Care Coordination Framework for People with Complex Needs:

Identifying Lead Care Coordinators and Developing Shared Plans of Care

Lauran Hardin MSN, RN-BC, CNL

March 10, 2015

The Situation

- Robert Wood Johnson Foundation reports 5% of the population uses nearly half of total healthcare spending (http://www.rwjf.org/en/topics/rwjf-topic-areas/health-policy/health-care-costs/HealthCareCostsFastFacts.html
- Focus on the Elderly in the Literature

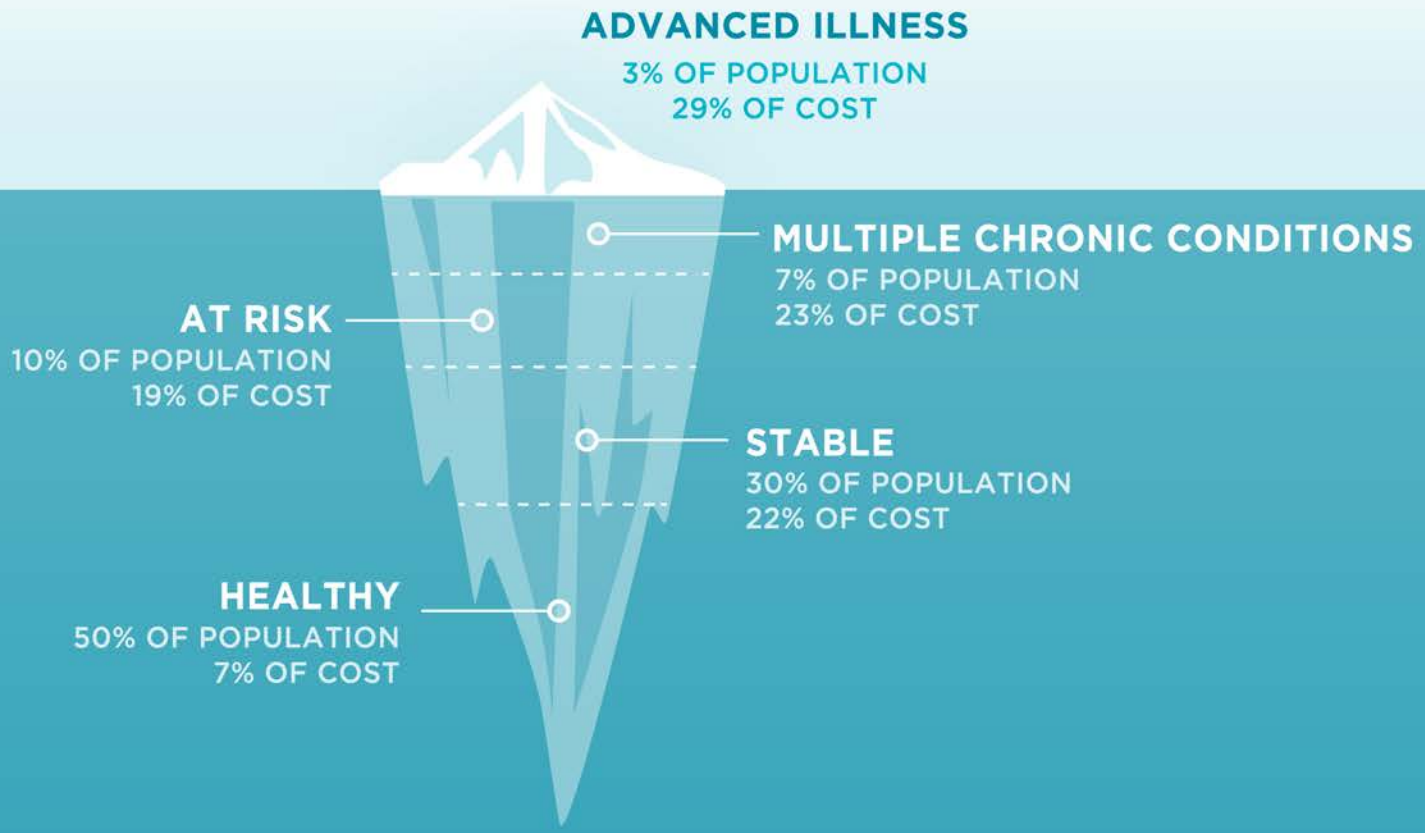
(http://archive.ahrq.gov/research/findings/factsheets/costs/expriach/index.html)

- Recent identification of impact of mental illness

http://www.hcup-us.ahrq.gov/reports/statbriefs/sb184-Hospital-Stays-Medicaid-Super-Utilizers-2012.jsp

