The Medical Neighborhood

A Primary Care Viewpoint

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## Problems with care coordination

<table>
<thead>
<tr>
<th>Coordination</th>
<th>Research</th>
<th>Source</th>
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<tbody>
<tr>
<td>PCP and Specialist</td>
<td>49% of referrals to specialist had no information. Specialist sent info 55% of time.</td>
<td>Forrest. Arch Ped Adol Med. 2000</td>
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<td>25% of specialist reports received &gt; 1 month after visit</td>
<td>Gandhi. J Gen Int Med. 2000</td>
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<td>34.8 % of specialists receive proper notification and information &quot;always&quot; or &quot;most of the time.&quot;</td>
<td>Arch Intern Med. 2011;171(1):56-65</td>
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<td>62.2 % of PCPs reported getting consultation reports &quot;always&quot; or &quot;most of the time.&quot;</td>
<td>Arch Intern Med. 2011;171(1):56-65</td>
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<td>52% specialists receive necessary information “always” or “regularly”</td>
<td>2011 Colorado SOC Survey - Kupersmit Research 2011</td>
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<td>38% PCPs included in care/support in role “always” or “regularly”</td>
<td>2011 Colorado SOC Survey - Kupersmit Research 2011</td>
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PCMH without a neighborhood
**Strengthening Medical Home Models**

**Barrier to Success of Medical Home**

- **Resistance to Collaboration**
  - Few incentives for hospitals and specialists to collaborate with PCP
  - Single-based data systems insufficient

- **Lack of Uncertainty of support**
  - Patient acceptability, fear of gatekeeping
  - Specialist acceptability, income threatened

- **Difficulty controlling costs**
  - Outside influences on costs
  - Savings in subpopulation offset by increased spending elsewhere

**Approaches to Overcome Barriers**

- **Share information among providers**
  - Require MH to specify networks for performance measures and information sharing
  - Require providers to meet connectivity standards

- **Establish performance measurements and rewards**
  - Transparency across continuum of care
  - Reward collaboration

- **Institute broad accountability for population-based savings**
  - Foster integrated delivery systems that share savings from Triple Aim

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Learning objectives

We should build a house.

Yes. I agree!
“I’ve got it, too, Omar … a strange feeling like we’ve just been going in circles.”
Working Together

What CAN a PCMH do?

• Care coordinator job description and protocol consistent with available resources.
  • Patient Navigator/Disease Management/Health Coach

• External care coordination
  • Hospital and skilled nursing facilities
  • Specialists

• Internal care coordination
  • High-acuity patients
    • Post-hospital
    • Multi-morbid diseases
    • Frequent ED utilization
Building a Neighborhood

Phase 1: Planning – Vision, Compact

Phase 2: Implementation – 5As

Phase 3: Evaluation

Phase 4: Sustainability and Continuous Improvement
Building a Neighborhood

Phase 1: Planning – where to start

- Complain
- Have a meeting
- Schedule more meetings
- Have a clear expectation for deliverables
- Do the hard work – focus on solutions not problems
- Patience and persistence
Phase 2 – the 5 As

Ask
- List
- Letters

Advise
- Message
- Send information

Assess
- Measure performance

Assist
- Toolkit
- Communication

Arrange
- Spread
- CQI
ADVISE:
The Implementation Message

- You as PCPs survive and thrive!

- Benefits to a PCMH-N
  - Patients
    - Activated, prepared, engaged
  - Specialty Care Physicians
    - Maintain autonomy, known for quality care, more exclusive patient volume from PCP
  - Practice of Medicine
    - Reclaim the joy of medicine, camaraderie, why you went into medicine
  - Health Care
    - Solvency, sustainability—jump start, pioneering—it’s the way of the future!
• Purpose and Principles
• Definitions
• Types of Care Transition
• Service Agreement
  • Transition of Care
  • Access
  • Collaborative Care Management
  • Patient Communication
• Transition of Care Records (PCP and Specialist)
Phase 3: Evaluation and Accountability

- Score Cards
  - 20 measures
  - Always or almost always (5); Usually (2.5); Occasionally (0); Rarely (-5); NA
  - 8 Must Haves ($\geq 2.5$)
- Transition of Care record audits
- Patient surveys
Extending the Neighborhood

Phase 4: Sustainability and Spread

- Physician-to-physician communication
  - Physician Champions
  - Mandatory emails
- Patient education
  - Pamphlet – *Welcome to the Neighborhood*
  - Wallet cards
- Engage
ASSESS: Measurement

Average % of TCR elements captured in referral notes from Primary to Specialty Care Providers
ASSESS: Measurement

Average % of TCR elements captured in notes from Specialty to Primary Care Providers
ASSESS: Measurement

Score Card % out of 100 points for Specialty Care

Jun-10: 74
Sep-10: 84.6
Dec-10: 86
Mar-11: 43
Jun-11: 76
Sep-11: 55
Dec-11: 56
WMC Medical Neighborhood

- Allergy-Immunology
- Cardiology
- Dermatology
- Gastroenterology
- Hematology-Oncology
- Mental Health
- Nephrology
- Neurology
- OB-GYN
- Ophthalmology
- Rheumatology
- Surgery
  - General
  - Orthopedics (3)
  - Spine (2)
  - Plastics and Hand
  - Urology

50+ Physicians
19 Specialty offices
1 Hospital
What did we learn about neighbors?

- Not aware of PCMH or Medical Neighborhood concept
- Most willing to participate and believe they are or can fulfill most expectations
  - “A slam dunk”, “Ideal in principle”
- Interpretation of the Compact not straightforward
- Unclear about definitions of transitions/management relationships and patient-centered care
- 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
- Specialists cater to many differing PCP requests
- **Transition of Care Record and QI** are main points of conversation
Change for the better requires that you shift from assuming excellence to pursuing excellence.

Tracy Hofeditz, M.D.

CO PCMH Pilot practice