



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

# Who is Responsible for Care Coordination

Elizabeth Whitney and Sue Pickett  
May 21, 2015



# *SAMHSA-HRSA Center for Integrated Health Solutions*

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

[www.Integration.samhsa.gov](http://www.Integration.samhsa.gov)

*under About Us/Innovation Communities*

# Today's Purpose

- Welcome
- NYC Health and Hospitals Corporation
- Wheeler
- LSF Health Systems
- Next Steps

# HHC Health Home

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April 21, 2015

# Agenda

- ▶ NYC HHC
  - ▶ HHC Health Home
  - ▶ HHC Health Home Care Coordination
  - ▶ Lessons Learned
  - ▶ Challenges
  - ▶ Q&A
- 

# NYC Health and Hospitals Corporation (HHC)

## Hospitals (11)

- ▶ Manhattan
  - Bellevue Hospital Center
  - Harlem Hospital Center
  - Metropolitan Hospital Center
- ▶ Bronx
  - Jacobi Medical Center
  - Lincoln Medical and Mental Health Center
  - North Central Bronx Hospital
- ▶ Brooklyn
  - Coney Island Hospital
  - Kings County Hospital Center
  - Woodhull Medical and Mental Health Center
- ▶ Queens
  - Elmhurst Hospital Center
  - Queens Hospital Center

## Diagnostic & Treatment Centers (6)

- ▶ Manhattan
  - Gouverneur Healthcare Services
  - Renaissance Health Care Network Diagnostic & Treatment Center
- ▶ Bronx
  - Morrisania Diagnostic & Treatment Center
  - Segundo Ruiz Belvis Diagnostic & Treatment Center
- ▶ Brooklyn
  - Cumberland Diagnostic & Treatment Center
  - East New York Diagnostic & Treatment Center



