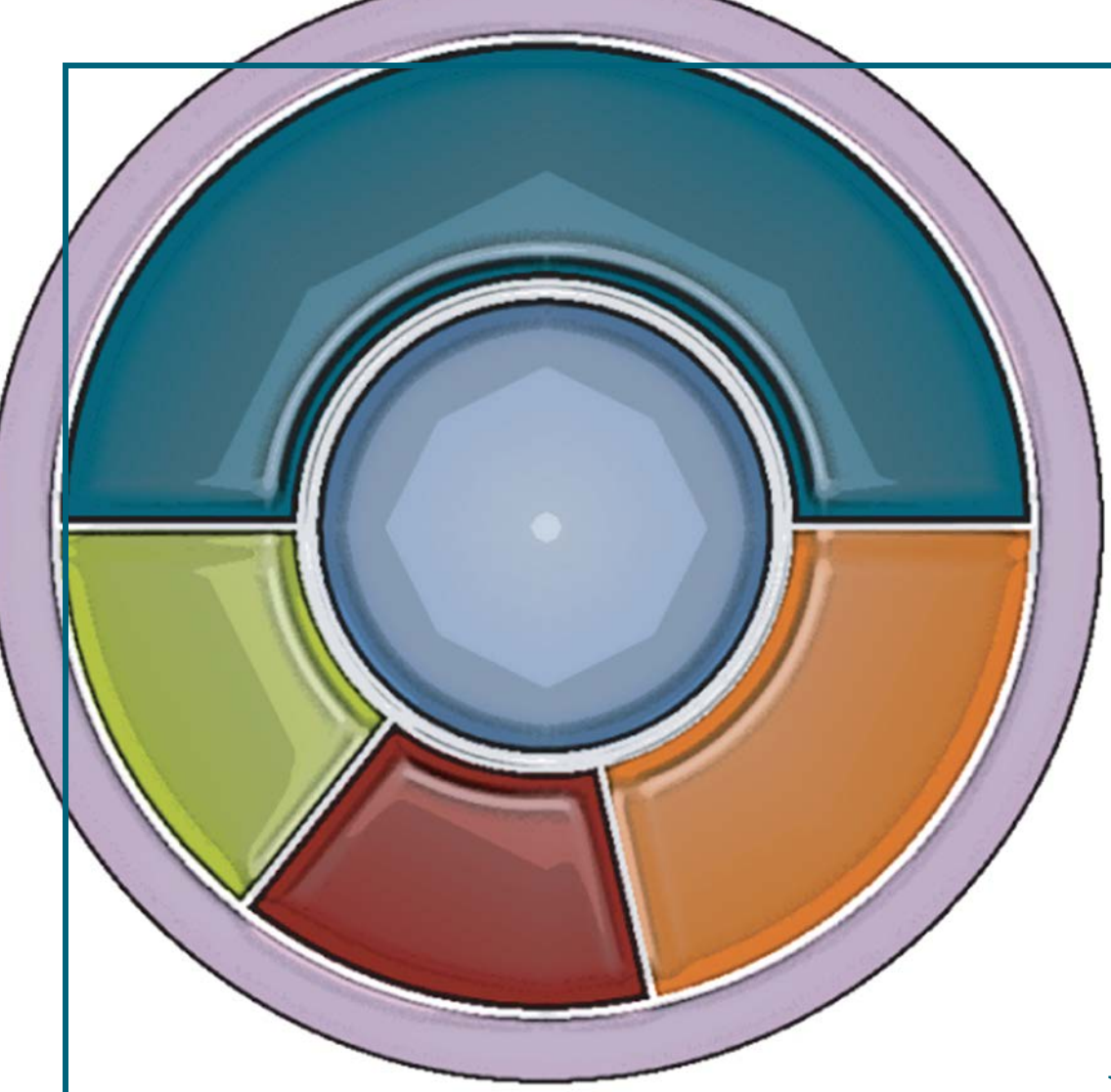

Milestone 6: Care Coordination Across the Medical Neighborhood

A Study of CPC Practice Approaches

August 2014

CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare and Medicaid Innovation

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TMF Health Quality Institute

This material is presented by TMF Health Quality Institute under contract with the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

Purpose of This Guide

This Guide provides an overview of **Milestone 6: Care Coordination Across the Medical Neighborhood** and the implementation strategies that CPC practices have used to meet the objectives.

The practice strategies herein are examples of the work that practices are doing to achieve this Milestone and are not representative of every potential strategy for creating systems for care coordination around hospital and emergency department transitions and for developing collaborative agreements across the medical neighborhood. CPC practices are heterogeneous in size, geography, ownership, and organization; they are encouraged to innovate and test strategies derived from evidence-based and/or best practices, and customize the work according to their particular needs, local dynamics, and other practice aspects that may shape how they create systems for care coordination.

This Guide captures the energy, innovative ideas, and rigorous and determined execution of the CPC practices as they test and implement the objectives of Milestone 6 in their practice. Through this Guide we hope you find in your colleagues' work the support for implementing Comprehensive Primary Care.

August 29, 2014

Overview of Milestone 6

The overarching work for Milestone 6 relates to the practices' ability to demonstrate active engagement in coordinating care for patients across the medical neighborhood. In Program Year (PY) 2013, practices worked on defining a process by which they identified those patients who had been seen in the emergency department (ED) and/or hospital and created a system of contacting those patients, creating a safety net to receive needed care and coordination after discharge back to their primary medical home. Another option was to create a viable referral tracking system to specialists, enabling practices to track the referrals made and ensure that appropriate information returned to the practice. The sharing of information permits the care team to appropriately attend to the patient and ensures records are integrated with the primary care team.

Reporting on Milestone 6 for PY 2014

For PY 2014, practices will expand and build on their PY 2013 activities: track percent of patients with ED visits who received follow-up contact within one week and contact at least 75 percent of patients who were hospitalized in target hospital(s) within 72 hours.

Practices will be asked to enact **care compacts/collaborative care agreements** with at least two groups of high-volume specialists in different specialties to improvement transitions of care and upload a copy of those care compacts to the web application.

The practices that chose care coordination for patients related to hospital transitions started by focusing on the primary hospitals that served their patients. The practices then worked on a system with their primary hospital to enable access to information about their patients' visits to either the ED or hospital admission through a portal or electronic communication system with that hospital or sometimes through a Health Information Exchange (HIE) or other methods.

After creating a system to capture and track their patients' visits to the hospital/ED, they turned their focus to an internal process by which they identified a person or persons to reach out to the patient to reconnect them with their primary care team.

The practices that focused on referrals to specialists likewise had to identify a process and staff member(s) to effectively track their referrals and ensure patients received the care required. They verified the outcome of the referral was meaningfully integrated back into the patient's record at the primary medical home.

In PY 2014, practices will expand their work and become more systematic by selecting two of three Milestone 6 options:

1. Tracking the percent of patients with ED visits who received follow-up contact within one week of the visit,
2. Contacting at least 75 percent of patients who were hospitalized in their target hospital(s) within 72 hours (or within two business days following discharge, as required for Transitional Care Management services) and
3. Expand their work of care coordination with specialists by enacting care compacts/collaborative agreements with at least two groups of high-volume specialists with the goal of improving communication and care coordination.

The Medical Neighborhood

The medical neighborhood comprises the primary care practice and all other clinicians, community agencies, public health agencies and various health care services that serve the needs of the patient. The primary care office is at the center of the neighborhood and coordinates the care with all other members. There is no firm geographical boundary for a medical neighborhood. Rather, it is more important to include the specialists, agencies and services that most appropriately care for our patients.

A well-functioning medical neighborhood delivers coordinated care to its shared patients. The neighbors must have regular communications among themselves, share in decision making and collaborate in the activities involving the patient. This occurs most fluidly when the medical neighborhood:

- Shares health information and performance measurement via IT.
- Has a clear agreement on roles and actions of all members as they care for the patient.
- Offers the opportunity for joint care conferences in the management of care for complex patients.
- Has continuity of medical care when a patient has a transition between care settings within the medical neighborhood.
- Creates strong links to various community services that provide both clinical and non-clinical services to meet the needs of the patient.

The Medical Neighborhood

Outcomes of a well-organized medical neighborhood are positive patient experiences, safe delivery of care with reduced duplications, and thus reduced cost. The patient is the primary stakeholder.

