Care Coordination in the United States

Erin Fraher, PhD MPP

Director, Carolina Health Workforce Research Center,
Deputy Director, Cecil G. Sheps Center for Health Services Research

With Victoria Petermann RN BSN and Thomas C. Ricketts III PhD MPH

16 Novembre 2017
Paris, France

UNC
THE CECIL G. SHEPS CENTER
FOR HEALTH SERVICES RESEARCH

One definition of Care Coordination

Care coordination *is the deliberate organization of patient care between* ***two or more participants (including the patient****) … to facilitate the appropriate delivery of health care. Organizing care involves the marshaling of* ***personnel and other resources*** *needed for all required patient care activities, managed by the* ***exchange of information*** *among participants responsible for different aspects of care*

McDonald KM, Sundaram V, et al. *Care Coordination*. Vol 7 of Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

I like this definition/ conceptualization better

- Care coordination roles and tasks vary across settings and populations
- Key function is to "span boundaries" across settings within and outside of the health care system (Ehrlich et al., 2011). Nurse care coordinators help patients navigate their care:
  - *within* health care settings (acute and outpatient, primary care and specialty care)
  - *between* health and community settings (transportation, social care)

Many new roles emerging in US health care system

Emerging Roles

- Patient navigators
- Case managers
- Care coordinators
- Community health workers
- Community paramedics
- Care transition specialists
- Living skills specialists
- Patient family activator
- Peer and family mentors
- Peer counselors

Implications

- Many play role in patient transitions between home, community, ambulatory and acute care health settings
- Evidence shows improved care transitions reduce unnecessary hospital admissions, lower costs and improve patient satisfaction

Examples of care coordination roles/functions

- Contact patients to enroll in care coordination programs
- Create care plans
- Follow up with patients to ensure access to services
- Coordinate care between providers and settings
- Provide patient education, particularly for self-management
- Conduct medication reconciliation
- Connect patients to community services

These activities are embedded in new care delivery and payment models

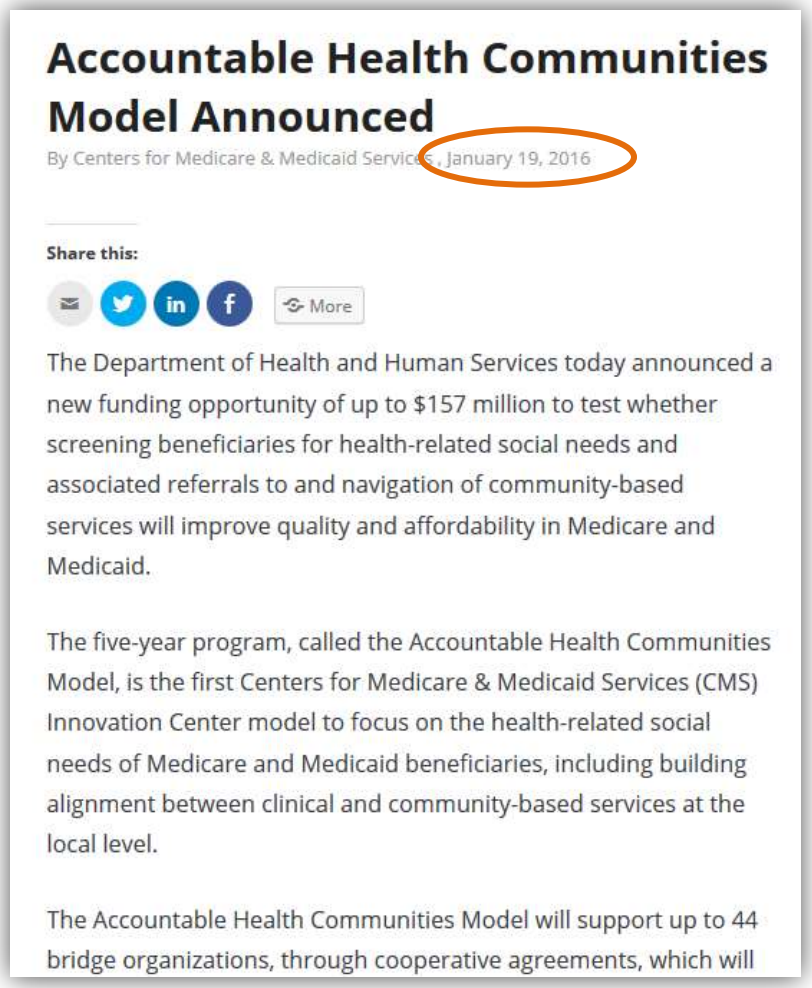
Patient Center Medical Homes and Accountable Care Organizations

- Seek to reduce fragmentation
- Increase access to care and reduce hospitalizaitons
- Emphasize primary, preventive and “upstream” care
- Use EHRs used to monitor patient and population health — increased use of data for risk stratification and hot spotting
- Focus interventions at both patient- and population-level

New Accountable Health Communities model focuses on patient navigator role for social services

"We recognize that keeping people healthy is about more than happens inside a doctor's office…we are testing whether screening patients for health-related social needs and connecting them to local resources like housing and transportation to the doctor will ultimately improve their health and reduce costs to taxpayers…"

Former Secretary Burwell,
http://www.hhs.gov/about/news/2016/01/05/first-ever-cms-innovation-center-pilot-project-test-improving-patients-health.html



Accountable Health Communities Model Announced

By Centers for Medicare & Medicaid Services, January 19, 2016

Share this: More

The Department of Health and Human Services today announced a new funding opportunity of up to $157 million to test whether screening beneficiaries for health-related social needs and associated referrals to and navigation of community-based services will improve quality and affordability in Medicare and Medicaid.

The five-year program, called the Accountable Health Communities Model, is the first Centers for Medicare & Medicaid Services (CMS) Innovation Center model to focus on the health-related social needs of Medicare and Medicaid beneficiaries, including building alignment between clinical and community-based services at the local level.

The Accountable Health Communities Model will support up to 44 bridge organizations, through cooperative agreements, which will

But it's complicated

- New roles may be filled by existing staff or new hires
- Some roles have similar functions but different titles—**care managers** and **case managers**
- Other roles have different functions but same name—**patient navigators**
- Depending on setting and patient population, roles are often filled by different types of **providers—medical assistants, social workers, nurses, etc**.

Barriers: Workforce Development Needs

- Need to minimize role confusion by clearly defining competencies and then training for new functions
- Job descriptions have to be rewritten or created
- Work flows have to be redesigned
- Lack of standardized training and funds to support training is big obstacle
- Existing staff won't delegate or share roles if they don't trust that other staff members are competent
- Time spent on training is not spent on billable services

Barriers: Payment

- **Good news:** Medicare now paying $42 per month for care coordination for chronic disease
- **Bad news:** Payment hasn't been used as frequently as expected due to physicians' lack of awareness of billing code and because patients refuse to pay co-payment
- **Good news:** Hospitals paying for care coordination to reduce risk of readmissions
- **Bad news:** Smaller practices cannot afford to pay for care coordinators

Barriers: Mixed evidence of effectiveness. 2 examples

- Sochalaski et al 2009-meta analysis of care management on heart failure patients found significant reductions in hospitalizations. Face-to-face interactions showed greater reduction than phone coordination
- Katon et al 2012-Effect of care manager for patients with depression, diabetes and heart disease showed short term gains that were not sustained at 18 and 24 months
- **Key issue:** Heterogeneity in intervention makes evaluation challenging

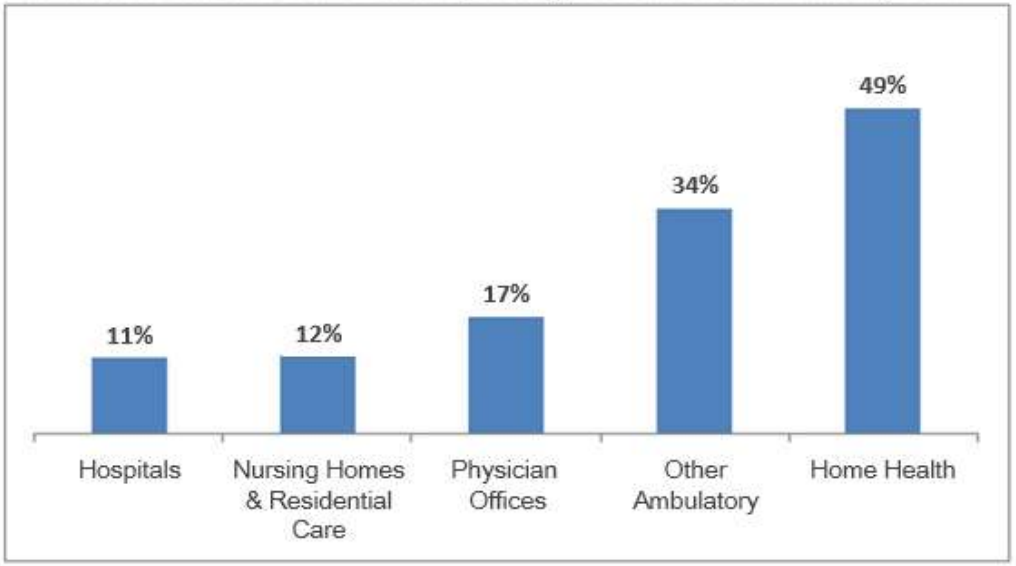
Need teams of providers: Community Aging in Place—Advancing Better Living for Elders (CAPABLE) Teams

