The National Evaluation of the
CHIPRA Quality Demonstration Grant Program

Evaluation Highlight No. 9, July 2014

The CHIPRA Quality Demonstration Grant Program

In February 2010, the Centers for Medicare & Medicaid Services (CMS) awarded 10 grants, funding 18 States, to improve the quality of health care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Quality Demonstration Grant Program aims to identify effective, replicable strategies for enhancing quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) is leading the national evaluation of these demonstrations.

The 18 CHIPRA quality demonstration States are implementing 52 projects in five general categories:

- Using quality measures to improve child health care.
- Applying health information technology (IT) for quality improvement.
- Implementing provider-based delivery models.
- Investigating a model format for pediatric electronic health records (EHRs).
- Assessing the utility of other innovative approaches to enhance quality.

The CHIPRA quality demonstration began on February 22, 2010, and will conclude on February 21, 2015. The national evaluation of this demonstration started on August 8, 2010, and will be completed by September 8, 2015.

How are CHIPRA quality demonstration States supporting the use of care coordinators?

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This *Evaluation Highlight* is the ninth in a series that presents descriptive and analytic findings from the national evaluation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Demonstration Grant Program.[1] The *Highlight* focuses on how six States—Alaska, Idaho, Massachusetts, Oregon, Utah, and West Virginia—are using grant funds to support practices' use of care coordinators by providing training, technical assistance, and/or funding as practices implement patient-centered medical home (PCMH) models. The analysis is based on work completed by the States during the first 3.5 years of their 5-year projects.

KEY MESSAGES

The experiences of the six States featured in this *Highlight* may be helpful to other States that are seeking to use care coordinators as an integral part of their strategy for achieving the functions of care coordination in primary care practices serving children and adolescents. Key messages include:

- States used different approaches to ensuring that care coordination would be effective, including educating practices about the functions of care coordination and providing them with technical assistance and/or funding to fulfill those functions.
- All care coordinators performed a broad set of functions in their work with children and families. They also supported practices in their effort to transform themselves into PCMHs. However, a coordinator's specific activities varied across States and practices.
- When practices were not involved in hiring the care coordinator, it was more challenging for them to integrate the coordinator into their daily operations. It was important for practices to be involved in hiring so they could select individuals with the credentials, demeanor, and communication style that best fit their needs and culture.
- States facilitated the integration of care coordinators into practices by providing supports such as sample job descriptions, training, learning sessions, and peer-networking opportunities for practices and care coordinators.
- States and practices reported that care coordinators contributed to increased patient-centeredness of care; improved population management; provider satisfaction, efficiency, and capacity; and caregiver satisfaction.
- Participation in the CHIPRA quality demonstration helped practices recognize the value added by care coordinators, leading many practices to plan on funding care coordination services after the CHIPRA quality demonstration ends.

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Background

Care coordination, a key element of high-quality care, is broadly defined as the deliberate effort of health care providers to facilitate and organize the appropriate delivery of health care services for a patient.[2,3,4] Care coordination comprises a wide range of functions—including establishing connections between patients and community and social services—and it requires close communication and collaboration among all care team members and across different care settings and providers.[5] Some evidence suggests that practices that coordinate care improve the quality of services and realize cost savings.[6] In addition, a systematic review of the effectiveness of PCMHs reveals that embedding care coordinators (sometimes referred to as care managers) in practices leads to positive health outcomes and reduced expenditures.[7]

Hiring a care coordinator or designating an existing team member as a care coordinator is one of many possible strategies for improving a practice's capacity to coordinate care effectively.[8] A variety of personnel, including nurses and nursing assistants, social workers, patient advocates, and physicians, can coordinate care.[5] Practices can identify the care coordination activities that should be performed and match them to team members based on an individual's expertise and availability.[5]

Care coordinators have traditionally been employed by health insurance plans, State Medicaid agencies, and other organizations to work with patients who are high-cost (such as those with complex chronic conditions or special needs) or are otherwise at risk for poor health. These entities have typically delivered care coordination services by phone.[9]

Care coordination is also a key feature of PCMH models. As part of the CHIPRA quality demonstration, six States supported pediatric practices in improving care coordination as part of the practices' broader goal of PCMH transformation. While these States took different approaches, the practices either embedded or otherwise integrated care coordinators to help manage the care of children with special health care needs (CSHCN)[10] and additional children at risk for poor health because of socioeconomic factors. The experiences of these States and practices may be helpful to other States and practices interested in using care coordinators as part of their strategy for achieving the functions of care coordination and, ultimately, improving health care quality.

