The Medical Neighborhood: *Coming to Agreement about Care Coordination*

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July 10, 2014

Reprogramming and Connecting to Solve the Right Problems the Right Way

Becoming patient centered…..and everything else flows from that

Starting thoughts

- What do you **love** about what you do? (related to your career in medicine)
- What makes your job hard/harder to do ?

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System change… a new approach…reprogramming

Systems awareness and systems design are important for health professionals but are not enough. They are enabling mechanisms only. It is the ethical dimension of individuals that is essential to a system's success. Ultimately, **the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system.** Avedis Donabedian

Many "drivers"……. "the secret of the care of the patient is in caring for the patient" Francis Peabody

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Change- doing things differently, another way

- Why
- What
- How
- Value

- We aren't talking about **Health Care Reform** (political, regulations, mandates)
- We are talking about *Care Delivery Transformation* (ground up/bottom up practice changes)

trans·form

verb \tran(t)s-ˈfȯrm\ : to change (something) completely and usually in a good way

- *a*: to change in composition or structure
- *b*: to change the outward form or appearance of
- *c*: to change in character or condition
- **trans·form**
- /v. trænsˈfɔrm; n. ˈtrænsfɔrm/ Show Spelled [v. trans-fawrm; n. trans-fawrm] Show IPA
- verb (used with object) 1. to change in form, appearance, or structure; metamorphose.
- 2. to change in condition, nature, or character; convert.

WHY ??- *because we all need it*

- Current *System* not sustainable
  - Things *will* change
  - Do it ourselves, solve the right problems
  - Reduce waste (duplicated services, unnecessary care, delayed care, safety issues/harms)
  - Prevent "rationing" and regulations from outside
  - It is needed and the right thing to do, "higher ground"
- Our *patients* and our *Community*
  - Health, stewardship, employers, resources
- *Ourselves*
  - Burnout vs. Joy (doing what we love)

Health care delivery in the USA

IOM CQC summary

- Highly Specialized
- Compartmentalized
- Disorganized
- Fragmented
- Falls short on measures of clinical quality

Underlying characteristics

- Acute care model
  - Staccato care
- Physician centered
  - Staff supports physician
  - "my practice" mindset
- Silos of care
  - Cut off
  - Focus on success of the silo not the system

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Patient Centered Care Models (PCMH/PCSP)

- Change from *acute care (ER visit)* model to the ***Chronic Care/ Expanded Care Model***
  - *Comprehensive, Continuous and Coordinated Care*
  - *Utilizes planned visits*
- Requires **team care** and **population management:**
  - Shift from the model of the physician doing everything
  - Utilize staff at "top of their license"
- Requires **payment reform**
- **Patient-Centered Care**
  - the patient is the center of care ("what is best for the patient")
  - the team cares for each patient and their population of patients (vs. task oriented mindset)

Tyranny of the urgent:

Day in the life of Primary Care

- Mid afternoon. Running behind. Seen 20 patients.
- 55 y.o. male with DM requesting refills and routine visit. Not seen for 9 months.
- Also has dizziness, a rash and knee pain
- No recent labs for over a year
- Med list not up to date
- Does not know last retinal exam
- Evaluate dizziness, look at the rash, briefly discuss arthritis, order labs, refill meds, discuss OTC meds. No diabetic education or foot exam. Not sure when he will be seen again.

Tyranny of the urgent:

Day in the life of Primary Care

And what about prostate exam, colonoscopy, immunizations, lipid panel and renal assessment……

The Patient Centered Medical Home

NCQA Standards

- Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Self-Management Support
- Track and Coordinate Care
- Performance Measurement and Quality Improvement

Day in the life of PCMH:

- 55 yo male with diabetes :
  - *Staff member* using *registry* has ensured that he has had retinal exam, A1c and other labs as well as colonoscopy and other preventive care such as immunizations
  - Planned and group visits for diabetes care
  - With *enhanced access* patient is able to make same day appt for evaluation of dizziness and other concerns; the staff member notes patient is due for foot exam and completes as patient is roomed; the PCP has adequate time for thorough assessment of new issues

