



## Beyond Implementation: Capturing the Value of Care Coordination

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Questions and Answers

**Faculty:**

Richard Antonelli, MD, MS, FAAP, *Boston Children's Hospital*

Hannah Rosenberg, MSc, *Boston Children's Hospital*

David Urion, MD, *Boston Children's Hospital*

Tami Chase, RN, *Boston Children's Hospital Primary Care at Martha Eliot Health Center*

**Moderator:**

Dian Baker, PhD, RN, *California State University, Sacramento, School of Nursing*

This document includes a summary of major questions presented by participants that were not answered during the live webinar due to time constraints. For additional resources and information related to care coordination, visit:

- [The National Center for Medical Home Implementation Care Coordination Web Page](#)
- [Building Your Medical Home: An Introduction to Pediatric Primary Care Transformation](#)
- [Patient- and Family- Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems](#)
- [Pediatric Care Coordination Curriculum: Boston Children's Hospital](#)

Questions	Answers
<p>Do you have an example of the Care Coordination Measurement Tool (CCMT) adapted for team-based, system level care coordination collaborative?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  This could really range based on the population that was being served. For example, the medical home CCMT that is available in the public domain could be used in that setting. For specific, individualized information, please contact Hannah Rosenberg:  <a href="mailto:Hannah.rosenberg@childrens.harvard.edu">Hannah.rosenberg@childrens.harvard.edu</a>.</p>
<p>For a primary care provider (PCP), how can telephone coordination with the family and subspecialist be reimbursed?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  The opportunity now exists to capture the value of non-reimbursable care coordination encounters, as the American health care delivery system begins to move away from fee-for-service (volume-based) reimbursement to global budget (value-based).</p> <p>Individual PCP's are reimbursed on the basis of current contractual arrangements with payers, but there are increasing number of payers across the US who are willing to finance care coordination. In many of these cases, however, the expectation is that the funding is not new, but is shifted from one domain (e.g., unplanned readmissions and unnecessary emergency department care) to ambulatory care coordination.</p> <p>For Medicare Beneficiaries : Beginning January 1, 2015, CPT code 99490 for non-face-to-face care coordination services is equal to 20 minutes of clinical staff time by physician or other qualified health care professional. [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf]</p> <p>The new codes:</p> <p><b>99487:</b> Complex chronic coordination services; first hour of clinical staff time directed by a physician or other qualified healthcare professional with no face-to-face visit, (once) per calendar month.</p> <p><b>99488:</b> First hour of clinical staff time directed by a physician or other qualified healthcare professional with one face-to-face visit, per calendar month.</p>

	<p><b>99589:</b> Each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (list separately in addition to code for primary procedure).</p> <p>The codes cover services provided to an individual residing in a home, domiciliary, or assisted living facility and are addressed by multiple disciplines and community service agencies. The reporting individual provider is the one who directs the management and/or coordination of services as needed for all medical conditions, psychosocial needs, and activities of daily living.</p> <p>Care coordination may include:</p> <ul style="list-style-type: none"> <li>• communication with the patient, family members, and caregiver decision-makers regarding aspects of care;</li> <li>• communication with agencies serving the patient;</li> <li>• patient and/or family education to support self-management;</li> <li>• identification of community resources;</li> <li>• facilitating access to care as needed; and</li> <li>• development and maintenance of a comprehensive plan of care directed by the physician or qualified healthcare professional.</li> </ul> <p>[<a href="http://medicaleconomics.modernmedicine.com">http://medicaleconomics.modernmedicine.com</a>]</p>
<p>When do you envision the complex care codes being reimbursed?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  We do not have specific prediction for pediatrics, but Medicare is focusing on complex care for its beneficiaries. This presents an opportunity for pediatric providers to define their role in improving care and cost outcomes.</p>
<p>How do you capture time locating new resources for families a part of care coordination?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  The CCMT can be adapted to reflect different activities; many groups that have used this tool have tracked time spent locating new resources for families.</p>
<p>Have you found there to be an optimal caseload number?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  It depends upon the priorities of the practice-based care coordinator. If the focus is on broad access to care (e.g., preventive care visits), the ratio can be higher. If the focus is on patients</p>

