# Orange County Care Collaborative For Kids

## Planning Efforts Evaluation Report

Report submitted by Help Me Grow to the Lucile Packard Foundation for Children's Health

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## Project Overview

Led by Help Me Grow Orange County, a Children's Hospital of Orange County/University of California Irvine Early Developmental Program dedicated to improving outcomes for children birth through five years of age, a collaborative emerged to pursue grant funding from The Lucile Packard Foundation for Children's Health (LPFCH). This new partnership, called the Orange County Care Coordination Collaborative for Kids (OC C3 for Kids), is comprised of key agencies that provide medical, social, care coordination and case management services for young children and families in Orange County. The purpose of the grant was to improve care coordination for children with special health care needs (CSHCN), and OC C3 for Kids used the 18-month LPGCH grant period to further develop a broad and representative countywide collaborative to better serve CSHCN and their families. OC C3 for Kids incorporated a combination of a care coordination, strategic planning and analysis, and a case review pilot to achieve the following goals:

**Overarching Goal:** To improve overall care for children and families with special health care needs by creating a collaborative care coordination system in Orange County.

**Goal 1:** To identify the specific needs of the Orange County care coordination collaborative starting with children birth to 5 years of age who have special health care needs (CSHCN) and their families**.**

**Goal 2:** To determine the organizational structure of the Orange County care coordination system for children birth to five years with special health care needs (CSHCN) and their families.

**Goal 3:** To conduct a pilot of the proposed Orange County Care Coordination model to validate the efficacy and refine team based development of procedures, tools, costs and processes before full implementation.

**Goal 4:** To create and implement a sustainability plan to secure resources to implement a care coordination countywide system with scalability and potential to expand to other age groups.

As part of this effort, OC C3 for Kids conducted an evaluation of its planning efforts. The evaluation, provided on the following pages, is focused on the effectiveness of achieving an improved system of care not only addressing gaps in services but also improving communication among CSHCN providers and families navigating the system.

## Evaluation Overview

The evaluation focused on systematic changes within OC C3 for Kids member agencies, while client/family outcomes were measured when they related to larger systematic issues. Keeping in mind that the goal of the collaborative is to improve overall care for children and families with special health care needs, the following objectives were developed to measure overall progress during this 18-month time period:

1. Create a coordinated system of care that will review, track and follow-up on cases
2. Develop a care coordination protocol
3. Increase communication among providers
4. Develop and promote common language via a county wide risk assessment (OC C3 for Kids Acuity Tool)
5. Ensure health insurance coverage for children
6. Enhance health literacy
7. Create a sustainability/scalability plan

Several activities and strategies were implemented to achieve the project objectives, with corresponding indicators to measure performance and progress:

1) Conduct monthly stakeholder meetings, consisting of case presentations, agency presentations, round table updates and planning activities
    a. Meeting attendance/agency participation
    b. Diversity of OC C3 for Kids collaborative agencies
    c. Number of case presentations
    d. Number of children with health insurance, primary care physician, history of NICU stay, type of needs
    e. Identification of system-wide Issues
    f. Increase in communication between OC C3 for Kids members
    g. Number and type of agency presentations

2) Develop common tools, such as the acuity tool, case review template and protocol for case review
    a. Pilot the acuity tool: number of agencies/families participating in pilot, feedback from pilot
    b. Achieve the development of all tools
    c. Utilize case review template
    d. Implement protocol for case review

3) Dedicate leadership to administer the project
    a. Effective leadership and governance
    b. Dedicated staff and appropriate structure
    c. Additional funding secured

The table below indicates how each activity or strategy contributed to the evaluation objectives. Details of each activity are discussed in the results section below.

| | Activities and Strategies Used to Meet Objectives | | | | | | |
|---|---|---|---|---|---|---|---|
| | Collaborative Meetings | | | Development of Tools | | | Leadership Team |
| Objectives | Case Presentation | Agency Presentation | Round Table Updates | Acuity Tool Development | Case Review Template | Protocol for Case Review | Planning Activities |
| 1. Creation of a coordinated system of care that will review, track and follow-up on cases | X | X | | X | X | X | X |
| 2. Development of a care coordination protocol | X | X | | | | X | X |
| 3. Increase communication among providers | X | X | X | X | X | X | X |
| 4. Develop and promote common language via a county wide risk assessment/ referral form | | | | X | X | | X |
| 5. Ensure health insurance coverage for children so that it is not the barrier to accessing services | | X | | | | | |
| 6. Enhancement of health literacy | | | X | X | | | |
| 7. Create a sustainability /scalability plan | | | | | | | X |

## Evaluation Methods

Qualitative and quantitative measures were used to evaluate OC C3 for Kids collaborative efforts including: meeting attendance logs; agency surveys; case presentation summaries; meeting minutes; interim and final grant reports; case presenter surveys; acuity tool submissions; and focus group summaries. Information was collected throughout the planning process and compiled for analysis at the end of the project.

## Evaluation Results

### 1. Conduct Monthly OC C3 for Kids Collaborative Meeting

The purpose of these meetings was to identify system-wide issues, provide a forum for agencies to communicate with each other, and to discuss/share information about the OC C3 for Kids project. Meeting activities included: case presentations, agency presentations, and a round-table report-out allowing all meeting participants to provide an update on important changes or issues regarding their agency. Indicators used to measure the effectiveness of the Collaborative Meetings were:

a. Meeting attendance/agency participation
b. Diversity of OC C3 for Kids collaborative agencies
c. Number of case presentations
d. Number of children with health insurance, primary care physician, history of NICU stay, type of needs
e. Identification of system-wide issues
f. Increase in communication between OC C3 for Kids members
g. Number and type of agency presentations

Collaborative Meetings: The collaborative meetings were 1.5 hours in length and averaged 20 participants. There were a total of 18 meetings from April 2013 through Sept 2014. The first six meetings focused primarily on case presentations and roundtable updates. Beginning in November 2013, agency presentations were added to the standing agenda.

