"Care Coordination"

The Heart of the Medical Home

Lessons from The Colorado Multi-Payer Patient-Centered Medical Home Pilot

Medical Home Summit
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Marjie Harbrecht, MD
Chief Executive Officer

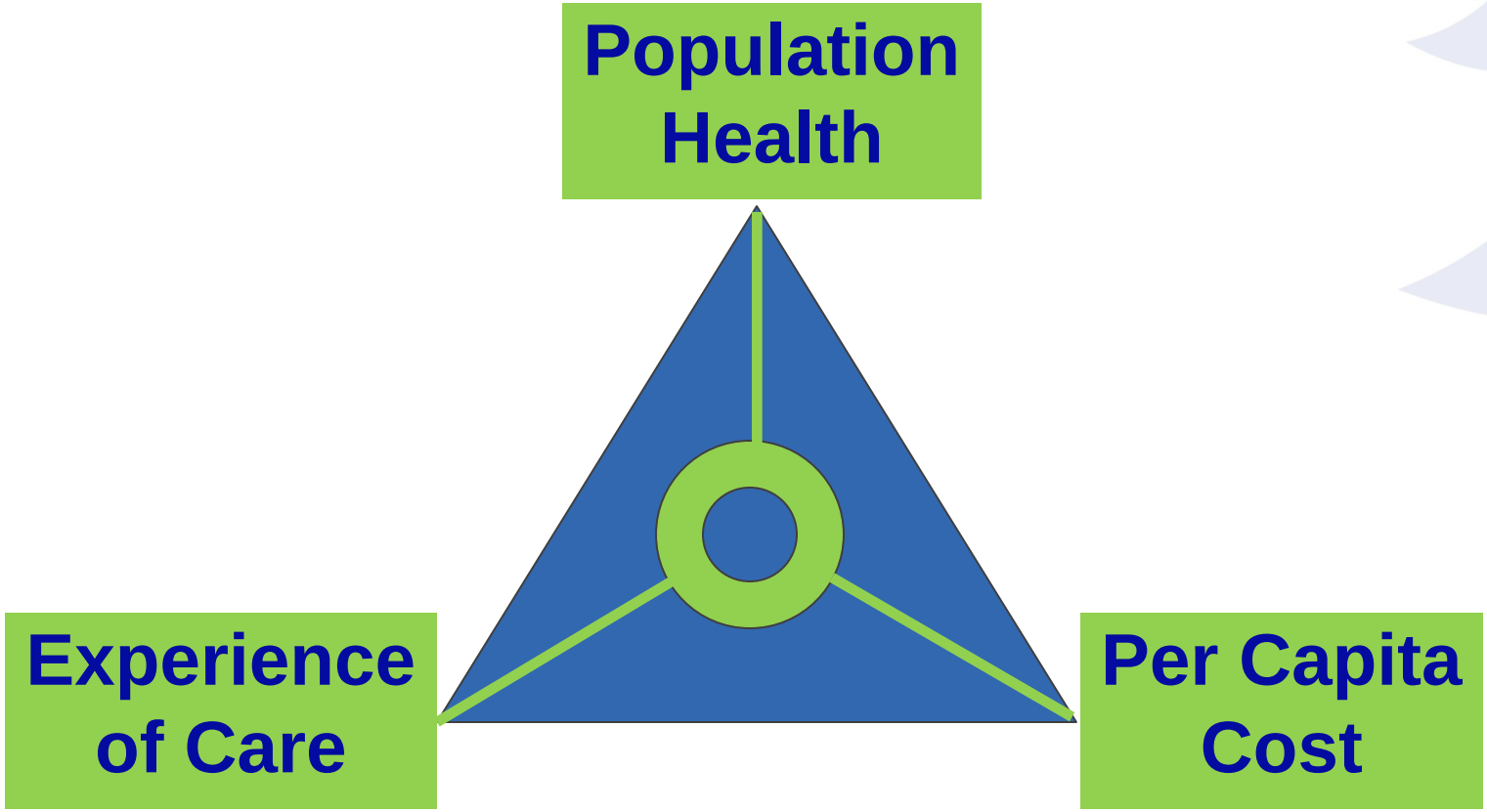
HealthTeamWorks

Building Systems. Empowering Excellence.

