The Meadowlark Initiative

HEALTHY PREGNANCIES & SECURE FAMILIES

Care Coordinator Position

TRAINING MANUAL

The Meadowlark Initiative Overview

The Meadowlark Initiative brings together clinical and community teams to provide the right care at the right time for patients and their families, improve maternal and family outcomes, reduce newborn drug exposure, neonatal abstinence syndrome, and perinatal complications, and keep families together and children out of foster care.

1 Mothers and their families receive care through prenatal care and behavioral health providers and are connected with a care coordinator. These three make up the core of the patient's **Clinical Team**.

The prenatal care provider screens all incoming prenatal patients for SUDs and mental illness. Patients who screen positive receive a same visit "warm hand-off" to the behavioral health provider.

The behavioral health provider assesses the patient and provides a brief counseling intervention, outpatient therapy, or an appropriate referral to higher-level care.

2 The care coordinator works with patients to identify social factors that may impede their treatment and continually facilitates the right care at the right time. This is done by utilizing a variety of resources to augment the **Clinical Team** and to establish a **Community Team** of social service providers, peer recovery coaches, and related caregivers. This group provides critically needed support for pregnant and postpartum women and their families.

3 The **Clinical Team** and **Community Team** work collaboratively to form a support system for the patient and their family.

The Care Coordinator's Role

The care coordinator is a critical member of the clinical team. They play two key roles:

1. Organizing "patient care activities between two or more participants involved in a patient's care to facilitate the appropriate development of health care services."[1] This means that the care coordinator helps providers monitor patients' plan of care progress and track key outcomes.
2. Coordinating outside services to address complex social situations that often impede treatment, such as unsafe or insecure housing, lack of transportation and childcare, and family violence.

[1] McDonald KM, Sundaram V, Bravata DM, et al. "Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination." Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

The Care Coordinator's Role *(continued)*

The care coordinator functions as the apex of the care team. They are the point of contact for the patient and family, ensure the patient remains connected to care, track progress on the plan of care and relevant clinical metrics, and provide the bridge between the practice and the community. The care coordinator's responsibilities include:

- Identifying the patient's social needs, such as safe housing, reliable transportation, healthy food, and childcare. (These factors are the social determinants of health.)
- Cultivating the community resources necessary for meeting the patient's social needs and actively engaging the patient and their family in connecting with those resources. This involves identifying potential barriers the patient may confront when trying to engage with available resources. Keep in mind, the patient's barriers may be internal, such as fear or uncertainty, or external, such as lack of transportation or childcare.
- Developing a system to track and follow up on key health problems and relevant clinical metrics, and track progress on addressing the social determinants of health. The care coordinator must keep the clinical team updated on challenges that persist and clinical benchmarks that are not being met. This tracking system can be developed inside or outside the electronic medical record (EMR), depending on organizational resources.
- Providing the clinical team with feedback on other factors influencing the patient and family's engagement with care, such as a history of trauma, cultural factors, or domestic violence.
- Working in partnership with the behavioral health provider to eliminate barriers the patient and their family may confront when trying to engage with care.

Three Steps to Care Coordination

Step 1

Screening for the Social Determinants of Health

Care coordination starts with a formal assessment of the patient's social needs, or the social determinants of health.

