What is Care Coordination and How Does it Impact My Practice?

Exploratory Paper

Christopher Varani, MBA, MSF, FACMPE, CPC

August 3, 2016

This paper is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.
What is Care Coordination and How Does it Impact My Practice?

Introduction.

Care coordination has become a common term in conversations of improved, patient-centered, healthcare. The Institute of Medicine (IOM) listed care coordination as a priority area for quality improvement in 2003. They saw that 125 million Americans suffer from a chronic condition and 60 million suffer from multiple conditions. The average Medicare beneficiary sees 6.4 different physicians in a given year. \(^1\) According to the Agency of Healthcare Research and Quality (AHRQ), “care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.” \(^2\)

New care models such as patient centered medical homes (PCMH) require some form of coordinated care to realize the triple aim of health care. Despite this, it is difficult to find a definition of care coordination that is agreed upon by everyone. The lack of clear definition makes it difficult to clearly articulate what a practice is doing for their patients or to implement a new care coordination program.

Each practice will find it necessary to examine their own strategic goals within their given patient population to determine their coordination needs. Each practice will have different resources available, requiring that they adapt their offerings and scope. Care coordination will look different across systems as each system tailors their program to their unique situations.

Objectives

1. To summarize a working definition of care coordination from current literature.
2. To explore how a primary care practice executive may implement elements of care coordination.
3. To explore the link between care coordination, patient centered care, PCMH and quality.
4. To explore possible costs and benefits for the valuation of care coordination to a practice.
**Research Methodology**

This paper is primarily based on a literature review of care coordination. Initially the search utilized the PubMed database for definitions, studies and possible valuation methodologies. Keywords included Care Management, Care Coordination + High Risk; Exclusive Provider Organization + Cost-Benefit Analysis, Exclusive Provider Organization + Care Management + Outcome + Cost-Benefit Analysis.

The literature review was further expanded to include assistance from the Medical Group Management Association (MGMA) knowledge center. This included current MGMA analysis of patient centered care and PCMHs as well as AHRQ and National Quality Forum (NQF) sources. Recent articles from the Centers for Medicare and Medicaid (CMS) were included as they pertained to the reimbursement of care coordination.

Finally, the examples used are based on the author’s experiences with different primary care practices in the past year. The care coordinator leaders for each clinic were interviewed for additions. The author has attempted to couple the hands-on experience with the literature review to provide clarity to a practice administrator trying to determine their care coordination requirements.

**What is Care Coordination and why is it necessary?**

The American healthcare system has become remarkably complex and more specialized. The days of a single doctor fulfilling all of the needs of a community are fading and likely only exist in rural corners of the nation. The added complexity and specialization has led to a fragmented system where patients have access to multiple specialists for each ailment. In 2010 the “average Medicare patient saw two primary care providers and five specialists a year.”³ It was not uncommon that “patients with multiple chronic conditions may see up to 16 physicians a year.”³
While sophisticated, this fragmentation makes it difficult for each provider to understand the treatment plans of the others. In the context of a patient with limited health literacy the added complexity and fragmentation breeds confusion, fear and safety errors. Maximizing the health and safety of the American system requires coordination of patient care by provider teams.

Picture a primary care clinic with a standard mix of patients. They may see Ms. Jody once or twice a year for a health maintenance visit and perhaps a flu shot because she is 26 years old and healthy. Mr. Dave, a 67 year old with coronary artery disease and diabetes, however, has drastically different needs. The clinic will need to work with cardiologists, ophthalmologists and possibly internists and surgeons to meet the standard of care for Mr. Dave. They may need assistance from pharmacists, lab technicians, a nurse to track his blood thinner levels and a financial counselor to help him figure out how to pay for it all. For the clinic to keep Mr. Dave on the golf course while minimizing his risks and cost, they must find a way to coordinate his care amongst all of his providers.

With a variety of terms, it is of little surprise that there are also many definitions. According to the NQF in 2014:

“Care Coordination is a multidimensional concept that encompasses the effective communication between patients and their families, caregivers, and healthcare providers; safe care transitions; a longitudinal view of care that considers the past, while monitoring delivery of care in the present and anticipating the needs of the future; and the facilitation of linkages between communities and the healthcare system to address medical, social, educational, and other support needs, in alignment with patient goals.”

