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HEALTH HOME INNOVATION FUND:

STRATEGIES AND MODELS FOR CARE COORDINATION AND COMPLEX CARE MANAGEMENT

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Introduction

National health reform and California's 1115 Waiver have accelerated practice transformation efforts in the health care system. The Patient Protection and Affordable Care Act (ACA) encourages and supports the implementation of Patient Centered Medical Homes (PCMH), or "health homes" to promote and improve care coordination and comprehensive case management in local health care service delivery. The ACA also expands health care coverage to a broader population, including people with complex, high cost health care needs, who can benefit from improved care coordination and care management.

Definitions and Distinctions Between Care Coordination and Care Management

- **CARE COORDINATION:** The goal of care coordination is to improve the appropriateness, timeliness, and efficiency of clinical decisions and care, thereby improving the overall quality of health care. Care coordination involves the transfer of information across providers to establish accountability for each aspect of a patient's overall care.
- **CARE MANAGEMENT:** The goal of care management is to improve patients' functioning and health status, and enhance care coordination, eliminate service duplication, and reduce utilization of costly medical services, such as ER and hospital readmissions.
- **COMPLEX CARE MANAGEMENT:** Complex care management is a more intensive intervention that targets the most complex, high acuity patients with multiple chronic medical conditions, limited functional status, psychosocial needs, and other social concerns.

Initiative Overview

Launched in 2011, the Health Home Innovation Fund (HHIF) supports partnerships among safety net institutions to build patient-centered, integrated systems of care and explores options for payment reform to sustain health home implementation. In partnership with The California Endowment, the Center for Care Innovations (CCI) funded eight geographically diverse collaborative projects for two years to facilitate health home transformation. The strategies and activities to transform systems of care vary by collaborative, but all grantees applied the resources and flexible funding available through this grant to implement complex changes and learn through experience, what it takes to prepare for a new health care environment.

This brief summarizes the strategies three HHIF collaborative projects implemented to address the needs of patients with complex and chronic health conditions. We highlight the implementation experiences, including accomplishments and challenges, lessons learned, effective components of the various models and plans for sustainability.

Featured Programs

- Redwood Community Health Coalition/Partnership Health Plan - Intensive Case Management Pilot Program
- San Francisco Community Clinic Consortium/San Francisco Health Plan - Complex Care Management & Delegated Care Support Program
- Health Improvement Partnership of Santa Cruz County- Central CA Alliance for Health - Health Navigator Program

Three Examples of Care Coordination and Complex Care Management

The three HHIF grantees featured in this brief focused their grant activities on care coordination, health navigation or complex care management interventions for low-income, complex, chronic patients. Although each program implemented different strategies to address the needs of this complex population, all 3 programs shared several core elements.

- Patient identification and outreach based on risk/need
- Patient engagement
- Designated “care home” and personalized care plan
- Service integration
- Provider supports
- Information exchange across providers and systems
- Performance measurement and accountability
- Financial incentives aligned with quality care

1. Redwood Community Health Coalition & Partnership HealthPlan of CA: Intensive Case Management Pilot

The Redwood Community Health Coalition/Partnership HealthPlan (RCHC/PHC) Collaborative is testing the effectiveness of different models of intensive case management at three health clinics participating in the Intensive Case Management Pilot:

- Contracted services model – clinic hires, trains, and supervises the case manager
- Embedded model – health plan hires and supervises a case manager who is embedded in the clinic

The models being tested vary across the three clinics sites participating in the Intensive Case Management pilot program. Two clinics are implementing different versions of the

3 Models of Intensive Case Management

1. Complex patients are managed by one dedicated care team (Dedicated model)
2. Complex patients are spread across all care teams in the clinic (Diffuse model)
3. Complex patients with co-occurring mental health and substance use conditions are targeted and managed by a health plan employee who works onsite at the clinic (Embedded model)

contracted services model where one assigns a dedicated care team to identified patients, while the other spreads identified patients across multiple care teams. The clinic implementing the embedded model differs from the other clinics by targeting case management services to patients with co-occurring mental health and substance use disorders, in addition to chronic health conditions.

