Mapping Care Coordination for Children in Minnesota

SOUTHEAST REGIONAL REPORT

MDH Minnesota
Department *of* Health

CHILDREN AND YOUTH WITH SPECIAL HEALTH NEEDS

Mapping Care Coordination for Children in Minnesota: Southeast Report

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Contents

Southeast Minnesota Findings

The following section details the findings of the regional care coordination systems mapping activities that occurred in the Southeast 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 Southeast area of the state are highlighted in Figure 1 below. The meeting took place in Rochester, 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 Wisconsin border on the east, to Rice, Steele, and Freeborn counties on the west. It stretches from the Iowa border on the south, to Goodhue and Rice counties on the north.

Figure 1: Southeast Region and Meeting Location
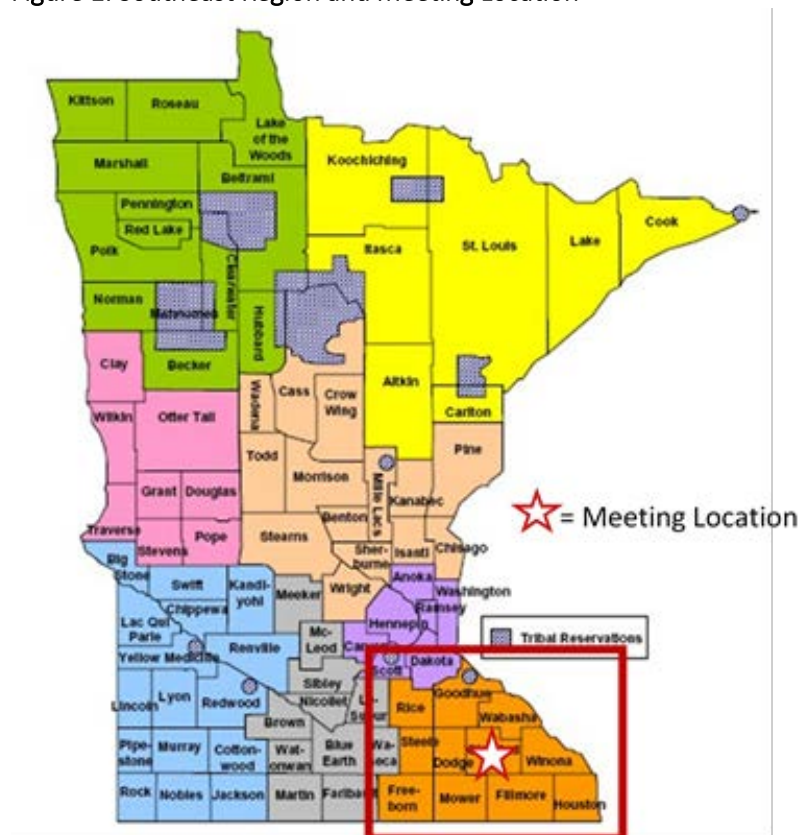
Strengths and Challenges in Providing Care Coordination

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 Southeast Minnesota are listed below.

"Care coordination of CYSHN in Southeast Minnesota currently works because…"

- Many Primary Care Providers/Practices are committed to family-centered care
- Parents/Families are committed to the care of the children
- Public Health/Human services keep track of support services for families and communicate
- Early childhood care providers collaborate
- Passionate care coordinators (extended definition of care coordinators) are invested in caring for families

**"Care coordination of CYSHN in Southeast Minnesota would be better if…"**

- More Primary Care Providers/Practices would be committed
- Communication were improved at transitions of care between care team
- Specialty care would communicate better with outside organizations
- Emergency departments were more educated on meeting the needs of CYSHN
- More education occurred on how community organizations can work better together
- More services would communicate with each other
- Commissioners put more support into children/families
- Communication were easier
- Specialists would coordinate their schedules more

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 Southeast Minnesota.

