Care Coordination Collaboratives

CENTRAL UTILITY, SHARED RESOURCE

Prepared by Marijane Carey and Susan Roman
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Help Me Grow
National Center

About the *Help Me Grow* National Center

Help Me Grow is a system that connects at-risk children with the services they need. The *Help Me Grow* National Center, based in Hartford, Connecticut, serves as a national resource to support the replication of *HMG* systems across the country.

Connecticut Children's Medical Center
282 Washington Street / Hartford, CT 06106
(860) 837-6232 / helpmegrownationalcenter.org

About the Office of Community Child Health

Launched in 2012, Connecticut Children's Office for Community Child Health brings together internal, local, state, and national stakeholders to ensure that children in all communities receive the best care possible.

Supported by a generous grant from the W.K. Kellogg Foundation

INTRODUCTION CARE COORDINATION & *HELP ME GROW*

A single data point sparked the *Help Me Grow* National Center's interest in care coordination: **On average it takes *seven* contacts to link identified young, vulnerable children and families to community-based services.**

Seven! This too-high number suggested to us that families need seamless care coordination to get connected to appropriate services more easily. But, we asked, do our current systems include sufficient care coordination?

The truth was, no. As we met with others to explore the topic, we would describe, tongue-in-cheek, a scenario of three care coordinators from three different programs arriving at the same doorstep looking for a family that relocated weeks ago. We expected people to chuckle — but they simply nodded. Our mission became clear. **We must build our capacity for care coordination collaboration so that families can easily get connected to the services they need.**

The Hartford Care Coordination Collaborative (HCCC) grew out of this urgent need to expand our care coordination capacity. The goals of HCCC include sharing activities, priorities and capacities across care coordination entities; encouraging synergy and cooperation; and minimizing redundancy and duplication. The HCCC also engages in collaborative problem-solving around common issues and the needs of shared families.

The success of the HCCC has had stunning implications at both the state and national levels. The Connecticut Department of Public Health now requires all five regions of the state to emulate Hartford in expanding regional Title V care coordination entities to create care coordination collaboratives. We, at the National Center, are extremely fortunate that the WK Kellogg Foundation supports and funds our technical assistance to *Help Me Grow* affiliates as they replicate the Care Coordination Collaborative model across the nation.

My personal enthusiasm for this model is boundless. It epitomizes our commitment to system building in support of young children's healthy development. It demonstrates the importance of data collection. It shows that we *can* address gaps and capacity issues, and that our vibrant, engaged and committed affiliate network can indeed embrace innovations and solve gaps and capacity issues to the betterment of children and families.

Welcome to the extraordinary community of Care Coordination Collaboratives!

Paul Dworkin, M.D.
Founder, Help Me Grow
Executive Vice-President, Community Child Health Director,
Office for Community Child Health, Connecticut Children's Medical Center

The Care Coordination Collaboratives Manual

This manual aims to familiarize you with the Care Coordination Model and help you develop one within your early childhood system. The manual includes an overview of how CC Collaboratives can help maximize the use of appropriate and affordable services for children and their families; a description of the model; tools and resources for developing and implementing a CC Collaborative; and guidance for continually improving and sustaining your CC Collaborative.

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OVERVIEW

What Is A Care Coordination Collaborative?

Care Coordination (CC) Collaboratives are comprised of people from the all the sectors related to early childhood development: care coordination, health, early childhood care and education, family advocacy, law, home visiting programs, state agencies, and more. They come together to learn from one another, identify areas of shared need, develop inter-agency solutions to common problems, discuss emerging challenges and connect with others engaged in improving access to services for vulnerable children and families.

Why Are Care Coordination Collaboratives Important?

Research consistently shows that services designed to assist families in caring for young children are often difficult to find and access. In an effort to address this documented problem, many organizations have hired and trained care coordinators. However, many care coordinators are limited in their work by the purpose and scope of their organizations. As a result, care coordination is often done in silos and lacks the comprehensive and holistic approach needed to address the full range of families' needs.

That's where CC Collaboratives come in. With a grant from the W.K. Kellogg Foundation, "Diffusing Successful Innovations to Promote Vulnerable Children's Healthy Development," the *Help Me Grow* National Center is working with affiliates to establish, operate and share their experiences in creating care coordination collaboratives in order to improve access to services. This diffusion project is based on the success of the Hartford Care Coordination Collaborative (HCCC) convened in Hartford, Connecticut in 2010.

Why Are Care Coordination Collaboratives Unique?

The CC Collaborative model has two very distinguishing features that set it apart from other initiatives designed to ensure access to services. First, the focus includes and extends beyond Children and Youth with Special Health Care Needs to all children, with special attention on those who are vulnerable and at risk.

"The Tangle of Coordinated Health Care"

Who coordinates the coordinators? More specifically, who coordinates the proliferating number of health care helpers variously known as case managers, care managers, care coordinators, patient navigators or facilitators, health coaches or even — here's a new one — "pathfinders"? *"Everybody's trying to help. But is everyone doing it in the most efficient and effective way for the consumer and the family? Or are we just confusing the issue?"*

New York Times, April 13, 2015

Second, care coordination activities and engaged agencies are found across multiple settings — from child heath to child welfare, housing, neighborhood safety and even economic development. The HCCC has seen involvement from unexpected but welcome sectors, such as nutrition and family workforce development.

What Are The Goals of Care Coordination Collaboratives?

CC Collaboratives are uniquely positioned to work on both the individual and policy or system level. On the individual level, CC Collaboratives focus on families seeking assistance and the care coordinators who work with them. **The goal on this level is to maximize the use of available, appropriate and affordable services for children and their families.**

The Collaborative achieves this goal by clarifying referral processes; coordinating the services offered by Collaborative members; documenting activities both during and between meetings; and collecting data that document Collaborative efforts and the results of those efforts.

This work, in turn, helps the Collaborative identify policy and/or systems issues that make it difficult for families to obtain the services and support needed and for care coordinators to help them. This information can influence decisions made by program administrators, legislators, state agencies, advocates, and funders. **The ultimate goal on the systems-level is to change systems and/or policies so that families can easily obtain needed services.** (Appendix A: Chart of Purposes, Tools, & Goals of CC Collaboratives)

Care Coordination Collaboratives within An Existing System

CC Collaboratives are a natural extension of *Help Me Grow*, a system designed to connect vulnerable children and their families to needed services by building collaboration across sectors, such as child health care, early care and education, and family support. In fact, participation in the Kellogg-funded diffusion of innovation grant requires that states have a *Help Me Grow* system with a centralized access point staffed by Care Coordinators.

CCC Testimonial: **Bryan Flint**

Shelter Director, Cornerstone Foundation, Inc, Vernon, CT

It's obvious that no one can know everything about every subject. I value being able to connect with people who are specialists and experts in their fields in a safe and encouraging environment where we can share both our knowledge and our needs for assistance. The Hartford Care Coordination Collaborative (HCCC) has been skillfully assembled to include not just "theoretical experts," but frontline workers who know the "ins and outs" of the extremely complex system of delivery, which we all need to navigate. **In the HCCC, I've come to realize that I don't need to know everything you know, I just need to know you!**

THE CARE COORDINATION COLLABORATIVE MODEL

The Care Coordination Collaborative Model consists of four core components and three structural requirements.

4 CORE COMPONENTS

Formal & informal convenings of care coordinators from diverse programs and services in your region

Regular, ongoing, formal Collaborative meetings are necessary for maintaining connections among Collaborative members. Just as important are the informal contacts that occure amont Collaborative members, such as non-Collaborative meetings, emails and phone calls, etc., focused on increasing knowledge of resources, assisting families in securing services, or documenting a service delivery problem. These informal contacts and networking activities must be tracked. (Appendix A: Template for Tracking Collaborative Activities)

Support to child health providers in expanding care coordination

The HCCC was formed, in part, to offer significant support to pediatric primary care providers. Primary care providers, Person Centered Medical Homes (PCMH), are uniquely positioned as a "go-to" resource for families seeking information, support and access to needed services for their children and household. This expectation has stretched the already limited time primary care providers have to see and treat patients.

By supporting the care coordination efforts of primary care practices, Collaboratives extend the capacity of practices to provide appropriate and timely connection to services. Offering support to child health providers is a responsibility of all CC Collaboratives.

Common access to central portal of entry to programs and services

Collaboratives offer opportunities to strengthen the *Help Me Grow* centralized access point as a comprehensive portal of entry to programs and services. The involvement of the *Help Me Grow* centralized access point is a requirement for participating in this innovation. The HCCC experience has shown that all CC Collaborative partners need to know about and use *Help Me Grow*.

Data collection, analysis and dissemination

Data collection and analysis is the core component that quantifies the Collaborative's work and makes it visible, valid and of interest to policy makers, legislators, advocates, funders and the media. Quantitative data, combined with a qualitative narrative, is powerful in reaching and holding the interest of a wide audience. This core component is the conduit for bringing regional Collaborative experiences to the state level.

3 STRUCTURAL REQUIREMENTS

Organizing entity

The organizing entity is the linchpin of CC Collaboratives. The organizing entity staffs the Collaborative, manages the initiative, facilitates meetings and staffs the Continuous Quality Improvement (CQI) process. It is either directly responsible for these tasks or can enter into a formal agreement with another entity or individual to perform this function.

Regional & statewide reach/impact

In order to address both family and system-level goals, CC Collaboratives must operate on a regional, community-based level and on the state level. CC Collaboratives must have mechanisms for informing statewide policy as it pertains to care coordination.

Data-informed CQI activities

CQI is a process-based, data-driven approach to improving the quality of a product or service. The CC Collaborative must have a CQI process in place in order to review, analyze and share CC Collaborative-generated data. Data collection and dissemination through a CQI process documents the internal workings of the Collaborative, as well as the outcomes generated by the Collaborative's measurable activities.

CCC Testimonial: **Mark Keenan, R.N., M.B.A.**

Director, Children and Youth with Special Health Care Needs CT Department of Public Health

The Hartford Care Coordination Collaborative (HCCC) has been a valuable and effective vehicle in a reduction in duplication of services, Affordable Care Act implementation and Maternal and Child Health National Performance Measure progress – including MCH Block Grant transformation. **The HCCC has served as an emerging front runner in the development of true shared care coordination.**

DEVELOPING A CARE COORDINATION COLLABORATIVE

BUILDING THE INFRASTRUCTURE

Select an Organizing Entity

Assign Collaborative Responsibilites to Staff

Conduct an Environmental Scan and Review Findings

Identify and Recruit Collaborative Members

BUILDING THE SYSTEM

Core Components

- Convene a diverse group of care coordinators (regional & state level)
- Support child health services providers
- Provide access to a central portal of entry to programs & services
- Collect, analyze and disseminate data

SUSTAINING THE SYSTEM

Develop a Continuous Quality Improvement Process

Work toward regional- and state-level reach and impact

Establish Sustainable Funding

DEVELOPING A CARE COORDINATION COLLABORATIVE

BUILDING THE INFRASTRUCTURE

Identify the Organizing Entity

The organizing entity, or lead organization, is pivotal to the success of the CC Collaborative. This entity needs to have a proven track record of accomplishments and must be trusted and respected by colleagues.

On a practical level, the organizing entity must have staff with the skills and time to manage the CC Collaborative (or find others with the skills needed). The Collective Impact term "backbone organization"[1] is an appropriate description of the organizing entity's leadership responsibilities.

Assign Collaborative Responsibilities to Staff

Staffing functions can be divided into project manager, communications (internal and external) manager, facilitator and data manager. These responsibilities are not mutually exclusive. One person may be able to assume more than one of these roles. Based on the Hartford experience, these combined responsibilities average 24 to 32 hours per month when Collaborative meetings are held monthly.

Conduct an Environmental Scan and Review Findings

The scan of meetings and groups as listed below will help to identify groups in the region and how the Collaborative could supplement ongoing efforts. The scan may also identify a group that offers an opportunity to combine efforts in estabilshing a CC Collaborative. The list below describes networks, consortiums, and collaborations that may operate in your area on local or state levels. Also ask staff at the *Help Me Grow* centralized access point, families, and outreach staff for information on meetings that they are aware of or attend.

- **Meetings convened specifically for care coordinators**
- **General networking meetings** to learn about resources, connect with colleagues
- **Issue-based meetings** focused on a specific topic and/or targeted population, to share information and updates
- **City- or town-wide meetings** to help providers network, share information, and document challenges confronting the city/town and its residents.
- **Case review meetings** to assist a specific child/family by having all involved meet with family members to address and resolve the presenting issues
- **Mandated advisory groups** attached to legislation or grants that require said group

Consider gathering with agencies that run meetings to support direct service providers (i.e., care coordinators) and address the needs of vulnerable children and their families. (Appendix A: Sample Environmental Scan Meeting Invitation Letter and Agenda)

1 Collective Impact, Stanford Social Innovation review, Winter 2011 http://www.ssireview.org/issue/winter_2011

For each group identified, determine if care coordinators participate in meeting and if the focus aligns with a CC Collaborative, including addressing the needs of vulnerable children at risk for negative outcomes, their families and/or those who work with families. For such groups, learn more about them, including:

- What is the purpose of the group?
- Review meeting agendas and summaries
- Who sponsors/staffs the meetings?
- In addition to care coordinators, who attends?
- How often meetings are held?

Consider reviewing meeting agendas and summaries. (Appendix A: Environmental Scan Guidance)

DECISION POINT

Review the environmental scan information to determine if a CC Collaborative should be created or established in partnership with an existing group. Consider sharing the work done to date with several key individuals for their feedback and support of the effort.

Identify and Recruit Collaborative Members

Consider the organizations listed below for recruitment to both local and state level CC Collaboratives. Regional collaboratives should recruit locally-based care coordinators, other direct service providers and managers. The state level group should recruit organizations' administrators, policy makers, and others that can effect system changes. Some organizations, such as state agencies and organizations that are state wide, may have representatives on both local and state level Collaboratives. If you are partnering with another organization that sponsors meetings, many partners will have already been identified. Use this list, as well as

- ***Help Me Grow* centralized access point**
- **State agencies**
  - Department of Health
  - Child Welfare Department
  - Department of Early Learning
  - Department of Education
  - Department of Mental Health
  - Agency or agencies administering Medicaid and CHIP; Maternal, Infant and Child Home Visiting (MIECHV) funds; Early Childhood Comprehensive Systems (ECCS) grant; and/or Part C
- **Behavioral health agencies**
  - Mental health clinics
  - Child guidance clinics
  - Family counseling agencies
- **Home visiting programs**
- **Advocacy organizations**
- **Organizations representing families**
- **Early Care and Education programs**
  - Head Start
  - School Readiness programs
  - Home based child care
- **Legal community representative**
- **Agencies that provide basic needs**
  - Community Antipoverty agency
  - Housing programs
  - Food assistance programs
- **Primary health care providers**
  - Federally Qualified Health Center (FQHC)
  - Hospital clinic
  - American Academy of Pediatrics (state chapter)
  - Private community practices
  - Healthy Start program
- **Other key agencies in your regions**

other organizations operating in your community, to determine who should be invited to participate in the Collaborative. (Appendix A: Recruitment Tracking Sheet)

SENDING RECRUITMENT LETTERS

Once organizations are identified, consider who, in addition to care coordinators, could contribute to the CC Collaborative's efforts.

Depending on the relationship between the organizing entity and the organizations being recruited, protocol may dictate that the invitation go the CEO. The invitation can include a recommendation suggesting that a specific person join the Collaborative.

The HCCC experience has shown that a mix of job functions and responsibilities enriches the group experience. In addition to care coordinators, members should include midlevel managers who often provide direct services, but also appreciate the administrative aspects of care coordination.

Other representatives can include, but are not limited to, managers/supervisors of care coordinators and other direct service staff; parents and parent advocates; home visitors; mental health clinicians/managers; a Medicaid representative; pediatric primary care practitioner and/or office manager; a person with data expertise; a person who maintains the community resource inventory for the *Help Me Grow* centralized access point. (Appendix A: HCCC Members List)

The recruitment letter needs to explain why a CC Collaborative is being convened and the benefits of participation. (Appendix A: Sample Recruitment Letters)

Expect that your Collaborative membership will change over time. Organization personnel will change. Some members will find the experience more valuable than others will. And, the issues your Collaborative addresses will necessitate new members.

CCC Testimonial: **Lisa Honigfeld, Ph.D.**

Vice President for Health Initiatives, Child Health and Development Institute, Farmington, CT

The Hartford Care Coordination Collaborative (HCCC) has evolved into an indispensable component of the child health delivery system. The dedicated care coordinators who meet monthly to learn about services, problem-solve difficult cases and develop relationships that help families access services have done so much to improve coordination of services in the greater Hartford area. **We talk a lot about cross sector collaboration in addressing the needs of vulnerable families and children, but the HCCC puts that into action.** It does not succumb to bureaucratic rules or unsubstantiated regulations in addressing the barriers that children and families face accessing services."

BUILDING & SUSTAINING THE SYSTEM

Convene the Initial Care Coordination Collaborative Meeting

Once agencies are identified, representatives recruited, a meeting date and location secured, the invitation can be sent. Given the size of some regions, you may consider offering conference call participation. If several members can call in from one location it would allow them to interact and lessen their isolation while on the call. (Appendix A: Sample Meeting Invitations)

This meeting begins the CC Collaborative process. The goal is to reach consensus on the need for the Collaborative, clarify expectations and discuss future meeting agendas. To help engage all meeting participants, consider collecting information, via a brief survey, on the members' care coordination efforts prior to the first meeting, and then sharing the results at the meeting.

For example, the Hartford Care Coordinator Collaborative (HCCC) surveyed members prior to the first meeting. Members were asked the following questions.

- How do you get your referrals?
- Who can make referrals for your services?
- Typically, how long are cases opened?
- After a case is closed, do you still maintain contact with the family?
- What do you hope to accomplish through this collaborative?
- How often you provide the following services in your role as a care coordinator within your organization?

	Always	Often	Sometimes	Never
Needs Assessment				
Care planning				
Home visits				
Family advocacy				
Linkages to specialists				
Linkage to community- based specialists				
Coordination of health financing resources				
Coordination with school-based services				
Chronic disease management				
Family education				
Other:				

The solicited information helped the HCCC members understand each agency's referral and care coordination process. The goal was to collect information that would be practical and useful. Sharing the results helped generate a productive discussion on the challenges confronting care coordinators and the families they serve, as well as hopes for the CC Collaboration. (Appendix A: HCCC Survey and Results)

FIRST MEETING TOPICS CAN INCLUDE

- Purpose of and vision for the Collaborative mission
- Long term goals
- Resources available to support the work of the Collaborative
- How often and where regional meetings will be held (follow up to select dates)
- Suggestions for topics for future meeting
- Participant contact information
- Identification of other potential members
- Challenges faced by care coordinators

Shortly after the meeting, send a Survey Monkey asking for feedback on the meeting as well as suggestions for future meeting agendas. At least a week before the next meeting, send a summary of the past meeting and a reminder of the next meeting, as well as a meeting agenda. Ask for RSVPs. (Appendix A: Sample Meetings Agenda, HCCC Mission, and Template for Tracking Collaborative Activities)

Convene Ongoing Care Coordination Collaborative Meetings

With ongoing input from Collaborative members, the organizing entity's team is responsible for organizing and holding meetings that are informative, meeting the needs of care coordinators and families and identifying/documenting gaps and barriers.

It is important that meetings are scheduled in advance. An annual calendar would be ideal, but even having meetings scheduled for at least three months out helps assure good attendance. CC Collaborative members determine the frequency of meetings, as well as the times, dates and locations. Reminders should be sent to invitees at least a week before the meeting and should include an agenda and other relevant information. (Appendix A: HCCC Meeting Agendas)

Agenda items can include, but are not limited to the following:

- **Presentations by CC Collaborative members** on the programs and services offered by their organization. The presentation should include specific information on what services are offered, eligibility requirements, referral protocols, and contact information.

- **In-services on programs/resources that are not represented on the CC Collaborative**. If CC Collaborative members show interest in learning more about a program/service (especially a new or confusing one), the meeting

facilitator should note the interest and arrange to have a presentation on the program/service at a future meeting.

- **Case presentations.** Case presentations are effective in demonstrating the real and significant challenges families confront in obtaining services for their child. Prior to the presentations, the facilitator should discuss the case with the presenter and then draft a narrative for the presenter to review and approve. At least a week before the meeting, the case narrative should be sent to members.

  The facilitator ensures that the cases are presented in a supportive, non-judgmental environment where the discussion focuses on:

  1. what can be done on the direct-service level to assist the care coordinator and family; and
  2. any systems issues that warrant attention.

  All offers to help and suggestions on other resources should be recorded and shared as part of the information in a post meeting email. Once there is new information to share, presenters should be asked to provide an update. If systems-level issues were identified, an update on those issues should also be shared with Collaborative members. (Appendix A: HCCC Case Narratives Templates and Examples)

- **Training in substantive areas.** Case presentations often identify areas in which Collaborative members want more training. When this occurs, the facilitator should acknowledge this need and work on securing a trainer on the topic identified. For the HCCC, these trainings tend to run over the typical hour and a half meeting time. Therefore, they are held in addition to regularly scheduled meetings. Invitations are extended to care coordinators in other regions of the state.

  HCCC sponsored-trainings have included:

  - New Vision for the Department of Children and Families (DCF) – What are, and how to access, DCF services available to families in the greater Hartford area
  - An Overview of Section 504 of the Americans with Disabilities Act
  - A Guide to the Camp Experience for Children with Developmental Disabilities
  - Understanding Children's Disability Programs – Social Security Income (SSI)

  Electronic copies of all materials should be emailed to all Collaborative members and any guests who attended the training. Materials should also be posted on a website.

Feedback on all meetings and trainings should be obtained and reviewed by the Care Coordination Collaborative project team. The easiest way to do this is with Survey Monkey. The information shared should guide future meetings and training sessions. (Appendix A: HCCC Survey Monkey Questions)

Support Child Health Providers in Expanding Care Coordination

Care coordination is a critical part of the medical home model. Providing care coordination ensures optimal quality, encourages family centered care and minimizes cost.

However, care coordination in pediatrics is challenging. It is best accomplished through cross-sector partnerships needed to meet the medical and non-medical needs of children and families — but primary care practices are not well-equipped to address cross-sector needs. This remains true even as practices are increasingly expected to coordinate care as part of Patient Centered Medical Home (PCMH) transformation.

