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CARE COORDINATION IN A FRAGMENTED WORLD

Grace White – Deputy Chief of Program System

Greg Basham – Director of Care Coordination

CEU check-in-code 2003

My Health My Resources of Tarrant County (MHMR)

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Background

The Texas system of community-based services was established in 1969

Services MHMR provides include:

- Mental Health services for children, adolescents and adults
- Substance Use Disorders for youth and adults
- 24-hour Crisis Line, Outreach
- Intellectual & Developmental Disabilities (IDD)
- Early Childhood Intervention (ECI) and Child & Family Services
- Special populations: People experiencing homelessness,
- Veterans and more

Our Services

- More than 8,000 adults receiving services each month (from averaging the state target)
- Nearly 4,000 children receiving services each month
- Nearly 4,500 babies receiving services each month
- Nearly 4,000 people with IDD receiving service coordination each month
- 103,636 calls to the ICARE Call Center

*Numbers are monthly estimates

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Our Services

- Adult and Youth Services
  - Mental Health
  - Substance Use
  - Parent and Youth Groups
- Perinatal Connections and Family Connects nursing home visiting program
- Early Childhood Intervention (ECI) home visiting program
- Service Coordination
- Group homes

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Objectives

Objective 1 : Describe and identify the barriers to effective care coordination.

Objective 2 : Outline implementation strategies to address social determinates as care coordination.

Objective 3 : Describe the tracking and monitoring of care coordination outcome measures.

Learn the ways of care coordination you will

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What is Care Coordination?

- Is it the Force that binds us and surrounds us?
- Is it a Jedi mind trick?
- Is it just something we say that we do because everyone else says it?
- Do we know it when we see it?

Care Coordination Defined

"[D]eliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."

-The Agency for Healthcare Research and Quality (AHRQ).

Definition for care coordination from AHRQ is also endorsed by the Texas Health and Humans Services Commission.

It’s the Law

Authority: Section 223 (a)(2)(C) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

“Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs.”

This also includes having partnerships or formal contracts with other community or regional services, supports and providers to include schools, criminal justice agencies and facilities, and Indian Health Services.

Care Coordination

Not always face-to-face

Planning transitions

Continuity of Care

Family-centered and person-centered

Know and understand the preferences and needs.

Patient choice and patient voice

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The Linchpin of CCBHC is **Care Coordination**

- Care coordination organizes and plans care among different services, providers, across various organizations and is clearly documented.
- Follow up:
  *Did the referral happen?
  *What was the result?
  *Are there additional steps?
- Align resources.
- Risk stratification to determine level of care coordination.
- Data sharing among all providers to achieve safe and effective care.
- Knowing patients' and families' preferences and needs.

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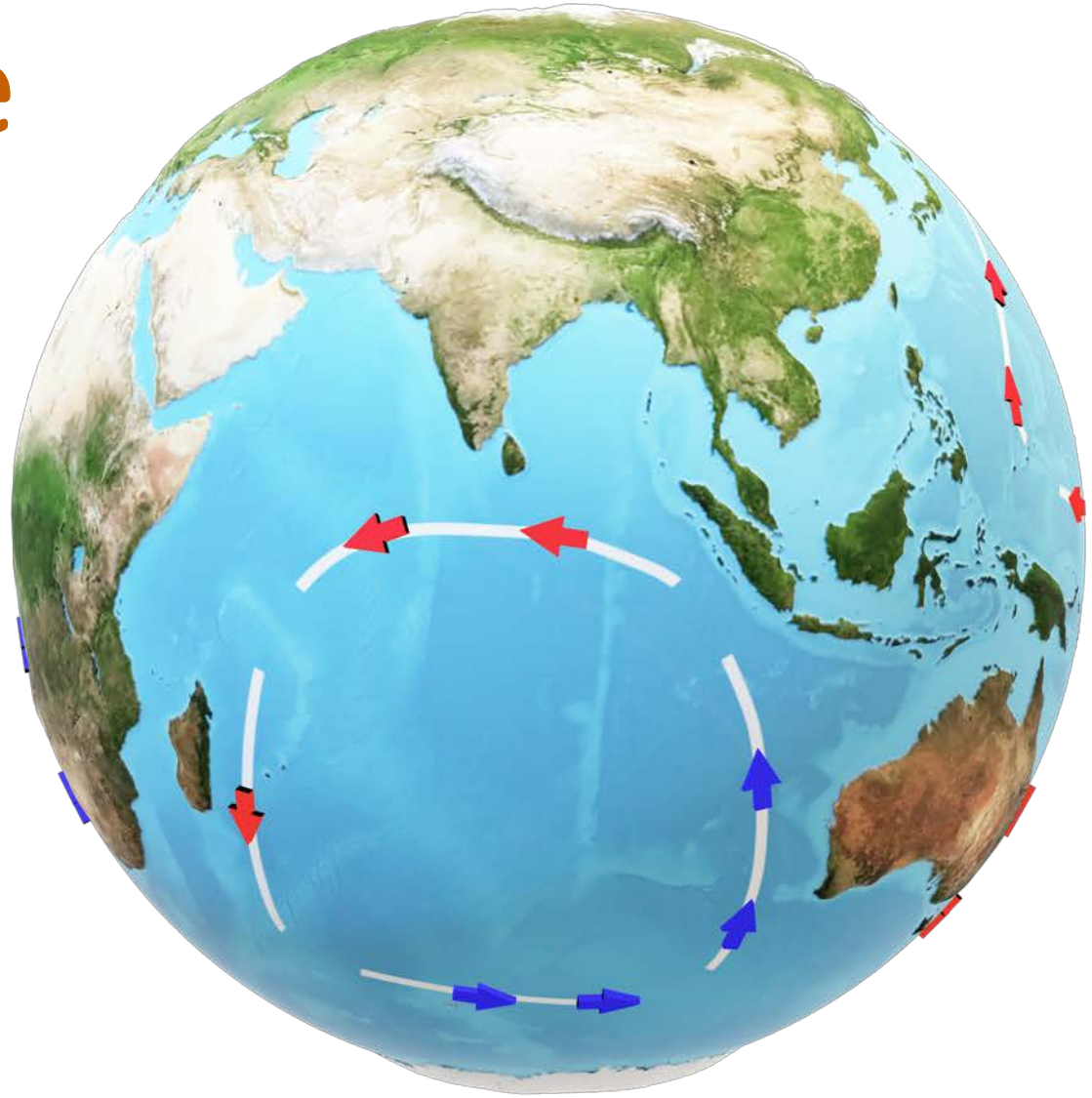
Evolution of Care Coordination



