NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

Improving Client Outcomes with Care Coordination

Wednesday, January 20, 2021

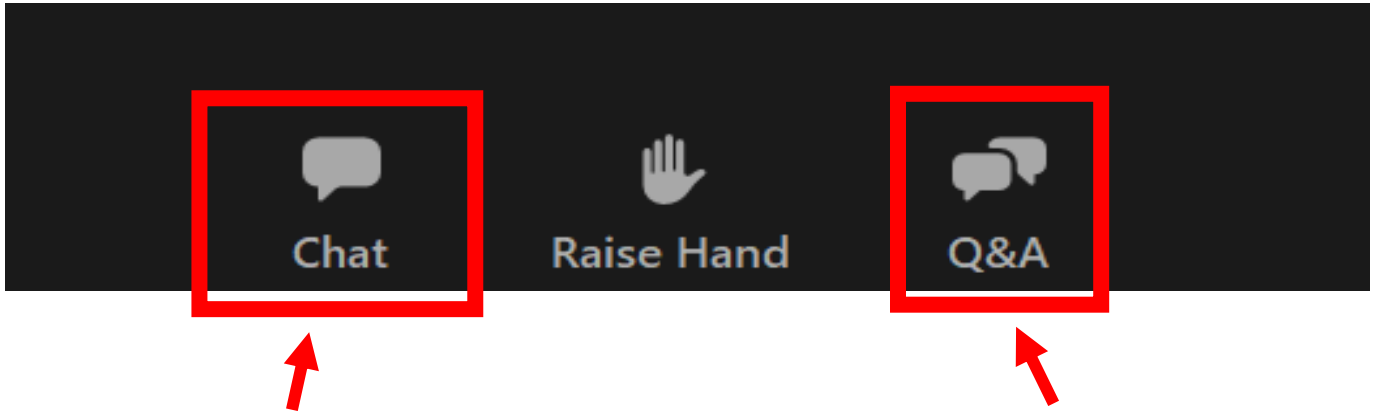
2:00-3:00pm EST

CoE

Center of Excellence for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration
Operated by the National Council for Behavioral Health

How to Ask a Question/Make a Comment



Type in a **comment** in the **chat box**

Type in a **question** in the **Q&A box**

Both are located at the bottom of your screen.

We'll answer as many questions as we can at the end of the presentation.

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SAMHSA
Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)

Poll #2: What best describes your organization? (check all that apply)

- Behavioral Health Provider
- Primary Care Provider
- Mental Health Provider
- Substance Use Disorder Provider
- Other (specify in chat box)

Poll #3: Where is your organization in the process of integration?

- Learning/Exploring
- Beginning Implementation
- Advanced/Full Implementation
- Ongoing Quality Improvement
- Other (specify in chat box)

Introductions

Joan King
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Clinical Director,
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Learning Objectives

In this webinar participants will:

- Define the role of care coordinator
- Identify the functions of care management and how care coordination fits into these functions
- Plan for change to improve their care coordination

A Moment to Arrive

Why Care Coordination/Care Management?

Begin with the end in mind…

The U.S. has a *SICK CARE* System NOT a *HEALTH CARE* System

- **45%** of Americans have one or more chronic conditions
- Over half of these people receive their care from ***3 or more*** physicians
- Treating these conditions accounts for **75%** of direct medical care in the US

