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|  | **Focus Areas by State Team** | | | | | | |
|  | **Care Coord (CC)** | **Shared Plan of Care (SPoC)** | **Rural Access (Tech)** | **Transition** | **Access to Home Care Svc (HC)** | **APMs** | **Other** |
| **AL** |  |  |  |  |  |  |  |
| **CO** |  |  |  |  |  |  |  |
| **IN** |  |  |  |  |  |  |  |
| **KY** |  |  |  |  |  |  |  |
| **MA** |  |  |  |  |  |  | Innovative community partnership |
| **MN** |  |  |  |  |  |  |  |
| **OR** |  |  |  |  |  |  |  |
| **TX** |  |  |  |  |  |  |  |
| **WA** |  |  |  |  |  |  |  |
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\* **All State Teams are currently working with Family Engagement**

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **AL** | New Aim Statement – to improve communication among our care providers who care for CMC by utilizing a comprehensive care coordination program. This is important because care coordination has been shown to enhance communication between patients who see multiple providers for their care.  We will do this using improvement science, support from the CoIIN collaborative, and the following actions:  1) Identify and track (registry) CMC in x counties, and at x provider offices (clinics)  2) Utilize care coordination model with x providers or clinics in x counties  3) Engage families in the development of a shared plan of care as part of the care coordination model | Our specific goals are by July 2021 to  • 50% increase reporting a single point/locus of management in a  patient/family-centered medical home  • 50% increase who have shared plan of care  • 25% decrease in the number of unscheduled hospitalizations  • 25% increase families reporting unmet needs being met  • Team-specific goals? | Initial:  1) Having Medicaid and private insurance companies (BCBS and VIVA Health) identify CMC through the data run by Dec 2018  2) Hire Care Coordinator to be placed in the newly formed complex care clinic at Univ of Southern Alabama (USA) (tentative hire early March 2019)  3) Continue GEMBA walks in the clinic  4) Working on IRB through USA health system and should hear back by early March. | CMC ages 1-16 care who meet CMC criteria at Pediatrics Complex Care Clinic with University of Southern Alabama Patients will be identified from the clinic then referrals & go into a registry in conjunction with Medicaid data recv’d | Plans for a recruitment flyer for referring physicians and families. Family team recruiting other families to bring knowledge | We are a multidisciplinary group dedicated to providing comprehensive, well-coordinated care for our CMC and their families at the Pediatrics Complex Care Clinic at the University of Southern Alabama. |

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **CO**  **CO Cont.** | We aim to: improve communication and collaboration between family, primary care, and sub-specialty providers using a co-management approach by:  1) Increase efficiency of care for families by establishing mutual understanding and awareness of the role of primary care providers, the special care clinic, and specialty providers  2) Improve collaboration by developing a systematic approach to using the long-term plan of care to facilitate communication  3) Increase access and utilization of a variety of communication methods by families and providers (i.e., TigerConnect, Patient Portal, PedsConnect, telehealth, eConsults, etc.) | 1) Addresses access inequity for families that live at a distance from specialty care (decrease burden of travel, out of pocket costs, missed school/work, improves access to TIMELY care, supports access to primary care)  2) Increases statewide PCP capacity to manage medical complexity in medical home shared plan of care aligns family goals with medical interventions | By establishing a core working group and an advisory committee that will include family and community partners, and enrolling practices and families that would benefit from coordinated care. We will leverage these collaborations with families and community partners to develop interventions that meet identified needs (i.e., care conference, written communications such as shared plans of care, consults, telehealth).  1. Establish a core working group and an advisory team (established and conducted first meeting on October 9, 2018) that will include family and community partners. The Advisory team meets quarterly. Core team meets several times a month.  2. Enroll practices (started contacting and enrolling at least 27 practices in October 2018, continuing presently) that would benefit from coordinated care.   * 5 practice enrolled (Oct. 18-Jan 19)   + 19 practices currently enrolled * 3-5 practice enrolled per quarter * Enroll cohort: comanaged patient. March 2019) with rolling enrollment * 100 patients identified that meet criterion, 20 to be enrolled by September 2019. * This is pending the Epic report with patients next appointment (will update as needed)   3. Starting after IRB approval -Approved late August 2019.  