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Evolution of Care Coordination

late 1960's

The "medical home" model was developed for patients with multiple needs and diagnosis.

1970's

Care coordination in nursing and health care was used as a central feature of community-based interventions and has evolved to be an integral part of nursing and medical organizations and services.

1980's

The System of Care (SOC) approach was first used for children and youth with serious emotional disturbances and their families.

2017

Care coordination was identified as the linchpin of the CCBHC model of care.

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Why Care Coordination?

- Unmet needs.
- Complex funding streams (insurance, benefits).
- Managing limited resources.
- Multiple participants at the same time.
- Technology provides more tools and resources.
- De-institutionalization.
- Emphasis on community care.
- Multiple transitions.

Barriers To Care Coordination

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SHARED VISION

- Do we have a common or shared definition of care coordination?
- Does each participant have a different understanding?
- Does your center have a shared understanding?
- Is that a barrier?

Conflicting Goals

Sometimes participants will have differing goals.

This may occur because of differing regulatory requirements (schools, courts, law enforcement, hospitals).

This may occur between a LIDDA and LMHA/LBHA.

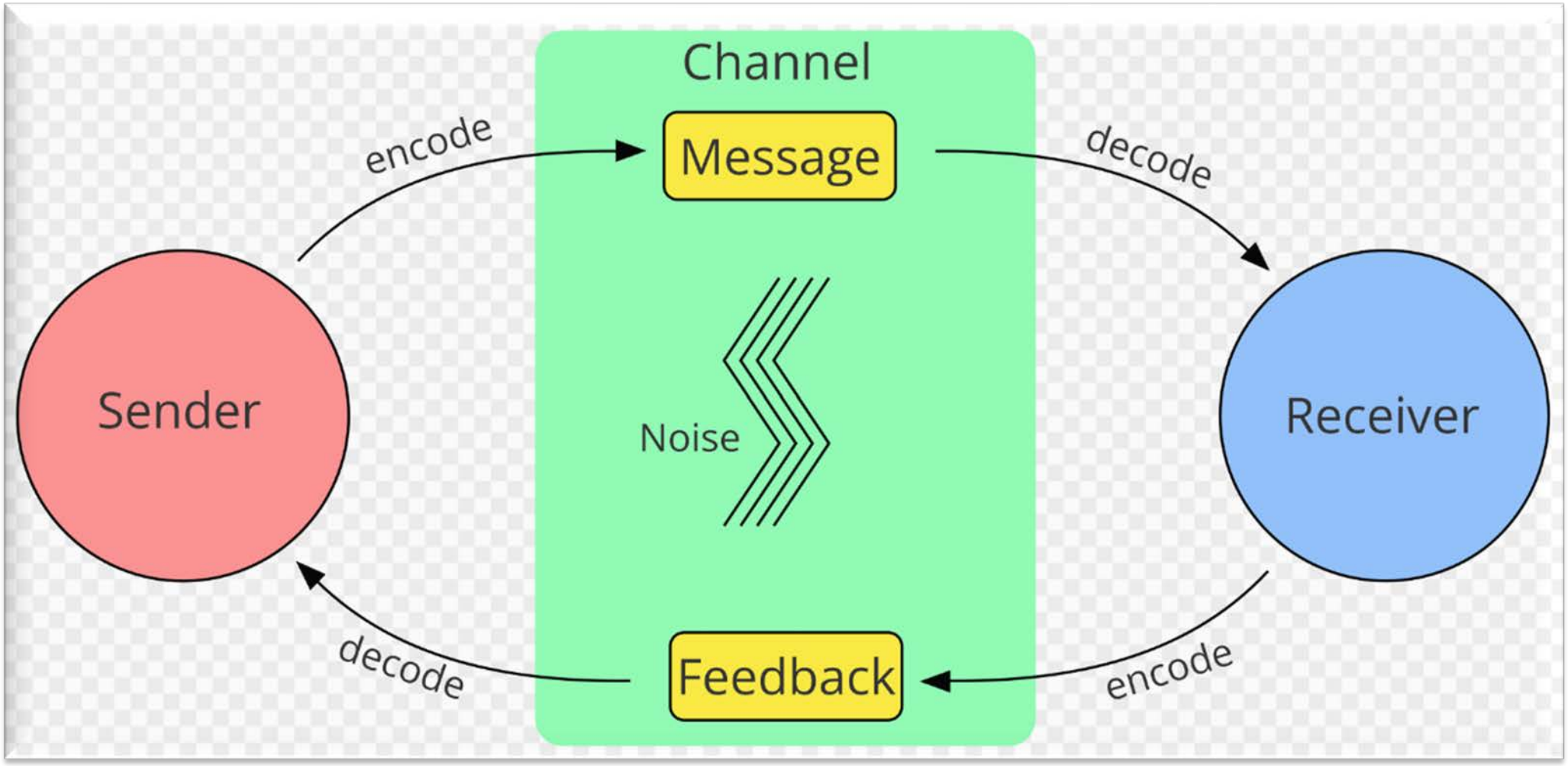
It may occur internally within an organization with multiple contractual and grant funded programs.

