The Patient-centered Medical Home: Care Coordination

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The pitfalls of fragmented care

1. You don’t know the people to whom you are referring patients.
2. Specialists complain about the information you send with a referral.
3. You don’t hear back from a specialist after a consultation.
4. Your patient complains that the specialist didn’t seem to know why s/he was there.
5. A referral doesn’t answer your question.
6. Your patient doesn’t come back to see you after a consultation.
7. A specialist duplicates tests you have already performed.
8. You are unaware that your patient was seen in the ER.
9. You were unaware that your patient was hospitalized.

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The good old days

PCPs and specialists talking over patients in the hospital cafeteria.

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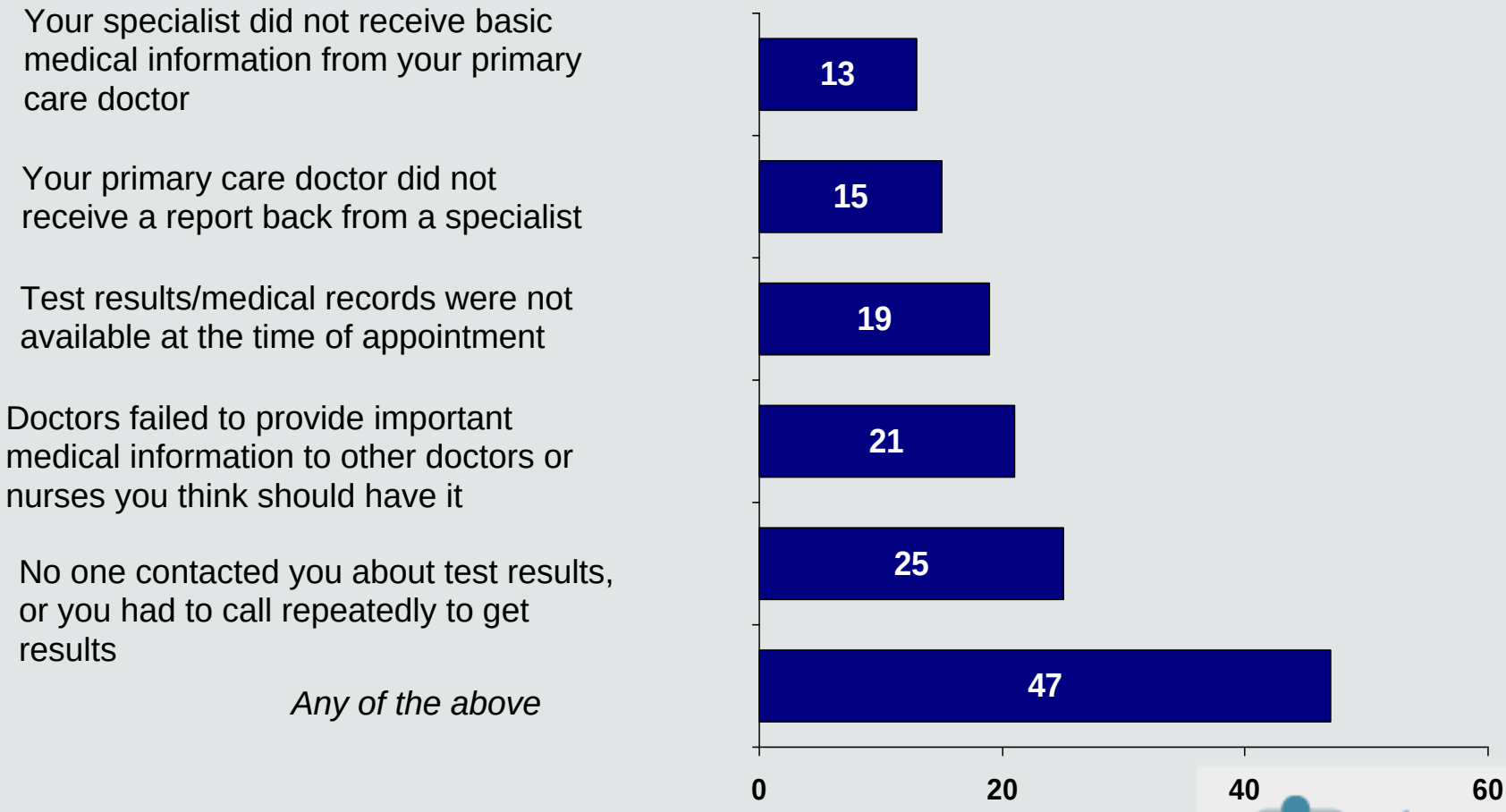
Poor Coordination: Nearly Half of Consumers Report Failures to Coordinate Care

