Care Coordination: Improving Care by Reducing Fragmentation

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Learning Objectives

At the end of this session, you will be able to:

• Describe the main features of a well-designed care coordination system

• Identify opportunities to implement key changes for care coordination in your practice

• Apply care coordination concepts to improve the management of care transitions
What’s Broken

1. You don’t know the people to whom you are referring patients.
2. Specialists complain about the information you send with a referral.
3. You don’t hear back from a specialist after a consultation.
4. Your patient complains that the specialist didn’t seem to know why s/he was there.
5. A referral doesn’t answer your question.
6. Your patient doesn’t come back to see you after a consultation.
7. A specialist duplicates tests you have already performed.
8. You are unaware that your patient was seen in the ED.
9. You were unaware that your patient was hospitalized.
Why Make Care Coordination a Priority?

• Patients and families hate it that we can’t make this work.
• Poor hand-offs can create risks for patient safety.
• There is enormous waste associated with unnecessary referrals, duplicate testing, unwanted and unnecessary specialist to specialist referral.
Case Study

Ms. G: A Case Study in Fragmented Care
What Makes Care Coordination So Difficult?

- Accountability shared; ambiguity on responsibility
- Fewer personal relationships PCP to specialists and hospitals make communication harder
- Few specialists to see uninsured patients in many communities
- Care coordination activities not reimbursed in most FFS payment structures
- Lack of staff and/or information infrastructure to ensure effective coordination
  - In just one year the typical primary care physician must coordinate with 229 physicians working at over 100 different practices (Ann Intern Med. 2009;150:236-242)
Essentials of Care Coordination

• **Deliberate integration of patient care activities** between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services

• Activities and interventions that **attempt to reduce fragmentation and improve the quality** of referrals and transitions.

Key Changes for Care Coordination

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
- Track and support patients when they obtain services outside of the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients/families.

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Care Coordination System - Better By Design

PATIENT-CENTERED MEDICAL HOME

- Accountability
- Patient Support

Relationships & Agreements

Connectivity

Community Agencies
Hospitals & ERs
Medical Specialists

- Involved providers receive the information they need when they need it
- Practice knows the status of all referrals/transitions involving its panel
- Patients report receiving help in coordinating care

High-quality referrals & transitions for providers & patients

Source: The MacColl Center for Health Care Innovation, Group Health Cooperative

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# Characteristics of a High Quality Referral or Transition

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely</td>
<td>Patients receive needed transitions and consultative services without unnecessary delays.</td>
</tr>
<tr>
<td>Safe</td>
<td>Planned and managed to prevent harm to patients from medical or administrative errors.</td>
</tr>
<tr>
<td>Effective</td>
<td>Based on scientific knowledge, and executed well to maximize their benefit.</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>Responsive to patient and family needs and preferences.</td>
</tr>
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<td>Efficient</td>
<td>Limited to necessary referrals; avoids duplication of services.</td>
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<td>Equitable</td>
<td>The availability and quality of transitions and referrals should not vary by the personal characteristics of patients.</td>
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</tbody>
</table>

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Elements of Design

1. Assume **accountability**
2. Provide **patient support**
3. Build **relationships and agreements**
4. Develop **connectivity**
Assume Accountability

- Setting up an infrastructure to track and support patients going outside the PCMH for care.
- Initiating conversations with key consultants, EDs, hospitals, and community service agencies.
- Establishing measures to track results
Patient Support: It Takes a Team

• Organize a practice team to support patients and families
  • Help patients identify sources of service especially community resources
  • Help to make appointments
  • Track referrals and help to resolve problems
  • Assure transfer of information (both ways)
  • Monitor hospital and ED utilization reports
  • Manage tracking and referral system
Build **Relationships and Agreements**

- Critical element for effective care coordination – referring and consulting providers agree on purpose and importance of the referral and the roles each will play in care
  - PCMH initiates conversations with key specialists
- Results in agreements, codified in writing or in e-referral systems
  - Agreements central to improving referrals and transitions
- Standardize information in referral requests and ensure it meets agreed upon expectations
Topics for Discussion

With specialists

• Guidelines for referral, prior tests and information.
• Expectations about future care and specialist-to-specialist referral.
• Expectations for information back to PCMH.

