The ACP Medical Neighborhood- the Specialist Viewpoint

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The PCMH- Neighbor Model

THE STORY

The ACP *"Neighborhood Development"* Process……

- The American College of Physicians (ACP) is the largest medical specialty organization: 45 % of its 129,000 members are in *subspecialty* practices.
  - COUNCIL OF SUBSPECIALTY SOCIETIES (CSS)

- How do Specialty practices work within the PCMH model ?

  - 2006 Advanced Medical Home Model proposed
  - Spring 2007 Joint Principles of PCMH released
  - Spring 2007 Workgroup on PCMH-N formalized
  - Fall 2010 PCMH-N Policy Paper released
  - Ongoing Workgroup efforts (CCA template for Referral Process, NCQA , ABIM, outreach)

Specialists' Reaction to PCMH

Defensiveness and Fear:

- **Hoarding** ("I'll make my practice a PCMH so I can get all that money for myself")
- **Dumping** ("so if they are going to get paid for coordination of care, I'll just send everyone back to them (PCMH) to do all the work")
- **Fear of being dumped on** ("they will just send us all the hard patients and they will keep all the money and get all the credit")
- **Fear of loss of territory** ("this is a plan to decrease referrals to specialists")
- "Things are fine the way they are…."
- "Specialists are the crux of the American health system"

First Steps Forward

- Recognition of the value of role differentiation
  - Appreciation of primary care issues
  - Specialty skill sets required for some care coordination and management
- Acknowledgement of a flawed system
- Longing for more "professionalism"
  - Better communication, respect and consideration, cooperation and integration

Finding the Gap: Defining the Gap

Dissatisfaction at Multiple Levels

- Patients: problems with access, poorly coordinated care, errors
- Physicians: Primary care inadequate time & compensation; Specialty care inequities, poor quality of referrals, difficulty coordinating care
- Purchasers/Employers: High cost of care, poorly coordinated, suboptimal outcomes
- Payers: suboptimal outcomes, mediocre performance on key metrics

Many defects in current system stem from its ***disorganization***.

Operate in Silos

- Fragmentation
  - No one coordinating and integrating
- Duplicated Services / Redundancies
  - Cost / Wasted Resources
- Safety Issues with Transfers and Transitions
  - Missing Information

Operate on Assumptions

- Integration depends on the diligence of the individual physicians
- There is no "system" for coordination
- Current payment model rewards the "staccato" Acute Care model instead of a continuous Chronic Care model thus does not "value" care coordination..
- Assumes it will "just happen"…

U.S. Health Care

- Great Skills
- Great Science
- Poor Integration / Delivery
  - No curriculum for communication/care coordination
  - No professional norms for communication or care coordination (documentation vs communication)
- Does this matter?

U.S. Men's Basketball Falls Flat on World Stage
By David DuPree, USA TODAY
August 15, 2004

ATHENS- There are no plausible excuses this time. It wasn't the 2002 World Championships, when an NBA "C" team lost games to Argentina, Serbia and Montenegro and Spain and finished in sixth place. It wasn't a meaningless exhibition game like the one the USA lost by 17 points to Italy 13 days ago.

- *This is the Olympics, and the U.S. men's basketball team was rocked, shocked, humiliated and exposed on sports biggest stage Sunday as Puerto Rico, a Commonwealth of 4 million residents, pulled off the upset of all Olympic upsets with a 92-73 drubbing of the Americans.*

Most SKILLED players in the world, this was "no C team" . What went wrong ??

GREAT PLAYERS vs. GREAT TEAM

It was never a contest.

- *"They played as a team," U.S. coach Larry Brown said of Puerto Rico. "They played so much harder and so much better than we did that the result isn't a surprise at all. I don't know what we can take from this. The only thing we can do is find out what we're made of. It's a chance for us to come together and see if we really are a team."*

It is Scientific……..