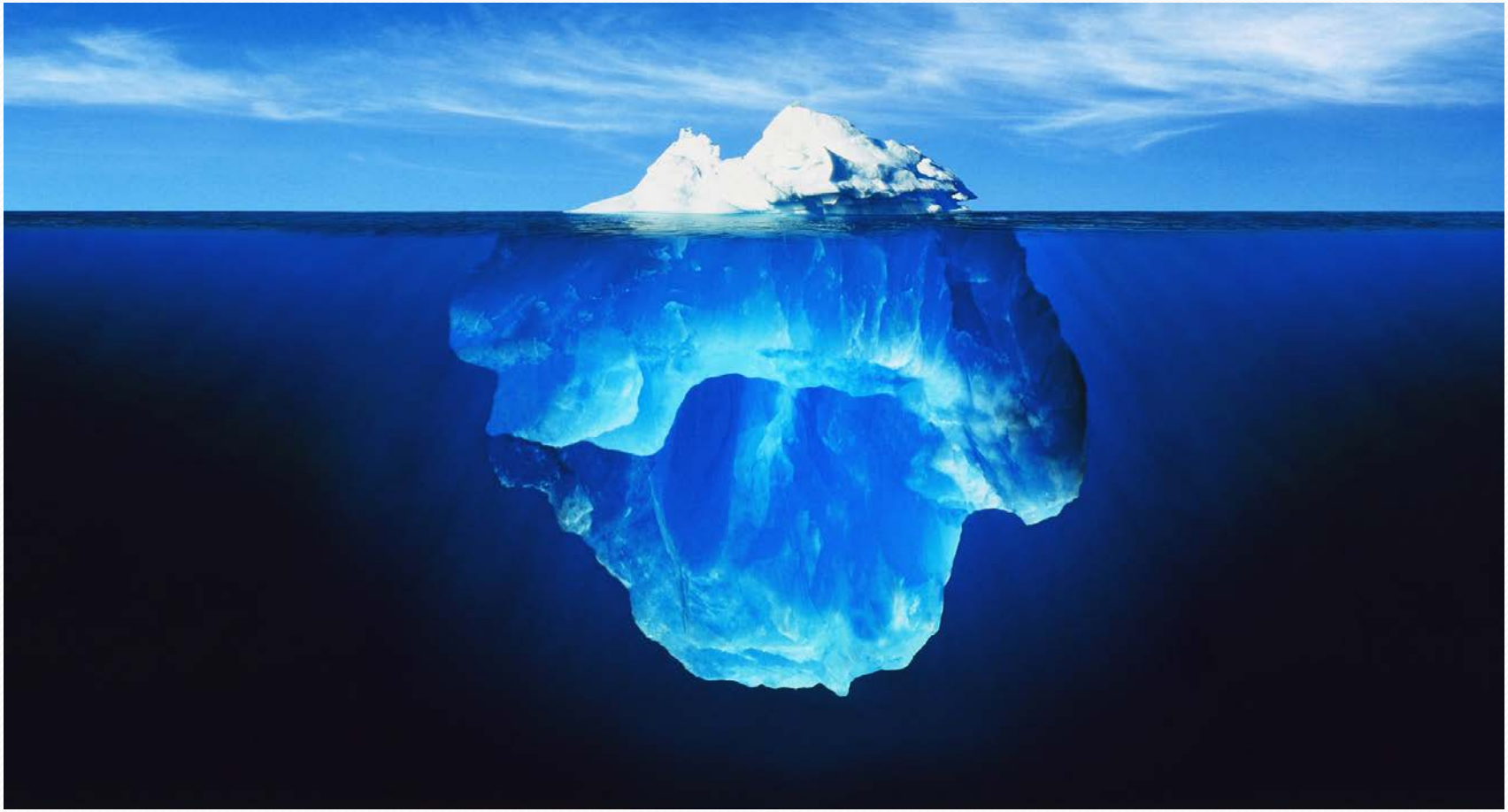
- Successful Population Health strategies include management of these high cost patients

A Population View



Source: Healthcare Risk Adjustment and Predictive Modeling by Ian Duncan

The Invisible Population



One Patient's Experience…..

Middle Aged Man

(stock photo, aggregate story)

- Care Providers across Multiple Systems
- Multiple Specialists – fragmented medical record
- Multiple Procedures and Encounters

Where are we going today?

- Root Cause
- Cross Continuum Team
- Building Shared Intervention

What is Root Cause?

One Patient's Experience.....

Middle Aged Woman

(stock photo, aggregate story)

- Multiple Medical Diagnoses – Colon Cancer and Liver Disease
- Alcohol Abuse
- 30 ED visits and 8 inpatient admissions in 12 months

- The rest of the story.....

What are common Medical Root Causes?

Medical Root Causes

- Lack of Evidence Based Treatment
- Lack of Symptom Management
- Polypharmacy and Medication Reconciliation
- Multiple Providers making Disease Management Plans
- Lack of Appropriate Referrals (Specialists, homecare, etc.)

What are common Psychiatric Root Causes?

