The State of Care Coordination

6 Illuminating Strategies You Should Know
There has never been a more interesting, exciting or challenging time to be in health care than right now.
Health care is under transformation.

Your patient populations are changing.
Your patients expect more than they used to.

All bets are off.

The old rules are out of date.
New rules seem to emerge every day.
It begins with a new role for care coordination in health systems.

But it’s also a time to impact care in a way you haven’t been able to before.
A NOTE ON THE TEXT

The patient quotes in this piece are from qualitative in-depth interviews with 50 patients dealing with complex care needs in these three groups: complex chronic, under 65 with disabilities, and over 65 with functional limitations.

In these interviews, we learned about patients building relationships with care providers, trying to make it through the system, coordinating their own care, advocating for themselves, benefiting from advocates, and managing their health in tough times. We learned what good and bad care coordination looks like. We heard victory. We heard struggle. We saw hope. We saw barriers to success.

Now, we want to share their voices.

Care coordinator quotes in this piece are from qualitative interviews of a small sample of care coordinators at a Midwestern regional health care provider.

Jim Rogers, RN, BSN, RPSGT, Director of Healthcare Solutions for Persistent Systems contributed to this eBook.

Contents

Strategy 1
Make meaningful front-end investments in health IT.................................................................17

Strategy 2
Stratify patients and proactively reach out to high-risk and at-risk patients..........................21

Strategy 3
Use patient education more effectively and efficiently..............................................................26

Strategy 4
Build a personalized yet consistent experience for every patient by using standard care plans .................................................................31

Strategy 5
Manage care transitions ............................................................................................................36

Strategy 6
Implement Chronic Care Management (CCM).........................................................................42

Care coordination in action.......................................................................................................47
“I’m very adamant about my medical situation. Just because it’s my health—it’s important. And I don’t want to mess around with it ... when it comes to my health, I don’t mess around. I care so much because it’s my life, and I want the quality of my life to be better than what it is now.

— PATIENT
The culture of care is changing.

For health systems already navigating big changes, care coordination presents yet another challenge—and opportunity. While some health organizations are established care coordination pioneers, many are just beginning to address the need for a comprehensive care coordination program and strategy.

The transformation of our care delivery system begins with reorienting the process of care delivery from a fee-for-service approach to the fundamental goal of the health care system: to keep patients healthy. This will require a significant cultural shift toward true patient-centered, team-based care, and a redefinition of how patients, caregivers, providers, insurance plans, and administrative staff interact with each other.
Why care coordination? Why now?

For health systems, care coordination is the key to engaging patients outside the walls of care, and it is more important than ever.
I went to the hospital eight times within a three-week time period. ... It was a different [doctor] every single time. Every doctor had a different reason for what was wrong with me. It was really frustrating ... whenever I go to the hospital, I basically never get any answers. And the doctors don’t talk to each other. It’s just like, ‘Here’s a quick fix for immediate results.’

— PATIENT

Complexity of care

The current health care system is complex. Patients may interact with any number of physicians, nurses, medical assistants, or other clinical professionals across multiple settings. Providers and health systems are increasingly rewarded for positive health outcomes and penalized for negative outcomes (e.g., hospital readmissions), so they also need to impact the patient’s behaviors away from their clinic.

Most providers realize that patients need more communication, but time pressure prevents spending very much time with patients. On a day-to-day basis, the patient oversees his or her own health, and daily decisions that people make have a huge impact on their outcomes and quality of life.

According to AARP, 90% of seniors and boomers desire to age-in-place in their own homes—proving that the need to monitor high-risk patients across multiple settings, including the home, will only continue to grow.
Chronic conditions leading to runaway health care costs

Providers must find new ways to provide communication to patients. For chronic conditions, especially, it is the patient who is in control. They decide whether they’ll change exercise or diet habits, fill prescriptions, or take the medications. Their actions will determine the outcome.

