Care Management & Care Coordination

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CARE MANAGEMENT

- To **manage** medical conditions more effectively
  - Team based approach
  - Assist patients and their support systems

CARE COORDINATION

- Deliberately **organizing** patient care activities
- Sharing information among **all** of the participants involved with a patient’s care
- Communicates the patient’s needs and preferences at right time
- Includes care management strategy
- Provides effective care
Care Coordination Model

**PATIENT-CENTERED MEDICAL HOME**
- Accountability
- Patient Support

**RELATIONSHIPS & AGREEMENTS CONNECTIVITY**
- Community Agencies
- Hospitals & ERs
- Medical Specialists

**Involved partners receive the information they need when they need it.**
- Practice knows the status of all referrals/ transitions involving its panel.
- Patients report receiving help in coordinating care.

**High-Quality Referrals & Transitions for Providers & Patients**

*Source: The MacColl Center for Healthcare Innovation Group Health Cooperative*
Role of the Care Coordinator

- Primary Care Physician
- Specialists
- Hospital System
- Post Acute Care
- Community Resources
- Ancillary Facilities
- Medical Equipment Providers
- Pharmacy
- Behavioral Health
- Family Members
What is a Care Plan?

- A collaborative document
  - Between patient, provider, care coordinator, etc.
  - Shared and agreed upon goals
  - Additional plans to support a high risk patient health care needs
  - Can be accessed and modified by entire care team
  - Can be shared with other clinical providers involved with patients care
Care Plans Include:

- Self-management goals
- Preventive and chronic illness care goals
- Action Plans for exacerbations of chronic illness
- End of life plans when appropriate
Guidelines for Developing a Care Plan

- Work collaboratively with the family
- Identify goals that are specific and short-term
  - SMART
- Provide regular feedback:
  - Phone follow-up
  - Email
  - Face-to-face
- Use external rewards
- Identify non-clinical supports as needed:
  - Public Health
  - Food bank
  - Behavioral Health

SMART:
- Specific
- Measurable
- Achievable
- Realistic
- Timely
Care Plan Example
# Medical Home Registry Patient Care Plan

**NAME**

**DATE**

<table>
<thead>
<tr>
<th>Main Concerns:</th>
<th>Contact number: Primary Care Provider:</th>
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<tr>
<th>Short Term Goals:</th>
<th>Long Term Goals:</th>
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<tbody>
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<td>1.</td>
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**Strengths:**

**Potential Barriers:**

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<tr>
<th>Resources Interested in:</th>
<th>Resources Received:</th>
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**Confidence Level:** (1) Not Sure / (10) Very Sure

**Additional Comments:**
Activity

- Pick a partner
- Assign Roles
  - Care Coordinator
    - Walk the patient through completing a care plan
  - Patient with diabetes (or other complex medical condition)
    - Provide input to the care plan, express your needs, concerns, fears etc.
- Switch roles!
Questions
References

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