The Promise of Care Coordination:
Transforming Health Care Delivery

Part of a series to help advocates understand and engage in key health system reform issues.

> There are many different definitions of care coordination, but all of them point to the same goal.[1] At its core, care coordination is just what the name implies: a mechanism through which teams of health care professionals work together to ensure that their patients' health needs are being met and that the right care is being delivered in the right place, at the right time, and by the right person.

The current health care system is complicated. When patients get care, they may interact with any number of physicians, nurses, medical assistants, or other trained professionals—not to mention insurance and billing offices—across multiple settings. If health care providers don't coordinate with each other, the consequences can be harmful to the patient. For example, medication errors, unnecessary or repetitive diagnostic tests, unnecessary emergency room visits, and preventable hospital admissions and readmissions all lead to lower quality of care, and ultimately, worse health outcomes.

Poor coordination can also make care more expensive than it needs to be. Preventable hospitalizations and duplicative tests increase health care spending. In fact, inadequate care coordination is estimated to have caused between $25 and $45 billion in wasteful spending in 2011 alone due to avoidable complications and unnecessary hospital readmissions.[2]

The Affordable Care Act has created many opportunities for states to design and test new models of care delivery and payment that improve health outcomes, improve patients' experience, and reduce health care spending. These new models include accountable care organizations (ACOs) and Medicaid health homes (for a definition of these models, see page 19). A main component of these new models is care coordination programs, which allow providers and other members of the health care system to work together for the benefit of the patient. If designed thoughtfully, care coordination programs can improve patients' experiences with the health care system and their health outcomes as well as reduce wasteful spending in the long run.

As states explore new ways of structuring their health care delivery systems, advocates can and should play an active role in the development of these reforms. This brief will describe what care coordination programs should look like, explain what advocates need to know to ensure that these programs meet the complex needs of patients, and provide steps for advocates to take to make sure their state's programs remain focused on improving care quality (not just reducing spending) and, ultimately, the health of patients.

What Does that Mean?

Check out our glossary of terms, "Demystifying Care Coordination," on page 19 if you run into a term you are unfamiliar with.

CASE STUDY

The current health care delivery system: Maria's experience

Navigating the health care system can be difficult for anyone, but it is particularly hard for those with many chronic conditions, like Maria.

Maria is 62 years old and lives with her daughter and three grandchildren. She suffers from chronic obstructive pulmonary disorder (COPD), hypothyroidism, diabetes, and anxiety. In the last six months she has visited the emergency room nine times and was hospitalized during four of those visits. Maria has health coverage, however, she still finds it hard to pay the copayments and seeing all of her doctors is a burden. She is supposed to see

an ophthalmologist, podiatrist, and endocrinologist at least once annually for her diabetes care, in addition to the pulmonologist, psychiatrist, nutritionist, and primary care physician that she sees more regularly. In order to get care she has to take three different buses, which can take at least an hour and a half, so she doesn't always go when she feels she should. Also, Maria feels most comfortable seeing her doctors with her daughter who helps her ask questions and ensures that she understands her treatment plan. However, her daughter does not have much flexibility in her work schedule, which makes it more difficult for Maria to schedule appointments.

Maria is currently on seven different medications, but sometimes she does not refill them on time because she cannot afford the copays. When she feels sick, she is often unsure of which of her doctors to call first. Because of Maria's complex health conditions, there are several potential causes for symptoms like low-grade fevers and lightheadedness. When Maria does call one of her physicians, she is often told to go to the emergency room because there are no available appointments that day or because she is calling after hours. At the ER, she undergoes hours of testing to determine why she is experiencing the symptoms she has. Many times Maria ends up being admitted to the hospital while the physicians try to understand her medical history, the interactions of her different medications, and what might be causing her symptoms.

> Many times Maria ends up being admitted to the hospital while the physicians try to understand her medical history, the interactions of her different medications, and what might be causing her symptoms.

If Maria were in a care coordination program, her care would be streamlined, making it easier for her to stay healthy. ■

To see how care coordination can improve a patient's care experience and health, see "Care Coordination: Julia and Paul's Experience," on page 7.

What Is Care Coordination?

