Beyond Policy: Implementing Care Coordination in Practice

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Noon – 1 pm Central Time

Questions and Answers

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This document includes a summary of major questions presented by participants that were not answered during the live webinar due to time constraints. For additional resources and information related to care coordination, visit:

- **The National Center for Medical Home Implementation Care Coordination Web Page**
- **Building Your Medical Home: An Introduction to Pediatric Primary Care Transformation (for sample care plans)**
- **Patient- and Family- Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems**
- **Pediatric Care Coordination Curriculum: Boston Children's Hospital**

Questions	Answers
What can families of medically complex children do if an event (e.g. surgery) occurs during transition and the former pediatric team is ready to transition patients but new adult team is not ready?	**Pediatrics South Team:** We usually keeps our patients until they are fully transitioned into an adult practice. **Renee Turchi:** We have the opportunity to allow overlapping visits with pediatric and adult primary care providers to assist in easing the transition to adult oriented systems and stage the transition over several visits. Family should also work with the pediatric team to have a comprehensive care plan/medical summary to help the adult clinician For more information on transitions of care, please visit www.gottransition.org.
During the transition period, are there specific adult providers with which Pediatrics South is involved?	Pediatrics South has established relationships with multiple adult practices in the nearby areas who will allow them to transition patients and will work with Pediatrics South to ensure the transition occurs smoothly. For more information on transitions of care, please visit www.gottransition.org.
What percentage of Pediatrics South patients have Medicaid coverage?	The Pediatrics South patient population includes 17% Medicaid beneficiaries.
Some primary care clinics, especially those that do not see a large number of children with medical complexity, are unsure how to coordinate the child's care. I am from a specialty care system that serves this complex population and we are testing models of 'partnership' care coordination with primary care, using many of the items discussed today. Any words of wisdom on how to be a good primary care partner?	**Pediatrics South Team:** Communication is the key. Noting what patients fit criteria and then working closely with the special needs coordinator, as you would with any subspecialist, making sure the clinical expertise and ability are appropriate. **Renee Turchi:** Engaging community partners and families is critical. Developing care plans is also essential. We have also found creating a community of learners is helpful where colleagues in an area can come together and collaborate on issues and resources in that specific area. **Linda Lindeke:** Joint patient/provider/family conferences are ideal, at least until people develop relationships so that they can pick up the phone and call each other about specific patient issues.

Can we see an example of what your care plans look like? Which EHR do you use? How are the care plans housed/accessed within your EHR?	The National Center for Medical Home Implementation has multiple sample care plans in the "Building Your Medical Home" online resource guide. The Pediatrics South team uses Allscripts EHR and created a care plan template similar to the ones available in the "Building Your Medical Home" resource guide. The Pediatrics South team tracks care plans on their medical home register. For more information on creating a care plan, view the Lucile Packard Foundation publication, "Achieving a Shared Plan of Care for Children and Youth with Special Health Care Needs."
Can Roxanne's job description be shared? What is the training/education of the care coordinator?	The National Center for Medical Home Implementation Web site contains samples of care coordinator job descriptions. The Pediatrics South care coordinator is a Medical Assistant (MA) who began working closely with the care coordination team through the Pennsylvania AAP, and then began establishing relationships with Pediatrics South families about what their needs were. The care coordinator needs to be willing to listen, learn, and conduct research to find resources to help families. Networking and organization skills are required for somebody in this role.
Do the faculty have any thoughts on the role of pharmacists in care coordination?	**Pediatrics South Team:** Pharmacists can be very helpful in regards to drug compounding, drug interactions, and prescription insurance coverage. We have a great working relationship with the pharmacist and our pharmacy team near our office; we can call and ask questions and help our patients with hard to find or compounded drugs. **Renee Turchi:** Working closely with pharmacies for prior authorizations is helpful to the medical home team. Additionally, it is important to communicate to pharmacists that they work with families on giving a 3-day supply of medication. **Linda Lindeke:** Pharmacists can be very useful on a limited basis for certain patient populations that require careful medication management (such as pediatric pulmonary patients, for example).