Participants may feel the need to “compete” for patients or establish “ownership” of a patient’s care.

Communication

- “Tower of Babel” syndrome – Participants speaking different languages from their point of view and specific to their discipline.
- Cultural differences among participants may lead to misinterpretations and misunderstandings.
- Difficulty scheduling meetings either in person, virtually or on the phone.
- How difficult is communication for you and your organization?
- What is communication?

Communication Model



Lack of Interoperability

The Cures Act requires the sharing of information with interoperability among healthcare organizations with their respective electronic health record systems.

Optimizations of resources - CareQuality and CareConnect.

Participants are not always healthcare organizations.

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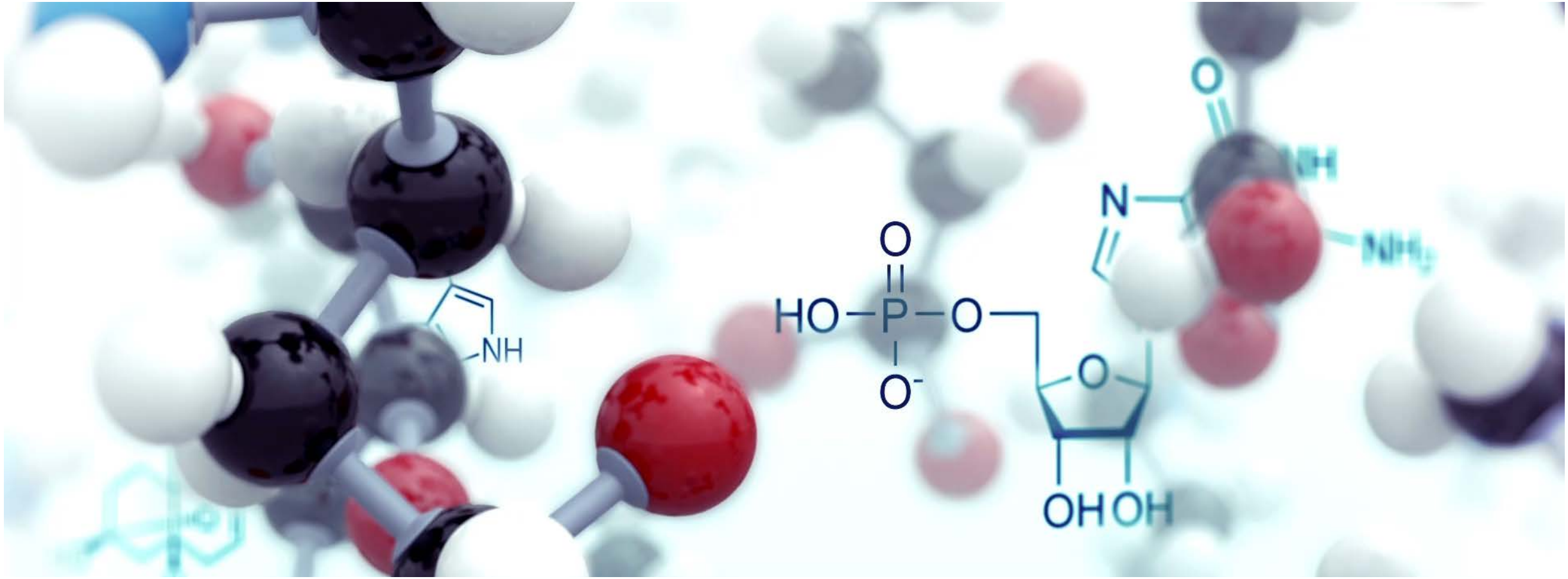
Social Determinants of Health



