• Team based care is a necessary approach to achieving best outcome for every patient every time.
• UnityPoint Clinic is utilizing the RN’s skillset in a new way through the Patient Centered Medical Home.
Objectives

• Understand the role of a Care Coordinator RN in a PCMH Primary Care Clinic Setting.
• Learn how team based care works and why it is important to patient, provider and staff satisfaction.
• Learn how team based care can impact patient outcomes, as well as Triple Aim goals.

What does a Care Coordinator do?

“New Work”
• Care Coordination
  • Support patient through transitions in care
• Patient education and coaching related to chronic disease self-management
  • Focus on rising risk patient population
  • Support patient and provider in goal attainment/identifying barriers
• Identify rising risk patients and proactively intervening with the guidance of the provider
• Promoting general population health
• Provide information regarding internal and external resources, including community resources
National Committee for Quality Assurance (NCQA)

- NCQA provides a very useful roadmap for clinics to operationalize the following PCMH features:
  - Patient Centered Access
  - Team Based Care
  - Population Health
  - Care Management
  - Care Transitions
  - Performance Improvement

“I can’t believe the outcomes [our Care Coordinator] is getting on patients that I have treated for years and have been unable to get the results that she is getting. She has a way to educate and get through to them that no one else has ever been able to do.” - Physician – QC Region
Patient-Centered Medical Home

- Primary Care
- Access and Communication
- Data and Metrics
- Team-Based
- Care Coordinator
- Care Protocols

Population Health Management

- **High Risk**
  - 5% of patients
  - Complex chronic conditions, comorbidities
  - Care navigators
  - Chronic care coordination
  - Wraparound services

- **Rising Risk**
  - 15%-35% of patients
  - May have conditions not under control
  - Patient-Centered Medical Home
  - Care coordinators

- **Low Risk**
  - 60%-80% of patients
  - Minor conditions, easily managed
  - Low-acuity access, education
  - E-health
Team-Based Care

A cooperatively functioning group that works with the patient and family toward ideal patient care

Patient and family, Providers, Care Coordinator, Clinical Staff, Patient Service Representatives, Clinic Administrator

All are Leaders (no hierarchy), Not competitive, Communication, no front-back office separation

Co-location

People with different job roles working in the same common workspace

Why it works

Communication!
Same day access
Care Coordination
Ideal patient care
Huddles

• Once/Twice a day 15 min
• Everyone attends
• Start/end on time

• Things to talk about
  • Patient issues
  • Successes/challenges
  • Quality
  • Scheduling – patients and staff
  • Process Improvement
  • Meaningful Use

“l like being able to stay up-to-date on the latest info...huddles help us do just that” - PSR-CR Region

Culture shift to team-based care

• Trust
• Time
• Understanding of new roles & relationship building
• Patient and family education
Change is Hard!

Care Coordination

- Integrated Approach
- Link patients with community resources
- Track and support patients
- Follow up with patients within few days of discharge from emergency room or hospital
- Patient Centered Care Plans
Top of licensure and skill set

- The approach and skill set of a Care Coordinator RN includes
  - Education, RN includes assessment, triage, and critical thinking
  - Motivational Interviewing
  - Teach Back
  - Self-Management Support
  - SMART goal setting
  - Action plans
  - Follow-up

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Comments from Providers & Staff

- “I began to see this patient…in August. She initially was depressed and feeling hopeless about her diabetes …. As of December 31st, her A1c has dropped to 7, she is checking and recording her blood glucose regularly (and taking insulin appropriately) and is now exercising…[the patient] really feels that I have helped her to coordinate care between her doctors, address other medical concerns as they come up, and now she feels confident about taking care of herself.” Care Coordinator, Cedar Rapids Region

- “It really promotes teamwork; everyone gets a say.” RN, CI Region
Comments from Providers and Staff

• “We had a gentleman with an A1c of 9.1 in May of 2014. His most recent A1c... was 6.8. Just having [our care coordinator] meet with [him] 2 times... [the provider’s comment was] she never thought she would see this patient start being compliant with his diabetes.” Clinic Administrator, Waterloo Region

• “Traditional Family Practice was primarily a siloed type of delivery care system whereas medical home has integrated our system as a function of a team, providing all the services that should surround the patient.” Physician, CI Region

Comments from Patients in a PCMH

• “My care coordinator is a professional friend who cares about my health and works hard to be supportive, encouraging and helpful.”

• “My daughter is helping herself on food choices that are best for her. It is amazing for her to want to eat healthy and to now understand why it is so important. She has spent a lot of time making individual recommendations for snacks and meals. She has helped her with social difficulties too. This experience is affecting a healthier eating style for our entire family which I can't even explain enough how amazing this is. I wish more kids could receive this much needed help.” Quote from Parent
Comments from Patients in a PCMH

- “I trust my medical home team and they are willing to work with me.”
- “I have comfort in knowing that I will be taken care of today by my care team.”
- “Having [the Care Coordinator here], I can’t thank UnityPoint enough, if they didn’t have her, I wouldn’t be sitting here today as a success story…I would be sitting here as a negative statistic…she’s changed my life.”
- “There is a visible difference in my health care since my clinic became a medical home. I would never want to go back.”

Patient Testimonials
Patient Stories

- Kimberly Wente RN, BSN-Senior Care Coordinator (previously Pediatrics-Lakeview Care Coordinator)

- Jen Kirstein RN, BSN-Family Medicine-East Des Moines Care Coordinator

Team based care-next steps

- Expand team within clinic setting where appropriate
- Continue to develop connections with teams outside clinic setting, Community based services
References


