WELCOME

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Implementing Equitable Care Coordination

A webinar brought to you by the National Resource Center for Patient/Family-Centered Medical Home, the National Center for Care Coordination Technical Assistance, Family Voices of Wisconsin, and Wisconsin Title V

Thursday, April 28, 2022
11:30am – 12:30pm CT
This meeting will be recorded for educational purposes and shared with participants publicly via the medical home website.
HOUSEKEEPING

- All participants have been muted
- Live captioning is available
- Utilize Q&A box for questions for faculty throughout the presentation
Richard Antonelli, MD, MS, FAAP
Medical Director of Integrated Care, Department of Accountable Care and Clinical Integration
Boston Children’s Hospital

Rich is a general pediatrician whose clinical work over nearly 4 decades has focused on providing care for children, youth, and young adults with special health care needs. He has extensive experience working at the national and global levels, and in many US states, assessing and improving systems of health care delivery. His efforts have informed the evolution of care coordination and care integration functions and activities, enabling systems to become high performing, integrated delivery models. As the Medical Director of Integrated Care at Boston Children’s Hospital, in the Department of Accountable Care and Clinical Integration, he focuses on developing and implementing methodologies, tools, processes, and measures to facilitate and improve integration of care and care coordination—especially for children and youth with special health care needs (CYSHCN) and for adults with complex needs transitioning from pediatric to adult care. These efforts collaboratively engage families, youth, nursing, primary care, subspecialty care, behavioral health, social service, Title V, Medicaid, and community service providers.
ABOUT THE PARTNERS

• National Resource Center for Patient/Family-Centered Medical Home
• National Center for Care Coordination Technical Assistance
• Family Voices of Wisconsin
• Wisconsin Title V
The National Resource Center for Patient/Family-Centered Medical Home is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $4,100,000 with no funding from nongovernmental sources. The information or content are those of the author(s) and do not necessarily represent the official views of, nor are an endorsement, by HRSA, HHS, or the US Government.
DISCLOSURES

• Faculty have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.

• Faculty do not intend to discuss an unapproved/investigative use of a commercial product/device in their presentations.
LAND ACKNOWLEDGEMENT

We acknowledge the land in Itasca, Illinois, upon which the AAP Headquarters is located, is the original homelands of the Kickapoo, Peoria, Kaskaskia, Potawatomi, Myaamia, Ho-Chunk, Winnebago and Očhéthi Šakówiŋ tribal nations. We can and should actively give voice to and solicit experience from Indigenous communities and all marginalized communities to inform our collective efforts to meaningfully, equitably, sustainably, and effectively address the needs of families from these diverse communities.
LEARNING OBJECTIVES

• Describe the need for and importance of effective care coordination within a patient/family-centered medical home for CYSHCN and their families.
• Identify at least 2 resources or tools that can be used to implement and/or measure care coordination at the practice and/or system level (e.g., Care Coordination Curriculum 2nd Edition, Care Coordination Measurement Tool, Pediatric Integrated Care Survey, and NASHP Care Coordination Standards).
LEARNING OBJECTIVES (CONT.)

- Identify at least 2 practical care coordination tips and strategies that can be implemented at the practice and/or system level to improve equitable access to care for CYSHCN.
- Identify at least 2 potential partnerships to pursue with key collaborators (e.g., state Title V/CSHCN programs, families, pediatricians or allied health professionals) to advance care coordination efforts within a patient/family-centered medical home.
Colleen Lane
Medical Home Project Manager
Children’s Health Alliance of Wisconsin

