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**SIM Delivery System Reform Subcommittee**

**Recommendations on Streamlining Care Coordination across SIM Initiatives**

Following is a collection of recommendations for the SIM Steering Committee to streamline care coordination across the SIM Initiatives operating in the Delivery System. This document contains a brief risk definition of fragmented, uncoordinated care; background on the process of mitigation by the SIM Delivery System Reform Subcommittee and Interested Parties; Dependencies identified for the SIM Payment Reform and Data Infrastructure Committees, recommendations for actions by the SIM Steering Committee to further mitigation, and a matrix of Key Principles and Core Functions of a streamlined approach to Care Coordination developed to inform providers and practice teams working at the ground level in the Delivery System.

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**Risk Definition:** The risk of fragmented, uncoordinated care coordination was identified by members of the SIM Delivery System Reform (DSR) Subcommittee and brought forward in early 2014. The SIM Steering Committee charged the DSR Subcommittee to explore the risk and develop mitigation strategies in the form of a recommendation focused on providers and staff teams working in the delivery system.

**Risk Identified:** Relationship between all the players in the SIM initiatives, CHW, Peer Support, Care Coordinators, etc., may lead to fragmented care and complications for patients.

* If care coordination is fragmented, siloed and duplicative then patient outcomes may be compromised, costs savings will be compromised and the health improvements will suffer
* Then continued fragmentation and siloed approaches will compromise patient outcomes and created inefficient and costly processes

Weighted a 5 (High Priority)

**DSR Subcommittee Risk Mitigation Process:** During the **March 5, 2014** DSR Subcommittee meeting, Members were asked to initiate the work, using an example of a patient story that illustrated the real breakdown in coordinated care at the patient level. Care Coordination practices known to work was also highlighted.

At the **April 9, 2014** meeting, presentations on Care Coordination occurred from SIM Initiative owners, including the primary care Health Home Learning Collaborative, Community Care Teams, Behavioral Health Home Learning Collaborative, and the Community Health Worker Initiative. In small workgroups, Subcommittee members identified the 3-4 critical core functions to ensure effective, high quality and patient centered care. A survey followed the April meeting to refine the small group work, resulting in a final comprehensive listing of Care Coordination Functions.

At the **May 7, 2014** meeting, the group continued to work on developing recommendations for providers and practice teams working at the ground level on Streamlining the Care Coordination across SIM initiatives. Members validated that the core functions were adequately captured; and moved into small group discussions to identify key principles and recommendations for providers and practice teams (broad disciplines) working at the ground level. This work was captured and synthesized with a goal of finalizing the recommendations for the Steering Committee in June, 2014.

Subsequent Interested Parties/Stakeholder explorations occurred at the Community Care Team Steering Group meeting during the month of May 2014; and in the Maine Child Health Improvement Partnership Advisory Meeting of June 13, 2014.

**Dependencies Tracking:** In addition to developing recommendations for providers and practice teams to streamline care coordination, the DSR Subcommittee identified critical dependencies that belong to the SIM Payment Reform and Data Infrastructure Subcommittees:

Payment for care coordination services is essential in order to ensure that a comprehensive approach to streamlined care coordination is sustainable; Care coordinators need to be paid fairly—reimbursement must be comparable-reasonable to be able to do this. Identify viable funding at the Practice Level-what can the practice bill for themselves vs how much support will they need from shared savings; All payers need to support payments for care coordination functions; BHHO concerns about the rate structure and challenges to sustaining viable coordinated approach – this exploration belongs to the **SIM Payment Reform Subcommittee**;

Electronic tools to support care coordination are essential, including shared electronic care plans, leveraging data from the Health Information Exchange, that allow diverse care team access – this exploration belongs to the **SIM Data Infrastructure Subcommittee; proposed for discussion at their September meeting**.

**Recommended Strategies:** DSR Subcommittee Members refined work on Care Coordination Key Principles and Core Functions, resulting in a recommended approach for adoption by all SIM Initiatives operating in the delivery system, and for broad dissemination to other provider and practice teams. Informed by the diverse expertise resident on the DSR Subcommittee Members, Interested Parties and Stakeholders, these recommendations are based on best practices nationally and locally, and on established evidence of ‘what works’ to ensure a comprehensive, patient-centered approach to streamlined care coordination. In addition to adopting and implementing these Key Principles and Core Functions, the DSR Subcommittee Members recommend the following strategies to support implementation and adoption:

* DSR Members and Stakeholders advise that the Key Principles and Core Functions be refined for adoption by providers and practice teams working in care coordination at the ground level by adding a linked glossary that provides local best practices of each component with examples and contacts for networking/mentoring on best approaches (e.g., see XYZ pediatrics for an example of how they…). This will entail research of best practices and consent to share.
* Create a Task Force at the Steering Committee level, that incorporates consumer members and care coordinators working in the delivery system, to ensure continuity and sustainability across SIM Initiatives;
* Align with parallel approaches in the delivery system (e.g, ME CHIP work on care coordination around child health; CCT and HIN recommendations to develop a shared electronic care plan linked to the health information exchange) including efforts underway by delivery systems and commercial payers;
* Launch a small, focused pilot to explore operationalizing the Key Principles and Core Functions, including primary care, CCT and key entities;
* Accompany Key Principles and Core Functions with educational approaches for providers and practice teams, including support for optimizing asynchronous[[1]](#footnote-1) communication tools and trauma-informed approaches;
* Support a structured, ongoing dialogue around patients who are difficult or unable to engage, to explore how care coordination teams can leverage natural supports and extend the capacity of patients facing challenges to engagement;
* Consider engaging a consultant/firm to inventory the many stakeholders involved; developing visual flow for streamlined approaches across disciplines and care domains

