Case Discussion: How a child with ADHD can open the door to practice improvement
(60 minutes – divide into small groups, each group should be led by a facilitator)

Resources: *(Distribute these in-session handouts)*
- Vanderbilt Assessment Scales, Evaluation Forms, and Scoring Instructions
- What Every Pediatrician Needs to Know about ADHD and School
- Getting Ready for Your Child’s IEP Meeting Brochure

Notes:
- Begin the small group session with individual introductions (name, practice type, experience with care coordination). Share the care coordinator feedback from the “Note to Facilitators” section above, as well.
- The case consists of 3 parts; each part should be discussed individually before proceeding to the next part. Participants will receive a copy of each part. Consider asking for volunteers to read each part. Questions will not be included in participants’ handouts and should be read by facilitator.

PART 1: INITIAL OFFICE VISIT

Isaac Smith is a generally healthy 8-year-old boy who comes to your office with his parents for his yearly routine visit. The medical assistant rooming the family has difficulty taking his vitals due to his restlessness and difficulty following directions. His parents inform the pediatrician that they have received calls from Isaac’s teacher, who says he is constantly getting out of his seat, disrupting class, and having trouble focusing on assigned tasks. He is doing “okay” in some subjects but is far behind his peers in reading. His parents have noticed similar behavior at home and say Isaac takes a very long time to finish his homework in comparison to his older brother. His father voices concern that Isaac’s classmates may be making fun of him. The pediatrician, who has known the family for several years, asks Isaac for his input, but he becomes teary-eyed and looks away. The pediatrician is concerned about ADHD as well as a potential learning disability.

After the visit you (the practice care coordinator) overhear the pediatrician talking with a nurse. She conveys her frustration about the limited time she has to deal with this important issue. She believes Isaac should be tested for a possible learning disorder but knows that there is a long waiting list for formal testing by a subspecialist. She is concerned that a delay in diagnosis could put Isaac further behind in his academic progress.

**Key questions for discussion:** Please orient the discussion to areas of particular interest for your group.

1. **Initiating Care Coordination:**
   - Ideally, how would you as the care coordinator hear about such a case? How might you introduce the idea of care coordination to this family?
     - Discuss how care coordination is part of the medical home and how practices introduce these concepts to patients and their families (business cards, brochures, face-to-face communication, provider referral, etc).
     - Share ideas as to what the next step should be once patients are connected to care coordinators.

2. **Identifying Resources:**
   - Have you faced challenging situations such as Isaac’s case in your practice?
     - Ask what information would be needed from the parents, patient, teacher(s), or school at this point to move forward most effectively.
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- The topic of behavioral/mental health can often be frustrating due to limited resources. Share what resources are currently available to deal with such issues. These can include clinic resources as well as external, community resources.
- What is the best way to track these families (phone, email, electronic medical record, patient visits, etc)? How are patients identified in the medical record as having established care coordination?

3. Care Coordination as Practice Improvement:
   How can care coordinators maximize both provider and family satisfaction?
   - Discuss how care coordinators may feel empowered by being in a position to improve the quality of the patient-provider relationship.
   - Examples may include providing pre-visit contact forms to enhance efficiency and quality of “face time” with providers; sending forms/questions to parents via email to be completed at their convenience; including the patient in the initial needs assessment and ongoing conversations.
   - Consider the potential MA/RN role: ensuring that parents complete developmental screening/assessment forms, mentioning observations to provider (such as in Isaac’s case), having pre-visit form available for provider to review prior to entering patient’s room to improve efficiency and satisfaction.

PART 2: PHONE CONVERSATION (1 week later)

As the care coordinator, you contact the family one week after the visit to see how things are progressing. Some new information is uncovered. Mr. Smith has recently been laid off his job and therefore has been the one in contact with the school while his wife continues working. Mrs. Smith tells you that she and her husband disagree about the severity of Isaac’s problems. Mr. Smith is afraid that Isaac is being made fun of in school and feels that they need to do anything and everything to help Isaac. Mrs. Smith is worried about Isaac, but she is also skeptical about starting medication for possible ADHD. She is concerned about side effects and making Isaac feel different from his peers. Mr. Smith dropped off the forms to be filled out by Isaac’s teacher the day after the last appointment, and the teacher was happy to fill them out. You suggest that they submit a request to the school for a formal educational evaluation, particularly in light of the long wait list to see a developmental specialist.

Key questions for discussion:

1. Care Coordination in Action:
   - When families disclose sensitive information to you, how do you decide what/when/how to share with the healthcare provider?
     - Review what information about the Smiths from Part 2 may be beneficial for the pediatrician to know. Strategize about how information should be relayed (email, electronic medical record, scheduled care coordination meetings, etc).