And the number of patients with chronic diseases is increasing. We face unsustainable growth in health care spending paired with health outcomes that are getting worse. Our per capita health expenditures are twice that of the U.K., Australia, and Sweden, yet we report worse health indicators. According to a study by the Milken Institute, chronic diseases cost the U.S. economy more than $1 trillion annually, or nearly 6% of the U.S. national debt.

Researchers have estimated that inadequate care coordination was responsible for $25 billion to $45 billion in wasteful spending in 2011 alone due to avoidable complications and unnecessary hospital readmissions.
By 2018, **50% of all Medicare payments** will be performance-based.\(^4\)

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**Shift to value-based care**

The shift to value-based care is starting with Medicare, but it’s not ending there. To meet performance-based standards, you’ll need to address the needs of patients when and where they want care. In fact, despite President Donald Trump’s actions to repeal the Affordable Care Act, industry experts say value-based care initiatives will likely continue under the new White House administration. “Efforts to move away from fee-for-service to value-based care are also enshrined in places besides the Affordable Care Act. This is a movement that’s happening independent of the ACA, or parallel to it,” said David Jones, an assistant professor of health law, policy, and management at Boston University’s School of Public Health.\(^5\)

In addition, a number of health systems, health plans, consumer groups, and policy experts formed the **Health Care Transformation Task Force**, and they aim to have 75% of their business based on value by 2020.\(^6\)
“I’ve tried to figure this out myself. I went on the websites and tried to make heads or tails of it. I couldn’t. I don’t know if they’re going to help me. If I could just talk to someone. I really am lost, to be honest. On what to do. How to avoid all the extra cost. It’s just far too much information for me. I wish there was a clearer path or to know which way to go to find out that information. It’s just too much information out there. I’m totally confused.

— PATIENT

It doesn’t have to be this way.
Where to begin.

workflow improvements
+
patient education
=
care coordination success

Despite the challenges and obstacles, hospitals and other health care providers can take immediate steps to move forward with care coordination or put their care coordination programs into high gear.

Creating a successful care coordination program starts with becoming patient-centered—focusing on patients’ needs and preferences. With that in place, health systems can concentrate on integrating key program strategies.

Care coordination is more than hiring care coordinators and moving on—it’s the powerful and systematic organization of patient care to transform health care delivery.

Having an effective care coordination program uncovers duplication and delivers services more efficiently, because someone is monitoring the patient throughout their health care experiences.
Each payer we contract with works on the ACO connection to make sure we are decreasing emergency room visits, decreasing hospital stays (stay the right amount of time), and decreasing cost of care for patient and payer.

— CARE COORDINATOR
So, how do you take the best care coordination practices to create the most beneficial experience for patients? It’s not as difficult as you think.

Here are six ways to jump-start your care coordination program no matter where you are in the process. What you’ll find are a few new twists to familiar tactics, along with real results and examples, so you can implement these ideas more effectively for yourself.

Let’s do this.
Strategies
Although more than 70% of eligible physicians and other clinicians and more than 95% of eligible hospitals have successfully used EHRs, there are challenges to making this technology work well for them and for their patients.

Using an EHR is fundamental to improving care coordination and decreasing the fragmentation of care. But simply having an EHR doesn’t guarantee a return on investment. The real return is generated by using the information gained from the EHR to provide better care.

Strategy 1

Make meaningful front-end investments in health IT

Sometimes I’m working simultaneously in up to four different applications. It would be great if some of these applications worked with each other.

— CARE COORDINATOR
50% of health systems and hospitals noted that a lack of a standardized EHR was one of the top three challenges their organization faces in developing and extending care continuum collaboration.

The right technology solutions help create a care coordination workflow that is:

- Integrated
- Connected
- Streamlined
Assess your organization’s current technology with an eye to care coordination workflow.

Take some time to assess your organization’s current technology to see how it affects care coordination and transition management. Then strategize and optimize that technology and collaborate with IT on data analytics and software solutions.

