
Expanding the team to the health care community

One practice's experience

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Objectives

- Develop a strategy for coordinating care effectively for patients' across hospital stays and through specialty care experiences in areas without shared electronic records
 - Recognize the role and create systems to incorporate the office team into these care coordination efforts
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Background Information

- Holly Cleney, MD
- Latham Medical Group managing partner
 - 11 Provider all FP Private practice
 - Part of Community Care Physicians
 - A 200 MD + multispecialty group including radiology, PT, urgent care and some specialists all on one EMR but no one hospital affiliation



Medical Home Experience

- CDPHP PCMH Pilot Project
 - 1 of 3 primary care practices selected for phase 1
 - Pilot program timeline – just finished 2 years now entering 1 year extension
 - Goals of program
 - Assess a severity risk adjusted capitation model
 - Expand in community to other practices
 - (20+ more in phase 2 this year)
 - Funded by private physician owned/run HMO
 - (Capitol District Physicians Health Plan = CDPHP)



Patient-centered Care Model



Care Coordination – Up close

Care Coordination

- Community-based resources
- Collaborative relationships
 - Emergency Room
 - Hospital care
 - Behavioral health care
 - Maternity care
 - Specialist care
 - Pharmacy
 - Physical Therapy
 - Case Management
- Care Transition

Items to Consider

- Process Mapping
 - Take a clinical perspective on the patient's experience
 - Referral patterns
 - Understand where your patients are going and what their experience has been
 - Patient education
 - Take time to inform the patient on care coordination
 - Get them involved on the importance of communicating with you on their experience and coach them on communicating with specialists to optimize their care
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Items to Consider (continued)

- Staff education
 - Set the tone on the importance of staff involvement with care coordination (everyone is a link to effective care)
 - Care Coordinator
 - Point person for assembling data and experiences
 - Team approach
 - Define roles of each of your team's members
 - Communication
 - Establish formal communication structure to celebrate successes and identify areas for improvement
 - Follow up
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The Scope of Care Coordination

Focus initial attention on the low hanging fruit...small successes

- Hospital care
 - Communicate your expectation regarding how you want to be communicated with, should you not be admitting.
 - Speak with Administration, Nursing Department and/or Discharge Planners to get them engaged in your practice's transformation
- Specialists
 - Let the specialist know the importance of collaboration and communication with you, on your patients care
 - Be clear how a lack of collaboration may negatively impact future referral patterns
- Urgent Care and Emergency Departments
 - Reach out to urgent care that your patients frequent. Hold them to the same level of collaboration and communication as the specialists as well as to the cost effective and evidence based care standards we should strive for


This is a relationship business, centered on patient care and their needs

Wish List in Care Coordination

- Patient Centered
 - Communication
 - Ideally via a patient portal; settle for fax, phone call
 - Timeliness
 - Of info to be received...set up expectation time ranges (i.e. 48 hours)
 - Accountability
 - Hold each player accountable for the patient's experience
 - Cost Effective Care
 - Stress to those your patients see to respect care (i.e. ancillary testing) previous done and not cost the system more money in considering clinical efficacy
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Other elements or care coordination

Internal processes

- Prepare for today's visit
 - Review of patients last visit and test results
 - Identify opportunities or breakdowns in the system regarding clinical information
 - After the visit, provide the patient with a summary of care provided and follow up care needed
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Specialist meetings...

- 2 practices working in the pilot project met several times to plan initial strategy
- Considered
 - Who we utilized most
 - Who are our biggest ‘problem practices/providers’
 - Who might respond most favorably/least favorably
 - Who we knew personally
 - What are we asking of them



Tool: Preparation Questions to ask yourselves...

For PCP - consulting physician relations?

- What is a reasonable expectation for urgent AND non-urgent access to consult/referral physician appointment?
- What is a reasonable timeframe for the (PCP) to expect follow-up documentation after a consult appointment?
- What is a reasonable timeframe to provide information to the consulting physician prior to an appointment?
- What info is important to send prior to a consult appointment?
- What info is important to receive from the consult appointment?
- How can this sharing of info and timeframes be accomplished?

Tool: discussion points

- **Benefits to the specialist for working with you...**
 - Improved patient care and patient satisfaction
 - Offer to coordinate refills
 - (recommend the pcp handles in PCMH)
 - **Better established referral patterns/communication**

Source: TranforMED Website

Specialist meetings

Who attended

- Care coordinator/Office manager
 - To establish the follow up mechanisms and tweak processes established at the first meetings
- Physician lead (s)
 - To lead the discussions



Specialists meetings...

