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Evolving Healthcare Delivery Models Demand Community Care Coordination

The cost of healthcare in the United States continues to rise without a corresponding increase in patient outcomes.

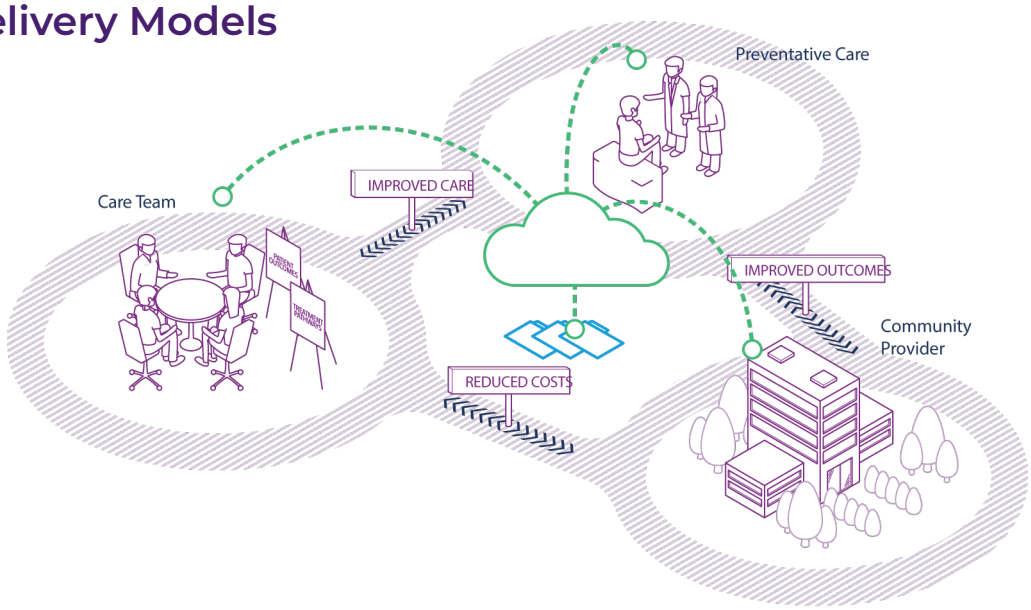
Despite spending more on healthcare than other countries, U.S. health outcomes are worse[1]. Pressed to improve both cost and outcomes, the healthcare system is shifting away from an illness-focused model toward a wellness-driven model that encompasses all aspects of an individual's health and emphasizes preventive care to keep costs manageable.

With funding for innovation available through sources like Medicaid waivers and the Accountable Health Communities Model, states, counties, and other health and human service collaborations are uniquely positioned to design and test new initiatives that support healthier individuals, families, and communities. Emerging healthcare delivery models involve providers across health, behavioral health, and social supports collaborating together to deliver whole person care. A patient's interaction across the continuum of providers is recorded and shared among all participants. States who have introduced innovative care delivery models include California, New Hampshire, and Colorado, among others.

California

In December 2015, The Centers for Medicare and Medicaid Services (CMS) approved a five year pilot for whole person care in California. The Whole Person Care pilot targets Medi-Cal patients with complex medical issues and combines physical and behavioral health care services with social services to improve the total health and well-being of beneficiaries. Specific populations targeted include individuals recently released from institutions or incarceration, those with mental illness or substance use disorders, and those who are currently experiencing homelessness or are at risk of homelessness.

Innovative Care Delivery Models



New Hampshire

In January 2016, CMS approved a 5-year 1115 Medicaid DSRIP or "Building Capacity for Transformation" waiver. The waiver allocates up to $150 million over five years to create integrated delivery networks that incorporate physical health, behavioral health and community supports to address mental health and substance use disorder.

Colorado

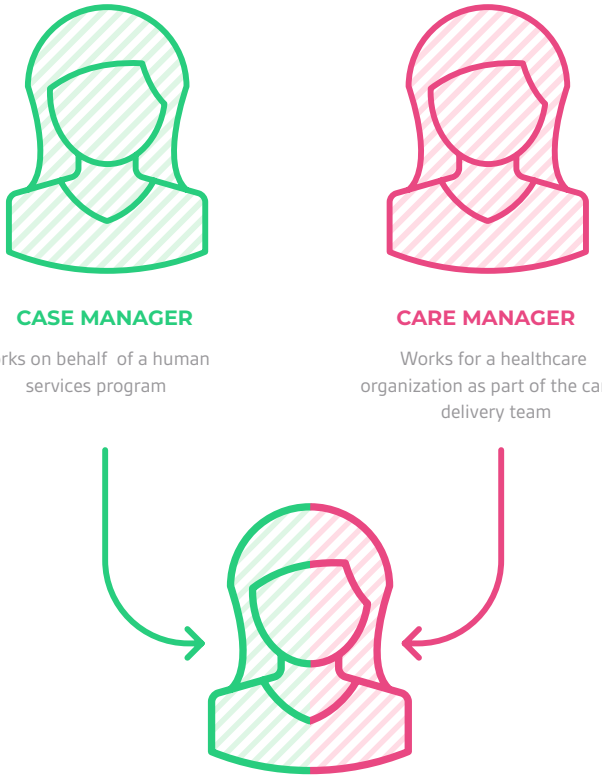
In 2011, Colorado established an Accountable Care Collaborative of 7 Regional Care Collaborative Organizations (RCCO) that coordinate care and delivery of services for Health First Colorado (Colorado's Medicaid Program). Each RCCO is responsible for improving the health and wellbeing of individuals within their region, with specific goals to increase collaboration and share encounter data among providers in order to deliver better whole person care.

The Whole Person Care movement has challenged existing care paradigms and introduced a new model of care: The Community Health Neighborhood. The Community Health Neighborhood relies on a high degree of community involvement, program-wide community care coordinators, a commitment to addressing root cause solutions through creative approaches to community problems, and a highly networked model of data sharing and care collaboration across all participating providers in the health neighborhood.

Defining Community Care Coordination

Because community care coordination includes providers and organizations from both health and human services, confusion may arise on the definition of the model and caregiver roles. Community care coordination builds upon the traditional care management model, but extends the scope of services to include health-related social needs. With the shift toward community-based care, a new role for care coordination has emerged: community care coordinator. The terms case manager, care manager, and care coordinator are often used interchangeably, and in fact share many commonalities in job description and scope of responsibility. However, in order to understand the community care coordination model, it is important to understand some distinctions in the goals and objectives of the different roles.

WHAT IS A CARE COORDINATOR?



CASE MANAGER

Works on behalf of a human services program

CARE MANAGER

Works for a healthcare organization as part of the care delivery team

COMMUNITY CARE COORDINATOR

works on behalf of a broader network of partners across multiple, complementary fields

CASE MANAGER

A case manager works on behalf of an organization to assist individuals to receive the full amount of services for which they are eligible. A case manager assesses individuals to determine if they are eligible for specific programs with well-defined acceptance criteria. Case managers often assist individuals to enroll in the offered programs and then track progress throughout the program, monitoring and reporting on achievement of milestones along the way. In general, case managers work with human service programs such as housing, workforce services, food assistance, or other programs focused on delivering human services to alleviate need.

CARE MANAGER

A care manager works for a healthcare organization as part of the care delivery team. The care manager helps patients manage their health conditions,

often dealing with chronic illness and care requiring a high degree of self-management. The care manager may refer patients to multiple providers within a facility or health system and help coordinate the care among multiple health providers. Traditionally, the care manager works in clinical settings and solely addresses the medical needs of a patient with the goal of reducing the need for further, more costly services. Sometimes a care manager is referred to as a primary care case manager.

CARE COORDINATOR

Where case managers typically work on behalf of a human services program, and care managers work on behalf of a medical provider, a community care coordinator works on behalf of a broader network of partners across multiple, complementary fields of service. The community care coordinator spans human services and healthcare providers, uniting case management and care management under the same role. Care coordinators address the full gamut of health and social needs of individuals to provide whole person care, with the goal of achieving higher quality outcomes at lower overall cost to the system. Care coordinators work closely with nurses, social workers, and community health workers in partner organizations to address simultaneous needs in the areas of human services, medical services, and behavioral health services.