- Colleen Lane has been a Project Manager with the Medical Home Initiative, Children’s Health Alliance of Wisconsin for eight years. Prior to joining the Medical Home team, she supported families whose children were diagnosed with cancer and life-threatening blood disorders at the Badger Childhood Cancer Network. Her career has involved working with non-profits with a focus on health care. Colleen has a BA in Journalism and Mass Communications from the University of Wisconsin-Madison. She serves on the board of directors for Wisconsin’s Supporting Families Together Association. Since being diagnosed with Type 1 Diabetes at age 14 and having family members with chronic illnesses, she is passionate about promoting and advocating for quality health care.
Leah Ludlum, RN, BSN
Public Health Nurse Consultant, WI Title V Program
Family Health Section: Bureau of Community Health Promotion
Division of Public Health
• Leah provides statewide technical assistance to community–based organizations, local health departments, tribal health agencies and primary care providers to assist in improving care and implementing system change efforts to promote optimal health of infants and children including children and youth with special health care needs. She is responsible for monitoring MCH Regional and CYSHCN/HUB and tribal contracts. Leah is currently managing the development and implementation of the Wisconsin Child Psychiatry Consultation Program. Prior to this role, Leah directed the nationally recognized Diabetes Prevention and Control Program in Wisconsin, promoting self-management to enhance skills for those living with a chronic disease and lead state efforts to ensure diabetes standards and quality of care for people living with diabetes. Leah has been a Registered Nurse for over 30 years, working in various inpatient and outpatient specialty areas. She is experienced in assessment, planning, marketing, developing, implementing and evaluating a variety of quality improvement programs and community events. She has developed strong partnerships with many different health care professionals and community organizations in Wisconsin, collaborating to design projects/programs to improve state outcomes. She received her Bachelor of Science and Bachelor of Nursing from the University of Wisconsin–Madison.
Brigit Frank, MA
Media and Education Manager
Family Voices of Wisconsin

- Brigit Frank, Family Voices of Wisconsin’s Media and Education Manager, has worked with our team for seven years. Before this Brigit, a mother of two adopted children with special health care needs, was a LEND family trainee. Brigit has two BAs in Psychology and Journalism and an MA in Journalism and Mass Communication with an emphasis on research. She worked as a media analyst and buyer before turning her attention to writing and editing. She has presented at AMCHP and has been published as part of the Pediatric Care Coordination Curriculum writing team with Dr. Antonelli of Harvard University/Boston Medical; and the Multistakeholder Approach to the Development of EP Activities in Complex Care writing team, published by Academic Pediatrics. Brigit also serves on several state and regional committees. In her spare time, she enjoys time with her family and the occasional run.
Wisconsin’s Journey: Implementing Equitable Care Coordination for Wisconsin Families
Wisconsin Demographics

- Wisconsin is becoming more urban, less rural-suburbanized.
- Increased diversity in some counties.
- Wisconsin diversity is 37.0% compared to 61.1% for the US.

Breakdown:
- White alone, not Hispanic or Latino: 78.6%
- Black or African American alone, not Hispanic or Latino: 6.2%
- American Indian and Alaska Native alone, not Hispanic or Latino: 0.8%
- Asian alone, not Hispanic or Latino: 3.0%
- Native Hawaiian and Other Pacific Islander alone, not Hispanic or Latino: 0.0%
- Some other race alone, not Hispanic or Latino: 0.3%
- Two or more races, not Hispanic or Latino: 3.5%
- Hispanic or Latino: 7.6%

US Census Bureau

American Academy of Pediatrics
Dedicated to the health of all children

Diversity Index by County: 2020
Wisconsin: 37.0%

Highlight County
Enter a county in the search bar to highlight it.

