NEW ENGLAND REGION COLLABORATIVE

2nd Annual Regional Learning Event
June 27, 2017
Important Webinar Notes

1. You are in listen-only mode

2. Please use the Q&A Function (top of screen) to ask questions or make comments. The “chat” function is disabled for this webinar.

3. Should you want to ask a question using your audio, please use the “Raise Your Hand” function on the top left of the zoom dashboard. Webinar host will “promote” you to a panelist so you can ask your question live.

4. Also your video screen size and location are adjustable.
Today’s Agenda

- Speaker Intros
- Presentation – Q&A
- Leaving in action
- Contacts
NERC INTRO

- CMS practice transformation contractors for NE Region – PTNs, SANs, QIN-QIO
- Six states – CT, MA, ME, NH, RI, VT
- NERC Model: Alignment - Duplication = Comprehensive practice transformation resources for all providers in NE
As you listen...

- Think about what actions you can take in your practice to improve the referral process and care coordination
  - For your patients
  - For the practice itself (for your staff & clinicians)
  - For reducing waste or unnecessary resource use

- Be engaged, learning, motivated & planning how you can improve the referral process in your practice
Outline

Why: The need for better coordinated & connected care

What: Best practices for high value care coordination based on physician derived & developed principles and tool kits

How: Action steps to move from disconnected to connected care

Working together is BETTER … for everyone
70 yo woman drives 2 hours to see me (an Endocrinologist)

- Not sure why she was referred
- No records
- Only voice mail at referring practice
- What to do?

What I did:
- Discussed diabetes and thyroid based on med list
- Ordered A1c and TSH
- Oops!
- A1c & TSH done 2 weeks prior - identical
- Left adrenal mass on abdominal CT

Duplicate tests
Additional visits
Not patient centered
Increased stress, burden dissatisfaction for clinician and patient
28 yo woman with appointment booked by her PCP office for evaluation of “fatigue”

- Routine referral- office staff to office staff
- No records sent
- 3 month wait

- Oops!
  - She has Lupus and needed Rheumatology not endocrinology)
  - Now 5 month wait….

Not Patient-Centered
Not Cost Effective (cost of delay)
Not good for business (loss)
No benefit for any involved
74 yo woman with dementia arrives for a referral to endo from her SNF

- Patient is unsure why she is here
- No records except MAR
- SNF physician not available
- Look in the HIE….

- 94 pages of reports
- Diabetes
- Pituitary mass
- Osteoporosis

But what’s the question?

Now what?
A lot of time & effort invested
…back end mess
No benefit for any involved
Scenarios like these are not uncommon

- For referred patients:
  - 60-70% of specialists reported receiving no information
  - 25-50% of primary care providers received no information
    - ~50% did not even know if their patient ever saw the specialist
  - 28% of primary care and 43% of specialists are dissatisfied with the information they receive from each other.
IOM 2001 (Crossing the Quality Chasm):

“A highly fragmented delivery system”

[with]…“poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays…

…physician groups, hospitals, and other health care organizations operate as silos, often providing care without … complete information”

a ‘non-system’
With a few exceptions, most practice in a silo, part of disconnected care

Silo Care / Disconnected Care is:

Not very patient centered

Not very cost effective

Not very satisfying & often burdensome on the back end
From Disconnected Care → High Value, Connected Care

- Duplicate/unnecessary tests
- Additional visits
- Misdiagnosis
- Delayed diagnosis and treatment
- Confusion, errors
- Access backlog/workforce needs
- Not Patient-Centered
- Increased stress, burden, dissatisfaction

- Eliminate wasteful testing
- Make visits as productive as possible
- Avoid misdiagnosis and treatment delays
- Patient-centered focus
- Better match of specialty utilization to patient needs
- Improve the patient and clinician experience
Shared EHR does not solve all the referral/ care coordination problems

Care Coordination requires:

- **Information sharing** *(can even be done without EMR)*
  - Adequate
  - Pertinent

