

Using Shared Plans of Care for Effective Care Coordination

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American Academy of Pediatrics-VT, Chapter President
Physician's Computer Company User's Conference

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Objectives

- Define “Effective Care Coordination”
- Why Shared Plans of Care?
- Achieving Shared Plans of Care
- PCC Care plan function
- Future ideas?

**hagan
rinehart
connolly
pediatricians** P.C.

Check out our new location

128 Lakeside Ave. Suite 115 Burlington, VT
t: (802)860-1928

welcome to our new medical home!

Doctors Hagan, Rinehart and Connolly are happy to announce our new location in Burlington's South End. New patients and transfer patients are welcome. We hope to see you soon!



Our Medical Home

- Three pediatricians: Dr. Hagan, Dr. Rinehart, Dr. Connolly
- Two pediatric nurse practitioners: Maryann Lisak and Ashley Boyd
- One main Care Coordinator (RN) Kristy
- Office manager, accounts manager, receptionists
- Six additional part time nurses, two medical assistants
- ~4000 active patients
- Insurance mix: 35% Medicaid, 55% private ,<5% uninsured

Care Study #1

- 13 year old boy with autism, non-verbal, self injury, polydipsia
- Parents struggling with bolting, overall safety
- Middle school unable to educate or keep safe
- Medical issues of skin infections, enuresis, sleep dysfunction, puberty, growth
- Family above and beyond capacity of most families to deal with this at home

Coordinated Care??

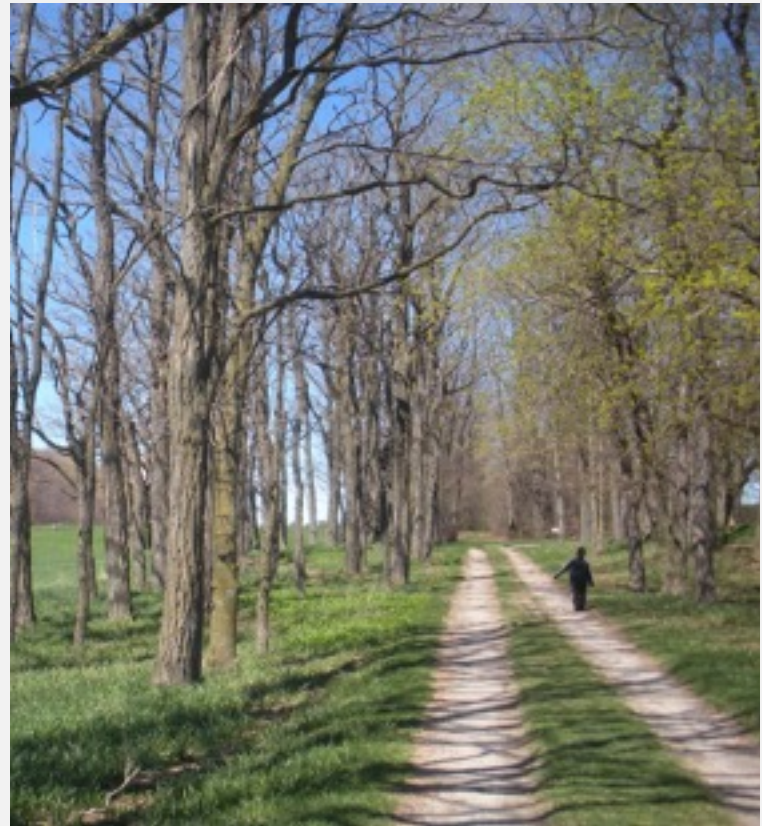


Mind the Gap

- Proactive
- Timely
- Accurate
- Problem Solving
communication

Family Centered Care

Family centered care is about meeting families where they are, and helping them get where they want to go...



Why is A Family- Centered Medical Home Important to *family*?



- Opportunity for the family to build a trusting and collaborative relationship with the pediatrician and office staff.
- Care coordination provides smooth facilitation among all members of the child's care team including family, specialists, pharmacy staff, community and school services.
- Comprehensive source of complete patient medical history

Care Coordination

- Is the set of activities that happens between
 - Visits, Providers and Hospital Stays

E-mails, prior authorizations, communication between providers (community and subspecialists), insurers, prescriptions, equipment needs, in home care providers, access to community resources



Care Coordination

“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 care giving capabilities* of families...”



Making Care Coordination A Critical Component of the Pediatric Health System: A Multidisciplinary Framework, Antonelli, McAllister, and Popp, The Commonwealth Fund, May 2009

Why? CMHI National Outcomes Study

Cost/Utilization

Medical Home Index:

43 Practices, 7 plans/5 states

- Higher overall MHI score or higher domain scores for care coordination, chronic condition management, office organizational capacity
 - Lower hospitalization rates
- Higher Chronic Condition Management domain scores
 - Fewer ER visits

Cooley, McAllister, Sherrieb, Kuhlthau,
Pediatrics, July 2009



Patient and Family Centered Care Coordination:

A Framework for Integrating Care
for Children and Youth Across
Multiple Settings

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

**Patient- and Family-Centered Care Coordination: A Framework for Integrating
Care for Children and Youth Across Multiple Systems**
COUNCIL ON CHILDREN WITH DISABILITIES and MEDICAL HOME
IMPLEMENTATION PROJECT ADVISORY COMMITTEE
Pediatrics 2014;133:e1451; originally published online April 28, 2014;
DOI: 10.1542/peds.2014-0318

The online version of this article, along with updated information and services, is
located on the World Wide Web at:
<http://pediatrics.aappublications.org/content/133/5/e1451.full.html>

Medical Home for Non-CSHN

“The Value of the Medical Home for Children Without Special Health Care Needs,” *Pediatrics*, December 2011

- Decreased outpatient sick visits
- Decreased emergency department sick visits
- Increased odds of “excellent/very good” child health
- Increased health promoting activities such as being read to daily, reported helmet use, and decreased screen time



Foundation of Medical Home

- AAP policy statement (reaffirmed, 2008)
- Provision of family-centered care through developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life
- Acknowledge family stories and information at every step along the way
- Quality improvement, practice transformation and the AAP includes family and consumer perspectives

5 Key Elements of Highly Effective Care Coordination

The Concept

1. Needs assessment for care coordination and continuing care coordination engagement
2. Care planning and communication
3. Facilitating care transitions
4. Connecting with community resources and schools
5. Transitioning to adult care

Antonelli et al (2009); Rinehart (2014)

The Person



PFCC Principles

Dignity & Respect

Providers listen to and honor patient and family perspectives, choices and incorporate their values, beliefs

into care delivery.



Collaboration

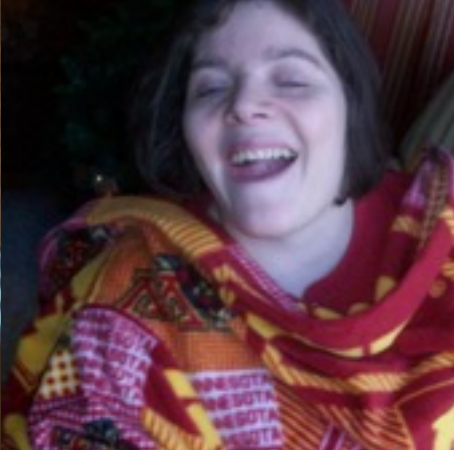
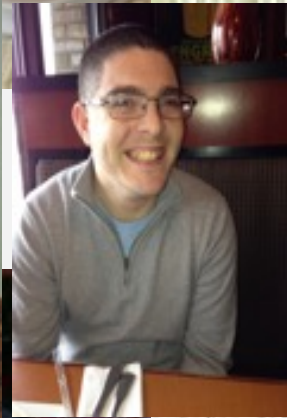
Patients, families and providers collaborate in policy, program development, implementation and care delivery.

Information Sharing

Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making

Participation

Patients & Families are encouraged and supported to participate in care and decision making.



“Care Plans”-recommended

Organization	Care Plan Specifics/Called for Recommendations
National Committee for Quality Assurance (NCQA)	Develop individual care plan includes treatment goals reviewed and updated at each visit
Centers for Medicare and Medicaid (CMS) Meaningful Use	“Visit summary of care” Mandates (ACA) care planning components “Continuity of Care Record”
National Quality Forum (NQF)	Plan of Care: Actively tracks up-to-date progress towards patient goals
AAP Care Coordination Policy Paper, 2002	Plan of care developed by family, youth, physician shared with other providers, agencies, and organizations involved with that patient’s care
IHI Care Coordination Model	A “planned visit” contains assessment, review of therapy, review of medical care, self-management goals, problem solving and a follow-up plan

Jeanne McAllister, et.al, “Achieving a Shared Plan of Care for Children and Youth with Special Health Care Needs,” supported by Lucille Packard Foundation for Children 2014

PCMH cross-walk

- PCMH 2 Team-based care
 - Element B - Medical Home Responsibilities
 - 2.B.1 - The practice is responsible for coordinating patient care across multiple settings
 - Element D - The Practice Team (Must Pass Element)
 - 2.D.2 - identifying the team structure and the staff who lead and sustain team based care
 - 2.D.3 - Holding scheduled patient care team meetings or a structured communication process focused on individual patient care (Critical Factor)
 - 2.D.5 - Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change

