Care Coordination in an Integrated, Person-Centered System of Care

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Introduction

Care coordination has emerged as an important goal in the evolving U.S. health care system both as an effort to improve quality of care and lower overall costs for high-needs populations (e.g., those with chronic conditions and functional limitations, those with high levels of service utilization). Americans are living longer, and, as a consequence, the average number of years that people have chronic health conditions and functional limitations has increased.[1] Individuals with multiple chronic conditions and functional limitations often interact with a number of different providers to address each health condition and may require additional services beyond the medical system. This complex web of players underscores the need for an integrated, person-centered approach to care that takes into account the need for both medical and non-medical supportive services as well as the whole person, caregiver, and family.

The concept of care coordination is rapidly becoming incorporated into state and federal policies. In 2003, the Institute of Medicine recommended care coordination within and between organizations to ensure that patients receive high-quality, seamless, and safe care.[2] The 2010 *Patient Protection and Affordable Care Act* (ACA) built on this guidance by establishing both federal agencies and care delivery models, directed at improving care coordination across various settings.[3-5] States are now utilizing these new authorities to launch initiatives aimed at coordinating care for vulnerable adults in Medicaid as well as those who are dually eligible.[6]

Despite an increasing importance among policymakers, advocates, and providers, the term "care coordination" still lacks a clear and consistent definition. To better understand the current landscape of how care coordination is defined and operationalized, The SCAN Foundation reviewed published statements on this topic from several organizations in the medical and social services fields. This background paper seeks to accomplish two objectives. First, it summarizes the key elements in these existing definitions, highlighting the variation across providers in the medical and supportive service realms. Second, it serves as the platform for deliberating on how the definition and principles of care coordination might evolve given the changing landscape toward integrated, person-centered systems of care.

Defining an Integrated System of Care

In 2012, The SCAN Foundation presented its vision for an integrated and person-centered system of care that could best serve individuals with chronic conditions and functional limitations.[7] As part of this vision, the ideal system would actively solicit the person's needs, values and preferences for care by all providers, organizations, and delivery systems that serve him or her.[8] An "integrated" system in this ideal vision is one in which the broad array of primary, acute, post-acute, behavioral, and long-term services and supports providers are engaged around an individual's care. The system may be integrated under a single risk-bearing entity (i.e., managed care) in which the financial incentives align to cover the broad service needs of the populations although other models for achieving the end goals of integration as described in the Foundation's ideal system may exist.

In this ideal system, care coordination is the necessary component to bring all the care delivery pieces together in light of an individual's particular circumstances. Successful care coordination from the consumer's perspective would mean that the right set of providers engage with individuals at the right time and right place, involving family as appropriate to create a rational plan that puts the individual's needs, preferences, and values first.

Defining Care Coordination

Volumes have been written about the fragmented, confusing, and inefficient nature of care delivery today for vulnerable older adults and people with disabilities.[5,7,9] Complicating efforts to improve this process are the multiple definitions of what "care coordination" is and the differing ways organizations refer to this set of activities. The SCAN Foundation conducted a review of definitions of the term "care coordination" from a variety of sources, including state and federal legislation and regulations; state and federal agency documents; and policy briefs and white papers from advocacy, research and professional organizations. Organizations with public statements on care coordination were identified through consultations with experts as well as PubMed and Google searches. A list of these organizations is included in Appendix A.

Most organizations define care coordination as a broad-based endeavor to integrate multiple systems of care, including medical services, long-term services and supports, and behavioral health care services. Some organizations use the terms "care coordination" and "case management" interchangeably. Care coordination is typically defined as ongoing and not confined to one episode of care. In contrast, case management is generally defined as a subset of care coordination – working to organize care in the medical system exclusively within one setting or a specific episode. Other definitional subsets include disease management (care management/coordination activities addressing a single disease), transitional care (activities associated with the move from one site of care to another), and utilization management (a payer-focused approach to reduce procedures deemed unnecessary or inappropriate).[9]

The Foundation's text analysis of the publicly available definitions of care coordination generated four common themes: (1) a focus on person-centered care; (2) integrating various systems of care; (3) detailing essential elements and processes required in care coordination; and (4) identifying ideal outcomes of care coordination.

