The Role of Care Coordination in Delivering High Value Care in the Era of Health Care Reform

Conversation with Colorado DPHE

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A Core Element of Integration: Care Coordination

Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families.

Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

Source:
MAKING CARE COORDINATION A CRITICAL COMPONENT OF THE PEDIATRIC HEALTH SYSTEM: A MULTIDISCIPLINARY FRAMEWORK
Antonelli, McAllister, and Popp, The Commonwealth Fund, May 2009

National Study of Care Coordination Measurement in Medical Homes

Antonelli, Stille, and Antonelli, 2008

Focus of Encounter – Aggregate Data –

Primary Focus	% Encounters
Clinical / Medical Management	67%
Referral Management	13%
Social Services (ie. Housing, food, clothing…)	7%
Educational / School	4%
Developmental / Behavioral	3%
Mental Health	3%
Growth / Nutrition	2%
Legal / Judicial	1%

Framework for Potential Measures of CC/ Integration

McDonald, et al, *Care Coordination Measures Atlas*. AHRQ Publication No. 11-0023-EF, January 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/careatlas/

GOAL: COORDINATED CARE (see Chapter 2)

MECHANISMS
Means of achieving goal

Coordination Activities
Actions hypothesized to support coordination. Not necessarily executed in any structured way

Broad Approaches
Commonly used groups of activities and/or tools hypothesized to support coordination

COORDINATION EFFECTS
Experienced in different ways depending upon the perspective

Patient/ Family Perspective

Health Care Professional(s) Perspective

System Representative(s) Perspective

COORDINATION MEASURES

Context: Settings, Patient Populations, Timeframe, Facilitators, Barriers

Triple Aim

Population Health

Experience of Care

Per Capita Cost

Principles reflect:

- **Patient-centeredness and family engagement**
- **Quality care for patients of all ages, populations, service locations, and sources of coverage**
- **Elimination of disparities**
- **Alignment of public and private sectors**

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The Urgent "Triple Aim"

Population Health

Experience of Care

Per Capita Cost

Medical Homes will not be successful unless…

…there is integration of care across the continuum, from patient/family perspective

What is integrated care?

- Integrated care is the seamless and coordinated provision of health care services, from the perspective of the patient and family, across the entire care continuum, irrespective of institutional and departmental boundaries.

Integrated Care Infrastructure Enables Interaction

MEDICAL HOME

(Typically, PCP; may be sub-specialist)

- **Accessibility**
- **Care Coordination**
- **Tracking & Registry**
- **Linkage to Community Based Organizations**
- **EMR**

- Clinical Communications
  - Care Plans
  - Structured Referrals
- Optimal Models of Care
  - Disease Specific Care Pathways
  - Collaborative Care Models
- Interoperable IT Infrastructure for IP and OP settings:
  - E-prescribing
  - Test & Referral Tracking
  - Personal Health Record (PHR)
- Utilization Management
- Performance Reporting
  - Quality/Outcomes
  - Finance

Strategic Approaches to Value Optimization

- HRU 0.5% of population accounts for 20% of spend
  - Strategies focus on subspecialty and hospital engagement with proactive care management
    - Unplanned re-admissions
- Children and Youth with Chronic Conditions 20% account for 65+% spend
  - Strategies focus on optimal utilization of subspecialists
  - Collaborative and shared care models
  - Provider Practice-Based Variation Analysis (PPBVA)
- Majority of Pediatric Population
  - Strategies focus on optimizing primary care sector’s ability to manage population health outcomes
  - PPBVA

Community

Family

Patient

PATIENT-CENTERED MEDICAL HOME

(providing primary care and serving as the main coordinator of care with others in the system)

Acute and post-acute care
- -inpatient hospital care
- -rehabilitation
- -skilled nursing care
- -home health services

Ambulatory care
- -specialty care
- -subspecialty care
- -ancillary services (e.g., physical therapy, podiatry, speech therapy)
- -retail clinics

Diagnostic services
- -lab
- -imaging

Pharmacy

State and local public health
(e.g., smoking cessation, tobacco use prevention, infectious disease control, chronic disease prevention)