Leverage collaborations with families and community partners to develop & test interventions that meet identified needs (i.e., care  conference, written communications such as shared plans of care, consults,  and adjustments to EPIC or MyChart, telehealth). (November 2018 – September 2020)  4. Provider Engagement and Communication Plan   * Pilot/ kick-off meeting (scheduled by 9/30/19) * Leverage practice managers to understand practice readiness, capacity, and needs   5. Implement & test interventions that meet the identified needs. (November 2018 – September 2020) | CMC who:  1) Need coordinated care from the special care clinic  2) Community-based PCP outside greater Denver Metro area | CMC will be enrolled based on the criteria of being co-managed in the **Special Care Clinic**.  We aim to enroll all the cohort within in a year. We are utilizing our Epic system to create a report of patients that meet our criteria and when their next appointment in our clinic will be to approach in-person. For those we are unable to enroll/ recruit in-person, a phone call will be arranged. | We are collaborating with Colorado families and providers to support the capacity of pediatricians to better meet the needs of **children with medical complexities (CMCs**) in rural areas of the stat. Our goal is to explore the use of technology to improve communication and quality of care between care teams and families.  We will do this by working together to understand local needs and resources better so that we can identify barriers to care coordination and communication and ultimately improve our ability to meet the goals on a child’s plan of care. |

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **IN**  **IN Cont.** | Using a primary-tertiary care coordination collaborative, we will create comprehensive, functional, fluid SPoCs for all 300 identified families within 3 years, which will be utilized by the family and all providers.  Defining comprehensive as seeking to identify unmet needs within medical, social, psychological, behavioral, educational, environmental, legal and financial, Life Course-framed domains.  Defining functional as feasible and realistic so that services are delivered when needed and desired, from a prepared and available provider, in the most geographically desirable place, with adequate funding.  Defining fluid as regularly adapted based on updates and changes in the child, family and care team, and environment.  Defining utilization of plan so that all members of care map have access to view and participate in the plan. | Apply a functional and consistent operational definition of care coordination so that its output meets the biopsychosocial needs of children while enhancing caregiving capabilities and addresses the variation that we see across our state’s geography | Steps:  1) We will obtain an annualized PMPM payment from Medicaid to afford to initially hire 3 nurse care coordinators for primary care practices and 3 multidisciplinary tertiary team members (MD, RN, MSW), while we are working on defining the sustainable future payment models using a value-based purchasing plan. (in progress)  2) The 300 families will be identified and receive intake services to begin their shared plans of care with a gradual intake roll-out process for approximately 6-8 families per week. We anticipate the need for about 1 year to enroll all the families.  3) Once needs and possible goals are established, practice-based care coordinator and family will prioritize next steps, assign accountability and negotiate responsibility for those steps. The plan is then communicated with members of care map. Regularly the care coordinator and family monitor, follow up and respond to change.  4) Measures collected of needs identified & achieved.  5) Community pathways and outcomes are evolved to sustain future Medicaid funding after the grant period. | ~300 children ages 0-16 ~insured through Medicaid programs  ~served by 3 identified practices  **ages 0-16 with the involvement of three organ systems** (as defined by three different specialists caring for them longitudinally). | Recruitment will be limited by the speed of the enrollment process of the care coordinator, in which families will be approached, agree to participate, and then data collection will begin.  Once the shared plan of care is pre-populated, then a virtual or actual visit at the primary care practice will be arranged.  An identified patient roster has been created in each of three involved practices. We anticipate that the care coordinator may be able to approach about 1-3 new families per day from the practice by phone at initiation for services. Face to face contact with then be arranged at the office whenever possible to review pre-population of the shared plan of care and shared goal setting.   The goal would be to do initial enrollment of the 100 youth and families over a three-month period.  We hope to enroll all participants by September 2019 and will **target ages 0-16 with the involvement of three organ systems** (as defined by three different specialists caring for them longitudinally). This will span and involve coordination and cooperation from three health systems: the state Medicaid office, the Managed Care Entities (MCEs), and the three pilot | Our care coordination is comprehensive, functional and fluid.  Comprehensive in seeking to identify unmet needs across awhole life framework.  Functional in delivering and funding the right services by the right providers in the right setting.  Fluid in regularly adapting to changes in the child, family, care team and environment. |