Figure 2: Southeast Minnesota Care Coordination Framework
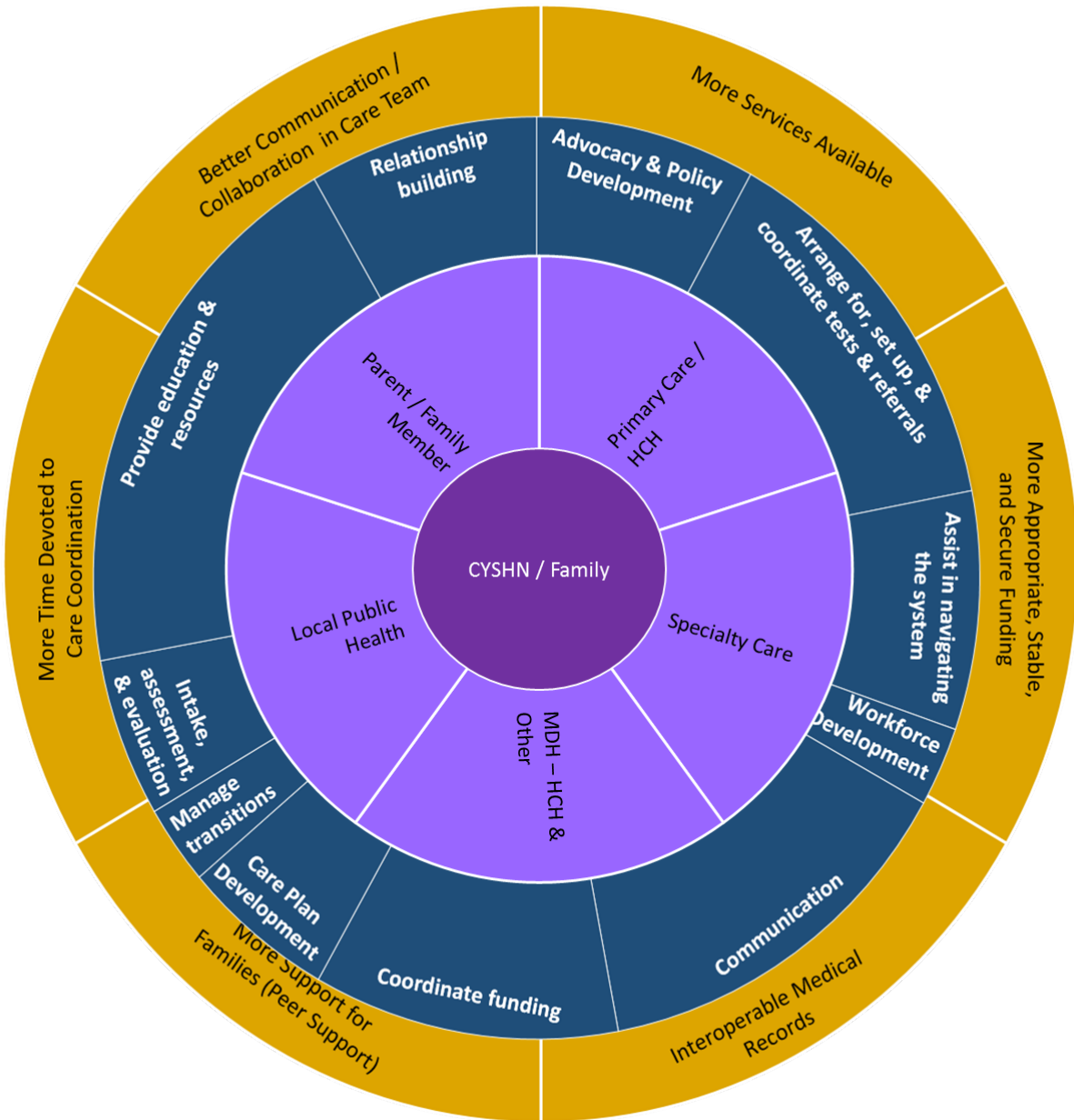
Child and Family at the Center

