The Community Care Team: A Model for Systems Alignment

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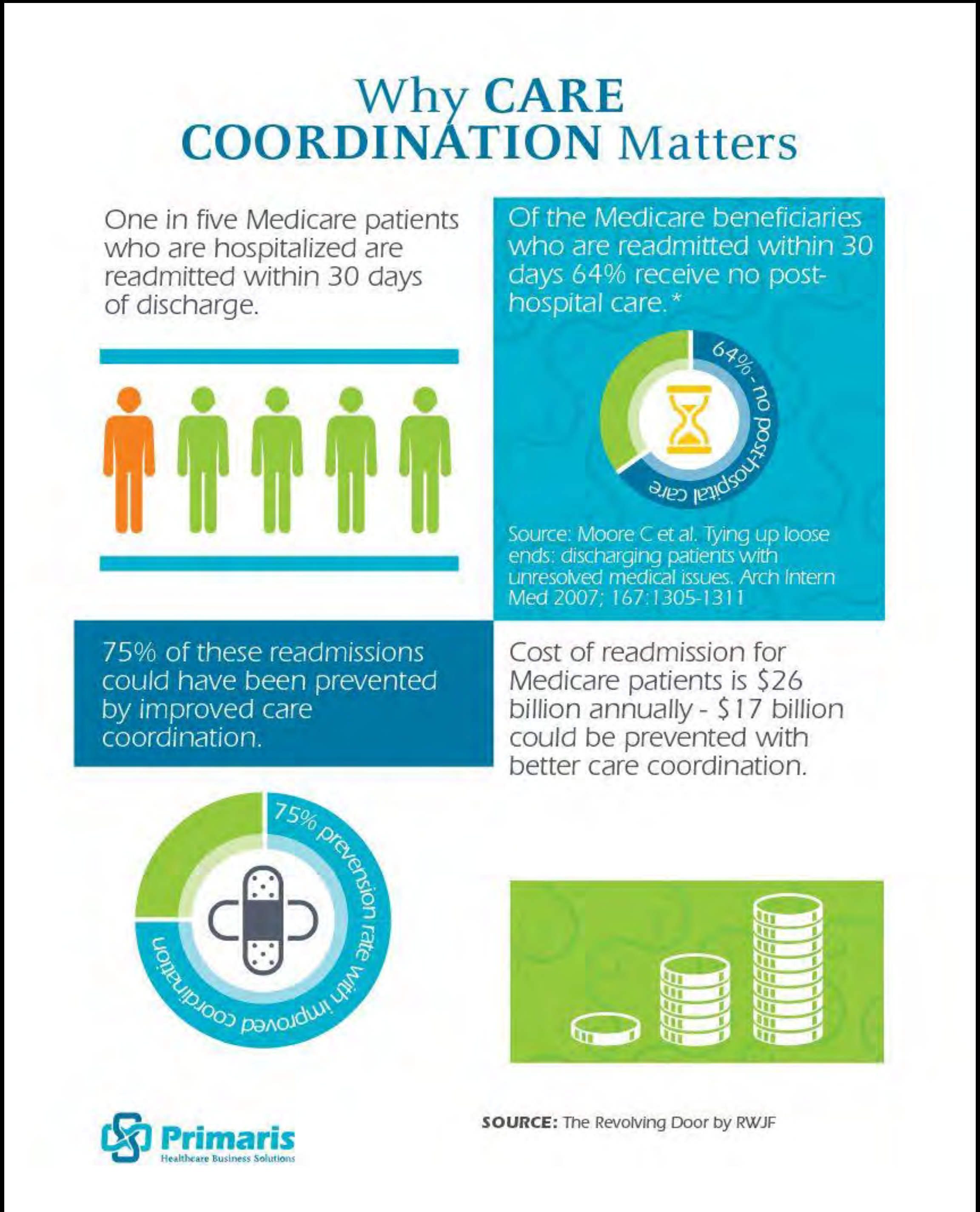
December 10, 2018

NH Behavioral Health Summit

TEAMWORK

Coming together is a beginning. Keeping together is process. working together is success.



Uncoordinated Care = Systems Not In Alignment

- Is More Expensive
- Is Less Effective
- Takes Longer
- Increases Risk of Duplication of Services
- Increases Risk of Missed Services
- Confuses Clients
- Increases Risk of Injury/Harm
- Makes Providers Look Less Competent
- Aggravates Clients
- Results in Provider/Caregiver/Workforce Burnout

Why doesn’t Teamwork ALWAYS get the job done better?

Why doesn’t everyone have the same goal in healthcare?


