15th Annual MIDAS+ User Symposium
Journey to Excellence

A NEW LOOK AT CARE
COORDINATION

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The IOM Highlights Care Coordination

Crossing the Quality Chasm

Organizations need to negotiate 6 major challenges:

- To redesign care processes to meet the needs of the chronically ill for coordinated seamless care.
- To coordinate care across patient conditions, services, and settings over time.
How would you explain it to your mother?!!
A New Look

- What is care coordination?
- What do we know about it?
- Why do we need to know more?
- How can we move ahead?
- What can you do in the meantime?
My Perspective

- Community Case Management at Carondelet
- The Community Nursing Organization (CNO)
- Case Management Society of America
- CCM (CM Certification)
My Thanks to:

Phyllis Ethridge
and the extraordinary nurses of Carondelet

Dr. Madeline Schmitt
University of Rochester

Dr. Francois Sainfort
Georgia Institute of Technology
Health Systems Institute
Care Coordination Defined

“A set of practitioner behaviors and information systems intended to bring together health services, patient needs, and streams of information to facilitate the aims of care.”

IOM, 2001, p, 133
Prevailing Models and Frameworks

- Perspective: From sociology and organizational psychology.
- Single level: Organizational structure or team behavior, not usually both.
- Ecological: The “whole” rather than the parts.
- Longer range: End-stage vs. intermediate outcomes.
Insights

- **Care Coordination** is an intentional process and involves bringing together diverse parts of the care process.
- Care coordination processes are sequential and cumulative.
- They are part of a continuum:

Cooperation  Coordination  Collaboration
Outcomes Linked to Care Coordination

- Increased patient satisfaction
- Reduced length of stay
- Fewer adverse events
- Lower mortality
- Less post-operative pain
- Improved functional performance
1990s – Picking up the Pace

• The Picker-Commonwealth Initiative on Patient-Centered Care
• Case management becomes increasingly popular in the community and the acute care setting
• Managed care embraces case management and care coordination
Changes in nursing delivery models – total patient care to functional to team to primary nursing to case management - were, in great part, intentional strategies to maintain nurses’ care coordination functions.

Carol Sammann, 2006
RWJ “INQRI” Initiative

Goal
To identify, develop, test, and use new measures that capture nursing’s contribution to improve the quality of care patient’s receive.

Priority Areas

Care Coordination
- Rescuing
- Pain Management
- Symptom Management
- Medication Management
**UHC: Critical Success Factors**

- Interdisciplinary focus
- Communication
- Nurses part of process
- Patient and family involved
- Case manage > 75% patients
- Daily rounds
- Unit-based care coordination team member
- Early discharge planning
- Follow-up after discharge
- Administrative and MD support

UHC, 2006
Compared to Other Countries

Sicker patients in the U.S. had the highest rates of:

- Repeating personal and health information
- Being sent for duplicate tests & procedures
- Receiving conflicting information
- Not having results when needed

Blenden, et al 2003
So Today, We Ask …

• What is care coordination – really?
• How do we know it when we see it?
• Who pays for it? Who gets paid?
• How do we do it better?
National Quality Forum
Endorsed Consensus Standards

- Care Coordination is a priority area for measure development and testing.

- NQF has designated several focus areas: including transitional care and communication.
### Eligibility for Care Coordination Benefit

<table>
<thead>
<tr>
<th>Eligibility Criteria</th>
<th>Medicare Members eligible</th>
<th>Percent Eligible</th>
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<tbody>
<tr>
<td>≥4 complex conditions AND 1 ADL or IADL</td>
<td>427,000</td>
<td>1.3%</td>
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<tr>
<td>Cognitive imp. AND 1 ADL or IADL</td>
<td>1,422,000</td>
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<td>≥3 complex conditions OR Cognitive imp. AND 1 ADL or IADL</td>
<td>1,969,000</td>
<td>5.8%</td>
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Cignolle, et al JAGS 2005
GAPS

- Teams as coordinators of care
- Individual contribution to the whole
- Intermediate outcomes
- Other structures that support care coordination
The Issues – In My View

- “Mushy” definitions and tools
- Ability to demonstrate impact
- Sustainability of various models
- Payment
A New Look

If we cannot measure care coordination, we cannot:

- Link it to outcomes
- Improve it
- Be paid for it
- Be incentivized to do it better
- Design better systems to support it
• **Where** is care coordination most likely to happen?

• **Who** is involved?

• **What** does each person do?

• **How** does the work get done?

• **Why?** What is the desired outcome?
## Benchmarking to Standards

<table>
<thead>
<tr>
<th>Research support available</th>
<th>NQF Hospital Consensus Standards</th>
<th>NQF Home Care Consensus Standards</th>
<th>NQF Nursing Home Consensus Standards</th>
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<tbody>
<tr>
<td>Falls</td>
<td>Falls</td>
<td>ADLs</td>
<td>ADLs</td>
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<tr>
<td>Patient Satisfaction</td>
<td>Patient Satisfaction</td>
<td>Pain</td>
<td>Pain</td>
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<tr>
<td>Discharge planning</td>
<td>Discharge planning</td>
<td>Hosp. Readmission</td>
<td>Hosp. Readmission</td>
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<td>Time of intervention for AMI</td>
<td>Wound healing</td>
<td>Weight loss</td>
</tr>
<tr>
<td>AMI</td>
<td></td>
<td>Improvement in urinary incontinence</td>
<td>Pressure ulcers</td>
</tr>
</tbody>
</table>
New Measures

- Valid and reliable
- Concurrent
- Usable
- Feasible
The Challenges

- Lack of integrated frameworks
- Methods not fully developed
- Outcomes difficult to measure
- Feasibility of ongoing data capture and monitoring
In the Meantime

1. Examine your own practice.
2. Talk to colleagues.
3. Look beyond individual activities.
4. Create your own list of care coordination activities.
5. Focus on a few relevant outcomes.
In the Meantime

6. Collect data.

7. Refine your data collection tools.

8. Address opportunities for improvement.

9. Don’t assume just because a process is in place, that’s it working well.

10. Let go of processes that do not get you where you want to go.