There are many different definitions of care coordination, but all of them point to the same goal.[3] At its core, care coordination is just what the name implies: a mechanism through which teams of health care professionals work together to ensure that their patients' health needs are being met and that the right care is being delivered in the right place, at the right time, and by the right person. Comprehensive care coordination involves coordinating with all of the different service providers necessary—including physicians, nurses, pharmacists, behavioral health specialists, insurance plans, community-based organizations, and more—to facilitate the patient's interactions with the health care system and improve their health outcomes.

Each care coordination program will have to determine who on the care team should assume the care coordinator responsibilities. The right person to coordinate care will be different for different patients. It will depend on the patient's unique health conditions. For some patients, the right care coordinator may be their primary care physician, or their specialist might be more appropriate. The care coordinator could also be a nurse practitioner or other mid-level health care practitioner or a person newly hired specifically to be a care coordinator. (Note: We will refer to the person who fulfills this role as the "care coordinator" for the remainder of this piece.)

The role of the care coordinator should be the same regardless of who is ultimately responsible for ensuring care coordination happens.

The care coordinator should be responsible for the following:

- Engaging the patient (and his or her caregiver, if appropriate) in the development of an individualized care plan that reflects his or her health care needs and priorities.

- Ensuring that the patient and his or her caregiver understand their role outlined in the care plan and feel equipped to fulfill their responsibilities.

- Identifying all of the barriers—psychological, social, financial, and environmental—that affect the patient's ability to adhere to treatments or maintain their health.

- Assembling the appropriate team of health care professionals to address the patient's needs.

- Assisting the patient in navigating the circuitous network of providers and often cumbersome insurance claims processes.

- Ensuring the patient's electronic health record appropriately reflects the most up-to-date information and is easily accessible to all care team members, including the patient.

- Facilitating appropriate and timely communication between care team members.

- Following up with the patient periodically to ensure their needs are being met and that their circumstances and priorities have not changed.

The scope of services that should be delivered will depend on the patient. Some patients merely need assistance making sure that their test results are accessible from multiple offices and that their providers are communicating. Other patients will need more services, such as assistance transitioning from a hospital back home or finding more affordable medications. Patients with multiple chronic conditions who regularly see multiple physicians—some may visit up to 16 different physicians in one year[4]—will require even more support. To meet the complex needs of these patients, it is not only important to coordinate among their multiple providers, but also to coordinate between providers and the patient and their caregivers, who are often very involved in helping patients manage their conditions. Patients are also likely to need other assistance, such as help with social supports, like transportation, and assistance navigating their insurance coverage or applying for financial assistance to cover the costs of their care.

What Needs to Change

In our current health care delivery system, care coordination does not happen uniformly. Improving care coordination will require a fundamental shift in how health care providers approach care delivery, and it will require that each member of the care delivery team reorient themselves to align with that approach. It is more than just a transitional care program, traditional case management, or primary care physicians and specialists talking about a shared patient. Comprehensive care coordination encompasses each of these components, but it also includes providing patients with access to a wider variety of

health and social services and with assistance navigating the system. For comprehensive care coordination to work, two main things need to change: 1) the culture of care and 2) how care is paid for.

Changing the Culture of Care

The transformation of our care delivery system begins with reorienting the process of care delivery from a fee-for-service approach to the fundamental goal of the health care system: to keep patients healthy. This will require a significant cultural shift toward true patient-centered, team-based care, and a redefinition of how patients, caregivers, providers, insurance plans, and administrative staff interact with each other.

> Care coordination will require a fundamental shift in how health care providers approach care delivery.

Care coordination programs will do the following differently:

- **Use a team-based approach to care.**
  As discussed in the previous section, care coordination involves a team that provides a wide range of services addressing patients' health needs. These include medical, behavioral health, social, and legal services, as well as long-term supports and services, care management, self-management education, and transitional care services.

- **Tailor care to the patient's needs.** Care coordination involves the care coordinator working with all of the patient's physicians and other care team members to create one comprehensive care plan tailored to the patient's health care needs and priorities. The care plan should be updated whenever the patient's needs change, such as after a hospitalization. Providers will need to actively engage patients in the decisions that affect their health and allow patients' voices to be the driving force behind the care they receive. Actively engaging the patient (and their caregiver when they have one) and making sure that he or she feels able to fulfill their responsibilities in the process and in the care plan is critical.

