Module 2: Leveraging the Power of Care Coordination
Module 2: Leveraging the Power of Care Coordination

Learning Objectives

- Describe the purpose of and resources needed for effective care coordination within the context of a patient- and family-centered medical home.
- Describe effective use of a comprehensive electronic health record to exchange necessary information to promote patient care.
- Describe effective partnerships for patient/family centered care among the primary care physician, families, community partners, and various specialists caring for a patient within a patient- and family-centered medical home model.

Pretest

1. Care coordination differs from case management in that it focuses on the medical needs of patients and utilization of health services, while case management takes a broader approach that includes patients’ psychosocial needs and connection with community social service and education professionals. True or false?

2. Recent federal and state health care reform initiatives may not incorporate adequate payment from public and private insurers for care coordination activities within a medical home. True or false?

3. *Current Procedural Terminology* codes can be used to partially cover the additional work involved in coordinating a child’s medical care. True or false?

4. The American Academy of Pediatrics Council on School Health offers the following guidelines to help clinicians coordinate care with a child’s school:
   a. Become recognized as a reliable medical expert, not just an advocate.
   b. Don’t use medical jargon.
   c. Don’t be turned off by educational jargon—speak up and ask for explanations of acronyms or unfamiliar phrases.
   d. Make no assumptions about health care staffing in the school; realize that while funding is decreasing, demands for health programs are increasing.
   e. All of the above.

5. Bright Futures is an American Academy of Pediatrics program that fosters care coordination by offering health promotion and disease prevention resources that can help clinicians and families work together to better meet children’s needs. True or false?

Overview

“Simply put, care coordination improves outcomes.” That assessment, from a recent policy statement of the American Academy of Pediatrics (AAP), sums up the importance of care coordination.1 Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems cites research to show that providing care coordination is positively associated with patient- and family-reported “receipt of family-centered care,” stronger partnerships among
professionals, enhanced patient satisfaction, easier access to referrals, and lowered out-of-pocket expenses for families. The policy statement, developed by the AAP Council on Children With Disabilities and the Medical Home Implementation Project Advisory Committee, also explains that better coordination results in favorable associations with parental employment and fewer school absences and emergency department visits.1,2

The AAP policy Statement explains:

Care coordination is a cross-cutting system intervention that is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.... Successful care coordination takes into consideration the continuum of health, education, early child care, early intervention, nutrition, mental/behavioral/emotional health, community partnerships, and social services....1

In other words, care coordination takes a truly holistic approach to patient care, recognizing that a patient’s and family’s health needs continue when they exit the office doors.

To better understand the role of care coordination in a patient- and family-centered medical home (PFCMH), it helps to compare it with another component of medical care: case management. The AAP policy statement points out that disease or case management concentrates primarily on patients’ medical issues.

Case managers work with and guide services intrinsic to their specific agency, often within the constraints of eligibility criteria. In contrast, care coordinators work with and guide the team process, which includes and is driven by the needs of patients and families for services across the community. These functions include care planning and building collaboration/partnerships with all medical and nonmedical providers working with a patient/family.1

Of course, applying all of the features of a PFCMH takes time and resources in practice, necessitating a payment system that recognizes this additional work. While payment for care coordination services has been met with limited success, there has been some progress on this front. For instance, the American Medical Association has added codes 99487 through 99489 to the Current Procedural Terminology manual.1

These codes, in turn, have been adopted by the Centers for Medicare and Medicaid Services; they allow payment for complex chronic care coordination provided by a physician or other qualified health care professional and clinical staff. Keep in mind that payment for services is ultimately negotiated at the practice level with individual payers and contracts.

Additionally, health information technology (IT) plays an important role in improving care coordination in PFCMHs. Health IT allows clinicians to create care plans in an EHR, which can be viewed by interdisciplinary team members using the same EHR system.
The role of medical home teams also needs to be considered in implementation of care coordination. For true care coordination to take place, members of a medical practice, including administrators and office staff, plus community partners and educators, function as a team and must maintain regular and candid communication with one another, work to improve the quality of communication, and build strong relationships with one another, patients, and their families. After all, patients and families are the most important members of the team.