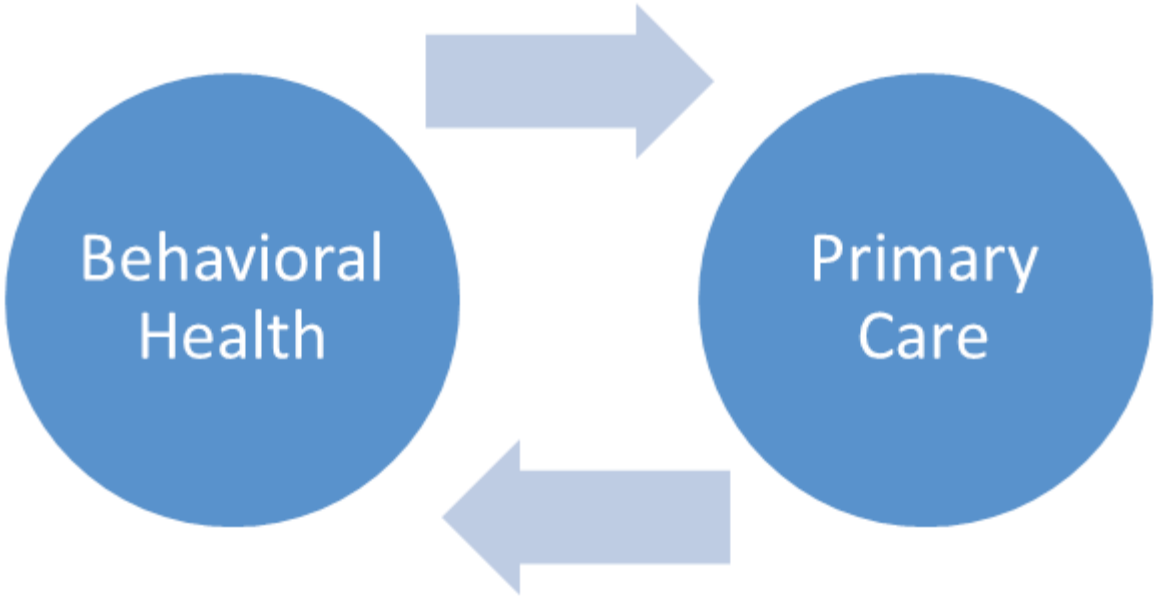
Source: Partnership to Fight Chronic Disease, https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf

12% of Americans Have 5+ Chronic Conditions

- **41% of healthcare spending**
- **32% visited ER at least once ($1,200 per visit, on average)**
- **Filled 6x the amount of prescriptions**
- **More than 50% have physical limitations that affect daily life**

Source: Thorpe, Kenneth. "Rising Chronic Disease Rates Portend Unsustainable Costs" June 20, 2017.

Integrated Care: The Context of Care Management



What is Integrated Care?

"Integrated care could be conceptualized as a **set of processes** expected to address a range of populations and health concerns and targeted to particular **outcomes**. These processes could be performed under any number of different structural models, some of which may be more feasible or effective for achieving good outcomes in certain contexts."

Source: Kwan & Nease Chapter 5 The State of the Evidence for Integrated Behavioral Health in Primary Care (see http://farleyhealthpolicycenter.org/wp-content/uploads/2014/08/Kwan-Nease-2013-Evidence-for-integration.pdf)

What does integrated care look like at your site(s)?

