June 1, 2016

Q&A: Take Action on Care Coordination

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

Respondents

- Colorado Access – Lisa Rossignol, MA, and Matt Lanphier, MPH
- Partners for Kids, Nationwide Children's Hospital – Kelly Kelleher, MD
- Lucile Packard Foundation for Children's Health – Ed Schor, MD
- Catalyst Center – Sara S. Bachman, PhD, and Meg Comeau, MHA

Q&A

What transportation assistance do you provide to families?

Colorado Access: In Colorado, non-emergent medical transportation (NEMT) is available for Medicaid members through a vendor called First Transit. Colorado Access Care Managers do not provide direct transportation services, but we will assist members to obtain services through the NEMT vendor.

Partners for Kids: PFK connects families to transportation assistance available as part of their managed care benefit, as well as to additional community specific resources that may also provide transportation services.

How are parents involved in these programs (besides obviously being a client)? Do they design? Involved in Quality Improvement (QI) initiatives?

Colorado Access: Colorado Access actively involves the member's parents/guardians during the care coordination process. Depending on the age of the child, the majority of the information on the member is provided by the parent/guardian. We also encourage the parent to work with the Care Manager to identify the care plan and both long-term and short-term goals.
Additionally, Colorado Access is developing several robust member and family engagement opportunities in an effort to identify engagement, motivation, and feedback.

Partners for Kids: PKF has a family member on its board. The care coordination program also seeks regular input from the family advisory council at Nationwide Children's Hospital to identify and prioritize issues as well as provide feedback on proposed solutions. This includes all components of QI projects, from selecting interventions to choosing measures of effectiveness.

How do you involve the child (patient) in the care coordination and ensure person-centered care? Not just the family, but also the child.

Colorado Access: Colorado Access involves the children in the process whenever possible. Depending on the age and mental capacity of the child this sometimes, can be difficult. We strive to adhere to best practice standards of person-centered care and involving the child/member whenever possible. Our Care Managers also encourage the parent/guardian to engage their children in the care coordination process as well.

Partners for Kids: The child, in addition to the caregiver, is included as developmentally appropriate in the assessment and selection of goals with the care coordinator. Some examples of areas where the child can provide valuable input include readiness to change, primary concerns, school performance, understanding of the treatment plan, and sufficiency of support. Activities of the care coordinator foster self-management directly with the child, particularly in cases of chronic disease management or behavioral health, to the degree that the child is willing and able to participate.

How successful are the case managers from insurance plans in reaching patients/parents by phone?

Colorado Access: Demographics for Colorado Medicaid population are not as accurate as we all would prefer. On average, our care management team is able to a successfully reach approximately 45% of our population.
Partners for Kids: When conducting outreach from a list of contacts provided by the health insurer, about 60% of the population is unable to be reached by phone, even though outgoing calls are represented as coming from the Nationwide Children's Hospital. In small populations, outreach efforts that included the primary provider in person at an office have yielded higher enrollment rates of about 85% or greater.

In these models, does the parent have a single point of contact *across* agencies or just at the medical home? In other words, does the coordinator also assist with Individualized Education Plans (IEPs), community access issues, etc., or is the focus only on the child's medical needs?

Colorado Access: For our more complex members/children, it is common to have multiple coordinators, case managers, social workers, etc., involved. At Colorado Access, we ask the member/parent/guardian to identify a lead coordinator for their care; we still make it our best practice to reach out to other identified providers and coordinators for basic information sharing and introductions. Additionally, Colorado Access has an advantage—we have 3 Regional Care Collaborative Organizations (RCCOs), 3 Behavioral Health Organizations (BHOs), and a Single Entry Point (SEP for disability services) which enables our organization and the care managers to coordinate more effectively and efficiently.

Partners for Kids: The care coordinator at PFK is a single point of contact for all agencies, including providers, healthcare services, and community agencies. Coordination of medical needs is only one aspect addressed by the care coordinator. Equal attention is given to psychosocial needs including food, shelter, school, financial resources, caregiver respite, coping abilities, and personal needs.

