Team-Based Chronic Care Management in an ACO/PCMH

Care Coordination For Each Patient Experience and Transition

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Definition of a Team

On a recent flight, I heard:

“Welcome aboard Flight 5322 to Atlanta. To operate your seat belt, insert the metal tab into the buckle, and pull it tight. It works just like every other seat belt; and, if you don't know how to operate one, you probably shouldn't be out in public unsupervised.”

Current Environmental Factors That Promote a Team-Based Model

One in Five Americans Doesn't Have a Doctor

- 60 million people — 1 in 5 Americans — have no usual source of medical care, such as a family doctor or clinic
  - 66% stated they never got sick
  - 14 % cited the cost of care
- Hispanics most frequently cited cost
- Uninsureds stated they did not need care
- Blacks were most likely to state they seldom or never got sick
- Asians were most likely to report not liking or trusting doctors

Communication

- Doctors and patients alike say that when they communicate well, healing goes better, and it can even make the difference between life and death. But a national survey of doctors and hospitalized patients finds that, in reality, effective communication often is sorely lacking.
- Only 48% of patients said they were always involved in decisions about their treatment, and 29% of patients didn't know who was in charge of their case while they were in the hospital.

www.usatoday.com/yourlife/health/healthcare/studies/2010-12-06-1Adoctalks06_ST_N.htm

What We Have Here Is A Failure To Communicate!

- 69.3% of PCPs reported "always" or "most of the time" sending notification of a patient's history and reason for consultation to specialists, but only 34.8% of specialists said they "always" or "most of the time" received such notification.
- Similarly, 80.6% of specialists said they "always" or "most of the time" send consultation results to the referring PCP, but only 62.2% of PCPs said they received such information.
- Physicians who did not receive timely communication regarding referrals and consultations were more likely to report that their ability to provide high-quality care was threatened.

Arch Intern Med. 2011;171(1):56-65. doi:10.1001

Hospital to PCP transfer

- Meta-analysis
- Direct communication between hospital physicians and primary care physicians occurred infrequently
- Discharge summary
  - Availability at first post-discharge visit low (12%-34%)
  - Remained poor at 4 weeks (51%-77%)
  - Affected quality of care in ~25% of follow-up visits
  - Often lacked important information (e.g., lab results, discharge medications, treatment, follow-up plan)

Kripalani S, et al. JAMA 2007;297:831-41.

Standards and Transparency

NCQA Medical Home Standards

- New medical home standards released by the National Committee for Quality Assurance on Jan. 31 place greater emphasis on patient feedback, access to physicians and care coordination.

NQF Care Coordination Standards

Preferred Practice 6: Healthcare providers and entities should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every patient.

Preferred Practice 8: The joint plan of care should be developed and include patient education and support for self-management and resources.

Preferred Practice 18: Decisionmaking and planning for transitions of care should involve the patient, and, according to patient preferences, family, and caregivers (including the healthcare home team). Appropriate follow-up protocols should be used to assure timely understanding and endorsement of the plan by the patient and his or her designees.

Preferred Practice 24: Healthcare providers and healthcare organizations should have systems in place to clarify, identify, and enhance mutual accountability (complete/confirmed communication loop) of each party involved in a transition of care.

Table 1: National Voluntary Consensus Standards for Care Coordination

incorporating strategies for continuity of care.

Preferred Practice 3: The healthcare home shall develop infrastructure for managing plans of care that incorporate systems for registering, tracking, measuring, reporting, and improving essential coordinated services.

Preferred Practices: Proactive Plan of Care and Follow-up Domain

Preferred Practice 6: Healthcare providers and entities should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every patient.

cardiovascular event.

Preferred Practices: Communication Domain

documented.

Preferred Practices: Information Systems Domain

Preferred Practice 15: Standardized, integrated, interoperable, electronic, information systems with functionalities that are essential to care coordination, decision support, and quality measurement and practice improvement should be used.