Dete
10%
5%
15%
30%
Source: *We Can Do Better — Improving the Health of the American People*, The New England Journal of Medicine, September 2007
...But patients are still looking for more help from their doctors to achieve their health goals.
89%
Lifestyle habits that could impact health
87%
Health goals
86%
Mental health history
84%
Ability to deal with stress
77%
Overall level of happiness and life satisfaction
Housing
Environmental Quality
Transportation
Education

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

Ingredients in Care Coordination?

1. **<u>Comprehensive:</u>** All services a client receives, including services delivered by systems other than the health system, are to be coordinated.

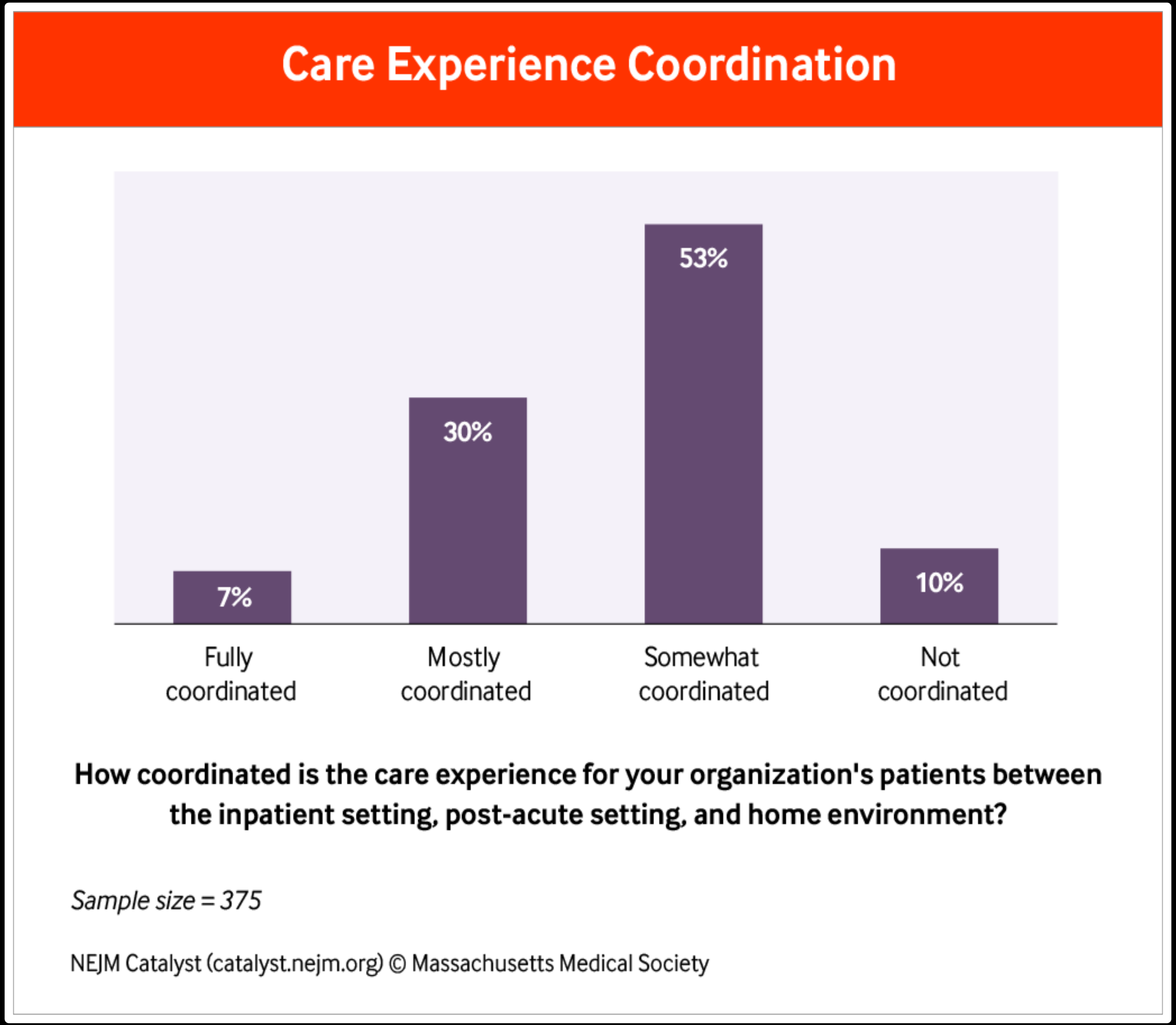
2. **<u>Patient-centered:</u>** Care coordination is intended to meet the needs of the client and the family, both developmentally and in addressing chronic conditions.