Remember that change will not happen overnight.

Changing the culture of care will take time. It will be challenging for everyone—patients, providers, caregivers, insurance plans, administrators, and others—to adjust to their new roles. It will be important to clearly define the responsibilities of each participant and the roles they will play in achieving coordinated care for their patients. Strong clinical—and non-clinical—leadership is necessary to provide a vision for how care should be delivered and to motivate behavior change across specialties to realize that vision.

The health care delivery system with care coordination: Julia and Paul's Experience

Care coordination can improve the quality of care that families, like Julia and Paul's, receive.

Julia and Paul live in a two bedroom apartment with their three children. Julia lost her job six months ago and Paul works part-time. They do not have health coverage, but their children are enrolled in CHIP. Their oldest son, John, is 12 years old and has severe asthma. He ends up in the emergency room at least once a month. The inhalers the doctor prescribes are expensive, which means that sometimes the family has to choose between paying for the inhalers and buying other necessities. John senses his condition is forcing his parents to make tough choices, and he has started having trouble sleeping at night. Paul thinks their cramped living space and the mold growing in their living room might be exacerbating John's asthma, but he has not been able to get their landlord on the phone to address the problem.

The primary care practice that John visits for medical care has adopted comprehensive care coordination. During one of his visits, a care coordinator sits down with John, Julia, and Paul and assesses all of John's health needs to determine if there are any other services that could help John stay healthy and out of the emergency room. The care coordinator's conversation with John and his parents reveals the significant psychological, social, and economic factors that might be aggravating John's condition. The care coordinator connects John to a behavioral health specialist to discuss why he might be having trouble sleeping, legal services to address the family's trouble with their landlord, a pharmacist to discuss if there are more affordable pharmaceutical interventions, and a social worker to connect the family with other community benefit programs they qualify for to try to lighten the strain on the family budget.

All of these professionals update John's electronic medical record as they make progress assisting the family. The pharmacist sees what medication John had been taking, and sends a secure message to the physician to ask if a particular, more affordable substitute would work. The behavioral health specialist talks with the social worker about enrolling John in an afterschool program in their community that teaches teenagers living with moderate to severe asthma to swim as a form of therapy. The electronic database that stores this information will send reminders to the care coordinator to follow up with John's family and to check on how he is feeling and the progress of these new treatment efforts.

Getting help for their son John was easy through a care coordination program, which connected them to professionals who will work together to improve his health. ◾

To see how the current health care system without care coordination works for patients, see "The current health care delivery system: Maria's experience," on page 2.

The care coordinator connects Julia and Paul to:

a behavioral health specialist to discuss why their son might be having trouble sleeping

legal services to address the family's trouble with their landlord

a pharmacist to discuss if there are more affordable pharmaceutical interventions

a social worker to connect the family with other community benefit programs they qualify for to try to lighten the strain on the family budget

Changing How Care Is Paid For

Changing the financial incentives of our health care system is critical to driving us toward true care transformation. True health care delivery system reform cannot happen without payment reform. Ensuring that payment reforms drive the delivery changes that we want to see will require four steps: 1) change the incentives, 2) build incentives on meaningful quality measures, 3) set appropriate payment levels, and 4) align payment strategies across all payers.

1. Change the incentives.

Right now, most providers are paid for providing individual services to patients. Under this fee-for-service payment system, providers are not adequately paid for providing care coordination services, and therefore, they do not stand to gain financially for providing them.

As a result of the changing structure of care delivery, providers are likely to experience reduced revenue as they provide fewer unnecessary services. In addition, for care coordination to work, providers will need to make investments in needed infrastructure and personnel. Therefore, it is important that payment reform include financial incentives for providers to coordinate care along the care continuum to best meet the needs of their patients. In accountable care organizations, for example, providers get to keep a share of the savings they produce by delivering care more efficiently as long as they maintain or improve patients' health.

