National: Milestone 6, Compact Collaborative Agreements

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Hello everyone. I am Krystal Gomez from TMF Health Quality Institute. Welcome to our national CPC Webinar entitled Milestone 6: Compact Collaborative Agreements. I'd like start things off today with a few announcements. The slides for today's presentation will be available for download on the Collaboration Site. You can also download the slides directly from the WebEx environment today by using the top toolbar and selecting File, which will open a dropdown menu. Then select Save As, and then Document. Today's program is being recorded and will be posted on the Collaboration Website once transcripts have been completed. We appreciate the presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products or vendors are expressions and opinions of the person speaking and not an opinion or nor endorsement by the Centers for Medicare and Medicaid Innovations, nor TMF Health Quality Institute nor the host of the program. As a reminder, all the lines will remain muted throughout today's session. To submit questions click on the Q and A tab on the right hand side of your screen. I am delighted to introduce today's speakers. I would like to introduce our subject matter expert for today's presentation, Nicole Deaner. Nicole is a Regional Director at HealthTeamWorks and within this role provides oversight for all programs and service that fall within the Mountain Time Zone region. As a member of the extended leadership team, she also directs HR and operations within the system's transformation team and participates in product development and other organizational growth strategies. Now, I'd like to hand the presentation over to Dr. Laura Sessums, who is the Division Director of Advanced Primary Care at the Center for Medicare and Medicaid Innovations. Dr. Sessums.

Thanks so much Krystal. Today's Webinar is all about the explicit mechanisms you can use to establish relationships with other medical practices so that all of you can work together more efficiently and effectively to provide care to the patient. All CPC practices have really worked very hard to transform how they deliver care internally. Some of you may even describe your practice now as a well-tuned team machine. But when you try to coordinate with other practices in the community, you might feel like your well-tuned machine, your Ferrari if you will, hits the really bumpy roads of your medical neighborhood. So developing relationships in your community can be really difficult. But you have already successfully worked to coordinate with at least one local hospital on patients being discharged after admissions and ER visits. As those of you who worked on this in the last year will know, a more difficult road to pave is the relationships you have with the specialists that see your patients. Back in the day, maybe 50 or so years ago, this wasn't really a problem. All physicians saw patients in the hospital and saw each other

there, too. They ate lunch together in the hospital dining room. Today, very few outpatient providers see patients or their colleagues in the hospital. Outpatient practices now have care teams. So there are far more people to know. And there are more patients with a number of chronic conditions today than there used to be. And those patients often require visits to multiple specialists. So the primary care teams don't often know the specialists or the people in those offices. Communication breaks down. That's why we are focusing today on how practices have worked to fill the roads of their medical neighborhood for patients. I think we all know the ruts in the current roads of the medical neighborhood. We don't get responses from specialists to whom we've referred patients or the questions we asked of them are not answered. Specialists, in turn, say that they often don't get the information they need when they see a patient. Everybody's frustrated. Even worse, duplicative testing is ordered, extra visits are required when necessary information isn't available the first time. Patients get conflicting advice. And everybody, the primary care team, the specialist offices and the patient is unsure who's supposed to take the next step. Who's supposed to tell the patient about the imaging result? Who's supposed to order the medication? Who is the patient supposed to call for advice about the symptoms after the referral has been written? This is where care compacts, and some people call them care coordination agreements come in. Most practices around the country have never heard of these. And certainly they have been implemented in only a few communities so far. But they're gaining traction through the work of a number of professional organizations and the practices who've implemented them. As with other aspects of CPC, your use of care compacts will make you one of the early adopters of this transformative idea. And, I hope, able to significantly improve your ability to coordinate the care of your patients and even improve your own satisfaction with the referral process. Now, let's hear from Nicole.

