# CoIIN to Advance Care for Children with Medical Complexity

CMC CoIIN State Team Webinar #14 –

## Putting Families First: Shared Plan of Care and Care Coordination

*With Special Guest Stars Rich Antonelli and Jeannie McAllister*

Wednesday, January 15, 2020 12:00pm – 1:30pm ET

**Boston University** School of Social Work
Center for Innovation in Social Work & Health

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number #UJ6MC31113: *Health Care Delivery System Innovations for Children with Medical Complexity* ($2,700,000 annually). This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsement be inferred, by HRSA, HHS or the U.S. government. Anna Maria Padlan, HRSA/MCHB Project Officer

BOSTON UNIVERSITY

# Agenda

**Welcome and Project Updates**

***Meg and Bethlyn***

**CMC CoIIN Objectives: Care Coordination and SPoC**

***Cara***

**Overview of SPoC**

***Paula***

***Jeannie***

**State Team Discussion**

***Featuring Teams Wisconsin and Indiana***

***Facilitated by Faculty***

**Care Coordination Measurement**

***Rich and Jess***

**Wrap-up and Next Steps**

***Meg and Bethlyn***

# Project Updates

## Affinity Groups

- Launched yesterday 1/14
- 3 groups: State Team Leads, Care Coordinators, Title V Staff
- Email Libbi at lethier@bu.edu if you want to join

## Google Groups

- Launching later this month
- Two Topics: Family Engagement and Care Coordination/Shared Plan of Care

## Getting the Word Out!

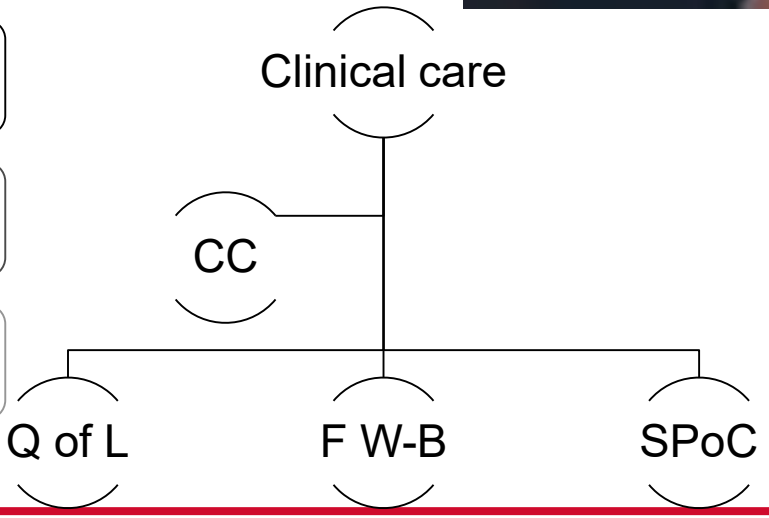
- Congrats to Rhonda Cady (MN), Elizabeth Castro (MA), and all of Teams MA and MN for being accepted to the Children's Hospital Association Quality and Safety conference!

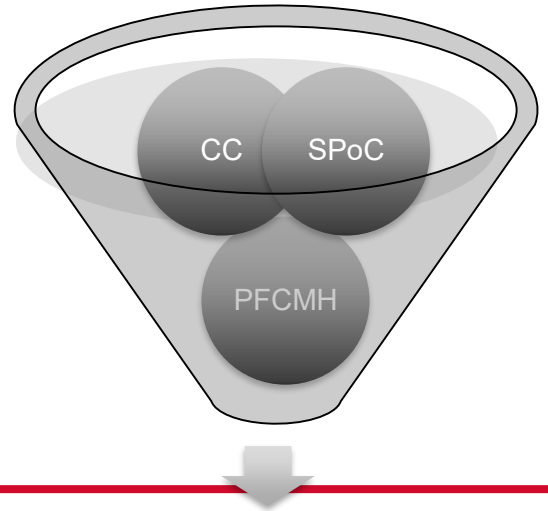
## Evaluation

- Round 1 family and staff survey data due today, 1/15
- Qualitative interviews happening in February and March

# The Wild Wild West: “Marrying” the SPoC and Care Coordination

- **SPoC** • Have all parts of checklist?
- **CC** • Who is CC and what are they coordinating? Checklist?
- **PFCMH** • Built to spec?




Integrated Family Centered Care?


BU
**Boston University** School of Social Work
Center for Innovation in Social Work & Health


CC → SPoC → PFCMH

# Coleman Chaos view of what care needs to be coordinated… and how!

# Medical Home & Care Coordination

*Soup and Sandwich* ♪

- ~ 2000  Care Coordination – how to do?
  - Not just why; not just what; but ***how***?
  - What do you want a Shared Plan of Care to do/reflect?

- LPFCH "Achieving a Shared Plan of Care" Report, addresses the ***how***
- *(Spirit)* Relational work - forging trusting partnership with families to work on shared goals (People)
  - Practiced behaviors /approaches – e.g. regular team structured contacts, communication (Process)
  - Creating/using a co-produced plan of care (process)  - which reflects trusting rapport, shared knowledge, goals, strategies and timeline.

# People, Process & Tools (/technology)

## A SPoC serves in a supporting role as a tool resulting from people and processes:

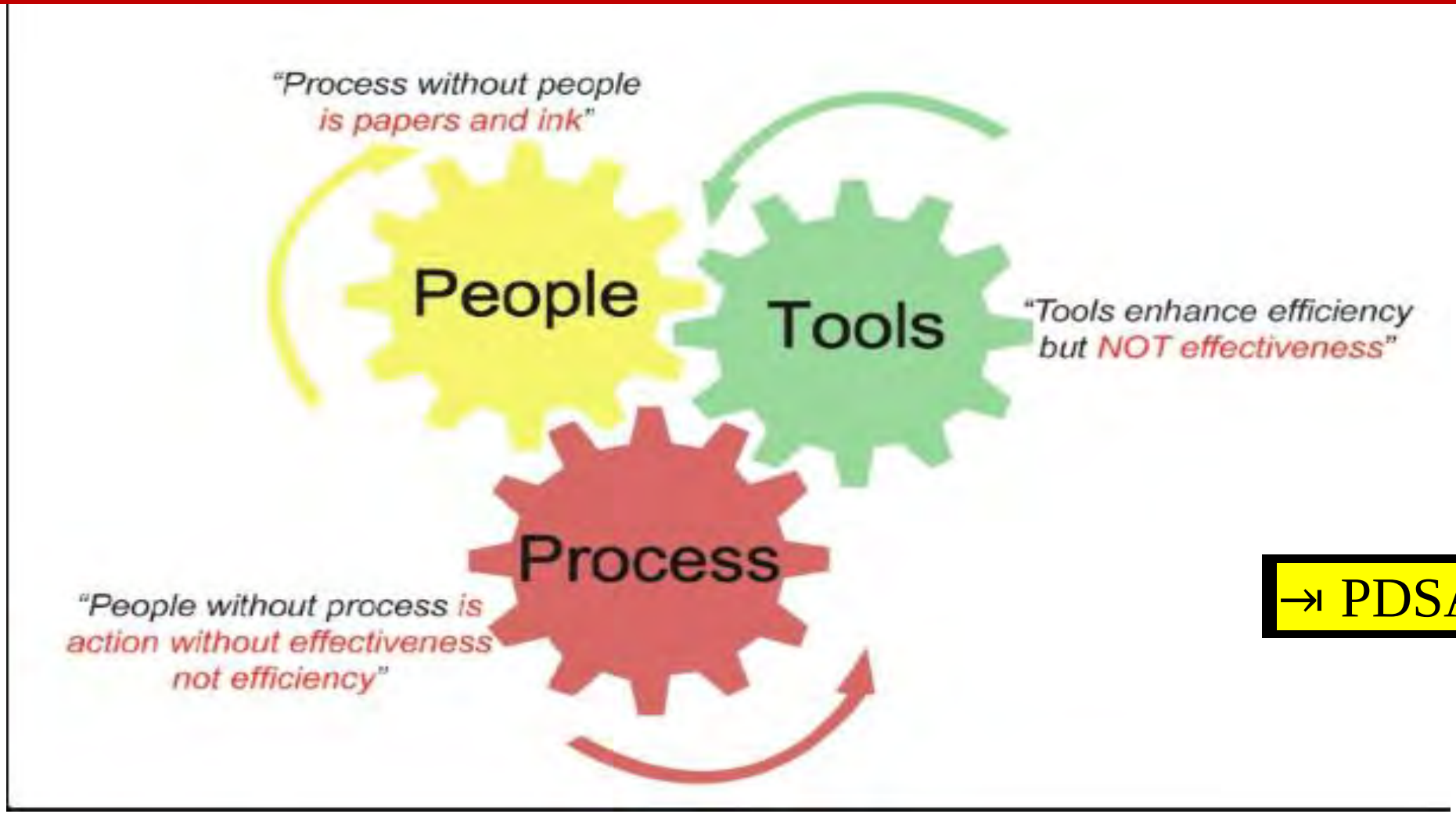
- [**People**] Core people/teamwork - partner with families
- [**Process**]
  - Using clear process to foster trusting rapport
  - Co-produce a plan of care, use it
  - Learn together what works (or does not)

