Shared Care Planning

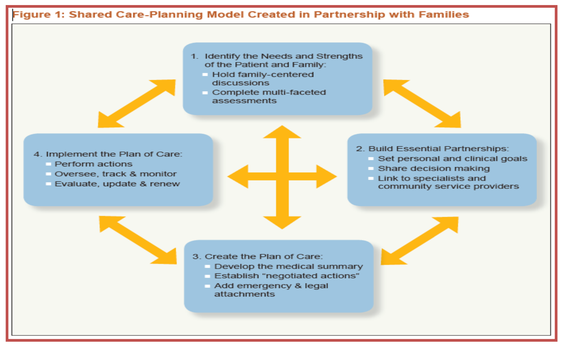
Coos, Deschutes, Harney, and Marion County Public Health Departments

Supported by the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)

Background

Children and Youth with Special Health Care Needs (CYSHCN) frequently rely on an astounding number of community services, medical providers and other resources to ensure care and support. A shared care plan can be a powerful tool to coordinate care among providers, and in partnership with families. However, practical challenges to this type of cross-agency collaboration are not well understood.

Figure 1: Shared Care-Planning Model Created in Partnership with Families



[1]Lucile Packard Foundation for Children's Health – Report.

Project Description

Four county public health departments participated in an Action Learning Collaborative (ALC) focused on various aspects of shared care planning.
ALC members identified elements of the Shared Care Planning Model and developed work plans to address these.
The ALC met monthly for four months during the spring of 2015.

The "Action Learning" model facilitates learning in an active way including learning by doing, experiential learning, reflecting on practice and collaborating.

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Objectives

The intent of this work was to increase understanding of practical challenges and facilitators that impact the process of developing a shared care plan.

This ALC was informed by the document *Standards for Systems of Care for Children and Youth with Special Health Care Needs.*[2] Specific focus was on the Core Domain "Medical Home: Care Coordination as part of the medical home and integrated with community-based services."

Outcomes

Coos County

Kathy Cooley RN, MPH
Home Visiting Program Manager

Focus: Building essential partnerships to support adolescent transition to adult care.
Challenges: Lack of cross-agency awareness of available services, lack of reimbursement for the time required to build effective partnerships, identification and implementation of HIPAA compliant communication strategies, agency-specific interests around plans of care.
Facilitators: Dedicated meeting time, personal relationships, identification of common interests.

Deschutes County

Pamela Ferguson RN, BSN, MHA
Nurse Program Manager

Focus: Developing the electronic health record to promote shared care planning across providers and systems.
Challenges: Identifying platform elements important to public health practice, identifying elements specific to CYSHCN, scheduling common planning time with key partners.
Facilitators: Learning from other organizations that are working toward similar goals.

Harney County

Barbara Rothgeb, RN, BScN.
Harney County Public Health Nurse

Focus: Telehealth access to primary and specialty health services.
Challenges: Lack of technology interoperability in multi-setting implementation, inconsistent reimbursement practices, identifying and implementing HIPAA-compliant communication strategies.
Facilitators: Rapid change/improvement in technology support, steps toward interoperability advanced by Federal initiatives such as HITECH.

Marion County

Jean DeJarnatt, RN, BSN
Nurse Coordinator for Early Childhood Teams

Focus: Team building across community-based services, including primary care (autism specific).
Challenges: Identifying and implementing HIPAA-compliant communication strategies, determining best ways to communicate with families about the plan of care, deciding who should "own" and who may access the plan of care.
Facilitators: Core team in place and engaged; dedicated meeting time.

Summary of Lessons Learned

- Decisions about who should "own" and who may access the plan of care are challenging.
- Identification and implementation of HIPAA compliant communication strategies is a consistent challenge.
- Interoperability of technological infrastructure across organizations is frequently lacking.
- Identification of common agency interests as well as dedicated meeting time are necessary facilitators of this work.

Next Steps

To build a foundation for effective and efficient care coordination, cross-agency health care teams must identify challenges and facilitators. We recommend formal process mapping as a means of improving cross-agency collaboration.

References:

[1]Lucile Packard Foundation for Children's Health – Report. *Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs: An Implementation Guide.* Jeanne W. McAllister. May, 2014.

[2]Association of Maternal & Child Health Programs and the Lucile Packard Foundation for Children's Health, National Consensus Framework for Systems of Care for Children and Youth with Special Health Needs Project. *Standards for Systems of Care for Children and Youth with Special Health Care Needs.* March 2014.

For additional information contact:
Marilyn Berardinelli or Caroline Neunzert
OCCYSHN 503-494-8303
Institute on Development and Disability
http://www.occyshn.org