Wisconsin counties
- Milwaukee County: 66.6%
- Racine County: 49.7%
- Kenosha County: 45.2%
- Dane County: 40.8%
- Sawyer County: 38.8%
- Brown County: 38.5%
- Rock County: 35.7%
CHILDREN AND YOUTH WITH SPECIAL NEEDS

- One out of five children (20%) have special health care need
- 6% of children ages 0-5 years have special health care need
- 23% of children ages 6-11 years have special health care need
- 29% of youth ages 12-17 years have special health care need
- Black children are more likely to have a special health care need (31%) compared to Hispanic (17%) and white (19%) children

National Survey of Children’s Health Wisconsin 2018-2020
ISSUES WE FACE

• Problems similar in Wisconsin:
  ▪ Premature Birth
  ▪ Infant mortality
  ▪ Poverty
  ▪ Alcohol use disorder
  ▪ Access to technology (rural doesn’t have 4G and Urban internet expensive)
  ▪ Inequities
  ▪ Housing
  ▪ Access to care
  ▪ Distance to care
  ▪ COVID-19
Wisconsin Title V Program Partnership

Bureau of Community Health Promotion
- Family Health Section
  - Tobacco Prevention and Control Section
  - WIC and Nutrition Section
  - Chronic Disease Prevention and Cancer Control Section

Title V Director
- Maternal and Child Health (MCH) Unit

CSHCN Director
- Children and Youth With Special Health Care Needs (CYSHCN) Unit
- Maternal and Infant Mortality Prevention Unit
- Sexual Violence and Injury Prevention Unit
- Reproductive Health Family Planning Unit

A Title V performance measure lead works here
Title V Program collaboration
TITLE V FUNDS THE CYSHCN NETWORK

- ABC for Health
  A Wisconsin-based, nonprofit, public-based law firm that ensures health care access for children and families with special needs or who are at risk. [www.safe4kids.org](http://www.safe4kids.org)

- Family Voices of Wisconsin
  A network of families with special health care needs and/or disabilities that provide training and leadership opportunities and inform parents on how to be partners in their child's care. [www.familyvoiceswi.org](http://www.familyvoiceswi.org)

- Five Regional Centers (CYSHCN)
  Provides families with children and youth with special needs and their providers, with free and confidential services referral information, parent support, insurance coverage information, transition planning, and connections to community resources. [www.dhs.wisconsin.gov/health/children/index.htm](http://www.dhs.wisconsin.gov/health/children/index.htm)

- Genetics Systems Integration Hub
  Integrates genetics with public health systems in order to support individuals with genetic disorders, their families, and the professionals who work with them. [www.geneticsinwisconsin.wisc.edu](http://www.geneticsinwisconsin.wisc.edu)

- Wisconsin Newborn Screening
  Through hearing, blood, and pulse oximetry testing, identifies babies who may have a condition that needs early treatment. [www.dhs.wisconsin.gov/newbornscreening/index.htm](http://www.dhs.wisconsin.gov/newbornscreening/index.htm)

- Wisconsin Medical Home Initiative (WISMHI)
  Promotes the concepts of medical home with clinicians, families, and service providers throughout Wisconsin. [www.cyshcn.org/initiatives/medical-home](http://www.cyshcn.org/initiatives/medical-home)

- Women, Infants and Children (WIC)
  CYSHCN/Birth Defects: Nourishing Special Needs Network
  A network of WIC dietitians/nutritionists trained in identifying and caring for the nutritional needs and feeding challenges of CYSHCN. [www2.wisconsin.wisc.edu/edd/wic](http://www2.wisconsin.wisc.edu/edd/wic)

- Youth Health Transition Initiative
  Supports youth, families, and providers around transition from pediatric to adult health care. [www.healthtransitionwi.org](http://www.healthtransitionwi.org)

- Parent to Parent of Wisconsin
  Provides a one-to-one connection with another parent who has a child with a similar need. [www.p2p.org](http://www.p2p.org)

- Tribal Health Centers
  Implements components of medical home and youth transition. [www.dhs.wisconsin.gov/tribal-offices/contacts.htm](http://www.dhs.wisconsin.gov/tribal-offices/contacts.htm)

- Well Badger Resource Center
  Statewide public health information and referral (I&R) service and resource program offering a toll free phone line and website. [wellbadger.org](http://wellbadger.org)

[Logo: American Academy of Pediatrics]

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CONTINUITY OF CARE COORDINATION

