Pediatric Care Coordination Curriculum

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Curriculum Overview:

Module 1 (2 hrs)
Integrating Care Coordination into Our Everyday Work:
How a Child with ADHD Can Open the Door to Practice Improvement

TOPIC: Introduction to holistic view of care coordination and participatory nature of curriculum

LEARNING ACTIVITY: Short didactic presentation along with small group sessions focused on case scenario capturing family, team and community dynamics

MODULE AUTHORS: Browning, Carpinelli, Conroy, Risko

LEARNING OBJECTIVES:
1. Identify ways to focus on proactive, longitudinal care within the patient/family-centered medical home.
2. Understand and use tools to integrate patient and family input throughout the course of care.
3. Describe ways to improve communication and accountability among providers both within the medical practice and in the extended medical home, including the school.
4. Recognize the role of care coordinators in working collaboratively to implement practice improvement.

Module 2 (2 hrs)
Building Patient/Family-Centered Care Coordination through Ongoing Delivery System Design

TOPIC: Conceptual overview of family-centered care coordination in the medical home, including team interaction

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LEARNING ACTIVITY: Substantial didactic presentation along with small group sessions focused on team collaboration

MODULE AUTHORS: Presler, Lindeke, Hackett-Hunter

LEARNING OBJECTIVES:
1. Identify key components of a high performing pediatric care coordination model that can be implemented in your medical home practice setting.
2. Design/refine care coordination model and practice in your medical home practice.
3. Evaluate strengths and areas for improvement in implementation of care coordination within your medical home practice.
4. Develop your take-home action plan for next steps for improving collaboration and teamwork in your practice.

Module 3 (2 hrs)
Care Coordination as a Continuous Partnership

TOPIC: Conceptual framework and strategies for care coordinators engaging with patients and their families

LEARNING ACTIVITY: Interactive didactic presentation, small group discussion

MODULE AUTHORS: Austin, Browning, Donohoe, Forlenza, McAllister

LEARNING OBJECTIVES:
1. Explore the nature and dynamics of different kinds of "care coordination partnership relationships" with children, youth and families
2. Define and understand five core components of building partnerships with children, youth and families:

- Building partnerships means appreciating that the most important tool you will ever use with children, youth and families is *yourself*.
- Building partnerships means working *with* children, youth and families, not doing things *to* them without their approval, or *for* them without their involvement.
- Building partnerships means meeting children, youth and families where they are and learning from them what they want.
- Building partnerships means helping children, youth and families to realize that they know more than they think they know (and often more than what *we* think they know).
- Building partnerships means appreciating that children, youth and families (as well as care coordinators) can learn what they don't know and need to know through practice.

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3. Discuss how these new understandings of building partnerships with children, youth and families can inform their practices going forward.

Module 4 (2 hrs)
Health-Related Social Service Needs:
Strategies to Assess and Address in in the Family-Centered Medical Home

TOPIC: Understanding social determinants of health as they impact on patients and families in the medical home context

LEARNING ACTIVITY: Didactic session focused on understanding care coordination in social/cultural context, along with small group sessions focused on interacting with community resources/caregivers through the use of online tool(s)

MODULE AUTHORS: Bottino, Fleegler

LEARNING OBJECTIVES
1. Understand the social determinants of health.
2. Identify commonly encountered health-related social service needs in pediatric primary care.
3. Recognize barriers to assessing unmet health-related social service needs in clinical practice.
4. Develop strategies to address unmet health-related social service needs in the patient and family-centered medical home.

How to Approach the Curriculum:
The four modules of the curriculum were designed independently by nationally recognized subject matter experts. They can be used as stand-alone learning activities or as a coordinated series of sessions. Groups considering the use of the curriculum should make themselves familiar with all four modules in order to decide which modules will best fit the learning needs of the audience at a given point in time.

