Module 1

High-Value Integrated Care Outcomes Depend on Care Coordination

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Module 1—Objectives

At the end of this session, participants 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 agencies, or clinics.

• 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.

Note to the facilitator:

Please be aware that when implementing this module, it is crucial to include local-, state-, and region-specific content.

A found in the module indicates the need for local content to be added, but facilitators should feel free to include local content wherever they see fit. Local content includes, but is not limited to, the following:

• Cultural aspects of the community (including assets, vulnerabilities, and language)
• Sociodemographic factors
• Geography
• Local, state, and/or regional resources

There are 2 tables included below. The first is a high-level agenda of the module. The second is the facilitator guide that includes a breakdown of slide content and talking points. The facilitator should use the guide as a resource to tailor the training.

The curriculum is intended to be tailored to fit the training needs, and the content can be modified for different audiences. Therefore, content from this module can be selected and incorporated into the tailored training. However, a suggested agenda for implementing this module as a stand-alone is included.
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Table 1

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time</th>
<th>Materials Required</th>
<th>Instruction/Notes</th>
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<tbody>
<tr>
<td>Pre-session reading</td>
<td>N/A</td>
<td>Ten Essential Characteristics of Care Coordination</td>
<td>Can be found at: <a href="https://jamanetwork.com/journals/jamapediatrics/article-abstract/2716802">https://jamanetwork.com/journals/jamapediatrics/article-abstract/2716802</a></td>
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<tr>
<td>Introduction</td>
<td>5 min</td>
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<tr>
<td>Didactic: care coordination from theory to practice</td>
<td>15 min</td>
<td>Slides</td>
<td>Create the slide deck using content from the didactic portion. Make sure there is opportunity for participants to speak.</td>
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<tr>
<td>Team activity: asset and needs assessment</td>
<td>20 min</td>
<td>Handouts, as needed</td>
<td>Distribute the handout to teams or individual participants as appropriate. Give participants 5 minutes to do the assets and needs assessment as a team (if applicable).</td>
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<td>(The assets and needs assessment can be found in the facilitator guide Getting Started: Identifying and Prioritizing Opportunities for Implementing High-Performing Care Coordination)</td>
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<tr>
<td>Case study: Keystone Pediatrics</td>
<td>35 min</td>
<td>Copies of case study, as needed</td>
<td>Give participants an opportunity to practice the concepts and tools they have learned during the training. Case studies can be tailored so that they are relevant to the audience/population.</td>
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<tr>
<td>Shared plan of care</td>
<td>25 min</td>
<td>Slides</td>
<td>Create the slide deck using content from the didactic portion. Make sure there is opportunity for participants to speak.</td>
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<tr>
<td>Action-oriented exercise: SMART goals</td>
<td>15 min</td>
<td>Copies of handout, as needed</td>
<td>Participants should complete the worksheet, detailing next steps to take after the session, based on work they have done in the session.</td>
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<tr>
<td>Closing/summary</td>
<td>5 min</td>
<td>N/A</td>
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**Introduction**

*Note from the authors*

The content included in this module provides a framework for facilitators to explore how care coordination activities serve the delivery of integrated health care for patients most vulnerable to care fragmentation. The goal is to provide practical guidance for learners to be able to identify opportunities for implementing care coordination activities in their own practices. Learners may be physicians or nonphysician clinicians of all disciplines, school or community partners, payers, agencies, or patients and families—ensure that all appropriate team members are included in this training opportunity.

General principles and recommendations for care coordination grounded in the literature are shared in this module, while enabling discussion of context-specific challenges and areas for improvement. It is important to embed local information, including resources or contacts, into the content of this module—this will make the learning experience more valuable and relevant. For example, facilitators may consider reaching out to community early intervention programs, school districts, behavioral health clinicians, Title V organizations, American Academy of Pediatrics chapters, and family advocacy groups, among others. There is a wide breadth of services used by families and children with special health care needs, some of which are listed in Appendix A of this module.

An important aspect of this module for understanding the relevant experiences of participating teams is the assets and needs assessment. What do care teams do to facilitate care transitions in their practices? How do they connect patients and families to community resources? These questions will help guide facilitators in determining the key focus points and resources to share throughout the session.

Following are some questions to debrief the learners about the pre-session reading:

- What essential characteristic of care coordination resonated most with your experience?
- Were any of these assumptions a surprise or something you did not realize was an aspect of care coordination?
- Think of your own team. Which of these do you do particularly well, and which have opportunity for improvement?

These questions will be delved into further throughout this module.
Be mindful that this activity will have optimal impact if it is presented as an interprofessional learning event, with patients and families as co-faculty and co-learners. This multi-stakeholder learning event is intended to set the foundation for a jointly created, shared vision for empowering patients and families to impact the quality of the care processes that impact their outcomes. Tactically, a common language of expectations, terms, and performance measures will be highlighted, ultimately resulting in care team members understanding their respective roles and responsibilities.

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After participating in this module, learners will be able to achieve the objectives included on this slide.

- 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 clinic.
- Prioritize areas of improvement in care integration and care coordination in the 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 the practice.
This slide is an overview of the activities that support the learning objectives.

Inform the learners that the session will start with a discussion about the key components of care coordination within an integrated model of care delivery. The discussion will distinguish between care coordination and care integration and explore how they are related.

Explain to the learners that today’s portion of the training session will teach them how to take care coordination from an “in-the-clouds” concept to on-the-ground action in their practices and communities.

Care coordination is the set of activities in the space between visits, care team members, and hospital stays. Examples may include booking appointments, following up on test results, and liaising with community services.

Metrics of care coordination include assessments of care transitions (eg, information handoffs) and care plan implementation.
Words matter! It is essential to acknowledge that there may be some variation in terminology, but the facilitator must get the group to come to consensus on how to define, operationalize, and measure performance of care coordination, care integration, case management, etc.

Care planning is an activity of care coordination, and care coordination leads to care integration. Care coordination is a domain of the broader framework of care integration and is necessary—but insufficient—to achieve integration. When care is integrated, families perceive collaboration between care team members. See Appendix B of this module on how to build a shared plan of care.

Case management is commonly confused with care coordination and care integration. Case management is a process that addresses the health needs of patients. It tends to be focused on a limited set of predetermined diseases or conditions and guided by potential health care cost savings. Traditionally, case management services are provided in a benefits package, often supported by a health plan or managed care organization.

This is the framework for care integration, which is the right side of the care fragmentation ➞ care integration diagram in the previous slide. This framework is foundational to understanding how various activities of care coordination (eg, referral to community resources or planning for the future) support the outcomes of care integration.

Further, it should be emphasized that this broadly inclusive framework is designed to include key priorities (health, medical, nursing, social, behavioral, and educational aspects of health) for care coordination implementation by addressing what is important to families, physicians, nonphysician clinicians, and community leaders.

Care coordination is a multidisciplinary team sport, and patients and families are essential team members.

Ask the learners whether they have the right people in the room when discussing care coordination and to consider all of the different types of care team members and settings. Agencies might include the Department of Mental Health, the Department of Developmental Services, and the Department of Children and Families.
This image of one family’s care map depicts all the different “loci” of care. Care mapping is an important activity for framing care coordination. It is a process that guides and supports the ability of families and care team professionals to work together to prioritize needs and achieve the best possible health outcomes.


The care mapping process is discussed in more detail in Module 2 as an effective and valuable tool for family-led discussions of care coordination needs and goals.

The care map shown here was developed by Cristin Lind, who invented the care map.

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Consider the impact of fragmented care. Some examples are included on this slide.

Presenteeism is when employees are physically present at work but not fully functioning (eg, due to distractions or concerns for their own health).

Caregivers of children and youth with special health care needs (CYSHCN), particularly caregivers of children with complex medical and behavioral health needs, are more likely to reduce their time or responsibilities at work or to quit, which contributes to their stress. To improve employee job attendance and productivity, suggest that the learners interface with employers in their region to determine how care coordination for CYSHCN impacts work.

Prompt the learners to consider the impact of care fragmentation on patients with behavioral health needs: 86% of families are singularly responsible for coordinating care for mental and behavioral health services (Pond et al., 2012).

Family experience with coordinating care for their children and youth with behavioral health needs demonstrates that this population is especially vulnerable to care that is fragmented, leading to significant stressors upon families.
Care coordination is a domain of the broader framework of care integration. Metrics of care coordination include assessments of care transitions (e.g., information handoffs) and care plan implementation.

The other domains of care integration are critically important in defining a comprehensive set of performance metrics that are geared toward achieving the Quadruple Aim.

Care integration is correlated with Quadruple Aim outcomes.

- **Improved quality indicators**: Care and services are integrated so that decisions are made collectively and ownership of tasks and responsibilities is determined together. This closes gaps in otherwise potentially fragmented systems.
- **Improved family experience**: Families feel more cohesive with their children’s care teams.
- **Improved provider experience**: A provider’s ability to provide comprehensive care improves.
- **Reduction of unnecessary costs**: The intention is to shift care from high-cost utilization services to lower cost ambulatory, or home- or community-based services.

These are the goals and purposes that care coordination activities can serve.

Share the following evidence for care coordination with the learners using the framework shown on the slide:

- According to an American Academy of Pediatrics (AAP) policy statement, the provision of care coordination was positively associated with patient- and family-reported “receipt of family-centered care,” resulting in “partnerships with professionals, satisfaction with services, ease of getting referrals, lower out of pocket expenses and family financial burden, fewer hours per week spent coordinating care, less impact on parental employment, and fewer school absences and ED visits.”
- An Illinois study showed that children, youth, and their families had a higher need for care coordination when communication between health care team members was inadequate.
- Care coordination within primary care pediatric practices is associated with decreased unnecessary office and emergency department (ED) visits, enhanced family satisfaction, and reduced unplanned hospitalizations and ED visits.
- Care coordination conducted as a standard of pediatric practice resulted in increased family satisfaction with the quality of care and also decreased barriers to care.

(Reference: AAP CC Policy Statement, 2014)
Contributors to complexity include psychosocial, socioeconomic, demographic, medical, behavioral, and environmental factors. Community leaders, advocates, and delivery system leaders must consider the broad needs and assets of the community when defining care coordination competencies and outcomes. Understanding this multifactorial model of health outcomes is essential in designing interprofessional care teams, with the patient and family at the center.

The prevalence of complexity, chronic conditions, and “typically” functioning children and youth suggests the need to define the characteristics of each segment of the pediatric population when one is developing care coordination and care management competencies.

Effective care coordination, especially for children and youth with special health care needs, requires an interprofessional team. The complexity of the given child’s or youth’s needs often determines the locus of care coordination and integration, along with how multiple stakeholders collaborate to achieve optimal outcomes.

Family experience with coordinating care for their children and youth with behavioral health needs demonstrates that this population is especially vulnerable to care that is fragmented, leading to significant stressors upon families.
Care coordination can seem like a great concept but hard to figure out how to operationalize and systematize.

Based on evidence, the AAP policy statement on care coordination includes recommendations for pursuing care coordination.

