Care Coordination Strategies

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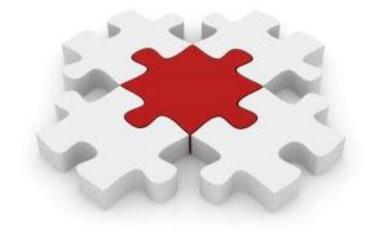


Why Care Coordination?

Population Health Management (PHM) seeks to improve the quality of health care of a group by monitoring and identifying individual patients needs within that group.

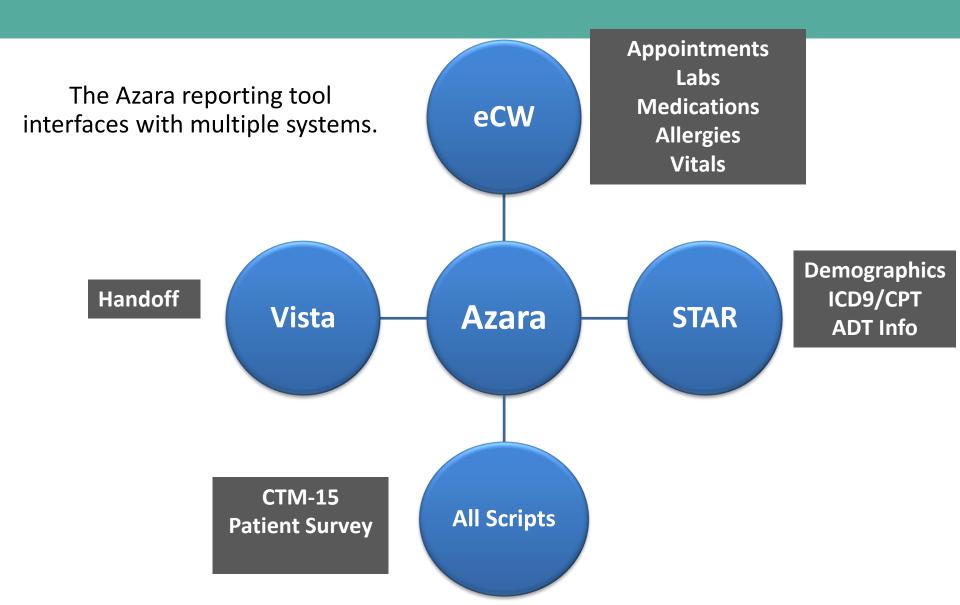
Triple Aim of Quality

- ✓ Improved patient outcomes
- ✓ Improved patient experience
- ✓ Decrease Health Care Cost





Data Management Tools





Which Patients to Manage?

Current Risk Stratification

High

Patient has 1+ of 11 risk diagnoses

AND

2+ ED and/or IP visits in the past 6 months.

Moderate

Patient has 1+ of 11 risk diagnoses

AND

< 2+ ED and/or IP visits in the past 6 months.

Low

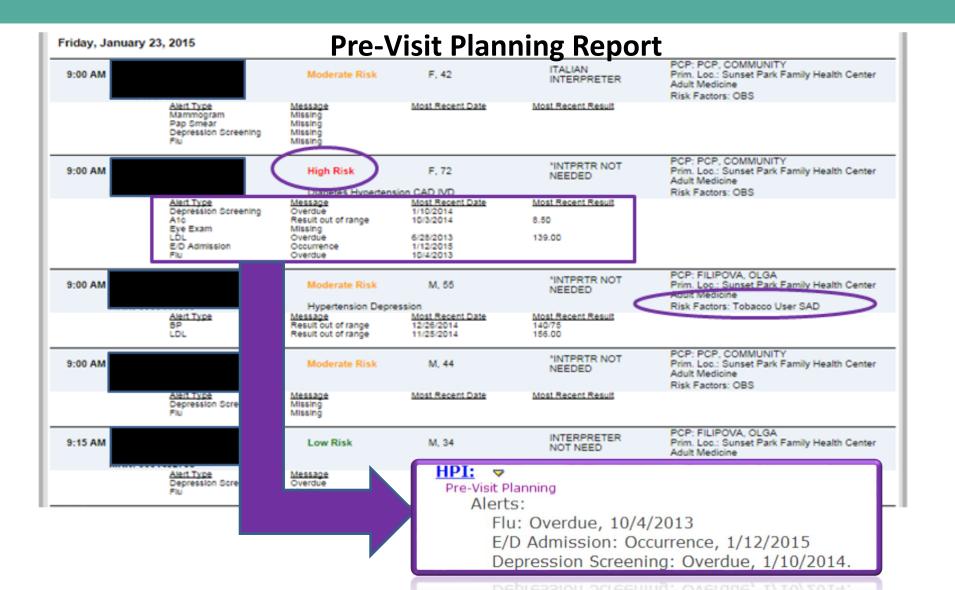
Patient has none of 11 risk diagnoses.

