California Community Care Coordination Collaborative (5C's)

Prospective Applicant Webinar

January 10, 2013

- **About the Foundation**
  - Holly Henry, PhD, Research Program Officer
- **Goals for 5C's Initiative**
- **What is Care Coordination?**
- **Essential Elements of Care Coordination**
  - Janis Connallon, Manager of CA Advocacy Network for Children with Special Health Care Needs
- **Proposal and Review Process**
- **Collaborative Learning and Technical Assistance**
  - Ed Schor, MD, Senior Vice President of Programs and Partnerships
- **Learning Collaborative - Lessons Learned**
  - Jill Rosenthal, Program Director for the National Academy for State Health Policy
  - Brian Lynch, MD, Mayo Clinic
- **Question & Answer Session**

Lucile Packard Foundation
for **Children's Health**

ABOUT THE FOUNDATION

- The vision of the Foundation is that all children in the communities we serve are able to reach their maximum health potential.

- The mission of the Foundation is to elevate the priority of children's health, and increase the quality and accessibility of children's health care through leadership and direct investment.

- The Department of Programs and Partnerships invests in efforts that promote better systems of care in California, for children with special health care needs (CSHCN).

GOALS FOR 5C'S INITIATIVE

- Goal: assist community-based, multi-agency coalitions to improve local systems of care coordination for CSHCN

- Goal: provide a structured opportunity for coalitions to learn from one another, identify areas of shared need, discuss emerging challenges, and connect with others engaged in improving care coordination for CSHCN

*Improving the coordination of services for CSHCN was the number one priority among families, service providers, agency staff, and other advocates surveyed by the Foundation in 2012.

Pediatric care-coordination is a family-centered, assessment-driven, team-based activity guided by individualized care plans designed to meet the needs of children and youth while enhancing the care-giving capabilities of families.

ESSENTIAL ELEMENTS OF CARE COORDINATION

1. A program that is accessible and community-based
2. Use of a qualified care coordinator
3. Intake screening
4. Comprehensive assessment
5. Team-based development of care plan addressing health and well-being
6. Family/patient-centered goal setting, planning, and services
7. Informing, arranging, and providing services, including advocacy and financing
8. Standardizing transmission of information among service providers
9. Monitoring service delivery
10. Ongoing reassessment
11. Ongoing relationship between client and care coordinator
12. Enhancing the care-giving ability of patients and families

EXAMPLES OF PROJECTS IN OTHER LOCALES

- Adoption of standardized referral and feedback forms among all service providers in a community

- Creating inter-agency agreements that delineate responsibilities for shared clients

- Expanding existing care coordination services to include new populations

- Creating a shared community budget for care coordination services

- Creating mechanisms for payment for multi-disciplinary team conferences

KEY PROPOSAL COMPONENTS

- Address care coordination needs of CSHCN and their families in California

- Describe target population

- Include key stakeholders as active participants: families of CSHCN, primary care professional association representative, California Children's Services, Regional Centers

- Describe proposed work including objectives, activities, responsible individuals, timeline, measurable outcomes, and evaluation

- Provide a statement of intention to participate in learning collaborative activities over the 18-month grant period

- May not include funding for direct services

- Maximum grant request is $40,000

APPLICATION PROCESS

- Application information available at: http://www.lpfch.org/programs/cshcn/CACommunityCareCoordinationCollaborativeRFP.html

- Proposal narrative (up to 15 pages) including Background, Methodology, and Products

- Budget proposal form

- Letters of support

- All components of proposal in **ONE** e-mail to grants@lpfch.org by **February 8, 2013**. Forms requiring a signature must be signed, scanned, and included in the e-mail.