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **KY**  **KY Cont.** | Aims:  a) Creating a comprehensive, multidisciplinary aero-digestive clinic.  b) Improving and facilitating care of CMC, especially those in rural areas, by utilizing teleconferencing technology for patient-centered care planning services.  c) Improving the care and quality of life for children on home ventilators and their families by working with Medicaid and other agencies to improve the system of care.  d) Creating a comprehensive clinic for young children recently discharged from the NICU, with medical complexity. | \*\*Specific goals outlined for each project (too large to include here!). See Storyboard for more details. | *1)* ***AD Clinic:***  Focus on communication, convenience, and care coordination. Patient care meetings will take place to discuss the SPoC, incl. all members of the care team and the family and care coordinator. The team will open the clinic for patient evaluations in Nov 2019. Marketing to PCPs June 2018.  *2)* ***Virtual care team:***  A dedicated VCTC Coordinator will organize virtual conferences utilizing telehealth technology. The conferences will include families, PCP, subspecialty physicians, therapist, school personnel and advocates as required. After clearly documenting the conference, the coordinator will send the documentation to all care team members; it will serve as a SPoC. The conferences will take place, in an environment that enriches family and patient autonomy.  *3)* ***PDN for CMC on home ventilators:***  Working with the KY Cabinet for Health and Family Services’ Office of the Inspector General, Certificate of Need officers and the Department of Medicaid Services, we will help revise current state regulations as they pertain to PDN. The CHFS – OIG has established a specialized work group to review KAR changes pertaining to CON and PDN. Proposed legislation has been written and currently being reviewed in the public comment period. | Target:  ***AD:*** Children birth to 18 years with conditions affecting airway, breathing, feeding, swallowing or growth that require a coordinated interdisciplinary diagnostic and therapeutic approach.  ***VCTC****:* All CMC served who would benefit from a SPoC.  ***ICCC*:** Infants birth through age 3 years discharged from the NICU with complex medical conditions. | Recruitment Plan:  ***AD****:* Initially patients will be recruited from the participating provider’s offices (pediatric Pulmonary, ENT, and Gastroenterology). As the service grows and we plan to advertise to the community through presentations, Children’s hospital Newsletter, UofL Department of Pediatrics Newsletter and KY chapter of the AAP for external referrals.  ***VCTC****:* We made a brochure for families and a brochure for providers explaining the service. We have also done presentations to different groups at the University of Louisville discussing the service to get buy-in. Primary care providers are currently referring patients; as we are contacting the subspecialty physicians, we are sending them a copy of the brochure. The discharge planners at the children’s hospital have been educated regarding the program and will be able to refer.  ***ICCC:*** Infants with medically complex conditions will be asked to follow-up in the clinic at the time of discharge. | Elevator Speech:  ***AD:*** Excellent communication, convenience, and care coordination! That is what you will get at UofL’s new Aero-Digestive clinic for kids with airway, breathing, feeding, swallowing or growth problem. Our team consists of pediatric ear, nose and throat surgeons, lung and GI doctors in addition to care coordinators, family advocates, and therapists. The clinic provides one-stop shopping for kids with medical complexity.  ***VCTC:*** Excellent communication is the key to an excellent quality of life! The VCTC service brings together families of children with medical complexity with their care providers using teleconferencing technology. Physicians, therapists, family advocates, and school personnel can communicate in real time with the family to develop a comprehensive shared plan of care. Distance is not a barrier!  ***ICCC:*** Excellent communication, convenience, and care coordination! That’ what you will get at the UK’s new Infant complex care clinic. Infants discharged from the NICU with multiple complex medical conditions can receive coordinated interdisciplinary care from our team of neonatal specialists and care coordinators in addition to family advocates and therapists. |

