PCMH Congress 2016: Summary

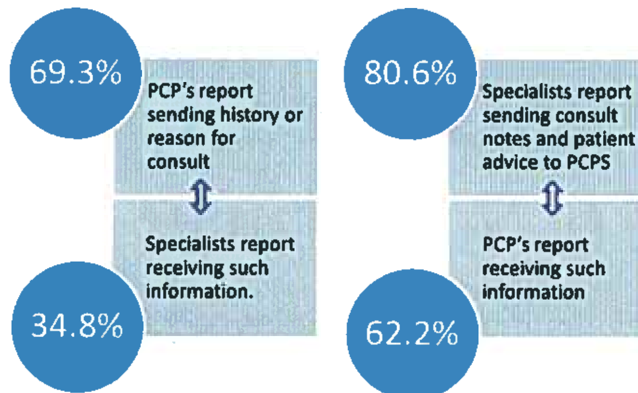
Medical Neighborhood

Care Coordination Challenges

- Patients with chronic conditions typically see many providers
  - Study found Medicare patients visits seven physician in four different practices annually
  - Conflicting advise, prescriptions, plan of care
  - Lack of follow-up for new diagnoses, tests, or other related procedures
- Burden of care coordination is high for PCP who services as the lead for communication and decision making

Pham HH, et al. *New Engl J Med.* 2007;356:1130-1139. O'Malley AS, et al. *Arch Intern Med.* 2011; 171(1):56-65.

Evidence of Dysfunction



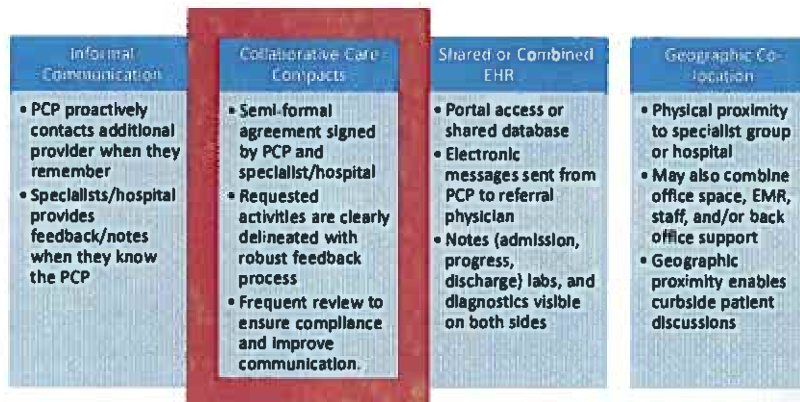
Mehotra A, et al. Milbank Q. 2001:89(1)39-68. O'Malley, et al. *Arch Internal Med.* 2011; 171:56-65. Barnett, et al. *Arch Inte[rn] Med.* 2012; 172:163-170

Medical Neighborhood

- *Set of principles and expectations, supported by the requisite system and process, to ensure coordinate and efficient care for all patients*
- *Provides a framework for structured, reciprocal relationships that integrate specialty care and extend the principles of the medical home to all practicing physicians*

Greenberg JO, et al. JAMA Intern Med. 2014;171(3);454-457

Options to Strengthen Medical Neighborhood



MiKnsey Center for U.S. Health System Reform

Neighborhood Foundation

- Collaborative Care Compact (CCC)
  - Structured process to ensure patient-centered approach to collaboration:
    - Appropriate and timely consultations, referrals, and testing
    - Efficient and effective flow of information
    - Determines responsibility on co-management situations
  - Extends goals of Medical home to specialist colleagues

American College of Physicians. The Patient-Centered Medical Home Neighbor: The interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia: American College of Physicians; 2010: Policy Paper.

Collaborative Care Compact

Pre-Consult

Referring physician agrees to ...
- State clinical questions
- Use agreed upon modality

Receiving physician agrees to...
- Respond to requests within specific time frame

Consult

Referring physician agrees to....
- Request referral and state reason
- Order appropriate test
- Refer to specialists

Referring physician agrees to...
- Have on contact point for each specialty
- Adhere to access timeframe
- Send visit note promptly

Co-Management

Both parties agree to...
- Agree on who manages medications, labs monitoring, etc.
- Notify each other of major interventions, ED visits, hospitalizations
- Offer urgent visits to patient within 1-2 days
- Confer with each other prior to ordering additional referrals related to the condition

Brigham and Women's Physicians Organization, Boston, MA

CCC Considerations

- Consider the following
  - Key information exchange
  - Communication between professionals(methods, frequency)
  - Communication to patient
  - Referrals
  - Timeliness
  - Documentation
  - Role/responsibility regarding services of each party
    - Prevention(immunizations, nutrition, smoking cessation, medical management, follow-up test/test maintenance)
  - Evaluation/satisfaction, quality assurance process
  - Process for transfer of care (temporary or permanent)

Tips for Getting Started

- Identify patient population to focus on (patients with diabetes, CHF, chronic pain)
- Start with 1-2 specialty practices
  - Those you already have a strong relationship and/or refer to often
- Conduct initial conversation to find common and comfortable ground
  - Identify mutual goals and address these first
  - Recognize all involved want the best for the patient
  - Focus on process or system, not people

Tips for Getting Started

- Start with small steps
  - Meetings
    - Large or small
      - evenings 1-2 hours, refreshments, or during lunch hours
    - Agenda driven – overview of PCMH concepts, introduction of co-management, assessment of interest
  - Letter
    - Invitation to specialist office
    - Interest parties to contact ______ or attend an information webinar/in-person meeting on _____.

Suggestions

- Ongoing communication
  - Establish routine check-ins (monthly, quarterly, semi-annual meetings)
  - Larger ALL Medical Neighbor meetings
  - Regular 'case review' meetings
- Evaluation Plan – internal audits, use of 'score card'

- Ophthalmologists
  - Recommended place to start
  - No responsibilities overlap

PCMH Congress

- http://www.pcmhcongress.com/

Collaborative Care Compact

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 workup

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
☐ Determines reasonable time frame for specialist appointment ☐ 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 ☐ 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
- 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 MH concept and 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

Adopted from the Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation.