



Implementing Care Compacts to Improve Care Coordination

Presented by:

Carol Greenlee, MD FACP FACE

Vice Chair ,Council of Subspecialty Societies, American College of Physicians

Co-Chair, PCMH-Neighbor work group, CSS, ACP

Chair ,High Value Care Coordination work group, CSS, ACP

Chair, Pediatric to Adult Care Transition Tools work group, CSS, ACP



Program Overview:

Establishing Care Agreements/Compacts

.After completing this activity, the participant will demonstrate the ability to

- Delineate the components of a care compact, define a good referral, and establish practice specific standards for elements within the compact
- Identify practice strategies that can drive enhanced bi-directional communication and collaboration for improved patient and quality outcomes
- Describe organizational procedures/workflows to support care coordination and shared care planning

Importance of Practice Change

- **“Sea Change” in Healthcare Payment Structures**
 - Volume Oriented ---- Value Oriented
 - Production Oriented --- Budget Orientation
 - Fee for Service --- Alternative payment models
- **Payers are Requesting Alternative Payment Models:**
 - Medical Home
 - Bundled Payments (e.g. Episode of Care, Procedural Bundles)
 - Shared Saving Programs (e.g. Medicare ACO)
 - Full and Partial Capitation



Importance of Practice Change

- **The skills being promoted through this Patient Centered Specialty Care (PCSC) program and that are part of the NCQA SPR program are those required to succeed under these alternative models:**
 - **Patient Centered Focus**
 - **Increased Care Coordination and Integration**
 - **Improved Quality and Efficiency**



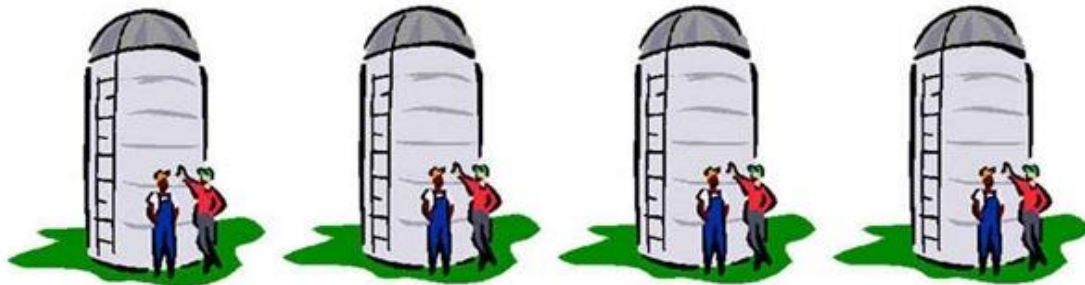
Quality Improvement:

How can we do things better in Care Coordination?

- **Why** focus on care coordination?
 - Diagnosis and Care can be complex
 - Patients often have many co-morbidities
 - Continuous, coordinated care is better for the patient
 - Working together (“cooperation”) is better for us
- **How** does it happen now ?
- **What** can we do to improve it?
 - Tools from Medical Neighbor & HVCC
 - Ways to start improving the process

Need for Extending Care Out to Specialists

The Medical Neighborhood



Neighborhood of Silos

Disconnected Care

What is it like on the inside for the specialists ?

■ **“Playing Charades”**

- 70 year old woman does not know why she was referred, PCP staff just told her to make appointment, no records, only get into voice mail at PCP office
- Cognitively impaired woman sent from SNF with only medication list

■ **“Wasted Days and Wasted Nights...”**

- Patient with Lupus in with Endocrinologist for “fatigue” instead of referral to Rheumatologist.

■ **“Volume Overload” (aka “chart dump”, “vomiting the chart”)**

- 63 year old male referred with long-standing diabetes and a 12# stack of records

What is it like for the Specialist

- Patient not told they were referred, specialty staff “cold call” to patient (*often not well received*)
- *Patient comes to appointment but does not know why referred and there are no records*
- No records with the referral and patient provides chief complaint that might or might not have anything to do with why they were actually referred
- *Referred for “abnormal XXX” but none of the results are sent with the referral*
- Surgeons like surgical cases

What is it like inside the silo for the PCP ?

