Secondary Driver 1.5: Coordination of Care Across the Medical Neighborhood

This secondary driver focuses on providing care coordination across the medical neighborhood. The purpose of care coordination is to facilitate smooth transitions of care through well-organized processes and workflows across various providers and organizations in the medical neighborhood.

Change Concepts for coordination of care across the medical neighborhood

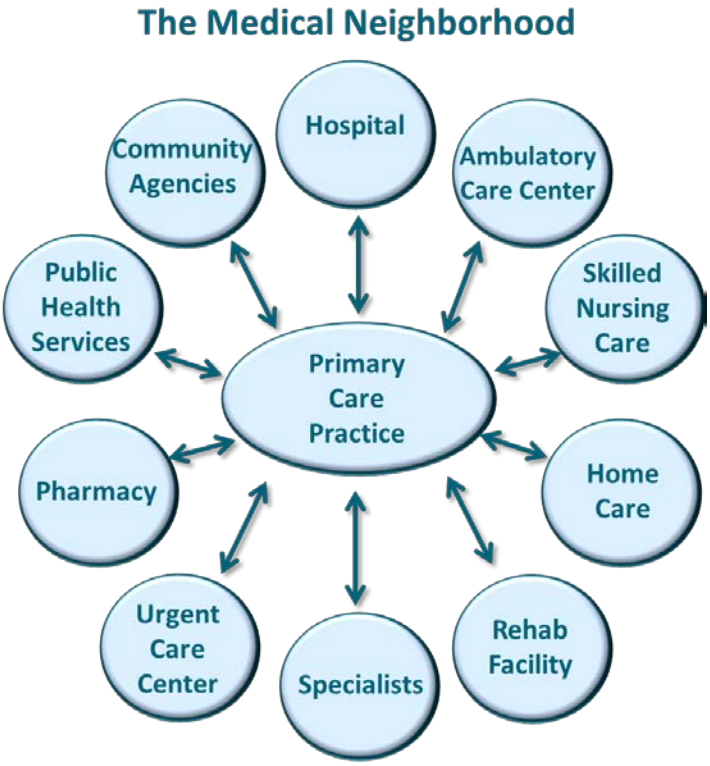
- Establish standard operations to manage transitions of care
- Establish effective care coordination and active referral management
- Ensure a bilateral exchange of necessary patient information to guide patient care
- Develop pathways to neighborhood/ community-based resources to support patient health goals
- Manage referral networks to meet behavioral health needs not available in the primary care practice

The phases of the work in CPC:

- Initially in CPC, practices focused much of their effort on managing the day-to-day needs of all the patients equally but later focused efforts on patients identified as highest risk according to their risk stratification system.
- Using tools and data they were developing as part of their CPC work, practices also began to identify sub-populations that may need specific resources or services.
- As practices identified populations, such as those with chronic conditions, they began to define aspects of optimal care and to develop programs to effectively plan and accomplish proactive care.
- Leveraging the entire team became an essential strategy to meet population health needs efficiently and effectively.

Care Coordination and the Medical Neighborhood

- Care Coordination integrates care among medical neighbors by closing gaps and ensuring seamless transitions.
- 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.



Change Concept: Establish standard operations to manage transitions of care

When a patient undergoes a transition in care there is a real danger of care fragmentation. Standard operations for care coordination make certain that all team members, ancillary providers, involved family members and the patients themselves are clear about what care is provided, by whom and when. When operations are well organized and consistent, it eliminates redundancy and duplication of services and keeps the member at the center of the care provided. A care transition is when total care of the patient transfers from one facility to another. The following are examples of care transitions:

- Hospital or emergency department (ED) discharge
- Urgent care to/from primary care
- Hospital to/from skilled care, extended care or rehab
- Skilled, extended or rehab care to/from home care

It is during these times of transition the communication between the primary care office and other providers of care decreases the opportunity for errors or adverse events to occur.

The authors of "Reducing Care Fragmentation," a publication from Improving Chronic Care state all referrals and transitions should meet the six aims of the Institute of Medicine (IOM).[1] Practices developing their care coordination programs will want to ensure they meet the following aims:

- Timely – Patients receive care from other facilities or specialists without unnecessary delays
- Safe – all referrals and transitions are managed in a manner that prevents harm to the patient
- Effective – All care is based on evidence-based knowledge and carried out in such a way that is most beneficial to the patient
- Patient-centered – the patient's needs and preferences are considered at all times
- Efficient – Restrict referrals and transitions to those that will most likely benefit patients and avoid duplication of services
- Equitable – Complete all referrals and transitions in a manner that does not vary based on personal characteristics of patients

Implementation tips for standard operations and transitions of care

- Establish leadership to support operations.
- Review data to understand frequency of transitions.
- Build an implementation team that will test changes and will be early adopters.
- Develop data-driven systematic monitoring and tracking.
- Define reliable operations and processes (identification and tracking of patients needing transition).
- Develop protocols for follow-up communication related to transitions of care.
- Develop documentation.
- Develop a communication plan and training for personnel.
- Assign responsible team members.
- Track consistency of progress and iterate as needed.

Change tactics CPC practices used:

- Partner with community or hospital-based transitional care services
- Transmit relevant medical information between facilities within the medical neighborhood

[1] Reducing Care Fragmentation. http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

Change Tactic: Partner with community or hospital-based transitional care services

Working within a medical neighborhood to transition patients between hospital-based care and community support services creates consistent pathways for communication between care facilities, reduces confusion over which medications should be used, and ensures discharge plans are followed up on and are consistent. Ultimately, this reduces complications and confusion for both providers and patients. Developing a partnership that defines the roles of both organizations standardizes the process, making it easier to identify and solve problems. This is a goal for all facilities, not just primary care.

