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INTERPROFESSIONAL CARE COORDINATION: LOOKING TO THE FUTURE

WITH SUPPORT FROM THE
JOSIAH MACY JR. FOUNDATION



FOREWORD

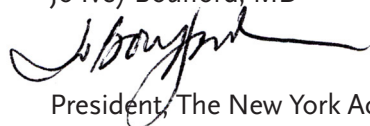
Dear colleagues:

I am pleased to present this important report, “Interprofessional Care Coordination: Looking to the Future,” which reflect the work of a project lead by the Social Work and Health Care Delivery sections and the Nursing Leadership Group of The New York Academy of Medicine, with the generous support of the Josiah Macy Jr. Foundation. The report was prepared by the Social Work Leadership Institute (SWLI) and shares a series of recommendations from national experts on care coordination from across the health professions convened over a two-year period as part of the NYAM Initiative on Interprofessional Care Coordination. The recommendations address the issues of how to operationalize effective interprofessional care coordination practice models in new and future health care delivery systems, and how to incorporate interprofessional educational and team training for care coordination into pre-clinical and clinical training.

I am deeply grateful to all who participated, especially Barbara Brenner, who leads the Social Work Section of NYAM, which was a key catalyst for the project, and the staff of the Social Work Leadership Institute under the inspired leadership of Pat Volland, its Director. We hope it will be a valuable resource in advancing interprofessional education and practice.

Sincerely,

Jo Ivey Boufford, MD

A handwritten signature in black ink, appearing to read 'Jo Boufford', with a long, sweeping horizontal flourish extending to the right.

President, The New York Academy of Medicine

INTERPROFESSIONAL CARE COORDINATION: LOOKING TO THE FUTURE

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INTRODUCTION AND BACKGROUND

Interprofessional care coordination is a tool, a means to achieve the Triple Aim of making care affordable, improving population health, and improving the experience of care. It plays an important role along the continuum of care, not only for those who live with complex medical illness and psychosocial problems and who generate high costs, but also to reduce duplication of services across professional silos for relatively healthy people and to prevent complications. Care coordination helps ensure a patient's needs and preferences for care are understood, and that those needs and preferences are shared among providers, patients, and families as the patient moves from one health care setting to another.

Since 2008, The New York Academy of Medicine (NYAM) has been engaged in efforts to inform and educate health professionals and policy makers on the importance of comprehensive care coordination to link health and medical care with the long-term care and social supports key to maintaining and improving health for older adults and individuals with multiple chronic conditions. In partnership with the American Society on Aging (ASA) and Rush University Medical Center, the Social Work Leadership Institute at NYAM co-founded the National Coalition on Care Coordination (N3C), a national membership organization dedicated to improving the quality of care for individuals through support for care coordination in health and social sectors. The Coalition is composed of 114 individual members representing 37 organizations, including consumer, aging, social service, health care, family caregiver, and professional organizations.

One of its early activities was a series of reports in which its members gathered and disseminated evidence on the effectiveness of care coordination to address the Triple Aim.¹ Options were explored for structuring, financing, and paying for care coordination that spanned the medical care and social support dimensions. N3C remained active in promoting potential models of care coordination and their effectiveness throughout the congressional debates prior to the implementation of the Affordable Care Act (ACA).²

With passage of the Affordable Care Act of 2010 (ACA), care coordination and interprofessional care teams were identified in law as important to improving health outcomes, preventing hospitalization, and reducing the cost of care for older adults and the chronically ill. The ACA has supported a range of demonstration projects that use “carrot” and “stick” incentives to integrate primary, acute, behavioral, and long-term care systems and that aim to improve the quality of chronic care through effective care transitions and care coordination. Simultaneously, a number of states have adopted “care coordination” language as central to the provision of care for Medicaid patients with complex and high-cost health, mental health, and substance abuse problems.

As an outgrowth of the work already underway at the Social Work Leadership Institute (SWLI) at NYAM, an interdisciplinary committee of NYAM Fellows was formed in February 2010 to explore what is known about care coordination models nationally as well as opportunities offered by the Affordable Care Act to incorporate care

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1. The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses, A Report Commissioned by the National Coalition on Care Coordination, By Randall Brown, Ph.D., March 2009.
 2. Structuring, Financing and Paying for Effective Chronic Care Coordination, A Report Commissioned by the National Coalition on Care Coordination, By Robert Berenson, MD, and Julianne Howell, PhD., July 2009.

coordination into the health care delivery system. Committee members represented medicine, nursing, social work, and psychiatry, and also included health care policy experts. Care coordination was acknowledged as often complicated with no single entry point to multiple systems of care, with providers from different disciplines playing pivotal roles in the care of patients in collaboration with the family. Complex criteria determine the availability of funding and services among public and private payers for the varying models of care coordination in use. There are both economic and socio-cultural barriers to coordination of care that may affect families and health care professionals.

The demand for improved coordination of health care will only increase as providers seek to implement more patient-centered and cost-effective services at both state and national levels for Medicare, Medicaid, and privately insured individuals. Gaps between current policies and services needed to support the transition of care from and between the hospital, the community, and long-term care and the need to build interdisciplinary care coordination models must be addressed. Of critical importance is the need for pre-clinical education and clinical training in interprofessional practice for the health professions most likely to be involved in making care coordination work—medicine/geriatrics, psychiatry, nursing, social work, physical and occupational therapists, and pharmacists. This also includes how to effectively work with community health workers and family and informal caregivers as members of the team.

