

Mapping Care Coordination for Children in Minnesota

NORTHWEST REGIONAL REPORT

Mapping Care Coordination for Children in Minnesota: Northwest Report

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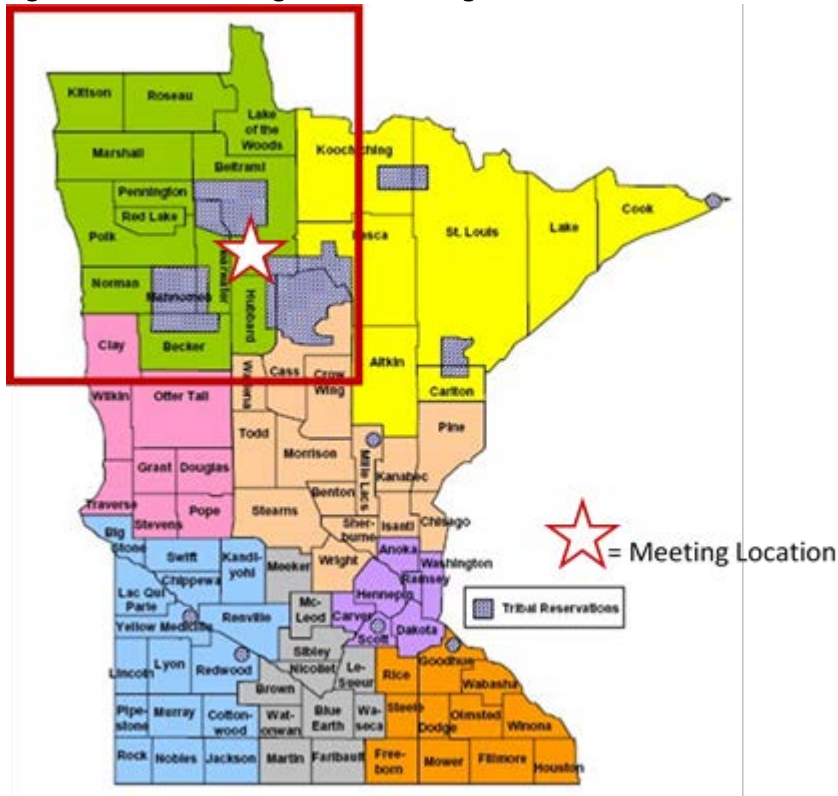
Northwest Minnesota Findings

The following section details the findings of the regional care coordination systems mapping activities that occurred in the Northwest Region of the State. Separate reports for each of the other regions can be found on the [“Mapping Care Coordination in Minnesota” webpage](#) on the MDH CYSHN website.

Regional Boundaries

The regional boundaries of the Northwest area of the state are highlighted in Figure 1 below. The meeting took place in Bemidji, MN, which is denoted with a star on the map. Participants represented families, agencies, clinics, and organizations located within the counties in the box outlined in red on the map. The region stretched from the counties aligning the North Dakota border on the west, to Koochiching, Itasca, and Cass on the east. It stretches from the Canadian border in the north to Clay, Becker, Hubbard, and Cass counties in the south.

Figure 1: Northwest Region and Meeting Location



Strengths and Challenges in Providing Care Coordination

In conducting systems mapping, it was important to begin by developing an understanding of what works well and what needs improvement in providing care coordination. The main themes from in strengths and challenges experienced around care coordination in Northwest Minnesota are listed below.

“Care Coordination of CYSHN in Northwest Minnesota currently works because...”

- Parents are doing most of the coordination – “Parents do everything”
- Online charting is available and makes keeping medical records up-to-date easier
- Medical providers do assessment, follow-up, and referrals to what they know
- Of the hard work and determination of the people associated with care coordination (parents, nurses, etc.)
- A care coordination program on the White Earth Reservation (WeCare) is being implemented
- Providers/practitioners give information to families
- Families seek information from providers and are vigilant in receiving needed care
- Teachers, parents, and other team members communicate
- Sanford is implementing medical home principles, including a comprehensive care plan and community partnerships (attending IEP meetings)
- Mental health agencies have school-linked grants allowing them to provide services in schools

“Care coordination of CYSHN in Northwest Minnesota would be better if...”

