Parcours de Soin
Pathways of Care
Coordination of Care
Care Management
Team Care

Thomas C. Ricketts, Ph.D. MPH

The University of North Carolina at Chapel Hill,

The American College of Surgeons

MOS EHESP

Objectives *Cibles*

- Explore the concept of coordination/*parcours*
- Review substantive literature that assesses coordination
- Suggest a primary axis of conflict in coordination
- Propose a structure for evaluation and assessment of coordination

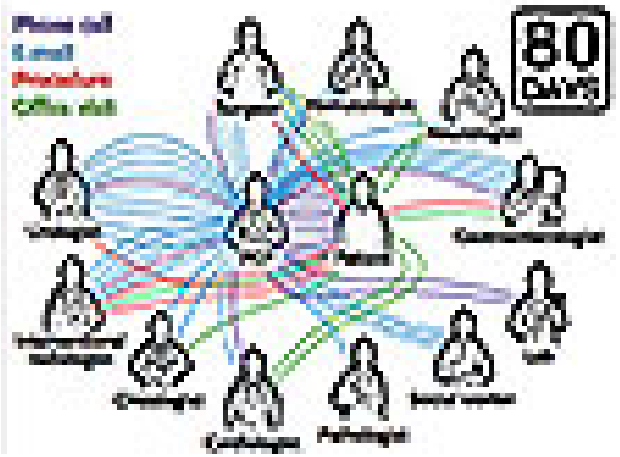
A “secret”?

“Nobody is responsible for coordinating care,” said Dr. Lucian Leape, a Harvard health policy analyst and a nationally recognized patient safety leader.
“That’s the dirty little secret about health care.”

Health Care’s ‘Dirty Little Secret’: No One May Be Coordinating Care
By Roni Caryn Rabin April 30, 2013 KHN Health News

Instant replay

- http://www.nejm.org/doi/full/10.1056/NEJMp1406033
- http://buff.ly/1nIUBpp



Common Knowledge

Care coordination 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. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care

McDonald KM, Sundaram V, et al. ***Care Coordination***. Vol 7 of Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

The many Faces & Names of ***Coordination***

Teamwork

Continuity

Disease Management

Case Management

Care Management

Chronic Care Model

Care/Patient Navigator

Communication

- A fundamental aspect of coordination

- I will **not** focus on communication and its problems but will posit its importance in all aspects of *parcours de soin*

Common Knowledge

- For many years, in many nations, “fragmentation” has been diagnosed as a dangerous malady in the health care system, and “integration” has been prescribed as a cure.
- Why doesn’t integration happen?
  - **“Professionals reject it”**

Katharina Janus and Lawrence Brown, *Health Policy* Oct 2014

Pause: What are we seeking?

- Pure knowledge of coordination/*parcours*
- Identifying the "Bounded Rationality" for coordination of care
  - **a heuristic to satisfy current expectations**
- What is the natural limit of information/translational research?
- What can we provide to policy makers?
- What links research to management and governance? Do we solve that poroblem?

Do we know more than what we knew in 2006?

2006: To date, this body of literature has failed to demonstrate conclusively that the use of teams will enhance patient or organizational outcomes..

Louise Lemieux-Charles, Wendy L. McGuire. What Do We Know about Health Care Team Effectiveness? A review of the Literature. Medical Care Research and Review 63:3, 263-300

