Milestone 6 Action Group: Use of Care Compacts

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Moderator: Rose Langdon, TMF Health Quality Institute

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Hello, everyone. Welcome to our first session of Use of Care Compacts to Coordinate Care Across the Medical Neighborhood. I am Rose Langdon, and I'll be your facilitator for this session. As a reminder, any statements regarding their technology, products, or vendors are expressions and opinions of the person speaking and not an opinion of nor endorsement by the Center for Medicare & Medicaid Innovations, nor TMF Health Quality Institute, nor the host of the program. We look forward to your participation during today's session. We'd like to know where each of you are located across our seven regions. To do this, please click the arrow to the left side of your screen and then indicate on this map your current location by clicking on that location. We've got people from all the areas. Wonderful! Thank you, very much. And now to avoid accidental annotation during the presentation, please click your arrow again. Remember that this is your Action Group. We will be as interactive as possible during these sessions, and we'd like you to actively engage using the chat feature and the Q and A feature. If you could do me a favor and chat right now what question would you like answered about care compacts in this action group? In addition to activity during this session, we encourage you to use the forum between sessions to continue the conversation among group participants. And now I'd like to introduce to you the facilitator for today's session, Marilee Aust with HealthTeamWorks. Marilee, you have the ball.

Great. Good morning, everyone. And I believe I have the ball now. So, good morning. This is Marilee Aust. I'm with HealthTeamWorks. I'm a quality improvement coach out here in Lakewood, Colorado. I did see on the map there, it looked like a lot of people were ringing in from Colorado. But there were also a lot on both coasts, including. I did see someone, I believe, by the name of Mary Provost who it looked like she was in Bermuda. But then she moved herself out to the Northeast. So I thought that was neat. Anyway, good morning. As you know, today is the first in a series of four Action Groups dedicated to Milestone 6 and, specifically, to care compacts. So as we get started here, we're going to have two different speakers joining us here in just a couple of moments to talk about their own experiences in using care compacts inside their own medical group. But to kick things off, we want to see how many of you have implemented a care compact in your practice. So have you selected the care compacts as one of your Milestone 6 selections? To do this exactly you guys still using that upper left-hand arrow to click on where you're at right now. Looking good, this is looking great, folks. Thank you. It looks like we're about, oh, half and half so far on folks clicking in on the poll here for whether or not you have selected care compacts as one of your Milestone 6 selections. And then it looks like you people are still ringing in, great. Well, we're going to learn a lot more about what care compacts can look like inside your practice today. And as we move forward, you know, it is a part of the care coordination piece of Milestone 6 and

how care is coordinated across all elements of the industry. So let's see, we'll move forward to the next one. It looked like it was about half and half. Maybe, do you think it was a little bit more than that, perhaps, on the no side of that. So as we talk, now we're looking for a chat. Which specialist or groups have you implemented a care compact with? You're going to choose the chat button in the upper right-hand corner. There's a little balloon there, and there's a little black button. And you want to click on that to implement your chat function. And then you can input in there. So care compacts can be, oh, implemented with all kinds of different specialists or groups, hospitals, the emergency department, other facilities. Perhaps skilled nursing facilities, home health agencies. Any other specialists that you would consider inside of your medical neighborhood, which we will be talking about more as we get started this morning. Of course, the care compacts does involve coordinating your internal systems first. And then, of course, going out to those providers as you move forward. Looks like we have a couple here coming in right away. Wonderful behavioral health. Compacts with dieticians, more behavioral health, multispecialty. It is difficult, so we're going to talk about how some of our practices that are on the line today have moved forward in getting folks to sign up with those care compacts cardiologists, hospitals. Great, wonderful. Okie dokey. Lots still coming in here. Anybody you can think of that you are working with currently with a care compact. Optometry, wonderful. I'm going to move on to the next slide. So today, in today's session, what can you expect? So as Rose had indicated, some interactivity. And we'll want to remember to just take that left-hand arrow button off so that you're not accidentally clicking on things. But, yes, interactivity is an important piece of what we're going to be trying to get out of this webinar today. Learning from one another, learning about how others have implemented care compacts in their practice. Including how to specifically define care compacts, what does that look like? How the care compact will impact care coordination across the medical neighborhood. And that one includes ED, the hospitals of specialists, those folks, your high volume specialists. And then how care compacts have impacted their patients and their practice. We, of course, as we were talking about earlier in the last slide and earlier today, we do want you to share your comments, questions, examples. And you can do that through that chat function, as well as through the Q and A if you just want to ask questions. Rose had noted that we can use the eraser in the upper, rather in the left-hand navigation button there. Down at the bottom, there's a little. The second from the bottom as an eraser button. That's okay. Any comments, questions, examples as we want to go forward, you can use your chat button at any time. So here we go. Another chat. What expectations do you have of today's webinar? Are you looking for examples of how other practices have implemented care compacts? Are you looking for stories about lessons learned, barriers, success stories? Anything like that that you're looking for from today would be very helpful. And, of course, anyone who's having success in their own practice or having a specific challenge or barrier, we would love to hear about that as well. Thank you for chatting those in on the right-hand side of the screen. And this is looking great, guys. Thank you so much. Looking for how practices selected who to have a care compact with. We will be answering that question specifically. Wonderful. I'll give it just about 10 more seconds here for anyone else that's trying to log in and chat with us. Okie doke. So why wait? We don't want you to wait to the end of the session, because sometimes you forget what your question might be or what the challenge barrier or success story that you're seeing. We want you to remember to add these in into the chat function on the right-hand side so that we see what's going on with you folks as we're going. So, again, please chat your questions as you have them. Also, feel free to use the chat to ask about any key elements. You'll hear practice

