Milestone 6 Action Group: Use of Care Compacts to Coordinate Care across the Medical Neighborhood

Presenter: Kari Loken, HealthTeamWorks (CO faculty)

Moderator: Rose Langdon, TMF Health Quality Institute

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Hello, everyone. I am Rose Langdon from the TMF Health Quality Institute. Welcome to the live session of the Milestone 6 Care Compacts Action Group. Today we're going to be talking about finding your partners. As a reminder, any statements about the quality or utility of any product or vendor made in this presentation is an expression of the opinion of the person making the statement only and is not an opinion or endorsement of the Center for Medicare & Medicaid Innovation, TMF Health Quality Institute, or the host of this presentation. We look forward to your active participation during today's session. And now we'd like to know where each of you are located across our seven regions. To do this, please click the arrow on the left side of your annotation toolbar, and then indicate this on your map by just clicking where you are located, and you guys catch on really quick. Thank you for participating. Wonderful, we've got people from all over. And now if you go back up to the arrow and click it so that you do not accidently annotate during the presentation we would appreciate it. Remember that this is your Action Group. We're going to be as interactive as possible during these sessions, and we want you to actively engage using the Chat feature, Q&A, as well as raising your hands and asking questions or making comments verbally. In addition, we encourage the use of the forum between sessions to continue the conversation among group participants. If you could please go to the chat now using the bubble that's up at the top of your screen, and indicate what you want to learn today about Care Compacts and finding your partners. I want you to remember that the action items that we'd like you to do after this session include to outreach to at least one medical neighbor and establish a Care Compact. We'd like you to post the specialty you chose for that Care Compact in the Action Group forum. Second, outline a method of monitoring the quality of care of your health care partner and post how you're doing this in the Action Group library or forum. And, third, post at least one question, comment or piece of information on the Care Compact Action Group Forum to keep that conversation going. We are very fortunate today to have presenters from Boulder Community Health and River Valley Family Medical Services. I'd like to introduce you now to your facilitator, Kari Loken, from HealthTeamWorks in Colorado. Kari, the microphone is yours.

Thank you, Rose, and thank you to Dr. Lipetz and Darren Jenkins from Boulder Community Health, Cathy Daboul and Dr. Daboul, as well as Tess Neal from River Family Medical Services. We really appreciate you taking your time today and preparing for this live Action Group. So questions, we can't say it enough, please free to Chat your questions in throughout the presentation or better yet raise your hand to ask those questions verbally. We want to hear from you, this is your Action Group, it's your

opportunity to talk to each other, as well as the presenters, about learning how different practices are implementing Care Compacts inside their practice and a lot of times inside even their region. And it looks like, let me just click here, the question, it looks like there is interest from one, from Susie McPeak [Assumed Spelling], asking about what a Care Compact actually looks like for behavioral health. And, Susie, thanks so much for submitting that. And today there isn't going to be discussion on the behavioral health, but there was early, I think our first Care Compact Live Action Session there was a presentation from Molly Pickett [Assumed Spelling] on a Behavioral Health Care Compact, and you can locate her sample Care Compacts, as well as that webinar on the Collaboration site. So please keep them coming in and what you're hoping to get from the live session today. So just a recap from November's live Action Group webinar, there was the request to run a report of your high-volume referrals and post the top four to the Care Compact Action Group Forum. And I would love to have you chat in using the Chat function or the question and answer chat stuff to let us know what your top four high volume referrals are in your practice. Next, we also ask that you share a Care Compact template from your EHR. We, you know, this is — we're pushing the edge on the EHRs and we'd love to see if there's any EHR out there that's actually building this in and post that to your Care Compact Action Group, to the Action Group library, or go ahead and Chat that in now. And then, of course, we're hoping that you'll post one question or comment on the Care Compact Action Group Forum. We have quite a length of time in between our live action sessions as part of this Action Group, and so we'd love to keep the conversation going on the Collaboration site. So please, as you come up with questions or you come up with ideas or you have a Care Compact you'd like to share please go ahead and post that on. All right. I'm not seeing anything coming in through the Chat. What we did find is in the fast facts that CMS provided is that gastroenterology is oftentimes a high-volume specialty or at least where a lot of practices that have implemented Care Compact have focused, as well as cardiology and orthopedics, likely not any big surprises there. At the last live session we talked about getting out your tools. One of our New York practices from a single provider practice outlined how they chose their partners and developed their tools, and Colorado Springs Health Partners talked about their process of implementing Care Compacts within their own system. So thanks to those who posted on the forum. We really appreciate that and, as I said, keep them coming. We'd really like to make sure that the conversation keeps going during this period of time between now and our next live session that'll happen in May. So I don't know about you guys, but I love to take a poll, and we'd love to hear from you. So please go ahead and click that annotation arrow and let us know have you started structuring a Care Compact? Great, this is super. I think that we're seeing from my recollection from the first webinar we're seeing more people in the yes and more practices and people in the planning stages and fewer in the no. So we hope that these Care Compact Live Action Sessions are helping you continue to move from planning to yes. All right. And we have a couple no's, and I'm not sure what the status is, and that's great. I would encourage you to go back to whomever in your practice might be able to fill you in on where you're at in the process. So, once again, why wait, ask your questions as they come up, and we may take them during the presentation, we may take them following each presenter, so please so you don't lose track of that question, like I do so much of the time, go ahead and chat that in and we'll make sure that we get it addressed.

