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Developing A Foundation For Integrated Care Coordination: Part 1

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Developing A Foundation For Integrated Care Coordination

PART 1

University Of New Hampshire

Center On Aging And Community Living &
NH Alliance For Healthy Aging

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Who We Are

The foundation for this brief is derived from work of the NH Alliance for Healthy Aging (NH AHA). NH AHA is a statewide coalition of stakeholders focused on addressing the needs of older people in NH. Stakeholders of NH AHA are a diverse group and include representation from the medical, social service, and informal care coordination systems. In 2015, the Alliance for Healthy Aging underwent an action planning process to establish the needs and priorities for creating communities across the state where older people are supported and provided dignity and choice. One of the highest priority strategies identified through this process was: *“Improve care coordination for older adults involving medical, mental health, social, community and oral health services”*.

NH AHA has identified six key domain areas that are critical to the creation of age friendly communities and include: Living Arrangements, Family Caregivers, Social and Civic Engagement, Physical and Mental Well-being, Advocacy, and Fundamental Needs. AHA is utilizing a collective impact model, which brings participants from different sectors together to collaborate on a common agenda for solving a specific social problem.

For more information on NH AHA visit www.nhaha.info.



Key Messages:

- As our national population is aging this creates an opportunity to rethink how we coordinate the multitude of systems that touch our lives as we age. Almost all of us will require some form of medical and/or social service as we age, necessitating that these services be coordinated to avoid duplication, complications and inefficiencies.
- Care coordination does occur in our three major systems today but is often in silos of the medical care and community social service, and informal support systems. There is opportunity to build upon these care coordination models to create an integrated model of care coordination.
- The informal support system typically serves to bridge the medical and community social systems but does not have direct access to those systems.
- Functions and titles related to care coordination are inconsistent within and across the systems of care, understanding the differences will help us create a collective language upon which an integrated system can be built.
- Integrated, person-centered care coordination that crosses all three systems of care can improve health.
- This brief, the first of a two-part series, describes current care coordination efforts in three major systems. The next brief will highlight best practices to advance quality person-centered and multi-system care coordination and provide recommendations to advance these models in NH.

Why Care Coordination?

The American population is changing, with people living longer now than ever before. This creates both challenges and opportunities for us as a society. As people are living longer lives, more people are experiencing a range of chronic health issues as they age. With longevity, many also experience financial challenges, social isolation and increased reliance on assistance from others. Opportunities exist in utilizing the collective knowledge of an aging society to build a system that supports and coordinates the range of needs experienced by all of us as we age.⁵

While everyone's natural process of aging is different, most individuals will need some form of assistance as they age. This might include medical attention, help with meals, or receiving assistance with daily activities – and often includes several different services, simultaneously. Trying to keep up with medical and social needs requires coordination and communication among systems of care. In the absence of integrated coordination, people can have inefficient, frustrating, and even unsafe experiences. Given this landscape, systematic support as people age is critically important.⁵

Currently there are three main systems of care that provide support to older people:

- **Medical Care System:** network of people, institutions, and resources that plan and provide medical care for individuals.
- **Community Social Service System:** organizations and people that plan and deliver human and social services for individuals.
- **Informal Support System:** partnership of an unpaid caregiver(s) (e.g., family, friend, volunteer) and the supported person, based on social relationships.

Navigating each of these systems individually can be a significant challenge; often times, individuals are accessing multiple systems at the same time. While access to specialty medical providers and pharmaceutical options in the medical care system provides for good medical care, the burden of multiple medical visits is taxing and can be confusing. The frequent need of multiple types of medical providers can also result in disjointed care. Similarly, it is common

