Phoenix Children's®
Care Network

Phoenix Children's Care Network:
Integrated Care Coordination (ICC) Services & Referrals

Care coordination is the set of activities in the space between visits, care, and hospital stays.

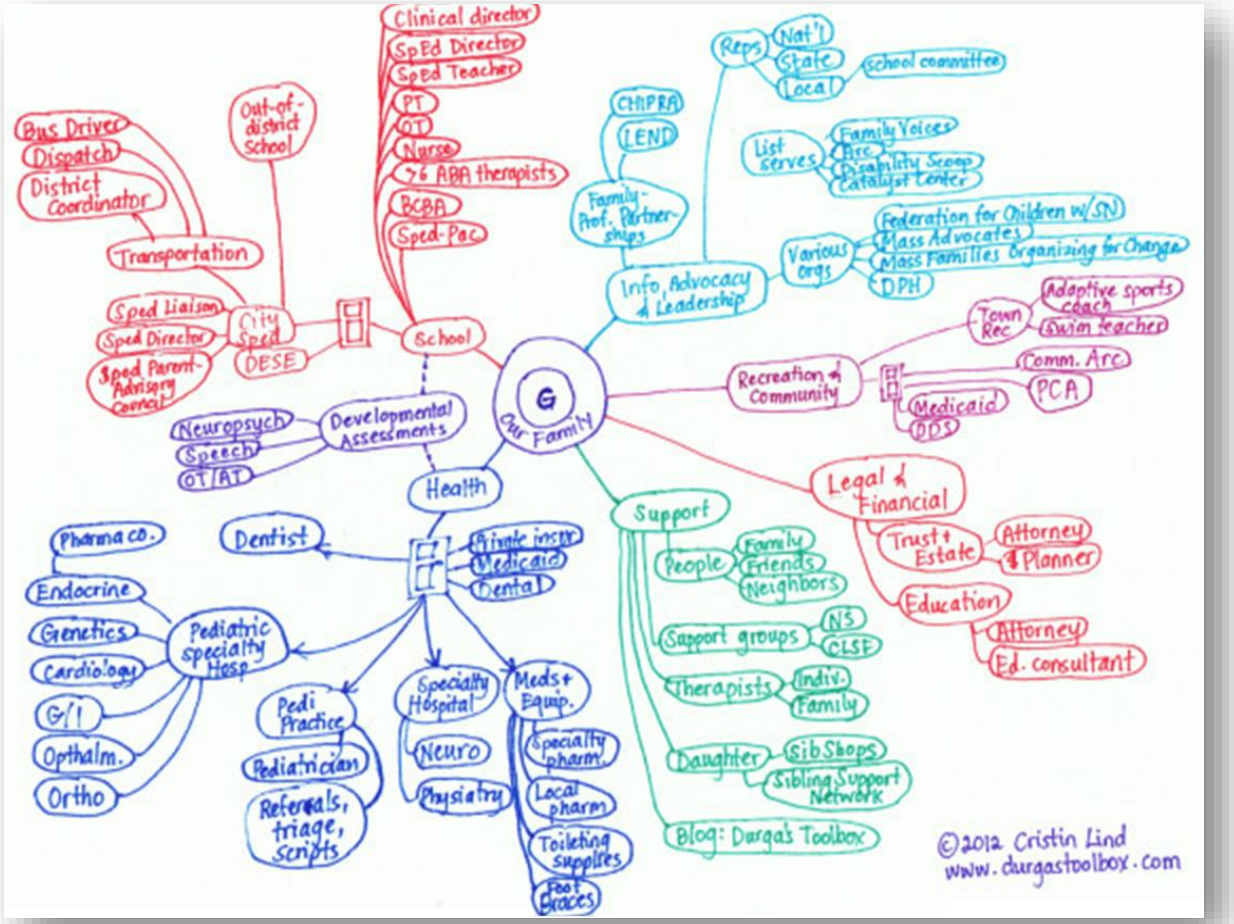
Today's Topics:

