Integrating Care for Children and Youth: Practical Application for Early Hearing Detection and Intervention Programs

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Acknowledgments

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Presentation hosted by….

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in partnership with the

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for Hearing Assessment and Management

and

Hands & Voices

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National Center for Care Coordination Technical Assistance

The mission of the National Center for Care Coordination Technical Assistance is to support the promotion, implementation and evaluation of care coordination activities and measures in child health across the United States.

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 (Grant number U43MC09134).

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Learning Objectives

By the end of this webinar, the audience will be able to do the following:

- Discuss the framework for care coordination and the key tenets of same
- State key tools to support care coordination capacity building and measurement
- Review practical strategies for implementing an integrated approach to care management
- Describe strategies for incorporating tools and measures into current practices with the EHDI population

Why Discuss Care Coordination?

There are gaps in coordination between the following:

- Primary Care Providers/clinicians
- Other health care providers
- Audiologists
- EHDI/Title V programs
- Early Intervention (EI) programs

Gaps

- National Data
  - ➢64.9% screened positive who were enrolled in Early Intervention

(2014 Data, CDC https://www.cdc.gov/ncbddd/hearingloss/2014-data/2014_EI_Summary_Web_3.pdf)

- Families experience gaps in care between multiple different providers
- Gaps can be measured and remediated

Care Coordination

Care coordination is the set of activities in “the space between” visits, providers, hospital stays, and procedures

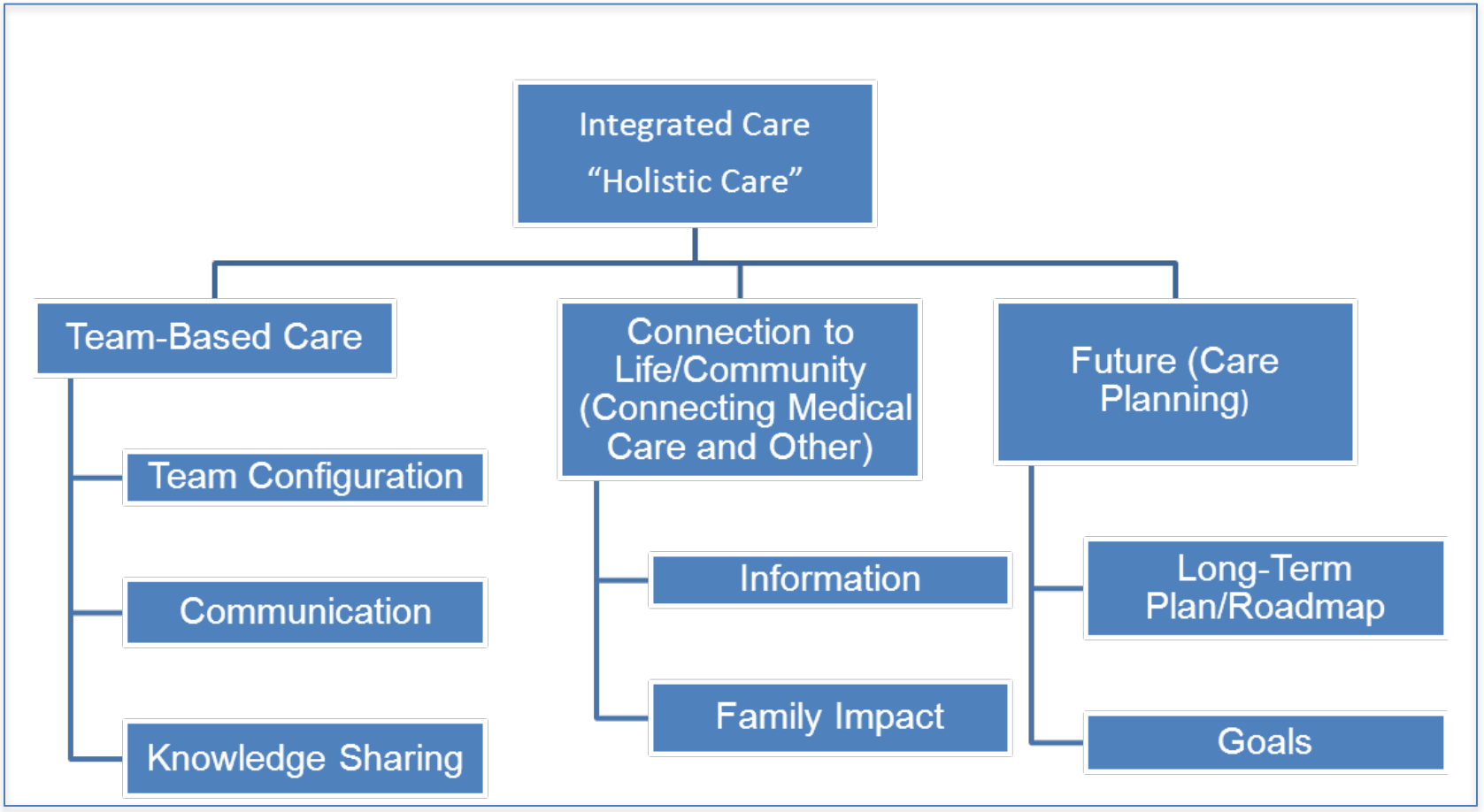
Turchi RM, Antonelli RC et al. Patient- and Family-Centered Care Coordination: A Framework for Integrating Care For Children and Youth Across Multiple Systems. *Pediatrics*. May 2014.