THE HUMAN SERVICES VALUE CURVE

The care coordinator position becomes essential as communities move up the human services value curve from a regulative approach to a generative approach to providing care, as described by the American Public Human Services Association (APHSA). At each step up the value curve, communities move from care based on eligibility for enrollments in programs to person-centered care that is driven by data-sharing among providers[2] .

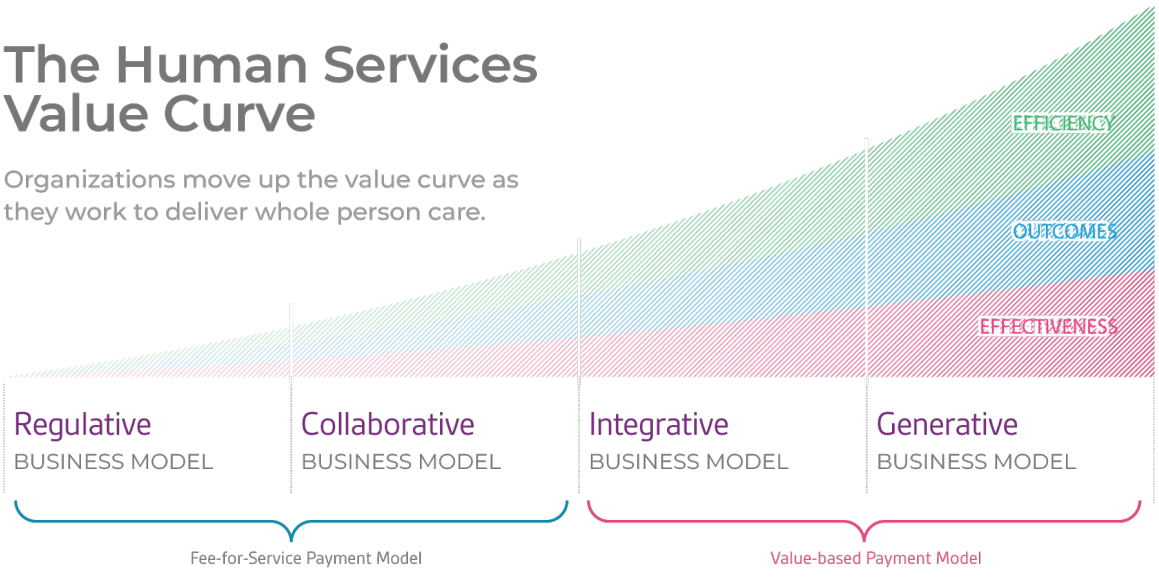
Regulative Model

The regulative model is the most basic form of human services delivery. Organizations operate independently, each seeking to fulfill its own mission and goals with little thought of allied organizations. Characteristics that identify the regulative model are:

- Programs operate in silos
- Little to no sharing of data across organizations
- Clients must enroll separately for each program of service
- Programs are evaluated on individual program performance and budget management

Collaborative Model

The collaborative model brings together similar organizations with shared goals for limited-scope joint projects. Organizations in this model frequently have regular collaboration meetings where they discuss the needs of individuals, but this data is rarely shared among partners. Collaborations may be across



public agencies (public-public collaboration), private organizations (private-private collaboration), or public and private organizations (public-private collaboration).

Characteristics that identify the collaborative model are:

- At least two distinct agencies cooperating for shared benefit
- A written agreement between parties that outlines the scope of collaboration
- A common objective aimed at the delivery of a public service to a targeted population
- Shared responsibility of risks, resources, costs and benefits to both organizations

Integrative Model

The integrative model extends the collaboration aspects of the collaborative model across a broader coalition of agencies and objectives.

Resources from one area can be deployed to address needs that exist in other areas, such as housing for health programs where housing (a human services need) is provided as a means to resolve medical health needs.

