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And the winner is…

CARE COMPACTS

Action Group Session 1 of 4

The Use of Care Compacts to Coordinate Care Across the Medical Neighborhood

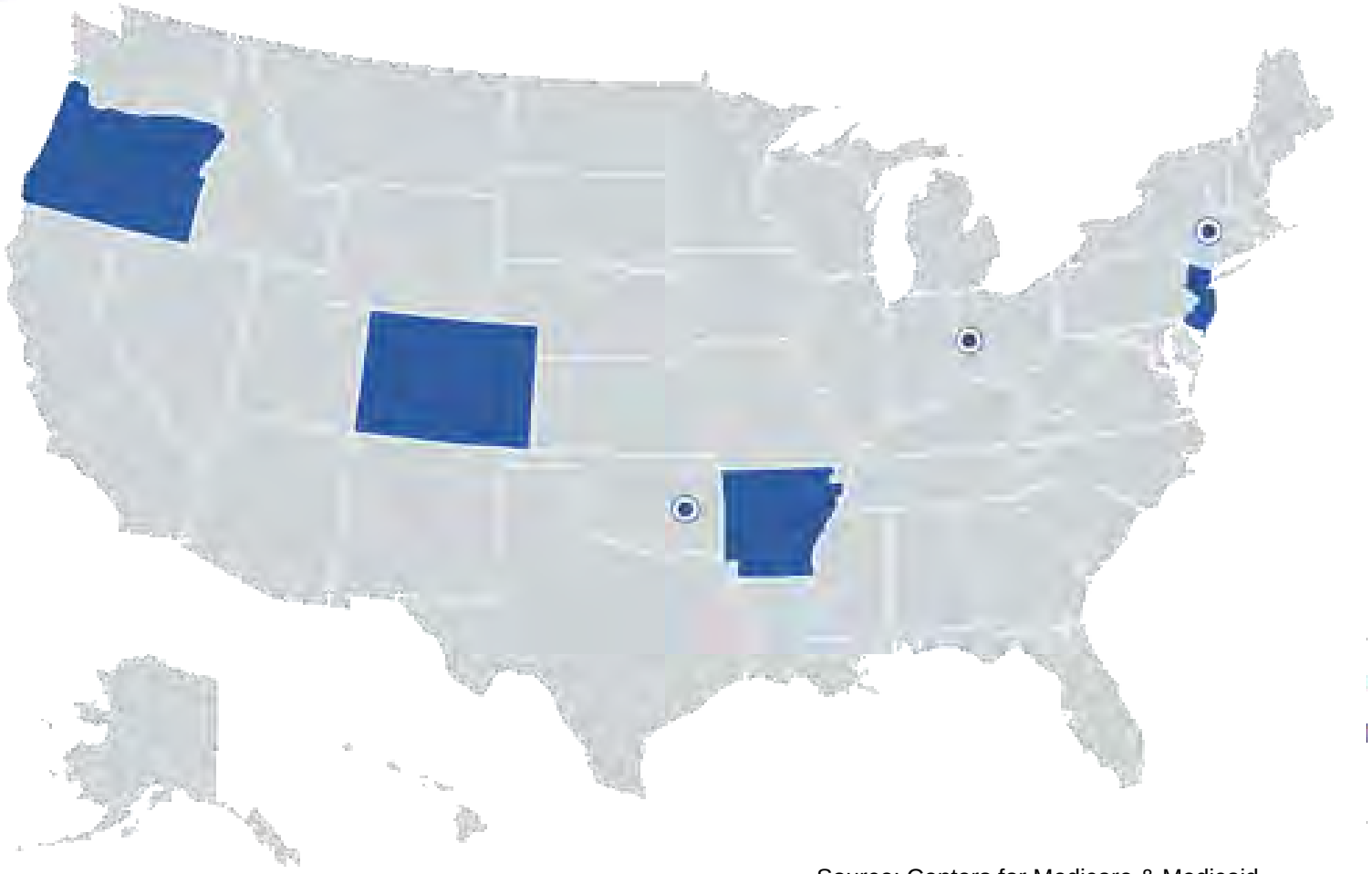
September 23, 2014 – 12-1 pm ET

Moderator

Rose Langdon

TMF Health Quality Institute

Click the arrow, then point to your location…



Source: Centers for Medicare & Medicaid Services

Action Group Pointers

- This is YOUR Action Group
- Will be interactive, using chat, polls and the forum
- More activity means more learning!
- ***Chat now:*** ***What question would you like answered about Care Compacts in this Action Group?***

Facilitator

Marilee Aust, MHA
HealthTeamWorks

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Use of Care Compacts to Coordinate Across the Medical Neighborhood Action Group

Molly Pickett, AGPCNP-BC
Mayfair Internal Medicine, Colorado

Kimberly Blackburn, LPN
Springfield Healthcare Center, Ohio

Have you selected Care Compacts as one of your Milestone 6 selections?

Yes

No

Chat: With which specialists or groups have you implemented a Care Compact?

What can you expect?

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- Interactivity
- Learn from the practice presenters about how they have implemented care compacts in their practice including how:
  - They have defined care compacts
  - How a care compact impacts care coordination across the medical neighborhood
  - How care compacts have impacted their patients and practice
- Share your comments, questions and examples

Chat: What expectations do you have of this webinar?

why? wait

