The Transforming Power of Care Coordination - An Overview of Care Coordination

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Sr. Program Specialist
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Rural Health Innovations’ Purpose

Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation’s leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI connects rural health organizations with innovations that enhance the health of rural communities.

The Centers’ Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation’s leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce
Today’s Purpose

- Understand the key role of care coordination in population health and value payment
- Establish a common language around care coordination
- Identify components of your organizations current efforts in care coordination and discover areas to strengthen
Moving From:

- High cost
- Low quality
- High chronic illness
- Low access

Moving To: The Triple Aim


Alternative Payment Models are Taking Shape

Focus on value is not diminishing...

“There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us.”

Alex M. Azar II, Secretary of HHS, March 5, 2018
(Remarks to the Federation of American Hospitals)

“In order to achieve the expected outcomes and performance required by VBP, primary care must review key components to providing quality care such as delivery, care management, and care coordination across the medical neighborhood.”

Source: American Academy of Family Physicians (AAFP), Value-Based Payment, https://www.aafp.org/about/policies/all/value-based-payment.html
Value Based Transformation

The Health Management Continuum (Stroudwater and Kaiser Family Foundation, 2010)

A Guide

The Care Coordinator: Your Personal Guide
Getting Started

The Transition

Courtesy of Community Care Alliance, CO
Your Organization

The Curve

First Curve
- FFS Reimbursement
- Quality Not Rewarded
- Volume Rewarded
- Fragmented Care
- Acute Care Focus
- Stand-Alone Providers Thrive

Straddle

Second Curve
- Value Payment
- Coordinated Care
- Population Health
- Providers at Risk for Payment
- IT Centric
- Requires Physician Alignment

Revenue Pressure
- Minimal Reward for Quality
- Volume Decreases

TIME

PERFORMANCE

Courtesy of Community Care Alliance, CO

The Bridge

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TIME

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As defined by World Health Organization (WHO), health is a "State of complete physical, mental, and social well being, and not merely the absence of disease or infirmity."

A Persons Health has Many Determinants

Source: Rural Health Value, "Understanding the Social Determinants of Health: A Self-Guided Learning Module for Rural Health Care Teams.", RUPRI, Status Health
Whole Person

Treat me!!

Treat me!!

Treat US!!

What a radical concept!

Social Determinants of Health (SDOH)

SDOH

Neighborhood and Built Environment

Economic Stability

Health and Health Care

Social and Community Context

Education
Tip of the Societal Disparities Iceberg

SDOH in Your Community

• What are the most visible SDOH in your service area?

• What are the SDOH below the water line?
The Case to Address SDOH

Health disparities are America’s chronic condition.
- Jay Bhatt, DO, MPH, MPA, FACP
  Vice President and Chief Medical Officer, American Hospital Association

Why treat people and send them back to the conditions that made them sick in the first place?
- Sir Michael Marmot, MBBS, MPH, PhD
  Chair of the Commission on Social Determinants of Health, World Health Organization

We need to know how to identify and address SDOH to be successful in promoting positive health outcomes for individuals and populations.
- American Academy of Family Physicians.
  Social determinants of health. [Policy Statement], March 5, 2018.
Your Community

- Spend some time individually brainstorming formal organizations, informal organizations, groups of people coming together around an issue or individual(s) in your community?
- Star the 5 that are most likely to make the biggest impact on the health of your community.
- Share these with others from your organization.
- Develop a short list (6-8) of organizations you should probably engage in the near future.

Providers and Community Organizations
What Is Health?

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."


Community Health Worker (CHW)

Addressing the SDOH

Primary Prevention

Safety net programs & secondary prevention

Medical care & tertiary prevention
Financial Effects

Annual Wellness Visit Revenue

R² = 0.9504

Chronic Care Management Revenue

R² = 0.9957

Care Coordination is the Key

Care Coordination
Care Coordination at the Heart

Care Coordination

- Community-based and integrated primary care, behavioral health, oral health, local health and community resources to provide person-centered, coordinated services.¹
- An opportunity to supplement the diagnosis and treatment priorities of medicine with clinical and non-clinical prevention and management in a system that also supports the social aspects of patients’ lives that contribute to health.²

Source: 1-Rural Health Innovations (RHI), National Rural Health Resource Center, Duluth, MN.
2-Rural Policy Research Institute (RUPRI) – Care Coordination in Rural Communities: Supporting the High Performance Rural Health System, June 2015, p. 2)
Care Coordination

Empowers Bridges Whole Person

My Journey
Care Coordination Study

Care Coordination Canvas Guide

Developing and Improving Care Coordination Efforts
May 2018

Keys of Care Coordination

- Target Population
- Assessments
- Care Team
- Care Plan
The Care Coordination Canvas

<table>
<thead>
<tr>
<th>CASE COORDINATION CANVAS TEMPLATE</th>
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<td>1. What is your Target Population?</td>
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<td>1b. How will the target population be identified?</td>
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**Common Language**

Target Population

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**Social Determinants of Health (SDOH):**
Assessment Tools

2. Assessment Tool(s): A tool or survey used by the Care Coordinator to assess a person's level of need:
- Social, environmental, mental health, physical and psychological functional needs
- Risk or severity level of a diagnosis and/or disease

2a. Is one needed?
- Commonly, this target population is generally defined. An assessment can help determine the level of coordination needed or what types of services are needed.

2b. What is the type or how will it be used?
- The type used will be determined by your target population and desired outcomes.

2c. How will results be communicated?
- Where will it be stored? Do the results need to be shared with the Care Team? Do they help identify members of the Care Team? Can the results be used for evaluation and measurement?

2d. How will technology be used to perform these functions?
- The assessment tool can be electronic, web-based, and saved in times. It can be communicated via secure messaging or portals.

Care Plan

3. Care Plan: An individualized Care Plan is developed with the person/caregiver and provider to identify the person's strengths in meeting their identified needs; then create an approach to meeting needs.

3a. What is the target population?
- What is the primary or secondary diagnosis?

3b. What is included (components of)?
- Goal or outcome
- Clinical and social needs
- Instructions and interventions
- Interdisciplinary care team members, including contact information
- Person demographics

3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?
- How will the Care Plan be updated as well as be shared?
### Care Team

**CARE COORDINATION CANVAS TEMPLATE**

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### Integrated Components

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**Notes:**

- Care Team: Provider identified with the person and/or caregiver that represents the clinical, behavioral & oral health, social services, long-term care and community resources needed to help meet the person’s goals and outcomes.
- Integrated Components: Component of the population & what the focused outcomes are, such as community health worker, social worker, nurse, physician assistant, certified medical assistant, physician, community paramedic.
### Other Considerations

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2. What is the focus of your care plan?  
3. What approach is being taken?  
4. How will you use technology to perform these functions?  
5. Leadership and stakeholder engagement?  
6. Social determinants of health (SDOH)?

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**Notes:**

- Other Considerations
- Care Coordination Canvas
- **Rural Health Innovations**

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After Break:
- Go in depth into each component
- Sit with other members of your organization
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http://www.ruralcenter.org