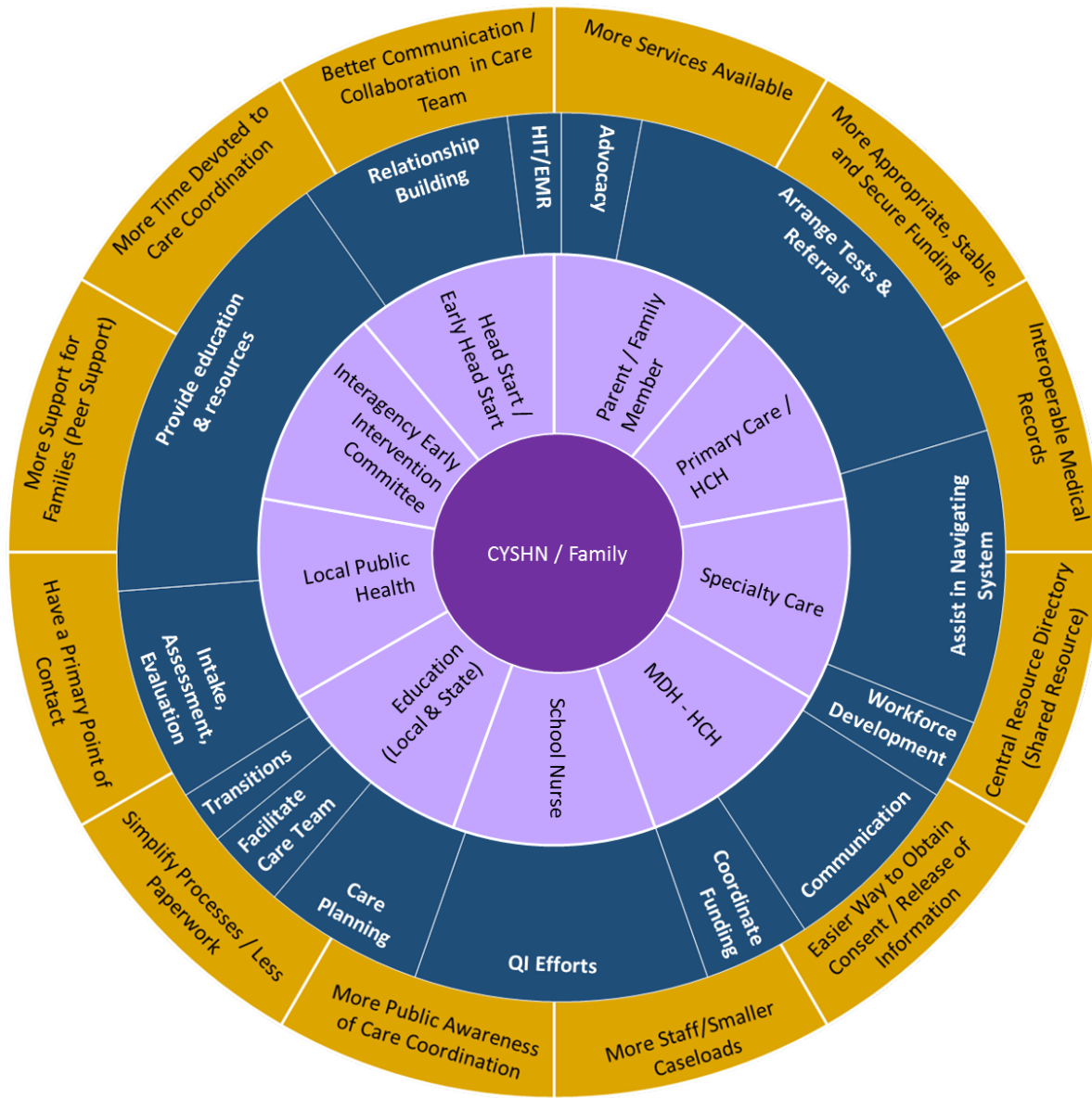
- Staff working with child would help families more with follow-up, referrals, etc
- Providers/partners would “play well together”
- There would be a universal Release of Information
- More collaboration between schools and the health care system would occur
- Medical providers and care coordinators knew more about resources available for families
- Care coordinators had more time devoted to helping families and reaching beyond the medical system
- All partners would “speak the same language”
- Gaps in communication- more whole team meetings
- Medical homes would have more direct partnerships with local public health and schools
- Everyone could communicate easier by having interoperable medical records

Regional Care Coordination Framework

All participants completed individual systems support maps (see Statewide Summary for more details), and then all the maps were compiled to create a regional care coordination framework using the Circle of Care Modeling (CCM) approach. CCM was used to identify the different various partners providing care coordination services, their primary responsibilities, and their common wishes on how to improve the system. *The CCM approach positioned CYSHN and their families at the center of the system; the roles of care coordinators and their responsibilities were then modeled around the family.* By mapping out the various partners providing care coordination and their responsibilities, we were able to expand our understanding of what families are experiencing in care coordination, and were also able to determine areas where the infrastructure needs to be built up to improve care coordination for CYSHN and their families.

The systems mapping approach is described in the next section, and is incorporated into Figure 2. We begin by describing the various partners who provide care coordination, and then move to their primary responsibilities in coordinating care. Finally, we explore wishes or opportunities for improvement at a systems-level; providing recommendations on how to build up the infrastructure to improve the provision of care coordination for CYSHN in Northwest Minnesota.

Figure 2: Northwest Minnesota Care Coordination Framework



Child and Family at the Center

For both the Statewide and Regional Care Coordination Frameworks, the child and family are placed at the center of the system. An [increasingly growing body of literature](#) points out that when the patient and/or family experience is placed at the center of care, more favorable outcomes are produced. By placing the child and family at the center of the framework, we are not only ensuring we think of their needs and experiences first, but that we also actively partner with them first when determining what systems-level improvements need to be made.

Roles of Partners

The next level of the Statewide Care Coordination Framework are the various roles of partners involved in care coordination. There were a total of 16 participants in the care coordination systems mapping meeting in Northwest MN. Participants represented the following areas: parents of CYSHN, primary care, local public health, specialty care, state agency staff, education, Head Start, school nurses, and interagency early intervention committees. *There are many different players involved in providing care coordination, or many different types of coordinators from different service/support systems. Also of note is that families often reported that they are the main coordinator of their child’s care – or at times can be the “coordinator of all the coordinators.”*

A breakdown of the organizations/roles of participants by region is included below in Table 1. The first row of the table includes all the types of different stakeholder groups who participated in any of the five regional meetings. The second row includes the number who participated in the Northwest Regional Meeting. As you can see, there were some stakeholder groups missing in the region. These roles/organizations are not included in regional care coordination framework (Figure 2).

Table 1: Care Coordination Systems Mapping Participant Organizations/Roles in Northwest MN

Participant Organizations/Roles	Northwest	Percent
Primary Care	5	31%
Parents	2	13%
Local Public Health	3	19%
Specialty Care	1	6%
Health Plans	0	-
MDH – Health Care Homes	1	6%
Education (District & State)	1	6%
Head Start/Early Head Start	1	6%
County Human Services	0	-
Mental Health	0	-
Family Organization	0	-
MN DHS	0	-
School Nurse	1	6%
Interagency Early Intervention Committee	1	6%
Home Care	0	-
TOTAL	16	

Missing Partners

Table 1 above includes the various roles or organizations of the participants in the Northwest Minnesota Regional Meeting. As you can see, there were quite a few different stakeholder groups who were not present, including: health plan representatives, county human services workers, and mental health and home care providers.

The participants in the meeting were also asked to list out other partners who were missing in the meeting. Responses included: physicians/specialty providers, patients (youth with special health needs),

transportation providers, pharmacy representation, hospital administrators, school administrators, and durable medical equipment providers.

