NATIONAL
RURAL HEALTH
RESOURCE CENTER

Health Information Technology & Care Coordination

Alyssa Meller

Chief Operating Officer

June 21, 2022

Statement

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,560,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

The Center's 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

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued.

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

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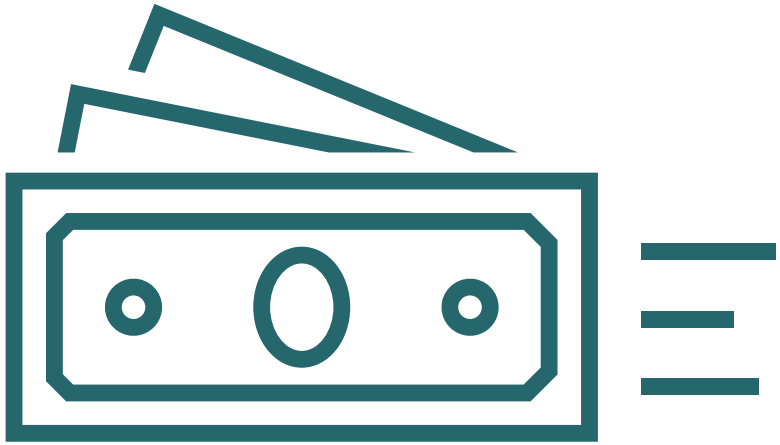
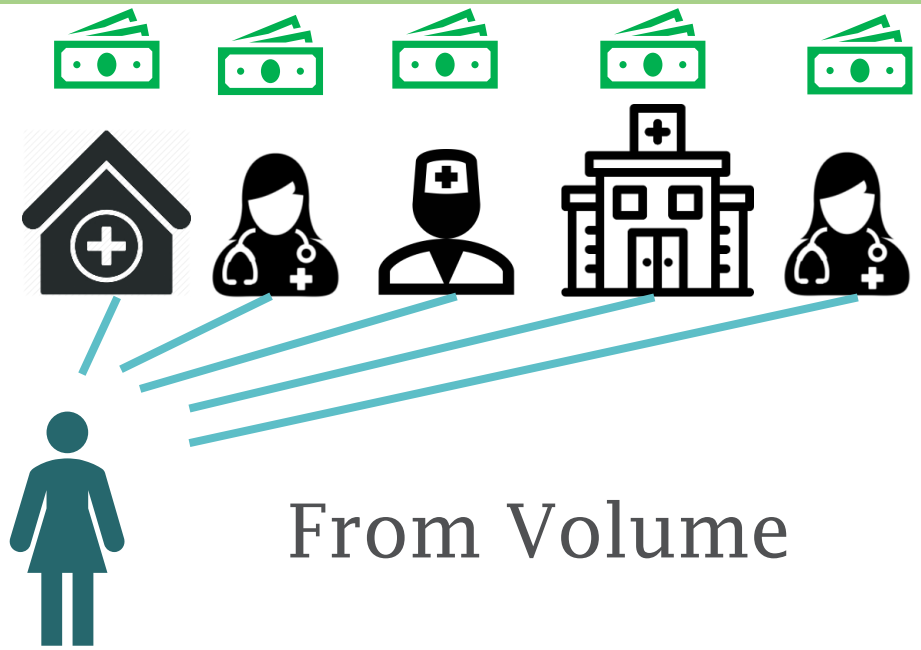
Value Based Payments

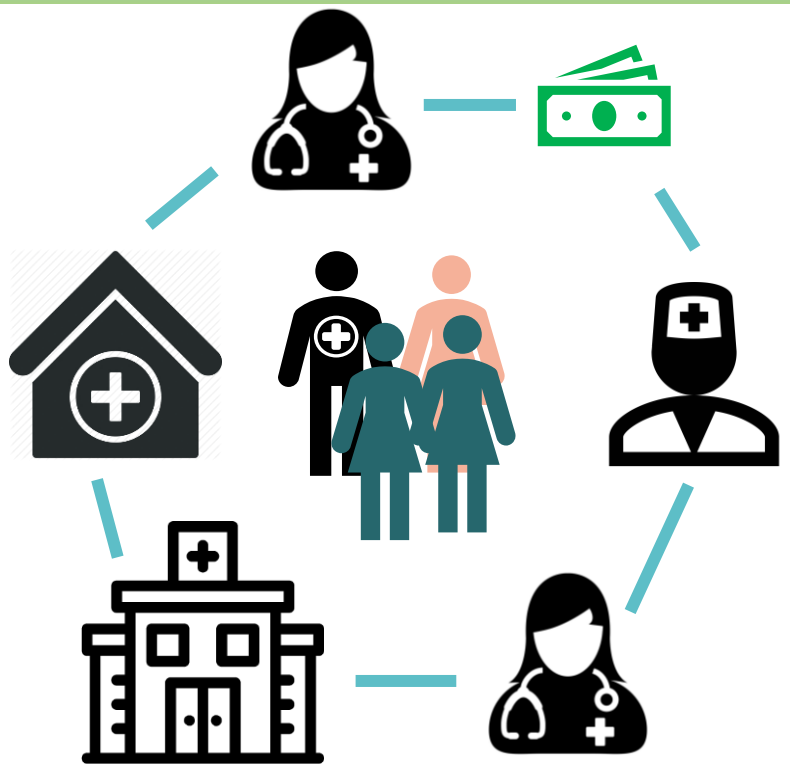
"In order to achieve the expected outcomes and performance required by VBP, primary care must review key components to providing quality care such as delivery, ***care management, and care coordination*** across the medical neighborhood."



