State Strategies for Using Shared Plans of Care to Improve Care Coordination for Children and Youth with Special Health Care Needs

Wednesday, October 31, 2018
3:00 – 4:00pm ET

Supported by the Health Resources and Services Administration

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Logistics

• Webinar Audio
  o Audio will be coming through your computer speakers
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    ▪ Call-in: 888-205-6786
    ▪ Passcode: 536273

• Q&A
  o Please submit all questions via the chat box
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| **Welcome, Introductions, and Overview**  
  • Karen VanLandeghem, Senior Program Director, NASHP |
| **A National Overview of Shared Plans of Care (SPoC) and Its Role in Care Coordination for CYSHCN**  
  • Jeanne McAllister, Associate Research Professor of Pediatrics at Indiana University School of Medicine, Children's Health Services Research Division |
| **State Approaches to SPoC Implementation: Oregon and Iowa**  
  • Marilyn Berardinelli, Community Connections Network and ACCESS Coordinator, Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)  
  • Drew Martinez, Program Coordinator, Division of Child and Community Health, University of Iowa |
| **Questions and Discussion** |
| **Wrap Up** |
An independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

As a non-profit, nonpartisan organization, NASHP is dedicated to helping states achieve excellence in health policy and practice by:

- Convening state leaders to solve problems and share solutions
- Conducting policy analyses and research
- Disseminating information on state policies and programs
- Providing technical assistance to states
Pathways to ‘Real’
Family-Centered Care Coordination

Jeanne W. McAllister, BSN, MS, MHA
Children’s Health Services Research
Family-Centered Care Coordination
Shared Plan of Care (SPOC) Implementation

Achieving a SPOC w/CYSHCN & Families

Principles

1) Patients & families are central and engaged
2) Teams are enabled/supported to help co-create/use SPOC
3) Health care and community efforts are integrated
4) Cross system, family-centered care coordination is continuous

Care Coordination Using a Shared Plan of Care

Why?
We Know - Families Experience:
- Time spent coordinating care
  - (14% > 11 hours/week)
- Financial impact (high costs, lost income)
- Need additional resources

We Know - Families Ask For Better:
- Access
- Communication
- Listening/Respect/Compassion
- Knowledge

Care Coordination

“REAL”

Fidelity to Best Practice Model:
Is it real care coordination?

Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children & Youth Across Multiple Systems, Pediatrics, May 2014 Vol.133(5)
Shared Plan of Care
- Proactive Planning
inform Co-Produced Care Coordination

1. About Me
2. Medical Summary
3. Negotiated Actions
1. **Identify** – who will benefit
2. **Discuss** – with families/colleagues the value
3. **Assess** – select and use a multi-faceted **assessment tool**
4. **Goals** – help families identify goals, merge with clinical ones
5. **Partner** - Identify, link them into the goal & planning process
6. **SPoC** – Develop a **Medical Summary** (assets, data, partners)
7. **SPoC** – Establish the **Negotiated Actions** (goals/strategies)
8. **Share** – Ensure the **SPOC** is available, accessible, retrievable
9. **Use** – Provide tracking, monitoring and oversight
10. **Population care** – Systematically *use* the SPOC/ model care coordination process with an identified group of patients and families
Team-based Care Coordination Program 2014-2017

Thomas Lock, Jeannie McAllister, Jordan Huskins, Rylin Rodgers, Rebecca McNally-Keehn, Holly Paauwe, Annie Clark & Margo Ramaker
Using a SPoC as Approach to Family-Centered Care Coordination (Workflow)

What Did We Find/Learn?

1. Family goals coded & progress measured

2. Family pre/post surveys - Care Coordination Measures:
   i. Mangione - Smith, Family Experience of Care Coordination Measurement Set (AHRQ)
   ii. National Survey CYSHCN (CAHMI)
   iii. Family Empowerment Scales (2 of 3)
   iv. Few tested, not validated questions
   i. CMHI, McAllister and Cooley

Care Coordination using a SPoC approach; intention/hypothesis:

1) Access to care coordination/coordinator ✔
2) Experience co-production/use of SPoC ✔
3) Identification/achievement of family & clinician goals ✔
4) Meet unmet needs (re: care/treatment of neurodevelopmental disabilities/other conditions) ✔
5) Family empowerment (navigation skills, confidence) ✔
6) Family worry- about their child’s health ✔
Understanding Family Goals – What Matters
7 Themes (Coded >1700 Family Goals)

1) Getting the Right Interventions & Treatment
2) Paying for Healthcare and Related Needs
3) Complex Care Access & Communication
4) Getting Appropriate Education
5) Quality of Family Life
6) Understanding the Diagnosis and Treatment
7) Meeting Basic Needs
Care Coordination Lessons

• Partnership relationships with patients/families
• Clarity of purpose, meaning and learning
• Workflow; continuous enhancements
• Open ended interviews; reflection back
• Trust (Speed of Trust)
• People, process and tools
• CC using SPoC drives integrated care


3. Kuo, D, McAllister, JW, Rossignol, L, Turchi, RM, Stille, CJ **Care Coordination for Children With Medical Complexity: Whose Care Is It, Anyway?**. Pediatrics 2018;141;S224.


