

# Care Coordination Statewide Strategy

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**Mission:** *Establish coordinated patient care as the standard in Iowa.*

**Vision:** *By 2019, improve patient outcomes and experiences through coordinated delivery of healthcare and community services in the right order, at the right time, and in the right setting.*

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1. Ensure coordination of services at the primary point of care.
  - **Objective 1.1: Advance patient-centered care practices.**
    - Tactic 1.1-A: Establish person and family engagement (PFE) as a standard of care through inclusion practices at the direct level of care through leadership/administration.
    - Tactic 1.1-B: Establish patient-centered care planning inclusive of patient and provider shared-decisions around care, treatment, and self-management.
    - Tactic 1.1-C: Increase access to needed medical services in locations and at times that meet patients where they are.
    - Tactic 1.1-D: Disseminate and promote evidence-based best practices for provision of best quality care, including diagnosis, treatment, and management.
    - Tactic 1.1-E: Increase the awareness and addressing of health literacy, including the use of patient conversation resources such as Teach Back and Ask Me 3.
    - Tactic 1.1-F: Promote the implementation of comprehensive and high quality health risk assessments that identify patient clinical, social and community needs.
    - Tactic 1.1-G: Create processes for clinical and community care communication encompassing closed-loop referrals for community services.
  - **Objective 1.2: Facilitate impactful delivery of healthcare services.**
    - Tactic 1.2-A: Educate patients and healthcare providers on evidence-based principles and best practices of care coordination.
    - Tactic 1.2-B: Establish high quality referral processes for other needed clinical, specialty, and community-based services.
    - Tactic 1.2-C: Designate defined care coordination roles and/or responsibilities within the clinic, practice, or organization.
    - Tactic 1.2-D: Promote collaborative provider relationships and team-based care practices, both within and among care settings
    - Tactic 1.2-E: Increase awareness and capacity to address social determinants of health (SDH), promoting inclusion of SDH as a component of implemented health risk assessments (HRAs).



- Objective 1.3: Establish coordinated connections to needed community-based services.
  - Tactic 1.3-A: Increase recognition and capacity to address SDH through education and incorporation within HRAs to identify patient-specific needs.
  - Tactic 1.3-B: Identify available assistance within the community and establish points of contact to enable resource sharing and referral.
  - Tactic 1.3-C: Create processes for clinical and community care communication encompassing closed-loop referrals for community services.
  
- Objective 1.4. Increase provider engagement and team-based care practice through ongoing education.
  - Tactic 1.4-A: Increase utilization of team-based care principles and evidence-based practices through educational offerings, such as TeamSTEPPS resources and other evidence-based curriculums.
  - Tactic 1.4-B: Align incorporation of care coordination and team-based care strategies as part of professional continuing education offerings.
  - Tactic 1.4-C: Increase provider and allied professional education and training focusing on patient engagement and activation, including motivational interviewing, Teach Back, and health literacy best practices.
  - Tactic 1.4-D: Cultivate ongoing development of integrated education and training opportunities for providers and expanded allied professional audiences.
  
- 2. Enhance cross-system collaboration across healthcare settings and services.
  - Objective 2.1: Develop multi-discipline patient-centered care teams.
    - Tactic 2.1-A: Establish designated roles for involvement of pharmacy, behavioral health, and other specialty providers as members of the patient care team.
    - Tactic 2.1-B: Develop and maintain protocols and processes to facilitate reciprocal care communication among care team members, setting expectations for reciprocal communication and closure of referral.
    - Tactic 2.1-C: Encourage involvement of team member participation in care services in alignment with highest scope of practice.
    - Tactic 2.1-D: Instill incorporation of multi-discipline/stakeholder approaches in care transition planning.
    - Tactic 2.1-E: Promote use of evidence-based team development and improvement practices, such as TeamSTEPPS, to ensure team execution and efficiency in patient care and safety.
    - Tactic 2.1-F: Incorporate involvement from non-clinical support systems as part of a whole-person-centered care model, including community-based services.
  