09:47

So, with that, enough for me. I'd love to introduce Dr. Lipetz from Boulder Community Health in Boulder, Colorado, who is the Chief Medical Officer of Physician Clinics Ambulatory Services, and she has with her Darren Jenkins, who is an RN and their Clinical Quality Director. So, with that, I'll turn it over to Dr. Lipetz, I'm passing you the ball.

Hi, I'm here. Really nice to meet all of you. For some reason I have a little thing saying it's setting up the event center, so I'd like to move that out of the way. Okay, can everybody hear me okay? All right.

We can hear you.

Okay, then I'll continue. So as Kari said, I am from Boulder Community Health. We are in Boulder, Colorado. And we have the wonderful thing about having been able to employ a lot of primary care practices in our area. So we have 12 primary care practices and five of those are in the CPCi initiative. We have a total of about 55 FTEs of physicians or mid-levels, and our total active population for patients is around 54,000. Our EHR is Greenway, Greenway does not have any premade templates for things like Care Compacts or many other things. So when we decided that it was time to have Care Compacts, we needed to design those on our own. But just to let you know a little more about us, our Care Team model is one provider to one medical assistant. Then in the Care Team we also have a care coordinator, and depending on which practice one is in we have either a medical assistant-level care coordinator or an RN-level care coordinator. We usually have three to five providers per Care Team and then, of course, we have significant support from our front desk staff, as well. So when we decided it was time to start working on Care Compacts we really didn't have much experience with it nor had we seen other Care Compacts, and so what we wanted to do was try to really align with practices that we were working with a lot. Our first step was to do what we called our easy Compacts and those were with neurology and with infectious disease, and the reason those were easy is that those practices were also employed by the hospital. They were on our same electronic health record or just about to be on our same electronic health record. And so communication amongst those two groups with the primary care was already pretty good. We then wanted to go for our highest, what we considered our highest cost specialties, and that means in terms of the care they give, how expensive the care is, and that was neurosurgery and orthopedics. And for Susie, I am currently trying to work on a Compact with a very large freestanding behavioral health practice in our community. We're just in the initial stages of that, and I would say one of the most important differences of that kind of Care Compact will be having upfront, very clear information about release of information so that you don't have to get into the concerns about the special HIPAA regulations around behavioral health. So when we started I basically was the one to go out and, first, I would contact the practice manager for the group we were interested in having a Care Compact with and by email sort of explain the concept of Care Compacts and that I wanted to meet with either the whole group or whoever was considered the lead administrative physician in that group. I did attach a copy of the blank Care Compact, and I had to actually use language that what we were going to talk about wasn't really as scary as the Care Compact made it look because some of the language in there feels kind of like you will do this and we will do that and that can frighten some people off. So that was how we did the original contact. And then our first successful Care Compact, to really figure out what I wanted in a Care Compact I basically reviewed lots of different Care

Compacts that I found on the internet from other organizations, from HealthTeamWorks, from places like that, where people had done them before. And I actually took what I thought was going to be useful for us from each of those and put together a set of responsibilities on the primary care physician side and responsibilities on the specialist side. And because we have such a big system we have lots of regulatory and compliance issues to which we have to pay attention because we're held to pretty much the same standard as the hospital, itself, because we are owned practices. And because of that we had to vet our Compact through our Legal Department, and I jokingly say that's why I tell the specialists that it may look like a contract, but it's not because it has some of that legal language in it that we all go, oh, my God, what is this? So I, again, really try to reassure the specialists before we start that it's not as scary as it looks.

