

MEMORANDUM

March 31, 2015

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst *gome*

SUBJECT: **Care Management Systems for Population Health**

Expected for this session:

Thomas Harr, Chief Executive Officer, Family Services, Inc.
Arlene Rogan, Division Director, Behavioral Health, Family Services, Inc.

CareLink

At this session, Family Services, Inc. will share with the HHS Committee their “CareLink” effort which provides case management and services to behavioral health patients from Washington Adventist Hospital and Shady Grove Adventist Hospital who are identified as likely to be readmitted. Hospitals are subject to significant reductions in rates if they do not reduce readmissions (and meet other outcome measures.) Washington Adventist’s Discharge Planning and Population Health staff contacted with Family Services in 2011 to see if intensive case management could reduce the relatively high 30-day readmission rate (about 20%) for behavioral health clients. The hospital’s request was to:

- Connect the client to community resources
- Implement the discharge plan
- Reduce or eliminate avoidable readmissions

The program started with complicated behavioral health clients but expanded to clients with medical and co-occurring conditions. When looking at 552 clients:

- 33% had complex medical conditions
- 39% had co-morbid medical and behavioral health conditions
- 29% had behavioral health conditions only

The medical unit at the hospital referred about 53% of clients and the behavioral health unit referred about 47% of clients. Just over 17% of clients were readmitted to the hospital, but 83% were not.

A CareLink Team consists of a Licensed Practical Nurse, Entitlements Coordinator, Clinical Manager (part-time), hospital liason (part-time), and data manager (part-time). The first part of the process is the “warm hand-off” where the client is quickly engaged, an address is verified, the client may receive a phone if they have no working number, a needs assessment is completed in the hospital and there is collaboration with the referring social worker. Because there is a benefit to the hospital in terms of meeting outcome requirements and avoiding financial penalties, they have paid Family Services for this program.

Family Services has received a grant from the Community Health Resources Commission to extend this model to Holy Cross Hospital in Silver Spring and Holy Cross Hospital in Germantown.

Healthy Montgomery Behavioral Health Plan and a “Warm Hand-off”

The CareLink program is based on the community care coordination model that also includes a community hub approach. The Center for Pathways for Community Care Coordination (PCCC) has adopted the following definition.

Community care coordination is the process of:

- Identifying and engaging individuals within their community home setting,
- Assessing their health and social needs,
- Connecting them to the health and/or social services they need.

PCCC says that many of the tenets of the Pathways Model align closely with ecological models of health and community development. The Pathways Model embraces individual and community engagement, empowerment, collaboration, equity, and sustainability. These tenets are fundamental both to health improvement activities and to community development efforts.

The following components are the foundation of the Pathways Model.