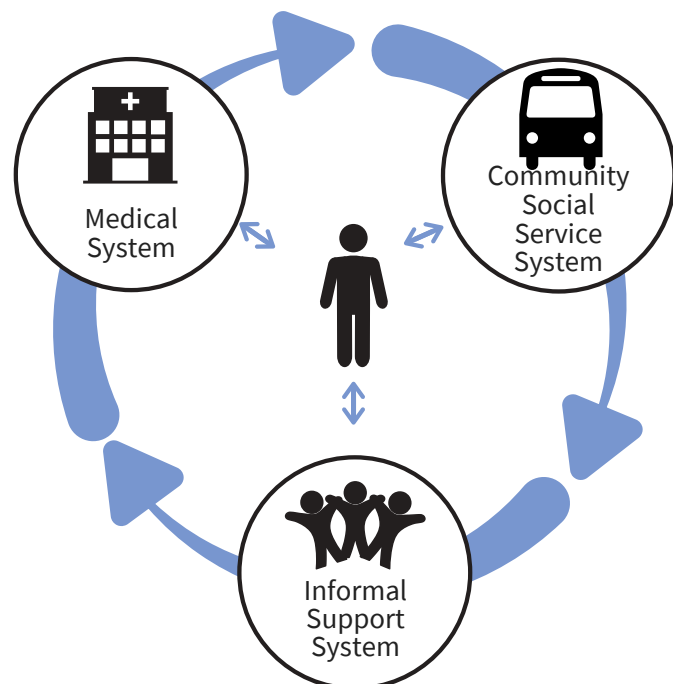
for many older adults to need multiple social services, such as transportation, meals, and social interaction simultaneously. In addition, both social needs and medical needs tend to be ongoing. For many, the unpaid caregiver or informal supports often act as a liaison, communicator, and memory bank for the care recipient in the medical care and community social service system yet has no formal role in the medical treatment and social service decision making.⁵

The existence and development of systems of care have grown substantially in the last century; however, they have grown in silos. One major problem is the lack of communication and coordination between the systems. People have needs from each system, but are left to navigate, manage, and track their own care across all of them. This lack of coordination and information sharing structures for each system often leaves individuals, care partners, and providers feeling frustrated and lost.⁹

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A Common Story

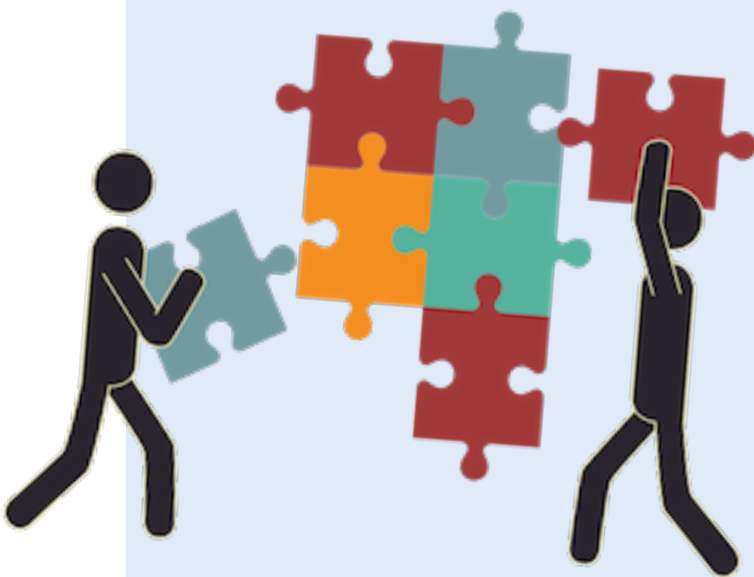
Wilma is a 72-year-old woman who lives alone in a small town in New Hampshire. After a car accident when she was in her early 60's, Wilma lost her vision. In addition to this, she has a number of other health conditions, including diabetes, chronic obstructive pulmonary disorder (COPD), and depression. Wilma does not feel comfortable going out in public alone. Since her husband's death, she depends primarily on her sister, Shirley, to help with travel to appointments, shopping, house maintenance, and various other tasks.

Wilma can attend as many as six or seven medical appointments a month for her health conditions, seeing five different providers. Wilma is often unsure which provider is responsible for the different parts of her care. She has six active prescriptions, written by four different providers. Wilma uses a transportation service to get to medical appointments when her sister is unavailable. Because she has to rely on others for errands, she tries to reduce the number of trips she goes on and often buys groceries that can be preserved longer (e.g., pre-packaged, canned, or frozen), which contradicts a healthy diet for a person with diabetes. She also has been known to cut her medications in half to make them last.

Wilma loves the small, rural town where she has lived for 35 years, but there are not many activities planned for seniors to interact. Wilma is dependent on Shirley and other infrequent visits from friends and family for social interaction. Shirley has other obligations, such as her immediate family and her job, so Wilma is often alone for days at a time. At times, Wilma has feelings of loneliness, isolation, and depression.

Shirley tries to help Wilma as much as she can but feels frustrated by the lack of communication and confusion between herself, Wilma, and the systems of care. For example, Wilma was recently having heart palpitations as a side effect of a new medication. Shirley was unaware of the new medication, because she was not at Wilma's appointment in which the new medication was prescribed. The doctors did not communicate to Shirley that they prescribed the new drug with potential side effects and/or interactions. When Shirley called Wilma's primary care doctor to find out the cause of the heart palpitations, the primary care doctor referred Shirley to Wilma's specialty doctors without finding a resolution. Finally, Shirley called the pharmacist who identified which medication might be interacting with the others.

