CCHHS Care Coordination

May 20, 2016

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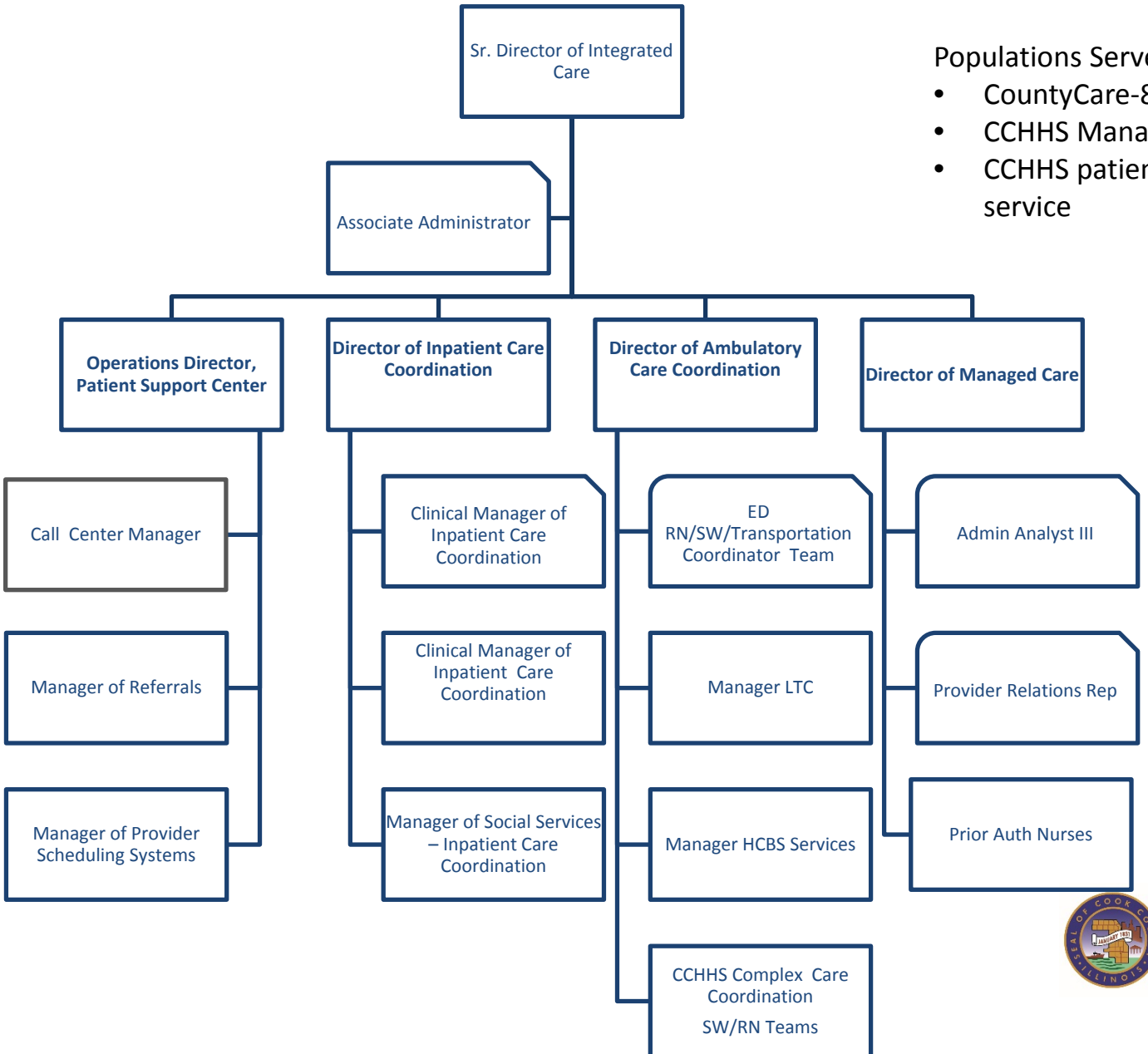
Overview

