



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

Who is Responsible for Care Coordination

Elizabeth Whitney and Patrick Gauthier

March 19, 2015



SAMHSA-HRSA Center for Integrated Health Solutions

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

www.Integration.samhsa.gov

under About Us/Innovation Communities

Today's Purpose

- Welcome
- Participating Organization Introductions
- Models of Care Coordination
- Implementation Challenges and Strategies
- Next Steps

Introducing...

| | | |
|--|----|--|
| LSF Health Systems | FL |  |
| Meridian Health Services | IN |  |
| Mirror Inc. | KS |  |
| New York City Health and Hospitals Corporation | NY |  |
| Partnership Health Center | MT |  |



Small group coaching calls

- April
- June
- August

Presentations by participating organizations – May and June

- Project plans
- Progress and early lessons learned

Care Coordination:

Common Challenges to Implementation and the Strategies to Overcome Them

**Patrick Gauthier, Director
AHP Healthcare Solutions**

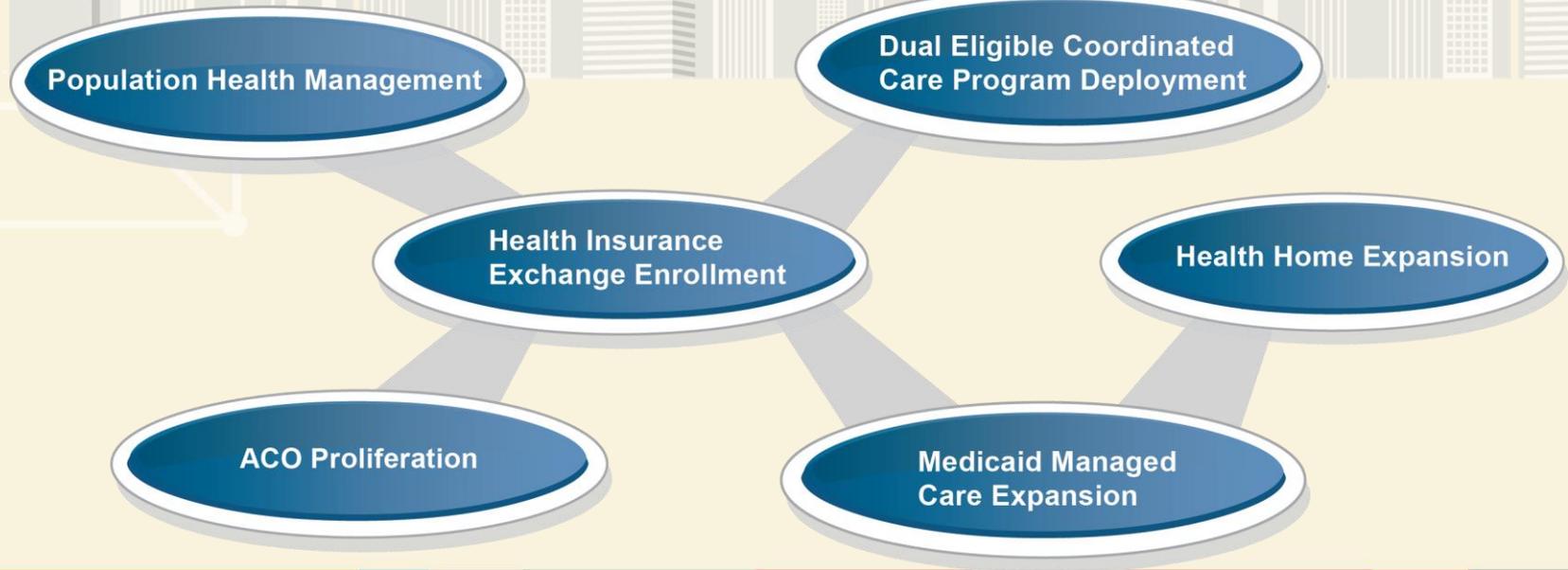
Patrick Gauthier



DRIVERS



Care Coordination Paradigm

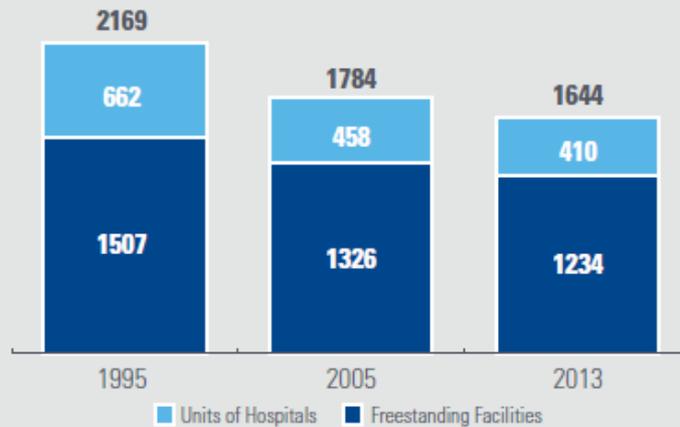


Why Coordinate Care?

Decreasing resources for behavioral health care have led more patients to turn to the ED for care.

