Community Care Coordination (CCC): A Model to Support Rural Health

RHPI HELP Webinar

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Agenda

- About Stratis Health
- Overview of community care coordination (CCC)
- Importance of community care coordination to rural health
- Program components and considerations
- Q & A

About Stratis Health

- Independent nonprofit organization that leads collaboration and innovation in health care quality and patient safety. We work across settings of care to improve the health of individuals and communities, and to improve the processes used to deliver care.
- Stratis Health facilitates learning and action networks across communities, and provides direct technical assistance to health care providers.
- Four key program areas: Rural Health, Health Disparities, Health IT, and Medicare Quality Improvement Organization (QIO)

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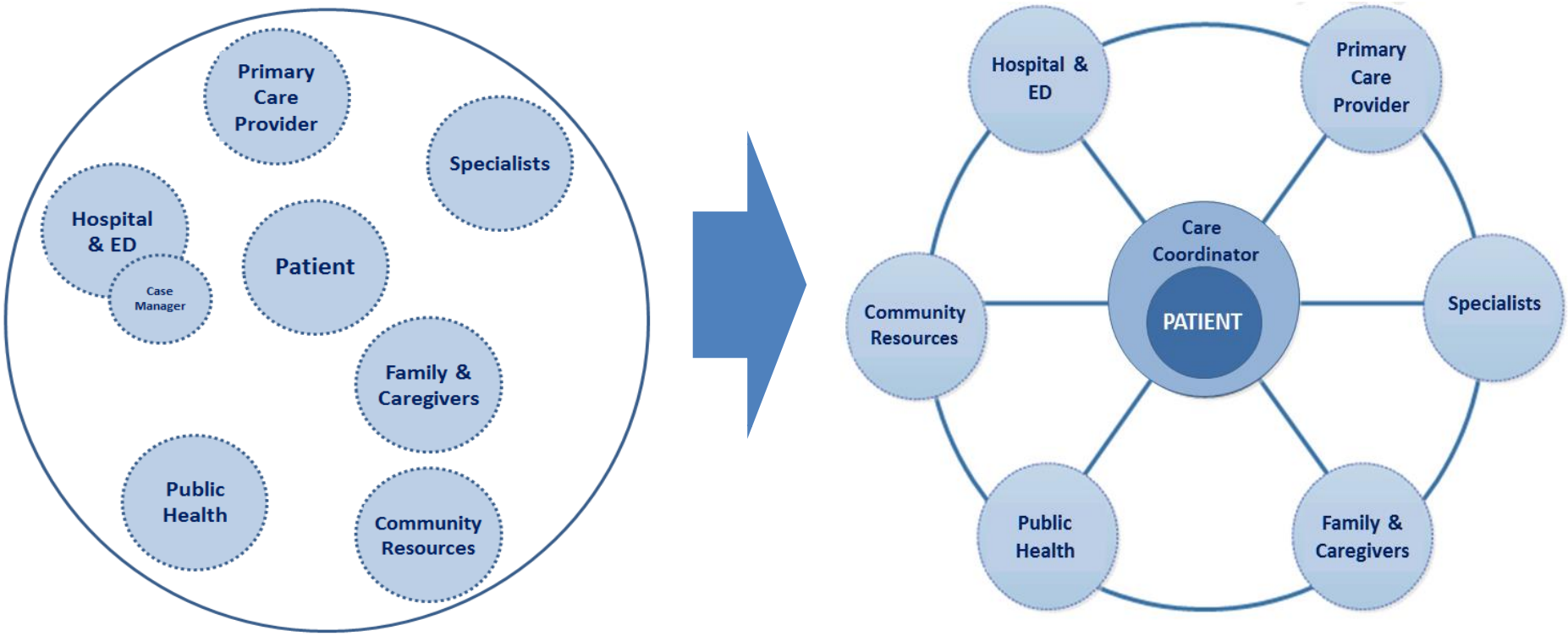
About Me

- Clinical practice transformation: Three rural FQHCs in North Dakota working toward Patient-Centered Medical Home (PCMH) recognition
- Community care coordination program development: CAHs, FQHCs and RHCs in nine rural communities across three states
- Mother/advocate of child with ADHD and depression
- Primary caretaker of parents with multiple health conditions associated with aging

Common denominator: Care coordination

Changing the Health Care Model



Traditional environment: Loose connection of providers working autonomously

New environment: Patient is the focal point

Requires: Collaboration among healthcare professionals and others

Which requires: Roles seen in a different light; new communication skills

Community Care Coordination

A **partnership** among health care professionals, clinics and hospitals, specialists, pharmacists, mental health professionals and community services and resources **working together** to provide **patient-centered**, coordinated **care**.

