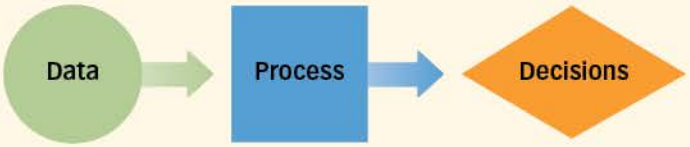
WORKFLOW 101:

Care Management
Care Coordination



Organization Name _____ Date _____

Why are Care Management and Care Coordination important in health care?

- Provides a holistic approach at evaluating a targeted patient population to identify, evaluate and implement strategies that will improve patient health status and reduce the need for expensive medical services.
- Effective care management programs will use both qualitative (physician or patient reported information) and quantitative (claims, electronic data) resources to identify high need, high cost patients.
- These patients may include those nearing the end of life, patients with multiple chronic illnesses, and patients with behavioral health issues or complex social needs.

Who in the practice or organization is tasked with Care Management and Care Coordination?

- It must be a multi-disciplinary team in place, appropriately licensed and utilizing shared responsibilities to impact the patient's health.
- It takes the entire health care team to address the needs of their population.
- A care coordinator will need to be identified to focus on the needs of the high-risk population.
  - The care coordinator can be a nurse, social worker, medical assistant, etc.
  - The care coordinator will assist front office staff to perform all pre-planning visit duties,
  - Place care alerts/ gaps-in-care in the patient's chart for the doctor to review at the time of the appointment.
  - Outreach to all discharged members, review discharge orders, schedule follow-up visit with PCP as needed, etc.
  - Outreach to members that have had ER visits to redirect, assess needs and make follow-up appointments.
- Front office staff, such as intake/checkout clerks or appointment team, can assist the care coordinator with:
  - Pre-planning visits preparation.
  - Outreach to schedule appointment for labs for patients with chronic conditions.
  - Outreach for follow-up appointments after ER or inpatient admission.

Who will the practice be targeting for coordinated care?

- Complex Care Patients
- High-risk patients due to (related to) chronic conditions
- Patients at risk for readmission
- Non Adherent/Non-Compliant Patients
- Patient with socio economic issues
  - Limited access to care
  - Unable to afford medication
  - No care givers or family to help

What tasks need to be assigned have an effective Care Management Program?

- Multi-disciplinary team in place and appropriately licensed
- Policies and procedures in place outlining expectations for Care Coordination and the Care Coordinators:
  - Pre Visit Planning
  - Outreach and follow-up for patients after discharge from ER, inpatient admits or outpatient procedures
  - Completing Referrals
  - Develop a protocol for referral tracking
- Create patient checklist for ER/Inpatient follow-up appointment (see Transition of Care Workflow).
  - Call patient for follow-up appointment
  - Instruct patient to bring in discharge instructions
  - Medication reconciliation
  - Risk factors to address
  - Education/plan to avoid future ER
- Identification of Targeted Population
- Risk Stratify Targeted Population
- Consistent approach for targeting high-risk patients and closing gaps-in-care, follows care management process for implementing patient activation and care plans
- View available Anthem Reports in Availity, MMH+, P360
  - For ER users, Hospital Admissions, Care Gaps
- Create Standing Orders (labs, referrals, diagnostics, medications)
- Establish bi-directional communication plan to share pertinent data and information (data walls, use of huddles, staff meetings, clinical reviews meetings)

When will assigned activities take place?

- Day and time for report review
- Care plan/SMS plan creation with patient and review
- When to educate patients? Scheduled appointment/proactive phone call
- How soon after ER/Inpatient discharge to begin calling patient and to get patient in for appointment

Where will assigned activities take place?

- Dedicated time and space to manage review of reports, patient calls and education