MANAGING PATIENTS WITH COMPLEX CHRONIC CONDITIONS: HIGH UTILIZERS AND CARE TRANSITIONS

Karen W. Linkins, PhD
Principal, Desert Vista Consulting
Assumptions about You and Your Organizations

• You are *somewhere in the process* of thinking about and addressing the issues of high utilization and care transitions
• You want to *get paid* for this work
• You’d like to expand your knowledge in about models that work to *increase the likelihood of success for your project*!
Some New Numbers

- 70% of outpatient visits in CA involve behavioral health-related issues
- Nearly 70% of adults with BH conditions have one or more physical health issues
- Only 50% of those diagnosed with a MH condition receives treatment
- Only 10% of those diagnosed with a SUD receives treatment
Root Causes of Ineffective Care
Transitions and High Utilization

• Communication breakdowns
  • Expectations differ between senders and receivers of patients in transition
  • Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
  • Inadequate amount of time provided for successful hand-off
  • Lack of standardized procedures in conducting successful hand-off
Root Causes of Ineffective Care
Transitions and High Utilization

• Accountability breakdowns
  • No physician or clinical entity that takes responsibility to assure that the patient’s health care is coordinated across various settings and among different providers
  • Providers – especially when multiple specialists are involved – fail to coordinate care or communicate effectively, which creates confusion for the patient and others responsible for transitioning the care of the patient to the next setting or provider.
  • Lack of information re: PCP/Clinic for hospital discharge planners
  • No confirmation that sufficient knowledge and resources will be available at home or the next setting for the patient upon discharge.
Root Causes of Ineffective Care
Transitions and High Utilization

• Patient education breakdowns
  • Confusing medication regimens, unclear instructions about follow-up care
  • Patients/caregivers not included in planning process
  • Lack sufficient understanding of the medical condition or the plan or care
  • Stigma that affects engagement of this population
Other Challenges

• **Clinical/Service Capacity**
  • Individuals with AOD issues, criminal justice involved – no real home anywhere (medical, BH or otherwise)
  • Workforce capacity issues (recruitment of bilingual providers)
  • Need for Open access and capacity to serve walk in clients
  • Gaps between referral and connection to service: no designated point of contact for follow up across agencies involved
  • Need for specific referral criteria and priority populations
More Challenges

• Data
  • Capacity for shared care planning and follow up on referrals/client goals with different EMRs
  • Tracking outcomes and using standard measures across systems
  • Identifying and accessing what’s needed to inform decision-making (financial, clinical, administrative) – labor intensive and limited data analytic capacity
  • Providers/staff need ongoing training to understand data sharing to support care coordination is not a violation of HIPAA
  • Need consensus on data elements to share, format, and timeframes for information exchange and communication
  • No designated point of contact across organizations to facilitate coordination and follow up
The Collective Impact Foundation

- **Collective Impact** is the commitment of a group of actors from different sectors to a common agenda for solving a specific social problem, using a structured form of collaboration.
The Collective Impact Foundation

• What we know…

• Isolated Impact:
  • The prevailing model of health and human services in the United States.
  • Historically promoted by payors and funders.
  • Has resulted in the development of over 1 million US nonprofit organizations devoted to isolated impact.

• Isolated Impact Definition: Efforts to effectively address a health or social problem by contracting with organizations that specialize in that particular problem.

• Problem: Complex Systems with many interconnected components do NOT respond well to isolated impact.

• Reality: The people, families, and communities you work with are the poster child of Complex Systems.
5 Collective Impact Components

- **Common Agenda**: All participants must have a shared vision for change.
- **Mutually Reinforcing Activities**: Each participant should undertake the activities at which it excels as part of a mutually reinforcing plan of action for CI to be successful.
- **Backbone Support Organization**: CI initiatives require a separate organization and staff to be successful because coordination takes time, and almost always none of the participating organizations has any time to spare.
- **Continuous Communication**: Participants need to meet regularly to appreciate the common motivation behind their efforts and to keep communication flowing among and within the network.
- **Shared Measurement Systems**: CI coalitions need to develop shared measurement systems.
National Models

• Numerous national models for health homes that emphasize the critical importance of care coordination for complex populations, e.g.,
  • NCQA PCMH 2014 Standards
  • SAMHSA-HRSA Health Home Framework
  • 2703 Health Home Models across US
Core Element of Integrated Care: Care Coordination

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

Source: Agency for Health Research and Quality (AHRQ)
Examples of broad care coordination approaches include:

- Establish Accountability
- Teamwork
- Care management
- Medication management
- Health information technology
- Patient-centered medical home
# Care Coordination Functions

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<thead>
<tr>
<th>Process</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. Outreaching, engaging, and facilitating access to appropriate services</td>
<td>The process of reaching out to persons (especially those persons who are difficult to engage), enlisting their participation in care, and ensuring their access to needed services.</td>
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<tr>
<td>2. Defining the Care Team for each client/patient</td>
<td>The process of identifying and entering into the registry, all of the key members of an individual patient’s care team (including natural supports).</td>
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<td>3. Ensuring and monitoring consent to share clinical information (ROI)</td>
<td>The process of ensuring that all consents for treatment and sharing information are obtained prior to the sharing of clinical information (PHI).</td>
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<td>4. Ensuring and monitoring appropriate screening for medical, mental health and substance use conditions</td>
<td>The process of systematic planning, administering, interpreting, and adjusting care based on standardized screening tools and measures.</td>
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<td>5. Facilitating referrals</td>
<td>The process of facilitating referral, performing “warm handoffs”, monitoring receipt of referral materials from other providers, and tracking completion of referrals. Intra-team referrals are streamlined.</td>
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<tr>
<td>6. Entering clinical information into caseload registry tool</td>
<td>The process of serving as primary “custodian” of the clinical registry data, and routinely updating information to ensure its accuracy.</td>
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<tr>
<td>7. Conducting multidisciplinary clinical care conferences</td>
<td>The process of performing systematic, population-based caseload review.</td>
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Source: CIBHS Care Coordination Collaborative; Dr. Marc Avery, AIMS Center
## Care Coordination Functions (cont.)