To advance progress in this thinking, the Josiah Macy Jr. Foundation provided funding in 2011 to NYAM and its Fellows Sections on Health Care Delivery, Psychiatry, Social Work, and the Interest Group on Nursing to develop the NYAM Initiative on Interprofessional Care Coordination, a blueprint for interprofessional care coordination practice and clinical education within emerging health care delivery systems.

THE NYAM INITIATIVE ON INTERPROFESSIONAL CARE COORDINATION

The purpose of the initiative was as follows:

- Raise awareness of interprofessional care coordination models within the health professions and among health care providers and policy makers;
- Identify the differences and similarities of the elements in and models for care coordination being promoted by different disciplines among the health professions as a basis for developing interprofessional models that can be implemented successfully; and
- Recommend the critical elements of a blueprint for policy makers and educators to implement evidence-based, interprofessional care coordination models and to integrate interprofessional care coordination principles and training experiences into health professions education.

Achieving these aims was accomplished in two phases of work:

PHASE I: A conference held on May 11, 2011, entitled, “Interprofessional Care Coordination: Looking to the Future,” which brought together expert practitioners and educators from the fields of medicine, nursing, social work, and community health to identify practice and policy issues that must be addressed and resolved in order to implement effective care coordination. Conference outcomes included the following:

- Development of agreement on a definition of interprofessional “care coordination,” and clarification of shared care coordination functions and competencies among the disciplines involved in the context of emerging delivery systems. The N3C working definition put forward by keynote speaker, Dr. Susan C. Reinhard, Senior Vice President for Public Policy and Director of the Public Policy Institute at AARP, was used:

“Care coordination” is a person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator.”
- Identification of current models of care coordination being implemented in the United States, their benefits, and costs, including who does what and in what settings.
- Identification of promising interprofessional pre-clinical and clinical education models currently being implemented in and across professional schools—medicine, nursing, social work, pharmacy, PT/OT, dentistry, clinical nutrition and others—and the challenges of implementing these models.
- Agreement that operationalizing effective care coordination will require concrete steps by health care payers and educators to integrate interprofessional practice and support training in clinical settings.

PHASE II: An invitation only Interprofessional Care Coordination Education and Practice Roundtable (ICCEPR) was convened on April 24, 2012, with 20 representatives from a cross section of health professionals, educators, clinicians, federal and state policymakers, consumer organizations, and foundations to build on the outcomes of the first conference and develop recommendations:

1. to operationalize effective interprofessional care coordination practice models in new and future health care delivery systems.
2. on how to incorporate interprofessional educational and team training for care coordination in clinical settings.

FINAL RECOMMENDATIONS

PART I: What will it take to operationalize effective interprofessional care coordination practice models in new and future health care delivery systems?

RECOMMENDATION 1: Effective care coordination must include end users—patients and their families and caregivers—in active decision-making.

To date, the voice of these end users has not been sufficiently present in defining care coordination models and/or competencies that must be included to maximize their effectiveness.

RECOMMENDATION 2: Make the business case for care coordination and its sustainability using available data and clarifying what data are not available.

Any business case needs to include the elements involved in achieving the Triple Aim of making care affordable, improving population health, and improving quality, including the experience of care. There are promising care coordination demonstration models that have been evaluated with CMS/CMMI support and from which we have much to learn, including transitional care, the GRACE model, and Guided Care.³ However, because of the variability in how care coordination is done, for whom, and by whom, the outcomes have been inconsistent across demonstrations in terms of comparing cost and quality. Thus, additional evaluation is necessary.

To make the business case, studies should include the following:

1. Clear definitions of the components of the care coordination model being used (inputs); the case mix of those being served; and clear measures/criteria for quality and team performance for models that address health, mental health, and non-care related health determinants including housing, the availability and adequacy of community resources, and location (e.g., urban vs. rural);
2. Identifying populations that can benefit most from care coordination because of the level of comorbidities, psychosocial needs, and costs of care;
3. Determining the levels of service needed in terms of duration and intensity (high touch vs. low touch) linked to measurement of functional status over time;
4. Replicating the strongest programs that are able to achieve the Triple Aim, including models that integrate health, social, and community resource variables.

The business case can be most effectively developed by a collaboration of practitioners, end users of services, health systems leaders, and public and private insurers who have a variety of data available to track and compare costs and effectiveness across populations and providers and different billing systems. Large systems like Kaiser Permanente and the Geisinger clinic can collaborate with CMS, state Medicaid agencies, and private insurance companies to pool and analyze data.

RECOMMENDATION 3: Support demonstration projects that test a “wraparound” model of care for vulnerable populations pooling dollars from health, social service, and community service silos and including the costs of community outreach.

One of the challenges in arguing that care coordination is more efficient are the silos in which health, social service, and housing operate, each with its own costs. For care coordination to be cost effective there is a need to look critically at duplication of services and identify costs and savings/benefits across these program silos.

3. The American Geriatrics Society, Comprehensive care for older adults with chronic conditions, 2011, [updated 2011 Mar 24; cited 2012 Aug 21]. Available from: <http://www.americangeriatrics.org/files/documents/AGS.Recommendations.Key.Elements.for.CMS.Demo.Projects.3.24.11.pdf>

Many of the highest need patients do not maintain regular contact with or access the health care system unless in crisis when it may be too late to intervene effectively, generating higher medical costs. The costs of community outreach for these patients and/or practice staff devoted to maintaining the engagement of “ever seen” patients should be built into these models and compared to the costs without these features.

RECOMMENDATION 4: Assure flexibility to promote a functional approach to defining the members of the care coordination team based on patient/family need, the setting (e.g., hospital, outpatient practice, or across settings) and other variables such as the presence or absence of community resources.