CPC resources related to transitional care services

CPC Practice Spotlight 29: Care Compacts Can Work with Various Health Partners (2014). This small independent practice set up a meeting with local hospitals, home health agencies and extended care facilities to deal with gaps in transitions of care. Use of a collaboration agreement and bi-directional communication has benefited their patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=52

Essential components

- Identify community facilities used by your patient population. Include hospitals, urgent care centers, skilled nursing, extended care, behavioral health (BH) organizations and rehabilitation facilities.
- Meet with key staff from each facility's leadership, admissions and hospital ED. Include a member of their IT department if possible. These individuals will be instrumental in formatting the flow of communication between your practice and the facility.
- Develop a clear work stream with designated points of contact for the patient, caregivers and facility. This may include standardization of medication reconciliation, arranging an office visit if needed, etc.
- Settle upon a formal or informal collaboration agreement that identifies the roles of each facility.
- Include a communication plan with established timeframes for sending information.

Considerations for your practice

- Establish regular meetings between the primary care practice and those facilities identified as providers of care for your patients. Use these meetings to identify any issues and plan solutions.
- Develop relationships with specialists in neighboring communities to increase the patient options when selection of specialists may be limited locally, such as in small or rural communities.
- Develop a health IT solution to access documentation and medical records.

Online (external) resources for care coordination

Reducing Care Fragmentation: A Toolkit for Coordinating Care. Prepared by Group Health's MacColl Institute for Healthcare Innovation, supported by The Commonwealth Fund (2011). Includes a change package and tools as well as relevant case studies and resources. http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs, IHI Innovation Series white paper (2011). http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Change Tactic: Transmit relevant medical information between facilities within the medical neighborhood

Provide relevant patient information that will streamline care and avoid duplication or contradictory efforts such as lab results, x-ray, medications, discharge instructions and plans of care. CPC practices found this information vital to provide seamless, safe care to the patient during transitions as well as reduce any redundancies.

For CPC practices, timely communications and notifications among facilities in the medical neighborhood were essential for proactive care management. This allowed practices to provide timely follow-up for patients recently seen in the ED or admitted to the hospital, adjust risk stratification for patients as needed and provide episodic or longitudinal care management services as appropriate (see additional information on these types of care management in **Secondary Driver 1.3: Risk-stratified Care Management**).

CPC resources related to transitions of care

CPC On Demand Video: How to Enhance Transitions of Care (2017). In this video, you will explore the tools you can use to help in your effort to reduce unnecessary ED visits and hospital readmission rates. https://www.youtube.com/watch?v=BlnCROIysJQ&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=4

Essential components

- Work jointly to establish standard procedures for sending and receiving data among identified partner facilities. Target timeframes should be set and documented in a memorandum of understanding among the facilities.
  - Admission to hospital or ED – information received by PCP in 24 hours. If possible, patient summary available on HIE or sent to hospital within 24 hours of receipt of notice.
  - Discharge from hospital/ED – PCP notified in 24 hours
  - Transition from skilled care, extended care or rehab to another provider – PCP notified within 24 hours or, if orders are needed, in advance of the transition
- For identified patients, include direct access to medical reports
  - Automated reports of all admissions, discharges and transfers (ADT)
  - ED visits, with discharge instructions
  - Ability to view plans of care
- Develop a health IT solution for bi-directional flow of information between your practice and the facility. This could include problem lists and medication lists as well as other information.
- Document all contacts with patients and facilities in the medical record. This avoids duplication of efforts and enhances the communication between all team members who care for the patient.

Considerations for your practice

- Be aware that health IT solutions vary with available interface capabilities.
- Ensure that the facility can easily email or call with information if electronic access is not available.

Measuring Success for Change Concept: Establish standard operations to manage transitions of care

Process measures for coordination of care across a medical neighborhood:

- Percent of time practice received notice of admissions/discharges from the hospital or ED within 24 hours. Trend month to month.
- Percent of time practice received a transition of care notice from providers other than the hospital. Trend month to month.

Outcome measures for coordination of care across the medical neighborhood:

- Quality measures related to chronic health conditions such as a decrease in A1c
- Patient satisfaction survey results
- Partner organization satisfaction survey results
- Hospital readmission rate

When evaluating the effect this work has on the total cost of care, the following data is helpful:

- Risk-adjusted expenditures on inpatient services and ED
- Utilization measures, including inpatient hospital, ED, ambulatory-care sensitive condition (ACSC) admissions and readmissions

Change Concept: Establish effective care coordination and active referral management

In the traditional model when additional services or a specialist is needed, the physician will typically send the patient to different locations for other needed services, such as laboratory tests, x-rays, specialty consultations and medications. Many times, patients end up seeing many different specialists for a variety of issues with little or no coordination or communication about treatments. This failure to communicate frustrates patients, families and health care providers alike.

When patient referrals are completed in a timely manner, and are proactively tracked as they go to and from specialty care, effective care coordination and referral management results. Tracking makes certain that all team members, ancillary providers, involved family members and the patients themselves understand where, when and why they are getting a referral. Tracking ensures the referral is actually completed and results incorporated, thus closing the loop. The provider can then discuss and incorporate recommendations into the treatment.