3. **<u>Access and Follow-up:</u>** Care coordination is intended not only to connect clients and their families to services, but also to ensure that services are delivered appropriately and that information flows among care providers and back to the primary care provider.

Essential Elements of Care Coordination

Rank the following tasks/services in order from what you currently do most (1) to what you do least (14).

____ Appointment scheduling and follow-up
____ Health education
____ Patient navigation
____ Care management
____ Medication management
____ Transition support
____ Referrals
____ Self-management support
____ Identifying Culturally competent and linguistically appropriate care
____ Transportation assistance
____ Translation services
____ Community outreach
____ Program eligibility and enrollment assistance
____ Linkages to other community-based or social services



Who Pays for Care Coordination?

- ✓ CPT Codes
- ✓ Bundled Payments
- ✓ PMPM
- ✓ Grants
- ✓ Someone Else
- ✓ No One

Care Coordination (vs.?) Case Management

- "Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client's health and human services needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes."

  - Brokerage Case Management (1-2 visits)
  - Strengths Based Case Management (client & family empowerment)
  - Clinical Case Management (acute care)
  - Collaborative Case Management (multidisciplinary teams)
  - Population Health Management (based on disease/condition panels)
  - Clinical Resource Management (Utilization Review case mgmt)

Types of Care Coordination & Care Management Program Models

Care coordination programs are designed to meet the unique needs of different populations and communities. This module identifies seven types of care coordination models that can be used to integrate health and human services. Links to descriptions of each type of care coordination model are below.

- The Program of All-Inclusive Care for the Elderly (PACE) Model: Designed to integrate care for frail older adults who are eligible for both Medicaid and Medicare.
- **Wraparound Model:** Helps coordinate services for children with significant or complex needs and their families.
- Community HUB Model: Creates a central registry of at-risk individuals for a network of care coordination agencies.
- Community Health Worker Model: Uses CHWs who can liaise between the target population and a variety of health, human, and social services organizations.
- Mobile Unit Model: Travels to rural communities to increase access to health and human services.
- Supportive Housing Model: Designed to coordinate a range of services for individuals experiencing homelessness.

Nurse-Family Partnership Model: Pairs first-time mothers with low incomes with maternal and child health nurses in order to promote healthy pregnancies, child development, and economic self-sufficiency.

Health Homes Model: Designed to coordinate healthcare and social services for Medicaid and Medicare-Medicaid dual eligible individuals with chronic conditions and mental or behavioral health problems.

Behavioral Health Homes Model: Team is responsible for the integration and coordination of the individual's health care (behavioral health care, as well as physical health services).

Integrated Health Homes Model: A team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Continuum of Integrated Care Models and Features

Little/No Accountability for Quality and Cost Outcomes → *Significant Accountability for Quality and Cost Outcomes*

Care Models	FFS Only; PCC; PCCM Plus P4P; PCMH	PCMH + Health Home; Network of PCMH; ACOs	Comprehensive ACOs; Other ICMs; Full ICMs
Measurement	Data capturing & sharing	Improved clinical processes	Improved outcomes (costs down, patient experience up)
Payment	Made to individual PCP; fixed $ amount $15-service / $5– quality; Possible bonus pool Individual Service-Focused	Made to individual providers or entity; upfront $, savings & FFS $10-service / $10– Quality/savings	Made to entity; $ based on savings $5-service / $15– Quality/savings Population-Focused
Success Indicators	Process measures indicate improved care in future, yield data collection for policy development and baseline	Clinical processes and new benchmarks informed by data collection; benchmarks adjusted for continuous improvement	Improved care outcomes, not volume; patient experience
Metrics/ Evaluation	Some MU core set; some adult/child core sets measures	Practice measurement changes and process measures that will lead to outcomes improvement	Population health, functional status, total cost of care
Examples	Oklahoma PCMH; Missouri PCMH HH	North Carolina CCNCs; Colorado RICOs	Minnesota ACOs; Oregon CCOs

Source: Centers for Medicare & Medicaid Services (CMS)

An Incremental Approach To Shared Care Planning

Operational Complexity

Medium High ---------------------------- Very High

Community Care Team

- Community Supports organizations are privy to PHI and Sensitive Conditions
- Consent required of all Medicaid Members served by Care Team
- Sophisticated Consent Tracking

+ "Boundary Crossers"

- Care Coordinators work with Community Supports
- Care Coordinators are privy to PHI and Sensitive Conditions – Translate but do not disclose
- PHI-free "Referrals to Supports"

Integrated Core Team

- PCPs, BH Providers, and Care Coordinators
- Personal Health Information (PHI) shared per HIPAA
- Written consent for sensitive conditions

1+ Mos. ---------------------------- 3+ Mos. ---------------------------- 12-18 Mos.

