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Medical Home – Series Two Part VII Care Coordination
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One of the "catch phrases" in 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 "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.

As with most issues of quality care in the 21st Century, a **process** has an **outcome** and a metric may measure one or the other. **Coordination of Care** is the process an organization goes through to assure that patients receive the care they need and **Coordinated Care** is the outcome, i.e., the experience and perception the patient has when the care has been organized for continuity, for convenience and for compliance.

The Agency for Healthcare Research and Quality (AHRQ) of Health and Human Services (HHS) published the following definition of Care Coordination:

"Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."

Care Coordination involves the following six elements:

1. Collaboration
2. Convenience
3. Comprehensiveness
4. Connection
5. Communication and Continuity

1. **Collaboration**

   No longer is the patient the passive recipient of the instructions and care of the healthcare provider; the patient is now an active part of their own healthcare team. Communication in the medical home is not a monologue by the provider to the patient but it is a dialogue (see below). It is a dialogue where the provider recognizes and

acknowledges that the "healthcare race is the patient's to run," and that what they need is not a coach that tells them what to do but a team mate with whom plans and activities can be and are discussed.

The physician, as a constable, imposing care upon and coercing change by the patient, is no longer an acceptable model of care. The physician as a collaborator, as a colleague and as a consultant to the patient is the medical-home model. This is the patient-centeredness of medical home. Not only is the welfare of the patient central but the participation and personal responsibility of the patent is central to medical-home care. The patient accepts responsibility for his/her own health and works with the healthcare team to establish a plan of care and a treatment plan which the patient is prepared to carry out and which the patient is capable of carrying out. This is medical-home care.

2. **Convenience**

Initially, the idea of convenience in the scheduling of appointments, particularly multiple appointments, was the extent of SETMA's understanding of this element of coordination. Eventually, "convenience" was translated into the understanding that coordinated care means more than just making patients comfortable; it meant and it resulted in:

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.

This 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 provide the resources for those needs.

Convenience is a process not an outcome of coordination of care.

3. **Comprehensiveness**

The Coordination of Care in the medical home is not only collaborative and convenient, it is comprehensive. The medical home does not simply coordinate the primary care needs; it coordinates all of the care the patient receives. This includes evaluating the care recommendations of other providers. Those recommendations are not only evaluated as to whether everything is done which should be done, but also to determine whether what is recommended should even be done. Often, the safety of a patient can be compromised by the recommendation of care which is inappropriate, unnecessary or excessive. These are all parts of the medical-home paradigm.

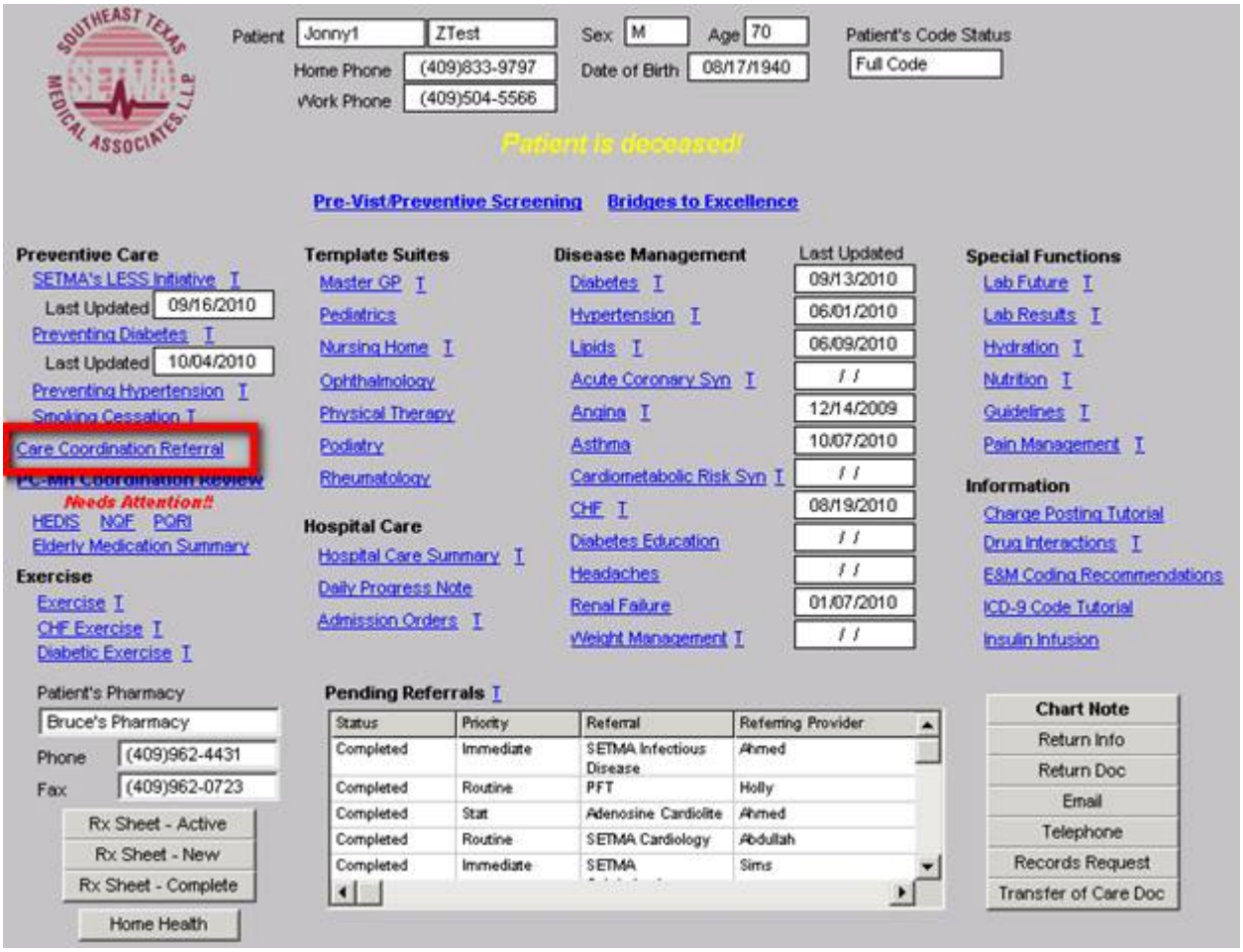
The inclusion of evaluations, assessments, testing and procedures from all points of care contributes to the comprehensiveness of the patient's electronic health record. For instance, at SETMA, laboratory results from a hospital stay are entered into the patient's ambulatory record. Those results interact with SETMA's disease management tools and with all quality metrics. This eliminates duplication of testing and continuity of care, both of which promote the cost effectiveness of care.