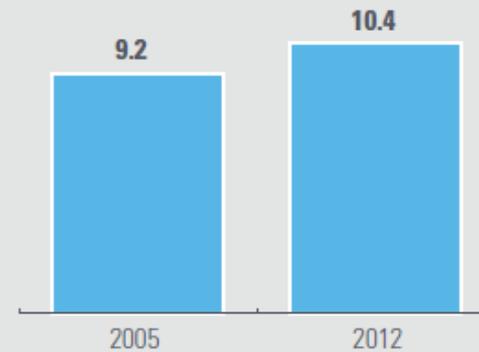
Chart 2

Inpatient Psychiatric Facilities,
1995 – 2013



Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2013.

Behavioral Health-related
Emergency Department Visits in Millions,
2005 – 2012



Source: Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample (20%), 2005 and 2012.



1. Prevalence, Incidence and Epidemiology of Disease

Multiple Chronic Conditions

- a. Diabetes
- b. Obesity
- c. Heart Disease
- d. COPD
- e. SUD/SMI

2. Systems of Care

Consolidation and Integration

- a. M&A
- b. Integrated Systems of Care
- c. De-Institutionalization (Hospital and Prison)
- d. Outpatient Services Emphasized

Communities

People

Providers

Coordination of Care (Case Mgmt.)

- a. Improved Patient Experience (QA)
- b. Population Health Mgmt. (Outcomes)
- c. Decreased Cost via Appropriate Care
- d. Home, School and Community-Based

4. Quality & Outcomes

3. Reimbursement

Global + Value-based Payments

- a. Medicare Shared Savings
- c. Pay-for-Performance
- c. Capitation

The Population Health Management Framework for Care Coordination



Source: Adapted from Frieden, Thomas R., "A framework for public health action: The Health Impact Pyramid." *American Journal of Public Health* 100, no. 4 (2010).

