Clallam Care Connection

Clallam County's new multiorganizational care coordination team

Charter and Attachments

Contents

Clallam Care Connection (3C) Charter

Updated February 23, 2021

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Purpose

Clallam Care Connection (3C) provides coordinated care to improve the health status of individuals with complex, chronic conditions to deliver a seamless experience of care that is person-centered, cost-effective, addresses social determinants of health, and results in improved health and wellness.

Clallam Care Connection (3C) Operating Principles

3C will establish interagency coordinated care coordination and communications across organizations to improve delivery of services and outcomes. Each member organization will appoint at least one representative to participate in the on-going 3C team meetings. The 3C team shall operate with respect and willingness to listen to different perspectives.

Responsibilities

- Direct individuals experiencing complex chronic health challenges away from emergency departments, emergency services such as 911, and law enforcement and into care by providing timely professional interventions
- Conduct warm hand-off referrals to medical and behavioral health services, social services, linkage to residential and outpatient substance use disorder services
- Coordinate with local social service agencies to address social determinants of health such as housing and food needs
- Promote and engage clients in self-care management
- Ensure all patients have a medical home
- Assist clients in accessing needed care and services
- Identify and engage future team members

- Provide feedback and insight to organizations and community on any system-level and environmental needs identified
- Track client referrals and services for monitoring and evaluation purposes

Composition

The 3C will be composed of diverse partners that may include, but are not limited to, medical, dental, and behavioral health entities, local hospitals, community-based nonprofit and social service organizations, Tribes, local and county agencies such as first responders and law enforcement, and other safety net providers.

A pilot 3C team includes participants from Port Angeles, WA. The 3C will expand to include partners from across Clallam County as 3C team systems are established and stabilized.

Pilot 3C members are:

- North Olympic Healthcare Network
- Port Angeles Fire Department
- REdisCOVERY
- Peninsula Behavioral Health

Member Responsibilities - 3C members will be expected to:

- Attend 3C client meetings at least twice a month
- Commit to using 3C forms
- Identify unique community needs and gaps in care coordination
- Provide timely review and feedback on documents when solicited
- Develop a prioritization method to determine high priority persons/population segments
- Ensure client has signed their agency's release of information documents
- See *Attachment E – 3C Member Responsibilities*

3C Team Lead - 3C members will identify a Team Lead. Responsibilities of the Team Lead include:

- Establish weekly client roster, including onboarding and graduating of clients
- Ensure that each client accepted onto 3C meets team criteria
- Maintain all client documentation
- Ensure monitoring and evaluation data is collected
- Coordinate and communicate with Olympic Community of Health staff as needed
- Track 3C member participation
- See *Attachment F – Team Lead Responsibilities*

3C Coordinator – Coordinator role will be filled by Olympic Community of Health during the pilot and scale-up phases of development. Responsibilities of the 3C Coordinator include:

- Assist the 3C team with assessment, planning, implementation and evaluation activities
- Develop and implement data collection methods, tools, and evaluation measures for 3C team interventions in conjunction with 3C members
- Document 3C team milestones and progress toward outcomes in reports to lead agency, funders, team members, and broader community (as appropriate)
- Identify and secure funding streams to cover costs of a 0.5 – 1.0 FTE Coordinator position
- See *Attachment G – 3C Coordinator Responsibilities*

Target Population
Multi-disciplinary case management will focus on individuals with complex, chronic issues which are not easily resolved including, but not limited to:

a. Complex chronic disease including serious mental health and substance use disorders
b. Repeat 911 or emergency department use
c. History of repeat hospitalizations or risk of hospital readmission
d. History of disjointed or discontinuous care
e. At risk of suicide

Criteria for being added to the 3C client panel: The 3C team will monitor and self-regulate the number of clients it can effectively manage. Clients will be referred for enrollment, screened for eligibility, and graduated from 3C based upon the criteria outlined in *Attachment A – Clallam Care Connection Client Prioritization and Onboarding* using the Client Assessment Tool shown in *Attachment B*. Eligible clients are contacted and must agree to be enrolled in 3C.

