

CARE COORDINATION COLLABORATIVE CHARTER

PROBLEM STATEMENT

Individuals with chronic medical conditions and serious mental health and/or substance use disorders experience services that are poorly coordinated and fragmented. This results in siloed care plans and treatment. Care recipients are also rarely supported to be informed (or literate) and active in their own care or to engage in healthy behaviors. The impact is profound: poor and confusing care access and follow-through, care redundancies and gaps, inefficient and inadequate services, often in inappropriate settings (Emergency Rooms, jails, etc.), higher health care costs, reduced satisfaction for clients and providers, poor health outcomes, and lower life expectancies.

AIM

Over a period of 15 months, teams consisting of primary care, mental health, substance use disorder, and other safety net providers, working with local public safety net health plans, will design new systems and redesign existing systems to provide coordinated medical and behavioral services to improve the health status of individuals who have complex, co-occurring conditions. Teams will work to establish multiagency communication, create workflows for coordinated care, promote self-management, and use clinical information systems to guide care planning and performance improvement efforts and to facilitate data sharing and track outcomes. As result of these efforts, teams will build a seamless experience of care that is person-centered, cost effective, and results in improved health and wellness.

GOALS

CCC will support teams to:

1. Increase the screening of individuals for mental health/substance abuse and chronic medical conditions within each care setting (mental health, substance use disorders, and primary care agencies) and follow-up for positive screens.
2. Increase the percentage of individuals with health and wellness goals shared between providers. Shared means documented in the records of each agency and discussed at huddles, virtual meetings, etc.
3. Increase the percentage of individuals with a care coordinator assigned by a lead partner (health home) and with whom your staff work to coordinate care.
4. Improve medication reconciliation within and across provider agencies.
5. Improve access to appropriate care for people with unmet needs.
6. Improve satisfaction with the experience of care.

7. Reduce avoidable emergency room visits and hospital stays (see Statewide Collaborative Quality Improvement Project, Reducing Avoidable Emergency Room Visits, Final Remeasurement Report: January 1, 2010 – December 31, 2010 – Appendix A).

OBJECTIVES

To achieve these goals, teams will pursue the following objectives:

1. Within the Collaborative timeframe, 75% of individuals in a care setting have been evaluated (through screening or other identification method) for a second condition requiring care from another provider with appropriate follow-up for positive screens.
2. 90% of individuals in the target population will have health and wellness goals shared between multiple service agencies.
3. 75% of target population individuals will have an identified care coordinator assigned by the lead partner (health home) and acknowledged by provider partners and the individual receiving services as accountable for coordinating care.
4. 60% of target population individuals will have documentation of medication reconciliation within and across all providers in the last 6 months or 2 weeks following a medication change.
5. 90% of target population will have seen a primary care provider in the last 6 months.
6. 90% of individuals referred to specialty mental health or substance use services will be seen by a clinician within 48 hours.
7. 80% of target population will report that their satisfaction/experience with care is good/excellent.
8. Reduce by 25% avoidable emergency rooms visits and hospitalizations.

GUIDANCE

Achievement of this aim and associated goals and objectives will require focus in some specific areas, including:

- a. During the Pre-Work Phase, each Partnership Team will identify the initial target population to be served by the Care Coordination Collaborative. Two criteria are suggested for identifying the target populations:
 1. Individuals who are known to obtain services and support from two or more partner providers or individuals who should be getting services from 2 or more partner providers, and
 2. Individuals who are likely to “bend the cost curve” (for example individuals with three or more conditions, individuals who are known to frequent the ED, etc.)
- b. Suggested screenings to be completed or documented by agencies that are part of the Collaborative Team include:
 1. Body Mass Index
 2. A1c

3. Blood Pressure
 4. PHQ9
 5. GAD 2
 6. Single Item for Alcohol and Drug Use (To be determined)
- c. Teams can be co-located, virtual, or a combination. Care team meets daily or weekly; multiagency teams meet weekly or monthly; this could be virtual or face to face”
 - d. A peer provider and peer run organization and a family member provider and family provider organization should be included as a participating member/agency of the team.
 - e. Although each collaborative team will consist of multiple agencies, it is expected that each agency will collect the collaborative measures and work together to track and improve care
 - f. Use of a clinical information system that promotes improvement in the following areas is a requirement of all participating teams:
 - Facilitating and providing optimal individual client care and services
 - Managing care and services for groups of clients (population health management)
 - Measuring the System
 - i. Improvement of the system
 - ii. Transparency with clients and communities
 - Accountability to external bodies- payers and regulators
 - i. Meaningful Use
 - Coordination and Management of Care
 - i. Referral tracking and follow up
 - ii. Sharing data with other organizations