You can begin by asking the following questions:

+ How does your present technology meet your team members’ and patients’ current care coordination needs?
+ Can the care team effectively collaborate and communicate?
+ Is the technology flexible, and does it allow for customization so that care team members can be more productive?

Having the right technology infrastructure expedites communicating patient data and reduces the errors and delays that are prevalent in paper-based transactions. The ideal technology for care transitions would enable providers to become better integrated, better connected, and more streamlined with their partners in care, whether they are hospitals, long-term care communities, ACOs, physicians, or pharmacies.

Empower the care team with simple, secure communication tools for interactions.

Organizations can grow reliant on traditional communication channels without recognizing that they haven’t evolved with the growth and mobility of the industry. Some care coordinators are working within multiple platforms and systems. The care coordinator may have to go to the EHR for patient data, then to a patient education solution to gather resources to send, then to an email application to send the information to the patient. This workflow isn’t ideal for productivity, effectiveness, or efficiency.

+ Explore options for applications that meet the needs of care coordinators and work within your technology requirements.
+ Consider new solutions and technologies available that provide this functionality in a single app or that integrate all this needed information for care coordinators into more easy-to-use dashboards.
+ Work with your IT department to verify that your communications are secure with encrypted and protected networks.

Create an implementation strategy and ongoing training on technology systems.

Implementing new technology, processes, and systems will require time and resources.

Ensure that you have an implementation roadmap that covers communication around the value and benefits of the new technology to help people get on board with the changes.

Provide training for your clinicians and care coordinators so they’re able to be successful.

It will take time for your organization to become proficient with new processes and systems. Plan to publicize small wins and gradual advances so that people can see the positive impacts of the changes. Demonstrating gains for all parties—clinicians, care coordinators, and patients—will help overcome any resistance there may be to changes and will help build support and momentum.
Assess your organization’s current technology with an eye to care coordination workflow.

Invest in software programs and solutions that seamlessly work with your EHRs, and eliminate obstacles that slow the care coordination workflow.

Empower the care team with simple, secure communication tools for interactions.

Create an implementation strategy and ongoing training on technology systems.
Know your audience

Strategy 2

**Stratify patients and proactively reach out to high-risk and at-risk patients**

Clearly defining your patient population informs every element of your care coordination strategy. Stratification indicates **who** your patients are and **which** patients you should focus your care coordination efforts on. It helps you understand **what** your patients are like—what their current lifestyle behaviors are, their barriers to success, and the resources that they need. Uncovering these characteristics shows you **how** to best reach them with interactions that proactively manage high-risk and rising-risk patients and monitor at-risk patients.

*Care for patients with [comorbid chronic conditions](#) costs up to seven times as much as care for those with only one chronic condition.*

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*Healthwise  |  The State of Care Coordination*
But during the times that I’m with him [my care coordinator], I do share a lot about myself. I find it easy to talk with him and to express my needs as well as my concerns about what’s going on.

— Patient
Identify cost-drivers and stratify patients into meaningful categories

Risk Stratification | Segmenting Populations

- **5%** High Cost Patients
  - CHF
  - COPD
  - HTN
  - Asthma
  - Diabetes
  - High ED

- **20%** Rising Risk Patients
  - Behavior Health
  - Barriers to Care
  - New Diagnosis

- **40%** At Risk Patients
  - Gaps in Care
  - Patient Education
  - Lifestyle Changes

- **35%** Healthy Patients
  - Gaps in Care
  - Patient Education
  - Monitor for Trigger Events

Care Coordination

Monitor

Strategy 2: Stratify patients and proactively reach out to high-risk and at-risk patients
Prioritize high-risk and at-risk patients.

It is important to identify higher-risk patients to proactively manage people who are at increased risk for poor outcomes. Also, developing or reshaping care plans for high-risk patients is a good place to start your care coordination program.

High-risk patients are an easily targeted population to achieve short-term cost and quality gains. The care team can identify missed care steps, such as missed appointments, lack of post-discharge follow-up, or unfilled prescriptions.

