CARE COORDINATION – A CONCIERGE MODEL

MARIBEL GUTIERREZ, MSW, BSBA, PPSC

Stanford Children's Health

Lucile Packard Children's Hospital Stanford

INTRODUCTION

THE ROLE OF THE CARE COORDINATION LIAISON (CCL) WAS CREATED TO PROVIDE CLINICAL ADMINISTRATIVE SUPPORT TO LICENSED CLINICIANS, ALLOWING THEM TO WORK UP TO THE HIGHEST LEVEL OF THEIR LICENSURE. THE GOAL WAS TO TAKE OVER TIME-CONSUMING TASKS SUCH AS CONFIRMING DURABLE MEDICAL EQUIPMENT DELIVERY TIMES, OBTAINING AUTHORIZATIONS FOR POST ACUTE CARE, FAXING CONCURRENT REVIEW, AND PLACING DISCHARGE COORDINATION REFERRALS. THE VISION WAS TO EXPAND THIS TYPE OF SUPPORT TO OTHER LICENSED HEALTHCARE PROVIDERS WITHIN THE MULTIDISCIPLINARY TEAM. TODAY, CARE COORDINATION LIAISONS SUPPORT RESIDENT PHYSICIANS, ADVANCED PRACTICE PROVIDERS, RN CASE MANAGERS, AND SPECIALTY CARE PROGRAMS ACROSS THE ORGANIZATION. CCLS PROVIDE PERSONALIZED CARE COORDINATION SUPPORT TO PATIENTS AND FAMILIES FROM ALL AROUND THE GLOBE.

OBJECTIVES

1. CREATE A MODEL FOR CARE COORDINATION SUPPORT OF LICENSED HEALTHCARE PROFESSIONALS WITHIN A HOSPITAL SYSTEM THAT EXTENDS BEYOND SUPPORTING RN CASE MANAGERS WITH DISCHARGE PLANNING
2. CREATE A MODEL FOR PROGRAM-BASED CARE COORDINATION OFFERING A SINGLE POINT OF CONTACT FOR PATIENTS AND FAMILIES SEEKING MEDICAL CARE AT ACADEMIC INSTITUTIONS
3. LEVERAGE AND OPTIMIZE EXISTING CARE COORDINATION TYPE ROLES TO PROVIDE A PERSONAL CONCIERGE SERVICE TO PATIENTS AND FAMILIES, NEW AND ESTABLISHED ALIKE

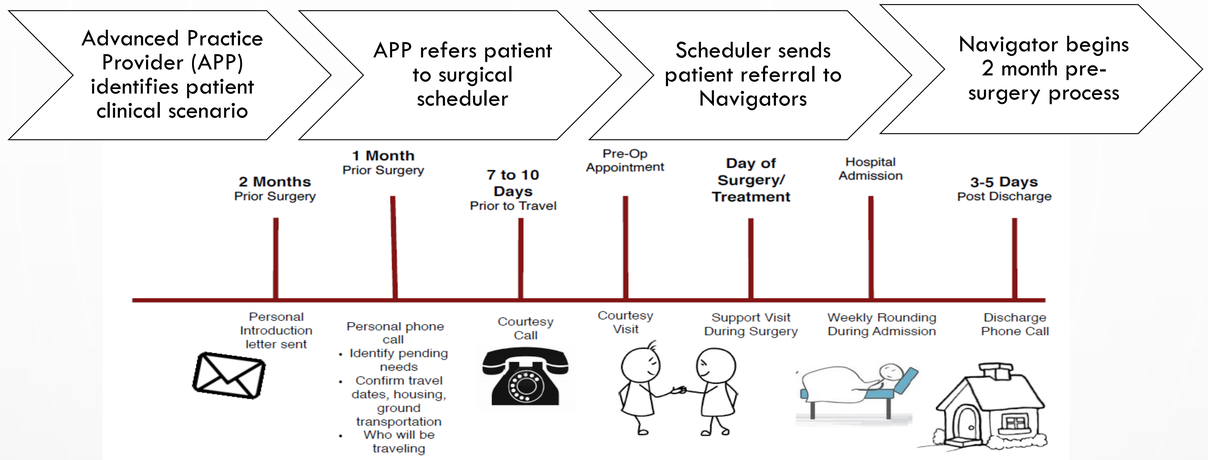
CCL ROLE

Utilization Management	Utilization review: clinical packets for payor review
PCP / Referring Identification/Notification	Assist in identifying PCP for patient, admission and discharge notification
Insurance Liaison	Verification, benefits, referral assistance, travel and lodging, etc.
Discharge Planning Assistance	Case management discharge planning
Medical Records	Obtaining internal and external records
Referrals	Palliative care, home health, rehab, OT/PT, hospice, dialysis, follow-up appointments, etc.
Patient Progression Meetings	Huddles, interdisciplinary rounds, care conferences, etc.
Durable Medical Equipment (DME) Assistance	Referral follow-up assistance for walkers, wheelchairs, enterals, beds, etc.
Non-DME Assistance	Supply order follow-up for syringes, prescriptions, etc.
Medical Transfer	Clinical packet for transfer, schedule transport, referral follow-up
Prior Authorization	Specialty medication authorization
Patient Education	Self management education and tools for patient and families

IMPLICATIONS FOR PROCESS:

- TRANSPOSABLE MODEL FOR PEDIATRIC AND/OR ADULT PATIENT POPULATIONS
- DECREASING ADMINISTRATIVE TIME TO ALLOW LICENSED EXPERTS THE ABILITY TO WORK TO HIGHER POTENTIAL

