Care Coordination and the Community Team

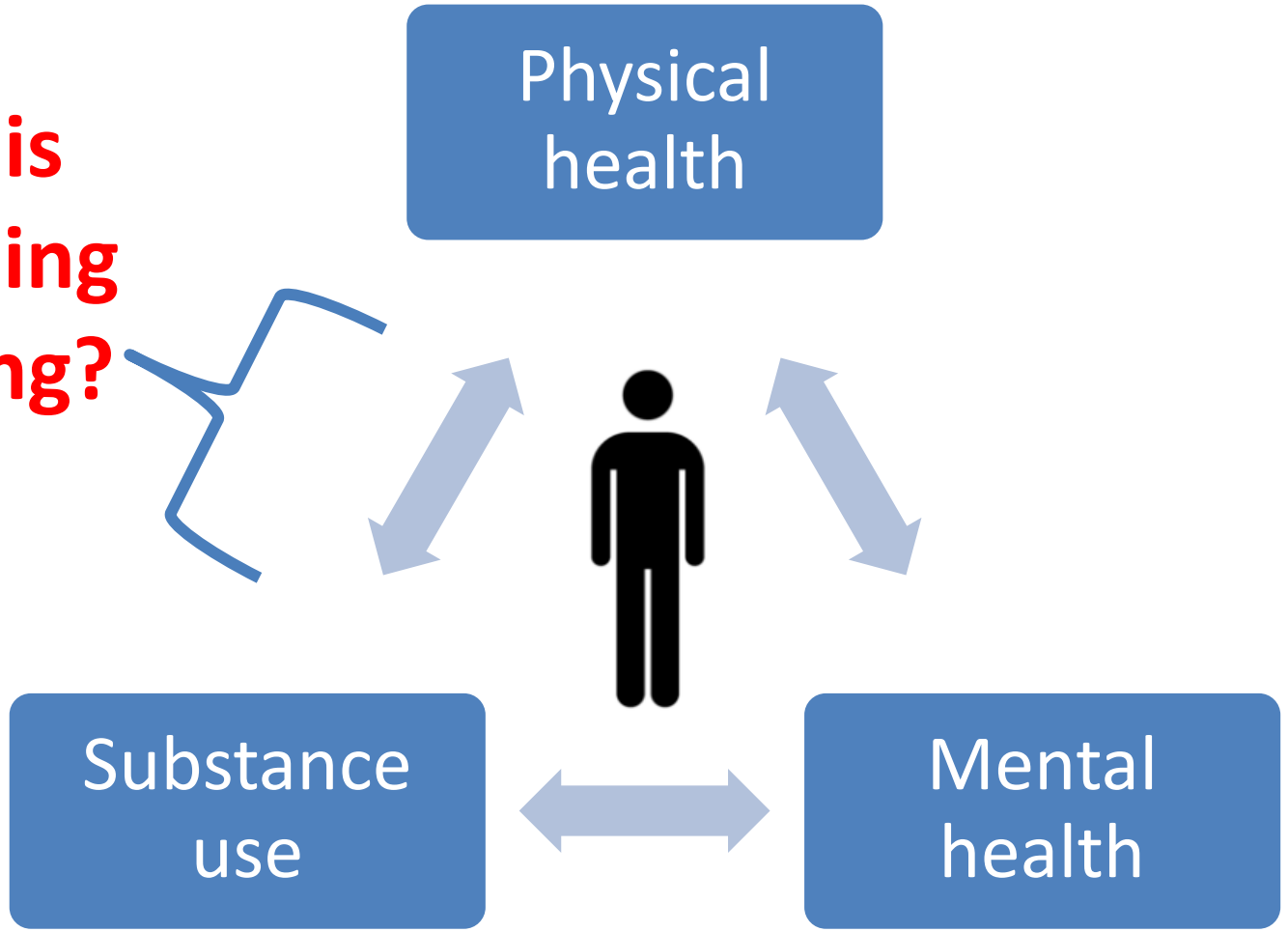
Joan Kenerson King RN, MSN

joank@thenationalcouncil.org

Stephanie Morton, MSW
Healthy Mother, Healthy Babies – The Montana Coalition
stephanie@hmhb-mt.org

Integrated Care = Whole Person Care

But… is anything missing?



Clinical Team

Care coordination ?

One process: Care Coordination Defined

"the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services."

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

The heart of care coordination

“Go to the people. Live with them.

