

James L. Holly, M.D.

Medical Home - Coordination of Care

Convenience is the new word for Quality	2
Director of Care Coordination	2
Integration of Care	3
Quality of Care and Patient Safety	3
Continuity of Care	4
Care Coordination and Coordinated Care	4
<u>Coordination Review</u>	5
Care Coordination Referral	5
<u>Clinic and Hospital Follow-up and Care Coaching Call</u>	5
Electronic Tickler File	5
CMS's Report on SETMA's Coordination Effectiveness - Project Done by RTI International	5

Coordination of Care

[Link to a series of articles about Care Coordination](#)

Beyond wellness and preventive care, the heart of PC_MH is the coordination of care. The following gives details about SETMA's Care Coordination. One of the "catch phrases" to medical home is that the care is "coordinated." While this process traditionally has referred to scheduling, i.e., that visits to multiple providers with different areas of responsibility are "scheduled" on the same day for patient convenience, it has come to mean much more to SETMA. Because many of our patients are elderly and some have limited resources, the quality of care they receive very often depends upon this "coordination." It is hard for the frail elderly to make multiple trips to the clinic. It is impossible for those who live at a distance on limited resources to afford the fuel for multiple visits to the clinic. "Coordination" has come to mean to SETMA, scheduling which translates into:

1. Convenience for the patient which
2. Results in increased patient satisfaction which contributes to
3. The patient having confidence that the healthcare provider cares personally which
4. Increases the trust the patient has in the provider, all of which,
5. Increases compliance in obtaining healthcare services recommended which,
6. Promotes cost savings in travel, time and expense of care which
7. Results in increased patient safety and quality of care.

Convenience is the new word for Quality

HIMSS 2012: Leaders and Innovators Breakfast Meeting

As with the structure of quality metrics in tracking, auditing, analyzing and public reporting process and outcomes measures, coordination requires intentional efforts to identify opportunities to:

- Schedule visits with multiple providers on the same day, based on auditing the schedule for the next 30-60 days to see when a patient is scheduled with multiple providers and then to determine if it is medically feasible to coordinate those visits on the same day.
- Schedule multiple procedures, based on auditing of referrals and/or based on auditing the schedule for the next 30-60 days to see when a patient is scheduled for multiple providers or tests, and then to determine if it is medically feasible to coordinate those visits on the same day.
- Scheduling procedures or other tests spontaneously on that same day when a patient is seen and a need is discovered.
- Recognizing when patients will benefit from case management, or disease management, or other ancillary services and working to resources those needs.
- Connecting patients who need help with medications or other health expenses to be connected with the resources to provide those needs such as The SETMA Foundation, or sources.

Time, energy, and expense are conserved with these efforts in addition to increasing compliance thus improving outcomes. In order to accomplish this and to gain the leverage, synergism and advantage of coordination, a system is necessary which brings us to a new position designed by SEMTA entitled, Director of Coordinated Care.

Director of Care Coordination (DCC)

The Director of Care Coordination is responsible for building a department of Care Coordination. In many ways this could be called the “Marcus Welby Department,” as it recognizes the value of each patient as an individual and has as its fundamental mission the meeting of their healthcare needs and helping them achieving the degree of health which each person has determined to have. The driving force is to make each patient feel as if they are SETMA’s ONLY patient, just like Dr. Welby.

Initially, the DCC will work as a department of one but will have others assigned to the department as the demands of the mission expand. The DCC will establish protocols and methods for facilitating the care of patients with: special needs, complex-care needs, disease management and case management needs.

An illustration of this new function will be that of a patient who is seen at SETMA's Wilson clinic on the West End of Beaumont. The provider determines that the patient needs an echocardiogram. The nurse will call the Care Coordination Department, which will determine if the patient can be sent to the Ultrasound Department immediately to have the test done that day. We believe that this will increase patient satisfaction as well as compliance which will improve the quality of care the patient will receive.

Integration of Care

The medical home sees the patient as a whole and not as a collection of isolated and disconnect disease processes. While this is not new and has always been the ideal of health care, it becomes a significant focus of the patient-centered medical home. Not only is the patient the major focus of the attention given, but all elements of the patient's needs are attended to and future needs are anticipated and addressed. No longer is a patient encounter simply used to address current needs but potential future needs are identified and addressed. For instance, the young person who is seen for an upper respiratory condition but who is moderately obese, and who has a family history of diabetes, has his disease-risk addressed. In addition, recommendations are made for diabetes prevention and wellness including exercise, weight reduction, avoiding tobacco and others. Future contacts are scheduled, with or without a clinic visit, for assessing whether the patient has made the changes necessary to maintain their health.

Furthermore, through NextMD, SETMA's secure web portal, the patient is referred to education material for achieving the desired results and a follow-up contact via e-mail is scheduled to remind the patient, without a clinic visit and without cost, to pay attention to their health.

