First STEPS (Strengthening Together Early Preventive Screening) Learning Initiative: Improving Developmental, Autism, and Lead Screening

Planned, Coordinated Care in the Patient & Family-Centered Medical Home

Jeanne W. McAllister, BSN, MS, MHA
Director, Center for Medical Home Improvement
At Crotched Mountain Foundation

Coaching Call, August 16, 2012

“ASQ” Not What Screening Can Do For You”
Agenda

• Welcome/Introductions
  – Amy Belisle, MD

• Planned, Coordinated Care in the Patient & Family-Centered Medical Home
  – Jeanne W. McAllister, BSN, MS, MHA McAlllister, BSN, MS, MHA Director, Center for Medical Home Improvement At Crotched Mountain Foundation

• Next Steps for First STEPS
  – Amy Belisle & Sue Butts-Dion
Objectives

1. Discuss how to include families in their medical home and connect to resources after a positive result on a screening for autism or developmental delay as they await an appointment with the specialist.
2. Discuss who should have a care plan in place
3. Outline key elements of a care plan
4. Outline key areas of care coordination and how to effectively use a care coordinator in the primary care setting
5. Highlight some challenges practices and patients may face when developing care plans
Planned, Coordinated Care in the Patient & Family-Centered Medical Home

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www.medicalhomeimprovement.org
My Goals Today – Successful Care Planning & Care Plans:

★ Who should have a care plan?
★ What are the key elements?
★ How care coordination functions contribute
★ Successes and Challenges
★ A few care coordination lessons learned or,
  ★ "Don't let the 17 Year Rule, Rule"
Medical Home – the quality standard of excellence for 21st Century primary care

CMHI describes the medical home as...

a community-based, primary care setting which provides and coordinates high quality, planned & family-centered:

- health promotion
- acute illness care &
- chronic condition management
MEDICAL HOMES: LIVING, BREATHING, COMPLEX ORGANIZATIONS
Medical Home Characteristics – care coordination greases all of the wheels
Our Medical Home Until
1:30 p.m. 2/15/01

Support Family & Friends

MEDICAL HOME
PRIMARY DOCTOR
CARE COORDINATOR*

DAYCARE

FAMILY
And Then... Along Came The Amazing Miss Kate

- Congenital Hydrocephalus
- Multiple revisions, infections, complications
- Cerebral Palsy, Epilepsy
- Downright remarkable
Our Medical Home
Post Diagnosis
1:35 pm 2/15/01

SPECIALISTS
Hospital

EDUCATION
EI, Preschool
School, Work

FUNDING

AGENCIES
CSHCN
Clinics
Equipment

FAMILY
MEDICAL HOME
PRIMARY DOCTOR
CARE COORDINATOR

On-Going Care Team
Social Worker
OT/PT/SLP Therapists
Daycare Staff & Aide

HOME CARE

SUPPORTS
Family,
Friends,
Respite
Advocacy
CMHI Lessons Learned
Patient and Families – need, hope for - - - expect (?)

① Team approach to care/access to team

② Coordination across multiple services & settings
   (Primary care hub - to pharmacy, specialists, home care, vendors, school/work, insurers, etc.)

③ Integration of information (ongoing flow of)
   ▪ Written/portable care plans (summaries/action)
   ▪ a sense of “we have your back”
Delivery of Patient & Family-Centered Care Coordination Services
Planned Coordinated Care & Care Plans

Source: TED.com
Simon Sinek, The Golden Circle
**WHY?**

We know that families and youth affected by special health care needs want:
- A team-based approach to care
- Integrated health care information
- A written plan of care

We know that care and health for all CYSHCN and their families can be *far better* with respect to preparation, planning, communication, coordination, & safety achieved through strong youth/ professional partnerships.

It is possible and some practice teams have achieved - better care/population health with:
- engaged youth and families
- empowered team / care coordinators
- tested tools and processes
**HOW?**

Proactive care planning/action plans capture:

1. Youth/family GOALS
2. Clinical goals
3. Conversations, concerns/needs, advice/knowledge, decision points, and agreed short term (health, information and life activity actions).
4. Scripts defining roles for youth, family and each team member
Care plans use a clear process of care planning
Include the development of three parts, a(n):

1. Medical summary
2. Emergency plan (if necessary)
3. Actionable care plan
   - Goals
   - Health, information & life plans
   - Role clarity
Delivery of Patient & Family-Centered Care Coordination Services
Identification of needs
Use of medical information and family input to understand a family’s needs, strengths, gaps and relevant resources