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



From Volume



To Value

Volume		Value
Fee-for-Service	**PAYMENT**	Bundled, Shared Savings, Capitated
Patient	**FOCUS**	Population
Treat	**INCENTIVE**	Prevent

Source: Rock Health

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Value – Based Models

1. Fee-for-service – no link to quality and value
2. Fee-for service – link to quality and value
3. Advanced payment models – built on fee-for-service
4. Population-based payment

Catalog of Value-Based initiatives for Rural Providers – Rural Health Value

Care Coordination is the Heart

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Care Coordination

Empowers Bridges Whole Person

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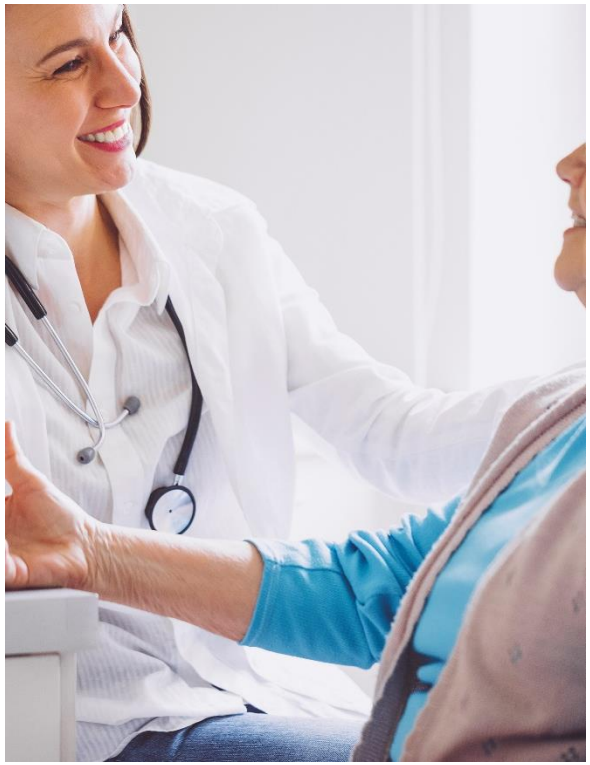
Definitions



Care Coordination

"Community-based and integrated primary care, behavioral health, oral health, local health and community resources to provide **person-centered**, coordinated **services**."

