



Care Coordination Collaborative Change Package

I. Develop effective collaborative care relationships

- a. Convene agencies that have a shared aim of improving the health status of individuals with serious mental health and/or substance use disorders and co-occurring chronic health conditions, such as diabetes or cardiovascular disease:
 - i. Share information about each partner agency's core values, capacity, assets, limitations, funding sources, and service gaps to identify opportunities to create care coordination
- b. Define the client/patient population on whom you will first focus your improvement efforts (referred to as the target population)
- c. Engage and strengthen relationships between the provider organizations convened to build a coordinated care system (including mental health, substance use disorders, primary care, peer and family member providers, and social service agencies) managed care plans (MCPs) and mental health plans (MHPs):
 - i. Use opportunities, such as designing care coordination sustainability plans, to build relationships
 - ii. Ask MCPs for data to identify high utilizers with co-occurring conditions
 - iii. Ask MCPs for access to existing client/patient data, such as: hospital follow-up time, re-admissions rate, engagement of client/patients with depression over six month period, engagement in alcohol and drug services, etc.
 - iv. All providers attend MCP sponsored Interdisciplinary Care Team meetings
- d. Increase knowledge of the roles peer and family member providers can play in care coordination among all convened and partnering agencies
- e. Develop the role of the Convener Organization. The responsibilities include:
 - i. Convene
 - ii. Build a vision and shared understanding of the potential benefits of a coordinated system

- iii. Develop the relationships and agreements
- iv. Promote a process to identify who among the partnering agencies will be accountable for the functions needed for effective care coordination, including:
 - Care coordination budget development
 - Resource development
 - Infrastructure development
 - Intervene and mediate
 - Bring innovative change ideas
 - Develop the objectives and measures for a coordinated system
 - Guide the testing and implementation of changes
 - Scan environment for new innovations and educate the team about new changes
- f. Establish the Care Coordination Team and individual agency roles and responsibilities, including designation of a sponsor within each agency for care coordination improvement
 - i. Develop, communicate and use shared standards of care, including standards of coordination
 - ii. Address HIPAA and 42 CFR part 2 barriers to coordination among partnering agencies by using a Universal Release of Information that includes substance use disorder providers
- h. Develop the role of the Care Coordinator (the activities of the care coordinator can be done by a variety of workers, including peer providers, family member providers, clinicians, care coordinators, etc.) and map care coordination processes across providers. Processes include:
 - i. Outreaching, engaging and facilitating complex clients access to appropriate services
 - ii. Defining the Care Team (including natural supports) is identified for each client/patient
 - iii. Ensuring and monitoring consent to share clinical information (ROI)
 - iv. Ensuring and monitoring appropriate screening for medical, mental health and substance use conditions
 - v. Facilitating referrals and tracking for completion
 - vi. Entering clinical information into caseload registry tool
 - vii. Conducting multidisciplinary clinical care conferences
 - viii. Ensuring and monitoring routine medication reconciliation

- ix. Supporting client self-management
- x. Ensuring and communicating shared care plan/shared care objectives among primary care, mental health, and substance use providers
- xi. Ensuring availability of ad hoc clinical case consultation
- xii. Ensuring urgent care access to specialty MH, SUD or primary care
- xiii. Monitoring transitions in care

- i. Build the Business Case for ongoing support of the care coordination effort
 - i. Create a Business Case Workgroup that consists of executive leadership and financial officers from the agencies participating on the care coordination team along with Health Plans, the Mental Health Plan, and other funders of care
 - ii. Review care coordination return on investment research and identify relevant data that can be used to set targets for reductions in utilization and cost
 - iii. Develop a care coordination revenue and expense budget (similar to creating a grant proposal) to identify the costs of the program
 - iv. Work with managed care plans, mental health plans, substance use services, and primary care/health services to identify data sets that can be accessed to collect historical utilization and cost data for client/patients served in the care coordination project; design spreadsheet and/or database repositories for compiling this information
 - v. Begin collecting historical and current data about target population
 - 1. Care coordination program actual revenue and expense data
 - 2. Historical health plan and mental health plan utilization and cost data
 - 3. Current health plan and mental health plan utilization and cost data
 - vi. Develop reports that summarize the historical and current data in an easy to understand format
 - vii. Business Case Workgroup meets on a periodic basis to review the reports and assess how well the care coordination project is bending the cost curve

