# LEVERAGING THE POWER OF CARE MANAGEMENT

## Connect the Dots in Community Services

2016 Population Health Colloquium
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# Agenda

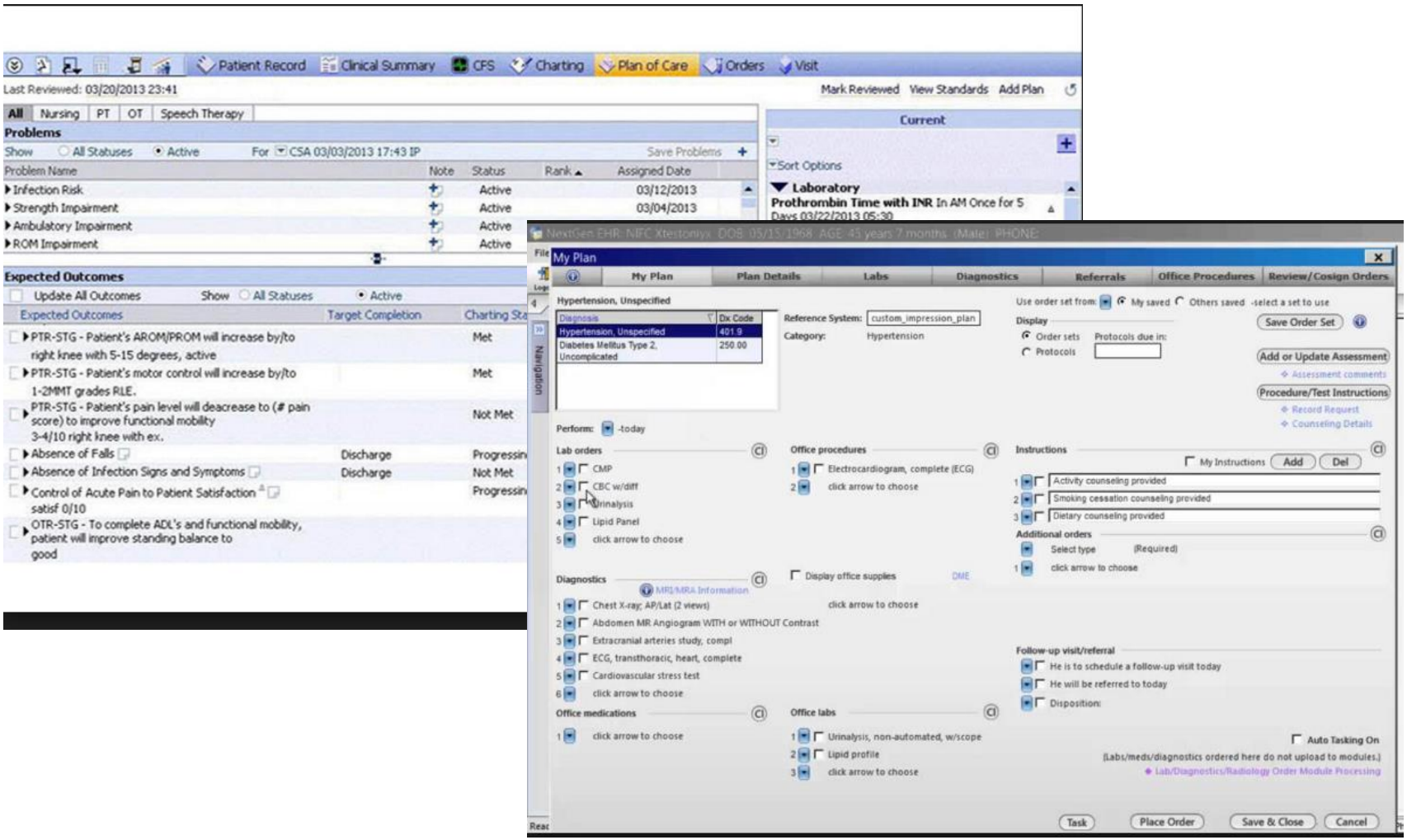
Leveraging the Power of Care Management to Connect the Dots in Community Services

- Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?
- The “Foundational” Approach to Community Care Coordination
- Care Managers Engaging with Patients and Families
- Discussion

# Care Management Solutions and Complex Patients

# Electronic Health Record

## Acute and Ambulatory……what's missing in the EHRs?

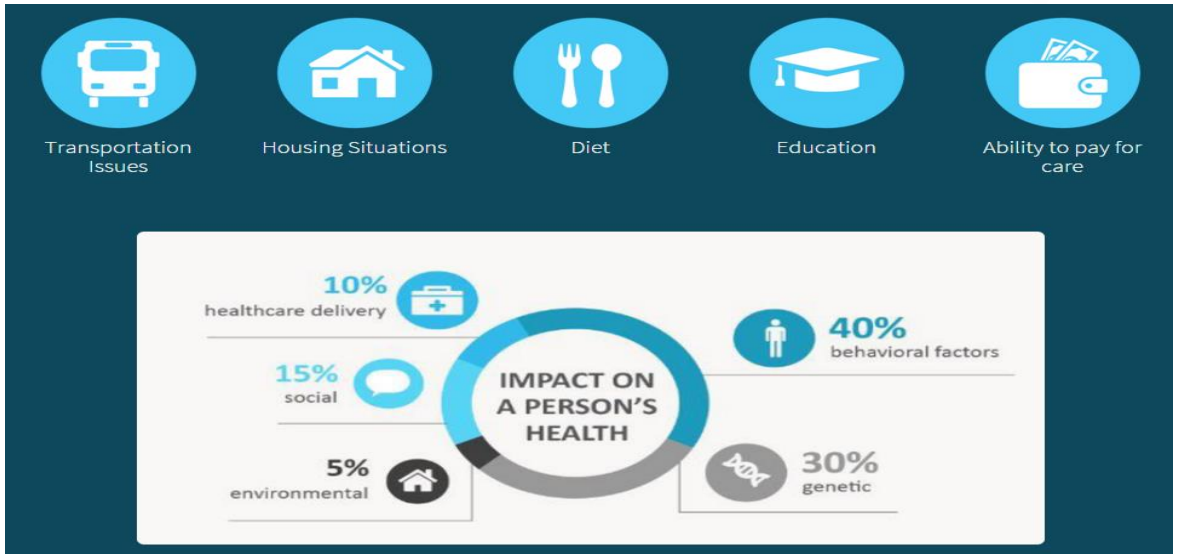


# Community Resources

Connecting patients to their neighborhood support services

## Health Related Social Needs

- Housing
- Food
- Utility Needs
- Safety
- Transportation

# Accountable Health Communities Model

CMS 1/5/2016

**“The Centers for Medicare & Medicaid Services (CMS) has announced an Accountable Health Communities (AHC) model to address a critical gap between clinical care and community services in the current delivery system.**

**The AHC model will test whether increased awareness of and access to services addressing health related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities.”**

Supporting Health Related Social Needs

- Housing
- Food
- Utility Needs
- Interpersonal Violence
- Transportation needs beyond medical transportation


Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Factsheets/2016Factsheetsitems