With EDs/Hospitals

• Notification of visit/admission and discharge.
• Involvement of PCMH in post-discharge care.
Develop Connectivity

- Most of the complaints from both PCPs and specialists focus on communication problems—too little, too late, unclear or no information.
- Evidence indicates that standardized formats for communication increase provider satisfaction.
- Three options for more effective flow of standardized information—shared EHR, e-referral, structured referral forms.
Care Transitions

• Two major goals for medical homes with respect to care transitions from ED and hospital:
  • Collaborate to ensure safe, effective and efficient transitions back to primary care for patients discharged from ED or hospital
  • Reduce avoidable ED visits and hospitalizations
• Nearly one-half of Medicare recipients re-admitted after a hospital discharge within 30 days never saw an MD
• At least one-third of all ED visits are identified as “avoidable” and majority of frequent users of ED care also have a PCP
Managing Transitions

- Four elements of Care Coordination Model apply to transitions of patients discharged from hospital
- PCMH initiates discussion with the local hospital used most frequently to collaborate and facilitate the safe discharge of patients back to PCMH
  - Prompt notification of admission of patient
  - Communication with PCMH prior to discharge
  - Collaboration between hospital care managers and practice care managers post-discharge
  - Prompt PCMH access to a comprehensive discharge summary
  - A timely post-discharge visit to PCMH for patient
Transitional Care Management Codes

- CPT 99495
  - Describe 30 days of service
- CPT 99496
- Communication (face-to-face, telephonic, or electronic) within two business days after discharge
- A face-to-face encounter within seven to 14 days after discharge
- Moderate to high medical decision-making
- Be sure to document:
  - Discharge date
  - Communication with the patient within the two days
  - Face-to-face encounter with date
  - Medical decision making for the patient
  - Activities performed for TCM

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APII Activities and Metrics
APII Activities for Support

• Assess operations of practice / opportunities to improve.
• Develop and record strategies to implement care coordination and practice transformation.
• Identify and reduce medical neighborhood barriers to coordinated care at the practice level. Describe barriers and approaches to overcome local challenges for coordinated care.
APII Metrics for Support / Shared Savings Incentive Payment Metrics

**Metrics for Support**

1. 70%+ high-priority beneficiaries have medical record care plan updated 2X/year
2. 67%+ high-priority beneficiaries seen by PCP 2X in past 12 months
3. 33%+ beneficiaries with acute inpatient hospital stay seen by healthcare provider within 10 days of discharge
4. 50%+ emergency visits categorized as non-emergent by NYU ED algorithm

**Shared Savings metrics** apply to subset of participating clinics; require intimate knowledge of patient population for success

All metrics based on 2014 claims data – first report end Q1 2015
## Resources

- Implementation Guide
- Key Activities

[www.safetynetmedicalhome.org](http://www.safetynetmedicalhome.org)

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### CARE COORDINATION

**Implementation Guide**

**SAFETY NET MEDICAL HOME INITIATIVE**

**CARE COORDINATION**

Reducing Care Fragmentation In Primary Care

**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>The Change Concepts for Practice Transformation</td>
</tr>
<tr>
<td>A Framework for PCMH</td>
</tr>
<tr>
<td>Care Management and Care Coordination: Understanding the Overlap and the Differences</td>
</tr>
<tr>
<td>Reducing Care Fragmentation</td>
</tr>
<tr>
<td>Toolkit for Coordinating Care</td>
</tr>
<tr>
<td>Appendix A: Health Information Technology</td>
</tr>
</tbody>
</table>

**Introduction**

The complexity of modern medicine demands specialization, and high quality healthcare must ensure that patients receive care from the caregivers and institutions that are trained and equipped to provide a service. Whether it be a surgery procedure, a medical evaluation, support for lifestyle changes, or financial services. As a consequence, care often involves referrals from provider to provider and transitions from one facility to another. This complex “system” of care delivery can be dangerous, frustrating, and expensive if not managed well. Reducing the potentially devastating effects of fragmentation is a central objective of the Patient-Centered Medical Home (PCMH) Model of Care. Care coordination begins with thoughtful identification of key service providers in the community followed by the “deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”

Care coordination is especially challenging in safety-net practices because of:
- The complexity of many patients’ medical, social, and financial situations.
- The diversity of languages and cultures and the challenge of ensuring patients with providers that can meet their needs.
- The difficulties of accessing specialty services for uninsured or Medicaid patients in many communities.

Safety-net practices have valuable assets that if organized well can potentially ensure effective care coordination. For example, safety-net practices have a rich knowledge of their community’s assets and resources, and often have staff and outreach-workers that can support patients outside of the practice.
Questions

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