Three Dimensions of Value

by

Institute of Healthcare Improvement



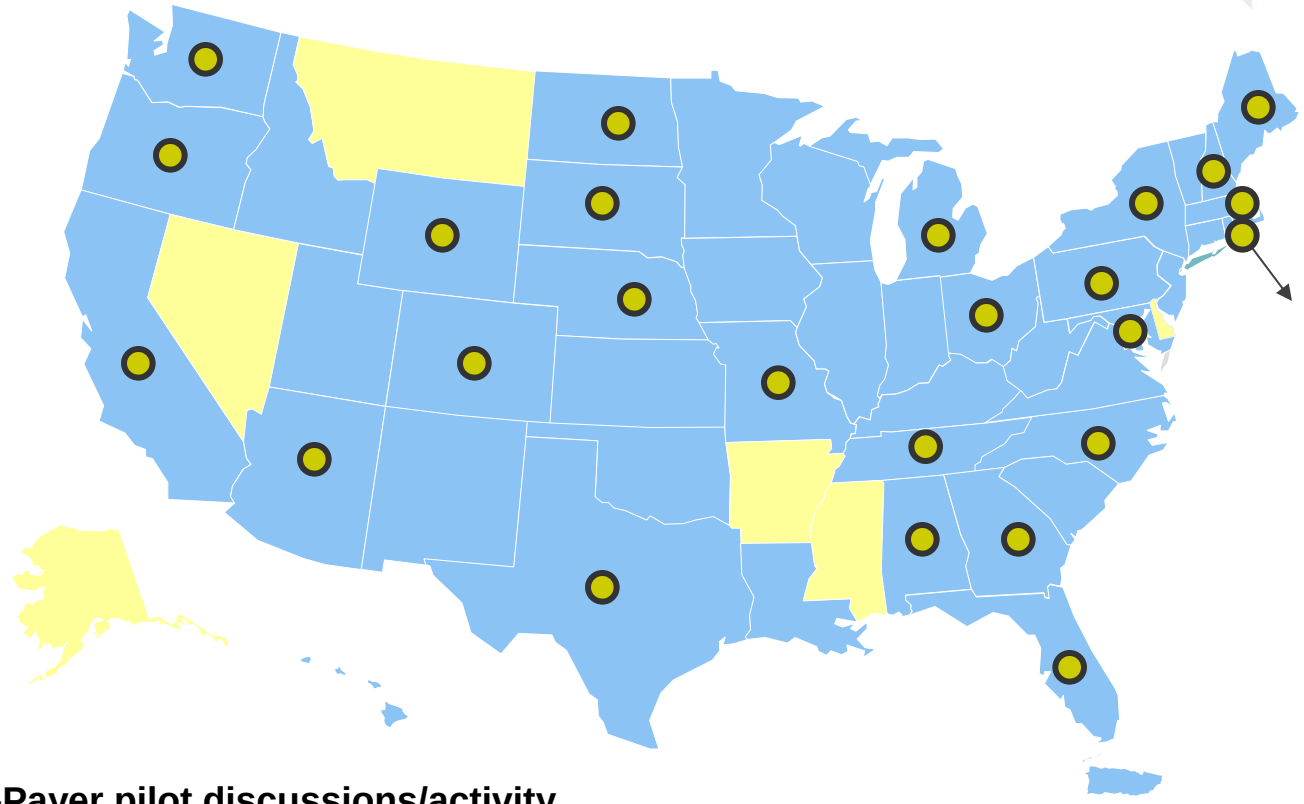

Case Manager
Transitions Coach
Boeing Model
Eric Coleman Model
CARE MANAGER
Health Coach
Chad Boult Model
Disease Manager
Care Coordinator
Vermont Blue Print Model

"Care Management":

The unintended consequences of good intentions

Patient-Centered Medical Home

2009 Overview of Pilot Activity and Planning Discussions



Multi-Payer pilot discussions/activity

Identified pilot activity

No identified pilot activity – 6 States

HealthTeamWorks

Building Systems. Empowering Excellence.

A nonprofit collaborative working to redesign healthcare and promote integrated communities of care, using evidence based medicine and innovative systems to optimize health, improve quality and safety, reduce costs, and improve the care experience for patients and their healthcare teams.

The Colorado Multi-Payer PCMH Pilot

Multi-Payer Pilot Stakeholders

The Front Line Innovators!

- Belmar Family Medicine
- Broomfield Family Practice
- Clinix Health Services of CO
- Family Care Southwest
- Family Practice Associates
- Ideal Family Healthcare
- Internal Med Clinic of Ft. Collins
- Lakewood Family Medicine
- Lone Tree Family Practice
- Michael Mignoli MD
- Miramont Family Medicine
- Mountaintop Family Health
- Provident Adult & Senior Medicine
- Southpark Internal Medicine
- Westminster Medical Clinic

Pilot Parameters

- Three-year pilot
  - Convened January 2008; TA December 2008
  - May 2009 – April 2012
- PCMH Joint Principles
- NCQA PCMH Recognition
  - 14 at Level III; 2 at Level II
- 16 Family & Internal Medicine Practice sites
  - 83 providers; 258 staff - various sizes
- 20,000 patients covered (100,000 affected)
- Three-tiered payment structure
  - Fee for service (FFS); Care management fee (PMPM); P4P

New Payment Methods Allow a New Way of Thinking!

- Transition from FFS “treadmill medicine” to coordinated, planned management of **entire panel**, with extra care for those who need it
  - Redefine “VISITS”
  - Add Care Management/ Care Coordination

- BUT…can do in the meantime in FFS model
  - 2:1 ratio for MA/Nurse to Provider

Goals/Measures

- Improve quality
  - Diabetes
  - Cardiovascular disease
  - Tobacco
  - Depression
  - Prevention
- Reduce cost trends
  - Emergency room (ER) visits
  - Hospital admissions
  - Generic pharmacy
- Improve satisfaction
  - Patients/families
  - Health care team