Non-Medical Drivers of Health

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Access to Technology

- Not all participants, with lack of access, are patients.
- The pandemic revealed socioeconomic disparities impacting access to broadband internet. (students, elderly, parolees/probationers)
- Technology has a financial cost (laptops, smart phones, cell phone bills, access limited to how far you can travel).
- Assumptions and prejudices about patient knowledge and understanding of technology.

Transportation

- Access to public transportation limited.
- Public transportation geographically limited.
- Costs of public transportation.
- Cost of vehicles.
- Cost of maintaining a vehicle (fuel costs, routine maintenance, insurance, registration fees, parking).
- Ride sharing costs.
- Distances between resources and services.

Child Care

- Cost of child care.
- Accessibility to child care.
- Availability of child care.
- Specialized child care.

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Housing

- Affordable housing options limited.
- Housing with access to resources.
- Past issues may limit access to housing (credit issues, criminal justice involvement).
- Housing in safe environments may be limited.

Sources of Income

- Employment opportunities limited.
- Employment with sustainable income.
- Limited knowledge of available benefits.
- Challenges in navigating benefit opportunities.

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Food

- Access to affordable food options.
- Residing in a food desert.
- Understanding food nutrition and impact on overall health.
- Impacts both behavioral health and physical health.

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Medical Costs

- Insurance premiums.
- Deductibles.
- Co-payments.
- Medication costs.
- Dental care often not available.
- Affordability of over-the-counter medications.
- Lack of reliable internet for virtual services

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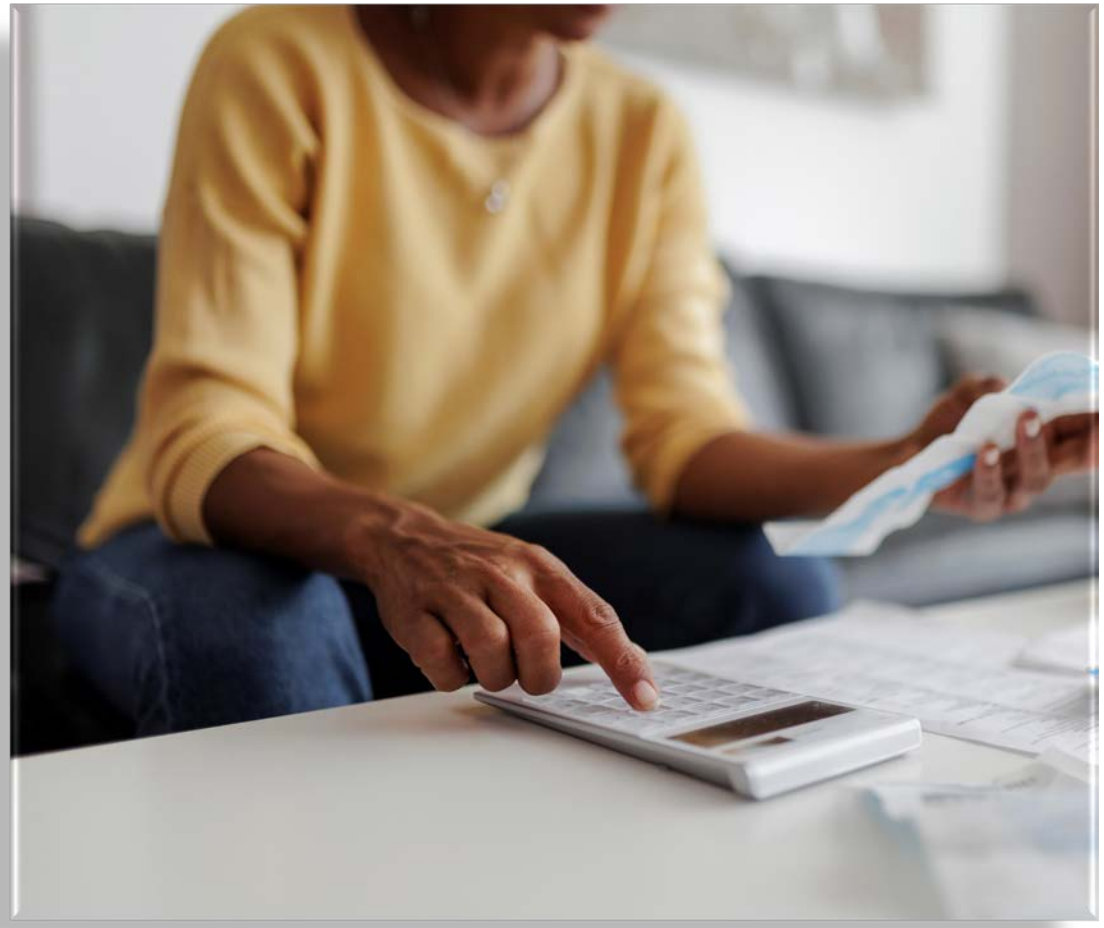
Other Financial Costs



- Debts.
- Court Costs.
- Restitution.
- Higher interest rates.
- Lower credit ratings.
- Missed time at work or school.
- Personal hygiene items.