This slide includes examples of actionable items that can help achieve some of these recommendations.

The AAP policy statement facilitates a structured approach to defining activities of care coordination and to aligning key stakeholders in implementation and performance measurements.

Facilitators may wish to highlight a particular AAP recommendation that is pertinent to the learners or team. Using the provided model, suggest actionable items for any recommendations chosen for discussion.

For each recommendation that is discussed, ask learners to share any actions they believe support that recommendation in their current practice. Facilitators can then show some suggested actions like the examples provided in this slide.

Delineation of roles and responsibilities includes the patient and family as well as all members of the care team. This process presages the functionality of the care planning tool known as the action grid, beginning with slide 44 in this module.
**Identify members of a child’s care team.**

The entire team is usually not located in the same physical space and is often geographically dispersed.

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**Key Elements of Care Coordination**

- Needs assessment and goal setting
- Care planning and communication
- Facilitating care transitions
- Coordinating with community resources and schools

**Objective**

Participants will be able to...

- Assess current practices that support care coordination and integrated care delivery in a variety of settings, including state, regional, delivery systems, community agencies, or clinics.
- Prioritize areas for care integration and care coordination improvements in the practice.
Distribute the handout to teams or individual participants as appropriate. Give participants 5 minutes to complete the asset and needs assessment as a team (if applicable).

Ask learners to reflect on their current activities.

• What are they already doing to provide care coordination for patients?
• What gaps did they identify?
• What area would they like to prioritize as an opportunity for improvement?
  ~ Encourage them to consider institutional priorities, stakeholder interests, and local resources.

Ask for some “headlines” to be shared in the larger group.

Gaining consensus on the framework, with its organized approach to defining elements, activities, and roles, will lead to a robust approach to measurement.

Facilitators should summarize the objective here.
Ask learners:
- Does this case study resonate?
- Is it realistic?
- What are the gaps??

Inform the learners that today’s discussion will address common issues associated with adolescent visits.

Ask participants to identify potential areas for improvement. Here are 2 opportunities that can be explored further:
- The gap in the structured process for completing well visits.
- The gap in the system of referrals and handoffs between team members.

This slide includes common issues associated with family well-visit attendance. The AAP policy statement offers several examples of how to improve these issues.
This module focuses on 2 of the AAP recommendations for care coordination. We will talk through operationalizing these recommendations and implementing tools and measures to support them.

For example, how can meeting the needs of patients and families be ensured? The first step is to understand patient and family experiences with health care.

This slide includes 2 tools that can be used to measure patient and family experience. Both tools include questions that are framed as “in the past 12 months.” Versions of the tools are available for transitions and handoffs, and both are available in English and Spanish.

- The Family Experiences with Coordination of Care (FECC) survey focuses on structure and process measures, including tools and resources that are available to support care coordination.
- The Pediatric Integrated Care Survey (PICS) focuses on outcome measures, including family expectations of care integration.

The FECC survey facilitates assessment of 20 caregiver-reported quality measures for children with medical complexity.
This slide includes 1 sample question from each of the 3 domains covered in the FECC survey.

Different questions can be selected from the survey and shared with the learners, depending on their interests and priorities.

The full tool is available at: https://www.seattlechildrens.org/research/centers-programs/child-health-behavior-and-development/labs/mangione-smith-lab/measurement-tools/

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PICS is a validated outcome measure of patient and family experience with care integration. The survey is already being implemented in multiple settings across the U.S. and is being considered for use by some state Medicaid programs.

PICS assesses parent and caregiver experience with integration across the entire care team or a specific entity (e.g., a particular subspecialty clinic). It assesses parent/family/caregiver experience with medical service delivery, behavioral health, education, and linkage to community organizations.

PICS contains 19 experience-related questions in 5 domains: access, communication, family impact, care goal creation, and team functioning.

This slide contains some examples from PICS.

Different questions can be selected from the survey and shared with learners, depending on their interests and priorities.

The full tool is available at: http://www.childrenshospital.org/integrated-care-program/patient-and-family-experience-outcome
In addition to the tools for measuring patient and family experience that have been shared during the session, patient experience tools are also available from Press Ganey and NRC Health.

However, this next portion of the module will look at tools that can be used to support high-quality handoffs before and after a clinical encounter.

**What is a handoff?**

It is the transfer of pertinent knowledge between members of a patient’s care team, enabling a care team member to safely assume responsibility for some aspect of care.

Handoffs occur in numerous contexts:

- To and from pediatricians and other physicians to pediatric subspecialists, pediatric surgical specialists, or nonphysician clinicians
- To and from communities and hospitals
- To and from an on-call physicians and nonphysician clinicians
- To and from pediatric medical subspecialists or pediatric surgical specialists on other services

The goal of a handoff is to enable the care team to maximize the utility of every patient interaction by ensuring knowledge learned by one part of a patient’s care team is communicated to other members at the right time and place.

Structured handoff communication using a standardized template in concert with team training has been associated with reduced medical errors (Starmer et al. 2014).
Ask learners what some of the key pieces of information are necessary to optimizing clinical encounters with patients and families.

Inform them that audits across the United States demonstrate that only 5% to 20% of referrals to pediatric medical subspecialists and pediatric surgical specialists include pediatricians’ or other physicians’ reasons for requesting consultations, and information about evaluations conducted to date, and expectations of consultations.

It may be helpful to clarify here the distinction between a referral request to a payer to obtain approval and a physician-informed or nonphysician clinician-informed reason for subspecialty consultation. This curriculum focuses on the latter.

This slide features a model template that can be used to ensure that the elements included in the template are available prior to every encounter.