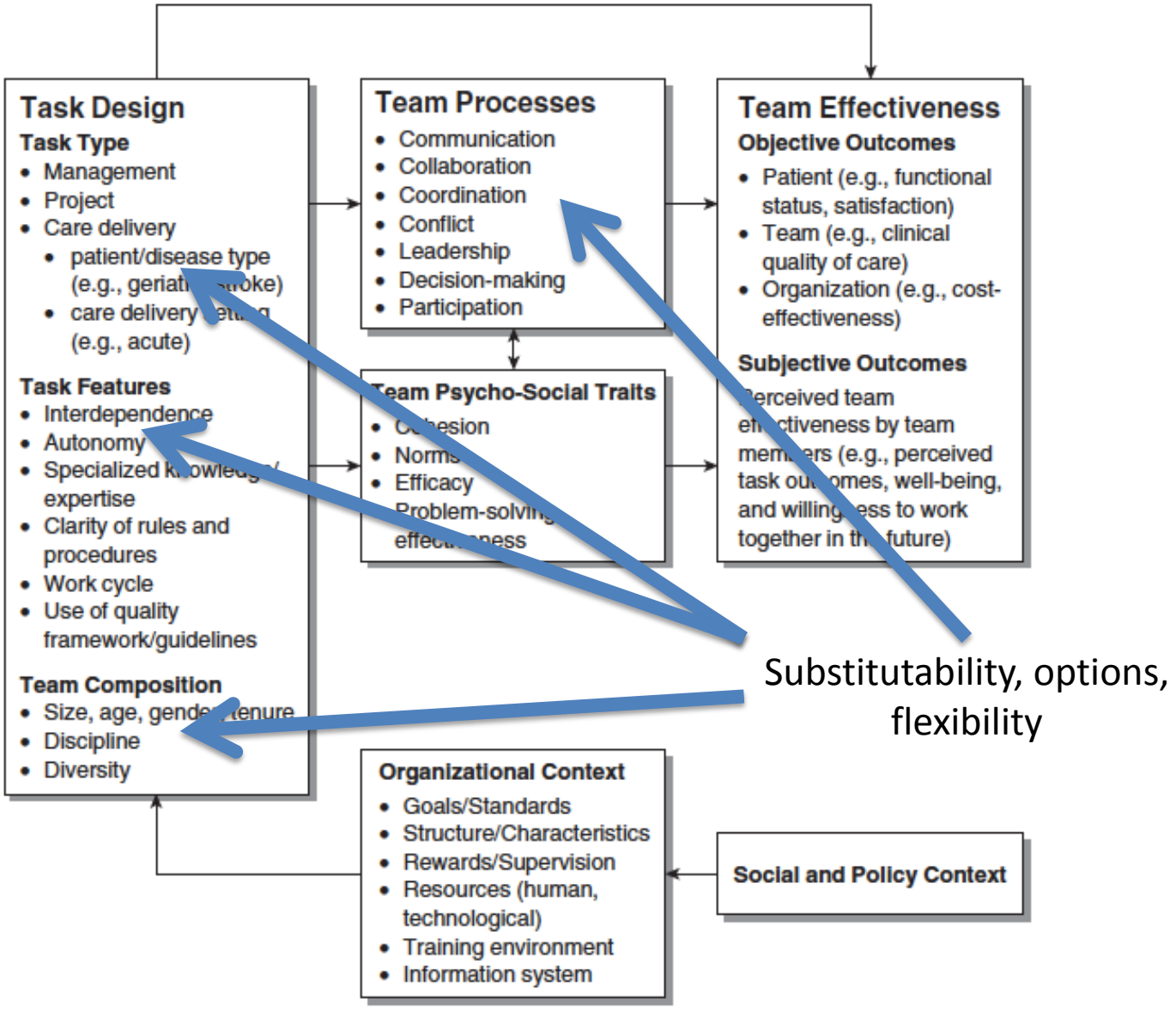


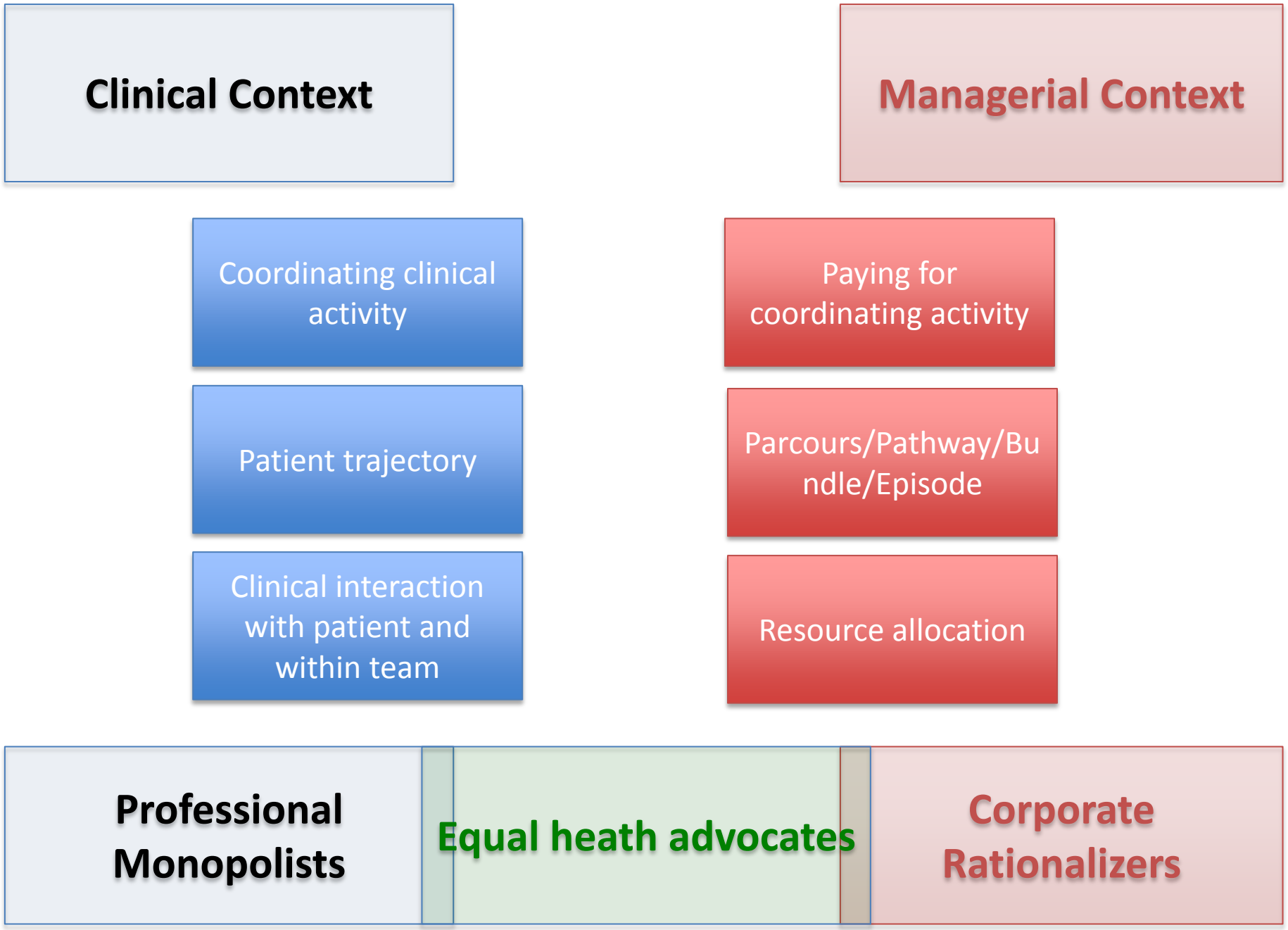
FIGURE 1 Integrated (Health Care) Team Effectiveness Model (ITEM)

Note: Adapted from cohen and Bailey (1997); Fried, Leatt, Deber, and Wilson (1988); and Shweikhart and Smith-Daniels (1996).

Coordination—Two Basic Types

I. Coordinating **clinical** care
   A. Focused disease pathway (Cancer, Stroke, Burns)
   B. Chronic Multiple disease patient (Diabetes, Alzheimers, Elderly)

II. Coordinating **payment**
   A. Bundled care, focused disease
   B. Value based payment, disease groupings
   C. Populations (ACOs, Managed Care, Case Management—*Maisons de Santé ENMR*, CCNC.


Clinical Context
Managerial Context
Coordinating clinical activity
Paying for coordinating activity
Patient trajectory
Parcours/Pathway/Bundle/Episode
Clinical interaction with patient and within team
Resource allocation
Professional Monopolists
Equal heath advocates
Corporate Rationalizers

Mapping tasks to coordination

- **Flexibilizing**: *corporate rationalizers*, rationalizing, refining, reassigning, top down for Efficiency through compliance and competence.
- **Fission**: *Professional monopolists*, splitting and dumping, centrifugal forces...for Quality through credentials and recognition.
- **Fusion**: *equality advocates* capturing and clumping, centripetal forces...for Solidarity through commonality with social and community groups.

Thomas R. Konrad, WMD and Health Professions, 2014 UNC Workforce Center Presentation.

Mapping tasks to coordination

- **Flexibilizing**: Product: *Consumer commodity.*
- **Fission**: Product: *Quality service*.
- **Fusion**: Product: *Emancipatory social project*.