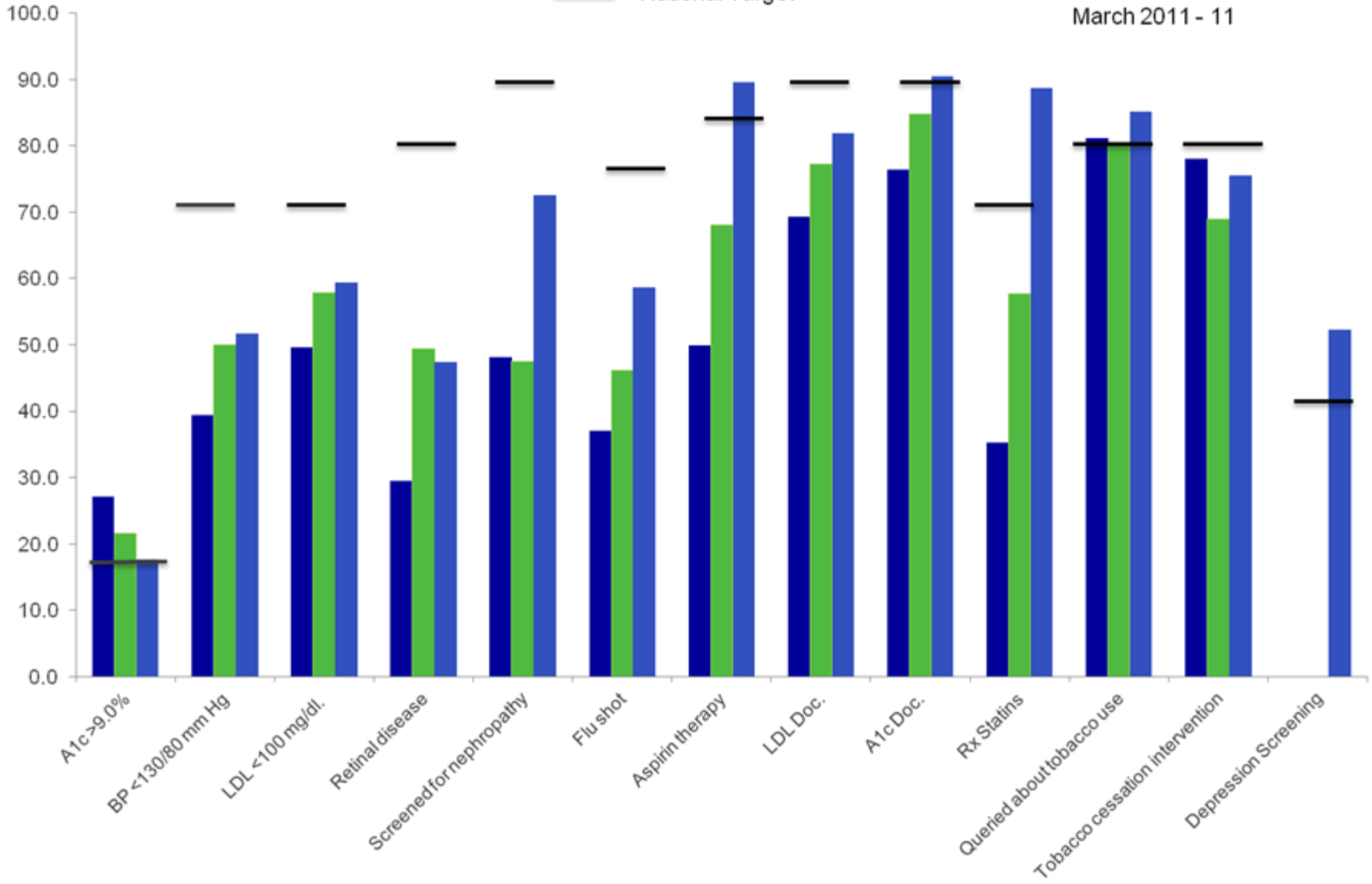
- **Internal**
- **External**
  - **Matched comparison design**
  - **Meredith Rosenthal**
    - **Harvard**

CO- Pilot Average for Diabetes Measures

Number of Patient
June 2009 - 1688
Feb 2010 - 2139
March 2011 - 2497

Jun-09 Feb-10 Mar-11
= National Target

Number of Practices Reporting
June 2009 - 9
Feb 2010 - 15
March 2011 - 11



Patient-Centered Planned Care

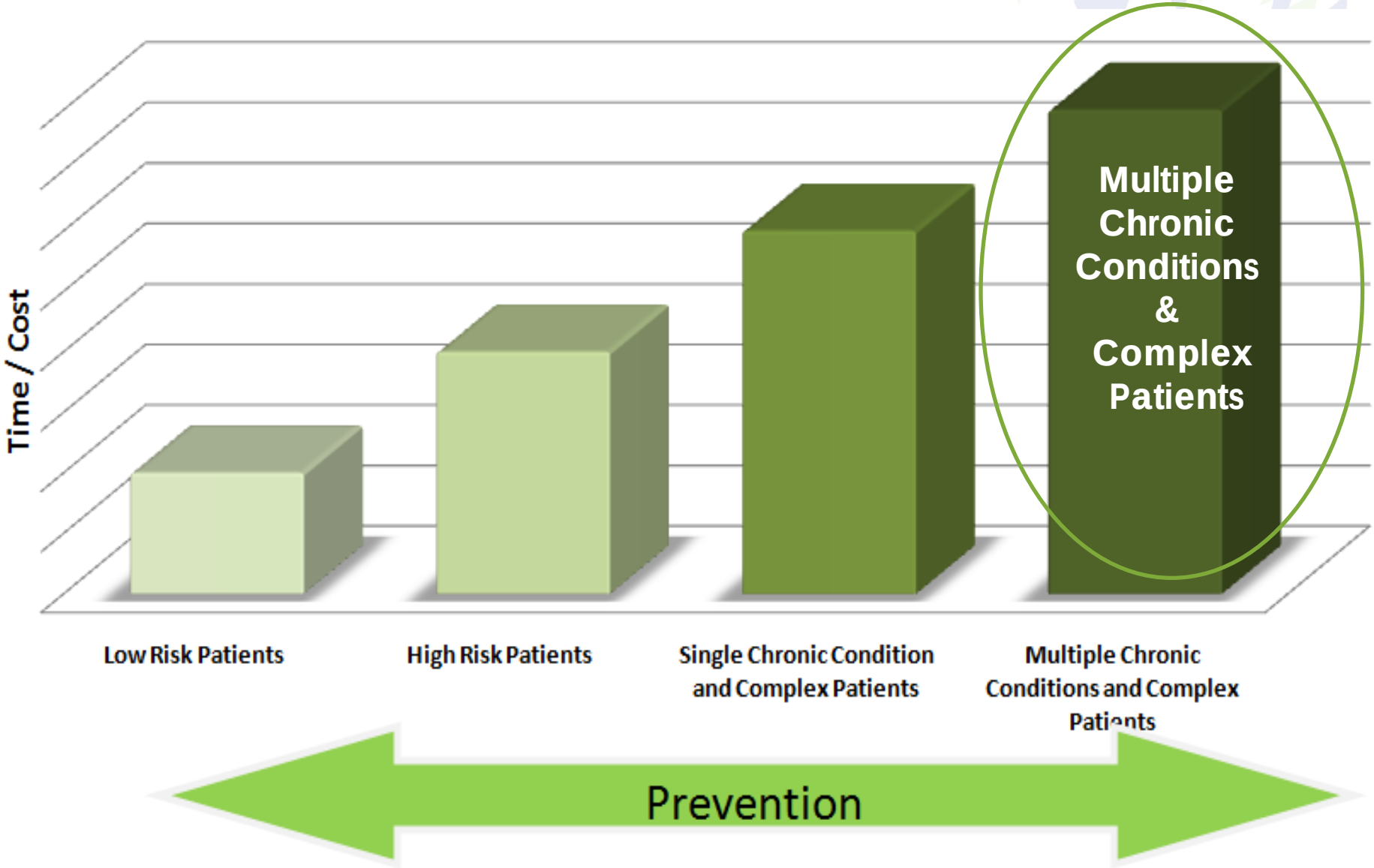
COLORADO CLINICAL GUIDELINES COLLABORATIVE

