Care Coordination Toolkit

A Guide to Implementing Care Coordination Elements into Clinic Workflow

Louisiana Department of Health | Office of Public Health | Bureau of Family Health

In 2006, the Bureau of Family Health partnered with Louisiana State University Health Sciences Center and Children's Hospital New Orleans to create the TigerCare Care Coordination Medical Home Model. Key components of the model include family partnerships, team-based care, population screens for children with special needs, and tiered care coordination services that holistically address health and social-related needs. This model was used to improve care coordination services in 15 academic practices across the state of Louisiana and a toolkit was created to provide a roadmap for providers to independently implement the model in order to develop care coordination services in their clinic.

This toolkit is a revision of the original version. It is based on clinical practice guidelines from national experts and lessons learned from the field.[1,2] Utilizing QI Frameworks, the content has been updated, then broken into steps/divided into sections, designed for ease of use at any (or various) stages of implementation. It is meant to be used by pediatric medical providers and staff (physicians, nurses, social workers, clinic managers, support staff, etc.) who want to maximize their capacity to make care coordination services as efficient and effective as possible in their clinic. This includes improving existing services, or integrating new services, into the regular clinic practice.

Our care coordination experts are available to assist with any questions you may have about the toolkit. Please contact them at 504-568-5055 or BFH-FamilyResourceCenter@la.gov for more information.

About Us

The Louisiana Department of Health, Office of Public Health, Bureau of Family Health works to make Louisiana a place where all people are valued to reach their full potential, from birth through the next generation. The Bureau is the state's Title V administrator and works to ensure that children and youth with special health care needs in Louisiana have access to the services they need. These services are designed to minimize their disabilities and maximize their ability to enjoy independent and self-sufficient lives.

Part of the Bureau's work is to expand pediatric and other clinical practices' capacity to provide services to Louisiana families. No cost, customized technical assistance packages around care coordination, youth health transition services, and developmental screening are available to support your quality improvement efforts. Call 504-568-5055 or email BFH-FamilyResourceCenter@la.gov for more information.

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Background

A pediatric medical home is a child-centered approach to providing comprehensive, coordinated primary care services from birth through transition to adulthood. It is a team-based healthcare delivery model that includes active collaboration between families, primary care providers, behavioral health providers, hospitals, clinical specialists, and community programs. The American Academy of Pediatrics (AAP) and National Standards for Systems of Care for Children and Youth with Special Health Care Needs (CYSHCN) endorse care in a medical home as the gold standard for ensuring high quality holistic and coordinated health care for pediatric populations.[3,4]

Building medical home capacity not only helps providers address a child's medical needs, it also helps them address challenges related to social barriers to health (i.e. access to housing, food, education, transportation, employment) through expanded community referral networks. Care coordination is an essential element of the medical home model.

Pediatric Care Coordination

The National Standards for Systems of Care for CYSHCN defines care coordination as patient and family centered, assessment-driven, team-based activities designed to meet the needs of children. It addresses medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes, and efficient delivery of health-related services within and across systems.[4] Care coordination is not explicit to chronic condition management, but rather takes a holistic approach to achieving optimal health and wellness outcomes. It is a core component of federal and state efforts to improve health outcomes, reduce caregiver and patient burden, eliminate redundancies, and decrease health care costs for children and adults.[4]

Many children require care from multiple providers. System navigation alone can create barriers to timely receipt of support services necessary to ensure optimal child health. Coordinated care involves gathering the people and resources needed to effectively care for a patient, and managing the exchange of information across those systems providing different aspects of care.[5] This allows patients to receive a more comprehensive level of care that better addresses their needs. Each member of a child's care team should have well-defined roles and responsibilities that focus on their area of expertise.[6] Families should be made aware of what each health care professional is focused on in regard to their child's care. Ideally, each child will have an individualized plan of care that is based on a thorough understanding of their health and family situation and shared amongst the providers on the care coordination team and the family.[6] The plan should be reviewed and updated regularly to keep up with changes in the child's conditions.

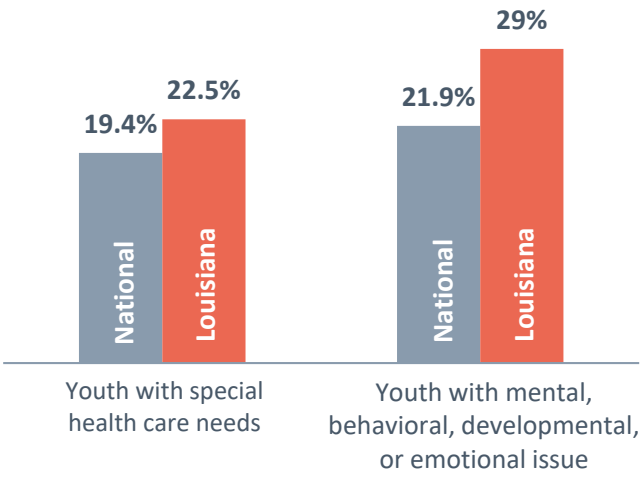
Children and Youth with Special Health Care Needs (CYSHCN)

The National Standards for Systems of Care for CYSHCN define CYSHCN as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.[4] CYSHCN may also be referred to as high needs pediatric patients, patients with complex health needs, etc., but we will use the acronym "CYSHCN" throughout this toolkit.

Care Coordination in Louisiana

According to the *National Survey of Children's Health,* children in Louisiana are among the highest at-risk populations in the country. For those children living in poverty, only 1/3 receive services in a pediatric medical home. In addition to poverty, children in our state with and without a diagnosed health condition, face social barriers, including access to transportation and food insecurity.

The 2019/2020 *National Survey of Children's Health* identified that about 1 in 4 Louisiana children (ages 0-17) have a special health care need (LA 22.5%/US 19.4%). Previous data (2018/2019) revealed that Louisiana leads the nation with the highest percentage of children (ages 3-17) with a mental, behavioral, developmental or emotional problem (LA 29%/US 21.9%). Child poverty rates in Louisiana compound these findings, with over 29% of our state's children (0-17) living under the federal poverty level.



The *2018 Louisiana Provider Survey* (implemented by the Bureau of Family Health) found that out of the 243 eligible respondents, many do not provide services that support patient-centered care.