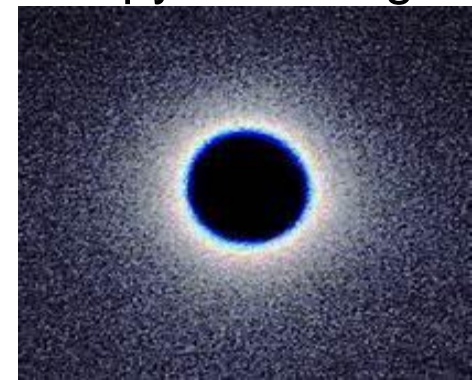
■ “Playing Charades”

- 70 yo woman with refractory HTN returns for f/u appt after referral to Nephrology/Cardiology/Endocrinology. She had some sort of test done but doesn't know what it was and was supposed to start a new medication but doesn't know the name of it and isn't sure which physician was supposed to prescribe and monitor it.

■ “Left out of the Loop...aka Treatment Plan Trampled”

- 82 yo male had f/u cardiology appointment for mild CHF, all labs repeated (duplicated) and patient is sent to Pulmonary and then to GI for various reasons including routine colonoscopy; with PCP and patient previously having diagnosed mild COPD that was already treated and having decided not to have colonoscopy due to age.

■The referral “*black hole*”



What is it Like for the Patient ?

- *“My doctor told me why he sent me to see you but I was so upset about the news he gave me that I don’t remember what he said.”*
- *“I understood I was here to have the procedure today, not just to talk about my stomach pain!”*
- *“I was supposed to call to schedule with that specialist? I thought her office was supposed to contact me.”*
- *“I had that MRI last month. You mean I was supposed to bring the report and the films with me to this visit. I assumed you had the information.*
- *“You mean I took a day off from work and you are not the person I have to see!!!!!!*

...and we all end up with



***poor communication leads to
poor care coordination***

Effects of Poor Care Coordination


- **Having to repeat unnecessarily medical histories and tests.**
- **Receiving inappropriate and non-reconciled medication.**
- **Receiving inconsistent medical instructions or information.**
- **Using higher intensity settings than necessary--- unnecessary emergency department use and hospital readmissions.**

MedPAC: Report to the Congress, June 20.5 bill2

- **Better Care Coordination in Medicare with CHF, COPD and Type 2 Diabetes would save \$1.5 billion per year.**

Rand 2014

Wasted Resources / Higher Risk

- 
- How do you get what you need with referrals ?
 - How do you coordinate care ?

Communication is critical



Collaboration is Critical

“Effective care coordination ... requires not only full access to all the ***necessary clinical information*** obtained at multiple sites, but also a willingness by all the physicians involved in a patient’s care to participate in ***collaborative*** decision making ...”