Characteristics that identify the integrative model are:

- A focus on addressing the root causes of client needs
- Coordination across multiple service agencies from multiple disciplines
- A high level of data sharing and service integration
- Single point of care solutions, e.g. the "health home"

Generative Model

The generative model expands the reach and scope of the integrative model to encompass entire communities. Once the services and program infrastructure are in place, with a proven track record of success, these services are broadened to include larger population groups, geographies, or coverage areas. Characteristics that identify the generative model are:

- Focus on large-scale, community efforts
- Focus on resolving root-cause issues (eliminating problems at the source)
- Expansion of whole person care concepts across entire service areas
- Highly networked and integrated program operations across multiple public, private, and non-profit organizations

Community-wide, integrated solutions are ideal to tackle the high level of complexity faced in today's health and human services organizations. Substance use disorder – to use one example – is a condition frequently accompanied by a myriad of concurrent needs that stem from the root problem. Individuals with substance use disorder face frequent bouts of unemployment, family instability, homelessness, food insecurity, and multiple urgent and chronic health conditions. Generative models of service delivery are designed to address the scope and complexity of even the most difficult client case scenarios.

The Community Health Neighborhood

The Community Health Neighborhood is the embodiment of the generative model of human services delivery. Client issues are addressed within a connected framework of public and private services that jointly administer solutions spanning multiple service delivery areas. A community care coordinator will coordinate service delivery efforts, matching client needs with available resources across a wide spectrum of service offerings, programs, and locations.

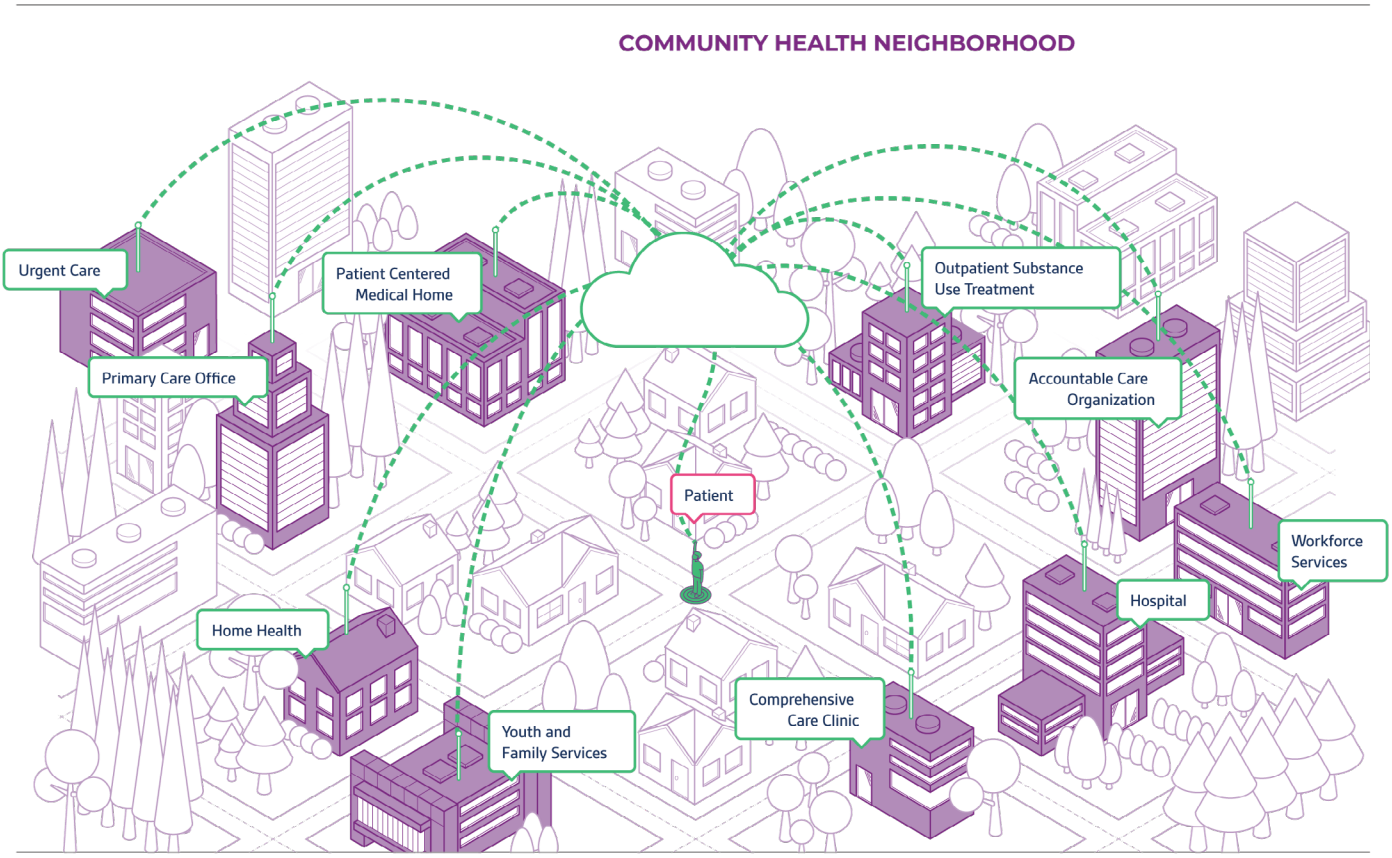
What is a Community Health Neighborhood?

