Today's Talk

Care Coordination and Shared Plans of Care

DATE: 4/12/23 12-1pm

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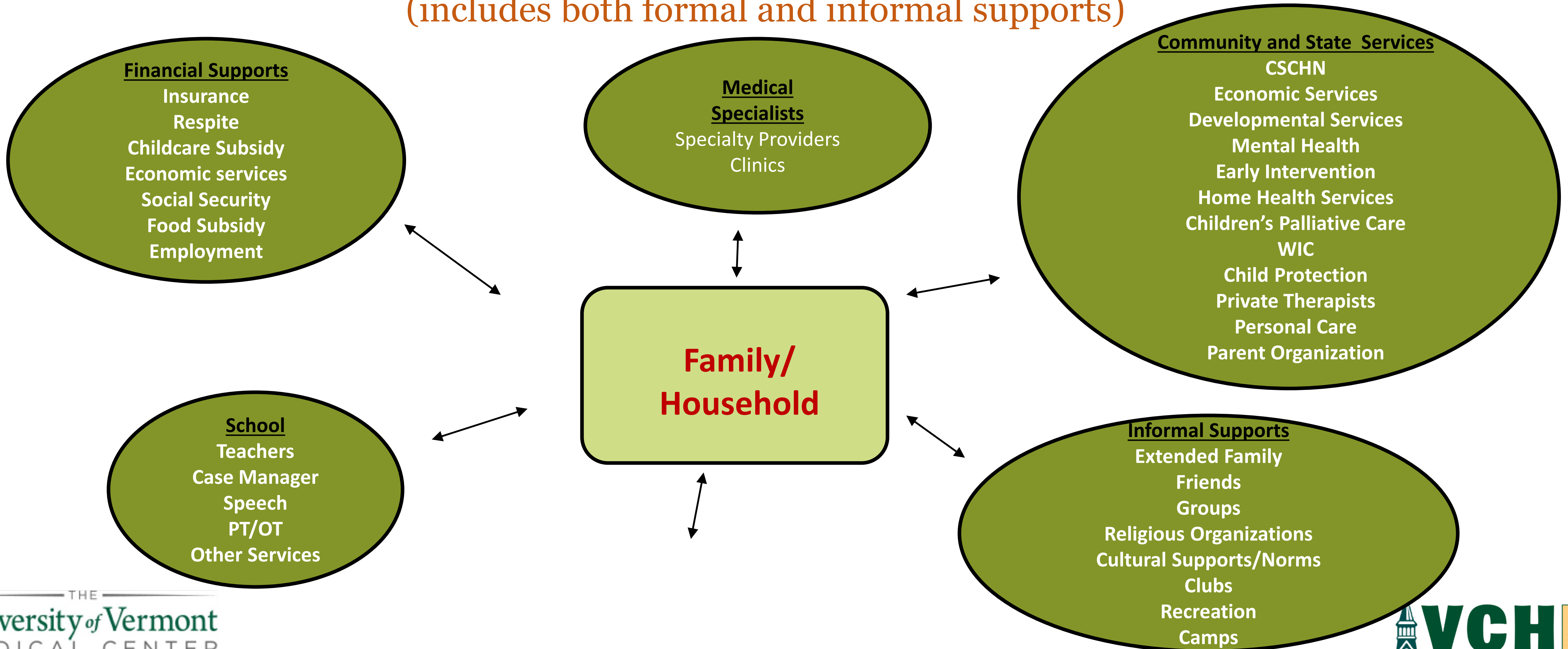
OBJECTIVES

- Learn the importance of knowing community services and building relationships with community providers
- Learn three care coordination strategies for developing, implementing, and monitoring shared plans of care (eco-mapping, care conferencing and care coordination rounds)
- Appreciate the value of a collaborative team approach that operates with good communication to efficiently and effectively provide patient care for best outcomes.

1. Ecomap
Graphic representation of the family in their environment (includes both formal and informal supports)



HOW TO CREATE AN ECOMAP

Always start by asking permission and explaining the purpose of doing an ecomap assessment

Example: " I'd like to ask you more about your family and who's helping you already so that we can plan next steps together"

Examples of Questions for Ecomap Development

Informal Supports:

- Who lives in the home? How old are the children living in the home?
- Are their grandparents, aunts, uncles, other relatives who live nearby?
- Who are your close friends that you rely on? Do you have neighbors that would be important to include?
- What kinds of things does your family like to do together?
- Do you belong to any groups outside of school or work? Groups with similar cultural backgrounds?

Formal Supports:

- Is your child receiving other services? How often?
- Are other children in the family receiving any services?
- What supports your family financially?
- How is your child and family's healthcare paid for?
- Have you worried about running out of money at the end of month to pay for things your family needs?

Tips for questions about extent of support:

Informal Supports:

Ask some questions in terms of *how often the family talks to or spends time with* the person(s) identified?

