ALIGNMENT OF DRAFT CACOON STANDARDS 2015-16
with CCO Incentive Measures, PCPCH Core Attributes and the Standards for Systems of Care Children and Youth with Special Health Care Needs

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June 12, 2015

DRAFT CaCoon Standard	CCO Measure[1]	PCPCH Core Attributes[2]	National Standards (AMCHP/Packard)[3]	Comments
1. As needed, the Contract Holder (CH) establishes and maintains a triage system for home visiting that prioritizes the most vulnerable children with special health care needs for CaCoon services. Priority will be given to: • Families with a newly diagnosed infant/child with a chronic condition and/or disability. • Families who report difficulty accessing or coordinating their child's care and services.				This standard speaks to organizational (contract holder) capacity and prioritization of services rather than to state or national standards.

2. When the CH is <u>unable to provide home visiting services</u> for a child who has been referred, the CH will, at a minimum<u>:</u> • Refer the child/family to primary care, specifically a patient centered primary care home when available, as well as appropriate educational services. • Notify the referring entity that CCH is unable to provide services and provide rationale.	PCPCH Enrollment		Access to Care (#1,2,3) Community-based services and supports – Overall Systems Standard	Tracking the numbers of referrals that exceed capacity of the CH system may be of interest to CH in terms of discussions with payers.
3. The CH assures timely contact with CaCoon home visiting referrals. At a minimum, <u>initial outreach</u> is implemented within 10 business days of receiving referral into the CH referral system. Initial outreach may be by telephone or other means.	CAHPS Composite: access to care CAHPS Composite: satisfaction with care	Access to care (1.A.2, 1.A.3)	Access to Care (#1)	
4. All nurses serving CaCoon clients collaborate with the healthcare team to <u>assure that the following assessments are completed</u> for each child/family on the CaCoon caseload: • Assessment of child/family's strengths, needs, and goals.		Comprehensive whole-person care (3.D.1)	Medical Home – Care Coordination (All) Family Professional Partnerships (#2,4)	

• Assessment of child/family's health-related learning needs. • Assessment of child's functional status and limitations, including ability to attend school and school activities. • Early and continuous screening for special health care needs including physical, developmental, mental health, and oral health assessments as recommended by the American Academy of Pediatrics. • Assessment of access to health care team members as well as social supports. • Assessment of access to supportive medical and/or adaptive equipment	Developmental Screening Dental sealants Childhood immunization status Immunization for adolescents Child and adolescent access to primary care providers Well child visits	Person and family centered care (6.B.1, 6.B.2, 6.B.3) Comprehensive whole-person care (3.A.1, 3.A.2, 3.B.0, 3.D.1, 3.E.1) Access to care (1.A.2, 1.A.3)	Family Professional Partnerships (#6,7) Screening and Assessment (#3, 4, 5, 6) Screening and Assessment (#3, 4, 5, 6) Medical Home – Pediatric Preventive and Primary Care (#1, 2,3,4,5,7) Access to care (#1, 5) Medical Home – Overall (#2,3,4,5, 6, 7, 8) Community-based	The American Academy of Pediatrics' Bright Futures Guidelines[4] are called out specifically both in the PCPCH Recognition Criteria (Standard 3.A – Preventive Services) and the National Standards (Screening and Assessment)

and supplies, e.g. suction machine, wheelchair, medications, formula, feeding tube. • Assessment of family financial burden related to care of child with special health needs. • Assessment of housing and environmental safety. • Assessment of emergency preparedness. • Assessment of preparedness for youth transition to adult health care, work, and independence, if appropriate to age. • Assessment of child/family satisfaction with services they receive.	CAHPS Composite: access to care CAHPS Composite: access to care Emergency Department Utilization Emergency Department Utilization Adolescent well-care visits CAHPS Composite: satisfaction with care	Comprehensive whole-person care (3.A.1, 3.A.2) Person and family centered care (6.B.1, 6.B.2, 6.B.3, 6.C.1, 6.C.2, 6.C.3)	services and supports (All) Family Professional Partnerships (#1,2,3,4,5,6,7) Transition to Adulthood – Pediatric Setting (#3) Adult Setting (#5) Family Professional Partnerships (#8))	
5. In partnership with the child/family and the broader health care team, nurses serving				

