# The Role of the Care Coordinator in Providing Integrated Care for Safety-Net Populations

Marc Avery, MD
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## Executive Summary

Integrated models of care are an evidence-based response to an American health care crisis of increased incidence of chronic conditions and an answer to our current, fragmented care systems. SMI populations are, in particular, at much greater risk of chronic health conditions, increased mortality, and a high level of health care disparities. Several models for integrated care have been found effective in improving outcomes and reducing costs in widely tested, rigorous studies. Most involve the use of care coordinators and medical/psychiatric consultants to assure person centered, population based, treat to target, evidence based, and accountable services. There are many examples of programs across the country that have successfully implemented integrated care, and we can draw on their experience to understand how to build effective care coordination.

## Introduction

Over the last half-century we have seen a dramatic increase in patients in the U.S. who are identified as having co-occurring chronic medical and psychiatric conditions. Currently, the top 5 disabling conditions in the U.S. are all chronic medical and psychiatric conditions. This increase is due to a number of factors -- changes in diet, lifestyle, and increased obesity leading to increased medical and mental health conditions; as well as increased detection related to better screening and outreach. In both cases, our health care system has clearly not kept pace with the changing health needs of our populations. Our system is fraught with dis-coordinated emergency rooms, hospitals, and specialty care centers -- and is simply too fragmented to manage the complex needs of persons with chronic medical and behavioral symptoms. Ironically, a fragmented model of care is also more costly. Our society's inability to adequately treat chronic conditions is one of the main drivers of poor outcomes and high costs in healthcare today. Fragmented care may work OK for acute conditions (like a broken arm, or appendicitis), but chronic conditions (like diabetes, depression, or cardiovascular illness) require more systematic, integrated care approaches. The negative consequences of fragmented care become especially glaring for persons/patients' with severe mental illness and/or co-occurring substance use disorders.

## A Fragmented Health Care System Results in Poor Outcomes

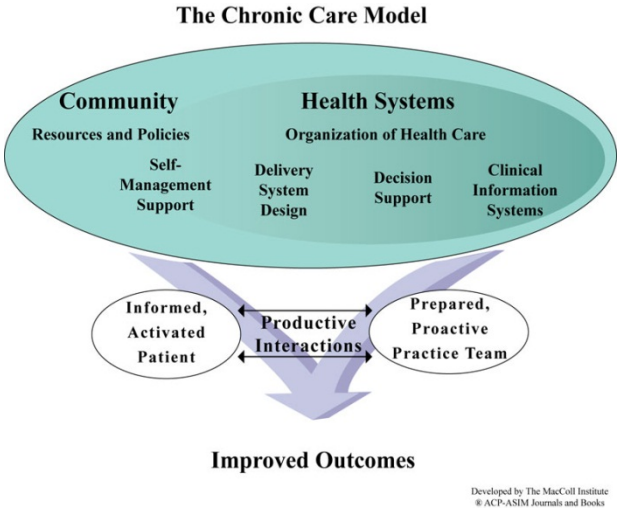
So what is wrong with a fragmented Health Care System? -- Why does it fail for people with chronic medical or behavioral conditions? It is because in a fragmented Care System, one simply cannot provide the necessary degree of systematic screening, tracking, outcome measurement, and care coordination needed to assure good health outcomes. Wang (2002) demonstrated that only about 40% of persons in the U.S. who are in need of treatment for depression actually received any sort of treatment at all, and less than half of those received care that was thought to be "minimally adequate".

The lack of coordination between our medical and mental health systems of care make even less sense when one considers the bi-directional risks of health conditions and health costs. For example, persons with diabetes are more likely to have psychiatric disorders, and vice versa. This "bi-directional" pattern is common with many chronic medical and psychiatric conditions. This bi-directional risk pattern also suggests that coordination of care between these two systems is even more important for SMI persons than the general population.

## New Models of Care Result in Better Outcomes and Lower Costs

Fortunately, models of care have been developed to address the needs of persons with chronic conditions. But, these models were not proposed without first having some false starts. In the early 90's there were a number a nation-wide efforts attempted to better address health issues – for example improved screening efforts, development of care guidelines, streamlining referrals to specialty MH care, or providing better caregiver education. Unfortunately, these efforts, when done in isolation, did not result in better outcomes for the population as a whole.

Then health experts began to promote the idea of integrated care strategies. The starting point was the work of Ed Wagner and colleagues at the Group Health Cooperative in the early 90's, who proposed the Chronic Care Model (See Figure). Wagner suggested comprehensive reform of our health care model via six-axes: Delivery System Design, Self-Management support, Decision support, and Clinical Information System, Health System Organization, and Community Resources Organization.




