Care Coordination

A Team Approach
Care Coordination

• A central component in many of the existing and emerging models of health care delivery

• It is key in both the

  \textit{Patient Centered Medical Home Model}

  \textit{Chronic Care Model}
Care Coordination: Defined

Care coordination is an ideal state that occurs when a patient specific care plan is implemented by a variety of providers/ programs in an organized way.

*Care Coordination: Integrating Health and Related Systems of Care for Children with Special Health Care Needs, Pediatrics Vol. 104 No. 4 Oct, 1999*
Care Coordination can involve:

– Planning treatment strategies
– Monitoring outcomes and resource use
– Coordinating visits with specialists
– Organizing care to avoid duplicative testing
– Sharing information among health care professionals and family
– Ongoing re-assessment and refinement of the care plan

Care Coordination: Goals

• Effective care coordination assists consumers and their support network to become engaged in a collaborative process to effectively manage their medical, social, and mental health conditions.

• The goal of care coordination is to help each individual achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

Improving the Quality and Cost Effectiveness of publicly Financed Care, Center for Health Care Strategies, Inc. 2007, www.chcs.org
COORDINATED CARE is a TEAM approach to care

It takes a team to meet complex patient needs in our complicated health care delivery system

Here are some of the things your team can expect:

• Great patient care
• Optimal outcomes
• Process improvement
• Patient satisfaction
• Positive work environment/ team satisfaction
What is a TEAM?

A team has 3-12 people

In an optimally functioning team

• Team members
  – share common goals
  – Share rewards
  – Share responsibility for goal achievement
  – Set aside individual needs for the greater good
Not all **TEAMS** are functioning at an optimal level
5 Dysfunctions of a Team

taken from Patrick Lencioni of The Table Group, Inc.
Each **TEAM** needs a **team leader**

Think outside the box when selecting a leader
An Effective Team Leader

• Focuses on team outcomes
• Confronts complex issues
• Forces clarity and closure
• Demands discussion and welcomes debate
• Is vulnerable

*taken from Patrick Lencioni of The Table Group, Inc.*
Why a team?

It takes a team to meet complex patient needs in our complicated health care delivery system

Here are some of the things your team can expect:

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Functional TEAMS

YouTube video

http://www.youtube.com/watch?v=WhcNLsSGApI&feature=related
It takes a village...

Excerpt from “Why Teamwork Will Make or Break Your Practice.”
Team Assessment Form
It will take a **TEAM**

to take your practice to the next level
Test Results or Medical Records Not Available at Time of Appointment, Among Sicker Adults

Percent reporting test results/records not available at time of appointment in past two years

<table>
<thead>
<tr>
<th>Country</th>
<th>2005</th>
<th>2007</th>
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<tbody>
<tr>
<td>United States</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>NETH</td>
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<td>12</td>
</tr>
<tr>
<td>GER</td>
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<td>17</td>
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<tr>
<td>AUS</td>
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<td>18</td>
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<td>UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAN</td>
<td></td>
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</tbody>
</table>

International Comparison

AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.


Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008
Preventive care screening rates are higher for all adults with a regular doctor; disparities in screenings narrow for Hispanics with a regular doctor. Percentage of adults ages 19 to 64 who reported receiving preventive care screening in past five years, 2005

Blood Pressure Check in Past Year

<table>
<thead>
<tr>
<th></th>
<th>Regular Doctor</th>
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<tr>
<td>White</td>
<td>92</td>
<td>96</td>
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<tr>
<td>Black</td>
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<tr>
<td>Hispanic</td>
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<td>87*</td>
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</table>

Cholesterol Check in Past Five Years

<table>
<thead>
<tr>
<th></th>
<th>Regular Doctor</th>
<th>No Regular Doctor</th>
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</thead>
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<td>White</td>
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<td>70</td>
</tr>
<tr>
<td>Black</td>
<td>76</td>
<td></td>
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<tr>
<td>Hispanic</td>
<td>79</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Regular Doctor</th>
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<tbody>
<tr>
<td>White</td>
<td>49</td>
<td>52</td>
</tr>
<tr>
<td>Black</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>57</td>
<td></td>
</tr>
</tbody>
</table>
National Models of Change: Health Care Delivery

