

Mapping Care Coordination for Children in Minnesota

NORTHEAST REGIONAL REPORT

Mapping Care Coordination for Children in Minnesota: Northeast Report

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Contents

Mapping Care Coordination for Children in Minnesota	0
Northeast Minnesota Findings	3
Regional Boundaries	3
Strengths and Challenges in Providing Care Coordination.....	3
Regional Care Coordination Framework.....	4
Child and Family at the Center	5
Roles of Partners.....	6
Primary Responsibilities.....	7
Infrastructure/Supports Needed to Improve Care Coordination (“Wishes”).....	8
Action Planning.....	9
Appendix: Data Tables from Figures/Charts	14

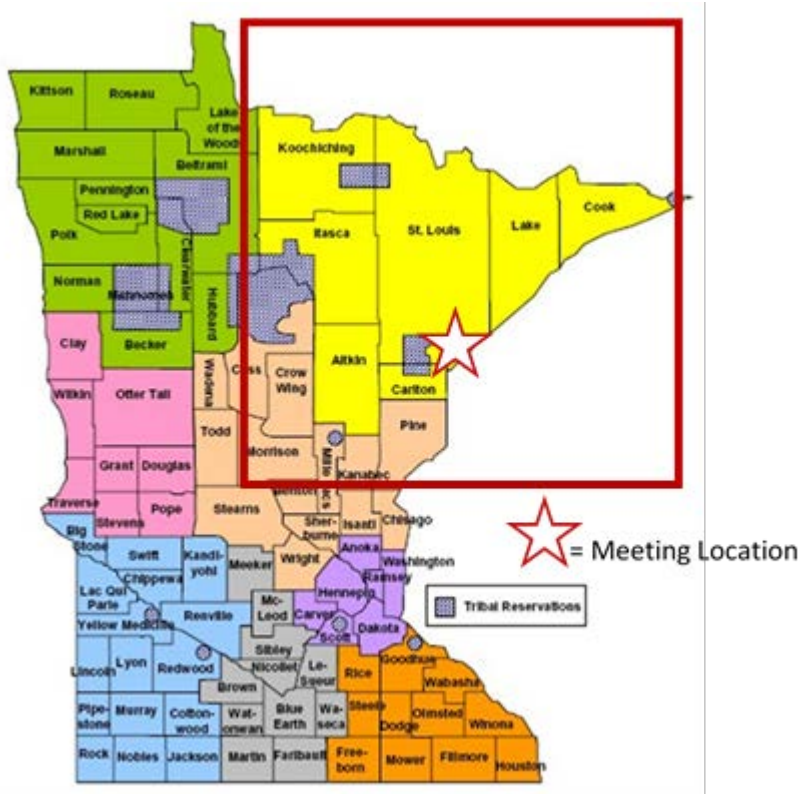
Northeast Minnesota Findings

The following section details the findings of the regional care coordination systems mapping activities that occurred in the Northeast Region of the State. Separate reports for each of the other regions can be found on the [“Mapping Care Coordination in Minnesota” webpage](#) on the MDH CYSHN website.

Regional Boundaries

The regional boundaries of the Northeast area of the state are highlighted in Figure 1 below. The meeting took place in Duluth, MN, which is denoted with a star on the map. Participants represented families, agencies, clinics, and organizations located within the counties in the box outlined in red on the map. The region stretched from the counties aligning the North Shore of Lake Superior on the east, to Koochiching, Itasca, Crow Wing, and Aitkin counties on the west. It stretches from the Canadian border on the north to Pine, Kanabec, Mille Lacs, and Morrison counties on the south.

Figure 1: Northeast Region and Meeting Location



Strengths and Challenges in Providing Care Coordination

In conducting systems mapping, it was important to begin by developing an understanding of what works well and what needs improvement in providing care coordination. The main themes from in strengths and challenges experienced around care coordination in Northeast Minnesota are listed below.

