Beyond Practice: Fostering Diverse Partnerships for Successful Care Coordination

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11 am - Noon Central Time

Questions and Answers

Faculty:
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Moderator:
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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**
- **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
Do you have any suggestions on how to engage Medicaid managed care systems with care coordination and collaborative efforts in counties and states outside of North Carolina?	**Marian Earls:** The Community Care of North Carolina (CCNC) infrastructure is a key component of our success. Other states are interested in replicating the CCNC model; Oregon has regional entities based on CCNC networks and they are integrating mental health. North Carolina has done consultation with several states including Texas, Arkansas, Mississippi; and our Assuring Better Child Health and Development (ABCD) project has done technical assistance with many states. The core functions that facilitate medical home within CCNC are Care Management (local, in practices, in homes, in hospital for transition) quality improvement, and practice support (these are key to provider engagement). We are also a provider run organization.
What are your plans for support and sustainability of your work given the end of the Child Health Insurance Program Reauthorization Act (CHIPRA) funding? Do you have any "words of wisdom" related to supporting cross-system care coordination given limited Medicaid funding that other states and organizations could learn from.	**Marian Earls:** We have been planning for sustainability from the outset with North Carolina CHIPRA. Our focus from the beginning has been to integrate the work into the infrastructure of CCNC. The Pediatric Teams at the regional networks are built from staff that are already a part of the networks. The model of the quality improvement specialist in each network utilizing data, engaging practices, and offering practice support has resulted in a CCNC central office quality improvement and Practice support team, and implementing the CHIPRA model in the networks for both pediatric and adult quality improvement and practice support. Care Managers have always been a core part of CCNC. The pediatrics team here continues to give technical assistance and training to care managers on pediatric clinical priorities. We have a monthly pediatric work group meeting that brings care managers and quality improvement specialists to discuss clinical topics, implementation, and challenges.
Are pediatric providers routinely administering standardized developmental screenings, such as ASQ? What about mental health or social-emotional screenings? If so, what tools are they generally using?	**Marian Earls:** CCNC has more than 90% of the primary care clinicians in the state. We have been involved in developmental screening since 2000. Practices in North Carolina primarily use the ASQ and the PEDS for 0-5. Practices are also doing autism screening at 18 and 24 months (MCHAT R/F). A significant number are also doing routine postpartum depression screening. Routine school age and adolescent screening has been part of our quality improvement promotion (recommended by Medicaid) and probably 1/4 of our practices have established this. We are now rolling out co-

	management guidelines for adolescent depression screening. We also work through our networks to help practices with referral and co-management
Can you talk about the major successes and challenges that remain with the Fostering Health NC program? Is there a contact person that would be available and willing to discuss that program in detail with the person who asked this question?	**Marian Earls:** Major successes: At least one county in all of our CCNC networks is working on collaboration among the local Department of Social Services, network and practices. We are already seeing reduction and cost Per Member Per Month (PMPM) and enhancement of follow-up care. We have consensus on forms (initial and comprehensive visits) and a passport on our provider portal of the Informatics Center. Dr Earls is available to discuss more in depth via email mearls@n3cn.org.
Do you have any issues with patients obtaining care outside of the state (like in counties/regions on the borders)? If so, what are some ways you are addressing those?	**Marian Earls:** This is not a major issue for us.
Of your 1.4 million members, how many are served through this program?	**Marian Earls:** There are 1.4 million Medicaid recipients, of which 75.2% are children and adolescents. In addition to the Medicaid population, we also serve our Child Health Insurance Program population.
Are your standardized forms/processes statewide? Did you pull in representatives from all regions as well as different provider types/agencies?	**Marian Earls:** The standardized forms and processes are statewide. We involve leadership at the state level who serve children including the Department of Social Service, Public Health, Mental Health, American Academy of Pediatrics and American Academy of Family Physicians state chapters. Our State Advisory group receives feedback from our quality improvement specialists who are from all networks across the state. These two groups meet quarterly.
Can you provide more detail about a community health mixer: what does it involve, how many people are there, where does it take place?	**Marian Earls:** As many as 50 primary care clinicians and an equal number of specialists/other clinicians gather often over dinner or snacks. Primary care clinicians and specialists have gathered at network conference rooms or hospital conference rooms.
Do the practices in this initiative have care coordinators that are practice specific?	**Marian Earls:** Yes, particularly the larger practices. One care manager may have more than one practice.

Can you expand more on how CCNC collaborates with individual practices/offices?	**Marian Earls:** CCNC has a central office and contains 14 regional networks. The key players are primary care managers, quality improvement specialists, and practice support specialists. Networks have regular meetings with practice representatives in Medical Management Committees to share data and discuss clinical priorities. Care managers are often embedded in practices. Quality improvement specialists visit practices to support workflow and quality improvement initiatives. The network pediatric team meets with practices to promote quality improvement.
Do you have any standard tools you use with child protective services that you could share?	**Marian Earls:** We have standardized forms for referral and follow-up that we are happy to share, please contact Dr Earls via email for more information: mearls@n3cn.org.
Did evaluation of the Hali project look at satisfaction of families, parent partners, and/or physicians?	**Brad Thompson:** The satisfaction survey was conducted for each of the three groups mentioned, with very positive outcomes in all three groups. I should also add that due to timing issues with the evaluation team and the size of the pilot project, the sample sizes for the parent partners and physicians were limited. They were however deemed to be statistically relevant by the evaluation team. A couple of Parent Partners indicated that they would have liked more training but in following conversations with them, they indicated that the monthly group calls filled in the gaps they found in the initial training.
Can you provide more detail about the three-day training for parents? Can the training curriculum be shared?	**Brad Thompson:** I would be happy to speak with individuals about their particular questions or requests about the curriculum in order to determine the best way to share the information: bthompson@southwest.org.
The Affordable Care Act, authorizes payment for non-licensed "Community Health Workers to perform such functions such as outreach, case management at the "recommendation " of a physician. The State Medicaid would have to submit a "state plan amendment" to CMS. Have you considered doing this, are you aware of this.	**Brad Thompson:** I was aware that the Affordable Care Act authorized reimbursement but am not informed as to how go about getting our Parent Partners project certified/approved to fill that role. I would be aggressive in pursuing this avenue, and would very much appreciate any guidance, direction, or mentoring if there is someone willing to help.
Are you aware of any projects similar to the Hali project available in other states?	**Brad Thompson:**

	I am aware of a program facilitated by the Rhode Island Parent Information Network (RIPIN); the Pediatric Practice Enhancement Project. I have visited and met with members of their team on a few occasions over the years. I am not aware of any other programs like this. The difference between our project and RIPIN would be that our Parent Partners are in the practices and are referred to all families who have children with special needs, both publicly and privately insured.
Can you describe the interaction between the parent partners and the providers at the sites where you work? Do they have regular check-ins or is it more ad hoc?	**Brad Thompson:** These interactions are practice specific and left to the "personality" of the practice. We have some who attend staff lunches and meetings and others who work closely with a nurse case manager or social worker who is in the staff meeting. It is essential to the program in each practice that they have some regular form of communication. We certainly recognize that even if the practice is not providing funding to the Parent Partner, it is their practice and we do work at their pleasure. I can say that those who invite the Parent Partners into their meetings are more likely to use their Parent Partners to their full potential.