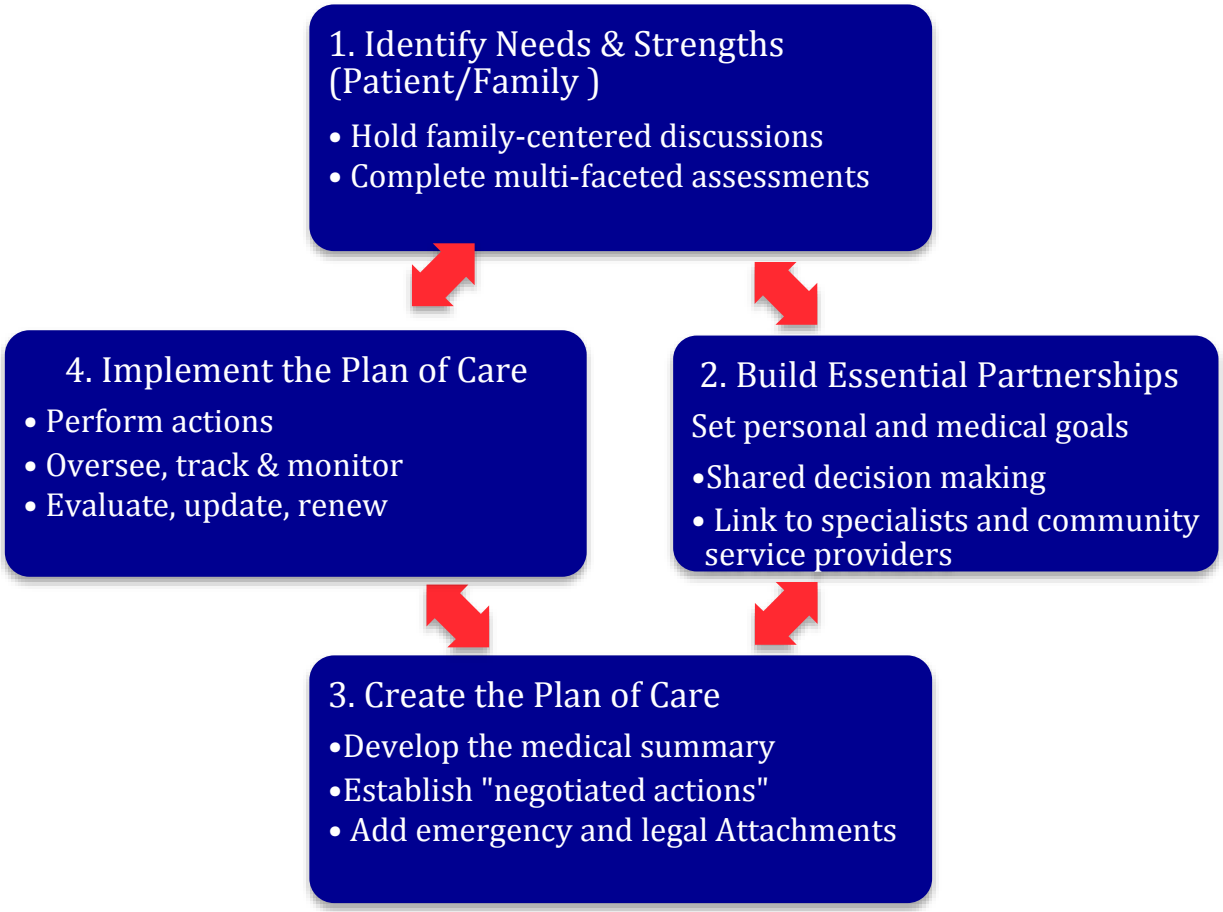
1) Develops partnerships
2) Proficient communicator
3) Uses assessments for intervention
4) Facile in care planning skills
5) Integrates all resource knowledge
6) Possesses goal/outcomes orientation
7) Approach is adaptable & flexible
8) Desires continuous learning
9) Applies solid team building skills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

Partnership 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 (in press), Lucille Packard Foundation for Children's Healthcare: Lucille Packard Foundation for Children's Healthcare.