Care coordination teams and team leadership will vary depending on patient and family needs. The team may include physicians, physician extenders, nurses, social workers, pharmacists, nutritionists, physical and occupational therapists, dentists, community health workers, and patient navigators. Community health workers and peer/patient navigators can play a special role as trusted community members who can serve as a bridge between the patient and the health care system and help the team address cultural competency and literacy issues.

Reimbursement and policies for care coordination need to be aligned to promote interprofessional care coordination. This may involve clarifying and/or removing regulatory impediments around scope of practice, professional reimbursement, and/or revenue sharing from savings as envisioned in health homes and ACOs.

RECOMMENDATION 5: Refine core competencies for interprofessional care coordination and incorporate these into general professional education, credentialing, and continuing professional education opportunities of all professional groups central to patient-centered care coordination.

Work is now underway by the Interprofessional Education Collaborative (IPEC) to refine educational content for interprofessional teams. Once completed, these open access instructional modules will represent the beginning of a national clearinghouse of competency linked learning resources for interprofessional education and models of team-based or collaborative care. Individual professions are working together to provide more collaborative and patient-centered care and include nurses, physicians, dentists, pharmacists, public health professionals, and other members of the patient health care team. IPEC is encouraged to reach out to additional professional groups not already represented by this important work (social work is one such example).

RECOMMENDATION 6: Community health workers are being increasingly identified as important contributors to community-based care coordination. Establishing roles and, where appropriate, certification should be undertaken.

The Health Resources Services Administration (HRSA) Office of Rural Health Policy (ORHP) has identified community health workers as important contributors to health care teams.⁴ Developed by ORHP in August 2011, the Community Health Workers Evidence-based Models Toolbox details the benefits gained from utilizing community health care workers and provides a framework for developing training programs that lead to certification for community health workers. These recommendations should be disseminated among policy-making bodies in education and health at state and national levels.

PART II: Develop recommendations on how to incorporate interprofessional educational and team training for care coordination in clinical settings.

The current body of evidence suggests there is considerable variation in curricula that emphasize collaborative practice among graduate-level health professions students. Information about pre-clinical and clinical curricular models of education for interprofessional practice and care coordination should be collected to build knowledge of existing educational models of IPE that support preparation for interprofessional care coordination in the clinical setting.

4 U.S. Department of Health and Human Services Health Resources and Services Administration Office of Rural Health Policy (ORHP). Community health workers evidence-based models toolbox [document on the Internet]. 2011 [cited 2012 Dec 17]. Available from: <http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf>

At the April 24 roundtable, promising educational models cited included the Veterans Administration (VA) Geriatric Research Education and Clinical Centers (GRECCs), University of Ohio at Akron, and tools developed for the implementation of the John A. Hartford Foundation's Geriatric Interdisciplinary Team Training (GITT) program.

Hospitals are not the only settings for learning teamwork and interprofessional care coordination, and additional training sites need to be identified by educational institutions, especially those that include experience with patient management across the care continuum. Options to be considered include the following:

- Teaching Health Centers⁵
- Nurse Managed Health Centers⁶
- VA Centers of Excellence in Primary Care Education⁷
- VA Geriatric Research Education and Clinical Centers (GRECCs)
- Home health agencies⁸
- Long-term care facilities

A major issue in preparing health professions students for interprofessional teamwork and care coordination is the availability of clinical training sites providing interprofessional care coordination. Students need to interact with and within interprofessional teams, have role models, and experience collaboration before their professional identities are set.

RECOMMENDATION 7: Pre-clinical experiences should be developed to prepare students from multiple disciplines for more effective interprofessional clinical training.

While interprofessional practice simulations are important, students should be prepared for them by thorough understanding of the theory and history of interdisciplinary team practice; an understanding of the preparation and skills of other health professionals, perhaps including shadowing them; and observing team practice in different settings. An in-depth exposure to the literature and practice of care coordination and the roles of various professionals in this is important, and should provide opportunities for role playing and/or simulation in preparation for experience in the clinical setting. Students need to be given meaningful roles, which lead over time to more advanced levels of interprofessional practice, including experiences with all members of a team, both professional and paraprofessional. Students also need exposure to different care coordination models and a variety of payment systems that support care coordination. This will require that schools and agencies develop opportunities for continuing, rather than episodic, experiences with individuals and families that persist across settings and changes in health status.

5 HRSA funded community-based ambulatory patient care centers that operate a primary care residency program, including: federally-qualified health centers; community mental health centers; rural health clinics; health centers operated by the Indian Health Service, an Indian tribe or tribal organization; and entities receiving funds under Title X of the Public Health Service Act.

6 Community based primary healthcare services, under the leadership of an advanced practice nurse, emphasizing health education, health promotion, and disease prevention, and their target population is usually the underserved. These centers are not-for-profit and usually have sliding scales for payment. A few NMHCs are Federally Qualified Health Centers.

7 Under the VA's New Models of Care initiative, five VA Medical Centers were awarded funding to foster transformation of clinical education by preparing graduates of health professional programs to work in and lead patient-centered interprofessional teams that provide coordinated longitudinal care.

8 Those already practicing need education and support to develop interprofessional skills in order to provide care coordination in emerging health care delivery systems.

RECOMMENDATION 8: Identify and develop new curricula and/or share existing curricula at the pre-clinical and clinical level that emphasize collaborative practice, and identify clinical settings that are delivering inter-professional care coordination, both generic and specialized, that currently include educational opportunities for clinical practice in medicine, nursing, social work and other health professions and share them widely with health professions school leaders and faculty.