Preferred Practice 16: An electronic record system should allow the patient's health information to be

Appropriate follow-up protocols should be used to assure timely understanding and endorsement of the plan by the patient and his or her designees.

Preferred Practice 19: Patients and their designees should be engaged to directly participate in

Preferred Practice 22: Healthcare organizations should develop and implement a standardized communication template for the transitions of care process, including a minimal set of core data elements that are accessible to the patient and his or her designees during care.

Preferred Practice 23: Healthcare providers and healthcare organizations should implement protocols and policies for a standardized approach to all transitions of care. Policies and procedures related to

- Cardiac rehabilitation patient referral from an outpatient setting
- Patients with a transient ischemic event ER visit who had a follow-up office visit

care)

- Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care])
- Melanoma continuity of care – recall system
- 3-Item Care Transitions Measure (CTM-3)[1]

www.qualityforum.org/projects/care_coordination.aspx

Affordable Care Act Will Boost Care Quality

- Place a greater emphasis on improving the quality and safety of medical care in America
- Stop doing things that don't work for patients and start doing things which do work
- “It's about better care: care that is safe, timely, effective, efficient, equitable and patient-centered.”[1]
- I still get pushback in talking about the business case for quality in health care. People say, 'There is no business case for quality.' I look at them and say, 'I really feel sorry for you. Those of us who know there is will prosper, and those who think there isn't will be left behind.' " [2]

1.O’Reilly, K. Health Reform Law Will Boost Care Quality. Amednews.com.
2. Lee Carter, chair of the board of trustees at the Cincinnati Children's Hospital Medical Center.

Establishing Quality Goals

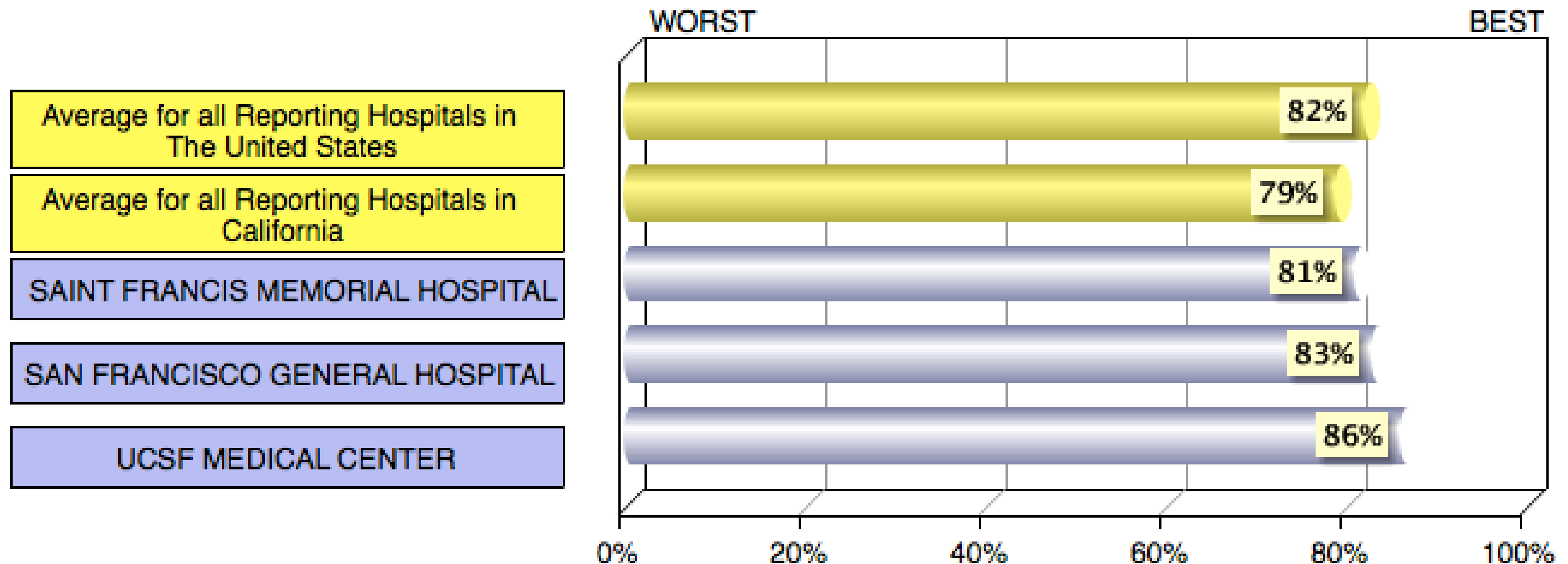
- On March 22, 2011, the U.S. Department of Health and Human Services released its National Strategy for Quality Improvement in Health Care (National Quality Strategy). The Affordable Care Act required the Secretary of HHS to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. This strategy is designed to guide federal, state, and local health initiatives.