2. Build incentives on meaningful quality measures.

Both private and public health insurance plans are starting demonstration projects that test new ways of paying for health care, particularly for services that strengthen care coordination. These demonstrations will show what effective payment strategies may look like. However, these new payment strategies need to be linked to relevant and meaningful quality measures, such as how often blood pressure is adequately controlled among patients with hypertension (this would be an outcome measure) or how often patients screened for a behavioral health condition actually receive a follow-up treatment plan (this would be a process measure). Setting payments based solely on reducing expenditures or reducing the number of services used can undermine quality.[5]

3. Set appropriate payment levels.

It will be important to address not only which incentives will drive practice change, but also how large incentives should be and whose behavior the incentive is trying to modify. Increasing payments for meeting certain quality goals, for example, is a good way to drive quality improvement. But it's important to ask questions like: Whose behavior needs to change to meet those quality targets? Are they equipped to make necessary changes? Will they be responsive to a financial reward, and if so, what is the appropriate reward for meeting those targets? It will be key to ensure that any new payment incentives not only align with

the goals for care delivery, but are appropriately targeted to have the desired effect.

4. Align payment strategies across all payers.

It is important for payment strategies to be aligned across both public and private payers. No strategy is likely to be successful unless multiple payers work together to provide consistent incentives to hospitals and providers. This is because individual practices often serve patients with different sources of insurance. For example, one clinic's patient population may consist of Medicare and Medicaid recipients as well as people enrolled in various private insurance plans. The incentives provided by one insurance company are unlikely to be strong enough to drive the change needed. It is, therefore, crucial to bring all payers—Medicare, Medicaid, and private insurance companies—to the table to discuss payment reform strategies that will financially encourage and enable health care practices to change.

What Is Happening Now

There have been a number of pilot projects and demonstrations of care coordination programs prior to the passage of the Affordable Care Act. In Pennsylvania, Mercy Health System and Keystone Mercy Health Plan, a Medicaid managed care organization, launched a joint project in 2008 designed to streamline care delivery for their patients. Their collaboration focused on embedding care managers in primary care settings and facilitating data sharing across the hospital and health plan tracking systems. This partnership resulted in a 17 percent drop in the hospital admission rate between 2008 and 2009, and the 30-day readmission rate also fell significantly.[6] In North Carolina, Community Care of North Carolina provides medical homes and care management for nearly 1 million Medicaid and CHIP beneficiaries. Between 2003 and 2006, asthma-related hospitalizations decreased by 40 percent, and more Community Care of North Carolina diabetes patients achieved optimal control of their blood sugar than specified in the quality benchmark established by the National Committee for Quality Assurance Diabetes Physician Recognition Program.[7]

> Many states and communities are beginning to develop care coordination programs in light of the opportunities presented in the Affordable Care Act.

Many states and communities are beginning to develop care coordination programs in light of the opportunities presented in the Affordable Care Act and because of increasing pressure to improve quality of care and to control spending. For example, seven states already have approval from Centers for Medicaid and Medicare Services (CMS) for Health Homes in Medicaid, and several other states have received planning grants.[8] The Affordable Care Act also authorized Medicare to test several different types of accountable care organization

(ACO) models. CMS is currently testing 32 Pioneer ACOs in 18 states and 153 Medicare Shared Savings Programs ACOs.[9, 10] Additionally, private health insurance plans have been working on strengthening care coordination for their enrollees. Blue Cross Blue Shield of Massachusetts has developed a new type of provider contract that is designed to foster greater coordination among providers and reward the delivery of high-quality services.[11]

One State's Approach to Care Coordination: Vermont's Blueprint for Health

Blueprint for Health is a statewide, public-private partnership in Vermont that provides physician practices with insurer-funded community health teams and access to real-time electronic information.

Originally authorized by the Vermont legislature in 2007, the program is designed to give existing primary care practices the support, infrastructure, and motivation needed to deliver coordinated, high-quality care in their current practice environment. Participating practices have access to community health teams that typically include nurse coordinators, behavioral health specialists, and social workers, but may also include health educators, nutritionists, exercise psychologists, and others. The composition of the team for a given practice is determined locally with input from community stakeholders.[12] These teams assist practices in identifying and assessing at-risk patients, facilitating access to needed services, and developing daily management and follow-up plans for patients. Additionally, practices receive access to a web-based clinical tracking system and registry that supports appropriate, evidence-based care by providing the latest information on clinical guidelines.

