

## James L. Holly, M.D.

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

By James L. Holly, MD

Your Life Your Health

*The Examiner*

January 20, 2011

Perhaps the most complicated and in some ways confusing element of Patient-Centered Medical Home<sup>R</sup> (Registered Trademark of NCQA, PC-MH)) is the concept of “care coordination.” In order to produce *coordinated care* (an outcome of care), it is important to define and describe *care coordination* (a process of care). The following two definitions of “*coordination*” are drawn from a medical dictionary and from a general dictionary:

- “the harmonious functioning of parts (as muscle and nerves) for most effective function.”
- “the act of coordinating, making different people or things work together for a goal or effect; the resulting state of working together; cooperation; synchronization; the ability to coordinate one's senses and physical movements in order to act skillfully.”

As we explore medical home, we discover that the use of these words as *jargon*, which is defined as:

“The language used by people who work in a particular area or who have a common interest. Much like slang, it can develop as a kind of short-hand, to express ideas that are frequently discussed between members of a group, though it can also be developed deliberately using chosen terms. A standard term may be given a more precise or unique usage among practitioners of a field. In many cases this causes a barrier to communication with those not familiar with the language of the field.”

In regard to medical home, “*coordinated*” and “*coordination*” are used to mean more than they do in general medical or in general popular usage, therefore they are *jargon*, and to be understood they must be described. Without this description, which is different from a definition, we will not understand what “*coordinated care*” is. We will not know what we are trying to achieve and we will not know if we have achieved it, if we should.

### The History of Care Coordination

The more we understand about Care Coordination, the more it is apparent that in medicine, care has always been coordinated. The questions are, “How effectively has it been done?” and if it has not been done effectively, “How must it be done to be effective?” Traditionally, Care Coordination has consisted of three statements. The healthcare provider tells the patient:

1. “I have called your medicines to your pharmacy,” or “Here are your prescriptions.”

2. "Please make an appointment for ten days."
3. If you get worse, call me.

This was essentially the total content of the provider's "plan of care" and "treatment plan," which are the elements of care coordination. Their inadequacy is obvious. In this analysis of care coordination at the time of a patient's visit to the healthcare provider, we can identify at least seven deficiencies.

### **Deficiency One: Structural.**

To be adequate, the "plan of care" and "treatment plan" must be written down; it must be personalized, not only with the patient's name, but with the patient's medical data. It must be given to the patient at the point of care and it must be complete.

Other than prescriptions, nothing is written down in the traditional care coordination, at least anything which is given to the patient. Even the prescriptions are not written for the patient. The intent of PC-MH requires that the "plan of care" and "treatment plan" be written and it must contain not only the treatment instructions but also:

1. The diagnostic assessment.
2. The goals of therapy.
3. The patient's risk stratification
4. An assessment of where the patient is in progress toward the goal.
5. How the patient can and should care for himself.
6. What complications the patient should be alert for and what to do if one or more occurs.
7. Time, date, place and provider with whom the follow-up appointment is scheduled.
8. Results and interpretation of the most recent laboratory values and/or other tests.

**Key Point:** 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.

### **Deficiency Two: Functional**

There are 8,760 hours in the year. If a patient receives significant healthcare in a given year, he/she may be in the healthcare provider's office twelve times. Even if the visits are sixty-minute, extended visits, and they seldom are, the patient is still "in charge" of their own health for 8,748 hours that year.

For the patient's healthcare team to "win" the "race to health," the dominant member of that team – the one in charge of the patient's care for the overwhelming majority of time, which is the patient -- must be equipped to assume responsibility for their own care. Even if it is argued by the provider that, "I told all of that to the patient," we are all aware of the recall anyone has of complex, unfamiliar matters, when the only "teaching and learning method" is auditory.

**Key Point:** 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:

**Firmly in the providers hand**  
**--The baton – the care and treatment plan**  
**Must be confidently and securely grasped by the**  
**patient, If change is to make a difference**  
**8,760 hours a**  
**year.**

"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.

**Key Point:** 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.

## **Deficiency Three: Cultural**

In a simpler time, everyone spoke the same language, or received care within their own community, where everyone had similar mores, values and even similar religious beliefs. The three-sentence “plan of care” with which we started this discussion makes certain assumptions, which may or may not be true. Most healthcare providers in the United States speak a single language and often the prejudice is, “If you don’t speak my language, learn it.” The standards of PC-MH, however, require that the provider assume responsibility for making certain that the patient “grasps” – comprehends and understands and is able to carry out -- the “plan of care” both from a linguistic and a literacy standpoint.

PC-MH does not require that the provider speak multiple languages but that he/she is aware that the patient’s primary or only language is different from English, and/or that the patient cannot read written instructions, or comprehend spoken ones. Later, we will discuss the Department of Care Coordination to which such needs should be referred.

