Learning Objectives

In today’s session the participants will develop a better understanding of:

- The definition, principles, and central activities of care coordination.
- The value of investing in Care Coordination.
- Steps to Consider in assessing your care coordination activities and making improvements.
- Key obstacles and critical success factors to consider when implementing a care coordination model.
- Care Coordination models and resources available.

Care Coordination - Defined

“The deliberate integration of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of healthcare services”.


Principles and Central Activities

Principles:
- Accountability

Central Activities:
- Assess Patient Needs
- Develop and update proactive care plan
- Emphasize communication
- Facilitate transitions
- Connect with community resources
- Align resources with population needs

Source: Fisher, E; Grumbach, K, et al. September 8, 2010 Consensus Meeting Briefing Materials on Care Coordination: Issues for PCMHs and ACOs

Why Invest? Necessary to improve our health care delivery system.

The six attributes of an ideal health care delivery system
- Information Continuity
- Care Coordination and Transitions
- System Accountability
- Peer Review and Teamwork for High-Value Care
- Continuous Innovation
- Easy Access to Appropriate Care

Why Invest?  Care Coordination work flows increase the effectiveness of meaningful use requirements

Examples include:
- Generating and coordinating patient lists in need of management of specific conditions and/or are high risk.
- Providing timely electronic access of a patient’s longitudinal health information
- Connecting to external providers in the primary referral network
- Patient reminders
- Care transitioning - medication reconciliation from one provider to another, transition summaries

Why Invest? Meet Nancy Green

- Is 70 years old.
- She is a retired nurse living alone.
- Her income is a retirement pension, Social Security and Medicare.
- She does not drive.
- Her daughter lives 30 miles away.
- Mrs. Green has 5 chronic conditions, 14 physicians, and is on 10 medications.

Mrs. Green:
- Is confused by care, meds
- Has poor quality of life
- Has high out of pocket costs

Mrs. Green’s Daughter:
- Cannot visit as she wants
- Has been forced to reduce work hours and has less income
- Struggles with mom about living situation

In 2011, Mrs. Green had...

- 4 Hospital Admissions
- 24 24 Scripts
- 8 Weeks Sub-acute Care

Important Steps in Care Coordination – How well are we doing?

- Get to know your patients.
- Understand your current relationships with providers and facilities involved with admission and discharge planning.
- Understand your current relationships with specialty providers.
- Understand your mechanism for communicating to outside providers.
- Understand what information is provided to outside providers in this communication.
- Understand what happens when information from outside providers is received in your office.
- Are care coordination workflows associated with these steps carried out using a structured, consistent, and timely methodology for every patient at each encounter?
- Are care coordination processes tracked and reported periodically to evaluate efficiencies and effectiveness?
Care Coordination Obstacles

- Patient Obstacles
- Physician/Practice Obstacles
- Facility Obstacles
- Payer Obstacles
- Community Obstacles

Critical Success Factor: Leadership

Physician leaders are known for having a more autocratic leadership style. Care coordination is most successful when incorporating a more collaborative style of leadership.

Critical Success Factor: Change and Relationship Building

Current Approach
- Care is based on visits
- Professional autonomy
- drives clinical variability
- Professionals control care
- Information is a record
- Secrecy is necessary
- The system reacts to needs

New Approach
- Care is based on continuous healing relationships
- Care is customized according to patient needs, values
- Patient is source of control
- Knowledge is shared and flows freely
- Transparency is necessary
- Needs are anticipated

Critical Success Factor: Communication

What do people do best?
- Establish and maintain relationship with patients
- Establish meaningful connections with providers
- Make decisions and be accountable for them
- Pattern recognition
- Judge the relative importance and value of information
- Put information into the context of the patient
- Use intuition and experience to give advice
- Assess the value of quality of life

What does technology do best?
- Supports the people in the task of care coordination
- Keeps track of large amounts of data
- Keeps track of data over long periods of time
- Integrates information into carefully designed workflows to achieve care coordination goals
- Organizes data so that patterns are apparent
- Remembers complex rules and protocols
- Enhances communication across a provider network
- Maintains check-lists for completeness
- Prompts humans with decision support
- Functions with constant reliable performance
HIT and Care Coordination Integration

Building Blocks to Creating Effective Care Coordination
- Engage an improvement team
- Develop a plan
- Set goals
- Gain provider consensus on goals and objectives
- Develop efficient mechanisms for sharing information
- Evaluate office workflows
- Implement the plan
- Reach outside your health center to communicate and negotiate your needs
- Facilitate agreements with collaborating partners
- Engage and empower your patients
- Follow-up

ED Care Transition Model:
Community Collaborative – A Win-Win
1 year cooperative alliance pilot program linking embedded Care Coordinators in the ED with embedded Care Managers in a community health center in NW Florida. Care Managers funded by hospital partner. Enabling software funded by HRSA Healthy Community Access Program. Identified and managed 376 low-income uninsured individuals presenting to the ED for non-emergent care, no primary care home, and having diabetes, hypertension, or depression. Utilized ED Software (IBEX), Care Management software (CareScope), PAP software (MedData) and EHR (Centricity)

ED Care Transition Model: Scope of Service
- Referral to ED Care Coordinator (Social Worker) by ED registration or ED clinical staff;
- Needs assessment to identify risks;
- Referral to a primary care home (FQHC);
- Referral to Care Management Program for all individuals presenting with or having known history of diabetes, CVD, or Depression;
- Medicaid Application Assistance and Follow-through;
- Charity Care Application Assistance and Follow-through;
- Referrals to other community providers as needs identified through needs assessment. Examples include free or discounted pharmacy assistance programs, homeless shelters, and mental health providers; and
- Post ED Follow-Up

ED Care Transition Model: Pilot Outcomes
1. ROI: 2:1
2. Uncompensated Care ED utilization savings resulting in decrease in ED utilization: $794,389.82
3. 20% reduction in ED utilization (133 visits post program/699 visits pre program)
4. 74% of individuals in care coordination program received services in which they were referred
5. 36% reduction in depressive symptoms (PHQ-9)
6. 12% of persons with diabetes reached HbA1c control of ≤ 7.0%
7. Statistically significant improvements documented in mental health SF-12 Quality of Life scores.

Resources
- Patient Centered Primary Care Collaborative – www.pcpcc.net
- Institute for Health Improvement – PCMH Assessment, www.ihi.org
- Transformed, www.transformed.com
- Agency for Healthcare Research and Quality, www.ahrq.org
- National Transitions of Care Coalition, www.ntocc.org
Models and Programs that include care coordination activities.

- IHI Care Coordination Model [www.ihi.org](http://www.ihi.org)
- CareOregon Care Support [www.careoregon.org](http://www.careoregon.org)
- Guided Care Nurse [www.guidedcare.org](http://www.guidedcare.org)
- Geisinger ProvenHealth™ Navigator [www.geisinger.org](http://www.geisinger.org)
- BOOST Care Transitions [www.hospitalmedicine.org](http://www.hospitalmedicine.org)
- Eric Coleman’s Care Transitions™ [www.caretransitions.org](http://www.caretransitions.org)
- Patient-Centered Medical Home Model [www.pcppnet](http://www.pcppnet)
- Wagner’s Chronic Care Model [www.ihi.org](http://www.ihi.org)

Why Invest? Our Goals are Lofty but the results are worth it ... just ask Mrs. Green

Thank you ... Questions?