# Medical Home Practice-Based Care Coordination:

## A Workbook By:

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**Beyond the Medical Home: Cultivating Communities of Support for Children/Youth with Special Health Care Needs**
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Workbook Contents

This workbook includes the tools and supports needed for a primary care practice to develop their capacity to offer a pediatric care coordination service; particularly for children with special health care needs. The health care team, determined to develop such an explicit service, makes an assessment of current care coordination practice and frames their improvement efforts to achieve proactive comprehensive practice-based care coordination. Tools included in this resource are: a definition of care coordination in the medical home, a care coordination position description, a framework for care coordination services including structures and processes, strategies for the protection of devoted staff time, and a logical sequence of care coordination improvement ideas offered in the context of the Model for Improvement (Langley, 1996). Each tool can be used as is or it can be customized in a manner which best fits your practice environment and the strategic plans your organization holds for medical home improvement activities.

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# Medical Home - Practice-Based Care Coordination

This workbook is designed to support practice-based quality improvement teams in their efforts to build comprehensive primary care "medical homes". The focus is specifically upon the professional role development for the provision of practice-based care coordination. The ideal care scenario is one where the staff within the medical home is proactively prepared to support the central care giving role of families. The role of care coordination discussed within this workbook is one designed in the service of children/youth with special health care needs (CYSHCN). It is acknowledged that care coordinators in different environments will apply their skills and efforts toward the care of all children as well as adults with special needs or chronic health conditions; you should find the structures and processes offered within suitably applicable.

Workbook Goals and Objectives:

Goal: To put forth a practice-based medical home care coordination framework from which practices can select and suitably customize. Contents include a medical home care coordination checklist, definition, position description, model framework with structures and processes, and strategies for effective and successful care coordination development and implementation.

Objectives:

1) Define practice-based care coordination for children with special health care needs in a medical home
2) Select and appropriately modify a position description that fits each unique medical home improvement team environment
3) Use a care coordination model framework to fit the role well within each practice environment
4) Draw from a list of time protection and resource allocation strategies those with the best fit for the practice environment and related improvements
5) Develop tests of change (PDSA - plan, do, study, act) for the incremental development of a comprehensive care coordination service model to include: care services, assessment of needs, care planning, transition support, and community outreach with resource linkages.

It is established in the literature that the medical home is meant to be a centralizing resource for children and families, particularly for CYSHCN (AAP Medical Home Advisory Committee, 2002) Evidence is building that care coordination is essential to a medical home (Antonelli, 2004). It has been suggested that you cannot be a strong medical home without the capacity to link families with a designated care coordinator; this is the ideal. The policy statement issued by the American Academy of Pediatrics on Care Coordination (CC) describes CC as complex, time consuming, even frustrating but as *key* to effective management of complex issues in a medical home; and states that a designated care coordinator is necessary to facilitate optimal outcomes and prevent confusion. Care coordination takes resources and time. Practices need to be reimbursed for this labor intensive role (AAP Committee on Children with Disabilities, 1999). Horst, Werner, and Werner (2000) state that in all types of systems, care coordination is an essential element to ensure quality and continuity of care for CSHCN and their families. In a 10 point strategy to

achieve transformational change within health care for all, issued by the Commonwealth Fund, care coordination is cited as one of ten key components to organize care and information around the patient (Davis, K. 2005).

Ideal care coordination provides timely access to services, continuity of care, family support, strengths-based rather than deficit-based thinking and advocacy. This is very time consuming, whether accomplished by parents or by parent professional partnerships (Presler, 1998). At the front lines of care, in the medical home Antonelli (2004) states that without the ability to support care coordination at the level of the medical home, barriers to achieve the Healthy People 2010 objectives remain. In the Future of Children (2005) the author claims that care coordination requires (at the very least) adequate personnel and time and is often limited in primary care by lack of the very time and resources necessary. This is substantiated by the AAP Periodic Survey of Fellows #44, (2000), by a national Family Voices Survey (2000) with parents reporting their physicians have the skill for coordination but are difficult to access and have minimal time available for care coordination activity/implementation. Similarly a survey of state Title V Directors and their perception of barriers to care coordination in the medical home includes: time, reimbursement, lack of physicians, lack of skill/training, and limited cultural effectiveness.