Integrated Care

Integrated care is the seamless provision of health care services, from the perspective of the patient and family, across the entire care continuum. It results from coordinating the efforts of all providers, irrespective of institutional, departmental, or community-based organizational boundaries.

Antonelli, *Care Integration for Children with Special Health Needs: Improving Outcomes and Managing Costs. National Governors Association Center for Best Practices, 2012*

Integrated Care Framework



Ziniel SI, Rosenberg HN, Bach AM, Singer SJ, Antonelli RC. Validation of a Parent-Reported Experience Measure of Integrated Care. *Pediatrics.* 2016;138(6).

Broad Recommendations

Promote interdisciplinary team functioning through training

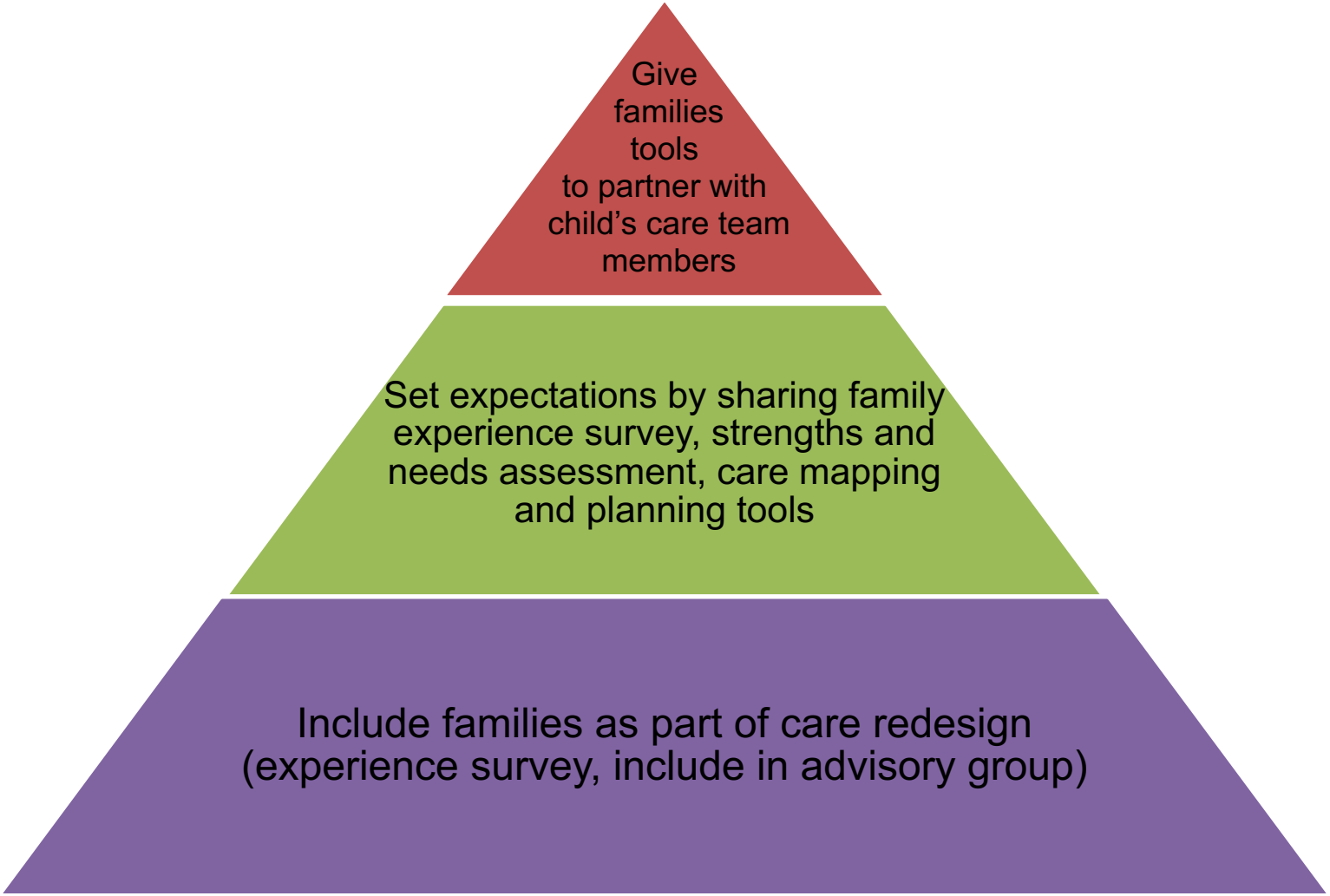
Collect family experience to assess gaps, use data to inform interventions