Shared Plans of Care

October 31, 2018

PRESENTED BY: Marilyn Berardinelli, BS and Alison J. Martin, PhD
Objectives:

• Provide info on Oregon’s impetus for shared care planning work

• Describe Oregon’s opportunities in developing and implementing SPOCs for CYSHN

• Describe Oregon’s implementation of shared care planning

• Describe challenges and successes
Impetus

- Federal impetus
  - MCHB priorities
  - SOS Grant
  - Literature
- Oregon impetus
  - Alignment with standards/metrics in healthcare & education
  - Alignment with accreditation and modernization of public health
Opportunities

- Build on CaCoon program expertise and infrastructure
- Lessons learned from a previous program focused on cross-systems care coordination
- Test feasibility of role for public health
Implementation: Target

Targeted children served by Shared Plans of Care:

- All meet the MCHB definition of CYSHCN
- 20% served are transition-aged
- 40% served have complex needs
- Not mutually exclusive
Implementation: Essential elements

- Family and/or youth participates
- Partners include: education, primary care, public health, and mental health
- Plan is created in real time
- Strengths-based
- Family/youth goal is the priority
- All goals are shared & plan supports the goals
- Plan is updated
Implementation: Support

• Technical assistance
• Tools and resources
• Continuous quality improvement
Challenges reported in year 1

• Time and scheduling (n=25)
  “Time required to get a meeting off the ground; can be a full time job even with cooperating partners.”

• Identifying and engaging partners (n=21)
  “Getting the school on board; they didn’t initially see the value.”

• Understaffed and staff turnover (n=14)
  “Changing staff in partner agencies... is also a challenge.”
Challenges observed

• Differentiating shared care planning from other community-based multidisciplinary efforts

• Access to TA opportunities

• Identifying and serving transition-aged youth
Perceived implementation successes in year 1

- Closer relationships
  - Among professionals
  - Between professionals and family members
- Family receives a consistent message
- Family relief at a clear message
- LPHA hears that partners value their work
- Partners better meet family needs without duplicating their services
There is role for public health outside of the pediatric medical home to support cross-systems care coordination for CYSHCH, though challenges exist.

- Challenges are not unlike those that exist for other care coordination strategies.
- Challenge of identifying and serving transition-aged youth is unique to this effort of supporting care coordination through public health.
“This was great for me and my child.”

“Once we got the care plan, it was nice. Everyone was on the same page, and this is what we’re working on.”

— Source: 2017-18 Oregon Parent describing her shared care planning experience
Supporting literature


For more information...

On implementation:
Marilyn Berardinelli: berardin@ohsu.edu

On evaluation:
Alison J. Martin: martial@ohsu.edu
Thank You

This project is funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Oregon's Title V Maternal and Child Health Block Grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.
Iowa’s Experience with the Shared Plan of Care for CYSHCN

Drew Martinez, MPA
Program Coordinator

Thomas Scholz, MD
Division Director

October 31, 2018
Report

Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs

An Implementation Guide

Jeanne W. McAllister, BSN, MS, MHA
Implementation Timeline

Pilot: April 2016
- Primarily behavioral health diagnoses
- Scope of 11 children
- One school district
- One pediatric practice
- Social worker lead
- Two counties

Phase 1: October 2016
- Primarily behavioral health diagnoses
- Scope of ~80 children
- All served by one waiver
- Multiple school districts
- Multiple pediatric practices
- Social worker lead
- Northeast Iowa

Phase 2: December 2017
- Primarily behavioral health diagnoses
- Scope of ~340 children
- Tiered at the “Severe” level
- Multiple school districts
- Multiple pediatric practices
- Social worker lead
- Northeast Iowa

Phase 3: August 2017
- Both physical and behavioral health diagnoses
- Scope of ~6,000 children
- Complexity determined by practitioner
- Multiple school districts
- Multiple pediatric practices
- Social worker and RN lead
- Entire state of Iowa
Implementation Setting

Social Worker

Nurse

Family Navigator

Secretary

Nurse Practitioner
Shared Plan of Care Workflow

Nurse

- Hold Clinic Team SPoC Brainstorm Meeting
- Receive Verbal Family Consent
- Alert Team
- Schedule Upcoming Family Contacts
- Create Patient Record in ACT.md
- Document Additional Form Information in ACT.md
- Hold Family Consultation
- Document Additional Form Information in ACT.md

Family Navigator

- Schedule Clinic Team to Identify Child
- Hold Family Consultation
- Document Additional Form Information in ACT.md

Secretary

- Schedule Clinic Team to Identify Child
- Hold Family Consultation
- Document Additional Form Information in ACT.md

SPoC Project Team

- Schedule Clinic Team to Identify Child
- Hold Family Consultation
- Document Additional Form Information in ACT.md
- Create Patient Record in ACT.md
Shared Plan of Care Workflow

Nurse:
- Reach Out to Care Team
- Make Follow-up Calls
- Document Collected Goals in ACT.md
- Hold Clinic Team Pre-SPoC Meeting Huddle
- Hold Shared Plan of Care Meeting

