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Care Coordination

Generic information given to the patient, which is not personalized and/or which does not contain the patient's personal health information will usually be ignored. But, when the patient is given educational materials or instructions with their name on it and with their data in it, they will pour over it. This is why the structure of "care coordination" requires that the information given to a patient have the patient's name on it and that it includes the patient's personal information. One of the most teachable moments in medicine occurs when the patient returns to a follow-up visit, and with the previously given "plan of care' and "treatment plan" in hand, declares, "This information is wrong!" At this point, the patient is engaged and ready to learn. This statement does not glorify error, if error exists, but it does focus on the value of patient realization that their “reality” appears to them to be unreal.

The more important information is, the more probable it is that a person will forget that information, remember it incompletely, or be confused by it. This is particularly the case when the information is complex, containing unfamiliar terms and spoken to the patient only once and briefly.

It is at this "transitions of care" - when the patient leaves the point of care, which most often is the healthcare provider's office-- where "care coordination" is most critical. As a result, a poster now appears in all of SETMA's examination rooms and in strategic points around the clinic. It is called "The Baton," and it illustrates the necessity for the healthcare provider to "hand off" "the baton" to the next member of the team - the patient -- who is to carry the team's plans and purposes to the goal - improved or sustained health.

The following appears on the "Baton" poster:

"The baton" is a metaphor for the "plan of care' and a "treatment plan" which informs and empowers the patient to assume responsibility for his/her own care. In this context, the term "grasp" is apt, as the word refers both to physical and mental acts. The patient must not only receive "the baton' in the hand physically (grasp it), but must also comprehend the content of the "baton" mentally - "lay hold of it with the mind." If the patient "grasps" - understands, comprehends -- the "plan of care" and the "treatment plan," i.e., "the baton," and if the patient accepts - agrees to it and determines to carry it out -- the "patient/provider complex" is formed, completing the team and maximizing the opportunity for the team's success.

The patient/provider complex" is the essential element of success for effective healthcare action to be taken; particularly in the ambulatory setting. Without the formation of this element, at best the process will be incomplete and the outcome will only be partially successful. The "baton" is the key "care coordination" document which is the core of "care transitions."

Medical Home Transitions of Care: One Form of Care Coordination

- Transition of Care - One form of Care Coordination
    - Care Transitions - the Heart of PC-MH
    - Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan
    - Changing the name to clarify the function
    - Medical Home Plan of Care and Treatment Plan
    - Passing the Baton
    - Summary of Care Transitions
    - Care Transitions Data Set from PCPI
    - Transitions of Care Management Codling
    - Transitions of Care To Reduce Preventable Readmissions
    - Improving SETMA Care Transitions and Care Coordination

Coordination is the process of continuity of care. In the case of all documents created in the care of a patient, whether:

- Ambulatory disease management plan of care or treatment plan: Medical Home Plan of Care and Treatment Plan

- Automated Team Patient Engagement and Activation Document: Patient Engagement and Activation -- Patient Engagement and Activation Document

- Ambulatory care summary of care document

- Hospital Admission Plan of Care and Treatment Plan, what was once called the "discharge summary": Hospital Admission Plan of Care

- Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan: An Example of SETMA's Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan. (De-identified)

Transforming Your Practice - Care Coordination

- A Care System for Effecting Reductions in Preventable Readmission Rates

  April, 2012 - Includes 15 links to other, related materials; 13 methods for reducing readmissions; The Baton; Lesions to Date.

- SETMA's Care Coordination Department's Functions

  At its founding in 2010, the Department had five functions. The following are a list of 12 "duties" performed by the Care Coordination Department at the beginning of 2013. Keep in mind that the Department's staff encounters many patient needs which are dealt with as they arise. These needs do not always fall into one of the following categories.

- SETMA's Care Coordination and Transitions of Care: Part I

  SETMA's work in coordinating care between inpatient hospital care, outpatient ambulatory, clinic care, long-term residential care, and SETMA's care coordination department activities.

- Patient-Centered Medical Home - Care Coordination and Coordinated Care

  January, 2011 - Traditional Care Coordination and its Seven Deficients.

- Medical Home Series Two: Part VII Care Coordination

  August, 2011 - Collaboration, Convenience, Comprehensiveness, Connection, Communication, Continuity, Integration of Care

- Medical Home Series Two: Part XII - National Quality Forum and Care Coordination

  The NQF states, "...the average Medicare patient sees two primary care physicians and five specialists a year...patients with multiple chronic conditions may see up to 16 physicians a year. For one-third of patients, the assigned primary physician changes yearly...clinicians are unaware of a patient's history. The challenge of coordinating basic information ...test results, allergies, prescription medications diagnosis...is extreme."

- Medical Home Series Two: Part XIII - National Quality Forum and Care Coordination Part II

  The "feedback loop" includes communication but communication with an open dialogue between the provider, the healthcare team, the patient and their family. A "dialogue" is by definition "a discussion." Often in human relationships people carry on two simultaneous monologues without ever really communicating. Perhaps no human enterprise has been more filled with monologues than healthcare. However, when both provider and patient are listening to one another with respect and interest, it is possible to create understanding and in the case where a healthcare action has to result from the conversation, a plan of care can result.

- SETMA's Inpatient Team Based Process Analysis: The Interaction of SETMA's Hospital Care Team - Collegiality and "Electronic Huddles"

  January, 2013 -- It is for this reason that SETMA has come to believe that while a personal relationship with a healthcare provider is valuable, ultimately the ideal of continuity-of-care is maintained by the EHR being available at every point-of-care and that the care at all points of care is documented in the same data base. The personal relationship is important to provider and patient, but patient safety and the goals of the Triple Aim (improved processes, improved outcomes and sustainability or lower cost) are supported more by the common data base than by the personality of the provider.

- Medical Home Part IV: Help and Hope in Healthcare

  March 12, 2009 -- The most innovative aspect of Medical Home and the thing which perhaps distinguishes it from any other well-organized and highly-functioning medical organization is the concept of Coordination of Care. This is the intentional structuring, reviewing, facilitating and practicing of a standard of care which meets all current

NCQA, CMS, national standards and HEDIS requirements for demonstration of excellence in the providing of care.

- From Homicidal Threat to Reciprocal Caring: A Patient-Centered Journey

  October 6, 2012 -- It was October 13, 2009. The morning was cold and raining - well, not really, but isn't that the way every story should start? When I arrived at the hospital early in the morning, I had a number of patients to see. On the South Tower, I was met by several nurses, who said, "You can't go into room_____." I asked why and they added because the patient said that he will kill the next doctor who comes into the room. I asked, "Does he have a gun?" They did not think so. I said, "Then let's go see him."

- Medical Home Part III: Requirement Number 1 of 28

  The most innovative aspect of Medical Home and the thing which perhaps distinguishes it from any other well-organized and well-functioning medical organization is the concept of "Coordination of Care." This is the intentional structuring, reviewing, facilitating and consistently practicing of a level of care which meets all current NCQA, CMS, national standards and HEDIS requirements for the demonstration of excellence. There are nine links at the bottom of this article.