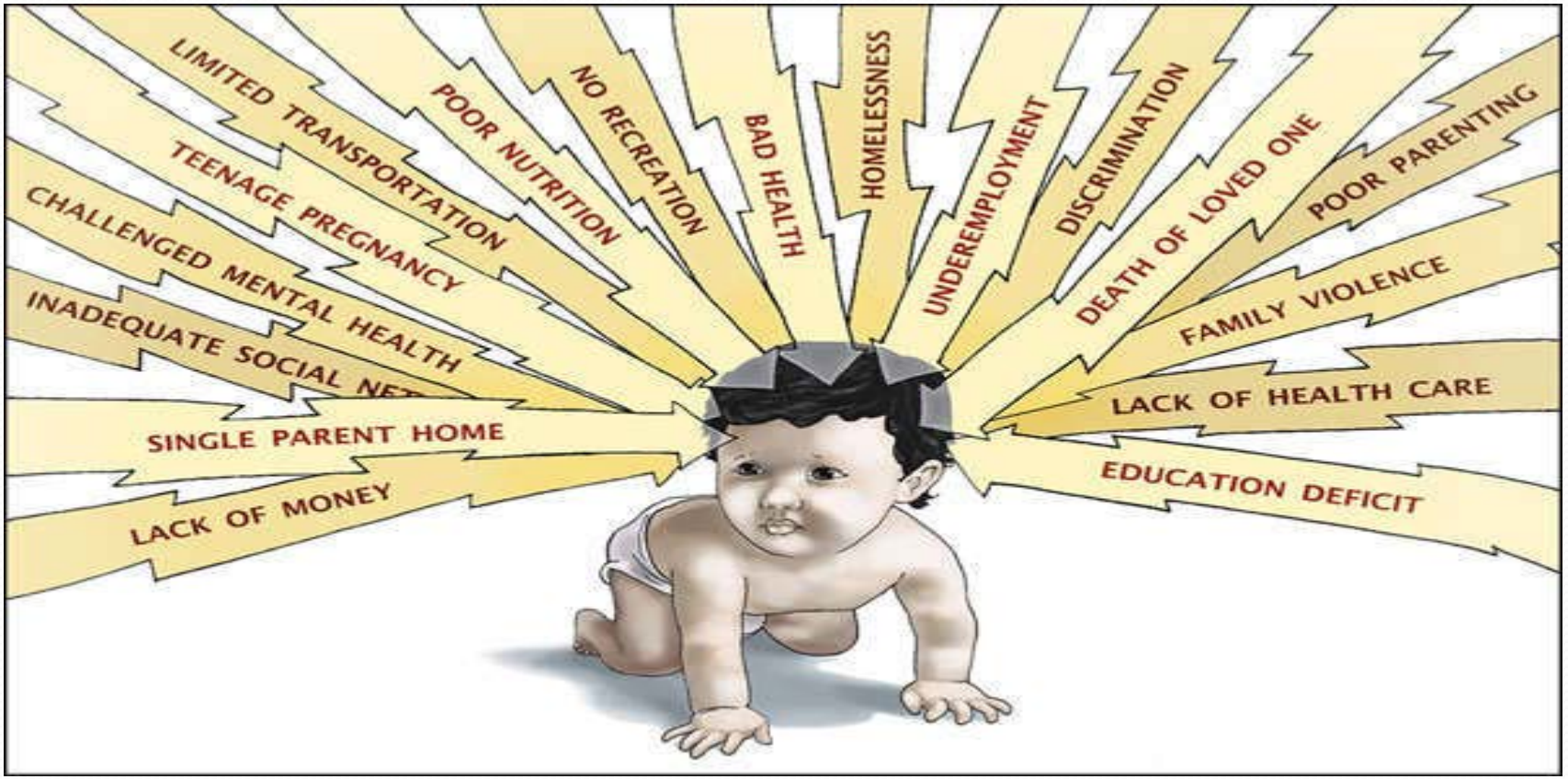
Mental Health and Substance Use Disorder

- 8.9 Million persons have co-occurring disorders
- Only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all.
- Untreated mental illness and substance use disorders lead to more deaths than traffic accidents, HIV/AIDS, and breast cancer combined
- Centers for Medicare and Medicaid Services (CMS) data show nearly one in four people with mental or substance use disorders lack health insurance. For those with both mental illness and substance use issues the figure is 30 percent
- (SAMHSA retrieved January 7, 2014 from http://www.samhsa.gov/co-occurring/topics/data/disorders.aspx)

Psychiatric Root Causes

- Lack of Diagnosis/Recognition
- Lack of Treatment
- Medication Issues
- Lack of Support Services
- Suicidality
- Unrecognized Trauma
- Co-occurring untreated addiction

Trauma Informed Care



What are common Social Root Causes?

Social Root Causes

- Safety
- Housing
- Transportation
- Access to Food
- Access to Employment
- Labeling/Bias

