CPC
Comprehensive Primary Care

Milestone 6: Compact/Collaborative Agreements

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Introductory Comments

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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.

Colorado Systems of Care/Patient

Centered Medical Home Initiative, funded by the Colorado Health Foundation 10/22/2010

The "Why"

- Patients assume a partnership between the primary care team and specialists; primary care is agent for care coordination & seamless transitions
- Primary care has robust role in managing the pathway to the system for the patient
- Preparing patients – do they understand why, do they agree, are they educated about expectations?
- How much time is your practice spending being reactive and chasing information versus being proactive?

Link to the Three-Part AIM

- **Patient Experience: 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 and can result in patient safety issue(s)**

Care Compact – key components

- Transition of care
- Patient communication
- Access
- Collaborative care management

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

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 first
- Collect data on key specialist groups, hospitals and community agencies to which you refer frequently
- Identify a person(s) to outreach to current & potential referrals; collect feedback from patients & providers about your medical neighbors (report card)

Implementation Strategy - Continued

- **Develop and maintain relationships with key agencies and develop compacts/agreements**
  - **Think about starting with "easy" relationships first**
- **Ensure the meaningful exchange of information across and between medical neighbors and patients**
- **Track process through PDSA cycle or other QI strategy**

Milestone 6 – Option C

- Identify at least **two** specialists with whom you will arrange a care compact
- Complete **two** care compacts with specialists

Mayfair Internal Medicine

Practice Experience

Practice Story

- How did we 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- "Killing two birds with one stone"

Practice Story, cont'd

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

Mayfair Internal Medicine, P.C.
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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

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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

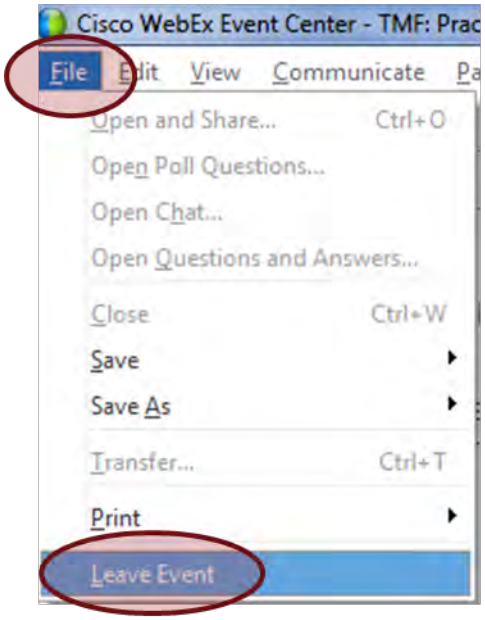
- Building our medical neighborhood
- Fixing long standing communication issues
- How to work with a mental health provider
- Mental health insurance changes
- Practices are more receptive than you might think

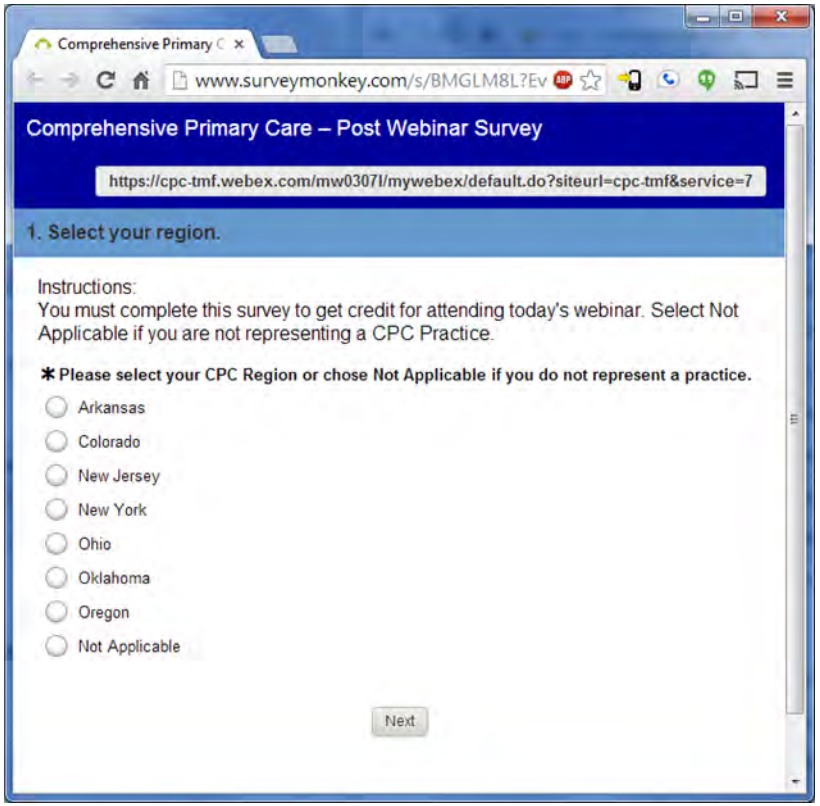
Questions?

What's Next

Event Date and Time	Title
Tues., June 10, Noon ET	Self-Management Support with Virtual Site Visits

Post Event Attendance & Feedback





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