- An occupational therapist, a registered nurse, and a handyman form team allowing seniors to age in homes
- Provide assistive devices and make home modifications to enable participants to navigate their homes more easily and safely
- After completing five-month program, 75 percent of participants (n=281 adults age 65+) had improved their performance of ADLs
- Symptoms of depression and ability to perform instrumental ADLs such as shopping and managing medications also improved
- CAPABLE is now in 12 cities in 5 states with a mix of payers, including Medicaid waiver in Michigan

US Workforce is shifting from acute to community settings

- Shift from fee-for-service to value-based payments and fines that penalize hospitals for readmissions are shifting care from inpatient to ambulatory and community-based settings
- But we generally train workforce in inpatient settings
- Need to develop innovative, "model" interprofessional training sites in community-based settings

Exhibit 1: Health Care Job Growth by Setting: December 2007–January 2017



Source: Authors' analysis of BLS Current Employment Statistics data.

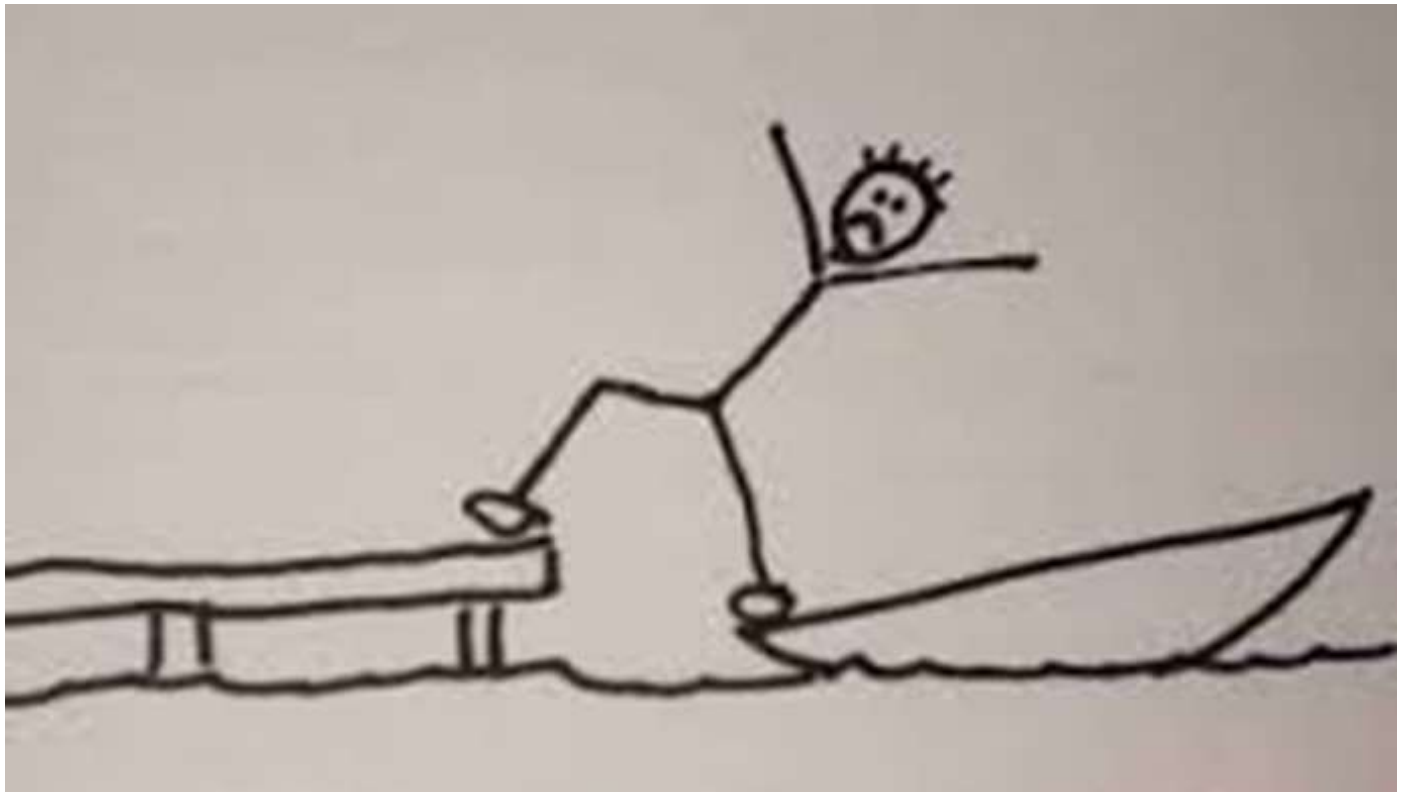
Source: Turner A, Roehrig C, Hempstead K. What's Behind 2.5 Million New Health Jobs? *Health Affairs* Blog. March 17, 2017. http://healthaffairs.org/blog/2017/03/17/whats-behind-2-5-million-new-health-jobs/