Percent U.S. adults reported in past two years:



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Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Doctors' Reports of Care Coordination Problems

Percent saying their patients "often/sometimes" experienced:	AUS	CAN	GER	NETH	NZ	UK	US
Records or clinical information not available at time of appointment	28	42	11	16	28	36	40
Tests/procedures repeated because findings unavailable	10	20	5	7	14	27	16
Problems because care was not well coordinated across sites/providers	39	46	22	47	49	65	37

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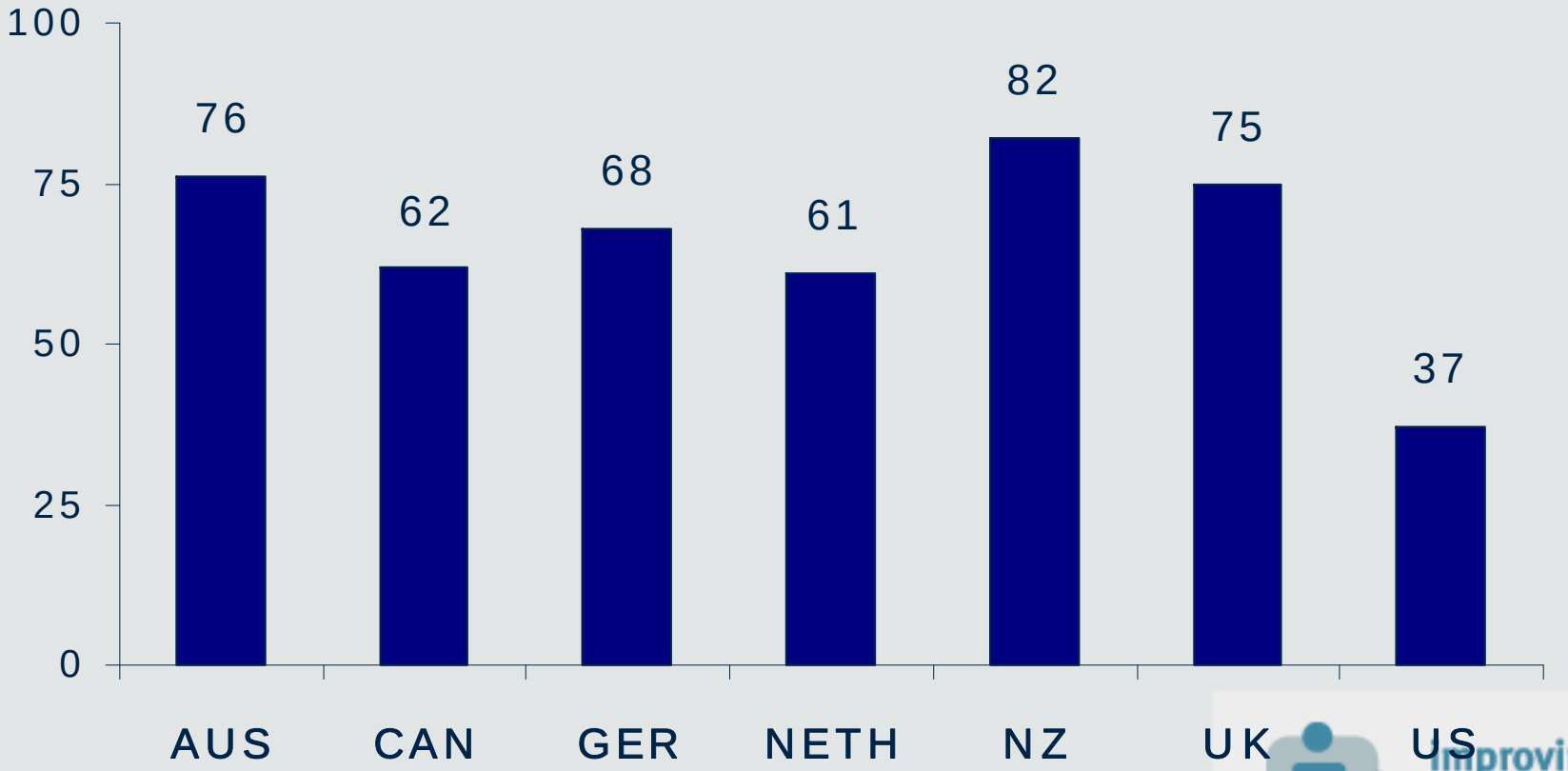
Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Commonwealth Survey of Primary Care MDs:

Percent reporting that they receive information back for “almost all” referrals (80% or more) to Other Doctors/Specialists



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Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Fragmentation of Care

- Provider referral networks have become depersonalized.
- Critical information for referrals and transitions are often lacking or missing, which distresses patients and unhelpful (or worse) for providers.
- Care coordination is “the deliberate integration of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”
- Care coordination refers to activities and interventions that attempt to reduce fragmentation and improve the quality of referrals and transitions.

