THE INDIANA COMPLEX CARE COORDINATION COLLABORATIVE
Children with Medicaid and Medical Complexity
Adults with Intellectual/Developmental Disabilities

Does your practice have special interests in caring for children with medical complexity? Or adults with intellectual/developmental disabilities?
Do you need help organizing your care delivery for these patients in the primary care setting?
Do they take more than the time you have allotted for their care?
Does your primary care practice group serve 100 children on Medicaid who are followed longitudinally by at least 3 subspecialists? Or 100 adults receiving Bureau of Developmental Disabilities waiver services?
Do you have up to 6 clinicians who will share a registry of 100, each overseeing 16-25 patients?

As part of a 10 state HRSA project spanning from 2018-2021, three Indiana pediatric primary care practices (Witham, ALL IN, IUH Riley Pediatric Care Center) implemented complex care coordination in their medical homes, which they now collectively praise for its value as a time-saver and for its improved patient care. They each hired a nurse (paid by the grant) who serves 100 families.

Due to its success, Indiana Medicaid has created a contract with IUSM to launch a 3-year program into 24 practices across the state. It is the aim to demonstrate a sustainable approach in preparation for launching a statewide Medicaid payment model for complex care coordination.

We are recruiting interested practices who will receive funding for a full-time nurse care coordinator. This coordinator will be part of a cohort of statewide coordinators who receive coaching from an expert team at IUSM. There are additional stipends for the participating clinicians.

Participating practices must commit to the following:

- Hire a full-time nurse, paid by the project, to serve in this role.
- Identify a physician champion to lead the implementation within the practice for a $5,000 stipend. Other participating clinicians will receive annual $3,000 stipends.
- Commit to working on quality measurement and improvements within the practice's regular team meetings.
- Employ chronic care management with at least semi-annual, and ideally quarterly, visits for registry patients.
- Participate in semi-annual family satisfaction and team surveys of coordination processes.

Program activities:

- Shared plans of care (SPOC) are created using a comprehensive social/medical assessment, synthesizing a medical summary, and prioritizing patient and caregiver/family actions to address unmet needs.
- Nurse care coordinators develop their care coordination skills through weekly coaching and group trainings and using resource playbooks for systems navigation.
- Clinician champions touch base weekly with their care coordinator to support the program.
- Clinician champions attend monthly hour zoom sessions with the cohort of other champions.
- Practices receive monthly quality reports, semi-annual family satisfaction and team satisfaction results.
- Participating clinicians participate in quarterly virtual hour learning collaborative.