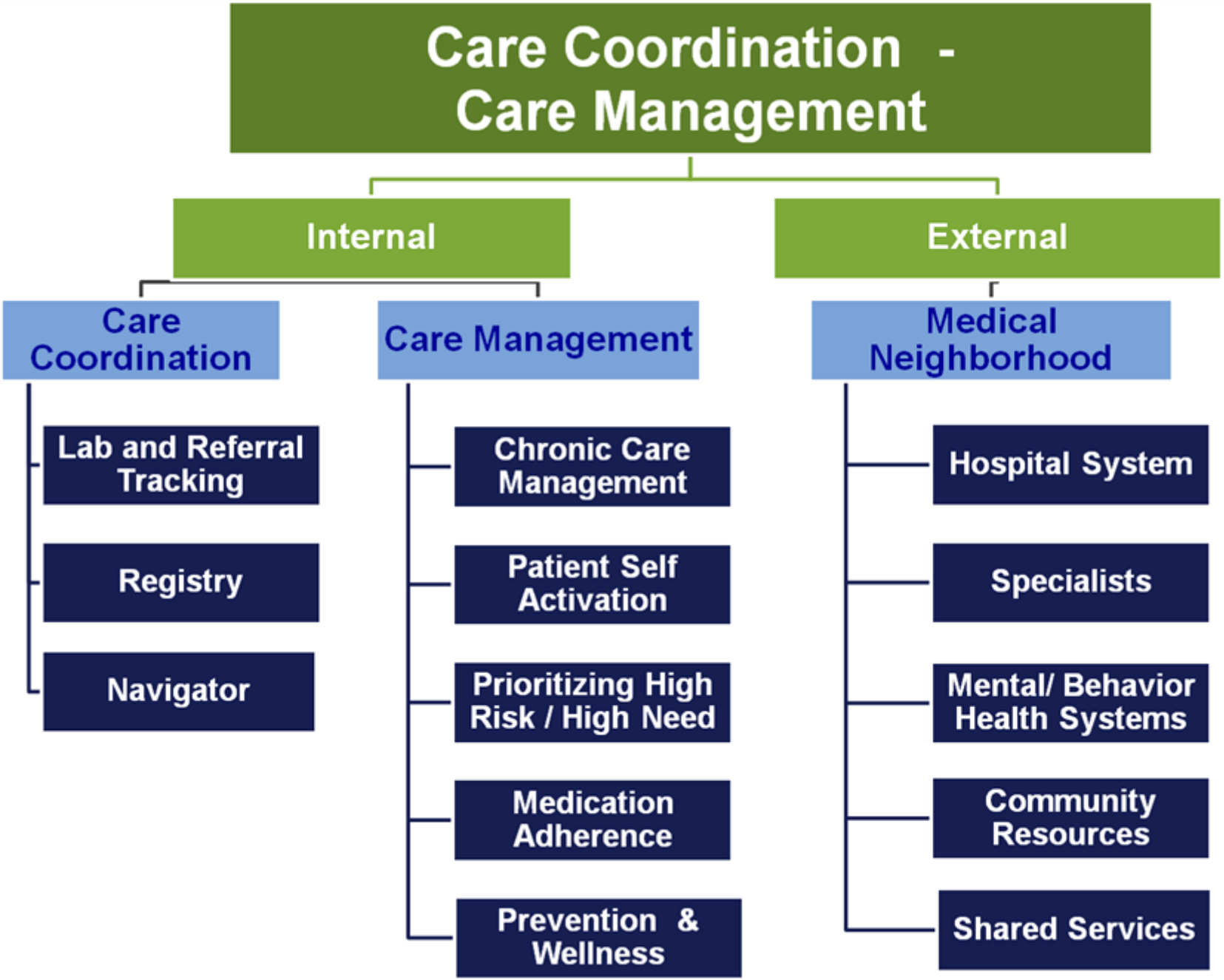
Improved Outcomes

- Increased Healthy Behaviors
- Improved Quality, Safety, and Clinical Outcomes
- Increased Collaboration between Patient, Care Team, and Medical Neighborhood
- Improved Physician and Staff Satisfaction and Retention
- Reduced Cost Trends

Adapted from:
www.NewHealthPartnerships.org

Prioritizing Care Management & Care Coordination




Care Coordination - Care Management
Internal
External
Care Coordination
Care Management
Medical Neighborhood
Lab and Referral Tracking
Registry
Navigator
Chronic Care Management
Patient Self Activation
Prioritizing High Risk / High Need
Medication Adherence
Prevention & Wellness
Hospital System
Specialists
Mental/ Behavior Health Systems
Community Resources
Shared Services

Key Elements

Tactical

- Lab and Referral Tracking
- Registry/EMR
- Practice “Point Person” and Patient Navigator

