

Enhancing Care Coordination for Children and Youth with Special Health Needs

HCH/SIM Webinar Series – July 21, 2016

Presenters:

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Agenda

- Background information on prevalence and characteristics of CYSHN
- Importance of care coordination from a family perspective
- Resources available to assist with care coordination and care planning

Children & Youth with Special Health Care Needs

**Maternal Child Health Bureau
(MCHB) definition:**

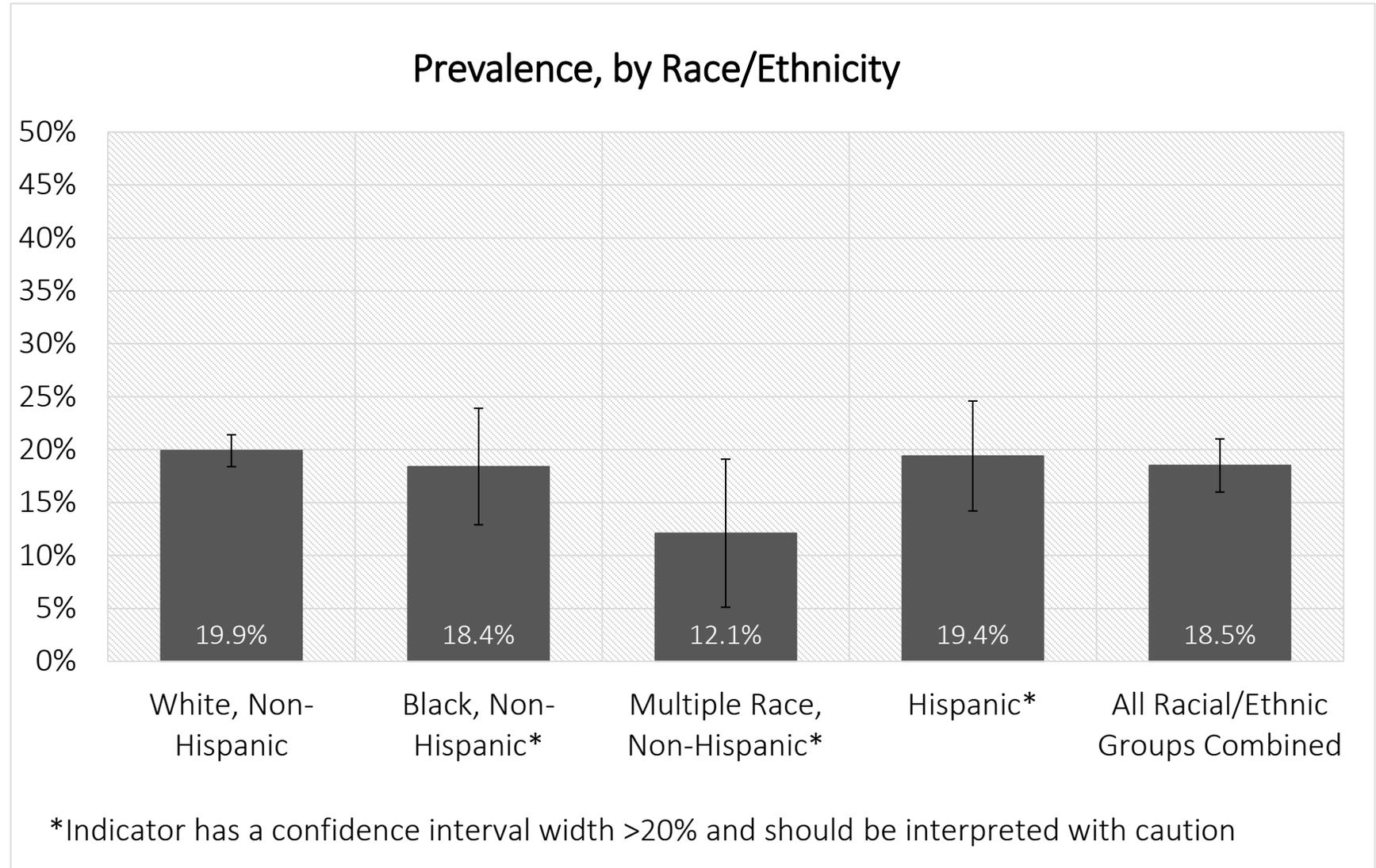
“those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”



