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Care Coordination:  
Findings and Recommendations

**“Care Coordination Among Specialists, Primary Care, Care Management & Patients”**

## ■ **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.*
- *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.*
- *Goal-setting for health behaviors, self-management support, and monitoring attainment of goals, and periodically reviewing progress toward goals with an eye to adjusting the plans*
- *Source: <http://www.ncbi.nlm.nih.gov/books/NBK44012/>*

## ■ **Patient-Centered Care:** *“providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions”*

- Source: Institute of Medicine
- Patient-centered care is a cultural concept that requires not only active patient engagement, but also the direct engagement of the clinician, healthcare organization, and community.

NOTE: DEFINE that “**PATIENT ENGAGEMENT**” is an approach that uses a set of IT and other capabilities, but it is also part of a different approach to healthcare called **Patient-centered Care**.

1. **Numerous participants** are typically involved in care coordination;
2. Coordination is necessary when participants are **dependent upon each other to carry out disparate activities** in a patient's care;
3. To carry out these activities in a coordinated way, each participant needs **adequate knowledge about their own and others' roles**, and available resources;
4. To manage all required patient care activities, **participants rely on exchange of information**; and
5. **Integration of care activities** has the goal of facilitating appropriate delivery of health care services.

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- The current state of EHRs facilitate within-office communication and is heavily driven by billing and documentation needs, rather than by patient and provider needs around clinical management and care coordination.
- Coordination of care across providers includes: patient referrals and consultations (e.g. between primary care and specialist practices); care transitions between settings (e.g. inpatient and outpatient); and emergency department (ED) visits.
- Maximizing clinicians' use of EHRs for care coordination requires EHR vendors to adopt MU criteria that support timely, accurate and clinically relevant data exchange, particularly for the end-user at point of care. .
  - Timeliness of data exchange, particularly for patients referrals
  - Relevant, concise narratives pertinent to care transition
  - Tracking referral and consultation process management, including “closing the loop” to include discussing with the patient of the results of the consultation
  - Access to consultants immediately, either electronically or by phone, to answer questions regarding referral appropriateness, testing strategies, diagnostic assessments or to follow-up on prior consultations.
  - Accuracy needs to be assured through a robust, yet user friend reconciliation process for patients, medications, allergies, problems, etc.
- Longitudinal Data Capture:
  - Individual Patient tracking - a management “dashboard” to assess progress along a care plan
  - Population-based tracking for patient panel - diagnostic reports from specialists and other facilities to the primary care practice in a format that populates the EHR
- Patient reported outcomes: capture patient preferences, clinical care experiences and support engagement in shared decision making.
- Longitudinal care plans:
  - Definition needs to be agreed upon as well as identification of the provider (or team of providers) accountable for developing the longitudinal care plan with the patient/family/caregivers.
  - EHR needs the capability of allowing the user to clearly delineate where in the record the clinician should resume work after interruption, or between contacts.
  - Ensuring a patient's longitudinal care plan is respected involves secure information sharing with providers with whom that patient may have important clinical contact.

# Meaningful Use Stage Definitions

- Stage 1
- Perform at least one test of the capability to exchange key clinical information among providers of care and patient authorized entities electronically
- MENU: Perform medication reconciliation for more than **50% of transitions** of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH
- MENU: Provide a summary of care record for more than 50% of all transitions and referrals of care
- Stage 2
- HIE test eliminated in favor of use objectives.
- The EP, eligible hospital or CAH performs medication reconciliation for more than **65 percent** of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).
- 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than **65 percent** of transitions of care and referrals.
  2. *The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record (including care plan and care team if available) using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals.*

# Vision Discussion