Identify patients who will likely benefit from outreach.

As you prioritize high-risk and at-risk patients, you’ll also want to look at what patients in those groups that you can affect.

Some organizations are concentrating on “impactability”—that is, spending time on patients whom they have a better chance of impacting through outreach.

Analyzing medical claims, pharmacy claims, electronic health record information, and other administrative data can help predict an individual’s risk of adverse effects.

The next step is to assess each person’s probable response to different preventive programs and then assign him or her to interventions per the potential benefits.

“Understanding [and knowing about] changes in a member’s social context, their willingness to engage, etc., is essential to selecting candidates for care management interventions and effectively tailoring those interventions to meet their specific needs.”

Pinpoint patients’ needs and wants by precision planning.

After you segment your population into meaningful categories, such as shown in the Risk Stratification chart, and then develop personalized interventions for each category, you can further pinpoint your patients’ needs and wants. You will build loyal relationships with your patients because you aren’t using a one-size-fits-all approach.

You can provide:

- Health information for patients’ unique requirements.
- A list of resources patients may need.
- Ways to overcome barriers that patients may be facing.

The care coordinator can understand them as real people and get to know them and their issues. And that is the key to effectiveness.
Key success steps in Strategy 2

**Stratify patients to reach out to high-risk and at-risk patients**

- Identify cost-drivers and stratify patients into meaningful categories for personalized interventions.
- Pinpoint patients’ needs and wants by precision planning.
- Prioritize high-risk and at-risk patients.
- Identify patients who will likely benefit from outreach.
Answer the questions

Strategy 3

Use patient education more effectively and efficiently

71% of survey respondents said patient and caregiver education was the top strategy deployed to engage patients.11

Care coordinators’ annual performance goals are usually tied to reducing the total cost of care, limiting ER visits, and decreasing the length of hospital stays. So they need access to tools and systems that help them educate people about their health condition, provide discharge instructions, and state why it’s important to adhere to medications.

“I help eliminate gaps in care and identify what patients need. Identifying if they are safe, if they are home, if they have everything they need, if they have medications.”

— Care Coordinator
Patient education is no longer a “nice to have.” It’s an integral part of how patient care is delivered.

Patients tend to immediately forget 40% to 80% of the information their care providers present to them.\textsuperscript{12}

Deliver consistent health information to patients
People crave health information.

72\% of Internet users say they looked online for health information within the past year.\textsuperscript{13}

Through care coordination, health information is communicated one-on-one with more impact, increasing:

- Appeal
- Comprehension
- Retention

Care coordinators indicated that these patient education features were most important to them:

- Easy to understand
- Easy to deliver
- Searchable in a variety of ways
- Fits into their workflow
- Previewable
Ensure that your patient education is unbiased and evidence-based.

Is your patient education unbiased and evidence-based? Why should you care? Unbiased information is necessary to ensure accuracy and reliability, because health content, like every form of content, can be manipulated by self-interested parties. You may be inadvertently helping a pharmaceutical or medical device company’s bottom line more than your own.

Unbiased and evidence-based content offers objectivity, which bolsters your credibility and builds trust with your patients.

Provide behavior change tools for care coordinators and patients.

69% of total U.S. health care costs were heavily influenced by consumer behaviors.¹⁴

For patient education to be most valuable, make sure it includes validated health behavior change tools and interventions so that the right education can be matched to each person’s needs. Patients need access to tools and information that can help them achieve their health care goals, and care coordinators need to gain an understanding of the whole patient—her condition and where she is on her care journey.

Best practices in behavioral science begin with listening to people, helping them identify personal motivators for change, and guiding them toward success experiences. Embedding these best practices into the workflow will allow for higher efficiency in care coordination.

Tools that motivate, interventions that are grounded in behavior change science, and content that engages allow you to reach each patient with more impact, which increases:

+ Appeal
+ Comprehension
+ Retention

Find out more about behavior change here.

Offer education that is easy to deliver and easy for patients to understand.

