



Integrated Care Initiative



Connect Care Choice Community Partners

A partnership between CareLink-RI and the State of Rhode Island's Medicaid Program



May 7 2014

Connect Care Choice Community Partners Overview

- Connect Care Choice Community Partners (4CP) option administered by EOHHS in partnership with CareLink
- Incorporates the Connect Care Choice Primary Care Case Management model with Long Term Services and Supports and a Community Health Team for individuals who:
 - Have both Medicare and Medicaid, aka “MMEs”
 - Have Medicaid only

Connect Care Choice Community Partners Program Purpose

- A Care Management program available to eligible individuals who need additional help to be able to live independently at home or in the community
- Aligns with the Patient Centered Medical Home model
- Fosters improved coordination between medical and behavioral health care services, LTSS and community resources

ICI and Connect Care Choice Community Partners Program Goals

- Patient-centered care
- Coordination of primary care, behavioral health care and long-term services and supports;
- Improve or maintain health and quality of life
- Improve transitions of care from the hospital or nursing home back to member's home
- Rebalance the long-term care system to support home and community-based living vs. institutional care
- Align financial and quality incentives to improve care

How does the ICI and Connect Care Choice Community Partners Program work?

- The State is using the ICI to help improve the health and quality of life for eligible Rhode Islanders:
 - Someone to help manage complex medical conditions
 - Help find services and providers, like home care agencies and specialty doctors
 - Conduct Telephonic Health Screen to find out if someone has health problems or needs
 - Live Member Services and after hours support
 - Help with getting non-Medical social supports, like Meals on Wheels or heating assistance
 - Extra help for members who want to return home

Connect Care Choice Community Partners Program Organization

EOHHS Administered Program

- Connect Care Choice
 - ❖ 17 Primary Care Practice Sites
 - ❖ Nurse Care Manager Integrated in the practice site
- Office of Community Programs/Division of Elderly Affairs
LTSS programs
 - ❖ Nurse Care Manager/Social Worker
 - ❖ DEA Case Management Agencies
 - ❖ Self-Directed Service Advisement Agencies
- CareLink/Coordinating Care Entity
 - ❖ Community Health Team
 - Nurse Care Manager/Social Worker/Care Manager
 - Peer Navigator

Connect Care Choice Nurse Care Manager Role

Nurse Care Manager will manage all high-risk, complex medical members

- Will conduct a Health Risk Assessment (HRA)
 - In-person
 - SF-36 Health Status Survey
 - PHQ-2/ PHQ 9 Depression Screen
 - Functional Assessment
 - Caregiver Assessment
- Develop and implement person-centered plan of care
- On-going care management and support
- Linkage with Community Health Team as needed

Office of Community Programs/Division of Elderly Affairs Care Manager Role

Nurse Care Manager or Social Worker will manage members with LTSS

- Will conduct a Health Risk Assessment (HRA)
 - In-person
 - SF-36 Health Status Survey
 - PHQ-2/PHQ-9 Depression Screen
 - Functional Assessment
 - Caregiver Assessment
- Development and implement person-centered plan of care
- On-going care management support
- Nursing Home transitions
- Service authorization
- Linkages with Community Health Team as needed

CareLink Coordinating Care Entity

- Assessment Nurses
 - ❖ Clinical Telephonic and Data Risk Profiling
 - ❖ Extensive experience in the field of mental health
- Member Services Specialist
 - ❖ Program overview and information
 - ❖ Member issues resolution
 - ❖ Transportation coordination
 - ❖ Fluent in Spanish
- Data Specialist
 - ❖ Data Analytic program operational support
 - ❖ Early Warning Indicators for members needing additional services
 - ❖ Quality and Oversight and Monitoring metrics

Community Health Team

Community Health Team will manage members needing linkages to community resources

- Nurse Care Managers
 - ❖ Extensive experience in the field of mental health
- Social Workers
 - ❖ Experience in community based needs for the elderly and individuals with disabilities
- Care Managers
 - ❖ Experience in mental health, developmental delays, and family services
- Peer Navigators
 - ❖ Experience in organizing and motivating community engagement
- Interdisciplinary collaboration with the Connect Care Choice nurses, the Office of Community Programs and the Division of Elderly Affairs

Community Health Team Requirements

Community Health Team Care Manager or Social Worker will manage members in the community without LTSS

Will conduct a Health Risk Assessment (HRA)

- In-person
- SF-36 Health Status Survey
- PHQ-2/PHQ-9 Depression Screen
- Functional Assessment
- Caregiver Assessment
- Development and implement person-centered plan of care
- On-going care management support
- Linkages with community resources

What Does the Community Health Team Do?

- ▶ Assessment nurses call each member to perform a Telephonic Health Screen (THS). This helps to determine who is in need of care management services, and what services or supports the individual may require.
- ▶ Lead Care Manager is identified based on the member's need.
- ▶ Care Managers and Social Workers then meet with members in their home or community to complete a Health Risk Assessment (HRA), including Caregiver Assessment. They also work with the member to develop a person-centered plan of care.
- ▶ The Peer Navigator, Care Manager and Social Worker provide regular and ongoing support and assistance to each member, based on their individual needs.
- ▶ CareLink CCE staff are available to members on a 24/7 basis for all non-medical emergency needs or questions.

How Can the Community Health Team Help?

- ▶ The Community Health Team can assist with or provide information to members on:
 - ▶ Person centered, strength based support and options counseling
 - ▶ Caregiver support
 - ▶ Transportation
 - ▶ Housing
 - ▶ Mental health and behavioral health services
 - ▶ Legal issues
 - ▶ Medical and dental services
 - ▶ Food, clothing, furniture assistance
 - ▶ Medicare and Social Security
 - ▶ Referrals for Long Term Services and Supports, and the Office of Community Programs

Additional Information

Call Connect Care Choice Community Partners Member Services

Toll Free

1-855-654-4067

Members and their families can contact this number 24/7 in the event of a non-medical emergency.

A live person will triage their call to the appropriate agency/representative within 15 minutes of the initial contact.

Or visit www.EOHHS.ri.gov and see “Integrated Care”