Care coordination in the Medical Home: Overview

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Objectives

- Describe the unique value of community practice-based care coordination to families and Medical Homes
- Describe lessons learned from a state-sponsored, practice-based care coordination pilot in pediatric primary care
- Understand the critical role of the care coordinator on the Medical Home team in the context of new payment models

Defining 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 caregiving capabilities of families.

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

-Antonelli et al., 2009
Defining CSHCN
- Kids who have or are at risk for any chronic medical or behavioral condition
- 15-18% of general population 0-17
- ~25% in population on Medicaid
- Up to 50% in some pediatric primary care settings

Coordination of care as a part of Medical Home

Primary care “Medical Home” as hub of coordination partnership
PCP= the child’s Primary Care PRACTICE (not just one provider)
- Specialists
- School
- Medical Home
- “functions”: explainer, interpreter, advisor, coordinator
- Family
- Therapies, Equipment, etc.
Logic model: how coordination improves outcomes

Evidence on care coordination

- Generally: mixed on financial outcomes; very positive on utilization/clinical outcomes
- Turchi et al (2009): families reporting adequate CC also report decreased missed school days, decreased ED visits
- Several disease-specific studies: CC reduces hospitalizations (though may not reduce overall charges/costs due to greater identified needs)

Why a care coordinator?

- Care coordinator as “specialist on team”
  - Special expertise and training: SW, RN, NP…and/or life experience
    - Home care, school issues, housing issues
  - Available frequently when I’m not
  - More time than a 15 minute visit; can help arrange team meetings/phone calls
  - Makes families talk, smile more
  - Lowers my blood pressure, makes best use of my time
Why a care coordinator?

- Docs aren’t trained to be care coordinators
- Docs can’t be reimbursed for care coordination (not easily, anyway)
- Docs’ time is very expensive
- Docs are too busy, some are not interested
- Families of kids with (and without) chronic conditions have so many needs beyond physician care!
- Practice re-engineering to train nurses and/or MAs and/or SWs one option

What happens without care coordination?

- Needs are not identified
- Identified needs are not followed up
- Referrals and other services not coordinated
  - Duplication of tests/treatments (waste)
  - Unnecessary ED visits

Massachusetts DPH pilot, 2006-8: lessons learned

- Prior to this: Title V care coordinators in regional DPH offices
  - Available to practices (or anyone) by phone
  - Little known
  - Little used
- Structure:
  - 6-12 practices per region (6 regions) had a shared care coordinator on site
  - Scope broad but variable
Massachusetts DPH pilot, 2006-8: lessons learned

- Each care coordinator would sit in practices with providers typically 2-3 days a week
  - Would interact with other practice resources somewhat (SW, medical-legal, +/- nursing)
  - Worked with families on site
  - Occasional home and school visits

Massachusetts DPH pilot, 2007-8: lessons learned

- Results:
  - Popular with families
  - Used variably by providers, seen as indispensable by some
  - Needs BROAD:
    - Medical and associated therapies (expected)
    - Many SW needs
    - Many needs related to navigating educational system
    - Many, many mental health needs

Massachusetts DPH pilot, 2007-8: lessons learned

- Results:
  - Days when CC not on site or on vacation: few calls to regional office, increased frustration
  - CCs who saw their role as broader were seen by families and providers as more helpful
  - CCs who were more engaged/proactive in managing patient schedules with providers were seen as much more helpful
Followup: UMass Pediatric Primary Care experience

- Grant funded care coordinator after DPH pilot ended, 0.5 FTE
- Bilingual, bicultural parent with BS and life experience with CSHCN
- Mentored by experienced DPH coordinator for 6 months
- Hugely helpful, though mentoring essential
- Biggest challenge: setting appropriate scope
- Able to stretch funding from 12 to 21 months!

Care coordination essentials

- On-site: useful within office flow
- "Non-categorical": not restricted to specific disease states
- "Payor-blind": no need to qualify based on insurance type or financial status
- "Need-based": services based on needs of family
  – Not just medical
  – Not just social work

Tasks

- Needs assessments: face to face best
- Connection with needed resources inside and outside medical system
- Proactive planning with medical team
- Care planning with families
- Collaboration with others with complementary strengths (e.g. nursing, SW, legal)
- Home visits as needed
- School visits as needed
Data gathering (please see handout)

- Types of needs for each child
  - Include medical, behavioral, educational, social
- Site of activities
  - Consider home, school visits
- Types of activities (80% medical but the other 20% is very valuable too)
  - Contact with many people; care plans; paperwork help
- Outcomes of activities
  - Medical, community linkages, educational, equipment/rx

Why is it so broad?

- Needs of children and families interact with one another (hard to treat child's diabetes if caregiver is depressed or housing unstable)
- Broader than the adult concept, which mainly concerns primary care-specialty coordination (but is broadening)... this has important policy implications

Yikes! How expensive is this?

- Many kids need a little CC, few need a lot
- Tiered model being developed
  - Kids we think about most are roughly 0.5%
- Best models use “tag team” or mentoring with each member “working to limits of license”
- CC increases productivity of more expensive team members!
**Funding care coordination in June 2012...**

- “Manna from Heaven” category:
  - State pilot projects
  - Grant-funded care coordination
  - These are great but TEMPORARY
- More permanent solutions:
  - Need institutional or permanent state funding
  - Business case (physician productivity; cost savings in capitated or eventual “ACO” arrangement)
  - Quality case (satisfaction; clinical outcomes)

**Care coordination in an “accountable care” world**

Picture a situation where “we” are held accountable for both costs and family outcomes... what are the issues?

- Addressing needs that translate into health and functional outcomes of the family
- Utilization: not too much, not too little
- Measuring what we do and how it works

**Care coordinator's effects on quality**

- Increased timeliness, decreased delays in care
- Elicit unspoken needs, so increase in met patient and family needs
- Better family-centered care, especially time spent and listening
- Potential for decreased disparities, depending on cultural strengths
Care coordinator's effects on cost

- Decreased inpatient hospitalization
- Decreased MD time, decreased RN time
- Decreased error rates/ rework of paperwork
- Potential for decreased waste in other areas (duplicate testing/treatments)
- Indirect: increased parent/child productivity through fewer missed work and school days

Spectrum of care coordination

- Important in an accountable care world- why? Tailoring need to resources.
- Few kids need “the whole package”
- Kids with technology dependence need a nurse CC
- Kids in an inner-city setting need a SW CC
- Kids in a setting with cultural/language diversity need navigators with expertise in their culture

Care Coordination Delivery: a spectrum

- Levels of CC:
  - Basic- 8 y.o. w/ mild intermittent asthma but an apartment with problems
  - Moderate- 30 mo old with language delay
  - Extensive- 17 y.o., CP, seizures, G-tube, nutrition, developmental and educational needs
- Flexible in methods, culturally effective
- Clarity of functions across team(s)
Conclusions

- Practice-based care coordination is more important now than ever for families of CSHCN
- Potential scope is necessarily broad but can and should be tailored to the needs of the population in each practice
- Care coordination personnel can/should be integrated into care team keeping in mind strengths/needs of existing resources

**Whatever you do, don’t do this…**