Q&A: Beyond Checklists: Care Planning for Children with Special Health Care Needs

Below are responses to questions the panel was unable to answer during the webinar.

Respondents

- **Annique K. Hogan, MD,** Medical Director of the Children's Hospital of Philadelphia Compass Care program and the Integrated Care Service

- **Jill S. Rinehart, MD, FAAP,** Partner, Hagan, Rinehart & Connolly Pediatricians, PLLC, and Clinical Associate Professor of Pediatrics at the University of Vermont College of Medicine

Q&A

Do you have a sample care plan form?
See an example (PDF) of a shared plan of care used at Riley Hospital for Children/Indiana University.

When using the electronic medical record (EMR) to help create a care plan, how does the family access the final care plan "product"?

Annique: The care plan is turned into a letter that we print and send to each family and primary care provider (PCP). In addition, an electronic copy is sent to the family through our patient portal in the electronic health record (EHR) and to each member of the care team.

Jill: We can print a medical summary and the Care Plan Goals, next steps and accountability then that is given to the family in paper form.

What are realistic options for paying for care planning?

Annique: This continues to be a significant challenge. Generally, the time and team members necessary for care planning are not covered adequately. There are care coordination codes that can be used, but with limitations as noted [during the webinar]. Future opportunities to cover the costs of care planning may be able to be found with different payment models such as shared savings arrangements with insurers.

Jill: Realistically health care reform dollars should be spent to support primary care's ability to do this work of care coordination well. Our state has money to support care coordination directly through "community health teams" that provide community based interventions to "health service areas of Vermont." Unfortunately "care coordination" and care planning gets lost in translation without specific guidelines and easily loses its family and patient-centeredness and becomes "panel management" when not including families in the work. There are fee-for-service codes that can be used in places where Medicaid or insurers are not already providing incentive-based services.

Could you discuss how easy/hard it was to work with IT to get the care plan integrated into the electronic medical record (EMR)? Did you have buy-in from higher-ups at your institution?

Annique: Our existing electronic health record (EHR), Epic, had the capabilities that we needed.

Jill: I work with Physician's Computer Company (PCC) and they have a pediatric only product that is fairly malleable, as far as electronic health records go. They (PCC) have a Care Plan feature. But even with that, some of the medical information that is in the EHR is not easily printed out or transferred electronically and not easy to share electronically. I am in a private practice, so I am the "higher-up," but even so, changing technology to meet the care planning needs is definitely a challenge. Other practices

we work with have a Word document template Care Plan that is scanned into the EHR and modified by the care coordinators or health care professional at visits, points of phone contact, etc.

If there are members of the care team who aren't a part of the hospital (teachers, home nurses), how do they gain access to the hospital portal? How are their services integrated into the care plans?

Annique: For providers who are outside of our institution, access to the plan of care varies depending on their role. If the family has included them in the care team, the provider has the ability to use a provider portal to access the plan of care in a "read-only" fashion and a hard copy can be sent. We also use secure email to communicate with providers outside of our institution.

Jill: We use secure email to share with teachers, visiting nurses, school teams, and therapists. We include them in our Care Conferences and they can have copy of the shared plan of care and goals/next steps/accountability if the family agrees. Using ACT.MD we can invite them to this HIPAA-compliant platform to communicate and access key information as well.

Does every patient get a shared plan of care? How many patients does each care coordinator manage?

Annique: All of the patients enrolled in our program have complex medical needs, therefore all of them have a care plan. Due to the high level of medical complexity and fragility of all of the patients in our program, we have approximately 75 patients for each nurse coordinator.

Jill: I always say not *every* patient needs a shared plan of care *every* time, but *any* patient should have the ability to have one *any* time it is deemed necessary. I think we have about 200 active patients right now that our care coordinator is familiar with, out of a practice of 4000 patients. We do about 8-12 care conferences in a month.

What has been your success in translating the care plan for non-English speaking families?

Annique: Unfortunately, we do not have the ability to translate the care plan. We explored this option but it was cost-prohibitive.

Are your care coordinators clinical or non-clinical?

Annique: The work of "care coordination" is done by both our Registered Nurse (RN) care coordinators as well as our social worker. We have a non-clinical office coordinator who also helps our families with scheduling all of their appointments, which has been a tremendous help for our families as well as our clinical staff.