Medical Home Model

Chaos → Organization

- Acute Episodes of care
- Doc works alone
- Hamster wheel practice
- Tyranny of the Urgent
- No time > multiple referrals

- Chronic Care Model
- Patient-Centered
- Team Care/Communication
- Registries
- Improved Access

Well-tuned team machine

But now, I'm a Ferrari on a dirt road…

Everything thrown out of alignment once the patient "leaves home"

U.S. Health Care

- Great Skills
- Great Science
- No system for care coordination
  - No curriculum for communication/care coordination
  - No professional norms for communication or care coordination (documentation vs communication)

  "***Consultation***"= whatever you want it to be

Referral and Consultation Communication Between Primary Care and Specialist Physicians

O'Malley, AS, Reschovsky JD. Arch Intern Med. 2011;171(1):56-65

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.
- SOC/PCMH Poll indicates 37% of specialists receive necessary information
- 62.2 % of PCPs reported getting it "always" or "most of the time."
- SOC/PCMH Poll indicates PCPs receive info 52% of time.

25% to 50% of referring physicians did not know if patients had seen specialist

(Mehrotra, A., Forrest, C.B., Lin, C.Y. The Milbank Quarterly, 2011

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 exam room for new consultation, I am an endocrinologist (cc/o at time of scheduling was "fatigue")
- **"Volume Overload" (aka "chart dump", "vomiting the chart")**
  - 63 year old male referred with long-standing diabetes and a 12# stack of records

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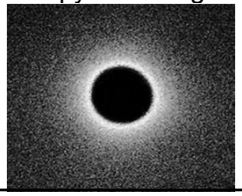
What is it like on the inside for the PCP ?

- **"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"***



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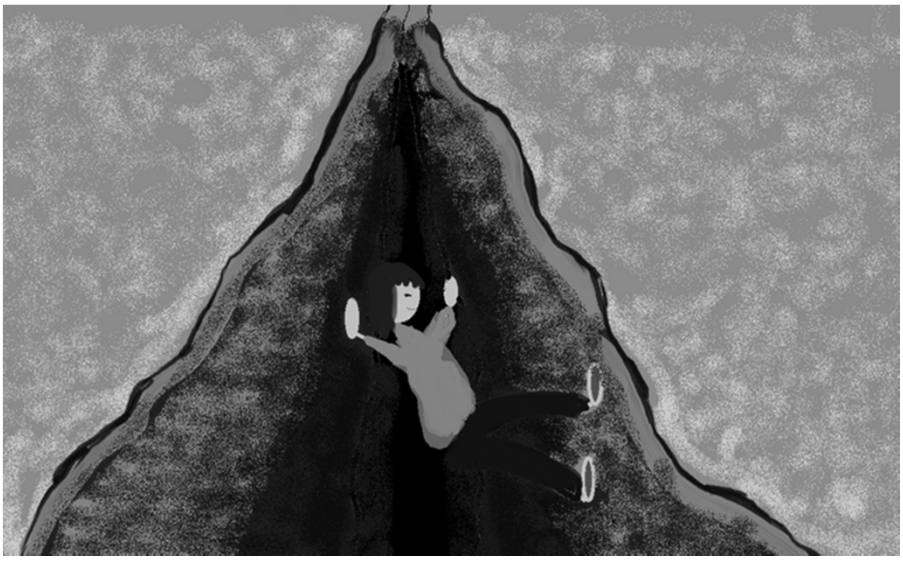
…and What is it like for the Patients ?



…and we all end up with

poor communication leads to poor care coordination

We need a way to work together

- We need better
  - **Hand-offs**
    - *Communication* (more than information exchange)
  - **Shared Care Plans (Patient-Centered Care)**
    - *Coordinated 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**

Care Coordination Agreement

- Platform that everyone agrees to work from (system)
  - ***Standardized*** Definitions/Formats/Expectations

Care Plan (Comprehensive)

- Coordinated Care (practice & patient)
  - ***Individualized*** Care

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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

* See provided model check list of suggested areas to address.