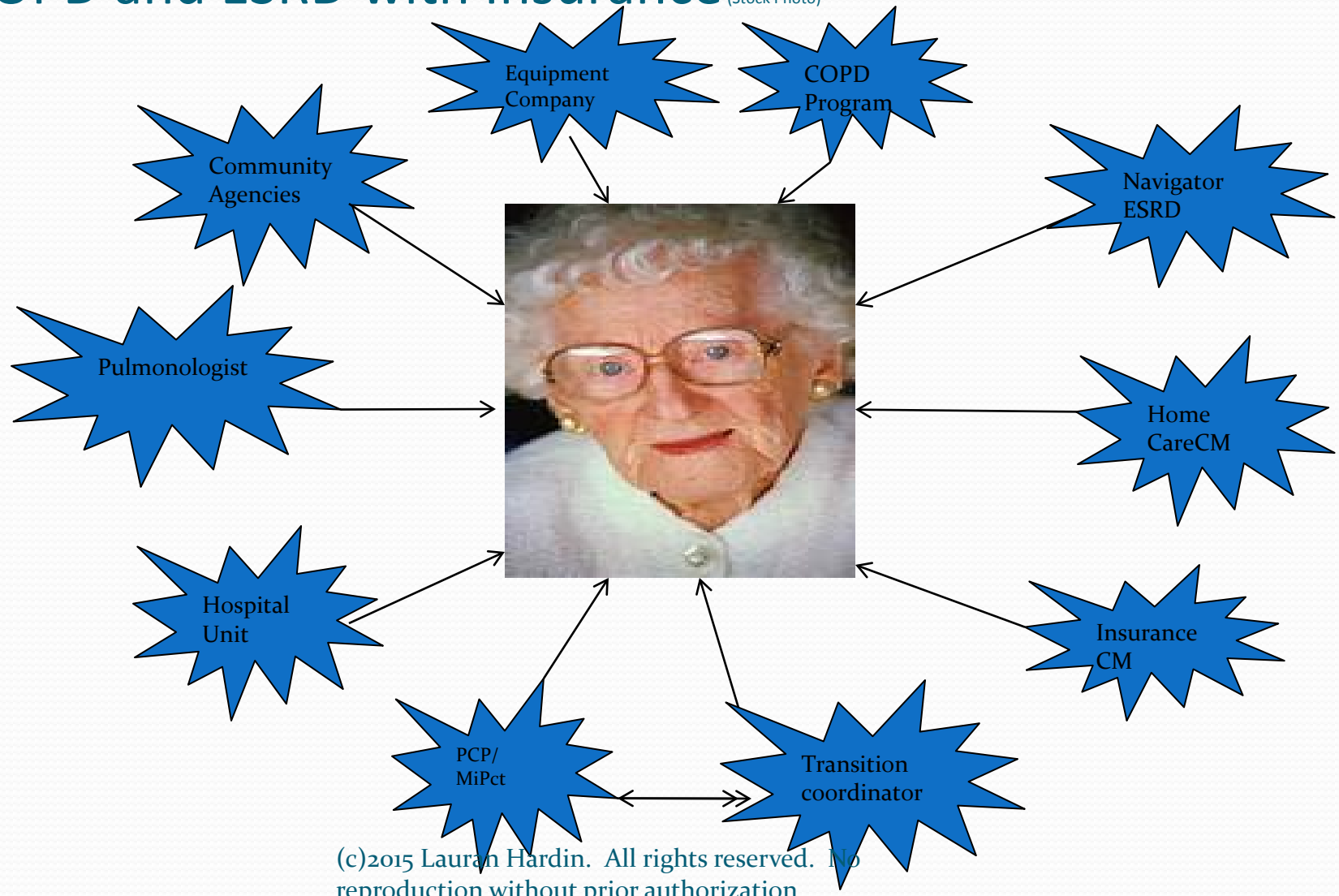
What are common System Root Causes?

System Root Causes

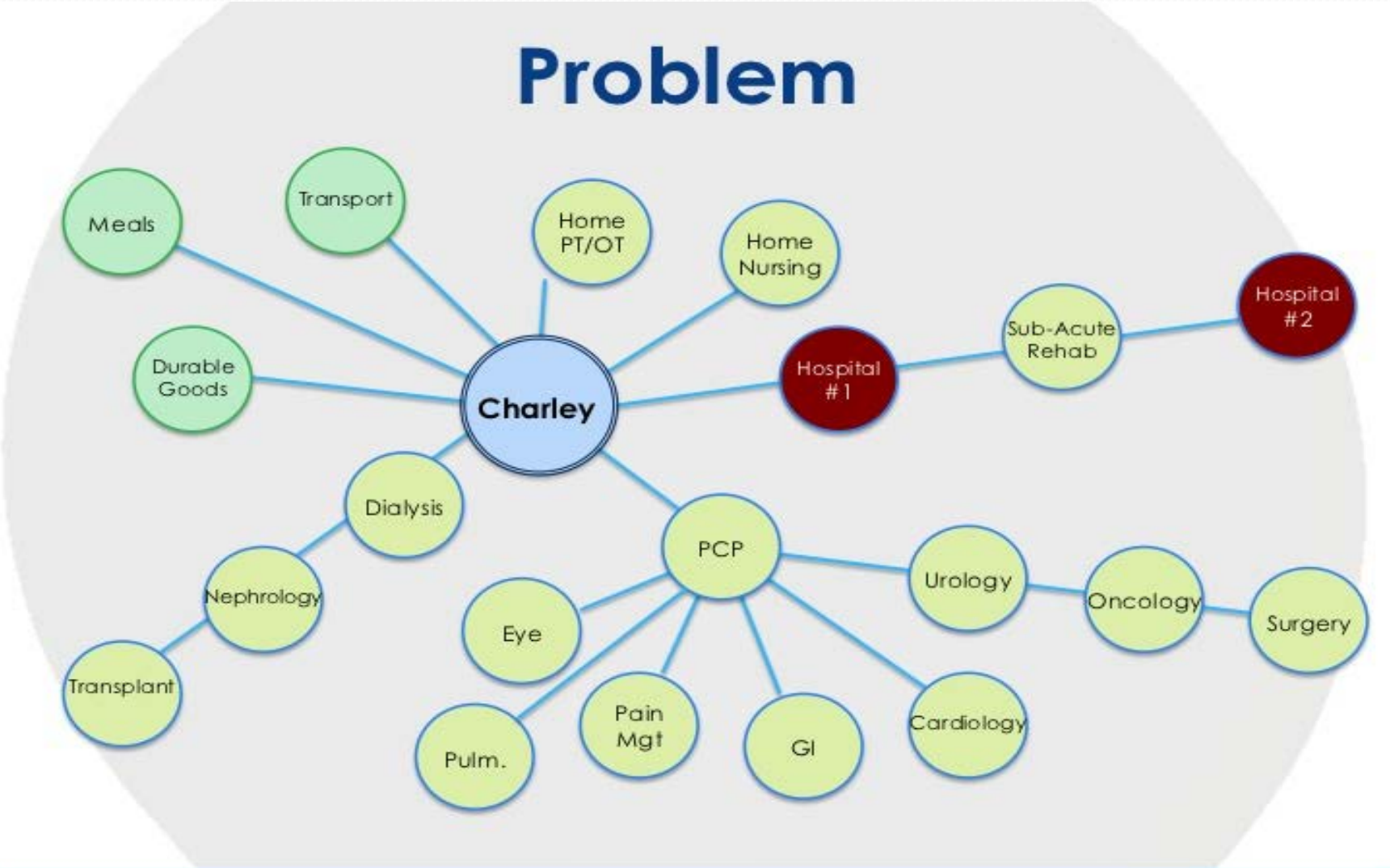
- Inaccurate Medical Record
- Lack of Access
- Hours of Operation/Capacity
- Formularies
- Barriers to Information Sharing

