Community Care Teams, Shared Care Coordination, and Improved Health Outcomes

Pat Conway and Heidi Favet

Minnesota Rural Health Conference
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Objectives
Participants will gain:

• Increased knowledge about the process of implementation of care coordination teams in rural and remote settings, including factors supporting that implementation and barriers.

• Increased understanding of patients’ and families’ opinions about care coordination and the impact of care coordination on their wellness.

• Increased understanding about relationships between organizations and change over time as a result of the development of a community care coordination team.
Implementing the Ely Area Community Care Team

Creating a local approach to improve health outcomes and reduce unnecessary health care usage, adapting care management and interorganizational teaming.
Located in a geographically remote, rural region with limited resources.
Key Components of the Community Care Team
“No wrong door”

Providers recognize and address needs of whole person, no matter their role or agency.

Mission: The Community Care Team provides collaborative care and support to help you achieve your wellness goals.
Ely Area Community Care Team Members

- Essentia Health-Ely & Babbitt Clinics
- Ely Bloomenson Hospital
- Ely Community Resource
- Range Mental Health Center
- ISD 696 & 2142
- St. Louis County Public Health & Human Services
- Project Care Free Clinic
- Northern Lights Clubhouse
- Greater MN Family Services

- Northwoods Care Partners
- Food Shelf
- Head Start
- Boundary Waters Care Center (Nursing Home)
- Hospice & Palliative Care
- Parish Nurse
- Vermilion Community College
- Center Rural Mental Health Studies
- Care Free Living
- Consumers and Families
Monthly CCT Meetings Include Opportunities to:

- Network
- Learn About Other Services
- Develop Tools and Systems for Collaboration
- Problem Solve Specific Concerns
- Case Management
- Collaborate on Primary Prevention
Consent to Release and Exchange Personal Information
Between Your Care Team Agencies

1. Purpose of the exchange of information: Coordination of your care
This release will permit the individuals and agencies you choose, to work together in a confidential, professional manner to meet your wellness needs.

2. Your basic information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Mt Last AKA</td>
<td></td>
</tr>
</tbody>
</table>

| Address       |               |

3. Type of information to be exchanged as it pertains to helping the team assist in your wellness:
Cross out and initial any item if you do not give this permission:

- History and Physical
- Diagnoses
- Medications
- Progress Notes
- Care Plan or Treatment Plan
- Mental and Chemical Health Diagnoses, Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications
- School IEP & Assessments
- Immunizations
- HIV/AIDS testing
- Emergency and Urgent Care Reports
- Discharge/Treatment Summary

4. Identify which of the following agencies and/or individuals are important in coordinating your care and give them permission to collaborate on your care by sharing information as noted above (Check the members to whom you’d like to give permission):

<table>
<thead>
<tr>
<th>Boundary Waters Care Center</th>
<th>Northwoods Hospice Respite Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center for Rural Mental Health Studies</td>
<td>Project Care Free Clinic</td>
</tr>
<tr>
<td>Ely Bloomenson Community Hospital</td>
<td>Range Mental Health Center</td>
</tr>
<tr>
<td>Ely Community Resource</td>
<td>St. Louis County Public Health &amp; Human Services</td>
</tr>
<tr>
<td>Essentia Health-Ely Clinic</td>
<td>St. Mary’s Hospice and Palliative Care</td>
</tr>
<tr>
<td>ISD 696</td>
<td>Northern Lights Clubhouse</td>
</tr>
<tr>
<td>ISD 2142</td>
<td>Vermilion Community College</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

5. When you sign this form it shows that you understand the following:
- You are giving permission for the written and/or verbal release and exchange of your personal information as indicated in section 3, between those named in section 4.
- No one will deny you help if you do not want us to share your personal information
- If you allow the release and exchange of information, this consent will expire in one year and/or you may cancel this consent at any time in writing to any agency listed above.
- If you submit a request to stop sharing your information, the request does not apply to information already shared before the time of your request.
- We shall release your information to protect the health/safety of you and/or others when required by law.
- Information released by an agency is no longer controlled by that agency and could be re-disclosed if it is no longer protected by federal or state privacy laws.
Care Coordination Continuum