Shirley and Wilma's situation is not unique, with the role of the informal support system being what ties the individual to the other systems of care. However, this situation puts the responsibility of coordinating the systems on the individual or family caregiver, which introduces a great deal of stress and risk for error.



A Common Definition

In recent years, much attention has been given to *care coordination* as a possible solution to improve health outcomes related to a fragmented care system. There are many successful care coordination models that organizations, systems, or groups can draw from in developing new programs. However, there is still much work to be done to achieve a truly integrated approach, cutting across silos and putting the person in the center.

Across the spectrum of healthcare systems, community social service systems, and informal support systems, the concepts and dialogue surrounding care coordination vary widely, with each system viewing the words “care coordination” differently. This lack of

consistency across models, rules, regulations, guidelines, and functions is a barrier to creating integrated care coordination systems. New Hampshire is not unlike other states in its lack of consistency in defining care coordination and in carrying out the functions and integrating across systems of care. There is no national consensus, nor do national organizations have common use of terms.⁷

Figure 1 summarizes the key concepts of care coordination in each of three systems of care. This includes the overarching priorities for each system, the language used to describe the role, and a description of the functional role played. Examples of services in each system are also listed (but it is not an all-inclusive list).

FIGURE 1: CONCEPTS OF CARE COORDINATION IN THE THREE SYSTEMS OF CARE*




System of Care	The goal is to...	To coordinate services that include...	And they are called...
Medical System	Facilitate linkages between medical providers across the array of medical services an individual may receive.	<ul style="list-style-type: none"> • Primary Care • Specialty Care • Pharmaceutical • Emergency Care • Urgent Care • Visiting Nurse 	<ul style="list-style-type: none"> • Patient Care Coordinator • Nurse Care Manger • Clinical Care Manager • Case Manager • Navigator • Outreach Educators
Community Social Service System	Identify needs and improve access to the services needed by an individual from community-based providers.	<ul style="list-style-type: none"> • Transportation Service • Meals Aligning With Medical Needs • Housing Options • In-Home Support Services 	<ul style="list-style-type: none"> • Long-term Support Counselor • Licensed Social Worker Case Manager • Medicaid Targeted Case Manager
Informal Support System	Fill the gaps in care coordination in and between the medical and community social service systems.	<ul style="list-style-type: none"> • Transportation Services • Shopping • Medical Care Coordination, Care Management, Case Management • Social Service Coordination, Care Management, Case Management • Civic Engagement • Financial Management 	<ul style="list-style-type: none"> • Wife • Husband • Daughter • Son • Sibling • Friend • Neighbor • Church Member

*the examples included in this graphic are not all inclusive

As shown in Figure 1, there is duplication in the use of terms in the three systems, but the roles and responsibilities of people with these titles vary. Figure 2, provides specific examples of how the “same” roles differ in terms of job function, credentialing, and goals. Of course, the title given to the role is not the most important aspect of the function; the most

important dimension is the person willingness to communicate with all the players in the individual’s care. However, the similar titles used interchangeably can cause confusion. Paired with the different priorities of each system, the variation of job roles further complicates addressing true integrated care coordination.

FIGURE 2: WHAT’S IN A NAME?^{1, 2, 3, 4, 10}

What is a ...	In the Medical System	In the Community Social Service System
<p>Case Manager</p> 	<p>Liaison between the patient, medical staff, and the patient’s family and friends. They monitor the patient’s treatment plan to ensure all parties are completing their parts of the plan. This role is often found in hospitals or physician practices, they can also be found in insurance organizations.</p>	<p>Functions include such items as assessment, planning, evaluation, advocacy, and providing options and support services to meet an individual’s and/or family’s social and health needs through communication and available resources.</p>
<p>Navigator</p> 	<p>Patient Navigator: Assistance provided to patients in “navigating” the medical care system to overcome barriers in accessing quality care and treatment.</p>	<p>Insurance Navigator: Unbiased assistance provided to an individual or organization to help look for health coverage options through the Marketplace.</p>
<p>Community Health Worker</p> 	<p>Often trained in a specific medical condition such as diabetes, cardiovascular, chronic obstructive pulmonary disease to act as a health educator, and possibly provide direct services such as blood sugar monitoring, blood pressure checks, and weight monitoring, and assist patients in accessing a variety of medical services. They work to activate the patient and assist them in understanding and meeting the health care systems goals.</p>	<p>May be a paid or unpaid community member who provides outreach, engagement, assessment, and person-centered treatment planning for individuals. They serve as an advocate for the family, teaching them how to navigate the medical and community health systems.</p>

