Care Coordination

What is it?
Why do we need it?
How do we do it?

MA Child Health Quality Coalition Care Coordination Task Force
A Picture Tells a Thousand Words... from Cristin Lind’s Care Mapping Project

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Care Coordination Definition

Pediatric 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 caregiving capabilities of families.

Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes.

The healthcare system is fragmented; patients/families forced to navigate an increasingly complex system

Quality care mandates focus on whole child

Lack of effective communication and coordination results in medication errors, unnecessary or repetitive diagnostic tests, unnecessary emergency room visits, and preventable hospital admissions and readmissions

Fundamental strategy for reducing costs while improving care
Courtesy of Susan Arndt (Family Leader, Framingham)
How Do We Do It?

- Team-based care: clear assignments, matching responsibilities to defined set of CC functions
- Central role for family: families as authentic partners, “doing with”
- Medical Home as key organizing entity, but need integrated care with accountabilities at multiple system levels to deliver optimal care
- CC TF recommendations for Key Elements across five domains in response to everyone asking: where do we start? what are the priorities?
## Key Elements: High-Performing Care Coord.

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>Sample Measures</th>
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<tr>
<td>1) Needs assessment, continuing CC engagement</td>
<td>Use of a <strong>structured</strong> care coordination needs assessment tool/process. Ask family: did you get what you wanted?</td>
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<tr>
<td>2) Care planning and coordination</td>
<td>Family engagement in co-creation and implementation of care plan. Care team on same page</td>
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<tr>
<td>3) Facilitating care transitions</td>
<td>“Closing the loop”: timely communication (to PCP/family/others), tracking completion. HEDIS measures, Patient Experience Survey, resource use</td>
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<td>4) Connecting with community resources/schools</td>
<td>Link to family partner. Referral connections made</td>
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<td>5) Transitioning to adult care</td>
<td>Acquisition of self-management skills. ID adult providers with capacity, expertise</td>
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**MA Child Health Quality Coalition CC Task Force Framework**
## CC Competencies and Functions

<table>
<thead>
<tr>
<th>Care Coordination Competencies:</th>
<th>Care Coordination Functions:</th>
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<tbody>
<tr>
<td>1. Develops partnerships</td>
<td>1) Provide separate visits &amp; CC interactions</td>
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<td>2. Proficient communicator</td>
<td>2) Manage continuous communications</td>
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<td>3. Uses assessments for intervention</td>
<td>3) Complete/analyze assessments</td>
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<td>4. Facile in care planning skills (PFC)</td>
<td>4) Develop care plans (with family)</td>
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<td>5. Integrates all resource knowledge</td>
<td>5) Manage/track tests, referrals, &amp; outcomes</td>
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<td>6. Possesses goal/outcome orientation</td>
<td>6) Coach patient/family skills learning</td>
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<td>7. Approach is adaptable &amp; flexible</td>
<td>7) Integrate critical care information</td>
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<tr>
<td>8. Desires continuous learning</td>
<td>8) Support/facilitate all care transitions</td>
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<td>9. Applies solid team/building skills</td>
<td>9) Facilitate PFC team meetings</td>
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<tr>
<td>10. Adept with information technology</td>
<td>10) Use health information technology for CC</td>
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Who Performs CC Functions?

- Family
- Officially Designated Care Coordinators
  - RNs/NPs
  - Licensed Social Workers and Child and Family Therapists
- PCP, Specialists, Other Clinical Providers
- Office Staff
- State Agency supports
- Family Partners
- Other Members of the Care Team!!
  - CHWs, school nurses, community resources
Matching Services to Complexity

Children with complex needs
--Neurodevelopmental (Autism, etc.)
--Behavioral/Psychiatric
--Oncology
  • Sickle cell
  • Hemophilia
--Technology dependent

Children with chronic conditions
--Behavioral (ADHD, depression, anxiety, PTSD)
--Asthma
--Diabetes

Healthy, Preventive
Elements of “high quality” referrals
- Identify information needed at transition points
- Timely transmission of information back to the PCP setting
- Family participation

Tracking “closing the loop” with referrals to outside behavioral health entities a high-priority gap