Successful medical homes result when partnerships with families offer fully implemented practice-based care coordination. Proactive care coordination and care planning are fundamentally essential for improved care quality, access to services and resources, health and function of children and youth, and quality of life as well as improved systems of care. No medical home will achieve optimal comprehensive, coordinated and compassionate care without dedicated time and resources to develop, implement, and evaluate a complement of care coordination activities. Such an investment is favorable in terms of cost and benefit for children/youth and families, primary care practices and their broader health care systems.

In summary, **care coordination:**

- Is accomplished everyday by families with and for their children and youth, but
- Support is desirable, feasible and beneficial coming from the medical home
- Requires critical funding and protected time
- Requires tested tools and strategies (some are included in this workbook, others have been developed and continue to evolve)
- Is a defining characteristic (element) of a fully implemented and comprehensive medical home

## Medical Home Care Coordination – A Definition

The literature offers several definitions of care coordination but most have been written for application across varied health care environments such as hospitals, specialty based centers, community & home health agencies. Few definitions focus exclusively on the distinctions found within the primary care medical home for the role of practice-based care coordinator. The focus of the Center for Medical Home Improvement is on the primary care practice with the provision of team-based care coordination, delivered from the centralizing resource of a primary care medical home with physician leadership and by experienced nurses, social workers, and/or comparable professionals.

## Care Coordination

Practice-based care coordination within the medical home is a direct, family/youth-centered, team oriented, outcomes focused process designed to:

- Facilitate the provision of comprehensive health promotion and chronic condition care;
- Ensure a locus of ongoing, proactive, planned care activities;
- Build and use effective communication strategies among family, the medical home, schools, specialists, and community professionals and community connections; and
- Help improve, measure, monitor and sustain quality outcomes (clinical, functional, satisfaction and cost

(McAllister, et al, 2007)

## A Vision for Practice Based Care Coordination

Children, youth, and families have seamless access to their team, enhanced by they availability of a designated care coordinator who facilitates a team approach to family-centered care coordination services.

(McAllister, et al, 2007)

**Is It Medical Home Care Coordination?**

Checklist – how are you doing?
What elements are in place, which require some additional attention?

| | NO / PARTIALLY/ YES |
|---|---|
| 1) Families know who their care coordinator is and how to access him or her (or their backup)? | 1 2 3 |
| 2) Values of family-centeredness are known to the medical home team and drive the development and provision of care coordination? | 1 2 3 |
| 3) A medical home care coordination position description is established; roles/activities are clearly articulated and care coordination training and education is available? | 1 2 3 |
| 4) Administrative leadership helps to develop/support a care coordination service system; protected time allows for CC role development? | 1 2 3 |
| 5) CYSHCN identification and assessment of child/family needs/unmet needs are completed; care planning is a core CC/medical home response? | 1 2 3 |
| 6) Education and counseling are offered as an essential part of medical home care coordination? | 1 2 3 |
| 7) Care coordination includes comprehensive resource information, referrals, and cross agency/organization communication? | 1 2 3 |
| 8) Child/family advocacy is a part of care coordination | 1 2 3 |
| 9) Families are asked for feedback about their experiences with health services/care coordination? | 1 2 3 |
| 10) Medical home system improvements are implemented simultaneously with the development of care coordination (care coordinator contributes to this quality improvement process)? | 1 2 3 |

Total score: _____/ out of 30.

Notes:

## Medical Home (Practice Based) Care Coordination - Position Description

The care coordinator works within the context of a primary care medical home, from a team approach, and in continuous partnership with families and physicians to promote: timely access to needed care, comprehension and continuity of care, and the enhancement of child and family well being.