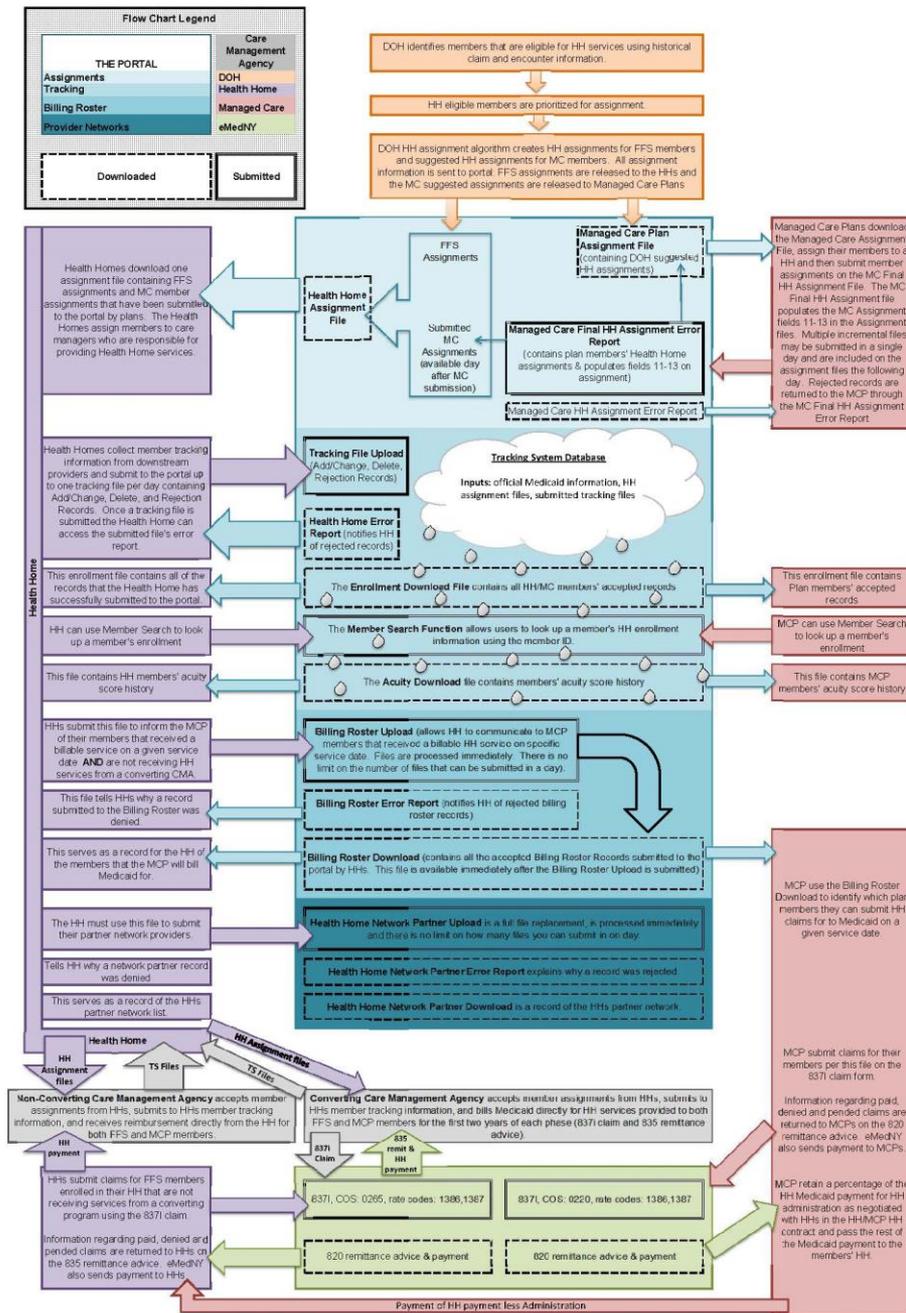
# HHC Facilities in NYC

**Legend:**  Hospital  Community Health Center  Child Health Center  Long Term Care



# HHC Services in NYC

**The Health Home Program Flow Chart**  
(revised July 15, 2013)



# NYS' Health Home Program Flow Chart!

# HHC Health Home

## ▶ Health Home Goals

- Coordinated and comprehensive care
- Improve health outcomes
- Reduce preventable hospitalizations, ER visits and unnecessary care

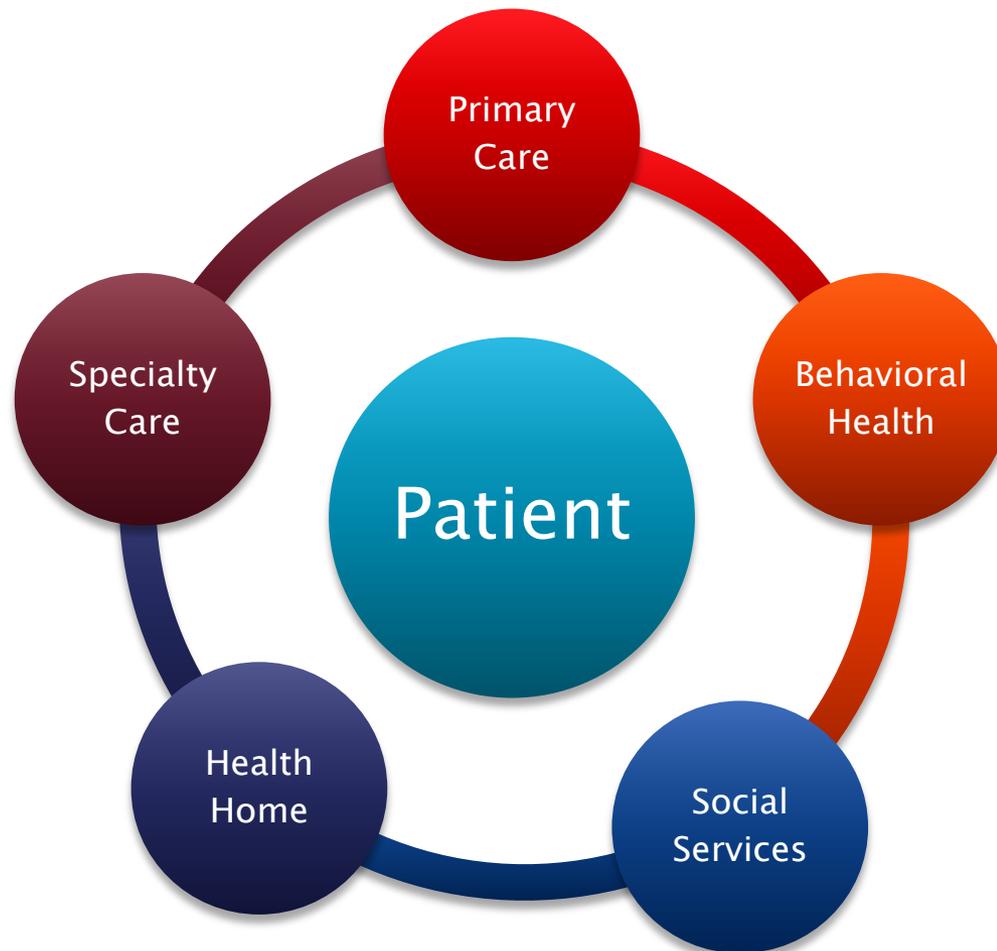
## ▶ Eligible patients:

- Active Medicaid
- 2 chronic conditions OR
- HIV/AIDS, OR
- Serious persistent mental health condition (SPMI) AND
- Significant behavioral, medical, or social risk factors

# HHC Health Home

- ▶ Designated Health Home since 2012
  - Consolidated 14 TCM, COBRA, & CIDP care coordination programs across the acute care facilities
- ▶ HHC Health Home care coordination teams currently based in 10 acute care facilities
- ▶ Partnerships with 14 Care Management Agencies across the 4 boroughs
  - CMA partnerships with specific facilities

# Health Home Care Coordination



# HHC Health Home Design

- ▶ Care Coordination for high-need, high-cost Medicaid recipients with chronic conditions
- ▶ Integrated approach to meet primary, behavioral, and acute health needs, substance abuse and social needs
- ▶ Linkages to community services and support (e.g housing, social, & family services)
- ▶ Single care coordinator
- ▶ Unified care team
- ▶ Linkage to PCP
- ▶ Coordinated communication
- ▶ Shared Care Plan
- ▶ Per Member/Per Month (PMPM) capitated rate

# HHC Health Home Services

- ▶ Comprehensive care management
- ▶ Health promotion
- ▶ Transitional care including appropriate follow-up from inpatient to other settings
- ▶ Patient and family support
- ▶ Referral to community and social support services
- ▶ Use of health information technology to link services

# Lessons Learned: Flexibility

- ▶ Different work cultures and personalities
  - ▶ Difficulty finding and enrolling patients (outreach is stand alone from care coordination)
- 

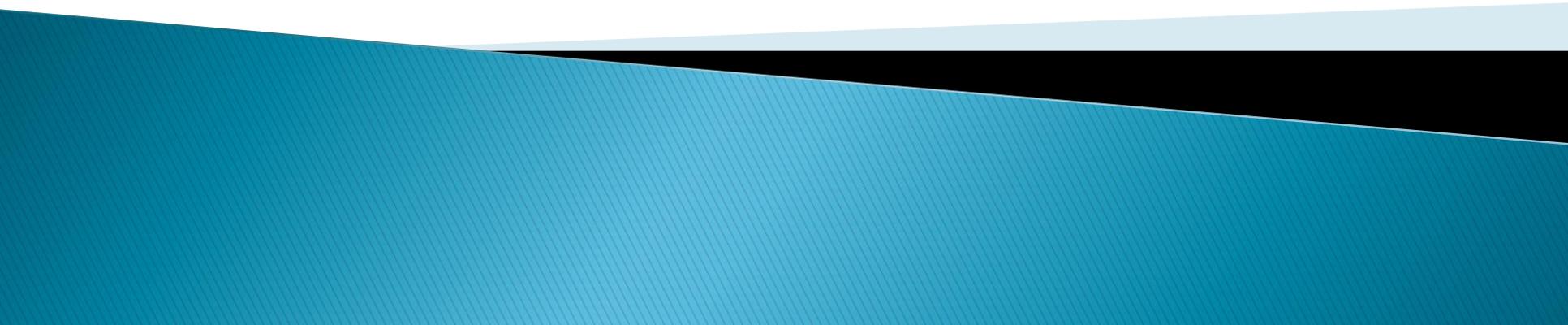
# Lessons Learned: Partnerships

- ▶ Working together with other Health Homes (not a competition)
  - ▶ Working with Managed Care Organizations— data, influence, support
  - ▶ Working with a variety of Care Management Agencies (language, geography, specialized services)
  - ▶ Integration: PCMH, Ambulatory Care, Social Work, Behavioral Health
- 

# Challenges

- ▶ Community program in a hospital setting
  - ▶ Ensure all providers feel included in the care plan
  - ▶ Communication flows
  - ▶ Health Home does not guarantee quicker access to care
  - ▶ Stakeholder investment: finance, legal, facility leadership, CMAs
  - ▶ Standardization across system—qualifications, roles
  - ▶ Focus on enrollment can overshadow focus on patient outcomes
- 

**Questions?**





Wheeler

WHEELER CLINIC  
Fostering positive change.