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 Southeast 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 Southeast 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 Southeast MN

Participant Organizations/Roles	Southeast	Percent
Primary Care	2	18%
Parents	2	18%
Local Public Health	2	18%
Specialty Care	3	28%
Health Plans	0	-
MDH – Health Care Homes	2	18%
Education (District & State)	0	-
Head Start/Early Head Start	1	-
County Human Services	1	-
Mental Health	0	-
Family Organization	0	-
MN DHS	0	-
School Nurse	0	-
Interagency Early Intervention Committee	0	-
Home Care	0	-
TOTAL	11	

Missing Partners

Table 2 above includes the various roles or organizations of the participants in the Southeast Minnesota Regional Meeting. As you can see, there were quite a few different stakeholder groups who were not present, including: health plans (payers), education representatives, school nurses, early intervention, county human services, mental health organizations, 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: doctors, financial workers, legal/legislative representatives, youth or young adults with special health needs, personal care assistants, hospital and clinic administrators, father of children with special health needs, and dentists/dental workers.

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 diagraming 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 Southeast Region. The most reported responsibility of care coordinators in the region was providing education and resources, and communication. Some of the more specific activities. Some of the more specific activities under providing education and resources included: become knowledgeable about resources in the Southeast, caregiver education, educate/ provide resource.

The second most reported responsibility was arranging for, setting up, coordinating, and tracking tests, referrals, and treatment, and communication. This included activities such as sharing resources available between counties, CTC coordination and outreach, School liaison Head start, EHS, IEP, ECI and EHDI/MEDSS coordinator connection.

Figure 3: Southeast Region Primary Responsibilities in Providing Care Coordination
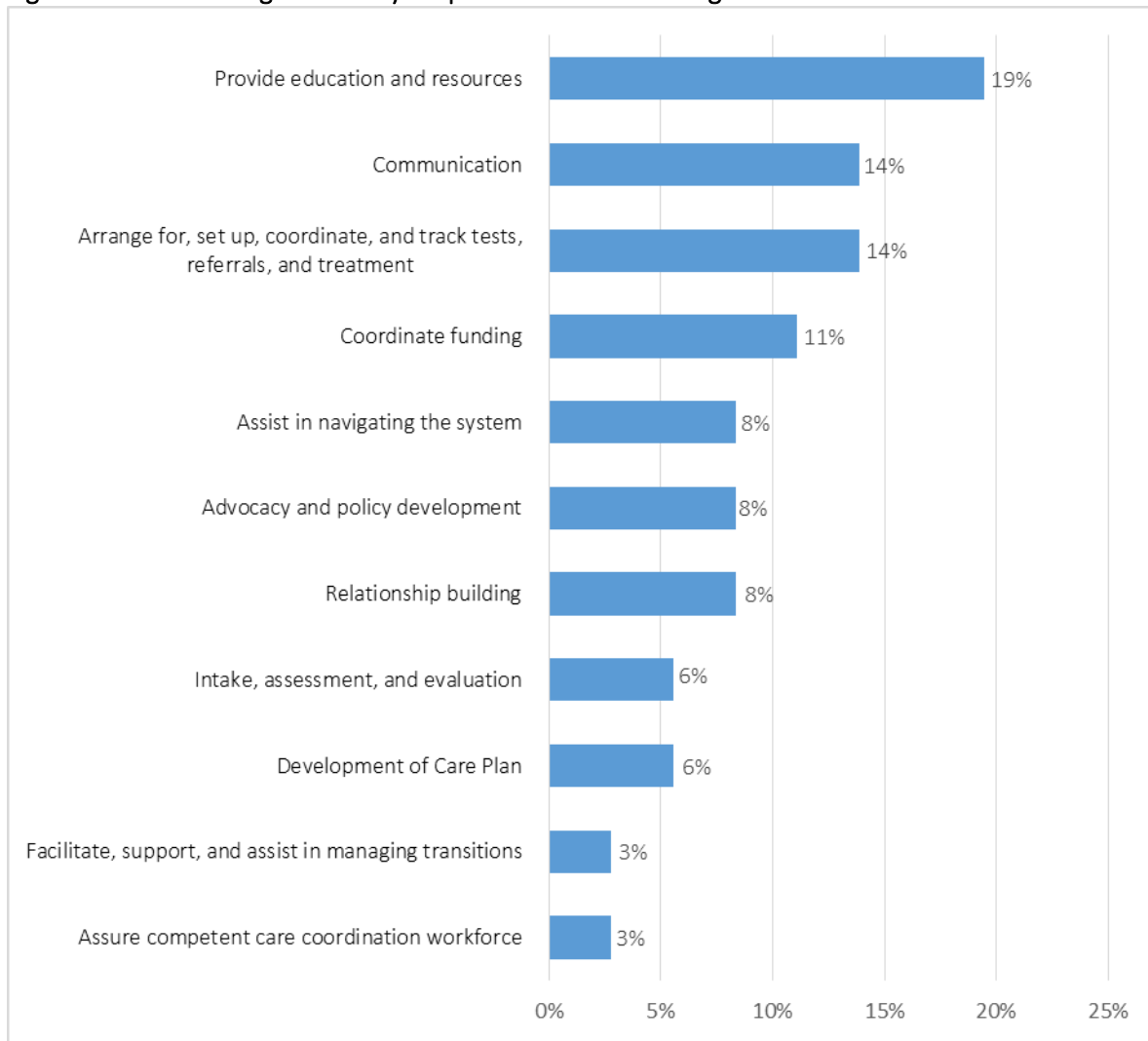
Infrastructure/Supports Needed to Improve Care Coordination ("Wishes")

