Systems and Technologies to Support Care Coordination in the Health Home Environment: A Lead Health Home's Experience

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Objectives

- Discuss the value of designing workflows and processes in preparation for building technology to support new models of care delivery
- Present CHN's experience developing and implementing practical workflows and tools to support care coordination efforts as a lead Health Home
- Share CHN's Roster Management Application and how the workflows and tools have been incorporated and rolled out among the downstream providers

About PCDC

- Founded in 1993

- Nonprofit organization dedicated to transforming and expanding primary care in underserved communities to:
  - Improve health outcomes
  - Reduce healthcare costs and disparities.

- PCDC's programs enhance access to primary care by offering:
  - **Capital Investment:** Flexible financing to build and modernize facilities
  - **Performance Improvement:** Coaching and training to strengthen care delivery
  - **Policy & Advocacy:** Leading policy initiatives to strengthen primary care policy

What is a Health Home?

- A "Home" that facilitates access to medical care, behavioral health care, and community-based social services for high risk patients
- Medicaid program patients with multiple chronic conditions and/or serious mental illness
- **Care coordination** and integration of services are provided by an **interdisciplinary team** of providers led by a dedicated **care manager**

Systems to Support Care Coordination

Many models describe what a care coordination system needs to include, few focus on how to operationalize it

The Health Home model presented many operational challenges:

- New systems and approaches to delivering care
- Staffing models and training
- Need for additional resources, including care management technology

Care Coordination Model Project Funded by the Altman Foundation

Timeframe: July 2012 – April 2014

Model – PCDC and CHN develop and test an actionable care coordination model for use by primary care providers serving the safety net

Spread – Pilot this model at 2 Brooklyn primary care practices

Share – Communicate and disseminate project results

Project Participants

- **Community Healthcare Network (CHN)** – lead Health Home in Brooklyn
- **Help PSI** – downstream provider in CHN Health Home
- **Housing Works** – downstream provider in CHN Health Home

Health Home Care Coordination Model Project

Methods:

- **Implementation Team:** patient navigators, care managers, site supervisors, director, and PCDC coach. Diagnose problems and identify, test, refine and implement solutions pertaining to challenge areas.
- **Managers Meetings:** site supervisors and directors. Discuss challenges and project direction with PCDC coach.
- **Executive team**: senior leadership, Health Home director, and PCDC coach. Project updates and approval of any large programmatic changes needed.

Developing Solutions for the Front Line

Goal/Objective

Current State

Challenges

Solutions

Test

Refine

Implement

Monitor

Health Home Care Coordination Model Project

Common Challenges:

- Outreach and Engagement
- Patient Assessments
- Developing Care Plans
- Patient monitoring
- Team communication
- Staff training on new workflows and tools

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BROOKLYN
CABS Health Center

Dear Medical Provider,

Your patient ___________________ is currently enrolled in Community Healthcare Network's Health Home Care Coordination Program. Health Homes is a care coordination/care management model that is designed to promote and/or facilitate the communication among all of the professionals (such as yourself) that are involved in a patients care in an effort to ensure that all of his/her medical, behavioral and social services needs are met in a comprehensive manner. Your patient became enrolled in the Health Home

Your patient has been assigned to a Care Management team. The Care Management team, lead by ______________________________ will:

- Thoroughly assess and assist with psycho-social needs to include housing, entitlements, legal, education and support services at the community level
- Remind patient of appointments
- Provide escorts to appointments
- Coordinate transportation if necessary
- Assist patient with navigating medical and social service systems
- Serve as a liaison between the patient and the service providers
- Reach out to the designated medical team periodically to discuss medical recommendations, incorporating them into the patient's care plan goals and provide updates on client progress through phone contacts and at scheduled appointments.

Mobile Clinic
Tel (646) 660-2804

Other Office Locations:

345 East 102nd Street, 4th Floor
New York, NY 10029
Tel (212) 360-8080 • Fax (212) 828-2325

260 Broadway, 3rd Floor
Brooklyn, NY 11211
Tel (718) 387-7506 • Fax (718) 387-6895

170 Broadway
Brooklyn, NY 11211
Tel (718) 486-4933 • Fax (718) 384-0149

Affiliated With:

NewYork-Presbyterian Healthcare System
United Way of New York City
Member of FPWA

- Serve as a liaison between the patient and the service providers
- Reach out to the designated medical team periodically to discuss medical recommendations, incorporating them into the patient's care plan goals and provide updates on client progress through phone contacts and at scheduled appointments.

We look forward to collaborating with your medical team to promote our mutual patients' adherence to care and treatment. If you should have any questions or concerns, please call the Health Home Care Coordination Program, toll-free, at (855) 246-4422.

