Division of TennCare

STATE OF TENNESSEE

Making the Case for Care Coordination

09/12/2017

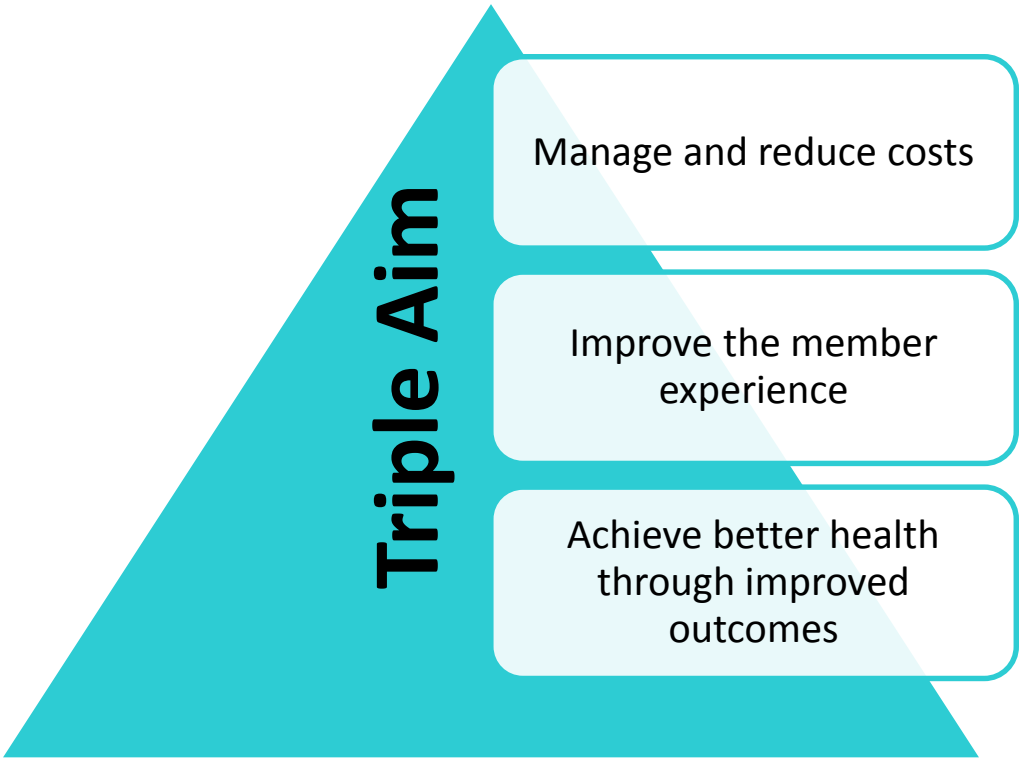
AGENDA

- Moving Toward a Care Coordination Model
- Interfacing with Primary Care
- Helping Members Manage Physical Health
- Overview of Quality and Efficiency Measures

MOVING TOWARD A CARE COORDINATION MODEL

Recent Healthcare Trends

- Shift from volume to value-based care
- Increased need for PCMH and Health Home models
- TennCare is committed to achieving the Triple Aim:



Case Management vs. Care Coordination

Case managers are traditionally used to providing behavioral health services within a siloed healthcare system

Care coordinators focus on removing siloed care to improve the effectiveness, safety and efficiency of health systems

Case Management:

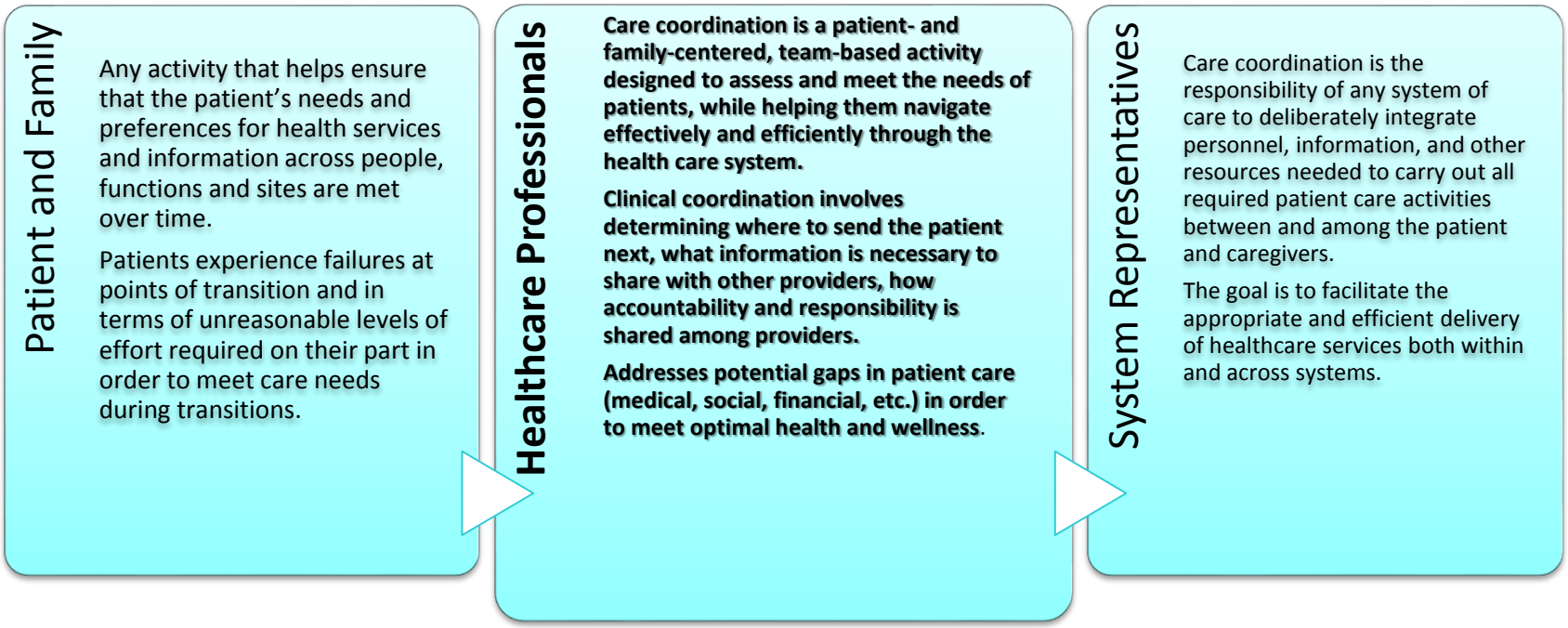
- Needs assessment
- Plan development and implementation
- Evaluation
- Connections to resources

Care Coordination:

- Family involvement
- Collaboration
- Identification of needs
- Medical assistance
- Communication
- Standards for outcomes
  - Member satisfaction
  - Function
  - Clinical
  - Costs of care

http://www.jhsph.edu/offices-and-services/practice-and-training/_documents/PHASE-past-projects-PDF/year10_2012-2013/SinghManasvini_MSPH.pdf

Perspectives on Care Coordination



http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html

Care Coordination

To proactively identify members who have multiple or complex medical and/or psychosocial needs or who are at risk of developing complex needs during an acute episode of illness

To provide early intervention to members when care coordination is appropriate

To support the clinical staff who focus on the delivery of medical care that maximizes quality of life and ensures that the care is provided in the most appropriate and supportive setting

To facilitate communication among the member, their families, health care providers, the community and the health plan in an effort to enhance cooperation while planning for and meeting the health care needs of member

To serve as a liaison between community resources to supplement services not covered by the benefit plan

To allocate resources and maximize the available benefits

To increase member and provider satisfaction through coordination and management of health care resources

To assist in the development and communication of the member's self-management plan

To function as an educator of all stakeholders including the health care team and the community regarding the care coordination process and specific health care issues

To partner with the member and family in assisting them to reach maximum achievable health and quality of life potential and maximum independence

To serve as an advocate for the member and family

http://www.integration.samhsa.gov/about-us/Who_is_Responsible_for_Care_Coordination_March_final.pdf

Care Coordination Activities

Communicate: Share knowledge among participants in a patient's care

- Interpersonal communication: The give-and-take of ideas, preferences, goals and experiences through personal interaction
- Information transfer: The flow of information such as medical history, medications, labs and other clinical data

Facilitate transitions: Occurs when information or accountability for aspects of a patient's care is transferred

- Across settings: From inpatient to outpatient settings, transitions between primary and specialty care, etc.
- As coordination needs change: Transition from pediatric to adult care, between acute and chronic care management, etc.