Anticipated Time to Implementation

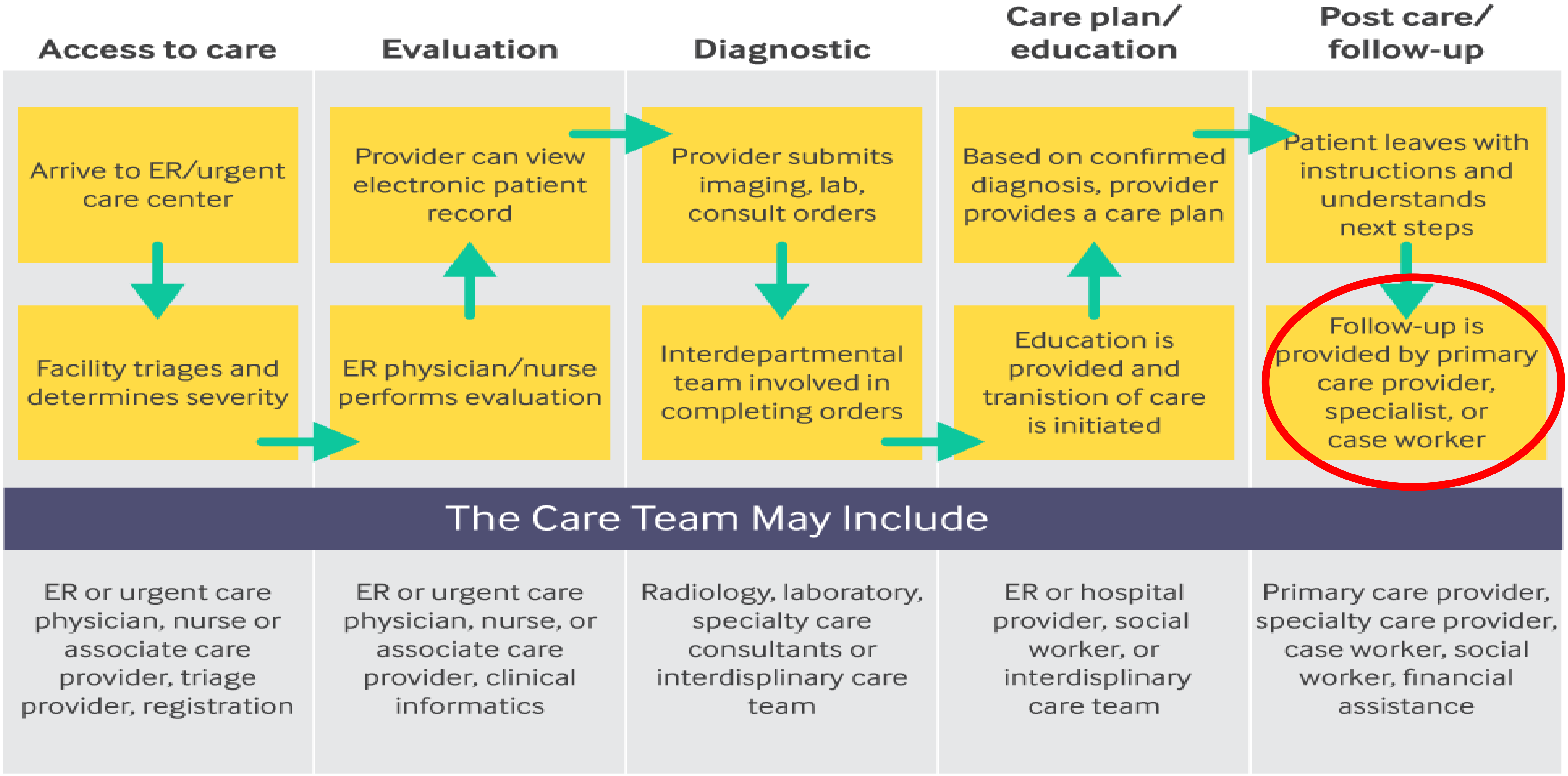
Region 6 Integrated Delivery Network

- Administrative Lead: **Strafford County**
  - Seacoast & Strafford Public Health Networks (36 cities/towns)
  - 30,100 attributed lives (Dec 01, 2018)
  - Key Clinical Partners
    - 2 CMHCS (Community Partners & Seacoast Mental Health Center)
    - Southeastern NH Alcohol & Drug Abuse Services
    - 3 Federally Qualified Health Centers
    - 4 Hospitals & affiliated primary care practices

How We Started

- Started slowly in Fall 2015
  - Greater Seacoast Coalition to End Homelessness
  - Based on Middlesex, CT Model to address Homelessness
  - Modest group of agencies and organizations
    - Scheduled a Meeting Date and…..