A community health neighborhood is formed when medical health, mental health, substance use disorder, and a variety of social service providers and community support agencies join together to improve the health and wellness of vulnerable populations in the community.

The Community Health Neighborhood brings together like-minded organizations to create a coalition of providers with the aim of meeting a community's medical, mental health, and behavioral health needs through the principles of whole person care. Participating service providers in the Community Health Neighborhood are connected to an extensive network of organizations including government agencies at the state and local level, educational institutions, housing services, faith-based groups, vocational supports, non-profit organizations, prevention programs, and social services organizations, in addition to the participating medical health, mental health, and behavioral health services.

One of the characteristics of the Community Health Neighborhood is a high degree of input from the local community. Providers come together with area residents to jointly address the health and well-being of community members, particularly the vulnerable populations within a community In keeping with the Generative model of human services delivery, the Community Health Neighborhood mobilizes residents, community organizations, and health institutions to identify the root causes of specific issues impacting a community. In particular, the Community Health Neighborhood focuses on the social determinants of health within the community – those conditions and circumstances that impact the community's ability to achieve and maintain health.

Providers participating in a Community Health Neighborhood realize significant advantages for themselves and their patients:



- Coordinated screenings for medical health, mental health, behavioral health, and human needs with pre-defined affiliated organizations to fulfill those needs
- Enhanced coordination of patient care across a wide scope of medical, mental health, and behavioral health services
- Single point of entry assessment and referral for services

- Increased treatment adherence by patients through the combined support of medical health, mental health, behavioral health, and community services organizations

- Decreased duplication of services through improved communication, care coordination, and data sharing across organizations

- Increased understanding by all providers within a community of the network of other providers and services available, with streamlined patient referrals to allied providers for needed services[3]

TYPES OF COMMUNITY HEALTH NEIGHBORHOODS

A Community Health Neighborhood can take various forms. More important than the organizational structure of the Community Health Neighborhood is agreement on a shared approach to jointly address the medical, mental health, behavioral health, and social determinants of health challenges within the community. Community Health Neighborhoods may be organized as:

- Accountable Care Organizations

- Regional Health Improvement Collaboratives

- County Medicaid whole person care programs

- Coalitions of community groups

COMMUNITY HEALTH NEIGHBORHOOD EXAMPLE: SAFE STATION

In November 2016 the community of Nashua, New Hampshire came together to address a challenging opioid addiction problem. The community saw opioid overdoses jump 36 percent from 2015 to 2016. The mayor of Nashua, local fire stations, Harbor Homes (an emergency shelter and Federally Qualified Health Center), and Keystone Hall (a residential addiction treatment center) joined forces to implement the Safe Station program.

