

Population Health Management Putting Care In Coordination

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Background

Present Situation:

- Elderly, low income, rural population
- Multiple chronic health issues
- Patients taking multiple medications
- Inefficient utilization of services
- Poor coordination of care
- Lack of public transportation
- Need for financial assistance

Plan

Coordinate patient care by identifying deficiencies in care delivery:

- Medication management reconciliations
- Close loop on referrals
- Identify care gaps
- Identify patient misunderstandings
- Identify medical errors
- Identify transportation & financial restraints
- Lack of care transition support
- Lack of self-management support

Do

Implementation of Care Coordination:

- Engaged two Patient Care Coordinators
- Patient Care Coordinators attended Compass PTN funded training
- Patient Care Coordinators implemented team approach with health care teams
- Began managing clinic deficiencies

Act

Ongoing assessment of patient outcomes:

CGCAHPS

Focus on person & family engagement

Additional Care Coordination (clinical pharmacist, diabetes educators, dietitian, public health, etc.)

Goal

Healthier people
Better care
Smarter spending

Team/Acknowledgment

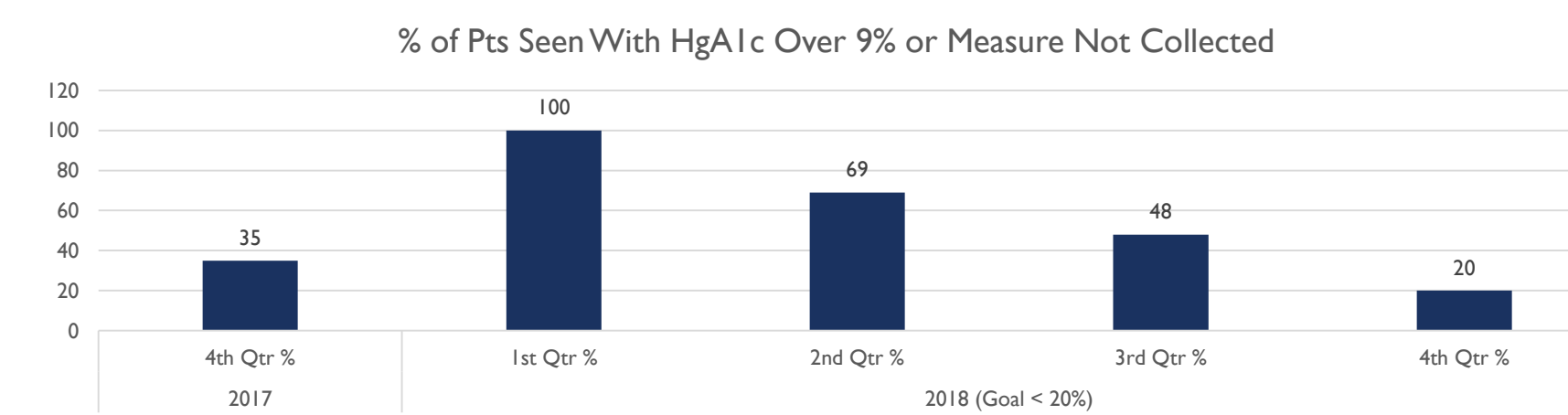
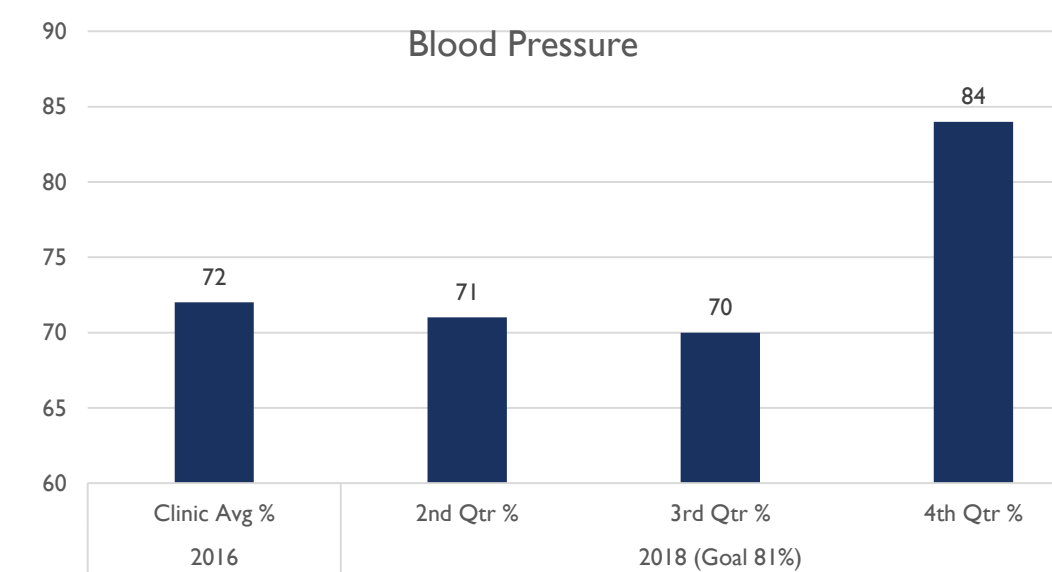
LCHCMC TCPI Committee Members:

Allison Krutsinger, PA-C; Amy McCurdy; Becky Runnells; Cathy Heston; Deb Black; Kenneth Anderson, DO; Kerri Guthrie; Lori Johnson; Sonya Bellon; Twilla Kruzic

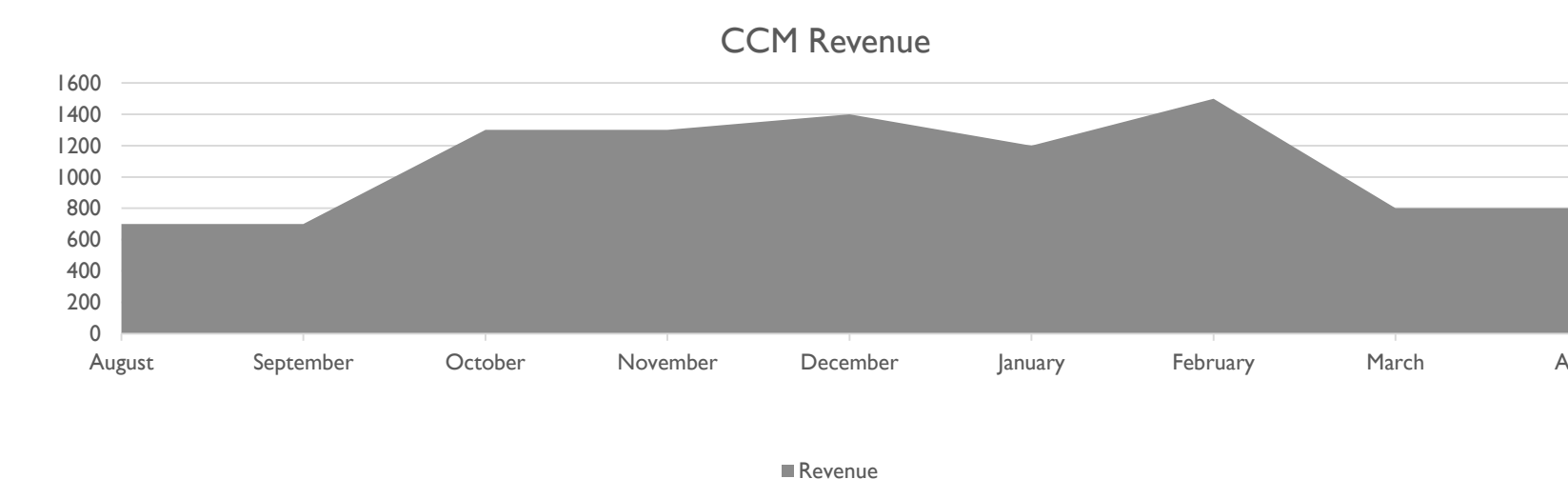
Study

Care Coordination Findings:

- Blood Pressures
- HgA1c's



	August	September	October	November	December	January	February	
Quantity		8	7	13	13	14	12	10
Revenue		800	700	1300	1300	1400	1200	1000



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