This template is available to learners at: [http://www.childrenshospital.org/integrated-care-program/high-quality-handoffs](http://www.childrenshospital.org/integrated-care-program/high-quality-handoffs).

The High-Quality Handoffs tool can be used to structure essential information for each member of the care team. This would include care transitions from primary care to subspecialist, subspecialist to other subspecialist, or primary care to other members of the care team, such as nursing, social work, and community-based providers.

Ask the learners what some of the key pieces of information are that need to be discussed with the patient and family and/or other members of the care team following a clinical encounter. Also, what needs to be done to ensure clear communication of patient and family goals and the plan of care with a timeline and responsibility for important tasks? What practices support reliable information sharing among members of the health care team so that nothing falls through the cracks?

These are common challenges, particularly across transitions in care and when team members are dispersed across multiple sites.

Inform the learners that the next part of the session will describe a tool that supports a shared mental model and closed-loop communication across the care team.
An action item grid is developed with the patient and family. It outlines an overall care goal, task to be completed, who is responsible, timeline for completion, and a contingency plan. The high-quality handoff is a critical first step to inform the patient encounter, and the action grid helps ensure closed-loop communication back to the referring care team.

This template is available to learners at: http://www.childrenshospital.org/integrated-care-program/multidisciplinary-care-planning

Share the key principles of the action grid from this slide with the learners.

Of note, finalizing the action grid may take more time than what is available during a single appointment. The action grid should be accessible and shared across the whole care team, as defined by family preferences.

If it supports the learners’ goals and time permits, use the activity from case study #1 to guide learners through a clinical scenario using the action grid.

Allow learners to discuss in small groups prior to sharing a few examples with the larger group.
Returning to the case study example, ask the learners to think about how these tools can be used to measure and address the gaps in care that were identified.

A structured approach to defining roles and responsibilities is essential, whether it is for patients with chronic and complex needs or those with straightforward and noncomplex needs. The tool featured on this slide can be adapted for nonmedical interactions as well (e.g., behavioral health or social service).

The action grid is cocreated with the patient and the family or caregiver. It assures clarity and transparency across all members of the care team. It also specifies a desired goal, necessary activities, a timeline, and the accountable entity. The action grid template was created as a result of family reports about how to reduce fragmentation of care as part of the project that created the PICS instrument. Experience has since revealed that health care team members also find this tool useful for essentially the same reasons as families.
Ask learners to reflect on their experiences as a care team member and/or family member.

These questions are from the Pediatric Integrated Care Survey (PICS). Feel free to use other measures from the PICS if they are more relevant to a case study that has been adapted.

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**Ask the learners to consider how they would operationalize the following phases for this particular case:**

- **Phase 1: Family outreach/engagement**
  The family was invited and provided with a thorough description of what a care coordination intervention could do to help them, and they agreed to participate.

- **Phase 2: Family and team pre-visit work**
  An assigned care coordinator reached out and learned that the family had no means of transportation, the father had no work leave time, and their English was very limited. They would require the following supports to ensure a successful period of care coordination: a Medicaid cab, a car seat, a specific dialect translator, and a visit timed to the father’s schedule because he does the communication for the family.

- **Phase 3: Population-based teamwork**
  The team members shared insights into Burmese culture and addressed the interventions needed to help the family attend a planned care visit (transportation, interpretation, safety, etc.). The team members reviewed the medical record and other documents and began to populate the medical summary.
The 10 steps found on this slide are foundational for ensuring a broad, strategic approach to implementing a shared plan of care.

This training session has addressed ideal elements of care coordination in high-functioning clinical teams, potential gaps in clinical practices, and practical strategies and tools for achieving AAP recommendations for care coordination.

The content covered thus far was intended to equip the learners with concrete ideas for implementing needed care coordination activities... tomorrow!

Now, it is time work on developing an action plan. [hand out action plan worksheet]

Ask the learners to reflect as a team (or individually) on their needs assessment from the beginning of the training and some of the strategies and tools that have been discussed.

Ask learners to identify 1 short-term goal (within 7 days) and 1 long-term goal (within 90 days) they have to improve care coordination in their practices.

Share the following mnemonic for SMART goal setting: goals should be Specific, Measurable, Achievable, Relevant, and Time-bound.
Now, ask learners to consider the following questions for each goal:

- What barriers do you anticipate?
- What is your specific plan to achieve this goal?

Considering these types of questions have been shown to improve transfer of training to the work setting and to increase likelihood of follow-through on goals.

Invite 3 to 4 participants to share their goals and action plans with the large group and to obtain feedback.

Then, discuss follow-up.

Consider:

- Having teams mail a letter within a defined timeframe to themselves with a copy of this worksheet.
- Having teams email a supervisor, director, or other identified leader to ensure accountability and to arrange a check-in.
- Arranging a follow-up phone call with the module facilitator.

The facilitator should get a sense of how the diverse group of learners has reacted to the dynamic of the session, as well as whether the participants have been able to integrate the content into their cognitive framing.

Encourage the group to reflect on the following:

- How can you begin to implement care coordination in your work in the next few days?
- What are some drivers that will encourage broad adoption?
- How can outcome measurement be implemented to assure sustainability?
What can be done to ensure clear communication of the patient’s and family’s needs and planned care with a clear timeline and responsibility for important tasks?

What practices support reliable and bidirectional information sharing among members of the health care team so that nothing falls through the cracks across transitions in care?