- Biggest Lifts:
  - Release of Information
  - Case Presentations



Source: Michael Marzoug, Management Consultant

When a Client leaves hospital care coordination for Post-Care/Follow-Up…

They also go from being surrounded by a choreographed, executed effort by people working as a recognizable team…

…to being surrounded by a chaotic free-for all with individuals who look like they MIGHT be on the same team, but the game has definitely changed.

CCT Guiding Principles

- **Objective**

To provide person-centered care and improve outcomes by developing wrap-around services through multi- agency partnership and care planning

- **Core Belief**

Community collaboration is necessary to improve health outcomes

- **Core Understanding**

Complex Bio-Psycho-Social problems are community problems. No one entity alone can effectively improve outcomes for this population


...AND THAT IS WHY WE LIFT ON THREE...
COMMUNICATION
©DOLIGHAN.
dolighan.com

Where we are today

- **237** Individuals have been discussed in 36 months
- **216** Currently considered active
  - 58% are Medicaid beneficiaries
  - 29% are Medicare beneficiaries
  - 63% had a PCP when referred to the CCT
  - 51% homeless
    - Additional 15% are unstably housed
  - 54% have a diagnosed or suspected mental health condition
  - 45% have a diagnosed or suspected substance use disorder
  - 52% are engaged with 1 or more organizations

Where we are today

- Release of Information & Confidentiality Agreement
  - (Members & Visitors)
- Process Improvements
  - Communication
    - Meeting Facilitation
    - Shared Care Plan/Event Notification
  - Case Template
- Meeting every 2 weeks in Strafford County since March 2018
- Starting a Team in Exeter/Hampton in January 2019

How We Do It

Greater Seacoast Community Care Team

Case Presentation Template

The Case presentation should be concise, presenting only known relevant information and generally including:

☐**New Referral** ☐**Existing Referral** **Date First Presented:**

This case is coming in front of the CCT for:

☐**Report** (to provide anticipatory/supportive situational awareness) or for

☐**Action** (to request a collaborative care plan or assistance addressing a barrier/gap)

REFERRAL NAME	
Date of Birth	
Insurance	
Military Service?	
Primary Care Provider and Visit History	
Emergency Dept History (if applicable)	
Other providers with whom patient/client is engaged	
Housing Status	
Income	
PHONE	

Presenting medical/psychosocial issues and any significant health and social determinant status and/or history.

Care plan from earlier referrals

Who We Do It With

IDN CCT members:

- Amedisys
- Beacon Health Strategies*
- Child & Family Services of NH
- Community Action Partnership of Strafford County
- Community Partners
- Connections Peer Support Center
- Cornerstone VNA
- Cross Roads House
- Crotched Mountain Community Care
- Dover Housing Authority
- Easter Seals of NH
- Exeter Health Resources
- Families First of the Greater Seacoast
- Families in Transition (FIT)
- Frisbie Memorial Hospital
- Goodwin Community Health
- Granite Pathways
- Granite State Independent Living
- Greater Seacoast Coalition to End Homelessness
- Haven
- Homeless Center for Strafford County
- Hope on Haven Hill
- The Homemakers Services
- My Friend's Place
- NH DHHS Bureau of Elderly and Adult Services
- NH Healthy Families*
- NH Housing Finance Authority
- OneSky Community Services
- Portsmouth Housing Authority
- Portsmouth Regional Hospital
- Region 6 Integrated Delivery Network
- Rochester Community Recovery Center
- Rochester Housing Authority
- Rockingham Community Action
- Rockingham VNA
- Safe Harbor Recovery Center
- Salvation Army, Portsmouth
- Seacoast Mental Health Center
- Seacoast Pathways (Granite Pathways)
- ServiceLink of Rockingham County
- ServiceLink of Strafford County
- Somersworth Housing Authority
- SOS Recovery Community Organization
- Southeastern NH Services
- St. Vincent dePaul Society
- Tri-City Consumers' Action Co-operative
- Veterans, Inc.
- Welfare Department, City of Dover
- Welfare Department, City of Portsmouth
- Welfare Department, City of Rochester
- Welfare Department, City of Somersworth
- WellSense Healthplan*
- Wentworth-Douglass Hospital
- Wentworth Home Care and Hospice/Amedisys
- Womenaid of Greater Portsmouth

