Institute for Healthcare Improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT
SUMMARY REPORT: 90-DAY PROJECT

Coordination of Services for the Community for Individuals with Needs

March 28, 2017

I. Intent:

The intent of this wave of activity is to use the work from the last wave of innovation titled: Designing a System for Clinical-Community Linkages at the Individual Level. In that research we outlined a structure that communities might use to coordinate community-based services for an individual in need. That paper focused some on clinical community referrals but we believe this work can apply to any community based organization.

II. Background:

This is a summary of the previous work on how to develop a system for the coordination of services for an individual in a community. To support the development, operation, and improvement of the system, an organization or coalition is needed to serve as an Integrator. The integrator serves as the hub for the coordination of services, with linkages to services provided by different community entities. Consideration needs to be given to mitigating the duplication of services between the various organizations trying to serve these individuals.

The role of an integrator includes aligning leadership at the community level that bridges disciplines and programs; clarifying roles and ensuring accountability; arranging for appropriate, sustainable financing and infrastructure support for the work; and managing change. Members of the community are involved in defining the problem and needs the system is trying to address, and the system is co-designed with individuals with lived experience.

1.Define the target population and the number of individuals who would benefit from the coordination of services.
2.Identify a coordinator(s) at the individual level and document their roles and responsibilities.
3.Identify the outcome goal (e.g. improvement in an individual's self-sufficiency) that is the result of the coordination of services.
4.Develop an outreach strategy to identify, engage, and recruit individuals in the target population into the coordination of services initiative. Develop a process for sharing the names of those recruited with participating organizations.
5.Develop an assessment tool to identify the services needed by an individual to achieve the goal. The assessment should be standardized to the greatest extent possible for organizations with a common goal in the community.
6.Develop a standardized, shared, community-wide referral process.
7.Develop a referral tracking system to include tracking and monitoring the initiation, follow-up, and outcomes of referrals. Develop a plan for making the information available to relevant parties.

8.Plan and conduct ongoing reviews of the referral tracking system and progress towards outcome goals. Learning from the review should be used for course corrections and to drive continuous process improvement.

III. Description of Work to Date:

In January we called a small group together from the work in North East Wisconsin to discuss this work. During that time there was affirmation that the structure we proposed was sound. I think there was some question on what they might achieve by working with us on this structure.

On January 30th in Appleton we had an hour breakout session where we discussed with a larger group our overall structure for working together. (we are using the framework as summarized in the background section of this paper.)

We asked them what was potentially missing from the framework and they shared the following:

- Progress towards goals
- Barrier removal process
- Cost to coordinate services
    - How much do we spend among multiple organizations per individual?
- Method to coordinate services
    - Is there one case manager throughout the entire process?
    - Are there warm hand-offs?
    - What is being done elsewhere?
- Shared data base
- Mechanism to share what we have already learned

And here is some additional feedback via email

- In the homeless systems work, most communities find it necessary to create some sort of shared release of information that becomes the first page of the shared assessment.
- For the navigator role or community health worker, we stress the importance of each client being "assigned" one navigator to avoid the challenges of duplication and lack of coordination that you lift up.

We also asked for other thoughts they had:

- Look into organizations already coordinating to learn from them. Ask what is working and not working.
- Connecting clients to agencies has been a sharp pain point.
- 2-1-1 will have more expansive services and information soon.
    - Can we invite the director to the table?
- Could we create learning communities with existing coordinating agencies?

Based on this feedback we developed a structured learning environment that we plan to use for the rest of our working time with them. The focus of this workgroup is on coordinating multiple referrals for an individual toward a specific outcome such as self-sufficiency.

We have four goals.

1. To prepare for scale in your community, scale being defined as the total target population that could use this service in your community
2. To learn from one another
3. To work through specific local process issues as the opportunity arises
4. We would like to see all of this learning used to improve the process of coordination for individuals. Some testing will be required.

These are questions that we are using for this process.

1. Describe the type of individual (target population) you are trying to help. How many people do you presently coordinate services for and what is the maximum number in the target population who could use your service in your community? What are the constraints to reaching this maximum number?

