NACCHO
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2017 Model Practices

Applicant Information

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Model Practice Title

Please provide the name or title of your practice: *

Implementing a Nurse Care Coordination Model in Partnership with the county Health and Human Services Department

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- [x] Access to Care
- [ ] Advocacy and Policy Making
- [ ] Animal Control
- [x] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [ ] Community Involvement
- [ ] Cultural Competence
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [ ] Health Equity
- [ ] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [ ] Organizational Practices
- [ ] Other Infrastructure and Systems
- [ ] Organizational Practices
- [ ] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce
- [ ] Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Is this practice evidence based, if so please explain. :

This practice involves use of the Nurse Care Model of Care Coordination, an evidenced based practice, to increased access to care through an Inter-Agency collaborative practice utilizing informatics and quality improvement strategies overseen by the Nurse Care Coordinator.

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☐ Nutrition, Physical Activity, and Obesity
- ☐ Tobacco
- ☐ Healthcare-associated Infections
- ☐ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☑ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

In April of 2016, Florida Department of Health in St. Johns (DOH-St. Johns) imbedded a Nurse Care Coordinator into partner agency St. Johns County's Health and Human Services' (HHS) community-based care Family Integrity Program (FIP) as an opportunity for cooperative efforts to improve access to medical and dental health of children in St. Johns County. DOH-St. Johns innovation of embedding a DOH registered nurse into FIP is proving highly effective in its conception year. Using the Nurse Care Model of Care Coordination, an evidenced-based practice, preliminary results indicate a positive response with increased access to care through this inter-agency practice utilizing informatics and quality improvement strategies overseen by the DOH-St. Johns Nurse Care Coordinator. DOH-St. Johns County (www.stjohns.floridahealth.gov) employs approximately 65 fulltime employees and provided clinical services of public health significance to 3,630 clients, as well as, essential public health services to the residents and visitors to the county during 2015. The Agency is led by the Director and Health Officer, Dawn C. Allicock, MD, MPH and a small Senior Leadership Team. Located in Northeast Florida, part of the Jacksonville metropolitan area, St. Johns County draws approximately 6.5 million visitors each year as the county seat is the City of St. Augustine - the nation's "Oldest City". The U.S. Census Bureau estimates the 2015 population of St. Johns County to be approximately 226,640 (89% White; 6% Black; 6% Hispanic), with a median income of $64,346. Since 2000, the County has experienced a 65% growth in population, three times greater than that of Florida, and almost six times that of the Nation. In the 2014-2015 school years, there were 34,511 children enrolled within the school district, which reflects a 4% increase from the previous year. It's important to note that for the past five years, St. Johns County has been ranked the healthiest county in Florida by Robert Wood Johnson Foundation's County Health Rankings report. Despite this, St. Johns County had the highest percentage of verified abuse reports for children in foster care in the beginning of 2016. In March 2016, this rate was 18.57 (per 100,000 days) against the state rate of 10.65. Furthermore, the Family Integrity Program lead agency scorecard indicates St. Johns County had the second lowest permanent placement rate in the state at 41.6%; the state rate is 54.9%. The target population includes the approximate 277 children serviced by FIP (in- and out-of-home, as well as, independent living). As noted in the 2015 Children and Youth Services published article, A Framework for Developing Healthcare Quality Measures for Children and Youth in Foster Care (Deans, et al), "…these children are at an increased risk for unmet medical, developmental, and behavioral conditions. Compared with children from the same socio-economic background… have higher rates of chronic physical disabilities, emotional and behavioral problems, and developmental delay." The goal of this collaborative model practice it to improve the child's access to care and the delivery of preventative health services while enhancing community linkages to additional services supporting Maternal and Child Health. This collaborative model practice was achieved by embedding a DOH-SJC registered nurse Care Coordinator into FIP. This allows for improved strategizing as well as use of informatics across both agencies. The Nurse Care Coordinator monitors and assists the target population who live county-wide. The Agency for Healthcare Research and Quality defines care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care." When delivered by a registered nurse, studies show favorable clinical and economic outcomes. The intended outcome of the Nurse Care Coordinator position was to increase medical and dental services to children. The position also allowed the two agencies to begin the development of a rapid response team for children most at-risk with medical needs. Although the data is preliminary, with two quarters of reporting measures collected, the data reflects dental services received increased from 84% to more than 96% in the first 6 months of the Nurse Care Coordinator tenure. The medical services, while consistently around 94% have increased to almost 97% in the past 6 months. Furthermore, there has been partnership enhancements between DOH and HHS that have directly impacted the health and well-being of several at-risk infants mitigating risk factors for infant mortality and improving quality of life for the infants; the most notable being a 2 month underweight infant that received intensive Care Coordination services across both agencies resulting in a now healthy and thriving 4 month old.

