Moving Beyond Our Silos: Better for Patients and Better for Us

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objectives

1. Describe how care collaboration and care compacts can improve patient care and practice functioning

2. Understand strategies on how to work together better between multiple different specialties

3. Identify practical tools for getting started and implementing better care coordination
Pain Points

Referral Process

Often Creates:
• Chaos
• Extra burden
• Frustration
• Confusion
• Waste
The Current State for Referral Processes

- 60-70% of specialists reported receiving no information
- 25-50% of primary care providers received no information
  - ~50% did not even know if their patient ever saw the specialist
- 28% of primary care and 43% of specialists are dissatisfied with the information they receive
- 8% of referrals are inappropriate (wrong specialist or are unnecessary) (average 43 referrals /specialist/year)
- Up to 50% of referrals are never completed}
delayed/missed diagnosis and/or treatment
"poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays…

…physician groups, hospitals, and other health care organizations operate as silos often providing care without … complete information”
They called US health care ....

a “non-system”

disconnected care
Disconnected, Silo Care => Low Value Care

“Unknowns” create delays & gaps in care:

- ?What is wrong/urgency
- ?Correct specialty
- ?What has already been done

- ?Why go
- ?Where do I park
- ?What will happen
Poor Referral Processes create Back-end Mess or Work for Practice Teams

- The tests you just sent the patient to the lab or radiology for had already been completed (and now we are getting TCOC calculated for our work …)

- You went down the wrong pathway; you discover patient was referred for another reason than the one you deduced ….you spent the appointment playing charades and got it wrong, now what?

- Patient took day off, signed in, filled out forms, your staff has entered data into EMR, you have reviewed and started assessment and half way through it becomes clear that the patient was actually referred for a disorder that needs a different specialty … everyone loses…
Patients take the brunt of the impact for poor referral processes

- Do not get the time they want or need with the appointment
  - Do not get questions asked or answered; confusion, concerns, etc.
  - Worse outcomes
- Lost time (*patient’s time is proposed quality metric*)
- Cost from lost wages, co-pays, deductibles
  - With high deductible plans, pay for duplicated, unnecessary care
- Cost of travel, parking, baby sitter, etc.
- Delay (*hefty cost to mental & physical health*)
  - Worry
  - Unable to work, reduced ADL
  - Unresolved or Worsening condition
- Often get the *blame* for lack of information with the referral
- Safety issues
What We End Up With

• The specialty care team does not get what they need ….
• The primary care team does not get what they need ….
• The patients do not get what they need ….

Instead, we get things we don’t need - everyone gets frustration, confusion, extra work, risk, dissatisfaction ….

and unnecessary costs
Imagine the impact of disconnected care on the bottom line of a Value Based Payment Plan

- Huge amounts of waste and poor outcomes (quality):
  - Unnecessary testing and care
  - Duplicated testing and care
  - Missed care
  - Delays
  - Safety issues

We need a way to get to communication, coordination, cooperation and collaboration
We need a system for care coordination

The “Medical Neighborhood”
  • An *approach* to care coordination
    • It’s about *working together* better
    • Promotes *connected care* wherever that care may be needed

High Value Care Coordination (HVCC)
  • Defining what is *needed & expected* for high value referrals and care coordination – *how do we get there?*

*How do we start connecting care for our patients?*
Make an Agreement....

Care Coordination Agreement
(Collaborative Care Agreement/Care Compacts)

An invitation to work together better

- Provides a platform that everyone agrees to work from:
  - Standardized Definitions
  - Agreed upon expectations regarding communication and clinical responsibilities.
- Can be formal or informal
- Internal practice policies and procedures should be organized & aligned to support the agreement
What is Included in the Care Compact?
(start with the basics)

1. Preparation of the patient — pre-consultation
2. Type of referral / role of the specialist
3. Provide a clinical question with all referrals
4. Core data set to accompany all referral
5. Pertinent supporting data for the referral
6. Communication protocol
7. Critical elements of the referral response
8. Protocol for making appointments
9. “Closing the Loop” protocol
Connecting the Care Roadmap to the Agreement

- Referral Guidelines
  - List of urgent-intermediate-routine referral conditions
  - How to handle urgent referrals
  - Pertinent data sets / referral guidelines for specific conditions
  - Timing of referrals
  - Essential information needed with the referral
    - Testing or therapeutic trials
    - Alarm signs and symptoms
    - Unique features / co-morbidities / complexities
    - Pre-op evaluation and peri-op management
- Agreement on how to handle secondary diagnoses
- Specifications on making secondary referrals
Who and How?