“Care coordination of CYSHN in Northeast Minnesota currently works because...”

- Those agencies/organizations working together are passionate about serving families
- Individual care coordinators/families take the time needed to release information
- There has been a lot of research conducted related to care coordination
- It works well for those who have strong networking and access in place
- Parents have a strong voice in the clinics
- People really care and want to have conversations
- “I coordinate the coordinators” – Parent
- Coordinators take the time to get to know the families
- Relationships and a sense of community is already in place
- Coordinators are working together in different “pockets” of the region – especially in the Duluth area

“Care coordination of CYSHN in Northeast Minnesota would be better if...”

- There were a more “universal” way to release information
- More organizations would embrace commitment to care coordination and a culture of health
- More efficient, streamlined workflows were already in place for exchanging information so they could be used right away once consent is obtained from families
- All systems would do more proactive consultation and engage in developing more innovative resources
- Someone would take the lead in the coordination
- Families would be given more information on what information school partners have
- Systems were set up to meet the family’s needs rather than provider or funder needs
- There was a centralized place to learn about resources
- Care plans were more easily accessible by families and others on the team (i.e., on a cloud-based portal or something similar)
- More services were available in more remote, rural communities – including childcare
- It were easier to gain consent and talk to each other
- Funding streams would work faster
- Families were able to access interventions earlier