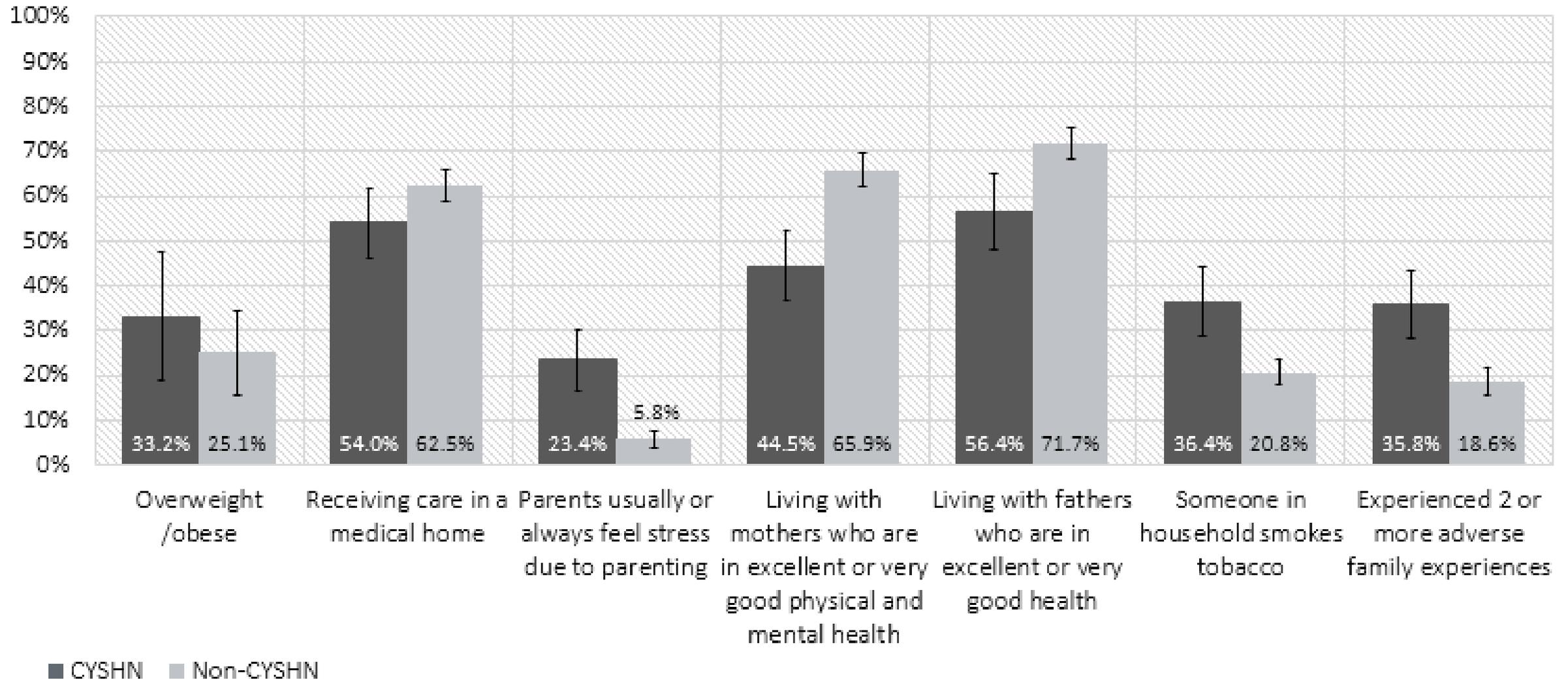
Prevalence of CYSHN

Total Prevalence:
236,953 CYSHN in
Minnesota – 18.5%
of the state’s
population under
the age of 18 years
old.