CARE COORDINATION TODAY

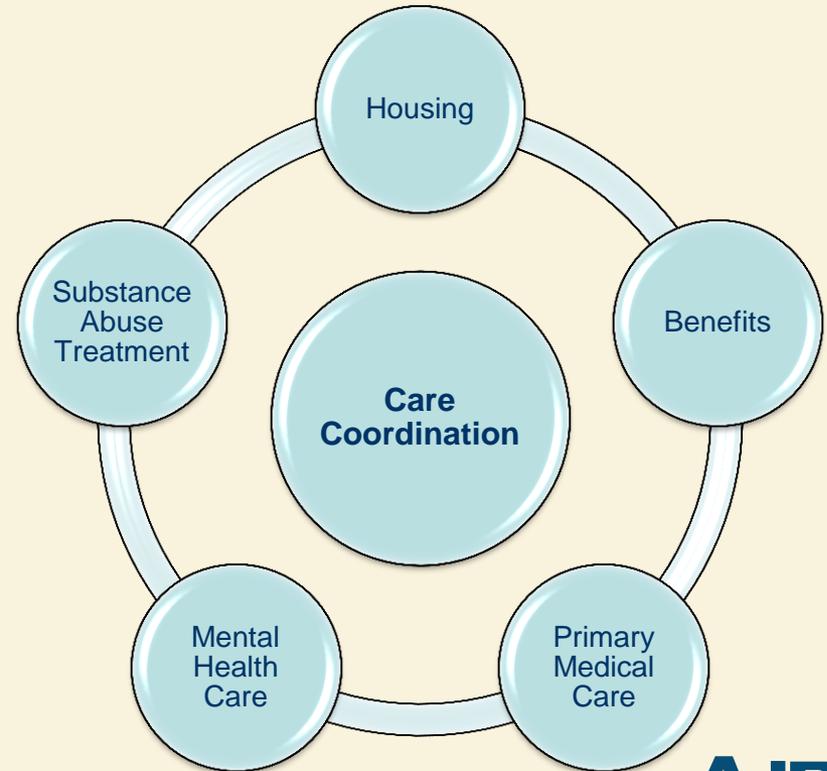


Comparing Paradigms

Goal-Oriented, Referral-Based



Quality of Life and Wellbeing Orientation, Collaboration-Based



Old Paradigm

**Managed Care
Organization
Case Manager**
(RN, LCSW)

**Hospital
Case Manager**
(RN)

Case Worker
(MSW)

**Behavioral
Health Case
Manager /
Provider**
(MHP)

- *Multiple perspectives, motives and intentions*
- *Differing roles and responsibilities*
- *Fragmented plans, teams and records*
- *Referral based*
- *Poor engagement and retention (follow-through)*
- *“Blame the client for not showing up”*



New Paradigm

Integrated Delivery System: ACO, PCMH, Health Home

**Medical
Manager**
(RN, PCP)

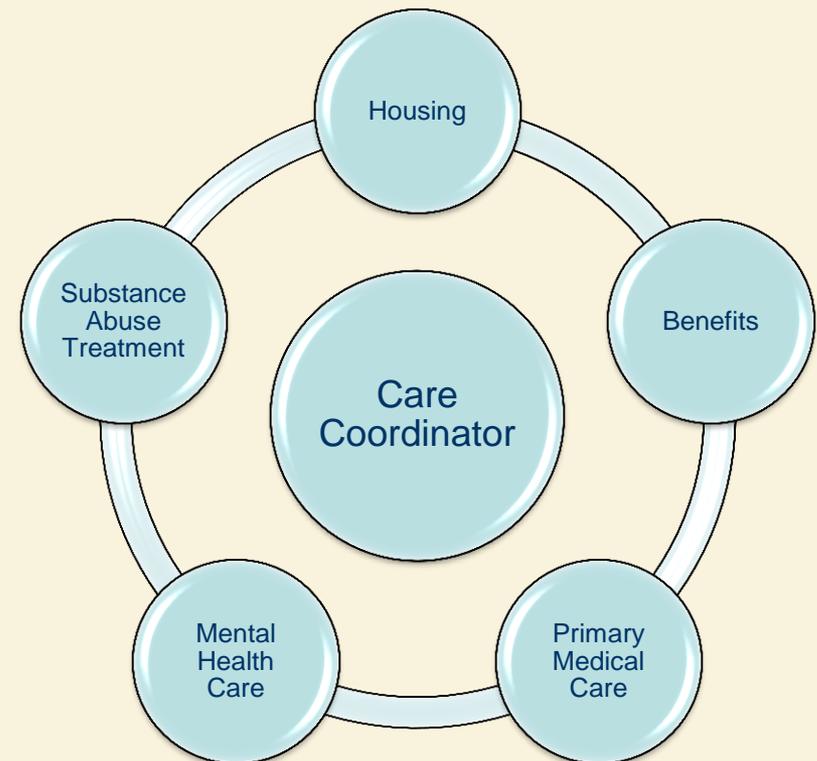
**Care
Coordinator**
(RN, LCSW,
MSW)

Care coordination involves 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. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.



Care Coordination in the New Paradigm

1. Addresses safe housing, health, behavioral health, socio-economic and other barriers to wellbeing
2. Integrated and co-located care/service teams
3. Multi-disciplinary, individualized plans of care and service
4. Multi-disciplinary teaming, communications, and shared performance measures
5. Treats multiple conditions simultaneously