Care coordination collaboratives are uniquely equipped to support practices in attaining PCMH goals by expanding care coordination capacity. Collaboratives should contact the medical homes in their regions to identify challenging cases, introduce collaborative members to practice staff and/or to engage practices in the collaborative.

By using the care coordination collaborative, practices can better serve their patients. Practices can share specific needs, strengths, resources and issues facing a community, and children and youth with special healthcare needs. (Appendix B: Enhanced Practice Packet)

Data Collection, Analysis and Dissemination: CQI

This core component ensures that the Collaborative's efforts are tracked and measured.

Data collection and analysis sets the stage for the work done on the regional and state level. The data validate the stories of families and the experiences of care coordinators in a manner that allows recommendations to be explored and implemented in a purposeful way. These recommendations are, in turn, monitored and tracked.

The vehicle for carrying out these tasks is the implementation of a Continuous Quality Improvement (CQI) process guided by a CQI committee, staffed by a data manager (assigned

CCC Testimonial: **R.J. Gillespie, M.D.**

Help Me Grow Oregon Physician Champion

Right now in our state, health care reform is crying for care coordination in practices; early childhood education is rallying around community-based care coordinators. Add health plans having care coordinators and hospital discharge coordinators, and pretty soon families will be inundated with care coordinators who will in turn need to be coordinated. I also feel that as a provider, I can't keep track of all of the community agencies in existence, what their eligibility requirements are, and whether or not they can take new patients. **It would be advantageous to the provider community to have a trusted resource that helps keep tabs on these community resources to allow for more effective support to families.**

by the organizing entity) and consisting of individuals with CQI experience. Membership need not to be limited to CC Collaborative members.

One of the challenges of the CQI committee is to keep all Collaborative members engaged, even those who are not as knowledgeable about data collection and analysis. Communication between the CQI committee and all Collaborative members needs to be ongoing, informative, and accessible. Adding a CQI committee report as a regularly scheduled agenda item will help to keep all members current on the CQI process.

In addition to updates, some meetings should be dedicated to CQI. All members should participate in the meeting, which should be structured around a CQI exercise or a discussion on CQI-inspired changes in the work of the Collaborative or in programs, policies or systems.

Various external audiences for data-sharing include policy makers, legislators, state agencies, program administrators, advocates, funders, families and the media.

CQI AND THE PLAN-DO-STUDY-ACT CYCLE

PDSA cycles are used to rapidly test and implement changes in real work settings by planning a change, trying the change, observing the results and acting on what is learned. The PDSA cycle determines if the change is an improvement.

(Appendix C: *Help Me Grow* Manual: CQI)

CQI AND THE PARTNER TOOL

PARTNER is a social network analysis tool. It is designed to measure and monitor collaboration among people and organizations.

The tool shows how members are connected, how much they trust each other, how resources are leveraged and exchanged, and how to link outcomes to the process of collaboration. The tool includes an online survey that you can administer to collect data and an analysis program that analyzes these data.

PARTNER helps you demonstrate to stakeholders, partners, evaluators and funders how your collaborative activity has changed over time and progress made in regard to how community members and organizations participate. (Appendix A: www.partnertool.net)

The HCCC used the PARTNER tool to analyze its work. Survey results reflected its effectiveness as a Collaborative — and also documented its lack of attention to data. This finding generated the establishment of a Data Workgroup (now the CQI Committee). The CQI Committee has developed tools to track and measure the work of the Collaborative, starting with obtaining feedback on Collaborative meetings and trainings. After each meeting, a Survey Monkey questionnaire is sent to Collaborative members. The CQI Committee reviews the results and shares them with all members on an ongoing basis. (Appendix A: Introducing the Partner Tool and HCCC Sample Survey Monkey Questions)

DOCUMENTATION TEMPLATE

A template developed by staff at the Special Kids Support Center at Conneticut's Children serves as multi-purpose document that summarizes meetings, identifies formal and informal connections among members that occur during or between meetings and the outcomes of those connections.

This tool helps to capture the informal activities and connections that are occurring as result of the relationships developed through the Collaborative. It documents the informal work being done and provides guidance on when informal activities should be formalized and measured as part of the CQI process. (Appendix A: Template for Tracking Collaborative Activities)

These tools inform the CQI process, the work of the Collaborative, and recommendations for improving care coordination efforts.

State-level Care Coordination Collaborative Efforts

As the CC Collaborative learns more about the work of member agencies and the challenges they confront in supporting families, suggestions and recommendations for improving care coordination will arise. Some recommendations will be directed at policy and systems on a state level. This will lead to engaging state-level players through the regional Collaborative or through the convening of a state-level group. The decision on how to proceed should be guided by the CQI process and state processes.

Depending on the issues identified and recommendations generated, the Collaborative can do either **administrative or legislative advocacy**.

ADMINISTRATIVE ADVOCACY: THE HCCC EXPERIENCE

Administrative advocacy is used when a policy already exists, but is not implemented or not well implemented.

HCCC embarked on administrative advocacy following a case presentation by a Department of Children and Families (DCF) nurse. The nurse was working with a foster family with a medically complex, fragile child recently discharged from the hospital. The family was stressed and in need of respite care, but the nurse could not secure it in a timely way because a respite care provider needed training in order to properly care for the child's condition.

The nurse acknowledged that prior to presenting this case, she never thought of including respite care in a discharge plan. If it has been addressed prior to discharge, she would have been aware of the training needed to make respite care available in time, and she would have been proactive making the respite care available when it was needed. The nurse stated that she will always include the provision of respite care, when warranted, in her discharge plans.

Her comments generated a discussion that resulted in a recommendation that DCF nurses always include the provision of respite care in discharge plans, when appropriate. The HCCC is tracking the formal implementation of this recommendation.

LEGISLATIVE ADVOCACY: THE HCCC EXPERIENCE

Legislative advocacy is used when the Collaborative's work identifies a need for legislation. The HCCC found the opportunity for legislative advocacy when the state sought input on a plan to improve children's mental health services and systems across the state.

In developing this plan, DCF invited input from parents, community members, mental health experts, and others interested in sharing relevant ideas, experiences and recommendations. Because Collaborative members had already found that their most challenging issue was assisting families in securing timely and appropriate mental health serivces for their chidren, a special meeting with DCF was held for Collaborative members who wished to participate.

The meeting was powerful and productive, resulting in the submission of our comments to DCF. It was gratifying and validating for the HCCC to see that most of their recommendations were included in the Children's Mental Health Plan that DCF submitted to the legislature. (Appendix A: HCCC Submitted Comments)

CC Collaboratives confirm that there is "power in numbers." Together, members can influence, guide and improve the provision of care and services for children and their families.

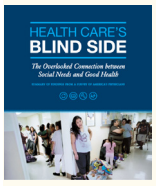
PLANNING FOR SUSTAINABILITY

Care Coordination Collaboratives are designed to improve communication, support better coordination and, where warranted, serve as a vehicle for integrating resources, which can be cost efficient while improving access to services. **Central utility, shared resource care coordination is a cost-saving innovation.**

The CQI process will generate valid and reliable data that measure the impact of the work of Collaboratives on both the micro and macro levels. This may interest funders who support children's issues. You can engage funders by keeping them informed of the Collaborative's efforts. The organizing entity should research funding opportunities on an ongoing basis.

Supporting primary care practices' care coordination efforts is another potential ongoing revenue source. As insurers and states encourage primary care practices to strengthen their status as primary care medical homes, there is a greater chance of reimbursement for care coordination activities. It is more cost effective and efficient to use CC Collaboratives rather than practices building such capacity on their own. As formal relationships between the CC Collaborative and practices are established, the feasibility of sharing the reimbursement for care coordination should be explored.

Why Health Professionals Need CC Collaboratives



"Health Care's Blind Side: The Overlooked Connections between Social Needs and Good Health" is a summary of findings from a survey of America's physicians. In it, 85 percent of primary care providers and pediatricians believe that unmet social needs are leading directly to worse health for all Americans. Furthermore, 4 in 5 physicians do not feel confident in their capacity to meet their patients' social needs, and they believe this impedes their ability to provide quality care.

Robert Wood Johnson Foundation, 2011

APPENDIX A

CARE COORDINATION TOOLS & RESOURCES

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(for organizations that sponsor ongoing groups, such as networks consortiums, collaboratives)

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APPENDIX A

PURPOSES, TOOLS, & GOALS OF CC COLLABORATIVES

	Purpose	Process/Tools	Goals
On the Local/ Community Based Level (The Micro Level)	To provide comprehensive and holistic care coordination services to ensure that vulnerable children and their families obtain needed services in a user friendly and timely manner.	• Presentations by Collaborative members on the services offered by their agency • In services on relevant programs • Training on substantive areas identified by Collaborative members • Case presentations	Maximize the utilization of resources that are available, appropriate and affordable for young children and the families they serve.
On the State Level (The Macro Level)	To identify system and policy level gaps and barriers that prevent young children and their families from obtaining needed services.	• Administrative Advocacy, used when a policy is already in place but not being acknowledged or properly implemented. • Legislation Advocacy, used when a gap in services has been identified and legislative action is required to address the gap.	Change systems and/or policies that hinder or prevent families from obtaining the needed resources and services identified by families, care coordinators and others who touch young children and their families.

MINUTES

File Name: Minutes-TrackingSheetTemplate ↓ Dec 3 2014 mtg folder

Date:	**Time:**
Members Present:	
Guests:	

Topic	Discussion	Linkages/Connections	Action Items / Person Responsible
Welcome & Introductions			
Collaborative Outcomes from prior meeting: ☐ Case Study Presentations ☐ In-service Training ☐ Presentations	**Changes in the following areas:** ☐ State Policy ☐ Organizational Policy ☐ Further or enhanced collaborative efforts ☐ Training Needs ☐ New Information learned		

Respectfully submitted,

APPENDIX A

HCCC GUIDELINES FOR MINUTES–TRACKING DOCUMENT

The Collaborative mission is to improve access to services for children by strengthening the relationships amongst care coordination agencies utilizing a shared resource model of care.

The Minutes Tracking Document serves as multi-purpose tool. The goal is to document the type of meeting being held, provide highlights, and identify formal and informal connections that occurred during or after the meetings; including outcomes, pending action item, and follow up.

Through this tracking document, collaboratives will be able to identify coordination efforts, training needs, and system's issues.

It is recommended that the tracking document be completed during regularly scheduled Collaborative Meetings.

- Meeting facilitator should consider identifying a scribe to take minutes and follow up with formal and informal connections via email or phone
- The scribe should present the minutes and any documentation at the beginning of each meeting.

There are four parts to this tool:

- Topic
- Discussion
- Linkages/Connections
- Action Items/Person Responsible

APPENDIX A

SAMPLE ENVIRONMENTAL SCAN MEETING INVITATION

Hello Everyone,

I am looking forward to seeing you at 10:30 on Wednesday, June 17 at the Government Center (6th Floor Conference Room) at a meeting to learn more about the Care Coordination Collaboratives the Department of Public Health is establishing in the 5 regions throughout the state. Since Stamford already has many well established and productive groups, we want to explore all options of working collaboratively in coordinating and/or integrating efforts.

This meeting is an opportunity to share information on the groups already meeting in Stamford and discuss how we can maximize all these efforts in supporting care coordinators and families. Mark Keenan, the Children and Youth with Special Health Care Needs (CYSHCNs) Director at DPH, along with Kareena DuPlessis, Director of Child Development Infoline, and Marijane Carey, a MCH Consultant will provide more information on the rationale for CC Collaboratives, examples of what the Hartford Collaborative has accomplished and the plans for convening of a state level Collaborative.

Thank you for your time and interest in this meeting. Your participation will help to ensure that the meeting is informative and productive.

Thank you.

APPENDIX A

SAMPLE ENVIRONMENTAL SCAN MEETING AGENDA

Meeting with Stamford Community Leaders
Re: Supporting Families through Collaborative Efforts

Wednesday, June 17, 2015
10:30 AM to Noon
Government Center, 6th Floor Conference Room

~ AGENDA ~

• Welcome and introductions	M. Mathur
• An overview and description of a medical home	M. Mathur
• Purpose of the meeting	M. Carey
• Information on the DPH/CYSHCNs Collaboratives	
○ Purpose of the Collaboratives	M. Keenan
○ Information on the Hartford CC Collaborative	K. DuPlessis
○ Plans to convene of a state level group	K. DuPlessis
• Identification and description of groups meeting in Stamford	Participants
• Discussion/brainstorm on how to work collaboratively	Participants
• Wrap up and review next steps	M. Carey

APPENDIX A

ENVIRONMENTAL SCAN GUIDANCE

Guidance for Collecting Information through an Environmental Scan of Groups
That Meet on a Regular Basis within a Specific Geographic Area

The purpose of the scan is to gather information in order to determine if Care Coordinators have a resource for obtaining information that will help them do their work, problem solve challenging situations, document gaps and barriers, and attempt to address them on a family and/or system level. Due diligence is accomplished through this exercise. The information collected can be used to summarize the groups already meeting and make a case for how a CC Collaborative can support care coordinators and their colleagues.

For each group identified, collect the following information:

Name of Group _____
Sponsoring organization _____
Contact person:
Name: _____ Title: _____
Email address_____ Phone number_____
Purpose of meetings and target population served _____
Check off type of meeting:
___ Meetings convened specifically for care coordinators
___ General networking
___ Issue-based, if checked off, list the issue _____
___ City or town wide focused
___ Case reviews
___ Legislatively mandated advisory groups
___ Other Describe: _____
Who attends (Check off all the apply)
___ care coordinators
___ health care providers
___ mental health clinicians
___ child care providers
___ family members
___ advocates
___managers/administrators
___state agency representatives, if checked off, which agencies
_____
___ Others _____

This information can be obtained by: convening a meeting for those organizations that sponsor groups; speaking individually with those responsible for hosting meetings; attending meetings; and reviewing any printed materials about the group.

Summary notes of scan findings on this group

APPENDIX A

RECRUITMENT TRACKING SHEET

Care Coordination Collaborative Member Recruitment Tracking Sheet

Name, Title & Agency of Recruit	Date of Initial Contact by Type of Contact	Date Formal Invitation Sent	RSVP Status		If Accepted, date added to member list If declined, the reason (if known)
Name: ____________________ Title: ____________________ Agency: __________________	__ Email – Date _______ __ Call – Date ________ __ In-person- ________		Accepted Date	Declined Date	
Name: ____________________ Title: ____________________ Agency: __________________	__ Email – Date ______ __ Call – Date ________ __ In-person _________		Accepted Date	Declined Date	
Name: ____________________ Title: ____________________ Agency: __________________	__ Email – Date ______ __ Call – Date ________ __ In-person _________		Accepted Date	Declined Date	
Name: ____________________ Title: ____________________ Agency: __________________	__ Email – Date ______ __ Call – Date ________ __ In-person _________		Accepted Date	Declined Date	
Name: ____________________ Title: ____________________ Agency: __________________	__ Email – Date ______ __ Call – Date ________ __ In-person _________		Accepted Date	Declined Date	
Name: ____________________ Title: ____________________ Agency: __________________	__ Email – Date ______ __ Call – Date ________ __ In-person _________		Accepted Date	Declined Date	

APPENDIX A

CONNECTICUT'S SAMPLE RECRUITMENT LETTER

Sample Care Coordination Collaborative Invitation for CT's DPH's Regional Medical Home Initiative for Children and Youth with Special Needs

Dear _____

We would like to invite you to join a Care Coordination Collaborative that we are convening for the [insert region] and hope that you are able to attend our first meeting, that will be held in [insert month]. More information on the meeting will be send out separately.

Background Information
This Collaborative, funded through the DPH's Medical Home Initiative for Children and Youth with Special Needs, is being modeled after the group that has been operating in the Hartford area since 2009. Over the years representatives from more than 15 organizations, including state agencies (DPH, DCF, DSS); state wide organizations (CHN, CT BHP, CT DHP, FSN) and local providers have come together to:

- learn about resources and services offered by colleagues
- problem solve challenges confronting families via case presentations
- design and offer trainings on issues identified through case presentations
- identify systems and policy barriers that prevent families from obtaining the services needed in a timely and efficient manner.

Our goal is to establish a Collaborative that can do similar work in this region. Your participation in this effort is important to ensuring its success. We hope that you are interested in representing your organization on the Collaborative. We anticipate that meetings will be held [insert how often] at [location if known].

If you would like more information about the Hartford Care Coordination Collaborative, contact Marijane Carey, lead consultant. She can be reached at mjcarey95@aol.com or by phone at 203 287-8953.

I look forward to hearing from you and to your participation in the Collaborative.

Thank you.

APPENDIX A

HARTFORD CC COLLABORTIVE MEMBERS

Hartford Care Coordination Collaborative
Contact List of Members by Organization
Prepared March 4, 2015

Carey Consulting

Marijane Carey	Principal	203 287-8953	Mjcarey95@aol.com

Center for Children's Advocacy, Medical Legal Partnership

Bonnie Roswig	Sr. Staff Attorney	860 545-8581	broswig@ccmckids.org

Child Development Infoline (CDI)

Shirley Caro	Supervisor	860 571-7529	Shirley.CDI@ctunitedway.org
Kareena DuPlessis	Director	860 571-7530	Kareena.duplessis@ctunitedway.org
Heather Spada	ECCS Project Manager	860-372-4240	heather.spada@ctunitedway.org

Child Health and Development Institute (CHDI)

Lisa Honigfeld	VP for Health Initiatives	860 679-1523	Honigfeld@uchc.edu

Community Health Network (CHN), Community Support Services Department

Maribet Carrion	Team Lead	1 800 859-9889 X 6145	mcarrion@chnct.org
Stephanie Corbin	Human Services Specialist	1 800 859-9889 X6117	scorbin@chnct.org
Deborah L. Pope	Intensive Care Manager, Team Lead	203-949-6019	dpope@chnct.org
Margy Roberts	Manager	1 800 859-9889 x 7276	mroberts@chnct.org
Kim Sherman	Social Worker	1 800 440-5071 x 4050	ksherman@chnct.org
Rebekkah Smith	Human Service Specialist	1 800 859-9889 x7218	rsmith@chnct.org

Community Health Network (CHN), Person Centered Medical Home

Carmen Messina	Community Practice Transformation Specialist Team Lead	203 949-4068	camessina@chnct.org
Kara Rodriguez	Program Administrator, Person Centered Medical Home	1 800 859-9889 X 6133	krodriguez@chnct.org

The Cornerstone Foundation, Inc.

Bryan Flint	Shelter Director	860 875-6343 860670-0587-Cell	bryanflint@aol.com

CT Behavioral Health Partnership (CTBHP), Clinical Services

Heidi Pugliese	Director	860 263-2018	heidi.pugliese@valueoptions.com
Erika Sharillo	Clinical Supervisor	860 263-2088	Erika.Sharillo@valueoptions.com

CT Children's Hospital, Ambulatory Departments

Joanne Meuci	Nurse Manager	860 545-9431	jmeucci@connecticutchildrens.org

CT Children's Hospital, Office of Community Child Health

Eminet Gurganus		860 837-5712	EGurganus@connecticutchildrens.org

CT Children's Hospital, Special Kids Support Center (SKSC)

Trisha Dickinson	Health Data Specialist	860 837-6203	Pdickin@connecticutchildrens.org
Katherine Raminez	Community Care Coordinator	860-837-6211	Kramirez01@connecticutchildrens.org
Ann Riley	Clinical Care Coordinator	860-837-6212	ariley@connecticutchildrens.org
Susan Roman	Manager	860 610-4207	Sroman@connecticutchildrens.org
Alison Wilson	Clinical Care Coordinator	860-837-6214	Awilson@connecticutchildrens.org

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HARTFORD CC COLLABORTIVE MEMBERS

CT Dental Health Partnership (CDHC)

Luis Miguel Ayala	Care Specialist	860 507-2325	luismiguel.ayala@ctdhp.com
Marty Milkovic	Director of Care Coordination & Outreach	860 507-2302	marty.milkovic@ctdhp.com

Department of Children and Families (DCF), Medical Health and Wellbeing Services

James George	Health Advocate	860 638-5910 (M-W-F) 860 418-8201 (Tue-Thu)	JAMES.GEORGE@ct.gov
Linda Raitt	Clinical Nurse Coordinator	860 550-6636	LINDA.RAITT@ct.gov
Cheryl Wamuo	Lead Health Advocate	860 560-5033	cheryl.wamuo@ct.gov
Dr. Fredericka Wolman	Director of Pediatrics	860 560-6643	FREDERICKA.WOLMAN@ct.gov

Department of Public Health, Children and Youth with Special Health Care Needs (CYSHCNs)

Mark Keenan	Director	860 509-7455	Mark.Keenan@ct.gov
Robin Tousey Ayers	Health Program Associate	860 509-8057	Robin.Tousey-Ayers@ct.gov

Department of Social Services (DSS)

Erica Garcia	Health Program Liaison, Managed Care Unit	860 424-5670	erica.garcia@ct.gov
Fatama Williams	Supervising Nurse Consultant, Division of Health Services	860 424-5181	fatmata.williams@ct.gov

Family Support Network (FSN)

Tesha Imperati	Executive Director	203 710-3041	timperati@ctfsn.org

Hartford Public Schools

Deborah Chameides	Health Services Coordinator	860-695-8760	CHAMD001@hartfordschools.org

InterCommunity, Inc., Outpatient Patient Children's Clinic & Child First

Rick Amaral	Director	860 291-1341	richardamaral@intercommunityct.org
Sarah Dagostino	Child FIRST Care Coordinator	860 992-3483 (cell)	sarahdagostino@intercommunityct.org

The Village for Children and Families

Renee Johnson	Care Coordinator/Case Manager		rtjohnson@thevillage.org

Vernon Public Schools

Laura Corliss	School Psychologist, Community Engagement Liaison	860 336-7207 - School cellphone	laura.corliss@vernonct.org

APPENDIX A

HCCC PRE-MEETING SURVEY

Questions for Members of the [Region] Care Coordination Collaborative

Your Name:_____ Your Agency:_____
Email: _____ Date Completed: _____

1. How do you get your referrals?

2. Who can make referrals for your services?

3. Typically, how long are cases opened?

4. After a case is closed, do you still maintain contact with the family?

5. What do you hope to accomplish through this collaborative?

Please indicate if or how often you provide the following services in your role as a care coordinator within your organization:

	Always	Often	Sometimes	Never
Needs Assessment				
Care Planning				
Home Visits				
Family Advocacy				
Linkages to Specialists				
Linkage to community based resources				
Coordination of health financing resources				
Coordination with school based services				
Chronic Disease Management				
Family Education				
Other:				

Other comments:

File name: Sample CCC survey questions.FINAL.apr 2015

HCCC PRE-MEETING SURVEY RESPONSES

	CTBHP	AmeriChoice	CDI	PCP @ CCMC	SFHC (AmeriChoice)	SKSC @ CCMC
How do you get your referrals?	Hospitals, any community provider, families, DCF, Collaboratives, DDS, DSS, Primary Care Physicians, all providers etc.	Either from CT Hospitals (coming out of hospitals needing case management) or the Members are served as part of our Husky A and B+ population	Via phone, fax, website- from families, physicians, child care providers and other social service agencies	Newborns from Hartford Hospital, referrals from the NICU, in patient service and specialists, and siblings of existing patients.	St. Francis ER, clinics, inpatient	PCP, specialty clinics, families, schools, CDI
Typically, how long are cases kept open?	As long as there is a clinical need identified. No time limit established as long as Husky member.	Members active cases remain open as long as in Case Management….(on DSS contract)	Between 2 and 12 weeks	Until all items are accomplished on the plan of care. In many cases, the cases are open until the patient leaves the practice or ages out (>18 years of age).	One month	Longer than anticipated: 3-6 months
After a case is closed, do you still maintain contact with the family?	The families can contact the service center at any time with concerns or questions. 8:30am – 5pm	Contact can be reopened at any time, providing member is in Husky	No, however, many families call back with additional needs at a later date.	Yes	No – unless the patient comes back to the ER	Depends on the family and what the needs have been in the past
What do you hope to accomplish through this collaborative?	Enhance and build a network of community providers to meet the needs of families without duplication of services. To continue to identify the gaps and barriers in the service delivery system and work collaboratively to build needed services and programs. To improve access to effective quality care.	Increase accuracy of information pertaining to members, thus accessibility to better provide case management services. Provide and receive support services in relation to provider and member initiatives designed to reduce incidence of readmissions to hospital. Enhance educational programs aimed at better health for members.	Maximize the use of resources to meet the needs of family and children and to improve the referral process into care coordination and other services for families.	Identify activities and resources of other agencies that will help us care for our patients.	Networking with other care coordinators & learning how we can work together to have smoother transitions. Many pediatric patients come to St Francis ER, and I want to collaborate with CCMC and the clinics to share information on these patients to help support them though the care continuum.	Working together to assist families without duplication of services

HCCC PRE-MEETING SURVEY RESPONSES

	Always	Often	Sometimes	Never
Needs Assessment	CT BHP CDI PCP @ CCMC SKSC @ CCMC	AmeriChoice	SFHC (AmeriChoice)	
Care Planning	CT BHP[1] PCP @ CCMC SKSC @ CCMC	AmeriChoice CDI	SFHC (AmeriChoice)	
Home Visits		SKSC @ CCMC[2]	CT BHP by the Peer s only AmeriChoice PCP @ CCMC	CDI SFHC (AmeriChoice)
Family Advocacy	CT BHP – Family support role PCP @ CCMC SKSC @ CCMC	CDI	AmeriChoice	SFHC (AmeriChoice)
Linkages to Specialists	CT BHP – if needed PCP @ CCMC	AmeriChoice SKSC @ CCMC	CDI	
Linkage to community based resources	CT BHP CDI PCP @ CCMC SKSC @ CCMC	AmeriChoice SFHC (AmeriChoice)		
Coordination of health financing resources		CT BHP CDI, St.Fran; PCP @ CCMC SKSC @ CCMC	AmeriChoice SFHC (AmeriChoice)	
Coordination with school based services		CT BHP CDI PCP @ CCMC SKSC @ CCMC	AmeriChoice	SFHC (AmeriChoice)
Chronic Disease Management	CT BHP[3] PCP@ CCMC		AmeriChoice SFHC (AmeriChoice)	CDI
Family Education	CT BHP CDI PCP@ CCMC	SKSC@ CCMC	AmeriChoice SFHC (AmeriChoice)	

[1] Assist direct clinical care providers in care planning
[2] When we meet with our families, it is often done at the hospital or clinic. We do meet with families in their homes but we are fortunate enough to be able to meet with them at appts or therapies.
[3] Coordinate with the Husky MCOs.

APPENDIX A

SAMPLE AGENDA FOR FIRST MEETING

The [Region] Care Coordination Collaborative
[Date] Meeting

~ AGENDA ~

- Welcome and introductions
  As part of the introductions, ask participants what they hope the collaborative can do to support their work and the families with whom they work

- Background information on the convening of care coordination collaboratives by the five Regional Medical Home Initiatives
  In the current grant for the Department of Public Health's Medical Home Initiative-Children and Youth with Special Health Care Needs,, the five regional programs are required to establish and maintain care coordination collaboratives.
  In addition to the convening of the five regional Collaboratives, there will be a state level Collaborative that will provide an opportunity for the regional Collaboratives to share experiences, lessons learned, and advocate for policy level solutions. Each regional collaborative will be represented on the statewide group.

- Describe the technical assistance available to support Collaborative efforts

- Share summary results of the survey questions *(optional)*

- Identify care coordination gaps and overlaps

- Discuss the purpose of the collaborative and how it might be able to address the gaps and barriers identified
  The purpose of the Collaborative is to maximize the resources available to children by improving communication among providers, increasing the knowledge of the referral process used by agencies, ensuring timely access to services needed by children and their families, and identifying the challenges that families confront in obtaining services.

  Reach consensus on the Collaborative, including an agreement to move forward with meetings that are designed to serve care coordinators and families with vulnerable children up to the age of 21.

- Identify additional members

- Set dates and discuss agenda items for the next three meetings
  Agenda options include presentations by collaborative members on the services they offer, a case presentation, and/or an in-service or training on a relevant topic

- Next steps

APPENDIX A

HCCC MEETING AGENDA

The Hartford Area Care Coordination Collaborative Meeting
2 to 3:30 PM
United Way of CT/2-1-1
Rocky Hill, Connecticut
January 23, 2015
~ AGENDA ~

- Welcome and introductions — M. Carey
- SKSC Case Presentation — B. Machado
- Presentation on DDS' Division of Autism Spectrum Services — J. Bogin
- Sharing reports on work of the Collaborative by the Data Workgroup — T. Dickinson & K. Ramirez
- Updates
  - LogisitiCare issues — B. Roswig
  - DCF Case presentation at the December meeting — M. Carey
  - Members updates
- Next meeting: date & agenda — M. Carey
  - February 27
  - Presentation on ECCS by Heather Spada

APPENDIX A

HCCC MISSION

The Hartford
Care Coordination Collaborative
Mission Statement
October 18 2013

The purpose of the HCC Collaborative is to serve families and child health care providers in the greater Hartford area in a holistic and efficient manner by identifying and maximizing the full range of resources available and supporting care coordinators in obtaining the care and services needed by children and their families.

In addressing the needs of families, the Collaborative also seeks to understand health and human service delivery systems in order to promote wellness, support the medical home, and assist families in negotiating these systems as well as to document the gaps and barriers that families confront when in need of assistance.

APPENDIX A

HCCC CASE NARRATIVES EXAMPLE

Case Presentation by DCF for the Hartford Care Coordination Collaborative
December 19, 2014 Meeting
DCF Presenters: Neng Jones, Social Worker & Mary Jean Quistorff, Nurse

Summary of Family Situation

DCF became involved in October 2013 due to conditions of the home, mother's medical issues and children's medical issues, and mother's compromised ability to parent her children due to her medical issues. This family, currently living in East Windsor, consists of a 38 year old Mom, who is morbidly obese, and her three children who are 9, 4 and 2 years old. Family was living in Manchester but needed to move due to housing issues and found a Section 8 apartment in East Windsor. Mom would like to move back to the Hartford area as transportation is a problem in East Windsor. The Hartford area offers better access to the services and resources the family needs.

In addition to her obesity, Mom has a number of other health issues including asthma, hypertension, foot pain, insomnia, sleep apnea, enuresis, increased urinary frequency and mental health issues. She is a trauma survivor and deals with depression. She has a number of doctors' appointment on a weekly basis. In addition to her primary care doctor, she is also being seen by a pulmonologist; podiatrist; nutritionist; and at a bariatric center. (She is a candidate for bariatric surgery and is preparing for the procedure). She is also in counseling at Eastern Services.

Transportation is very problematic. The family does not have a car, there is no public transportation available to meet their needs and Mom's doctors are located throughout the state.

Children also have health issues. The 9 year old has enuresis and some mental health issues, which are being treated. He goes to therapy three times a week. The two younger children have asthma.

Due to the obesity and related health problems, Mom is not able to work. Family has HUSKY A coverage and receives WIC and SNAP, but has no income. She has applied for SSI and has been denied twice. She is appealing the second denial. DCF is working on getting cash assistance from DSS for the family. Family is also receiving from DCF Intensive Family Preservation Services. Community Health Network (CHN) provides Mom with an Intensive Care Manager and support from Community Support Services. The 4 year old goes to HeadStart. Father of the two youngest children is involved, but there is tension between the parents. He is quite a bit older and their views on parenting are very different. Father of the oldest child is not involved. Mom is estranged from her family and only has contact with a half-sister and a cousin, who pays for Internet access and the home phone.

Despite many challenges Mom is an advocate for herself and her children. She is taking online courses at Post University for a Bachelors of Science, Health Administration/Health Management degree.

DCF is looking to close this case and wants to make sure the resources and services needed are identified and shared with the family.

Information/guidance/suggestions from Collaborative members is being sought around

1. Basic needs
    a. Transportation (Logisticare will not transport 2 year old with Mom when going to her medical appointments)
    b. Food
    c. Moving back to the Hartford area
2. Ongoing case management and support services
3. Program for 2 year old, especially when Mom has medical appointments.
4. Financial aid (DCF is working with DSS on getting her on cash assistance)
5. Home health support (helping with cleaning, laundry, etc.)
6. Support for Mom – clothes, toiletries, etc.
7. Other thoughts/ideas?

APPENDIX A

CASE NARRATIVES EXAMPLE

Case Presentation by the Special Kids Support Center (SKSC) at Connecticut Children's
for the Hartford Care Coordination Collaborative
January 23, 2015 Meeting
SKSC Presenter: Brenda Machado, Care Coordinator

Summary of Family Situation

SKSC became involved with this family at their first appointment with Primary Care at CCMC in November. In October 2014, they moved from Puerto Rico in order to obtain better medical care for their daughter who has a number of medical issues. She has a diagnosis of Lupus, Agenesis of Corpus Callosum, Hydrocephalus with shunt, Right Partial Heterotopias, Left Hemiparetic Cerebral Palsy, Epilepsy and Septum Malformation. She had two shunts in her brain and has had more than 20 surgeries. One of the shunts was removed as it was not functioning so currently she only has one. This child has difficulty walking and occasionally uses a wheel chair. She is developmentally delayed and has difficulty reading, writing and talking. She is difficult to understand, except for her parents who seem to be able to comprehend what she is saying. The medications that she takes daily are: Plaquenil, Relpax, Apap, Prevacid, Phenobarbital, Prelone, Albuterol and Ranitidine.

Resources and services that the family has either obtained or are in the process of receiving include:
Medicaid – has coverage
DSS – cash assistance and food stamps
SSI – application submitted
FAVOR – found eligible for respite funds
CHN - Child has ICM nurse.
VNA – Nursing services being provided after discharged from hospital
New Britain school system – providing a home tutor until she is able to return to school
DDS – eligibility needs to be determined. Child was not able to attend school in Puerto Rico. She is now enrolled in the New Britain school system and loves it. They are in the process of doing an evaluation, which has been held up due to her hospitalization for an infection. (She was admitted in the middle of December and released on January 15.) She has a PICC line and will not be able to attend school until it is removed. The school is sending a tutor to the home until she is able to return to classes.

The family is staying with a cousin of the mother and are looking for a place of their own. They are in Bloomfield's Section 8 lottery. They receive $586 monthly cash assistance. They want to buy a car. Neither parent is working. Both worked in Puerto Rico, but Mom could not keep a job for long due to her daughter' medical needs. Dad worked in a gas station. He does not speak much English

Information/guidance/suggestions from Collaborative members is being sought around

1. Furniture/household items
2. Housing
3. Resources for a car
4. Employment training support for dad
5. Support for family
6. Other thoughts/ideas?

APPENDIX A

HCCC CASE PRESENTATION TEMPLATE

DATE: _____

PRESENTER: _____

AGENCY: _____

CLIENT INFORMATION:

Age: _____

Gender: _____

Town of Residence: _____

Insurance: _____

Referral Source: _____

BRIEF HISTORY/BACKGROUND OF CLIENT:

PRESENTATION ELEMENTS:

1. Presenting problem/issue identified by family :

2. Other problems/issues identified through the CC process:

3. Agencies/Individuals involved with child/family:

4. Actions taken:

5. Outcome(s) from the perspective of the Care Coordinator and from the family:

6. Positive outcomes:

DISCUSSION QUESTIONS:

A. What could have been done differently/lessons learned?

B. Recommendations?

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HCCC CASE PRESENTATION GUIDELINES

Through case presentations, Collaborative members coordinate efforts to meet the needs of children and their families through discussion, resource sharing, and linkage to community services.

Cases should be presented during regularly scheduled Collaborative Meetings as per each region's work plan.

- Meeting facilitator will schedule date for case presentation
- Prior to Care Coordination Collaborative Meeting, the presenter completes the Case Presentation Form and forwards the document to the meeting coordinator for review
- It is recommended that case presentations are limited to 30 minutes (20 min presentation/ 10 min questions/answers)
- Confidentiality is maintained throughout case discussion

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HCCC CASE PRESENTATION SURVEY MONKEY QUESTIONS

CARE COORDINATION COLLABORATIVE - HARTFORD AREA
PRESENTATION SURVEY

DATE: 10-24-2014

TITLE:
Div of Autism Spectrum Services -
Jennifer Bogin

Choose what best matches your organization:

- ☐ Community based org
- ☐ Health Provider
- ☐ State Agency
- ☐ State ASO
- ☐ Other

Indicate your degree of understanding of the topics BEFORE the presentation:

	Poor	Fair	Good	Excellent
Knowledge of services offered	☐	☐	☐	☐
How to make a referral	☐	☐	☐	☐
Able to explain the services offered to families	☐	☐	☐	☐
	☐	☐	☐	☐

Indicate your degree of understanding of the topics AFTER the presentation:

	Poor	Fair	Good	Excellent
Knowledge of services offered	☐	☐	☐	☐
How to make a referral	☐	☐	☐	☐
Able to explain the services offered to families	☐	☐	☐	☐
	☐	☐	☐	☐

Indicate your agreement with the following statements about the today's presentation:

	Strongly Disagree	Disagree	Agree	Strongly Agree
Provided information relevant to my work:	☐	☐	☐	☐
Will be of immediate use to me:	☐	☐	☐	☐
May be of use to me in the future:	☐	☐	☐	☐

What was the most useful information discussed at todays presentation?

What else would have been helpful to you as part of today's presentation?

Suggestions for future events, topics of interest and potential participants/ speakers?

- ☐ Barriers experienced by families w/ pvt ins
- ☐ Behavioral / Mental Health
- ☐ Financial Assistance
- ☐ Food/Nutrition (SNAP-WIC)
- ☐ Legal
- ☐ Providing trauma informed care
- ☐ Serving undocumented families
- ☐ Shelter / Housing
- ☐ Special Education
- ☐ Transition
- ☐ Repite Care
- ☐ Home Health Care

Other Suggestions:

Other comments from today's entire meeting:

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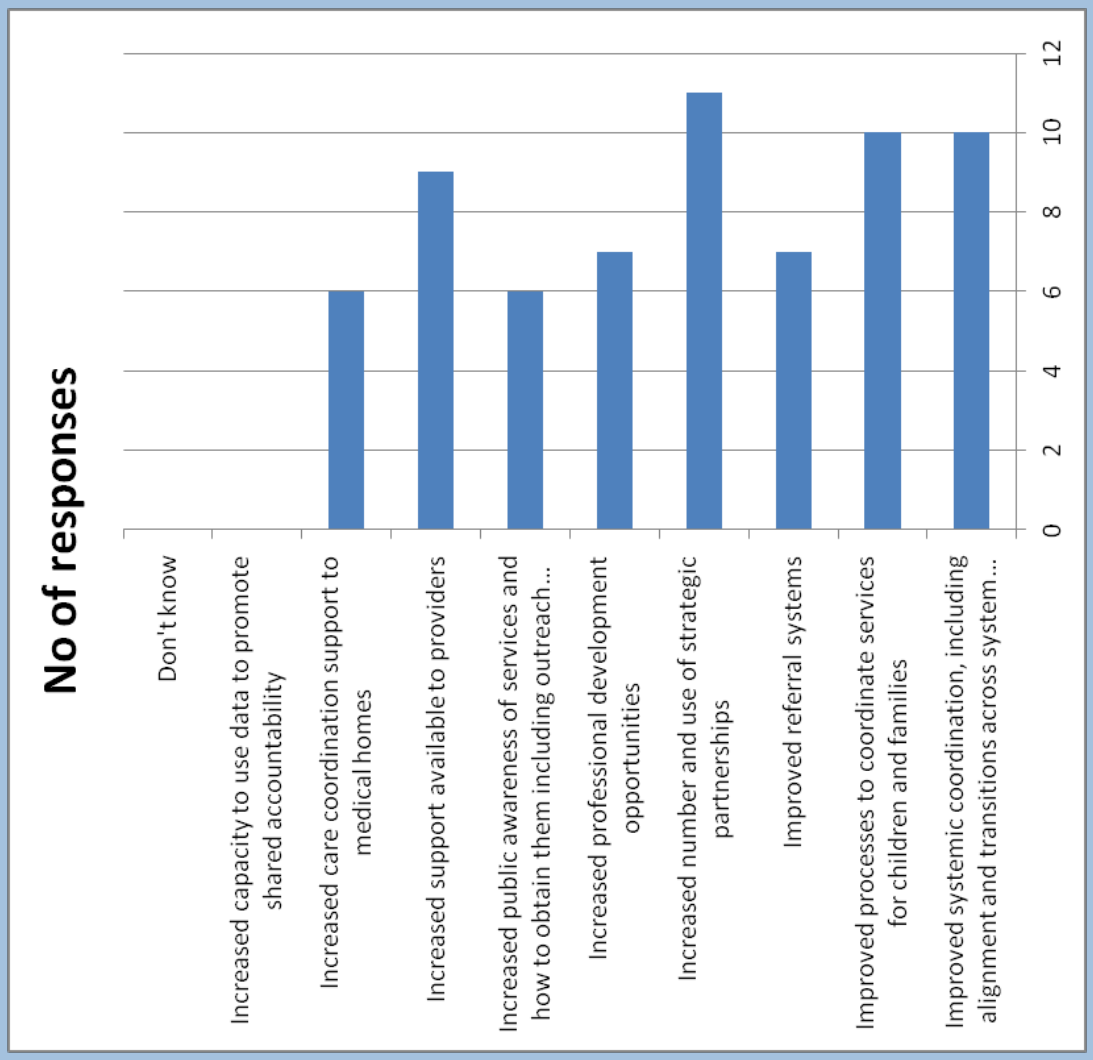
Hartford Care Coordination Collaborative

Partnerships Assessment Using the PARTNER Tool

February 2014

APPENDIX A

The Collaborative has made progress on the following outcomes (choose all that apply).



