CPCPracticeSpotlight30

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Full HIE Access Facilitates Real-Time Care Management

Internal Medicine Associates of the Grand Valley, Grand Junction, Colorado System (affiliation as of Dec. 2013); 4 physicians; 4,500 patients

Nov. 21, 2014

This innovation addresses CPC Milestones 2, 6 and 9, and these Change Package Drivers:

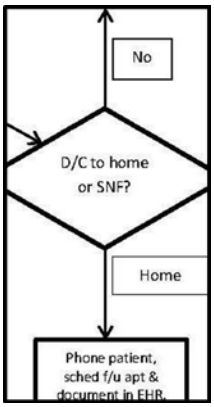
- 1.1: Access and Continuity
- 1.3: Risk-Stratified Care Management
- 1.5: Coordination of Care Across the Medical Neighborhood
- 4.2: Data Exchange
- 5.1: Engaged Community

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: Like 80 percent of the medical providers in western Colorado, **Internal Medicine Associates** (IMA) accesses a health information exchange (HIE) for notification and tracking of the practice's hospitalized patients. Administered through Quality Health Network (QHN), the HIE allows physician subscribers direct access to all patients' information with real-time status updates through its data repository.

However, non-physician clinical staffers have more limited access. For example, a nurse care manager may only view information pertaining to her provider's patients, and not all practice patients admitted by a specialist or surgeon. Additionally, non-physicians cannot access daily admissions updates until a physician reviews and transfers them to the patients' medical records within the practice.

Innovation: With support from the practice's physician champion, **Donald Maier, MD, FACP,** IMA petitioned QHN in November 2012 to grant full repository access to the practice's care manager, **Kirsten Wiegert, BSN, RN**. IMA's rationale was that real-time, daily access to the QHN data repository by a qualified nurse care manager facilitates proactive team-based care management. Further, coordination at times of transition is instrumental to patient safety and continuity of care.



Learn more about IMA's workflow for inpatient discharge follow-up on the Collaboration site.

In January 2013, QHN granted Wiegert repository access for her care management work, but a volume of similar requests from subscribers prompted QHN to re-evaluate its access policies. In April 2014 QHN updated its policies for repository data access for care teams of QHN participating physician providers, who agree to assume responsibility for monitoring the care team members' appropriate usage.

Wiegert's repository access is filtered to specific streams of information: emergency department registrations, admissions and discharge reports. Working across two monitors, she displays the repository dashboard beside the practice and hospital EHR dashboards. As she sifts through QHN notifications throughout the day, she can see when patients are admitted and for what reasons. If patients transfer from the ED to observation or are admitted, this notification also crosses her dashboard. Typically she sees eight to 10 admissions and five to seven ER visits in a 24-hour period.

Each morning, she reviews inpatient and ED charts from the previous 24 hours. She reviews labs, imaging and EKG reports, as well as nursing, therapy and consultation notes as appropriate. Wiegert relays pertinent information to practice physicians to keep them abreast of patient conditions.

For one patient with a lengthy and complex hospital stay involving multiple specialties, IMA's consistent monitoring eased his transition to home with an appropriate care plan. The patient's family understood the patient was terminally ill but misunderstood the purpose of a palliative care consultation in the hospital. When they sought clarification from IMA, the physician was ready to explain the situation and provide appropriate care planning because Wiegert had already passed along salient points from the notes.

A second, parallel effort to improve continuity of care involved collaborating with hospitalists. Dr. Maier and Wiegert met with hospital and physician leadership in 2012 to build partnerships that improve patients' transitions and ongoing needs. Wiegert attended hospitalist staff meetings to introduce herself, discuss her acute care experience and answer their questions. A similar meeting took place at a smaller hospital a few months later to explore how the practice's physicians could best make social rounds on admitted patients, which resulted in a collaborative agreement. IMA found hospitalists too are increasingly concerned with reducing avoidable readmissions, and many were interested in learning more about IMA's approach.

Hospitalists now routinely contact Wiegert as patients are discharged to discuss follow-up needs, any pending tests or to review medication changes. If the patient is in the practice's highest risk strata, Wiegert generally makes a follow-up call within 24 hours. Lower-risk patients are assigned to trained MAs for follow-up. IMA's post-discharge follow-up was 100% for the first two quarters of 2014. From quarter 2 to quarter 3, the practice's ED follow-up improved from 59.37% to 76.75%, an improvement Wiegert attributes to closing gaps in processes.

Clearly the increased requests for expanded HIE access shows care coordination is of rising importance in this medical neighborhood. Until the care team is the mainstream model for care delivery, Wiegert points to developing relationships with acute care facilities as a key to IMA's care management success.

TMF Health Quality Institute

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