Person-Centered Care Coordination

December 8, 2016

Connecticut Department of Social Services
Making a Difference

Connecticut Person-Centered Medical Home

Presenters

- Department of Social Services (DSS)
  - Person-Centered Medical Home (PCMH) Program Lead
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- Community Health Network of Connecticut, Inc. (CHNCT)
  - Community Practice Transformation Specialist (CPTS)
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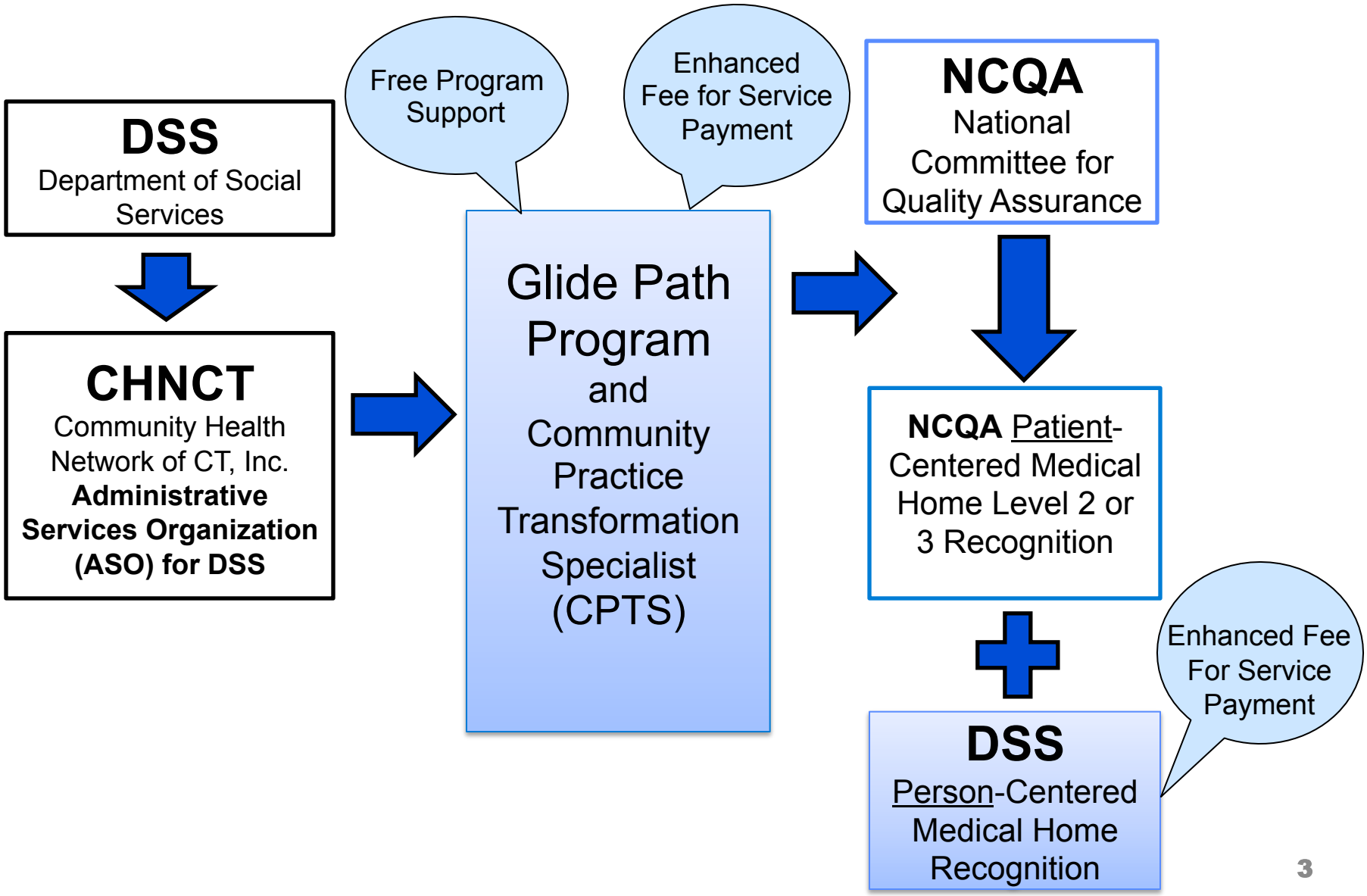
Learning Objectives