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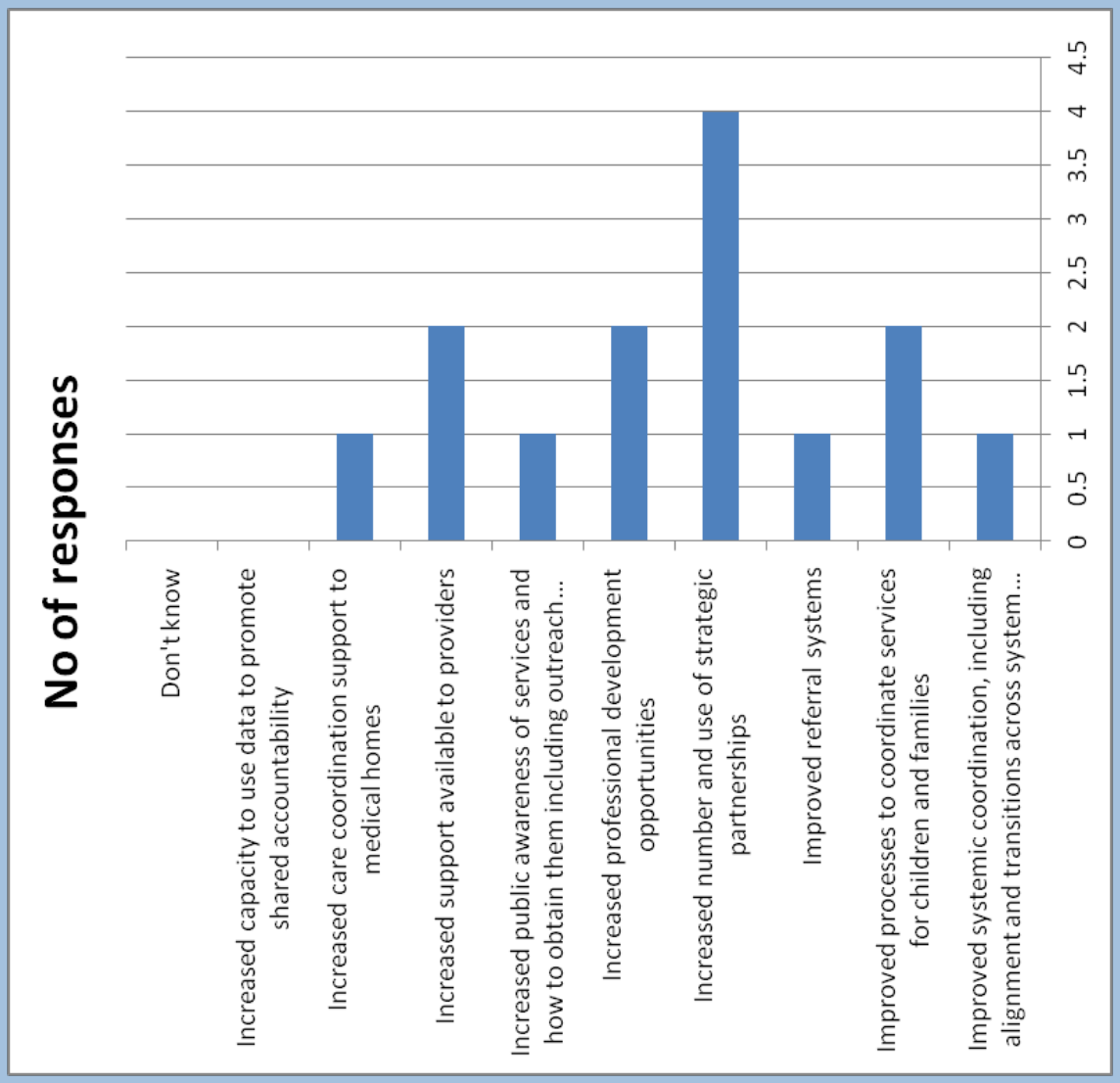
Which of the outcomes that you indicated in Question 6 has the Collaborative most successfully achieved? (Choose only one)



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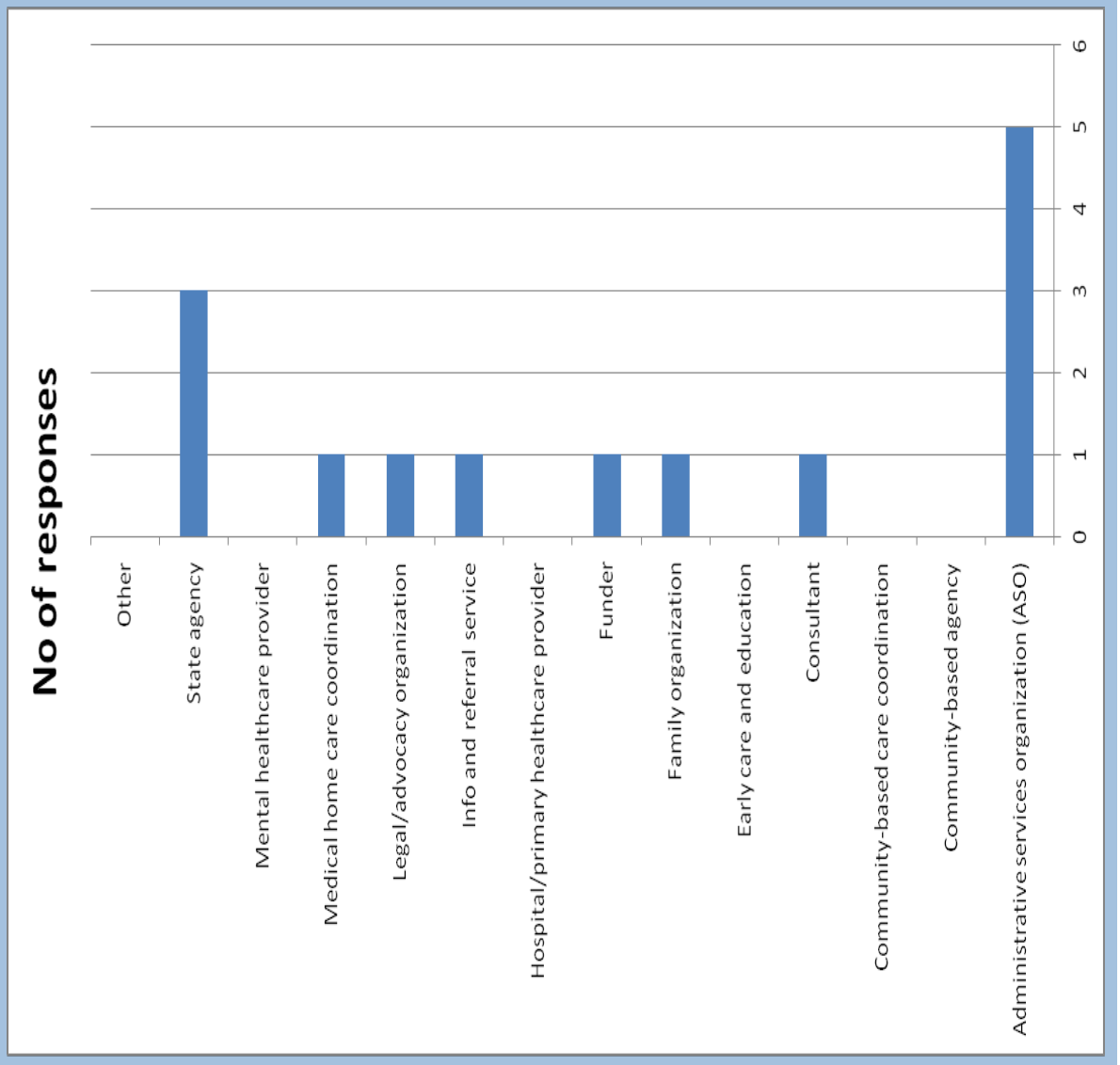
Which sector best describes your organization/program/department/division? (Choose only one)



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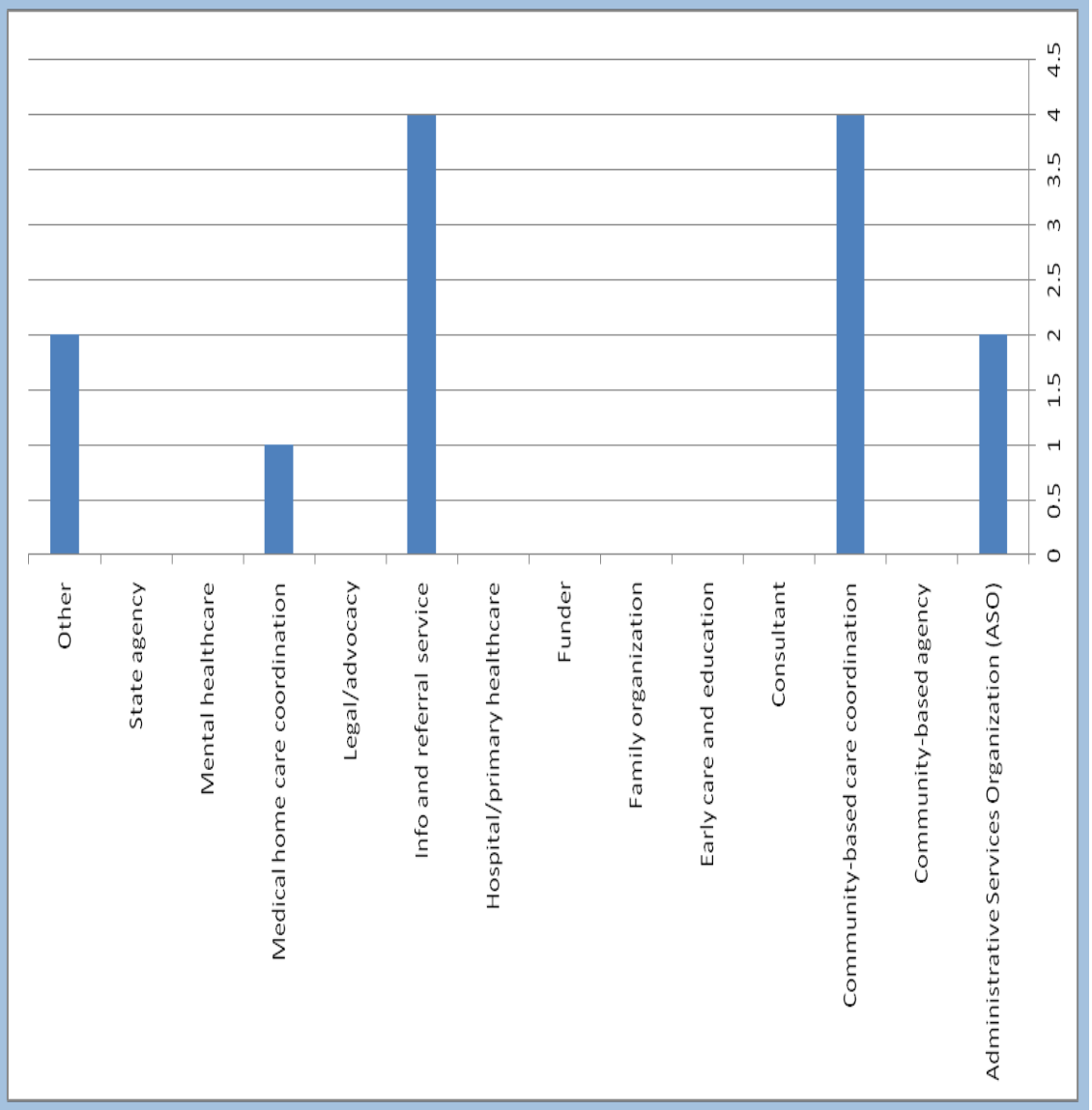
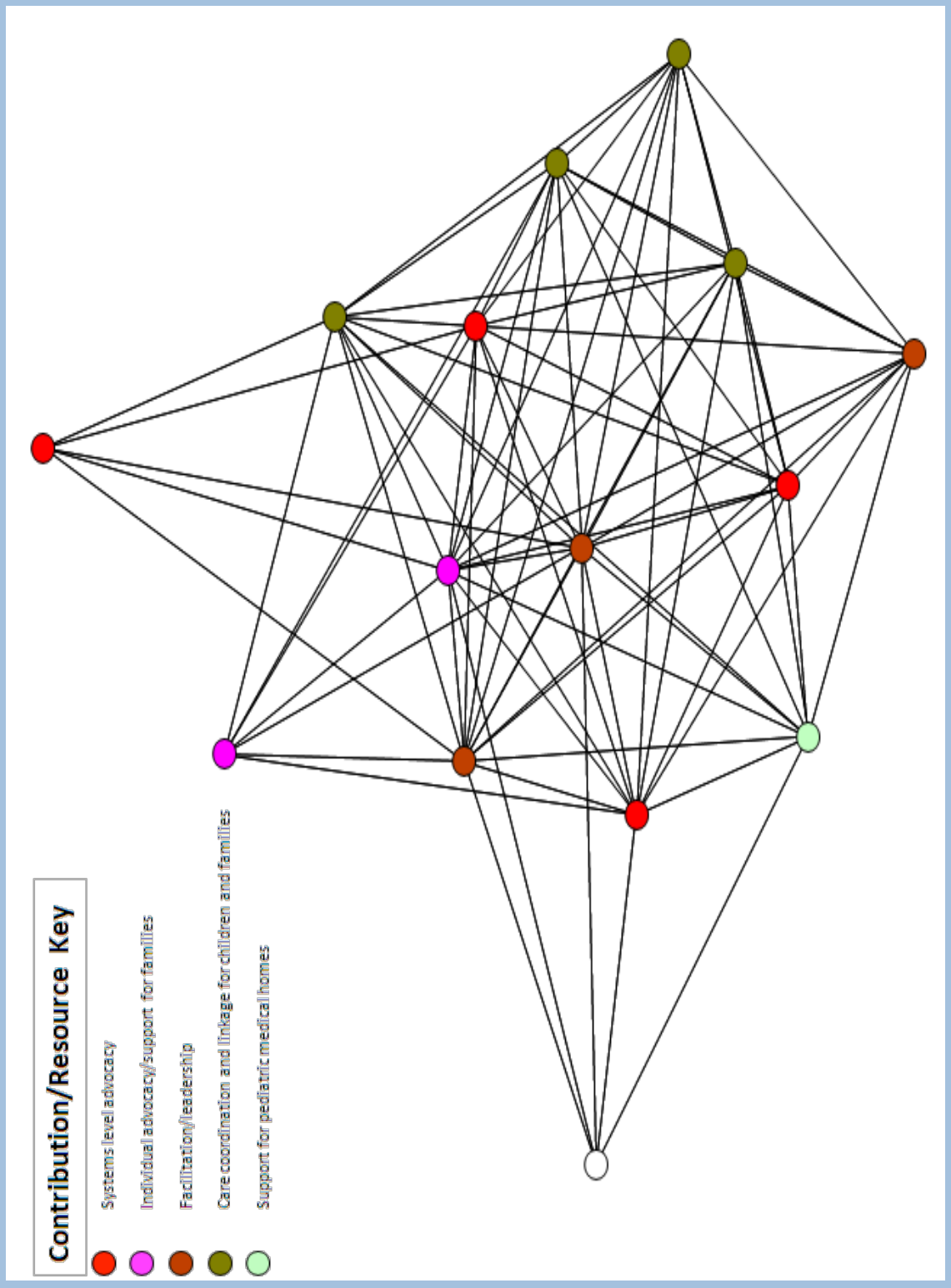
In which sector(s) has the Collaborative achieved the most success at improving and sustaining the quality, availability, capacity, and accessibility of care coordination services? (Choose only one)



APPENDIX A

What is your organization/program/department/division's most important contribution to the Collaborative (choose only one)?



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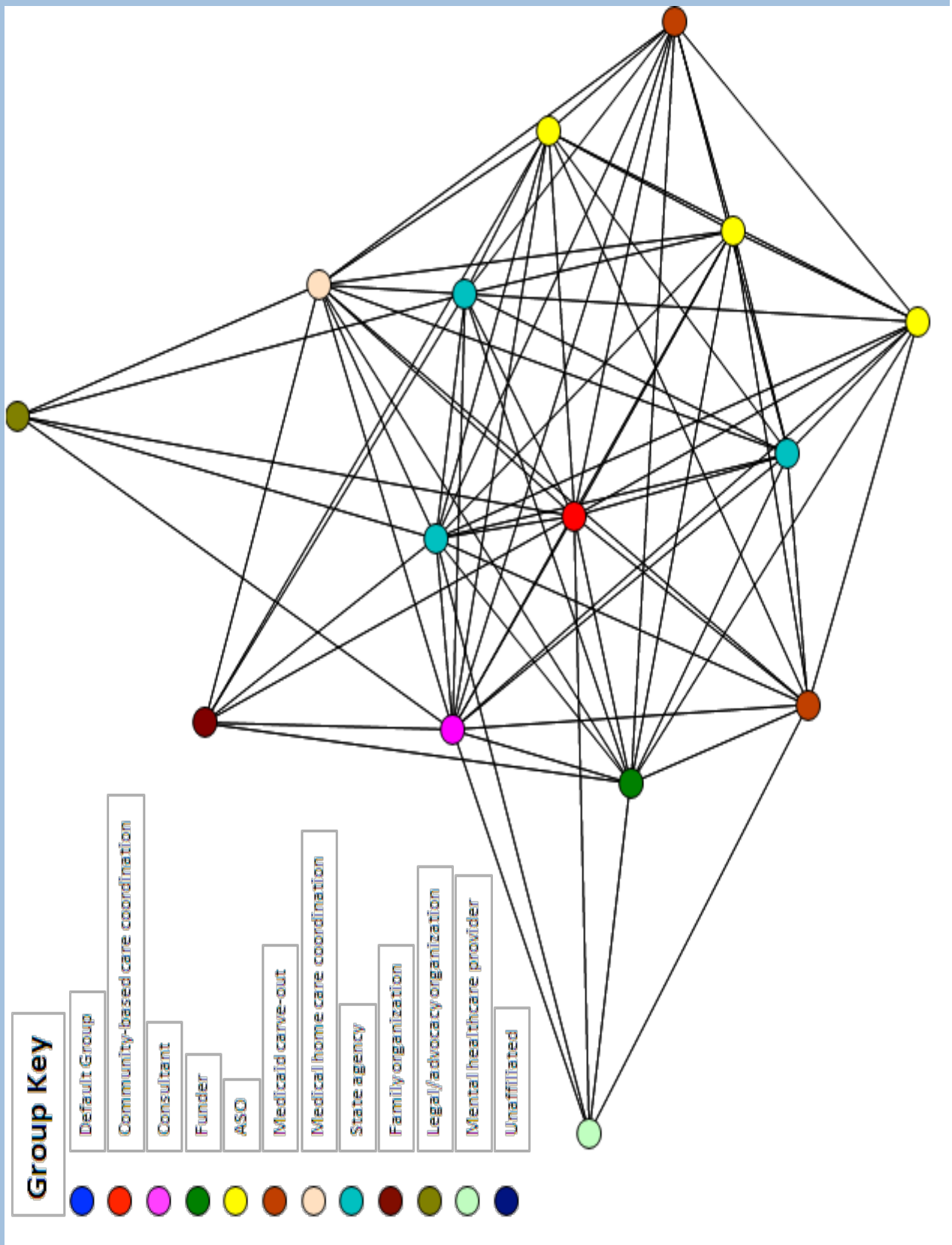
Connectedness of Collaborative Members



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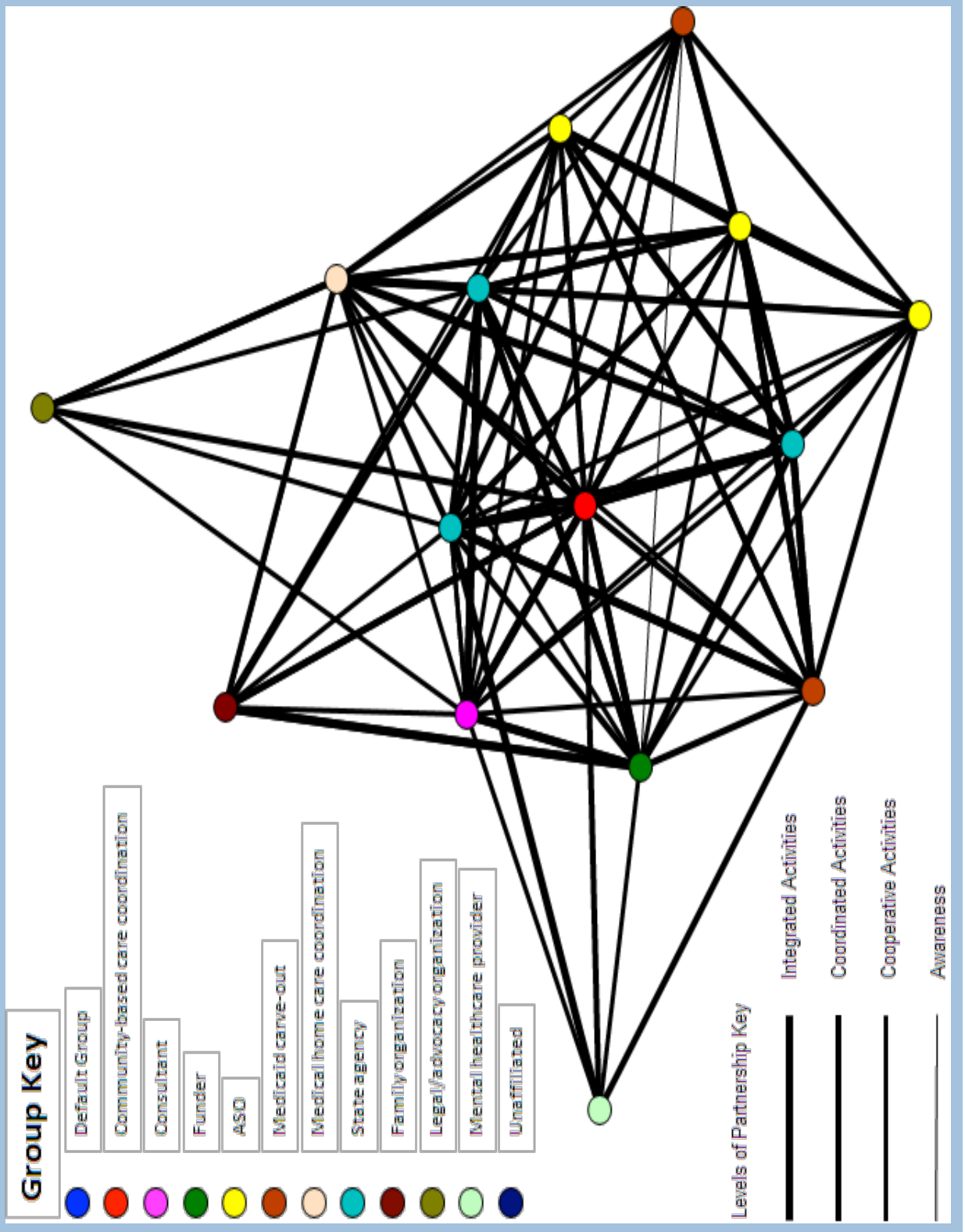
Strength of Relationships among Collaborative Members



Strength of Relationships among Collaborative Members

- ***Please describe the nature of your relationship with this organization/ program/department (Note: The responses increase in level of collaboration).***
  - **Awareness** of what this organization/program/department/division's role is in the system (e.g., understanding of services offered, resources available, mission/goals)
  - **Cooperative Activities:** exchanging information, attending meetings together, informing other programs of available services (e.g., understanding how to coordinate services with or access services from this organization/program/department/division)
  - **Coordinated Activities:** cooperative activities + exchange of resources/ service delivery; coordinated planning to implement things such as client referrals, data sharing, training together (e.g., coordinating services for a child/children in the community with this organization/program/ department/division)
  - **Integrated Activities:** cooperative + coordinated activities + includes shared funding, joint program development, combined services, shared accountability, and or shared decision making (e.g., a formal program with funding exists between the two organizations)

