The Community Care Team: A Model for Systems Alignment

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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?
...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

## Social Determinants of Health

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

**Health Outcomes**

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Ingredients in Care Coordination?

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

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

3. **Access and Follow-up**: 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).

1. Appointment scheduling and follow-up
2. Health education
3. Patient navigation
4. Care management
5. Medication management
6. Transition support
7. Referrals
8. Self-management support
9. Identifying Culturally competent and linguistically appropriate care
10. Transportation assistance
11. Translation services
12. Community outreach
13. Program eligibility and enrollment assistance
14. Linkages to other community-based or social services
Who Pays for Care Coordination?
✓ CPT Codes
✓ Bundled Payments
✓ PMPM
✓ Grants
✓ Someone Else
✓ No One

Care Experience Coordination

How coordinated is the care experience for your organization’s patients between the inpatient setting, post-acute setting, and home environment?

Sample size = 375

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
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

<table>
<thead>
<tr>
<th>Care Models</th>
<th>Little/No Accountability for Quality and Cost Outcomes</th>
<th>Significant Accountability for Quality and Cost Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS Only</td>
<td>Made to individual PCP; fixed $ amount</td>
<td>Made to entity; $ based on savings</td>
</tr>
<tr>
<td>PCC</td>
<td>Possible bonus pool</td>
<td>Population-focused</td>
</tr>
<tr>
<td>PCCM Plus PAP</td>
<td>Individual Service-Focused</td>
<td></td>
</tr>
<tr>
<td>PCMH</td>
<td>Made to individual providers or ent. upfront $, savings &amp; FFS</td>
<td>$10-service, $10-quality/savings</td>
</tr>
<tr>
<td>PCMH + Health Home</td>
<td>Clinical processes and new benchmarks</td>
<td></td>
</tr>
<tr>
<td>Network of PCMH</td>
<td>Process measures indicate improved care in future, yield data collection for policy development and baseline</td>
<td></td>
</tr>
<tr>
<td>ACOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive ACOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other ICMs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full ICMs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Measurement:
- Data capturing & sharing
- Improved clinical processes
- Improved outcomes (costs down, patient experience up)

Payment:
- $15-service, $5-quality
- $5-service, $5-quality/savings
- $10-service, $10-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 CCs

Source: Centers for Medicare & Medicaid Services (CMS)
An Incremental Approach To Shared Care Planning

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

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”

Operational Complexity

Medium High

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
<table>
<thead>
<tr>
<th>Access to care</th>
<th>Evaluation</th>
<th>Diagnostic</th>
<th>Care plan/education</th>
<th>Post care/ follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrive to ER/urgent care center</td>
<td>Provider can view electronic patient record</td>
<td>Provider submits imaging, lab, consult orders</td>
<td>Based on confirmed diagnosis, provider provides a care plan</td>
<td>Patient leaves with instructions and understands next steps</td>
</tr>
<tr>
<td>Facility triages and determines severity</td>
<td>ER physician/nurse performs evaluation</td>
<td>Interdepartmental team involved in completing orders</td>
<td>Education is provided and transition of care is initiated</td>
<td></td>
</tr>
</tbody>
</table>

**The Care Team May Include**

| ER or urgent care physician, nurse or associate care provider, triage provider, registration | ER or urgent care physician, nurse, or associate care provider, clinical informatics | Radiology, laboratory, specialty care consultants or interdisciplinary care team | ER or hospital provider, social worker, or interdisciplinary care team | Primary care provider, specialty care provider, case worker, social worker, financial assistance |

Source: Michael Marzoug, Management Consultant
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
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.
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
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
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)

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

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

**Other Organizations:**
- 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
<table>
<thead>
<tr>
<th>Vendor Name &amp; Location</th>
<th>Vendor eligible?</th>
<th>Program Cost</th>
<th>Program Availability</th>
<th>Residential or Day only options?</th>
<th>Wrap Around needed? (PT/OT/Speech/Nsg)</th>
<th>Available Wrap Around vendors?</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Supported Apt): Newmarket</td>
<td>Yes</td>
<td>Yes: immediate</td>
<td>Residential</td>
<td>Yes</td>
<td></td>
<td>Rockingham VNA Cornerstone VNA Maxim Wentworth Homecare Personal Touch (LNA?)</td>
<td></td>
</tr>
<tr>
<td>(Supported Apartment): Lyme</td>
<td>Yes</td>
<td>Yes: pending</td>
<td>Residential</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evergreen Center : Milford Mass <a href="https://www.evergreenctr.org/">https://www.evergreenctr.org/</a></td>
<td>Unknown</td>
<td>Unknown</td>
<td>Residential &amp; Day</td>
<td>LNA @ home if @ day program</td>
<td>see previous local list for Nmkt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melmark New England: Andover Mass <a href="http://www.melmarkne.org/admissions-process-1">http://www.melmarkne.org/admissions-process-1</a></td>
<td>Unknown</td>
<td>Unknown</td>
<td>Residential &amp; Day</td>
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**TEAM:**

- **XXX & XXX’s Mom Captains**: Identify goals and priorities for Care. Explore, consider, and evaluate 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 tijennison@co.strafford.nh.us msillari14@gmail.com
- **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**

- **Priority 1**: Request assessments & services for short-term In-Home supports for XXX via Dr. Turner’s office (PT/OT/Speech/LNA) Tory/IDN
- **Priority 2**: Assess eligibility, 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

**LEADING the STEP**

- **Priority 1**: Request assessments & services for short-term In-Home supports for XXX via Dr. Turner’s office (PT/OT/Speech/LNA) Tory/IDN
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- **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
Consent Date: 11/16/2017

Risk: LACE Assessment: 13.00
Fall Risk: 8.00/High

Primary Assigned Care Coordinator

Primary Care Team Member
## Patient Level Assessments

### LACE Assessment
- **Group:** Both
- **Score:** 12
- **Status:** Complete
- **ResAFT:** Bowker, Tammy
- **ResAFT Date:** 11/23/2017 9:48 AM (ET)
- **Last Modified By:** Bowker, Tammy
- **Last Modified Date:** 11/23/2017

### Care Coordination Assessment
- **Group:** Care Director
- **Score:** Complete
- **ResAFT:** One, User
- **ResAFT Date:** 11/16/2017 12:02 AM (ET)
- **Last Modified By:** One, User
- **Last Modified Date:** 11/16/2017
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

**Patient:**
- 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

**Collaborative:**
- Improved patient care
- Improved agency-specific care plans
- Improved inter-agency communication and relationships

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