



Developing Care Coordination (CC) as a Critical Component of a High Performance Pediatric Health Care System

Jeanne McAllister,BSN,MS,MHA Richard Antonelli,MD,MS, & Jill Popp,MA
Supported by a grant from The Commonwealth Fund



PEDIATRIC CARE COORDINATION FRAMEWORK

Care Coordination Definition:

Pediatric care coordination is a patient and family-centered, assessment driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health and wellness outcomes.

Defining Characteristics of Care Coordination

- | | |
|---|--|
| 1. Patient and family-Centered (PFC) | 3. Promotes self-care skills & independence |
| 2. Pro-active, planned, & comprehensive | 4. Emphasizes cross-organizational relationships |

Care Coordination Competencies:

- 1) Develops partnerships
- 2) Proficient communicator
- 3) Uses assessments for intervention
- 4) Facile in care planning skills (PFC)
- 5) Integrates all resource knowledge
- 6) Possesses goal/outcome orientation
- 7) Approach is adaptable & flexible
- 8) Desires continuous learning
- 9) Applies solid team/building skills
- 10) Adept with information technology

Care Coordination Functions:

- 1) Provide separate visits & CC interactions
- 2) Manage continuous communications
- 3) Complete/analyze assessments
- 4) Develop care plans (with family)
- 5) Manage/track tests, referrals, & outcomes
- 6) Coach patient/family skills learning
- 7) Integrate critical care information
- 8) Support/facilitate all care transitions
- 9) Facilitate PFC team meetings
- 10) Use health information technology for CC

Delivery of Family-Centered Care Coordination Services includes:



FRAMING CARE COORDINATION

Value: Care Coordination (CC) is of critical importance to closing the quality gap in the US health care system - with its potential application across organizations along the continuum of care (Institute of Medicine)

Issue: Lack of consensus remains regarding competencies & core functions of CC; *who* should provide CC; what the essential CC outcomes are; how to measure & pay for CC services

Solution: Forging a multidisciplinary framework for pediatric CC , developing accompanying measurement & necessary infrastructure

PURPOSE

Propose a multidisciplinary framework for pediatric CC with a model suitable for implementation across all health care settings and related disciplines

METHODS

1. Literature review
2. *Key informant interviews & expert panel* (diverse representation including: family, nursing, medicine, social work, payer, policy, etc.)

RESULTS

1. Care Coordination Brief outlining:
 - a) CC Framework (center of poster)
 - b) CC Measures - multiple levels (below)
 - c) Future CC development - recommendations (below)

MEASURES/OUTCOMES	PATIENT FAMILY	PRACTICE/TEAM	SPECIALISTS COMMUNITY PARTNERS	HEALTH PLAN
Clinical	4	4	4	4
Functional	4	4	4	-
Satisfaction	4	4	4	-
Cost	4	4	4	4

RECOMMENDATIONS:

- Identify promising CC practices/community models
- Develop consensus around CC standards
- Develop/endorse CC measures
- Evaluate characteristics of CC models
- Assess CC value across varied populations
- Integrate CC tools into EMR/HIT
- Create rigorous CC education/curriculum/tools
- Identify/develop policy frameworks supportive of CC
- Cross fertilize CC lessons to inform adult care models

* Select photos from the Colorado Health Care Program for CSN