Closing the Quality Gap:

A Critical Analysis of Quality Improvement Strategies

Volume 7—Care Coordination

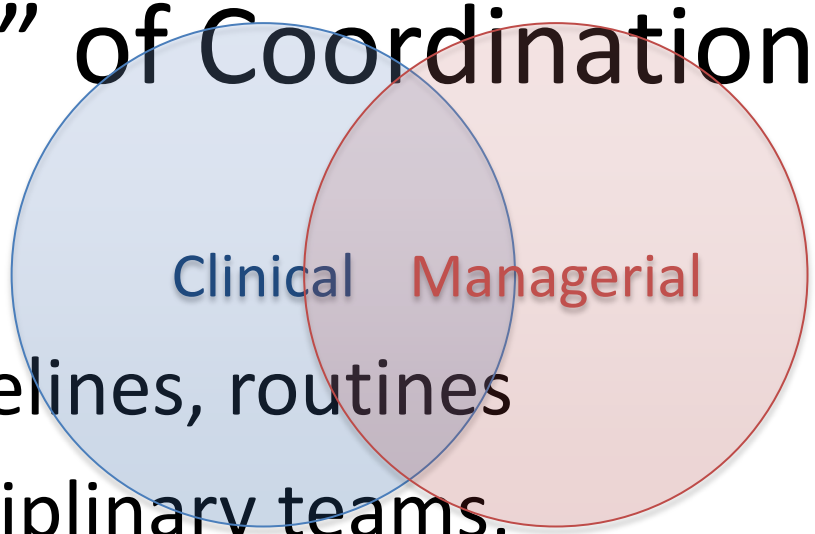
AHRQ REVIEW OF COORDINATION OF CARE, 2007

AHRQ* Process for Coordination

Clinical Context	Managerial Context
Assessment	
Develop care plan	
Identify participants	
Communicate to patient and participants	
Execute care plan	
Monitor and adjust care	
Evaluate health outcomes	

US Agency for Healthcare Research and Quality ≈ HAS ≈ NICE

AHRQ "Features" of Coordination



- Information systems
- Tools: protocols, guidelines, routines
- Techniques: Multidisciplinary teams, collaborative practice models, handoff, transitions management
- System redesigns: payment for management, payment for episode or bundle, architectural flow design, access solutions

“Key Gaps” in Evidence (AHRQ)

Measures.

- Care coordination metrics
- Metrics for calculating costs and savings associated with care coordination.

Evidence.

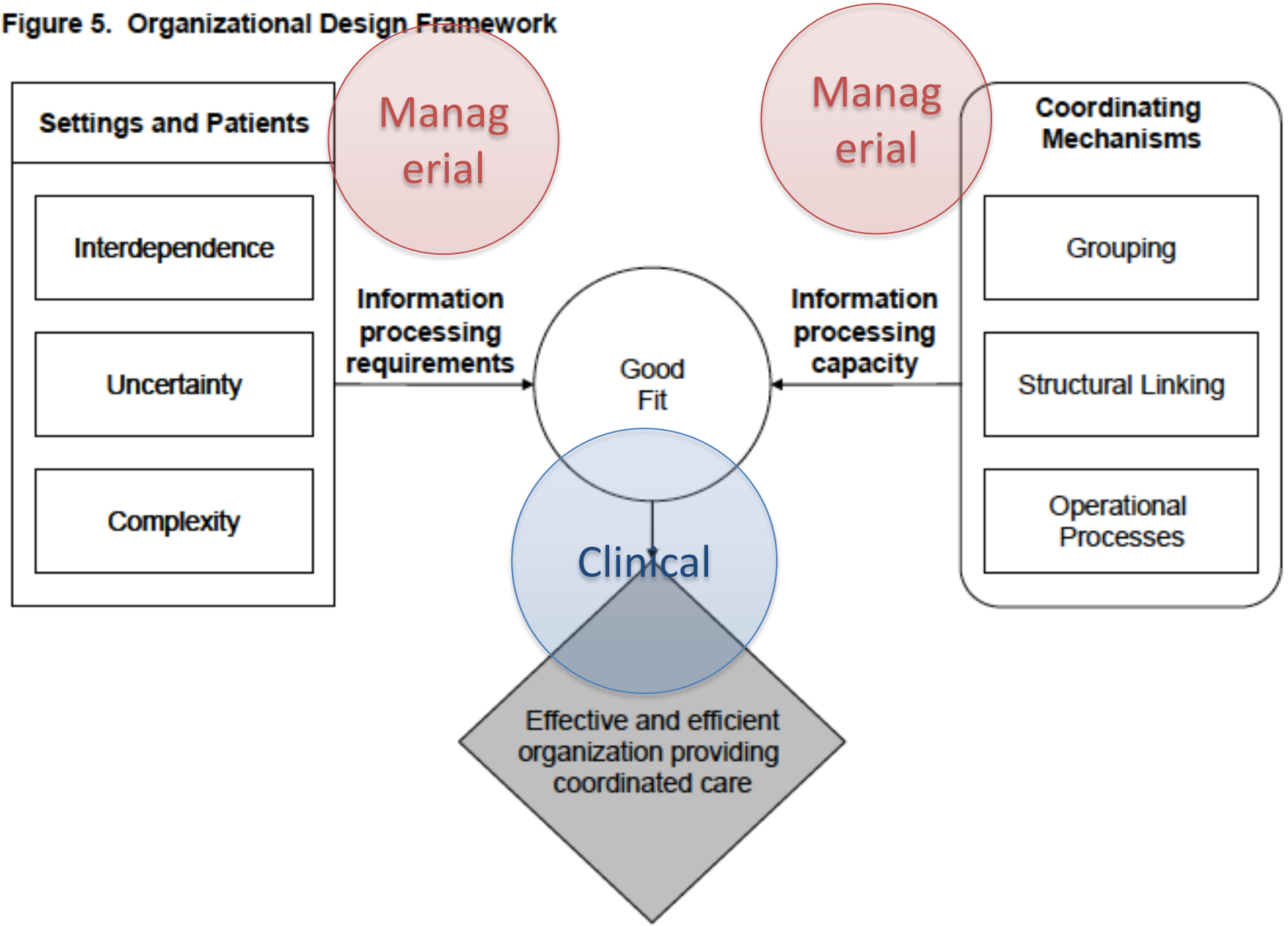
- Evidence on the efficacy of care coordination.
- Identification of best practices for care coordination.
- Guidelines for coordination of care of patients with multiple chronic conditions.
- Research on care coordination as it pertains to patients with chronic conditions.
- Relative effectiveness of integrated, practice-centered approaches versus “carve out”

Conceptual Frameworks.

- A consensus **definition** of care coordination.
- Common **terminology**/vocabulary for describing and evaluating coordination.
- A **model** for implementing and evaluating care coordination.
- Framework for describing and relating the elements of care coordination.
- Different considerations and needs depending upon perspective: broad systems level with responsibility for longitudinal, **population-based care versus clinical care** concerned with managing handoffs between care providers).
- Research models on how best to coordinate care for specific healthcare settings and patient populations.
- A model of communication that will help provider groups to interact.

