Care Coordination and the Healthy Start Community

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E P I C

Supporting communities to give every child a Healthy Start.

Healthy Start EPIC Center

Welcome & Purpose

Webinar Purpose

To provide Healthy Start grantees with additional information on implementing care coordination protocols for pregnant women, interconception women, and their infants.

Target Audience

Healthy Start Project Directors, Project Managers, Care Coordination Supervisors, & Healthy Start Case Managers

Webinar Objectives

- Recognize the role of care coordination in the Healthy Start program
- Define care coordination and case management
- Define the key components of care coordinated case management
- Apply the key components of care coordinated case management to a Healthy Start case example

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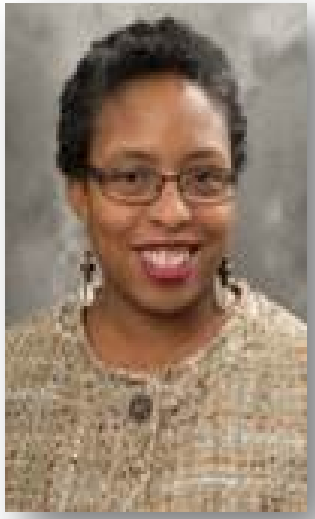


Service Delivery in Healthy Start

Coordination & facilitation of access to care is major tenet of the Healthy Start Program

Healthy Start Projects work to ensure program participants have:

- A medical home
- Access to needed services
  - Medical, social, developmental, behavioral, educational, and informational support services

Service Delivery in Healthy Start

Service delivery is centered around the needs of program participants.

Components of Healthy Start service delivery include:

- A comprehensive needs assessment
- Creation of a care plan
- Identification of appropriate services
- Facilitation of linkages to additional services
- Monitoring of progress
- Responsive to changes in needs

