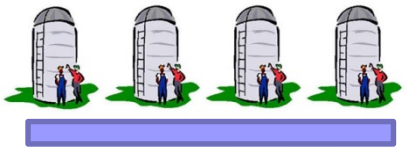
Coordinated Care Delivery: Establishing Medical Neighborhood Roles

1.5 Coordinated Care Delivery

1.5.2 Establish Medical Neighborhood Roles

We have needed a system for care coordination



The **Medical Neighborhood**

- Designed to be the inner workings of all connected care models
  - *Defining* what is *needed & expected* for high value referrals and care coordination
- Is an ***approach*** to care coordination
  - It's about working together better
  - Provides ***connected care*** where ever that care may be needed through
    - *Information sharing*
    - *Communication*
    - *Collaboration*

Roles based on Patient-Centered Principles

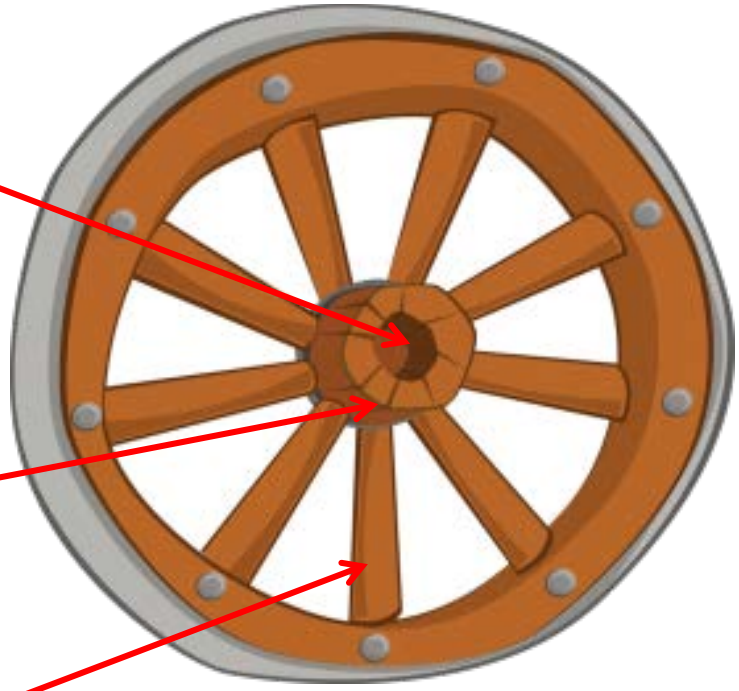
Medical Home

- **Personal physician** - with *ongoing relationship* to **provide first contact, continuous and comprehensive care.**
- **Physician directed medical practice-team** who collectively take responsibility
- **Whole person orientation** – includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated across all elements of the complex health care**
- **Quality and safety** are hallmarks
- **Enhanced access to care**

Medical Neighbor

- **Communicate, coordinate and integrate bi-directionally with medical home as well as with patient**
- **Ensure appropriate & timely consultations and referrals**
- **Ensure effective flow of information;**
- **Address responsibility in co-management situations;**
- **Support patient centered care**
- **Support the medical home practice as the "hub" of care and provider of whole person primary care to the patient**

Roles in the Patient-Centered Medical Neighborhood



- *The Patient is in the center*
- *Primary Care is the necessary hub of care*
- *Specialty/ancillary care is an extension of care*
  - *Helping with care*

The Role of the Patient

- The patient is in the *center of care*
  - *Working in **partnership*** for what is best for the patient
    - ***Active participation*** in care leads to ***accountability***
    - The *work of the patient* in their care is considered
- The patient experience is central
- The patient voice is heard
  - for clinical care
  - for practice operations
  - for policy issues

Role of Primary Care / the Medical Home

- Serves as the *central hub* of care for the patient
  - Utilizing an *expanded care team* including nurses, pharmacists, care managers, behavioral health, etc
  - primary care provision
    - Patient-centered, *first contact*, continuous & comprehensive *whole person* care
  - Integration of patient information
  - Care coordination across the system of care as a part of the continuum of care for the patient
    - Ensuring connected care is part of *taking care of* the patient