Elliott Fisher, M.D., New England Journal of Medicine 2008

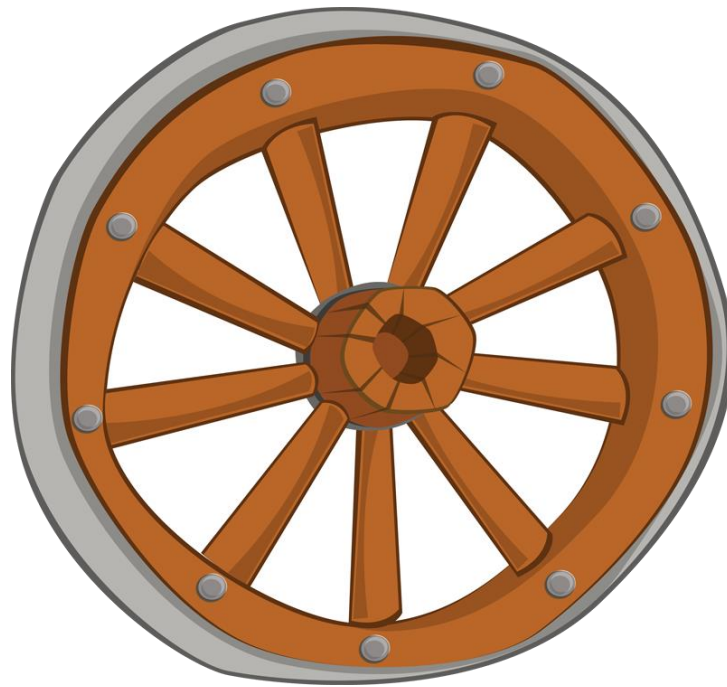


Shared EHR does **not** solve all the referral/ care coordination problems

- Missing elements:
 - System-wide referral policy
 - Communication
 - Collaboration
 - Standardization of referral procedures
 - Clarity in roles and responsibilities
 - A *Patient-centered* approach

Need for Extending Care out to Specialists

The Medical Neighborhood



Continuous Connected Care

ACP[®]

AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

**THE PATIENT-CENTERED
MEDICAL HOME NEIGHBOR
THE INTERFACE OF THE
PATIENT-CENTERED MEDICAL
HOME WITH SPECIALTY/
SUBSPECIALTY PRACTICES**

American College of Physicians
A Position Paper
2010

http://www.acponline.org/advocacy/where_we_stand/policy/



PCMH-Neighbor Defined as practices that:

- **Communicate, coordinate and integrate bi-directionally with PCMH as well as with patient**
- **Ensure appropriate & timely consultations and referrals**
- **Ensure effective flow of information;**
- **Address responsibility in co-management situations;**
- **Support patient centered care**
- **Support the PCMH practice as the “hub” of care and provider of whole person primary care to the patient**

ACP | High Value Care



Collaboration of Primary Care, Specialty and Patient/Family organizations

Care Coordination *starts with the Referral*

Check lists:

- *Referral Request*
- *Referral Response*

What is needed for a “good” (high value) referral?

- Appropriate and Adequate Information
- Collaboration for Continuous Care



Can't do this by yourself.....

How do you Collaborate ?



Care Compacts

- **Platform that everyone agrees to work from with:**
 - **Standardized Definitions**
 - **Agreed upon expectations regarding communication and clinical responsibilities.**
- **Policies and procedures should be aligned to support the agreement**

Referrals, Consults, Co-management: General: for all patients

PCMH

- 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
- 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

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 PCMH practice 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 PCMH**)
 - 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.

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Referrals, Consults, Co-management

General: for all patients

PCMH

- 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 PCMH for handling unless directly related to the referred problem.
 - If secondary diagnosis is followed up by Neighbor, notify PCMH.
- Information regarding any secondary referrals made by Neighbor needs to be communicated to PCMH.
- Notify Referring Provider of No Shows and Cancellations.
- If patient is self-referred or referred by another specialist/Neighbor, the PCMH provider needs to be copied on the referral response upon obtaining appropriate patient permission.



Elements to Consider in a Care Compact

- 1. The PCP defines the type of referral relationship being requested**
- 2. The PCP agrees to provides a clinical question with all referrals**
- 3. The PCP and Specialty practice establish a core data set to accompany all referral.**
- 4. The PCP and Specialty practice establish a pertinent data set for specific clinical conditions.**
- 5. The PCP and Specialty practice establish a communication protocol**
- 6. The Specialty practice agrees to respond to a referral request that includes the agreed upon critical elements**
- 7. The PCP and Specialty practice agree on a protocol for making appointments**
- 8. The PCP and Specialty practice agree on a “Closing the Loop” protocol**



Elements to Consider in a Care Compact

- 1. The PCP defines the type of referral relationship being requested.**

I am referring this patient for:

- ___ Medical Consultation: Evaluate and advise with recommendations for management and send back to me
- ___ Procedural Consultation: Specialist to confirm need for and perform requested procedure if deemed appropriate.
- ___ Co-management: I prefer to share the care for the referred condition (PCP lead, first call)
- ___ Co-management: Please assume principal care for the referred condition: Specialist assumes care, first call
- ___ Please assume full responsibility for the care of this patient (Complete transfer of care)

Referral Relationship --- Pre-visit Advice

- **Pre-visit preparation or assistance which can take place before any type of formal referral can include:**
 - **request for guidance regarding whether referral is appropriate and/or necessary**
 - **Request for guidance on the urgency of the referral**
 - **Request for guidance for pre-visit work-up.**

Through these interactions, an educational process occurs between the practices --- a set of referral guidelines are established.

Dyspepsia less than age 50: It sounds like you are referring this patient for dyspepsia. In patients under 50 years of age without alarm symptoms, the *following workup is recommended before* we see the patient in the GI Clinic.

- 1) Please check an H pylori serum IgG. If the patient is positive, treat with triple therapy. If symptoms resolve, no further workup is needed.
- 2) If patient has been previously treated for H pylori, then obtain a stool antigen test for H pylori after at least 14 days off PPIs, and 8 weeks after completing H pylori therapy. If the stool antigen is positive, treat with a different regimen.
- 3) If H pylori testing is negative, or if symptoms do not resolve after treatment, give the patient an 8-week course of a proton pump inhibitor taken twice daily, 30 minutes before eating. If symptoms resolve, the PPI should be titrated down to the lowest effective dose.

If the *above workup does not relieve the dyspepsia, please notify me and I will have your patient scheduled.*

If the patient has, or subsequently develops, any *alarm symptoms* (such as weight loss, early satiety, GI bleeding, dysphagia), please notify me, and I will have the patient scheduled to be seen in clinic.



Elements to Consider in a Care Compact

1. The PCP defines the type of referral relationship being requested.
2. **The PCP agrees to provide a clinical question with all referrals**

Clinical Question/ Reason for Referral

- “eyes” “thyroid” “gallbladder”
- *68 year old female with sudden reduction in visual acuity with eye pain*
- *24 year old male with 3 cm left thyroid nodule and FNA cytology suspicious for thyroid cancer*
- *39 year old female with severe RUQ pain, abnormal US and known diabetes*

Elements to Consider in a Care Compact

3. The PCP and Specialty practice establishes a **core data set** to accompany all referrals

- Active problem list
- Updated medication list; medical allergies
- Summary of any significant medical and surgical history
- Summary of any significant family history
- Summary of any significant behavioral habits/social history
- Care Team members --- List of physicians and other healthcare professionals participating in the care of the patient.

Elements to Consider in a Care Compact

4. The PCP and Specialty practice establish a **pertinent data set** for specific clinical conditions

- Clinical information **directly relevant to the referral question**. May include:
 - recent office visit notes
 - care summaries;
 - relevant lab, imaging or other data
 - specific clinical information requested by the referred t specialty/subspecialty practice prior to the consult.

Pertinent Data set for clinical question/ reason

■ Pertinent (*not data dump*)

- Attach the Abnormal labs or Imaging reports that may have triggered the referral
- Attach past test results that might indicate change or progression (or put in brief summary)
- Notes regarding symptoms, signs, discussions

■ Adequate (*reduce duplication*)

- Additional test results that may be needed and will prevent the specialist from unnecessarily repeating the test (e.g. a Creatinine level for referral for diabetes management)

Pertinent Data set for clinical question/ reason

- **Pertinent** (*not data dump*)
- **Adequate** (*reduce duplication*)
- Ideally, use **Referral Guidelines** for what to send
 - ACP workgroup on **High Value Care Coordination – Pertinent Data Sets**
 - **Ability to Triage if correct specialty**
 - **Ability to triage appropriate urgency**
 - **Ability to do something at the first specialty appointment**



