



SAMHSA-HRSA Center for Integrated Health Solutions

Who is Responsible for Care Coordination

Introductory Webinar

Elizabeth Whitney and Carol Bianco

December 19, 2014



SAMHSA-HRSA Center for Integrated Health Solutions

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

www.Integration.samhsa.gov

under About Us/Innovation Communities

Setting the Stage: Today's Facilitators



Elizabeth Whitney, LICSW
Senior Program Manager

Carol Bianco
Deputy Director

Advocates For Human Potential, Inc.

**Setting the Stage:
Today's Moderator**



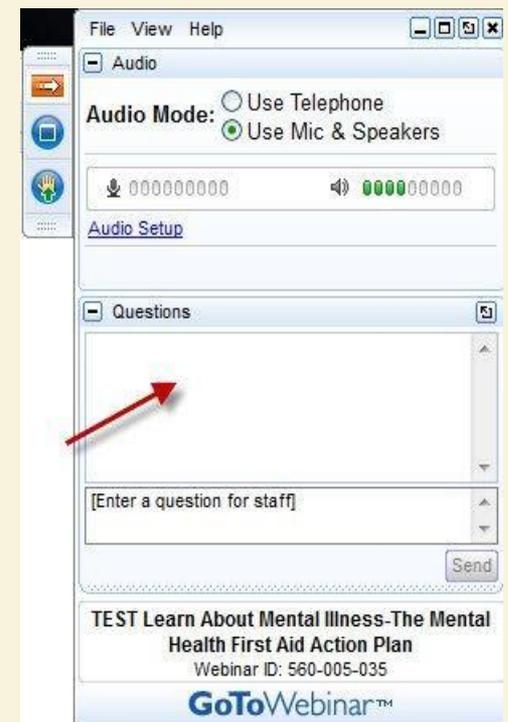
Hannah Mason, MA
Senior Associate
SAMHSA-HRSA Center
for Integrated Health
Solutions

How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



Today's Purpose

- Welcome
- Overall Goal for the Innovation Communities
- Goal for Care Coordination Innovation Community
- What to Expect
- Participant Key Tasks
- Next Steps



Innovation Communities

1. Chronic Disease Self Management in Behavioral Health Settings
2. Population Health Management in Behavioral Health Providers
- 3. Who is Responsible for Care Coordination**
4. Developing High Functioning Primary Care Teams
5. Building Integrated Behavioral Health in a Primary Care Setting

Overall Goal for the Innovation Communities

Address three key components:

1. Topic-specific foundational information, knowledge and best practices
2. Innovation implementation planning
3. Adoption of the innovation and sustainability

Innovation Communities Purpose

The IC's are designed to engage organizations in acquiring knowledge & skills to implement measureable improvements in a high priority area related to healthcare integration. Lessons learned over the course of the IC will be compiled & shared with the healthcare field so other organizations can benefit.

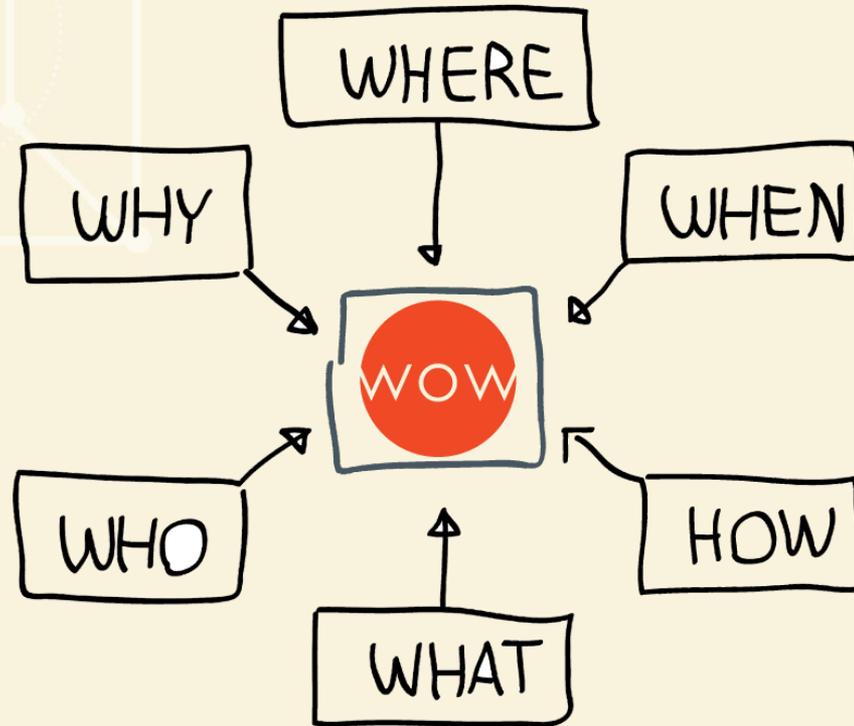
The IC focuses on topics and approaches that align with the following:

- Widespread relevance & applicability across integrated care settings
- Addresses a challenging problem related to integrated care
- Establishes practical & meaningful performance indicators achievable in a 9 month timeframe
- Continuously monitors progress, implementation barriers, & effective strategies
- Identifies tools & resources associated with successful implementation
- Records the lessons learned about the systemic & organization specific factors affecting the adoption & sustainability of integrated health innovations

Goals for Who is Responsible for Care Coordination Community

- Adopt common definition and understanding of care coordination
- Assess organizational readiness
- Identify gaps
- Clarify existing strengths
- Develop and implement change process work plan

What to Expect



Defining Care Coordination

Deliberately organizing patient care activities and ***sharing information*** among all of the participants concerned with a patient's care to achieve safer and more effective care. The ***patient's needs and preferences*** are known ahead of time and communicated at the ***right time to the right people***, and this information is used to ***provide safe, appropriate, and effective care*** to the patient.

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

Defining Care Coordination: Making It Real

- Clarifying personal preferences, resources, strengths
- Organizing care activities and sharing information in order to meet individuals' needs and preferences
- Getting the right care from the right people and resources at the right time
- Working with multiple partners and participants who individually provide specialized knowledge, skills and services and who together provide a comprehensive, coherent and continuous response to an individual's unique care needs

Poll #1: Defining Care Coordination at Your Organization

- How well aligned is your organization's definition of care coordination with these concepts?
 - a. Perfectly aligned: we follow this definition in our planning
 - b. Somewhat aligned: our definition captures some of these concepts
 - c. Not well aligned: there are new aspects to care coordination that are presented here that we haven't included
 - d. We don't have a working definition of care coordination yet

Care Coordination Elements

- Accountability
- Patient and Family Centered Support
- Cross Agency Relationships and Agreements
- Communication, Connectivity and Care Flow