The shared elements of these models could be identified and disseminated to catalyze and support the development of shared learning resources for faculty and learners at all levels and speed the development of effective interprofessional learning experiences adapted to the local environment. Such care models that were identified that have a well established affiliation with graduate institutions for healthcare professions, and include the following:

- VA – the Veterans Administration
- Geriatric Resources for Assessment and Care of Elders (GRACE – developed at Indiana University)
- FQHCs – Federally Qualified Health Centers
- PCMHs – Patient Centered Medical Homes
- GITT program at Rush University Medical Center (as referenced above)⁹
- Presidential Scholars Program at the Medical University of South Carolina¹⁰
- IPE program at the University of Nebraska Medical Center¹¹
- Interprofessional Graduate Medical Education program at University of Toronto¹²
- Interprofessional Education for Collaborative, Patient-Centered Practice (IECPCP)¹³

RECOMMENDATION 9: The integration of students into interprofessional teams in non-traditional settings and at different points in time must be evaluated in order to determine what level and model of educational preparation is the strongest predictor of effective interprofessional teamwork and care coordination and in which practice settings for each involved health profession. These include models in the pre-clinical, clinical, or residency years in medicine and dentistry; baccalaureate or advanced practice years in nursing; and baccalaureate or master's degree years in social work and other health professions.

RECOMMENDATION 10: Work with private insurers for recognition of interprofessional clinical education as part of interprofessional care coordination models that they will fund.

Current models of Graduate Medical Education are built into public financing programs for medical care (Medi-

9 Cole, K.D., Waite, M.S., & Nichols, L.O. (2003). Organizational structure, team process, and future directions of interprofessional health care teams. *Gerontology & geriatrics education*, 24(2), 35-49.

10 Ragucci, K. R., Steyer, T., Wager, K. A., West, V. T., & Zoller, J. S. (2009, March). The Presidential Scholars Program at the Medical University of South Carolina: An extracurricular approach to interprofessional education. *Journal of interprofessional care*, 23(2), 134-147.

11 Margalit, R., Thompson, S., Visovsky, C., Geske, J., Collier, D., Birk, T., et al. (2009, September). A campus-wide interprofessional education (IPE) program at the University of Nebraska Medical Center. *Quality management in health*, 18(3), 165-173.

12 Verma, S., Paterson, M., & Medves, J. (2006, Summer). Core competencies for health care professionals: What medicine, nursing, occupational therapy, and physiotherapy share. *Journal of allied health*, 35(2), 109-115.

13 Canadian Interprofessional Health Collaborative. Interprofessional Education for Collaborative, Patient-Centred Practice [homepage on the Internet]. c2008[cited 2012 Sept 12]. Available from: <http://cihc.wikispaces.com/Interprofessional+Education+for+Collaborative,+Patient-Centred+Practice>

care and Medicaid). It is now important that public insurers and private insurers build some support for the costs of clinical education for other health professionals into funding models. Some private insurance plans, such as United Healthcare, have incorporated plan-based care coordination for insured patients with high-risk conditions. An all payer approach to advancing interprofessional education and practice will be important in order to spread this approach and provide a meaningful evidence base on the best models for interprofessional care coordination services.

RECOMMENDATION 11: Create academic recognition and incentives for faculty who teach and do research in interprofessional settings and consider special academic recognition for students who complete more advanced interdisciplinary coursework and care coordination practicums.

The current academic rewards system is still not geared to cross-disciplinary scholarship and/or practice, and faculty must see that their careers and tenure opportunities will not be at risk for moving into this area.

Not all students in the health professions will work in settings that require care coordination, but all health professional education should incorporate some elements of and experience in interprofessional learning and practice. Those students who will work with older adults, the chronically ill, and patients with multiple medical, social, psychiatric, and substance abuse problems do require more intensive training in interprofessional teamwork and care coordination. Special academic recognition for excellence in interprofessional learning and practice could be devised to acknowledge these more intensive educational experiences.

RECOMMENDATION 12: Promote the importance of educational and practice environments needed for training in interprofessional practice and care coordination to educational leaders.

High-quality sites for interprofessional team practice and care coordination must be established. Faculty members who take on the challenge of educating students in these settings and in classroom work that prepares all students for some interprofessional experiences should be rewarded. Changes in scheduling and timing of educational offerings must be made to permit students from different schools to have educational experiences, and will require support at the highest levels of the educational enterprise—Vice Chancellors for Health Affairs and Deans—within academic institutions. They, in turn, must support efforts to influence key educational and practice policy makers to help promote this kind of educational and practice experience for our future health professionals.

Roundtable participants are listed in Appendix A.

A summary of the first conference on May 11, 2011 is in Appendix B.



INTERPROFESSIONAL CARE COORDINATION: LOOKING TO THE FUTURE

APPENDIX A:

List of Attendees, Roundtable on Interprofessional Care Coordination Education and Practice, Tuesday, April 24 2012

