Public Meeting Notice

Please note this meeting is open to the public and is being recorded
Anything said during this meeting may be part of the public record

Building Enhanced Referral & Care Compact Relationships - Improving Outcomes Through Effective Collaboration

Learning Objectives

During the training, participants will:

- Identify elements of enhanced referral and learn specific steps to build enhanced referral networks.
- Discover the lessons learned in the Douglas County Mental Health Initiative Adult Care Compact and how this is informing design of the child/youth care compact.

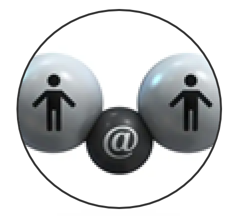
Following the training, participants will be able to:

- Describe best practice approaches in building a care compact for individuals with complex needs.
- Distinguish components of effective collaborative partnerships and use this to build and inform coordination of care as well as development of care compacts.
- Apply tangible steps for engaging partners and patients in the referral process including determining the continuum of collaboration and shared treatment needed.

Enhanced Referrals

For Improved Outcomes and Provider Partnership

Continuum of Partnership for Improved Care



Standard Referral

- Referral through phone, email or discharge paperwork
- Often in hands of client
- Providers may or may not know each other well
- Understanding of services are minimal to moderate

Enhanced Referral

- Proactive and planned collaboration between providers
- Service knowledge is detailed
- Shared treatment planning/tracking of progress
- Workflow for referral is pre-set by partners
- Engagement of individual is high

Care Compact

- Proactively developed partnership across agencies
- Specific goals and purpose for partnership with an identified population
- Processes for shared work including clear roles and responsibilities created ahead of time
- Communication and
- Shared data through agreements and platforms

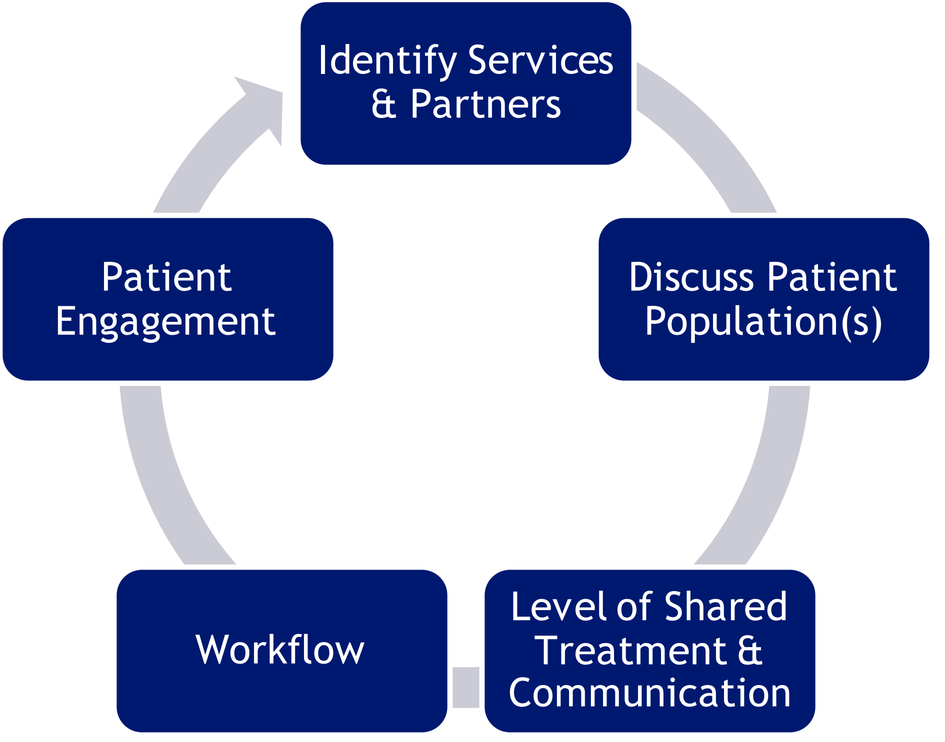
What is Enhanced Referral?

- Proactive partnership development for shared treatment
- Practices work together to fill treatment gaps through planned referral relationships
- Identify partners with complementary services for better outcomes
- Defined population for referrals
- Degree of shared treatment can vary on a continuum

What is Benefit to Providers?

