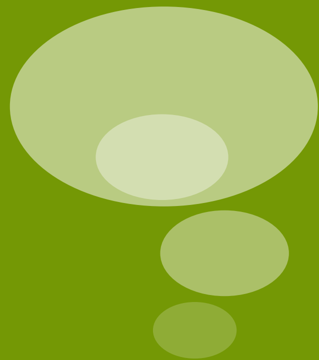


# Enhancing Care Coordination For Maternal and Child Health Clients

IDPH Bureau of Family Health
Fall Conference, October 2011

# Today's Objectives

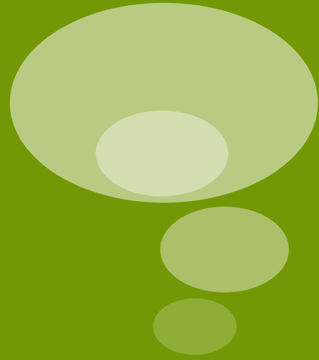
**What we WILL do:**

1. Review the "Enhancing Care Coordination" project.
2. Present the results of discussions about care coordination within the Bureau of Family Health.
3. Present the results of key informant interviews with agency leadership.
4. Further discuss care coordination through your written responses to a short survey.
5. Hold a focused conversation about care coordination in each session.

**What we will NOT do:**

1. Teach you how to "do" care coordination.
2. Fix any existing "issues".
3. Be bored.

The history behind the project.



We started with ourselves.

# THE QUESTIONS

Think about Care Coordination. What comes to mind?

- What is our current situation related to care coordination? How have we discussed this subject in the past? How have we performed?
- What is most clear? What is confusing? What concerns us? Where is more work needed?
- What is the importance of effective care coordination? What other things do we need to consider? What kinds of changes will we need to make? What are our options?
- What are we really committed to? What ideas do we have for action?

## Basic Concepts

Hand- holding families

Advocating

Linking with care

## Current Situation

Under-paid

Under-utilized

In a rut

## What’s Confusing

Billable vs. Non-billable

Never-ending evolution of rules

Exceptions are not clear

## Also Consider

Protocols and service models

Ask the experts

Change is not easy

## Commitments

Families first

Leading, not following

Less talk, more action

## Ideas For Action

Develop an understanding of how care coordination works in practice

Face-to-face sharing of information

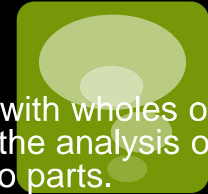
# The Definition

Care coordination is a comprehensive, family centered approach that proactively engages and links clients and families to needed health services, including medical, oral, emotional, behavioral, and health education services. It encompasses a specific set of activities that promote a client's potential for optimal health and facilitate quality outcomes. By working with the client, family, and other involved disciplines, a care coordinator can promote seamless access and a holistic approach to service provision.

Care coordination incorporates the following:

- ✓ Meaningful assessment of client needs and concerns
- ✓ Shared development of care plans
- ✓ Mobilization of agency and community resources
- ✓ Continued monitoring and follow-up
- ✓ Clear and transparent communication
- ✓ Complete documentation

# And What We Meant Was:



DEFINITIONS

- Approach 1a) the taking of preliminary steps toward a particular purpose; 1b) a particular manner of taking such steps
- Comprehensive 1) covering completely or broadly: inclusive; 2) having or exhibiting wide mental grasp
- Encompasses 1a) Envelop 1b) include; 2) bring about, accomplish
- Engages to induce, to participate
- Facilitate 1) to make easier: help bring about <facilitate growth>
- Family-centered Family-centered care is a collaborative approach to care giving and decision-making. Each party respects the knowledge, skills, and experience that the other brings to health care encounters. The family and health care team collaboratively assess the needs and development of the treatment plan. By contrast, in family-focused care, professionals often provide care from the position of an "expert" assessing the patient and family, recommending a treatment or intervention and creating a plan for the family to follow. They do things to and for the patient and family, regarding the family as the "unit of intervention."
- Holistic Relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts.
- Link 1a) a connecting element or factor <found a link between smoking and cancer> 1b) a unit in a communication system
- Optimal 1a) most desirable or satisfactory: OPTIUM
- Proactively acts in anticipation of future problems, needs, or changes
- Promote to contribute to the growth or prosperity of: further
- Seamless Having no awkward transitions, interruptions, or indications of disparity
- Transparent 1a) free from pretense or deceit: FRANK 1b: easily detected or seen through: OBVIOUS 1c) readily understood 1d) characterized by visibility or accessibility of information especially concerning business practices.