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)
- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to

Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

The transient nature of foster care in St. Johns County was negatively impacting the health and wellness of children managed by FIP showing significant gaps in care in both medical and dental services. The DOH-St. Johns CHD and St. Johns HHS FIP collectively recognized an opportunity for collaboration in the role of the Nurse Care Coordinator. Having a nurse embedded into one agency with direct access to another agency's data allows for efficient collection and dissemination of data as necessary to ensure limited gaps in care. "Many children enter foster care with inadequate preventative visits, ill-managed chronic conditions, a high prevalence of complex trauma exposure, and have mental and/or behavioral problems" (Deans, et al). A comparative study in 2008 looked at the attendance of preventative medical and dental visits of children with special healthcare needs and children without special healthcare needs. The research indicated that children with special healthcare needs have significant unmet needs for medical and dental care (Van Cleave and Davis, 2008). Children in foster care typically require higher usage rates of emergent and inpatient care. These children may also be at increased risk for subacute dental problems that could be addressed at preventative dental visits. The research showed that those children who attend preventative medical and dental visits at similar or higher rate than other children are less likely to have unmet needs. The Children and Youth Services Review (Deans, et al) reports that in 2010 a study had been completed showing that over 75% of the sampled foster-care Medicaid-eligible children did not receive their preventative medical, dental, and vision screenings. In St. Johns County, with more than 200 children receiving medical and dental oversight through FIP, less than 84% were receiving their dental care prior to the introduction of a Nurse Care Coordinator. The target population, as stated above, is children currently under the FIP case management services. St. Johns County has approximately 277 children serviced under the Community Based Care FIP (in and out of home as well as independent living). The Nurse Care Coordinator provides monitoring and assistance for 215 children county-wide. Past practice includes Family Integrity case managers, with limited clinical knowledge, being responsible for medical and dental preventative care gaps along with their overarching goal of personal safety. This has historically led to an opportunity in these HEDIS measures. Current data from the Lead Agency Scorecard indicates 96% of St. Johns County children received a medical service in the past 12 months. The Nurse Care Coordinator is currently working to hone the reporting structure of that HEDIS measure to distinguish between preventative medical services, such as a school physical, and sick visits to a provider or hospital. Current data from the Lead Agency Scorecard indicates 96% of St. Johns County children received a dental service in the past 7 months. The Nurse Care Coordinator is currently working to hone the reporting structure of that HEDIS measure to distinguish between preventative dental services, such as a cleaning, and additional services to a dental provider. Pamela Cipriano wrote a policy brief in 2012 for American Academy of Nursing on Policy recognizing that evidenced-based care coordination and transitional services are strategically important for achieving the priorities in the National Quality Strategy and the Partnership for Patients. "Several care models have been implemented by nurses and other non-physician providers with demonstrated positive impact on clinical and economic outcomes."