Care Coordination Qualifications: The care coordinator shall have:

- Bachelor's preparation as a nurse, social worker, or the equivalent with appropriate past experience in health care
- Three years relevant experience, or the equivalent, in community based pediatrics or primary care, particularly in the care and service of vulnerable populations such as children/youth with special health care needs (CYSHCN)
- Essential leadership, advocacy, communication, education and counseling, and resource research skills
- Core philosophy or values consistent with a family-centered approach to care
- Culturally effective capabilities demonstrating a sensitivity and responsiveness to varying cultural characteristics and beliefs

Medical Home Care Coordination Responsibilities The care coordinator will:

1) Demonstrate and apply knowledge of the philosophy/ principles of comprehensive, community based, family-centered, developmentally appropriate, culturally sensitive care coordination services
2) Facilitate family access to medical home providers, staff and resources
3) Assist with or promote the identification of patients in the practice with special health care needs (such as CYSHCN); add to registry and use to plan and monitor care
4) Assess child/patient and family needs and unmet needs, strengths and assets
5) Initiate family contacts; create ongoing processes for families to determine and request the level of care coordination support they desire for their child/youth or family member at any given point in time
6) Build care relationships among family and team; support the primary care-giving role of the family
7) Develop care plan with family/youth/team (emergency plan, medical summary and action plan as appropriate)
8) Carry out care plans, evaluate effectiveness, monitor in a timely way and effect changes as needed; use age appropriate transition timetables for interventions within care plans
9) Serve as the contact point, advocate and informational resource for family and community partners / payers
10) Research, find, and link resources, services and supports with/for the family
11) Educate, counsel, and support; provide developmentally appropriate anticipatory guidance; in a crisis, intervene or facilitate referrals appropriately
12) Cultivate and support primary care & subspecialty co-management with timely communication, inquiry, follow up and integration of information into the care plan
13) Coordinate inter-organizationally among family, medical home, and involved agencies; facilitate "wrap around" meetings or team conferences and attend community/school meetings with family as needed and prudent; offer outreach to the community related to the population of CYSHCN
14) Serve as a medical home quality improvement team member; help to measure quality and to identify, test, refine and implement practice improvements
15) Coordinate efforts to gain family/youth feedback regarding their experiences of health care (focus groups, surveys, other means); participate in interventions which address family/youth articulated needs

# Medical Home (Practice Based) Care Coordination Position Description Responsibilities Worksheet – Customize for Your Practice

| **Care Coordination in a Medical Home – The Care Coordinator will:** | **Accept** | **Reject** |
|---|---|---|
| 1) Demonstrate and apply knowledge of the philosophy/ principles of comprehensive, community based, family-centered, developmentally appropriate, culturally sensitive care coordination services | | |
| 2) Facilitate family access to medical home providers, staff and resources | | |
| 3) Assist with or promote the identification of those with special health care needs (such as CYSHCN); add them to the registry and use it to plan and monitor care | | |
| 4) Assess child/patient and family needs/unmet needs, strengths and assets | | |
| 5) Initiate family contacts; create ongoing processes for families to determine and request the level of care coordination support they desire for their child, youth or family member at any given point in time | | |
| 6) Build care relationships among family and team; support the primary care giving role of the family | | |
| 7) Develop care plan with family/youth/team (emergency plan, medical summary and action plan as appropriate) | | |
| 8) Carry out care plans, evaluate effectiveness, monitor in a timely way and make changes as needed; use age appropriate transition timetables for interventions within care plans | | |
| 9) Serve as contact point, advocate and informational resource for family and community partners/payers | | |
| 10) Research find, and link resources, services and supports with/for the family | | |
| 11) Educate, counsel, and support; provide developmentally appropriate anticipatory guidance; in a crisis, intervene or facilitate referrals appropriately | | |
| 12) Cultivate and support primary care & subspecialty co-management with timely communication, inquiry, follow-up and integration of information into the care plan | | |
| 13) Coordinate interorganizationally among family, the medical home, and involved agencies; facilitate “wrap around” meetings or team conferences and attend community/school meetings with family as needed and prudent; offer outreach to the community related to the population of CYSHCN | | |
| 14) Serve as a medical home quality improvement team member; help to measure quality and to identify, test, refine and implement practice improvements | | |
| 15) Coordinate efforts to gain family feedback regarding their experience with health care(focus groups, surveys, other means); participate in interventions that address family/youth articulated needs | | |