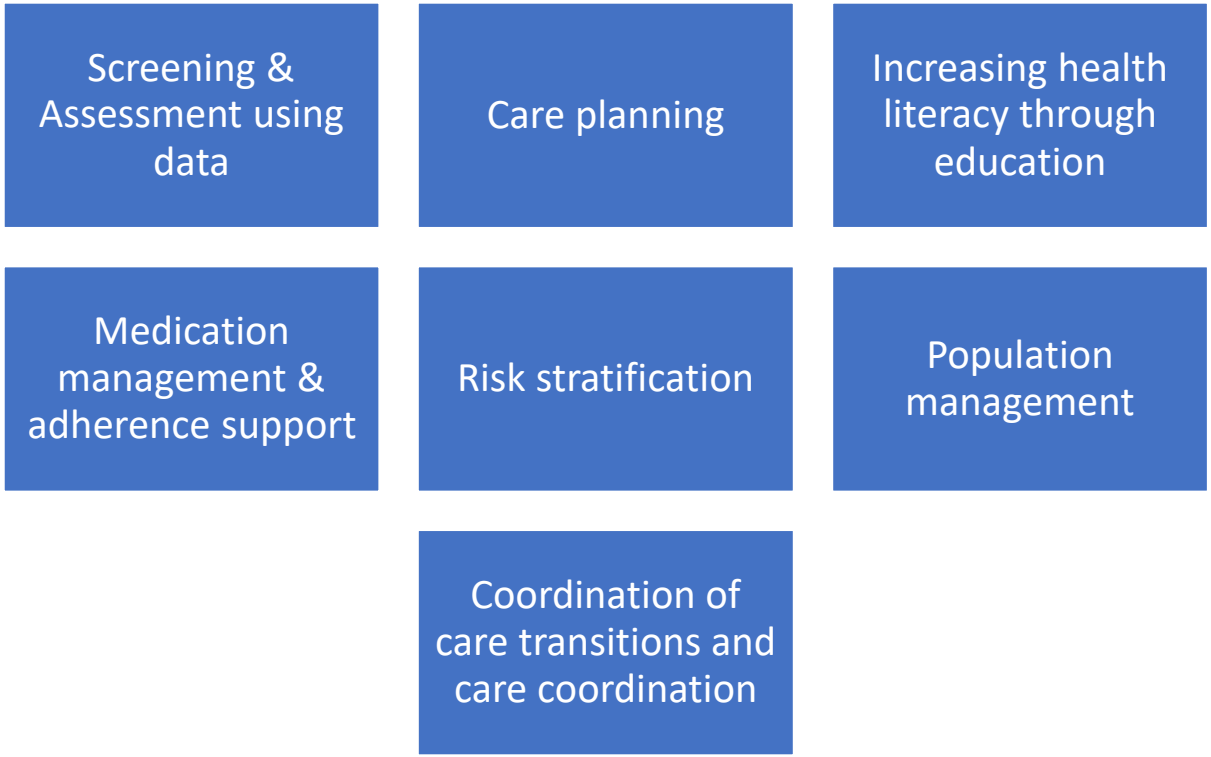
- Communication flow
- Outcome of one visit informs all services?
- How do you coordinate/collaborate with internal primary care provider?
- How do you coordinate/collaborate with external primary care or specialty care providers?

One Process: Care Management

Care management refers to activities performed by health care professionals with a goal of achieving the person-centered treatment to target outcomes with the person.

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.

Activating Care Management



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.

Care Coordination?

Care Coordination Defined: A Function and a Role

"The deliberate organization of patient care activities between two or more **participants** involved in a patient's care to facilitate the **appropriate** delivery of health care services."

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.

Isn't Care Coordination Someone's Job?

- Some agencies do have a Care Coordinator position but, as we'll see, **it is still the responsibility of all**.
- Care Coordination **duties should be made explicit** in all job descriptions/scope of work/practice documentation.
- Care Coordination must have **target measures**.
- Care Coordination **measures must be monitored** and **brought back into specification** if targets are not met using CQI methods.

Perspectives on Care Coordination

Patient & Family ask…

✓How easy is it for me to get the care I/my loved one needs?

Healthcare Provider asks…

✓How easy is it for me to do my work?

System Representatives ask…

✓How easy is it for me to know care is effective & efficient?

Source: McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C,Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

What is meant by "Transitions of Care"?

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change

- **Across health states**: e.g., palliative care to hospice, or personal residence to assisted living
- **Between providers**: e.g., PCP to a psychiatrist, or acute care provider to a palliative care specialist
- **Within settings**: e.g., primary care to specialty care team, or intensive care unit (ICU) to ward/department
- **Between settings**: e.g., inpatient hospital to outpatient care, or ambulatory clinic to senior center

Source: NTOCC

Characteristics of Patients Who Are Readmitted to Hospitals

- **Inadequate information and preparation for post-discharge care and self-care.**
- **Untimely and uncoordinated post-hospital care in their community.**
- **Preventable medical errors/ complications during the first hospital stay.**
- **Poor transmission of hospital records and discharge instructions to primary care clinicians or to organizations which authorize or provide post-discharge care.**

The highest rates of readmitted patients:

- Have heart failure, chronic obstructive pulmonary disease (COPD), psychoses, intestinal problems, and/or have had various types of surgery (cardiac, joint replacement, or bariatric procedures).
- Take six or more medications, have depression and/or poor cognitive function, and/or have been hospitalized in the previous six months.
- Are discharged on weekends and holidays.