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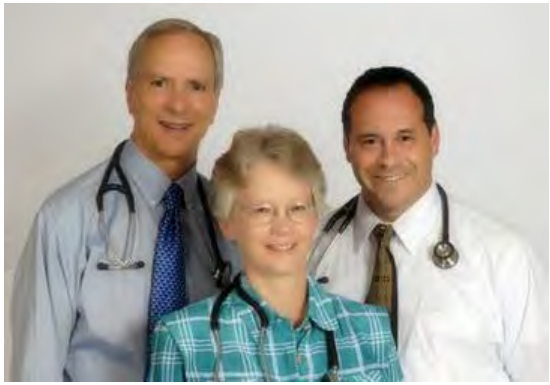
Mayfair Internal Medicine

Denver, CO

Independent, 3 physicians, 1 ANP, 2,500 patients



Molly Pickett, RN, AGPCNP-BC

Care Compact overview

A care compact is a framework for standardized communication between primary care and specialty care providers to improve care transitions for patients with a focus on patient safety and satisfaction.

It is a process by which practices identify the highest volume specialists, go through the process of building relationships and garnering patient feedback about the providers and process as it is about a specific compact or agreement template.

Link to the Three-Part AIM

- Patient Satisfaction: Fragmented care causes delays, miscommunication, gaps in care and thus is a major irritant to patients
- Cost: Fragmented care leads to unnecessary service especially related to ED & hospital visits
- Quality: Lack of a care compact can lead to lack of coordination across providers on plans of care that can often contradict and/or not align patient goals

The "Why"

- How much non-reimbursed time does your staff spend trying to get information back after a referral or transition?
- How integrated is information from other agencies back into the care at your practice?
- How do you know who will be the primary provider of care in your patient's care and what information do you exchange with other providers?

The "Why" Continued

- Do you know if the specialists to whom you make referrals get helpful information from your practice?
- Do you know if your patients are satisfied with your primary referral sources?
- How are patients educated about their referrals, transitions?

