Population Health

Care Coordination

Based on the CMSA Standards of Practice for Case Management

Today's Presenters

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Trainer for MI-CCSI with care management experience in the primary care, behavioral health, and payer settings. She has trained hundreds of clinicians on the care management process and motivational interviewing.

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Liscense RN in the State of Michigan with expertise in practice transformation, care management, quality improvement and understanding of models of care and payment models in respect to the healthcare industry.

OBJECTIVES

At the conclusion of this presentation, the participant will be able to:

- Discuss care coordination strategies to optimize patient care.

AGENDA

1	Comprehensive Care Management
2	Care Coordination

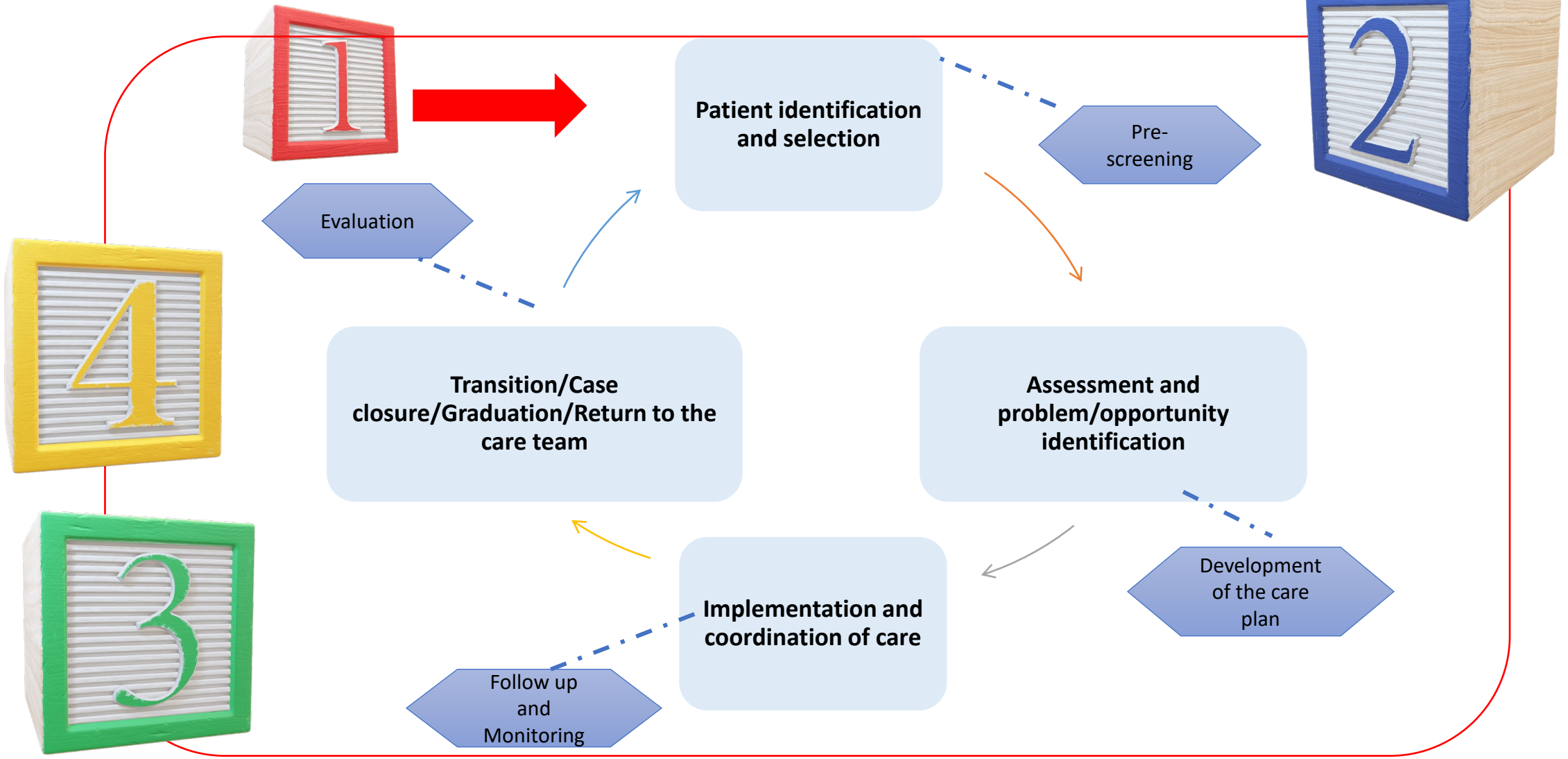
Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Comprehensive Care Management

Case Management

It's A Process



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Comprehensive Care Management

- Assessment of each beneficiary, including behavioral and physical health care needs
- Assessment of beneficiary readiness to change
- Development of the Behavioral Health Home care plan
- Documentation of assessment and care plan in the Electronic Health Record
- Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.