Taking Aim: Better Care, Healthy People/Healthy Communities, and Affordable Care

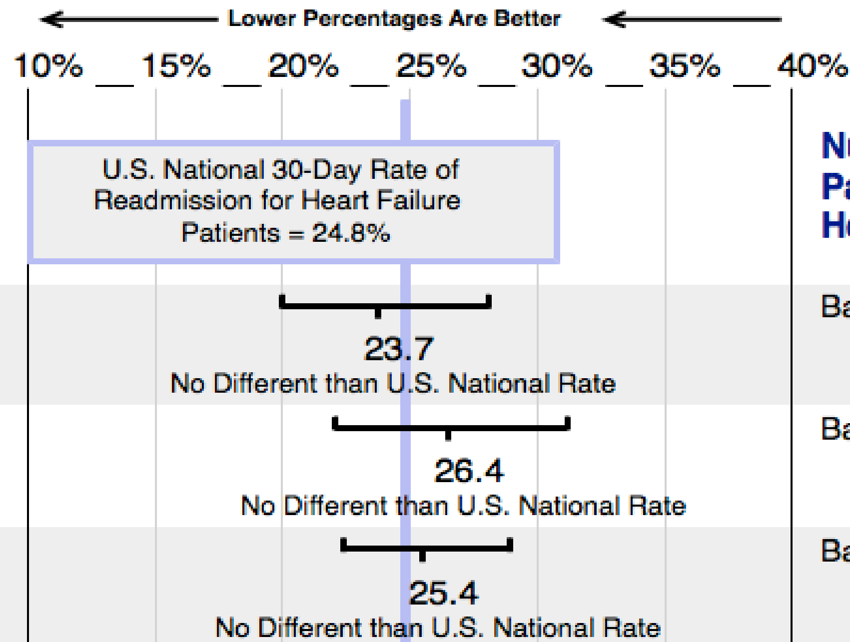
Six Strategies to Advance these Aims:

- Prevention and Treatment of Leading Causes of Mortality
- Making care safer by reducing harm caused in the delivery of care
- Ensuring that each person and family members are engaged as partners in their care
- Supporting Better Health in Communities
- Making Care More Affordable
- Promoting effective communication and coordination of care

Transparency



Transparency



Value--Based Payment Modifier Under the Physician Fee Schedule

- The Secretary of Health and Human Services (HHS) will develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The new payment system will be phased in over a 2-year period beginning in 2015.

What’s the Answer?

Add Text Here

Collective Accountability

HUDSON RIVER PLANE LANDING
January 15, 2009

The Continuum of Health Care

www.cmsa.org/SOP

Care Coordination

Definition:

Care coordination is a function that
helps ensure that the patient's needs
and preferences for health services and information sharing across people,
functions, and sites are met over time.

Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.