Primary Responsibilities

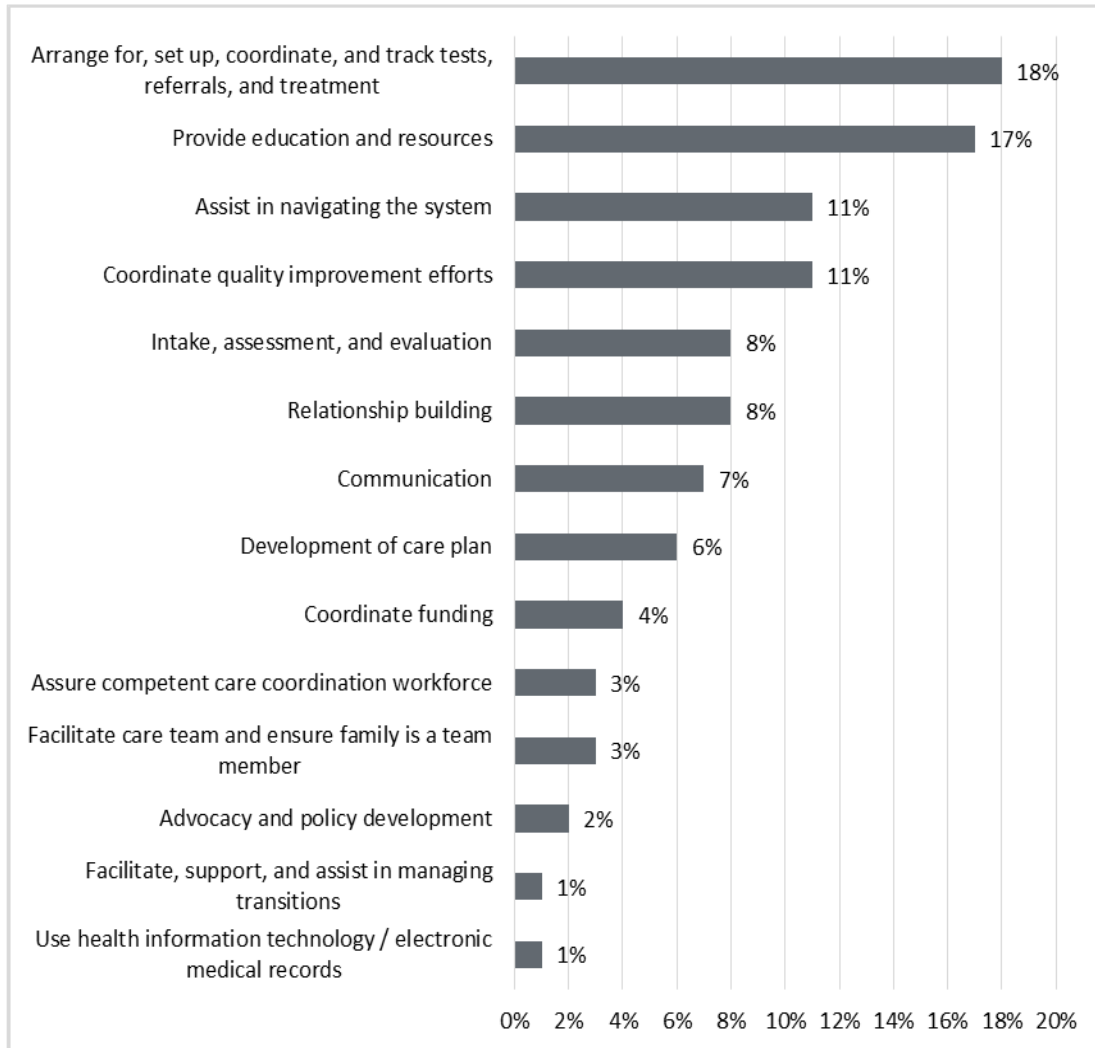
Moving out to the next level of the care coordination framework are the primary responsibilities of the providers of care coordination. Participants were asked to identify their top five responsibilities when it comes to providing care coordination for CYSHN. It is important to understand these responsibilities because they can help point toward the areas that care coordinators spend most of their time and effort. The responsibilities reported by the participants were aggregated utilizing an affinity diagramming process, and then were grouped into 14 different categories, including:

1. Advocacy and policy development
2. Arrange for, set up, coordinate, and track tests, referrals, and treatment
3. Assist in navigating the system
4. Assure competent care coordination workforce
5. Communication
6. Coordinate funding
7. Coordinate quality improvement efforts
8. Development of care plan
9. Facilitate care team and ensure family is a team member
10. Facilitate, support, and assist in managing transitions
11. Intake, assessment, and evaluation
12. Provide education and resources
13. Relationship building
14. Use health information technology/electronic medical record

Figure 3 provides the overall responsibilities reported by care coordinators in the Northwest Region. The most reported responsibility was arranging for, setting up, coordinating, and tracking tests, referrals, and treatment. This included activities such as helping to coordinate services, assisting with crisis prevention and management, guiding families so they can receive needed services and supports, and working to remove barriers experienced by families in navigating the system.

