



**TOOLS FOR CARE  
COORDINATION: USING  
CARE PLANS AND CARE  
COORDINATORS IN A  
MEDICAL HOME  
PRACTICE**

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**And**

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# MEDICAL HOME CORE TEAM

- Parent Partners
  - Shelley and Tony Sheff
  - Mark Albertson
- Tammy Carlson, R.N.
- me



# MEDICAL HOME EXPANDED TEAM

- Danielle Randolph – PSA
- Tiffany Lipinski – Clinical Assistant
- Sharon Quinlan – Director of Clinic Operations
- Margie Randolph – Pediatric Nurse Manager
- Mari Wagner – Social Worker Polinsky Rehab
- Jean Larson – MN Dept of Health
- JoHannah Bergstrom – Child Life



## MEDICAL HOME DEFINED

- The American Academy of Pediatrics introduced the concept of Medical Home in 1967



## MEDICAL HOME DEFINITION - AAP

- AAP 2002– Not a building, house, or hospital, but rather an approach to providing comprehensive primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective.



## MEDICAL HOME DEFINITION - AAFP

- The American Academy of Family Physicians believes that everyone should have a *personal medical home* that serves as the focal point through which all individuals – regardless of age, sex, race, or socioeconomic status – receive acute, chronic, and preventive medical services. Through an on-going relationship with a family physician in their medical home, patients can be assured of care that is not only accessible but also accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians.



## 2007 CONSENSUS STATEMENT ON MEDICAL HOME BY ACP, AAFP, AOA, AND AAP

- The Patient-Centered Medical Home is an approach to providing comprehensive primary care for children, youth and adults... that facilitates partnerships between individual patients, their personal physicians and when appropriate the patient's family ... and includes patients and families participating in quality improvement at the practice level ...



# MEDICAL HOME DEFINITION

- It's a process.
- It's a system for providing:
  - Family Centered Care
  - Chronic Disease Management
  - Quality Improvement



# MEDICAL HOME

- Often nothing gets done because there are so many things that need to be changed that it's overwhelming.
- Need to take Baby Steps.
- MH provides
  - the process
  - the system
  - the suggestions
  - the encouragement.



# PEDIATRIC CARE PLAN

- Each family is given a printed Care Plan
- Studies have shown that the single most important factor in decreased admissions and ER visits is having a printed Care Plan



# CARE PLAN DESCRIPTION

## ○ Identifying Information

- Patient name
- Birthday
- Medical Record Number

## ○ Severity Status

- 1-4 rating scale based on severity of medical issues

## ○ Code/Resuscitation Status

- For children who are DNR/DNI, it is listed up-front
- This is not included if not relevant



# CARE PLAN DESCRIPTION

## ○ Current Active Problem List

- This constitutes the main portion of the Care Plan
- Diagnosis
  - Date of the diagnosis
  - Notes on diagnosis
- Example:
  - Seizures                      2/1/05
  - Note: His seizures are stereotyped with mouth opening and generalized tonic and brief limited tonic-clonic activity. Non-epileptic events (dystonia) include autonomic dysfunction with tachycardia, flushing, and tonic head deviation and eye deviation



# CARE PLAN DESCRIPTION

- PAST DIAGNOSES
  - Past Medical History
    - Diagnoses and dates of diagnoses
- PAST SURGERIES
  - Surgery
    - Description of surgery
    - Date of surgery
- FAMILY HISTORY



# CARE PLAN DESCRIPTION

- CURRENT MEDICATIONS
  - Most difficult area to keep up to date
- ALLERGIES
  - Medication allergies
  - All other allergies
- IMMUNIZATIONS
  - All immunizations and dates listed



# CARE PLAN DESCRIPTION

- CONTACT/FAMILY INFORMATION
  - Social History and family info
  - Address
  - Email
  - Cell phone, etc



# CARE PLAN DESCRIPTION

## ○ ALL ABOUT ME!

- I like to be called: \_\_\_\_\_
- I best communicate by: (i.e. using words, blinking, my eyes, squeezing someone's hands, using hand gestures): \_\_\_\_\_
- The easiest way for me to take medication is: \_\_\_\_\_
- My bathroom routine/patterns are: \_\_\_\_\_
- My eating routines/patterns are: \_\_\_\_\_
- My bathing and dressing routine/patterns are: \_\_\_\_\_



# CARE PLAN DESCRIPTION

## ○ ALL ABOUT ME!

- I can move myself by (i.e. walking, crawling, using a wheelchair, cane or crutches): \_\_\_\_\_
- I want staff to know about special medical needs I have: \_\_\_\_\_
- I want staff to know about medical equipment/materials to use for my care: \_\_\_\_\_
- I'm easily distracted or entertained by: \_\_\_\_\_
- You can tell I'm happy when: \_\_\_\_\_
- You can tell I'm upset when: \_\_\_\_\_
- When I am hurting or scared, my parents help by: \_\_\_\_\_
- Personal information: \_\_\_\_\_



# CARE PLAN DESCRIPTION

- All About Me!