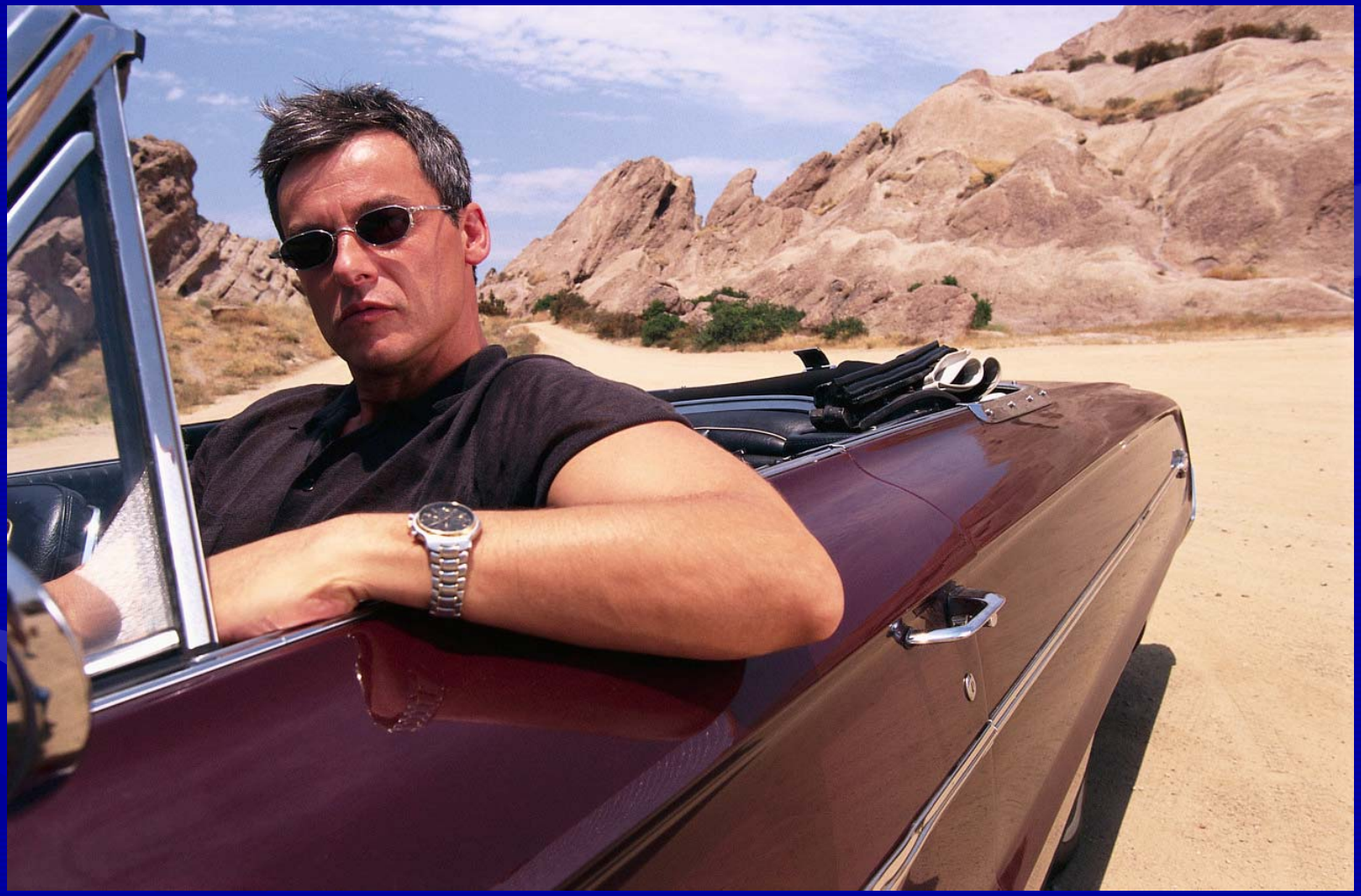
- When People Cooperate as a Team, They are More Effective at What They Do