Care Coordination

In the practice, there may be some confusion between the functions of care coordination versus care management. Whereas care management focuses on the individual's health needs using a proactive approach to improve a patient's health status, care coordination sets up the processes and workflows to ensure that there is coordination across transitions in care. It is system-focused and integrates care between and among medical neighbors by closing gaps and ensuring seamless transitions. In reality, the same staff in the practice may take on roles in both care management and care coordination.

Care coordination is essential to a highly functioning medical neighborhood. Patients already assume a partnership exists between the primary care team and specialists, hospitals and other community agencies. They have the right to expect that all the providers involved in their care are using the same information and working

from the same general plan. Although all in the medical neighborhood bear responsibility to ensure seamless care, it is the role of primary care to assure that this occurs.

Primary care acts as the hub for care coordination for patients, and one potential systematic intervention in care coordination is to engage patients as partners in ensuring seamless care. This may involve setting expectations with patients about their role in ensuring the flow of information following referrals, ED visits and hospitalizations and about the optimal use of services in the medical neighborhood. This might include, for example, education about the primary care practice, hours of operation, contact information after regular hours and the practice's process for patients to contact their provider after hours should the need arise. This may avoid unnecessary and expensive trips to the emergency room. If the patient uses a provider outside of the practice for emergency or special care, educate the patient about the practice's expectations of the patient after such a visit.

Historically, practices have spent an inordinate amount of time being reactive and chasing information about their patients. A more intentional, systematic approach to coordination of care creates standard work processes and reduces some of that "chasing" that feels so inefficient in the practice. This intentional care coordination hinges on a two-part process: first, information is reliably received about patients' visits to and from hospitals, and second, reliable follow-up is established by developing care compacts with their medical neighbors to frame an effective working relationship.

ED and Hospital Follow-Up

The primary care team plays a crucial role in providing support, coordination and continuity for the patient following a hospitalization or emergency room visit. This work directly links to Milestone 2 and the care manager's role of care planning with the patient going forward. High-risk patients are especially vulnerable to adverse events in the period immediately following discharge; therefore the primary care team has a real opportunity to focus its energy on making the care transition from the hospital or ED smooth and well-coordinated to avoid unnecessary readmission and to re-engage the patient with the primary care office.

In PY 2013, practices identified which patients visited the ED and/or hospital. That effort deepens in PY 2014 as practices develop systematic flows of information between their practice and the hospitals that their patients use and create follow-up processes to reach out to those patients.

To ensure effective transition following post-hospital/ED, the practice should consider:

1. How will they know that a patient was seen in an ED or discharged from hospital?
2. How will information about the ED visit or hospitalization come to the practice?
3. How will that information be incorporated into the patient's medical record so that the information is available at the time of the follow-up visit?
4. How will the patient be contacted following the ED visit or hospitalization?
5. Who will need in-person follow-up and what time frames will be feasible and effective?
6. What will happen in the follow-up visit to ensure seamless care?

In all of these steps the use of standardized processes (modified as needed for particular patients) will make for a more efficient workflow.

Care Compacts/Collaborative Agreements

A care compact (collaborative agreement) is a framework for standardized communication between primary care and specialty care providers to improve care transitions.

A care compact or collaborative agreement lays out expectations between a primary care practice and another health care provider. Care compacts can improve the patient experience of care by reducing delays, miscommunication and gaps in care. Each of these creates frustration and difficulties for patients. Costs are lowered when coordinated care eliminates unnecessary or inappropriate services, especially those related to duplication of tests, ED visits and avoidable hospitalizations. Last, quality improves when coordination among providers includes shared plans of care that are in agreement and align with patient goals. Compacts improve patient safety by reducing the risk contradicting orders or medications and other types of communication gaps.

Implementation strategy at the practice level

Success with the establishment of care compacts or collaborative agreements is dependent on strategic planning up front. There must be collaboration in the planning phase in an effort to have a powerful outcome that will work for all involved, especially the patient.

- Make the case for better care coordination with your practice – the "why."
- Define a champion who will spearhead the project.
- Collect data on key specialist groups, hospitals and community agencies to which you refer frequently.
- Collect feedback from patients and providers about your medical neighbors to validate your selected partners.
- Reach out to current and potential referral sources.
- Develop and maintain relationships with key specialists or agencies; develop compacts/agreements.
    - Think about starting with "easy" relationships first.
- Ensure the meaningful exchange of information across and between medical neighbors and patients
    - Consider the ability to do electronic exchange of information if possible to reduce the workload at both the ends of the agreement.
- Track process through PDSA cycle or another QI strategy.

Case Studies

In the following case studies, CPC practices describe their work in Milestone 6. Strategies and approaches vary by practice size and the needs of the practices' patients.

Emergency Department Follow-up: Overcoming Challenges

St. Charles Family Care, Sisters, Oregon
System; 1 physician; 1,800 patients (adding an ANP and physician in fall 2014)

Coordinating care of patients after an emergency room visit is challenging, especially when their visit is not communicated to the primary care practice. **St. Charles Family Care** recognized the problem and collaborated with the local hospital to improve care coordination in this area.

The opportunity to improve care and outcomes depends on the hospital communicating with the PCP when the patient visits the emergency room. Root cause analysis determined the lack of notification derived from the following reasons:

- Patients do not identify their PCP during admission to the ED or admitting staff do not ask.
- The hospital's system, Paragon, lacked an automated communications function to alert the practice when a patient is admitted to the ED.

Key Points:

- Collaborate with hospital to develop a process
- Develop process for staff to complete follow up with patients and document results

To correct this, the practice and hospital collaborated to improve the quality of data in this field in the hospital EHR. At the practice, patients are reminded to provide their PCP's name any time they visit the ED. The result of the collaborative efforts is that now when a patient visits the ER, notification is automatically emailed to the office when the PCP field is completed. This has improved from zero notification to 95 percent.

The only data that comes in the notification email is the patient's name, date of birth and the timeframe of the ED visit. This triggers the care coordination staff to go into the hospital's EHR and review the ED notes to identify the reason for the visit. The practice is then able to make a follow-up call to the patient and determine if an office visit is needed as a result of the ED visit. They also take that opportunity to educate the patient on his or her care and, if needed, on coming to the primary care office instead of the emergency room for conditions that could have been cared for in their office. This phone call and the actions taken are documented in the practice's EHR, Allscripts.

An example of the success of these follow-up calls is a patient who had an encounter with a bat. It was not determined if she was bitten, but she chose to have the rabies vaccination series nonetheless. She received her first dose at that ED visit, and then went back to the ED for her second dose. The care coordinator contacted the patient and educated her that vaccinations could be given at their office and she did not have to go to the ED for that series. The office obtained the vaccine and administered the remainder of the series at the office. This follow-up saved the patient from further ED visits and reduced the cost of care for this incident.

Hospitalization Follow-Up: A Disciplined, Standardized Process

The Christ Hospital Health Network, Cincinnati, Ohio
System; 41 physicians, 6 ANPs; 64,000 patients

Practices in **The Christ Hospital Health Network** found that following a disciplined, standardized process for hospitalization follow-up has improved the overall outcomes for their patients. The system uses Epic EHR and HealthBridge to receive notification of patients who are hospitalized. These notifications are pushed to their EHR from the network hospitals, and HealthBridge is used for admissions outside of their network.

Key Points:

- Standardize scripting and documentation
- Survey continuously for ongoing feedback
- Track progress through PDSA cycles

The RN Care Managers call the patients within 48 hours of discharge, using a discharge phone call script to standardize communication and uniformly gather information and provide information to the patient. The script covers the following:

- Signs and symptoms the patient experienced
- What actions patient took to relieve those signs and symptoms
- What change in condition prompted the patient go to the hospital
- A review of discharge instructions
- What "red flag" symptoms should prompt the patient to call the physician or go to the ED
- Medication reconciliation
- Schedule follow-up appointments as needed or indicated

The calls are documented in the EHR (Epic) with a care transition note template. This triggers an alert in the chart for the provider at the follow-up appointment.

