Care Coordination

Katharine Willis, LCSW

Managed Services Division

Department of Mental Health and Addiction Services

Care Coordination

- What Is Care Coordination?
- Why is Care coordination important?
- Care Coordination Models
- Key Components of Care Coordination
- Care Coordination Tools

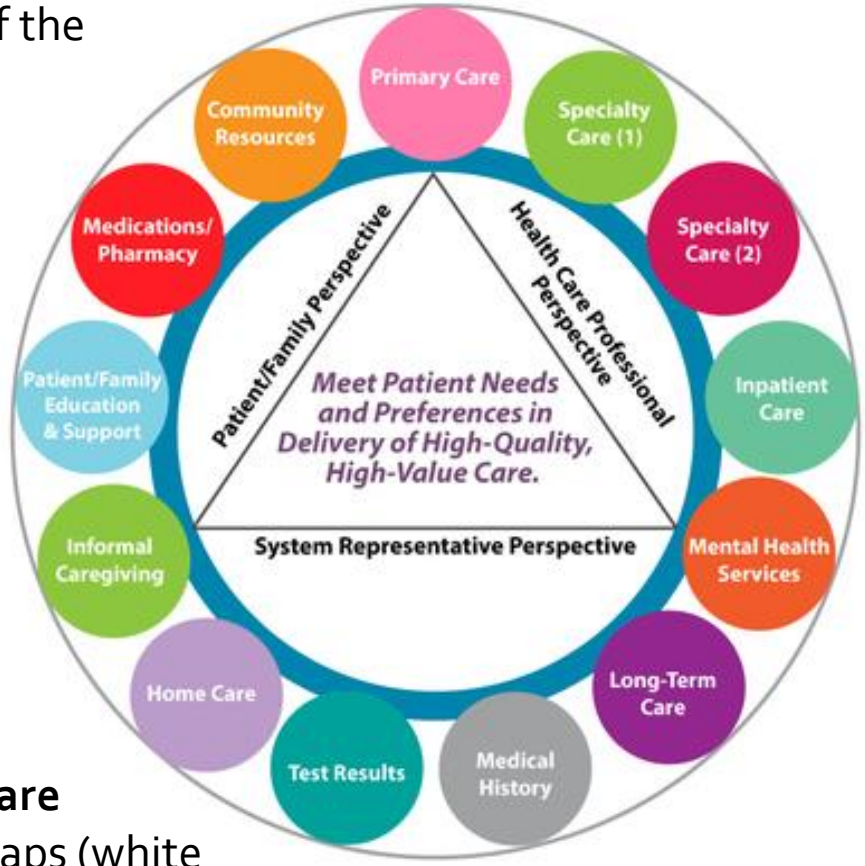
What is Care Coordination?

- Care coordination means different things to different people; no consensus definition has fully evolved.
- A recent systematic review identified over 40 definitions of the term "care coordination.[1]
- The systematic review authors combined the common elements from many definitions to develop one working definition: *"Care coordination is 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. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."*

1AHRQ Care Coordination Atlas Update Chapter 2. What is Care Coordination? | Agency for Healthcare Research and Quality (ahrq.gov)

What Is Care Coordination?

The *central goal* of care coordination is shown in the middle of the diagram. The colored circles represent some of the possible participants, settings, and information important to the care pathway and workflow.



The blue ring connecting the colored circles is **Care Coordination**—namely, anything that bridges gaps (white spaces) along the care continuum.

What is Care Coordination?

- Care coordination is a set of activities that *minimizes the dangers of fragmentation* by ensuring that all providers involved in a patient's care share important clinical information and have clear, shared expectations about their roles, and provide both medical and non-medical services.
- Care coordination is a *liaison* between the patient/client and other health care team members to make sure that the treatment plan put in place by the care team is working effectively for all involved.
- Care coordination works to make sure *everyone is on the same page* so that the patient can get the best care possible.
- Care coordination is care that *addresses the entire individual*, which includes medical needs as well as non-medical services such as assistance with food and housing.

Why is Care Coordination Important in Behavioral Health?

