"Practical Approaches to Enhance Communication and Coordinated Care in the PCMH"

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Objectives

- Describe the benefits of enhancing communication in the continuity between health systems
- Identify three practical approaches to enhance communication and co-management and their potential applications for improved chronic care management
- Discuss the importance of primary/specialty care collaboration in the provision of a comprehensive, family-centered care provided in the MH.

What is a Medical Home?

- *"**The Medical Home*** is the model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner."

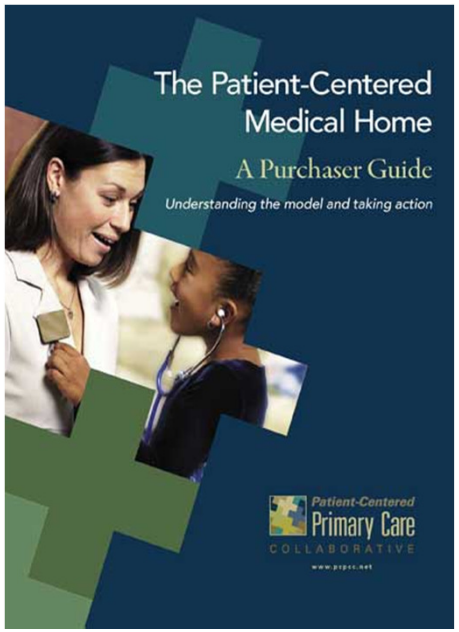
-American Academy of Pediatrics
www.pediatricmedhome.org/

Joint Principles of Medical Home

AAP, AAFP, ACP, AOA, 2007

- Personal physician
- Physician-directed practice
- Whole-person orientation
- Coordinated care
- Quality and safety
- Enhanced access
- Appropriate payment

Patient-Centered Primary Care COLLABORATIVE

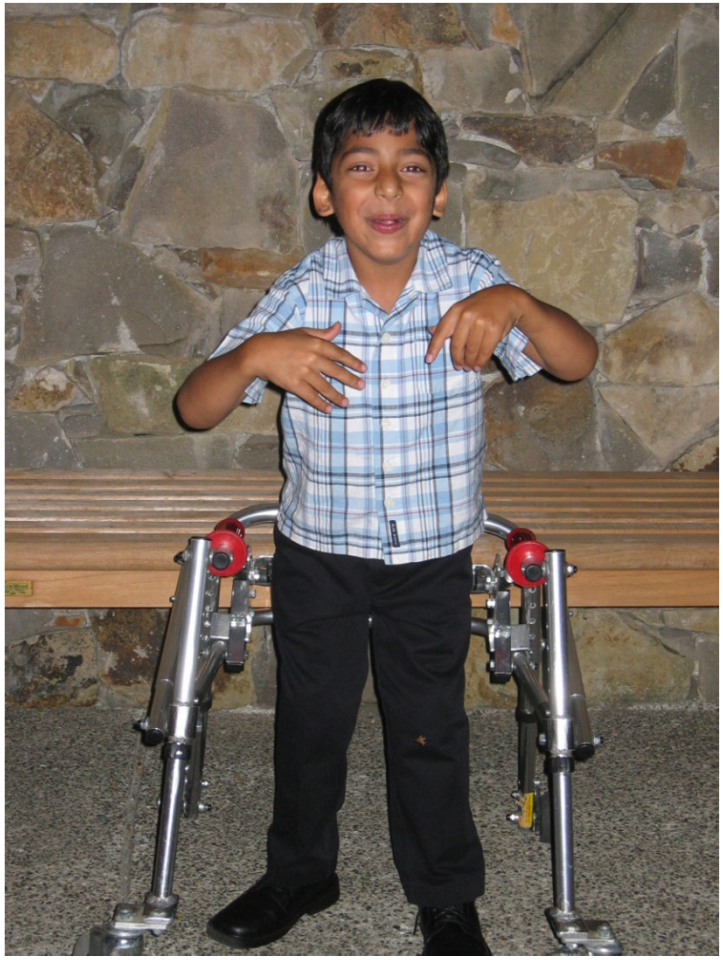


Welcome to Our Medical Home!