- Proactive referral relationships for known gaps or needs to meet needs—reduces referral gaps
- Pre-determined and planful processes for successful referral simplifies the process & saves time
- Communication with partners rather than gaps in patient's care which makes care easier and higher quality
  - Cross provider team planning
- Potential for sharing outcome data
- Build your referral network to grow your practice

Building Effective Enhanced Referral Relationships



Identify Services and Partners

- Consider frequent patient needs or services that are not delivered within your organization
- Consider services that would expand impact and improve patient health that are frequent referral needs
- Consider partners that you frequently refer to already
- Once you identify partners, meet to understand each other's services in detail

Shared Patient Populations

- Learn about shared populations
- Learn about populations that you may serve that are different
- Explore specific areas of expertise with partners and how skills may support treatment options
- Consider whether you will focus on particular shared populations for referral

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Discuss the Level of Shared Treatment and Communication

Shared Referral Form

- Level 1 shared treatment
- Create shared referral form that has pre-set information and tailored elements for referral back and forth
- Referral form meets the needs of both partners and streamlines referral
- Build understating of each organization's referral process

Consultation and Treatment Planning

- Level 2 shared treatment
- Consult with one another via phone to discuss patients or discuss questions and gain from each other's expertise
- Shared treatment planning around shared patients to inform interventions, treatment strategies and discussion of how to improve care and what's not working

Outcome Measurement

- Level 3 shared treatment
- Share data with one another on shared clients to improve care
- If using measurement-based care, share data and work together to reach treatment targets or benchmarks

eneration Workflow Template

nes patient
s referral

Generates referral order

Generates encounter documentation

Receives
Care doc
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Patient receives referral

Contacts specialty provider for appointment

Receives referral order

Obtains insurance authorization, if needed

Generates referral

Routes
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Generate Summary of Care Document

Send referral documentation via eExchange, secure email, faxing, or printing

Rec
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specialt

Receives referral documentation

Schedules appointment

Provides specialty service(s) to patient

Generates encounter documentation

Genera
Summa
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Discuss Shared Workflow

- Each organization has a workflow for referrals which needs to be outlined and clear to the other partner
- Partners need to work together to outline the steps between organizations to support an effective referral
- Ensures that each organization knows the steps and process and there is a standardized process (part of what makes this enhanced and elevates outcomes)
- Determine whether the workflow can include a warm handoff

Patient Engagement is Key

- Explain rationale for referral and how it aligns with treatment goals
- Share information about the partner and the referral process and what will happen—outline the steps, timelines and expectations
- Where possible engage in warm or cool handoffs rather than cold handoffs
- Explore barriers or challenges to referral and address with the patient
  - Insurance barriers
  - Time
  - Concerns (transportation, fear of treatment, etc.)
- Focus on guiding rather than convincing and use motivational interviewing skills
- Identify any administrative barriers and work on solutions in partnership with the patient and family members

Role of the Managed Care Entities in Enhanced Referrals

- Elevate the concept of enhanced referral across networks
- Support providers in identifying partners where enhanced referral could support gaps in care and outcomes
- Review data on provider organizations with complementary skills and shared populations
- Technical assistance in how to build enhanced referral networks

Memorandum of Agreement and Technology

Memorandum of Agreement

- Formalize the partnership and describe the roles of each partner and expectations of the relationship
- Incorporate a data sharing agreement for treatment consultation and shared outcome data

Technology

- Consider how to leverage technology to support referral process
- Can interoperability between electronic health records support referrals?
- Shared data, registries or dashboards and outcomes through technology?

Exercise: Consider Enhanced Referral Needs for Approach to Care

What are the types of services that you commonly need a referral partner to address (e.g., mental health or substance use, primary care/medical needs, housing, food, or clothing)?

Do you have existing relationships for referrals for these needs?

Do you know the sources of referrals to your practice/agency (e.g., who are your prime referral sources and who else should be referring to you because you offer a complementary service)?

What new referral relationships would you like to develop and why? (i.e., how will this relationship improve care for your patients? how will this relationship create opportunities to provide your services to other patients that need them?)

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HEALTH MANAGEMENT ASSOCIATES

Care Compact

What is it? Who is it for? How does it work?

What is a Care Compact?