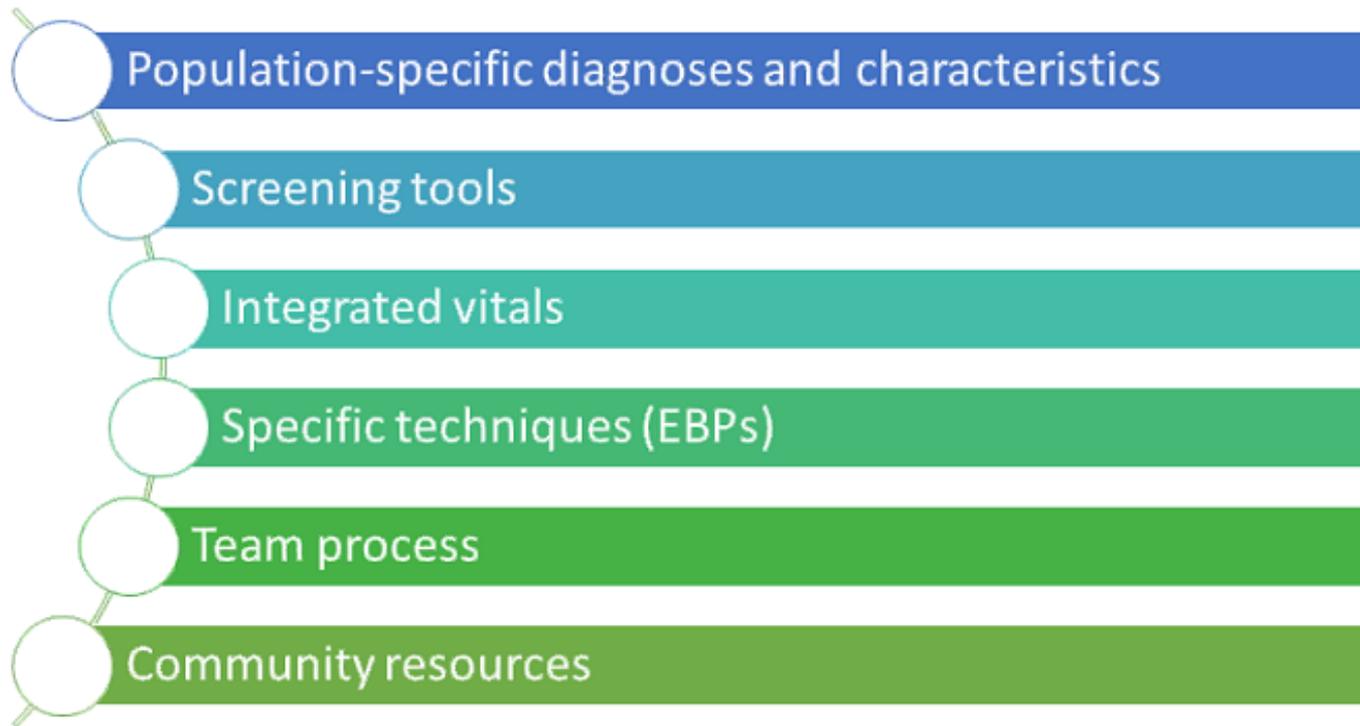
Care Coordination

- To proactively identify members who have multiple or complex medical and/or psychosocial needs** or who are at risk of developing complex needs during an acute episode of illness
- To provide early intervention** for members appropriate for care coordination
- To support the clinical staff** focus on the delivery of medical care that maximizes quality of life and ensures that the care is provided in the most appropriate and supportive setting
- To facilitate communication** among the member, their families, health care providers, the community and the health plan in an effort to enhance cooperation while planning for and meeting the health care needs of the member
- To serve as a liaison** between community resources to supplement services not covered by the benefit plan
- To allocate resources** and maximize the available benefits

Care Coordination

- To increase member and provider satisfaction** through the coordination and management of health care resources
- To assist** in the development and communication of the member's self-management plan
- To function as an educator** of all stakeholders including the health care team and the community regarding the care coordination process and specific health care issues
- To partner** with the member and family in assisting them to reach maximum achievable health and quality of life potential and maximum independence
- To serve as an advocate** for the member and family

What is Multi-Disciplinary Care Coordination?





CHALLENGES



Challenges

1. Infrastructure development costs, time and human resource capacity
2. Identifying and selecting a model or protocol (1 or more)
3. Identifying a securing market and funding/revenue sufficient for sustainability and return-on-investment
4. Integrating behavioral health and social services with medical and primary care providers
 - a. Reimbursement
 - b. Communications
 - c. Speed
 - d. Collegiality and respect
 - e. Culture

STRATEGIES



Strategy #1

Infrastructure Development

Time

Expertise

Workforce

Capital

Facilities, hardware, software,
vehicles, etc.