- Suburban Private Practice, 2 offices, self-owned
- Duke University and University of NC Medical Centers within 15 miles
- 12 MD providers, 9 F.T.E.
- 72% Managed Care
- 17% Self Pay (incl. HSA)
- 11% Medicaid + SCHIP
- >30 year history of collaboration with both medical centers
- Office hours 365 d/year
- Evening/weekend office hours
- Nighttime Nurse triage and daytime Advice Nurses
- Transition to EMR in fall 2007
- Around 50,000 visits/year at 2 sites; 12,233 physicals
- See til 21, 43% in registry are 12 and older
- Age 12-21 = 24% of 2009 physicals; 4% > age 18
- 27% CSHCN in registry are Medicaid-insured

Big Goals, Small Steps

- Family satisfaction
- Adequate time for care
- Planned visits
- Better co-management with specialists
- Help with referrals and resources
- Avoid duplications, errors
- Fiscal Viability
- *Caution-Don't wait for consensus*



CYSHCN represent the whole health system in MH demands

- Family and patient see “whole picture” and expect seamless care.
- High severity; 30% in our registry have 2 or more specialty providers
- Exacerbation may require ED use
- Issues with access (physical, financial)
- Require primary-specialty access and collaboration
- Issues with compliance, consent
- Patient education is a key to outcome

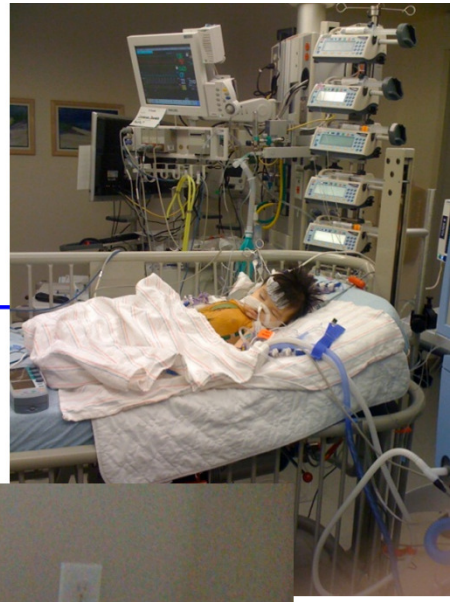
Essential Components of a Medical Home System

- Relationships/Respect
- Ready Access
- Registry
- Records
- Resources (internal, external)
- Reimbursement
- Recruitment

Imagine:

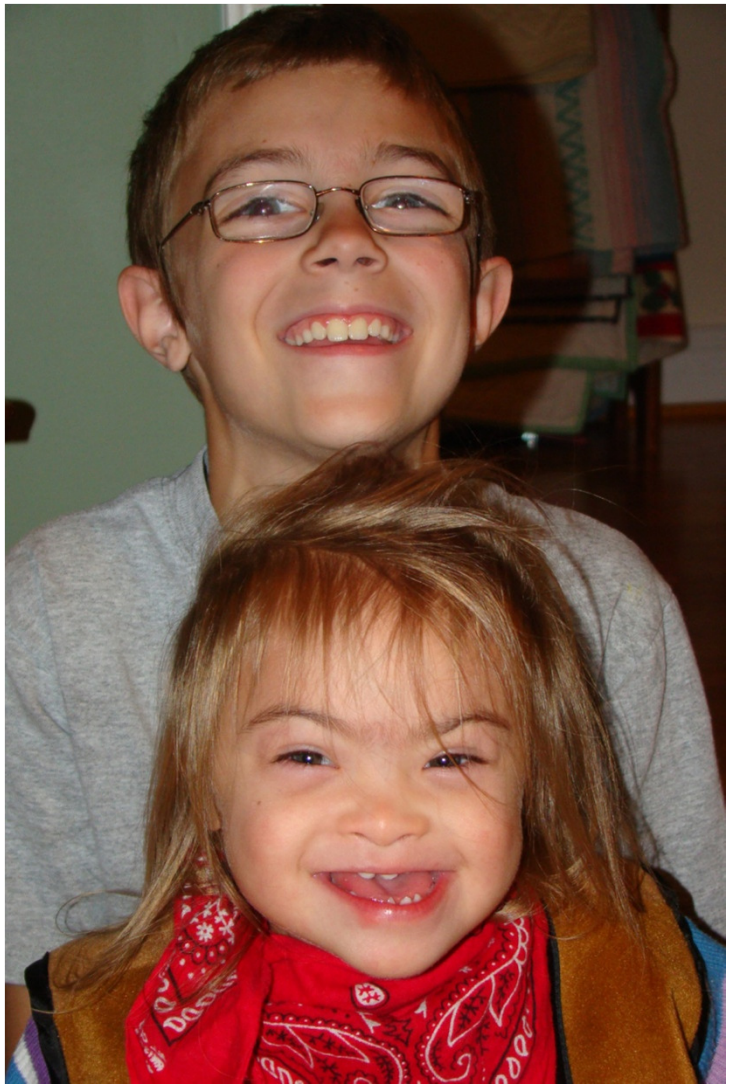
- Staff recognizing a parent/child when appt. is made
- Adequate time scheduled for that child
- Specialist's records in your hands prior to the visit, including lab and X-ray results
- Parent concerns identified before the visit
- Lab slips ready, and EMLA cream on child prior to visit
- Help by your staff for families with referrals, resources, equipment
- Followup to assure completion of tasks
- How does it work?

