

# Rural Health Networks Care Coordination Models

Alyssa Meller & Debra Laine

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### Objectives

- Understand the role Care Coordination plays in the new Value-Based payment model.
- Gain insight into the basic components of Care Coordination
- Understand how the technology is a integral part of each component
- Introduced to a tool to assist in developing Care Coordination program



### It's Changing!

### Triple Aim

- Better health
- Better care
- Better cost





### Population Health Has Many Partners

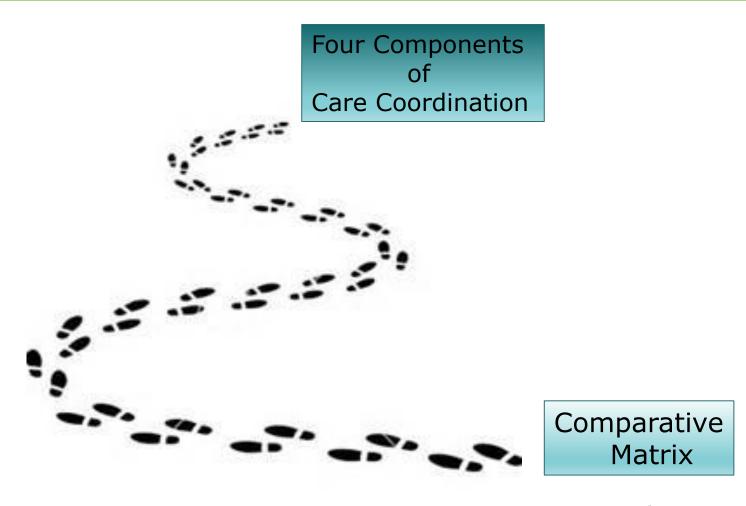
### Predictors of Health Status\*

- 10% Clinical Care
- 10% Genes and Biology
- 40% Social and Economic
- 30% Behavioral
- 10% Environmental

The ah-ha: Health care providers can't change the U.S. health outcomes alone.

<sup>\*</sup>Determinants of Health Model based on frameworks developed by: Tarlov AR. Ann N Y Acad Sci 1999; 896:281-93; and Kindig D, Asada Y, Booske B. JAMA 2008; 299(17): 2081-2083.

# Matrix to Components





### Components to Worksheet



Network
Care Coordination
Worksheet

Four Components of Care Coordination



### Health

Health is a state of complete physical, social and mental well-being, not merely the absence of disease or infirmity.

Source: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946: signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1048.



### Care Coordination

Community-based. Integrates primary care, behavioral health, local health and community resources to provide <u>person-centered</u>, coordinated <u>services</u>.

Source: Rural Health Innovations (RHI), National Rural Health Resource Center, Duluth, MN.

### Care Coordination

An opportunity to supplement the diagnosis and treatment priorities of medicine with clinical and nonclinical prevention and management in a system that also supports the social aspects of patients' lives that contribute to health.

Source: Rural Policy Research Institute (RUPRI) – Care Coordination in Rural Communities: Supporting the High Performance Rural Health System, June 2015, p. 2)

### Care Coordination

Provide information to clinicians to share and provide next care steps in diagnosis and treatment. It assures the patient is in appropriate care setting as they transition across settings.

Source: Certification Commission of Health Information Technology (CHHIT) - A Health IT Framework for Accountable Care, June 6, 2013.



### The Four Components

### Target Population

 Improving the care, health and reducing costs for a specific group of people.

#### Assessment

 A tool or survey used by the care coordinator to assess a person's level of need for services and coordination.