1. Gregory Allen, MSW
*Director, Division of Program Development and Management
Office of Health Insurance Programs
New York State Department of Health*
2. Jeane W. Anastas, PhD, LMSW
*Professor of Social Work; Director, Strategic Planning and New Initiatives
New York University Silver School of Social Work*
3. Carol Aschenbrenner, MD
*Chief Medical Education Office
Association of American Medical Colleges*
4. Emma Barker, MSW
*HPPAE Program Officer
Social Work Leadership Institute at the New York Academy of Medicine*
5. Polly Bednash, PhD, FN, FAAN
*CEO/Executive Director
American Association of Colleges of Nursing*
6. Jo Ivey Boufford, MD
*President
The New York Academy of Medicine*
7. Barbara Brenner, DrPH, MSW
*Associate Professor Preventive Medicine
Mount Sinai School of Medicine*
8. Mary Ann Christopher, MSN, RN, FAAN
*President & CEO
Visiting Nurse Service of New York*
9. Elaine P. Congress, DSW, MAT, MA
*Professor and Associate Dean
Fordham University Graduate School of Social Service*
10. Steven Counsell, MD
*Mary Elizabeth Mitchell Professor
Director, IU Geriatrics
Scientist, IU Center for Aging Research
Indiana University School of Medicine*
11. Venus Ginés, MA
*CEO
Día de La Mujer Latina, Inc.*
12. Michael Ginsburg, LMSW
*Program Manager
Social Work Leadership Institute at the New York Academy of Medicine*
13. Susanna Ginsburg, MSW
*Owner
SG Associates Consulting, LLC*
14. Robyn Golden, MA, LCSW
*Director of Health and Aging
Rush University Medical Center*
15. Ida Hess, MSN, FNP-BC
University of Illinois at Chicago College of Nursing

16. Janet Heinrich, DrPH, RN, FAAN
*Associate Administrator, Bureau of Health Professions
Health Resources and Services Administration
U.S. Department of Health and Human Services*
17. Judith L. Howe, PhD, MS, MPA
*Professor, Departments of Geriatrics and Preventive Medicine, Mount Sinai School of Medicine
Director, New York Consortium of Geriatric Education Centers
Associate Director/Education & Evaluation, VISN 3 GRECC at James J. Peters VAMC
Director, VA Interprofessional Palliative Care Fellowship Program*
18. Todd James, MD
*Medical Director, GRACE
Wishard Memorial Hospital*
19. Robert Kerr, PharmD
*Vice President of Academic Affairs
American Association of Colleges of Pharmacy*
20. Ronda Kotelchuck
*CEO
Primary Care Development Corporation*
21. Gerri Lamb, PhD, RN, FAAN
*Associate Professor
College of Nursing and Health Innovation
Arizona State University*
22. Mildred D. Mailick, DSW
*Professor Emeritus
Silberman School of Social Work at Hunter College*
23. Beverly Malone, PhD, RN, FAAN
*CEO
National League for Nursing*
24. Diana J. Mason, PhD, RN, FAAN, DHL (Hon.)
*Rudin Professor of Nursing
Hunter College-Bellevue School of Nursing of the City University of New York*
25. Susan Mende, BSN, MPH
*Senior Program Officer
Robert Wood Johnson Foundation*
26. Mathy Mezey, EdD, RN, FAAN
*Associate Director, Education Initiatives
Hartford Institute for Geriatric Nursing
New York University College of Nursing*
27. Ronnie Moore, PharmD
*Senior Director of Pharmacy Experiential Courses
Touro College of Pharmacy*
28. Nora Obrien-Suric, PhD
*Senior Program Officer
The John A. Hartford Foundation*
29. Pat Polansky, RN, MS
*Director, Center to Champion Nursing in America
AARP Public Policy Institute*
30. Vicki Rizzo, MSW, PhD
*Assistant Professor of Social Work
Columbia University School of Social Work*
31. Cheryl Schraeder, PhD, RN, FAAN
*Director of Policy & Practice Initiatives, Institute for Health Care Innovation (IHI)
University of Illinois at Chicago College of Nursing*
32. Lloyd Sederer, MD
*Medical Director
New York State Office of Mental Health*
33. Kenneth Shay, DDS, MS
*Director of Geriatric Programs
VA Office of Geriatrics and Extended Care
Ann Arbor VA Medical Center*
34. Carol Storey-Johnson, MD
*Senior Associate Dean
Weill Cornell Medical College*
35. George E. Thibault, MD
*President
Josiah Macy Jr. Foundation*
36. Judith Trachtenberg, LCSW
*Columbia University School of Social Work
Wurzweiler School of Social Work at Yeshiva University*
37. Patricia J. Volland, MSW, MBA
*Director, Social Work Leadership Institute
New York Academy of Medicine*
38. Brenda Zierler, PhD, RN, FAAN
*Professor, Behavioral Nursing and Health Systems
University of Washington*



INTERPROFESSIONAL CARE COORDINATION: LOOKING TO THE FUTURE

APPENDIX B:

On May 24, 2011, The New York Academy of Medicine (NYAM) sponsored the conference “Interprofessional Care Coordination: Looking to the Future” to raise awareness and disseminate information about models of interprofessional care coordination, the education of the interprofessional care team, and its role in carrying out comprehensive care coordination.

The Affordable Care Act of 2009 raised the profile of care coordination by identifying interprofessional care teams as important to improve health outcomes and reduce excessive hospitalization. Federal and state policy-makers are looking at financial incentives to improve the coordination of care across medical, psychiatric, and social service delivery systems. In addition to highlighting effective care models using interprofessional teams, conference panelists explored the development of interprofessional competencies and how they are being used to guide education in this important area.

The conference was planned and organized by NYAM Fellows from the disciplines of health care policy, nursing, psychiatry, and social work, and had these objectives:

- Define “care coordination.”
- Identify and describe interdisciplinary/interprofessional care coordination models currently being implemented across the United States, their benefits, and their costs.
- Identify issues that must be addressed and resolved in order to implement effective care coordination, especially funding and integration into health care delivery systems and preparation of the health care workforce to work within interprofessional teams, and with patients and their caregivers.

