HMA

Care Coordination Training: Train-the-Trainer

Day 1

July 22 and 23, 2024

HOUSE KEEPING

- Please mute yourself when you are not speaking.
- We want this to be interactive, so please come on camera, if you are able and feel comfortable.
- We welcome your questions anytime! You can use the chat or come off mute.
- We will also provide an email address to submit your questions. We will compile all questions and answers to develop an FAQ that can accompany the materials you have already received.

TODAY'S PRESENTERS

Melissa Vergeson
Bureau Chief of Medicaid Quality
Florida Agency for Health Care Administration

Catherine Knox, RN, PHN, MSN
Principal
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Reem Sharaf, LCSW-C, MSW
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OBJECTIVES

At the end of this two-day train-the-trainer event, you will:

- Be familiar with the modules and accompanying tools
- Come away from these sessions feeling confident in facilitating these trainings
- Recognize that care coordination is an evolving practice, guided by a set of principles, and should be tailored to the population and families you are serving

AGENDA – DAY 1

- Background and Purpose of Training
- Facilitation 101: Approach to Your Training
- Orientation to the Care Coordination Training Curriculum
- Orientation to the Modules
- Orientation to the Facilitation Guide
- Orientation to the Assessments and Evaluations
- Bringing Life to the Scenarios
- Knowledge Checks
- Reflection
- Q&A

BACKGROUND AND PURPOSE OF TRAINING

- On July 14, 2023, an order of Injunction was entered in United States v. Florida, No. 12-60460-CV (S.D.Fla.) The Injunction directs the State of Florida to comply with three main orders:
  - Require the Managed Care Organizations (MCOs) to ensure the provision of all covered and authorized private duty nursing (PDN) services and develop methods to measure Provider performance, including real time reporting of PDN Provider issues
  - Inform and facilitate the transition of children from nursing facilities to a home or community setting
  - Improve the existing Care Coordination system to strengthen accountability and collaboration
- AHCA's goal is to promote high-quality training and education as a key foundational activity in its efforts to strengthen the system of care in Florida for children with Complex Medical Needs.
- Consistent with the injunction, this training includes the following topics:
  - How to engage with the families of children with Complex Medical Needs
  - The array of services available to these children
  - Removing barriers to community integration
  - Cultural competency
  - The mechanisms by which to liaise with providers, schools, and CMATs

FACILITATION 101

FACILITATION 101: APPROACH TO YOUR TRAINING OVERVIEW

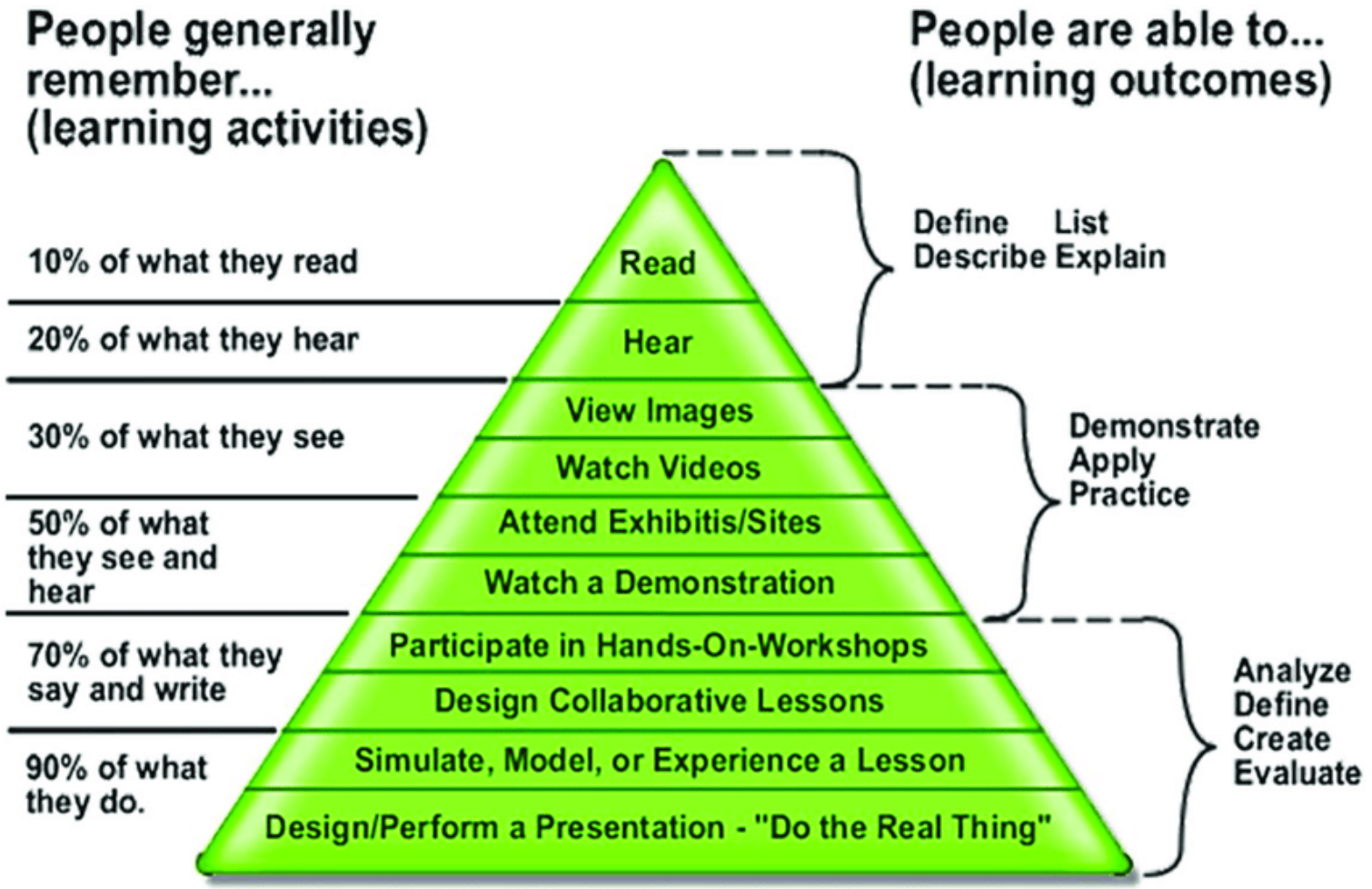
- Facilitator Role and Qualities
- Adult Learners
- Building and Maintaining Engagement
- Receiving and Addressing Feedback
- Facilitator’s Toolbox

FACILITATION 101: FACILITATOR ROLE AND QUALITIES

- Facilitation is the art of helping others learn through engaging with and processing the presented material
- Facilitator Role: facilitating the Care Coordination Curriculum
- You do not need to be an expert to be a good facilitator
- Creating a safe and meaningful environment for all participants
- Dual roles: you may hold multiple roles, as well as the role of facilitating the content. Understand and clarify the different responsibilities associated with those roles, if applicable
- Its important to understand your audience and how the presented material is relevant to their experience
- Verbal and non-verbal qualities

FACILITATION 101: FACILITATOR ROLE AND QUALITIES

Edgar Dale's "Cone of Experience"

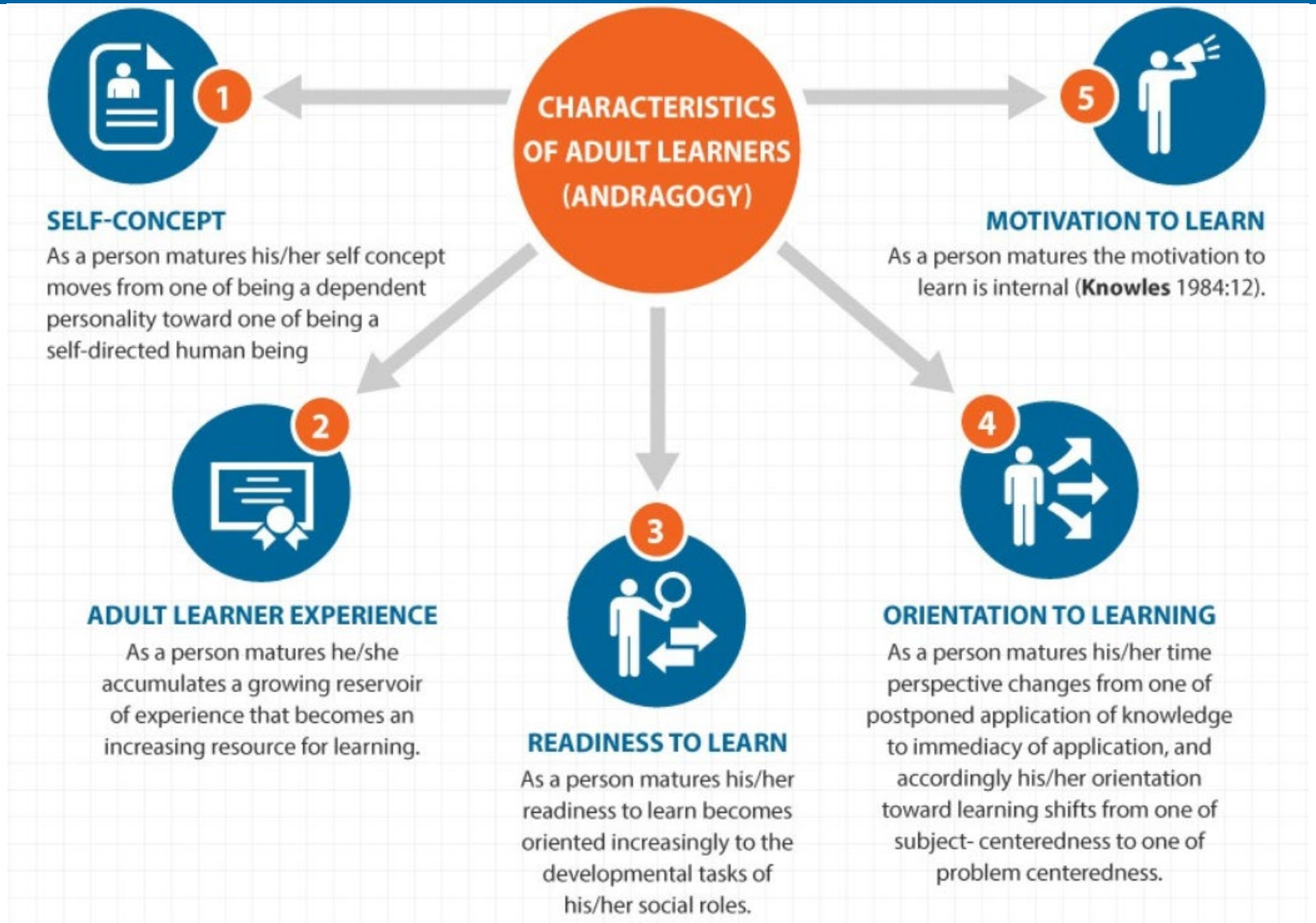


Source: Pietroni, Eva. (2019). Experience Design, Virtual Reality and Media Hybridization for the Digital Communication Inside Museums. *Applied System Innovation 2, 4: 35*. https://doi.org/10.3390/asi2040035

FACILITATION 101: ADULT LEARNERS

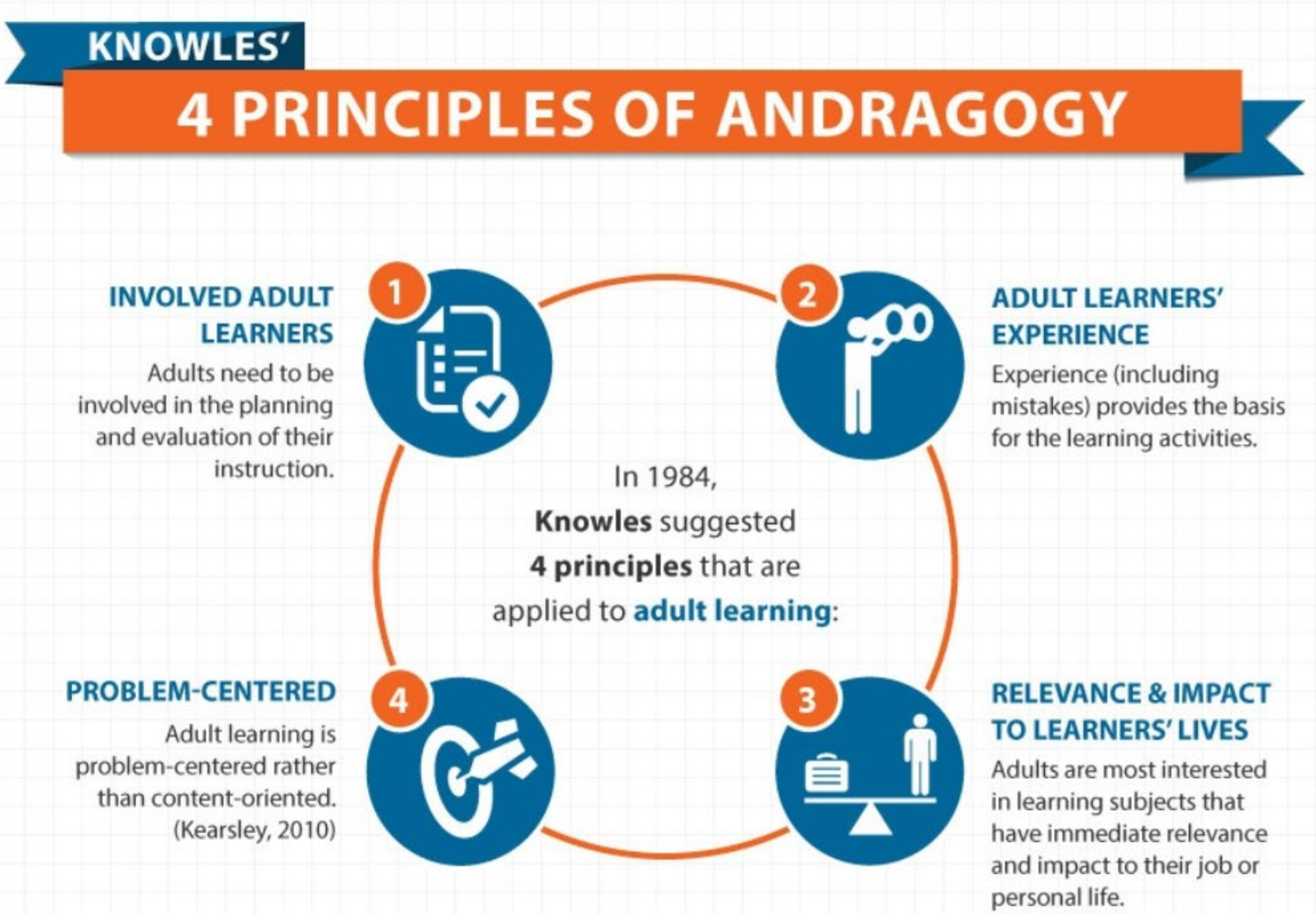
- Adragogy: the principles and practice of adult education
- American Educator Malcolm Knowles founded the term, and it became synonymous to “adult education”
- Knowles argues that unlike children, adult learners have unique needs and motivations that impact their understanding, retention, and application of learned material
- He defined:
  - 5 Characteristics of adult learners
  - 4 Principals to apply into practice

FACILITATION 101: ADULT LEARNERS CONT.



Source: The Adult Learning Theory - Andragogy – Infographic. Retrieved: https://elearninginfographics.com/adult-learning-theory-andragogy-infographic/#google_vignette

FACILITATION 101: ADULT LEARNERS CONT.



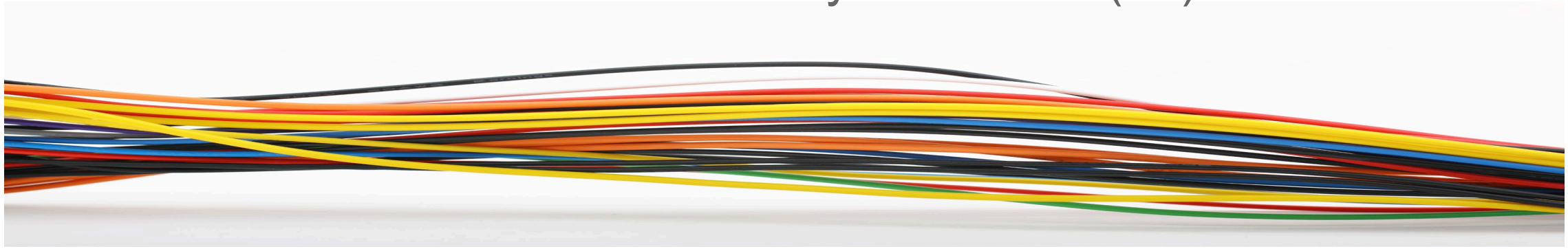
Source: The Adult Learning Theory - Andragogy – Infographic. Retrieved: https://elearninginfographics.com/adult-learning-theory-andragogy-infographic/#google_vignette

FACILITATION 101: BUILDING AND MAINTAIN ENGAGEMENT

- Key to good facilitation is building and maintaining engagement
- Opportunity for peer-to-peer learning
- Whiteboard activity

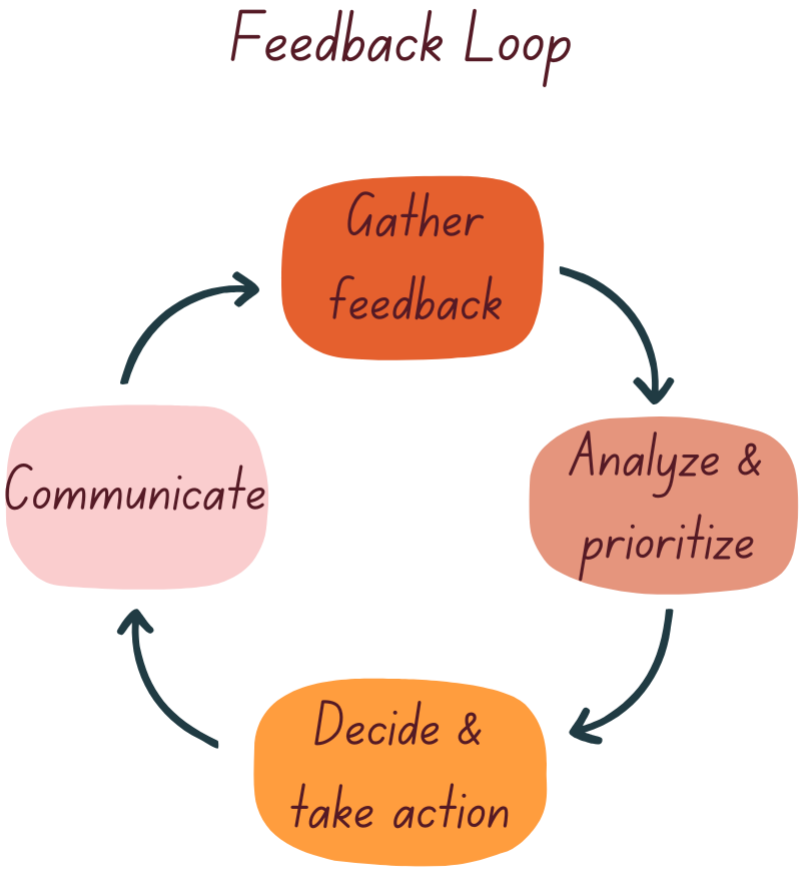
FACILITATION 101: RECEIVING AND ADDRESSING FEEDBACK

- Feedback: an opportunity to identify gaps and opportunities for improvement
- Tools: evaluation form, office hours, contact information and an invitation to connect afterwards, etc.
- Acknowledging and validating challenges
  - Content: theory of care coordination versus practice of implementation
- Open invitation for **peer-to-peer learning**: “how would you navigate this situation” or “how would/have you address(ed) this”



FACILITATION 101: RECEIVING AND ADDRESSING FEEDBACK

- Follow through: how as an agency are you committing to take the feedback, analyze it, identify opportunities for improvement, and communicate those decisions/actions?
- We can't meet the needs of all participants all the time, but having robust feedback and follow through allows for increased understanding, commitment to the work, trust, transparency, and team building