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.

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Prepared Patient

- Patient aware of and in agreement with referral with appropriate expectations
- Consideration of *what matters to the patient*
  - Reading material for patient prior to appointment *(homework)*
- Alert specialty practice of any special needs (impaired vision, hearing, cognition, care giver status, etc)
- Use of Referral Guidelines
  - Appropriate specialist at appropriate time
  - Appropriate testing or therapeutic trials prior to referral
- Adequate/ Pertinent data supplied ("handoff" takes place)
- Patient understand role of specialist and who to call for what

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agree to Referral *Request* Elements

- Type of service/co-management requested
- Clinical question or reason for referral
  - Ideally a summary or ***synopsis*** of events
- Core Data Set (reconciled med list, allergies, etc)
  - Care plan for the patient
- Data set for clinical question
- Urgent (recommend direct contact), sub-acute or routine
- Contact info for more information

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The referral process starts with YOU:

- What do you want from the referral?
  - Diagnostic assistance
    - Does this patient have diabetic neuropathy/nephropathy or something else ?
  - Advice on management
    - Recommendations sent back to you
  - Help Managing a challenging condition
    - Someone to check in with on an ongoing basis
  - A procedure done
    - Cardiac catheterization /CABG
  - The specialist to manage a certain aspect of care
    - Insulin pump therapy/complicated MDI
    - ESRD

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)

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Clinical Question/Reason for Referral

- "thyroid" " "abnormal thyroid" "thyroid issues
- *"26 year old female with severe thyrotoxicosis 5 months postpartum"*
- *"68 year old man new onset thyroid swelling and tenderness"*
- *"32 year old female with repeatedly normal thyroid levels is convinced her fatigue, weight gain and hair loss is due to thyroid and wants a trial on thyroid hormone. Would appreciate consultation to reassure patient that thyroid disorder not being missed."*

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Referral Request Elements

- Type of service/co-management requested
- Clinical question or reason for referral
  - Ideally a summary or ***synopsis*** of events
- Core Data Set (reconciled med list, allergies, surgeries, problem list)
- **Data set for clinical question**
  - **Pertinent** (*not data dump*); **Adequate** (*reduce duplication*)
  - Ideally, use ***referral guidelines*** for what to send
    - ACP workgroup on ***High Value Care Coordination***
      - ***Ability to Triage if correct specialty/urgency***
      - ***Ability to do something at the first specialty appointment***
- Urgent (recommend direct contact) or routine
- Contact info for more information

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ACP | High Value Care

Pertinent Data Sets

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	• 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	• 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	• 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	Healthcare Professional Information: Osteoporosis in Men Clinical Practice Guideline http://www.endocrine.org/~/media/endosociety/Files/Publications/Clinical%20Practice%20Guidelines/FINAL-Osteoporosis-in-Men-Guideline.pdf Patient Information: http://www.rheumatology.org/Practice/Clinical/Patients/Information_for_Patients/ 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/

I am referring this patient for:

- ___Pre-consultation/ pre-visit assistance/preparation
- ___Medical Consultation: Evaluate and advise with recommendations for management and send back to me
  - □ E-consult (non-face-to-face encounter/ provider to provider)
- ___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)

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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.

Pre-Consultation ("working the referral")

Intended to expedite/prioritize care

- ***Referral guidelines*** *(ties into Pertinent Data Sets)*
  - Recommendations for what preparation and/or "pertinent" data will best facilitate the referral evaluation and /or management (what to send with the referral) or help with *when* to refer
    - Example for prep: Chronic diarrhea referred for colonoscopy: be sure stool culture negative, negative celiac screen
    - Example for data: Short stature/growth delay: send growth chart
    - Example VA: "filters": back pain (criteria) ; hepatitis clinic (attend class before appointment-Patient Decision Aid)
  - Utilize providers at the top of their license ('neurosurgeons not seeing muscle strain')
- Urgent Cases
  - Expedite care
  - Improved hand-offs with less delay and improved safety
- Coordinated visits *("virtual Mayo clinic")*
  - Radiology/specialist/surgeon
  - Diabetes educator/endocrinologist

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.