TARGET POPULATION.

Partnership HealthPlan of CA (PHC) identified and provided a list of 100 high cost members

to each participating clinic, and then each clinic targeted 50 patients with complex, chronic conditions to receive case management services. The enrollment process included a comprehensive initial assessment and development of a care plan that addressed patient physical, psychosocial and self-management goals as well as insurance or benefits needs that may enhance access to services.

COMPLEX CARE MANAGEMENT APPROACH. The RCHC/PHC intensive case management pilot includes clinical care transformation within the participating clinics, supported by strategic oversight and technical assistance, and outcome data monitoring coordinated by the health plan.

a. Clinical Enhancements. All three pilot clinics are engaging in activities to increase access, create stronger communication and coordination across team members, and address the physical and behavioral health needs of the patients through screening and integrated care. Example strategies include: piloting and expanding tele-health visits, using geo-mapping to more efficiently plan case management home visits by clustering appointments by geographic location, and elevating the role of behavioral health within the care team planning. Clinics are focused on process improvement work, including incorporating discussions about case management into daily team huddles and monthly care team meetings. Another important component of the complex care management model involves relationship building with hospital partners to work collaboratively during discharge transitions.

b. Oversight and Technical Assistance. The Intensive Case Management Pilot is monitored by an Intensive Case Management Workgroup, facilitated by the PHC Medical Director. This group meets monthly and includes representatives from the health plan, clinic consortia, clinic pilot sites and hospital partners. The purpose of the meetings is to share case management best practices, provide feedback to RCHC/PHC on various programmatic components such as acuity assessment protocols, structure and components of the care plans, discharge criteria, and data documentation protocols. During the meetings the health plan shares preliminary data on program outcomes and case managers share stories of patient experience.

The group also provides input to strengthen and build program capacity, such as establishing core and specialized training topics for new and existing case managers to advance their work. Example training topics include:

- Overview of PHC services and benefits
- Motivational interviewing
- Care transition models
- Advanced care planning
- Health literacy
- Patient Activation Measures
- Trauma informed care
- Cultural competency

Partnership HealthPlan also hosts a project documentation website where clinics can access a library of resource documents, including a Complex Case Management Tool Kit.

c. Outcome Measurement and Data Analysis. PHC is investing in and committed to a robust analytic strategy to compare the effectiveness of various case management models with the intent of understanding how best to expand the program to reach additional high-risk members, while decreasing utilization and costs associated with high cost services, such as emergency department visits and inpatient hospitalizations. To strengthen the evaluation

Clinical Enhancements

1. Tele-health visits
2. Geo-mapping to improve home visit planning
3. Elevating Role of Behavioral health
4. Daily team huddles
5. Focus on hospital transitions

design of the HHIF pilot program, PHC is comparing the utilization and cost outcomes of the case managed patients to various control groups including patients with similar characteristics from other clinics in the network that are not receiving case management services. Clinics are also producing program narratives that capture implementation best practices, including patient stories and lessons learned.

EARLY PROGRAM ACCOMPLISHMENTS. In the first 6 months of program implementation, clinics report a high level of satisfaction with the collaborative nature of the Intensive Case Management Workgroup, and the on-going support and guidance provided by the clinic consortium and health plan. Participants value the process of sharing expertise across clinics and providers, as well as engaging in training across a variety of clinical and operational topics.

Outcome Measures Tracked by Clinics:

- Initial assessment and care plans
- Health status and quality of life (SF-12)
- Depression (PHQ-9)
- Patient Activation Measure (PAM)
- Advanced care planning status
- Patient experience

Outcomes Monitored by Partnership HealthPlan:

- ER Visits
- Hospital admissions
- Inpatient days
- Cost

Another success factor is the analysis, validation, and review of outcome data between the health plan and health centers. By examining the data together, stakeholders are able to work collaboratively on program implementation and practice transformation activities that achieve their collective goals. Clinics have experienced a cultural shift that is more patient centered as a result of the program tailoring services to the needs of the client. Early data analysis on service utilization suggests case management patients are accessing primary and preventive care more frequently and in a timely manner and that the program is providing better care transitions for patients with multiple chronic diseases and limited social support.