This *Highlight* is based on two rounds of interviews: one conducted in the spring and summer of 2012 with State CHIPRA quality demonstration staff and staff in primary care pediatric practices, and a second round conducted in December 2013 with CHIPRA quality demonstration staff only. We also examined the six States' final operational plans and semiannual progress reports.

Findings

States approached the use of care coordinators differently

All six States established similar overarching goals for their CHIPRA quality demonstrations—to improve the quality of care for CSHCN and expand the PCMH capabilities of practices. To achieve these goals, all States requested that practices develop strategies to improve the coordination of care (Table 1). The States differed, however, on whether to require practices to have an embedded care coordinator as part of their overall coordination strategy.

Idaho, Utah, and West Virginia required practices to embed care coordinators into their care teams as a condition for participating in the CHIPRA quality demonstration. These States used CHIPRA quality demonstration funds to partly or fully pay for the care coordinators.

The other three States did not require practices to embed a care coordinator in their care team. Massachusetts deployed care coordinators from the State Department of Public Health's (DPH) Title V Maternal and Child Health Block Grant program to mentor practice staff in building care coordination systems. Alaska and Oregon focused on educating practices about the broad functions of care coordination, allowing the specific strategies for fulfilling these functions to develop organically in each practice and allowing each practice to decide whether a care coordinator would be the most effective way to coordinate care. Using their own funds, all practices in Alaska and Oregon decided to hire care coordinators.

In five of the six States, each care coordinator is embedded in one practice and works either part or fulltime. The exception, Massachusetts, deploys a DPH care coordinator to each practice 1 day per week to mentor the care team. The intent is to develop the practices' capacity for coordinating care in ways that could be sustained when DPH-funded staff are no longer available. Some Massachusetts practices are building systems to support care coordination with existing staff, while others have decided to hire a care coordinator.

Table 1. Features of State Approaches to Supporting Care Coordinators

Program Feature	Alaska	Idaho	Massachusetts	Oregon	Utah	West Virginia
State-level requirement	Each practice is required to provide care coordination functions	Each practice is required to include care coordinator on its care team	Each practice is required to provide care coordination functions	Each practice is required to provide care coordination functions	Each practice is required to include care coordinator on its care team	Each practice is required to include care coordinator on its care team
Care coordinator approach	Delegated to practices; care coordinator part of care team	Designated care coordinator embedded in care team	Capacity building; external care coordinator mentors care team	Delegated to practices; care coordinator part of care team	Designated care coordinator embedded in care team	Designated care coordinator embedded in care team
Funding source	Practices; some practices used CHIPRA quality demonstration funds that the State had given them to implement PCMH	CHIPRA quality demonstration grant	Title V Maternal and Child Health Block Grant program	Practices; some practices used overhead and allocated a portion of existing staff's time to care coordination; some practices leveraged the ACA section 2703 (Health Homes for People with Chronic Illnesses) enhanced Federal match to fund care coordinators (until 9/30/13)	Practices and CHIPRA quality demonstration grant	CHIPRA quality demonstration grant
Hiring responsibility	Practices	State and practices together	Department of Public Health	Practices	First the State, then practices	State and practices together
Employer	Practices	State	Department of Public Health	Practices	First the State, then practices	State contractor
Hours worked	Varies; part to fulltime	Varies; part to fulltime	8 hours per week	Varies; part to fulltime	Varies; 30-40 hours per week	Fulltime

In contrast to Oregon and Alaska, States that took a more directive approach to improving care coordination found that it was important to consider the practices' needs and expectations, and the extent to which they were ready to integrate a care coordinator. For example, West Virginia's original Request for Proposals (RFP) to participate in its PCMH demonstration stated that practices would share a care coordinator hired by a State contractor. When no practices responded to the RFP, West Virginia responded to the practices' reluctance to share staff by deciding to assign one care coordinator to each practice and to involve practices in the hiring decision.

In Massachusetts, some practices could not effectively integrate DPH staff into their culture and work processes. In response, the State permitted practices to access technical assistance with care coordination from DPH on an on-call basis rather than deploying a care coordinator to the practice site on a set schedule.

Practices that played a substantial role in hiring found it easier to integrate a care coordinator

States found that involving practices in the hiring of care coordinators built support for the arrangement and increased the likelihood that the coordinator would be a good fit for, and used effectively by, the practice. In Alaska and Oregon, for example, practices had full responsibility for hiring care coordinators, so they were able to select individuals who could best bridge the gaps in care coordination functions at their respective practices.