- viii. Business Case Workgroup shares their ROI findings with the clinical team, identifying areas where things seem to be working (and not)
- ix. Assuming that not all data will be readily available in the early stages of the project, work with managed care plans, mental health plans, substance use services, and primary care/health services to expand access to data
- x. Based on the business case results and projections, convene meetings with Executive Leadership of Health Plans. Review and discuss with Health Plan short and long term support for care coordination

II. Engage clients/patients in their whole health

a. Do outreach:

- i. Engage complex clients/patients through outreach to “fall back service sites” such as emergency rooms and jails
- ii. Include emergency room doctors in both “in-reach” and outreach planning
- iii. Train a team from mental health and/or substance use disorder outpatient clinic to work with hospitals or emergency room staff on planning transitions out of the hospital to prevent readmissions

b. Actively engage each client/patient in his/her Care Coordination

- i. Care Coordinator contacts the client/patient, introduces themselves, and their role
- ii. Care Coordinator explains coordinated care and its benefits to clients/patients, including providing language and literacy level appropriate informational materials to client/patient
- iii. Care Coordinator asks client/patient about their natural supports and whether they would like them involved in their care planning and self-care
- iv. Care Coordinator contacts other care providers (e.g. Primary Care), introduces themselves, explains their role, and obtains ROI when clinically or legally indicated for sharing information
- v. Care Coordinator responds to telephone calls and text messages from client/patient and from their health care providers around coordination of care

- vi. Care Coordinator provides outreach to clients/patients who are disengaged, e.g., who do not show for appointments, struggle to adhere to medication
 - vii. Care Coordinator asks clients/patients about their care and progress toward wellness goals during every encounter
- c. Screen clients/patients' whole health (physical, mental health, substance use, and social) needs using standardized criteria/tools to identify clients/patients needing coordinated services. Screening includes: health vitals (BP and BMI); labs (fasting glucose, A1c, LDL); and assessments for functional status, depression, and substance use disorders (PHQ2, GAD2, validated single-item alcohol and drug screeners)
- d. Follow up with more in-depth assessments for patients who screen positive
- e. Actively engage each client/patient in his/her Care Planning:
 - i. Increase clients/patients' understanding of their health and treatment progress by reviewing their (basic) health indicators and care plan objectives during each visit
 - ii. Share with client/patient their health measures and wellness goal trends, if available
 - iii. Ensure that clients/patients participate in planning their care/treatment and wellness goals
 - iv. Use Brief Action Planning and Motivational Interviewing to develop and support client/patient health goals
 - v. Design care plan to include: dated milestones, dates for review of plan, and outcomes of referrals
- f. Actively engage each client/patient in his/her Self Management:
 - i. During follow up visits in/encounters providers will review client's progress, experience, and concerns about their Action Plan
 - ii. Use Shared Decision Making strategies
 - iii. Offer or refer clients to evidence-based education
 - iv. Identify client self-management support team to include friends, family, primary care and mental health providers
 - v. Promote use of WRAP plans for both physical and mental health self-care
 - vi. Promote use of technology or web-based supports, for example: www.mood247.com
 - vii. Adapt smoking cessation programs to unique needs of tobacco users with mental illness, such as Tobacco Harm Reduction program

- viii. Apply “5As” to smoking cessation programs for clients
- ix. Access and use web-based resources to get information about wellness programs for individuals with serious mental illness and self management, for example see:
 - 1. <http://smokingcessationleadership.ucsf.edu/Resources.htm>
 - 2. <http://health.nih.gov/>
 - 3. http://health.nih.gov/see_all_topics.aspx
 - 4. <http://www.nimh.nih.gov/health/publications/index.shtml>
 - 5. <http://www.samhsa.gov/co-occurring/topics/training/self-management-support.aspx>
- g. Develop the roles of peers as mentors, navigators, health coaches, and supporters
 - i. Train peer providers to offer evidence based interventions and supports to increase client self-management, such as WRAP, HARP, and WHAM
 - ii. Use peers as health navigators
 - iii. Promote peer-led health education groups, for ex. Pathways to Recovery
 - iv. Use peer providers to assist clients in utilizing NAMI Hearts and Minds site, an online, interactive, educational initiative promoting the idea of wellness in both mind and body.
- h. Collaborate with the client/patient/family to develop a whole health service plan including services from agencies outside the partnership
- i. Promote health literacy using a wide array of educational resources, such as classes, online and printed materials
- j. Match level/intensity of care coordination to the needs of the individual. Individuals with highly complex health, mental health, and substance use issues will require active care management

III. Deliver Coordinated Services

- a. Assign Care Coordinator to identified clients/patients with complex co-occurring conditions, preferably culturally matched.
- b. Make Clinical Care Managers (individuals assigned to clients/patients who are extremely high utilizers of care to assist them in managing their medical and psychosocial problems more effectively) available for those clients/patients who are identified by Care Team as needing *clinical* coordination of their care