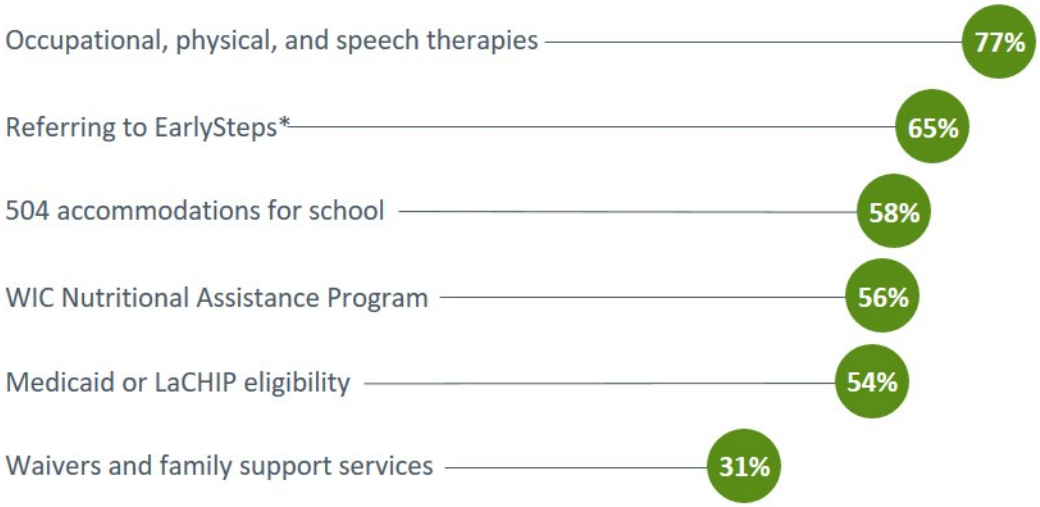
21%
Utilized a designated care coordinator

60%
Identified the CYSHCN population

35%
Always provided translation services

49%
Do not screen when a parent is concerned

% of PCPs in Louisiana who reported discussing the following services with their patients with high needs



*EarlySteps is the Early Intervention Program for Louisiana families with children 0-3 years old. Anyone can refer a child to EarlySteps, and they will do the necessary evaluations to determine if the child is eligible to receive services.

About This Toolkit

The Care Coordination Toolkit uses a step-wise quality improvement framework designed to maximize clinic capacity and make implementation of care coordination services as easy, efficient, and effective as possible. It can help clinics integrate new care coordination services into regular clinic practice or expand on services already offered. The toolkit was created for primary care practices, but can also be used by other health care or social service professionals.

This toolkit provides existing clinical staff with the information needed to develop and implement improvement targets at your practice. Your practice already has some care coordination services in place (e.g. scheduling diagnostic tests, referring out to specialist) and this toolkit can help build on current processes and improve efficiency of workflows. Clinics can tailor care coordination services based on their specific or individual goals related to staffing, technology, and spatial capacity. It is intended to be customizable and will help you assess, plan, and implement services at your own pace.

Steps for Implementation

This toolkit uses a 3-step framework for implementing or improving care coordination services. We have created checklists and worksheets to help you work through the steps listed below. An example of how to use each document is provided, and **blank copies are located in the appendix**. An electronic version of this toolkit with fillable PDFs is available at PartnersForFamilyHealth.org/Medical-Home.

1. **Assess your clinic's care coordination services**
   - Inventory existing care coordination elements
   - Identify opportunities for improvement

2. **Develop a plan for implementing your priority task and train your team**
   - Brainstorm what would be needed to improve on the care coordination elements identified in Step 1 to identify your priority task
   - Break your priority task down into smaller steps to identify processes, protocols, and staff needed to implement
   - Create the plan and assign roles and responsibilities
   - Train your team

3. **Test new care coordination service/process/workflow**
   - Plan: Develop a test and make a prediction
   - Do: Conduct the test and collect data
   - Study: Analyze the data and summarize results
   - Act: Refine changes for the next cycle

Before you Begin

It is important to have support from clinic leaders before using this toolkit to implement new care coordination services. Ensure clinic leaders understand the project and what expected outcomes will be. They will need to be willing to follow through on tasks such as authorizing pilots/tests of change, establishing new workflows, updating staff job descriptions, and adapting electronic health records (EHR) to support team communication. Once you have leadership on board**, form a small workgroup of 2-5 people from different areas of the clinic** (e.g., physicians, nurses, support staff, billing, etc) to help complete the steps in this toolkit. If you have any questions at any point during implementation, please contact our care coordination experts at BFH-FamilyResourceCenter@la.gov.

MOC-4 Credits

This toolkit can be used to receive American Board of Pediatrics Maintenance of Certification 4 (MOC-4) credits. See the Quality Improvement section on page 18 for more information.

Step 1: Assess Your Clinic's Care Coordination Services

All clinics provide some level of care coordination, whether that is having a process for scheduling patients or having a full-time care coordinator to complete referrals. The first step in improving care coordination services, is assessing what your clinic is already doing. The first step will utilize the **Care Coordination Capacity Checklist**. A blank version of this tool can be found in the Appendix.

Goal: The goal of Step 1 is to assess the care coordination elements your clinic currently offers and identify the most feasible elements your clinic could add or improve on.

1. Inventory existing care coordination elements

Fill out the Care Coordination Capacity Checklist (a blank template is in the Appendix) moving across each row and putting a check next to the elements that best describe your current clinic activities. This will help assess what services and processes you currently offer and to what degree they are implemented. As you work your way through the list, reflect on what works and what doesn't.

2. Identify opportunities for improvement

Once you complete the checklist, go back through it and **identify where there are gaps in services. Unchecked elements or those that fall under the basic or intermediate levels are the areas where you could improve.** Take a couple minutes to brainstorm your clinic's priorities and capacity to expand or implement new care coordination services. Consider what you would need in terms of staffing, processes, documentation, etc. Circle 1-3 care coordination elements that would be most feasible to improve on at this time.

Identifying Children with Special Healthcare Needs (CYSHCN)
Identification of clinic's CYSHCN (high needs patients) is an important item on the checklist. It is essential to ensure that your highest needs patients have access to and are linked with necessary services. If this element came up as an area of improvement on the checklist, you may want to consider making it a priority task. We recommend using the CSHCN Screener or the Developmental Screening Toolkit to identify this population.

Care coordination encompasses far more than what we've listed in this capacity checklist. You can apply this same framework for assessing capacity and identifying priorities to any service you come across or would like to improve on. Check out the **Medical Home Index-Short Version** and Stratis Health's **Community-Based Care Coordination Maturity Assessment** for more examples of care coordination services. Please see an example of the **Care Coordination Capacity Checklist** on the next pages.

Need Help?

Our experts can provide technical assistance to you through this process. See the Implementation Training and Support Request Form in the Appendix and contact us at **BFH-FamilyResourceCenter@la.gov** or 504-568-3405 for more information.

Example: Care Coordination Capacity Checklist

Care Coordination Implementation

The table below lists key care coordination elements based on the National Standards for Systems of Care for Children and Youth with Special Health Care Needs (CYSHCN) domains.[4] Each element is broken up into three different levels of implementation based on clinic capacity.

- **Basic** refers to clinic structures that may limit or restrict service provision due to a small number of staff, lack of technological tools and data system, spatial restrictions, etc.
- **Intermediate** refers to practices that have the staff and physical space to support comprehensive care coordination services. Practices have a functional data system/EHR and mechanisms to modify the system.
- **Advanced** refers to practices that have at least one designated care coordinator on staff who works to develop, implement, and ensure follow-up for the patient plan of care. The care coordinator tracks outcomes and drives quality improvement efforts.