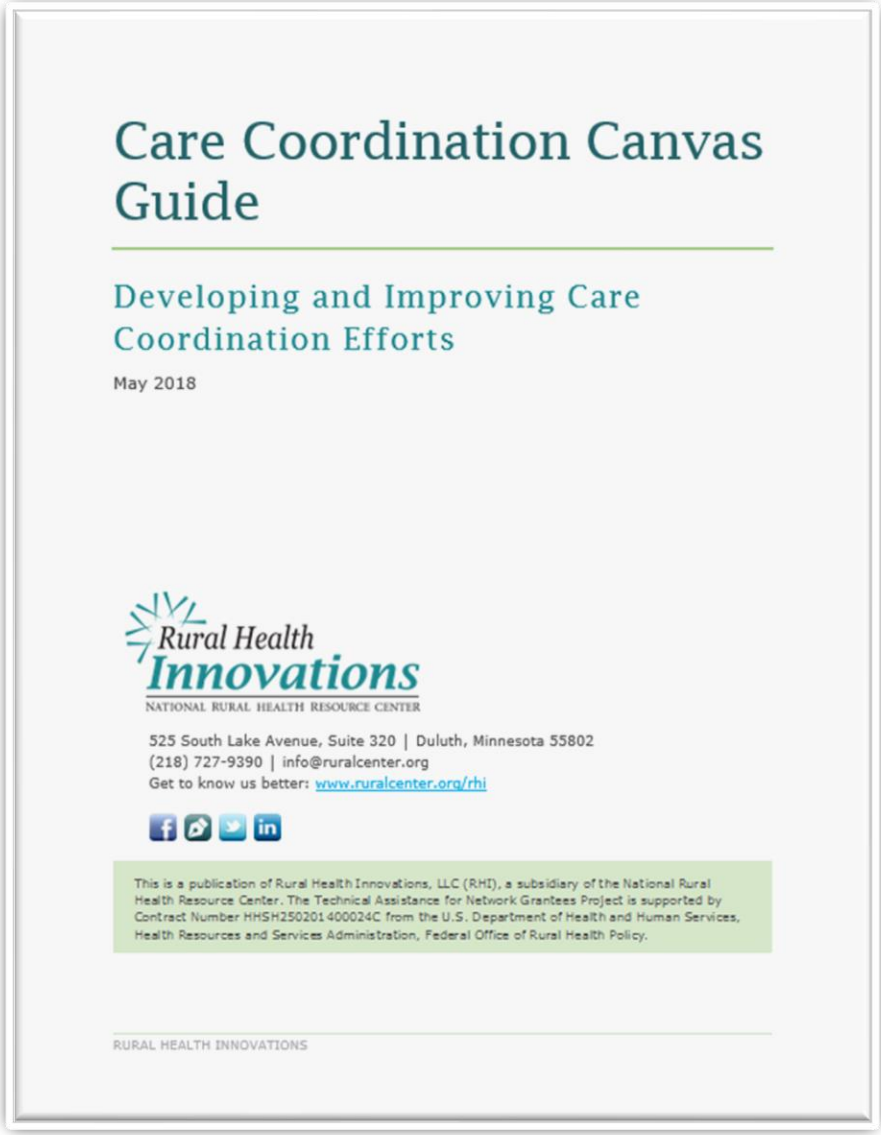
"An opportunity to supplement the diagnosis and treatment priorities of medicine with **clinical and non-clinical** prevention and management in a system that also supports the **social aspects** of patients' lives that contribute to health."

"Provide information to clinicians to share and provide next care steps in diagnosis and treatment. It assures the patient is in an appropriate care setting as they transition across settings."

Community Care Coordination

"A **collaboration** among health care professionals, clinics, hospitals, specialists, pharmacies, mental health, community-services, and other resources working together to provide person-centered coordinated care."

Care Coordination Study



Care Coordination Canvas Guide

Developing and Improving Care Coordination Efforts

May 2018

Rural Health Innovations
NATIONAL RURAL HEALTH RESOURCE CENTER

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Get to know us better: www.ruralcenter.org/rhi

This is a publication of Rural Health Innovations, LLC (RHI), a subsidiary of the National Rural Health Resource Center. The Technical Assistance for Network Grantees Project is supported by Contract Number HHSH250201400024C from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy.

RURAL HEALTH INNOVATIONS

[Care Coordination Canvas Materials]

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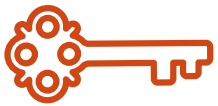
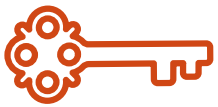
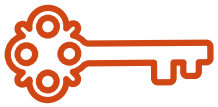
Keys of Care Coordination

 Target Population

 Assessments

 Care Team

 Care Plan

The Care Coordination Canvas

CARE COORDINATION CANVAS TEMPLATE			
1. What is your Target Population?		2. What Assessment Tool(s) is your organization using?	
1a. Is it specific enough? Further refine if needed.	1b. How will the target population be identified?	2a. Is one needed?	2b. What is the type or how will it be used?
1c. How will you communicate with and engage the population?		2c. How will you communicate the results to who needs it? Store it?	
1d. How will technology be used to perform these functions?		2d. How will technology be used to perform these functions?	
Collaboration:			
3. What is the focus of your Care Plan?		4. Who is a part of your Interdisciplinary Care Team?	
3a. What approach to developing the Care Plan is being taken?	3b. What is included (components of)?	4a. Who is the coordinator?	4b. How will you build collaboration with the provider or partners of the Care Team?
3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?		4c. How will the Care Team communicate with the chosen population, coordinator and amongst themselves?	
3d. How will technology be used to perform these functions?		4d. How will technology be used to perform these functions?	
5. Leadership next steps?		6. What is your Business Model?	
Social Determinants of Health (SDOH):			