- We discussed
 - Each other's roles in communication
 - What info does specialist want PCP to send
 - What and when we want re communication back
 - Avenues for efficient emergency contacts
 - Inside lines were forthcoming for ease of communication
 - Cost effective care
 - 'consult and return to primary care' vs a 'consult and assume treatment'



Specialist meetings

- Collaboration with other practice
- Every other month meetings
- Divide & Conquer, re-establish priorities
- Formulate follow up plans/mechanisms



Turf Wars: Psychiatrists vs PCPs
MEDSCAPE SPECIAL REPORT

9/10/2010

- **Turf Wars: Psychiatrists vs PCPs**

Medscape Psychiatry & Mental Health > Finding on Psychiatry

Antipsychotics in Young Patients: Who Should Prescribe?

Medscape Psychiatry & Mental Health

Should Psychologists Prescribe?

Medscape Psychiatry & Mental Health

Smile as You Steal my Patient: Primary Care vs Specialists

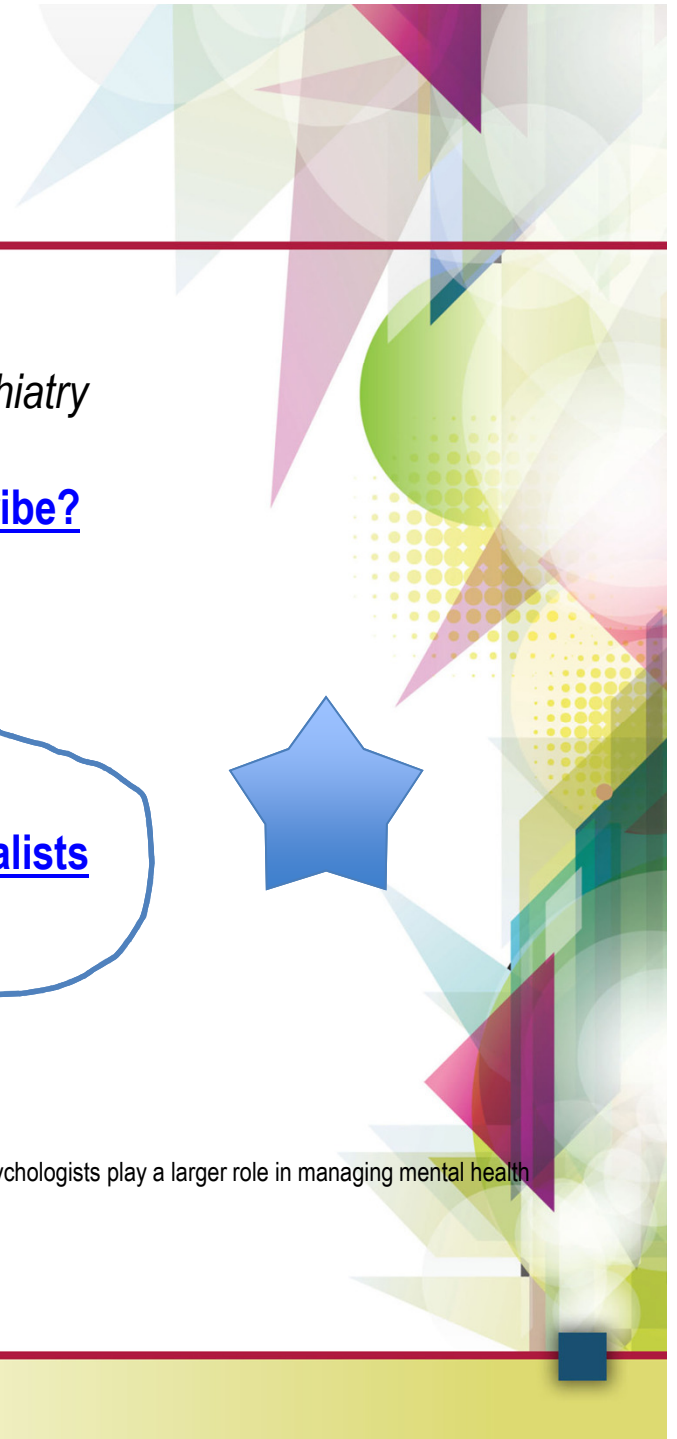
Medscape Business of Medicine

Should PCPs Prescribe Antipsychotics?*

Medscape Business of Medicine > Stats

- INTRODUCTION

- Delegation of psychiatric care and prescribing is increasingly common, as primary care providers and psychologists play a larger role in managing mental health symptoms and disease. Is this a problem or a sigh of relief?