Source: National Priorities Partnership Compact Action Brief, "Preventing Hospital Readmissions: A $25 Billion Opportunity"

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Transitions of Care Elements

Seven Essential (and Measurable) Elements:

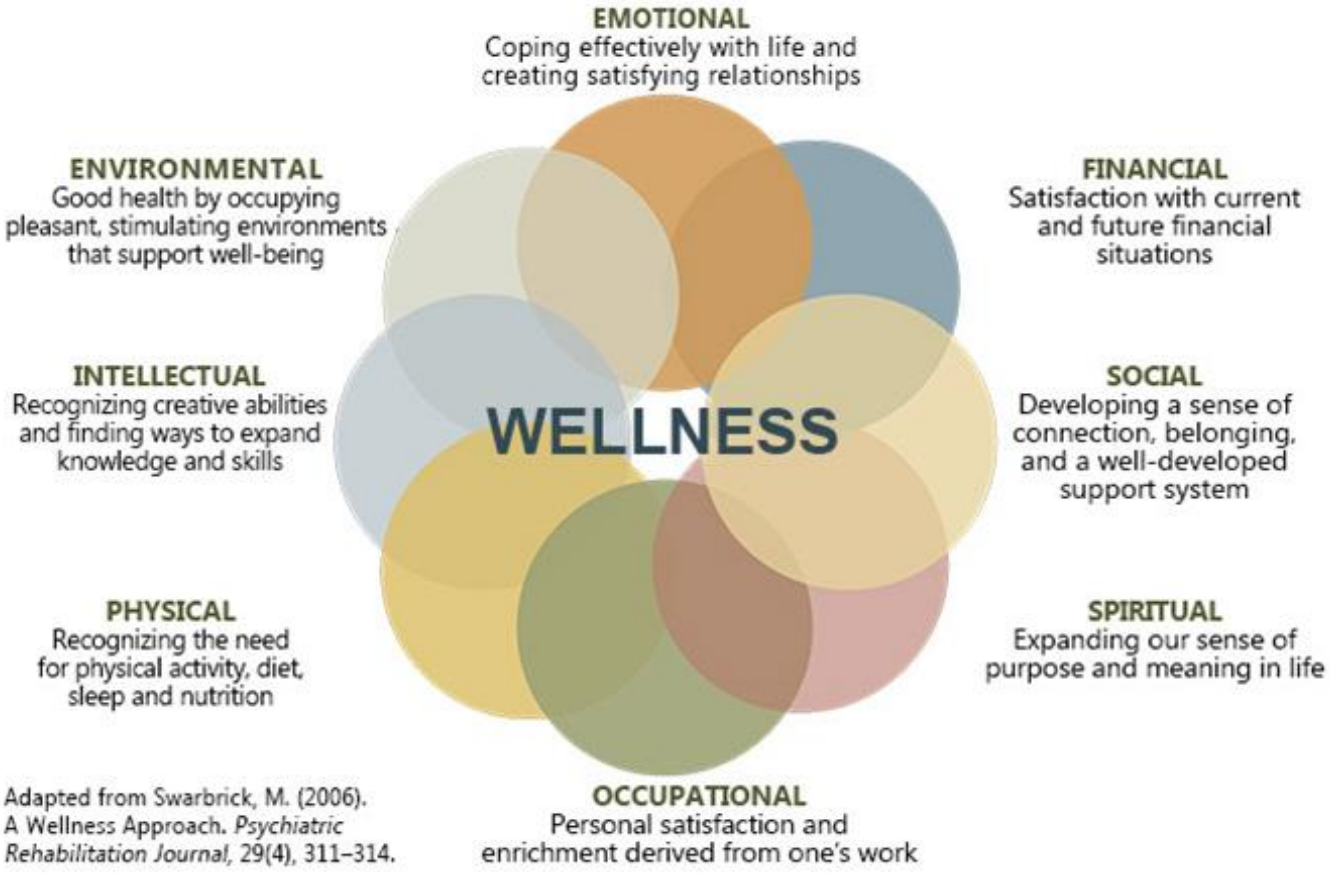
1. Medication Management
2. Transition Planning
3. Client and Family Engagement
4. Information Transfer
5. Follow-Up Care
6. Healthcare Provider Engagement
7. Shared Accountability Across Providers and Organizations