Common Language

Care Coordination Canvas

CARE COORDINATION CANVAS TEMPLATE			
1. What is your Target Population? **Q1: Target Population**		2. What Assessment Tool(s) is your organization using? **Q2: Assessment**	
1a. Is it specific enough? Further refine if needed.	1b. How will the target population be identified?	2a. Is one needed?	2b. What is the type or how will it be used?
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1d. How will technology be used to perform these functions?		2d. How will technology be used to perform these functions?	
Collaboration:			
3. What is the focus of your Care Plan? **Q3: Care Plan**		4. Who is a part of your Interdisciplinary Care Team? **Q4: Care Team**	
3a. What approach to developing the Care Plan is being taken?	3b. What is included (components of)?	4a. Who is the coordinator?	4b. How will you build collaboration with the provider or partners of the Care Team?
3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?		4c. How will the Care Team communicate with the chosen population, coordinator and amongst themselves?	
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Social Determinants of Health (SDOH):			

Integrated Components

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5. Leadership next steps?		6. What is your Business Model?	
Social Determinants of Health (SDOH):			

How will you communicate with…
How will technology be used…

Other Considerations

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5. Leadership next steps?		6. What is your Business Model?	
Social Determinants of Health (SDOH):			

Collaboration…
Social Determinants of Health…

The Care Coordination Canvas (again)

CARE COORDINATION CANVAS TEMPLATE			
1. What is your Target Population?		2. What Assessment Tool(s) is your organization using?	
1a. Is it specific enough? Further refine if needed.	1b. How will the target population be identified?	2a. Is one needed?	2b. What is the type or how will it be used?
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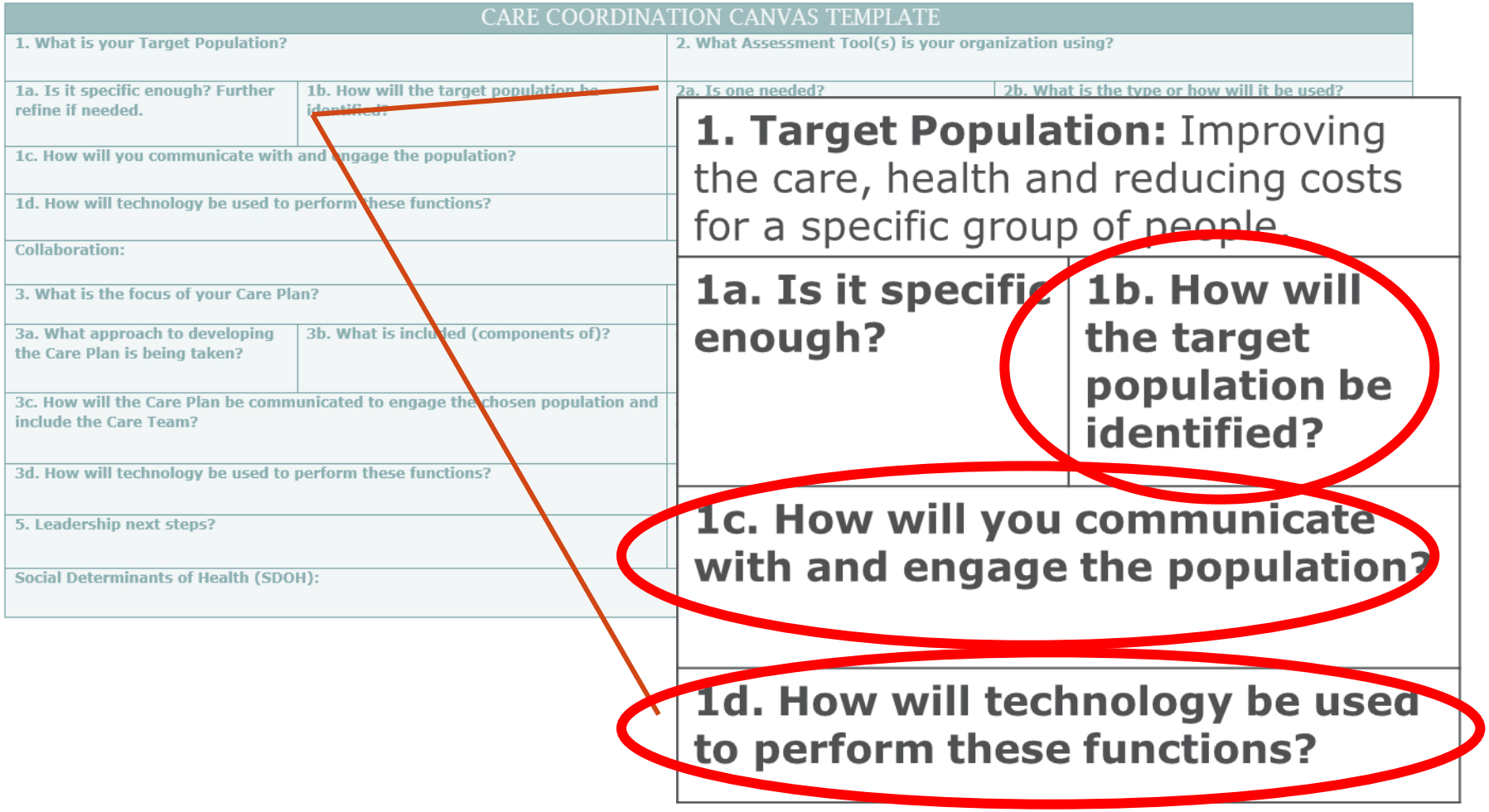
Target Population