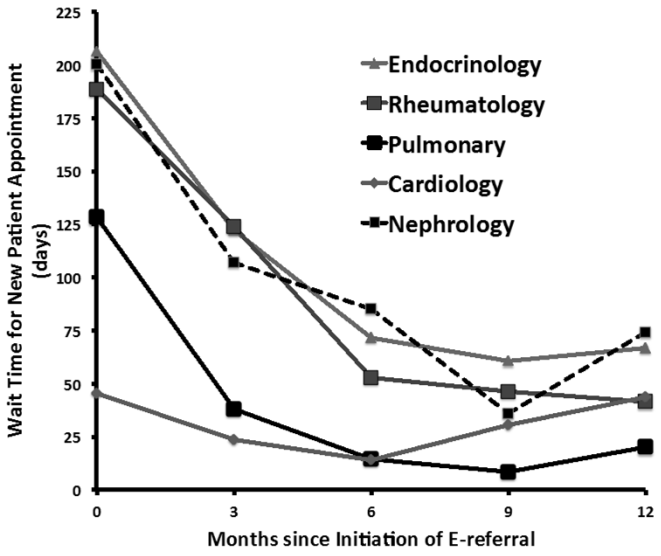
1) Please check an H pylori serum IgG. If the patient is positive, treat with triple therapy. If symptoms resolve, no further workup is needed.
2) If patient has been previously treated for H pylori, then obtain a stool antigen test for H pylori after at least 14 days off PPIs, and 8 weeks after completing 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.

courtesy of Justin Sewell SFG

Impact on Wait Times



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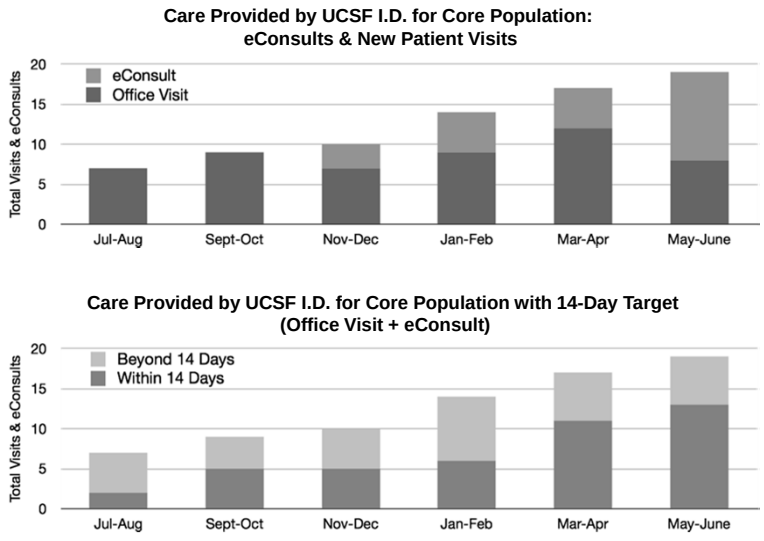
Non-Face-to-Face Consultation including e-Consultations

- 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
  - Compensated time and effort
  - Exchange records and responses
    - Documentation: "Based on the information I received, I recommend…"

Access to Care: Infectious Diseases



Agree to 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)

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Agree to 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 and/or copy PCP on all)
- Any recommended services or actions to be done by the PCMH
- F/u scheduled or recommended

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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**
  - **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"**

