Kansas Foundation for Medical Care, Inc.

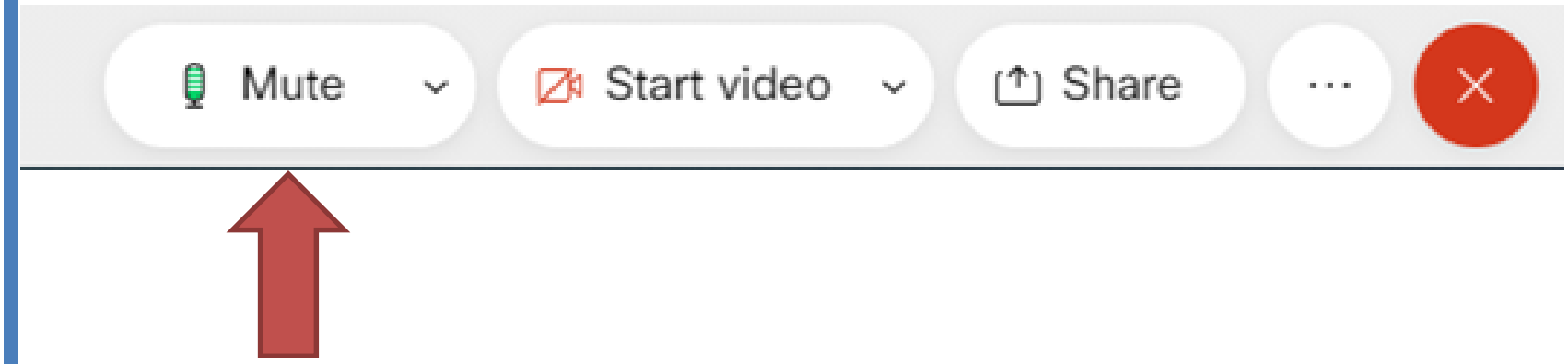
Thank you for joining. Our presentation will start soon.

Please introduce yourself in the chat

Practice Transformation Webinar Series
Session 4

Collaboration in the Care Community

Muting and Unmuting Audio



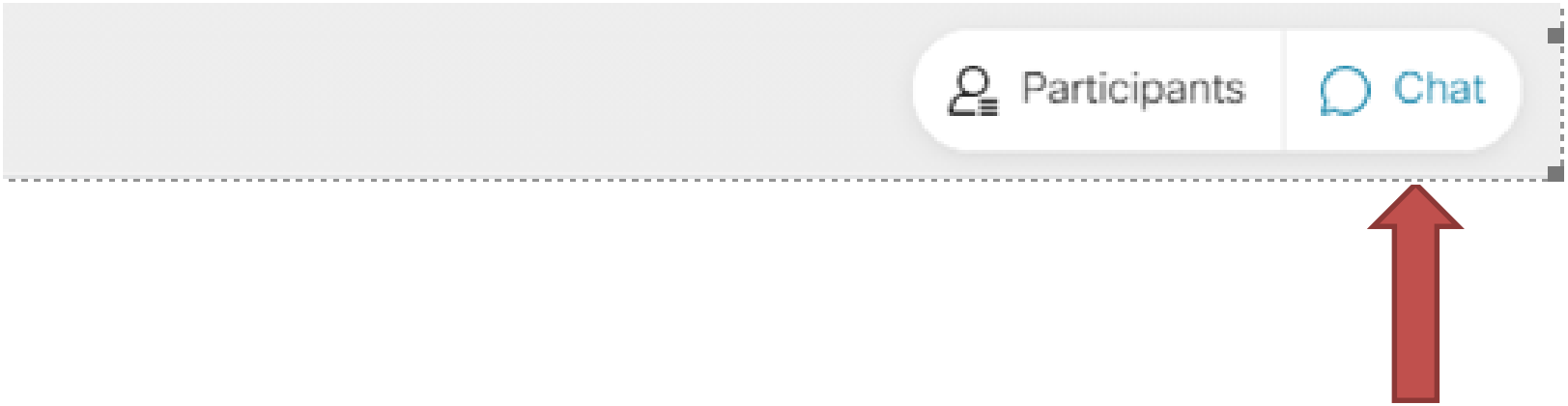
To mute your audio, click the microphone icon at the bottom of your screen (icon will turn red).

To unmute, click the microphone icon again.

If your icon is green, you are unmuted.

Chat Panel

Click on the “chat” icon at the bottom right of your screen to open the chat panel



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1. Select “Everyone” from the **To:** dropdown list
2. Click in the chat box and type a question or comment
3. Click **Enter**

About this Webinar Series

- Five 30 minute sessions
- Covers 1-2 foundational elements of practice transformation in each session
- Tailored to small practices with limited resources
- Designed for you to take small steps at a time

Steps in Practice Transformation

- Identify your patients
- Provide enhanced access to care
- Utilize care management services for high-risk patients
- Use team-based care to improve care delivery
- ***Improve collaboration with other providers***
- Engage patients in their care
- Leverage data to drive improvement activities

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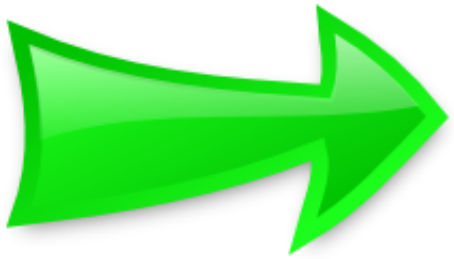
Better Outcomes



Lower Cost

While improving patient and provider experience

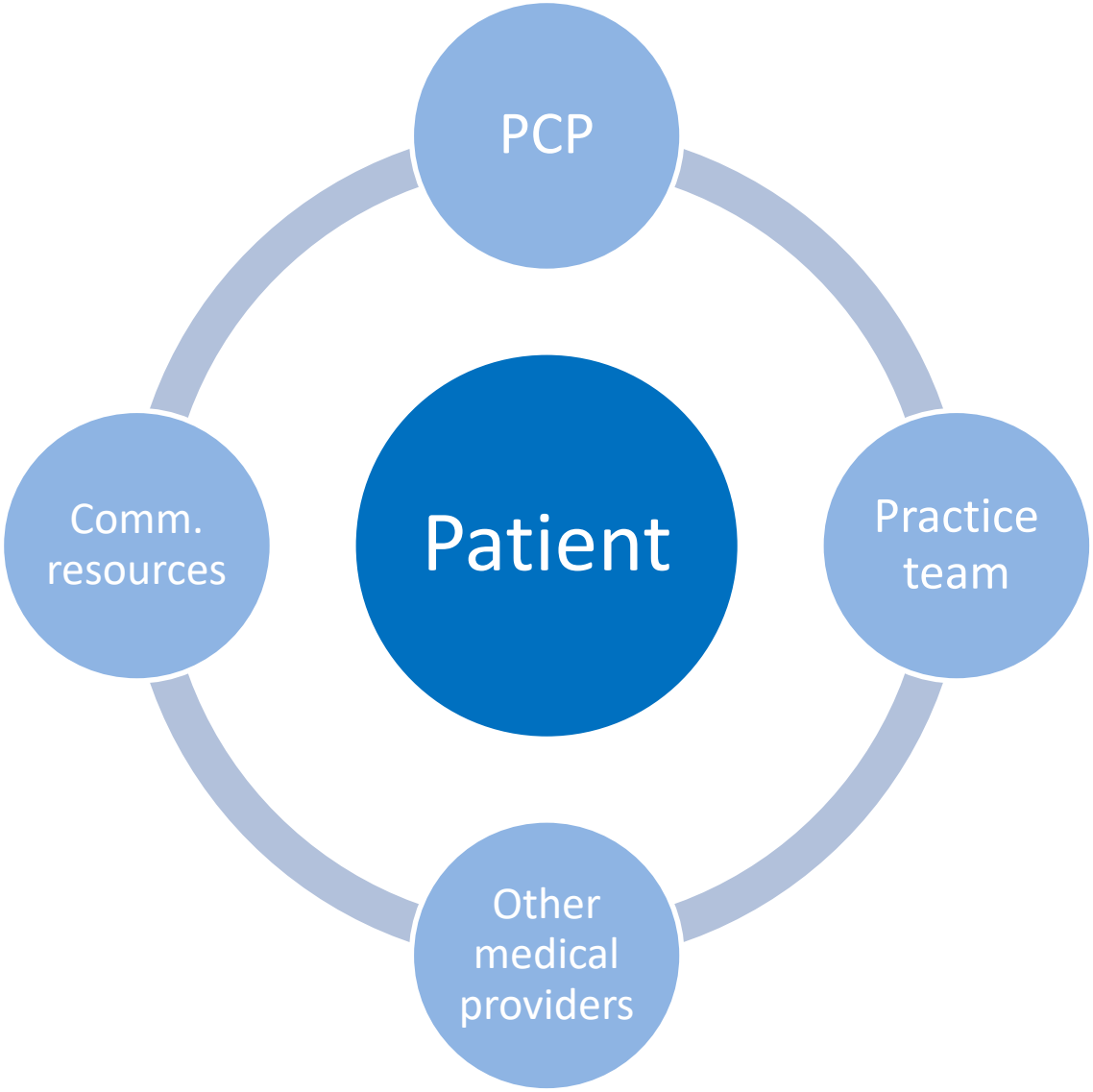
Definitions

Team-based care

The provision of health services to individuals, families, and/or their communities by at least two health providers who work ***collaboratively*** with patients and their caregivers — to the extent preferred by each patient — to accomplish shared goals within and across settings to achieve coordinated, high-quality care.*

*Core Principles and Values of Effective Team-Based Health Care, National Academy of Medicine (NAM)

Team-Based Care



Why is it important?

Improve collaboration

- Improve communication with other providers
- Be notified of ED and hospital discharges
- Avoid duplication of testing
- Reduce unnecessary referrals
- Address social determinants of health

Specialty Collaboration

"Typical" Referral Process

Need

- Identify patient needs to see specialist
- Choose specialist
- Staff calls specialist's office for appointment

Visit

- Patient visits specialist
- Tests performed

Follow-up

- Summary of visit sent to primary care provider

Specialty Collaboration

Collaborative Agreement

A framework for standardized communication between primary care and specialty care practitioners to improve care transitions.

Specialty Collaboration

What's in it for me?

Increases communication and clarifies expectations between the PCP and specialist

Lowers costs by eliminating unnecessary and inappropriate services

Alleviates the administrative burden of monitoring for follow-up