	with high complexity needs (e.g., care management), the ratio is lower. These priorities are often worked out as part of contracting discussions.
How is care coordination working for patients enrolled in Medicaid Managed Care programs? Any differences between them, patients in fee-for-service (FFS) Medicaid, and patients with private insurance?	<p><b>Richard Antonelli and Hannah Rosenberg:</b> New proposed regulations from CMS are defining specific obligations for Medicaid Managed Care. In our opinion, there has not yet been enough experience in pediatrics to compare care coordination outcomes in each of these reimbursement arrangements.</p>
What was your method of quantifying the percentages in the outcome columns? (Slide 33)	<p><b>Richard Antonelli and Hannah Rosenberg:</b> These numbers were calculated from a feasibility study using data collected over approximately a 3.5 month period. Out of the total numbers where prevention was noted as an outcome, the CCMT user selected the outcomes as what was prevented due to care coordination service delivery.</p> <p>See: <u>Antonelli RC, Stille CJ, Antonelli DM. Care Coordination for Children and Youth with Special Health Care Needs: A Descriptive, Multisite Study of Activities, Personnel Costs, and Outcomes. <i>Pediatrics</i> 2008; 122.</u></p>
How were they able to determine that an unnecessary ER visit, etc. was avoided when using the CCMT? (Slide 33)	<p><b>Richard Antonelli and Hannah Rosenberg:</b> Although the notion of assessing prevention resulting from a care coordination encounter is quite subjective, the study participants were asked to use the following framework in which to make a judgment: “If you had not taken the time to perform that specific care coordination activity, what would have been the result?”</p> <p>The CCMT only allows coding for a single prevented outcome. Based on these criteria, 32% of care coordination encounters prevented a level of resource use that would have gone beyond the primary care setting (e.g., emergency department).”</p> <p>Please see: <u>Antonelli RC, Stille CJ, Antonelli DM. Care Coordination for Children and Youth with Special Health Care Needs: A Descriptive, Multisite Study of Activities, Personnel Costs, and Outcomes. <i>Pediatrics</i> 2008; 122.</u></p>

<p>How is case management done within care coordination and who on the medical home team does each?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  We have seen this vary from institution to institution and state to state. Different models work for different teams. If you'd like individualized technical assistance on this topic, please contact Hannah Rosenberg: <a href="mailto:Hannah.rosenberg@childrens.harvard.edu">Hannah.rosenberg@childrens.harvard.edu</a></p>
<p>How much of the administration of care coordination is done by Primary Care vs the integrated Specialty Care team members?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  This can vary greatly. At Boston Children's Hospital we are testing a model in which there is a partnership between primary care and specialty care, and accountability is determined by answering the question of who can best serve the needs of the patient.</p>
<p>Are you aware of anyone who has incorporated the CCMT into Electronic Medical Records? If so, which EMRs, and how well does it work especially for pulling data back out?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  We have developed the CCMT into an electronic tool using the platform REDCap. We have tested it by incorporating a link into our EMR. However, we are aware of other institutions who are working with their EMR vendor to incorporate CCMT. If interested in learning more about this, please contact the National Center for Care Coordination Technical Assistance Manager, Hannah Rosenberg: <a href="mailto:Hannah.rosenberg@childrens.harvard.edu">Hannah.rosenberg@childrens.harvard.edu</a>.</p>
<p>How do urgent care facilities fit into the coordination of care?</p>	<p><b>Richard Antonelli and Hannah Rosenberg:</b>  This can vary greatly. We encourage all groups to partner with anyone contributing to care/care coordination for patients/families that they serve and to develop a systematic way to provide care coordination service delivery. A truly integrated model includes primary/specialty/inpatient/ambulatory/social work/care coordinators/school/community and <u>families themselves</u> all communicating and working together.</p>
<p>When Dr Urion orders a secondary consult how was the PCP notified, and how often did that happen?</p>	<p><b>David Urion:</b>  The PCP was always told about secondary consultation, usually in the text of the letter sent to the PCP from the visit (and letter generation within 10 days of visit is in excess of 90% for all the clinics studied, since this is an institution standard).</p> <p>A good example of such secondary consultation would be a child referred to neurology for evaluation and treatment of Rett syndrome, who was found upon examination to have spasticity sufficient to warrant co-management by neurology and orthopedics or physiatry. The secondary consult was to address the original intent of consultation, but the patient proved to need services beyond neurology in order to address that.</p>

	<p>In terms of how "often did that happen", if the inquirer is interested in the volume of secondary consultations, the first slide of Dr Urion's presentation has this data. If the inquirer is interested in how often the PCP was informed of the secondary consultation, this number is close to 100%</p>
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