# Innovation Community Care Coordination

**May 21, 2015**

**Sabrina Trocchi, Ph.D. Candidate, MPA**  
Chief Strategy Officer

# Presentation Overview

1. About Wheeler
  - a. Mission
  - b. Continuum of Care
  - c. Person-Centered Approach
2. Wheeler's Care Management Initiative
3. Innovation Community Care Coordination Work Plan
4. Lessons Learned/Next Steps

# About Wheeler



- Founded in 1968
- Community need shaped our mission
- Developed in the 1970s with deinstitutionalization of individuals with serious and persistent mental illness
- Strong community collaborations and partnerships
- Innovative, highly respected, influential leader in the behavioral health, special education and primary care communities
- Joint Commission Accredited since 1988
- Effective May 1, 2015 Designated as a FQHC-LAL
- \$70 million revenue, 900 employees, 27 locations, over 100 programs



# Wheeler Clinic Mission

Wheeler Clinic fosters positive change in the lives of individuals and families, as well as in communities. We provide cutting-edge human services that address a diverse range of needs and backgrounds, enhance strengths and provide the supports that encourage recovery from challenges for a satisfying life in the community.



# Continuum of Care

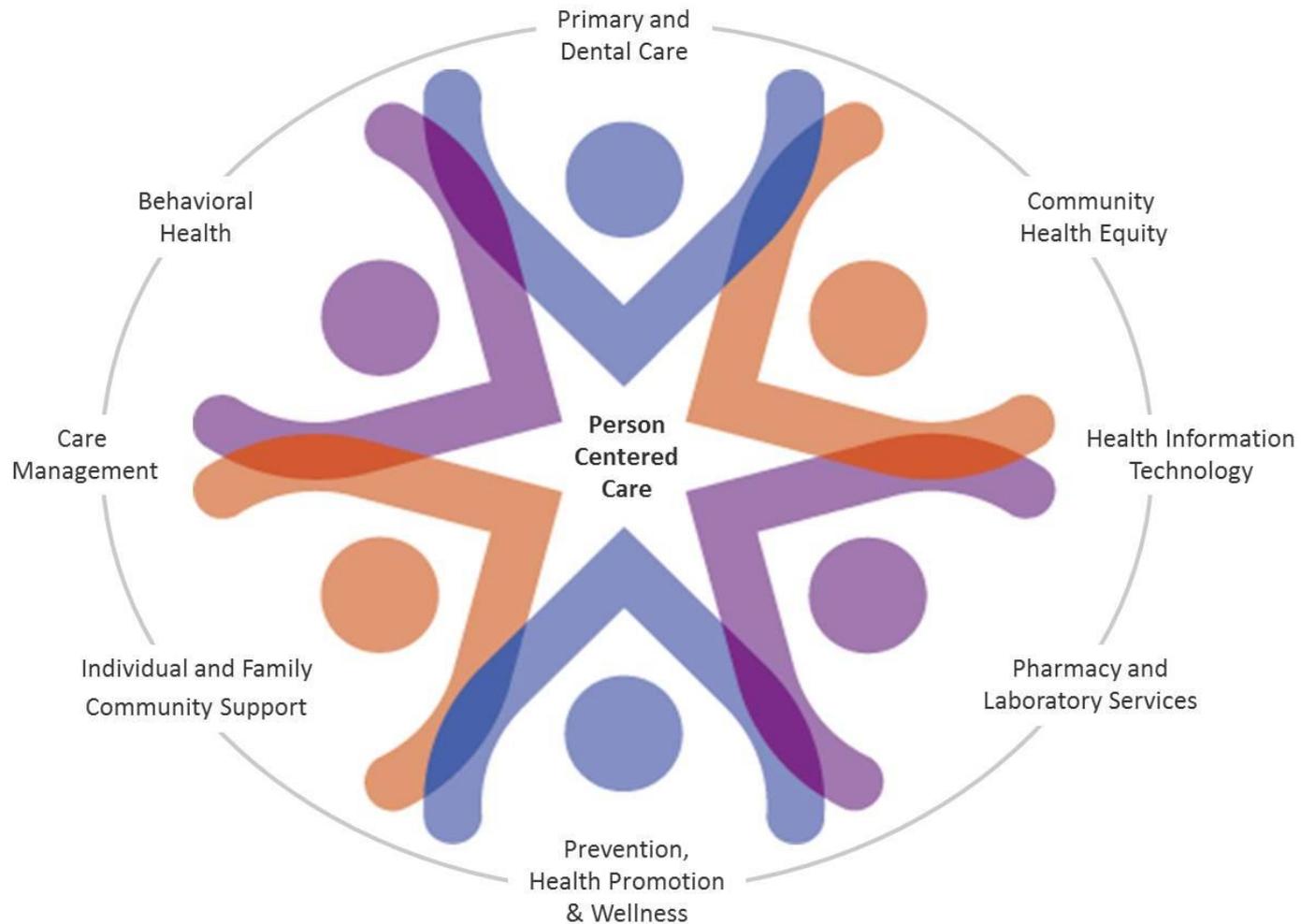


- Education
- Mental Health & Substance Abuse Outpatient Recovery
- Crisis Intervention
- Primary Care
- Child Welfare
- Early Childhood
- Intensive Home-Based Services
- Congregate Care
- Foster Care
- Community Justice
- Connecticut Center for Prevention Wellness and Recovery
- Employee Assistance



*The right care at every age and every stage*

# Person-Centered Care



# Care Management Initiative

**Effective April 2015, Wheeler launched a new Care Management resource for adults with *complex health care* needs who present to Wheeler's Outpatient Clinics in Hartford or Bristol.**

- Complex health condition is defined as one or more chronic medical conditions that require treatment or interventions in addition to a behavioral health condition.

## **Goals of the Care Management initiative include:**

- To promote positive health and improve overall health outcomes;
- To improve patient experience in care and overall quality of care;
- To eliminate health disparities and enhance health access and equity;
- To engage and empower patients in self-care; and
- To decrease health care costs, including unnecessary emergency room visits and hospitalizations, while delivering high quality, integrated care.

# Care Management Initiative (Cont.)

- **Targeted Wheeler outpatient sites is utilizing a different primary care integration model:**