- **Patient-Centered Medical Home Model**
  - Model that provides all people with a “medical home”
  - A “medical home” is a place where all patient care needs are managed and **care is coordinated**

- **The Chronic Care Model**
  - A care delivery system that has demonstrated improved outcomes for patients when **care is coordinated**, patients are activated and informed, and practice teams are prepared and proactive
Patient Centered Medical Home

- The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults.

- The PC-MH is a healthcare setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

*Joint Principles of the Patient-Centered Medical Home, February 2007*
Patient Centered Medical Home Model Key Elements

• Personal Physician
• Physician Directed Medical Practice
• Whole Person Orientation
• CARE IS COORDINATED AND/ OR INTEGRATED
• Quality and Safety
• Enhanced Access
• Payment
Defining the Medical Home

Superb Access to Care
- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- Email and telephone consultations are offered.
- Off-hour service is available.

Patient Engagement in Care
- Patients have the option of being informed and engaged partners in their care.
- Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

Clinical Information Systems
- These systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

Care Coordination
- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

Team Care
- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers, and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

Patient Feedback
- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.
Adults Across Countries Place High Value on Having a “Medical Home”—Accessible, Personal, Coordinated Care

When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

Percent saying very or somewhat important

Chronic Care Model

- The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high-quality chronic disease care.
- The goal of this model is to use evidence based change concepts to foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.

Improving Chronic Illness Care at http://improvingchroniccare.org/index.php?p=Model_Elements&s=18
Chronic Care Model Key Elements

• The Community
  – Resources and policies
• Self-management Support
• The Health System
  – Organization of health care
    • Care coordination
    • Patient safety
• Delivery System Design
  • Cultural competency
  • Case management
• Decision Support
• Clinical Information Systems
  • Care coordination
Common themes

• The patient is at the center of their own care
• Care is delivered from a “medical home”
• Team approach to care - that may include non-traditional staff roles
• Care is coordinated and integrated
• The patient and his or her family/ caregivers are active participants in managing care
• Standardize care that can be standardized
Today

Many definitions for CARE COORDINATION exist
## Care Coordination

<table>
<thead>
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<th>Percent reported in past two years:</th>
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<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test results or records not available at time of appointment</td>
<td>11</td>
<td>11</td>
<td>8</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Duplicate tests: doctor ordered test that had already been done</td>
<td>10</td>
<td>5</td>
<td>15</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Percent with either coordination problem</td>
<td>18</td>
<td>15</td>
<td>19</td>
<td>9</td>
<td>12</td>
<td>13</td>
<td>23</td>
</tr>
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2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.
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*Improving the Quality and Cost Effectiveness of publicly Financed Care, Center for Health Care Strategies, Inc. 2007, www.chcs.org*
Care Coordination

- Links patients with community resources to facilitate referrals and respond to social service needs.
- Provide care management services for high risk patients.
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
- Track and support patients when they obtain services outside the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients/families.

taken from www.improvingchroniccare.org
Videos

• http://improvingchroniccare.org/video/PlannedCareVideo-ProviderPOV.wmv

• http://improvingchroniccare.org/video/PlannedCareVideo-SelfmanageInterview.wmv

• http://www.improvingchroniccare.org/video/cc_video.html
Tools

• Making changes
  – Team Assessment
  – Patient-Centered Medical Home Checklist
  – Improving Office Practice: Working Smarter, Not Harder
    • Pre-visit questionnaire
    • Post-visit order form
  – Assessment of Chronic Illness Care- ACIC
  – Patient Assessment of Chronic Illness Care- PACIC
  – Understanding Goal Setting

others at

www.improvingchroniccare.org
www.aafp.rg/pcmh
www.transformed.com