Getting Started

Pediatric Care Coordination Curriculum

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

2ND EDITION

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What Is Pediatric Care Coordination and Why Does It Matter?

Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families and caregivers. Care coordination reaches across medical and nonmedical domains to address interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes.1,2 Care coordination is an essential component of the services provided by members of the patient- and family-centered medical home (PFCMH) team. For children and youth with special health care needs, including those with significant social determinant of health risk factors, the PFCMH is a critical element of an integrated care model, offering care coordination in collaboration with the members of the diverse care team, across settings. This diverse care team includes patients, families, caregivers, nurses, physicians, social workers, community health workers, care managers, care navigators, case managers, early intervention providers, education professionals, and staff from Title V programs.

Health care is often provided in "silos," where patient care is fragmented due to lack of accountability, communication, and effective coordination. Successful care coordination with structure and measurement processes that support accountability and communication, enabling interprofessional integration to achieve shared goals, is of highest value to families and patients, especially children, youth, and young adults who are medically, socially, and behaviorally complex. Furthermore, since health outcomes are substantially impacted by contributions of providers of essential health-related resources, such as social services, education, family support, housing, transportation, literacy, and social justice, truly effective care coordination must play a key role in aligning and integrating efforts across both medical and nonmedical domains.

In the 8 years since the first edition of the Pediatric Care Coordination Curriculum was published, care coordination has been demonstrated as an essential cross-cutting intervention capable of filling in the gaps of the fragmented U.S. health care system. As new tools and measurements have been developed, this second edition offers valuable updates from the field.

This curriculum was designed to cultivate new learning about the elements of care coordination, emphasizing the central role of families, caregivers, children, youth, and young adults in collaboration with a multidisciplinary group of care team members. It identifies a framework for integrating efforts across time, settings, and disciplines. The curriculum aims to build the capacity of the multidisciplinary care team and families through effective implementation of key components of care coordination, constructive and collaborative communication within interprofessional care teams and families, and investment in technology solutions. It will also provide tools to measure challenges and successes in coordination of care to engage in continuous quality improvement. These competencies will support provisions of high-value patient- and family-centered care.

What Is New in the Second Edition?

Based on user feedback, the modules were adapted for this edition to emphasize development of measurable capabilities and outcomes through shared, interprofessional learning activities. Prior to implementing the curriculum, the facilitator should review all modules to become familiar with materials and decide which modules will best fit the desired learning goals and outcomes relevant to the group's needs for improving care coordination and care integration. Experience with the first edition established that it is not necessary to adapt and implement all the modules concurrently. Many successful implementers planned modules based on local and regional priorities. In other words, it is acceptable to start small!

Considering the audience's purpose for engaging in this learning experience is key. Are participants interested because they share a broad goal (eg, improving outcomes directed by policy, quality, or contractual mandates)? Are they attending because there is a shared passion for providing better care? Is there a marketing driver to be the highest performing delivery system in a region as assessed by outcomes important to family of children and youth with special health care needs?

The facilitator will want to be practical in planning and mindful of tactical and logistical constraints, such as the number of learners, availability of space and time, and preexisting experience and relevant background of the learners. Facilitators should also consider their own experiences and training in relation to the material.

The following is an overview of the content and learning objectives embedded in each module of the second edition of the Pediatric Care Coordination Curriculum. This is intended to guide the leadership group organizing the effort on the adaptation and implementation of the curriculum. Adaptation enables the organizing group to decide how much of the content to deliver based on its priorities. Also essential for the group in the adaptation process is to include information pertinent to local, regional, and state-specific resources. The sections for which adapted resources are especially important are denoted by a blue dot 

Curriculum at a Glance

Most stakeholders beginning to implement and measure care coordination will likely find that Module 1 is foundational to the content in the other modules.

Module 1

High-Value Integrated Care Outcomes Depend on Care Coordination

By the end of this module, learners should be able to:

- Discuss key components of care coordination within an integrated model of care delivery.
- Assess current practices that support care coordination and integrated care delivery in a variety of settings, including state, regional, delivery system, community agency, or clinical.
- Prioritize areas of improvement in care integration and care coordination in their current practice.
- Identify established tools and processes that can be used to implement key components of care coordination.
- Develop an action plan outlining specific goals to facilitate care coordination in their practice.

Module 2

Developing and Sustaining Strong Family/ Professional Partnerships

By the end of this module, learners should be able to:

- Explain the value and importance of family/professional partnerships.
- Explain the family role in health care improvement.
- Describe ways to engage families and members of the care team to improve integration.
- Demonstrate knowledge of tools, resources, and strategies to improve family/professional partnerships.
- Demonstrate the ability to operationalize family/professional partnerships through planning an initiative and/or event.

Module 3

Social Determinants of Health

By the end of this module, learners should be able to:

- Understand what social determinants of health and health disparities are.
- Understand how social conditions influence health.
- Recognize 5 core health-related social needs for screening and referral with implications for care coordination.
- Understand the importance of bias and health equity.
- Recognize some innovations aimed at addressing social determinants of health..

Module 4

Measurement Matters: Creating an Effective and Sustainable Integrated Care Model

By the end of this module, learners should be able to:

- Outline key elements of a care coordination measurement framework.
- Use tools and measures to effectively assess elements of care coordination.

Module 5

Using Technology to Improve Care Planning and Coordination

By the end of this module, learners should be able to:

- Assess current practice of care coordination with and without technology.
- Describe ways to use technology to connect key players in care coordination.
- Provide an overview of system requirements.
- Create an action plan for integration of technology platforms.

