



**SAMHSA-HRSA
Center for Integrated
Health Solutions**

Who is Responsible for Care Coordination

Elizabeth Whitney and Sue Pickett
June 18, 2015

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FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

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**Slides for today's webinar are
available on the CIHS website at:**

www.Integration.samhsa.gov
under About Us/Innovation Communities

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Today's Purpose

- Welcome
- Presentations:
 - AspenPointe
 - Mirror
 - Meridian Health Services
- Next Steps

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ASPEN POINTE™

Integrated Care Coordination

Robin Anderson, Program Manager
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Who we are

- AspenPointe has been providing behavioral health services for over 125 years in Colorado Springs, CO area and surrounding counties
 - Majority of our clients have Medicaid
 - Provide an array of services providing for the “whole person”
- 

What We Do

- Outpatient therapy - adult, child and family, psychiatric
 - Crisis stabilization and in-patient services
 - Substance Use treatment and recovery support
 - Care coordination for children and their families, in partnership with the Dept. of Human Services
 - Career and Educational services
 - Health Coaching and Chronic Disease Management
 - On-site physical health care alongside behavioral health care in partnership with FQHC
 - Behavioral Health Consultants housed at primary care practices
- 

The Need

- Care coordination has been a part of the role of all service providers in the organization
 - There was not a centralized process or expectation for care coordination
 - Clients didn't know who to call with questions or concerns
 - Communication between providers, internal and external, was limited
 - comprised of occasional emails, phone calls or chart reviews
- 

The Goal

To facilitate an integrated approach to client care:

- Define the role of care coordination and processes that lead to effective and efficient care
 - Provide a point of contact for clients
 - build a trusting relationship – reduce no-show rate
 - Facilitate communication between internal and external client health care providers
 - to create a shared understanding of client goals, to better understand client needs
- 

The Plan

- Phase I
 - Develop role, duties and responsibilities
 - Develop training
 - Hire up to 25 Integrated Care Coordinators by end of FY 2015-16
 - Five current, six more hired by mid July
 - Begin developing care teams at all sites
 - Track outcomes, assess and make needed changes
- Phase II
 - Determine case load size, performance metrics
 - Evaluate how many INTCCs will be needed to extend this support to all clients
 - Plan for sustainability

Continually assess – Is this making a difference?



Integrated Care Coordinator Role

- Create the relationship with the client
 - The main contact for clients, regardless of type or number of services they are receiving
 - Maintain the chart and all updates needed
 - Responsible for making sure all providers are communicating with each other
 - Are connecting with client care coordinators from other provider organizations
 - Many orgs have care coordinators – coordinators must coordinate with each other!
 - Continually assess for barriers to care & client needs and refer to services when needed
- 

Challenges

- Culture change
 - The clinician is no longer the “holder of the chart”
 - Understanding the difference between case management, client advocacy, other client supportive services and care coordination
 - Introducing the Care Team model
 - Keeping the care coordinators “in the right lane”
 - Helping others understand this new role

Intended Outcomes

Care coordinators :

- **Will initiate contact at the beginning of services to build relationship**
 - Measurement: documentation of care coordinator contact with the client w/in 2 days of intake & will have a minimum of one additional contact within first 30 days
- **Will communicate consistently with internal and external service providers to coordinate care**
 - Measurement: documentation of care coordination efforts with internal providers at least once per month and primary care physicians at least once every 2 months

Client:

- **Will be more engaged in treatment**
 - Measurement: comparison of no show rates of clients who have a care coordinator and those who do not
- **Will be satisfied with services and the level of communication by care coordinators and the treatment team**
 - Measurement: client satisfaction survey
- **Will maintain or improve their level of functioning as a result in engaging in care coordination services**
 - Measurement: Pre and posttest scores using the SF12 and PHQ9

Intended Outcomes

Internal provider:

- **Will be satisfied with services and the level of communication by care coordinators**
 - Measurement: satisfaction survey
- **Will increase the number of hours available to provide treatment**
 - no longer have care coordination responsibilities
 - No longer responsible for maintaining the chart
 - Measurement: comparing provider billable hours, before and after care coordination begins

External providers:

- **Will know who to contact when their patients have needs that are outside of their scope of work**
 - Measurement: satisfaction survey



Questions?