Quality of Care and Patient Safety

A medical home measures the quality of care which patients are receiving both through process analysis and outcomes measurement through quality metrics. Quality Improvement Initiatives are planned for the improvement of care across an entire population of patients. For instance, while it is anticipated that the new Director of Coordination of Care will result in improved care, that must be measured and analyzed before it will become obvious that the anticipated improvement has occurred.

As the Director of Care Coordination works with SETMA's Call-Center staff to address preventive health needs of our patients, it will be important to see if more people are getting their mammograms, bone densities, immunizations, etc. If they are, then the position will have proved value. If they aren't then new ways will have to be used to improve those outcomes. If the DCC is responsible for scheduling multiple visits or studies on the same day, it will be necessary to measure whether or not that has improved compliance and consequently quality of care. If the DCC is responsible for evaluating whether the post-hospital follow-up call program and the post-clinic-visit follow-up call program is having the desired result, it will be necessary

to measure those outcomes. If the desired result does not occur new or additional initiatives will have to be designed.

Continuity of Care

To be a medical home, a practice must provide communication with a personal physician who accepts primary responsibility for the patient's care. This is more than a friendly affect when the patient is seen in the clinic. It means answering inquires about health from the patient at times other than when they are seen in the clinic. It means providing telephone access with same-day response; e-mail contact through a secure web portal with same day access; it mean eliminating a patient's anxiety about whether or not their healthcare provider cares about them by the provider being available to the patient. It may mean in some cases that the patient has the provider's home telephone number or cell phone number. It means doing whatever is necessary for making sure the patient knows how to access care when it is needed. The reality is that the more confident a patient is that they can reach their provider when needed; the less likely the patient is to pester the provider over trivial or unimportant matters.

Continuity of care in the modern electronic age means not only personal contact but it means the availability of the patient's record at every point-of-care. One of the AAAHC surveyors said that his standard for judging medical records is, "Could I pick up this chart and provider excellent care for a patient whom I had never seen?" His answer after reviewing dozens of SETMA charts is, "I could easily treat any of these patients as the records are legible, complete and well organized." Because all of the patient's health needs are clearly documented; because all preventive and screening health needs are constantly and automatically audited; because every patient's laboratory results, medications and diagnoses are interactive; every patient can be confident that all of their health needs are being addressed, can be addressed and will be addressed, no matter who the provider is that they see.

Another issue of continuity of care is communication among all providers and institutions that are providing care for each patient. The Health Information Exchange which SETMA is launching will provide the confidence that care given by hospitals, emergency rooms, specialists, other primary care providers, etc., will be accessible to all providers and will be integrated into the patient's health record. In addition the secure web portal, NextMD, will allow the patient to maintain and periodically review their own personal health record. This places the patient at the center of their healthcare decision-making process, which is the ideal of patient-centered medical home.

- **Care Coordination and Coordinated Care**

These are the elements of the process of care coordination and when fulfilled, they should result in coordinated care. The outcomes of care should be improved and excellent care should be the result of all who are part of a Patient-Centered Medical Home.

- [**SETMA's Department of Care Coordination: History, Development and Functions**](#)

The twelve functions of the Care Coordination Department are described

- [**Medical-Home-Coordination-Review-Tutorial**](#)

This function allows the aggregation of data required for the coordination of patient care including care givers, barriers to care, quality metrics including HEDIS, NQF and others,. This review is done by the provider and his/her staff.

- [**Patient-Document-for-Coordination-of-Care**](#)

When the Coordination Review has been completed, a document is completed which is given to the patient so that the patient knows the status of their care coordination. This is an important aspect of patient activation, engagement and shared decision making.

- [**Department-of-Care-Coordination-Director-of-Care-Coordination-and-Care-Coordination-Referral-Template**](#)

This describes the functions of the care coordination department and the function of the ability of providers to send referrals to the department for home health, adult and child protective services, financial assistance and other special needs.

- [**Using The Clinic and Hospital Follow-up Call Templates**](#)

A significant part of care coordination and care transition is enhanced communications with the patient. This includes follow-up calls from the clinic when appropriate and follow-up, care-coaching calls to all patients who are discharged from the hospital.

- [**Electronic Tickler File Tutorial**](#)

Healthcare providers need a method for effectively following-up on care needed by patients. This tool allows an electronic reminder to be created so that the provider and the clinic staff can make certain that scheduled care was done whether it is three months or three years later.

- [**CMS's Report on SETMA's Coordination Effectiveness on Fee-for-service Medicare Patients 2008, 2009, 2010**](#)

CMS contracted with RTI International to study 312 Medical Homes benchmarked against 312 non-coordinated practices for quality, coordination and cost. SETMA's result is posted here.