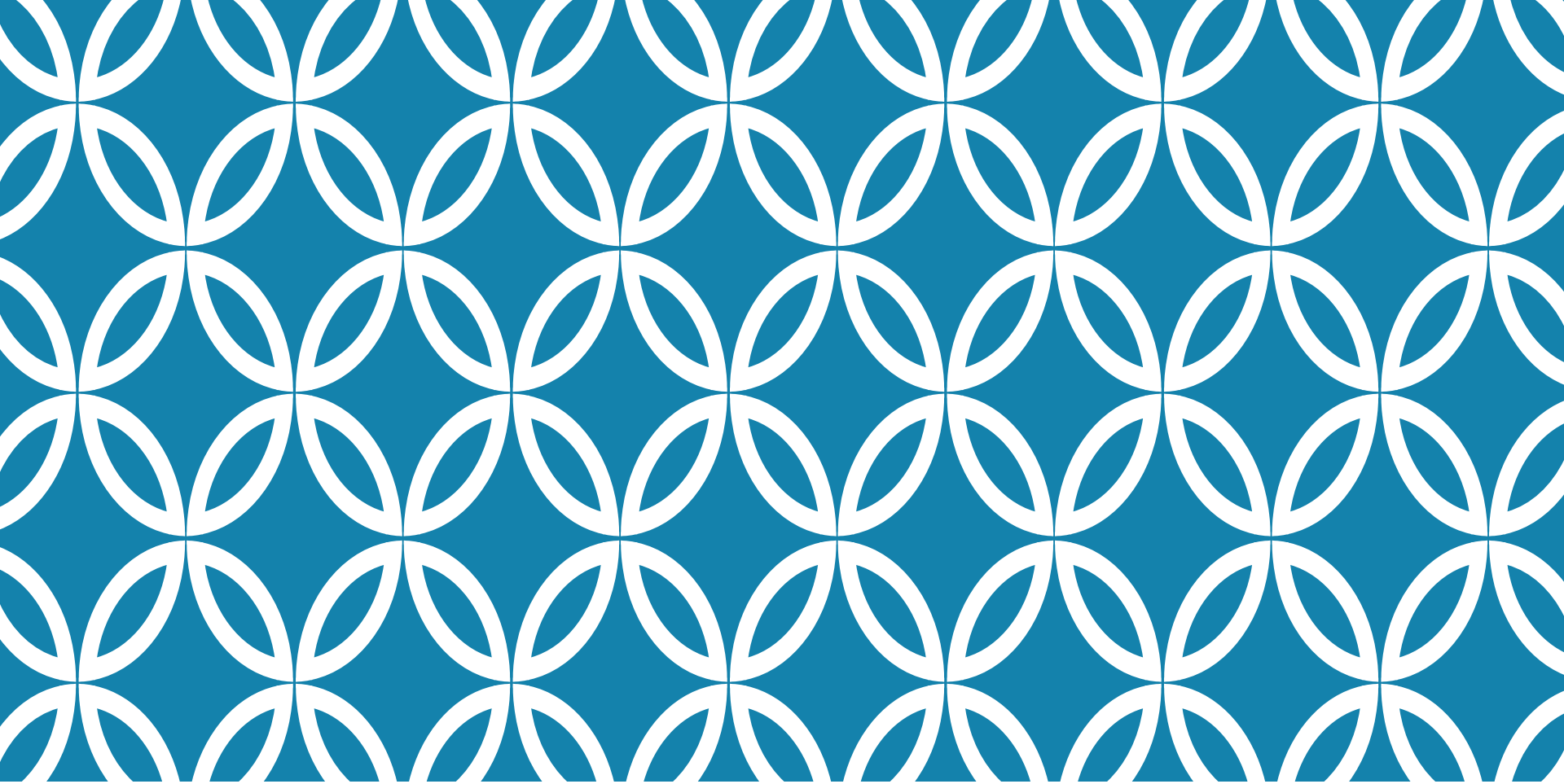
Case Management & Healthy Start

- The provision of services through a coordinated, culturally competent approach includes client assessment, referral, monitoring, facilitation, and follow-up on utilization of needed services.
- For pregnant women, these services include those that assure access and utilization of quality prenatal care, delivery, and postpartum care.
- For infants up to two years of age, these services assure access and utilization of appropriate quality preventive and primary care services.

Care Coordination

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.



MEET YOUR NEXT 4 REFERRALS

BRITTANY

- 17 year old high school honor student
- 3 months pregnant with first child
- Brittany's mother (single parent) was a teen parent and is disappointed that her daughter didn't learn from her mistakes
- She practices tough love and will not help Brittany since she seems to "learn the hard way"
- Boyfriend was recently deported after a traffic stop, but promised to sneak back in and take care of her and their baby

LADAWN

- 38 year old
- Released from prison last year after serving a drug and prostitution sentence
- Back together with “bad news” boyfriend/pimp
- 4 months pregnant with twins. Other 8 children are living with relatives or are in foster care
- Using again?
- Developed gestational diabetes, has a history of preeclampsia last pregnancy, and has missed her last 3 prenatal care appointments

