Who is Responsible for Care Coordination

Elizabeth Whitney and Sue Pickett
June 18, 2015

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
• Presentations:
  • AspenPointe
  • Mirror
  • Meridian Health Services
• Next Steps

Integrated Care Coordination

Robin Anderson, Program Manager
719-314-2547
robin.anderson@aspenpointe.org
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
  - 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
AspenPointe
719-314-2547
robin.anderson@aspenpointe.org
Mirror makes a difference for more people, families, and communities through comprehensive, integrated health and wellness approaches.

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.
Mirror MUST make a difference for more people, families and communities....
How Many More?

Proforma Perspective: Socio-Economic

- Employed Kansans With Employment Insurance: 1,081,634 (Private) 57,368 (Public)
- Kansas Population: 2,802,433
  - <100% FPL: 383,991 (26.7% Uninsured)
  - 100 – 199% FPL: 527,457 (21.7% Uninsured)
  - 200-299% FPL: 536,937 (12.9% Uninsured)
  - 300-399% FPL: 410,947 (8.1% Uninsured)
  - >400% FPL: 43,101 (3.7% Uninsured)

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

- Comprehensive Care Management
- Individual and Family Supports
- Referral to community and social supports
- Health Promotion
- Comprehensive Transitional Care
- Care Coordination

MCO  ●  HHP
Brand Architecture and Organizational Drivers

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
New Brand Identity

Mirror
Integrated Health

A whole new outlook on life

Care Coordination
SAMHSA Innovation Community

Maria Vail, LCSW
Practice Supervisor
Meridian Health Services

- FQHC
- Integrated Care Model
- PCMH Level 2

Members of Our Team

- Patient & Family Caregiver
- Primary Care Providers: MD & NP
- Behavioral Health Consultant: LCSW, Psychiatrist: MD
- Traditional LCSW & Behavioral Clinicians
- Patient Educator: LPN
- Diabetes Coordinator
- Community Health Workers
- Referral Coordinator
- Federal Navigator (Insurance Enrollment)
- Triage RN
- Clinical Support Staff: MA & LPN
- Federal Navigator (Insurance Enrollment)
- Referrals Coordinator
- Community Health Worker
- Outside Agencies
- Psychiatry Provider: MD
- Traditional LCSW & Behavioral Clinicians
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
Self Management Goals

Internal Referrals

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

- Full-Time Referral Coordinator
- Referral Tracking

Challenges

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

Questions?

Maria Vail, LCSW
maria.vail@meridianhs.org
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

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:
July 16, 2015 1-2 pm EST

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

For More Information...

Elizabeth Whitney, LICSW
Senior Program Manager
Advocates for Human Potential, Inc.
ewhitney@ahpnet.com
Office phone: 978-261-1407

Sue Pickett, Ph.D.
Senior Scientist for Behavioral Health
Advocates for Human Potential, Inc.
spickett@ahpnet.com
Office phone: 312-376-1870
Office cell: 978-760-9142

Hannah Mason, MA
Senior Associate
SAMHSA-HRSA Center for Integrated Health Solutions
National Council for Behavioral Health
hannahm@thenationalcouncil.org
202-684-3738

Questions? SAMHSA-HRSA Center for Integrated Health Solutions
integration@thenationalcouncil.org
Thank you for joining us today! Please take a moment to provide your feedback by completing this survey: https://www.surveymonkey.com/r/X5GWDBN