- Example:
- My Bathrooms routines are:

Clean intermittent cathing 6 times a day, 12 Fr catheter via Mitrofanoff. Nightly enema of 20 ml glycerin + 40 ml NS given in a 60 ml syringe via 10 Fr cath in RLQ stoma, followed by 40ml NS flush. Has diarrhea sometimes, wears Pull-up



# CARE PLAN DESCRIPTION

- PRIMARY MEDICAL PHYSICIAN & SPECIALTY PHYSICIANS
  - Listing of:
    - Physician
    - Clinic
    - Address
    - Phone
    - Fax



# CARE PLAN DESCRIPTION

- School contact Information
  - School nurse
  - Special Ed contact
  - Classroom teacher
  - Paraprofessional
  - Social Worker
- Emergency Contact Information
- Primary Medical Physician and all of my contact info
- Asthma Action Plan
  - Graphic added at the end
  - In EPIC – formatted as a letter



# CARE PLAN 101 – BY DR. SHAR VALENTINE

- **Important things to know about your care plan**



# CARE PLAN 101 – BY DR. SHAR VALENTINE

## ○ What is a care plan?

- It is a valuable tool that you can use to provide medical and educational information regarding your child to others such as doctors, the school or others that care for your child.
- It is a quick reference with child-specific information needed in a medical emergency.
- It provides a medical summary. It includes your child's current problem list, medications, past medical history and can list the services they receive from the community.



# CARE PLAN 101 – BY DR. SHAR VALENTINE

## ○ When do I use my care plan?

- *In the emergency room: Especially when you are traveling! This will give the ER an overview of your child and special instructions from your provider regarding care of your child.*
- At a specialist appointment: You can present the care plan for their review and changes to your child's medications or new diagnoses can be made.
- When your child is admitted to the hospital.
- Prior to your child's well child check: Review the care plan for any omissions or errors and add any information that you feel would be helpful. Example: All blood draws should be finger pokes if possible.
- If medications or equipment change, please correct the care plan.
- At your school: If your child has asthma or severe allergic reactions, the care plan will document what treatment the school should administer.
- As a document you leave with your child's caregiver such as a babysitter, respite care.
- Have multiple copies of the care plan: In your car, your child's wheelchair, at mom's house and dad's house, etc.
- At your child's school meetings: Such as IEPs. The school is welcome to have a copy of the care plan if you chose.



## CARE PLAN 101 – BY DR. SHAR VALENTINE

### ○ **How do I make changes to my care plan?**

- Write on it! Make changes to your child's care plan by crossing out wrong information, old medication, etc. Bring this updated care plan to your child's doctor's appointment for discussion.
- Call, fax, drop off or mail the changes you or a specialist has made and we will change the care plan and send you a new copy. Please tell us if you'd like multiple copies at the time.



## PROCESS FOR UPDATING CARE PLANS

- Tammy and I scan the schedule 2 weeks at a time
- Tammy produces a Care Plan
- A note is placed in my office schedule telling the CA to print the Care Plan when the patient arrives
- Family is given paper copy to review/correct and return to us
- Tammy/Danielle update the plan and mail it to family



# MEDICAL HOME FAMILY INDEX

Question	Never	Sometimes	Often	Always
Use and follow through with Care Plans they have created	6%	24%	29%	41%
Use a Care Plan to help follow my child's Progress	6%	29%	29%	35%
Review and update the Care Plan with me regularly	6%	24%	47%	24%

# FAMILY PERCEPTION OF MH SURVEY RESULTS

- ■ Child visited an emergency room in last 6 months: 46% of the medical home teams showed improvement
- ■ Child missed school or adult missed work due to child's poor health: 69% of the participating clinics improved in this area
- ■ Child visited doctor or nurse for preventive care: 31% improved in the area of preventive care



## DEPT OF HUMAN SERVICES UTILIZATION STUDY: INPATIENT ADMISSIONS

- Teams sent DHS (Medicaid) a list of children identified Medical Home patients (Medical Home Registry)
- DHS/Medicaid selected the children on those lists that were utilizing Medicaid (Medical Assistance).
- DHS reviewed utilization one year prior to joining the medical home and 2 years after
- Results: Decrease in Hospital Admissions - 28.55 admissions per 1000 member months
- Significant?
- yes,  $p = <.0001$



# PEDIATRIC CARE PLAN

- Can be life changing for families!
  - Mom who couldn't leave home
  - Sarah



# EMERGENCY CARE PLANS



# EMERGENCY CARE PLANS

- Sarah's UTI Emergency Care Plan
  - Parents may call if they feel their child may have a UTI. The nurse will schedule a lab only appointment and place orders for a urinalysis/urine culture. Parents will have sterile specimen container at home.



