

## Care Coordination in the Community

**Organization:** St Christopher's Hospital for Children-The Center for Children and Youth with Special Health Care Needs

**Location:** Philadelphia, PA

### Describe the project:

- The Center for Children with Special Health Care Needs (CYSHCN) at St Christopher's Hospital for Children houses a Medical-Legal Partnership. This primary care practice is a multi-disciplinary "one-stop shop" to provide resources and services to address medical and social needs of the families and the children with medical complexity the clinic serves. The Medical-Legal Partnership is a joint partnership with the Legal Clinic for the Disabled in Philadelphia where onsite attorneys are embedded in practice and help to support families. The project began in 2004 with 150 patients, two physicians and one care coordinator and has since expanded to 3,000 patients, and the addition of staff, including care coordinators, community health workers, dietitians, nurses, social workers, administrators, parent partners, medical assistants, and an attorney. The multi-disciplinary staff has assisted the clinic in meeting the many needs of children, youth, and families with positive social determinants of health (SDoH) screens and linking them to the team member best suited to meet their needs.
- An SDoH screening tool was tailored to meet the needs of the St Christopher's community and to assist staff in determining needs and services that could be addressed at the clinic versus referral to community resources or agencies.

### Implementation Strategies and Lessons Learned

- **Care coordination** is a critical component of SDoH screening, referral, and follow up. Effective screening, referral, follow up is supported by a **multidisciplinary approach** that focuses on family strengths and addresses the medical, social, behavioral, developmental, financial, and educational needs of the family.
- Before screening families for SDoH, assess what **services can be met by the clinic/practice** or within the community for referral for families who have a positive screen. Tailor the SDoH screening tool used in the clinic to ensure that family needs can be met either by the clinic or in the community.
- Collaborate and partner with community resources and agencies to build a **referral network** for families in order to address positive SDoH screens that cannot be addressed by the clinic.
- After screening families and referring for services when a positive screen is identified, **follow up with families** to ensure they received the needed services.
- **"Closing the loop"** on referrals and linkages to resources is vital in ensuring that patients and families receive the necessary services and tools to ensure they can care for their children.
- **Partner with families to build trust with clinic staff and community groups.** Strong partnerships and goal setting with families are important components for more efficient and successful follow up from referrals, especially for more sensitive positive screens, such as legal services.

- **Transformation is not accomplished in a day;** it is a process that is continuously reviewed, improved, and adjusted to meet the needs of the community and staff capacity.
- **Nothing can be accomplished without buy-in from families.** Develop trust with families, so they feel comfortable obtaining services and resources available through the clinic and community.
- **The family voice is critical to successful implementation of care coordination.** Ensure parent partners are included in discussions and decisions related to care coordination and continuous quality improvement as true partners in this work.
- Consider building up in-house resources to meet the needs of families so **families can receive services directly at the clinic or practice.** Providing services to address positive SDOH in-house allows staff to document services received by families more thoroughly and accurately in the medical record. Detailed documentation in the medical record makes it easier for staff to follow up with families after receiving services while maintaining patient confidentiality and safety regarding the sensitivity of the screening items (e.g. literacy, housing issues, intimate partner violence etc.)

#### **Tools and Resources Supporting this Project:**

- [Care Coordination Measurement Tool](#) (CCMT)
  - The CCMT was used to identify community partners to support the project and to track the length of visits for families utilizing medical and social resources at the clinic.
  - For practices interested in utilizing the CCMT for their care coordination work, an [Adaption and Implementation Guide](#) has been developed to assist users in adapting the CCMT to meet their needs.
- [Pediatric Integrated Care Survey](#) (PICS)
  - The PICS was implemented to measure the family experience of care integration as part of this project.
  - Measuring family experience is critical to inform quality improvement for care integration. A [User Manual](#) for the PICS is available to assist users through the implementation of the tool. The PICS is also available in Spanish – contact the [National Center for Care Coordination Technical Assistance](#) for more information.
- [Pediatric Care Coordination Curriculum, Second Edition](#) (PCCC)
  - The curriculum is designed to build capacity among diverse stakeholders (AAP Chapters, Maternal and Child Health Title V/Children and Youth with Special Health Care Needs programs, pediatricians, families, and others) through the following activities:
    - Effective implementation of key components of care coordination
    - Collaborative communication within inter-professional care teams
    - Investment in technology solutions