   In what ways can you as care coordinator effectively connect with Isaac’s parents, understanding that they have differing perspectives?
     - Brainstorm about conversations care coordinators could initiate with Isaac’s parents to help allay their concerns. One suggestion might be to give each parent a separate Vanderbilt questionnaire to complete. Another could be to uncover Mr. and Mrs. Smith’s common ground: both want Isaac to get better and neither wishes for Isaac to feel out of place at school.

2. Care Coordination and Education:
   - How might you assist Isaac’s parents in asking the school for assistance?
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- Discuss the school’s responsibilities to a student such as Isaac and how parents are informed of this information. Some clinics may already offer parents a packet that includes a sample letter to the school, as well as literature on requesting formal evaluations, securing an individualized education plan (IEP), etc.
- Encourage care coordinators to talk with each other about how they can learn more about the school’s responsibility if this is not something with which some participants are currently familiar.
- Brainstorm about outside help, such as Medical Legal Partnership for Children, Project Health, community resources.

PART 3: NEXT OFFICE VISIT (2 weeks later)

The assessment forms are received from Isaac’s teacher and his parents. Based on these and the pediatrician’s assessment, a diagnosis of ADHD is made, and both parents are now open to a trial of medication. The pediatrician expresses mixed feelings about starting Isaac on medicine, given the possibility of a learning disability that could be clouding the diagnostic picture. She did refer Isaac to a developmental pediatrician to do formal testing, but the waiting list is backed up six months.

Mr. Smith asked Isaac’s teacher for an educational evaluation. The teacher responded by saying that the school has limited resources due to budget cutbacks, and it may take months to get the evaluation. Mr. and Mrs. Smith are encouraged to formally request an educational evaluation from the school. They are willing to do this, but they say they do not feel confident in their ability to get the school to take action.

Key questions for discussion:

1. Longitudinal Coordination:
   - If Isaac were started on medicine at this time, what would be your role as care coordinator in monitoring return visits, medication effectiveness, side effects, need for refills, coordinating referrals, etc?
   - Give examples of how the electronic medical record might facilitate communication of such information. One example might be using EMR to alert/flag the provider/social worker/care coordinator, etc when input is needed.
   - Emphasize the idea of proactive/longitudinal care, as opposed to reactive/episodic encounters.
   - Discuss how efficiency of referrals within the extended medical home is perceived and how it can be improved.

2. Accountability and Collaboration:
   - Think of the concepts of accountability and teamwork: Who is responsible for care coordination beyond the care coordinator?
     - As a specific example, if the school called the clinic to discuss Isaac’s case, to whom would the call be transferred?
     - Introduce the concept of the pre-clinic “huddle” to ensure all members of the medical home are on the same page regarding patients with complex needs.
     - How does the emphasis on collaboration in the care coordination model set it apart from traditional case management?

3. Identifying Key Stakeholders:
   - Consider who the decision makers are in your practice. Whose “buy-in” must you secure in order to make care coordination a successful reality? Brainstorm ways in which you can build alliances with these people so that they are meaningfully involved.
Conversely, imagine what might happen if you focus only on these “key” players and exclude the input of others. Emphasize that the entire office staff must be informed of and involved in any transformational change in order for it to be successful. Initiate discussion about how this might happen—surveys, staff meetings, etc.

**WHITEBOARD EXERCISE**

(25 minutes)

Stop and think about your vision of high-quality, effective care coordination in the medical home in its most complete form—your image of exactly what you would like to see. Let’s imagine that you go to work tomorrow morning, and that vision is now a reality.

- How would things look different than they do now?
- What would be the specific indicators you would notice that would indicate that your vision has come true?
- What shifts would you be seeing in how people are interacting with each other?
- Think about this in the context of Isaac’s case—how would his scenario play out in this ideal version of care coordination?
- When was the last time you saw a sign—even if only for a short time—that could lead to your vision? Who was involved in creating that sign? If you were involved, what was your contribution? What skills, knowledge, and/or values did you bring to the situation?

**CLOSING COMMENTS**

(15 minutes)

- If time permits, ask that one speaker from each small group share memorable take-home points with the large group.
- If your group did not divide into smaller groups for the case, encourage each person to say one thing they will take away from this module.

In closing, consider that patient and family narratives may help our work stay grounded and family-centered. As an example, listen to the words of one mother:

*When my daughter was one year old, I was told she would never have children of her own, go to college or live independently. All my dreams were destroyed in a twenty-minute office visit. That conversation was also the beginning of my becoming an expert, both in terms of understanding my daughter’s physical and developmental disabilities, and in terms of knowing her as a unique human being—a funny and courageous kid, talented artist, lover of animals, and the foundation of our family. Our clinicians understand some pieces of the puzzle; I understand many others. More and more, our relationships with the medical team are fueled by mutual respect. When that happens, I can relax a bit, knowing that my daughter will get what she needs from all of us.*

- Meg Comeau, Institute for Professionalism & Ethical Practice family faculty member (and mother of a child with special healthcare needs)