Osteoporosis

Developed by	American College of Rheumatology (ACR) and The Endocrine Society (ES)
How developed	Developed initially through separate ACR and TES Task Forces, and combined through consensus discussion.
Additional essential patient information	<ul style="list-style-type: none"> • Full report of bone densitometry (DEXA) • Is there a history of adult fracture? • Serum calcium • Serum creatinine • Vitamin D 25-OH
Additional patient information, if available	<ul style="list-style-type: none"> • CBC • TSH • 24 hour urinary calcium • Chemistry panel • Serum Protein Electrophoresis • Parathyroid hormone level • Celiac panel • Testosterone level in men with low bone density • CTx or NTx
Alarm symptoms/conditions	<ul style="list-style-type: none"> • Recurrent fracture • T-score <-4.0 • Painful vertebral fracture • Refractory or intolerant to medical therapy
Tests/procedures to avoid prior to consult	None provided
Common rule-outs to consider prior to consults	None provided
Relevant "Choosing Wisely" elements	None provided
Healthcare professional and/or patient resources	<p>Healthcare Professional Information:</p> <p>Osteoporosis in Men Clinical Practice Guideline http://www.endocrine.org/~media/endosociety/Files/Publications/Clinical%20Practice%20Guidelines/FINAL-Osteoporosis-in-Men-Guideline.pdf</p> <p>Patient Information:</p> <p>http://www.rheumatology.org/Practice/Clinical/Patients/Information_for_Patients/</p> <p>Osteoporosis and Bone Health Patient Fact Sheets http://www.hormone.org/diseases-and-conditions/bone-health http://www.rheumatology.org/Practice/Clinical/Patients/Diseases_And_Conditions/Osteoporosis/</p>



Recommendation for Referral Information

- Identify your practice's top reasons for referred patients (or inappropriate referrals or inappropriate testing done prior to referral)
- Identify the Pertinent Data Sets for those conditions (what data related to the condition needs to be sent with the referral)
- Create check list for referring practice

Elements to Consider in a Care Compact

5. The PCP and Specialty practice establish a **communication protocol** to address:
- **Contact information for physicians/NP/PAs** both for routine and urgent contact
 - **Method for exchanging referral information** (e.g. through common EHR system, HIE, fax, secure email system).
 - Expected **timeline** for Specialty practice to respond to:
 - **routine and urgent contact requests**



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5. The PCP and Specialty practice establish a communication protocol
6. **The Specialty practice agrees to respond to a referral request with the agreed upon critical elements**

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 completed, scheduled or recommend**
- **Education completed, scheduled or recommended**
- **Any “secondary” referrals made (confer with &/or copy PCP on all)**
- **Any recommended services or actions to be done by the PCMH**
- **F/u scheduled or recommended**

Critical Elements of Referral Response

- **Do not want to contribute to “data dump” problem ---- send multiple page report where the referring physician cannot access critical information.**
 - If possible, develop ***synoptic summary*** of referral response
 - ***What is the specialist going to do***
 - ***What is the patient asked to do***
 - ***What is the Primary Care practice asked to do***
 - Set up protocol with referring physician that critical elements will be placed in a specific part of the referral response report e.g. Under “Assessment and Planning”

Elements to Consider in a Care Compact

7. The PCP and Specialty practice agree on a **protocol for making appointments**

For routine appointments

- the patient will call to schedule an appointment
- the specialty practice should contact the patient
 - Allow for Pre-visit assessment

For urgent appointments

- E.g. The referring practice will phone the Specialty practice to discuss with specified contact person.



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8. **The PCP and Specialty practice agree on a “Closing the Loop” protocol**

“Closing the Loop” (Referral Tracking)

- **Referral request sent**
- **Referral request received and reviewed**
 - Referral *accepted* with *confirmation of appt* and date **sent back to referring practitioner**
 - Referral *declined due to inappropriate referral* (wrong specialist, etc) and **referring practice notified**
 - *Patient defers* making appt or cannot be reached and **referring practice notified**
- **Referral response sent** (must address clinical question/reason for referral)
 - *Referral Note* sent to referring clinician and PCP
 - *Notification of No Show or Cancellation* (with reason, if known)

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.