The staff was trained using Chronic Care Professional educational materials. During weekly staff meetings, the team discusses successes and challenges to learn from each other. Recently the following information was shared: "I got word from one of our medical assistants that one of the TCM calls I made last week caused a patient to reconsider leaving our practice. The patient was getting ready to switch PCPs to an office closer to her home but said that when she got my call it changed her mind! She told the MA that no other office had ever called her to check on how she was doing after going to the hospital and that made her want to stay with us."

This practice collects informal feedback from the care managers regarding the process. The practice continues to evaluate feedback and continually modifies the script based on feedback. So many issues were uncovered during calls, and because the care managers were able to clarify or address patient issues, the usefulness of the calls became apparent. The script begins the conversation, but each call requires customized conversations depending on the findings. Patients are grateful for the call and the help provided and they regularly provide that feedback to the physicians. PDSA cycles track progress and improvements over time.

Post-Hospitalization Follow-up Workflow

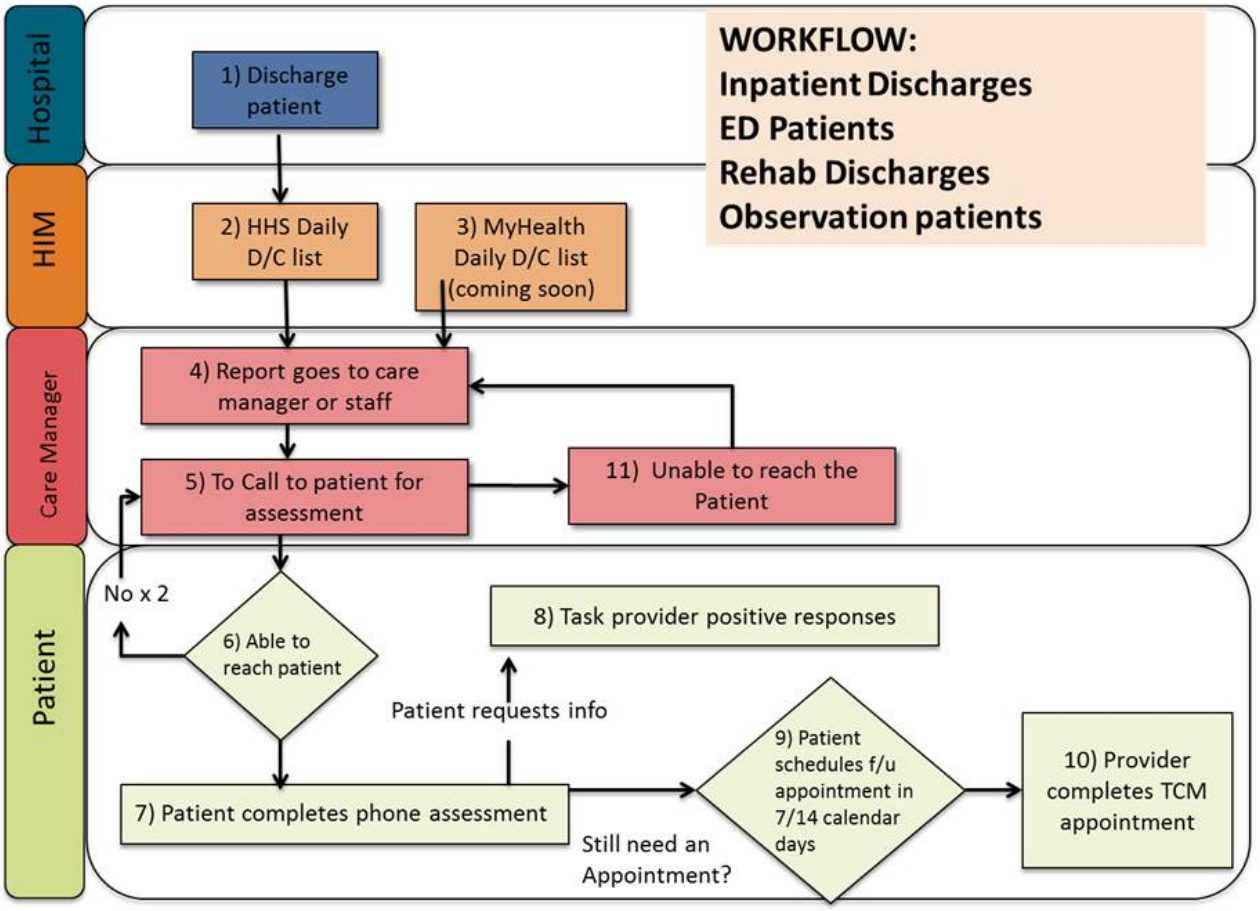
Utica Park Clinic – Owasso, Owasso, Oklahoma
System; 10 physicians, 1 ANP; 14,105 patients

Utica Park Clinic – Owasso is one of the largest clinics in the Utica Park Clinics group. Of the 10 physicians, five are family practice, two are internal medicine and three are pediatricians. At this time the pedicatricians are not participating in CPC, although they actively manage their patients using the technology and processes the CPC physicians use.

Key Points:

- Standardized communication
- Standardized and improved workflow
- Prioritized medication reconciliation

Approximately one year ago Utica Park Clinics developed a process for managing the care coordination of patients discharged from the hospital, both inpatient and emergency. The workflow pictured below is followed by all practices the Utica Parks Clinics group, not just those participating in CPC.



Discharge reports are received in one of two ways: a daily discharge list from the health system or from the HIE (My Health) for discharges from hospitals or facilities outside of their health system. The reports are sent to all nursing staff in a timely manner, enabling contact to be made immediately after discharge. Calls are made to all patients, with at least two attempts made to reach them within 48 hours of discharge. At the Owasso clinic the medical assistants make the first call and request assistance from the care coordinator as needed. The follow-up questions are embedded in the EHR (NextGen) so that responses can be recorded during the call.

The following are the questions consistently asked during the call, with pre-determined responses (in bold below) programmed as option buttons (radio buttons) in the EHR:

1. Compared to the time of your discharge (in-patient/OBS), would you say you are feeling **better, worse or about the same?**
2. Do you have any questions about your discharge instructions? Would you like someone from our team to **call you to discuss your discharge instructions and answer any questions you have**?
3. Some of our patients receive new or changed medication prescriptions in the hospital. **Would you like someone from our patient care team to call you to discuss your new or changed medications** and answer any questions you have?

4. Have you already scheduled your follow-up appointments? If not, **can I schedule an appointment for you?**
5. I hope you were you satisfied with the care you received. Are there any **questions or concerns that I may relay to your provider or healthcare team?**

Transitions of Care Template in EHR

Logout | Save | Clear | Delete | UPC OWASSO ADULTS | GALLES, JEFFREY L DO | Patient | History | Inbox | PAQ | ICS | Close

06/14/2013 02:45 PM : "UPC Transition Of Care"

Transition of Care

Contact made with:
Home: Preferred
Work: ext Preferred
Other: Preferred
Discharge Date: / /
Days since discharge:
Discharge Facility Type:
Discharge Facility Name:
Discharging Physician:
Discharged to:
Discharge Diagnosis: Add or Update Assessment

View Scheduled Appts

Dx 1	250.00	Diabetes Mellitus Type 2, Uncor	Dx 3	401.1	Hypertension, Benign
Dx 2	272.0	Hypercholesterolemia	Dx 4		

*** Questions to cover with the patient ***

1) Compared to the time of your discharge, are you feeling better, worse, or about the same? better worse same
2) Do you have any questions about your discharge instructions? Yes No
3) Some of our patients receive new or changed medication prescriptions in the hospital. Do you have any questions about your medications? Yes No
4) Have you already scheduled an appointment with your primary care provider? Yes No
5) I hope you were satisfied with the care you received. Are there any other questions or concerns that I may relay to your provider/healthcare team? Yes No
6) Would you like someone from your care team to contact you? Yes No

Comments

Provider Comments

Document: Preview Offline

*** If the patient could not be reached ***

Date of 1st Attempt: / / Comments:

Date of 2nd Attempt: / / Comments:

Medication reconciliation post-discharge is completed and has been beneficial. When patients are contacted, the care coordinator reconciles all medications over the phone. Some of the issues found were patients who had double medications due to using both the generic and brand-name medication, individuals who had stopped all home medications and were only taking the new medications from the hospital and patients who could not afford their new medications. Resolving these issues has prevented adverse outcomes in many cases. In one instance, if the care coordinator had not identified the patient had stopped all home medications the patient may have had grave consequences. When patients are not financially able to purchase their medications, samples may be used until a social worker connects with the patient.