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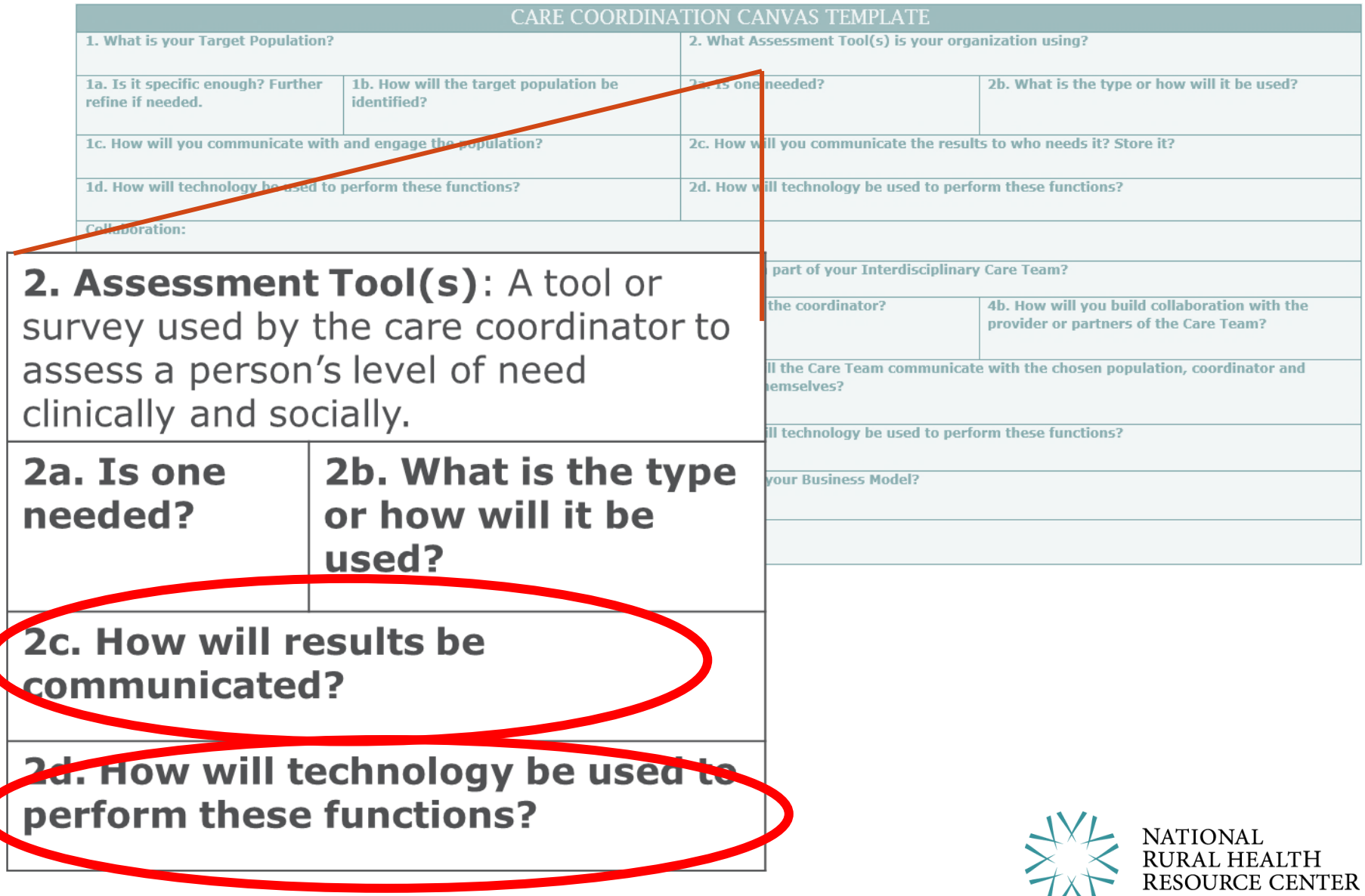
Assessment Tools