PCMH cross walk

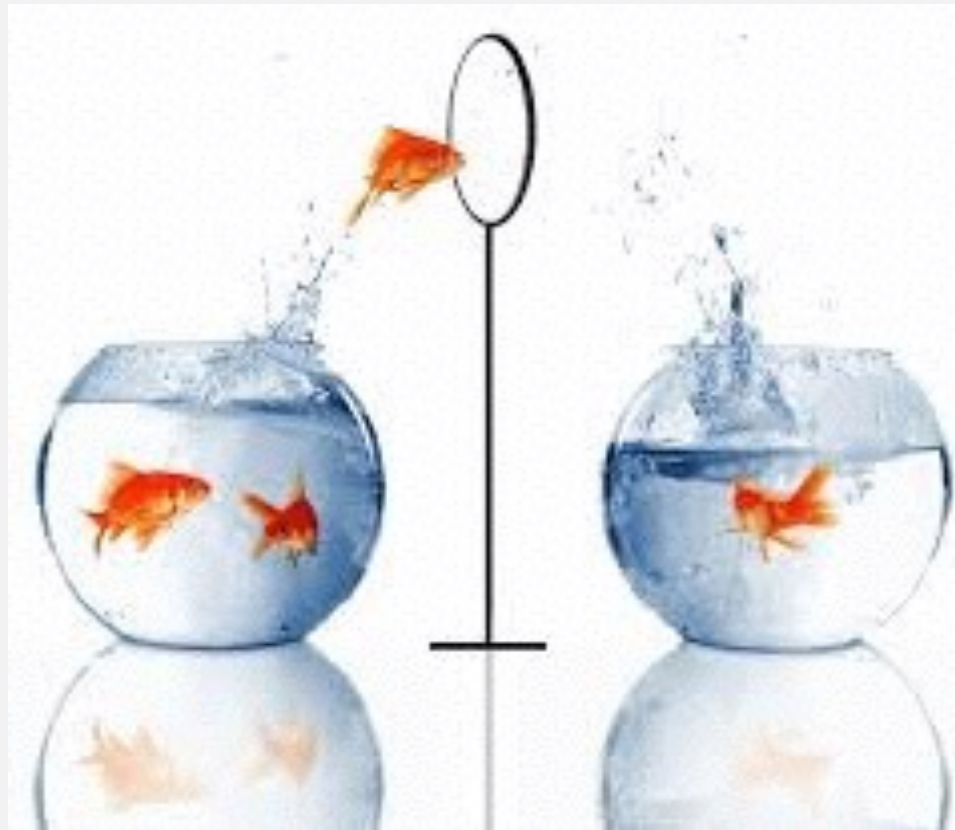
- PCMH 5 Care Coordination and Care Transitions
 - Element C:1 - Proactively identifies patients with unplanned hospital admissions and emergency department visits
 - C:2 - Shares clinical information with admitting hospitals and emergency departments
 - C:3 - Consistently obtains patient discharge summaries from the hospital and other facilities
 - C:4 - Proactively contracts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit
 - C:5 - Exchanges patient information with the hospital during a patients' hospitalization
 - C:6 - Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners
 - C:7 - Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care

PCMH crosswalk

- PCMH 6 Performance Measurement and Quality Improvement
 - Element B - Measure Resource Use and care coordination
 - 6.B.1 - At least two measures of care coordination
 - Element C - Measure Patient/Family Experience
 - 6C: 1 - The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:
 - * Access
 - * Communication
 - * Coordination
 - * Whole person care/self-management support
 - Element D - Implement Continuous QI (Must Pass Element)
 - 6D:3 - Set goals and analyze at least one measure from Element 6:B
 - 6D:4 - Act to improve at least one measure from Element 6:B
 - 6D:5 - Set goals and analyze at least one patient experience measure from Element 6:C
 - 6D:6 - Act to improve at least one patient experience measure from Element 6:C
 - Element E - Demonstrate Continuous Quality Improvement
 - 6.E.3 - achieving improved performance on one utilization or care coordination measure

-

Hoop Jumping



Is Being a PCMH Good Enough?

“Comparison of Individual –Level Versus Practice –Level Measures of the Medical Home”

- Each practice had an NCQA level (2 at Tier 3, 3 at Tier 2)
- Of 180 parents only 52% had MH according to NSCH
- No significant association between family perception of medical home and being a practice wide medical home

Change Concepts for Practice Transformation

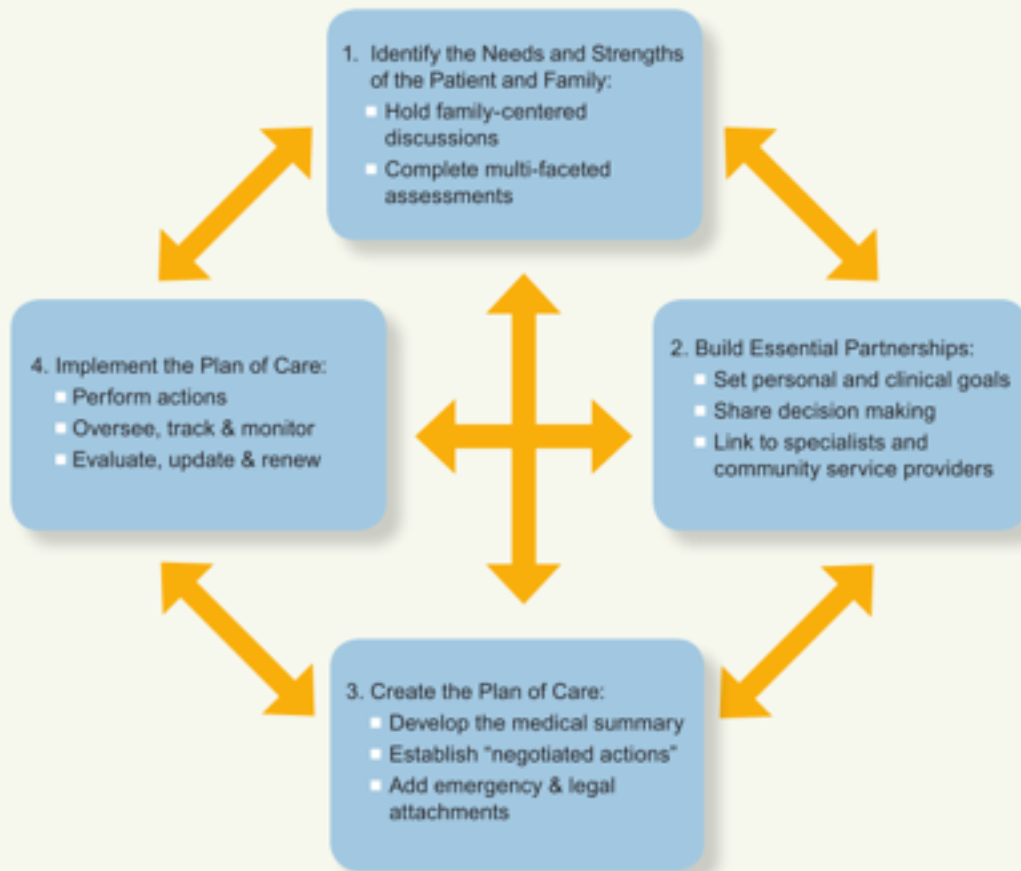


Straddling 2 worlds

- Old World: Fee-for-service
- New World: Get paid enough PMPM
- Old World: 99215, prolonged service
- New World: Care coordination supported by funds directed toward the practice
- Old World: Physician: patient dyad
- New World: Team based, integrated care

Pediatric Care Coordination Learning Collaborative

Achieving a Shared Plan of Care



Following the guidelines of the Lucille Packard Foundation's "Achieving a Shared Plan of Care Implementation Guide"

Purpose

Plan, implement and evaluate the impact of effective care coordination by working with

- Vermont's primary and specialty health care professionals
- Patients and their families
- Community-based, child-serving agencies and organizations

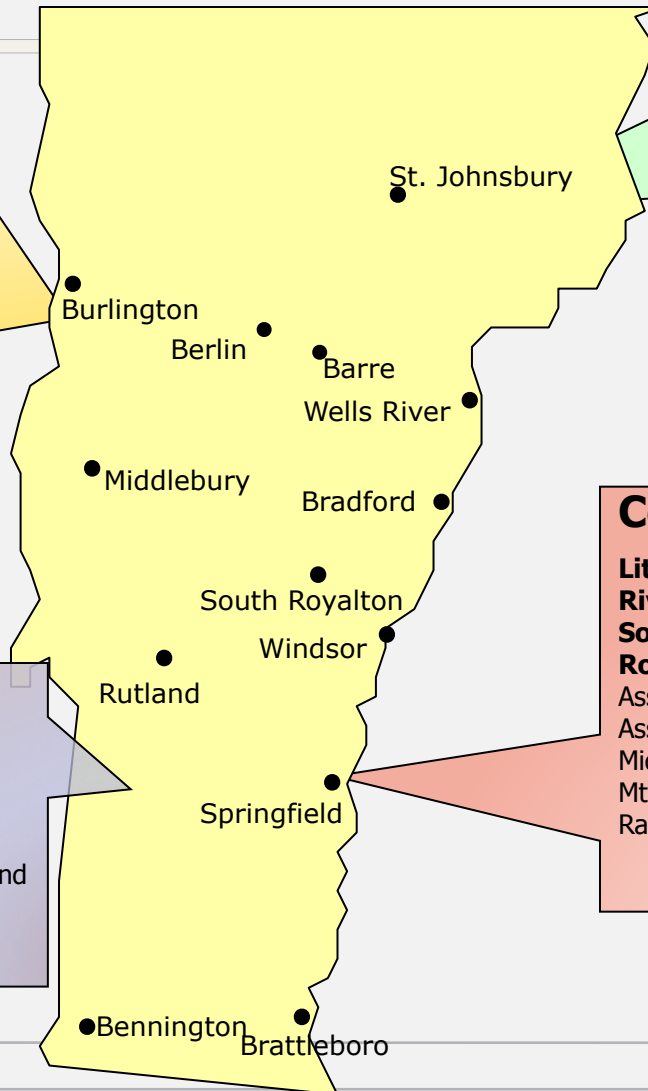
Pediatric Care Coordination Participating Practices