Kathy? This is Kari. And one question that's come in is when you reached out to those specialists and you said it's not as scary as it was, what was their reaction to you at those meetings?

Well, they really were pretty receptive of this, amazingly so. When we'd sit and talk it through they'd realize that it really was all about communicating and I did bring up issues, and that's on this current slide, that really we were hoping to decrease unnecessary costs and overutilization. And I think, at least verbally, most of them bought into that. As you'll find later in my presentation, we're still not at a point where we know how well that's actually working, but that's the whole concept between it. And I really, when I'd get there, you know, presented it in a really collegial way that we're all, that we're partners trying to take care of the same patients and we want to make sure that we're all doing the best care for them and not losing things due to lack of communication, and so that's why we'd have those discussions.

Thank you.

Yes. And it's Valerie, by the way — you called me Kathy. But, anyway, so the Care Compact partners that we want are because we do need to really get some care neighborhood alignment going. As I said earlier, we really wanted to decrease unnecessary costs and overutilization, and we also started seeking out some partners with whom communication had been poor in the past compared to some of our other specialists. So the most important elements of the Care Compact are that you want to put in there what mutual responsibilities there are, and then if there's specific responsibilities that are on the PCP side versus the specialist side, you need to call those out. And, again, to make it clear that the whole reason we're doing it is for improved communication. So I'm going to click over to our Specialty Compact now, so I can kind of run through it with you. I do have a standard Compact that I've used for all of our different practices, the exception is going to be I'm going to need a different design for behavioral health. And, certainly, when you're having these discussions if there's real sticking points, obviously, you need to be willing to change the Compact somewhat, but so far I have not had to do that with our specialty providers. So this is our Compact, we called it a Specialty Provider Collaborative Care Management Compact. And we kind of described what it's for, and that's the purpose. And you guys have access to this and you can download it, so I'm not going to spend a ton of time on it now, and you guys can all look at this and see what works for you and what doesn't. As I said, the language is kind of legalistic, only because we're in a situation where we had to do that. I suppose in a freestanding practice

that isn't held to all of those regulatory issues you guys can make it a little lighter. So the first is the purpose, why we have a Compact, and it also calls out that we still want people to do their own professional judgment, you know, that we're not going to say this is how you have to practice medicine. And then the next part is what the responsibilities and expectations are. So we have what the mutual responsibilities are, and I'll let you look through that.

19:58

So this first one, agree on the type of relationship between the PCP and the specialist, there's some definitions at the end of the Compact that go over that. And then, again, it's all about really trying to be respectful to each other, to communicate with one another, and to try to take care of the patient in the way that best fits the patient's needs. So then, this is the part I told you about where we divided up what the primary care physician's responsibility should be and what the specialist's responsibility should be. And, again, I'm not going to go through this in detail, but you're certainly going to be able to access this at the end of the talk, download it, whatever you need to do. And then, as I said, below that are the definitions, and that's where we define Patient Centered Medical Home, we defined the different levels of consultation that one could choose. So, again, it goes everywhere from having the specialists do the principal care for the patient, to just a onetime consult. And then when we go through all of that, I sign for our primary care practices and the specialist signs for their practice if they're the administrative specialist. So I'm going to go back now to the slide deck. Interesting thing about these, you know, going in and having these talks with the specialist providers, it's also an opportunity that even if it's something that's not specifically in the Compact it opens the discussion so you can start talking about things. For us the big deal was trying to get access to specialty care for our Medicaid patients, so I didn't actually put that in the Compact, but after we'd had this nice talk and we were agreeing about how important it is to take care of patients, and we both signed, then I used that as an opportunity to bring up, you know, we're really having a hard time getting our Medicaid patients seen, would you guys be willing to see X number a month? And to start opening those sorts of discussions with the specialists, and that's really kind of a fun side thing to use this for. So when we first started trying to implement this, the first thing I did was design the Care Compact and I emailed it to all of our primary care providers in the system and asked them for feedback. I really didn't get a lot of feedback, unfortunately, some of that may mean that they didn't read it, some of it may be they read it and they were fine with it. And I really only had one physician who was really concerned about some of the wording. She was quite concerned that because it sounded like this is what you have to do and this is what I have to do that we would, quote, be losing our specialists, that they wouldn't want to work with us, that they wouldn't be collegial. And I talked to her about what we had been seeing and how the conversations were going, and she was really relieved by that, and as far as I can tell she's quite comfortable with the Compact now. And I think one of the hardest things, especially given that we're trying to do this as a CPCi Milestone, et cetera, is how do we really measure the quality that our partners are delivering? And that's been tough, we're just beginning this measurement. We have to do a lot of reliance on either hospital generated quality measures of the specialists or some of our payers are willing to give us utilization measures so we can look at that to see how our specialty group is doing in terms of meeting some of those cost reduction and quality of care measures. And then in terms of really monitoring the compliance as to whether they're really sticking to the Compact, we don't yet have a standardized way to measure that. Currently we rely on our providers

