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Coordination of Care in the Medical Home

By Dave Hutchinson, M.D., MAFP President-Elect

(Editor's Note: This article continues a series exploring the definition and practical implications of the core tenets of The Medical Home.)

The MAFP Position Paper on the Medical Home Outlined Six Core Principles:

Enhanced Access	The Personal Physician
Comprehensive Care	Quality & Safety
Coordination of Care	Patient Centeredness

Defining organizations envision the well-crafted Medical Home as the **center of communication** that supports and coordinates all care for patients, integrating all service from clinic centers, specialists, hospitals, home health,

nursing homes, and the patient's community (family, public and private services). This vision constitutes what MAFP past-president George Schoephoerster, M.D., calls **SEAMLESS CARE**. We might call the opposite 'unseemly care'...

As physicians, we revel in the joy of success resulting from excellence in knowledge, effort, judgment, system navigation, communication, and connection to patients. We're also all too familiar with examples of suboptimal outcomes, missed opportunities, inefficiency, and increased cost to patients/payers/providers in instances when patient care is NOT fully

Medical Home - Continued on page 6

2007 National Conference - What's Your Passion?

By Lisa Regehr, Conference Coordinator

Minnesota medical students poured into the 2007 Student Congress filling their assigned row and then sitting on the floor to place their votes on Family Medicine issues – this was their chance to affect change in the specialty on a national level. With 24 students, Minnesota was the largest delegation at the congress. Addie Licari, the MAFP Student Director, held a caucus earlier that day, where Minnesota students discussed which resolutions they would vote for - and speak to - at the congress. Resolutions debated in the student congress included increasing exposure to full-spectrum family medicine in medical school clerkships, alternate sources of funding for family medicine interest group programming, the use of ultrasound in family medicine and aggressive promotion for health system reform.

"It was inspiring to see so many residents and students from Minnesota participate in the conference. Their enthusiasm for the future of family medicine was contagious. There were many residents and two full rows of students



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who attended the closing business sessions, many of whom offered thoughtful testimony on issues of relevance to primary care," said Nancy Baker, M.D., Chair of the 2007 National Conference Planning Committee.

The 2007 National Conference of Family Medicine Residents and Medical Students, held August 2-4, asked *What's Your Passion?*

National Conference - Continued on page 4

INSIDE

- ▶ Winter Conference Preview Page 7
- ▶ Legislative Achievement Awards Page 8
- ▶ Recruitment Luau Page 8
- ▶ Student and Resident Director Reports Page 9
- ▶ Financial Report Page 10

REGULAR FEATURES

- ▶ President's Message Page 3
- ▶ What's New Page 4
- ▶ Membership Report Page 5
- ▶ Bulletin Board Page 11
- ▶ Practice Opportunities Page 12-15



coordinated. Tests are duplicated. Former care plans are re-implemented. Patients or providers make decisions without full information in hand, though it was available. Cross-covering partners weren't aware of our most recent recommendations, or those of our consultants. Personal physicians don't know a prescription has been changed elsewhere. Nursing home policy doesn't structurally accommodate a physician's intention. Consultants see inpatients merely upon our "postings", and outpatients upon blind referrals. Information doesn't accompany patients to all settings. Cross-coverage care happens by assumption, rather than by intention. Consultants initiate cascading lateral referrals. ER physicians operate in the dark, without access to patients' clinic records or their personal physicians. Patients don't fully comprehend our advice or our concerns. Admissions and discharges occur without meaningful involvement, or even awareness of continuity clinicians. Everyone writes orders independently. Refill requests arrive in the office for medications long discontinued. Patient's self-refer within multiple systems, or use the ER as primary care. Providers are unaware of or don't problem-solve around patients' obstacles and limitations. Multiple providers carry multiple agendas... I get, I get it, you're saying. All parties in the care process could collaborate and organize more completely.

Uncoordinated care becomes *unaware care*, and is unsafe, unsightly, unsatisfying, and unfair. We all deserve better.

We all recognize, often, "there should be a hub in the wheel, a viewer of the forest, a kindly and interpretive voice of reason and understanding for all." Family Medicine was born of such need – we were to be the specialists who could bridge patients with patient care, experts in knowledge of medicine, and experts at connection to and knowledge of individuals. In today's multifaceted, frenetic, and production-driven health care world, we find increasing challenges to serving effectively as that bridge.

MAFP past president Dr. Ray Christensen observes:

"Over the years I've come to realize one of the reasons that the Mayo Clinic is so successful. The physician that you see upon entry to their system, generally, regardless of specialty, assumes an overarching responsibility for coordination of your care, communicating with others, explaining results, treatment options, and arranging follow-up care, all the primary functions of a personal physician."

Our solutions to better *coordination of care* which is patient-centered, physician-led, and continuity-accented, are manifold. The organizations defining the Joint Principles of a Patient-Centered Medical Home foresee care coordination facilitated

by **patient registries, information technology, and reliable information exchange**. Many also envision **patient-carried electronic health records** as part of our health system future in a mobile society. Others, like author Steve Bergeson, M.D., (*JAMA*, Dec., 2006), note the general importance of strong **clinician commitment** to providing patients with what they need and expect, and of implementation of clinic processes that prioritize **reliability in communication** – within the care team, between medical home team members and patients, and among care settings and the clinicians staffing them. *For this to occur reliably, all components of the medical system need to observe the principles and serve the principals, and structure, of the Medical Home*. Noting, as does the Institute of Medicine, that errors occur in care around patient transitions between care settings, Dr. Bergeson also promotes utilization of **designated Care Coordinators**. Such a person within the primary care team would help to minimize communication oversights, would function as a patient's advocate, help individuals navigate and access the system at appropriate times, and could ensure that information is in the right place at the right time. In some settings, the Personal Physician and/or a team nurse would logically serve as this person. In other settings, these roles might be delegated.