Source: NTOCC's Seven Essential Elements of Transitions of Care

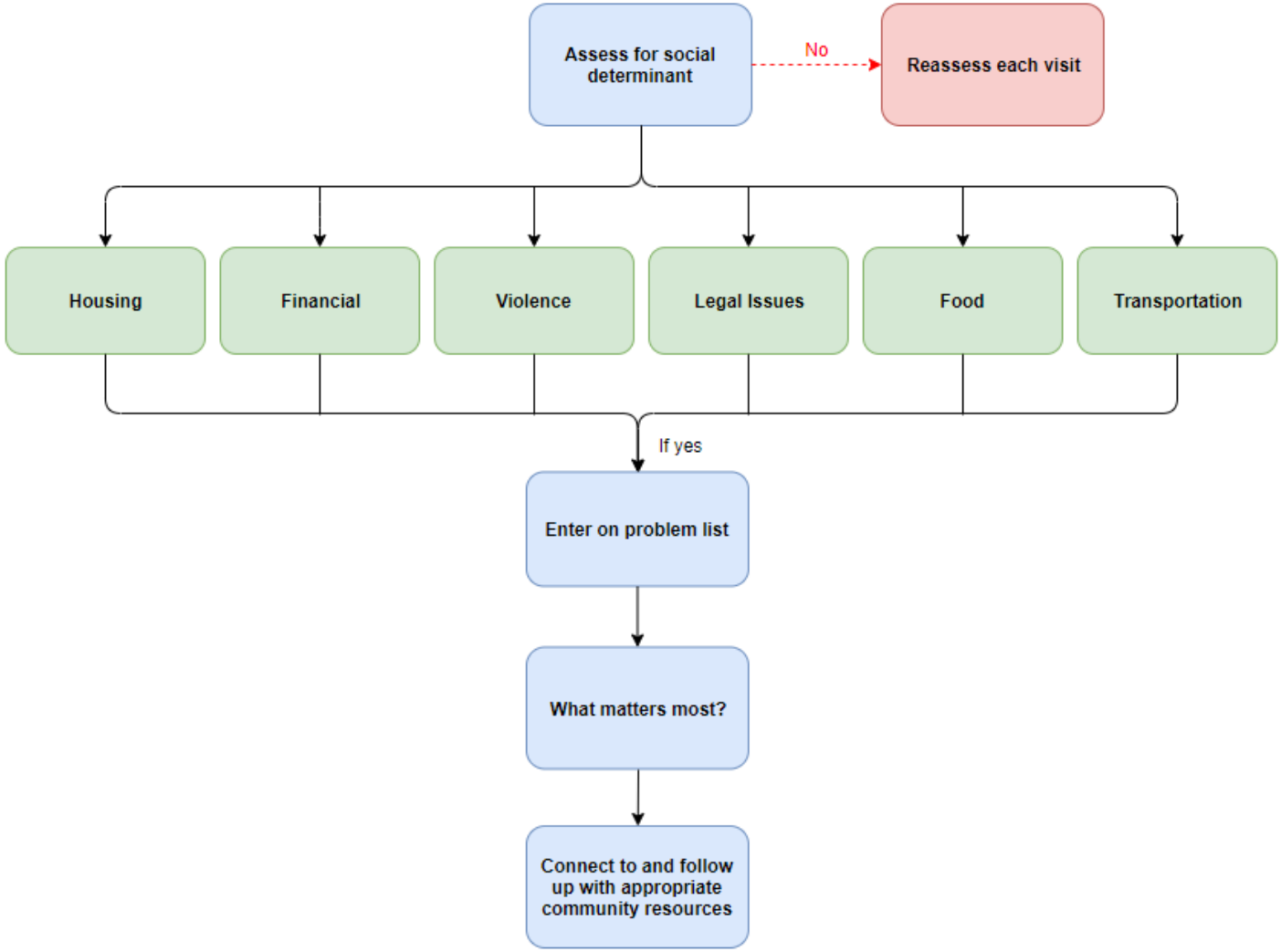
Care Transition (CT) Elements and Associated Metrics