to report any problems they're having with the specialty groups to me, and then I seek out the provider to find out exactly what's going on and then go back to the specialty group to see if we have to re-discuss something. So as the program matures we're really hoping that we can also then follow up with the specialty groups to make sure that we're holding up our end of the bargain. Our specialty groups that we've had so far have been good about that. I'm trying to send our Care Compact back out to all the primary care physicians and say here's a reminder, just make sure you're following it, and we'll work on that as we go. So I see there is a question about having a Care Compact with the hospitalists. We're in an interesting situation in that our hospitalists are also employed by our hospital system, they're not a separate group, so we have not put together a Care Compact with them and rather we've had some ongoing discussions about making sure that we get the post-hospitalization information we need in a timely fashion, et cetera, but we haven't actually needed to build a Care Compact with them specifically. If it was an independent hospital group then, yes, I certainly would have wanted to put together a Compact with them. So that is our Care Compact in somewhat of a nutshell, so if there's other questions I'm happy to take them. And I'm going to give the little ball back to Kari.

Great. Thank you, Dr. Lipetz. And there are a couple more questions that have come in through the Chat. One is does your office participate in a health exchange and, if so, how do you get — and also how do you get reports from a specialist that's not affiliated with your system?

Okay, we have some narrow networks, and we do have a health exchange, CORHIO, but we have not yet really been using that as the way to get the information from our specialists. One of the things we do in our own EHR is we have a way to track our referrals just to make sure that we got something back, and if we don't get something back from the specialist then one of our medical assistants will call, first the patient to make sure they actually went and had the consultation, and then the specialty group to ask them to send that back to us. Interestingly, most of our Care Compact specialty groups have already been pretty good about sending us their consultation notes.

Great. Thank you.

I hope that answered the question.

Thank you. And another follow-up question to your meeting with the specialists, did you find that they had some areas that they felt could be improved on from your offices, as well, in terms of communications they received with the referral?

Yes, and we tried to make sure that when we send a referral we send the necessary information they would need. Some of the specialists are very good about wanting to communicate directly with the primary care provider, and that's been a little problematic on both sides because there's some physicians who are very comfortable with having their day interrupted to come talk to the specialist, and some who aren't. We've certainly made it that if anything is urgent in terms of needing to get the person in for the referral or if the specialist finds something worrisome when they see the patient that they should be able to feel comfortable calling and interrupting the physician. And that's a cultural change that we're trying to make sure we're addressing, both with our own providers and with the specialists.

Excellent. Thank you. Are there other questions? Feel free to raise your hand and be able to ask Dr. Lipetz the question directly. We can unmute your line or, if you feel more comfortable, please feel free to use the Chat feature and chat in your question. All right. Well, thank you, again, Dr. Lipetz. We certainly appreciate your wonderful sharing that you provided with the group today. So thank you very much. And Dr. Lipetz will be on the call through the end, so if you think of another question for her or her team she'll be on and we'll open it up again at the end and feel free to Chat your question at any time. Thank you.

Thank you.

So next we're going to ask the audience do you have a mechanism in place to monitor compliance to the deliverables outlined in your practice's Care Compacts? So please go ahead and use your arrow, your annotation arrow again to answer that question. They're coming in. Please feel free to continue. Excellent. We're getting a couple of yeses, a couple no's, a few not sure's, and a lot of we don't have a Care Compact in place yet, right, yet? All right. Thank you very much for participating there. Now I would like to introduce the folks from River Valley Family Medical Services in Barryville, New York. We have Cathy Daboul, who will be the primary speaker, and with her is Dr. Daboul and their Case Manager, Tess Neal. So, Cathy, I'll turn it over to you. Thank you, again.