Coordination of care across settings permits an integration of services that is centered on the comprehensive needs of the patient and family, leading to decreased health care costs, reduction in fragmented care, and improved patient/family experience of care."
American Academy of Pediatrics, 2014

- Individuals benefit from coordinated care by living longer lives and receiving the most out of their care.
- Reduce the per capita cost of healthcare.

Why is Care Coordination Important in Behavioral Health?

Improves patient health by assessing and treating all of a patient's needs

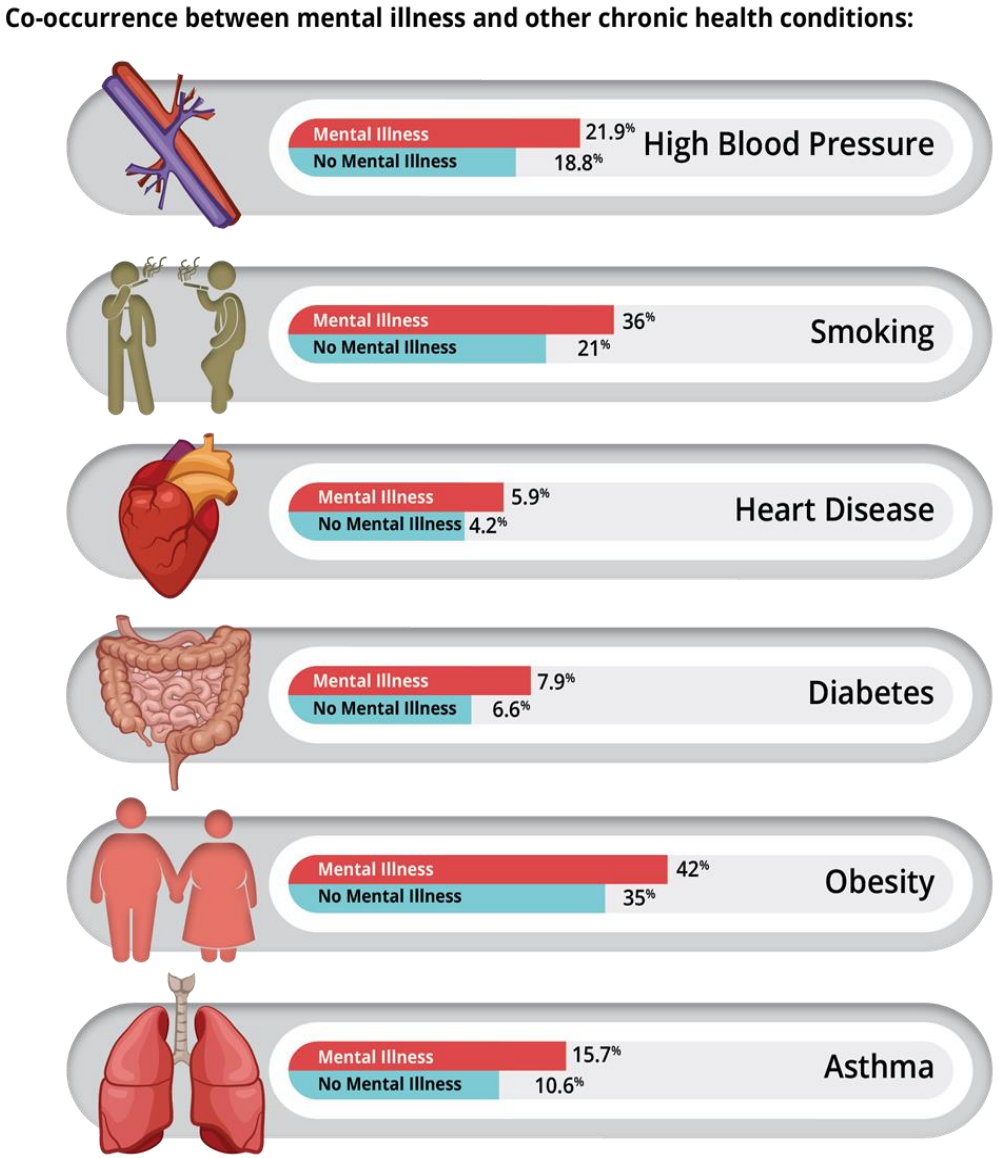
Having a mental health condition is a risk factor for developing a chronic physical health condition

and

Having a physical health condition is a risk factor for developing a mental health condition

Individuals with Serious Mental Illness (SMI) may die as much as 25 to 30 years younger than those without an SMI diagnosis AND they often die from avoidable medical conditions.