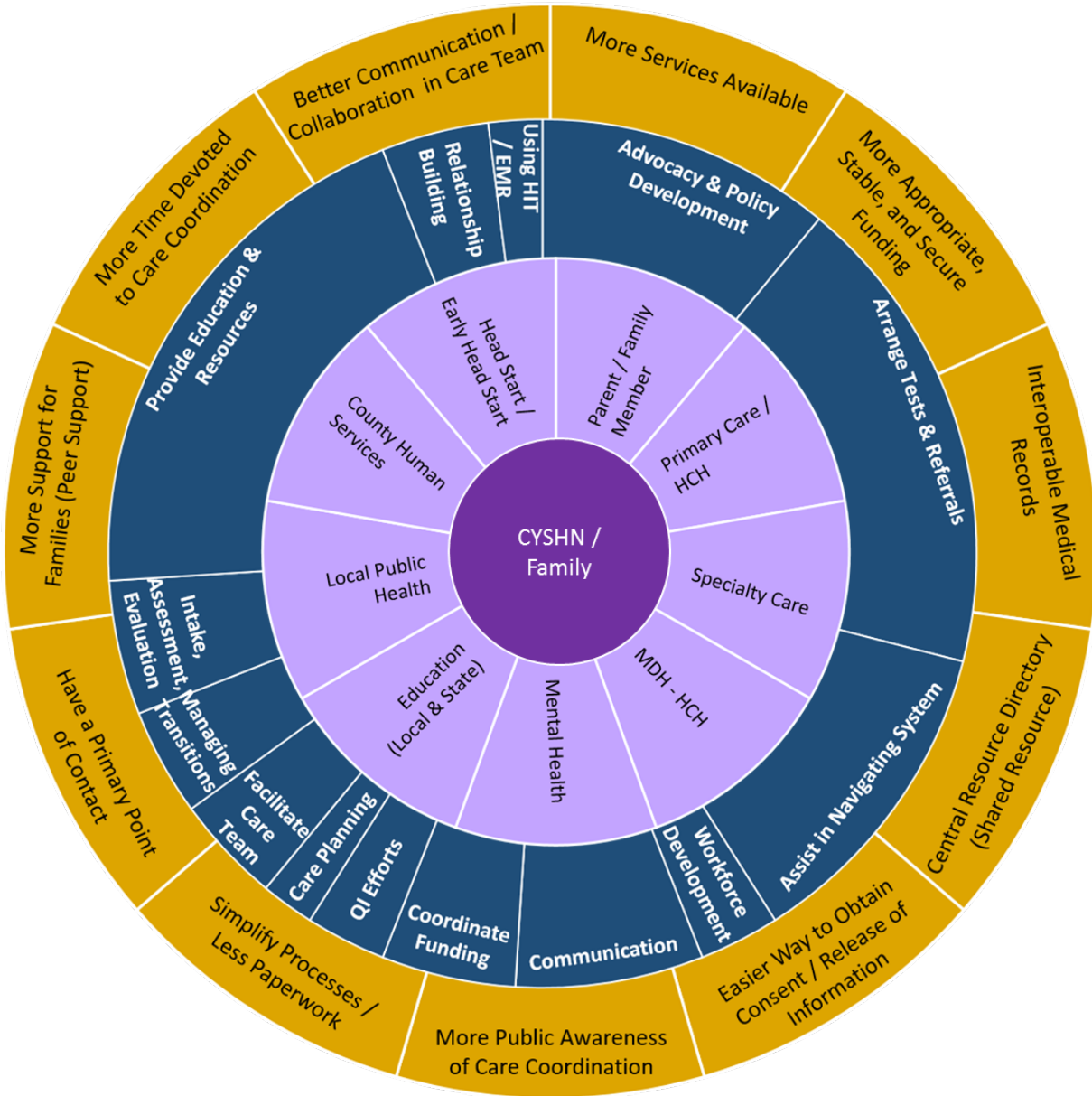
Regional Care Coordination Framework

All participants completed individual systems support maps (see Statewide Summary for more details), and then all the maps were compiled to create a regional care coordination framework using the Circle of Care Modeling (CCM) approach. CCM was used to identify the different various partners providing care coordination services, their primary responsibilities, and their common wishes on how to improve the system. *The CCM approach positioned CYSHN and their families at the center of the system; the roles of care coordinators and their responsibilities were then modeled around the family.* By mapping out the various partners providing care coordination and their responsibilities, we were able to expand our understanding of what families are experiencing in care coordination, and were also able to determine areas where the infrastructure needs to be built up to improve care coordination for CYSHN and their families.

The systems mapping approach is described in the next section, and is incorporated into Figure 2. We begin by describing the various partners who provide care coordination, and then move to their primary

responsibilities in coordinating care. Finally, we explore wishes or opportunities for improvement at a systems-level; providing recommendations on how to build up the infrastructure to improve the provision of care coordination for CYSHN in Northeast Minnesota.

Figure 2: Northeast Minnesota Care Coordination Framework



Child and Family at the Center

For both the Statewide and Regional Care Coordination Frameworks, the child and family are placed at the center of the system. An [increasingly growing body of literature](#) points out that when the patient and/or family experience is placed at the center of care, more favorable outcomes are produced. By placing the child and family at the center of the framework, we are not only ensuring we think of their

needs and experiences first, but that we also actively partner with them first when determining what systems-level improvements need to be made.

Roles of Partners

The next level of the Statewide Care Coordination Framework are the various roles of partners involved in care coordination. There were a total of 16 participants in the care coordination systems mapping meeting in Northeast MN. Participants represented the following areas: parents of CYSHN, primary care, local public health, specialty care, state agency staff, Head Start, and county human services. *There are many different players involved in providing care coordination, or many different types of coordinators from different service/support systems. Also of note is that families often reported that they are the main coordinator of their child’s care – or at times can be the “coordinator of all the coordinators.”*

A breakdown of the organizations/roles of participants by region is included below in Table 1. The first row of the table includes all the types of different stakeholder groups who participated in any of the five regional meetings. The second row includes the number who participated in the Northeast Regional Meeting. As you can see, there were some stakeholder groups missing in the region. These roles/organizations are not included in regional care coordination framework (Figure 2).