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We define care coordination as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

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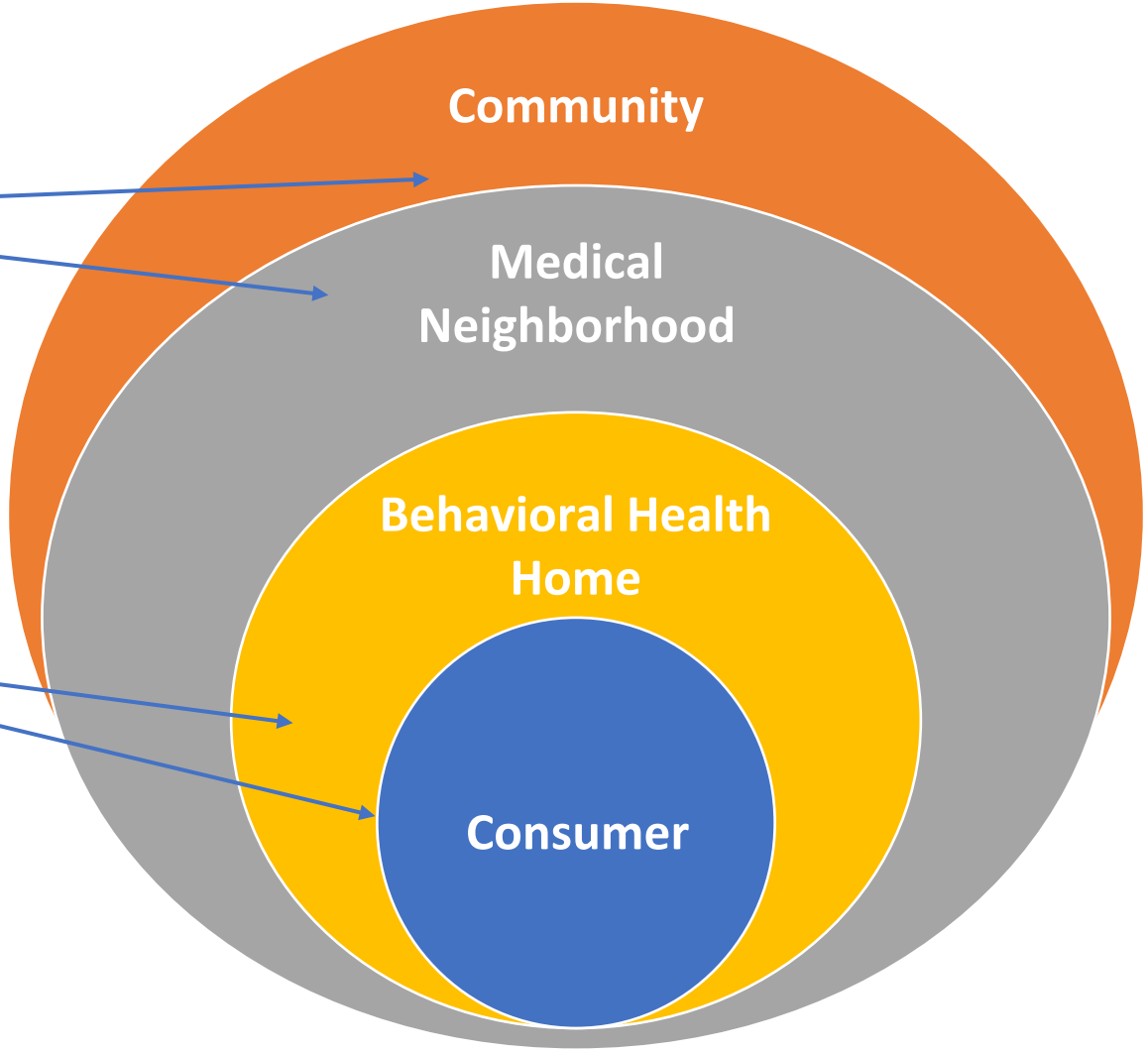
Care Coordination

Population Health - Activity

Where Coordination Happens – Community Team Members

The affiliated Team

The Core Team



Why of Care Coordination

The Behavioral Health Home (BHH) will provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance.