- What PCCN's Integrated Care Coordination (ICC) Program is
- Who is eligible for PCCN ICC
- What services PCCN's ICC Program offers your patients
- The difference between Phoenix Children's and PCCN
- PCCN's ICC Closed-Loop Communication Process
- Real-life examples of how PCCN's ICC program has helped patients

Our Clinical Program – Gabe's Story

- We are <u>not</u> a health plan
  - Member = Patient(s) / Child / Children / Family
  - PCCN Care Coordination is designed to support patient, families, providers, and care teams

- Focus on Biopsychosocial Model of Health
  - Medical/Physical
  - Social/Community
  - Behavioral/Mental



What is PCCN's Integrated Care Coordination Program?

- ICC services are for patients aligned with PCCN contracted insurances and PCCN aligned pediatricians
- PCCN's ICC Program provides services to patients with the following health plans:

AHCCCS Health Choice Arizona

AHCCCS Mercy Care Plan

UHC Special Needs Initiative

AHCCCS UHCCP

Cigna: Open Access Plus and Local Plus

Intel Connected Care

Employer's Health Network

- Care Coordination is provided for the following needs:

Medical

Behavioral

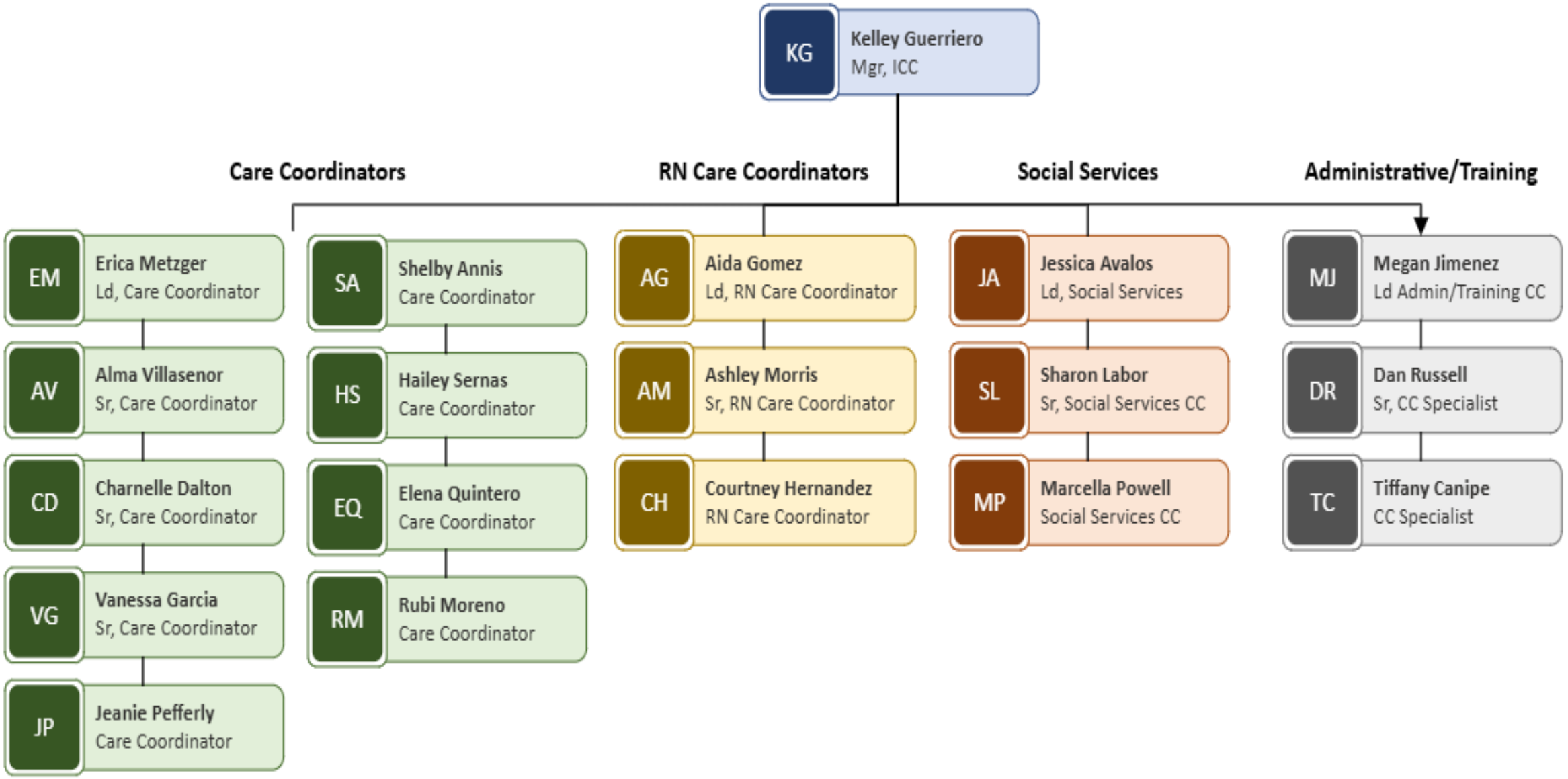
Developmental

Educational

Social

Search for contracted PCCN Provider's here: https://phoenixchildrens.org/pccn/find-a-pccn-doctor

ICC Team Structure