Robin Harris (Master's in Education thesis, 2007) observes pervasive differences between patients and their physicians in understanding of health problems, implications, choices, and recommendations. She helps to highlight the importance of routine **patient education** by trained clinical educators as an important step toward well-coordinated, patient-centered care. We might imagine combining the patient advocate/care coordinator/patient educator roles in some settings. In all cases, with the medical home model recognizing the coordination value of **relational and continuity-based care**, the personal physician will remain prominently in the loop regarding patient information intake, and care plan formulation and coordination. The pediatric literature has long demonstrated the value of **organized Care Plans**, especially for patients with chronic conditions, as they keep care team members organized, informed, and pointed in a unified direction for patients. Finally, national and state leaders are also working for **compensation reforms** that will support coordination of care, the complex management of chronic disease, and maintenance of the high quality connections between patients and personal physicians that facilitate trustful and efficient achievement of care coordination.

"Every visit to a consultant should be considered a round trip."

-Tom Day, M.D., Director, Duluth FMRP

Health care CAN be coordinated. The value of patient-centeredness demands that we help make it so. In complex systems, this truly takes a lot of work (which takes time), requiring insightful and reliable communication. We have

to talk to each other – a lot, directly – and to those who help us, and we have to spend time on patient’s records. Personal physicians in a medical home must redefine themselves as such. We must attach ourselves to office and system redesign, and to the *informed coordinator* role. We must obtain and digest all health service information about patients, and assure that it is inserted into their charts understandably, easily accessible to all care team members. We must organize medical home team responsibility for following up with patients to assure that everything important (e.g. periodic A1C testing and other monitoring for diabetics, e.g. keeping appointments for counseling for depressed patients, e.g. completion of consultative visits and acquisition of records from those contacts) is explained, accomplished, processed, and responded to. Perhaps, most importantly, we must convince our partner components of the medical system – those institutions in our own and neighboring communities with whom we network to construct Medical Homes – to utilize our expertise and maximize our effectiveness as personal physician contributors to exceptional and sensible care. (Will ER docs and hospitalists reliably access what we know about patients? Can you consistently know what they’ve done and record that for your team?) And we must be paid for doing these things verifiably, so that we have time and staff to do them, are incented to do them, and so that we are as valued as we are valuable.

For reading members, we offer the following link (www.mafp.org/carecoor.asp) to our MAFP website, to view a (growing) list of suggested considerations, with an eye

toward practical and ideological evolution, as you assess your clinics’ achievement of *care coordination* in the medical home model. We hope you’ll help us modify this list so that it reflects your collective wisdom. The website also invites you to link to other articles about Medical Homes, catalogued for your reference.

Dr. Paul Terrill in Grand Marais muses: “Patients who don’t have an active medical home are kind of like tourists wandering around in Beijing without a guide. They may never get where they want or need to go, and there are a lot of vendors along the way who want/need to peddle their goods. If everyone has a good medical home that felt an ethical obligation to offer care that is evidence-based, necessary, best value, (and coordinated), I can easily see this country saving billions.”

Once again, *home* is where you’re known, valued, tended, and safe. Effective coordination of care implies – and in turn conveys – familiarity, caring, tending, and safety. A Medical Home must achieve those ends for a patient in health care terms, in order for patients to identify themselves as being “home”. Their care must be SEAMLESS. When patients enter the health care world without medical homes as patients, they’re just “tourists in Beijing without a guide”.

The next article in this series will focus on the concepts of Patient Centeredness, and Enhanced Access. Please offer your thoughts on these or other Medical Home topics in support of this educational efforts. Emails can be sent to office@mafpo.org.

2008 MAFP Winter Conference will Focus on Pediatric Topics

Pediatrics is the focus for our 2008 Winter Conference on February 1 & 2 at Arrowwood Resort in Alexandria. Confirmed sessions include Children with Special Needs, Dermatology, Heart Murmurs, ADHD, and Autism. In the works, we have Childhood Obesity, Teen Sexuality and the HPV Vaccine and Diabetes.

At this conference, CME sessions take place in the mornings, leaving afternoons open to spend with family or to get away on your own. Arrowwood’s Big Splash Indoor Waterpark has four-story slides, a lazy river inner tube ride, a tropical whirlpool spa and a 500 gallon splash bucket! Trek (across the parking lot) to Arrowwood’s Snow Center for cross country skiing, ice skating, snowmobiling, sledding and ice fishing. Or, unwind at the Darling Reflections Spa with a pampering massage. Hours and rates are available at www.arrowwoodresort.com. Arrowwood lies just outside the charming town of Alexandria which is packed with shops, restaurants and a movie theater. Visit www.alexandriamn.org to learn more.



Rooms are being held by Arrowwood at a special rate until January 1, 2008. Waterpark tickets can be wrapped into your room rate upon request. Please remember to mention the Minnesota Academy of Family Physicians when making your reservation at (320) 762-1124. Childcare is provided through Camp Arrowwood which provides games, movies and supervision for children ages 4 – 12. The cost is \$25/child for one day or \$35/child for two days. **Parents must register their children before January 18** by calling the above number and asking for the Camp Arrowwood Extension 270. Specify which day(s) child care is needed and that you are with the Minnesota Academy of Family Physicians’ Conference. Children must be at least 4 years old and potty trained to attend. Arrowwood can provide a list of babysitters for children under 4.

The Winter Conference is possible through the work of our planning committee and the support of our exhibitors. Watch your mail this fall for a registration brochure. For more information contact Lisa Regehr at (952) 542-0130, (800) 999-8198, or lregehr@mafpo.org.