Change tactics CPC practices have used:

- Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings
- Engage patients throughout the referral process
- Track patients referred to specialists through the entire process and include information into the plan of care

Implementation tips for effective care coordination and referral management

- Define leadership and team to develop and test changes.
- Identify the specialty providers most used by the patient population.
- Meet with high-volume specialists to develop a care coordination plan.
- Develop care compacts/agreements with specialists, defining responsibilities of each party.
- Train staff in engaging patients in decision making concerning referrals.
- Establish a process for the practice to track all referrals from beginning to end.
- Define the patient's role in the care coordination process with specialists.
- Establish a process to incorporate pertinent information from specialists into the patient plan of care.
- Test and iterate changes.

Change Tactic: Establish effective care coordination agreements with frequently used consultants

Care coordination agreements (care compacts) between primary care and specialty care are beneficial to both parties. These agreements should set provider expectations for how and when information flows between providers. The content and format of a care compact varies, yet the key elements are similar. They delineate the responsibilities of each party and the processes required to complete the referral cycle.

CPC practices sought care compacts with a range of specialties in their medical neighborhood, including BH specialists. They found most specialists were receptive to creating a referral process and standard for timely communication. When practices followed up with patients who abandoned referrals or checked in about their specialist visit, more patients began to understand that the primary care setting was the hub for their coordinated care.

Essential components

- Identify those specialists who receive referrals most often from your practice. Consider use of available payer data containing this information to identify the specialists.
- Arrange a conversation, preferably in person, with the specialist office.
- Develop the care compact/agreement with the practices chosen, outlining the responsibilities and actions of both parties. The following are common elements in care compacts:
  - Responsibilities of each party
  - Information to be exchanged
  - Workflow of the information exchange
  - Timelines for the entire process

CPC practice examples related to care coordination with specialists

CPC Practice Spotlight 46: Innovative Care Compacts Result in Timely Care, Continuity and Efficiency (2015). A solo practitioner in New York created a wrap-around care compact process that resulted in timely specialist consults and bi-directional communication. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=11

CPC On Demand Video: Building Relationships and Referral Processes with Specialists (2017). A practice manager explains how providers developed close working relationships with specialists in their medical neighborhood. https://www.youtube.com/watch?v=gJZjMUMrBYw&index=21&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Considerations for your practice

- Determine how to evaluate the care provided by selected specialists. If a specialty provider consistently has sub-optimal outcomes on patient satisfaction, health outcomes or communication responsibilities, consider how to discuss the issue and make a plan for improvement. If the situation does not improve, consider selecting a new specialist to work with.

Change Tactic:
Engage patients throughout the referral process

With fewer than 25 percent of patient referrals being completed, patients must be included in the decision making process.[2] Engaging the patient starts with understanding their needs. For instance, they may lack transportation, cannot pay the co-pay or may not even understand the significance of the referral. By finding out what they are actually willing to do, priorities can be identified, problem solving can happen and patients can participate in their care. Not only does this save time and reduce wasted resources in the long run, it further demonstrates patient-centered care.

Online (external) resources for referral management

Always Use Teach-back! Training Toolkit. This training tool will assist the practice staff in learning this valuable technique. http://www.teachbacktraining.org/

The creation of a referral often means that the patient is experiencing intensified symptoms or a change in diagnosis. The provider/team has an opportunity to discuss options and set expectations for the steps of the referral. This supports the notion of shared responsibility for outcomes between the patient and provider/team. When the patient is engaged, the likelihood of the referral being scheduled increases and referral cancellations decrease.[3]

Essential components

- Explain the reason for the referral to the patient and the patient's caregivers using easily understood language. One tool to use to assess patient understanding is the "teach-back'' technique (see the inset above).
- Involve patients in the selection of the specialty provider.
- Encourage patients to ask any questions related to the referral to enhance their understanding and comfort with the care suggested.
- Discuss arranging the appointment. Will the PCP office make the appointment? Does the patient need to call the specialist office?
- Discuss any potential barriers that may affect the patient's follow-through with the specialist appointment. These may include financial problems, insurance coverage, transportation and other barriers the patient may present. Discuss solutions to any barrier presented.
- Explain the patient's responsibilities related to the referral. This may include any tests to be completed before the appointment, taking test results with them to the appointment, arranging someone to accompany them to the appointment, etc.
- Provide the patient with a written document outlining all of the information discussed. This document becomes a reference for the patient. Include the phone number of the PCP office with an invitation to call should they have any questions.

Considerations for your practice

- Understand the patient's insurance benefits. If you send three referrals and the co-pay is $50 for each one, you may need to prioritize the referrals for the patient.
- Include any extenuating preferences. Does the patient have an end-of-life plan that identifies his or her wishes related to specialty care?
- Keep in mind that communication with a patient related to referrals to specialty care may occur when the patient is under stress, and he or she may therefore not be able to absorb all the information provided.

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[2] Barnett M, Sirui S, Landon B. Trends in Physician Referrals in the United States. Arch Intern Med. 2012; 172(2):163-170. doi:10.1001/archinternmed.2011.722

[3] Coulter A, Collins A. Making shared decision-making a reality: no decision about me, without me. http://www.kingsfund.org.uk/sites/files/kf/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf (accessed 07 Nov 2014).

Change Tactic: Track patients referred to specialist through the entire process and include information into the plan of care

Tracking patient referrals through the entire process ensures accuracy and timely follow-through that leads to safe and effective care.[4] When a referral is made, there is often some form of action required such as follow-up on recommendations, reviewing and communicating test results, further testing or consultation with the specialist. Adverse outcomes, including delayed or even completely missed diagnosis and treatment can result from not having the system in place.