**Note to the facilitator:** This module includes a clinical scenario that can be used to illustrate practical ways to operationalize the above recommendations. This scenario can be adapted or a new scenario can be developed that resonates with the participants. For example, instead of having participants place themselves in the shoes of a pediatrician or other physician, they could discuss the case of a subspecialist or allied health provider who is seeking to develop recommendations and communicate them to primary care, community agencies, or school. Ensure the case has the following elements:

- Patient characteristics (What types of patients do the participants see? Is there a particular disease process or functional challenge commonly faced among the participants?)
- Clinical setting (In what setting are patients typically seen? Is it an interprofessional clinic, private practice, specialty consultant service, or community agency?)
- Need(s) to be addressed outside of the clinical setting (This may include a subspecialty referral that is being placed for a clinical question, a follow-up required with a pediatrician or other physician, or a concern raised in a school or community setting or by a behavioral health clinician.)

Independently read and reflect on the following case then discuss it in your small group. After 5 minutes, we will debrief as a larger group.
Eric

Eric is a 12-year-old boy with sickle cell disease who had a recent ischemic stroke, which has led to the development of a seizure disorder. You coordinate Eric’s care in the primary care clinic and are reviewing his case between visits. He is already followed in the general neurology and sickle cell hematology clinics. At his last neurology appointment, transferring recommendation was made to transfer Eric’s care to a pediatric stroke team at the local tertiary care center. You also see that Eric’s mother called the clinic last week, expressing concern that Eric’s learning difficulties have worsened at school, and you recognize that his individualized education plan from school needs to be updated.

- Who are the team members that need to come together to best coordinate Eric’s care?
- What transition is occurring?
- What needs and care goals can you identify?
- What actions will you take to coordinate Eric’s care to ensure a smooth transition for Eric and his family across multiple settings?
- What challenges might you face in this process?
  
  Probe: Who are the new members on Eric’s team? How will you communicate these roles to the family?

Note to the facilitator: As small groups discuss their responses, consider offering the following probing questions to stimulate discussion:

- How will you communicate with Eric’s family regarding the new membership and roles in his health care team?
- How will you share information between members of the health care team?
- What tools or resources might you need to best assist Eric and his family?

After 5-10 minutes, debrief in a larger group. Write 2 headings on the board: “Challenges” and “Actions.” Ask each small group to share their “headlines”—1 or 2 key points that they discussed or key questions that they had.
Actions may include:

- Notify Eric's family of the recommendation to refer him to a stroke clinic.
- Send the referral to the stroke clinic administration with a recommended time frame.
- Contact the family to ensure the school is aware of Eric's medical condition and risks, and communicate with the clinic nurse to ensure that any medications needed at school have an updated medication order.
- Reconvene a meeting with Eric's school team and advocate for a reevaluation to be completed or financially supported through the school. Consider exploring whether having the assessment covered by medical insurance is a feasible and/or faster option.
- Explain to Eric's family exactly who their new health care team is (pediatrician, neuropsychologist, administrative assistant, nurse, etc.) and who to contact for potential issues (i.e., Who will manage fevers or urgent care needs? Who will prescribe and monitor each medication? Identify the need for a fever action plan in the care plan, outlining steps to initiate, who to call, and when to take Eric to the emergency department for a fever or pain crisis.)
- Develop and update a care plan for Eric. Include the names, roles, and contact information for each care team member. (Decide who is responsible for updating and managing the care plan among the multiple partners involved in Eric's care.)
- Ensure the care plan is accessible to all members of the health care team (i.e., in the electronic health record and patient or family portal and give a hard copy to the family).
- Advise the family that if they have not heard from the stroke program administration in 2 weeks, for example, they should contact the clinic directly.

  ~ Tell the family that this type of action is an example of contingency planning—outlining steps to be taken if expected results do not occur and preparing for alternative outcomes to ensure immediate and appropriate follow up of potential issues.

  ~ Also, highlight the importance of closing the loop on this referral—make a plan to reconnect with the family or clinic to ensure the appointment was made and attended.
Challenges may include:

- Ensuring Eric is seen by the stroke team in a timely fashion and establishing a mechanism to follow up on this
- Maintaining communication with Eric and his family so they are aware of the transition to the stroke clinic, understand the roles of the new care team members, and understand who is responsible for managing each potential health issue
- Developing a comprehensive care plan and comanaging with care team members in different health care settings
- Identifying a point person to coordinate care team member roles and follow up on action items
- Ensuring accessibility of the care plan—forms of communication that are reliable and secure
- Communicating with Eric’s school and arranging for a neuropsychologist evaluation to inform a new individualized education plan
- Ensuring the care plan is updated consistently and accurately, reflecting all of the care by Eric’s care team

Didactic

Slide: Coordinating Care Across Transitions

Transitions in care are frequent! Each transition should be accompanied by a thoughtful handoff to ensure important information isn’t lost or forgotten.

- Handoff: The transfer of pertinent information between members of a patient’s care team, enabling the person to safely assume responsibility for some aspect of care.
- Handoffs occur in multiple contexts:
  ~ To and from the community and hospital
  ~ To and from an on-call physician or nonphysician clinician
  ~ To and from a consultant
  ~ To and from a medical subspecialist or surgical specialist on another service
  ~ To and from home care services
  ~ From pediatric to adult care team members or settings

Facilitator notes: This training session has addressed suggested actions that the learners can take to their practice to facilitate smooth transitions in care for patients like Eric. Here are some tools that can help the learners implement these actions...tomorrow!
**Slide: Tools for Ensuring Smooth Transitions in Care**

- Collaborative consults: outlining the purpose of a visit, relevant clinical information, requested referral relationship, and timeline
- Care mapping: creating a visual representation of a patient’s care team members in collaboration with the family, discussing roles and who-to lines of communication
- Action grid: development of an action item grid with the family outlining the overall care goal, task to be completed and person responsible for completing the task, timeline for completion, and contingency plan
- Care plan: a comprehensive, integrated, shared, and dynamic document that incorporates a summary of medical issues, care team membership, prioritized goals of care, and necessary actions to achieve the goals

*Facilitator notes:* Demonstrate how 2 of these tools could be used in Eric’s case.