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What constitutes a high quality referral or transition?

Safe	Planned and managed to prevent harm to patients from medical or administrative errors.
Effective	Based on scientific knowledge, and executed well to maximize their benefit.
Timely	Patients receive needed transitions and consultative services without unnecessary delays.
Patient-centered	Responsive to patient and family needs and preferences.
Efficient	Limited to necessary referrals, and avoids duplication of services.
Equitable	The availability and quality of transitions and referrals should not vary by the personal characteristics of patients.

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Care Coordination in PCMH Practices

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
- Proactively track and support patients as they go to and from specialty care, the hospital, and the emergency department.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Test results and care plans are communicated to patients/families.
- Provide care management services for high risk patients.

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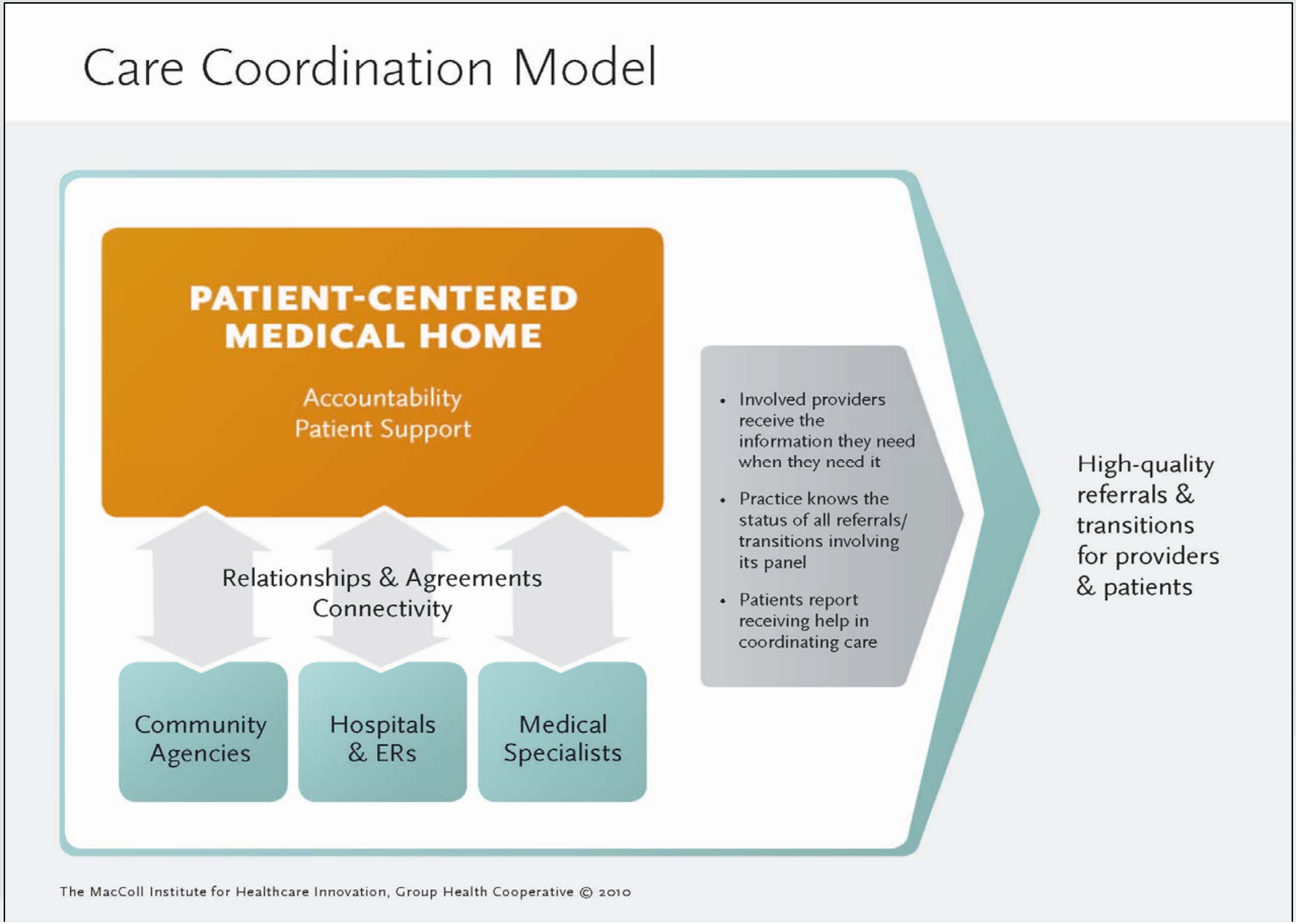
Coordinating Care in the PCMH



