

Working as an Integrated Multi-Disciplinary Care Team: Developing and Using Shared Plans of Care

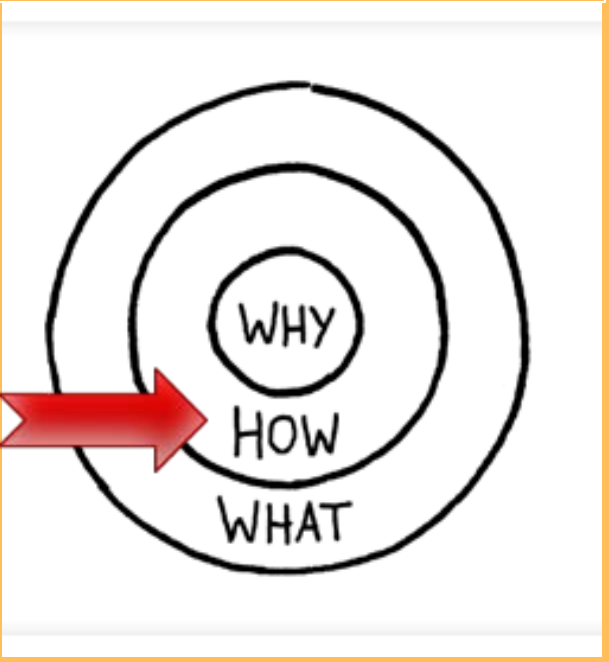
Jeanne W. McAllister, BSN, MS, MHA

VT: Integrated Communities Care Management Learning Collaborative

May 19, 2015



The Why, How and What of a Shared Plan of Care



- **Why? (What we know)**
  - Engaged patients and families
    - better - access, information, enhanced navigation, improved health outcomes, & more
- **How? 10 Step Approach**
  - Preparation and planning
  - Assessment, goal setting, implementation and oversight
  - Relational care coordination
- **What? Shared Plan of Care**
  - Medical Summary , Negotiated Actions & Attachments (e.g. emergency plan, legal needs)

Source: TED.com
Simon Sinek, The Golden Circle

Care Plans & Care Planning – A *function* of care coordination

?

- In few (1-3) words
- Care Coordination

Care Plans Care Planning – A *function* of care coordination

COHESION

- In few (1-3) words
- Care Coordination -

Care Coordination

A patient & family-centered, assessment driven, continuous, team-based activity designed to:

- **meet the bio-psychosocial needs of children youth, and adults while**
- **enhancing person & family care-giving skills and capabilities.**

Reference: Commonwealth Fund 2009, LPFCH 2014, AAP 2014

Why Shared Care-Planning?

- **Care is fragmented across multiple providers /systems**
- **Coordination of care is lacking**
- **Information sharing across providers often falls to patient/ family**

Why Shared Care-Planning?

- **Patients and Families ask for:**
  - Help in system & resource navigation
  - Team-based care
    - With access to a clear contact person
  - Goals and strategies used consistently across providers (aka standards of care)

Why Shared Care-Planning?

- **Clinicians/teams seek a better approach:**
  - Partnership relationships with patients/families
  - Succinct, at-a-glance Medical Summaries
  - Clarity of next-steps, responsibilities and accountabilities

A Little Backstory

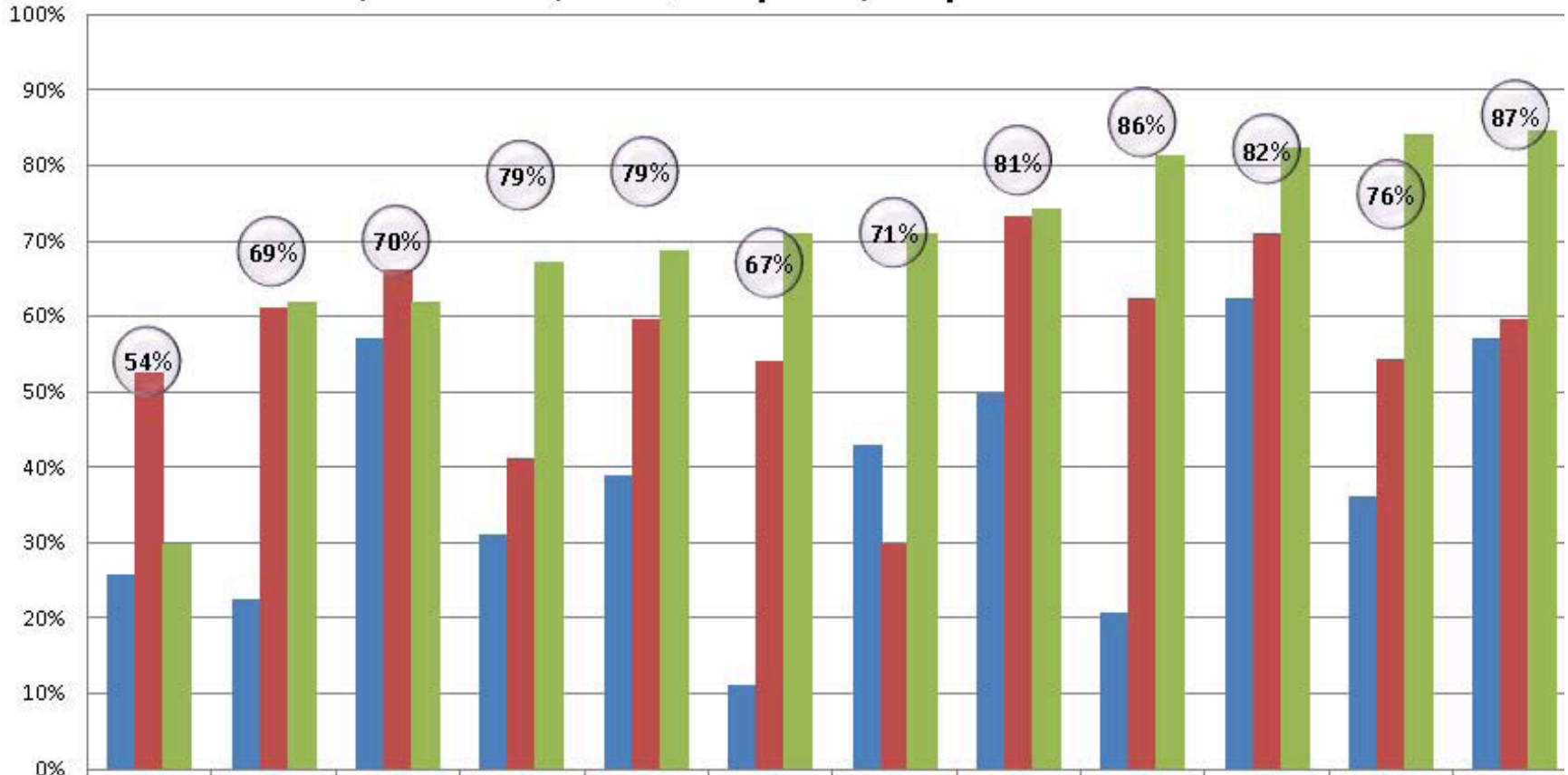
DEER in the HEADLIGHTS!

2003-2004 50 Primary Care Teams with newly identified family partners and Sponsoring Title V Leadership – "You want us to do what?"

CMHI: Studying Medical Home Transformation in Pediatric Primary Care (AHRQ) 2010-2012

Medical Home Index and Adaptive Reserve for Scores 12 Transformed Practices

MHLC Pre, MHLC Post, AHRQ Study 2011, Adaptive Reserve 2011

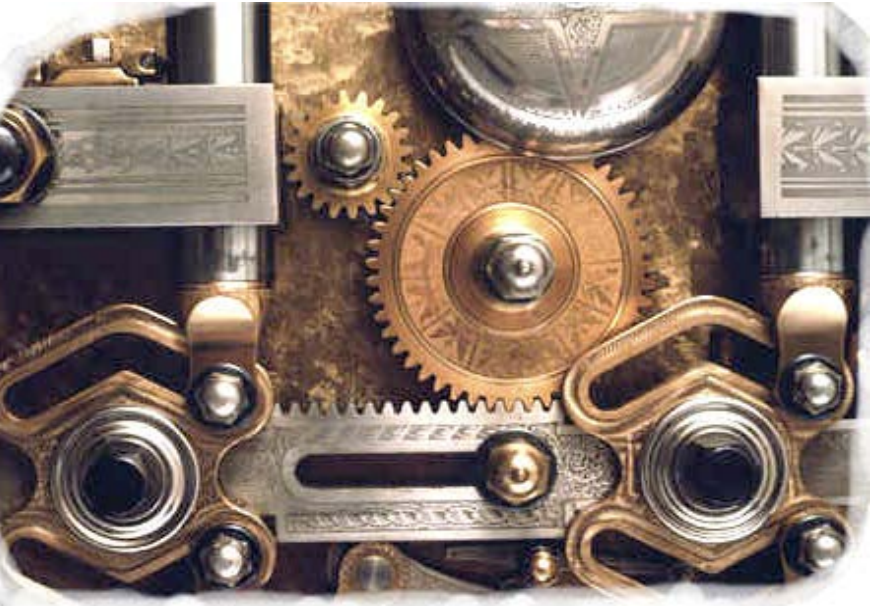


	1 512	2 728	3 854	4 262	5 853	6 265	7 582	8 438	9 359	10 815	11 404	12 546
Pre LC	26%	22%	57%	31%	39%	11%	43%	50%	21%	62%	36%	57%
Post LC	53%	61%	66%	41%	59%	54%	30%	73%	62%	71%	54%	59%
AHRQ	30%	62%	62%	67%	69%	71%	71%	74%	81%	82%	84%	85%
% Adaptive Reserve	54%	69%	70%	79%	79%	67%	71%	81%	86%	82%	76%	87%

CMHI - Center for Medical Home Improvement

MHLC - Medical Home Learning Collaborative

Adaptive Reserve Scores



Medical Home Transformation What Drives Change?

Mixed Methods: Medical Home Index, Adaptive Reserve, Q –Interviews

4 Essential Elements:

1) Quality Improvement
2) Family Centered Care
3) Team based care
4) Care Coordination/ Plans of Care

(★*Physician and staff satisfaction was strong/high*)

McAllister, J.W., et al., *Medical home transformation in pediatric primary care--what drives change?* Annals of Family Medicine, 2013. 11 Suppl 1: p. S90-8.

Change Concepts for Practice Transformation

Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice*. 2012; 39:241-259.