FACILITATION 101: FACILITATOR'S TOOLBOX

- Every facilitator has their own unique style and preferences
- Think of what has helped you facilitate in the past, or if its your first time, what would help you better convey the content?
- In-person versus virtual facilitations
  - Recognizing the differences and, the benefits and challenges of both
  - Tailor to your audience
  - Tech support as needed
  - Accommodations as needed for different learning styles

FACILITATION 101: FACILITATOR'S TOOLBOX

- Some example tools
- Drop in the chatbot other helpful tools

In-person	• Pens • Paper • Refreshments • Sticky notes • Tech support • More as needed
Virtual	• Chat box and reaction buttons • Zoom whiteboard: blank and templates • Zoom and other vendor games: i.e. Kahoot • Building in breaks • Tech support • More as needed


BREAK

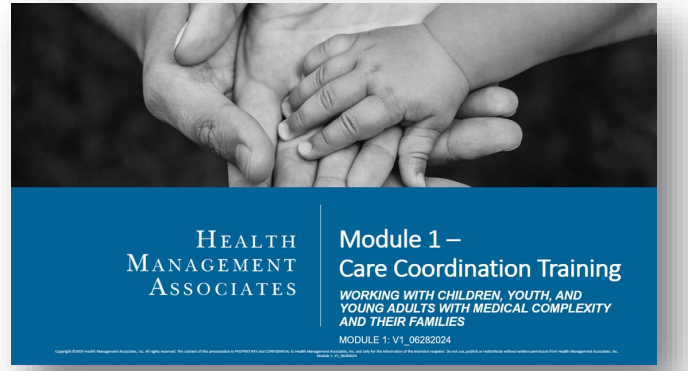
ORIENTATION TO THE CARE COORDINATION TRAINING CURRICULUM

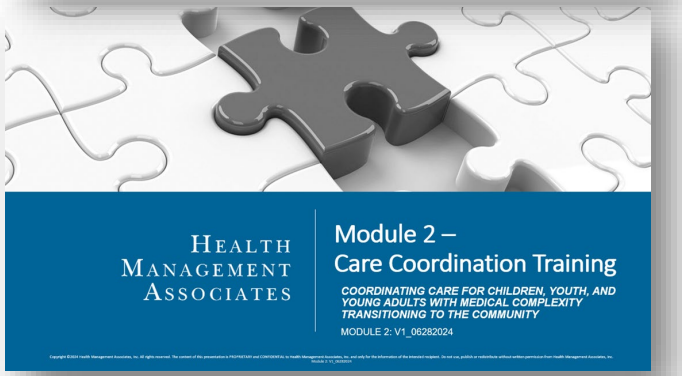
3 Modules

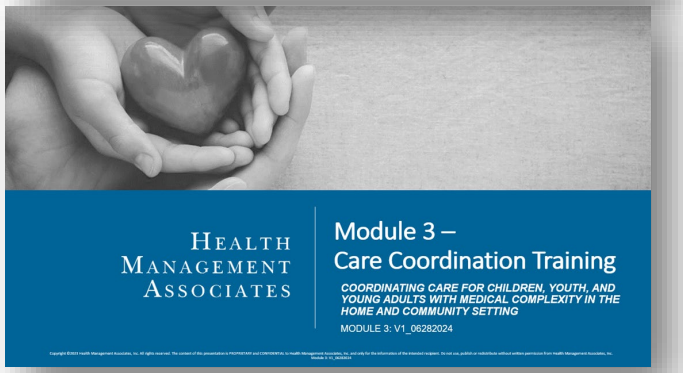
- Working with Children, Youth, and Young Adults with Medical Complexity and Their Families
- Coordinating Care for Children, Youth, and Young Adults with Medical Complexity Transitioning to the Community
- Coordinating Care for Children, Youth, and Young Adults with Medical Complexity in the Home and Community Setting

Each module has:

- Powerpoint slides
- Facilitation guide
- Assessment
- Evaluation



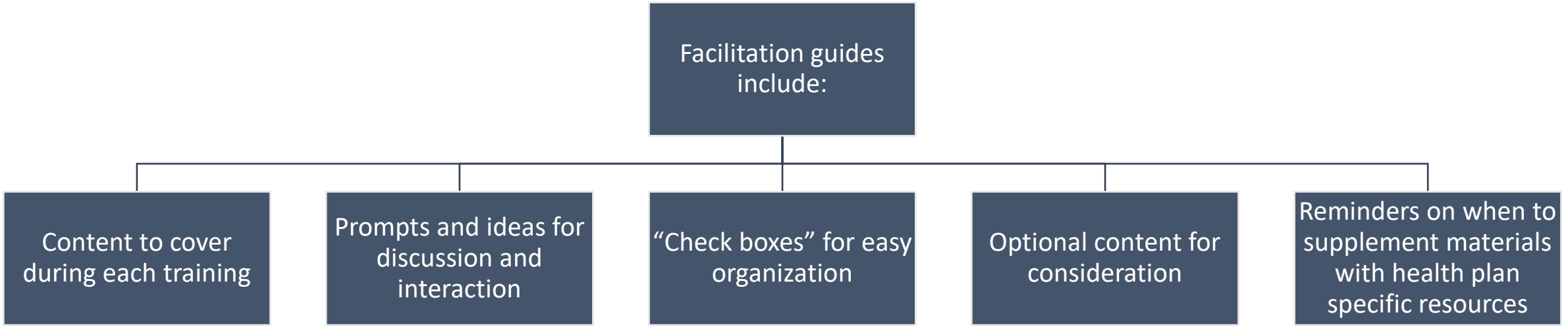




ORIENTATION TO THE MODULES

- Every module has:
  - Outline
  - Objectives
  - Scenarios and case studies
  - Knowledge checks
  - Summary slide
- Content within each section is generally laid out the same:
  - Definitions
  - Introduction to the concept(s)
  - Application for care coordinators
  - Scenario
  - Knowledge check

ORIENTATION TO THE FACILITATION GUIDES



ORIENTATION TO THE ASSESSMENTS AND EVALUATIONS

Assessments

- Questions include:
  - Matching
  - Multiple Choice
  - Select All that Apply
  - True/False
- Key at the end (remove when distributing)
- Need 80% to pass
- Collect and submit scores (not the actual assessments)

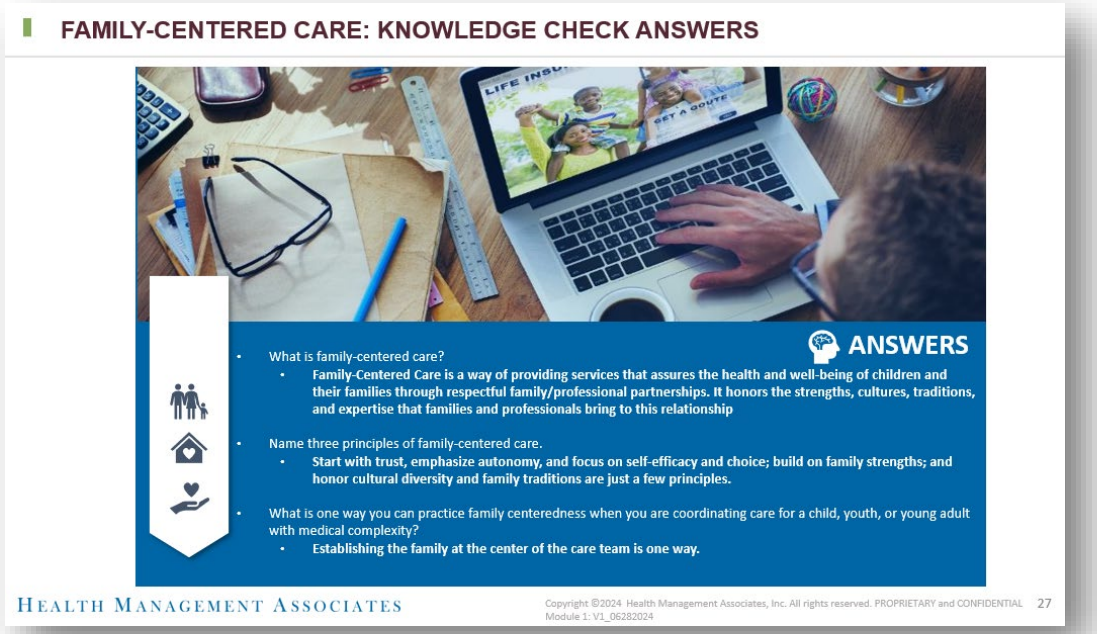
Evaluations

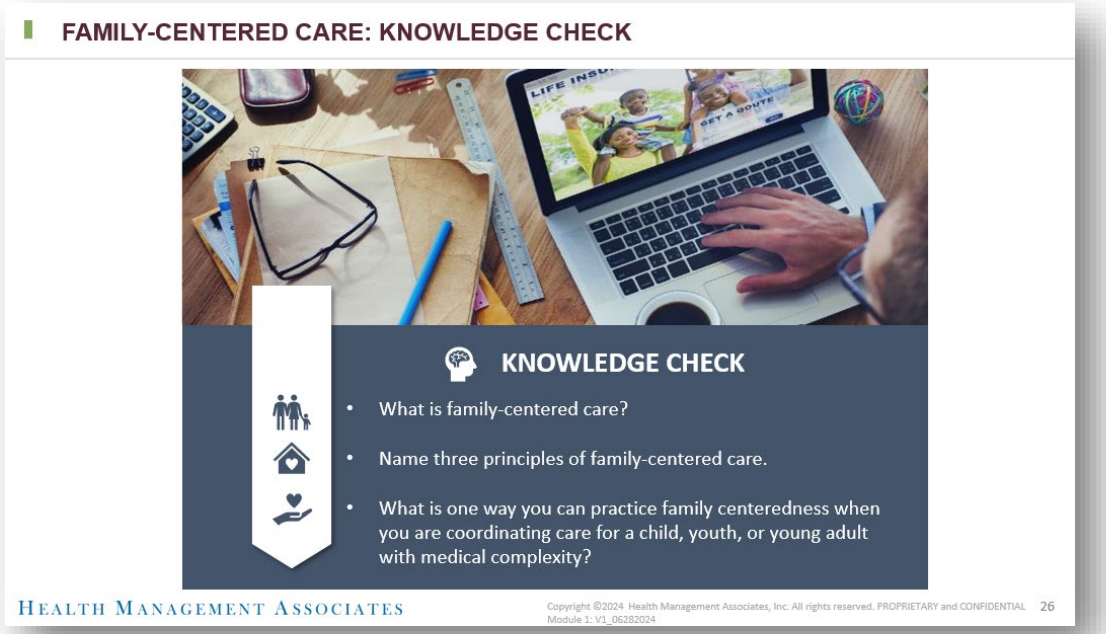
- Same set of 5 questions:
  - Quality
  - Relevance
  - Things they enjoyed
  - How to make it better
  - Topics to include for future iterations
- Collect and submit these

BRINGING LIFE TO THE SCENARIOS

- Strategies for engagement:
  - Break out rooms
  - Role playing
  - Come prepared with questions/prompts/possible answers
  - Include additional scenarios, based on the population the audience is coordinating care for
    - Draw from real life (maintain HIPAA)
    - Consider variation, including geographic or other cultural nuances relevant to the care coordinators in the audience

KNOWLEDGE CHECKS





- At the end of each section
- Can use the answers as a starting point for more discussion
- Consider best approach to knowledge checks (e.g., completing individually, as a group, in a breakout)

REFLECTION

QUESTIONS AND ANSWERS

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Day 2

July 22 and 23, 2024

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AGENDA DAY 2

- For Each Module
  - Review Content
  - Case Study Opportunities
  - Enhancing Materials with Additional Resources
  - Navigating Challenging Topics
  - Q&A
- Reflection
- Q&A


MODULE 1

MODULE 1

- Module 1
  - Review Content
  - Case Study Opportunities
  - Enhancing Materials with Additional Resources
  - Navigating Challenging Topics
  - Q&A

HEALTH MANAGEMENT ASSOCIATES

Module 1 – Care Coordination Training

WORKING WITH CHILDREN, YOUTH, AND YOUNG ADULTS WITH MEDICAL COMPLEXITY AND THEIR FAMILIES

MODULE 1: V1_06282024

INTENDED AUDIENCE

Slide 3

This training is for Care Coordinators in Florida who serve Medicaid enrollees who have medical complexity.

This is the first module in a three-part series. Complete the following trainings, once you have completed this module (Module 1):

- *Module 2 – Care Coordination Training: Coordinating Care for Children, Youth, and Young Adults with Medical Complexity Transitioning to the Community*
- *Module 3 – Care Coordination Training: Coordinating Care for Children, Youth, and Young Adults with Medical Complexity in the Home and Community Setting*

Slide 4

Outline

- Cultural Competency
- Family-Centered Care
- Trauma-Informed Care
- Family Engagement
- Putting it all in Practice – A Case Study
- Conclusion

FRAMEWORK

Slide 6

Slide 7

Cultural Competency

CULTURAL COMPETENCY: KEY DEFINITIONS

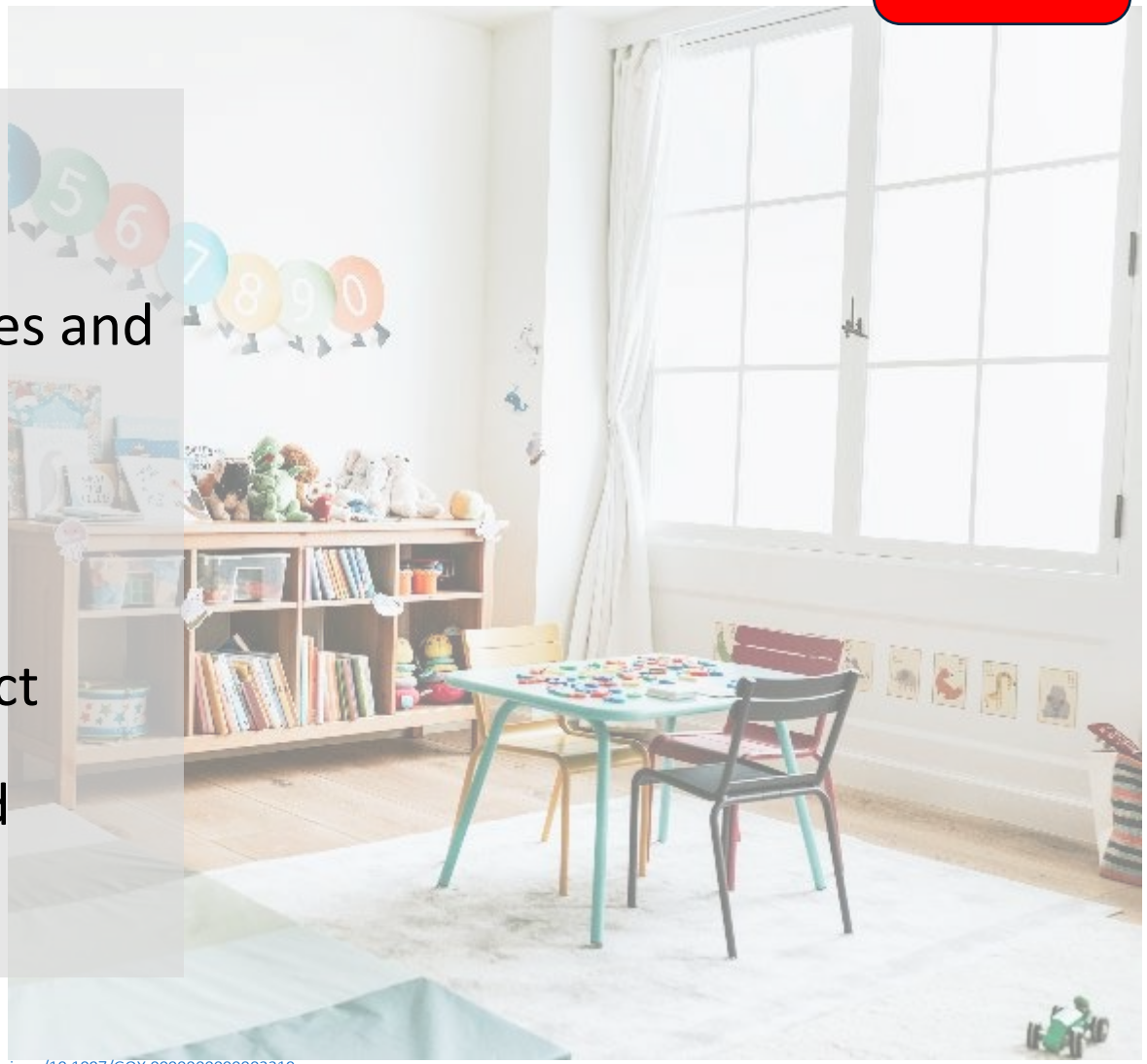
Slide 8

Cultural Competence

The ability to collaborate effectively with individuals from different cultures; and such competence improves healthcare experiences and outcomes.[1]

Culturally Competent Care

Care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors.[2]



1. Nair, L., & Adetayo, O. A. (2019). Cultural Competence and Ethnic Diversity in Healthcare. Plastic and reconstructive surgery. Global open, 7(5), e2219. https://doi.org/10.1097/GOX.0000000000002219
2. Agency for Healthcare Research and Quality. Improving Cultural Competence to Reduce Health Disparities for Priority Populations. https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol

CULTURAL COMPETENCY: 5 ESSENTIAL ELEMENTS

Slide 11

1. VALUE DIVERSITY
2. ADAPT TO DIVERSITY AND CULTURAL CONTEXTS
3. ACQUIRE CULTURAL KNOWLEDGE
4. SELF-ASSESSMENT
5. MANAGE THE DYNAMICS OF DIFFERENCES

1. Georgetown University's National Center for Cultural Competence. https://nccc.georgetown.edu/foundations/framework.php

MEET MICHAEL

- Michael is 10 years old and was in a car accident when he was younger. He has multiple comorbidities and receives PDN for 12 hours nightly.
- Michael's father works while his mother cares for him and his two younger siblings.
- Michael's mother is Puerto Rican, and his father is Portuguese-American.
- Recently, Michael's condition has changed, and he needs 24/7 PDN, but his family wants a female Spanish-speaking nurse to fill the additional shifts and the home health agency does not have the workforce that fits the family's request.

CONSIDER:

To effectively engage with Michael and his family:

- How will you examine your own understanding and beliefs about:
  - Children with medically fragile conditions?
  - The different cultures represented in Michael's family?
- How will you explore your own attitudes about and openness to other's cultural norms and family needs?
- What information will you need to gather to increase your knowledge about the factors impacting Michael's and his family's experience?
- What will your interactions look like when you are displaying cultural competence?
- What cultural considerations will you need to consider when you are developing a care plan for Michael?