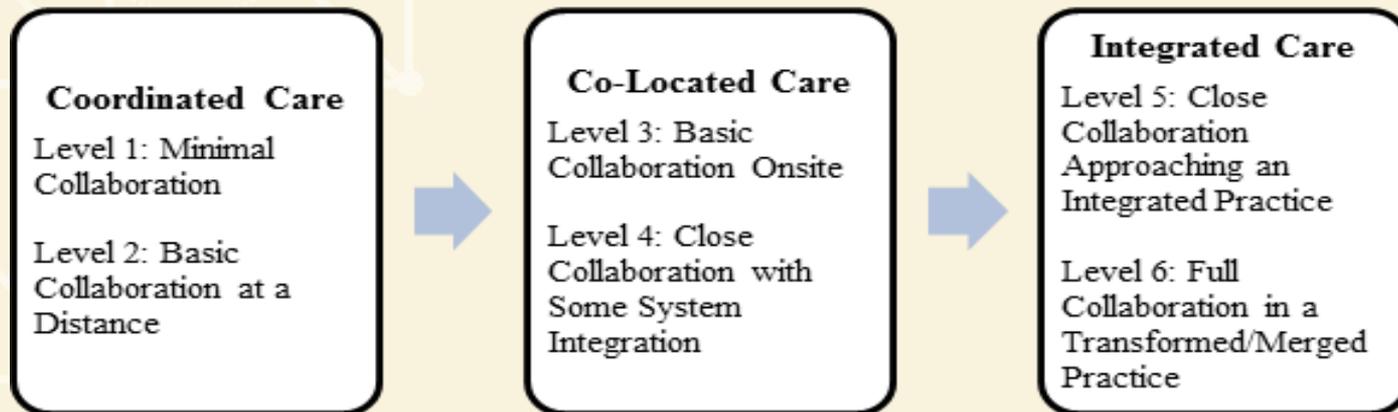
Common Care Coordination Activities

- Establish accountability and agree on responsibility
- Communicate and share knowledge
- Assess individual needs and goals
- Create proactive care plans
- Facilitate care transitions
- Monitor, follow-up and respond to changing needs
- Support individual self-management goals
- Link to community resources
- Align resources with individual and population needs

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>

Care Coordination Models

Heath, B., Wise Romero, P., & Reynolds, K.A. (2013). *A standard framework for levels of integrated health care*. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions



Poll #2: What care coordination model are you currently using? (Select the best answer for your organization)

- a.** Coordinated care: minimal/basic collaboration
- b.** Co-located care: basic collaboration on site
- c.** Integrated care: close collaboration/ fully integrated practice
- d.** None of the above

Next Steps: Who is Responsible for Care Coordination and How is It Working?



Analyze your Current State

What is happening now with your organization:

- What type of care coordination approach do you use?
- Who is responsible for care coordination: at the leadership level? among practitioners?
- Do you have a clear definition and principles from which to work?

Let's chat

What works well?

Where are there gaps or redundancies?

Looking Forward: How will You Transform your Practices?



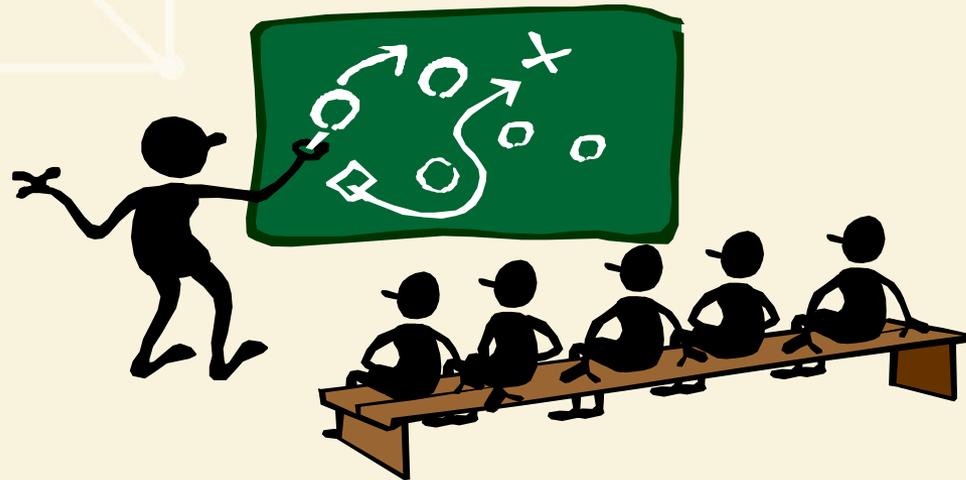
Define Where You Want to Be

What would you like to change to improve care coordination at your organization?

- How does care coordination add value to your mission and purpose?
- How will you identify and prioritize change efforts?
- How will you measure success – identify indicators or metrics?
- What benchmarks or milestones will allow you to know that you are heading in the right direction?

How Will You Get from Here to There?

Who
What
How
When
Where
Why



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

Participant Expectations

1. Complete and submit self-assessment by January 14th
2. Develop a detailed work plan for effective behavioral health integration
 - Goals, tasks, staff leads, timelines, deliverables
3. Participate in webinars and coaching calls
4. Share your experience and learning with others

Next Steps

Next scheduled webinar: January 22, 2015 2-3 pm EST

Homework: - Complete self- assessment; submit results to Sue Pickett at Advocates for Human Potential

spickett@ahpnet.com

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

Senior Associate

hannahm@thenationalcouncil.org

202-684-7457, ext. 255

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

integration@thenationalcouncil.org

Happy Holidays!





SAMHSA-HRSA Center for Integrated Health Solutions

Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.