Agency Presentations: To increase knowledge among the collaborative agencies, presentations provided an opportunity for participants to increase their working knowledge of other agency's services and referral criteria, and gave presenters the opportunity to address misconceptions about their agency and the services they provide. Ten presentations were conducted during collaborative meetings covering topics of eligibility for California Children's Services (CCS) and Regional Center services, accessing Mental Health Services in Orange County, and overviews of Cal Optima and Social Services Agency Children and Family Division. For a full list of presentations see Appendix A.

Roundtable Updates: To provide the opportunity for agencies to share information about agency activities that related to children with special health care needs, the first 20 minutes of each Collaborative meeting was designated for roundtable reporting. Information shared

included: upcoming workshops or conferences; staffing changes and open positions, changes regarding policies or practices, and legislative updates.

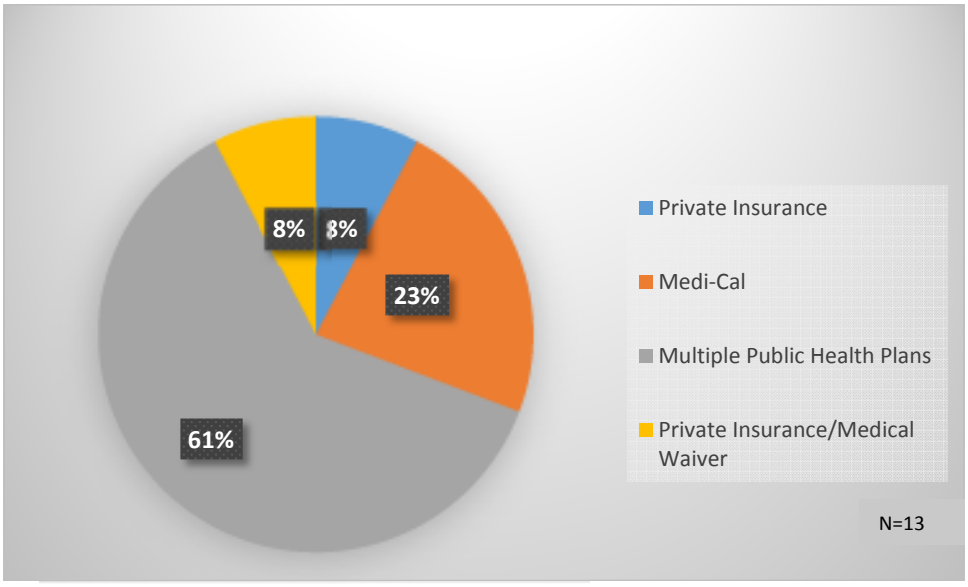
### *Meeting Participation/Agency Participation/ Diversity of Collaborative Agencies*

OC C3 for Kids had consistent agency participation in their monthly Collaborative meetings with an average attendance of 20 participants at each meeting and 21 agencies participating. Meeting attendance ranged from 15 to 25 participants with some agencies sending more than one representative. The diversity of the agencies participating in the collaborative ranged from county agencies, such as County of Orange Health Care Agency, hospitals, clinics and community based agencies such as Family Support Network. For a complete list of agencies participating in the collaborative see Appendix B, however the following agencies were critical to the case presentation/discussion process due to their likelihood of sharing a case: Regional Center of Orange County, CCS, Children's Hospital of Orange County, County of Orange-Health Care Agency, Family Support Network, The Center for Autism and Neurodevelopmental Disorders, Early Development Assessment Center and Cal Optima.

### *Case Presentations*

A total of 13 cases were presented during monthly Collaborative meeting. Agencies were directed to select cases that focused on young children who were experiencing difficulty in obtaining care and/or services related to their special health care needs. A presentation was given by agencies who provide direct services to CSHCN families with two agencies presenting twice. Children ranged in age from newborn to eleven years of age, with 10 cases focusing on children under six years of age. Medical needs was the presenting factor for nine children, three children had behavioral health needs and one had a developmental delay. Neonatal Intensive Care Unit (NICU) stays were reported for all children whose case presented with a medical need, while those cases with behavioral health or development delay did not have NICU stay. All children had health insurance and eight children were identified as having more than one type of insurance to cover their medical needs.

Figure 1



Primary care physicians (PCP) were identified for six children, two children were in transition to a new PCP at the time of the case presentation and five children did not have a PCP identified. The quality of the PCP was not assessed. However, case presentations identified that 'obtaining a response from pediatrician's office' regarding health care follow-up was 'often lacking'; while pediatricians reported the process to 'obtain authorization for services, was time intensive'.

### *System-wide Issues*

The case presentations identified the following system-wide issues for the cases presented:

Delay of Care: The initial breakdown in care appears to be a delay of services due to one or more of several reasons:

- **Approval process** - paperwork is incorrect or not signed by right party (e.g. PCP) or not getting to the right place at the right time to facilitate services.
- **Insurance** - tied to approval process – referral is not getting generated in a timely manner, or paperwork is not signed correctly, or there is lack of knowledge about what is covered.
- **Eligibility** - some conditions are simply not eligible for services at specific agencies (e.g. child with high functioning autism may not qualify for Regional Center services; in other cases the condition is not described in a way to ensure eligibility or paperwork is a problem.
- **Scarcity of Specialists** - even when eligibility/approval is available, scarcity of specialists/services may delay care e.g. wait lists for therapy or sub-specialists.