Source: 2011/2012 National
Survey of Children’s Health

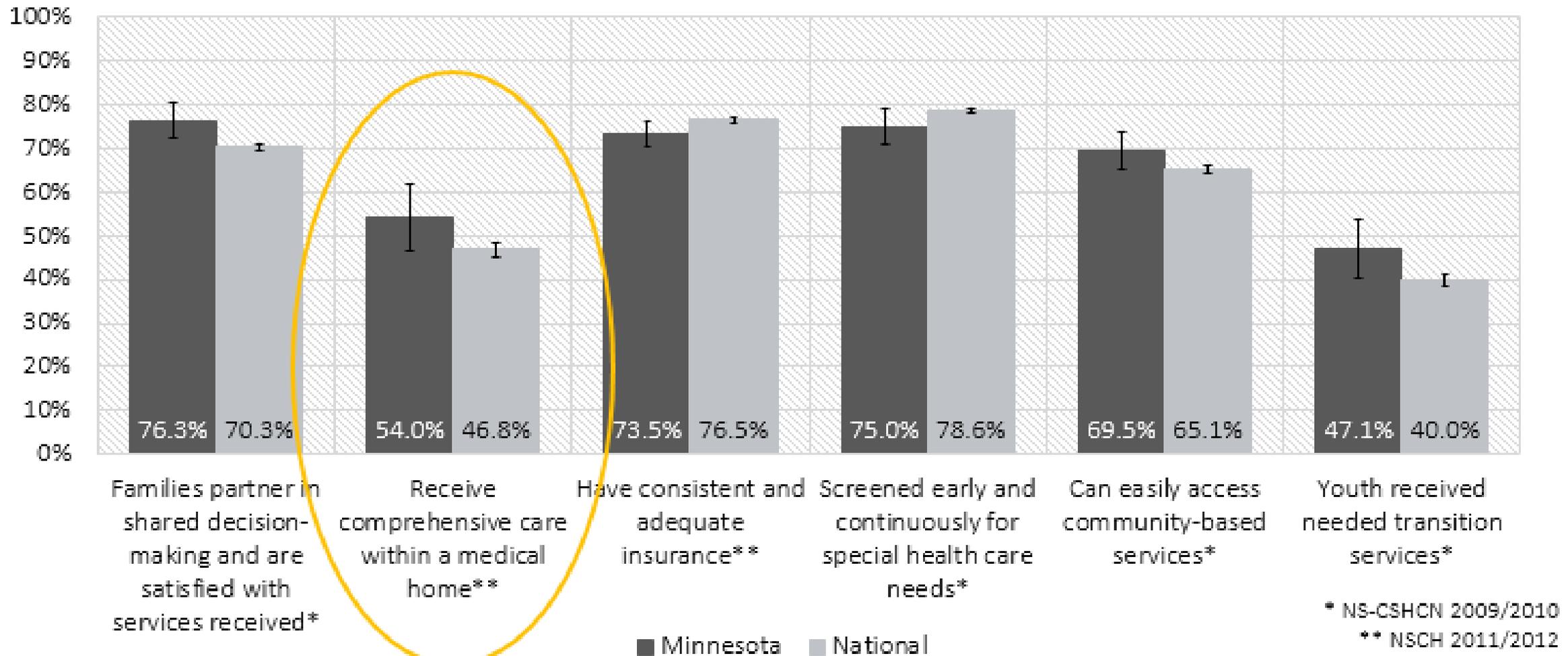


Disparities in Minnesota