While still early in program implementation, PHC and the collaborative partners are confident that they will continue to see cost savings from the intervention and that investments in intensive case management will yield a positive return.

IMPLEMENTATION CHALLENGES. Clinics are experiencing implementation challenges that include gaining timely information from

hospitals to support care transitions such as lab results and discharge orders, and accessing medical records from specialty providers. In addition to gaps across the system, client engagement in case management services and capacity for self-management are additional challenges that affect program outcomes.

In terms of the “embedded” case management model, the clinic has found management and supervision to be duplicative. The case manager identifies and operates as a clinic employee, but there are additional administrative challenges since formally the health plan is the employer. At this point, there does not seem to be significant added value to having an embedded case manager since the clinic has sufficient infrastructure and capacity to provide this expertise in house.

According to data analyzed by the PHC, patients receiving case management services have:

- Improved health status, quality of life and PAM scores
- Decreases in ER visits, hospital admissions and total hospital days
- Decreased overall costs of care

Lessons Learned

Many early lessons have emerged from the project, particularly the challenge addressing the needs of patients with un-diagnosed and under-treated mental health and substance use issues, housing instability and limited social supports. The extent of disenfranchisement among this patient population complicates and extends the time required to impact their complex physical, behavioral health, and social issues. Having behavioral health expertise on the care team or within the clinic is important for successful complex care management. Other important lessons learned include:

- **Align outcome expectations** with the scope of the intensive case management intervention. Clinic based providers have less influence over hospital length of stay, which requires additional collaboration between the health plan and hospital providers in the network.
- **Engage consumers** early in program branding and implementation to improve engagement and patient experience (e.g., patients expressed concerns over language of “case management” because they do not want to be labeled as a “case” or be “managed.”)
- **Consider a mix of clinical and psychosocial expertise** on the care team to leverage staff strengths across a broad spectrum of need.
- **Develop a stepped or tiered approach** to care based on acuity level, including clear “dis-enrollment” criteria.
- **Same day notification** of ER use is critical for effective care transitions.
- Provide hard to reach patients with cell phones facilitated contact and engagement with program staff.
- Motivate and engage providers and clinicians by sharing outcome data that demonstrates impact of clinical care.
- Programs that rely on a single provider or one care team rather than a “diffuse model” are more vulnerable to staff changes.

CONSIDERATIONS FOR SUSTAINABILITY. PHC and RCHC are preparing for project sustainability by identifying the infrastructure needed to support system level changes and scale the case management program up -- both within the existing clinics and to other clinics across the network. One task involves defining the standard components that are critical to the model, including the team composition. Following the CareOregon model, one approach the collaborative is considering is employing non-medical providers or community health workers rather than nurses for some psychosocial aspects of case management services. Other factors that are important for long-term sustainability include:

- Continuing to share best practices across sites
- Sponsoring regular trainings to build and reinforce skills and competencies
- Providing opportunities to support case management teams to alleviate stress, isolation and burnout
- Maintaining a culture of quality improvement
- Creating an equitable strategy to define and re-invest cost savings across the system and create incentives for non-reimbursable services

2. San Francisco Complex Care Management Program

The San Francisco Health Plan (SFHP) launched a two-year pilot for calendar years 2012 and 2013, known as Delegated Care Support (DCS), to supplement care management services done by SFHP and to invest in patient-centered health homes. This program was a community partnership with the San Francisco Community Clinic Consortium (SFCCC), the San Francisco Department of Public Health, and the University of California San Francisco Center for Excellence in Primary Care (CEPC). The DCS program provided short-term complex case management, care coordination, and health coaching for high-risk Medi-Cal managed care members in the clinic setting. CareSupport is San Francisco Health Plan’s (SFHP) high-risk care management program, which deploys health plan care coordinators into the community to work directly with high-utilizing members. The name “delegated care support” reflected the effort to delegate this function to clinics and medical groups, to ensure the work was closely coordinated with the PCP.

