



Care Coordination Collaborative (CCC) Charter

Problem Statement, Care Coordination Aim, Goals and Objectives, and Guidance

Proposed: December 16, 2013

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| Problem Statement | |
| <p>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 active in their own care or to engage in healthy behaviors. The impact is profound -poor or confusing care access and follow-through, inefficient and inadequate services, higher health care costs, reduced satisfaction for clients and providers, poor health outcomes, and lower life expectancies.</p> | |
| Proposed Aim | |
| <p>Over a period of fifteen (15) months, Care Coordination Collaborative Partnership Teams consisting of primary care, mental health, substance use disorders, and other safety net providers, working with local public safety net health plans, will make changes to improve the health status of individuals who have complex, co-occurring conditions and require coordinated services. Teams will work to establish multiagency communication, create workflows for coordinated care, promote self-management, and use clinical information systems. These changes will build a seamless experience of care that is person-centered, cost effective, and results in improved health and wellness.</p> | |
| Target Population | |
| <p>The target population is the collection of individuals who have serious mental health and/or substance use disorders with co-occurring diabetes or cardiovascular disease, and require services from two or more service-provider organizations. The target population is identified through systematic population-identification methods (for example clinical screening or service utilization data review).</p> | |
| GOALS | OBJECTIVES |
| 1. Increase the screening of individuals for mental health/substance abuse and chronic medical conditions within each care setting (Mental Health Agencies, Substance Use Disorder Agencies, and Primary Care Providers) | 1. Within the Collaborative timeframe, 75% of individuals in a care setting have been evaluated for a second condition requiring care from another provider |
| 2. Increase the percentage of individuals with shared care objectives that address physical health and specialty mental health and/or substance use disorder conditions | 2. 75% of individuals in target population will have shared care objectives that include physical health, mental health and substance use concerns |
| 3. Increase the percentage of individuals with a care coordinator assigned by any partner and with whom your staff work to coordinate care | 3. 90% of target population individuals will have an identified care coordinator assigned by one of the participating partners and acknowledged by provider partners and the individual receiving services as accountable for coordinating care |



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| GOALS (cont.) | OBJECTIVES (cont.) |
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| 4. Improve medication reconciliation across 2 (or more) provider agencies | 4. 60% of target population individuals will have documentation of medication reconciliation across all providers in the last 6 months or 2 weeks following a medication change. |
| 5. Improve access to appropriate care for people with unmet needs | 5. 90% of target population will have seen a primary care provider and any of their needed specialty care providers in the last 6 months |
| 6. Improve satisfaction with experience of care | 6. 80% of target population will report that their satisfaction/experience with care is good/excellent |
| 7. Reduce emergency room utilization | 7. Reduce by 25% the use of emergency rooms |
| 8. Reduce hospital utilization | 8. Reduce by 25% hospitalizations |

Guidance

- a. Each Partnership Team will be identifying the initial target population members that will be served by the Care Coordination Collaborative during the Pre-Work Phase, including the sub-population(s) that is/are likely to “bend the cost curve” (for example: individuals with three or more conditions, or individuals at risk for inpatient hospitalization). Below are **Hot Spotting Strategies** to help the Partnership Team identify the Target Population
- **Strategy 1: Formal Hot Spotting** through analysis of historical medical care cost and utilization data to identify the complex, high cost individuals who may benefit from care coordination; and then working with the provider team to refine the list, drawing on their “real life” knowledge and experience. This information often will come from a health plan’s database and is drawn from the last one to three years of claims data.
 - **Strategy 2: Informal Hot Spotting** by going directly to the provider team to identify those individuals who they know to have complex conditions resulting in frequent use of emergency room and inpatient care. This strategy should be employed when historical medical care cost and utilization data are not readily available. Hospitals and emergency rooms are also good sources of data.
 - **Strategy 3: Real-Time Hot Spotting** by setting up protocols to identify individuals with complex, high cost conditions as they are served in the clinic. This strategy should be used when it is not practical to use Strategies 1 or 2.
- b. Suggested screenings to be completed or documented by agencies in the Collaborative Team include:
- Blood Pressure
 - Body Mass Index
 - A1c
 - LDL
 - PHQ2 or PHQ9
 - GAD 2
 - Single Item for Alcohol and Drug Use



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Guidance (cont.)

- c. Teams can be co-located, virtual, or a combination
- d. A peer provider or peer run organization and a family member provider or family provider organization is highly recommended 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. Testing 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)
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 - 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