  - Hartford Site: Co-location of primary care services in partnership with local hospital system
  - Bristol Site: Direct delivery of primary care services (FQHC-LAL)
  - Foundation for Wheeler's pursuit of Joint Commission BHH Certification
- **Multidisciplinary Care Management Team includes:**
  - Nurse Care Manager
  - Care Facilitator
  - BH Clinician
  - Psychiatrist/APRN
  - Primary Care Provider

# Care Management Initiative (Cont.)

## **Patient Identification (Population Health Management)**

- Embedded in the Wheeler assessment/evaluation tool are behavioral health and primary health risk questions, i.e.,
  - Do you have a PCP?
  - What physical health issues does patient report?
  - Have you visited ER in the last 6 months?
  - Do you smoke?
  - What is your weight and age? (BMI rating calculated)
- Each question is assigned a numerical value and a tally of individual scores will generate an automatic Patient Health Score (PHS).
- A score >17 renders the patient eligible for care management services.

# Current Innovation Community Care Coordination Work Plan

**Overall Project Goal:** Achieve full integration of the Care Management within Wheeler's Behavioral Health Outpatient Clinics for adults.

**Goal Area 1: Embed Care Management within Wheeler's Adult Behavioral Health Outpatient Clinics**

**Objective 1a:** Define Care Management Roles and Responsibilities

**Status:** Completed

- Used to inform development of training curricula

**Objective 2a:** Develop Care Management Workflow

**Status:** Completed

- Used to inform development of training curricula

# Work Plan (Cont.)

**Objective 3a:** Develop and Implement Staff Training based on identified needs

**Status:** Initial Training Completed; Identified Next Training Needs

- Training curricula for adult clinicians was completed (March 2015)
  - Client engagement
  - Primary health education and wellness
  - Development of person-centered primary healthcare treatment goals
- Adult clinicians training completed by April 30, 2015
- Next steps: Adapt training for child clinicians, other direct/non-direct care providers

**Objective 4a:** Identify process measures to assess effectiveness of Objectives 1a-3a.

**Status:** Initiated

# Lessons Learned / Next Steps

## **Lessons Learned**

- Use of Multidisciplinary Team Approaches
- Staff inform training materials and other resources
- Update existing policies and procedures to reflect new care coordination approaches
- Importance of having IT systems adapted to address new care coordination approaches
- Training needed across all staff—from direct care to front desk staff