**** Add additional key responsibilities here (use additional paper):*

## A Medical Home (MH), Team Based, Care Coordination (CC) Framework

| Fundamental Structures | Medical Home Interventions | Tools |
|---|---|---|
| ***Access to Medical Home, Health Care and Other Resources*** | ♦ Identify and register the CYSHCN population<br>♦ Establish with families effective means for medical home/office access<br>♦ Provide accessible office contract for family and community agencies<br>♦ Catalog resources to link families to appropriate educational, information and referral sources<br>♦ Promote and "market" practice-based care coordination to families and others (e.g. brochures, posters, outreach efforts) | |
| ***Community Connections*** | ♦ Establish alliances with community partners<br>♦ Facilitate practice & family linkages with agencies (e.g. family support, schools, early intervention, home care, day care &agencies offering respite, housing, & transportation)<br>♦ Align transition support activities with schools & other groups<br>♦ Collaborate to improve systems of care for CYSHCN (families, payers, provides, and agencies) | |
| **Fundamental Processes** | **Medical Home Interventions** | |
| ***Proactive Care Planning*** | ♦ Help to maintain health and wellness & prevent secondary disease complications<br>♦ Maximize outcomes (e.g. alleviation of the burden of illness, effective communication across organizations, enrollment in needed services, and school attendance/success)<br>♦ Listen, counsel, educate, & foster family skill building<br>♦ Screen for unmet family needs<br>♦ Develop written care plans; implement, monitor and update regularly<br>♦ Plan for future transition needs; incorporate into plan of care<br>♦ Facilitate subspecialty referrals, communication & help family integrate recommendations of specialists<br>♦ Link family, staff to educational/financial resources | |
| ***Improving and Sustaining Quality*** | • Establish alliances with community partners<br>• Facilitate practice & family linkages with agencies (e.g. family support, schools, early intervention, home care, day care & agencies offering respite, housing, & transportation)<br>• Align transition support activities with schools & other groups<br>• Collaborate with families, payers, providers and community agencies to improve systems of care for CYSHCN | |

# A Medical Home (MH) Care Coordination Framework - WORKSHEET

| Fundamental Structures | Medical Home Interventions | Who? How? |
|---|---|---|
| ***Access to Medical Home, Health Care and Other Resources*** | ♦ Identify and register the CYSHCN population<br>♦ Establish with families effective means for medical home/office access<br>♦ Provide accessible office contract for family and community agencies<br>♦ Catalog resources to link families to appropriate educational, information and referral sources<br>♦ Promote and "market" practice-based care coordination to families and others (e.g. brochures, posters, outreach efforts) | |
| ***Community Connections*** | ♦ Establish alliances with community partners<br>♦ Facilitate practice & family linkages with agencies (e.g. family support, schools, early intervention, home care, day care &agencies offering respite, housing, & transportation)<br>♦ Align transition support activities with schools & other groups<br>♦ Collaborate to improve systems of care for CYSHCN (families, payers, provides, and agencies) | |
| **Fundamental Processes** | **Medical Home Interventions** | **Who? How?** |
| ***Proactive Care Planning*** | ♦ Help to maintain health and wellness & prevent secondary disease complications<br>♦ Maximize outcomes (e.g. alleviation of the burden of illness, effective communication across organizations, enrollment in needed services, and school attendance/success)<br>♦ Listen, counsel, educate, & foster family skill building<br>♦ Screen for unmet family needs<br>♦ Develop written care plans; implement, monitor and update regularly<br>♦ Plan for future transition needs; incorporate into plan of care<br>♦ Facilitate subspecialty referrals, communication & help family integrate recommendations of specialists<br>♦ Link family, staff to educational/financial resources | |
| ***Improving and Sustaining Quality*** | • Establish alliances with community partners<br>• Facilitate practice & family linkages with agencies (e.g. family support, schools, early intervention, home care, day care & agencies offering respite, housing, & transportation)<br>• Align transition support activities with schools & other groups<br>• Collaborate with families, payers, providers and community agencies to improve systems of care for CYSHCN | |