Collect care coordination activities and outcomes data to inform QI and prepare for value based care

Co-create and implement care plan (include care team members and family)

Systematize handoffs between care team members and family

Family Partnership



Tools

Pediatric Integrated Care Survey (PICS)

- Family experience measure of care integration, considered outcome measure
- Used to conduct quality measurement to inform improvement work in the space of pediatric care integration
- PICS tool consists of the following:
  - Nineteen (19) validated experience questions + health care status/utilization and demographic questions
  - Supplementary and topic-specific modules
  - Spanish version is available

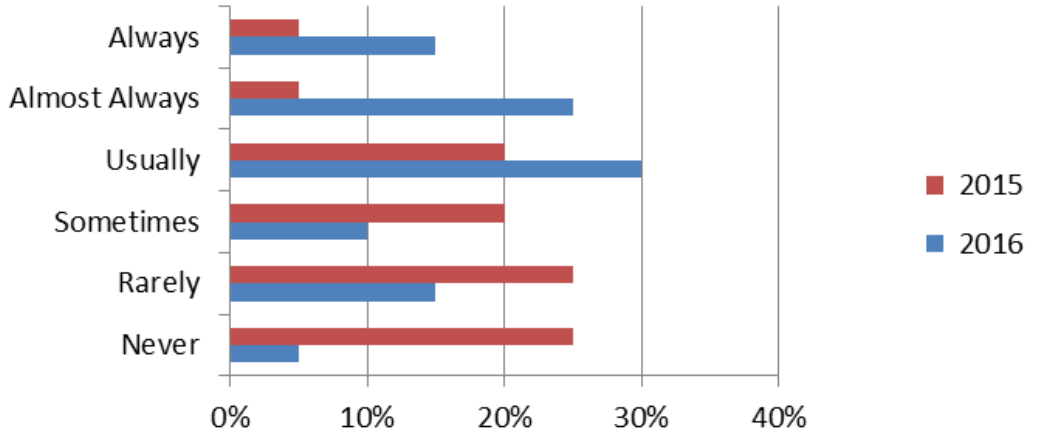
Pediatric Integrated Care Survey (PICS)

- Assess family experience of medical service delivery, behavioral health, education, linkage to community organizations

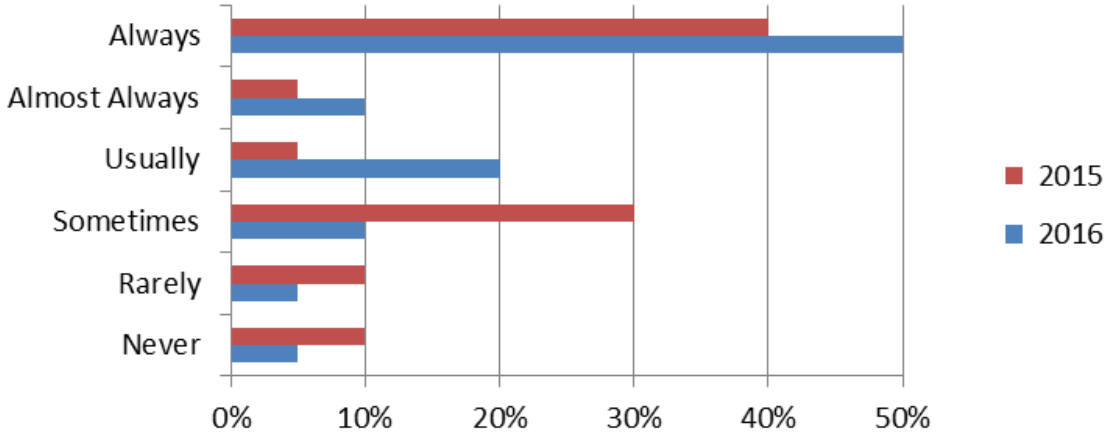
- Assess the family experience of integration across the entire care team or specific to an entity