1. *Focus on Person-Centered Care*

Historically, care coordination focused on integrating various parts of the *medical* system, and the individual receiving care was referred to as a *patient*. In the literature, "patient-centered" care has generally been focused on treating individuals within the medical system and involving the care of specific diseases. Alternatively, "person-centered" or "person-focused" care encompasses the entire individual and includes needs that may fall outside of the medical care system, such as community-based services and supports, and is less disease- and episode-oriented.[10] This trend of referring to the individual as a *patient* is changing, and a substantial number of the definitions stress creating a system of care coordination that is focused on the *person* and an individualized plan of care.[11-20] Many definitions of care coordination also focus on the importance of involving the individual in the creation and evolution of their plan of care (i.e., making the care plan consensual and self-directed), including the family and caregiver in the process, and stressing the importance of education and engagement.[19-26] The State of Illinois definition stresses the importance of culturally and linguistically appropriate care,[27] while others emphasize the need to include in-person meetings to best capture the person's needs and preferences.[11,26,28,29] Finally, several definitions of care coordination include the need to provide care that promotes the maximum level of independence for the person and allows him or her to live in the least restrictive setting possible, a key tenet of the *Olmstead* decision.[25,30-33]

2. *Integrating Various Systems of Care*

The majority of the definitions underscore the importance of including an interdisciplinary team in the care coordination effort, including providers such as primary care physicians, specialists, pharmacists, therapists, psychiatrists, social workers and caregivers – formal and informal.[11,15,18,20,22,24,34-36] Several definitions also stress that facilitating the exchange of information about the person's care preferences and status across people and sites is critical.[17,19,21,22,24,30,32,35,37-40] The sharing of information and overall care coordination is noted as particularly important during transitions of care.[30,34,35,38,40] Finally, many definitions view the role of care coordination as a way to link the fragmented parts of the system for the person and caregiver.[14,16,17,19,24,26,36,40-48]

3. Detailing Essential Elements and Processes Associated with Care Coordination

Many definitions detail the essential elements and processes that must be included in the care coordination process. The majority of the definitions identify the role of care coordination as assisting or advocating on behalf of the person for access to needed services and supports – both medical and social. The inclusion of an assessment to determine the needs of the individual is considered essential in most definitions, in addition to a process that monitors and evaluates the individual's progress and status on an ongoing basis.[12,13,15,16,19,20,26,30-32,34,36,38,41,42,44,45,47,49,50] Several definitions include the recommendation that the care plan be evidence-based[15,39,43] and improve the quality of care for the individual.[12,17,20 ,27,30,41,45]

4. Identifying Ideal Outcomes of Care Coordination

Outcomes were identified in several definitions, including outcomes for both the individual receiving care and for the health system. For example, the AARP Public Policy Institute notes that "interventions that support patients and (and their caregivers) with information and strategies for managing and coordinating their care can improve quality of life, functional autonomy, and efficiency in the use of health services and can help control the cost of care."[30] Several organizations and agencies touch on the issue of providing cost-effective care coordination and maximizing the return on investment, ideally producing cost-savings for the payer.[15,19,20,23,25,30,39,41,43] Various definitions also cite that an ideal care coordination effort should improve healthcare outcomes, reduce and prevent hospitalizations, and raise the quality of care.[12,17,19,23-25,30,32,40,41,43] A few definitions focus on person-centered outcomes, such as one from the Centers for Medicare and Medicaid Services (CMS) which stresses that an ideal outcome of care coordination would "permit low-income seniors and people with disabilities to remain at home, living independently."[31] Finally, two entities, the National Quality Forum and the State of New Mexico, specifically focused on improving personal satisfaction with the care provided as an ideal outcome of care coordination.[17,19]

Conclusion

This review provides a baseline for understanding the current landscape of how care coordination is defined by various organizations and agencies. The majority of definitions focus on creating a system of care organized around the individual and family and incorporating the person's preferences in the assessment process. The definitions also focus on a system of care that is integrated in a variety of ways – legally, technologically, and financially – to align incentives and improve coordination. Finally, the definitions and principles focus on the specific factors that must be present in the care coordination process, including in-person assessments and ongoing evaluation and monitoring.

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Appendix A

List of organizations identified in this review with definitions of care coordination and/or principles or elements of care coordination.

- AARP Public Policy Institute
- AHRQ
- American Academy of Nursing on Policy
- American Geriatrics Society, Position Paper
- American Medical Association
- American Nurses Association
- Amerigroup
- Centers for Medicare and Medicaid Services
- Community Catalyst
- Eldercare Workforce Alliance
- Families USA
- Gerontological Society of America
- Institute of Medicine
- Leadership Council of Aging Organizations
- Mathematica Policy Research
- National Association of Geriatric Care Managers
- National Association of Social Workers
- National Center for Frontier Communities
- National Coalition on Care Coordination
- National Council on Disability
- National Quality Forum
- National Transitions of Care Coalition
- Paraprofessionals Healthcare Institute
- Service Employees International Union
- Social Work Leadership Institute, New York Academy of Medicine
- State of Alaska, Alaska Department of Health and Social Services, Senior and Disabilities Services
- State of California, Department of Health Care Services
- State of Illinois
- State of Iowa, Department of Elder Affairs
- State of Maine, Aging and Disability Services
- State of Maryland, Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration
- State of Missouri, Department of Social Services
- State of New Mexico
- State of New York, Department of Health
- State of Tennessee, Bureau of TennCare
- State of Vermont, Department of Aging and Disabilities
- State of Virginia, Department for the Aging
- State of West Virginia, Department of Health and Human Resources

- U.S. Senate, Senate Bill 3465
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