Registry—Knowing Who Needs Care



- Proactive care for chronic conditions (flu shots, Synagis, labs)
- Planned care
  - adequate appt. time
  - pre-visit contacts
  - alerts staff and providers to special needs

Registry—Creating Links to Care



- Parent-to-Parent interaction around diagnosis
- Population-based data collection and analysis
- Assures key data to specialist for consult
- Track referrals and specialist reports
- Assists with NCQA certification

From Random to Registry

- Define registry population and assign Champion
- Link registry to appt. scheduling ("Special")
- Link to care coordination for clinical benefit
- MD and computer recall of CSHCN
- Identify CSHCN in process of care
- Notebooks → Excel → Access → EMR
- Software issues are low frequency, high complexity illnesses without care protocols; need to handle multiple diagnoses

Records -Paper or Electronic?

- Paper-based MH possible
  - Registry developed
  - Care Coord. Begun
  - Resources Directory done
  - Fax-back w/ specialists done
- Electronic
  - “front-end loaded”-cost and work
  - Worth the effort!

Electronic Medical Records—lessons learned

- Analyze your workflow processes
- Critically study Vendor options
- Build in 2 years for “conquest”
- Registry helps retro-fit charts for EMR
- Customize your own templates
- Link to local Medical Centers, specialists
- Demand a registry function

Internal Resources-Who can help from within?

- Care Coordinators
- Parents and Families!!
- Dedicated Staff

Care Coordination Program

- **“The Left Ventricle of the Medical Home”**
- **Separate from Advice Nurses**
- **Direct Phone Extension**
- **Brochures and Business Cards**
- **Care Coordinators Link to Other Care Coordinators!**