Taking this variation into consideration, the NH AHA Care Coordination Group focused efforts on developing a common definition for care coordination. The NH AHA Care Coordination Group is a cross-disciplinary group of stakeholders who gathered for over a year to champion change in our state among the three systems of care. The group collectively agreed that a person-centered and a multi-system approach to care coordination efforts are important to improving the care of individuals. In the fall of 2016, this group of stakeholders

developed a definition of care coordination as a common ground to advance integrated efforts (See Figure 3).

The NH AHA definition of care coordination can be seen as a foundation for New Hampshire's efforts to improve care coordination. While significant barriers, including payment restrictions and scope of practice regulations exist, the first step to achieving success is a shared understanding of the focus and function that each system of care has created.

FIGURE 3: NH AHA CARE COORDINATION GROUP DEFINITION



“Care coordination is an individual and family centered, team-based partnership designed to assess and meet the needs of an individual to help them effectively and efficiently access resources to meet the individual’s interrelated health, social, behavioral, informal supports financial, and functional needs in order to achieve optimal health wellness, or end-of-life outcomes, according to individual preferences.”

Creating An Integrated System That Works For All

The AHA Care Coordination Group focused on the interrelated needs of individuals and the need to integrate services to link those needs. Research indicates an *integrated system of care* would best serve older people with chronic conditions, functional limitations, and social service needs. An integrated system of care “actively solicit[s] the person’s needs, values and preferences for care by all providers, organizations, and delivery systems that serve him or her.”⁸ This would span the medical care system, the community social service system,

and the informal support system. Within an integrated system of care, care coordination would ensure that the care delivery pieces are specifically tailored for each individual. This means that each person receives the right services at the right time from the right provider, the individual’s informal support system is informed and involved in care, and the individual’s needs, preferences, and values are put first. The integrated system of care coordination has several important tenets that make it successful:⁹

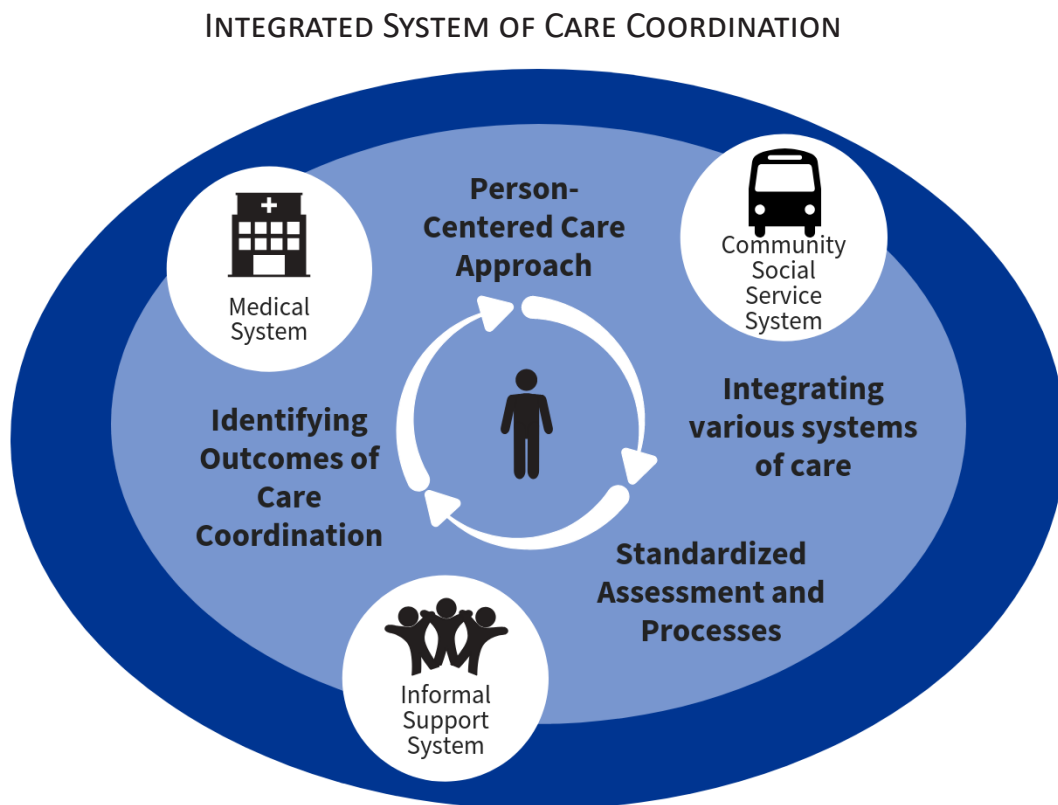
Person-Centered Care Approach: Person-centered care puts individual values and preferences at the heart of care decisions in a way that supports realistic and evolving health and life goals.⁸ In the **traditional healthcare model**, there are two types of providers: “*paternalistic*” who aim to ensure that individuals receive what the provider thinks is best for them, and “*informative*” who provide information to the person but are non-directive.⁶ The **person-centered care approach** incorporates in a third type of provider, “*shared decision maker or interpreter*” who help patients determine what they want, then suggest methods to achieve that individual’s priorities in partnership with the individual.⁶ The person-centered care approach also includes the needs of an individual across medical and community-based social services.