## Time Protection Tips & Strategies

The statement (on page 4) that no medical home will achieve optimal comprehensive, coordinated and compassionate care without dedicated time and resources to develop, implement, and evaluate a complement of care coordination activities warrants a few tips about how to achieve such dedicated time. Ideas for the successful implementation of practice based care coordination include administratively supported techniques and the resulting implemented care coordination (systematic) processes. Consider the following suggestions for time protection and use them to craft your own strategic approaches.

**Administrative Strategies for Achieving Some "Think" and Implementation Time**

- Personnel - proactively allocate a block of dedicated time. This includes the number of hours, days and time blocks or hours and how those hours will be prepared for, spent and accounted for. (This can be done as a trial or test of change)
  - You may need a private place, an office, or even a "my care coordination development hat is on today" sign!
- Clear activities – Use the position description and the CC framework on page 9 to select the focus and logical progression of this role development and how time will be spent
- Determine how you will document and/or account for this time
- Team based care coordination – determine how you will allow for the development of care coordinator - family partnership.
- Could there be a designated clinic time for specific group of CYSHCN, or a special condition focused approach with a care coordination protocol?
  - Some practices have held what is referred to as a DIGMA (drop in group medical appointments) for a group of families with children with similar conditions. A DIGMA can take on many forms such as family education, community resource connections, or even time for care coordination introduction and development with the opportunity to meet, greet and complete care plans.

**Approaches Helpful to Building Time into Your System**

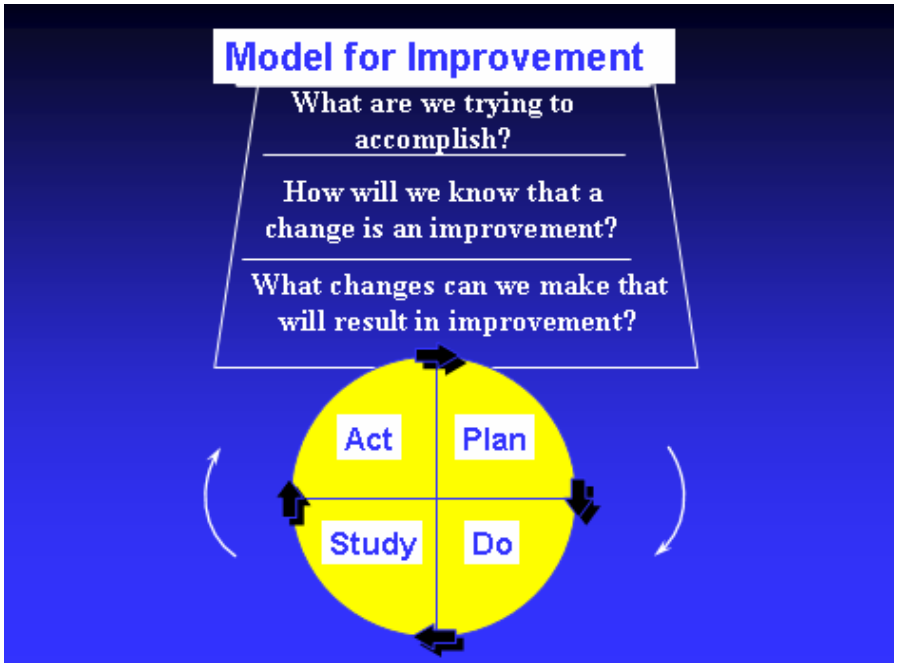
- Use your population identification system to determine who needs care coordination
- Use the development of your CC role to establish systematized screening assessments and resulting care planning and monitoring
- Hold medical home related staff meetings; offer education regarding CYSHCN and gain buy-in and staff understanding for the value of providing care coordination
- Engage families who can educate staff about the complexity of their child's needs
- Create a reporting line to senior leaders from the Care Coordinator so that CC development is built into their role expectation
- Develop the capacity for care coordination "rounds" by discussing direct CC efforts around individual children and youth with staff; gaining the input of colleagues will help you with staff education and their buy in to the medical home and practice-based care coordination approach; all will then learn about complex health and community based needs and resources
- Maximizing Reimbursement for Care Coordination:
  - Ensuring affordability and sustainability by:
    Developing smart legitimate up-coding;
    Tracking CC data (service/outcome) to negotiate new payment opportunities
  - Prepare for the use of new codes (care plan oversight)
  - Become aware of and access Title V supports