One barrier to success is having an incorrect phone number, or no phone number, for the discharged patient. The practice added a process that prompts anyone in the practice who has contact with the patient to verify the correct phone number and enter it into the system. An improvement has been noted over time with a decreasing number of incorrect or absent patient phone numbers.

Initial attempts to access hospital discharge reports were met with resistance. However, through communication with the health system, the practice and the system realized a mutual understanding of how the discharge reports benefit all providers and the patient. This has improved delivery of the reports in a timely manner. Despite this improved communication, delivery remains uneven, and the practice has tasked its staff to pull reports when they are not delivered on time.

The effect on the the patient population has been positive. Patients are pleased to be called after discharge, and if needed, are scheduled to see their PCP within seven to 10 days of discharge. Greater acceptance of discharge instructions has reduced readmissions or other adverse consequences. The overall readmission rate for the Hilcrest system is lower, yet exact data for the practice is not available. Fifteen CPC practices are affiliated with the Hilcrest system, and the reduction in readmission rates corelated at the time of the CPC Milestone work.

Tracking Hospital Admissions: Using Data as a Catalyst for Change

Foresight Family Physicians, Grand Junction, Colorado
Independent; 2 physicians, 1 ANP, 1 PA; 5,000 patients

This practice believed it wasn't receiving hospital discharge information in a timely manner. To test this theory, **Foresight Family Physicians** created a plan to track the information and share data with its community partners to drive improvement through transparency and competition.

To ensure local hospitalist groups and hospital medical directors knew Foresight was tracking timeliness of information, the practice leadership met with these community partners to describe the project and to offer to share the data. The groups collaborated with Foresight on workflows and agreed to share information with the practice when requested.

Key Points:

- Collect baseline data
- Use data to drive change and competition
- Capitalize on Health Information Exchange data
- Focus on internal and external systems

The practice started with baseline workflow process maps to track how information flowed between the hospitals and the practice. It also developed a structured process that would allow staff to track how and when the information was exchanged. Specific staff members were tasked to monitor the data, and they quickly found multiple gaps in communication. The practice narrowed its focus to unplanned admissions to the hospital. They noted they were not receiving reliable communication due to the admission being at the last minute and created a workflow to address these occurrences.

When the HIE alerts the practice that one of their patients has been admitted, Foresight staff fax a medical summary to the hospitalist group managing the admitted patient's care. In return, the hospitalist group sends the admissions history and physical. Foresight's "ideal state" target was to have both exchanges of information complete within 48 hours of admission.

For timely notification of hospital discharges, Foresight asked each hospitalist group to call the practice when their patients are discharged, providing any information that might be pertinent for follow-up. Foresight provided a dedicated phone line for this exchange so incoming calls are not placed on hold. The receptionist retrieves the messages and transfers them to the appropriate provider in a timely manner.

The receptionist documents in the EHR (eClinicalWorks) when the admission information is received and the medical records' staff documents in the EHR when the discharge summary and medication reconciliation documents are received. A telephone encounter "virtual visit" is created in a structured format. The structured data is entered into the HPI and interim health history sections of the EHR. This allows the practice to pull information and run reports from the registries.

After tracking this data for several months, the practice was able to create reports that compared the timeliness for admissions and discharge information among the community partners. The reports were sent to the medical directors of each hospital as well as directors of each hospitalist service with complete transparency. Provider groups could see the others' data. There has been a definite improvement in data as well as communication between hospitals and the practice.

The practice continues to have more difficulty with patients who are admitted electively for procedures by their consultants (no hospitalist is involved). It is important to note that the difficulty arising from this type of admission and not true "admissions" lies in the ADT (Admission, Discharge, Transfer) notices received. There is no information that clarifies that a specialist has admitted the patient for a procedure. The notice simply gives a diagnosis and date of admission. This causes a gap in communication between the admitting physician and the PCP. Their plan for 2014 will be to communicate with the major specialty services used and who directly admit their patients (orthopedics, general surgery and oncology) and request they follow the same protocols.

Care Coordination for Hospital, Emergency and Urgent Care Visits

Warren Clinic – Internal Medicine, Tulsa, Oklahoma
System; 3 physicians; 3,000 patients

The Care Coordinator position was added to **Warren Clinic – Internal Medicine** one year ago. As a part of a large system, the clinic is notified electronically when patients are admitted to the hospital as well as when they visit the emergency department (ED) or urgent care center (UC). This only covers those facilities within this health system. Both the provider and the care coordinator receive the notification.

Although care management focuses on those patients in high-risk strata, care is coordinated for all patients, regardless of risk strata. Once the care coordinator receives the notification of a visit to the ED/UC or a hospital admission, she contacts the patient. These are the timelines for contacting the patient:

> *"It is an integral piece of care coordination to be accessible, dependable, accountable."*

- Hospital admission – two business days after discharge with appointment with PCP scheduled
- Emergency Department visit – within seven days of the visit; follow-up PCP visit is scheduled as needed
- Urgent Care Center – same protocol as ED

If a patient is transferred or admitted to a skilled nursing facility, the care coordinator will contact the facility, provide her information and request notification prior to discharge so the transition home goes smoothly for the patient.

Over time, strong relationships have been built both with patients and families. The care coordinator serves as a dependable and accountable resource for patients as they navigate the Patient Centered Medical Neighborhood. She provides her direct phone number to patients so they can reach her quickly when they need her, a privilege that a patient has never abused. Feedback from the patients has been positive, stating they feel supported by their primary care team.

Change can be hard on the primary care team. Within the office, having an RN on staff was different for the other staff. A period of adjustment was needed as the RN undertook care coordination efforts, with the medical assistants working directly with the physicians. Over time, relationships were formed, and trust in each other's role on the primary care team formed. Patients notice the teamwork and are benefactors.

The outcomes from care coordination are tangible. The efforts have resulted in fewer phone calls and increased timeliness of response to patient needs. In addition, the workload of the providers has been decreased as a result of the triage work done when contacting patients. One example is a patient who has gone to urgent care or the ED over the weekend for an infection and started on an antibiotic. In the past those patients were asked to call Monday morning to make an appointment to see their PCP. The care coordination process is in place so that patients are educated to see the PCP at the completion of their antibiotic for a follow-up visit, and the appointment is set. In the past, the doctor may have seen them immediately and then again after their course of antibiotics. This opens appointment slots for other patients, lowers costs and increases patient satisfaction. The practice is awaiting data to analyze the effect from these efforts, although they are confident they are making progress toward the CPC aim of better health, better care and lower cost.

Care Coordination: Follow-up on Hospital, Emergency and Specialist visits

Lawrence Family Medicine, Conway, Arkansas
Independent; 1 physician, 1 PA; 10,558 patients

Consistent follow-up on all patients who are admitted to the hospital, visit an emergency room or are sent to a specialist has reaped benefits for **Lawrence Family Medicine**. Care coordination is a team effort at this independent practice, with all staff taking responsibility to ensure follow-up.

Care coordination activity began with the practice's participation in CPC. The practice decided to actively track all emergency room visits and hospital admission to their local hospital, Conway Regional Medical System. Access to the hospital's EHR made it possible to monitor these activities. When patients are seen at the hospital, they are asked the name of their primary care physician. This is entered in the hospital's EHR, enabling the PCP office to monitor all patients admitted for Dr. Lawrence. The RN checks this system at least three times each week. She notes the reason for the visit, any medication changes and seeks a discharge report.

When a patient has been seen in the emergency room the RN calls that individual to check on his or her status. During the discussion with the patient, the RN educates the patient on when to go to the ED versus calling the PCP office. Follow-up appointments to see the PCP are made as necessary, based upon the reason for the visit.

Prior to CPC, follow-up with patients who visited the ED was completed approximately 10 percent of the time. Improvement has been achieved every quarter, and now stands at more than 93 percent. This activity has achieved a decrease in the number of unnecessary visits to the emergency room for the practice's patient population.

The same process is followed for hospitalized patients. The RN calls the patient within 24 hours of discharge whenever possible. The discussion centers on the patient's immediate condition and their current needs. An appointment is made for a follow-up visit with the practice. The policy is to schedule these appointments within 48 hours of discharge to aid in the transition of care. Reduced readmission rates have been noted as a result of this activity.