Program Designed to Support PCCN Practices

- We are a program made available to you through our Clinically Integrated Network and our Value Based Partnerships
- We are an independent business entity and program, affiliated with but separate from the operations of Phoenix Children's Hospital
  - We DO NOT solicit business for PCH
- PCCN ICC staff are remote and do not operate on a PCH campus

- We work with patients that MAY be seen at PCH clinics or hospitals as well as with patients of NON-PCH community pediatricians and specialists
- We DO schedule and coordinate services with Banner, Non-PCH Specialists, etc.
- Assist families in Rural areas (if eligible)

What services does PCCN ICC provide to your patients?

Complex Care Needs

- Facilitate referrals and orders
- Get specialty appts scheduled
- Partner with facilitating DME

Discharge Follow-up

- Inpatient Hospitalization Follow-Up
- ED Follow-up (Avoidable)
- ED/IP Frequent Fliers

Government Programs – Guidance/Advocacy

- DDD/ALTCS/SSI/AzEIP referrals
- WIC/AHCCCS/SNAP

Behavioral Health

- Finding services (Including, IOP, PHP, SA)
- Advocating at Child and Family Teams (CFT) meetings
- Facilitate comprehensive evaluations
- Post ED/IP Follow-up

Education/School

- IEP/504 Plan
- Chronic Illness Forms, Seizure Action Plan, Asthma Action Plan
- Medications, medical needs
- Advocacy
- Developmental Preschool