- Collaborative agreement between agencies
- Clearly defines:
  - who is responsible for care
  - how it's delivered
  - what clinical information is shared
- Short-term case management/care coordination
- Information sharing:
  - Health Information Exchange
  - BAA for data sharing (when appropriate)
- Workflow elements:
  - Specific referral forms
  - Preferred communication
  - Designated individuals
  - Shared treatment plans

Care Compacts: When and Why

When

- Person in multisystem of care
- Collaborative care planning is needed
- Support high-risk populations
- Safe transition of care between providers is needed

Why

- Enhance coordination
- Streamline care
- Reduce duplication of services
- Holistic approach
- Empower and engage
- Increase efficiency
- Address systemic barriers
- Reduce/Divert high risk acute care utilization

Reduce the gaps and cracks in care and support individuals in achieving better outcomes

Degrees of Care Compact

- Population size
- Complexity of needs
- Available resources
- Geographic considerations
- Collaborative partnerships

Stock Photo by Cameron Casey

Key Components & Considerations

- Clearly defined roles
- Identified client population
- Criteria for determining lead partner
- Consent
- Information sharing agreements

Stock Photo posed by models

Communication and Operational Considerations

- Clear communication protocols
  - Designated contact person per partner agency
- Regular interdisciplinary meetings
  - Feedback mechanisms
  - Continuous quality improvement
- Use of technology
  - Information sharing (e.g., EHR)
- Standardized care coordination tools
  - Referral form
  - Care plan
  - Documentation templates
- Timely information sharing
- Crisis response protocols

Engagement & Consent

- Informed Consent
- Privacy Protection
- Empowerment and Education
- Inclusion in Care Team
  - Care planning meetings
  - Involvement in Decision-Making
- Youth Considerations
  - Developmental considerations
  - Youth-friendly approaches
  - Family involvement
  - Youth buy-in

Disabled And Here Photo by: Chona Kasinger

Measure & Evaluate Effectiveness

Clinical

- Outcome Measures
- Process Measures
- Healthcare Utilization

Stakeholder

- Feedback
- Satisfaction Measures

Impact

- Cost-Effectiveness
- Population Health Outcomes

How Emergency Departments Inform Care Compacts

- Coordination and Referrals
- Case Management
- Integration of Services
- Patient Education and Empowerment
- Advocacy and Support

Stock Image: Posed by Models

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Exercise: Collaboration Among Providers

- How do you experience collaborative care?
- When coordinating care across multiple health providers, what are your preferences or priorities?

Douglas County, Colorado

The Care Compact (TCC) & Youth Care Compact (YCC)

An Approach to Care Compacts: Douglas County

November 2021

What Brought the Need for a Care Compact?

Douglas County Co-Responder model designed for crisis intervention, stabilization, short-term case management

- Care Compact as next ring of support

Complex cases often involved multiple systems of care and support, not always coordinated. Falling through the cracks.

Long-term, sustainable solutions needed

Goals & Objectives within the DCMHI's Blueprint for a Community-Based Mental Health System

- Create a Networked System of Care
- Enhanced Referral
- Improve care coordination for complex needs
- Increase the peer workforce

The Care Compact (TCC) Model

Intensive case management program **serving adults (18+) with complex mental health, substance use disorder, intellectual and developmental disability (IDD) and safety net needs** (housing/shelter, food, clothing, cash assistance, insurance, long term care, etc.).

Links existing case management and care coordination service providers through a streamlined network.

14 Community Partners:

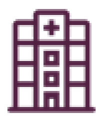
Hospitals, Substance Use services, IDD/Single Entry Point services - waivers, Community Mental Health Center, Regional Medicaid, County Government (Human Services, Administration, County Attorney, Community Development), Detentions, Probation, Courts).

The Care Compact (TCC) Model - Goals

Reduce duplication of services

Improve transitions between levels of care

Ensure fewer gaps in treatment



Reduce interaction and dependence on crisis, emergency and inpatient levels of care

Improve health and quality of life outcomes

The Care Compact Model

- Population caseload
- Work closely with individual and align with person-centered goals
- Navigator and lead provider(s) guide care team
- Regular facilitated team discussions
- Partners coordinate across systems
- Work closely with RAE when Medicaid patient
- Coordinate with DC Government (Attorney, Human Services, Community Development, etc.)
- Track data in a registry
- Document in Julota (shared case management system)

Criminal Justice, Jail
In-patient settings
Case Manager/ Peer Recovery Coach
Co-Responders
First Responders
Crisis System
SUD/MH
Primary Care
IDD
RAE
Justice System, Courts
Housing
Faith Community
Food security and other safety net domains
Case Manager/ Peer Recovery Coach
Lead Provider/ Coordinator
Care Compact Navigator
Client/ Patient