- Understand the DSS PCMH & the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home
- Describe person-centered care
- Define and provide an understanding of care coordination
- Recognize the need for an effective care coordination workflow
- Discover how to improve clinical quality outcomes
- Identify important CHNCT resources

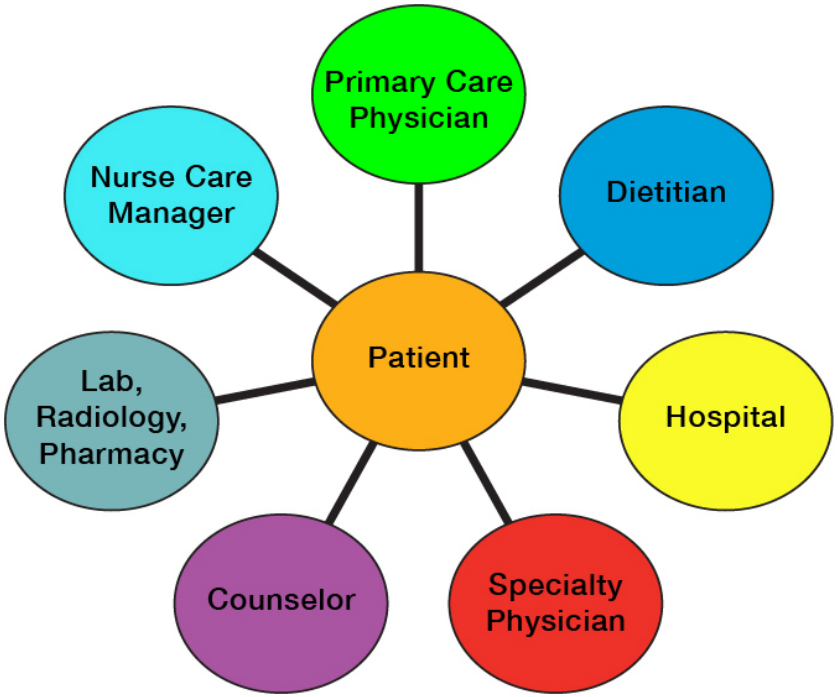
Connecticut Person-Centered Medical Home