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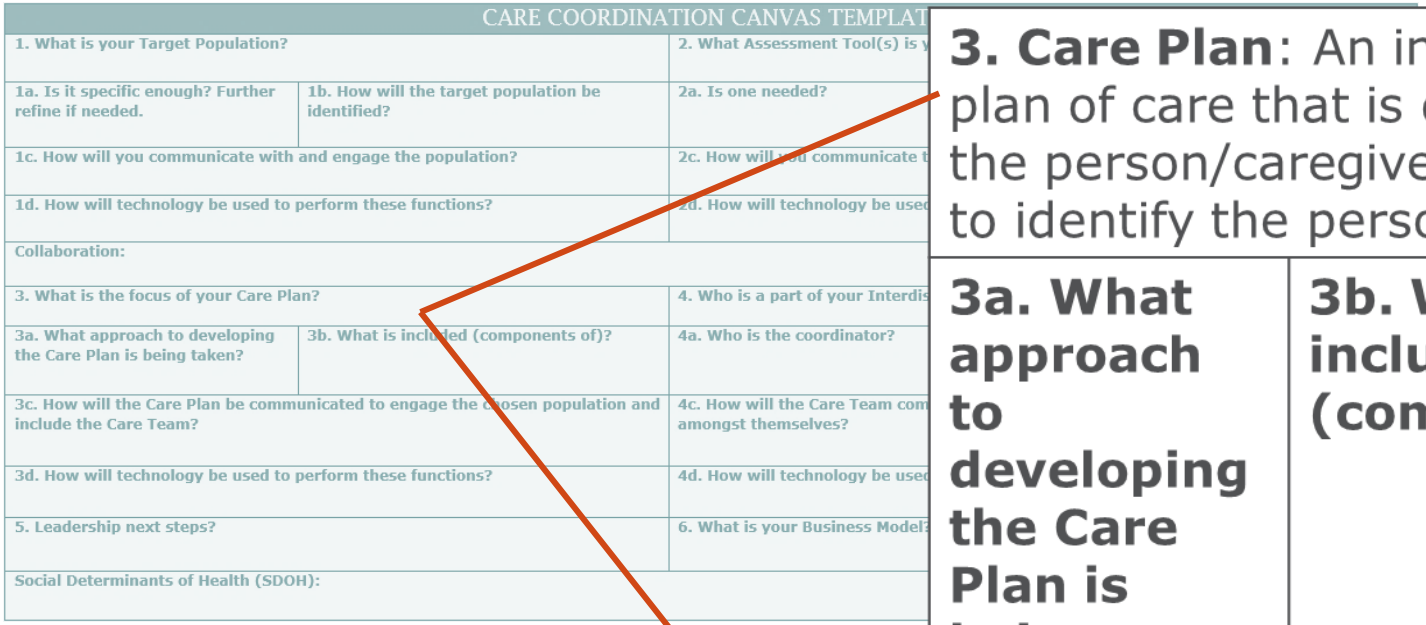
Care Plan



3. Care Plan: An individualized plan of care that is developed with the person/caregiver and providers to identify the person's needs.

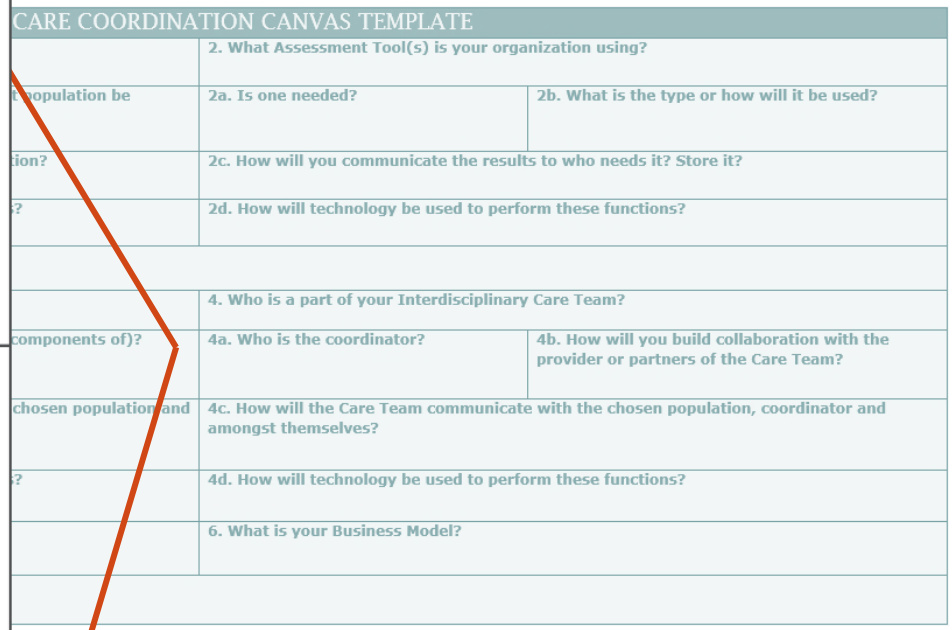
3a. What approach to developing the Care Plan is being taken?	**3b. What is included (components of)?**
3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?	
3d. How will technology be used to perform these functions?	