(Cipriano, 2012). The Nurse Care Coordinator remains a constant to ensure timely delivery of services. A meta-analysis in 2002 was conducted on patient intervention programs when Care Coordination was beginning to develop into a full-fledged component of nursing. The analysis showed that patient education was the most commonly used intervention. However, when more than one intervention was utilized, patient adherence showed significant improvements. (Weingarten, et al, 2002). Since 2002, the role of Nurse Care Coordination has evolved. The American Academy of Nursing continues to support the need for "expanding and accelerating implementation of effective care coordination and transitional care models" (Cipriano, 2012). The Council on Accreditation (COA) also endorse coordinated healthcare services for each child in foster care, in order to ensure continuity of care and the receipt of comprehensive healthcare services (Deans, et al). The ANA White Paper on Care Coordination offers the following definition from 2010: Care coordination has been defined by numerous groups, many of which have focused on specific patient populations in specific settings. ANA has adopted the approaches of the National Quality Foundation and the Agency for Healthcare Research and Quality. Care coordination is (a) a function that helps ensure that the patient's needs and preferences are met over time with respect to health services and information sharing across people, functions, and sites; and (b) the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Additionally, the best coordination model is one in which a patient experiences primary care as delivered by an integrated, multidisciplinary team that explicitly includes at least one staff care coordinator. The value of registered nurses in care coordination roles has been demonstrated in numerous health care reform initiatives focused on integrative service delivery. Nurses design, implement, and participate in care coordination projects and practices that seek to improve patient outcomes and decrease costs, frequently demonstrating the effectiveness of nurse-led and patient-centered care coordination. In 2012, the National Quality Forum endorsed 12 Care Coordination Measures. "The domains of these practices include the healthcare home, developing and implementing a proactive and patient-centered plan of care, effective communication between patients, families and caregivers, efficient information systems that support timely communication, and transitions of care that promote safe, evidence-based care." The AHRQ identifies the main aspects of care coordination as: • Establishing accountability and agreeing on responsibility • Communication/sharing knowledge • Helping with transitions of care • Assessing patient needs and goals • Creating a proactive care plan • Monitoring and appropriate follow-up including response to changes in patients'' needs. • Support patients' self-management goals • Linking to community resources • Working to align resources with patient and population needs. Care coordination, at its very best, is an interdisciplinary care model merging patient-driven education at an appropriate health literacy level, dynamic appropriate psychosocial support, and facilitation of community linkages and referrals specifically aimed at closing a gap caused by health inequities. The implementation of the Nurse Care Coordinator was a dual agency initiative. A registered nurse with significant experience in both maternal/child health and case management was chosen to begin laying the groundwork. The practice of Nurse Care Coordination had been successfully implemented in the Healthy Start Program in St. Johns County where care coordination for vulnerable high-risk women has documented effective short-term and long-term outcomes for both mothers and babies. The Nurse Care Coordinator was placed under the direct supervision of the Healthy Start Program Manager to encourage Nurse Case Management/Care Coordination practices and protocol adherence. The Nurse Care Coordinator has an office within FIP and has access to both DOH and HHS FIP reporting platforms; this dual access is the first time in St. Johns County that a