CULTURAL COMPETENCY: KNOWLEDGE CHECK ANSWERS

Slide 16

ANSWERS

- What is cultural competence?
  - **The ability to collaborate effectively with individuals from different cultures; and such competence improves healthcare experiences and outcomes.**
- What are the four pillars of cultural competency?
  - **Awareness, Attitude, Knowledge, Skills**
- What is one way you can practice cultural competency when you are coordinating care for a child, youth, or young adult with medical complexity?
  - **Avoid imposing your values on others, recognize cultural differences that may impact family preferences and goals, and use visual aids to promote understanding are just some ways.**

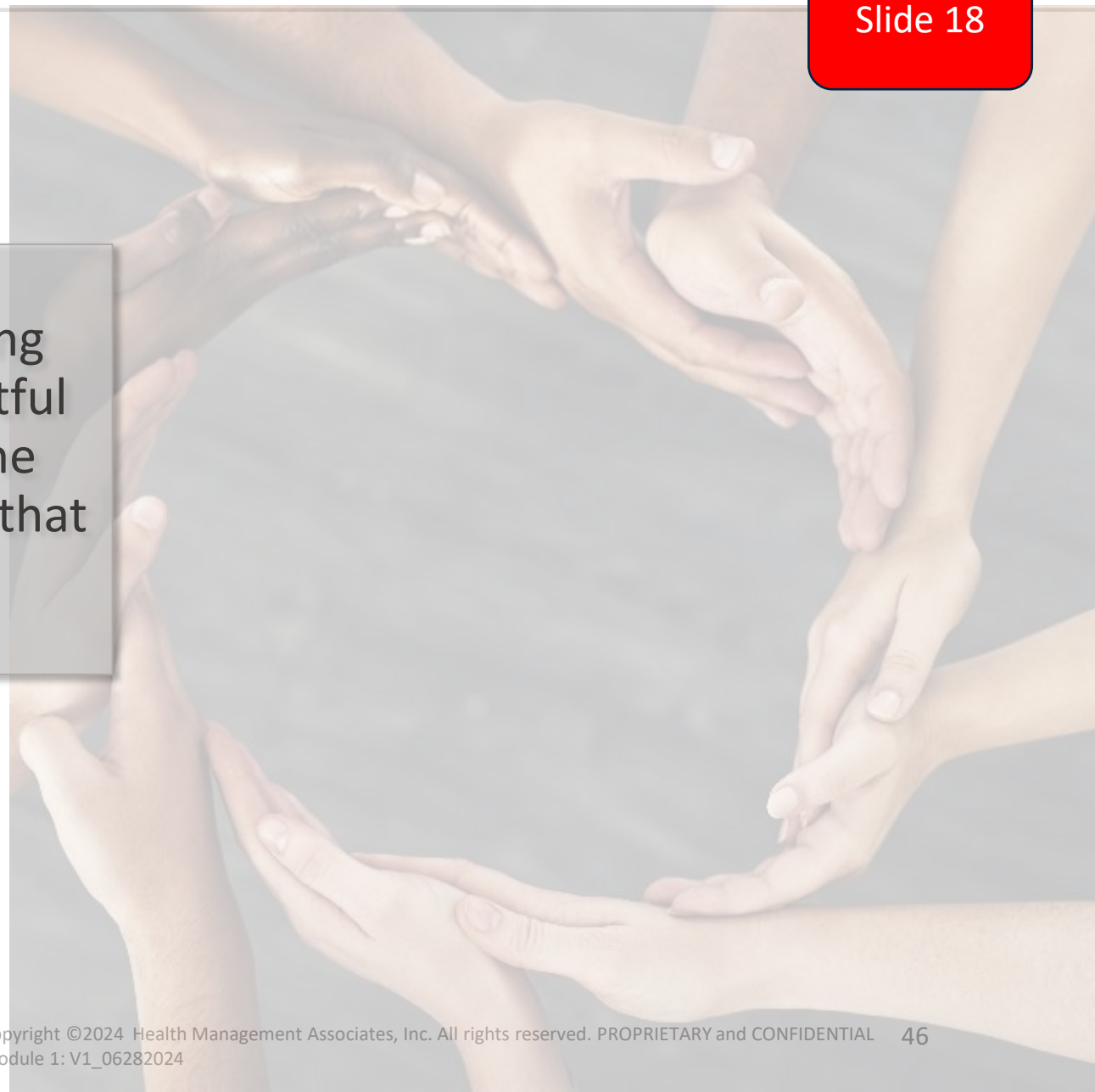
Slide 17

Family – Centered Care

FAMILY-CENTERED CARE: DEFINITION

Slide 18

Family-Centered Care is a way of providing services that assures the health and well-being of children and their families through respectful family/professional partnerships. It honors the strengths, cultures, traditions, and expertise that families and professionals bring to this relationship.[1]



1. Family Voices. Family-Centered Care. https://familyvoices.org/familycenteredcare/

FAMILY-CENTERED CARE: PRINCIPLES FOR COORDINATING CARE FOR CYSHCN

Slide 19

- Starts with trust, emphasizes autonomy, and focuses on self-efficacy and choice
- Builds on family strengths
- Honors cultural diversity and family traditions
- Recognizes the importance of community-based services
- Promotes an individual and developmental approach
- Encourages family-to-family and peer support
- Supports youth as they transition to adulthood
- Develops policies, practices, and systems that are family-friendly and family-centered in all settings

Adapted from Family Voices. Family-Centered Care. https://familyvoices.org/familycenteredcare/

FAMILY-CENTERED CARE: KEY CONSIDERATIONS

Slide 20

All children should have equal opportunity to attain their full health potential.

Lived experiences are valued and addressed using Trauma-Informed and Strengths-Based approaches.

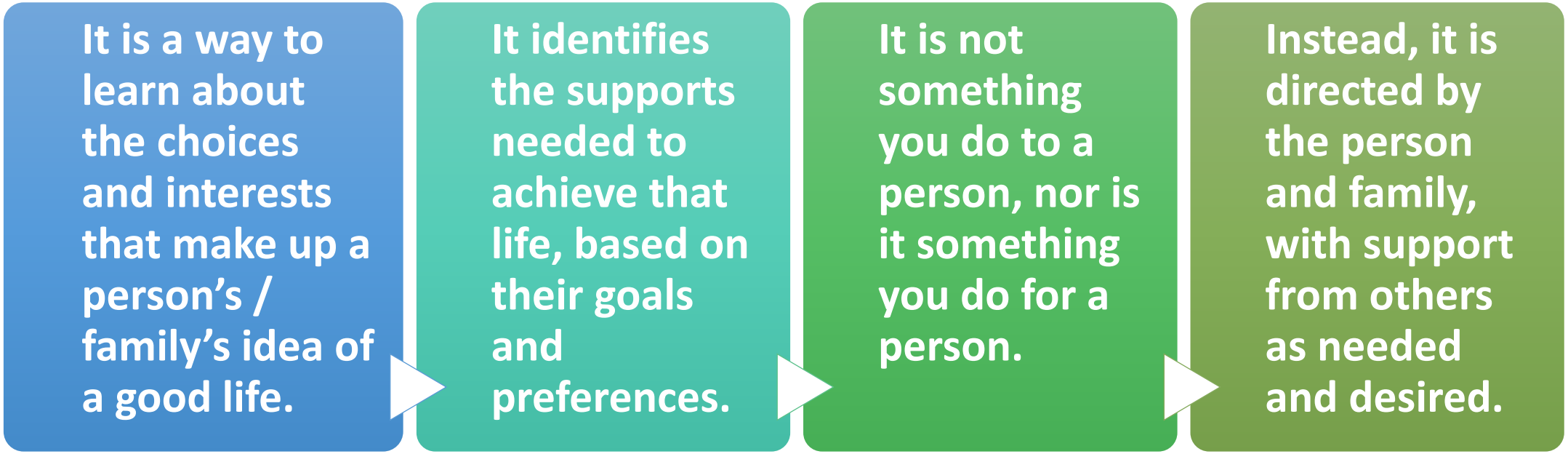
The child and family are engaged and recognized as active and equal partners.

Seamless navigation and access to needed services is achieved by working amongst and across teams.

Adapted from the National Care Coordination Standards for Children and Youth with Special Health Care Needs

FAMILY-CENTERED CARE: APPROACH TO THE PLANNING PROCESS

Slide 21



5 Competency Domains for Staff who Facilitate Person-Centered Planning. Janis Tondora, Bevin Croft, Yoshi Kardell, Teresita Camacho-Gonsalves, and Miso Kwak November 2020

Slide 24

MEET CLAIRE

- Claire is Haitian, 4 years old, and was born with hydrocephaly. She has several co-occurring conditions that keep her medically fragile.
- After multiple hospitalizations this year, her parents decided to transition her to a nursing facility where she could receive a constant, higher level of nursing care.
- Now that they feel like Claire is more stable, they want to start planning to bring Claire home.

Slide 25

CONSIDER

To effectively engage with Claire and her family:

+ What principles in family-centered care are you prioritizing in your interactions?
+ How will you work with Claire's parents to identify Claire's goals for transitioning that are centered in the family's preferences and needs?
+ Are there key components of person- and family-centered planning that will be critical to transition planning with Claire's family?

FAMILY-CENTERED CARE: KNOWLEDGE CHECK ANSWERS

Slide 27

ANSWERS

- What is family-centered care?
  - **Family-Centered Care is a way of providing services that assures the health and well-being of children and their families through respectful family/professional partnerships. It honors the strengths, cultures, traditions, and expertise that families and professionals bring to this relationship**
- Name three principles of family-centered care.
  - **Start with trust, emphasize autonomy, and focus on self-efficacy and choice; build on family strengths; and honor cultural diversity and family traditions are just a few principles.**
- What is one way you can practice family centeredness when you are coordinating care for a child, youth, or young adult with medical complexity?
  - **Establishing the family at the center of the care team is one way.**

Slide 28

Trauma – Informed Care

TRAUMA-INFORMED CARE: DEFINITIONS

Slide 29

A Trauma Informed…

child and family service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers.[1]

approach to care coordination involves care providers having an understanding about the different types of trauma that people can experience and the potential influence of trauma on individuals, families, and communities. An understanding of the impacts of trauma can help care coordination programs better manage the complex needs of patients and understand some of the causes and challenges for seeking care.[2]

1. The National Child Traumatic Stress Network: https://www.nctsn.org/
2. The Rural Health Information Hub: https://www.ruralhealthinfo.org/toolkits/care-coordination/3/whole-person

TRAUMA-INFORMED CARE: DEFINITIONS CONT.

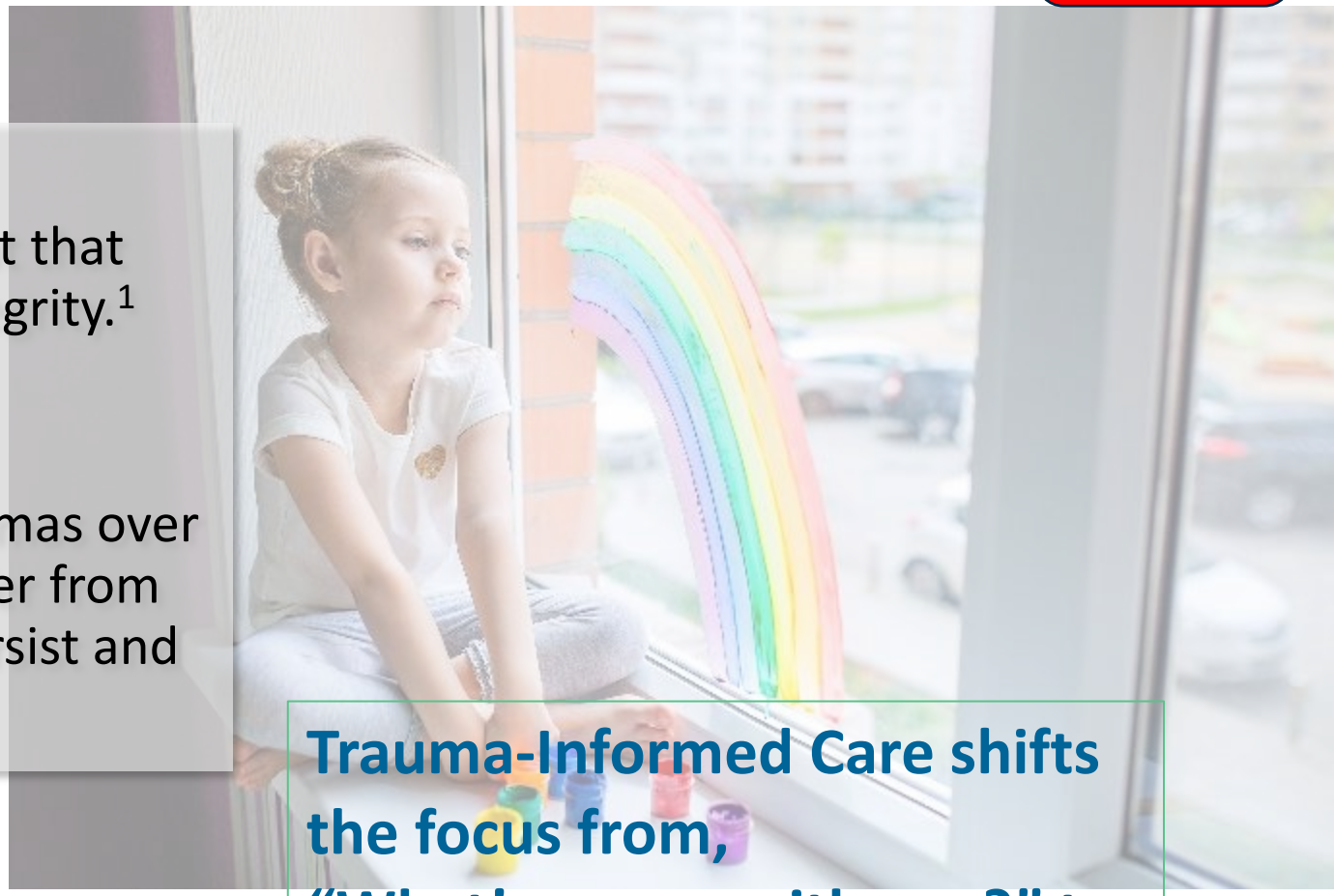
Slide 30

A Traumatic Event

is a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity.[1]

Traumatic Stress

is a result of exposure to one or more traumas over the course of their lives. Children who suffer from traumatic stress develop reactions that persist and affect their daily lives.[1]

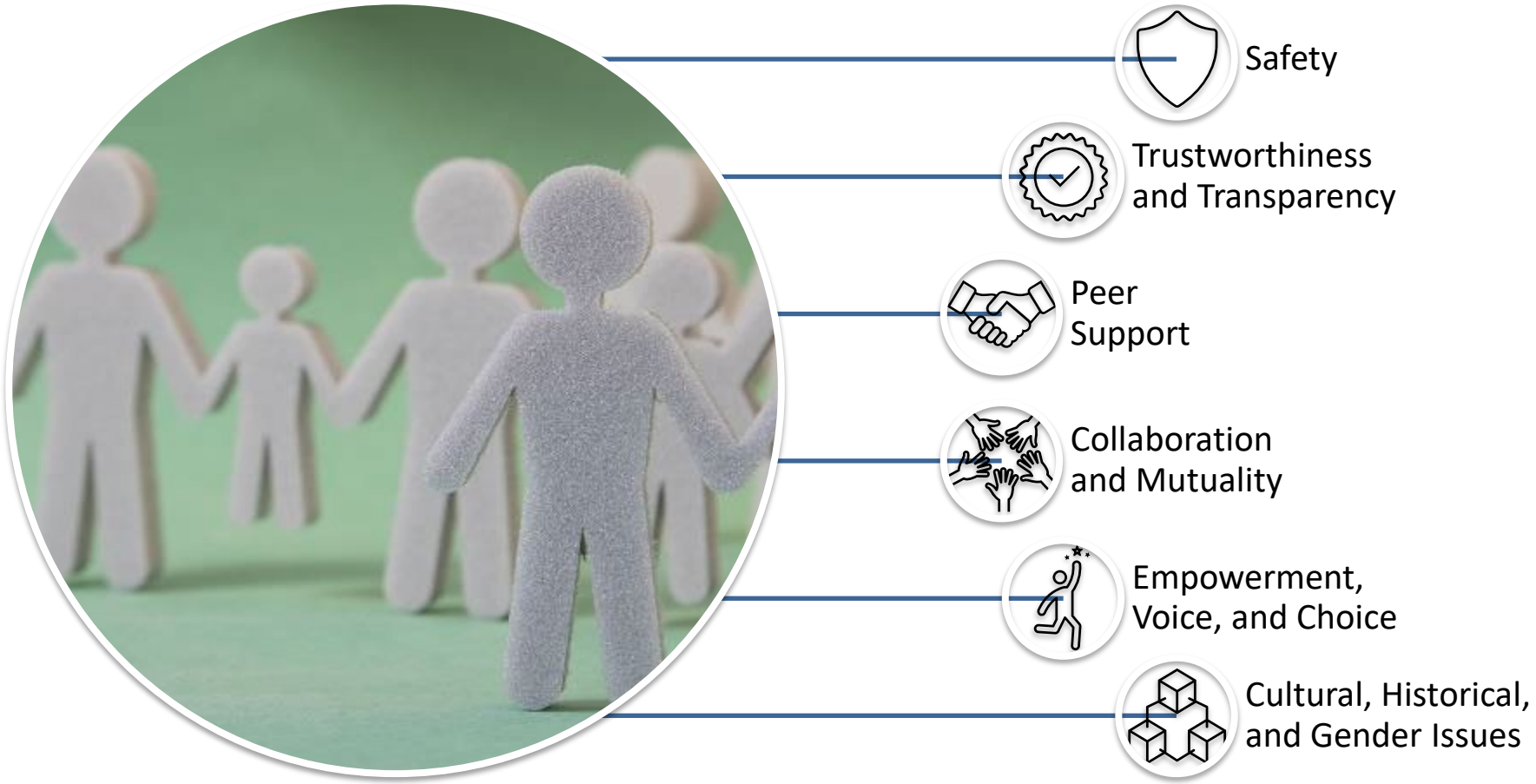


Trauma-Informed Care shifts the focus from,
"What's wrong with you?" to,
"What happened to you?"

1. The National Child Traumatic Stress Network: https://www.nctsn.org/

TRAUMA-INFORMED CARE: KEY PRINCIPLES[1]

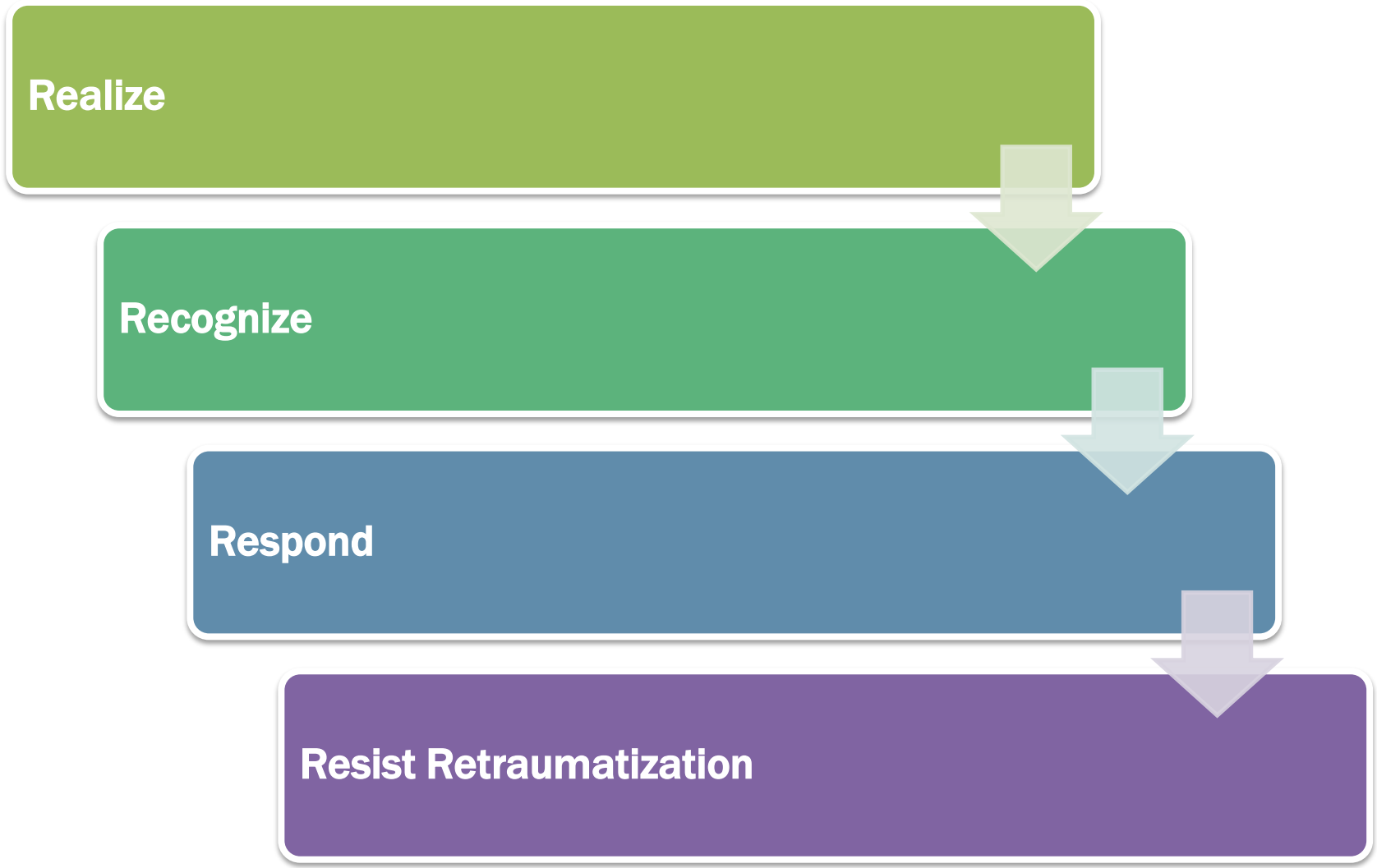
Slide 31



1. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: https://www.samhsa.gov/resource/dbhis/samhsas-concept-trauma-guidance-trauma-informed-approach

TRAUMA-INFORMED CARE: KEY ASSUMPTIONS – THE FOUR "Rs" FRAMEWORK[1]

Slide 32



1. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: https://www.samhsa.gov/resource/dbhis/samhsas-concept-trauma-guidance-trauma-informed-approach

Slide 34

MEET SOPHIE

- Sophie is 15 years old. She has been in a nursing facility since she was 2 years old, after unsuccessfully transitioning to her home from a long stay in the NICU and several admissions to the PICU. Sophie experienced traumas related to her birth and is completely ventilator-dependent and non-mobile; however, she does communicate with a device.