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

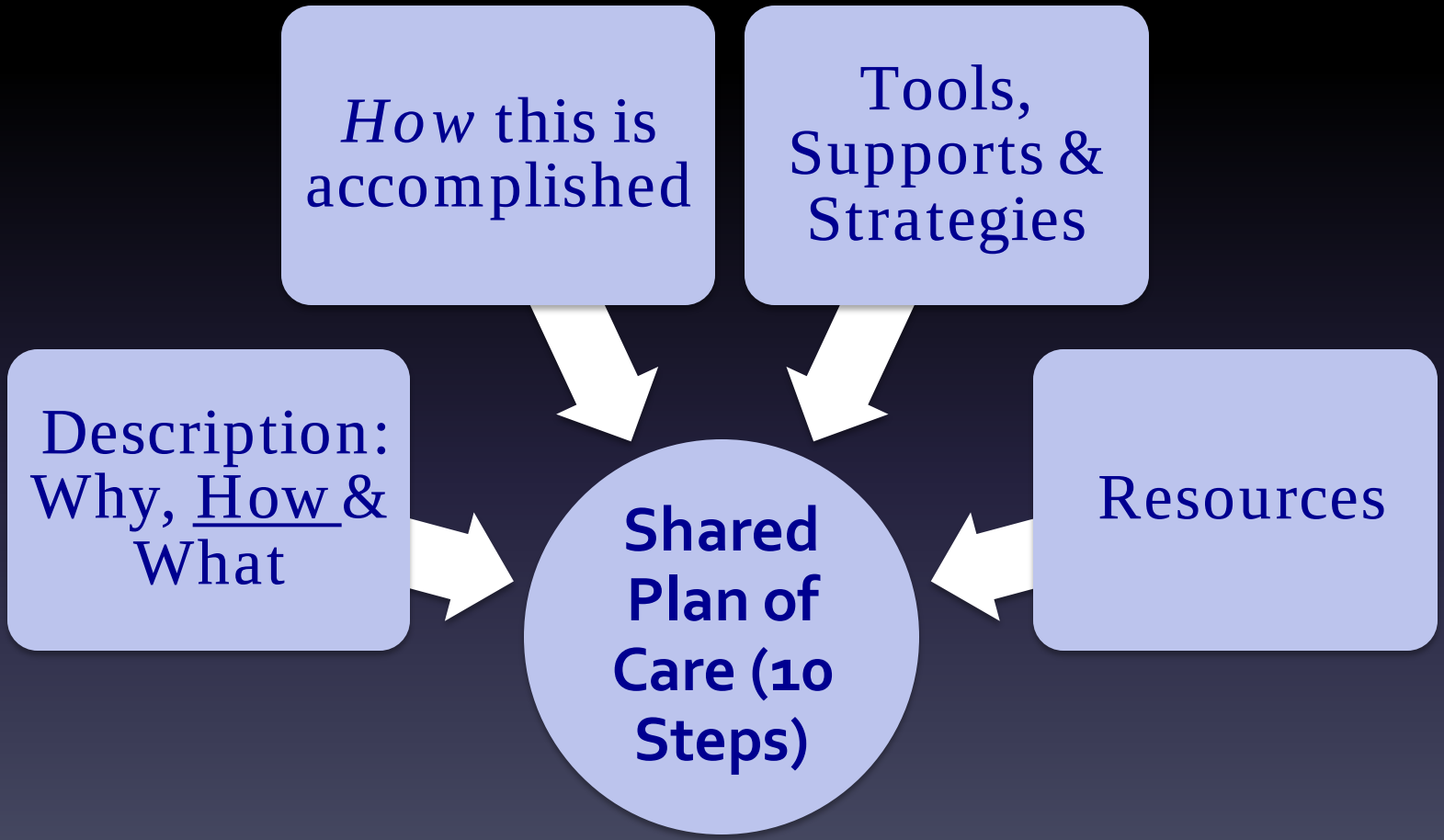
- ***Family***

Care coordination “elevator speech”?

Care coordination "elevator speech"?

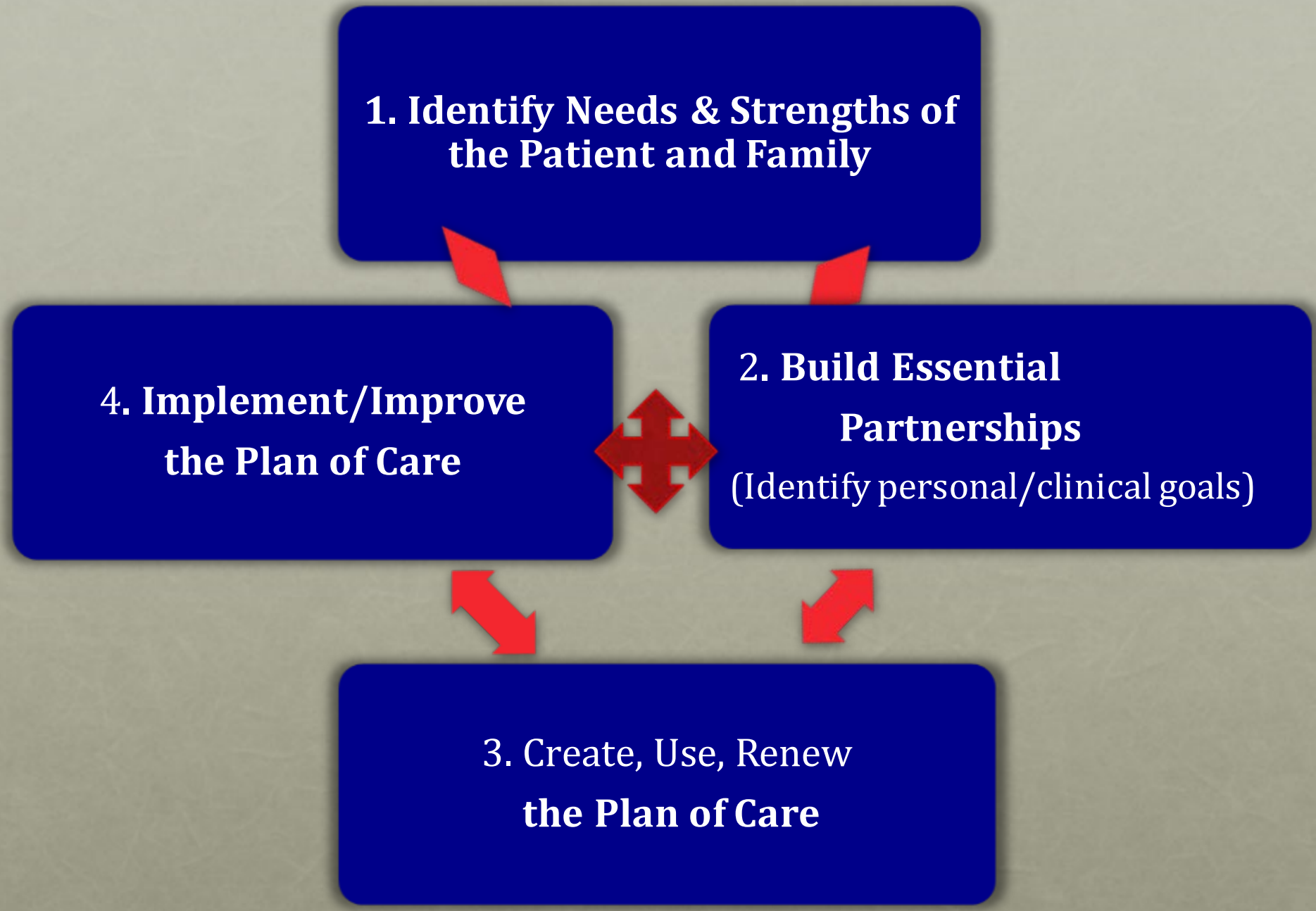
"With care coordination…you have to take the stairs!

Objectives: Shared Plan of Care as a Function of *Care Coordination*



The Purpose of Shared Care-Planning

1. Improve care and reduce fragmentation
   for children/families -subsequently for an identified population
2. Guide a family-centered, multi-disciplinary team process - joint development /use of a plan of care
3. Enable the patient, child/family and their "care neighborhood" to communicate, collaborate, and operate from the "*same page*" SPoC
4. Deliver oversight with developed timelines
   ensuring responsibilities and accountabilities



Model of Shared Care-Planning Achieved in Partnership with Families LPFCH

10 Step Approach to a Shared Plan of Care

1. Identify who will benefit from a plan of care
2. Discuss with families and colleagues the value of developing and using a comprehensive and integrated plan of care.
3. Select, use and review a multi-faceted assessment with a child, youth and family
4. Set shared personal and clinical goals
5. Identify other needed partners (e.g. subspecialists, and community providers) and link them into the shared care-planning process

10 Step Approach to a Shared Plan of Care

6. Develop the plan of care – “Medical Summary
7. Establish the plan of care “Negotiated Actions”
8. Ensure that the plan of care is available, accessible, and retrievable (for all permissible partners)
9. Provide tracking, monitoring and oversight for the plan of care
10. Systematically use the shared care-planning model process with a group of patients and families

Step 1
Identify who will benefit from a ***plan of care***

- **Patient Family Request** standard of care
- **Criteria –**multiple needs, providers, plan, barriers
  - Who?
- **Complexity –** Examples
  - HOMES
  - Bobs
- **Co-management -**
  - Psych and primary care
  - Neuro and developmental peds

Selecting Assigning & Using a Complexity Score

NDBS Care Coordination (CC) Pilot: Complexity Levels

The NDBS Care Coordination Pilot is for children with a neurodevelopmental diagnosis (specifically ASD, developmental disability and/or intellectual disability) who are between the ages of 2 and 8.

1) Use this form to identify and assess the level of CC need for enrolled children and families
2) This will typically be done after the care coordination visit during a huddle with the clinician and coordinator.
3) Review the 5 domains below describing different levels of need/support: 1) health services, 2) family support services, 3) behavioral/mental health services, 4) educational services, and 5) special issues.
4) Calculate a total score between 5 and 15 and transfer onto the child's "Care Coordination Monthly Measure" form
5) Scores will occur at visit and again at the 3-month conclusion of the care coordination period.

Dimension	1 Minimal Need	2 Moderate Need	3 Extensive Need
1. Health & Services	Health status is stable, care is routine /preventive, child may see a specialist annually	Health status is generally stable; regular office visits are to review management; periodic consultation occurs with 1 or more specialist	Health status is unstable +/or frequent office visits occur; many hospitalizations & ER visits; frequent consultations with 1 or more specialists
2. Family Support	Family status stable; no major environmental stresses; traditional social supports present and utilized	One or more stressors may be present, family requires occasional support from office and other community resources	Multiple major stressors are present, family resources are strained, extensive community support needed +/or major concerns about care giving environment
3. Behavioral and Mental Health	Behavioral health status is stable, routine anticipatory guidance	Regular office visits to review care management or regular consultation & counseling with mental health providers	Behavioral health status is unstable, extensive supports from office and community professionals; may require day treatment program or in-patient treatment
4. Education	Routine monitoring of developmental/school progress, in regular classroom with minimal support	Child needs or has an *IFSP, IEP or 504* plan, most of child's needs are met in a regular classroom, may require 1 special health procedure at school	Extensive support required, full-time aide or special class for most of the day, +/or multiple special health procedures in educational setting
5. Special Issues	Child and family follow recommendations readily, there is limited need for decision supports; no or few cultural factors impact care, child/family proactively manage care	Child and family require extra time to understand healthcare recommendations with regular need for decision supports; translator required for appointments or occasional missed visits	Extensive need for decision supports and care reminders; cultural issues are major barriers to care, limited capacity for self-management, or major disagreements with the plan of care

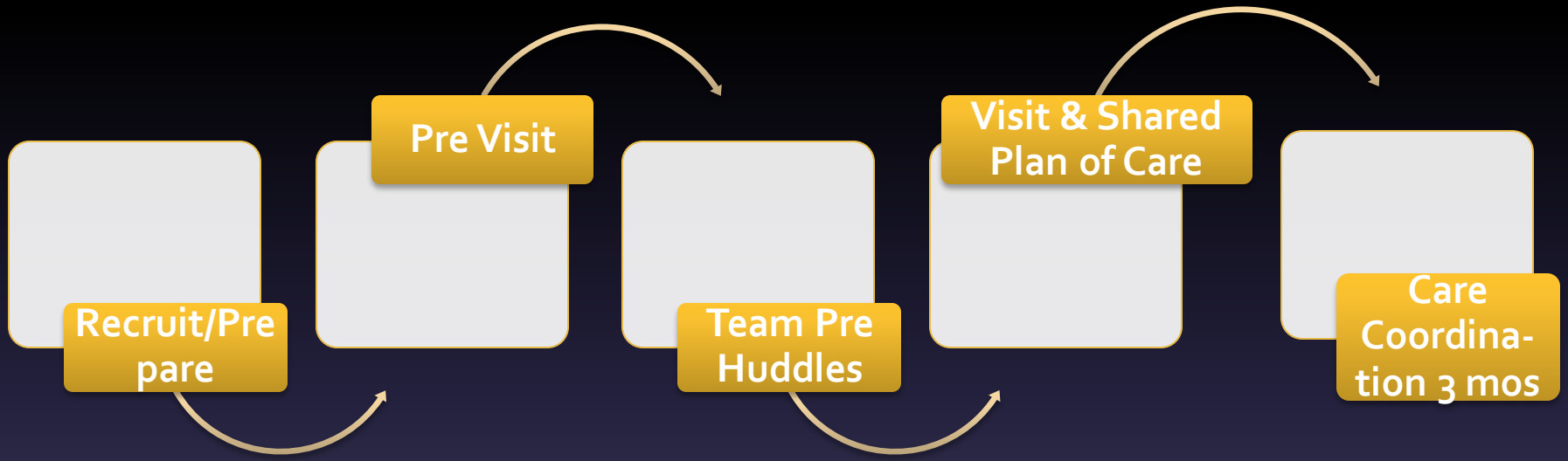
Step 2

Discuss with families & colleagues the value of developing and using a comprehensive /integrated "plan of care".