PCMH Program Structure

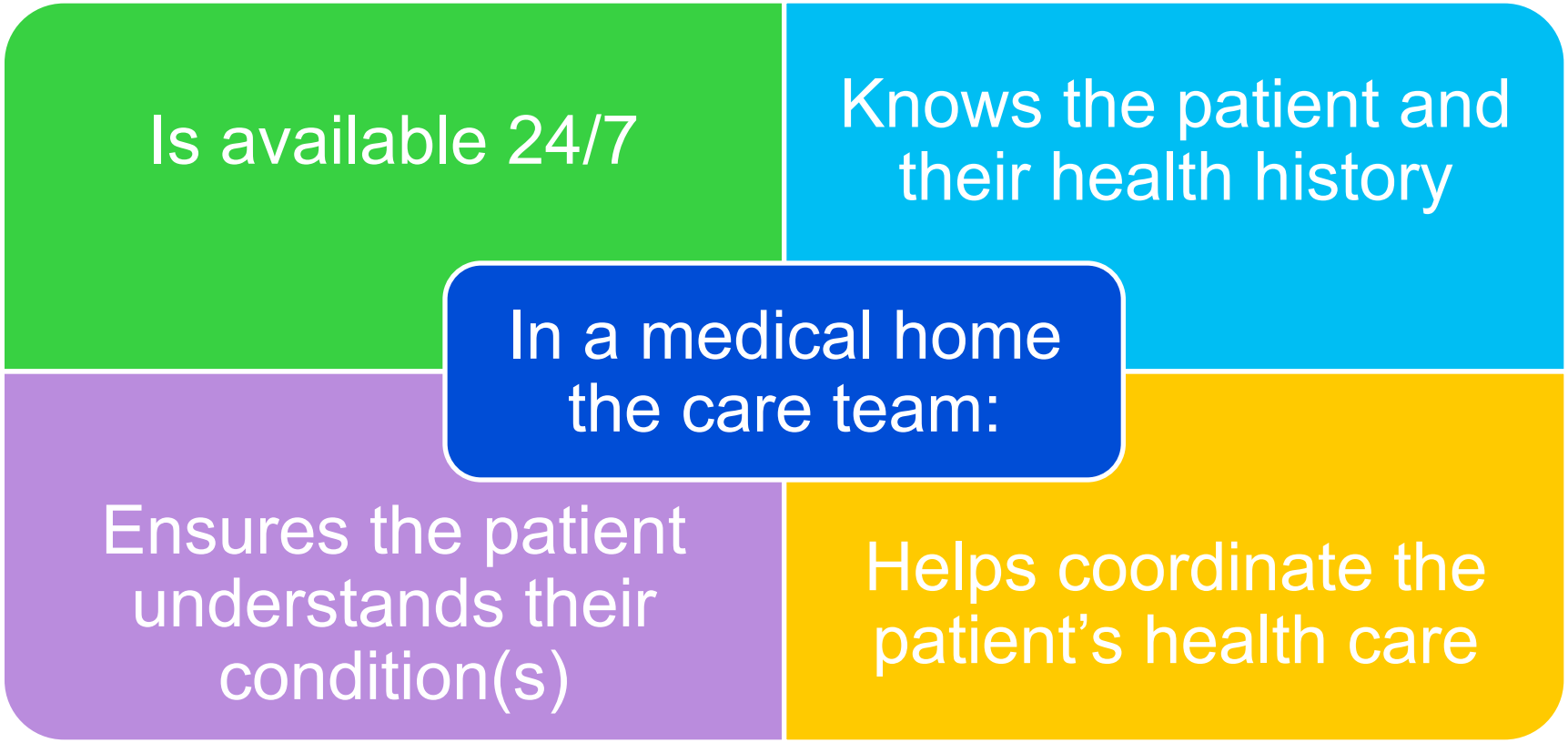


Patient-Centered Medical Home

- A PCMH has the patient at the center of the healthcare system
- The healthcare system provides primary care that is:
  - Accessible
  - Continuous
  - Comprehensive
  - Family-centered
  - Coordinated
  - Compassionate
  - Culturally effective



A Person-Centered Medical Home



Person-Centeredness

What is Care Coordination?

"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."

Care Coordination. May 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

Primary Care Physician (PCP) Coordinates Care

- Lab Tests
- Imaging Tests
- Specialist Visits
- Hospital/Emergency Department Visits
- Behavioral Health Services
- Dental Services
- Dietitian Visits
- Physical/Occupational Therapist Visits
- Facilities Transitions
- Medication Reconciliation
- Patient Self-care Results
- Self-referrals
- Prior Authorizations for Insurance

PCMH Model - Triple Aim

- Improve patient health outcomes through clinical quality
- Enhance patient experience
- Reduce healthcare costs

Continuous Quality Improvement

Design Elements of Care Coordination
Accountability
Patient Support
Relationships and Agreements
Connectivity