Improves patients' experience of care, quality of care and safety

Specialty Collaboration

What to include

- Needed patient information
- Access and scheduling expectations
- Patient preparation and education
- Timely communication and exchange of information

Sample Agreement

Sample Care Coordination Agreement
Referrals, Consults, Co-management
General: for all patients

Primary Care Practice Agrees to:

- **Prepare patient**
  - Use referral guidelines where available
  - Patient/family made aware of and in agreement with reason for referral, type of referral, and selection of subspecialist/specialist
  - Patient provided with expectations for events and outcomes of referral
- **Provide appropriate and adequate information** *(Optimally adopt mutually agreed upon referral form with Neighbor*)*
  - 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
- **Indication of urgency**
  - Make direct contact with subspecialist/specialist for urgent cases
- **Provide subspecialty/specialty practice with number for direct contact for additional information or urgent matters**
  - Needs to go directly to responsible contact

Subspecialty/Specialty (Neighbor) Practice Agrees to:

- **Review referral requests and triage according to urgency**
  - Reserve spaces in schedule to allow for urgent care
  - Notify referring primary care practice of recognized referral guidelines and inappropriate referrals
  - Work with referring primary care practice to expedite care in urgent cases
  - Anticipate special needs of patient/family
  - Agree to engage in pre-referral consult if requested.
  - Provide primary care practice with number for direct contact for urgent/immediate matters.
- **Provide appropriate and adequate information in a timely manner** *(Optimally adopt mutually agreed upon referral response form with primary care practice*)*
  - To include specific response to referral question and any provision of or changes in type of recommended interaction; diagnosis; medication; equipment; testing; procedures; education; referrals; follow-up recommendations or needed actions

Sample Agreement

Primary Care Practice Agrees to:

- **Review secondary diagnoses** or suggested referrals identified by subspecialist/specialist.
- **If co-managing with subspecialty/specialty practice**, provide them with any changes in patient's clinical status relevant to the condition being addressed by the subspecialty/specialty practice.
- **Contact the patient**, if deemed appropriate, when notified by subspecialty/specialty practice of failure to keep appointment.

