

Title:

Care Coordination Training at a Community Health Center

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Session Title:

Poster Presentations

Slot (superslotted):

PST: Saturday, 18 March 2017: 7:30 AM-8:00 AM

Slot (superslotted):

PST: Saturday, 18 March 2017: 9:45 AM-10:15 AM

Slot (superslotted):

PST: Saturday, 18 March 2017: 1:30 PM-2:00 PM

Slot (superslotted):

PST: Saturday, 18 March 2017: 3:45 PM-4:15 PM

Keywords:

Care coordination, Population health and Primary care

References:

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Abstract Summary:

Care coordination training was developed, implemented and evaluated at a community health center in central Illinois. It highlighted a daily workflow based on their specific needs while defining the role and increasing the self-efficacy of the care coordinator in the primary care setting.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to explain how the care coordinator role can help reduce healthcare cost and improve the quality of care for patients in the healthcare system.	Discuss the role of the care coordinator and evidence to support how it improves quality of care and reduce cost.
The learner will be able to describe the foundation for a successful care coordination program in a primary care setting.	a) Discuss the assessment findings and framework used to guide the structure of the program. b) Describe the care coordination training program specifications including methodology & sample and data analysis.

The learner will be able to discuss the benefits of a Patient-Centered Medical Home (PCMH) in the primary care setting.	a) Define and discuss Patient-Centered Medical Home (PCMH) and the importance of care coordination. b) Brief background of the identified local community health center and the purpose of the care coordination program to their organization.
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Abstract Text:

Purpose of Study: Care coordination is an essential element of population health with an emphasis on a team-based, patient-centered approach. Based on an assessment of the care coordination program at a community health center in central Illinois, it was determined that a structured care coordination (CC) training, focused on the role of the care coordinator, was needed to improve care. The purpose of this project was to develop, implement and evaluate a CC training to increase care coordinator self-efficacy and measure their ability to implement core components of their role, which included a daily workflow and discharge planning.

Primary Practice Setting: Primary care clinic in a community health center.

Methodology and Sample: A quasi-experimental, one-group pre/posttest quality improvement design was used to determine if a pilot CC training affected self-efficacy for four care coordinators. Outcome data were collected via written questionnaires and chart review and analyzed using descriptive statistics, Mann-Whitney U and Spearman Correlation tests.

Results: A pre/posttest questionnaire was used to evaluate the degree of change in self-efficacy. Of the four care coordinators in the primary care setting, two participants completed usable pre/posttests (n=2). The pre/posttest result indicated a 55% increase in self-efficacy of the care coordinators. Review of the written documentation by the care coordinators after CC training of the four elements of the care coordinator workflow, which outlined their daily responsibilities, demonstrated that 50% of the participants correctly identified all four elements and 50% correctly identified two of the four elements.

Implications for Case Management Practice: Evidence reveals that care coordination reduces healthcare costs and improves quality of care for patients in the healthcare system. However, adequate training programs are imperative for the professional development of the care coordinator to perform their role. As it relates to this CC training pilot study, one implication for practice is the need for additional training. This will be important as the care coordinators at this community health center continue to move into the full scope of their role. Another implication is the need for an adequate number of providers in the primary care setting. This is important in forming a quality care team. Lastly, the need for the development of a multidisciplinary workgroup which includes: care coordinators, providers, medical assistants and administration. Recommendations include developing and implementing a process of collecting and providing data to the care coordinators of the appropriate patients for follow up appointments after ED visits, hospitalizations and for preventative care. Likewise, there needs to be an annual care coordination competency that is either web-based or in-person training for continuing education. Finally, employee recognition and continuous communication would help increase staff engagement and create a culture in which the common goal is to provide patient-centered care and maximize clinical quality.