CYSHN vs. Non-CYSHN Populations



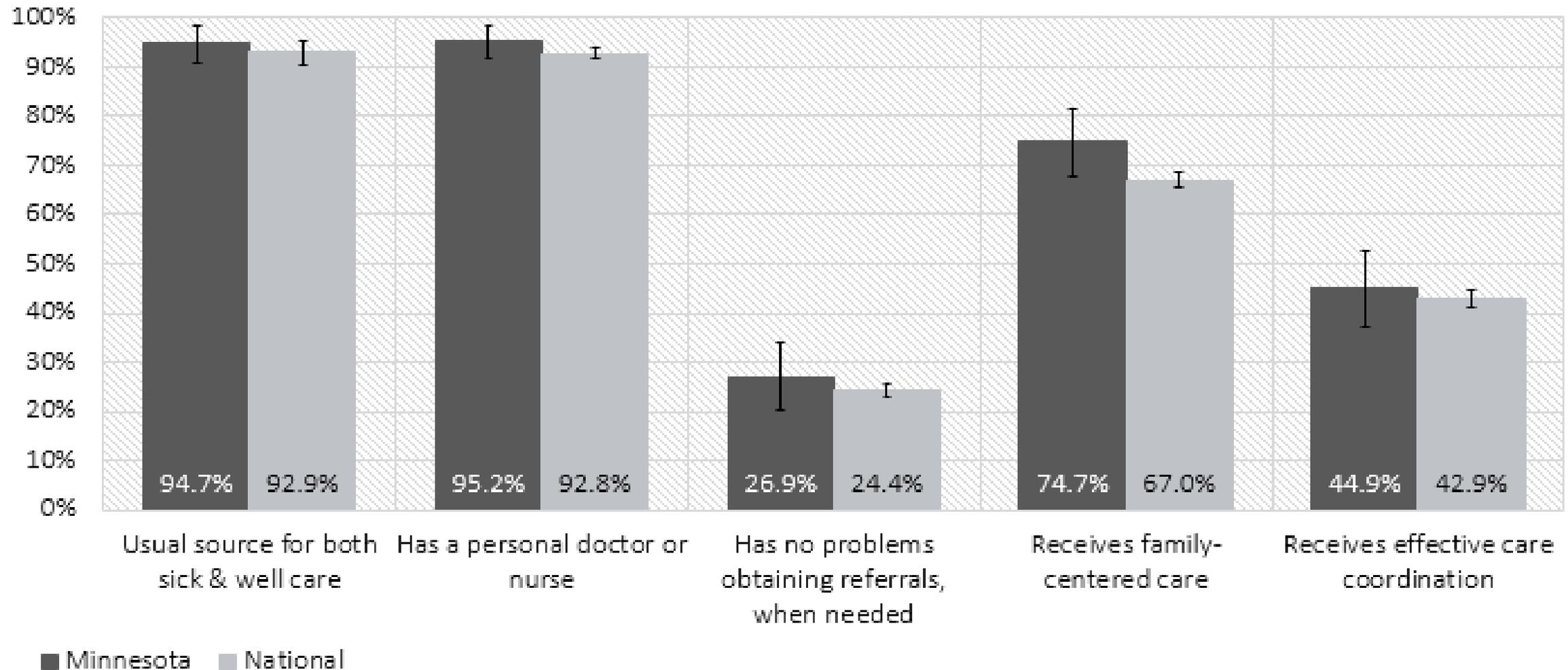
Components of a Well-Functioning System for CYSHN