Hi. Okay. Hi, how are you guys? Hello, my name is Cathy Daboul. I'm the Practice Manager and Care Coordinator for River Valley Family Medical Services. Our practice is located in Barryville, Sullivan County, New York, a health [inaudible] shortage area, and in Orange County, New York. We are in the tristate area of New York, New Jersey and Pennsylvania. We have about 2,000 patients. Unlike Dr. Valerie, she has 54,000. So we help just a really small amount of patients, 2,000 active patients in our EMR eClinicalWorks. Our care team is made of one MD, one Practice Manager Care Coordinator, one RN Case Manager, one Biller, two Office Front Staff and one part-time Clerk. The overview of our Care Compact — the decision to develop the Care Compact agreement was made by the physician, Dr. Daboul and myself, Care Coordinator. We identified which high-volume result we used and the [inaudible] were chosen. We chose Home Health Agency, Laboratory Services, we use Lab Corp and Crest Lab, they're integrated in our EMR, but I chose to talk about the AMBA Wellness Program, it's a training program that is in our neighborhood, and also I wanted to talk about the specialists, just an overview and services from our community, what the hospital offers and what the local dietician from the Shop Rite [Assumed Spelling] offers. The initial contact was made with the Care Coordinator and the Case Manager and we followed the process. Next slide? For our Home Health Agency, how we do that, when the patient is identified by either the hospital discharge planner or our office, a referral is faxed to the Home Health Agency. Upon receipt the Agency contacts the physician and reviews diagnosis and medication. After the nurse goes into the patient's home, a written care plan is formulated, sent back to the physician for review and signature. While the patient is in the care of the Home Health Agency there's constant communications between the nurse and the physician as to what to do for the patients and the condition of the patient. The AMBA Wellness Program is a laboratory screening program that's run by Quest Diagnostics. They partner with the community organization that comes to the area at certain times of the year. They offer testing, such as [inaudible] metabolic panel, CBC, lipid panel for about $30. Additional tests, such as CSA, hemoglobin A1c, PSH [inaudible] for about $25 or less. Such

laboratory [inaudible] the year. The agreement is on file so that patients enrolled in the program, AMBA is able to run the basic tests. The physician also agrees to receive these results and contact the patient if the results are abnormal. As the Care Coordinator for this office I contacted our local church to sponsor this program and they have been coming to our community for the past 10 years. Next slide?

Cathy, may I chime in with a couple questions that have come in?

Yes.

What was the Home Health Agency's reception of this level of care coordination directly with the physician, how did they receive that and what was their response?

Well, they're pretty receptive to it because they want to see, you know, to know what the condition is. When we sent the referral, when they call they want to know what the condition of the patient, how they're going in there, are they allowed actually by CMS to go in there? Sometimes if it's not something of a nursing, they're able to advise us that, oh, this particular condition doesn't need nursing service, so maybe you would need some kind of a home health aide that would come in or maybe you just need physical therapy that comes in. So right there we discuss what's needed, and maybe the nurse will only come in once and then she reviews or he reviews what's needed by the patient, and then come back to the doctor and say we don't really think she's got some nursing care needed, but we do think that she needs occupational therapy or physical therapy and things like that.

Excellent. And for Dr. Daboul, how are you finding this high level of coordinated care with Home Health?

I think it's working very well.

Excellent, and do you find that they then are more receptive to reaching out to you on an ongoing basis with questions rather than sending them automatically to the ED?

Yes. Can you repeat that again, please?

So do you think that there's an increased level of care coordination and communication that you've built with your Home Health Agency, that they're more likely to call you with questions rather than immediately sending a patient to the emergency room if they have concerns?

Definitely, yes. They contact us very often and routinely, yes.

As a matter of fact, if I may add, a lot of times patients are in hospice and the nurse are in there, so a lot of times the nurse is in communication with the doctor and tells them the condition, she tells them, okay, this person needs this medication, a comfort pack. So there's also a pharmacy in the area, they actually — doctor will contact the pharmacy, call in the prescription that's needed and then because we are in New York State he also writes that prescription. And at the end of the day or during the day, so the pharmacy either picks up that prescription or ourselves, we bring the prescription to the pharmacy, you know, if it's something of a controlled substance. So it works very well, yes.

Wow, what a wonderful community. All right, I'll go ahead and go on to your next slide. Thank you for answering those questions that are coming in.

