BACKGROUND

• A community health center in central Illinois recently focused on improving their current care coordination program.
• A renewal process in designated Patient-Centered Medical Home (PCMH) was approaching.
• Determined after comparing the revised 2014 National Committee of Quality Assurance (NCQA) PCMH Standards and current structure of the care coordination program that many required components in the updated standards were missing.
• Care coordination is "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care."
• Care coordinator role is broad and a crucial component of an effective and seamless health care system.
• Patient-Centered Medical Home is a health care model that emphasizes care coordination and has proved to lower costs and provide a higher quality of care for patients. Agency for Healthcare Research and Quality (2015a).

Based on assessment and discussion with key stakeholders it was determined that a more structured care coordination training was needed that focused on the care coordinator role as evidenced by:

1) Lack of structure & guidelines for the care coordinator role and the need for consistent training
2) Care coordinators unclear of their role
3) Care coordinators not regularly meeting with providers
4) Care coordinators not currently identifying and contacting patients with recent unplanned hospital admissions and Emergency Department visits to schedule follow-up appointments
5) Dialogue with the key stakeholders that led to the conclusion that the care coordinator role was not being fully and effectively utilized

Literature support that effective care coordination improves the quality of care, transitions, quality of life for patients with chronic illness and disability and communications across care settings:

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OBJECTIVES

• The learner will be able to explain how the care coordinator role can help reduce healthcare cost and improve the quality of care for patients in the healthcare system.
• The learner will be able to describe the foundation for a successful care coordination program in a primary care setting.
• The learner will be able to discuss the benefits of a Patient-Centered Medical Home (PCMH) in the primary care setting.

MATERIALS & METHODS

• The Care Coordination Training included a two-hour training session with a focus of defining the care coordinator role and increasing their self-efficacy in the primary care setting.
• The care coordinator daily workflow, outlining the daily responsibilities, was developed based on the specific needs of the community health in the primary care setting.

RESULTS

• 55% increase in the self-efficacy of the care coordinators in their role from baseline based on a pre/posttest
• 50% of the participants documented all four elements of the care coordinator daily workflow correctly
• 50% of the participants documented only two elements of the care coordinator daily workflow correctly
• All four patients (100%) identified for care coordinator discharge in the morning huddles had their discharge planning documented in the electronic medical record (EMR)

CONCLUSIONS

• Additional training needed which will result in the care coordinators at the community health center to begin to fully and effectively be utilized in their role.
• A focus on obtaining adequate provider staffing who are a fundamental component in building an effective care team in the primary care setting.
• The need for a multidisciplinary workgroup developed that includes a representative from the care coordinators, providers, medical assistants and administration to continue working on process workflows in the primary care setting.

RECOMMENDATIONS

• Develop and implement a process of collecting and distributing important patient information for follow up after Emergency Department visits, hospitalizations and for preventive care.
• Maintain an annual care coordinator competency via web-based or in-person.
• An employee recognition program and continued communication improvements

LIMITATIONS

• Sample size
• Lack of available data
• Design of this project limits generalizability
• Current culture of the primary care setting
• Transitional period
• Lack of adequate provider staff

REFERENCES


ACKNOWLEDGEMENTS

I thank Rush University College of Nursing, Susan Swider, Community Health Center in central Illinois, Mary Manatis, Rommel McKinnor, Family, Northside Hospital