Assess needs and goals: Determine care needs and coordination including health, functional status, history, etc.

Create a proactive plan of care: Establish and maintain a plan of care, jointly created and managed by patient/family and care team, outlining current and longstanding needs and goals for care and coordination gaps

Monitor, follow up and respond to change: Jointly with patient/family, assess progress toward goals.

Support self-management goals: Tailor education and support to patients' preferences

Link to community resources: Provide information on available community services and resources, coordinate

Align resources with patient and population needs: Assess needs of patients and populations, allocate resources

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http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html

INTERFACING WITH PRIMARY CARE

Comorbidities in a Medicare-Medicaid Population

CCW Comorbidity Analysis (%)	Categorical Chronic Condition Group Denominator												
	Mental Health Condition	Anemia	Stroke	Diabetes	Eye Disease	Heart Condition	Hip/Pelvic Fracture	Kidney Disease	Lung Disease	Musculoskeletal Disorder	Neoplasm	Other Metabolic Disorder	Tobacco Use
Mental Health Condition		47	54	42	39	42	61	45	52	46	40	55	63
Anemia	36		53	43	39	38	75	65	42	41	49	48	29
Stroke	9	12		10	9	9	16	14	10	9	10	11	7
Diabetes	36	49	51		43	45	40	60	43	41	42	42	32
Eye Disease	21	28	29	27		26	26	26	24	28	29	27	15
Heart Condition	75	90	95	92	86		93	95	87	87	88	87	74
Injury Hip/Pelvic Fracture	2	3	3	1	2	2		2	2	2	2	3	1
Kidney Disease	18	36	34	29	20	22	32		25	21	26	25	18
Lung Disease	30	31	33	28	26	28	36	34		31	35	31	48
Musculoskeletal Disorder	42	50	48	44	48	45	66	45	49		47	50	38
Neoplasm	6	9	8	7	7	7	10	9	8	7		7	7
Other Metabolic Disorder	13	15	15	12	12	12	21	15	14	13	12		9
Tobacco Use	18	11	12	11	8	12	10	12	24	12	13	10	

Source: CY 2008 CCW Medicare and Medicaid data, FFS enrollees with at least six months enrollment in Medicare Parts A and B and/or Medicaid.