The Care Compact Model – Infrastructure

Interagency Memorandum of Understanding (MOU)

- The collective agreement between partners detailing the guiding principles of TCC, the roles and responsibilities of each organization, and the program scope of work

Universal Release of Information (U-ROI)

- Streamlines information sharing between partners working with mutual clients
- Eliminates barriers to gathering multiple releases for each agency

Business Associates Agreements (BAA)

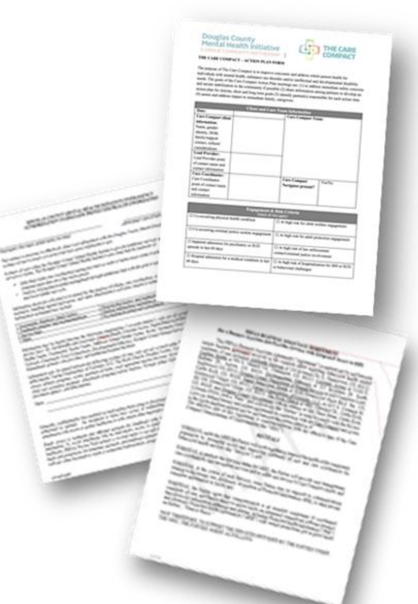
- Addresses the handling of protected health information to ensure compliance with privacy and security requirements

Shared Referral Form

- Identifies current engagement in other systems and known risk factors
- Highlights individual needs, cultural considerations, and client-centered goals
- One form shared by partner agencies; distinct form for individuals/families/caregivers

Meeting Action Plan - Facilitation Structure

- Guides the creation of a shared treatment/care plan for clients which prioritizes addressing immediate safety concerns, identifying risk factors, and securing stabilization in the community
- Identification of lead provider and eliminating duplicative work
- Assigns goals and next steps to participating care coordinators/providers



Key Collaboration – How TCC Works With Co-Responders

Ongoing, intensive, coordinated case management for most complex cases

Collaborate on pick-up orders, community-based crisis assessment and follow-ups for shared clients

CRTs are the No. 1 referring party

TCC is next ring of support around Douglas County's Community Response Teams (CRT)

Other Co-Responder/Paired Response Collaborations

- Douglas County Homeless Assistance Engagement Resource Team (HEART)
- The Dyad – Case Manager and Peer Recovery Specialist team

Lessons Learned and Effective Strategies That Have Emerged

Dedicated Points of Contact: Leadership, middle management (Operations Leads), and case management (i.e., Care Team Leads)

Identifying Care Plan Priorities: Intentional flexibility to include client-centered goals and safety/stability needs (e.g., addressing acute crises first and addressing unmet basic needs)

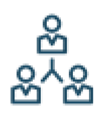
Individualizing Approaches (sometimes less is more); adaptive strategies to improve access to care

Learning Limits of roles & scopes of service within partner organizations, while improving quality of care and creating accommodations when necessary

Programming Innovation to address gaps and improve engagement: DYAD case manager & peer (hands-on, community-based support); Civil MH Court

Outcomes and Impacts

How is TCC Making a Difference?



150 Referrals

119 Client Enrollments

495 Service Connections

1818 Partner Interactions

Of those with Housing Needs (at-risk of homelessness or currently homeless), TCC helped to **sustain existing housing or secure new housing for 59% of clients.** Of that 59% who met their housing need:

32% Sustained Existing Housing

System Process Improvements

Streamlined connection to services and reduction in barriers to intake

Improved communication and collaboration between partners

Smoother transitions of care (between levels and agencies)

December 2020 – February 2024

The Care Compact: Impact and Outcomes

Client Demographics	
Gender	63% Male 35% Female 2% Non-binary
Income	65% SSI/SSDI 21% Unemployed 6% Trust/Inheritance/ Natural Support 6% Unknown
Age	21% 18-25 31% 26-40 29% 41-55 19% 56-74
Insurance Type (Primary)	92% Medicaid 6% Medicare 2% Private

December 2020 – February 2023

Diagnosis/Needs	% of Clients w/Housing Need
Mental Health	100%
Substance Use Disorder	35%
Intellectual & Dev Disability	31%
Traumatic Brain Injury	27%
Co-Occurring Conditions (2+ of the above)	65%

Emergency System Utilization	Pre-TCC	3 mos. Post-TCC	6 mos. Post-TCC
LE Contacts	34	0	0
ED Transports	19	1	0
CRT Responses	15	0	0