HEATHER

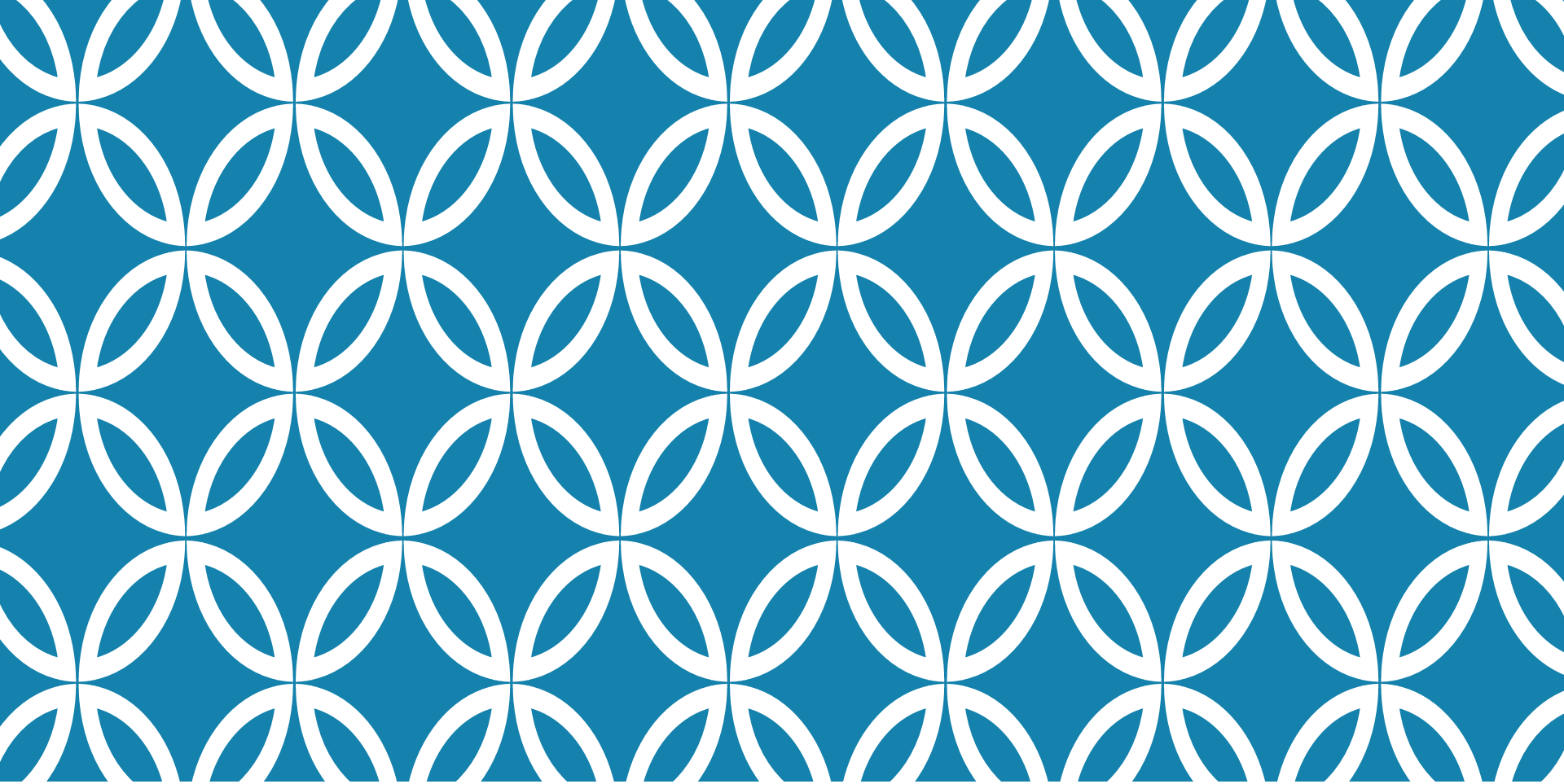
- 26 year old stay-at-home mom
- 5 months pregnant with a Small for Gestational Age fetus
- Generational poverty
- Failed out of high school in 9th grade
- In an abusive relationship with the father of her other 2 children
- Wants help becoming an LPN and learning how to support herself and her kids so she can flee

MEME

- 19 year old married student working on her cosmetology certificate
- 8 weeks post-partum after delivering her 3rd infant in the last 4 years
- After quitting while pregnant, she has started smoking again (cigarettes and marijuana)
- Difficulty breastfeeding and her 27 year old husband is encouraging her to give it up
- She missed her follow-up OB appointment and is not utilizing any family planning methods
- She recently moved into a Section 8 apartment and her oldest child (who was premature) has been in the ER twice for asthma exacerbations

WHAT DOES YOUR PROGRAM HAVE TO OFFER?

- Is your HS model structured to provide all 4 of these very different women the services they need?
- Do you have access to the expertise needed to address all of their issues?
- How will you measure your success? How would your client measure success?
- What does it mean to successfully "coordinate" the interventions and services needed in each individual case?



