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Achieving Person-Centered Care Through Care Coordination

The SCAN Foundation aims to identify models of care that bridge medical care and supportive service systems in an effort to meet people's needs, values, and preferences. Care coordination is a central component of this vision, which ultimately leads to more person-centered care. This brief outlines The SCAN Foundation's vision for care coordination in a person-centered, organized system of care.

Introduction

Care coordination has emerged as an important feature of the evolving U.S. health care system, both as an effort to improve quality of care as well as to lower overall costs for high-needs populations (e.g., those with chronic conditions and functional limitations). In 2003, the Institute of Medicine (IOM) identified care coordination as one of the top priorities for quality improvement within and between organizations to ensure that individuals receive high-quality, seamless, and safe care.[1] The 2010 *Patient Protection and Affordable Care Act* (ACA) built upon the IOM guidance by establishing the Center for Medicare and Medicaid Innovation and the Medicare-Medicaid Coordination Office, and by creating incentives to develop new care delivery models such as Accountable Care Organizations (ACOs) and health homes, both of which seek to coordinate care across settings and providers.[2-4] States have utilized these new authorities to establish demonstrations that seek to better coordinate care for Medicaid populations as well as individuals who are dually eligible for Medicare and Medicaid.[5]

Older adults with chronic conditions and functional limitations are among the highest utilizers of medical care and supportive services, incur the highest health care costs, and often have poor health outcomes.[6-8] Many of the challenges faced by this population are the result of the highly fragmented nature of the current system of care. These individuals might see multiple providers from various sectors – medical, social, behavioral – all of whom may have different care processes, payment arrangements, and health record systems. As a person moves from one provider to another, a lack of communication between them can lead to disorganized transitions, as well as confusion and frustration for all involved.[9] Older adults with both chronic conditions and functional limitations are the focus of this exploration because they stand to benefit the most from a strong

model of care that organizes all the players and processes in a way that meets their needs, values, and preferences.

Defining Care Coordination

Volumes have been written about the fragmented, confusing, and inefficient nature of care delivery today for individuals with chronic conditions and functional limitations.[4,10,11] 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 Foundation reviewed definitions of the term "care coordination" and organizational statements of care coordination principles, finding over 40 entities with publications on the topic.* On September 12, 2013, we convened a group of 17 national content experts from various organizations to review these reports and collectively identify the key features or principles of care coordination in a person-centered, integrated system of care (see Acknowledgments).

Care coordination is "...a service based on consultations and information with and among the individual, his/her providers, and family members where appropriate, facilitated by a knowledgeable and trained professional that leads to the individual obtaining the right care, in the right place, at the right time to address his/her needs with an appropriate use of resources."

Based on this groundwork, The SCAN Foundation developed the following working definition of care coordination: *a service based on consultations and information with and among the individual, his/her providers, and family members where appropriate, facilitated by a knowledgeable and trained professional that leads to the individual obtaining the right care, in the right place, at the right time to address his/her needs with an appropriate use of resources*. Care coordination in a person-centered system is about meeting the needs of the individual and should not be constrained by existing system components. The system may not be responsible for covering the costs of all services, but is responsible for identifying the critical needs of the individual and supporting him/her in getting access to those services.

In the next section, we describe key structure and process components of care coordination to achieve outcomes based on our definition.

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*Content review was conducted through a careful search of PubMed, an online search, and consultation with experts in the field. Publications reflecting the perspectives of more than 40 entities were identified, including state and federal legislation and regulations; state and federal agency documents; and policy briefs and white papers from advocacy, research and professional organizations. The SCAN Foundation developed a background paper that summarizes the literature on care coordination. This paper can be found at: http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf-care_coordination_working_paper-12-4-13.pdf.

Principles of Care Coordination

Structural Concepts: A successful model of care coordination in a person-centered system includes a structure designed primarily to serve the individual, with providers as secondary. The primary structures described below, if implemented fully, can lead to the greatest likelihood of establishing a care coordination model that puts people's needs, values, and preferences first.

- *A Single Person Accountable to the Individuals's Needs:* Individuals have and know how to access a single person accountable to their needs who works to organize and coordinate services and the providers engaged in their care plan. This care coordinator builds a relationship with the individual that creates continuity over time and across providers. This is the primary structural element from the individual's perspective.

- *Comprehensive and Effective Screening and Assessment:* Existence of comprehensive screening and assessment to develop a sound care plan that maps to the needs and preferences of the individual. Screening to identify those at risk for poor outcomes (broadly defined) can reduce

the likelihood of the person receiving services that will not be a benefit to him/her. Limited information can be gathered at the time of screening and, where integrated information systems exist, that information can be transferred to other providers, reducing the number of times the person is asked the same questions over again, which can be frustrating and burdensome. Individuals identified through the screening process as potential beneficiaries participate in an assessment that is revisited over time as their needs and preferences change. The assessment focuses not only on clinical and functional needs, but also considers the strengths of the individual and his/her support system. The assessment elicits preferences and goals and is conducted in a manner sensitive to cultural and linguistic needs and differences among people.