Medical Home Model

- Chaos
  - Acute Episodes of care
  - Hamster wheel practice
  - Tyranny of the Urgent
- Organization
  - Chronic Care Model
  - Patient-Centered
  - Team Care/Communication
  - Registries
  - Improved Access

Well-tuned team machine

But now,
I'm a Ferrari on a dirt road…



Paving the Roads

- We need SKILLS, we need SCIENCE, but to pull it off well, we need to work as a TEAM, we need to know what POSITION we play and we need a GAME PLAN

- We need to connect to each other; we need a SYSTEM or a GRID for COMMUNICATION & CARE COORDINATION

PCMH-Neighbor Model

Proposes a ***Framework*** for Interactions between PCMH practices & Specialty Practices

- An infra-structure/ scaffolding upon which Care Integration and Information Exchange can be built
- Restore Professional Interactions needed for Patient Centered Care
- Improve Care Transfers and Transitions to enhance Safety and Stewardship

PCMH-Neighbor Defined as practices that:

- Communicate, coordinate and integrate bidirectionally with PCMH as well as with patient
- Ensure appropriate & timely consultations and referrals
- Ensure effective flow of information;
- Address responsibility in co-management situations;
- Support patient centered care
- Support the PCMH practice as the "hub" of care and provider of whole person primary care to the patient

How Does PCMH-Neighbor Model Work?

– Care Coordination Agreements

- The "structural elements" of the Neighbor model
- Intended to serve as a "grid" upon which care integration and communication can be built

Care Coordination Agreements/ Compacts define:

- Types of Interactions
  - Pre-visit assistance to expedite/ prioritize care
  - Consultation /procedure
  - Comanagement
    - Shared care
    - Principal care
- Responsibility for the elements of care
- Expectations for information exchange

- Provide foundation of *Definitions* and *Expectations*

The *Principles* of Care Coordination Agreements for PCMH –PCMH-N

- A GUIDE for the content of these agreements
  - What is OPTIMAL
  - What is CRUCIAL
  - What is FEASIBLE
- Allows for Flexibility: need for Local determination of actual agreement
  - Availability of specialists /capacity
  - Availability of PCMH
  - Availability of Resources / HIT
  - Local Tradition; what works already

Referrals, Consults, Co-management: General: for all patients

PCMH

- Prepare patient
  - Use of referral guidelines where available
  - Patient/family aware of and in agreement with reason for referral, type of referral, and selection of specialist
  - Expectations for events and outcomes of referral
- Provide appropriate and adequate information. *(Optimally adopt mutually agreed upon referral form with neighbor*)*
  - Demographic and insurance information
  - Reason for referral, details
  - Core Medical Data on patient
  - Clinical data pertinent to reason for referral
  - -- Any special needs of patient.
- Indicate type of referral requested:
  - Pre-visit Preparation/Assistance
  - Consultation (Evaluate and Advise)
  - Procedure
  - Co-management with Shared Care
  - Co-management with Principal Care
  - Full responsibility for all patient care
- Indication of urgency
  - Direct contact with specialist for urgent cases
- Provide Neighbor with number for direct contact for additional information or urgent matters
  - Needs to be answered by responsible contact

* See provided model check list of suggested areas to address.

Neighbor

- Review Referral Requests and Triage According to Urgency
  - Reserve spaces in schedule to allow for urgent care
  - Notify referring provider of recognized referral guidelines and inappropriate referrals
  - Work with referring provider to expedite care in urgent cases
  - Verify insurance status
  - Anticipate special needs of patient/family
  - -- Agree to engage in pre-referral consult if requested.
  - Provide PCMH practice with number for direct contact for urgent/immediate matters.
- Provide appropriate and adequate information in a timely manner. *(Optimally adopt mutually agreed upon referral response form with PCMH*)*
  - To include specific response to referral question and any provision of or changes in type of recommended interaction; diagnosis; medication; equipment; testing; procedures; education; referrals; follow up recommendations or needed actions

* See provided model check list of suggested areas to address.