- c. Use a universal release of information (ROI) that addresses substance use disorders, primary care, and mental health; explain to clients/patients what type of information will be shared; clarify and get their agreement about information/level of clinical detail that will be shared
 - i. Keep it current and updated to meet each partner's consent cycle requirements
- d. Develop and use standard referral processes and protocol, including referral and access standards specifically defined by partners for the target population
 - i. Prepare individual being referred; for example, role play the visit and clarify expectations and the questions to ask
 - ii. Determine the type of approach to referrals that works best in your environment and formalize the role, for example: warm hand offs, access to appointments, direct phone numbers, etc.
 - iii. Send data needed by the receiving referral organization
 - iv. Verify referral was completed
 - v. Complete the loop and obtain data/feedback from the individual who was referred as well as from the organization to where they were referred
 - vi. Share data with payer and inform them of referral status and results
- e. Create processes and workflows to achieve coordinated care
 - i. Develop a care coordination workflow that details each partner's activities as well as care coordination functions across partnering organizations. Update regularly
 - ii. Train all employees in each organization in their role for care coordination and the role of the Care Coordinator
 - iii. Hold regular meetings for managers from all partners to improve processes and workflows
 - iv. Create and utilize shared communication processes, for example "shared care planning"
 - v. Include persons with lived experience in the range of coordinated/integrated care job functions, including cross-agency multidisciplinary teams

- f. Conduct regular multi-disciplinary meetings, face to face or virtual, to facilitate service coordination
 - i. Conduct regular care conferences including partnering providers and clients/patients and their family members/significant others (if client/patient permits)
 - ii. Hold morning huddles to identify clients/patients needing outreach, follow-up or specific care interventions (Generally huddles are face-to-face but it is possible to conduct “virtual huddles” using secure technology)
 - iii. Use a HIPAA compliant, easy way for providers to communicate on a regular and ad hoc basis across agencies/specialties, e.g., secure email, secure conference call, access to EMR, secure cloud-based site
 - iv. If signed consent allows, include each client/patient’s referred SUD providers in the regular communication even if client/patient is still in “contemplation” phase of accepting treatment
- g. Require multidisciplinary team meetings for:
 - i. Medication Assisted Treatment (MAT)
 - ii. Treating Chronic Pain
 - iii. Smoking Cessation
- h. Perform Monthly Medication Reconciliation:
 - i. Each agency provides a summary of medications easily accessible in medical record—should include medications from all prescribers
 - ii. Each agency develops a protocol and procedure for routinely updating clients/patients’ medications at each visit
 - iii. Involve client/patient in “brown bag medication review” and educate client/patient about the importance of reporting all prescription as well alternative/across the counter medications (See CalMEND Brown Bag Medication Reconciliation Protocol)
 - iv. Partnering agencies share each client/patient’s medication list on regular basis (preferred monthly/minimum quarterly). Determine sharing method (electronic, fax, etc...)
 - v. Pursue opportunities to reduce the number of “sources” of medications
- i. Care Coordinator insures clients/patients have a single medication list that is reconciled across primary care and specialty mental health and substance use disorders providers

- j. Develop Shared Care Plans across primary care, mental health and substance use :
 - i. Develop and use processes for the collecting and updating shared goals among client/patient and providers
 - ii. Develop and use processes for communicating and supporting client's shared goals among providers

IV. Care Coordination Infrastructure

- a. Address mental health and substance use stigma:
 - i. Develop a pain specialty clinic in primary care and offer clients/patients with substance use disorders health coaches and pain specialists as compared to only traditional substance use providers
 - ii. Develop substance use services in primary care that are packaged differently, for example wellness programs that offer diet support, exercise support and smoking cessation
 - iii. Increase primary care providers' comfort with "psychiatric patients" and persons with substance used disorders by:
 - Offering basic training to them about mental health and substance use disorders, recovery, treatment guidelines, common evidence-based practices, mental health and SUD agency common operating procedures, etc., for example Mental Health Friendly Docs
 - Creating reciprocal process for educating mental health and substance use disorder providers about basic primary care practice and critical medical conditions common to the shared target population
 - Assuring care managers ongoing involvement
 - Offering informal "curbside consultation" available by phone from a on-call county psychiatrist
- b. Integrate Peer Providers in all agencies that are part of the Partnership Team
 - i. Develop peer provider roles. Peer providers can:
 - Enhance hope and expectations for recovery
 - Coordinate care specifically for clients/patients who are not currently living in their own homes
 - Work as a promoter
 - Facilitate health behavior groups for clients/patients, especially in the primary care clinic. Some topics include: psycho-education; diet and exercise; smoking cessation
 - Serve as the care coordinator