Percent of CYSHN Meeting National Core Outcomes



Medical Home Components

Percent of CYSHN Meeting Components of Medical Home



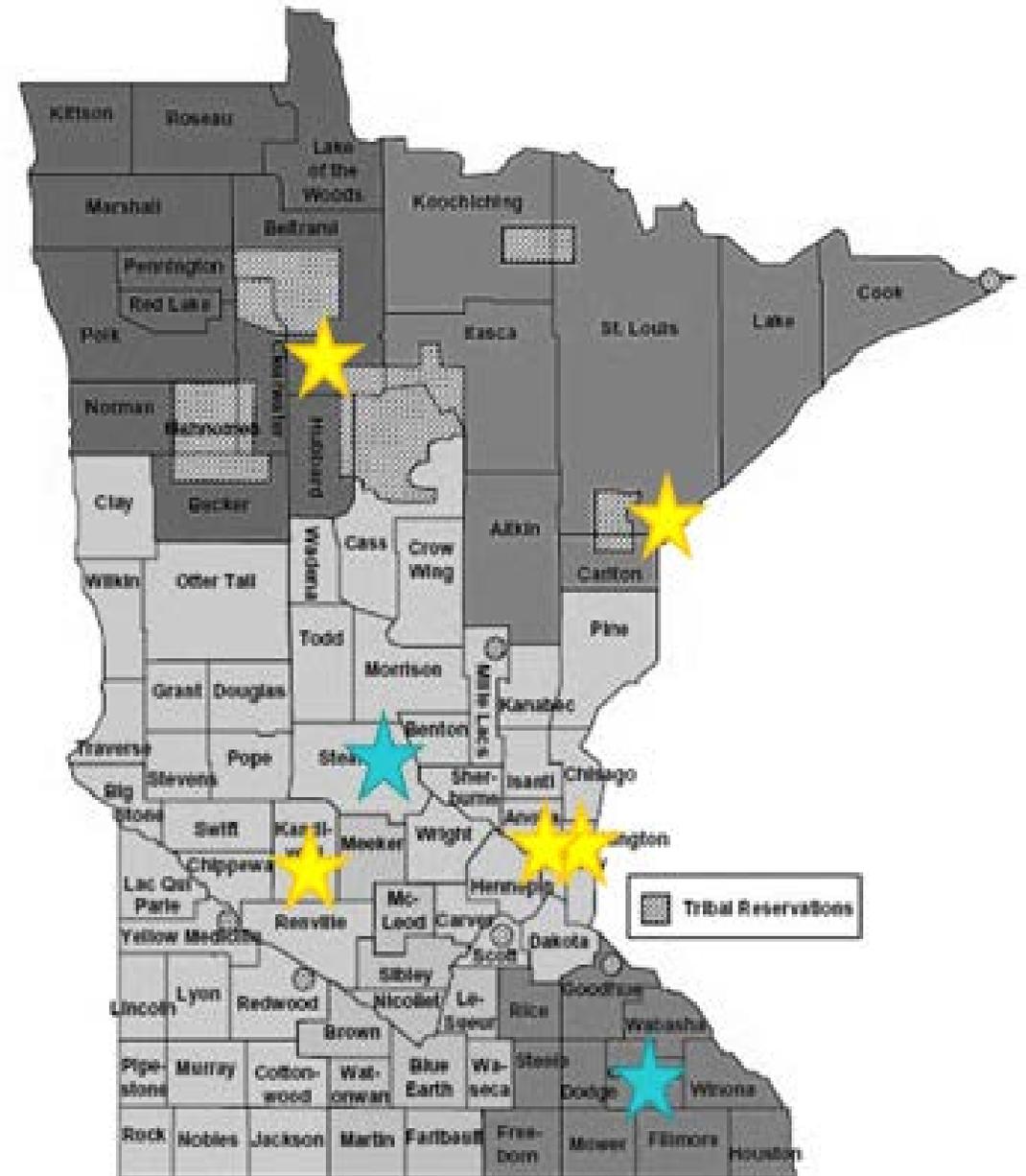
Regional Care Coordination Mapping Assessment

Summer 2015

- Duluth, MN
- Bemidji, MN
- Willmar, MN
- East Twin Cities Metro
- West Twin Cities Metro

Summer 2016

- St. Cloud, MN
- Rochester, MN



Strengths and Weaknesses in the Current System

Care Coordination of CYSHN in Minnesota Currently Works Because...

- Care coordinators are passionate and dedicated to helping families
- A lot of focus has been placed on early childhood
- There is strong networking and collaboration between care coordinators
- More care coordinators are being employed by primary care and specialty care
- Certified health care homes have care coordinators
- There is a focus on developing relationships and a sense of community
- Care coordinators are knowledgeable of the needs of families
- Care coordinators do a good job linking families with resources
- There are a lot of resources available (more applicable to Metro)

Care Coordination of CYSHN in Minnesota Would be Better if...