Background:
The critical importance of care coordination as a core component of the medical home in the design of a high performance health care system has garnered significant attention. Several national health policy recommendations identify care coordination as an essential cross-cutting intervention capable of filling the gap between what exists and what is needed in health care today. Furthermore, the literature demonstrates that when care coordination activities do occur, they are performed by multiple stakeholders, including patients and families themselves, often with a diversity of patient- and family-centered outcomes. **(**http://mchb.hrsa.gov/chscn/pages/prevalence.htm**).**

Figure 1 presents a framework upon which we based our approach to defining the elements and activities of care coordination. (Antonelli, McAlister, Popp, 2009). It is essential to note that

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our approach was not specifically targeted to a particular professional category (e.g., nursing, social work, physicians). Rather, the intention was to articulate the principles and activities necessary to support any individual in the role as a care coordinator—including the patient/ family.

This educational initiative was designed to be a "participatory curriculum" focused from the start on real-time learning among various individuals serving the function of care coordinators as well as other primary care-based team members. The curriculum was designed to provoke new learning (knowledge and skills) about what care coordination is, why it matters, and what needs to be done to work collaboratively toward making it more fully integrated into the delivery of healthcare services in the pediatric medical home. It was also designed to be revised through the period of its implementation in an iterative manner, integrating the input and feedback of the learners themselves.

For the complete curriculum, please email Dr. Richard Antonelli.

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Figure 1. A Framework for Highly Performing Pediatric Care Coordination

PEDIATRIC CARE COORDINATION FRAMEWORK

Care Coordination Definition:

Pediatric care coordination is a patient and family-centered, assessment driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health and wellness outcomes.

Defining Characteristics of Care Coordination

1. Patient and family-Centered (PFC)
2. Pro-active, planned, & comprehensive
3. Promotes self-care skills &independence
4. Emphasizes cross-organizational relationships

Care Coordination Competencies:

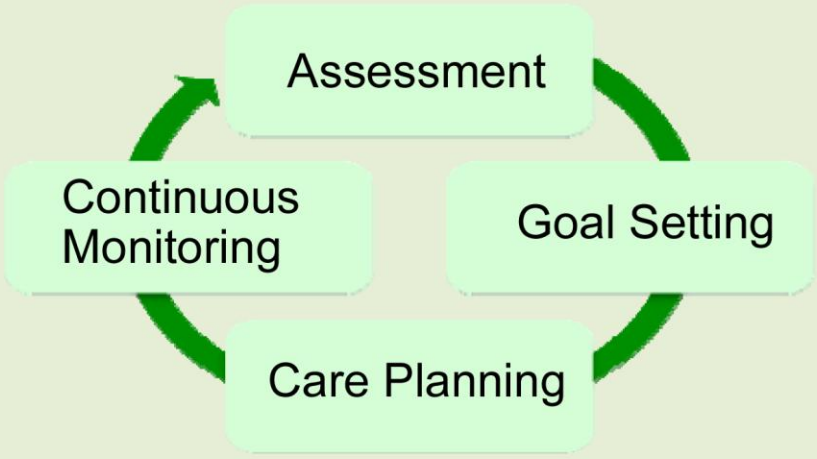
Develops partnerships

1) Proficient communicator
2) Uses assessments for intervention
3) Facile in care planning skills (PFC)
4) Integrates all resource knowledge
5) Possesses goal/outcome orientation
6) Approach is adaptable & flexible
7) Desires continuous learning
8) Applies solid team/building skills
9) Adept with information technology

Care Coordination Functions:

1) Provide separate visits & CC interactions
2) Manage continuous communications
3) Complete/analyze assessments
4) Develop care plans (with family)
5) Manage/track tests, referrals, & outcomes
6) Coach patient/family skills learning
7) Integrate critical care information
8) Support/facilitate all care transitions
9) Facilitate PFC team meetings
10) Use health information technology for CC

Delivery of Family-Centered Care Coordination Services includes:



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Boston Children's Hospital
Until every child is well