- **Invite in**, reach out; build rapport
- ***Explanatory**/descriptive materials
  - (Can family partners help with?)
- **Workflow** – your design (see guide)
- **Prepare** –Pre Work & team and family "think time"
- **Patient /Family feedback** (PDSA)

This is practice of teamwork to achieve together

Workflow


Recruit/Prepare
Pre Visit
Team Pre Huddles
Visit & Shared Plan of Care
Care Coordina-tion 3 mos

NDBS Care Coordination Program – Process "Map"

Recruitment/Consent/ Enrollment	Pre-Visit Preparation Work	Team Pre-Huddles	Planned Care Visit; Co-Create Shared Plan of Care	→ 3 Months Continuous, Team-based Care Coordination using Shared Plan of Care
Apply steps # 1 and #2 of to "Achieving a Shared Plan of Care →	**Prepare; introduce to family a draft medical summary for review →**	**CC All Team Pre-Visit meetings and "Huddles"; CC Meet together weekly in addition →**	**Implement steps # 3-7 to achieving shared care planning with a shared plan of care →**	**With shared plan of care ready begin "post visit" follow through (Non-linear process) → Responsibilities/accountabilities and partnership with family & community/"neighborhood" contacts**
1) Identify who will benefit from a plan of care **2) Discuss with families the value of developing and using a comprehensive integrated plan of care.** **First: Identification of children /families using *criteria (2-8, ASD/DD/ID) Riley clinics*** **Second: Family consent/ agrees** **Third: Family explanation letter goes out:** - Confirms pre CC phone call and visit date/time Fourth: PCP Letter goes out to inform PCP of families agreement to participate /request for their input Fifth: CC begins pre-population of the medical summary Sixth - Family receives: 1. Pre-populated medical summary to review and correct 2. Pediatric care coordination assessment (to review, (not fill out) reflect and bring to appointment)	**Next Steps:** • Care coordination phone contact occurs • Clarify family preference for **visit configuration** • Care coordinator (CC) reviews data (medical record, phone intake, Level 1 & 2 data; Further assembles medical summary /prepares questions/gaps for huddle Pre Visit Phone Call *CC asks family to:* • Review medical summary data for additions, clarifications /corrections • Review Pediatric Care Coordination Assessment and address questions; request they bring to visit • Prioritize concerns for face-to-face visit • Identify any urgent needs • Confirm date for planned NDBS coordinated care visit	-CC /Clinician Team are matched with individual children & families and hold huddles -CCs review work and information gathered thus far and can post concerns w/small team -CC prepares team for planned care visit, follows up on any other pre visit planning and tasks - Pertinent questions, comments and facts are brought to whole CC Pilot Team; all ask and answer questions helping each other learn and improve - Care Coordinators also use separate weekly peer group meetings for sharing resources, problem solving, and gaining direction.	3) Select, use and review the Pediatric CC assessment with family 4) Set shared personal and clinical goals 5) Identify other needed partners (e.g. subspecialists, and community providers); link them into the shared care-planning process 6) Develop the plan of care – "Medical Summary" and merge with negotiated actions described in #7 7) Establish the plan of care "Negotiated Actions" and merge with the medical summary (in step #6)*& See that permissions/releases are established)* - Clinician and coordinator huddle/debrief and score NDBS Care Coordination (CC) Pilot: Complexity Levels **Note: 2 Visit Configurations offered (1 long visit, 2 shorter visits; see page 5)**	8) Ensure that the plan of care is available, accessible, and retrievable (for all permissible partners) 9) Provide tracking, monitoring and oversight for the plan of care *10) [Future] Systematically use the shared care-planning model process with a group of patients and families.* • CC coalesces data /assembles semi-final plan of care • Team promises: * Draft action plan day of visit * Follow-up contact & plan within 2 weeks -Clinician reviews, clarifies, adds - Family reviews, clarifies, adds -All declare Shared Plan of Care "ready for use"; and CC distributes as agreed • Follow Plan of Care/ Negotiated Actions with responsibilities, accountabilities and timeline. • Family has clear access to CC for 3 months • All partners prioritize and work on their assigned tasks & documentation (flexibility as needed) • All use one another as resources • CC/Clinicians communicate with family and external partners per plan • CC monitors, oversees, completes **monthly measures** • **Care Coordination Huddles as needed and CC Rounds for individual/ population health** • **AT end of 3 months warm pass off to local care coordination contact is explicit** * **Note:** Anyone initiates reconvening team/new visits

STEP 3

Select, review and use a multi-faceted assessment with each patient and family

- Examples: "*Pediatric CC pre- visit Assessment", Bright Futures, Guided visit
- Use to frame health care "not as usual, this is something different"
- Prepare to address gaps with plan of care/visit, patient directed goal setting

Pre Visit Assessment Form (handout)

Families, please use the following to think through your top concerns and priorities for your child. We will discuss these on the phone and/or at your visit. Thank You.

Child/Youth Name_____Date_____
Family Name _____

1) What would you like us to know about your child?
What does he/she do well? Like? Dislike?

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

3) Do you have any concerns or worries for your child? (Some examples below)

- ❑ Their growth/development
- ❑ Learning
- ❑ Sleeping
- ❑ Self-care
- ❑ Making and keeping friends
- ❑ Communication
- ☐ Doing things for themselves
- ☐ Falling behind in school
- ☐ Behavior
- ☐ The future
- ☐ Playing with friends
- ☐ Other

4) Have there been any important changes recently, such as a:

- ❑ Brother of sister leaving home?
- ❑ Move to a new town?
- ❑ Sickness or death of a loved one?
- ☐ New job or job change?
- ☐ Separation or divorce?
- ☐ Other (fill in below)?

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

- ○ **Medical** (For example, help finding or understanding medical information; help finding health care for yourself or your family)?
- ○ **Social** (For example, having someone to talk to when you need to; getting support at home; finding supports for the rest of your family)?
- ○ **Educational** (For example, explaining your child's needs to teachers; help reading or understanding medical information)?
- ○ **Legal** (For example, discussing laws and legal rights about your child's health care or their school needs)?
- ○ **Financial** (For example, understanding insurance or finding help paying for needs that insurance does not cover - such as medications, formulas, or equipment)?
- ○ Environmental (For example help finding clean rugs, air filters or safety items for your home)

STEP 4

Set shared personal and clinical **goals**

- ***What Matters to you?***
  - vs. What is the Matter with you?
- Support patients and families to frame personal *goals
  - Short term clinical/personal
  - Long term goals "parking lot" (life-course)
  - Examples: behavior, preschool, enjoy a family event, prepare & go to college, find jobs, etc.

STEP 5

Identify other needed **partners** (e.g. subspecialists, community providers); link them into shared care-planning process

- Gather data supportive of a planned visit (e.g.)
  - Build Registry – CC, PCP,
- "Care Neighborhood"
  - Eco Maps
- Example: IN tap the "bench" – e.g. neurology, psychiatry, developmental pediatrics, child development, etc.

REGISTRY

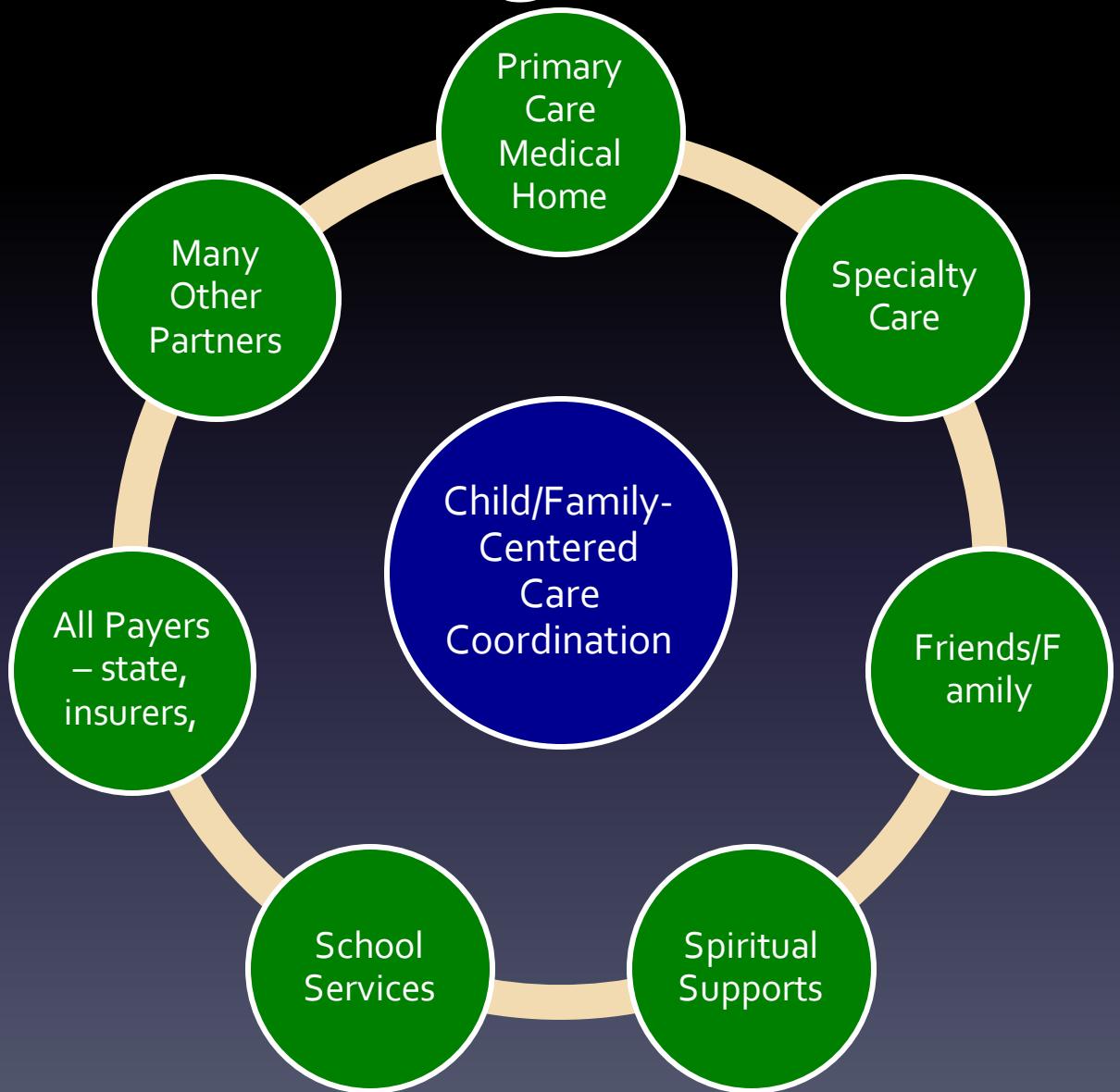
Name
Demographics
Date care coordination begins
Plan of care in place? Date
Condition
Primary Care Provider
Multiple Providers/Neighborhood
School/other
Complexity Score

Patient	DOB	Diagnosis	ETC.