Applying principles outlined in the AAP policy statement can have a significant effect on a physician’s daily practice routine, as is illustrated in the following case study. Please keep in mind that the patient scenario that follows is not designed to provide residents with the full clinical picture and management of a patient but to illustrate how care coordination can be put into action in everyday medical practice.

**Case Study**

Thomas Harris, 12 years of age, has attention‐deficit/hyperactivity disorder, as well as a seizure disorder requiring care by a neurologist. His seizures recently required hospitalization to bring them under control. Fortunately, his pediatric practice has adopted the medical home model, so the entire practice staff is committed to providing comprehensive care, focusing on all Thomas’ needs including medical, psychosocial, financial, and educational. The following scenario highlights the importance of care coordination in care transitions from hospitalization back to home.

An essential component of care coordination is good communication between inpatient and outpatient clinicians and team members. Thomas was discharged from the hospital 7 days ago. Two days before the family comes in for a post‐hospitalization follow‐up visit, the medical home team ensures proper communication with the hospital, making sure that the discharge summary has arrived. Since the hospital and medical home don’t share the same electronic health record (EHR) system, a nurse in the practice proactively reached out to the hospital by telephone to request a secure faxed copy of his records from this recent hospital admission. Those records indicated that his medication had been changed to help control the seizures.

Before patients arrive, the medical home team meets briefly to discuss all patients scheduled in clinic each morning. The National Center for Medical Home Implementation recommends daily pre‐clinic meetings, called huddles, and suggests they improve the quality of patient care and allow for ongoing review of the practice’s operations. The morning of Thomas’ visit, the medical home team discusses his case and checks that all necessary information is in hand for his visit.

When the Harris family arrives, the pediatrician reviews all of his medications to make sure Thomas and his family understand and are following the latest drug recommendations since his discharge from the hospital. Laboratory tests done during his recent hospitalization revealed elevated levels of liver enzymes, so the pediatrician explains possible implications of those results. He asks a nurse to communicate the laboratory test results and coordinate any follow‐up visit with the neurologist. That is especially
important since the changes in levels of liver enzymes may suggest anticonvulsant toxicity and may necessitate an adjustment in his anticonvulsant regimen. Fortunately, the neurologist shares the same EHR system as the medical home, which makes sharing laboratory test results much easier.

Thomas’ parents indicate his care plan was not updated since his hospitalization reflecting the change in medication dosing. A care plan encompasses a child’s entire life course and takes into account his transition into adulthood. “Ingredients” of that plan may include diagnoses, surgeries, relevant medical history, medications, allergies, therapies (occupational, physical, speech), insurance information, needed medical equipment, and home nursing services, as well as a child’s needs and strengths.

Many useful resources help medical homes in care planning and care plan development, including the Lucile Packard Foundation for Children’s Health Report Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs. Care planning will be discussed in more detail in the next module in this educational series.

The pediatrician works with Thomas’ parents to update his care plan. The pediatrician explains that his new care plan will be accessible on the patient portal for retrieval after the office visit. Patient portals are another useful IT tool that can improve care coordination, allowing families to gain quick access to laboratory test results, portions of medical records, and immunization records, as well as make appointments or referral requests more easily. The pediatrician then does a warm handoff with the family to the practice care coordinator who will work with family on other aspects of Thomas’ care.

The care coordinator obtains basic information related to Thomas’ school that will be important to coordinating his care, including the school name and primary contact person and asks the following school-related questions:

- How well is Thomas doing in school?
- How many days of school has he missed during the last semester?
- Were any of those absences due to specific symptoms or health issues?
- Are the teacher and school nurse cooperating with administering his medication regimen?
- Is the school fully on board, ensuring any change in his medication regimen is in his records?
- When was his last Individualized Education Program (IEP) meeting? How can the medical home assist with the IEP and be aware of any changes?