Designated Point Person/Agency to Follow Up: When care gets "stuck," there is not a common, designated organization responsible for coordinating care. Who is responsible for following up on a child's care?

- **Parents** could be advocates, but may not have the necessary information to follow up (e.g. don't know that an authorization wasn't signed); or, they may not have the supports to be their child's advocate (overwhelmed, don't have culturally appropriate help, etc.).

- **Primary Care Providers (or staff at medical home)** could be advocates, but there are barriers:
  - Handoff from the NICU (if a child was in a NICU) to PCP is undefined or lacking. In nearly every case reviewed to date, the PCP or a medical home was not involved.
  - PCP may not have needed background/expertise to take on a medically fragile child with complex health needs.

- Medical home may not be appropriate for the family so they don't utilize it (problem with transportation, familiarity, cultural barriers)
- PCP may not be adequately compensated for caring for CSHCN.

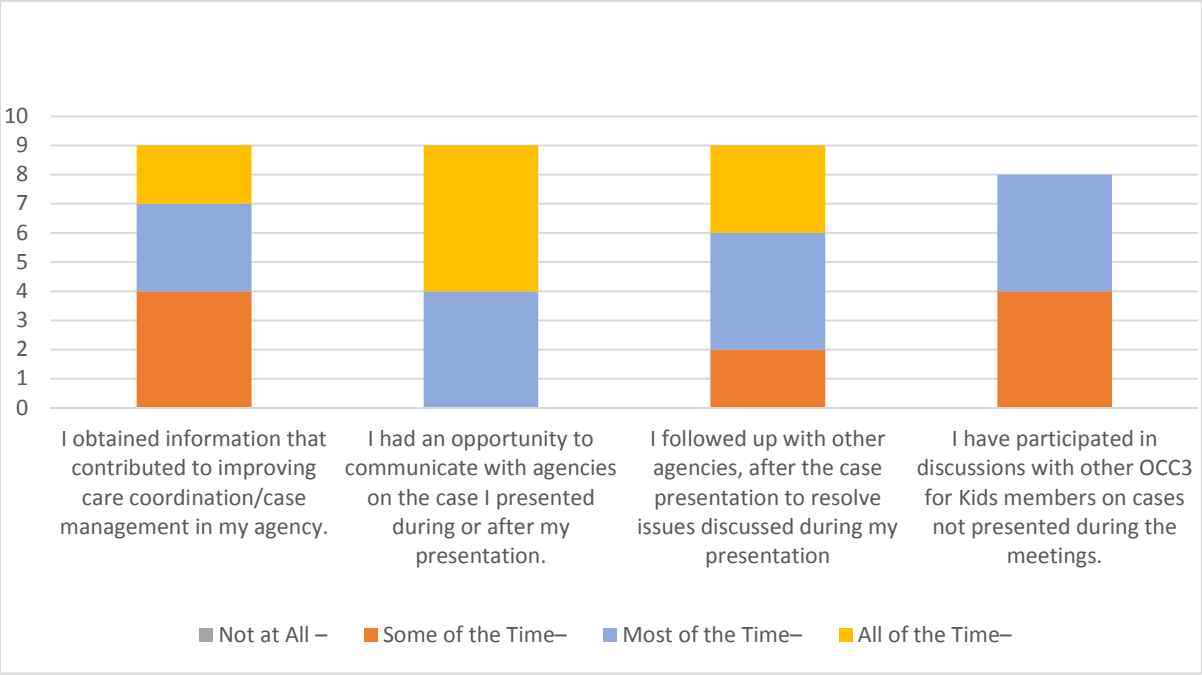
Other areas that were identified as significant issues when present in the family situation:

a. Constraints of the foster care system
b. Transferring from or into another county and maintaining health coverage
c. Mental health of parent

### *Increase in Communication between Collaborative Agencies*

Upon the completion of the award period, agencies were asked to complete a short survey on the impact presenting a case had in the areas of communication, care coordination, and policy or procedural changes. Complete results of the survey can be found in Appendix C. The survey had a 64% response rate (nine of 14 presenters responded). Of those who responded, 56% indicated they had an opportunity to communicate with agencies on the case presented during or after their presentation "all of the time," and 44% 'most of the time." Further 77% responded they have followed up with other agencies, after the case presentation, to resolve issues discussed during their presentation "most or all of the time." The response "Not at All" was not selected for any question. (See Figure 2)

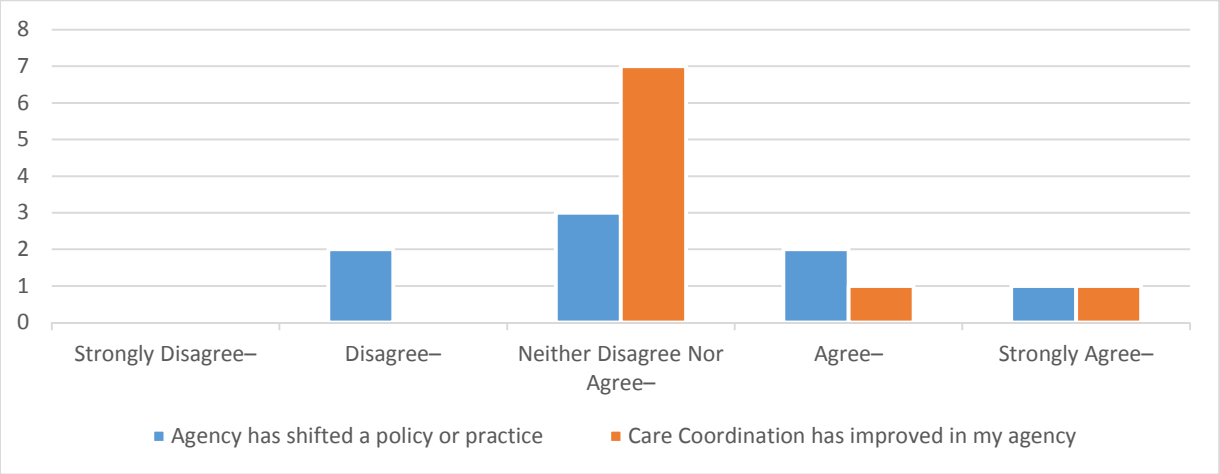
*Figure 2*




Additional questions were asked of the same group regarding policy or procedural changes within their agency. Fully 66% of respondents reported an overall increase in communication between their agency and the other agencies that provide services, while 100% of survey

