Care Coordination: Tools for Building A Medical Neighborhood

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MacColl Institute for Healthcare Innovation

Session 3A
March 8, 10:30AM-12:00PM
Site Presentations

Health West American Falls
• Mark Horrocks, MD, Medical Director
• Hailey Lusk, Health Educator, Living Well in Idaho Wellness Coordinator
• Mindy Stosich, MBA, Compliance and Development Officer
• Lori Seaton, Care Manager

Squirrel Hill Health Center
• Andrea Fox, MD, MPH, Medical Director
• Lindsay Losasso, MPH, Program and Grants Manager
We are less important than we think…but care coordination matters

The “empowered patient’s medical home” …?
IT’S ALL ABOUT RELATIONSHIPS!!

• With Your Team
• With Your “Neighbors”
• With Your Patients/Families
Patient-Centered Medical Homes

An approach to providing high quality, safe, continuous, coordinated, comprehensive care, with a partnership between patients and their personal healthcare team.
A Medical Home Without An Integrated Medical Neighborhood

Is Just An Island
Defining Care Coordination

The deliberate integration of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services. (McDonald, 2007)
Care Coordination Model

**Patient-Centered Medical Home**
- Accountability
- Patient Support

- Relationships & Agreements
- Connectivity

- Community Agencies
- Hospitals & ERs
- Medical Specialists

- Involved providers receive the information they need when they need it.
- Practice knows the status of all referrals/transitions involving its panel.
- Patients report receiving help in coordinating care.

High-quality referrals & transitions for providers & patients

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Levels of Patient Support

Self-mgt Support & Medication Mgt.
Clinical Monitoring
Logistical

Care Management
Clinical Monitoring
Logistical
Clinical Follow-up Care
Logistical

Care Coordination
Key Changes – by whom?

1. Assume **accountability**
2. Provide **patient support**
3. Build **relationships and agreements**
4. Develop **connectivity**
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Questions?