LEARNING OBJECTIVES

• Understand the concept and need for the Medical Neighborhood

• Learn the typology of care transition

• Review a PCP-Specialty compact

• What are the strategies for improving coordination with specialists and hospitals in a way that is mutually beneficial?

• Learn tools and resources to incorporate the Medical Neighborhood into practice
Rescue a fragmented health care system, put it together, and return it to the people.

AAFP Founders, 1970
COORDINATION OF CARE
PATIENT PERSPECTIVE
"I’ve got it, too, Omar … a strange feeling like we’ve just been going in circles."

Larson
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*
Coordination of Care (major area of focus)

Communication with other facilities (totally or very satisfied)

Receives Necessary Information from Referrals (always/regularly)

PCPs included in development of specialist treatment plan

PCPs support treatment plan & recommendations

- PCPs: 15%, 36%, 36%, 55%
- Specialists: 21%, 41%, 36%, 70%
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.

- 62.2% of PCPs reported getting it "always" or "most of the time."
PCMH WITHOUT A NEIGHBORHOOD
Patient-Centered Medical Home (PCMH)

• A Physician-guided team that provides comprehensive, coordinated care to patients across the complex health care system and ensures first-contact access and longitudinal and trusting relationships that provide high quality and safe care based on evidence-based medicine and shared-decision making.

Medical Neighbor (PCMH-N)

• A clinician or facility that collaborates with a PCMH or another medical neighbor to facilitate the efficient, appropriate and effective flow of patient information and participates in the care team that effectively addresses issues of responsibility and accountability in transition of care and shared decision making.
MAKING CONNECTIONS

Care coordinator

Job description and protocol consistent with available resources.

- Patient Navigator/Disease Management/Health Coaching

External care coordination

- Hospital and skilled nursing facilities
- Specialists

Internal care coordination

- High-acuity patients
  - Post-hospital
  - Multi-morbid diseases
  - Frequent ED utilization
Primary Care-Specialty Care Collaborative Guidelines

- Purpose and Principles
- Definitions
- Types of Care Transition
  - Transition of Care
  - Access
  - Collaborative Care Management
  - Patient Communication
- Transition of Care Records (PCP and Specialist)
Types of Care Transition

- Pre-consultation exchange
- Formal consultation
- Co-management (Referral)
  - With Shared management
  - With Principle Care of the disease
  - With Principle Care of the patient
- Complete transfer of care (Specialty Medical Home Network)
- Technical Procedure
# 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

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ PCP maintains complete and up-to-date clinical record including demographics.</td>
<td>☐ Determines and/or confirms insurance eligibility</td>
</tr>
<tr>
<td>☐ Transfers information as outlined in Patient Transition Record.</td>
<td>☐ Identifies a single referral contact person to communicate with the PCMH</td>
</tr>
<tr>
<td>☐ Orders appropriate studies that would facilitate the specialty visit.</td>
<td>☐ When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up</td>
</tr>
<tr>
<td>☐ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit.</td>
<td>☐ Provides patient with specialist contact information and expected timeframe for appointment.</td>
</tr>
</tbody>
</table>
## 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

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

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

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

Allergy-Immunology
Cardiology
Dermatology
Gastroenterology
Hematology-Oncology
Mental Health
Nephrology
Neurology
OB-GYN
Ophthalmology
Rheumatology
Surgery
  - General
  - Orthopedics
  - Spine (2)
  - Plastics and Hand
  - Urology

Specialists & Community Resources
Primary Care
Skilled Nursing Home
Home Health

50+ Physicians
17 Specialty offices
1 Hospital
## Medical Neighborhood Successes

<table>
<thead>
<tr>
<th>Medical Neighbor</th>
<th>Successes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Sends 99.3% of elements of Transition Care Record to specialist prior to visit</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Calls before invasive interventions and to discuss care plan</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Refers treatment of other lesions back to PCP</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Working on TCR and care plan re: colonoscopy guidelines</td>
</tr>
<tr>
<td>Neurology</td>
<td>Decrease in secondary referrals</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Faxes diabetic retinal exam reports; Same day access</td>
</tr>
<tr>
<td>Surgery – Orthopedics</td>
<td>Sends patients back to PCP with care plan and patient goals</td>
</tr>
<tr>
<td>Urology</td>
<td>Collaborative teamwork, TCR</td>
</tr>
</tbody>
</table>
“Somebody has to do something, and it’s just incredibly pathetic that it has to be us.”