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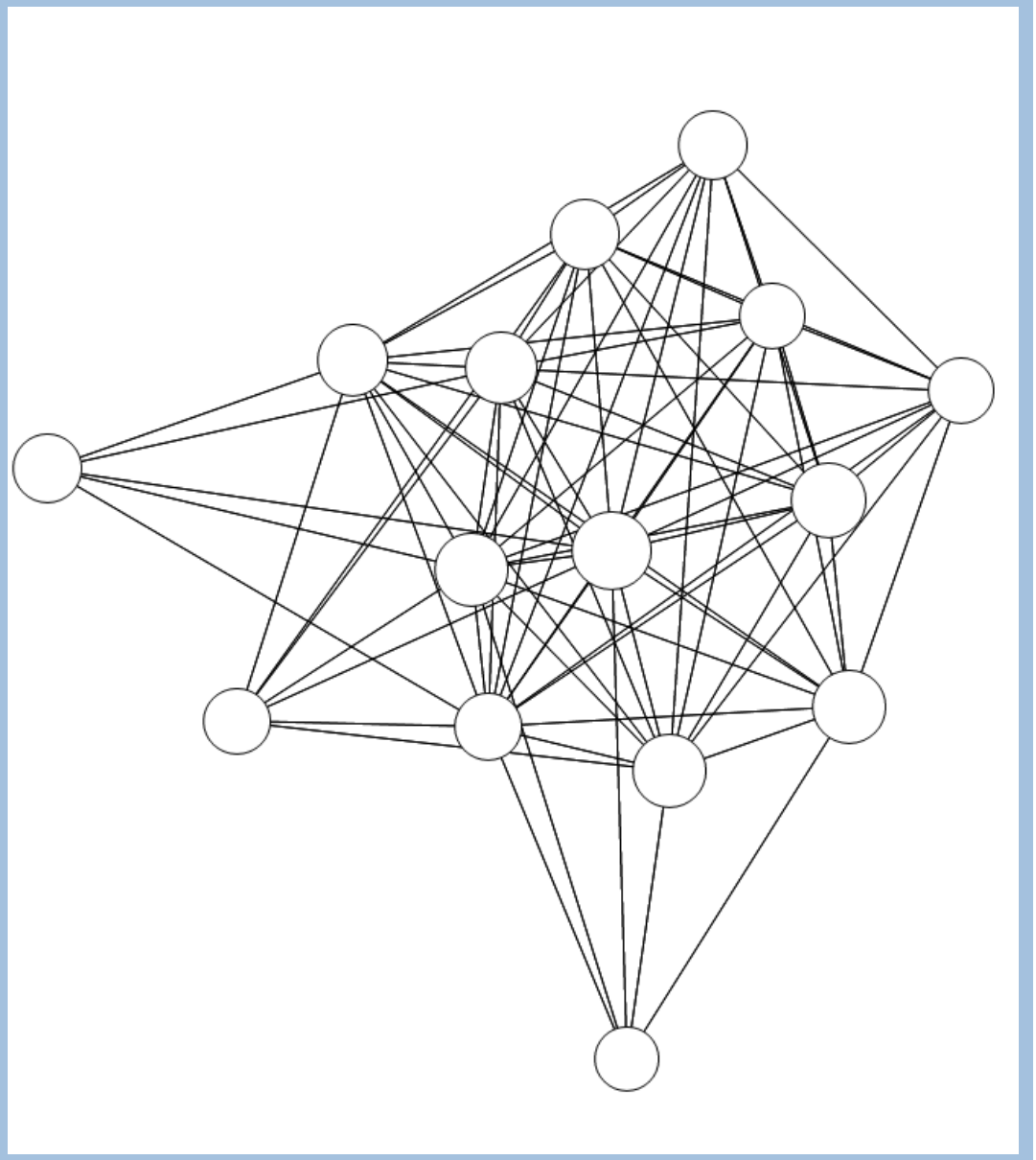
Attributes of Collaborative Partnerships

Overall Value - a combined score of all respondents along three dimensions of value: Power/ Influence, Level of Involvement, and Level of Resource Contribution



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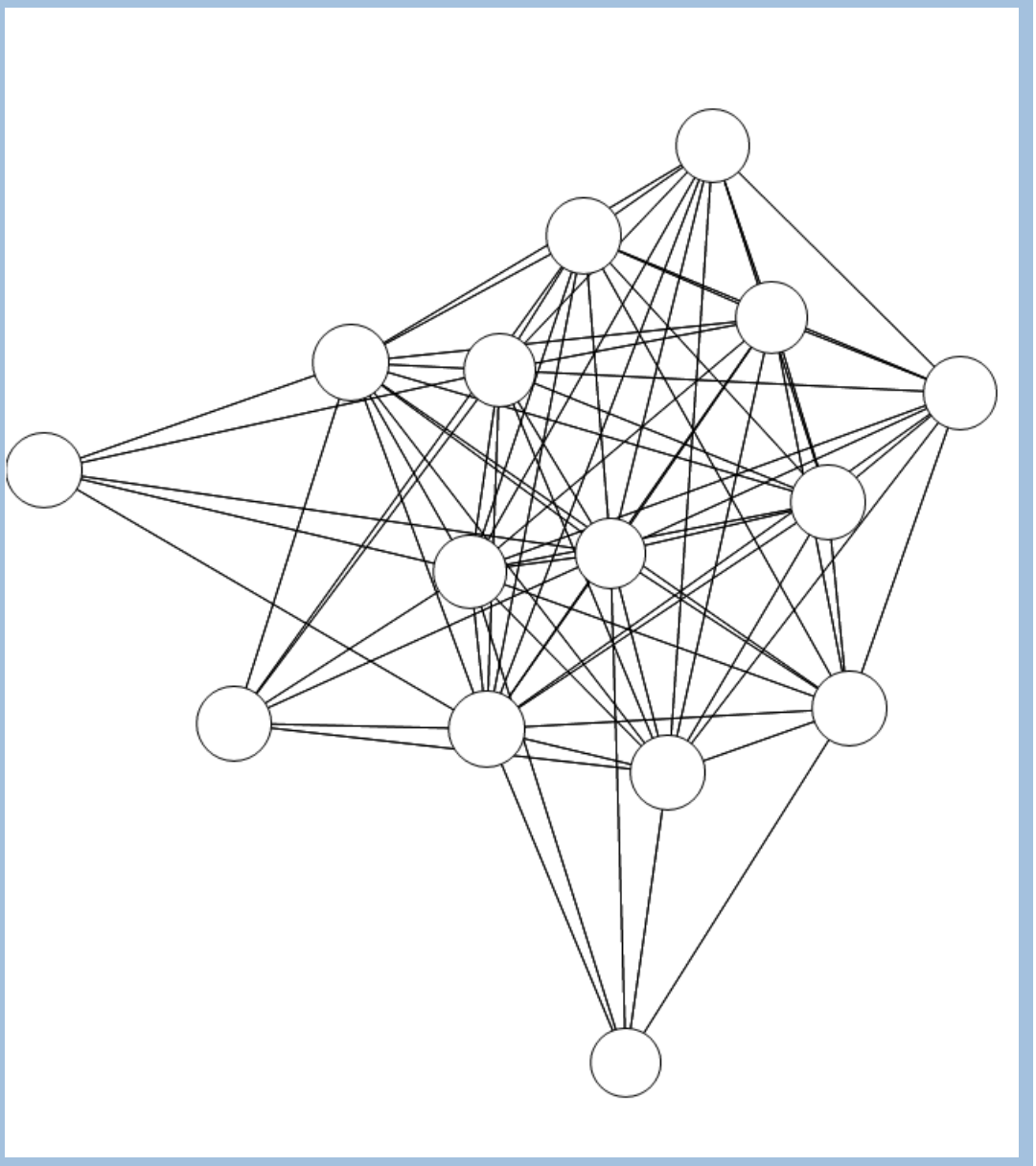
Attributes of Collaborative Partnerships

Overall Trust - a combined score of all respondents along three dimensions of trust: Reliability, Mission Congruence, and Openness to Discussion



Key Points

- Potential strategies to facilitate greater awareness and stronger partnerships
  - The importance of continuing presentations by Collaborative members on the services offered by their agency
  - Developing a directory of expertise of Collaborative members
- Assess potential opportunities to involve partners from unrepresented sectors
  - Medical home representative
  - Early care and education
- Find ways to maximize services/supports available to Collaborative members and the families they serve
  - Develop a common intake form
  - Develop referral process (e.g., experience in Norwalk)
  - Develop a data agenda and common agreement on what signifies success
  - Find ways to coordinate services/supports outside of meetings (e.g., directory of expertise)

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HCCC SUBMITTED COMMENTS

MEMO

TO: Jeffrey J. Vanderploeg, Ph.D
Associate Director, Center for Effective Practice
Child Health and Development Institute

FROM: Marijane Carey on behalf of the Hartford Care Coordination Collaborative

DATE: June 9, 2014

RE: Comments on the State's Children's Mental Health Plan

The following comments are from members of the Hartford Care Coordination Collaborative, which was established in June 2010 as a vehicle for bringing Hartford area care coordination providers together in order to:

- learn about the services available from each organization that offers care coordination;
- identify barriers that prevent maximizing the coordination of resources for the range of services that families need;
- develop an ongoing process for more communication, better coordination and timeliness of services/care offered to families;
- address on both a direct service and systems' level the obstacles confronting families in securing appropriate services in a timely manner; and
- create a collaborative process that can be replicated in other regions of the state.

A meeting was held on May 9 for the purpose of discussing access to and the provision of mental health care services as experienced by care coordinators and the children and families with whom they work.
Organizations represented at this meeting were:
Community Health Network of CT (*Nancy Crespo, Rene Frost, Kara Rodriguez, Kim Sherman*)
The Department of Social Services (*Erica Garcia and Fatmata Williams*)
CT Family Support Network (*Tesha Imperati*)
The Special Kids Support Center at CT Children's Medical Center (*Ann Riley, Susan Roman and Allison Wilson*)
Department of Public Health (*Robin Tousey-Ayers*)
The Office of Community and Child Health at CT Children's Medical Center (*Eminet Feyissa*)
The Medical Legal Partnership/Center for Children's Advocacy (*Bonnie Roswig*)
Child Development Infoline/ United Way of CT (*Shirley Caro and Kareena DuPlessis*)

Check the area of behavioral health for which you are providing input:

√ Child welfare system and mental health
√ Educational system and mental health
√ Infant and early childhood mental health
√ Integrated medical and mental health care

The Hartford Care Coordination Collaborative and comments made by members of this group can be used in the Children's Behavioral Health Plan or in any other planning document.

What are the strengths of Connecticut's service system and services for children and families?

- Connecticut is doing a better job than many other states.
  Connecticut has:

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  - 2-1-1
  - Emergency Mobile Psychiatric Services (EMPS)
  - Evidence based models of treatment
  - A child centered medical center
  - Enhanced care clinics
  - Support programs, such as Family Support Network, CT Chapter of the National Alliance on Mental Illness (CT NAMI) and CT FAVOR, Inc.
  - Use of the Ages and Stages, Social/Emotional Questionnaire (ASQ-SE)
- The work being done in the area of infant mental health by the CT Association for Infant Mental Heath
- The increase awareness of the impact of psychological trauma on children and those who care for them
- The establishment of the pediatric consultation line for help from child psychiatrists
- The establishment of regional care coordination collaboratives modeled after the one established in Hartford. Through funding from the Department of Public Health (DPH), the Children and Youth with Special Needs (CYSHCNs) section, the five regional collaboratives will serve as a "shared resource" model of care coordination designed to assist children, families and providers in securing services in an efficient and timely manner.

What are the major areas of concern about Connecticut's service system and services for children and families?

- The stigma associated with having and/or seeking help around a mental health issue can be paralyzing. Families fear that they will lose their child if the Department of Children and Families (DCF) becomes involved, which is problematic when a family is considering voluntary services.
- Workforce issues -- "How do we get the right people (with the appropriate training) in the right job" who are then available to efficiently triage to the proper resource. There is also a need for a mental health workforce that is racially and ethnically representative of the families needing services.
- There is a lack of timely responses to requests for assistance. Issues need to be addressed at the time when the family is seeking information, guidance and assistance. Delays in responding are lost opportunities that often escalate into crisis situations.
- Pediatric care providers are not comfortable dealing with mental health issues. They do not have the training, time or ability to bill for the provision of mental health services. They don't know how (or have the time) to find the resources that could help a child and family.
- There is no integration of medical and behavioral health services which creates system level barriers in obtaining care in a timely manner. It was noted by a meeting participant that over 50 per cent of calls to PCPs are behavioral health related, which is consistent with the finding that nearly half of all Americans will develop a mental health illness during their lifetime as stated in the January 2012 issue of the American Hospital Association's Trendwatch. Representatives from the Department of Social Services (DSS) and Community Health Network (CHN) talked about their long term commitment to address this issue and originally thought by simply sharing resource information the problem would be addressed. Focus has now evolved to working on a systems level approach. See recommendations section of more information.
- Another systems level barrier is the inability to share information due to HIPAA requirements. While confidentially must be honored, it is sometimes a barrier that a family is willing to waive
- More needs to be done within schools. Need to be prepared to do more where children are. Meeting participants shared incidences of children being taken to the emergency departments and in some cases having the police involved. Resources, such as school based health centers and school

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nurses, need the training and support to address the needs of children on site whenever possible. Bringing mental health services on site is another option.
- While Connecticut provides evidence based services, they are limited to due eligibility criteria, wait lists and inadequate funding. More funding is needed to support and expand evidence based services.
- More funding is needed for autism spectrum disorders.
- Lack of services for children who fall into the ”grey” area. CT has the resources to serve children with high end and low end of mental health needs, but families struggle to find services for their kids who are beyond having a low need and are trying to obtain services before there is a crisis.
- There is a lack of continuity of care. This is due to staff turnover at mental health agencies and when children transition from one system to another, such as aging out of DCF services and moving into the Department of Mental Health and Addiction Services (DMHAS) system for young adults. The transition needs to be well planned and thoughtful.
- There is a need to be holistic and to learn the histories of children seeking help. Traumatic histories, family dynamics and involvement with the local community and service delivery systems affect the health and well- being of children.
- Systems and the services offered within these systems need to be designed from a family perspective. There is a lack of communication with parents around their rights and responsibilities and what to expect with the mental health treatment their child is receiving. As a result of this lack of communication, parents often get discourage, don’t keep appointments and are labeled as non-compliment.
- There is a limited number of providers of mental health services, especially for young children (ages birth to three)
- There is limited private insurance coverage for mental health services, which deters families from seeking services.

What are your recommendations for improving Connecticut’s service system and services for children and families?
- While we support and encourage efforts to reduce the stigma of mental health illnesses, we are proposing consideration of changing the agency responsible for children’s mental health from DCF to DMHAS. Despite best efforts to reduce stigma in seeking help, as the state’s child welfare agency, families will continue to be reluctant to seek care from DCF.
- Look at high level system integration of primary care and mental health providers.
    - Work to support the implementation of the National Committee for Quality Assurance’s (NCQA) 2014 Person Centered Medical Home (PCMH) standard related to mental health
        - The new standards further integrate behavioral health into PCMH. Practices are encouraged to disclose their behavioral health care capabilities to patients and establish formal collaborative agreements with behavioral health care providers.
    - Explore implementing recommendations from Agency for Healthcare Research and Quality's (AHRQ) Academy for Integrating Behavioral Health in Primary Care, including the development of a shared lexicon for behavioral health and primary care providers.
    - Create more opportunities for co-management of patients and/or co-location of services.
- Work on integrating into electronic medical records information needed to care for children in a comprehensive and holistic manner.
- Workforce development issues
    - Support the CT Infant Mental Health Association’s endorsement process.

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    - Look at the licensing process for clinicians as a way to accurately identify areas of expertise that can be substantiated through education, training and expertise. Share this information with those (providers and families) seeking referrals.
    - Recruit and train minorities for positions in the mental health field.
- Move CT toward being a trauma informed state by ensuring that all systems/services that touch children and their families offer trauma informed care. If trauma is not recognized and reflected in the Children's Mental Health Plan it will not be successful to serving some of the state's most vulnerable children.
- As they become operational, monitor the work done in the regional Care Coordination Collaboratives to determine the impact of this "shared resources" effort on the provision of mental health services for children and their families.
- Consider drafting legislation, similar to Vermont's which calls for integrating screening for adverse childhood experiences in health services, and for integrating the science of adverse childhood experiences into medical and health school curricula and continuing education. (Vermont update: Only a fraction of bill H. 762, The Adverse Childhood Experience Questionnaire, passed but the proposed legislation provides guidance on drafting a CT bill.)
- Increase funding for evidence based mental health services for children.
- Increase mental health screening efforts, especially for adolescents.
- Increase culturally competent promotional activities around children's mental health.

Hartford Care Coordination Collaborative

The Feasibility and Value of a "Central Utility, Shared Resource" Care Coordination Model

Office for Community Child Health, Connecticut Children's Medical Center
Child Development Infoline, United Way of Connecticut

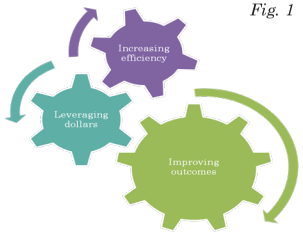
Background

- The Hartford Care Coordination Collaborative (HCCC) was established in June 2010 in response to the gaps and inefficiencies in the service delivery systems that care coordinators were attempting to negotiate on behalf of families, as identified through the *Help Me Grow* experience.

- The Collaborative was developed to:
  - Increase knowledge of those who work with children and families about available resources and services
  - Reduce duplication in service provision
  - Help families navigate complex systems of care
  - Help care coordinators from a variety of child services sectors help the children and families with whom they work.

- HCCC "coordinates" the care coordinators by **facilitating communication, cross-sector collaboration,** and **resource sharing.**

Fig. 1



- "Central utility, shared resource" care coordination is an **innovative** model that utilizes a **collective impact** approach to achieve **system level** outcomes and **cost savings**.

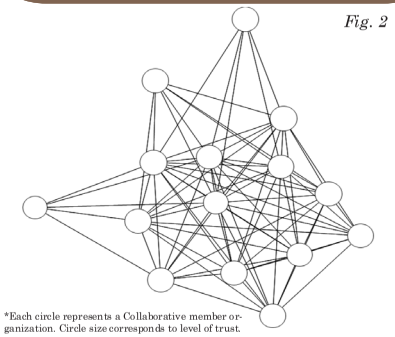
Strength of Partnerships

HCCC used **PARTNER**, a validated social network analysis tool, to assess the quality of Collaborative partnerships.

Results from the survey showed:

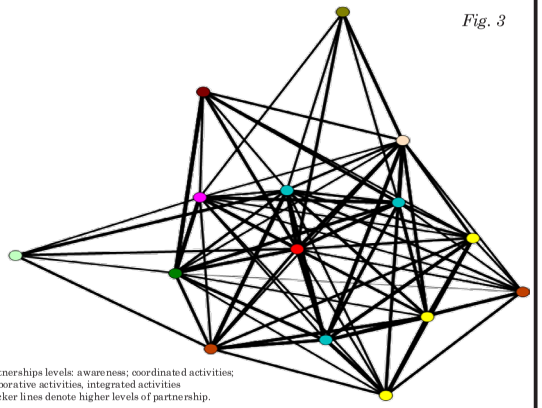
- Robust partnerships, as shown by thick connecting lines in the network map (Fig. 3)
- High density of connections among members (Fig. 3)
- High levels of centrality in the network map (Fig. 3)
- Uniformly high levels of trust, as shown by high trust scores. Trust combines metrics of reliability, mission alliance, and openness to discussion. (Fig. 2)

Fig. 2



*Each circle represents a Collaborative member organization. Circle size corresponds to level of trust.

Fig. 3



*Partnerships levels: awareness; coordinated activities; collaborative activities, integrated activities
*Thicker lines denote higher levels of partnership.

Group Key

- Community-based care coordination
- Consultant
- Funder
- Administrative services organization
- Medicaid carve-out
- Medical home care coordination
- State agency
- Family organization
- Legal/advocacy organization
- Mental healthcare provider

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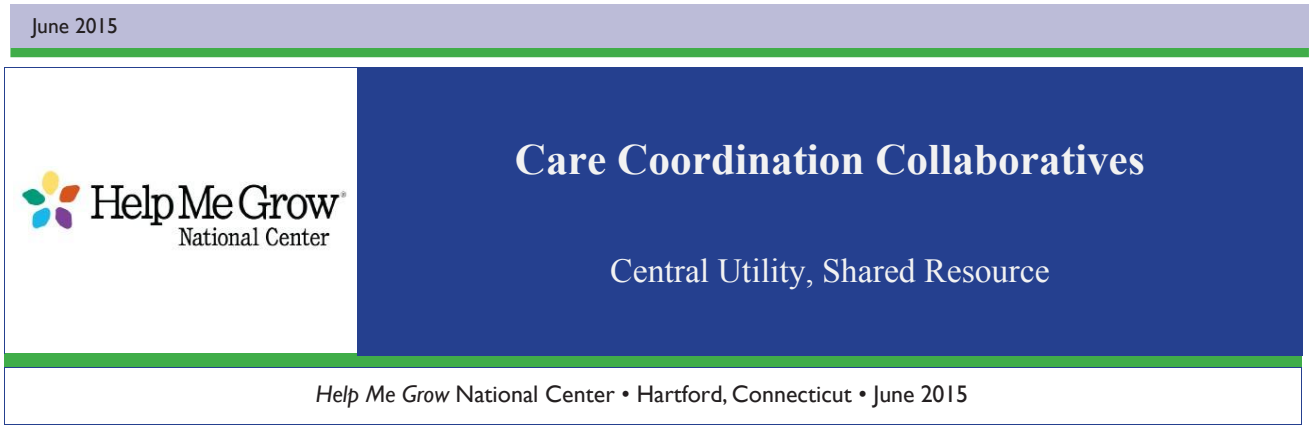

What Is A Care Coordination Collaborative?

Care Coordination (CC) Collaboratives are local coalitions of people from the all the sectors related to early childhood development: health, early childhood care and education, family advocacy, law, home visiting programs, and state agencies, and more. They come together to learn from one another, identify areas of shared need, develop inter-agency solutions to common problems, and discuss emerging challenges and connect with others engaged in improving access to services for vulnerable children and families.

Why Are Care Coordination Collaboratives Important?

Research consistently shows that services designed to assist families in caring for young children are often difficult to find and access. In an effort to address this documented problem, many organizations have hired and trained care coordinators. However, many care coordinators are limited in their work by the purpose and scope of their organizations. As a result, care coordination is often done in silos and lacks the comprehensive and holistic approach needed to address the full range of families' needs.

Background Information on the Innovation: The Connecticut Experience

In 2009, the Hartford Area Care Coordination Collaborative (HCCC) was established as a vehicle to improve communication among diverse programs providing care coordination to children and families; increase the efficiency and effectiveness of care coordination within a comprehensive child health system; and serve as a resource for medical homes seeking community-based services for their families. The goal was to coordinate the coordinators and ensure that children and families were connected to services across several sectors as effectively and efficiently as possible. The Care Coordination Collaborative has now become the care coordination model for Children and Youth with Special Health Care Needs (CYSHCN) services in Connecticut, and is being expanded to address the needs of all vulnerable children.