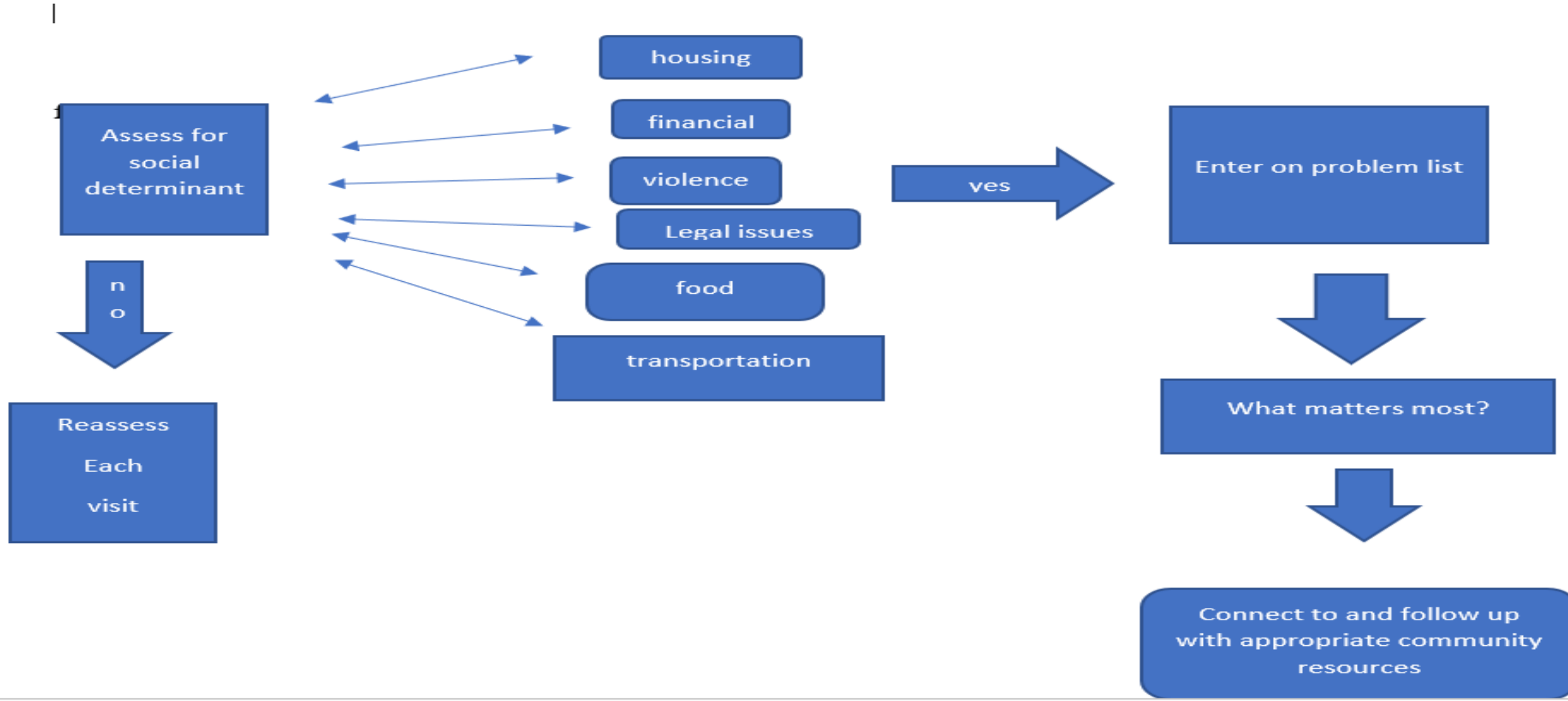
Learn from them. Love them.

Start with what they know. Build with what they have.

But with the best leaders, when the work is done, the task accomplished, the people will say 'We have done this ourselves.”

— **Lao Tzu**

Care coordination starts with assessment:



file:///C:/Users/JoanK/Downloads/Social-Determinants-of-Health-wp%20pdf.pdf

Stress kills…and it starts in childhood

- ***Stress response*** is the cascade of changes triggered by the release of corticosteroids and other stress hormones when the body perceives a threat and goes 'on alert.' The resulting physiological changes include increased heart and respiration rates, higher blood pressure, and more glucose released from the liver into the blood stream.

- ***Chronic Stress.*** Whereas acute stress arises from special events or situations which involve threat, novelty and uncertainty, chronic stress results from repeated or persistent exposures to situations which cause the release of stress hormones. Over time, this constant activation of the stress response— even at low levels—can injure the brain and body, increasing the risk for high blood pressure, diabetes and other chronic diseases and for emotional, cognitive and behavioral problems.

Source: California Newsreel. (2017). The Raising of America.

Impact of Stress

- Responding to stress is natural and necessary for survival
  - Flight or fight
- But there are limits to our stress response /reactivity
- Acute versus chronic stress

- Impacts of the biological response to psychological stress include impairments to:
  - Cardiovascular, endocrine, circulatory, neurological, and metabolic systems.
- Resulting in:
  - Hypertension, diabetes, rheumatoid arthritis, heart attack, stroke, cancer, infectious disease, and lowered immunity, among others.