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Care Compact Example (on Collaboration site)

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

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

Primary Care Provider Signature / Date

Specialist Signature / Date

Practice Name

Practice Name

Implementation Strategy

- Make the case for better care coordination with your practice – the "why"
- Define a champion who creates an improvement team and strategy with a focus on internal transition/referral tracking system
- Collect data on key specialist groups, hospitals and community agencies
- Identify a person or persons to outreach to current and potential referrals and collect feedback from patients about your medical neighbors

Implementation Strategy - Continued

- Develop and maintain relationships with key agencies and develop agreements
- Ensure the meaningful exchange of information across and between medical neighbors and patients
- Track process through PDSA cycle or other QI strategy

Practice Story

- How did you decide where to start?
  - What clinics does our practice refer to the most?
  - What could be improved with the current referral process with these practices?
- Denver Digestive Health Specialists
- Maria Droste Counseling Center (MDCC)
  - “Killing two birds with one stone”

Practice Story, continued

- **What have we done so far?**

Mayfair Internal Medicine, P.C.
Larry Plunkett, M.D.
Edith Lovegren, M.D., Ph.D.
David Bolshoun, M.D.
Molly Pickett, AGPCNP-BC

Denver Digestive Health Specialists
shedding light on gastrointestinal problems

HealthTeamWorks

Care Compact	Mayfair Internal Medicine	Denver Digestive Health Specialists
Referral Process	**STEP 1 (at initial office visit)** ☐ At visit, PCP discusses reason for referral to Specialist with patient/family ☐ If visit is urgent, PCP office will call Specialist office to notify of need for immediate appointment ☐ If urgent, referral is faxed prior to visit, with all pertinent information ☐ DDHS contact information is provided to patient in printed care and follow-up plan **STEP 2 (within 24-48 hours of visit)** ☐ Referral/Care Coordinator verifies insurance coverage ☐ Pertinent records and information will be included with referral form ☐ Referral/Care coordinator or PCP will	**STEP 1 (within 24 - 48 hours of visit)** ☐ If visit is urgent, Specialty office will schedule patient within 24-48 hours (or less) depending on urgency ☐ If not urgent, Specialty office receives referral fax information of referred patient and awaits patient our reach to schedule office visit ☐ Insurance eligibility/benefits are reviewed when appointment is scheduled by DDHS **STEP 2 (within 72 hours of initial visit)** ☐ Complete consult report will be sent back to PC office within 72 business hours of scheduled appointment this should include, follow up, continued care recommendations and other

Mayfair Internal Medicine, P.C.
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Maria Droste Counseling Center
Colorado's Center for Mental Health

HealthTeamWorks

Care Compact	Mayfair Internal Medicine	Maria Droste Counseling Center
Referral Process	**STEP 1 (at initial office visit)** ☐ At the office visit, PCP will discuss reason for referral to Specialist with patient/family ☐ If visit is urgent, PCP office will call Maria Droste office intake line to notify of need for a more expedited appointment and outreach to the patient ☐ Maria Droste Counseling Center contact information is provided to patient in printed care plan and follow-up plan **STEP 2 (within 24-48 hours of visit)** ☐ All referrals will be sent via fax through our electronic health record (EHR) to Maria Droste Counseling Center intake department. The referral will include the patient's face	**STEP 1 (within 24 - 48 hours of visit)** ☐ Maria Droste Counseling intake office receives fax and intake office will contact patient to schedule visit and complete intake assessment ☐ Insurance eligibility/benefits are reviewed when appointment is scheduled ☐ The patient will be placed with a therapist/counselor that is deemed a 'good fit' for the patient based on psychological assessed needs and insurance coverage. **STEP 2 (within 7-10 days of initial visit)** ☐ The specialist office documents in SBAR format or another consultation report of the therapists choosing, for bidirectional communication

Practice Story – Next Steps

- Implementation
- Referral tracking
  - Are these care compacts working?
- Quarterly follow up with both practices
- Continued improvement and adjustments as needed

Practice Story – Lessons Learned

- Building your medical neighborhood
- Fixing long-standing communication issues
- How to work with a mental health provider
- Mental health insurance changes
- Practices are more receptive than you might think

Questions?

Please enter your questions into the Q&A section, or raise your hand to ask verbally.

why? wait

Using the POLL feature on the right side of the screen: How many FORMAL care compact(s) does your practice have in place?