For each care coordination element, move across the row and put a check next to the elements that best describe your current clinic activities. For some elements, you may fall into the Basic level, for others you may be Advanced. After you go through all the elements listed on this page and the next, take a look at the checklist as a whole. Focus in on the elements where your clinic is at the basic or intermediate level. These are likely areas for improvement. Circle 1-3 elements that would be most feasible to improve on at this time. You will use those in the next step.

Screening, Identification, and Assessment

Care Coordination Elements	Basic	Intermediate	Advanced
Screening processes	☑ Basic screening/needs assessments in place for identifying unmet child/family needs.	❑ Systematic and timely screening services are provided per Bright Futures Preventative Health Periodicity Table ❑ Systematic screening for special health care needs.	❑ Information and data from multiple data sources are built into screening and assessment processes (including complexity of child's health status, health/social inequities, etc.)
Identification of clinic's CYSHCN (high need patients)	☑ A definition and mechanism for identification of CYSHCN is in place and used to enhance care (pre-visit planning, additional visit time, safe-wait space, etc.)	❑ Systematic and universal method is used to identify CYSHCN patient charts to ensure consistency and efficiency of supports and services.	❑ CYSHCN patients are assigned a complexity level, diagnostic codes are documented, and there is a plan of care for ongoing monitoring and referral tracking.
Assessment of needs	☑ Care coordination assessment is conducted in addition to, or in alignment with, other initial screens.	❑ Care coordination assessment (including social related needs) findings are consistently documented and incorporated within the plan of care.	❑ Action items identified through care coordination assessments are used for goal-setting based on family needs, priorities. ❑ Reassessments and follow-up protocols are in place.

	Care Coordination Elements	Basic	Intermediate	Advanced
Care Planning and Continuity	**Shared Plan of Care**	☑ Written plan of care is collaboratively developed and shared with family - addresses clinical and functional needs.	❑ Clinic team implements, monitors and updates the plan of care that includes social related health needs during the course of patient visits and phone encounters.	❑ A designated care coordinator conducts ongoing plan updates and monitors the plan of care within/across systems.
	Resource Linkage	☑ Basic community resource referral/linkage without follow up.	❑ Linkage to community resources with follow up (closed referral loops). ❑ Ready access public health and community program materials/resources.	❑ Designated care coordinator provides ongoing coordination support and community referrals with follow-up based on patient/family needs.
Systems and Workforce	**Appointment Scheduling**	☑ Basic scheduling and pre-visit processes in place.	❑ Policies implemented that address special accommodations and/or visit supports for CYSHCN.	❑ Detailed communication strategies in place that support effective CYSHCN services; easy access clinic contact for families, such as designated care coordinator or nurse.
	Staff Roles and Policies	☑ Loosely defined staff roles, clinic lacks fully adopted care coordination definition with assigned staff roles.	❑ Clear practice-based care coordination definition with staff assigned to specific care coordination activities.	❑ Designated care coordinator with clearly defined role and fluid level of involvement based on a patient/family needs.
Transition to Adulthood	**Youth Transition Processes**	☑ Typical adolescent anticipatory guidance provided.	❑ Providers use a transition checklist and developmental approach. ❑ Transition needs assessment and guidance is offered related to wellness, vocational planning, community supports, etc.	❑ Practice implemented a youth transition policy. ❑ Transition progression is outlined/tracked in the EHR. ❑ Adolescents receive practice support to link their health and transition plans with other relevant providers, services, and agencies.
Quality Standards	**Continuous Quality Improvement (QI)**	☑ Practice conducts family satisfaction surveys and uses feedback to guide practice improvements. ☑ Practice has scheduled monthly/quarterly staff meetings.	☑ Practice has a quality improvement (QI) team. ❑ Practice uses continuous quality improvement (CQI) to ensure current best practices are implemented and processes remain effective and efficient.	❑ Staff and families of CYSHCN are supported to participate in CQI activities. ❑ Policies, procedures, and mechanisms are in place to review care team activities on a regular basis to assess quality and outcomes.

Hint: *Start with doable practice improvement goals. Break down into steps. Start small, and celebrate wins. Success will build team momentum!*

Step 2: Develop A Plan for Implementing Your Priority Task and Train Your Team

Now that you have identified 1-3 care coordination elements to improve on in Step 1, you'll need to think through what is needed to implement change. You can use the **Brainstorm and Project Planning Worksheets** to help think through which element would be most feasible to work on and create a step-by-step process for implementation.

Goal: The goals of Step 2 are to create a step by step plan for implementing your care coordination element, identify who will be involved in the plan, and train the team accordingly.

1. Brainstorm what would be needed to improve on the care coordination element identified in Step 1

Take one of the elements you circled in Step 1 and **run it through the questions on the Brainstorm Worksheet**. Think through what you would need to implement change and if it is feasible for your clinic to execute. Consider how you can use the resources you already have, and what new things you'll need. You can do this for as many elements you are interested in implementing as you'd like. Whichever one is most feasible and highest priority for your clinic will be your priority task. This task will be your focus as you move through the rest of the toolkit.

2. Break your priority task down into smaller steps to identify processes, protocols, and staff needed to implement

Use the Project Planning Worksheet to break down your priority task into smaller sub-tasks or steps. You can use a process map to help with this (see the examples on pages 12 and 13). Creating a step-by-step process for implementing your priority task will help you identify what needs to happen, where things will happen, and who will be involved. Review care coordination resources listed towards the end of this toolkit, or through your own online search, to see examples and figure out what will work for your team.

3. Create and assign roles and responsibilities

Based on your process map, **identify roles that need to be filled to carry out tasks and determine who the best person would be to fill them**. Consider staff who will lead care coordination efforts and disseminate information to the rest of the team. There are opportunities for everyone to get involved – MD/DO, NP, PA, MA, Nurse, Pharmacists, Clinic Managers, etc. Approach leaders and those you think may be interested in overall quality improvement.

4. Train your team

Once roles are assigned, you'll want to **train your clinic leaders and team members involved in carrying out the tasks**. Determine specific training needs, explore training materials, and other resources online.

Need Help?

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Example: Brainstorm Worksheet

Care Coordination Implementation

Now that you've identified areas of improvement you'd like to work on, think through what will be needed to implement a change in your clinic. Take the most doable element(s) identified from the **Care Coordination Capacity Checklist** and write it below. Answer the questions to determine if your clinic would be ready to work on it and break it down into actionable steps. You can run as many elements from the checklist through these questions as needed. Once you identify the one you would like to implement, it will become your priority task.

Element to Brainstorm: Systematic and universal method is used to identify Children and Youth with Special Healthcare Needs (CYSHCN) patient charts to ensure consistency and efficiency of supports and services.