Strategies

Removing Barriers and Improving Care Coordination

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Identify Key Roles in Care Coordination

- Nursing.
- Benefits staff.
- Case management.
- Outreach staff.
- Peer and Family supports.
- Community Partners (schools, parole/probation, courts, primary care).
- Managed Care Organizations (MCO).
- *THE PATIENT.*

Formalize Care Coordination

Make it a part of your policies and procedures.

Establish and sustain protocols, workflows, teamings and staffings.

Everyone has a voice in continuous quality improvement.

EXPECT Care Coordination.

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PROVIDER FORM (short version)

Underlined answer options indicate a positive response for a social need for the housing, food, transportation, and utilities categories.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

A value greater than 10 when the numerical values for answers to the following questions are summed indicates a positive screen for personal safety.

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

8. How often does anyone, including family, insult or talk down to you?[1]
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. How often does anyone, including family, scream or curse at you?[1]
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

Sum of questions 7–10: _____
Greater than 10 equals positive screen for personal safety.

ASSISTANCE

11. Would you like help with any of these needs?
   - ☐ Yes
   - ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

Risk Stratification Tool

Helps direct, improve, and change the way we care for patients

- Focuses on Social Determinates of Health (SDOH)
  - Quantifies the patients' physical, behavioral, and social needs
- Evaluate trends and adjust care accordingly
  - Levels: Mild, Moderate and High Risk

Does not require the patient or family to be present

Complete form by using ANSA/CANS, Housing Assessments, MedNote, Labs, CCDs, jail records, etc.

Collaborative process

Can assign to other team members for input.

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Community Partnerships: Develop & Sustain

- Community outreach as a part of your system of care.
- Identify points of contact.
- Establish lines of communication.
- Regular interactions and meetings.
- Build relationships.
- Monitor the community partnerships for effectiveness and areas of improvement.
- Identify collaborative opportunities.

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Community Partners

- School systems.
  - Public school districts, private schools, co-op school programs for home schoolers.
- Criminal Justice Agencies
- Veteran Services and Programs
- Texas Native Health Services
- Federally Quality Health Centers (FQHC)
- Hospitals (county and private).

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Staff Support

- Developed care coordination codes for individual care coordination notes.
- Identified service codes to “roll-up” as care coordination.
- Training providing on when to apply the code.
- Open-office hours with staff.

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Analyzing Organizational Structure and Care Coordination

System of Care

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MHMR of Tarrant County Program Services Strategic Plan

The Values and Core Principles of our strategic plan are Person-Centered and Trauma-Informed with both staff and patients.

- ❑Person-Centered & Family-Driven.
- ❑Evidence-Based & Data Driven.
- ❑Accessible & Available.
- ❑Coordinated & Collaborative.
- ❑Equitable and Responsive to Cultural Differences.