**Care Coordination Development:**

1) **The Model for Improvement**

2) **Care Coordination Aim Statement**

3) **Plan Do Study Act (PDSA) cycles or "tests of change"**




| Model for Improvement Questions | Medical Home Improvement Responses |
|---|---|
| 1) What are we trying to accomplish? | Medical Home - Care Coordination |
| 2) How will we know that a change is an improvement? | Measures – Medical Home Index, Medical Home *Family* Index & Survey, Other |
| 3) What changes can we make that will result in an improvement? | Good ideas - ready for use (e.g. CC definition, job description, framework & activities, PDSA examples |

## 2) Care Coordination Aim Statement

### A good aim statement includes the following elements:

- ✓ **Population - CYSHCN**
- ✓ **Timeframe – by when**
- ✓ **Intent – what/why**
- ✓ **Stretch goals – e.g. identify 100% CSHCN**

### Example:

### Overarching Aim - Care Coordination

Between Learning Session 2 and spring of 2006 we will customize and use a model of medical home care coordination for children/youth with special health care needs so that a position description and framework of activities are explicit, with time protected and accounted for and **~ 75%** (goal) of children, youth and families report that they:

- Know who their care coordinator is
- Know they are receiving care coordination
- Participate in decisions about the level of care coordination needed
- Are satisfied with their access to care, care coordination, and resources (most of the time)

### ♈ For Veterans - Advanced Care Coordination Aim Goals

### Youth and families report that:

- A transition timetable is shared among family, practice and community professionals
- They have coordinated support getting their child's needs met within the community and from sub-specialists

## Thinking Through Some Measurement Ideas – For Practice-Based Care Coordination – PDSA Cycles

### Care Coordination Outcomes

Family satisfaction

- decrease in worry and frustration (CMHI survey tools)
- increased sense of partnership with professionals (CMHI survey tools)
- improved satisfaction with team communication (CMHI survey tools)

Staff satisfaction

- improved communication and coordination of care
- improved efficiency of care
- elevated challenge and professional role

Improved child/youth outcomes

- Decrease in ER visits, hospitalizations, & school absences (family, plan report)
- Increase in access to needed resources (CMHI survey tools)
- Enhanced self-management skills (CMHI survey tools)

Improved systems outcomes

- decreased duplication
- decreased fragmentation
- improved communication and coordination (CMHI Medical Home Index)

**PDSA** **CMHI Plan-Do-Study-Act Worksheet**

**Team:**

**Aim:**

## PLAN:

Objective: (Including details (who, what, where, when)

What additional information will you need to take action?

What do you predict will happen?

How will you know your change is an improvement?

## DO:

Was the plan carried out?

What was observed that was not part of the plan?

## STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

## ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

## CMHI Plan-Do-Study-Act (PDSA) Worksheet

## PDSA Example #1 Care Coordination Role/System

**Team:**

**Aim:** Use from page 13 or create own

### PLAN:

**Objective:** (Including details (who, what, where, when)
We will develop and test a clearly defined system of care coordination (CC) services using strategies that fit our practice environment. This will include the use of a: 1) clear CC definition, 2) CC position description and 3) CC framework with an outline of activities. CC role, contact and access information will be explicit for families.
{Our test of change will include dedicated time for the CC to share plans with staff and implement CC PDSA cycles (see examples in following pages). We will feed back lessons learned to our Medical Home Improvement team for guidance and direction.