- Care Management Organizational Structure
- Working Definitions
- Approach to Care Coordination at CCHHS
- Ambulatory Care Coordination Goals
- CountyCare transition
- Current activities
- Initial results
- Next Steps

Integrated Care Management Structure



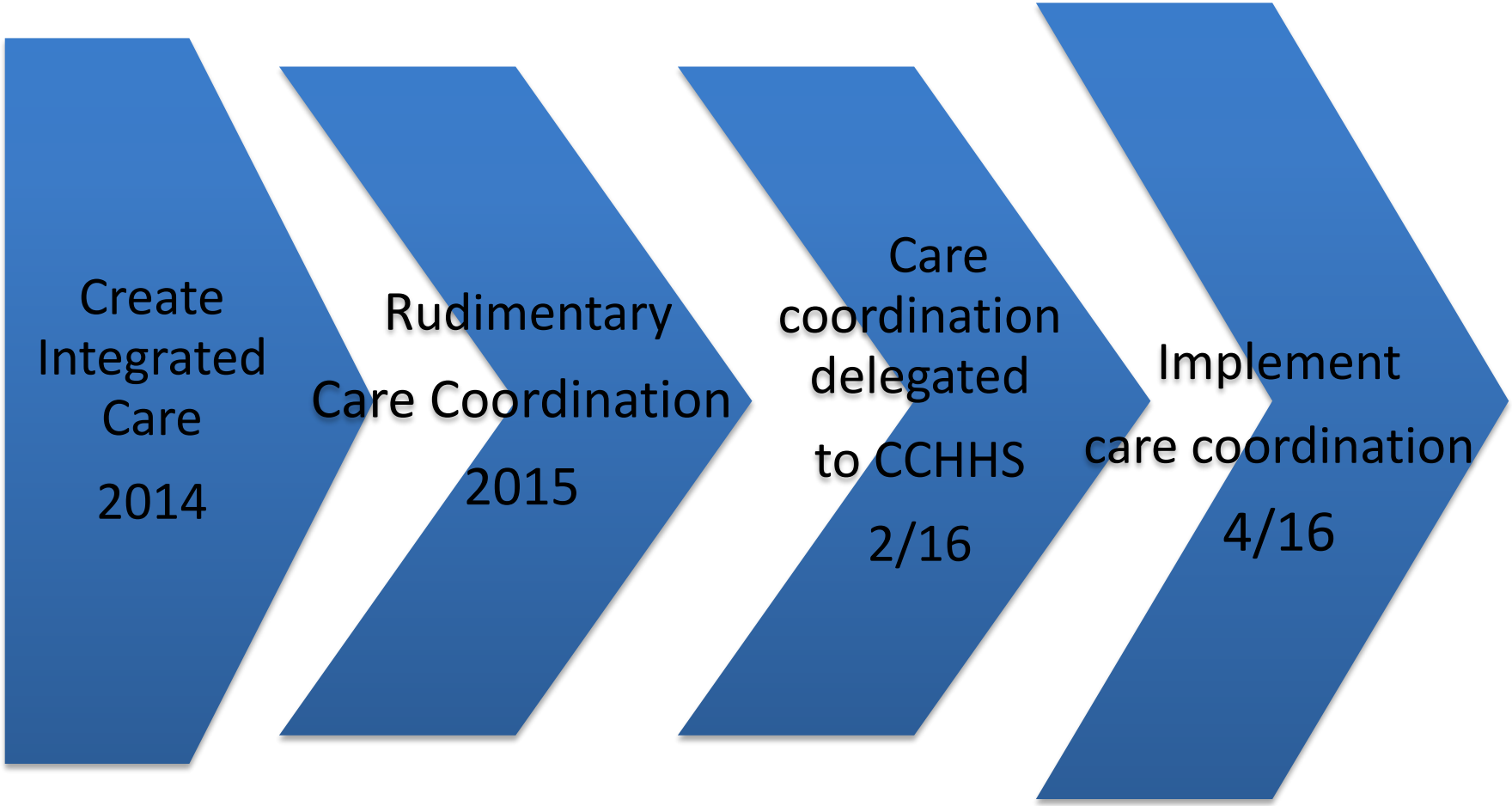
Populations Served

- CountyCare-81,000
- CCHHS Managed Care-15,650
- CCHHS patients receiving service

CCHHS Working Definitions

- Population Health has three components
  - Analytics, engagement and care coordination
- Care Coordination
  - To support participation in an organized approach to their care that reflects their priorities and best practice. Long term goal is to make them self-sufficient to manage their conditions
  - Can be completed by different levels of staff depending upon the care requirements of the patient.