A systematic and reliable tracking system need not be complex but must be able to identify gaps and close the referral loop. In the past, practices may have used a clipboard and paper or a spreadsheet. CPC practices used the EHR to complete the process. This allowed not only tracking the referral, but also obtaining data on length of time between referral and receipt of the outcome, as well as other data useful to improvement of care coordination processes.

Essential components

- Establish the tracking policies and procedures
  - Who will schedule different types of referrals (patient or clinic)
  - How to contact the patient
  - How to document and track each step
  - Time frames for expected results and follow up
  - Managing missed appointments
  - Including results in the EHR
- The tracking system should be able to track specific dates and times and be able to remind staff when an action is overdue.
- Choose a specific person to be responsible for the logistics and management with the entire team having access to the information. However, consider cross-training staff to ensure backup.
- Discuss the outcome of all referrals with the patient.
  - Determine patient attendance at referral appointment. Troubleshoot incomplete referrals: reasons, solutions.
  - Make note of patient satisfaction with the referral provider and intentions for follow-through.
  - Identify patient preference for treatment suggestions resulting from the consultation.
- Document the actionable care identified in the consultation report on the plan of care. Review the total plan of care with patients and seek their agreement with the plan.

CPC resources related to care compacts and referral management

CPC Practice Spotlight 19: Forming Successful Care Compacts with a High-Volume Specialist and a Behavioral Health Provider (2014). This small independent practice initiated care compacts to address the needs of their patient population and established a referral tracking process. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=41

CPC Practice Spotlight 41: Following Data Over the Long Term Aids in Maintaining Improvement (2015). This Oregon practice developed a workflow to track referrals and the resultant testing, including tags in its EHR. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=6

Online (external) resources for referral management

Referral Tracking Guide (2008). Published by Improving Chronic Care, with permission from the American College of Physicians as a portion of its Reducing Care Fragmentation toolkit. http://www.improvingchroniccare.org/downloads/3_referral_tracking_guide.pdf

Referral Coordinator Curriculum (2011). Published by MacColl Institute for Healthcare Innovation as a portion of its Reducing Care Fragmentation Toolkit. http://www.improvingchroniccare.org/downloads/5_referral_coordinator_curriculum.pdf

[4] Institute of Medicine. Health IT and patient safety: building safer systems for better care. Washington, DC: National Academies Press; 2012.

Considerations for your practice

- The referral tracking system should include access to the insurance plan, ICD-10, lab results from the EMR, and sent and received documents.
- Use information about the patient's insurance plan to match specialist recommendations with in-network providers.
- Remember HIPPA compliance when contacting patients.
- Generate referral utilization data to identify patterns of use and panel information.
- Generate reports by physician listing referred specialty, patient name and diagnosis.
- Include referrals as part of the patient history to provide a more accurate record of treatment.
- Use data collected that may be useful in renegotiating payer contracts.
- Make a follow-up call to the patient the day after the consultant appointment date to gather actionable data such as whether the patient attended and what the patient understands was the outcome of the visit.

Measuring Success for Change Concept: Establish effective care coordination and referral management

Process measures for effective care coordination and referral management

- **For care compacts in the medical neighborhood**
  - Time from referral to visit date with specialist.
  - Time from specialist visit to receipt of consultation report.
  - Time from subsequent appointment with same specialist to receipt of report.
  - Patient satisfaction with specialist visit

- **For referral tracking**
  - Percentage of referrals ordered (total)
  - Percentage of referrals scheduled (total)
  - Percentage of referrals scheduled by patient versus clinic
  - Percentage of referrals scheduled by specialist and community organization (name and type)
  - Percentage of referral appointments attended
  - Percentage of referral reports received from provider or community organization
  - Percentage of referral information scanned into chart and entered into discrete fields in the EHR

Outcome measures for effective care coordination and referral tracking

- Patient satisfaction
- Provider satisfaction
- Decrease gaps in care
- Preventive care measures
- Timeliness and accuracy of diagnosis and treatment

Change Concept: Ensure a bilateral exchange of necessary patient information to guide patient care

Patient information means different things to different practices, but essentially ensures that providers have access to the treatment information about their patients — even when they do not have access to an EHR. Readily exchanging information has been more recently motivated by Stage 2 Meaningful Use. This requires at least 10 percent of patients transferred between hospitals and physicians to have an electronic summary. For safety and comprehensive care coordination, the type of information exchanged should include clinical, financial and administrative.

There are three elements to bilateral information exchange:

- Direct information exchange between hospitals, specialists and primary care providers
- Query-based exchange where a provider can request relevant information about the patient's treatment
- Patient-facing information exchange through which patients can access their own record and share with providers themselves

Information can be exchanged with the use of health IT to ensure timely communication. HIPAA-compliant instant (text) messaging and email is also an option.

Some health systems use patient portals to ensure patients have access to their records, while others are building their own electronic health information exchanges (HIEs), while still others use statewide health information exchanges. Several are even pursuing multiple approaches.

Change tactics CPC practices have used:

- Participate in an HIE if available
- Use structured referral notes

Implementation tips for bilateral exchange of information

- Identify leadership to guide process.
- Determine a team to implement the improvement.
- Determine gaps in information exchange.
- Prioritize practice information needs.
- Work with your EHR vendor to verify your EHR is capable of connecting to the HIE, and assisting with set up.
- If available, connect to an HIE that would best meet the needs of the practice patient population.
- Consider building an HIE if one is not available, potentially in partnership with others.
- Develop practice workflows to manage the information from the HIE.
- Develop structured referral notes to enhance the communication between the practice and its medical neighborhood partners.