Patient Empowerment

- Health care needs to be more inclusive, integrated and collaborative.
  - Specialists working together with primary care physicians to prescribe the best medical treatment for patients
  - Physicians teaching their patients about new medical procedures and techniques relevant to their disease state
  - diabetic patients networking over Facebook to learn how they can better manage their current condition and overall health and wellness.
- Collaboration or “team care,” appears to be the direction the medical profession will need to head to address some of the growing complexities of today’s health care system.
- Health care knowledge is global but health care delivery is local.

Active Patient & Family Engagement

- Patient’s and family caregivers need resources they can use and understand
- Health coaching supports patients and their family caregivers in addressing interaction with the providers and team collaboration
- Written directions without any support or coaching are often loss, forgot or not understood
- The patient is the expert in his or her own life
- Understanding the patient’s perspective and motivation is key to bi-directional communication

Engagement & Motivational Interviewing: R-U-L-E

- **R –** Resist the temptation to "fix" the patient problem
- **U –** Uncover and understand the patient's motivation for engaging, working and changing behavior
- **L –** Listen carefully to the patient and try to understand their perspective that may be different than yours
- **E –** Encourage the patient in their ability to self manage adherence to the care plan and change

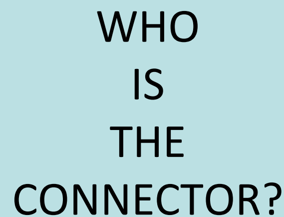
Four Basic Principals of Motivational Interviewing: R-U-L-E, Glovsky, E., MI Institute, Jan 2011

Patient Education

- Does the patient know:
  - What's wrong?
  - What they need to do?
  - Why is it important?
- IF not,
  - What's your plan for:
    - Patient/caregiver education
    - Identifying and removing barriers to adherence
  - Who implements the plan?
  - Who gathers information and outcome information?

Transition Connector

- Collaborative Team
  - Patient
  - Physician
  - Pharmacist
  - Nurse
  - Social Worker
  - Case Manager
  - Allied Health
    - Respiratory Therapist
    - Dietitian
    - Physical Therapist
    - Educator

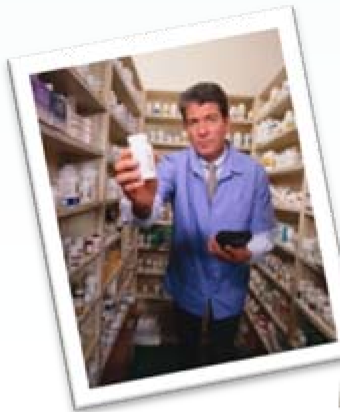


- Community Team
  - PCP
  - Specialist
  - Skilled Nursing Facility
  - LTC Services
  - Pharmacy
  - Community Clinic
  - Home Care
  - GCM/CM
  - Rehabilitation
  - Hospice
  - Community Resources
  - Health Plan
  - Medical Home