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **MA**  **MA Cont.**  **MA Cont.** | We are addressing these goals using several tools. All patients who are complex will have a surgical clearance visit with a Complex Care Service provider; during this visit, they will complete a surgical shared care plan with the family that identifies the needs of the child prior to surgery. This plan of care will be uploaded into the child’s medical record and regularly updated; copies will be given to the family, their surgeon, anesthesia, and any other important care team member. The family will also be given a packet with two forms: a “Get to Know Me” form with information the family wants the care team to know about their child and an Individualized Numeric Pain Scale that allows families to describe the behaviors their child exhibits at different levels of pain. These forms are laminated, and then hung in the child’s room after surgery. | •Increase the number of children coming to Boston CH (BCH) for surgery who have a medical home by 50%  • Increase the number of children coming to Boston CH for surgery pre-operative consultations in the complex care department by 50%  • Increase the number of children with peri-operative shared surgical care plans by 50 %  • Decrease the number of last-minute surgical cancellations by 25% | We will work with a multidisciplinary team to create a shared surgical care plan as well as a guided decision-making process for families and providers. For those patients coming to BCH for surgery who do not have a well-established medical home, we will take the opportunity to help them engage with a more coordinated medical home system.  PHASE ONE (March 15-November, 2019)  **Baseline Data Collection**  A group of 40 CMC who have undergone surgery in the past year will serve as a baseline cohort for pre-intervention purposes. The project RA will obtain names from a surgical registry to identify 40 CMC who have undergone surgery in the 24 preceding months. The RA will complete a chart review and administer a survey identical to the survey that study participants will receive. The survey will be sent via email to the family to complete. They will receive a $20 gift card for their participation, similar to study participants.    Program Initiation and Feasibility Phase (March 15-November 1, 2019)  Simultaneous with the baseline data collection, we will begin enrollment in the intervention arm of the project. We anticipate enrolling about 25-40 patients in this program initiation phase and then enrolling 25-40 patients every 3 months for 7 additional 3-month cycles (see Phase Two below). Patients meeting inclusion criteria will be eligible to participate in the **ENGAGE** program. An ENGAGE study team member will introduce the study to the families and provide them with a brochure that describes the study and indicates how their experience will differ from the traditional state of care (please see Additional Documents: ENGAGE Brochure).  The exposures in this study that differ from traditional care are described above and include:  1. Surgical Shared Plan of Care  2. “Get to Know Me”  3. Individualized Numerica Pain Scale  3. Navigator  These ENGAGE team interventions have been designed in collaboration with the ENGAGE parent advisors to ensure that the CMC families have enhanced opportunities for engagement in the planning process for their children’s surgery and are comfortable with the level of communication and coordination among a large number of team members involved in their children’s care. Through the family partners on the ENGAGE team, we have learned that continuity of care is highly valued and that families hope for an experience where their child’s individual responses to painful and uncomfortable situations are understood and where caregivers learn from parents what are the most successful interventions to minimize | Children and youth with undergoing hip, spine fusion, or baclofen pump surgery at Boston Children’s Hospital | A weekly review of new patients with surgical dates, as well as those who will have surgery within the next six months, will be identified as possible candidates for ENGAGE. If they meet criteria for type of surgery as well as complexity level, a pre-op surgical clearance appointment with a Complex Care provider will be made. During this visit, the research assistant will present the study and ask the family if they would like to participate. | Family representatives at BCH have stated the importance of improving  The perioperative experience for CMC undergoing surgery. They want their care team to know their child to better prepare for their hospital stay and improve communication. To address this, our program has created several tools for both family and care team. Families will fill out a “Get to Know Me” document, that identifies key information such as the child’s interests, how to tell when they are unwell, and what their basic daily function is. They will also complete an Individualized Pain Scale, where parents write the behaviors that their child do depending on their level of pain. A task manager, or shared plan of care, will be kept in the child’s medical record; this will be used by the Navigator and care team to make sure that everything is completed for surgery. |