- Sophie's parents are divorced, but visit her together, once a week, nearly every week. She is an only child. Her mother is African American, and her father is White.

- Sophie's mom is ready to bring her home; however, her father continues to have reservations about Sophie's safety.

CONSIDER

To engage with Sophie and her family:

- What techniques in trauma-informed care are you prioritizing in your interactions?
- How will you work with Sophie and her parents to identify Sophie's goals, based on her preferences and values? Their preferences and values?
- Are there key components of a trauma-informed approach that will be critical to transition planning with Sophie's family?

TRAUMA-INFORMED CARE: KNOWLEDGE CHECK ANSWERS

Slide 37

ANSWERS

- What is a trauma-informed approach to care coordination?
  - **A trauma-informed approach to care coordination involves care providers having an understanding about the different types of trauma that people can experience and the potential influence of trauma on individuals, families, and communities. An understanding of the impacts of trauma can help care coordination programs better manage the complex needs of patients and understand some of the causes and challenges for seeking care.**
- Name three principles of trauma-informed care.
  - **Safety, trustworthiness and transparency, and peer support are just a few principles.**
- What is one way you can practice trauma-informed care when you are coordinating care for a child, youth, or young adult with medical complexity?
  - **One way to practice trauma-informed care is to build and maintain trusting and healing environments by creating spaces and encounters that are characterized by compassion and safety.**

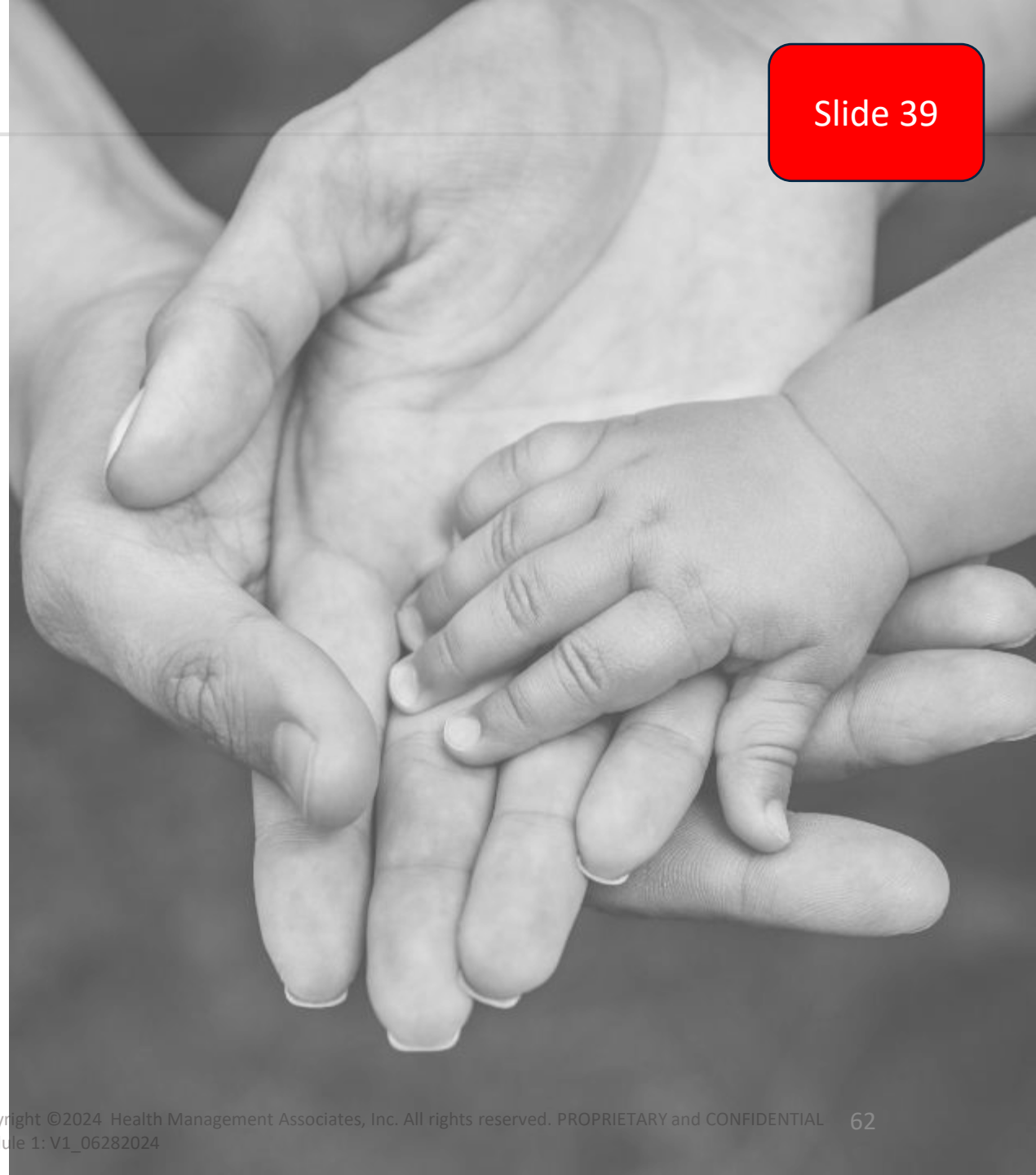
Slide 38

Family Engagement

FAMILY ENGAGEMENT: DEFINITION

Slide 39

- Strong **Family Engagement** happens when families have a primary and meaningful role in all decision-making that impacts a child and their family.[1]
  - Family engagement on the individual level is a key element of family-centered care.[2]
  - Active partnership between professionals and families helps ensure that the lived experience of families informs care and support services.[2]



1. Youth.Gov. Family Engagement: https://youth.gov/youth-topics/family-engagement#:~:text=Description%20of%20Family%20Engagement&text=Family%20engagement%20also%20happens%20at,the%20family's%20ideas%20of%20success.
2. Boston University. Family Engagement and Children and youth with Special Health Care Needs. https://ciswh.org/wp-content/uploads/2019/03/Infographic_Family_Engagement.pdf

FAMILY ENGAGEMENT: FAMILY AS AN ACTIVE AND EQUAL PARTNER

Adapted from:

- Centers for Medicare & Medicaid (CMS) Person & Family Engagement Strategy: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/person-and-family-engagement-strategy-summary.pdf
- National the National Care Coordination Standards: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/person-and-family-engagement-strategy-summary.pdf

FAMILY ENGAGEMENT: APPLICATION FOR CARE COORDINATORS

Slide 42

Interventions include building skills to manage their child's conditions and needs with efficacy. This may include advocacy skill-building too.

Care Plans are shared and communicated across the system.

Care Plan goals are co-created and based on the individual's and family's preferences and values, promoting their personal and family strengths.

Children, youth, and young adults, along with their families, are encouraged to share their preferences and values in a non-judgmental and supportive environment.

Families receive up-to-date information about the care and services available to their child.

Assessments include understanding the individual's and family's health literacy. Interventions are adapted to an individual's health literacy level and are designed to increase health literacy over time.

MEET KYLE

- Kyle is 9 years old and has Prader-Willi Syndrome and other co-occurring conditions including frequent seizures.
- Kyle needs constant supervision and medical care, resulting in an order for PDN 24/7.
- After an extended stay in the hospital, Kyle has transitioned home to live with his biological aunt, who is his guardian.
- Kyle's aunt did not have a pleasant experience with the hospital staff and is suspicious of Kyle's nurses and his Care Coordinator because she feels like she can't trust anyone and no one is listening to her.

CONSIDER

To effectively engage with Kyle and his family:

+ What principles of family engagement are you prioritizing in your interactions?
+ Are there key components of family engagement that will be critical to care planning with Kyle's aunt?

FAMILY ENGAGEMENT: KNOWLEDGE CHECK ANSWERS

Slide 46

ANSWERS

- What is family engagement?
  - **Family Engagement occurs when families have a primary and meaningful role in all decision-making that impacts a child and their family.**
- Name three techniques of family engagement.
  - **Focusing on health literacy, promoting informed decision-making, and encouraging sharing of preferences and values are just a few techniques.**
- What is one way you can practice family engagement when you are coordinating care for a child, youth, or young adult with medical complexity?
  - **One way to practice family engagement is to ensure that your interventions include building skills to manage their child's conditions and needs with efficacy.**

Putting it all in Practice – A Case Study

MEET THE SUAREZ FAMILY

Slide 48

The family resides in a suburb of Miami, Florida.

Mom is a second-generation immigrant from Cuba, with family still residing in Cuba. She works part-time as a hairstylist.

Dad is a Florida native, raised in Northern Florida. His mother lives with them in a spare bedroom. He works full-time as a realtor.

They have two kids together, their son is 4 years old, and their daughter is 7 years old. Their daughter has Spina Bifida and is residing in a nursing facility.

Currently, the Suarez family shares one vehicle and though both mom and dad have flexible work schedules, they are often visiting their daughter alone. It seems they are getting different information from her care team each time they visit. They feel like their daughter would benefit from living at home, but don't know how to ask for this or plan for it.

Activities & Hobbies
- Church
- Going to the beach
- Weekly family dinners
- Family walks, exercise at home

Health Information
- Private insurance
- Medicaid for their daughter
- Daughter is assigned a care coordinator
- Daughter's health fluctuates

Gains (with better coordination)
- More family time
- Clear communication
- Shared health goals for their daughter

Pains (consequences of poor coordination)
- Mistrust
- Frustration
- Missed opportunities for bonding as a family

CASE STUDY: THE SUAREZ FAMILY

YOU are the Care Coordinator in this scenario. What happens next? Think through these questions and write down any ideas that stick out to you.

Slide 49

1

Identifying the most important things first:

- Where do you see the biggest issues for their daughter? Their family?
- What will your next interaction with the family look like?

2

Cultural Competency

- Are there things you want to understand about the family first? About yourself?
- How will you be culturally responsive and competent in your next interaction with the family?

3

Family-Centered Care

- How will you help this family identify goals to help their daughter come home safe?
- How will you work with them to understand their daughter's needs and strengths? The family's needs and strengths?

4

Trauma-Informed Care

- How will you acknowledge and incorporate the family's past traumas into how you interact with them?
- How will you help them focus on resiliency and recovery?

5

Family Engagement

- What will you need to do to help engage them more in their daughter's care and care team conversations?

CASE STUDY: THE SUAREZ FAMILY

Slide 50

Hypothesize what action steps you will take for Suarez family after thinking through the exploratory questions earlier:

01 The most important thing I identified was...

02 I will express cultural competency through...

03 I will implore a family-centered care framework by...

04 I will ensure I have trauma-informed perspective by...

05 I will engage the family further by...

Slide 51

Conclusion

CONCLUSION

*Working with children, youth, and young adults with medical complexity, and their families requires skills in **cultural competency**, **trauma-informed care**, **family-centered care**, and **family engagement**.*

Cultural Competency

Cultural Competency respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors.

The four pillars of cultural competency are:

1. Awareness
2. Attitude
3. Knowledge
4. Skills

Family Engagement

Family Engagement happens when families have a primary and meaningful role in all decision-making that impacts their child and their family. On the individual level, it is a key element of family-centered care.

Techniques to promote family engagement include focusing on health literacy, promoting informed decision-making, encouraging the sharing of preferences and values, co-creating goals, leveraging personal and family strengths, and building self-management and self-efficacy skills.

Family-Centered Care

Family-Centered Care is a way of providing services that assures the health and well-being of children and their families through respectful family/professional partnerships. It honors the strengths, cultures, traditions, and expertise that families and professionals bring to this relationship.

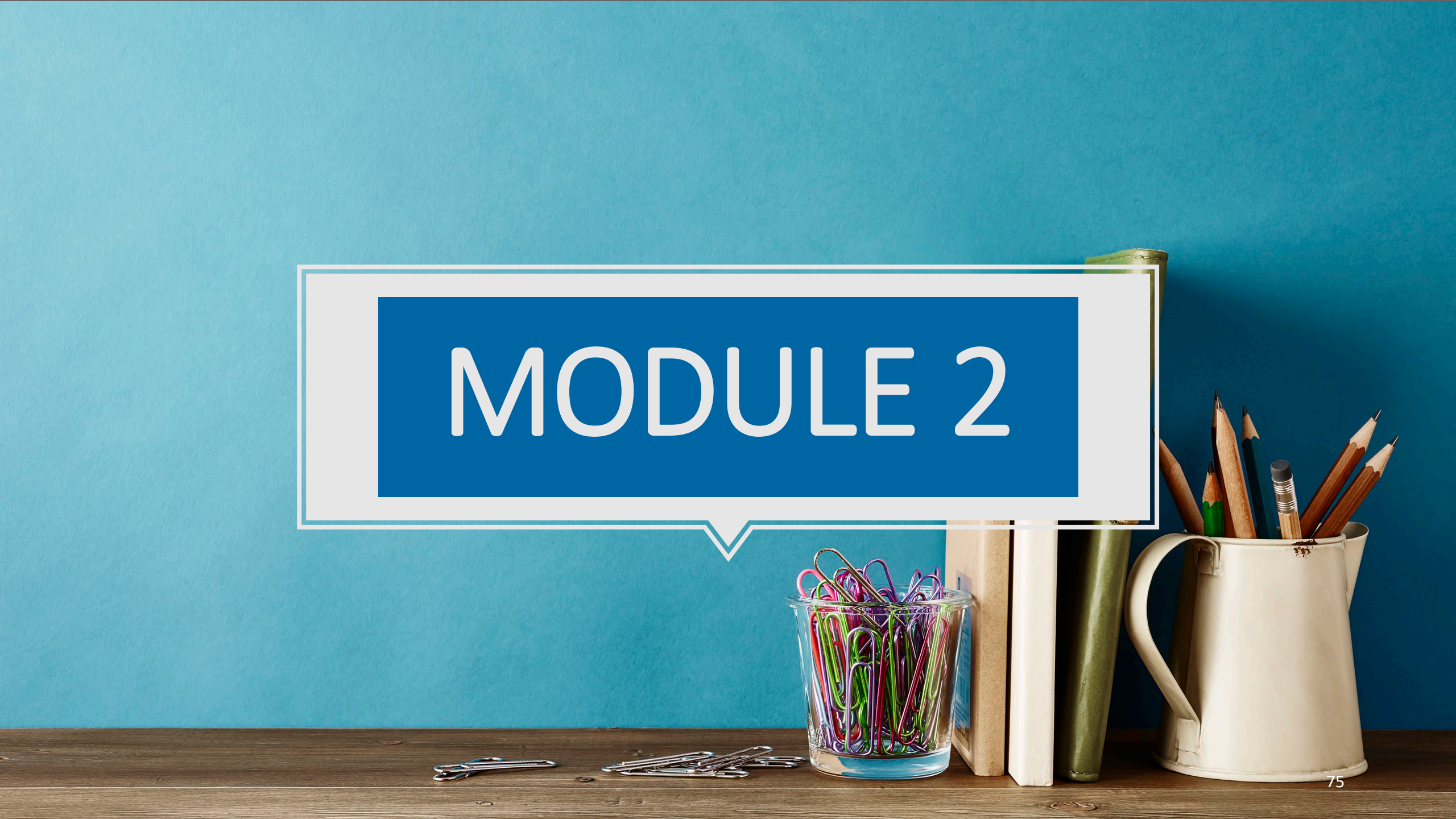
Principles of family-centered care include building on family strengths; honoring cultural diversity and family traditions; recognizing the importance of community-based services; promoting an individualized and developmental approach; encouraging family-to-family and peer support; supporting youth as they transition to adulthood; developing policies, practices, and systems that are family-friendly and family-centered in all settings; and celebrating successes.

Trauma-Informed Care

Trauma-informed care involves the recognition of the impact of trauma on health, including effects of traumatic stress and the potential influence of trauma on affected individuals. Trauma-informed care puts emphasis on the context behind a medical condition, rather than placing blame or shame on the individual. Key principles of trauma-informed care include creating the feeling of safety, trustworthiness and transparency, and empowerment of voice and choice (among others).

QUESTIONS AND ANSWERS

MODULE 2



MODULE 2

- Module 2
  - Review Content
  - Case Study Opportunities
  - Enhancing Materials with Additional Resources
  - Navigating Challenging Topics
  - Q&A

Slide 1

HEALTH MANAGEMENT ASSOCIATES

Module 2 – Care Coordination Training

COORDINATING CARE FOR CHILDREN, YOUTH, AND YOUNG ADULTS WITH MEDICAL COMPLEXITY TRANSITIONING TO THE COMMUNITY

MODULE 2: V1_06282024

INTENDED AUDIENCE

This training is for Care Coordinators in Florida who serve Medicaid enrollees who have medical complexity.

This is the second module in a three-part series. Complete *Module 1 – Care Coordination Training: Working with Children, Youth, and Young Adults with Medical Complexity and their Families* before continuing. Once you complete this module (Module 2), complete *Module 3 – Care Coordination Training: Coordinating Care for Children, Youth, and Young Adults with Medical Complexity in the Home and Community Setting*.

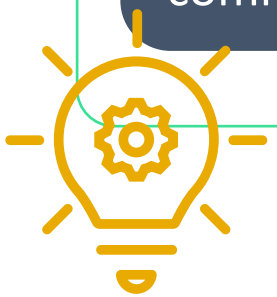
OBJECTIVES

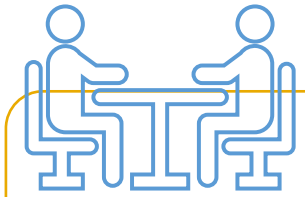
Slide 5

At the end of this training, you will be able to:

Explain **effective transition planning** practices.

Identify individualized **services and supports** available to children, youth, and young adults in nursing facilities as they transition to a community setting.





Describe **effective liaising** with entities, including providers, schools, Children's Multidisciplinary Assessment Teams (CMATs), and community-based organizations.

Assess for and plan to remove **barriers to community integration.**

Slide 6

Effective Transition Planning

EFFECTIVE TRANSITION PLANNING: GOALS

Slide 7

1. Medicaid.gov, Improving Care Transitions: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/improving-care-transitions/index.html

EFFECTIVE TRANSITION PLANNING: BEST PRACTICES

Slide 8

1

Proactive Processes

Transition Planning begins ***before*** admission

2

Promote Family Engagement

Transition Planning is family-centered and trauma-informed, delivered in a culturally competent way that promotes and values family engagement

3

Readiness Assessments

Readiness Assessment includes:

- A Home Evaluation
- Family/caregiver skills checklist
- Services and supports identified; including providers, equipment, and supplies
- Emergency and Safety Plans

EFFECTIVE TRANSITION PLANNING: BEST PRACTICES

Slide 10

Post Transition Best Practices:

1 Discharge Follow up

Coordinate with families to follow up post-discharge to ensure that parents feel knowledgeable and comfortable, that environment and equipment are suitable for their child as planned, no gaps in care are occurring, and that no new needs have been discovered not previously planned for.