	For more information on team-based care, visit the National Center for Medical Home Implementation Web site and the "Building Your Medical Home" online resource guide.
Any suggestions and how to get the whole practice team on board with care coordination, and working beyond their license and/or certification?	**Pediatrics South Team:** Each staff member has a role to play in maximizing the success of care coordination. It is critical to know what resources are available, but doing the research is time consuming. **Renee Turchi:** We have our practice coordinators work on doing a needs assessment of the practice and their team members. We also have an approach to implementation that we use as well. It is key to have a core team identified that includes office staff, nursing clinicians, and management to work through an organized approach and identifying roles and operationalizing relational care coordination. **Linda Lindeke:** It is important to not have the team work "beyond their license and/or certification", but rather have incentives to work "to the top of their license/certification". Incentives such titles, wage increases, specific training, can be helpful. Using online training materials is helpful. Connecting staff to blogs and listservs as a support system and another option. Not all people will find care coordination rewarding so finding the right person for the role is very important. The sensitivity and dedication to families are key qualities that every care coordinator must have, as well as being a problem solver, system thinker and resource finder.
Has research been done on training families as care coordinators?	**Renee Turchi:** There is research supporting the favorable impact of engaging families in family-centered care. The favorable impacts include family satisfaction, health care utilization, decreased health disparities, and favorable patient outcomes. Hiring care coordinators that have children with special health care needs themselves is beneficial and has been shown to have the value added of someone who can relate to families in a way that is unsurpassed. **Linda Lindeke:** Please keep in mind that HIPAA may be an issue in these situations.

	For a detailed collection of research and evidence in support of family-centered care and the medical home model, please view the National Center for Medical Home Implementation Web site.
Is Pediatrics South receiving enhanced payment to support their care coordinator position (or for medical home), or is this managed with a fee-for-service payment? Please describe in more detail how you are billing and financing the care coordinator role.	Pediatrics South is not receiving enhanced payment to support the care coordinator position and rather absorbing costs within the organization. Pediatrics South does appropriately bill for complex care using the CPT codes: 99214/99215.
Which payers allow Pediatrics south to bill for the new CPT Codes?	This has not yet been instituted. For example, 99387-99489, which can be used for our severe and complex patients, pays $1.00 by our largest insurer.
What are some of the biggest challenges to care coordination?	**Pediatrics South Team:** Having the time available to conduct care coordination in its entirety, and make sure that all the needs are being met. Reimbursement continues to be a challenge as well. **Renee Turchi:** An additional challenge is ensuring that cross training occurs and that care coordination is institutionalized in the practice. Time is key but the literature supports that care coordination is not time prohibitive if you can ensure that staff is working at the top of their license and that staff roles are clearly defined and met. **Linda Lindeke:** Finding the right person for the job and rewarding the person that stays in this role. It takes a long time to learn all the resources and to build up the relationships in the community, with the patients/families and with the providers.
As a home health therapy agency, how can we best participate in care coordination and encourage the medical home model to come to life in our area?	**Pediatrics South Team:** Home health is one critical piece of this puzzle of the many needs of care coordination. Communication with offices is the most important in a concise, direct, and comprehensive way. Since having one person as a contact person at our office in regards to care coordination, there is now a direct link between our office and home health agencies.

	Renee Turchi: Having monthly meetings with a contact from the home health agency is helpful. Bi-directional communication on what is working and what is not to ensure quality improvement on both ends is important. This is also helpful to enforce community partnerships with families. **Linda Lindeke:** Community-based partnerships with primary and specialty care clinics, hospitals, schools, therapy agencies (OT/PT/Speech), behavioral health, and early intervention.
Does the Pediatrics South team have any cost and/or quality data that indicates having a care coordinator is improving quality of health care delivery and reducing costs for their patient population?	The Pediatrics South team does not currently use/have any direct data, however they will be working to collect that information while being involved with the care coordination project through the Pennsylvania Medical Home initiative.
Do you see any reduction in concerns for medical neglect in your practice with the implementation of care coordination?	The Pediatrics South Team indicated that getting to know complex needs patients better has allowed them to recognize issues that arise and be proactive with a solution earlier to help the patient and family.
What criteria is used by providers to assess need for care coordination? Is there a tool used to stratify level of complexity and how many are a caseload for the care coordinator?	**Pediatrics South Team:** The practitioners will see a patient, and if they feel they could benefit from the care coordination plan, they are referred to Roxanne (the care coordinator) or the Behavioral Health Team depending on what type of services are needed. Scoring levels of severity are directed from the Pennsylvania AAP Medical Home Initiative. At present, we have 383 patients currently on our Medical Home register. Each day is different with one day having 10 patients requiring intervention, while the next day requires only 1. We also do not limit our care coordination patients to just those on the register. **Renee Turchi:** We have used severity indexes and burden of care scores. Insurance companies have risk adjustment measures to identify patients they view as high risk or high utilizer of health care.