Making the strategic decision and commitment to invest human and other resources requires:

- market research
- a business model
- a financial business case
- Leadership and vision
- a plan of action
- oversight and accountability

Strategy #1

Infrastructure Development

| Challenge | Tactic | Notes |
|---|---|-------|
| Time | <ul style="list-style-type: none"> • Delegate secure and stable business to capable teammates • Invest in a plan first, then execute • Outsource anything that is not core to mission • Partner with trusted peers | |
| Expertise | <ul style="list-style-type: none"> • Partner with those who have it • Engage a consultant on basis of a defined scope of work • Engage new staff and/or interns, recruiting for expertise you need • Market research may turn up low-cost technical assistance in surprising places | |
| Workforce | <ul style="list-style-type: none"> • Don't begin with assumptions. Let market research and product development – even contracting – indicate workforce needs. Be patient | |
| Capital | <ul style="list-style-type: none"> • Foundation grants • Social Impact Bonds • Partnerships and affiliations | |
| Facilities and other Physical Assets | <ul style="list-style-type: none"> • Don't begin with assumptions. Let market research and product development indicate needs | |

Strategy #2

Identify and Select Models

- *Naylor Transitional Care Model*
- *Coleman Model - Care Transitions Intervention (CTI)*
- *Targeted Case Management (TCM)*
- *Complex Case Management*
- *DIAMOND/Impact*

Others:

- *Psych Consult*
- *Models specific to population (age, gender, race, conditions, CJ system involvement, socioeconomic conditions, etc.)*

Strategy #2

Identify and Select Models

Common Elements:

- Engaged Primary Provider
- Interdisciplinary Teams (RN, PCP, MHP)
- Health Coaches
- Peer Support Specialists
- Red Flags (clinical alerts)
- Information Exchange
- Personal Health Records
- Medication Adherence
- Self-Management (patient and family education)

Strategy #2

Identify and Select Models

Common Principles

- Develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary
- Conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes
- Ensure that service plan development is conducted in the best interests of the beneficiary
- Ensure that the provision of case management is neither coerced nor a method to restrict access to care or free choice of qualified providers (conflict-free)
- Includes strong oversight and quality management to promote consumer-direction and beneficiaries are clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery

Strategy #2

Population Focus

The decision to pursue Care Coordination in the interest of containing the costs of “*Super-Utilizers*” involves:

1. Identifying the *super-utilizer* subpopulations within the state;
2. Identifying factors driving high-utilization among these populations;
3. Assessing the feasibility of eliminating unnecessary utilization through a set of targeted interventions to address those factors;
4. Estimating both the potential costs and savings associated with a program that is able to address those drivers and reduce unnecessary utilization.

Strategy #2

Protocol/Model Considerations

- ❑ Population Served by Protocol
- ❑ Reliability of Source/Author
- ❑ Protocol/Model Requirement for Technology
- ❑ Evaluation
 - Proven Effective
 - Published Results
 - Replicable
- ❑ Existing Workforce - Competent and Capable?
- ❑ Can Necessary Skills be Trained/Learned in Reasonable Time at Reasonable Cost?
- ❑ Consistent With Values?
- ❑ Physical Infrastructure Sufficient to Implement?
- ❑ Estimate of Time Required to Implement
- ❑ Estimate of Cost to Implement

- Conducting market research into specific needs of payers, funders and partners will reveal likeliest paths forward in identifying appropriate protocols.
- In fact, many times, a model is required to be implemented.
- Consider each protocol or model you want to evaluate from the perspectives listed here.
- Engage several of your key management and executive team members in this process as implementation cuts across organizational boundaries and functions.
- Rate each of the criteria and examine results together as a team.

Strategy #3

Understanding Reimbursement

- **Medicaid Case Management Payment:** Use fixed per-member-per-month (PMPM) Primary Care Case Management or other care coordination fee to fund care managers supporting primary care practices
- **Multi-Payer Case Management Payment:** The program receives Medicaid Health Home PMPM payments for Medicaid beneficiaries, Medicare PMPM payments from the Multi-Payer Advanced Primary Care Practice Demonstration and federally qualified health center (FQHC) Advanced Primary Care Practice Demonstration for Medicare beneficiaries, and PMPM payments from commercial insurers for privately insured individuals. The PMPM payments fund Community Care Teams working in partnership with Medicaid Health Homes, Advanced Primary Care Practices, and FQHCs.