Monthly Measures (see step 9)

Shared Plan of Care
Goals/progress against
Care Coordination Activity & Time:
- Prevent
- Promote

The Neighborhood



STEP 6

Develop the plan of care

–

*“Medical Summary”

- Shared Plan of Care - Template
  - Clinical section, CC section, Family section
  - Workflow
    - CC initiates assembly
    - Interacts with team
    - Shares/reviews w/family
    - Reiterates
- Outcome of visit or care conference
- {(IN) Special team develops/shares back to PCP with support to help them continue}

Name:
Last Review and update:

NDBS CC Pilot

Shared Plan of Care (Medical Summary & Negotiated Actions)

ABOUT ME

[INSERT PICTURE]

Strengths & preferred activities:	
How I learn:	
Interaction tips:	
Communication style:	
Tips to avoid triggers/behaviors:	
Mobility:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Medical Record Number/System:		
Primary contact last name:	First:		Birth date:	Age:	Sex: ☐ M ☐F
Street address:					
P.O. box:	City:		State:	Zip:	
Emergency contact:					

Name:
Last Review and update:

NDBS CC Pilot

About My Family

Race/Ethnicity:	
Unique family attributes:	
Family description of health condition:	
Family's support "system"	
Family life stressors:	
Housing:	☐ Own ☐ Rent
Emergency exit plan (fire, tornado, etc.):	
Transportation access/safety:	
Caregivers' occupations:	
Family financial concerns:	

Insurance Information

Primary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	
Secondary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	

Waiver application	Type:	☐ Waiting List	Date applied:
Medicaid redetermination date:			

Professionals & Services

Primary care clinician:		Phone:		Fax:	

Name:
Last Review and update:

NDBS CC Pilot

School

Setting:	☐ First Steps ☐ Head Start ☐ Preschool ☐ K-12; Grade: _____ ☐ Homeschooled ☐ Other_____		
School Name:		School District:	
Primary Contact:	☐ Classroom teacher ☐ Teacher of Record ☐ Other_____		
Contact Name:		Contact Email:	Contact Phone:
Services	☐ Has a 504 Plan ☐ Has an individualized education plan (IEP/IFSP) ☐ Response to intervention (RTI) ☐ Gifted services ☐ Physical therapy (PT) ☐ Occupational therapy (OT) ☐ Speech ☐ Other_____		

Childcare

Childcare type:	☐ Full-time ☐ Part-time ☐ In-home ☐ Center-based ☐ Voucher supported ☐ Respite only		
Name:			
Primary contact	☐ Classroom teacher ☐ Director ☐ Other_____		
Contact name:		Contact email:	Contact phone:

Vital Signs

Height:		Weight (date):	
Baseline BP/HR:		Baseline RR:	
BMI:	Percentile:	Z-score:	

Medication & Treatments

Medication name	Dose	Time of day	Reason	Route (by mouth unless noted). Other comments:

STEP 7

Establish the plan of care

*"Negotiated Actions"

- Framed goals are addressed
  - Develop strategies, timeline, responsibilities and accountabilities – *this is different*
- "Teach backs" and "reflect backs"
- Timely follow-up and duration
- {Example - IN team finalize plan, get back to family within 10 days, use for 3 months, transfer to "locus of care coordination" in community}

Name:
Last Review and update:

NDBS CC Pilot

Plan of Care: Negotiated Actions

Prioritized Goals	Action Items/strategies (To reach short term goals)	Person responsible	Target date	Resolved (Date)
Family Personal Goals & Priorities				
Communication with primary care and community				
Clinical Goals & Priorities				
Communication with primary care and community				


Don't let the
perfect
be the enemy
of the good.

STEP 8

Ensure that the plan of care is available, accessible, and retrievable

DREAMS

- Assemble into e-health record
  - E-Health Record prompts
    - ✓ Has Plan of Care
    - ✓ Needs Plan of Care?
    - ✓ Touch points in system
- Family access/print through portal
- Message to other providers

– "a common document is available"

WORKAROUNDS

- Electronic, paper, scanned, cloud, jump drive, what ever it takes! ***SHAREPOINT***
- Families are encouraged to advocate for use of plan of care across systems

STEP 9

Provide tracking, monitoring and oversight for the plan of care

- Frequent follow-up CC contacts
  - (Don't attempt all in 1 visit!)
  - Registry & ***monthly measures***
  - Progress against goals?
- Care coordination role development
- Planned check-in
- Supports patient/family/team with functions/oversight of plan of care
- Patients/families know they can call/contact
- *Build skills and locus of care coordination*

STEP 10

Systematically use the shared care-planning model process with patients and families identified in Step 1

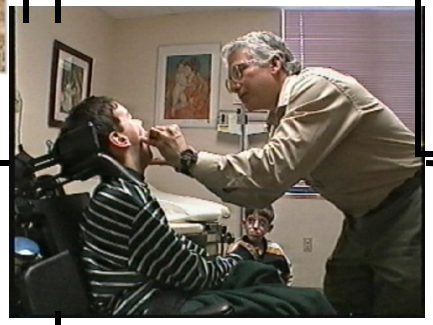
- VT CC Learning Collaborative
- MN Network-wide effort
- IN NDBS Statewide CC integrated
- Culture of practice
- More…

If this was *easy* . . .

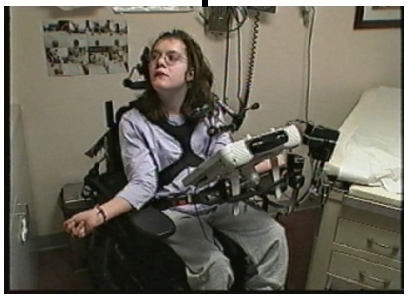
. . . .we would already have it nailed

Preparation

Planning



Coordination Of Care



Studied Implementation

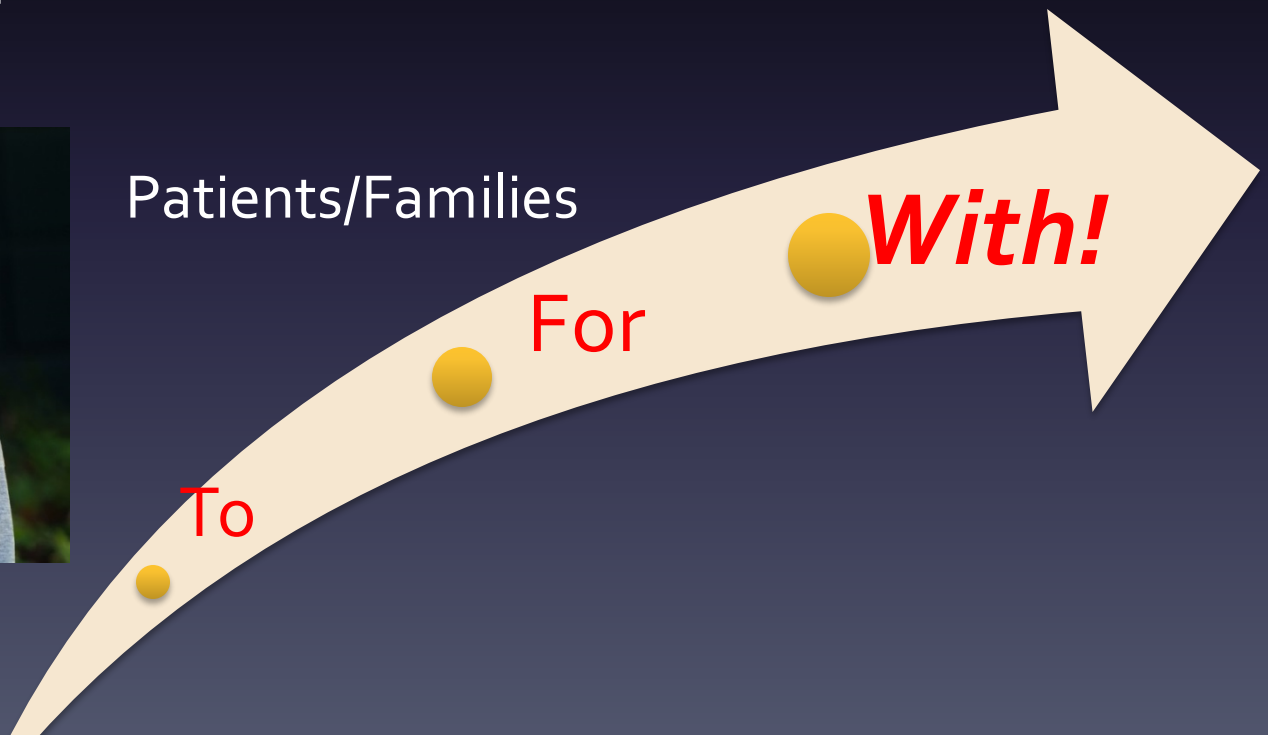
Testing & Continuous Improvement

PFC MEDICAL HOMES - Living, breathing, complex organizations

Quality Care/ Care Coordination

- Is best defined ***as close as possible*** to those for whom actions are meant to help and/or support

Gaucher & Coffey



Jeanne W. McAllister
jwmcalli@iupui.edu

Care plans are the solution!

(But what is at the root of the need, or question?)

Clarify: What do you want the plan of care to do, and for whom?

Clinician

Family

Shared Plan of Care
Needs/ Benefits for Patients For Kids/Youth/Families

Shared Plan of Care
Needs/ Benefits for Patients For Kids/Youth/Families

Engagement
Safety
Partnership
Relationship
Continuity
Helps

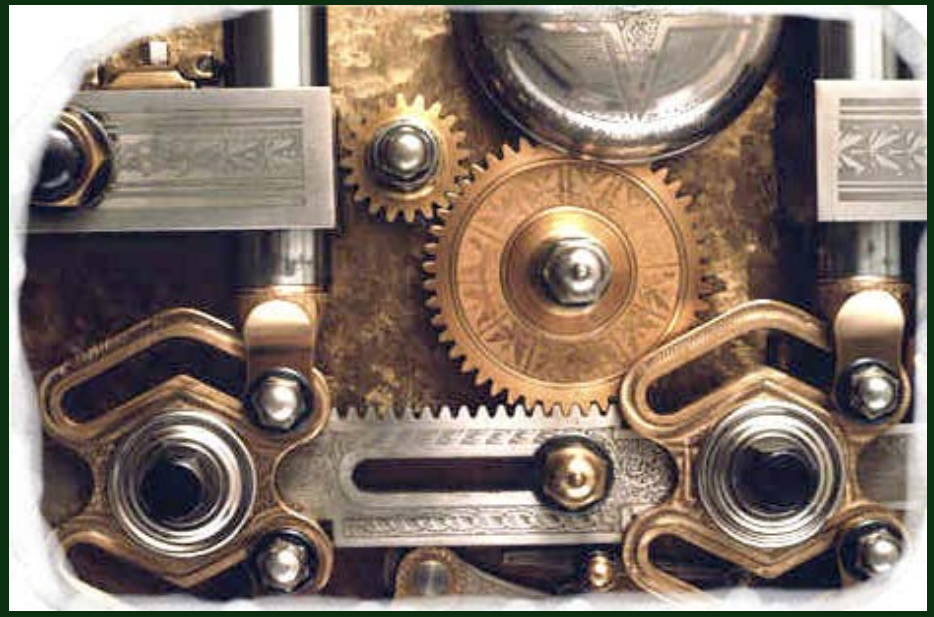
Shared Plan of Care

Needs/ Benefits – For Team / Providers

Shared Plan of Care
Needs/ Benefits - For Team / Providers

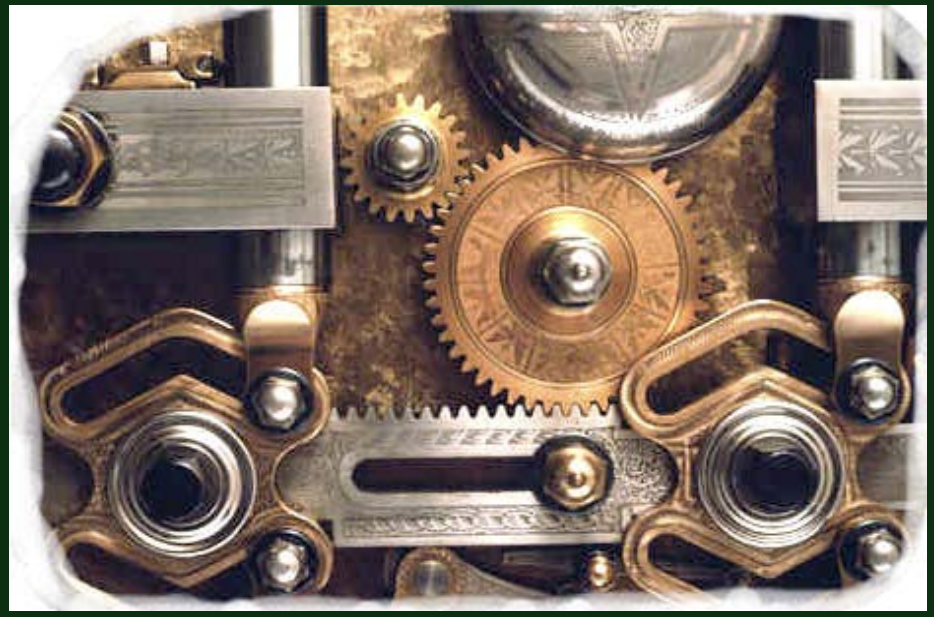
Clarity
Speed
Safety
Teamwork
Co-management
Learning

Shared Plan of Care Needs/Benefits – for System



Shared Plan of Care Needs/Benefits – for System

Collective impact (shared goals)
Population health
Integration
Costs



Care plans are the solution!