- **Communication**
  - With patient & family and the medical home team
  - With Extended Care team (e.g., clinical question)

- **Collaboration/Working Together**
  - Standardization & expectations of referral procedures
  - Clarity in roles and responsibilities

- **Patient-centered approach**
  - Contextual care: considering patient’s needs & circumstances
  - Shared goals and decision making
Outline

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How: Action steps to get you moving from disconnected to connected care

Working together is BETTER … for everyone
Care Coordination Best Practices & Tools

The Patient-Centered Medical Home Neighbor
The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices

High Value Care Coordination Tool Kit
Medical Neighbor Collaborative

Designed & Tested by Practicing Clinicians
Specialty, Subspecialty and Primary Care
Along with Patient & Family Advocacy Organizations
Medical Neighbor defined:

- Communicates, collaborates & integrates
- Appropriate & timely consultations
- Effective flow of information
- Responsible co-managing
- Patient-centered care
- Support medical home (PCP) as hub of care
Anticipated roles to meet patient needs

- Pre-consultation/pre-visit assistance
- Medical Consultation
  - E-consult (*virtual clinician-to-clinician*)
- Procedural Consultation
- Shared care Co-management
  - *virtual co-management*
- Principal Co-management
Pre-visit Advice/Pre-consultation

- **Pre-visit Advice**
  - Does the patient need a referral
  - Which specialty is most appropriate
  - Recommendations for what preparation or when to refer

- **Previsit Review**
  - Is the clinical question clear
  - Is the necessary data attached
  - Triage urgency (risk stratify the patient’s referral needs)

- **Urgent Cases**
  - Expedite care
  - Improved hand-offs with less delay and improved safety
Formal Consultation

- **Cognitive consultation (advice)**
  - To obtain specialist’s opinion on a patient’s diagnosis, abnormal lab or imaging study result(s), treatment or prognosis
  - Limited to one or a few visits that focus on **answering a discrete question**.
    - **e-Consultation**: provide advice/recommendations without an office visit *(clinician to clinician)*

- **Procedural consultation**
  - To obtain a technical procedure for diagnostic, therapeutic or palliative purposes
  - Include detailed report back to referring physician
  - **Examples**: Colonoscopy, Bone Marrow Biopsy, MRSA infection with recurrent carbuncles
Non-Face-to-Face Consultation including e-Consultations

- Reduce unnecessary specialty visits
- Streamline patient care decisions
- Key Elements
  - Answer clinical question, and tailor to specific patient characteristics
  - Non-binding...convert eConsult to standard visit if too complex (*by any party*)
  - Compensated time and effort
  - Exchange records and responses
    - Documentation: “Based on the information I received, I recommend...”
Co-Management
(ONGOING management of a patient’s medical condition)

• Shared Care for the disease
  • PCP responsible for Elements of Care, takes ‘first call’

• Principal care for the disease.
  • Specialist responsible for Elements of Care for that disorder or set of disorders, takes ‘first call’ for the disorder

• Principal care of the patient for a consuming illness for a limited period of time
  • specialist serves as first contact but patient maintains PCP as Home
Take a minute ...

- How can defining the type of referral (role of the specialist) add to the value of the care?

- How can that role be communicated so that the patient as well as all involved clinicians are aware?

- How could having a “pre-consultation” process improve things for both the patient and the involved practices?
We need a system for care coordination

High Value Care Coordination
- Defining what is needed & expected for high value referrals and care coordination

The “Medical Neighborhood”
- An approach to care coordination
  - It’s about working together better
  - Promotes connected care where ever that care may be needed
Patient-Centered Connected Care- the patient’s medical neighborhood

- The Patient is the **center** of care
- Primary Care is the necessary **hub** of care
- Specialty/ancillary care is an **extension** of care
  - Helping with care to meet patient needs
High Value Care Coordination

What do you need to connect care?