Goal: flexible workforce that can adapt to rapidly changing health care system

Both new entrants to the workforce

And our “seasoned workers”

There is lots of uncertainty out there. Makes implementing role difficult but even more important



Questions?
Contact info

Erin Fraher
erin_fraher@unc.edu
(919) 966-5012

Carolina Health Workforce Research Center and
Program on Health Workforce Research and Policy
http://www.healthworkforce.unc.edu

UNC
THE CECIL G. SHEPS CENTER
FOR HEALTH SERVICES RESEARCH

Nursing workforce: New roles, new rules

"What will it take to optimize contributions of nurses?

- ***Redesign*** *the nursing curriculum to educate nurses with new competencies;*
- ***Retrain*** *existing nurses with new skills and knowledge;*
- ***Revamp*** *licensing examination and requirements to reflect the new curriculum; and*
- ***Restructure*** *the state regulatory system to allow flexible deployment of the nurse workforce."*


Penn LDI | Interdisciplinary Nursing Quality Research Initiative

Nursing in a Transformed Health Care System: New Roles, New Rules

Key takeaway message: Although the supply of nurses is likely to meet overall demand, the nature of a nurse's job is changing dramatically. In redesigned health care systems, nurses are assuming expanded roles for a broad range of patients in ambulatory settings and community-based care. These roles involve new responsibilities for population health, care coordination and interprofessional collaboration. Nursing education needs to impart new skills and regulatory frameworks need to be updated to optimize the contributions of nurses in transformed care delivery models.

Introduction

The health care system is undergoing rapid changes that put new emphasis on population health, quality of care, and the value of the services delivered. These changes present both opportunities and challenges to the 2.9 million registered nurses (RNs) employed in the United States. There are about four times as many nurses in the health workforce than there are physicians; nurses, by sheer numbers, will play a significant role in this transformation, and will themselves be transformed in the process. Because immediate concerns about RN shortages have abated, there is an opportunity to turn attention and resources away from expanding the educational pipeline toward redesigning the system to support nursing practice in a transformed health care system. In this Research Brief, we describe the changing roles nurses have in the delivery system and assess the educational, policy, and regulatory structures that must change with them. We address the fundamental question: how can we create the right mix of nurses in the right locations, specialties, and practice settings, with the skills and competencies needed to meet these goals?