**SIM Delivery System Reform May 2014 – Care Coordination Operational Key Principles and Core Functions**

| Principle | Key Functions |
| --- | --- |
|  | Systems Pre-Alignment | Active Engagement |
| Build effective team relationships. | * Identify and build relationships with team members from diverse organizations including specialists and community providers, peer specialists, community resources, payer care managers, hospital discharge planners, social service agencies, CCT, addiction specialists, worksite wellness, behavioral health, pharmacy, transportation, health and fitness promotion, peer navigators, care coordinators in primary care practices, child care providers, schools, Head Start, public health nursing, home visiting, early intervention services, medical specialists.
* Where appropriate and feasible, develop written agreements between organizations to facilitate sharing of privileged health information.
 | * Ensure that the entire care team understands (ideally maps out) who performs specific roles and functions, and what the constraints are of their work that may need to be addressed at the system level.
* Emphasize personal communications (face-to face; phone), case conferences with patients/families to build team functioning.
* Ensure use of locally-informed team members for effective connections with appropriate local resources.
* Facilitate and monitor connections to community-based resources.
* Support effective provider to provider relationships.
* Provide patients with information on advocates available to support them as appropriate
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| Establish accountability. | * Identify a lead coordinator, who accepts accountability for core care coordination functions.
* Understand the constraints that payors may place on the determination of who/which entity is able to function as lead coordinator. Work with payers to allow patients to select the lead coordinator
* Evaluate and ensure effectiveness of leader.
* Evaluate and ensure effectiveness of referral management.
* Develop training and supervision plan for care coordinators.
* Identify who will benefit from care coordination and determine how appropriate population and panel size will be determined (#clients, levels of risk,) and how much staffing time will be needed (FTE).
 | * Activate patient to accept responsibility for care plan and management; encourage patient to assign leader.
* Identify who has most effective/active relationship with the patient; establish leader.
* Identify if a family has more than one care coordinator for different members and how that care can be streamlined (parents and children).
* Lead/manage coordination with all team members and specialists; ensure accountability for follow up.
* Maintain strong connection to PCP or BHHO for central coordination.
* Manage and track referrals and follow up.
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| Engage patient, family and caregivers. | * Develop and provide educational materials for patients/families including system level support and caregiver roadmap guidelines.
* Develop a shared plan of care that includes medical summary, negotiated actions, emergency and legal documents.
* Develop ways that teams can monitor progress against goals, provide feedback and adjust plan of care to ensure effective implementation.
 | * Jointly identify strengths/assets and needs of patient/family with the care team and the patient/family/caregivers; determine current relationships (ecomap) and identify level of need for patient/family.
* Acknowledge the economic and workforce participation requirements of the family – work to streamline and consolidate appointments related to care, in order to minimize work disruptions for the patients and caregivers.
* Identify and leverage natural supports to extend the capacity of patients/members.
* Understand and capture the ‘story’ of the patient
* Identify and honor patient and family preferences and goal setting both personal and clinical.
* Work with patients and families on teaching self-care and self-efficacy, and help build their skills around care coordination.
* Include families/caregivers on care team as desired by patients.
* Ensure that patients understand what is being discussed and documented. Consider cultural context of the patient’s home/community/environment, etc., including the ability of special populations to comprehend care and processes.
* Require and Encourage patient (and family) participation in decisions. For patients who are difficult or unable to engage, explore strategies to understand barriers and extend capacity.
* Ensure that home visits are available as a means to improve access, assess environment, accomplish medication reconciliation and connect with family, friends and caregivers.
* Incorporate strategies for shared decision making
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| Communicate across systems of care. | * Establish and utilize systems for communication flow and regular checkpoints (i.e. let the PCP know when a patient is accepted for care; etc.)
* Utilize technology (electronic communication tools, secure email and portals, phones, electronic health records, HealthInfoNet.)
* Determine if there are additional ways that patients/families can communicate with providers (secure email/portal/texting, etc.) to update care team on conditions.
 | * Identify and communicate with relevant providers and members of the care team.
* Ensure communication across every transition i.e. hospital to home, early intervention to school, between specialist and PCMH, adolescent to adult care, between PCMH and behavioral health providers.
* Make content appropriate to cultural context.
* Engage cross-functional team through case conferencing.
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| Manage information effectively. | * Determine roles of panel management/managing registries (population base care) vs care coordination.
* Develop and utilize shared care plans that are accessible and useful to all members of the team including the patient/family.
* Use HIT connectivity, shared electronic health records/HealthInfoNet to inform treatment and transition plan including community based team members.
* Launch strategies to educate providers and care teams on how to optimize asynchronous communication strategies to advance effective and timely information sharing. Ensure appropriate agreements are in place to support and optimize asynchronous communications.
* Align metrics where possible.
 | * Ensure patient (family) access to information.
* Engage patients (family) to ensure that information is correct and understood.
* Ensure alignment among all providers receiving referrals about a patients care.
* When indicated, a complete review of the patient’s medical record over a look-back period of several years is completed by a clinical professional.
* Launch strategies and systems to support asynchronous communication, including functions in electronic medical records, secure email, messaging, etc.
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1. From: <http://www.linfo.org/asynchronous.html>: *Asynchronous communication* is the exchange of messages, such as among the [hosts](http://www.linfo.org/host.html) on a [network](http://www.linfo.org/network.html) or devices in a computer, by reading and responding as schedules permit rather than according to some clock that is synchronized for both the sender and receiver or in *real time*. It is usually used to describe communications in which data can be transmitted intermittently rather than in a steady stream. [↑](#footnote-ref-1)