At about the same time, clinical researchers led by Drs. Wayne Katon and Jurgen Unutzer (University of Washington), and Ben Druss (Emory University) began looking at clinical models of care to improve outcomes. When these investigators began testing better care coordination, they found improvements in outcomes. The earliest (and best studied) care models include P-Care, TeamCare and Impact. All of these care models focus on care that is highly coordinated. The results of these studies were dramatic; for instance the IMPACT model

showed a doubling of positive clinical outcomes compared to usual care. Over 80 research studies have now validated the clinical benefits of integrated care models.

However the research, to date, has primarily focused on integrating behavioral care into the primary-care clinic. There has been less research completed or published on using integrated/coordinated care principles to treat and support persons with severe mental illness in community mental health treatment settings.

***Box 1:*** *Early investigators also wondered if they could get better medical outcomes in patients with both medical and psychiatric conditions by first treating the mental disorder – in effect "clearing the way" so that patients can take better care of themselves. Unfortunately, this approach DID NOT result in positive health outcomes. It was not until the teams specifically targeted diabetes measures "head on" that we began to see improved outcomes and reduced costs. The researchers concluded that care must be focused on a specific condition in order to better treat it – a concept that is now known as "Treat to Target".*

Since the success of these early studies, integrated care has been spreading across the country. Much of this trend was due to Don Berwick's (previously director of the Institute for Healthcare Improvement and CMS) call to arms to achieve the "triple aim"-- better care experience, better care outcomes, and reduced costs. Integrated care was quickly identified as a way to begin to achieve these three aims.

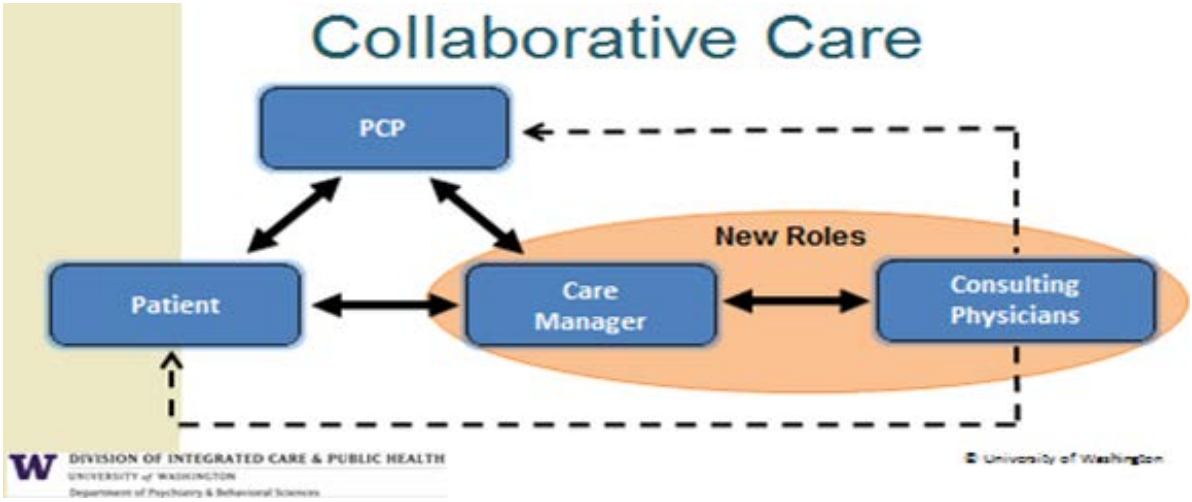
Things have really started to take off in the last several years. In 2012 it was the clinical theme for the annual conferences the American Psychiatric Association the National Council and the Institute For Psychiatric Services - three of the largest national behavioral health conferences.
Since these initial studies, there have been many dozens of studies that have validated the effectiveness of integrated care in improving outcomes and reducing costs. The majority of these still focused on primary care integration with less-severe psychiatric populations though there have been some studies working with the SMI population (Ben Druss's P-care study in particular). However, the dramatic health disparities and increased mortality of the SMI population has served as a "call to arms" to test these strategies with our patients with more complex conditions. Anecdotal information thus far suggests positive effects but, achieving bi-directional integrated care remains challenging. Data from a very large SAMSHA service grant with over 100 organizational grantees is expected to published data. There are currently three large integrated care collaboratives underway – sponsored by the National Council, the Institute for Healthcare Improvement, and the California Institute for Behavioral Health Solutions-formerly CiMH.

