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Rural Health Networks Care Coordination Models

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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

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It's Changing!

Triple Aim

- Better health
- Better care
- Better cost

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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.

***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.**

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Matrix to Components

Four Components of Care Coordination

Comparative Matrix

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Components to Worksheet

Network
Care Coordination
Worksheet

Four Components
of
Care Coordination

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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 on22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on7 April 1048.

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Care Coordination

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

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

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Care Coordination

An opportunity to supplement the diagnosis and treatment priorities of medicine with clinical and non-clinical 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)

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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.

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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.

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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 providers 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

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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	

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Target Population

Network Care Coor[d...]	
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)	

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

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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?	**3b. What is included (components of)?**
Family driven and patient centered	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.

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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	

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Use of Tool

Network Care Coordination Worksheet

1. Target Population: Improving the care, health and reducing costs for a specific group of people.

1a. Is it specific enough?
- Clearly define the goal or outcome of the identified problem
- Be Specific
- It Must Be Measureable

1b. How will the target population be identified?
- Community Health Needs Assessments
- EHR Data
- Payer Claims Data
- Population Focused
- Registries
- Referrals

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 can be of great assistance to 'mine' data. Communication: Secure messaging, portals

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

2a. Is one needed? Commonly the target population is generally defined and an assessment can help determine the level of coordination needed or what types of services are needed.

2b. What is the type or how will it be used? The type used will be determined by your target population and desired outcomes.

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 tool can be electronic, web based and saved in EHRs. Can be communicated via secure messaging, portals.

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

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

3b. What is included (components off)?
- Goal or outcome
- Clinical and Social needs
- Instructions and Interventions
- Interdisciplinary Care Team Members, Including Contact Information
- Person Demographics

3c. How will the care plan be communicated and shared with the person, the care team?
How will updates be shared and the care plan updated

3d. How will technology be used to perform these functions? EHRs, secure messaging, portals

4. 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.

4a. Who is the coordinator? 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

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

4d. How will technology be used to perform these functions? EHR, secure messaging, portals, phone, video conferencing

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

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