Subspecialty/Specialty Practice Agrees to:

- **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 primary care practice for handling unless directly related to the referred problem.
  - If secondary diagnosis is followed up by subspecialty/specialty practice, notify primary care practice.
- **Information regarding any secondary referrals** made by subspecialty/specialty needs to be communicated to primary care practice.
- **Notify referring primary care practice** of no-shows and cancellations.
- **If patient is self-referred** or referred by another subspecialist/specialist, their primary care practice needs to be copied on the referral response upon obtaining appropriate patient permission.

* See model checklists of suggested areas to address in referral and referral responses, developed through the American College of Physicians' High Value Care Coordination Project and available at http://hvc.acponline.org/physres_care_coordination.html

Specialty Collaboration

"Ideal" Referral Process

Need

- Identify patient needs to see specialist.
- Select cardiologist that has a collaborative agreement with practice.
- Staff calls cardiologist's office to schedule appointment. Since this is an urgent referral, patient leaves PCP office with an appointment already scheduled for the next 72 hours.

Pre-Visit

- PCP office sends all insurance information and clinical record to cardiologist's office via secure email.
- Patient obtains echocardiogram at local imaging center in preparation for cardiology visit.
- Patient completes paperwork online for cardiology appointment, per instructions from PCP office.

Visit

- Cardiologist able to review echo results that were sent to their office.
- All patient records reviewed.
- Cardiologist able to diagnose patient and develop treatment plan during office visit.

Follow-up

- Summary of office visit sent electronically to PCP immediately upon completion of note.
- PCP knows their role in management of patient condition, based on office visit note.
- PCP staff update patient medication list based on cardiologist note.

Specialty Collaboration

Increases communication and clarifies expectations between the PCP and specialist

Lowers costs by eliminating unnecessary and inappropriate services

Alleviates the administrative burden of monitoring for follow-up

Improves patients' experience of care, quality of care and safety

Steps to Implementation

- Identify specialists
  - High volume
  - Good existing relationship
  - New referral specialist
- Reach out to them and ask what their expectations are of your practice when you make a referral
- Collaborate with their office to determine scheduling and follow-up expectations
- Record this in a document that is shared with the specialist, as well as accessible to staff making referrals

Measuring Success

- Ease in scheduling
- Efficiency in specialty appointment
- Timeframe for follow-up
- Patient satisfaction

Hospital Collaboration

Communication

- Admission, Discharge, Transfer (ADT) feed
- Discharge notes
- ED visit notification
- Access to hospital EMR

Collaboration

- Utilize hospital SW to impact frequent ED use
- Communication with discharge planners
- Attend care team meetings