Impact of SDH in Early Life

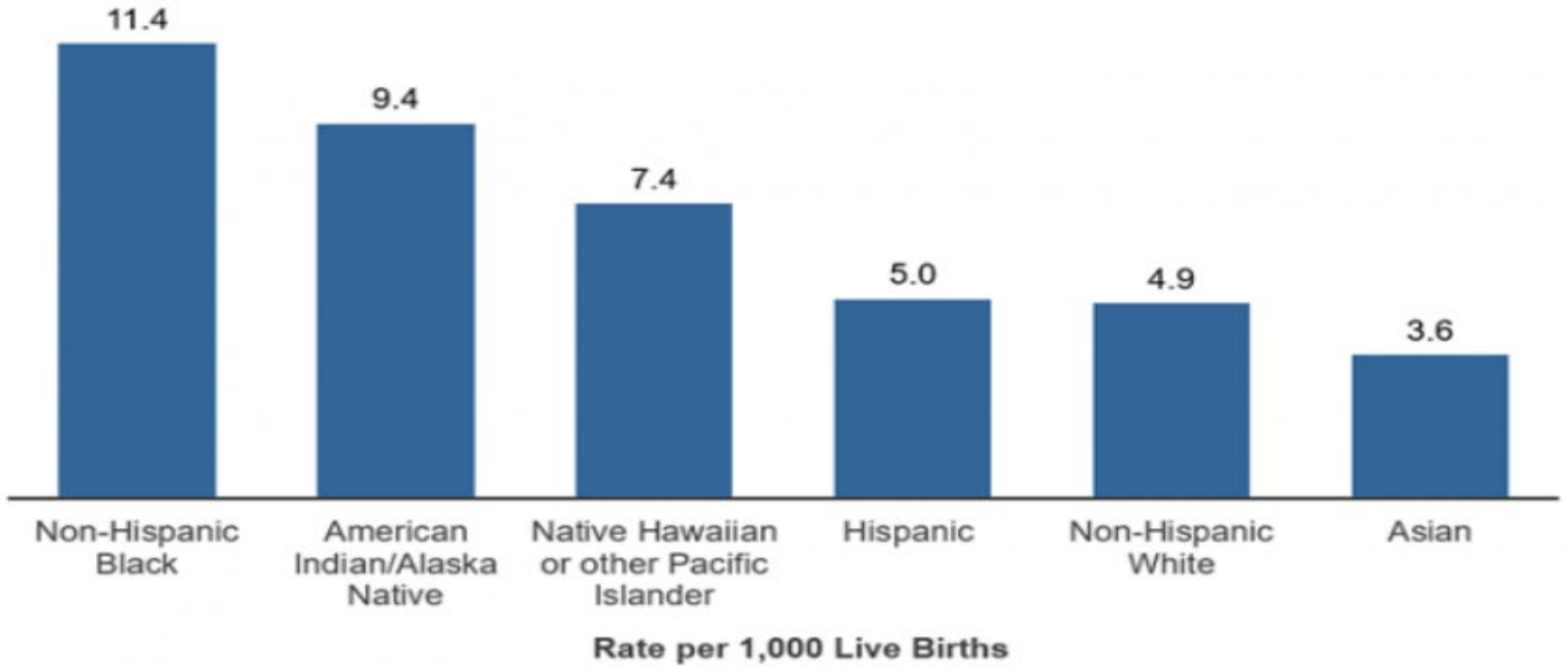
- Prenatal growth critical for lifetime health
  - Formation of cells, organs, tissues impacted by maternal health, behavior, care & nutrition, genetic, environmental exposures
- Poor socio-economic environment in early life increases risks to health through interaction of negative environmental factor and developmental processes
  - Maternal low-education/literacy, unhealthy behaviors, inadequate parenting skills & unhealthy behaviors
  - Impacts child development, physical, psychosocial, cognitive growth & development

Impact of SDH on Children

- **Income:**
  - In 2015, 14.5 million or approximately 20 percent of children in the U.S. lived in poverty.
- **Food Insecurity:**
  - 13.1 million children lived in food-insecure households in 2015
- **Nutrition:** compared to their peers in food-secure families, food-insecure children under age 3 are:
  - 90 percent more likely to have fair or poor health rather than good or excellent health
  - 31 percent more likely to spend time in the hospital
  - 76 percent more likely to have problems in cognitive, language, and behavioral development
- **Homelessness:**
  - about one in 30 American children was homeless at some point last year. That's about 2.5 million kids, and an **8 percent** increase to "an historic high," according to the study from the National Center on Family Homelessness. Just over half are younger than six years old. (2014)

Frontline PBS: Poor Kids, 2012, Urban Child Institute, Robert Woods Johnson Foundation

Infant Mortality Rates by Race and Ethnicity, 2016



*Source: p. 80 of the User Guide to the 2016 Period Linked Birth/Infant Death Public Use File [PDF – 1.25MB]

What gets in the way of screening for and addressing SDH?