- Information Sharing
- Communication
- Collaboration

Start with Check Lists for:
- High Value Referral Request
- High Value Referral Response
Expectations for High Value Referrals

Referral Request
- Prepared Patient
- Type of referral
- Clinical question
- Urgency
- Core Data Set
- Pertinent Data set

Referral Response
- Answer the clinical question
- What the specialist is going to do
- What the patient is instructed to do
- What does the referring physician need to do & when
- What follow up is needed & with whom
**Prepared Patient**

- **Patient as partner in care**
  - Patient included in the process
  - The patient’s needs & goals considered
- Patient understand **role of specialist** and who to call for what
  - **Pre-visit patient education** regarding
    - the referral condition and/or type of/role of the specialist
- Appropriate (patient-centered) “handoff”
  - Specialty practice alerted of **special needs** of the patient
  - Appropriate specialist at appropriate time to meet the patient’s needs
  - Appropriate preparation with testing or therapeutic trials prior to referral
Take a minute ...

- How often are the patients prepared for the referral now (from perspective of both the requesting or receiving practices...and the patients)?

- What process do you use communicate or to learn about the patient’s goals for the referral?
provide a clinical question (or summary of reason for referral) with all referrals

- “eyes” “gallbladder” “diabetes”

- 68 year old female with intermittent double vision. Is ophthalmopathy assessment the correct starting point?

- 39 year old female with severe RUQ pain, abnormal US and known diabetes, does she need surgery?

- 20 yo female with T1 DM since age 8 on insulin pump therapy, transferring from pediatric to adult care
Attach the Patient’s Core (general) Data Set

- Active problem list
- Past medical and surgical history
- Medication list
- Medical allergies
- Preventive care (e.g., vaccines and diagnostic tests)
- Family history
- Habits/social history
- List of providers (care team) (other specialists caring for patient)
- Advance directive
- Overall current care plan and goals of care
Attach supporting data (pertinent data set) for the referred conditions

- **Pertinent** (*not data dump*)
- **Adequate** (*reduce duplication*)

To allow the specialty practice to
- determine if the referral is to the appropriate specialty
- effectively triage urgency
- effectively address the referral (enough info to do something)
Anaphylaxis (including idiopathic anaphylaxis, possible reaction to drug, insect sting, food, exercise, etc.)

<table>
<thead>
<tr>
<th>Developed by</th>
<th>The American Academy of Allergy, Asthma &amp; Immunology (AAAAI) and the American College of Allergy, Asthma and Immunology (ACAAI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How developed</td>
<td>Prepared by task force of the AAAAI and the ACAAI with approval by both organizations</td>
</tr>
</tbody>
</table>
| Additional essential patient information         | History is essential and patients are more likely to remember preceding events more clearly closer to the event. Therefore the following history should be obtained:  
- List of all foods consumed and drugs taken within the 4 to 6 hours preceding the event  
- Circumstances of a preceding bite or sting  
- Preceding activities (exercise, sexual) |
| Additional patient information, if available     | Tryptase levels (be sure to note when the tryptase was drawn in relation to the time of the event)                        |
| Alarm symptoms/conditions                        | Prescribe intramuscular epinephrine for possible future episode. Antihistamines often inadequate                           |
| Tests/procedures to avoid prior to consult       | See Choosing Wisely section                                                                                                                                 |
| Common rule-outs to consider prior to consults   | None provided                                                                                                                                 |
| Relevant “Choosing Wisely” elements              | • Do not order specific IgE testing for foods  
• Do not be concerned about allergy reaction to egg protein in influenza and other egg based vaccines |
| Healthcare professional and/or patient resources | Healthcare Professional Information:  
Update on influenza vaccination of egg allergic patients: Ann Allergy Asthma Immunol 2013; 111: 301-302  
Healthcare Professional and Patient Information:  
http://www.aaaaai.org  
http://www.acaai.org |
Critical Elements of Referral Response

- Answer the clinical question/ address the reason for referral
  - Summary or *Synopsis* (include some thought process)
- Recommend type of interaction/form of co-management
- Confirm existing, new or changed diagnoses; include “ruled out”
- Medication /Equipment changes
- Testing results, testing pending, scheduled or recommended (including how/who to order)
- Procedures & education completed, scheduled or recommend
- Any “secondary” referrals (confer with and/or copy PCP all)
- Recommended services /actions to be done by the PCP/ PCMH
- Follow-up scheduled or recommended
A referral is part of *taking care* of the patient... *meeting the needs of the patient*

Collaboration is Critical

How do you get to collaboration?
Make an Agreement....