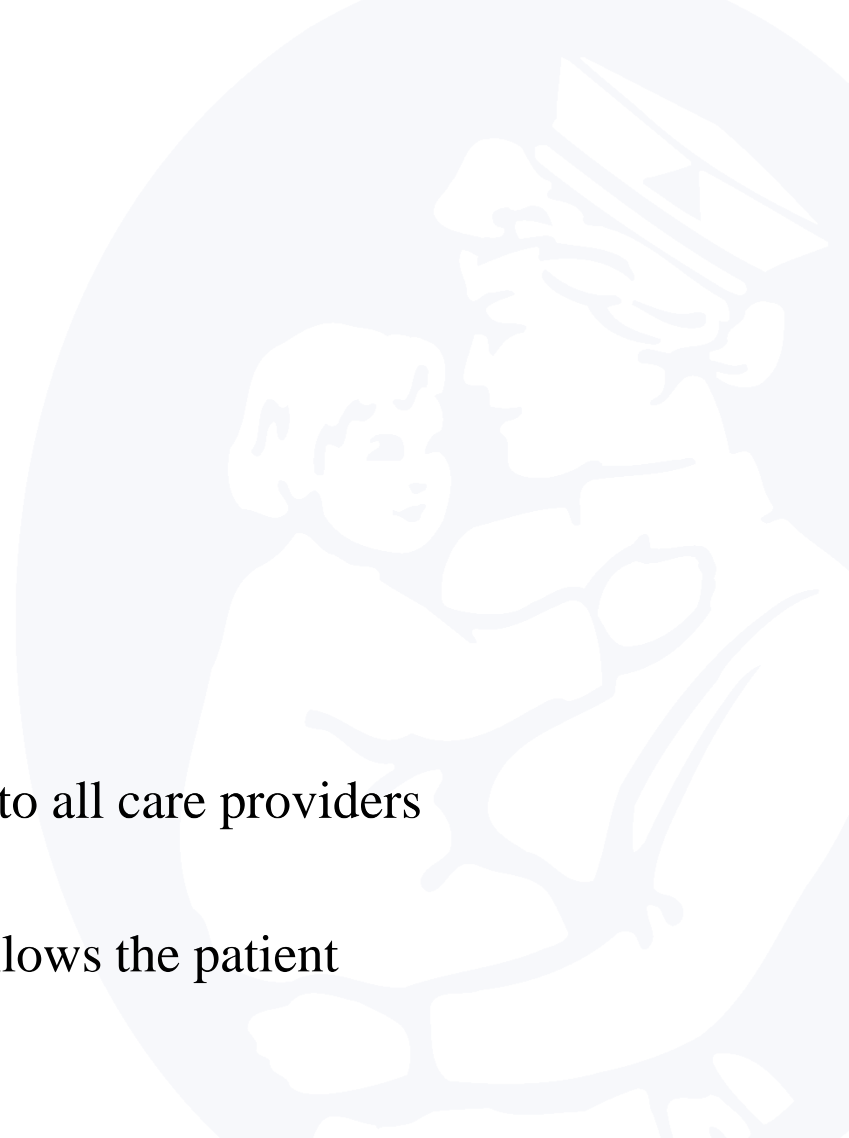
Community and social services
(e.g., hospice, personal care services, home-delivered meals, home modifications, assistive technology, accessible transportation, education and support for patient self-care)

Family-Centered Community-Based System of Services for Children and Youth

Family with CYSHCN
Spiritual resources
Recreational programs
Informal supports and services
Voluntary organizations
Medical home
Other medical
Insurance/ financing
Transportation
Juvenile justice
Public safety
Public health
Housing
Vocational services
Education
Social services
Mental health
Formal supports and services
Community-based system of services

Perrin, J. M. et al. Arch Pediatr Adolesc Med 2007;161:933-936.

Building a System that Supports Care Coordination for this Population Across the Continuum of Care



- Measures of "Complexity"
  - Medical
  - Care Coordination
    - Psychosocial and socioeconomic
- Proactively Identify patients and families
- Define locus of accountability for CC
  - Subspecialists
  - PCP's
  - Others
- Information available on as needed basis to all care providers
- Team-based care
- Multidisciplinary, dynamic care plan– follows the patient
- Transparency to patients and families

Collaboration Strategies

- Co-Management
  - Well defined roles and responsibilities for all care team members
    - Primary Care
    - Subspecialists
    - Families
    - Especially useful for Youth with chronic conditions transitioning to adult systems of care
- Structured Consultations
  - PCP as primary manager
  - Specialist as primary manager
  - Shared Care
- Critical Elements
  - Relationship-based
  - Patient/ family critical partners in requesting consultations and understanding follow-up

Adult-Focus: "Clinically-Enhanced Starter Set" ACO Demonstration Dartmouth Institute/ Brookings

Category I: Diabetes
- HbA1C Control
- LDL Control
- BP Control
- Eye Exam
- Kidney Disease Screen
- Aspirin Prophylaxis

Category II: Coronary Artery Disease
- LDL Control
- Aspirin Prophylaxis

Category III: Chronic Heart Failure
- Beta-blocker with LVE< 40%
- BP Control
- LDL Control

Category IV: Hypertension
- BP Control

Category V: Care Coordination
- Tobacco Use Inquiry or Counseling
- Childhood immunization
- BMI recorded
- Influenza vaccine
- Pneumovax vaccine
- Medication reconciliation

Broad Issues for Pediatrics

- Vulnerable populations could be at increased risk as systems evolve
  - Depend upon measures chosen
- Lack of pediatric quality measures in general
- Strong emphasis in ACO pilots on in-patient and adult care
- Determinants of "health" are often not medical
  - Poverty
  - Linguistic, literacy barriers
  - Housing
  - Food Security
- Lack of generally accepted pediatric risk adjustment methodologies
- Time Horizon for Return on Investment
  - months versus years versus decades
- Should there be pediatric-only ACO's?
- Should/ could there be CYSHCN-only ACO's?
- How Do Care Coordination Activities Relate to EPSDT?

Brief Bibliography

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