Through Blueprint for Health, all insurers—including Medicare, Medicaid, and private insurers in the state—provide participating practices with bonuses for improving performance based on a set of quality standards published by the National Committee for Quality Assurance (NCQA). Practices receive an enhanced per person per month (PPPM) payment based on how they perform on the NCQA scoring system.[13]

Even though the program is still relatively new, preliminary evaluations show that Blueprint for Health has been successful in improving health, patient experiences, and bending the cost curve.

Expenditure and utilization data for 2007–2010 for commercially insured patients at seven Blueprint pilot sites and a comparison control group were collected and analyzed. The results showed that for the Blueprint participants, annual expenditures per capita increased at a lower rate than controls and the annual rate of inpatient stays decreased by 6 percent as compared to less than 1 percent in the control group. ■

The Role for Advocates

The development of new health care delivery models and care coordination programs provide a great opportunity to ensure that providers are able to better serve patients with complex health conditions. Therefore, advocates should encourage the development of these programs, but it is also imperative to make sure that the consumer's best interest is kept in mind. While care coordination can reduce the delivery of unnecessary services and has the potential to reduce spending, it is critical that these models be implemented in ways that promote greater access to needed care. Advocates must ensure that new models adequately meet the needs of patients and include consumer protections.

Conversations about payment and delivery reform are already happening in many states across the country, and there are a number of ways advocates can get involved. Deciding how to design, implement, and evaluate care coordination programs in your community should be a multi-stakeholder process shaped by the unique needs, strengths, and health care infrastructure in your community. Advocates can play an instrumental role in defining those needs and ensuring the program development process is both community and patient driven. This is a unique opportunity for advocates to introduce a path to true system reform that is based on the needs of the patient.

Before you engage in conversations about care coordination in your state, here are four issues you should think about and share with other stakeholders at the table:

CARE COORDINATION

1 Design matters.

2 Care coordination should not be done solely to reduce spending.

3 More—and better—evaluation is needed.

4 Results will take time.

1. Design Matters.

Achieving the desired results of improved health and patient experience will depend largely on how care coordination programs are designed.

Advocates should promote elements that strengthen patient-centered care and fight against design elements that threaten consumers' access to needed services. As always, the devil is in the details. Whenever possible, program design should be rooted in evidence-based strategies for successful coordination and care management for complex patients.

Though care coordination programs will need to be tailored to the communities they serve, in general, the following are emerging program design elements that have been shown to accelerate success:

- **Target high-need, high-risk patient populations.**
  Programs able to identify and engage high-need, high-risk patients are more likely to improve health outcomes and reduce costs.[14] Having a system in place to routinely identify the right patients—patients who have complex needs but whose needs can still be managed in an outpatient care setting—is crucial to ensuring no patient falls through the cracks.

- **Feature frequent, in-person interactions with patients.**
  In-person interaction with patients leads to more successful care coordination programs. The successful Medicare Coordinated Care Demonstration programs averaged nearly one in-person contact per month for the first year of the patient's participation in the program.[15] Coordination and care management activities performed over the telephone have not been as successful in managing patients with complex health needs.

- **Provide access to timely information on hospital and emergency room admissions.**
  Outpatient providers learning about hospital and emergency room admissions in real time improves the likelihood of preventing future complications and subsequent hospital readmissions.[16] Patients are particularly vulnerable after these admissions and could benefit from follow-up calls and appointments where primary care providers can further explain discharge instructions and discuss self-care plans. Once available, information on hospital and emergency admissions can become the foundation for a transitional care program.

- **Include strong transitional care programs.**
  Transitional care programs help patients transition from the hospital setting to their community setting. Program staff follow up with patients periodically for four to six weeks post-discharge to ensure they understand discharge instructions, can recognize symptoms that might indicate there are complications requiring immediate attention, and that they go to follow-up appointments with their primary care physicians. Randomized controlled trials of these programs have indicated their effectiveness in reducing hospitalizations.[17] However, poorly coordinated care transitions have been shown to have a negative impact on patients' health and result in higher costs.