Referrals, Consults, Co-management
General: for all patients

PCMH

- Review secondary diagnoses or suggested referrals identified by Neighbor/specialist.
- If co-managing with Neighbor, provide them with any changes in patient's clinical status relevant to the condition being addressed by the Neighbor.
- Contact the patient, if deemed appropriate, when notified by Neighbor of failure to keep appointment.

Neighbor

- Indicate acceptance of referral category or suggest alternate option and reasoning for change.
- Refer follow-up of any secondary diagnoses (additional disorders identified or suspected) back to the PCMH for handling unless directly related to the referred problem.
  - If secondary diagnosis is followed up by Neighbor, notify PCMH.
- Information regarding any secondary referrals made by Neighbor needs to be communicated to PCMH.
- Notify Referring Provider of No Shows and Cancellations.
- If patient is self-referred or referred by another specialist/Neighbor, the PCMH provider needs to be copied on the referral response upon obtaining appropriate patient permission.

Starting point:
Focus on the *Referral Process:*

- Define the Interactions and the Expectations for Accountability and Information Exchange
- The Components of the Referral Process:
  - Core Data Set
  - Referral Request
  - Specialty Response
  - "Prepared Patient
- Concept of *Referral Guidelines* (recommendations for what preparation and/or data will best facilitate the referral evaluation and /or management)

Types of Interactions:

- ***Referral & Co-Management Agreements*** need to be:
  - clearly communicated and understood by all parties including the PCMH and the specialty practice as well as patients and their families and caregivers.
  - Fluid (dynamic) to adapt to changes in patient or disease status

Pre-consultation Exchange/Non-Face-to-Face Encounter– intended to expedite/prioritize care

- **Avoid unnecessary specialty visit**
  - Answer clinical question
  - Identify inappropriate referral
- **Expedite care**
  - Urgent cases
- **Referral guidelines**
  - Prepared patient
  - Utilize providers at the top of their license

Formal Consultation – to deal with a discrete question / procedure

- Limited to one or a few visits that focus on **answering a discrete question**.
- May include a **particular service** request by a PCMH for a patient.
- A **detailed report and discussion of management recommendations** would be provided to the PCMH.
- *Examples*: Colonoscopy, Bone Marrow Biopsy, MRSA infection with recurrent carbuncles

***Co-Management*-Primary care and specialty care**

- Co-management with **Shared Care for the disease** (PCP responsible for Elements of Care)
- Co-management with **Principal care for the *disease*.** (Specialist responsible for Elements of Care for that disorder or set of disorders)
- Co-management with **Principal care of the *patient*** for a consuming illness for a limited period of time **(specialist serves as first contact but patient maintains PCP as Home)**

Co-Management Oncology examples:

- Shared Care for the Disease
  - CLL
- Principal Care of the Disease
  - Ductal carcinoma in situ (non-invasive breast cancer – DCIS)
- Principal Care of the Patient
  - Metastatic colon cancer with adjuvant chemotherapy

Expectations for Information Exchange

- Important at all levels for continuous coordinated care
  - *All* Transitions and Transfers
- Need to reduce "clutter" while increasing true communication of relevant essential data
  - Data can be lost in "mass" as well as omission
    - Referral Request from PCP with no information vs. entire medical record
  - Need to communicate pertinent information clearly and in detail
    - think "handoff"
    - think check list with some "meat" /thought process added in
- Examples from the ACP Neighbor:
  - Referral Response Critical Elements

Example: Nephrology referral response for evaluation of 36yo male with Type 1 diabetes, hx of Graves' disease & Celiac disease with Cr 1.9 and K+ 5.7

- Impression: Stage 3 CKD
- Plan: Recommend change from ACEI to CCB

- Why ?
- Who does what ?
- What is plan for f/u and which provider ?