Care coordination at Lawrence Family Medicine also includes follow-up on all referrals to specialists. When a referral is made, this information is added to a spreadsheet to track the process. In addition, a follow-up appointment is scheduled with the PCP at the time of the referral to ensure the loop is closed. The receptionist handles all incoming faxed reports and marks the report as received on the spreadsheet. If a report has not been received within two weeks of the appointment with the specialist, a call to the specialist office is made to request the report so that it can be available for the doctor's review before the follow-up visit. The team's close monitoring has resulted in a positive relationship with the specialists, with a more timely return of reports without prompting.

This activity has positively affected the patient experience. Patients remark that they are pleased that their primary care office knows any time they are hospitalized or go to the emergency room. They are comforted to know their doctor is on top of things and makes the time in his schedule to care for them. The practice continues to strive to reach 100 percent follow-up, although this is challenging due to the inability to reach some patients by phone. The effort will continue, and as time goes on more patients are aware they can expect a call from their doctor's office and will respond to that call.

Tracking ED Visits: Creative Solutions

Physicians Medical Center, McMinnville, Oregon
Independent; 13 physicians, 4 APRNs, 1 PA; 23,000 patients

Physicians Medical Center faced several challenges in the initial stages of improving care coordination for patients who visited the emergency department (ED). These challenges included:

- Notification of visit from the local hospital was slow.
- Patients used the ED for non-emergent visits.
- Patients lacked knowledge regarding the practice's hours and directions on accessing the practice.
- Data mining was challenging without dedicated IT staff.

Key Points:

- Engage and educate patients about practice's extended office hours
- Direct access to local hospital's EHR
- Dedicated staff to do follow-ups and reminders

PMC's first steps were to set up access to the local hospital's EHR system and add a care coordinator to the practice. This improved response times because the practice did not have to rely on or wait on reports to be sent. Later, Advice Nurses were added to the workflow to support

follow-up calls and to assist with scheduling follow-up appointments. The Advice nurses log in daily to each hospital's system to download the ED and hospital discharge reports for the practice's patients.

The practice began pulling, filtering and analyzing the EHR data from the local hospital. Using this information on hospital and ED admissions, PMC has created workflows for the care coordination team to call all patients admitted to the ED or the hospital. The advice nurses call all of the ED discharges within five days of their visit, and the care coordinators call all hospitalized patients within three days of discharge.

Educating patients about expanded office hours and access was another tactic to lower ED use. Office hours are posted on the practice website, patient portal and in the lobby. The advice nurses and care coordinators also provide another layer of education about the expanded office hours and access. The practice provided information about same-day access, the Saturday clinic and how to reach on-call physicians. The practice has found that patients not only need reminders to call the clinic first but also the reminder calls serve as an opportunity to offer follow-up care, review medications and to set up referral appointments with specialists. Implementation of the care coordinator and use of advice nurses to make call backs has shown a reduction of ED visits. Visits to the ED have decreased by 16.1 percent, while the rate of visits has decreased by 25.7 percent. Qualitatively the patients are very appreciative of getting the follow-up phone calls.

The practice's EHR (GE Centricity) does not have the capability to run reports to quantify the progress on this process. The practice's work-around was to hire a consultant who built an Access database that uses their EHR data and displays it in any reporting format needed. PMC staff has learned how to mine EHR data into Access for ED reports and export to MS Excel for processing and analysis. The practice's care coordinator and EHR clinical manager filter data for qualified patients and visits, tabulate the total number of visits per quarter and the total number of patients per quarter. This data is then used to calculate the rate of visits per patient per quarter.

Tracking ED Visits: Communication with Patients and Medical Neighborhood

Orlando F. Mills Family Practice, Freehold, New Jersey
Independent; 1 physician; 1,900 patients

Prior to enrolling in CPC, this practice had an established HIE connection to CentraState, the hospital most of the practice's patients use for emergency care and procedures. Familiarity with this system facilitated procuring the additional permissions needed to access detailed discharge information for those patients seen in the emergency department (ED). The practice can also track patients with Horizon (Blue Cross Blue Shield) coverage who visit EDs throughout New Jersey through Navinet, a web-based system.

Early in the practice's CPC work, Dr. Mills hired a registered nurse part time to perform care management responsibilities under the job title of patient care coordinator (PCC). Her duties include follow-up with patients recently discharged from the ED. She currently works two days per week but has been so valuable to the project (and the practice) that the practice is seeking an additional full-time RN.

Key Points:

- Leverage existing technology
- Standardize processes and communication
- Educate patients

The PCC checks the CentraState HIE and Navinet each day she works to identify patients recently seen in the ED and then finds the cause for the visit in the discharge information. She then contacts patients, following a script the practice created.

During these calls she reviews with the patient the reason for the ED visit. If it was unnecessary or inappropriate, she emphasizes to the patient that the practice office is the "first contact" and checks if the patient has a "Resources in My Medical Neighborhood" handout. The practice created this fact sheet that lists community resources patients may find helpful, including local urgent care centers for patients to access afterhours in lieu of the ED. If the patient doesn't have the handout, she notes in the EMR that she covered the information during the call but the patient should receive the hard copy during the next office visit.

The PCC also uses this call to record any medication changes, schedule a follow-up appointment (if needed) and share information about local resources the patient may find beneficial. The PCC documents this communication in the patient record as a care coordination note, which ensures the entire care team can access the information. If the patient calls while the PCC is not working, any member of the care team can access the care coordination note for information specific to the patient.

All members of the care team can provide the "Resources in My Medical Neighborhood" handout and know how to document the patient's receipt of this handout in a searchable field in the EMR. Patients seen during office visits are provided this information if they have not received it in the past.

New Jersey is in the process of opening a statewide HIE that will allow primary care practices to access patient records from all New Jersey hospitals. Although most Dr. Mills' patients go to CentraState, the statewide HIE will expand the practice's ability to reach patients using other hospitals. Currently the practice is unaware if a patient visits other hospitals and cannot obtain the necessary records for these patients unless the patient provides this information directly or a consulting physician sends a report. The statewide HIE should help eliminate this care coordination gap.

Care Coordination Using Transition of Care Guidelines in a Large System

Taconic Independent Physicians Association, Hudson Valley, New York

Adverse events most frequently occur following a patient's transition across care environments (e.g., patient discharge from hospital back to the care of the PCMH). The most frequent adverse events are medication errors due to ineffective communication at the time of care transitions. Along with physician leaders from **Taconic IPA,** CPC initiative physicians formed the Physician Leadership Group and identified the imperative to develop a strategic plan to implement a patient centered medical neighborhood (PCMN) in their region. This shifted the focus from checking the box for CPC Milestone 6, and a core Meaningful Use Stage 2 measure to the real goal of sustainable improvements in the delivery of care throughout the Capital District and Hudson Valley.

Key Points:

- Physician champions
- Build consensus
- Create action group(s) to do the work
- Standardized guidelines (care guidelines) with local choice of partners
- Disciplined PDSA cycles

One of the core Meaningful Use Stage Two (MU2) measures is sending 10 percent of all clinical transition of care messages electronically. The clinical leaders immediately recognized the advantages to capitalizing on this MU2 requirement to best support their patients as they transition across care settings within the PCMN, as well as to support meeting CPC Milestone 6. Some of the required data elements in all transition of care messages are an active reconciled medication list, problem list and medication allergy list. It was clear to the group that this would be a powerful tool in enhancing care communication and thereby decreasing adverse events. This would result in enhanced care quality, patient satisfaction with care and lower costs of care.

The group created a project plan that first identified their highest priority areas of focus for their patients' transitions of care. The areas identified were specialists, specifically orthopedics, cardiology and hematology/oncology; acute care; and long-term care. The decisions were based on transition frequency and high cost of care.

Using the references related to Milestone 6 in the *CPC PY 2014 Implementation and Milestone Reporting Summary Guide* and other resources as reference material, an initial draft of a Primary Care/Specialist Transition of Care Agreement Template was created and substantially edited and adopted by the leadership group. The group then tackled creating and editing an Ambulatory/Acute Transition of Care Agreement.