nurse has access to as much of that child's medical and dental history as possible. This innovative implementation allows the nurse the ability to collect, assess, and interpret the data in an efficient manner as well as collaborate with the Managed Care Organization to improve access to care, increase appointments made and kept for preventative services, and investigate health inequities and their barriers in an effort to collaboratively find solutions to ensure care is delivered in a timely manner.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

The goal of placing a registered nurse in the Care Coordinator role embedded into the FIP is to utilize available informatics across both agencies to improve the child's access to care and delivery of preventative health services while enhancing community linkages to additional Department of Health programs supporting Maternal and Child Health. Children and Youth Services Review indicated a foster child's medical care should include ongoing primary care and periodic reassessments of their health, development, and emotional status to determine the need for additional services and interventions (Deans, et al). The Nurse Care Coordinator monitors all children under the supervision of the FIP. This nurse is able to routinely research immunization and dental records within the Department of Health; collection and proper documentation of services is allowing the Department of Children and Families to more accurately track preventative care for the children. The intended outcome of the Nurse Care Coordinator position was to increase medical and dental services to children. The position also allowed the two agencies to begin the development of a rapid response team for children most at-risk with medical needs. All children currently enrolled in the Community Based Care Family Integrity Program (FIP) are assigned a case manager, that case manager has direct access to the Nurse Care Coordinator. "Medicaid administrative data are useful for tracking healthcare services, however extensive information on custodial arrangements and potential medical and emotional concerns related to the need for state custody are found only in administrative systems within the Child Welfare System" (Deans, et al). The Nurse Care Coordinator has access to both FIP records and DOH clinical records. The Nurse Care Coordinator also has direct access to the Managed Care Organization assigned to FIP children allowing the Nurse Care Coordinator efficient and accurate insurance claims as well as medical and dental appointments to ensure accurate documentation of timely services. The Nurse Care Coordinator was hired in April of 2016. She has quickly acclimated to the new agency's needs and can deftly liaison between agency priorities focusing on improving the HEDIS measures through FIP as well as positively impacting both immunizations within DOH – St Johns as well as the robust pediatric dental clinic at DOH - St Johns. Stakeholders for the Nurse Care Coordinator role include the DOH-SJC (and service centers), the HHS's FIP, as well as the Managed Care Organization overseeing insurance liability for these children and multiple collateral community partners affected by the improvement of preventative care in our county's children. As an agency of the integrated Florida Department of Health, DOH-St. Johns provides essential public health services to the county's approximately 218,000 residents and 6.5 million annual visitors. DOHs mission is to protect, promote and improve the health of all people in Florida through integrated state, county and community efforts. The Agency is led by the Director and Health Officer, Dawn C. Allicock, MD, MPH and a small Senior Leadership Team. Services are provided directly by DOH-St. Johns include: Disease Control and Health Protection via Surveillance & Outbreak Investigations and Epidemiology (STD, TB, HIV/AIDS, Hepatitis, Reportable Diseases); Clinical Services (Immunizations, Pediatric Dental Services, Communicable Disease Management and Treatment, HIV/AIDS Medical Management, and Family Planning Services) Women and Infants Case Management Services (WIC, Healthy Start Program Services, and Pregnancy Referral/Linkage Services); Environmental Public Health Services (Sanitary Nuisance Investigation, Drinking Water & Community Facilities, Septic System Permitting); Public Health Preparedness and Response; Public Health Statistical Analysis and PH Informatics; and Community Health Assessment and Health Improvement Planning. DOH-St. Johns has created a culture focused on high performance and continuous improvement and achieved numerous statewide and national recognitions. In 2004, shortly after Dr. Allicock was appointed as health department Director, DOH-St. Johns adopted the Malcolm Baldrige Award criteria as our performance management model in DOH-St. Johns. We have implemented that model and made numerous systematic improvements since that time. In 2009 and in 2015, we were a recipient of the Florida Governor's Sterling Award for performance excellence (state Baldrige Award) and in 2011 we received the Governor's Sustained Excellence Award. We are one of only two local health departments ever to