presenters while they're speaking. You might want to ask those questions over in the chat function. And then we'd also love, like I said earlier. We want you to share your examples, and then any comments regarding care compacts that you might have as we go. Successes are wonderful. And then the elements that must be in the collaborative agreements as I'm reading here on my right-hand side.

10:01

So lots of great stuff that you guys have questions about. And, hopefully, we will see answers to all of those. And, in not, we want you to remember that this is the time to get those questions out there so we can be interactive with our peers. Okay, so at this point, I'd like to introduce Molly Pickett. She is a nurse, but she's also board certified adult geriatric primary care nurse practitioner. There's a mouthful for you. And she's out of our own backyard here in Denver, Colorado at Mayfair Internal Medicine. She is with an independent practice, has three physicians. One advanced nurse practitioner and 2500 patients. So we are excited to hear about the different care compacts that she and Mayfair have implemented. And I am going to turn it over to you right now.

Thanks, Marilee. Thank you, everyone, for joining us today. I am particularly passionate about care compacts just as I feel this is something we should have been doing really all along. And I just wanted to kind of do a overview with you all kind of briefly here on exactly what a care compact is. So, you know, essentially, it should just be a collaboration agreement, an arrangement that you develop, a workable framework between you and a practice of your choice. It could be a practice you feel like maybe you have a good relationship with, or it could be a practice that maybe you really want to improve your relationship with as far as your doctor communication, standardizing those workflows, document sharing between practices, and then also just kind of developing maybe a relationship with a specific person at that practice. It can be your go to person and contact when issues arise. So, you know, a good way to do this is to maybe keep in mind the three part aim and just kind of. This can be part of your development collaboration process. And keep in mind that patient satisfaction is always number one on everyone's list. And this, you know, patients definitely notice when you have really great communication with your collaborative practices. As I've noticed, I've had a couple patients actually make a couple comments to us in office here as well as we've heard some feedback from one of our collab groups that the patient was incredibly excited and impressed with just the amount of communication that had gone on between the docs. And also cost being a huge factor. Just stop preventing the evaluation overlap. You can really work this from great and a lot of different angles. You know, think about what, think about what lab work that you're doing that you want to try to assist with in getting done for your collaborative groups. And kind of make each other accountable for, okay, I'll get this lab value or this test for these particular patients. And you can do this. And, again, you're sharing the information accordingly. And then just remember quality. It's, you know, you should really expect the kind of care from your collaborative docs as you would want to give to your patients. So keep those things in mind when you are developing some of these care compacts. The why of care compacts, again, I feel like we should have been doing this all along. It's really created a lot of non-reimbursable time for your offices. It's, you know, trying to get the referral information back. Trying to just chase the paper trail. You know, hey, can I get that progress note? When are you going to send it over? This will really help develop a timeframe for those types of issues that you may have been really having a struggle with your practices.