The second most reported responsibility of care coordinators in the region was providing education and resources. Some of the more specific activities under providing education and resources included: educating self on diagnoses and programs; educating other staff, coordinators, and care team members; educating or coaching families; and sharing or providing information on resources or diagnoses to families.

Figure 3: Northwest Region Primary Responsibilities in Providing Care Coordination



Infrastructure/Supports Needed to Improve Care Coordination (“Wishes”)

The final level of the Care Coordination Framework includes the systems-level actions that are needed to be able to improve care coordination. The participants were asked to give the top three things that they “wish” for that could help improve care coordination. We focused on calling these “wishes” because we wanted to encourage participants to think “big” when brainstorming things that could improve care coordination. Sometimes when stakeholders are asked to think of things that can improve the system or make it more easily navigable, responses can be stifled because they only will think of the smaller level things rather than the bigger problems or solutions – calling them wishes increased the creativity and honesty of the responses. All the responses statewide were compiled and grouped using an affinity diagramming process – categories were then determined based on the groups. The top “wishes” in the Northwest Region included:

- More services available for families:** Related to this category, participants wished for increased access to resources, services, and supports for patients and families – including: increased staffing of nurses in schools, more medical homes/certified health care homes, more

transportation services, and better home care services. They especially wished for this in the more remote areas of the region.

- **Medical records that span multi-systems and are family-friendly:** Participants wished for electronic health records that include more up-to-date contact information on families and that are automatically updated with assessments, test results, etc.
- **More appropriate, stable, and secure funding for services and care coordination:** Some of the wishes that fit within this category included: having more equitable state funding for schools, having a payment methodology for care coordination that fits children/families, and having waivers/financial assistance programs that are not dependent on income but rather on need.
- **Better communication/collaboration between care team members (including family):** Participants wished for better communication between families and education, health care, and other providers. They wished for more collaboration to occur between primary care and other systems partners (especially the schools and public health). They wished that care coordinators from the different systems across the region would be able to meet more regularly (monthly/quarterly). Other wishes included having more open channels of communication between state agencies/departments.
- **More support for families / family-centered care:** Participants wished for expanded parent partnerships and advisory team meetings.
- **Central resource directory / shared resource:** Participants wished for a resource map/directory for all communities that would automatically update.
- **Having a primary point of contact – “coordinator for the coordinators”:** This category included wishes for a primary contact or “go-to” person who would coordinate care.
- **Simplify processes for obtaining financial assistance / services – less paperwork, less duplication:** This included wishing that processes for obtaining financial services would be easier and less stressful for families, and that paperwork would be streamlined to eliminate duplication.
- **Easier way to obtain consent / Release of Information:** Participants wished for a universal release of information mechanism to be in place that would be accepted by all systems partners so information can be exchanged quicker and more efficiently.
- **More time devoted to care coordination:** They wished for more time to be able to devote to helping families on things that will make a difference.
- **More public awareness of care coordination:** Participants wished that there would be more public awareness of what care coordinators are able to do to help families – and increase the number of patient served. They wished for more advocates to help increase the political will to make the needs of CYSHN and their families a priority.
- **More staff/smaller caseloads:** Participants wished for more staff to be able to provide care coordination services – including more social workers and nurses.

Action Planning

After developing the Care Coordination Framework, participants were asked to take into consideration the various roles, responsibilities, and wishes discussed and brainstorm some concrete action steps that could be taken to improve care coordination. The action step planning was done at four levels to gather both short and long term steps as well as get at the different stakeholders involved in the steps. These four levels included: The overall action planning responses from the Northwest Region were grouped with those from other regions to create a set of major themes action steps. They were asked to think of four levels of action planning, including:

1. Things they can do right away, on their own, in the next week to month
2. Things they can take back to their organization/team to work on over the next 3 to 12 months
3. Things they can collaborate with someone else in their region over the next 6 to 12 months
4. Things that can be worked on at the broader state level over the next 1 to 2 years

For the first three levels, participants completed a worksheet in which they listed out action steps. Some common themes and examples from these levels are included in Table 3. Responses are not included in any specific rank. Those responses included more than once are bolded.