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 Southeast Region included:

- **More services available for families:** Related to this category, participants wished for plan of care that is interactive across agencies and providers, extend PEDS care coordination beyond Rochester primary care.

- **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 stable funding for programs and needed trainings, health care expense reform and more investment in infrastructure to support community HC care systems with broader focus on health and wellness.
- **Better communication/collaboration between care team members (including family):** Participants wished for one linked Health/communication portal, plan of care that is interactive across agencies and providers, better collaboration/ communication between HCP/ LPH/ Schools/ Other community partners.
- **More support for families / family-centered care:** Participants wished that they spent more time with families and networking, less time with dailies and charting. They also wished that e there was a more efficient way to conduct interdisciplinary and interagency planning for families/patients.
- **More time devoted to care coordination:** They wished for more time to be able to devote solely to providing care coordination for families.

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: Southeast 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 Communication / Collaboration with Others in Region	- Continue to network with community partners who care for CYSHN (i.e., Public Health, schools) - Look for other community providers (i.e., daycare providers, dentists) - Contact Family Voices of MN to spread reach of organization to Mankato - Connect with the family home visiting consultant to find out what she is aware of and resources for LPH in the region	- Ways we can improve communication on a county level with Public Health and Human Services to other providers and especially families - Open lines of communication	Reach out to public health to identify potential collaboration
Improving Resource Directories / Databases	- Begin to compile community resource list - Clean up my resource list/contacts to make it easier to find and promote them when they are needed - Create a system support map	- Create a resource (financial and community list) directory for staff and patient or families - Perfect educational resources - Look into my resources and see if anything needs to be done	- Collaborate with Liz Thomson in Mankato area specific resources - Find more "out of the country" resources to share - Look for grant/funding to promote more resources for parents /care givers of CYSHN - Work with LPH department to find out more about resources they need when working with children/families with special needs