Safety Net Medical Home Initiative. Horner K, Schaefer J, Wagner E. Care Coordination: Reducing Care Fragmentation in Primary Care. In: Phillips KE, Weir V, eds. Safety Net Medical Home Initiative Implementation Guide Series. 2nd ed. Seattle, WA: Qualis Health and The MacColl Center for Health Care Innovation at the Group Health Research Institute; 2013. Accessed from: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf

Pediatric Case Study

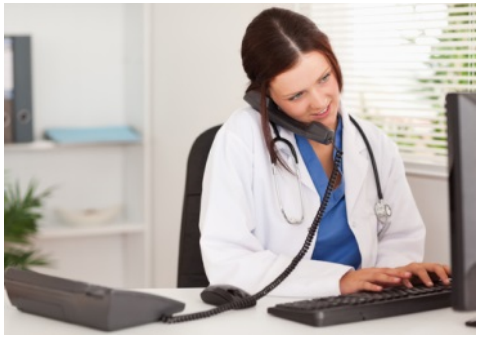
Clinical Summary:

- 12 year-old boy
- Attention-deficit/hyperactivity disorder and seizure disorder
- Hospitalized for uncontrolled seizures
- Seamless transition of care from hospital to home
- Scheduled post-hospitalization visit with pediatric practice within 7 days after discharge

Pediatric Case Study (cont'd)

PCMH Care Coordination Interventions:

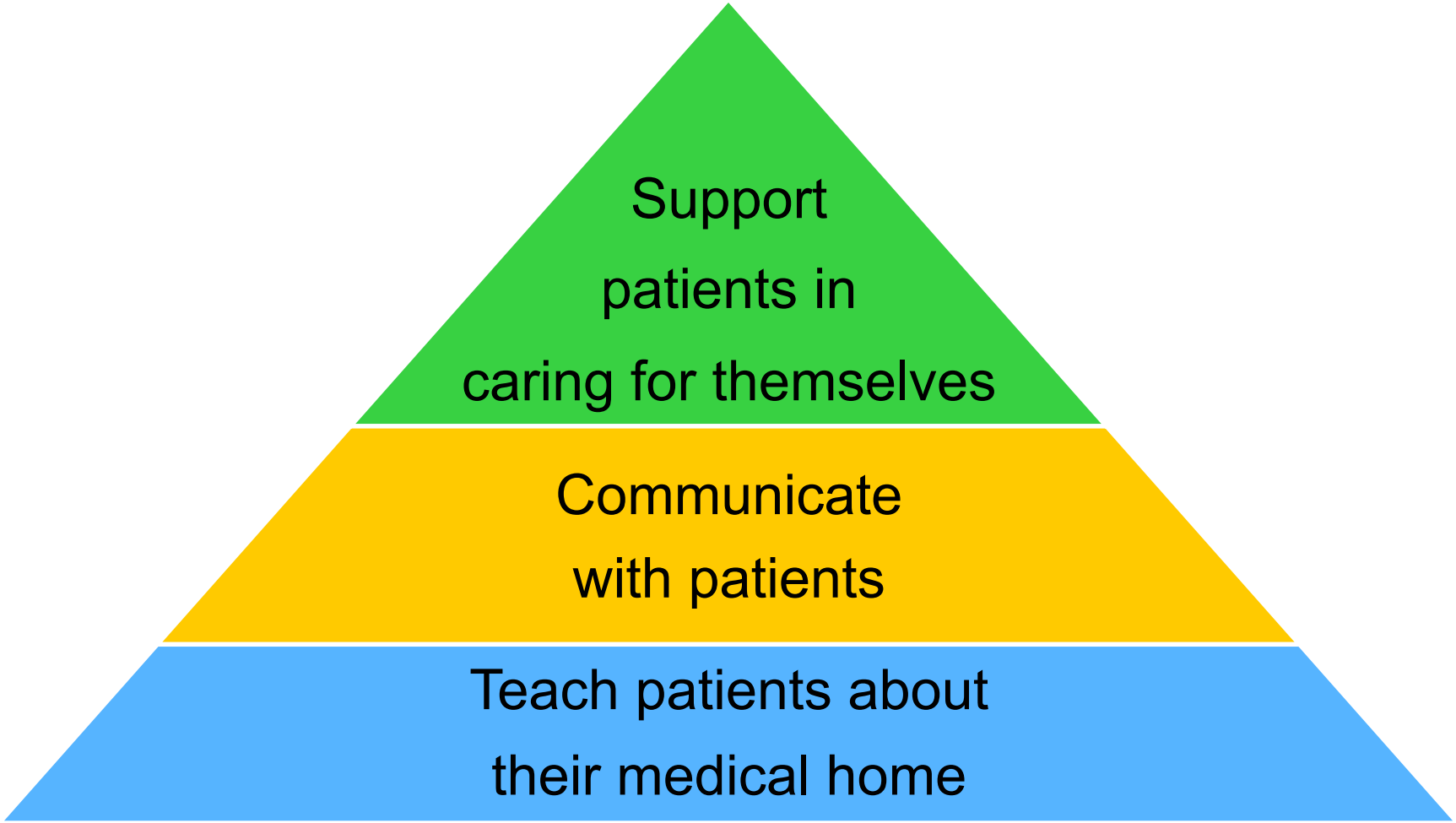
- Nurse proactively reached out to hospital for records
- Morning of visit
  - Medical team "huddled" to discuss patient and check all necessary information
- At visit
  - Pediatrician reviewed medications, conducted lab tests, and coordinated follow-up visit with specialist
  - Clinical Care Manager
    - Provided access to patient portal
    - Updated care plan
    - Sent care plan to school nurse