## What Does Integrated Care Look Like?

To the untrained eye, integrated models of care don't look that different from traditional models of care --- patients still have a primary care provider, may have a psychiatrist or counselor, and may talk to a social worker from time to time. It is not so much WHO is on the team, as HOW the patient's team provides that care, and what gets prioritized.

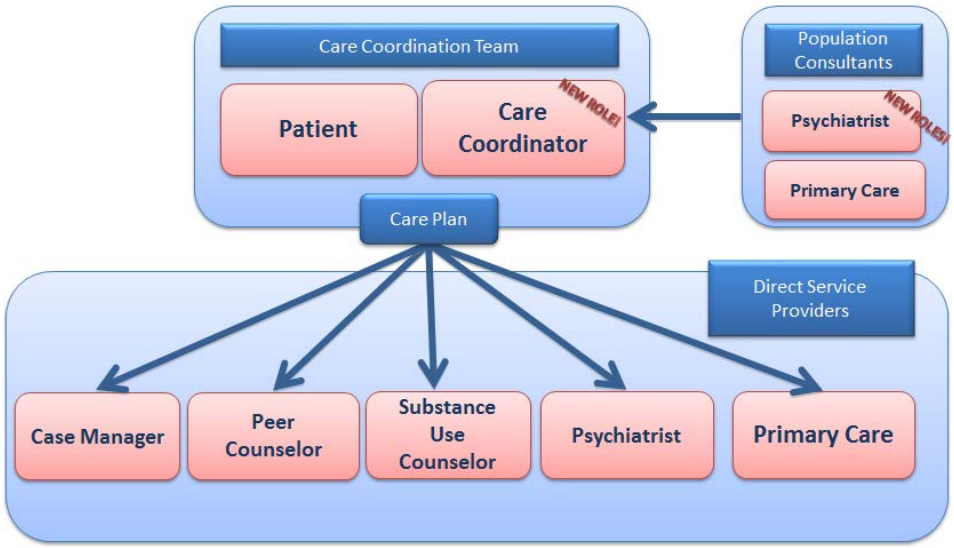
Integrated models of care all have one element in common – an identified care coordinator that is responsible for assuring that all the cogs and gears of a patients care/care team are working together. This person has some responsibilities similar to functions of a "traditional" mental health case manager – but with much expanded roles (very complex patients might even need BOTH a care coordinator and a case manager). One model of integrated care, promoted by the AIMS Center at the University of Washington, includes a care coordinator as a central care provider (as depicted in the figure below).

Figure 2, The MHIP Model of Care in Washington State.




This model of care is focuses on bringing BH services to the primary care clinic. That may not be the best model for persons with severe mental illness or co-occurring MH/substance use disorders. Here, the care coordinator is more likely to be working in a mental health center, and the care team is likely to be more complex – such as depicted in figure 3:

Figure 3: A hypothetical Integrated Care Team for SMI patients.



## The Role of the Care Coordinator / Care Manager

So what does the Care Coordinator do? It depends on the needs of the patients and the population served, of course, but there are a number of typical core duties. Here is a list of the core functions for a care coordinator:

1. Outreach and engagement
2. Ensures client support and (health) education
3. Ensuring communication between providers
4. Screening and Tracking outcomes
5. Facilitating referrals
6. Entering data and maintaining care registry
7. Conducting systematic caseload review
8. Medication reconciliation
9. Supporting client self-management
10. Shared care planning

Looking at this list – you might think that many of these duties are similar to those of a mental health case manager. However, the care coordinator role is quite different. Whereas the case manager is typically identified as part of the mental health or social service teams – the care coordinator serves in an overarching role – coordinating (or assuring) ALL of the services that a person receives. The care coordinator is usually understood to be as much a "part" of the medical team as the specialty mental health or substance use disorder services team. Finally, a care coordinator is responsible for care functions that are not usually "on the desk" of a case manager (such as medication reconciliation). See figure below for a comparison of typical case manager versus care coordinator roles.

| Case Manager | Care Coordinator |
|---|---|
| **Goal: Manage Services** | **Goal: Improve Outcomes** |
| **Outreach** | **Screening** |
| **Linkage** | **Manage transitions** |
| **Intake** | **Facilitate and Track Referrals** |
| **Referrals** | **Shared care plan** |
| **Care planning** | **Single point of contact** |
| **Applications / Benefits** | **Sharing information** |
| **Money Management** | **Engagement** |
| **Advocacy** | **Identification of Care Team** |
| **Crisis Intervention** | **Medication Reconciliation** |
| | **Support self-management** |
| | **Population-based** |
| | **Track outcomes / T2T** |