Sincerely,

Rosemary Cabrera, MSW

AVP of Health Homes
Community Healthcare Network

Site Name

Health Home Patient Assessment

Medical Template – Patient

☐ Complete

Patient

Collect the following information from the patient during the assessment:

1. Have you been given any medical diagnosis? Tell me about your condition and how it affects you.
2. What doctors do you see? How long have you seen them? Do you have their contact information? Who are you familiar with there?
3. When was your most recent medical appointment? Do you have any upcoming medical appointments? If not attending appointments, what are the barriers?

CARE PLAN FLOW

DATE: 9/30/12

Complexity	Client Name	Goals	Care Manager	Patient Navigator	Care Coordinator	Date of Completion
High	**Henry**	M: Attend medical appt. by 11-30-12; Increase T-cell 20-100 H: obtain 1br. In BX SA: Meth. Program daily adherence- Remain drug free	find patient and make appt.	call Landord	N/A	11/30/12

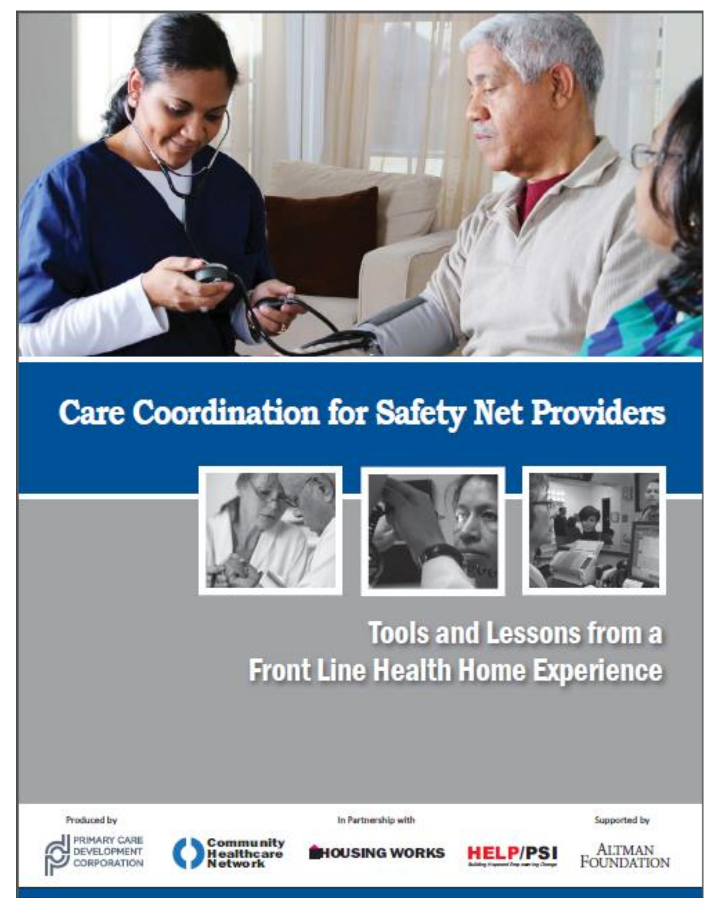
Results

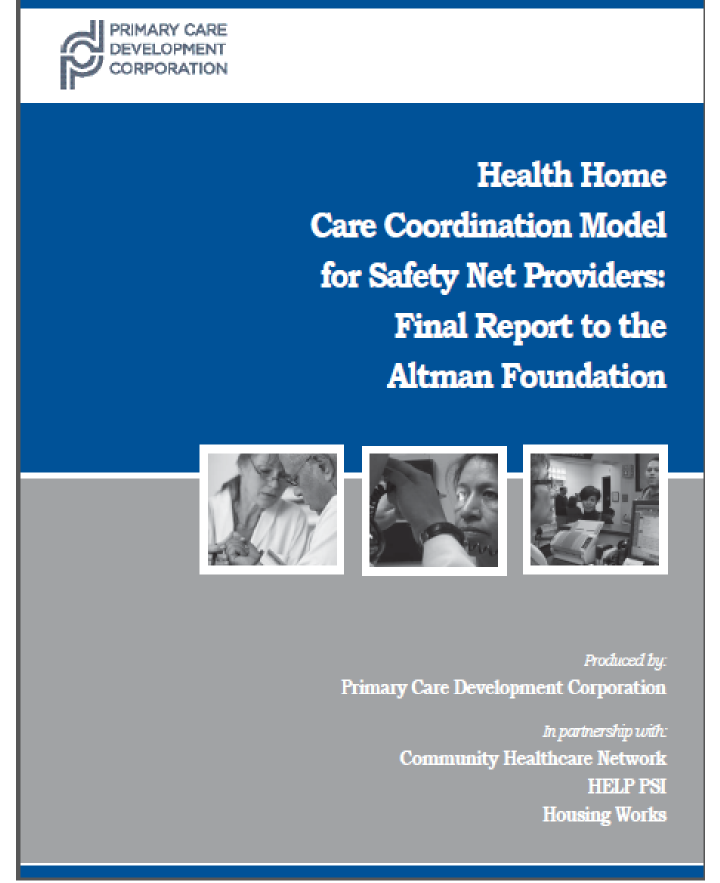
- Over 82% of care management staff and their managers at all three organizations reported that the new workflows and tools helped them to:
  - Produce more complete assessments on time
  - Manage day-to-day tasks for their larger caseloads
  - Improve their understanding of the care planning process
  - More efficiently train new staff