**What additional information will you need to take action?**
Knowledge of and securing the availability of senior leader support with designation of one (or more) staff members to provide CC leadership

**What do you predict will happen?**
There will be false starts with "tyranny of the urgent" keeping us from our task; our will, ideas and execution will overcome this in the end.

**How will you know your change is an improvement?** Staff/families begin to ask for care coordination / CC activities (e.g. care plan); selected outcome measures improve (see page 14)

### DO:

Was the plan carried out?

What was observed that was not part of the plan?

### STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

### ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

**PDSA** **CMHI Plan-Do-Study-Act Worksheet**

**Team:**

**Aim:**

## PLAN:

Objective: (Including details (who, what, where, when)

What additional information will you need to take action?

What do you predict will happen?

How will you know your change is an improvement?

## DO:

Was the plan carried out?

What was observed that was not part of the plan?

## STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

## ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

## CMHI Plan-Do-Study-Act Worksheet

## PDSA Example #2 Care Coordination Needs Assessment

**Team:**

**Aim:** Use from page 13 or create own

### PLAN:

**Objective: (Including details (who, what, where, when)**
With MH lead physician review pending CYSHCN visits; select 3 CYSHCN who will benefit from an assessment for care coordination. By "a week from next Tuesday" complete an assessment (e.g. parent/youth screening tool in appendices behind page 26) either before the office visit or by pre-visit phone call. Begin care planning process with child/youth and family

**What additional information will you need to take action?**
Listing of pending CYSHCN visits from the CYSHCN list or "registry"

**What do you predict will happen?**
Some false starts finding the right CYSHCN and with timing; we will succeed if persistent over slightly longer time span

**How will you know your change is an improvement?**
Follow up with 3 families in 2 weeks to determine if pre-visit assessment and follow-up planning are helpful and what needs to be added/improved; review value with lead physician as well.

### DO:

Was the plan carried out?

What was observed that was <u>not</u> part of the plan?

### STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

### ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

**PDSA** **CMHI Plan-Do-Study-Act Worksheet**

**Team:**

**Aim:**

## PLAN:

Objective: (Including details (who, what, where, when)

What additional information will you need to take action?

What do you predict will happen?

How will you know your change is an improvement?

## DO:

Was the plan carried out?

What was observed that was not part of the plan?

## STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

## ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

**CMHI Plan-Do-Study-Act Worksheet**

## PDSA Example #3 Comprehensive Care Planning

**Team:**

**Aim:** Use from page 13 or create own

PLAN:

**Objective: (Including details (who, what, where, when)**
1) Develop/choose care plan *medical summary* and use with 5 identified CYSHCN/week. 2) Add an *emergency plan* if warranted. 3) Study provider and family feedback and integrate to improve the plan and the process for plan use.
Create immediate *action plan* for how to meet resource, educational and other needs of CYSHCN/patient and family 4) Use lessons learned to share, engage, educate and spread medical home to staff.

**What additional information will you need to take action?**
Sample care plans to choose from using team priorities; identified CYSHCN with pending visit to initiate plan with. Also identify educational needs of staff /families.

**What do you predict will happen?** Will start slow, 1-2 per week and pick up speed to reach 5. *Value* will result in better preservation of care coordinator time to complete plans, thus increased use of CC and team process. Ultimately, we may schedule comprehensive care planning "rounds" with team/staff; review 3-5 CYSHCN/patients who are receiving this care coordination. Use rounds to review successes, challenges, needs of child/family with staff and address questions.

**How will you know your change is an improvement?**
Review with families for benefit, follow up in 4-6 weeks; review also with staff

DO: Was the plan carried out?

What was observed that was <u>not</u> part of the plan?

STUDY: What happened?

Is this what you predicted? What new knowledge was gained?