The growth and development of Care Coordinators by PDSA cycles

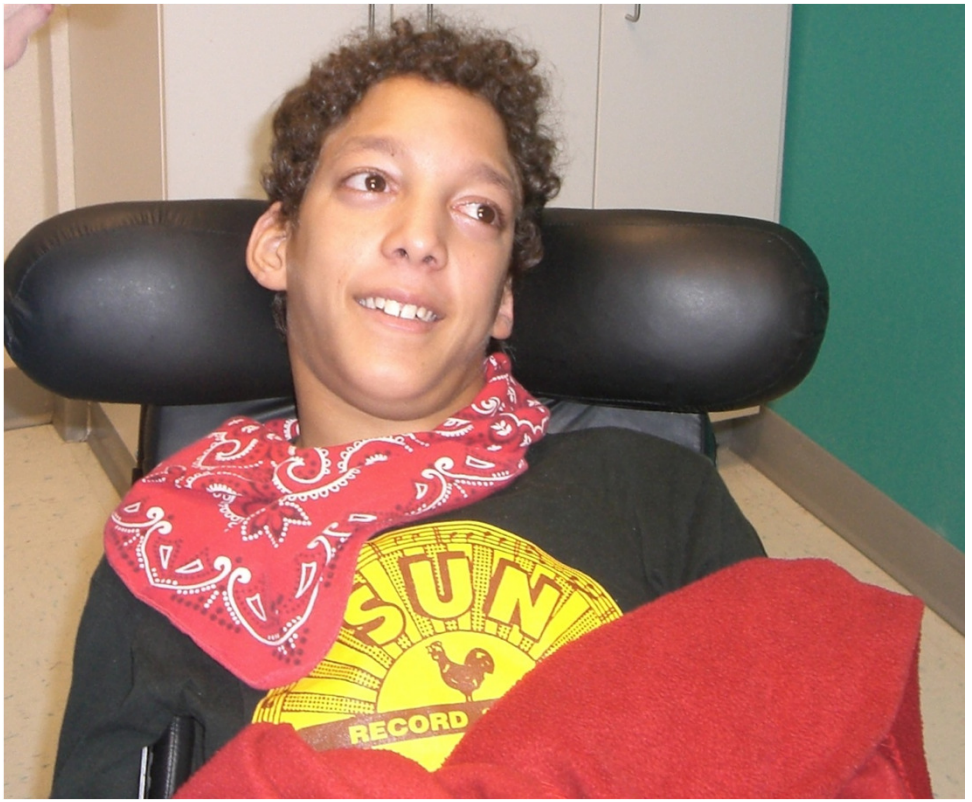
- Staff volunteer attended MHLC-1
- BCBS Foundation funded 3 hours/week
- 3 hr/week, 40 in registry in 2004
- Title V grant as Demo. Project
- 20 hr/wk, 540 in registry in 2006
- CC supported entirely by CHPA
- 72 hr/wk, 1645 in registry in 2011
- Practice supports CC services – better efficiency, coding, reimbursement, referral support and tracking

Care Coordinators use Registry for many support services

- Make and track referrals
- Link for Parent-to-Parent support
- Inform parents of dx-specific opportunities
- Recall for checkups, flu shots, Synagis
- Dx-specific enquiries
- Do Pre-visit Contacts
- File complexity scores

Pre-Visit Contacts

- Care coordinator screens schedule for upcoming CSHCN physicals
- The child's MD assesses child's complexity and requests PVC
- Care Coordinator makes call to parent.
- Parent concerns are identified
- Labs (and pain control!) are anticipated and scheduled for
- Consultant notes are available
- ED and specialty visits are noted
- New issues/special needs are anticipated



Risk Stratification = Complexity Scores

- More time?
- Communication devices?
- Technological support?
- Translator?
- Pre-Visit Contact?

REGISTER YOUR PATIENT WITH SPECIAL HEALTH CARE NEEDS-*completed form to Peggy*

Name:_____Race_____
Sex_____Birthdate_____Chart #_____
Insurer:_____
Primary CHP Provider: SBH MI CM JO AD SVH RMC KS JL RSW KM
Diagnoses: 1)
2)
3)
4)

CSHCN Complexity Rating	Description	Examples
1	1 chronic condition, well-controlled OR Significant PMH, quiescent or resolved	Asthma, mild per. Repaired VSD
2	1 evolving chronic condition, unstable OR 2 chronic conditions, both well-controlled	Asthma PCOS +Type 2 DM Asthma +ADHD
3	2 or more chronic conditions, with either unstable	GERD Asthma w/ER visit
4	Any tech. dependent pt. Mod./severe cognitive delays	(wheelchair, walker, GT, Trach) MR, Autism, Group Home res.
+1	Language barrier	Non-English speaker
+1	Behavioral Disorder	OCD, Anxiety in addition to above
+1	Family/Social Complications	Divorce, Horizons
	Total complexity score	

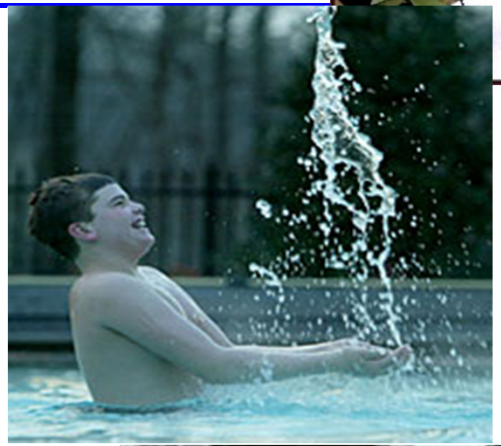
DO YOU WANT A PVC DONE? ☐ YES ☐ NO

Care Coordinators Tasks:

- -Maintain registry of 1645 pts.; data entry, annual purge, data enquiries

- -Referrals: 1690 in 2008, 1800 in 2009, 2100 in 2010
  - -contact parent
  - -assure referral data is at specialist
  - -obtain and scan notes from specialist appt.
  - -referrals directly from parent after familiar with CC system
- -Pre-Visit Contacts: 298 in 2008, 473 in 2009, 537 in 2010
- -Transition Care:
  - -Hospital and ED fup, locating records, calling family, scan to EMR
  - -Newborn entry to practice; discharge summary, NBS results
  - -New pts: obtain old med records, PVC's with families
  - -Capture of episodic care and return to care system
  - -Bridge of information for parents between school/Medical Home
- -Pre-authorizations
  - -radiology procedures
  - -insurance authorizations for specialists
- -Medical Necessities:
  - -durable med. eqpt
  - -mattress/pillow covers
  - -Bipap machinery
  - -authorizations for CAP-C, CAP MR/DD
- -Medicaid Interface:
  - -capture of episodic care
  - -collaboration with Medicaid Case Managers
  - -Followup on missed primary and specialty appts.

Our Parents/Families as Resources



- **Education!**
- **Parent-to-Parent Collaboration**
- **Advocacy Groups**
- **Personal Knowledge of Local Providers and Services**
- **Word-of-mouth referrals**
- **Physical Plant walk-through**
- **Boardmaker™**

Our Staff as a Resource

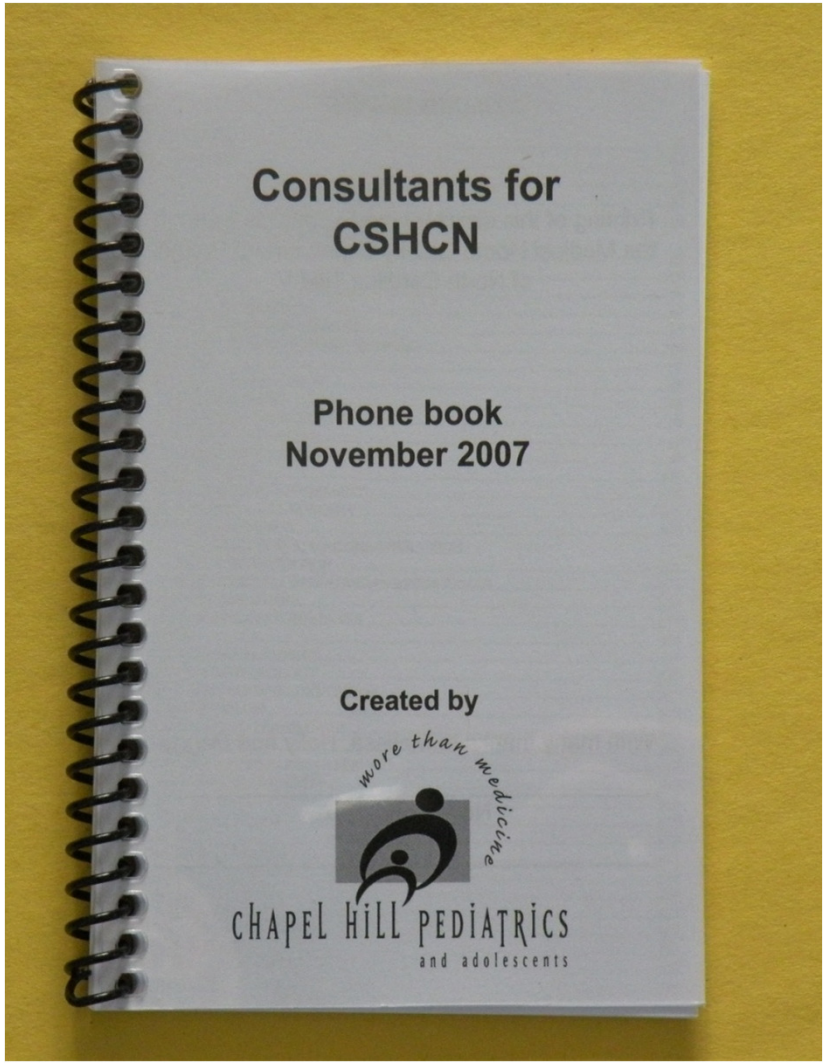
- 88 % of staff report INCREASED job satisfaction from caring for CSHCN
- 76% find caring for CSHCN DOES NOT increase job stress
- 70% are interested in developing an area of “expertise” in CSHCN conditions
- RN teaches CPR to parents; Asthma nurse educator, Advice nurses

External Resources-Who are your MH Friends?