FINANCIAL INCENTIVES FOR CARE MANAGEMENT. Clinics received a \$5 per member per month (pmpm) supplemental payment from SFHP to help with start-up costs related to embedded clinic care management. The \$5 pmpm was paid for Medi-Cal members in the Senior and Person with Disability category, assigned to the clinic for primary care, with the expectation that approximately 10% of them would require care management.

CLINIC READINESS FOR PARTICIPATION. SFHP’s first step in implementing the DCS program was to determine clinic readiness for participation. SFHP looked at the following factors prior to selecting clinics to participate in the program:

- Established care teams
- Dedicated personnel
- Buy-in of clinic leadership
- Time allocated for training/practice coaching
- Prior experience providing intensive case management

Stakeholders	Role
San Francisco Health Plan	Provides financial incentives for program participation
UCSF Center for Excellence in Primary Care	Provides training and practice coaching for participating clinics
San Francisco Community Clinic Consortium and San Francisco Department of Public Health	Clinics are eligible to participate in the program
General Medicine Clinic	Was the first clinic to fully participate and implement the Delegated Care Support program

The role of CEPC in the program was to develop a training curriculum and provide on-site mentoring to complex care managers (e.g., RNs, social workers, health workers) to work intensively with high-risk SPD patients at participating clinic sites. The philosophy of the CEPC training curriculum adopts a health coaching and empowerment model and serves as a supplemental benefit for clinics implementing complex care management programs. Patients receiving these services are taught about self-management strategies, and how to navigate the health care system.

TARGET POPULATION. Identifying patients to enroll in the care management program requires negotiation between the health plan and the clinics based on differences in their organizational perspectives. The health plan desires management and coordination efforts focused on their high-risk, high-cost members, many of whom may not be connected to a specific clinic as their medical home. However, the clinics and providers prefer to focus the intervention on the patients who come to their clinic with the highest clinical acuity, regardless of payer source. As a compromise, patients were referred to the program using both SFHP data and provider referrals.

General Medicine Clinic (GMC) was the first clinic with sufficient capacity and staffing resources to implement the program. GMC launched the program in January 2012 and enrolled 45 patients with complex medical and behavioral health issues in the first year. Enrolled patients were primarily middle-aged, with multiple chronic diseases and high rates of mental illness and substance abuse. Most enrollees had Medicare and Medi-Cal, or Medi-Cal-only health insurance coverage.

COMPLEX CARE MANAGEMENT APPROACH. New patient enrollment includes comprehensive, patient-centered assessment in the home, clinic or by phone by a Registered Nurse. The care team (RN, social worker, MA/health coach) works with the patient to develop a goal-based care plan. A home visit is performed at the time of engagement. The level of intensity of the care management intervention varies according to the needs and acuity level of the individual patient. After meeting all of their care plan goals, patients “graduate” from the program and return to “normal” care in the clinic. GMC has a patient advisory board for the DCS program that meets every other month to provide valuable feedback to the program on topics such as marketing, outreach and engagement strategies.

PROGRAM ACCOMPLISHMENTS. Intended outcomes for the DCS program are to improve the experience of SFHP members by coordinating care and facilitating communication across services, improve health outcomes, decrease overutilization and unnecessary costs, empower members to participate in their health, and ensure these efforts are coordinated with the PCP. The care model leverages coaching and supportive case management to better manage the health needs of the Medi-Cal managed care population, in turn reducing unnecessary appointments.