### The Four Components

### · Care Plan

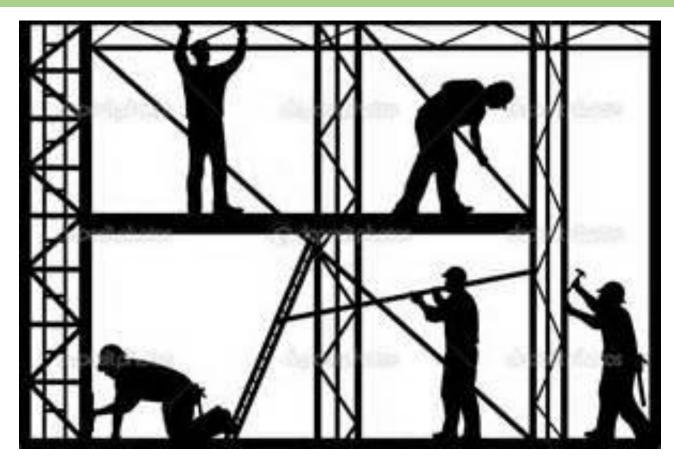
 An individualized plan of care that is developed with the person/caregiver and providers to identify the person's needs.

#### Care Team

 A team of interdisciplinary <u>providers</u> identified with the person and/or caregiver that represents the clinical, behavioral health, social services, long-term care and community resources needed to help meet the goals and outcomes of the person.



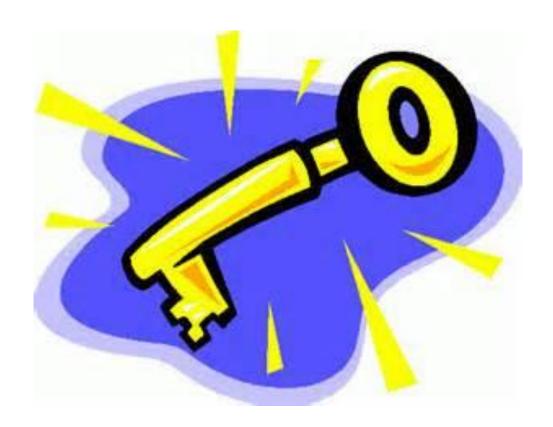
### Technology



Part of the infrastructure



### Communication & Collaboration





### Tool

Network Care Coordination Worksheet			
1. Target Population		2. Assessment tool(s)	
1a. Is it specific enough? Further refine if needed?	1b. How will the target population be identified?	2a. Is one needed?	2b. What is the type or how will it be used?
1c. How will communication occur with the person?		2c. How will results be communicated+? Store it?	
1d. How will technology be used to perform these functions?		2d. How will technology be used to perform these functions?	
3. Care Plan		4. Interdisciplinary Care Team	
3a. What approach to developing is being taken?	3b. What is included (components of)?	4a. Who is the coordinator?	4b. How will you build collaboration with the provider or partners of the care team?
3c. How will the care plan be communicated with the person, the care team?		4c. How will the care team communicate with the person, coordinator and amongst themselves?	
3d. How will technology be used to perform these functions?		4d. How will technology be used to perform these functions?	
5. Leadership next steps		6. Business Model	



### Target Population

#### **Network Care Coord**

#### 1. Target Population

Children and families that are having a hard time accessing Mental Health, Health care

# 1a. Is it specific enough? Further refine if needed?

No, need to narrow it down more

### 1b. How will the target population be identified?

- Developed a specific referral mechanism
- Try to clarify the needs
- Some telephone calls

#### 1c. How will communication occur with the person?

Telephone and in person

#### 1d. How will technology be used to perform these functions?

Community needs assessment, public health's records. (This is a Gap for us)



### Assessment

#### ordination Worksheet

#### 2. Assessment tool(s)

- Ages and stages questionnaire
- Pediatric Symptom Checklist
- The child depression inventory
- PHQ-9 and GAD-7 for adult screening or adult teenagers

#### 2a. Is one needed?

Yes

2b. What is the type or how will it be used?

Used to develop the care plan

#### 2c. How will results be communicated? Store it?

The care coordinator is usually the one doing the screening.