What is a Cross Continuum Team?

A Common Array of Care Managers for a Patient with COPD and ESRD with Insurance (Stock Photo)



Problem


Meals
Transport
Home PT/OT
Home Nursing
Durable Goods
Charley
Hospital #1
Sub-Acute Rehab
Hospital #2
Dialysis
PCP
Nephrology
Urology
Oncology
Surgery
Transplant
Eye
Pain Mgt
GI
Cardiology
Pulm.

Patient with Asthma and Diabetes and no Insurance: ED = PCP (Stock Photo)

Community Agencies

ED=PCP

Equipment Company

Cross Continuum Team Identification

- All providers impacting patient outcomes
- Doesn't have to be an official healthcare provider
- Helpful to have a Relationship for Life

Cross Continuum Team Identification

- What roles are in your team?
- What roles will you partner with?

Let's Practice....

MSSP Patient

(Aggregate Patient Story/Sample Outcome Numbers/Stock Photo)

Elderly Woman

7 Inpatient Admissions and 6 ED Visits in 12 months

- Who is her CC Team?
- What might be her root causes?

FQHC - Meeting the Needs of Vulnerable Populations (Aggregate Patient Story/Sample Outcome Numbers/Stock Photo)

Male 48 years old

50 ED Visits and 4 Inpatient Admissions in 12 months

- Who is his CC Team?
- What might be his root causes?

Dual Eligible Patient

(Aggregate Patient Story/Sample Outcome Numbers/Stock Photo)

Middle Aged Woman

8 Inpatient Admissions and 14 ED Visits in 12 months

- Who is her CC Team?
- What might be her root causes?

Coordinating Across Specialties

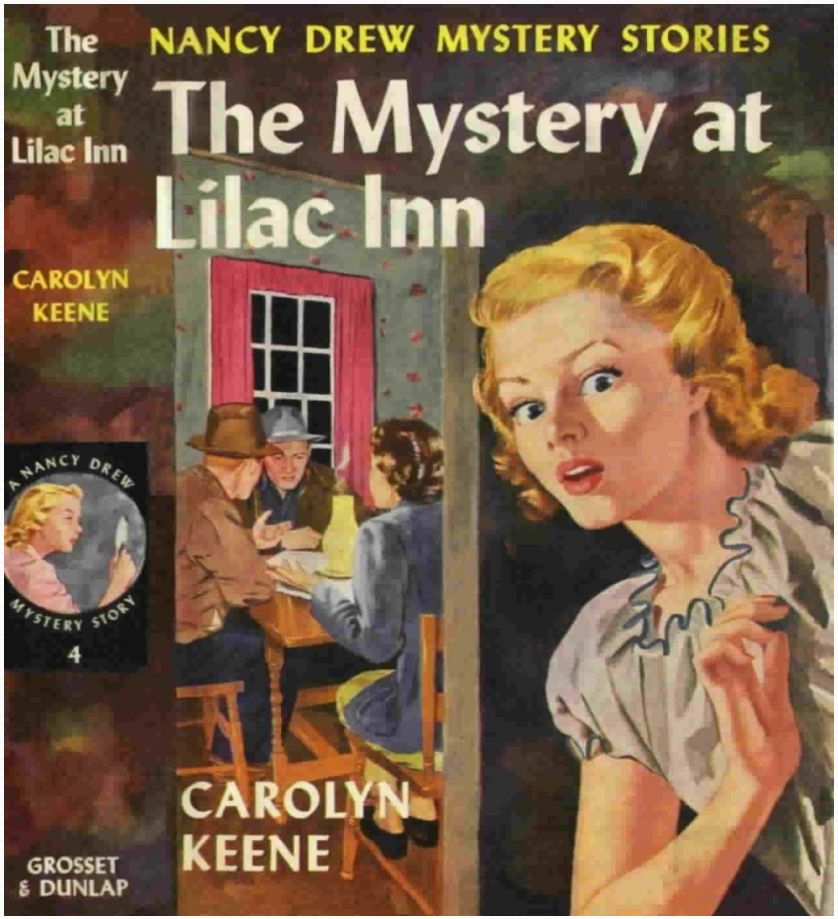
(Aggregate Patient Story/Stock Photo)