Shading indicates comorbidity ≥ 50%

Common Chronic Conditions Affecting Behavioral Health

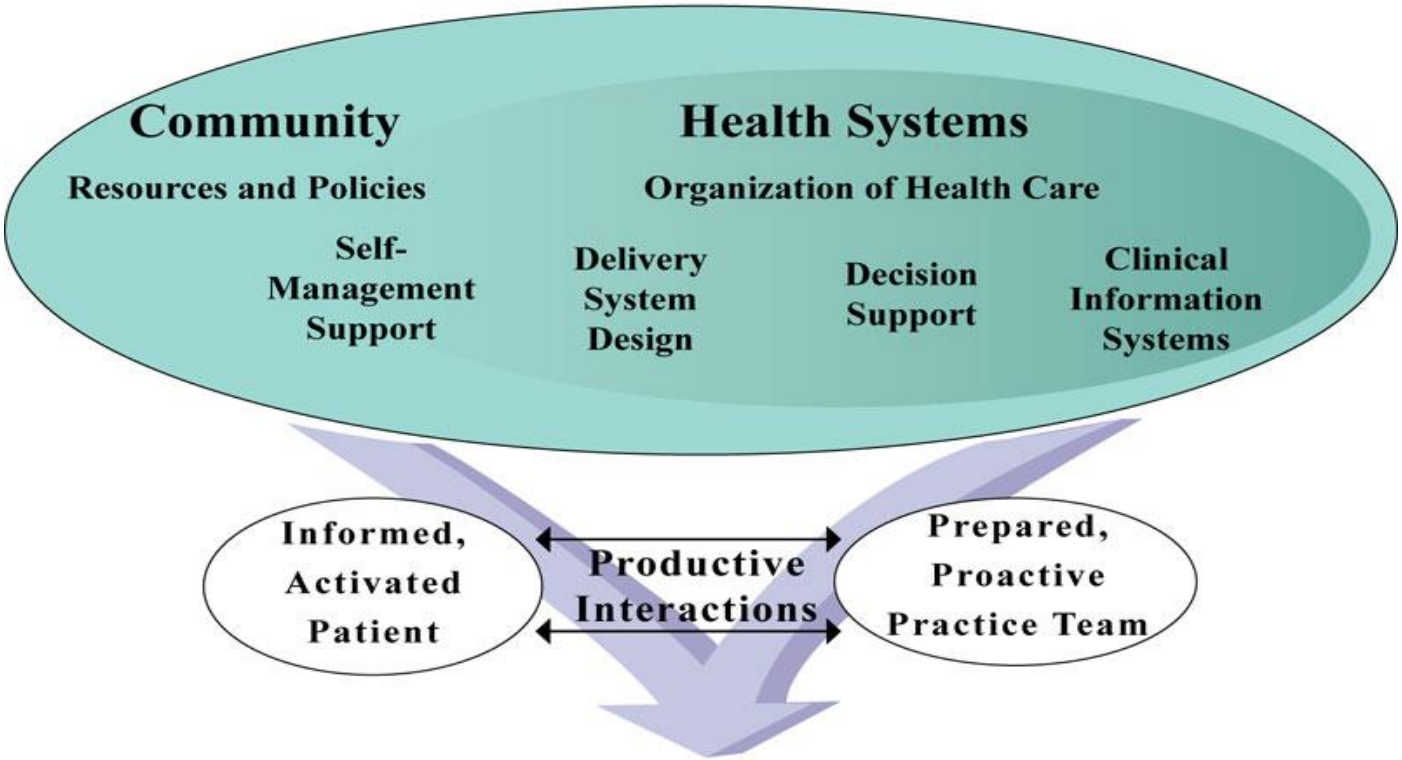
Condition/ Disease	Definition	Common Diagnostic Tests	Common Medications/ Treatment	Care Coordinator Intervention Examples
Asthma	Long-term and persistent inflammation of the airways. Episodes can be caused by allergens, respiratory infections, changes in weather, stress, etc.	• Lung function tests such as spirometry or peak flow	• Inhaler	• Episode tracker (diary of triggers, time, severity, etc.) • Medication tracker
Cancer	Tumors, or abnormal growth of cells, in a particular area of the body.	• Biopsy	• Chemotherapy • Radiation • Surgery (tumor removal)	• Oncology appointment tracker
Chronic Hepatitis	Inflammation of the liver for more than six months. There are different types (A, B, C, D and E) which are spread in different ways (e.g., via blood, sexually transmitted, etc.).	• Blood test (viral serology)	• Antiviral medications	• Medication tracker
Chronic Kidney Disease (CKD)	Decreased functioning of the kidneys.	• Kidney function tests	• Diuretic (reduces fluid in body) • Dialysis (machine-driven waste removal from blood)	• Dialysis appointment tracker
Chronic Obstructive Pulmonary Disease (COPD)	Persistent respiratory symptoms and airflow limitations which progress over time and are usually caused by exposure to noxious particles or gases (e.g., cigarette smoke).	• Lung function test such as spirometry • Chest X-ray	• Inhaler	• Episode tracker (diary of triggers, time, severity, etc.) • Medication tracker

Common Chronic Conditions Affecting Behavioral Health

Condition/ Disease	Definition	Common Diagnostic Tests	Common Medications/ Treatment	Care Coordinator Intervention Examples
Diabetes – Type 1	Improper use of glucose (a type of sugar in the body), so that not enough insulin is produced.	• HbA1c (indicates average blood sugar level for the past 2-3 months) • Blood sugar tests	• Proper diet (i.e., carbohydrate counting) • Insulin	• Insulin log book (includes medications, meals, exercise) • Endocrinology appointment tracker
Diabetes – Type 2	Improper use of glucose (a type of sugar in the body), so that the body does not respond properly when insulin is produced.	• HbA1c (indicates average blood sugar level for the past 2-3 months) • Blood sugar tests	• Proper diet (i.e., carbohydrate counting) • Metformin	• Insulin log book (includes medications, meals, exercise) • Endocrinology appointment tracker
Heart Disease	Decreased functioning of the heart.	• Electrocardiogram (ECG or EKG) • Echocardiogram • Blood tests • Chest X-ray	• Diuretic (reduces fluid in body) • ACE inhibitors (decreases blood pressure)	• Daily weights (for congestive heart failure) • Medication tracker • Food log
HIV/AIDS	Virus which interferes with the body's ability to fight off infections.	• Blood test (viral serology)	• Antiretroviral therapy	• Medication tracker • Diet and exercise log
Hypertension	High blood pressure which causes the heart to work harder than normal.	• Blood pressure	• Diuretic (reduces fluid in body) • ACE inhibitors (decreases blood pressure)	• Diet and exercise log • Blood pressure tracker • Medication tracker

