Achieving Pediatric Care Coordination

Along the health care continuum; across the life course
Objectives

• Convey why care coordination (CC) is essential:
  – Better care/experience of care - for children and families
  – More satisfying delivery of care - for professionals
  – Cohesion (vs. fragmentation) - across health care systems

• Describe current CC best practices

• Detail lessons from CC implementation in Indiana

• Relay excitement, challenges & opportunities
  – Coming up
If you can bring us real care coordination, you will have saved our family’s life.
Community Alliance Church in Hinesburg

Children's Ministry

Outings- Sugar House, Echo, Lowes, town activities, swimming etc.

Section 8 Housing

Child Only Reach Up Grant

Wheels for Johnny-Fundraiser for handicap accessible vehicle

Shelburne Nursery School

Medical Store

Hagan, Rinehart and Connolly Pediatricians

CSHN Social Worker

3 Squares Vermont

Champlain College-Healthcare Technology

Dr. Hastings-Peds-Ophthalmology

Dr. Benjamin-physiatrist

Dr. Bauer-Peds-Neurosurgeon at Dartmouth

Dr. D'Amico-Gastroenterologist

Dr. Tranmer-Neurosurgeon

Keen Medical

CSHN Registered Dietitian

PCA

Biomedic Appliances

Debbie-Para-professional

S.A., MGM friends

Petsmart

Therapy Dogs of Vermont

Dr. Filiano-Neurologist at Dartmouth

Dr. Benjamin-Peds-Ophthalmology

Dr. Bauer-Peds-Neurosurgeon at Dartmouth

Dr. D'Amico-Gastroenterologist

Dr. Tranmer-Neurosurgeon

Keen Medical

CSHN Registered Dietitian

Swimming at YMCA

School Physical Therapist

Occupational Therapist

School Physical Therapist

School Physical Therapist

Speech Language Pathologist

Fragmented attempts to improve a fragmented system:

*I need a coordinator to coordinate the coordinators*

Family Quote, 1993
Fragmented attempts to improve a fragmented system:

I need a coordinator to coordinate the coordinators

Family Quote, 2015
Shared Principles for Care Coordination

- Children and Families are Central
- Local Community is Emphasized
- Health Care and Community Efforts are Aligned, &
- Family-Centered Care Coordination is Sustained
Benefits to Stakeholders
Sweet Spot Solutions

Patients/Families
Providers
System
Shared Care-Planning:
As a key care coordination strategy

1. Improves care / reduces fragmentation
2. Guides a family-centered, multi-disciplinary team process
3. Enables communication and collaboration
   - Patient, child/family, and their “care neighborhood” operate from the same goals & “same page”
4. Delivers oversight
   - With developed timelines, responsibilities and accountabilities
## “Shared Plans of 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>
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<tr>
<td>Centers for Medicare and Medicaid (CMS)</td>
<td>“Visit summary of care” {Mandates (ACA) care planning components “Continuity of Care Record”}</td>
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<td>Meaningful Use</td>
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<td>National Quality Forum (NQF)</td>
<td>Plan of Care: Actively tracks up-to-date progress towards patient goals</td>
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<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 McAllister, 2014</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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“Turnkey” Care Coordination?
Care Coordination Elevator Speech?
Care coordination “elevator speech”?

“With care coordination...you have to take the stairs! (1-2 steps at a time)
Excitement – What We Know

- Care coordination is a standard of care (Ref 1 AMCHP)
- Care coordination definition, framework, functions and competencies (Ref 2 Commonwealth Fund, Ref 3 AAP)
- Shared plan of care as a CC implementation strategy
  - (Ref 4) Lucile Packard Foundation for Children’s Health Report;
    - Achieving a Shared Plan of Care – Ten Steps
- Improvement carried out with (not for) families
  - Pilot - Riley Hospital for Children/IU Health
  - Grant – USMCHB/CYSHCN, 16 States
    - CC/shared plans of care a priority
10 Step Approach to a Shared Plan of Care

<table>
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<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Identify who</td>
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<td>2.</td>
<td>Discuss value</td>
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<td>3.</td>
<td>Assess “What I Need”</td>
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<td>4.</td>
<td>Set Goals “what matters”</td>
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<td>5.</td>
<td>Identify partners</td>
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<td>6.</td>
<td>Create the “Medical Summary &amp;”</td>
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<td>7.</td>
<td>“Negotiated Actions”</td>
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<tr>
<td>8.</td>
<td>Make available, accessible, retrievable</td>
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<td>9.</td>
<td>Provide oversight</td>
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<td>10.</td>
<td>Systematize</td>
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Challenges

• Alignment in definition, model and approach to care coordination (remember family quote)

• Complexity & Chaos
  – Children/families with chronic health conditions
  – Competing, fragmented health care systems
  – Achieving cohesion, meeting expectations
    • Hard to do, needs multiple sources of support

• Establishment of a true accountable
  – “locus of care coordination”
Even when there is knowledge and skill, a lack of supportive structures remain:

_In 2015, system constraints render us unable to deliver evidence based care to meet our patient’s needs_

Clinician Quote, 2015
This isn’t working at all... I should warn others not to put their cart before the horse.

Care Coordination (CC)
Evidence before CC Testing & Implementation?
Opportunity 1: Riley Hospital for Children Outpatient Care Coordination Pilot 2015-2016

Horse *before* Cart

**Kids with Shared Plan of Care (Sept > 100)**

- **Population**
  - 180 kids ASD, Ages 2-8, followed in neurodevelopmental specialty programs
- **Team based**
- **Achieving a Shared Plan of Care Model**
- **Implementation Science (How)**
- **Data:**
  - *Pre Post Family*
  - *All Team*
  - *Care Coordination*
  - *Financial*
Opportunity 1 & 2

Quaternary/Tertiary Hospitals
Specialty Centers

Public Health

Public Programs
Insurers

Family-Centered Medical Home  School
Social Supports

Care Coordination: Integration Across the Life Course & Care Continuum

★

• Daily family life
• Specialized care
• Communications
• Aligned, integrated approaches
• Coordination of Care
  • Shared plan of Care
  • Resource TA
  • Policy supports
Why Planned Coordinated Care using a Shared Plan of Care Is a Win Win

- Motivates, empowers (mutual goal setting)
- Promotes teamwork/QI
- Engages family in assessment & care conversations
- Documents clear, integrated information
- "Scripts" patient/family & team roles
- Monitors progress against set goals
- Links to "other" care plans
- Impacts costs - redundancy, system failure/waste

Better Care, Health & Costs
Care Coordination is a family-centered, assessment driven, continuous, team-based activity designed to meet the bio-psychosocial needs of children, while enhancing family care-giving skills and capabilities.

| Family Centered | • Family goals (e.g. learning growth and development) |
| Assessment driven | • “What I need” (e.g. fiscal resources, school communication) |
| Continuous | • Locus of care coordination (clear designated go to CC); non episodic coordination |
| Team based | • Clinician - CC dyads, supportive structures (relational coordination, team huddles) |
| Bio psychosocial needs | • $ support - diapers - ABA – up to integrated complex care |
| Skill Building | • Family learning & navigation; Professionals – learn from and with families, achieve CC |
References


