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RESOURCE CENTER

Care Coordination and its Role in Transforming Local Health Care

Part One

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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:

- Performance Improvement
- Health Information Technology
- Recruitment & Retention
- Community Health Assessments
- Networking

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Webinar Objectives

- Learn the fundamentals of care coordination with community partners
- Discover considerations for health care IT
- Address concerns in privacy and security when working with multiple entities
- Examine your organization's role in engaging local providers and community organizations in care coordination

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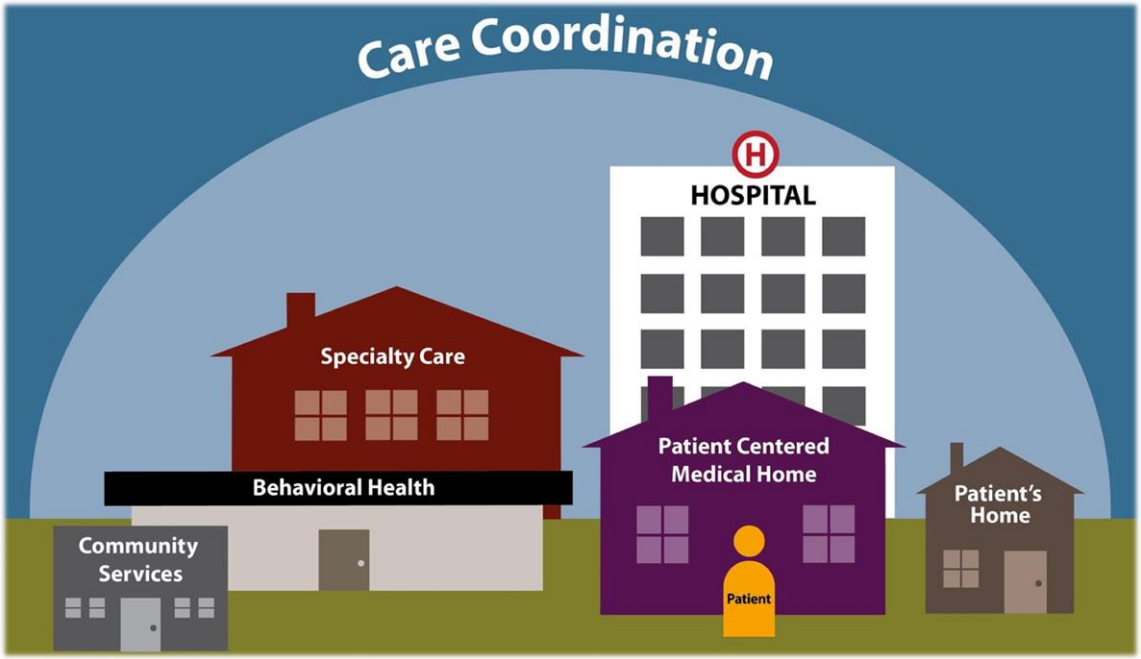
Care Coordination: Part One

- Care Coordination and the Triple Aim
- Components of Care Coordination
- Target Population
- Assessment



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Current Health Care Business Model

Based on volume; the more you do, the more money you make

Population Health Has Many Partners

Predictors of Health Status*

- 10% Clinical Care
- 10% Genes and Biology
- 40% Social and Economic
- 30% Behavioral
- 10% Environmental

The ah-ha: Health care providers can't change the U.S. health outcomes alone.

*Determinants of Health Model based on frameworks developed by: Tarlov AR. Ann N Y Acad Sci 1999; 896:281-93; and Kindig D, Asada Y, Booske B. JAMA 2008; 299(17): 2081-2083.

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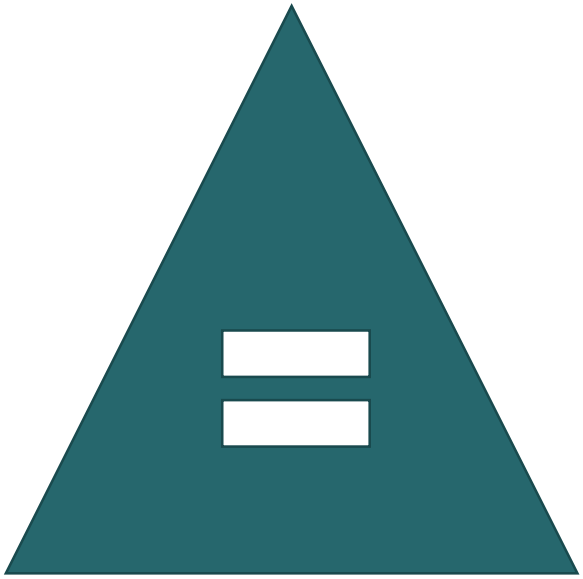
It's Changing: Value-Based Model

Better Quality + Better Health + Lower Cost



Triple Aim for Value

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Participate in Value Based Models

- Partner with local providers and community organizations
- Coordinate care across the continuum
- Improve and document quality
- Improve and document efficiencies

Poll Time!

Please take the polls

on your screen.

Care Coordination is…

Community-based. Integrates primary care, behavioral health, local health and community resources to provide person-centered, coordinated services.

Source: Rural Health Innovations (RHI), National Rural Health Resource Center

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Care Coordination is…

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.

Source: Rural Policy Research Institute (RUPRI) – Care Coordination in Rural Communities: Supporting the High Performance Rural Health System, June 2015, p. 2)

Care Coordination is…

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.

Source: Certification Commission of Health Information Technology (CHHIT) - A Health IT Framework for Accountable Care, June 6, 2013.

The Four Components

- **Target Population**
  - Improving the care, health and reducing costs for a specific group of people
- **Assessment**
  - A tool or survey used by the care coordinator to assess a person's level of need for services and coordination

The Four Components

- **Care Plan**
  - An individualized plan of care that is developed with the person/caregiver and providers, to identify the person's needs
- **Care Team**
  - A team of interdisciplinary 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 goals and outcomes of the person

Technology

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Target Population

- Who is your care coordination targeting?
- Is this group focused enough? Or is this group too large?
- How will individuals in the target population be identified?
- How will those individuals be communicated to?
- How will technology be used to identify the target population?

Target Population

Network Care Coordi	
1. Target Population Children and families that are having a hard time accessing Mental Health, Health care	**2**
1a. Is it specific enough? Further refine if needed? No, need to narrow it down more	**1b. How will the target population be identified?** • Developed a specific referral mechanism • Try to clarify the needs • Some telephone calls
1c. How will communication occur with the person? Telephone and in person	
1d. **How will technology be used to perform these functions?**	
3. Care Plan	

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Assessment

- Is an assessment tool (s) needed?
- What assessment tool(s) is going to be used?
- How will the results be used?
- How will be the results be communicated to the care team?
- How will the information be stored?
- How will technology be used to perform these functions?

Assessment Examples

ordination Worksheet

2. Assessment tool(s)

- Ages and stages questionnaire
- Pediatric Symptom Checklist
- The child depression inventory
- PHQ-9 and GAD-7 for adult screening or adult teenagers

2a. Is one needed?	**2b. What is the type or how will it be used?**
Yes	Used to develop the care plan

2c. How will results be communicated? Store it?
The care coordinator is usually the one doing the screening.

2d. How will technology be used to perform these functions?
All the screening are done with pen and paper. Hopefully in the future it will be done electronically

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Part Two Preview (Tomorrow)

- Care Coordination Components
  - Care Plan
  - Care Team
- Engaging your Community
- Privacy and security issues
- HIT Discussion

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