# Next Steps

- **Increased utilization of Population Management Approaches:** Increased measurement of population level to inform interventions that are intended to address the patient's needs.
- **Further enhancements to Population Identification Process/Procedures**
- **Health Information Technologies:** Further enhancements to EHR, including dashboard and related reporting systems, to facilitate real-time data capture, patient tracking and outcomes review.
- **Adoption of Coordination Tools:** Enhanced communication and care coordination tools are being developed to ensure that care is consistent among all of a patient's many clinicians, as well as consistent for patients between the office and home.

# Questions?





LSF Health Systems

# Care Coordination

# Objectives

- LSF Health Systems Overview
- Function of LSFHS Care Coordination
- Activities of LSFHS Care Coordination
- Identification of Consumers
- Care Coordination Database System

# LSF Health Systems Overview

- LSFHS is located in Jacksonville, Florida and is the Northeast Region Managing Entity.
- We are probably a lot different from others in this collaborative in that we do not provide direct services.
- Instead, we are charged with taking state dollars, and using those dollars to design, develop and manage a comprehensive behavioral health system of care across the Northeast region to meet the needs of the indigent population.

# LSF Health Systems Overview

- LSFHS contracts with network service providers across the region to provide a comprehensive system of care.
- Our network service providers, provide services to all ages across the lifespan and their services that span the continuum – from least restrictive to most restrictive -prevention to inpatient residential.

# LSF Health Systems Overview

- Our goal is to identify through data, those individuals with high recidivism rates in the most restrictive levels of care – CSU, detox, and residential and through collaboration with our providers identify barriers to recovery so that these may be remedied and the quality of life for the consumer greatly improved.

# Function of Care Coordination

- Respond to the fragmentation of behavioral health services for our most vulnerable consumers.