- Parents would not have to coordinate all the care coordinators
- Coordinators would communicate more with each other and not rely on the family to do the back and forth
- There were more sustainable funding for care coordination (and the funding better met the needs of children and families)
- A universal Release of Information was available
- Data sharing laws and practices didn't get in the way
- Electronic health records would communicate between each other
- There was more collaboration between schools and health care
- There were more resources available (more applicable to out-state regions)

Resources to Improve Care Coordination / Care Planning

Achieving a Shared Plan of Care with CYSHCN

- <http://www.lpfch.org/publication/achieving-shared-plan-care-children-and-youth-special-health-care-needs>
 - Report
 - Implementation Guide



Lucile Packard Foundation
for Children's Health

10 Steps to the Shared Plan of Care

1. Identify which patients and families 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 multi-faceted assessments with a child, youth, and family.
4. Set shared personal (child and family) and clinical goals.
5. Identify other needed partners (e.g., subspecialists, community providers) and link them into the shared care-planning process.
6. Develop the plan of care “medical summary” and merge with “negotiated actions” in step 7.
7. Establish the plan of care “negotiated actions” and merge with the “medical summary” in step 6.
8. Ensure 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 plan of care model process as a life course and a population health approach.

Index - 10 Steps to the Shared Plan of Care

- The implementation guide provides 10 steps to follow in the development of a shared care plan. Clinics are encouraged to review each step and then rate themselves on their progress, gaps, and learning needs using the scale below...

Our Team Needs To...			
Learn More About this Activity	Try this Activity	Master this Activity	No Change/ Improvement is Needed

American Academy of Pediatrics: National Center for Medical Home Implementation

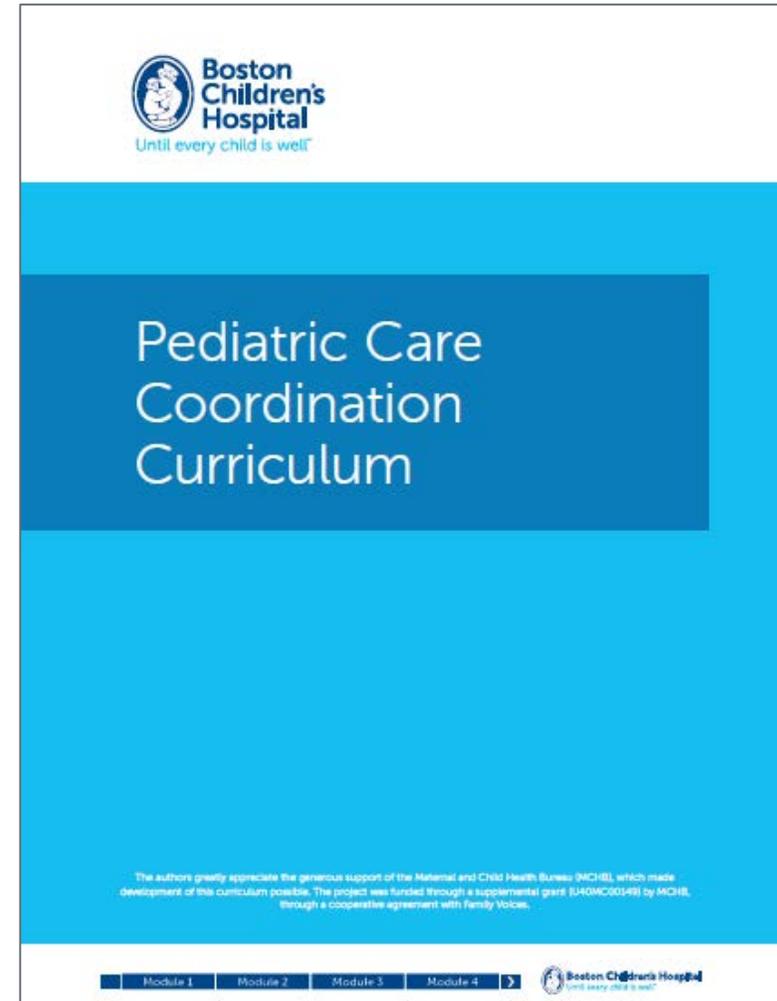
- <https://medicalhomeinfo.aap.org/tools-resources/Pages/Care-Coordination.aspx>
 - National Center for Care Coordination Technical Assistance
 - Care Coordination Curriculum – Pediatric Professionals, School Nurses, and Families (Boston Children’s Hospital)
 - Care Coordination Measurement Tool
 - Listserv/Community of Learners
 - Examples of job descriptions, policies, etc.