Key Changes

1. Assume **accountability**
2. Provide **patient support**
3. Build **relationships and agreements**
4. Develop **connectivity**

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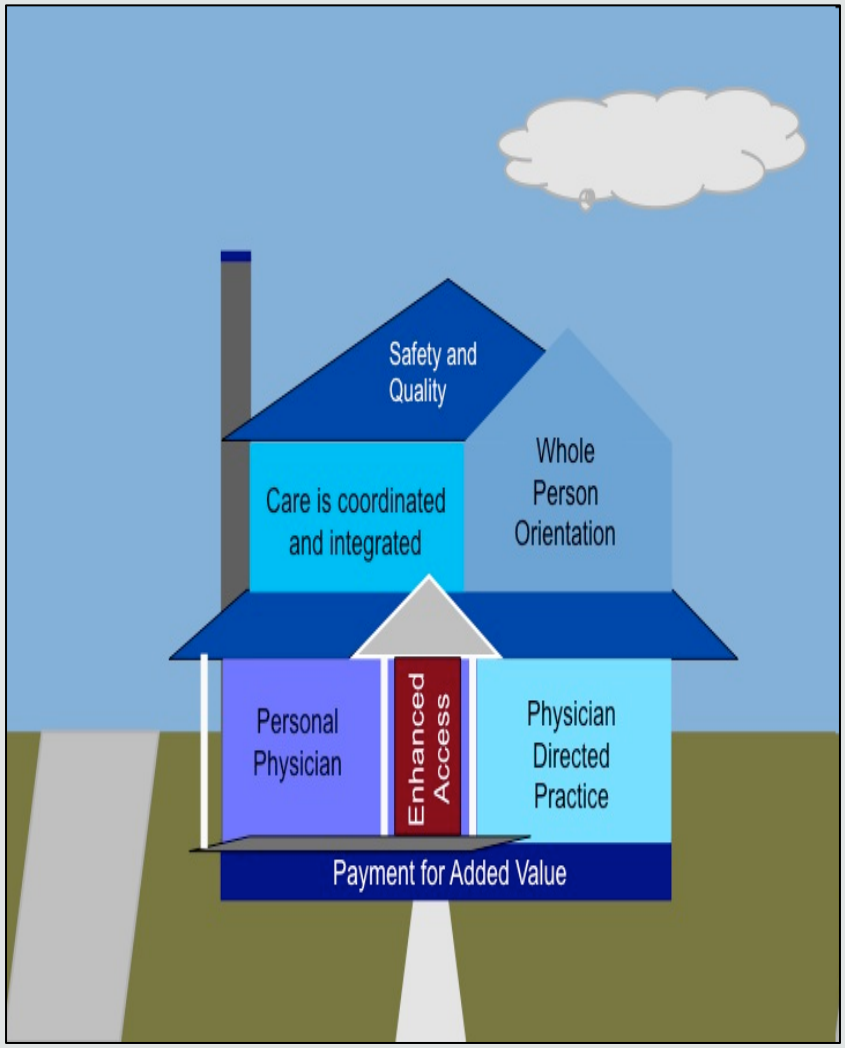
#1 Assume **Accountability**



- Why must the medical home assume primary responsibility for coordinating care when accountability is obviously shared?
  - Because specialists, ERs, and hospitals aren't.

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What's involved in assuming accountability?

- Initiating conversations with key consultants, ERs, hospitals, and community service agencies.
- Setting up an infrastructure to track and support patients going outside the PCMH for care.