PROCESS MAP (PREVIOUS STATE)



ROOT CAUSE ANALYSIS

METHOD
- No standardized procedures for questions
- Too many staff involved
- Duplication of effort

MACHINES
- Missing Ancillary documentation
- No access/training to clinical documentation
- Lack of follow through

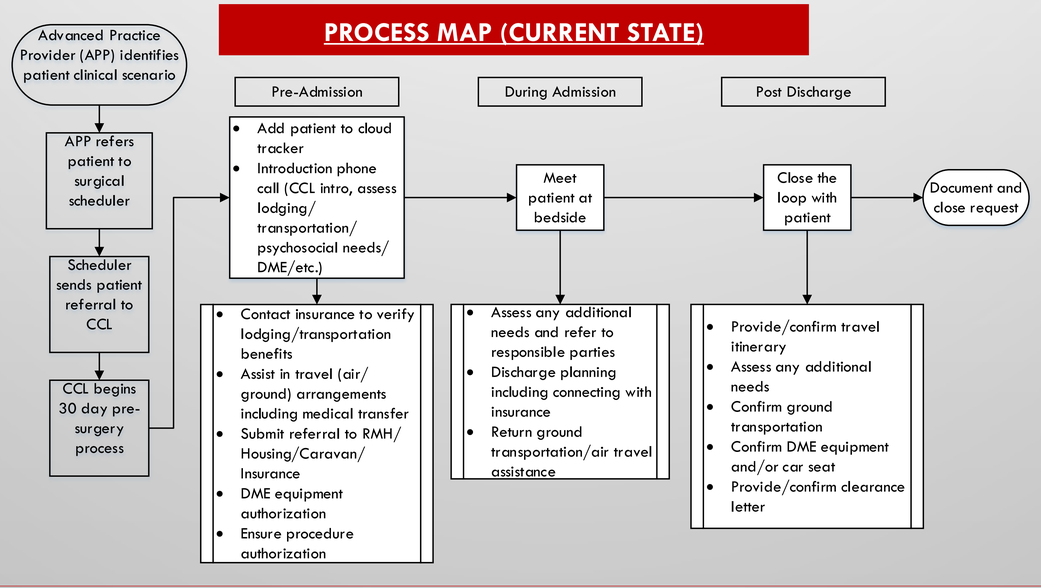
MANPOWER
- Lack of clinical skills
- Time consuming
- No point person

ENVIRONMENT
- Staff turnover
- No hand off process
- No cross training
- Changing leadership

MEASUREMENT
- No clear direction
- No ability to measure
- No metrics on financial impact

MATERIALS
- Responses delay
- Incomplete intake referrals

PROCESS MAP (CURRENT STATE)



RESULTS

1. PARTNERSHIP DEVELOPMENT
2. COMMUNICATION PROFICIENCY
3. USE OF ASSESSMENTS FOR INTERVENTION
4. FACILE IN CARE PLANNING SKILLS
5. RESOURCE KNOWLEDGE INTEGRATION
6. ADAPTABLE AND FLEXIBLE APPROACHES
7. CONTINUOUS LEARNING MODEL
8. TEAM BUILDING SKILLS
9. PROFICIENT WITH INFORMATION TECHNOLOGY
10. PATIENT AND FAMILY COACHING (GOAL SETTING)
11. PROACTIVE PLAN OF CARE WITH FOLLOW UP MONITORING

CONCLUSION

THE CONCIERGE MODEL IS ASSESSMENT DRIVEN, PATIENT AND FAMILY CENTERED TO PROVIDE INDIVIDUALIZED CARE SPECIFIC TO THE NEEDS OF THE PARTICULAR PATIENT POPULATION. ADDITIONALLY, THIS MODEL PROVIDES A SINGLE POINT OF CONTACT THAT DELIVERS MULTI-LEVEL SUPPORT, INCLUDING FAMILY SUPPORT, FINANCIAL ASSISTANCE, GOAL PLANNING, AND MUCH MORE. FROM FY18 TO FY22, THE CARE COORDINATION DEPARTMENT HAS EXPANDED BY 60%, THE CONCIERGE MODEL HAS DOUBLED, AND DEMAND FOR THE CCL ROLE HAS CONTINUED TO GROW WITH REQUESTS ORGANIZATION WIDE, YEAR OVER YEAR. PROJECTED FY23 GROWTH IS UPWARDS OF 30%. IN CONCLUSION, AN INTEGRATED CARE COORDINATION INFRASTRUCTURE IS ESSENTIAL TO CREATING AND SUSTAINING A HIGH-PERFORMANCE PEDIATRIC CONTINUITY OF CARE MODEL CONTRIBUTING TO POTENTIAL HEALTH CARE COST SAVINGS.

REFERENCES

Antonelli, R., McAllister, J., & Pop, J. (2009, May). *Commonwealth Fund.* Retrieved from http://www.lpfch.org/sites/default/files/care_coordination_a_multidisciplinary_framework.pdf

National Quality Forum. (2017). *Care Coordination Measures*. Retrieved from National Quality Forum: http://www.qualityforum.org/ProjectDescription.aspx?projectID=73700

CONTACT

MARIBEL GUTIERREZ, MANAGER OF CARE COORDINATION
MARIGUTIERREZ@STANFORDCHILDRENS.ORG
SHIRLEY CHEUNG, DIRECTOR OF CARE MANAGEMENT
SHCHEUNG@STANFORDCHILDRENS.ORG

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