Outcome:

Care coordination efforts resulted in effective communication with the patient and specialists, collaboration with educational system, and access to community resources.

Care Team Responsibility



Care Coordination Challenges

Time & Capacity

- Manual and inefficient processes overburden the clinical staff

Data Management

- Insufficient system capabilities

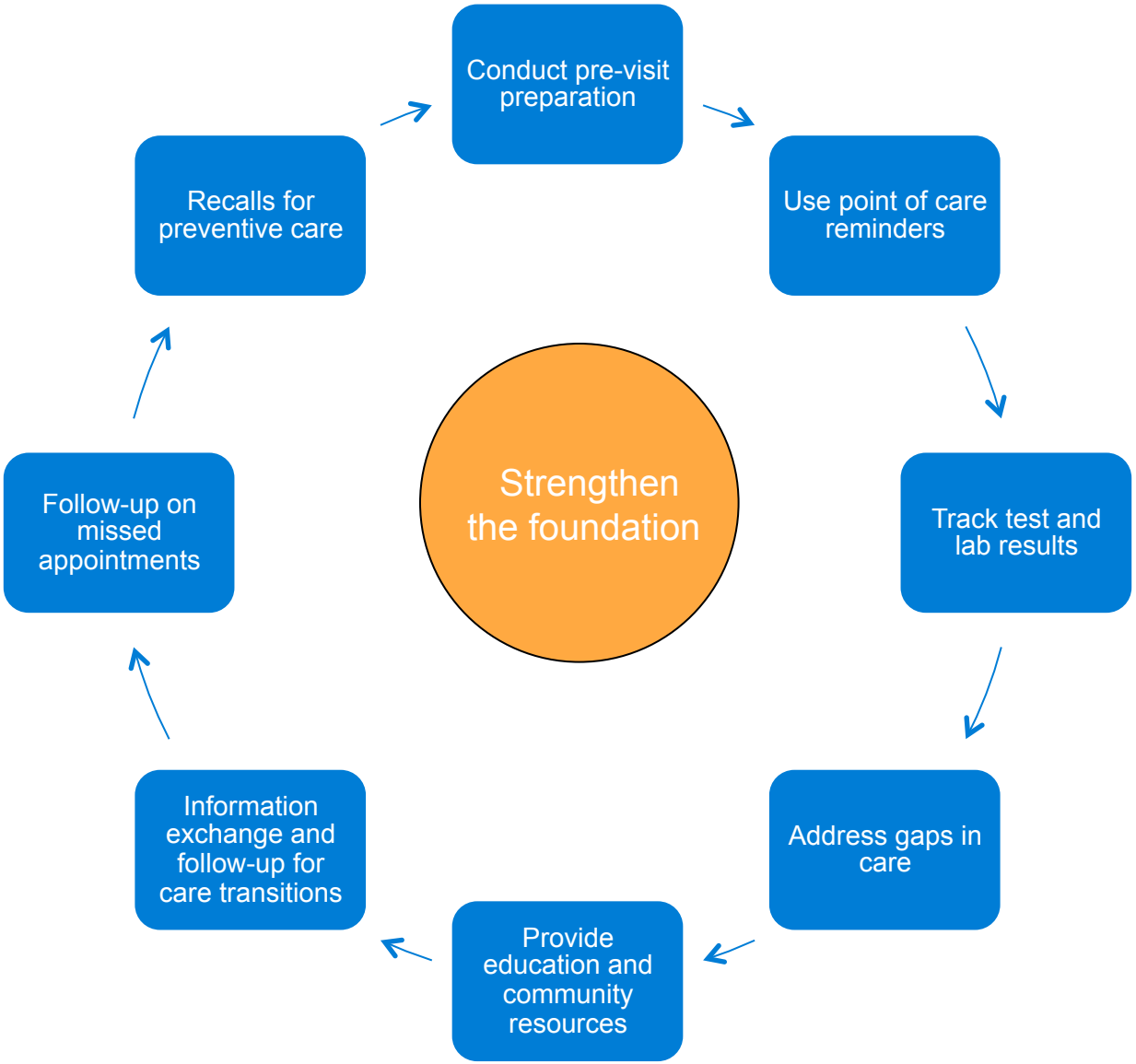
Resources

- Navigating a complex healthcare system

Electronic Health Record Technology

- Pre-visit Prep
  - Gap-in-care alerts
  - Reminder services
  - Lab and test results
- Point of Care
  - Medication adherence
  - Gap-in-care intervention
  - Doctor/patient discussions
  - Support enrollment
- Post-visit Follow-up
  - Specialist referrals
  - Education and community resources

Care Coordination Workflow



Workflow Process

- Improve performance and increase efficiency
- Use technology pre-visit, at point of care and post-visit
- Identify and address challenges faced by staff and patients
- Decide what is and what is ***NOT*** realistic
- Analyze data to measure patient outcomes and effectiveness