Practices that were not involved in hiring found that integrating care coordinators was more of a challenge, regardless of whether the coordinator was employed by the State or the practice. For example, CHIPRA quality demonstration staff in Utah initially hired a pool of care coordinators who were then assigned to work with two practices each. The ensuing dissatisfaction among some Utah practices was related to three key factors: (1) the care coordinator not being available full time to one practice; (2) a poor fit between the care coordinator assigned by the State and the practices' staff, culture, and processes; and (3) the practices' inability to manage the position.

Utah subsequently modified its strategy such that the practices hired care coordinators directly with support from the State in the form of: (1) sample job descriptions; (2) assistance with

recruiting if desired; (3) semimonthly meetings, which provide a forum for ongoing education and networking between care coordinators; and (4) funds provided via contracts to practices. Learning from its partner, Utah, Idaho found success in taking a collaborative approach to hiring by working with practices from the start, even though the State is the employer.

Matching care coordinators to practices' needs and culture is essential

Some characteristics, such as being highly communicative and able to engender trust among providers, were mentioned by multiple States as important qualities for all care coordinators to have. States also reported that matching a care coordinator's skills, demeanor, and communication style with a practice's needs, goals, and culture is essential to successfully integrating a care coordinator into the care team and to ensuring that the team will see the coordinator as an asset. Staff in several States described situations in which a mismatch between the working styles and expectations of a care coordinator and practice staff impeded the coordinator's ability to perform effectively.

Even in States in which practices did not independently hire care coordinators, States structured the hiring process to support practices' needs. For example, Idaho set minimum job requirements for care coordinators, and CHIPRA quality demonstration staff and practice staff interviewed coordinators together. However, practices were permitted to make the final selection. As a result, the two Idaho practices interested in improving behavioral and mental health care selected care coordinators with social work experience. The practice interested in being recognized as a PCMH sought a care coordinator who could help with data collection and analytics and therefore hired a person with a master's degree in public health.

As a result of this deliberate effort to match care coordinators with practices, the coordinators in the six States make up a diverse group of individuals. They are registered nurses, nurse practitioners, licensed social workers, medical assistants, former parent partners,[11] special education teachers, and health care administrators.

Care coordinators perform care coordination and quality improvement activities

Care coordinators in the six States split their time between care coordination activities and quality improvement (QI) activities aimed at transforming practices into PCMHs. The balance between the two varies by State. Care coordinators in West Virginia, for example, spend more of their time, on average, coordinating care for children and families. Care coordinators in Idaho (known as medical home coordinators) spend more time, on average, on PCMH transformation activities.

Care coordination activities. The States noted that practices should determine the types of services provided by care coordinators and how the services are delivered. As a result, a care coordinator's activities vary widely from State to State and from practice to practice. In some practices, a care coordinator's primary activities include facilitating, managing, and tracking referrals. In others, care coordinators administer screening and assessment tools, facilitate meetings of the care team, teach families about self-care, and support them in their self-care efforts. Care coordinators also identify and gather key information from caregivers to support clinicians during upcoming visits and the management of children's care over the long term via previsit calls and/or the development of shared care plans. In addition, care coordinators manage care across providers; coordinate with social and community services; and less commonly, facilitate care transitions to new providers.

> "I affectionately refer to [care coordinators] as 'barrier busters.' Whatever the barrier is for the family, that's what they work on."
>
> — West Virginia Demonstration Staff, May 2012

Although supporting families that have CSHCN is the primary focal point of care coordination, States reported that care coordinators often reach out not only to other children and families identified through patient registries and provider referrals, but also to families that self-identified as needing additional supports such as transportation, housing, or other assistance.

QI activities. Care coordinators play a key role in transforming practices into PCMHs. This role typically involves participating in learning collaboratives on PCMH transformation and helping practices apply the lessons learned, such as redesigning a practice and/or adjusting workflows to better integrate care coordination functions. Care coordinators also serve on practices' QI teams. In this capacity, they oversee data collection and chart reviews, support the creation and maintenance of registries, and implement population-based strategies. Care coordinators in Utah and Idaho also manage the application process for being recognized as a PCMH.

States helped practices understand how care coordinators can be of value

The CHIPRA quality demonstration staff and practice staff agree that care coordinators are most effective under two conditions: (1) when clinicians and administrators value their contributions and (2) when practices understand the role a care coordinator can play in achieving both care coordination functions and practice transformation.