Thank you so much, Dr. Sessums. That was a great introduction. And I want to welcome everybody to our webinar today on care compacts and collaborative agreements. I did want to mention that Dr. Sessums already mentioned this, but as I say care compacts through the presentation, as Dr. Sessums said, many practices might call them collaborative agreements or care coordination agreements. So, I don't want to be too stuck on the language. So when I say care compacts, I may be referring to what you would call a collaborative agreement. And this sort of highlights a lot of what Dr. Sessums said. But basically a care compact provides a framework for a standardized communication plan between primary care and specialty care providers. This could also be other providers. But today we're talking about specialty care providers. Essentially to improve care transitions for patients, but especially with the focus on patient safety and satisfaction. And it's a way for practices to sort of identify who are their highest volume specialists? How do I build good relationships with those specialists? And then how do I know from my patients and my providers if the compact is working and if the relationship with the specialist is working? I want to congratulate you, as Dr. Sessums also said, on this pioneering effort. There aren't many practices that are working on this yet. And so we have a practice to share today and a few other practices in CPC working on this. But I think this will be an exciting growth area for your practice in this coming year. So, I wanted to talk a little bit about why care compacts are important. I think in many -- in most all cases patients are assuming that there already exists a partnership between their primary care team or their primary care provider and the specialist they're seeing. So they kind of see their primary care team as already operating as an agent for care coordination and sort of

understanding what transitions are happening, which medications the patient is on. And so the patient is coming to your office already assuming this is happening. And so therefore, in a comprehensive primary care model, really, the primary care team has a very robust role in managing the pathway to the system for the patient. That could be to the ED or the hospital, to a specialist or to another community agency. But basically, as we look at primary care really expanding its role to its full potential, we see your critical and crucial role in getting the patient to and from other systems in your medical neighborhood back to your practice. Also, preparing patients for a transition or referral. Often patients are going to other providers not really understanding why they're going or whether they really agreed or what the expectations of them are going to be during that transition. And so a lot of times patients will show up at another provider and not really be able to give good information. And maybe they don't even make the appointment because they don't necessarily agree that they want to proceed with that. So I think there's a whole piece to understanding the primary care practices' role in helping patients understand the expectations. And then, thinking about your practice and how much time people are spending being reactive and sort of running around the office looking for faxes, trying to find out if referral information came back before the patient comes in. And all that time sort of being reactive and chasing information takes away from the ability to be proactive in the patient's care. So when they show up you're prepared. You know what happened as you transition them to another care provider. And as they come back, you can sort of integrate that information meaningfully back into the care you provide the patient.

09:39

And definitely care compacts link to the Three-Part Aim. As I've already mentioned with patient experience, fragmented care can often cause delays, miscommunication, gaps in care and so can be sort of an ongoing irritant to patients and really affect how they feel about the care at your practice based on how they transition through the system. Related to cost, often fragmented care that isn't coordinated leads to unnecessary service, especially related to the work that you've been doing on ED and hospital visits. So, whether a patient actually follows through with their referrals and transitions, whether that information meaningfully gets back to your practice and integrated into your relationship with the patient, all of those things impact what services the patient uses and whether they're able to use the appropriate level of service that they need. And quality. Definitely the lack of a care compact between care providers can lead to that lack of coordination that can also lead to a contradiction or a misalignment of patient goals that can ultimately result in patient safety issues. So if I'm an elderly patient and I'm seeing my primary care provider and I'm seeing three specialists, and none of those care providers are talking, I may be communicating different things to each of those providers and also receiving plans of care that aren't communicated across those providers that could cause safety issues for me, especially related to when I'm thinking about elderly patients, medications or things like that. So there are some key components to a care compact that I wanted to highlight. One is sort of how the transition of care is managed. So when a patient goes in and out of their medical neighborhood, whether that be to a fellow care provider, whether that's in the ED or the hospital, whether that's to a community agency, how are those transitions handled? What does the information flow look like? What does the patient communication look like, which is the next key component? Who's communicating to the patient? And when and how? And access. What are the expectations of access for the patient? If I'm