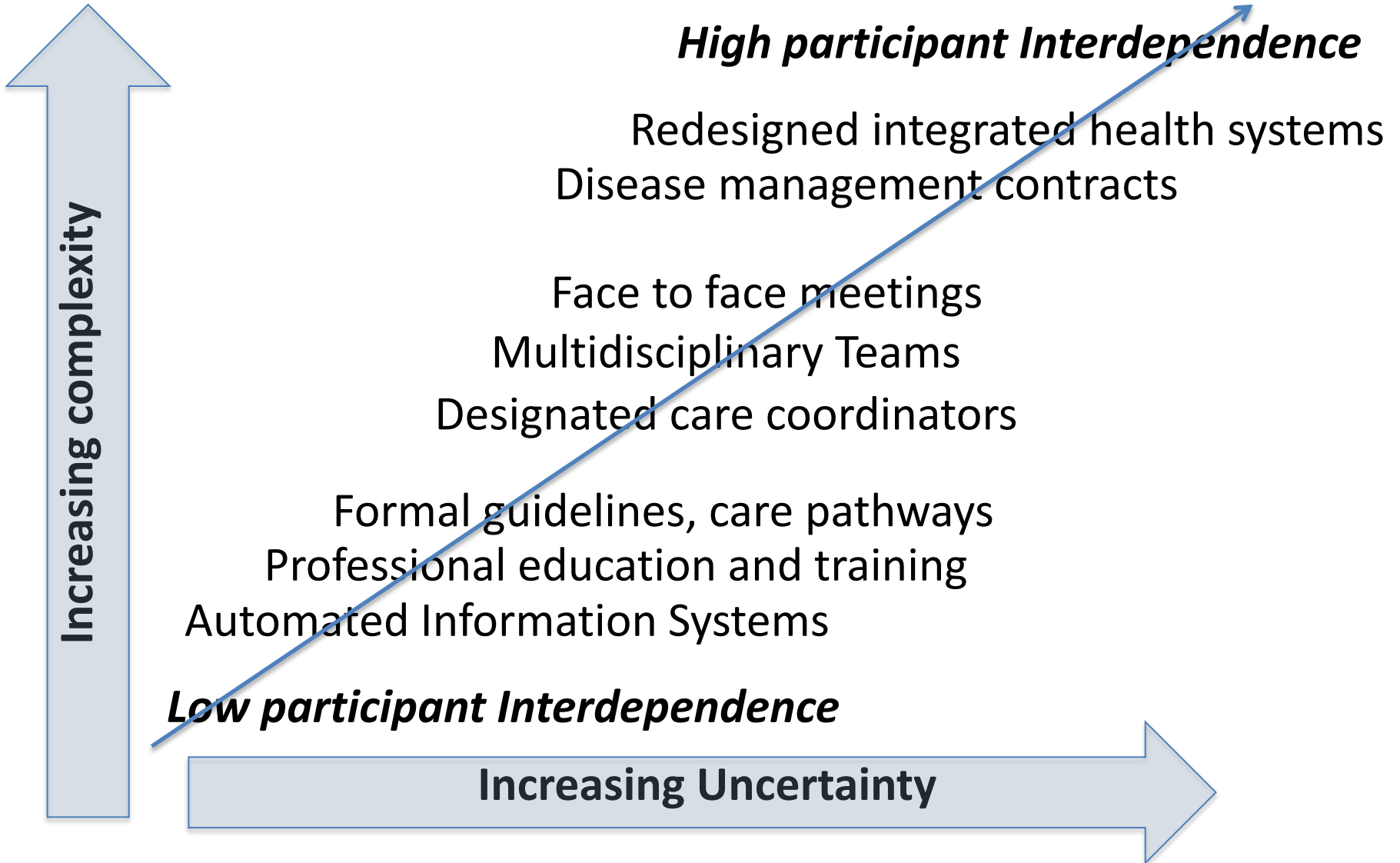
Other.

- Effects of widespread use of electronic medical records
- Caregivers role in care coordination schemes.
- **Effects of reimbursement for performing care coordination tasks.**
- Effects of improved integration across specialties.



Gittell and Weiss, Coordination networks within and across organizations: A multi-level Framework. J. Mgt Studies 2004; 41(1):127-53

Relationships between situational characteristics and Appropriate Care Coordination approaches



AHRQ Synthesis of Coordinating Processes

Table 17. Operational processes

Operational Process	Definition	Healthcare Examples
Standardization	Formalized mechanisms that pre-specify the [illegible]nsibilities, and activities; the [illegible]ns of intermediate outputs; and/or [illegible]s needed to perform specific activities.[309, 310]	- Practice guidelines - Care maps - Protocols - Clinical pathways - Checklists - CME (continuing medical education) that aims to standardize skills or knowledge
Adjustment	Mechanisms that facilitate ongoing assessment [illegible]djustment of roles, responsibilities, and [illegible]ions among multiple participants, either [illegible]een individual participants or among a designated group of participants.[91, 130, 141, 305, 309, 310]	- Individual performance feedback - Team meetings - Consultations - Multidisciplinary patient rounds
Monitoring	Mechanisms to facilitate timely assembly of [illegible]rmation regarding delivery of services and [illegible]ging patient care needs [91]	- Planned visits - Group visits - Automated relay of clinical information from home-based monitoring devices
Organizational [illegible]	Resources that influence the ability of an [illegible]rdinating	- Co-location of care sites - Information systems (e.g., computerized decision support systems) - Staffing decisions - Incentives

Standardization

Adjustment

Monitoring

Organizational Supports

The **organizational** challenge

Patients with complex health care needs, their families, and their providers often must traverse numerous professional, geographical, information system, and organizational ***boundaries*** to ensure that necessary care activities are performed adequately

Evidence says (2007)

Care coordination interventions represent a wide range of approaches at the service delivery and systems level. Their effectiveness is most likely dependent upon ***appropriate matching between intervention and (the) care coordination problem***