Mesa County Independent Physicians Association

40 Year History

- Risk contracting
- 300 Members
  - 40% Primary Care

CBC
Colorado Beacon Consortium

MCPIPA Medical Neighbor Agreement

Referral Request
Patient aware
Clinical Question asked
Appropriate records

Close the Loop
Confirmation of referral

Referral Response
Address Clinical Question

Referral Tracking

Radiology Clinical Question

PROVIDER REFERRAL REQUEST FORM

Referring To	Specialty:	Phone:	Fax:
	Practice Name & Address:		
	Please Schedule (select all that apply): ☐ Urgent– Referring physician called: _____ ☐ Routine Appointment with Specific Physician listed: _____ ☐ First Available with any Physician		
	Referring Provider's Name:	Phone:	Fax:
Type of Referral	☐ Evaluation consultation with treatment recommendations that primary care physician will continue to follow ☐ Evaluation consultation with assumed care for this condition ☐ Evaluation consultation with treatment recommendations and shared care	☐ Specialist to Specialist*–Secondary Referral *Send copy of this referral to patient's primary care physician. ☐ Other (designate)_____	
Patient Information	Patient Full Legal Name:		DOB:
	Preferred Phone:	Best time to call:	
	Special Patient Considerations:		
	Patient Insurance Information:		
	Patient's Primary Care Provider:	Phone:	Fax:
General Information	Reason for Referral (*Clinical Question*):		
	Comments/Considerations Related to Clinical Question: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.**		
	Patient aware of reason for referral? ☐ Yes ☐ No: Explain		

PROVIDER REFERRAL CONFIRMATION

Referral Confirmation	Referral Accepted? ☐ Yes ☐ No: Explain	
	Appointment Scheduled with:	Date & Time:
	☐ Patient refused scheduling ☐ Patient prefers to contact specialist to schedule at a later date	
	Request for additional supporting clinical information (please detail):	
	Person completing confirmation:	Date of Confirmation:

Inside the Practice

Supporting data

Requesting more data

Referral by fax

Cancellations

Received confirmation

Electronic referrals

No shows

Is there a clinical question?

The referral request sent

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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***

Patient Centered Care

- "…care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions." Institute of Medicine 2001

- "not superficial attention…to keep the patient happy, be nice to the patient, call him Mr. or Mrs., remember his name….but the idea that patients should be involved in their care….The role of the doctor is to be sure that the patient arrives at a decision that is reasonable for him or her, without being manipulative." Avedis Donabedian
- Not "Press Ganey"