  (how is context specific - open ended interviews, pre-visit contacts, conversations ~ *what matters to families* &/or what concerns the clinical team; care conference approaches, other -intake/assessment conversations).
  - Listen, share back what you are hearing…check accuracy
  - Captured in a supportive tool (SPoC) … [**Tools/technology**]

## Reflective Qs:

- Does the SPoC tool help "***script***", or guide, care coordination activities going forward?
- Does the SPoC r*eflect* what matters to the family; what the shared aims/goals/work is – including the "what, how, who, by when"?
- Are you making joint progress around set priorities?
  - (e.g. Goal Met? In progress? Dropped or on hold?)
- Are you (families/team) learning and building new skills?
  - ID resources, networks, and what it takes to do what it takes?
  - How lessons help the broader population
  - How the work/process addresses – family engagement, multidisciplinary team-based care, provider vitality, QI, population health, etc.
    - Double, triple, quadruple etc. product!

# THINGS THAT MATTER DO TAKE TIME




→ PDSA

# Team Indiana's Shared Plan of Care

De-Identified Shared Plan of Care:
https://cmccoiin.box.com/s/n3xrv98gwz15hc81stl8fbqqlbzqmqzj

Blank Shared Plan of Care:
https://cmccoiin.box.com/s/a2dkr163hnvrmk2j6799tp2hw32sa5p0

Intake Visit Care Coordinator Cue Card:
https://cmccoiin.box.com/s/7s5m7rhzx2jb8e9kcqfhl1y3nqelfulb

Family Intake Form:
https://cmccoiin.box.com/s/1br2kbhji23q7wrg5284tu1oliozjy6c

# Wisconsin SPoC User's Guide

https://cmccoiin.box.com/s/v2jmn7mzbzndaffvgk8spsw0kfg9e4i2

- Rolled out SPoC in 2017
  - "Deliverable" for our payment mechanism
- Multiple PDSA cycles for our SPoC
  - Cross-system collaboration and sharing
  - Sate of WI Title V program grants focused on SPoC
- Interprofessional team identified need for "user's guide" for families
- Created and revised over the course of a year

# State Team Care Coordination and Shared Plan of Care Share Out


Boston University School of Social Work
Center for Innovation in Social Work & Health

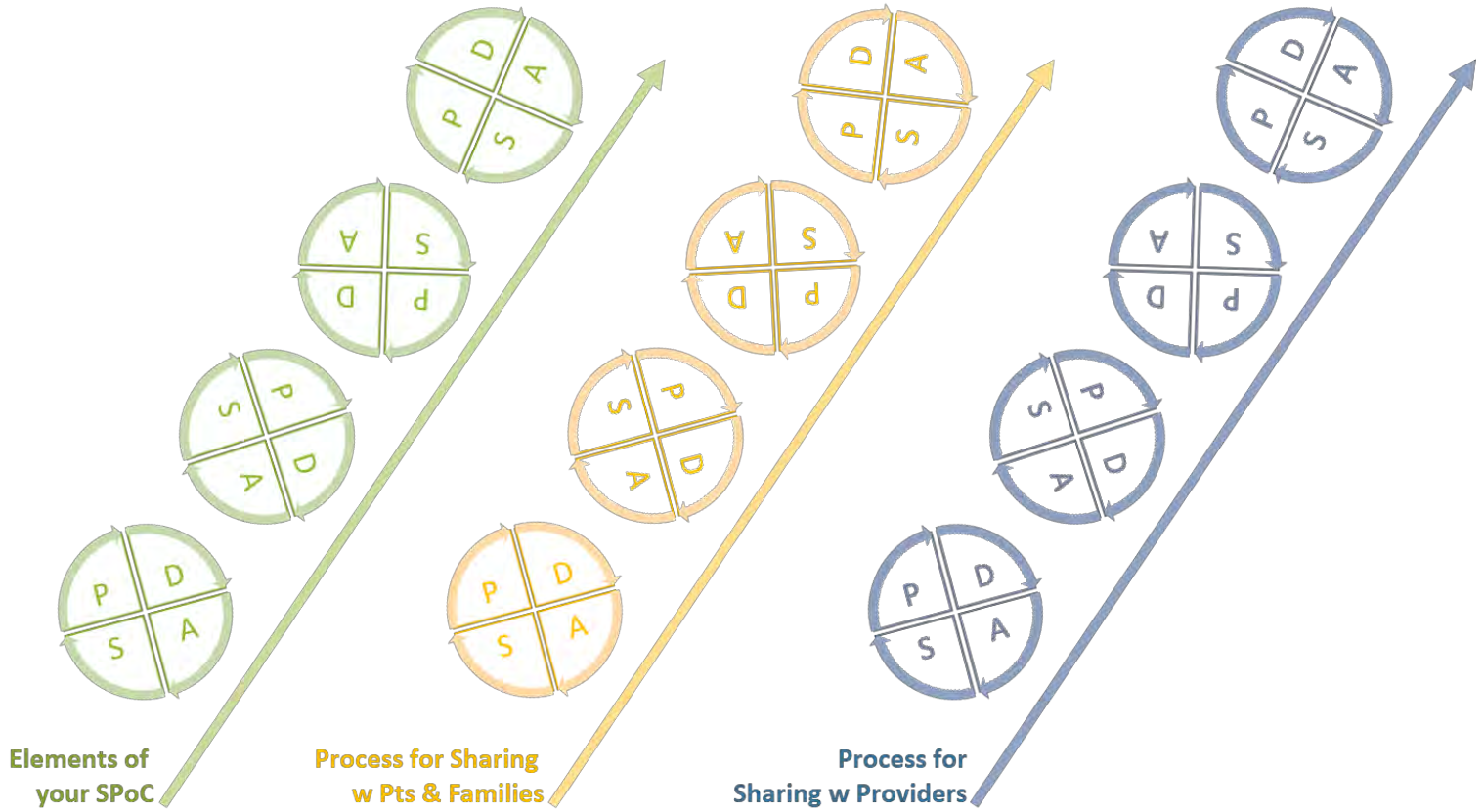
**What challenges are teams facing in implementing SPoC?**

**What information and resources do you need to best address these challenges?**

# Keep Your PDSAs Rolling!

**Did you hear anything today that you want to test?**

- Always consider if you should test on a small scale before wide scale implementation.
- Remember, tests should be quick! (They should help you implement faster with more success)
- Don't be afraid to run multiple tests in parallel.
- Plan to hold brief 5-10 minute huddles during active testing to capture lessons learned and decide on next steps.