And then how to integrate information from the other agencies is just huge, because you need to know how you can implement that and use that in your day to day practice, as well as what you can do to help them implement your information that you send to them. So, again, just kind of remember the why and keep that in the back of your mind when you are developing all of your care compacts. Just keep asking yourself these why questions when you're going back. And the Collaboration website has this care compact example available. And I really appreciated Kari Loken in that you should not try to re-create the wheel. That's always been her great piece of advice. So if you're really struggling with what this should look like for your practice, just go to this and modify it as you need to. It's a Word document. You can make this whatever you need to. And you can really just go from there. And remember it's a workable document. It doesn't have to be set in stone. It's not something you have to be absolutely married to. If something's not working that you had thought would work initially, change it. Make it your own. And so the implementation strategy, I feel that for our practice, especially, we're really still working on the implementation. We got started maybe a little late in the year. However, we did get started. And it seems to be going pretty well so far. So we're still kind of in the development stage and implementation stage. And just seeing how this is all going to play out. So give it time. It's not going to be an overnight change. You're going to have to tweak it and work it and make it your own. And just keep all of that in mind. But, you know, remembering the whys, defining a champion to figure out who's going to be talking and interacting with your comp groups is really important. And then just developing and maintaining that relationship is another way that we're really trying to work on to continue the ongoing talk. And just development of our care compacts with our agencies that we've picked. So getting to our practice story, specifically, here at Mayfair, we decided, you know, what clinics, where to start. I just felt like care compacts were actually going to be an easier way to go. And, you know, they've actually been an awesome, an awesome experience so far for our clinic. So we decided to kind of go from the direction of what clinics were we referring to the most. And we did a registry poll on our referrals over the last year and found that we have a group, specifically Denver Digestive Health Specialist which is one of our local GI doc groups that we do the majority of our referrals to. For anywhere for colonoscopies to just general GI complaints that we need more further evaluation for. And so we went ahead and decided that would be a great route. And then the other route we also felt very important and just absolutely a must for our practice was going with Maria Droste Counseling Center for behavioral health integration and compacting. So these, again, we're kind of killing two birds with one stone with the Maria Droste compact for both Milestone 2 and Milestone 6. So, and it's actually been an amazing experience so far with both groups. So you can kind of ask yourself which direction you would like to go. But, again, it's open and you kind of got to go from what direction works for your practice. This is what our care compacts look like. Again, I used the example that was provided to us from the Collaboration website. And they are great documents, very workable. And we've tweaked them as needed for both practices. And that's on both sides. So we've implemented since June, our care compacts with both groups. And we've been working with Maria Droste at least on a monthly, if not bimonthly, kind of collaboration on our document workflow, bidirectional communication, and also just in general how we can get this to work. Because it's a very unique situation with a behavioral health specialist. And as you know, there's a lot of barriers there and people just assume, oh, we can't talk to behavioral health about anything. But that's just not the case. And then referral tracking, we kind of had in place already for our MAs have been working hard in trying to close those care gaps. And so we

decided with Denver Digestive that we just wanted to be more proactive in figuring out how to get documentation back from them. And that's been a big piece of our care compact with that group. And we do continue to follow up quarterly. If not more, probably more like on a monthly basis with those groups, just to see how things are going. And we're continuing to improve and adjust as we need to. And so, you know, building the medical neighborhood obviously is going to be a huge factor in all of this. You really want to hold your local groups accountable, and just make them just as excited about this care compact as you are. And just, you know, try to hype it up, so to speak.

20:00

Fix the long-standing communication issues that you've been having with some of your groups is kind of a key piece to this. For example, our Denver Digestive care compact, our biggest issue is that we weren't getting pathology reports back on a timely basis for our colonoscopy referrals. And so we really weren't sure what the timeframe should look like for their follow-up colonoscopies. So this is kind of a big piece that we really tried to drive home with them that we were looking to get a little bit more prompt return of the pathology reports from them. And they didn't even realize there was an actual issue until we brought this up to them. And so it got fixed pretty promptly. And we are seeing quite an improvement in the percentage of pathology report return, which is interesting because the reports that we run from the quarter to date this year versus last year is actually showing us a decline. However, we actually feel that we're tracking appropriately now. So that's kind of where we're going from that direction. And, you know, we've really learned quite well how to work with a mental health provider at this point. And just figure out where we can kind of break down those barriers of communication between a mental health provider and a, you know, a primary care provider, because it feels that that communication flow has never really been there. We were lucky enough to have the opportunity to have a group that was very willing to work with us and have actually done a lot of the legwork for us in developing their own documentation on bidirectional communication. And that is anywhere from an authorization for release of records form to a simple, you know, S bar note format that they're providing our office after the visits that they're having. And we've actually seen a 50 percent referral closure rate approximately with our Maria Droste referrals, which is huge because we had zero last year. So we're really finding that's been an amazing collaboration, and we're getting a great response out of that. And then just the mental health referral insurance changes that have occurred since the Affordable Care Act went into play this year has also been a big piece of our learning curve of figuring out who can actually be seen by mental health, behavioral health specialist. And, you know, just kind of remember in the back of your mind that practices that you approach might be more receptive than you think they would be. And keeping them accountable is probably the biggest piece to take away. Any questions so far?