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Partners in Community Care Coordination

Community Care Coordination: A Story

40-year-old Jeremie Seals

- Heart attack at 35
- Congestive heart failure
- Nerve pain in legs
- Deteriorated health, unable to hold a job, slept in his car

2011: Visited ED 15 times; admitted to hospital 11 times

Enter Lisa Pearlstein, Care Coordinator (Health Share of Oregon)

Care Coordinators guide patients through the medical maze.

National Public Radio: *How Oregon Is Getting 'Frequent Fliers' Out of the ER*. July 10, 2013.
Retrieved from http://www.npr.org/blogs/health/2013/07/10/200406181/how-oregon-is-getting-frequent-fliers-out-of-the-er

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Community Care Coordination (continued)

First meeting:

Jeremie complained about wet feet.

Lisa: *"Why are your feet wet?"*

Jeremie: *"I have holes in my shoes."*

Lisa: *"Would you like a new pair of shoes?"*

Lisa bought him boots, a pillow and a warm sleeping bag. ***They connected.***

Lisa helped Jeremie by:

- Scheduling doctor appointments
- Helping him understand what he needed to do
- Getting him needed dialysis
- Teaching him to take medications correctly
- Getting passes for local community center to shower
- Negotiating a spot in adult foster care
- Teaching him to communicate effectively with his doctor

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Community Care Coordination (continued)

Jeremie's doctor saw an amazing change:

*"When he has the resources available to him and when housing had stabilized for him, he is actually wanting to be adherent to the medication." **

With care coordination/intervention:

- ED visits dropped from 15 in 2011 to 4 in 2012
- Hospital stays went from 11 to 3

*"It doesn't take very many ED visits and it takes less than one hospital admission avoided to actually more than pay for the time that Lisa spent with Jeremie." ***

* Quote from Christina Milano, MD (Jeremie Seals' doctor)

** Quote from Rebecca Ramsey of CareOregon, a nonprofit health plan for Medicare and Medicaid patients

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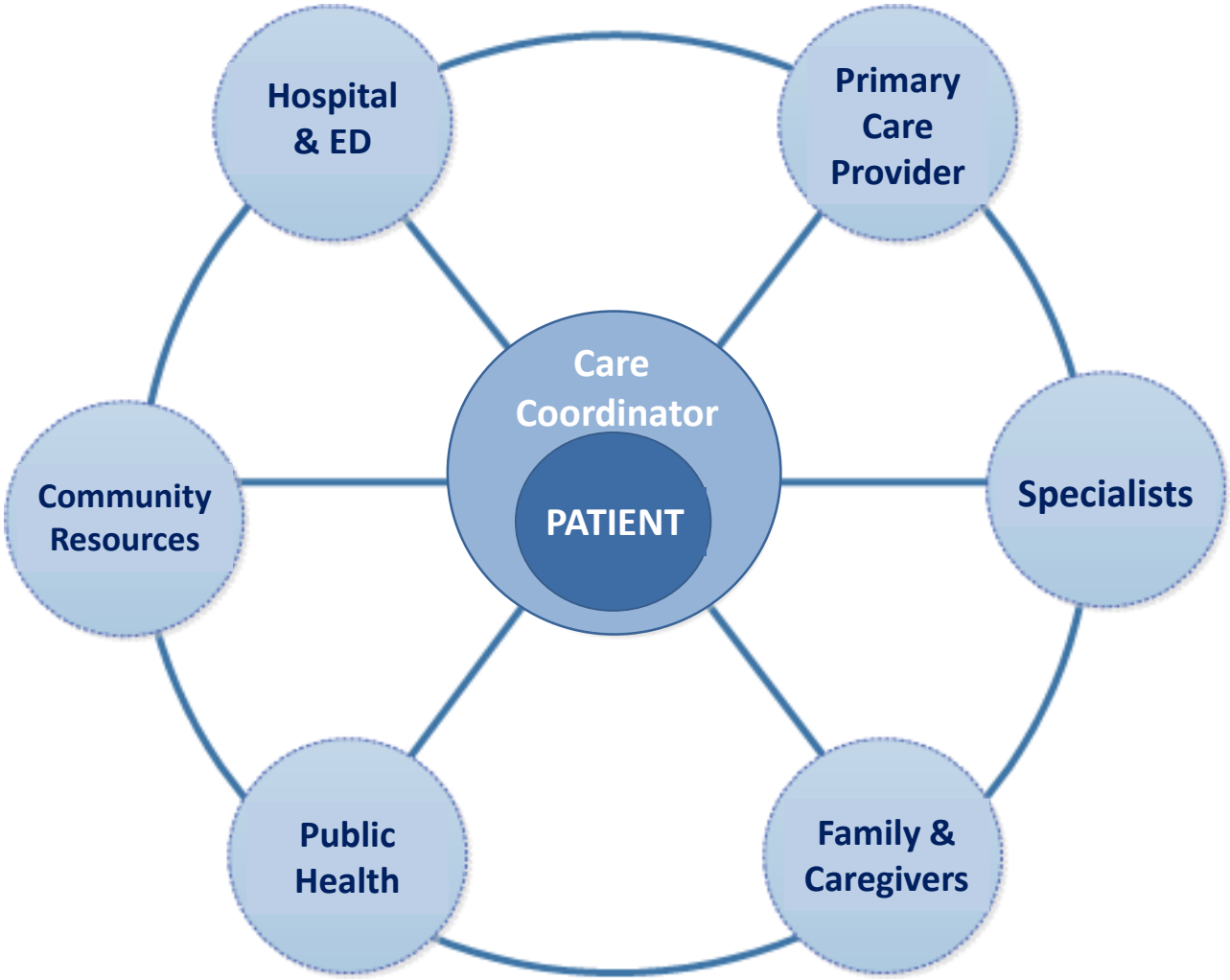
Communication / Interdependencies