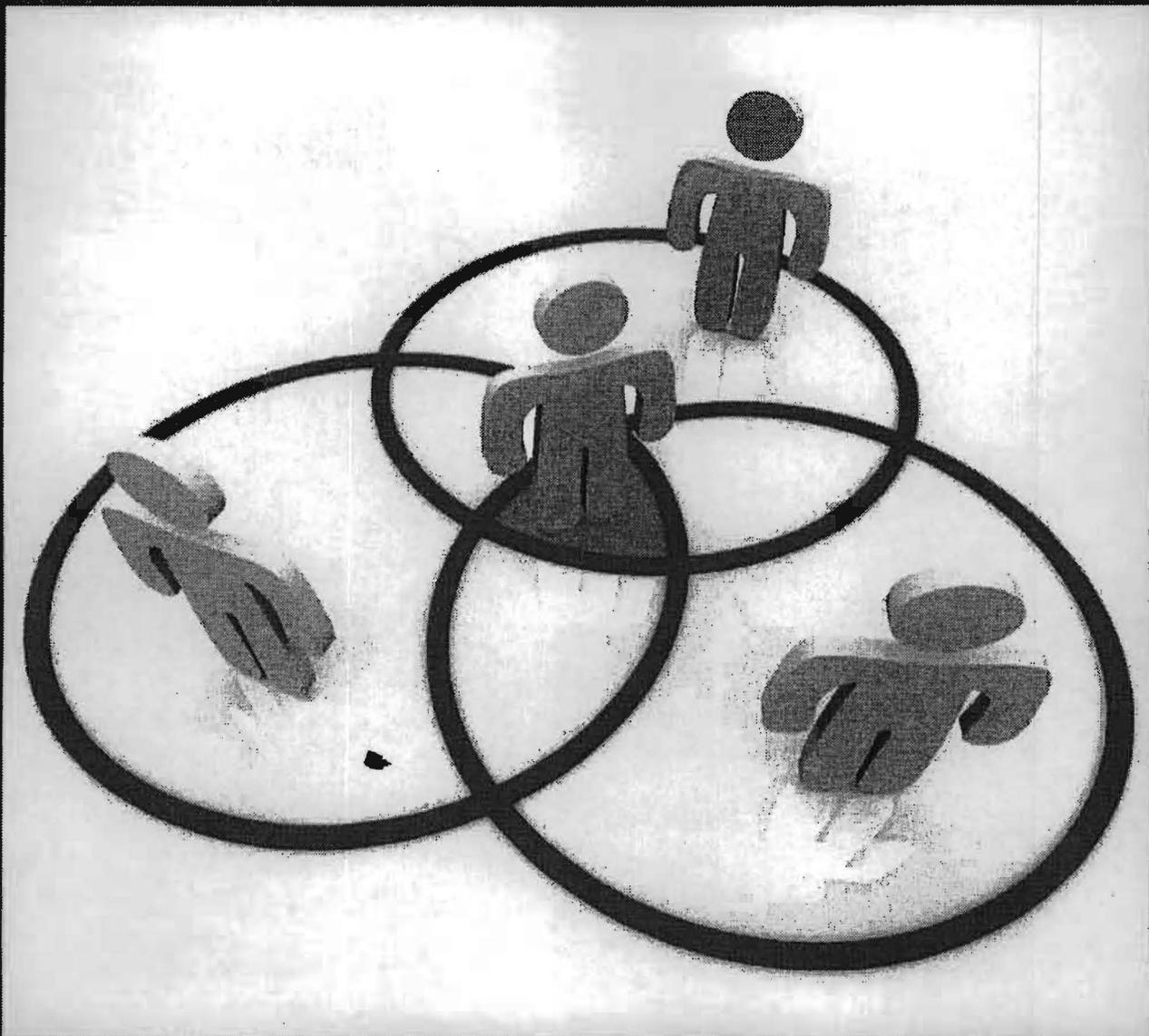
- Core pathways – measurement tools to define the problem to be addressed (health or social issue), the desired measurable outcome, and the key intervention steps to achieve the outcome
- Community HUB – a regional point of registry and outcome tracking that networks health care providers, social service agencies, and health care payers that implement these Pathways
- Pathway payments – payment for care coordination that is based on outcomes instead of activities

In the Family Services’ model, Family Services is coordinating all the services through the CareLink Team and is working with identified institutions.

The Healthy Montgomery Behavioral Health Action Plan also calls for implementing strategies that would develop and put in place protocols for facilitating the transfer of consumers from institutional settings (hospitals, emergency departments, schools, etc.) to community based services through a warm hand-off. This would help address someone's inability to navigate the health system. The Action Plan also calls for establishing a system of care that connects community resources for the good of the consumer, shared case management plans that could be viewed across and used by agencies and would achieve higher rates of success and collective responsibility.

The HHS Committee may wish to discuss with Family Services how their experience with the CareLink effort can inform the larger work of Healthy Montgomery to develop systems that would work across multiple points of entry and with multiple providers. In this larger situation, there should also be access for people who self-identify as needing this kind of case management service, which is different than the CareLink model where the hospital has specifically identified certain clients who it assesses are likely to be readmitted.

Attached to this memo are a brief overview of Pathways Community HUB (©1-5) and summaries of Healthy Montgomery Behavioral Health Action Plan Issue areas 2 and 3 (©6-7).



Pathways Community HUB

Sarah Redding, MD, MPH

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Care Coordination Systems

The Pathways Community HUB Model

The model involves working across organizational silos within a community to reach at-risk individuals and connect them to health and social services that yield positive health outcomes.

Through communication, collaboration, and built-in incentives, the HUB increases the efficiency and effectiveness of care coordination services. Rather than allow providers of health and social services to continue functioning in isolated silos, the community HUB requires them to work collaboratively, reaching out to those at greatest risk and connecting them to evidence-based interventions, with a focus on prevention and early treatment.

To ensure quality and accountability across all providers of care coordination services, the HUB acts as a central clearinghouse that “registers” and tracks at-risk individuals, making sure that their biological, psychological, and social needs are met. The HUB provides ongoing quality assurance that results in less waste and duplication, lower costs, improved health status, and fewer health disparities. In short, the HUB ensures a connection to community resources and holds providers, practitioners, employers, families, and individuals accountable for desired outcomes.

