Care Coordination is More Than a Care Coordinator

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Objectives

As a result of this session, participants will:

- Understand the difference between a care coordinator and care coordination.
- Know the key evidence- and experience-based strategies for improving care transitions and coordination.
- Be able to begin to plan for their own next steps in improving care coordination.

Who is Stratis Health?

- Independent, nonprofit, community-based Minnesota organization founded in 1971
  - Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Funded by federal and state contracts, corporate and foundation grants
- Working at the intersection of research, policy, and practice
- Rural Health is longstanding priority focus

Current alignment toward care coordination

- Incentives, penalties, and new payment models are driving a shift to population health and wellness which values (and pays for!) well coordinated patient care
- New models and approaches are emerging and being tested that can inform how care is delivered
- Need and opportunity to address medical *and* psycho-social needs of patients

But it can be confusing

- What is the difference between care coordination, a care coordinator, a care navigator, a case manager, a health coach, disease management, a care guide?
- A 2007 AHRQ systematic review found 40 different definitions for “care coordination” in the literature

Key definitions

- Care Coordination: function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites that are met over time (NQF)

Key definitions (continued)

- Care Coordinator: a person in charge of coordinating client care in a clinical or health care setting, typically responsible for developing care plans, arranging and tracking appointments, educating clients/patients and coordinating other aspects of clients' wellbeing

Differences

Care coordination

- A function
- Based on a population and their needs
- A deliberate, systematic organization of patient care
- Infrastructure, policies, and resources

Care coordinator

- A person
- Individualized action and support for a patient
- Could involve case management, coaching, advocacy
- May be clinical or non-clinical

How do you know you are effectively coordinating care?

In 2012, NQF endorsed 12 care coordination measures

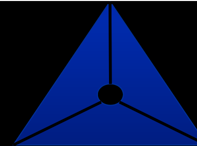
- Medication reconciliation (4 versions)
- Acute care hospitalization
- ED use w/out hospitalization
- Advance care plan
- Timely initiation of care
- Medical home system survey
- Transition record with specified elements received by discharged patients (2 versions)
- Timely transmission of transition record

What is the RARE Campaign? A Minnesota Example

- A campaign across the continuum of care to improve care transitions and reduce avoidable hospital readmissions
  - Large-scale, statewide approach
  - Initially focused on hospitals, but with active engagement across the continuum of care and the community, acknowledging that readmissions are the result of a fragmented health care system
  - Support of key stakeholders including physicians, health plans, state agencies

RARE Campaign: Maintaining patient health after a hospital stay…

Triple Aim Goals



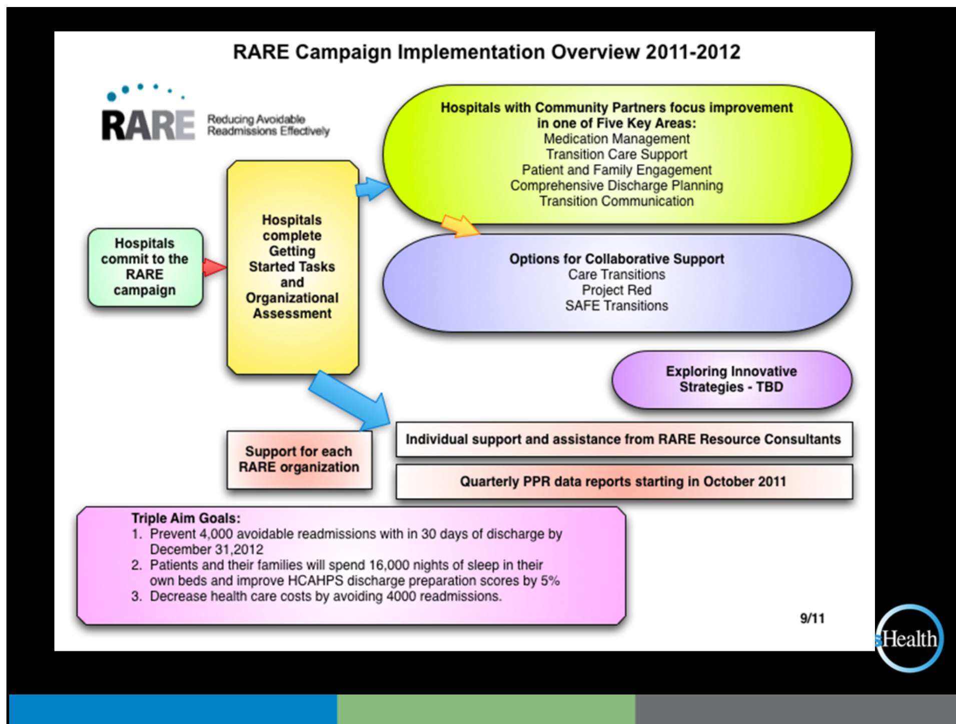
- Population health
  - Prevent 6,000 avoidable readmissions within 30 days of discharge by the end of 2013
  - Reduce overall readmissions rate by 20% from the 2009 and maintain that reduction through 2013.
- Care experience
  - Recapture 24,000 nights of patients' sleep in their own beds instead of in the hospital
- Affordability of care
  - Save $50 million in health care expenses