Young Pregnant Woman

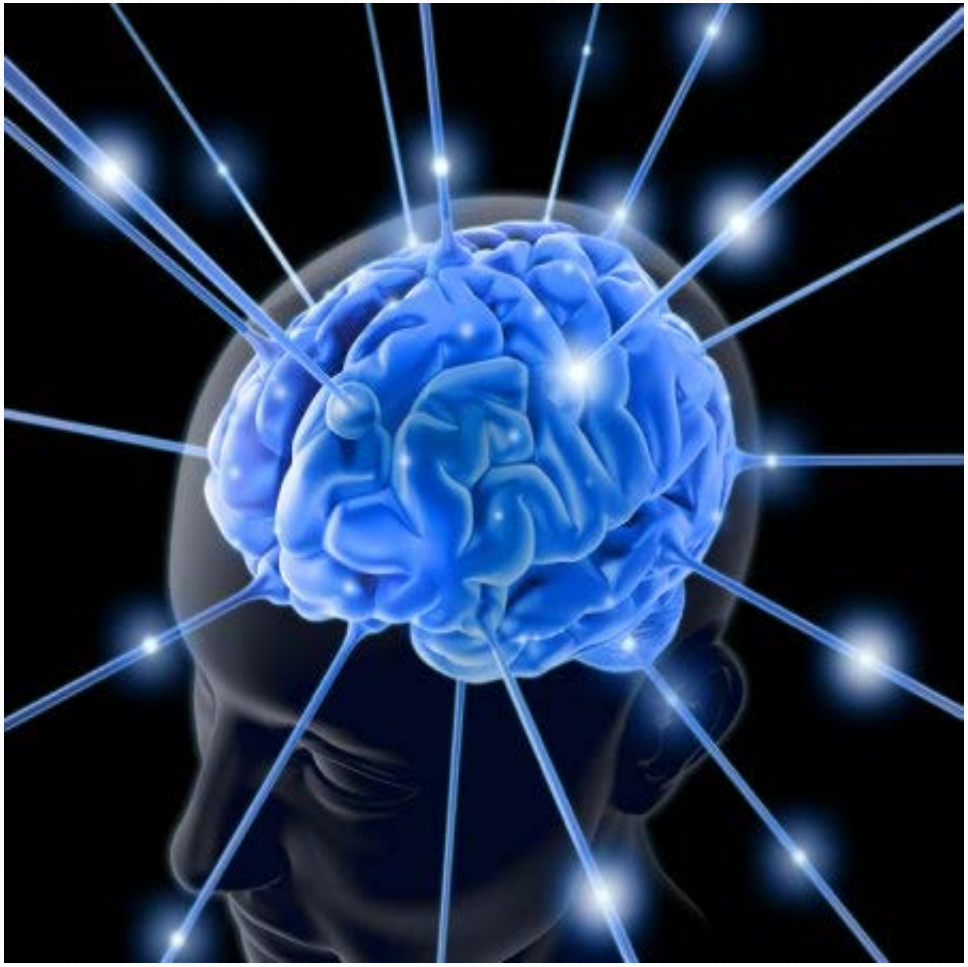
9 Inpatient Admissions and 15 ED Visits in 6 months

- Who is her CC Team?
- What might be her root causes?

Seeing Differently…..no matter where you work…



First Awareness……Then Action



- Time for a break…..

Care Coordination Framework for People with Complex Needs:

Identifying Lead Care Coordinators and Developing Shared Plans of Care PART 2

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What are the roles in your Interdisciplinary Team?

Interdisciplinary Team

- Physician
- Case Manager
- MSW
- Pharmacist
- Psychiatrist
- Community Health Worker/Health Coach
- Resource Coordinator
- Financial Services Support
- Risk/Patient Relations

Key Functions

- Chronic Disease/Medical Management
- Medication Reconciliation
- Care Transitions Navigation
- Health Promotion & Education
- Mental Health/Trauma Informed Care
- Access to Resources
- Preventive Care
- Shared Plan Cross Systems
- Building Trust

What tools do you need for intervention?