- Practices you work with frequently
  - Including multispecialty groups in same organization

- Practices you need “more” from
  - PCP needing timely referral response notes
  - Specialty group needing more than ICD code with referrals
  - PCP needing colonoscopy reports from GI group
  - Surgeon needing pre-op prep assistance

- Practices you need “less” from
  - Chart dump with referrals
  - 40 page referral response notes (with every order, etc. in it)
Models for Establishing Agreements

• “One-on-One” Compacts with selected medical neighbors
  • PCP practice with specialist / specialty to specialty
  • ACO with a specialty

• System-wide adoption (all players within system)
  • Closed or integrated systems (VA, ACO, IPA, employed groups)

• Unilateral approach
  • Medical Center / Specialty Practice ("This is how we agree to work with those who refer to our center/practice and this is what we would like from you when you refer a patient ")
Getting Started

- Decide what to include in the Care Coordination Agreement
  - Start with basics (elements of good referral process)
    - Add in co-management elements if & when ready / needed
  - Include critical issues that need to be addressed
    - Wait time
    - Needed information sent with request or as a response
- Have a conversation
  - “we really enjoy seeing your patients/we so appreciate your help with our patients…it would help us if…” or
  - “we want to be sure you are getting what you need…”
- Decide on forms
  - Serves as checklist, helps with team care around referral
Basics that Benefit

• Having a conversation
  • Defining needs
    • Many misperceptions
  • Benefit of discussing issues/working together
    • Meeting mutual needs for the benefit of the patient

• “Forms” - “Formal” Agreement
  • Defines the elements (reference, enduring, modifiable)
  • Reinforces/encourages completeness (“compliance”)
    • “Hard stop” for clinical questions
    • “Patient informed” check box
  • Enhances tracking & team roles
Apply to All Referral Situations

- Primary Care to Specialty Care (Behavioral Health, Radiology, Pathology and Hospital Medicine)
- Specialty to Specialty
- Specialty to Primary Care
- Emergency Dept to Primary or Specialty Care
- Ancillary & other services (Diabetes Ed, Physical Therapy, Nutrition, etc.)

Agree to work together in the care of mutual patients
Voices from the Medical Neighborhood

LaRae Eggleston -
- Invision Sally Jobe – Breast Imaging → collaborative care for breast cancer between multiple different specialty care practices
- Why was this needed?
- How did you get started & get buy-in to work on it with the different groups?
- What care coordination agreements were put in place?
- What difference has it made?

Kathryn Steele -
- TCPi practice facilitator - Durango TCPi enrolled practices → care coordination between medical community primary care & specialty care partners
- Why was this needed?
- How did you get started & get others to work with you?
- What care coordination agreement(s) have you put in place?
- What difference has it made?
Creating the Invision Sally Jobe Care Compact

Patient Centered Specialty Care: A component of NAPBC accreditation
Overview

• What is a Care Compact?
• How does a Care Compact impact care delivery and why is that important?
• Elements of a successful Care Compact
• Expectations of participating physicians
Care Compact Defined

A bidirectional agreement that aims to enhance communications between providers and patients. By sharing preferences and expectations across the referral process, a Care Compact facilitates effective care management and coordination across the continuum. (AHRQ 2017)
How Does a Care Compact Impact Care Delivery?

- Creates standards of communication between referring MDs
- Openly shares information to streamline the care process and ease of use in navigating the healthcare system for the patient
- Provides standards for appropriate and timely care
- Is a patient-centered delivery approach
- Clearly defines the role of each participant in the Care Compact
Elements of a Successful Care Compact

• Open and regular communication between participating providers
• Measurable goals
• Accurate and timely flow of information
• Supports patient-centered care
• Aligns with nationwide best practices for members of the compact
Expectations of Participating Providers

Invision Sally Jobe

1. Provide timely* breast cancer screening and diagnostic services to patients.
2. Expedite post-diagnosis breast MRI and/or genetic test results to aid in surgical decision making.
3. Report on a monthly basis to participants:
   i. The number of patients who receive mammography services.
   ii. The number of patients diagnosed with breast cancer.
   iii. Where patients went for surgical consultation and why (i.e. PCP preference, patient preference, insurance directed, etc.).
   iv. Where and with which surgeon patients ultimately had surgery.
4. Participate in and support NAPBC and other accreditation efforts for HealthONE breast programs.
5. Assist in educational initiatives for HealthONE partner hospitals and referring physicians per NAPBC guidelines.