Children's repeat admissions into the crisis stabilization unit



Adults experiencing homelessness and multiple arrests



Adults discharging from the state hospital

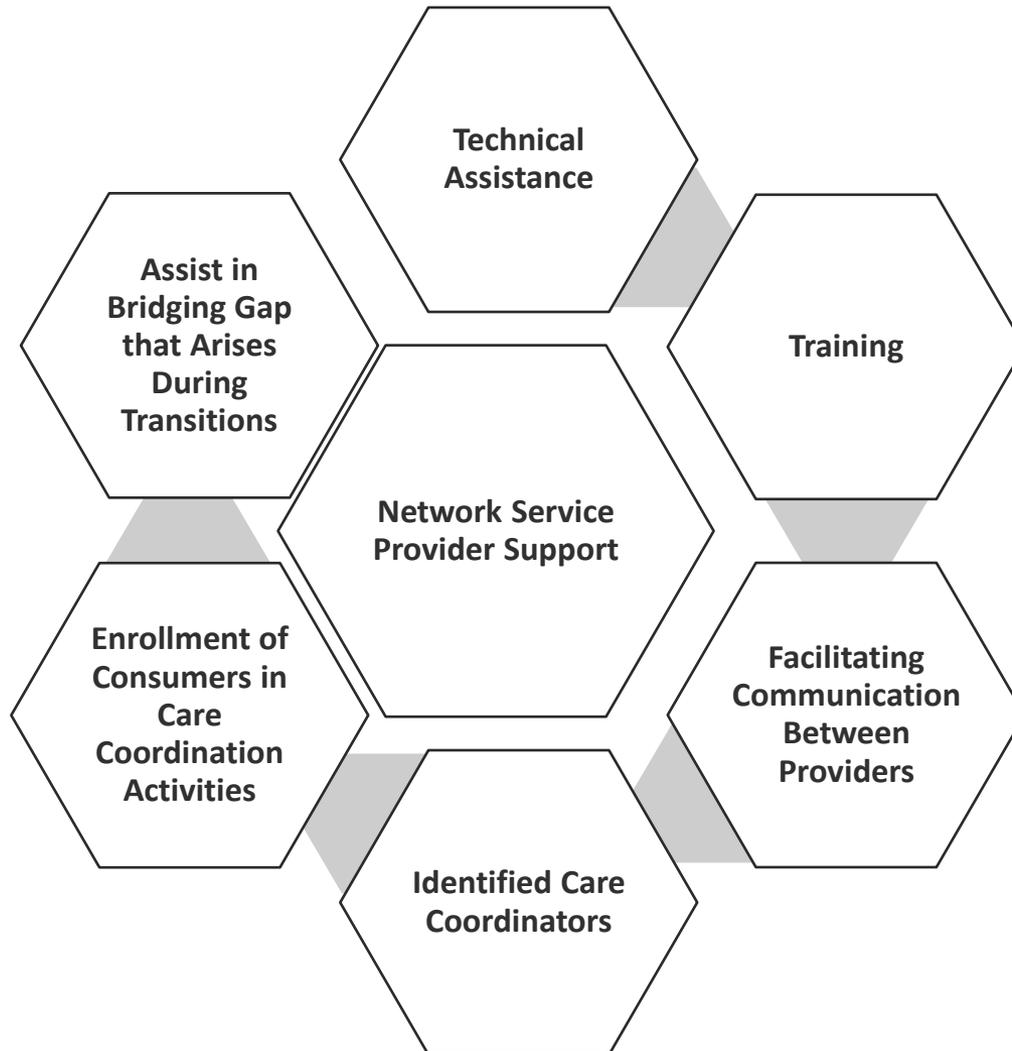


Adults with repeat admissions in detoxification services

# Activities of LSFHS Care Coordination



# Network Service Provider Support



# Facilitate Continuous Communication Between Service Providers

- Fragmentation occurs most often during and in response to care transitions.
- Goal is to bridge the gap during the transitions from a higher level of care to a lower level of care.
- LSFHS track consumers throughout our system of care to ensure continuous communication occurs.

# Align Resources With Consumer Needs

- Ensure consumers are linked to services to meet their identified needs.
- Care Coordinators are assigned to enrolled consumers.
- LSF Health Systems maintains a 24-Hour Access to Care Line that provides mental health and substance abuse treatment referrals.

# Involve Community Partners

- LSFHS has identified long standing systemic issues which can, and oftentimes do, impede an individual's recovery.
- LSFHS is working with providers and other community partners to begin to resolve these BIG issues with the goal of ultimately changing the SOC as a whole, for all consumers, insured and uninsured, old and young alike.
- Promotion of continuity of care.

# Facilitate Transitions

- Care Coordinators review discharge plan documentation and scheduled post-discharge appointments.
- Care Coordinators contact network service providers to ascertain that the consumer appeared for scheduled post-discharge appointments.
- If the consumer failed to appear for recommended scheduled aftercare services, Care Coordinators elicit from the service provider any barriers to the consumer participating in the service.

# Monitor, Follow-up and Respond to Change

- Review behavioral health documentation of consumers enrolled in care coordination.
- Determination of whether the consumer's clinical presentation is consistent with previous admissions or whether symptoms have intensified.
- Coordination of care responsive to the consumer's identified needs.

# Identification of Consumers

- Care Coordination enrollees are exclusively LSFHS consumers.
- Data set compiled from information submitted by network service providers.
- Network services provides notify Care Coordinators when a consumer meets criteria to be enrolled in care coordination.

# Care Coordination Database System

The screenshot shows a web browser window displaying the Lutheran Services Florida (LSF) Care Coordination System. The browser's address bar shows the URL `staff.lsfnet.org/Pages/CareCoord.aspx`. The page header includes the LSF logo and the text "Lutheran Services Florida - Employee Resource Center" with the tagline "Healing, Hope, and Help". A search bar and user profile for "Linda Wilson" are also visible. The main content area has a light orange background and features a navigation menu on the left with the following items: "Care Coordination", "Main Functions", "Select Client", "Registration", "Outcome", "Notes", "Discharge", "Reports", "Administration", and "CC e-File". The main content area displays the text "Welcome to LSF Care Coordination System".

# Care Coordination Data

- Demographic information
- Primary Diagnosis
- Number of days incarcerated
- Number of days homeless
- Number of days in school
- Number of days employed
- Number of arrests
- Number of child welfare investigations
- Number of days in adolescent residential mental health treatment



# LSF Health Systems

Questions?



## Small group coaching calls

- June
- **July 7, 2015 – new date**

## Presentations by participating organizations – June

- Project plans
- Progress and early lessons learned

# 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:**  
June 18, 2015 1-2 pm EST

**Small Group Coaching Calls**  
June 11 and July 7, 2015 1 – 2 pm EST

**For More Information...**

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