According to the AAP Council on School Health, “Pediatricians are well-respected members of the community and can serve as a bridge between the education and health systems. Your opinions are highly regarded and school officials often appreciate your expertise and support.” The council offers the following tips on interacting with schools:

- Work with, not against, the education system; consider its goals and primary responsibilities.
- Recognize the education system is as complex as the health care system.
- Recognize education systems have a different culture than health care systems; learn as much as possible about this culture and respect it.
- Become recognized as a reliable medical expert, not just an advocate.
- Don’t use medical jargon.
- Don’t be turned off by educational jargon—speak up and ask for explanations of acronyms or unfamiliar phrases.
- Make no assumptions about health care staffing in schools; realize that while funding is decreasing, demands for health programs are increasing.
• Are his IEP and family goals being addressed? If not, how can the medical home team and community partners assist his family in meeting these needs?

To more fully coordinate care between the Harris family and Thomas’ school, the care coordinator working with the family prints his care plan from the medical home’s patient portal and sends it by secure fax to the school nurse, with parental permission. Alternatively, a secure e-mail containing the care plan could be sent to the school nurse.

Also during the meeting with the care coordinator, several patient and family resources were identified that may be helpful to Thomas and his parents, and referral information was provided. Linking patients and families to resources in their community and working collaboratively with community partners is critical in care coordination. As children are active in their communities, and care coordination occurs in the community setting, it is essential that care be integrated between community partners and the medical home. Linking families to others with similar experiences is invaluable as parents like Mr and Mrs Harris have needs of their own as caregivers. Fortunately, several options are available to parents.

Family Voices, for instance, is a grassroots network, providing families with children and youth with special health care needs or disabilities with resources and support. The National Center for Medical Home Implementation explains, “[Family Voices] provides families with tools to advocate for improved public and private policies, and build partnerships among professionals and families.”5 This resource is available at www.familyvoices.org.

Family Voices provides assistance and training to state-based Family-to-Family Health Information Center. Each state or commonwealth has its own Family-to-Family Health Information Center, which is an accessible resource for patients, families, and professionals. Family-to-Family Health Information Centers referenced above can assist families in connecting with their state’s Title V program.

Title V programs are valuable resources to improve care coordination for many patients enrolled in a medical home. Begun in 1935 as part of the Social Security Act, these programs offer several valuable services for families and youth with special health care needs. Part of the Health Resources and Services Administration Maternal and Child Health division, they offer block grants to states and fund a set of national centers and partners to help children and youth gain access to quality health care, including comprehensive general health, oral health, mental health, and substance abuse prevention and treatment services.

Bright Futures, a valuable resource from the AAP, is a national health promotion and disease prevention initiative that can help clinicians and families better meet children’s needs. It provides educational materials that cover mental, physical, and emotional health issues for infants, children, and youths through age 21. Among the resources for families is a series on nutrition, socialization, and a variety of other topics. Among the professional tools offered by Bright Futures is Performing Preventive Services: A Bright Futures Handbook, which includes guidelines on assessing and managing attention-deficit/hyperactivity disorder.6

The family is provided an after visit summary and can access the summary via an online patient portal.
At the end of the follow-up visit, a nurse in the practice provides the family with a printed after-visit summary that includes an updated medication list, future appointments, individualized patient instructions, and relevant laboratory test results. This same information is accessible via the patient portal. In addition, the nurse adds Thomas’ name to a Health IT enabled registry for patients with seizure disorder, allowing the practice to track appropriate scheduling of laboratory tests and clinic visits.

Summary

Research shows that care coordination has a significant effect on clinical outcomes while, at the same time, strengthening bonds between clinicians and families, enhancing patient satisfaction, and lowering out-of-pocket expenses. To implement this core PFCMH principle, pediatricians and their colleagues need to improve the lines of communication with specialists or other professionals caring for their patients; reach out and collaborate with educational systems (eg, schools, teachers, school nurses) to help bolster the child’s chances of succeeding academically by coordinating any medical care and discussing aspects of a child’s Individualized Education Program when appropriate; and offer families referrals to other needed community resources, when necessary.