Boston Children's Hospital

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

# Measuring and Improving Care Coordination: Pediatric Care Coordination Curriculum 2nd Edition as a Tool to Support Implementation

Jessica Beliveau, MPH, Manager
Richard Antonelli, MD, MS, Medical Director

National Center for Care Coordination
Technical Assistance (NCCCTA)

CMC CoIIN Webinar– January 15, 2020

# Acknowledgement

*The National Center for Care Coordination Technical Assistance is supported through a sub-contract with the National Resource Center for Patient/Family-Centered Medical Home (NRC-PFCMH).*

*The National Resource Center for Patient/Family-Centered Medical Home is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $4,100,000 with no funding from nongovernmental sources. The information or content are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.*

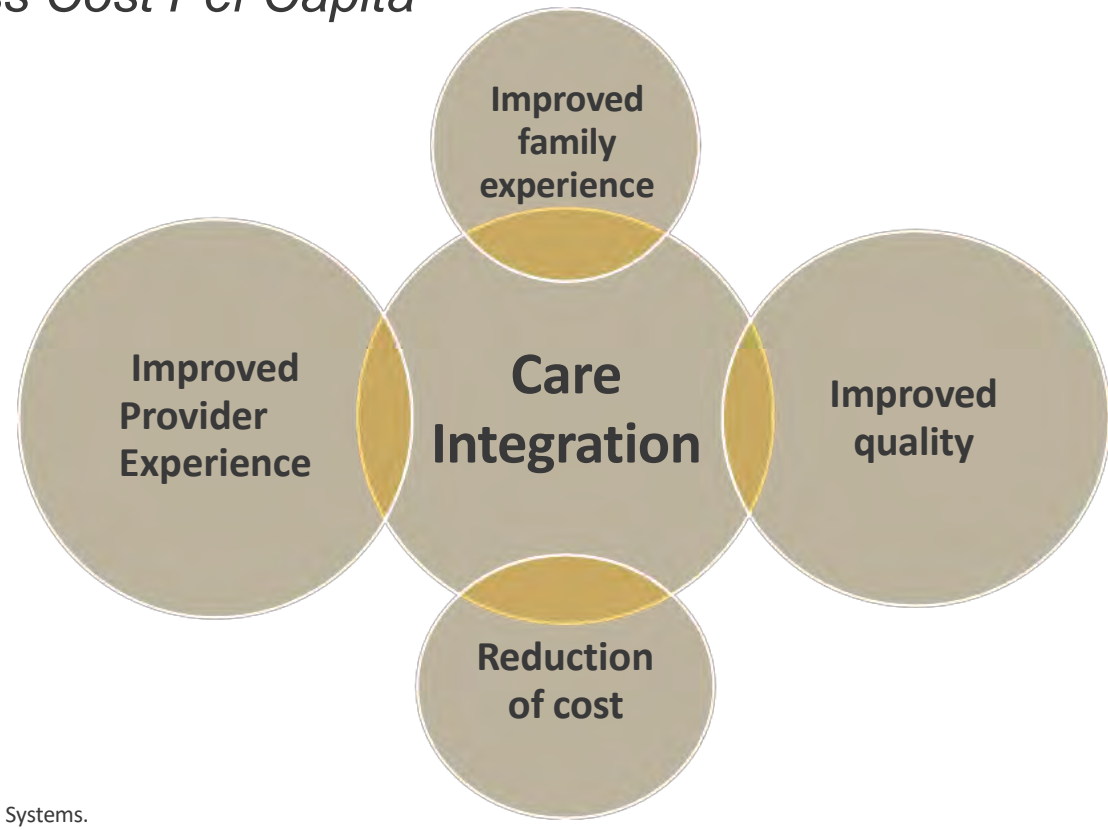
# Objectives

1. Review tools, measures, and resources provided by the National Center for Care Coordination Technical Assistance; all of which are contained in the USMCHB funded Pediatric Care Coordination Curriculum, 2nd Edition
2. Learn about applications of this work in partner sites across the United States

# Measure What Matters - Domains of Integrated Care

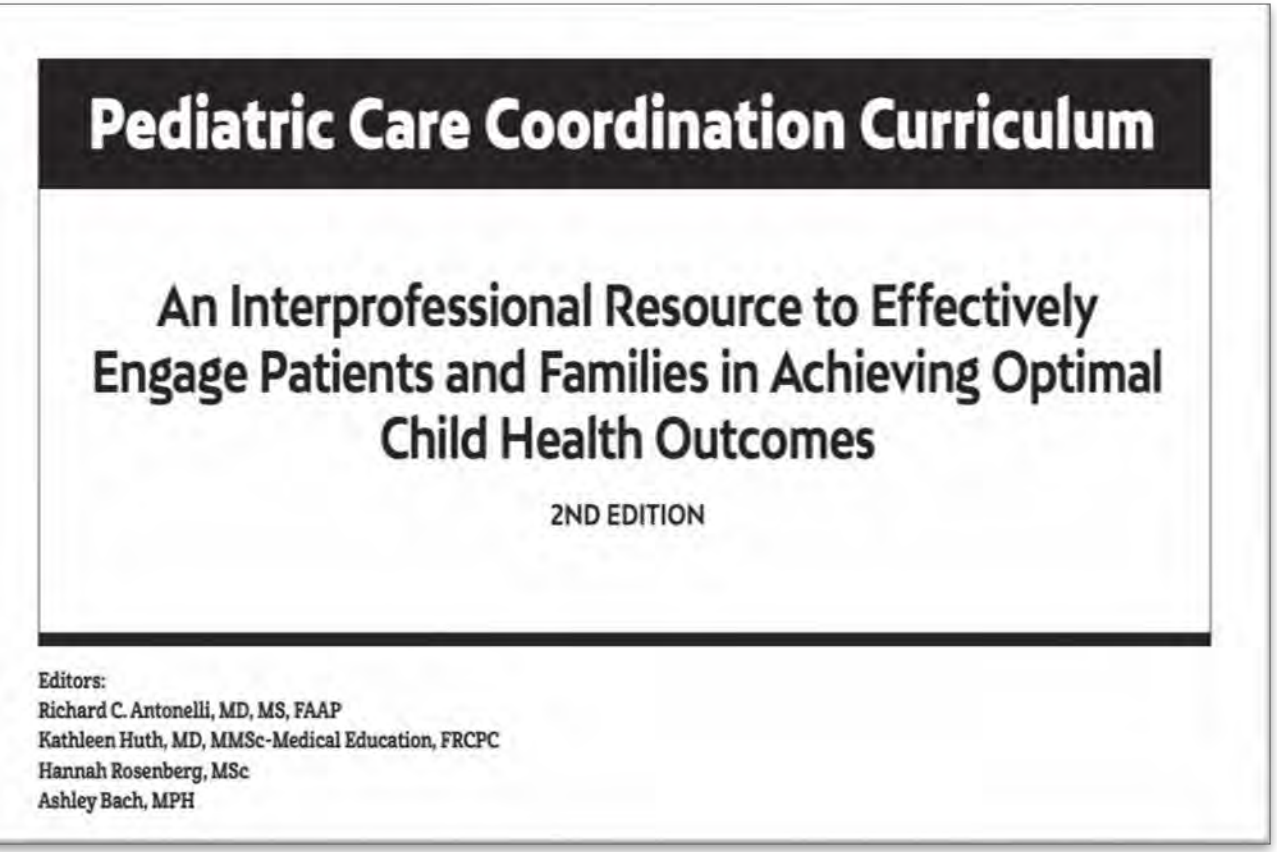
*Align with Quadruple Aim– Better Health, Better Care, Less Cost Per Capita*