CCHHS Care Coordination Evolution



Care Coordination Historical Approach

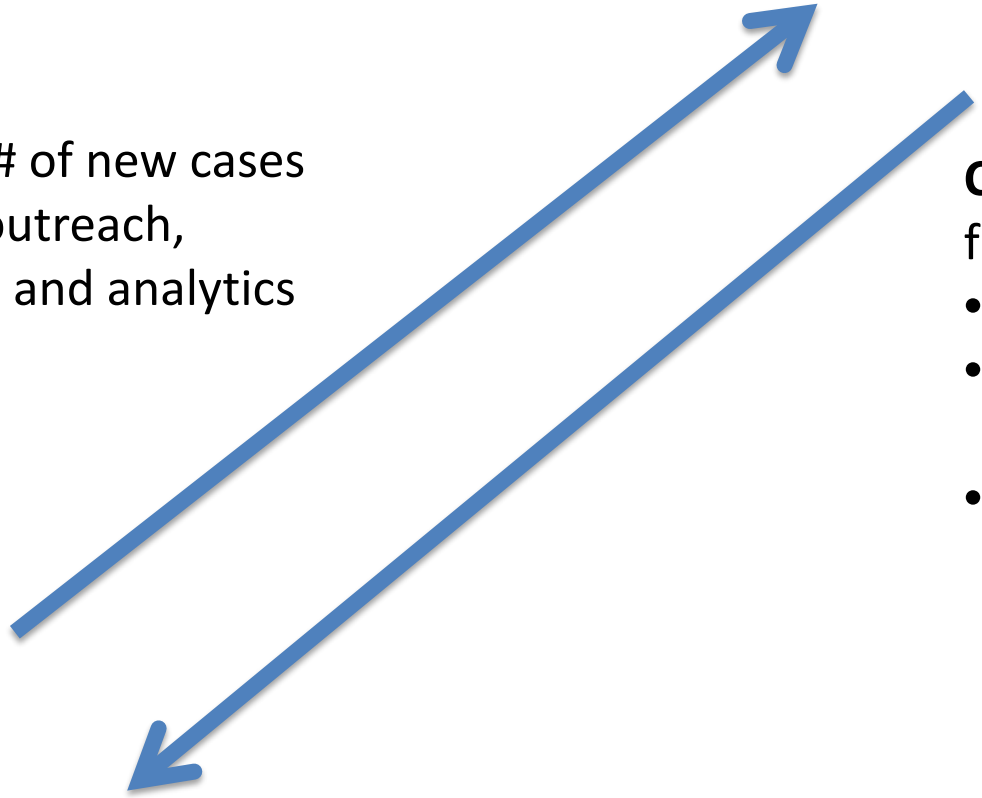
- Physicians care manage cases-give patients their pager #s
- Care management visits at ACHN for chronic disease teaching, status checks etc.
- Departments may have obtained resources to support navigation for their patients
- CORE center activities supported by grant funds
- Home IV antibiotics and home care in lieu of facility placement for selected populations

CountyCare Transition

- Assumed responsibility for Care Coordination for enrollees assigned to ACHN, Access and 16 FQHCs medical homes (approx. 81,000 members)
- Diverse care coordination population served includes high risk, waiver, transplants, behavioral health, discharges from the hospital, nursing facility residents, pregnant patients
- Diverse settings-home, health centers, hospitals, nursing facilities

