Weekly Collaborative Rounds (WCR)

Primary Goal of WCR: Collaboration with Sunshine to support clients considered high risk or high need (defined below). The focus of the collaboration is to coordinate supportive services and treatment support across the health ecosystem to improve health outcomes, lower costs, and improve satisfaction with service delivery, and to create, adjust, or update the client's care plan. Clients who are deemed non-complex and are not currently being case managed by Sunshine may be included to help identify resources that Sunshine could provide to ICNF clients (e.g., transportation assistance, referral to PCP). ICNF provider organizations may choose to incorporate WCRs with Sunshine into existing multi-disciplinary rounds or case reviews that already take place at the organization.

Priority Clients: The primary focus of WCR is on high risk individuals who are members of Sunshine Health. Clients generally will have multiple comorbidities with complex support needs. HealthEC will generate a proposed list of clients to be included in the WCR based on the high risk criteria listed below (to be listed clients must have two or more chronic health issues, plus 2+ ED visits or inpatient admissions in the last four months OR a gap in medication refills of more than 30 days for one or more medications). ICNF provider organizations may choose to remove or add clients from this pre-populated list based on clinical information available. Sunshine Health may also request a member be included in a WCR via HealthEC.

ICNF High Risk Level Criteria which may indicate the need for WCR:

- Two or more chronic health issues which require considerable community interventions, such as:
  - Adults:
    - Substance Use Disorder (all modifiers except mild)
    - Bi-polar disorder
    - Schizophrenia
    - Schizoaffective disorder
    - Major depression
    - Diabetes
    - Chronic obstructive pulmonary disease (COPD)
    - Congestive heart failure (CHF)
  - Children:
    - Disruptive mood dysregulation disorder (DMDD)
    - Oppositional defiant disorder (ODD)
    - Bipolar Disorder
    - Intermittent Explosive Disorder
    - Conduct Disorder
- Two or more ED visits or inpatient admissions in the last four months
- Participation in BH care has been inconsistent, high percentage of community interventions may be necessary to ensure engagement
- Inability to form therapeutic alliance, potentially necessitating a high level of community interventions initiated by provider
- A gap in medication refills of more than 30 days for one or more medications, requiring community interventions including medication reviews and assistance with filling prescriptions
- Social Determinants of Health (SDOH) needs identified via an ICNF provider organization's standard assessment or other tool (e.g. Sunshine SDOH tool) which may require significant community interventions
- Jail and/or high level of criminal justice involvement creating barriers and challenges that may require considerable community interventions

Participants: The ICNF CCO and Sunshine CM will collaborate to lead the WCR process, inclusive of gathering lists of participants and scheduling, ensuring compliance with HealthEC documentation, and collaborating to accommodate all required supports to activate the revised care plan. Ideally, the client, legal guardian, and family members should provide input into the care plan as appropriate. If adjusted, the care plan should be reviewed with them after the WCR is complete.

Participants may include representatives of the client's care team (e.g., Sunshine CM, ICNF provider organization, ICNF clinical staff) who are under the appropriate confidentiality terms to share healthcare information and support needs of the client. Other Sunshine staff, such as pharmacy director or medical director, may be included at times as well.

Process: The WCR structure is anticipated to have the capacity to review a number of clients each week (expected to vary by ICNF provider organization) and will need to be scheduled so that the right people are able to attend (clinical team and Sunshine staff will vary). Therefore, participants will need to join by phone/web conference line. Every effort will be made to make the scheduling of WCR as efficient as possible for all parties.

Standing Agenda for WCRs:
The HealthEC agenda will include some pre-populated agenda items, however provider organizations should be prepared to discuss the following at WCR.

1) Confirm the **desired outcome** (i.e., what we want to accomplish in the meeting) is agreed to by the team at the beginning of each meeting. When possible, the meeting's proposed outcomes should be identified in advance of the WCR so time during the WCR can be focused on identifying clinical solutions for clients.
2) **Brief summary** of the client's background highlighting individual goals, barriers, and identified needs. (Visually sharing a screen can shorten this summary if written information is deemed part of the standard process.)
3) **Events** (ED visits, etc.) **or changes** in client status since last meeting and/or changes in client's needs.
4) **Review of care plan and adjustments** as appropriate. This includes medical needs, pharmaceutical compliance, ancillary services, and SDOH support. Review of tasks from last meeting, identifying if task is completed, on track, or needs adjustments. Any new tasks are assigned to individuals for follow-up.
5) **Upcoming appointments, lab tests, RX refills, or other events.**
6) **Open for other comments** from all participants.

Documentation: WCR documentation is on an individual client basis, with a summary for each meeting documented. Recommended WCR documentation will capture decisions described above with key outputs included in the care plan and assignments to providers and Sunshine Health. WCR activity will be documented in HealthEC.

Collaboration between WCRs: The Sunshine CM is typically the central point for communication for these clients and related providers; therefore, if an issue arises that needs immediate action or collaboration across providers, communication should be channeled through the Sunshine CM e.g. phone, instant message via HealthEC. Communication should be noted in HealthEC.

Example Documentation (in HealthEC):
John Smith, member # 92372459347; white male, age 52; lives alone in apartment.
WCR Date: 1/1/2020 **Last WCR:** 12/15/2019; First WCR of record: 3/1/2019

High Risk due to: Depression with secondary diabetes and morbid obesity. 3+hospitilizations in last six months and 4 ED visits
Patient goal: to not be hospitalized or go to ED; to lose 50 pounds by 7/1/2020; walk to park 3 blocks away with no assistance
Providers include: Dr. Jones, PCP, Helen Peters, PhD, Home Health RN CM Tom Carson.
Changes since last WCR: Oldest son visited from out of town; very positive impact on mood. Saw Dr. Peters, therapist on 12/27; no major issues identified. RN visited patient at home on 12/20 – **noted small ulcer on right ankle**. Noted high compliance with meds and no changes in sleep or anxiety levels.
Care plan: (lots of variances to this)
Not go to ED; actions: see therapist weekly. CM weekly visits through end of March to verify med compliance, monitor for issues, and assess mood/depression.
Lose 50 pounds by 7/1/20; actions: Patient to walk 3x/day; document on form that CM reviews Diet and nutrition support by RN. See PCP in 3 months.
New goal for 1/1/20:
Small ulcer healing; actions: CM followed up with Sunshine CM and referral made to PCP to identify best tx protocol.