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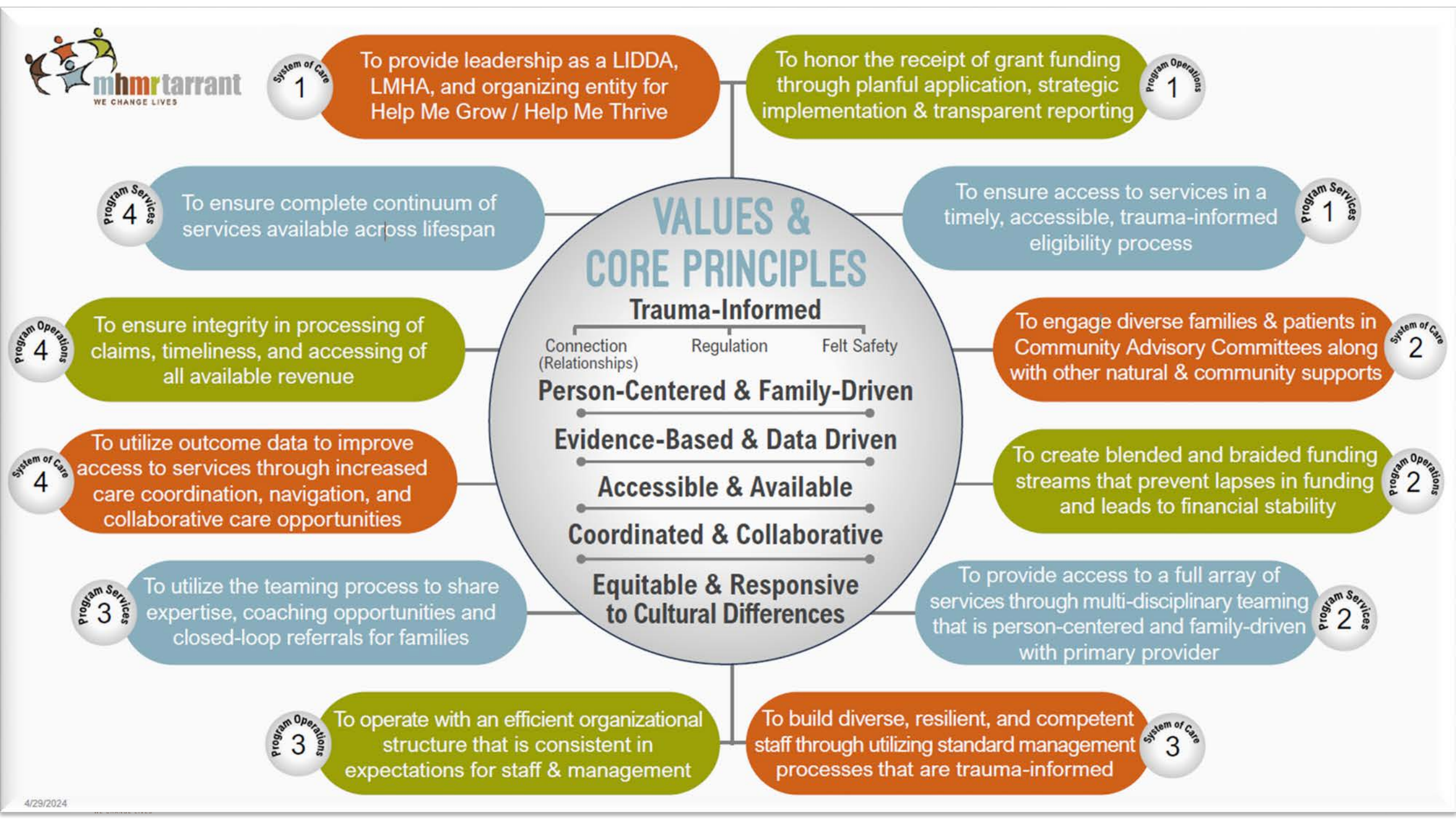
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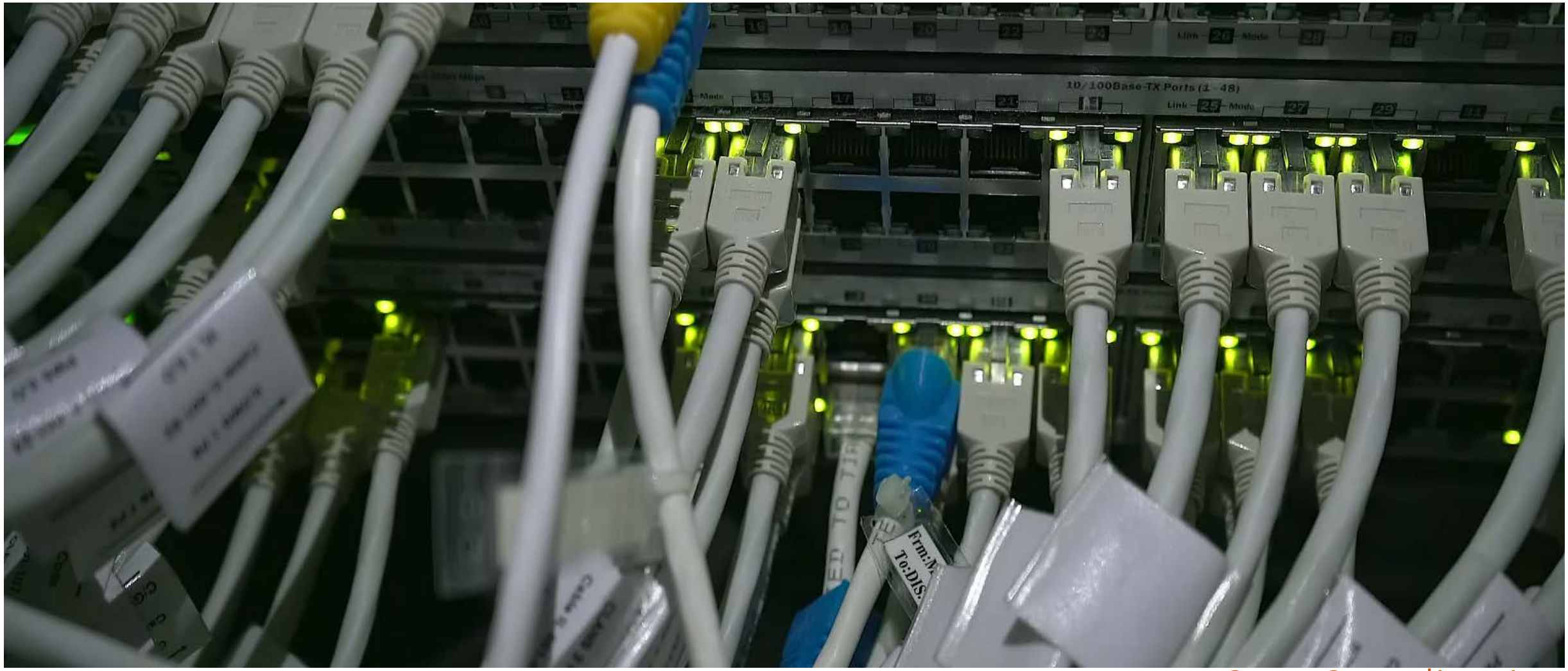
System of Care 1
To provide leadership as a LIDDA, LMHA, and organizing entity for Help Me Grow / Help Me Thrive
Program Operations 1
To honor the receipt of grant funding through planful application, strategic implementation & transparent reporting
Program Services 4
To ensure complete continuum of services available across lifespan
Program Services 1
To ensure access to services in a timely, accessible, trauma-informed eligibility process
VALUES & CORE PRINCIPLES
Trauma-Informed
Connection (Relationships)
Regulation
Felt Safety
Person-Centered & Family-Driven
Evidence-Based & Data Driven
Accessible & Available
Coordinated & Collaborative
Equitable & Responsive to Cultural Differences
Program Operations 4
To ensure integrity in processing of claims, timeliness, and accessing of all available revenue
System of Care 2
To engage diverse families & patients in Community Advisory Committees along with other natural & community supports
System of Care 4
To utilize outcome data to improve access to services through increased care coordination, navigation, and collaborative care opportunities
Program Operations 2
To create blended and braided funding streams that prevent lapses in funding and leads to financial stability
Program Services 3
To utilize the teaming process to share expertise, coaching opportunities and closed-loop referrals for families
Program Services 2
To provide access to a full array of services through multi-disciplinary teaming that is person-centered and family-driven with primary provider
Program Operations 3
To operate with an efficient organizational structure that is consistent in expectations for staff & management
System of Care 3
To build diverse, resilient, and competent staff through utilizing standard management processes that are trauma-informed