Change Tactic: Participate in an HIE if available

According to the Office of the National Coordinator for Health Information Technology (ONC), the definition of a HIE is a mechanism that "allows doctors, nurses. . . and patients to appropriately access and securely share a patient's vital medical information electronically; improving the speed, quality, safety, and cost of patient care."[5] An HIE captures health care information electronically across a state or region that includes hospitals and community systems. It provides the capability to access and move clinical data between health systems to provide safer, more efficient care. Efficient care is foundational to well-organized care coordination.

In addition to providing streamlined, coordinated care, leveraging an HIE reduces manual printing, scanning and faxing of documents. It reduces the physical mailing of records. Most importantly, it allows teams to quickly identify gaps in information and increase their ability to reduce duplicity in patient testing.

Essential components

- Research available HIEs. The federal HIE site has a link to identify what is available in your state, with contact information to obtain more information. An HIE may be state-operated or a private exchange system. There are also EHR vendor solutions.
- Verify that your EHR has HIE capabilities.
- Organize a defined set of documents with procedures for use. These are the most common documents:
  - Patient Medical Summary
  - Hospital Discharge Summary
  - History and Physical
  - Lab Results Report
  - ED Physician Note
- Evaluate the information exchange regularly. Verify the validity of data received, as well as that of information provided to the exchange.

Considerations for your practice

- Practices may choose to build their own HIE, or join with a group of providers to build this system. Be mindful that joining an HIE may be less costly than building one.
- The document types should conform to the Clinical Document Architecture to support Meaningful Use.
- The technology involved is sometimes complicated and will require access to IT-savvy individuals for both the practice EHR and the HIE. System practices will require system-affiliated IT staff.
- Include the use of an HIE as you consider medical neighborhood partners. This will ensure timely and accurate exchange of information between PCPs and their partners.

CPC resources related to bilateral information exchange

CPC On Demand Video: How to Enhance Transitions of Care (2017).Explore tools you can use to reduce unnecessary ED visits and hospital readmission rates, including an HIE. https://www.youtube.com/watch?v=BlnCROIysJQ&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=4

CPC On Demand Video: Using the Health Information Exchange to Improve Communication and Coordination Across the Medical Neighborhood (2017). A practice describes using HISP to share information across the medical neighborhood, which helps guide care and patient transitions. https://www.youtube.com/watch?v=xa1x3Oy8Amg&index=22&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Practice Spotlight 30: Full HIE Access Facilitates Real-Time Care Management (2014). A system-affiliated practice worked with the local HIE and hospitals to access information needed to provide care for transitions and reduce readmissions. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=53

Online (external) resources for health information exchanges

Health Information Exchange (HIE) (2014). https://www.healthit.gov/HIE

High Value Care Coordination Toolkit (2016). Scroll to "Model Specialty Out-Patient Referral Request and Response Checklists" for structured forms example. https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

[5] https://www.healthit.gov/

Change Tactic: Use structured referral notes

The use of structured referral notes standardizes the communication between medical neighborhood partners. Use these forms for communication between the PCP and specialists, hospitals and other partners. Structured referral notes are not limited to sharing information with specialists. The goal in using them is to enhance the information available to all parties, resulting in the highest quality care given to the patient.

Essential components

- Create forms to provide information to the respective parties. An example of such forms is in the High Value Care Coordination Toolkit published by the American College of Physicians.[6]
- Basic elements of a referral form:
  - Detailed information about the problem
  - Clinical questions to be answered
  - Details about patient's capacity or functioning
  - Other medical problems
  - Treatments already tried
  - Relevant lab results
  - Medications
- Basic elements supplied by the consulting provider:
  - Diagnostic considerations
  - Specific answers to specific questions
  - Detailed outline of pros and cons of recommended treatments and outline of other potential treatment options
  - Medication plan if applicable
  - Detailed comments on possible effect on quality of life and functionality
  - Prognosis
  - Recommendations for follow-up

Considerations for your practice

- Consider the needs of both parties involved when creating structured notes. Is the PCP providing valuable information to this partner? What does the PCP want to receive from the partner that will improve the care of the patient?
- Include use of structured referral notes in your care agreement with specialists and other partners.

[6] High Value Care Coordination (HVCC) Toolkit (2016). Model Specialty Out-patient Referral Request and Response Checklists. https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

Measuring Success for Change Concept: Ensure a bilateral exchange of information to guide patient care

Process measures

- Determine percentage of completed/missing provider report data fields
- Count of inaccurate provider report data fields
- Time between patient diagnosis and treatment
- Examine office workflows. What is the cycle time from receipt of information to action taken? How has the HIE or structured notes decreased this cycle time?

Outcome measures

- Number of phone calls related to referrals since implementation of Health Information Exchange and structured referral notes.
- Number of faxes received after implementation of HIE.
- Employee satisfaction level via survey
- Referral provider satisfaction
- Evaluate the effect on total cost of care
  - Reduction in duplicate testing by specialists, hospitals, other facilities OR by the PCP office when testing is noted to have been completed by a partner
  - Reduction in utilization – hospitalizations, readmissions, ED/urgent care visits
  - Patient satisfaction level. Use CAHPS or other patient survey tool to evaluate the following:
    - Satisfaction with the flow of information
    - Satisfaction with how referral management has affected their care.

Change Concept: Develop pathways to neighborhood/ community-based resources to support patient health goals

Developing pathways to community-based resources that will meet social needs can improve patient's management of chronic health conditions. Community organizations are excellent resources for group support, self-management support, health condition education, prescription help as well as employment and housing resources, financial assistance, elder care and other valuable services. Building a relationship with community-based resources will help the practice as it works with patients to meet their health care goals and addresses issues that may prove to be barriers to their success.