TER

Care Team

4. Care Team: Providers identified with the person and/or caregiver that represents the clinical, behavioral health, social services, long-term care and community resources needed to help meet the person's goals and outcomes.

4a. Who is the coordinator?	**4b. How will you build collaboration with the provider or partners of the Care Team?**
4c. How will the Care Team communicate with the chosen population, coordinator, and amongst themselves?	
4d. How will technology be used to perform these functions?	



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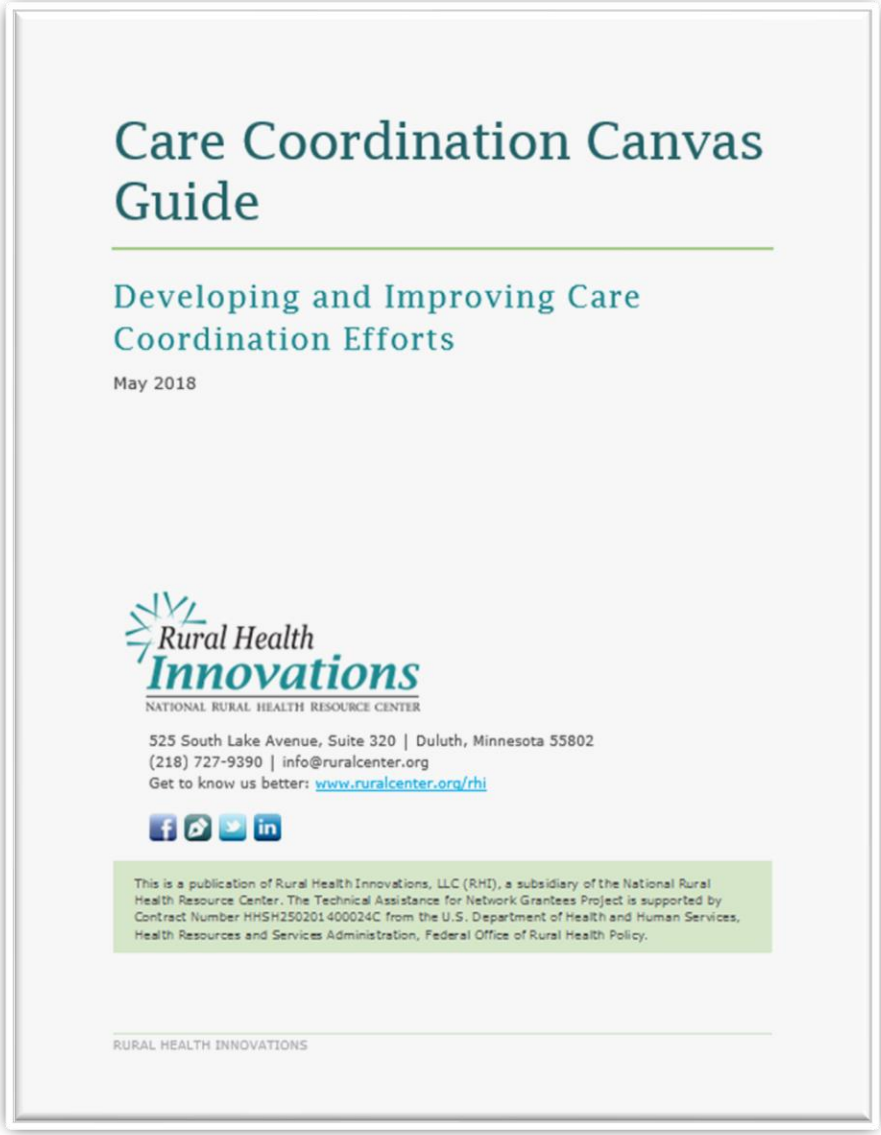
Care Coordination Study (again)



Care Coordination Canvas Guide

Developing and Improving Care Coordination Efforts

May 2018

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RURAL HEALTH INNOVATIONS

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Website

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Care Coordination Canvas Guide

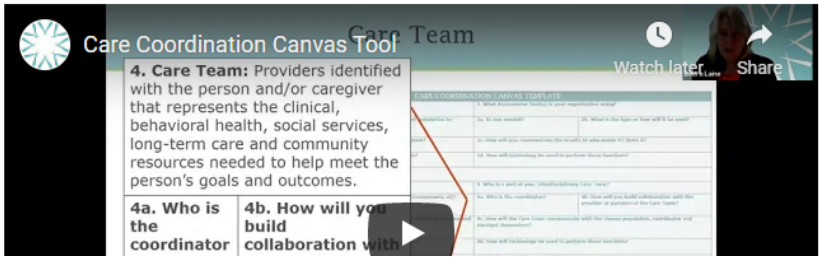
Downloads & Links

- Care Coordination Canvas Guide (PDF Document - 28 pages)
- Care Coordination: An Essential Tool for Value (PDF Document - 3 pages)
- Case Studies From the 2017 Care Coordination Comparative Study (PDF Document - 39 pages)
- Care Coordination Canvas Worksheet (Word - 6 pages)
- Potential Partners Worksheet (Word - 2 pages)
- Care Coordination Canvas Tool (PDF Document - 2 pages)