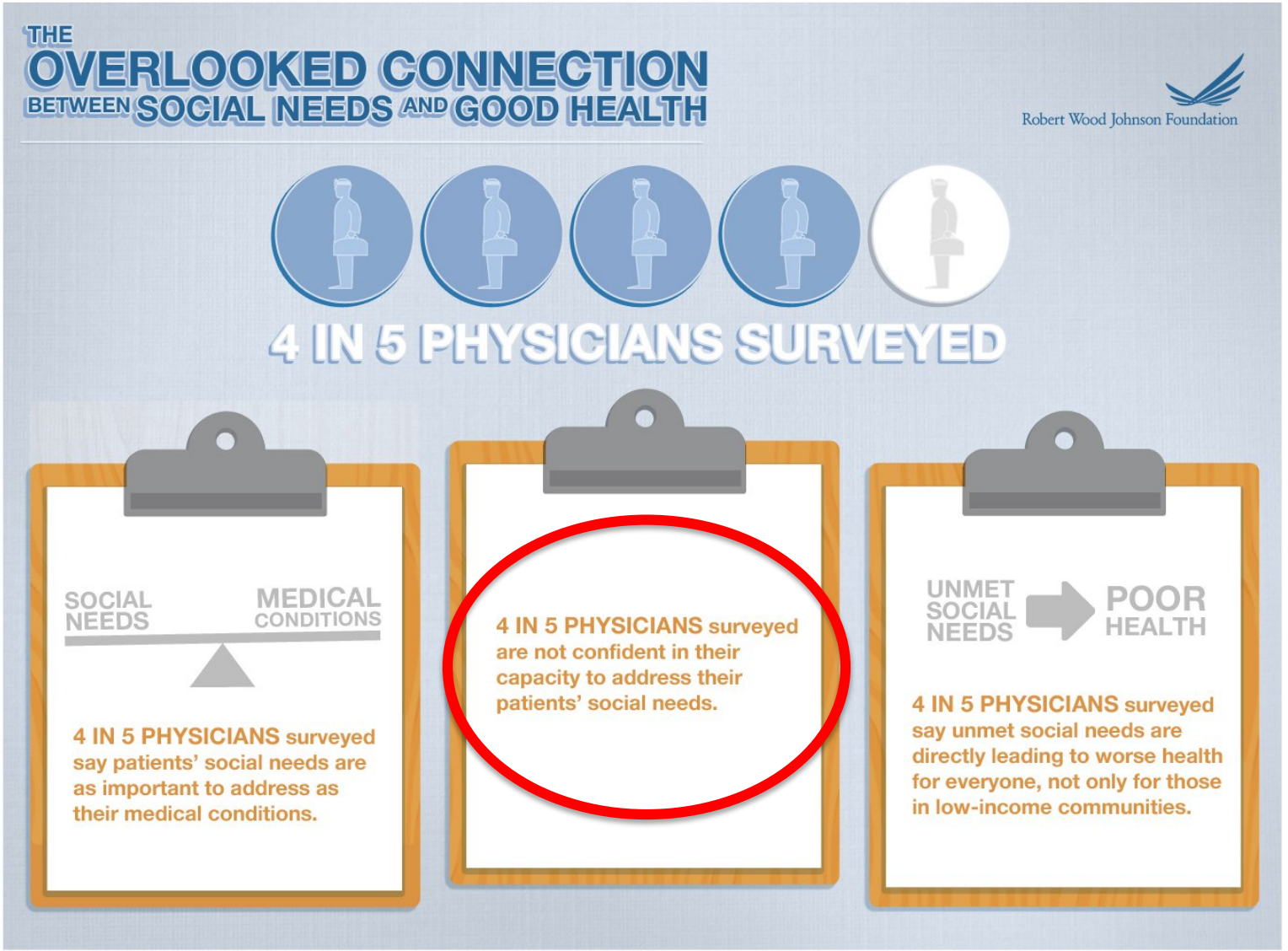
At the individual/clinician level?
At the organization level?
At the societal level?

Individual/Clinical Level

Are we comfortable with asking about:

- ❑ Income
- ❑ Insurance status
- ❑ Public benefits
- ❑ Safe and healthy housing
- ❑ Literacy or education levels or needs
- ❑ Immigration/legal status and challenges
- ❑ Domestic violence

Why or why not?



Source: Robert Wood Johnson Foundation. (2017). Health Care's Blind Side. Retrieved from https://www.rwjf.org/en/library/research/2011/12/health-care-s-blind-side.html

Many providers will say…Why ask when we don't have this…

Pandora's Box Effect

- A business case/funding for resources to address SDH
- Lack of referral networks and pathways to services

BUT…

- Informed clinical decision-making
- Understanding of the Theory of Accompaniment
  - Just asking helps!

Org. Level Implementation Challenges

Accessing SDH Data

- To encourage review of an individual's SDH data, associated review tools should be easy to find in the EHR.