ACT: As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

**PDSA** **CMHI Plan-Do-Study-Act Worksheet**

**Team:**

**Aim:**

## PLAN:

Objective: (Including details (who, what, where, when)

What additional information will you need to take action?

What do you predict will happen?

How will you know your change is an improvement?

## DO:

Was the plan carried out?

What was observed that was not part of the plan?

## STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

## ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

## CMHI Plan-Do-Study-Act Worksheet

## PDSA Example #4 Transition to Adult Care & Services; Up-coding to maximize reimbursement

**Team:**

**Aim:** Use from page 13 or create own

### PLAN:

**Objective:** Have MD & Care Coordinator jointly see (2) YSHCN & family for transition visit; use a transition assessment (timetable) checklist to guide the visit and align activities with community partners. Bill for visit – document nature of complexity

**Details (who, what, where, when**) CC Schedules 2 YSHCN for transition care plan visit next week, with family permission informs/communicates with key community partners about assets & needs. Codes for "99214" for 60 minute visit with established patient and document extent and complexity of the visit

**What additional information will we need to take action?**
- Extract from list of CYSHCN youth over 14 due for visit; communicate with family and learn community partners
- Clarify with senior leaders ability to track reimbursement results for these visits

**What do we predict will happen?** (E.g. May take time to match YSHCN with open slots; will need to follow up with payers for denials and use documentation to justify activities).

**How will you know your change is an improvement?**
Review with family staff; community partners. Select other ongoing measures (p14)

### DO:

Was the plan carried out?

What was observed that was not part of the plan?

### STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

### ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

**PDSA** **CMHI Plan-Do-Study-Act Worksheet**

**Team:**

**Aim:**

## PLAN:

Objective: (Including details (who, what, where, when)

What additional information will you need to take action?

What do you predict will happen?

How will you know your change is an improvement?

## DO:

Was the plan carried out?

What was observed that was not part of the plan?

## STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

## ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

## CMHI Plan-Do-Study-Act Worksheet

## PDSA Example #5 Community Outreach / Resources

**Team:**

**Aim:** Use from page 13 or create own

### PLAN:

**Objective: (Including details (who, what, where, when)**
Plan for care continuity across the: medical home, school, and community agencies with 4 families and children/youth over the next four weeks. Use a selected communication strategy (fax back, e-mail, NCR paper, electronic forum, other) to centralize key information with strengths, goals, care plans, access information, and releases fostering cross organizational communication; the CC performs as a "*hub of the wheel function*" in these activities.

**What additional information will you need to take action?**
Identification of children/youth and families in need of transition and/or community-based coordination; identification of key community partners; consensus on communication strategy

**What do you predict will happen?**
Territorial barriers will crop up and family will need to be front and central to the process.

**How will you know your change is an improvement?**
Review with family and agencies whether there has been improved care communication, also consider other systematized outcome measures (see page 14).

### DO:

Was the plan carried out?

What was observed that was not part of the plan?

### STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

### ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

**PDSA** **CMHI Plan-Do-Study-Act Worksheet**

**Team:**

**Aim:**

## PLAN:

Objective: (Including details (who, what, where, when)

What additional information will you need to take action?

What do you predict will happen?

How will you know your change is an improvement?

## DO:

Was the plan carried out?

What was observed that was not part of the plan?

## STUDY:

What happened?

Is this what you predicted? What new knowledge was gained?

## ACT:

As a result, list next actions:

Are there organizational forces that will help or hinder efforts?

Objectives for next test of change:

## Appendices A.

Key Websites for Care Coordination Tools

1) Center for Medical Home Improvement (CMHI): www.medicalhomeimprovement.org
2) National Center for Medical Home Initiatives (AAP) www.medicalhomeinfo.org
3) Utah Medical Home Portal www.medhomeportal.org

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CROTCHED MOUNTAIN
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CMHI

# Center for Medical Home Improvement (CMHI)
# Crotched Mountain Foundation
# Greenfield, New Hampshire
# 2007