These are benefits of developing pathways:

- Coordinating health care, public health and community-based resources promotes healthy behavior
- The primary care team can fill gaps in needed services
- The primary care team can offer access to services that support patients in making positive lifestyle changes

The types of pathways that practices can create include setting up services, coordinating between several different services and receiving follow up information.

Change tactics CPC practices have used:

- Maintain formal (referral) links to community-based wellness resources with the potential for bi-directional flow of information
- Provide a guide to available community resources

Implementation tips to develop pathways to community-based resources

- Identify leadership to guide process.
- Determine a team to implement the improvement.
- Assess frequent social needs of patients in the population or community.
- Identify local community resources to meet needs (housing, food, employment, etc.).
- Meet with potential community partners.
- Develop a workflow for referral and follow up.
- Develop method to communicate available resources to patients. Could include portal or information available in office.
- Schedule periodic meeting to review coordination effort.
- Develop evaluation method for use of community resources.

Online (external) resources for community-based resources

HealthLeads (2016). Resource for screening for social determinants of health; discusses locating pertinent community resources for the patient population. https://healthleadsusa.org/

United Way 2-1-1 Community Resources Directory (2016). Easily locate resources in your community. http://www.referweb.net/211CommunityResources/

Administration on Aging (2016). Locate resources in your community. https://aoa.acl.gov/

Change Tactic: Maintain formal (referral) links to community-based wellness resources with the potential for bi-directional flow of information

Collaborating with community-based wellness resources provides patients and practices with various options to support patients with lifestyle changes. Common examples include chronic disease self-management support programs, exercise classes or facilities, weight loss programs, nutrition classes and other wellness programs. For some, just providing the contact information is enough while others may be better suited for a formal partnership to streamline the referral process. (See the next change tactic in this section on page 18 for suggestions on locating wellness resources in your community.)

Essential components

- Identify community resources that would most benefit your patient population. Find these online or through a central community knowledgebase.
- Contact organizations to get information of referral procedure.
- Provide information to staff and establish basic procedures.
- Keep information in an easy to access location.

Considerations for your practice

- Be aware that most community resources are not formal health care providers and are therefore unable to receive PHI from the practice.
- Locate a community calendar or newsletter with events to display in the office for both staff and patients.
- Become familiar with organizations that may have pamphlets to share with patients.
- Consider a formal method to exchange information. Keep in mind that permission is required to share patient information. Yet there may be an opportunity to develop a relationship that allows sharing of basic information with patient permission. An example is allowing the patient to enroll in a self-management support class through the PCP office. The information is then sent to the community partner.
- Hold or attend gatherings for community resources and primary care to develop relationships and gain an understanding about services available in the community, as well as common needs of primary care. One example is a community fair for physician offices with community services displaying their services and answering questions.

CPC resources related to community resources

CPC Practice Spotlight 20: Focused Care Management and Coordination Reduced Emergency Room Visits for Patient (2014). This practice dealt with managing a complex patient by coordinating care with home health agencies and other community resources, yielding a reduction in ED visits. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=42

CPC Practice Spotlight 28: It Takes a Neighborhood to Increase Medication Safety for Patients (2014). This practice established informal care compacts with two local pharmacies. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=51

CPC Practice Spotlight 78: Manage Care Coordination with Teamwork, Persistence and Technological Support (2016). This practice scours the community for resources for patients, in addition to reaching an agreement with local hospitals to allow access to patient EHR portals to monitor transitions in care for its patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=38

CPC On Demand Video: Building Relationships with Community Resources to Meet Patient Needs (2017). This practice describes how finding and connecting patients to community resources supported its patients' health. https://www.youtube.com/watch?v=JzknAjzakSM&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=9

CPC On Demand Video: Self-management Support for Patients with Chronic Conditions (2017). A practice shares how it established effective goal setting for patients with chronic conditions. https://www.youtube.com/watch?v=aEwPg-unkhY&index=12&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Change Tactic: Provide a guide to available community resources

To effectively provide community resources, staff must have access to an up-to-date, readily available guide with all the resources categorized. Categories for common resources include:

- Self-management support classes or support groups
- Financial, housing or transportation assistance
- Employment assistance
- Prescription drug assistance
- Food pantry
- Senior citizen support services

Since social service agencies and organizations often change, regularly checking websites and contact information will be important. The guide can be part of the EHR (patient portal), on a shared drive or as a booklet to distribute.

Online (external) resources for community resource measures

Primary Care Team Guide: Clinic-Community Connections (2016). This learning module will help guide the primary care team with these important connections. http://www.improvingprimarycare.org/work/clinic-community-connections

United Way 211 Community Resource Directory (2017). This site allows you to enter your Zip code to locate resources in your community. http://www.referweb.net/211CommunityResources/

Some CPC practices found that other agencies or entities in their community had created and maintained similar guides for their clientele. Before starting a guide from scratch, practices should inquire around their communities to see if such a resource already exists. Try the local agency on aging, Meals on Wheels, United Way or other nonprofits providing support services in your community.

Essential components

- Supply identified resources listed by category.
- Provide easy access to both patients and providers/teams.
- Determine the person responsible for updating information.
- Update information every six months (contact information, services and hours).
- Make sure to document referrals to community resources in the EHR. Use discrete fields. This supports the ability to evaluate the number of referrals to community resources and patient follow-through. Building a field to document the patient's experience provides even more in-depth information to perform an analysis later.
- Follow up with patients to note their satisfaction with the resource and the encounter's outcome.