Brainstorm Questions

What changes would you like to see?
We want to create a method for flagging CYSHCN charts to provide extra support/care coordination when a child screens "at risk" on any of the developmental screens. This will help make sure we give proper referrals and follow-up with families and other providers. It will also help reduce calls from families after their visit.

Who will be involved in these changes? Will you need to hire additional staff?
Recruit at least one primary care provider (PCP) from pediatric staff, one medical assistant (MA) and/or nurse, one rep from the desk staff, and clinic manager to work with the quality improvement team to create a plan. Will also need IT to help make changes in electronic health record (EHR). Do not need to hire additional staff.

How will this change the workflow at your clinic? What will be needed to get staff to follow a new protocol?
Staff will need to know when a chart should be flagged, how to flag the chart, and what additional services are needed for charts that are flagged (additional screening, care coordination, referrals).

What else will you need to make this change successful - technology, equipment, etc?
Support from leadership, development of new processes for how to flag a chart and changes in protocol for working with patients who have a flagged chart, training for clinic team, support from IT to help with EHR chart flag.

What would the next steps be in order to implement this change? What needs to be approved by leadership?
Clinic manager presents to leadership team/providers and gets approval.

Is this a doable option for the clinic at this time?
Yes. This may take more staff time upfront, but will create a smoother process to free up staff time once implemented.

Priority Task: *Flag chart in EHR to identify a child as high need patient/child with a special health care need (CYSHCN) when they have an "at risk" result on a developmental screen to ensure they receive additional coordination support.*

Example: Project Planning Worksheet

Care Coordination Implementation

Now that you've chosen a priority task and brainstormed what is needed, you can start to plan out more detailed next steps. You will need to either modify a current process to include these changes or create a new one. Identify the staff you have available and plot out the steps that will need to occur in order to reach your goal. Identify who will fill each roles, what training staff should receive, and if you need any additional resources or support.

Planning Your Next Steps

Now that you've chosen a priority task and brainstormed what is needed to implement, you can start thinking about next steps. Use the table below to identify that your next steps are, who will carry them out, who will be involved in implementation, what kind of training will be needed, etc.

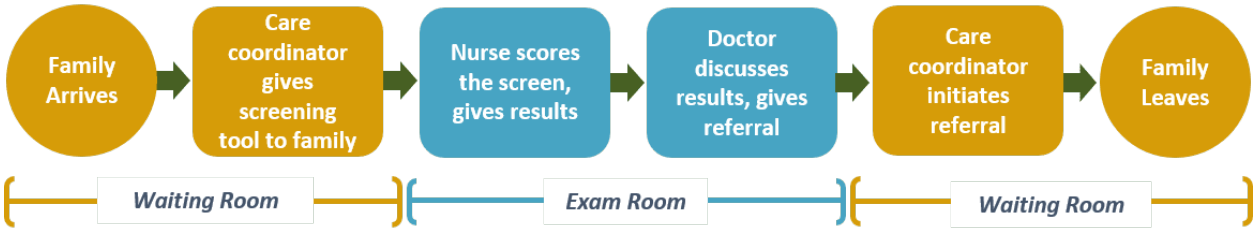
Next Steps	Person (s) Assigned	Notes
Leadership proposal – seek approval for project	*Patti (clinic mgr)*	*Patti will present idea to leadership on 1/10*
Team will meet to discuss what is needed (process, technology, staff)	*Sharita (MA desk), Brandon (NP), Patti (mgr), Sue (LPN)*	*Patti will schedule meeting and provide project overview. Will create a process (using process mapping) for defining CYSHCN population/flagging charts and identify staff who will be involved in the process.*
Get feedback and approve the plan	*All staff involved*	*Patti will send plan to leadership and staff involved to give them the opportunity to review and provide feedback.*
Train staff	*All staff involved*	*Supervisors will identify training needs and make sure each staff member knows how to carry out their role.*
Test strategy	*All staff involved*	*Use the Plan Do Study Act Worksheet to test flagging charts between 2/5/25-2/9/25.*

Planning Tool: Process Mapping

Process mapping may be a helpful tool to use as you plan out your project. Process mapping is exactly what it sounds like – mapping out each step of a specific process to show how it works in a given setting. They can help your implementation team identify problems, solutions, and improvement opportunities within current systems. They can also be helpful for creating processes and explaining them to others

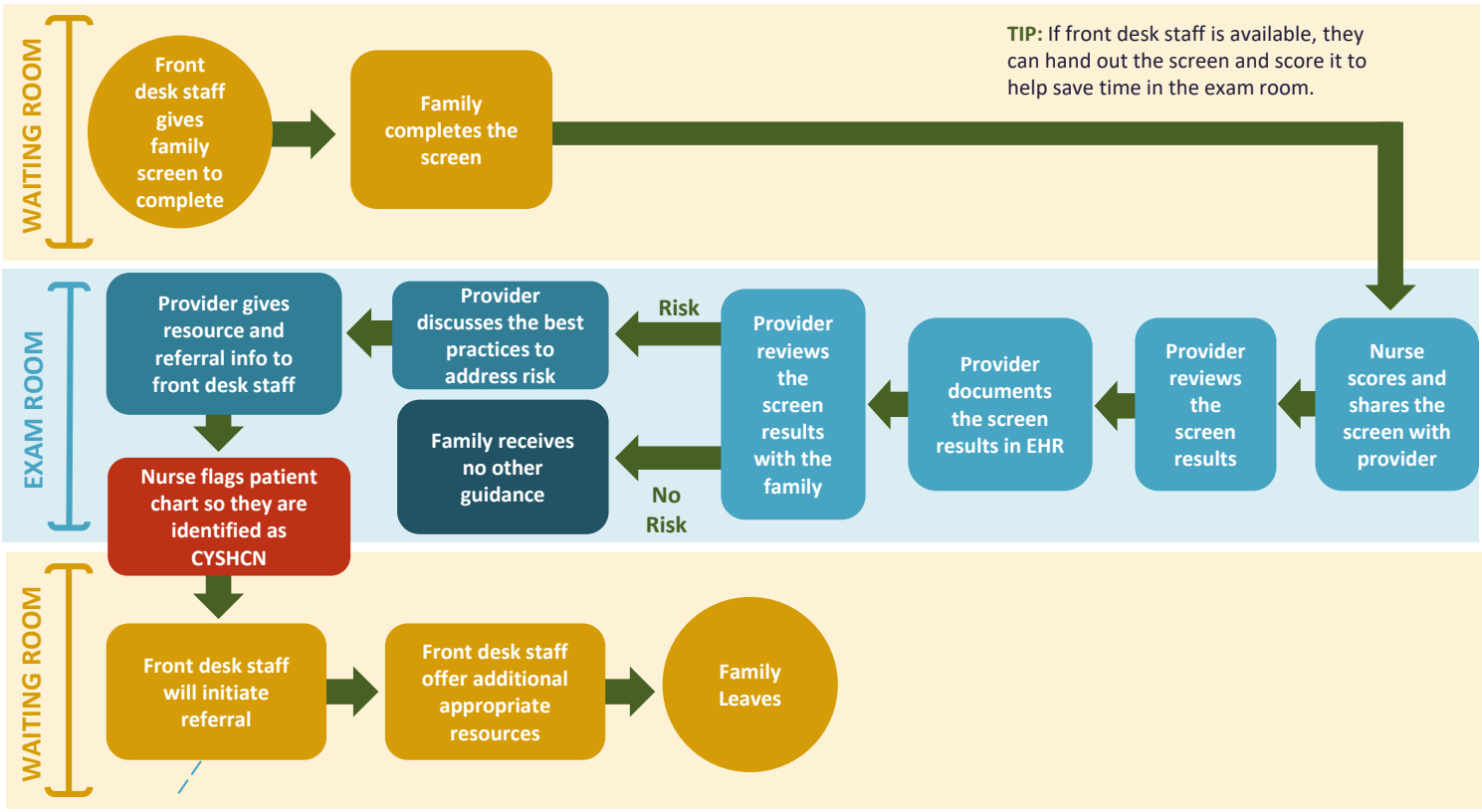
A process map illustrates the sequence of activities and flow of work. Consider staff you have available to do each step you identify. Use different colors and shapes to help distinguish between categories. Grab a blank piece of paper and create a process map for the priority task you identified. Check out the example below, additional examples in the Appendix, and this video on how to use a process map to help guide you.