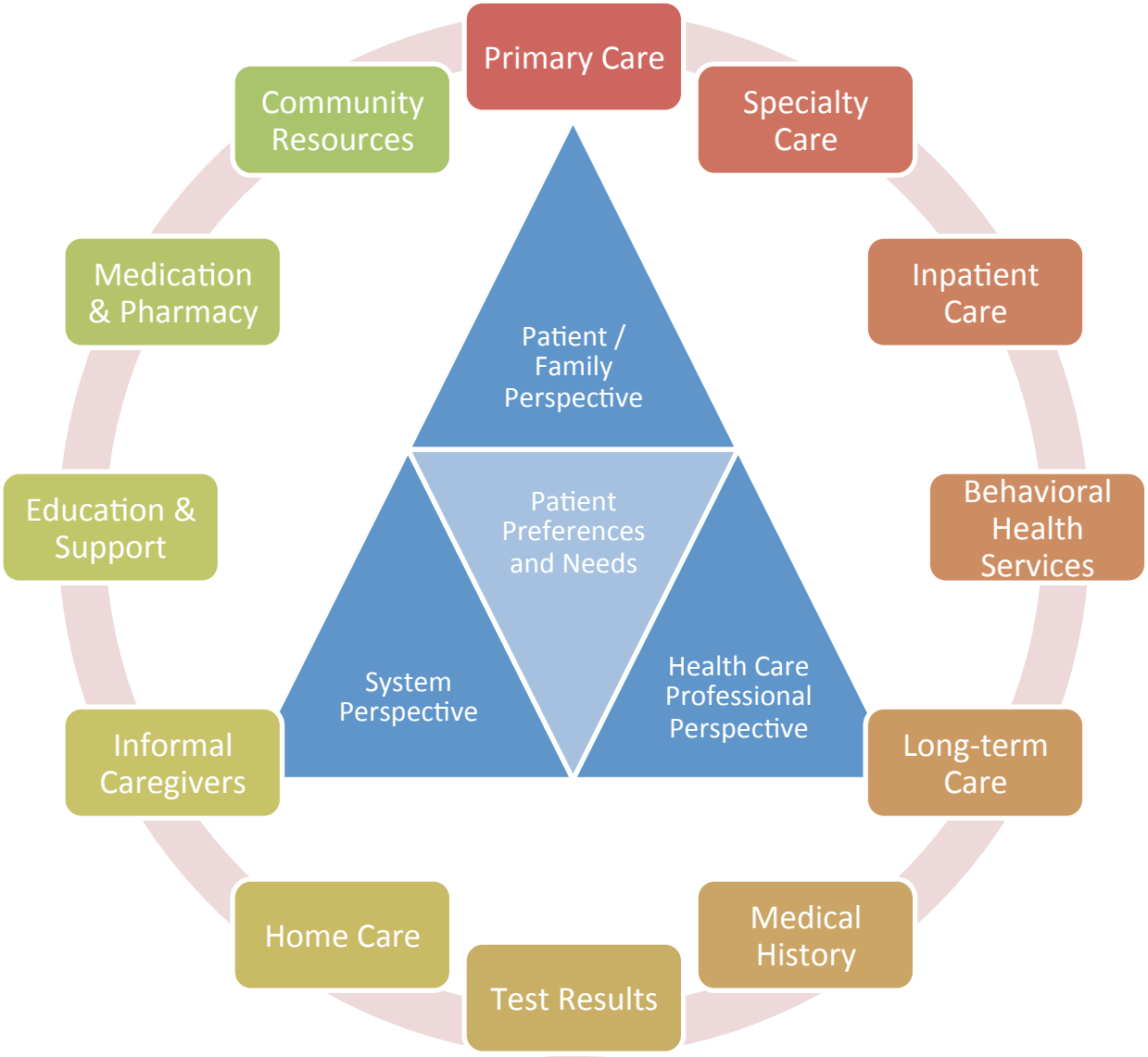
Care Coordination & Continuity

- Staff Responsibilities
  - Effective communication
  - Teamwork
- Patient/Family Involvement
- Access to Information
  - Personalization of care

Care Coordination Success

Teamwork
Care Management
Medication Management
Reduced Cost of Care
Enhanced Patient and Family Engagement
Improved Communication Across Multiple Settings

Components of Person-Centeredness



Chapter 2. What is Care Coordination? June 2014. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html

CHNCT Resources

- HUSKY Health website: www.ct.gov/husky
- Secure Provider Portal: http://www.huskyhealthct.org/providers/providers_login.html
- CareAnalyzer®: https://careanalyzer.dsthealthsolutions.com/careanalyzer/login.aspx
- HUSKY Health PCMH Microsite: http://www.huskyhealthct.org/providers/pcmh.html
- Intensive Care Management & Community Health Worker Provider Line: 800.440.5071, ext. 2024
- CPTS Team
  - By email: pathwaytopcmh@chnct.org
  - By phone: 203.949.4194

All PCMH webinars are located on the HUSKY Health website page: "Pathway to PCMH Webinar Recordings and Presentation Materials"

Questions/Comments