Molly, we've had some excellent questions in the chat.

Great.

One question was can you make a collaborative agreement with an emergency room in order to get the utilization numbers improved?

I would hope so. However, there might be a little bit more red tape with an ER because I would think that. You know, you're kind of dealing with the whole hospital as an entity rather than just a smaller office. So you might want to, you might have to go a little bigger there, I would think, by actually approaching maybe hospital administration or the emergency room director, critical care director, that sort of thing. But I would hope, yeah, you should be able to collaborate and connect with an ER. Anybody else have thoughts for that? Anybody?

This is Maren Wheat [phonetic], Rose. I'm not sure if Marty's out there listening to us. I did see his question or her question. And regarding anti-kickback and stark laws. And to my limited knowledge about that, it specifically, care compacts do not cover or even discuss costs or fees. And with stark, we all know that that covers and prohibits, specifically, kickbacks for referrals. So my suggestion would be that that, of course, never cross the boundary on your care compact in talking about money, but also that the attorney that you have for your practice will be able to help you navigate through those waters. So I don't know if that answers the question or not. I tried to answer that question in the Q and A, but hopefully that helps everybody who's listening also with that particular question. Does that help?

Great, Marty, wonderful. Also I did have a question quickly for Molly. Molly, some really great information. Especially with your behavioral health integration and the care compact you did with Maria Droste. You did mention tracking success and barriers with them. How, specifically, do you do that?

Right now, we have since the beginning of care, you know, CPC. We've really developed a good referral tracking program through our MAs and our care coordinators that have been really prompt and developed a good workflow on how to track those referrals. So we've integrated Maria Droste's referrals specifically into our referral process. And we're taking that and just making sure that we're closing the gap with getting those documents back from them. And recently, we've had to make them more accountable for return of documents. And we have a great champion on their side, David, that is really helping us out with that. And he's getting to these providers over there, the therapists. He's working with them, he's educating them on how the communication should work between with the documents that they've created between them and our office. And so the accountability factor is just, it's really ramping up at this point. And we're lucky enough because we have that champion in David to be doing that work on their side. So that's kind of how we're directing and kind of approaching that. And then when we finally get the documents back, we're calling that our closed referral. But they will continue to send us information on the patient's status throughout the course of their therapy.

Excellent, thank you for that. I love that you're closing the gaps, the loop. I have heard that in some of the practices that I've been working with, this is a note for all of you out there. Is that once you do have a care compact in place with a practice, you'll want to share the details of that care compact with everybody who's responsible for doing something in the referral process. So whether it's somebody at the front desk, somebody at the MAs, the docs, et cetera. That everybody recognizes what the agreement is. What is expected not only from the specialist or the ED or the hospital, but also what's expected of us inside the primary care physician's office. So hopefully that will help some of you. And then why don't we, do we have any more questions? And we can move on to Kimberly Blackburn out in Ohio. And we will get. You can, absolutely. But I would say that I think that that answer would just come

from Molly. And I don't know if she's on mute. There we go. I think Molly's connection might have been lost. Sorry, Rose. But we can come back to that question at the end when she jumps back on. But if I could ask. Yeah, if I could ask Jeff to hand me back the ball, we can move on to the next section. And remember those questions as we go forward, because we did build in some time at the end for all of these wonderful Q and A. So.

Sorry, I lost question there, guys.

Oh, that's okay Molly. We're going to come back to those questions at the end if that's okay.

Sounds fine.

Thank you so much. So, again, don't wait. I love that everybody is getting in here, chatting up with questions. And we're going to get to those questions with some answers at the end and then as we go as well. So I really appreciate the other panelists on here who are manning that and putting forward questions as they come up.