Family Navigator:
- Reach Out to Care Team
- Make Follow-up Calls
- Document Collected Goals in ACT.md

Secretary:
- Document Negotiated Goals in ACT.md

SPoC Project Team:
- Document Negotiated Goals in ACT.md
Shared Plan of Care Workflow

### Monthly
- **Nurse**
  - Share Care Plan with Team and Secretary
  - Invite Care Team to ACT.md
  - Check in on SPoC Goals

- **Family Navigator**
  - Invite Care Team to ACT.md

- **Secretary**
  - Upload Shared Plan of Care in Epic

- **SPoC Project Team**
  - Review Child’s Standing

### Annual Review Process
- **Nurse**
  - Schedule Clinic Team Annual SPoC Review Meeting

- **Family Navigator**
  - Receive Verbal Family Consent

- **Secretary**
  - Schedule Clinic Team to Review SPoC

- **SPoC Project Team**
  - Alert Nurse to Upcoming SPoC Anniversary
Implemented Shared Plans of Care

209 shared plans of care implemented as of September 30, 2018

Renewed Care Plans
New Care Plans
Care Coordination Platform

Connect all care team members and drive action through one cloud-based platform.

- Develop, communicate, and execute shared care plans
- Reduce duplication through clear roles and responsibilities
- Hardwire and scale evidence-based processes and operational best practices
- Drive compliance to care plans
- Engage patients, families, caregivers, and community resources
For Patients, Families, Caregivers & Care Teams

An intuitive, convenient, and delightful experience designed to empower patients and families to become knowledgeable and accountable members of their care teams.

Patients, families, and caregivers can send messages, share tasks, and keep private notes.

Care teams can add rich media such as video to engage and educate consumer users.
Care Team View

Anyone can be invited to participate in ACT.md’s cloud-based platform.

All users can keep track of and connect with everyone on the dynamic care team, including family & caregiver contacts as well as clinical & community contacts.

These tools help users make role-based handoffs and reduce duplication through clearly defined roles and responsibilities.
Care Plan Detail View

This is a shared space for collaborative care planning, in a digital format that is:

- Secure
- Flexible
- Multi-authorable & editable
- Real-time
- Available 24x7

Patients, families, and caregivers can share work within care plans, access plans on any device, and share access as needed.
Patient Panel View

See all of your team’s patients, or only your patients.

Easily filter your patient panel by intervention enrollment, care management program, referral source, diagnosis, and more.

See all shared and/or overdue tasks of care, ensuring nothing falls through the cracks, and care keeps moving forward.
Task Analytics View

Gain unique insight into your team’s care coordination performance.

With visibility into engagement, team workload, individual performance, and success of care processes, you can optimize your team’s workflows and evaluate the performance of team interaction patterns on patient outcomes.
“It gave us time to touch-base with the key players – they can see what he is really about – what he is experiencing” – parent interview
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<tr>
<th>SPoC Key Components</th>
<th>Percentage Met</th>
<th>Count</th>
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<tbody>
<tr>
<td>Family/youth consultation meeting</td>
<td>100%</td>
<td>7</td>
</tr>
<tr>
<td>Outreach and follow up to care team members</td>
<td>100%</td>
<td>7</td>
</tr>
<tr>
<td>Date of SPoC meeting and who attended</td>
<td>43%</td>
<td>3</td>
</tr>
<tr>
<td>Family goal included in negotiated goals</td>
<td>57%</td>
<td>4</td>
</tr>
<tr>
<td>School and PCP goal represented</td>
<td>86%</td>
<td>6</td>
</tr>
<tr>
<td>Transition goal represented (if appropriate)</td>
<td>83%</td>
<td>5</td>
</tr>
<tr>
<td>SPoC is distributed to family</td>
<td>No Data</td>
<td>No Data</td>
</tr>
<tr>
<td>SPoC is distributed to partners, providers and agencies.</td>
<td>No Data</td>
<td>No Data</td>
</tr>
<tr>
<td>SPoC is scanned into Epic.</td>
<td>86%</td>
<td>6</td>
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Lessons Learned

- Start small, foster champions, and move forward incrementally
- Works well in times of transition
- Balance organic vs systematic outreach
- Engage family early and often
- Invest time in family and youth goal identification
- SPoC implementation can take from 6 – 9 hours
- Invest in PCP engagement
- School is an eager partner
Questions?

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Please enter your questions in the chat box.
• Webinar: Medicaid Managed Long-term Services and Supports Programs for CYSHCN
  o December 4, 3:00 – 4:00pm ET

• Strengthening the Title V-Medicaid Partnership: Strategies to Support the Development of Robust Interagency Agreements between Title V and Medicaid

• State Strategies to Leverage Medicaid and Title V Programs to Improve Care for CYSHCN in Medicaid Managed Care

• Structuring Care Coordination Services for CYSHCN in Medicaid Managed Care: Lessons from Six States

• State Medicaid Managed Care Program Design for CYSHCN

• State Strategies to Advance Medical Homes for CYSHCN

• For more, visit NASHP’s CYSHCN Resources webpage!
Thank You!

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