Northwestern Vermont

Hagan, Rinehart & Connolly Pediatricians, Burlington
Timber Lane Pediatrics, Burlington
Timber Lane Pediatrics, South Burlington
UVMC Pediatrics, Burlington

Southern Vermont

Green Mountain Pediatrics, Bennington
Brattleboro Primary Care, Brattleboro
Maplewood Family Practice, Brattleboro
Community Health Centers of Rutland Regional, Rutland
Just So Pediatrics, Brattleboro
Family Medicine Associates, Springfield



Northeastern Vermont

St. Johnsbury Pediatrics, St. Johnsbury

Central Vermont

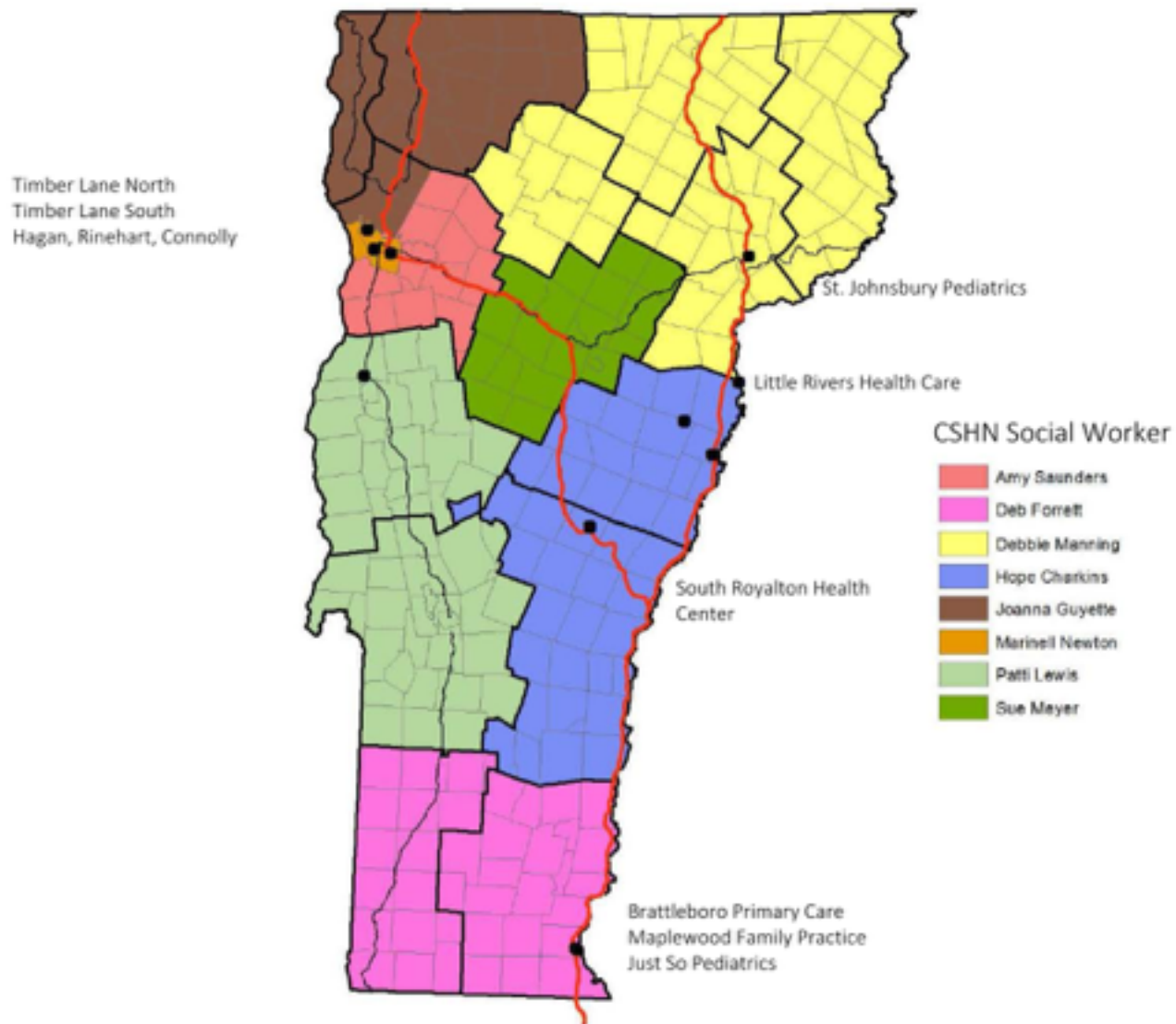
Little Rivers Health Care, Bradford & Wells River

South Royalton Health Center, South Royalton

Associates in Pediatrics* - Berlin, Berlin
Associates in Pediatrics* - Barre, Barre
Middlebury Pediatric & Adolescent Medicine
Mt. Ascutney Hospital & Health Center, Windsor
Rainbow Pediatrics, Middlebury

Family Health Partners

D70 Care Coordination Cohort #2 Practice Map



PARENTS' VOICES

NO CARE COORDINATION

- “There was no continuity. We would call the primary care office with a concern and they would say “Oh, you need to talk to your specialist about that.” We would call the specialist and they would say “Oh, you need to talk to your primary care doctor about that.” It was just back and forth all the time and the concerns never got addressed.”

WITH CARE COORDINATION

- “Now there is a sense that I’m being listened to – that his medical needs are being addressed. We have a plan with where we are headed, especially with the school, we know where we are going.”

Maier, Parent interview, March 6, 2014

Faculty All-Stars



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

- Jeanne McAllister, BSN, MS, MHA
- Supported by Lucille Packard Foundation for Children's Health-Children with Special Health Care Needs





Medical Home and Care Plans – they go together, you can't have one without the other!
-*Family*

Shared Care Planning Model



What is a Shared Plan of Care?

- A guide for moving care forward using a clear summary of information and a collaborative approach.
- Requires a family-centered, team-based, relational course of continuous action. The family has a clear contact point and access to their plan.



What is in a Shared Plan of Care?

- Includes: (as a comprehensive and integrated, concise and user-friendly set of information and set decisions)
- **•A Medical Summary**– which details child/ family demographic information; current medical care facts; lead team members and contacts; and core child and family knowledge including their personal preferences and goals.
- **•Negotiated Actions/Next Steps/Accountability:** highlights personal and clinical goals and joint strategies to address and /or achieve goals with timelines, responsibilities and accountabilities

Why Shared Care Planning?

- Care is fragmented
- Lacking coordination
- Information sharing across providers falls on the parents
- Families asking for:
 - Resource and system navigation
 - Team based care
 - Problem solving discussions

Principles for Successful Use of a Shared Plan of Care

Best results occur when:

1. Children, youth and families are actively engaged in their care.
2. Communication among their medical home team is clear, frequent and timely.
3. Providers/team members base their patient and family assessments on a full understanding of child, youth and family needs, strengths, history, and preferences.
4. Youth, families, health care providers, and their community partners have strong relationships characterized by mutual trust and respect.

Jeanne McAllister et.al, “Achieving a Shared Plan of Care for Children and Youth with Special Health Care Needs,” supported by the Lucill Packard Foundation for Children, 2014

Principles for Successful Use of a Shared Plan of Care

5. Family-centered “teams” can access the information they need to make shared, informed decisions.
6. Family centered care teams use a selected plan of care characterized by shared goals and negotiated actions; all partners understand the care planning process, their individual responsibilities and related accountabilities.
7. The team monitors progress against goals, provides feedback and adjusts the plan of care on an on-going basis to ensure that it is well implemented.

Principles for Successful Use of a Shared Plan of Care

8. Team members anticipate, prepare and plan for all transitions (e.g.early intervention to school; hospital to home; pediatric to adult care)
9. The plan of care is systematized; as a common, shared document; it is used consistently, by every provider within an organization, and by all providers across organizations.
10. Care is subsequently well coordinated across all involved organizations/systems

The Tools



Identify Population

- Youth with one complex chronic condition: Asthma, ADHD, Anxiety/Depression
- Children with complex medical needs
- Registry



HOMES score

Category	Criteria	Score
H-ospitalizations, ER visits, Subspecialty Visits (past yr)	1= 1 hospitalization,ED, specialist 2= 2 or >Hosp, ED, specialist	
O-ffice Visits, Phone calls, prolonged time for visits	1= 1-2 OV or MD/RN calls 2= 3 or more OV or MD calls	
M-edical Condition(s) (One or more diagnoses)	1= 1-2 conditions (no complications) 2= 1 or 2 conditions with complications or 3 or more conditions	
E-xtra Care and Services at MH, home, school, community setting	1= One service from list below 2=Meds, technology, therapeutic assessments/treatments/procedures, care coordination	
S-ocial Concerns	1="At risk" family/school/community concerns 2=Current/urgent complex social need	

Reminders

Medical Summary		Pebbles Flintstone 10 yrs, 1 mo 5/21/06		
Recent and Upcoming Appointments				
Last Visit: 07/17/16 (2d ago) Crusher				
Diagnosis: none				
Last Physical: 05/29/15 (1y 1m ago)				
Next Physical Due: 06/03/16 (6w 4d overdue)				
Scheduled Appointments: none				
Siblings				
Open Chart Dino Flintstone 4 yrs, 3 mos 03/29/12 M				
Reminders Modified 06/10/16				
Headed to regional soccer championships 10/11.				
Lost best friend to a neighborhood house fire in 12/10.				
Problem List Modified 06/10/16 Display: All Statuses ▾				
Status	Problem	Problem Note	Onset	Resolved
Resolved	Urinary Tract Infection (599.0)			03/12/10
Active	Obesity Exogenous (278.00)			
Active	Asthma Mild Persist (493.00)			
Allergies Modified 06/10/16 Display: All Statuses ▾				
Status	Allergy	Reaction	Onset	Resolved
Active	Allergy Cat Hair (477.8)			
PCC eRx Allergies Updated 07/19/16 10:11 AM				
Drug	Reaction	Onset		

Where to Start? Engaging Families:

During a Visit

Wow! This
problem list is
a mess!