Target Population identification

- Provider identification – 3C will work with health care, emergency service, and social service providers to identify those individuals who they know fall into the target population as described above.
- Real-Time identification – 3C will establish protocols to identify individuals with complex care needs who meet criteria for 3C participation. This will include previously uninsured individuals and those with no medical home who are referred for care by the PAFD Community Paramedic or other sources.

Referrals, Information Sharing, and Reporting
Each agency participating in 3C will have signed Business Associate Agreements (BAA) in place with each HIPAA-covered team member. Each organization and agency is responsible for ensuring that their clients sign their agency's release of information documents. 3C will use a shared digital information exchange platform if one becomes available and if the parties agree to pay and participate in its use.

The 3C Team Lead will establish weekly case rosters and assist with tracking data for monitoring and evaluation. The Team Lead will share de-identified data with the Team Coordinator for monitoring, evaluation, and reporting purposes.

Confidentiality and Privacy – HIPAA & 42CFR Part 2

3C will implement practices to maintain confidentiality and compliance with HIPAA and 42CFR Part 2. Protected health information ("PHI") is defined as individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

Each member of the 3C team commits to establishing a BAA with 3C team partners and adhering to their agencies' release of information practices. Client's must agree to receiving care management services from 3C. Client's may decline to 3C care coordination, in this case they can continue to receive services from their individual providers and organizations and will not be enlisted for the 3C team services. See *Attachment C – Client's Rights and Responsibilities.*

Each member of the 3C team commits to ensuring client's have a signed release of information (ROI) that conforms with their organization's confidentiality and privacy requirements.

De-identified health information will be used for purposes of monitoring and evaluating 3C progress and outcomes, identifying public health trends, and grant reporting. Health information is de-identified by removal of specified individual identifiers so that the data neither identifies nor provides a reasonable basis to identify an individual.

Timeline

This 3C Charter is valid through 2021 and will need to be updated by January 2022 if not before.

Monitoring and Evaluation

Goals and objectives have been identified for the purpose of monitoring and evaluating the effectiveness of 3C interventions. Objectives and tracking measures have been identified which provide meaningful information on the impact of 3C. Goals and objectives will be reviewed after six months and may be amended annually. *See Attachment H – Goals, Objectives, Monitoring & Evaluation.*

Oversight

3C is subject to the direction and oversight of the Clallam Health Network Leadership Team. While the CHN Leadership team is under development, 3C is subject to the direction of Kate Weller MD, Chief Medical Officer, North Olympic Healthcare Network and Ken Dubuc, Fire Chief, Port Angeles Fire Department.

Staff

Olympic Community of Health ("OCH") will provide staffing assistance, within limits to be agreed upon, to support the start-up and scale-up implementation phases of Clallam Care Connection. This staffing support is subject to expiration on December 31, 2021. Staff will report to Clallam Health Network Leadership Team and to OCH's Executive Director.

Attachment A – Clallam Care Connection Client Prioritization & Onboarding

3C team Purpose: The Clallam Care Connection (3C) provides coordinated care to improve the health status of individuals with complex, chronic conditions to deliver a seamless experience of care that is person-centered, cost-effective, addresses social determinants of health, and results in improved health and wellness.

Client Prioritization - Priority will be given to individuals with:

a. Complex chronic disease including serious mental health and substance use disorders
b. History or at risk of repeat 911 or emergency department use
c. History or at risk of repeat hospitalizations or risk of hospital readmission
d. History or at risk of suicide attempt
e. History of disjointed or discontinuous care
f. History of or at risk of homelessness
g. Need to transition back into community from in-patient services or jail/prison
h. Medical or behavioral health care provided by at least one of the partner organizations

Onboarding - Individuals will opt-in to 3C participation in the following manner:

Step 1 3C team identifies referred individual(s) who meet established prioritization criteria.