- This will be especially important for:
  - Any special equipment such as ventilators and oxygen
  - Medications
  - Private Duty Nursing Coverage

2 Check-ins

Establish frequent check-ins with family to identify and address issues early as they emerge. Consider alternative ways for the family to connect with you, as needed and according to their needs and preferences.

3 Reconvening the Multidisciplinary Team (MDT)

As set (or convene earlier if indicated) conduct an MDT to comprehensively assess any ongoing and new needs.

1. Savithri Nageswaran, Megyn R. Sebesta, Shannon L. Golden; Transitioning Children With Medical Complexity From Hospital to Home Health Care: Implications for Hospital-Based Clinicians. Hosp Pediatr August 2020; 10 (8): 657–662. https://doi.org/10.1542/hpeds.2020-0068, Accessed: https://publications.aap.org/hospitalpediatrics/article/10/8/657/591/Transitioning-Children-With-Medical-Complexity?autologincheck=redirected

EFFECTIVE TRANSITION PLANNING: KNOWLEDGE CHECK ANSWERS

Slide 12

ANSWERS

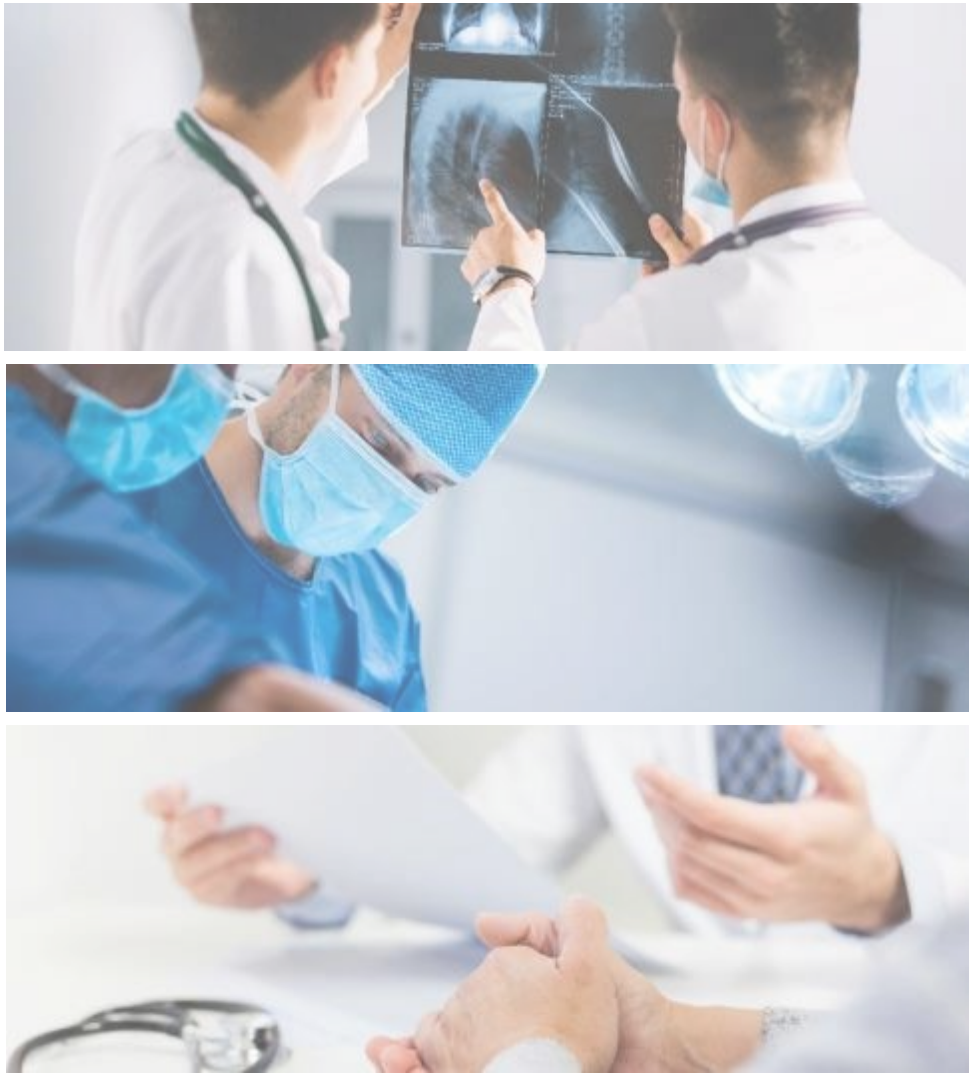
- What is one goal of transition care planning?
  - **To identify issues for early intervention**
- Name two components of a readiness assessment.
  - **Home Evaluation & Creating Emergency and Safety Plans**
- What is one best practice for post-transition care coordination?
  - **Frequent Check-ins**

Slide 13

Available Services and Supports

AVAILABLE SERVICES AND SUPPORTS: AN OVERVIEW

Slide 14



The complexity of an individual's condition does not mean they can't be cared for at home, if that is their parent/guardian's preference.

Children, youth, and young adults in nursing facilities may require multiple services and supports to help them transition home.

Care Coordinators need to effectively communicate with enrollees and families about these services so they can make informed decisions.

Services and supports will vary by county or region. Care Coordinators need to be familiar with what is available in the family's area and actively help make connections where possible.

AVAILABLE SERVICES AND SUPPORTS

Service	Description
Private Duty Nursing (PDN)	• One-on-one, medically necessary nursing care from a nurse • These services are available in the home and the child may be eligible to receive up to 24 hours a day of PDN per day (based on diagnosis, medical condition, and needs, including Prescribed Pediatric Extended Care (PPEC) hours, if provided) • The court has ordered the State to provide reliable PDN to any child who transitions from a nursing home to the community
Medical Equipment and Supplies	• Items for every day, or extended use at home, including: ○ Ventilation equipment and supplies ○ Oxygen equipment and supplies ○ Feeding equipment and supplies ○ Mobility devices such as a wheelchair
Medical Transportation	• Non-emergency Medical Transportation for the child and a caregiver to get to and from medical appointments

AVAILABLE SERVICES AND SUPPORTS

Service	Description
Prescribed Pediatric Extended Care (PPEC)	• Centers for children through age 20 • Provides skilled nursing supervision, medical services, nursing services, personal care, psychosocial services, respiratory therapy services, and developmental therapies in a non-residential setting • Transportation is provided by the PPEC Center • Provides caregiver training • Available for up to 12 hours a day
Medical Foster Care	• A program for children through age 20 • Provides temporary placement for 24-hour care in a licensed foster home with specially trained foster parents • Participation in this program is time-limited unless the child is in state custody
Family-to-Family Home Visits	• An opportunity for families to visit other family homes where children are receiving PDN in the home • During the visit, they will observe PDN provided to the child and have an opportunity to ask questions • Visits can be in-person or virtual and the child's care coordinator can accompany the family
Family-to-Family Peer Support	• An opportunity to connect the family to another family that has received PDN for a child with Complex Medical Needs • Interactions may be one-on-one, or with a group of families • Interactions may be in-person, virtual, or by phone

AVAILABLE SERVICES AND SUPPORTS

Slide 17

Service	Description
Expanded Benefits	• Benefits that are offered by the child's health plan, in addition to the standard benefit package (such as housing assistance, home delivered meals, trips to non-medical appointments, and transition assistance from the nursing facility to home)
Developmental Disabilities Individual Budgeting (iBudget) Waiver Program	• The iBudget Waiver Program is designed to promote and maintain the health of individuals with developmental disabilities and to provide medically necessary supports and services to prevent placement in a nursing home • Services are for eligible children 3 or older with a developmental disability • Services include: ○ Home Modifications: Adaptations to home for accessibility, such as ramps and door-widening ○ Vehicle Modifications: Adaptations to the vehicle for accessibility, including portable ramps ○ Consumable Medical Supplies: such as diapers, wipes, and pads ○ Residential Habilitation: Enables eligible children to live in licensed group homes up to 24 hours a day with nursing services and medical supervision • As the child's care coordinator, you can help families apply for this program through the Agency for Persons with Disabilities

AVAILABLE SERVICES AND SUPPORTS

Slide 18

Service	Description
Other Florida Medicaid Waiver Programs	• Long Term Care Waiver Program: ○ The Long-term Care Waiver Program is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while receiving services at home and in the community. Individuals in the program may also be served in a nursing facility setting ○ Service eligibility includes individuals 18 years of age or older and eligible for Medicaid by reason of disability and needs nursing facility level of care, or individuals 18 years of age or older with a diagnosis of cystic fibrosis and have a hospital level of care ○ Services include over two dozen home and community-based services and nursing facility services through this program. This Waiver Program is offered as a managed care program ○ **Your Care Coordinator can help you apply for this waiver by completing a CARES (Comprehensive Assessment and Review for Long-Term Care Services) referral**

AVAILABLE SERVICES AND SUPPORTS

Service	Description
Other Florida Medicaid Waiver Programs - Continued	• Model Waiver Program: ○ The Model Waiver Program is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while receiving services at home and in the community ○ Services are for individuals 20 years of age or younger that: ▪ Are living at home, or are medically fragile and have resided in a skilled nursing facility for at least 60 consecutive days prior to entrance on the waiver ▪ Have a diagnosis of a degenerative spinocerebellar disorder which is generally identified in the 330-337 range of ICD9-CM diagnostic classifications, or is Medically Fragile as defined in F.A. C. 59G-1.010 ▪ Meets the disability criteria for Social Security Disability ▪ Has a level of care determination of "at risk for hospital placement", or must meet skilled nursing facility level of care determined by CMAT, and reside in a nursing facility for a minimum of 60 days ▪ Is able to live safely at home ○ Services include: ▪ Assistive Technology and Service Evaluation ▪ Environmental Accessibility Adaptations ▪ Respite ▪ Transition Case Management ○ **This waiver is only available to Medicaid recipients that are fee-for-service**

AVAILABLE SERVICES AND SUPPORTS

Slide 20

Service	Description
Other Florida Medicaid Waiver Programs - Continued	• Familial Dysautonomia Waiver Program ○ The Family Dysautonomia Waiver Program promotes and maintains the health of eligible recipients with Familial Dysautonomia and minimizes the effects of illness and disabilities through the provision of needed supports and services to delay or prevent hospital placement or institutionalization ○ Services are for individuals who have been diagnosed with Familial Dysautonomia by a physician, are aged 3 through 64, and are at risk for hospitalization ▪ Adult Dental Services for recipients aged 21 years and older ▪ Behavioral Services ▪ Consumable Medical Supplies ▪ Durable Medical Equipment ▪ Non-Residential Support Services ▪ Respite Care ▪ Waiver Support Coordination ○ **This waiver is only available to Medicaid recipients that are fee-for-service**

AVAILABLE SERVICES AND SUPPORTS

Florida Medicaid

Care Coordinators must be familiar with Florida Medicaid covered services as well as plan-specific services and programs, including in lieu of services and expanded benefits.

"Find-a-Provider" Tools and Directories

Health Plan "Find-a-Provider" Tools can also be used to provide families with customized information about available providers for services and supports in their area.

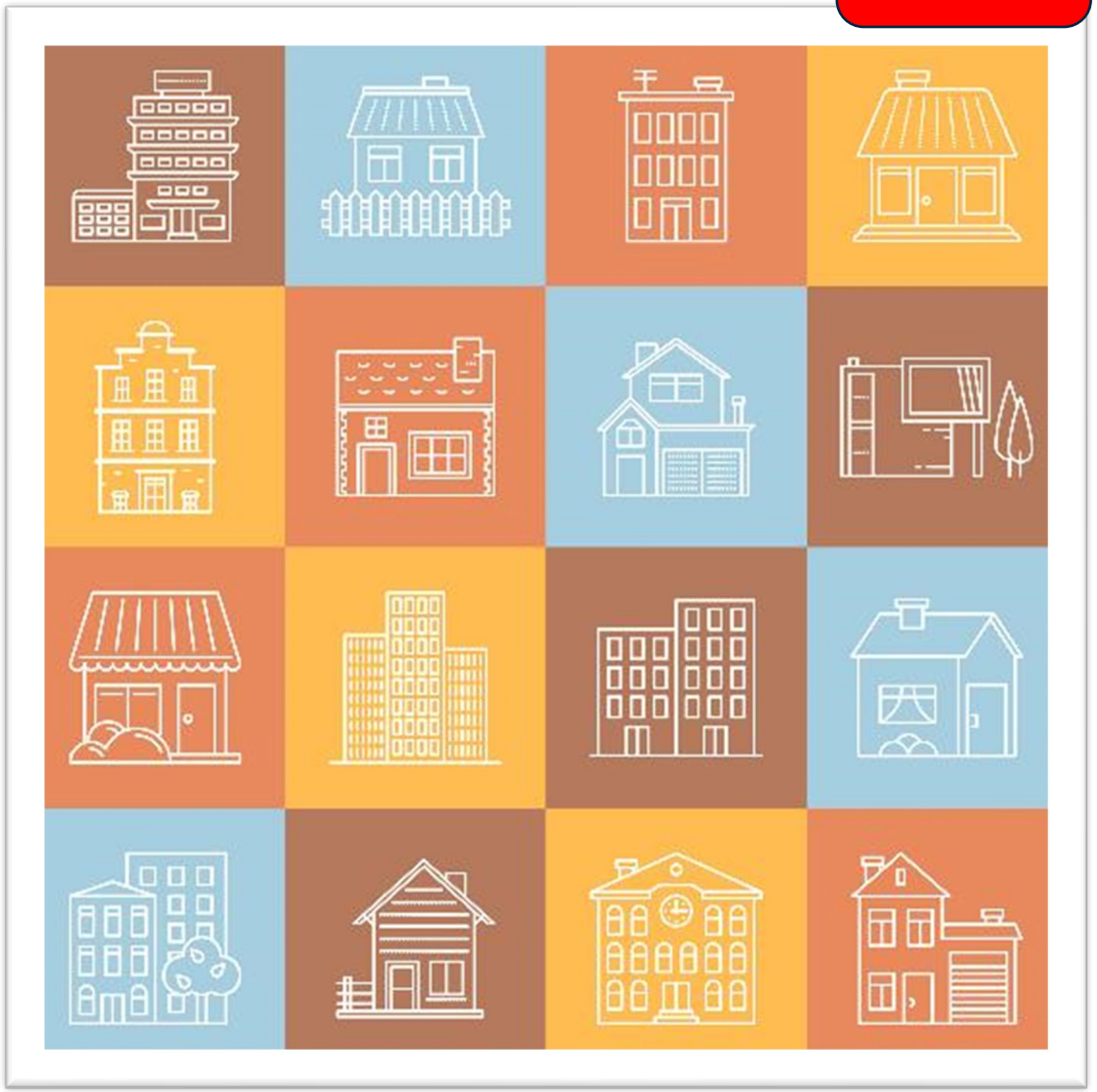
Additional Research

Online search engines or health plan-specific closed-loop referral systems should be used for additional needs and services (including those to address health-related social needs), such as:

2-1-1 | Florida Alliance of Information and Referral Services | Unite US | findhelp | Hope for Healing Florida | Florida Youth to Adult Transition – FLY2AT

AVAILABLE SERVICES AND SUPPORTS: HEALTH RELATED SOCIAL NEEDS

- Stable and safe housing is a key health-related social need and available housing-related resources must be considered to determine the needs of the family holistically.
- Several Florida resources include:
  - Hope Florida Pathways to Prosperity – Hope Navigators can assist families with all their health-related social needs, including housing.
  - Legal Aid and Medical Legal Partners – Can assist with civil issues, including housing/tenant issues. They can also assist with public benefits (food stamps, disability, etc).
  - HUD | Florida Emergency Rental Assistance | Continuum of Care Providers | Disability Rights Florida | FloridaHousingSearch.org PublicHousing.org | Florida Housing Finance Corporation



MEET WILL

- Will is 6 months old, currently living in a nursing facility, and is involved in the child welfare system.
- His birth parents are not involved, but his grandmother visits him semi-regularly.
- Will experiences seizures, has congenital heart disease, and severe anemia. He is taking multiple medications, including infusions, and his breathing needs to be monitored regularly.
- The CMAT is meeting today to explore options for Medical Foster Care.

CONSIDER:

To effectively transition Will to a medical foster family:

+ What will your transition planning process look like?
+ What services and supports will he need? The medical foster family? The grandmother?
+ How will you incorporate these services and supports into your transition planning process?

AVAILABLE SERVICES AND SUPPORTS: KNOWLEDGE CHECK ANSWERS

Slide 29

ANSWERS

- What services and supports are available to children, youth, and young adults and their families as they transition from nursing facilities to home?
  - **Things such as private duty nursing, medical equipment and supplies, transportation, PPEC, Medical Foster Care, Family-to-Family Home Visits, Family-to-Family Peer Support, Expanded Benefits, and the iBudget Waiver**
- How should you seek out up-to-date information?
  - **By being familiar with Florida Medicaid covered services as well as plan-specific services and programs, using your plan's find-a-provider tool, and by using sites such as: 2-1-1, Florida Alliance of Information and Referral Services, Unite US, findhelp, Hope for Healing Florida, Florida Youth to Adult Transition – FLY2AT**
- How will you incorporate these services and supports into your transition planning process?
  - **Ensuring informed decision-making by making sure I communicate frequently and clearly with families about available services and supports**

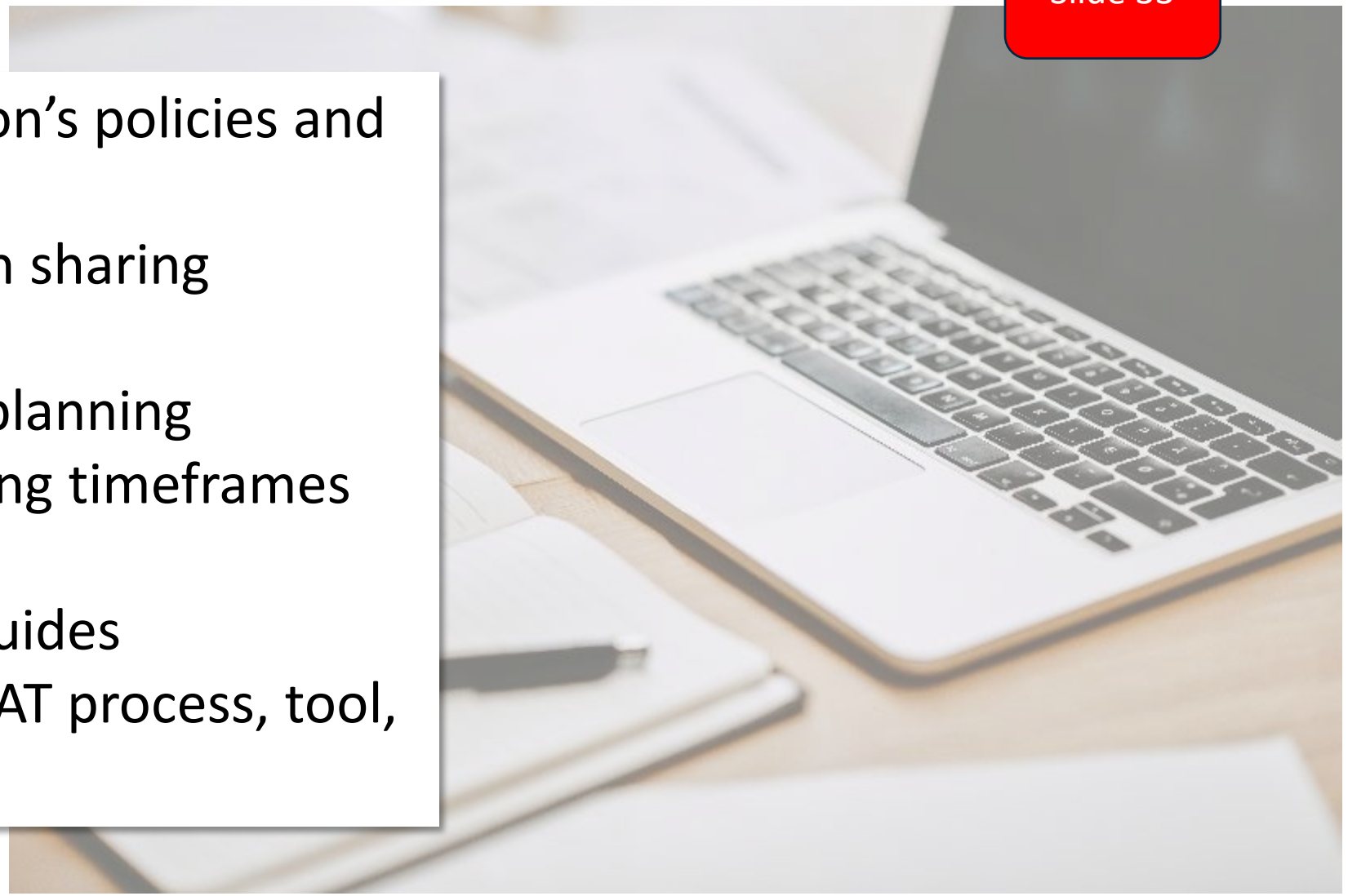
Slide 30

Your Liaising Role as a Care Coordinator in the Transition Planning Process

YOUR LIAISING ROLE AS A CARE COORDINATOR

Slide 33

- Identify your organization's policies and procedures for:
  - Data and information sharing guidelines
  - MDT and transition planning requirements, including timeframes and responsibilities
  - Workflows or desk guides
- Be familiar with the CMAT process, tool, and your local team.[1]



https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/cmat/index.html

YOUR LIAISING ROLE AS A CARE COORDINATOR: APPLICATION

1

Effective Communication

Establish clear communication pathways upfront.