- Impression: Stage 3 CKD due to type 1 diabetes and HTN with no evidence of additional autoimmune renal disease
- Plan: Shared Care with annual f/u
- Recommend change from ACEI to CCB due to persistent significant hyperkalemia due to type IV RTA and delay renal replacement
- I have provided script for amlodipine 5 mg qd with refills x11
- He is to see you for BP check and BMP in 1 month
- Please feel free to contact me if K+ still elevated or BP not controlled
- Provided handouts on CKD to pt

PCMH-NEIGHBOR MODEL

- *Patient-Centered extension of team care* (team members working for what is best for the patient)
- *Care Coordination* (define roles and accountability)
- *Clear Communication* (define expectations)
- Provides for *flexibility and fluidity*

Specialists' Reaction to Neighbor

- **Are you telling me that I do not communicate ?**

- *You* might communicate superbly, but we need *everyone* to do so
- Let's look at the data……

Failures in care coordination are common and can create serious quality concerns. *Bodenheimer NEJM 2008*

- For referred patients:
  - **68% of specialists** reported receiving **no information** from the primary care provider prior to referral visits: **25% of primary care providers** had not received any information from specialists **4 weeks after** referral visits:
  - 28 % of primary care and 43% of specialists are **dissatisfied with the information they receive** from each other. *Gandi et. al. J Gen. Int. Med. 2000*
- Referring physicians received **feedback** from specialist **only 55 % of the time.** *Forrest et.al Arch of Ped. Adol Med 2000*

Referral and Consultation Communication Between Primary Care and Specialist Physicians

Arch Intern Med. 2011;171(1):56-65

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 time.

Specialists' Reaction to Neighbor

- Are you telling me that I do not communicate ?
- **I do not have enough time to do this**
- **I do not get paid to do this**

- *REALLY ?*

Samplings from My list of "I do not have time to do this/ I do not get paid for this"

- Cognitively impaired woman sent from SNF with only medication list
- Patient with Lupus in exam room for new consultation, I am an endocrinologist
- Called by hospitalist to see patient with 15 year hx with another endocrinologist
- 63 yo male referred with long-standing diabetes and a 12# stack of records
- 70 yo woman does not know why she was referred, PCP staff just told her to make appt, no records, only get into voice mail at PCP office
- Observation: No pediatric cases listed here…..

Communication & Care Coordination is *Valuable*

- It does take time
- It does take effort
- The benefits are obvious
- The ROI is huge
- We need that INVESTMENT from *all* participants to improve the Hand-Offs: to improve Care Coordination
- *Payment Reform needed to support these efforts*

