Family Services and Supports – Objective 7.4 Holistic Care Coordination Initiatives

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REPORT – October 2021 through September 2022

Holistic Care Coordination (HCC) Implementation Toolkit: Title V recognized that the HCC model established and implemented by the KS-SHCN program, adapted in partnership from the Boston Children's Hospital, has shown to be effective in meeting the needs of those engaged in care coordination. Because of this, Title V moved to expand this model across Title V/MCH programs and beyond through the provision of resources, information, and targeted technical assistance.

Building from the established KS-SHCN model, and aligned with the National Care Coordination Standards for CYSHCN, development of the implementation toolkit has begun, with the first stage of the toolkit accessible online. This toolkit is intended to support providers, practices, and programs interested in establishing a care coordination model at different stages, both in public health and primary care settings. The toolkit is organized following the National Care Coordination Standards for CYSHCN domain areas: Screening, Identification, and Assessment; Shared Plan of Care; Team Based Communication; Individual and Family Empowerment; Care Coordination Workforce; and Care Transitions. The toolkit currently includes foundational context, and considerations based on the Standards. Tools and resources for planning/implementation, evaluation and sustainability, sample job descriptions and training plans for care coordinators, and other resources to support needed technical assistance were identified and collected into a spread sheet to be added in the upcoming year. Title V was already focused on this expansion beyond the KS-SHCN program and across other MCH programs. The All in for Kansas Kids plan has identified this as a strategy under Goal 2: Community-Level Coordination and in partnership with this work is a focus on primary care settings.

The expansion for primary care has been led by the MCH Director, moving to the System of Care (SOC) Program Consultant. The expansion across MCH programming has been led by the CSHCN Director, who initially established the model and is leading the care coordination expansion efforts within the KS-SHCN program, Bridges. More information about Bridges can be found in the CSHCN Plan narrative. While these expansion efforts are happening in parallel, the synergy between all of these initiatives is complimentary and collaborative. Throughout the implementation toolkit development, the SOC Consultant has focused on outreach and promotion, provider input, and quality improvement focused development activities. During this reporting period, a video series was developed with Trozzolo Communications Group. The series consists of one short video on each of the domains from the Standards and can be found within the domain sections of our HCC Toolkit.

Expansion work also included an ECHO series in partnership with the Kansas Chapter of the American Academy of Pediatrics with pediatricians as well as individuals providing care coordination being the primary audience. The ECHO series pulled in COIVD-19, as that was an identified need by providers. The session was titled "COVID Support through Care Coordination" and consisted of the following sessions:

- 50 participants, February 8th – "Building Relationships with Patients and Communities"
- 28 participants, February 15th – "Empowering and Partnering with Patients and Families"
- 35 participants, February 22nd – "Identifying Patients and Families to Benefit from Care Coordination"
- 38 participants, March 1st – "Creating Family- and Patient-Driven Action Plans"
- 28 participants, March 8th – "Helping Patients and Families with Care Transitions"

During this reporting period work started on building out a system for technical assistance in conjunction with the tools available in the toolkit. Two pilot sites were onboarded and worked through the readiness assessment to determine what they already provide as it relates to care coordination. Through this assessment, an individualized technical assistance plan was developed with both practices to incorporate care coordination services into practice. One practice worked towards developing a policy for referrals and follow-up. The other practice worked towards identifying what care coordination could look like in a busy practice with short staff, ideas included Standards training for care coordinator staff or improvements to their screening process.

Care Coordination Training Curriculum: Title V planned to develop continuing education curriculum for case managers, care coordinators, and community health workers (CHW) on the provision of holistic care coordination services, adapted from the training conducted with the KS-SHCN Care Coordinators. However, during this reporting period, there was a major push for community health workers in Kansas. With this, and to avoid duplication, it was determined that to understand the workforce and any training needs, full knowledge on the current training offerings for community health workers was needed. The SOC Consultant completed the CHW course in October 2022 and has begun connecting with other KS-SHCN Care Coordinators to understand the overlap and gaps of the current trainings in order to identify any additional need for HCC training.

An HCC Environmental Scan has been started to gain insights into care coordination in the state. Phase 1 was started in 2022 and focused on HCC billing, insurance, and sustainability. Phase 2 will use information gathered from phase 1 but move the focus more specifically on the children and youth with special health care needs population and their access to adequate care and insurance coverage.

PLAN – October 2023 through September 2024

Holistic Care Coordination (HCC) Implementation Toolkit: To expand holistic care coordination across the state. An Implementation Toolkit has been developed. The initial phase can be found on the HCC site, which shares important considerations for implementing each domain of the National Care Coordination Standards for CYSHCN, developed by the National Academy for State Health Policy. While these standards were developed for the special health care needs population, KDHE has broadened the standards and believes that all populations would benefit from this type of holistic care coordination. In FY24, tools and resources will be added to this site, however, to access them, individuals will be required to provide an email address so that the System of Care Consultant can follow up to offer technical assistance as needed.

HCC Technical Assistance Center: In FY24, a TA plan will be finalized with the Special Health Care Needs Program Team and the Health Consultants to begin offering TA to providers across the state working to offer HCC within their practice. The TA Center plans are aligned with the National Care Coordination Standards and offer assistance in each of the domains listed in the standards: Screening, Identification, and Assessment; Shared Plan of Care; Team-Based Communication; Patient and Family Empowerment; Care Coordination Workforce; and Care Transitions.

HCC Training Opportunities: In addition to TA, there will be ongoing training opportunities such as ECHO series for providers to learn more about implementing care coordination in their practice. In September 2023 a 6 series ECHO on building community connections will begin and stretch into FY24. The target audience for

the ECHO will be any individual providing care coordination including care coordinators, community health workers, nurses, primary care providers. The initial session will provide information on ways of community mapping as well as a guiding document for participants to complete throughout the series. The subsequent sessions will focus on highlighting statewide bureau of family health programming and include contact information so that participants can begin to map out resources available within their communities. Input from that ECHO series will help determine other future trainings for providers.

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