Elements	Metric Examples
Medication Management	Prescriptions filled by client
Transition Planning	Number of CT meetings between CMH/hospital
Client and Family Engagement	Number of CT meetings with client/family/CMH/Hospital staff
Information Transfer	Care Coordination Data shared between providers
Follow-Up Care	Appt scheduled within 7 days of hospitalization
Healthcare Provider Engagement	Number of no-shows
Shared Accountability across Providers and Organizations	Metrics defined in BAA

How Does Your Care Coordination Span these Dimensions of Wellness?



Care Coordination Starts with Assessment



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Community Level Activities

1. **Mapping of organizations providing & helping** to coordinate services *(Who does what and how in your community?)*
2. **Agreement on cross agency care coordination standards** *(e.g., no wrong door, data sharing and review, fast track referral, etc.)*
3. **Process & Outcome Measures** *(How do you know if you have a good/horrible value proposition/follow-thru w/ Care Coordination?)*
4. **Policy/Protocols for monitoring care coordination** efficiency/effectiveness including post action reviews
5. **Cross training** on and supervision for standards
6. **Regular meetings** between providers to review data
7. **Use of safety/crisis plans** between and within organizations

Community Level Care Coordination

- Prevention Agencies
- Faith Community
- Housing (includes group homes, landlords & homeless services)
- Food Banks
- Employment Services
- Financial Services
- Primary Care
- S/A Providers
- MH Providers
- Specialty Physical
- Dental Providers
- Pharmacies
- Schools
- Police
- Courts
- Emergency Medical Services
- Emergency Rooms
- Transportation Services
- Utilities & Utilities Assistance
- Clothing, Furniture, etc.
- Legal Aid
- Hospice
- Nursing Homes
- Elder Care Providers

Action Planning

- What gaps are present?
- How do you address them, what is a first step?
- How are your direct care staff prepared for their role/participation in care coordination?
- How do your care coordinators understand their function with other internal and external care team members?

Care Coordination in Certified Community Behavioral Health Centers (CCBHC)

- Care Coordination and Care Management in CCBHCs
- Care Coordination in CCBHC model
- Best practices and strategies

Western Mental Health Center - Minnesota

Western Mental Health Center

Questions?

Resources

- Institute for Healthcare Improvement “Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs”
- Missouri Department of Health Care Coordination Toolkit
- Reducing Care Fragmentation: A Toolkit for Coordinating Care
- Partnership to Fight Chronic Disease, Growing Crisis of Chronic Disease in the U.S. Factsheet
- Rising Chronic Disease Rates Portend Unsustainable Costs article by Kenneth Thorpe
- The State of Evidence for Integrated Behavioral Health in Primary Care
- Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7 Care Coordination)
- Care Coordination Measures Atlas Version 3

Resources (cont'd)

- National Transitions of Care Coalition – Transitions of Care Measures
- National Priorities Partnership Compact Action Brief "Preventing Hospital Readmissions: a $25 Billion Opportunity"
- National Transitions of Care Coalition – Seven Essential Intervention Categories
- A Wellness Approach (Swarbrick 2006)
- Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework
- Reducing Care Fragmentation: A Toolkit for Coordinating Care
- Team-Based Care Toolkit – Making the Case for High-functioning, Team-based Care in Community Behavioral Health Care Settings
- Toolkit for Designing and Implementing Care Pathways

Upcoming CoE Events:

Population Health Management Strategies
Register here for webinar on Jan. 28, 2-3pm ET

CoE Office Hours: Resources to Advance Health Equity Within Your Organization
Register here for Office Hour on Jan. 21, 3-4pm ET

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Thank You

Questions?

Email integration@thenationalcouncil.org

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