---

**Slide: Collaborative Consults**

**Pediatric Stroke Program Referral**

<table>
<thead>
<tr>
<th>Reason for Visit</th>
<th>Relevant Clinical/Psychosocial Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-time evaluation for multidisciplinary care following ischemic stroke in a child with sickle cell disease.</td>
<td>12-year-old boy with history of sickle cell disease. Developed a seizure disorder following ischemic stroke, has been followed in general neurology program up to this point. Learning difficulties noted at school.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requested Referral Relationship</th>
<th>Question to Be Answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ One-time consultation</td>
<td>What surveillance is required given Eric’s history of ischemic stroke?</td>
</tr>
<tr>
<td>☐ Comanagement/shared care</td>
<td></td>
</tr>
<tr>
<td>☐ Subspecialty-based management</td>
<td></td>
</tr>
<tr>
<td>✗ To be determined</td>
<td></td>
</tr>
</tbody>
</table>
Case-Based Learning

Slide: Action Grid

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action</th>
<th>Who is responsible</th>
<th>Timeline</th>
<th>Contingency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure appointment management and preventative care for stroke and its sequelae</td>
<td>Transfer of care to the pediatric stroke program</td>
<td>PCP</td>
<td>Referral sent on Jan 2nd requesting an appointment within 4 weeks.</td>
<td>If family has not received a call from the stroke clinic in 2 weeks, they should call the clinic directly at (111) 111-1111. Clinic administrative assistant will contact family in 2 weeks to follow up on referral.</td>
</tr>
<tr>
<td>Support Eric’s learning at school</td>
<td>Neuropsychological evaluation to inform a new IEP</td>
<td>Social worker</td>
<td>Will establish school contact Jan 9th and convene school team meeting to plan reevaluation.</td>
<td>Social worker will contact family the week of Jan 16th to coordinate meeting and share care plan with school.</td>
</tr>
<tr>
<td></td>
<td>Ensure school has updated medical information</td>
<td>Clinic nurse</td>
<td>Will call school the week of Jan 9th.</td>
<td>Nurse will call family to confirm when contact has been made.</td>
</tr>
<tr>
<td>Update/maintain care plan for Eric with input from all team members and family</td>
<td>Incorporate plans/recommendations from all specialists and PCPs, IEP components, specialists into care plan</td>
<td>Clinic nurse/PCP</td>
<td>Will collect this input prior to appointment below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Engage patient and family to obtain input and identify needs and their goals</td>
<td>Clinic nurse/PCP</td>
<td>Appointment arranged for week of Jan 16th to discuss care plan.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distribute care plan to members of the health care team.</td>
<td>Clinic nurse/PCP</td>
<td>Nurse and PCP will send care plan to the patient portal and email/mail a copy to parents, school, specialists for review and to community recreation center after above appointment.</td>
<td></td>
</tr>
</tbody>
</table>

What practices will YOUR TEAM use to share information and coordinate patient care across transitions?

We have discussed 2 tools that you can use starting tomorrow:

- The collaborative consult
- The action item grid
Case-Based Learning

CASE STUDY #2

Care Planning and Coordinating Care Across Transitions

**AAP policy statement recommendation #1:**
Use and create mechanisms for patients/families to learn the skills they may need to be partners in their own care and in decision-making for optimal care coordination.

**AAP policy statement Recommendation #2:**
Ensure that the patient’s and family’s needs for services and information sharing (eg, care planning) across people, systems, and functions are met via (a) formal assessments, (b) infrastructure (eg, teams), and (c) tracking (eg, registries); this is crucial in operationalizing care coordination.

**AAP policy statement recommendation #4:**
Use and develop efficient and accredited health information systems and information technology advances to foster successful transfer of information; to support collaborative communications between patients, families, and the care team; and to facilitate shared decision-making (eg, developing and using care plans).

**AAP policy statement recommendation #5:**
Use care coordination across transitions between entities of the health care system (eg, between and among patient care teams, across settings, between caregivers, and between health care organizations) and with transitions over time (eg, across the life span, between episodes of care, across trajectory of illnesses).

**AAP policy statement recommendation #6:**
Ensure that comanagement and communication occur among specialists and primary care providers. This care model requires reciprocal and bidirectional communication (eg, secure e-mail, phone call, note, fax), which can be augmented, but not replaced, with health information technology.

**AAP policy statement recommendation #7:**
Ensure ongoing education of elements of care coordination and the medical home for practicing physicians, nurse practitioners, physician assistants, nurses, medical students, resident trainees (across disciplines), mental/behavioral health care practitioners, social workers, and other health care professionals via specific training/curricula, continuing medical education programs, and publications.

**AAP policy statement recommendation #10:**
Understand and use new care coordination codes (99487-99489; 99495-99496) and advocate for payment of these care coordination services by payers.

- What can be done to facilitate shared decision-making for families and foster care integration?
- How should care team members engage patients and families in care planning and shared decision-making?
- What strategies and tools (eg, health information technology) can care team members use in comanagement and to ensure an effective transition of care?
- What billing codes can be used to help support the time spent in coordinating care in practice?