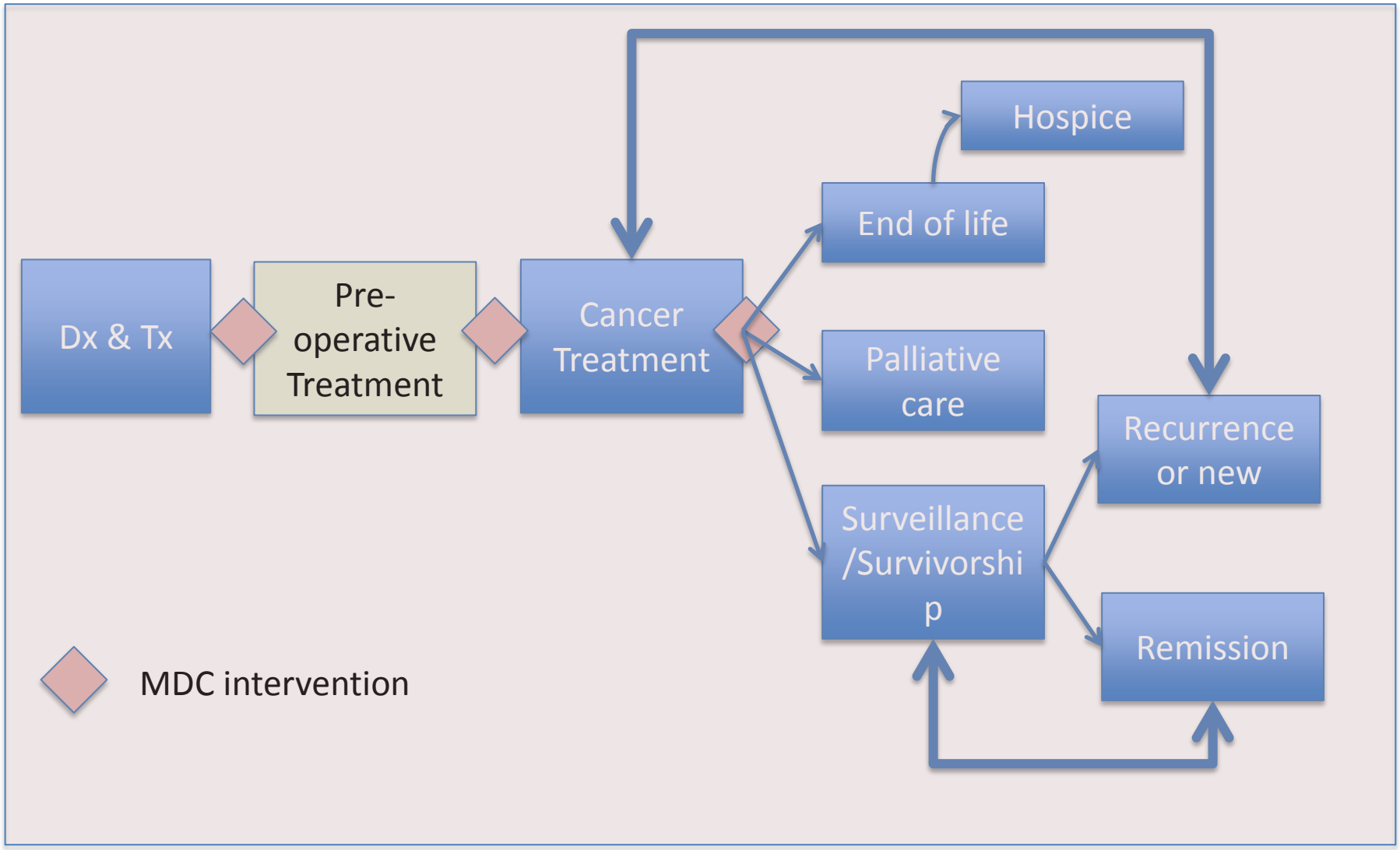
Mary Fennel

Organizational culture (as distinct from the team's culture) as well as teamwork have been associated with variation in quality of care in quality improvement research

Fennel's recommendation

Embed teams in organizations, use this relationship to guide research

Multidisciplinary treatment care (MDC) intervention across transitions in care



Fennel et al, 2010

Clauser et al..Multilevel Intervention **MLI Research**

- The term “multilevel intervention” refers to an intervention targeted to influence more than one contextual level (individual, group, organization, and community).
- “Few MLI research applications in cancer have used sophisticated approaches to measure group- or organizational-level constructs, such as leadership and team cohesion … these measures are well developed and used extensively in the management, social psychology, and general health literature

MLI Cancer Research Issues/Problems

- No overarching theory
- No standard of level / context
- Trials are feasible but may not be optimal
- Team/organizational levels underused
- Nonlinear/nonhierarchical relationships

Clauser, et al. Recommendations

- Consider a variety of promising nonrandomized designs: for example, multimethod, quasi-experimental, rapid learning, action/pragmatic research
- Consult management and sociological sciences for measures of teams and organizations
- Measure nontraditional aspects of interventions (eg, practical, feasible, scalable, cost-efficient)
- Consider hierarchical linear (and nonlinear) modeling; structural equation modeling and simulation modeling

Barriers: Walsh et al, 2010

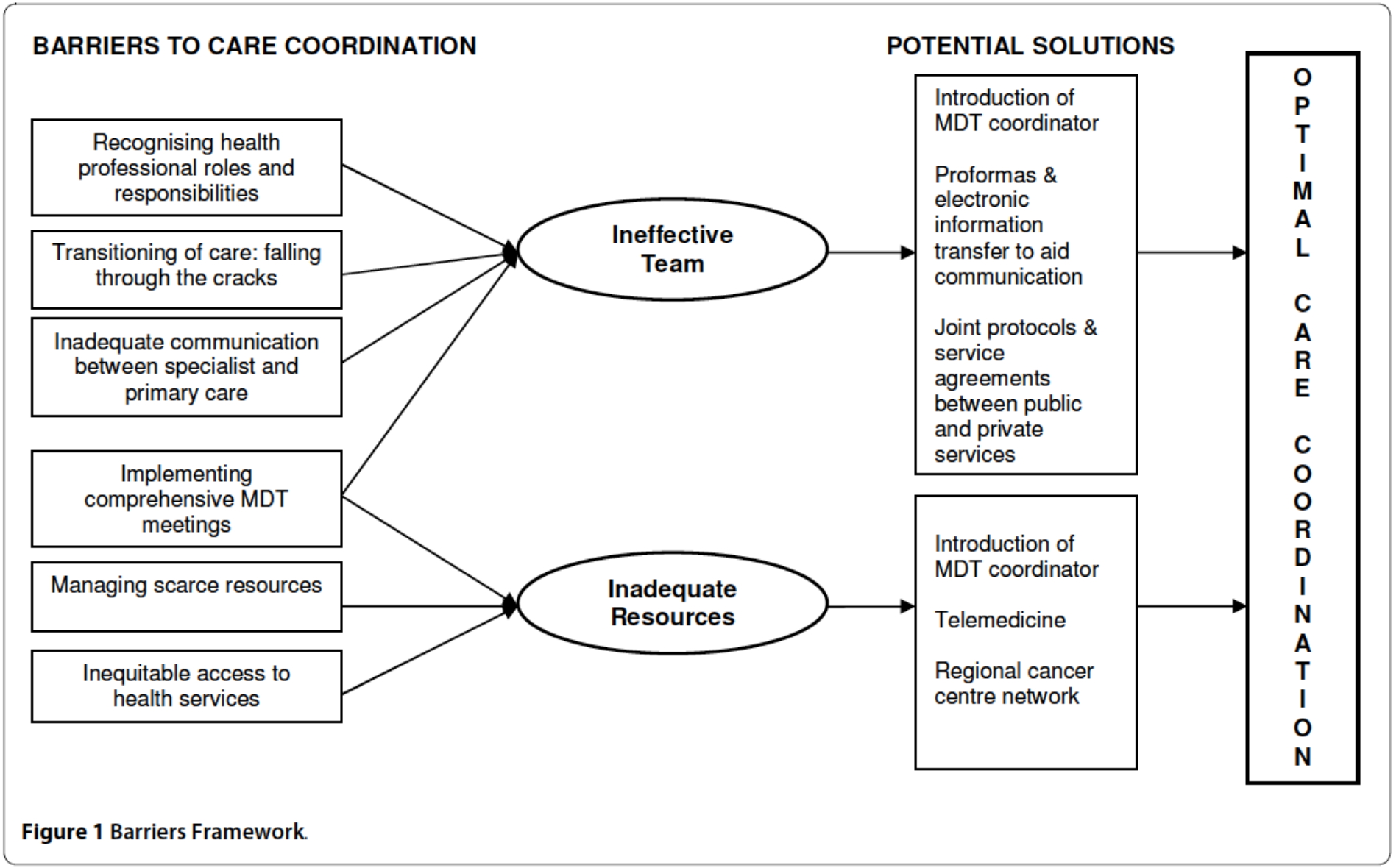


Figure 1 Barriers Framework.