Community

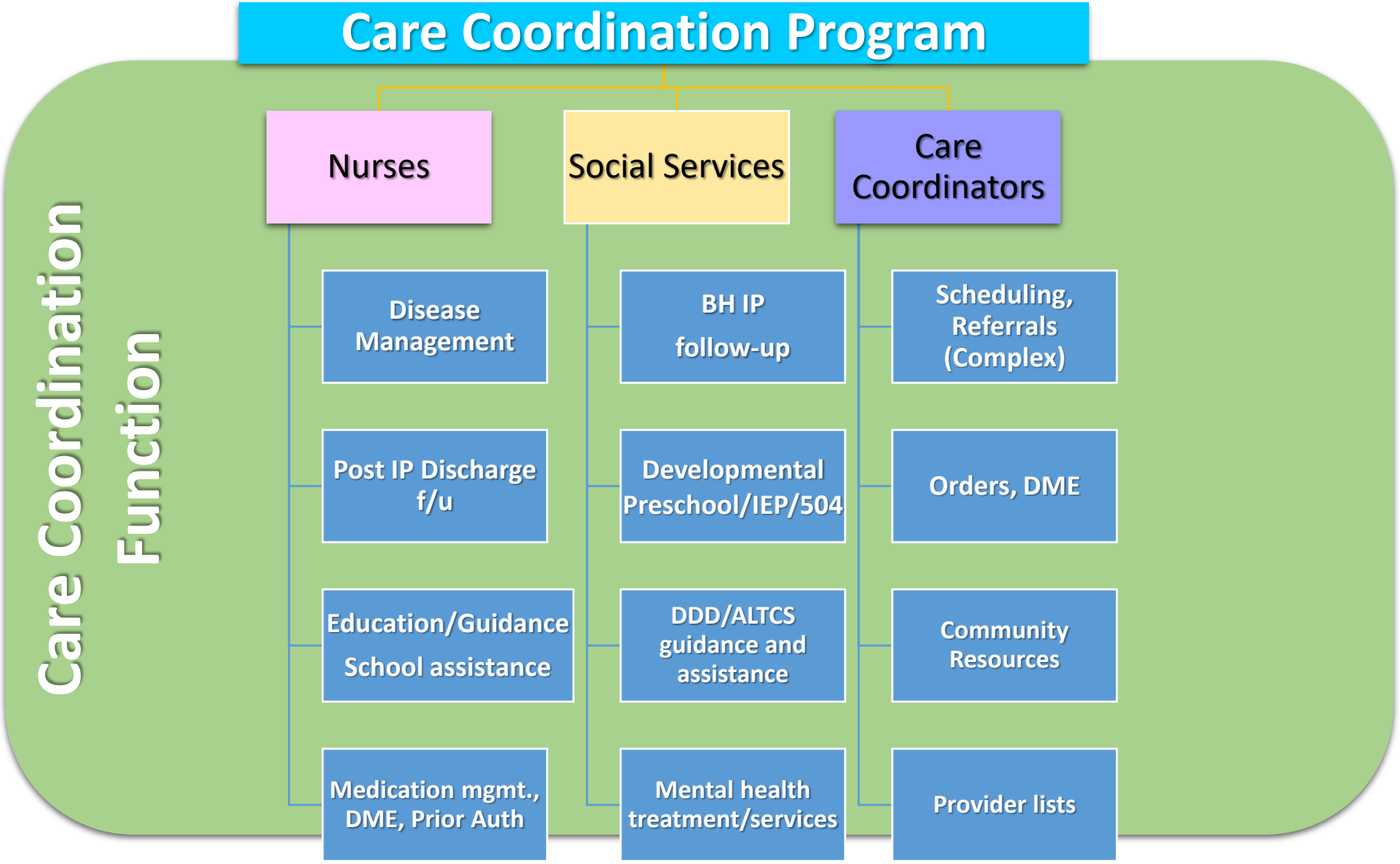
- SDOH needs
- Community resources
- Transportation
- Transition to Adulthood

Other

- Assist with Scheduling (Medical/Dental/BH, etc.)
- Locate contracted providers
- Medication adherence/Pharmacy navigation
- Partner with facilitating prior auths
- Provide patient education
- Reinforce education for conditions/management

These are examples of the services we provide, not an exhaustive list. If you have a need that is not listed, please discuss with your practices assigned Care Coordinator.

How can PCCN ICC team assist with for your Patients and Families?



Why refer to PCCN ICC?

- Well-Child Check/Specialty/Complex scheduling
  - Reminders for pts with a history of non-compliance or disorganized guardians
- New patients – directing pts to your office that want/need a new provider
- Frequent ED/IP visits – we can research, educate, direct to lower levels of care, including back to your office and/or after-hours service!
- Provide outcomes to designated office staff for every patient
- Providers can re-refer at any time *(if eligibile)* even if we didn't reach them the first time
- Orders – assist with referrals, DME needs, prior authorization
  - Communicating with DME agencies, facilitating the orders and supporting documentation, confirming delivery.
- We can provide ongoing follow-up!
  - Confirm receipt and outcome of resources sent
  - Post appt f/u
  - Post new diagnosis/new medication education or assistance
    - Ex. Diagnosed with Autism – need IEP
    - Ex. ADHD – need 504 plan
    - Ex. Need Asthma Action/Seizure plan at school
      - Coordinating forms between school, provider office, parent

We're your contracted partners!