Robin Anderson, Program Manager

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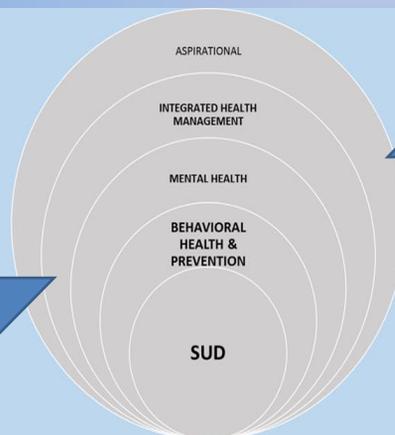
MIRROR 2020

Mirror makes a difference for more people, families, and communities through comprehensive, integrated health and wellness approaches.

MIRROR
2020

What does “integrated health and wellness” mean?

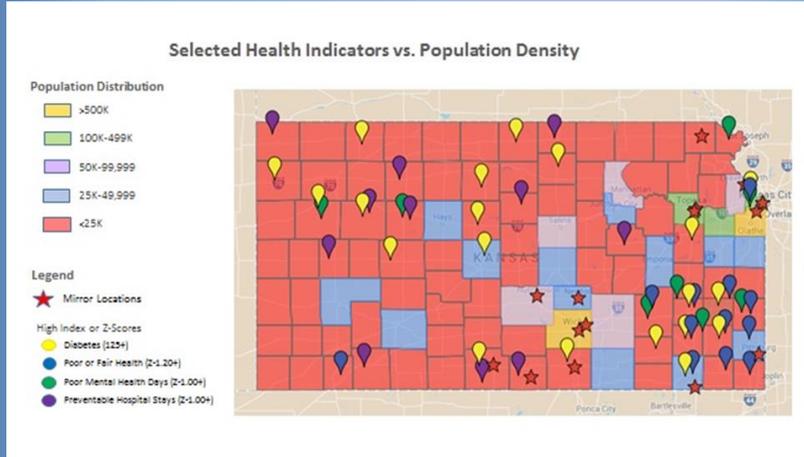
Policy and competitive forces push against and eclipse narrowly defined players



Integration is relevant and builds defensible strategic position

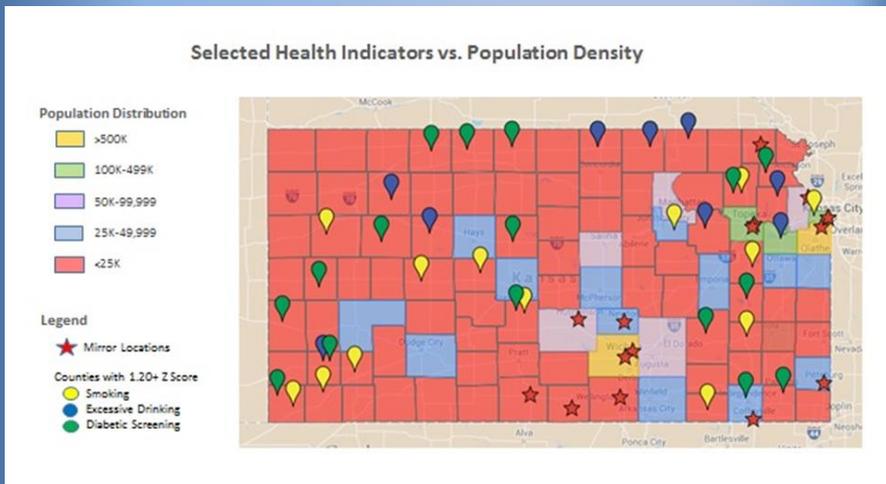
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Mirror MUST make a difference for more people, families and communities...



