Strategic Planning FY2020- 2022

Integrated Care Management

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Chief Operating Officer, Integrated Care

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COOK COUNTY HEALTH

Integrated Care Management Department Organization

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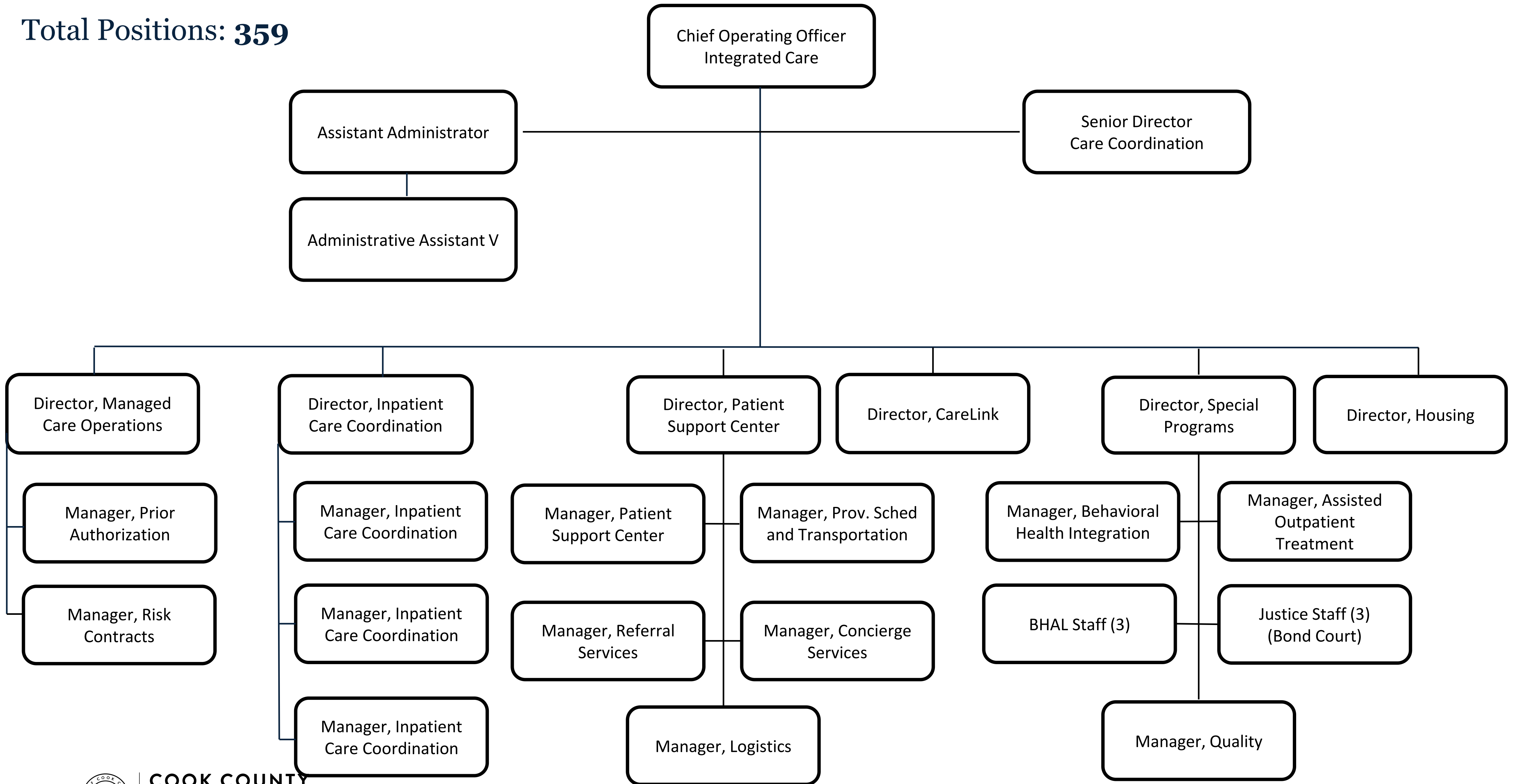

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Department	Primary Function	Units
Managed Care	Contracting, contract compliance, managed care education, Managed Care Organization (MCO) interface, Cook Medical Group	Contract administration Prior authorization Cook Medical Group Administration
Patient Support Center	Home transportation, physician schedules, specialty referrals, appointments, care coordination logistical support, Concierge Services	4-Ride, Physician Schedules, Referral Support Center, Patient Appointments, Care Coordination logistics, patient navigation
Complex (Ambulatory) Care Coordination	Support high/moderate risk patients, link patients to community based services, provide transitions between health services, supports access to behavioral health services	Complex Care Coordination Long Term Service and Support Diabetes and Asthma Mgt. Behavioral Health Access Transition of Care Justice related Care Coordination
Inpatient Care Coordination	Provide medical justification for acute care, Support patient-centered discharges	Nurse Team Social Worker Team Emergency Department Team
Carelink	Administer Carelink Program	Matrixed
Housing	Interface with housing agencies, develop housing models	TBD

- Senior Director Care Coordination
  - Director, Waiver Services
    - Manager, Hm/Comm Based Waiver Svcs
    - Manager, Extended Care Services
    - Manager, Hm/Comm Based Waiver Svcs
    - Manager, Hm/Comm Based Waiver Svcs
    - Manager, Hm/Comm Based Waiver Svcs
    - Manager, Hm/Comm Based Waiver Svcs
    - Manager, Hm/Comm Based Waiver Svcs
    - Manager, Hm/Comm Based Waiver Svcs
  - Director, Complex Care Coordination
    - Manager, Complex Care Coordination
    - Manager, Complex Care Coordination
    - Manager, Complex Care Coordination
    - Manager, Complex Care Coordination
    - Manager, Transition of Care
    - Manager, Complex Care Coordination
    - Manager, CHW
    - Educator