Pediatric Integrated Care Survey (PICS)

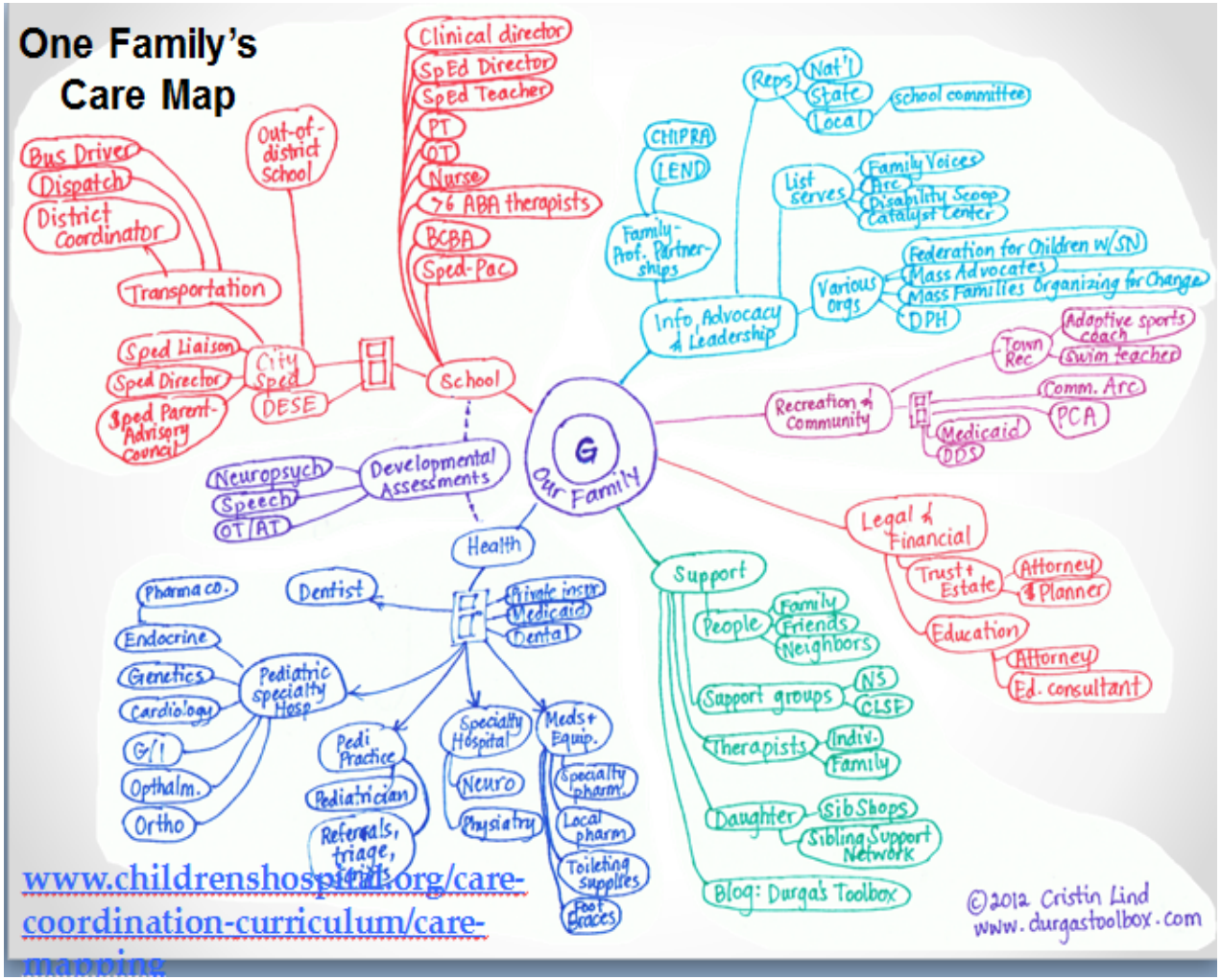
In the past 12 months, how often did you feel that your child's care team members in the Smith Clinic knew about the advice you got from your child's other care team members?