(But what is at the root of the need, or question?)

Clarify: What do you want the plan of care to do, and for whom?

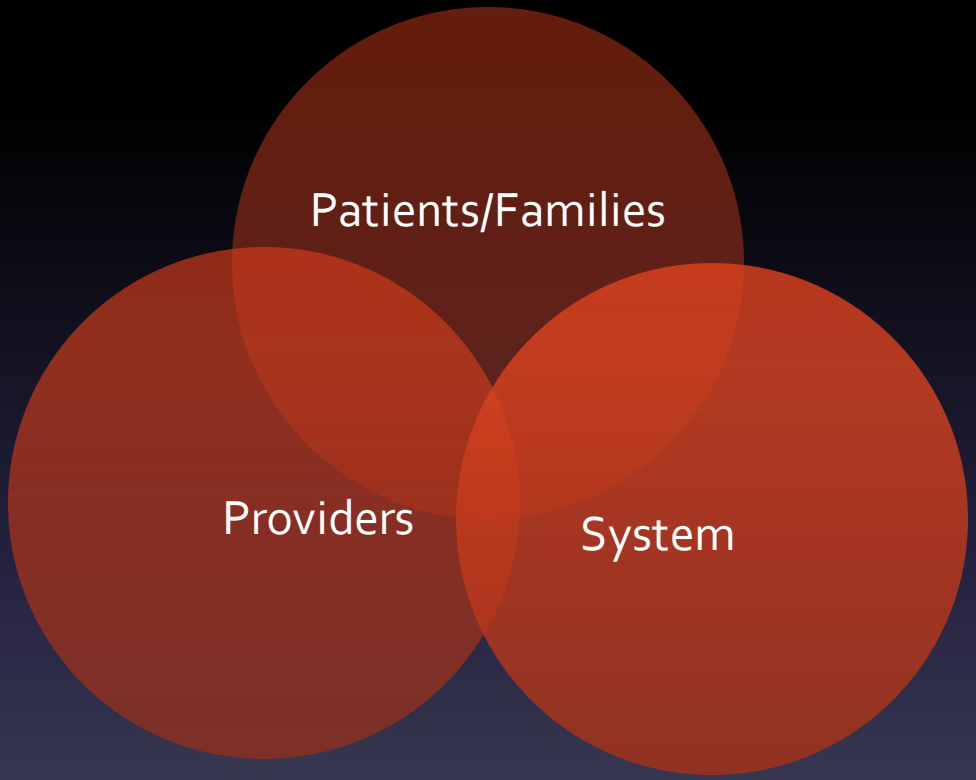
I want that critical medical information right in front of me; what's the problem & what's the solution…

Clinician

I want the doctor or nurse to know who my child is, what pleases her, our preferences and family strengths . . .

Family

Win Win



WHITNEY is a 15-year-old female who on her best days dreams of getting a drivers license. She has a history of longstanding uncontrolled Type 1 Diabetes. Compounding social factors contribute to school absences/truancy charges.

6-months prior to a switch - medical home w/care coordination /planned care-

9 ER visits;7 ketoacidosis related hospitalizations.

Overall Aim:

- Effective control management of Type 1 Diabetes
- Improved communication, collaboration, coordination among teen, family, clinicians & school team

Shared Goals:

1) Transition to insulin pump (pending Diabetes control)
2) Drivers license
3) Improve school performance

Negotiated Actions

- Enroll in quality medical home
- Engage with care coordinator
- Support teen / family
- Hold/attend care conferences
- Develop a plan of care; align partners
- Increase contact & communications /collaboration-medical home/school
- Overcome (persistent) communication & transportation barriers counseling
- Work w/Diabetes educator 2X/month
- Work w/ Dietician 2X/month

Goals ***Personal Goals***	**Strategies**	**Accountabilities**
1.Obtain drivers license	1. Link to Diabetes management adherence; requires good control	1. Teen and family work to achieve control with health care home assistance
2.Transition to an insulin pump	Same as above	Same as above
Clinical Goals	**Strategies**	**Accountabilities**
3.Diabetes Control (target glucose range of 70-180)	Food log, adherence to glucose monitoring and recording 4X/day, insulin management (now all dependent on mother/home vs. previous support of diabetes educator and dietician) as precursor to pump as well as driver's license	Patient and family will manage at home and communicate with care coordinator (X/ ---frequency)
4.Prevent admissions for ketoacidosis	Same	Monitoring will determine readiness for insulin pump as well as license
5.Reduced anxiety and depression	Services from a MN Family Treatment program; camp horse program participation	Family, Family Treatment and health care home team monitoring.

Results:

★ Medical Home, Care Coord, Care Conf, Plan of Care, ↑contacts, counseling

★ Ten mo. after "plan of care"
- 2 ER, 0 hosp.,
- A1C improved,
- ↑school attendance

licence & pump pending

AFTERNOON

STEP 6

Develop the plan of care

–

*“Medical Summary”

- Shared Plan of Care - Template
  - Clinical section, CC section, Family section
  - Workflow to complete
    - CC initiates assembly
    - Interacts with team
    - Shares/reviews w/family
    - Reiterates
- Outcome of visit or care conference
- {(IN) Special team develop/share back to PCP with support to continue}

Shared Plan of Care Medical Portion

Name:
Last Review and update:

NDBS CC Pilot

Shared Plan of Care (Medical Summary & Negotiated Actions)

ABOUT ME

[INSERT PICTURE]

Strengths & preferred activities:	
How I learn:	
Interaction tips:	
Communication style:	
Tips to avoid triggers/behaviors:	
Mobility:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Medical Record Number/System:		
Primary contact last name:	First:		Birth date:	Age:	Sex: ☐ M ☐F
Street address:					
P.O. box:	City:		State:	Zip:	
Emergency contact:					

Shared Plan of Care (Medical Summary & Negotiated Actions)

ABOUT ME	
Strengths & preferred activities:	Affectionate and sweet; good child; can easily figure out toys, can play games on phone/tablet; loves to help; likes Lego, Playdoh, cars, animals, books; shows good creative play; eats diverse foods
How I learn:	Benefits from picture cues to facilitate communication; Follows some 2-step directions; break down instructions into simpler steps
Interaction tips:	Uses utensils to self-feed, drinks with straw; uses crayons to scribble and color; some help with dressing; not toilet trained; time-outs work well
Communication style:	Some single words (10-20 words, difficult to understand), some signs (eat, drink, fish) and other gestures (waves "bye" and shakes head "no", pointing, crossing arms)
Tips to avoid triggers/behaviors:	Does not like loud noises; easily frustrated which can trigger aggression
Mobility:	Ambulatory but clumsy (due to balance problems – falls often)

Jenny
Sweet five year old girl with:
Neurodevelopmental: developmental delay, significant expressive communication delay
& History of ear infections, bilateral tubes, adenoidector
Ophthalmology: amblyopia
Genitourinary: incontinence

CONDITIONS & MEDICAL HISTORY LIST			
DIAGNOSIS	**DATE OF DIAGNOSIS**	**DIAGNOSIS**	**DATE OF DIAGNOSIS**
Birth/Genetic:		Cardiovascular:	
Dental:		Endocrine:	
Ears, Nose,Throat: **history of ear infections; bilateral tubes, adenoidectomy**		Gastrointestinal:	
Genitourinary: **incontinence**		Hematology:	
Infectious Disease:		Musculoskeletal:	
Neurologic:		Ophthalmology: **amblyopia**	
Psychiatric/Psychological:		Renal:	
Respiratory: **asthma**		Skin:	
Neurodevelopmental: **developmental delay; significant expressive communication delay**		Behavioral:	

Shared Plan of Care Medical Portion

- Pre School
- IEP/IESP (Speech and language improvement
  OT /Speech
- In childcare part time

School Name:	**Southview Preschool Center** Fax: 765-640-5162	School District:	**Anderson Community School Corporation**
Primary Contact:	X Classroom teacher X Teacher of Record ☐ Other_____		
Contact Name:	**Mrs. Washington**	Contact Email:	Contact Phone: 765-641-2360
Services	☐ Has a 504 Plan X Has an individualized education plan (IEP/IFSP): ***Speech/Language Imp.*** ☐ Response to intervention (RTI) ☐ Gifted services ☐ Physical therapy (PT) X Occupational therapy (OT) X Speech ☐ Other_____ **Current IEP effective date: of 3/10/2014-3/10/2015*		
Childcare			
Childcare type:	☐ Full-time x Part-time ☐ In-home ☐ Center-based ☐ Voucher supported ☐ Respite only		
Name:	**Erin McCarty – maternal grandmother in Jayden's or her home**		
Primary contact	☐ Classroom teacher ☐ Director X Other: grandmother		
Contact name:	Erin McCarty	Contact email:	Contact phone:
Vital Signs			

Shared Plan of Care

Name:
Last Review and update:

NDBS CC Pilot

About My Family

Race/Ethnicity:	
Unique family attributes:	
Family description of health condition:	
Family's support "system"	
Family life stressors:	
Housing:	☐ Own ☐ Rent
Emergency exit plan (fire, tornado, etc.):	
Transportation access/safety:	
Caregivers' occupations:	
Family financial concerns:	

Insurance Information

Primary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	
Secondary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	

Waiver application	Type:	☐ Waiting List	Date applied:
Medicaid redetermination date:			

Professionals & Services

Primary care clinician:		Phone:		Fax:	

Shared Plan of Care Medical Portion

Last review and update:

ALERTS

EMERGENCY/ADVANCED CARE INFORMATION:

**If needed, please see attached emergency or advanced care plan.*

MEDICATION ALLERGIES:

VITAL SIGNS

Height:		Weight (date):	
Baseline BP/HR:		Baseline RR:	
BMI:	Percentile:	Z-score:	

CONDITIONS & MEDICAL HISTORY LIST

DIAGNOSIS		DATE OF DIAGNOSIS	DIAGNOSIS		DATE OF DIAGNOSIS
Birth/Genetic:			Cardiovascular:		
Dental:			Endocrine:		
Ears, Nose, and Throat:			Gastrointestinal:		
Genitourinary:			Hematology:		
Infectious Disease:			Musculoskeletal:		
Neurologic:			Ophthalmology:		
Psychiatric/Psychological:			Renal:		
Respiratory:			Skin:		
Neurodevelopmental:			Behavioral:		