Integrating Various Systems of Care: Integrated care coordination includes an interdisciplinary team of providers across all three systems of care to communicate and assist in care coordination. The exchange of information

about an individual’s care preferences and status, across providers and sites, is critical to successful coordination.⁸

Standardized Assessment and Processes within Care Coordination: Research indicates that for an integrated system of care coordination model to be successful, it needs to include a standardized needs assessment tool across all three systems of care. Additionally, the integrated system would have a process in place for monitoring, tracking, and evaluating each individual’s progress on an ongoing basis.⁸

Identifying Outcomes of Care Coordination: Another tenet of integrated care coordination includes providers agreeing to outcomes on an individualized level, and on a health system level. An example outcome at the individual level could be remaining at home, living independently. An outcome at the health system level could be a reduction in emergency department visits. Integrated care coordination would include agreement to work towards both outcomes.⁸



Conclusion

As New Hampshire's population continues to age, developing and implementing an integrated, person-centered approach to care coordination within our state is vital to the work of building communities that support older adults and their families. The AHA definition of care coordination, *an individual and family centered, team based partnership designed to assess and meet the needs of an individual to help them effectively and efficiently access resources to meet the individual's interrelated health, social, behavioral, informal supports, financial, and functional needs in order to achieve optimal health wellness, or end-of-life*

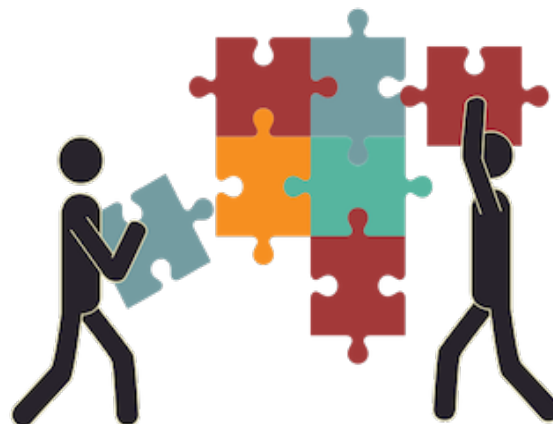
outcomes, according to individual preferences, captures the essence of a truly integrated, person-centered system of care. Improving care coordination for older people in our state starts with acknowledging the three systems of care, understanding the role and functions within the current systems, and establishing tenets to be applied in adjusting existing care coordination models. A person-centered integrated care system puts the person's needs, values and preferences at the center of his or her care, and it is a model that can be beneficial to both the person and the systems delivering services.

Rewriting the Story

Wilma, who lives with multiple chronic conditions and has interactions with all three of the systems of care, will need coordination across systems for the rest of her life. With person-centered, integrated care Wilma's story would be a lot different. Wilma's needs for transportation, appropriate meals, and socialization would be equally important as her medical needs. Wilma would not have to update her five different medical providers on her health status at every visit, because they would have information shared between them. Her medication would be

managed efficiently, addressing both health and financial aspects. Wilma would be supported in her decisions across medical and social systems to support maximizing her independence. Shirley would feel clarity around Wilma's care. Finally, Wilma would feel confident living alone and would be able to access supports to reduce her feelings of isolation, because the systems for her medical, social, and informal support needs would be coordinated.

The next brief in the series will explore examples of person-centered integrated care on state and national levels. It will also explore implementing these models in New Hampshire and will discuss recommendations and solutions to achieving an integrated care system in the state.



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