COORDINATING CARE FOR VICTIMS & AT-RISK OLDER ADULTS – THE COMMUNITY COMPLEX CARE RESPONSE TEAM C³RT

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SERVICE MODEL & PROJECT OVERVIEW
CORE PARTNERS

• Michigan State University
• University of Texas Health Science Center at San Antonio
• Yale University School of Medicine
• CareWell Services Southwest (MI Region 3B Area Agency of Aging)
• Elder Law of Michigan
Calhoun County, MI

Located in south central Michigan
Total Population – 140,000
Balance of Urban and Rural
Largest City: Battle Creek
Best Known for the home of Kellogg’s cereal
**PROJECT BACKGROUND**

- **2012 OVW**
  - Calhoun County Elder Abuse Prevention Network
  - Identified need to share information between health & human service agencies
  - Developed uniform consent form and informal coordinated community response team

- **2015 Hartford Action Award**
  - Formalized CCR model protocol for coordinated case management
  - Developed & piloted electronic case management system along with model protocol & uniform consent form
  - Expanded stakeholders to become C³RT

- **2016 RWJF S4A**
  - RCT to evaluate impact of C³RT care model as primary prevention strategy
What Is C³RT?

- C³RT is a model of integrated service referral and delivery
  - A partnership of multi-sector agencies that serve community-dwelling older adults
  - Guided by principles of the “warm transfer” and person-centered care
  - Based on a philosophy of **open data sharing** (with consents and agreements)
  - Enabled by a custom built technology to allow for data exchange and communication between partners
C³RT Goals

- Decrease vulnerability of older adults by promoting and supporting independence and capacity for self-care

- Redesign service model to provide comprehensive multi-sector delivery via a community-driven coordinated case management approach
PROJECT’S KEY FEATURES

• Provides a means of aligning services across sectors to increase availability of and access to preventative and supportive services for vulnerable older adults

• Community partners engage in shared decision making and information exchange through coordinated case management to affect the best outcomes possible for clients
C³RT Process & Tools – Big Picture
SERVICE MODEL OVERVIEW

Referral Partners:
Identify Vulnerable Older Adults

High-Risk Case Management Partners:
Engaging in Community-Based Coordinated Care

- Geriatric Evaluation & Management
  - Custom EHR
  - Comprehensive Service Planning & Delivery of over 60+ multi-sector services
  - Information Exchange
  - Loop-Back Communication
  - Shared-Decision Making

- Area Agency on Aging

- FQHC

- WAIVER

- PACE
C³RT in Practice & Impact on Clients
Before Initial Client Contact

• Start investigating to build a picture of potential areas of risk:
  • Read hospitalization record (if referred from healthcare system)
  • Check AAA Harmony database for past/current service use
  • Check State DHHS system for enrollment in state/millage programs
    • May be they are a client of a AAA next door
    • Enrollment in other case management programs (PACE, DHHS case management)
  • Checks Medicaid status
    • Active? Spend down? Low income subsidy eligible?
**Initial Client Contact - Phone**

- Explain why we got the referral
- Listen to initial concerns
- Explains we may be able to offer services
  - Asks if they are interested
  - Asks if they consent to sharing of information for service planning purposes
- Schedule home visit
- *Then, taking into consideration all “known” information, what is the best approach to proceed, areas of concern, game plan for visit*
SECOND CONTACT

• Home visit is preferred, but client can refuse
• Explains approach and philosophy
  • Person-centered & compassionate communication
  • Listen to the individual
  • Build rapport with client
• Identifies client’s areas of concerns (and our own)
• Focus on social determinants of health as well as health maintenance
SECOND CONTACT, CONTINUED…

- Home visit should be kept to one hour in length
  - Draw out of the individual what they value – how to “increase joy & reduce burden”
  - Through “guided” conversation, client identifies needs, goals, and preferences
  - What are the major concerns
  - Top 3 goals – “Next Steps”
  - Depending on need – subsequent visit scheduled
  - Empower the individual – “do with, not for” (except when it's necessary)
The Next Steps Form

Shared Plan for ____________________________________________

Next Steps

My Concerns
Topics to discuss with my care team:
☐ My ability to manage my chronic conditions  ☐ Financial Issues
☐ Thinking or memory problems ☐ End of Life Issues
☐ Family issues ☐ Spiritual Support
☐ Emotional Issues ☐ Access to Health Care
☐ Maintain independence ☐ Supportive services
☐ Meeting basic needs ☐ Nutrition
☐ Safety

Comments: __________________________________________________________________________________
____________________________________________________________________________________________

My Life Goals - What motivates me?

