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Medical Home Series 2 Part XII National Quality Forum and Care Coordination
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As SETMA continues to grow as a patient-centered Medical Home, we continue to think about the concepts associated with "Care Coordination," which is a process and "Coordinated Care," which is an outcome, or, stated a different way, which is the result of "Care Coordination." Since 2009, we have published a number of articles about *Care Coordination*. These can be found by going to www.jameslhollymd.com and accessing *Your Life Your Health* and clicking on the icon entitled *Care Coordination*. There you will find the following articles and their dates of publication:

- A New Day in Healthcare for You and For Us - Part VI - Meaningful Use September 23, 2010
- Care Transitions: The Heart of Patient-Centered Medical Home May 24, 2011
- Medical Home - Series Two: Part VII Care Coordination August 18, 2011
- Medical Home Part III: Requirement Number 1 of 28 March 03, 2009
- Medical Home Part IV: Help and Hope in Healthcare March 12, 2009
- Patient-Centered Medical Home - Care Coordination and Coordinated Care January 20, 2011

A related set of articles specifically addressing *Transitions of Care* which is directly relate to *Care Coordination*. The *Transitions of Care* articles can be found by going to www.jameslhollymd.com and accessing *Your Life Your Health* and clicking on the icon entitled *Care Transitions*.

- Concierge Medicine and the Future of Healthcare January 27, 2011
- Medical Home - Series Two: Part VI Care Transitions August 11, 2011
- Passing the Baton: Effective Transitions in Healthcare Delivery March 12, 2010
- Patient-Centered Medical Home and Care Transitions: Part I April 21, 2011
- Patient-Centered Medical Home and Care Transitions: Part II April 28, 2011
- Reducing Preventable Readmissions to the Hospital March 31, 2011
- SETMA and the National Quality Forum November 11, 2010
- The Future of Healthcare - SETMA's View October 14, 2010
- **The Baton** - this is the pictorial representation of the patient's plan of care and treatment plan March 12, 2010
- HIMSS Quality 101 Care Transitions
- NQF's Transition of Care Conference in Washington, DC - Summary of Comments September 2, 2010

SETMA's understanding of both the process and the outcome of coordinating patient care was recently expanded by the review of two documents published by the National Quality Forum (NQF). The NQF is described in the November 11, 2010 article entitled "SETMA and the National Quality Forum," referenced above. The NQF publications are:

1. NQF Quality Connections, Care Coordination, October, 2010
2. Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report, NQF, 2010.

The Problem

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."

"The Problem" is magnified when patient care is documented by paper, in the worse case handwritten illegibly, and in the best case transcribed, which while it is legible, it is made up of isolated, unconnected instances of care which are not interactive with one another. Furthermore, these records, like hospital, home health, hospice, physical therapy, pharmacy and other patient-care records are "geographically bound." They are located in one place and when that place is not available, the patient information is not available.

One solution to "The Problem" is electronic records, which are legible, can be made available at multiple locations simultaneously, can always be available, and which can be interactive. But, the potential benefits which are available through electronic records are often not realized because the electronic record is not connected to points-of-care other than the provider's office. In addition, one electronic solution, which is used by one provider, is not interoperable with another electronic solution used by another provider, who sees the same patient. Both providers use electronic records but neither electronic record can communicate with the other, thus recreating the same dysfunction which paper records had. And, worse yet, the electronic record used by one provider is not available to that provider at any points-of-care other than his/her office. Thus, the same provider creates different records for the same patient in different locations, thus accentuating "The Problem" while using electronic records.

Electronic Solutions for "The Problem"

There are three major opportunities for solving "The Problem" with electronic records. The most obvious benefit comes when a patient is seen at every point-of-care utilizing the same electronic record. This was the ideal which led SETMA to make the electronic health record which we use available in the clinic, hospital, emergency department, nursing home, hospice, home health, physical therapy, provider's home and at ALL points-of-care. Not only is a patient's health record available at the clinic where the patient routinely gets care, their

healthcare is available at all SETMA clinics. When the patient's care is documented in the same electronic record at all points-of-care the problems of medication reconciliation, care transitions, data aggregation, screening and preventive care measures and health record reconciliation problems are all decreased tremendously. It is one thing to have problems with multiple providers communicating with each other; it is a more fundamental problem when a single provider has difficulty communicating with his/her own self at different points-of-care.