Transitioning Care Coordination

Increase # of new cases through outreach, screening and analytics



Close cases inherited from Centene

- No longer eligible
- Risk status has decreased
- Case goals met

Care Coordination Goals

- Improve patient outcomes
  - Preventive Services
  - Compliance with guidelines for chronic conditions
  - Resource utilization shift
  - Engagement and self-sufficiency
- Engage physicians and medical home teams
  - Care coordination viewed as beneficial
  - Access to providers for care plan development
  - Mechanisms for data sharing and program enhancement
- Improve patient satisfaction
  - Care Coordination is a reason for a member to bond to system or CountyCare

Current Care Coordination Approach

- Centralized management-local deployment
- Intensive training due to role complexity
- Team approach
- Mobile technology-phones, tablets, hot spots
- Clinical supervision-joint visits, chart review
- Care management system with significant interfaces
- All “hands-on-deck”

Care Coordination Knowledge/Characteristics Required

- Managed Care Organization (MCO) rules, benefits and eligibility processes
- Cultural awareness
- Comprehensive knowledge of inpatient, outpatient and social services
- Knowledge of gender and age specific preventive health service requirements
- Understanding of disease processes both physical and mental
- A “can do” attitude-will organize resources to make things better
- Empathy/a willingness to accept where the enrollee is
- Engages technology
- Street savvy

Impact on CCHHS

- Requires and receives major support from many departments-IT, HR, ACHN, Medical Leadership, CountyCare
- Measured Diffusion into CCHHS operations
  - Screening-at touchpoints (ACHN visits, welcome calls, ED visits, returning care coordination calls, inpatients)
  - Integration of Care Teams into ACHN sites
- Creation of additional phone queue to field care coordination calls

April Results

- Everyone wants a care coordinator!
  - PSC received approximately 4,600 care coordination calls (in addition to their regular calls)
- Completed Screenings-736
  - As expected significant # are high risk
  - Behavioral Health Assessment 171
- Members touched-1,018
- Home visits completed 131

Addressing Social Determinants

- Out of 736-263 are at risk solely due to social determinants. Issues identified will addressed by social worker and team
- Needs addressed via “Purple Binder”
  - Food (171)
  - Housing (153)
  - Clothing (118)
  - Substance abuse treatment (35)
  - Utilities (31)

Impressions

- Incredible first month effort
- As expected, this cohort of patients has high disease burden-
  - Prevalence of mental health issues may be related to the disease burden-but still requires a strategy/intervention
- Seemingly unlimited ability to impact
- Have a window into medical home performance

Short Term Activities (6-8 months)

- Stabilize and document core processes
- Develop a relevant set of performance metrics
- Complete hiring of staff
- Continue to partner with CountyCare to develop options to better care for patients
- Formalize and expand care coordination phone queue-expand to all CCHHS patients not just CountyCare
- Complete implementation of Care Management System.

Strategy

- Develop and implement a system-wide care coordination approach that leverages CCHHS resources to promote quality, patient experience and efficient care.
- Program processes and outcomes meet or exceed external accreditation requirements
- Leverage knowledge gained to support education, research and funding

Support Health Equity

- HEDIS gaps closed in patients participating in care coordination
  - Performance approaches those of employed populations
- Care coordination extended to those who need/benefit

Provide Quality, Safe, Reliable Care

- Engage at least 80% of the high risk patients in care coordination
- Focus on marginalized populations use quick improvement cycles to identify what works
- Understand and reduce variations in process that lead to poor outcomes
- Develop relationships with community partners to support the continuum of care

COOK COUNTY HEALTH & HOSPITALS SYSTEM
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Demonstrate Value, Benchmarking

- Evaluate program outcomes in light of standard managed care metrics-e.g. utilization, cost, patient outcomes
- Align operations to support top decile performance for measures relevant to the population
- Collaborate with managed care payers to support their objectives regarding quality and cost

Human Capital

- Develop an orientation/on-boarding program that provides the necessary knowledge and skill base to succeed as a care coordinator
- Leverage training and on-going education activities across system to create awareness and bench strength

Education and Research

- Collaborate with schools of nursing and social work to develop electives regarding care coordination
- Engage Collaborative Research Unit (CRU) to determine suitability of understanding what works for the population

Strategic Planning