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **MN** | Aims:   1. Promoting shared plans of care as a tool to increase coordination of care across the child’s providers and family   *Potential Activities:*   * *Focusing on care planning process – Achieving a Shared Plan of Care* * *Testing electronic options for care planning (software, apps, etc.)*  1. Supporting families and providers to work as colleagues in the child’s care,   *Potential Activities:*   * *Education and implementation around care mapping*      1. Promoting the services and supports families need to successfully care for CMC in the home,   *Potential Activities: TBD*   1. Demonstrating the cost-effectiveness and benefits of comprehensive family-centered care coordination.   *Potential Activities: TBD* | By July 2021, we will advance the system of comprehensive, family-centered care coordination that supports families of CMC | **Phase 1: Environmental Scan and Planning Interventions (Through August/September 2018)**   * Pulling together Gillette QI Team (Lead: Rhonda Cady) * Conducted two virtual focus groups with Minnesota families of children with special health needs in August 2018, to better understand the ‘current state’ in Minnesota. (Leads: Rhonda Cady & Blair Olson)   **Phase 2: Implementation and Evaluation (September 2018 – Project End)**   * Gillette QI Team Meeting – responsible for day-to-day work on the project, implementing PDSAs, etc. (Clinical Site Work Plan) * Conducted Gemba walk and assessment of current state in relation to the 4C Change Package. From this information, identified and categorized (Impact Matrix) potential QI projects * Created new clinic brochure to better explain purpose/value of CCC * Initiating first component of SPoC: Get to Know Me section. Document will be beta tested with select families. Once format finalized, will be pilot tested with families coming to clinic for follow-up appt. * Next section of SPoC: Access Plan * Had demo of Team TX ‘Story’ App * CCC clinical champion (Dr. Gagnon) understands value of Family Voices Peer Support program. Unfortunately referrals to program from our organization are non-existent. * Care Managers will begin offering Family Voices information to families. * Measuring impact of our changes with the CoIIN QI Measures Survey     **Phase 3: Spread and Sustainability**  Planned and conducted a day-long Care Coordination Seminar on Thursday 6/20/19. Keynote Confirmed speakers include Bill Schwab (AmFam Hospital, UW-Madison), Jeanne McAllister (Riley Children’s) and David Bergman (Stanford/Lucile Packard Children’s Hospital). | Families engaged with Family Voices of MN and CMC enrolled in the Complex Care Clinic (CCC)  Begin with “Quick Wins” projects for initial PDSA cycles; then move to Major Projects  EMR currently has no support for a electronic plan of care document;  Evaluating other options including cloud-based SPoC and paper-based SPoC  Carolyn Allshouse will present research on Peer Support to Pediatrics Team in Oct 2019, with plan for wider presentation once this group onboard.  As per guidelines, collect 40 surveys each 6 month period.  125 parents, providers, care coordinators or any other roles working with CMC | Invite posted on Family Voices of MN website;  Email invite sent to CCC parents  12 parents participated in the two focus groups.  Parent advisors for QI team ‘recruited’ from focus group (above) participants.  Initial PDSA testing involving family done by parent advisors, then tested with CCC families.  Provide paper survey to all english-speaking parents for children attending a ‘follow-up CCC visit’ (completed their initial/intake 2 hour clinic visit). Survey given after clinic ‘check-in’ and while waiting for appointment to start. Can leave completed survey with clinic staff or return via mail (self-addressed stamped envelope provided).  Mailings to providers (minimal attendance), posting to organizational and professional websites, word of mouth.  Final registration: 150. Very successful:) | The key to effective care coordination is the relationship. There must be shared trust and mutual respect. Without this foundation, identifying goals and developing the shared plan of care are ineffective.  We have a VERY engaged and collaborative QI team. Includes all clinic staff and 3 parent advisors. Have watched the clinic staff grow in terms of understanding what pt/family-centered care means from the pt/family perspective. Very different from clinic perspective  Representation from parents, home care, school nurses, primary and specialty care coordinators, providers, payers. Evaluation indicates need for additional education on detailed materials and processes for effective family-centered care coordination. |