Table 2: Northwest Region Action Planning Themes and Examples

Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Taking information from meeting back to staff	<ul style="list-style-type: none"> • Educate my co-workers on meeting • Communicate with staff on gaps identified during meeting • Share information with parent partners meeting and advisory team meeting • Share notes from today with Beltrami Service Collaborative and school board/cabinet • Inform other local public health directors in the NW region about highlights from the meeting 	<ul style="list-style-type: none"> • Share with administration team points regarding care coordination • Make needs known to special education staff • Review information from today with Region 2 IEIC 	<ul style="list-style-type: none"> • Share ideas within our CHB education/update the other nurses/staff about the information to improve services
Improving internal clinic/agency/organization care coordination processes	<ul style="list-style-type: none"> • Work on school care plans • Communicate with peers and administration • Meet with RN HC in pediatrics to develop plan for continued implementation growth of medical homes in Pediatric clinic at Sanford Bemidji 	<ul style="list-style-type: none"> • Education and build up local public health nurse capacity and resources for CYSHN • Increase care coordination for pediatric patients that seek care locally • Integration of pediatrics in clinics • Standardization of processes • Communicate NW MN barriers to MDH-HCH 	<ul style="list-style-type: none"> • Collaborate with health coach to understand how to effectively do my job and learn resources • Staff education on pediatrics' role

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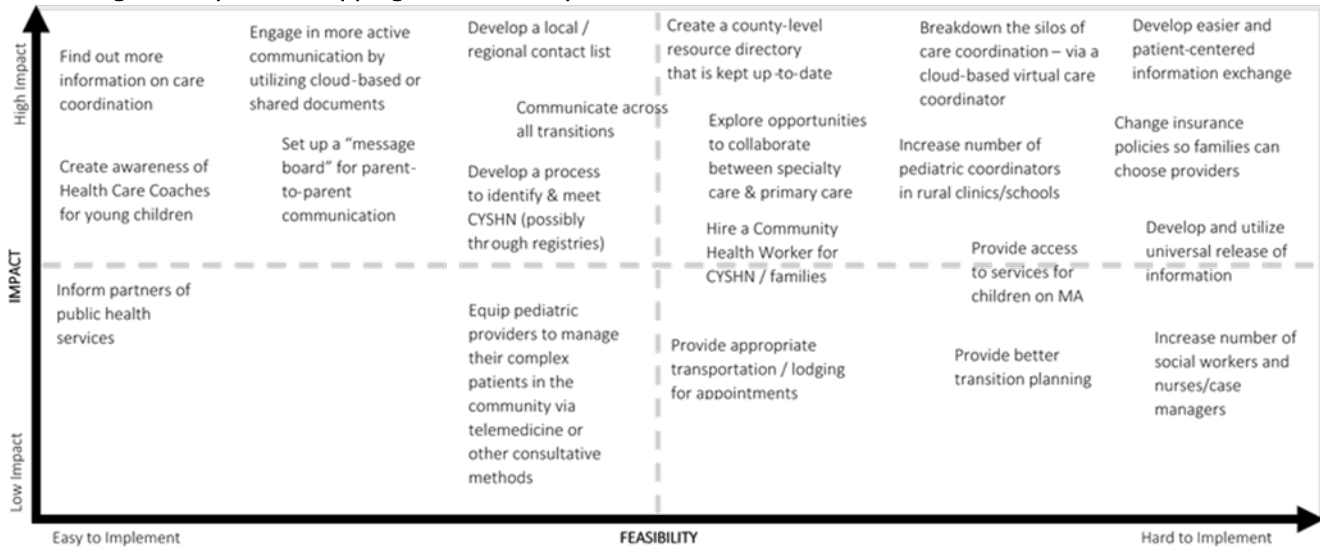
Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Involving families / learning about their needs / promoting family-centered care	<ul style="list-style-type: none"> • Set up meetings with parents • Identify the parents' and children's needs • Continue to connect and serve special needs children/families 		
Improving communication and collaboration with others	<ul style="list-style-type: none"> • Collaborate as local public health with other agencies • Bridge the gaps, talk with community • Make visits to collaborating partners and increase awareness, find out what is working • Talk to county social services to attempt to increase involvement • Email district ECSE staff to let them know of Sanford Health Coach 	<ul style="list-style-type: none"> • Determine/establish monthly/quarterly meetings for community resource contacts for care team coordination • Contact and learn more about what collaborating partners offer • Invite Sanford Health Coach to meet ECSE and special education teachers(connections) • Increase communication with schools • Increase communication with community entities • Develop relationship with schools(special education, school nurses) 	<ul style="list-style-type: none"> • Find out who is in my region • Collaborate with RN Health Coach in Bemidji pediatrics to discuss cases, optimal asthma care, care planning for medical homes • Invite Sanford Health Coach to meet ECSE and special education teachers(connections) • Connecting with appropriate contacts at local schools helping to increase communication for mutual patients • Serve as a HCH resource with anyone in the NW region of the state • Increase collaboration between Parent-to-Parent Support Group and Health Care Homes