Okay, this next slide is just a sample flier of the AMBA Wellness Program. It's a really good program. Patients like it. We advertise it well in our office, it's advertised in the community, and because it's a cheap program, the testing — we have patients that have high lipids, are on cholesterol medication, patients that are diabetic, plus medications to be monitored. So some of them have no insurance, so what we do is we say there's this AMBA Wellness, sign up for it, get your testing done. Then this way we can monitor your medications. So a lot of patients are liking it, especially sometimes insurance have high deductibles so this is a good alternative. And, by the way, we run it once a year around April in our community, in our church, so which is up in Barryville, so it's about a mile away for people, but then another during the year another one is run in 15 miles away so maybe in October, so there's that two times a year that patients can go to. And then they're also around communities, they run this testing, so it's a really nice thing to have in the community. The next slide is just a sample of the hospital support groups that meet through the year. Although we don't have a Care Compact for this type of thing, we do refer patients to it. There is a bariatric group, a cancer group, a weight management group, a diabetic group. We like to send patients there because it's free to the community. Next slide?

39:57

Let's go to the next slide, Kari? Okay, how do we choose the Care Compact provider in our medical neighborhood? Our area is geographically very large, but the population is sparse. There are not very many service providers to choose from so we are not able to really pick and choose. Provider insurance participation also dictates which provider patients are allowed to use. So, again, availability and insurance participation is a key in our choosing our Care Compact for the patient. Next slide? Sometimes it starts with an informal verbal Care Compact. There is, as I mentioned before, an example of this is the dietician from the local Shop Rite grocery chain. She offers free nutrition advice and services, and she will even help patients with their shopping. Cathy, myself, contacted her and told her that once in a while we'll be sending patients to her. So it's been about a year now and we've actually sent patients to her and she's helped them with their nutritional advice and everything. For the specialists it's just basic — we didn't really look to see who is our highest volume specialist, which I guess it's probably a gastroenterologist and a cardiologist, but we just send our basic referral through our EMR. And on the next slide I will show you how we track our EMR. Kari next slide, please? This is a view of our EMR referrals. As you can see, we are able to see how many referrals are out there, and every day we look at it and if we see that there are referrals that are out for a long period of time, this is why we have a part-time clerk. She actually looks, and then we send out a letter to the specialist to follow up on the report. The next slide? This is a copy of the letter that we send out to the specialist to say, hey, we sent you a patient, did the patient come and see you? Otherwise, if she didn't, let us know so we can follow up with the patient. So, please, next slide? So reports, how do we measure the quality of our partners? Again, informally, it's not really a patient survey that we give out, although that's something that we are going to think about for the following year, but we ask our patients how did you like Dr. Ryder or how did you get, you know, did he tell you or did they go on with treatment, and things like that. So it's more of an informal question to the patient when they come back to us. Reports can be very difficult, there

are many specialists who do not report back to the PCP after patients are referred to them, so that's why the standard letter. Another thing that I added is that in the past few months the hospital also adopted an electronic health record, and we because we belong to the hospital, are allowed to access that, so now we are able to obtain patient reports and if they're seen by a specialist in their hospital we're also able to see those reports, say a colonoscopy, we're able to see the colonoscopy, the post-op reports, we're able to see that. So we tend to actually send patients to the specialist that is affiliated with the hospital before we even go out of the system. And my conclusion is that there are many services in the community that are offered for free or at a very low cost. When we are made aware of these services we try to use them, especially if we know it can positively impact our patients' health. Thank you.

Thank you, Cathy. Thank you very much, Cathy. I appreciate your presentation today and how you've really resourced, taking advantage of the community resources that you have in your community. So a question for you is what is the patient reaction when the provider asks how did that specialist referral go? What's the patient reaction to that?

Well, a lot of times they're very honest, if they didn't like that provider they'll tell the physician. They will say, oh, no, he didn't have a very good bedside manner or I'm not going back there or, you know? Or and then we just say, okay, we'll just get you somewhere else or we need a second opinion. Or most of them are very positive, I really liked this doctor, you know? Sometimes we have these things where we have a specialist, we send them to one specialist, and this one is sending them to another specialist, and then we have to stop there, we just, we don't like that, you know what I mean? Without even having to come back. We actually encounter that a lot, when we send to one specialist and then another specialist, and then we don't have a — that specialist that we sent to never sends us a letter or any report or why they're sending to a specialist. The next thing we know the patient is seeing someone else and someone else, you know? So that's something that really we have no control over sometimes.