Why is Care Coordination in Behavioral Health Important?



Why Is Care Coordination in Behavioral Health Important?

Improves Patient Experience with Healthcare

Communication breakdowns between providers and facilities can lead to unnecessary hospitalizations, duplicate tests and procedures, medical and medication errors, and other problems. Care coordination reduces these risks.

Care coordination reduces use of higher levels of care (emergency room and inpatient hospitalizations) and help patients remain in community when appropriate.

Why is Care Coordination in Behavioral Health Important?

- Nationally, it was projected Medicaid could save an estimated $12.3 to $17.2 billion each year if Medicaid programs successfully integrated behavioral health and medical care1.
- Medical costs for treating those with chronic medical and comorbid behavioral health/substance use disorders (BH/SUD) are two to three times higher on average compared to the costs for those who do not have comorbid BH/SUD.
- Most of the increased cost for those with comorbid MH/SUD is attributed to medical services.

1Melek, S P, Norris, DT, & Paulus, J. Potential Economic impact of integrated medical-behavioral healthcare. Milliman American Psychiatric Association Report.2014.

2017 PMPM Healthcare Costs by population and presence of BH conditions , MEDICAID

Medicaid Population	Behavioral Health Diagnosis	Medical	Behavioral	Medical Rx	Behavioral Rx	Total
	No Mental Health/Substance Use Disorder	$391	$6	$90	$7	$494
	Mental Health/Substance Use Disorder	$957	$380	$243	$128	$1,708

Individuals with a treated behavioral condition typically cost two to three times as much on average as those without a behavioral condition. This trend is seen in all market segments, including Medicare and commercial[1].

1Melek, S P, Norris, DT, & Paulus, J. Potential Economic impact of integrated medical-behavioral healthcare. Milliman American Psychiatric Association Report.2014.

.

Demographic Comparison Between BHH and CT Medicaid

Total BHH Profile

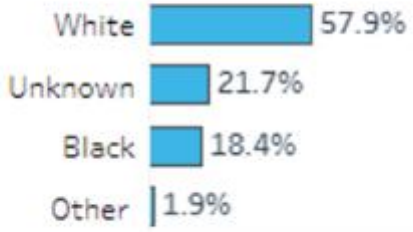
Total BHH Enrollees : 7,217

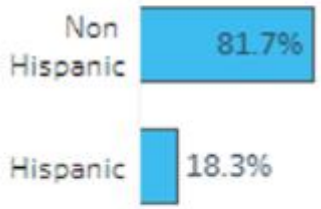
Chronic Comorbid Disorders (BH & Med): 87.7%

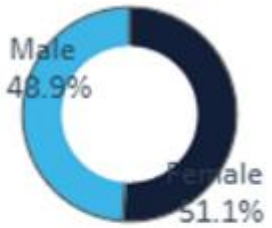
Hypertension Rate	43.0%
Hyperlipidemia	35.0%
Diabetes Rate	28.8%
Obesity Rate	24.6%

7.1% were Homeless

Lives in Rural Area 4.2%







Average Cost Per Member: $35,631

Total Dental Cost	$1,005,959
Total Pharmacy Cost	$55,310,290
Total Medical Claims Cost	$66,724,345
Total Behavioral Health Cost	$134,647,924
Total Member Cost	$257,688,517

Total Adult CT Medicaid Profile

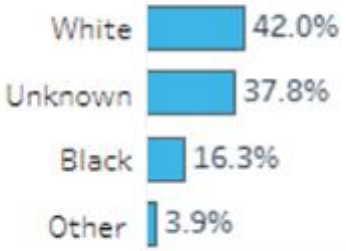
Total CT Medicaid : 643,637

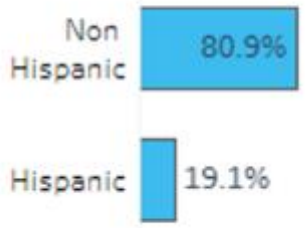
Chronic Comorbid Disorders (BH & Med): 28.5%