- 0
- 1
- 2
- 3+

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Springfield Health Care Center

3 physicians and 3600 patients

Kim Blackburn, LPN, Care Manager

Springfield Health Care Center

- Noticed a wide range in care delivery, timeliness, and bi-directional communication
- Implemented verbal agreements prior to the milestone expectation
- Wanted to verbalize our expectations of care for the benefit of our patients
- Care Coordinator made phone calls, scheduled meetings, and made site visits with leadership throughout the community

Springfield Health Care Center, continued

- Who did we reach out to first?
  - Patients with the greatest care gaps
    - How did we identify these patients?
  - Those facilities where increased communication was imperative for patients during critical transitional care points
    - Home Health Care, ECFs

Sample Communication Tools for ECFs

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We identified a barrier and created a solution!

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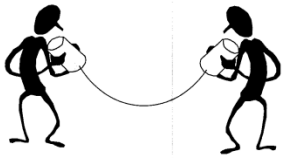

Partnering for better Continuity of Care!

Let's Communicate...
for better Continuity of Care!

Care Coordinator
Kim Blackburn

Dr. Vipul K. Patel, MD

Dr. Elizabeth Marsh, MD

Dr. Robert J. Scott, MD

Phone: (937) 328-2310

Fax: (937) 717-9847

Please let us know how we can help you provide continuity of care for our patients.

We ask that you would contact our Care Coordinator prior to discharging our patients from your facility. Discharge medication lists and all other pertinent information can be faxed to the above number.

Thanks for your partnership!

30 Warder Street
Suite 100
Springfield, Ohio 45505

SPRINGFIELD HEALTH CARE CENTER
YOUR COMMUNITY... YOUR HEALTH... YOUR HOME!

30 Warder Street, Suite 100, Springfield, OH 45504

Attention Admission/Discharge Planner

You are now caring for one of:

Dr. Vipul K. Patel's **Dr. Elizabeth Marsh's** **Dr. Robert Scott's**

Patients.
We are their Primary Care Provider!

Patients Name:_____DOB:_____

Would you please help us provide continuity of care by alerting our office, When this patient is discharged from your facility?

Please FAX a discharge medication list and any pertinent information regarding their stay to:

FAX: 937-717-9847

PHONE: 937-328-2310

We sincerely appreciate your partnership in providing coordinated care for our patients!
If you have any questions or concerns please contact the
Care Coordinator
Kim Blackburn
937-328-2310
kblackburn@springfieldhealthcarecenter.com

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Care Compact with Community Mercy Home Health Care and Villa of Springfield Nursing Facility

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"YOUR COMMUNITY...YOUR HEALTH...YOUR HOME"

Care Compact

Springfield Health Care Center and ***Community Mercy Home Health Care*** are committed to excellence in care coordination and collaboration for the benefit of our mutual patients. Listed below are the agreed upon items that will increase communication and provide a safer transition of care and reduce the risk of readmission for our patients.

Expectations	
Springfield Health Care Center	Community Mercy Home Health Care
☐ SHCC will be available M, T, Th, Fri 8am-5pm and Wed 8-12pm for medication reconciliation, questions and/or concerns. ☐ A SHCC physician will be available via the after-hours line for urgent situations. ☐ SHCC will provide up to date, thorough information that will assist the home health nurse in gaining more detailed information on the patient's medications and condition(s) upon request. ☐ SHCC will provide a timely response to any questions/concerns from the home health care provider regarding the patient. ☐ SHCC will provide timely signature of Face to Face orders and re-certifications via the folder system. ☐ SHCC will provide verbal orders to the home health care provider. ☐ SHCC will provide a directory of staff nurse names and extensions for each physician to assist in proper direction for inquiries. ☐ SHCC is committed to quarterly meetings with CMHHC leadership to enhance current processes for excellence in care coordination.	☐ CMHHC will make every effort to initiate start of care within 24 hours of a discharge or referral. ☐ CMHHC will make every effort to see patient high risk patients same day of discharge or referral if requested or identified as high risk for readmission. ☐ The nurse initiating the start of care will complete thorough medication reconciliation at first visit and will make every effort to call SHCC while in the home for a medication review with care coordinator or nurse. ☐ CMHHC will immediately communicate abnormal labs, assessments and concerns regarding safety and condition. ☐ CMHHC will utilize the after-hours line in urgent situations that may require orders or direction from the physician to attempt to prevent admission/readmission. ☐ CMHHC will alert SHCC via telephone and fax when a patient is discharged from services and ensure the patient has a follow up appointment with the PCP.