Those already on this journey may find the Assets and Needs Assessment listed below helpful in guiding where to begin in the curriculum. Facilitators are encouraged to use this tool to assess their current status in performing care coordination and to identify strategic goals and priorities. Although the Assets and Needs Assessment is contained in this module, it is useful for starting with any of the modules.

Assets and Needs Assessment

Please answer the following questions to help us better tailor future learning opportunities.

Demographics

1. Organization type
    - ☐ Clinical practice
    - ☐ Family advocacy organization
    - ☐ Health care delivery system
    - ☐ Community organization (eg, early intervention, school, child care)
    - ☐ Title V, other state agencies
    - ☐ Other (specify): _____
2. Organization size: _____
3. Team membership (disciplines): _____
4. Medical Home Certification (NCQA or JAHCO): ☐ Yes ☐ No
5. Practice setting: ☐ Rural ☐ Urban

Getting Started: Essential Questions

1. Why are you engaging in the process to implement, measure, and improve care coordination?
2. What are your goals?
    - ☐ Quantitative
    - ☐ Qualitative
    - ☐ Other (specify): _____
3. Do you have any incentives or disincentives influencing your commitment to this effort?
4. Given that the effective care of children, youth, and young adults with special health care needs must be coordinated across settings and disciplines, what role do you foresee in integrating into this broader community of care?
    - Are any stakeholders in this broader community of care joining you in this process?

Assets and Needs Assessment

continued

	Does your team:	Yes	No
NEEDS ASSESSMENT AND GOAL-SETTING	Collect feedback on patient experience using a standardized tool?		
	Engage patients/families in quality improvement activities?		
	Conduct behavioral health screenings (depression, anxiety, substance use, ADHD) using a standardized tool?		
	Measure and report on clinical quality measures (ie, immunizations, preventive care, behavioral health)?		
	Identify patients that might benefit from care management (ie, high health care utilization, complex conditions, behavioral issues, social issues)?		
CARE PLANNING AND COMMU-NICATION	Have regular care team meetings, pre-visit huddles, or another structured process for staff to communicate about upcoming appointments, patient needs, and workflow?		
	Offer communication in ways other than an in-person visit (ie, phone, email, Skype, or telehealth) if no physical examination is necessary?		
	Use a patient portal or other means for two-way electronic communication with families (ie, for sharing care plans)?		
	Have care plans for patients in need of care management that are developed collaboratively with patients/families, shared across care team members/settings, and updated routinely?		
FACILITATING CARE TRANSITIONS	Have a staff person or care coordinator who helps families coordinate care?		
	Have a process for following up with patients who have had a hospital admission or emergency department visit?		
	Have a systematic process for referral management (ie, providing pertinent clinical information and timing, tracking referrals, and closing the loop on referrals)?		
CONNECTING WITH COMMUNITY RESOURCES AND SCHOOLS	Work with families to identify needed community-based services (ie, programs or support groups)?		
	Use routinely collected information on social determinants of health (ie, food insecurity or housing instability) to address identified gaps?		
	Engage in supportive partnerships with schools and community agencies?		
	Actively assist in linking families to other families who share similar life situations and challenges?		
	Assess family experience using a standardized tool (ie, the Pediatric Integrated Care Survey)?		
TRANSITION-ING TO ADULT CARE	Collaborate with families to develop a written plan for patients with complex needs who are transitioning to adult care?		
	Consider health literacy and communication preferences in development of patient materials?		

Note to Facilitators

The target audience of this curriculum is intentionally broad because care coordination is a team-based competency. This curriculum is designed to inspire learning in patients, families, caregivers, nurses, physicians, social workers, community health workers, care managers, care navigators, case managers, early intervention providers, education professionals, and staff from Title V programs, Medicaid agencies, and commercial and managed care entities. The learning will proceed more organically if there is a diversity of faculty and learners. While it is important that everyone's perspectives are heard and respected, it is essential that input from patients and families be actively solicited and shared.

Tips for Facilitators: Ways to Keep the Workshop on Track
Sometimes during a workshop or group activity, things can get a bit off track. For example, some participants may feel strongly about adding topics to the training, causing conflict between participants, or efforts for an organized workshop flow may become stymied. Following are ideas that may help with keeping a workshop on course or getting it back n track in a gentle and reassuring manner.

How to handle challenging group dynamics and keep a workshop flowing

- Make everyone feel comfortable, welcome, and valued.
  - ~ Welcome people in the roles that brought them to the workshop but also as people with personal experiences
  - ~ Consider dedicating time or a method for sharing stories (set aside time in the agenda, collect stories or ideas on sticky notes to discuss later, or form small work groups)
  - ~ Allow time for cultural connections
- Present and explain the agenda and expectations frequently—repetition improves connections and keeps everyone on track.
  - ~ Encourage participation from all of the learners
  - ~ Listen and observe and ensure that others show respect and listen as well
  - ~ This ensures that all who participate feel heard
- Clarify group discussions.
- Recognize and appreciate the contributions of all participants.
- Be aware of different learning and processing styles.

How to manage conflict and resolution

Honest disagreement is often a good sign of progress. —Mahatma Gandhi

Dealing with conflict:

- Keep an open mind
- Use "I" statements
- Do not take things personally
- Ask questions
- Stay focused on the topic
- Concentrate on solutions
- Take a break
- Remember the purpose of the workshop and redirect people back to it.

Resolving conflict:

- Pay attention to interests
- Listen first and talk second
- Make good relationships the priority
- Keep people and problems separate
- Present the facts
- Explore options together

Works Cited

1. Antonelli R, McAllister J, Popp J. Making care coordination a critical component of the pediatric health system: a multidisciplinary framework. The Commonwealth Fund. May 2009.

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