

	Question	MCHB	Answer	References
1	Is it okay if our learning community only has 1 pediatric care practice that is willing to provide data in years 2 and 3 about services to children in that practice?	Lori	One practice would be the minimum allowable for baseline data.	
2	I can see several issues with trying to recruit pediatric care practices to provide data about the services provided to children who are D/HH in those practices.		<p>First, given that only 2-3 per 1,000 newborns are D/HH, many pediatric care practices will have few, if any, children who are D/HH. It won't be very meaningful to report to report the type of data outlined in the FOA if there is only 1 child per year.</p> <p>Please note that we define "practice" broadly. The cohort of D/HH children could be those seen in a Federally Qualified Health Center, a health plan or health system, a university system or center. The goal of collecting the data is to report on behavioral change within the participating practice(s) and/or families.</p> <p>Second, if the questions on which we need to report are still evolving, it will be very difficult to get people to agree to participate in the learning community and to provide data if they don't know exactly what the questions are.</p> <p>The learning community metrics have not changed but are being clarified to ensure that the learning community participants have a solid understanding of the data that will be collected.</p> <p>Third, if a practice does have a lot of children who are D/HH, collecting and reporting data could be expensive...that could make recruitment difficult.</p> <p>While not mandatory, grantees may want to think about providing various forms of incentives to participating practices.</p>	
3	We must report on the # of D/HH patients that have a care coordination plans. What is the definition of "D/HH patients" – all children who are D/HH in the state (if so, what ages)?		No, this reporting is only applicable to D/HH patients in a practice that is being represented and participating in the learning community.	
	All children who are D/HH in the participating practices (if so, what ages)?		The age range for patients that are D/HH is from birth to 21 years of age.	
	Also, does each state decide on the definition of "care coordination plan" that will be used in collecting these data?		MCHB recommends that states use the "Shared Plan of Care" as is most closely aligns with the expectations of the FOA. We recommend that grantees use the following definition of a shared plan of care based on guidance from the American Academy of Pediatrics (AAP): a shared plan of care focuses on partnering with families and patients to compile information and support coordination of care for the "multiple needs of an individual child or youth and his/her family." Additionally, shared plans of care are "developed and implemented with input from members of the team caring for a child, including community partners, educational specialists, primary care providers, dental providers, medical subspecialists and surgical specialists, and, most importantly, the family and patient themselves." The most recent edition of Bright Futures indicates that a shared plan of care is typically developed in partnership with the family and multiple care providers and describes the child and family's priorities and plans to support optimal health. Additionally, it takes into consideration the child's medical information, development plan, Individual Family Service Plan for young children, and educational plan (Individualized Education Program). ¹	'McAllister JW. Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs: An Implementation Guide. Pal, Also, CA: Lucille Packard Foundation of Children's Health; 2014
4	Are the questions about # of care coordination plans developed with the parents or family and # of care coordination plans that are shared across providers irrelevant because it can't be a care coordination plan if parents/family are not involved or if the plan is not shared and coordinated with other providers?		These questions are critical process questions to ensure that plans of care are developed with families and shared across providers. There are instances when care coordination plans are developed without input from the family members who are the caretakers. Additionally, care coordination plans are not always shared with other providers. Hence, the purpose of these questions is to ensure that the necessary partners are involved in the development of the plan and that it is being shared among pertinent providers.	
5	Is the question about the "number of health care professionals that have developed partnerships with state Title V CYSHCN programs regarding systems integration and family centered care coordination" only asking about health care professionals who are participating in the learning community or are we supposed to determine this for all health care professionals in the state?		This only pertains to health care professionals who are participating in the learning community.	
6	I have never heard of a learning community that brought outside experts in to provide information to the members of the learning community. Doesn't that run counter to the definition of a learning community where everyone is an equal partner in the community?		Having an expert speaker on a particular topic does not mean that the learning community participants are not equal partners. It should be noted that the grantees have complete discretion as to whether or not they would like to invite experts to provide information on a particular topic.	
	Also, to get enough experts to address the pros and cons of all 9 topics, we'd need 40-50 people on the learning community. What do you advise?		Please be advised that having experts is not mandatory. Grantees can choose which topics they would like to invite experts to address. Grantees can also choose not to have any experts participate in the learning community. It should also be noted that each topic does not require a separate learning community.	
7	Reporting data every 6 months in years 2 and 3 seems excessive. Would you consider making these annual reports instead of every 6 months?		It is not the intention to create excessive work for the grantees. It is important to be able to track the progress of the learning communities which is why data will be collected every six months in years 2 and 3.	