- Support clients/patients with care planning
 - Assist primary care providers to work with clients/patients around symptom management and other activities that are not common knowledge in primary care clinics
 - Offer resources and education to clients/patients in their own language
 - Outreach to all disengaged clients/patients with co-occurring substance use disorders
 - Involvement in Patient Advisory Committees (Primary Care)
- c. Integrate Family Member Providers in all agencies that are part of the Partnership Team
- i. Develop family member provider roles. Family member providers can:
 - Provide education to clients/patients, for example *NAMI Provider Education*
 - Support the importance of client/patient self-management with family members
 - Offer culturally informed care coordination
- d. Use clinical information systems to coordinate and monitor services for individuals and populations
- i. Use an information system (e.g., registry, relational database with reports) for storage and reporting of clients/patients' demographics, health and wellness information
 - ii. Care coordinator uses the information system as their primary tool for care coordination and management
 - iii. Provide access to a common medical record used by a team or partnering providers
 - iv. Proactive Planned Care: Use run-charts to track key health indicators (e.g., blood pressure, BMI, PHQ-9) to assist client/patient and provider(s) in monitoring health and wellbeing
 - v. Population Management: Use population-based reports to identify clients/patients who are at risk or need follow-up for untreated health conditions, overdue screening and monitoring, etc.
 - vi. Monitor performance of coordination team and service system, both within the partnership and relative to community
- e. Measure coordination of care and outcomes

Glossary of Terms

1. **Care Coordination**¹: 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 marshaling 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. (Agency for Healthcare, Research, and Quality)
2. **Care Coordinator**: The person assigned to perform activities and interventions to insure the integration of patient care activities between two or more participants involved in a patient's care to facilitate referrals and transitions and the appropriate delivery of health services.
3. **Care Management**²: A set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aims of improving patient's functional health status, enhancing the coordination of care, eliminating the duplication of services, and reducing the need for expensive medical services.
4. **Clinical Information System**³: Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders for needed services, with the summarized data helping to track and plan care. At the practice population level, an information system can identify groups of patients needing additional care as well as facilitate performance monitoring and quality improvement efforts. Organize patient and population data to:
 - a. Facilitate efficient and effective care
 - b. Provide timely reminders for providers and patients

¹ Innovations Summit based on McDonald, et. al. Closing the Quality Gap, Vol. 7, AHRQ, 2007

² Bodenheimer and Berry-Millet, NEJM, 2009

³ Clinical Information Systems : Improving Chronic Illness Care. (n.d.). Retrieved July 2013, from http://improvingchroniccare.org/index.php?p=Clinical_Information_Systems&s=25

- c. Identify relevant subpopulations for proactive care
 - d. Facilitate individual patient care planning
 - e. Share information with patients and providers to coordinate care (2003 update)
 - f. Monitor performance of practice team and care system
5. **Convener:** The organization that builds connections among health care, government, and social service organizations so they can improve health more efficiently.
 6. **Integration**⁴: Any situation in which behavioral health and medical providers work together. The integration of behavioral health and primary care is defined as follows:
 - a. The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.
 - b. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.
 7. **Medication Reconciliation**⁵: The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.
 8. **Self Management Support**⁶: Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up. All patients with chronic illness make decisions and engage in behaviors that affect their health (self-management). Disease control and outcomes depend to a significant degree on the effectiveness of self-management.

⁴ The Academy | Integrating Behavioral Health and Primary Care. Retrieved July 2013, from <http://integrationacademy.ahrq.gov>

⁵ Centers for Medicare & Medicaid Services. Eligible Professional Meaningful Use Menu Set Measures Measure. Retrieved July 2013, from http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/7_Medication_Reconciliation.pdf

⁶ M. Von Korff, J. Gruman, J.K. Schaefer, S.J. Curry and E.H. Wagner, "Collaborative management of chronic illness", *Annals of Internal Medicine* 127 (1997): 1097-1102.

Effective self-management support means more than telling patients what to do. It means acknowledging the patients' central role in their care, one that fosters a sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. Self-management support cannot begin and end with a class. Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way. Empower and prepare patients to manage their health and health care by:

- a. Emphasizing the patient's central role in managing their health
- b. Organizing internal and community resources to provide ongoing self-management support to patients