Step 2 Individual agrees to be served by the 3C team. Individual signs a 2 copies of the Client Rights and Responsibilities document, one is given to client and one is retained for 3C records.

Step 3 Individual works with 3C Team Lead (or other assigned staff) to complete onboarding and ongoing activities which support active client participation in his/her/their care coordination process including, but not limited to: intake interview, issue prioritization, other tools and assessments as needed.

Step 3 An individual is considered to "graduate" from 3C when she/he/they have not required 3C team services for six months.

Step 4 An individual has the right to request removal from the 3C Client Roster at any time.

Attachment B – 3C Client Assessment Tool

Client Name/ID _____

Date of Birth _____

Insurance: _____

Contact information _____

Referred by _____

Today's date _____

Priority Factor		**Suggested supporting documentation**
Complex chronic disease including serious mental health and substance use	__Yes __No	medical/behavioral health records Client self-report
Repeat 911 ED Use	__History of __At risk of	911 records
Repeat Emergency Department Use	__History of __At risk of	Emergency Department records
Repeat hospitalizations	__History of __At risk of	Hospital records
Suicide Risk	__History of __At risk of	Suicide risk assessment tool Client self-report
Disjointed or discontinuous care	__History of __At risk of	medical/behavioral health records Client self-report, lack of insurance
Homelessness	__History of __At risk of	Agency report Client self-report
Transition from in-patient services or jail/prison	__Yes __No	Anticipated release date:
Medical or behavioral health care provided by 3C partner(s)?	__Yes __No	Partner Partner
Rights & Responsibilities reviewed and client agrees to participate in 3C?	__Yes __No	Notes

Please fax completed form to John Astgen, 3C Team Lead, at NOHN fax # 360-504-3943

Attachment C – 3C Client's Rights & Responsibilities

Clallam Care Connection (3C) helps you meet your health and wellness goals by strengthening coordination among the health and social service organizations involved in your care.

As a client of the Clallam Care Connection…

You have the right

- To be treated with respect, dignity, consideration, and compassion.
- To receive care coordination services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.
- To participate in creating your wellness plan.
- To be informed about services and options available to you.
- To withdraw your voluntary consent to participate in care coordination.
- To have confidential information released only:
  - as approved in your signed release of information.
  - when there is a medical emergency.
  - when a clear and immediate danger to you or others exist.
  - when there is possible child or elder abuse.
  - when ordered by a court of law.

You have the responsibility

- To treat members of Clallam Care Connection with respect and courtesy.
- To participate in your own wellness plan.
- To make and keep appointments to the best of your ability, and to change an appointment time as needed.
- To stay in communication and let us know of address or phone number changes.

Who We Are:
Clallam Care Connection (3C) is a new collaborative effort in Clallam County. Current 3C members are:

- North Olympic Healthcare Network
- REdisCOVERY
- Port Angeles Fire Department
- Peninsula Behavioral Health

I have read these Rights and Responsibilities and agree to Clallam Care Connection helping me meet my health and wellness goals.

Name _____ **Date** _____

Attachment D – 3C Client Satisfaction Survey

Your opinion is important to us. For each statement below, check √ the box that best matches how you feel. Your responses are confidential and will be used for program improvement.

Item	Strongly Agree	Agree	Disagree	Strongly Disagree
Clallam Care Connection (3C) helped me by coordinating care among health providers and other social services (such as housing, food, or transportation)				
I am respected by 3C team members				
I know who to talk to if I have a concern or problem				
I am satisfied with the support provided by 3C				
I take more of a role in managing my own health and wellness than I did before being helped by 3C				
My health care team worked well together				
I am satisfied that my care was well organized				
The 3C team contacts me to see how things are going for me				
Staff are concerned about my well-being				

What is most helpful about the care coordination services you receive from 3C?

_____

_____

_____

How has your situation has improved because of these care coordination services?