Next, the practices identified the health care organizations with which they most frequently exchange patients. They began to engage these organizations in both reviewing and signing the relevant Transition of Care Agreement as well as planning for direct exchange of information with the organization using their 2014 certified EHRs. As the practices began using the Transition of Care Agreements, it quickly emerged that the documents were perceived as a legal agreement. This resulted in the partner organizations initiating an extensive and time-consuming legal review. As part of the Leadership group's PDSA cycle, they recognized that this legal review was likely due to the title including the word "Agreement." The group agreed that the purpose of the document was not a legally binding contract but guidelines for best practices to coordinate patient care across care transitions. The group universally agreed to change the document titles to Transitions of Care "Guidelines." In addition, the group recognized the need to add a purpose statement, disclaimer and Frequently Asked Questions sections to all of the Guideline documents to make them all more user friendly.

The Leadership Group physicians actively meet with their clinical trading partners to make sure they are in the process of or have already upgraded to their 2014 certified EHR. This assures that trading partner has a viable option to pilot Direct Transition of Care messaging. They have also been working with their trading partners to review the guideline templates, modify the templates as needed, and then finalize them. Nearly all of the practices represented by the Leadership group are in the process or nearing finalizing this work with their trading partners. One leader's practice is currently completing direct transition of care electronic message exchange testing and should be exchanging electronic messages by summer 2014. Several others are following closely behind.

The ultimate goal of the Leadership group is to use all of the experience garnered and develop a Standard Operating Procedure for Transitions of Care and disseminate it to colleagues across the community, creating a true PCMN in the Capital District/Hudson River Valley region.

Many positive outcomes have resulted from this effort to date. A particularly impressive outcome is that organizations that are direct competitors are now working closely together to agree on best practice Transition of Care guidelines. They see the benefits of sharing information to fundamentally improve patient care, patient experience of care and ensure smooth transitions across the patient centered medical neighborhood. Another is that hospitals have both small (solo) and large practices (multisite affiliates) focusing on this effort.

Care Compacts for Behavioral Health

Hinman Family Practice, Longmont, Colorado
Independent; solo practitioner, 1 PA; 2,500 patients

Mark Hinman, MD, is a solo provider who chose to develop a care compact for behavioral health to better support his Milestone 2 advanced primary care strategy for integrating behavioral health. As a small office, the staff largely communicated verbally with specialists. However the practice understood formalizing the communication would better support collaborative relationships.

The practice could also see how a formal care compact would meet a range of priorities for the practice:

- The compact would formalize an effective partnership for its CPC Milestone 2 work.
- CPC was likely to expand the use of compacts in the coming years.
- The project served as a timely opportunity to pilot and test the work.
- The practice was re-certifying for NCQA-PCMH and the compact would complement that work as well.

A patient recommended a psychologist for the practice's behavioral health partner. The practice met with the psychologist, explained its PCMH work and how it was creating a medical neighborhood. The psychologist agreed to partner with the practice and provide the majority of the behavioral health care for Dr. Hinman's patients.

Key Points:

- Use patient feedback to identify good partners
- Start with an "easy" relationship first
- Link work to other Milestones and practice priorities

The staff is finding that the care compact aids with communication by making it more proactive and comprehensive. Stated standards for communication and follow-through for the patients are beneficial for both the patients and providers. For example, the practice referred a patient with an anxiety disorder to the psychologist for treatment, but the patient wasn't on the psychologist's insurance panel. Due to an agreement in the care compact, the psychologist arranged for another behavioral health specialist to see the patient for treatment. Not only did the patient see the appropriate provider in a timely manner for treatment, the practice staff wasn't tasked with identifying a new provider and arranging the care.

Care Compact for Mental Health Services

Longs Peak Family Medicine, Longmont, Colorado
Independent; 5 physicians; 8,695 patients

Long's Peak Family Practice felt a collaboration agreement with their mental health providers would improve coordination of care for behavioral health care. A group of therapists was identified based on the practice's comfort with the care they provided.

The next step was to identify the goals of both the primary care practice (PCP) and the mental health office. They noted at times they would refer a patient who was not accepted at the mental health provider. It was decided that if that is the case, the mental health provider will suggest mental health providers within network for that patient and notify the PCP.

Key Points:

- Track mechanisms for success
- Track progress through PDSA cycles
- Include responsibilities of the patient

Responsibilities for the PCP practice, the mental health provider and the patient, were developed. The care compact was then put into use. The patient is responsible for making the appointment with the mental health group. The PCP practice sends the information to the practice to prepare for that appointment. A feedback loop was created to benefit both specialties. If the patient does not follow through and make the appointment, the mental health group notifies the PCP using their established communication form.

A tracking mechanism is in place to monitor transactions. Each month they run a report of patients with depression and anxiety from their EHR (Amazing Charts). They note who they referred the patient to, and if notes came back. A fax request for the notes is sent if they have not yet been received.

Since this is early in the implementation cycle, they will continue to work through the PDSA cycle and improve upon the process over time prior to initiating other care compacts.

Appendix

Primary and Specialty Care Transition Guidelines, Taconic IPA (8 pages)

Primary and Specialty Care Transition Guidelines

I. Purpose

- To provide optimal health care for our patients.
- To provide a framework for better communication and safe transition of care between primary care and specialty care providers.

II. Principles

- The central goal is safe, effective and timely patient care.
- Effective communication between primary care and specialty care is key to providing optimal patient care.
- Mutual respect is essential to building and sustaining a professional relationship and working collaboration.
- Establish a high functioning medical system of care providing patients with access to the right care at the right time in the right place.

III. Definitions

Generalist – a primary care provider (PCP) whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients across a lifetime.

Specialist – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of diseases or type of patient.

Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision making and self-management.

Transition of Care – an event that occurs when the medical care of a patient is assumed by another medical provider or facility such as a consultation or hospitalization.

Technical Procedure – transfer of care to obtain a clinical procedure for diagnostic, therapeutic, or palliative purposes.

Patient-Centered Medical Home –a community-based and culturally sensitive model of primary care that ensures every patient has a personal provider who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.

Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.

IV. Types of Care Management Transition Between PCP and Specialist

- **Pre-consultation exchange –** communication between the generalist and specialist to:
  1. Answer a clinical question and/or determine the necessity of a formal consultation.
  2. Facilitate timely access and determine the urgency of referral to specialty care.
  3. Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.

  Example: Requesting information from a specialist regarding the appropriateness of ordering a given diagnostic test as the next steps in working up a complicated patient.

- **Formal Consultation –** a request for an opinion and/or advice and treatment on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the generalist after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.
  1. **Advice**

     Example: Patient has a rotator cuff tear with chronic pain. Patient is referred to orthopedic surgery for a recommendation on physical therapy versus surgery.

  2. **Advise and Treat**

     Example: Patient with multiple elevated Calcium levels and elevated PTH is referred to endocrine surgery.

- **Complete transfer of care to specialist for entirety of care –** due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient's health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources as outlined by the "Joint Principles".

  Example: Patient has a newly diagnosed colon cancer and is transferred to the Oncologist to manage the episode of care. The Oncologist will coordinate the patient's care with the colorectal surgeon and keep the PCP informed throughout the episode of care.

- **Co-management** – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.

  Example: Patient with MS is followed by a neurologist for their MS and their PCP for their other conditions and health maintenance.

- **Co-management with shared management for the disease** - the specialist shares long-term management with the primary care provider for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the PCMH and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.

  Example: Patient with brittle diabetes that has been very difficult to control is managed by both the PCP and the endocrinologist who share management for this condition.

- **Co-management with principal care for the disease (Referral)** – the specialist assumes responsibility for the long-term, comprehensive management of a patient's referred medical/surgical condition. The PCMH continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The generalist continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.
  - **Consuming illness** – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The PCMH remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.
    Example: See above new diagnosis of cancer requiring multi-modality therapy
  - **Emergency care** – medical or surgical care obtained on an urgent or emergent basis.
    Example: Acute appendicitis requiring urgent surgery.

V. Specialist to Comply with the Request for Appointments by PCP or Immediately Let PCP Know Request Cannot Be Filled

- Urgent appointment
  - Same day or within 24 hours of the request
  - By the named specialist or another like specialist in the practice.
- Within a week of the request
  - By the named specialist only.
  - By the named specialist or another like specialist in the practice.
- First available (limit of this timeframe to be mutually agreed upon)
  - By the named specialist only.
  - By the named specialist or another like specialist in the practice.

