Implementing Care Coordination in the Patient Protection and Affordable Care Act
Recommendations from the NATIONAL COALITION ON CARE COORDINATION (N3C)

In the United States, nearly half the population suffers from at least one chronic condition, and the prevalence of multiple chronic conditions is increasing, particularly among Medicare beneficiaries. Chronic disease by its very nature requires ongoing attention and management of medical, psychological, economic, and social factors. The National Coalition on Care Coordination (N3C), a coalition of 40* national stakeholder organizations representing leading aging, health care, family caregiver and social services organizations, has contributed to assuring that the Patient Protection & Affordable Care Act (ACA) includes access to care coordination as a key strategy for improving the quality and cost effectiveness of health care. Care coordination adds value to current health care delivery by improving individual experience and producing better health and functional outcomes without raising, and often lowering, costs. As ACA’s provisions for care coordination are implemented, it is strongly recommended that clear and consistent guidelines be established to ensure that care coordination services reflect evidence-based standards of practice. To this end, N3C applies the following definition:

“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.

The aim of this definition is to emphasize a person-centered approach where the individual, as well as family members and other caregivers, is supported in managing physical health, behavioral health, and psychosocial needs. In addition to addressing medical needs, care coordination must encompass services from multiple social support and community providers; bridge gaps in care; and ensure provision of the appropriate level of care.

Building the Evidence for Effective Care Coordination

N3C uses the evidence for best practices to advance public policies in support of comprehensive care coordination for older adults. Based upon initial synthesis of practitioner experience, high quality care coordination includes:

- a person-centered approach with the involvement of the interdisciplinary team, older adult, and caregiver;
- a comprehensive, culturally relevant assessment of the older adult’s and caregivers’ needs that also emphasizes their capabilities, strengths, and preferences;
- an appropriately targeted intervention based on level of need. Groups, such as dual-eligibles and people with multiple chronic conditions, represent the highest level of need and should receive the highest level of care coordination;
- a dynamic care coordination process with the older adult, caregivers, and interdisciplinary team working together to identify services and to develop a comprehensive care plan, addressing the older adult’s medical, behavioral, and social needs and supports;
- coordinating implementation of the care plan and communicating progress toward goals among all providers (physicians, nurses, social workers, and others) thereby establishing or strengthening ongoing relationships;
- facilitating care transitions and coordination between various settings of care (e.g., hospital, nursing facility, home health agency, home and community based services);
- periodic evaluations of the care plan by the interdisciplinary team with older adults and their caregivers;
- availability based on need and choice, regardless of insurance coverage.
An evidence-based review commissioned by N3C identified the basic components of comprehensive care coordination, listed below. N3C recommends that these components be considered the baseline wherever care coordination is referenced in ACA:

**Targeting:** Individuals at substantial risk of hospitalization in the coming year are most likely to benefit from the intervention.

**In-person contact:** Successful interventions involve substantial amounts of in-person contact with the individual, with designated care coordination staff primarily interacting with patients face-to-face in the home or clinical office setting or by telephone.

**Access to timely information on hospital and emergency room admissions:** Learning about acute episodes very shortly after they occur is a critical factor. Individuals are particularly vulnerable for readmissions after a hospitalization or emergency room visit, which provides a heightened opportunity to explain how better adherence and self-care may prevent such occurrences.

**Close interaction between care coordinators and primary care physicians:** Two primary factors affect the strength of the relationship between care coordinators and primary care physicians: 1) the opportunity for individuals to interact face-to-face with their care coordination team; and 2) a consistent care coordinator who works with all the program patients for a given primary care physician.

**Services provided:** All of the successful programs focus their interventions on assessing, care planning, educating, monitoring, and coaching individuals on self-management. Teaching individuals how to take their medications properly is a particularly distinguishing factor of successful programs. Social supports, such as assistance with daily living activities, transportation, or overcoming isolation, are also important for selected individuals.

**Staffing:** Nationally, care coordinator qualifications vary depending on the program and state. In state home and community based service programs, care coordinators have varying levels of education and experience. The qualifications range from having no experience at all to having multiple years; and from no education requirement to at least a Bachelor’s degree or licensure in nursing, social work, or another social service area. In care coordination programs in primary and acute care, the care coordinators are predominantly registered nurses who link or partner with social workers having Master’s degrees. iii No official body provides universally accepted credentialing or authorization for the function of care coordination. However, several entities represent professional certification in this practice field. Interdisciplinary teams are increasingly recognized as most effective in addressing the needs of people with multiple chronic conditions, with one member of the team taking direct responsibility for coordinating care for a particular individual. Demonstrated effectiveness has been shown with a nurse/social worker pair or team assuming responsibility for coordinating care. iv

Not all services are required for all people. Effective care coordination takes place over time and depends on the needs of the individual. It is, therefore, critical that an initial assessment be implemented by an interdisciplinary team to address psychosocial, physical, and economic needs. The complexity and variability of individual needs require linkages across the spectrum of health/medical and community/long-term care supports and services. Effective care coordination improves quality of care by emphasizing patient-centeredness and has a positive impact on controlling costs through appropriate service referral, increasing the length of time to Medicaid spend-down, and reducing both nursing home and hospital admissions. v

The Coalition continues to work on building the evidence for effective care coordination and will share this work as it develops.
*N3C membership attached

Endnotes


v SWLI, 2009, p.4.