Care Coordination

What is care coordination?

Care coordination is at the heart of patient- and family-centered care. It is driven by data, accomplished by a team, and designed to meet the needs of patients, their families and caregivers. Care coordination is holistic. It addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness for patients.

Care coordination activities include:

- Helping patients choose specialists and obtain medical tests when necessary. The care coordination team, led by the practice care coordinator, should share information with specialists and help arrange any special accommodations patients might need.
- Tracking referrals and test results, sharing results with patients, and ensuring they receive appropriate follow-up care and understand treatment recommendations.
- Identification and referral of patients to appropriate programs and community resources.
- Assisting patients and families as the patient transitions from one care setting to another; such as, from hospital to home.
- Developing systems to help prevent errors when multiple clinicians, hospitals, or other providers are caring for the same patient including medication reconciliation and shared medical records.

Who is the practice care coordinator?

Our program supports a team based approach to patient-centered care. Practices participating in Enhanced Personal Health Care should designate a staff member who will hold primary responsibility for coordination and care management in their offices. This person could be any member of the practice staff including a medical assistant, social worker, or nurse. Ideally this person should have some experience in care planning; usually, though not always, those with a clinical background are best suited taking on this role.

What is a care plan?

A care plan is a detailed approach to care that is customized to an individual patient's needs. Care plans are useful when a patient can benefit from personalized physician instruction and feedback to help manage a health condition or multiple conditions.

Care plans include, but are not limited to, the following:

- Prioritized goals for a patient's health status.
- Established time frames for reevaluation.
- Resources that might benefit the patient including a recommendation as to the appropriate level of care.
- Planning for continuity of care including assistance making the transition from one care setting to another.
- Collaborative approaches to health including family participation.

To learn more about care plans, see the Enhanced Personal Health Care (EPHC) Program Description, the Provider Toolkit, and the Care Plan Playbook which can be found on your EPHC webpage. Or, contact your Care Consultant for more details.

Anthem®

Updated 08/01/19