Boston Children's Hospital: Pediatric Care Coordination Curriculum

<http://www.childrenshospital.org/care-coordination-curriculum>

4 module curriculum:

1. Building Patient/Family-Centered Care Coordination through Ongoing Delivery System Design
2. Care Coordination as a Continuous Partnership
3. Integrating Care Coordination into our Everyday Work
4. Health-Related Social Service Needs: Strategies to Assess and Address in the Family-Centered Medical Home



CYSHN Navigator

www.kidsnavigator.MinnesotaHelp.info

- **Goes live on August 1, 2016**
- Web-based resource directory tool created to help increase knowledge of services and supports available
- Includes chat and phone functionalities

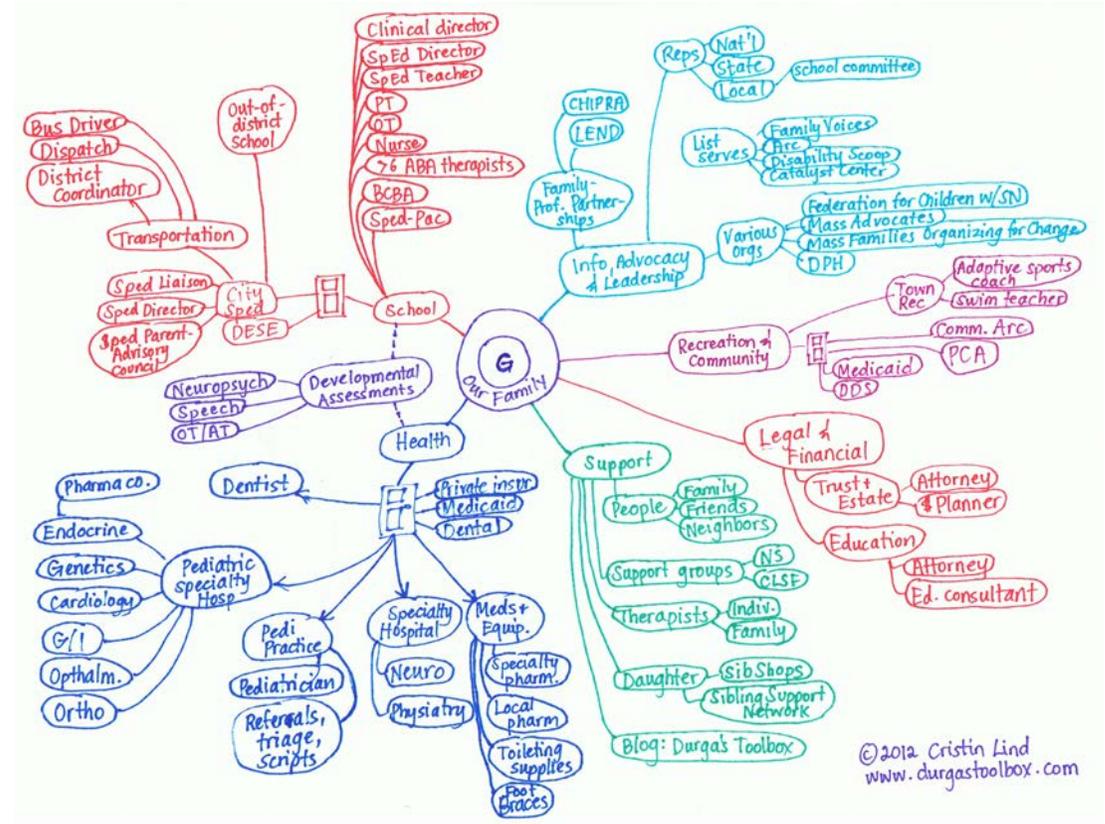


Children and Youth
with Special Health Needs
Navigator

www.KidsNavigator.MinnesotaHelp.info

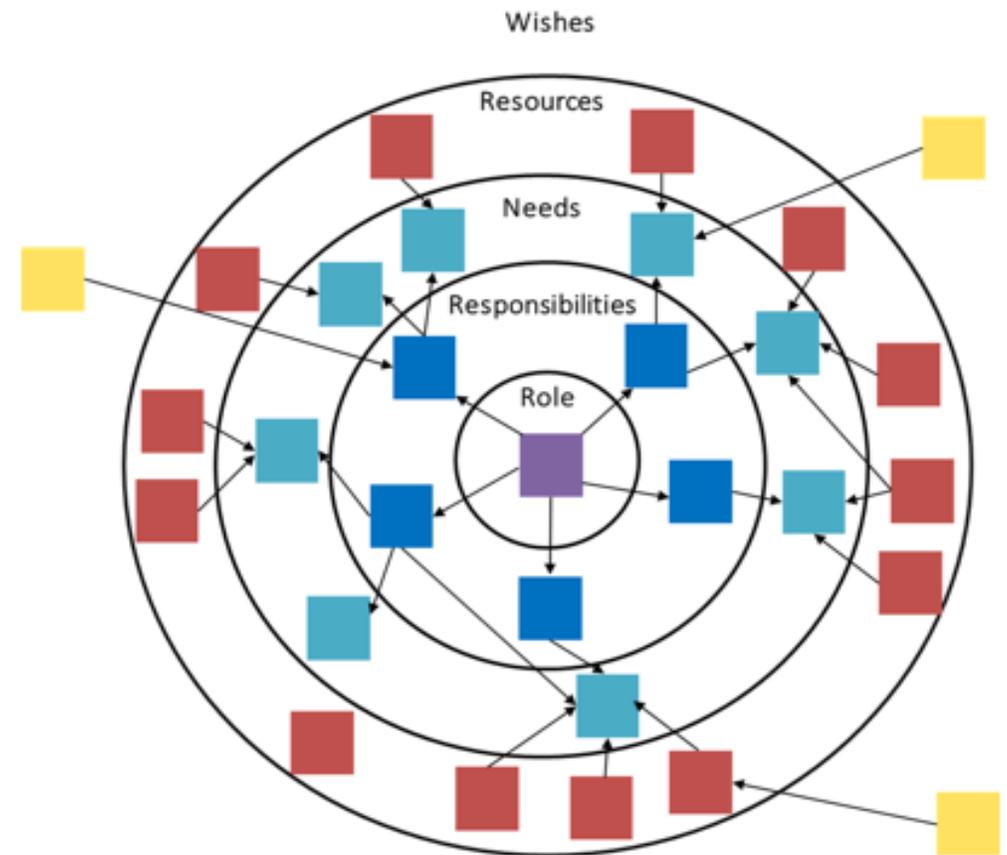
Care Mapping: A Tool to Support Authentic Family-Professional Partnership and Care Coordination

- Boston Children's Hospital
- <http://www.childrenshospital.org/care-coordination-curriculum/care-mapping>
- Includes "How-To Guides" for Families and Professionals Supporting Families



Care Mapping: Systems Support Mapping

- Developed by National Maternal & Child Health Workforce Development Center at the University of North Carolina at Chapel Hill
 - Web-based care mapping tool that can be used in a variety of settings, including with families
 - <http://people.renci.org/~stevec/ssm540/> (works best in Firefox or Chrome web browsers)
 - For more information (or for a PDF of instructions on how to use the website), please email sarah.cox@state.mn.us



Questions?



Thank you!