TIMELINE AND APPROACHES

- **Systems Integration Grant (SIG)** (2014-2017)
- **SIG ends** (2017)
- **Shared Plan of Care (SPoC) QI Grants** (2016-2020)
- **Children with Medical Complexity (CMC) CoIIN** (2017-2021)
- **SPoC QI Grants Expand** (2018-2020)
- **SPoC Grants end** (2020)
- **CMC CoIIN ends** (2021)
- **CMC CoIIN evolves into CMC Collaborative** (2021-current)
- **Tribal Health Centers in SPoC grants** (2018-2021)
- **Revision of Tribal Health Center Grants** (2022-current)
- **Concerning Developmental Screens to Intervention** (2022)
- **Food Security and Health** (2021-present)

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WISCONSIN’S JOURNEY BEGAN WITH THE SYSTEMS INTEGRATION GRANT

- September 2014: 3-year grant to the Wisconsin Children and Youth with Special Health Care Needs (CYSHCN) Program
- Network partners met to develop a state plan
- Medical Home Implementation team met to advance goals
- One goal in plan was to advance the understanding of care coordination for Wisconsin CYSHCN to include:
  - Statewide care coordination mapping
  - Development and promotion of care coordination curriculum for families.
  - Piloting shared plan of care document with clinicians and families of children with special health care needs
INITIATED RESOURCE DEVELOPMENT

- Shared Plans of Care
  - CCMT
  - Care Coordination Curriculum
- Goal Cards for clients
  - 39 goal cards
- C.A.R.E. Medical Home Series for Families
  - Caring for the Whole Family
  - Assembling a Care Notebook
  - Requesting a Shared Plan of Care
  - Exploring Care Mapping

Photo courtesy of Children’s Health Alliance of Wisconsin (iStock): https://www.chawisconsin.org/initiatives/medical-home/family-engagement/
Examples of Internal Work

- Designed RFP for mini grants with teams selecting to participate
- Developed a structured work plan for Tribal Health Centers with ongoing technical assistance
- CYSHCN network coordinated to support teams, such as adding in family engagement activities with support lead by WI FV and through quarterly family calls and surveys
- Integrated and promoted network resources for team supports
NETWORK SUPPORT TO ADVANCE CARE COORDINATION

Examples of External Support of Grantees

• Established learning communities: Tribal Health Centers and Health Systems
• Organized annual summits
• Provided technical assistance and QI support
• Secured opportunities to connect teams to experts
Many Lessons Learned

These are a few:

• Partnerships and collaboration are key
• Need to include family partnerships and perspectives
• Social determinants of health has to be part of the conversation
• Health systems differ, don’t assume one mold will fit all (i.e., learning communities were combined initially, then separated)
# Shared Plan of Care

**Successes**
- Consistent TA led to increased trust especially in tribal agencies
- Care Mapping understood by families more
- Trusting relationships
- Tribal staff experienced support from other tribal agency staff
- Staff were creative in trying to promote SPoC with families

**Challenges**
- Significant staff turn over
- Poor uptake on family learning calls
- Limited use of network resources
- Integration of tools into EHR (SPoC, SDoH screener, ASQ-3 difficult
- Lack of team support
- Competing priorities
Sample Team Flyer

Shared Plans of Care

Information for Families
A Shared Plan of Care is a generated report to help children with special needs get the right services and supports. It is called a “shared” plan because it's for you and your child's health, and Forest County Potawatomi Health & Wellness Center service providers share the work of creating the plan and putting it into action.

A Shared Plan of Care is readily available for you upon request during your office visit and/or can be mailed to you quarterly upon your request and permission.

How Shared Plans of Care Help
You share your insight and expertise about your child with his or her teachers, therapists, health care providers, and others.

Your goals for your child are the first priority.

You get a clear report that addresses your child's needs. The Shared Plan of Care spells out who will do what, and when.