A 2007 University of Connecticut study estimated the economic drain of poor health literacy in our country at between $106 billion and $238 billion a year.¹⁵

An essential tool in addressing our nation’s health literacy challenges is health information written in plain language. Access to information is a start, but clear communication helps people comprehend and use information to make better health decisions. Pain, fear, stress, medications … any of these can affect our ability to grasp information. By providing health information in plain language, you can help people take actions to improve their health.

But offering easy-to-understand health education is only one side of the coin. It’s important that health content is also easy for your care coordinators to find and prescribe. A good patient education solution will be integrated into your patient management system and allow care coordinators to quickly get to the right education at the right time to meet each patient’s needs.
Deliver consistent health information to patients.

Ensure that your patient education is unbiased and evidence-based.

Provide behavior change tools for care coordinators and patients.

Offer education that is easy to deliver and easy for patients to understand.
I often just feel like there are just so many hands in the pot. No one is really keeping track of the whole picture. Someone might have five different specialists, each with their own appointments. If we had a care plan in place, we could all reference the same plan.

— CARE COORDINATOR
When standardized care is used, quality increases, variation in care plans decreases, and costs decrease.16

Get on the same page

Strategy 4

Build a personalized yet consistent experience for every patient by using standard care plans

Care coordinators in our user experience research pointed out that care coordinators are supposed to be building on the doctor’s care plan as opposed to creating their own for the patient. The care plan helps give a direction to the call. One coordinator put it this way: “Without a care plan it just ends up being ‘How you doin’? You doin’ good?’”

Most care coordinators’ frustration and inefficiency comes from not knowing what another team is aiming to do: indeed, a clinician’s direction can be fuel for the care coordinator’s engine. Begin the process of standardizing care by asking these questions:

- What’s your organization’s main goal?
- What are the clinicians doing to help reach that goal?
- What are care coordinators doing to help reach that goal?

After you have identified the answers to these questions, it’s time to map out the steps that will best address your goals.
Train your care coordinators.

Train your staff to maximize interactions with patients. Patients will usually spend more time with your care coordinators than they do with their physicians. It’s important that care coordinators foster a caring atmosphere to help patients and that they have the proper training on the tools that they will use to do their job successfully.

And at a higher level, a crucial aspect of great patient service is ensuring that your care coordinators understand their underlying purpose in your organization.

Define patient care plans to standardize care and education.

Patient education is the foundation for building a successful patient engagement strategy. It has a major impact on patient experience and satisfaction. Patients, their families, and clinicians all benefit when each provider has a consistent body of educational material to use at each visit. Don’t leave its selection up to the whims of each clinician.

Proactively identify the best education for each step of your care plans. It makes the process more efficient and ensures your patients get the right information every time.

The power of patient education is magnified when it is consistent throughout your enterprise.

Develop metrics for tracking compliance.

By capturing and measuring clinical metrics, you can identify process gaps and other possible inefficiencies. For example, you can measure whether your heart failure patients are taking a certain medication or if they are following an exercise program, or you can see the last time they visited their primary care physician.

These metrics—facts about the patients—are ones that you can impact and to which you can assign a value. Tracking these values will tell you whether the quality improvements you have instituted are yielding the desired outcomes.
Balance care plans with standardization and personalization for better patient outcomes.

**Standardization**
- Consistent Quality
- Reduced Costs
- Improved Efficiency

**Personalization**
- Circumstances & Resources
- Values & Beliefs
- Motivation & Learning Ability

**Better Outcomes**
Provide education prior to an admission for preplanned surgical procedures.

Developing a care plan and educating the patient about the procedure—what to expect during a hospital stay and what the transition back to ambulatory care will be like—can reduce complications and prevent readmissions.

For example, Bundled Payments for Care Improvement (BPCI) for Joints and Comprehensive Care for Joint Replacement (CCJR) are two programs where a health care organization is at risk for the total cost of care for all aspects of care: pre, acute, and post.