From the online Merriam-Webster dictionary:

Care - “things that are done to keep someone healthy, safe, etc. & things that are done to keep something in good condition”
Coordination - “the process of organizing people or groups so that they work
together properly and well”

The AHRQ offers a more concise and healthcare specific definition that can be used as the basis for further discussion:

“Care coordination involves deliberately organizing patient care activities and
sharing information among all of the participants concerned with a patient's care
to achieve safer and more effective care.”

These definitions and the broad concept of care coordination offer the reward of “safer
and more effective care.” To realize these rewards, however, a practice must develop a plan that includes the fundamental concepts of organization, communication, all stakeholders and an extended period of time. The vagueness of these concepts will be intimidating to a practice administrator attempting to build a coordination program for her patients. They don’t specify the steps the administrator must take or the resources that the practice must budget for. This is also the strength of the proposed definitions; the administrator can craft a program that fits their unique practice!

Care coordination has had many names and has been around for decades. It was often called case management in the 1980s and 1990s and seen as a way for managed care plans such as Healthcare Maintenance Organizations (HMO) to reduce costs. A 1994 nationwide study “reported that, within managed care programs alone, case management definitions varied considerably, case loads varied between 20 and 120, and the settings in which case management took place also ranged from inpatient hospital through outpatient clinical operations and home settings.” The same is true today. Although HMOs have fallen out of favor, the coordination of care has only become more important as newer care models are adopted.

There are many synonymous terms. The following are only a few that were seen frequently during this review as well as some brief nuances. A practice may already be using any
or many of these terms to describe their processes. It is important that an administrator recognize that the goal of coordinated care may be realized even if it carries a slightly different label.

**Patient navigation** - Frequently used now, this term is often attributed to the growing career field of community navigators. This term correctly builds a mental image of guiding a patient through their care. It is important to also remember the complex communication and organization implied by the term coordination.

**Chronic care** - A term favored by payers attempting to reduce the costs incurred by high healthcare users. Hospitals or practices may use this term when specifically talking about patients with diabetes, COPD, heart failure, dementia, etc. It is appropriate and value maximizing for a practice to target the chronically ill with their coordination measures. These patients likely require additional staff and processes to keep them healthy while minimizing usage. This term is best included as a subset of care coordination. A properly built care coordination program, however, will benefit nearly all patients.

**Case management** - This implies that an individual patient or case receives individualized care. In primary care this often is an older but equal term for care coordination. One insurance company used this term to label their patients awaiting approval for specialized care and considered it distinct from their care coordination. As mentioned above, this term may be associated with HMOs or be seen as less humanizing than care coordination.

Care coordination is “considered a fundamental component to the success of healthcare systems.” Practice administrators should craft and refine care coordination programs as a means to improve the quality of care and patient satisfaction. By reducing confusion amongst all stakeholders including providers, family and patients, care coordination also holds the potential to reduce errors and the overall risk of care.
How do new care models address care coordination?

Healthcare providers and organizations continue to develop care models as new medical treatments, technologies and standards are introduced. The practice executive must also adapt to the quickly changing legislation and payer strategies they are faced with. New or updated solutions must be employed as the industry attempts to switch from fee-for-service to fee-for-value. Both the increase of consumerism in healthcare and the triple aim set by the Institute for Healthcare Improvement have created a dramatic movement towards patient-centered care. All of these trends make care coordination more valuable and more necessary to the practice executive.

The Centers for Medicare and Medicaid Services (CMS) have been testing the concept of Accountable Care Organizations (ACO) with several of their provider networks. They define the ACO as, “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.” CMS hopes that by focusing on coordination of care these new models will be timely and safer for their patients while avoiding redundant services and reducing costs. Practice executives interested in being part of an ACO must be able to coordinate care amongst a larger network of healthcare settings and often these networks and coordination processes are led by large hospital systems.

Patient Centered Medical Homes are popular new models that may affect smaller provider networks. These are meant to provide a primary care model and may be more achievable for primary care clinics able to coordinate with local community providers and resources. The idea of a “medical home” has been around at least since the 1960s but new standards and certifications in 2007 made the concept more transportable. The AHRQ defines a “PCMH as a promising model for transforming the organization and delivery of primary care and comprehensive, coordinated, accessible and continuously improving through a systems-based approach to quality and safety.” Care coordination is a central requirement for practices wishing to become certified as a PCMH.
Administrators interested in gaining the PCMH must show that their practices meet standards in care coordination before they can become certified.\textsuperscript{11} The National Committee for Quality Assurance (NCQA) is one of several certifying agencies and they require core standards including:

1) Plan and manage care
2) Provide self-care support and community resources
3) Track and coordinate care

Specific to care coordination, the NCQA requires for certification:

The practice systematically tracks, tests and coordinates care across specialty care, facility-based care and community resources, and uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.\textsuperscript{12}

Another certifying agency, the Joint Commission, also has requirements specific to care coordination:

These standards require the primary care medical home to coordinate care across all elements of the broader healthcare system, including specialty care, hospitals, home healthcare, and community services and support. Standards require care coordination during transitions between sites of care, and having clear and open communication among patients and families, the medical home and members of the broader care team.\textsuperscript{12}

Specialty clinic executives should also consider care coordination programs. Many of the new models are anchored by primary care but a patient-centered approach will affect executives at specialty clinics as well. ACOs often require that specialty clinics within their network share the burden of coordination. Specialty clinics that are able to reciprocate coordination processes with a local PCMH may have a competitive advantage for referrals.
What are the practice requirements?

Executives interested in bolstering their care coordination processes should start by assessing their clinic climates and current resources. Some clinics will find that adopting a patient-centered approach with care coordination requires a cultural adjustment. They should assess their patient population and community to determine where care coordination efforts should be targeted for maximum value. Once a strategy starts to form, the administrator may determine that they need additional or retrained staff. The administrator will need to assess their relationships with community partners to ensure they have the communication and infrastructure to support coordination efforts. Finally, the administrator may need to modify the clinic’s infrastructure, including their information technology, so as to integrate with their community care resources.

Care coordination requires a culture of teamwork and a willingness to spend extra time communicating about patients both within and external to a practice. This is natural for some clinics and challenging for others. The practice executive may find that adapting the clinic culture to support coordination processes is the most difficult task. This will be easier if the decision to add care coordination processes is made jointly with the providers, ideally with them driving the shift.

Practice administrators should recognize and start with a few critical coordination requirements. These include:

Medication Reconciliation - Errors with prescription medications represent the bulk of medical errors in America. As the patients see more providers, they are more likely to have medications added to their care. Good care coordination includes periodic drug list reconciliation for patients. It also requires processes for changing the drug lists when care plans have been updated. Proper care coordination will ensure that when Ms. Amy returns from her referral to the endocrinologist that her new prescription for
levothyroxine for thyroid treatment is added to her medication list. The list should also be checked for any new possible drug interactions in case the endocrinologist did not know the patient was also being treated with medications by a psychiatrist.

**Care transitions** - Transitions in care are particularly hazardous for patients and warrant extra coordination processes. The first challenge an administrator will face is identifying patients that are facing a care transition. Most administrators will know of the transition when it is directed by one of their own providers such as a referral to the endocrinologist. Unless the practice has established relationships with local hospitals, however, they may never know that one of their patients visited the emergency department for a broken arm or was admitted to the hospital for chronic heart failure and fluid overload. Hospitals are incentivized to notify primary care providers (PCP) when they discharge a patient in order to reduce re-admit rates but how that is done varies. Clinics using compatible electronic health records may receive a digital message the next morning. Other emergency departments will leave it to the patient to contact their PCP in the next week or if they have questions. These transitions are so important because they generally involve changes to the care plan for the patient. Perhaps the original care plan was not working well enough to prevent the hospitalization. Often the patient will be discharged with new medications and new instructions that may add confusion or even conflict with prior plans. Good care coordination quickly recognizes care transitions and uses timely communication to ensure all stakeholders are comfortable with the adjusted care plan going forward.

**Lab results and diagnosis communications** - Following up with patients about labs and testing results once they are available continues to be a source of medical error. A blood draw or chest x-ray is of little value if the provider and patient do not receive the results. Delays in communicating test results may also delay diagnosis and treatment. A patient found to have high cholesterol on an annual screen is at increased risk for a heart attack. A good
care coordination program would receive these results within a few days and the provider could call the patient right away to discuss an exercise program and maybe a prescription for a statin (cholesterol medication) to reduce his risk. A lack of coordination would leave the patient at higher risk for months or years. A properly functioning care coordination program recognizes dangerous lab values and directs immediate treatment. The same is true of new or changing masses and suspicious lesions found on CT scans.

**Referrals** - As the American healthcare system becomes more fragmented and specialized the frequency of referrals increases for patients. The practice executive needs a system for tracking patients that have been referred for care outside of the clinic. Care coordination would also involve tracking the results and recommendations generated by those referrals. The coordination would include updating the patient’s overall care plan to reflect the questions answered by the referral. Additionally, executives may coordinate with their patients to find out how their experience was at the specialist. If patients generally have better experiences with a particular neurosurgeon or worse experiences with a specific physical therapy clinic it can impact their care. The executive can coordinate for better care by communicating with the specialists and providing the trends to referring providers.