Your child gets a valuable service at no cost to your family.

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SHARED PLANS OF CARE DATA

Family Surveys (n=555 surveys):

- 86% agree/strongly agree the SPoC helps ensure more of their child’s needs are met
- 82% agree/strongly agree the SPoC helps them tell other health care providers about their child’s needs
- 81% agree/strongly agree the SPoC helps them tell other service providers (school, home visiting) about their child’s needs
SHARED PLANS OF CARE DATA

Family Survey and Experiences (n=555 surveys)

“When you have a child with special needs, you have more responsibilities and stress. The shared plan helps reduce stress significantly. Thank you!”

“I do not have to worry about beating the ambulance to the emergency room because the physician on call will have no idea how to handle my child.”

“I believe my shared plan of care needs updating.”
SHARED PLANS OF CARE

Care Team Surveys and Experiences (n=170 surveys)

• Overall, 95% agreed or strongly agreed SPoC helped to communicate, partner and engage with families

“Using SPoCs, we have had providers and nurses comment that it has helped make care more efficient and patient-centered. It highlights areas of care/patient preferences that are to families and patients.”

“Helps us to collaborate and communicate with specialists and other partners for youth and young adults with medically complex conditions.”
FAMILY VOICES OF WISCONSIN STORY

- Member of the Wisconsin Medical Home Implementation Team
- Created curriculum tools, resources and trainings for families
  - Online Training
  - Care Mapping Template with video
  - Facilitator Instruction Guide
  - Tip Sheet - for providers to reach families
  - Care Notebook
  - Shared Plan of Care (Samples)
  - Evaluation(s)
  - Fact Sheets with Mental Health Focus
  - Promotional Pieces for Wisconsin families
Trainings Piloted with Families

- CYSHCN Regional Centers assisted with organizing 5 in-person pilot trainings around the state
  - Family feedback obtained
  - Post training debriefs completed with Regional Center Staff, feedback complimented what families said
  - Pilot opened doors to family partnerships
    - UW Pediatric Pulmonary Center Grant through the Center of Medicine
- Feedback from families and RC staff was shared with stakeholders and used to improve trainings
- Families need to advocate for care coordination in a medical home
  - Education for care coordination must be ongoing
KEY LESSONS LEARNED

• Piloting trainings is critical
• Provide outreach with a meaningful message
  ▪ Hard to create something that appeals to all families
• Technology does not guarantee success
  ▪ Access to trainings difficult for many families
• Educating our families is one piece of the puzzle
• All stakeholders must advocate for our vulnerable families
Tips

• “Bake” care coordination into everything
• Study solicited feedback to refine your message
  ▪ Short videos
  ▪ Understand concept and its importance
  ▪ Continually help families learn how to advocate
• Learn what resonates with your audience (i.e., evaluations, verbal feedback)
  ▪ Creating tools such as care mapping
WE CAN’T DO THIS WORK ALONE

Patients and Families are Central

- WI Department of Health Services
- Title V Program
- CYSHCN Network
- WI Chapter AAP
- Complex Medical Care Clinics
- Variety of Health Care Systems & Specialties
- Tribal Health Centers
- Children’s Long Term Support Program
- Birth to 3 Program
- Home Visiting Program
- Food Systems
- Medicaid Program
- And many others!
Our Care Coordination Journey Continues

However:

- COVID-19 has changed our work in many ways
- Staffing vacancies, resignations, retirements and exhaustion is high
- Health Systems and Tribal Health Agencies remain stressed
- Learned to pivot when needed
Next Steps

• Continue collaboration with internal and external organizations
• Continue efforts to engage the community and family voice
• Ongoing efforts to address inequities
• Reengage with Health Care Systems
• Seek opportunities to serve underserved communities
• Adapt trainings for diverse audiences
• Just started collecting demographic data (not easy)
THANK YOU!