- Person, Patient, Family, Caregiver Experience
- Care Coordination
  - Closing the Loop
  - High Quality Handoffs
  - Care Tracking
  - Care Planning
- Utilization and Financial Outcomes
  - Admissions, readmissions, Emergency Dept utilization
- Provider Experience




[1]Institute for Healthcare Improvement. [http://www.ihi.org]. 2014
[2]AAP Policy Statement: Patient- and Family-Centered Care Coordination: A Framework for Integrating Care For Children and Youth Across Multiple Systems. *Pediatrics*. May 2014.

# Building Interprofessional Capacity to Perform and to Measure CC




Modules:

1) High-Value Integrated Care Outcomes Depend on Care Coordination
2) Developing and Sustaining Strong Family/Professional Partnerships
3) Social Determinants of Health
4) Measurement
5) Using Technology to Improve Care Planning & Coordination
6) Evaluation

Boston Children's Hospital

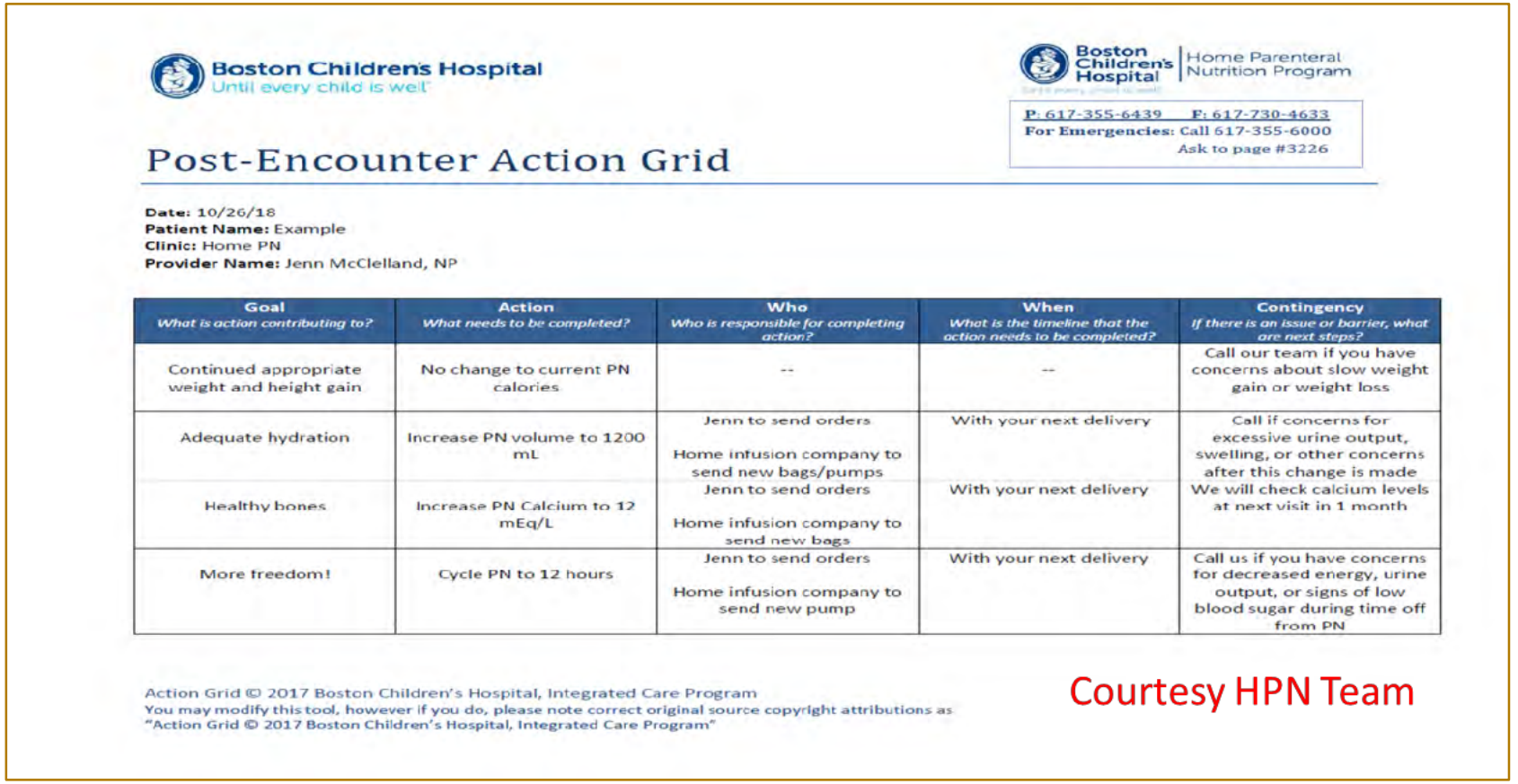
# Care Planning– The Process is Essential

- SPoC
- Action Grid

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

# Action Grid

- Used to identify goals and actions, and to delegate tasks and timelines to the most appropriate care team members
- Helps patients and families to have a better understanding of expectations, next steps, and “big-picture” view of how their care is coordinated



Boston Children's Hospital
Until every child is well

Boston Children's Hospital | Home Parenteral Nutrition Program

P: 617-355-6439 F: 617-730-4633
For Emergencies: Call 617-355-6000
Ask to page #3226

## Post-Encounter Action Grid

**Date:** 10/26/18
**Patient Name:** Example
**Clinic:** Home PN
**Provider Name:** Jenn McClelland, NP

| Goal<br>*What is action contributing to?* | Action<br>*What needs to be completed?* | Who<br>*Who is responsible for completing action?* | When<br>*What is the timeline that the action needs to be completed?* | Contingency<br>*If there is an issue or barrier, what are next steps?* |
|---|---|---|---|---|
| Continued appropriate weight and height gain | No change to current PN calories | -- | -- | Call our team if you have concerns about slow weight gain or weight loss |
| Adequate hydration | Increase PN volume to 1200 mL | Jenn to send orders<br>Home infusion company to send new bags/pumps | With your next delivery | Call if concerns for excessive urine output, swelling, or other concerns after this change is made |
| Healthy bones | Increase PN Calcium to 12 mEq/L | Jenn to send orders<br>Home infusion company to send new bags | With your next delivery | We will check calcium levels at next visit in 1 month |
| More freedom! | Cycle PN to 12 hours | Jenn to send orders<br>Home infusion company to send new pump | With your next delivery | Call us if you have concerns for decreased energy, urine output, or signs of low blood sugar during time off from PN |



Courtesy HPN Team

# Measurement

## Pediatric Integrated Care Survey (PICS): Care Planning Domain

1. In the past 12 months, how often have your child's care team members talked with you about specific goals for your child's health care?
2. In the past 12 months, has a member of your child's care team documented these goals in the form of a written care plan?
3. Did you and/or your family members contribute to the content of this written care plan?
4. In the past 12 months, was this written care plan easily accessible to you?
5. Was this care plan written in a way that you could easily understand?
6. In the past 12 months, has someone on your child's care team regularly updated this written care plan to reflect changes and progress?