CaCoon clients develop the <u>nursing care plan</u> which: • Is based in, and responsive to accurate and appropriate assessments (see above). • Includes goals, progress notes, and a plan for discharge from CaCoon services.				Appropriate documentation is a State Board of Nursing requirement.[5] Appropriate documentation is a State Board of Nursing requirement.[5]
• Demonstrates evidence of nursing support to increase patient/family engagement with primary care; specifically a patient centered primary care home when available.	PCPCH Enrollment	Coordination and Integration (5.A.1b, 5.C.1, 5.C.2, 5.C.3, 5.E.3)	Medical Home – Care Coordination (All)	
• Demonstrates evidence of effective coordination with the primary care physician and specialty providers as well as the broader health care team. Coordination includes: ○ Timely and appropriate referral to needed services. ○ Identification and problem-solving around barriers to referral follow-up. ○ Identification and elimination of redundancy of services. ○ Promotion of a shared and actionable plan of care that speaks to the continuum of child/family experience with	CAHPS Composite: satisfaction with care Ambulatory Care: Outpatient and emergency department utilization Child and adolescent access to primary care	Person and family centered care (6.B.1, 6.B.2, 6.B.3, 6.C.1, 6.C.2, 6.C.3)	Medical Home – Care Coordination (All) Children are screened early and continuously for special health care needs – Referral/Follow-up (#1,2)	

healthcare and related systems. ○ Timely, informative, and concise updates that are shared with appropriate members of the health care team, including the primary care provider and the family.	providers			
• Demonstrates evidence of patient/family centeredness, including: ○ Strategies to increase the child/family's capacity to obtain, process, and understand health information to make informed decisions about health care ○ Evidence of child/family partnership in developing the plan of care ○ Evidence of interventions that increase the patient/family's capacity to implement the plan of care, e.g. caregiver support, teaching, and provision of anticipatory guidance. ○ Cultural and linguistic responsiveness	CAHPS Composite: satisfaction with care Ambulatory care: Outpatient and emergency department utilization	Person and family centered care (6.B.1, 6.B.2, 6.B.3)	Family Professional Partnerships (#1,2,3,4,5,6,7)	
• Provides for nurse visits that are sufficient in frequency and length to	CAHPS			

achieve the goals outlined in the care plan. • Anticipates and supports youth transition to adult health care, work, and independence. • Is re-evaluated as required with changing circumstances, but no less frequently than every six months.	Composite: satisfaction with care Child and adolescent access to primary care providers		Transition to Adulthood – Pediatric Setting (#3) Adult Setting (#5) Medical Home – Care Coordination (#3)	
6. The CH works with partners, at both the state and local level, to <u>collect data</u> and inform system-level quality improvement efforts and achieve optimal health outcomes for CYSHCN.		Access to care (2.D.1, 2.D.2, 2.D.3)	Quality Assurance and Improvement (all)	Quality improvement is integral to achieving the Triple Aim, i.e. improving the individual experience of care, improving population health management and decreasing the cost of care. CCOs, PCPCHs, and the AMCHP Standards all identify the Triple Aim as being foundational to their work.
7. Each CaCoon nurse and supervisor actively participates in <u>educational opportunities</u> that support continuous improvement of his/her CaCoon practice. At a minimum: a. When beginning his/her CaCoon practice, each CaCoon nurse completes the "Introduction to CaCoon" posted on the OCCYSHN website. b. The majority of nurses working with				Workforce development activities support nurse home visiting skills that are intended to produce desired program outcomes. This workforce development standard is specific to the contract between OCCYHN and the CH.

the CaCoon program in a given county participate in the annual CaCoon Regional Meetings.				
8. The CH designates an individual who has the authority to assure accountability to contract standards. This individual will submit a short (2-4 pages) annual report describing how the CH is meeting each of the standards. The report is due to OCCYSHN by July 1, 2016.				This operational / accountability standard is specific to the contract between OCCYHN and the CH.

[1]Coordinated Care Organizations – Oregon Health Authority Measure Sets, November 2014
http://www.oregon.gov/oha/analytics/CCOData/2015%20Measures.pdf

[2]Patient Centered Primary Care Home Program – Oregon Health Authority, 2014 Recognition Criteria
http://www.oregon.gov/oha/pcpch/Documents/2014%20PCPCH%20Criteria%20Quick%20Reference.pdf

[3]Standards for Systems of Care for Children and Youth with Special Health Care Needs – A product of the National Consensus Framework for CYSHNCN Project (AMCHP, Lucile Packard) March 2014
http://lpfch-cshcn.org/publications/research-reports/developing-structure-and-process-standards-for-systems-of-care-serving-children-and-youth-with-special-health-care-needs/

[4]American Academy of Pediatrics "Bright Futures" - Recommendations for Preventive Pediatric Health Care - Periodicity Schedule.
https://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx

[5]Oregon State Board of Nursing – Division 45
http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_045.html