Early Outcomes:

- Reductions in ER visits
- Reductions in hospital days
- Improved provider perception of care quality
- Improved provider satisfaction

Early outcome data from the program show significant decreases in utilization of high cost services. An analysis of one-year, pre-post data of patients enrolled in the DCS program for 6 months or longer showed a 39% decrease in the number of hospital days and a 31% decrease in the number of ED visits that occurred at San Francisco General Hospital. In addition, baseline and six month follow-up surveys show improvements in provider perceptions of quality of care and provider satisfaction across multiple domains including patient communication, care coordination and referrals to community resources. The goal for these patients now is maintenance and continued connection to their health home care team.

Implementation Challenges:

- Patient engagement
- Complexity of patient need
- Limited staffing capacity and time for follow up

IMPLEMENTATION CHALLENGES. The DCS program at GMC experienced implementation challenges related to the patient engagement, complexity of patient needs, and staffing capacity. The program did not enroll as many patients as projected, primarily due to patient complexity and instability with health and psychosocial factors. Engaging this complex patient population requires significant staff time for outreach and follow up, which affects the pace of enrollment. Team members are challenged to balance time between clinical care and coaching existing patients, while allocating additional time to enroll new patients.

Lessons Learned

After the first year of program implementation, several lessons emerged regarding program design, creating incentives, training and service delivery, including:

1. Analyze data on the target population to understand the service and staffing capacity needs prior to implementation to provide the “right services for the right population.”
2. Ensure that clinics have implemented care teams and PCMH components (e.g., panel management) to support additional care coordination and management activities with sub-population of patients with complex issues.
3. Nurse-led interdisciplinary care management teams can provide clinical services for complex patients to decrease ED visits and hospital admissions.
4. Trained health coaches are effective at improving patient self-management and assisting with health navigation, which allows nurses to focus on clinical issues.
5. Medication reconciliation is a key area for intervention with most complex patients, particularly during hospital transitions.
6. Dedicated complex care management teams can alleviate burnout for other clinicians and improve provider satisfaction.

7. Behavioral health issues impact both medical issues and health services use. Patients with homelessness, substance use and mental illness are not well equipped to manage chronic medical conditions until psychosocial factors are stabilized.
8. Health services utilization data from all area hospitals should ideally be accounted for in program analyses, as patients often access care at more than one location.
9. Many patients with high health service utilization in one year will not be heavy users the next year. Identifying the “right” patients, those who will continue to be chronic users of health services over time, and for whom proposed interventions would have an impact, remains a challenge.
10. Health plan and clinic priorities may differ. It is important to define who will be accountable to provide care management for patients repeatedly using the emergency department and the hospital, who may be *assigned* to a particular clinic for care, but who are not engaged in care at that clinic.

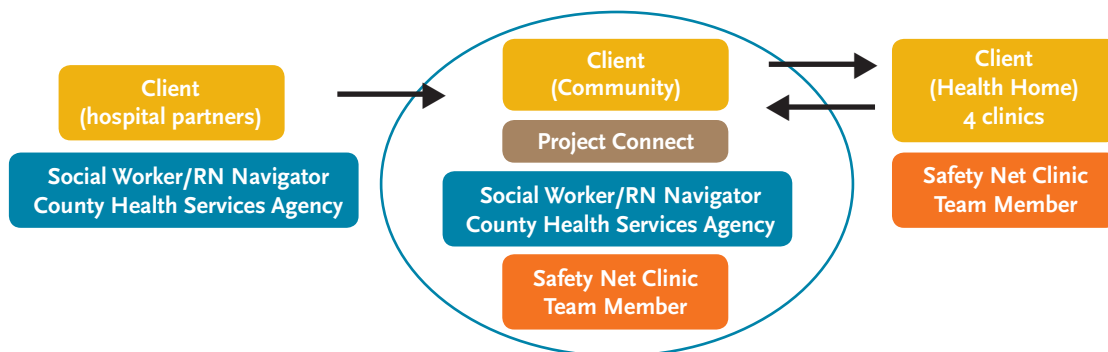
CONSIDERATIONS FOR SUSTAINABILITY. The capacity to continue and expand the program will require clarification of several aspects of the program:

- **Target Population:** Questions remain regarding how best to define the target population for the program. Is it best to focus on the highest cost patients across the system, or a less complex, but still “at-risk” population that can engage more fully and benefit more from the intervention?
- **Role of Health Plan and Clinics:** Clinic-based and health-plan based care management models have different strengths in terms of scope and effectiveness. Expanding the complex care management program in San Francisco will require clear roles for both models across the continuum of need for patients.
- **Staffing Model:** The current nurse-led medical care management programs are more expensive than non-medical, behaviorally focused programs. Because complex care management targets a population with *both* medical and behavioral conditions, it is important to connect the right staff with the right patients, to be able to address the issues in a cost-effective way. Many services (e.g., escorts to medical and other appointments, referrals to supportive services, etc.) needed by complex populations are best delivered by non-licensed staff.
- **Financing:** While care management yields savings in ED visits and hospitalizations, there is not a direct link between accrued savings on the hospital side and sustained or new funding for care management positions in the clinics. Additionally, in many clinic systems, there is an indirect link between revenue cycles and cost cycles, which makes it difficult to add staff positions, even when they ultimately save money for the entire system.

3. Health Improvement Partnership of Santa Cruz County: Health Navigator Program

The Health Improvement Partnership (HIP) Health Navigator program benefited from the experience of a prior pilot program that assisted uninsured low-income adults with hospital to outpatient transitions. The prior program focused on assisting hospital patients at discharge with enrollment into health care coverage (e.g., Medi-Cal, county based MediCruz). The HHIF funded Health Navigator Program shifts the focus to care coordination and case management of discharged patients by a hospital-based nurse navigator, and an embedded care team at participating clinics across the county.

PROGRAM PARTNERS. The Health Navigator (HN) program uses an interagency community-wide team model. Under the coordination of the HIP team (program coordinator, consulting nurse, and consulting physician), the program involves representatives of the County Health Services Agency (RN Nurse Navigator, social worker), as well as team members at 4 participating safety net clinics, 2 local hospitals, and Project Connect, a community based case management program targeting high users of emergency departments.



TARGET POPULATION. The target population is low-income adults ages 19 - 64, who are either newly insured through MediCruz Advantage (the low income health program (LIHP)) or uninsured, hospitalized, and medically and socially complex. The program launched in October 2012 and has the capacity to serve a total caseload of 75 active clients.

COMPLEX CARE MANAGEMENT APPROACH. The nurse health navigators work from two local hospitals to identify, enroll, and assist clients with the transition to a “health home” and facilitate access to community resources, home and community based services, and primary care. The program establishes clients in health homes to reinforce utilization of primary care instead of emergency care. To enroll patients, navigators conduct an “assessment of fit” at the time of hospital discharge. This assessment process helps the team identify individuals that are most likely to benefit from short-term

The assessment of program fit process helps the team identify individuals that are most likely to benefit from short-term care coordination efforts between the hospital and health home.

care coordination efforts between the hospital and the health home. Patients with greater psychosocial needs, such as housing instability and behavioral health issues, and with limited capacity to connect to a health home, are referred to Project Connect for more intensive and longer-term care management.

The intervention also includes “hot spot” teams at 4 safety net clinics and at Project Connect. The nurse navigator and clinic-based community health workers on the teams work collaboratively to:

1. Facilitate follow-up appointment scheduling
2. Assist with insurance enrollment processes
3. Conduct home/community visits
4. Arrange for medication refills and medication drop off
5. Link clients with diabetes education, substance abuse treatment programs, employment resources, etc.
6. Distribute “flex fund” resources to assist patients with transportation to their appointments and address barriers to program engagement

PROGRAM ACCOMPLISHMENTS. Intended outcomes of the program are to leverage home and community services, and establish health homes to increase proper primary care utilization and reduce preventable re-hospitalizations and ED visits for low income, high-risk adults. The program is tracking 30-day hospital readmission rates, ED visits, program costs per client, and client satisfaction. Preliminary data demonstrate that a team-based model that begins at hospital discharge is effective in improving connection to a primary care home and, ultimately, health outcomes.