Addressing transitions in and out of programs (e.g. aging out of Early Intervention services, moving from DMH residential services back into community) a significant issue

Transitioning to adult care a special issue in pediatrics: importance of teaching self-care and communication skills early. Shared accountabilities for transition with adult providers.
Connecting to Community Resources

- Heightened priority for children/youth, incl links to schools/day care, after school, recreation
- Addressing medical and psychosocial issues; must be systematic assessment of community referral needs
- Importance of connections to family support organizations: partners to help navigate system, build capacity to participate
- Big challenges creating two-way communication channels with community-based organizations
- Identify opportunities to reduce duplication of efforts in building knowledge of available community services; promise of centralized resources like 211/Help Me Grow/ Warmlines models
Team-Based Care
Foundational for Effective Care Coordination

- Engage team: broadly defined -- family, community, schools as well as medical/BH clinical and support team

- Assign clear roles and responsibilities: address potential overlaps (multiple agency engagement, health plan case managers, BH and medical care coordination needs)

- Use care plan as communication vehicle for keeping all the players up-to-date

- Capacity building: authentic family–provider/care team partnerships require family/youth capacity building and professional skill building
## CHQC CC Accountability Framework

<table>
<thead>
<tr>
<th>Levels of Accountability</th>
<th>Roles/Measures</th>
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<tbody>
<tr>
<td>Child/Family</td>
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<tr>
<td>Community/Schools</td>
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<tr>
<td>Group Practice/Medical Home (Primary Care) Individual Providers</td>
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<tr>
<td>Psychiatric and Other Specialty Practices Individual Providers (Sub-specialists)</td>
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<tr>
<td>Community-Based Organizations</td>
<td>Community Service Agencies (CSAs), Other Service Providers (EI, CSA, rehab)</td>
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<tr>
<td>Inpatient Facilities</td>
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<tr>
<td>Health Systems/ACOs</td>
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<tr>
<td>Health Plans</td>
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<tr>
<td>State</td>
<td></td>
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<tr>
<td>National/Regional</td>
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Source: MA CHQC CC TF
Barriers to Successful CC

- Lack of time, limited staff at many pediatric practices
- Lack of reimbursement
- Lack of integrated data systems
- Lack of medical specialty and community services to which children can be connected
- Staff turnover, losing expertise about services
- Turnover of community service providers, difficulties in maintaining resource lists
Promoting Implementation

- No magic bullet – a range of models can work; need culture change and workforce development to achieve shared accountabilities, authentic partnerships
- Payment models w/ bundled payments enabling care coordination and other services for identified populations at core of achieving optimal value
- Medical Home is a necessary component of a high performing health care system, but it is not sufficient to deliver optimal value outcomes
- Families’ role as authentic partners fundamental component to success; support reciprocal capacity building
- Need to promote testing of measures embedded into QI perspectives that operationalize shared accountabilities
- Don’t ignore the long-term -- benefits from whole family, life course, prevention, population-based strategies
Medical Home and behavioral health integration transformation projects
  - MA Primary Care Payment Reform initiative, Health Policy Commission PCMH Certification, Health Homes Initiative
  - NCQA PCMH recognition standards, Meaningful Use funding

Integrating with state agency initiatives
  - Title V, DMH, DCF, CBHI/MCPAP

Opportunities within grant-funded programs
  - MA SIM grant, ACO pilots, payers’ QI programs

Advocating for testing: huge gap in ability to measure impact (NOT ready for P4P)

Advocating for pediatric components in new payment models
For More Information

Contact Gina Rogers (grogers@mhqp.org)

MA Child Health Quality Coalition Care Coordination Task Force

Co-Chairs:
Rich Antonelli, MD, Boston Children’s Hospital
Barbara Leadholm, Health Management Associates
(formerly Commissioner, MA DMH and Senior Advisor, MassHealth)