## Family Experiences with Coordination of Care (FECC): Protocols/Plans Domain

1. Child has shared care plan.
2. Child has written transition plan.
3. Child has emergency care plan.

Source: AHRQ FECC Measure Set

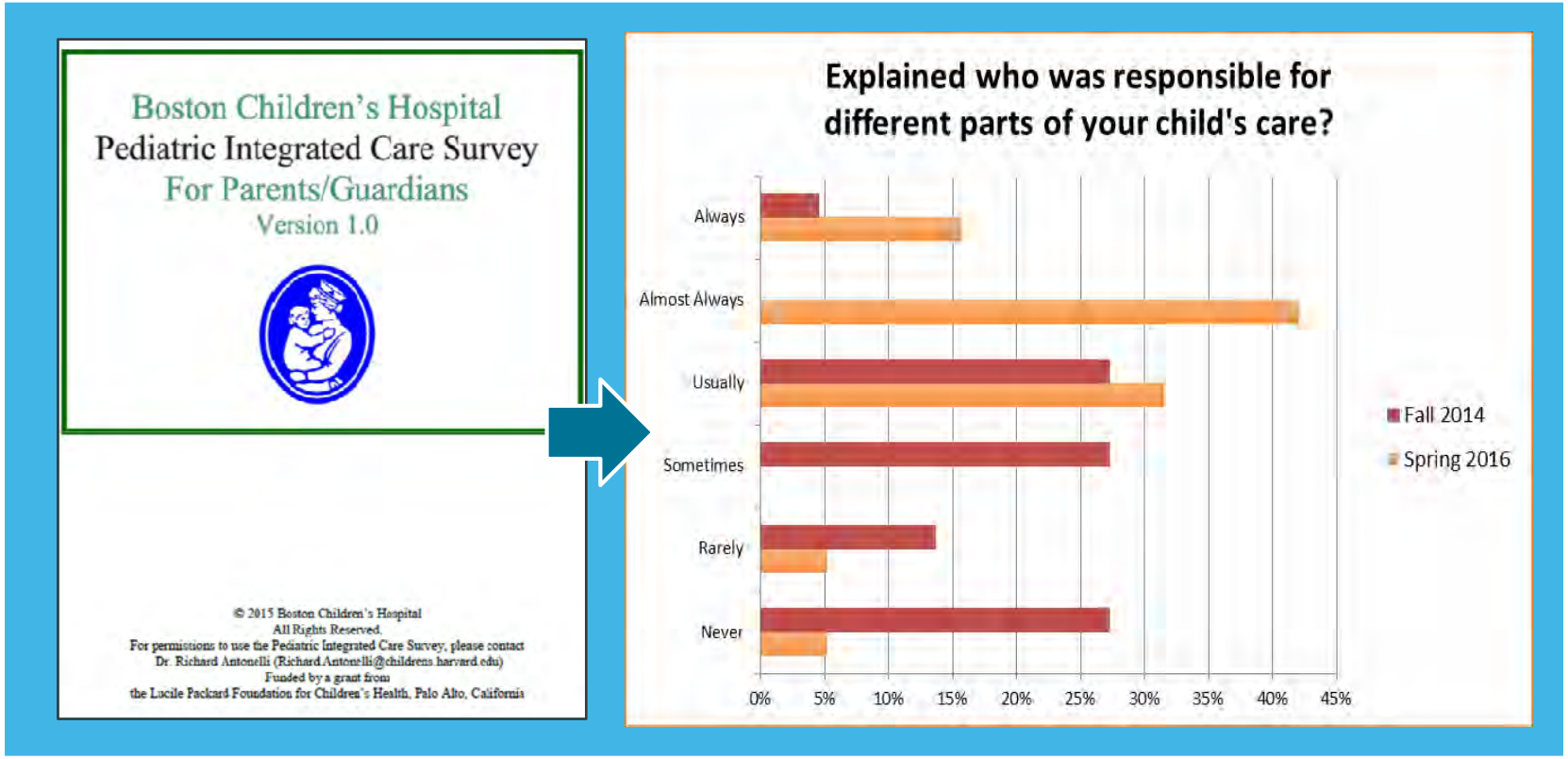
# Pediatric Integrated Care Survey (PICS)

***Family Reported Experience of Care Integration***

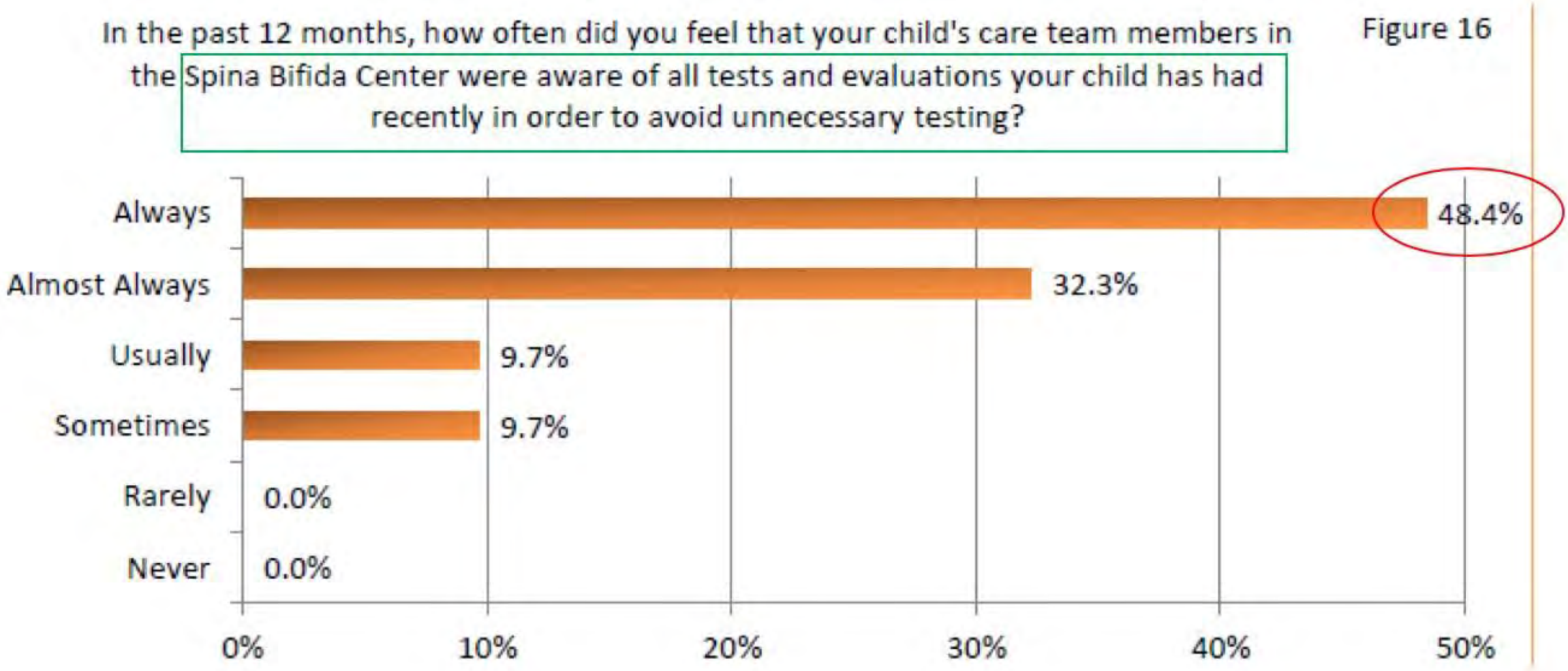
**<u>Validated assessment</u>** of experience of integration for medical, behavioral, social, educational, and family support