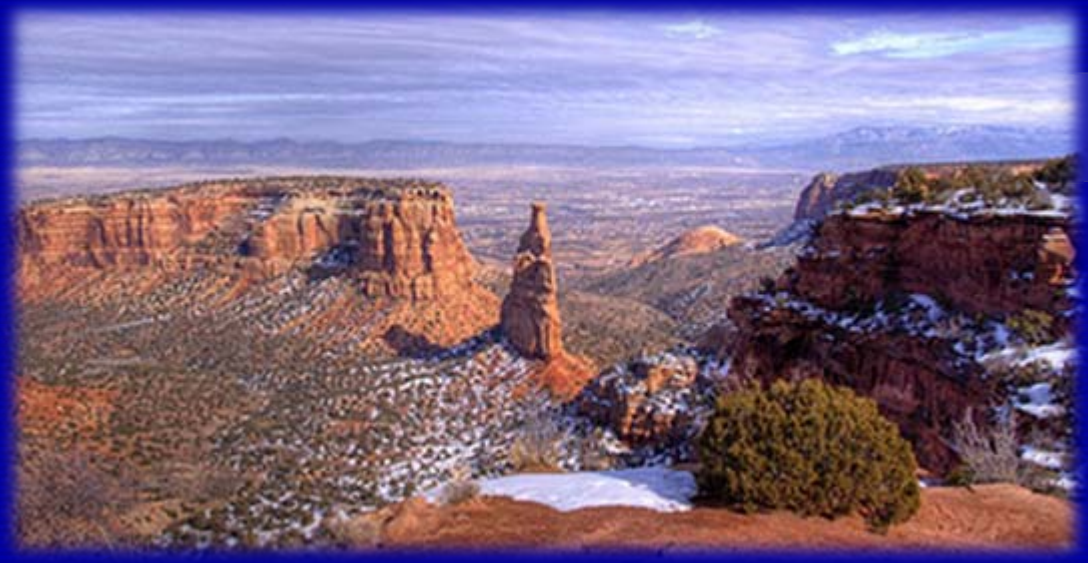
Building the Neighborhood

- Tools from the Trenches
  - Provider to Provider
  - Organizational
  - System wide
  - www.acponline.org/running_practice/pcmh/understanding/specialty_physicians.htm
- Insights from Mesa County Physicians' IPA

Mesa County Independent Physicians Association

35 Year History

- Risk contracting
- Messenger Model
- 282 Members
  - 90% of the physicians in the county
    - 20% Hospital Employed
    - 40% Primary Care
- Incentive Programs
  - Earn back With-hold $



MCPIPA Incentive Programs

- Primary Care
  - Past
    - Wagner Chronic Care Model, Generic Prescribing
    - Diabetes, CVD measures, Utilization measures
  - Current
    - Registry Deployment
    - QHN participation
  - 2012
    - ***Referral transitions (Medical Neighbor)***
    - ***Measure Improvement***
- Specialist Physician
  - Past
    - $/referral
    - Generic prescribing
  - Current
    - QHN Participation
    - Patient Satisfaction Survey
  - 2012
    - **Care transitions (Medical Neighbor)**

Referral Form

PROVIDER REFERRAL REQUEST FORM

REFERRING TO

Specialty:	**Phone:**	**Fax:**
Practice Name & Address:		

Please Schedule (select all that apply):

- ☐ Urgent– Referring physician called _____
- ☐ Routine Appointment with Specific Physician listed: _____
- ☐ First Available with any Physician

Referring Provider's Name:	**Phone:**	**Fax:**

TYPE OF REFERRAL

- ☐ Evaluation consultation with treatment recommendations that primary care physician will continue to follow
- ☐ Evaluation consultation with assumed care for this condition
- ☐ Evaluation consultation with treatment recommendations and shared care
- ☐ Specialist to Specialist*–Secondary Referral
  *Send copy of this referral to patient's primary care physician.
- ☐ Other (designate)_____

PATIENT INFORMATION

Patient Full Legal Name:		DOB:
Preferred Phone:	Best time to call:	
Special Patient Considerations:		
Patient Insurance Information:		
Patient's Primary Care Provider:	Phone:	Fax:

GENERAL INFORMATION

Reason for Referral (*Clinical Question*):

Comments/Considerations Related to Clinical Question: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.**

Patient aware of reason for referral? ☐ Yes ☐ No: Explain

PROVIDER REFERRAL CONFIRMATION

REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No: Explain

Appointment Scheduled with:	**Date & Time:**

☐ Patient refused scheduling ☐ Patient prefers to contact specialist to schedule at a later date

Request for additional supporting clinical information (please detail):

Person completing confirmation:	**Date of Confirmation:**

The Medical Neighbor Incentive

- 1st Quarter: Educational Meetings
  - *Physicians and Office Managers*
- 2nd Quarter: Policy & Procedure submission
  - *PCPs: referral generation & tracking*
  - *Specialists: referral confirmation & response*
- 3rd & 4th Quarters: Audit of Forms & Responses
  - *Use of the form*
  - *Referral Tracking*
  - *Response f/u (Letter, No Show or Cancellation)*