30:00

So remember don't wait. But in your question while you're thinking about it. So here comes another poll. So this is poll is going to be, I'm going to hand it back over to Rose who's going to conduct this particular poll.I think it's important to add here, Rose, that this is a question that we will ask in every one of our webinars. So this is a series, this is number 1 of 4. And we're going to continue to ask this question as we progress throughout the next 8, 10 months. And we want to hopefully see this number go up. And so I just wanted to make sure that everybody knew that we're going to be tracking this question as we go. Wonderful, great. So, again, with this particular poll, we would not expect everybody to have 1 or 3. Zero is perfectly fine. And a care compact, again, can be with anybody. It can be with any specialist. High volume or not. It could be with the ED, the hospital, skilled nursing facilities, home health agencies, et cetera. And it looks like there we've got some folks coming in here. Do you want to talk a little bit about the results you're seeing, Rose, or would you like me to? Okay, so for those folks who have answered it, it looks like we had about the majority are saying zero. I kind of expected that at the beginning seeing that a lot of folks hadn't really gotten into this business yet. But we have eight who have three or more care compacts in place. That's wonderful. And then just a handful with one or two. So thank you for that, wonderful. Again, as expected, most of you who are on the phone today and on this action group do not have any formal care compacts in place. You might have some informal ones like we always refer out to Dr. Smith for endocrinology. But, again, totally expected to have a zero at this point. Not unexpected at all. Okay, so we'll close that poll here in just a moment in case anybody else wants to answer. We do want your answers even if it is a zero. That's perfectly fine to say that. And I'm going to move on and introduce our next speaker from Springfield Healthcare Center. Kim Blackburn is an LPN and the care manager at Springfield. They have three physicians, about 3600 patients. And they have also had some success as well in implementing care compacts. So I'm going to turn the ball over to Kim. And let her take it to the next slide.

Thank you, Marilee.

Thank you.

Can everyone hear me okay, I guess. I think I've unmuted appropriately. My name is Kim. And I am an LPN, care manager here for the practice. Like she said, we have three physicians and approximately 3600 patients. Thanks so much for having us speak about this. I hope and my goal would be that I would give you some really great useful information that you can really take back and implement for your own practice. I think, first and foremost, I was surprised to see in the poll, or really not surprised to see that the majority of the polls came in either zero or three. And there wasn't a lot of middle ground there. And I think the reason for that is really once you get these care compacts up and running, once you have one, it's really easy to just get that disseminated out to several specialties. And we can talk about that through the slides. So I just want to give you some nitty gritty information here of what we've really found, and a little bit about our story and how we've been very successful in our care compacts. So first and foremost, when I came back in April of 2013, one of the first things we noticed in some of our early Milestone accomplishments for transitions of care and preventing preadmission and the reduction of ER visits and things like that, we really noticed just a wide range in care delivery, timeliness of the care, you know, especially, at discharge. Examples like home health care not really showing up for a few days. And just really the need for a lot of bidirectional communication just was not happening. And so right from the very beginning, I needed the help. And I found that I needed to just go out in the community and really educate. Not just the patients about, hey, we have care coordination in the practice now. There's a lot of education involved, a lot of opportunity for some extra services. But really found that we had a lot of education to do with other providers and other disciplines in our community. And so very quickly, I went personally to I think almost every extended care facility in our area and met with leadership there and really just sat down with them for a while and explained to them what CPCi was all about and what we were accomplishing for the patients. And I really tried to get them excited about what was up and coming for care coordination. I wanted to verbalize our expectations and how that would be a benefit to our patients. And so I was the one that just really initiated this, the care coordinator. I made phone calls, I scheduled meetings. Like I said, I made site visits with leadership all throughout the community. And really, like I said, the reason for that is because I found that every discharge we had from the hospital when these patients would leave with their med rec and their med list correct. Then they would maybe go to an extended care facility for some rehab for a few weeks. And when we tried to do our implementation of the 48-hour phone call to do a med rec at discharge and then get them in to complete the second part of that and get them in the office for their transitional care appointment, we really lost them once they left the hospital and went to rehab. We weren't being alerted when they left rehab. And then we would kind of hope and pray that they would have some sort of home health care that followed them home. And who was that and what sort of equipment and medications did they have? So who do we reach out to first? That was a no brainer. When Milestone 6 came along, you know, at first you say, oh, gosh. You know, formal care compacts. How are we going to do this? But then we just went back and realized that we were already doing it. We were just doing it verbally. And now we just needed to get this on the paper. So we reached out to those with the greatest care gaps. And that was our transitions of care. I was fortunate enough to have been a floor nurse at the hospital for quite some time. And get to know a lot of the leadership at the hospital. So we've had lots of communication with case management at the hospital about discharges. The CEO, the CNO at the hospital, the ER. But

we really reached out to home health care and the extended care facilities because those were the critical transitional care points for our patients. So when I went to the extended care facilities and kind of explained a little bit about what we were doing and what we were trying to get accomplished for the patient to fill the gaps, I kept, you know, asking the same question to them. What keeps you as an extended care facility from reaching out to the primary care physician once these patients go home? What keeps you from letting us know that they're going home? And surprisingly, a lot of them said, we just don't know who you are. We don't know who this patient's primary care provider is. And, again, working at the hospital, I used to get those packets together at discharge and know that they were sent home with a face sheet. And, sadly, a lot of the time the primary care physician was not on that face sheet. So as you can see on this slide to the right, the attention admission discharge planner, I went and met with every admission discharge planner at every facility. And said what would it take, what could I do for you to help you get communication back to us?