Many have tried but few have conquered the call…

Definitions of Care Coordination

National Center for Biotechnology Information

- Completed an analysis to look at care coordination
- Identified over 40 definitions of care coordination
- They looked at similarities in services, characteristics, words used, etc.

Definitions of Care Coordination

Care Coordination definitions are not usually transferable across programs

- AAP: Care coordination is a process that facilitates the linkage of patients and their families with appropriate services and resources in an coordinated effort to achieve good health.
- Allred 1995: Coordination refers to the regulation of activity between the nurse and the case manager so that necessary patient activities do not go unperformed
- Brown 2004: The term care coordination has no well established definition. Rather, it is generally understood to mean a process of improving communication among the various medical professionals with whom patients come in contact and between these professional and the patients themselves and their families.

Definitions of Care Coordination

- **Flocke 1998:** Coordination of care refers to the incorporation of information from referrals to specialists and previous health care visits into the current and future medical care of the patient.
- **Gittell 2004:** Coordination is an activity that is fundamentally about connections among interdependent actors who must transfer information and other resources to achieve outcomes for patients.
- **Kibbe 2001:** Care coordination is a term that encompasses a variety of care management methods-from case to disease management-that aim to improve the quality of care provided to patients with chronic illness while decreasing avoidable costs associated with their delivery…
- **Young 1998:** Coordination has been defined as the conscious activity of assembling and synchronizing differentiated work effort so that they function harmoniously in attainment of organizational objective.

Working Definition

The deliberate organization of patient care activities between two or more participants including the patient involved in a patient's care to facilitate the appropriate delivery of health care services.

Commonalities in Definitions

- Medical model in nature with medical care central to process
- You are working with *patients* (a person under medical treatment)
- Assumes something is wrong that must be corrected, and how it should be corrected is prescribed

Care Coordination vs. Case Management

Case Management

- Collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individuals' health needs through communication and available resources to promote quality cost effective outcomes. (Case Management Society of America)
- Case Management enhances care coordination through the designation of a case manager whose specific responsibility is to oversee and coordinate care delivery for high risk patients with a diverse combination of health, functional, and social problems.

Commonalities in Definitions

- Model depends on type of management (homeless, behavioral health, etc.) services are central to process
- You are working with clients (a person utilizing services of a professional or organization)
- Assumes there is an unmet need

Care Coordination + Case Management =

Care Coordinated Case Management

Key Components of Care Coordinated Case Management

Numerous participants are typically involved in care coordination, including:

- Patients, family care givers, MDs, nurses, pharmacists, social workers, support staff, etc. involved in the delivery of health care services

Additional participants are considered when talking case management

- Examples: home visiting, community organizations, grassroots service providers, housing, legal aid, schools, etc.
- Medical is no longer the central piece

Key Components of Care Coordinated Case Management

Coordination is necessary when participants are dependent upon each other to carry out disparate activities related to patient care.

- Coordination for patients with complex health care needs requires professionals with specialized knowledge.

When these potential complex health needs are augmented by complex social needs, management is needed to ensure key issues are being addressed.

- Management requires someone being in charge and assuring follow up.

Key Components of:
Care Coordinated Case Management

In order to carry out the needed/requested/recommended activities, each participant needs adequate knowledge about their own and the role of others as well as available resources. They must understand the pieces and the whole.

- Decisions cannot be made in a vacuum. When decisions are to be made, information from multiple sources is required and should strongly incorporate the ideas and desires of the client.
- Must be clear about the scope of services each participant that is involved can realistically offer.
- Someone must be in charge as the main advocate for the client and be empowered to make the final decision when disagreements occur.

Key Components of: Care Coordinated Case Management

In order to manage all required client care activities, participants must rely on the exchange of information.

- Plans must be shared and integrated. The rationale behind the plans must be explained.
- Documentation is key.
- Accountability is essential.

Key Components of:
Care Coordinated Case Management

Integration of activities and services has the goal of facilitating the delivery of the right mix of appropriate social and health interventions.