Barriers: Humans and Teams

- What is the capacity for individuals to:
  - Multi-task?
  - Shift focus?
  - Adapt to changes in roles?
  - Accept shifting responsibility?
- Can we “engineer” team workers?

Barrier: The Production Function

- Tasks should be split into their most efficient units of effort.
- Time and motion studies have improved industrial production, surgery, and the operation of hospitals...why not chronic care?

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

Time and Motion Studies Database

http://healthit.ahrq.gov/health-it-tools-and-resources/time-and-motion-studies-database

Lopetegui, M., P.-Y. Yen, A. Lai, J. Jeffries, P. Embi and P. Payne (2014). "Time motion studies in healthcare: What are we talking about?" Journal of Biomedical Informatics **49**(0): 292-299.

Barriers: Times and Places

- Time: Life courses
  - Of people, patients and populations
  - Of health policy making
  - Of health care delivery systems
- Places: Systems, Institutions, *Habitus*
  - Health protection, monitoring
  - Health care delivery
  - Homes and habitats

Examples: Shortell; Janus & Brown:

- Physician (professional) integration must precede clinical integration

- The design of incentive systems that support physician–organization integration remains a work of ***organizational art***.

Overview of incentives. Incentives used by organizations

	US	Engl	Germany
Monetary incentives, Distn in %			
Salary	53.1	63.9	25.6
Fee-for-service	3.7	0	2.6
Case rate	0	0	5.1
Capitation	3.7	0	66.7
Mixed forms of payment	39.5	36.1	0
Nonmonetary incentives, Cited in % of Orgs			
Quality improvement	18.5	100	56.4
Culture of learning	6.2	15.6	35.9
Professional prestige	32.1	35.5	10.3
Transparency	4.9	25.8	10.3
Improved service coordination	12.3	100	61.5
Information technology	60.5	42.3	53.8

Janus & Brown

Newcomer: Study of “semi-episodic” payments.... costs lower

Table 2. Summary of Payment Method Used in Fee-for-Service and the Episode Model for Various Service Types

	Payment Method	
Service Type	**Episode Model**	**Standard Model**
Physician office visit	FFS	FFS
Chemotherapy administration	FFS	FFS
Chemotherapy medications ASP	0%	ASP+ contracted %
Diagnostic radiology	FFS	FFS
Laboratory	FFS	FFS
Physician hospital care	**Episode**	FFS
Hospice management	**Episode**	FFS or none
Case management	**Episode**	None

Newcomer et al, 2014 An Episode Payment Model

European Observatory on Health Systems and Policies

a partnership hosted by WHO

What is the evidence on the economic impacts of integrated care?

Ellen Nolte, Emma Pitchforth

The economics of integrated care

Nolte, Pitchforth Reviewed three economic outcomes:

- utilization,
- cost–effectiveness and
- cost or expenditure...

The most common concepts or terms were

case management,

care coordination,

collaborative care or a combination of these

Conclusion: There is evidence of cost–effectiveness of selected integrated care approaches but the evidence base remains weak. Eight of the nineteen studies reported on cost–effectiveness.

Examples: Stroke

- Lack of resources,
- Coordination problems among staff and among facilities
- Suboptimal professional and organisational practices
- Inadequate public education about stroke

Manag erial

Manag erial

Manag erial

Clinical (popula tion)

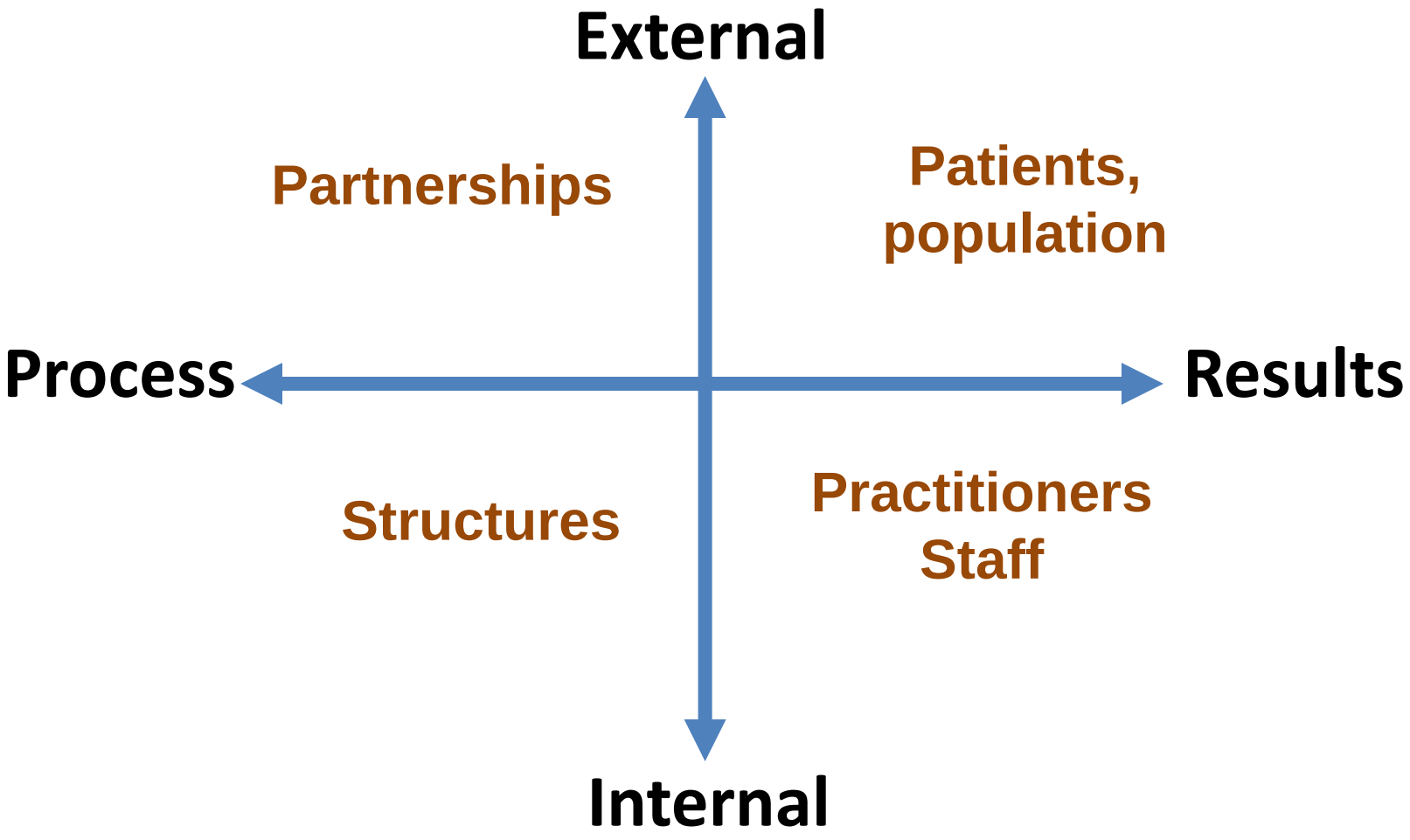
Gache et al., Main barriers to effective implementation of stroke care pathways in France: a qualitative study. BMC Health Services Research 2014, 14:95

