Improving Rural Community Health Through Care Coordination

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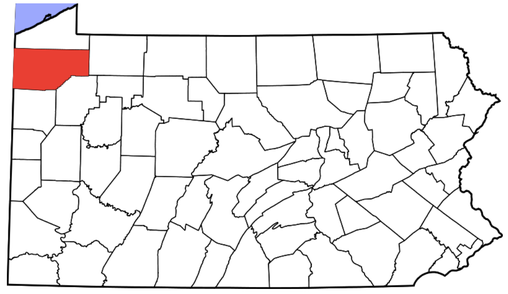
CRAWFORD COUNTY, PENNSYLVANIA



DEMOGRAPHICS OF CRAWFORD COUNTY[1,2]

- Population – 87,600
- Population density – 86.5 per mi^2
- Ratio of patients to PCPs – 1,685:1
- Number of hospitals – 2
- Population 65 and older – 17.4%
- Overweight – 65% Obesity – 32%
- Population with Diabetes – 12%
- Heart disease death rate – 200 deaths per 100,000 people.

The above percentages and rates of disease are either equal to or higher than the averages for the state of Pennsylvania.

References

1. "2014 County Health Profiles." *Pennsylvania Department of Health*. 2014. Available at: www.statistics.health.pa.gov. Accessed September 2015.
2. "County Health Rankings & Roadmaps." *University of Wisconsin Population Health Institute*. 2015. Available at www.countyhealthrankings.org.
3. McDonald KM, et al. Care coordination. Vol. 7. Closing the quality gap: a critical analysis of quality improvement strategies. Stanford, CA: Stanford University, 2007.

CARE COORDINATION[3]

- Care coordination has been defined as "the deliberate integration of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services."
- There is increasing desire to *provide better care, improve patient experience, and lower health care costs*. Care coordination helps work towards this goal by:
  - Increasing a patient's access to information and care
  - Enhancing their experience through consistent communication
  - Improving adherence to treatment and follow up, thus reducing costs to the health care system.
- Health care is a limited, scarce resource. It is important to allocate resources as efficiently as possible. Coordination allows for the reduction of the demand placed on physicians and nurses, and it can help link patients to community resources or self-care.

THE COMMUNITY CARE NETWORK

- Patients are identified in inpatient settings and can also be referred by physicians.
- Services provided: Appointment and treatment adherence (via scheduling assistance, phone calls, and visits), nutritional support, medication support and reconciliation, emotional support, access to insurance, referrals to community resources, and more.
- CCN utilizes *health coaches* - college students trained through an elective course to participate in the care coordination. Health coaches call and visit patients with chronic diseases weekly, and they help to identify any potential needs or barriers to care *before* they become serious issues.