Transition Planning Care Coordination for XXX

Vendor Name & Location	Vendor eligible?	Program Cost	Program Availability	Residential or Day only options?	Wrap Around needed? (PT/OT/Speech/Nsg)	Availabile Wrap Around vendors?	NOTES
(Supported Apt) : Newmarket	Yes		Yes : immediate	Residential	Yes	Rockingham VNA Cornerstone VNA Maxim Wentworth Homecare Personal Touch (LNA?)	
(Supported Apartment): Lyme	Yes		Yes : pending	Residential	Yes		
Evergreen Center : Milford Mass https://www.evergreenctr.org/	Unknown		Unknown	Residential & Day	LNA @ home if @ day program	see previous local list for Nmkt	
Melmark New England: Andover Mass http://www.melmarkne.org/admissions-process-1	Unknown		Unknown	Residential & Day	LNA @ home if @ day program	see previous local list for Nmkt	

TEAM:

XXX & XXX's Mom	Captains	Identify goals and priorities for Care		
		Explore, consider, and evlaute available Care Plan options (initial & ongoing)		
Pediatric Associates of Hampton & Portsmouth	Dr. Turner	Primary Care Provider		
	?	Nurse Care Manager		
Northeast Rehab	Dr. D.	Physiatrist/ordering PT/OT		
	Cheryl	Care Coord./Scheduling		
OneSky	Lenore	Coordinating OneSky efforts (development and oversight of coordinated services)		
	Sheena	Coordination of Admission options for XXX Adult Services		
	Aslyn	Coordination of all XXX's ongoing Adult Services		
Portsmouth Welfare	Ellen T.	Financial eligibility & family support		
Region 6 IDN	Tory J	Facilitation of Care Plan development & Team & resource identification (incl. clinical if indic	603.312.0492	tjennison@co.strafford.nh.us
	Maria S.	Care Team coordination and administration		msillari14@gmail.com
	Aimee	Enhanced Care Coordination Case Manager (available*if desired by Care Team)		
NH Healthy Families	Kim D./Kathy S.	Support and information re: benefits and access to services		
Monarch School	Kate S.	Contact for any desired Monarch School support for transition planning into Adult Services		

	NEXT STEPS	LEADING the STEP
Priority 1:	Request assessments & services for short-term In-Home supports for XXX via Dr. Turners's office (PT/OT/Speech/LNA)	Tory/IDN
Priority 2:	Assess eligibiity, cost & availability for Evergreen Ctr & Melmark	OneSky - ? Sheena?
Priority 3:	Schedule mtg to review eligibility/cost/availability findings with family & any family supports/advocates to clarify assumptions & options	Family/OneSky/Ellen/IDN
Priority 4:	Develop & execute Care Plan based on preferences & goals identified by Family given options determined to be feasible & acceptable in Priority 3.	Full Team

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Patients

Add a Patient: Patients | Apply

View: Active and New | Load | Save | Save As | Delete

Print

Add Filter | Patient Status | Active, New | ... | Filter

Remove Filter | Assigned User | Logged in user

	Patient Name		MRN / EMPI	Programs	Risk	Care Team	Status	Patient Contact Numbe	Assign
⊞	Gruber, Hans		11510033	Details	LACE Assessment: 13.00	Details	Active	Details	One, User
⊞	Notwell, Ima		14400050112017	Heart Failure	-	Details	Active	Details	Details

1

2 Total Records

Tasking Worklist

Tasking Worklist | Apply

View: Default View | Load | Save As

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Gruber, Hans

P2 CD: Active

Gender Male *DOB* 01/29/1983 *MRN* 11510033 *Next Intervention* 11/23/2017 Assist patient with quitting by helping... *Next Assesment* 11/23/2017 Jills Thanksgiving Assessment

Next Task 4/27/2018 CFH - Potential CCM Patient Screen

- Face Sheet
- Patient History
- Patient
  - Patient Profile
  - Patient Details
  - Assessments
  - Care Plan
  - Tasks
  - Referrals
  - Programs
  - Enrollment
  - Documents & Forms
  - Patient Notes
  - Financial
  - Risk
  - Care Team
  - Assigned Users
  - Contacts
  - Medication Management
  - Clinical Data
  - Visits
- Admissions
  - 115100033042017

Hans Gruber

EMPI: Edit
MRN: 11510033
DOB: 1/29/1983 (age 35 years)
Gender: Male
Marital Status: Married
Race: CAUCASIAN Edit
Ethnicity: Edit Edit
Religious Affiliation: LUTHERAN

Most Recent Admission: 115100033042018, 4/16/2018, 4/17/2018, SEPSIS/ESRD, 01e
Summary of Care
Address: 1058 Moon Trail Rd, Blood
Raleigh, NC 27587
Home Phone: (919) 982-8222
Work Phone: (919) 982-8222
Alternate Phone: Edit
Mobile Phone: Edit
Email: Edit