SELECTION CRITERIA

- Documentation of the need for a care coordination system in the proposed community using reliable data sources

- Feasibility and likelihood of successful, community-wide, systemic changes, structural or procedural, in care coordination services

- Evidence of community-wide, public and private sector collaboration and commitment to the project

- Identification of measurable indicators of success and a data collection plan

- Strategic use of grant funds and justification for their use

- Likelihood of project being sustained after funding period ends

- Applicant's experience and qualifications for conducting the project

- Time commitment of key project staff members who have the skills and experience to perform the tasks required

TIMELINE

Proposals Due	**February 8, 2013**
Projects Selected and Approved	March 7, 2013
Award Letter Emailed	March 12, 2013
Award Letter Due Back to the Foundation	March 26, 2013
Project Start Date	April 1, 2013
First Learning Collaborative Conference Call	Mid-April 2013
First Learning Collaborative Meeting	May 2013

COLLABORATIVE LEARNING AND TECHNICAL ASSISTANCE

- Learning collaborative activities will be designed to meet the needs of coalition members

- Technical assistance is designed to support and assist the coalitions in their work

- Technical assistance events will include:

  - Conference Calls and Consultation

  - Face-to-face meetings of the Learning Collaborative at LPFCH

  - Site Visit

  - Check-in Calls

Promoting Healthy Child Development:
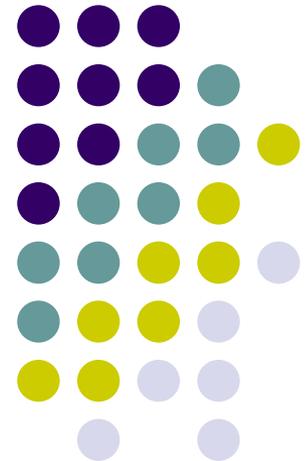# Lessons from ABCD States

Jill Rosenthal
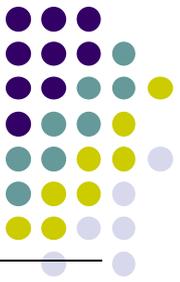
Program Director
National Academy for State Health Policy

Lucile Packard Foundation for Children's Health
January 10, 2013

NATIONAL ACADEMY
for STATE HEALTH POLICY

NASHP

- National Academy for State Health Policy
  - Working across states, agencies, and branches of government
  - Helping states to advance and implement workable solutions for major health policy challenges
- NASHP has administered the Assuring Better Child Health and Development (ABCD) initiative since 2000
- Supported by The Commonwealth Fund
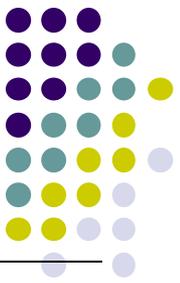
Common state goals

- Increase appropriate, effective screening by pediatric primary care providers

- Ensure providers and families have information they need to identify, refer, and provide treatment

- Ensure effective linkages to services

  - ABCD III: Develop and test sustainable models for improving care coordination and linkages between primary care providers and other providers who support children's healthy development

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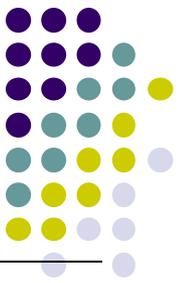
Who are ABCD states?

- ABCD I: General development
  - NC, UT, VT, WA   2000-2003
- ABCD II: Social/emotional development
  - CA, IA, IL, MN, UT   2004-2007
- ABCD Screening Academy: Wide-spread adoption of effective developmental surveillance and screening
  - 21 states   2007-2008
- ABCD III: Care coordination and linkages
  - AR, IL, MN, OK, OR   2009-2012

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Policy improvements: linkages to services
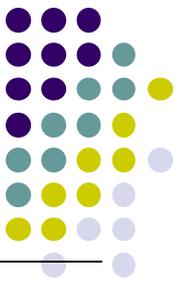
- Developing consistent instruments, tools and processes

- Using provider incentives

- Implementing continuous improvement strategies

- Linking existing or building data systems

- Improving systems

- Building consensus and/or shared visions to promote spread and ensure sustainability

Linkages to services: examples
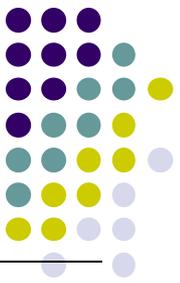
- Develop standard universal referral, consent and feedback forms for primary care and Part C providers to use statewide (AR, IL, OK, OR))

- Medical homes models (MN, OK, OR)

- Maintenance of certification credit (IL, MN, OR)

- Web portals and data sharing systems (IL, OK)

- Managed care performance improvement projects (OR)

- Strengthen community/parent engagement (AR, OK, OR)

- New billing codes (OR)