**<u>Five Core Domains</u>**

- Access to Care
- Communication with Care Team
- Family Impact
- Care Goal Creation/ Planning
- Team Functioning/Quality



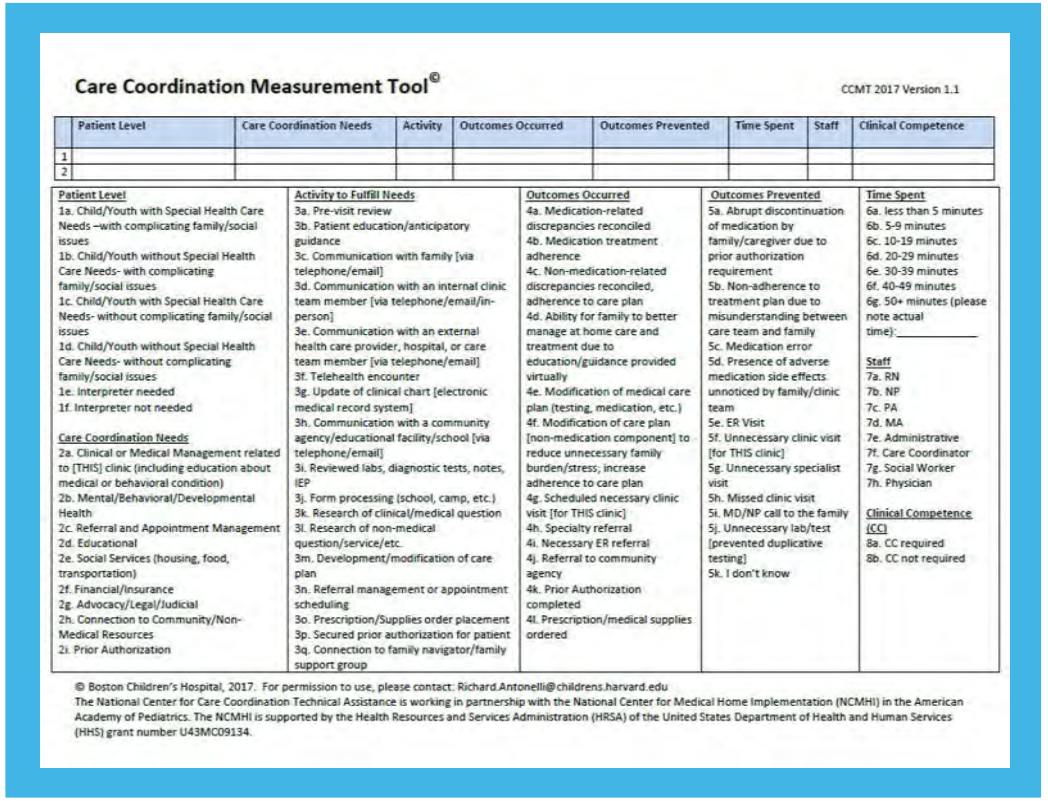
# BCH Spina Bifida Clinic: Implementation



# Care Coordination Tracking and Planning

## *Care Coordination Measurement Tool (CCMT)*

- <u>Captures Value of CC activities – For Both QI and Business Planning</u>
  - Supports efforts of all disciplines doing CC
    - Nursing, Social Work, other staff involved in care coordination
  - Identify gaps and redundancies in care



**Care Coordination Measurement Tool©**

CCMT 2017 Version 1.1

| | Patient Level | Care Coordination Needs | Activity | Outcomes Occurred | Outcomes Prevented | Time Spent | Staff | Clinical Competence |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |

**Patient Level**
1a. Child/Youth with Special Health Care Needs –with complicating family/social issues
1b. Child/Youth without Special Health Care Needs- with complicating family/social issues
1c. Child/Youth with Special Health Care Needs- without complicating family/social issues
1d. Child/Youth without Special Health Care Needs- without complicating family/social issues
1e. Interpreter needed
1f. Interpreter not needed

**Care Coordination Needs**
2a. Clinical or Medical Management related to [THIS] clinic (including education about medical or behavioral condition)
2b. Mental/Behavioral/Developmental Health
2c. Referral and Appointment Management
2d. Educational
2e. Social Services (housing, food, transportation)
2f. Financial/Insurance
2g. Advocacy/Legal/Judicial
2h. Connection to Community/Non-Medical Resources
2i. Prior Authorization

**Activity to Fulfil Needs**
3a. Pre-visit review
3b. Patient education/anticipatory guidance
3c. Communication with family [via telephone/email]
3d. Communication with an internal clinic team member [via telephone/email/in-person]
3e. Communication with an external health care provider, hospital, or care team member [via telephone/email]
3f. Telehealth encounter
3g. Update of clinical chart [electronic medical record system]
3h. Communication with a community agency/educational facility/school [via telephone/email]
3i. Reviewed labs, diagnostic tests, notes, IEP
3j. Form processing (school, camp, etc.)
3k. Research of clinical/medical question
3l. Research of non-medical question/service/etc.
3m. Development/modification of care plan
3n. Referral management or appointment scheduling
3o. Prescription/Supplies order placement
3p. Secured prior authorization for patient
3q. Connection to family navigator/family support group

**Outcomes Occurred**
4a. Medication-related discrepancies reconciled
4b. Medication treatment adherence
4c. Non-medication-related discrepancies reconciled, adherence to care plan
4d. Ability for family to better manage at home care and treatment due to education/guidance provided virtually
4e. Modification of medical care plan (testing, medication, etc.)
4f. Modification of care plan [non-medication component] to reduce unnecessary family burden/stress; increase adherence to care plan
4g. Scheduled necessary clinic visit [for THIS clinic]
4h. Specialty referral
4i. Necessary ER referral
4j. Referral to community agency
4k. Prior Authorization completed
4l. Prescription/medical supplies ordered

**Outcomes Prevented**
5a. Abrupt discontinuation of medication by family/caregiver due to prior authorization requirement
5b. Non-adherence to treatment plan due to misunderstanding between care team and family
5c. Medication error
5d. Presence of adverse medication side effects unnoticed by family/clinic team
5e. ER Visit
5f. Unnecessary clinic visit [for THIS clinic]
5g. Unnecessary specialist visit
5h. Missed clinic visit
5i. MD/NP call to the family
5j. Unnecessary lab/test [prevented duplicative testing]
5k. I don't know

**Time Spent**
6a. less than 5 minutes
6b. 5-9 minutes
6c. 10-19 minutes
6d. 20-29 minutes
6e. 30-39 minutes
6f. 40-49 minutes
6g. 50+ minutes (please note actual time):_____