Inside the Practice

Supporting data

Referral by fax



Requesting more data

Cancellations

Electronic referrals

Received confirmation

No shows

Is there a clinical question?

The referral request sent

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”*

Need for Practice Transformation

- Improving care coordination and communication ***between*** practices requires workflow changes ***within*** practices
 - Improved hand-offs between practices don't "just happen": **the agreement is just the beginning**
 - New **processes** are needed
 - Policy & Procedures
 - ***Siloes within siloes***
 - Need improved hand-offs **within** practices !
- **Secret is in Culture/mindset change**
 - ***Patient Centered Team Care***

Change: How to get Started

- Look at your own referral processes first
 - **Process Map** of your current process
 - What happens to referrals now
 - How are urgent referrals handled
 - Are you tracking referrals ?
 - Are referring practices notified of appt, no shows, cancellations
 - Where are the gaps?
 - Clinical Question/Reason for Referral (not “lungs”, “vision”)
 - What role are you asked to play (consult or comanagement)?
 - Necessary records attached?
 - Are the providers getting the information?
 - Timing of referral response note/test results
 - Are you communicating clearly on who is to do what ?

Policy & Procedure for Referral Process

■ Work Flow

Who touches the referral in or out?

■ Include them in the process/ planning changes

What are your current procedures ?

■ **Process mapping** as a tool

Walk through how it is done now

What changes are needed

■ Are new **forms/formats** needed?

How will you send back a confirmation or deferral of appointment?

How will you request missing components?

How will you notify of cancellation or no show?

Western Slope Endocrinology

Carol Greenlee M.D. FACE, FACP

603 28 1/4 Road

Grand Junction, CO. 81505

Phone: 970-263-2650

Fax: 970-263-2695

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

Policy & Procedure

- How are you going to make it happen?
 - Tracking System
 - Utilize LOG to ensure all components/steps completed
 - Separate System often needed
 - EMR referral tracking systems often not complete
 - Extra work, value-added
 - Implementation
 - Assign specific responsibilities
 - Make it mandatory
 - “Add on” to current work load or develop new roles
 - Internal Monitoring

NCQA *Specialty* Practice Recognition

- Track & Coordinate Referrals
 - Referral Process & Agreements
 - Referral content
 - Referral Response
- Provide Access & Communication
 - Access
 - Electronic Access
 - Specialty practice responsibilities
 - CLAS
 - The Practice Team
- Identify & Coordinate Patient Populations
 - Patient information
 - Clinical data
 - Coordinate patient populations
- Plan & Manage Care
 - Care planning & self-care support
 - Medication management
 - Electronic prescribing
- Track & Coordinate Care
 - Test tracking & follow up
 - Referral tracking & follow up
 - Coordinating Care Transitions
- Measure & Improve Performance
 - Measure Performance
 - Measure patient/family experience
 - Implement & Demonstrate Continuous Quality Improvement

PCSP 2E: The Practice Team

The practice uses a team to provide a range of patient care services by:

- Defining roles for clinical and nonclinical team members
- Having regular team meetings or a structured communication process focused on patients (*Huddles: review schedule patient needs*)
- Using standing orders for services
- Training and assigning care teams to coordinate care
- Training and designating care team members in communication skills
- Involving care team staff in the practice's performance evaluation and quality improvement activities
- Holding regular practice team meetings

Quality Improvement is not a 4 lettered word

- QI is Finding ways to improve what we do, so we can do it better
- QI processes:
 - Much like the scientific method we are all familiar with (discovering what works and how well it works)
 - Allow for making changes on the changes (“adjustments” vs “overhaul”)
 - Short cycle test
 - Step-wise changes
 - Test to see if idea/ changes actually work
 - What are the unintended consequences

System Thinking

- **Each of us must work for his own improvement, and at the same time share a general responsibility for all humanity."**
- -- Marie Curie,
physicist and chemist