Hospital Coordination

- Initial planning stage considerations
 - Defined our patients' most utilized hospitals in the area
 - What info we desired from hospital and how to most efficiently get it...
 - **ANYTHING** as long as it's immediate
 - Contact person established to reach out to hospitals
 - Rose our care coordinator
 - What we will do with the info once we get it that's more efficient and effective than what we currently do...
 - Who on the team takes what role in that process

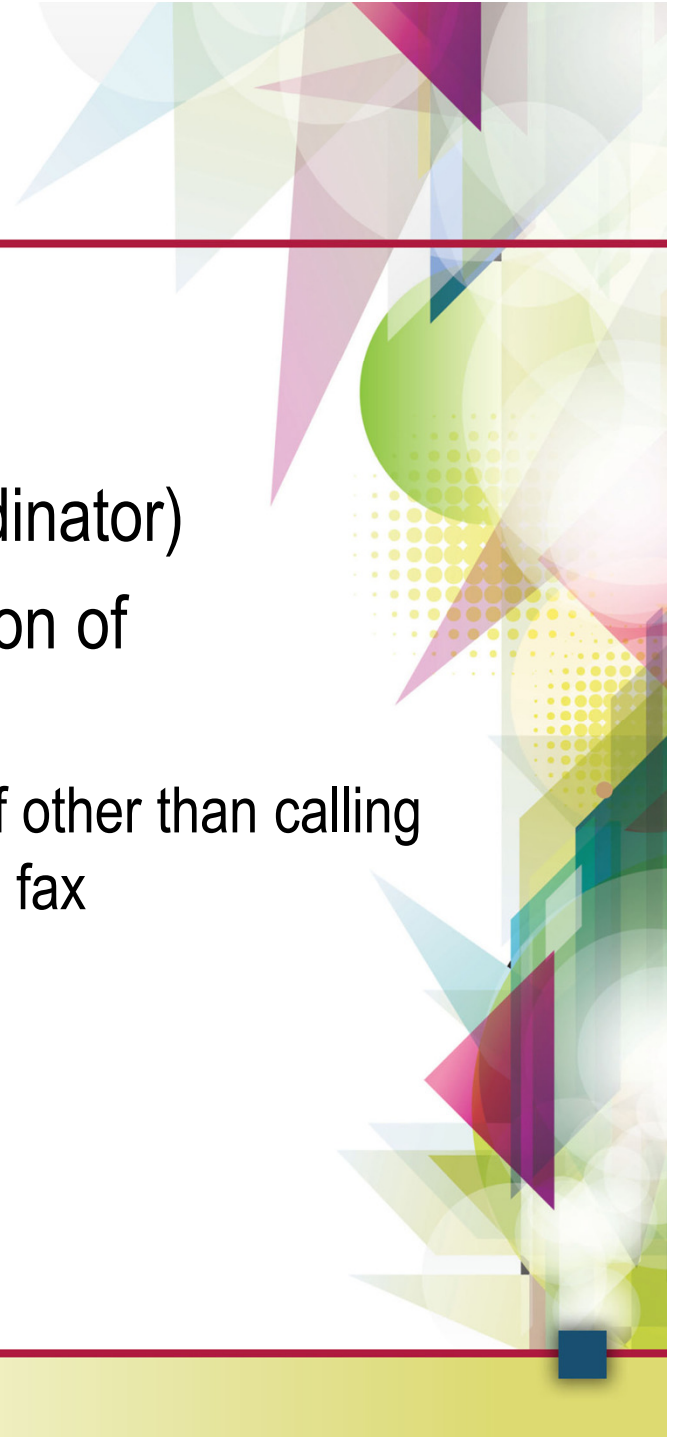
Coordinated Care questions for PCP- hospitalists/ER physicians/UC provider relations?

- What is a reasonable timeframe for notification of PCP regarding an ER visit, hospital admission or UC visit?
- What information would be beneficial for PCP to provide if aware of an ER visit for Hospital admission?
- What information is beneficial to receive following an ER visit or Hospital Admission?
- What is a reasonable timeframe for notification to PCP regarding a hospital discharge?
- What information is beneficial to receive following a hospital discharge?

How can the above sharing of information and timeframes be accomplished?