Care at other clinics is integrated into the medical-home patient's cumulative medical record. Diagnoses established elsewhere are display in the patient's chronic problem list and become an active part of the patient's follow-up care. Care recommended at another clinic is followed-up both for appropriateness and outcomes once the recommended care is completed. This eliminates the segmentation of the patient's care where one clinic only knows that part of the patient's health picture.

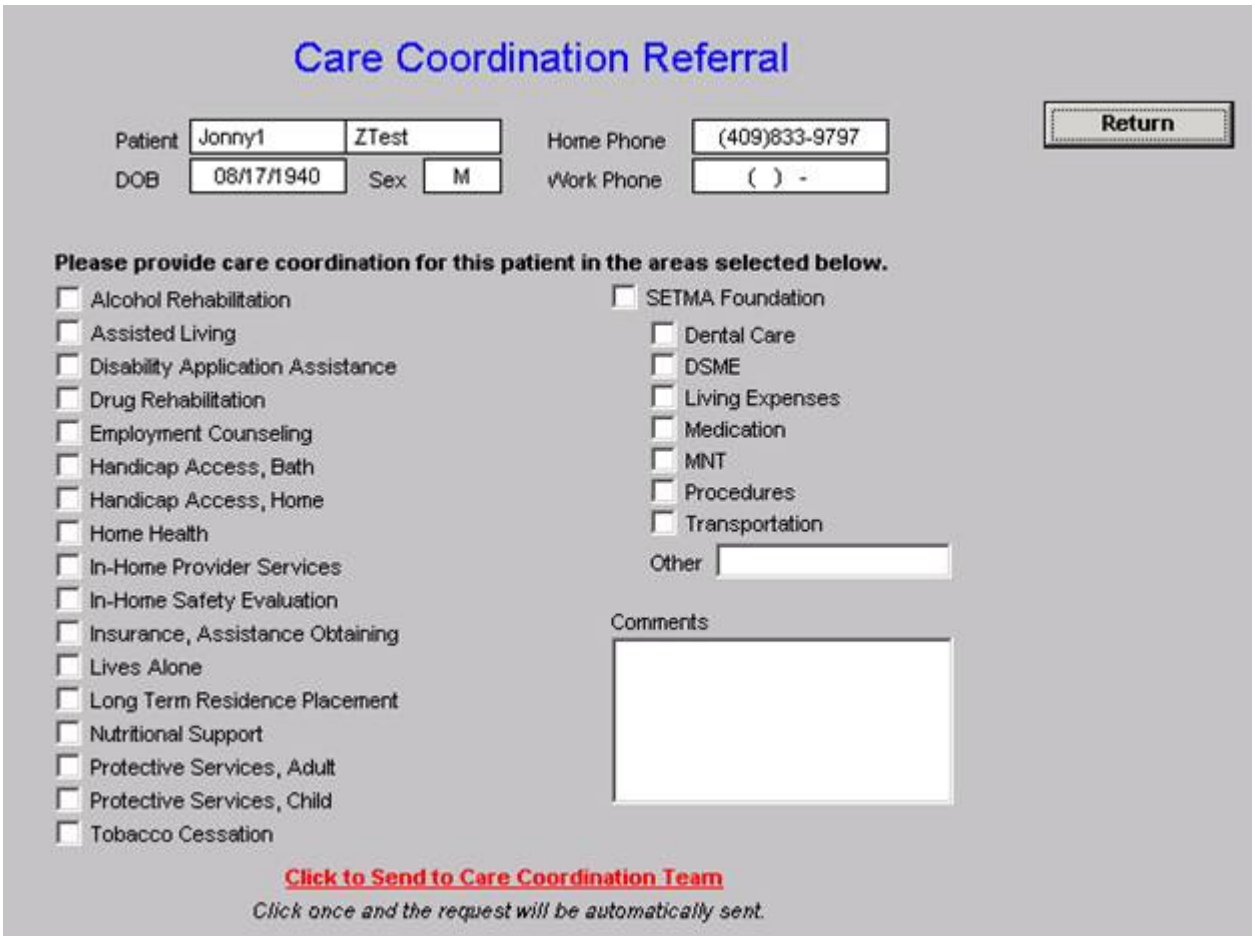
4. **Connection**

"Connections" has to do with providing or helping patients find the resources for the care needed. Patients who need help with medications or other health expenses are connected with the resources to meet those needs. In this way, Medical Home provides the healthcare professional with the opportunity to be more involved with the patient than ever before.

At SETMA not only are barriers to care evaluated, but a "care coordination referral" can be initiated by the provider. The Care Coordination Referral can be made by simply clicking the button in red on the template below:



This is the Care Coordination Referral template



This template allows the provider and/or nurse to send an e-mail to the Department of Care Coordination, which helps find resources for a patient's special needs. Several functions are included with this template:

1. If a provider completes three or more referrals in any given encounter, an e-mail is automatically sent to the Director to allow for the coordination of those referrals to increase convenience and compliance.
2. The first column allows for the provider to indicate the special needs which the patient has and which would or might benefit from a follow-up contact from the Care coordination team.
3. A comment box is present which allows for a description of a need not covered by those listed.
4. The second column allows for the provider to indicate that the patient has financial needs and the service for which that need exists.

Once the provider or nurse checks the needs which exist, the red button entitled "Click to Send to Care Coordination Team" is launched. The button will turn to green which indicates that the e-mail has been sent to the Director of Care Coordination.

5. **Communication and Continuity**

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 or a medical-home "team mate" being available to the patient twenty-four hours a day, seven days a week.

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 also means the availability of the patient's record at every point-of-care. During SETMA's on site survey by the Accreditation Association for Ambulatory Health Care, one surveyor 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 was, "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;