The Youth Care Compact (YCC)

Development and Pilot Scope

- Payor blind model, complementing existing care coordination efforts that exist for youth, intentionally designing the program to not duplicate efforts but work in-sync or fill a gap for underserved youth and their families
- Family system approach
- Tailoring approach to accommodate youth engagement, parent engagement, based on age and legal age of consent to treatment
- Focused on school-aged children and youth (5-17) with multi-system involvement or co-occurring needs

New/Different Partners

- Douglas County School District
- Juvenile Assessment Center
- Collaborative Management Program
- The Family Center of Douglas County
- Children's Hospital of Colorado

Costs and Funding

County General Fund

- Care Compact Administrator (Adult)

County American Rescue Plan Act (ARPA)

- Dedicated case management at partner agencies
- Client flex funds

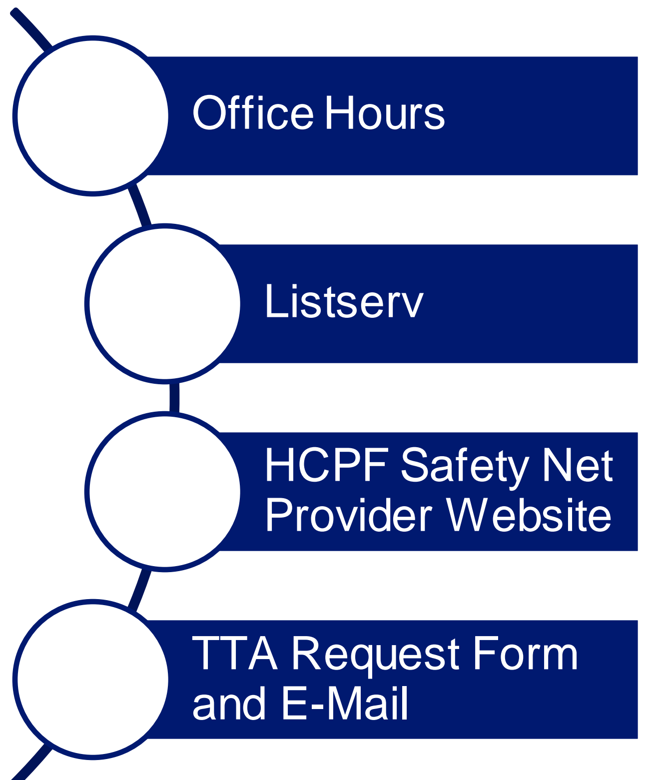
Grant Funding

- Youth Care Compact development and staff
- Community-based peer recovery specialist/case manager dyad proof of concept

To better inform our future trainings as well as request topics for office hours, please complete this short survey. Use the QR code or short URL to access it. Your feedback is important. Thank you!

https://bit.ly/bhprovidertrainingsurvey

Appendix A: Additional Resources



Last Friday of the month @ 12pm MST
May 31, 2024- Register here
June 28, 2024- Register here

Join the Listserv to receive notifications of trainings, technical assistance, and other stakeholder engagement opportunities: Register Here

Visit the website for details on upcoming training topics and announcements, training recordings and presentation decks, FAQs and more: https://hcpf.colorado.gov/safetynetproviders

Request TTA support or share your ideas, questions and concerns about this effort using the TTA Request Form or e-mail questions and comments to: info@safetynetproviders.com

Appendix B: References

- Colorado Systems of Care/Patient Centered Medical Home Initiative: Colorado Primary Care – Specialty Care Compact.
- Douglas County Mental Health Initiative (DCMHI) https://www.douglas.co.us/mental-health/mental-health-initiatives/
- Douglas County, Colorado: The Care Compact https://www.douglas.co.us/mental-health/mental-health-initiatives/care-project/
- Stock Photos: Affect The Verb https://affecttheverb.com/gallery/disabledandhere/meetinglistening/
- Adding Mental Health Responders to 911 calls is saving lives and reducing suicides https://www.youtube.com/watch?v=Pavr4VdpnUk
- Health Management Associates. Blue Print for a Community-Based Mental Health System in Douglas County. Prepared for The Douglas County Mental Health Initiative https://www.douglas.co.us/documents/blue-print-for-a-community-based-mental-health-system-in-douglas-county-prepared-by-health-management.pdf/?autosuggest-term=blue%20print