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ABCD Process: Why it works

- Builds on partnership with key stakeholders
  - MCH, Early Intervention expected
  - Physicians, community and family advocates required
- Links policy and practice improvements
- Results in data useful for performance measurement at multiple levels
- Leverages existing assets at various levels
- Involves payers
- Spread and sustainability are built in

Public/private partnerships

- Arkansas Early Childhood Systems Working Group

- Maryland Developmental Screening Advisory Group through the Parents Place of Maryland

- Minnesota Mental Health Action Group (MMHAG)

- The Oregon Pediatric Improvement Partnership (OPIP)
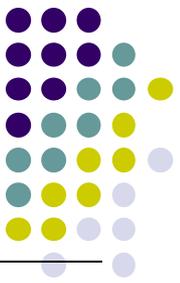
Recommendations

- Identify critical stakeholders and partnerships
  - Offer incentives for participation
- Identify complementary efforts
  - Varied- screening in child care, medical homes
- Use practice to inform policy
  - Target interventions at multiple levels
  - Develop processes that enable providers to communicate clearly, consistently, and easily
- Measure results
- Learn from others
- Keep at it
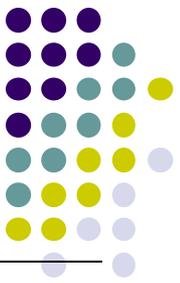
For more information

- Email: jrosenthal@nashp.org

- Website: www.nashp.org
  - Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States
  - Improving Care Coordination and Service Linkages to Support Healthy Child Development: Early Lessons and Recommendations from a Five-State Consortium
  - Supporting Healthy Child Development through Medical Homes: Strategies from ABCD III States
  - Maintenance of Certification: ABCD III State Efforts to Capitalize on an Incentive for Quality Improvement

- ABCD Resource Center: http://www.nashp.org/abcd-welcome
  - Look for reports and state resources, bi-weekly e-news

NATIONAL ACADEMY for STATE HEALTH POLICY

Communities Coordinating for Healthy Development

Brian Lynch, MD

www.state.mn.us/cchd

Minnesota Department of **Human Services**

MN CHIP
Minnesota Child Health Improvement Partnership

Objectives

- Describe CCHD Olmsted County Project
- Outline how project has affected communication between community agencies and the primary care home and care for children at risk for developmental or behavioral problems

Coordinating Communities for Healthy Development
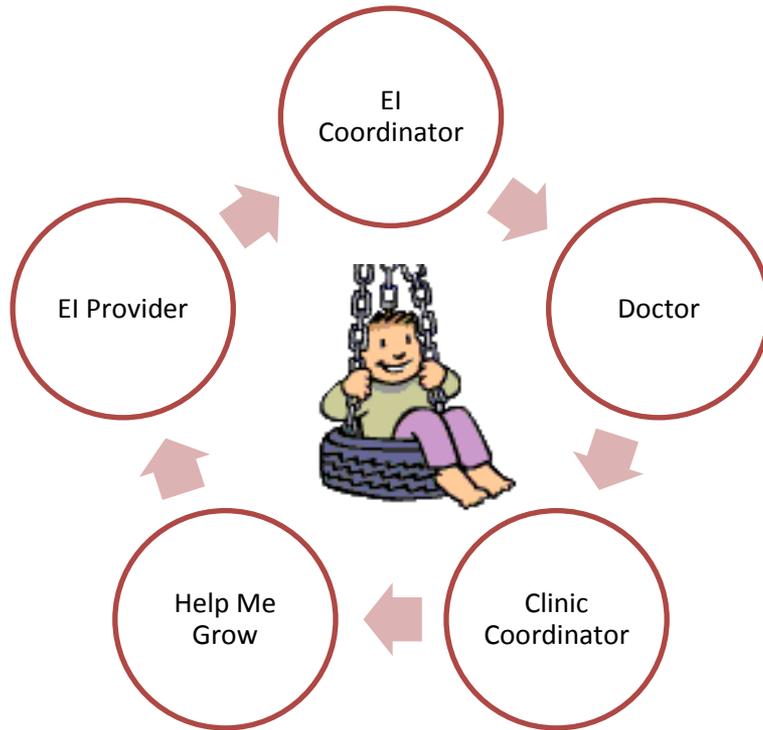
The goal of the CCHD project is to create and institutionalize a feedback communication loop between clinical providers and early intervention service providers, to benefit children with developmental delays or socio/emotional or behavioral health concerns.