Paying for Value, Not Volume

The United States spends significantly more money per capita on health care services than any other nation in the world. But we lag behind most other developed countries in terms of key outcome measures, including infant mortality, health equity, and patient perceptions of safety, efficiency, and effectiveness. Much of the gap between spending and outcomes stems from the American health care system’s difficulty identifying at-risk individuals and providing them with effective, coordinated medical and social services. Connecting those at risk to timely, high-quality care requires expertise, accountability, and investment. Yet the current business model for the provision of care coordination services to at-risk populations remains inadequate. Care coordination contracts typically purchase “work products” that have no meaning or clear positive impact on the clients being served. Contracts typically do not require those who provide care coordination to ensure that individuals actually get connected to or benefit from needed services. Rather, payments are based on the volume of work products provided, such as the number of individuals added to a case list, visits or phone calls made, or notes charted. In addition, the current payment structure creates no incentive for the multiple organizations providing services to communicate or collaborate with each other, thus leading to duplication and other inefficiencies.

The Community HUB and its accompanying Pathways can help improve the payment system by fundamentally changing the way care coordination contracts are written. Under the Pathways model, payments are revamped to recognize the time, resources, cultural competence, and skill required to achieve measurable and meaningful results. This type of system can help the United States close the health care cost and quality gap with other developed nations.



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A Community HUB with Pathways and Pathways HUB Connect

As noted, the HUB infrastructure creates accountability among specific providers of care coordination services by tying payment to the achievement of patient-centered outcomes, including improved health status as well as fewer disparities, and lower costs. The aforementioned Pathways serve as the primary mechanism for achieving this transition, as they promote and incentivize value rather than volume of services. A community HUB uses Pathways to track, document, and report the provision of services to at-risk individuals and to hold providers of care coordination services accountable.

Rather than acting as a detailed procedural guide, Pathways function as visual, logical work management tools that facilitate measurement of outcomes and payment based on those outcomes. Pathways can be used in three distinct ways: (1) within a single agency and its workforce; (2) across multiple agencies providing care coordination services to the same individuals within a community; and (3) across multiple communities that have their own unique approaches to connecting at-risk individuals to services.

Pathways outline key stages required for the delivery of high-quality, efficient care coordination services. Each Pathway focuses on one significant client need or problem and identifies and documents the key steps that lead to a desired, measurable outcome. To create incentives for positive outcomes, financial payments are tied to key stages of the pathway. For example in the Pregnancy Pathway payments for the Pathway may be tied to both the number of prenatal visits achieved as well as tied to the final birth outcome with an incentive when the weight of the infant is greater than 5 pounds 8 ounces.

Pathways Mobile[™] enables efficient care coordination. Information from the community care coordinators in the field is synchronized within minutes throughout the HUB. Supervisors have immediate access to clients' newly-gained information. HUB staff are able to invoice for billable outcomes and services without waiting two weeks for the information to come into the office. Most importantly, the client's care team has access to the information to make actionable decisions quickly. The tablet in the hands of a community care coordinator in the client's home adds value to the client's education and their relationship, as well. It provides a window for health learning.

At risk individuals most often have multiple health social and behavioral health issues to address. Each issue identified becomes a Pathway with accountability to achieve the final positive outcome. One individual may be homeless and on the Housing Pathway, pregnant and on the Pregnancy Pathway, Depressed and on the Medical Referral Pathway to assure connection to behavioral health services. One trained care coordinator can serve as the primary care coordination resource to connect the patient to all health, social, behavioral health and educational needs.



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Client risk determination is highly innovative and robust through **Pathways RiskQ[™]** and useful to the community care coordinators to find and serve their highest at-risk clients. Supervisors and HUB managers also have access to use the tools for client risk identification and analysis. From the library of 1300+ risk attributes validated through evidenced-based research, practical experience, and complete access to client, checklist, pathways, and tools information, a high-level user may create any number of RiskQs for risk determination scoring. Their RiskQs may be scheduled to process past, current, or all future information allowing for continual social and community health research opportunities. The results may be shared within the HUB providing actionable, risk determination information to those in the field.

Funding for care coordination can remain organized and accountable utilizing the Pathway as both the outcome tracking measurement tool as well as the billing tool, coded to focus the work and funding back to the appropriate funding resource. For example the Pregnancy Pathway may be coded and billed to an insurance provider and the Housing Pathway to the division of social services or United Way. This approach allows the complex individual to be served by one primary resource for care coordination and eliminates unnecessary duplication of care coordination resources and developing one trusted relationship. For optimal outcomes, the work of the Primary Care Coordinator is tied to and supportive of the primary care provider achieving effectiveness in assisting the client in navigating critical medical and community services.

With the immediate access to Pathways and field information, the **Pathways HUB Connect[™]** system continues speeding up care coordination and further enhances the HUB and agency operational efficiency in determining billable outcomes and prepares payment transmissions. No longer does the HUB or agency have to wait 30 days to bill and months for payments to be received, each billable outcome or service may be invoiced now and payment received in less than a week.