Previewing the
Week Schedule

Doc, you may
not want to come
in on Tuesday...

Phone Calls
(discharges, family,
community)

My son is being
discharged
tomorrow from
Children's after
neurosurgery...

My child's
teacher says his
behavior is out
of control...

This family hasn't
responded to calls
from visiting
nurses for the past
month

Condition
Specific

I'm taking
control of
Asthma!

I'm taking
control of
Behavioral
Health!

Can Begin with:
Family, Patient, Community Partner,
or Health Care Professional

Implementing the Shared Plan of Care: Pre-Visit Planning

- Before you enter the room...



- Already have recent, relevant information
- Screening tests (ACT, PHQ9)
- An agenda from the family for today's visit
- Labs, radiology, specialist visit reports
- Follow up from community members (Vanderbilt's, therapists, subspecialists)

Work Flow for Care Planning

Team Person/Roles	Pre-Visit→ Preparation	Visit→ Caring Partnership interactions	After Visits→ Accountable follow through
Care Coordinator	Gathers recent information (recent labs, subspecialist notes, community provider updates) Identifies goals	Updates Care Plan Family/Personal Goals Medical Goals	Negotiate Next Steps
Youth/Family	Bring Questions? Share ideas Referrals?	Participates in Goal Setting	Negotiate Next Steps
Pediatric Clinician	Reviews communications Asks about goals Follows up w/ referrals	Assesses Needs Updates Care Plan	Negotiates Next Steps

Family Centered Assessment Tool



The form is titled "Family-Centered Care Coordination" in an orange header. It includes a section for "INSERT-Practice Name" and a logo of two blue figures holding hands under a sun. The form contains five numbered questions with checkboxes and lines for answers. Question 1 asks about things the parent likes to know about their child/youth. Question 2 asks about things the parent likes to know about their family. Question 3 asks about concerns or worries for the child/youth, with a list of options including growth/development, learning, sleeping, self-care, making and keeping friends, doing things for themselves, behavior in school, behavior, life events, and playing with friends. Question 4 asks about changes since the parent last saw the child, with options for moving, separation or divorce, and changes in family structure. Question 5 asks if the parent needs help with any of the following needs: Medical, Social, Educational, Financial, Legal, or Personal. The form ends with a "Notes:" section and a footer with the National Center for Medical Home Implementation logo and website address.

Family-Centered Care Coordination

INSERT-Practice Name

1) What would you like us to know about your child/youth?
a. What does he/she do most/ best? Dislike?

2) What would you like us to know about you/your family?

3) Do you have any concerns or worries for your child/youth? (see example below)

<input type="checkbox"/> Does growth/development	<input type="checkbox"/> Doing things for themselves	Other (fill in):
<input type="checkbox"/> Learning	<input type="checkbox"/> Behavior in school	
<input type="checkbox"/> Sleeping	<input type="checkbox"/> Behavior	
<input type="checkbox"/> Self-care	<input type="checkbox"/> Life events	
<input type="checkbox"/> Making and keeping friends	<input type="checkbox"/> Playing with friends	

4) Have there been any changes since we saw you last, such as a-

<input type="checkbox"/> Member of your family moved?	<input type="checkbox"/> Separation or divorce?
<input type="checkbox"/> Where is a new child?	Other (fill in):
<input type="checkbox"/> Children or death of a loved one?	
<input type="checkbox"/> New job or job change?	

5) Can we help you with any of the following needs?

<input type="checkbox"/> Medical For example: help finding or understanding medical information; help finding health care for parent or your family
<input type="checkbox"/> Social For example: having someone to talk to when you need it; getting support at home; finding support for the rest of your family
<input type="checkbox"/> Educational For example: explaining your child's needs to teachers; help making or understanding medical information
<input type="checkbox"/> Financial For example: understanding insurance or finding help paying for needs that insurance does not cover – such as medications, therapies, or equipment
<input type="checkbox"/> Legal For example: discussing laws and legal rights about your child's health care or their school work
<input type="checkbox"/> Personal Please let us know what else you need help with if we don't know, we will work with you to find the answer!

Notes:

National Center for Medical Home Implementation

“No one has ever asked me these questions before...”
Parent

National Center for Medical Home Implementation: http://www.pediatricmedhome.org/pdfs/3_Assessment_of_Care_Needs.pdf

Understanding Needs & Strengths

Strengths*

- Concrete Support in Time of need
- Knowledge of Parenting and Child Development
- Parental Resilience
- Social and Emotional Competence
- Social Connections

Family

- What would you like us to know about your child? (What does s/he do well? Like? Dislike?)
- What would you like us to know about you/your family? (Culture, values)

Needs

- Worries or Developmental concerns? (Sleep, moving, language)
- Social changes?(Job, Divorce, Death, Move)
- Medical
- Educational
- Financial
- Legal

Strengths Based

PCC EHR

File Edit Reports Tools Help

PCC EHR **FIND**

Medical Summary

Recent and Upcoming ...

- Siblings
- Reminders
- Parent's Work
- Snap Shot (Strengths)
- Problem List
- Allergies
- PCC eRx Allergies
- Medication History
- Medical History
- Care Plan
- Family History
- Family Medical History
- Social History
- Confidential Notes

Demographics

History

Prescriptions

Create Visit

Medical Summary

12 yrs, 4 mos **F**

Amy Saunders-LBHIN social worker
Bonnie Norton-school case manager Flynn
Tracey Rubman Flynn Special educator-trubman@bsdvt.org, 316-6309
Kasey Chmura-RD, CSHH
Monica Ogleby, palliative care manager, 879-5616
Nina Madore, Flynn SLP, cmadore@bsdvt.org, 793-6089
Dr Walter Kaufman, dept of neurology and rett clinic at CHB-617-355-8994-Rachel (Dr. Kaufman's assistant) fax: 617-730-0279

1/7/12 current meds: trazodone, Vitamin D, L-glutamine, Prevacid, Dextromethorphan, Lamictal

Parent's Occupation Modified 01/21/13
Parent resource coordinator for early intervention (EIS)
works for WCAX

Snap Shot (Strengths) Modified 01/22/13
Hannah loves music, is supported by an engaged school team and loving family.

Problem List Modified 06/10/14 Display: All Statuses

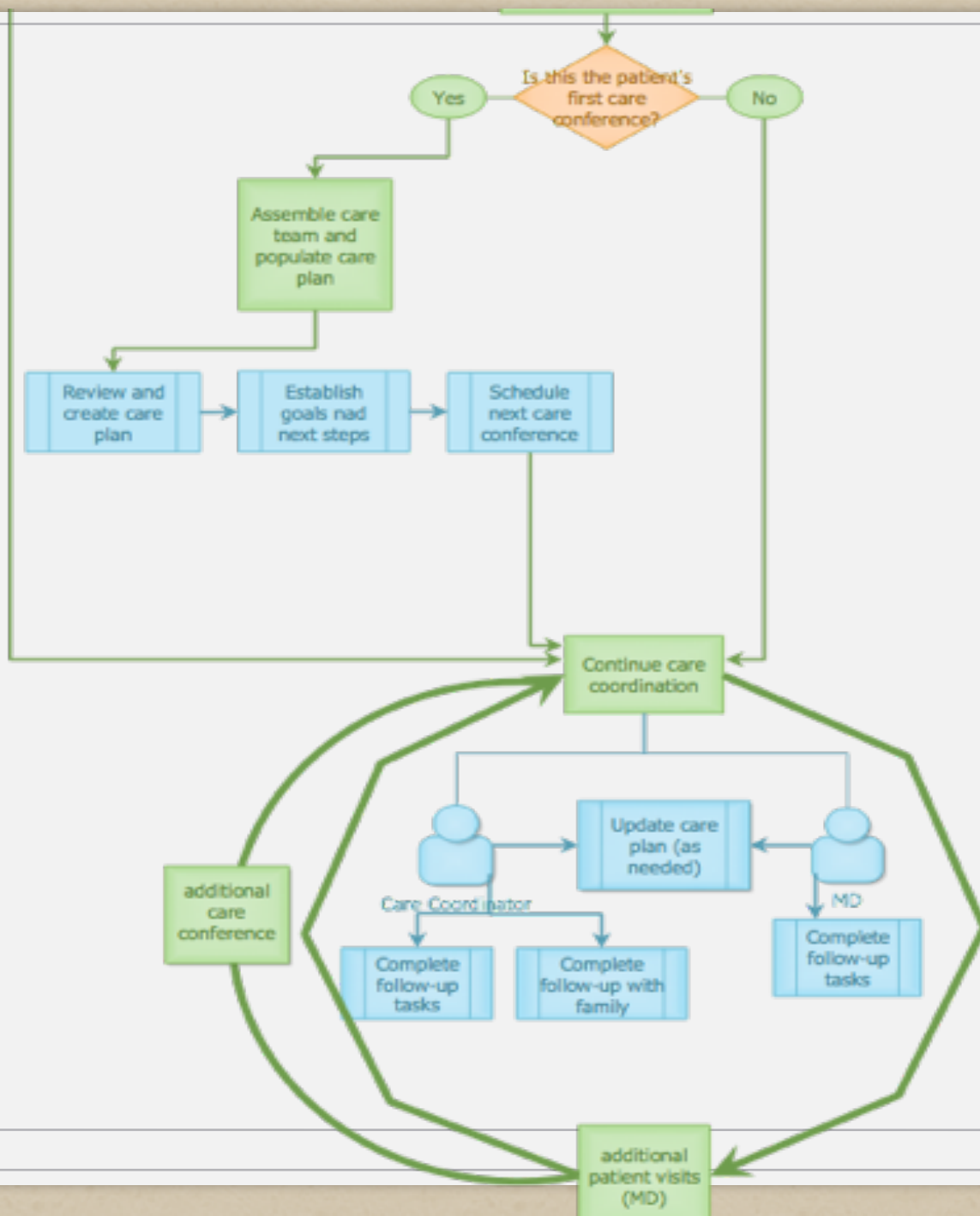
Status	Problem	Problem Note	Onset	Resolved
Active	Rett's syndrome (330.8)	saw Rett Clinic at Boston 2/2013, study also		
Active	Epilepsy (345.90)	as part of #1, Lennox Gastaut syndrome		
Active	Developmental Delay (315.8)	as part of #1		
Active	Autistic disorder			
Active	Underweight			
Active	BMI <5th%ile (V85.51)			
Active	Nutrition Failure-gtube (263.8)	Peptomen Jr. 1.5 via g-tube main nutrition source		
Active	Dysphagia (787.20)	swallow study no aspiration 12/2011		
Active	Sleep Movement Disorder, unspecified (780.58)	trazodone works well		
Active	Ataxia (781.3)	as part of #1		