Identify the points in the patient experience when and where patient education can make a difference.

There are certain episodes in care where patient education can make a big impact. Think about including patient education with personal support relating to these episodes in care:

- Treatment options and decisions
- Provider choices, locations, and appropriate care levels
- Prescriptions and other medications

Personalize care plans for better outcomes.

A more personalized experience for your patients that caters to their individual problems, interests, needs, and wants is a sure-fire way to keep people engaged and active. Your care plans can balance standardization and personalization for patients to achieve better outcomes.
Key success steps in Strategy 4

**Build a personalized yet consistent experience for every patient by using standard care plans**

- Train your care coordinators.
- Define patient care plans to standardize care plans and education.
- Develop metrics for tracking compliance.
- Provide education prior to an admission for preplanned surgical procedures.
- Identify the areas in the patient experience when and where patient education can make a difference.
- Personalize care plans for better outcomes.
Craft a smooth transition

Strategy 5

Manage care transitions

Nearly 1 out of 5
Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over $26 billion every year. ¹⁷
Care transition models

Medicare Innovation Models for alternative payment programs rely heavily on managing care transitions. Building a high-quality, post-acute network supportive of these models will improve continuity and coordination of care.

We see this specifically in:

+ Post-acute care models such as Bundled Payments for Care Improvement (BPCI), Models 2 and 3 (48 clinical episodes including Joint Replacement, CHF, COPD, Diabetes)
+ Comprehensive Care for Joint Replacement (CCJR)
+ Oncology Care Model
+ Comprehensive Primary Care Plus (CPC+)
+ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to include the Merit-Based Payment Incentive System (MIPS) and Alternative Payment Models (APM).

Reaching vulnerable patients

Patients undergoing care transitions are particularly vulnerable and are likely to benefit from care coordination interventions. During an episode of illness, patients may receive care in multiple settings. If interventions aren’t developed to assist patients and their families in making smooth transitions, the result can be duplication of service, inappropriate or conflicting care recommendations, medication errors, and higher costs of care. Improved discharge planning and post-acute outreach can improve patients’ care and prevent readmissions.
Care coordination can improve the care transition process in many ways.

**Strengthen communication during transitions between clinicians, care coordinators, patients, and family.**

The increasingly complex needs of patients undergoing care transitions requires more effective communication among care team members and patients and caregivers. A robust care collaboration solution will bring together the people, data and processes needed to improve engagement and enable problem solving and more informed decision making whether patients are in the hospital, provider’s office, or at home. In addition, high-quality communication between care team members and patients has been shown to have a positive influence on patient health outcomes.

**Share information between settings by automating the exchange process with EHRs.**

Automating the exchange of information through EHRs is fundamental to supporting the flow of information through settings. Unfortunately, care transitions often rely on manual fax, and telephone-based processes which can lead to miscommunication, delays, and patient and provider confusion.

In the U.S., more people die from medical errors caused by miscommunication than from accidents, diabetes, Alzheimer’s disease, AIDS or breast cancer. Medical errors are ranked fifth in the list of top 10 causes of death in the United States.

Don’t leave it to chance:

- Set up clear policies and guidelines that spell out how information must be shared.
- Standardize care transition workflows.
- Train team members on how the technology works.
- Set regular briefings to measure their efficiency.

**Educate patients and caregivers and equip them with tools to manage their own care.**

Patients or caregivers sometimes receive inconsistent directives, confusing medication routines, and unclear instructions about follow-up care. Patients may not have an understanding of the medical condition, plan, or care. Therefore, they don’t know how to follow the care plan or the importance of following the care plan.

Standardizing the process for delivering patient education during transitions can prevent patient and caregiver confusion and support care plan adherence. And providing information written in plain language and in the patient’s preferred language will allow for better transitions.
Facilitate access to care through telehealth technology.