**Key Point:** When the cultural issue is literacy, it is more important to increase the patient’s knowledge than it is to attempt to provide care with the knowledge they already for. Respect for the important of our patient’s to the provider/patient complex requires that we believe, that in most instances, the patient is able to learn everything they need to know in order to participate effectively in their own care. However, that learning will only result when the patient is given the information in a language they understand and in a format they comprehend.

## **Deficiency Four: Social**

As the family structure in our society has deteriorated, more and more of the task which once were fulfilled by the family unit is now being assumed by the society which most often means the government. Whether this is right or wrong is not the intent of this discussion. The intent is for the provider to recognize that no matter how accurate his/her diagnosis, no matter how excellent his/her “plan of care” and “treatment plan” is, if the patient is unable to access or acquire that care, the best care available anywhere has done the patient no good.

It is imperative for the provider to know whether the patient lives alone and/or has a social structure for support in obtaining healthcare and for carrying out the “plan of care” and “treatment plan.” One of the most valuable ICD-9 codes – the system whereby providers document the patient’s diagnosis -- in a geriatric practice is described as, “Social – Lives Alone.” Many “transition of care” issues are seriously impacted by this one piece of information. Both the cost of care and the effectiveness of care will be affected by not knowing this one thing.

When trying to control the blood pressure or blood sugar of an elderly lady, it is impossible

unless you know that a grandson, who is on drugs, lives with the patient and adds enormous stress to the patient's "golden years." Whether a person lives in social isolation, or in a nurturing social environment is critical to the plan of care and treatment plan.

**Key Point:** The involvement of social agencies, home care agencies and/or protective services is important to the care of vulnerable populations whether young or old. Attempting to coordinate care without social information is impossible.

### **Deficiency Five: Financial**

The "plan of care" and "treatment plan" must include documentation as to whether or not the patient has financial barriers to their carrying out the plan. If a patient cannot purchase medications, the prescriptions will do them no good. If a patient attempts to "stretch" their medications to make them last until their next pay check by taking a reduced dose, or decreasing the frequency of medication, the prescription does them no good.

Care Coordination will not only include an assessment of financial barriers to care but will also include an attempt to help the patient obtain the care they require. This may be done by social agencies, pharmaceutical-assistance programs, or it may be done by the medical practice forming a Foundation through which resources can be obtained. Whatever the method, and there will probably be multiple ones, the medical home will help the patient obtain their care if they are unable to do it for themselves.

**Key Point:** The assessment of the patient's ability to obtain care is as important as an accurate diagnosis and treatment.

### **Deficiency Six: Integration of Care**

The simple "plan of care" and "treatment plan" which was traditional did nothing to determine what other care the patient needed. A thorough plan of care must take into account other care required by the patient and whether the patient has the transportation and ability to receive that care. It must also account for whether the care given at point A could or does interfere with or interact with the care the patient will receive at point B. Integration of care means that laboratory results required by multiple providers will be available either through a health information exchange, or through someone taking responsibility for making that information available to all providers. What cannot happen is that the patient is given multiple appointments at the same time, or in a time-frame where one appointment overlaps with another.

The patient's convenience should be considered, particularly when they live at some distance from the point-of-care. For instance, this writer attended an appointment with a friend at a world-famous facility. The travel time was significant and the family wanted the patient, who was ill and ill-equipped to travel frequently, to return four days in a row for

four different appointments. Appeal was made and when the appeal was resisted, pressure was applied to do all appointments in that one trip. When the accommodation was made, it was shocking that the duration of three of the appointments were 90 seconds for one, 55 seconds for the second and three minutes for the third. The facility wanted the patient to travel a total of twelve hours for visits lasting a total of 325 seconds.

**Key Point:** The patient's convenience is not the most important consideration but it is not to be ignored either. Often, when a complicated treatment plan is prescribed, the patient will not complain but will decide what he/she will do and what he/she will not do. We can improve compliance by integrating care.

### **Deficiency Seven: Preventive and Screening Care**

Our traditional three-part plan of care and treatment plan also is deficient in that it does not overtly address the patient's preventive health and disease screening needs. At a time when the healthcare debate is about extending excellent healthcare to all Americans, a movement has arisen and is being embraced by many where only the wealthy are promised excellent care. This movement is called "concierge" medicine. Patients pay the doctor an annual fee which ranges between \$1,500 and \$3,000, for which the patient is guaranteed same-day-access to their provider, preventive health care and screening health test and a personalized wellness assessment and plan. All of these are a part of a medical-home treatment plan. At every visit to the medical home, the patient's preventive health status and their screening health needs should be assessed and should be reported to the patient in their "baton," their plan of care and treatment plan. This should be done without extra cost to the patient such as that required by the "concierge" practice model.

### **Summary**

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.