Strategy #3

Understanding Reimbursement

- **Per-Episode of Care Payment for Program Services:** The program receives a single payment for each episode for each insured individual from payors (including Medicaid managed care organizations). This payment covers all program costs for the specific duration and can be adjusted up or down based on the complexity of the individual's condition(s) as represented by a risk score of some sort – for example, the cumulative number of medical, psychosocial, and behavioral conditions of the individual
- **Per-Member Per-Month Payment to Managed Care Organization (MCO):** The state Medicaid agency provides a risk-based capitation payment for each Medicaid client enrolled in an MCO which is part of a larger integrated delivery system. The MCO uses that payment to cover the costs of providing both medical and behavioral health services as well as the data analytics and care interventions for super-utilizer programs.

Strategy #3

Understanding Reimbursement

- **Shared Savings for Total Cost of Care:** Similar in some respects to a fully capitated model, the state Medicaid agency enters into a partial risk-sharing arrangement with the care team organization, providing a negotiated share of the savings if program clients incur lower-than-expected costs over a fixed time period (and perhaps penalizing the care team organization if clients incur higher-than-expected costs).
 - For example, Minnesota's Integrated Care Model will implement Medicaid shared savings to hold providers accountable for care delivered by sharing in savings and losses for the total cost of care.

Strategy #4

Know Your Options

1. Centralized

- Care managers or outreach workers employed or contracted by the managed care, accountable care or other type organization like PCMH or Health Home
- Embedded in primary care practices
- Primary care practices are selected either because they serve a high volume of patients or they are high-performing patient-centered medical homes with the infrastructure to work closely with the additional staff to address the needs of their most complex patients.

Strategy #4

Know Your Options

2. Supportive Networks

- Not-for-profit, community-based organizations provide care managers
- Support a network of primary care practices in their region
- Care managers travel between primary care practices and build capacity within multiple practices in their network to address the needs of their highest utilizers.

Strategy #4

Know Your Options

3. Community-Based Care Teams

- Interdisciplinary teams including nurse care managers, social workers, and behavioral health workers
- Based in the community, visiting patients in their homes and community settings
- Teams target the highest utilizers in a geographic region but work with the primary care practices to identify referrals and coordinate care for patients.
- Teams may be organized by home health agencies, community-based organizations, or large community-based primary care practices such as federally-qualified health centers.

What You Can Do Next

- 1. Scan your environment** – who is doing what, why, where and when? Is there a demand? How do “they” want it?
- 2. Develop a preliminary product**
 - Focus on core competencies and populations
 - Identify best practices based on findings of environmental scan
 - Staffing model
 - Infrastructure requirements
 - Identify demand and opportunities
 - Costing and pricing your services
 - Revenue projections and return-on-investment modeling
- 3. Business Development** – market research, networking, promotion, capture management .
- 4. Implementation Planning** – interfacing systems, revenue share models, staffing, training, management
- 5. Contracting**

Questions?

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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

Next Steps

Visit **LinkedIn** group

Next scheduled webinar:

April 16, 2015 1-2 pm EST

Small Group Coaching Call

April 2, 2015 1 – 2 pm EST

Complete draft of Innovation Work Plan

email to: ewhitney@ahpnet.com

For More Information...

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APPENDIX A



Care Coordinator: Duties

1. Direct communication between the provider and Patient/Client/Member/Family
2. Patient and family education
3. Coordination of carved-out and linked services, and referrals
4. Promotion of co-location of service delivery, particularly for people receiving mental health or chronic substance use disorder services
5. Intense coordination of resources to meet Individualized Care Plan (ICP) goals
6. With Patient and Multi-Disciplinary Treatment Team input, development of an ICP specific to individual needs, and updating of these plans regularly
7. Person-Centered Planning
8. Assessment of clinical risks and needs
9. Enhanced self-management training and support
10. Frequent contact
11. Establish and participate in Multi-Disciplinary Treatment and Service Teams
12. Refer to community resources or other agencies for needed specialty medical or social services or items
13. Facilitate communication among the team members
14. Engage in other activities or services needed to assist people in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status
15. Facilitate timely access to primary care, specialty care, and other health services, including referrals to address any physical or cognitive barriers to access.



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Thank you for joining us today!
**Please take a moment to provide your
feedback by completing this survey:**
<https://www.surveymonkey.com/r/NFZL2HX>