Care Coordination

Why Do It?

Coordinating a patient's care across health care providers and systems can be complicated, but doing so effectively reduces waste and improves the patient experience. Complex case management is aided by shared care plans, referral and specialty care coordination, transitions of care, health information exchange and community resource development. See the tip sheets on *Comprehensive Care* and *Team Based Care* for other ideas, and watch the Institute webinar "Referral Tracking & Care Coordination".

Where to Start

1. Identify a dedicated employee (or employees) whose role will be care coordination. If possible, keep this role distinct from other clinical and front-desk responsibilities. Unlike some clinical roles that rely on a specific degree of technical knowledge or training, successful care coordination depends more on relational skills and the ability to keep track of details. Check out the tip sheet on *Recruitment & Retention* for help. The Care Coordinator's scope of responsibility can be broad or narrow based on the training of the specific employee filling the role, but at a minimum, look for employees with:

a. **good communication skills** including nonverbal abilities, patience and sensitivity to different learning styles;
b. **ability to "go with the flow,"** adapting quickly without getting thrown off course when plans or situations change;
c. **attention to detail** and ability to navigate a job that requires frequent and consistent documentation.

"We hire now absolutely for culture and not for skill. We feel skill is something you can train and culture you can't…they tend to bring them in and do a half day and just 'let's shadow around and you can do my job for a day to see how you fit.' And it's really less about what does your resume look like and more about how do you connect with patients?"

2. Identify a panel of patients with complex conditions to assign to your Care Coordinator. For example, select all patients who unnecessarily utilized the emergency department within the last 30 days, or all patients with poorly controlled diabetes. See the tip sheet *Access* for more information.

a. Care Coordination can be most valuable for working with patients who benefit from (or seek out) **frequent contact with the care team**. Leverage your Care Coordinator to build relationships with these patients to support busy providers. Check out the tip sheets on *Team Based Care, Leadership* & *Culture and Change Management* to get started.
b. Care Coordinators are valuable points of contact for patients who need help to navigate the health care system. They can also be alternate points of contact for patients who are less

comfortable talking directly with providers for social, cultural or financial reasons. Also, see the tip sheet *Patient and Family Engagement.*

3. Assess your clinic's workflows, particularly the tasks that happen immediately before and after a typical visit. See the tip sheet *Quality Improvement* for steps. Focus on diverting non-clinical tasks and those that can be done by phone to your Care Coordinator. For example:

a. calling patients before visits to discuss needs and establish visit goals;
b. discussing referral options for specialty care and helping coordinate scheduling of referrals and transfer of records rather than assigning this task to the patient;
c. following up by phone after visits to answer questions about the care plan, troubleshooting any challenges in filling prescriptions or following a referral;
d. conducting "check in" calls between recurring visits to identify and proactively address emerging issues;
e. rapid follow-up calls after all hospital or emergency department discharges.

4. Train all staff in "soft hand-offs." Utilize your Care Coordinator to facilitate transitions between clinicians. Identify the points in your workflow where a visit transitions from primarily administrative to clinical tasks (and vice versa). Establish your Care Coordinator's scope of work to align with these transition points. Support your Care Coordinator with **cross-training and shadowing** to develop an understanding of clinic processes that will help facilitate hand-offs. Also see the tip sheets *Quality Improvement* and *Recruitment and Retention.*

Tips for Making the Most of Care Coordination

- Successful Care Coordinators develop a solid understanding of the resource and referral networks within their communities. Consider sending your coordinator to **visit specialty practices** in person so they can describe the settings to patients during referrals. Encourage them to **subscribe to and monitor community newsletters** to stay current with resources for food, housing, and transportation assistance in the area. Also see the tip sheet on *Comprehensive Care.*
- Care Coordination is most powerful when coupled with use of care plans. This allows all members of the care team, and particularly providers, to trust that care is being managed without verifying all steps along the way. If you are just getting started with care plans, don't retrace your steps! **Develop generic care plan templates** for frequently diagnosed conditions that you can then customize for a specific patient's needs.
- **Standardize your referral tracking process.** Have your Care Coordinator run batch reports of outstanding referrals once a week and follow-up to ensure care is moving forward. Monitor the response times of referral partners and have your Care Coordinator provide feedback when response times are not satisfactory.
- Include your Care Coordinator in **team huddles and discussions** about how to improve the clinic's workflows. They have a unique perspective on your patients' experience of care and will have valuable ideas!

PCPCH tip sheets were developed from the reported experiences of recognized PCPCH's, by a Portland State University research team under contract with the Oregon Health Authority, 2016. These recommendations are not part of the official OHA technical assistance guide and are not a guarantee of program recognition. Access this Tip Sheet and other resources: http://www.pcpci.org/search/resources