Project 3: Community-based Integration
E5: Enhanced Care Coordination for High-Needs Populations

b. Project Selection Rationale and Expected Outcomes

Region 7 chose this project as a means to enhance primary care and behavioral health integration by increasing care coordination for high needs populations. Enhanced care coordination in the region will create a partnership among health care professionals, health centers and hospitals, specialists, pharmacists, mental health professionals, substance use disorder professionals, and community services and resources working together to provide patient-centered, coordinated care. By enhancing the focus on care coordination, and allocating resources to all of the potential partners, relationships will be strengthened and patient outcomes impacted in positive ways. Care coordination is the logical strategy to compliment the core competency project, work of the transitions in care project as well as the HIT and workforce initiatives. Care coordination will be most effective if there is adequate workforce at various levels of provider teams, adequate health information technology that facilitates exchange of relevant information, and sufficient support for patients and families. Care coordination for high need adult and child populations with multiple physical health and behavioral health chronic conditions is essential to improve outcomes and improve overall health. Region 7 suffers from significant levels of Medicaid beneficiaries who have physical health conditions as well as behavioral health indicators. The table below indicates the percentage of the Region 7 populations with selected physical health conditions who also have behavioral health indicators:

Region 7 populations by age group with physical health conditions and behavioral health indicators				
	Age	**Diabetes condition**	**Respiratory condition**	**Cardiovascular condition**
Behavioral Health indicator	0-11	.67%	41.79%	3.44%
	12-17	.47%	37.24%	6.38%
	18-29	2.83%	33.49%	12.00%
	30-49	9.6%	36.78%	22.76%
	50-64	20.09%	47.93%	42.38%
	65+	26.39%	52.31%	58.80%

Region 7 stakeholders believe that enhanced care coordination will help reduce duplication of services and will assist patients/clients with successful navigation of a very fragmented system. Enhanced care coordination will increase patient's engagement in their own care and encourage greater awareness of available resources and services. Better coordination will ultimately result in reduced cost and help eliminate waste in the system. Regional partners feel strongly that enhanced care coordination will not only benefit patients, but will also improve communication and collaboration among health care providers and agencies.

Community based care coordination integrates primary care, behavioral health, and local health and community resources to provide person-centered, coordinated services. According to the Rural Policy Research Institute, care coordination provides 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.[1]

In order to effectively implement this project, organizations will use a common process to:

- Identify the target population (within the required target populations):

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

a. Adults (18 and older) with behavioral health disorders with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors that are barriers to community living and well-being
b. Children (<18 years) diagnosed with chronic serious emotional disturbance
c. Developmentally disabled population/ aged blind and disabled population with co-occurring behavioral health disorders

- Utilize a tool or survey that will be used by the care coordinator to assess a person's level of need for services and coordination
- Develop a person-centered care plan that is developed with the person/family/caregiver to clearly identify the person's needs
- Develop an interdisciplinary care team of providers identified with the person/family 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

Some of the Region 7 partner organizations already engage in care coordination at various levels. Enhanced care coordination will build on successful models already happening around the region, and best practices will be shared. An assessment will be made so effective tools are used throughout the region. Electronic Health Records (EHRs), electronic registries, personal health records, and health information exchange systems will be important to incorporate into organizational and regional systems. Common scheduling tools and referral/tracking follow-up tools will be evaluated and recommended for use.

This project will focus on the following outcomes:

1. Improved Provider Relationships
   Care coordination will increase communication between primary care providers and other caregivers, including behavioral health and substance use disorder treatment providers. Communication between and among inpatient and outpatient services will also be improved and/or developed.
2. Increased Quality of Patient Care
   Effective care coordination will increase the ability of patients/clients to maintain or improve their functional status. It will also improve patient/client engagement in their own care and health outcomes. Care coordination will also reduce the need for repeat acute care and services for patients/clients. An important benefit of enhanced care coordination will also be savings that may be distributed to address the social determinants of health. Building a network of providers to collaborate among services and resources will improve access to care which will ultimately result in improved quality of care.
3. Reduced Cost of Care
   Comprehensive care coordination is a key strategy that will improve patient/client health and reduce excess cost in the health care system. Effective care coordination is designed to reduce unnecessary services, provide more comprehensive care, and improve health. Coordinated care will potentially have an impact on reducing medication errors, unnecessary or repetitive diagnostic tests, and preventable emergency room visits. All of these costs, in addition to hospital readmissions contribute to excess spending which is sometimes considered "wasteful spending."