39:56

And they said, well, we just need to know who you are and we can get the information back to you. So I created this sheet. And so at discharge from the hospital, as soon as I would know our patient was going home. Or, I'm sorry, going to the extended care facility, I would read in case management notes that they were going to a particular facility. And I would fill out one of these alert forms, and I would circle which primary care physician here in our office was taking care of this patient. And I would write the patient's name and their date of birth down and this just simply asked them, you know, would you provide us that continuity of care by alerting our office when you do discharge our patient from your facility? And I wasn't really sure how this would work at the beginning, and it has worked beautifully. Every facility that we go do now will call me occasionally. And say, hey, we didn't get your alert. Did you know your patient's here? And there are times that, you know, a couple have slipped through and we haven't known about their discharge from the hospital to the extended care facility. But this has really bridged that gap for us. And so they stick this alert in their chart. And at discharge, they call and they fax us the information that we need. And to the left, this is just a sheet that I kind of created at the beginning for the nurse's station to identify our practice and which physicians were in the practice. And if they needed anything by means of care coordination, they could call us at any time and we'd be happy to have that bidirectional communication with them. So this is where we identified a barrier. We created a solution, and it has worked beautifully. The next slide here, this just shows how simple our care compacts really are. We just made two columns essentially and said this is what we can do for you to help you accomplish your goals and to give excellent care for the patient. And on the other side, you can see one is with the home care agency and the other is with a nursing facility. And so on one column is what we can do for them and what we've agreed to do for them. And what they in turn can give us for our patient. And I won't go through all of this in detail, but the biggest things were medication, medication, medication. You know, having a home health care nurse go out to the home and try to make sense of a discharge summary from the hospital, a discharge summary from an extended care facility, and then in our office, we have a med rev that obviously is not up to date yet from all the changes that were made. And so these home health care nurses were going out into had home and looking at multiple lists and seeing bottles and bottles of medications from different providers. So one of the things that we implemented first and foremost was we just wanted to set our expectations high.

And, you know, we told all of our home health care agencies we will never put all of our eggs in one basket. We want to give our patients a choice. So here's our expectation of excellent care. Can you rise to the occasion and give us what we need for our patients? And so we have gotten things accomplished like visits the same day of charged discharge. Visits within 24 hours. The home care nurse that goes to the home now calls us while they're in the home to do a complete med reconciliation and know when the patient is due back in our office for their transitional care appointment. And flipping over to the nursing facility side, one of the biggest things there was when they're going home, they might send them home with a new medication and only send two days' worth home with them. And so we've said, okay, can you agree that you will send a minimum of seven days' supply of these medications home with our patients? And I will tell you that we will get them in the office within seven days to see these patients so that they don't go without a critical medication. So that's just a couple of examples of our care compacts. And at this point, it's just easy to get that out to all of our home health care agencies. We have exciting news that on September the 9th, I had a collaborative meeting with Springfield Regional, our hospital here in town: case management, Villa of Springfield Nursing Facility, and Community Mercy Home Healthcare. We all sat down at a table and signed care compacts that day and really realized that we're all accomplishing or trying to accomplish the same thing for excellent care. And by signing these compacts, we're really paving the way for our community to really step it up a notch in communication surrounding transitions of care. Now we have actually facilities and hospitals who are reaching out to us to learn what are you doing differently? We want to be a part of this. How are you making this happen? And just to touch quickly. You know, this isn't an easy process. It takes time to build relationships. It's ongoing, we're going to tweak things as we go along. If we find different needs, we can sit down and we're actually going to meet monthly for a while. All of these facilities, home healthcare, case management, have decided. Yeah, let's meet monthly and see how this is going, see what we can do to improve filling any additional gaps that might be identified. It does require a lot of education and communication with those people in the community. It requires a lot of patience and dedication to the process. We quickly wanted them to know this was a two-way street. We wanted to make it easy for them to communicate back with us. We said, what do you need from us? We identified a barrier, we got a solution. It's, like I said, working beautifully. But, of course, you have some of those that just have a lack of the same interest as we do. And we have had facilities that just aren't nearly as interested as we'd like for them to be with, you know, getting that communication back to us. So we have really tried to heavily work with those who are the least bit interested in hearing from us and really pushing them to a higher expectation. Very quickly, we just identified where do we need to improve? And we found that in order to build a great house of communication, we needed to have an excellent foundation for other providers to build upon. So we've really pushed our office staff to the limit every visit, every touch point with that patient. Let's clean up that med rec and really do an excellent job of having a great foundation. So that it makes it easier, you know, to build upon. We have plans for a medication safety project because that seems to be the surrounding issue with readmissions and high-risk patients. Is just making sure that their medications are correct, they're available, they're taking them properly, they're bringing those at every visit. And we have even have some plans for what I have kind of thought to be a medical passport. Where their medication list and their signed passport of what doctors they have been to since their last regular office visit would be housed in some sort of a medication safety bag. Reciprocate communication by creating an alert sheet, I've already touched on that. So, you