respondents have acquired a contact on whom they can rely to help with issues or questions. However, a majority of respondents reported that they "neither disagreed nor agreed" to statements: a) I or my agency have shifted a policy or practice to improve care coordination/case management due to the information learned through my case presentation or b) I feel that care coordination/case management has improved in my agency due to participating in OC C3 for Kids (See Figure 3).

*Figure 3*




Case presenter survey results also reported that the OC C3 for Kids acuity tool is being implemented in two agencies, while two agencies began obtaining feedback from staff regarding care coordination/case management practices. No agencies began a new practice of obtaining family feedback, although data collected via collaborative members in September 2013 indicated that five OC C3 for Kids agencies do obtain family feedback on a regular basis and compile the results to use in planning.

*Figure 4*

| Answer Choices | Responses | |
|---|---|---|
| Adopted the "OCC3 acuity tool" as a means of assessing a child's needs | 28.57% | 2 |
| Began obtaining family feedback for families receiving service | 0.00% | 0 |
| Began obtaining feedback from staff on care coordination/case management services | 28.57% | 2 |
| Agency is In the process of revising care coordination/case management practices | 28.57% | 2 |
| Made a change to an existing policy or practice to address issues raised during OCC3 for Kids meetings | 0.00% | 0 |
| Adopted a new policy or pratice to address issues raised during OCC3 for Kids meetings | 0.00% | 0 |
| Other (please specify) Responses | 42.86% | 3 |
| Total Respondents: 7 | | |

## 2. Develop Tools

A variety of tools were developed throughout the course of the project. These tools included an acuity tool, case review template, HIPAA confidentiality sign, and protocol for case reviews. Tools were developed in collaboration with agency representatives and finalized with their approval.

### *Acuity Tool*

The acuity tool was designed to identify cases that would require care coordination at a county level. It was developed over the course of three workgroup meetings with Collaborative representatives who reviewed similar tools used in Kern County and a subset of Orange County Hospitals. The tool is made up of 25 questions grouped into family, child and other risk factors. Each question is answered on a scale of 'none/low; moderate; or high.' The tool is scored by each risk factor and a total risk score. Other information such as client name, date of birth/age, primary care providers, health insurance, language of caregiver, language spoken in the home, time spent in NICU, and referrals already provided to the family are also requested from the agency screening the child. As a complement to the acuity tool, a scoring sheet was provided which gave the screener definitions for each risk factor on how to score each answer. For example:

| FAMILY RISKS | *None/Low* | *Moderate* | *High* |
|---|---|---|---|
| Substance Abuse | No known or suspected substance abuse<br><br>Caregiver or household member has a history of substance abuse but has had formal treatment | Suspected substance abuse, or caregiver or household member has a history of substance abuse and has had no had formal treatment | High risk behavior indicating recent or current substance abuse<br><br>There is proven substance abuse |
| Emotional or Behavioral Concerns | No family members have serious emotional or behavior problems | One or more family members exhibit occasional inappropriate emotional behavior | One or more family members exhibit inappropriate emotional behavior which interferes with activities of daily living, such as depression or inappropriate anger<br><br>Hospitalization for mental illness and/or attempted suicide within the past five years. |

The tool was piloted from April 2014 through August 2014 by seven agencies: CHOC residents at a primary care clinic; University of California Irvine Medical Center NICU; CHOC pediatrician at a high-risk infant follow-up clinic; CCS; The Hope Clinic, the Regional Center of Orange County, and Help Me Grow. A total of 182 families participated in the pilot. Data was summarized and shared with OC C3 for Kids leadership team and two focus groups were conducted to obtain feedback from the agencies administering the tool.

- All who participated in the focus groups thought the tool was beneficial.
- Parts of the tool need refinement.
- When/where the screening is administered is important, and may be different for various organizations.
- Certain risks were mentioned more frequently as impactful by the interviewers.
- Family reaction to the tool ranged widely.

A final revision of the tool is forthcoming and will be put into effect in the upcoming months. As of the time of this evaluation report two agencies report incorporating the tool with all of their cases as a means to conducting an assessment of child/family needs.

### *Case Review Template/HIPAA Confidentiality Guidelines*

Developed and refined within the first three meetings, the case review template provides the agency presenting a case a framework to address historical and current issues. The template structures the presentation into: 1) case milestones which are separated into action steps and 2) the issue that resulted from the action step. General information such as age of the child, age of the child when first referred to the agency, gender, health insurance, medical home, primary and secondary diagnosis, birth weight, presenter name and agency as well additional case background is requested as a summary at the top of the form. No identifying information is requested and agencies are asked to coordinate with those sharing the case when presenting. (See Appendix D)

Complementing the case review is 2 x 3 foot sign that is posted onsite during the case presentations, with the HIPAA confidentiality guidelines displayed as well as the 18 data elements that would identify the client. Agencies presenting cases also asked their clients to sign an agency consent form allowing them to present to OC C3 for Kids.