Early on, some States used data to illustrate the value of care coordination and care coordinators to practices. For example, in learning collaboratives, CHIPRA quality demonstration staff in Oregon shared data from both standardized measures of "medical homeness" and family experience surveys that identified CSHCN and the unmet care coordination needs of these children and their families. This information (1) made it easier for practices to understand the key functions and benefits of care coordination, (2) helped practices to appreciate the magnitude of their unmet needs and the ways in which care coordinators could help to address them, and (3) led all practices to hire their own care coordinators. Similarly, Massachusetts supported practice staff in using their data and their experiences in the CHIPRA quality demonstration to establish the benefits of care coordination. Consequently, several practices decided to use their own resources to hire a care coordinator.

States also found that practices whose care team clearly understood the role that care coordinators could play used their coordinators more effectively. To that end, States held learning sessions for practices to help them clarify the care coordinator's role and their expectations of a care coordinator. In these sessions, the States explored the functions and benefits of care coordination and shared materials that described care coordinator competencies. For example, Idaho gave practices a care coordinator checklist to help them identify the aspects of care coordination they wanted their coordinator to focus on.

West Virginia worked with care coordinators to help them build the practices' understanding of their role and their value so that they would be used more fully. When Massachusetts discovered that some practices were unclear on the care coordinator's role, the State encouraged practices and care coordinators to have goal-setting discussions in which they jointly defined and clarified their expectations.

> "Our practice had to see the worth [of a care coordinator] before [we] were willing to [bring one into the practice], but certainly [we] saw the worth as we worked through the CHIPRA project and . . . saw what the intent of care coordination was."
>
> — Oregon Demonstration Staff Member and Provider, December 2013

States provide training and support directly to care coordinators

The States prepared care coordinators for their roles in many ways. They offered learning sessions, connected them with support from other organizations, and provided opportunities for them to learn from each other. For instance, all six States involved care coordinators in learning sessions on care coordination functions; the sessions were held either with other practice staff or for care coordinators exclusively. To help care coordinators grow into their role, Idaho sent them to conferences on mental health, obesity, and use of community resources. Alaska launched a pediatric care coordinator program at a local university and worked with a statewide pediatric partnership to help care coordinators make referrals to subspecialists.

States also regularly host in-person meetings and teleconferences in which care coordinators can check in with each other and with CHIPRA quality demonstration staff on the project's status, discuss how to overcome challenges, and share resources. Some States facilitated contact between care coordinators electronically. West Virginia, for example, established an email distribution list so that care coordinators can easily share information, such as available community services, and reach out to each other for assistance. Utah and Idaho built a Web site for care coordinators, clinicians, and families about caring for CSHCN, including information on a wide range of local providers and community services.[12] Some States gave new care coordinators the opportunity to "shadow" experienced care coordinators.

States and many practices reported that care coordinators improve health care quality

All States are measuring the practices' progress in achieving medical home transformation, including care coordination. States noted that it is difficult to isolate the impact of care coordinators from the impact of other transformation activities practices were implementing. The CHIPRA quality demonstration States and many practices view care coordinators as a

promising source of support, and some practices offered anecdotal evidence that the presence of care coordinators enhances the quality of care. Practices noted the following:

- **Care that is more patient-centered**. Many practices found it easier to stay up to date on their patients, tailor visits more precisely to the needs of children and families, and engage patients in shared decisionmaking because of the previsit phone calls and shared care plans developed by care coordinators.
- **Better population management**. Many providers noted that, after care coordinators were brought into practices, utilization rates were higher for key preventive services such as immunizations, well-child visits, and developmental screenings; they also reported higher rates of completed referrals. Providers attributed these improvements to the care coordinators' tracking of, and following up with, patients.
- **Increased provider efficiency and capacity**. Because of the hands-on services provided by care coordinators to children and families, some clinicians have been able to enlarge their panels overall or increase the percentage of CSHCN they serve.
- **Greater caregiver satisfaction**. Caregivers were more satisfied with the services their families received because they included help from care coordinators with identifying and accessing additional community resources and with managing the multiple providers with whom they interact.

> "Families say they are really appreciative of my efforts and the fact that I offered to do care coordination for them so that they can just be a mom or dad—just relieve a little bit of stress."
>
> — Idaho Medical Home Coordinator, December 2013

Some practices plan to fund care coordinators beyond the demonstration

Practices can find it challenging to fund a care coordinator because practices are usually paid only for face-to-face encounters with patients, not for care coordinators' activities. However, the CHIPRA quality demonstration gave many practices a better understanding of the value added by coordinators, and these practices have found, or are working on finding, ways to sustain care coordination services after the CHIPRA quality demonstration ends in 2015.