Closed-Loop Referral Process

Note:

- Each PCP Provider Office has an assigned PCCN Care Coordinator, if you need their information, please reach out to our Lead Care Coordinator Erica Metzger at ecook2@phoenixchildrens.com.

- Your Practice Integration Representative can also help you identify your assigned care coordinator.

Unlocking the Impact of PCCN ICC on Your Daily Practice

When you recognize PCCN ICC staff calling, we can support you and your patients and families with:

- Orders: labs, DME, therapies
  - Facilitating updates/sending orders to complete a service for your patients
  - Obtaining/sending supporting documentation from specialists (P.A.)
  - We can go “back and forth” with the community agencies, advocating for process completion
  - Confirming providers receive and are processing orders/referrals that were sent by your practice
- Scheduling a WCC appt/follow-up/sick appt on behalf of patient, it is in support of the provider and office success
  - Increased compliance with AHCCCS measures and programs
- Office staff builds a relationship with assigned PCCN Care Coordinator
  - Symbiotic – both sides can support each other
  - Office staff can call on CC assigned to assist with family's needs
- Due to participation agreements currently in place between provider offices, care coordination is covered under HIPAA to provide these services and to share patient information for coordination of care.
- We are an extension of your office as contracted partners, to assist in supporting your patients and families through care coordination

Communication, Communication, Communication!

Disconnected Care: The Risk of Not Engaging PCCN ICC

When office staff aren't familiar with PCCN ICC staff, this can lead to:

- Delay in providing needed information so PCCN ICC staff can provide care coordination services
- Families are hesitant to work with us if they don’t know we are reaching out
  - Please inform families that you are referring to us
- Difficulty with scheduling WCC and other appointments
  - Part of our role is to schedule appts for families
  - Schedule post hospital and additional appts like WCC in one call *(different days)*
- Delayed steps in the process of coordination timelines, approval, delivery
  - DME
  - Therapy
  - Specialty medications
- Barrier to PCCN ICC coordinating care
- As noted in our partnership contracts
  - We are your partners and support both your office and the families to meet their needs

How To Refer to PCCN ICC:

Complete a referral form *(PDF or electronic)*

(https://www.phoenixchildrens.org/phoenix-childrens-care-network/integrated-care-coordination)

- Please Include:
  - Specific reason for referral
  - Health plan name and ID
  - Pt contact information
  - Send Face sheet if possible
  - Please inform patient/family that we will be reaching out to them
  - If your office has implemented an SDOH survey, this can serve as the referral form

Submit the completed PDF form to:

PCCNCareManagement@PhoenixChildrens.com OR Fax to 602-933-4331

Patient Example #1: Teamwork = Positive Outcomes

Excerpts from Parent email:

**DX: Autism, OCD, feeding tube dependent*

**Case duration 2 months and counting*

The first time PCCN reached out to family of this 9-year-old patient, parent disengaged. When we reached them one month later, parent reported that family is living on limited income d/t one parent receiving unemployment. Parent has epilepsy/receives infusions every 2 weeks, and the medical bills are piling up, causing great stress, currently more than $6k/mo. Moreover, the child is having increased behaviors/med changes. "It's hard to put into words just how difficult things have been for us, recently"

Identified Needs:

- In-Network ABA Providers – Provided
  - *(search/capacity/referral/appt)*
- Coordinate lab work support/escort for child- Provided
  - *(Child Life PCH, d/t child being very fearful of hospital)*
- Special Needs Swimming Classes - Provided
- Parent Support Programs – Provided
- Help resolve Parents Medical bills – *(Payer)* Provided

Partnering with Payers

- PCCN SW reached out to the payor contact regarding parent medical claim denials and hefty bills
- Initially there were no findings, but the payor kept digging! She found billing errors resulting in inappropriate charges and was able to resubmit the claims for 1 issue and get corrected
- Payor was able to locate a 2nd issue regarding incorrect billing to secondary insurer, able to resubmit claim and get corrected.