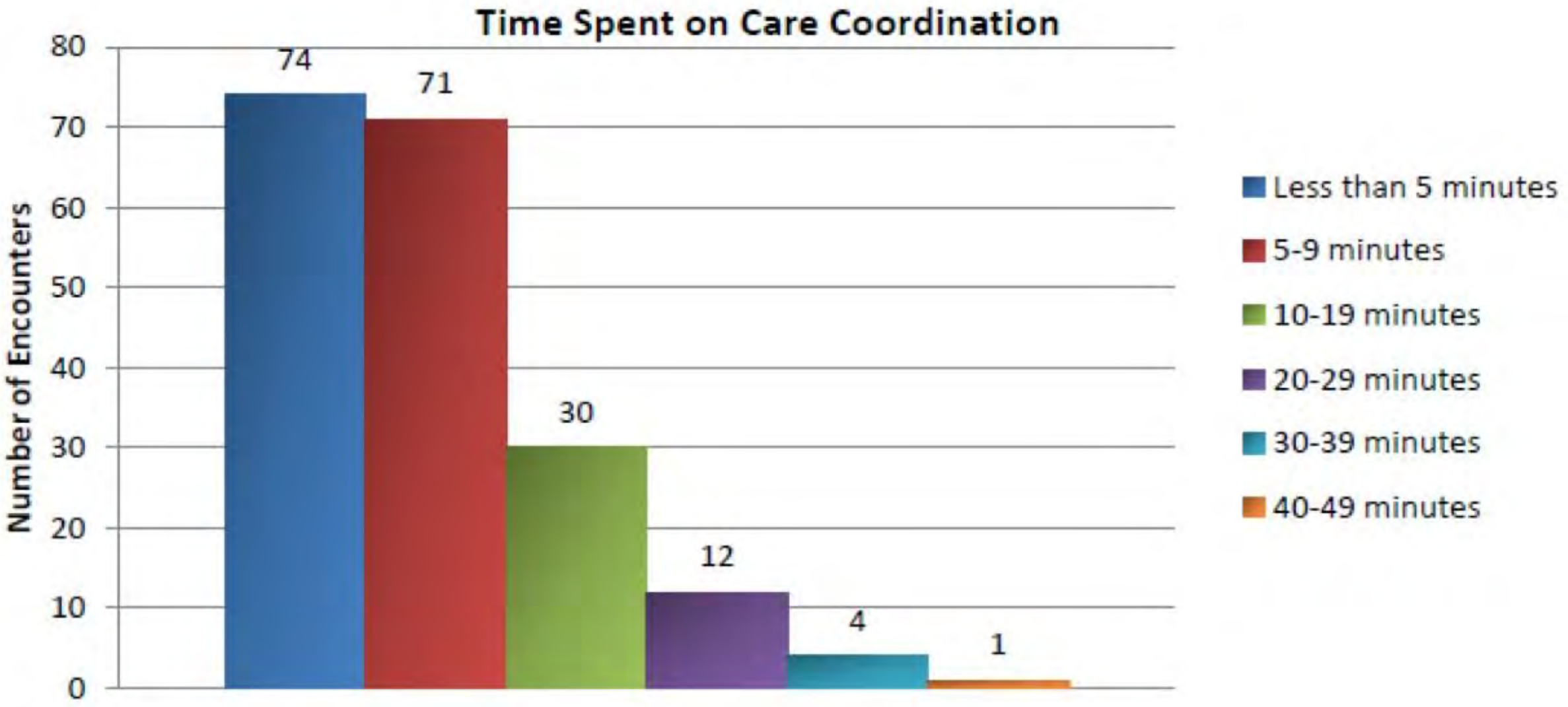
**Staff**
7a. RN
7b. NP
7c. PA
7d. MA
7e. Administrative
7f. Care Coordinator
7g. Social Worker
7h. Physician

**Clinical Competence (CC)**
8a. CC required
8b. CC not required


The National Center for Care Coordination Technical Assistance is working in partnership with the National Center for Medical Home Implementation (NCMHI) in the American Academy of Pediatrics. The NCMHI is supported by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (HHS) grant number U43MC09134.

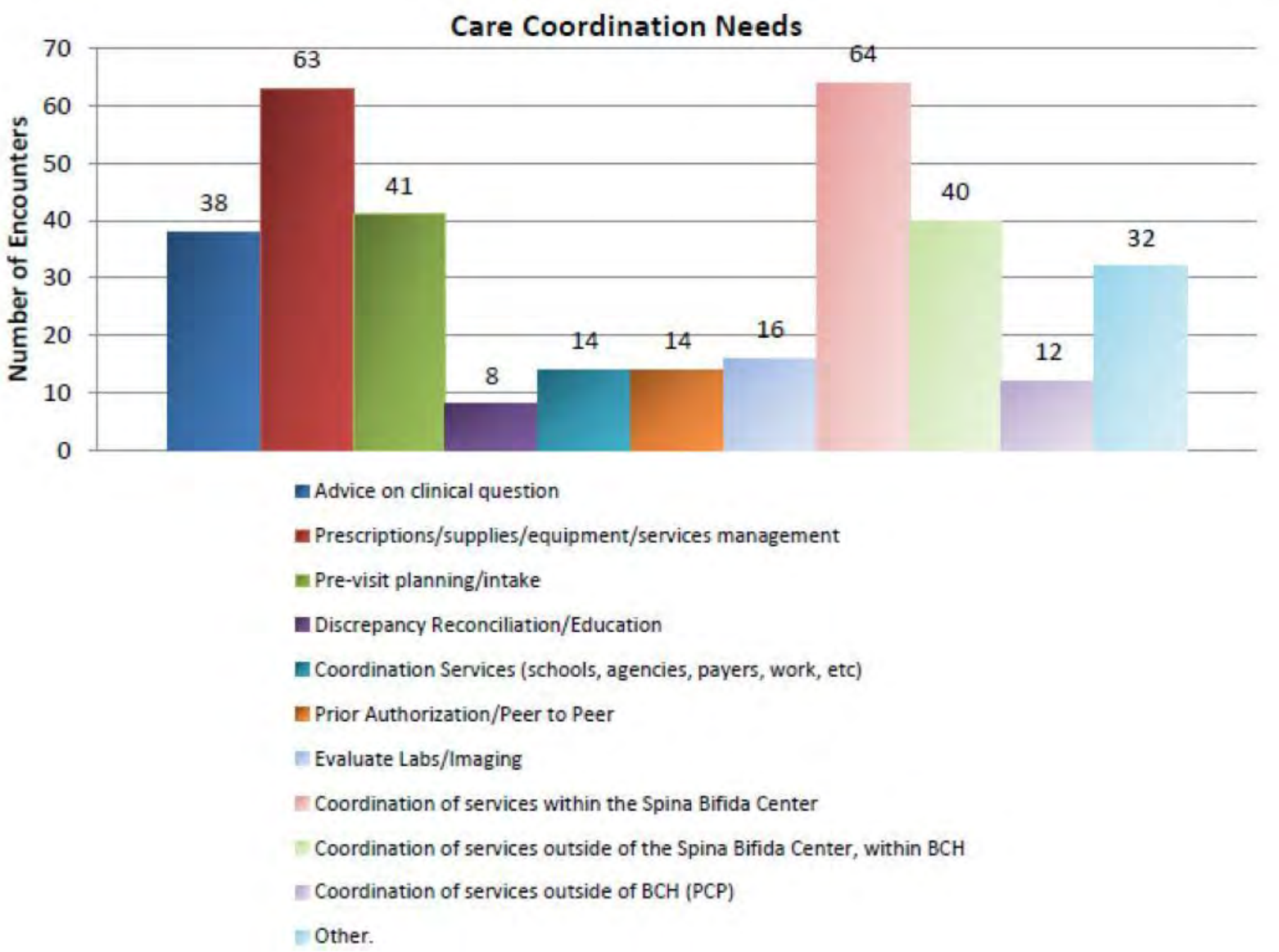
# BCH Spina Bifida Clinic: CCMT Implementation

*courtesy of Rebecca Sherlock, RN, NP, BCH Department of Urology, Spina Bifida Center*