Table 1: Care Coordination Systems Mapping Participant Organizations/Roles in Northeast MN

Participant Organizations/Roles	Northeast	Percent
Primary Care	2	14%
Parents	3	21%
Local Public Health	1	7%
Specialty Care	3	21%
Health Plans	0	-
MDH – Health Care Homes	1	7%
Education (District & State)	1	7%
Head Start/Early Head Start	1	7%
ounty Human Services	1	7%
Mental Health	1	7%
Family Organization	0	-
MN DHS	0	-
School Nurse	0	-
Interagency Early Intervention Committee	0	-
Home Care	0	-
TOTAL	14	

Missing Partners

Table 2 above includes the various roles or organizations of the participants in the Northeast Minnesota Regional Meeting. As you can see, there were quite a few different stakeholder groups who were not present, including: health plans, school nurses, interagency early intervention committees, and home care providers.

The participants in the meeting were also asked to list out other partners who were missing in the meeting. Responses included: more families, staff from the Department of Human Services, representatives from more rural and tribal communities, faith-based organizations, community organizations (e.g., Lutheran Social Services, ARC Northland), special education, more local public health nurses, physicians/providers, policy-makers (e.g., County Commissioners, Legislators, and School Board Members/Administrators).

Primary Responsibilities

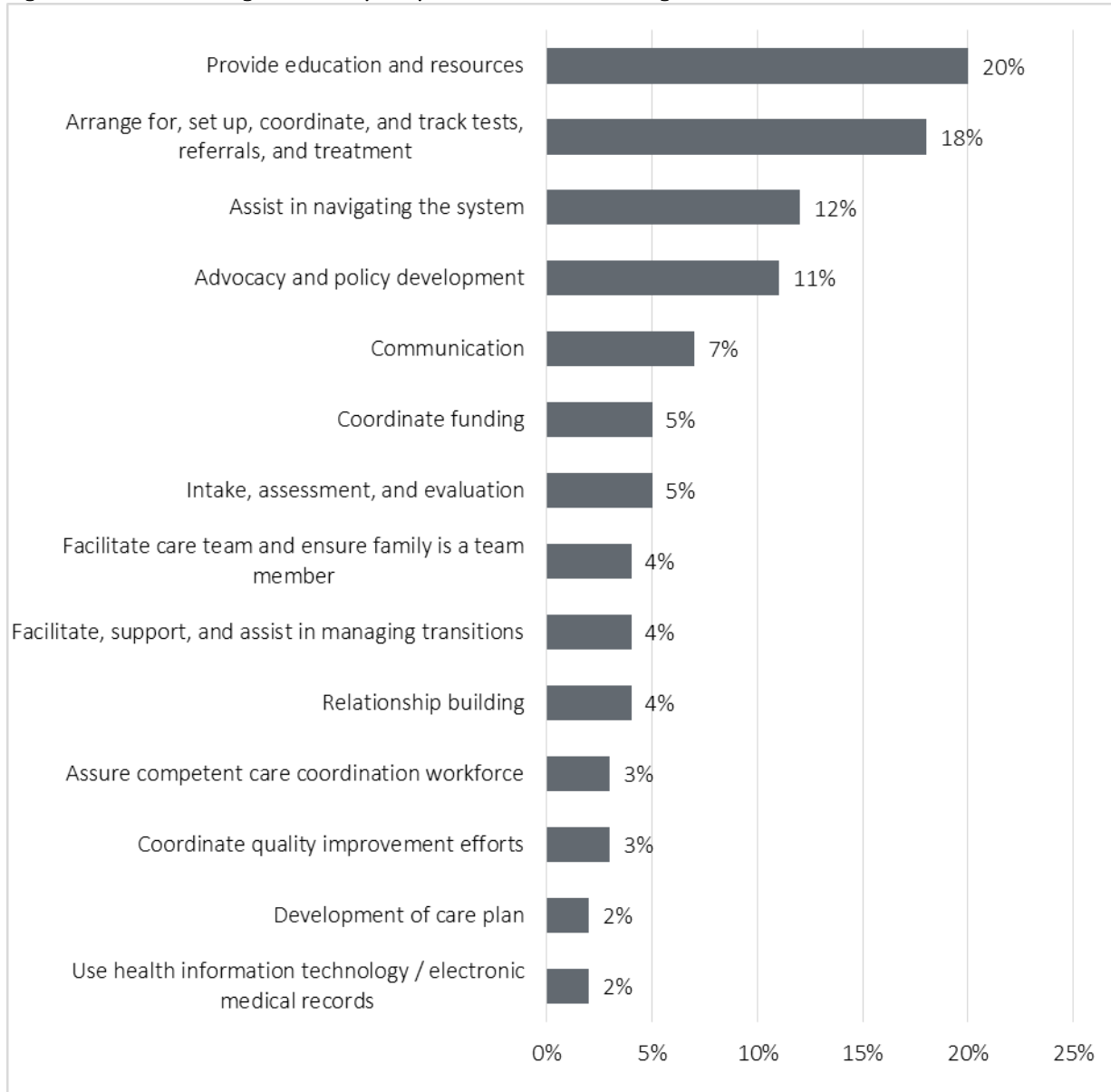
Moving out to the next level of the care coordination framework are the primary responsibilities of the providers of care coordination. Participants were asked to identify their top five responsibilities when it comes to providing care coordination for CYSHN. It is important to understand these responsibilities because they can help point toward the areas that care coordinators spend most of their time and effort. The responsibilities reported by the participants were aggregated utilizing an affinity diagramming process, and then were grouped into 14 different categories, including:

1. Advocacy and policy development
2. Arrange for, set up, coordinate, and track tests, referrals, and treatment
3. Assist in navigating the system
4. Assure competent care coordination workforce
5. Communication
6. Coordinate funding
7. Coordinate quality improvement efforts
8. Development of care plan
9. Facilitate care team and ensure family is a team member
10. Facilitate, support, and assist in managing transitions
11. Intake, assessment, and evaluation
12. Provide education and resources
13. Relationship building
14. Use health information technology/electronic medical record

Figure 3 provides the overall responsibilities reported by care coordinators in the Northeast Region. The most reported responsibility of care coordinators in the region was providing education and resources. Some of the more specific activities under providing education and resources included: educating self on diagnoses and programs; educating other staff, coordinators, and care team members; educating or coaching families; and sharing or providing information on resources or diagnoses to families.

The second most reported responsibility was arranging for, setting up, coordinating, and tracking tests, referrals, and treatment. This included activities such as helping to coordinate services, assisting with crisis prevention and management, guiding families so they can receive needed services and supports, and working to remove barriers experienced by families in navigating the system.

Figure 3: Northeast Region Primary Responsibilities in Providing Care Coordination



Infrastructure/Supports Needed to Improve Care Coordination (“Wishes”)

The final level of the Care Coordination Framework includes the systems-level actions that are needed to be able to improve care coordination. The participants were asked to give the top three things that they “wish” for that could help improve care coordination. We focused on calling these “wishes” because we wanted to encourage participants to think “big” when brainstorming things that could improve care coordination. Sometimes when stakeholders are asked to think of things that can improve the system or make it more easily navigable, responses can be stifled because they only will think of the smaller level things rather than the bigger problems or solutions – calling them wishes increased the creativity and honesty of the responses. All the responses statewide were compiled and grouped using an affinity diagramming process – categories were then determined based on the groups. The top “wishes” in the Northeast Region included:

- **More services available for families:** Related to this category, participants wished for more care coordination in the primary health care sector, more accessible and innovative services (especially mental health services in the more rural areas of the region), more coordination in the specialty care setting, and resources that fit across the spectrum and are tailored to families.
- **Medical records that span multi-systems and are family-friendly:** Participants wished for expanded technology (including telehealth and data exchanges), that there would be one universal medical record or a centralized hub where all care plans can be accessed by all appropriate team members (some participants wished this would be a ‘cloud-based resource’).
- **More appropriate, stable, and secure funding for services and care coordination:** Some of the wishes that fit within this category included: having less stringent criteria for financial eligibility for services, having funding available according to the need of families rather than their income, and having less fear of reimbursement amongst providers which would promote more collaboration/reduced competition.
- **Better communication/collaboration between care team members (including family):** Participants wished to be able to more easily communicate with other providers, that more communication would occur between services, and that more care providers would see the importance of collaboration.
- **More support for families / family-centered care:** Participants wished that families would be the focus rather than the systems or costs. They also wished that parent support would be more socially acceptable to access.
- **Central resource directory / shared resource:** Participants wished for a regional resource map or directory.
- **Having a primary point of contact – “coordinator for the coordinators”:** This category included wishes for a central navigator or contact person who could respond to all the families’ needs.
- **Simplify processes for obtaining financial assistance / services – less paperwork, less duplication:** This included wishing for less ambiguity in the process of applying for financial assistance, wishing for more simplicity and common language across all funding streams. They wished a centralized, one-stop application process for applying for financial/medical assistance and waivers.
- **Easier way to obtain consent / Release of Information:** Participants wished for a quick and easy way to obtain consent from families so that providers/coordinators can speak with one another.
- **More time devoted to care coordination:** They wished for more time to be able to devote solely to providing care coordination for families.
- **More public awareness of care coordination:** Participants wished that there would be more knowledge within the general public about care coordination.

Action Planning

After developing the Care Coordination Framework, participants were asked to take into consideration the various roles, responsibilities, and wishes discussed and brainstorm some concrete action steps that could be taken to improve care coordination. The action step planning was done at four levels to gather both short and long term steps as well as get at the different stakeholders involved in the steps. These four levels included: The overall action planning responses from the Northeast Region were grouped with those from other regions to create a set of major themes action steps. They were asked to think of four levels of action planning, including:

1. Things they can do right away, on their own, in the next week to month

2. Things they can take back to their organization/team to work on over the next 3 to 12 months
3. Things they can collaborate with someone else in their region over the next 6 to 12 months
4. Things that can be worked on at the broader state level over the next 1 to 2 years

For the first three levels, participants completed a worksheet in which they listed out action steps. Some common themes and examples from these levels are included in Table 2. Responses are not included in any specific rank.

Table 2: Northeast Region Action Planning Themes and Examples

Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Improving internal clinic/agency/organization care coordination processes	<ul style="list-style-type: none"> • Ask clinics if they are using parent partners to strategize care coordination improvements (communication and prevention of silos) 	<ul style="list-style-type: none"> • Talk to my rehab leadership: Spread of care coordination services to patients/families - Also bring to CCP team to increase care coordination 	

MAPPING CARE COORDINATION NORTHEAST REGION REPORT

Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
<p>Improving communication and collaboration with others</p>	<ul style="list-style-type: none"> • Make a plan to improve the communication between myself and other community providers/specialty care clinics • Follow up with other care coordinators on shared patients • Make contacts with providers in my area • Start creating a more cohesive network of contacts • Working locally and internally to enhance services • Call the Minnesota Department of Education (MDE) and get clarification regarding “consent from parents” statement for the Help Me Grow system • Ask MDE about legal method to respond to referring agencies (“closing the loop”) 	<ul style="list-style-type: none"> • Speak with public health nurse and social workers regarding school-based services • Continue to work on improved communication between myself and other community providers and specialty care clinics • Set up Google Doc and provide access to all school providers 	<ul style="list-style-type: none"> • Work on closing the loop on referrals (ensuring that referrals receive follow-up) • Referrals and information sharing in the community-improving this process • Brainstorm and planning for early, childhood services coordination and transition mapping • Continue community partnering meetings • Connect with Gillette to learn more about their services • Collaborate with St. Luke’s Pediatrics • Connect public health nurses to Residential Services, Inc. (mental health provider serving many northeast counties and Duluth) • Gillette will be meeting with public health nurses in Aitkin, Itasca, & Koochiching counties in November • Collaborate with care coordinators in health care homes • Work with staff member from Early Childhood (Birth to Three) to increase facilitation of information • Collaborate with Local Public Health in Duluth • Build working relationships with care coordinators in specialty care settings

