Building out the Medical Neighborhood using Care Compacts

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Objectives

- System of Care Experience
- Key Messaging for Specialists
- Efforts to spread the physician compact
- Lessons Learned
Elements Necessary for 21st Century Health Care

A system must demonstrate the ability to:

1. Effectively Communicate & Coordinate Care
   - Health Information Technology/Exchange Infrastructure

2. Demonstrate Continuous Improvement
   - Quality Improvement Approach

3. Establish Standards & Monitor Performance
   - Evidence Based Medicine & Population Management

4. Provide Value to the Community
   - Efficiency, Quality & Safety

Patient Centered Approach
System of Care Initiative Overview

- Educate both primary care and specialty care physicians on the medical home approach

Focus Areas:
- **Awareness**: increase in awareness about the patient centered medical home and integrated system of care models.
- **Activation**: increase in physician participation in PCMH and system level activities.
- **Policy**: concurrently support policy efforts that further the development of medical homes.

- Partnership between Colorado Medical Society, Colorado Academy of Family Physicians, Colorado Society of Osteopathic Medicine, American Academy of Pediatricians, CO Chapter, American College of Physicians, CO Chapter, Health TeamWorks
Awareness of the Medical Home Approach

Statewide physician poll in 2009 to understand Colorado physicians perceptions and priorities.

Awareness of PCMH (very or somewhat familiar)
- PCPs (2009): 80%
- Non PCPs (2009): 56%
- PCPs (2011): 77%
- Non PCPs (2011): 57%

Likely to become PCMH / Support PCMH approach
- PCPs (2009): 74%
- Non PCPs (2009): 57%
- PCPs (2011): 74%
- Non PCPs (2011): 74%

Perceived Benefits of the Medical Home Approach

- Care Coordination
  - PCPs (2009): 70%
  - Non PCPs (2009): 62%
  - PCPs (2011): 70%
  - Non PCPs (2011): 76%

- Patient Satisfaction
  - PCPs (2009): 68%
  - Non PCPs (2009): 59%
  - PCPs (2011): 60%
  - Non PCPs (2011): 68%

- Patient Outcomes
  - PCPs (2009): 78%
  - Non PCPs (2009): 50%
  - PCPs (2011): 72%
  - Non PCPs (2011): 76%

Re-surveyed in 2011 to determine progress
Overall Satisfaction with Care Coordination

Coordination of care (major area of focus)

Receives necessary information from referrals

PCPs included in development of specialist treatment plan

PCPs support treatment plan & recommendations

Are you willing to meet with primary care?
Perception

- 69.3% of PCPs reported they "always" or "most of the time" send notification of a patient's history and reason for consultation to specialists.

- 80.6% of specialists said they "always" or "most of the time" send consultation results to the referring PCP.

Reality

- 34.8% of specialists said they receive it "always" or "most of the time.

- SOC/PCMH Poll indicates 37% of specialists receive necessary information.

- 62.2% of PCPs reported getting it "always" or "most of the time."

- SOC/PCMH Poll indicates PCPs receive info 52% of the time.
Care Coordination Ring

- Transitions over entities
  - Among members of one care team (receptionist, nurse, physician)
  - Between patient care teams
  - Between patients/informal caregivers and professional caregivers
  - Across settings (primary care, specialty care, inpatient, emergency department)
  - Between health care organizations

- Transitions over time
  - Between episodes of care (i.e., initial visit and followup visit)
  - Across lifespan (e.g., pediatric developmental stages, women's changing reproductive cycle, geriatric care needs)
  - Across trajectory of illness and changing levels of coordination need

Convergence of key reform efforts

**Medical Home Elements**
- Care Management & Care Coordination
- Manage a population using evidence based guidelines
- Leadership & Team Based Care
- Outcomes Reporting
- Patient Engagement & Access
- Efficient Use of Resources

**Payment Reform**
- Method for tracking high risk patients
- Capability for tracking patient care & ensuring follow-up
- Coordinated relationships with other specialists & hospitals
- Data & analytics to measure and monitor utilization & quality
- Resources for patient education & self management support
- Physician with time for diagnosis, treatment planning and follow up

**Integrated Delivery Systems**
- Identification & management of high risk/high cost patients
- Provider collaboration to collectively manage patients
- Governance with performance standards
- Data and analytics to assess quality, cost & utilization
- Responsible for health of population
- Aligned financial incentives

H. Miller
Key Messaging

- Create Core Competencies & Capabilities to be nimble:
  - The functional elements of the medical home are the same characteristics of newly designed care delivery and payment systems.