**Joint care plans** - Every provider will likely provide a care plan to the patient for every illness or medical condition they are seen for. A care coordination program can combine all of these into a single, joint care plan. With appropriate communication, the coordinator will resolve any conflicts among the care plans and provide a cohesive plan for the patient.

After critical areas are addressed, further care coordination opportunities will likely depend upon the clinic’s patient population. High-risk patients and patients with chronic conditions will likely benefit the most from coordination. An executive working in a community plagued by diabetes may improve care and reduce hospitalizations through nutrition courses and
more proactive blood sugar management. A geriatric population may benefit from coordination programs that work with home nursing and emphasize end of life planning. A younger population might benefit from immunization programs and coordination with school health clinics. Identifying trends in the community will help the administrator identify where they can maximize value with their care coordination resources.

Especially initially, care coordination is labor intensive and requires trained and engaged staff. The MGMA report found that 55% of PCMH respondents to a 2012 study had increased other clinical staff including Licensed Practical Nurses and technicians mildly or moderately. 40.8% had increased registered nurses and 43.2% had increases in non-physician providers. A medical assistant with training and sufficient communication with providers might do medication reconciliations and lab follow-ups. Registered nurses have the clinical skills to follow up with patients after they are discharged from a hospital or when more frequent follow-up visits are required for chronic conditions. A randomized study showed that clinical pharmacists working as case managers for diabetic patients had much greater impact on patient blood sugar levels than routine primary care.

Additional courses in community resources and communication may be helpful. Motivational interviewing and cultural sensitivity training are also useful components. Staff must be aware of resources that they can coordinate for patients. Executives may find it helpful to send staff to other clinics for relationship building and to assess capabilities first hand. As the clinic begins to coordinate more closely with local specialists they may find that they are providing more of a health neighborhood for their patients.

Information technology (IT) is often the clinic infrastructure that most needs to be upgraded for care coordination. As populations and programs grow, a simple spreadsheet and basic Excel skills quickly become insufficient to track or manage care. MGMA found that 69.5% of PCMHs had mild or moderate increases to their IT systems. This included electronic health records (EHR), referral systems and coordination or registry systems.
The variation in Electronic Health Records makes it challenging to prescribe IT requirements for a practice. Some EHRs include care coordination metrics in drop down menus and note templates. These may offer automatic quality reporting reports as well. Budget EHRs do not offer these and administrators will need to supplement with other tools such as spreadsheets or databases. Health registries are useful spreadsheets or databases that can be used to track and assess care coordination throughout the community. They are often necessary as care coordination grows into a subset of population health management.

**How might care coordination differ based on the organization using the term?**

Care coordination is unique to each clinical setting based on goals, resources available, patients and providers. This flexibility allows the executive to design a program and to implement it in phases or all at once. The following are two examples of care coordination programs in primary care clinics.

**Example #1** is a five-provider primary care clinic affiliated with a moderate sized community hospital and provider network. It is a stand-alone clinic but uses the same EHR as the hospital and network, facilitating the sharing of patient and population information. Their care coordination is essentially multi-tiered.

The physician provider literally works side by side with a medical technician who is responsible for rooming the patients and handling medication reconciliations. They are also responsible for daily tracking of all labs, imaging, referrals and specialty coordination. This system ensures that one person is coordinating the specifics of the care plan for each patient seen by the provider.

Additionally, the network has hired a team of 3-5 registered nurses to be care coordinators. One works part-time at this clinic. The care coordinator is responsible for assisting both with transitions of care and with patients with chronic conditions that the physicians feel
could benefit from extra provider education and contact. The coordinators typically start their day by contacting all patients that have been discharged from the emergency department or hospital within the previous 1-3 days and again 1-2 weeks later. They answer all questions and assess for the need for outpatient follow-up. They have full access to the network EHR and are able to schedule follow-up appointments either with providers or themselves.

Patients with chronic conditions are tracked in a series of spreadsheets. The coordinators are often asked to assist with extra diabetes education and blood sugar monitoring or providing more frequent calls to patients with frequent COPD exacerbations and patients with multiple hospitalizations for heart failure. Patients with depression or severe anxiety are often identified to the care coordinator and tracked in the spreadsheets for monthly or bi-monthly phone calls.