2

Clear Roles

Review and agree on roles, functions, and responsibilities. (Begin with the roles, functions, and responsibilities of care coordinators outlined in AHCA's PT 2023-14 or any subsequent updates).

3

Promote Trust

Promote trust among the providers and entities you work with by remaining accountable for action items and follow up/follow through steps.

4

Relationship Building

Build the relationship using cultural competence and a trauma-informed approach, centering your work in family-centered care principles, and promoting family engagement in all your interactions.

MEET BEN

- Ben is 11 years old and has cerebral palsy and developmental delay.
- His parents are ready to transition him home, but they need help identifying community providers, including PT/OT/ST, and the right school environment for him.

CONSIDER:

To effectively help plan for and connect Ben to the providers and services he needs:

+ How will you engage the providers and school in the multidisciplinary team meeting and the transition planning process?
+ What will you need to put in place for effective communication and collaboration?

YOUR LIAISING ROLE AS A CARE COORDINATOR: KNOWLEDGE CHECK ANSWERS

Slide 38

ANSWERS

- Why is it important to facilitate information sharing and coordination of care among and between providers and others involved in the individual's care needs?
  - **Effective facilitation promotes cooperation, coordination, and effective communication; ultimately this improves the child and family's experience and outcomes.**
- Name two techniques for effectively liaising with providers and other entities such as schools and CMATs.
  - **Making sure that everyone has access to the child's Transition Plan, along with other pertinent information, and making sure that the MDT has clearly delineated roles, functions, and responsibilities**
- What is one way you can be a more effective liaison in your role?
  - **By establishing clear communication pathways upfront.**

Slide 39

Removing Barriers to Community Integration

REMOVING BARRIERS TO COMMUNITY INTEGRATION: ASSESSING FOR BARRIERS

Slide 40

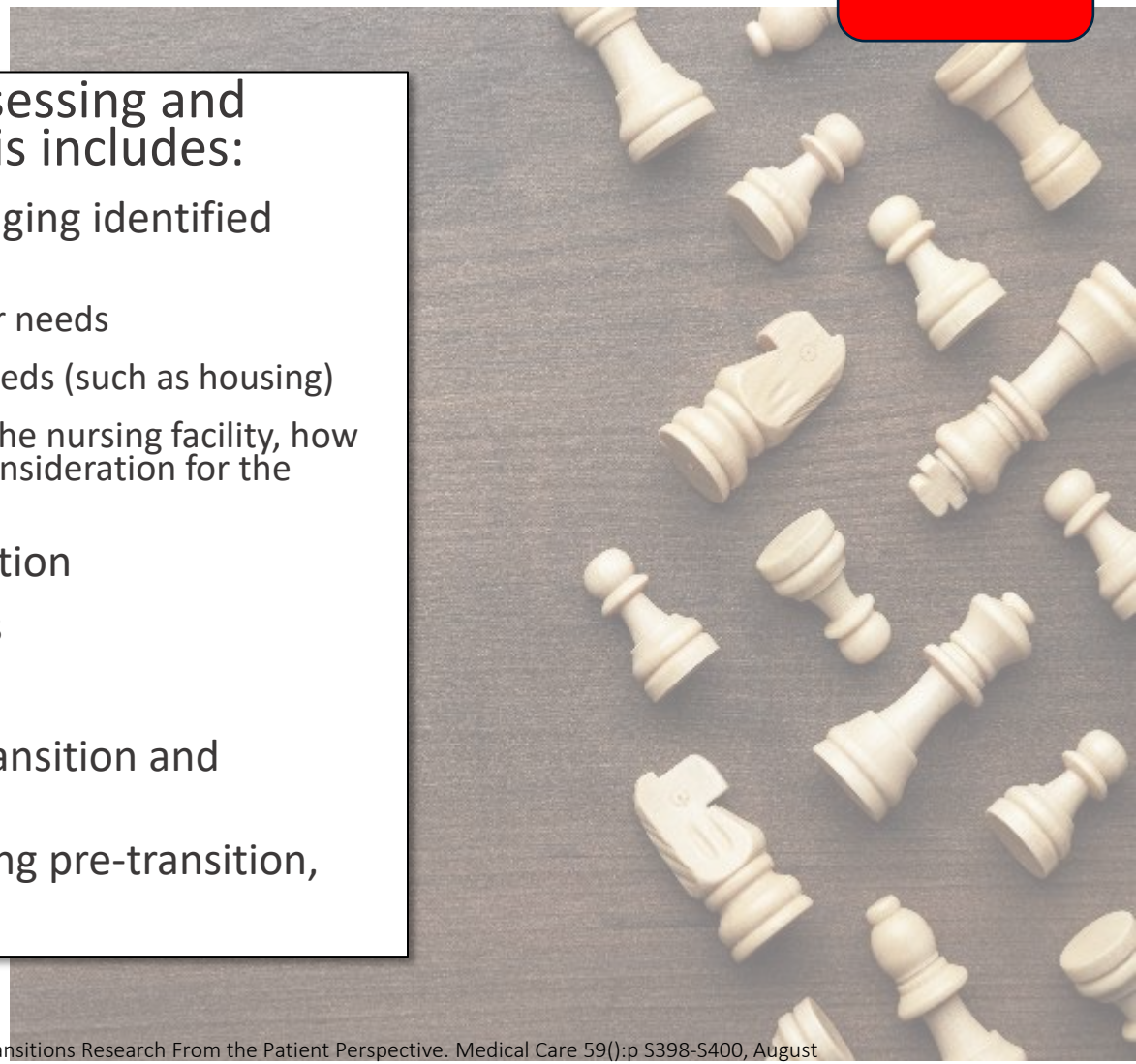
Attitudes	• Stereotypes and stigma • Assumptions about needs and available resources
Communication	• Lack of accessible information in one's preferred language and learning style • Not considering health literacy needs
Physical	• Spaces that are not accommodating one's mobility needs
Policy	• Lack of understanding about available resources and eligibility criteria
Programmatic	• Lack of inclusive design to accommodate one's special needs (e.g., inconvenient scheduling, lack of accessible equipment)
Social	• Health-related social needs such as housing, food, and education • Family dynamics, composition, and needs
Transportation	• Lack of access to reliable transportation • Lack of access to a transportation modality that can accommodate special needs or equipment

Source: Centers for Disease Control and Prevention. Disability and Health Promotion. Common Barriers to Participation Experienced by People with Disabilities. https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html

REMOVING BARRIERS TO COMMUNITY INTEGRATION: APPLICATION FOR CARE COORDINATORS

Slide 42

- Care Coordinators need a robust strategy for assessing and removing barriers to community integration. This includes:
  - Family-centered and family-informed planning, leveraging identified strengths
    - This includes assessing and planning for the family/caregiver needs
    - Integrate assessing and planning for health-related social needs (such as housing)
    - Be clear on what is needed for a successful transition from the nursing facility, how will you track it, and what success will look like, including consideration for the patient and family experience
  - Effective, multidisciplinary, and cross-sector collaboration
  - Processes to identify issues early for quick resolutions
  - Open and clear communication
  - Family education and support for all aspects of the transition and discharge plans
  - Accountability for ensuring all loops are “closed” during pre-transition, transition, ***and post-transition***



Adapted from:
1. The National Care Coordination Standards for Children and Youth with Special Health Care Needs
2. Cook, Nakela L. MD, MPH; Clauser, Steven B. PhD, MPA; Shifreen, Aaron MBA; Parry, Carly PhD, MSW, MA. Reconceptualizing Care Transitions Research From the Patient Perspective. Medical Care 59():p S398-S400, August 2021. | DOI: 10.1097/MLR.0000000000001594, Accessed: https://journals.lww.com/lww-medicalcare/Fulltext/2021/08001/Reconceptualizing_Care_Transitions_Research_From.12.aspx

MEET AMY

- Amy is 7 years old. When she was younger, she was diagnosed with an aggressive form of cancer. She had to have a bilateral leg amputation above the knees as a result. She also suffered from multiple infections during her treatment, resulting in multi-organ failure and an eventual lung transplant.
- After a 2-year stay in a local nursing facility, Amy's parents are ready to transition her home.

CONSIDER:

To effectively identify and remove barriers to Amy's successful transition home:

- First consider the various services and supports that she and her family will need.
- Second, what are the known barriers to her accessing those services?
- Then, what will you include in her Transition Plan to mitigate for and solve any barriers?
- Finally, how will you work with Amy's family and her providers to identify new barriers as they come up and how will you proactively plan to solve them?

REMOVING BARRIERS TO COMMUNITY INTEGRATION: KNOWLEDGE CHECK ANSWERS

Slide 46

ANSWERS

- What are three common barriers to transitioning from a nursing facility to the home?
  - **Attitudes, communication, and physical barriers**
- As a Care Coordinator, what are some ways you can remove barriers for the individuals and families you work with?
  - **Family-centered and family-informed planning, leveraging identified strengths; effective, multidisciplinary, and cross-sector collaboration; and processes to identify issues early for quick resolutions**

Slide 47

Putting it all in Practice – A Case Study

REMEMBER THE SUAREZ FAMILY

Slide 48

The family resides in a suburb of Miami, Florida. They share a family vehicle.

Mom is a second-generation immigrant from Cuba, with family still residing in Cuba. She works part-time as a hairstylist.

Dad is a Florida native, raised in Northern Florida. His mother lives with them in a spare bedroom. He works full-time as a realtor.

They have two kids together, their son is 4 years old, and their daughter is 7 years old. Their daughter has Spina Bifida and is residing in a nursing facility.

We met the Suarez family in Module 1 when they were curious about bringing their daughter home but didn't know where to start and felt like they kept getting different information from the care team. As the daughter's Care Coordinator, you began working with them to identify their goals for their daughter using your skills in cultural competency and trauma-informed care to meaningfully engage the family in family-centered care planning and helped get them involved in their daughter's care team at the nursing facility.

Activities & Hobbies
- Church
- Going to the beach
- Weekly family dinners
- Family walks, exercise at home

Health Information
- Private insurance
- Medicaid for their daughter
- Daughter is assigned a care coordinator
- Daughter's health fluctuates

Gains (with better coordination)
- More family time
- Clear communication
- Shared health goals for their daughter

Pains (consequences of poor coordination)
- Mistrust
- Frustration
- Missed opportunities for bonding as a family

CASE STUDY: THE SUAREZ FAMILY

YOU are the Care Coordinator in this scenario. What happens next? Think through these questions and write down any ideas that stick out to you.

Slide 49

1

Identifying the Most Important Things First:

- Where do you see the biggest issues for their daughter? Their family?
- What will your next interaction with the family look like?

2

Effective Transition Planning

- How can you practice family engagement and family-centered care in transition planning?
- How will you help facilitate and support the completion of the key components of a readiness assessment?
- What resources do you need to ensure a complete readiness assessment?

3

Services and Supports for the Child and Family

- What services and supports will this child and family need?
- How will you plan to secure these needed services?

4

Your Liaising Role as a Care Coordinator in the Transition Planning Process

- Who is part of your multidisciplinary team?
- How will you effectively communicate with the team?
- How will you make sure the Suarez family is engaged?

5

Removing Barriers to Community Integration

- What barriers do you anticipate this family will encounter?
- How will you plan to solve them? Who will you need to involve?

CASE STUDY: THE SUAREZ FAMILY – EXAMPLE CARE PLAN

Slide 51

+ Here are the transition plan goals you developed with the Suarez Family:

Service/Step	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date
PDN	Set up PDN within one month	- Home health agency availability -Finding the right RN/LPNs that "fit" the needs of the family	1. Obtain order 2. Identify home health agency 3. Home health agency to complete intake and assessment 4. Home health agency to identify available nurses 5. Home health agency to submit a service authorization 6. Home health agency receives authorization approval 7. Services begin	1. Care Coordinator to work with PCP 2. Care Coordinator to provide family with provider options and family selects home health agency of their choice 3. Home health agency 4. Home health agency works with family 5. Home health agency 6. Health Plan 7. Home health agency	1. 2/1/2024 2. 2/5/2024 3. 2/12/2024 4. 2/16/2024 5. 2/19/2024 6. 2/29/2024 7. Upon discharge
PT/OT	Set up PT/OT for in home services within one month	-PT/OT availability	1. Obtain order 2. Identify provider 3. Provider to submit a service authorization 4. Provider receives authorization approval 5. Services begin	1. Care Coordinator to work with PCP 2. Care Coordinator to provide family with provider options and family selects provider of their choice 3. Provider 4. Health Plan 5. Provider	1. 2/1/2024 2. 2/5/2024 3. 2/19/2024 4. 2/29/2024 5. Upon Discharge
DME	Obtain within one month: - Bed - Shower Chair - Adaptive Seat for the dining room - Continence Supplies - Catheter Supplies	- Supply availability	1. Obtain order 2. Identify DME Provider(s) 3. Provider to submit a service authorization 4. Provider receives authorization approval 5. Supplies delivered	1. Care Coordinator to work with PCP 2. Care Coordinator to provide family with DME company options and family selects provider of their choice 3. DME Company 4. Health Plan 5. DME Company	1. 2/1/2024 2. 2/5/2024 3. 2/19/2024 4. 2/29/2024 5. As supplies come in

CASE STUDY: THE SUAREZ FAMILY – EXAMPLE CARE PLAN CONT'

Slide 52

Service/Step	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date
Home Modifications	Family needs to widen three doorways and modify the bathroom to meet the daughter's mobility needs – before discharge home	- Community-based organization availability	1. Identify a community organization that offers this service 2. Secure a time for modifications to take place 3. Complete home modifications	1. Care Coordinator will work with family 2. Care Coordinator will work with community organization and family 3. Community organization	1. 2/9/2024 2. 2/20/2024 3. 2/29/2024
Multidisciplinary Spina Bifida Team	Daughter needs to have a follow up appointment scheduled within 7 days of discharge	- Transportation	1. Make appointment 2. Make transportation arrangements	1. Care Coordinator 2. Care Coordinator	1. 2/9/2024 2. 2/9/2024
Primary Care Provider	Daughter needs to have a follow up appointment scheduled within one month of discharge	- Transportation	1. Make appointment 2. Make transportation arrangements	1. Care Coordinator 2. Care Coordinator	1. 2/9/2024 2. 2/9/2024
School	Daughter will begin attending school for the last nine weeks (will continue virtual school through the third 9 weeks as she transitions home)	- Need to update daughter's IEP	1. Confirm internet and device is available at home for the third 9 weeks 2. Contact daughter's school to schedule her IEP 3. Conduct IEP 4. Identify and secure needed supports for school day	1. Care Coordinator and family 2. Family (with Care Coordinator support) 3. School 4. School	1. 2/9/2024 2. 2/9/2024 3. 3/8/2024 4. 3/18/2024

CASE STUDY: THE SUAREZ FAMILY

Hypothesize what action steps you will take for Suarez family after thinking through the exploratory questions earlier:

01 The most important thing I identified was...

02 I will create an effective transition plan by...

03 I will identify more services and supports through...

04 I will be an effective liaison by...

05 I will remove barriers to community integration by...

CASE STUDY: THE SUAREZ FAMILY

YOU are the Care Coordinator in this scenario. What happens next? Think through these questions and write down any ideas that stick out to you.

1

Identifying the most important things first:

- Where do you see the biggest issues for their daughter? Their family?
- What will your next interaction with the family look like?

2

Transitional care needs:

- How are you confirming that all plans are in place, as outlined in the transition plan?
- When and how often will you need to check in with the family?
- Who else do you need to be communicating with before, during, and after transitioning the child to a community setting?
- What is the backup plan when things change?

3

Ongoing needs:

- How will I identify the ongoing and new needs of the child and family?
- How will I ensure team-based communication and information sharing?
- How will I support child and family empowerment and skills development?

Care Coordination Check List (Example for Suarez Family)

Slide 56

Just prior to discharge (1-3 days)

- Confirm that readiness assessment components are complete
- Confirm orders, including that the home health agency is ready to assume care upon discharge
- Confirm all needed equipment and supplies have been delivered and that equipment is functioning properly
- Check in with family for last minute needs or changes, including readiness of home and transportation needs

Day of discharge

- Care team “huddle” to review sequence of discharge events
- Check in (again) with home health agency to confirm nurse availability for PDN, to ensure no last-minute changes
- Confirm transportation has been set up
- Check in with family for last minute needs or changes
- Confirm prescriptions are filled
- Confirm that PCP is in place and follow up visit is scheduled
- Make sure member/family understands process for reporting missed shifts and has the care coordinator’s contact information

Post discharge (1-3 days or within the week, depending on needs and family preferences)

- Check in with family to confirm services are being received as prescribed, assess for gaps, and to identify new needs or changes
- Plan for and confirm any upcoming appointments

Ongoing

- Frequent check-ins
- Education and coaching as needs/condition of the member changes
- Routine MDTs, assessments, and care plan updates
- Continue to make sure member/family understands process for reporting missed shifts and has the care coordinator’s contact information
- Frequent communication with supervisor for when issues arise and to resolve persistent barriers to services (such as missed PDN shifts)

CONCLUSION

Working with children, youth, and young adults with medical complexity and their families requires skills in effective transition planning; understanding and offering services and supports that will help transitioning to home; liaising with entities such as providers, schools, CMATs, and community-based organizations; and removing barriers to successful community integration.

Working with Providers, Schools, and CMATs

- Part of a care coordinator's role is to facilitate information sharing and coordination of care among and between providers and others involved in the child's care needs.
- Care coordinators can use team-based communication techniques, as well as techniques clearly outlined in policies, etc. to establish clear communication pathways upfront; review and agree on roles, functions, and responsibilities; and promote trust among the providers and entities you work with by remaining accountable.
- Relationships with providers and other partners can be cultivated by using cultural competence, centering your work in family-centered care principles, and promoting family engagement in all your interactions.