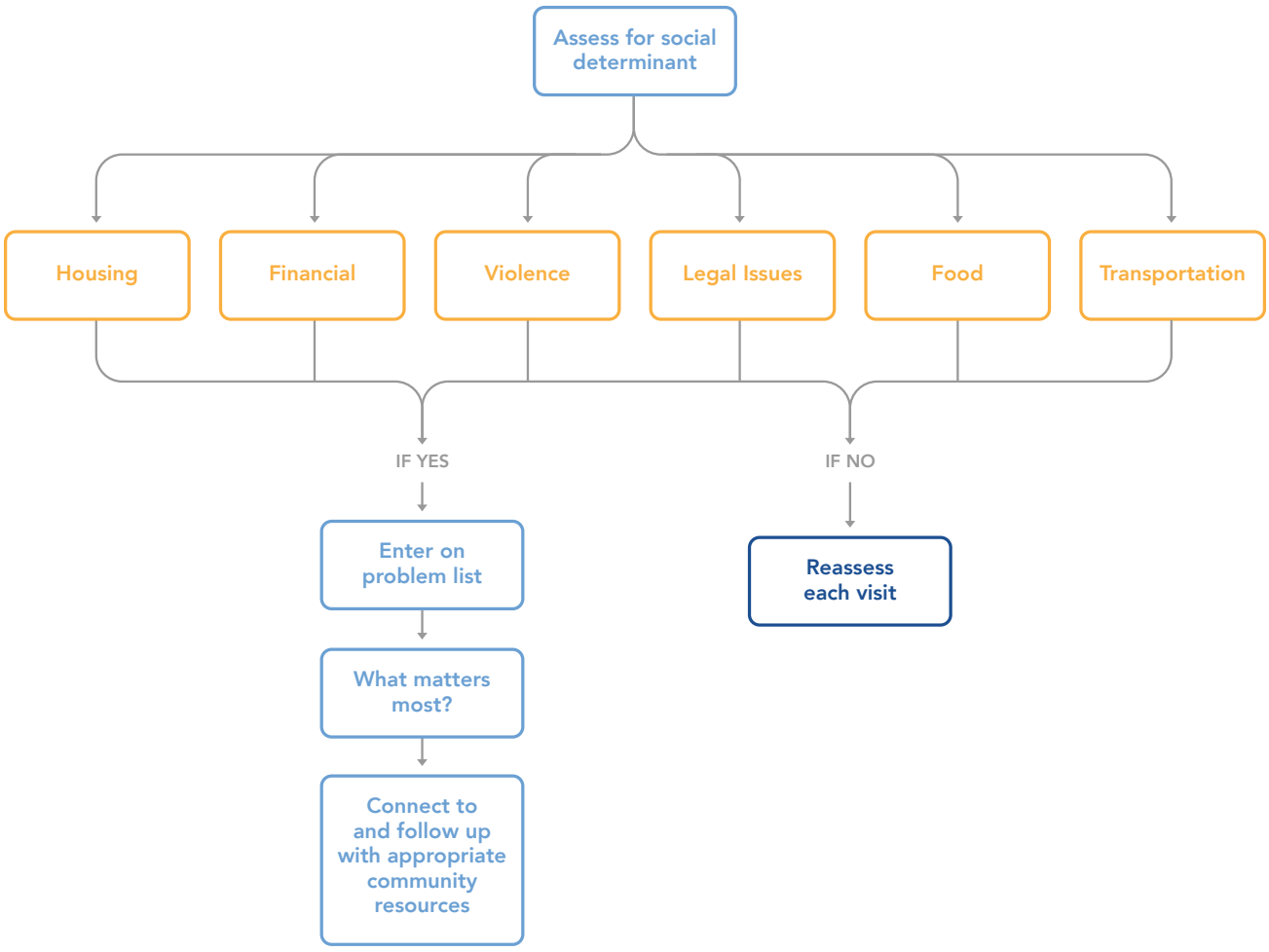
> "The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries."
>
> — World Health Organization[2]

[2] World Health Organization, About Social Determinants of Health www.who.int/social_determinants/sdh_definition/en

Screening for the Social Determinants of Health *(continued)*

Historically, questions related to the social determinants of health were part of the history collected during the patient's admission to care. The questions were often vague and recorded in the social history section of the EMR. However, there is now an increased focus on the social determinants of health as they have been proven to account for up to 40% of clinical outcomes. The social determinants of health can now be coded and tracked over time to demonstrate improvement, which means that using a standardized approach to screening becomes increasingly important. The assessment process should include a set of standard questions, preferably ones that have been validated by research (like the PHQ9 or GAD7). (See Appendix A for a list of standardized tools.) Each practice will choose the questions and tools that work best for them. This screening should be done for all women coming into care and repeated at regular intervals (potentially every visit) throughout the pregnancy and postpartum period.

The care coordinator plays a critical role in responding to the needs identified in the screening and working with the team to intervene and resolve them. They also work with the behavioral health provider to identify how the patient's needs may interfere with her ability to engage with care and develop strategies to overcome these barriers.



