WHAT MAKES CARE COORDINATION WORK BEST?




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Like many important questions, the answer to what makes care coordination work best is that we don't really know. An analysis of 75 systematic reviews of care coordination concluded that health benefits have been demonstrated for patients with heart failure, diabetes, severe mental illness, recent stroke or depression.[1] However, it also found insufficient evidence to assess the impact of individual components of care coordination on effectiveness. Another thorough systematic review found evidence that "most changes for better coordination improve quality and save resources," but that "it depends on which approach is used, how well it is implemented and on features of the environment in which a provider is operating."[2] More recent systematic reviews and meta-analyses have not filled these knowledge gaps.[3-5] This lack of information about the models and factors contributing to successful care coordination makes it difficult for care systems, clinicians and payers to know how to structure their approach.

Fortunately, help is on the way for Minnesota's leaders and health care professionals in primary care and their complex patients with multiple morbidities that could benefit from care coordination. The Patient-Centered Outcomes Research Institute (PCORI) has funded a $4 million contract to a consortium of organizations in Minnesota to answer three important questions about care coordination.

- What care coordination model produces the best outcomes for patients: a traditional medical-nursing model or one that incorporates a social worker on the team?
- What other components of either model are important for best outcomes?
- What other aspects of the community, care system or patients help to explain differences in outcomes?

Minnesota received funding to study care coordination because of our unique environment enabling the important observational study needed to answer these questions.

ORGANIZATIONS IN MINNESOTA ENABLING THE STUDY OF CARE COORDINATION

- A Minnesota Department of Health (MDH) program for certifying primary care clinics as health care homes that includes care coordination as a standard requirement and involves 60% of the primary care clinics across Minnesota
- A nonprofit organization—MN Community Measurement (MNCM)—that collects and reports, publicly, on key quality measures for all patients in the state
- Health care payors willing to provide utilization data for the study (Blue Cross and Blue Shield of Minnesota, UCare, HealthPartners and Minnesota Department of Human Services)

- A research organization with the resources and skills to put together a successful application and implementation of a study (HealthPartners Institute)
- A majority of clinics and care systems that want to support a study that will help them to improve their care
- Patient representatives

BACKGROUND ON THE MINNESOTA CARE COORDINATION EFFECTIVENESS STUDY

Although MNCARES (the Minnesota Care Coordination Effectiveness Study) was officially funded in May 2020 for three years, its initial plans were stymied (like much else) by the COVID-19 pandemic that overwhelmed care systems and greatly disrupted previous care processes and patient access. Instead, much of that first year was spent developing and obtaining approval for a modified plan and recruiting participating clinics. The new plan, just approved in May 2021, still aims to answer the original questions, but delays the sample of care coordination patients to 2021 and adds a second cohort of patients that began to receive care coordination prior to the pandemic. These changes will also allow us to learn just how problematic the pandemic has been for complex, high-cost patients—many of whom may also be more likely to be impacted by social determinants of health. PCORI has provided additional funding for a fourth year.

Fortunately, despite the conflicting pressures from the pandemic and (recently) from huge vaccination programs, recruitment of clinics and care systems has gone very well. Out of the 397 potentially eligible adult primary care clinics and 70 care systems in Minnesota and border areas that are certified as health care homes, 83% (329 clinics from 48 care systems) have agreed to participate. Representing considerable diversity in location and organizational type and size, these forward-looking clinics will help us all to identify the best ways to serve the patients who are in most need of complicated medical care and social services.

So, what are these care coordination patients like, and what are their needs? From the limited data we have available, it appears that, typically, only 1% of patients are receiving care coordination services, but those who are mostly have multiple chronic conditions. One early benefit of the study is that it will provide us with the ability to describe the patients chosen to receive these services and their needs, both medical and social. Since no other region has so many clinics providing care coordination, these data will provide a unique understanding of their problems for planning purposes.

If care coordination works, what outcomes are affected? With the cooperating organizations, we hope to be able to assess the impact of care coordination on care quality (as measured by MN Community Measurement), utilization (as measured by health care payor claims data) and patient reported outcomes (as reported on patient surveys). Through surveys of care coordination patients, we will be assessing the patient's perspective on the care coordination experience as well as its effect on their care and social factors that influence their health. We hope to also be able to identify which types of patients appear to benefit most from care coordination services. Additionally, the survey of care coordination patients who lived through the pandemic will allow us to describe the impact of the economic, medical care and social disruptions on the lives of patients with multiple morbidities or complex medical needs. That information may be important for better meeting their needs if/when another major disruption occurs in the future.

CONNECT WITH RESEARCHERS FOR THE MINNESOTA CARE COORDINATION EFFECTIVENESS STUDY

If your clinic/care system is participating in MNCARES (or if you are personally interested), here are some ways you can stay abreast of what's happening and let us know about your ideas:

- Visit and bookmark the MNCARES web page: www.health.state.mn.us/facilities/hchomes/mncares.html
- View the recorded May 11 "Welcome to MNCARES" webinar for clinics under the MNCARES Update tab at the page above or at mncm.org/past-events-webinars
- Watch for updates in newsletters from MDH (www.health.state.mn.us/facilities/hchomes/newsletter). and MNCM (mncm.org/news).
- Send your ideas about what factors are most important for effective care coordination to **mncares@healthpartners.com**, or reach out to any of the authors.

This study provides an opportunity to enhance the collaborative approach to health care that has made Minnesota stand out nationally. We also hope to provide information that clinics and care systems can implement to improve patient care quality, reduce utilization burden and

continued on page 12

continued from page 11

improve patient-centered outcomes, while also illuminating the effect of social needs on overall health and identifying whether care coordination is effective in addressing social needs and reducing disparities. We will do our best to ensure that the lessons learned are widely disseminated and implemented.

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