Effective Transition Planning

- Effective transition planning includes working to prevent medical errors, identifying issues for early intervention, preventing unnecessary hospitalization and readmissions, avoiding duplication of processes and efforts, and providing support towards person and family preferences and choices.
- To help ensure effective transition plans, care coordinators can consider planning for transition before admission, prioritize family engagement, and complete full readiness assessments to identify any barriers to success.

Services and Supports

- Unless the youth/young adult or child's parent/guardian desires for their child to reside in a nursing facility, an individual's complex medical needs ordinarily do not preclude them from living in the community setting of their (or their parent/guardian's) choice.

- Children, youth, and young adults in nursing facilities may require multiple services and supports to help them transition to the community setting of their choice. These include services such as PDN, medical equipment and supplies, transportation, PPECs, Medical Foster Care, Family-to-Family Home Visits, Family-to-Family Peer Support, Expanded Benefits, and Medicaid waiver programs, such as the iBudget Waiver (includes services such as home modifications). Online search engines will also support local-level identification of such services, and additional supports such as housing, food assistance, and mental health services.

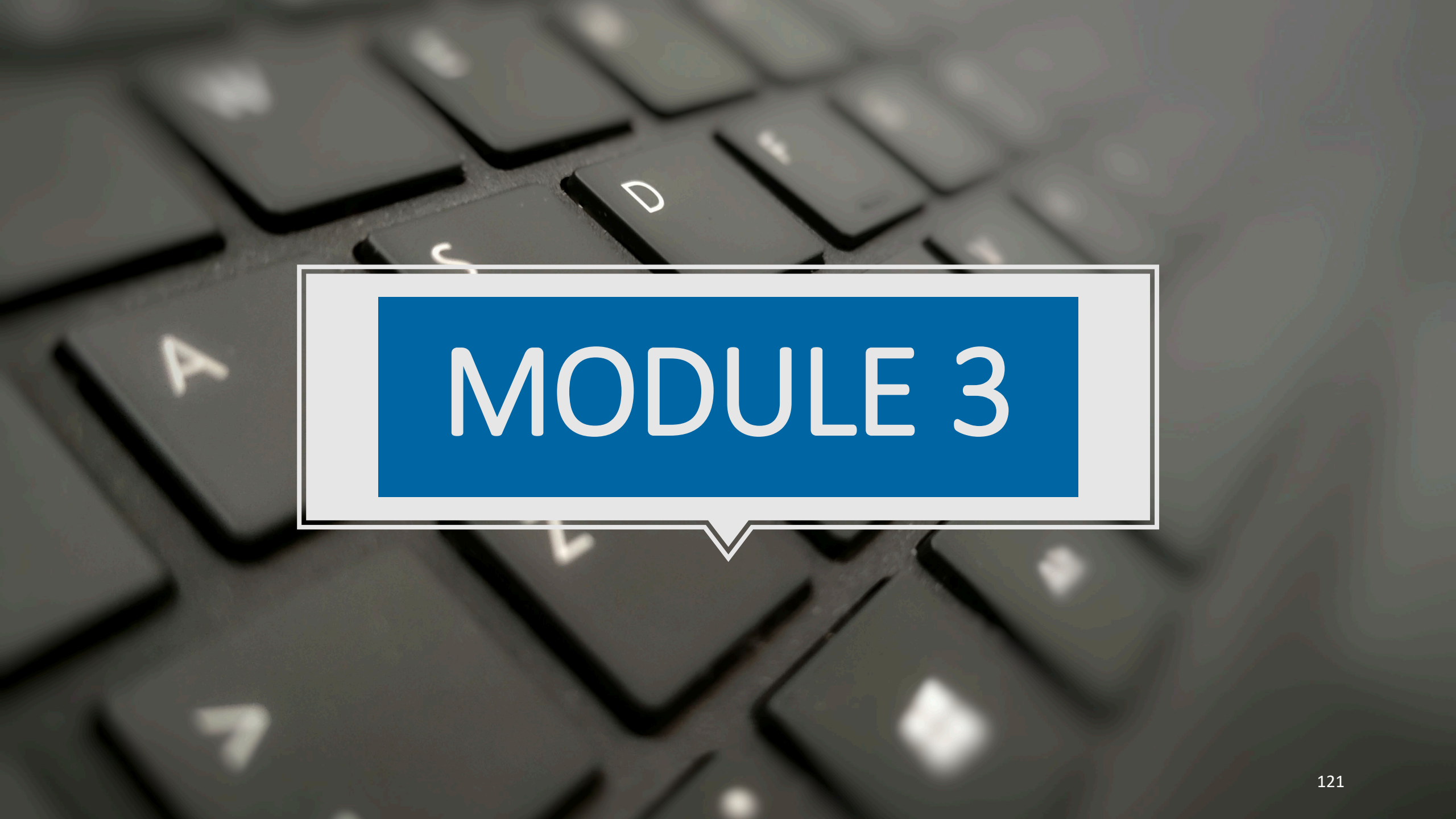
- Available services and supports are to be discussed and reviewed during the individual's Transition Planning Process, at a minimum, and documented on the Transition Plan.

Removing Barriers

Assess, identify, and work collaboratively to remove barriers.

QUESTIONS AND ANSWERS


BREAK


MODULE 3

MODULE 3

- Module 3 –
  - Review Content
  - Case Study Opportunities
  - Enhancing Materials with Additional Resources
  - Navigating Challenging Topics
  - Q&A

HEALTH MANAGEMENT ASSOCIATES

Module 3 – Care Coordination Training

COORDINATING CARE FOR CHILDREN, YOUTH, AND YOUNG ADULTS WITH MEDICAL COMPLEXITY IN THE HOME AND COMMUNITY SETTING

MODULE 3: V1_06282024

INTENDED AUDIENCE

This training is for Care Coordinators in Florida who serve Medicaid enrollees who have medical complexity.

This is the third module in a three-part series. Complete these trainings before continuing:

- *Module 1 – Care Coordination Training: Working with Children, Youth, and Young Adults with Medical Complexity and their Families*
- *Module 2 – Care Coordination Training: Coordinating Care for Children, Youth, and Young Adults with Medical Complexity Transitioning to the Community*

OBJECTIVES

At the end of this training, you will be able to:

Identify the domains of the **National Care Coordination Standards** for CYSHCN

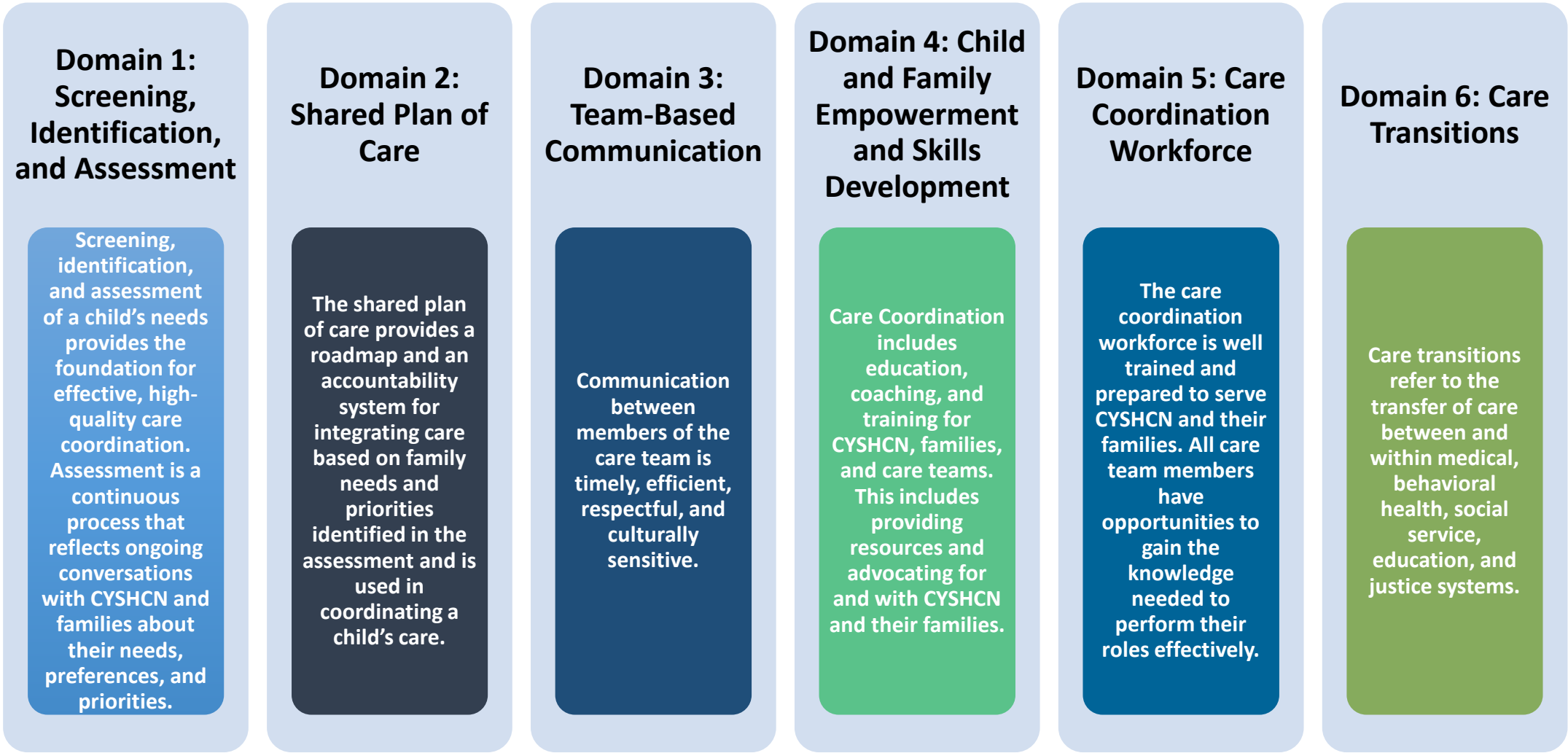
Explain how **coordinated, holistic and integrated care** is important for CYSHCN and their families

Describe how care coordinators can ensure that their enrollees receive needed **ongoing services and supports** to promote healthy outcomes and quality of life

National Care Coordination Standards for CYSHCN

HEALTH MANAGEMENT ASSOCIATES

NATIONAL CARE COORDINATION STANDARDS FOR CYSHCN: DOMAINS



National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN), October 2020. National Academy for State Health Policy. https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2022/12/care-coordination-report-v5.pdf.

MEET BREE

- Bree is a 6 year old, recently transitioning from a nursing facility to her home with her two parents and two younger siblings.
- She is ventilator dependent, has a G-tube, and paralyzed from the waist down.
- She has an order for 12/7 PDN, which is fully staffed, with occasional callouts.
- Mom calls you because Bree will be starting school next month, but she has not heard from the school's ESE Director and wants to make sure everything is lined up.
- Bree is new to your caseload.

Picture source: https://www.choa.org/medical-services/rehabilitation/inpatient-rehabilitation

CONSIDER:

Consider the domains of the National Care Coordination Standards for CYSHCN as you interact with mom:

- What will you need to do to help mom with her initial request?
- How will you identify if she has any other unmet needs? How will you identify if the sporadic PDN callouts are becoming a long-term issue?
- Who will you need to work with to coordinate mom's request and what will that look like?
- Is there any education or coaching that you anticipate needing to provide?
- What about your own knowledge and skills? What do you need to make sure you have proficiency in to help Bree and her mom?
- What do you anticipate that Bree and mom will need as she transitions to a school campus? Are their implications to her PDN hours?

Picture source: https://www.choa.org/medical-services/rehabilitation/inpatient-rehabilitation

NATIONAL CARE COORDINATION STANDARDS: KNOWLEDGE CHECK ANSWERS

ANSWERS

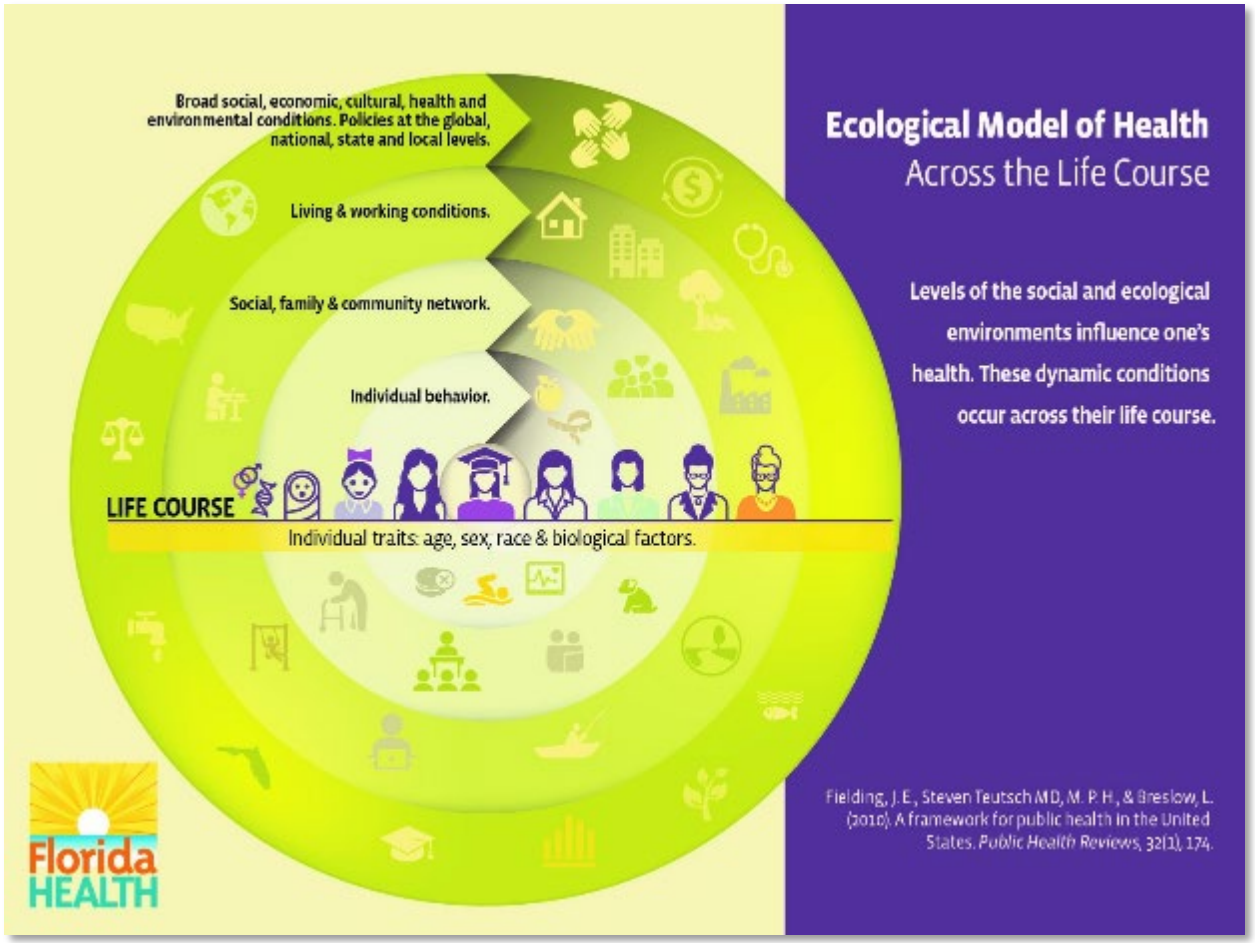
- What are the 6 domains of the National Care Coordination Standards?
  - ***Screening, Identification, and Assessment***
  - ***Shared Plan of Care***
  - ***Team-Based Communication***
  - ***Child and Family Empowerment and Skills Development***
  - ***Care Coordination Workforce***
  - ***Care Transitions***
- What is one way to better incorporate the components of these domains into your activities as a Care Coordinator?

  Share your thoughts with the group.

Coordinating Holistic and Integrated Care

COORDINATING HOLISTIC AND INTEGRATED CARE: DEFINITIONS

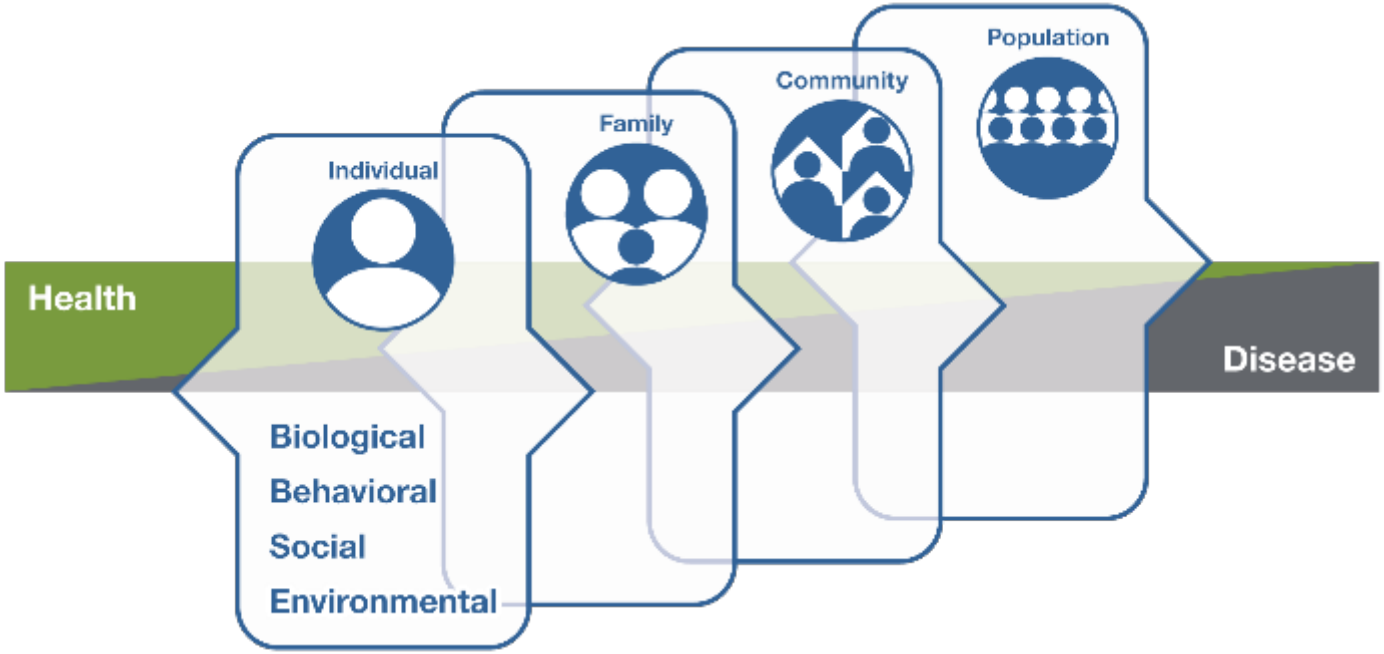
The life course perspective or life course theory (LCT) is a multidisciplinary approach to understanding the **mental, physical and social health** of individuals, which incorporates both life span and life stage concepts that determine the health trajectory.[1]



1. Association of University Centers on Disabilities. Life Course Perspective: https://www.aucd.org/template/page.cfm?id=768
2. Image: Ecological Model of Health Across the Life Course, Florida Department of Health: https://www.floridahealth.gov/programs-and-services/womens-health/florida-life-course-indicator-report/lc-concepts-ecological-model-PPT-01.jpg

COORDINATING HOLISTIC AND INTEGRATED CARE: DEFINITIONS

Whole Person Health involves looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease. It means helping and empowering individuals, families, communities, and populations to improve their health in multiple interconnected biological, behavioral, social, and environmental areas. Instead of treating a specific disease, whole person health focuses on restoring health, promoting resilience, and preventing diseases across a lifespan.