For each step of the process, be sure to include: **What** happens, **Who** is involved, and **Where** the step will take place. Once you have that, you can begin to identify specific people who will be involved and what training they will need.



Process Mapping Example

Below is an example of what a process map could look like. You can draw your process map on a blank piece of paper or even use sticky notes on an empty wall to easily move things around.



Opportunity to build staff capacity: Who has the time and resources to provide services?

Step 3: Implement Your Care Coordination QI Plan

Once you identify the processes and staff needed to implement your priority task, you'll want to perform quality improvement by implementing the tasks into your clinic workflow. Quality improvement (QI) is the framework used to systematically improve the way health care is delivered to patients. It refers to the process of planning and testing changes on a small scale, with the goal of implementing them across the entire practice. This toolkit utilizes the Plan-Do-Study-Act (PDSA) method of QI to help you figure out which strategies work best. The PDSA provides a systematic framework for working through tasks and will help you document the process, communicate with staff, and work through issues that may arise.

The **PDSA Worksheet** will help you plan and test different ways to implement your priority tasks in hopes of finding a strategy that works. You'll need to complete a new worksheet for each test of each priority task. Start with the priority task that seems the easiest to implement. For additional instruction on how to complete a PDSA, check out the resources listed in the Quality Improvement section on page 18 of this toolkit.

Goal: The goal of Step 3 is to test different strategies for implementing your priority tasks. Once you determine what works best, you can establish a system that allows you to successfully integrate care coordination services into your workflow.

1. Plan: Develop a test and make a prediction

Answer the following questions in the box, then make a prediction about what you think will happen.

- Who will be performing the task?
- What specific things will they be doing?
- Where will the task be performed?
- When will it happen?

2. Do: Conduct the test and collect data

Carry out the plan you created. Start small. You can test out your tasks on a few patients, with a few providers, or over a short period of time. **Document what happens**, including any data you are able to gather. Note any barriers you encounter, as well as what goes well.

3. Study: Analyze the data and summarize results

How did it go? Look at the data you collected and **summarize the results**. Are there any trends in the data? Compare the actual results to the prediction you made in the Plan phase of the PDSA cycle. How do they compare?

4. Act: Refine changes for the next cycle

Based on the results, **decide what to do next**. The 3 options are:

- **Adapt**: Consider what changes could be made to improve the way your task was implemented. Get a new PDSA worksheet and go through these steps again with those modifications. Continue making small changes and working through the PDSA cycle until you find a strategy that works well.
- **Adopt**: If you are satisfied with how the test went and want to implement it across the clinic, create a timeline for bringing it up to full scale and execute it.
- **Abandon**: If your plan was unsuccessful or you've gone through this cycle a few times and nothing seems to be working, you may want to abandon the idea. If you decide to abandon this plan, consider other strategies or services that could be implemented.

Example: Plan-Do-Study-Act (PDSA) Worksheet

Care Coordination Implementation

Use this worksheet for Step 3 to implement your priority task. A Plan-Do-Study-Act (PDSA) cycle is a simple scientific method for accelerating quality improvement (QI). Use this worksheet to test a change you wish to implement or improve in your facility.

Title: Flag chart in EHR to identify a child as high need patient/child with a special health care need (CYSHCN) when they have an "at risk" result on a developmental screen to ensure they receive additional coordination support.

Planned Test Date(s): 2/5/25-2/9/25 **Today's Date:** 1/31/25

1: PLAN Develop a test and make a prediction

DESCRIPTION OF TEST/TASK

Who: Nurse (Sue), provider (Brandon), front desk staff (Sharita)

What: Flag chart as CYSHCN and provide family with referral and relevant resources

Where: Exam room & front desk

When: 2/5/25 -2/9/25

PREDICTION

100% of charts that need to be flagged as CYSHCN will be and 100% of patients identified at risk will receive all relevant referral info and resources.

2: DO Conduct the test and collect data

STEPS TAKEN

When a patient screens "at risk" on any developmental screen:

- Nurse will flag chart as CYSHCN in EHR using newly added feature.
- After discussing results with family, provider will give front desk staff referral information and advise them on any additional resources the family should receive.
- Front desk staff will initiative referral and provide additional relevant resources.
- At future visits, any patient flagged as CYSHCN will review their plan of care with the nurse, and discuss any additional resources/supports, school documentation, or prescriptions, etc.

COLLECT DATA

- # "at risk" screens reported: 10
- # charts flagged: 10
- # referrals made: 7

3: STUDY Analyze the data and summarize results

ANALYZE DATA

100% charts flagged
70% referrals given

RESULTS

Front desk staff said the follow-up took longer with families and created backup at the desk. Some families left before receiving referral.

COMPARE RESULTS TO PREDICTED OUTCOME

Achieved goal for flagging charts, but not for providing referrals.

4: ACT Refine changes for the next cycle

☑ **ADAPT** (write out changes to be made next time)
Stagger appointment times for children receiving a developmental screen whenever possible to prevent extended wait for families to receive follow up from front desk staff.