Minnesota RARE Campaign: Evidence-based Practices

- 5 focus areas known to impact readmissions
  - Comprehensive discharge planning
  - Transitions care support
  - Transitions communication
  - Patient and family engagement
  - Medication management

Implementation of 5 Focus Areas

- Group learning collaboratives:
  - Choice of: Project RED, Care Transitions Interventions, SAFE Transitions of Care
- RARE Resource Consultant for each hospital
- Action Days twice a year
- Topic-specific webinars, workgroups, RARE Conversations
- Website and newsletter rich with tools and resources, stories, and more



RARE Campaign: Results

- 82 hospitals participating, accounting for more than 85% of the annual statewide hospital readmissions
  - 38 Critical Access Hospitals participating
  - Enthusiastic and engaged participation
- Prevented 5,441 readmissions between 2011 and 1st quarter of 2013
- Other care settings seek greater involvement

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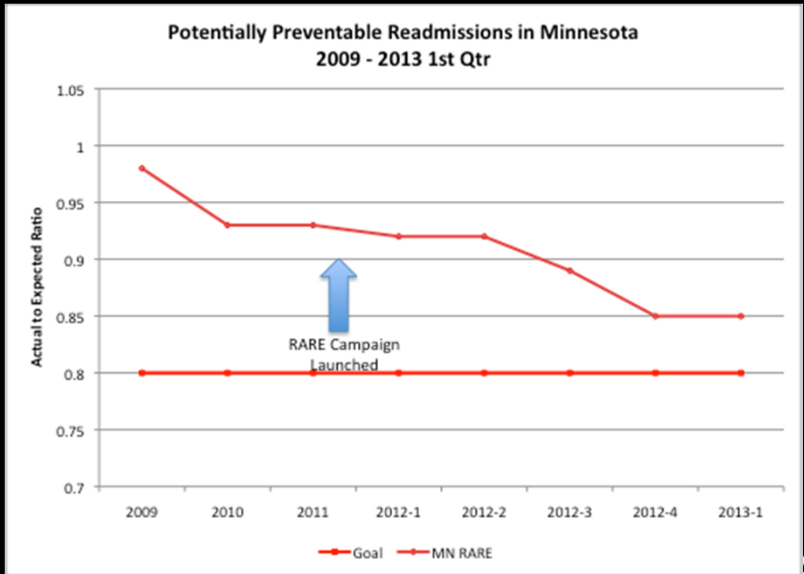

Potentially Preventable Readmissions in Minnesota
2009 - 2013 1st Qtr
Actual to Expected Ratio
1.05
1
0.95
0.9
0.85
0.8
0.75
0.7
RARE Campaign
Launched
2009
2010
2011
2012-1
2012-2
2012-3
2012-4
2013-1
Goal
MN RARE

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RARE Campaign: 5,441
Readmissions Prevented to Date
Each person represents 250 prevented readmissions, and
1,000 more nights of sleep in their own beds for Minnesotans

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Care Coordination Advice and Considerations for Rural Communities

- *One Size Does not Fit All*
- *Build for Sustainability*
- *Understand your Build-or-Partner Options*
- *Engage in Data-Driven Decision Making*
- *Leverage Shared Goals and Challenges*

Advice and Considerations

- *One Size Does not Fit All:* Use a comprehensive needs assessment to understand your current care coordination processes, gaps, and needs; then establish your goals and build a program to meet those goals – there is no universal or off-the-shelf solution (although there are many useful tools and resources to draw upon once you know what you need and want)

Advice and Considerations

- *Build for Sustainability:* Care coordination is a function which is by necessity led and managed at the local rural site – you need to build your capacity through a strong interdisciplinary team, and you have unique opportunities to connect and implement in meaningful ways within and beyond the health care system in your community

Advice and Considerations

- *Understand your Build-or-Partner Options:* The temptation may be to build rather than partner to gain the comprehensive medical and psycho-social services you need for effective care coordination – instead, engage expert, trusted community-based partners who already deliver cost-effective services

Advice and Considerations

- *Engage in Data-driven Decision Making*: data, accompanied by thoughtful analysis and interpretation, is essential to good decision making – use data and analytics to make well informed, strategic, and patient-/community-centered decisions and then measure your progress, even if you have small numbers (one or more of the NFQ measures are likely to address your focus)

Advice and Considerations

- *Leverage Shared Goals and Challenges:* While there are differences across the rural communities, there also are many common challenges and needs – find peers and colleagues who can support you, teach you, share with you

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.