2.How do you define engagement with your clients? What is your rate (%) of engagement? How do you sustain the engagement with your clients to help them achieve their goals? How could you improve your engagement rate? What would you like to test?

3.How did you decide the type of person you would look for and the skills they would need to act as coordinator of services? What has surprised you thus far about this position? How did you decide on your training for the coordinators?

4. How do you insure in your community that all services needed by an individual are coordinated by one person (coach) so you do not have multiple coaches working with the same person at the same time? Are there changes you would want to test to improve this process?

5.What assessment tool are you using? What process issues do you have related to using it? Do most CBO use the same tool in your community? What is your plan to move to get others to use it in your community? What will you need to test?

6.In the homeless systems work across the US, most communities find it necessary to create some sort of shared release of information that becomes the first page of the shared assessment. Are you able to share your assessment tool with other agencies? What challenges do you still face?

7. Are you using standard documented pathways for each service (e.g. each element of the self-sufficiency matrix)? How well are the pathways working? What improvements could be tested?

8. Describe the process to co-create a set of goals and a plan for each individual you work with. Do you identify the outcome goal (e.g. improvement in an individual's self-sufficiency) that is the result of the coordination of services? How do you monitor progress toward goals? What is your approach to helping the individual remove barriers? What steps in this process need to be improved?

9.What is your present outreach strategy to identify, engage, and recruit individuals in the target population into the coordination of services initiative? What will you need to change and test if you are going to reach the maximum number in the target population that can use your service? Do you have a process for sharing the names of those recruited with participating/partnering organizations?

10.How did you develop a standardized, shared, community-wide referral process?

11.Describe your referral tracking system to include tracking and monitoring the initiation, follow-up, and outcomes of referrals. How do you make the information available to relevant parties? What changes need to be made to this system?

12. How do you plan and conduct ongoing reviews of the referral tracking system and progress towards outcome goals? How do you use reviews for course corrections and to drive continuous process improvement?

13. What is your cost per client to coordinate services? What is your present funding model? What kind of future funding model would you need to have to reach the maximum number you shared in question1? What other barriers do you face to grow your program besides funding: space, people, information sharing or communication?

Optional Question: Who is acting as the integrator of services for individuals? Is it just one organization doing that or is it a network of organizations? Why did the community choose this structure?

IV. Results of the work:

Based on the work with community organizations at the time of this writing, we are making a few generalized observations:

1.Engagement of individuals needs to be considered both at the beginning of a program and throughout the program. Since we have limited resources to support the work, we need to maximize each interaction to improve engagement. For example one program identified a target population of 13,000. They have initially reached a population of 209 who have completed an intake process. From that population they have a self selected population of 40 who are willing to work toward a set of self-sufficiency goals. How could they improve the intake process so that they don't loose as many (209 down to 40)?

2. Data agreements and releases are needed between organizations. Coordination of services requires the ability to share information at an individual patient level and that requires release of information from individuals to be able to share the information. Also, CBOs pursue memorandums of understanding between organizations.

3. Until proven otherwise, there is duplication of services and coordination in any community.

4. It is hard for any individual CBO to think about the larger system and what scale might look like for a community. In addition, a CBO probably doesn't have the money to reach scale.

5. If an organization works across multiple communities, they will find significant variation on how coordination of services is handled in each community.

6. At a community level, it would be good to create a system such that no matter which CBO a person had initial contact with, that the CBO would get them in contact with a coordination service.

At this point in time, the CBOs are testing some ideas on how to decrease no shows after referrals are made and how to improve the referral rates for individual who want additional services. They continue to work through issues around data sharing.

V. Conclusions and Recommendations:

We were able to use the work from R and D to create a framework and set of questions. These questions have been helpful as we work with CBO's. The interaction with CBOs allowed us to outline bigger issues and delve into process issues that they face. This has led us to some observations about the work that were discussed in the results section. We plan to continue to work with CBOs for another three months to help and learn with them**.**