And how do you address that, if you find that it's the same — or I guess the first question to that is how do you — do you find that it's the same specialist that tends to do that, and how do you address it when it does happen?

I think we've found that there is a certain group that does that in our area. So we tend not to send patients to them, actually. Before we even send patients to them we actually try to look for other specialists. But sometimes our main thing about referrals is insurance participation. There's not many specialists that participate in patients' insurance, so that's a barrier that's really — especially in this area, we have, like I said, we belong to a tristate area, and New York, New Jersey, Pennsylvania. Sometimes Pennsylvania people can't go to New York people, so it's very hard to just have one, you know?

That would be challenging, that would be challenging. So a question for both of you, Cathy and Dr. Lipetz, and we'll start with Cathy since you're on the line. What are your next steps in 2015 to refine your Care Compacts with existing and are you planning to formalize Care Compacts with additional groups in 2015?

I really like Dr. Lipetz' idea of the Care Compact, what she has learned. If she doesn't mind, I'm probably going to copy that. And probably really go to see, I know we send a lot of gastroenterology and cardiology out, so that is something that I probably, you know, we have one gastroenterologist that we send to, we'll probably start there. We have orthopedists that we send to. And start doing the Care Compact with them through almost like the contract that she had. And, again, we discussed yesterday about the patient survey, making up a little card for the patient with questions about the specialist, and then maybe approaching the specialist about — even to say thank you, my patient says this or, you know what I mean? And then just doing that I think is a good idea, a small card when the patient comes back to say by the way I sent you to this specialist, how would you rate this specialist?

That's wonderful. Thank you, Cathy. And, Dr. Lipetz, would you mind sharing what your next steps are in 2015 and if you see expanding to additional Care Compacts?

Yes, Cathy, thank you for your faith in my Care Compact. One of the things in there that when you were talking about all that problem, you send the person to a specialist and then they send them to someone else, and someone else and someone else. We did address that in our Care Compact by letting them know that we did not want them to send anybody to a tertiary referral without talking to us first unless it was emergent. So, yes, when you put your Care Compact together that's one of the things you can try to control. So for our future, one is that big behavioral health Care Compact that I'm hoping to get together. That's going to be very challenging, and I'm excited about it, but also a little apprehensive. I do want to get our endocrinologists onboard. Our cardiologists are employed by the hospital, but not directly under us, so I may need to try to set up a Care Compact with them. It is going to be easier with the cardiologists because eventually they will be on the same EHR we are, so it may be more like those first ones that I told you about. The other thing we're really hoping to do in 2015 is come up with some kind of way of measuring compliance with the Care Compact, and I suspect it'll start just probably with provider and specialist surveys, you know, where we say is this working for you, what is working, what isn't working? If we can get some actual evidence that we're showing a decrease in high cost services that would be terrific, but we're not sure we'll make that this year or that'll still be another year away before we can really demonstrate that.

Excellent. Thank you. So at this time ...

I have a question, Kari.

Yes?

Since I spoke about Home Health Agency and the signatures of the doctor, is it necessary for us to do a Care Compact or the agreement, you know, the care plan and the signature of the doctor, mutual agreement about patients and care and that referral, is that enough? We don't need to do a Care Compact like a specialist, right?

I think that's really dependent upon your relationship with them. My recommendation would always be to put something in writing. It's going really well, what do you think? And kind of inviting that conversation in around what is going well, what are we doing that we could be doing better? This is

some hiccups that we're seeing from you. And just allowing that conversation to happen, and something to come back to when there is a problem, let's revisit the Care Compact and it kind of opens it up for when — even setting them up, I know many practices that I've worked with said let's do a check-in when they're brand-new in three months and see how it's going, and then they might extend that to once a year or biannually, depending on the practice and the specialists and their relationships with them. But I never think it hurts to put it in writing in a group like that, it seems like they would be really receptive to that and it may unearth some opportunity for improvement on both sides.

Okay. Thank you.