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| **OR**  **OR Cont.**  **OR Cont.**  **OR Cont.** | Aims:  (a) Collaborating with innovative partnerships to ensure the medical home is available for young adults with medical complexity  (b) Promoting shared plans of care (SPOC) as a tool to increase coordination of care among the young adult’s care providers  (c) Incorporating shared decision-making among young adult, family, and providers in our SPOC approach  (d) Preparing adult providers to serve as a medical home for young adults with medical complexity who is transitioning to adult care | The overall goal of is to improve the quality of life for our state’s transition-aged CMC, the wellbeing of their families, and the cost-effectiveness of their care. | **September 2019**  We will approach our first two potential enrollees on Friday, September 6.  Identification of Young Adults with Medical Complexity (YAMC):  OHSU is using the Pediatric Medical Complexity Algorithm for various primary care purposes. The OHSU team is making patient PMCA score available to providers for patients in their panels. Because our CoIIN problem statement focuses on the transfer of care, our implementation team will initially identify YAMC ages 17 and older. Although Simon et al. (2014) validated the algorithm on pediatric patients under 18 years of age, Alison and Reem agreed to use it for patients 18 years and older because the individuals will still be pediatric patients and because this project’s purpose is for quality improvement and evaluating innovative transfer of care practices.  Our QI approach continues to be one where we start small, i.e., testing an approach on a small number of patients, learn what worked and did not, revise, and scale.  Project Details:  The project will consist of three stages designed to prepare YAMC and their families for care transfer to an adult primary care physician (PCP) and identify to help identify an adult PCP to transition to.  **Stage I** will focus on teaching YAMC and their families about the medical home concept, developing a care map to illustrate the youth’s medical home team members, and starting to complete a form (created by Kim Solondz and Tamara Bakewell) that tracks the different pediatric specialists the youth works with and when their provider will want them to transfer from their care. We expect to test the discussion of this information occurring in person versus over the phone. We also discussed that this discussion would not occur during a well-child visit as there are already many issues to cover during those visits.  **Stage II** will focus on helping the youth to learn about their health issues and medications, completing a “Health Passport” to ensure that critical information is available in an easily digestible format in case of emergencies.  **Stage III** will focus on identification of an adult PCP including determining the role of insurance in the identification of a provider, scheduling an appointment with the new care provider, verifying that the appointment was completed in the adult medical home, and providing opportunities for the pediatric and adult primary care clinics to discuss the patient. OHSU team members will assist in the identification of adult providers.  With family input, our team developed a “Transition Workbook,” which will help focus the discussions during appointments and the between appointment homework. Nurses also will have a binder to track intervention implementation (I.e. process data).  Recruitment and enrollment steps are described in a subsequent column.  OCCYSHN's evaluation team will administer the survey to the family by emailing their contact a unique Qualtrics link. We will track completion and send reminder messages at recommended intervals (per Dillman and colleagues) per our approved IRB protocol. The reminder messages will be tailored based on whether the family contact has begun the survey or not. | Young adults 17 years and older who experience medically complex conditions | OHSU has prepared a report that identifies patients who are in the top PMCA tier (Complex Chronic Disease) and are ages 17 and older. The clinical team members generate these results for patients who have an appointment in General Pediatrics within the coming two to four weeks. The clinical lead approaches the patient’s primary care physician to ask whether the clinical team can approach the patient/family about participating in the intervention. If the physician agrees, the nurse approaches the family about the intervention following the patient’s appointment with a scripted introduction to the project. If the patient/family is interested a study team member contacts the patient/family to consent them into the study/intervention. | Young adults with medically complex conditions are living longer lives. Yet they, and their families are not adequately prepared for, or supported in, the transition from pediatric to adult healthcare.  As these children approach 18 years of age, health systems do not consistently provide support to identify adult providers. This lack of support can result in gaps in care for these young adults.  Supporting an empathetic and smooth transition ensure these young adults maintain care that is essential to their quality of life. |