Lessons Learned

- Involve staff at all levels for successful change
- Implement a uniform set of care coordination systems, workflows and tools
- Conduct onsite training that connects workflows and tools to processes and care coordination skills
- Taking the time to develop and test practical workflows and processes will help technology support staff in their new roles

Final Report and Tools





Available for download at www.pcdc.org

Health Home Care Coordination Project
CHN’s Experience

Brief History of CHN

- Provided COBRA case management services for 20 years
- Lead Health Home provider in Brooklyn and Queens and a Co-Lead in the Bronx and Manhattan
- Comprehensive and robust provider network
- Level 3 Medical Home in 11 Health centers and 1 Mobile Van
- Joint Commission Accredited
- Won Case management National Award

HH implementation Challenges

- Quick roll out process by the State
- Higher caseloads
- Care management staff learning new EMR, Development of electronic CM module, and the new required documentation
- Expanded target population: from HIV with co-morbidities to numerous Chronic Conditions
- Working with more specialty external providers
- Lack of funding to build infrastructure
- Limited community awareness of HH and its impact

Training Implementation through Project and Beyond

- Prior to HH implementation staff had two years of train the trainer preparation regarding HIV population and overall adherence
- Provided trainings on Chronic Conditions through the lens of Health Literacy
- Provided numerous trainings on new documentation and HH work flows
- Additional investment and staff involvement in documenting all work flows: i.e.

  Assessments

  Care Plans

  Patient Monitoring

RMA- Roster Management Application

- History of the RMA
- Incorporating tools into an electronic system
    - Monitoring monthly client services
    - Tracking assessments, care conferences, care plan updates, etc
    - Assistance in reporting and tracking to DOH
    - Care Plan development

Caseload Coverage

https://hhdemo.chnnyc.org/reports/caseload_coverage?utf8=%E
Caseload Coverage : Health H...
Caseload Coverage : Health...

File Edit View Favorites Tools Help

Suggested Sites (2) Suggested Sites

rosterwrangler Patients Manage Search Patients My Settings Help Sign out

DEMO

Caseload Coverage

Filter Criteria

Year 2014 CMA Segment Type

Month March Care Manager Billing Status

Update

Displaying **all 14** active patients

Patient	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
O Fritz Furgeson																															
O TIM TEBOW																															
O MARYANN VAN HOGAN																															
O CARL WEATHERS																															
O GENE WEEN				M																								C			
E ARTHUR AARDVARK																															
E Lulu Bankhead																															
E Bob Barker																												C			
E BILL BRASKY																															
E MARC JACOBS																															
E Sophia Linden																															
E Charlie Rosado																															
E STEVE URKEL																															
E Henry Wadsworth																															

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Caseload Overview

https://hhdemo.chnnyc.org/reports/caseload_overview

Caseload Coverage : Health H... | Caseload Overview : Health ...

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Suggested Sites (2) Suggested Sites

rosterwrangler — Patients | Manage | Search Patients | My Settings | Help | Sign out

Filter Criteria

Patient CMA

CMA Location

Care manager

Update

Note: this report shows only patients who have a current **enrolled** segment.

Displaying **all 11** patients

Patient	Care Manager	HH Consent Date	Latest Fact-GP	Latest Assessment completed	Latest Assessment reviewed	Care Plan last updated	Care Plan review/approval	Latest Care Conferences
ARTHUR AARDVARK	Sabrina Henderson	3/5/2014	2/12/2014	3/28/2014	--	7/30/2014	Reviewed and approved on 7/29/2014 by Ryan Wilcoxon Review requested on 7/30/2014 by Ryan Wilcoxon	
Marc Anthony	Andrea Martinez	--	--	--	--	7/30/2014		
Lulu Bankhead		--	1/14/2014	3/13/2014	--	--		
Bob Barker	Tywan Mata	3/3/2014	3/21/2014	--	--	7/29/2014		Medical: 3/28/2014
Mark Brown	Olos Pitts	--	--	--	--	--		Medical: 4/23/2014
MARC JACOBS	Phil Sharpe	--	6/3/2014	6/13/2014	--	6/13/2014		MH: 6/25/2014
Billy Joel		--	--	--	--	7/31/2014	Changes requested on 7/31/2014 by Cady Herman	
Sophia Linden		--	1/15/2014	--	--	--		MH: 6/10/2014

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Outreach Segments

https://hhdemo.chnnyc.org/outreach_segments_auditor | Caseload Coverage : Health H... | Outreach Segments Auditor...