referring to a specialist and they can't get in for four weeks, and I consider it an urgent need to be seen by that specialist, have I made an agreement with that provider about when a patient can get in, how they can access services? So I think having an explicit agreement across providers about how patients access services is critical. As well as Dr. Sessums mentioned, the collaborative care management. So, who does the patient see as their primary provider? Do they see that as their primary care provider? Or do they see that as their specialist? And knowing who's actually taking primary care of the patient sort of determines that information flow and the communication structure and who educates the patient about what. So being explicit about that is important as well. So here I just wanted to highlight just one example of a care compact that's been posted by HealthTeamWorks on the Collaboration site. And it's sort of takes you step by step through some of those key components. On the left hand side of the care compact is the responsibility of the primary care physician. And on the right is of the specialty office. And so I just wanted to give you an example. I know some of the practices that are already implementing care compacts are using this or have revised it and are using it. But it sort of could be a starting point to look at. HealthTeamWorks and TMF have also developed a tip sheet for care compacts and collaborative agreements. And that will be posted on the Collaboration site. So by no means is this care compact the only example out there. There's quite a bit of information that will be available to you on the Collaboration site. So here we see with the referral process, and what I've done in each of these slides is circle where the provider is communicating with the patient. Because we think that is so critical. So here you can see for a primary care provider considering a referral, the primary care provider discusses the reasons for the referral to the specialist with the patient and family. Also, if the visit is urgent, the agreement is that the primary care physician office will call the specialists' office to notify of the need for immediate appointment. And so it sort of takes it step by step through what would happen. So once the referral is made, you can see on the specialist side to the right, if the visit is urgent, the specialty office will schedule the patient within 24 hours depending on urgency. If not urgent, the specialty office will receive fax and contact the patient to schedule a visit. And so you can see how explicit it becomes between the primary care office and the specialist office. And I think what this does is a couple of things. It develops a mutually respectful and meaningful relationship between the two offices to make sure that the best care to the patients is being provided. And so I think sometimes we can sit back and say, well we've worked with this specialist for 10 years. And I think we have a good relationship. But like with many things in the Comprehensive Primary Care initiative, you're becoming much more intentional about documenting and being explicit about expectations in order to do the best thing for the patient. And I think it's easy to get caught up in what exactly needs to be in my care compact in each section. And how many do I need to have? But actually, it's really about the process of developing these relationships, sitting down and saying okay, my office needs this type of information when the patient is referred to have the best type of visit with the patient. And the primary care office would say well, this is the best type of information we can receive back so that we can integrate the care and notify the patient. And so it's really becoming much more intentional, not only about what each office will do, but also finding out from your providers and patients how is this working? Do you like this specialist? You can come to find out that after working for five years at referring a patient to a certain agency, organization or provider that ultimately when you start asking the patients how it's going, they may be struggling with that referral for various reasons. And so integrating that is so important.

So, to the next step is just another example of patient access. So, if the primary care office considers a visit urgent, again, they'll call the specialist. It says that for the primary care office, once the referral information comes back, the patient will be scheduled within two to three weeks of the call to the specialist's office unless the urgent visit is indicated. And so it really defines the relationship back and forth for each of these types of issues between practices. Again, transitions of care. Really emphasizing informing the patient of the need, purpose and expectations and goals of the specialty visit. And really trying to garner that agreement. Again, does this align with patient goals? Is it a priority for them? Are they activated to get this type of care? And it really sort of highlights that need for the partnership, that relationship with the patient. Do I know my patient? Have I talked to them about why this is important? Have they told me what they think? Can they afford it? Do they have transportation to get there? So really integrating that patient piece into the care compact is really critical. Again, patient co-management. Who resumes care of the patient? Who assumes the responsibility and incorporates the care plan recommendations into the overall care of the patient? And I think that can be really a struggle when you have your own care plan and you're learning to develop care plans with patients and you've outlined the patient goals. But how do you integrate other information from community agencies and specialists into that care plan to make sure that it's a well-integrated plan for the patient?