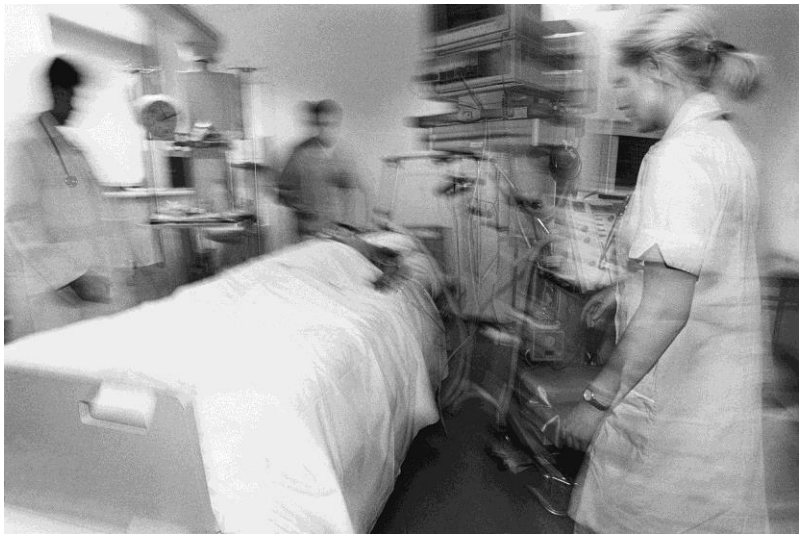


The care coordinator is an advocate for the patient and is in communication with all of these entities

Care Coordination in Rural Communities

Challenges and Barriers

- Transportation
- Health literacy
- Family and social support
- Community resources
- Transitions of care
- IT infrastructure
- Health information exchange
- Access to specialty care
- Staff limitations



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Building a CCC Program: Considerations

- **Readiness and commitment**—leadership *and* staff
- **Community capability** and willingness to participate
- **Capacity** (time, resources, priorities, competencies)
- **Licensure** of Care Coordinator (RN, NP, PA, LSW, CHW)
- **Support team** (patient recruiting, referral tracking/follow-up, appointment scheduling, etc.)
- **Quality metrics** and reporting
- **Infrastructure** (EHR, registry, HIE)
- **Target populations**

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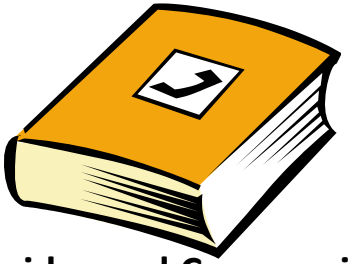
A Few Helpful Tools . . .