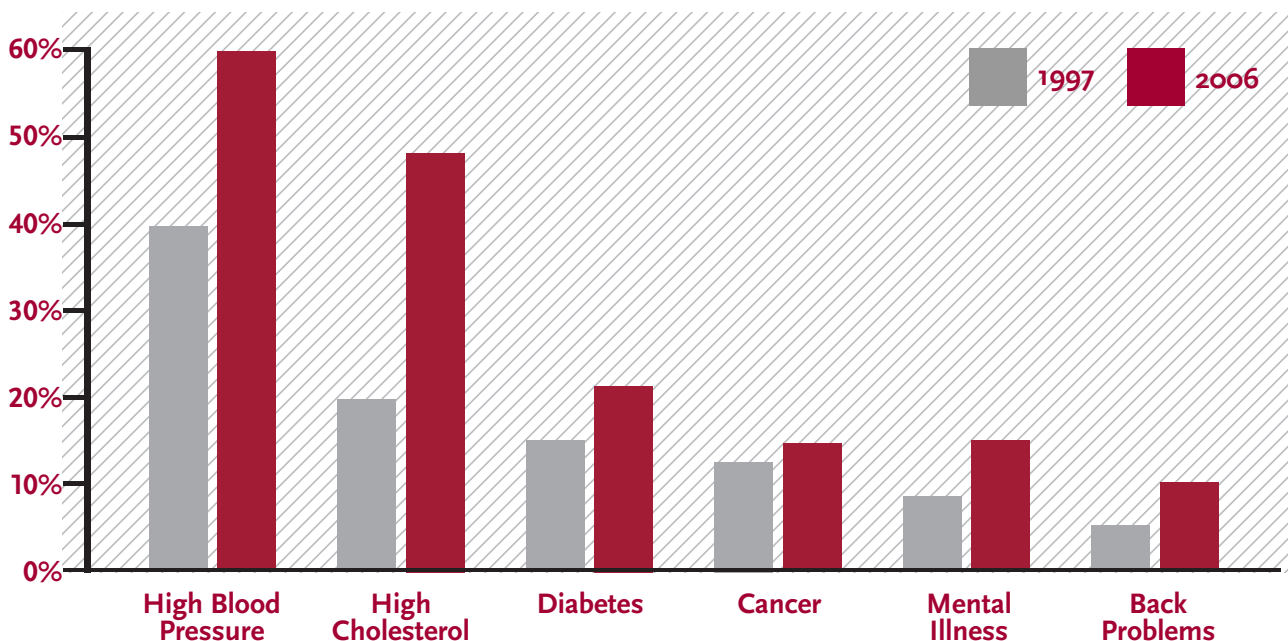
DEFINING & IDENTIFYING THE NEED FOR CARE COORDINATION

Keynote speaker Dr. Susan C. Reinhard, Senior Vice President for Public Policy and Director of the Public Policy Institute at AARP, recommended using the definition of care coordination developed by the National Coalition on Care Coordination (N3C):

“‘Care coordination’ is a person and family-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator.”

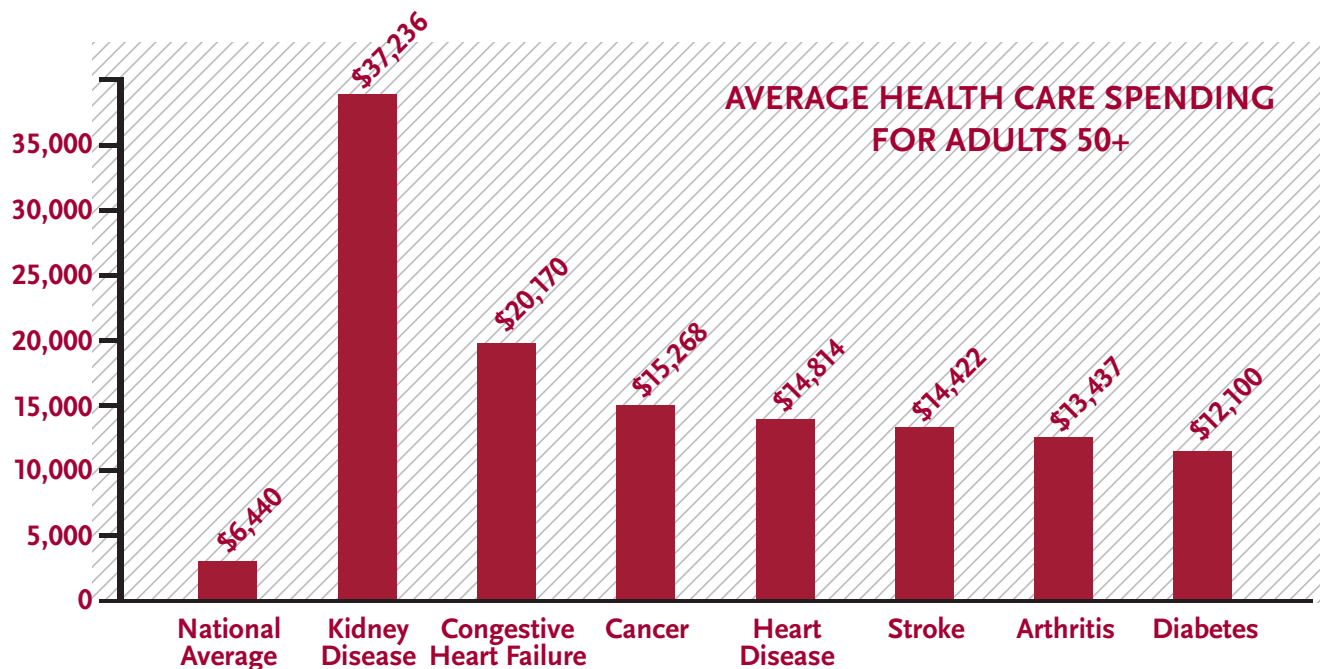
Both the Agency for Healthcare Research and Quality (AHRQ) and the American Geriatrics Society use definitions that also highlight the importance of interprofessional teams in delivering care coordination.