Ingredients for Care Coordinated Case Management Success

Keep the client in the center: Needs of the client should be the driving factor, not the needs of organizations, partners, providers

Collaboration: Shared power and authority

Teamwork: Everyone brings specialized knowledge/expertise in a nonhierarchical relationship, responding to situational demands, not traditional roles

Continuity : There should be some account that ties everything together

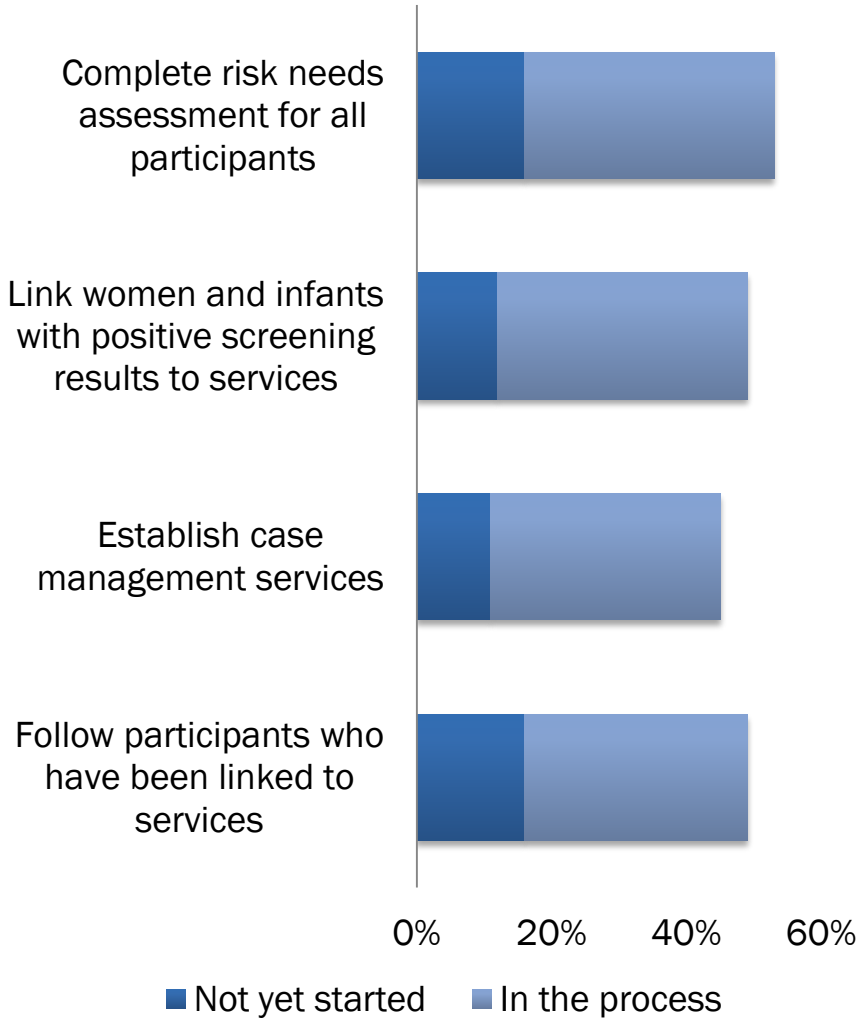
Checks and Balances: Success is dependent on all pieces of the puzzle being completed

Mutual respect : No partner at the table knows everything about everything; humility is a learned skill