- **Include strong self-management educational components.**
  When patients do not understand how to manage their own chronic conditions, they can end up exacerbating their health problems. Self-management education programs can address this issue. These are community-based programs designed to equip patients and caregivers with the knowledge and skills they need to manage their chronic conditions.

Several randomized, controlled trials have shown that these kinds of programs can reduce hospital admissions and emergency room visits.[18, 19, 20]

■ **Engage patients in their health care.**
Engaging patients in their own health care decisions empowers them to take a more active role in managing their health conditions. When patients are engaged, they will feel more comfortable discussing their values and preferences with their providers when making treatment decisions. There is an increasing body of evidence that shows consumers and caregivers who are engaged, well informed, and who communicate effectively with their health care providers are more likely to receive preventive care and adhere to prescribed treatments.[21, 22]

■ **Employ multi-disciplinary teams to deliver a wide scope of care.**
Ensuring that care teams include professionals who can address the psychosocial and socioeconomic needs of patients can help address barriers patients may face in adhering to recommended treatments. For example, if a physician suggests weight loss as part of a recommended treatment plan for a newly diagnosed diabetes patient with uncontrolled blood glucose levels, it may be helpful for the patient to consult with a nutritionist, a health educator, as well as a community resource specialist who can talk with the patient about how to find affordable childcare options to allow her to exercise more frequently.

Successful Medicare Coordinated Care Demonstrations had staff available to address psychosocial health needs of their patients.[23] The demonstrations also showed that close interaction between patients, care coordinators, and key care team members (such as the primary care physician) was also important.

■ **Make sure that quality improvement is driven by data.**
It's important that care coordination programs take advantage of new developments in health information technology. Using technology will be crucial to encouraging continuous learning and improvement in our health care system.

Access to data that reflects relevant and meaningful evaluation measures is critical to ensuring progress is made toward program goals. We cannot expect to manage what we cannot measure. The Institute of Medicine recently released a report, *Best Care at Lower Cost: A Continuously Learning Health Care System*, that describes a health care system that is constantly improving as providers collect and use data measuring aspects of day-to-day interactions with patients. Comprehensive care coordination must begin to lay the foundation for this kind of learning health care system.

In this learning health care system, the best available clinical information about diagnostics and treatments is readily available to physicians in the exam room through electronic health record systems. For example, electronic health records can provide clinicians

with reminders and alerts about certain patients that can help them eliminate gaps in care and prevent duplicative services in real time. This enables physicians to more consistently provide high-quality, evidence-based health care to their patients.

This type of health information software is also equipped with tools to capture and analyze the progress a physician practice is making toward its goals of high-quality, coordinated care. These tools can help providers identify problems, respond to trends, and decide how to optimize available resources to effectively manage multiple care processes.[24]

While each care coordination program will look different and be tailored to the needs of the specific population it serves, there are best practices emerging that can help accelerate success. As you join conversations in your state about designing and implementing care coordination, be sure to draw from the lessons already learned about what has worked.

2. Care coordination should not be done solely to reduce spending.

The primary goal of care coordination should be to improve the health of patients, not to reduce health care spending. Comprehensive care coordination has the potential to reduce wasteful and unnecessary spending while improving health outcomes, by, for example, reducing the number of avoidable hospitalizations, lowering the number of emergency department visits, and minimizing unnecessary or repetitive tests. However, when talking with stakeholders,

it is important to emphasize that any savings seen from care coordination should come from reducing inappropriate or preventable use of services, not withholding services.

However, there are health systems that are starting to see their care coordination programs slowly reduce spending. In 2006, the Geisinger Health System implemented the ProvenHealth Navigator program, an advanced medical home model that emphasizes case management, care coordination systems, information management, and new payment strategies in Pennsylvania.[25] An independent evaluation team developed a model to compare each participant's cost before entering the program to the participant's observed total cost after participation in the program. The model estimated that between 2006 and 2010, the ProvenHealth Navigator program reduced Geisinger's overall costs by 7.1 percent.[26] In Vermont's Blueprint for Health program, annual expenditures per capita for Blueprint participants increased at a lower rate than expenditures for the controls.[27] This means that the Blueprint program was able to keep costs lower for that population than they would have been if the program had not been implemented. (For more on Blueprint for Health, see "One State's Approach to Care Coordination: Blueprint for Health" on page 10.)