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
Having Discussions on Roles in Coordination		• Better understand how my child's primary care physician is meeting their care coordination responsibilities; if not, encourage them to do so • Ask about a Patient/Family Advisory Board • Meet with DON and team members to discuss how each of us fit on the map and hold each member accountable for developing her resource network	
Improving Release of Information / Data Sharing Processes			• Advocate with Gillette and other specialty groups/parents to come up with one communication portal
Increasing Awareness / Providing General Education or Training	• Educate myself on grant resource available for parents/caregivers of CYSHCN in MN • Reach-out/Contact the BPCC that support the MDH grant to explain IPCM pilot • Share my map and this information with the office • Share session information with co-workers and team • Share what happened at this meeting with co-workers at Public Health, MN choices team and birth to three/early head start	• Training for scheduling from parent/patient perspective • Explain map to my family	• Support Parent Training • Share family focus Information with Mankato Clinic

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
Promote Care Coordination	• As MDH continues to move and progress the HCH model to a more advanced level are there learnings to take away and inform the care coordination standard? • Look at my chart and those things I identified as need and try to do something about them • Discuss ideas for better community collaboration with pediatric population •	• Connect with CYSHN and be informed of learnings/next steps of care coordination mapping meetings • Ways to improve collaboration with parents in the creation and implementation of care plans/goals • Work with other special needs parents and share map • Identify ways to coordinate • Visual care coordination services in larger radius through regional primary care clinics	• Find out what to do when a clinic may not be implementing care coordination in the most helpful way

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
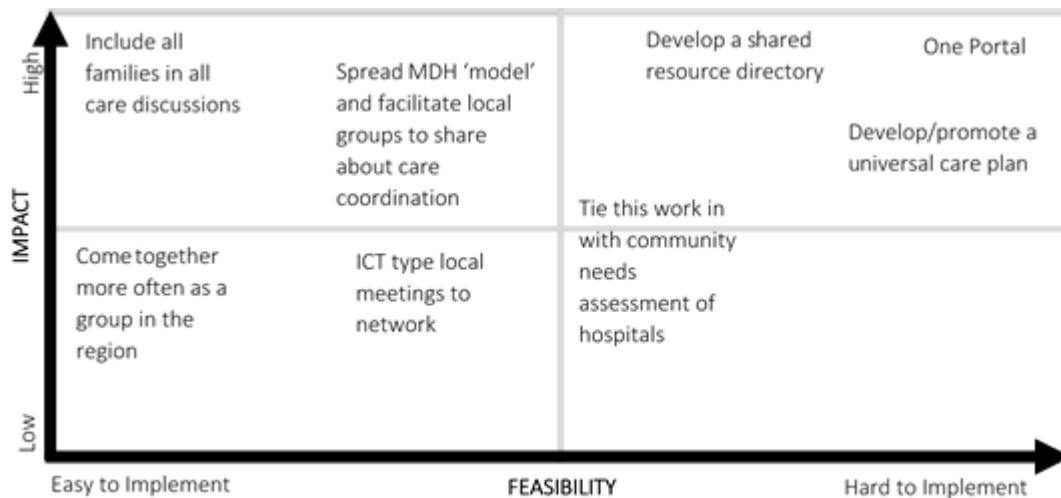
Appendix: Data Tables from Figures/Charts

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

Primary Responsibility Group	Percent
Use health information technology / electronic medical records	0%
Development of care plan	6%
Coordinate quality improvement efforts	0%
Assure competent care coordination workforce	3%
Relationship building	8%
Facilitate, support, and assist in managing transitions	3%
Facilitate care team and ensure family is a team member	0%
Intake, assessment, and evaluation	6%
Coordinate funding	11%
Communication	14%
Advocacy and policy development	8%
Assist in navigating the system	8%
Arrange for, set up, coordinate, and track tests, referrals, and treatment	14%
Provide education and resources	19%

Systems Mapping Action Priority Matrix (Data from Figure 4)

	1 Easy to Implement	2	3	4 Hard to Implement
2 High Impact	Include all families in all care discussions	Spread MDH "model" and facilitate local groups to share about care coordination	Develop a shared resource directory	• One portal • Develop/promote a universal care plan
1 Low Impact	Come together more often as a group in the region	ICT-type local meetings to network	Tie this work in with community needs assessment of hospitals	