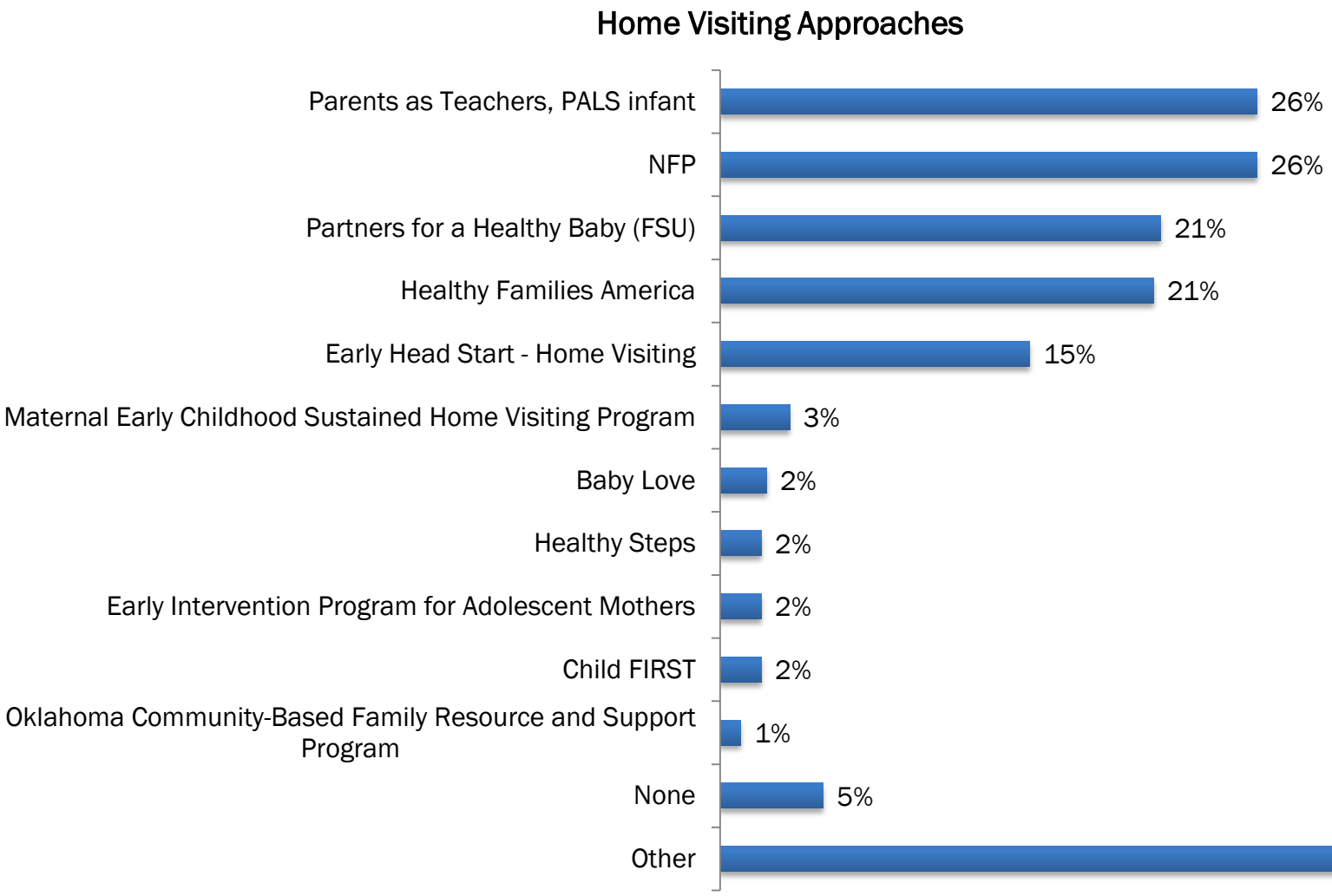
Steps to Care Coordinated Case Management

1. **Assess Client:** Identify likely challenges to successful outcomes
2. **Develop a Plan with the client:** Plan for challenges and organize care plan
3. **Identify necessary participants and specify roles:** Specify who is primarily responsible for oversight
4. **Communicate to client and all other participants:** Ensure information exchange across all entities
5. **Execute plan:** Implement managed coordination interventions
6. **Monitor and adjust care:** Identify and monitor failures and weaknesses
7. **Evaluate outcomes:** Is client better off?