☐ **ADOPT** (create a timeline for full implementation)

☐ **ABANDON**

Sustainability

Sustainability refers to holding the gains of an improvement project, even in the face of staff and organizational turnover. [7] Without sustainability, valuable time and resources are wasted investing in organizational improvement. Due to the high level of variability in health care, quality improvement must be continuously integrated into an organization's culture in order to provide high-quality care and reliable safe practices. Project fatigue can be prevented by making new processes routine. Organizations that monitor outcomes are able to evaluate themselves and take control of their own improvement. Continued senior leader engagement will also improve as leaders see the return on investment and routinely prioritize safety and quality improvement efforts. Lastly, sustainability engages staff to create a safety culture that lasts beyond the life of the project.[8]

Signs of Sustainability

Recognizing when a quality improvement project is ready to be sustained or implemented can be challenging, but several signs exist. When a project exhibits the signs listed below, it suggests that the initial phase of improvement work is complete and you are ready to create a sustainability plan.[7]

- The changes have been tested in different conditions with different staff, each providing feedback on performance.
- The necessary infrastructure (personnel, supplies, equipment) exists to support the project long-term.
- The project has achieved a high level of performance for several weeks/months.
- Measures have been identified to monitor performance over time, along with responsibility assigned for performance measurement and reporting.

Developing a Sustainability Action Plan

You will need to better understand, assess, and review the factors that influence a clinical practice's capacity for sustainability, then develop an action plan to increase the likelihood for sustainability. The Agency for Healthcare Research and Quality (AHRQ) developed the Clinical Sustainability Assessment Tool to help with this.

Once you assess your clinic's capacity to sustain your new care coordination element, you can start to develop a Sustainability Action Plan. The AHRQ tool has the plan broken out into the following steps:

- Assemble the planning team
- Review your practice's goals
- Review your Clinical Sustainability Assessment Tool results
- Determine which practice elements need to be maintained, eliminated, or adapted
- Prioritize the areas of sustainability capacity to address first.
- Write a Sustainability Action Plan with specific action steps.

Once you have your sustainability plan documented, you can start carrying out the action steps and then reevaluate the plan on an annual basis. Remember to recognize and celebrate successes along the way - it is important for implementation and long term sustainability.

Care Coordination Resources

Below are additional resources related to care coordination and supporting children with special health care needs. Review these resources to get a better understanding of the supports available to the patients you serve and share relevant resources with your patients.

AAP's National Resource Center for Patient/Family-Centered Medical Home | medicalhomeinfo.aap.org
This is a technical assistance center focused on improving the health and well-being of, and strengthening the system of services for, children and youth with special health care needs and their families by enhancing the patient/family-centered medical home. Find their Pediatric Care Coordination Curriculum here.

The National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) | nashp.org
The standards outline the core, system-level components of high-quality care coordination for CYSHCN. They are designed to help identify and assess the need for care coordination, engage families in the care coordination process, build a strong and supportive care coordination workforce, and develop team-based communication processes to better serve children and families.

Developmental Screening Toolkit | ldh.la.gov/DevScreenToolkit
Developmental screening is one way to identify children with special health care needs in your clinic. Screening all children ages 0-5 improves early detection of developmental delays and disabilities in children and provides an important avenue for referring children to early intervention services. Use this online toolkit to implement the Louisiana Developmental Screening Guidelines and screening services into your day-to-day practice.

Local Referral Resources

Family Resource Center | ldh.la.gov/FamilyResourceCenter
The Family Resource Center (FRC) assists providers in linking families to resources and services such as early intervention, childcare assistance, insurance, and disability support. The team is available to answer questions and give personalized recommendations based on a child's case. You can contact the FRC at BFH-FamilyResourceCenter@la.gov or (504) 896-1340 (Monday - Friday, 8am - 4pm).

Regional Resource Guides | ldh.la.gov/page/1129
These guides were created to help providers refer families to relevant services and share resources for children with special healthcare needs. Each regional guide has local contact and referral information for agencies and services. Additional guides specific to developmental screening results can be found at ldh.la.gov/page/4067.

EarlySteps & Child Search | ldh.la.gov/earlysteps
EarlySteps is the Early Intervention Program for Louisiana families with children 0-3 years old. Anyone can refer a child to EarlySteps, and they will do the necessary evaluations to determine if the child is eligible to receive services. To refer a family, contact the Intake Coordinator at the System Point of Entry Office in your region and complete the referral form found on this page under "Resources". Child Search is the Early Intervention Program for Louisiana families with children from birth to 21 years of age with developmental disabilities. Contact information for Child Search can be found in these Regional Resource Guides.

Other State Agencies That Provide Care Coordination Services

- Medicaid Managed Care Organization (MCO) Care Management: All MCOs provide care coordination services to children with complex health conditions. A child can be given a health needs assessment to see if they qualify.
- Office for Citizens with Developmental Disabilities (OCDD): OCDD serves as the Single Point of Entry into the developmental disabilities services system.
- Louisiana's Coordinated System of Care (CSoC): CSoC helps ensure that young people in or at risk of out of home placement with significant behavioral health challenges are able to receive the supports and services they need.

Family Engagement Resources

Family engagement is an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.[9]
Family-centered care improves patient and family outcomes, increases family and clinician satisfaction, decreases health care costs, and improves effective use of health care resources.[10] All practices are encouraged to use family-centered approaches with every child, at every visit. Parents and families are the experts on their children and all decisions should be made with them, together as a team.

It is important to talk with families about what they should expect for their children, in terms of growth and development, and to remind them to reach out if they have any concerns. These conversations should emphasize realistic timelines and should be culturally relevant to each family. For example, culturally relevant guidance may mean that for some cultures, not making eye contact is deferential and is not necessarily a "red flag" for autism. There are resources linked below to share with families to help guide conversations and serve as a helpful take-home tool to keep families engaged in their child's development on a regular basis.

Resources to Improve Family Engagement

- Family Engagement Assessment Tools: Family Voices developed tools to assess family engagement at both the systems-level and the individual-level.
- National Center for Medical Home Implementation (NCMHI) Family Engagement Quality Improvement Project (FEQIP): A quick look at lessons learned from this project with strategies, tips, and resources for implementing family engagement in clinical settings. Click here to view the full implementation guide.

Resources to Share with Families

- Vroom Mobile App: A science-based mobile app with daily brain building activities for parents to do with children ages 0-5.
- CDC's Milestone Tracker Mobile App: Caregivers can access and complete developmental milestone checklists, watch videos of milestones in action, and find developmentally appropriate activities through this app.
- Developmental Screening Regional Resource Guides: Review these guides with families to help them explore relevant services and resources. Each has local contact and referral information for agencies and services, as well as family-oriented resources such as milestone tracking apps.
- Sesame Street in Communities: Activities, videos, and more for families to do with their children.
- Youth Engaged 4 Change: Share this with your teen patients to connect them to resources and opportunities that will empower them to make a difference by improving their knowledge and leadership skills.
- SmoothMovesYHT.org: A virtual health and transition teen resource that provides a comprehensive overview of transition topics and hosts a library of transition tools and resources.
- Louisiana State Bar Association: A guide to Becoming an Adult provides information on voting, driving, housing, parenting, and more.
- Louisiana Rehabilitation Services: Find information on job fairs, pre-employment, and vocational rehabilitation to assist with developing a lifetime career.
- Exceptional Lives: Easy to understand resources for parents and caregivers of children with disabilities that include SSI benefits, health care transition guides, and more

Quality Improvement (QI) Resources

Quality improvement (QI) is the framework used to systematically improve the way health care is delivered to patients. It refers to the process of planning and testing changes on a small scale, with the goal of implementing them across the entire practice. Plan-Do-Study-Act (Step 3 of this toolkit) is a popular QI framework. Using evidence-based QI strategies while implementing care coordination elements will strengthen your clinic's services and provide staff with the tools to improve efficiency, patient safety, and clinical outcomes. Building clinic QI capacity does not have to be costly or overwhelming. Evidence tells us that selecting a QI method and using it consistently is key to success! There are many no and low cost, evidence-based QI trainings that provide the framework needed to get started. The resources listed below can be used to better understand QI and how to use the PDSA framework.