# The AHRQ's Care Coordination Ring

Primary Care
Specialty Care (1)
Specialty Care (2)
Inpatient Care
Mental Health Services
Long-Term Care
Medical History
Test Results
Home Care
Informal Caregivers
Patient/Family Education & Support
Medications/ Pharmacy
Community Resources

Patient/Family Perspective
Health Care Professional(s) Perspective
System Representative(s) Perspective

*Meet Patient Needs and Preferences in Delivery of High-Quality, High-Value Care*

McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

# Important Perspectives

**PATIENT/FAMILY PERSPECTIVE**

Patients, their families, and other informal caregivers experience failures in coordination particularly at points of transition. Transitions may occur between health care entities and over time and are characterized by shifts in responsibility and information flow. Patients perceive failures in terms of unreasonable levels of effort required on the part of themselves or their informal caregivers in order to meet care needs during transitions among health care entities.

**HEALTH CARE PROFESSIONAL(S) PERSPECTIVE**

Health care professionals notice failures in coordination particularly when the patient is directed to the wrong place in the health care system or has a poor health outcome as a result of poor handoffs or inadequate information exchanges. They also perceive failures in terms of unreasonable levels of effort required on their part in order to accomplish necessary levels of coordination during transitions among health care entities.

**SYSTEM REPRESENTATIVE(S) PERSPECTIVE**

Failures in coordination that affect the financial performance of the system will likely motivate corrective interventions. System representatives will also perceive a failure in coordination when a patient experiences a clinically significant mishap that results from fragmentation of care.

# The Care Coordination Ring: Iowa Style

Support Services
Interpretation
Assess-ments
Transportation
Follow-up
Appointments
Housing
Child Care Providers
Family Resources
Informal Caregivers
Finances
Community Resources
Parent Support
WIC
HOPES
MH Prenatal Care
Other Title V Agencies
State Programs
Federal Programs
Patient/Family Perspective
Oral Health Services
Preventive Oral Health Care
Meet Patient Needs and Preferences in Delivery of High-Quality, High-Value Care
Health Education
Anticipatory Guidance
Early Access
Behavioral Health Care
MH Counseling
Home Visiting (Nursing, SW, CC)
Head Start
AEA
Health Insurance Navigation
Outreach
Lead Tests
Educational Institutions
CHSC
Medical Providers (OB,
Health Coverage: Title XIX Title V
Immunizations
Primary Preventive Medical Care
Dentists
Lab Tests
Mental Health Providers
Specialists (Hearing, Vision, Speech)
Hospitals

# The Role of the Coordinator

- Convenes and forms the relationship with the family and client;
- Take the hand of the family and go around the circle and hook them up; they link the change;
- They are the conductor
- Assure communication
- Follow-up and completion
- Assess needs
- Translate
- Must keep health literacy in mind (this not handing a brochure).
- Must develop community partnerships
- They work with both client and professionals
- Must know their community resources and continually update. This assures that the client is appropriate referred. It speaks to the quality of the services and people they are referred.
- Skilled communicator including Good listener /active listening/ empathic listening e.g., open ended questions, teach back skills,
- Consolidator and summarizer for a care plan development
- Honest and real and create trust in relationships
- Coach, empowering, encouraging
- Health care promoter
- Assesses family's needs, concerns, culture
- Bridge the gap of social disparities. They assure LSES, minorities get the same care (parity in care)
- Educated about health and children development and women of child bearing age
- Educated about the population that they are working with.
- Detail oriented
- Out-going
- Comfortable with technology
- Self starter
- Passionate about the work and the people you serve
- Comfortable with face to face and phone contacts
- Comfortable with cold calling
- Good communicator
- Being an advocate

More information was needed.

Stage 2 was launched.

# A Deeper Understanding Through Critical Conversations

**A Three Step Process**

Step 1: Key Informant Interviews

Step 2: Surveys

Step 3: Focus Groups

# Key Informant Interviews

August and September 2011

# The Questions

1. Thinking about your agency, please list the programs or service areas where care coordination is provided.
2. For each of the programs and service areas, who is the staff person(s) responsible for coordinating care for clients?
3. Are there written protocols for each of the service areas and programs listed that helps staff know when care coordination is to be provided?
4. Discuss how care coordination is provided in each of the service areas listed. For each, please discuss how you determine when a client receives care coordination, and where care coordination occurs (physical location).
5. Thinking about your agency's experience in providing care coordination, what does your agency do well when providing care coordination?
6. What makes it difficult to provide care coordination?
7. How could expanding care coordination benefit your agency and clients?
8. What opportunities exist within your agency to improve care coordination?
9. What can IDPH do to assist you?