New Nursing Roles in a Redesigned Health Care System

Health care payers, including the Centers for Medicare and Medicaid Services (CMS), are shifting away from fee-for-service payments that reward volume toward paying for value, including improved population health outcomes. HHS Secretary Burwell recently announced that by 2018, 30 percent of Medicare payments will be tied to value through alternative payment and care delivery models, such as Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). As payment models shift, health care providers—including hospitals, clinics, physicians'

Robert Wood Johnson Foundation

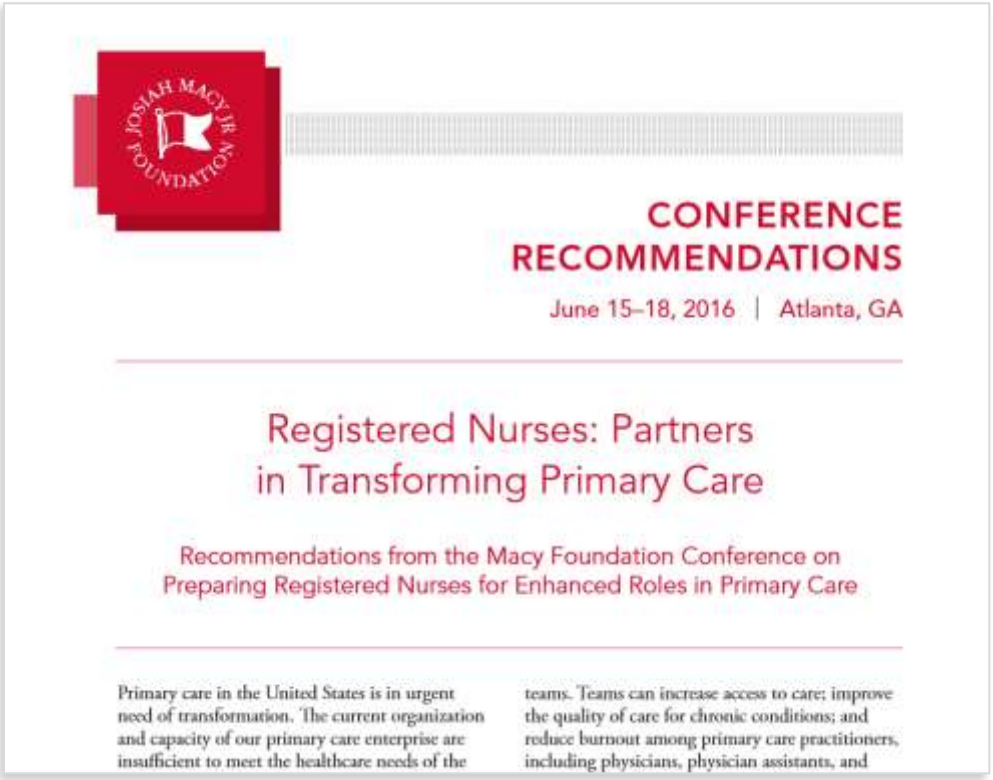
http://www.shepscenter.unc.edu/wp-content/uploads/2015/07/inqri-ldi-brief-nursing.original.pdf

*-Quoted from **Janet Weiner, MPH**. Penn LDI Voices Blog. "Re: Nurses". June 25, 2015. http://ldi.upenn.edu/voices/2015/06/25/re-nurses*

Citation: Fraher E, Spetz J, Naylor M. Nursing in a Transformed Health Care System: New Roles, New Rules. LDI/INQRI Research Brief. June 2015. http://ldi.upenn.edu/uploads/media_items/inqri-ldi-brief-nursing.original.pdf.

Macy Report: Registered Nurses are underutilized in primary care

1. Culture change needed to elevate primary care in RN education
2. Practices should redesign care delivery models to better utilize RN skills
3. Educators need to put more emphasis on primary care content
4. Lifelong learning opportunities needed to support RNs in primary care
5. Better alignment needed between RN education and practice
6. More interprofessional education and teamwork needed in curricula



JOSIAH MACY JR. FOUNDATION

CONFERENCE RECOMMENDATIONS

June 15–18, 2016 | Atlanta, GA

Registered Nurses: Partners in Transforming Primary Care

Recommendations from the Macy Foundation Conference on Preparing Registered Nurses for Enhanced Roles in Primary Care

Primary care in the United States is in urgent need of transformation. The current organization and capacity of our primary care enterprise are insufficient to meet the healthcare needs of the

teams. Teams can increase access to care; improve the quality of care for chronic conditions; and reduce burnout among primary care practitioners, including physicians, physician assistants, and

http://macyfoundation.org/docs/macy_pubs/201609_Nursing_Conference_Exectuive_Summary_Final.pdf