Acting on SDH Data

- Staff are not trained to screening and address SDOH
- Strategies for SDH referral-making may need to address factors such as: (i) the difficulty of keeping community resource information up to date in the EHR, (ii) the need for unfamiliar competencies from non-clinical staff tasked with making these referrals, and (iii) the difficulty of tracking referral outcomes, since referral follow-up is usually by patient self-report.
- Referral 'closure' rates can be a reported quality measure, so it is necessary to enable formally 'closing' SDH referrals / noting them as 'no follow-up needed.'
- Standardized SDH screening using EHR tools may serve as a prelude to a richer conversation with the patient, to hone in on how to most effectively provide support; e.g., staff may want to know if an identified SDH need is a priority.

What you can do!

- Use data and team huddles to keep discussing SDH needs and inform continuous quality improvement to improve approaches to addressing it
- Remind providers that assessing and addressing social determinants of health leads to better pt/dr relationships and health outcomes
- Participate in community teams and bring information back
- Talk often of whole health/wellness

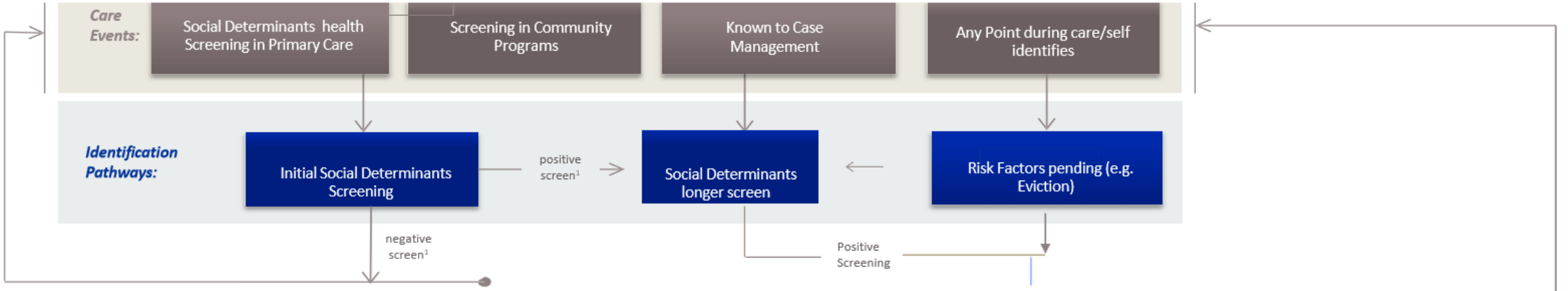
What you can do!

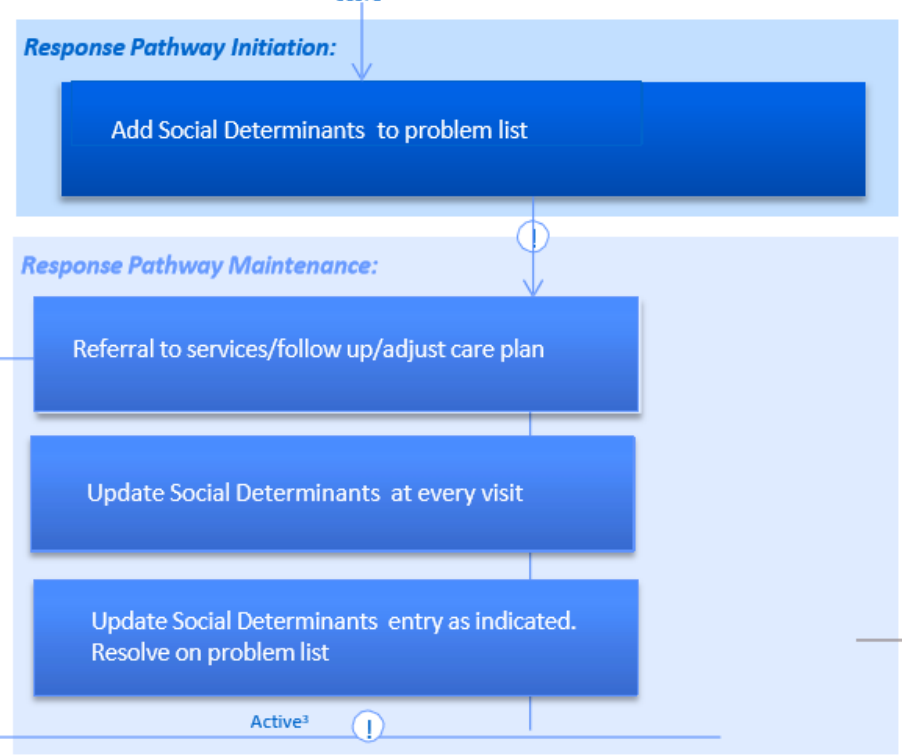
- Encourage use of ACES and other measures that get at social determinants of health
- Code for social determinants of health to build a business case
- See this as an opportunity to leverage value-based approaches
- Take care of yourself

Assessing for social determinants:

- Are there standard questions in your EMR?
  - Standardization is important, just as we do universal screening for mood and SUD we need to use standard questions for assessing SDOH?
  - Without this you can't track, count, compare
- Can you put the questions in a broader context for the person you are interviewing?
- Do you have a pathway for response?