Using your registry
Identify those patients and families most in need of care coordination support and other medical home services
Coordination – Assessment (handout)

Family-Centered Care Coordination - Assessment

1) What would you like us to know about your child? Assets? Likes? Dislikes?
2) What would you like us to know about you/your family?
3) When it comes to your child, what matters most to you right now? (Goals?)
4) Do you have any concerns or worries for your child? (Some examples below)
   - Their growth/development
   - Learning
   - Sleeping
   - Self-care
   - Making and keeping friends
   - Other (fill in):

5) Have there been any changes since we saw you last, such as a:
   - Brother or sister leaving home?
   - New job or job change?
   - Move to a new town?
   - Separation or divorce?
   - Sickness or death of a loved one?
   - Other (fill in)?

6) Can we help you with any of the following needs?
   - Medical (For example, help finding or understanding medical information; help finding health care for yourself or your family)?
   - Social (For example, having someone to talk to when you need to; getting support...
Coordination – Goal setting

Goal setting
Merging of patient & family goals with clinical goals

Eliciting goals
☑: **Not** – *What is the matter with you?*
☑: **Instead** – *What matters to you?*
Coordination – Goal setting

**Examples:**

- Socialization
- Hold and feed my baby
- Ride a bike
- Sit in truck
- Burger King
- Physics
Team-based Care Planning

1. Medical summary

2. Emergency plan (AAP form, if necessary)

3. Actionable care plan
   • Goals
   • Health, information & life plans
   • Role clarity
Medical Summary (see example)

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<th>Secondary:</th>
<th>Emergency Plan: Yes [ ] Not Applicable [ ]</th>
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**MEDICATIONS:**

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**SPECIALISTS:**

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From a Parent Partner...7 years out

- The Medical Home and care plans...you can’t have one without the other.

- When we travel, we have a copy; our ER has everything in place that’s accurate.

- At 3AM 'What’s your name?' could be a tough question! This helps!

- I don’t think pediatricians know how much of a difference it makes for us-
  - to make our lives a little easier.
Care Planning/ Action Plans

Care coordination translates an assessment into an **action plan**

- **Action plans**
  - Use assessments and address goals
  - Identify who is responsible for each action, when completion is expected, and who will track completion

- An **action plan** is the dynamic component of a care plan that may also include:
  - a portable medical summary and
  - an emergency plan
# Care Planning – Action Plan

**Child’s name:**

**DOB:**

**Parents/Guardians:**

**Primary diagnosis:**

**Secondary Diagnosis:**

**Secondary diagnosis(s):**

**Original Date of plan:**

**Last Updated:** / / / / / /

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<th>(2) Team &amp; Family Goals</th>
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<th>Current Plans/Actions</th>
<th>Person(s) Responsible</th>
<th>Date of Progress/Complete?</th>
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**Parent/Caregiver Signature:**

**Clinician Signature:**

**Care Coordinator:**

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<th>VISION</th>
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J. McAllister, 2011; adapted from Knoster, T. from Enterprise Group, LTD (1991)
Care Plan Use

Putting the action plan (summary & emergency plan) into effect

Assuring that the family has the resources needed for the action items

Scripts roles for family/team

Coordinated Care
Monitoring

Tracking of the action plan
Updating medical summary & emergency plan
  • Was the specialist consultation appointment made? Kept?
  • Does the medical home team have the results of the consultation?
  • Has follow-up/ follow-through in the medical home been arranged?
  • Similar – for lab work, x-ray, referral to early intervention, application for entitlement service, etc.
Planned Coordinated Care w/ Actionable Care Plans:

**Assessment**
- Focuses on Needs

  - Use with family; later a readiness assessment helps prepare for emerging adulthood

**Goals**
- Drives Planning

  - Family
  - Child/Youth
  - Clinical Goals

**Action Plan**
- Negotiated, Updated

  - Addresses goals and gaps
  - Team based, integrates health, life activities & other information
  - In hands of all partners
When they work {care plans} it is amazingly effective, (but we’re still working on getting that system working).

The patients that I have been able to have a well-child visit, create a care plan, and then six months later, a chronic care visit, it’s like their problems melt away.

It amazes me how that works. It’s almost supernatural. Their problems just quit.

