Creating Medical Home Communities

Systems of Care/Patient Centered Medical Home Initiative

Building out the Medical Neighborhood using Care Compacts

Karen Frederick Gallegos, Director of Quality Initiatives

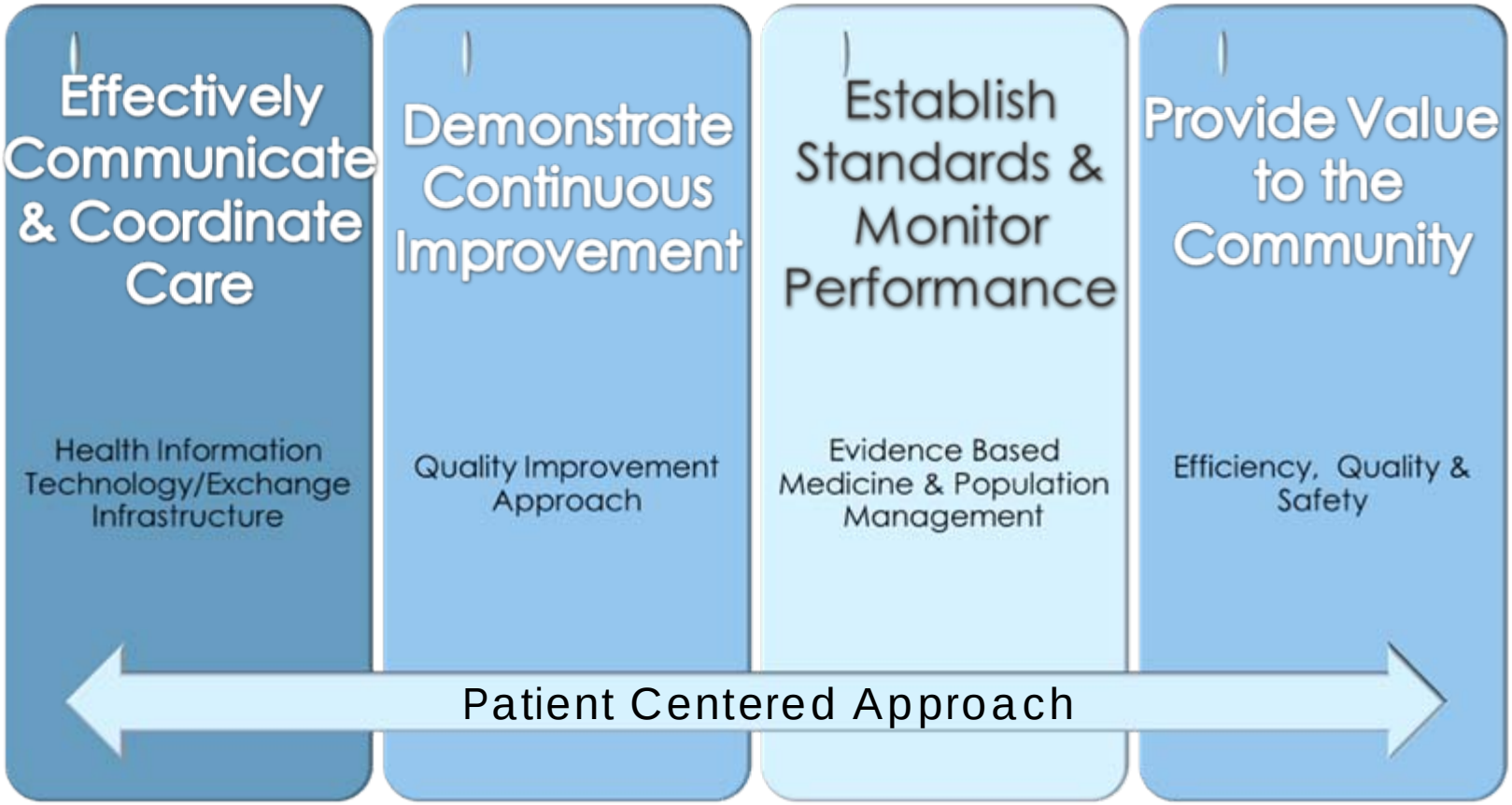
Colorado Medical Society

Objectives

- Overview of Colorado Systems of Care/PCMH Initiative
- Where does a compact fit into care coordination strategies?
- Efforts to spread the physician compact
- Key Learnings