Figure 3

## Are there other new clinical roles on the team besides the care coordinator?

Yes! In order to do population-based caseload review (see the description of five principles of integrated care, below) you will need a clinical consultant – usually a psychiatrist (for MH caseload review), or a primary care physician (for medical caseload review). These consultants do not see patients directly, but rather serve as a regular consultant to the care coordinator. This consultation – which has been come to be known as a "population review", "caseload consultation" or a "multi-condition caseload consultation" – is a new way of efficiently and effectively reviewing cases on a population, targeting reviews on cases that are not improving as expected. This consultation is supported via the use of a care registry, a (usually electronic) list of patients that makes it easy to track key outcome measures.

## Are there tools that care coordinators need?

Yes! As mentioned above (and below) one important tool is a care registry. The care registry is really just a fancy list of patients and their outcome data. This tool is needed to keep track of patients and their outcomes, and also to facilitate the population-based care discussions between the care coordinators and the caseload consultant(s). In small teams, a simple excel spreadsheet might be adequate. Larger care systems, such as the MHIP program in Washington State, utilize a web-based, HIPAA secure application with many thousands of patient record entries.

# The Five Principles of Effective Integrated Models of Care

Not every program will implement integrated care is exactly the same way. In recognition of this fact, a number of experts from across the country came together at the AIMS Center in 2011 to define the principles of integrated care. They were able to come up with a five-axis description of integrated care: Person-centered and coordinated, Population-based, Treat to target, Evidence-based, and Accountable

## Person-centered and Coordinated

The principle of person-centeredness means that all care should be aimed toward accomplishing the patient's stated health goals. And, the principle of coordinated care suggests that all of the care providers serving any one patient should all be working as a team. In order to achieve both of these principles, careful system planning is required. In most instances, they are accomplished via identification of a care coordinator for each patient. The roles and responsibilities of the care coordinator are described in more detail later in this report.

## Population-based Care

Population-based care means keeping track of all the patients in a population to assure that everyone is achieving expected health outcomes – that is, making sure that nobody "falls through the cracks". This is no small challenge in our current system which favors a "one person at a time" model of service delivery. It is simply too easy for persons who are not improving to fall off our radar screens. In order to achieve true population-based approaches to care clinical tools are usually required -- such as a care registry (see below). It is use of tools like this that help us to systematically keep track of people and their clinical outcomes. Population-based care is also facilitated via the use of population consultants who oversee entire care populations and make recommendations based on whether patients are achieving expected clinical outcomes or not.

## Treatment is Targeted to Meet Expected Outcomes

The third principle of integrated care is the targeting of care to meet expected outcomes. This is typically achieved via the use of structured screening and tracking tools. The first step is implementing screening tools that help us to identify who is in need of service and who isn't. This is not typical practice in most behavioral health systems (where patients are sent to us only AFTER they come to the attention of authorities -- well beyond the point when early interventions could be effective). The second step is the systematic use of outcomes tracking tools (such as the PHQ-9). There are similar outcomes tracking tools for medical indicators as well. This is not simply an "add on" duty but rather a clinical service that should be integrated into the counseling that the patient receives.

## Treatments are Evidence Based

Evidence-based care plays a pivotal role in the services provided to persons in an integrated care setting. However, unlike what most behavioral health providers are used to, a more flexible approach to EBPs is suggested. Gone is the old-fashioned "keep doing it until it works" strategy. Instead we now recommend a strategy of "try something to see if it works, if it doesn't, try something else!" We use the outcomes scores mentioned above to help guide us in our recommendations as to whether or not individuals are getting better.

## Accountable

Finally integrated care incorporates the concept of accountability for care. The accountability principle asserts that at all stages of care—providers, regulators , payors, and patients alike should all be able to answer the question "Is the care being provided working and if not, why not?" In integrated care settings, accountability is not measured by a report that you print out after the fact in order to get paid, etc. To the contrary, a care coordinator and caseload consultant are overseeing their care real-time while they are doing their work. Accountability is real time and continuous.

## Summary

Integrated models of care are an evidence-based response to the American Health Care crisis of increased incidence of chronic conditions and begin to address and improve current, fragmented care systems. SMI/SUD populations are, in particular, at much greater risk of chronic health conditions, increased mortality, and yet they experience more health care disparities. Several models for integrated care have been found to be effective in improving outcomes and reducing costs in widescale, rigorous studies. Most involve the use of care coordinators and clinical consultants to assure person centered, population based, treat to target, evidence based, and accountable services. MA