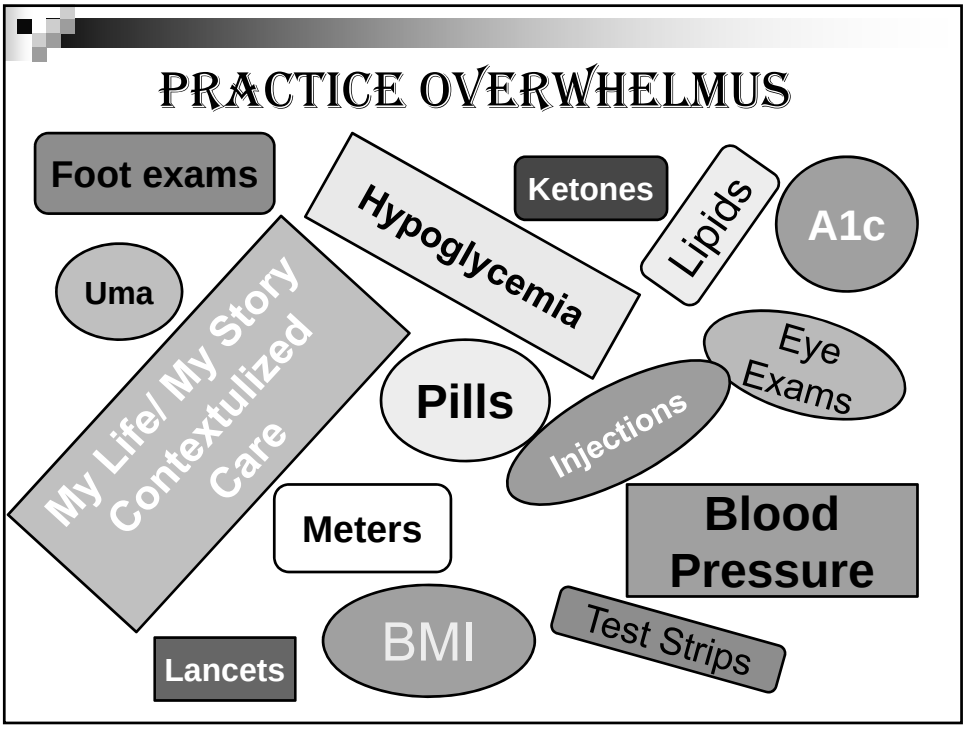
Contextualizing Care

Shared Decision Making

Patient-Centered Decision Making

'The process of adapting ***best evidence*** to the care of the ***individual patient***'

"taking into account needs and circumstances (context)"



You have Help: TEAM CARE

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

Team ≠ Collection of individuals

- Working together ≠ Functioning as a team
- "a team is a group with a specific task or tasks, the accomplishment of which requires the interdependent and collaborative efforts of its members"

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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

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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
  - Trained to practice at the top their license/highest function allowed
    - Help with patient intake, foot exams, smoking cessation
  - Organizational chart/ division of labor
  - Goal is to ***Take Care of the Patients*** (instead of the physician)
  - ***Team work*** instead of ***Task work***
- 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

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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, scheduling (urgent cases)
    - In AM before clinic or evening the day before: what is needed for the day
    - Often evolves into continuous communication
- 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

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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
- Using **standing orders** for services
  - Urgent diagnosis list/inappropriate diagnosis , process for self referred
  - Refills
  - Registry items
    - Order UMA
- 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
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- Involving care team staff in the practice's performance evaluation and quality improvement activities
  - Care of the patient is a team project
  - Ideas on how to make it better: PDSA cycle to test
    - Example: UMA data, referral response time
    - PIM (practice improvement module); where are your gaps?
- Holding regular practice team meetings

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The Practice Team

Requires:

- Culture change ("reprogramming")
- Structure and Process
  - Policy
  - Procedures
  - Practice
- Patience
- Leadership
  - Servant Leadership: Helping others do their job better

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Start with a Policy & Procedure

- **For Referrals In**
  - **Focus of Specialty Care**
- **For Referrals Out**
  - **Both Primary Care and Specialty Care**

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?

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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

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Policy and Procedures needed

- Positions (who prepares and sends the referral)
  - Who "prepares the patient"/ Who fills in special needs of patient ?
  - Who determines type of referral (consult, co-management)? Who determines Urgency ? How relayed and documented
  - Who writes the clinical question/synopsis or reason for referral ?
  - Who attaches the clinical summary /core data set
  - Who determines and attaches the data pertinent to the referral ?
  - Who tracks the referral ?
    - Referrals sent
    - Confirmation of appointment date
    - Receipt of referral response
  - Who is notified if referral declined or deferred?
  - Who is notified if patient No Shows or Cancels appt?

Policy and Procedures needed

- Work Flow
  - How is referral process initiated once decided upon ?
  - How is data gathered and sent ?
    - How ensure all data included ?
  - How is referral tracking logged and monitored?
    - What system used ?
    - What information included?
    - How triggered?
  - How are recommendations from specialist incorporated into the care plan ?
    - Was the clinical question answered or reason for referral addressed ?
    - Was the type of interaction agreed upon ?
    - Are there recommended actions for the referring physician to do ?
    - What follow up is recommended if Comanagement ?