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Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Improving resource directories and databases	<ul style="list-style-type: none"> Determine who community resource contacts are (for example: school, public health, special ed., etc.) Finalize resource folder for staff at Sanford to resource reference when needing help locating resources/connections for patients Elevate need for sharable resource list Share community resources with National Help Me Grow 	<ul style="list-style-type: none"> Set up resource list for parent-to-parent contact; help with discussions and other resources Find more resources 	<ul style="list-style-type: none"> Work with other bordering counties to establish UTP resource list Coordinate quarterly resource meeting in Fargo-Moorhead area
Promoting care coordination and better defining roles of care coordinators		<ul style="list-style-type: none"> Make medical homes known to the public 	
Implementing a Systems Support Mapping Process		<ul style="list-style-type: none"> Use care mapping to define care coordination model 	
Promoting shared care plans			<ul style="list-style-type: none"> Creation and communication of inclusive care plans that can be easily communicated when needed

Finally, participants were asked to identify state-level action steps that could be taken to improve care coordination for families of CYSHN. They then placed these action steps on an action priority matrix based on their perceptions of the potential level of impact and feasibility of the items. A summary matrix of is included in Figure 4.

Figure 4: Systems Mapping Action Priority Matrix



Appendix: Data Tables from Figures/Charts

Table 3: Primary Responsibilities in Providing Care Coordination (Data from Figure 3)

Primary Responsibility Group	Percent
Arrange for, set up, coordinate, and track tests, referrals, and treatment	18%
Provide education and resources	17%
Coordinate quality improvement efforts	11%
Assist in navigating the system	11%
Relationship building	8%
Intake, assessment, and evaluation	8%
Communication	7%
Development of care plan	6%
Coordinate funding	4%
Facilitate care team and ensure family is a team member	3%
Assure competent care coordination workforce	3%
Advocacy and policy development	2%
Facilitate, support, and assist in managing transitions	1%
Use health information technology / electronic medical records	1%

Systems Mapping Action Priority Matrix (Data from Figure 4)

	1 Easy to Implement	2	3	4	5	6 Hard to Implement
4 High Impact	Find out more information on care coordination	Engage in more active communication by utilizing cloud-based or shared documents	Develop a local / regional contact list	Create a county-level resource directory that is kept up-to-date	Breakdown the silos of care coordination – via a cloud-based virtual care coordinator	Develop easier and patient-centered information exchange
3	Create awareness of health care coaches for young children	Set up a “message board” for parent-to-parent communication	Communicate across all transitions	Explore opportunities to collaborate between specialty care & primary care	Increase number of pediatric coordinators in rural clinics / schools	Change insurance policies so families can choose providers
2	Inform partners of public health services		Develop a process to identify & meet CYSHN (possibly through registries)	Hire a Community Health Worker for CYSHN / families	Provide access to services for children on Medical Assistance	Develop and utilize universal release of information
1 Low Impact			Equip pediatric providers to manage their complex patients in the community via telemedicine or other consultative methods	Provide appropriate transportation / lodging for appoints	Provide better transition planning	Increase number of social workers and nurses / case managers