Tools

- Business Associates Agreement

Contract between a HIPAA covered entity and a HIPAA business associate (BA) that is used to protect personal health information (PHI) in accordance with HIPAA guidelines.

http://www.camdenhealth.org/cross-site-learning/resources/engagement/hospitalprovider-agreements-for-super-utilizer-interventions/

- One Contact Person

Referrals

Questions

- Huddles

Coordinate care

Treatment planning

Identification of new opportunities for collaboration

- Integrated Consent

Additional Tools

- IRB
- Photo/Story Permissions
- Evidence Based Evaluation Tools
- EMR / Documentation
- Data Analysis Tools

http://www.camdenhealth.org/about/resources-2/

How will you build partnerships?

Our previous state

Separate Silos

- By Medical Specialty
- "Other People" do behavioral health
- Only in My Building
- Reinventing the Wheel

Separate Silos

- Location
- Treatment Plans
- Prescriptions
- Coordination

The Effect of the Silos

- Duplication
- Fragmentation
- Increased Cost
- Missed Opportunity
- Tough to solve complex problems alone
- Poor Patient Experience

Developing Partnerships

"It's not important how clever individuals are; what really matters is how smart the collective brain is"

- Matt Ridley

Our Own Lens

Our Shared Lens

Steps to Developing Partnerships

- Define the need for a partnership
- Identify potential partners - similar goals
- Meet with potential partners to discuss the goal
- With partners, determine shared goals and activities
- Clearly identify what each partner brings to the table * Resource(s)
    - * Areas of cooperation/collaboration to reduce redundancy in services, bring together resources, or enhance/increase programs or initiatives
- Develop and implement a shared action plan
- **Evaluate results**

Let's Practice....

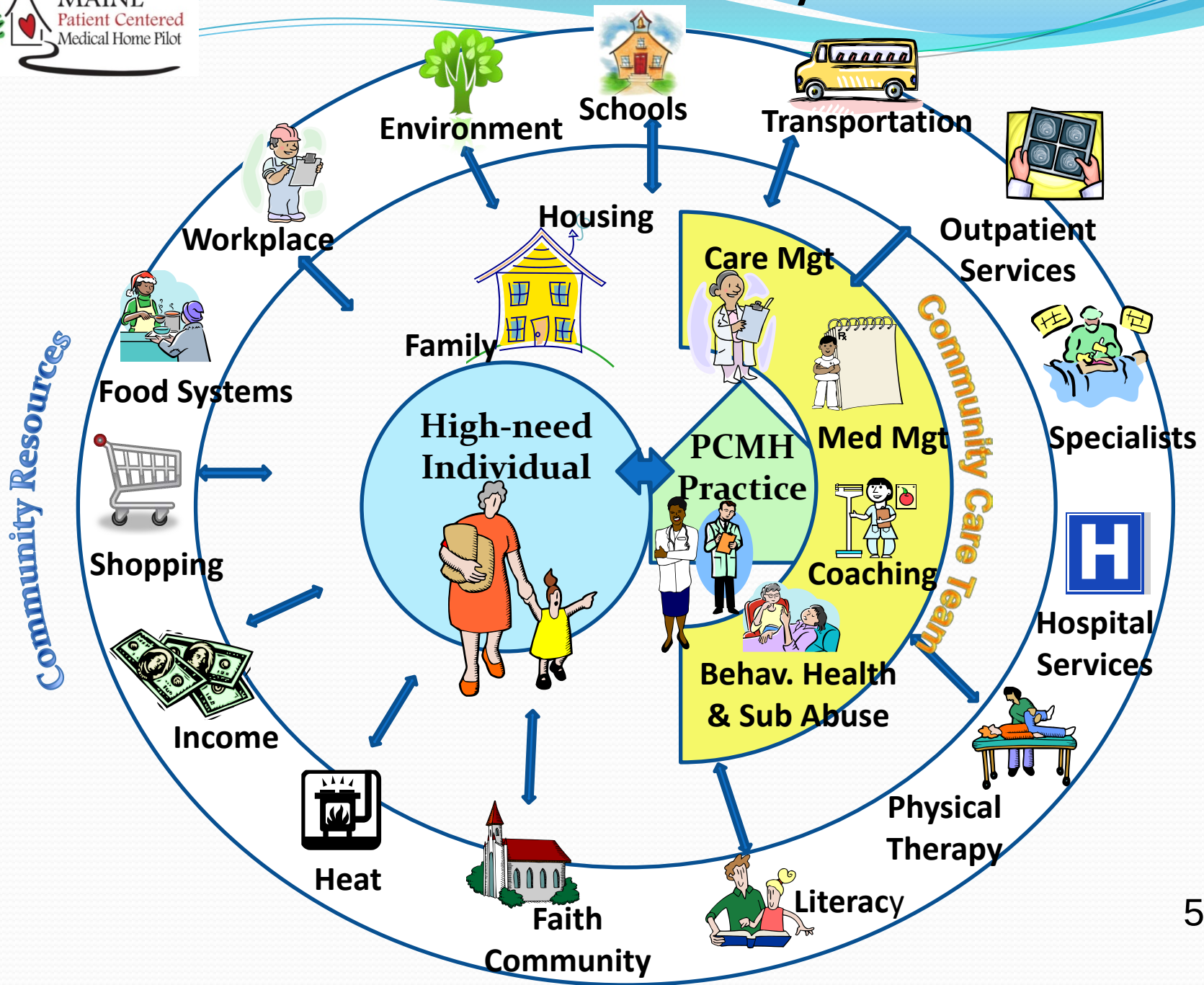
Who will be your key partners?