HELPING MEMBERS MANAGE PHYSICAL HEALTH

The Chronic Care Model

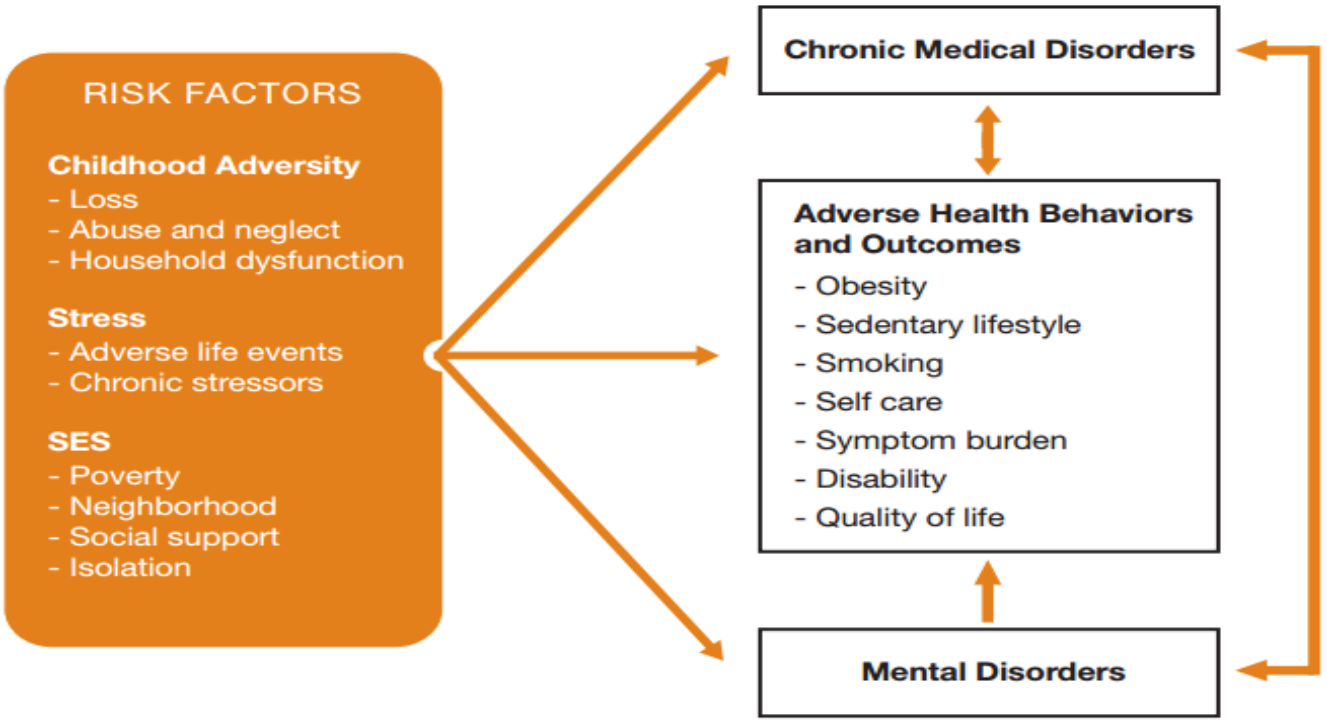


Improved Outcomes

Developed by The MacColl Institute
® ACP-ASIM Journals and Books

Comorbidity: Link Between Behavioral Health and Physical Health Conditions

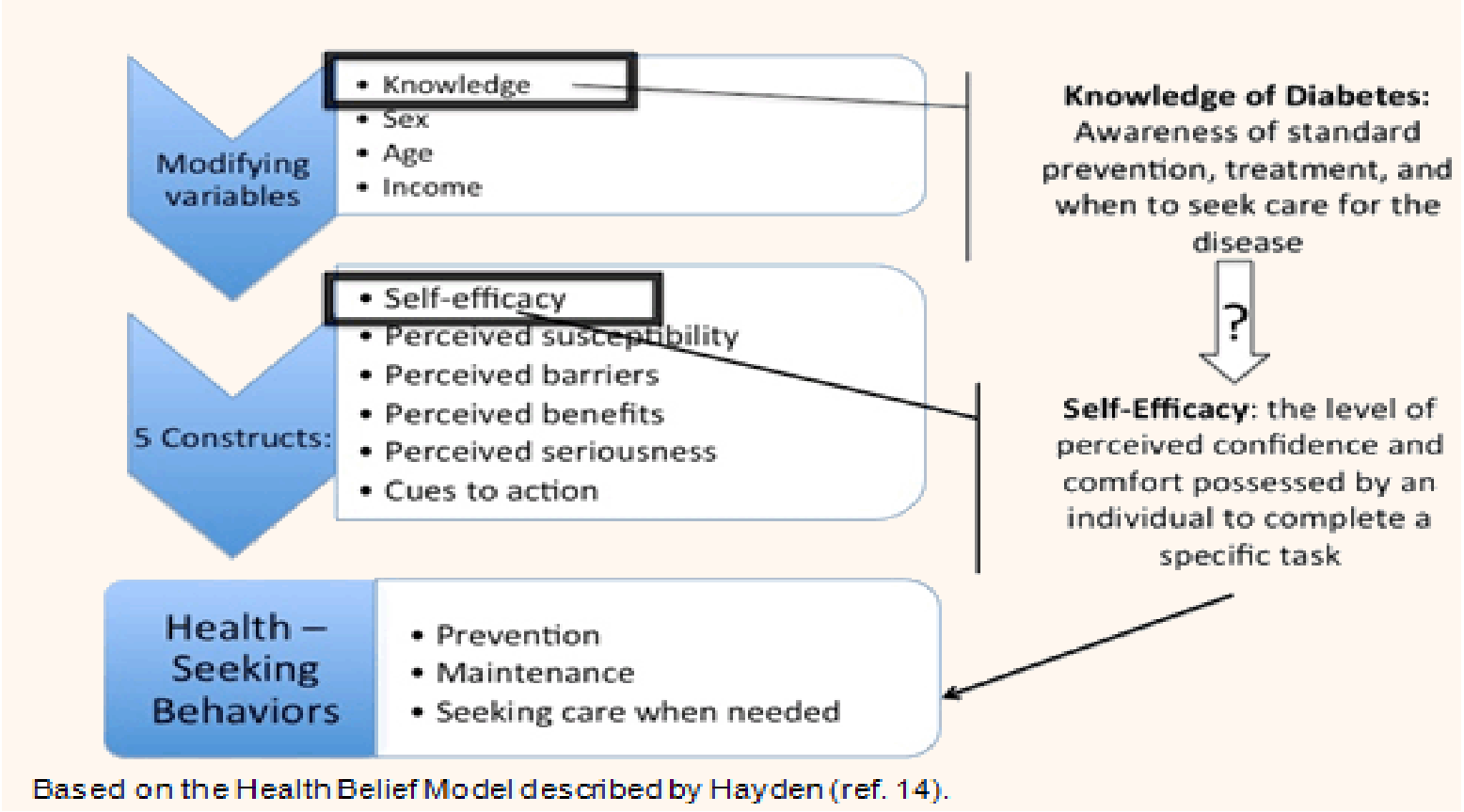
- Approximately **25 percent** of American adults have a diagnosable behavioral health condition and **nearly half** of those report having at least one chronic medical condition



Katon WJ. "Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness." Biological Psychiatry, vol. 54, no. 3, 2003.
Kessler RC, Chiu WT, Demler O, Walters EE. "Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication." Archives of General Psychiatry, vol. 62, no. 6, 2005.

Increasing Self-Management Skills for Chronic Conditions

- Focus on the attitudes and beliefs of members' related to health – **perceptions of health affect health outcomes!**



Based on the Health Belief Model described by Hayden (ref. 14).