I wanted to talk a little bit about the implementation strategy that you could consider at your practice before we go to a great practice example. This is just something to start from if you haven't already. So obviously with all things in your practice, when you're considering implementing something new, you really want to try to make the case for why it's important to do better care coordination. So giving examples of patients who fell through the cracks. Or talking about great patient examples when their care was coordinated. What came out of it? So really building that why with the practice. As usual, defining a champion who creates an improvement team and a strategy is really critical to each thing you do with transformation. And specifically with this one, we think that the champion should really focus on the internal and transition referral tracking system first inside before going outside to the medical neighborhood. So how are we doing on our referrals? What does our tracking system look like now? What's working? What's not working? Because when you go to sit down with another provider, you really want to be explicit about what works for you as far as communication and what your expectations are. So you sort of need a baseline of where your practice starting. Also, collecting data on key specialist groups, hospitals and community agencies to which you refer frequently is important. And I think there are definite ways to do this. And I think it's one of the key baseline data needs before you start going out and trying to create your care compact. So, by key specialist groups, that could be the specialist groups you refer to most often. It could be the ones with whom you have the best relationship that you want to sort of develop it further with the care compact. It could be those that have the highest impact on your patient goals and patient safety. And so you really want to be thinking about, okay, when I start with my specialist groups, who were the most important ones to target? And getting care team input on that. Identifying a person to outreach to your current and potential referrals is also important. So having not only your goal your improvement plan, but who's actually going to have responsibility for this. And that person could also actively collect feedback from patients and providers about your medical neighbors that you're referring to frequently. We've seen providers who do this well-developed little report card so when the patient comes back from the specialist they can fill out this small report card about how it

went and how they feel about their care with that specialist. Likewise, you can get provider input intentionally, either through surveys or word-of-mouth or a report card system as well. But getting that feedback is so crucial. And then there's sort of this ongoing development and maintenance of relationships with your key agencies. And again, it's easy to get caught up with, you know, we need a hundred care compacts. And they need to be saved in this place. And they need to be updated this often. But really what it is about developing a meaningful process by which you develop these relationships. You know who your key referrals are. You have good relationships with them. So in this Milestone, it's really important to develop those care compacts and get really good at developing that relationship. And in an ongoing way, it's important not to get caught up in the actual agreements and what they exactly look like and how often you need to do them, but more about being a primary care office that sort of expects and demands a mutually respectful relationship with your medical neighbors. And again, you want to make sure that exchange of information is meaningful. It's not just that we send a fax two days before or that we call. But what information are we giving each other to protect our patients and their safety? And then finally, with any changes, it's always great to track your process through either a PDSA cycle or some other quality improvement strategy to make sure you know that the implementation is going well and that it's being effective.

21:52

And finally, I just wanted to highlight the exact expectations for Milestone 6. Option C, which is to identify at least two specialists with whom you'll arrange a care compact and complete two care compacts with specialists. Before I move on to our practice example, I just wanted to make sure we didn't have any questions at this point. We'll also leave time at the end.

Thanks Nicole. This is Krystal. There is one question that's come in to the Q and A box. Where could they -- where could a practice get the step-by-step instructions that you were just showing on the screen?

Okay, so the implementation strategy. So this -- the slides and the Webinar will be uploaded to the Website. So I -- you know, I just went over them. And I think you can print the slides. I believe someone gave you instructions at the beginning of how to directly be able to print the slides from here. So, is that right, Krystal? Or is there some other way that I'm not thinking of?

Yes, they can load the slides directly from here. I think they might have also been referring to the graphic a few slides -- go a few more slides -- right there.

Oh, okay. So the care compact. Okay. So the care -- the HealthTeamWorks care compact example is uploaded on the Collaboration site. And I believe it's linked to Milestone 6, which is where the tip sheet will be saved as well. I don't have the exact location right this second, but I know that several states have been using it. So I know it must be linked to Milestone 6, Option C because people are electing to use it and make changes to it.

And this is Krystal. We can add the direct link or more direct link to the same area where we upload the slides onto the Collaboration site just for easier finding for practices.

Thank you Krystal. Were there any other questions?

Okay, great. So at this time, again, we will leave questions at the end as well. I want to introduce Molly Pickett who is the Care Manager Nurse Practitioner from Mayfair Internal Medicine in Colorado. Molly has been really a spearhead of the CPC program at Mayfair Internal Medicine. She is the project manager for a lot of the new implementation strategies for the milestones. And so she's here to talk about the process she's been spearheading for implementing and integrating care compacts within her practice. And so she's been really working on relationships with two partners that she'll talk about. And she's been coordinating all the communication between her practice and the other practices. So with that, I'm going to transition the slides over to Molly.

