



# Population Health Management: Care Coordination

**Care Coordination** is the process of working in a coordinated way with community partners (hospitals, counselors, pharmacies, and others) to support the full range of health needs for high-risk patients. It involves three parts: identifying the patients who are or who may get the sickest; sharing information among involved healthcare stakeholders; and managing the patient's use of care to prevent unnecessary services. The end result is better health.

Health centers are using Care Coordination as one Population Health Management (PHM) strategy to achieve the "Quadruple Aim" — improved patient experiences, improved clinical outcomes, and lowered costs while also improving the work life of health care providers.

**Population Health Management (PHM)** is a *"set of interventions that can improve people's health across the full continuum of care..."* (Felt-Lisk, S. & Higgins, T.)

The 5 Core Concepts of PHM are:

1. Patient-Centered Access
2. Team-Based Care
3. Care Management
- 4. Care Coordination**
5. Quality Improvement/Performance Measurement

Care Coordination uses a long-range, comprehensive approach. It relies on being connected with other service providers used by patients. The health center's ability to manage and control higher risk patients through the full-range of their care needs, leads to better health outcomes. It may include tracking referrals, working with the pharmacy to manage a patient's medication use, and aligning treatment plans when there are several health issues. It is a way to build better care plans, prevent care gaps, and prevent emergency room (ER) visits. It is also a way to help patients gain more self-control over their care.

**When focusing on Care Coordination, start by understanding your patient population and who is at risk. Answer these questions:**

- Based on service use and other factors, can our health center identify patients who are at risk for poor clinical outcomes or high cost? For example: people with many chronic illnesses (at least one is uncontrolled) and high rates of inappropriate ER visits.
- How can our health center track, coordinate, and communicate with patients about their care?
- Can we gather and share information with other providers used by patients?
- Who at our health center is qualified to serve as a Care Coordinator and liaison for patients – intervening between visits to keep patients on track?
- Do we track patient lab tests across organizations?
- Do we follow-up with patients after certain procedures (like biopsies)?
- Are we timely with transition records?

## Key Population Health Management Tools for Care Coordination

The **NCQA Patient Centered Medical Home Standards and Guidelines (2014)** suggest that Care Coordination includes:

- Information on consultants/specialists for referral recommendations
- Formal and informal agreements with specialists, including behavioral healthcare providers, based on established criteria
- The ability to share important demographic and clinical data, including test results and the current care plan with other consultants or specialists
- The capacity for the electronic exchange of key clinical information with other providers and organizations
- Tracking information on referrals, labs and pharmacies; and the collection of reports to ensure that follow-up is established
- Tracking self-care instructions kept in the patient's medical record
- Tracking for self-referrals and a way to collect reports from those clinicians

To offer true Care Coordination services, your health center will have to use the power of your Electronic Health Records (EHRs), Patient Registries, and other IT systems. Your records will be most complete when you can collaborate with other providers, labs, and pharmacies in the community.

Fully utilize your **EHR, Patient Registries** or **PHM software** to learn about high-risk patients and the services they use

- Use predictive analytics to identify patients that *could* be at risk of high cost or poor outcomes
- Use PHM software programs such as i2i Tracks/ PopIQ, Azara DRVS, and Acuere QOL to create patient registries and plan care

Use the **Health Information Exchange (HIE)** to **electronically exchange information** with partner organizations

**Define appropriate care with partners** to create supportive, beneficial relationships

Appoint appropriate staff to **serve in care coordination roles**

- Coordinators will share care plan information with other providers. Use daily, monthly or quarterly face-to-face meetings and share information electronically.

Employ a **LPN/LVN or RN model**

- These can be centralized or localized based on available resources and interventions that will occur

### Measures of Success\*:

1. Percent of patients sticking to their medication plans
2. Percent of patients receiving Care Coordination services that show improved outcomes
3. Percent of patients with electronic exchange of information between providers
4. Decrease in the percent of incomplete orders (labs, medication orders, referrals)

*\*Targets are situational. Please refer to the 2014 PCMH Recognition Standards and Guidelines.*