IMPLEMENTATION CHALLENGES. The program experienced many delays in hiring key staff and consequently made significant changes to the work plan, budget, staffing, and timeline. In addition, the administrative and legal process to launch the program with a partnering hospital was lengthy and complex. Also, health information exchange (HIE), an important capacity for this cross-system program, is limited. Each week, team members cull through hospital records for each client looking for visits because of the time lag for claims data. The program is working on electronic data collection and data warehousing solutions, but currently relies on Google docs for sharing care coordination documentation.

Successful care coordination across multiple health care systems requires capacity for health information exchange.

System barriers include the county enrollment cap on the Low Income Health Program (LIHP), which resulted in significantly more uninsured clients in the program than originally expected. As a result, many of the potential clients with challenging social issues and medical problems have limited access to covered benefits. Additionally, there are resource capacity issues in the county for mental health, substance

use, and housing services. The team has identified behavioral health problems as the primary barrier to achieving optimal health for many clients.

Lessons Learned

The key lesson learned during implementation of the program centers around aligning the target population with the short-term, care coordination intervention.

1. The health navigator program is most appropriate with clients for whom coordination with and connection to a health home will substitute effectively for ED use and prevent hospital admissions.
2. The team has experienced less success when clients have complex behavioral health and social issues that preclude them from effectively connecting and engaging with a community-based health home.
3. The program is more able to successfully meet the needs of more “episodic” versus frequent users of hospital-based services.
4. The involvement of numerous agency representatives with diverse skill sets and cross-system representation has been beneficial, but the contracting process for establishing this collaboration is lengthy and requires significant planning and trust.
5. Formal communication through in-person team coordination meetings every other week as well as ongoing e-mail messaging improves the delivery of care and facilitates solutions to client problems.
6. Communication flow between nurse navigators, participating clinics and the hospital discharge and case management teams requires ongoing time investments by staff, and clearly defined roles established through formal agreements and MOUs.

CONSIDERATIONS FOR SUSTAINABILITY. HIP is preparing for project sustainability by identifying additional funding opportunities to strengthen and institutionalize the program. The program has recently submitted proposals to foundations and the State to build additional dimensions of the program, including the capacity to include clients with both physical and behavioral health co-morbidities, and to employ additional social workers and psychiatrists as part of the team. In addition, HIP has secured funding through the California Wellness Foundation to advance and leverage the existing work implemented during the HHIF grant period.

Conclusion

The HHIF, by design, funded local coalitions of health plans, clinics, hospitals, and community-based organizations to develop local solutions to addressing the needs of the safety net population and improve the overall health of the community. Individuals with complex, chronic conditions are a critical subset of the safety net population and require tailored interventions to coordinate care and better manage their health, and improve their quality of life.

No single system can address the range of needs of a complex population to achieve the desired goals of improving the health of the population and reducing overall costs of care. A unique achievement of the HHIF is the cross-system collaborative approach that promoted the establishment of strong partnerships across the safety net. This collective approach to identifying a shared target population and developing treatment interventions, creates and strengthens accountability across the systems for meeting the Triple Aim goals of improved population health, improved patient experience of care and lower overall health care costs.

Common characteristics present in successful care management programs, including those funded by the HHIF, include:

- Appropriate identification of high-risk patients
- Multidisciplinary teams (expertise across medical, behavioral health, benefits advocacy, and social services)
- Team skills match patient needs
- Patient involvement in goal setting and care planning
- Home and community based care
- Specialty trained care managers
- Smaller case loads
- Health coaching



For more information on the Center for
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Innovation Fund, visit:

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