CCHHS Care Coordination

May 20, 2016

Mary Sajdak
Senior Director of Integrated Care
Overview

- Care Management Organizational Structure
- Working Definitions
- Approach to Care Coordination at CCHHS
- Ambulatory Care Coordination Goals
- CountyCare transition
- Current activities
- Initial results
- Next Steps
Integrated Care Management Structure

Sr. Director of Integrated Care

Associate Administrator

Operations Director, Patient Support Center
- Call Center Manager
- Manager of Referrals
- Manager of Provider Scheduling Systems

Director of Inpatient Care Coordination
- Clinical Manager of Inpatient Care Coordination
- Clinical Manager of Inpatient Care Coordination
- Manager of Social Services – Inpatient Care Coordination

Director of Ambulatory Care Coordination
- ED RN/SW/Transportation Coordinator Team
- Manager LTC
- Manager HCBS Services
- CCHHS Complex Care Coordination SW/RN Teams

Director of Managed Care
- Admin Analyst III
- Provider Relations Rep
- Prior Auth Nurses

Populations Served
- CountyCare-81,000
- CCHHS Managed Care-15,650
- CCHHS patients receiving service
CCHHS Working Definitions

• Population Health has three components
  – Analytics, engagement and care coordination

• Care Coordination
  – To support participation in an organized approach to their care that reflects their priorities and best practice. Long term goal is to make them self-sufficient to manage their conditions
  – Can be completed by different levels of staff depending upon the care requirements of the patient.
CCHHS Care Coordination Evolution

- Create Integrated Care 2014
- Rudimentary Care Coordination 2015
- Care coordination delegated to CCHHS 2/16
- Implement care coordination 4/16
Care Coordination Historical Approach

- Physicians care manage cases—give patients their pager #s
- Care management visits at ACHN for chronic disease teaching, status checks etc.
- Departments may have obtained resources to support navigation for their patients
- CORE center activities supported by grant funds
- Home IV antibiotics and home care in lieu of facility placement for selected populations
CountyCare Transition

• Assumed responsibility for Care Coordination for enrollees assigned to ACHN, Access and 16 FQHCs medical homes (approx. 81,000 members)

• Diverse care coordination population served includes high risk, waiver, transplants, behavioral health, discharges from the hospital, nursing facility residents, pregnant patients

• Diverse settings-home, health centers, hospitals, nursing facilities
Transitioning Care Coordination

**Increase** # of new cases through outreach, screening and analytics

**Close** cases inherited from Centene
- No longer eligible
- Risk status has decreased
- Case goals met
Care Coordination Goals

• **Improve patient outcomes**
  – Preventive Services
  – Compliance with guidelines for chronic conditions
  – Resource utilization shift
  – Engagement and self-sufficiency

• **Engage physicians and medical home teams**
  – Care coordination viewed as beneficial
  – Access to providers for care plan development
  – Mechanisms for data sharing and program enhancement

• **Improve patient satisfaction**
  – Care Coordination is a reason for a member to bond to system or CountyCare
Current Care Coordination Approach

• Centralized management-local deployment
• Intensive training due to role complexity
• Team approach
• Mobile technology-phones, tablets, hot spots
• Clinical supervision-joint visits, chart review
• Care management system with significant interfaces
• All “hands-on-deck”
Care Coordination
Knowledge/Characteristics Required

• Managed Care Organization (MCO) rules, benefits and eligibility processes
• Cultural awareness
• Comprehensive knowledge of inpatient, outpatient and social services
• Knowledge of gender and age specific preventive health service requirements
• Understanding of disease processes both physical and mental
• A “can do” attitude-will organize resources to make things better
• Empathy/a willingness to accept where the enrollee is
• Engages technology
• Street savvy
Impact on CCHHS

• Requires and receives major support from many departments-IT, HR, ACHN, Medical Leadership, CountyCare

• Measured Diffusion into CCHHS operations
  – Screening-at touchpoints (ACHN visits, welcome calls, ED visits, returning care coordination calls, inpatients)
  – Integration of Care Teams into ACHN sites

• Creation of additional phone queue to field care coordination calls
April Results

• Everyone wants a care coordinator!
  – PSC received approximately 4,600 care coordination calls (in addition to their regular calls)

• Completed Screenings-736
  – As expected significant # are high risk
    – Behavioral Health Assessment 171

• Members touched-1,018

• Home visits completed 131
Addressing Social Determinants

• Out of 736-263 are at risk solely due to social determinants. Issues identified will addressed by social worker and team

• Needs addressed via “Purple Binder”
  – Food (171)
  – Housing (153)
  – Clothing (118)
  – Substance abuse treatment (35)
  – Utilities (31)
Impressions

• Incredible first month effort
• As expected, this cohort of patients has high disease burden-
  – Prevalence of mental health issues may be related to the disease burden—but still requires a strategy/intervention
• Seemingly unlimited ability to impact
• Have a window into medical home performance
Short Term Activities (6-8 months)

• Stabilize and document core processes
• Develop a relevant set of performance metrics
• Complete hiring of staff
• Continue to partner with CountyCare to develop options to better care for patients
• Formalize and expand care coordination phone queue-expand to all CCHHS patients not just CountyCare
• Complete implementation of Care Management System.
Strategy

• Develop and implement a system-wide care coordination approach that leverages CCHHS resources to promote quality, patient experience and efficient care.

• Program processes and outcomes meet or exceed external accreditation requirements

• Leverage knowledge gained to support education, research and funding
Support Health Equity

• HEDIS gaps closed in patients participating in care coordination
  – Performance approaches those of employed populations

• Care coordination extended to those who need/benefit
Provide Quality, Safe, Reliable Care

- Engage at least 80% of the high risk patients in care coordination
- Focus on marginalized populations use quick improvement cycles to identify what works
- Understand and reduce variations in process that lead to poor outcomes
- Develop relationships with community partners to support the continuum of care
Demonstrate Value, Benchmarking

- Evaluate program outcomes in light of standard managed care metrics—e.g. utilization, cost, patient outcomes
- Align operations to support top decile performance for measures relevant to the population
- Collaborate with managed care payers to support their objectives regarding quality and cost
Human Capital

• Develop an orientation/on-boarding program that provides the necessary knowledge and skill base to succeed as a care coordinator

• Leverage training and on-going education activities across system to create awareness and bench strength
Education and Research

• Collaborate with schools of nursing and social work to develop electives regarding care coordination

• Engage Collaborative Research Unit (CRU) to determine suitability of understanding what works for the population
Strategic Planning

Building a high quality, safe, reliable, patient-centered, integrated health system that maximizes resources to ensure the greatest benefit for the patients and communities we serve

- Close HEDIS gaps
- Extend care coordination to CCHHS population

- Engage at least 80% high risk patients in care coordination
- Use quick improvement cycles to find solutions
- Identify and reduce variations in process to impact outcomes
- Develop relationships with community partners to support continuum of care.

- Evaluate program outcomes (utilization, cost, outcomes)
- Align operations to support top decile performance
- Collaborate with managed care partners

- Leverage training and ongoing education to increase organizational knowledge

- Collaborate with schools of nursing and social work to develop electives regarding care coordination
- Engage Collaborative Research Unit (CRU) to determine what works for the population