The San Mateo County Prenatal to 5 Partnership
January 7, 2010 Meeting Notes

Debby Armstrong welcomed everyone to the meeting. Participants introduced themselves (see list of participants at the end of the minutes.)

Debby Armstrong reviewed the meeting agenda. No changes were requested.

The September Meeting notes were approved with the correction to add additional attendees to the roster of meeting participants. The group was reminded to sign the attendance sheet so accurate attendance can be recorded.

F5SMC Updates

Debby Armstrong announced the new meeting space location for future Prenatal to 5 partnership meetings which will be held at Silicon Valley Community Foundation's new conference center located at 1300 S. El Camino Real in San Mateo.

Karen Pisani provided an update on the Kit for New Parents Packard Proposal. Suggestions from the Prenatal to 5 Partnership committee were incorporated into the proposal. The RFP will be released on the F5SMC website on Friday, January 8th.

Care Coordination: Overview, Group Work, and Next Steps

Karen Pisani gave a presentation on Care Coordination vs. Case Management and how Systems of Care "talk" to each other through these activities. The group participated in a discussion regarding how Care Coordination and Case Management are similar/different across the county and provided concrete suggestions to further the effectiveness of these functions.

General thoughts re: the definition of Care Coordination vs. Case Management include:

- Case Management addresses the need directly while Service Coordination ensures non-duplication of services.
- In the pediatric setting, the Doctor can serve as the Service Coordinator, providing general guidance as to determining needed services, while the Nurse acts as the Case Manager becoming more involved with the client directly to further inform health treatment modalities and assess needs.
- Sometimes Case Management and Service Coordination are defined as: Case Management is anything that is within the purview of a particular Case Manager – anything falling outside of that purview then becomes an issue for service coordination (because they are services that cannot be coordinated by the case manager).
- Case Management can be defined as the identification of needs, while Care Coordination can be defined as the linking of the client to the needed service providers.
- Many agencies have protocols re: Service Coordination, but in day-to-day work they are in the background, so it's hard to know how each entity defines service coordination and how they expect to interact with each other. So, working together cooperatively with respect for each agency and its available resources is very important.
- Sometimes Care Coordination has to do with ensuring the different systems understand each other and communicate at a higher level (ie, Trish Erwin's prior work).

- At the WMG Demonstration Site, Care Coordination and Case Management are provided by the same person; the two activities are distinguished by the level of care provided.
- In the medical setting the Case Manager is mainly concerned with enrolling the patient and then checking in periodically to ensure they remain eligible for services, while the Care Coordination has to do with many Case Managers coming together to collectively coordinate care for patients.
- The group noted that it is difficult to provide top-notch service coordination when people don't know what services are provided by which agencies. Service mapping has been conducted in the county many times over the years, but each map has a shelf-life and expires as funding streams start and stop and programs start and stop.
- It is difficult for families who receive Care Coordination from multiple agencies to know how to prioritize the available services – this can overwhelm them. No one service coordinator is tasked with helping the family triage resources made available to them from multiple sources.
- Care Coordination could be improved by teaching families how to be better advocates for themselves and access services.
- Conversely, it would be ideal if the services were constructed to "wrap-around" and surround the family so as not to leave them with the burden of care coordination. A visual was given of the child in the center of a circle and the services on the outside, reaching toward the child…think of it as a family-centered process rather than a professional distinction.
- Service Coordination is almost logistical in nature, Care Coordination is how it is going to happen.
- Some agencies are "core" agencies and provide multiple services, other only provide one or a few – it would have a central "clearing house" of services, like 211. CIP is good, but funding for printing the brochure has been cut.
- Sometimes there is a clash between what providers think a client needs and what the client themselves need – this can negatively impact service coordination.
- Empowerment vs. Advocacy – How intense should a Service Coordinator's role be, how much "hand holding" is appropriate and when is it dysfunctional?

At this point in the discussion the group realized that there are many different ways to define and label Case Management, Care Coordination, Service Coordination, etc, and that coming up with a universal definition is not necessary. The group then focused on determining what concrete, systems-change opportunities exist in our county with which F5SMC could possibly help. Ideas generated include:

- Helping to fund the printing of the CIP brochure
- Helping to implement a County-wide 211 system
- Expanding the Ability Path website to include resources for professionals (right now it just has resources for parents).

- Helping communicate the need for Care Coordination because it can be linked to additional dollars (ie, agencies receiving reimbursements for TCM are required to conduct Care Coordination activities in order to receive TCM dollars).
- Develop tools for parents to become better advocates. Perhaps create a packet that lists questions to ask your pediatrician if you have concerns.
- Strengthen Pediatricians' interaction with families (almost all 0-5 children have a pediatrician who could become their Service Coordinator if supported to do so). Maybe pilot a program like this somewhere in the County using the medical home model?

<u>Meeting Evaluation</u>
Meeting Plus/Delta:

Plus:
- Rich conversation with all
- Learned from the discussion
- It was good to "grapple" with the issue, got us to purpose
- Facilitation
- Diversity of perspectives
- Group was engaged and "self-driving"
- 1 topic to discuss was good
- Able to get out of comfort zone
- Snacks
- Presentation before discussion helpful
- Name tents helpful
- Large group vs. small groups good
- Felt comfortable with the group
- Thought provoking
- F5's interest in care coordination
- "ditto"

Delta:
- Review of minutes not helpful
- Get more to attend and participate

<u>Next Meeting</u>
The next meeting is scheduled for **Thursday, March 4th,** from 2:30pm to 4:00pm in Room 114 (Silicon Valley Community Foundation).

The San Mateo County Prenatal to 5 Partnership January 7, 2010 Meeting Attendees	
Name	**Organization**
Cynthia Alvarez	First 5 San Mateo County
Debby Armstrong	First 5 San Mateo County
Anand Chabra	Family Health Services
David Fleishman	First 5 San Mateo County
Damaris Mendoza	Youth and Family Enrichment Services
James Miller	San Mateo County Health Department/Family Health
Susan Naify	Sitike
Cheryl Oku	Community Gatepath
Fran Oliden	San Mateo County Health Department – Family Health Services
Karen Pisani	First 5 San Mateo County
Sarah Poulain	Youth and Family Enrichment Services
Ronell Reyna	Prenatal to Three
Emily Roberts	First 5 San Mateo County
Candace Roney	Lucile Packard Children's Hospital
Eliana Schultz	Family Health Services
Sabrina Spadavecchia	Our Second Home
Dottie Vura-Weis	San Mateo County Health Department – Family Health Services
Jasmin Wettstein	Prenatal to Three/Family Health Services
Sherin Ziadeh	Our Second Home