Care Coordination/Case Management Practices



Home Visiting



Popular Healthy Start Models

	Parents as Teachers (26%)	Nurse Family Partnership (26%)	Partners for a Healthy Baby (21%)	Healthy Families America (21%)
Goals	• Increase parent knowledge of early childhood development and improve parenting practices • Provide early detection of developmental delays and health issues • Prevent child abuse and neglect • Increase children's school readiness and school success	• Improve pregnancy outcomes by helping women improve prenatal health • Improve child health and development by helping parents provide sensitive and competent caregiving • Improve parental life course by helping parents develop a vision for their future, plan subsequent pregnancies, continue their education and find work	• Improve birth outcomes • Reduce rates of child abuse • Strengthening families • Enhancing child health and developmental outcomes • Promoting family stability and economic self sufficiency	• Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth • Cultivate and strengthen nurturing parent-child relationships • Promote healthy childhood growth and development • Enhance family functioning by reducing risk and building protective factors
Brittany				
LaDawn				
Heather				
MeMe				

LADAWN

Which model would serve her best?

- 38 year old released from prison last year after serving a drug and prostitution sentence
  - Has a good relationship with parole officer who she trusts
- Back together with "bad news" boyfriend/pimp
  - He has arranged a furnished apartment for her, a cell phone, and money for food and transportation
- 4 months pregnant with twins. Her other 8 children are living with relatives or are in foster care
  - She was also a twin and believes that being pregnant with twins is a sign of God's forgiveness for the choices she has made.
- Using again?
  - Drugs help her nerves and helps her keep from gaining too much weight
- Developed gestational diabetes, has a history of preeclampsia last pregnancy, and has missed her last 3 prenatal care appointments
  - Afraid of bad news or being judged by the staff at the clinic

The Basics of Care Coordinated Case Management

Observe the steps

1. Assessment of needs
2. Development of a plan
3. Identify participants
4. Communication
5. Execute plan
6. Monitor and evaluate

http://www.youtube.com/watch?v=5fwEGgZaolA

The Basics of Care Coordinated Case Management

Observe the steps

1. **Assessment of needs**: LaDawn's immediate needs: safety, risky pregnancy, prostitution, and drug use.
2. **Development of a plan**: Prioritize issues (triage). If LaDawn is not ready to get off the streets, then this should not be a top priority in the initial plan.
3. **Identify participants**: Who needs to be at the table (social work, domestic violence, law enforcement, mental health, medical, etc.) ?
4. **Communication**: How will group communicate? Set ground rules and expectations; identify barriers up front.
5. **Execute plan**: Include a timeline that is realistic and agreed upon by all for each aspect of the plan or issue being addressed.
6. **Monitor and evaluate**: Determine what success looks like for LaDawn, not for the individual organizations at the table.

References

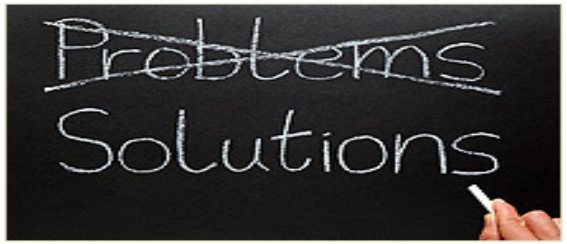
- Care Coordination. October 2014 Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care /improve/coordination/index.html
- Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol 7: Care Coordination)

QUESTIONS?

Next Steps for Care Coordination

Discussion Group

- Three conversations
- Co-facilitated by HS Grantee & EPIC Team Member
- Focus: Peer sharing & learning



Wrap Up and Reminders

Upcoming Webinars:

- **Using Doulas As a Resource for Case Management**: April 21 from 3:00–4:00 PM EST
- **Reproductive Life Planning**: April 28 from 3:00–4:00 PM EST
- **Centering Pregnancy and Centering Parenting**: Innovative models for prenatal, well-woman, and well-baby care on April 30 from 3:00 – 4:00 PM EST
- **Quality Family Planning Recommendations and Healthy Start**: May 5 from 3:00–4:00 PM EST

EPIC Center website: http://www.healthystartepic.org

- Includes all recorded webinars, transcripts, and slide presentations