11 Risk Diagnoses

- Asthma
- COPD
- Diabetes Mellitus
- Heart Failure
- Hypertension
- Obesity
- Alcohol Abuse
- Alcohol Dependency
- Drug Abuse
- Drug Dependence
- Severe Mental Illness



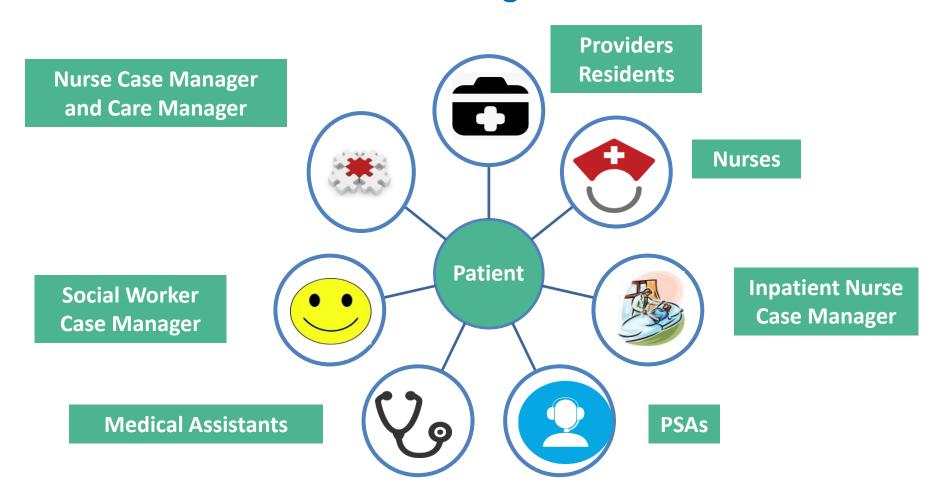
Actionable Data





Care Team

Site Morning Huddles





Case Management

Outpatient CM embedded in LFHC sites:

- ✓ Conducts follow up calls to discharged patients
- ✓ Confirms medical appointment & addresses transportation needs
- ✓ Alerts patient service coordinator if health concerns reported
- Deploys community health worker if assistance required
- ✓ Engages Nurse or Social Work Case Managers for patients
 with complex medical conditions and/or psychiatric disorders

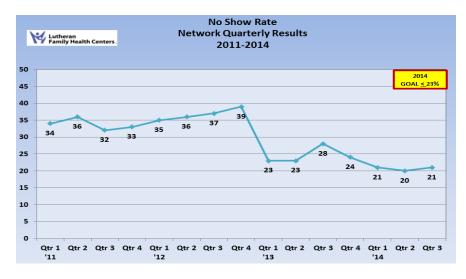
Centralized Appointment staff:

- ✓ Conducts follow up calls to ED patients
- Sets up appointments to appropriate provider if necessary

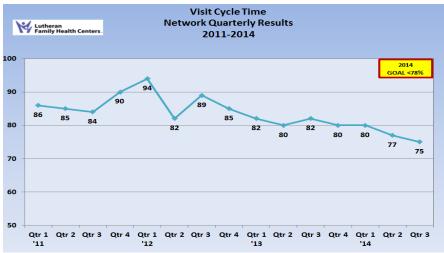


Improved Patient Experience

■ Decreased and Sustained No Show Rates 21%



■ Decreased Visit Cycle Time to 75 minutes

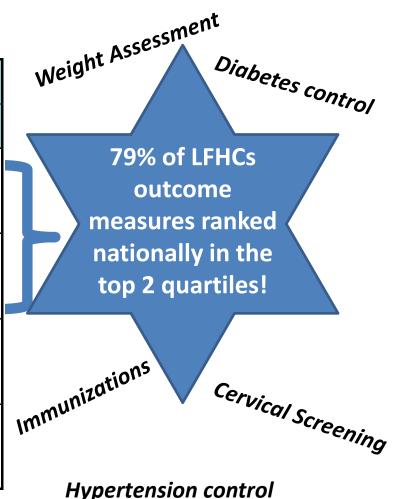




Improved Patient Outcomes

■ BPHC Clinical Outcomes Ranking

Quartile Performance			
	2011	2012	2013
1st Quartile	9%	29%	29%
2nd Quartile	18%	36%	50%
3rd Quartile	46%	21%	14%
4th Quartile	27%	14%	7%





Decrease Health Care Costs