Reinhard identified care coordination as a critical component of future health care delivery and described what is driving its emergence and adoption. The increasing in multiple chronic conditions among older adults and increased Medicare spending associated with these conditions is paramount:



Source: AARP. "Beyond 50.09: Chronic Care: A Call to Action for Health Reform." Washington, DC. 2009.

Health care spending for older Americans with selected chronic conditions is also higher than average:



Source: AARP. "Beyond 50.09: Chronic Care: A Call to Action for Health Reform." Washington, DC. 2009.

Fragmentation of care and the poor “hand-offs” of care when transitioning from one care setting to another are costly in terms of quality, costs, and poor health outcomes. Major barriers to improving care for people with chronic conditions are the poorly aligned payment incentives in both public and private insurance systems that have failed to recognize the value of better integration of services, and the fee-for-service payment systems that encourage overutilization of services.

However, the Affordable Care Act includes multiple policy tools to improve care for the chronically ill. Many involve interprofessional care coordination. CMS leadership is supporting a range of demonstration projects that use “carrot” and “stick” approaches to bring primary, acute, behavioral and long-term care together in integrated systems and use payment reform that support care transitions and care coordination. These include penalties for avoidable hospital readmissions, shared savings and bonuses to providers for cost savings and improving quality through Accountable Care Organizations (ACOs), and bundled provider payments linked to episodes of care. There is a particular focus on improving quality and reducing cost in the care of the “dual eligibles,” chronically ill patients who are eligible for and enrolled in both Medicare and Medicaid and who account for 45% of Medicaid and 25% of Medicare spending. Funds of \$10 billion per year for 10 years are available for demonstration of models for improving chronic care coordination.

KEY STEPS TO IMPLEMENT & INTEGRATE CARE COORDINATION SERVICES

- Clarify shared care coordination functions and establish care coordination competencies across professions.
- Identify team member roles, tasks, privileges, responsibilities in specific settings—i.e., what are the roles of professionals, non-professional caregivers, patients, and family members? And where is care coordination delivered—primary care, inpatient care, or community-based care settings?
- Develop and implement educational programs that provide interprofessional training in schools of medicine, nursing, dentistry, nutrition, occupational and physical therapy, pharmacy, and social work and other practice settings to strengthen the future workforce’s capacity to provide care coordination services.

MODELS OF CARE: IMPLEMENTING CARE COORDINATION – PANEL I

The conference’s first panel described interdisciplinary care coordination models that have or are being implemented and tested as categorized by the target population served and duration of care coordination involvement. Panelists presented examples of hospital-based transitional care models, usually from inpatient hospital to home, and community-based long-term models utilizing professionals and non-professionals as care coordinators. The panel moderator was Sue Ginsburg, MSW, SG Associates Consulting LLC.:

- Paul Shelton, EdD, University of Illinois School of Nursing, presented an overview of several care coordination models supported by CMS and managed by the U of I School of Nursing.
- Robyn Golden, LCSW, Director of Older Adult Programs, Rush Medical College and co-chairperson of the National Coalition on Care Coordination (N3C), described the Rush model, a transitional care model that is hospital-based and led by social workers.
- Steven Counsell, MD, Director of Geriatrics, University of Indiana, described the GRACE model, a long-term care coordination model that extends well-beyond the initial transition from hospital to home.

- Regina Neal, MPH, MS, Director of Practice Redesign & Performance Improvement, Primary Care Development Corporation (PCDC), described a patient-centered medical home (PCMH) with a primary care focus for a specific enrolled population.

Panelists discussed care coordination models in terms of components, common domains, or services that are often considered essential for success. The overall goal for each of these models is to improve quality of care, although quality measures do vary by program. The other desired outcome is to reduce the overall cost of care. Until recently, most programs utilizing care coordination have been hospital-based and focused on the transition from home to hospital, reducing hospital readmissions and emergency room visits. However, the patient centered medical home is a community and population-based model that has the capacity to look at health outcomes and in which care coordination will play an increasingly important role.

KEY ISSUES TO ACHIEVE SUCCESS IN CARE COORDINATION

- Target populations with multiple chronic conditions and specific functional limitations that are high utilizers of costly services.
- Improve communications and rapport of physicians, care coordinators, and other team members during face-to-face interactions. Building interprofessional relationships is crucial: building relationships with patients and caregivers is equally important.
- Begin to address psychosocial issues with comprehensive assessments and development of a care plan.
- Provide team members, including patients, with appropriate resources and training to support patient self-management.
- Integrate medication management into the care coordination program.
- Incorporate all relevant professionals into the interprofessional team based on the comprehensively assessed needs of the patient and caregiver.
- Incorporate technology—i.e., the electronic medical record—as support for effective communication.
- Address payment reform so that reimbursement is made for services that are available and required, as well as for the care coordination function. Payment reform should also integrate all sources of payment into a single payment structure.
- Provide sufficient, appropriate training for care team professionals, including ways to effectively work in interprofessional teams, while also directing some attention to cultural competence.

IMPLICATIONS FOR HEALTH CARE PROFESSIONAL EDUCATION – PANEL II

The Josiah Macy Jr. Foundation, represented at the conference by George Thibault, MD, President, was recognized for its leadership in advancing interprofessional education and training. Dr. Thibault served as moderator for Panel II.