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Elizabeth (Liz) Blair, APRN-BC
Deputy Manager
National Center for Care Coordination Technical Assistance

- Liz Blair is a Nurse Practitioner who has worked in community health for the past 19 years. For the last 10 years her focus has been on providing healthcare to adolescents in Boston, most recently in the School-Based Health programs within Boston Public Schools. She also works at Boston Healthcare for the Homeless in their respite facility. She is passionate about helping adolescents learn how to navigate the health system so that they can become strong advocates for their own health. She joined the NCCCTA team working with Dr Antonelli and Jessica Genova in December of 2021 and is very excited to join their initiatives for quality improvement in care coordination.
Jessica Genova, MPH, PMP
Manager
National Center for Care Coordination Technical Assistance

- Jessica is a public health professional with nearly a decade of experience supporting children and youth with special health care needs and their families through research and quality improvement efforts. As the Manager for the National Center for Care Coordination Technical Assistance, she supports organizations across the country in the adaptation and implementation of tools, measures, and resources to measure and improve care coordination and care integration. Jessica also serves as a Research Project Manager at the Epilepsy Foundation, a national non-profit foundation supporting people with epilepsy and their caregivers. She previously served as a care coordinator at the Boston Children's Hospital Epilepsy Center, a research team member at the Boston Children's Hospital Integrated Care Program, and a health policy researcher at the Duke University Margolis Center for Health Policy. Jessica holds a Master of Public Health (MPH) in Maternal and Child Health from the University of North Carolina at Chapel Hill and a project management professional (PMP) certification. She is passionate about improving systems of care so that people with special health care needs, their caregivers, and their health care teams can overcome obstacles and thrive.
Many challenges exist for families that receive care in multidisciplinary clinics.

Some include:

- Fragmentation
- Lack of coordination
- Lack of reimbursement or necessary resources to provide care coordination

This contributes to poor health outcomes, less than optimal family experience, and use of high cost, unnecessary emergency service utilization.
WHAT CAN WE DO?

• First step is measurement!

• We can address core issues by:
  ▪ Assessing family experience
  ▪ Assessing care coordination activities and outcomes
  ▪ Using the data collected by both to make improvements
We partner with individuals and organizations across the country in adapting and implementing resources, measures, and tools to improve care coordination and care integration for patients and their families.
Publicly available resources, measures, and tools include:

- Pediatric Care Coordination Curriculum, 2\textsuperscript{nd} edition (PCCC 2\textsuperscript{nd} Edition) and Telehealth Case Studies
- Pediatric Integrated Care Survey (PICS)
- Care Coordination Measurement Tool (CCMT)
- Family Experience of Care Coordination (FECC)
- Action Grid
- High Quality Handoff

Tools, resources, and measures are being used to address medical, behavioral, and social needs.
An interprofessional resource to effectively engage patients and families in achieving optimal health outcomes

Modules include:

- High-Value Integrated Care Outcomes Depend on Care Coordination
- Developing and Sustaining Strong Family/Professional Partnerships
- Social Determinants of Health
- Measurement
- Using Technology to Improve Care Planning & Coordination
- Evaluation
Pediatric Care Coordination Curriculum

An Interprofessional Resource to Effectively Engage Patients and Families in Achieving Optimal Child Health Outcomes

2ND EDITION

Editors:
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Hannah Rosenberg, MSc
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Using Telehealth to Coordinate Care for Youth with Complex Needs

Transitioning from Pediatric to Adult Care: 19-year-old young adult with autism spectrum disorder, intellectual disability, and attention-deficit/hyperactivity disorder

Lily Payvandi, MD, Kevin Hummel, MD, Kathleen Huth, MD, MMSc-Medical Education, FRCPC, and Richard C. Antonelli, MD, MS, FAAP

Care Planning and Coordinating Transitions from Inpatient to Outpatient Settings: 11-year-old with Multisystem Inflammatory Syndrome in Children (MIS-C) as a result of COVID-19 infection