Edit **Add Phone Note** **Close** **Save** **Save + Exit**

Logged In: jim

HRC Care Coordination Workflow Draft





PARENT VOICES

NO CARE COORDINATION

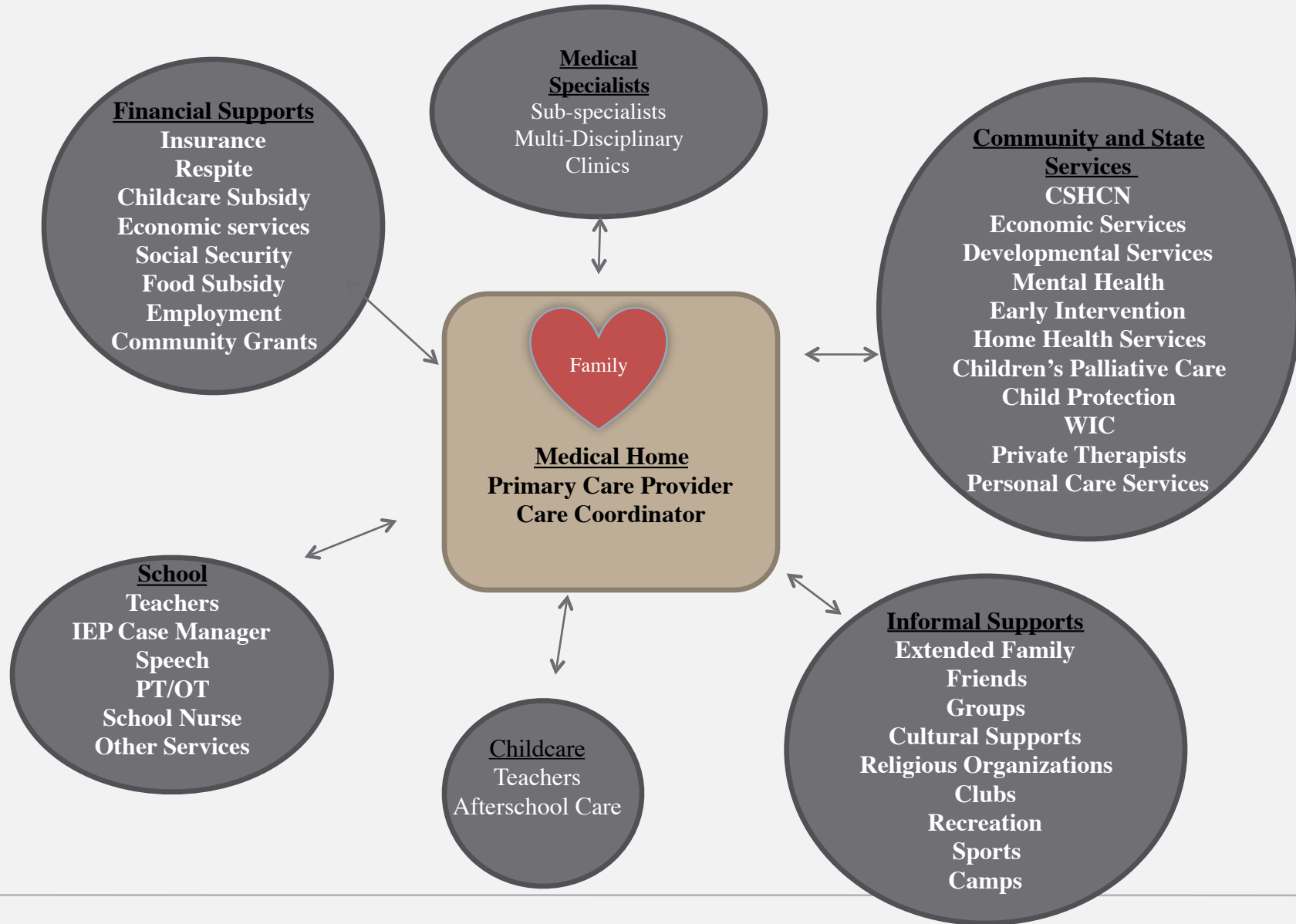
- “Before, we were always treating symptoms...I always felt that I was leading the conversation, like: “Don’t you think we should consider doing____?” I guess I was kind of a problem parent for them.”