### *Protocols for Case Review*

The protocol for case review was developed for the purpose of opening the case presentations to agencies who do not participate in OC C3 for Kids. The protocol incorporated best practices from the 13 cases presented and requires the presenter to complete a case review form, the acuity tool, and adhere to HIPAA confidentiality standards. Best practice standards that have maximized case coordination include:

- Contacting other agencies who share the case and inform them of the presentation
- Being available after the presentation to follow-up on next steps identified during the presentation
- Completing the case review form

The final revision of the protocol will be presented at the November 2014 meeting.

## 3. Dedicated Leadership

Led by the Help Me Grow Program Manager, Rebecca Hernandez, the leadership team is comprised of four additional individuals: Madeline Hall, Grant Development Manager from CHOC Children's Foundation; Lisa Burke, a consultant to facilitate the collaborative meetings; Cynthia Miller, a consultant to conduct the evaluation and Marc Thibault, care coordination consultant from Kern County on a grant from the Lucille Packard Foundation. The leadership team conducts the administrative activities for the award and monthly collaborative meetings, coordinates the speakers and case presenters, developed and refined the acuity tool,

represents OC C3 for Kids to various collaborative agencies, and participates in the 5 C's activities and meetings in Palo Alto.

Using the Bridgespan Group identification of an effective collaborative, a questionnaire was administered to collaborative agency representatives in April 2013 and again in July 2014 to measure the effectiveness of the leadership team's efforts on the following concepts:

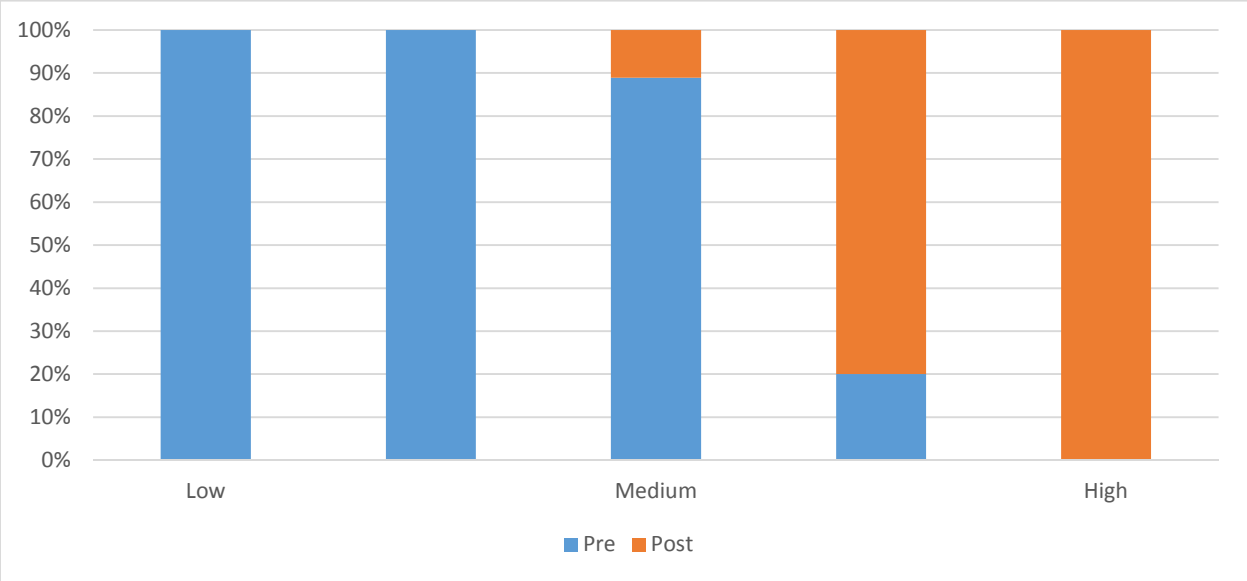
- Effective leadership and governance: keeping decision makers at the table
- Dedicated staff and appropriate structure
    - Convening
    - Facilitation
    - Data collection
    - Communications
    - Administration

It should be noted that there are other measures as part of the tool that provide a holistic picture of the collaborative, but were not used in this evaluation. They can be found in Appendix E.

Results show a significant shift in the area of "Effective Leadership and Governance: Keeping Decision Makers at the Table", with most respondents moving their answers from low and medium to medium to high (See Figure 5).

*Figure 5*

*Effective Leadership and Governance: Keeping Decision Makers at the Table*



Responses also shifted in the same direction, from low/medium to medium/high, on "dedicated staff and appropriate structure"; as well as each sub category (see Figure 6).

*Figure 6*

| B. Characteristics of success | Low | | Medium | | High | |
|---|---|---|---|---|---|---|
| *4. Dedicated staff and appropriate structure* | 0 | 4 | 3 | 0 | 0 | 7 |
| *Post* | | | | 3 | 6 | 9 |
| • *Convening* | 3 | 5 | 6 | 0 | 0 | 14 |
| *Post* | | | 2 | 3 | 6 | 11 |
| • *Facilitation* | 5 | 6 | 4 | 0 | 0 | 15 |
| *Post* | | | 1 | 4 | 6 | 11 |
| • *Data collection* | 7 | 4 | 4 | 0 | 0 | 15 |
| *Post* | | | 1 | 6 | 5 | 12 |
| • *Communications* | 5 | 3 | 5 | 0 | 0 | 13 |
| *Post* | | | | 5 | 7 | 12 |
| • *Administration* | 7 | 4 | 5 | 0 | 0 | 16 |
| *Post* | | | 1 | 3 | 8 | 12 |
| *5. Sufficient funding: targeted investments* | 11 | 2 | 4 | 0 | 0 | 17 |
| *Post* | | | 1 | 5 | 3 | 9 |

## *Secure additional funding*

CHOC Foundation, fiscal sponsor for OC C3 for Kids, communicated with six private sector funders and the County of Orange Health Care Agency regarding care coordination needs in Orange County. In addition to the contribution CHOC Foundation provides OC C3 by not charging administration fees for their time towards these activities, the following additional funding was secured or identified:

- In October 2013, secured $12,500 from the Carl E. Wynn Foundation.
- In October 2014, CHOC Foundation secured $10,700 from the Carl E. Wynn Foundation.
- Secure 80% of funding needed for 3-year plan, which will be achieved through Federal Financial Participation (FFP) and private fund.