Care Coordination Agreement
(Collaborative Care Agreement/Care Compacts)

- Platform that everyone agrees to work from:
  - Standardized Definitions
  - Agreed upon expectations regarding communication and clinical responsibilities.
- Can be formal or informal
- Your policies and procedures aligned to support the agreement
What type of things are included in the Care Compact? (start with the basics)

1. Preparation of the patient
2. The type of referral / role of the specialist
3. Provide a clinical question with all referrals
4. The core data set to accompany all referral.
5. The pertinent supporting data for the referral
6. A communication protocol
7. The critical elements of the referral response
8. A protocol for making appointments
9. A “Closing the Loop” protocol
Define the protocol for making appointments

- the expected protocol:
  - the **patient** will call to schedule an appointment
  - the **specialty practice** should contact the patient
    - Allows for Pre-visit assessment/referral disposition
    - Allows for tracking of referrals/accountability
Referral Tracking “Closing the Loop”

- Referral request sent
- Referral request received and reviewed – referring practitioner notified:
  - Referral accepted with confirmation of appointment date
  - Referral declined due to inappropriate referral (wrong specialist, etc.)
  - Patient defers making appt or cannot be reached
- Referral response sent - address clinical question/reason
  - Referral Note sent to referring clinician and PCP timely
  - Notification of No Show or Cancellation (with reason)
- Secondary referrals include notification of the patient’s primary care clinician
Referral Processing and Tracking Sheet: date________________________
Referring Practitioner: ____________________________________________
Patient: ___________________________ DOB __________________

We have received your referral______: Patient has called for appointment_______
____We have scheduled new patient appointment for___________________________
____placed on move up list
____Appointment NOT schedule due to_______________________________________
____Patient deferred appointment at this time due to_________________________
____Patient was NO SHOW: ____Patient cancelled appt due to ______________________

We need additional information:
____Clinical Question or Reason for Referral with brief summary of issues
____Type of Interaction Requested
____Consultation only with Recommendations for management sent back to me
____Co-Management: I prefer to Share the Care for the Referred Disorder (s)
____Co-Management: Please assume Principal Care for the Referred Disorder(s)
____Please have Dr Greenlee recommend type of interaction best suites this case

____Additional DATA
Core Data______________________________________________________________
Lab___________________________________________________________________
Imaging_______________________________________________________________
Office Notes ___________________________________________________________
Other_________________________________________________________________

Thank you, 
Care Coordinator for Western Slope Endocrinology
Referrals, Consults, Co-management:
General: for all patients

**PCP**
- Prepare patient
  - Use of referral guidelines where available
  - Patient/family aware of and in agreement with reason for referral, type of referral, and selection of specialist
  - Expectations for events and outcomes of referral
- Provide appropriate and adequate information. *(Optimally adopt mutually agreed upon referral form with neighbor)*
  - Demographic and insurance information
  - Reason for referral, details
  - Core Medical Data on patient
  - Clinical data pertinent to reason for referral
  - Any special needs of patient.
- Indicate type of referral requested:
  - Pre-visit Preparation/Assistance
  - Consultation (Evaluate and Advise)
  - Procedure
  - Co-management with Shared Care
  - Co-management with Principal Care
  - Full responsibility for all patient care