# Care Management Solution Requirements

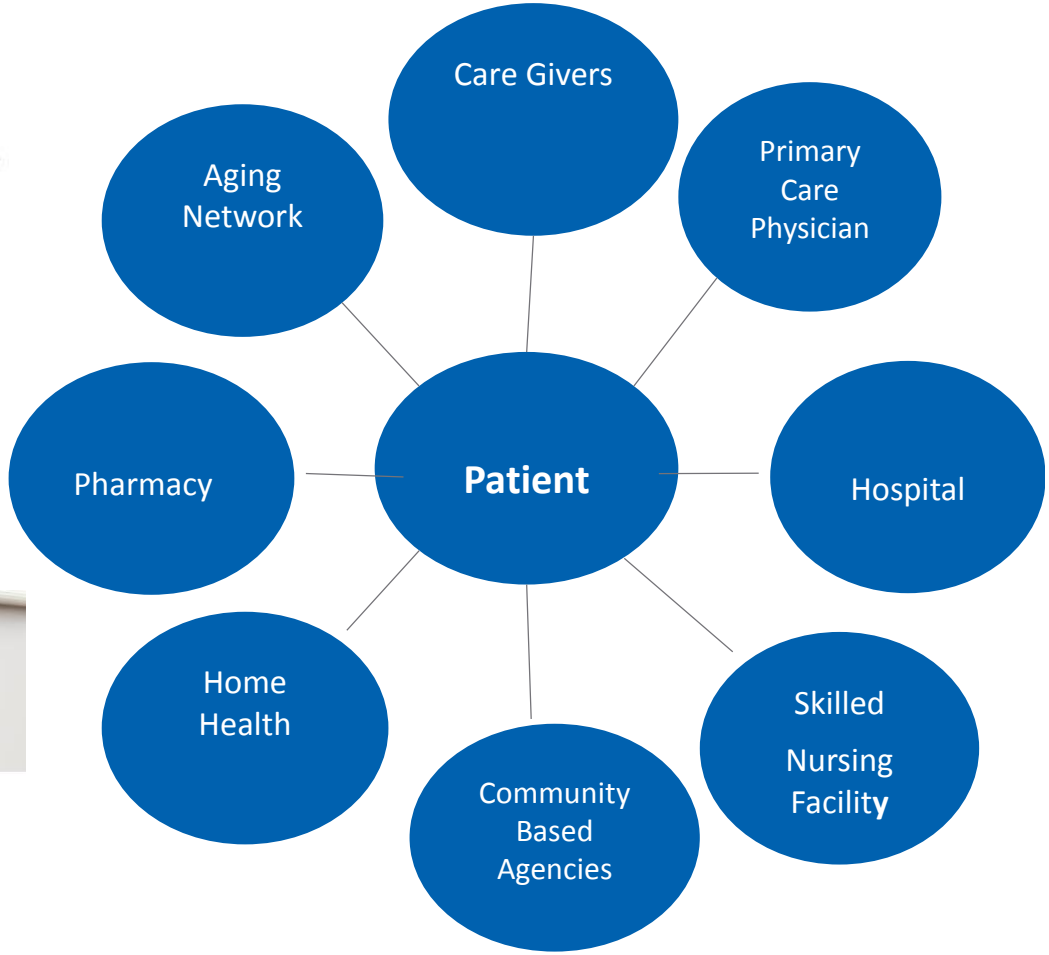
- **Community Shared Care Plan**
  - Incorporate the physician treatment plan via CCDA
  - Evidence Based Content for Assessments and Care Pathways
  - Incorporate the patient and family in goals and intervention planning
  - Accessible by all care team members, as well as the patient and family
  - Multidisciplinary problems, goals and outcomes
  - *Incorporate community resources to support non medical gaps in care*
  - *Manage referrals to community resources*
  - *Contract and Services management*
  - *Longitudinal Care Plan*
  - *Ability to view patterns of ED and Hospital utilization*

- **Strong MPI for patient safety and quality of care**

# The “Foundational” Approach to Community Care Coordination

# It takes a team centered approach

# Stakeholders Community Shared Care Plan




Community Aging in Place Advancing Better Living for Elders

# Care Managers Engaging with Patients and Families

# Roles of the Patient Centered Medical Team

## Sample of roles and responsibilities

- **Primary Care Manager (RN/BSW) -** Lead the Care Management Team
  - Initial engagement with the patient
  - Face to Face encounters
  - Conduct home visits and complete/update CHA and complete screenings
  - Establish appropriate interventions and set patient centered goals
  - Responsible to other members of the team for establishing individualized plans of care and implementation
- **Care Coordinator (SW) -** Co-lead on the team
  - Responsible for completing social, behavioral, and emotional at-risk assessment
  - Link patients to community resources
  - Support RN Care Manager and collaborate with other members of the Care Management Team.
- **Clinical Care Coordinator (LPN)**: Provide support to the RN Care Manager in the holistic multi-disciplinary team approach, which includes social and emotional assessment, planning, facilitating, education and advocacy for the patient protocol.

Source: http://www.p4communitycare.org/programs-initiatives/care-management

# Community Health Workers

## Community Health Worker

- A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served
- This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and **cultural competence of service delivery**

# Discussion