Elements Necessary for 21st Century Health Care

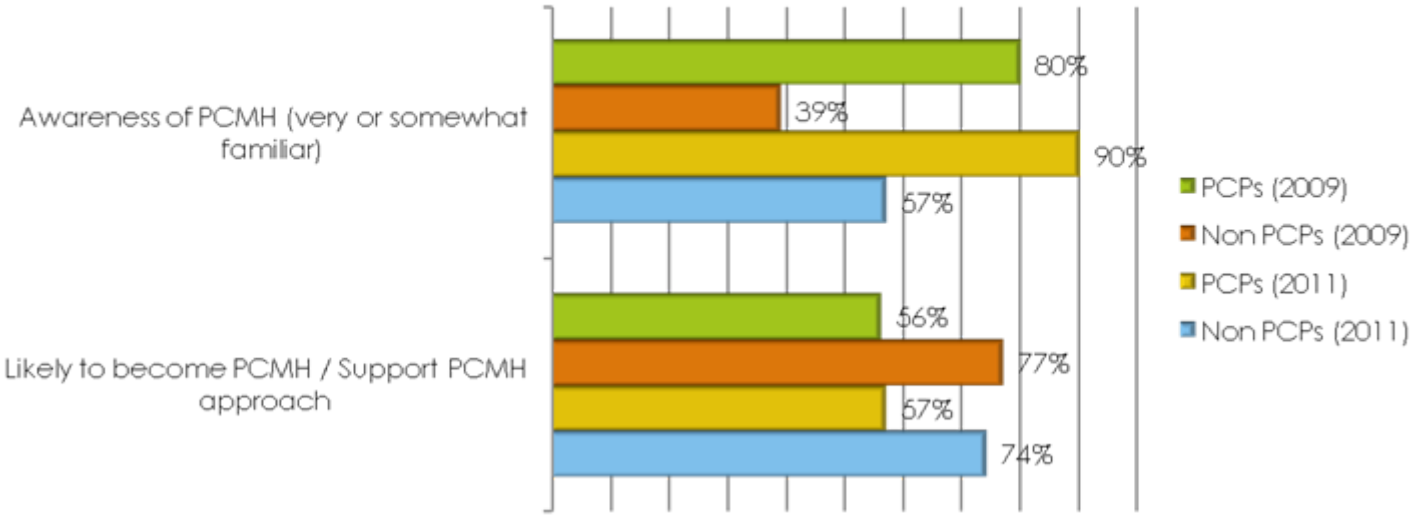
A system must demonstrate the ability to:



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

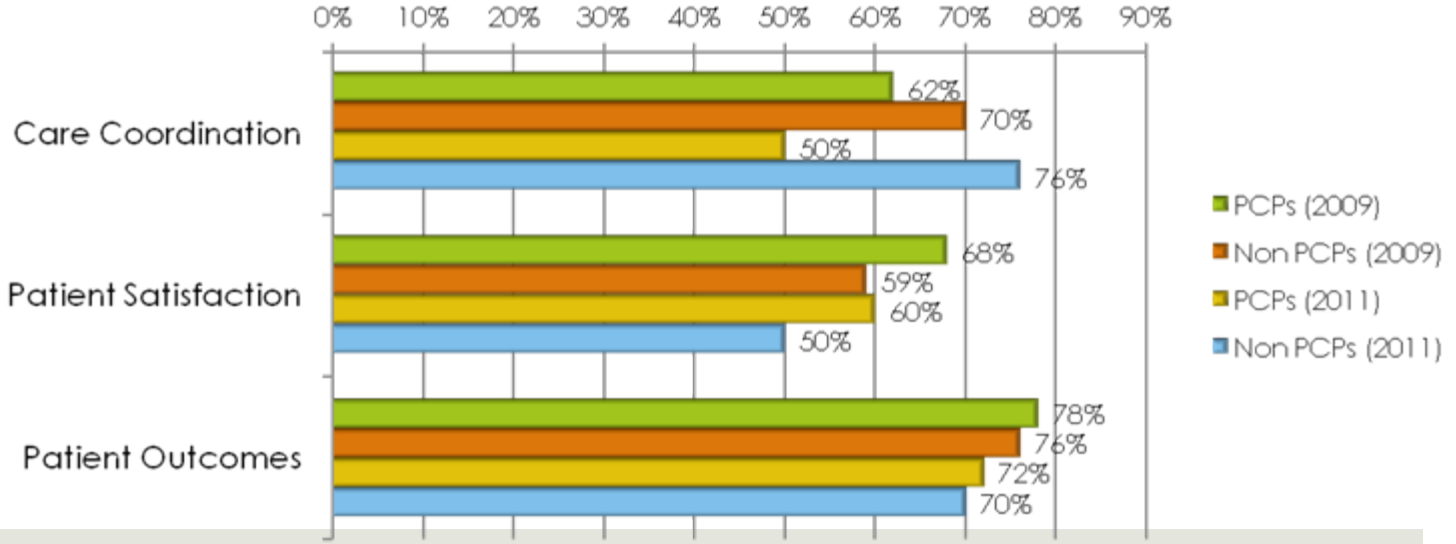
Awareness of the Medical Home Approach



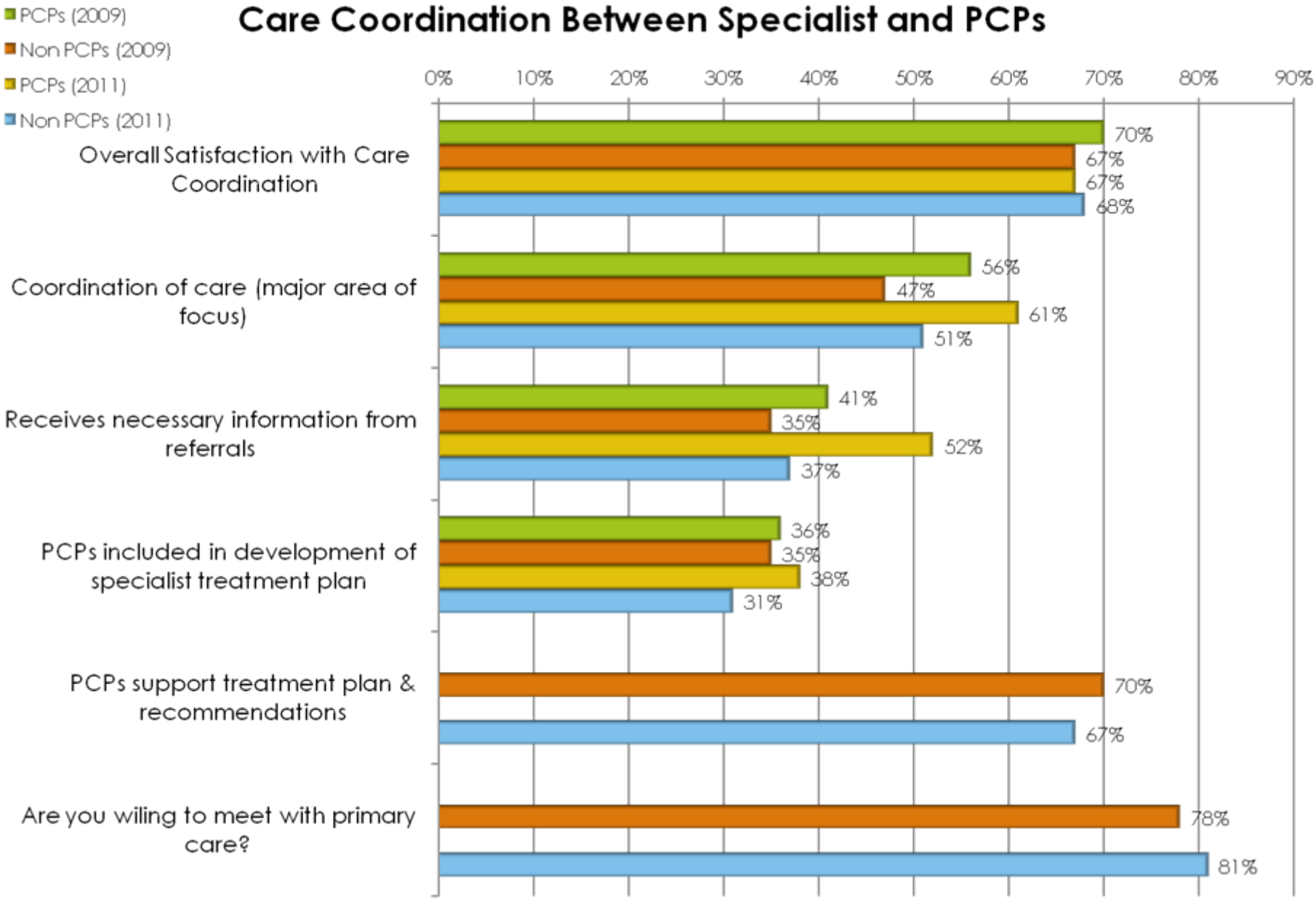
Statewide physician poll in 2009 to understand Colorado physicians perceptions and priorities.