For more information on Pathways from Care Coordination Systems, AHRQ has provided multiple publications including Connecting Those at Risk to Care <http://www.innovations.ahrq.gov/guide/QuickstartGuideTOG.aspx>



Care Coordination Systems

Care Coordination Systems

Provides the Pathways Community HUB solution through a turn-key approach:

- Programmatic organizational structure template.
- Business collaborative development identifying funding sources and community agencies.
- Training for community care coordinators that is nationally-recognized and comprehensive
- Training for coordinator supervisors and HUB personnel including systems training.
- Risk determination tools to enable the care coordinators and HUB personnel to find and serve the highest need patients; **Pathways RiskQ**tm.
- **Pathways Mobile**tm in-field connectivity and efficiency with Pathways and mobile tablets for care coordinators.
- Streamlined operations for HUBs and agencies with **Pathways HUB Connect**tm platform for collecting information, reporting, invoicing and analysis.
- Social health information system with connectivity to other systems.
- Business intelligence for research, reporting, and operations optimization analysis with **Pathways Insight**tm.
- Accurate information through training, supervision, and system information audit processes.
- Onsite and online support
- Advisory services for HUB planning and operations

For more information regarding Care Coordination Systems' Pathways Community HUB model and how CCS can develop the right comprehensive HUB model for your community, please contact Dr. Sarah Redding, 419-631-9263, sarah.redding@ccspathways.com or contact Robert Harnach, 708-906-3057, bob.harnach@ccspathways.com.

Local Health Issue Areas Identified for Improvement
Healthy Montgomery Action Plan Report: Behavioral Health

Strategy	Resources/Assets	Short-Term Outcomes	Long-Term Outcomes
<p>LHIA 2. There is a need to develop improved mechanisms for providers to communicate among themselves regarding shared consumers and to create effective linkages for consumers (warm hand-offs) as they move between providers or levels of care.</p>			
<p><i>1. Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.</i></p>	<p>This strategy can build on multiple existing efforts by various hospital and community level behavioral health providers collaborating on developing coordinated referrals. Extensive availability of quality public, non-profit and private behavioral health services.</p>	<p>The protocols are adopted and used by the discharging institutional settings (hospitals, emergency rooms, correctional facilities) and the behavioral health providers initiating community level care for the discharged patients.</p>	<p>All Montgomery County behavioral health care institutions and community providers agree on a common policy for transfer/release of patients to the community and adopt and utilize a common transfer protocol.</p>
<p><i>2. Establish adequate mechanisms for providers communicating among themselves regarding shared consumers and consumer linkages to enable informed client intakes, coordinated care, and adequately supported discharges; establish a system that is conducive to navigating between providers effectively, further contributing to coordinated care and preventing clients being lost to follow-up.</i></p>	<p>Completed strategy #1 as this (Strategy 2) will build on the protocols and automated system linkages for transferring clients from institutional settings to community behavioral health organizations. This strategy needs further thought in aligning it with the next LHIA (LHIA 3 - Explore the creation of a coordinated system of care) A Task Force with former BHWG members and other experts can work on the further development of this strategy.</p>	<p>Barriers and challenges: Insufficient membership of somatic care providers Further thought needed on this strategy's alignment with the next issue area (LHIA 3.) The BHWG did not have resources to research best practices/models to address a major component (shared electronic interface providing specific consumer information in real time).</p>	<p>TBD</p>

Local Health Issue Areas Identified for Improvement
 Healthy Montgomery Action Plan Report: Behavioral Health

Strategy	Resources/Assets	Short-Term Outcomes	Long-Term Outcomes
<p>LHIA 3. There is a need to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.</p>			
<p>1. <i>Establish a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.</i></p>	<p>The national movement toward formal integrated systems, including coordinated systems of care; The Affordable Care Act requires the integration of behavioral health services into the insured health care system. Multiple existing local collaborative efforts among behavioral healthcare providers and hospital/somatic care providers in Montgomery County collaborating on integrating care. Extensive availability of quality public, non-profit and private behavioral health services.</p>	<p>Grant applications are developed by either the HMSC (Advisory Board) or the Coordinated System of Care Task Force to secure funding to implement the Action Plan. The funding application includes funding for a leadership consultant.</p>	<p>Sufficient providers in all categories of care (somatic, mental health, substance abuse) and settings (hospital, emergency departments, somatic, behavioral health and corrections clinics) participate in a partnership based coordinated system of care or similarly organized entity to meet the needs of the target population.</p>