VI. Mutual Guideline for Care Management

- Review tables and determine which services you can provide.
- The *Mutual Guideline* section of the tables reflect the core elements of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.
- The *Expectations* section of the tables provide flexibility to choose what services can be provided depending on the nature of your practice and working arrangement with PCP or specialist.
- The *Additional Guidelines/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to specialty care, processes should be in place to determine the patient's overall needs and reintegrate further care with the PCMH, as appropriate.
- The Guideline is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient.
- Upon signing this Guideline, each provider should agree to an open dialogue to discuss and correct real or perceived breaches of this Guideline, as well as, the format and venue of this discussion.
- This Guideline is effective for 2 years *(or other defined timeframe)* and then should be renewed.

Transition of Care

Mutual Guideline

- Maintain accurate and up-to-date clinical record.
- Agree to standardized demographic and clinical information format C-CDA, as defined by Meaningful use stage 2.
- Ensure safe and timely transfer of care of a prepared patient.

Expectations

Primary Care	Specialty Care
☐PCP maintains complete and up-to-date clinical record including demographics. ☐Transfers information as outlined in Patient Transition Record. ☐Orders appropriate studies that would facilitate the specialty visit. ☐Informs patient of need, purpose (specific question), expectations and goals of the specialty visit ☐Provides patient with specialist contact information and expected timeframe for appointment. ☐Sends information to the specialist at the time of referral order	☐Reviews with PCP appropriate referrals based on the specialist's scope of practice ☐Determines and/or confirms insurance eligibility ☐Provides single source referral contact person ☐When needed, be ready to communicate with the PCP prior to the appointment to assist in the preparation of patient and appropriate pre-referral work-up ☐Sends information to the PCP at the time of completing the consultation visit. ☐Sees patient within the timeframe requested, or immediately informs PCP of their inability to do so, and does not refer patients to ED if Specialist is unable to schedule an urgent appointment.

Additional Guidelines/edits:

Access

Mutual Guideline

- Be readily available for urgent help to both the physician and patient via phone or secure messaging.
- Provide visit availability according to patient needs.
- Be prepared to respond to urgencies.
- Offer reasonably convenient office facilities and hours of operation.
- Provide alternate back-up when unavailable for urgent matters.

Expectations

Primary Care	Specialty Care
☐Communicates with patients who "no-show" to specialists. ☐Determines reasonable time frame for specialist appointment. ☐Provides Direct option for communication with specialist. (See Appendix 2: Definition of Direct).	☐Notifies PCP of "no-shows" ☐Provides visit availability according to patient needs. ☐Is available to the patient/patient delegate for questions to discuss the consultation. ☐Schedules first patient appointment with physician. ☐Is available to PCP for pre-consultation exchange by phone and/or secure email. ☐Provides Direct option for communication with provider. (See Appendix 2: Definition of Direct). ☐Provides PCP with list of practice physicians who agree to compact principles. ☐Provides urgent appointment availability if necessary.

Additional Guidelines/edits:

Collaborative Care Management

Mutual Guideline

- Define responsibilities between PCP, specialist and patient.
- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, care plan, follow-up, etc.).
- Maintain competency and skills within scope of work and standard of care.
- Give and accept respectful feedback when expectations, guidelines or standard of care are not met.
- Agree on type of specialty care that best fits the patient's needs.

Expectations

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

Additional Guidelines/edits:

Patient Communication

Mutual Guideline

- Engage and utilize a secure electronic communications platform for high risk patients, i.e. a patient portal.
- Prepare the patient for transition of care.
- Patient/delegate shared decision making in care management, diagnostic testing and treatment plan.
- Provide to and obtain informed consent from patient according to community standards.
- Explores patient issues on quality of life in regards to their specific medical condition and shares this information with the care team.

Expectations

Primary Care	Specialty Care
☐Informs patient of the reason for care transfer and expectations. ☐Determines appropriate time frame for visit to specialist. ☐Provides specialist name and contact information. ☐Explains specialist results and treatment plan to patient, as necessary. ☐Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in their care team.	☐Informs patient of diagnosis, prognosis and follow-up recommendations. ☐Provides educational material and resources to patient. ☐Recommends appropriate follow-up with PCP. ☐Will be accountable to address patient phone calls/concerns regarding their management. ☐Participates with patient care team.

Additional Guidelines/edits:

PCP	Date	Date	Initial	Date	Initial
Specialist	Date	Date	Initial	Date	Initial

Longs Peak Family Practice Care Compact (two pages)

Care Compact Concepts	Primary Care	Specialty Care
Referral Process	**STEP 1 (at visit)** ☐ At visit, PCP discusses reason for referral to Specialist with patient/family ☐ If visit is urgent, PCP office will call Specialist office to notify of need for immediate appointment ☐ If urgent, referral is faxed prior to visit, with all pertinent information **STEP 2 (within 24-48 hours of visit)** ☐ Referral Coordinator verifies insurance ☐ Referral Coordinator contacts patient with Specialist name and phone number ☐ Labs, imaging, prior testing results, and other pertinent medical information will be included with referral form ☐ Referral coordinator faxes referral form and accompanying report documents ☐ Referred patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit is indicated	**STEP 1 (within 24 - 48 hours of visit)** ☐ If visit is urgent, Specialty office will schedule patient within 24 hours (or less) depending on urgency ☐ If not urgent, Specialty office receives fax and contacts patient to schedule visit ☐ Insurance eligibility/benefits are reviewed when appointment is scheduled **STEP 2 (within 72 hours of visit)** ☐ Complete consult report will be sent back to PC office within 72 business hours of appointment (labs, imaging, f/u recommendations, and other pertinent medical information) **STEP 3 (on-going management)** ☐ If patient does not schedule or is no-show, notification will be sent to PC office within 60 days.
Patient Access	**STEP 1 (within 24 hours of visit)** ☐ If visit is urgent, PC office will call Specialist office to notify of need for immediate appointment **STEP 2 (within 24-48 hours of visit)** ☐ Patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit indicated **STEP 3 (on-going management)** ☐ If patient does not schedule or is no-show, notification from Specialist office will be sent to PCP office within 60 days	**STEP 1 (during patient PCP visit)** ☐ If visit is urgent, PCP office will call Specialist office to notify of need for immediate appointment ☐ If PCP wants same day appt. and MD is unavailable, Mid-Level is acceptable **STEP 2 (within 24-48 hours of visit)** ☐ Referred patient will be scheduled within 2-3 weeks of call to Specialist office unless urgent visit **STEP 3 (at visit)** ☐ If patient needs to be seen for follow up visit – patient will schedule directly with Specialist office

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Transitions of Care	**STEP 1 (at visit)** ☐ Informs patient of need, purpose, expectations and goals of the specialty visit ☐ Patient/family in agreement with referral, type of referral and selection of Specialist ☐ Unless urgent, PC office provides patient with Specialist contact information and patient calls to schedule appointment **STEP 2 (within 24 hours of visit)** ☐ PC office documents appropriate orders on referral form that would facilitate the Specialty visit	**STEP 1 (at visit)** ☐ Reviews reason for visit with patient/family ☐ If patient needs to be seen in ED, arrangements will be made then Specialist office will notify PC office within 24 hours **STEP 2 (within 72 hours of visit)** ☐ Specialist office documents in consult recommendations for follow-up, if indicated
Patient Co-Management	**STEP 1 (within 48 hours of visit)** ☐ If ED/Hospitalization occurs that would affect Specialty care, PC office will notify Specialist office within 48 business hours **STEP 2 (On-going management)** ☐ Refills will be handled by Provider managing patient unless Specialist indicates variation on consult ☐ Resumes care of patient, outlined by Specialist, assumes responsibility and incorporates care plan recommendations into the overall care of patient ☐ Shares data/pertinent additional consultations from other care providers with Specialist	**STEP 1 (after visit)** ☐ If indicated, Specialist can refer to an additional Specialist without PCP consent unless indicated otherwise in referral **STEP 2 (within 48 hours of visit)** ☐ If ED/Hospitalization occurs that would affect PCP care, Specialist will notify PC office within 48 business hours **STEP 3 (On-going Management)** ☐ Refills will be handled by Provider managing patient unless variation indicated on consult ☐ Secondary/tertiary Specialty referrals will be documented in consult