The Collaborative model brings together the care coordinators from a variety of child serving sectors with regularly scheduled meetings to do the following:

- Learn, through presentations from area/state resource providers, about services for children and how to help families access them;
- Collectively review challenging cases and develop cross sector solutions to meeting children's and families' needs;
- Develop and advocate for policy level solutions to families' struggles in connecting to services; and
- Support pediatric primary care in meeting the care coordination needs of families.

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June 2015

Collaborative members include care coordinators from child welfare, Medicaid, mental health services, home visiting and Title V CYSHCN services. United Way 211 Child Development Infoline, *Help Me Grow*'s central access point in Connecticut, staffs Collaborative meetings and activities.

The HCCC has designed and tested a set of tools to measure the impact of their work. The Collaborative has improved connection among child serving sectors, increased knowledge about resources available for children and families and maintained strong connectivity among members as well as with outside organizations.

With a grant from the W.K. Kellogg Foundation, "Diffusing Successful Innovations to Promote Vulnerable Children's Healthy Development," the *Help Me Grow* National Center is working with affiliates to establish, operate and share their experiences in creating care coordination collaboratives in order to improve access to services.

My personal enthusiasm for this model is boundless. It epitomizes our commitment to system building in support of young children's healthy development. It demonstrates the importance of data collection. It shows that we can address gaps and capacity issues, and that our vibrant, engaged and committed affiliate network can indeed embrace innovations and solve gaps and capacity issues to the betterment of children and families.

Paul Dworkin, M.D.
Founder, Help Me Grow
Executive Vice-President, Community Child Health Director,
Office for Community Child Health,
Connecticut Children's Medical Center

Help Me Grow National Center

Connecticut Children's Office for Community Child Health

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ENHANCED PRACTICE PACKET FROM SPECIAL KIDS SUPPORT CENTER OF CONNECTICUT CHILDREN'S MEDICAL CENTER

APPENDIX B

ENHANCED SUPPORT FOR CHILD HEALTH PROVIDERS TO EXPAND CARE COORDINATION

Increased care coordination capacity can be achieved by providing practices with education and training; deploying highly skilled care coordinators to support children with complex conditions; and bridging practices to the CC Collaborative.

To help practices in meeting many of the PCMH standards for National Committee for Quality Assurance (NCQA) recognition, a CC Collaborative can:

- educate practice staff on the medical home model;
- offer training for level 1 care coordination (simple request for resources and referral information);
- offer training for level 2 care coordination (short-term care coordination for specific needs); and
- provide care coordination for level 3 patients (long term care coordination for complex patients).

Moreover, access to care coordination collaboratives help practices connect directly with organizations that can provide appropriate and timely services and resources to their families.

Those involved in your *Help Me Grow* outreach to pediatric providers and your *Help Me Grow* physician champions are excellent resources for serving as conduits between the Collaborative and pediatricians.

Defining Populations with Greater Needs For Services

Children and youth with special health care needs and vulnerable children are at greater risk for poor health outcomes and greatly benefit from receiving care coordination services within their medical homes. To best serve their needs, we need to agree on definitions for common terms.

Definition of Children and Youth with Special Health Care Needs

Children and youth with special health care needs (CYSHCN) "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required by children generally"[1]

Definition of Vulnerable Children

"Vulnerable children are at risk for adverse developmental and health outcomes by virtue of their exposure to the cumulative impact of risk and protective factors, as well as the timing of exposures."[2]

1 D Cooley, W. C., & McAllister, J. W. (2004). Building medical homes: Improvement strategies in primary care for children with special health care needs. Pediatrics, 113(5), 1499. Retrieved from http://pediatrics.aappublications.org/content/113/Supplement_4/1499.full.html

2 Neal Halfon, MD, MPH

APPENDIX B

Definition of Risk Factors

Households without English speakers: Children in households where all members over age 14 years speak a non-English language and are not proficient in English

Large family: Children in families with four or more children

Low parental education: Children whose parents lack a high school degree

Residential mobility: Children in families who have changed residences one or more times in the last 12 months

Single-parent: Children in families with one unmarried parent in the household

Teen mother: Children whose mothers were teenagers when the child was born

Non-employed parent(s): Children whose parents had no employment in the previous year

Definitions of Economic Hardship

Extreme poverty: Less than 50% of the Federal Poverty Level[3]

Poverty: Less than 100% of the Federal Poverty Level

Low-income: Less than 200% of the Federal Poverty Level

Levels of Care Coordination

Care coordination is broken down into three levels based on the assistance a patient/family needs. Practices can utilize this tool to connect patients and families to basic resources before they even leave the office (levels 1 & 2).

Some practices may be able to support level 3 care coordination work. If not, practices should reach out to the Medical Home Initiative in their state. (See the AAP National Center for Medical Home Implementation http://www.medicalhomeinfo.org/state_pages/)

Level 1 – A simple request for resource(s) and referral information

STEPS FOR LEVEL 1

Link to community, services, and resources

Level 2 – Short-term care coordination for specific needs

3 For a family of three, the 2012 FPL is $19,090. For more information on the Federal Poverty Level, go to: http://aspe.hhs.gov/poverty/12poverty.shtml

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Children with special health care needs may be at risk due to life circumstances (environment, socioeconomic status, basic needs, etc.) and/or be medically complex and need assistance with coordinating multiple services

STEPS FOR LEVEL 2

Perform a needs assessment (See appendix for sample tool)
Collaborate with others involved (Specialists, Agencies, Schools, etc.)
Refer the patient/ family to available resources

Level 3 – More intensive care coordination that may be long-term

Children who are medically fragile/complex or are at risk due to psychosocial and environmental issues. These children may experience barriers with their existing resources. Caregivers may need continual guidance and redirection.

STEPS FOR LEVEL 3

Perform an intensive needs assessment and comprehensive care plan
Monitor and modify the care plan according to child's needs
Collaborate with two or more providers (i.e. Specialists, Medical Legal Partnership, Therapists and Schools, etc.)
Conduct home visits as needed
Attend meetings/case conferences as needed on case by case basis

(Appendix B: Care Plan with Needs Assessment)

Engagement Process for Working with Primary Care Practices

The HCCC Experience

The following steps show how the HCCC has engaged primary care practices.

SEND LETTER to medical home contacts to discuss collaborative and offer training for the practice. The collaborative director or member responsible for medical home contacts sends letter. (See Appendix B: Sample Letter to Practices)

MEET WITH the practice to provide general overview

Pre-Assessment Tool

EPIC care coordination training by Special Kids Support Center (SKSC) staff or your collaborative medical home component

Review of screening process to identify level one, two or three care coordination needs

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Referral process to SKSC for care coordination services for level 3 patients

Post-Assessment Tool

IDENTIFY LIAISON with practice (office manager, provider, other)

Identify process for positive screener/positive needs

Identify process for positive screener/negative needs and negative screeners

SETTING UP THE FIRST IN-PERSON VISIT

The first visit is an opportunity that only comes once. **First impressions matter.**

The first visit with a practice is an opportunity to establish both a relationship and credibility. Therefore, thoughtful preparation is very important. Ideally, more time will be allotted for this first visit than for subsequent ones as there are several items to cover.

Though there are several potential functions of the first visit, the key ones include: building relationships and trust; establishing ground rules and expectations; identifying strengths and concerns at the site; and sharing tools and resources that can support the practice in getting started with the transformation work. On the following pages are some of the strategies and activities that can help facilitate a great initial site visit.

BEFORE THE VISIT

Do some research. Prior to any initial contact, do some research on their practice. Note who the staff is and their roles. View their website if they have one to see what and how they are presenting to the world. Look for participation in other initiatives or projects, what kinds of resources they have available for their patients, any data, and any information on their key leaders.

Set up a call with senior leadership at the practice. Use this call to better understand their intentions for care coordination assistance and to assess their understanding of the amount of effort and time needed to meet their care coordination needs. Discuss overall expectations and how you will work with them. Make clear who you expect to attend the visit so it can be scheduled to accommodate all team members.

Identify tools and resources. Based on your conversations and research, think of what tools you can take to the visit that may be useful to the team. Consider what has been useful with similar organizations and initiatives.

Set an agenda. Make sure you know how much time you will have with the leadership and with the team members. Consider the key activities you want to accomplish and information you'd like to gather and prioritize how you will use your time. Share the agenda ahead of time with attendees.

Schedule the visit. Ideally, use a regularly scheduled team meeting time if they have one or a time that all

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team members can be available.

DURING THE VISIT

Make introductions. Briefly introduce yourself and your background to establish credibility, but remember this visit is about them. Have all team members introduce themselves and their role at the site. Ask questions to elicit more detail and to show interest. Identify the key contact person (or people) with whom you will interact regularly.

Do an overview. Share what you will do for and with them. Include how often you intend to do site visits, types of support you can offer, and how you will provide feedback to them.

Identify barriers and resources. Ask them to identify things they do really well in the process of coordinating their patient's needs. Ask the senior leader on the team (maybe an MD or an administrative executive), to share their vision for participation and how they intend to support care coordination.

Share tools. Take time to share any tools you have developed. (Needs assessments, description of care coordination levels, screeners, regional resources, etc.)

Identify team meeting time. Ideally, the team will already have a regular meeting time established. If not, make setting one a priority. They may choose to do this as a weekly meeting or may choose formal meetings once a month.

Ask for feedback. Do a short debrief of the visit and identify any topics that didn't get covered or need additional attention.

Establish a next meeting time and action items. This may be a call or another site visit, as appropriate. Use their already set team meeting time if possible.

AFTER THE VISIT

Summarize visit. Take time to write down any additional thoughts or observations that you observed during the visit.

Send a thank you note. Acknowledge the time and effort of the team members and the senior leadership. Let them know you will be following up soon with answers to any questions and next steps. Include your contact information and the best times and ways to reach you.

Contact experts. Gather answers to any questions the team had that you could not answer.

Send materials. Once you've received answers to their questions, send those along with any tools and

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resources identified as needed during your visit. These may include forms and templates, process improvement content, examples from other organizations, and links to other resources.

PRE & POST ASSESSMENT TOOL GUIDELINES

The Pre-Assessment Tool is designed to obtain a baseline assessment of the practices' knowledge of care coordination and available community services and resources. It includes questions about the patient population and attitudes on how well their patients are served in the community.

The six-month Post-Assessment Tool is intended to determine if the primary care providers have made changes to their practice as a result of receiving enhanced care coordination training. Those changes include:

- engaging in level 1 and 2 care coordination activities;
- referring to the regional medical home for complex care coordination; and
- utilizing the tool kit.

(Appendix B: Pre and Post Assessment Tools, NCQA 2014 Standards with Focus on PCMH Coordination, and Examples of HCCC Practice Supports)

TOOLS & RESOURCES

Care Plan with Needs Assessment

Sample Letter to Practices

Pre and Post Assessment Tools

NCQA 2014 Standards with Focus on PCMH Coordination

Examples of HCCC Practice Supports

CHNCT PCMH 2014 Recogniti manual?)

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CARE PLAN WITH NEEDS ASSESSMENT

Connecticut Children's Medical Center
Special Kids Support Center
282 Washington Street
Hartford, CT 06106
Toll Free: 877 835-5768

North Central Connecticut
Medical Home Initiative for
Children and Youth with
Special Health Care Needs*

NEEDS ASSESSMENT AND PORTABLE CARE PLAN

Date: _____

Screened P ☐ N ☐
Chart / Needs Y ☐ N ☐

Child/Youth's Name: _____ Date of Birth: _____

Parent / Caregiver: _____ Relationship: _____

Phone #: _____ PCP: _____

Diagnosis /History: _____

Specialists: _____

Medications: _____

NEEDS ASSESSMENT:

	Has	Needs	N/A		Has	Needs	N/A		Has	Needs	N/A
Birth to 3	☐	☐	☐	Financial Assistance	☐	☐	☐	Mental Health	☐	☐	☐
Child Care	☐	☐	☐	Food/Nutrition	☐	☐	☐	Shelter/Housing	☐	☐	☐
Dental	☐	☐	☐	SNAP	☐	☐	☐	SSI	☐	☐	☐
Education	☐	☐	☐	WIC	☐	☐	☐	Transition	☐	☐	☐
Safety	☐	☐	☐	Medical	☐	☐	☐	Transportation	☐	☐	☐
Emergency Planning	☐	☐	☐	Developmental Screening 0-5 yr	☐	☐	☐	TANF (cash assist)	☐	☐	☐

Other: _____

PORTABLE CARE PLAN: N/A ☐

GOALS	ACTION	Completed By:
		☐ Family ☐ MHI ☐ Other
		☐ Family ☐ MHI ☐ Other
		☐ Family ☐ MHI ☐ Other

Care Coordinator: _____ Date: _____

Care Coordinators at Special Kids Support Center

Brenda Machado | **Debbie McAdams, RN** | **Rachelle Tirrell, RN**
Allison Matthews-Wilson, LCSW | **Katherine Ramírez, MS** | **Laura Knapp**
Ann Riley, MSN RN | **Jessica Lozada** | **Susan Roman, MPH RN**

*The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs is a program supported by the State of Connecticut Department of Public Health. Information is available on their website at www.ct.gov/dph

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SAMPLE LETTER TO PRACTICES

Connecticut Children's Medical Center
Special Kids Support Center
Medical Home Initiative - North Central Region
SAMPLE LETTER

Date:

Dear Dr.

The American Academy of Pediatrics defines the concept of the medical home as a mutually responsible and respectful relationship between care providers and their patients and families. Care coordination is a critical component of this health care delivery model. Providing care coordination ensures optimal quality, while minimizing cost, encouraging family centered care, and demanding partnerships across public and private sectors. Moreover, children and youth with special health care needs and vulnerable children are at greater risk for poor health outcomes and greatly benefit from receiving care coordination services within their medical homes.

The Special Kids Support Center (SKSC) has been providing culturally competent care coordination to its patients and families for many years. Through our role as the lead for the regional Hartford Care Coordination Collaborative, we have been able to collaborate with many partners and agencies in the State of Connecticut to insure that children with special needs are being served appropriately. **SKSC is in the unique position to help build care coordination capacity in your practice.** The Center can provide the following:

1. **Offer E.P.I.C Training (Educating Practices In the Community) on care coordination**

2. **Assist with Patient Centered Medical Home-NCQA recognition for care coordination standards**

    a. **Train staff to provide basic/intermediate care coordination (level 1 & 2)**

    b. **Provide your practice with a customized binder of regional services and resources and/or website information**

    c. **Provide care coordination for children with complex medical, behavioral, social conditions (level 3) through SKSC staff of Registered Nurses, Licensed Clinical Social Workers, and Community Care Coordinators**

3. **Provide access to the Hartford Care Coordination Collaborative (a shared resource model of care coordination to support medical homes seeking community-based services for their families)**

If your practice is interested in participating or learning more about the Medical Home Initiative and Care Coordination, Please contact us at [INSERT YOUR PHONE NUMBER].

Best regards,

[INSERT NAME]

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PRE-ASSESSMENT TESTS

[INSERT YOUR HEADER]

Practice Care Coordination Training
Pre-Assessment Tool

Date: _____

Practice Name: _____ City/Town: _____

Number of Clinicians:

MD's ____ APRN's ____ PA's ____ Other ____

Who took the lead in completing this form? _____

Title/ Role/ Position: _____

Phone: _____ Contact E-mail: _____

Who should we contact if we have questions about your responses? _____

Name (if different than person completing this form): _____

Best phone number to reach contact if different than above: _____

---

1. Is there a Care Coordinator working at your practice that supports children, youth and families?
   YES ___ NO ____
2. What is the estimated number of children that your practice cares for? _____
3. What is the estimated percentage of children with special health care needs in your practice?
   (Check one) 0-20% ___ 21-40% ____ 41-60% ___ >60% ____
4. Estimate how many children in your practice are in need of care coordination services at this time: _____
5. Score your knowledge regarding care coordination at this time:
   VERY POOR ___ POOR ___ ADEQUATE ___ GOOD ___ VERY GOOD ___
6. At this time, are you aware of various services and supports for your children and youth with special health care needs?
   YES ___ NO ____
7. At this time, do you feel that children and families with special health care needs are adequately being served beyond their medical conditions?
   YES ___ NO ___
8. What issues are most pressing for your population of children? *(Check all that apply)*
   Educational ___ Mental Health ____
   Financial ___ Social *(Basic needs, housing, food)* ____
   Medical/Dental ___ Developmental Delays ____

THANK YOU FOR COMPLETING THIS SURVEY!

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POST-ASSESSMENT TESTS

[INSERT YOUR HEADER]
Practice Care Coordination Training
Post-Assessment Tool

Date: _____

Practice Name: _____ City/Town: _____

Who took the lead in completing this form? _____

Title/ Role/ Position: _____

Phone: _____ Contact E-mail: _____

---

1. Have you utilized the care coordination binder since the initial care coordination training?
   Yes _____ No _____
   i. If yes, how often:
      1. Once _____
      2. Once a week_____
      3. More than once a week_____
      4. A couple of times a month_____
   ii. If no, why?
      1. Didn't need to use it_____
      2. Forgot we had it _____
      3. Too busy _____
      4. Not user friendly _____
   iii. Is the binder helpful?
      Yes _____ No _____ Comments:
   iv. Are there additional resources that you would like in the binder?
      Yes _____ No _____ Comments:

2. Have you called the Special Kids Support Center for technical advice since your training?
   Yes _____ No _____
   Was it helpful? Yes _____ No _____
   Additional Comments:

3. Would you be interested in having the staff present in the office to assist with care coordination?
   Yes _____ No _____

4. Additional Comments/feedback:

THANK YOU FOR COMPLETING THIS SURVEY!

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NCQA CARE COORDINATION STANDARDS PAGE 1

NCQA 2014 Standards with Focus on PCMH Care Coordination

A Medical Home:

- Delivers "whole-person," coordinated care to transform primary care into "what patients want it to be"
- Prizes clinician-patient relationships to keep patients healthy between visits
- Supports "team-based care" that frees providers to work to their highest level of training
- Aligns use of information technology to help providers support the Triple Aim and improve population health

6 Standards / 27 Elements

1. Enhance Access and Continuity
2. Team-Based Care
3. Population Health Management
4. Plan and Manage Care
5. Track and Coordinate Care
6. Measure and Improved Performance

2014 Standard Updates: Major Enhancements

- Team-based care
- Behavioral and mental health integration
- Measuring health care costs
- "Meaningful Use" alignment
- Continuous improvement
- Care coordination

Standard 4: Care Management

A. Identify Patients for Care Management
B. Care Planning and Self-Care Support
C. Medication Management
D. Use Electronic Prescribing
E. Support Self Care and Shared Decision-Making

Intent of Standard

- The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

Meaningful Use Alignment

- Practice implements evidence-based guidelines
- Practice reviews and reconciles medications with patients
- Practice uses e-prescribing System
- Patient-specific education materials

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NCQA CARE COORDINATION STANDARDS PAGE 2

Standard 5: Care Coordination and Care Transitions

A. Test Tracking and Follow-Up

B. Referral Tracking and Follow-Up

C. Coordinate Care Transitions

Intent of Standard

- Track and follow up on all lab and imaging results
- Track and follow-up on all important referrals
- Coordination of care patients receive from specialty care, hospitals, other facilities and community organizations

Meaningful Use Alignment

- Incorporate clinical lab test results into the medical record
- Electronically exchange clinical information with other clinicians and facilities
- Provide electronic summary of care record for referrals and care transitions

For more information on NCQA (National Committee for Quality Assurance) and Patient Centered Medical Home (PCMH) visit:
http://pages.ncqa.org/pcmh/?campaign=PCMH+Exact&group=PCMH&keyword=PCMH&type=exact+match&gclid=CIy14KmMssUCFYgRHwodIowAGA

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EXAMPLES OF PRACTICE SUPPORTS

Examples of Practice Supports
The Connecticut Experience

Enhancing practices aims to assist primary care practices to deliver coordinated, accessible, comprehensive, and patient-centered care. The resources below include multiple supports and play a vital role in strengthening practices ability to provide optimal healthy development.

Professional Education

- **Academic Administration/Continuing Medical Education**
  This CT Children's Medical Center based program offers programming, in-services, and training to physicians and their practices on the trends, challenges and advancements that affect the vulnerable and special needs populations they serve.

  For further information visit (http://cme.connecticutchildrens.org/).

- **Child Health and Development Institute of Connecticut: Educating Practices In Connecticut (E.P.I.C)**
  It aims at improving the content and delivery of child health services by assisting providers in implementing practice changes that are supported by community and State resources. There are currently 17 models of EPIC presentations focusing on issues from Post-partum to Autism screening and Lead-Poisoning.

  For further information visit (http://www.chdi.org/our-work/health/educating-practices-community-epic/).

- **Regional Pediatric Services (RPS)**
  This group provides linkage between community physicians and the CT Children's Medical Center by developing relationships, offering "Lunch and Learn" talks, webinars, serves as major regional pediatric education resources, as well as a database of communications and publications. They also assist primary care providers to navigate the hospital's services and system.

Resources

- **Access Mental Health**
  The goal is to provide live-time pediatric psychiatry consultation teams throughout the State to help Primary Care Providers meet the needs of children and adolescents with mental health challenges during their clinic visit.

  For further information visit (http://www.accessmhct.com/).

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EXAMPLES OF PRACTICE SUPPORTS

- **Child Development Infoline**
  Child Development Infoline (CDI) is a specialized unit of United Way of Connecticut. CDI care coordinators provide education on development, behavior management strategies and programs, make referrals to services, and provide advocacy and follow-up as needed. This is the gateway for parents, providers, and pediatric professionals to help families connect with various programs.
    - Children and Youth with Special Health Care Needs (Birth to Age 21)
    - Connecticut Birth to Three System (Birth to 36 months of age)
    - Help Me Grow (Birth through Age 8)
    - Early Childhood Special Education (Ages 3 through 5)

  For more information visit http://www.ctunitedway.org/cdi.html.

- **Medical Legal Partnership Project (MLPP)**
  A department of the Center for Children's Advocacy, this group offers on-site (based in 5 statewide hospitals) traditional legal representation with a comprehensive approach to the healthcare and mental health care needs of each child. They offer in-services, trainings and consultations to practices.

  For further information visit (http://www.kidscounsel.org/our-work/aboutus_programs_mlpp/).