Step 2

Addressing Social Needs

The care coordinator is primarily responsible for managing the connections to community resources, helping remove barriers to care, and re-engaging women who miss appointments. They should identify organizations, agencies, and programs in the community that offer resources that may be helpful to patients, such as transportation to and from appointments, nutritional programs such as WIC and SNAP, housing assistance, legal aid, public health home visiting, domestic violence assistance, and so on. Over time, the care coordinator should connect with and help coordinate these organizations and programs, which form the community team.

Once the patient's needs have been identified through the screening process, it is critical to prioritize the needs that are most important to the patient and her family. What appears most pressing to the care team may not be most pressing to the patient. Providing patient-centered care requires balancing the woman's needs with her safety and her baby's safety.

Having identified the most important social needs, the care coordinator works with the woman and relevant organizations in the community team to connect her with needed resources.

The roles of the care coordinator and behavioral health provider overlap somewhat, since the behavioral health provider works on the internal factors that interfere with health and care. For example, if a patient does not have stable housing, the care coordinator will explore community resources, actively connect her with the available resources, and ensure that she is able to get to needed appointments. The behavioral health provider, on the other hand, may work with the patient on planning skills, managing her anxiety and fear about reaching out for help, and other feelings that may stand in the way of her achieving stable housing. The care coordinator will track the patient wherever she goes in the system to make sure she doesn't drop out of care or get lost in the process.

Step 3

Monitoring and Managing Plan of Care Progress

The care coordinator uses the EMR or a separate registry to track progress on the individual plan of care. The prenatal care provider, behavioral health provider, and care coordinator each contribute to an integrated individual care plan that reflects the patient's physical and behavioral health, social needs, and the desired outcomes. The prenatal care provider may need to track attendance at routine prenatal visits, prenatal lab results, and any referrals to specialists. The behavioral health provider may need to track improvement on depression scores, results of any changes in medication for depression, or improvement in substance use disorder outcomes. The care coordinator may need to track the success of referrals for housing, food programs, and transportation assistance. Using a registry or EMR, the care coordinator is responsible for tracking these metrics, ensuring appropriate progress toward desired outcomes, and alerting and coordinating responses by the clinical team when concerns arise.

Care Coordination Staffing

For medically intensive services where patients have more than one chronic condition, care coordination is often provided by a registered nurse care manager. This level of care coordination is required when a group of providers are treating multiple complex conditions.

In prenatal and postpartum services where the level of medical complexity may be lower (except in practices that focus on high-risk and medically complex prenatal patients), the focus of care coordination is on the whole of the woman's life and factors that may impact her and the baby's health. This focus opens the care coordination role to different kinds of staff, who may bring the necessary combination of skills and aptitude to the role, such as:

- Community health workers
- Peer support staff and medical assistants with additional training in care coordination
- Childbirth educators
- Social work or psychology staff with a bachelor's degree

Care Coordination Staffing *(continued)*

Some key skills to consider for this role include:

- Knowledge (or ability to gain knowledge) of community resources
- Strong engagement and relationship skills that will be used not only with the patient and her family but also with the internal team and community resources
- Planning and coordination skills
- Communication skills
- Knowledge of pregnancy and postpartum care, as well as potential behavioral health challenges that may emerge during care
- Assertiveness, persistence, and compassion

Appendix A

Additional Resources

Recommended Tools for Assessing Social Determinants

- The Accountable Health Communities Health-Related Social Needs Screening Tool, Center for Medicare and Medicaid Innovation go to link on innovation.cms.gov

- The Potential of PRAPARE: Annual Health Care Symposium Linking Communities to Quality Health Care, Blue Shield of California Foundation go to link on ccalac.org

General Information About Social Determinants and Their Impacts

- Social Determinants of Health: Know What Affects Health, Centers for Disease Control and Prevention go to link on cdc.gov

- Three Tools for Screening for Social Determinants of Health, American Academy of Family Practice go to link on aafp.org

- Social Determinants of Health Play a Key Role in Outcomes, American College of Obstetrics and Gynecology go to link on acog.org