Online (external) resources for social determinants of health

Social Determinants of Health: Know What Affects Health (2016). This resource from CDC provides links and education about this topic. https://www.cdc.gov/socialdeterminants/

Healthy People 2020: Social Determinants of Health (2016). https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Considerations for your practice

- Patients are sometimes hesitant to ask for help. Completing a social determinants of health survey may be beneficial in identifying unmet needs. The CDC website provides a deeper understanding of social determinants of health.[7]
- Keep the guide at the front desk, with the care managers and with the clinical staff. This allows discussion of options at all points of contact with the office.
- Resources are an extension of your practice when you refer them. Keep organizations in the guide that have a good reputation and have been beneficial.

[7] Social Determinants of Health: Know What Affects Health (2016). https://www.cdc.gov/socialdeterminants/

Measuring for Success: Develop pathways to neighborhood/ community-based resources to support patient health goals

Process measures

- Number of referrals the practice made to community resources
- Number of referrals completed

Outcome measures

- Construct patient surveys using a Likert scale for evaluative items. Use scores to evaluate patient experience with the resource
- Chronic disease management indicators (CQMs) such as weight loss, A1c, blood pressure, etc.

Online (external) resources for community resource measures

Clinical-Community Relationships Measures Database (2016). This database may help the practice to identify measures to evaluate its relationships with community-based resources. http://primarycaremeasures.ahrq.gov/clinical-community

Change Concept: Manage referral networks to meet behavioral health needs not available in the practice

One of the most challenging resource needs in most states includes BH services for the patient population. These challenges vary. For example, in rural settings the resources may not be readily available. In all settings there may be long wait times to get an initial appointment or continued care. Mental health issues as well as substance abuse, dementia and other behavioral concerns often require referrals to specialists. One solution can be to develop collaboration agreements with existing community services, whether in the form of a care compact or other formal referral relationship to address patient's BH needs.

Change tactics CPC practices have used:

- Develop formal referral relationships with mental health and substance abuse services in the community

Implementation tips for managing referral networks for behavioral health

- Identify sources of BH care in your community and neighboring communities.
- Arrange to visit these sites.
- Construct a working agreement with each site.
- Arrange for information sharing methods, following federal and state regulations.
- Determine who will coordinate care.
- Determine how behavioral and SA treatment goals can be included in the plan of care.

Change Tactic: Develop formal referral relationships with mental health and substance abuse services in the community

Formal referral relationships with providers of mental health and substance abuse services offer primary care a range of benefits, including the possibility of shortening the wait time for appointments and enhancing the quality of the care provided to patients.

CPC practices sought out a range of providers in their communities for these formal relationships. The care compact agreements frequently mirrored those established with other specialty groups.

Essential components

- Identify sources of BH care in your community and neighboring communities. Patients may prefer to go outside of their local community for mental health or substance abuse care. There may also be providers who specialize in a particular issue. An example is substance abuse treatment.
- Arrange to visit these sites. Discuss how they could work with your practice to meet the BH needs of the patient population.
- Construct a working agreement with each site. Include how to handle communication (referral and consultation notes) and how to share information between the two providers that would most benefit the patient, considering any regulations about this activity in your state. SAMHSA-HRSA Center for Integrated Health Solutions published a paper that describes some of the regulations related to sharing of BH information that may be useful to review.[8]
- Develop a method to survey patients about their experience with these providers as a means of evaluating your referral choices. It is one thing to identify potential BH providers, but it is more important that they are providers that patients want to use and who positively affect their health outcomes.

Considerations for your practice

- Although detailed psychotherapy notes are not necessary, obtaining information from the BH provider that may help with the patient's physical health care is important. (Secure any necessary patient authorization to share this information before the first appointment.) These items may include the following:
  - Confirmation the patient is attending appointments
  - Diagnosis
  - Treatment plan
  - Medications suggested or prescribed
  - Results of clinical tests performed

CPC resources related to behavioral health

CPC Practice Spotlight 19: Forming Successful Care Compacts with a High-Volume Specialist and a Behavioral Health Provider (2014). This small independent practice initiated care compacts to address the needs of its patient population. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=41

CPC On Demand Video: Creating Effective Care Compacts with Behavioral Health Specialists (2017). A practice describes how it successfully manages referrals to BH specialists. The specialists, in turn, inform the providers about the patient's course of therapy. https://www.youtube.com/watch?v=WB_MlNQbG6Y&index=23&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Online (external) resources for sharing behavioral health information

The Current State of Sharing Behavioral Health Information in Health Information Exchanges, SAMHSA-HRSA Center for Integrated Health Solutions (2014). This paper provides insight into some of the regulations in place for sharing BH information. http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf.