Provider and Community Resource Directories

EHR Registry

Electronic Health Record

Personal Health Record

Health Information Exchange

Steering Committee

Business Associate Agreement(s)

Health Risk Assessment(s)

Scripts/Talking Points

Patient Action Plan Template(s)

Guide to Patient Self Management

Patient Health Diary

Scheduling Tool

Referral Tracking/ Follow-up Tool

CC Job Description

Team Roles & Responsibilities

Communication Plan

Building a CCC Program: My Best Tips

- A **physician champion** is paramount
- Be prepared! Plan and **communicate with all stakeholders**
- **Engage community resources** from the very beginning
- Ensure **infrastructure** is in place—including support team
- Be clear about **roles and responsibilities**
- **Start with small cohort** and build capacity as you learn
- Determine **process *and* outcome metrics**, and data collection plan
- Be transparent with measures, and **build workflow and quality improvement mechanisms**
- **Learn and share** with other practices

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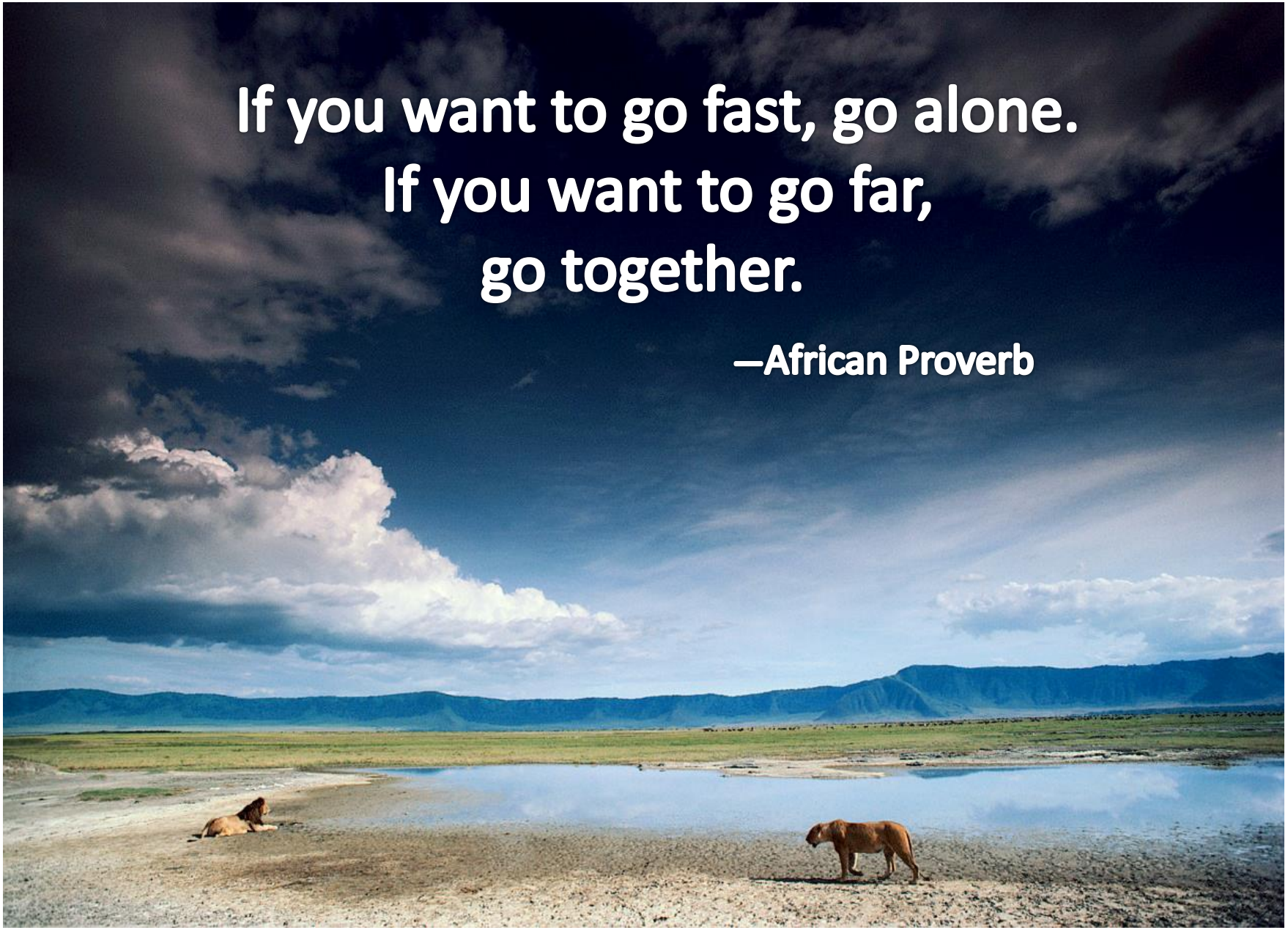
Questions / Discussion


If you want to go fast, go alone.
If you want to go far,
go together.
—African Proverb

Contact Information

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.