Additional agreements/edits:

_____
_____
_____
_____
_____
_____
_____

SPRINGFIELD HEALTH CARE CENTER
"YOUR COMMUNITY...YOUR HEALTH...YOUR HOME"

Care Compact

Springfield Health Care Center and ***Villa of Springfield*** are committed to excellence in care coordination for the benefit of our mutual patients. Listed below are the agreed upon items that will increase communication and provide a safer transition of care and reduce the risk of readmission following the stay at ***Villa of Springfield***.

Springfield Health Care Center	Villa of Springfield Nursing Facility
☐ SHCC will send a fax alert immediately upon admission to identify patients who belong to this practice. ☐ SHCC will be available to provide any pertinent information or answer questions or concerns upon admission to Villa. ☐ SHCC will provide assistance in complex discharge planning needs when necessary. Ex: HHC agency used in the past, ☐ SHCC can provide clarification on discharged medications, orders or instructions when patients are received from Springfield Regional Medical Center. ☐	☐ Villa commits to begin planning for discharge upon admission. ☐ Once the PCP has been identified, if the patient is seen by SHCC and a fax alert has not been received, Villa will contact SHCC via telephone to ensure SHCC is aware of the patient's admission to the facility. ☐ Care Coordinator or other nursing staff at SHCC will be alerted of a planned date of discharge for our patient at minimum 24 hours prior to discharge. ☐ Villa will take into consideration the risk and complexity, services needed, and preparation required to care for the patient and contact SHCC in a time frame that allows for proper planning. Ex: discharging high risk patients on weekends and Fridays without alerting SHCC. ☐ Discharge planner at Villa will call the Care Coordinator and schedule the Transitional Care appointment with the PCP prior to the patient leaving the facility. ☐ The discharge planner will disclose any pertinent information regarding HHC, DME or any outside services ordered or needed. ☐ Villa commits to providing at minimum a (**7) day** supply of medications at discharge. ☐ Villa will fax a list of discharge medications to the care coordinator or

Springfield Health Care Center – Story

September 9th, 2014

Collaborative meeting between:

- Springfield Regional Case Mgmt.
- Villa of Springfield Nursing Facility
- Community Mercy Home Health
- Facilities & hospitals are now reaching out to us to learn about what we are doing differently. Wanting to be a part!
- Building relationships is an ongoing process, our care compacts were birthed from lots of communication and sharing needs with one another.
- Identification of care gaps and filling those gaps!

- Required a lot of education and communication with providers.
- Requires *patience* and *dedication* to the desired outcome.
- This was a two-way street. Needed to make it easy for them. What did they need from us?
- Some lacked the same vested interest in the success and purpose. Lots of episodic care…working in silos!

Areas that needed improvement

- We needed to establish a great foundation for other providers to build upon
- Plans for medication safety project
- Reciprocate communication by creating an alert sheet

Areas that needed improvement, continued

- The focus wasn't on improving numbers…but improving *communication* to fill critical gaps in care!
  - Fewer gaps in transitional care
  - Enhanced communication among providers
  - Reducing readmission risk
  - Timeliness of care
  - Early identification of urgent needs

Questions?

Please enter your questions into the Q&A section, or raise your hand to ask verbally.

Chat: What is a reasonable goal for increasing the number of Care Compacts in your practice by May 2015?