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CHNCT PCMH 2014 RECOGNITION CHECKLIST PAGE 1

CHNCT PCMH 2014 Recognition Checklist

(Standards 4 and 5)

Practice Name: **Completed by:** **Date:**

Standard		*Requirement*							
PCMH 4: Care Management and Support									
Element 4A - Identify Patients for Care Management (4 points)									
☐	1. Behavioral health conditions	☐	Process that describes the criteria for identify patients (Note: these patients are used to draw a sample (30 patients) for the Record Review Workbook)						
☐	2. High cost/utilization	☐							
☐	3. Poorly controlled or complex conditions	☐							
☐	4. Social determinants of health	☐							
☐	5. Referrals for care management by outside entities (e.g. insurers), practice staff or patient/family/caregiver	☐							
☐	**6. Monitor the % of total patient population identified in factors identified in 4A**	☐	**Report showing the number and % of the total patient population**						
Comments:									
Element 4B - Care Planning and Self Care Support~MUST PASS (4 points)									
☐	1. Incorporates patient preferences and functional/lifestyle goals	☐	Recent 3 Month Report	**Or**	☐	Record Review Workbook (RRWB)	**And**	☐	Example demonstrating how each factor is documented
☐	2. Identifies treatment goals	☐			☐			☐	
☐	3. Assesses and addresses potential barriers to meeting goals	☐			☐			☐	
☐	4. Includes a self-management plan with goals and ways to monitor self care	☐			☐			☐	
☐	5. Is provided in writing to the patient/family/caregiver	☐			☐			☐	
Comments:									
Element 4E - Support Self-Care and Shared Decision Making (5 points)									
☐	1. Uses E.H.R. to identify patient-specific education resources and provides them to > 10% of patients	☐	Recent 3 Month Report **(Core MU)**						
☐	2. Provides educational materials and resources to patients	☐	3 examples of resources, tools **or** aids covering 3 separate conditions/topics						
☐	3. Provides self-management tools to record self-care results	☐							
☐	4. Adopts shared decision making aids	☐							
☐	5. Offers or refers patients to structured health education programs, such as group classes and peer support	☐							
☐	6. Maintains a current resource list of importance to the patient population including services offered outside the the practice and it affiliates	☐	Materials demonstrating 5 resources of topics or key community service areas of importance						
☐	7. Assesses usefulness of identified community resources	☐	Materials or survey showing how the practice collects information on the usefulness of referrals						
Comments:									

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CHNCT PCMH 2014 RECOGNITION CHECKLIST PAGE 1

Practice Name: **Completed by:** **Date:**

	Standard		***Requirement***					
PCMH5: Track and Coordinate Care								
Element 5B - Referral Tracking and Follow-Up ~MUST PASS (6 points)								
☐	1. Considers available performance information on consultants/specialists when making referral recommendations	☐	Examples of specialist performance information					
☐	2. Maintains formal and informal agreements with a subset of specialists based on established criteria	☐	Example					
☐	3. Maintains agreements with behavioral healthcare providers	☐						
☐	4. Integrates behavioral healthcare providers within the the practice site	☐	Materials explaining behavioral health integration					
☐	5. Gives consultant or specialist the clinical question, required timing and type of referral	☐	Process	**And**	☐	5-Day Report or log or other means to show process is followed		
☐	6. Gives consultant or specialist pertinent demographic and clinical data including test results & current care plan	☐			☐			
☐	7. Has the capacity for electronic exchange of key clinical information & provides an electronic summary of care record to another provider for > 50% of referrals	☐	Screen shot AND Report (Core MU)					
☐	**8. Tracks referrals until the consultant or specialist's report is available, flagging & following up on overdue reports**	☐	**Process**	**And**	☐	**5-Day Report or log or other means to show process is followed**		
☐	9. Documents co-management arrangements in the patient's medical record	☐	3 Examples					
☐	10. Asks patients/families about self-referrals and requesting reports from clinicians	☐	Process	**And**	☐	5-Day Report or log or other means to show process is followed		
Comments:								

Element 5C - Coordinate Care Transitions (6 points)

☐	1. Proactively identities patients with unplanned hospital admissions & emergency department visits	☐	Process	**And**	☐	Report	**Or** ☐	Log
☐	2. Shares clinical information with admitting hospitals & emergency departments	☐			☐	3 Examples		
☐	3. Consistently obtains patient discharge summaries from the hospital and other facilities	☐			☐			
☐	4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit	☐			☐	3 Examples	**Or** ☐	Log
☐	5. Exchanges patient information with the hospital during a patient's hospitalization	☐			☐	Example		
☐	6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners	☐	Process					
☐	7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another facility for > 50% of patient transitions of care	☐	3 month report	**And**	☐	Screen Shot or document showing test of capablity		
Comments:								

APPENDIX C

CQI

HELP ME GROW MANUAL

Continuous Quality Improvement

Authored by MaryCatherine Arbour MD MPH
Associate Physician for Research
Division of Global Health Equity
Department of Medicine
Brigham and Women's Hospital, Boston, MA

Continuous Quality Improvement, or CQI, is the third structural requirement of a *Help Me Grow* system.

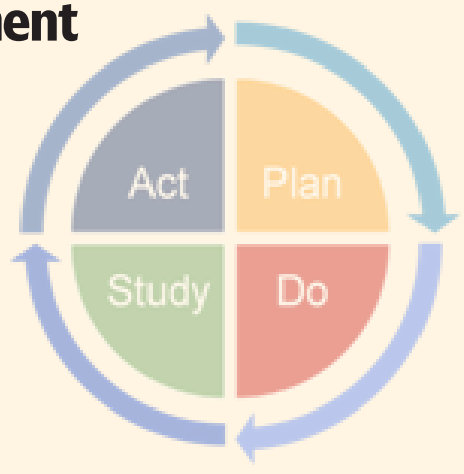
CQI is the use of a deliberate and defined process to grow a system's capability to fulfill its mission.It refers to a continuous and ongoing effort to achieve measurable improvements in the timeliness, effectiveness, and responsiveness of programs, and to optimize internal resources while improving outcomes.[i] The best quality improvement efforts help to bring forth solutions to problems experienced by service providers and people needing their services. In the case of *Help Me Grow*, CQI creates an environment and provides a method for all involved in the *Help Me Grow* system to ensure that the system remains responsive to families, service providers and system staff, and meets their needs in an ongoing way.

CQI is a practical application tied to strong, formal science. It provides methods and tools not just to know what makes things better or worse, but to make things better.[ii] Improvement does not just happen spontaneously, at least not on any consistent basis.

Improvement comes from the knowledge and creative actions of people. Improvement of quality requires an approach that will help people learn about the systems at work in their organizations and make changes to better, and more consistently, satisfy customer needs.[iii]

IN THIS SECTION:
Continuous Quality Improvement

The Model for Improvement
Examples of CQI in Action
Forming a CQI Team
CQI Team Meeting Frequency
CQI: Where to Start?
CQI: Training & Tools



Two elements that are central to CQI efforts' success in driving improvement are:

1. frequent and continuous measurement of quality, the tools to interpret those measures and a commitment to using those measures transparently with all members of the CQI team to guide organizational changes; and
2. organizational changes to implement improvements. (Organizational changes usually involve giving frontline workers, those most knowledgeable about the processes under study, new responsibilities and power.[iv])

Both of these elements can be fostered within an organization in two ways:

1. adopting a CQI model to guide and structure the work of the CQI team. There are several specific QI models that have been applied successfully in public health, including the Model for Improvement, Lean, Six Sigma, Juran's Trilogy, the Baldrige Method, the Turning Point Model. All of these models have merit and significant commonalities. Choosing one model to provide a unifying process for the CQI team is more productive and helpful than exploring or comparing multiple models and the variations between them. In this chapter, we focus specifically on the Model for Improvement; and
2. creating a local CQI team comprised of program leaders, staff, and recipients. In the case of *Help Me Grow*, CQI teams should include local *Help Me Grow* system leaders (e.g. Program Director), supervisors and front-line staff (e.g. call center manager and care coordinators), community liaisons, physician outreach coordinator, evaluator, affiliate service providers and families. Well-run CQI teams that meet regularly help all levels of an organization contribute to the positive growth and evolution of their shared enterprise.

"CQI is the process that enables adherence to *Help Me Grow* core components, while supporting teams in successful system implementation. It is how our frequent acknowledgement that '*all politics are local*' is put into operation."

—Paul Dworkin, M.D.
Founder of *Help Me Grow*

CQI Model: the Model for Improvement

The Model for Improvement, developed by Associates in Process Improvement, is a simple yet powerful tool for accelerating improvement. The model consists of two parts: addressing three fundamental questions and engaging in tests of change.[v]

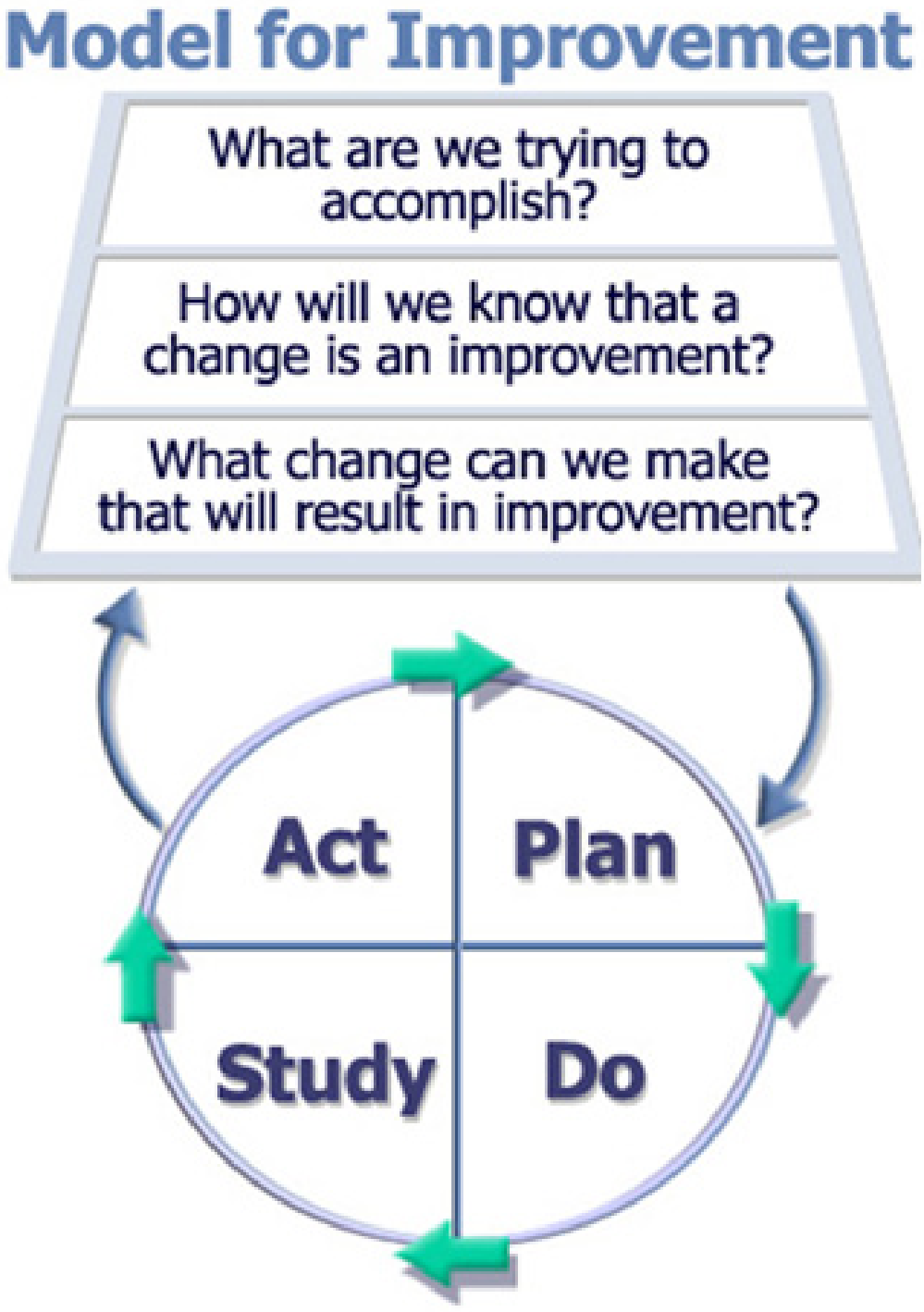


Image courtesy Associates in Process Improvement

Three Fundamental Questions

- **What are we trying to accomplish?** The improvement team develops a specific, time-limited and measurable aim statement.
- **How will we know if a change is an improvement?** The team identifies process and outcome measures to collect over time in order to track improvement and evaluate progress.
- **What changes can we make that will result in improvement?** The team identifies ideas for changes to try.

Tests of Change: Plan-Do-Study-Act (PDSA) Cycles

PDSA cycles are used to rapidly test and implement changes in real work settings by planning a change, trying the change, observing the results and acting on what is learned. The PDSA cycle guides the test of a change to determine if the change is an improvement.

The Model for Improvement stresses prediction and measurement as critical features of the PDSA cycle. Teams use PDSA cycles to test changes (initially on a very small scale in order to minimize risk), quickly identify promising ideas, and build confidence that the changes are leading to improvement. Changes that show promise are expanded for testing on larger and larger scales, until the team can be confident that the change should be adopted widely.

How to Use the Model to Test Changes and Drive Improvements

Example 1: Water & Sugar-Sweetened Beverages in a Preschool Classroom

Obesity in childhood has reached epidemic levels, and habits that contribute to obesity begin in early childhood. A quality improvement effort in preschools in Chile included a focus on promoting children's healthy development and reducing obesity.[vi]

In one preschool, the CQI team—comprised of the school principal, a preschool teacher, a teacher's aide, and parents—recognized that most children were drinking sugar-sweetened beverages at snacktime and during lunch. Sugar-sweetened beverages are known contribute to the development of obesity in childhood. They decided to do a test of change to try to eliminate sugar-sweetened beverage consumption among preschool children and to replace it with water.

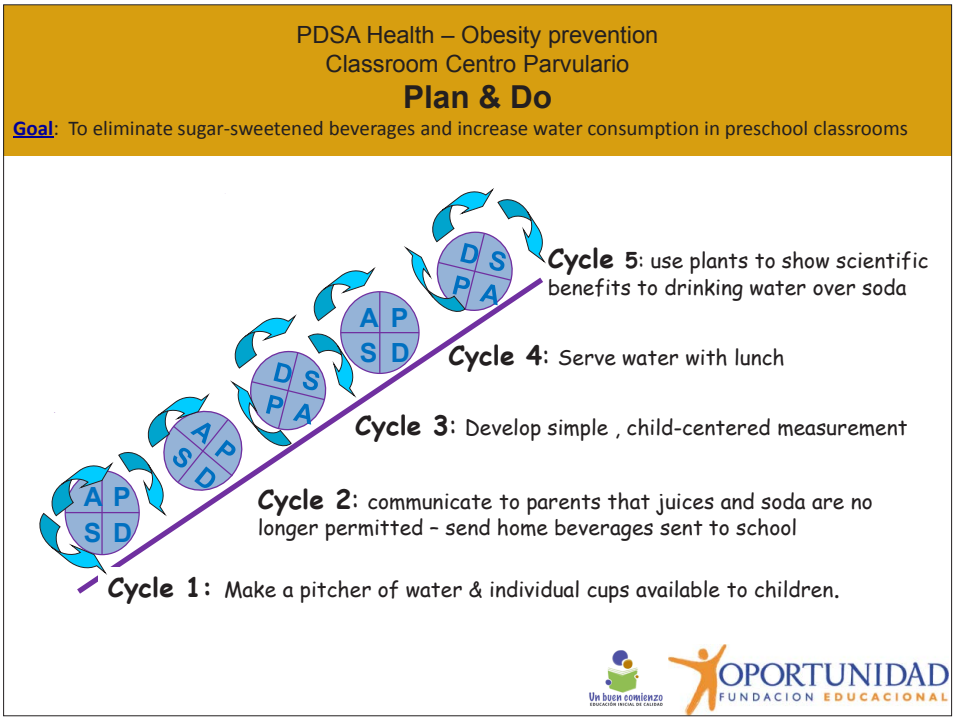
Three Fundamental Questions

- **What are we trying to accomplish?** To eliminate sugar-sweetened beverages and increase water consumption in the Preschool Center between April and May, 2012.
- **How will we know if a change is an improvement?** We will measure:
    1. the percent of children who bring sugar-sweetened beverages to school each day; and
    2. the number of glasses of water consumed per child each day.

- **What changes can we make that will result in improvement?**
  Sugar-sweetened beverages will no longer be allowed to be consumed in the classroom. Any sugar-sweetened beverages that are sent to school with the child will be sent home unopened in their backpacks, with an explanation that there is a new school policy prohibiting sugar-sweetened beverages and promoting water consumption in an effort to prevent obesity. At the same time, the team will make a pitcher of water and glasses available for children to serve themselves throughout the day. Children did not have easy access to water before this effort.

Tests of Change

The team ran five consecutive Plan-Do-Study-Act (PDSA) Cycles. Each one incorporated the learning from the previous cycles to make an adjustment to the intervention.

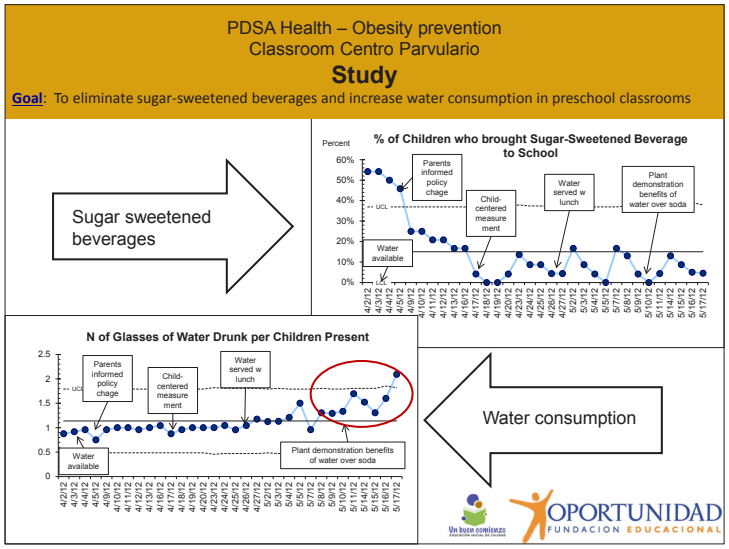


Notice several characteristics to this Test of Change:

1. **The CQI team answered the Three Questions of the Model for Improvement**, and therefore, they had a clearly defined aim, indicators, and change idea to test. The aim and indicators remain constant throughout all five cycles of the test of change. New ideas can be added to the test as the team learns from one cycle to the next.

2. **The CQI team measured the process and outcome indicators every day**, and they used the data to inform their work. They met as a team every week to reflect on the results and experience of one PDSA cycle (to conduct the 'Study' portion of the cycle) and to make changes for the next week's cycle (the 'Act' portion of the cycle).

3. **The CQI team graphed their data over time**, and included annotations on the graph to indicate when each change idea was tested. These kinds of graphs are called run charts. By graphing the data over time in this way and including median on the chart, probability-based rules can be used to determine when a change results in an improvement. The red circle on the bottom run chart indicates a 'shift'—six or more points in a row on one side of the median—which is a signal of improvement.



4. **The CQI team involved everyone affected by the system on the team**—school leadership, teacher, teacher's aide, and parents —in weekly reflection and planning.

   Notice how this:

   - contributed to the creativity you see in the change ideas they tested, as in the plant demonstration of the effects of drinking water versus soda; and
   - led to the idea to introduce child-centered measurement. This served two purposes. First, it allowed the children themselves to have an active role in the test of change and let them see their own water consumption each day. Second, it solved a problem of measurement for the teacher and teacher's aide. They didn't want to interrupt their teaching activities to keep track of all of the water children served themselves through the day. By designing and introducing child-centered measurement, they could add up the total number of beads each child put on his own picture in 5 minutes at the end of the day.

Example 2: Improving Care Coordinator Skills

In the fall of 2014, *Help Me Grow*, Orange County underwent two changes that prompted them to focus on the quality of the call center's responses to parents' needs and concerns. First, they experienced 100% turnover of their *HMG* Child Development Care Coordinators; one went on maternity leave and the other moved on to a new job. The new care coordinators were good, but green.

Second, they were able to incorporate a supervisor at the call center assigned part-time to the *HMG* call center staff, and this new supervisor had the responsibility and experience working on quality assurance with the staff at the 2-1-1 call center. They decided to do a test of change to assure consistent, high quality responses by the *HMG* Child Development Care Coordinators to parents' concerns and needs.

Three Fundamental Questions

- **What are we trying to accomplish?** To assure consistent, high quality of the call center responses to parents' concerns and needs.
- **How will we know if a change is an improvement?** The supervisor will measure the quality of calls using a standard protocol. She will listen in on one call for each care coordinator each week.
- **What changes can we make that will result in improvement?** Cycle 1: Provide each care coordinator direct feedback on the quality of the call by giving her the scored form and having her listen to the recorded call with the scoring sheet in hand.

PDSA 1 Cycle 1

PLAN

Who: Supervisor and two *HMG* Child Development Care Coordinators

What: Supervisor will listen to one call for each care coordinator, complete the quality form and give it to the care coordinator. Each care coordinator will listen to the recorded call with the quality sheet in hand.

When: January 30, 2015

Tasks or tools required: Adaptation of a quality scoring form

The Supervisor took a quality form she had used for 2-1-1 call assessment in the past and adapted it for *Help Me Grow*. She eliminated anything that was 2-1-1 specific and added *Help Me Grow*-specific items. The supervisor and *Help Me Grow* Program Manager reviewed the form together and incorporated changes so that the five categories she would evaluate reflected the components that really mattered:

1. intake at time of initial call and follow up care coordination including documentation of outcomes at the time of case closure;

2. professionalism (communication skills);
3. accurately assessing and defining concerns;
4. documenting correctly (intake, referrals); and
5. providing correct referral for concern and providing quality care coordination.

The Supervisor scored whether the care coordinator completed each of the five categories not at all (0 = no), somewhat (1 = sort of) or completely (2 = yes). She added the total score together (0 = minimum, 10 = maximum) and multiplied the total by 10 to calculate a percent of quality achieved score from 0-100. See Sample Call Quality Assessment Form.