Hospital Coordination

- Facility
 - Who met with Rose (our Care Coordinator)
 - Mechanism established for notification of admission/discharge
 - And for how we are to obtain records if other than calling medical records dept and requesting a fax



Hospital Coordination

Albany Medical Center

- Assistant Director of case Management & Social work
- automated faxing of a face sheet triggered by registration of patient at admission
- Several docs and higher level managers from Community Care also met w/ higher level managers from Albany Med to iron out wishes for other means of communication...
 - Also automating a face sheet on discharge
 - Possible read only access to their EMR system also

Hospital Coordination

- St. Peter's Hospital
 - The practice manager of the residency program that admits for us and the senior resident
 - FP residents that admit our patients directly message in our EMR the PCP d/c info on day of discharge
- Seton Health (smaller community hospitals)
 - Assistant VP Business Development, Medical Director of Hospitalist Group
 - Hospital may call or pt may call for appointment

Hospital Coordination

- Northeast Health (2 larger community hospitals)
 - Clinical Resource Manager, Clinical Care Coordinator, Discharge Planner
 - Hospitalist calls our stat dictation line w/ brief summary
 - Also hospital is calling for patient's follow up appointment
 - We have 24/7 access to all electronic health information

Hospital Coordination

- “Coach Program” for Transitional Care
 - Grant funded attempt at reduction in readmissions 30% in 1 yr
 - All CDPHP patients and CHF patients regardless of payer currently, adding other disease management programs later (COPD, ESRD, Diabetes)
 - Hospital staff makes patients follow up appointments
 - Hospital staff does in home visits until transition to outpatient deemed well established focusing on
 - Medication reconciliation
 - Red Flag identification
 - PCP and Specialist follow up
 - Personal Health record and patient medication list

Hospital Coordination

- Ellis System (several smaller community hospitals)
 - Hospital Medical Affairs Director, medical Director of Informatics, Hospital Director of Inpatient Services
 - Hospital calls or patient calls for appointment
 - Currently working to gain access directly to their ‘Sorian’ technology so we’ll have 24/7 access to all electronic hospital records
- Saratoga Hospital
 - Director of Discharge Planning
 - Hospital or patient calls for follow up appointment

Hospital Coordination

- Veterans Administration Hospital
 - Signed “release of medical records” needed for EACH admission required and clearly impeding timely exchange of info as patient may be in office for follow up by the time we can obtain this...Care coordinator working with them on what can be done to streamline this...

Hospital Coordination

- Embedded Case manager from CDPHP (health plan) in our office 2 days /week
 - sends us a weekly listing of admits/discharges via fax
 - We send her results from our admission tracking tool with diagnoses for her to cross-reference

Hospital Coordination

- CDPHP's pilot program also adopted in past year
 - CHF, COPD and CAD patients identified by CDPHP while inpatient and a nurse sees them in the hospital and again 24-48h after discharge
 - Shares this info w/ PCP
 - Successful follow up visit if warrants significant time and documentation supports it plan advises can bill a 99215
 - Nurse places follow up call 7-10d after visit to ensure all needs were met
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Hospital Coordination

In office procedure for Hospital Follow-up

- Act immediately on any info regarding an admission/discharge in a coordinated manner with well defined roles of each member of the in office team

- Currently done for both ER visits and Hospital Admissions

Hospital Discharge follow up process

- Anything paper received indicating admission/ER visit or discharge received in the office
 - Immediately to Med Records and nurse coordinators
 - (2 designated floor nurses who took on this responsibility on a volunteer basis- hospitals divided)
 - More records obtained by MR to nurse
 - Nurse contacts pt immediately (when discharged) to
 - Ensure appropriate time frame appt made
 - Review med list and questions regarding
 - Assess pt status
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Hospital Discharge follow up process

- If first indication of admission/discharge is the patient calling for follow up appointment
 - Post-ER/hospital template completed by receptionist indicating Facility name, pt name dob, date of discharge and appointment date made w/ pt on that call
 - Message sent high priority to nurse coordinator and Med records so records can be obtained and pt called as previously noted ASAP

Hospital Discharge follow up process

- Note in EMR re this contact and records to pcp to review, scan and message back to MR if any other information is needed for visit (i.e. cultures still pending etc)
 - Hospital follow up visits scheduled w/ pt's actual PCP whenever possible for continuity as part of the written protocol
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Hospital Discharge follow up Process

- Tracking tool
 - Excel spreadsheet all in office have access to
 - managed by Care Coordinator and nursing coordinators
 - Fields for:
 - Name **DOB** Facility **Dates of Service** Type of Admit **PCP** Discharge Destination **Discharge Diagnosis** Follow up call Date **Follow up appt scheduled (comments)** Was patient sent to ER by LMG? (Date and Initial reason) **Date fax/mail notification received** Med records requested date **Med records received date** Comments **Insurance Coverage** Where is paperwork currently?