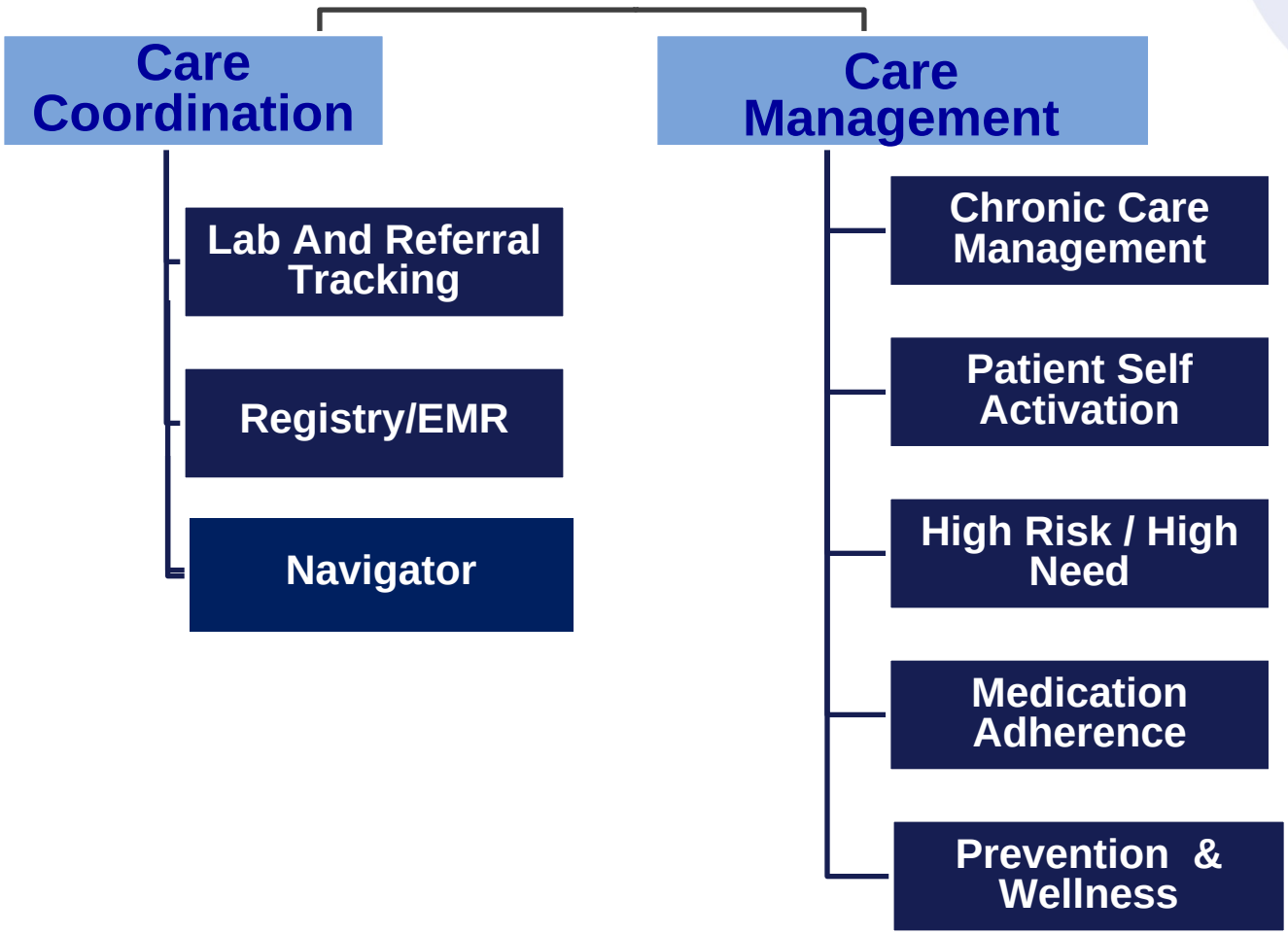
Cultural/Behavioral

- Leadership
- Team Based Care
- Communication
- Patient Activation
- Continuous Quality Improvement

“Culture eats strategy for lunch …over and over again.”

– Anonymous

Internal Coordination and Management



Care Coordination

Roles	Skill Sets
A. Help Patient Implement Individual Care Plan	
• Track tests and referrals ordered • Implement reliable process to get reports into medical record • Filter information and reports coming into practice	LPN, MA
B. Registry Set-Up & Maintenance	
• Ensure registry functionality and process to maintain it • Manage and present reports on individual patients and overall practice population for team discussion • Use outreach reports to identify patients overdue for services • Use Health Plan and Hospital reports to prioritize those patients needing more intensive case management/care coordination	Data Person, Front Desk, MA, Practice Manager
C. Coordination of Care (Medical Neighborhood)	
• Point person for outside entities to facilitate bi-directional communication and follow-up • Navigator for patients for services outside clinic, including community resources.	LPN, MA, Health Educator

Care Management

Roles	Skill Sets
A. Help Patient Implement Individual Care Plan	
• Assess barriers for patients struggling with care plan • Self management support, **motivational interviewing** to assess patient's self-efficacy in reaching their goals. Use education materials, tools, counseling, group visits, etc. • Discuss medication adherence, reconciliation and management using protocols developed by physicians	RN, PA, MD, Social Worker, Health Educator (limited) (Requires higher skills, training/licensure/certification than Care Coordinator Role)
B. Increase Patient Access	
• Phone Calls, Emails, Extended Hours - 24/7 coverage	MA, RN, PA, MD, Scheduler