Okay great. Thank you Nicole. I appreciate it. I thank you all for joining this awesome presentation today. This is -- care compacts actually is something I'm pretty passionate about. I feel this is something we honestly all should have been doing from the get go to better serve our patients and their needs. Because this is just kind of a no brainer. We really should have some responsibility and some set ground rules on how we need to coordinate patients' care efficiently and appropriately. So this is actually something I've been super excited about and actually had wonderful experience with so far. So, in getting started with this and where we've decided to start was the fact that, you know, we had a couple clinics that we really refer a lot to. And we decided, you know, from there, where should we really take this and run with it? And we thought of a few different factors. So, you know, the Denver Digestive Health Specialists for GI is where we do the majority of our referrals at this point. And I'd say approximately 300 referrals a quarter, at least, go to this practice. And they also do the majority of our colonoscopy, just routine screenings and also diagnostic screenings. And so we felt kind of that bringing all of that together for also, you know, Meaningful Use tracking and also just kind of really hammering out some of the issues we were noticing with some information transitions is really kind of where we wanted to go with this. So that's why our clinic decided to pursue a care compact with the Denver Digestive Health Specialists. And again, you know, in your own areas, you really need to figure out where and how to best, you know, what would be the best place to start for you. And what clinic do you think, you know, you can really build upon a great relationship and try to improve the communication and the workflow and best ability to serve those patients. So what could be improved with the current referral process? You know, Denver Digestive, they're a wonderful clinic to work with. The doctors are all very receptive. And we have great communication already with them. However, we did find some gaps in our information process. And we were finding that the pathology reports in our colonoscopies were not coming over in a very timely fashion, in fact, if ever. And so when we did finally make a meeting and sit down with the office manager and we were discussing and reading through our care compact with her and we brought this to light. She was actually quite shocked because she had assumed that the workflow was already in process and that, you know, the information was being transferred to us in a timely fashion because it actually was through another vendor where the colonoscopies take place. And so, again, this is kind of bringing to light, wow look, you know? We have a lot of areas of improvement even on their side, not only our side, but their side as well, where they had assumed a workflow was already in process and was already appropriately channeling all of the direct information to the primary care doctors who were referring out for these colonoscopies. But when in actuality, we weren't getting the reports after all. So, you know, you really do end up along the way finding a lot of areas of improvement that people had just assumed were already in place. Workflow was working. But

it actually wasn't. So that was something really great that we were able to add to our care compact and really try to improve our doctor communication. And that way, again, we, you know, our garnering that really good relationship with not only Denver Digestive, but especially with the patient. And we're being able to present them with their test results and be able to really get all the knowledge that they need after they had a pretty intensive procedure. The other care compact that we chose to pursue was something very special to me, and especially with our patient population here is with the Maria Droste Counseling Center. Also, you know, we're really killing two birds with one stone at this point because not only are we satisfying, you know, the Milestone 6 for the care compact and collaboration agreement, but we're also now satisfying behavioral health integration with Milestone 2. So this is one that I felt was really exciting. And we were going to really get a lot of work done with. And we actually are having an amazing experience with Maria Droste and their counseling center. And they are just as excited about it and really working hard on their side as well to make this collaboration as smooth and as focused as possible.

29:57

So, so far we've actually done a ton. The care compacts I did choose to use here were what were -- they were provided from us from the HealthTeamWorks site that you all were asking about the step-by-step instructions. I've, of course, tweaked those and adjusted them according to the needs of both our practice and the practices that we are collaborating with. And I will continue to kind of adjust and revise those. And I've approached our coordinating facilities with the fact that, you know, these are working collaboration agreements. We need to figure out what's going to work for everybody. If we run into oh hey, that's not working for us, to be able to, you know, discuss -- you know, we can't refer this patient to that - you know what I mean. So, you know, if there's any issues concerns, problems, they're all working collaboration agreements. And I try to really just open it up for that when you are approaching your groups with these. So, you know, so far it's been wonderful. I really haven't had to do a lot of tweaking to our care compacts. And we're really doing that well. I've approached these practices both with meetings. And we continue to have update meetings, emails, and we're, you know, it's really been great having better and more open communication with these clinics. Because at first, it just felt like well how do we talk to these people? And, you know, who do we call? And you just kind of got a -- you really have to start somewhere. And just kind of getting out there and putting out feelers, especially to anybody that you're familiar with in those practices is really a good place to start. Let's see. So implementation. We are -- essentially we're really building our referral process in right now for both of those practices. And also any sort of bidirectional communication is our other huge piece that we're really trying to make sure that we're figuring out the best way to implement that. And then referral tracking is something we're really just kind of building from on from what we've already, the work process and workflows we've already put into place for the previous year for CPCi. And so, that's kind of another place we're starting to go is, well, from referral tracking, how are we going to go from here? And, you know, we'd never referred to a psychiatric clinic before. So this is a new referral process for our clinic here. And so as we go on with that, we'll just kind of -- we're going to learn and grow and build as we go. We were hoping to do quarterly follow up with both of the practices at minimum. I have a feeling we'll end up at first doing more frequent monthly follow up with both practices until we both get more stabilized and consistent with our workflows. And then I think we'll go to quarterly from there. And then continued