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Suggested Sites (2) Suggested Sites

rosterwrangler Patients Manage Search Patients My Settings Help Sign out

DEMO

Outreach Segments Auditor

Segments on this list have either been open too long, or have been closed past the 3 month cutoff for Outreach Segments.

Patient Name	Medicaid ID	Start Date	End Date	Health Home	Care Management Agency	Outreach/Enrollment Code
Fritz Furgeson	QA45678Z	2014-01-01		Queens Coordinated Care Partners (QCCP)	ACMH	Outreach
CARL WEATHERS	ZZ28603Q	2014-01-01		VNS Bronx	Community Healthcare Network	Outreach
TIM TEBOW	ZZ44431Q	2014-01-01		CHN Brooklyn	Community Healthcare Network	Outreach
Jay Z	ZZ23455L	2014-05-01		CHN Brooklyn	Puerto Rican Family Institute	Outreach

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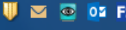

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Care Plan

Care Plan for ARTHUR AARDVARK

Patient Version | Clinical Version | Care Plan Info | View/Print PDF

Patients / ARTHUR AARDVARK / Clinical Version

Supervisor review of this care plan was requested on 7/30/2014 by Ryan Wilcoxon.

+ Add Problem

Care Team

Care Manager
Sabrina Henderson
Office phone: 212-555-1234
Cell phone:

Medical - Primary Care Provider
Dr. John David
718-778-0198
1167 Norstrand avenue, Brooklyn, NY 11225

Medical - Other Medical
Dr. Brandon Hamilton
Specialty: Nutritionist
Bronx Health Center
9172828651
2110 Westbury Ct #6D

Medical - Other Medical
Dr. Loris Omesh Drepaul
Specialty: urologist
St. Stephen's Hospital
718-231-6700
3071 Perry Avenue Bronx NY 10467

Medical - Podiatry
David Wallach

MEDICAL CONCERNS

Problem: Patient's diabetes is not being managed. His A1C was 10 as of 2/3/14.

Started 4/2/2014
Patient had been out of care and recently engaged with a new PCP. Due to this, his diabetes is out of control which resulted in him fainting on the subway and being taken to the ER.

Goal: Patient will reduce his A1C from 10 to 8 in the next 6 months. [High Priority]

Patient struggles with medication adherence and with sticking to a healthy diet.
Start date: 4/2/2014
Target completion date: 10/2/2014

Task	Responsibility	Target Date	Completion Date	Status
Arthur will meet with the nutritionist to discuss a diet plan	Patient	4/18/2014	4/11/2014	Completed
Patient Navigator will schedule a follow-up appointment with PCP to do lab work	Patient Navigator	4/18/2014	4/18/2014	Completed
Care Manager will connect Arthur to a pharmacy that will deliver to his house	Care Manager	4/11/2014	5/1/2014	Completed
Nutritionist will develop a realistic and individualized diet plan for Arthur that he can follow	Nutritionist	4/25/2014	5/20/2014	Completed
Care Manager will provide additional health education around medication adherence and	Care			

Incorporating Pre-Existing and New Best Practices

- **Pre-Existing Best Practices**
  - Staff prior expertise in community-based experience
  - Prior experience in comprehensive assessments and interdisciplinary team conferences
  - Ability to outreach + engage effectively
  - Standardized protocols in place that needed to be revised

- **New Best Practices**
  - Development of HH Script
  - Document old and new workflows
  - Extensive training around the standard workflows and protocols inclusive of caseload coverage and patient monitoring
  - Extensive training around HH billing standards and requirements

Future Development in the RMA

Disease specific care conference templates

- Will guide Care Managers in the discussion with the provider
- Ensure that we are following up on HEDIS & QARR measures
- Will give us the ability to track data and health outcomes over time

Inclusion of the Care Plan Flow into the RMA

- Will allow Care Managers to delegate tasks from the care plan to themselves and the Patient Navigator
- Will ensure that the team is always working off of the care plan so that the care plan will be kept "live"

Questions

Contact Information

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