Care Coordination

Consent Date: **11/16/2017**
Status: **Active**
Priority: 2
Referral Source:
Risk: LACE Assessment: 13.00
Fall Risk: 8.00/High

Primary Program: Edit
Additional Programs: Asthma

Care Team

User One
Primary Assigned Care Coordinator

Edit
Primary Care Team Member

Edit

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  - 115100033042017

Edit
Primary Care Physician
Work: Edit

Contacts

Edit
Primary Contact
Home: Edit
Alternate: Edit
Work: Edit

Edit
Medical Power of Attorney

Edit
Financial Power of Attorney

Financial

Payment Source(s)

MEDICARE PART A

MEDICARE PART A

Attribution Plan(s)

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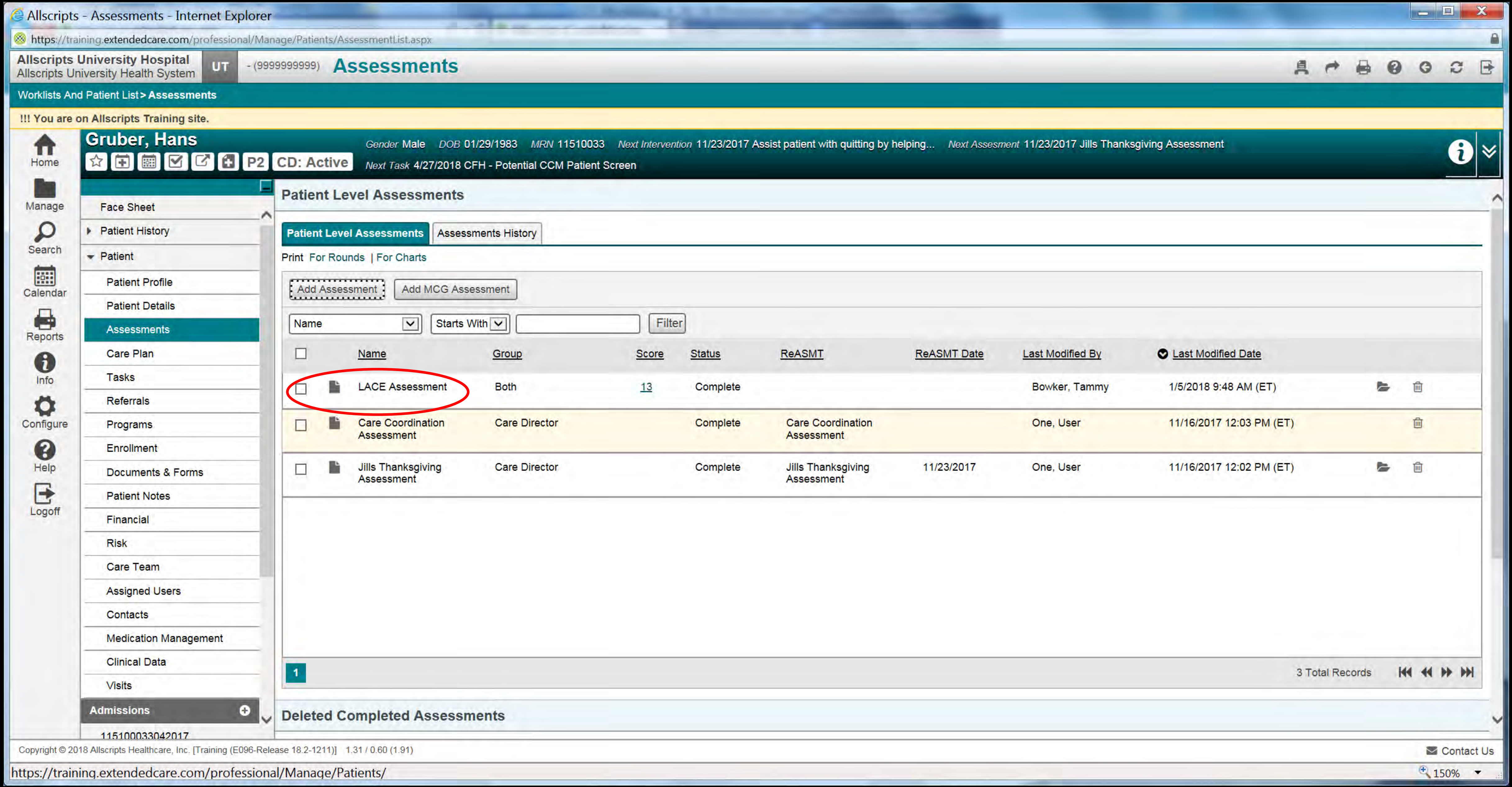
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Patient Level Assessments
Assessments History
Print For Rounds | For Charts
Add Assessment
Add MCG Assessment
Name
Starts With
Filter
Name
Group
Score
Status
ReASMT
ReASMT Date
Last Modified By
Last Modified Date
LACE Assessment
Both
13
Complete
Bowker, Tammy
1/5/2018 9:48 AM (ET)
Care Coordination Assessment
Care Director
Complete
Care Coordination Assessment
One, User
11/16/2017 12:03 PM (ET)
Jills Thanksgiving Assessment
Care Director
Complete
Jills Thanksgiving Assessment
11/23/2017
One, User
11/16/2017 12:02 PM (ET)
1
3 Total Records
Deleted Completed Assessments
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  - Visits
- **Admissions**
  - 115100033042017