Under Safe Station, anyone seeking treatment or recovery from addiction to opioids or other substances may visit a fire station to seek help.

Trained firefighters perform a quick evaluation of the individual's immediate medical status. Based on that assessment, the individual may be taken immediately to emergency medical services or, if the individual is not in imminent medical danger, the firefighters contact Harbor Homes. A representative from Harbor Homes responds immediately to the call, arrives at the fire station, and enrolls the individual in the Safe Station program.

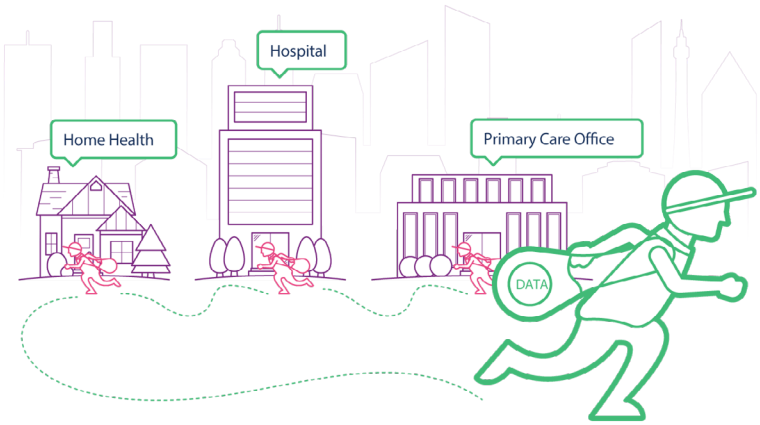
The individual is then transported to either the emergency shelter or to Keystone Hall. A comprehensive assessment is performed by a licensed alcohol and drug counselor to determine the full scope of needs. Based on the assessment, the individual is enrolled either in a medical respite program or into the Keystone Hall comprehensive addiction treatment program.

In the first six months, more than 270 people sought help through Safe Station, with 97 percent of those receiving an evaluation from a licensed drug and alcohol counselor. Savings to the community are estimated at $1.9 million, based on avoided overnight stays in the emergency room.

Better yet, the number of overdoses in the city have dropped back to 2015 levels, with additional reduction in overdose levels expected[4] .

Data Collaboration: The Community Postman

If the Community Health Neighborhood is a tightly networked community of caregivers and recipients of care, data interoperability is the community's postman: the always-reliable supplier of information that is indispensable to the community's successful operation.



Data sharing among providers is an essential characteristic of the Community Health Neighborhood. In order for providers to collectively address the social determinants of health alongside the medical, mental health, and behavioral health needs of patients, social determinant and health data must be readily available to all partners in the health neighborhood. Shared assessments, intake and enrollment, care plans, and progress notes are accessible at the point of care so providers are fully informed of all aspects of the patient condition.

Just as the postman collects, stores, and distributes information in a community, the care coordination system performs this function within the Community Health Neighborhood. Information recorded in one area of the partner network is available for viewing by other community partners. The care coordination system facilitates collaboration among providers on multiple dimensions of patient care.

A care coordination system uses industry-standard interoperability protocols such as HL7 and FHIR to facilitate data sharing across community health systems, medical EHRs, behavioral health systems, and other networked systems such as Health Information Exchanges (HIE), Homeless Management Information Systems (HMIS), criminal justice systems, and other information repositories.

All information is encrypted and protected with multiple levels of data security to ensure compliance with the data protection and confidentiality standards of HIPAA and 42 CFR Part 2.

LARGE-SCALE DATA COLLABORATION: LA COUNTY WHOLE PERSON CARE

The Los Angeles County Whole Person Care initiative is a Medicaid 1115 waiver pilot program that addresses the needs of some of the most vulnerable county residents:

- Homeless population
- Residents involved with the criminal justice system
- High-risk mental health patients
- Residents with substance use disorder
- High-risk medical patients

Through the Whole Person Care pilot, individuals in these targeted populations are eligible to receive additional support services, such as care management or care coordination services. Eligible residents will typically receive care coordination and support services, navigation to physical and behavioral health services, and social support services, such as housing and placement support services, benefits establishment, transportation, food, and childcare services.

