“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
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)

<table>
<thead>
<tr>
<th>CSHCN Complexity Rating</th>
<th>Description</th>
<th>Examples</th>
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<tbody>
<tr>
<td>1</td>
<td>1 chronic condition, well-controlled OR Significant PMH, quiescent or resolved</td>
<td>Asthma, mild per. &amp; Repaired VSD</td>
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<tr>
<td>2</td>
<td>1 evolving chronic condition, unstable OR 2 chronic conditions, both well-controlled</td>
<td>Asthma, PCOS &amp; Type 2 DM, Asthma &amp; ADHD</td>
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<tr>
<td>3</td>
<td>2 or more chronic conditions, with either unstable</td>
<td>GERD, Asthma w/ER visit</td>
</tr>
<tr>
<td>4</td>
<td>Any tech. dependent pt.</td>
<td>(wheelchair, walker, O1, Trach) MR, Autism, Group Home res.</td>
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<tr>
<td>+1</td>
<td>Language barrier</td>
<td>Non-English speaker</td>
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<tr>
<td>+1</td>
<td>Behavioral Disorder</td>
<td>OCD, Anxiety in addition to above</td>
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<tr>
<td>+1</td>
<td>Family/Social Complications</td>
<td>Divorce, Horizons</td>
</tr>
<tr>
<td></td>
<td>Total complexity score</td>
<td></td>
</tr>
</tbody>
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**DO YOU WANT A PVC DONE? **

- YES
- NO
Care Coordinators Tasks:

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

  - 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

- Parent calls for physical appt. for CSHCN “Special”
- Care Coordinator identifies for Pre-visit contact
- CC calls parent, notes concerns, and interim encounters
- CC gathers specialty reports, assures adeq. time
- Lab and XR slips are created, EMLA cream made available

- MD/nurse visit, referrals made, resources found
- MD previews chart, requests more info or time
- PVC, spec. data to MD for Preview
- CC helps parent with referrals, resources

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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 synchronized 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

- Relationships/Respect
- Ready Access
- Registry
- Records
- Resources
- Reimbursement
- Recruitment
“My family, with all its challenges, is a success story, but part of that success is because we have had a Medical Home”… Libby