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<tr>
<td>8. Ensuring and monitoring routine medication reconciliation</td>
<td>The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.</td>
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<td>9. Supporting client self-management</td>
<td>The process of engaging the patient, family, and other natural supports in developing skills and abilities for self-care.</td>
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<tr>
<td>10. Ensuring and communicating shared care plan goals among client/patient and providers</td>
<td>The process of communicating for high-level goals shared by all providers (primary care, mental health, and substance use providers) in a coordinated care team.</td>
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<tr>
<td>11. Ensuring availability of ad hoc clinical case consultation</td>
<td>The process of ensuring availability of ongoing, as needed, impromptu consultations between all providers, but especially to primary care provider by specialty providers.</td>
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<td>12. Ensuring urgent care access to specialty MH, SUD or PC</td>
<td>The process of ensuring that patients have access to appropriate urgent care services as clinically needed.</td>
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<tr>
<td>13. Monitoring transitions in care</td>
<td>The process of monitoring critical healthcare transitions (such as discharge from a hospital) so that patients don’t “fall through the cracks”.</td>
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Activities of Integrated Behavioral Health Teams

• Health education materials covering the nature of the condition and the self-care, treatment and recovery
• Evidence driven, clinical treatment strategies
• Care coordination staff to coordinate and communicate between providers
• Psychiatric consultation and support for primary care on medication and other clinical conditions
• A preferred network of preferred, affiliated providers for other levels of inpatient, intermediate and specialty care
• Peer and recovery support
• Follow-up
Community Health Teams
(The Vermont Blueprint for Health)

- Connect patients to primary care
- Track patients overdue for appointments or tests
- Help patients being discharged from hospitals
- Health and nutrition coaching
10th Decile Project – Los Angeles (CSH)

• Collaborative effort in LA County to connect frequent ED users to housing and appropriate care
• More than 25 organizations (5 Health Centers) in 6 neighborhood networks to address the needs of the top 10% highest cost, highest need
• Health Centers provide integrated PC/BH care
• Priority housing through the Coordinated Entry System for highest need individuals
10th Decile Project – Los Angeles (CSH)

- Key Features:
  - Targeting (top 10%)
  - Triage Tool with an algorithm to identify individuals based on demographics and health status
  - Collaboration – homeless services, hospitals, and health centers
  - Supportive Housing – with rent subsidies through Section 8 or Shelter Plus Care vouchers
  - Intensive Case Management – by a health worker (sometimes at a health centers), providing management of referrals and clinical care, such as medication review (warm handoff)
  - Care Coordination – Linking individuals with primary and BH services and communicating with providers

“Don't walk behind me; I may not lead. Don't walk in front of me; I may not follow. Just walk beside me and be my friend.”

~ Albert Camus
Consumer Themes

Providers need training on communication, listening and empathy to build trust and learn how to ‘partner with the patient’

Prioritize greater attention and training on the impact of the social determinants to health as part of assessment and overall health service delivery

Trained peer support specialists (by DMH) and advocates (CSH) are eager to partner with the health care sector to improve health outcomes for complex patients through outreach and system navigation

This population is new to health care coverage and will need significant education on how to access services/benefits, communicate with providers, health plan and advocate for themselves

Consumers want to be part of the broader health care workforce, with experience and skills to offer. They need to be part of the solution and the ‘Team’ to achieve the desire outcomes of The Triple Aim
Consumer Themes (continued)

- Provide access to a health home in a primary care setting that’s not the hospital ER
- Employ *peers with lived experience* as system navigators to work in all settings
- Need priority access to healthcare services (primary care, MH and SUD) and housing
- ‘Bring the services to the people’ with ‘whole person’ care staffed by integrated mobile care teams comprised of peer navigators and multi-disciplinary healthcare professionals
- Partner with providers that have long established, trusting relationships with homeless populations
- Implement one universal assessment, accessible across all providers, and data-sharing
- Facilitate pathways to access care through mobile integrated care teams linked to primary care, MH, SUD, housing
Priorities

Make access easy, welcoming

Communicate and coordinate

Support the “whole person”

Outreach and engage
Discussion Questions:

• How do you interface with your health plans, Beacon, the County for screening?
• How do you plan to increase visibility and presence in the community for outreach, engagement and follow up?
• What is the role of Beacon and Partnership Health Plan in care coordination efforts aimed at getting patients to the right level of care?
• What is the role of the hospitals and what is your current relationship with them?
• What is the identified target population (and N) for care coordination? Would there be a benefit for starting with a specific number of individuals to pilot test the current workflows and processes?
• What would it take to get dedicated staff at each agency to serve as the primary point of contact for cross-system coordination activities?
• How many referrals can each agency take based on caseload size and current capacity?
Additional Questions

• What screening/assessments are in place to identify MH needs of the high utilizers?

• Outcome measurement — what tools are being used, what metrics are being tracked, frequency, populations and what is the current thinking on how to increase data analytics capacity? Is there any way that partner agencies can leverage the data analytic capacity available at the county?

• What is the current status of the ROI process with hospitals and other organizations? Are all providers across all agencies are on the same page?