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<th>Goal Description</th>
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My Next Steps - How I get there

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The Next Steps Form
Authorization to Share

Coordinated Community Response Model
Authorization to Share Information

Customer’s Name: ________________________________
Customer’s Birth Date: _________________________
Parent/Legal Guardian (if applicable): ______________

The persons and agencies listed below may be involved in providing services to the customer noted above. I hereby authorize the following persons and agencies to share information with one another as indicated below. In doing so, I am aware that I may, without penalty, refuse authorization for the sharing of information by any of the listed persons or agencies. I understand that each of these agencies may provide or receive the information.

The following agencies authorized to exchange information with the CCR Model (please check one or more methods & agencies):

☐ verbal exchange ☐ written exchange ☐ electronic exchange

☐ Senior Health Partners* ☐ Bronson Battle Creek*
☐ Region SB Area Agency on Aging* ☐ Bronson at Home
☐ Community Health Connections* ☐ Adult Protective Services
☐ Family ☐ Primary Care, Care Management
☐ Family ☐ Grace Health
☐ Friend ☐ MSU research team led by Dr. Christopher Maxwell*
☐ Physician ☐ Battle Creek Police Department
☐ Physician ☐ Lifecare Ambulance

INFORMATION TO BE DISCLOSED: (must be completed)
Records relating to the following services provided:
☐ Assessment(s) ☐ Progress/Treatment Results
☐ Psychiatric Evaluation ☐ Discharge Summary
☐ Treatment plan ☐ Service Utilization & Billing Information
☐ Medication Management Notes ☐ Other

Release clinical records above:
☐ from all dates of services or ☐ for treatment after the following date: ______________________

Information not to release:

________________________________________

The purpose of this authorization for the release and exchange of information is to coordinate and evaluate service delivery.

My authorization is voluntary and shall be effective for two years from date of service delivery or until I withdraw it in writing.

At any time, you can revoke your authorization by contacting the Area Agency on Aging at 269-441-0994 or by mailing your request to Bonnie Hogboom, 200 W Michigan Ave # 102, Battle Creek, MI 49017.
**Benefits to Sharing Data & Communications**

- Wrap-around approach – improved case coordination
  - Person in the center
  - Communication & sharing data
  - Ability to share burden with high-need clients
  - Remain within scope of practice
  - Ex: client was scheduled for an appointment at the FQHC – sent communication – alerting them of mental health symptoms

- Closed loop system – results & feedback
  - Ex: client changed phone number but hadn’t updated medical provider
Short Term Safety Net Services

• Communicating & sharing data enables us to identify and assist clients in need of short term safety net services
  • Stabilize a crisis situation
  • Maintain stability while waiting for long term care services to begin
    • Ex: Provide adult day center or in home services while waiting for PACE enrollment
• Flexible – based on circumstance and individual need
  • Purchase a locked medication dispenser for 91 year old addicted to pain medication
COMPLEX CASES - Case Example

- Referral from police department for elderly woman with advanced dementia & 63 year old son with multiple chronic medical conditions and substance abuse issues
  - More than 60 calls to police (response to home) for 6 month period prior to referral
  - Son forced to move from home due to verbal and physical abuse by both individuals
  - Niece moved in with aunt to provide care
- Service connection for mother: Adult day center, elder law attorney, minor home repair, back tax assistance, DHHS SER furnace repair, home delivered meals
- Service connection for son: Informal counseling, debt management assistance, advocacy with banking institution (over draft fees)
- Open communication with CMH provider – behavioral health
- Significant reduction in calls to police after referral
POSITIVE IMPACT ON PARTNERS

From: Chad in France [chad@...]
Sent: Saturday, July 08, 2017 11:10 AM
To: Hogoboom, Bonnie
Subject: RE: original CCCRT referral

Hello Bonnie, I believe the referrals made on A[...] and R[...] have significantly reduced police calls for service. I'm on vacation, so I don't have access to the exact number of times that the PD has responded since the referral but it has taken a dramatic turn around for the betterment of their lives and the community at whole. It seems like the PD responded to A[...] once every 2-3 days and I'll go out on a limb to guess that the PD has since been involved maybe 5-10 times (if that!!) since you and your agency's work. You have positively affected their quality of life by assisting with basic needs to help them self-improve.

I'm not dealing with Root's property but bunch of good stuff. But I know he really appreciates all of your assistance in possibly getting his house back :)

LESSONS LEARNED WORKING WITH LOCAL PARTNERS

• Important to build collaborative partnerships and trust
  • Shared consent or authorization to share information is vital for health integration into providing social and community supportive services

• Integration improves outcomes and client experience
  • Increased communication has positive impact for all involved

• Home visit provides comprehensive perspective
  • Clear picture of what is REALLY going on
QUESTIONS?