Option 1: What about adaptability?

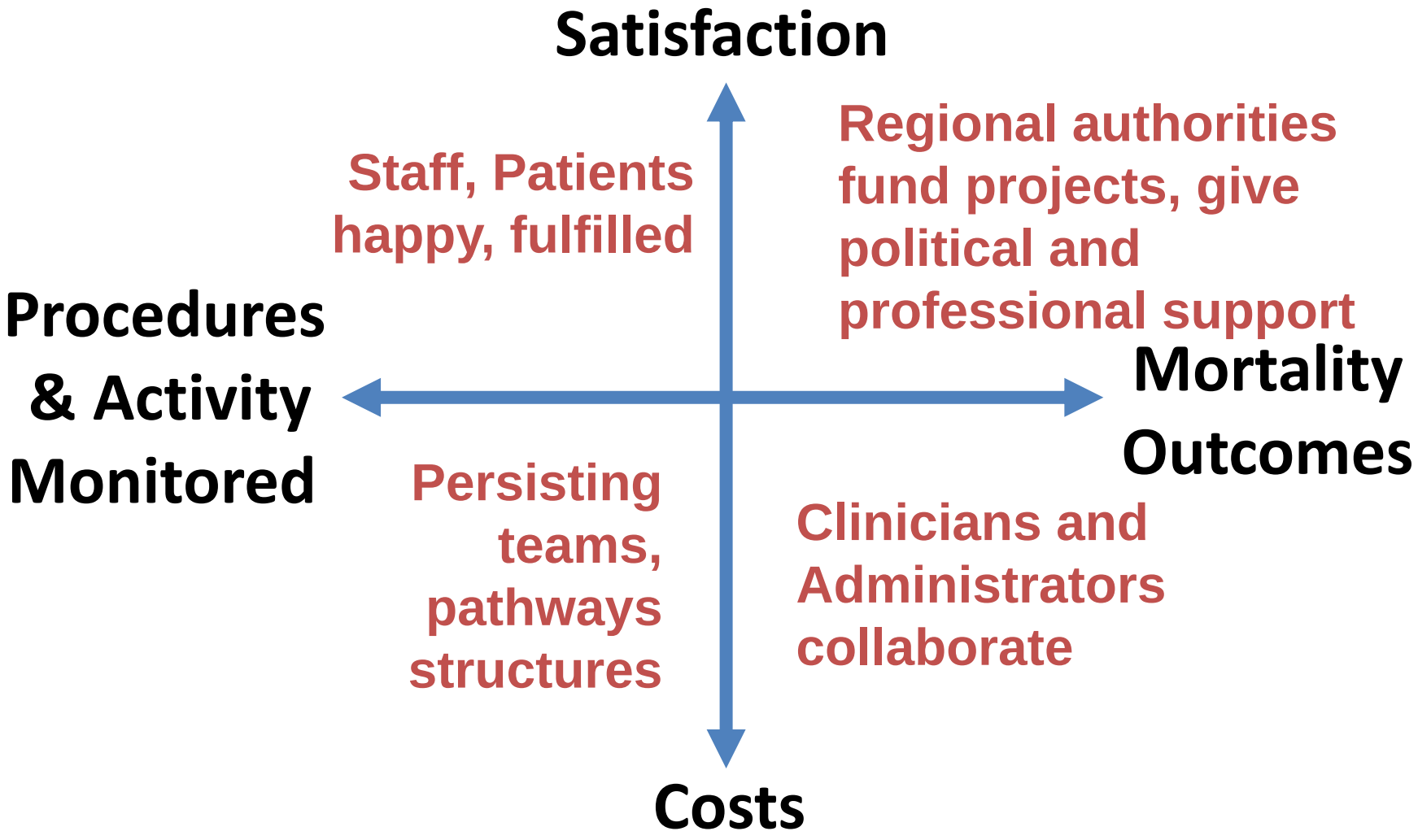
- Systems and models need to be able to "customize"
- The key research question is: **'What works, for whom, and under what circumstances?'**
- Research should be as **flexible** as the teams/coordinating systems are