**Neighbor**
- Review Referral Requests and Triage According to Urgency
  - Reserve spaces in schedule to allow for urgent care
  - Notify referring provider of recognized referral guidelines and inappropriate referrals
  - Work with referring provider to expedite care in urgent cases
  - Verify insurance status
  - Anticipate special needs of patient/family
    - Agree to engage in pre-referral consult if requested.
    - Provide PCP with number for direct contact for urgent/immediate matters.
- Provide appropriate and adequate information in a timely manner. *(Optimally adopt mutually agreed upon referral response form with PCP)*
  - To include specific response to referral question and any provision of or changes in type of recommended interaction; diagnosis; medication; equipment; testing; procedures; education; referrals; follow up recommendations or needed actions

* See provided model check list of suggested areas to address.
Referrals, Consults, Co-management

General: for all patients

**PCP**

- Indication of urgency - Direct contact with specialist for urgent cases
- Provide Neighbor with number for direct contact for additional information or urgent matters
  - Needs to be answered by responsible contact Review secondary diagnoses or suggested referrals identified by Neighbor/specialist.
- If co-managing with Neighbor, provide them with any changes in patient’s clinical status relevant to the condition being addressed by the Neighbor.
- Contact the patient, if deemed appropriate, when notified by Neighbor of failure to keep appointment.

**Neighbor**

- Indicate acceptance of referral category or suggest alternate option and reasoning for change.
- Refer follow-up of any secondary diagnoses (additional disorders identified or suspected) back to the PCP for handling unless directly related to the referred problem.
  - If secondary diagnosis is followed up by Neighbor, notify PCP.
- Information regarding any secondary referrals made by Neighbor needs to be communicated to PCP.
- Notify Referring Provider of No Shows and Cancellations.
- If patient is self-referred or referred by another specialist/Neighbor, the PCP provider needs to be copied on the referral response upon obtaining appropriate patient permission.
Focus on the **Referral Process**:  
- **Referral Request**  
  - Clinical Question  
  - Supporting data  
- **Prepared Patient**  
- **Referral Response**  
  - Address Clinical Question  

**Referral Tracking**  
- Confirmation of appointment or decline (redirect) referral  
- Notification of **No Show or Cancellation**
Apply to All Referral Situations

- Primary Care to Specialty Care (Radiology & Pathology)
- Specialty to Specialty
- Specialty to Primary Care
- Ancillary & other services (Diabetes Ed, Physical Therapy, Nutrition, etc.)

Agree to work together in the care of mutual patients
Take a minute ...

• How would having care coordination agreements make your life easier?

• Which practice or practices would you most like to work out a care coordination or referral agreement?
It matters what you connect with.

*True Tales from the Trenches*

- “We had to fax the same records to the specialist 6 times”
- “I referred the patient for a shoulder injury but received a note back about his old knee injury”
- “We sent the records, the front desk received the records but the specialist (physician) never saw them and had no idea why the patient was referred/prior work up”
- “the specialist said they didn’t have time to look at the records my PCP sent”
- “we have no idea if the patient was ever seen or not”

For a strong bridge, you need strong bridge abutments
To have connected care between practices, need to have connected care within practices

We often have silos within our silos

- Need to develop Patient-centered team care (entire staff) around the referral process
  - Make it part of taking care of the patient
  - Work as a team to design improvements, test and implement
- Intentional internal processes (Policy & Procedures)
- Track the referrals and the process
Outline

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What: Recommendations and best practices for high value care coordination based on physician derived & developed principles and tool kits

How: Action steps to get you moving from disconnected to connected care

Working together is BETTER …for everyone
Start with One Step at a time....