While this early evidence is encouraging, it is important that all stakeholders understand that any reductions in health care spending that might occur will not appear on the balance sheet immediately. In particular, early financial analyses of coordinated care

models will disproportionately show the costs of upfront investments in infrastructure and personnel. Additionally, patients who have multiple, complicated health conditions have extensive health care needs and will continue to use a lot of services. Reductions in spending are by no means guaranteed.

> Savings seen from care coordination should come from reducing inappropriate or preventable use of services, not withholding services.

Advocates can play a role in managing the expectations of various stakeholders around spending reductions and remind them that the primary goal of care coordination is to improve the health of patients.

3. More—and better—evaluation is needed.

As more care coordination programs are developed and implemented, it will be crucial to ensure that the evaluations are rooted in relevant and useful metrics that can both capture the program's success in a meaningful way and identify its shortcomings. Evaluations should include metrics on the program's effect on health outcomes, patient experiences, and spending.

There is particularly little evidence for how care coordination can improve patients' experience of care. It will be important to find out how it is working for patients. For

example: Do patients feel like more of their needs are being met? Do they feel they are more in control of the care they receive? Are patients comfortable interacting with the multiple members of their health care team? All of these questions—and more— are still largely unanswered.

While some programs claim to have demonstrated that patients have better health care experiences after their providers have implemented the program, the demonstrations are sometimes based on inadequate proxy measures.[28, 29] Instead of assuming that continued patient participation in the program directly translates to improved experience, measures should reflect elements of the care experience that matter to patients. These measures should be developed in partnership with patients to ensure they capture what matters to them. They might include whether or not the patient feels that he or she had autonomy over his or her care decisions and that his or her needs were being adequately addressed. Advocates can play an important role in emphasizing the need for stronger evaluation in this area, as well as the development of more robust tools that can capture elements of the care experience that patients care about.

4. Results will take time.

In the last few years, Medicare and some state Medicaid programs have tested different care coordination approaches, which have had mixed success.

Some early evaluations of care coordination programs, however, can be misleading and may not reflect the full potential benefit of care coordination interventions. This can be problematic if continued funding is

based solely on early results. The early results from the Medicare Coordinated Care Demonstration programs are an example of this. In 2002, the Center for Medicare and Medicaid Services (CMS) selected 15 sites for the Medicare Coordinated Care Demonstration. Each program was allowed to define its own target population and design the scope of its intervention accordingly. While only two programs initially showed significant reductions in overall annual hospitalizations,[30] four programs have since been found to significantly reduce hospitalizations among a subset of high-risk enrollees.[31] If care coordination programs are well designed, they can become more successful over time.

Looking Ahead

As states continue to explore new ways of structuring their health care delivery and payment systems, advocates can and should play an active role. Comprehensive care coordination will be a key strategy in new care delivery models that aim to improve patient health and reduce waste in the health care system. This promise of better care and lower cost, however, will only be realized if programs are well designed and implemented effectively.

Advocates should push key leaders in the state to begin the process of care transformation now. Care coordination will pay off if there is long-term commitment from key stakeholders to make and sustain necessary changes to improve the health of the community.

Comprehensive care coordination promises to be a key strategy in new care delivery models that aim to improve patient health and reduce waste in the health care system.

Additional Resources

If you are interested in learning more about care coordination and different types of delivery models that support care coordination, here is a short collection of useful resources:

Sarah Baggé, *Health Homes in Medicaid: Challenges and Opportunities for Advocates* (Washington: Families USA, November 2012), available online at http://familiesusa2.org/assets/pdfs/health-system-reform/Health-Homes-in-Medicaid.pdf.

Robert Berenson and Julianne Howell, *Structuring, Financing and Paying for Effective Chronic Care Coordination: A Report Commissioned by the National Coalition on Care Coordination (N3C)* (Princeton, NJ: National Coalition on Care Coordination, 2009).