know, we've identified areas of improvement. We have done that. And hope to continue to really just find places that we can improve. And let me see this next slide here. We just wanted to say that our goal really wasn't about improving numbers at the beginning. This was about improving communication for better care. And since we have done that, we've noticed fewer gaps in our transitional care. Enhance communication, reducing admission risks, and, again, we've really improved the timeliness of care at discharge where the home health care nurses are getting out there in a record amount of time. And we have been able to identify early urgent needs that the patient may have once they go home. And I could go on and on with a list of some really critical things that we've found. But I'd be happy to talk to anybody at any time from any other office and share some really great success stories that we've had. But I know we're running out of time, and I don't want to take any more time. So, Marilee, I'll pass it back to you. And if there's any questions, I'd be happy to answer those the best I can.

Wonderful. Thank you so much. What a wonderful review provided to everybody on the call today regarding how you're doing it. I love that you said you were already doing it, you know. We were just doing it informally. And so, you know, you're already doing the work. Why don't you formalize it and make everybody accountable? And it's interesting. I read something, I think it was frame AHRQ that the typical primary care provider has like 230, I think it was 229 exactly.

50:02

Other physicians that they essentially have information coming in or going out within 117 other practices. So no wonder it gets confusing. No wonder you get like so frustrated with what's coming from which direction, if you will. So I love that you've found who you needed to work with first. And then to go forward from there, I also love that attention to the discharge planner document that you had. I know that there were some questions. We want to definitely get these up in the library on the Collaboration site. So Kim's going to be sharing those documents with me so I can get those up there later today. So everybody has access to those. I do believe that there was a question. I think Suzy was perhaps sending this to you, Kim. How many home health nurses do you have and also how many nurse care managers? Does that sound like the question that was directed at you?

How many home health care nurses or how many home health care agencies?

It says home health nurses do you have and how many nurse care managers?

I am the nurse care manager for the practice.

Right.

And I am it for our entire practice. I'm hoping I answer this correctly. We have formal care compacts with one home health care agency right now as of September 9th because we were finalizing the care compact. But we have plans to get this out to at least five other agencies and other extended care facilities. We were just anxious to sit down at the table with one of each of them. Kind of our leading communicators in the community just to get the ball rolling, but that's where I said you can go from zero to four in no time with care compacts.

So let me see, make sure I heard you correct. That you said that you have one care compact currently with one home health agency. But you have five on the horizon; is that correct?

Yes. We have at least five home health care and extended care facilities that are actually chomping at the bit coming into the office weekly. Saying, hey, do you have that care compact? Hey, do you have that care compact? And as of September 9th, we finalized it, we got the signatures, and now we are ready to get the rest of those signed.

Great, thank you. And that is incredible. And your timing on that? And I'll get to the next question. For those extra five home health agencies and ECFs?

Well, as soon as we survive reporting here in a few days.

Okay, great. The next question came out. Does every patient who's been discharged get a home health visit?

No, they don't. It depends. Dr. Patel rounds in all of our patients in the hospital. We do not have our hospitalists see our patients. It's determined at that point whether they're safe to go back home unassisted or with assistance. And so if they do go home strictly with home health care, that is who I contact first. And actually we've refined this process so well that I typically get a phone call from the home health care nurse at the start of care visit before I can even get to the patient. And that's usually within 24 hours. So, again, it just kind of depends. We either hear from the home health care nurse if they go home, or the extended care facility when they leave that facility.