receive these awards. In 2014, DOH-St. Johns (along with its community partners) was honored to be one of 12 collaboratives to be included in the University of Kentucky College of Public Health's national study of successful partnership involving hospitals, public health departments and other stakeholders. DOH-St. Johns has strong nursing leadership and tenured nursing staff with considerable experience in implementing and supporting evidence-based case management and care coordination programs, practices and services. DOH-St. Johns has experience in Nurse Case Management across the lifespan and in various disease processes. The practice of Nurse Care Coordination had been successfully implemented in the Healthy Start Program in St. Johns County where care coordination for vulnerable high-risk women has documented effective short-term and long-term outcomes for both mothers and babies. There is also nurse case management in all clinical services including family planning, HIV- Ryan White Program, and epidemiology. DOH- St. Johns will be looking to enhance nurse case management into all areas of population health based on the successes of this program and Healthy Start. DOH – St. Johns has a robust pediatric public health dental program that provide service both in the clinical setting as well as in our local school-based sealant program in partnership with the local school district and Head Start program. As mentioned previously, DOH-St. Johns chairs the St. Johns County Health Leadership Council (HLC) which was recognized in 2014 in a University of Kentucky College of Public Health study for its strong local health department and hospital partnership. The HLC serves as an unofficial board focused on community health improvement though systematic community health assessment, health improvement planning and implementation. In 2014, the HLC completed its fourth triennial Community Health Improvement Plan, which is now in the implementation phase. The HLC has membership comprised of DOH-St. Johns, Flagler Hospital (community hospital), St Johns County School District, private providers and approximately 35 local government, not-for-profit, and faith-based agencies, all focused on the betterment of community health. In addition to the HLC, DOH-St. Johns has numerous other recent examples of convening healthcare partners to address issues of concern in the community. Of particular note is the St. Johns County Fetal Infant Mortality Review (FIMR) project convened in 2014. FIMR is a national collaborative model developed by the HHS and the American College of Obstetricians and Gynecologists. It uses an evidence-based process to identify and mitigate the causes of infant deaths. St. Johns County is the only county in Florida to have convened its own FIMR project, with representatives that include the health department, local physicians, Flagler Hospital and the Northeast Florida Healthy Start Coalition. DOH-St. Johns has several staff members who are skilled at organizing, facilitating, developing action plans, and overseeing specific actions in support of various improvement efforts. This skill has been developed and honed as a result of the implementation of the Baldrige performance management model. Action plans are regularly developed and deployed as a part of our annual strategic planning process. Some important action plans that have been successfully deployed in recent years include, expansion of pediatric dental services; improved medication compliance for HIV/AIDS clients; development and deployment of the Community Health Improvement Plan (done with community partners); the improvement of client two-year old immunization rates, and the process to initiate enhanced surveillance and communications with local hospitals, urgent care centers, physicians, clinics, local schools and pharmacies during the Ebola event in 2014. The start-up costs and funding services associated with this practice are currently limited to one employee. In 2005, an article was published, Cost and Utilization Analysis of a Pediatric Emergency Department Diversion Project, in Pediatrics. In that article: a total of 17,382 children who were enrolled in the enhanced access program (intervention group) and 26,066 Medicaid-eligible children who received services from other local community primary care providers (control group) were included in the study. In the 12-month period subsequent to program initiation, the average per member per month cost for ED utilization of the intervention group was 1.36 dollars less than that of the control group. However, there was no significant difference in terms of per-visit cost related to ED utilization. Therefore, the savings seemed to come as a result of a reduction in ED visits, not from reduced cost per visit. On average, children in the intervention group visited the ED approximately 8 fewer times per thousand members per month than the control group, yet there was no significant difference in the overall (ED and non-ED) cost of care between the intervention and control groups. The conclusion was that the utilization of the ED was significantly lowered among healthy children. The premise of Nurse Care Coordination is through enhanced preventative services, the need for emergent services decline thereby showing an overall cost savings to the system and improved healthcare outcomes for the children. Healthy children tend to require emergent services less than children with special healthcare needs. In an effort to maintain or improve the overall health of a child, it is imperative they maintain preventative medical and dental services regardless of their foster care status.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)
    - List any secondary data sources used (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.
    - Describe how results were analyzed
    - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