Care Conferences

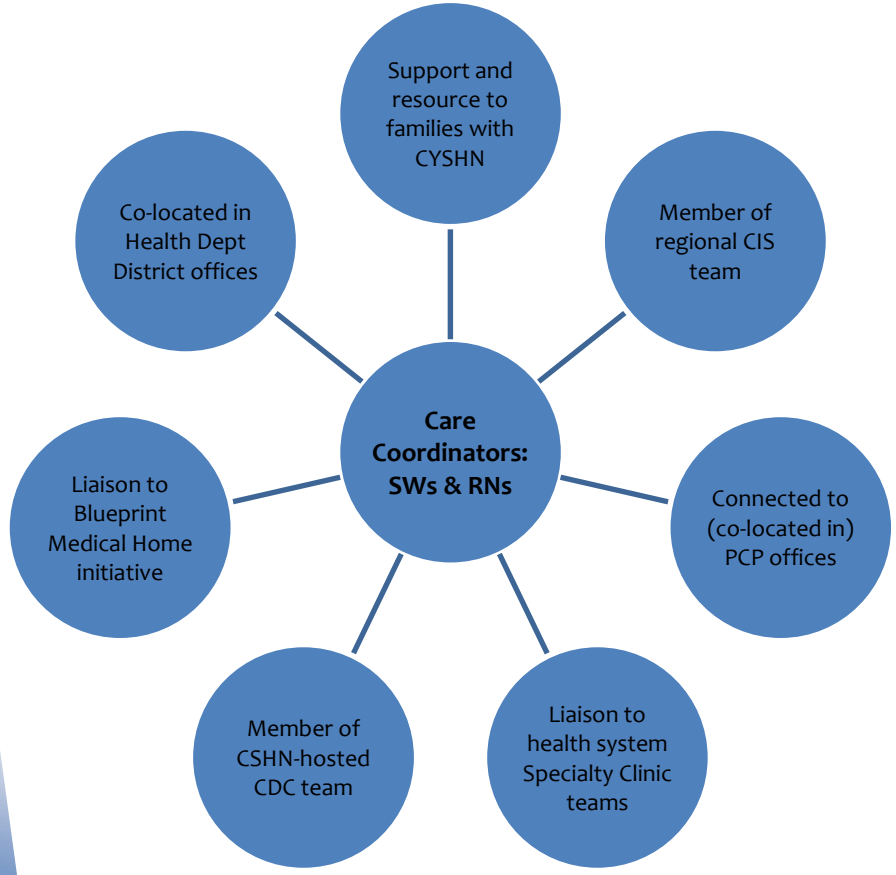
A facilitated, family-centered meeting (typically 1 hour) among the family, primary care, community providers, schools, formal and informal family supports to facilitate detailed communication about strengths, challenges, current services, and gaps in services. A coordinated plan of care is developed 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.