# Practices and Ideas
# To Enhance Care Coordination

2, 4%
1, 2%
7, 14%
6, 12%
14, 29%
11, 23%
3, 6%
5, 10%

- Staff
- Service Model
- Technology
- WIC
- Partners
- Follow-Up
- Extended Hours
- Billing

# Practices and Ideas To Enhance Care Coordination

- We differentiate between billable and non-billable. Helps to show that this information is collected even when it's not billable.
- We could be more intentional about our follow-up.
- Increasing collaboration with providers - to give a positive outcome for clients accessing services.
- We could do more presumptive eligibility. This is a timeframe when more care coordination could be provided.
- We could cross-train more staff.
- We are tracking the care coordination for EPSDT, whether it is entered into CAReS or not.
- There exists opportunities to expand services outside of WIC clinics.

# Requests for Technical Assistance

3, 5%
4, 6%
8, 12%
14, 22%
5, 8%
6, 9%
25, 38%

- DHS Liason
- Link to Best Practices
- Data System
- Communication
- Billing
- Funding
- Training

# Requests for Technical Assistance

- If you could expand the opportunities for billing, it would help sustain our program.  We don't need to expand it, but need to be reimbursed to sustain it.
- Continue to receive guidance on the quality of our service documentation.
- Somehow WIC and MH databases were linked. Improvements to CAReS would be helpful.
- Piece of being voice to DHS – having power of changing phone numbers and addresses.
- More billable care coordination would provide more revenue to help pay staff to provide more care coordination to help clients.
- Would like to hear other peoples best practices.  Always room to improve.
- Staff have had initial training and could benefit by additional training opportunities.

# Barriers to Care Coordination

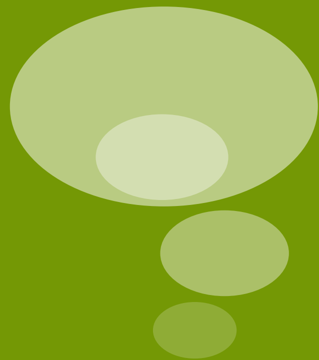
Tech, 7, 4%
Time, 24, 14%
S&E, 14, 8%
IDPH, 6, 3%
Resources, 9, 5%
R&R, 26, 15%
HTR, 29, 17%
Cost, 22, 13%
Documentation,10, 6%
Other, 26, 15%

- Time
- Resources
- HTR
- Documntion
- Other
- Cost
- R&R
- IDPH
- S&E
- Tech

# Barriers to Care Coordination

- Not always knowing the available resources and what Medicaid will cover.
- Time – Don’t get reimbursed for your time especially the no answer, not available, letter sent.
- Providing is not difficult.  Reaching the client is difficult.
- It takes considerable time to complete the documentation of services.
- Getting a true definition of care coordination – knowing what that is – it is a very difficult thing to define the billable piece.
- If you don’t get paid, it is not a priority.
- It is happening, but is part of other services
- We receive information but don’t understand how it would fit into how we do things.
- CC is ambigous and agencies are just now catching on.
- We need to come up with a better way to follow-up on non-clinic (PH) visits, like at doctor or dentist offices.

What can you tell me about care coordination? What suggestions do you have for the remainder of our journey? Where do we go from here? How should this information be used?



# THANK YOU!

Stay Tuned!

# For More Information

The Care Coordination Measures Atlas: http://www.ahrq.gov/qual/careatlas/careatlas.pdf

**Articles from the National Academy for State Health Policy: http://www.nashp.org/.**

Linking Children to Services: Building on Community Assets to Pilot Test Improvement Strategies: linking.children.to_.services.pdf.

Improving Care Coordination and Service Linkages to Support Healthy Child Development: Early Lessons and Recommendations from a Five-State Consortium: improving.care_.support.healthy.child_.development.pdf.

Linkages to Service for Young Children: Opportunities for States: Care Coordination Linkages.

State Strategies for Care Coordination, Case Management, and Linkages for Young Children: A Scan of State Medicaid. Title V, And Part C Agencies : ABCD Scan.