--the late Jerry Garcia of the Grateful Dead
BUILDING A NEIGHBORHOOD

Phase 1: Planning

Phase 2: Implementation

Phase 3: Evaluation

Phase 4: Sustainability and Continuous Improvement
PHASES AND THE 5 A’S

Phase 1: Planning
- Adopted/established a structure (Compact)
- Care coordination protocol
- Develop a Timeline for your office

Phase 2: Implementation

ASK
- Develop a list of Specialists
- Send an invitations to join your Neighborhood

ADVISE
- Introduce Medical Neighborhood concept
- Discuss physician philosophies, agree on common values
- Compact and TCR
ADVISE: Transition of Care Record (TCR)

- 22 Elements, 8 Sections
- **Specialist-to-PCP**
  - Practice information
  - Patient demographics as name, DOB
  - ICD-9 Diagnosis codes
  - Reason for referral and clear goals of care and interventions
  - Clinical Data
    - Medical history, current medications
    - Labs or diagnostic test results
    - Care team = other doctors who see the patient
  - **Recommendations for treatment**
    - Who is responsible for followup, monitoring the patient and when
    - Patient’s treatment goals, education materials given to patient
    - Medication changes, new diagnoses, changed diagnoses
  - Technical procedures completed
  - Communication preferences: fax, letter, email, phone
  - **Type of Care Transition**
    - Defining the Relationship (Ex. co-management with principle care)
      - Definitions were developed by the American College of Physicians
ADVISE:
THE IMPLEMENTATION MESSAGE

- You as PCPs survive and thrive!

- Benefits to a PCMH-N
  - Patients
    - Activated, prepared, engaged
  - Specialty Care Physicians
    - Maintain autonomy, known for quality care, more exclusive patient volume from PCP
  - Practice of Medicine
    - Reclaim the joy of medicine, camaraderie, why you went into medicine
  - Health Care
    - Solvency, sustainability—jump start, pioneering—it’s the way of the future!
Phase 3: Evaluation

ASSESS

- Measure your own performance
  • Monthly TCR audits

- Measure your Neighborhood’s performance
  • Quarterly Score Cards and TCR audits
  • Patient Satisfaction Survey
Average % of TCR elements captured in referral notes from Primary to Specialty Care Providers
ASSESS: MEASUREMENT

Average % of TCR elements captured in notes from Specialty to Primary Care Providers

- Jun-10: 54.2
- Sep-10: 59.8
- Dec-10: 67.2
**ASSESS: MEASUREMENT**

Medical Neighborhood Score Card

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>Transition of Care</th>
<th></th>
<th></th>
<th></th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Determines or confirms insurance eligibility</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b</td>
<td>Ease of Communication</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Must Have</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1c</td>
<td>Communicates readily with PCP on pre-referral workup</td>
<td>3.75</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a</td>
<td>Insurance Participation</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b</td>
<td>No-show notification</td>
<td>N/A*</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2c</td>
<td>Access to scheduling</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Must Have</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2d</td>
<td>Provides list of ‘neighborhood’ providers</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Must Have</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2e</td>
<td>First visit with physician</td>
<td>1.25</td>
<td>1</td>
<td>**ACTION PLAN necessary; Did not pass MUST HAVE</td>
<td></td>
</tr>
<tr>
<td>2f</td>
<td>Readily available to</td>
<td>2.5</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Score Card % out of 100 points for Specialty Care

- Jun-10: 74
- Sep-10: 84.6
- Dec-10: 86
Q2, Q3, Q4 2010
Score Card Totals for Neighborhood

