A care coordination success story

Gary* is a 66-year-old diagnosed with Type 2 diabetes in 2014, with an A1c of 8.5. He is also morbidly obese. Shortly after diagnosis, Gary was referred to care coordination for in-person and telephonic support. The care coordinator provided education and an action plan to help him adopt healthy eating habits and increase his activity level. Seven months later, Gary has lost 65 pounds, his A1c is 5.8 and he no longer needs to take medication to manage diabetes and high blood pressure.

**Patient name has been changed to protect their privacy.*

Patients with chronic conditions and other serious medical risks require intensive, ongoing support to improve their health. However, your practice is already trying to do more with less today and may not have the time or resources needed to offer this level of care. That's why SCICN-VC has developed an Ambulatory Care Coordination program to provide personalized outreach for these patients. It is available to the "high risk" and "rising risk" patients of physicians that have joined SCICN-VC.

"I have had the pleasure of utilizing the CI chronic care coordination team for more than 75 of my senior patients. The patient response has been overwhelmingly positive and it has been instrumental in improving their home health care. From being a kind, receptive ear to recommending a major change in acute medical care, the staff always made a positive impact on my patients' well being. It has been very pleasing as a geriatric provider to hear directly from my patients that just having someone to talk to made them feel better. I commend you on a job well done!" **–Gary Deutsch, M.D.**

Southern California
Integrated Care Network®
Ventura County Chapter

scicn-vc.org

Supporting your efforts to engage patients and improve their health.

An introduction to the Southern California Integrated Care Network–Ventura County Chapter (SCICN-VC) Ambulatory Care Coordination Program

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How the program works

The Ambulatory Care Coordination Program is staffed by highly trained care coordinators. These registered nurses have access to a wide variety of resources, which may include other clinical and social support professionals. Ongoing patient outreach may be conducted in-person and/or by telephone.

Our care coordinators work closely with your high risk and rising risk patients to promote better management of their health on an ongoing basis by:

- Developing personalized goals and self-management improvement strategies for patients.
- Helping these individuals maintain regularly scheduled office visits at your practice.
- Assessing medication adherence, potential medication risks and patient educational needs.
- Educating patients to better understand their medical issue(s) and your treatment plan.
- Preventing avoidable hospital admissions through an assessment of clinical and social factors that place the patient at risk during transition of care.
- Coordinating a transition of care plan if hospitalization is needed.
- Assessing behavioral health challenges, such as substance abuse and mental health issues, and coordinating referrals as appropriate.

A unique physician-directed approach

Unlike many traditional care coordination models, our Ambulatory Care Coordination program is physician-directed, which means that it serves as an extension of your own care practices. Once you refer a patient to the program, you will consistently stay informed of their progress and will be involved in decision making related to their treatment. This includes face-to-face meetings within your practice, as well as the sharing of care plans, outreach reports and documentation of a patient's progress.

Identifying patients for care coordination support

The SCICN-VC Ambulatory Care Coordination team will work closely with you to identify high risk and rising risk candidates for this program. Patients that meet the program criteria will likely have one or more of the following:

- Two or more chronic conditions
- Multiple chronic or high-risk medications
- Multiple emergency department visits and/or hospitalizations
- Social barriers—for example, living alone without caregiving assistance
- Other provider-identified needs

We also utilize advanced analytics to determine which patients need additional assistance, including individuals that haven't maintained an ongoing relationship with a physician.

In these cases, we may refer new patients to your practice as needed. At the same time, we analyze data from our hospitals to implement timely transition care efforts whenever a patient is discharged from our emergency department or an inpatient stay.

SCICN-VC is dedicated to giving you the tools and resources you need to improve the health of your patients.

To learn more about the Care Coordination program, please call 805-256-1380, fax 805-256-1378 or email us at CareCoordination@IdentityMSO.com

Clinical Integration Care Coordination Provided by identityMSO

"We understand that in today's "values based environment" complex patients can greatly benefit from a more integrated and multidisciplinary approach to care. That is why SCICN-VC is bringing together care coordination resources to help our physician members care for their complex patients. We believe this model brings value to our patients and helps participating providers offer more comprehensive care."

–Gary Greensweig, DO FAAFP, Chief Physician Executive, Physician Integration & Population Health