Specialty Care is an Extension of Care

Helping with care *when* needed

- Urgent
- Intermediate (subacute, “move up”)
- Routine

Helping with care *how* needed

- Advice
- Procedure
- Co-management
  - Shared
  - Temporary until stable
  - Principal/ongoing

Ideally, specialty care meets the referral needs of the patient in the most appropriate way

Care Coordination Agreements/ Compacts define:

- Types of Interactions/ Type of Referral
  - Pre-visit assistance to expedite/ prioritize care
  - Consultation /procedure
  - Comanagement
    - Shared care
    - Principal care
- Responsibility for the elements of care
- Expectations for information exchange

Make it part of the referral process

Referral Request Elements

- **Type of service/co-management requested**
  - **Do you want Consult or Co-Management**
- Clinical question or reason for referral
  - Ideally a summary or ***synopsis*** of events
- Core Data Set (reconciled med list, allergies, etc)
- Data set for clinical question
- Referral status: Urgent (recommend direct contact) or routine
- Contact info for more information

Referral Response Elements

- Answer the clinical question/ address the reason for referral
  - Summary or Synopsis (include some thought process)
- **Recommend type of interaction/ form of co-management**
- Confirm existing, new or changed diagnoses; include “ruled out”
- Medication /Equipment changes
- Testing results, testing pending, scheduled or recommended (including how/who to order)
- Procedures completed, scheduled or recommend
- Education completed, scheduled or recommended
- Any “secondary” referrals made (confer with and/or copy PCP on all)
- Any recommended services or actions to be done by the PCMH
- F/u scheduled or recommended

Pre-visit Advice / Pre-consultation

Intended to expedite/prioritize care

- ***Previsit Advice***
  - Does the patient need a referral
  - Which specialty is most appropriate
  - Recommendations for what *preparation* and/or “pertinent” data will best facilitate the referral evaluation and /or management (what to send with the referral) or help with *when* to refer
- ***Previsit Review***
  - Is the clinical question clear
  - Is the necessary data attached
  - Triage urgency
- ***Urgent Cases***
  - Expedite care
  - Improved hand-offs with less delay and improved safety

Formal Consultation

- **Cognitive consultation (advice)**
  - To obtain specialist's opinion on a patient's diagnosis, abnormal lab or imaging study result(s), treatment or prognosis
  - Limited to one or a few visits that focus on **answering a discrete question**.
    - **e-Consultation**: provide advice/recommendations without an office visit *(clinician to clinician)*
- **Procedural consultation**
  - To obtain a technical procedure for diagnostic, therapeutic or palliative purposes
- Include detailed report back to referring physician
- *Examples*: Colonoscopy, Bone Marrow Biopsy, MRSA infection with recurrent carbuncles

Co-Management

(ONGOING management of a patient's medical condition)

- **Shared Care for the disease**
  - (PCP responsible for Elements of Care, takes 'first call')
- **Principal care for the *disease*.**
  - (Specialist responsible for Elements of Care for that disorder or set of disorders, takes 'first call' for the disorder)
- **Principal care of the *patient*** for a consuming illness for a limited period of time
  - **(specialist serves as first contact but patient maintains PCP as Home)**

Co-Management Oncology examples:

- Shared Care for the Disease
  - CLL
- Principal Care of the Disease
  - Ductal carcinoma in situ (non-invasive breast cancer – DCIS)
- Principal Care of the Patient
  - Metastatic colon cancer with adjuvant chemotherapy

ELEMENTS of CARE
Who is Responsible?

- Recommended pre-referral testing
- Pharmacologic therapy and equipment
  - Prescribing, monitoring, refills, prior authorization
- Referral management
  - Additional specialists or services
- Diagnostic testing
  - Ordering, communication of results, tracking
- Informed consent
- Patient education on disease management
- Addressing secondary diagnoses
- Care teams/ community support
- Patient phone calls/concerns/disease and medication issues
- Monitoring/surveillance/follow up

Roles are *fluid*….

….. As the patient or the condition changes

Consider “*graduation*” if condition allows

Roles in the Medical Neighborhood….

….. *defined by the needs of the patient*