- Social Needs Tools & Resources, Oregon Primary Care Association go to link on orpca.org

Care Coordinator Sample Job Descriptions

- Care Coordinator Sample Job Description, Stratis Health go to link on stratishealth.org

- Care Coordinator Job Description, Betterteam go to link on betterteam.com

- Patient Care Coordinator, American Academy of Pediatrics (Note: While this is for a pediatric practice, it lays out the functions of care coordination in maintaining a registry, contact with patients, and a team role.) go to link on aap.org

Appendix B

Codes for Social Determinants on the Problem List

Social Determinant of Health ICD 10 Z Code	Proposed Use
EDUCATION ISSUES	
Z55.0 Illiteracy and low-level literacy	Use for individuals with less than a high school education/GED, regardless of the country where the education was achieved.
Z55.9 Problems related to education and literacy, unspecified	Use for individuals who have issues understanding health information when presented in their language of preference.
EMPLOYMENT ISSUES	
Z56.0 Unemployment, unspecified	Use for individuals who are currently unemployed and seeking employment.
Z56.9 Unspecified problems related to employment	Use for individuals who are currently employed and have problems there and/or the problems are triggering seeking job change.
ECONOMIC HARDSHIP – HOUSING ISSUES	
Z59.0 Homelessness	Use for individuals who are chronically homeless, reside in a shelter, reside in the street/subway, or will be discharged to a shelter.
Z59.8 Other problems related to housing and economic circumstances	Use when the individual is unstably housed (doubled-up, couch surfing, staying with friends) and/or at risk of eviction.

Social Determinant of Health ICD 10 Z Code	Proposed Use
ECONOMIC HARDSHIP – HOUSING ISSUES *(CONTINUED)*	
Z59.1 Inadequate housing	Use for individuals whose housing quality is undermining their health (e.g., bugs, pests, mold, dampness, inadequate heat, lead).
+Z77.120 Contact with and (suspected) exposure to mold (toxic)	Add if mold, dampness, water leaks are suspected.
+Z77.011 Contact with and (suspected) exposure to lead	Add if peeling paint is expected.
+Z77.22 Contact with and (suspected) exposure to environmental tobacco smoke (acute, chronic)	Add if secondhand smoke is suspected.
ECONOMIC HARDSHIP – FOOD INSECURITY	
Z59.4 Lack of adequate food and safe drinking water	Use for individuals who have food insecurity.
ECONOMIC HARDSHIP – OTHER BASIC NEEDS	
Z59.7 Insufficient social insurance and welfare support	Use for individuals who are worried about or have trouble meeting basic needs due to cost. These individuals may need to be enrolled in additional public benefits, are on public benefits and they are insufficient, or are ineligible for public benefits.
Z75.3 Unavailability and inaccessibility of health care facilities	Use for individuals who have challenges in accessing health care due to transportation.
Z91.120 Patient's intentional underdoing of medication regimen due to financial hardship	Use for individuals skipping medication due to cost.

Social Determinant of Health ICD 10 Z Code	Proposed Use
ISSUES WITH INDEPENDENT LIVING	
Z60.2 Problems related to living alone	Use when the individual lives alone and needs assistance with activities of daily living.
CAREGIVING NEEDS	
Z63.6 Dependent relative needing care at home	Use for clients who need support for caregiving of dependents.
ISSUES WITH PRIMARY SUPPORT GROUP	
Z63.7 Other stressful life events affecting family and household	Use for stressful family events other than caregiving, including conflict getting along with primary support group.
Z63.8 Other specified problems related to primary support group	Use when individual is lacking a primary support group and/or feels socially isolated.
LEGAL ISSUES	
Z65.2 Problems related to release from prison	Use for individuals who are justice involved.
Z65.3 Problems related to other legal circumstances	Use for individuals who need legal help.
VIOLENCE/SAFETY	
Z91.41 Personal history of adult abuse	Use for clients who have experienced abuse as adults.
+Z63.0 Problems in relationship with spouse or partner	Add if the history of adult abuse is with a spouse or partner.

Prepared for the Meadowlark Initiative by the National Council for Behavioral Health.