Care Coordination-Current Positions

Number and Type of Staff

	CCC-High Risk	MLTSS LTSS Waiver	Transition Of Care	Behavioral Health Access Line	Justice Related Care Coord
Nurses	41	16	7	0	0
Social Workers	17	89	7	3	3
CHW*	12	4	0	0	1
Directors	1	1	0	0	0
Managers	6	8	1	0	0
Total	**77**	**118**	**15**	**3**	**4**

*Community Health Worker

Impact 2020 Update

Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuables Assets
- Impact Social Determinants
- Advocate for patients

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Impact 2020

Progress and Updates

Focus Area	Name	Status
Deliver High Quality Care	1.1 Screen patients using evidence-based management techniques. Screen at least 70% of the assigned CountyCare population, approximately 56,000. (2019 membership is 178,000)	Ongoing resources added 1/19
	1.3 Deploy or enhance care coordination throughout the System and CountyCare, including community health workers.	Completed care coordination patients (CCC/LTSS)
	1.3 Conduct analysis of services and identify gaps in the continuum of care and add services.	Ongoing
	1.6 Integrate services with correctional health.	Complete behavioral health and primary care needs

Impact 2020

Progress and Updates

Focus Area	Name	Status
Foster Fiscal Stewardship	3.1 Maximize reimbursements from Managed Care Organizations (MCOs) and private insurance and complete on value, grow membership and influence in MCO strategy	In Progress increase likelihood of payment
Impact Social Determinants	6.3 Partner with other organizations to address population health; Screen for other social determinants of health including housing, exercise, clothing, drug and alcohol abuse, transportation and utilities.	Ongoing (Agreements in place) Depository
Impact Social Determinants	6.4 Further develop care coordination services across the CCHHS continuum of care to address social determinants of health to improve population health.	Ongoing coordination

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The Future

Environmental Scan of Market, Best Practices and Trends

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Environmental Scan of Market, Best Practices and Trends

Integrated Health Homes

- Fully integrate the delivery of behavioral, physical, and social healthcare
- Scale intensity of service provision to needs of the population
- Collaborative agreements to support a full provision of care
- Coordinated with and paid by MCOs
- Fee for service, with Pay for Performance (P4P)
- Membership is tiered according to Clinical Risk Group Software based upon 18 months of in/out patient and pharmacy data
  - Tier A-High behavioral, high physical
  - Tier B-High behavioral
  - Tier C-High physicial
- CCH, Complex Care Coordination Team has been accepted as an IHH

Environmental Scan of Market, Best Practices and Trends

Themes

State

- If Integrated Health Homes (IHH) is launched, significant change to structure, process, staffing patterns and technology requirements
- External MCOs requesting CCH support their IHH initiatives. CCH is in discussions and has predicated payment changes upon IHH participation.

National

- Recommendations for complex care coordination best practice from Institute for Health Care Improvement, Center for Health Care Strategies, and National Center for Complex Health and Social Needs

Thought Leaders

- Cross sector collaboration e.g. housing and health, justice and health

SWOT Analysis

Strengths, Weaknesses, Opportunities and Threats

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SWOT Analysis

Strengths	Weaknesses
transportation, Legal Aid Foundation	care performance coordination benefits population served

Opportunities	Threats
creating a model that recognizes and responds to high-risk patients to help Care Coordination leap forward-determine what works?	risky in light of bullet #1 experience, quality and safety is major consideration of health plans when developing provider network

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Deliver High Quality Care

FY2020-2022 Strategic Planning Recommendations

Care Coordination

outcomes for patient and provider

Grow to Serve and Compete-

FY2020-2022 Strategic Planning Recommendations

Referral Center

for patients seen who have community based providers

Foster Fiscal Stewardship

FY2020-2022 Strategic Planning Recommendations

Item

- Improve authorization process for inpatient/observation care by Inpatient Care Coordination team
- Reduce the number of denials for inpatient/observation care
- Evaluate ability of non-licensed, bachelor's prepared staff to support increased care coordination activities
- Create ability of select Patient Support Center staff to appoint patients identified as a result of discharge, care coordination, or reporting illness
- Support and track out-of-network admissions who are returned to CCH services for continued care (Cook Medical Group, County Care)

Invest in Resources

FY2020-2022 Strategic Planning Recommendations

Advanced Analytics

and the intersection of the two

achievement

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Leverage Valuable Assets

FY2020-2022 Strategic Planning Recommendations

CCDPH Partnerships

outcomes for the people and communities served

provided by CCH

Impact Social Determinants/Advocate for Patients

FY2020-2022 Strategic Planning Recommendations

for Serious Mental Illness (SMI)

funding expires e.g. recovery coaches, AOT Assisted Outpatient Treatment (AOT) program, etc.

for scalability and ease of referrals

needs

Impact Social Determinants/Advocate for Patients FY 2020-2022 Strategic Planning Recommendations

Organizing for Impact and Sustainability

Create a coordinating committee -- success will depend on cross-department collaboration and coordination

Identify working definitions for social determinants of health, which ones may be in the purview of CCH departments and strategies for others that may have significant impact

- Complete gap analysis and provide recommendations
- Document resource requirements, training etc.
- Enter into discussions to support collaboration

Review information from cataloging existing programs and determine next steps

Complete implementation of social service data base

Thank you.

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