Best Practices in Care Coordination

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Lucile Packard Foundation for Children’s Health
CCS Plus Care Coordination Summit
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Triple Aim Goals and Some Approaches

• **Improving the experience of care**
  – Care planning and implementation
  – Receipt of recommended services
  – Informed decision-making

• **Improving the health of populations**
  – Life course perspective
  – Prevention and health promotion

• **Reducing per capita costs of health care**
  – Appropriate use of services
  – Efficient systems of care
What is Care Coordination?

“Care coordination occurs when care plans are implemented by a variety of service providers and programs in an organized fashion.” – AAP Council on Children with Disabilities

“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.” – Antonelli, McAllister & Popp
Essential Elements of Quality Comprehensive Care Coordination

- Accessible, including community-based
- Qualified care coordinator
- Intake screening
- Comprehensive assessment
- Develop a care or service plan
- Family/patient-centered goal setting, planning and services
- Services: Inform, arrange and/or provide services (includes advocacy and financing)
- Transmit/transfer information among service providers
- Monitor service delivery
- Ongoing reassessment
- Ongoing relationship between client and care coordinator (ideal)
Delivering Care Coordination

- Assessment
- Continuous Monitoring & Improvement
- Goal Setting
- Care Planning and Facilitation

## Distribution of Children By Chronic Illness Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Population</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metastatic Malignancy</td>
<td>0.06%</td>
<td>2.36%</td>
</tr>
<tr>
<td>Life Long Progressive</td>
<td>0.01%</td>
<td>0.64%</td>
</tr>
<tr>
<td>Technology Dependent</td>
<td>0.10%</td>
<td>1.68%</td>
</tr>
<tr>
<td>Life Long Progressive</td>
<td>2.45%</td>
<td>12.65%</td>
</tr>
<tr>
<td>Life Long Chronic</td>
<td>12.30%</td>
<td>26.44%</td>
</tr>
<tr>
<td>Episodic Chronic</td>
<td>85.1%</td>
<td>56.2%</td>
</tr>
<tr>
<td>Non-Chronic</td>
<td></td>
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</table>

Source: J. Neff, Treo-CRG
Care Coordination in Pediatric Practices

**Designated Care Coordinator**
- Yes: 39%
- No: 57%

**Keep List of Community Service Providers**
- Yes: 81%
- No: 16%

Commonwealth Fund IHP Survey 2009
Pediatric Practice Creates Written Care Plans for CYSHCN

The Commonwealth Fund, IHP Survey, 2009
Pediatric Practices Receiving Payment for Care Coordination

- All Payers: 1%
- Some Payers: 9%
- None: 86%

The Commonwealth Fund, IHP Survey, 2009
# Care Coordination in Pediatric Primary Care Practices

<table>
<thead>
<tr>
<th></th>
<th>No Psychosocial Issues</th>
<th>Psychosocial Issues*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-CSHCN</strong></td>
<td>9.4 minutes (clinical and referral management and education)</td>
<td>14.1 minutes (mental health, legal and social services)</td>
</tr>
<tr>
<td><strong>CSHCN</strong></td>
<td>17.6 minutes</td>
<td>19.3 minutes (mental health, legal, and social services)</td>
</tr>
</tbody>
</table>

Costs ranged from $4.39 to $12.86 per CC encounter; average $7.78

Source: Antonelli RC, Stille CJ, Antonelli DM. Care Coordination for CYSHCN. Pediatrics 2008; 122(1):e209-e216
Improving Linkage: 3 Levels of Strategies

1. Practice-level systems change
2. Community partnerships
3. Community systems change

Organizational Options for Care Coordination

Key question: Point of Entry & Point of Service: Single Vs Multiple?

- Referral coordinator in practice or agency
- Care Coordinator in practice or agency
- Office-based supported by regional entity
- Care coordinator shared among practices or agencies
  - Private arrangement
  - Health care organization
  - Public agency
- Regional resource providing facilitation and support
  - Telehealth models: Help Me Grow; Massachusetts Child Psychiatry Access Project
  - eReferral models: SF General; Doc2Doc
Mechanisms for Providing Care Coordination

• Individual care coordinator
• Care coordination team
• Face-to-face with client
• Contact with physician (face-to-face or other)
• Various e-care options:
  – Telephone
  – Email
  – Messaging devices
  – Digital photos
  – Video
• Relationship-based among providers and organizations
Local Policies to Facilitate Care Coordination

• Referral and Feedback Systems

• Interagency Agreements
  – Accountability
  – Standardized forms and processes
  – Privacy policies (HIPAA, FERPA, IDEA)

• Data Sharing Agreements
Structural Factors that Support High Quality Care Coordination

- Interdisciplinary advisory committee
- Parent advisory committee to practices
- Ongoing quality improvement
- Adequate reimbursement
- Incentives for quality
- Clear standards and quality measures
- Health Information technology
- Interagency collaboration in community or state
Shared Resources: Outsourcing
Community Care of North Carolina: Medicaid

Asthma Initiative: Pediatric Asthma Hospitalization rates

(April 2000 – December 2002)

In patient admission rate per 1000 member months

- 14 networks, > 3,200 MDs, >800,000 patients
- $3 PMPM to each network
- Hire case managers/medical management staff
- $2.50 PMPM to each PCP to serve as medical home and participate in disease management
- **Care improvement:** asthma, diabetes, screening/referral of young children for developmental problems, and more!
- **Case management:** identify and facilitate management of costly patients
- **Cost savings analysis (per Mercer):**
  - FY2003: $60 million
  - FY2004: $124 million
  - FY2005: $77-85 million
  - FY2006: $154-170 million

Source: L. Allen Dobson, MD, presentation to ERISA Industry Committee, Washington, DC, March 12, 2007
Vermont Blueprint for Health
Sharing Resources to Integrate Care & Control Costs

Community Care Team
- Nurse Coordinator
- Social Workers
- Dieticians
- Community Health Workers
- Care Coordinators
- Public Health Prevention Specialist

Hospitals

Mental Health & Substance Use Disorders

Public Health

Community Practice

Community Practice

Community Practice

Community Practice

HIT | Global Information | Evaluation | Operations
Cost Savings

• Adult practices with high proportion of chronically ill patients are able to save money

• Direct interaction with the physicians and significant in-person interaction with patients increased possibility of cost savings

• Pediatric practices with low proportion of chronically ill patients have not documented cost savings
Paying for Case Management and Care Coordination

- Targeted Case Management
- CPT Codes for Multi-Disciplinary Care Coordination
- Capitated Payment: Per Member Per Month Fees
  - Risk adjusted (biologic and social)
  - Tiered based on complexity and time
- Pay for Performance
- Medical Homes Certification Bonuses
- Health Homes enhanced federal match
### Evaluating Care Coordination

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<tr>
<th></th>
<th>Access</th>
<th>Quality</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Structure</td>
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<td>Process</td>
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<tr>
<td>Outcome</td>
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*Fill in the blanks*
Centrality of Families

“The health and well-being of children are inextricably linked to their parents’ physical, emotional and social health, social circumstances, and child-rearing practices.”

Resources


- O’Malley AS, Tynan A, Cohen GR, Kemper N, Davis MM. *Coordination of Care by Primary Care Practices: Strategies, Lessons and Implications*. Center for Studying Health System Change. Research Brief No. 12, April, 2009