Revision completed by Supervisor & Program Manager: November 2014

Plan for Data Collection. The supervisor will write notes on the quality scoring form during the call, and calculate category-specific and total scores at the end of the call. She will email the score sheet to the *HMG* Child Development Care Coordinators after the call.

Predictions. The supervisor predicts that both *HMG* Child Development Care Coordinators will score above 50% on their first assessment, and both will have the most difficulty expressing empathy on the phone.

DO

Supervisor listened to and scored one call for the first *HMG* Child Development Care Coordinator on December 4, 2014, and for the second *HMG* Child Development Care Coordinator on December 6, 2014.

STUDY

Overall, both *HMG* Child Development Care Coordinators scored well (88.9%) and exceeded the supervisor's prediction. There was a shared weakness. Both of the *HMG* Child Development Care Coordinators scored 50% in professionalism and helpfulness, because they 'sort of' expressed empathy, made reflective statements and built rapport with the caller. *Help Me Grow* ideally wants care coordinators to listen and build rapport at the beginning of a call before asking questions.

ACT

For the next PDSA cycle, the supervisor will provide training on what the call flow should be, with special attention to building rapport before proceeding with questions.

PDSA 1 Cycle 2

PLAN

Who: Supervisor and two *HMG* Child Development Care Coordinators

What: Supervisor will provide refresher training on call flow with special attention to building rapport, and then she will listen in and score one call for each care coordinator

When: December 29, 2014 to January 2, 2015.

Tasks or tools required: Supervisor prepares training

Plan for Data Collection. The supervisor will write down notes on the quality scoring form during the call, and calculate category-specific scores and total scores at the end of the call. She will email the score sheet to the *HMG* Child Development Care Coordinator after the call.

Predictions.

DO

Supervisor provided refresher training on call flow with special attention to building rapport before asking questions. She then listened to and scored one call per *HMG* Child Development Care Coordinator.

STUDY

The training was well-received by both *HMG* Child Development Care Coordinators. One was excited, the other anxious about following the data elements and filling in the information needed to complete the intake in the exact order it is shown on the computer monitor. On their calls, both *HMG* Child Development Care Coordinators scored higher (94%). This time, one *HMG* Child Development Care Coordinator scored 100% on professionalism and completely expressed empathy, made reflective statements and built rapport with the caller. The second scored 50% on professionalism and 'sort of' expressed empathy, made reflective statements and built rapport with the caller. Again, the feedback to her was to provide reflection before asking the formal *Help Me Grow* intake questions.

ACT

For the next PDSA cycle, the supervisor will ask the *HMG* Child Development Care Coordinators to independently complete training on communication.

PDSA 1 Cycle 3

PLAN

Who: Supervisor and two *HMG* Child Development Care Coordinators

What: The *HMG* Child Development Care Coordinators will complete training on communication independently. Supervisor then will listen in and score one call for each care coordinator.

When: January 5-January 9, 2015

Tasks or tools required: *HMG* Child Development Care Coordinators independently review the 2-1-1 site communication trainings. *How to de-escalate someone who is upset? How to communicate with someone who is scattered in telling story and describing needs/concerns? How to communicate bad news (e.g. no resources for a particular concern)?* Then practice with the trainer in English and Spanish.

Plan for Data Collection. The supervisor will write down notes on the quality scoring form during the call, and calculate category-specific scores and total scores at the end of the call. She will email the score sheet to the care coordinator after the call.

Predictions.

DO

HMG Child Development Care Coordinators reviewed communication trainings independently. They practiced with their supervisor in English and Spanish. The supervisor listened to and scored one call per care coordinator.

STUDY

Both *HMG* Child Development Care Coordinators enjoyed the training and practice session, especially the breaking bad news scenarios. On their calls, again, both care coordinators scored well (100% and 94%).

ACT

The *HMG* Child Development Care Coordinators seem to be improving their communication skills and professionalism. For the next PDSA cycle, the supervisor will continue to monitor these skills. She will ask each *HMG* Child Development Care Coordinator to listen to one of her own calls and score herself on the Quality form. Then the supervisor will listen to the same call, and score it. They will compare scores. Together they will discuss the similarities and differences. Coaching will occur as needed.

PDSA 1 Cycle 4

PLAN

Who: Supervisor and two *HMG* Child Development Care Coordinators

What: Each *HMG* Child Development Care Coordinator will listen to one of her own calls and score herself on the Quality form. The supervisor will listen to the same call and score it. The supervisor and care coordinator will compare scores and the coordinator will receive coaching.

When: February 2-6, 2015

Tasks or tools required: Recorded call; Quality form.

Plan for Data Collection. The *HMG* Child Development Care Coordinators and supervisor will write down notes on the quality scoring form during the call, and calculate category-specific scores and total scores at the end of the call. They will sit together to review the scores.

Predictions. The Supervisor at 2-1-1 predicts that the care coordinators will realize 1) what they're being measured on, 2) how much time the supervisor spends on this, and 3) that it is an important program priority.

DO

pending

STUDY

pending

ACT

pending

Additional Learning

During this test of change, the supervisor noticed another challenge shared by both *HMG* Child Development Care Coordinators: They both had difficulty searching the 2-1-1 resource inventory. Sometimes the search terms were not correctly filtered or found. Sometimes the resource inventory database wasn't completely up to date or accurately labeled. The 2-1-1 Supervisor realized that this problem was beyond the control of the two *HMG* Child Development Care Coordinators. Solving it will require the participation of others involved in managing the *Help Me Grow* resource inventory: the *HMG* community liaisons; the technical support staff; and the care coordinators.

To tackle this challenge and improve the functionality of the database, the CQI team would need to expand its membership to include these other staff. A new Test of Change could be started. The CQI teams would respond anew to the **Three Fundamental Questions** and run multiple PDSA Cycles until they accomplish their aim.

- **What are we trying to accomplish?** To improve the functionality of the *Help Me Grow* resource inventory by ensuring timely updates, cleaning and appropriate search terms.
- **How will we know if a change is an improvement?** The team would need to define a way of measuring the functionality of the database
- **What changes can we make that will result in improvement?** The team would introduce ideas on improving functionality, based on that barriers that prevent timely updating and the assuring accuracy of the search terms.

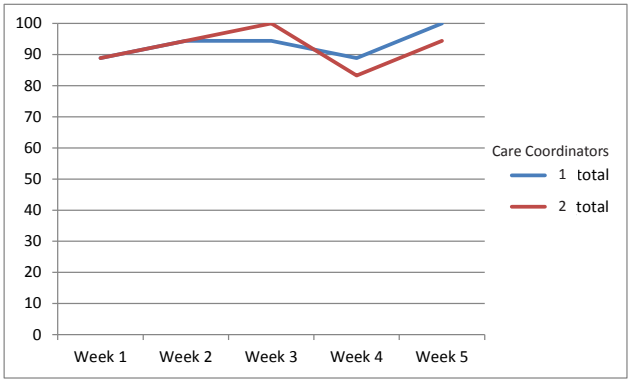
Notice several characteristics to Example 2 Test of Change

1. The CQI team answered the **Three Questions of the Model for Improvement**. Therefore, they had a clearly defined aim, indicators, and change idea to test. The aim and indicators remained constant through all cycles of the test of change. The team added new ideas to the test as they learned from one cycle to the next.

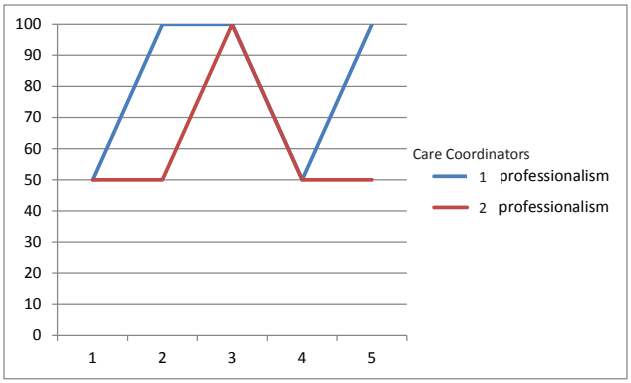
Orange County Test of Change

Aim: To assure consistent, high quality in call center responses to parents' concerns and needs

Call Quality Assessment: Total Score



Call Quality Assessment: Professionalism Score



2. The CQI team **measured the quality indicators every week, and they used the data to inform their work**. The supervisor emailed scores to the care coordinators each week with the Call Report and Contact ID number, so that care coordinators could listen to the calls with their score in hand. The supervisor also reviewed each care coordinators' weekly quality scores in monthly face-to-face supervision. **Sharing data transparently with the whole team, including the front-line staff, is a central tenant of CQI.** Every member of the team should reflect on the data, learn, and propose changes that could lead to improvement.
3. The CQI team did not **graph their data over time**, but we do so here (see page 96). Ideally, we would include dates on the Y-axis and annotations on the graph to indicate when each change idea or intervention was tested. Sharing data visually and publicly strengthens data feedback and potentiates data use. By graphing the data over time in this way and including median on the chart, probability-based rules can be used to determine when a change results in an improvement.
4. The CQI team working on this PDSA on the quality of the call center response **involved the care coordinators, the supervisor and the program manager**. It would be interesting to include a parent on this team.
5. This Test of Change **helped identify another area in need of improvement**: functionality of the referral bank database, with timely update and cleaner search terms. Another test of change with its own Three Fundamental Questions and PDSA cycles could be designed and run. The CQI team would need to expand to include all of the staff involved in and affected by the process of updating and cleaning the resource inventory database.

TIP

Building a *Help Me Grow* System

Start Small with CQI

Consider designing your first PDSA cycle at a very, very small scale with very rapid completion. For example, you can **PLAN** and **DO** a test of change with one client, in one day. At the end of the day, can you reflect as a team (i.e., **STUDY**) with questions such as: *What it was like to do the test? What was it like to collect the data? What did the indicator show? Did the experience and the data match your prediction, or not? What did you learn?* You may learn something as simple as that the data collection sheet was tricky to use and could be tweaked for easier use.

Then, **ACT**. What would you adapt or change for the next cycle? **PLAN** the next cycle immediately. You may decide to adapt the data collection sheet and run the PDSA test again, either at the same very small scale (one staff person with one client, in one day), or one size larger (one staff person with 2 or 3 clients, or two staff members testing in parallel with 1-2 clients each).

Keep the PDSA cycle as quick as possible. Especially at the beginning, it's best to run at least one small, nimble PDSA each week to get into a rhythm and to get comfortable with the methods.

Transforming Early Detection & Intervention in Home Visiting with CQI

by Paul Dworkin, M.D., Founder of *Help Me Grow*

I am privileged to serve as faculty for the Maternal and Child Health Bureau's (MCHB) Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN). The Network offers participating home visiting program grantees the chance to learn about three topic areas: maternal depression, breast feeding, or developmental surveillance and screening. All grantees must also focus on family engagement.

Faculty either support programs within a specific topic area or bring expertise in continuous quality improvement (CQI) to all participants. My experience has been informative, validating, and inspiring, as well as highly relevant to our work in the *Help Me Grow* National Center.

To Join or Not To Join the Faculty

When MCHB's Carlos Cano, MD, MPM, and the leadership of Education Development Center, Inc. (EDC), approached me about joining the HV CoIIN in 2013, I had a major reservation.

"I don't want to disrupt any progress that participants have made to date in learning about developmental screening," I said. I hold strong views on the topic, and I worried that they would be at odds with the philosophy and priorities of the participants.

Specifically, I believe in surveillance and screening as the evidence-informed process to perform early detection. I believe that screening test results must always be interpreted in the context of all that is known about the child and family. And I believe that screening/early detection is justifiable only when it leads to appropriate and timely intervention.

"If these beliefs are concerning or unfamiliar to participants and faculty, I fear that they will be controversial and counterproductive," I said. I did not want in any way to derail the work of HV CoIIN.

Embracing Key Concepts of Surveillance & Screening

Dr. Cano put my fears at ease, and I joined a team of distinguished faculty including Jon Korfmacher, PhD, Associate Professor at the renowned Erikson Institute in Chicago and Brenda Jones-Harden, PhD, a highly-respected expert in early childhood development. Brenda is Associate Professor in the Department of Human Development & Quantitative Methodology, University of Maryland College Park.

Jon and Brenda, as well as Mary Mackrain, Project Director for HV CoIIN at EDC, were extraordinarily receptive to my thoughts on developmental surveillance and screening. They embraced the key concepts that drive our efforts to enhance early detection through *Help Me Grow* in the following ways:

- CoIIN's Developmental Screening topic area was renamed Home Visiting Developmental Surveillance and Screening (HV DSS CoIIN);
- the Key Driver Diagram for the initiative evolved to reflect key concepts of *Help Me Grow*, including reliable and effective systems for surveillance & screening, referral, and follow-up; and
- home visitors were supported in addressing development in the target population and engaging families in the promotion of their children's healthy development.

Home visiting programs have also evolved their thoughts and actions in support of early detection and intervention, as well. Initially, most home visiting programs selected this topic area with a worthy but narrow aim: to learn how to choose, administer and score developmental screening tools, and use the

continued on next page

Transforming Early Detection & Intervention in Home Visiting with CQI

by Paul Dworkin, M.D., Founder of *Help Me Grow*

continued from previous page

results to refer children to their state's early intervention program for evaluation.

While these remain important priorities, participating programs have now embraced all of the key steps in the early detection process, including:

- engaging parents and eliciting their opinions and concerns;
- appropriately administering and interpreting screening tools in the context of all that is known about the child and family;
- ensuring that children identified as at risk or delayed are referred for the most appropriate intervention, whether the state's Part C early intervention program, a community-based program or service, or more intensive developmental support delivered by the home visitor; and
- being certain that children receive the appropriate services in an appropriate time frame.

Impressive Results, Better Outcomes for Children

The results HV DSS CoIIN's work are very encouraging. Consider the following statistics.

1. In 80-100% of all home visits, parents are asked if they have any concerns about their child's development, learning, or behavior
2. 80% of children are being screened for developmental risk/delay.
3. 80-100% of children with parental concerns are receiving developmental support from their home visitor.

The focus on family engagement, both within the DSS CoIIN and the broader initiative, is especially validating. Engaging parents as partners in the process of developmental surveillance and screening is a fundamental construct. We must appreciate the importance and validity of their opinions and concerns for their children's development. The HV DSS CoIIN lives this value by sharing the results of screening with parents and enhancing support of their children's development.

During a recent topic conference call with our participating programs, the team from the Marion, Ohio, Adolescent Pregnancy Program (APP) shared their efforts to increase parents' support of their child's development by providing all families with written feedback from their developmental screening. APP also provides activities that parents can do with their children to support emerging skills.

What a spectacular example of parent/family engagement!

The Power of Effective CQI

CQI processes made these positive changes possible. The use of effective CQI tools, such as Plan-Do-Study-Act (PDSA) cycles and data collection and analyses, are propelling the HV DSS CoIIN teams forward to success.

Indeed, we have been so impressed with the progress, led by CQI faculty MaryCatherine Arbour, MD, MPH, of Harvard Medical School, that we have engaged MaryCatherine in helping us strengthen our *Help Me Grow* affiliates' processes and performances through CQI.

We frequently and enthusiastically celebrate the close relationship between *Help Me Grow* and home visiting. The HC CoIIN is yet another example of how much we learn from each other in the context of early childhood system building and continuous quality improvement. As always, your comments are welcome.

Find Dr. Dworkin's original blog post at www.HelpMeGrowNational.org

Implementing CQI

Forming a CQI Team

CQI encourages staff members at all levels to to do the following.

- Work as a team.
- Draw on their collective experiences and skills.
- Analyze systems and processes.
- Use information to identify the nature and size of each problem.
- Design and implement activities to improve services.

A CQI Team is composed of all of the people involved in and affected by the processes you are trying to improve, including leadership, supervisory staff, front-line staff, community partners, evaluators and families. For *Help Me Grow*, it should include representatives of each component of the *Help Me Grow* system, representatives of groups or organizations that support the system, and families who use the system.

For example, the *Help Me Grow* Connecticut CQI team includes:

- the director of the centralized access point;
- a Call Center care coordinator;
- the physician outreach coordinator;
- a community liaison;
- an evaluator; and
- a representative from the funding agency.

CQI Team Meeting Frequency

The CQI Team meets regularly and as frequently as necessary to keep PDSA testing and improvement moving quickly. In the two examples above, at least part of the CQI team met weekly to reflect on the learning and feed that learning forward into the next PDSA cycle. In some industries, CQI teams meet daily in "Team Huddles" of ten to 15 minutes to study data and make quick adjustments to the process for the day. In the case of partial daily or weekly huddles, the full CQI team may meet weekly, biweekly or monthly to keep up with the learning and invite all to shape the testing and improvement.

The Model for Improvement and PDSA testing are the motor that drives improvement. If a team conducts one PDSA cycle per month because they are meeting monthly, it is like driving in first gear. Progress will be slow. The danger to slow progress is that it's difficult to see, and teams can get discouraged or lose motivation. CQI team meetings should be frequent enough to keep up rapid cycle testing (a minimum of a PDSA test every two weeks) so that teams are continuously learning and incorporating new ideas and energy into the improvement process.

CQI: Where to Start?

The beginning of your local affiliate CQI efforts depend entirely upon your needs and priorities. The Model for Improvement and PDSA cycles have been applied to drive improvements in industry, healthcare, education and social service processes and systems. For *Help Me Grow*

affilliates, this process could be used to improve any one of *Help Me Grow*'s Core Components or for the other structural components (marketing, funding and expanding).

The decision to start with a particular area should be informed by the needs of the program, the needs of the community, and the ability of to assemble a CQI team that includes all of the actors involved in and affected by the process.

CQI: First Steps

Once a CQI team is assembled and its primary focus has been chosen, one of the first tasks for the team is to define a SMART aim. SMART aims are specific, measurable, actionable within the realm of influence of the CQI team, realistic and time-bound. In simple terms, the aim should state how much will be accomplished and by when. In the Preschool Center classroom in Example 1, the SMART aim was to eliminate the consumption of sugar-sweetened beverages and increase water consumption to one glass of water per day per child by May 30, 2012.

Once the SMART aim is established, the team must choose indicators or measures that will help it to know whether or not that aim was accomplished. Often it is beneficial to include outcome measures (the number of glasses of water consumed per child per day) and process measures (the percent of children who brought sugar-sweetened beverages to school with them).

Sometimes it is useful to include a balancing measure—a measure of something that may be negatively affected by heavily investing your energy and attention in one outcome. In the preschool example, teachers were concerned that increased water consumption might lead to increased trips to the bathroom and lost teaching time. So, they included a balancing measure of "number of trips to the bathroom per day," and they were reassured when it did not increase.

Next, the team should define its first PDSA cycle. The team should choose the first change idea they would like to test, and design a small, quick PDSA cycle. One of the strengths of Example 2 above was that the supervisor decided that the Test of Change would begin with a PDSA cycle that was one week long. She scored one phone call for two care coordinators, provided them with their scores and asked them to listen to the call with the scoresheet in hand. This could be accomplished in one week, and the learning could be fed forward into the next cycle.

CQI Training & Tools

Designing PDSA cycles takes practice and coaching. Several examples and resources of PDSAs from multiple industries are available in Langley et al, The Model for Improvement.

One online course with multiple modules focused on many aspects of quality improvement is available at the IHI Open School. The examples are drawn from healthcare, but the five modules and 18 lessons cover a wide range of topics including System Modification, the Model for Improvement, Defining SMART Aims, Measurement, Developing and Testing changes, Spreading Change, and the Human Side of CQI.

An abundance of additional CQI tools are available for visualizing processes, understanding variation, considering human psychology of change and defining a shared theory of change. One excellent compilation is The Improvement Handbook by API at www.pipproducts.com.

ACTION PLAN

Continuous Quality Improvement

- [ ] Form a comprehensive CQI team

  A CQI Team is composed of all the people involved in and affected by the processes you are trying to improve, including leadership, supervisory staff, front-line staff, community partners, evaluators and families.

  Determine meeting frequency.

- [ ] Answer the Three Fundamental Questions

  1. ***What are we trying to accomplish?*** Define a SMART aim. This is a specific, time-limited and measurable aim statement.
  2. ***How will we know if a change is an improvement?*** Identify process and outcome measures to collect over time in order to track improvement and evaluate progress. Consider using a balancing measure.
  3. ***What changes can we make that will result in improvement? T***he team identifies ideas for changes to try.

- [ ] Choose the first change idea to test

- [ ] Plan a small, quick PDSA cycle.

  Consider designing a PDSA cycle at a very, very small scale and very rapid turnaround for your first cycle. For example, you can test the idea you've chosen with one client, once, and then reflect (Study): What it was like to do the test? What was it like to collect the data? What did the indicator show? Testing the idea in just a few days and then reflecting on that test is a completely legitimate PDSA cycle.

- [ ] Do the first PDSA cycle

- [ ] Study the results of the first PDSA cycle

- [ ] Collect, analyze and graph data on each PDSA cycle

  Reflect on what the experience was like: complement the graph with qualitative data. What did you learn? Was your prediction correct? What surprised you?

- [ ] Act on first PDSA cycle results

- [ ] Take what you learned from each PDSA and use it to design the next cycle

  Based on your experience, what will you do differently in the next PDSA?

CQI Resources

Help Me Grow Western Summit: Collective Impact Powerpoint Presentation (2011)

Channeling Change - Making Collective Impact Work (SSIR 2012)

Collective Impact Stanford Social Innovation Review, Winter 2011)

CQI Team Guide

IHI Open School (training modules)

The Improvement Handbook by API

The Model for Improvement (Langely, et al)

Planning Documents

Resources for More Coaching

To view CQI resources, visit the Affiliate Sectior ofwww.helpmegrownational.org/

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ii Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. (2009). The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition). San Francisco, CA: Jossey-Bass Publishers.

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iv Kritchevsky, S. B., & Simmons, B. P. (1991). Continuous quality improvement: concepts and applications for physician care. Jama, 266(13), 1817-1823.

v Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. (2009). The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition). San Francisco, CA: Jossey-Bass Publishers.

vi Un Buen Comienzo, Fundacion Educacional Oportunidad, Santiago de Chile.

NOTES

Help Me Grow
National Center

www.helpmegrownational.org
(860) 837-6232