Social Determinants of Health Pathway





Social Determinants H Diagnosis Code (ICD-10)
Education issues
Z55.0 Illiteracy and low-level literacy
Z55.9 Problems related to education and literacy, unspecified
Employment issues
Z56.0 Unemployment, unspecified
Z56.9 Unspecified problems related to employment
Economic hardship - Housing Issues
Z59.0 Homelessness
Z59.8 Other problems related to housing and economic circumstances
Z59.1 Inadequate housing
+ Z77.120 Contact with and (suspected) exposure to mold (toxic)
+ Z77.011 Contact with and (suspected) exposure to lead
+ Z77.22 Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
Economic hardship - Food Insecurity
Z59.4 Lack of adequate food and safe drinking water
Economic hardship – Other basic needs
Z59.7 Insufficient social insurance and welfare support
Z91.120 Patient's intentional underdoing of medication regimen due to financial hardship
Z75.3 Unavailability and inaccessibility of health-care facilities
Issues with independent living
Z60.2 Problems related to living alone
Caregiving needs
Z63.6 Dependent relative needing care at home
Issues with primary support group
Z63.7 Other stressful life events affecting family and household
Z63.8 Other specified problems related to primary support group
Legal Issues
Z65.2 Problems related to release from prison
Z65.3 Problems related to other legal circumstances
Violence/Safety
Z91.41 Personal history of adult abuse
+Z63.0 Problems in relationship with spouse or partner

Note: While ideally all detected Social Determinants H diagnosis should go in the claim, we recommend a concerted effort to always include food and housing insecurity and of skipping medication due to cost through inclusion of these codes in the claim any time it is identified.

ICD 10 Coding for Disparity & Social Determinants

Problems related to education and literacy

Code	Social Determinant
Z55.0	Low level of Literacy
Z55.1	Unavailable schooling
Z55.2	Failed Examinations
Z55.3	Underachievement in School
Z55.4	Educational maladjustment and discordwith classmates and/or teachers
Z55.8	Other problems related to education and literacy

Problems related to employment and unemployment

Code	Social Determinant
Z56.0	Unemployment, unspecified
Z56.2	Threat of job loss
Z56.3	Stressful work schedule

Problems related to housing and economic circumstance

Code	Social Determinant
Z59.0	Homelesss
Z59.1	Inadequate housing
Z59.4	Lack of adequate food
Z59.5	Extreme Poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances

Problems related to social environment

Code	Social Determinant
Z60.0	Problems of adjustment to life-cycle transitions
Z60.1	Atypical parenting situation - problems related to a parenting situation
Z60.2	Living Alone
Z60.3	Acculturation Difficulty
Z60.4	Social exclusion and rejection/ Isolation
Z60.8	Other problems related to social environment