Monitoring Outcomes



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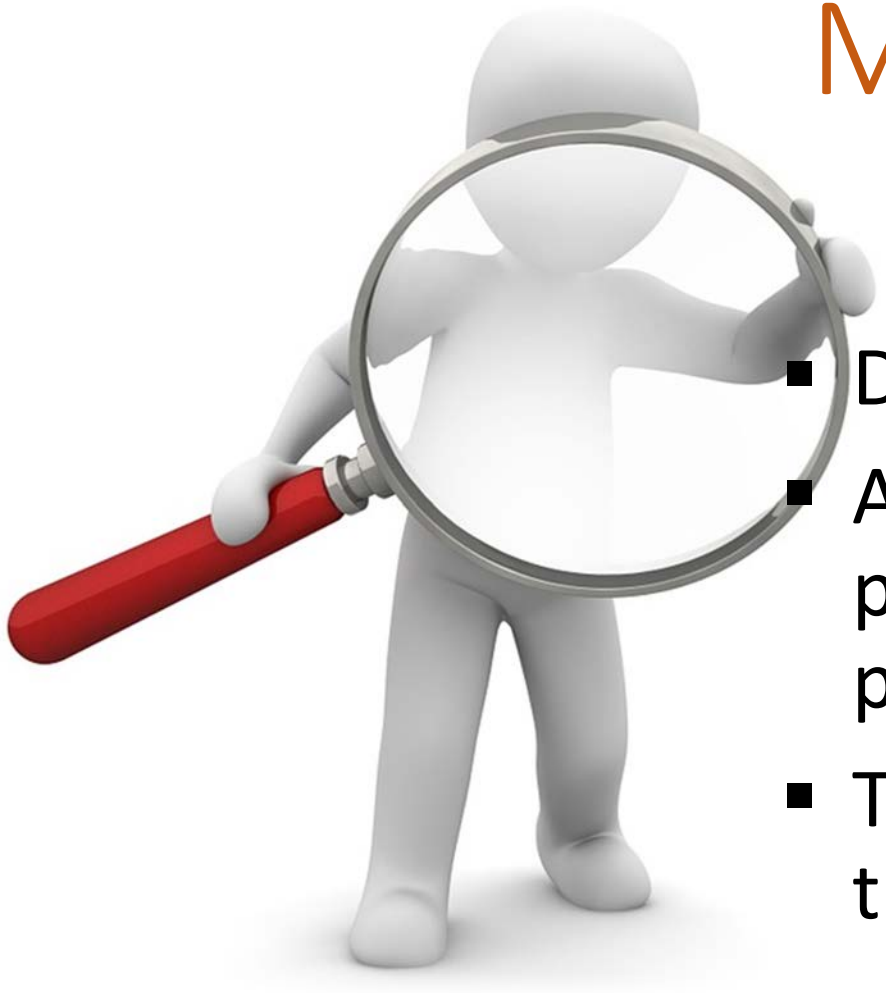
Monitoring Outcomes



- Dashboards.
- Artificial Intelligence (AI) to review progress notes, person-centered recovery plans.
- Tracking referrals for follow-up and closing the loops.