Posttest

1. Care coordination differs from case management in that it focuses on the medical needs of patients, while case management takes a broader approach that includes patient’s psychosocial needs and connection with community social service and education professionals. True or false?

Explanation:
Disease or case management concentrates primarily on patients’ medical issues. Case managers work with and guide services intrinsic to their specific agency, often within the constraints of eligibility criteria. In contrast, care coordinators work with and guide the team process, which includes and is driven by the needs of patients and families for services across the community. These functions include care planning and building collaboration and partnerships with all medical and nonmedical professionals working with a patient and family.¹

2. Recent federal and state health care reform initiatives may not incorporate adequate payment from public and private insurers for care coordination activities within a medical home. True or false?

Explanation:
While payment for care coordination services has been met with limited success, there has been some progress on this front. The American Medical Association has added codes 99487 through 99489 to the Current Procedural Terminology manual that take into account the additional work involved.² These codes, in turn, have been adopted by the Centers for Medicare and Medicaid Services; they allow for complex chronic care coordination provided by a physician or other qualified health care professional and clinical staff to be paid for. Clinicians must keep in mind, however, that payment for services is ultimately negotiated at the practice level with individual payers.

3. Current Procedural Terminology codes can be used to partially cover the additional work involved in coordinating a child’s medical care. True or false?
Explanations:
The American Medical Association has added codes 99487 through 99489 to the Current Procedural Terminology manual that take into account some of the additional work involved in providing care coordination for patients.

4. The American Academy of Pediatrics Council on School Health offers the following guidelines to help clinicians coordinate care with a child’s school:
   a. Become recognized as a reliable medical expert, not just an advocate.
   b. Don’t use medical jargon.
   c. Don’t be turned off by educational jargon—speak up and ask for explanations of acronyms or unfamiliar phrases.
   d. Make no assumptions about health care staffing in the school; realize that while funding is decreasing, demands for health programs are increasing.
   e. All of the above.

Explanations:
Following the American Academy of Pediatrics recommendations listed above will reinforce the status of pediatricians as well-respected members of the community and help bridge the gap that sometimes exists between education and health systems. It will also help patients receive individualized attention in school and optimize your relationship with school officials.

5. Bright Futures is an American Academy of Pediatrics program that fosters care coordination by offering health promotion and disease prevention resources that can help clinicians and families work together to better meet children’s needs. True or false?

Explanations:
Bright Futures is a collaborative initiative that combines the expertise of the American Academy of Pediatrics and the Maternal and Child Health Bureau, a branch of the Health Resources and Services Administration. Bright Futures is a national health promotion and disease prevention initiative that can help clinicians and families better meet children’s needs. It provides educational materials that cover mental, physical, and emotional health issues for infants, children, and youths through age 21. Among the resources for families are series on nutrition, socialization, and a variety of other topics. Among the professional tools offered by Bright Futures is Performing Preventive Services: A Bright Futures Handbook, which includes guidelines on assessing and managing attention-deficit/hyperactivity disorder.

Reflections to Consider

The following questions are meant to prompt thought and discussion either individually or in a small group. There are no right or wrong answers.

- How would care coordination improve the care of your patients?
- What has been your experience with care coordination in practice? What was similar and different about your experience with case management?
- What aspects of your practice provide opportunities for care coordination to better meet the needs of your patients and families?
• What approach(es) would you take to encourage patient and families to engage them in care coordination?

• What things could you do to foster care coordination and partnerships with communities and educational partners in your practice?

References


Resources


American Academy of Pediatrics HealthyChildren.org
(www.healthychildren.org/English/Pages/default.aspx)

Bright Futures

• “Clinical Practice” Web page (https://brightfutures.aap.org/clinical-practice/Pages/default.aspx)
• “Family-centered Care” Web page (https://brightfutures.aap.org/families/Pages/default.aspx)
• “Resources for Families” Web page (https://brightfutures.aap.org/families/Pages/Resources-for-Families.aspx)

National Center for Medical Home Implementation *Community Resource List* handout (https://medicalhomes.aap.org/Documents/CommunityResourceList.pdf)