Re-surveyed in 2011 to determine progress

Perceived Benefits of the Medical Home Approach



Care Coordination Between Specialist and PCPs



Reality of Care Coordination

- The **typical primary care physician has 229 other physicians** working in 117 practices with which care must be coordinated.

  Pham et. al Ann Int Med. 2009

- In the Medicare population, the **average beneficiary sees 7 different physicians** and fills upwards of 20 prescriptions per year

  Partnership for Solutions, Johns Hopkins Univ. 2002

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.

PCP/Specialty Conclusions

- Reform has created deep unease and physicians are looking for ways to position themselves to take advantage of decreasing resources.
  - Potential for inter-specialty tensions. Important to identify win/win scenarios.
  - Systems are being rapidly developed; direct care providers are in the best position to influence delivery system design.
- Care coordination is a common pain point for all physicians.
  - Care coordination will be a part of new integrated care delivery systems.
- Not very many practical tools to address the problem of care coordination.
  - Developed a physician care compact to facilitate primary care/specialty care communication

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

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.

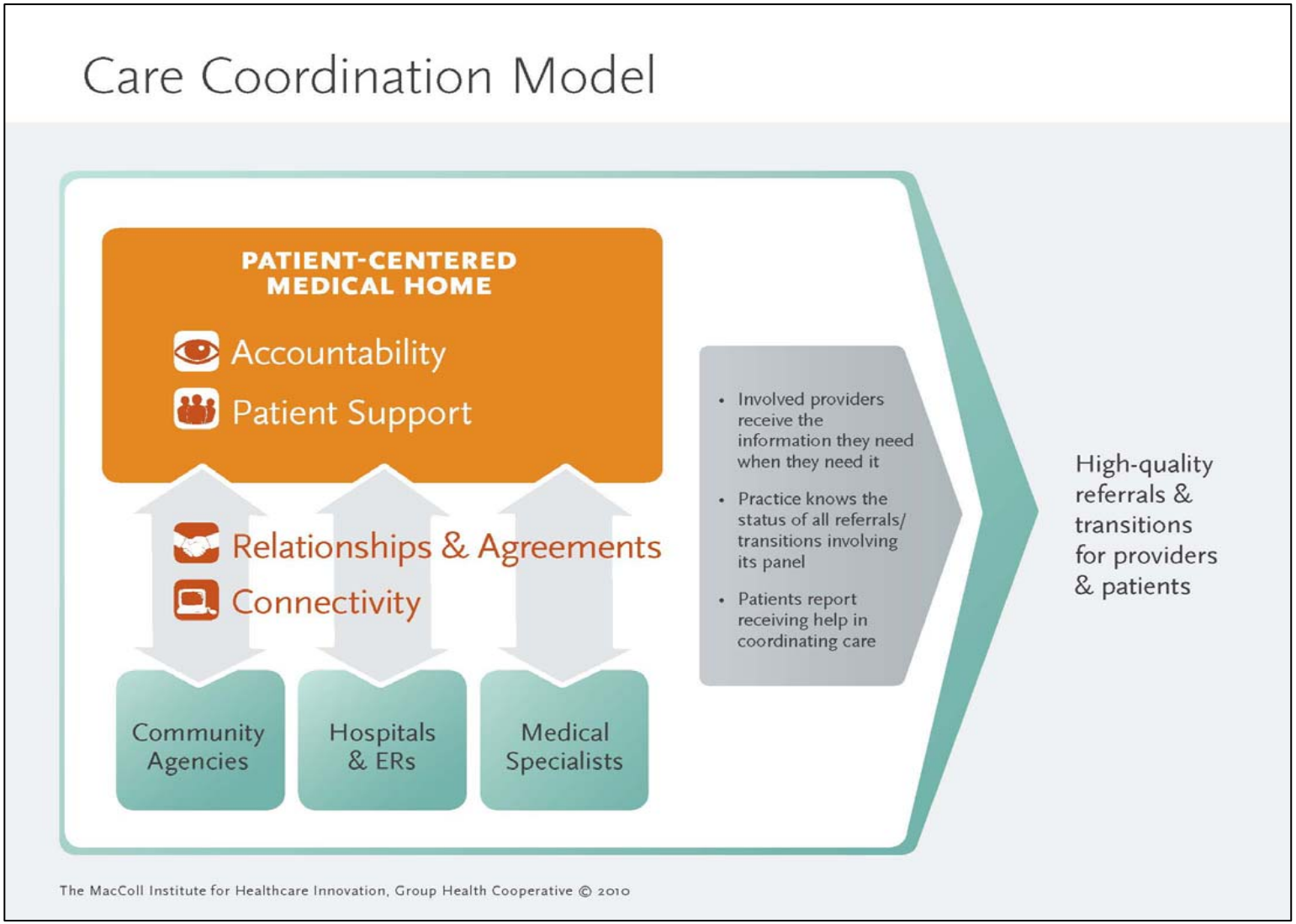
Care Coordination Elements:

- **Coordination Activities – unique activities that support coordinated care**
  - Establish Accountability or Negotiate Responsibility
  - Communicate (interpersonal and information transfer)
  - Facilitate Transitions
  - Assess Needs and Goals
  - Create a Proactive Plan of Care
  - Monitor, Follow up and Respond to Change
  - Support Self-Management Goals
  - Link to Community Resources
  - Align Resources with Patient and Population Needs

- **Broad Approaches – means of achieving coordinated care**
  - Teamwork focused on care coordination
  - Health Care Home
  - Care Management
  - Medication Management
  - Health IT – enabled coordination

Care Coordination Measures Atlas. AHRQ Publication No. 11-0023-EF, January 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/careatlas/

Ed Wagner's Care Coordination Framework



Collaborative Guidelines
Service Agreement

Transition of Care	
Mutual Agreement	
• Maintain accurate and up-to-date clinical record. • Agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD] • Ensure safe and timely transfer of care of a prepared patient	
Expectations	
Primary Care	**Specialty Care**
☐ PCP maintains complete and up-to-date clinical record including demographics. ☐ Transfers information as outlined in Patient Transition Record. ☐ Orders appropriate studies that would facilitate the specialty visit. ☐ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit ☐ Provides patient with specialist contact information and expected timeframe for appointment.	☐ Determines and/or confirms insurance eligibility ☐ Identifies a single referral contact person to communicate with the PCMH ☐ When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up

Access

Mutual Agreement

- Be readily available for urgent help to both the physician and patient via phone or e-mail.
- Provide visit availability according to patient needs.
- Be prepared to respond to urgencies.
- Offer reasonably convenient office facilities and hours of operation.
- Provide alternate back-up when unavailable for urgent matters.

Expectations

Primary Care	Specialty Care
☐ Communicate with patients who “no-show” to specialists. ☐ Determines reasonable time frame for specialist appointment. ☐ Provide a secure email option for communication with patient and specialist.	☐ Notifies PCP of first visit ‘no-shows’ or other actions that place patient in jeopardy. ☐ Provides visit availability according to patient needs. ☐ Be available to the patient for questions to discuss the consultation. ☐ Schedule patient’s first appointment with requested physician. ☐ Be available to PCP for pre-consultation exchange by phone and/or secure email. ☐ When available and clinical practical, provide a secure email option for communication with established patients and provider. ☐ Provides PCP with list of practice physicians who agree to compact principles.

Collaborative Care Management

Mutual Agreement

- Define responsibilities between PCP, specialist and patient.
- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
- Maintain competency and skills within scope of work and standard of care.
- Give and accept respectful feedback when expectations, guidelines or standard of care are not met
- Agree on type of specialty care that best fits the patient's needs.