You're welcome. So, in summary, I think — thank you, again, Dr. Lipetz and Cathy, for sharing. And what I heard that was really exciting from both groups is that you're finding value in this, that you're looking to expand the groups that you're putting formal Care Compacts in place that were in really stages of measurement, which I think is reflected on the survey that we took a little bit earlier today. And that it's always good to start somewhere. The process doesn't have to be perfect, sometimes it starts informally with informal verbal Care Compact, and it opens that door for communication. And also what I loved here is using that as a platform to talk about other things that might not be in that Care Compact, but in building that relationship and that communication stream from specialist to specialist can open up a lot more opportunities that maybe you didn't anticipate. So, with that, I'm going to go ahead and get us to the next slide here. And I'd like you to respond, all of the participants, which health care partner in your medical neighborhood would be a good first or next candidate to establish a Care Compact with? Marie and Andrea and Susie and those that are saying other, I'd love for you to chat in what other specialists that or health care partner that you might establish a Care Compact with? So those that are marking other please chat in what other areas? Maybe it might give other folks ideas of where they might want to start.

And feel very comfortable to raise your hand if you'd like to discuss it.

Absolutely. Thank you. It looks like we've got a lot of cardio and GI and hospital, and a lot of other, so I'd love for those others to either raise their hand or chat.

And, Kari, I think we lost your sound. I don't know if maybe you accidently muted your headset? You're doing a great job responding to this, and I'm not seeing any chats that are going to tell us who the other is. I know Dr. Lipetz is down there, and one of them is going to be BHI, I remember that.

Yes, hi, it's Valerie Lipetz. Yes, behavioral health definitely is one of the others, and then endocrinology is another for us.

Okay, very good.

I have a quick question on the behavioral health. We have Orange County Department of Health in our neighborhood, and I think it would — I don't know how — they're very closemouthed about their sharing, even if it's when we have our patients and we send them to them, they ask us for records for the patient, if we did any kind of laboratories and everything, but and then we send them the referral,

that we want the patient to see them, but when it comes for us getting reports from them they say that we can't do it. I don't know how else I can get any reports from them because they will not do it.

Cathy, its Valerie. What we're going to try to do with ours, and what the groups that they were talking about at the beginning that did the presentation before on the Care Compact, is you have to kind of get them through their fear that they're releasing information without the patient's permission. So what I'm going to work toward is when we actually send the referral over there we send over a signed release that the mental health group had already agreed upon with us that the patient has already signed so there's no question there that it's okay to release it.

Sometimes it's just medication that we want to know, you know? And they don't, they're very, very closemouthed about it, they just won't do it, so I'm probably going to have to have a formal conversation with them to say we did refer the patient, ask for you to send out the referral, so, you know. But you're right, probably another written authorization will probably do it, so we're going to try that.

When you have something that's very specific about what you want and the patient has signed it, that really eases their tension.

Okay. Thank you.

Excellent discussion.

Are you able to hear me now?

Yes.

Excellent. This is Kari, again. So thank you very much for those questions and responses, Cathy and Dr. Lipetz. So next, we're running out of time here so I'm just going to speed through these. Again, these Action Groups are not limited to these live sessions. The live sessions are just a small piece of it. The best way to keep the conversation going in between our live sessions is to use that Collaboration site, and I've been seeing a little bit of activity and would love to see a lot more. So the action items for the next period of time between now and May, and that time seems long, but it will go by before we know it, is to outreach to at least one medical neighbor and establish a Care Compact. There's several Care Compact examples on the Collaboration site. I will add BCH's today, and so there's lots to choose from. And then post the specialty you chose to implement that Care Compact with on to the forum, on our Care Compact Action Group Forum. Then outline a method for monitoring. It sounds like we're really early in the stage of figuring out how these are going and if they're really working, so be thinking about a way how you might monitor how that Care Compact is going and post how you're going to do that on the Care Compact action library group. And then post at least one question or comment to that group forum. So, Rose, you want to hit the next slide? So our next live group session is May 19 at one o'clock Eastern, and we'll be loving to hear from you, as well, on what you might like to have the topic be for that May webinar. Again, this is your Action Group, so please fill us in on what you'd like to hear about in May. Let's go to the next slide? And I'll turn it back to Rose. Thank you very much.

And thank you, all, for attending, and I wanted to thank our speakers, who gave us a very interactive conversation. As you complete the evaluation for this session please indicate the practice you are representing. If you happen to have multiple attendees gathered together today and are from more than one CPC practice ID please contact your regional learning faculty and let them know the names of the attendees and which practice ID they are from. CPC is a practice-based initiative, and we would like to capture practice level participation and feedback. Thank you, again, and we look forward to our continued discussion on the collaborative site forum. Have a great day.