Quality Improvement Resources

- **American Academy of Pediatrics (AAP) Quality Improvement in the Pediatric Practice - Tutorial**
  aap.org/en/practice-management
  An introduction to QI and the PDSA framework. Topics covered include the basics of QI, creating a QI team, and how to complete a PDSA.
- **The National Institute for Children's Health Quality (NICHQ) Quality Improvement 101/102 - Virtual Training**
  nichq.org/resource/quality-improvement-101 & nichq.org/resource/quality-improvement-102
  Self-directed courses that introduce quality improvement science concepts. QI 102 provides lessons, exercises, and examples of best practices and offers direction on moving from one PDSA cycle to the next.

Create a culture of quality improvement in your practice

- Educate staff on Quality Improvement (QI) and provide opportunities for all staff to participate.
  - Encourage all staff to share ideas on what could be improved.
  - Designate a staff member as the point person for QI ideas.
- Use QI methods for small improvement projects and embed continuous QI into the framework of your practice.
  - Include QI in regular staff meetings and set a schedule for routine monitoring and review of data.
- Articulate the value of QI.
  - Communicate results from improvement projects to the clinic and community at large.
- Celebrate successes.
  - Recognize staff members' efforts by including their QI contributions in performance evaluations.

American Board of Pediatrics Maintenance of Certification 4 (MOC-4) Credits
This toolkit can be used as an American Board of Pediatrics MOC-4 project for providers who are heavily involved in leading the QI efforts. Review the checklist, application questions, and project examples at abp.org/content/yourown-qi-project so you know what you'll need to submit to qualify for credits. For more information about American Board of Pediatrics MOC-4 credits, visit abp.org/content/quality-improvement-part-4.

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Appendix

This toolkit is available online with fillable PDFs for the following documents at ldh.la.gov/cshs.

- **Implementation Training and Support Request Form**: Our team of experts is available to meet in-person or virtually to provide technical assistance in youth health transition, developmental screening, and care coordination. Use this form to request trainings and resources in these topic areas.

- **Care Coordination Capacity Checklist**: Follow the example in Step 1 to fill out your own Care Coordination Checklist using this blank template.

- **Project Planning Worksheet** Follow the example in Step 2 to fill out your own Project Planning Worksheet using this blank template.

- **Plan-Do-Study-Act (PDSA) Worksheet:** Follow the example in Step 3 to fill out your own PDSA using this blank template.

Louisiana Department of Health ● Office of Public Health ● Bureau of Family Health

Implementation Training & Support

The Bureau of Family Health offers trainings and resources to Louisiana providers that can help enhance and expand their clinical services. Our team of experts is available to develop a tailored plan to fulfill your clinic's needs, and can meet in-person or virtually to provide technical assistance. We use a quality improvement framework that helps embed continuous improvement into your practice. We provide trainings on the following topics:

- Developmental screening
- Care coordination
- Youth health transition

These trainings and resources are available at no cost. If you're interested in learning more, please complete the information below and email it to DevScreen@la.gov. We will contact you to provide more information and schedule a training. For more information about each of these topics, visit PartnersForFamilyHealth.org/medical-home.

Step 1: Tell Us Your Interests

Check the following services you are interested in for each of the topic areas.

	Referral Resources	Tools to Use in Clinic	Implementation Training*
Developmental Screening			
Care Coordination			
Youth Health Transition			

*Implementation Training can be done in-person or virtually. Training includes:

- Project planning
- Staff training
- Process mapping
- Implementation Assistance

Step 2: Tell Us About Your Practice

Provide the following information about your clinic. We will contact you using your preferred method of communication.

Clinic: _____ Contact Name: _____

Address: _____ Contact's Role: _____

City: _____ Phone: _____

EHR System: _____ Email: _____

Clinic Owner: _____ Preference: ☐ Phone ☐ Email

Care Coordination Capacity Checklist

Care Coordination Implementation

The table below lists key care coordination elements based on the National Standards for Systems of Care for Children and Youth with Special Health Care Needs (CYSHCN) domains.[4] Each element is broken up into three different levels of implementation based on clinic capacity.

- **Basic** refers to clinic structures that may limit or restrict service provision due to a small number of staff, lack of technological tools and data system, spatial restrictions, etc.
- **Intermediate** refers to practices that have the staff and physical space to support comprehensive care coordination services. Level 2 practices have a functional data system/EHR and mechanisms to modify the system.
- **Advanced** refers to practices that have at least one designated care coordinator on staff who works to develop, implement, and ensure follow-up for the patient plan of care. The care coordinator tracks outcomes and drives quality improvement efforts.

For each care coordination element, move across the row and put a check next to the elements that best describe your current clinic activities. For some elements, you may fall into the Basic level, for others you may be Advanced. After you go through all the elements listed on this page and the next, take a look at the checklist as a whole. Focus in on the elements where your clinic is at the basic or intermediate level. These are likely areas for improvement. Circle 1-3 elements that would be most feasible to improve on at this time. You will use those in the next step.

Screening, Identification, and Assessment

Care Coordination Elements	Basic	Intermediate	Advanced
Screening processes	❑ Basic screening/needs assessments in place for identifying unmet child/family needs.	❑ Systematic and timely screening services are provided per Bright Futures Preventative Health Periodicity Table ❑ Systematic screening for special health care needs.	❑ Information and data from multiple data sources are built into screening and assessment processes (including complexity of child's health status, health/social inequities, etc.)
Identification of clinic's CYSHCN (high need patients)	❑ A definition and mechanism for identification of CYSHCN is in place and used to enhance care (pre-visit planning, additional visit time, safe-wait space, etc.)	❑ Systematic and universal method is used to identify CYSHCN patient charts to ensure consistency and efficiency of supports and services.	❑ CYSHCN patients are assigned a complexity level, diagnostic codes are documented, and there is a plan of care for ongoing monitoring and referral tracking.
Assessment of needs	❑ Care coordination assessment is conducted in addition to, or in alignment with, other initial screens.	❑ Care coordination assessment (including social related needs) findings are consistently documented and incorporated within the plan of care.	❑ Action items identified through care coordination assessments are used for goal-setting based on family needs, priorities. ❑ Reassessments and follow-up protocols are in place.