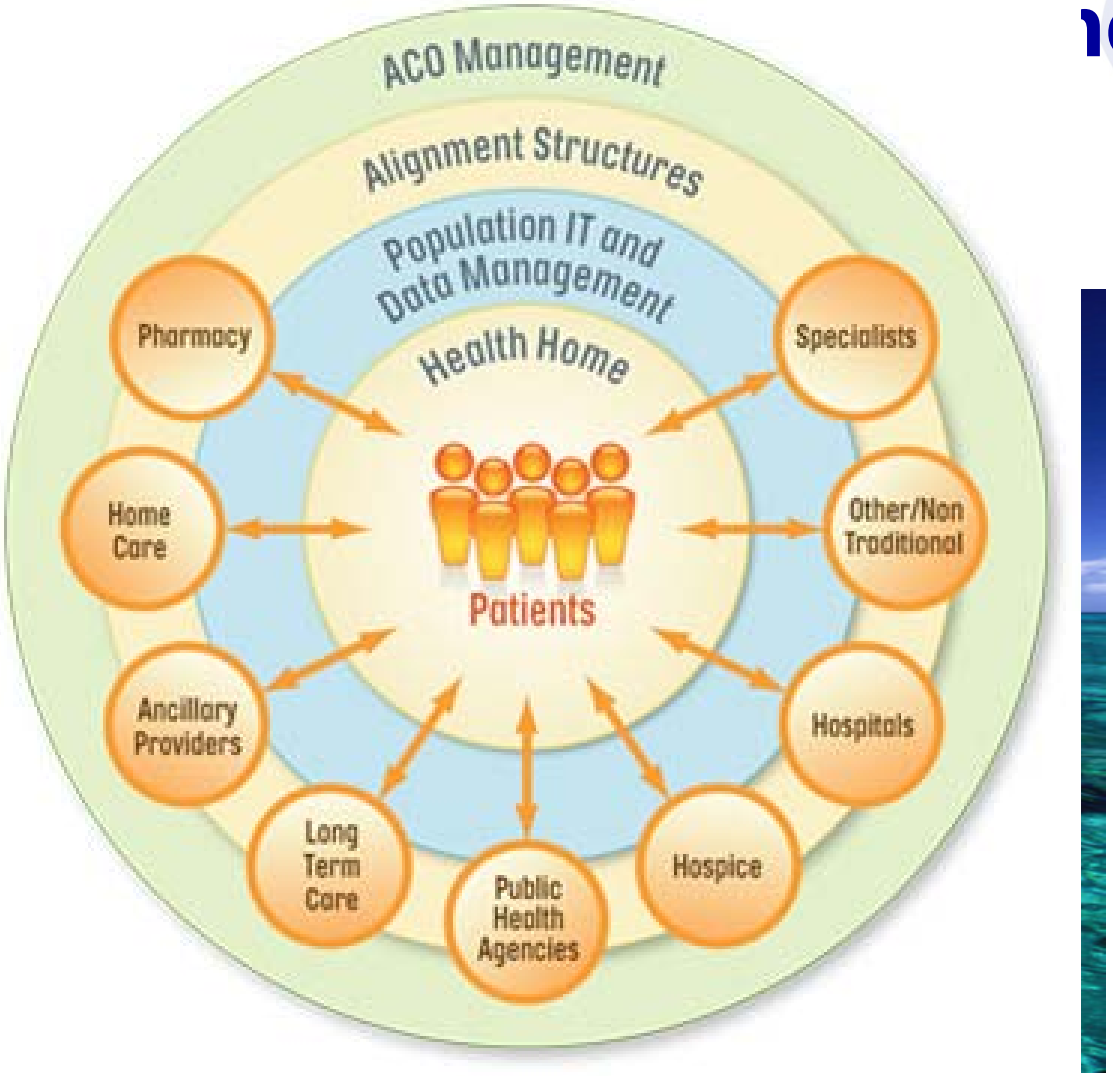
Lessons Learned

- Guidance needed for new roles/responsibilities
  - Clear job descriptions, particularly for turnover
  - Clarify roles with providers, staff, neighbors, patients
  - Hiring right; Initial and ongoing training
- Team-Based Approach
  - Every staff member is part of care team
  - Develop work flows and strategies for communication
  - Follow-up calls make huge difference to patients
  - Warm hand off by “team” works better for referrals
- Strategies for patient engagement/experience
  - Do patients know what a PCMH is or philosophy of patient centered care?
  - What is patients’ experience of their care?

Role of Physicians

- Customized Care Plan
  - Shared Decision Making
  - Prevention, Chronic Care, Acute Care issues
- Identify patients needing care coordination and more complex care management
- Hand off to care coordinators/managers
- Define roles of care team for patient
- Follow-up as necessary

Integrated Community of Care
(Accountable Care Organizations)
Medical Home Without Walls
Integrated Neighborhood



External Coordination

Building Your Medical Neighborhood

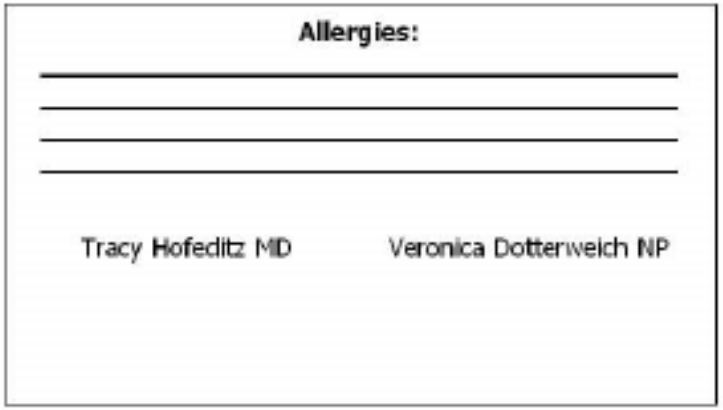
- Specialists including Behavioral Health
  - Integration, co-location, referral
  - Build **relationships**; clarify roles (Compacts)
  - Monitor progress with regular communication/feedback

- Hospitals
  - Identify Primary Care Provider (PCMH) - Wallet Cards
  - Notify PCMH about patient in ER or Hospital
    - Templates for content (fax, text, HIE)
  - Care Coordinators login to Hospital EHR daily for list of patients and details of visit
    - Challenge if no admitting privileges