Models of Care are Evolving

How do you build a cross-continuum plan?

Maine PCMH Pilot Community Care Teams

MAINE Patient Centered Medical Home Pilot



Let's Practice....

Seeing Beyond the Acute Episode of Care

(Aggregate Patient Story/Stock Photo)

Young 30 year old Woman

- Chronic Pain & Dependent on legally prescribed Narcotics (overuse)
- Borderline Personality
- Accessing multiple EDs for narcotics
- Multiple CT Scans
- Multiple EMS calls for transport to ED

?Root Cause

?Cross Continuum Team Members

Volunteers for a Cross Continuum Conference…

Looking at more than Medical Disease…..

Young Man (Aggregate Patient Story/Stock Photo)

- Complex Medical Disease
- Gastroparesis
- Substance Dependence
- In a PCMH

?Root Cause

?Cross Continuum Team

Cross Continuum Plans

- Do the Homework
- Think Ahead
- Be the Facilitator
- Make sure everyone is heard
- Identify responsibilities
- Follow up
- Reconvene when needed

What do you need to build and sustain your team?

Key Tools

- A Noble Mission
- Role Clarity
- Rounds, Huddles and Collaboration
- Reasonable Measures of Success
- Carrying the Complexity
- Safety
- Disenfranchised Grief
- Celebrating Success

- http://www.ahceducation.umn.edu/resources/index.htm

How can you engage the community?

Key Elements for Success

- Community Wide Care Plans
- Narcotic Prescription Infrastructure
- Coalitions and Partnerships
- Unusual Allies

Ohio Community Collaboration
http://www.healthy.ohio.gov/ed/guidelines.aspx

Policy Issues and Complex Care

Policy Issues

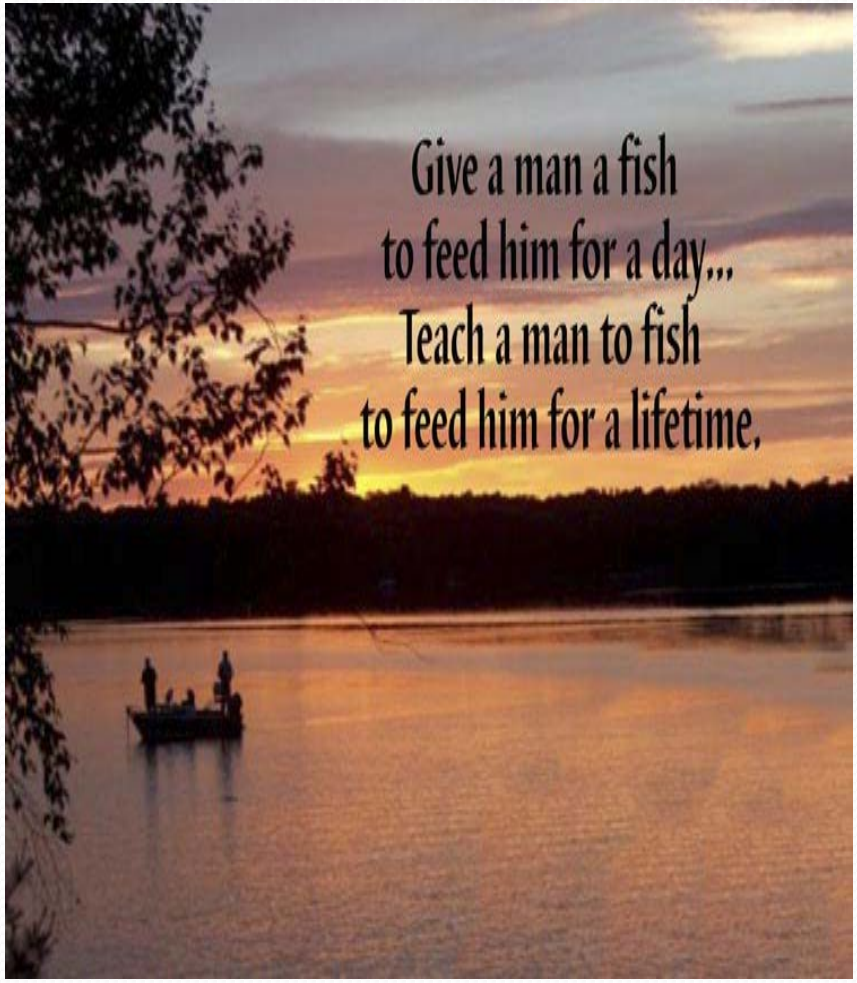
- HIPAA/42 CFR
- “Firing” Patients
- Home Bound status
- Criminalization of Mental Illness
- Guardianship & Competency
- Care Coordination payment
- Felony Records

Promising Practices for Complex Care

On the Horizon

- Integration of Behavioral Health
- Housing First
- Community Intervention Teams
- Veterans & Mental Health Courts
- Psychiatric Advance Directives
- AIM Models

Questions?



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What's Next…..