MAPPING CARE COORDINATION NORTHEAST REGION REPORT

Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Improving resource directories and databases	<ul style="list-style-type: none"> • Ask clinics what they are doing to create and test resource lists • Contact the United Way-211 to discuss improvement of resource listing 	<ul style="list-style-type: none"> • Develop spreadsheet with community resources for parents • Gain more information on available resources and how to access those resources - Reach out to more community resources to make them aware of care coordination services at SLPA • Learn about resources in the Northeast • Comprehensive resource list per county and per area of need • Continue conversation about resource development 	
Promoting care coordination and better defining roles of care coordinators (both at clinic/organization and at a systems level)	<ul style="list-style-type: none"> • Talk to public health nurses in each of my counties regarding their role in care coordination and what they see as needs. I expect that there will be differences in counties/communities outside Duluth. 	<ul style="list-style-type: none"> • Collaboration on role of coordinator • Ask public health nurse consultants in other regions if we can explore the role of care coordination and public health nursing 	
Improving Release of Information / Data Sharing Processes	<ul style="list-style-type: none"> • Ask clinics what their most successful methods to address ROI to support sharing pertinent information 		<ul style="list-style-type: none"> • Work on electronic sharing of early childhood screening occurring in physician offices

Finally, participants were asked to identify state-level action steps that could be taken to improve care coordination for families of CYSHN. They then placed these action steps on an action priority matrix based on their perceptions of the potential level of impact and feasibility of the items. A summary matrix of is included in Figure 4.

Figure 4: Systems Mapping Action Priority Matrix



Appendix: Data Tables from Figures/Charts

Primary Responsibilities in Providing Care Coordination (Data from Figure 3)

Primary Responsibility Group	Percent
Use health information technology / electronic medical records	2%
Development of care plan	2%
Coordinate quality improvement efforts	3%
Assure competent care coordination workforce	3%
Relationship building	4%
Facilitate, support, and assist in managing transitions	4%
Facilitate care team and ensure family is a team member	4%
Intake, assessment, and evaluation	5%
Coordinate funding	5%
Communication	7%
Advocacy and policy development	11%
Assist in navigating the system	12%
Arrange for, set up, coordinate, and track tests, referrals, and treatment	18%
Provide education and resources	20%

Systems Mapping Action Priority Matrix (Data from Figure 4)

	1 Easy to Implement	2	3	4	5	6 Hard to Implement
5 High Impact	Next time we have a regional meeting, invite policy/decision-makers	Always include families in discussions on care coordination	Facilitate regular meetings with care coordinators (2-3 times/year) – similar to regional public health nurse meetings	Cloud-based regional resource list including information specific to counties	Create/implement simplified ROI/waiver for MN	1 Menu, 1 Funding System, 1 Waiver
4	Hold a patient- and family-centered care conference	Form collaboration between Health Care Homes care coordinators in the region	Share meaningful data	Develop a care navigation system for CYSHN	Models of care coordination by 1) characteristics of cc, 2) scope of practice, 3) target population	Create a cloud-based system where each family has a password-protected hub for communication. Family chooses who gets to access and what can be shared.
3	Get “ARRM” involved	Educate general public about health care homes for all populations	Map resources for 7-county area and link to Region 3 IEIC membership list	Provide enough staff to properly administer public assistance programs	Get rid of some rules and regulations that hold up quality services and timing to start	
2		Elect people who are sympathetic to the needs of people with special health needs	Track referral & follow-up data			Increase sustainability of services through different funding streams
1 Low Impact		Continue talking with providers				