# EMERGENCY CARE PLANS: GABE'S ASTHMA ACTION PLAN

- Green Zone
  - Pulmicort 0.5mg via neb twice a day
  - Singulair 10mg - 1 tab daily



# EMERGENCY CARE PLANS: GABE'S ASTHMA ACTION PLAN

- Yellow Zone
  - albuterol: 2 nebs back to back and then every 4 hours
  - May increase albuterol to every 2 hours
  - Increase inhaled steroids to Pulmicort 0.5mg 4 times a day
  - May add Atrovent nebs tid if using albuterol every 2 hr
  - Increase VEST treatments to every 4 hrs until improved
  - Wean albuterol nebs as tolerated
  - Discontinue Atrovent when albuterol is down to tid
  - Call office to discuss possible Zithromax
  - Oxygen as needed to keep sats > 90%



# EMERGENCY CARE PLANS: GABE'S ASTHMA ACTION PLAN

## ○ Red Zone

- Prednisone 20mg twice daily for 5 days
- Pulmozyme 2.5 mg neb - 2 vials twice a day for 5 days for excessively thick secretions



# GABE'S DYSTONIA EMERGENCY CARE PLAN

## MILD DYSTONIA:

Clonidine 0.05 mg (1/2 of 0.1 mg tab) per GT. May repeat within the hour time once in addition to maintenance dose given at scheduled time.

## MODERATE DYSTONIA:

Clonidine 0.1 mg tab per GT in addition to scheduled time for maintenance dose.

## SEVERE DYSTONIA:

Give 1 mg of Ativan. If no response in 10 minutes, give a second 1 mg dose of Ativan.

If still severe dystonia, give 1-2 mg Ativan every 3-4 hours on schedule.

Once dystonia is under control, maintain on scheduled ativan (1-2 mg) every 4 hours. May decrease frequency as condition improves (according to sedation and control of dystonia).

If MODERATE dystonia recurs in same 24 hours, do not repeat 0.1 mg of clonidine, but give ativan 1 mg and use ativan (may need less frequently than for severe dystonia example prn every 4-8 hours per status).

Institute Bipap 6/4 spontaneous with rate of 12 if unable to keep sats greater than 90% per O2 cannula or respiratory rate is less than or equal to 9 due to sedation.



## ROLE OF THE CARE COORDINATOR

- Reviews Dr. Harvieux's and Dr. Valentine's schedules for Medical Home patients or potential Medical Home patients
  - Ensure they are given appropriate appointment times
  - Make certain that staff is aware that the child is in Medical Home



# ROLE OF THE CARE COORDINATOR

- Generate Care Plans
  - Along with getting a new Care Plan, newly identified Medical Home patients will get a Medical Home folder
- Update Care Plans
  - Either the Care Plan can be updated after the visit, or families bring them/send them to the office with updates



# ROLE OF THE CARE COORDINATOR

- Maintain patient registry
  - children with special health care needs
    - (currently 518 CSHCN)
  - severity scores (1-4)
  - completed care plans
    - (currently 350 completed)
  - each individual month
    - new patients identified
    - new care plans completed



# ROLE OF THE CARE COORDINATOR

- Triage Medical Home patients when calling through the designated phone line
  - Private access line for children that have severity scores of 3 and 4
  - Urgent use only is encouraged



# ROLE OF THE CARE COORDINATOR

- Pre-visit phone calls
  - Review allergies
  - Update medications
  - Go through the Problem List
  - Look at Past Medical History
  - Review Care Plan
  - Discuss objectives for the visit
  - Forward information to the Provider prior to the visit



# ROLE OF THE CARE COORDINATOR

- Monthly conference call for the MN Dept of Health
  - All Minnesota Medical Home teams encouraged to do monthly conference call
  - Discuss what teams are working on
  - Get feedback from other teams
  - Talk about upcoming Learning Collaborative
  - Updates on Legislature



## ROLE OF THE CARE COORDINATOR

- Attends Learning Collaborative three times per year
- Helps direct the every other week meetings of the expanded Medical Home team



# ROLE OF THE CARE COORDINATOR

- Medical Home education with families
  - In office teaching
    - Define Medical Home
    - Present the Medical Home folder
      - Review Care Plan and how families use Care Plan (ER, Specialists, School)
      - Care Plan 101
      - Discuss special parking
      - Access line/private phone line
      - Bulletin Board
    - Talk about Transition



# ROLE OF THE CARE COORDINATOR

- Advocate for families
- Resource for families



# MEDICAL HOME CARE PLANS AND CARE COORDINATION



- Even the smallest person can change the course of the future.
  - Galadriel
    - The Fellowship of the Ring
    - JRR Tolkien



# MEDICAL HOME CARE PLANS AND CARE COORDINATION

- All we have to decide is what to do with the time that is given to us.
  - Gandalf
    - The Fellowship of the Ring
    - JRR Tolkien

