Care Coordination

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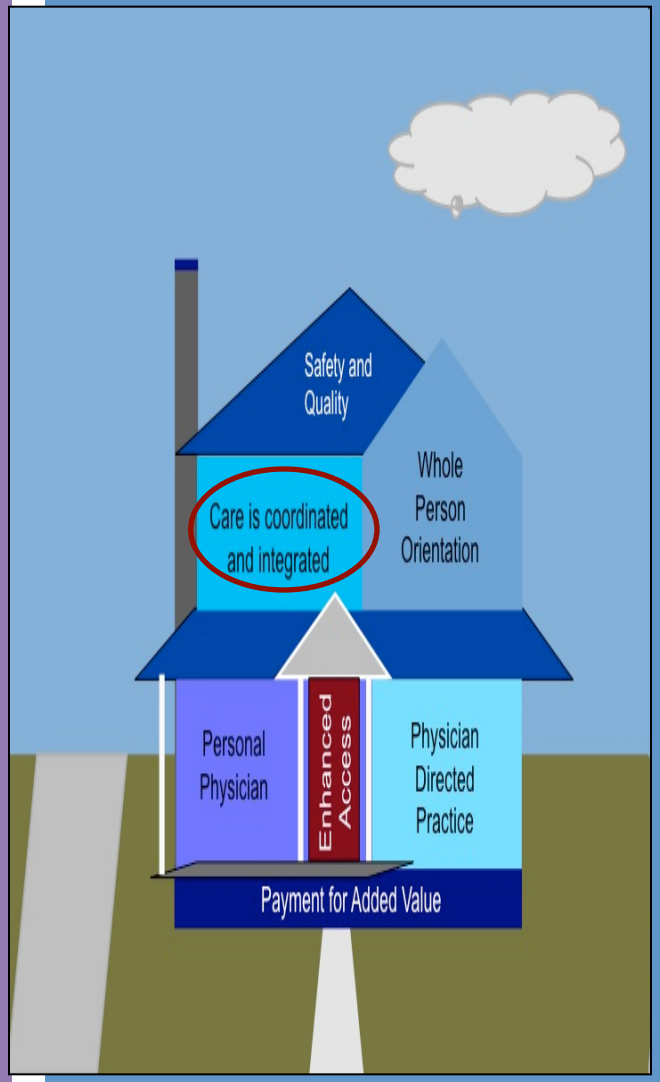
Health Care & Housing Are Human Rights

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

The Patient-centered Medical Home



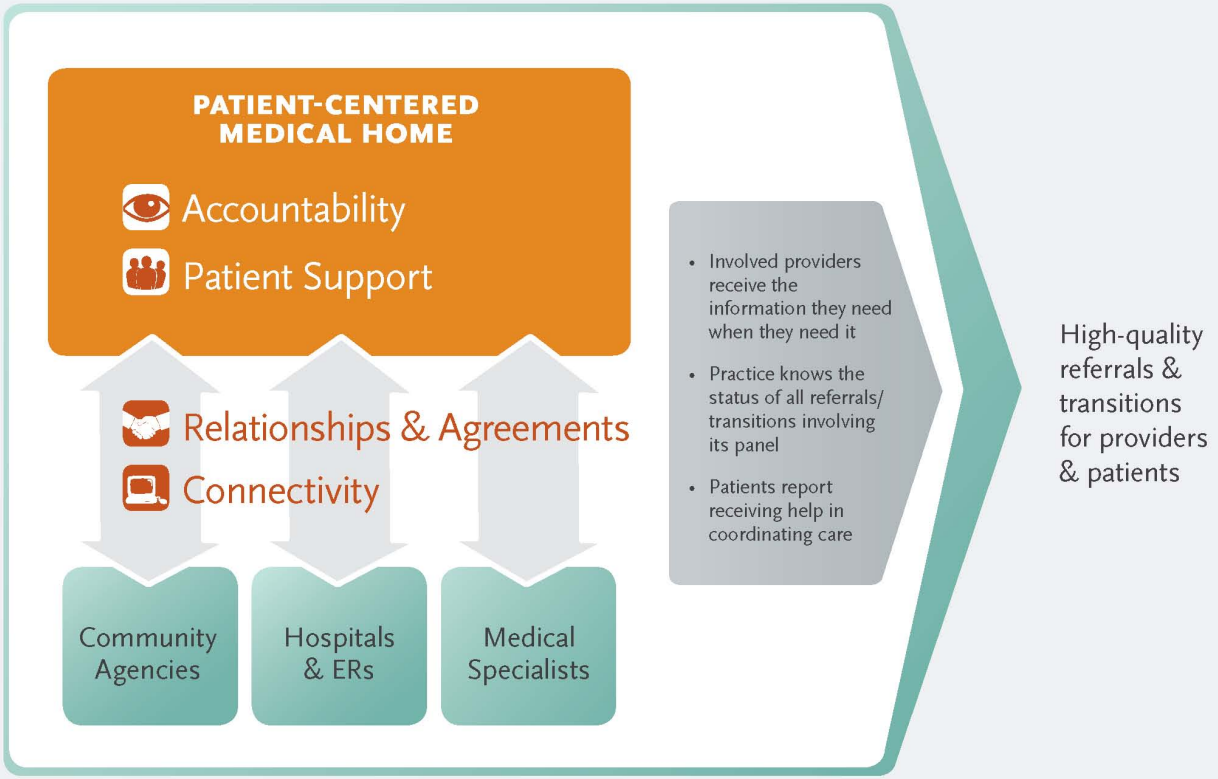
Key Features:

1. Engaged leadership
2. Quality improvement strategy
3. Empanelment
4. Patient-centered interactions
5. Organized, evidence-based care
6. Care coordination
7. Enhanced access
8. Continuous, team-based health relationships

Care Coordination defined…

The deliberate organization of patient care activities between members of the health care team to facilitate the appropriate delivery of health services. (NCQA)

Care Coordination Model



Key Components:

Accountability

Provide **patient support**

Build **relationships & agreements**

Connectivity

Care coordination in the trenches

Care Manager, LPN, Intake Coordinator, NP, LCSW

Steps:

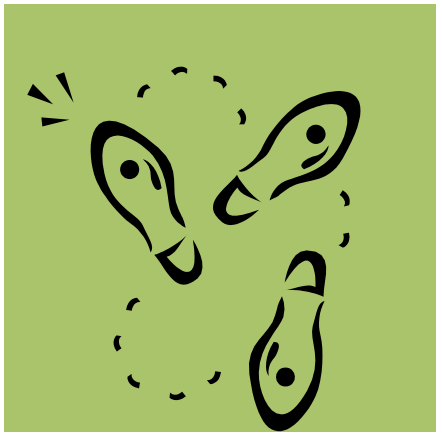
Build rapport and trust with team and understand boundaries

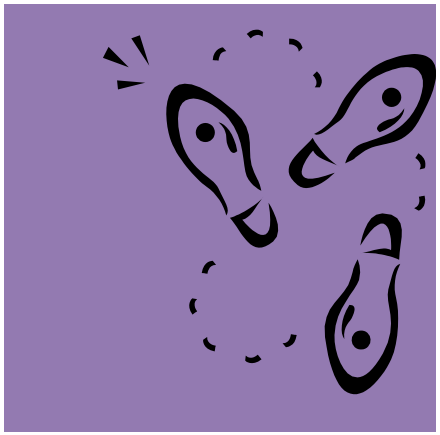
Define Accountability

Patient support

Build network of specialists including medical, social service and housing

Electronic Medical Record





A well orchestrated dance…

Build rapport and trust with team and understand boundaries

- Importance of trust and honesty
- Define work ethic
- Professional boundaries
  - Patients

Accountability

Team collaboration and communication

- **Daily huddles**

Referrals

- **Getting appropriate info to specialist**
- **Closing the loop? How is info fed back?**

Clinic access: appointment opportunities via call center and high risk care manager

Outcomes

Who is responsible?

Patient engagement

Meet the patient where they are…
What are the immediate needs of the patient?
- clinical assessment
- medication management

Identify barriers to care
Identify care management needs
- Self management goals
- Health literacy issues
- housing issues, etc...

Electronic Medical Record

- Meaningful use
- Improves efficiency and safety
- Enhances transparency

Care Management in the Free Clinic setting…

- Community Access Network
  - Partnership between NWS, Heartland Health and SWB
  - Goal: to educate Medicaid and self pay individuals how to manage their health through a care management system

    Free Clinic process:

    SWB's case manager works with providers to serve as provider extenders assisting with education, referrals, and follow-up needs.

    The care manager reviews the hospital lists for ER visits made by SWB patients and any hospital discharges.

    High Risk care managers

    Appointment slots…after hours call

    The care team meets every two weeks to discuss difficult cases and create action plans.