Care Coordination Codes

Developed and implemented single care coordination code to be used for progress notes.

Identified a list of other codes for notes that “roll-up” into the care coordination code that close the loop for care coordination activities.

February 2024
Internal Review of Care Coordination Coding

- ***3,545 instances of the care coordination code application.***
- ***1,520 care coordination services were provided with patient present.***
- ***Over 282 hours of care coordination sevices documented using the code.***

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February 2024
Internal Review of Care Coordination Coding

Commendations

- Benefits staff documenting care coordination in E.H.R.
- Nursing staff continue applying care coordination codes.
- More than half the staff are utilizing AI function to document care coordination.
- Observed staff diligently working to assist patients meet their needs and close the loops in services and referrals.
- Care coordination codes revealed staff serving patients quickly after traumatic event.

February 2024
Internal Review of Care Coordination Coding

Issues

- AI function and templates for E.H.R. documentation not fully utilized by staff.
- Staff have a trend of doing services FOR the patient but not WITH the patient.
- Care coordination is misapplied with services such as providing trust fund checks and providing information on services but referring and linking services.

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Care Coordination Progress Notes

Examples

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Care Coordination Progress Note

Practitioner	Location	Service Code	Episode (Program)	myAvatar Note Type	Session Date/Time
[redacted]	Respite	Care Coordination	#1 - 09/06/2023 (Mens Crisis Respite OP)	Crisis Intervention	02/06/2024 2:40 PM - 2:55 PM

Goals

No data has been entered in the section.

Diagnosis

1. P F33.2 Major depressive disorder, recurrent episode, severe

Session Time

Start	Stop	Duration	Length of Session
2:40 PM	2:55 PM	00:15	00:15

Care Coordination Progress Note

C[redacted] and [redacted] provided care coordination services regarding [redacted] following conditions: Cl[redacted] assisted [redacted] by walking him to the DCR building, for critical documents.

The following care coordination activities were addressed: Benefits and Continuity of Care

[redacted] will receive a copy of his Birth Certificate from Abilene, Texas so that he is able to get a Texas identification card on the 28th of February 2024.

Cl[redacted] and [redacted] will continue to work on his critical documents so that he will have before he discharges from the Men's Crisis Respite Unit program.

Additional Information: None at this time.

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Care Coordination Progress Note

Practitioner	Location	Service Code	Episode (Program)	myAvatar Note Type	Session Date/Time
[redacted]	Other Community Setting Phone/Audio Only	Care Coordination	#1 - 10/12/1998 (ABH Community Services)	Case Management/Service Coordination	02/01/2024 4:48 PM-4:49 PM

Goals

No data has been entered in the section.

Diagnosis

1. P F33.3 Major depressive disorder, recurrent episode, with psychotic features

Session Time

Start	Stop	Duration	Length of Session
4:48 PM	4:49 PM	00:01	00:01

Care Coordination Progress Note

RCM/leasing agent for Villas on the Hill Apts provided care coordination services regarding [redacted] following conditions: Housing

The following care coordination activities were addressed: Patient Advocacy

RCM reached out to leasing agent to determine if any forward movement or decisions had been made regarding the application patient has submitted. A financial assistance application for the move will need to be submitted once an apartment is secured.

Additional Information: Leasing agent stated the application had been forwarded to her corporate office, and she was waiting on a response. She then stated she needed to talk to the patient personally. RCM confirmed she had received ROI completed by patient that allowed her to exchange information with RCM. RCM called patient's son back and passed on the message that his mother needed to call the apartment ASAP and speak to the leasing agent.

PN (G&I) Custom Note Sections

Crisis Indicator: no

Recipient Code: collateral only

Care

Success Stories

“We have a patient with a serious mental illness and cerebral palsy. He uses a wheelchair and was provided care by his mother until she recently suffered a stroke.

We referred the family to additional services include peer support services, a wellness nurse providing home visits along with a referral to the Star-Plus program.

This coordination results in staff finding more programs and benefits available to the family to enable the family, including the patient, to meet their needs and choice to remain in their home. ”

- Terry Huston, RN Care Coordinator

Care Coordination

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Questions?

For more information on any of our services, visit or contact:

www.MHMRtarrant.org

Facebook.com/MHMRtarrant

communications@mhmrtc.org

ICARE Call Center

Toll-free call/text

(800) 866-2465

Call us anytime for mental health crisis support or access to MHMR services.