The Federal Financial Participation is federal funding that requires:

- The local program must use qualifying non-federal funds (i.e. local county/city/state/private funds) to draw down Title XIX matching/reimbursement.
- Allowable use is to assist individuals on Medi-Cal to access Medi-Cal providers, care and services.
- Funded staff must be from a public agency.

OC C3 has a partnered with the County of Orange Health Care Agency to draw down these funds to hire a care coordinator for OC C3 for Kids. Activities listed below will finalize the process and allow OC C3 for Kids to hire a care coordinator.

- Development of Job Description/Scope for this countywide system Care Coordinator "to improve systems of care in Orange County for children with special health care needs and their families by reducing barriers to and delay of care" and to "build a strong foundation of collaboration between Public Health Nursing and OCC3 for Kids."
- Budget development for a 12-month pilot by Division Management of Orange County Health Care Agency.
- OCHCA submits the FFP position as part of the County's Maternal, Child and Adolescent Health budget and makes state-required revisions.
- With final approval, matching funds to be provided by CHOC Foundation.

## Conclusions

OC C3 for Kids contributed to improving the overall care for children and families with special health care needs by creating a collaborative care coordination system in Orange County through the following systematic changes:

- Creating a common language through the implementation of a case review template for case presentations and an acuity tool with definitions that clearly identify children's medical, social and environmental needs. Having two agencies already adopt the tool indicates a need for such an instrument and will continue to promote common language across different agencies.
- Improving communication between the OC C3 for Kids collaborative members who were given an opportunity to discuss shared cases, and continued to follow up on these shared cases to ensure a coordinated care plan moving forward. Members also improved their ongoing communication by beginning to establish practices of communication on cases shared that were not presented to the OC C3 for Kids Collaborative.
- Maintaining ongoing commitment from OC C3 for Kids members as observed with consistent meeting attendance and the dedication of the leadership team.
- Obtaining health insurance is not a significant barrier for this population, however obtaining the correct eligibility to cover the health care is a barrier. Coordination and communication on those cases with multiple types of insurance will continue to be needed.
- All children whose case was presented with a medical condition, versus a developmental/behavioral condition, had a history of NICU stays. Considerations on the entry point for countywide care coordination should identify referral sources that would target children with NICU stays as well sources that treat older children.
- Securing sustainable funding through private and public funding which will result in the hiring of a countywide system Care Coordinator.

Results also indicated the following areas in which improvements could be made:

- Securing both public and private insurance companies to be a part of the OC C3 for Kids membership. As indicated in the case reviewed, 61% of children with special health care needs have more than once insurance coverage increasing the need for coordination.
- Communication has improved between Collaborative members; however agency policies and practices have not shifted with the same amount of change, as reported via survey responses indicated.
- Forty- six percent of case presentations had an identified primary care physician, but still experiences delays in care. Further assessment of the PCPs ability to be the child's medical home should also assess the ability for the PCP to manage the various need of the child.

Appendix A

**OC C3 for Kids List of Presentations**

| Month | Presenters | Agency | Topic |
|---|---|---|---|
| November 2013 | Harriet Fain-Tvedt, PT, MPA<br>Julie Koga, BSN, PHN | California Children Services | California Children Services |
| November 2013 | Pat Glancy, MSW | Regional Center of Orange County | Regional Center Eligibility: Early Start and Lanterman Services |
| December 2013 | Pat Orme, MSN, RN, PHN | Orange County Health Care Agency | Public Health Nursing Division |
| January 2014 | Marc Lerner, MD | Center for Healthy Kids and Schools, OCDE | The Pediatrician's Role in Care Coordination for Children with Special Health Care Needs in California |
| Feb 2014 | Ilia Rolon, MPH | Cal Optima | The Impact of the Affordable Care Act on Orange County Children |
| March 2014 | Holly Henry, PhD | Lucile Packard Foundation of Children's Health | Care Coordination for Children with Special Health Care Needs. |
| March 2014 | Regan Foust, PhD | Lucile Packard Foundation of Children's Health | KidsData.org |
| April 2014 | Pegi Williams | Cal Optima | Introduction to CalOptima |
| May 2014 | Nathan Lopez, PhD | Orange County Health Care Agency: Behavioral Health Services | Children and Transitional Age Youth Services |
| June 2014 | Pamela Kahn, RN, MPH | Orange County Department of Education | Caring for Children with Special Health Care Needs in the School Setting |

Appendix B

**OC C3 for Kids Collaborative Agencies**

1. American Academy of Pediatrics, California Chapter IV
2. Bridges Maternal Child Health Network
3. Cal Optima
4. California Children's Services
5. Children and Families Commission of Orange County
6. Children's Health Initiative of Orange County
7. CHOC Children's Foundation
8. CHOC Early Development Center
9. CHOC Primary Care Clinic Pediatricians
10. Comfort Connection Family Resource Center
11. County of Orange Children and Family Services
12. County of Orange Health Care Agency
13. County of Orange Social Services Agency
14. Family Support Network
15. Help Me Grow Orange County
16. Orange County Department of Education Center for Healthy Kids and Schools
17. Regional Center of Orange County
18. School Readiness Nurses
19. State Council of Developmental Disabilities
20. The Center for Autism & Neurodevelopmental Disorders
21. The Hope Clinic