Expectations

Primary Care	Specialty Care
☐ Follows the principles of the Patient Centered Medical Home or Medical Home Index. ☐ Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills. ☐ Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. ☐ Reviews and acts on care plan developed by specialist. ☐ Resumes care of patient when patient returns from specialist care. ☐ Explains and clarifies results of consultation, as needed, with the patient. Makes agreement with patient on long-term treatment plan and follow-up.	☐ Reviews information sent by PCP ☐ Addresses referring provider and patient concerns. ☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. ☐ Confers with PCP before refers to secondary/tertiary specialists for problems within the PCP scope of care and uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization when needed. ☐ Sends timely reports to PCP to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions. ☐ Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations. ☐ Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs. ☐ Provides useful and necessary education/guidelines/protocols to PCP, as needed

Patient Communication

Mutual Agreement

- Engage and utilize a secure electronic communications platform for high risk patients such as ReachMyDoctor or CORHIO.
- Prepare the patient for transition of care.
- Consider patient/family choices in care management, diagnostic testing and treatment plan.
- Provide to and obtain informed consent from patient according to community standards.
- Explores patient issues on quality of life in regards to their specific medical condition and shares this information with the care team.

Expectations

Primary Care	Specialty Care
☐ Explains specialist results and treatment plan to patient, as necessary. ☐ Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in their care team.	☐ Informs patient of diagnosis, prognosis and follow-up recommendations. ☐ Provides educational material and resources to patient. ☐ Recommends appropriate follow-up with PCP. ☐ Will be accountable to address patient phone calls/concerns regarding their management. ☐ Participates with patient care team.

Compact Spread Efforts

Implementation Scenarios

1. Primary Care/Medical Home creates medical neighborhood with specialists.
2. Specialist/Service Line 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 (not yet 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.

PCP TOOLKIT EXAMPLES

Provider Checklist

Transition of Care Record Checklist
Providers

Instructions: Add red elements in shaded box to designated location in [black brackets].

1. Practice details
   - ☐ Practice name and address
   - ☐ Contact numbers (regular, emergency, fax, e-mail)
2. Patient demographics
   - ☐ Patient name,
   - ☐ Identifying and contact information,
   - ☐ Insurance information,
   - ☐ PCP, referring provider and contact information.
3. Diagnosis
   - ☐ ICD-9 code

4. Query/Request
- ☐ **Provide a clear clinical reason for patient transfer and anticipated goals of care and interventions.** [Referral(Outgoing) → Diagnosis/Reason]

5. Clinical Data provided:
   - ☐ Medical and surgical history
   - ☐ Current medication
   - ☐ Immunizations
   - ☐ Allergy/contraindication list
   - ☐ Caregiver status
   - ☐ Advanced directives

- ☐ **Problem list** [Progress Note → Problem List OR Medical Summary Attachment]
- ☐ **Care plan** [Progress Note → Treatment]
- ☐ **Patient cognitive status** [Referral → Diagnosis → Browse]
- ☐ **Pertinent labs and diagnostics tests** [Referral → Diagnosis/Reason → Attachments]
- ☐ **List of other medical providers** [Progress Note → Medical History]

6. Type of transition of care
- ☐ **Consultation, Shared management, Technical procedure, Transfer of care** [Referral → Diagnosis →Browse]

7. Visit status
- ☐ **Routine, urgent, emergent (specify time frame)** [Referral →Diagnosis→Browse]

8. Follow-up request
- ☐ **Mail, fax, phone call, e-mail** [Referral → Diagnosis → Browse]

Referral Checklist

Transition of Care Record Checklist
Referral Personnel: Glenna

Instructions: 1) Add elements in shaded box to TCR
2) Verify all other elements are present; if not, send back to appropriate person

1. Practice details — *Should be automatic*
   - ☐ Practice name and address
   - ☐ Contact numbers (regular, emergency, fax, e-mail)
2. Patient demographics
   - ☐ Patient name,
   - ☐ Identifying and contact information,
   - ☐ Insurance information,
   - ☐ PCP, referring provider and contact information.
3. Diagnosis
   - ☐ ICD-9 code

4. Query/Request — *Providers*
   - ☐ Provide a clear clinical reason for patient transfer and anticipated goals of care and interventions.