Kevin Hummel, MD, Daniel Slater, MD, FAAP, Lily Payvandi, MD, Kathleen Huth, MD, MMSc-Medical Education, FRCPC, and Richard C. Antonelli, MD, MS, FAAP
**Family Experience Measurement of Care Integration**

**Pediatric Integrated Care Survey (PICS)**

- The Pediatric Integrated Care Survey (PICS) is a family experience measure of care integration, considered **outcome measure**
- Designed to conduct quality measurement to inform improvement work in the space of pediatric care integration

**Consists of:**
- 19 validated experience questions, health care status/utilization, and demographic questions
- Supplementary and topic specific modules
- English and Spanish versions available
**FAMILY EXPERIENCE MEASUREMENT OF CARE INTEGRATION**

**Pediatric Integrated Care Survey (PICS) vs. Family Experience of Care Coordination (FECC)**

<table>
<thead>
<tr>
<th>PICS: Care Planning Domain</th>
<th>FECC: Protocols/Plans Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the past 12 months, how often have your child’s care team members talked with you about specific goals for your child’s health care?</td>
<td>1. Child has a shared care plan.</td>
</tr>
<tr>
<td>2. In the past 12 months, has a member of your child’s care team documented these goals in the form of a written care plan?</td>
<td>2. Child has written transition plan.</td>
</tr>
<tr>
<td>3. Did you and/or your family members contribute to the content of this written care plan?</td>
<td>3. Child has emergency care plan.</td>
</tr>
<tr>
<td>4. In the past 12 months, was this written care plan easily accessible to you?</td>
<td></td>
</tr>
<tr>
<td>5. Was this care plan written in a way that you could easily understand?</td>
<td></td>
</tr>
<tr>
<td>6. In the past 12 months, has someone on your child’s care team regularly updated this written care plan to reflect changes and progress?</td>
<td></td>
</tr>
</tbody>
</table>

Source: AHRQ FECC Measure Set
CARE COORDINATION TRACKING AND PLANNING

Care Coordination Measurement Tool (CCMT)

• Captures the value of care coordination activities for both quality improvement and business planning
• Supports the efforts of all disciplines doing care coordination
  ▪ Nursing, Social Work, other staff involved in care coordination
• Identify gaps and redundancies in care
• Paper version or web-based versions (such as REDCap) have been used by organizations in past
Care Coordination Measurement Tool (CCMT)

Over 6-week study period, NPs captured **442 interactions in 306 patients:**
- 351 new
- 91 follow-ups

- 26% less than 5 minutes
- 46% 5-9 minutes
- 28% 10 minutes or greater

*Used with permission of Carlos Estrada, MD, and Spina Bifida Center, Boston Children’s Hospital*
SUMMARY

• Care coordination measurement can address challenges, such as fragmentation and lack of coordination, for people with special health care needs and their families.

• Care integration can improve health outcomes, optimize patient and family experience, and reduce high cost, unnecessary utilization.
**Resources**

- **NRC-PFCMH Care Coordination Resources**
- **Pediatric Care Coordination Curriculum, 2nd Edition**
- **Case Studies**
  - Care Planning and Coordination Transitions from Inpatient to Outpatient Settings
  - Using Telehealth to Coordinate Care for Youth with Complex Needs
  - Transition from Pediatric to Adult Care
- **Pediatric Integrated Care Survey**
  - User Manual
- **Care Coordination Measurement Tool**
  - Adaptation and Implementation Guide
- **NASHP National Care Coordination Standards for CYSHCN**
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• Wisconsin Family Health Section: Bureau of Community Health Promotion, Division of Public Health
  ▪ Leah Ludlum, RN, BSN, Public Health Nurse Consultant; Leah.Ludlum@dhs.wisconsin.gov
PARTICIPANT QUESTIONS
THANK YOU FOR YOUR PARTICIPATION!