*5 business days or less for diagnostic evaluations and biopsies within the ISJ network

Participating Breast Surgeons

1. Ensure patients can be seen for initial consult within 5 business days of the referral by MD or designated physician extender within the practice.
2. Perform surgeries at a HealthOne hospital or surgery center, unless instructed differently by the patient.
3. Communicate post-surgical information to ISJ for documentation in the medical record.
4. Ensure that patients return to ISJ for post-treatment imaging, in recommended intervals, to provide continuity of care.
5. Participate in and support NAPBC and other accreditation efforts for HealthONE breast programs.
Participation Agreement

• I understand this agreement is non-binding and does not guarantee surgical referrals from Invision Sally Jobe.

• I agree to keep all volume data and referral data shared from Invision Sally Jobe confidential to participating members of the compact.

• I understand my information will be shared with all participating members of the Care Compact.

Signature______________________________________________ Date____________

Lora D. Barke, DO, Medical Director, Section Chief – Breast Imaging
Invision Sally Jobe Breast Centers

Signature ______________________________________________ Date ____________

Print Name _____________________________________________

Participating Breast or Plastic Surgeon
Building the RMCC/ISJ Care Compact

LET'S DISCUSS
Developing Care Coordination Agreements in Community Practices

- Lessons Learned from Durango – Kathryn Steele
  - Getting started
  - How to get buy-in
  - Making progress – getting agreement
  - Sustaining
  - Outcomes
Template Care Coordination Agreement

**PCP / Requesting**

- Prepare patient
  - Use of referral guidelines where available
  - Patient/family aware of and in agreement with reason for referral, type of referral, and selection of specialist
  - Expectations for events and outcomes of referral
- Provide appropriate and adequate information*
  - Demographic and insurance information
  - Reason for referral, details
  - Core Medical Data on patient
  - Clinical data pertinent to reason for referral
    - Any special needs of patient.
- Indicate type of referral requested:
  - Pre-visit Preparation/Assistance
  - Consultation (Evaluate and Advise)
  - Procedure
  - Co-management with Shared Care
  - Co-management with Principal Care
  - Full responsibility for all patient care

* See provided model check list of suggested areas to address.

**Neighbor / Responding**

- Review Referral Requests and Triage According to Urgency
  - Reserve spaces in schedule to allow for urgent care
  - Notify referring provider of recognized referral guidelines and inappropriate referrals
  - Work with referring provider to expedite care in urgent cases
  - Verify insurance status
  - Anticipate special needs of patient/family
  - Agree to engage in pre-referral consult if requested.
  - Provide PCP with number for direct contact for urgent/immediate matters.
- Provide appropriate and adequate information in a timely manner*
  - To include specific response to referral question; verify type role; any changes to diagnosis; medication; equipment; testing; procedures; education; referrals; follow up recommendations or needed actions

* See provided model check list of suggested areas to address.
**Template Care Coordination Agreement**

**PCP / Requesting**

- Indication of urgency - Direct contact with specialist for urgent cases
- Provide Neighbor with number for direct contact for additional information or urgent matters
- Needs to be answered by responsible contact Review secondary diagnoses or suggested referrals identified by Neighbor/specialist.
- If co-managing with Neighbor, provide them with any changes in patient’s clinical status relevant to the condition being addressed by the Neighbor.
- Contact the patient, if deemed appropriate, when notified by Neighbor of failure to keep appointment.

**Neighbor / Responding**

- Indicate acceptance of referral category or suggest alternate option and reasoning for change.
- Refer follow-up of any secondary diagnoses (additional disorders identified or suspected) back to the PCP for handling unless directly related to the referred problem.
- If secondary diagnosis is followed up by Neighbor, notify PCP.
- Information regarding any secondary referrals made by Neighbor needs to be communicated to PCP.
- Notify Referring Provider of No Shows and Cancellations.
- If patient is self-referred or referred by another specialist/Neighbor, the PCP provider needs to be copied on the referral response upon obtaining appropriate patient permission.
THANK YOU!

for attending.