MEDICATIONS & TREATMENTS

Medication name	Form	Dose	Time of day	Reason	Route (by mouth unless noted). Other comments:

Last reconciled:	
Special medication instructions:	
Treatment Plan:	
Medication History:	
Allergies:	
Diet:	
Current Equipment:	
Equipment Needs:	

PROFESSIONALS & SERVICES

Primary care clinician:		Phone:		Fax:			
Non-clinician contact:		Phone:		Email:		Last visit:	
Street Address:	City:	State:	Zip:	Practice:			
Preferred pharmacy:		Phone:		Fax:			
Preferred hospital:		Phone:		Fax:			

Shared Plan of Care Medical Portion

Last review and update:

OTHER PROVIDERS	NAME/TYPE/LOCATION	LAST VISIT	REASON FOR SERVICE	CONTACT INFORMATION
Specialist 1:				
Specialist 2:				
Specialist 3:				
Specialist 4:				
Psych / Behavior:				
Dentist:				
Vision:				
Therapy (OT/PT/etc.):				
Hearing:				
Home Care:				
Community agency:				
Government services:				
Waiver/Other case manager:				
Equipment/Vendor:				

IMMUNIZATIONS

DTaP/DTP/TD								
OPV/IPV					HPV			
MMR			Varicella			Hep A		
Hep B				Meningococcus				
PPD				Pneumovax				
Flu								
HIB				Rotovirus		Tdap		

FAMILY MEDICAL HISTORY

Condition	Who?	Condition	Who?	Condition	Who?
Coronary Artery Disease:		Hypertension:		Diabetes:	
Mental Health:		Cancer Type:		Genetic:	
Neurodevelopmental:		Lipids:		Other:	

NOTES:

HOSPITALIZATIONS (date, reason, location if known)

SURGERIES (date, reason, location if known)

PROCEDURES (labs, imaging, etc.)

DIAGNOSIS SPECIFIC MONITORING

STEP 7

Establish the plan of care

*"Negotiated Actions"

- Framed goals addressed
  - Develop strategies, timeline and responsibilities and accountabilities – *this is different*
- "Teach backs" and "reflect backs"
- Timely follow up and duration
- {Example - IN team finalize plan get back to family within 10 days use for 3 months, transfer to "locus of care coordination"

Shared Plan of Care
Negotiated Actions

Name:
Last Review and update:

NDBS CC Pilot

Plan of Care: Negotiated Actions

Prioritized Goals	Action Items/strategies (To reach short term goals)	Person responsible	Target date	Resolved (Date)
Family Personal Goals & Priorities				
Communication with primary care and community				
Clinical Goals & Priorities				
Communication with primary care and community				

JON – Family from Malaysia; speak Hakha Chin and require very specific interpretation

ABOUT ME	
Strengths & preferred activities:	**Enjoys playing with cars, a musical keyboard and watching television**
How I learn:	
Interaction tips:	**Reaches towards what he wants; can make choice between 2 items; understands some simple commands; responds to his name; engages in reciprocal ball play**
Communication style:	**Single words**
Tips to avoid triggers/behaviors:	**Becomes frustrated when people do not understand what he needs/wants**
Mobility:	**Crawls, pulls to stand, limited walking with support from furniture and people**

I also have:
Global Developmental Delay; gross motor delay; expressive language delay

Plan of Care: Negotiated Actions

Prioritized Goals	Action Items/strategies (To reach short term goals)	Person responsible	Target date	Resolved (Date)
Family Personal Goals & Priorities				
Find therapy services that meet our family's schedule and transportation needs	1) Find nearby locations and/or one location that can provide all therapies 2) Coordinate therapies to be scheduled into fewest days and at times that do not conflict with school and work schedule 3) Determine ongoing transportation scheduling support	Holly/Family/Therapy providers	May 2015	
Get help with specialty doctor referrals and setting up appointments	1) Prioritize recommended referrals based on needs and concerns 2) Work with Dr. Geise to get needed referrals 3) Help schedule specialist appointments and arrange transportation 4) Provide family with written information about the appointment	Holly/Dr. Geise/Specialty providers/Family	June 2015	
Explore ways to extend [redacted] school day and learning opportunities	1) Check into Head Start programs 2) To be determined (as needed)	Holly/Family/Community Partners	July 2015	

Clinical Goals & Priorities				
Get diapers covered through Medicaid	1) Request order for incontinence supplies from Dr. Geise under incontinence diagnosis 2) Call to set-up account and service with Medicaid incontinence provider	Holly/Dr. Geise/Family	May 2015	
Apply for programs to help meet costs of needs	Explore appropriateness and eligibility for the following: 1) Children's Special Health Care Services 2) Women, Infants, and Children (WIC) program 3) Medicaid Waiver programs 4) Various grant programs, as needed	Holly/Family	June 2015	

Mary

Mary is an engaging verbal 4 year old, with cognitive strengths
Mary's parents are very involved with developing expertise, loving family,

Mary is also a 4 year old with tuberous sclerosis and intractable seizures) her self-injurious behaviors, tantrums, sleep dysfunction have her heading towards an in-patient psychiatry hospitalization

Seizures seemed the least of her concerns in comparison to behaviors
Despite having a developmental services waiver, respite care and a team of multidisciplinary medical experts at the quaternary center

Dr. Jill Rinehart

Patient/Family/Team Goals	Negotiated Next Steps Shared Care Planning	Process and Outcome measures
Less need for "crisis" intervention	Co-management from psychiatry, medical home and subspecialists In-home behavior list	Less need for police, mental health crisis support
Improve Sleep (all)	Same behavior plan across settings	Less communication errors about medications Improved work attendance
Increase Home Safety-of Mary and family	Improved psych pharm CSHN SW: Waiver allowed for enhanced access to in-home behaviorist	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

STEP 8

Ensure that the plan of care is available, accessible, and retrievable

DREAMS

- Assemble into e-health record
  - E-Health Record
    - ✓ Has Plan of Care
    - ✓ Needs Plan of Care?
    - ✓ Touch points in system
- Family access/print through portal
- Message to other providers

– "a common document is available for you"

WORKAROUNDS

- Electronic, paper, scanned, cloud, jump drive, what ever it takes! ***SHAREPOINT***
- Families are encouraged to advocate for use of plan of care across systems

SharePoint- Our workaround

Childs Record Can Contain	Team how can view/access
• Shared Plan of Care • Previous records/IEP • CC Notes/measures • Letters/Co-management agreements • Disability/waiver/other forms • Archive	• Care Coordinators • Clinicians across system • Researchers • Entire team • CC Help family access individual items

STEP 9

Provide tracking, monitoring and oversight for the plan of care

- Frequent follow-up CC contacts
  - (Don't attempt all in 1 visit)
  - Registry & ***monthly measures***
  - Progress against goals?
- Care coordination role development
- Planned check-in
- Supports patient/family/team with functions/oversight of plan of care
- Patients/families know they can call/contact
- *Build skills and locus of care coordination*

Monthly Measures

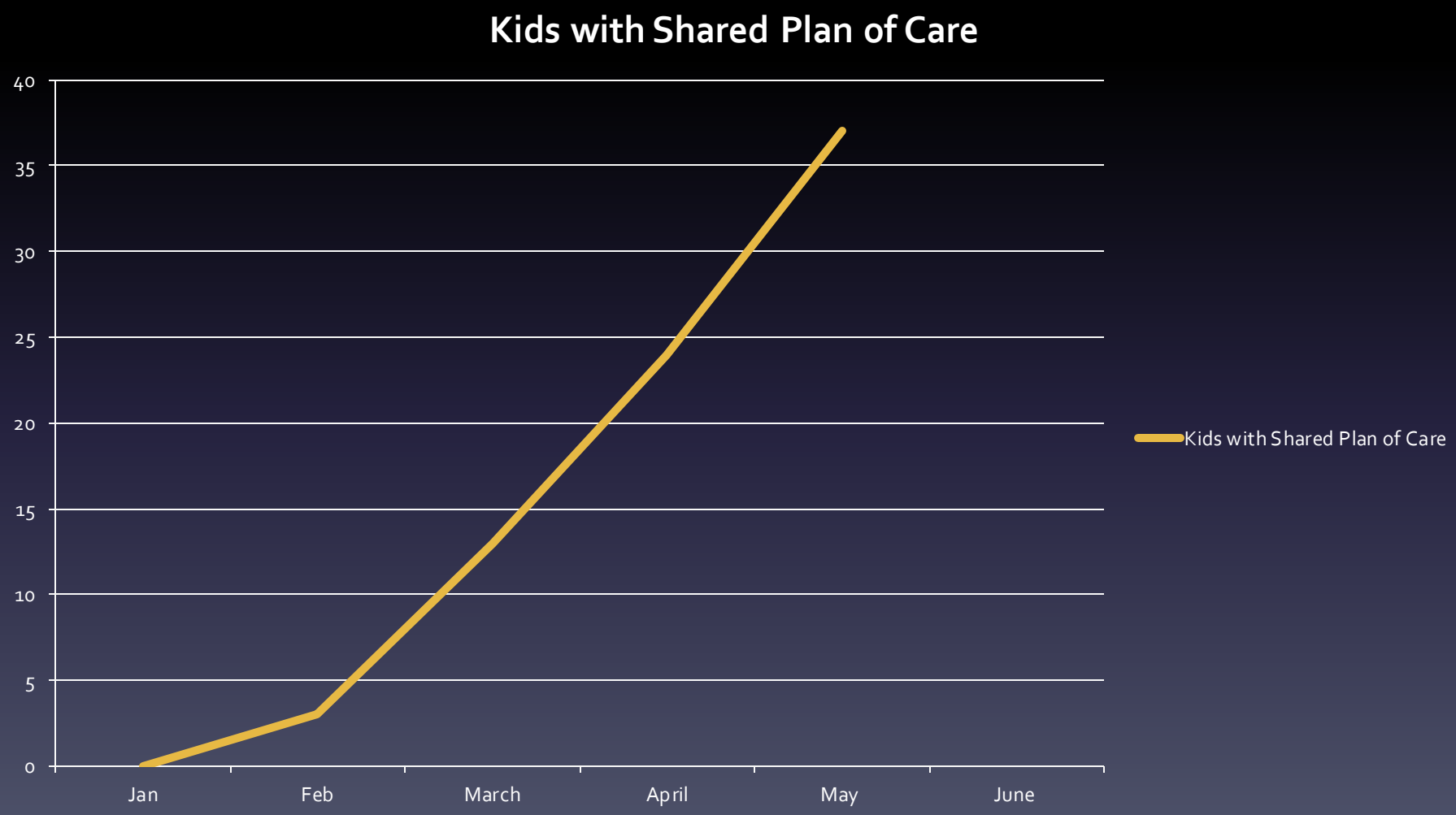
Child's Name | DOB | Planned Care Visit /Date | Complexity Score (1): | (Exit):