The transient nature of foster care in St. Johns County was negatively impacting the health and wellness of children managed by FIP showing significant gaps in care in both medical and dental services. The Department of Health and Department of Health and Human Services collectively recognized an opportunity for collaboration in the role of the Nurse Care Coordinator. Having a nurse embedded into one agency with direct access to another agency's data allows for efficient collection and dissemination of data as necessary to ensure limited gaps in care. "Many children enter foster care with inadequate preventative visits, ill-managed chronic conditions, a high prevalence of complex trauma exposure, and have mental and/or behavioral problems" (Deans, et al). While in foster care, it is difficult to adequately provide a stable medical and dental home for children. When children are moved out of their parent's custody or to another foster home, that foster parent often seeks to move the child(ren)'s medical and dental care to a more convenient provider. This change in providers often leads to missed preventative care treatments and services. The goal of placing a registered nurse in the Care Coordinator role embedded into Health and Human Services is to utilize available informatics across both agencies to improve the child's access to care and delivery of preventative health services while enhancing community linkages to additional Department of Health programs supporting Maternal and Child Health. The intended outcome of the Nurse Care Coordinator position was to increase medical and dental services to children. The position also allowed the two agencies to begin the development of a rapid response team for children most at-risk with medical needs. The data collected through the Lead Agency Scorecard exhibits promising preliminary data. Trend data graphs/figures are available upon request. The rate of abuse per 100,000 days in foster care prior to the embedding of a DOH Nurse Care Coordinator was 18.57; this rate has decreased to 8.72 as of September 2016 (FY17 Q1). While this improvement cannot be directly contributed to the Nurse Care Coordinator, it can begin to explain the collaborative atmosphere that is brought about with an inter-disciplinary approach to care coordination. The data that can be directly attributed to the function and efficacy of a Nurse Care Coordinator are those HEDIS measures she is directly responsible for – HEDIS measure 9 and 10 – the medical and dental services received by children in the FIP. Again, in the table below, the data clearly indicates the FIP has increased their medical service, measure #9 from 96.10 to 96.80 which is a two-year high for that indicator. More impressive, is the result of a collaborative effort between HHS and DOH particularly the DOH Dental Clinic. The Nurse Care Coordinator has been able to quickly affect the percentage of dental services received by children in care from 84% to 96.6% which, again, is a two-year high for that indicator. The Nurse Care Coordinator, along with her direct supervisor in DOH and her overseeing supervisor in HHS evaluate the practice regularly. The Nurse Care Coordinator role has expanded and contracted over the past 6 months in a fluid attempt to meet the needs of the program during the acclimation phase of implementation. The Lead Agency Scorecard is reviewed quarterly. However, the Nurse Care Coordinator has developed extensive spreadsheets to monitor her impact weekly. These spreadsheets are reviewed regularly and application of the Nurse Care Model in case management is reviewed monthly. Modifications are continuously being made to this promising practice. As HEDIS measures are assessed for fidelity of application and the documentation of the completion of services is evaluated, opportunities for improvement in both the capturing of services and the fidelity of the measure is implemented. While the initial phase is promising, it is apparent as more case managers and non-clinical personnel begin to view themselves as stakeholders in the success of a Care Coordination program, the results should further improve and be able to replicate the process in other service areas. The Nurse Care Coordinator, with a background in maternal/child health, is developing collaborative relationships with the providers in St. Johns County in an effort to more efficiently connect children to the preventative services and community resources they or their foster families may require.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.*)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

DOH-St. Johns CHD and partnering agency St. Johns County HHS's Family Integrity Program share a committed determination in the sustainability of the Nurse Care Coordinator. DOH – St. Johns continues to seek out opportunities to develop and implement a comprehensive nurse care coordination/case management program for all clinical services. DOH- St Johns will be using this position and its successes and opportunities as a transformative model for future expansion of nurse case management. The dual agency leads are also seeking innovative rapid response team development to quickly address high-risk needs of children in the community. The lessons learned through the collaborative process continue to unfold. As active observers to each agency's practices and protocols, the Nurse Care Coordinator has been vital to identifying several process gaps for the program. The Nurse Care Coordinator participates in routine regional and statewide learning and sharing opportunities which has caused the Community Based Care programs to begin evaluating the documentation completed by non-clinical staff as well as the fidelity of the measure they are hoping to impact. Consistent and complete documentation will further validate results in coming months. Numerous recommendations for quality measures are relevant for children in foster care. In 2015, it was suggested that "nearly half of the children in foster care have chronic medical conditions and 40-80% have behavioral or mental health problems (Deans, et al). The article revealed a recent study conclusion: In an examination of almost 2400 children in their first year in foster care, foster children received fewer overall outpatient services than did their Medicaid-eligible peers, with 27% if the foster children having no visits to any ambulatory care setting during the year even though current recommendations call for increased visits for them. Children of all ages in foster care exhibited increasing reliance on the emergency department for ambulatory care services. In closing, the innovative collaboration between the Department of Health – St. Johns and the HHS Family Integrity Program has already provided positive outcomes both economically and clinically for the children in St. Johns County. With continued stakeholder commitment to the success of care coordination, the program will continue to evolve and provide further assistance to the community based care programs throughout the region.

Additional Information

How did you hear about the Model Practices Program:: *

- [x] I am a previous Model Practices applicant
- [ ] At a Conference
- [ ] NACCHO Website
- [ ] Public Health Dispatch
- [ ] Colleague in my LHD
- [ ] Model Practices brochure
- [ ] NACCHO Exhibit Booth
- [ ] NACCHO Connect
- [ ] Colleague from another public health agency
- [x] E-Mail from NACCHO
- [ ] NACCHO Exchange