For enrolled beneficiaries, the BHH will:

- Function as the central point of contact for directing patient-centered care across the broader health care system.
- Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care.
- The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs.

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Care Coordination Goals

- Improve patient outcomes
- Provide efficient, coordinated, and integrated behavioral and physical healthcare
- Increase access to healthcare
- Increase hospital post-discharge follow up
- Create a continuum of care
- Reduce healthcare costs
- Reduce unnecessary hospital admissions and readmissions
- Reduce unnecessary emergency room visits
- Increase the use of health information technology

Breakout Activity

Discuss how your team(s) address and assist consumers with the care coordination goals

Breakout Activity

Debrief

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BHH Care Coordination Expectations

- Organization of all aspects of a beneficiary's care
- Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services
- Information sharing between providers, patient, authorized representative(s),and family; o Resource management and advocacy; o Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact)
- Appointment making assistance, including coordinating transportation
- Development and implementation of Behavioral Health Home care plan
- Medication adherence and monitoring; o Referral tracking

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BHH Care Coordination Expectations (Continued)

- Use of facility liaisons; o Use of patient care team huddles
- Use of case conferences; V1.11 6 o Tracking of test results
- Requiring discharge summaries
- Providing patient and family activation and education
- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.)
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.)

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Care Coordination: Health Promotion

- Providing patient and family activation and education
- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.)
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.)
- Promoting healthy lifestyle interventions
- Encouraging a routine preventative care such as immunizations and screenings
- Assessing the patient and family's understanding of the health condition and motivation to engage in self-management
- Using evidence-based practices, to engage and help patient participate in and manage their care

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Care Coordination: Transitions of Care

- Connecting the beneficiary to health services
- Coordinating and tracking the beneficiary's use of health services through Health Information Technology (HIT)
- Providing and receiving notification of admissions and discharges
- Receiving and reviewing care records, continuity of care documents, and discharge summaries
- Post-discharge outreach to ensure appropriate follow-up services for all care
- Medication reconciliation
- Pharmacy coordination

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Care Coordination: Transitions of Care (Continued)

- Proactive care (versus reactive care)
- Specialized transitions when necessary (i.e., age, corrections)
- Home visits to ensure stability through transitions

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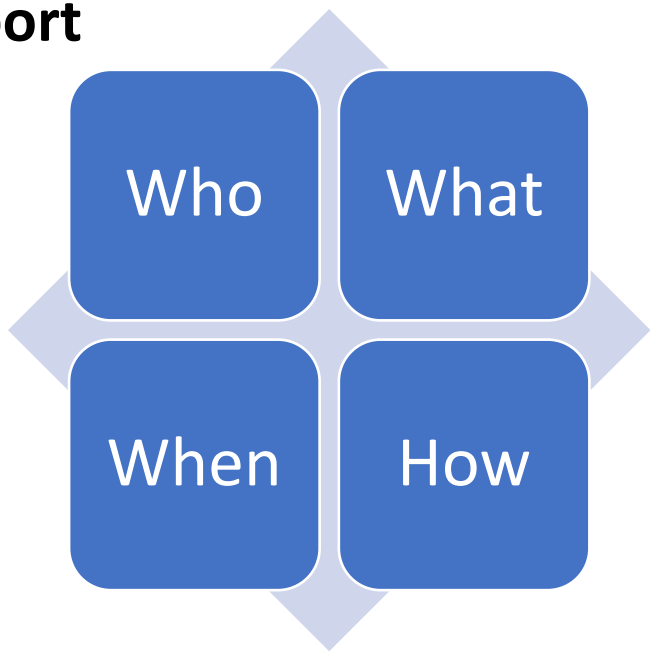
Care Coordination: Community and Social Support

- Providing beneficiaries with referrals to support services
- Collaborating/coordinating with community-based organizations and key community stakeholders
- Emphasizing resources closest to the beneficiary's home
- Emphasizing resources which present the fewest barriers
- Identifying community-based resources
- Providing resource materials pertinent to patient needs
- Assisting in obtaining other resources, including benefit acquisition
- Providing referral to housing resources
- Providing referral tracking and follow-up

Breakout Activity

Share how team member assists with care coordination in the following areas:

- **Health Promotion**
- **Transitions of Care**
- **Community and Social Support**



Breakout Activity

Debrief

One (1) area you can focus on to assist the team and consumer to achieve care that is coordinated.

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Q & A

Thank You