Care Coordination: Improving Health Care Quality in Your Community

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History of Northland
Who is Northland?
What do we do?
Services that we offer
Programs

Northland Services
- Account Management
- Anesthesia Equipment
- BioMed Equipment Services
- Capital Equipment Maintenance
- Capital Equipment Acquisition Services
- Collections
- Community Reporting
- Care Coordination
- Grants Management
- Grant Writing Services
- Information Technology
- Leadership Training
- Mobile Imaging
- Natural Gas Purchasing
- PACE
- Sterilizer Maintenances
- Sterilizer Installation
- Supply Management Services
- Telemedicine

Care Coordination is different than PACE but some similarities
- Interdisciplinary Team/Team Approach
- Same Population
- Keeps the elderly in their home healthier, safer, and more independently
- Began work with PACE in 2004
- Attended Rural PACE meeting
- One of 14 sites to receive a CMS Core Grant
An Expansion of an Idea

- ALTC Concept
- Modify PACE
- Innovation Funding
- Gave it a shot

Conceptual Design

- Bounced idea off members
- Modified concepts
- Developed funding proposal
- Developed a PACE-like model

Why Care Coordination?

- Adapt to changes in healthcare
- Prepare for pay for performance
- Increase Quality and Satisfaction
- Reduce Medication errors
- Reduce unnecessary readmissions
- Better coordination between healthcare providers to improve collaborative efforts
- Patient Engagement & Empowerment
Program Goals

- Better Health Care
  - Provide Care Coordination
  - Implement Individualized Inter-Disciplinary Team
- Lower Cost
  - Lower Cost by Reducing
    - ER visits
    - Unnecessary IP Hospitalizations
- Better Health
  - Better Health Care
  - Implement Individualized Care Plan
  - Monitor Health Status
    - Blood Pressure
    - Hemoglobin A1c
    - Health-Related Quality of Life Survey
  - Collaborate with Community Health Care Providers

Logistics

- Staffing includes
  - Project Director
  - Marketing Coordinator
  - Administrative Assistant/Intake Coordinator
  - Data Analyst
  - Community Care Coordinators
    - Community Care Coordinator II – RN, LSW
    - Community Care Coordinator I – LPN, CNA, Medical Assistants
- Eligibility
- Enrollment
  - As of April 30, 2015 – 584 Participants
  - Serving over 834 Participants since January 31, 2013

Logistics

- 10 Coordinators at 7 sites serving 18 counties

Service Areas—approximately 1 hour travel time radius of:
- Bismarck/Mandan
- Beulah/Hazen/Center
- Bowman
- Dickinson
- Ellendale
- Garrison
- Linton

Note: Counties within Service Area
Note: Counties served with MCO bids
Care Coordination Definition

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."


Care Coordination: What do we do?

• Transitional Care
  • Ensure discharge plans are implemented and followed through in the home.

• Coordination of Care Management
  • Ensure services are delivered at the right time and place.

• Move from Care Management to Self Management
  • Motivate Participants to become engaged and empowered in their healthcare.
  • Educate Participants to self-manage their chronic conditions.

Transitional Care

• Medication Reconciliation from hospital discharge and pharmacy and communicate to Primary Care Provider
• Ensure discharge plans are implemented
• Home Visit and assessments after discharge
• Encourage and help patient to communicate concerns with Primary Care Provider
• Anticipate increased Patient Satisfaction
• Help patient access their Patient Portal
Coordination of Care Management

- Monthly communication with Participant, face to face preferred.
- Ensure access to community services at the right time and place.
  - Recommend visits/contact with PCP before ER visit or hospitalization occurs
- Assess Participant
  - Disease Awareness
  - Adherence Attitudes
  - Treatment Competence
  - Ability to communicate with healthcare providers
- Increase Patient Activation Measure

Self Management

- Develop self-management health record for Participant
  - Medical Contacts
  - Current Service Providers
  - Self-management goals
  - Chronic Disease red flags
- Educate Participants on chronic disease self-management pathways
- Long term enrollment

Key Partnerships

- Healthcare Providers
- Community Organizations
- Interdisciplinary Team Members
- Participant and/or Caregiver
- Family Members
- Kissito Healthcare Collaborative Care Solutions working with Dr. Steven R. Hahn, MD of The Albert Einstein College of Medicine
  - Adopted the Collaborative Patient Care Pathway “CP2”: Patient-Centered Communication for Chronic Disease Self-Management
Three Pillars of Chronic Disease Self-Management

1. Four-Domain Model of Chronic Disease Self-Management Competence
2. Patient-centered communication
3. Family-centered care

1. Four-Domain Model of Self-Management Competencies

- Disease Awareness
- Healthcare Communication
- Adherence Attitudes
- Treatment Competence

2. Patient-centered communication

- The participant and family are the experts in their experience of the illness and its treatment
- What is important to the participant?
- Is the Participant ready for change?
  - Motivational Interviewing
### Stages of Readiness Change

<table>
<thead>
<tr>
<th>Stage</th>
<th>Psychology</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Ignorance or denial</td>
<td>Raise concern</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Ambivalence</td>
<td>Shift the balance</td>
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<tr>
<td>Decision</td>
<td>Determination</td>
<td>Make an action plan</td>
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<tr>
<td>Action</td>
<td>Active engagement</td>
<td>Provide skills, knowledge &amp; resources</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Integrate behaviors in daily routine</td>
<td>Sustain perceived need, reduce concerns</td>
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<tr>
<td>Relapse</td>
<td>Loss of confidence &amp; self-efficacy</td>
<td>Restore confidence, self-efficacy &amp; commitment</td>
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</tbody>
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### Motivational Interviewing

- Assess the stage of readiness for change
- Ask – Tell – Ask
- Rulers
- Reflection
- Next Step
- Provide information and resources

### 3. Family-centered care

- Patients survive by the support provided or perish by the burdens imposed by the family
- Genogram based interview
  - Need for family/caregiver involvement
  - Caregiver competencies
  - Caregiver burden
Challenges

- Funding for services
- Acceptance of all providers
- Getting Data to Demonstrate Value
- Staffing with the right staff
- Consistency and flexibility

Outcomes

- Self-monitoring measuring plan
- Cost/Utilization
- Health Outcomes
- Timeliness
- Satisfaction
- Data is showing positive trending
- The model is unique
- Very high satisfaction from participants

Contacts/Questions

Call 701-204-0418 for referrals or questions on eligibility

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