Goals & Tools

Goal	Tool
Build Relationships with Early Intervention Service Providers	Team
Implement a Work Flow for Communication between Clinic and EI Providers	Sample Work Flow Team members
Simplify Communication Process While Following Consent Rules	Sample Referral Response Forms Team Members
Track Referrals and Communication to Monitor Progress	Electronic Medical Records Database Team Members

Model for Implementing Change

The model leads the team through testing out small changes toward big goals, in a Plan-Do-Study-Act process.

More information on the Model is found in the CCHD toolkit.
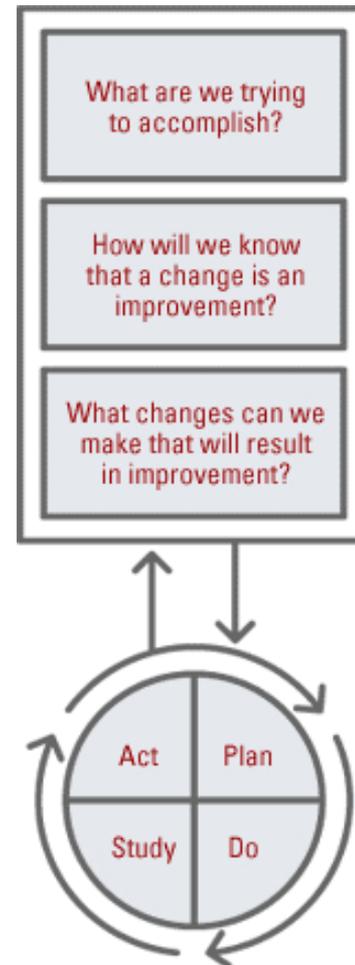
Mayo Clinic – Work-Flow for Early Intervention Referrals

Follow Along Program
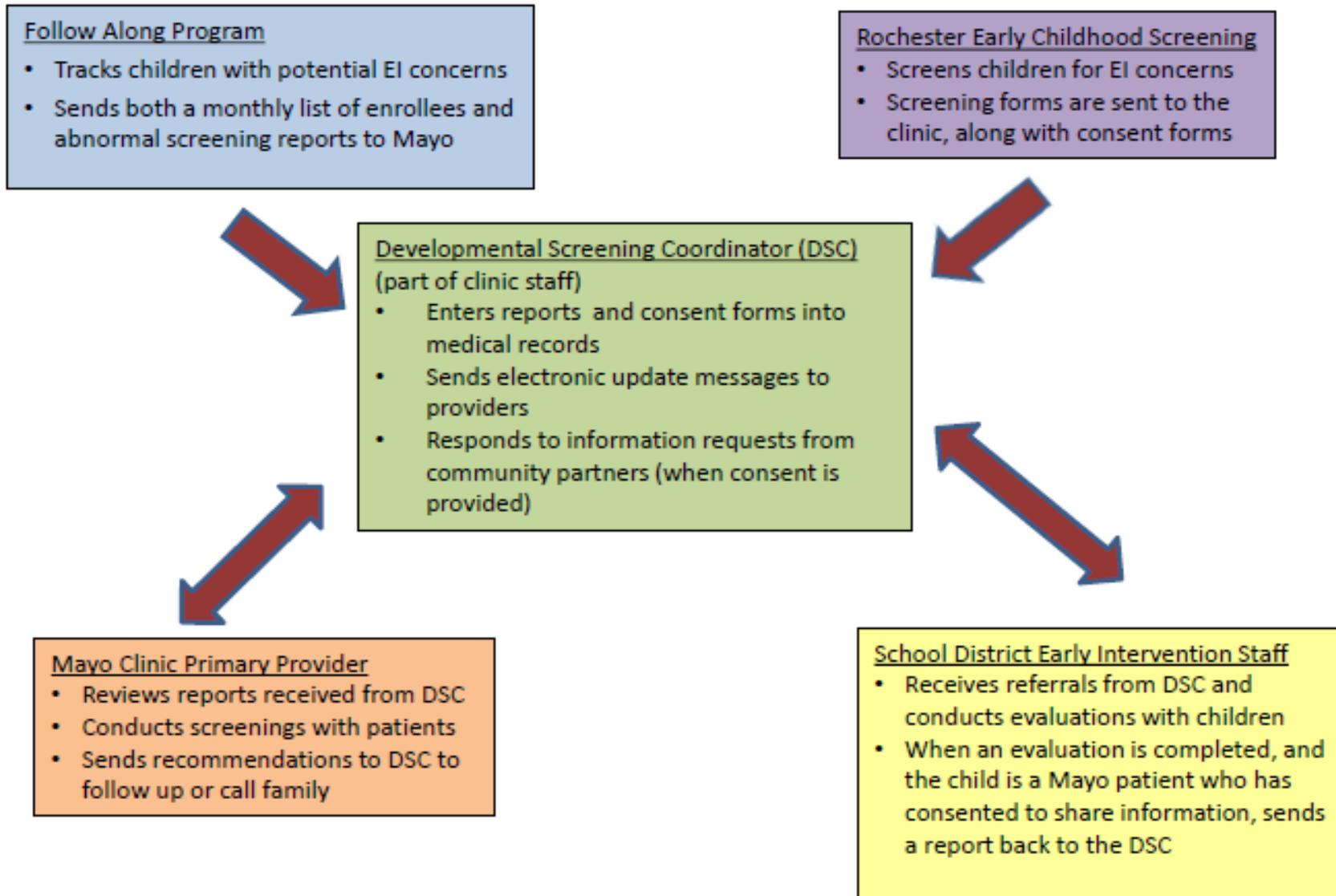- Tracks children with potential EI concerns
- Sends both a monthly list of enrollees and abnormal screening reports to Mayo