improvement and adjustments as needed. Again, you just really need to tweak it and you need to adjust it according to what's going to work for both practices. And you both need to take responsibility for where we both can improve. And I do believe that it is in our place to kind of essentially call out a doc or a specialist office that's really not kind of pulling their weight. And, you know, that's kind of part of this care compact. And we need to remember that it's all about the patient. And if it's affecting patient care, that's the bottom line. And we need to make sure that we are making people responsible for that fact. And again, you know, building the medical neighborhood is so very important. And that's part of why I really love doing these care compacts and collaboration agreements. Because this to me feels like something we really should have been doing from the get go to really benefit our patients and serve our patients as appropriately as possible. Fixing long-standing communication issues is, again, a huge piece. Another group that I had considered doing a care compact with, we do have some very serious bidirectional communication issues, especially in even getting the progress note after a referred visit. And just something as simple as that, and you know, making it known that, you know, we're really not getting good communication from your office, you know? Really would like to get our progress notes back from you in a timely fashion. So that way, when we do follow up with our patients, we're able to give them better information and it doesn't make everybody across the board look kind of silly. How to work with a mental health provider? You know, that goes a huge way for primary care. And I feel that there's such a barrier that has been built up between mental health providing and just primary care. And it's very odd stigma that's been developed that we're not supposed to talk to each other. But that's really not the case. So, speaking with the mental health provider has actually been an amazing experience thus far. And the workflows and reporting process that we put into place is something that one of my physicians here has actually said several times, in 30 years I've never gotten a progress note from a mental health provider. So he is just loving it. And the mental health insurance change is another thing that we're incorporating into our collaborative agreement because most commercial insurances now do offer mental health coverage. And that's something that we're all learning about and incorporating into our collaboration agreement. And we're really finding that, again, the practices are so much more receptive than you might think to also build these collaboration agreements and compacts. So, keep that in mind when you are building your and/or approaching any practice with these collaboration agreements, that it's really -- it's mutually beneficial. And both sides are going to be able to benefit from it greatly. So I think that's all I have.

Thank you Molly.

Yes, thank you Molly. I see one question in the Q and A box. It says do you have the referring provider sign an agreement yet?

Yes. In fact, actually we definitely have Maria Droste on board, our mental health collaboration. They are -- we're in full swing with them in our collaboration. And we've actually lucked out on their side in that they have a PhD student that's working on his dissertation for his PhD. And we kind of became his -- we kind of became his pet project as well as he becoming ours. So they have been in absolutely the most helpful mode you could imagine for this counseling center. And we're doing monthly meetings with them. We're doing mental health collaboration. It's just been such a wonderful experience so far. And we're still working on our [inaudible] of health specialist. We're still kind of working with them and

figuring out for Meaningful Use Stage 2 some of the -- some of the electronic health record documentation and bidirectional communication issues. And then we will have that underway. And really, the referral process is not really going to change much at all. It's mainly just getting information back with them.

38:12

Okay, Molly. I have --

Thanks for that question.

Yes, thank you. I have a couple of questions. I think this one you might have touched upon, but maybe you have a little more you could add to it.

Mm-hmm.

It says how do you report this for Meaningful Use?

