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

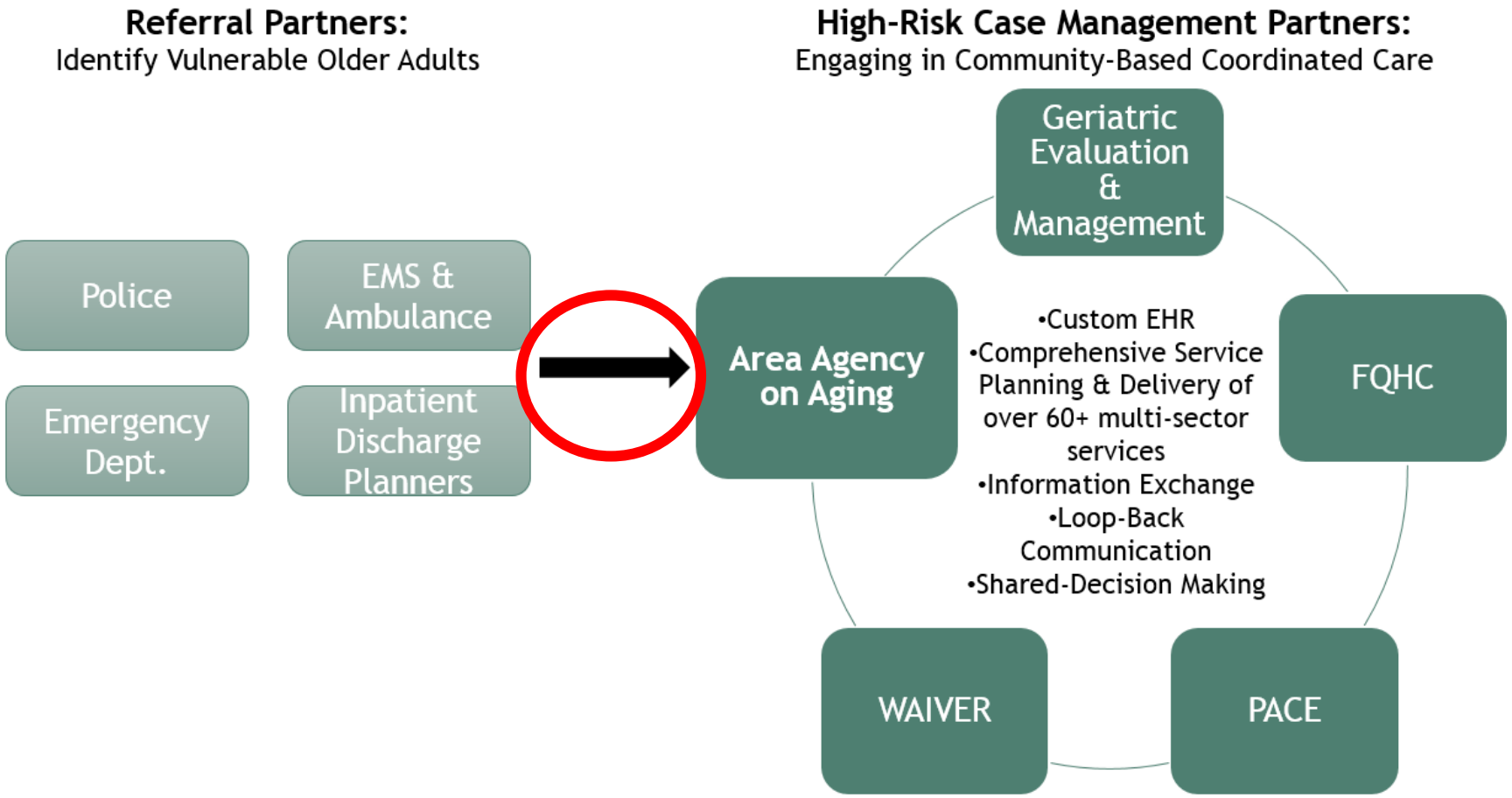
Project's Key Features

- 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



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 its neccessary)

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
☐Thinking or memory problems
☐Family Issues
☐Emotional Issues
☐Maintain independence
☐Meeting basic needs
☐Safety
☐Financial Issues
☐End of Life Issues
☐Spiritual Support
☐Access to Health Care
☐Supportive services
☐Nutrition

Comments:_____
_____
_____

My Life Goals - What motivates me?

Completed	Goal Description
☐	
☐	
☐	

My Next Steps - How I get there

Completed	Date	Description
☐		**Step:**
☐		Action:
☐		Action:
☐		**Step:**
☐		Action:
☐		Action:
☐		**Step:**
☐		Action:
☐		Action:

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 ✓ one or more methods & agencies):

___ verbal exchange ___ written exchange ___ electronic exchange*

____ Senior Health Partners*
____ Region 3B Area Agency on Aging*
____ Community Health Connections*
____ Family _____
____ Family _____
____ Friend _____
____ Physician _____
____ Physician _____
____ Bronson Battle Creek*
____ Bronson at Home
____ Adult Protective Services
____ Primary Care, Care Management
____ Grace Health
____ MSU research team led by Dr. Christopher Maxwell*
____ Battle Creek Police Department
____ LifeCare Ambulance

INFORMATION TO BE DISCLOSED: (must be completed)
Records relating to the following services provided

☐ Assessment(s)
☐ Psychiatric Evaluation
☐ Treatment plan
☐ Medication Management Notes
☐ Progress/Treatment Results
☐ Discharge Summary
☐ Service Utilization & Billing Information
☐ 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 269-441-0984 or by mailing your request to: Bonnie Hogoboom, 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: [redacted]
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[redacted] and R[redacted] 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 [redacted] 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.
[redacted] 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?