_____
Primary Care Provider Signature / Date

_____
Specialist Signature / Date

_____
Practice Name

_____
Practice Name

Longs Peak Family Practice Communication Form

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LPFP REFERRAL COMMUNICATION TO KCA

Date of referral: _____

Patient Name: _____

DOB: _____

Parents Name(s) (for child referrals) _____

Phone # of patient

Referring Physician

- ☐ Susan Roach, MD
- ☐ Mary Faini, MD
- ☐ Chris Madden, MD
- ☐ Rebecca Meyers, MD
- ☐ Eric Traister, MD
- ☐ Other_____

Reason for referral

- ☐ ADD/ADHD
- ☐ Alcohol
- ☐ Anxiety
- ☐ Depression
- ☐ Drugs
- ☐ Family Conflicts
- ☐ Grief
- ☐ Lifestyle Change
- ☐ Marital
- ☐ Nicotine Cessation
- ☐ Other_____
- ☐ Parenting
- ☐ Psychological testing
- ☐ Stress
- ☐ Trauma

Insurance Coverage

- ☐ Aetna
- ☐ Anthem EAP
- ☐ Anthem
- ☐ Cigna
- ☐ Cofinity
- ☐ Great West
- ☐ Humana
- ☐ Magellan
- ☐ Medicaid
- ☐ Medicare
- ☐ MultiPlan
- ☐ Optum
- ☐ Other_____
- ☐ PHCS
- ☐ Self pay
- ☐ United Healthcare
- ☐ Value Options

Notes to KCA

Release attached Yes / No

KCA REFERRAL COMMUNICATION TO LPFP

Patient scheduled with:

- ☐ Amy Cheng, MA
- ☐ Heidi Ardern, PhD
- ☐ Jackie Philipps, LCSW
- ☐ Kate Ellard, LCSW
- ☐ Kathleen Lowe, LMFT
- ☐ Louis Krupnick, EdD
- ☐ Mary Beggs, PhD, LMFT
- ☐ Miles Meason, PsyD
- ☐ Rhonda Beaupre, LMFT
- ☐ Richard Jones, PhD
- ☐ Other_____

Unable to accommodate referral due to:

- ☐ Patient needed appointment hours/days that were unavailable
  - Needed evenings / weekends
  - _____
- ☐ Patient wanted appointment sooner than we had available
- ☐ Insurance issue_____
- ☐ Patient unable to work outside of insurance coverage
- ☐ Other_____

Provided patient with the following names of therapist(s) in the community:

Date of initial appointment:

☐ **Patient has not returned KCA call to schedule**

FOLLOW-UP COMMUNICATION FROM KCA

- ☐ Patient kept initial appointment / Consult report attached
- ☐ Patient rescheduled initial appointment to:_____
- ☐ Patient cancelled/missed initial appointment and has not rescheduled
- ☐ Other

Hinman Family Practice Care Compact

Mark W. Hinman, MD, LLC
1350 Tulip Street
Longmont, CO 80501

Care Compact for Primary Care and Specialty Care

A. Purpose
- To provide optimal health care for our patients.
- To provide a framework for highly effective collaboration between primary care and specialty care providers.

B. Principles
- High quality and timely patient care is our central goal
- Effective communication between primary care and specialty care is an essential component to providing optimal patient care.

C. Definitions
- Patient-Centered Medical Home-a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.
- Medical Neighborhood-a system of care that integrates the PCMH with the medical specialists in the community through enhanced, bidirectional communication and collaboration on behalf of the patient.

Expectations for Primary Care and Specialty Care	
Primary Care	**Specialty Care**
☐ Orders appropriate studies that would facilitate the specialty visit. ☐ Informs patient of need, purpose, expectations, and goals of the specialty visit. ☐ Communicates reason for referral and sends relevant information to specialist (laboratory results, scans, etc.). ☐ Schedules appointment with specialist for patient or provides patient with specialist contact information and expected timeframe for appointment. ☐ Follow up with patients who did not follow through with appointment to assist in problem solving. ☐ Resumes care of patient when patient returns from specialist care and acts on care plan developed by specialist,	☐ Have timely appointment availability within a reasonable timeframe to meet patient care needs. ☐ Orders appropriate diagnostic testing and treatment for patient, including the ordering of RX and refills while the patient is under direct specialist care. ☐ Informs patient of diagnosis, prognosis, and follow up recommendations. ☐ Provides appropriate educational materials and resources for patient/family ☐ Sends timely reports to PCP to include a care plan, follow up, recommendations, and results of diagnostic studies or therapeutic interventions. ☐ If a secondary referral is indicated, the specialist may arrange but will notify to secondary referral of the patient's PCP and "cc" the referral note to the PCP. Specialist obtains prior authorization, if required.

PCP _____ Date _____

Specialist _____ Date _____

References/Resources

Care Coordination Across the Medical Neighborhood, Ohio Learning Session, May 15, 2013 (51-page PDF)
This presentation highlights resources to help develop the best practices of primary care coordination, and to understand the challenges of care coordination from the consumer perspective. (Listed are the recording of the presentation and the presentation slides.)

Care Coordination Agreements: Barriers, Facilitators, and Lessons Learned. Carrier, Emily et al. American Journal of Managed Care. 2012; 18(11):e398-404
Semi-structured interviews with participating providers and national thought leaders in care coordination were reviewed to develop key themes to solutions for effective agreements. Findings include that Care Coordination agreements were most successful in settings where providers had established communications (person-to-person or electronically) as well as existing working relationships.

Chen, AH, Improving the Primary Care-Specialty Care Interface. **Arch Intern Med. 2009;169:1024-1025** Available at: http://archinte.jamanetwork.com/article.aspx?articleid=773522andresultClick=3

Chen, AH, Improving Primary Care–Specialty Care Communication: Lessons From San Francisco's Safety Net: Comment on "Referral and Consultation Communication Between Primary Care and Specialist Physicians" **Arch Intern Med. 2011; 171(1):65-67** Available at:
http://archinte.jamanetwork.com/article.aspx?articleid=226311andresultClick=3

Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms (45-page PDF)
Describes mechanisms of communication between PCP and other providers.

Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

High Value Care Coordination Toolkit
This online toolkit from the American College of Physicians provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors. Scroll through the page to find data sets, checklists, and tips on facilitating patient- and family-centered conversations about the referral process.

Kaiser Permanente: Care Coordination Resources and Training
Regional Health Education online portal from the Permanente Medical Group. Offers training for clinicians in several topics including care coordination, medication adherence and disease self-management. The site requires you to create an account.

Medical Neighborhood/PCMH in Colorado
This webpage describes how the Colorado Medical Society has partnered with primary care societies in Colorado to further the adoption of medical home models. Two examples of care compacts – a "101 basic" version and an expanded version – are posted here. Each specifies key areas of a mutual care management agreement like transitions of care, access, collaborative care management and patient communication.

Milestone 6-Smoothing Cross-Provider Care Coordination
This Oklahoma Regional Webinar held on May 2, 2014 presents a number of examples of care coordination, including the Work Flow from Utica Medical Clinic in Owasso, Oklahoma.

National Center for Medical Home Implementation
This website features care delivering management topics, including care coordination, care plans, and other resources and tools to enhance the management of care delivery.

NIH Components of Care Coordination
Table excerpted from the AHRQ Technical Review, "Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)" shows the components to care coordination and how NQF domains and principals apply.

The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices (35-page PDF)
This position paper from the American College of Physicians makes recommendations about the collaboration with specialty and subspecialty practices to achieve the goal of improved care integration and coordination with the PCMH model. The paper offers a set of principles for developing care coordination agreements between PCMH and "neighbor" practices.

Reducing Care Fragmentation (136-page PDF)
A toolkit for coordinating care from the Improving Chronic Care Organization. Includes a change package and tools as well as relevant case studies and resources.

Sample Compact Care Agreements
A range of sample physician-to-specialist agreement forms, including primary care to cardiology, gastroenterology, orthopedics and sub-acute services (for example, a skilled nursing facility).

Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011. (Link to article)