- Community Resource Directory
- Medical Centers/Specialists
- Medical Home advocates http://www.medicalhomeinfo.org, www.medicalhomeimprovement.org
- School Systems
- State Medical Societies
- DX-Based Advocacy Groups
- Insurers
- Funding support for QI initiatives (Insurers, AAP CATCH grants, Title V)
- MH Certifications (NCQA, JCAHO, etc.)
- Uncompensated support by like-minds–

  "steal shamelessly"

Community Resources Directory "answers in our pockets"



- Ask MD's to submit their favorites from all disciplines
- MD's who respond get a copy!!
- Parent Partner and Care Coordinator add Local Resources
- Annual update
- Pocket size fits Lab coat
- 5th edition is now in use

CSHCN Directory Index

- State Programs for CSHCN
- Alternative Medicine
- Audiology
- Augm. Comm./Asst.Technology
- Autism
- Baby Nurses
- Carseats for CSHCN
- Child Abuse
- Child Psychiatry/Psychology
- Community MD's
- Compounding Pharmacies
- Dentistry
- Devel. Eval and Therapy
- Domestic Violence
- Early Intervention
- Eating Disorders
- G-tube and Trach care
- Genetic Testing
- Grief Counseling/Hospice
- Group Homes
- Gynecology
- Handicapped Parking
- Health Depts.
- Home Health Care/Eqpt.
- Lactation Services
- Nutrition
- Orthotics
- OT/Feeding
- Parent-to-Parent
- Podiatry
- PT
- PT Sports/Injury
- Rare Disorders
- Recreation for CSHCN
- Rehabilitation Specialists
- Respite/Residential Care
- School Systems
- Social Services
- Smoking Cessation
- Speech
- SSI
- Substance Abuse
- Travel for CSHCN
- Voc. Rehab.
- Misc.