Orthopedic 1
Orthopedic 2
Orthopedic 3
Dermatology
Cardiology
Oncology
Neurology
Surgery 1
Ophthalmology
Urology

Top bar: Q2  Middle bar: Q3  Bottom bar: Q4
PHASES AND THE 5 A’S

Phase 3: Evaluation
ASSIST

- PCP MN Toolkit
- Specialty MN Toolkit
- A few elements of the Toolkits
  - 6 Steps to Becoming a PCMH Neighbor
  - “Types” of Care Transition case histories and checklist
  - Information for PCPs and Specialists why to join a MN
  - Electronic and manual “identifier” as a PCMH

Phase 4: Sustainability
ARRANGE
ASSIST: 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-0 code

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

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: Gianna

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:
   - 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-0 code

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

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

   - Relevant notes:
     - Recent office visit, recent hospitalization and lab/Dx for previous 3 months unless otherwise specified
     - Pertinent labs and diagnostics tests (if not added by provider)

   - Problem list
   - 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
   [Referral → Diagnosis → Browse]

7. Visit status:
   - Routine, urgent, emergent (specify time frame)

8. Follow-up request:
   - Mail, fax, phone call, e-mail
ASSIST: SPECIALIST EXAMPLES

SPECIALTY PROVIDER

Transition of Care Record
Specialist Checklist

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 designation
3. Communication
   □ Communication preference – Mail, fax, phone call, e-mail
4. Diagnosis
   □ ICD-9 codes for diagnoses
5. Clinical Data provided:
   □ Problem list
   □ Current medications
   □ Pertinent labs and diagnostics tests
   □ Medical/surgical history
   □ List of other medical providers
6. Recommendations
   □ 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
     • 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
   □ 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
   □ Communication preference – Mail, fax, phone call, e-mail
   □ 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.

Westminster Medical Clinic
Phone 301.487.5171
Fax 301.487.5196

Patient-Centered Medical Home
NCQA Level III Recognized

Westmed Family Healthcare
Phone 301.457.4497
Fax #: 301.254.4369

To:

Fax: __________________________ Date: __________________________

Re:

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

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

SOC – Patient-Centered Medical Home Neighborhood Initiative

Contact Westminster Medical Clinic to join our PCMH-Neighborhood!
ASSIST:
MEDICAL NEIGHBORHOOD TOOLKIT

- Facilitation
  - Compact (SOC-PCMH Initiative)
  - Proposed Timeline / Gantt Chart
  - Medical Neighborhood Invitation
  - Medical Neighborhood Introduction Guide
  - Medical Neighborhood Practice Profile (SOC-PCMH Initiative)

- Implementation
  - Care Coordination Policy and Protocol
  - ACP Care Transition Definitions & Scenarios
  - Score Card Excel Template; Score Card Word Template
  - **TCR Checklists**: PCP Provider; Referral Coordinator; Medical Assistant; Specialist
  - Patient Satisfaction Survey
  - Patient information pamphlet about the Medical Neighborhood
  - PCP-Specialist Fax Sheet (PCMH identifier)
  - PCP-Specialist Newsletter
  - PCMH-ID Card example (Health TeamWorks)
ARRANGE: SUSTAINABILITY

- Spread to other Specialties and Primary care practices
- A foundation for clinical integration: ACO?
- Payment reform
- Continuous quality improvement for PCP and Specialists
  - Continuous communication/feedback
  - Create Action Plans!
- Utilize resources
  - CMS SOC-PCMH Initiative
  - Health TeamWorks
- Refining MN Toolkit
- Expand Compact to other transitions
WHAT DID WE LEARN ABOUT NEIGHBORS?

- Not aware of PCMH or Medical Neighborhood concept

- Most willing to participate and believe they are or can fulfill most expectations
  - “A slam dunk”, “Ideal in principle”

- Interpretation of the **Compact** not straightforward

- Unclear about definitions of transitions/management relationships and patient-centered care

- 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

- Specialists cater to many differing PCP requests

- **Transition of Care Record and QI** are main points of conversation