Spring, 2014
Additional References

CC Task Force

Vignettes: Shared Accountabilities with Measure Bundle Concepts
Integrated Model

Scenario: 14 y.o. in-patient psychiatry discharge to community

- **Family**
  - Family participates in care planning
- **Primary Care**
  - Liaison with PCP
  - PCP receipt
  - Discharge summary and care plan
- **In-Patient**
  - Preparation for discharge
- **Subspeciality Care (Ambulatory)**
  - Care plan discussion
- **Behavioral Health (ambulatory)**
  - Receipt of plan
  - Receipt of plan (enough information to ensure safety)
- **School**
- **DMH**
- **Payer**
- **Family-to-Family Support**
- **Referral**
Integrated Model: Early Intervention Vignette

- **Family**
  - Positive M-CHAT (autism screen @ well visit (HMV))
  - Make referral
  - Track referral
  - Registry entry
  - Receive report
  - Incorporate into care plan
  - Review with family

- **Primary Care**
  - Evaluation
  - Care/Treatment Plan
  - Receive referral
  - Track referrals
  - Track measures (close the loop outcomes)

- **Subspecialty Care (Ambulatory)**

- **Commun. Based Orgs/Early Interv**

- **DPH/Title V**
  - Track referrals
  - Report utilization
  - Quality family and provider experience

- **Payer**

- **Family-to-Family Support**
Bundle Measure: “Closing the Loop”
18 month old w/ positive MCHAT

PCP

Measure – referral received

Measure – referral sent

EI

Family receives confirmation of transmission and receipt

PCP

Measure – Report Sent

Family receives confirmation of transmission and receipt

Measure – Report Received
Each element of the bundle is measured
Reported at each site within the bundle
Can segregate the components
  ◦ Referral sent/ received sub-component
  ◦ Evaluation report sent/ received sub-component
Challenges
  ◦ Not currently done automatically (ie, electronically)
Caveat: Must start somewhere!!
Implications for Accountability

- Measure at all Levels of the System
- Transparency of Performance
- Incentives Supporting Activities in “Space Between”
  - Education of work force
  - Support for those activities
  - Support for measurement
Additional References

Survey of MA Families about Community Resource Linkages

Provided by Bonnie Thompson, CHIPRA Grant Family Leader, Mass Family Voices of the Federation for Children with Special Needs
Most Useful Community Resources

- Parent support groups
- Disability specific organizations (mental health conditions, autism support centers, diagnosis specific groups)
- Schools
- Libraries
- Adapted recreation programs
- Family run organization call centers (Parent Professional Advocacy League-PPAL, Mass Family Voices, Federation for Children with Special Needs-FCSN, Family Ties of MA)
- Boys & Girls Club
- Children’s Behavioral Health Initiative (CBHI)
- Resources for Community and People (RCAP Solutions)

....continued...

Results of survey of Massachusetts family leaders experienced in providing peer support and Family Partners in NICHQ PCMH Learning Collaborative  (Oct. 2013) Provided by Bonnie Thompson, MFV
Community resources most useful to families… (continued)

- REGIONALLY LOCATED to get information on resources in or near their community
- Provide information on LOCAL AID (housing, food pantries/bank, fuel assistance, WIC, child care)
- Groups that can LINK PARENTS TO OTHER PARENTS with similar needs and concerns
- If payment required, within families’ HEALTH INSURANCE NETWORK
Barriers Hindering Making Connections

- conflicting demands for family or patient’s time
- cost
- location
- scheduling ease and availability of appointments
- siblings’ competing needs
- parent capacity and wellness
- knowing what is out there
- lack of response from resources contacted
- family readiness to engage
- language barriers
- transportation
- limited time resource (funding ends)
- weather
- many non-profit resources are at capacity; challenged to get out, do outreach and spread the word
What needs to further develop to encourage greater community linkages?

- Expanding resource knowledge to more staff so information not lost when staff moves on
- Thorough documenting of resources, updated regularly
- More family partners/leaders embedded in clinical practices facilitating connections
- Funding for an independent organization or persons with lived experience to create a family driven/youth guided plan to link resources together
- Need to see kids holistically, not carved out by specialty, system or silo
- To have someone who can look at the gaps and see the opportunities to innovate; how to do better and address unmet needs
- When used, improvements to health insurance case management can work when the assistance is meaningful, otherwise it leaves families frustrated.
- Family-centered care; looking at the whole family relative to the child needs