Ask some questions in terms of *how well the family gets along with* the person identified?

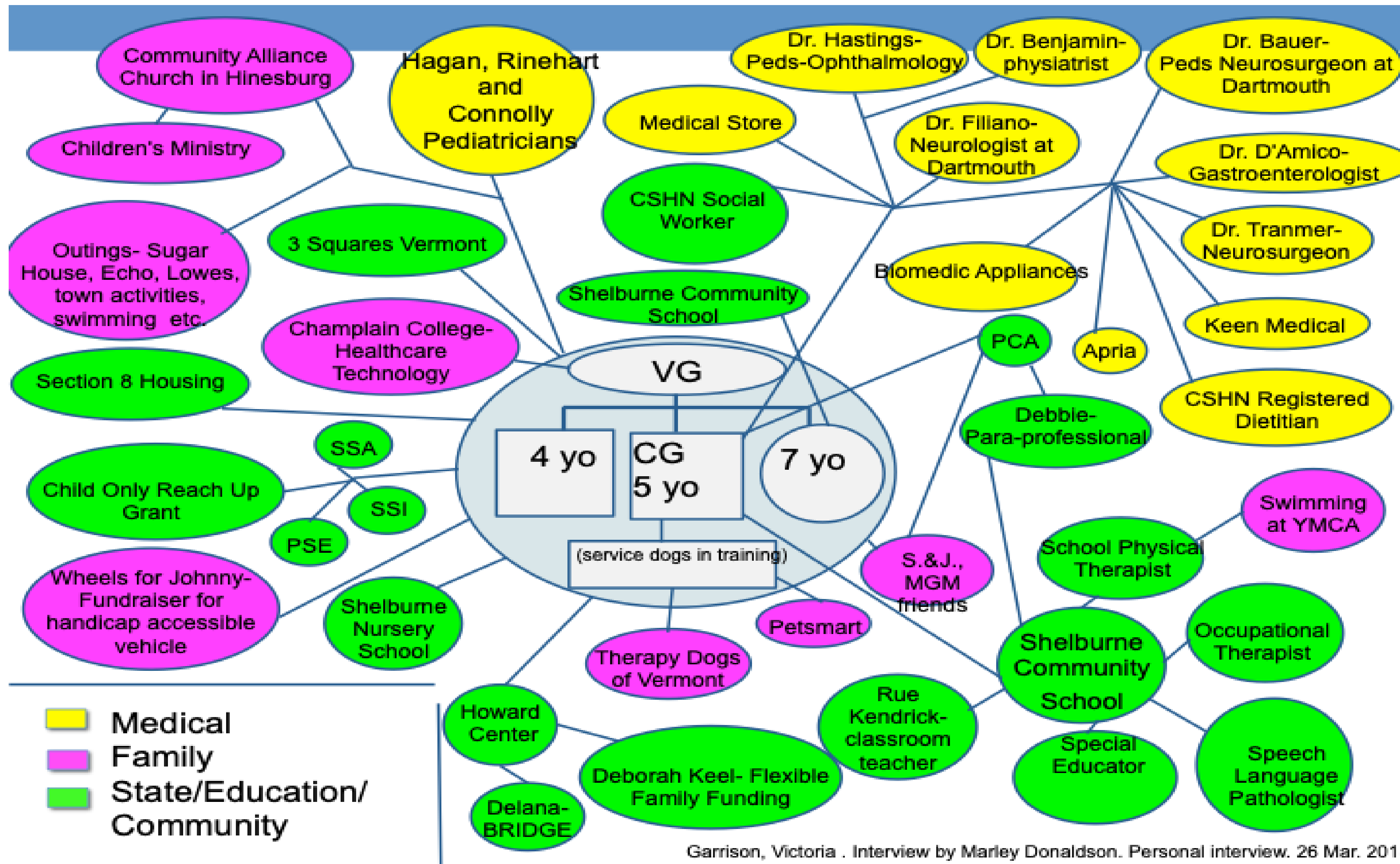
In what ways are informal supports helpful or not helpful?

Formal Supports:

How is communication between services providers going? Do you feel services are coordinated?

Is there a primary person who helps your family the most?

Are the services meeting your families needs? Are there areas of need not being addressed?
Who or what is missing that would be supportive?