[8] The Current State of Sharing Behavioral Health Information in Health Information Exchanges (2014). SAMHSA-HRSA Center for Integrated Health Solutions. http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf

Measuring Success for Change Concept: Manage referral networks to meet behavioral health needs not available in the practice

Process measures

- Number of referrals for BH in the past month, quarter or year
- Number of referrals resulting in feedback from BH provider

Outcome measures

- Patient experience data — This data is helpful for practice improvement efforts. Patients see the BH provider as an extension of the practice. Knowing the patient's perception of the provider and the benefit received will assist in making the decision to continue to refer to that provider.
- Decrease in PHQ score or other screening tools

Resources for Secondary Driver 1.5: Coordination or Care

Administration on Aging: Administration for Community Living (2016). Locate resources in your community. https://aoa.acl.gov/

Always Use Teach-back! Training Toolkit. This training tool will assist the practice staff to learn this valuable technique. http://www.teachbacktraining.org/

Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs, IHI Innovation Series white paper (2011). http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Clinical-Community Relationships Measures Database (2016). This measures database may help the practice to identify measures to evaluate their relationships with community-based resources. https://primarycaremeasures.ahrq.gov/clinical-community

CPC On Demand Video: Building Relationships and Referral Processes with Specialist in Your Medical Neighborhood (2017). A practice manager explains how providers developed close working relationships with specialists in their medical neighborhood. https://www.youtube.com/watch?v=gJZjMUMrBYw&index=21&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Building Relationships with Community Resources to Meet Patient Needs (2017). This practice describes how finding and connecting patients to community resources supported their patients' health. https://www.youtube.com/watch?v=JzknAjzakSM&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=9

CPC On Demand Video: Creating Effective Care Compacts with Behavioral Health Specialists (2017). In this video, one practice describes how it successfully manages referrals to behavioral health specialists. The specialists, in turn, inform the providers about the patient's course of therapy. https://www.youtube.com/watch?v=WB_MlNQbG6Y&index=23&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: How to Enhance Transitions of Care (2017). In this video, you will explore the tools you can use to help in your effort to reduce unnecessary emergency department visits and hospital readmission rates. https://www.youtube.com/watch?v=BlnCROIysJQ&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=4

CPC On Demand Video: Self-management Support for Patients with Chronic Conditions (2017). One practice shares how they established effective goal setting for patients with chronic conditions. Includes resources for SMS in the community. https://www.youtube.com/watch?v=aEwPg-unkhY&index=12&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Using the Health Information Exchange to Improve Communication and Coordination Across the Medical Neighborhood (2017). A practice describes using HISP to share information across the medical neighborhood, which helps guide care and patient transitions. https://www.youtube.com/watch?v=xa1x3Oy8Amg&index=22&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Practice Spotlight 19: Forming Successful Care Compacts with a High-Volume Specialist and a Behavioral Health Provider (2014). This small independent practice initiated care compacts to address the needs of their patient population. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=41

CPC Practice Spotlight 20: Focused Care Management and Coordination Reduced Emergency Room Visits for Patient (2014). This practice dealt with managing a complex patient with multiple needs by coordinating care with home health agencies and other community resources, yielding a reduction in emergency room visits. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=42

CPC Practice Spotlight 28: It Takes a Neighborhood to Increase Medication Safety for Patients (2014). This solo-provider independent practice established informal care compacts with two local pharmacies to help their patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=51

CPC Practice Spotlight 29: Care Compacts Can Work with Various Health Partners (2014). This small independent practice set up a meeting with local hospitals, home health agencies and extended care facilities to deal with gaps in transitions of care. Use of a collaboration agreement and bi-directional communication has benefited their patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=52

Resources

CPC Practice Spotlight 30: Full HIE Access Facilitates Real-Time Care Management (2014). The system-affiliated practice worked with their HIE as well as hospitals to establish the ability to get information needed to provide care for transitions, as well as a working relationship to help patients with their transitions of care to reduce readmissions. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=53

CPC Practice Spotlight 41: Following Data Over the Long Term Aids in Maintaining Improvement (2015). This Oregon practice developed a workflow to track referrals and the resultant testing, including tags in their EHR. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=6

CPC Practice Spotlight 46: Innovative Care Compacts Result in Timely Care, Continuity and Efficiency (2015). A solo practitioner in New York created a wrap-around care compact process that resulted in timely specialist consults and bi-directional communication. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=11

CPC Practice Spotlight 78: Manage Care Coordination with Teamwork, Persistence and Technological Support (2016). This practice scours the community for resources for patients, in addition to reaching an agreement with local hospitals to allow access to patient EHR portals to monitor transitions in care for their patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=38

The Current State of Sharing Behavioral Health Information in Health Information Exchanges (2014). SAMHSA-HRSA Center for Integrated Health Solutions. This paper provides insight into some of the regulations in place for sharing behavioral health information. http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf

Health Information Exchange (HIE) (2014). https://www.healthit.gov/HIE

HealthLeads (2016). Resource for screening for social determinants of health; discusses locating pertinent community resources for the patient population. https://healthleadsusa.org/

Healthy People 2020: Social Determinants of Health (2016). https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

High Value Care Coordination Toolkit (2016). 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. https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

Primary Care Team Guide: Clinic-Community Connections (2016). This learning module will help guide the primary care team with these important connections. http://www.improvingprimarycare.org/work/clinic-community-connections

Reducing Care Fragmentation. Prepared by Group Health's MacColl Institute for Healthcare Innovation, supported by The Commonwealth Fund (2011). Includes a change package and tools as well as relevant case studies and resources. http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

Referral Coordinator Curriculum (2011). Published by Group Health's MacColl Institute for Healthcare Innovation as a portion of their Reducing Care Fragmentation Toolkit. http://www.improvingchroniccare.org/downloads/5_referral_coordinator_curriculum.pdf

Referral Tracking Guide (2008). Published by Improving Chronic Care, with permission from the American College of Physicians as a portion of their Reducing Care Fragmentation toolkit. http://www.improvingchroniccare.org/downloads/3_referral_tracking_guide.pdf

Social Determinants of Health: Know What Affects Health (2016). This resource from CDC provides links and education about this topic. https://www.cdc.gov/socialdeterminants/

United Way 2-1-1 Community Resources Directory (2016). Easily locate resources in your community. http://www.referweb.net/211CommunityResources/