All Needs met!

Patient Example #2: Follow-up post BH ED Discharge

*DX: Major depressive disorder, Anxiety Disorder NOS

*Second case with PCCN – previously provided food resources, utility assistance, and list of contracted psychiatrists for patient.

17-year-old patient seen in the ED for frustration with self-harm, anger outbursts. Teen refuses to see another counselor as has a long history of different counselors and agencies that he reports not getting along with. Patient blames mom for breakup with his girlfriend. Patient has been on psychiatric meds previously but reports he doesn't take them as they make him feel "empty." Parent reports having a lot of medication in the home and is nervous due to patient's previous suicide attempts.

Parent shared that they need resources for food, near the home.

Parent shared that she did not have insurance or a PCP for herself, and she was having health concerns.

Identified Needs:

- PCP ED follow-up < 7 days – scheduled/attended Provided
- Psychiatry follow-up– in 24 hrs- scheduled/attended
  - Provided (agreed to try new med regime)
- Medication Lock box– 2 boxes shipped to parent's home - Provided
- List of low-cost, adult medical providers near home, LAR scheduled and was seen for her needs- Provided
- Food Resources–Provided

Outcome: All Needs Met!

"Extremely grateful"

"I love PCCN and tell everyone about them!"

Patient Example #3: Asthmatic Non-compliance Positive Outcome

Background:

Pt was a 6-year-old female. Diagnosed with Severe persistent Asthma with Acute Exacerbation. Family is Spanish speaking. Referral due to multiple ED visits, hospital admissions due to asthma exacerbation, multiple missed Pulmonology Clinic visits and noncompliance with medications *(medications not picked up from pharmacy)*.

Barriers:

- •Language - limited in English and did not ask for an interpreter.
- •Lack of knowledge – Mom did not understand diagnosis, instructions or treatment plan, Medications or how clinic operated between visits.
- •Scheduling limitations – Appointment limitations *(work and school schedules)*, not able to recall appointments.
- •Medications/Refills - reported she was not aware there were prescriptions pending
- •ED visits due to needing medications, would hold off going to ED and pt would need to be admitted.

Identified needs:

- Education – Asthma teaching, Medication teaching *(Control vs Rescue)*, Asthma Action Plan, Clinic contact information.
- Scheduling - Options *(call/online/PCCN)*, Clinic locations, Reminders, School/Work Notes.

Outcome: Pt/family followed for several months by PCCN ICC RN

- Pt back on track/re-established with pulmonology clinic attended pulmonology and multidiscipline clinic
- Medications picked up
- Family understood diagnosis, medications and importance of compliance with medications and follow up appointments
- Remained out of ED and no hospitalizations during the time followed by PCCN.

What we discussed today:

- What is PCCN's Integrated Care Coordination (ICC) Program?
  - Care Coordination Team (Care Coordinators, Social Work, and Nurses) here to support YOU and your patients.
- Who is eligible for PCCN ICC?
  - Any patient who is aligned to a PCCN partnered health plan and assigned to a PCCN PCP.
- What services does PCCN's ICC Program offers your patients?
  - Complex Care Needs, Discharge Follow-Up, Education/School, Community, Behavioral Health and more!
- What's the difference between Phoenix Children's and PCCN?
  - PCCN ICC is community based and here to serve patients in the outpatient setting
- How does PCCN's ICC facilitate a Closed-Loop Communication Process?
  - We communicate patient outcomes to you on cases that you refer to us!
- Real-life examples of how PCCN's ICC program has helped PCCN patients
  - PCCN has the capability and resources to support patients/families with diverse sets of Medical, Behavioral, Developmental, Educational and Social needs.

Phoenix Children's®
Care Network

Questions?

Thank you!