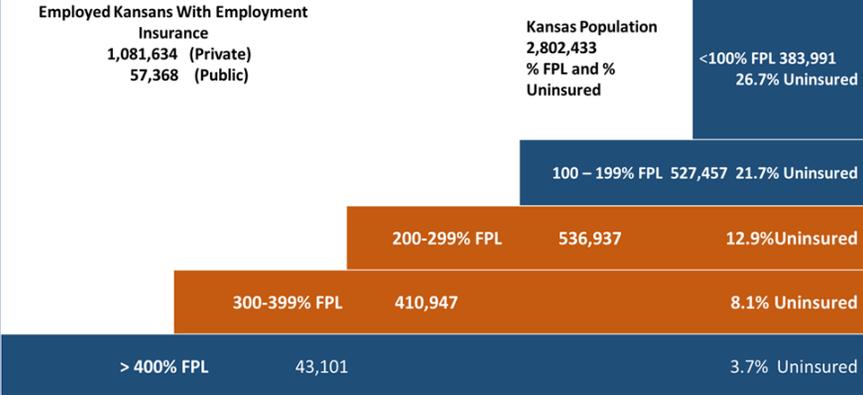
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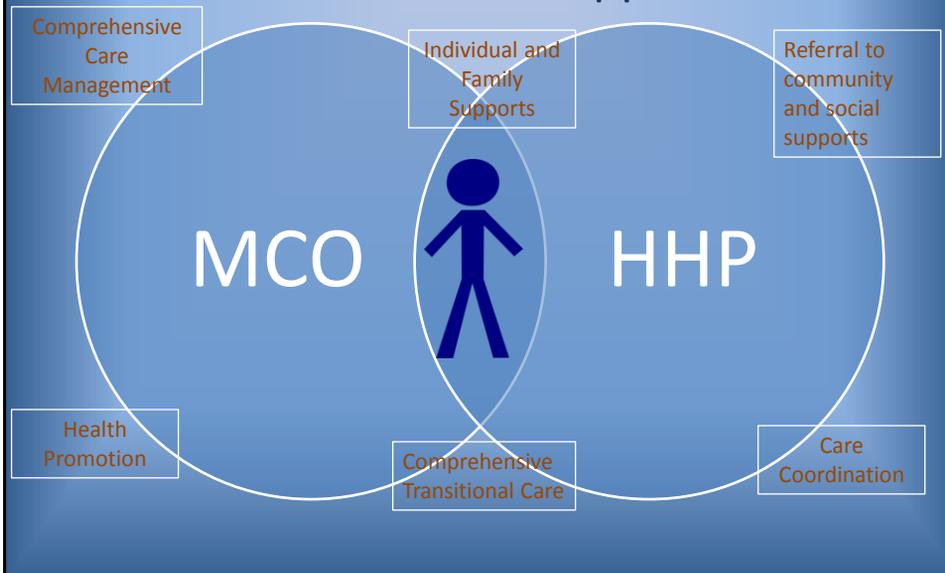


How Many More?

Proforma Perspective: Socio-Economic

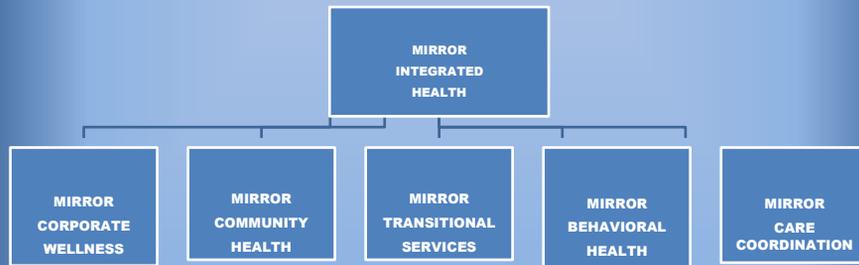


...through comprehensive, integrated health and wellness approaches.



MIRROR
2020

Brand Architecture and Organizational Drivers



MIRROR
2020

Blue Print for Change

1. Integrated Outcomes-Based Delivery Model
2. Service & Product Development
3. Brand, Marketing, & Business Development
4. Strengths Assessment and GAP Analysis
5. Leadership Development
6. Organization Development
7. Technology Drivers
8. Quality & Accreditation
9. Workforce
10. Financial
11. Board Development

MIRROR
2020

New Brand Identity



Mirror

Integrated Health

A whole new outlook on life

Care Coordination

SAMHSA Innovation Community

Maria Vail, LCSW
Practice Supervisor



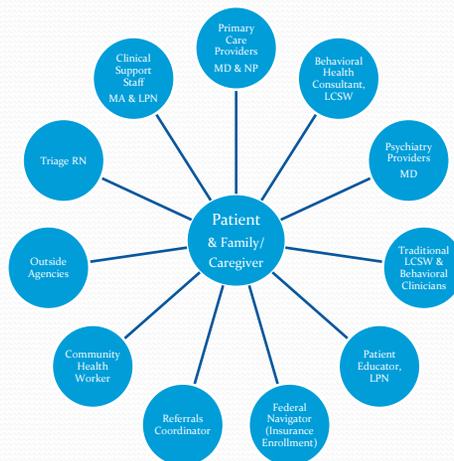
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HEALTH Services
Physical. Mental. Social Well-Being.

Meridian Health Services

- FQHC
- Integrated Care Model
- PCMH Level 2



Members of Our Team



The “C’s” of Care Coordination

- **Continuity**-Patient Selects Primary Care Provider
 - Scheduling
- **Communication** -Daily Care Team Huddles
- **Collaboration**- Monthly Meetings
 - Providers
 - All Staff
 - Interdisciplinary Care Team



Current Information

- IHIE
- CHIRP
- Lab Interface with EMR
- Obtaining Records from Outside Providers



Welcome back to Meridian Health Services Primary Care. To ensure we are addressing all your health needs, please complete the following information regarding your visit today.