One major benefit of telehealth technology is that it gives patients access to a platform they can use to engage and interact when and where they need care. While email communications work well in many situations, at times, such as when the patient is confused about a message or the topic is sensitive, it’s more effective to use telehealth technology. Listening to what patients have to say makes them feel more respected and serves as a valuable source of feedback to improve your care transition process.

Identify the areas in the clinical workflow that need interventions.

Measuring care episodes across the network can help identify obstacles and quality issues by showing where patients are spending the most time and by evaluating the care they are receiving at each setting.

Additionally, there are Medicare Transition Care Management (TCM) codes that can be billed for interactive contact with patients and family members during the 30 days’ post-acute stay. This includes providing education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living.

78.5% of patients said they would be at least somewhat comfortable interacting with a physician via online video or online chat.21
I think what we do is so important because we are contacting them in their home settings when they really need help. We are getting into a different aspect of the patient’s life.

— CARE COORDINATOR
Strengthen communication during transitions between clinicians, patients, and family.

Share information between settings by automating the exchange process with EHRs.

Educate patients and caregivers by equipping them with tools to manage their own care.

Facilitate access to care through the use of telehealth technology.

Identify the areas in the clinical workflow that need interventions.

Key success steps in Strategy 5

Manage care transitions
Despite new CMS payments to physician practices for select chronic care management (CCM) services, almost half of health care organizations lack a formal chronic care management program, leaving critical reimbursement dollars on the table, according to new market metrics from the Healthcare Intelligence Network (HIN).  

Imagine increasing clinical revenue while improving self-management, health outcomes, and patient satisfaction for Medicare Fee-For-Service (FFS) beneficiaries with two or more chronic conditions.  

Interventions that are targeted to specific patient populations have a greater impact on quality improvement and cost savings than broader approaches. Chronic Care Management (CCM) is one way to target your Medicare population and substantially impact elderly patients and those with multiple chronic diseases.  

CCM is defined as the non-face-to-face services provided to Medicare beneficiaries who have two or more significant chronic conditions. These services include electronic and phone communication with the patient, medication management, and being accessible 24 hours a day to patients and other care providers. The creation and revision of electronic care plans is also a key component of CCM.  

Many care coordinators do some level of chronic care management and reach out to high-risk patients and help them manage their illnesses indefinitely.
The report says they are noncompliant. Let’s dig in and learn why. Is it because they don’t have money for medications? Do they not have food? I’m trying to figure out what those issues are.

— CARE COORDINATOR
**Strategy 6: Implement Chronic Care Management (CCM)**

**Begin implementing CCM by following these steps:**

1. **Ensure EHR system certification and capabilities.**
   The EHR system must be certified to 2011 or later standards, as this is a requirement for billing the chronic care management code. The EHR needs to be able to support documentation of team care and care outside of an office visit.

2. **Identify patients.**
   Providers can bill for CCM for Medicare patients diagnosed with two or more chronic conditions that will last a year. Search EHR records to identify the patients who qualify.

3. **Invite patients to participate.**
   You must have an eligible patient's written consent to participate in CCM, along with authorization to share the patient's records electronically with other providers.

4. **Build a care plan.**
   A care plan must be created for each patient and must include an assessment of the patient's medical, functional, and psychosocial needs. The care plan needs to be consistent with the patient's choices and values.

5. **Document.**
   Remember to document the patient consent and the care plan in the patient's EHR.

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As with transitional care management, CCM has codes that can be billed for patients with chronic diseases. The chart below shows the requisites needed to satisfy the CCM code requirements.

<table>
<thead>
<tr>
<th>Eligibility Requirements:</th>
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<tbody>
<tr>
<td>1. Multiple (two or more) chronic conditions are expected to last at least 12 months, or until the death of the patient.</td>
</tr>
<tr>
<td>2. Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.</td>
</tr>
<tr>
<td>3. A comprehensive care plan is established, implemented, revised, or monitored.</td>
</tr>
<tr>
<td>4. Chronic care management services must include at least 20 minutes per calendar month of clinical staff time directed by a physician or another qualified health care professional (including nurses and clinical care coordinators).</td>
</tr>
<tr>
<td>5. Services must be provided non-face-to-face, and most services require patient education.</td>
</tr>
</tbody>
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Key success steps in Strategy 6

**Implement Chronic Care Management (CCM)**

- Ensure EHR system certification and capabilities.
- Identify patients.
- Invite patients to participate.
- Build a care plan.
- Document.
A good care coordinator understands her patient as a whole. We can’t just look at this one disease they have. We have to look at all the issues. It’s really more than just medical.