- Create Win/Win Scenarios: Care coordination & transitions are a common pain point for all physicians.

- Relationships Matter:
  - Communication suffers in the absence of a good working relationship
  - Performance and payments will be assessed across an episode – be purposeful about managing your medical neighborhood.

- Practical & Accessible Tools:
  - Developed a physician care compact to facilitate primary care/specialty care communication
  - Working with state HIE on e-referral module
Medical Neighborhood & Care Coordination

- Medical Neighbor (PCMH-N)
  - A clinician that collaborates with a PCMH, or another medical neighbor, to facilitate the efficient, appropriate and effective flow of patient information and participate in the care team that effectively addresses issues of responsibility and accountability in transition of care and shared decision making. (ACP Position Paper on the Medical Neighborhood, 2010)

- Care Compact/ Collaborative Care Agreement developed to standardize communication between providers in the referral process.

- Key Elements:
  - Types of Care Transition (defining responsibility)
  - Principles of agreement (identifying what can be provided)
  - Transition of Care Record (Minimum Data Set for referral)
  - Opportunity for physicians establish/re-establish personal relationship

- Developed compact facilitation guide and medical neighborhood toolkit to support implementation of the care compact.
Compact Spread Efforts

Implementation Scenarios

1. Primary Care/Medical Home creates medical neighborhood with specialists.
2. Specialist/Service Lines drives implementation of compact
3. Community gathers to use compact as communication standards for referrals.
4. Hospital develops compact and implements across staff and with community referring physicians as part of care transitions (currently being tested)
Medical Home creates medical neighborhood

- Scott Hammond, MD authored care compact and piloted development of medical neighborhood.

- Individual invitations to key specialists inviting them to a meeting and introducing compact and requirements

- Quarterly review of adherence to compact requirements using a score card.

- Performance is communicated to specialists and timeframes and requested for improvements

- Medical Neighborhood toolkit developed to help specialists implement compact.

- 50+ Physicians, 18 specialties and 1 hospital participating to date

- Medical home has confidence that when they refer patients to specialists participating with a compact that they will receive necessary information and can engage in shared care planning.
Specialist Initiates the Medical Neighborhood

- Very large cardiology group affiliated with an integrated hospital system realized the utility of the compact to support a cardiology service line and championed implementation.

- Hosted a meeting between cardiology and primary care physicians to review the compact and conducted a facilitated activity to map the referral process.
  - Identified top 5 referring conditions and tagged critical clinical information
  - Identified data elements that need be included in e-referrals within EHR.
  - Rolling out new referral template system-wide and identifying practices to pilot more in-depth compact implementation (August).

- Hospital and Medical Group leadership sees the compact as an opportunity to: facilitate physician relationships, create a system-wide standard of communication and supports the foundation for building an ACO.
Community Approach

- Local medical society convened physicians to develop a vision for physician communication within their community.
  - Hosted an educational meeting and facilitated an activity with participants to develop aim statement and identify top 3 priorities to improve care coordination.
  - Developing 5 part community curriculum using Ed Wagner’s Care Coordination Framework
  - Established workgroup to blend compact & e-referrals
- Physician vision is to use the compact as a standard for referrals, regardless of affiliations. “The rising tide floats all boats”. 
Key Change Concepts

Assume **accountability**

Provide **patient support**

Build **relationships & agreements**

Develop **connectivity**
Relationships & Agreements

- Physician Care Compact
  - Clarification of Care Management Roles: clearly defines who is doing what in patient’s care.
  - Transition of Care Record: establishes minimum data set that will travel with patient referrals.
  - Agreements & Expectations: Sets up clear expectations for how referrals should be handled
Develop Connectivity

- CORHIO’s e-referral module:
  - Provides secure technology platform to enable electronic transfer of referral request
  - Ensures necessary clinical information is available at point of service
  - Tracks key milestones in the referral process
  - Allows high degree of flexibility & customization
Community Based Referral Template

Care Compact

E-Referral Module

Community Based Template
- Roles
- Min Data
- Expectations
What did we learn?

- Different value propositions for stakeholders – all conclude that it’s the right thing to do!
- Most willing to participate and believe they are or can fulfill most expectations
- Interpretation of the **Compact** not straight forward
- Wide variety of practice infrastructure, capacities, effort and barriers to change
  - Staffing, technology, teamwork
  - Systems improvement (QI) not on radar
  - Overwhelmed
  - Progress subject to inertia
- It’s a very purposeful process, important to have your own house in order first!
- Walk your way into a new way of thinking!
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