	Care Coordination Elements	Basic	Intermediate	Advanced
Care Planning and Continuity	**Shared Plan of Care**	❑ Written plan of care is collaboratively developed and shared with family - addresses clinical, functional, and social needs.	❑ Clinic team implements, monitors and updates the plan of care that includes social related health needs during the course of patient visits and phone encounters.	❑ A designated care coordinator conducts ongoing plan updates and monitors the plan of care within/across systems.
	Resource Linkage	❑ Basic community resource referral/linkage without follow up.	❑ Linkage to community resources with follow up (closed referral loops). ❑ Ready access public health and community program materials/resources.	❑ Designated care coordinator provides ongoing coordination support and community referrals with follow-up based on patient/family needs.
Systems and Workforce	**Appointment Scheduling**	❑ Basic scheduling and pre-visit processes in place.	❑ Policies implemented that address special accommodations and/or visit supports for CYSHCN.	❑ Detailed communication strategies in place that support effective CYSHCN services; easy access clinic contact for families, such as designated care coordinator or nurse.
	Staff Roles and Policies	❑ Loosely defined staff roles, clinic lacks fully adopted care coordination definition with assigned staff roles.	❑ Clear practice-based care coordination definition with staff assigned to specific care coordination activities.	❑ Designated care coordinator with clearly defined role and fluid level of involvement based on a patient/family needs.
Transition to Adulthood	**Youth Transition Processes**	❑ Typical adolescent anticipatory guidance provided.	❑ Providers use a transition checklist and developmental approach. ❑ Transition needs assessment and guidance is offered related to wellness, vocational planning, community supports, etc.	❑ Practice implemented a youth transition policy. ❑ Transition progression is outlined/tracked in the EHR. ❑ Adolescents receive practice support to link their health and transition plans with other relevant providers, services, and agencies.
Quality Standards	**Continuous Quality Improvement (QI)**	❑ Practice conducts family satisfaction surveys and uses feedback to guide practice improvements. ❑ Practice has scheduled monthly/quarterly staff meetings.	❑ Practice has a quality improvement (QI) team. ❑ Practice uses continuous quality improvement (CQI) to ensure current best practices are implemented and processes remain effective and efficient.	❑ Staff and families of CYSHCN are supported to participate in CQI activities. ❑ Policies, procedures, and mechanisms are in place to review care team activities on a regular basis to assess quality and outcomes.

Brainstorm Worksheet

Care Coordination Implementation

Now that you've identified areas of improvement you'd like to work on, think through what will be needed to implement a change in your clinic. Take the most doable element(s) identified from the **Care Coordination Capacity Checklist** and write it below. Answer the questions to determine if your clinic would be ready to work on it and break it down into actionable steps. You can run as many elements from the checklist through these questions as needed. Once you identify the one you would like to implement, it will become your priority task.

Element to Brainstorm: _____

Brainstorm Questions

What changes would you like to see?

Who will be involved in these changes? Will you need to hire additional staff?

How will this change the workflow at your clinic? What will be needed to get staff to follow a new protocol?

What else will you need to make this change successful - technology, equipment, etc?

Is this a feasible option for the clinic at this time?

What would the next steps be in order to implement this change? What needs to be approved by leadership?

Priority Task: _____

Project Planning Worksheet

Care Coordination Implementation

Now that you have decided on your priority task, you can start to plan out in detail what needs to happen for changes to occur. You will need to either modify a current process to include these changes or create a new one. Identify the staff you have available and plot out the steps that will need to occur in order to reach your goal. Identify who will fill each roles, what training staff should receive, and if you need any additional resources or support.

Planning Your Next Steps

Now that you've chosen a priority task and brainstormed what is needed to implement, you can start thinking about next steps. Use the table below to identify that your next steps are, who will carry them out, who will be involved in implementation, what kind of training will be needed, etc.

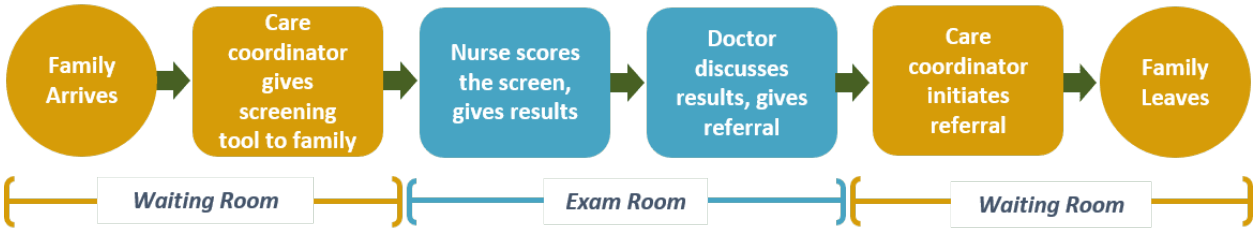
Next Steps	Person (s) Assigned	Notes

Planning Tool: Process Mapping

Process mapping may be a helpful tool to use as you plan out your project. Process mapping is exactly what it sounds like – mapping out each step of a specific process to show how it works in a given setting. They can help your implementation team identify problems, solutions, and improvement opportunities within current systems. They can also be helpful for creating processes and explaining them to others

A process map illustrates the sequence of activities and flow of work. Consider staff you have available to do each step you identify. Use different colors and shapes to help distinguish between categories. Grab a blank piece of paper and create a process map for the priority task you identified. Check out the example below, additional examples in the Appendix, and this video on how to use a process map to help guide you.

For each step of the process, be sure to include: **What** happens, **Who** is involved, and **Where** the step will take place. Once you have that, you can being to identify specific people who will be involved and what training they will need.



Plan-Do-Study-Act (PDSA) Worksheet

Care Coordination Implementation

Use this worksheet for Step 3 to implement your priority task. A Plan-Do-Study-Act (PDSA) cycle is a simple scientific method for accelerating quality improvement (QI). Use this worksheet to test a change you wish to implement or improve in your facility.

Title: _____

Planned Test Date(s): _____ **Today's Date:** _____

1: PLAN Develop a test and make a prediction

DESCRIPTION OF TEST/TASK

Who:_____

What: _____

Where: _____

When: _____

PREDICTION

2: DO Conduct the test and collect data

STEPS TAKEN

COLLECT DATA

3: STUDY Analyze the data and summarize results

ANALYZE DATA

RESULTS

COMPARE RESULTS TO PREDICTED OUTCOME

4: ACT Refine changes for the next cycle

❑ **ADAPT** (write out changes to be made next time)

❑ **ADOPT** (create a timeline for full implementation)

❑ **ABANDON**