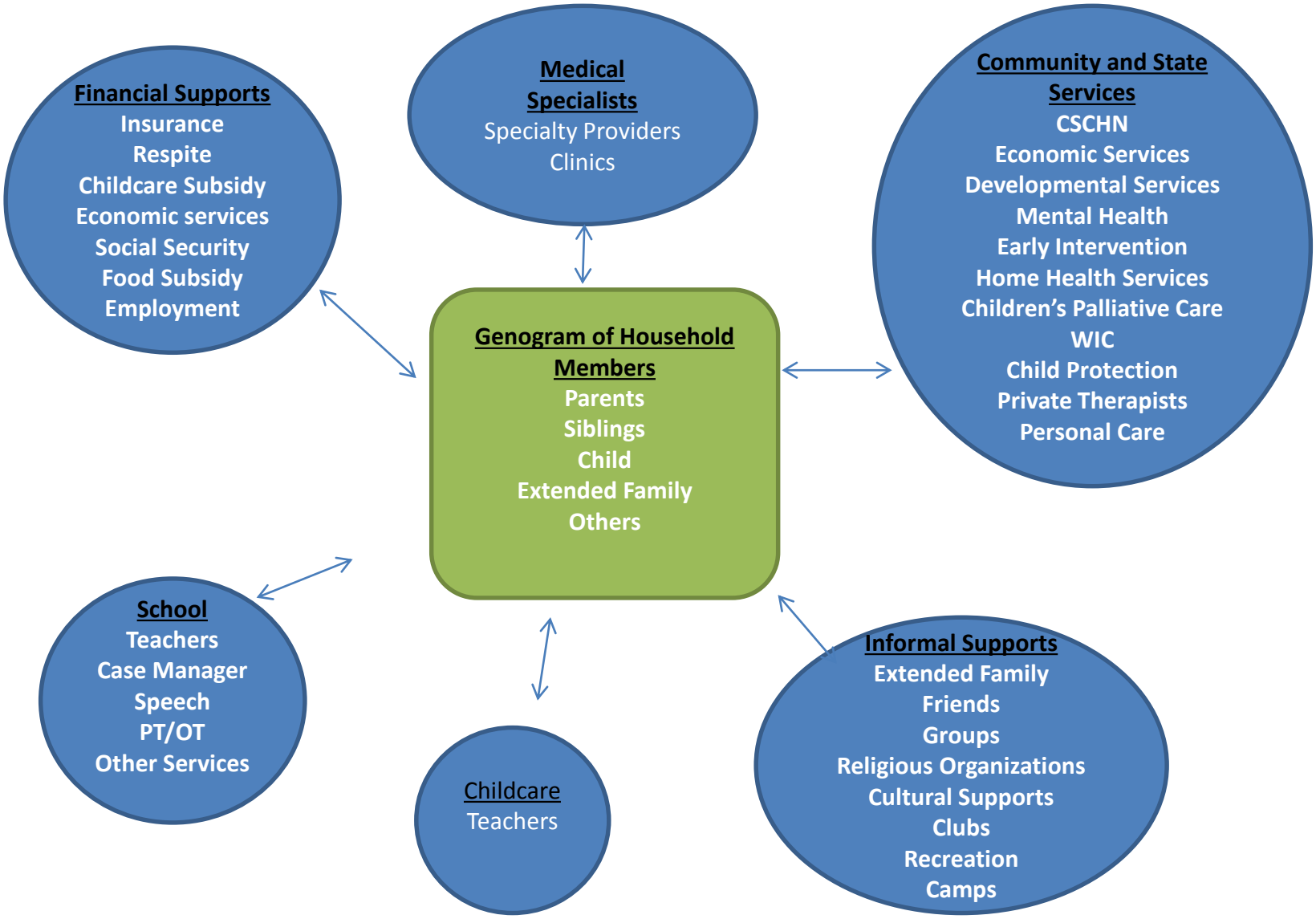
Medical Home

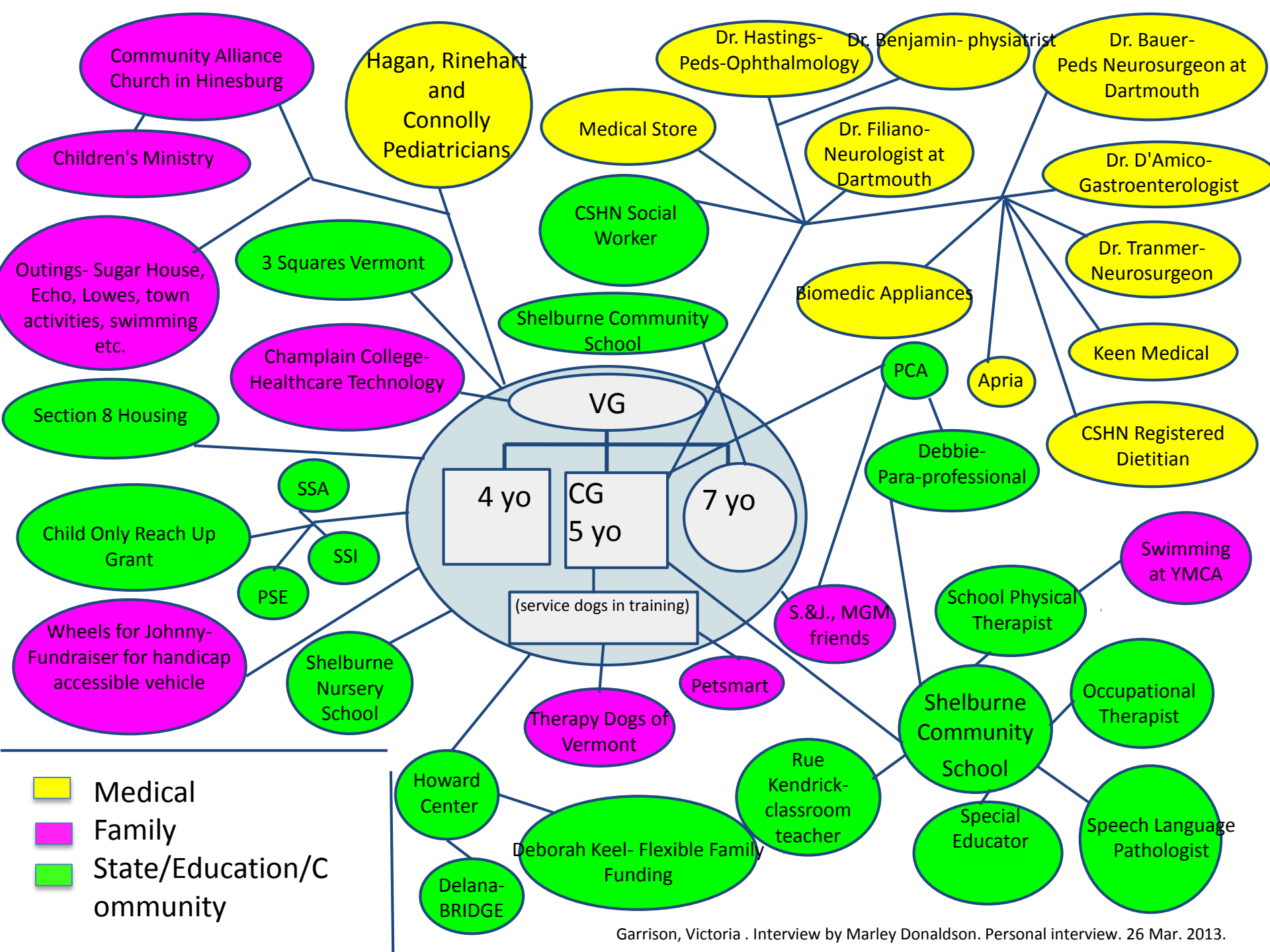
CSHN Social Worker

CIS

Child Development Clinic & CSHN Services

ECOMAP


Financial Supports
Insurance
Respite
Childcare Subsidy
Economic services
Social Security
Food Subsidy
Employment
Medical Specialists
Specialty Providers
Clinics
Community and State Services
CSCHN
Economic Services
Developmental Services
Mental Health
Early Intervention
Home Health Services
Children's Palliative Care
WIC
Child Protection
Private Therapists
Personal Care
Genogram of Household Members
Parents
Siblings
Child
Extended Family
Others
School
Teachers
Case Manager
Speech
PT/OT
Other Services
Childcare
Teachers
Informal Supports
Extended Family
Friends
Groups
Religious Organizations
Cultural Supports
Clubs
Recreation
Camps



Garrison, Victoria . Interview by Marley Donaldson. Personal interview. 26 Mar. 2013.