Community Alliance Church in Hinesburg
Children's Ministry
Outings- Sugar House, Echo, Lowes, town activities, swimming etc.
3 Squares Vermont
Champlain College- Healthcare Technology
Section 8 Housing
SSA
Child Only Reach Up Grant
SSI
PSE
Wheels for Johnny- Fundraiser for handicap accessible vehicle
Shelburne Nursery School
Hagan, Rinehart and Connolly Pediatricians
Medical Store
CSHN Social Worker
Shelburne Community School
Dr. Hastings- Peds-Ophthalmology
Dr. Benjamin- physiatrist
Dr. Bauer- Peds Neurosurgeon at Dartmouth
Dr. Filiano- Neurologist at Dartmouth
Dr. D'Amico- Gastroenterologist
Dr. Tranmer- Neurosurgeon
Biomedic Appliances
Keen Medical
Apria
PCA
CSHN Registered Dietitian
Debbie- Para-professional
VG
4 yo
CG
5 yo
7 yo
(service dogs in training)
S.&J., MGM friends
Swimming at YMCA
School Physical Therapist
Occupational Therapist
Petsmart
Therapy Dogs of Vermont
Howard Center
Delana- BRIDGE
Deborah Keel- Flexible Family Funding
Rue Kendrick- classroom teacher
Shelburne Community School
Special Educator
Speech Language Pathologist
Medical
Family
State/Education/ Community
Garrison, Victoria . Interview by Marley Donaldson. Personal interview. 26 Mar. 2013

2. Care Conferences
Conversations to coordinate and facilitate communication across providers

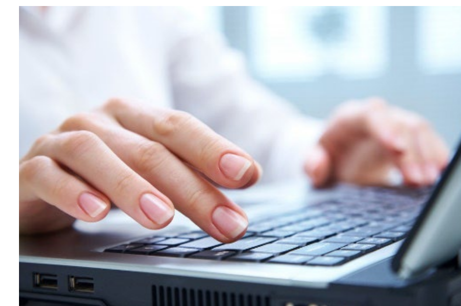
- Introductions/Contacts
- Set Agenda
- Set Roles: Facilitator
- Start with Strengths
- Care map
- Discussion
- Minutes Recorded
- Update Plan with Next Steps & Accountability
- Next Care Conference Date (if needed)
- Care plan is shared at end of meeting

PROBLEM SOLVING DISCUSSION

- Each provider has a piece of the puzzle & a role to play
- Keep an open mind
- Getting from A to B may require going to C and D first
- Patience
- Kindness
- Humility
- Respect
- "Parking Lot" and follow up

3. Care Coordination Rounds

Regular interactions with practices care coordinator, physicians and community providers



- **Can be in person, phone calls, or electronically**
- **Potential agenda items:**

  - updates on the progress of the care plan,

  - **needs more intervention,**
  - **who is doing what part of the work,**
  - **discussion of systems issues (barriers)**

- **Prepares provider and community to address family's needs and keeps the progress toward share care plan goals moving forward.**

Elements of a Shared Care Plan for Children in Foster Care

- Identifying Information:
  - Name, DOB, preferred pronouns
  - Contact information (foster parents, parents, Case Worker)
  - Care Conference Participants/Role
  - Medical Home (+ Specialists)
  - Pharmacy
  - Dental Home
  - Mental Health Home
  - Early Care & Learning/School
- Strengths/What is going well
- Immediate issues
- Acute problems
- Chronic problems
  - Specialists, upcoming appts
  - Medications: effects, side effects
  - Who is responsible (appts, re-filling meds, etc)
- Dental Health: next appt
- Mental/Behav/Dev Health: next steps
- Goals: Immediate & Long Term
- Next Care Conference

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SHARED PLANS OF CARE: CONSIDERATIONS

- Who is the Plan shared with?
  - DCF Case Worker
  - Foster family
  - Family of origin
  - Youth in foster care
  - Early Care & Learning site, School
- How can it be updated to be a "living document"

BENEFITS TO PEDIATRICIANS

- Each clinician doesn’t feel he/she must to have all of the solutions
- More time for medical thinking and deeper understanding of situation
- Improved clinical outcomes
- Feel better prepared
- Less time spinning wheels
- More time discussing the important issues and not “catching up”
- Less phone time

CODING FOR CARE MANAGEMENT

- Medical Team Conference:
  - With Patient/Family Present:
    - 99366: Conference with interdisciplinary team of **non-physician** health care professionals, with patient and/or family, 30 minutes or more
    - Use appropriate E/M Code (99214, 99215) if physician/advanced practitioner is present
  - Without Patient/Family Present:
    - 99368: Conference with interdisciplinary team of **non-physician** health care professionals, with patient and/or family not present, 30 minutes or more
    - 99367: Same as above, if physician/advanced practitioner is present
- There are ways to bill for other time spent coordinating care, but there are lots of caveats:
  - See AAP "Coding for Care Management & Other Non-Direct Services" https://downloads.aap.org/AAP/PDF/coding_factsheet_nondirectcare.pdf
  - Talk to your office coding expert or Gainwell representative

TAKE AWAY MESSAGES

- Community partners and families have knowledge and skills that can help solve complex problems and help track and monitor progress of care plans.

- Three care coordination strategies to use:
  - Ecomaps to identify families strengths, challenges and preferences and identify additional needs.
  - Care conferences to coordination and facilitate communication across providers.
  - Care coordination rounds to keep care providers up-to-date and resolve issues.

- Identifying and maintaining good communication with a family's care team can optimize patient care and outcomes.

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