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **TX**  **TX Cont.** | 1) Engage and support patients/families in meaningful ways to promote shared decision-making.  2) Integrate required assessments to minimize duplication and guide the development of individualized care plans that inform service delivery.  3) Utilize technology-based tools such as a patient-controlled care coordination platform to promote a shared plan of care.  4) Identify patterns of service/supply usage in the areas of therapy, durable medical equipment, private duty nursing and subspecialist utilization in various subpopulations to maximize efficiency. | 1) 50% increase in reporting a single point/locus of management in a patient/family-centered medical home.  2)50% increase the number of CMC with SPoC.  3)25% decrease in the number of unscheduled hospitalizations.  4) 25% increase reporting unmet needs are being met  5) 50% increase pre-review sessions completed by a provider-RN team  6) 50% increase number of UM approved comprehensive care plans within 30 days of preventative visit  7) Increase family engagement in clinic workflow design by involving families in iterative process improvement | Collaborate among stakeholders, including patients, families, clinicians, policymakers, payers and state agency representatives to transform workflows into an integrated care delivery model that provides family-driven care, optimizes patient/family satisfaction and improves health outcomes.  **Time Line**   * The hiring of RNCM team (Completed 2/2019) * HHSC Approval for delegation (Completed 2/2019) * eTherapy Module (Launched 2/2019) * Preventative visit workflow transformation (Launched 1/2019) * Inpatient Coordination Project (Launched 9/2018) * Electronic care plan launch (Anticipated 3/2019) * Sign contract with MCOs for delegation of service coordination (Anticipated 3/2019) * MCO training of RNCM (Anticipated 3/2019) * Family survey (Anticipated 3/2019) * Dashboard Launch (Anticipated 4/2019) | Children who are on the MDCP waiver and utilize private duty nursing services in the community. | Patients are referred to the CCC (Complex Care Clinic) by physicians or specialists in the community or self-referred. They are screened for inclusion criteria and admitted to the clinic. Children on MDCP waiver or have PDN will be automatically recruited. | This is the only program in Texas where multiple stakeholders including MCOs, the medical school, HHSC, the children’s hospital system, family advocacy organization, and Title V are working together in a fully integrated way to a common goal - improving care for children with complexity. We are most proud of the collaborative framework, our unique patient-controlled app and a transparent relationship of data sharing with MCOs.  We have secured Texas Medicaid approval for the two health plans to delegate many of their service coordination functions to the clinic, and now are working with the plans to enter into value-based contracts for this role. |

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| **State Team** | **Aims** | **Goals** | **Project Plan {please add in more detail with dates}** | **Target** | **Recruitment Plan** | **Elevator Speech** |
| **WA**  **WA Cont.** | WA Birth to One CMC CoIIN is a 4 year national QI collaborative, funded by the federal Maternal and Child Bureau, through Boston University.  10 states have established a local collaborative that includes state CSHCN programs, hospitals, and parent and community agencies to address improvement opportunities in the care of children with medical complexity. WA State’s Birth to One collaborative includes Seattle Children’s, WA Dept of Health, UW Center on Human Development and Disability (CHDD), Partners for Action, Voices for Empowerment (PAVE- a parent to parent agency) and UW Medical Home Partnership Project.  Our focus is to help families of infants discharged from the hospital establish care in a medical home, activate essential community services and resources, establish a nutrition home, and to gain the opportunity for parent to parent support.    Our hypothesis is:  There are a wealth of community resources available to children with special needs.  However, many of these resources aren’t activated as early as evidence suggests they should be.  We can help families build resiliency earlier if we can assure that they have a visit/conversation with a public health nurse, have an initial intake with early intervention services, engage with their PCP clinic team, have a dietitian actively monitoring their post-discharge nutrition status, and assist the parent in identifying/engaging in parent support systems. We are starting with infants discharged from SCH but will be expanding that to other hospitals next year. | Capitalizing on the statewide resources of WA State Medical Home, Seattle Children’s, the WA State Nutrition Network for CYSHCN, the WA Community Feeding teams, and the expertise of PAVE Partnerships for Action Voices for Empowerment to engage parents and caregivers in identifying opportunities and addressing barriers, we will improve the outcomes of 150-300 infants who live in WA State.   * Increase to at least 90% the number of caregivers who identify with a medical and nutritional home * Increase to 80% the number of infants with an activated plan of care (“Roadmap”).  Decrease by 25% the number of infants with unmet needs * Decrease by 25% the inpatient and ED utilization of these infants, by July 31, 2021. | Upcoming milestones:   * Enroll 80 patients by Nov 2019 * Meet or exceed survey target of 60% by Nov 2019 * Add care coordination FTE for enrollment through 90 days phase of intervention Oct 2019 * Add at least one additional non-SCH NICU referral path by October 2019 * Pilot new state-wide ESIT referral form at SCH in October 2019 * Establish graduation process/handoff for stable/ low intervention enrollees who reach their first birthday * Enroll 150 patients by July 2020 | * 150-300 infants who reside in western WA. * Enrolling infants 0-3 mo. old and following them for one year. | Gabi Chavarria, community resource care coordinator, reviews the list of infants close to discharged from SCH, as well as referrals sent in from internal and external providers.  She reviews their discharge note, any care coordination notes, what community referrals may have been made. She then reaches out to the parent to explain the program and her role, which is primarily assuring referrals result in service, assuring the child’s broad community-based team have each other’s contact information, assisting the parent in understanding the intent of referrals and the community resources available to them.  The care coordination is intended to reduce in intensity as each of the services is activated. Once care coordination needs have stabilized, the patient is supported by parent navigators. Enrollees will graduate in 12 months or by first birthday, with a warm handoff to their Birth to Three provider, PCP or other community resource. | CSHCN, ESIT, SSI, P2P, PCP, DME, FRC. Alphabet soup, for the parent of an infant with complex needs. Everyone wants to help, but the system is fragmented, leaving parents with the burden of connecting the dots, remembering the next steps, and communicating between multiple agencies. WA State Birth to One CMC CoIIN will improve quality and cost outcomes for infants with complex needs by:   1. Engaging with parents prior to/soon after discharge and assisting them in navigating community resources once they are home 2. Assuring infants are supported by a medical home, and their developmental and nutritional needs are met 3. Encouraging parents to seek out peer supports 4. Facilitating communication between providers and community agencies 5. Improving the cohesiveness of the system of care supporting infants with complex needs and their parents. |

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| **WI** | Aims:  a) DRAFT- Increase by 20% over baseline (Oct 31, 2019) the number of families answering "always" or "almost always" to the SPoC questions on the CMC CoIIN family survey (to be discussed by team at in-person meeting)  b) 10% increase over baseline of CCP participants also enrolled in CLTS waiver program    c) Develop and use an Anticipatory Guidance Tool (AGT). | Our specific goals are by July 2021 to  • 50% increase reporting a single point/locus of management in a patient/family-centered medical home • 50% increase who have shared plan of care • 25% increase families reporting unmet needs being met Additional state-specific measures will be created | One current project involves creating SPoC goals that are meaningful and actionable. Possible drivers of this work include   * Discussion around goals prioritized during clinic visits * Global goals are separated from goals that are able to be impacted by the CCPs * Families understand SPoC and difference between global goals ("hopes & dreams") and goals that are able to be impacted by CCPs   Possible tests of change include   * Re-ordering clinic visit topics so that goals are discussed first * Moving global goals ("hopes and dreams") to "Who am I?" section   SPoC fact sheets developed and tested by FV of WI, in collaboration with CCPs | CMC identified from our complex care program | To meet these goals (particularly unmet needs), the WI team is developing a plan to enroll children also enrolled in the CLTS Waiver program | We at team WI serve as a collaboration of professionals dedicated to improving the meeting of needs of the child with medical complexity along with their families. Our newly developed shared plan of care (created along with our family team members) will work to ensure each enrolled child has accurate registrations within waiver programs through specialized care coordination. |