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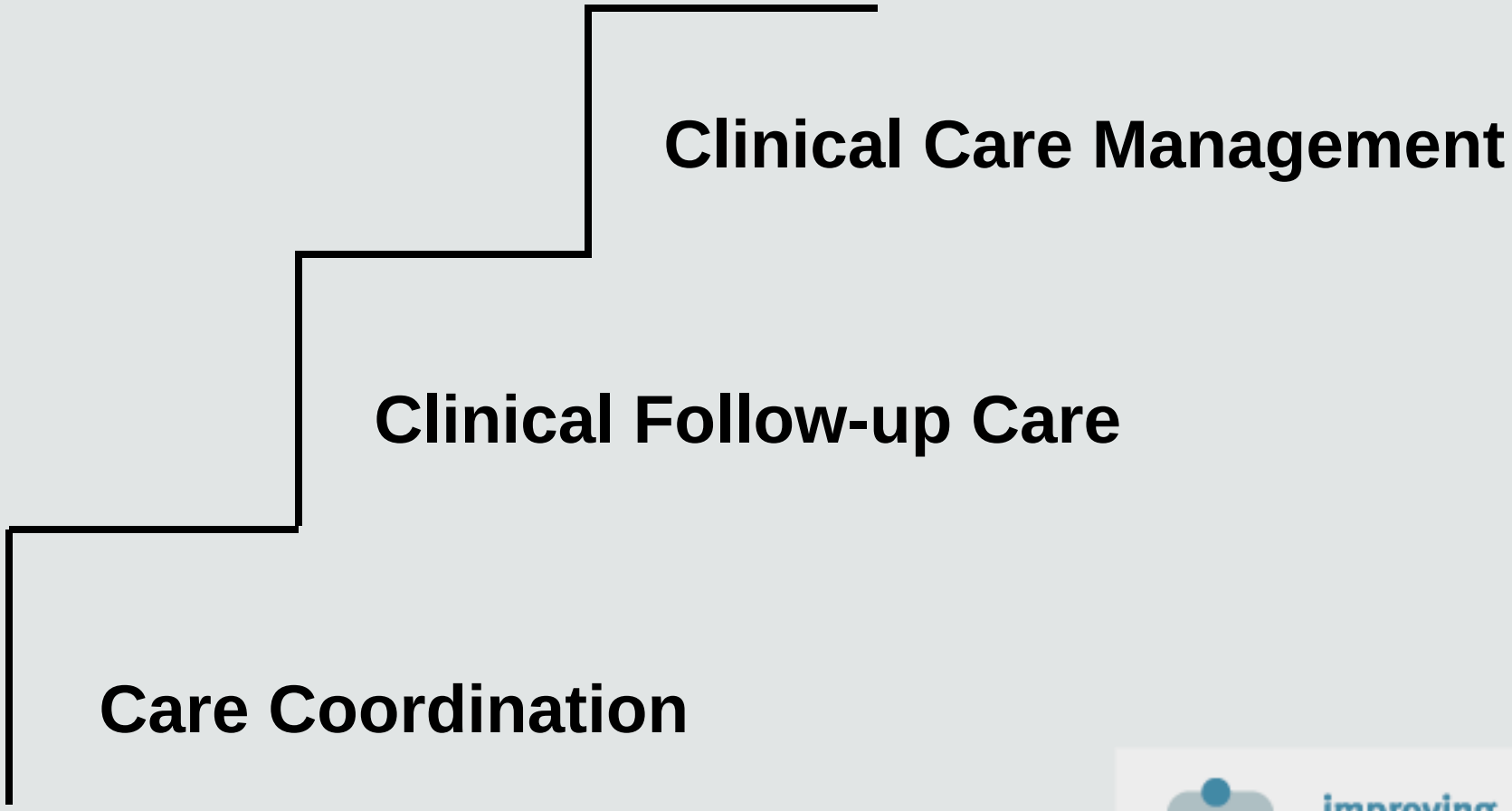
#2 Provide Patient Support:

Three levels of support



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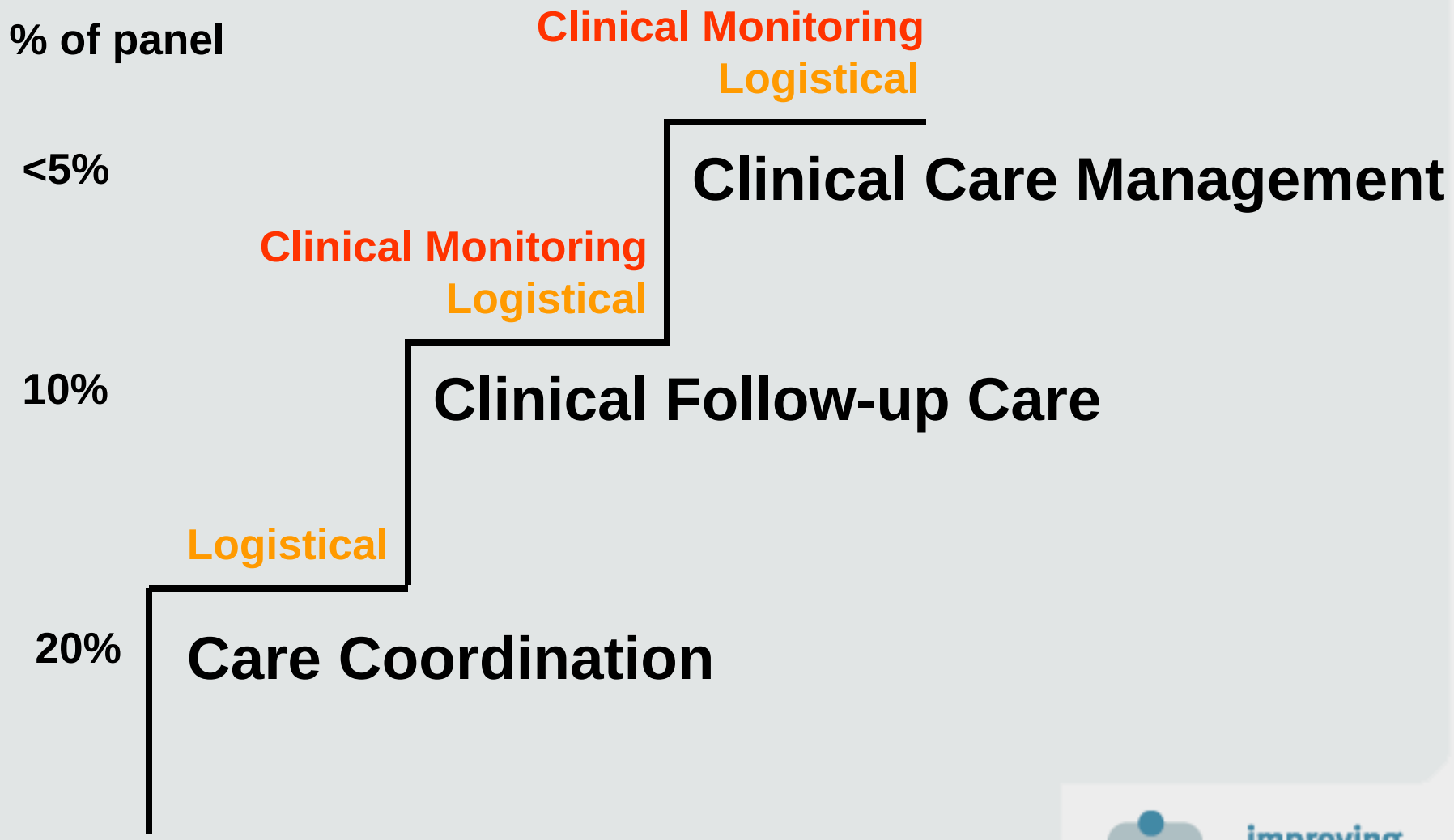
Self-management Support & Medication Management



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What's involved in providing logistical support?

- Helping patients identify sources of service—especially community resources
- Helping make appointments
- Tracking referrals and helping to resolve problems
- Assuring transfer of information (both ways)
- Monitoring hospital and ER utilization reports
- Managing e-referral system

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#3 Build Relationships and Agreements

- Primary care leaders initiate conversations with key specialists and hospitals around mutual expectations.
- Specialists have legitimate concerns about inappropriate or unclear reasons for referral, inadequate prior testing etc.
- Agreements are sometimes put in writing or incorporated into e-referral systems.

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Topics for Discussion

With specialists

- Guidelines for referral, prior tests and information.
- Expectations about future care and specialist-to-specialist referral.
- Expectations for information back to PCMH.

With ERs/Hospitals

- Notification of visit/admission and discharge.
- Involvement of PCMH in post-discharge care.

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#4 Develop Connectivity

- Most of the complaints from both PCPs and specialists focus on communication problems—too little or no information, etc.
- Evidence indicates that standardized formats increase provider satisfaction.
- Three options for more effective flow of standardized information—shared EMR, e-referral, structured referral forms.

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Electronic Referral

- Web-based, and may or may not be connected to EMR.
- Effectiveness depends on consultants or hospitals participating.
- Can embed referral guidelines and other elements of agreements.
- Can monitor completion of referrals and return of information to the PCMH.
- Users of e-referral systems often gravitate to experimenting with e-consultations.

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Transitions

- Medicare has found that nearly one-half of Medicare recipients re-admitted after a hospital discharge within 30 days never saw an MD.
- Many hospitals have instituted some form of transition management with care managers following high risk patients post-discharge.
- Transition care needs to be integrated with the PCMH.
- Checking with patients shortly after discharge from ER or hospital critical.

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Why make care coordination a priority?

- Patients and families hate it that we can’t make this work.
- Poor hand-offs lead to delays or other problems in care that may be dangerous to health.
- There is enormous waste associated with unnecessary referrals, duplicate testing, unwanted and unnecessary specialist to specialist referral.
- Primary care practice will be more rewarding.