Panel II speakers presented frameworks for developing interprofessional education competencies and described the capacity and/or potential to train professionals for practicing team-based care coordination, including several models that have been or are currently being demonstrated across the United States.

- Madeline Schmitt, PhD, RN, FAAN, FNAP, Professor Emerita, University of Rochester School of Nursing, reviewed the recent work of the Interprofessional Education Collaborative (IPEC) organized by AAMC that developed competencies for interprofessional collaborative practice and how to introduce these competencies into education across professions.
- Mark Earnest, MD, Director of Interprofessional Education for the Anschutz Medical Campus, University of Colorado School of Medicine, provided insights into the development of the interprofessional program at his institution.
- Terry Fulmer, PhD, RN, FAAN, Dean of the NYU School of Nursing, shared innovations being incorporated in the interprofessional curriculum at NYU Schools of Medicine and Nursing.
- Pat Volland, MSW, MBA, Director, Social Work Leadership Institute, New York Academy of Medicine, discussed how research and development of care coordination competencies contributed to master's level social work education and the New York State Department of Health's blueprint for delivering comprehensive care coordination
- Discussant, Chris Langston, PhD, Program Director at the John A. Hartford Foundation, concluded that care coordination remains a critical function of effective health care delivery and that interprofessional and team work training is essential and urgently needed.

Dr. Madeline Schmitt led with a review of the recent work of IPEC (Interprofessional Education Consortium), a consortium of six national health professions education associations (AACN, AACOM, AACP, AAMC, ADEA, ASPH), to develop a framework of joint activities that support patient-centered team-based care, promote delivery reform, and foster interprofessional learning. In 2010 an expert panel recommended common core competencies for interprofessional collaborative practice to be incorporated into education across professions. Learning experiences and educational strategies for achieving the competencies were recommended. The report defines interprofessional competency as “behavioral demonstrations of an integrated set of knowledge, skills and attitudes for working together across the professions, with other health care workers, and with patients/families/communities/populations to improve health outcomes in specific care contexts.”

The panel's consensus was that interprofessional education and training will be absolutely necessary if care coordination models are to succeed. Effective teams and collaboration at the bedside, in transitions from hospital care, and in the community have traditionally focused on the physician-nurse relationship. However, the important role of other health professions in team based care and in care coordination must be recognized with the inclusion of these professions in interprofessional education and training. Outstanding questions are:

1. How to identify the interprofessional care coordination team members
2. What are the core competencies to be acquired through curriculum and practicum experience?
3. How do we measure success in interprofessional learning?

The panel emphasized the absolute value of professionals learning together in both professional schools and post-graduate training, rather than just being taught together. While difficult to build evidence in the short term, the hypothesis is that learning together with an interdisciplinary curriculum helps create and foster actual interdisciplinary practice.

IMPORTANT INTERPROFESSIONAL COMPETENCIES

1. Values/Ethics: Work with individuals of other professions to maintain a climate of mutual respect and shared values.
2. Roles and Responsibilities: Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of the patients and populations served.
3. Interprofessional Communication: Communicate with patients, families, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and treatment of disease.
4. Interprofessional Teamwork and Team-based Care: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable.

Research conducted in 2008 by the Social Work Leadership Institute for the New York State Department of Health sought to establish competencies for care coordination. Fifty state programs, nationally recognized guidelines, and the perspective of New York State stakeholders were analyzed via multiple focus groups with older adults, caregivers, and providers of care management. The following essential domains were identified:

- Develop and maintain relationships
- Train and educate patients
- Goal setting
- Care planning
- Coordination of services
- Ensure cost effectiveness while maintaining quality
- Ongoing quality improvements

CHALLENGES TO IMPLEMENTING INTERPROFESSIONAL EDUCATIONAL MODELS

- The culture of education, which emphasizes lecture formats
- The need for faculty to learn how to teach interprofessional groups and then assess their teaching
- A gap in alignment between clinical work and education
- IT capacity to have interdisciplinary notes written in patient records
- Different academic schedules (block vs. semester) for medical and nursing students make common learning difficult
- Insufficient time to evaluate what “sticks” in interprofessional learning, i.e., will interprofessional learning continue into professional practice after graduation, internships, residencies, and so on? Does it go away or become minimized in practice?
- Inclusion of social workers and other health care professionals—e.g., pharmacists, nutritionists, physical therapists—as potential members of care coordination teams in interprofessional education programs

Support for interdisciplinary competencies continues to grow. Examples of interdisciplinary models and competencies, as well as resources for support can be found from the American Geriatrics Society; John A. Hartford Foundation, particularly the Geriatric Interdisciplinary Team Training Program (GITT); Health Resources and Services Administration (HRSA) and the Geriatric Education Centers; the Institute of Medicine; professional groups, the Partnership for Health Aging; and the Veterans Administration program Geriatric Research Education, and Clinical Centers (GRECCs).

RECOMMENDATIONS TO PREPARE FOR AND IMPLEMENT CARE COORDINATION PRACTICE IN THE HEALTH CARE SYSTEM:

- Effectively articulate the importance of interprofessional care coordination.
- Effectively articulate the core competencies needed to provide care coordination within our changing health care systems.
- Establish protocol for incorporating competencies within interprofessional education, both formal education and clinical experiences: professional associations and groups; professional schools; primary payers of education (HRSA); and primary payers of care (Medicare/Medicaid/private insurance).
- Establish policy strategies in support of interprofessional practice and education that incorporates care coordination competencies.

For more information, please visit:

<http://www.nyam.org/news/nyam-news/interprofessional-care-may-24-2011.html>



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