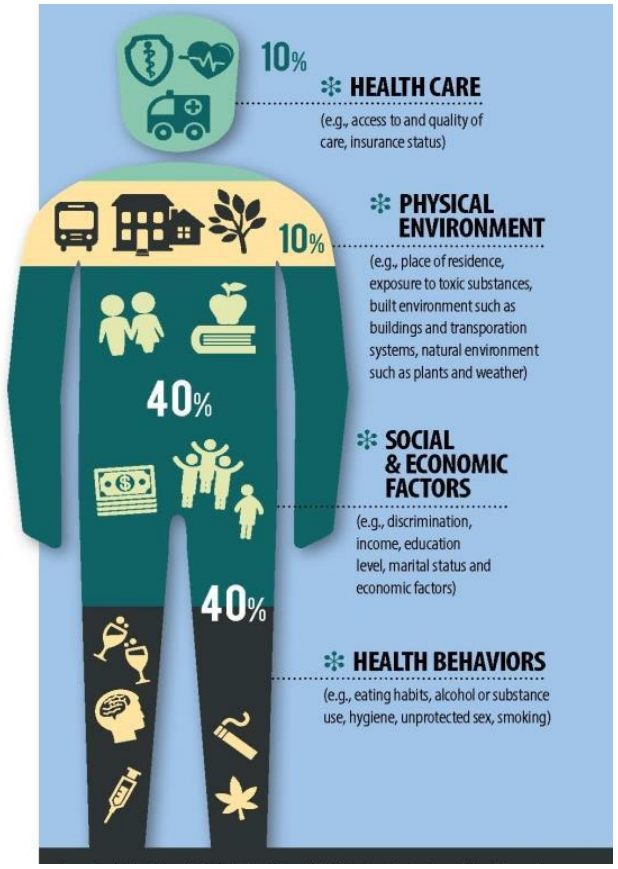
Rural Health Innovations
NATIONAL RURAL HEALTH RESOURCE CENTER

RHI WHITE PAPER

Care Coordination: An Essential Tool for Value

As federal and state reimbursement for health services shifts from pay for procedures to pay for value, health care organizations are redesigning their service delivery systems to focus on prevention, chronic illness, population health management, quality improvement and cost savings. At the core of these new systems is care coordination.

Care coordination effectively integrates the patient experience across a continuum of services including primary care, hospital, behavioral health, social services, rehabilitation, long-term care and home care. According to multiple research studies, clinical health care is responsible for only about 10 percent of a person's health outcomes, as seen in the graph to the right. Environmental, social and life style factors have an even greater effect. Care coordination provides a team-based, integrated approach to population health management; this approach systematically addresses many of the factors that affect health outcomes. In new value models, care coordination is key to both successful patient care outcomes and financial success.



Statistics from: Booske, B. C., Athens, J. K., Kindig, D. A., Park, H., & Remington, P. L. (2010). Image from: http://ww.naco.org/sites/default/files/documents/Social Determinants of Health.pdf

In 2017, the National Rural Health Resource Center (The Center) and Rural Health Innovations (RHI) conducted a survey of rural health networks engaged in implementing care coordination initiatives. The purpose of this study was to identify common characteristics, benefits, unique attributes, obstacles and lessons learned. These findings led to a refinement of the "Care Coordination Canvas Tool". The highlights of the study follow.

Highlights of the RHI Care Coordination Study

Taking a Flexible Approach

- Each approach has four basic components: target population, assessment tool(s), care plan and care team.
- However, each community is unique and utilizes these components in a one-of-a-kind care coordination approach.
- Different approaches have different focuses from achieving clinical outcomes, accessing appropriate out-patient care, establishing clinical directives, medication reconciliation and behavioral health.

Linking Clinical Health Care with Community Stakeholders

- The programs are engagement driven; they connect the person with needed community and clinical services, while including the person and their family.
- It effectively addresses a person's health behaviors, physical environment, social and economic factors. This is done by connecting clinical health care with community and behavioral health resources.
- High value is placed on effective partnerships of clinical, community and public entities developing a "circle of partners" around the person and family.

> *"How can a person effectively manage their diabetes if they are food insecure, can't afford the testing equipment or get to their provider?"*
>
> *Network Director*

Integrating and Coordinating Care Across the Continuum

- Ensures better care and smarter spending by directing the person to the right care at the right time. Examples of this are transitional care and chronic condition management.
- Care plans are determined through assessments of clinical needs, Social Determinants of Health (SDOH) and medication reconciliation. They are carried out by inter-disciplinary, inter-professional teams.

Focusing on Outcomes

- Because care coordination provides person centered, coordinated and integrated services people are meeting their health goals and avoiding hospital re-admission.
- Care coordination decreases Emergency Department (ED) utilization, increases primary care utilization, improves care and creates a healthier population while generating cost savings.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Source: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946: signed on22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on7 April 1948.

Conclusion

Care coordination is an essential tool for developing new value-based payment systems. This study confirmed the four common factors and identified additional elements that are part of successful rural care coordination approaches.

Successful approaches include:

- Four basic components: target population, assessment tool(s), care plan and care team.
- Incorporating communication, collaboration and technology as integral functions of each component.
- Linking clinical health care with community stakeholders developing a 'circle of partners' around the person and family.
- Integrating clinical, behavioral health and social needs carried out by an inter-professional care team.

RHI has created a Care Coordination Canvas and guide to assist with developing and refining a care coordination approach. For more information visit RHI's website and review the Care Coordination Canvas Guide (https://www.ruralcenter.org/care-coordination-canvas). As always, please contact us with any questions or comments by email at NetworkTA@ruralcenter.org or by phone at (800)997–6685, ext. 222.)