Nurses were noted to be part of the care coordination team. Do the nurses in this model have direct (child) patient contact/communication or not? There are some nurse care coordinators who, by law, are not authorized to have direct patient contact but are rather expected to collaborate with health care staff, social workers, insurance entities, and parents.

Colorado Access: We do have Registered Nurses (RNs) and they have contact with the member/family in a care coordination role to collaborate with providers, health care staff, family, community resources and entities, etc. The RNs do not perform any direct patient care.

Partners for Kids: Nurses have direct contact with the patients and all others involved in the patient care. This includes home visiting, attendance at medical appointments and telephonic. The nurses do not provide treatment, for example, procedures, medication administration or home nursing services.

Have there been efforts to explore how this links with California Children Services?

LPFCH: The Foundation invited CCS staff to attend its National Symposium and to view the webcast of the Symposium. In addition, the Foundation has provided the Department of Health Care Services (DHCS)/CCS staff with a variety of written documents describing how other states have approached improving care coordination for children with special health care needs. Foundation staff members serve on the state's CCS Redesign Advisory Group.

For non-Medicaid patients, what is the best way for a clinic to fiscally provide a care coordination service to families when private insurance reimbursement is limited?

Catalyst Center: This challenge is one we encountered frequently in our work researching *The Care Coordination Conundrum*. First, ensure that you are maximizing use of Current Procedural Terminology (CPT) codes. There is a list on page 15 of the report. In addition, the National Center for Medical Home

Implementation (NCMHI), a project under the American Academy of Pediatrics, has a variety of evidence-based practice support resources related to care coordination available on the NCMHI website. You may be able to stretch limited resources by ensuring that you are aware of and using other care coordination providers the child and family might be involved with, such as Title V MCH programs, mental or behavioral health agencies, social service agencies, etc. Change is necessary on the macro level, however, to really impact this challenge.

We lay out a series of recommendations in the report, including.

1. Develop a new care coordination paradigm grounded in pooled resources and broad population-based financing and reimbursement models that include CYSHCN as well as other population groups such as adults with chronic illnesses and frail elders.
2. Establish the evidence base for care coordination for children and develop specific metrics and outcomes for the service, including return on investment (ROI) from multiple stakeholder perspectives, including payers, providers, and families.
3. Develop risk-adjustment models for CYSHCN to level the playing field and encourage health plans and providers to enroll and serve high-need groups.
4. Identify the care coordination services that should be part of a bundled/capitated payment.
5. Link bundled or capitated payments to improved quality indicators and health outcomes.
6. Provide care coordination in teams that include licensed and non-licensed staff with shared responsibility for clinical and non-clinical coordination tasks. Including peer parents on these teams will increase appropriate family involvement, promote communication with family members, and aid in quality improvement efforts.

What are some CPT codes to use for care coordination; what CPT codes can I use when the patient is not present?

Catalyst Center: See page 15 of the report, *The Care Coordination Conundrum*, for a list of CPT codes, including those without direct patient contact.

Can anyone recommend a training, webinar or refresher for care coordinators that focuses on or reiterates the importance of the family's role and collaboration within the care coordination process?

Catalyst Center: There are many exceptional resources available on this topic; one that comes immediately to mind is the Pediatric Care Coordination Curriculum, found on the National Center for Medical Home Implementation website. Another is an upcoming webinar focused on discharge planning, which is an important locus for care coordination. "Family Participation in Discharge Planning: Voices of Patients, Parents, and Advocates" will be held from 3 to 4:30 p.m. ET (12 to 1:30 p.m. PT) on Thursday, June 9. Visit the website for more information and to register for the webinar, which is supported by the Lucile Packard Foundation for Children's Health.

What are the outcomes of a client being managed by a care coordinator or nurse case manager?

Catalyst Center: The outcomes are as variable as the models in practice; there's no simple or easily generalizable answer to this important question. If you are interested in measuring the impact of your own care coordination practice model, a tested resource is the Care Coordination Measurement Tool, found on the National Center for Medical Home Implementation website.