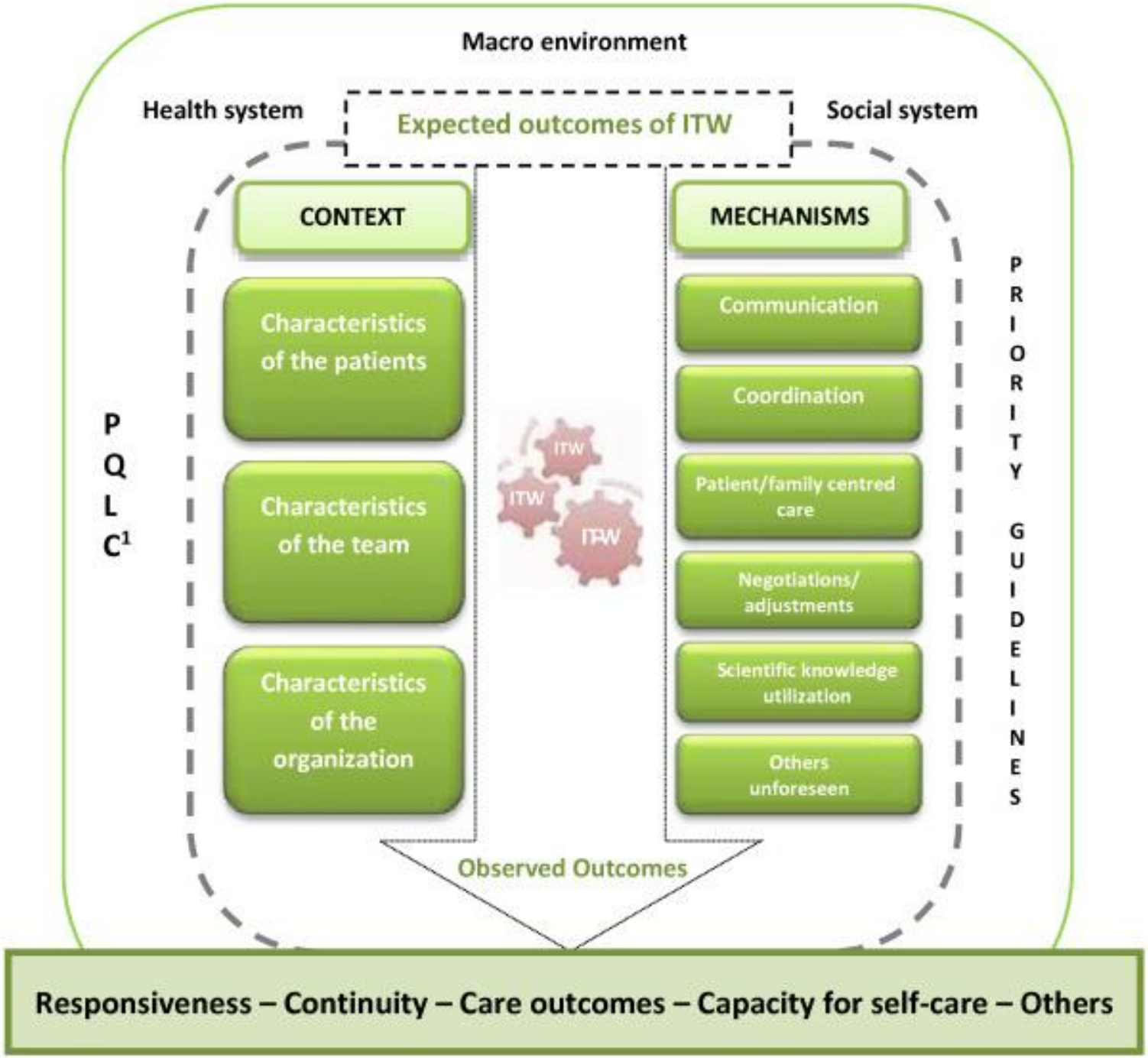
Programme québecoise de lutte contre le cancer (Quebec Cancer Program) Tremblay et al Impl Sci Jun 2014.

Option 2: “Balanced Scorecard”

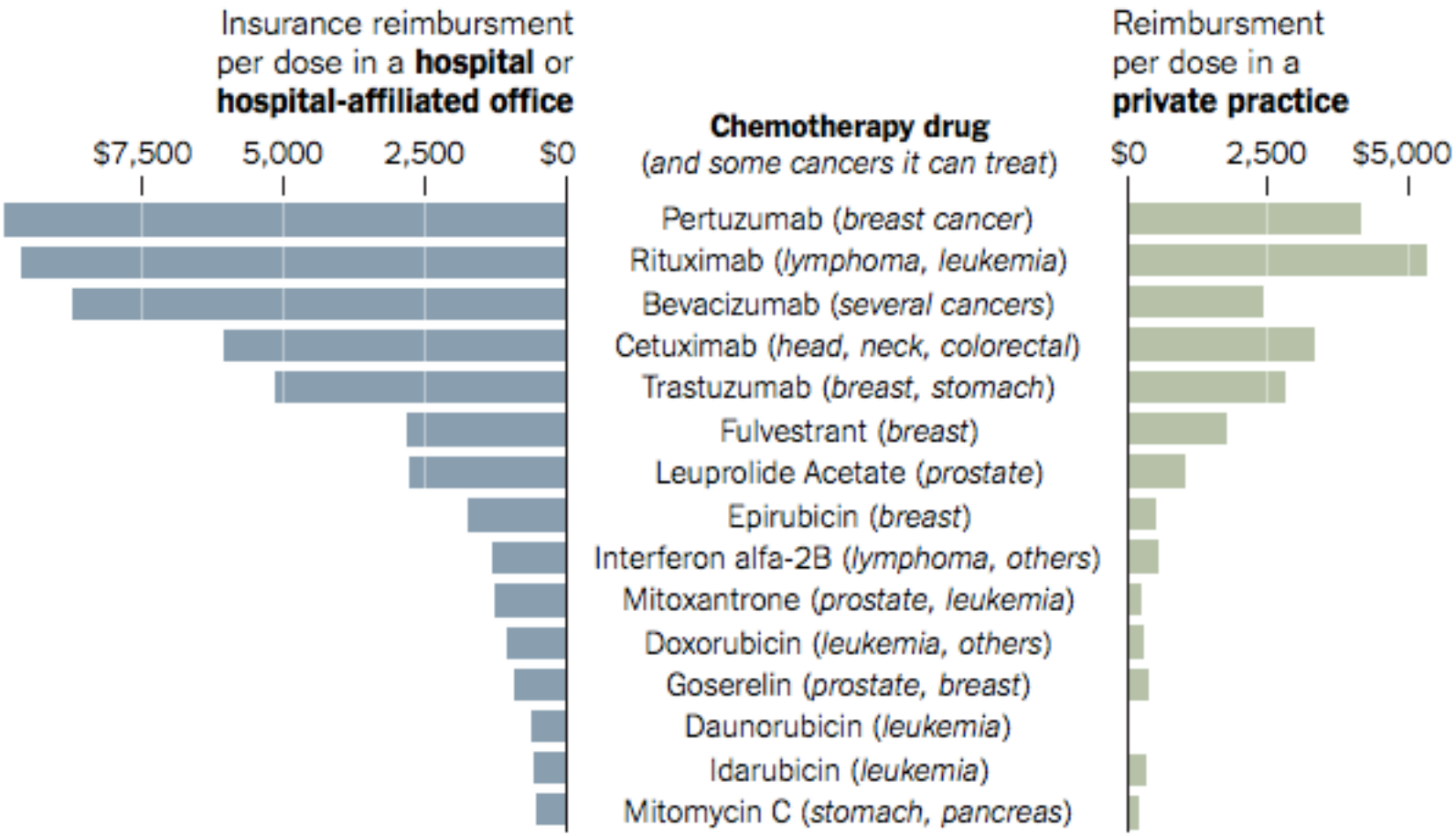


Balanced outcomes




Macro environment
Health system
Expected outcomes of ITW
Social system
CONTEXT
MECHANISMS
Characteristics of the patients
Characteristics of the team
Characteristics of the organization
Communication
Coordination
Patient/family centred care
Negotiations/ adjustments
Scientific knowledge utilization
Others unforeseen
ITW
ITW
ITW
PQLC[1]
PRIORITY GUIDELINES
Observed Outcomes
Responsiveness – Continuity – Care outcomes – Capacity for self-care – Others

Distortions in US Payment System



Sources: IMS Institute for Healthcare Informatics; RxList

By The New York Times