Care Plan: Pre-CTI Enrollment Care Plan Template Info

Care Team Notes

+ Show Care Team Notes

Care Plan Search

+ Show Care Plan Search

Print: Care Plan | Activity Notes

***In the patient-friendly view, the clinical name is displayed where no patient-friendly name exists.**

Expand All | Collapse All | Add Problem | Add Care Plan Template | Add Activity Note | Add Barrier | Share | Update Care Plan | Update Rank | Refresh

Show Inactive | Show Complete | Show Activity Notes Only | Show Barriers | Show Patient Friendly Version

Hierarchy	Name	Owner	Due Date	Outcome	Actual End Dat	View	Notes	Barrier	Add	Edit
Problem	**CTI-Eligible Event**									
Goal	Client will complete Pre-CTI Assessment	Gruber, Hans								
Intervention	Client will meet with CTI CM	Two, User								
Intervention	Core Comprehensive Standard Assessment	Two, User								

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Notwell, Ima Gender Female DOB 05/27/1930 MRN 14400050112017

P1 CD: Active

- Face Sheet
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  - Patient Profile
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  - Visits
- Admissions
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Comments/Notes:

Document Type: --Nothing Selected--

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Forms --Select--

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Care Director DOH Form	Form	.pdf	Two, User	4/26/2018 2:05 PM (ET)

1 — 1 Total Record

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Evaluation: Process Improvements

- Efficiency
  - Introductions (staff turnover/new representatives)
- Plenty of notice of the cases scheduled for discussion
- Everyone MUST come prepared
- Ensuring the meeting isn't dominated by discussion of one case
- Structure for follow-up and accountability
  - Consistent communication between/after meetings
    - Still phone, most often
    - Email limited by PHI/security risk
    - Beta-testing shared care plan

Evaluation: Challenges to Value

- Time on clients that aren't "mine"
- Poor audio when members call in
- Coordination of agenda, including:
  - Meeting Facilitator
  - Plan/template for presentation
  - More equitable allotment of time for discussion of each case
  - More accountability and follow-up of cases in future meetings

Evaluation – Values/Benefits

COLLABORATION

- Real-time, multi-agency group interaction on solutions/resources - efficiency
- Collaboratively develop and align care plans that result in closing gaps and improving outcomes
- Identifying resources – no one is alone in this
- Learning about partner agency operations

NETWORKING

- Building my network of providers
- Helping me see the big picture and how the pieces fit together
- Opportunity to network with other providers and gather and give information.

MORE COMPLETE PICTURE OF CLIENT

- Putting pieces of the puzzle together, including behavior patterns.

Evaluation: Outcomes Tracking

<u>Patient</u>:
- Decreased Vulnerability/Risk
- Improved quality of life:
  - Recovery
  - Mental health stabilization
  - Reduced homelessness
  - Re-entry to workforce
  - Re-connection with family
  - Achievement of feelings of self-worth and respect
- Linkages to:
  - Primary care physicians, psychiatrists, specialists, etc.
  - Housing & Community Services
  - Appropriate outpatient services

ENGAGEMENT

<u>Collaborative</u>:
- Improved patient care
- Improved agency-specific care plans
- Improved inter-agency communication and relationships

<u>Community/Social:</u>
- Prevention and Response Infrastructure
- Increase in safety to all
- Reduction in Medicaid & Medicare costs
- Increased community capital

EFFECTIVENESS

Value-Based Payments Require Valuing What Matters to Patients

Valuing What Matters to Patients Requires Knowing What Matters To Patients

Knowing What Matters to Patients Requires Knowing Patients

The Next Best Thing To Knowing Patients is Knowing the Other People That Know Patients