The next level of solving "The Problem" is when electronic communication is possible between the patient and his/her primary care provider. This is most efficiently done through a secure web portal. 'Secure" means that the information transmitted electronically is protected by passwords and "fire walls," which prevent confidential and sensitive health information from being accessed by those who have no right nor need to see that information. "Web portal" means that there is a website which the patient can access to:

- Review medications, tests, procedures and other healthcare information.
- Communicate with their healthcare provider to ask questions or to give the provider updated health information.
- Maintain their own personal health record which empowers the patient to know their health record and to coordinate what is in that record.
- Anticipate a visit for routine or acute healthcare by completing part of their clinic visit prior to arriving at their provider's office. This allows a thoughtful, thorough record to be given to the provider which can be made a part of the patient's permanent record. Most people can read faster than another person can talk which means that a record is now accurate, complete and in the patient's voice.
- An electronic, reusable record of the patient's care can be available to the patient routinely.

SETMA has deployed solution to the web portal name NextMD. It allows SETMA providers to communicate with patients in a HIPPA compliant method and allows patients to actively participate in their own care. If you are a SETMA patient, use a computer and have not signed up for the NextMD program, call our office and ask for directions.

The third level of connectivity which promotes coordination of care through electronics is a Health Information Exchange (HIE). An HIE is simply an electronic method where multiple healthcare providers - hospitals, home health, physical therapy, pharmacies, nursing homes, healthcare providers - who give care to the same patient, can overcome the barriers discussed above. A community-wide and particularly a region-wide HIE provides great safety to patients. When all pharmacies are reporting to a common HIE, there is decreased danger of a patient being on conflicting medications and in the instance when a patient becomes dependent upon medications and begins to take more than they should, it will be instantly known to all provides who are caring for that patient. The HIE provides opportunity for:

- All care given to a single patient by multiple providers to be available to all care givers.
- A common medication list which is updated by all providers so that medication errors and conflicts can be reduced and eventually eliminated.

- All providers giving care to a patient has the patient's history remote and recent available at the point-of-care.
- Repetition of care is eliminated because all care becomes transparent to all care givers eliminating the need for repetition of tests due to either it not being know that the test was done or the results not being available This is particularly valuable between hospitals and their emergency departments. If a patient is seen at one emergency room one night and has a CT of the brain and is seen at another emergency room a few night's later, with no change in condition, the CT results is available and repeating the tests can often be avoided.

With an HIE in place all of the elements of "The Problem" identified by the NQF above are solved. While it is still ideal that the same provider sees a patient regularly, electronic health records connected to a secure web portal and an HIE goes a long way to increasing patient-care safety and continuity. The NQF Quality Connections report, addressing "The Problem" concluded, "The resultant lack of commutation among providers often means that critically important information is never conveyed, or is lost or ignored, to the patient's detriment." Electronic health records, used by a provider at all points-of-care of a patient connected with a secure web portal and an HIE eliminates this potential danger.

SETMA has solved this area of care coordination through the Southeast Texas Health Information Exchange (SETHIE). SETHIE is already functioning with Baptist Hospital and in the next few months, it is hoped that it will expand to other area hospitals and to other healthcare providers. Once it is completely in place, SETHIE will provide care coordination at the highest standard with any healthcare system in the nation.

Care Transitions - Plan of Care and Treatment Plan

Care Transitions is a major part of Care Coordination and when it is absence, "The Problem" is accentuated. NQF said, "Even for patients without chronic conditions, the transfer of care responsibility from one clinician to another - the "hand off" - is rife with error. Follow-up care for patients discharged from an acute care hospital, or sent home from a practitioner's clinic after a diagnosis also presents a problem area, when patients are not fully instructed on what they should eat or avoid eating (and when), what medications they should take, or when to return to visit the clinician."

As "The Problem" is solved by effectively using electronic records at all points-of-care, coupled with a web portal and HIE, this element of "The Problem" is addressed by a personalized, written "Plan of Care and Treatment Plan" which is give to the patient at each point-of-care. For those patients who are computer literate, this "hand off" can be made via the web portal but for those who do not have access to the use of, or the knowledge of the use of computers, this will have to be done by a printed plan of care and treatment plan.

The plan of care and treatment plan must identify:

- The patient's current condition
- Specifics of that condition - history, physical, test results, procedure results, etc.
- Goals of care
- Where the patient is in progress toward that goal.
- What changes the patient should make in order to pursue those goals.
- A medication list with names, dosages and instructions for taking medications which are to be continued and the names of medications which are to be stopped.

The NQF makes the following comment about the plan of care: "A critical construct of coordinated care is the 'plan of care' - the written plan that anticipates routine needs and tracks progress toward a patient's goals. A proactive plan of care that emphasizes self-management, goals and support should serves as a central care coordinating mechanism for all patients, families and care team members...the plan of care becomes an important guidepost between clinician-driven care and patient self-management. The plan of care is...vital during handoffs and transition of care, because it can serve as the main communication document between clinicians and care settings and outline elements such as the medication list, follow-up steps, identification of care problem and resources for nonclinical care."

SETMA's plans of care and treatment plans include these elements and more. As we learn, this part of our care coordination will improve, also.