In the past 12 months, how often have your child's care team members in the Smith Clinic treated you as a full partner in the care of your child?



Care Planning Tools



www.childrenshospital.org/care-coordination-curriculum/care-mapping

Section B: Help Needed by Domain

Medical/health care:

- Referrals needed, medications, functional status, self-care, DME, managing special health problems (growth/nutrition, sleep, etc)
- Reminders to include assessment of oral health needs
- Address Transition to Adult Care needs when patient age warrants

Behavioral:

- Help managing behavioral issues, meeting child's emotional needs
- Identify behavioral issues/risky behaviors as barriers to care
- For adolescent-age youth, address drugs or alcohol abuse and other risk-taking behaviors

Social:

- Making/keeping friends, family support network/caregiver needs, family issues (siblings, divorce, etc), parenting groups/ recreational programs/other community resources, domestic violence shelters, counseling services

Educational:

- Learning/school performance, IEP/504 plans/ADA/Individual Health Plans at school, educational advocates/lawyers, literacy, ESL, GED, tutoring, after-school pgm
- Make connections between school issues and mental health issues (home schooling, extended absences, home tutoring for suspensions… have to separate from medical reasons for absences
- Any release paperwork needed for school communications?

Financial:

- Understanding insurance, helping paying for things insurance doesn't cover, potential social service programs (disability, food stamps, WIC, child care/housing/transportation subsidies)
- Dental insurance warrants special consideration

Other (housing/environmental/legal/etc):

- Food, Housing, Independent Living, Utilities, Immigration, Transportation, Guardianship, Other Legal Issues

Clinician Reason for BCH Visit

Referring Provider:	**Today's Date:**
Patient Name: **DOB:** **Phone Number(s):**	**Patient Address:**
Requested BCH Subspecialty:	**Requested Referral Relationship:** ☐ One-time consultation ☐ Co-management/shared care ☐ Subspecialty-based management ☐ To be determined
Clinician Reason for BCH Visit:	**Relevant Clinical/ Psychosocial Information:**
Recommended Timeframe of Appointment: ☐ 24-48 hrs (Urgent) ☐ 72hrs-1 week ☐ 2-4 weeks ☐ 4-6 weeks ☐ No preference	**Clinical Documentation Included:** ☐ Recent progress note ☐ Recent well child visit ☐ Lab results ☐ Imaging studies ☐ Growth chart ☐ Other:
Referring Physician Practice Information:	**Additional Information:**

