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## LCAO CARE COORDINATION PRINCIPLES

Care coordination should be provided to older adults and people with disabilities with complex chronic conditions, disabilities, or dementia. Care coordination can improve the quality of and access to health care for older adults and may reduce costs by helping to prevent unnecessary hospitalizations and nursing home placements. The Leadership Council of Aging Organizations (LCAO), a diverse coalition of 56 national organizations representing millions of Americans, believes that the following set of principles should guide the development and implementation of care coordination programs.

### Definition

Care coordination is a person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in which an individual's needs and goals are assessed and a care plan developed to address those needs and goals. Services are managed and monitored by a trained care coordinator or interdisciplinary team according to established standards of care.

### Care Coordination Goals

- Ensure that older people with complex conditions and people with disabilities attain or retain the highest practicable physical, mental, psychosocial or cognitive functioning.
- Improve communication and coordination among providers, individuals, their caregivers and payers across all settings.
- Integrate acute and post-acute health care services, and long-term care and social support programs, especially during transitions between care settings.
- Increase access to social and support services that allow individuals to receive health care while remaining in the community.
- Avoid the physical, emotional and financial cost of unnecessary emergency room visits, hospitalizations, outpatient procedures, and nursing home use.
- Support family caregivers' ability to care for their loved ones at home or in the individual's setting of choice and includes family caregivers in the care team as appropriate.

### Principles

The following principles should inform public and private care coordination efforts.

- **Person-centered.** Care coordination should always be person-centered to ensure that the individual's choices regarding service type and delivery are respected. The care coordinator should educate the individual about choices and options so that the individual can make informed choices. Services should be made available based on an assessment of an individual's needs, involving the individual or her/his surrogate in decision-making. Care coordination should promote the individual's maximum level of health and independence by maintaining optimal physical, psychosocial and cognitive functioning.
- **Assessment driven.** Care coordination must be based on an assessment, including, as appropriate, the individual's physical, mental, psychosocial, and cognitive functioning, spirituality, medication use, use of adaptive equipment and family caregiver capacity to provide care. The assessment should also indicate potential risks and problems that may arise due to health conditions. An assessment should be culturally appropriate, and be conducted in accordance with the individual's risks, needs, goals and preferences. The assessment also should include input from the individual and family caregivers or significant others, if the individual so desires and needs their assistance to remain independent. The assessment should provide a foundation for determining needs and prioritizing them.

- **Comprehensive written care plan.** The outcome of the assessment process should be a comprehensive written care plan, developed collaboratively with the individual, and risk assessment that addresses all of the individuals' known physical, mental, cognitive, psychosocial and family support needs. A care coordinator, working in collaboration with an interdisciplinary team, can help the individual or family carry out the care plan and navigate the health care system. The care plan should evolve as the individual's goals and needs change and as the care coordinator identifies challenges in accessing targeted services.
- **Care coordinator qualifications.** A care coordinator should be aware of and understand an individual's goals, abilities, culture, and medical and psychosocial needs and be able to manage the medical and psychosocial needs of persons with complex chronic conditions, disabilities, or dementia. Care coordinators should be professionally trained and able to demonstrate a set of core competencies such as assessment, communications, planning, and monitoring. They should have knowledge of major chronic conditions, including their impact on an individual's physical, mental, psychosocial and cognitive functioning and of available medical and psychosocial services and supports.
- **Interdisciplinary teams.** An interdisciplinary care team, centered on the specific problems/risks, needs, and goals of each individual, should be a part of care coordination. The team should include the individual, her or his family caregivers, and appropriate health care providers. These could include: physicians, physician assistants, nurses, social workers, certified professional geriatric care managers, rehabilitation therapists, dietitians, direct-care workers, pharmacists, and others, depending upon the goals and needs of the individual.
- **Workforce.** Care coordination depends on developing, training, employing and retaining a qualified workforce to provide services to those who need them. Older adults and people with disabilities should have access to a qualified workforce, including physicians, physician assistants, nurses, social workers, certified professional geriatric care managers, rehabilitation therapists, dietitians, direct care workers, pharmacists, and others to provide necessary services.
- **Accessible.** Care coordination should be available to individuals with functional, mental, and cognitive impairments who would benefit from the services. Services should not be designed based on assumptions about availability of family caregivers, nor denied because family caregivers are not available. Regardless of type of insurance coverage (public or private), the individual should be able to receive these services in medical offices, the community, her/his own home, or by telemedicine.
- **Payment.** Payments to providers should more accurately reflect the effort involved in providing health care services to individuals who need care coordination and who provides the services. Payments should be risk adjusted to take into consideration the complexity of the individual's condition and care coordination services provided, as well as the amount of time necessary to communicate with the individual and family or decision-maker.
- **Services.** Care coordination should address a full range of health-related and community-based services that support an individual's care plan. Care coordination should address acute, primary and long-term services and supports that work together to assure quality care wherever the individual receives services. When possible, health information technology, such as interoperable electronic health records or telehealth, should be used (with appropriate consumer privacy protections) to help care coordinators to collect data and manage of treatments and services. Continuity of care should be ensured across multiple settings and providers. Care coordinators should incorporate evidence-based practices as appropriate and available.
- **Eligibility.** All individuals who initially meet the eligibility requirements based in part on functional, mental, or cognitive impairments should have access to continued eligibility if the services are necessary to maintain their current capabilities or to prevent further deterioration of their condition. Participation should be voluntary.
- **Evaluation.** The relationship between the individual and his or her family caregivers and the care coordinator should be ongoing. A care plan should be regularly reviewed and revised, as needed, to meet the individual's needs as they change.
- **Consumer Protections.** Care coordination benefits should include legal safeguards such as an individual's appeal rights, the right to an expedited appeal, quality review, and informed consent for the individual and notification to the patient's current health care providers, voluntary and involuntary disenrollment rules, and disclosure requirements. Individual participation should be voluntary and without additional costs, and should not affect access to other services. Individuals must be permitted to opt-out of participation if they are automatically enrolled. There should be no lock-ins and individual privacy must be protected. Protections for individuals with cognitive impairments should be explicitly addressed. Incentives should be permitted to encourage enrollment and participation.

Approved April 8, 2009