Enhanced care coordination will ensure that a Care Coordinator is in place who is an advocate for patients/clients and their families, and who communicates with all of the entities involved individual-centered care.

c. Participating Organizations: Selection Criteria

Organizations choosing to participate in this project will submit a proposal in response to the sub-recipient request for funds previously discussed. Organization's proposals will be reviewed to ensure they meet the criteria below for effective implementation of the project. Targeted participating organizations for this project will include primary care providers, behavioral health providers (including those that provide mental health and substance use disorder services), and community-based social support service

organizations. Almost all of the Region 7 participating organizations have identified enhanced care coordination as a project in which they would like to participate. Organizations seeking funds to participate in this project must provide services that facilitate linkages and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, as well as linkages to other community supports and resources. Organizations choosing to participate in this project must ensure a collaborative model that will include coordination with other programs or resources that serve similar patients in order to have only one care coordinator who is playing a lead role in the management of a patient's care plan. Organizations will be required to include agencies that are new partners, and must have a collaborative spirit. Organizations must commit to defining a specific care coordination model that will be used and the exact target population they will serve.

Participants in this project will be asked to complete a "Care Coordination Template"[2] shown below:

<table>
<tr><th colspan="4">Care Coordination Template</th></tr>
<tr><td colspan="2">1. Target Population: improving the care, health, and reducing costs for a specific group of people</td><td colspan="2">2. Assessment Tool(s) to be 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</td></tr>
<tr><td>1a. Is it specific enough?
Clearly define the goal or outcome of the identified problem
Be specific
It must be measureable</td><td>1b. How will the target population be identified?</td><td>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</td><td>2b. What is the type or how will it be used?
The type will be determined by the target population and desired outcomes</td></tr>
<tr><td colspan="2">1c. How will you communicate and engage the person? By phone, in-person or a combination. Where will it take place and how often</td><td colspan="2">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?</td></tr>
<tr><td colspan="2">1d. How will technology be used to perform these functions? Technology can be of great assistance to 'mine' data. Communication: secure messaging,</td><td colspan="2">2d. How will technology be used to perform these functions? The assessment tool can be electronic, web based and saved to EHRs. Can</td></tr>
</table>

[2] Adapted from the National Rural Health Resource Center. Duluth, MN

<table>
<tr><td colspan="2">portals?</td><td colspan="2">be communicated via secure messaging, portals.</td></tr>
<tr><td colspan="2">3. Care Plan: An individualized plan of care that is developed with the person/caregiver and providers to identify the person's needs</td><td colspan="2">4. Care Team: Providers identified with the person and/or caregiver that represents the clinical, behavioral health, social services, long-term care and community resources needed to meet the person's goals and outcomes.</td></tr>
<tr><td>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</td><td>3b. What is included?
Goal or outcome
Clinical and social needs
Instructions and interventions
Interdisciplinary Care Team Members, including contact information
Person demographics</td><td>4a. Who is the coordinator?
Dependent on the needs of the population, what the focused outcomes are, but can be: community health worker, social worker, nurse, physician assistant, medical assistant, etc.</td><td>4b. How will you build collaboration with the provider and partners of the care team?
Team meetings to effectively build out the work flow. Communicating so each member of the team knows their role, expectations, and hand offs.</td></tr>
<tr><td colspan="2">3c. How will the care plan be communicated to engage the person, and include the care team? How will updates be shared and the care plan updated</td><td colspan="2">4c. How will the care team communicate with the person, coordinator, and amongst themselves? This is the workflow.</td></tr>
<tr><td colspan="2">3d. How will technology be used to perform these functions? EHRs, secure messaging, portals</td><td colspan="2">4d. How will technology be used to perform these functions? EHR, secure messaging, portals, phone, video conferencing</td></tr>
<tr><td colspan="2">5. Leadership next steps?
Community coaches
Develop advocates
Community education and information meetings
Focused conversations</td><td colspan="2">6. What is your Organizational Model?
Community mental health
Primary care integration
Provider based
Social support based</td></tr>
</table>

e. Monitoring Plan

Organizations implementing projects related to enhanced care coordination will be required to monitor and report to the IDN Lead agency on a regular basis. Each project will be reviewed quarterly by the appropriate Work Group to ensure progress of the project is in line with overall improvement of outcome measures. If sufficient progress is not being made toward identified outcomes, Work Group members will designate an appropriate member to work with the organization and the Administrative Lead to assess the project and propose alternative activities.