Family Name | Data points: 1/Date 2/Date 3/Date 4 /Date 5/Date

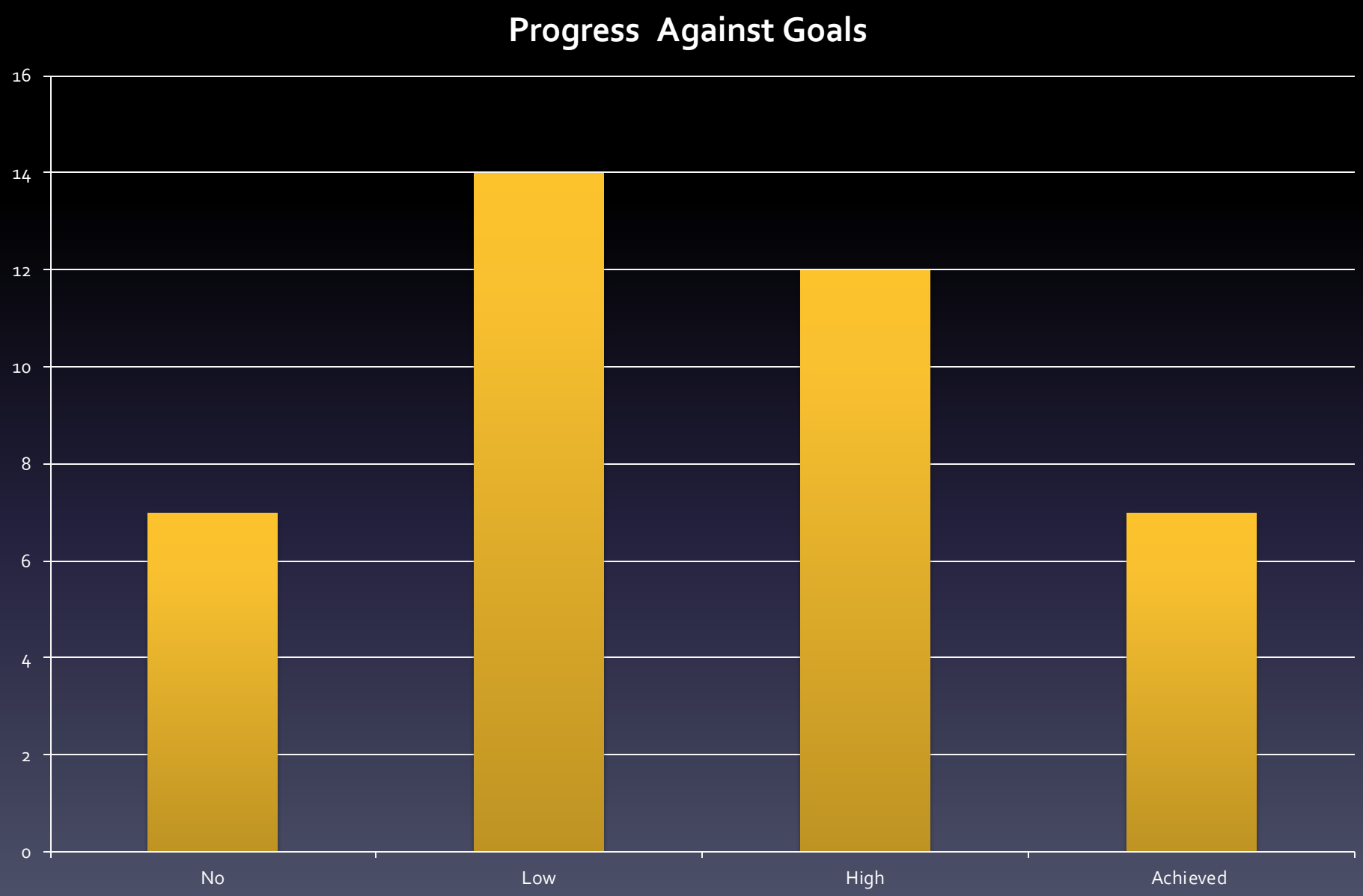
Planned Care with a Shared Plan of Care (medical summary, negotiated actions, other attachments)

1. **A shared plan of care is currently in place?** Yes No
2. **Child/family strengths are articulated in the shared plan of care?** Yes No
3. **Child/family preferences are articulated in the shared plan of care?** Yes No
4. **Family can identify a local "locus" or "go to" care coordinator(s) for future support?** **Yes** **No**
5. **Family articulates unmet health care needs?** None 1-3 needs More than 3 areas of need
6. **Family articulates unmet social support needs?** None 1-3 needs More than 3 areas of need
7. **Team identifies unmet bio-psychosocial needs?** None 1-3 needs More than 3 areas of need
8. **Coordinator/family shared assessment of *progress against goals*:**
   a. Child/family *progress against personal goal #1 (*original: _____) No Progress Low Progress High Progress Goal Achieved
   b. Child/family *progress against personal goal* #2 (original: _____) No Progress Low Progress High Progress Goal Achieved
   c. Team /family progress against clinical goal #1 (original: _____ _) No Progress Low Progress High Progress Goal Achieved
   d. Team/family progress against clinical goal #2 (original: _____) No Progress Low Progress High Progress Goal Achieved
9. **"Care Neighborhood" communication contacts this month:**
   a. Care coordinator (CC)/clinician initiated contacts with patient's "medical home" None 1-3 times More than 3 times
   b. "Medical home" initiated contacts with care coordinator/clinician None 1-3 times More than 3 times
   c. Contacts between *family and their medical home* (estimated) None 1-3 times More than 3 times
   d. Contacts among *family, coordinating team & specialists* (estimated) None 1-3 times More than 3 times
   e. Other initiated contacts (name): _____ None 1-3 times More than 3 times
10. **Care Coordination Activities:** **_Estimated_ Time (minutes)** **Outcome(s)/ activity promoted/prevented (goals, skills, ED/visits, etc.)**
    a. Develop/update plan of care _____ _____
    b. Communicate and connect _____ _____
    c. Counsel and teach _____ _____
    d. Advocate to secure resources _____ _____
    e. Other (name) _____ _____
11. **Other outcomes/comments:**

Monthly Measures



Monthly Measures – N=40



Teamwork/Care Conferencing
What are the salient facts?

Intro/Recap

Child _____is a ____years old boy/girl
Lives with _____
Lives in (county)_____
Primary language is _____
Strengths are _____
Diagnosis is/(are)
Primary care provider is
Relationship with PCP is strong, moderate, weak

Needs, Concerns & Priorities

What outcomes are resulting?

Outcomes as a result of care coordination

I am promoting____

I am preventing____

I am learning _____

Any early outcomes from CC activities include_____

What are the costs?

Clinician Enters Care Plan Oversight Code

99339-XX (<30")
99340-XX (> 30")

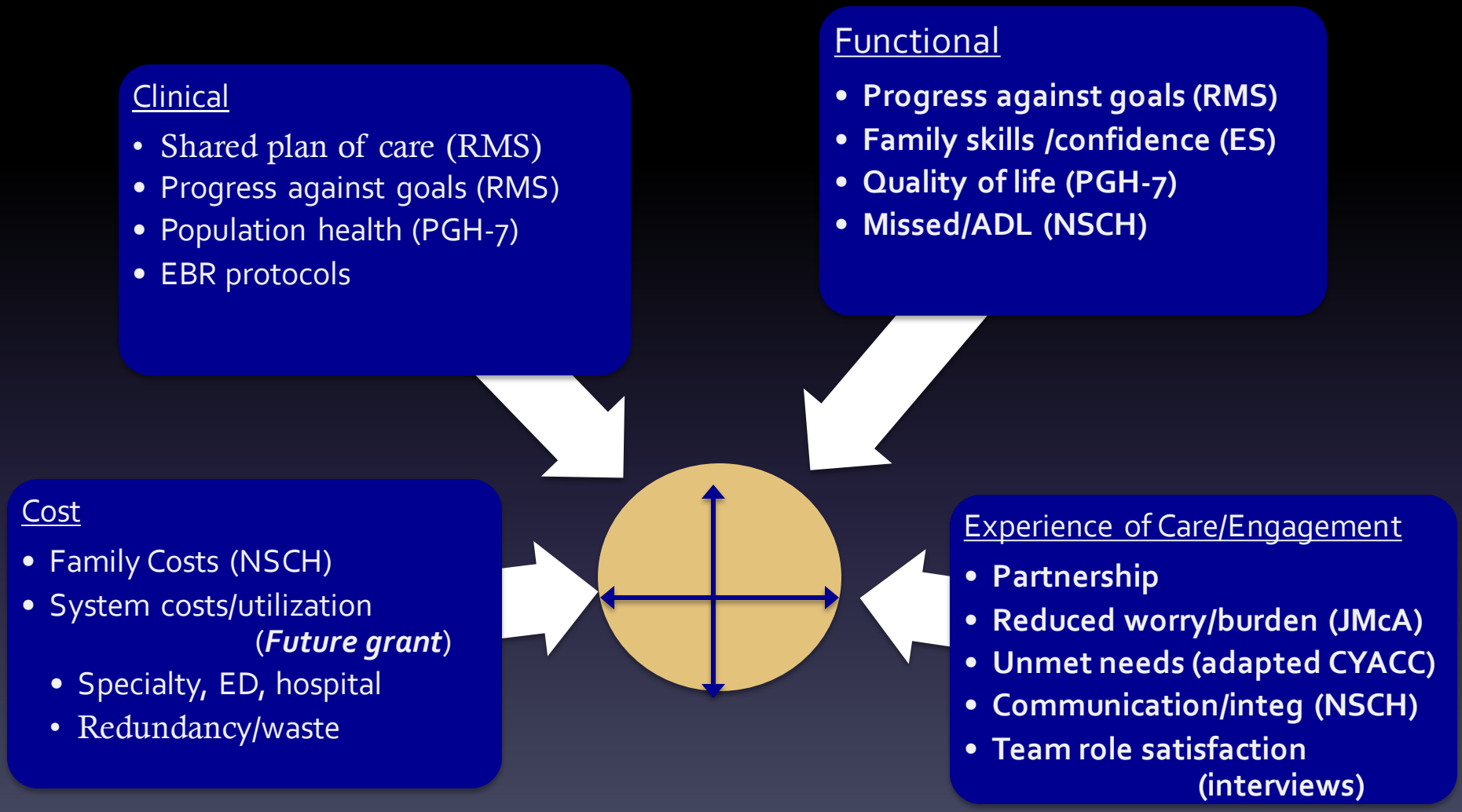
Track billable time for E&M or consultation visit
Track "dummy billing"
Track care coordination time and outcomes

STEP 10

Systematically use the shared care-planning model process with patients and families identified in Step 1

- Culture of practice/ or practices
  - Care Coordination Rounds
- VT - CC Learning Collaborative
- MN - Network-wide effort
- Indiana NDBS Statewide Care Coordination efforts
- More …

Shared Plan of Care – Anticipated Outcomes
Child, Family & Team Indicators



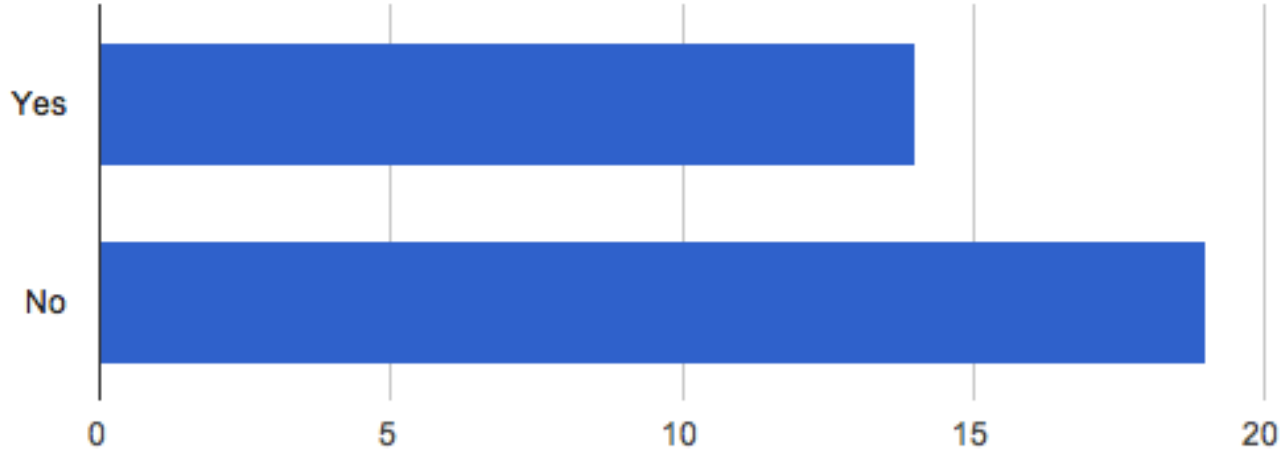
Framed using the clinical values compass; Batalden, P. & Nelson, E., Dartmouth Med

In the last 3 months, did anyone at your child's doctor or nurse's office work with you to create a plan of care?

