PRESENTATION TITLE

SPEAKERS

1. **JOHN DOE,** Meals on Wheels Bloomingdale
2. **LUCY QUINN,** Senior Services of Dupont
3. **Dr. CAROL TELLY,** Moms Meals
4. **SAM SMIT,** Meals on Wheels Glover Park
5. **KELLY GREGORY,** Tenleytown Meals on Wheels

Care Coordination 101

Megan Coffman
Policy Research Program Administrator
mcoffman@aafp.org

Introduction to Care Coordination

What is Care Coordination/ Management?

According to the Agency for Healthcare Research & Quality, care management is a team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively.

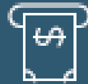
Why do we need Care Coordination?

- 75% of hospitalized patients are unable to identify the clinician in charge of their care.
- On average, Medicare patients see seven physicians at 4 different practices.

A Blueprint for Key Components of Effective Care Coordination

Care Coordination: Key Components

Value Based Payment Systems



VALUE BASED PAYMENT SYSTEM

Aligned incentives

Flexibility

Innovation

Care Coordination: Key Components

Culture of Care Management

CULTURE OF CARE MANAGEMENT

Organization wide buy-in

Investments in infrastructure and personnel

Education and training

Care Coordination: Key Components

Effective Teams

EFFECTIVE TEAMS

- Communication
- Transitions of Care
- Clear roles and responsibilities
- Continuity
- Co-location of team members
- Community presence and engagement

Care Coordination: Key Components

Customized Care

CUSTOMIZED CARE

- Identify patient needs
- Individual care plans
- Removal of barriers
- Risk Stratification

Care Coordination: Key Components

Trust

Relationships

Top down and bottom up

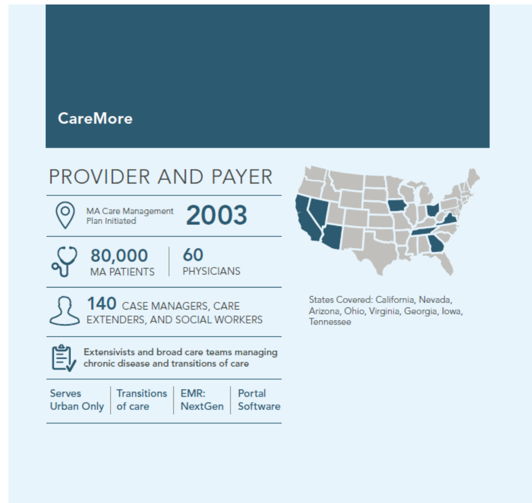
Patient buy-in

Bright Spots in Care Coordination

Who is doing it well

- The Grace Model
- CareMore
- InterMed
- Johns Hopkins Medicare Advantage Plan

CareMore



CareMore

Key Characteristics

Collaboration - Care managers lead interdisciplinary teams so that their perspectives are heard.

Co-Location - Care Managers and providers are co-located at the same facility.

Can-Do Orientation - The CareMore culture asks employees to do “whatever it takes” to care for patients.

Continuity - A CareMore physician will follow a patient at the hospital, skilled nursing facility, and outpatient setting.

Grace Model

GRACE Model Indiana University Health Medicare Advantage Plan

PROVIDER | States Covered: Indiana*

MA Care Management Plan Initiated **2011**

11,000 MA PATIENTS | **300 in the CM program**

1 MEDICAL DIRECTOR | **3 TEAMS** ONE NP & SW

In-home care that supports PC, with focus on 12 geriatric conditions.

Serves Urban and Rural | Transitions of care | EMR: Cerner

AFFILIATIONS: Indianapolis VA Medical Center, Indiana ADRC Care Transitions Program, Indiana University Health MA Plan and ACO

Grace Model

GRACE Model Indiana University Health Medicare Advantage Plan

PROVIDER | States Covered: Indiana*

MA Care Management Plan Initiated **2011**

11,000 MA PATIENTS | **300 in the CM program**

1 MEDICAL DIRECTOR | **3 TEAMS** ONE NP & SW

In-home care that supports PC, with focus on 12 geriatric conditions.

Serves Urban and Rural | Transitions of care | EMR: Cerner

AFFILIATIONS: Indianapolis VA Medical Center, Indiana ADRC Care Transitions Program, Indiana University Health MA Plan and ACO

Grace Model

Key Characteristics

- **Communication Leading to Shared Awareness -** The care management team conducts weekly interdisciplinary rounds.
- **Community Presence and Engagement -** Nurse practitioner and social worker dyads conduct multiple home visits annually and within 2-5 days of discharge from the hospital.

InterMed

InterMed

PROVIDER | States Covered: Maine

MA Care Management Plan Initiated 2008

4,400 MA PATIENTS | 89 PHYSICIANS

NP/PA CARE MANAGERS

Focus on transitions of care and pod structure that foster trust and continuity

Serves Urban and Rural | Transitions of care | EMR: ECW

InterMed

Key Characteristics

- **Co-Location**- Team Members are co-located
- **Continuity-** InterMed care team pods are comprised of 4-5 physicians, each with 1-2 clinical assistants, one nurse practitioner/physician assistant care manager, and a clinical assistant that supports the pod's care manager. The teams are rarely altered and support a defined patient population.