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www.improvingchroniccare.org

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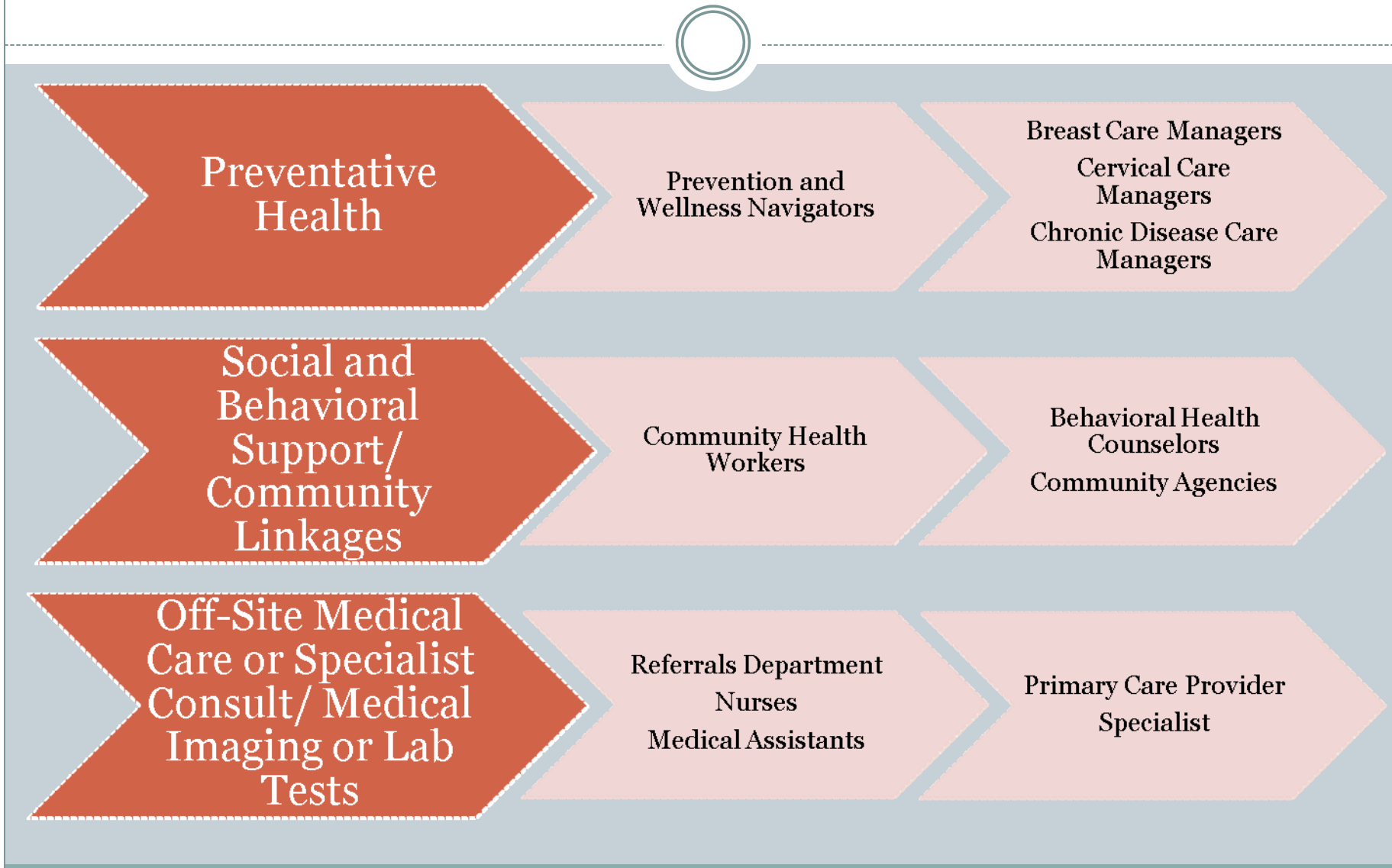
Care Coordination at the Joseph M. Smith Community Health Center