Refresh Plot | View as Bar Chart

Total Count (N)	Missing	Unique
33	3 (8.3%)	2

Counts/frequency: Yes (14, 42.4%), No (19, 57.6%)

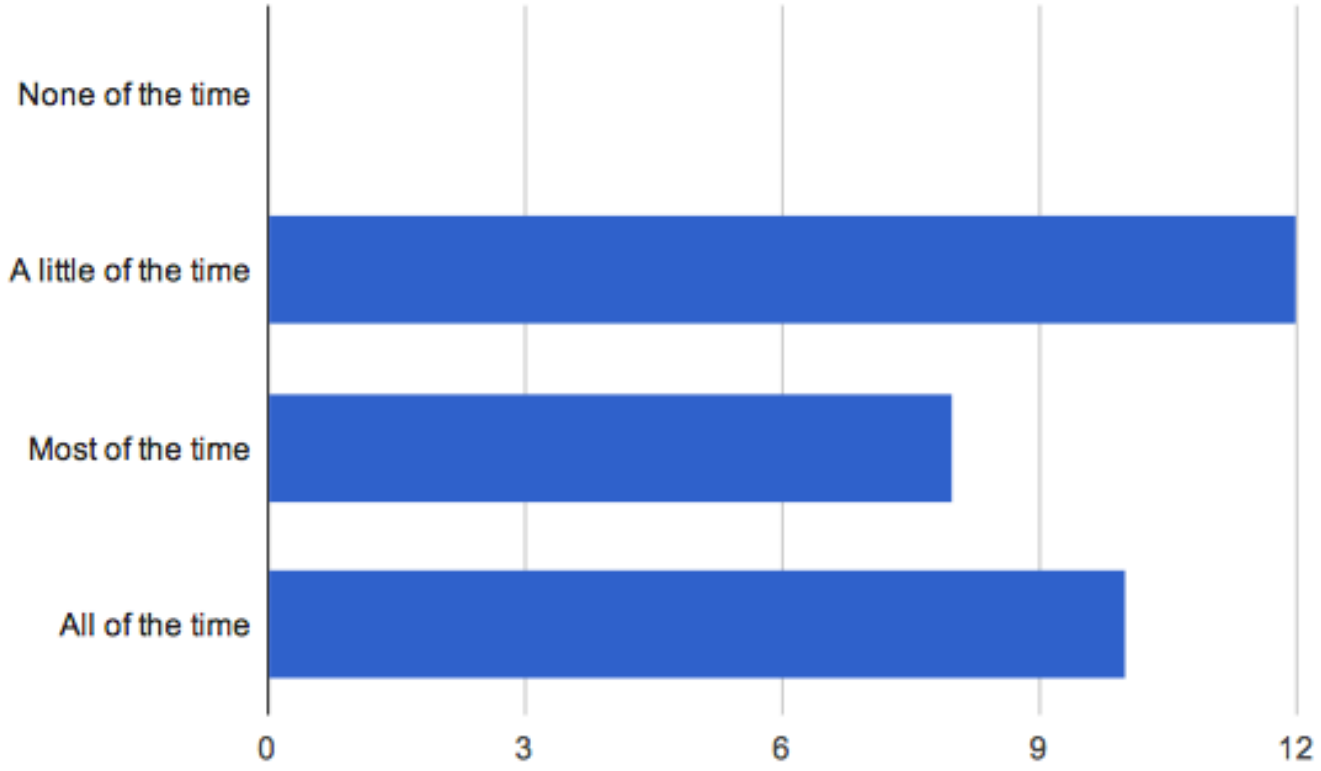


During the last 3 months how often have you worried about your child's health?

Refresh Plot | View as Bar Chart

Total Count (N)	Missing	Unique
30	6 (16.7%)	3

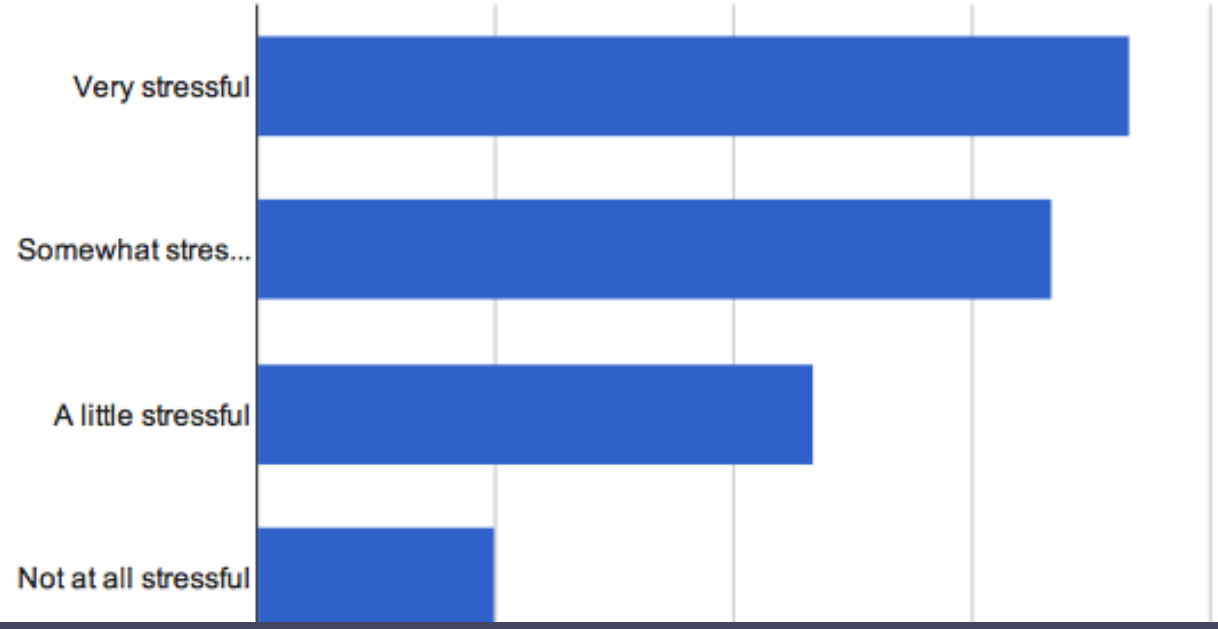
Counts/frequency: None of the time (0, 0.0%), A little of the time (12, 40.0%), Most of the time (8, 26.7%), All of the time (10, 33.3%)



How stressful is it to take care of your child?

Total Count (N)	Missing	Unique
31	5 (13.9%)	4

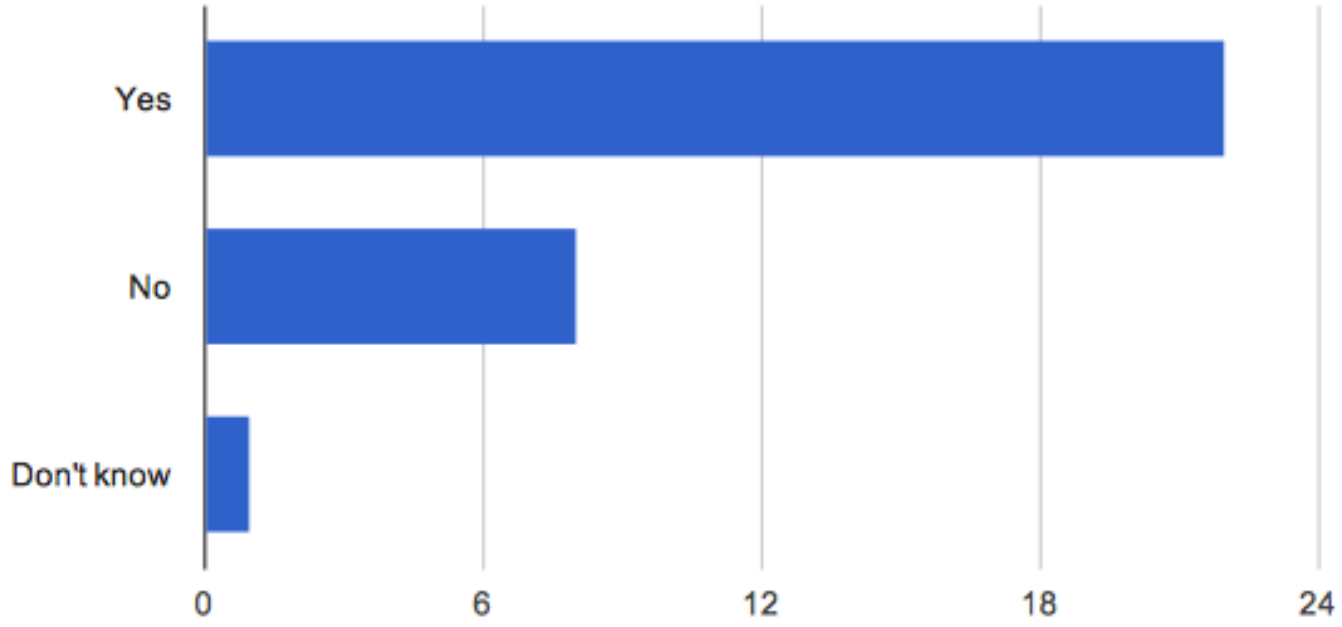
Counts/frequency: Very stressful (11, 35.5%), Somewhat stressful (10, 32.3%), A little stressful (7, 22.6%), Not at all stressful (3, 9.7%)



Does your child's medical, behavioral, or other health conditions (emotional, developmental, or behavioral problems) interfere with his or her ability to go on outings, such as to the park, library, zoo, shopping, church, restaurants, or family gatherings? Refresh Plot | View as Bar Chart

Total Count (N)	Missing	Unique
31	5 (13.9%)	3

Counts/frequency: Yes (22, 71.0%), No (8, 25.8%), Don't know (1, 3.2%)



A few more thoughts

- Research and evaluation/ collect analyze & share data
- Implementation science approach
- Budget, scope, duration
- Ready, aim, aim, aim - must go forward!
- Select together:
- -Model, definition, approach, population, criteria,
- Meetings-
  - Lots: all, coordinators, managers
  - For – process, patient care, "dating and speed dating"
  - Billing and dummy billing (Indiana example)

Coordination - management of interdependencies between distinct *tasks*.

Relational coordination- management of interdependencies between the *people* who perform tasks (Jody Gittell).

Optimize Relational Coordination:

1. Shared goals
2. Timely communication
3. Creation of new knowledge

Mutual respect

Use "Boundary Spanners"

- Care coordinators
- Shared goals across settings


Don't let the
perfect
be the enemy
of the good.

Patient & Family-Centered Medical Home
Planned Coordinated Care & Plans of Care
Across the life course for children, youth and adults

References

1. National Quality Forum. NFQ endorses care coordination measures. Retrieved at http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Care_Coordination_Measures.aspx
2. American Academy of Pediatrics Council on Children with Disabilities and Medical Home Advisory Committee. (2014). Patient and family centered care coordination: A framework for integrating care for children and youth across multiple systems. *Pediatrics*, 133(5), e1451-e1460.
3. Antonelli, R.J., McAllister, J., & Popp, P. (2009). *Making care coordination a critical component of the pediatric health care system: A multidisciplinary framework*. New York, New York: The Commonwealth Fund.
4. McAllister, J.W. (2014). Achieving a shared plan of care with children and youth with special healthcare needs: White paper and implementation guide. Lucile Packard Foundation for Children's Health. Retrieved from http://lpfch-cshcn.org/publications/research-reports/achieving-a-shared-plan-of-care-with-children-and-youth-with-special-health-care-needs/
5. Cooley, W. C, McAllister, J.W., Sherrieb, K., Clark, R.E. The Medical Home Index: Development and Validation of a New Practice-level Measure of Implementation of the Medical Home Model. Ambulatory Pediatrics, July/August 2003 ; Vol 3, No 4: 173-180.
6. Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs*, *20*(6), 64-78.