Care Coordination Rounds

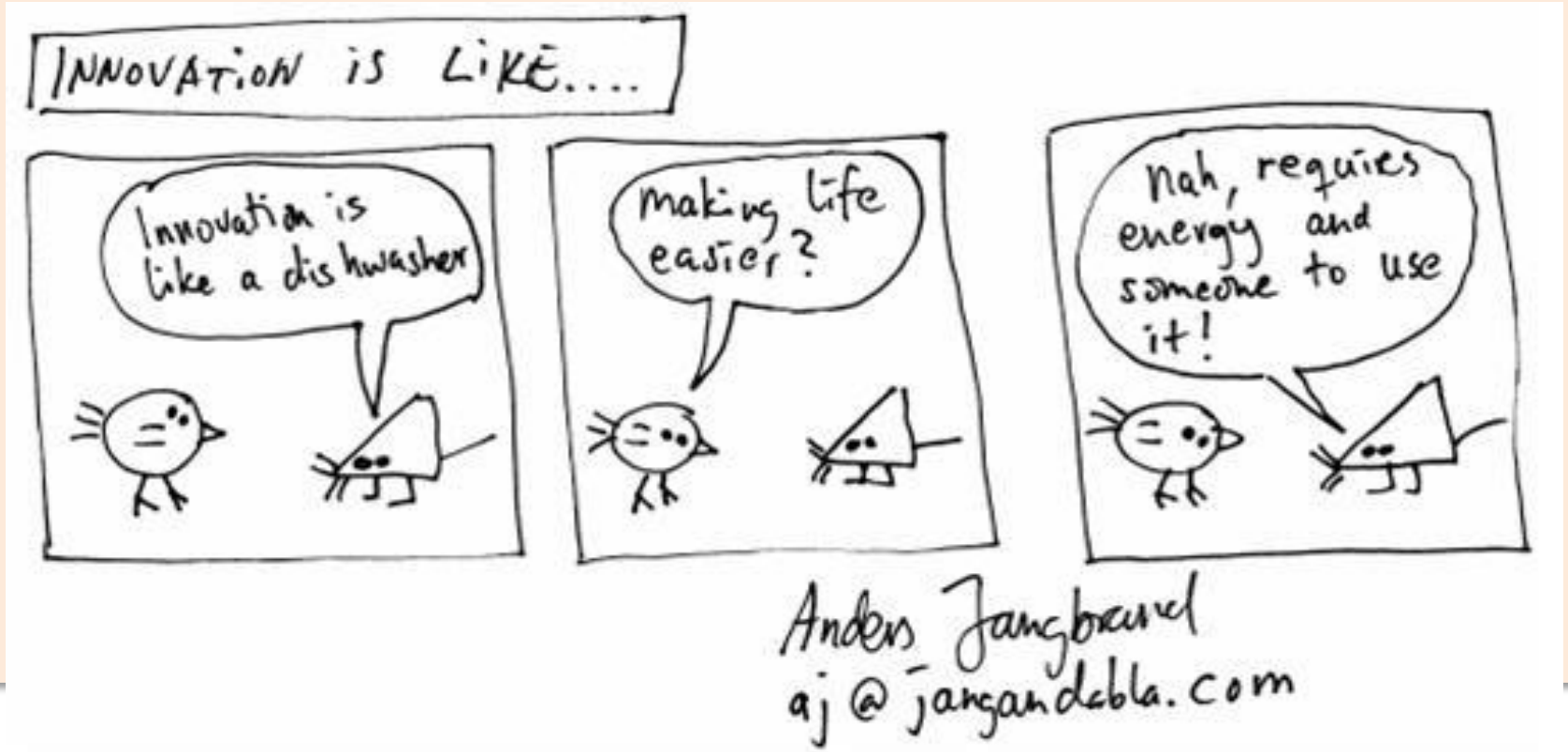
- Regular meetings (typically 1 hour) with practice care coordinator, physicians, CHT social worker, (sometimes other community partners as needed)
- Discussion of patients (who needs more intervention and who is doing what part of the work)
- Systems issues

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)

INNOVATION

- What gets measured – gets improved!
- Start small – Do something!



THANK YOU!