8	Please clarify the measurement "number of health care professionals that have developed partnerships with state Title V CYSHCN programs regarding systems integration and family centered care coordination."		The number of health care professionals that have developed partnerships with state Title V CYSHCN programs regarding systems integration and family centered care coordination pertains to the number of health professionals that are in the learning community.	
	I'm really not sure how to operationalize that. So, say my learning community is 5 people: 1 parent, 1 pediatrician, 1 county based case manager ("care coordinator"), 1 hospital EHD coordinator, and 1 audiologist. Questions: 1) do only 4 of these people count as "health care professionals" (i.e. not the parent) when I do my count?		That is accurate. However, please recognize that the parent representative on the learning community is a critical partner in the process, and we highly encourage their involvement.	
	What specific examples can you give me of that "partnership" would look like?		We are looking for examples of meaningful partnerships that include consistent communication, understanding and awareness of programs, people, including representation on committees or the establishment of referral processes. For some states, these partnerships are well-developed, in others, this will provide an opportunity to build and or strengthen these partnerships.	
	Would the audiologist have to actually refer a family to the home visiting program or just be aware of its existence?		The audiologist is encouraged but not required to refer the family to a home visiting program but should be able to provide the family with accurate information on how to contact the home visiting program.	
	If I have a 6th member of my community that is the state Title V coordinator, would their collaboration on the committee count as a "partnership?"		Yes, a state Title V coordinator's collaboration on the committee would count as a partnership.	
9	Does our learning community have to have a pediatrician on it if we are just focusing on diagnosis?		Ideally, the learning community should have a pediatrician. Including other pediatric health care professionals is also acceptable.	
10	Can the members of your stakeholders group also be a part of the learning community?		Yes, members of the stakeholders group can also participate in the learning community.	
11	For the Individualized Family Service Plan (IFSP) to count as a care coordination plan, would the child's pediatrician have to sign off on it?		Many elements of the IFSP can be included in the shared plan of care, but an IFSP that is signed by a pediatrician is not the same as a shared plan of care. A shared plan of care is developed with the involvement of a health care professional, ideally a pediatrician or primary care provider. Please see earlier answers for more specifics about the shared plan of care.	
12	Will you be outlining what you expect to be in the care coordination plan?		The AAP shared the following from the shared plan of care fact sheet: <ul style="list-style-type: none"> • Comprehensive compiling of information needed to support coordination of for multiple needs of a child and family. This includes medical, social, developmental, psychological, behavioral, education, financial information; and • The shared plan of care can also include information on how families and patients access health care services such as transportation, phone numbers to call. 	
13	Can you provide us with examples of other conditions that already have a care coordination plan and what those plans look like?		The AAP provided the following resources: The National Center for Medical Home Implementation sample care plans can be found at https://medical-homes.aap.org/Documents/PediatricCarePlan.pdf and a Diagnosis Prevalence List is available via the Medical Home Portal developed by the Department of Pediatrics at the University of Utah. This may reasonably reflect the relative prevalence of diagnoses among children in primary care practices and thus, may support the idea that care planning or shared plans of care for children who are D/HH can be somewhat generic and similar to care plans developed for children/families with other conditions.	
14	Who is considered a pediatric health professional? Can that be audiologist or maybe Ear Nose and Throat (ENT) specialist?		The point of involving a pediatric health professional is to ensure the linkage to the child's medical home, which is not a typical role of an audiologist or an ENT, but more likely a primary care professional. Therefore, no, an audiologist nor an ENT is considered a pediatric health professional.	
15	The learning community obviously needs to be organized with membership and agendas. However, is it a requirement that they also develop AIM statements or develop other overarching documents that lead the group?		No. While AIM statements may be beneficial, it is not a requirement to develop AIM statements or to develop other overarching documents to lead the learning community.	
16	It may be challenging to secure a three-year time commitment from any given member. Is it acceptable to have members rotate in as their time allows?		Yes, it is acceptable to have members rotate during the three years as long as there is a replacement representing the same sector (e.g. parent, pediatric health care professional) during their absence.	
17	For the members that represent pediatric practices, one of the requirements is that they report on the number of children who are D/HH in their practice with a care coordination plan, among other measures. In extending the invitation to them, I want to be as clear as possible as to what the expectation is. Will it be up to the individual learning communities to define what constitutes each of these measures or will there be a minimum standard set by HRSA?		The broad measurement guidelines were included in the FOA, and we will provide recommended guidance on what constitutes a shared plan of care, as well as other measures.	