Randall Brown, *The Promise of Care Coordination: Models That Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses* (Princeton, NJ: National Coalition on Care Coordination, 2009), available online at http://www.nyam.org/social-work-leadership-institute/docs/N3C-Promise-of-Care-Coordination.pdf.

Randall S. Brown, Deborah Peikes, Greg Peterson, Jennifer Schore, and Carol M. Razafindrakoto, "Six Features of Coordinated Care Demonstration Programs That Cut Hospital Admissions of High Risk Patients," *Health Affairs* 31 no. 6 (June 2012): 1156-1166.

Michealle Gady and Marc Steinberg, *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know* (Washington, DC: Families USA, Updated February 2012), available online at (http://familiesusa2.org/assets/pdfs/health-reform/ACO-Basics.pdf).

Demystifying Care Coordination:
A Glossary of Key Terms

There are a number of different ways care coordination programs can be organized and a number of different components that should be a part of comprehensive care coordination. Over the last several years, many terms have sprung up to describe these organizational entities and programs. Some of these terms are more defined than others. Here is a brief list of some key terms to help demystify conversations about care coordination.

Accountable Care Organization (ACO): An ACO is an entity that consists of health care providers across the continuum of care (including acute care, long-term care, and behavioral and mental health care) that agrees to be held accountable for improving the health of its patients. If patients' health care costs end up being less than would otherwise be expected while health care quality is maintained or improved, the providers get to keep a share of that savings.[32] For more information, see *Making the Most of Accountable Care Organizations (ACOS): What Advocates Need to Know* (Families USA).

Care Management: Care management is a set of activities designed to engage patients and their caregivers in a collaborative process intended to assist them with managing medical conditions and psychosocial problems more effectively. The goals of care management are to improve patients' health status and reduce the need for future medical services.[33] This term is often used interchangeably with case management. Care management programs are not standardized or regulated and therefore can vary widely in their scope and design. Comprehensive, well-structured care management programs are integral to achieving comprehensive care coordination.

Case Management: The Case Management Society of America defines case management as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes."[34] This term is often used interchangeably with care management. Case management programs are not standardized or regulated, and therefore can vary widely in their scope and design. Comprehensive, well-structured case management programs are integral to achieving comprehensive care coordination.

Health Home: A health home is a provider or group of providers who coordinates care for all the medical and non-medical needs of Medicaid patients with two or more chronic conditions. The Affordable Care Act created this option as a way to allow states to use Medicaid funding to better coordinate care for high-need, high-risk populations. States can set up a health home program by amending their state Medicaid plans. For more information, see *Health Homes in Medicaid: Challenges and Opportunities for Advocates* (Families USA).

Patient-Centered Medical Home (PCMH): The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults.[35] The PCMH facilitates partnerships between patients, physicians, and caregivers. The National Committee for Quality Assurance sets standards that lay out specific criteria for practices to meet and work towards to become an accredited PCMH.

Transitional Care Program: Transitional care programs manage the process in which a patient's care shifts from being provided in one setting of care to another. Most of these programs concentrate on the transition from hospital-based care to community-based care. In these programs, patients are engaged at the hospital to develop a comprehensive discharge plan and are followed closely for four to six weeks post-discharge. The goal is to prevent readmission to the hospital.

Endnotes

[1] The National Coalition on Care Coordination (N3C) defines care coordination as "a person-centered, assessment-based interdisciplinary approach to integrating health and social support services in which a care coordinator manages and monitors an individual's needs, goals, and preferences based on a comprehensive plan." The National Quality Forum's (NQF) provides a more concrete definition by describing it as "a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time to achieve improved outcomes." For more information, see Robert Berenson and Julianne Howell, *Structuring, Financing and Paying for Effective Chronic Care Coordination: A Report Commissioned by the National Coalition on Care Coordination* (New York: National Coalition on Care Coordination, July 2009), available at http://www.urban.org/uploadedpdf/1001316_chronic_care.pdf; and National Quality Forum, *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination* (Washington, DC: National Quality Forum, 2010), available at www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=49506.

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