- all preventive and screening health needs are constantly and automatically audited;
- every patient's laboratory results, medications and diagnoses are interactive;

Every patent 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.

Coordination of care requires enhanced communication between the medical home and the patient. This communication can be initiated by the patient, the patient family, the patient care giver or the healthcare provider. Telephone calls initiated by the clinic to the patient following hospitalizations or complicated outpatient visits, allows for continuity of care, convenience of care and for assuring comprehensive care which is safe and appropriate. The availability of a web portal which allows a secure electronic connection between the patient, their record and their provider adds to the coordination of care through communication. This is further enhanced by a health information exchange so that communication between providers and points of care are seamless,

efficient and effective. The ability of the patient to review parts of their medical record and to recommend corrections or additions

Activities of SETMA's Care Coordination Department

Currently, these are the responsibilities of SETMA's Care Coordination Department:

- Follow-up calls on all patients discharged from the hospital
- Follow-up clinic calls as requested by the providers
- SETMA Foundation referrals
- Contact patients with 3 or more referrals
- Infectious disease reporting to the state
- Contact patients that no showed with Diabetes and Hypertension
- Meet with patients in the clinic as requested by providers to give immediate help with needed care.
- All complaints are directed to our office for resolution
- Development and deployment of effective patient satisfaction surveys

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.

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 and objective 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 our without a clinic visit, for assessing whether the patient has made the changes necessary to maintain their health.

The Medical Home intentionally fulfills the highest and best healthcare needs of all patients. In addition, the patient is involved in this coordination by making them aware of the standards of care and giving them a periodic review, in writing, of how their care is or is not meeting those standards. Patients are encouraged to know and to initiate the obtaining of preventive care on

their own. Perhaps the ultimate judge of the success of Medical Home is when healthcare providers hear the following from their patients, "I am here today for preventive healthcare." At that point, you know that the patient has taken charge of their own care which is the ideal of medical home.