— CARE COORDINATOR
In 2014, a large health system in Colorado wanted to create a high-performing clinical network of providers and facilities and begin managing defined populations beginning with Medicare Shared Savings (MSSP).

They started with a dedicated ambulatory care coordination and began with the following steps:

- Defining the population to be managed
- Risk-stratifying that population
- Creating specific cohorts of patients to actively care coordinate
- Creating care plans, outreach plans, and standing order sets based on best practices and approved by the primary care provider (PCP)
- Engaging patients via phone, email, and face-to-face visits with the PCP
- Adopting active care coordination

Since implementing their care coordination process, they’ve realized impressive results.
Results

**Commercial results**

- **0% readmissions** in one commercial population over 18 months
- **3.2% readmission rate** on another large commercial population
- **Total cost of care** down in each of the four major commercial ACOs
- **Emergency room visits** down by 1,000 in all four commercial ACOs

**Medicare results**

- **Reduced avoidable ER visit costs** by $4 million in 1 year.
- **Reduced ER utilization** by 60% in the first year.
- **Lowered total cost of care**
  - 2015: $8,709 per beneficiary per year
  - 2016: $8,173 per beneficiary per year
- **Skilled nursing facility (SNF) related costs**
  - 2015: $532 per beneficiary
  - 2016: $194 per beneficiary
Adding It All Up

Care coordination can be a powerful force in revolutionizing health care. For the best outcome, we’ve identified these six strategies that drive care coordination success:

1. Make meaningful front-end investments in health IT.
2. Stratify patients to reach out to high-risk and at-risk patients.
3. Use patient education more effectively and efficiently.
4. Build a personalized yet consistent experience for every patient by using standard care plans.
5. Manage care transitions.
6. Implement Chronic Care Management (CCM).

The patient is a person, not a case. While clinicians may deal with a certain condition every day, in many cases this is the first time a patient or family member is experiencing the problem. Remember that the impersonal routines and small humiliations of medicine can leave patients feeling demoralized. This is where the one-to-one relationship with the care coordinator can help. Care coordinators can know a patient’s background and family life.
A good care coordinator understands her patient as a whole. We can’t just look at this one disease they have. We have to look at all the issues.

— CARE COORDINATOR
The Power of Care Coordination

Health care is on the cusp of a major transformation. Health systems of all sizes need to act now to put the power of care coordination to work to increase revenue, cut costs, and enhance the quality of patient care. By building on the experience, expertise, and services of others, each health system leader can accelerate the process of becoming an enterprise that reaches patients inside and outside the walls of care.

When care coordination is implemented thoughtfully, as a multi-faceted approach that supports the care team and focuses on the patient, providers—and patients—stand to achieve a transformed experience.

The most important benefits from devising and implementing a comprehensive care coordination strategy are improved health for patients and increased patient satisfaction. This strategy also allows the shifting of some patient engagement and care from busy physicians to ancillary staff. Also, it has the potential to reduce the number of hospitalizations, lower the number of emergency department visits, and minimize unnecessary or repetitive tests. Early evidence is encouraging.24

Radical change in how care is delivered and paid for is inevitable. But when care coordination is implemented thoughtfully, as a multi-faceted approach that supports the care team and focuses on the patient, providers—and patients—stand to achieve a transformed experience.
Resources


23. Jim Rogers, RN, BSN, RPSGT, Director of Healthcare Solutions for Persistent Systems contributed to this eBook.

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