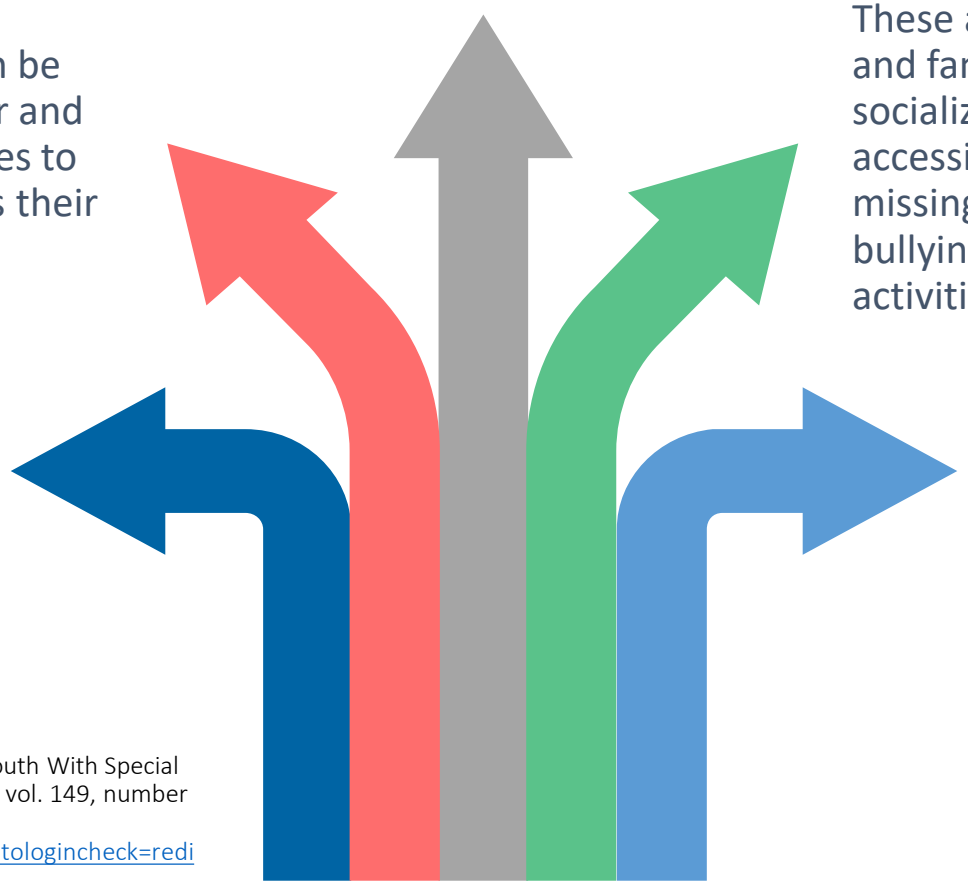
1. National Institutes of Health. National Center for Complementary and Integrative Health (NCCIH). Whole Person Health: What You Need to Know. https://www.nccih.nih.gov/health/whole-person-health-what-you-need-to-know.
2. Image: Illustration of the multilevel whole person health framework, NCCIH.

COORDINATING HOLISTIC AND INTEGRATED CARE: APPLICATION FOR CARE COORDINATORS

Implications for Care Coordinators serving children with medical complexity:

Concepts of both the Life Course and Whole Person Health approaches can be used as a framework for assessing for and connecting enrollees and their families to needed services and supports, across their development into adolescence and adulthood.

These approaches can help Care Coordinators and families identify protective factors (e.g., socializing with friends, participating in accessible services) as well as risk factors (e.g., missing school, missing work, experiencing bullying) when developing interventions and activities to meet care plan goals.[1]



These approaches can help Care Coordinators consider the needs of the enrollee and family holistically, promoting whole person care across the lifespan.

Knowledge of these approaches can help Care Coordinators seek ways to identify goals and connect enrollees and families to services and supports that promote well-being and quality of life, based on the enrollee's and family's preferences and goals.

1. Coleman C.L., et al. Quality of Life and Well-Being for Children and Youth With Special Health Care Needs and their Families: A Vision for the Future. Peditrics, vol. 149, number s7, June 2022. e20211056150C. Accessed: https://publications.aap.org/pediatrics/issue/149/Supplement%207?autologincheck=redirected.

COORDINATING HOLISTIC AND INTEGRATED CARE: INTEGRATED CARE NEEDS AND CARE PLANNING

Integrated Care Needs and Care Planning:

- Starts with the principles outlined in Domain 2 of the National Care Coordination Standards: Shared Plan of Care
- Incorporates a holistic and lifespan view of the enrollee and family's needs (Life Course and Whole Person Health approaches)
- Is adapted based on the enrollee's and family's preferences and goals

Consider how you will coordinate care in these instances:

- During your assessment, you discover that the enrollee needs to be connected to a behavioral health care provider and you find out that the night nurse has missed several shifts over the past month.
- During a check in with the enrollee's mother, you discover that she has been diagnosed with a terminal illness and she is the child's sole caregiver.
- During a conversation with a family of a child that recently started attending school, you find out that they are struggling academically, and their respiratory condition is causing them to need to go emergency room frequently. You also find out that the family must find another home because they are no longer able to afford their rent.

COORDINATING HOLISTIC AND INTEGRATED CARE: CONTINUITY OF CARE AND CARE TRANSITIONS

Continuity of Care and Care Transitions:

As the child with medical complexity ages and as their condition changes over time, continuity of care and care transitions need to remain an essential component of the care planning process. For example, how will you coordinate care, prepare for continuity of services, and promote a seamless transition in these instances:

- The child needs to have a medical procedure that will require a prolonged hospital stay
- The child develops pneumonia and is admitted to the hospital, where their medical condition requires a tracheostomy
- The child is now school-aged and will transition from the home setting with 24/7 PDN orders to school five days a week
- The adolescent receiving nighttime PDN is now developmentally ready to take on some self-care in their daily routine
- The adolescent will be turning 18 soon and has been accepted to college in a different city and they require 24/7 PDN care
- The young adult is turning 21 and will be transitioning to long-term care and adult services

EFFECTIVE TRANSITION PLANNING: KNOWLEDGE CHECK ANSWERS



ANSWERS

- What is Life Course Theory?
  - ***It is a multidisciplinary approach to understanding the mental, physical and social health of individuals, which incorporates both life span and life stage concepts that determine the health trajectory.***
- What is Whole Person Health?
  - ***It involves looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease. It means helping and empowering individuals, families, communities, and populations to improve their health in multiple interconnected biological, behavioral, social, and environmental areas. Instead of treating a specific disease, whole person health focuses on restoring health, promoting resilience, and preventing diseases across a lifespan.***
- What is one way you can adapt your care coordination activities to better incorporate these frameworks?
  - ***Share your thoughts with the group.***

Ongoing Services and Supports for Children Receiving PDN and Their Families

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES

Service	Description	Ongoing Considerations for Care Coordinators
Private Duty Nursing (PDN)	• One-on-one, medically necessary nursing care from a skilled nurse • These services are available in the home and the child may be eligible to receive up to 24 hours a day of PDN per day (based on diagnosis, medical condition, and needs, including Prescribed Pediatric Extended Care (PPEC) hours, if provided). • The court has ordered the State to provide reliable PDN to any child who transitions from a nursing home to the community.	• Ensure up-to-date orders and authorizations • Monitor for and be aware of changes based on the medical needs of the Member or preferences of the family • Educate families on how to report missed PDN hours* • Identify issues early and collaborate with your supervisor as needed for resolution • Coordinate with home health agencies for continuity of care between nurses and agencies (and locations, such as home and PPEC)

Medical Equipment and Supplies	• Items for every day, or extended use at home, including:
	  ○ Ventilation equipment and supplies
	  ○ Oxygen equipment and supplies
	  ○ Feeding equipment and supplies
	  ○ Mobility devices such as a wheelchair
		• Ensure up-to-date orders and authorizations
		• Help family obtain additional supplies for “go” bags, increase in usage needs, etc.
		• Monitor for and assist with obtaining updated equipment and supplies (e.g., needs/orders change, child grows)

Transportation	• Non-emergency Medical Transportation for the child and a caregiver to get to and from medical appointments	• Ensure that family knows how to schedule, and assist as needed (remember that needs change) • Ensure that family knows how to reach out if issues arise • Ensure that transportation vendor able to accommodate child’s medical needs/equipment

*Will go into more detail in subsequent slide

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES

Service	Description	Ongoing Considerations for Care Coordinators
Prescribed Pediatric Extended Care (PPEC)	• Centers for children through age 20 • Provides skilled nursing supervision, medical services, nursing services, personal care, psychosocial services, respiratory therapy services, and developmental therapies in a non-residential setting • Transportation is provided by the PPEC Center • Also provides caregiver training • Available for up to 12 hours a day	• Ensure up-to-date orders and authorizations • Establish collaboration and communication with PPECs, including them as part of the care team and care planning process

Medical Foster Care	• A program for children through age 20
	• Provides temporary placement for 24-hour care in a licensed foster home with specially trained foster parents
	• Participation in this program is time-limited unless the child is in state custody
		• Ensure collaboration and communication with the CMAT and DOH Medical Foster Care Program and staff (also including them as needed as part of the care team and care planning process)
		• For Voluntary Medical Licensed Out-of-Home Care:
		  • Track progress
		  • Upon placement, begin transition planning (placement is for up to 180 days)

Family-to-Family Home Visits	• An opportunity for families to visit other family homes where children are receiving PDN in the home • During the visit, they will observe PDN provided to the child and have an opportunity to ask questions. • Visits can be in-person or virtual and the child's care coordinator can accompany the family.	• Educate and connect families to participate in these programs voluntarily to support others with similar lived experiences and care needs for their child
Family-to-Family Peer Support	• An opportunity to connect the family to another family that has received PDN for a child with Complex Medical Needs • Interactions may be one-on-one, or with a group of families. • Interactions may be in-person, virtual, or by phone.	

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES

Service	Description	Ongoing Considerations for Care Coordinators
Expanded Benefits	• Benefits that are offered by the child's health plan, in addition to the standard benefit package (such as housing assistance, home delivered meals, trips to non-medical appointments, and transition assistance from the nursing facility to home)	• Stay up-to-date with health plan offerings and the needs of the Member

Developmental Disabilities Individual Budgeting (iBudget) Waiver	• The iBudget Waiver is designed to promote and maintain the health of individuals with developmental disabilities and to provide medically necessary supports and services to prevent placement in a nursing home.
	• Services are for eligible children 3 or older with a developmental disability.
	• Services include:
	  ○ Home Modifications: Adaptations to home for accessibility, such as ramps and door-widening
	  ○ Vehicle Modifications: Adaptations to the vehicle for accessibility, including portable ramps
	  ○ Consumable Medical Supplies: such as diapers, wipes, and pads
	  ○ Residential Habilitation: Enables eligible children to live in licensed group homes up to 24 hours a day with nursing services and medical supervision
	• As the child's care coordinator, you can help families apply for this program through the Agency for Persons with Disabilities.
		• Assist Members and families in waiver application as necessary
		• Ensure service provision
		• Establish collaboration and communication with the Member's iBudget Waiver Providers, including them as part of the care team and care planning process
		• Monitor for and assist with obtaining additional waiver services as indicated

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES

Service	Description	Ongoing Considerations for Care Coordinators
Other Florida Medicaid Waiver Programs (see descriptions in Module 2 if needed)	• Long Term Care Waiver Program • Model Waiver Program • Familial Dysautonomia Waiver Program	• Assist Members and families in waiver application as necessary • Ensure service provision • Establish collaboration and communication with the Member's Waiver Providers, including them as part of the care team and care planning process • Monitor for and assist with obtaining additional waiver services as indicated • If needed, assist with transition to fee-for-service Medicaid or another Medicaid health plan, if needed

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES: MISSED PDN HOURS

REPORT

Parent(s)/Guardian(s) are encouraged to report provider failure to provide PDN services in real time.

DOCUMENT

Any notification by the parent(s)/guardian(s) of failure to provide PDN services must be documented in the child's case record with a note and the completed form (template provided by the Agency).

REMEDIATION

Upon notification and no less than 24 hours from notification, the managed care plan must contact the provider to remediate the issue that caused the failure and to ensure that future authorized PDN services will not be interrupted.

NOTIFY

Care Coordinators must submit the completed form to the Agency within 2 business days after receiving notification of the missed PDN hours via secure email to PDNFamilies@ahca.myflorida.com. Each managed care plan also submits a monthly summary log within 10 days after the end of the reporting month.

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES: ADDITIONAL CONSIDERATIONS FOR PDN NEEDS

- **Strategies for Care Coordinators to improve access to PDN services:**
  - **Offer coaching and education** to families to help them improve their communication skills with home health agencies and nurses.
  - **Connect families** to family advocacy and peer organizations that have lived experiences navigating home health agencies and working with nurses in their homes.
  - **Consider alternatives** to offer the parent(s)/guardian(s) (e.g., exploring PPECs or new home health agencies).
- **Communicating ongoing issues related to the provision of PDN hours:**
  - In addition to the Parental Real-Time Reporting, Care Coordinators need to **provide additional insights to prolonged and systemic issues** in the coverage of PDN hours to their supervisor.
  - **Collaborate with peers to identify creative solutions that** can be replicated or adapted for your Members.

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES: SCENARIO

MEET ALEX

- Alex is 12 years old and has an order for 24/7 PDN.
- Alex's daytime nurse recently retired, and the home health agency has been sending temporary nurses to fill those shifts.
- Alex's parents are upset because these nurses are not reliably reporting to their shifts on time or in some cases altogether, and when they do come, Alex's parents do not trust that they understand subtle changes in Alex's temperament that indicate an issue.
- During your scheduled phone call with them, Alex's parents tell you that they want to look at other options for Alex.

Picture source: https://www.istockphoto.com/search/2/image-film?phrase=special+needs+children

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES: SELF-REFLECTION

CONSIDER:

To effectively work with Alex's parents:

+ What will you need to do first?
+ How does Alex's family's culture and health care preference impact your approach?
+ Who will you need to involve to resolve his parents' concerns?
+ What options will you explore with his parents?
+ How will you make sure you have the right information and that you provide it to the parents in a way that they feel empowered to make the right health care choices for Alex?
+ Are there other considerations you need to explore with the family, remembering to take a life course and whole person health approach to coordinating care for Alex?

Picture source: https://www.istockphoto.com/search/2/image-film?phrase=special+needs+children

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES: KNOWLEDGE CHECK ANSWERS

ANSWERS

- What services and supports are available to children with medical complexity residing in the community?
  - ***Medical equipment and supplies, transportation, PPEC, and the iBudget Waiver are some***
- What should you do if you find out that PDN services were not provided as authorized and requested?
  - ***Any notification by the parent(s)/guardian(s) of failure to provide PDN services must be documented in the child's case record with a note and the completed form (template provided by the Agency).***
  - ***Upon notification and no less than 24 hours from notification, the managed care plan must contact the provider to remediate the issue that caused the failure and to ensure that future authorized PDN services will not be interrupted.***
  - ***Care Coordinators must submit the completed form to the Agency within 2 business days after receiving notification of the missed PDN hours via secure email to PDNFamilies@ahca.myflorida.com. Each managed care plan also submits a monthly summary log within 10 days after the end of the reporting month.***

- Name one strategy to try and increase access to PDN services that you can do as a Care Coordinator?
  - ***Share your thoughts with the group.***

Putting it all in Practice – A Case Study

CASE STUDY: THE SUAREZ FAMILY

YOU are the Care Coordinator in this scenario. What happens next? Think through these questions and write down any ideas that stick out to you.

1

Identifying the most important things first:

- Where do you see the biggest issues for their daughter? Their family?
- What will your next interaction with the family look like?

2

Transitional care needs:

- How are you confirming that all plans are in place, as outlined in the transition plan? In an updated care plan (post-transition to the community)?
- When and how often will you need to check in with the family?
- Who else do you need to be communicating with after transitioning the child to a community setting?
- What is the backup plan when things change?

3

Ongoing needs:

- How will I identify the ongoing and new needs of the child and family?
- How will I ensure team-based communication and information sharing?
- How will I support child and family empowerment and skills development?
- What will I do when the needs of the child or family change?
- How will I address their needs holistically and across the lifespan?
- What will I need to plan for with new transitions of care?

ONGOING SERVICES AND SUPPORTS FOR CHILDREN RECEIVING PDN AND THEIR FAMILIES

Care Coordination Check List (Example for Suarez Family)

Just prior to discharge (1-3 days)

- Confirm that readiness assessment components are complete
- Confirm orders, including that the home health agency is ready to assume care upon discharge
- Confirm all needed equipment and supplies have been delivered and that equipment is functioning properly
- Check in with family for last minute needs or changes, including readiness of home and transportation needs

Day of discharge

- Care team "huddle" to review sequence of discharge events
- Check in (again) with home health agency to confirm nurse availability for PDN, to ensure no last-minute changes
- Confirm transportation has been set up
- Check in with family for last minute needs or changes
- Confirm prescriptions are filled
- Confirm that PCP is in place and follow up visit is scheduled
- Make sure member/family understands process for reporting missed shifts and has the care coordinator's contact information

Post discharge (1-3 days or within the week, depending on needs and family preferences)

- Check in with family to confirm services are being received as prescribed, assess for gaps, and to identify new needs or changes
- Plan for and confirm any upcoming appointments

Ongoing

- Frequent check-ins **(for those receiving PDN, this means a minimum of one face-to-face visit and one telephone contact each month)**
- Education and coaching as needs/condition of the member changes
- Routine MDTs, assessments, and care plan updates
- Continue to make sure member/family understands process for reporting missed shifts and has the care coordinator's contact information
- Frequent communication with supervisor for when issues arise and to resolve persistent barriers to services (such as missed PDN shifts)

CONCLUSION

Working with children with medical complexity, and their families requires knowledge of the national care coordination standards, skills in coordinating holistic and integrated care, and the ability to meet the ongoing needs of children receiving PDN and their families.

National Care Coordination Standards

- 6 Domains:
  - •Screening, Identification, and Assessment
  - •Shared Plan of Care
  - •Team-Based communication
  - •Child and Family Empowerment and Skills Development
  - •Care Coordination Workforce
  - •Care Transitions

Coordinating Holistic and Integrated Care

- Concepts of both the Life Course and Whole Person Health approaches can be used as a framework for assessing for and connecting Members and their families to needed services and supports, across their development into adolescence and adulthood.
- These approaches can help Care Coordinators consider the needs of the Member and family holistically, promoting whole person care across the lifespan.
- Integrated Care Needs and Care Planning:
  - Starts with the principles outlined in Domain 2 of the National Care Coordination Standards: Shared Plan of Care
  - Incorporates a holistic and lifespan view of the Member and family's needs (Life Course and Whole Person Health approaches)
  - Is adapted based on the Member's and family's preferences and goals

Ongoing Services and Supports for Children Receiving PDN and their Families

- Ongoing connections to services:
  - Ensure orders and authorizations are up-to-date.
  - Monitor for and be aware of changes in conditions and subsequent needed changes to orders, equipment, etc.
  - Communicate, collaborate, and coordinate with providers and other entities, including ensuring participation in the care team, as applicable.
  - Help families know who to contact if they need assistance with things (e.g., missed PDN hours, scheduling for transportation).
  - Ensure families are educated with up-to-date information about available services and supports for their child and family, assisting them connect to services as needed.
- Missed PDN hours:
  - Parent(s)/Guardian(s) are encouraged to report provider failure to provide PDN services in real time.
  - Care Coordinators will use the provided template to report parent/guardian report of missed PDN hours and follow all instructions.
  - Any notification by the parent(s)/guardian(s) of failure to provide PDN services must be documented in the child's case record.
  - Upon notification and no less than 24 hours from notification, the managed care plan must contact the provider to remediate the issue that caused the failure and to ensure that future authorized PDN services will not be interrupted.

The family resides in a suburb of Miami, Florida. They share a family vehicle.

Mom is a second-generation immigrant from Cuba, with family still residing in Cuba. She works part-time as a hairstylist.

Dad is a Florida native, raised in Northern Florida. His mother lives with them in a spare bedroom. He works full-time as a realtor.

They have two kids together, their son is 4 years old, and their daughter is 7 years old. Their daughter has Spina Bifida and is residing in a nursing facility.

BEST PRACTICE EXAMPLE – SUAREZ FAMILY TRANSITION PLAN

REFLECTION

QUESTIONS AND ANSWERS