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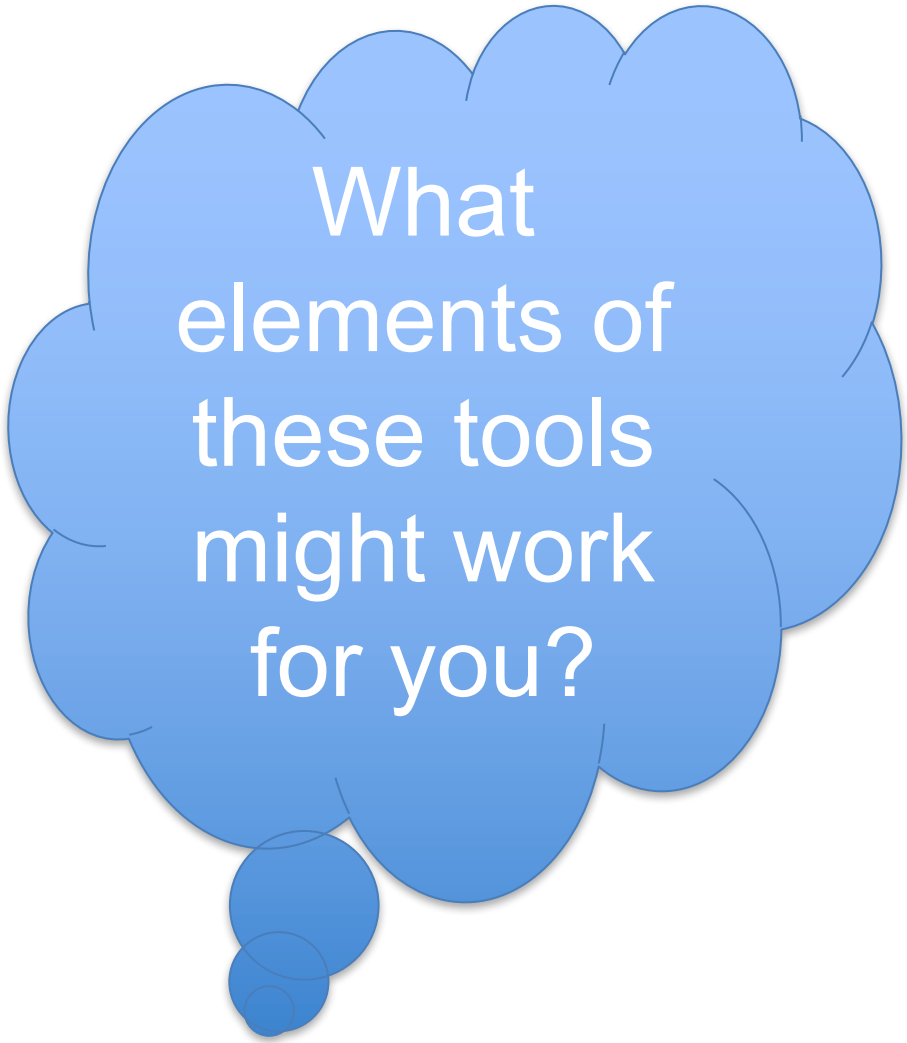
Until every child is well™

Post-Encounter Action Grid

Date:
Patient Name:
Clinic:
Provider Name:

Goal *What is action contributing to?*	Action *What needs to be completed?*	Who *Who is responsible for completing action?*	When *What is the timeline that the action needs to be completed?*	Contingency *If there is an issue or barrier, what are next steps?*

Simplifying



Care Coordination Measurement Tool (CCMT)

- Best way to improve coordination is to measure it
- Intended to be adapted to reflect activities and outcomes of teams in diverse settings
- Tool can be implemented in different ways depending on goal of collecting data→ for every encounter, once a week every quarter, etc
- Paper version or web-based versions have been used in past
- Is in AHRQ Atlas, core tool can be found on BCH website: http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement

Care Coordination Measurement Tool©

	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
2g. Prior Authorization

Activity to Fulfill 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 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

Outcomes Occurred
4a. Medication-related discrepancies reconciled
4b. Medication treatment compliance
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-compliance 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. ED 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
7f. Physician

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

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EHDI Coordinators Capacity Building

- Building team-based model of care coordination (CC)
- Pediatric Care Coordination Curriculum
  - 80/ 20 Rule: 80% of CC is core activities and functions
    - 20% is specific and must be developed "organically", reflecting Assets, vulnerabilities, culture, language, socio demographics, geography
  - CC training necessary for EHDI families, nurses, social workers, trainees, community health workers, physicians and other pediatric clinicians
  - 2nd Edition published in late 2017

Care Coordination Curriculum Antonelli, Browning, Hackett-Hunter, McAllister, Risko; Lind. Boston Children's Hospital; funded thru Family Voices/MCHB HRSA grant. 2012. www.childrenshospital.org/care-coordination-curriculum

Care Coordination Curriculum

Care Coordination Curriculum

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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 family's caregiving capabilities. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health and wellness outcomes. Key activities of Care Coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family.