Hospital Discharge follow up

Tracking tool can report on...

- Frequent fliers in ER that case management may be indicated for
 - Re-admissions to dissect our process and whether we could have prevented it
 - Better stats on hospital utilization
 - Who's communicating in a timely manner
 - Who's going to the ER without our advice
 - Common diagnoses being admitted....
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Hospital Coordination

Benefits

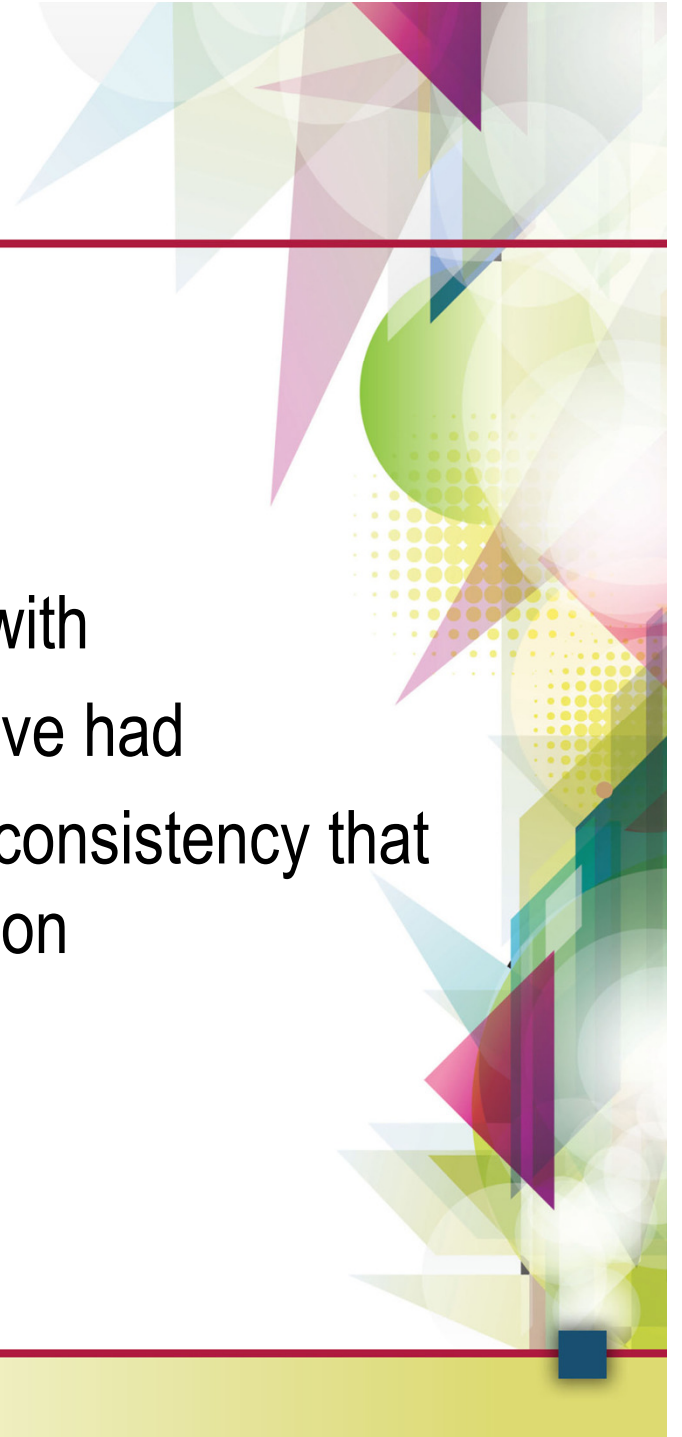
*patients feel we've been actively involved in the transition from inpatient to outpatient especially since we don't admit any longer

*provider and patient better prepared for the post-hospital visit making it more productive

***We hope....**reduced re-admission rates**

Care Coordination

- Yet to accomplish...
 - Meetings with Urgent care and ER's
 - Many specialist groups yet to meet with
 - Follow up on the initial meetings we've had
 - Continue improving time frame and consistency that hospitals notify us of patient admission



Where Do We Go From Here?

- Continue the improvement and integration process with other elements of the patient centered medical care model
- Identify new sources of funding to continue the PCMC effort
- Implement and expand
 - Patient portal – secure communication
 - Virtual visits

Questions ?

Thank You