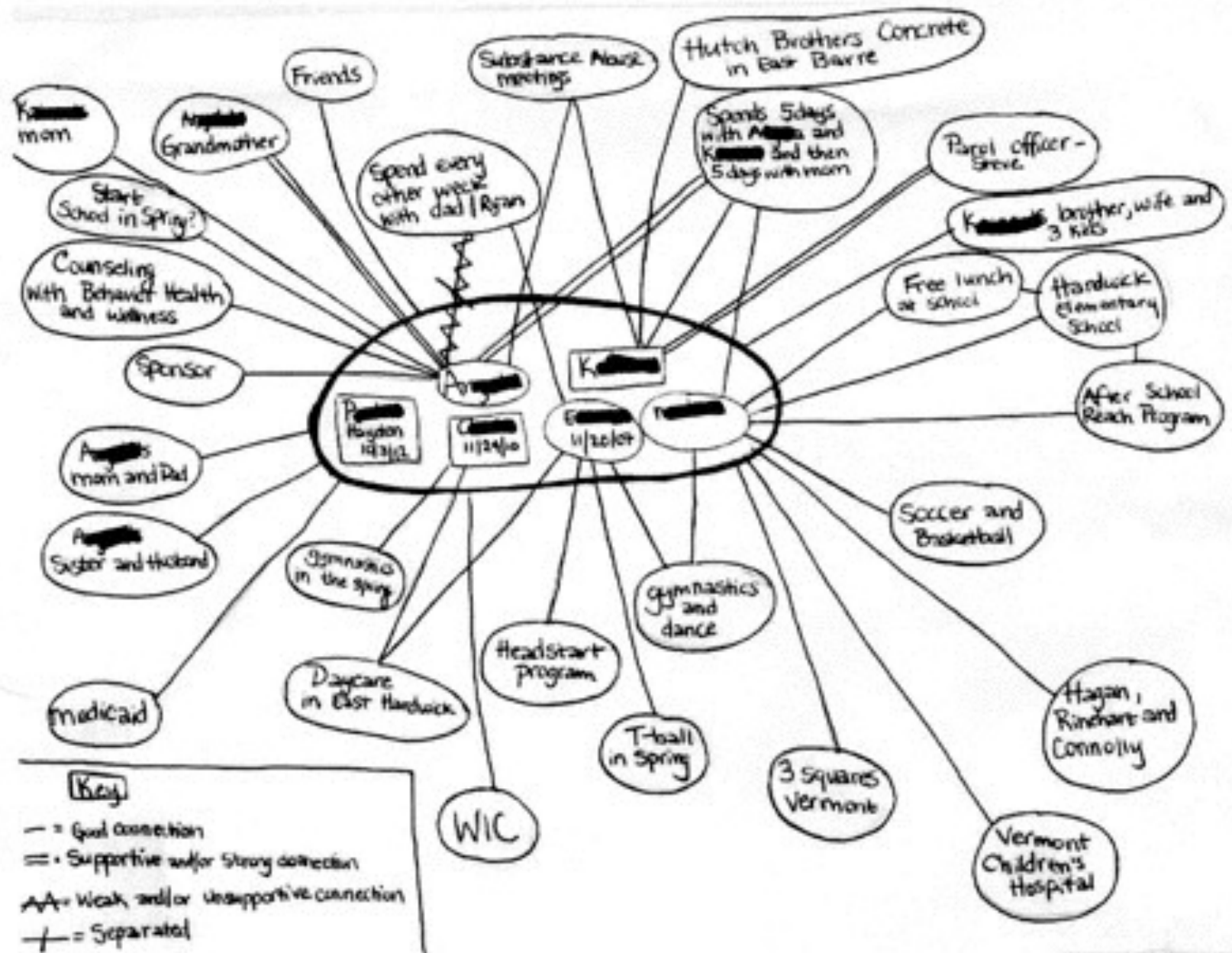
Maier, Parent interview, March 6, 2014

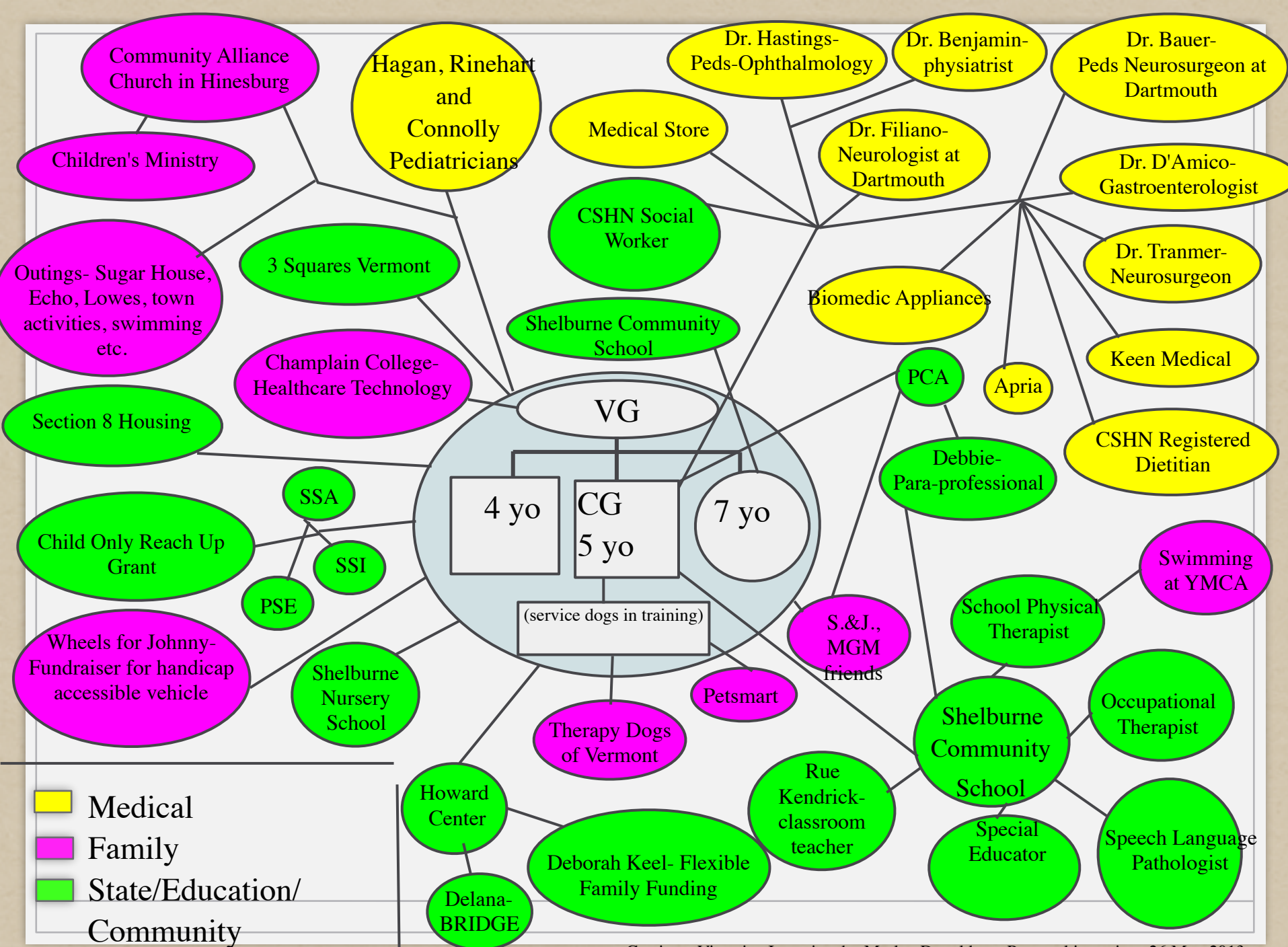
WITH CARE COORDINATION

- “I don’t have to be advocating and pushing all the time. Every visit, even sick visits, at the end, we look at where we want to be and how we will take baby steps to get there, even when there are setbacks, and there are always setbacks, but I don’t get as discouraged, because we have a plan, we know where we are headed.”

ECOMAP







Contact List

PCC EHR **Medical Summary** **[Redacted]** 12 yrs, 4 mos **[Redacted]** **F**

FIND

[Redacted] PCC# [Redacted]

Medical Summary

Recent and Upcoming ...

- Siblings
- Reminders
- Parent's Work
- Snap Shot (Strengths)
- Problem List
- Allergies
- PCC eRx Allergies
- Medication History
- Medical History
- Care Plan
- Family History
- Family Medical History
- Social History
- Confidential Notes

Demographics

History

Prescriptions

Note:

[Redacted] (Custodian, Guardian) Address: **[Redacted]**

Home Phone: **[Redacted]**
Alt Phone: **[Redacted]**
Email: **[Redacted]**

Note:

amy saunders Organization: CSHN social worker
Phone: 865-7723

Note:

maryann lisak (Pediatrics) Organization: hrpc
Phone: 860-1928

Note:

Gerry Prutsman Organization: School special ed case manager; Hunt MS
Phone: 603-359-1910 Address: hunt ms, 1364 north ave
Burlington, VT 05401

Note:

Kasey Chmura, RD, CD Organization: CSHN
Phone: Cell 802-272-8479 Address: PO Box 70
Email: kaseychmura@hotmail.com Burlington, VT 05402

Note:

Sue Smart-Howard Organization: VNA
Phone: 802-860-4420 x 3116 Address: 1110 Prim Road
Fax: Cell 802-343-7887 Colchester, VT 05446
Email: smart-howard@vnacares.org

Note:

Contacts

Demographics

No Preference

Home Address

Wilma Flintstone
15 Quarry Lane
Winooski, VT 05404

Phone

Home Phone: 802-555-0194
Work Phone: 802-555-0197
Cell Phone: 802-555-0161
Emg Phone: 802-555-0168

E-mail: stones@HannaBarbera.com

Account Flags: CONFIDENTIAL

Pebbles Flintstone 10 yrs, 1 m

Billing Address

Fred Flintstone
1400 Rock Road
Winooski, VT 05404

Phone

Home Phone: 802-555-0105
Work Phone: 802-555-0146
Cell Phone: 802-555-0112
Emg Phone:

E-mail: stones@HannaBarbera.com

Account Flags: Billing Problem

Relation to Bill Payor: Child

Personal Contacts

Barney Flintstone (Uncle)

Phone: 802-564-2039

Note: Watches Pebbles after school.

Address: 1 Main Street
Winooski, VT 05404

Betty Rubble (Registered Nurse, Other)

Organization: Bed Rock School
Address: 1245 Bed Rock Ave
Winooski, VT 05404

Note: School Nurse

Care Conferences

- Introductions, share contact information
- Set Agenda
- Set Roles: Provider and Family facilitate meeting
- Start with Strengths
- Discussion following the Agenda
- Minutes recorded (by Care Coordinator)
- Update Plan with “Next Steps, Accountability
- Next Care Conference Date (if needed)
- Care plan is shared at end of meeting



Coordinated Care??

- Mind the Gap



Shared Care Planning

Patient/Family/Team Goals	Negotiated Actions	Process and Outcome measures
Less Self- Injury	Psychiatry Assessment Co-management In-home behavioralist	Keeping family together Less need for police and Crisis support
Improve school attendance Improve education supports	Same behavior plan across settings Explore alternative school placement	Clear communication btwn home/school/providers Alternative program found
Repetitive behaviors	Improved psychopharm Improved wrap around services Improved behavior plans	Innovation: across silos of mental health, developmental disabilities, CSHN and school

Care Story 2

- Mary is a 4 year old with tuberous sclerosis whose self-injurious behaviors, tantrums, sleep dysfunction-- heading towards inpatient psychiatry hospitalization
- Despite having a VT developmental services waiver, respite care and a team of multidisciplinary medical experts at Mass General
- Intractable seizures seemed the least of her concerns in comparison to behaviors
- Strengths: strong parent involvement and expertise, loving respite family, Mary engaging, verbal with cognitive strength (can anticipate seizures)

Patient/Family/Team Goals	Negotiated Actions	Process and Outcome measures
Less need for “crisis” intervention	Co-management from psychiatry, medical home and subspecialists In-home behavioralist	Less need for police, mental health crisis support
Improve Sleep	Same behavior plan across settings	Less communication errors about medications Improved work attendance
Increase Home Safety-of Mary and family	Improved psychopharm CSHN SW: Waiver allowed for enhanced access to in-home behavioralist	Innovation: region contracted with vendor outside of network Less Crisis Need
Mary to attend school Improve social relationships	Communication opened between school, behavioral plans, family, medical home	Making academic gains Attendance improved Cannot pick her out from peers

PARENTS' VOICES

NO CARE COORDINATION

- I would be on hold for an hour, and then they would tell me to go to the hospital. We were going to the ER pretty much every other week.
- Don't get me wrong, I love Dr_, but it was the structure, the organization, that was the problem.