Let's put the ACTION in Action Groups

1. Post care compact (as applicable) to the Action Group Library
2. Review multiple posted care compacts
    1. If you have questions or comments about compacts you have reviewed, please jot them down and bring them to the next action group session or post on the collaboration site
3. Post **at least one** question or comment on the **Care Compact Action Group Forum**

Summary

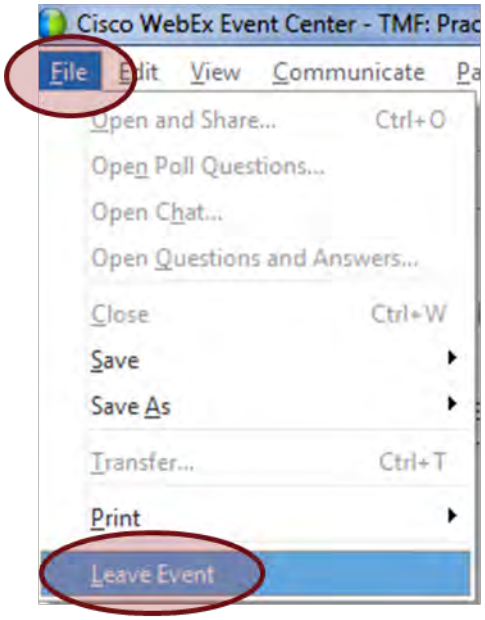
Keep the Discussion Going!

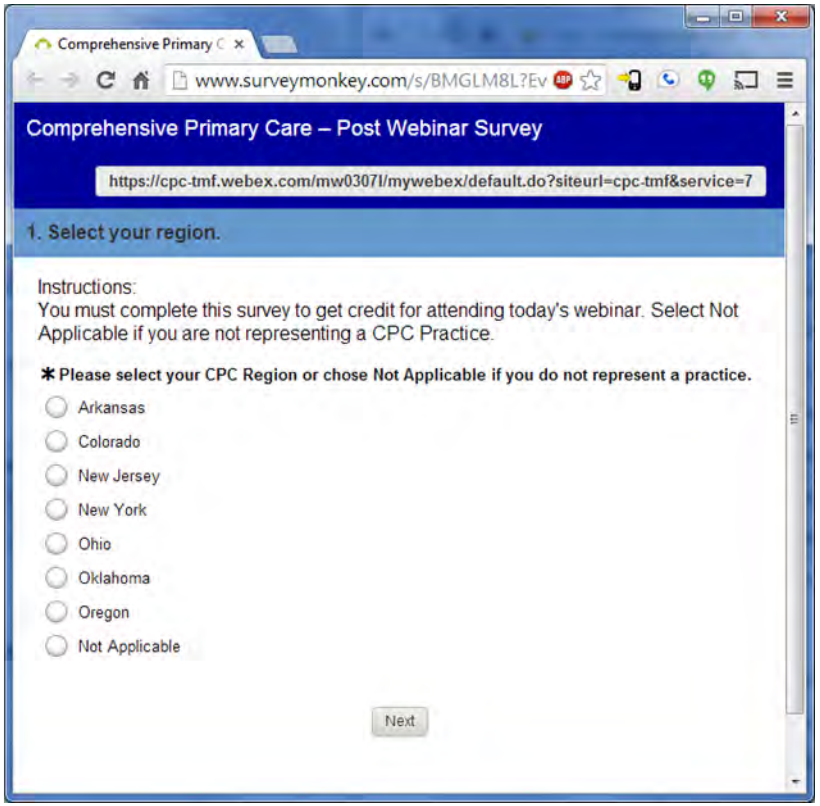
- To participate fully in the Action Group, you received directions to sign up for the forum and subscribe to receive notifications for this group.
- Post documents in the Library folder corresponding with your action group.
- ***You may sign up for as many forums as you wish!***

Next Action Group Session

Date and Time	Title
Nov. 18 (12-1 p.m. ET)	**Care Compacts Action Group:** Get out your Tools! Building the Foundation of your Care Compact

Post Event Attendance & Feedback





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