Independently read and reflect on the following case then discuss the case in your small group. After 5 minutes, we will debrief as a larger group.
Lucia
Lucia is a 14-year-old female with spina bifida, who you have cared for since birth. You and your team are the primary care clinicians and work closely with her specialty team, including orthopedics, urology, neurology, and physical medicine and rehabilitation. Her mother, a single caregiver, has been forced to move several times due to housing instability and financial challenges. You have started to address Lucia’s adolescence, including learning self-care, in recent visits to allow her independence at school and in the community. Yesterday, her mother left a message for you indicating concern about a recent hospitalization and new urology team. She stated Lucia was recently admitted and there were “changes being made.” Uncertain of the new plan and new medications, she also stated they had not received the new catheters from the medical equipment company that were ordered at the last urology visit.

- Discuss the team members who are needed to best coordinate care for Lucia.
- Identify some of the psychosocial issues that need to be addressed with Lucia’s mother as one of the care team members.
  Probe: Think about family-centered care and building trust.
- What aspects of care transition need to be addressed for Lucia?
  ~ Transition to adult-oriented systems (self-care)
  ~ Transition of care across settings, from hospital to home
- What is the biggest challenge in coordinating her care?

Facilitator notes: As small groups discuss their responses, consider offering the following probing questions to stimulate discussion:

- Social determinants of health have a profound impact on health outcomes. Some social determinants of health include poverty, literacy, food and housing security, environmental risks, health insurance status, immigration status, interpersonal and neighborhood safety, energy security, and transportation needs.
- What role are the social determinants of health playing in caring for Lucia and her family?
- How can you ensure medical needs, community partners, and identified resources are part of the care team and care planning? Think about the roles of the hospitalist team, discharge planning team, and medical equipment providers.
- What tools can foster comanagement and ensure communication across settings? Think about care planning, patient portals, shared decision-making, and transition of care planning.

After 5-10 minutes, debrief in a larger group. Write 2 headings on the board: “Challenges” and “Actions.” Ask each small group to share their “headlines”—1 to 2 key points they discussed or key questions they had.
Case-Based Learning continued

**Actions may include:**

- Meet with Lucia’s mother to better understand her housing and financial challenges and identify resources that may help her:
  ~ Connect her to community partner(s) and resources that can assist her or a social worker who can discuss potential options with her. Be sure to follow up to confirm that this connection occurred to close the loop.
  ~ Consider employing a screening tool for social determinants of health to facilitate a proactive approach with patients and families. Recognize that families may be more likely to disclose financial struggles and challenges related to social determinants of health on paper versus face-to-face screening.

- Contact the urology group to better understand any changes made and plans for follow-up, necessary equipment, and medication changes. Be sure to check that Lucia’s mother is aware of these plans and demonstrates an understanding of the recommendations.

- Work with Lucia’s mother to set goals for Lucia’s care and ensure her understanding of Lucia’s medications, care, and equipment and encourage her understanding of shared decision-making, both in your office and with other care team members.

- Develop and maintain a care plan for Lucia that includes all of her specialist information, medical equipment providers, therapists, IEP information, community nursing services, medications, community providers, school/educational information, names, phone numbers, home nursing information, insurance, and supplies (e.g., size, amount, and type of formula).
  ~ Be sure that Lucia and her mother review and inform the content of the care plan prior to finalizing the content.
  ~ Ensure that the role of each care team member is outlined in the care plan so Lucia and her mother know who to contact for issues as they arise.
  ~ Work on reconciling the home nursing orders for Lucia with your care plan, ensuring accuracy, parent goals being met, and smooth communication about Lucia’s needs.
  ~ Track your time coordinating care, and bill care coordination codes (99487–99489) as outlined in the contracts with Lucia’s insurance carrier.

- Provide Lucia and her mother with several hard copies of Lucia’s care plan. Fax or email Lucia’s care plan to the specialists involved in her care, the appropriate contacts at her school, her therapists, and her medical equipment providers.

- Add Lucia’s care plan to her patient portal to make it easily accessible for her mother.
  ~ Ensure that Lucia’s mother understands how to log in to the patient portal and access it via her smartphone, and when Lucia is hospitalized, how to access the patient portal in community settings and communicate the care plan across settings.

- Work with Lucia and her mother on transition care planning for adult-oriented care. Consider using a self-management tool to begin to teach Lucia about self-care and spina bifida and to assess her readiness to take a more active part in her health care.

- Contact the hospitalist team managing Lucia during a hospital admission, and have your care coordinator connect with the discharge planning team to better understand the events that occurred during her admission, recommendations, and her discharge plan.
Case-Based Learning
continued