The unplanned hospitalizations just tend to go away.
TOOLS FOR YOUR USE

Care Coordination - Comprehensive Care Planning Tools

- Assessment
- Portable Medical Summary
- Action Plan

Questions?
Questions?
TEAM CHALLENGE (QI or PDSA work)

**PROCESS**
1) Identify 1 or 2 children/youth in your practice to perform an assessment, establish gaps/skill building needs.
   a) Discuss their needs and your concerns

2) Inquire about child/youth/family goals & highlight in an action plan
   Child, youth and family goals:
   Clinical goals

3) Capture (blend) in a negotiated ACTION PLAN (tool)

**WORKFLOW**
- How will you use a team-based approach?
- How will you communicate with your team members?
- Where will action plans reside; how might they be retrieved and updated?
- Can you get them into the hands of your youth/families?
- What is your PLAN for practicing care plan development?
- What are your predictions for what will happen?
- How will you make corrections?
CMWF Framework
A definition

Care coordination is a patient and family-centered, assessment driven, team-based activity ...

...designed to meet the needs of children, youth and adults while enhancing the care giving capabilities of families.

...Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health, and wellness outcomes.

Antonelli, McAllister, Popp, 2009
Components of Care Coordination

- Patient & family-centered
- Community-based
- Pro-active, providing planned, comprehensive care
- Promotes the development of self-management skills with children, youth, adults and families
  - (Care Partnership Support)
- Facilitates cross-organizational linkages, relationships, communications (both ways)
CC Functions

- Provide separate CC visits
- Complete/analyze assessments
- Manage continuous communication
- Develop care plans with patients/families
- Manage/track tests, referrals, and outcomes
- Coach patients/families
- Integrate/consolidate critical care information
- Support/facilitate care transitions (pedi, adult, nursing home, hospital, etc.)
- Facilitate (participates in) team meetings
- Use health information technology (IT)
Care Coordination With Care Plans

- The opposite of coordination is **fragmentation**

- Care that is not coordinated is likely to be fragmented – there is nothing in between

- Care coordination is expressed through *communication with*
  - Patients and families
  - Team members in the medical home
  - Other health care providers and settings
  - Community-based organizations

★★ **Patients and families need to know that care coordination help is available and how to access it** ★★
Change is not easy...care planning is not easy, but....

Method to support change is needed, CC as part of team QI
Do not let the perfect be the enemy of the good

Voltaire
Care Plans – Policy Environment

- **Pediatric**
  - NCQA
  - AAP
    - Toolkit
    - CC Policy Paper
  - NASHP/Medicaid CC Reports
  - CMHI (research)
  - NICHQ
  - ACA
    - Essential benefits
    - Medical/health home

- **Adult**
  - NCQA
  - Care Transitions (E. Coleman U. Colorado)
  - Guided Care - (J. Hopkins)
  - Grace Program (IUPUI)
  - Institute for Healthcare Imp
  - Accountable Care Act (ACA)
    - Essential benefits
    - Medical/health home
Family-Centered Medical Home
*Across the lifespan for children, youth and adults*

It Takes Planned, Coordinated Care
I welcome your questions -
Next STEPS

• Report your August data and PDSA/Process (if you have not done so already)
• Phase 2 Learning Session 2 Sept 14th at the Hilton Garden Inn Freeport (Celebration event for Phase 1 at Harraseeket 5-7 PM)
• Next All Practice Call Thursday October 11th, 2012 (12 noon-1 PM)
YOU’RE INVITED

The First STEPS leadership team invites you to a celebration dinner.

Join us for an opportunity to celebrate your accomplishments and honor practices that had outstanding success!

First STEPS
Celebrate Excellence in Childhood Immunizations

Friday, September 14, 2012 | 5–7 p.m.
Harraseeket Inn in Freeport, Maine

Maine Quality Counts
Better Health Care, Better Health.

Thank you to the MaineHealth Childhood Immunization Task Force for providing us with a grant to host this celebration.

Look for your formal invitation in the mail!
Please RSVP to Lisa Brochu, Membership and Events Coordinator, Maine Quality Counts at lbrochu@mainequalitycounts.org or (207) 622-3374 ext. 226.

The First STEPS learning initiative is part of the Maine Improving Health Outcomes for Children demonstration grant awarded by the Centers for Medicare and Medicaid Services to MaineCare in partnership with the Maine Center for Disease Control and Prevention, the Muskie School of Public Service at the University of Southern Maine, Vermont’s Medicaid Program, and the University of Vermont.
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