5. Clinical Data provided: — *MAs*
   - ☐ Medical and surgical history
   - ☐ Current medication
   - ☐ Immunizations
   - ☐ Allergy/contraindication list
   - ☐ Caregiver status
   - ☐ Advanced directives

- ☐ **Relevant notes**
  - Includes previous office visit, recent hospitalization and labs/DI for previous 2 months unless otherwise specified.
- ☐ **Pertinent labs and diagnostics tests (if not added by provider)**

- ☐ Problem list — *Providers*
- ☐ Care plan
- ☐ Patient cognitive status
- ☐ Pertinent labs and diagnostics tests
- ☐ List of other medical providers

6. Type of transition of care
   - ☐ Consultation, Shared management, Technical procedure, Transfer of care
7. Visit status
   - ☐ Routine, urgent, emergent (specify time frame).
8. Follow-up request
   - ☐ Mail, fax, phone call, e-mail

Specialist Examples

Specialty Provider Checklist

Transition of Care Record
Specialist Checklist

1. Practice details
   - ☐ O Practice name and address
   - ☐ O Contact numbers (regular, emergency, fax, e-mail)
2. Patient demographics
   - ☐ O Patient name,
   - ☐ O Identifying and contact information,
   - ☐ O Insurance information,
   - ☐ O PCP designation.
3. Communication
   - ☐ O Communication preference --Mail, fax, phone call, e-mail
4. Diagnosis
   - ☐ O ICD-9 codes for diagnoses
5. Clinical Data provided:
   - ☐ O Problem list
   - ☐ O Current medications
   - ☐ O Pertinent labs and diagnostics tests
   - ☐ O Medical/surgical history
   - ☐ O List of other medical providers
6. Recommendations
   - ☐ O Consultation/Co-management - communicate opinion and recommendations for further diagnostic testing/imaging, additional referrals and/or treatment. Develop an evidence-based care plan with responsibilities and expectations of the specialist and primary care physician that clearly outline:
     - new or changed diagnoses
     - medication or medical equipment changes, refill and monitoring responsibility.
     - recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
     - secondary diagnoses.
     - patient goals, input and education provided on disease management .
     - care teams and community resources.
7. Procedures
   - ☐ O Technical Procedure – summarize the need for procedure, risks/benefits, the informed consent and procedure details with timely communication of findings and recommendations.
8. Follow-up status
   - ☐ O Communication preference --Mail, fax, phone call, e-mail
   - ☐ O Follow-up – Specify time frame for next appointment to PCP and specialist. Define collaborative relationship (Consultation, Shared management, Technical procedure, Transfer of care) and individual responsibilities.

PCMH "Identifier"

Westminster Medical Clinic
Phone 303.487.5171
Fax 303.487.5196
Patient-Centered Medical Home
NCQA Level III Recognized

Westmed Family Healthcare
Phone 303.457.4497
Fax #: 303.254.4369

"Transforming Healthcare One Neighborhood at a Time."

To:

Fax: Date:

Re:

From: **Jan, RN**, Care Coordinator & **Glenna**, Referral Coordinator

Integrated & Coordinated Care

SOC – Patient-Centered Medical Home Neighborhood Initiative

- *Contact Westminster Medical Clinic to join our PCMH-Neighborhood!*

Features of a Medical Home

- *Whole-person orientation of care*
- *Enhances access to healthcare*
- *Improves quality, safety, integration, and care coordination*
- *Promotes prevention programs and chronic disease care management*
- *Emphasizes patient self-management*
- *Electronic health records*

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 a educational meeting and facilitated an activity with participants to develop aim statement and identify top 3 priorities to improve care coordination.
  - Follow up meetings being scheduled to pilot between multiple primary care and specialist practices
- Physician vision is to use the compact as a standard for referrals, regardless of affiliations. “The rising tide raises all boats”.

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
  - "A slam dunk" , "Ideal in principle"
- 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!

For More information:

Karen Frederick Gallegos
Colorado Medical Society
Karen_frederick-gallegos@cms.org
720-858-6323

The Colorado Health Foundation™

Special thanks to Dr. Scott Hammond and Caitlin Barba at the Westminster Medical Clinic.

Systems of Care Initiative

Generously funded through the Colorado Health Foundation