- Talk with the hospital team to determine the optimal process for achieving bidirectional communication (including phone calls and sharing of information) when your patients are admitted to the hospital.
  ~ Discuss roles, team members, and information sharing, including care plans and reasons for admissions.
  ~ Consider implementing post-discharge follow-up calls for all of your patients following hospitalizations to assess families’ understanding of discharge instructions, necessary medications, prior authorizations, and need for follow-up visits.
  ~ Establish a standard of care for scheduling patients for post-hospitalizations within 7 to 14 days.
  ~ Familiarize yourself with the required communication, documentation, timing of post-discharge visits, and billing codes for post-hospital discharge visits (99495 and 99496).
- Explain to Lucia and her mother who the members of Lucia's health care team are (physicians, nonphysician clinicians, mental health practitioners, community partners) and who to contact for potential issues (ie, Who will manage fevers or urgent care needs? Who will prescribe and monitor each medication? Who will order and manage equipment?). Be sure this is clear on Lucia's care plan.
- Set up a meeting with the top 3 insurance carriers to discuss payment for codes associated with care coordination and hospital follow-up. If these codes are not included in your current contract, explain the amount of communication that is required by you and your team for care coordination and hospital follow-up. Discuss possible benefits for patients, your practice, and the payer, and payment structures.
  ~ Transition of care codes (99495 and 99496)
  ~ Care coordination codes (99487–99489)
- Work on regular education sessions and, possibly, a staff retreat on patient- and family-centered care, team building, huddles, transition of care planning and care to adult-oriented systems, and the role of care coordination. Be sure to include physicians, nurse practitioners, physician assistants, nurses, medical students, resident trainees (across disciplines), mental/behavioral health care practitioners, social workers, community health workers, parent partners, and community partners.
- Engage parent partners in your practice to give feedback and participate in care coordination education for your staff supporting the critical role of family-centered care.
- Advise Lucia’s mother that if she has not received her new catheters within 24 hours or has any questions about medication administration, she should contact the clinic directly.
  ~ Highlight this type of action as an example of contingency planning—outlining steps to be taken if expected results do not occur and preparing for alternative outcomes to ensure immediate and appropriate follow-up of potential issues.
  ~ Instruct Lucia’s mother to make a follow up appointment with the urology office and to contact your office with any issues. Ensure someone from your office is following up with her.
Challenges may include:

- The social determinants of health challenges facing Lucia’s mother, including housing and financial instability with the lack of handicapped accessible housing, and lack of resources, time, and social workers in practice.
- Understanding and launching the transition to adult-oriented systems with Lucia and her mother, and addressing self-care.
- Getting team buy-in across the practice for care coordination training and understanding roles and definitions.
- Working with insurance companies on coding and payment for care coordination and transition of care.
- Ensuring adequate communication with the hospitalist team and the specialists caring for Lucia.
- Ensuring that Lucia’s mother understands shared decision-making and can advocate for herself.
- Developing a comprehensive care plan and comanaging with care team members in different health care settings.
- Reminding Lucia’s mom about the availability of the care plan in the electronic patient portal.
Didactic

Slide: Social Determinants of Health
- Conditions in the places where people live, learn, work, and play that can inform their health risks and outcomes
- The role of patient- and family-centered care and trust
- Examples:
  - Housing
  - Access to food
  - Transportation
  - Exposure to crime, violence, domestic violence, interpersonal violence
  - Social support
  - Access to educational, economic, and job opportunities
- Identify and work with community partners.
  - WIC, housing resources, HUD
- Use tools designed for social determinants of health
  - Food insecurity
  - Adverse childhood events (urban)

Slide: Care Coordination Tools
- Care planning list of components for a care plan
- Instructions for patient access to the patient portal
- Patient huddles
- Shared decision-making for families

Slide: Transition to Adult-Oriented Systems Tools
- Six core elements of transition
  - Transition policy (Facilitator note: Have teams work through what their ideal transition policy might include)
  - Transition index for practices
- Self-management tools/transition readiness assessment tools
  - On Traq
  - Assess caregivers and youth when appropriate
  - Address guardianship and power of attorney when indicated
- Gottransition.org
Slide: Billing for Care Coordination Services and Transition of Care

CARE COORDINATION 99487–99490

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

99487: Used if a nonphysician staff member spends more than 1 hour over a 30-day period on care coordination

99488: Includes 1 hour of care coordination with a nonphysician and a face-to-face visit

99489: Used for 30-minute increments over the initial hour of care coordination.

TRANSITION BETWEEN CLINICAL SETTINGS 99495

Transitional care management services with the following required elements:

- Communication (direct telephone contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit within 14 calendar days of discharge

99496

Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face within 7 calendar days of discharge

Slide: Tools for Ensuring Smooth Transitions in Care

- Pre-encounter handoff: outlining the purpose of a visit, relevant clinical information, and requested referral relationship and timeline
- Care mapping: creating a visual representation of the patient’s care team members in collaboration with the family and discussing their roles and who-to lines of communication
- Post-encounter handoff: development of an action item grid with the family outlining the overall care goal, task to be completed, who is responsible, timeline for completion, and contingency plan
- Care plan: a comprehensive, integrated, shared, and dynamic document that incorporates a summary of medical issues, care team membership, and prioritized goals of care and actions to achieve them

Facilitator note: Demonstrate the use of 2 of these tools in Lucia’s case.
Slide: Action Grid—Develop Care Plan Components for Lucia

Facilitator note: Have participants list core elements of the care plan.

Some ideas are listed below: LUCIA CARE PLAN

**Essential Fields/Components**
- Name
- Date of birth
- Insurance (primary and secondary)
- Phone number and emergency contact information
- Parent or caregivers’ names
- Diagnoses
- Medications
- Allergies with doses
- Specialists’ names and phone numbers
- Hospitalizations and surgeries
- Child or youth strengths
- Family goals for their child

**Support Services**
- Equipment (if applicable, catheters, tracheostomies, gastrostomy tubes, wheelchair, orthotics, etc.)
- Therapies (speech, PT, OT)
- School/child care/IEP
- Home care and/or nursing services
- Pharmacy
- Mental health agencies and providers
- Dental care
- Community agencies
- Transition care plan elements, if applicable

**Secondary Elements**
- Past medical history and review of systems
- Communication devices
- Home modifications
- Activities of daily living (challenges, toileting, hygiene)
- Respite
- SSI
- School information (grade, teacher, IEP, IFSP)
- Feeding, diet, nutrition
- Housing and transportation needs
- Hearing and vision services

**Alternative Medicine, Palliative Care**


Accessed May 16, 2019