Name: _____

What is your reason for visit today? _____

What medications are you currently taking? _____

What is your current pharmacy? _____

Have you seen another provider for your medical needs since we last saw you? **YES NO**
If yes, please list who and why: _____

Have you had any labs done since the last time we saw you? **YES NO**
If yes, please list what and where: _____

Were you recently hospitalized? **YES NO**
If yes, please explain why and where: _____

Do you have any allergies? **YES NO** If yes, please describe: _____

Do you smoke? **YES NO** If yes, how many packs a day: _____

Do you have a history of falling? **YES NO**

Self Management Goals

Date of Service: _____ Patient Name: _____ Date of Birth: _____

Meridian Health Services
Self-Management Goals

I, _____ have agreed that to improve my health I will do my part of the following goal(s):

      	I Will: (choose 1 goal) • Do something good for myself • Increase my physical activity • Cut down or stop smoking • Improve my food choices • Enhance my spiritual well-being • Reduce my stress level • Take these steps to better manage my health: See an eye specialist See a foot specialist See a dentist Attend Chiropractic Take Medications more consistently Follow up with PCP as indicated	1.) Describe it: How: _____ Where: _____ When: _____ What: _____ Frequency: _____ 2.) Barriers (What might get in the way): _____ _____ 3.) Plans to overcome the barriers (What could you do to handle the barriers?): _____ _____ 4.) On a scale of 1-10 (if other is less than 6, state one): Importance level: _____ Confidence level: _____ 5.) Follow up (Who are you going to talk to about the plan and when?): _____ _____
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Patient Signature: _____ Date: _____
 Clinician Signature: _____ Date: _____

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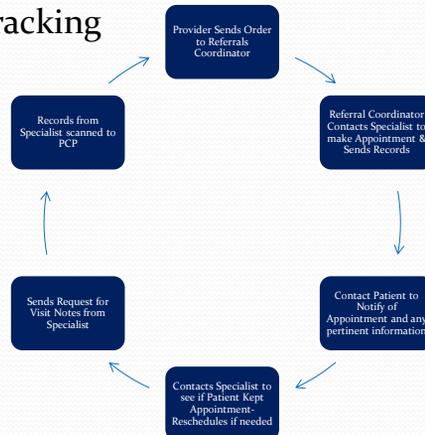
Internal Referrals

- Warm Hand-Off to BHC
- Outpatient LCSW
- Case Management
- Tele-Psychiatry
- Patient Education

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HEALTH Services

External Referrals

- Full-Time Referral Coordinator
- Referral Tracking



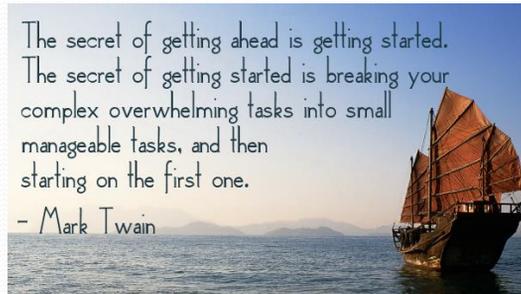
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Challenges

- Use of 2 Electronic Health Records
- Rural Areas- Shortage of Psychiatry & Specialists
- Maintaining Continuity Amidst Staff Turnover

The secret of getting ahead is getting started.
The secret of getting started is breaking your complex overwhelming tasks into small manageable tasks, and then starting on the first one.

- Mark Twain



MERIDIAN
HEALTH Services

Patient Story



SUCCESS
Because you too can own this face of pure accomplishment



Questions?

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Coming Attractions

Small group coaching calls

- June
- **July 7, 2015 – new date**

Progress Reports and Feedback

- One-page summary of progress and lessons learned
- Summary and discussion in August webinar

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What to Expect

- January / February**
 - Further exploration of definitions and components of care coordination
 - Complete self-assessment
 - Review assessment results for use in work plans
 - Create work plan for change process with coaching calls to refine work plans
- March - June**
 - Implement work plans / PDSA cycle
 - Focus topics based on needs of the group
 - Team presentations
 - Small group coaching call
- July - September**
 - Focus topics based on needs of the group
 - Sustainability strategies and lessons learned from the field
 - Small group coaching call
 - Curated materials for dissemination in September

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Next Steps

Visit **LinkedIn** group

Next scheduled webinar:
July 16, 2015 1-2 pm EST

Small Group Coaching Calls
July 7, 2015, 1 – 2 pm ET

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