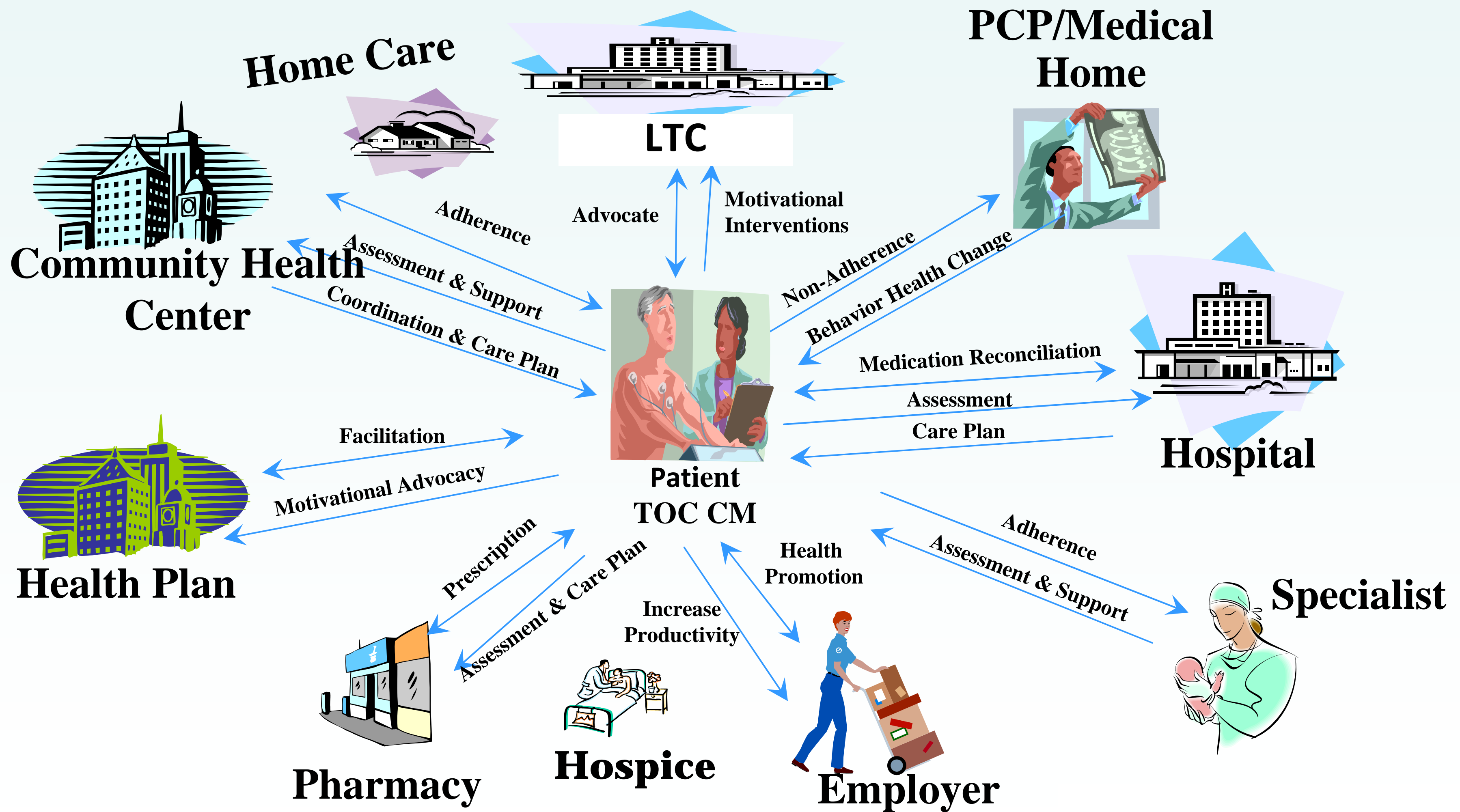
The Integrated Team

- Patient
- Physicians
- Wellness or Health Coa
- Lab and Radiology Professionals
- Rehab
- Skilled Case Managers

- Caregivers
- Pharmacists
- Specialists
- Hospitalists
- Nurses
- Therapists
- Behavioral Health



Transitioning The Continuum of Care with Bi-Directional Communication



The Communication Rule

Advancing Patient Engagement,
Empowerment and Education

Transitions of Care
Provider Accountability
Care Coordination Hub
Verify
Send / Sender
Key Information
Receive / Receiver(s)
ACT
Clarify
Active Patient/Family Engagement
Transitions of Care

Team Responsibilities in Ensuring a Safe and Successful Care Coordination

- Educate the patient and ensure patient & caregiver understanding on their disease process and factors that can influence their condition
- Ensure the patient has the resources to manage their disease after transition
- Make certain that the transition will be for the individual patient and they feel confident they can manage
- Ensure that the patient understands the plan for transition of care and their medication plan to the next transition setting
- Make certain that the patient has access to the follow up care and therapy

Thank You

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