Increasing Self-Management Skills for Chronic Conditions

- Motivational Interviewing
- Goal-setting
- Regular check-ins
- Simple props (e.g., educational charts, figures, etc.) can serve as good reminders
- Teach-Back Method – Close the loop – have the member repeat the information during a visit

Common Comorbid Conditions

DEPRESSION

- Comorbid depression and chronic health conditions are associated with a decrease in self-care and less adherence to treatment recommendations such as diet, exercise, tobacco cessation, taking medication as prescribed, and following through with procedures. They may be at greater risk for suicidal ideation and chronic conditions:
  - **Diabetes:** Between 15 to 30% of people with diabetes also have depression, resulting in worse outcomes, such as higher body-mass index and increased risk of other medical conditions (e.g., coronary artery disease, cerebrovascular disease, and microvascular complications affecting eyes, kidneys, feet, and sexual function).
  - **Heart Disease:** Up to 33% of people experience depression following a heart attack.
  - **Cancer:** Comorbid depression affects 15 – 25% of people with cancer.

Common Comorbid Conditions

ANXIETY

- Anxiety disorders such as generalized anxiety disorder, post-traumatic stress disorder, panic disorder, phobias, and social anxiety disorder can have a significant impact on many physical health conditions.
- The prevalence of anxiety disorders in primary care range from approximately 8 percent with generalized anxiety disorder to 12 percent with post-traumatic stress disorder.
- Higher rates of gastrointestinal, respiratory, cardiac, and neurological disorders are associated with increased incidence of the following:
  - Cardiovascular disease (myocardial infarction, angina, sudden cardiac death, and hypertension)
  - Asthma
  - Cancer

Common Comorbid Conditions

ALCOHOL AND DRUG MISUSE

- Comorbid substance use disorders (SUD) and physical health conditions result in poorer clinical outcomes and worse adherence to treatment, especially in hypertension, diabetes, asthma, chronic liver disease, chronic obstructive pulmonary disease, pain, and stroke.
- People living with SUD have:
  - Risk of developing pneumonia that is 12 times greater
  - Nine times greater risk of developing congestive heart failure
  - Risk of developing cirrhosis that is 12 times greater
  - Binge-drinking is associated with a 43% increase in risk of developing diabetes.

Communicating with Primary Care Providers

- Consider who you are communicating with – different providers may want different information and the way you deliver it
  - Pay attention to the way they engage with you
- Brevity and clarity are always appreciated
  - What is the bottom line? Why does it matter to them?
- Find out when a primary care provider needs to see the member again
- Primary care is historically uncomfortable addressing behavioral health needs – how can you frame this aspect of the member's health to relate it to primary care?
  - Does a member's depression affect them taking medications for physical health conditions?)

Building Relationships with Primary Care Providers

- Members are **shared** between behavioral health and primary care in TennCare's program – both disciplines should collaborate to improve members' **outcomes**
- Find incentives for PCPs to become motivated to work with behavioral health agencies
  - Need to create buy-in
- Leadership meet-and-greets
  - Face-to-face introductions often increase communication and referrals
  - Have referral trainings (behavioral health to primary care and vice versa)
- Develop organization-specific primary care communication forms to exchange member information and discuss behavioral health issues (need Release of Information forms/member consent)

Preparing Members for Primary Care Appointments

Care coordinators should fully understand the purpose of the visit and talk to the member prior to the appointment. Care coordinators should ensure that members share the following information with the PCP (if known/applicable):

1. Symptom(s)
2. When the symptom(s) began
3. What time of day it happens and how long it lasts
4. How often it happens
5. Anything which makes it better or worse
6. Anything it prevents the member from doing
7. Current medications (e.g., prescription medications, over-the-counter medications, vitamins, etc.)
   - Can use medication charts to track
8. Use of assistive devices
9. Daily habits
10. Significant life changes
11. Recent medical encounters
12. Other information (e.g., insurance cards, contact information for other physicians and preferred pharmacy and medical records if not sent previously)