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

Consider starting with Radiology

- Clinical Question on radiology referral/order
  - Determines **what** and **how** imaging done (technical)
    - "A CT scan is not a CT scan, an MRI is not an MRI"
  - Helps referring clinician get the information they need (interpretation)
  - ***HUGE*** cost impact
    - 76% of radiology orders result in call back to ordering practice
    - Wrong technique:
      - Repeat studies
      - Delay in treatment
      - Radiation exposure

A better way…

Team Care

Integration

Co-ordination

Medical Neighbor Model

Chaos → Organization

- Referral Black Hole
  - Patient referred
    - ?????
- Assumptions
- Disconnected care
- Working in Isolation
  - Physician focused
- Confused patients

- Care Coordination Agreements
- Patient-Centered
- Team Care/Communication
- Improved Access
- Individualized

Well-tuned team machine

It is Scientific……..

- Relationships are important in life and they are important in medicine
  - "Hello" is a quality and a safety "enhancer"
- Cooperation builds defense against distress
- When People Cooperate as a Team, They are More Effective at What They Do
- Being part of BIGGER whole reduces stress/enhances life

Instead of being cut off in Silos ("my practice")

How can we work together: "My System", "My Community" mindset

Thank You

Questions?

- **M. Carol Greenlee, MD FACP**
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  Chair High Value Care Coordination workgroup
  Vice Chair Council of Subspecialty Societies, ACP
  Chair Clinical Integration Committee, Mesa County Physicians IPA
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ACP | High Value Care

Pertinent Data Sets

Anaphylaxis (including idiopathic anaphylaxis, possible reaction to drug, insect sting, food, exercise, etc.)

Developed by	The American Academy of Allergy, Asthma & Immunology (AAAAI) and the American College of Allergy, Asthma and Immunology (ACAAI)
How developed	Prepared by task force of the AAAAI and the ACAAI with approval by both organizations
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: Lieberman et al. The Diagnosis and Management of Anaphylaxis Practice Parameter: 2010 Update. J Allergy Clin Immunol. 2010; 126: 477-80 Update on influenza vaccination of egg allergic patients: Ann Allergy Asthma Immunol 2013; 111: 301-302 Healthcare Professional and Patient Information: http://www.aaaai.org http://www.acaai.org

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Pertinent Data Sets

Hypothyroidism

Developed by	The Endocrine Society (ES)
How developed	The Endocrine Society utilized a task force made up of 5 members with special interest in the area of care coordination and referral process. The task force proposed the conditions for which pertinent data sets would be developed. These were then approved by the Clinical Affairs Core Committee (CACC) with oversight by a member of our Council (Board of Directors). The task force members were each assigned one or more of the conditions and developed the items for the PDS. The task force members reviewed these by email and by conference call, discussed as a group and modified them as needed. They were then submitted to the CACC for review and comment. Changes were made and then resubmitted for approval with a simple majority vote of the CACC constituting approval. As part of the process, the task force referred to the published guidelines on the selected conditions as well as any pertinent Choosing Wisely recommendations.
Additional essential patient information	• TSH • Free t4
Additional patient information, if available	• Thyroid imaging studies • Antibody testing • Chemistry Panel • CBC
Alarm symptoms/conditions	Severe hypothyroidism or difficulty titrating medications with any of the following conditions: • Decompensated congestive heart failure • Pregnancy • Active coronary artery disease • Bradycardia
Tests/procedures to avoid prior to consult	None provided
Common rule-outs to consider prior to consults	None provided
Relevant "Choosing Wisely" elements	Do not order a total or free T3 level when assessing levothyroxine (T4) dose in hypothyroid patients.
Healthcare professional and/or patient resources	Healthcare Professional Information: https://www.aace.com/files/final-file-hypo-guidelines.pdf Patient Information: http://www.hormone.org/questions-and-answers/2010/hypothyroidism http://www.hormone.org/hormones-and-health/myth-vs-fact/wilsons-temperature-syndrome

htpp://hvc.acponline.org/physres_care_coordination.html

Care Coordination Agreements (Compacts)

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