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CENTER for INTEGRATED
HEALTH SOLUTIONS

**Who is Responsible for
Care Coordination:
Lessons Learned**

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Defining Care Coordination

Deliberately organizing patient care activities and ***sharing information*** among all of the participants concerned with a patient's care to achieve safer and more effective care. The ***patient's needs and preferences*** are known ahead of time and ***communicated at the right time to the right people***, and this information is used to ***provide safe, appropriate, and effective care*** to the patient.

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

What is Included in Care Coordination?

Care coordination **can be:**

- A distinct role (Care Coordinator, Health Navigator, etc.) or shared by a team (Team Care Model)
- Focused across services / care system to connect all service types throughout an episode of care, or focused on specific time points in care episode (such as CC for referrals, or Transition Care Model)
- Provided to all clients or targeted to specific groups (example, “high utilizers”)

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What is Included in Care Coordination?

Care coordination **includes the creation of partnerships:**

- Within organizations and systems of care (example, ensuring that different programs and services know what each provides, how to refer and communicate with each other, establish accountability, etc.)
- Between organizations, providers, payors, state and county agencies, etc.

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- Care coordination often helps to bring together traditional health and behavioral health services and home and community-based services and social services to address whole person needs
- Effective care coordination is driven by and attends to the identified needs of clients and families who use the services

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Care Coordination Innovation Community Goals

- Adopt common definition and understanding of care coordination
- Assess organizational readiness
- Identify gaps
- Clarify existing strengths
- Develop and implement change process work plan

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Summary Learnings

Gathered from:

- Work Plans
- Small group calls
- Webinars
- Evaluations

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Work Plans

Each participating organization submitted a work plan laying out their goals, action steps, and perceived barriers



Example goals:

- Enhance Care Team Coordination by having efficient communication mechanisms and clear expectations among team
- Assess training needs to staff. Develop training plan
- Identify process measures to assess effectiveness of above activities.

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Work Plan Feedback

Thinking carefully about a plan revealed the need to do more foundational work at the organization to prepare for planned changes

Taking time to work on the plan as an implementation team over time allowed time to identify and work on logistical issues and address culture change required for innovation

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Discussion

Work plan status?



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THEMES

Strategies, Challenges & Examples

- Workforce
- Collaboration
- Technology
- Access to Services
- Process and Workflow



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Workforce – Barriers/Challenges

- Need for additional, specially trained staff person to implement new service (ex/ on-site nurse coordinator for telemedicine service)
- Turnover on the implementation team
- Training needs and challenges
- Need for service has grown faster than ability to keep up with it with current funding/staffing levels
- Training needed across all staff types; important to get staff input on training materials and resources

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Workforce Breakthroughs/Learnings

Developed Workforce Development Innovation Team of direct care professionals, charged with making recommendations to senior leadership on:
caseload, training, morale, culture, technology – develop Internal groups/processes for keeping program alive

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Collaboration

Barriers- Making time for providers to meet to collaborate

- Difficulty in effectively sharing updates in consumer health issues and care plans in real time

Breakthrough- Face to face meetings (case conferences, team meetings) leads to better and more efficient care; reduce redundancy



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Technology

- Technology and EHR challenges to adapt to new service
- Need to adapt IT systems to address new care coordination approaches



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Access to Services

Barrier-

- Need to orient consumers of services to the new service; how it work; how it will benefit them

Breakthrough-

- Allows people to get service (such as access to psychiatry) that was not available to them before
- Consumers love having a single “go-to” person to help them navigate services

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Process and Workflow



- Holding providers accountable; changing staff behaviors to be in line with new policies and practices
- Systemic and regulatory barriers
- Need to change many processes within agency (referral, intake, team assignment, urgent care)
- Need to update existing policies and procedures to reflect new approaches

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Advice for Colleagues

Planning

- Identify the scope of your project/service system
- Clearly define target population and how will identify consumers within your system who are part of the population
- Clearly understand capabilities of your EHR system and develop tools to help with population management as well as data capture for feedback mechanisms
- Think of the consumer *experience* when designing your program

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Advice for Colleagues

Staffing

- Hire people with positive attitudes who can accomplish new tasks despite barriers
- Clearly define roles and responsibilities
- Form a steering committee for your change that is representative of all staff who facilitate and provide different services; incorporate management and front-line staff

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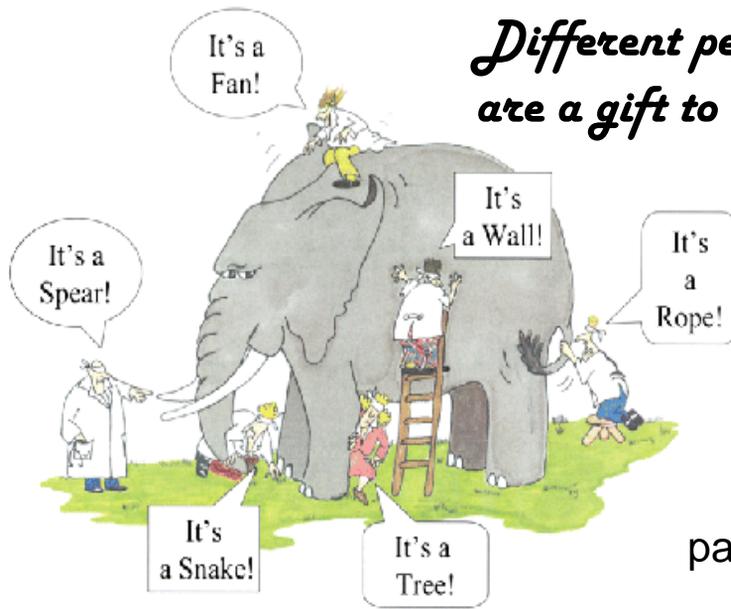
Advice for Colleagues



Evaluation and Assessment

- Establish a baseline of your system; evaluate your organization and your plans carefully
- Assess efficiency and effectiveness as you go along
- Elicit feedback from multiple sources (providers, collaborators, administrators, consumers) on how the service can be improved

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*Different perspectives
are a gift to innovation*

Thank
YOU
for
participating!

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Keep in Touch!

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