- *Integration of Services and Alignment of Incentives:* This includes a full scope of care services and adequately trained providers, supported through an appropriate and flexible payment mechanism that incentivizes coordination. Care coordination has the greatest opportunity to succeed in systems that align financial incentives, often through a single payment stream, to cover all needed services: primary, acute, post-acute, behavioral, and long-term

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services and supports. Providers are knowledgeable about the broader array of services available to the individual, and communications are in place for them to engage with the person and each other to develop and implement a care plan. Resources can be flexibly allocated based on what the individual needs.

• *Existence of "Compatible Infrastructure":* This can include information technology systems to support broad information sharing capacity, an integrated electronic health record, and seamless financing and billing, among other functions. Ideally, all providers and institutions in the system can access the information in order to review and support the care plan, avoid duplication of service, and prevent poor outcomes that are typically attributed to poor information transfer (e.g., medication interactions, contraindications in care).

Process Components: The following process components describe how the care coordination work gets done to ensure that people get the right care at the right time by the right provider. These are listed in no particular order as they have equal importance, and the absence of any one of these processes can weaken the outcomes of care coordination efforts.

• *Care Coordinator as Knowledgeable Facilitator:* A process is in place that "matches" the individual with a care coordinator based on their needs. The care coordinator understands the systems that the person needs to access and convenes appropriate providers as part of a responsive care team (see below). The care coordinator is predominately responsible for working with the individual to navigate the system and ensuring continuity in care plan implementation. The care coordinator is empowered to engage the individual with responsive providers.

• *Responsive Care Team:* The care coordinator engages and involves all providers necessary to discuss and implement the care plan with the individual. In instances where the person is unable or chooses not to engage directly with the team, the care coordinator ensures that the individual remains informed about the process. The care coordinator facilitates communication with the aid of information technology as needed to ensure all relevant providers receive appropriate notifications of the person's condition and changes in the care plan, consistent with each individual's needs and preferences.

• *Dynamic Care Planning Process:* The care coordinator initiates the care planning process, reflecting the goals and preferences of the individual based on a completed comprehensive assessment. The care coordinator considers all relevant providers when developing the care plan with the individual. When a new provider emerges, the care coordinator ensures the appropriate transfer of relevant care plan information in a secure fashion. In addition, the care coordinator follows up with all providers on a regular basis to ensure the receipt of services. Should services fail to be provided, the care coordinator engages with providers to determine the reasons and to develop a plan of action. The care coordinator maintains primary responsibility for ensuring fidelity to the care plan, while recognizing that the care planning process is fluid and may require alterations based on the changing condition or preferences of the individual. The care plan is modified as necessary and all providers remain engaged in the interdisciplinary care team, receiving notification upon changes in the care plan.

• *Ongoing Engagement:* A care coordinator maintains ongoing engagement with the individual and his/her social network (e.g., a spouse, a personal

care attendant), based on the individual's preferences. This relationship is built on trust and supports choice and autonomy on behalf of the person.

• *Accountability of Care Coordination Efforts:* Established processes ensure the accountability of the payer, providers, and the system to supporting the individual care plan. Ongoing evaluation of processes that comprise care coordination is critical to quality improvement efforts. Should the individual experience poor outcomes or should the system fail to honor her/his needs and preferences, a timely feedback loop alerts the care coordinator and relevant providers to facilitate appropriate changes in alignment with the person's needs, values, and preferences.

Conclusion

These structural and process elements of care coordination are, in many ways, aspirational in the current health system environment. While major infrastructure changes take time and resources, there are opportunities for health plans, Accountable Care Organizations, or other payer/multi-provider systems to move forward on some of these elements. Where could organizations start to make a substantial improvement

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toward a person-centered care coordination experience? These four activities will put an organization firmly on the path toward transformation:

- Review organizational capacity for engaging in and/or adopting the whole body of care coordination elements described above.

- Create a single point of contact for the individual and his/her family and begin to identify issues and needs before they become urgent.

- Adopt a uniform assessment process that incorporates functional need to be shared with the broad range of providers that people access.

- Incorporate the individual and his/her family directly and intentionally in developing a plan of care with whatever services are in the organizational rubric today. While the goal is to integrate the broadest array of services, including both medical and supportive, an organization can make important improvements to care and outcomes by starting to coordinate among services and providers already offered.

Organizations that start by taking small steps will be better positioned to adopt broader delivery systems and concurrent payment changes that are the future of the U.S. health care system.

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