Maier, Parent interview, March 6, 2014

WITH CARE COORDINATION

- Now, someone immediately picks up. They are always calm and responsive and find the right person to talk to me. Now, there is always a plan. I know what steps to take, and when to call back.
- Now, (the doctor) is able to network better and is proactive. There is more of a holistic view, why are the symptoms happening, what to do to figure out the bigger picture...we have only been to the ER once in the last six months"

Medical Summary

File Edit Reports Tools Help

PCC EHR

FIND

PCC#

Medical Summary

Recent and Upcoming ...

Siblings

Reminders

Parent's Work

Snap Shot (Strengths)

Problem List

Allergies

PCC eRx Allergies

Medication History

Medical History

Care Plan

Family History

Family Medical History

Social History

Confidential Notes

Demographics

History

Prescriptions

Create Visit

Medical Summary

Joanne Wexler 12 yrs, 4 mos **F**

Recent and Upcoming Appointments

Last Visit: 06/10/14 (2d ago) Rinehart

Diagnoses: Rett's disorder, Failure to gain weight, Sleep disorder, Epilepsy, Gastroesophageal reflux disease

Last Physical: 02/28/14 (3m 1w ago)

Next Physical Due: 03/05/15

Scheduled Appointments: 09/30/14 12:00pm Care Conf Rinehart Office

Siblings

Open Chart 9 yrs, 7 mos F

Open Chart 42 yrs, 2 mos F

Open Chart 47 yrs, 7 mos M

Reminders Modified 06/10/14

****Keppra--not tolerated****

Current Medications: 6/2014
Lansoprazole 15 mg BID
Depakote 350 mg BID
Rufinamide 400 mg BID
Trazodone 75 mg at hs (1.5 tablets)
Vitamin D 400 IU/day
Probiotic and Fiber

Rett Surveillance:
Needs EKG each year to rule out prolonged QTlast done fall 2012
Spine films annually/regularly for scoliosis last done spring 2012
Gallstones/GI surveillance
Osteopenia lab/ vitamin D level

Team:
Joanne Wexler-PCA care manager
Amy Saunders-CSHN social worker

Edit **Add Phone Note** **Close** **Save** **Save + Exit**

Logged In: jim

Important Synopsis

PCC EHR

File Edit Reports Tools Help

PCC EHR

Medical Summary

12 yrs, 4 mos **F**

Medical History Modified 06/10/14

presented as an 18 month old with developmental regression, trichotillomania and an abnormal EEG upon neurology consult. By age 2 it was clear had lost language, though she has preserved ambulation and genetic confirmation of MECP2 gene through Dr. Burke secured diagnosis of Rett syndrome (with milder end phenotype).

Neurology: Dr. Bingham involved in original Diagnosis. Concerns for seizures at time, also has breath holding behaviors. Epilepsy first diagnosed 12/2012-negative reaction to Keppra, Lamictal started in January 2013 now at 10 mg BID..Glutamine. 2014-- ongoing management issues, having 6-7 sz a day, considering Charlotte's Web (marijuana) treatment in Colorado... Dr. Greg Holmes and Dr. Bingham and epileptologist Dr. Scott all consulting re: Hannah 5/2014 to Boston Rett center neurologist/ kaufman: referral to epileptologist there Ambulation: SMO's with Deb Wilde. Sees Dr. Benjamin for spasticity/scolio/hip monitoring--no interventions at this time.

Endocrine: Dr. Kacer saw in February, 2012 for puberty questions, had an episode of hypoglycemia. Bone Health: DEXA scan 2009 (part of study), on vitamin D and Calcium supplements.

GI: Dr. D'Amico placed PEG, ongoing Nutrition concerns, constipation/diarrhea/lactose intolerance. Benefiber and Prevacid help with distress, along with Culturelle. January 2013: Normal endoscopy and colonoscopy, but concern for "bacterial overgrowth" treated with cipro and Alinia. Developed bloody stools, so this was stopped before end of treatment. Endoscopy and colonoscopy January 2013-normal biopsies. LACTOSE INTOLERANT

Supplements: Bifido bacterium, Vitamin D, Benefiber.

Nutrition: Saw FAHC Nutrition, now CSHN RD following for G-tube handling most of her nutrition, oral feedings are for pleasure. Peptamin JR 1.5 now blenderized diet Casy Chumera following

Sleep disturbance: On Trazodone 75 mg at hs. Consistently works to sustain sleep in a child whom sleep was previously extremely disrupted.

Dysphagia: Swallow study shows no aspiration 12/2011. Dysphagia of thick things, saliva..etc.

Vision: Dr. Hastings sees annually. Developed astigmatism where glasses may be useful. Last visit 3/2011

Specialty Center:
Rett clinic at Boston Children's Dr. Kaufmann is neurologist
Ballinger Kennedy Kriner Institute...was enrolled in a study of Doxymethurethan use for girls with Rett but left this in 2013/2014

Recent and Upcoming ...

- Siblings
- Reminders
- Parent's Work
- Snap Shot (Strengths)
- Problem List
- Allergies
- PCC eRx Allergies
- Medication History
- Medical History
- Care Plan
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- Family Medical History
- Social History
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Demographics

History

Prescriptions

Create Visit

Edit

Add Phone Note **Close** **Save** **Save + Exit**

Logged In: jim

Negotiated Next Steps

PCC EHR

File Edit Reports Tools Help

PCC EHR

06/10/14

12 yrs, 4 mos

Status: Active

Medical Summary

Recent and Upcoming ...

- Siblings
- Reminders
- Parent's Work
- Snap Shot (Strengths)
- Problem List
- Allergies
- PCC eRx Allergies
- Medication History
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Demographics

History

Prescriptions

Create Visit

Goals

- Improving care team communication around seizure management
- Making the Transition to Middle School easier
- Continuity of care providers when possible
- Boston supporting primary medical home in caring for [redacted] needs
- Improve communication: would like to use TOBI as soon as possible--be set to use it for school next year
- Having Friends who know her already continue to develop relationships
- Maximize weight gain potential
- Manage respite-PCA money well-

Actions

Next Steps

Get records to Boston, including shelly requesting video EEG

Recommended going back to an epileptologist- kristy to call dr kaufman august-shelly has a date for nutrition

In the summer time will have time with the para to get used to H/ and for H/ to get used to school

Hiring a second para (back up)

Stephanie as para hired to be IA will support the new hire

School has a specialist augmentative MEG Delorme to approve the TOBI and help with its use

Consistency of nursing care at school--emergency plans-nasal midazolam [redacted] to provide

Kasey -- to increase her calories and meeting with family to increase calories/ protein powder:family ready to move forward with night feeds and maximize calories in

neurology about meds-- recent notes to be provided and Dr. R to send information

Sue smart haward-connect when needed pumps--co-visit with nutritionist

palliative care art therapy-- art therapy with pedi palliative care-->hadley/-Sue/Kasey to f/u on this

music therapy could she use respite funds to cover this? (sholanda-->is therapist)

Care Coordination Notes (internal use)

Team Members

Tracey Rubman (Case Management)

Phone: 316-6309

Email: trubman@bsdvt.org

Organization: Flynn Elem School-special educator

Edit

Add Phone Note

Close

Save

Save + Exit

Care Plan

Medical Summary **Pebbles Flintstone 10 yrs, 1 mo 5/21/06**

PCC eRx Allergies Updated 07/19/16 10:11 AM

Drug	Reaction	Onset
amoxicillin	mouth swelling	

Medication History Updated 07/19/16 10:11 AM Display: All Statuses

Active	Drug	Formula	Details
✓	Adderall XR (dextroamphetamine-amphetamine)	capsule, extended release 24hr 20 mg	Take 1 capsule by mouth twice a day Dsp. 60 capsule by Mark Williams, M.D.
	cefadroxil (cefadroxil)	suspension for reconstitution 500 mg/5 mL	Take 0.5 teaspoon dissolved in water twice a day Dsp. 50 ml (last 06/19/16 stop 06/29/16) by Mark Williams, M.D.

Care Plan Print Display: All Statuses

▼ 07/19/16 Status: Active

Goals

- Control Asthma
- Start soccer with asthma controlled

Actions

Next Steps

Pebbles will start taking a new medication for her asthma and will also have her inhaler for physical activity. We will follow up with the school nurse and her PE teacher and coach to assess Pebble's progress on the new medication. We will schedule follow up appointments with Pebbles every three months to check vital signs and check-in on her medication use and overall health.