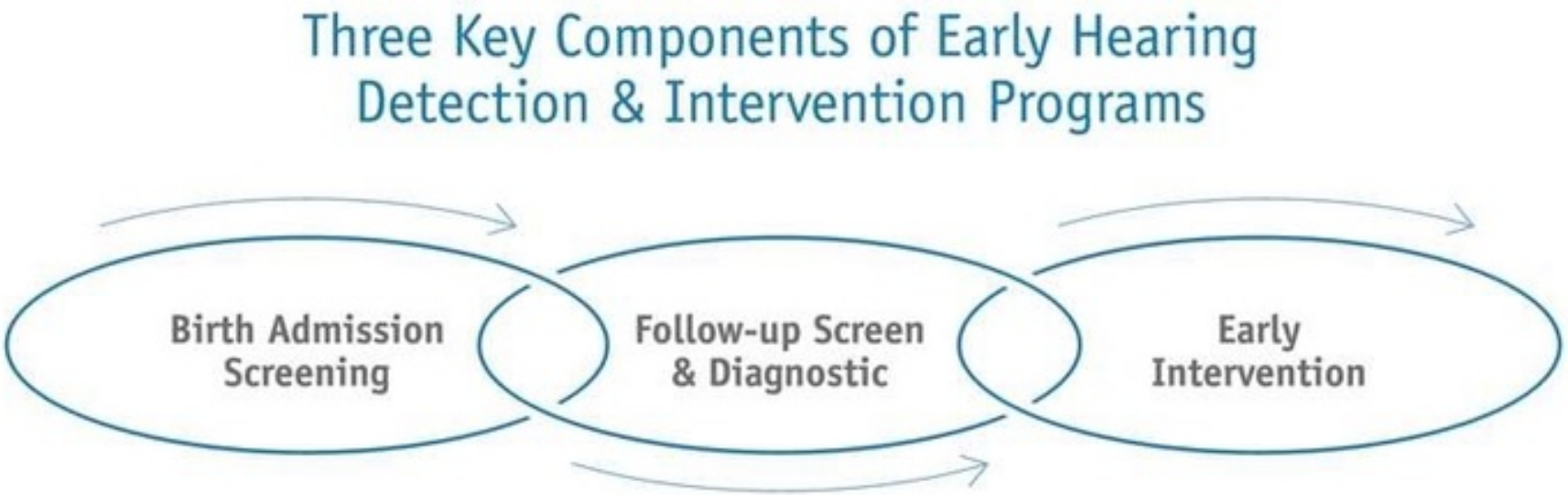
This curriculum was developed to support the provision of family-centered care coordination activities in pediatric medical homes. The goal was to develop a robust, but streamlined curriculum which could be adapted to the needs of any entity (a single practice; a network of practices; a community; a state wide organization such as Title V). The majority of the content is widely applicable, but it's highly recommended that local content be added to the curriculum –specific information about connecting to state programs and local resources.

This educational initiative was designed to be a "participatory curriculum" focused on real-time learning among various individuals serving the function as care coordinators, as well as other primary care-based team members, including pediatric and mental health providers. The intention of the curriculum is to articulate the principles and activities necessary to support any individual in the role as a care coordinator – including the patient / family.

Join us today by downloading the full version of the Care Coordination Curriculum.

Let’s put this into practice!

Care Coordination within EHDI



Care Coordination within EHDI

By 1 month….

- Results are shared with state EHDI program
- PCP should ask about hearing screening results and speak with the family about those results
- PCP talks with parent about the importance of follow-up and assists with the referral to audiology (and other specialists as needed)
- PCP establishes a follow up procedure to ensure that appointments are kept

Care Coordination within EHDI

By 3 months….

- Family completes the hearing re-screen or attends the diagnostic evaluation (depending on state resources)
- Once audiologist determines the level of hearing, results are reported to EHDI so next steps can be taken. (This is where the development of a “Shared Plan of Care” begins.)
- Team is identified and works toward 1-3-6 Goals. (This includes connection with Hands & Voices or other family support program.)
- Family meets again with PCP to discuss next steps for care (eg, early intervention, communication and hearing technology options, parent and family support, and impact)

Care Coordination within EHDI

By 6 months….

- Family follows up with Early Intervention (EI) services and child is enrolled for the appropriate services
- PCP is notified of services and continues to monitor care as outlined by the Shared Plan of Care

Selected References

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- Antonelli, RC, Stille, C, and Antonelli, DM, **Care coordination for children and youth with special health care needs: a descriptive, multisite study of activities, personnel costs, and outcomes**. Pediatrics. 2008 Jul;122(1):e209-16.
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- **AHRQ Care Coordination Atlas** (McDonald Nov 2010, June 2014) and companion document Care Coordination Accountability Measures for Primary Care (McDonald Jan 2012).
- **Care Coordination Curriculum and Care Mapping Tool User Guides:** Antonelli, Browning, Hackett-Hunter, McAllister, Risko; Lind. Boston Children's Hospital; funded thru Family Voices/MCHB HRSA grant. 2012. www.childrenshospital.org/care-coordination-curriculum
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Thank you!

Questions and Discussion