Problems related to negative life events in childhood

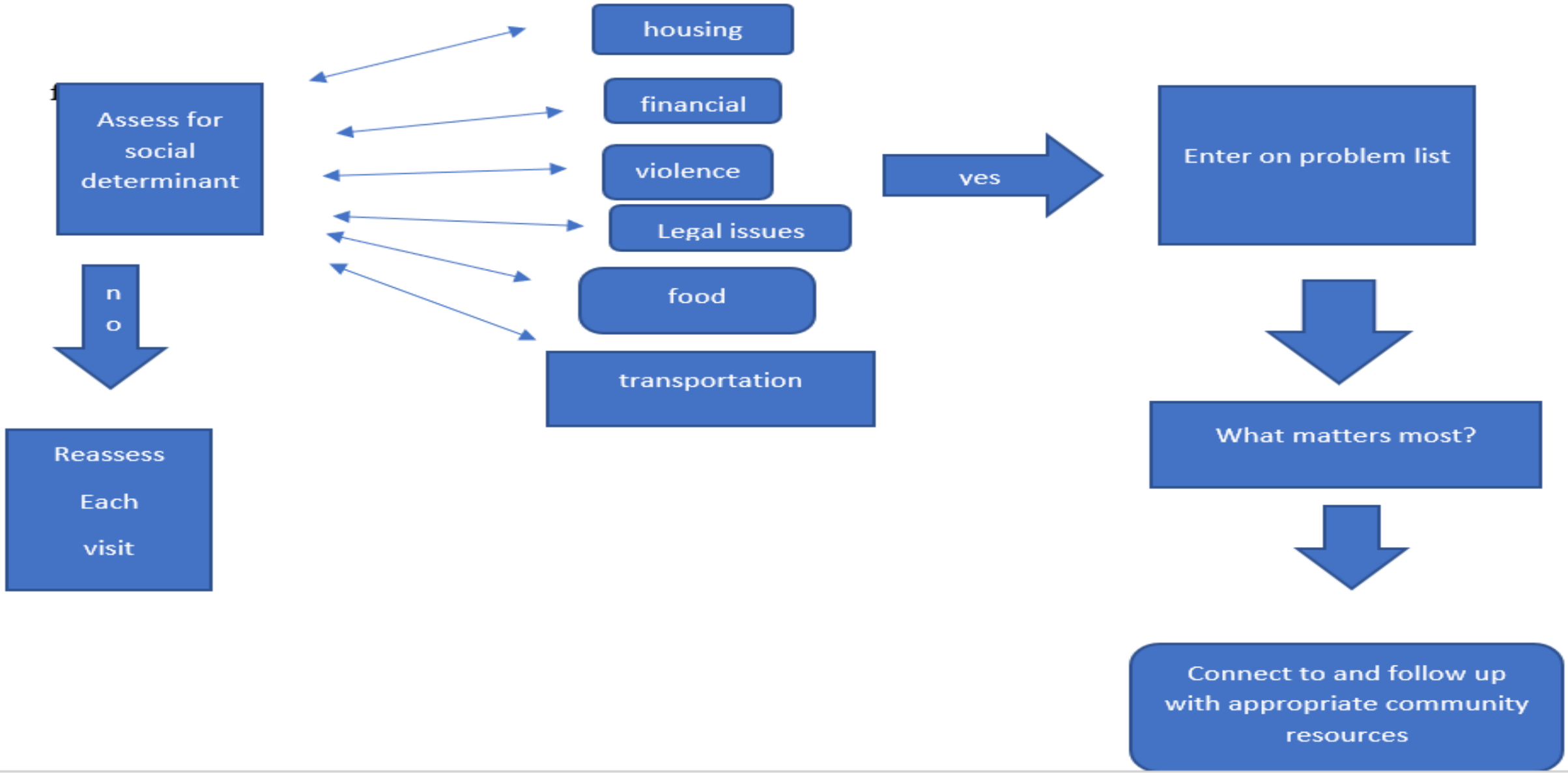
Code	Social Determinant
Z61.1	Removal from home in childhood
Z61.4	Problems related to alleged sexual abuse of child by a person within primary support group
Z61.5	Problems related to alleged sexual abuse of child by a person outside primary support group
Z61.6	Problems related to alleged physical abuse of child
Z61.8	Other negative life events in childhood
Z62.0	Inadequate parental supervision and control
Z62.2	Institutional upbringing
Z62.4	Emotional neglect of child
Z62.5	Other problems related to neglect in upbrining

Other problems related to primary support group, including family circumstances

Code	Social Determinant
Z63.0	Problems in relationship with spouse or partner
Z63.2	Inadequate family support
Z63.4	Disppearance/death of a family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.7	Other stressful life events affecting family and household
Z63.72	Alcoholism and drug abuse in family

Problems related to psychosocial circumstances

Code	Social Determinant
Z64.0	Problems related to unwanted pregnancy
Z65.0	Conviction in civil and crimminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to relase from prison
Z65.3	Problems related to other legal circumstances


Assess for social determinant
housing
financial
violence
Legal issues
food
transportation
yes
Enter on problem list
What matters most?
Connect to and follow up with appropriate community resources
no
Reassess Each visit

Moving beyond the problem list to the priorities

- SDOH are often interconnected
- Our priority as care providers may not be the priority of the patient or family
- Understanding context is key
- Asking “what matters most to you” is critical.

Moving beyond referrals to connections: coordination is a 360 degree, team based process

- Assess level of need:
  - Knowledge: does this person know what to do?
  - Skill: do they have the ability to do it?
  - Attitude: do they have the confidence, hope, belief to follow through?
- Develop a tracking system/registry
- Involve BHP when things aren't working
- Inform the team when things have changed
- Close the problems in the EMR/registry
- Celebrate success!!!

The Role of Community

- We can’t do it all alone inside the health care system
- SDHs impact the health outcomes of our patients
- So we need to impact SDHs!
  - Through partnerships with resources in our communities

Communities can be the source of sustainable, meaningful change in individual lives, systems of care and a catalyst for policy change.

Our Community Teams

Diverse
Cross Sector
Responsive

- Housing
- Public Health System
- Home Visiting
- Nutrition Assistance Programs (SNAP, WIC, etc.)
- Childcare
- Child and Family Services
- Economic Security
- Education
- Employment

- Legal Services
- Parenting Resources
  - Respite care, physical goods, parenting classes
- Religious organizations
- Social Supports

Who / what else?

Community Teams

Activities of Community Team Members

- Provide resources/information/services needed to clients
- Bring information/data to the table

Activities of the Community Team

- Meet to share information
- Provide mutual aid
- Link one another to resources needed
- Identify resource gaps in the community
- Define shared goals and plans together
- Raise awareness of perinatal health issues and services available in the community

How do I find my community team?

Identify Key Stakeholders

You probably already know many of these folks and organizations!

If you don't though, fear not

Identify Existing Resources

Is there a community resource guide already in existence?

Begin **relationships** with stakeholders

How do I find my community team? (cont.)