Care Coordination Notes (internal use)

Team Members

Created by Elizabeth Casey, M.D. 07/19/16 10:09am

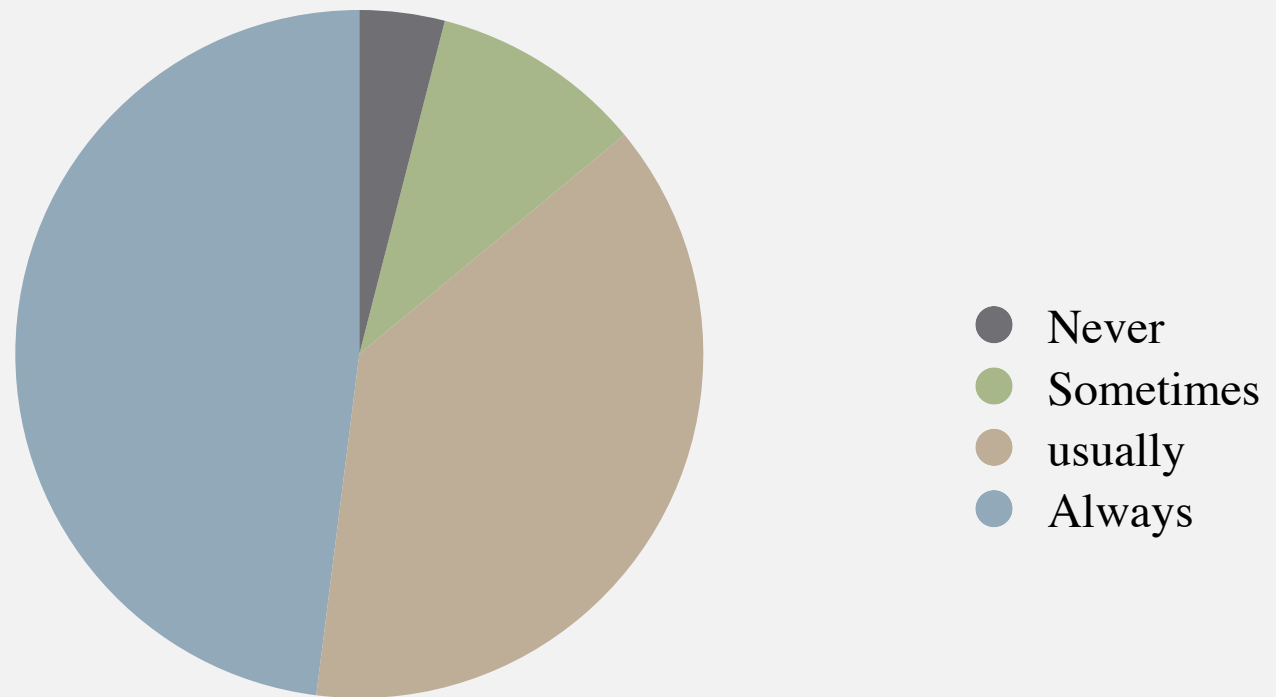
All Practice Data

Enrolled: 138	Baseline	6 month follow	
At least one care conference	20	35	
Working with CSHN SW	56	65	
Shared Plan of Care	25	66	



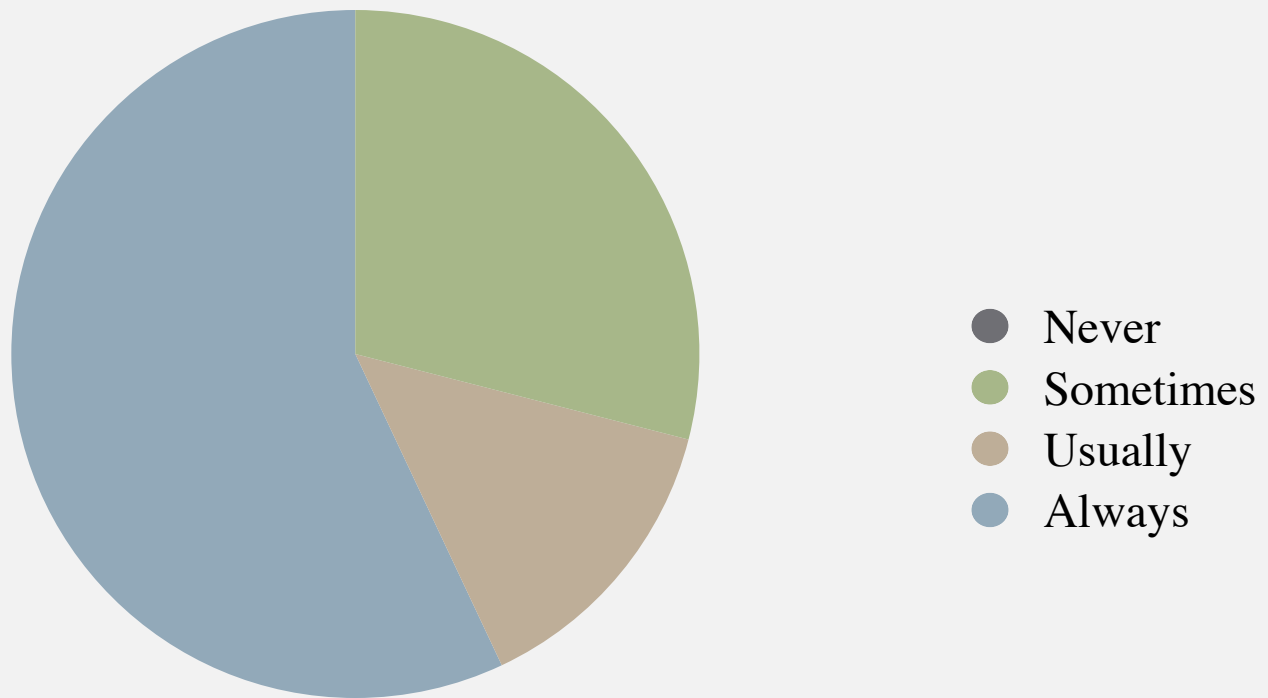
How often did the practice help the family get needed family services?

Baseline



How often did the practice help the family get needed family services?

Sales



Complex Care Coordination Codes

- 99487-9—Clinical Staff Reimbursement Codes, non- face-to-face
- 99488 includes one office visit plus one hour of care coordination services.
- 99487 involves one hour care coordination
- 99489 for each additional 30 minutes for care coordination
- **99215 highly complex office visit-care conferences**
- **Prolonged Visit**

Future?

- Access to the shared care plan from community, families, medical home and subspecialists
- Adequate investment in this primary care system to support care coordination
- 16 states involved in Shared Plans of Care and outcomes measurement
- Care coordination is practice transformation for health care reform
- “App Orchard”

Thank you to our family partners

Crystal Abair

Carolyn Brennan

Tammy Carrol

Victoria Garrison

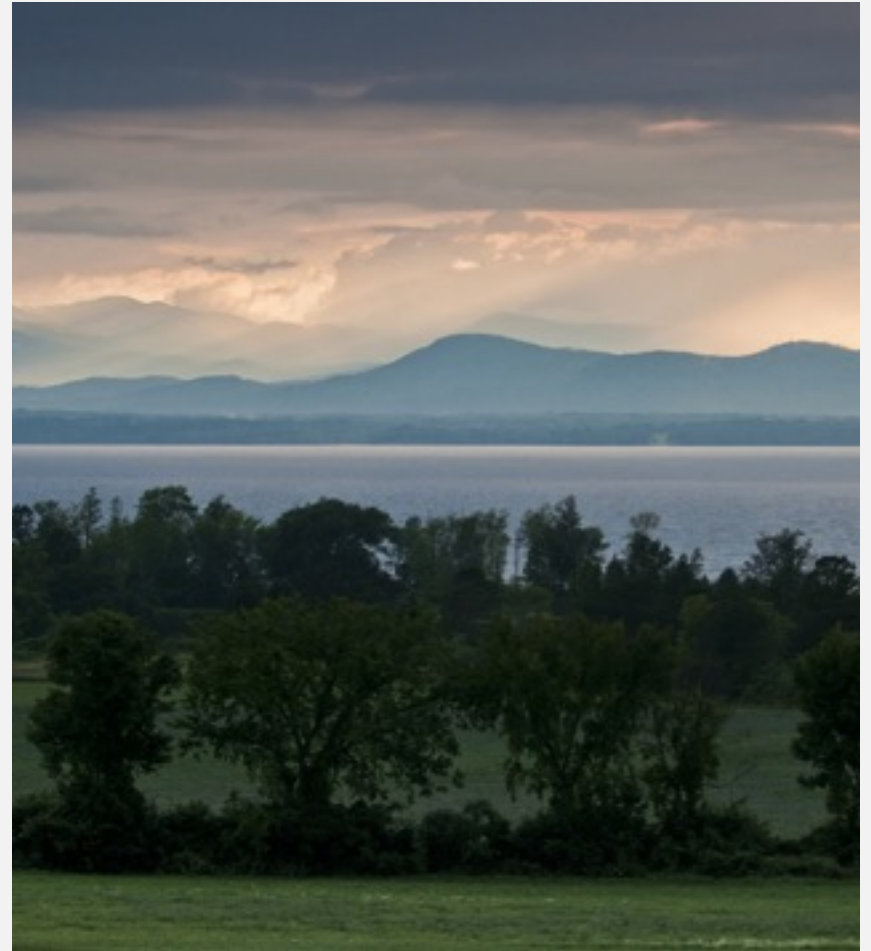
Liz Metevier LeFebvre

Peggy Mann Rinehart

Theresa Soares

Kate & Michael Stein

Shelly Waterman



References

Antonelli, Browning, Hackett, McAllister & Risko (2014). *Pediatric Care Coordination*, Boston children's Hospital.

Antonelli, McAllister, Popp. *Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework*. The Commonwealth Fund, May 2009

Cooley C, McAllister J, "CMHI National Outcomes Study Cost/Utilization," *Pediatrics*, July 2009

Garrison, Rinehart (2013). *Innovations in Medical Home*, Presentation VFN annual Conference

McAllister, Jeanne, *Achieving a Shared Plan of Care for Children and Youth with Special Health Care Needs*, with support from Lucille Packard Foundation for Children's Health, 2014

Maier (2014). *Pediatric Care Coordination presentation*, Barre Vermont.

Rinehart (2014). *Pediatric Care Coordination Grand Rounds*, Burlington, VT.

Rinehart, Sheehey (2014) "*Pediatric Care Coordination Learning Collaborative*" Presentation

Questions?