Appendix C

## OC C3 Case Presentation Post Survey - Results

| | Not at All | Some of the Time | Most of the Time | All of the Time | N/A | Total | Average Rating |
|---|---|---|---|---|---|---|---|
| I obtained information that contributed to improving care coordination/case management in my agency. | 0.00%<br>0 | 44.44%<br>4 | 33.33%<br>3 | 22.22%<br>2 | 0.00%<br>0 | 9 | 2.78 |
| I had an opportunity to communicate with agencies on the case I presented during or after my presentation. | 0.00%<br>0 | 0.00%<br>0 | 44.44%<br>4 | 55.56%<br>5 | 0.00%<br>0 | 9 | 3.56 |
| I followed up with other agencies, after the case presentation to resolve issues discussed during my presentation | 0.00%<br>0 | 22.22%<br>2 | 44.44%<br>4 | 33.33%<br>3 | 0.00%<br>0 | 9 | 3.11 |
| I have participated in discussions with other OCC3 for Kids members on cases not presented during the meetings. | 0.00%<br>0 | 44.44%<br>4 | 44.44%<br>4 | 0.00%<br>0 | 11.11%<br>1 | 9 | 2.50 |

Appendix C

| | Strongly Disagree | Disagree | Neither Disagree Nor Agree | Agree | Strongly Agree | N/A | Total | Average Rating |
|---|---|---|---|---|---|---|---|---|
| I feel that communication has improved between me (my agency) and the other agencies that provide services to our clients. | 0.00% 0 | 0.00% 0 | 33.33% 3 | 55.56% 5 | 11.11% 1 | 0.00% 0 | 9 | 3.78 |
| I have acquired contact(s), at one or more of the agencies, that provide services to our clients, on whom I can rely on to help me with issues or questions. | 0.00% 0 | 0.00% 0 | 0.00% 0 | 66.67% 6 | 33.33% 3 | 0.00% 0 | 9 | 4.33 |
| I or my agency have shifted a policy or practice to improve care coordination/case management due to the information learned through my case presentation. | 0.00% 0 | 25.00% 2 | 37.50% 3 | 25.00% 2 | 12.50% 1 | 0.00% 0 | 8 | 3.25 |
| I feel that care coordination/case management has improved in my agency due to participating in OCC3 for Kids. | 0.00% 0 | 0.00% 0 | 77.78% 7 | 11.11% 1 | 11.11% 1 | 0.00% 0 | 9 | 3.33 |

Appendix C

## Have you or your agency implemented any of the following activities as a result of your participation in OCC3 for Kids? (Please select all that apply)

| Answer Choices | Responses |
|---|---|
| Adopted the "OCC3 acuity tool" as a means of assessing a child's needs | 28.57% 2 |
| Began obtaining family feedback for families receiving service | 0.00% 0 |
| Began obtaining feedback from staff on care coordination/case management services | 28.57% 2 |
| Agency is In the process of revising care coordination/case management practices | 28.57% 2 |
| Made a change to an existing policy or practice to address issues raised during OCC3 for Kids meetings | 0.00% 0 |
| Adopted a new policy or pratice to address issues raised during OCC3 for Kids meetings | 0.00% 0 |
| Other (please specify) Responses | 42.86% 3 |
| Total Respondents: 7 | |

Other: responses

- I think more time is needed to implement new policies/activities, but participation has led to discussions and thoughts about making changes.
- Family feedback is already a service that is part of the evaluation component to assure service outcomes
- Continue participation with OC C3 for Kids

Appendix D

**OC C3 for Kids Protocol for Case Review**


## Orange County Care Coordination Collaborative for Kids Protocol for Case Review

**Purpose:** To ensure all individuals in Orange County serving CSHCN are able to present cases to be reviewed at the monthly Orange County Care Coordination Collaborative for Kids (OCC3 for Kids).

**Process:** The individual requesting to have a case reviewed will follow these steps.

1. Find out if your agency/organization has a representative at OCC3 for Kids. If yes, work with this individual to coordinate the case presentation.
2. Complete OCC3 for Kids screening tool and fax to Help Me Grow at 949.221.0048 Attn: Rebecca Hernandez.
3. Use cover page stating the request to present at OCC3 for Kids with your contact information including phone number and email address.
4. Complete case review template (Attachment A). Please be aware of the 18 identifiers under the HIPPA Privacy Rule (Attachment B) that are not to be included in the case review information.
5. If any other agency is involved in the case, contact the agency representative participating in OCC3 for Kids. Roster is available from Rebecca Hernandez.
6. Confirm date with Rebecca Hernandez (Rherman2@uci.edu) when case review will be on the OCC3 for Kids agenda.
7. Make at least 20 copies of competed case review template and bring on day of presentation.
8. Be prepared to present case to the larger group highlighting key points, strengths and challenges of family and child.
9. Completed case review forms will be collected at the end of the meeting and shredded.
10. Follow-up with agencies/individuals and possible next steps identified during discussion.