Convene Stakeholders

Logistics: Establish a regular meeting time, allow for virtual attendance

Relationships!

Expand Your Table

Ask your community partners as you establish them, “Who do you think is missing at our table? Who do you work with regularly?”

Ask your clients

How do I get my clients to accept community referrals?

Follow

Follow Your Clients

Be client centered.

Trust in their expertise in their own lives

Lead

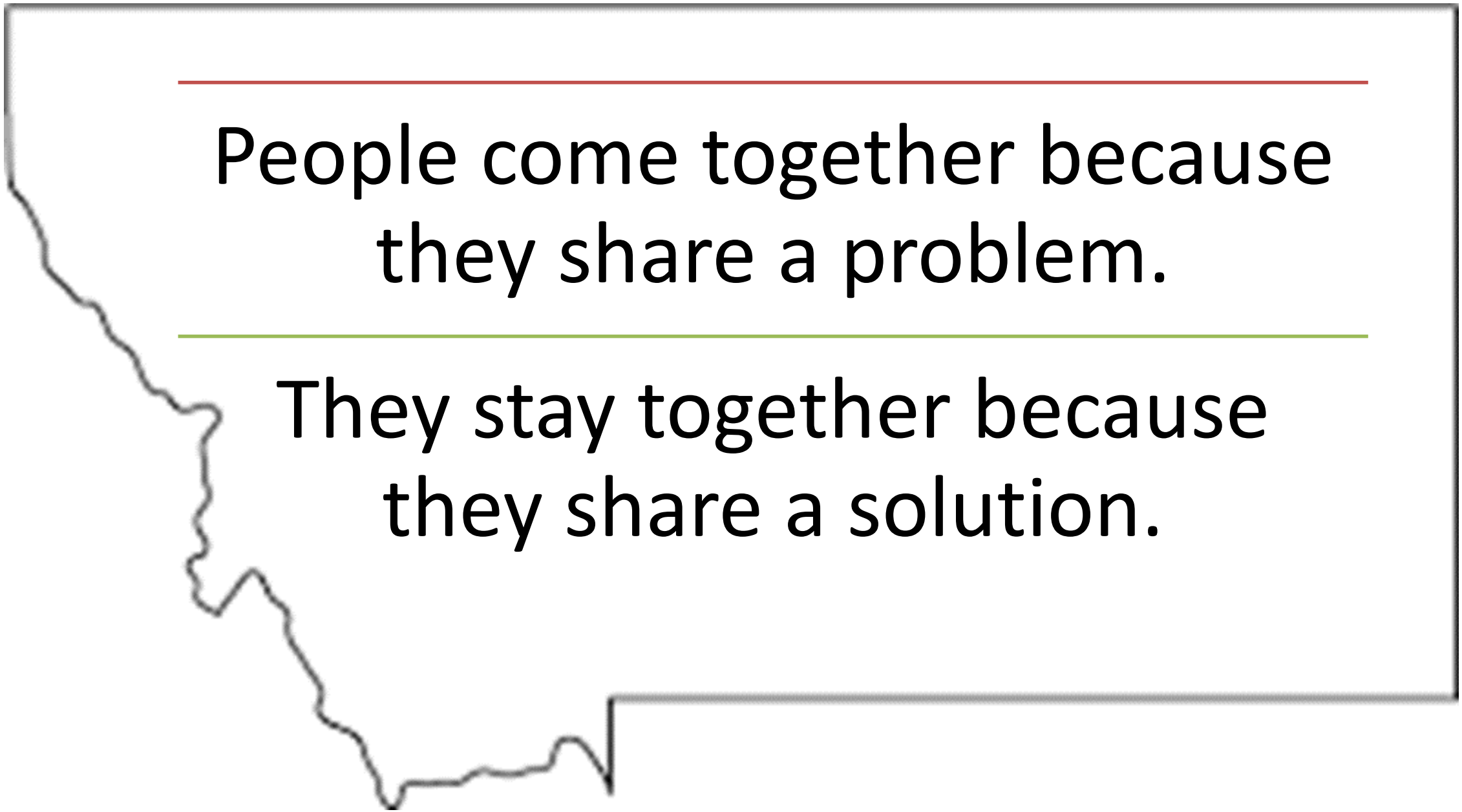
Lead Your Clients

When clients deny needs or referrals, know that offering and educating may be all you can do.

Inform

Inform Clinical Team

When clients resist referrals use your team to provide psychoeducation and build a space for clients to ask questions of every team member



People come together because they share a problem.

They stay together because they share a solution.

Resources

- California Newsreel (2008) Unnatural Causes
  - Documentary series about health inequity including video clips and discussion guides
- Center for Health Care Strategies, Inc. (2017) Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations
- Centers for Medicare and Medicaid Services (2017) Tools for Putting Social Determinants of Health in Action
- National Center for Medical-Legal Partnership
- **Health inequity: America's chronic condition?** -Esteban López, M.D. See: https://www.youtube.com/watch?v=56ZKfSNkcJc