The data sharing challenges for a project with the scope of the LA County Whole Person Care are enormous. Health and human services are delivered here on a grand scale: at 10 million residents, LA County has the highest population of any county in the nation, with a county population exceeding that of 42 U.S. states. The county's homeless population is the second highest in the nation at 57,000. And Medi-Cal (the state Medicaid program) covers nearly 40 percent of county residents[5] .

> "These are not the average clients that have a handful of issues that can be addressed predominantly in one or two settings. These are individuals that often have multiple case managers working across multiple settings."
>
> Dr. Clemens Hong, MD, MPH, Director of Whole Person Care and Medical Director of Community Health Improvement

Because the Whole Person Care initiative focuses on the most high-risk members of the targeted population groups, multiple care teams are involved in delivering care to nearly every patient.

The county's care coordination system must store and transmit thousands of records daily from a dizzying array of sources – community care providers addressing the social determinants of health, medical primary care providers, specialty medical providers, behavioral health counselors, substance use disorder counselors, HMIS systems, HIEs, criminal justice records, and a variety of governmental records systems.

Providers of all types need the ability to record their own interactions, view other providers' activity, provide input into care plans, review patient progress, and adjust recommendations as circumstances change. The patient's housing situation, medication types and dosage, employment and income, family situation, and legal status are all critical components of determining and adjusting recommended treatment and must be readily available to all providers authorized to view the data.

Having access to these information resources shapes the conversation between provider and patient and contributes to improved patient outcomes. The care coordination platform:

- Assists providers with care prompts, alerts, and reminders
  - By proactively bringing action items to the provider's attention, the care coordination platform helps ensure consistent care across all providers

- Provides evidence-based knowledge
  - As a repository of information, the care coordination platform helps providers of all types to select the best care plan based on all available information

- Simplifies data collection and interpretation through standardized forms and templates
  - A uniform system across multiple disciplines helps eliminate the confusion that arises from viewing information in a variety of styles and presentations, helping to prevent inaccuracy of data and action

- Streamlines data presentation
  - Eliminates the confusion of dealing with a multiplicity of systems, each with its own unique screens, commands, and workflows to present data in a consistent, easily understandable format

For more information on the care collaboration platform used by the LA County Whole Person Care initiative, visit https://eccoviasolutions.com/community-care-coordination/

Community Health Neighborhoods: Uniting Communities to Improve Lives and Health

The Community Health Neighborhood movement harnesses a broad range of community resources to address some of the most challenging health situations: individuals with multiple, concurrent health conditions who are also struggling with some of life's difficult circumstances such as homelessness, unemployment, food insecurity, substance use disorder, and possible involvement with the correctional system. The structure of the Community Health Neighborhood enables it to address and overcome these challenges through care teams of coordinated providers across medical health, mental health, behavioral health, and community services.

The unique structure of the Community Health Neighborhood not only makes it an ideal system to deliver healthcare and related services but also makes it ideal to address common challenges within the U.S. healthcare system: fragmented care, duplicated services, high cost services substituting for preventive care, and sub-par patient outcomes.

With Community Health Neighborhoods already demonstrating improved outcomes at lower cost with the most challenging patient populations, they should be seriously considered as the ideal framework for any community looking to dramatically improve the health and well-being of residents within the community.

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1 Claxton, Gary et al. Measuring the Quality of Healthcare in the US. Kaiser Family Foundation. 2015 Sep.

2 Toolkit: Moving Through the Value Curve Stages. APHSA. Accessed at aphsa.org 03 Aug 2017.

3 Health Neighborhoods: A Toolkit for Service Delivery Providers. Los Angeles County Department of Mental Health. 2016 April.

4 Lowest overdose rates since 2015; Drop in ODs linked to Safe Stations and enforcement. The Telegraph. 01 Feb 2017.

5 Proportion of California Population Certified Eligible for Medi-Cal By County and Age Group – September 2015. Medi-Cal Statistical Brief, California Department of Health Care Services. 2016 Jan.

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