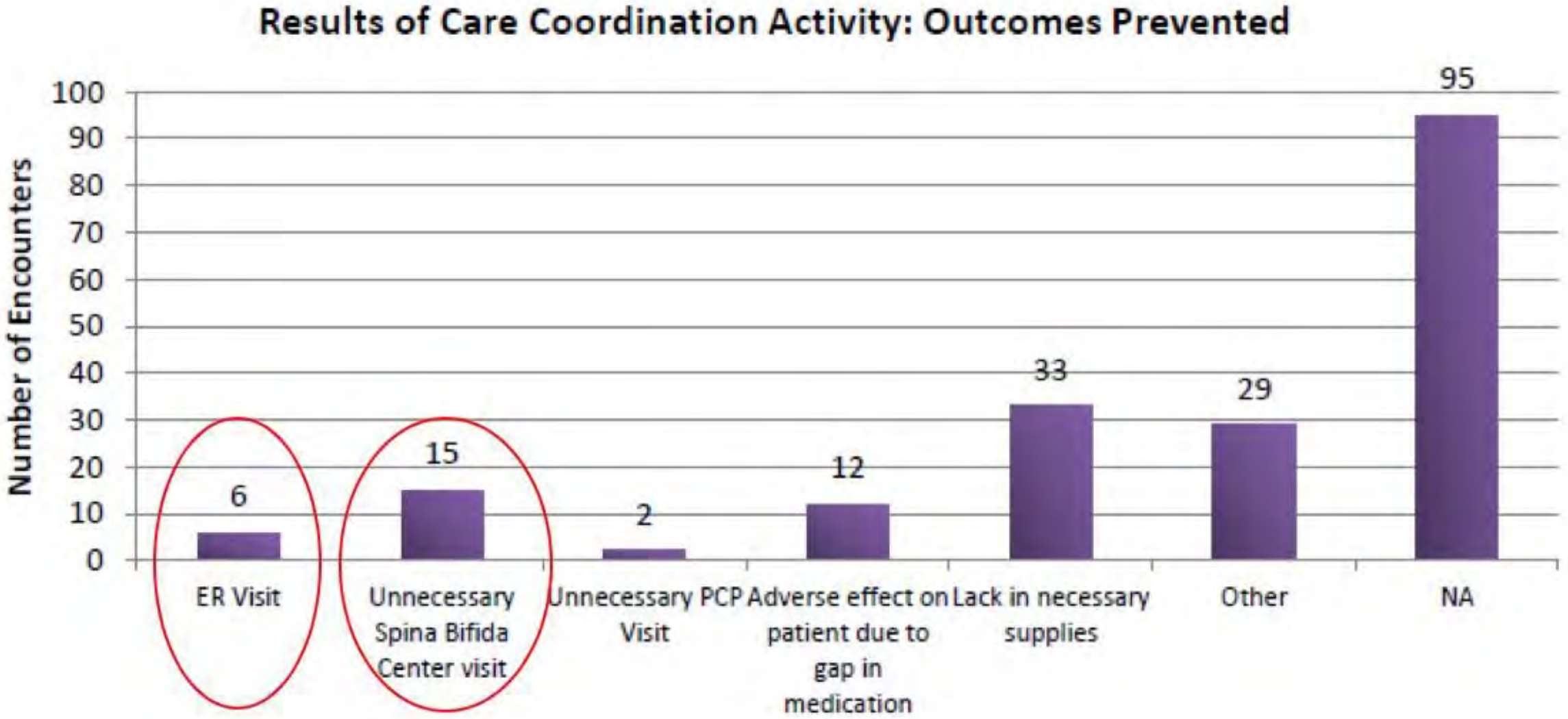
# BCH Spina Bifida Clinic: CCMT Implementation

***courtesy of Rebecca Sherlock, RN, NP, BCH Department of Urology, Spina Bifida Center***



# BCH Spina Bifida Clinic: CCMT Implementation

*courtesy of Rebecca Sherlock, RN, NP, BCH Department of Urology, Spina Bifida Center*



# Spread: Spina Bifida Association of America

Five Spina Bifida subspecialty clinics have adapted and implemented key NCCCTA tools to measure care coordination and improving care integration.

The tools include:

- Pediatric Integrated Care Survey (PICS)
- Care Coordination Measurement Tool (PICS)
- Pediatric Care Coordination Curriculum, 2nd Edition

Data collection is underway; SBAA planning to roll out another wave of NCCCTA tool adopters in subspecialty Spina Bifida clinics.

# National Center for Care Coordination Technical Assistance (NCCCTA) Tools and Resources

Pediatric Care Coordination Curriculum, 2nd Edition (PCCC)

Care Coordination Measurement Tool (CCMT)

Pediatric Integrated Care Survey (PICS)

Action Grid

High-Quality Handoff

http://www.childrenshospital.org/integrated-care-program

**Questions?**

**Thoughts?**

**Reactions?**

*Thank you!*

*Jessica Beliveau, MPH*
*Manager, National Center for Care Coordination Technical Assistance:*
*jessica.beliveau@childrens.harvard.edu*

# Sampling of Recent Publications and Presentations


1. Chase, T . “Beyond Implementation: Capturing the Value of Care Coordination”. American Academy of Pediatrics webinar series, May 2015.
2. Connor JA et al. Measuring Care Coordination in the Pediatric Cardiology Ambulatory Setting. The Journal of Nursing Administration. Vol 38(2); 107-113.
3. Foley C, Rosenberg H, Ryan C, Pixley L, Costas K, Tarrant S, Fee C, Antonelli R, Bergin A. Improving Quality of Care in a Ketogenic Diet Program: Collaboration between a Keto care team and the Integrated Care Program at Boston Children’s Hospital. Poster presented at: American Epilepsy Society Annual Meeting; Dec. 1-5; Washington DC.
4. Hartigan, Lori. “Measure What Matters: Advancing Multidisciplinary Care Coordination in Primary and Subspecialty Settings”. Webinar hosted by National Center for Care Coordination Technical Assistance and National Center for Medical Home Implementation, May 2018.
5. McCrave JM, Curro-Harrington C et al. “The Clinical and Economic Impact of Telephone Triage”- Poster Presentation at American Association of Neuroscience Nurses, March 2017
6. Myers T, Aspinwall S, Flath Sporn S. The Ambulatory RN Role for Improving Patient Access and Care Coordination.-Poster Presentation at Boston Children’s Hospital Nurses week in Boston MA May 2016 and at the AAACN ( American Academy of Ambulatory Care Nursing ) annual conference in Palm Springs CA , May 2016
7. Myers T, Flath Sporn S. The Evolving Ambulatory RN Liaison Role for Improving Patient Access and Care Coordination. -Poster Presentation at Boston Children’s Hospital Nurses Week, Boston MA, May 2017.
8. Vaz et al. “Utilizing a Modified Care Coordination Measurement Tool to Capture Value for a Pediatric Outpatient Parenteral Antibiotic Therapy (OPAT) Program” *Journal of the Pediatric Infectious Diseases Society,* 2017.
9. Yogman M, Betjemann S, Sagaser A, Brecher L. Integrated Behavioral Health Care in Pediatric Primary Care: A Quality Improvement Project. Clinical Pediatrics. 2018; 57(4):461-470.
10. Zanello et al. Care coordination for children with special health care needs: a cohort study. Italian Pediatrics. 2017; 43(1):18.
11. Ziniel SI, Rosenberg HN, Bach AM, Singer SJ, Antonelli RC. Validation of a Parent-Reported Experience Measure of Integrated Care. *Pediatrics.* 2016; 138(6).

# Wrap-Up & Next Steps

**Boston University** School of Social Work
Center for Innovation in Social Work & Health

# Next Steps

- Reach out with any further questions!
- Submit survey data by today 1/15
- Stay tuned for how to engage via Google Groups

# Evaluation

https://www.surveymonkey.com/r/WGKJB8G