- Get your own “house” in order
  - Do a Process Map
    - Make it a team approach
    - Look for gaps (“opportunities”) in the referral process
  - Develop a P&P (policy & procedures)

Think *continuous improvement*
Process Map (Mess)
Tips to Help your Process Map

**Primary Care**
- **Process Start and End**
  - Start = Decision to refer
  - End = Referral reconciled
- **Referral reconciled means:**
  - Response received and incorporated into the care in partnership with patient OR
  - Incomplete and next steps made in partnership with patient

**Specialty Care**
- **Process Start and End**
  - Start = Receipt of referral
  - End = Referral Response sent
- **Referral Response can be:**
  - Redirected to appropriate specialist
  - Not needed or Answer to question w/o appointment
  - Notice of No Show, Cancel
  - Completed with note
Think through the Steps in the Process

- Look at the way it is now
  - How many different ways is the same step done?
  - How are urgent referrals handled
- Are you tracking referrals?
  - Are requesting practices notified of appt, no shows, cancellations
- Where are the gaps?
  - Clinical Question/Reason for Referral (not “lungs”, “vision”)
  - What role is specialist asked to play (consult or comanagement)?
  - Necessary records attached?
    - Are the providers getting the information?
- Timing of referral response note/test results
- Is communication clear on who is to do what?
Develop a P&P (Policy & Procedures)

- Set a practice policy for referrals
  - Example primary care policy: “Our policy is to provide standardized referrals with a clear reason or question stated and attach the appropriate information so that our patients get the care they need efficiently, effectively and safely”
  - Example specialty policy: “Our policy is to provide high value, patient-centered referrals appropriate to the needs of the patient”

- Design the Procedures the way you want it to work
  - See if it works
  - Make improvements/changes as needed to get it working well
Policy & Procedure for Referral Process

- Work Flow
  - Who touches the referral in or out?
    - Include them in the process/planning changes
  - Are new **forms/formats** needed?
    - How will you send confirmation or deferral of appointment?
    - How will you request missing components?
    - How will you notify of cancellation or no show?
  - How are you going to make it happen?
    - Implementation
      - Assign specific responsibilities
      - Make it mandatory
      - “Add on” to current work load or develop new roles

- Internal Monitoring
WHY focus on Care Coordination?

- Care Coordination is part of *taking care* of the patient
- Specialty Care should be an *extension* of Primary Care, (*helping with care, not separated care*)
- Communication improves the *value* of care
- Communication improves *safety and satisfaction* for our *patients*
- Communication *reduces stress* in our own lives
- Having a system/processes for referrals will make your life *easier* in the long run.
A checklist of information to include in a **generic referral to a subspecialist/specialist practice**.

A checklist of information to include in a subspecialist/specialist’s response after **responding to a referral request**.

**Pertinent data sets** reflecting specific information, in addition to that found on the generic referral request, to include in a referral for a number of specific common conditions to help ensure an effective and high value engagement. These were developed by the participating CSS societies.

Model care coordination agreement templates **between primary care and subspecialty/specialty practices**, and **between primary care and hospitalist practices**.

An outline of recommendations to physicians on **preparing a patient for a referral in a patient-centered manner**.
Leave in action....

- Perform a referral process walk-through (Process Map)
- Identify gaps in “Critical Elements”
- Identify needed team members, roles & responsibilities
- Develop a Policy & Procedure document (can be added to & tweaked as progress through the additional steps)
- Commit to participate in the ACP implementation project for High Value Care Coordination/the Medical Neighborhood
  - Practices in Vizient & SNE PTNS –implementation pilot
  - All others-implementation project open soon
NERC Contact Info

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Extra Slides

- Example template for Basic Care Coordination Agreement / Care Compact
- Process mapping example
Process Mapping

**Inputs:** eggs, milk, bread, butter, bacon, plates, utensils, cookware, potatoes

**Make Breakfast**

**Outputs:** scrambled eggs, toast, crisp bacon, pan-fried potatoes

**Prepare Ingredients**

**Cook Ingredients**

**Serve Ingredients**

**Cook Bacon**

**Cook Eggs**

**Toast Bread**

**Fry Potatoes**

**Heat Pan**

**Pour Mixture**

**Stir Mixture**

**Add Pepper**

**Remove Eggs**
Questions?

- Please feel free to use the Q&A function to type your question

OR

- Use the “Raise Your Hand” function and you will be able to ask your question live