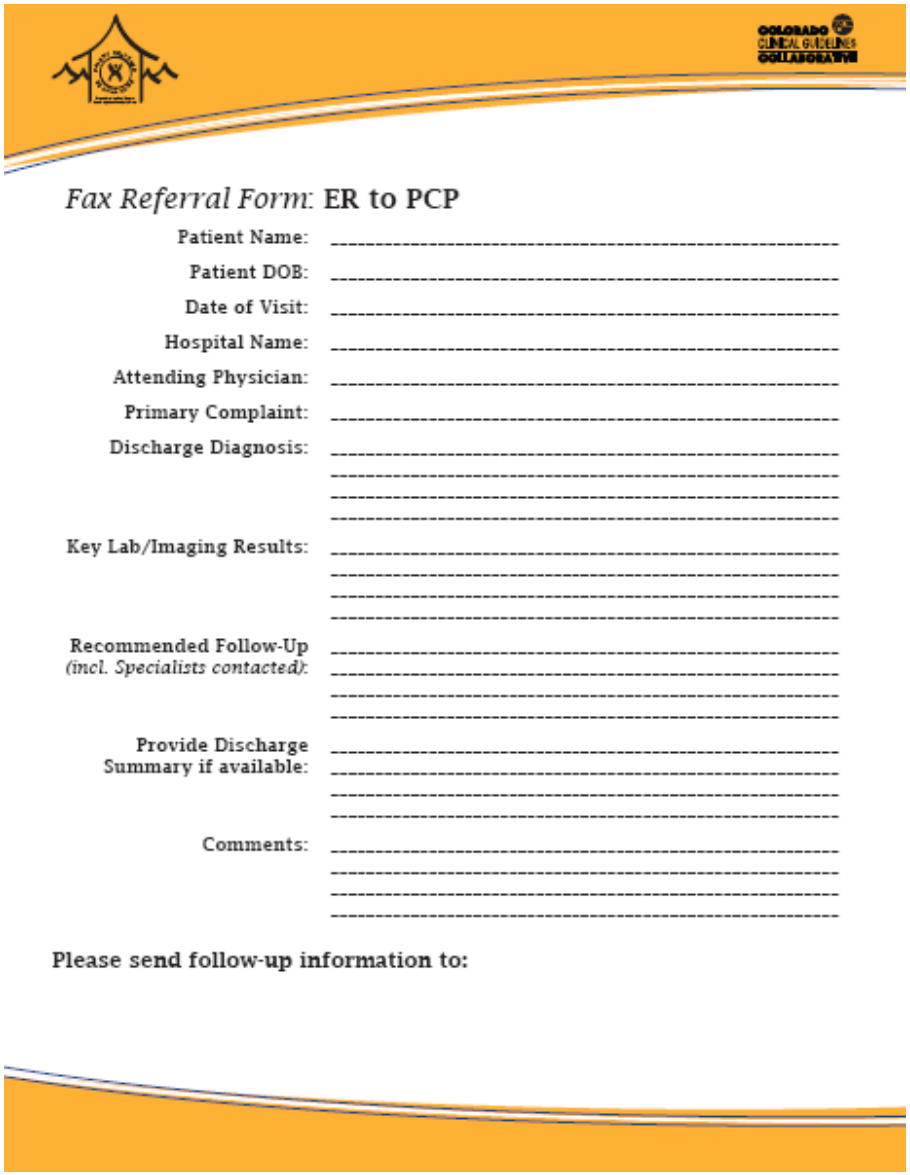
Patient Wallet Card

Front side

Back side



Fax Referral Form



Fax Referral Form: ER to PCP

Patient Name: _____

Patient DOB: _____

Date of Visit: _____

Hospital Name: _____

Attending Physician: _____

Primary Complaint: _____

Discharge Diagnosis: _____

Key Lab/Imaging Results: _____

Recommended Follow-Up *(incl. Specialists contacted)*: _____

Provide Discharge Summary if available: _____

Comments: _____

Please send follow-up information to:

Challenges/Lessons Learned

- Specialists
  - Fragmented system with misaligned incentives
  - Varied awareness and reception to PCMH/Medical Neighborhood concept
  - Mental/Behavioral health - HIPAA issues; payment/carve outs; “culture/language” barriers; timeliness
- Hospitals
  - Varied responses from hospitals (“one off”)
  - Login difficult without privileges
  - PA/NP often aren’t identified in system
  - Re-evaluate need for patients to have a “designated” PCP?

Shared Services Model

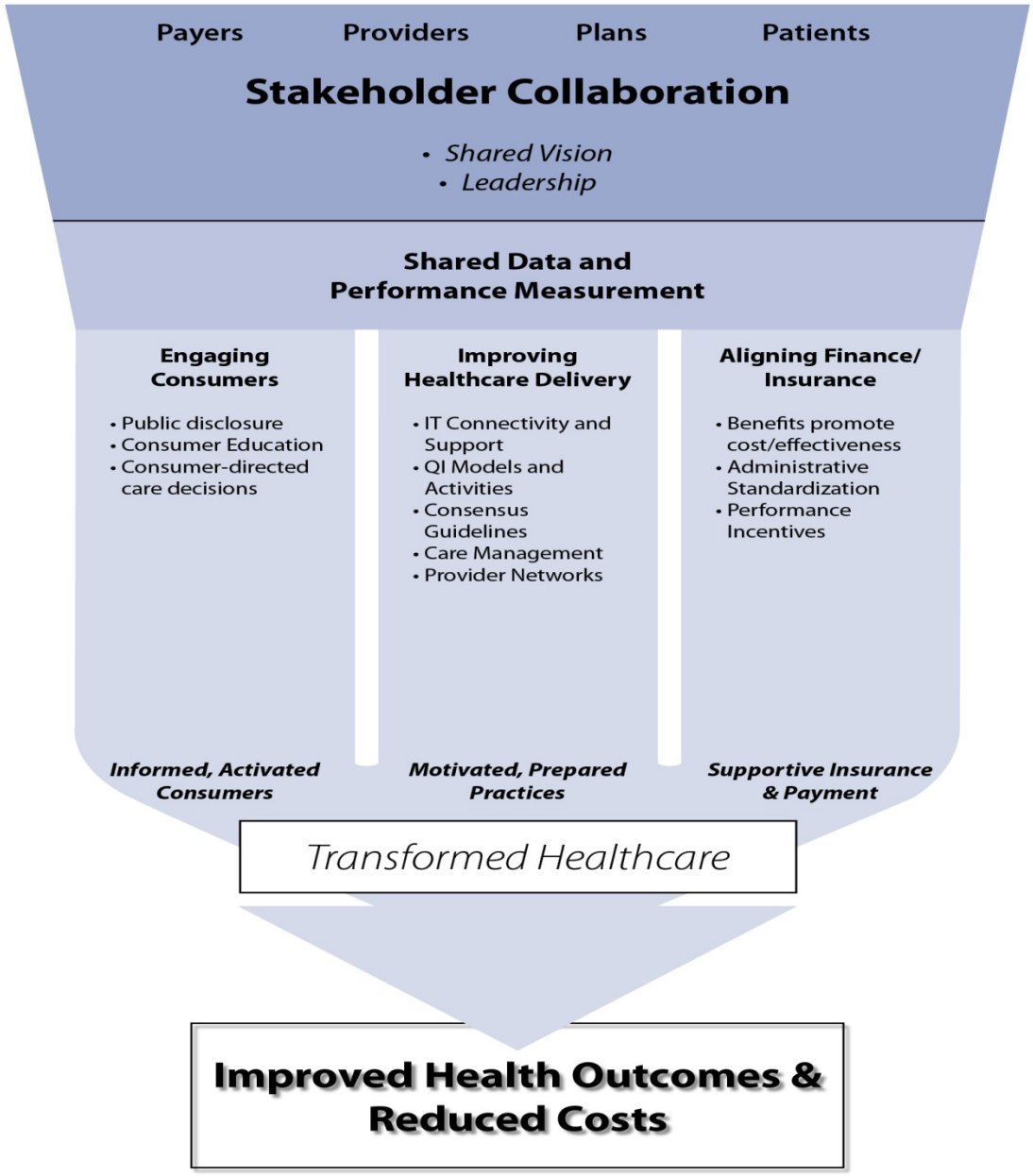
- Complex Case Manager (i.e., RN)
- Clinical Pharmacist
- Social Worker
- Mental Health consultants
- Others

Making Sense of Various "Care Coordination/Care Management" Roles - Possible Scenario

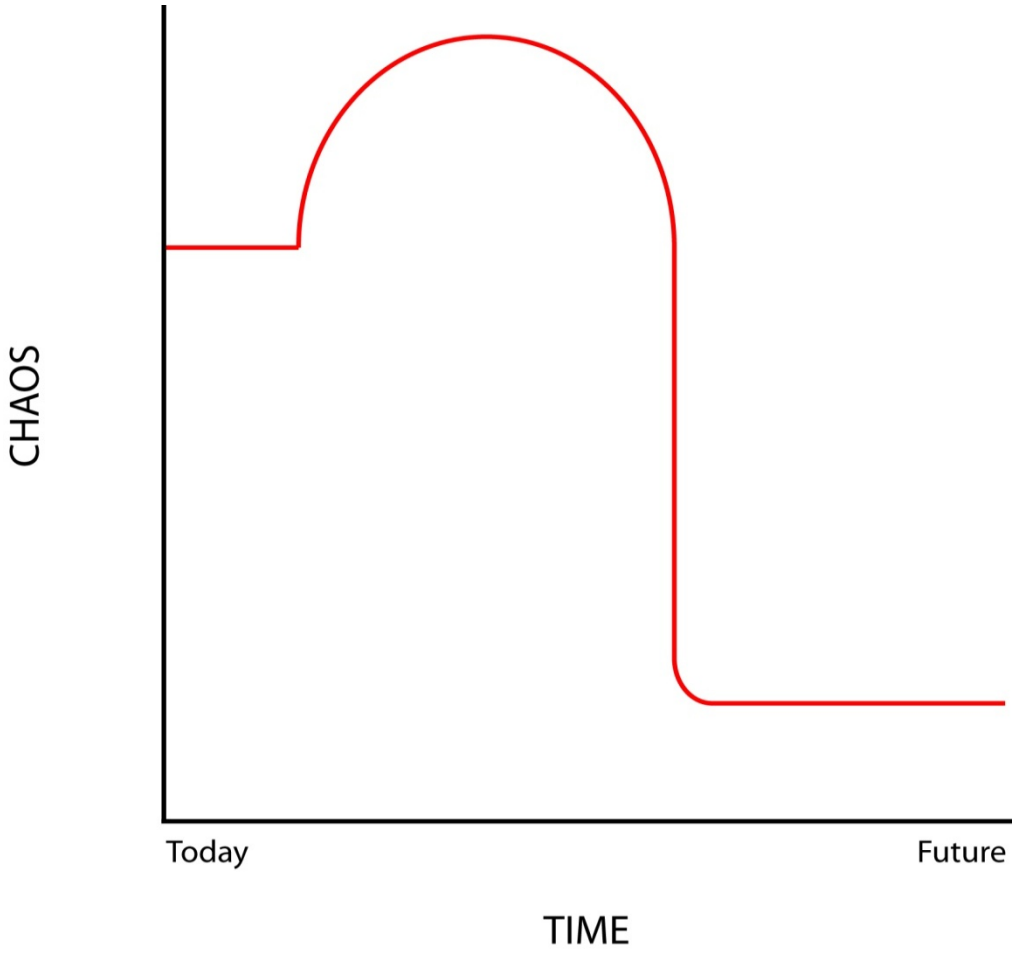
- Care Coordination/Care Management (PCMH)
- Complex Case Management and other shared services (IPA, ACO, Community)
- Transitions/Health Coach – (Hospital, ACO, community with bridge to PCMH)
  - Lay and Professionals

In Summary

It Takes A Region



Investment Required to Reduce CHAOS and Build Solid Infrastructure



"Runners to your mark. Get set. Go! ... OK, come get your T-shirts."

IT'S ALL ABOUT RELATIONSHIPS!!

With Your PATIENTS!
With Your TEAM
With Your NEIGHBORS

Start Small – Start Somewhere!

Success is a journey,

not a destination…

- Arthur Robert Ashe, Jr.