



Medical Home Care Coordination & Family Involvement

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Reality for Families

- 13.5% say they spend 11+ hours/wk coordinating care for their child or youth with special health care needs
- 24.9% indicate families cut back on work due to child's or youth's condition
- 28.5% indicate families stop working due to child's or youth's condition



MCHB/NCHS, National Survey of Children with Special Health Care Needs, 2002

What Exactly does a Medical Home with care coordination look like?



Care Coordination Definition

- **Pediatric care coordination:** patient- and family-centered assessment and management of child/youth's interrelated medical (chronic conditions), social, developmental, behavioral, educational and financial needs
- **Adult care coordination:** generally patient-centered assessment and management of chronic health conditions
- **Geriatric care coordination:** patient- and family-centered assessment and management of adult's interrelated medical (chronic conditions), social and financial needs



KEY POINTS

- Care Coordination ≠ Medical Home
- Care Coordination ≠ Case Management
- Patient- & Family-Centered
- Proactive, Planned & Comprehensive
- Promotes Self-Care & Independence
- Emphasize Cross-Organizational Relationships
- Volume of CC Will Vary Widely by Practice
- Medical Home Teams w/Designated Care Coordinator Position Provide Greater Variety of CC Services Than Teams Without Care Coordinator



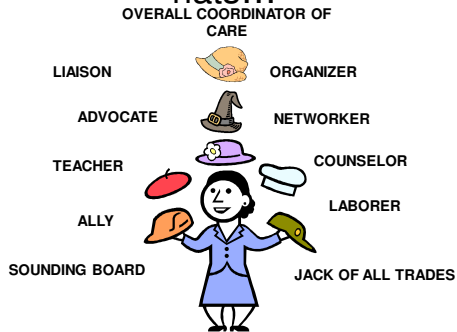
Who is the Care Coordinator?

- Can be a social worker, nurse, parent or other trained professional
- Staff person clearly identified as the care coordinator in the practice
- Trained specifically in the care of special needs/chronic disease
- Demonstrates skills in: working with families and patients, navigating systems, and knowledge of the impact/stressors associated with caring for person with chronic disease



Care Coordinators wear many

hats...



Care Coordinators Must be...




Care Coordination: When?

- New diagnosis
- Transition
- School issues
- Multiple specialty providers
- Frequent ER use
- Unplanned inpatient admissions
- Difficult psychosocial issues




Care Coordination: Who receives?


- **Use of practice reports**
 - ICD-9 based reports
- **Staff referrals**
 - Triage nurse
 - Nursing staff
 - Referral coordinator
 - Practice receptionist
- **Physician referrals**
 - “Pink slip” kids



Care Coordination: How much?

- **Tier One**
 - Illness with very specific issue with limited assistance needed
- **Tier Two**
 - Moderate Needs well matched to resources available
- **Tier Three**
 - Complex illness with multiple needs or psychosocial issues
 - Needs often fall between the cracks of available resources





Care Coordination Tasks:

- Complete intake forms to gather comprehensive information on each patient
- Complete referrals to community agencies (*early intervention, mental health, etc*)
- Gather medical records including specialist visits and labs in preparation for future appointments



Care Coordination Tasks:

- Process prescriptions for items such as:
 - Therapies (*PT, OT, SLP, aqua, horse, music*)
 - Disposable/consumable supplies (*catheters, formula, enteral products, oxygen, wound care, etc*)
 - Durable medical equipment (*wheelchairs, orthotic devices, bathchairs, lift systems, etc*)
- Work with home health vendors to process and follow-up on requests and prescriptions



Care Coordination Tasks

- Write letters of medical necessity for the following:
 - Appeals for services and supplies*
 - Special authorizations for additional or excessive use of supplies*
 - Authorization for specialty services*
 - Diagnosis and Prognosis*
 - Guardianship*
 - Theme park special pass*
 - School orders/special education*
 - Misc services and advocacy*



Care Coordination Tasks:

- Act as a liaison between the medical practice and health insurance companies, therapists, schools, community agencies and any other entity or person involved in the care of the patient
- Assist families with grievance and appeal processes



Care Coordinator Tasks:

- Assist families with transitions at all stages of development:
 - Early intervention to early childhood special education*
 - Early childhood special education to elementary school*
 - Middle school to high school*
 - Pediatric to adult medical care*
 - Independent living to assisted living*
- Assist families to understand eligibility criteria and apply for federal, state and/or local public services and insurance programs



Care Coordinator Tasks:

- Provide resource information and support services
- General advocacy services within the health care system and community
- *Provide accessible, family/patient-centered, continuous, comprehensive, coordinated, compassionate and culturally-effective care to all families, but especially those with special needs/chronic disease and their families*

Coordinated



- Care plan shared with other providers, agencies, and organizations involved with the care of the patient (copy given to family/patient)
- Care among multiple providers is coordinated through the medical home
- A central record or database containing all pertinent medical information, including hospitalizations and specialty care, is maintained
- Shared information among the patient, family, and consultant with specific reasons for referrals



Coordinated

- Links to family support groups, parent-to-parent groups, and other family resources
- Assistance to the patient and family in communicating clinical issues
- Evaluation and interpretation of consultant's recommendations for the patient and family



Self-Management Support

- Empower patients to manage their health



Self-Management Tasks

- Assess patient's belief's, behavior and knowledge
- Advise patients by providing specific information about health risks & benefits of change
- Agree on collaboratively set goals based on patient's confidence in their ability to change the behavior
- Assist patients with problem-solving: identify barriers, strategies & support
- Arrange specific f/up plan



Pediatric “Care Coordination” Services in Iowa

- Child Health Specialty Clinics
- Early ACCESS
- EPSDT Care for Kids Program
- 1st Five Healthy Mental Development
- Medicaid HCBS Waiver Programs



Resources

- <http://www.aap.org/>
- <http://www.aafp.org/online/en/home.html>
- <http://www.ahrq.gov/>
- <http://www.familycenteredcare.org/>
- <http://www.hrtw.org/>
- <http://www.ihl.org/ihl>
- <http://www.improvingchroniccare.org/>
- <http://www.medicalhomeimprovement.org/>
- <http://www.medicalhomeinfo.org/>
- <http://www.ncqa.org>
- <http://www.nichq.org/nichq>
- <http://www.uihealthcare.com/depts/state/chsc/>
- <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/May/Making-Care-Coordination-a-Critical-Component-of-the-Pediatric-Health-System.aspx>



Medical Home with care coordination and family involvement