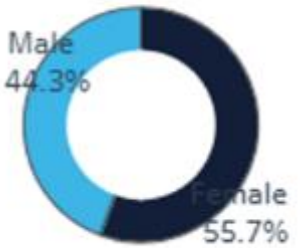
Hypertension Rate	20.5%
Hyperlipidemia	15.3%
Diabetes Rate	11.1%
Obesity Rate	11.6%

2.2% were Homeless

Lives in Rural Area 6.1%







Average Cost Per Member: $11,140

Total Dental Cost	$63,492,363
Total Pharmacy Cost	$1,319,171,603
Total Medical Claims Cost	$3,536,609,273
Total Behavioral Health Cost	$2,250,857,740
Total Member Cost	$7,170,130,978

Basic Components of Care Coordination

Successful care coordination requires several elements:

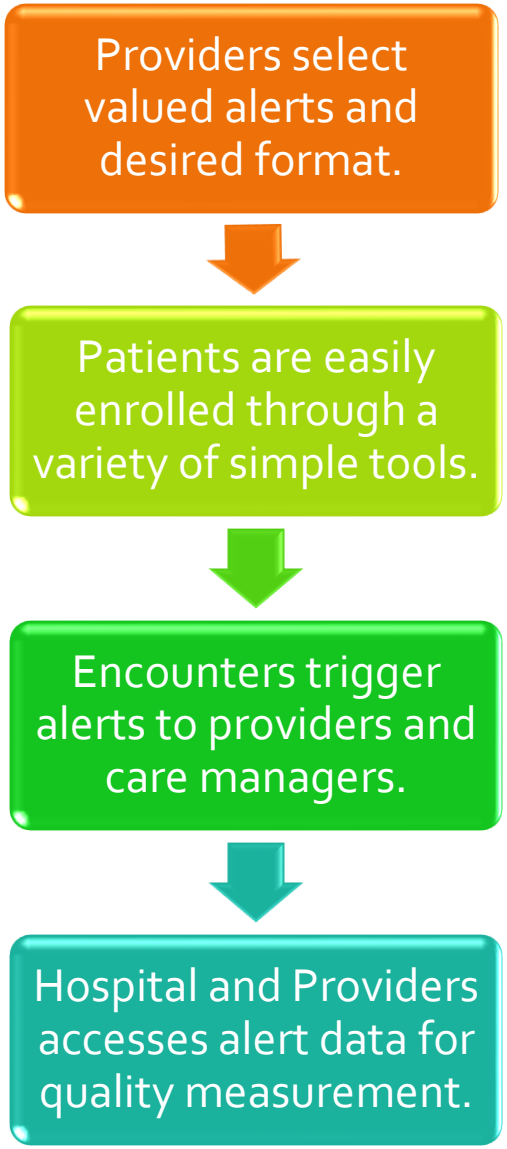
- Relationships with a wide range of health care services and providers
- Knowledge of community resources
- Team-based care - Interdisciplinary care teams address the full range of patient needs and integrate all of a client's needs.
- Good communication
- Regular health/needs assessments
- A focus on transitions in care
- Clear and simple information that everyone can understand

Care Coordination Tools

Communication of timely and accurate information between providers

- Project Notify/Patient Ping/ CONNIE
- Electronic health records
- Release of information
- Templates for collecting and sharing information among care team
- Regular multidisciplinary team meetings become standard procedure
- Appointment reminders and post-visit follow ups

Care Coordination Tool Project Notify



How it works

Providers/health plans subscribe to the program to receive custom health event alerts configured for their system environment.

Easy Enrollment

Patients/Members are registered by their provider.

Actionable, Instant Alerts

When an event takes place an alert is generated, encrypted and forwarded to PCPs, specialists and care managers using direct messaging or other preferred method.