General Observations

- Process of creating the form is part of the transformation process & buy-in (avoid 'Pre-fab' form)
- The lure of the status quo is powerful
  - Have a preset strategy /plan for change
  - Place "change agents" on task force / committee
- There are many misconceptions & wrong assumptions
  - Include Specialists(Surgical & Medical) & Primary care in the same work groups
    - Example: PCP thought it best if their office made the appt for patient but specialist knew that was associated with high No Show rate.
    - Specialist thought they were helping by referring on to another…..
  - Include Different "Generations" (Junior & Senior staff)
    - Our "Vodka Meeting"

Generational Observations

- PCMH/ Practice Transformation: Junior > Senior
  - Autonomy vs Team Care
- Neighbor Model: Senior > Junior …unexpected ?
  - Junior Specialty members:
    - Did not understand reason for PCP, patient referral or notes
    - Notes for Billing purposes, personal use
    - Never read notes from other physicians
  - Realization: "Born into & grew up" in Silo Care
    - Need to go from KNOWN to NEW
    - Great enthusiasm and engagement can follow

Essential Items

- Education
- Processes (Urgent referrals, special needs, "record keeping", "prepared patient", etc) …Make it a focus (promotes team work within practices)
- Audits (random charts) (feedback & reworking)
- Tie in to HIT
- Patient-Centeredness (what is best for the patient)

Hopes & Concerns

- Enthusiasm & Engagement replacing Paranoia
- Physicians wanted More Physician Involvement
  - Not just for Office Managers
  - Include Radiology, Anesthesia, Pathology, etc
- Want to do more not less/ sooner not later
  - Limited by need to audit for incentive with finite staff resources (opted to still 'expect' it even without audit & incentive)
- Concerns
  - Secondary Diagnoses & Referrals (trust issues)
  - Specialists' wider range of referrals (outside referrals not utilizing same process) (hope to engage Colorado Beacon community)

Neighbor is about Relationships, about coming together as a team for patient care: *knowing our position, knowing the game plan and communicating*

Extra slides

Core Data Set

- Goes with patient in all transitions and transfers of care
- "Fixtures" of that patient's medical history
  - Demographics of patient
  - PCMH and other providers /contact info
  - Reconciled current problem list and medication
  - Allergies, PMH, Procedures, Family HX, Habits
  - Advanced directives
- "WORM" – Written Once Read Many Times *William Tierney MD, IOM*

Referral Request

- Type of service/ co-management requested
- Clinical issue or question
- Core Data Set (reconciled med list, allergies, etc)
- Clinical data set for that issue
- Urgent (recommend Direct contact) or routine
- Contact number for more information

Critical Elements of Response

- Answer the clinical question
- Recommended form of co-management
- Confirm existing or add new or changed diagnoses
- Medication changes
- Equipment changes
- Testing results, testing pending, scheduled or recommended (including how/who to order)
- Procedures completed, scheduled or recommend
- Education completed, scheduled or recommended
- Clearly stated any recommended services or actions to be done by the PCMH /PCP
- F/u scheduled or recommended

Prepared Patient

- Appropriate specialist at appropriate time
- Appropriate testing or therapeutic trials prior to referral
- Patient aware of and in agreement with referral with appropriate expectations
- Adequate/ Pertinent data supplied

Pre-Consult Exchange Issues

- In integrated systems - "e-referrals" *(Bodenheimer NEJM 2008)*
  - Hasten access to specialists/reduce unnecessary face-to-face specialty visits (improve access)
  - Improve coordination of care/ exchange of information
  - Reduce costs
- Barriers in Fee for Service model
  - Currently not reimbursed
    - Requires effort from both PCMH and Neighbor providers
    - Both should receive "credit"
    - Savings (cost and time) for system and patient
  - Liability issues