#### 2d. How will technology be used to perform these functions?

All the screening are done with pen and paper. Hopefully in the future it will be done electronically



### Care Plan

#### 3. Care Plan

- Model is very family and is specific to that family.
- Try to include strengths and resources that the family has currently available to them
- We cannot force parent to do something they do not want to so try to focus on small goals and grow from there

### 3a. What approach to developing is being taken?

Family driven and patient centered

#### 3b. What is included (components of)?

Interventions

Family strengths are incorporated

#### 3c. How will the care plan be communicated to the person, the care team?

- It is communicated to the family via care coordinator
- They must sign off on the care plan
- If they are under are under 12 they do not have to sign the care plan

#### 3d. How will technology be used to perform these functions?

Excel spreadsheet.



### Care Team

#### 4. Interdisciplinary Care Team

- Any service provider that is involve in that families services.
- Constant is a primary care physician/school/sometimes mental health provider/early childhood intervention/Care coordination.
- Very specific to each family

#### 4a. Who is the coordinator?

Need at least a bachelor's degree so they can bill for Medicaid. Bachelors in psychology or education is preferred.

### 4b. What provider or partners are part of the care team?

Dependent on the client

### 4c. How will the care team communicate with the person, coordinator and amongst themselves?

- Biweekly team meetings and the staff is constantly on the phone with each other
- Supervised individual one on one meetings every other week
- Also meet on a need basis

#### 4d. How will technology be used to perform these functions?

Text messages, email and phone...possibly in the future using video conferencing



### Use of Tool

Network Care Coordination Worksheet				
Target Population: Improving the care, health and reducing costs for a specific group of people.	2.Assessment Tool(s) A tool or survey used by the care coordinator to assess a person's level of need:  Social, environmental, mental health, physical and psychosocial functional needs  Risk or severity level of a diagnosis and/or disease			
a. Is it specific enough?  Clearly define the goal or outcome of the identified problem  Be Specific  It Must Be Measureable  Community Health Needs Assessm  EHR Data Payer Claims Data Population Focused Registries Referrals	Commonly the target population is The type used will be determined by your target			
1c. How will communication occur with the person? By phone, In-Person a combination. Where will it take place? How often will it happen?      1d. How will technology be used to perform these functions? Technology.	2c. How will the results be communicated? Where will it be Stored? Do the results need to be shared with the care team, do they help identify members of the care team? Can the results be used for evaluation and measurement?      2d. How will technology be used to perform these functions? The assessment			
be of great assistance to 'mine' data. Communication: Secure messaging, portals	tool can be electronic, web based and saved in EHRs. Can be communicated via secure messaging, portals.			
<ol> <li>Care Plan: An individualized plan of care that is developed with the person/caregiver and providers to identify the person's needs.</li> </ol>	Care Team: A team of interdisciplinary providers identified with the person and/or caregiver that represents all the providers needed to help meet the needs, goals and outcomes of the person.			
3a. What approach to developing the care plan is being taken, so that it is:  Developed with the person Based on assessed needs Accounts for medical, behavioral health, wellness and human service's needs (social determinants) Incorporates existing care and treatment plan information  3c. How will the care plan be communicated and shared with the person, care team? How will updates be shared and the care plan updated  3d. How will technology be used to perform these functions? EHRs, secur messaging, portals	Dependent of the needs of the population, what the focused outcome are, but can be: Community Health Worker, Social Worker, Nurses, Physician Assistants, Certified Medical Assistant, Physician, Community Paramedics  the  4c. How will the care team? Collinical Behavioral Health Social Services Long Term Care Community Resources  4c. How will the care team communicate with the person, coordinator and amongst themselves? This is the workflow. Clearly articulate who does what, when and WRITE it down.			
5. Leadership next steps? Community Coaches Develop Advocates Community Education and information meetings Focused Conversations	6. What is your Business Model? Community Mental Health Primary Care Integration Health Plan Based Provider Based			





# Alyssa Meller

Director of Operations
National Rural Health
Resource Center
600 East Superior Street
Suite 404
Duluth, MN 55802
218-727-9390 ext. 240
ameller@ruralcenter.org

# Debra Laine

Program Specialist
National Rural Health
Resource Center
600 East Superior Street
Suite 404
Duluth, MN 55802
218-727-9390 ext. 242
dlaine@ruralcenter.org

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