Care Coordination Tools

John Smith was a client at ABC agency and received services to help him with mental health and substance use. His symptoms stabilized and he was able to find housing and a job. He went to Hartford to visit family and while there he relapsed. He lost the money he needed to return home and he lost his phone. Lost, homeless and experiencing an increase in his mental health symptoms, he began frequenting area hospitals. His hospital visits triggered a series of notifications to ABC agency. Working with his primary care provider at the agency, staff was able to connect with him following a hospital admission. Next a peer support specialist was able to work with John to find a bed at a residential treatment facility and he was transported directly to that facility following his discharge from the hospital. Once he completed residential treatment, he reengaged with outpatient services at ABC agency.

Models of Care Coordination and Integration

Person Centered Medical Home

Provides person-centered, comprehensive and coordinated care to HUSKY members. Seeks to improve HUSKY member's overall health and assists with access to services like access to healthy food, transportation to appointments and assistance in finding community agencies that support housing or employment.

Health Homes

A Medicaid initiative designed to improve the health outcomes of Medicaid recipients through the provision of six core services, including transitional care management and care coordination. Connecticut elected to design a health home focused on Medicaid members with serious mental illness. Connecticut's Behavioral Health Home (BHH) is a "whole person" approach where BHH providers integrate and coordinate all primary, acute, behavioral health and long term services and supports.

Models of Care Coordination and Integration

Collaborative Care

The collaborative care model is a systematic approach to the treatment of depression and anxiety in primary care settings that involves the integration of care managers and consultant psychiatrists, with primary care physician oversight, to more proactively manage mental disorders as chronic diseases, rather than treating acute symptoms.

Certified Community Behavioral Health Clinics (CCBHC)

CCBHCs are non-profit organizations or units of a local government behavioral health authority. They must directly provide (or contract with partner organizations to provide) nine types of services.

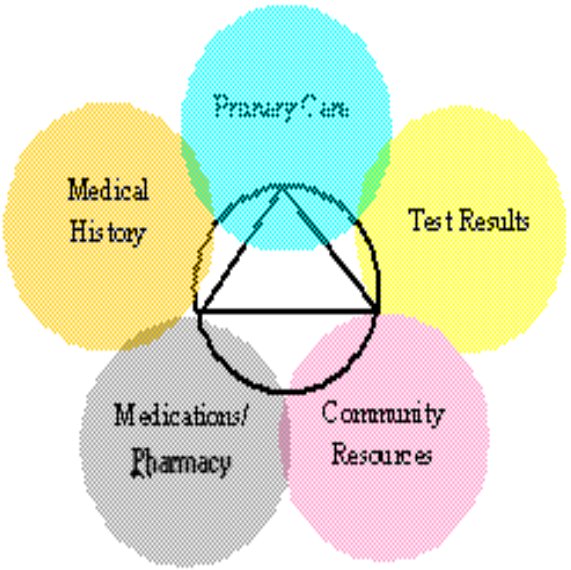
Expanded care coordination with local primary care providers, hospitals, other health care providers, social service providers, and law enforcement, with a focus on whole health and comprehensive access to a full range of medical, behavioral and supportive services.

Care Coordination Examples

- The level of care coordination need will increase with greater system fragmentation (wider gaps between circles), greater clinical complexity (greater number of circles on ring), and decreased patient capacity for participating effectively in coordinating one's own care

Care Coordination : Low Need

- Mrs. Smith is a 55 year old woman who goes to see her PCP for her annual routine physical. Blood tests are ordered to evaluate cholesterol levels. Mrs. Smith mentions she is still having pain from an ankle sprain from a few months ago. PCP orders x-ray. After receiving results of blood tests, PCP sees cholesterol is high and prescribes medication. PCP receives x-ray results and it shows no fracture. PCP makes referral for physical therapy. Mrs. Smith picks up her prescription and schedules appointment with PT.



Care Coordination: High Need

- Mrs. Smith is a 55 year old woman with major depressive disorder and diabetes. When she is depressed she overeats and does not test her blood sugar levels. She is not sure what to eat to help control her blood sugar. She is seen by her PCP after a visit to the ED for low blood sugar. . PCP makes referral and CC sets up appointment with a dietician to work with client to develop a meal plan. Care coordinator finds a pharmacy that will deliver prescriptions to her home. Client is discussed at multidisciplinary team meeting and individual therapy will be added to help client develop coping skills when her depression is symptomatic.