Specifically you don't really -- I mean, we're not tracking for Meaningful Use. However, with Denver Digestive, we also have found they're also in Meaningful Use Stage 2. And so we kind of approached them and we took that to our benefit because we're also in Meaningful Use Stage 2. So we have approached them with the fact that it's mutually beneficial for both practices to utilize certain functions in the EHR to be able to communicate to satisfy for some menu in core measures for Meaningful Use. Also, we wanted to kind of incorporate the fact that we need to track for -- I'm sorry, for colonoscopy tracking. And so we are also incorporating that into our care compact and the importance of that in the screenings. So there's several different ways you can actually report for Meaningful Use. It's just it's not specific and you have to figure out based on who you want to do a care compact with, how it's going to benefit you and how you can report for Meaningful Use. So that's a great question.

Wonderful. We have another one. What is the official opinion of your malpractice carrier about these agreements?

We've actually talked to COPIC, especially about our mental health referral and also about just the information that we may or may not share. And we have come up with an authorization form to kind of quell any issues that might arise from collaborative information sharing between us and a psychiatric facility. And it doesn't seem to really pose any threats or issues. And really, we're not changing anything, to be honest with you, other than better bidirectional communication between the two practices. So, really there shouldn't be a malpractice issue there.

Thanks Molly. And we have another one. What difference have you seen specifically with the patients for the behavioral health compact? What would change for your high risk patients?

One more time. I'm sorry. Could you repeat that question?

Okay, sure. What difference have you seen specifically with high risk -- I mean, with your behavioral health compact? And what will change for your high risk patients?

Again, that's an awesome question. With all of our patients, we're really -- we found that we had not really had any sort of consistent ability to refer them to any sort of mental health provider prior to this. And so that's made even just that alone being able to give somebody a name, a number and then a group that actually contacts them has been a huge goal that we've met here for these patients. And we're already noticing less utilization between our patients and our office and also, you know, a better satisfaction for those patients in general. So it's really, you know, what you can't do -- if your mind's not well healed you can't really heal your body. You can't take care of your self-management. So that's why, again, it's so important for behavioral health integration. And so we have found a really good response from that so far.

Awesome. Thanks Molly. Are you planning to get provider and patient feedback about your referral services? And if yes, how?

That's a good question. We probably need to look into that. So far everything we've gotten has been verbal. And it's been very positive. And patients have been very satisfied with the communication and also the process of getting over to our referring mental health specialists, especially. So again, I think that's probably something we need to work on here. And we will figure out -- I'll probably have to come up with a workflow to figure out how to question those patients.

Great. Thanks Molly. And I know you're in the beginning stages. And there's a lot of questions still to be answered as you work through this [inaudible].

Absolutely.

We have another question. Did the referring group have a direct address yet?

I guess I'm not quite sure what that question means.

Okay.

I -- they both have addresses.

Yeah. It said D-I-R-E-C-T.

I don't know what a direct address is, I guess.

Okay. So if that was your question, if you have an additional follow-up, if you would post that in the question and answer tab so we can --

Direct Meaningful Use purposes for Stage 2.

Um --

Molly, this is Jeff Nordyke.

Yeah.

I can probably answer that question.

Go ahead.

Direct is the term used for health information exchange. And essentially it's a secure email between providers.

Okay. Well, you know, the way that we're actually communicating in a secure fashion with these -- with our Denver Digestive Health, they also are testing for Stage 2 this year. You know, we're doing that through our EHR. And since we do have different EHRs, our EHR, we are eClinicalWorks, does offer a provider to provider method of documentation and also coordination and direct emailing, messaging and we can send our progress notes securely over that interface. And so we are developing that with our patients -- or I'm sorry -- we're developing that with Denver Digestive. And also we've set that up with Maria Droste. And of course they're a counseling center, so they don't have an electronic health record. So, right now, that's the only way we're really communicating with them in a secure fashion. I hope that answers your question, Ellen.

And I do not see -- yes. I do not see any of the [inaudible] questions in the question and answer tab. So if we have a few minutes. Molly, if you could [inaudible].

One more came here.