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Appendix D

## Case Summary OC C3 for Kids

**Date:** **Case #:** **Presenter:**
**Presenting Agency:**

**Referral Source:**

**CHILD INFORMATION:**

Gender: M/F Gestational Age: Birth weight:

Child's age at time of referral to your agency? Current age:

Health Insurance: Medical home: Y/N

Primary diagnosis: Secondary diagnosis:

**ADDITIONAL CASE BACKGROUND** (Other issues to consider including strengths):

**CASE MILESTONES** (actions taken/where were referrals made/ include if services were received or denied and why)

| Action 1<br>Age of child: | Action 2<br>Age of child: | Action 3<br>Age of child: | Action 4<br>Age of child: | Action 5<br>Age of child: | Action 6<br>Age of child: |
|---|---|---|---|---|---|
| | | | | | |

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Appendix D

## Case Summary OC C3 for Kids

**Current Status** *(health, family, services, etc.)*:

**Challenges/Issues/Barriers/Strengths:** *(What is working? What went wrong? Identify challenges, breakdown, or problems. If possible, circle the level(s) the issue occurred.)*

| Issue 1 (circle type): System/Provider/Service/Family | Issue 2 (circle type) System/Provider/Service/Family | Issue 3 (circle type) System/Provider/Service/Family | Issue 4 (circle type) System/Provider/Service/Family | Issue 5 (circle type) System/Provider/Service/Family |
|---|---|---|---|---|
| | | | | |

**System Level Implications:** *(What is working? Where are the gaps in the system of care? What's fixable and what is beyond our control? What are the solutions? What are the structural barriers that will require advocacy and policy changes? Funding limitations?)*

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Appendix D

## Case Summary OC C3 for Kids

Attachment B

The 18 Identifiers under the HIPAA Privacy Rule (Protected Health Information)
Protected Health Information (PHI): Information in any format that identifies an individual, including demographic information. Info created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse that relates to an individual's past, present or future physical or mental health/condition.

- Names
- All elements of dates except year related to an individual
- E-mail Addresses
- Phone #s
- Vehicle identifiers and serial #s
- URLs
- Fax #s
- Biometric identifiers, incl. finger and voice prints
- IP address #s
- SS #s
- Full face photographic and comparable images
- Certificate/license #s
- Account #s
- Any other unique identifying #, characteristic or code
- Health plan beneficiary #s
- Med Record #s
- For Orange County, last 2 digits of 5-digit zip code
- Device identifiers/serial #s

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Appendix E

## OC C3 for Kids Needle Moving Results

| A. Operating Principles | Low | | Medium | | High | # of Respondents |
|---|---|---|---|---|---|---|
| ***1. Commitment to long-term involvement*** | 1 | 2 | 5 | 5 | 3 | 16 |
| ***Post*** | | | 1 | 2 | 9 | 12 |
| ***2. Involvement of key stakeholders across sectors*** | 4 | 2 | 7 | 2 | 1 | 16 |
| ***Post*** | | | | 2 | 10 | 12 |
| ***3. Use of shared data to set the agenda and improve over time*** | 12 | 4 | 1 | 0 | 0 | 17 |
| ***Post*** | | | 2 | 4 | 6 | 12 |
| ***4. Engagement of community members as substantive partners*** | 1 | 5 | 8 | 1 | 2 | 17 |
| ***Post*** | | | | 3 | 9 | 12 |
| **B. Characteristics of success** | **Low** | | **Medium** | | **High** | |
| ***1. Shared vision and agenda*** | 5 | 5 | 6 | 1 | 0 | 17 |
| ***Post*** | | | 1 | 5 | 6 | 12 |
| ***2. Effective leadership and governance: keeping decision makers at the table*** | 6 | 2 | 8 | 1 | 0 | 17 |
| ***Post*** | | | 1 | 4 | 7 | 12 |
| ***3. Alignment of resources: using data to continually adapt*** | 12 | 3 | 2 | 0 | 0 | 17 |
| ***Post*** | | | 3 | 6 | 3 | 12 |
| ***4. Dedicated staff and appropriate structure*** | 0 | 4 | 3 | 0 | 0 | 7 |
| ***Post*** | | | | 3 | 6 | 9 |
| • ***Convening*** | 3 | 5 | 6 | 0 | 0 | 14 |

| | | | | | | |
|---|---|---|---|---|---|---|
| ***Post*** | | | 2 | 3 | 6 | 11 |
| • ***Facilitation*** | 5 | 6 | 4 | 0 | 0 | 15 |
| ***Post*** | | | 1 | 4 | 6 | 11 |
| • ***Data collection*** | 7 | 4 | 4 | 0 | 0 | 15 |
| ***Post*** | | | 1 | 6 | 5 | 12 |
| • ***Communications*** | 5 | 3 | 5 | 0 | 0 | 13 |
| ***Post*** | | | | 5 | 7 | 12 |
| • ***Administration*** | 7 | 4 | 5 | 0 | 0 | 16 |
| ***Post*** | | | 1 | 3 | 8 | 12 |
| ***5. Sufficient funding: targeted investments*** | 11 | 2 | 4 | 0 | 0 | 17 |
| ***Post*** | | | 1 | 5 | 3 | 9 |
| **C. Ability to Thrive** | **Low** | | **Medium** | | **High** | |
| ***1. Increasing the visibility and legitimacy of collaborative work*** | 6 | 4 | 4 | 2 | 0 | 16 |
| ***Post*** | | | 4 | 5 | 3 | 12 |
| ***2. Supporting policy and system change*** | 6 | 5 | 5 | 0 | 1 | 17 |
| ***Post*** | | | 4 | 4 | 3 | 11 |
| ***3. Providing knowledge and implementation support*** | 5 | 3 | 8 | 0 | 1 | 17 |
| ***Post*** | | | 4 | 2 | 6 | 12 |
| ***4. Funding for infrastructure and implementation support*** | 11 | 6 | 1 | 0 | 0 | 18 |
| ***Post*** | | | 4 | 4 | 2 | 10 |
| ***5. Pushing for greater community partnership*** | 4 | 3 | 8 | 0 | 1 | 16 |
| ***Post*** | | | 2 | 3 | 7 | 12 |