_____

_____

_____

Attachment E – 3C Member Responsibilities

Clallam Care Connection
Team Member Responsibilities

3C members commit to:

- Participate in 3C Team meetings at least twice a month
- Ensure all clients have a medical home
- Promote and engage clients in self-care management
- Develop and follow a prioritization method to determine high priority persons/population segments to be served by 3C
- Ensure clients have signed their agency's release of information documents
- Provide timely review and feedback on 3C documents and forms
- Participate in 3C monitoring and evaluation activities
- Identify unique community needs and gaps in care coordination, provide feedback and insight to organizations and community on system and/or environmental challenges and opportunities
- Identify gaps in Team membership and recruit new members

Attachment F – 3C Team Lead Responsibilities

Clallam Care Connection
Team Lead Responsibilities

3C Team Lead is responsible for oversight and monitoring of the 3C client process. Responsibilities of the Team Lead include:

- Establish and maintain 3C client roster, including onboarding and graduating of clients
- Ensure that each client accepted onto 3C team meets team criteria and consents to participation in 3C
- Maintain all client documentation in accordance with privacy policies
- Ensure monitoring and evaluation data is collected in alignment with 3C evaluation and funding requirements
- Coordinate and communicate with Olympic Community of Health staff and 3C team members as needed
- Track 3C team member participation and engagement in meeting identified client needs
- Complete reports in partnership with 3C Coordinator

Attachment G – 3C Coordinator Responsibilities

Clallam Care Connection
Coordinator Responsibilities

3C Coordinator is responsible for assisting with administrative and management duties. Responsibilities include, but are not limited to:

- Reports to Clallam Health Network Leadership team and to funding agency
- Work with 3C team to track progress toward project goals and objectives
- Assess training/technical assistance needs and organize training opportunities
- Develop and implement data collection methods, tools, and evaluation measures for 3C team interventions in conjunction with 3C team members
- Assist the 3C team with assessment, planning, implementation and evaluation activities
- Document 3C team milestones and progress toward outcomes in reports to lead agency, funders, team members, and broader community (as appropriate)
- Conduct literature/resource reviews to identify and implement best practices
- Facilitate development of strategic plan in collaboration with 3C members
- Support recruitment and onboarding of new members
- Coordinating community outreach/education related to 3C activities and progress
- Identify & secure funding streams to cover costs of a 0.5-1.0 FTE Coordinator position

Attachment H – DRAFT Goals, Objectives, Monitoring & Evaluation

Goals	Objective	Source/Method
Timeframe: Baseline and quarterly		
Improve access to appropriate care for people with unmet needs	90% of 3C team clients will have at least one (1) successful referral for needed services	Client Tracking Tool/HIE
Reduce emergency room utilization	reduce by 25% the use of emergency department visits	Client Tracking Tool
Reduce avoidable and repeat hospitalizations	Reduce by 25% avoidable and repeat hospitalizations	Client Tracking Tool
Timeframe: Every six (6) months and at time of graduation from 3C team services		
Clients are satisfied with experience of care	80% of target population will report satisfaction with 3C experience is "good" or "excellent"	Client Satisfaction Survey

Client Tracking Tool – outline	
Items to be included in a client tracking tool are:	
	Quantitative data
1	# unduplicated individuals served
	total # and stratified by zip code, gender, age brackets, ethnicity
2	how referred to 3C team
	ED, 911, medical or behavioral health provider, community organization, other
3	Insurance Coverage at enrollment:
	# Medicaid only
	# Medicaid/Medicare
	# that had no insurance at time of enrollment into 3C team
4	Reduced visits to ED - # individuals who were redirected from unnecessary ED visit
5	Reduced 911 EMS use - # individuals who were redirected from unnecessary 911 calls
6	# individuals with successful discharge from program with no contact for at least 60 days (# discharged/total unduplicated clients)
	Qualitative data
1	Describe collaborative efforts and outreach activities employing collect impact strategies
2	Describe individual successes which resulted as a result of 3C team interventions
3	Client Satisfaction Survey (See Attachment D)