- Improving Outcomes
- Team Care Coordination
- Identify and Address Barriers
- Provide Connection and Warm Handoff
- Provide Information and Resources
Psychosocial Services

Primary Providers

Core Team

Patient

Faith Community
Civic Groups, Non-profits
Community Members

Physical Health
Mental Health

Family Support
Coordinator
Others as needed

Education, Services
and Resources
Ely Clinic’s Internal Model

- Essentia Health
- Ely Clinic
- and Babbitt Clinic
- Health Care Homes

- Community Care Team

Care Coordination Team
- RN Care Coordination
- Community Health Worker
  \{Behavioral Health Specialist\}
Community Health Worker

- Coordinate non-medical issues that affect health and wellness of our patients.
- Care Manager for patients whose primary needs are not medical.
- Provides support to RN care coordinator for psychosocial needs of CDM patients.
- Provides information and warm referrals for patients who need connections to additional resources, but do not need care coordination/
- Provides resource for ALL staff.
Evaluation

• Community-Based Participatory Research Principles.
• Method developed as the project has developed.
• Data collected through interviews and electronic surveys (Survey Monkey), observation in the community, and electronic data collection using already established instruments (iPad).
• Sample: Providers. Clients/consumers/patients.
### Logic Model

<table>
<thead>
<tr>
<th>Inputs/Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short Term Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong community commitment to improved wellbeing.</td>
<td>1. Schedule monthly CCT meetings for care coordination and coordination between organizations.</td>
<td>Schedule of meetings</td>
<td>Patient outcomes (satisfaction and wellbeing)</td>
<td>Use of community resources is maximized and patient outcomes are improved through the CCT.</td>
</tr>
<tr>
<td>Organizations that have supported the development of the CCT Project in the first year.</td>
<td>2. Refine the tiered model of care coordination created in Year 1 and adapt for community agencies.</td>
<td>Roster Minutes</td>
<td>Organizational satisfaction</td>
<td></td>
</tr>
<tr>
<td>Common assessment tool and referral process developed in Year 1.</td>
<td>3. Implement the community-centered tools and protocols created in Year 1.</td>
<td>Generic Model</td>
<td></td>
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</tr>
<tr>
<td>Staff with capacity and commitment.</td>
<td>4. Create and implement a community-focused hospital discharge plan.</td>
<td>Adapted models</td>
<td></td>
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<tr>
<td>External collaborators and funding.</td>
<td></td>
<td>Number of patients and families</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Referrals</td>
<td></td>
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<td>Meetings of Subgroup</td>
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<tr>
<td></td>
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<td>Community-focused hospital discharge plan model</td>
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<td>Completed plans</td>
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<td></td>
<td>Community-focused hospital discharge plan implemented.</td>
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</table>
Number of Organizations and Type of Relationship with Essentia Health-Ely Clinic

Essentia Health-Ely Clinic

- Have a Relationship, Currently Working Together Successfully
- Have a Relationship, Would Like To Strengthen
- Have a Limited Relationship
- No Relationship
Social Network Analysis of CCT

- Characteristics of organizational relationships
- Patterns of referrals
- Sharing funding
- Sharing data
Two Relationships

Created with NodeXL (http://nodexl.codeplex.com)
Patient Reported Outcomes

Adults
• Describe sample
• Instruments
  ➢ SF-36
  ➢ PACIC
• Data Collection
  ➢ iPad

Children
  ➢ Conversation
Lessons Learned

1. Rural community structure different because of limited resources
2. Funding streams for care coordination and care team support staff limited
3. Identifying and measuring realistic short and long range outcomes
Made Possible By

- Essentia Health Foundation
- Minnesota Department of Health
- UMN Clinical and Translational Science Institute
- Family Services Collaborative
Questions?

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