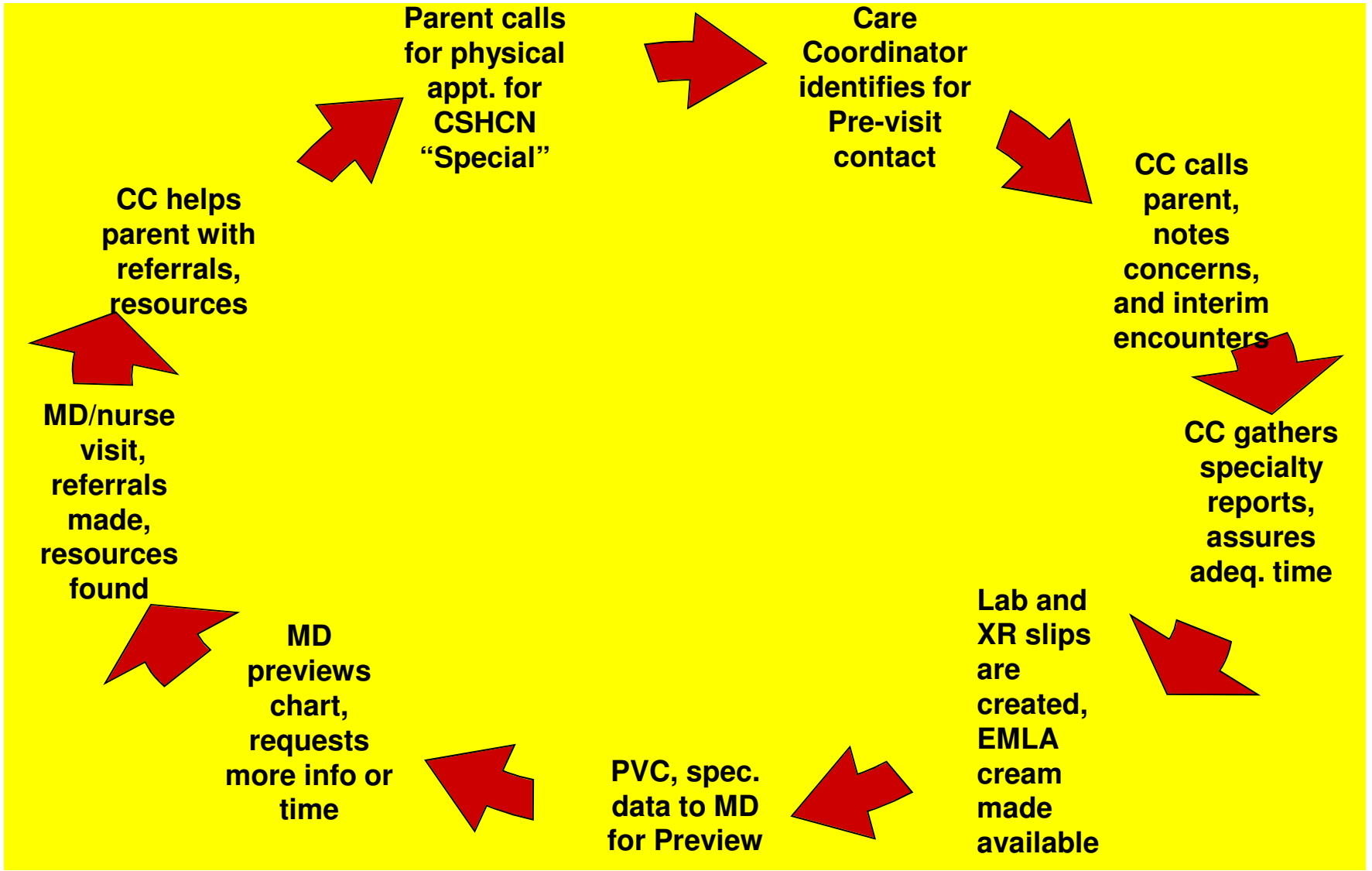
MH and Medical Center --working together

- Electronic access to records for followup
- “Lunch and Learn”
- Phone/email care dialogue
- Care coordinator collaboration as a bridge
- 2-way communication for referrals
- Specialty f/up in MH (labs, weights, BP’s)

Medical Home services ease transitions

- Trusted relationships
- Established access to care
- Providers identified (medical and support)
- Current Problem List defined
- Established mechanisms of communication
- Resources and obstacles identified
- Upcoming needs anticipated

Registry, Care Coordination, PVC & Resources promote Planned, Patient-Centered Care



J.L., 4 year old girl with MR of ? etiology, severe sz disorder, osteopenia, GTube, recent adm. for spont. hip fx and post-op pneumonia. . .
(Neuro, Ortho, Endocrine, Surgery are consults)

Calls for appt. for fever and cough. . .

- Extra time is scheduled for J.L. ☑
- Front desk knows she's in wheelchair and watches for her arrival with her 2 sibs ☑
- Discharge summary is on chart for your review☑
- You ask CC to get most recent XR results and labs from on-line connection with Med Center EMR☑
- Your clinical dx: pneumonia rx: antibiotics and fup 1 day ☑
- Mom reports she has bisphosphonate infusion in 2 weeks at hospital; consultants #'s are in your pocket. ☑
- Phone call to Pulm. CC arranges consult on infusion day to eval. and consider vibratory vest. ☑
- CC tracks referrals and sends you reminder of visit ☑
- Pulm. sends on-line report about consult☑
- ED visit, admission are avoided; fup care is synchonized for patient, and Pulmonary advice/care prevents further pneumonias

So how do we get there?

- Identification of problem areas
- Establish explicit goal to address
- Break process into tiny steps
- Create tools to support weak spots
- Try ONE SMALL change
- Measurement of improvement (or failure!)
- Try another test of change and see if you're ready to grow that change

Improvements that “stick”

- DEFINE YOUR GOAL
- PLAN-consider a needed improvement
- DO-try some SMALL changes to make it better (“test of change”)
- STUDY-measure if your changes helped
- ACT-refine the process to make it work even better

Essential Components of a Medical Home System

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- Ready Access
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"My family, with all its challenges, is a success story, but part of that success is because we have had a Medical Home"… Libby