The care coordination required the hiring of several nurses as well as the additional training and utilization of the medical assistants. The EHR already established provides access to hospital and clinic records but does not have specific coordination or population health capabilities. The care coordinators have overcome this temporarily with complex spreadsheets but are currently researching health registry options.

Example #2 is a student-run, interdisciplinary, free clinic established in 2015 to meet the needs of uninsured patients. They currently serve several hundred patients of varying risk; many with multiple chronic care needs. Care coordination is one of the largest volunteer groups within the clinic and consists of interdisciplinary healthcare and undergraduate students. The care coordinator’s “role is to deliberately organize patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate communication, planning, follow-up, and linkage to care. The goal of care coordination is to improve outcomes, increase patient satisfaction and in some instances, reduce cost.”

Clinical care coordinators meet with patients at the end of their visit to ensure the care plan is coordinated, understood and practical. They schedule follow-up visits and assist the
patient in navigating community resources. The new longitudinal care coordinators “synchronizes the health activities of the patient across time in order to achieve the patient’s care plan and optimize their health.” Each longitudinal coordinator is responsible for a portfolio of patients with varying risk levels. They are tasked to communicate with their patients regularly, at least every 6 months, in order to help them navigate the health system and community resources. The goal is that patients with more ED visits or chronic illnesses or less health literacy are contacted more frequently to ensure they are doing well or brought to the clinic quickly if there are problems or pending exacerbations.

Coordinators use contact notes within the EHR as well as several spreadsheets for tracking coordination tasks and patient needs. For compliance purposes, IT mostly includes Microsoft Office 365 and several anonymous phone and fax applications for communicating. Task tracking and follow-up has been an ongoing challenge and the managers are experimenting with different calendars or database applications for future use instead of spreadsheets.

The clinic is entirely volunteer so the majority of costs have been student time. Several 2-5 hour training sessions have covered procedures, note writing, motivational interviewing, cultural sensitivity, interpreter usage and community awareness. With a team of students each managing small groups of patients, significant leadership oversight of 4-15 hours/week has been necessary to ensure care is standardized and timely. Patients have appreciated care coordination and there are several anecdotal reports of improved patient health. The clinic hopes to demonstrate financial value through reduced ED visits, CMS reimbursement rates for similar services and improved clinical outcomes for chronic condition populations versus national averages as time and volume increase.

**Care coordination integration with a practice’s quality improvement program.**

Care coordination programs should integrate smoothly with a clinic’s quality improvement program. The NQF has endorsed twenty quality metrics specific to care
The majority of these address care transitions, communication and medication errors. CMS offers many cross-cutting measures targeted at care coordination. The executive can use these to meet Physician Quality Reporting System (PQRS) requirements. For example, verifying a patient’s medical list at every visit is a critical part of care coordination and fits well with a quality program and PQRS reporting.

Good care coordination can increase patient satisfaction and patients often feel that their experience and care was better if they know it is coordinated throughout the system. This can be reflected in increased volume and prolonged customer relationships. Targeted feedback surveys or Consumer Assessment of Healthcare Providers and Systems (CAHPS) ratings can be used as tools to assess both quality and care coordination.

Both quality and care coordination programs originate from the desire to improve care. Care coordination is a process that will likely need continuous improvement and thus should be measured and addressed by quality programs. Coordination efforts provide the quality program a new outlet for care improvement with improved communication and better health outcomes. A high quality care coordination program provides clinically impactful data for a quality program to assess.

**How can a practice value care coordination?**

To be sustainable for a clinic, care coordination needs to add value. There are many costs associated with care coordination, notably in time, staffing adjustments and IT. Practice executives will likely find it difficult to calculate a return on investment for care coordination programs. Programs should be valued with longer timeframes in mind, typically 5yrs or longer. In the context of the clinic’s community goals, the executive should be prepared to value both tangible and intangible returns.

A study published in 2013 demonstrated a cost benefit analysis of enhancing care for diabetic patients by using clinical pharmacists for care management. The authors did show better
blood sugar control but focused primarily on how the reduction in cardiovascular events more than offset the added costs of the pharmacist directed program. In their base case, they estimated the program cost $35,740 per patient versus $44,528 for the control group and added nearly a year of life over 10 years.21,22

A small 1999 randomized control study looked at a nurse directed outreach program for pediatric asthmatics. They found that providing a solid upfront education reduced emergency department visits, hospitalizations and cost in their control group. The group that received education plus care coordination, however, decreased their usage and costs an additional 57 – 75%. The authors calculated that they saved “$7.69 to $11.67 for every dollar spent on the AOP nurse’s salary.”23

