

# Coordinated Care Management

The comprehensive health and social care record in Epic moves healthcare beyond clinics and hospitals. Coordinated Care Management provides case management tools to roll out population health, social, and community related programs to improve a person's well-being through care management and outreach.

## A Comprehensive View of Wellness

Coordinated Care Management can help your organization keep more people well. Use tools in Epic to address social determinants of health, map support networks, connect people to community services, and measure outreach and program effectiveness. If you're interested in installing Coordinated Care Management, talk to your Epic representative to discuss how these tools fit your needs.

## Address Social Determinants of Health

With EpicCare, clinicians, social service providers, and community partners can capture a person's social determinants of health – such as isolation, depression, food insecurity, and barriers to reliable transportation. Social determinants can also be submitted directly in MyChart. Users have easy access to this information in the Epic chart and can use it, combined with medical information, to inform the care and services they provide.

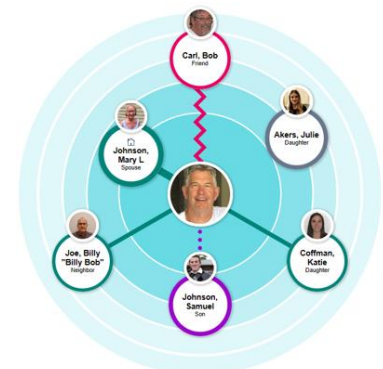
With Epic's Coordinated Care Management license, you can use social determinants of health history to drive decision support, risk stratification, and analytics. These tools help you target outreach and program enrollment to the most vulnerable in your population, leading to improved health outcomes and reduced costs through prevention.



## Engage Support Networks

Extend traditional family and emergency contacts to build a network that includes neighbors, friends, caretakers, coworkers, and other community partners.

This expanded network can help you identify and close gaps in social support. Engage those who can help a person stay healthy, make it to and from appointments, and adhere to their plans of care. You can track a person's complete support network as well as the specific people he relies on for a particular program he's enrolled in.



# Care Beyond the Clinic

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Keeping populations you serve healthy requires more than treatments and interventions in the clinic. With the features available with the Coordinated Care Management license, you can support whole-person care by connecting a person's care and service coordination teams with community resources.

## Coordinate Programs

With program management tools, you can organize and manage large-scale programs – like chronic care management and child welfare services – that benefit many different types of populations in your community. You can:

- Identify candidates for programs with decision support and reporting.
- Enroll program participants with referrals and applications, including a transparent application status visible in MyChart.
- Establish a program's targets and timelines in order to track the program's status relative to its goals.
- Track the services a person receives for each program he's enrolled in.
- Securely share a person's assessments and documents across multiple programs and provide confidential information specifically to program staff who need access.
- Manage staff workloads by visualizing program data like case load distribution by case manager and outstanding tasks by owner.
- Improve population health by enrolling consumers in structured programs, which include milestone tracking, integrated client plans, and actionable population reports with discrete, measurable outcomes.
- Providers bring care to people where they are with a mobile toolset for telehealth and home visits.

## Find Community Resources & Plan Coordinated Services

Access to an embedded Community Resource Directory helps users match and connect persons to the services they need, such as food pantries, transportation services, youth programs, community centers, and more. You can populate your directory by licensing resource catalogs to import from third-party vendors like Aunt Bertha and NowPow, available via the App Orchard. You can also self-manage and manually add resources to the directory.

Closed-loop referrals are supported with the Coordinated Care Management license and Healthy Planet Link. Your staff can recommend a local resource to a person, send care requests directly to community providers, and receive documentation from those providers that becomes part of the person's record.