High Functioning Health Home: Best Practices in Care Management

Lessons from the Field

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Overview: Core Elements

Review of Pilot Studies:
* Program design
* Integration of services
* Designated care home/team
* Staffing and training
* Consumer identification & selection
* Consumer engagement
* Provider engagement
* Information exchange among all stakeholders
* Performance & quality measurement
Conducted between 2010-2013
Eight different models providing services to individuals with complex medical & social needs

Summary of findings:
* Improved care experience
* Increased use of primary care
* Decreased use of inpatient care
* Improved health
* CMSP claims data showed spending declined 56% after participation
Lessons learned:

- **Participants:** participant engagement & readiness to change, high rates of mental health or substance abuse & fluidity among population
- **Partnerships:** community partnerships with clinics, hospitals, specialty providers & community resources were indispensable
- **Practices:** importance of adaptability & flexibility, changes related to IT systems & reporting/evaluation & value of providing seamless eligibility & enrollment system
Lessons learned:

* Identifying the right staff experienced & comfortable with target population is critical in providing patient-centered care

* Importance of providing a holistic or multidisciplinary approach that includes social services

* Access to health care coverage does not equal access to care

The Lewin group, Inc. (August 2013) CMSP’s Local Health Connections Pilot project: Findings and lessons learned
Conducted between 2011-2013
3 models of care featured

Findings for success:
* Appropriate identification of high risk patients
* Use of multi-disciplinary teams
* Team skills match patient needs
* Patient involvement in goal setting
* Home & community-based care
* Specialty trained care managers
* Smaller case loads
* Health coaching

Desert Vista Inc, (2013), Strategies and models for care coordination and complex care management
Program Design

Care Team Model
* Integrated into primary care health home

Health Plan Model
* Managed care plan offers care management services for beneficiaries

Contracted Model
* Independent organization contracts for care management services

County Heath Department
* Sonoma County Department of Health offers care coordination services
* Hospital or health system based

No single system can address the needs of a complex population!
Program design considerations:

- Number of individuals needing services
- Community resources available
- Partnerships
- Hospital/SNF to home
- Home visits, phone, or in-clinic visits
- Financial resources
- Use of acuity scale
- Screening tools
Well-coordinated/seamless care:

* Primary care
* Mental health services
* Substance abuse screening/treatment
* Dental services
* Application assistance
* Use of screening tools
Designation of Care Home or Team

- Central Hub
- Provide “Safe care”
- Team-based approach to care management:
  - Physical, behavioral & psychosocial needs are met
  - A dedicated “go-to person” in each team serves as Primary Care Manager
  - Provides familiarity & consistency for patients & Primary Care Providers
Choosing the right staff:
RNs, Social Workers, CHWs, Peer Advocates

* Experience with the population served
* Adaptable & flexible
* Competent & capable
* Committed to the mission
* Team-oriented but can work independently

* No “Bleeding Hearts”
  * Vicarious trauma
Beyond Care Coordination Basics:

- Motivational Interviewing
- Health Coaching
- Trauma-informed Care
- Health Literacy
- Mental Health Diagnosis
- Suicide Ideations
- Elements of Addiction
- De-escalation Skills
- Community Resources
- Case Conferencing
Stratify & triage beneficiaries by level of risk & need

Predictive modeling: forecast high-opportunity candidates
- RX drug use, ER usage, medical DX, mental health DX, substance abuse, LTC use

Referrals from providers
- Increase patient & provider engagement

Initial health screening
- Addressing both clinical & non-clinical issues

High-cost patients
- Past claims data may not be predictive of “current state”

Self-identification
Engaging consumers is the most difficult task!

- Understanding their needs & goals & aligning services to these goals
- Persistent outreach & sleuth work
- Use of incentives
- Highly personalized approach
- Assessment tool (PAM)

Challenges

- Poor contact info, unstable housing, overwhelming socioeconomic challenges, lack of trust
Provider Engagement

- Care management is most effective when delivery is closely integrated with Primary Care Provider
- Seeking provider input in the development of the program
- Accepting provider referrals
- Provider access to care management notes/documentation
- Access to Care Plans & patient goals
- Co-located care management team
Greater use of information technology & information exchange is essential

- Access to timely relevant clinical information
- Identify care needs
- Identifying future health risks
- Avoiding negative outcomes
- Feedback loop
Promoting some measure of accountability

- Shared savings
- Shared risk

Process measures can support implementation of effective care delivery

- Feedback is essential from managed care partners
- Development of quality dashboard
Learned Best Practices

- Nurse call line
- Cell Phones
- Ensuring patients receive the right care in the right setting at the right time
- Going to the patient vs. having patient come to us
- Stay focused on patient goals
References


• Lewin Group Inc. (2013). CMSP’s local health connections pilot project: Findings and lessons learned. County Medical Services Program Governing Board