A hospital-based system implemented a telehealth case management program targeting high-risk elderly patients. They used interactive home telehealth equipment that was able to collect vitals and allow communication with nurse coordinators. If any vitals were out of range or had concerning trends, an outpatient visit was scheduled for further review. For the 250 patients in this test, they calculated a “52% decrease in hospital admissions, a 45% decrease in total hospital days, and a 34% decrease in ER visits. Savings exceeded the cost of equipment.”24

These examples were chosen to show a variety of techniques for valuing care coordination. The primary goal for patients is generally to retain function but the practice executive must also convert that into positive terms on an income statement. If a clinic is able to coordinate with local hospitals or obtain payer data to track emergency department visits for their patients, the executive can calculate the impact of care coordination using an average ED figure. The same can be true for hospital admissions25 as in the asthma example. Assigning a value amount (typically $50,000 in the US) to a Quality of Life Year (QALY) and correlating care coordination with improved health as in the diabetes example above can provide a dollar value. These tangible figures are often cost savings to the “health system” rather than the clinic but can have a real impact to the clinic when negotiating contracts with payers. Practices might also
negotiate to have payers provide in-clinic care coordinators to improve care while decreasing their own costs.\textsuperscript{26}

More direct, CMS currently reimburses for an expanding list of care coordination codes. Transitional care management services, procedural codes 99495 and 99496, reimburse for providers coordinating the transition of patients from a hospital setting to a community (home or assisted living facility).\textsuperscript{27} These were new in 2013. CPT code 99490, new in 2015, can be used to bill for chronic care management. To bill for this, providers must meet certain access and reporting capabilities that an executive should look at when designing their program.\textsuperscript{28} Additionally, CMS has created a diabetes prevention program that reimburses for a series of education and meetings in order to reimburse CDC approved sites that are expending resources coordinating for improved diabetes health.\textsuperscript{29}

Practice executives should watch closely for expanding CMS reimbursement options in upcoming years. The 2016 physician fee schedule proposal includes more codes for chronic care management, mental health and cognitive impairment care coordination as well as coordination for patients with mobility-related impairments.\textsuperscript{30} Practices may find that the majority of their care coordination efforts involve high-risk Medicare and Medicaid patients. For the rest, private payers often follow CMS trends and may be more agreeable to reimburse for services that are already approved by the government payer.

Just as important but more difficult for the executive to quantify is the improved patient satisfaction that is associated with care coordination. Studies show that patients are usually grateful for their coordination and that “feeling cared for appeared to have a very real effect on the quality of life of some patients.”\textsuperscript{31} Satisfaction might be measured by reduced patient turnover, increased patient referrals or even a prolonged billable lifespan of patients. More often, however, it is measured in patient satisfaction surveys. A trend towards increasing patient satisfaction can provide fiscal value in at least three ways. First, it provides a great marketing tool for drawing new customers. Second, improved satisfaction can be used when negotiating
contracts with payers and building relationships with other community providers. Third, it can be used a retention tool for providers who want to feel that they are making a positive impact and appreciate increased patient adherence to care plans. The intangible returns for a care coordination program can be very significant and should be factored into the executive’s cost benefit analysis.

![Figure 1: A proposed planning flowchart for the practice executive implementing or improving their clinic's care coordination program.](image)

**Conclusion**

Coordinating care for patients has the potential to improve their health while reducing costs for a practice. It can reduce patient confusion and helps to ensure there is a single joint care plan agreed upon by multiple providers. This becomes even more critical as healthcare becomes more specialized and reimbursement models shift to a value base. Practice executives
need to examine their patient population, resources and clinical strategies within their health neighborhoods to determine what their specific care coordination needs may be. An administrator should include an assessment of the practice’s quality goals, costs required and anticipated long-term values. A practice executive might be interested in newer care models such as an ACO or PCMH. Figure 1 above provides a simplified planning flowchart that an executive may base their program analysis on.

Care coordination may appear different at each clinic as the administrators address their unique environment. Although there are several critical areas the executive may choose to address first, there is flexibility in designing the care coordination process. The executive might adopt a national definition of care coordination or they may refine the term to improve the safety and effectiveness of care for their unique patients and practice. Care coordination is time consuming and the practice will likely accrue costs to start. The executive must consider both tangible and intangible returns when estimating the potential long-term value to the clinic and patients.

Works Cited:


13. <Proactive Case Management of High-risk Patients With Type 2 Diabetes.pdf>.