Rochester Early Childhood Screening
- Screens children for EI concerns
- Screening forms are sent to the clinic, along with consent forms

Developmental Screening Coordinator (DSC) (part of clinic staff)
- Enters reports and consent forms into medical records
- Sends electronic update messages to providers
- Responds to information requests from community partners (when consent is provided)

Mayo Clinic Primary Provider
- Reviews reports received from DSC
- Conducts screenings with patients
- Sends recommendations to DSC to follow up or call family

School District Early Intervention Staff
- Receives referrals from DSC and conducts evaluations with children
- When an evaluation is completed, and the child is a Mayo patient who has consented to share information, sends a report back to the DSC

CCHD Accomplishments

- Develop a common two-way communication form
- Integrate community developmental screening results into the Mayo Medical Record
- Develop a follow-up communication system from Early Intervention for referred children to better track outcomes
- Establish a contact for community agencies for Mayo Clinic pediatric patients (RN developmental screening coordinator)

CCHD Challenges

- Standardizing the consent process for communication between agencies
- Population instead of individual patient approach to outcome management
- Standardizing communication system from Early Intervention to referring agencies
- Standardizing referral process to Early Intervention
  - Online, phone, fax

Conclusions

- A tremendous amount of pediatric developmental and behavior prevention and care occurs outside of the traditional medical setting

- Working collaboratively with community partners can decrease duplication of services and improve health outcomes for children with developmental concerns

Resources

- Developmental Screening Overview: http://www.health.state.mn.us/divs/fh/mch/devscrn/

- Developmental Screening Tools: http://www.health.state.mn.us/divs/fh/mch/devscrn/instruments.html

- Online Developmental Screening Training Module:

http://www.health.state.mn.us/divs/fh/mch/webcourse/devscrn/index.cfm

- Institute for Healthcare Improvement's Model for Improvement: http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

- Information for Parents and overview of MN's online referral system:

- www.mnparentsknow.org . Follow the button in the top right hand corner to Help Me Grown, the online referral page.

- Online trainings for practitioners, with CME Credits: www.edopc.net, go to training page and look for "Coordinating Care Between Early Intervention and the Primary Care Practices"

- Helpful Toolboxes for Clinicians www.nashp.org

QUESTIONS?

For more information, contact Holly Henry, PhD, Research Program Officer, at (650) 736-0677 or holly.henry@lpfch.org.

Resource information on care coordination can be found at:

http://www.lpfch.org/programs/cshcn/CACommunityCareCoordinationCollaborativeRFP.html