Are care coordination services 'limited' to children with special health needs, or are social/financial needs addressed as well, even for 'well' children?	At present, Pediatrics South addresses only children with special needs. However, the practice also works with families who have financial constraints and/or behavioral issues.
Pediatrics South mentioned having an alert display notifying anyone opening the chart that the patient is on the medical home registry. Are there any hospitals or specialty clinics that have the ability to see that patients are on the medical home registry? If so, does that change their care delivery in any way?	Not at the present. As an independent practice, the interface with hospitals and clinics is limited.
Can you better define the Parent Partner role other than providing testimonials (job description)?	Parent Partners are individuals who have worked within the system and are willing to share that information with the Pediatrics South team. Parent partners are also parents of children with special health care needs. For a sample job description for a parent partner, please contact Medical_Home@aap.org
What is the care coordinator to patient ratio that the Pediatric South is serving? Are nurses serving in this role?	This depends on the direct daily needs, both medical and behavioral. Clinical staff works on this as well.
What type of EHR does Pediatrics South use? Does this EHR system have good capacity for developing registries or does Pediatrics South use an interfacing product?	The Pediatrics South team uses Allscripts. Pediatrics South is working to make it more user friendly for care plans. Registries are done by hand using an Excel spreadsheet, directed from the Medical Home Initiative template.
Are patients "empaneled" to one doctor at Pediatrics South, or a team of doctors?	The Pediatrics South team utilizes a team of practitioners, but practitioners stay at each site, so a small and designated number of professionals work with each patient.
Did you have to make physicians take EPIC education curriculum? Otherwise, how was this curriculum enforced?	**Pediatrics South Team:** We conduct educational webinars through EPIC, but they are not mandatory. **Renee Turchi:** We do not require physicians to engage with our program. We have practice coaches/parent advisors regionally placed across the commonwealth of Pennsylvania to provide onsite technical assistance, conduct a needs assessment, and assist in getting practice transformation started.

	We have been able to offer care coordination mini-grants to practices ($6,000 – $10,000) to help "jump start" care coordination and offset the time needed to start this process. We will fund practices for up to 2-3 years. Additionally, we host biannual face-to-face meetings with the entire network in a central location in Pennsylvania. We have a topically themed one-day meetings with CME and community partners as well as parents present. We host monthly webinars on a variety of topics as well and reach out to practices on a regular basis. We have worked with over 150 practices across Pennsylvania. **Linda Lindeke:** EPIC rollout teams that are institution-specific create mandatory EPIC education, in my experience. It is carefully designed and supervised with on-site "super users" present until everyone is comfortable with the new system.
How do practices use patient portals for families who do not speak/read English?	**Pediatrics South Team:** We have not yet crossed that bridge; however we can accommodate non-English speakers in the office using interpreter services. **Renee Turchi:** There are some software programs that are able to translate information in patient portals. We are working on getting our portal available in Spanish, however I think we need to work on this across the board.
How do you suggest engaging and energizing staff across a multi clinic system again, especially when there are things such as Team Care going on?	**Pediatrics South:** Since we have staff stay at one site, there is usually a knowledge base of patients; there is always somebody who knows the families well. We are very fortunate to have the majority of our staff members already on board with our work. Those who were hesitant at the start of the implementation of the program are now seeing the benefits of care coordination and are utilizing the care coordinator more. **Renee Turchi:** Having a medical home/care coordination on staff meeting agendas and omnipresent fosters the culture of quality improvement and change. Some practices have utilized newsletters and email

	updates to keep the entire team informed and connected. However, I think quarterly face-to-face meetings together within a system are paramount with effect and action oriented agendas and idea sharing. **Linda Lindeke:** Team care is an ideal setting for implementing care coordination. Leadership must be enthused and non-territorial. Families must be involved as well as children/youth and consumers of health care services. Consultants can be found to assist systems in implementing new care systems.