# Care Coordination Valuable Then, Vital Now

*By Cindy Ehnes, Executive Vice President*

Recognition of the need to better coordinate the fragmented pieces and parts of a patient's health care services is not new. Coordination of care has, however, become an increasingly hot topic with the implementation of the Affordable Care Act (ACA) and health reforms that encourage decreased traditional hospital utilization paired with enhanced care management, particularly for the most at-risk, chronically ill and frail patients.

Whether called patient navigators, care coordinators, or something else, the goal is the same—for these crucial members of the health care team to guide patients battling acute or chronic conditions through the maze of complex healthcare systems. . It's become complicated enough to navigate for those who have had insurance for years, but the influx of newly insured patients and those just recently eligible for Medicaid and the subsidized Health Insurance Exchanges further underscores the importance of providing patients with expert guidance.

Our Health Care Talent Innovations services offer a workforce development 'pipeline' of trained (licensed and non-licensed) healthcare professionals, including Care Coordinators, that address the human capital needs of hospitals and health systems. The newly-introduced Care Coordinator role serves as a critical component in keeping patients healthy and out of the hospital. After all, studies have shown that nearly half of emergency department visits are attributed to avoidable causes, or the kinds of issues that care coordinators and their processes identify and prevent.

Proactive health management at a population level, rather than reactive sick care, has always been at the heart what drives our team at COPE Health Solutions. That is why COPE Health Solutions created a program to do just that well before the ACA was signed into law as part of California's "Coverage Initiative" 1115 Medicaid Waiver. In 2008, COPE Health Solutions worked with Kern Medical Center, a public hospital safety net provider in Bakersfield, Calif., to establish a health plan to cover 3500 previously uninsured community members. A key strategy for this health plan was a Care Management program for low-income adults deemed to be at highest risk for future high cost hospital utilization. Through the program, a care coordinator staffed the ED to make referrals and a trained care manager was assigned to eligible patients to help them with tasks like explaining discharge instructions, scheduling appointments and refilling medications. Later the model was expanded and exported to hospitals across the Los Angeles region.

The program in Kern County had measurable and documented successes (Consider citing to article), including a significant drop in the likelihood of emergency department utilization. However, at that time the financial incentives of fee-for-service were not yet

aligned to support long-term financial viability for the expansions in Los Angeles – hospitals simply did not yet realize a financial benefit and in fact were financially penalized for keeping patients healthier and out of the hospital and ED.

With the sweeping changes in healthcare reform that center around population health management; however, it is now not only financially sustainable, but a critical success factor for any hospital or health care system that sees Medicare members or is engaged in risk-based contracting to implement sustainable care coordination programs that can help reduce the use of high cost acute care services and enhance member health. Financial incentives—through the ACA and programs and penalties under the Centers for Medicare and Medicaid—are more closely aligned with the Care Coordination model.

While physicians, nurses, pharmacists, licensed social and behavioral health workers are essential members of team-based care, many of these critical roles in care coordination and population health management are 'middle-skill' jobs, requiring education and training but not requiring clinical licensure. These responsibilities can be supported by specially-trained, culturally-competent, non-licensed clinical staff.

With a program to be customized according to identified needs, these HCTI Care Coordinators can assist in hospital and ambulatory clinic care management initiatives for identified individuals with multiple chronic conditions, limited functional status, and/or psychosocial needs, who account for high care-utilization. Care Coordinators help coordinate patient care, connect patients with resources, help patients understand the healthcare system, and reduce barriers to care.

A recent article in The New York Times lauded the roles of care coordinators because of the need to make sense of a fragmented system. But the same article also criticized the approach because of its own frequent fragmentation, where care coordinators do not communicate with one another or do not have enough of an infrastructure to manage the process.

This is another area in which COPE Health Solutions' approach is different, thanks to a training and development curriculum, standardized processes and division of labor that are thoughtfully planned and carefully executed.