Oregon used CHIPRA quality demonstration funds to foster the practices' understanding of care coordination functions, not to support care coordinators directly. Consequently, the practices used their own funds to hire care coordinators and plan to continue to do so after the end of the CHIPRA quality demonstration. Many practices in States that financed care coordinators with CHIPRA quality demonstration funds also indicated that they plan to either keep the coordinators on staff or hire new care coordinators by using their own funds.

In Utah, for example, all participating practices plan to fund care coordinators after the CHIPRA quality demonstration ends. In addition, several practices that did not participate but are affiliated with participating practices are hiring care coordinators because they saw the advantages offered by the coordinators. Some CHIPRA quality demonstration practices in Massachusetts also plan to use their own funds to hire a care coordinator because of the demonstrated benefits of care coordination.

> "What I see happening [since the integration of the care coordinator] is really tag teaming so [that] we actually have a service delivery team that can build relationships with the parents and kids, so they are a resource [for] these folks."
>
> — Alaska Provider, May 2012

States believe that practices unable to continue funding a dedicated position will likely distribute the care coordination responsibilities among other staff. This approach is being taken by some practices in Massachusetts, where DPH care coordinators were intended to help practices determine how best to build a sustainable system for care coordination with existing staff. Other States are exploring external sources of funding such as future grants or payer demonstrations.

Conclusion

While CHIPRA quality demonstration States structured and funded their care coordinator strategies differently, care coordinators across States took on similar coordination and QI functions. Care coordinators have been well received in the States featured in this *Highlight* and in most practices, the general perception being that the coordinators enhanced the quality of care, the patient- and family-centeredness of care, provider efficiency and capacity, and caregiver satisfaction.

To be most effective, strategies for deploying care coordinators need to be tailored to the particular needs, circumstances, and readiness of practices. To support both the integration of care coordinators into care teams and the effective use of their services, States involved practice staff in the hiring process, provided guidance on the functions of care coordination, and helped practices to recognize the value added by care coordinators. States also provided training and support directly to care coordinators.

Financing care coordination services can be challenging. Although most States and practices have not yet settled on a financing strategy, many practices are committed to finding a way to sustain care coordination services after the end of the CHIPRA quality demonstration. The payment and delivery systems unique to each State will affect whether and how States can continue to help practices improve care coordination in general and support care coordinators in particular.

Implications

States interested in supporting the use of care coordinators in primary care practices that serve children and adolescents may want to consider the following lessons learned by the CHIPRA quality demonstration States featured in this *Highlight*:

- Educate health care providers about care coordination and the value that care coordinators can add to a practice.
- Consider the capacity and care coordination needs of practices before requiring a designated care coordinator. Some practices may be able to build effective care coordination systems with existing staff, whereas others may decide that a designated coordinator is the better option.
- Support practices in hiring care coordinators or allow them to play a substantial role in the hiring process to ensure that a coordinator's skills, communication, and work style match the practice's culture and needs.
- Help practices clearly define the care coordinator's role at the outset, including setting realistic expectations for what a care coordinator will do. This role will vary according to a practice's capacity to fulfill the functions of care coordination, the characteristics of the children and families served, and the evolution of the practice's needs. Define CSHCN needs broadly so that a care coordinator focuses on more than just high-utilization patients.
- Provide training and support directly to care coordinators to ensure that they are adequately prepared for, and can grow into, their roles. One way to illustrate the value of care coordinators to practices is to instruct the coordinators in the use of data (e.g., registries, family experience surveys.) Understanding and conveying this value to practice staff can facilitate a practice's commitment to funding care coordination services over the long term.
- Help practices develop a sustainability plan for care coordination. Business models can capitalize on payment incentives for providing patient-centered care. Consider payment methods that are anchored to the goals of care coordination and that provide practices with the flexibility and resources for achieving those goals.

Endnotes

1. We use the term "national evaluation" to distinguish our work from the activities of evaluators who, under contract to many of the demonstration grantees, are assessing the implementation and outcomes of State-level projects. The word "national" should not be interpreted to mean that our findings are representative of the United States as a whole.
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10. Most CHIPRA quality demonstrations use the Maternal and Child Health Bureau's definition of CSHCN: "those who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

11. To learn more about parent partners, see http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/highlight07.pdf.

12. www.medicalhomeportal.org. Accessed February 20, 2014.

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Additional information about the national evaluation and the CHIPRA quality demonstration is available at http://www.ahrq.gov/chipra/demoeval/.

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