Author: Rural Health Innovations (RHI)

Care Coordination is at the core of being successful in today's health care environment. As reimbursement for health services shift pay from procedures to value, care coordination is a key component. The Center and RHI have developed a framework to help organizations develop an effective care coordination program.

The purpose of the Care Coordination Canvas Guide is to assist organizations to develop a formal care coordination program. This tool can also be used to evaluate your current care coordination efforts. This tool and guide are based on a survey conducted by The Center and RHI that identified the common characteristics and benefits of care coordination, along with the unique attributes, obstacles encountered, and lessons learned.



Related Collections

The following collections feature this content:

COLLECTION

Community Care Coordination and Chronic Care Management

Tools to develop an integrated care delivery system and resources on care coordination models.

COLLECTION

Care Management and Coordination

Effective care management is key in achieving the aims of health care transformation and the journey down the road to value-based care. This collection of resources focuses on developing and improving the management of care within organizations, networks or communities.

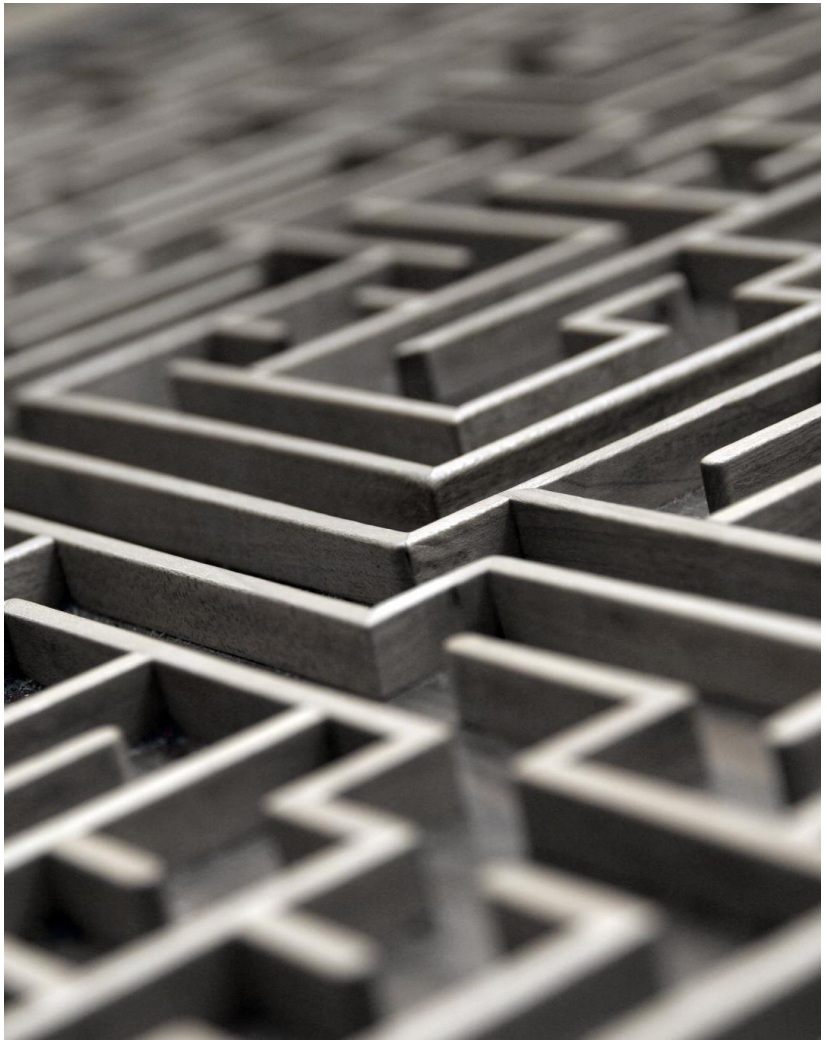
COLLECTION

Continuous Improvement

This collection includes resources related to health information technology and care coordination models that are pertinent to networks, members and partners as part of day-to-day operations.

Challenges

- Dedicated Staffing
- Time
- Reimbursement
- Systems/workflows



Care Coordination is the Key

Value Based Payments

Population Health

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