COPE HEALTH SOLUTIONS

COPE Monthly Digest

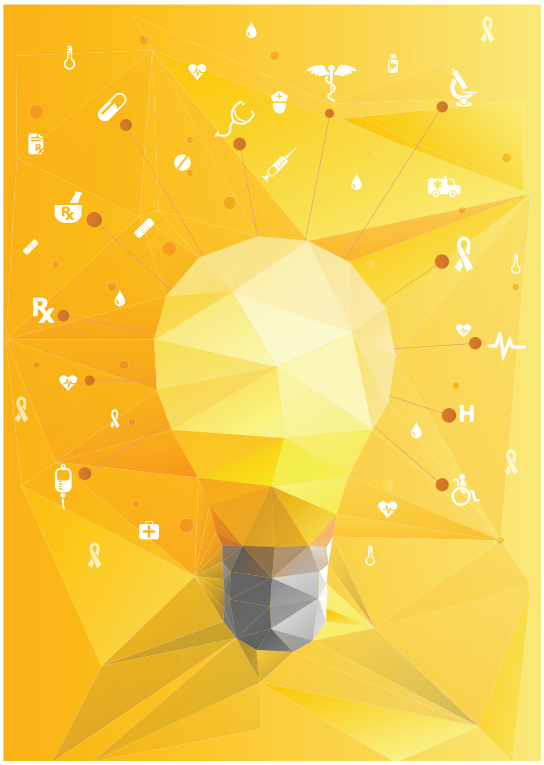
Monthly tips to achieve visionary, market relevant health care solutions

Health Care Talent Innovations

8 Strategies to Build a Care Coordination Model that Works



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For most patients in the U.S. health care system, navigating the maze of uncoordinated, fragmented medical care and social services has become a norm. The diverse array of providers and institutions have left patients as the main conduit of information between clinicians they see. As health systems strategize on how to respond to market demands of the post-ACA environment, care coordination is not only key to demystifying a complex health system for patients, but also a way for providers to achieve the most touted principles of the Triple Aim: improving population health, reducing overall costs and improving patient satisfactions.

Health systems that are designing and developing care coordination program should consider the following:

1) **Define the care coordination model:** Care coordination is a fluid term with different meanings for different provider types and organizations. Having a strong population health management strategy at a system-level, complimented by a care coordination model tailored to individual organizations, provides for appropriate care across settings. Successful care coordination models have defined core principles that can be shared and understood at all levels across a health system.

2) **Develop a model that is focused on consumer friendly, patient-centered care:** Consumer friendly, patient-centered care encompasses medical and non-medical needs of the individual. Providers are armed with the resources they need in order to work directly with the patient and their caregiver to develop a plan that meets their medical and social needs. The personalized approach allows providers to flag patient problems regarding their care to intervene earlier and prevent problems from getting worse, thus keeping the patient healthier and reducing overall cost.

3) **Provide continuity of medical and non-medical services:** Care that is truly coordinated addresses the entire individual, which includes medical needs as well as non-medical services such as assistance with food and housing. Such a model draws on multiple aspects of a system of care (health plans, nursing homes, hospitals, social services agencies, etc.) that directly impact a patient's health.

4) **Implement tools for delivering care:** Effective care coordination requires health systems to implement appropriate clinical and organizational supports that enable providers to work across health care settings. Communication of timely and accurate information between providers, patients and caregivers is critical to provide high quality, patient-centered care. The use of standardized electronic health records (EHRs) to track patient care, identify care opportunities, and communicate with other provider types is a requirement for effective care coordination across settings. Furthermore, patients having access to their own medical record enables enhanced patient engagement and compliance.

5) **Focus on improving transitions of care:** With health systems increasingly at risk for readmission rates, improving transitions of care has become a focal point in care coordination models. Through the use of EHRs and health information exchange across various settings, providers have the opportunity to enhance communications during transitions of care. Health systems should also work on aligning financial incentives and establishing accountability particularly among hospitals, SNFs, primary care and specialty physicians.

6) **Conduct health assessments to understand more about your patient population:** Conducting periodic health assessments of your patients provides an opportunity for primary care providers to get a snapshot on the health status and risks of empaneled patients. Obtaining a health assessment not only provides an opportunity for providers to understand medical and non-medical needs of their patients, it also allows providers to take advantage of available incentives from payers or accrediting agencies.

7) **Develop and refine stratification methodologies in order to provide tailored case management to those most at-risk:** As value-based care delivery and risk-based contracting become increasingly common, risk stratification is now more important than ever. In order to change cost structures and improve outcomes, interventions must be designed to target high-risk, high-cost patients. All interventions, no matter how effective, are predicated on accurately identifying and stratifying those patients.

8) **Provide team-based care through the use of interdisciplinary care team:** Interdisciplinary care teams (ICTs) address the full range of patient needs, integrating healthcare and non-medical services. A basic care team includes a member, PCP and PCP support staff. Patients with higher acuity may have a larger ICT that also includes a health plan representative, mental health or substance abuse providers and other social services or community-based organizations. Through the use of an ICT, different types of staff work together and share expertise, knowledge and skill to solve complex problems that cannot be solved by one discipline alone.

COPE Health Solutions partners with health care organizations to develop customized programs and solutions that address the ever-changing demands of health care systems. In a post-ACA environment, health systems and their respective communities are tasked with providing quality, patient-centered care to diverse populations with even more diverse needs. As health systems increasingly participate in value- and risk-based contracting, and become more at-risk for meeting specific quality standards, turn-key solutions that encompass strategic planning considerations, workforce gaps, and local market trends is imperative in meeting the health care demands of today. Integrating these eight key considerations with a thoughtfully customized population health management strategy provides the foundational success for providing high quality care to local communities while achieving goals of *Triple Aim.*

For more information about Care Coordination or Health Care Talent Development services, please contact carecoordination@copehealthsolutions.org.