Wonderful, thank you. You know, that does sound like a very refined process. And something that can be very easy once you kind of get the ball rolling, if you will. I know that our Medicare patients, this is also from AHRQ, see about seven different physicians every year. And have more than 20 prescriptions written every year as well. So it's just a lot of different moving parts. And it's just so wonderful that this care compact can address those things and get those patients where they need to be. Where they need to be and who's paying attention to them at the right time and the right place. There is another question here on care compacts. So would a care compact work for a teaching university who has 32 residents? My initial thought to this was yes because we have care compacts, we do teach residencies here in Colorado. But I'm looking for anyone else who might have other questions or answers, excuse me, to that particular question about using a care compact in a teaching university. Does anyone have an example of that? If they could please chat in their answer. We have about five minutes left. So if you will pass me the ball, Kim. And we will start wrapping it up.

And, Marilee, there was another question directed to Kim.

Okay, I missed that.

And, Kim how does your practice know when a patient is admitted to the hospital?

We have a process called Health Bridge. And it gives us what we know as ADTs. Admit, discharge, transfer sheets. And I jokingly say it's the magic fact that I don't know exactly how it all works. My office

manager handles Health Bridge. But, essentially, it's something that we've signed up for and we get these alerts. Whether they're observation, inpatient. And then in turn, we get another alert when the patient is discharged. But, again, as collaboration. Or I'm sorry, a compact that we've sort of made with our hospital is they knew about this project before I left the hospital. And so they enabled me to keep my access to EPIC because we don't use the same system as the hospital. And so Dr. Patel and I, our offices are right beside of each other. And we talk daily about who's inpatient, who's going home, who's been flipped to observation status. And then I track them live in the computer. I can see case management notes as soon as they're made with any discharge plans. So that's kind of how we do it at this point.

Thank you, Kim. Great stories. And so many wonderful examples. I really appreciate your expertise in this area and your sharing with folks today. So I did want to answer. There was a question from, or rather Donna had noted that when you do a care compact with a, if you will, hospital that would include the emergency department. And you wouldn't necessarily, you would not do it separately. The emergency department and the hospital are usually one in the same, of course. And so that said, it's a really big task for a hospital to try to do a care compact with let's say all admissions or all ED visits. So you can start with one or the other. You don't have to start with the whole thing. It can be just one. It might just be one department. So just trying to kind of show them how much better things get once we both have bidirectional communication happening between two departments, or the ED, or the admissions folks. So I hope that that will clarify that. I wanted to make sure that I did bring that back up. So we've got just about two minutes left here. We have one more poll I want to make sure that we get to. In this particular chat, what's a reasonable goal for increasing the number of care compacts you have in your practice by this coming May? May 2015. So if you will chat in a number in there, I know a lot of you, a majority of you, were at the zero mark. So a goal might be one. It might be five. But I think that a couple is probably reasonable. And if you would chat those numbers in, that would be great. Again, that chat box is the little black or blue button at the top right-hand side of your screen. And I will then. You guys keep chatting your numbers because I want. The spirit of efficiency here is one more minute here to go. We want to put the Action in Action Groups. So we're going to post, pardon me. Our care compacts is applicable in the action group library. Specifically, Molly's are already up there. I am going to post Kim's today. And so that you folks can have those examples at your fingertips that you can look at and use to just get ideas. And we also want you all to post yours. I know a lot of you don't have anything formally in place. But if you will post your examples, this just helps everybody. It doesn't matter if it's a hospital or with home health or with a cardiologist or with a retinologist or whoever it might be, just post those up there. It gives everybody wonderful ideas so that we can get these care compacts going.

1:00:06

Again, if you have questions or comments about compacts that you have reviewed, write those down. Bring them to the next Action Group session. Or you can post those questions into the Collaboration site. If you would also. We're putting like I said Action in Action Groups. One question or comment inside the Care Compact Action Group Forum. We all monitor that, and we would love to have you get your questions in there or comments. That's fine, too. And so as you know, we were talking today. This is the first in a series four action group webinars specifically related to care compacts. We had two wonderful

speakers. One from Denver, that was Molly Pickett and one out of Ohio, and that was Kim Blackburn who shared their experiences today with different care compacts in their primary care practices. And that will, again, let's keep the discussion going. We want everybody to participate in the action group. And if you have any questions, please let us know. Again, you can continue to chat on the right-hand side and sign up for as many forums as you want. With that said, the next action group webinar will be on November 18th. Again, same time, essentially and same place. Being from noon to 1 Eastern Time right here on this channel. And this will be about getting out your tools. This is about essentially building the foundation of your care compacts. We're going to show you specifically how to do this from the ground up and answer those questions that you may have as we go. And at this point, I am passing the ball back over to Rose so that we can close our session. Oops.

And we want to thank you for attending today. You've been a great group. We hope that you've found this session informative. And we look forward to continuing this conversation on the collaborative site forum. We'll see you on November 18th.

Thank you, everyone.