Sure, if you could --

Are you using actions to follow up on referrals or are you leaving the referrals open? Generally, our process is pretty much the same for any of our referrals. As soon as we get a progress note back from our referring provider, then we will close that referral. We're still kind of yet to figure out how to close our Maria Droste referrals because we do anticipate there will be some ongoing care throughout a period of undefined time. And so we do anticipate getting some updating progress notes monthly from them. And so that again will be kind of open. And so -- but for now we've decided to follow our actions. And the workflow is essentially the same for our referral process. It's going to be closed as soon as we get a primary progress note back from the specialist.

Thanks, Molly.

Sure, sorry.

It looks like there's one question. And while you're answering it, if you could just pass me the presenter ball.

Sure, I'm sorry.

No problem.

So it said could you provide your contact information in case any of the practices have questions?

Of course. For $5,000. [Laughs]. So we'd be happy to talk to anyone, any time, about questions they may or may not have. This is something I really enjoy talking about. And anything that you might -- any of you all might have to share as well would be greatly appreciated.

And so, Molly, if you'd like to enter your email address or contact information in the chat window.

Sure.

Open to all participants. Then everyone would have access to that information. And then one additional question came in. Have you begun any work on ambulatory to acute care coordination agreements?

Um, we -- I don't -- have we begun work on any ambulatory to acute care?

Correct.

Um -- no, not really, other than just a few occasional patients I might have. But that's kind of outside of our care compacts.

Thanks, Molly. So I have now put on the screen our next learning opportunity is available June 10. And it will be offered at noon Eastern Time. And it is a deep dive into self-management support with virtual site visits. So we'll actually be hearing from some practices who have started on their journey for self-management support. And we have a few minutes, so I'm going to -- there's one more question from Virginia King.

Mm-hmm.

Are you getting your reports faster without asking for them since you've signed the agreements?

Yes. And it's been amazing.

48:39

Wonderful. Thanks, Molly. So, I would like to thank everyone for attending. We hope that you found this presentation informative. You can exit this session by clicking on the file menu option at the top left of your screen and select the option to leave the session. You will be taken to a post-webinar survey that needs to be completed in order to receive credit for attending this presentation. And I'm going to hand it over to Nicole for some -- Nicole Deaner for some conclusion comments. Go ahead, Nicole.

Hi everyone. I just wanted to say thank you so much to Molly for sharing her practice story. And I think she highlighted a couple of great areas to be thinking about that Dr. Sessums and I talked about earlier. One is probably starting with those specialists that you have good relationships with first so that you can practice this out in a trusting relationship versus starting with the practices where you may be struggling to get information back, or you have struggled to develop a relationship. I think the other great thing that she highlighted is linking her work on this Milestone to other Milestones. So the great work they're doing on behavioral health and liking what they're doing with the Maria Droste Counseling Center with their compact work as well. And then finally, I just want to say that I think having someone spearhead this who has passion about it really helps. And it helps drive, I think, the change in the practice as well as

communicating the passion with the other practice about why this is important and really linking it to the patients and maybe thinking about giving some patient examples of where care coordination didn't go well. Or how, you know, it might look if patient coordination improved. And how that might look for patient safety. So I think a lot of great things were highlighted. And I think with everything with CPC and with improving primary care, it can seem intimidating. But I think there are great examples out there in the tip sheet as well as the HealthTeamWorks example and those will give you a really good place to start. They're not -- a care compact or a collaborative agreement is not something that you have to do an exact same way as everybody else. But as Molly said, it's really supposed to reflect the relationship between you and the other provider and what you both need to make that relationship work. So I really encourage you to try this out with the practice that you feel like you have a really good relationship with and really start small, as well as, as Molly said, really focusing internally on your implementation, your referral tracking, the things that you're doing to really make it a solid quality improvement process. So you can see and you can track how you're doing. So I really like the idea of keeping in contact with the practices to keep making those adjustments as well as keeping internally sort of a pulse on how things are going and if you're getting the information back and how those transitions are going and how patients are feeling about it. So, great job, Molly. And I wish you guys all the best in trying this out. And if you have any questions, Molly provided her information. And HealthTeamWorks is also happy to connect you with other practices that are doing this work as well. Thanks Krystal.

Thanks everyone.