The types of process measures that will be used to monitor care coordination programs will include:

- Number of direct/indirect encounter or visits
- Number of duplication/unduplicated encounters
- Number of care coordinators trained to serve patients using an evidence-based curricula
- Number of healthcare providers offering care coordination services
- Number and level of participation of organizations involved in the program
- Number of referrals to other providers
- Number of people receiving services from a care coordinator
- Number of participants who have a self-management plan
- Changes in patient's healthy behaviors

- Changes in patient costs (e.g. streamlining visits with specialty care)

Monitoring criteria that will be implemented for enhanced care coordination projects will be adapted from the Care Coordination measurement framework from the Agency for Healthcare Research and Quality (AHRQ). [3] AHRQ identifies certain domains required to achieve care coordination. Broad approaches to measure care coordination include:

- Teamwork focused on coordination
- Health care home
- Care management
- Medication management
- Health IT-enabled coordination

All organizations will be required to have adequate workforce to carry out activities related to this project. Organizations participating in this project will determine their capacity and have a work plan that reflects their ability to implement all project activities. All sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants.

Specific monitoring sources will include: 1) referral tracking forms; 2) encounter forms and/or outreach logs; 3) targeted qualitative methods (eg. semi-structured interviews or surveys) to understand how the project is unfolding and to account for overall contextual factors that may affect implementation and sustainability of program efforts either positively or negatively; and 4) EHR data and/or hospital data when available. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data. Organizations will be responsible for reporting progress on project activities on a quarterly basis.

The draft measurement plan below for this project provides information about collection of data for each primary outcomes. For ongoing outcomes data, there will be an assessment of the usability and feasibility of a dashboard, similar to the format outlined in the previous community-project plan.

Measurement plan for Region 7

	What	Where	How	When	Who
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Improved provider relationships	# new provider/organization collaborations	Care Plan/Reporting template	Participating organizations complete tracking tool	Quarterly	Program Manager
	Clearly articulate responsibilities of participants in patient care	Care Plan/Reporting template	Participating organizations complete tracking tool	Quarterly	Program Manager
	Facilitate transitions	Referral/tracking form	On-line survey	Quarterly	Program Manager

[3] http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter3.html

		EHR	program		
	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Increased quality of patient care	Resources aligned with patient	Care Plan/Reporting template	Tracking tool	Quarterly	Program Manager
	Medication management	Care Plan/Reporting template	Tracking tool	Quarterly	Program Manager
	Proactive care plans created and communicated	Care Plan/Reporting template	Tracking tool	Quarterly	Program Manager
	Monitor, follow up and respond to change necessary for patient progress toward care and coordination goals	Care Plan assessment EHR	Tracking tool	Quarterly	Program Manager
	Support self-management goals	Care plan	Tracking tool	Quarterly	Program Manager
	What	**Where**	**How**	**When**	**Who**
Program Objective	**Measure and Target**	**Source of Data**	**How is the Data Collected**	**Frequency of Data Collection**	**Who is Responsible for Gathering the Data**
Reduced cost of care	Decreased visits to specialty care	Care Plan/Reporting template EHR	Tracking tool	Quarterly	Program Manager
	Reduced hospital readmissions and ED visits	Reporting template EHR	Tracking tool	Quarterly	Program Manager

f. Challenges and Proposed Solutions

Key challenges the IDN faces in implementing this project include:

1) Addressing the needs of a very sick population and the lack of motivation they have to accept change. Care coordination with this population will be successful if patients are encouraged to begin with small changes that grow over time. Outreach, marketing, and education to both patients and providers will be essential for the success of this project. Both patients and providers have to understand that they are all part of a team that is committed to the success of the patient. In order for this population to be successful it will be important to identify services and to offer choices to them, rather than to just direct what providers believe will be most helpful.
2) Provider and agencies may be resistant to change if an enhanced care coordination model is something new to their practice. It will be important to engage providers and agency staff in problem solving and to create "buy-in" for any new program implementation. Effective models

of care coordination may take time to initiate because trusting relationships among providers that have not worked together in the past will have to be established. Providers will need to explore options that may blend services within organizations to create efficiencies in the system.

3) Financial challenges related to both resources and staff. Financial challenges will be need to be addressed through new alternative payment models that include care management as part of bundled payments. Effective assessments of resources will have to be completed that reduce redundancy and identify opportunities for efficient service delivery.
4) Health information technology (HIT) is not used effectively for care coordination measurement. It will be important to address underutilization of HIT system capabilities and clinical workflow barriers. It is hoped that this challenge will be addressed with support from the statewide IT work group. Once organizations have HIT capacity, it will be important to address the lack of data standardization and limited HIT system interoperability; to create protocols for staff to enter selected information into structured fields; and to deal with the technical hurdles required to access the data that is in the system.