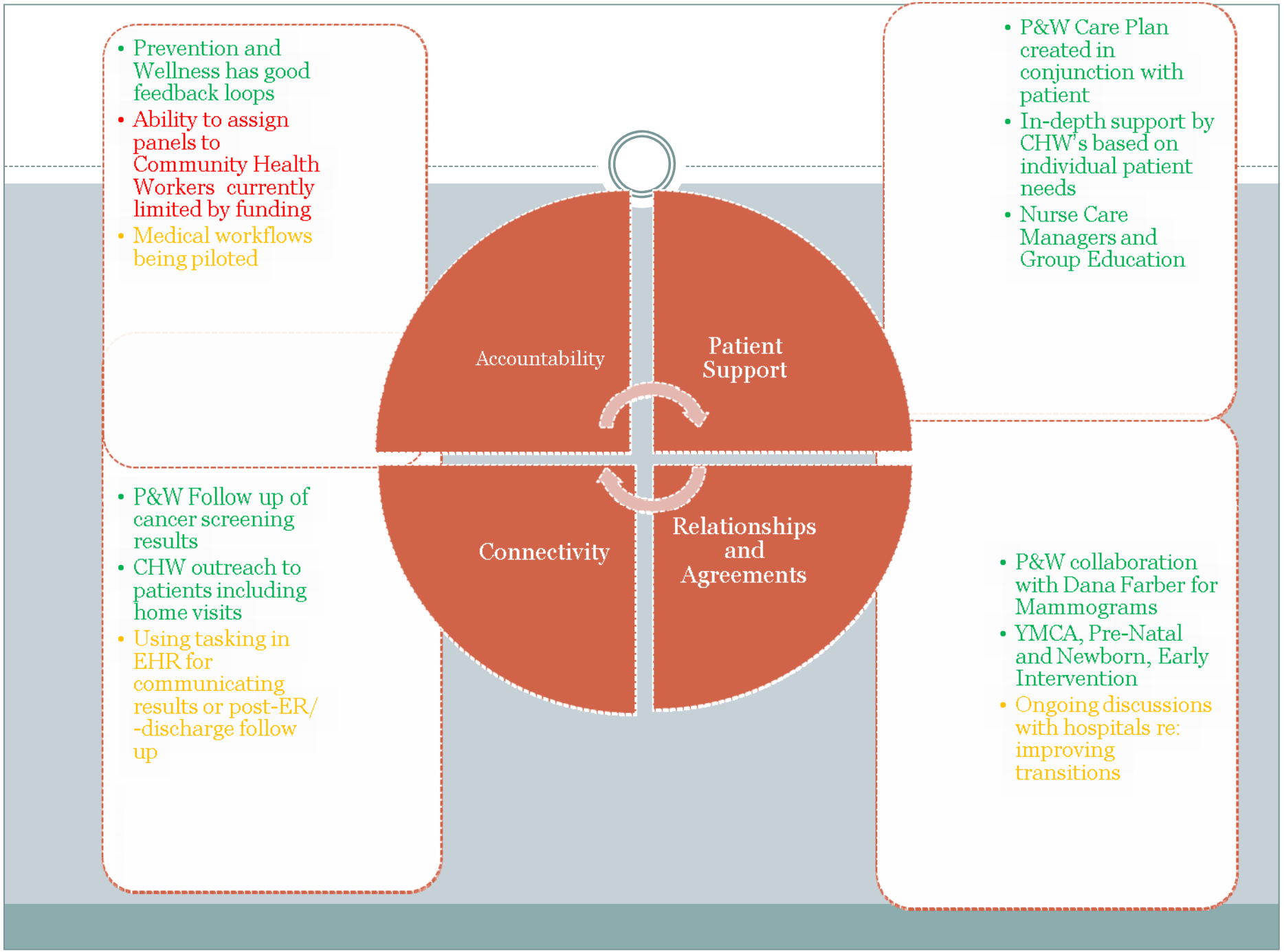
OLGA MCLELLAN RN, BSN, CDE

Joseph M. Smith Community Health Center

- 2 sites: Allston and Waltham, Massachusetts
- 12 Providers (MD/NP's), 25 Clinical Support Staff
- Served 12,309 patients through 63,164 visits in 2009
- 62% of our patients at or below Federal Poverty Level
- 45% of our patients are uninsured
- 47% of our patients need services provided in a language other than English
- Only 11% of our patients carry private insurance

Care Coordination at JMSCHC




• Prevention and Wellness has good feedback loops
• Ability to assign panels to Community Health Workers currently limited by funding
• Medical workflows being piloted
• P&W Care Plan created in conjunction with patient
• In-depth support by CHW's based on individual patient needs
• Nurse Care Managers and Group Education
Accountability
Patient Support
Connectivity
Relationships and Agreements
• P&W Follow up of cancer screening results
• CHW outreach to patients including home visits
• Using tasking in EHR for communicating results or post-ER/ -discharge follow up
• P&W collaboration with Dana Farber for Mammograms
• YMCA, Pre-Natal and Newborn, Early Intervention
• Ongoing discussions with hospitals re: improving transitions

Next Steps

- **Accountability:** Use data for proactive RN care management of high risk patients. Maximize use of non-RN staff to help with outreach
- **Patient Support:** Optimize nursing staff for group education classes and patient education visits
- **Relationships and Agreements:** Continue dialogue with area Hospitals to improve information sharing and transition management
- **Connectivity:** Pilot standing orders for RN outreach to newly discharged patients for transition management