  - Objective 2.2: Use of health information technology (HIT) to facilitate cross-communication and documentation.
    - Tactic 2.2-A: Promote use of available HIT resources to allow mutual access to patient care information from all appropriate members of the patient care

team, i.e. Iowa Health Information Network (IHIN), shared Electronic Health Records (EHR) view and messaging functionalities.

- Tactic 2.2-B: Use available EHR and data systems, such as registries, to identify and target high risk or at-risk patients for targeted care coordination and support.
- Tactic 2.2-C: Encourage use of EHR patient access or patient portals to facilitate direct availability and inclusion of information by patients and caregivers.
- Tactic 2.2-D: Promote transparency of relevant and necessary patient care information across appropriate healthcare settings to facilitate optimal care planning and delivery.

- **Objective 2.3: Establish standardized processes and protocols for collaborative care delivery.**

- Tactic 2.3-A: Create and maintain policies for patient-centered care practices across team settings, emphasizing inclusive team-based care, shared-decision making, and patient activation strategies.
- Tactic 2.3-B: Create and maintain active referral processes across services and settings establishing plans for proactive communication and closed loop referrals.
- Tactic 2.3-C: Identify and incorporate non-clinical services that can be used in care coordination practice processes and protocols to support comprehensive patient-centered care.

- **Objective 2.4: Enhance collaboration among healthcare providers, community-based services, and the payer community to ensure effective and efficient provision of care and support services.**

- Tactic 2.4-A: Align payer-supported educational strategies with prioritized evidence-based practices for patient-centered care and coordination of services.
- Tactic 2.4-B: Explore mutual support and sustainability strategies with the payer community to optimize care coordination efforts and resources utilization.
- Tactic 2.4-C: Champion streamlined processes for closed-loop referrals with clinical sites, payers, and community-based services.

### 3. Execute community-based strategies that proactively link and support clinical and community-based services.

- **Objective 3.1: Align community-based services for each patient/service recipient to ensure greatest impact.**

- Tactic 3.1-A: Identify and engage available and existing clinical and community-based service stakeholders
- Tactic 3.1-B: Establish points of contact and relationships among clinical providers and community-based services.
- Tactic 3.1-C: Establish referral and reciprocal communication for closed-loop referral processes between and among clinical providers and community-based services.

- Objective 3.2: Connect clinical services with community-based services.
  - Tactic 3.2-A: Build, enhance and maintain collaborative relationships and functional referral mechanisms between health care systems and community-based services.
  - Tactic 3.2-B: Establish processes for reciprocal communication and information sharing.
  - Tactic 3.2-C: Establish processes for referral follow-up between and among community-based services and clinical providers.
  - Tactic 3.2-D: Establish community partners and service providers as integral members of the care team, focusing on connection of social determinant of health services and approaches.

#### 4. Use data strategies to drive improvement and demonstrate value-based care.

- Objective 4.1: Promote and enhance the use of health information technology (HIT) to identify, track, and monitor population health.
  - Tactic 4.1-A: Encourage full use and optimization of EHR capacities to facilitate collection and capture of patient population health status and care coordination processes.
  - Tactic 4.1-B: Promote use of community-based service data systems to track community-based service provision including referrals, participation and person-based and community outcomes.
  - Tactic 4.1-C: Promote cross-systems access and communication among team members and service providers to encourage comprehensive person-centered coordination of care.
- Objective 4.2: Develop common metric set for care coordination.
  - Tactic 4.2-A: Identify available clinical quality measures aligned with national quality conventions, such as CMS and National Quality Forum.
  - Tactic 4.2-B: Explore and identify defined metrics to capture care coordination activities within non-clinical and community-based settings.
  - Tactic 4.2-C: Champion streamlined reporting processes, aligning mechanisms and metrics prioritized across providers and settings.
- Objective 4.3: Promote the inclusion of care coordination quality measures in publicly available reports.
  - Tactic 4.3-A: Support and encourage the inclusion of care coordination and related clinical quality measures as a part of incentivized reporting mechanisms.
  - Tactic 4.3-B: Explore public availability and access of care coordination data through establishment of a report highlighting the status of care coordination in Iowa.
  - Tactic 4.3-C: Actively use and share both qualitative and quantitative data that can be used to fully present the status of care coordination in Iowa.