OVERVIEW OF QUALITY AND EFFICIENCY MEASURES IN HEALTH LINK AND PCMH

Health Link Quality Metrics

1. **7- and 30-day psychiatric hospital / RTF readmission rate**
   - 7-day
   - 30-day
2. **Antidepressant medication management** ★
   - Acute phase treatment
   - Continuation phase treatment
3. **Follow-up after hospitalization for mental illness within 7 and 30 days**
   - 7-days
   - 30-days
4. **Initiation/engagement of alcohol and drug dependence treatment**
   - Initiation
   - Engagement
5. **Use of multiple concurrent antipsychotics in children/adolescents**
6. **BMI and weight composite metric** ★
   - Adult BMI screening
   - BMI percentile (children and adolescents only)
   - Counseling for nutrition (children and adolescents only)
7. **Comprehensive diabetes care (Composite 1)** ★
   - Diabetes eye exam
   - Diabetes BP < 140/90
   - Diabetes nephropathy
8. **Comprehensive diabetes care (Composite 2)** ★
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (> 9%)
9. **EPSDT: Well-child visits ages 7-11 years** ★
10. **EPSDT: Adolescent well-care visits age 12-21** ★

★ **Represents shared or similar measures with PCMH**

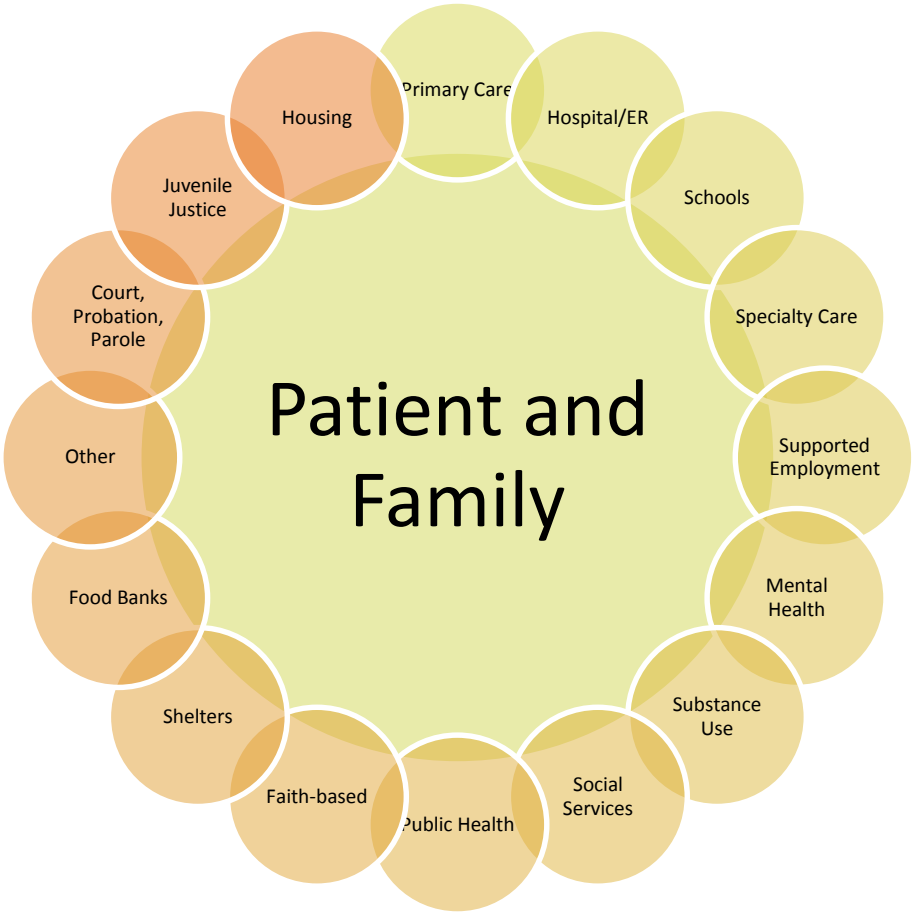
Health Link Efficiency Measures

1. All-case hospital readmissions rate
2. Ambulatory care – ED visits
3. Inpatient admissions – Total inpatient
4. Mental health utilization – Inpatient
5. Rate of inpatient psychiatric admissions

Care Coordination

- According to the Care Coordination Measures Atlas,[1] Care Coordination may be defined as:

"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 marshalling 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."



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THANK YOU

Questions?