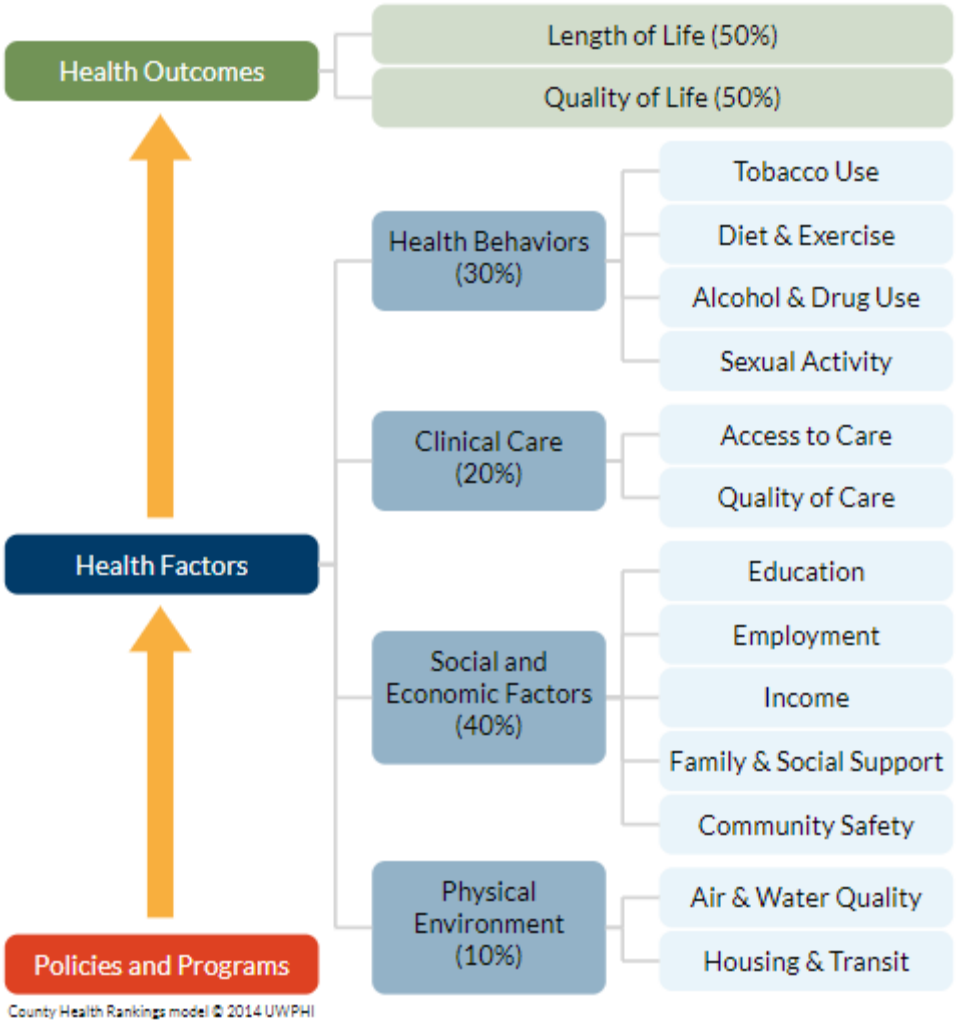
Steps to Implementation

- Establish a data feed
- Establish a point of contact
  - HIM or IT for data feed
  - Case management or social work director
- Define the level of collaboration
  - In-patient
  - Skilled patient
  - ED patient
- Feedback and evaluation

Measuring Success

- Rate and timeliness of ADT notifications
- In-patient warm hand-offs and f/u appointments
- Inclusion in care plan meetings
- ED patient outcomes

Community Collaboration



Source: [County Health Rankings Model]

Community Collaboration

Food insecurity	• Lack of access • Lack of finances • Lack of healthy choices
Housing	• Utilities • Rent • Substandard housing
Transportation	• To medical appointments • To work • To obtain food

Steps to Implementation

- Establish a list of resources
  - Aunt Bertha
  - United Way 211
  - Your staff!
- Reach out to each resource to determine point of contact and needed documents
- Discuss with each resource options for follow-up
- Make the resource directory available for all staff and update it regularly

Steps to Implementation

Food Insecurity

- Food pantry
- Harvesters

Housing

- Affordable Housing Midwest
- Low Income Energy Assistance Program

Transportation

- KanCare

Measuring Success

- Screen for Social Determinants of Health
- Track referrals for community needs
- Touch base with resources
- Solicit patient feedback

Next Steps

- Choose one specialist to enact a collaborative agreement with.
- Contact the hospital to establish a process to improve collaboration.
- Compile a community resource directory and establish a relationship with one resource.

Reach out to Tammy and Gary for assistance!

Kansas Foundation for Medical Care, Inc.

Questions?

Consultation Services

- We can assist you on your Practice Transformation Journey.
  - Tailored support from KFMC consultants
  - Workflow and process analysis services
  - Data analysis
  - HIT consultation
- *Free for eligible practices*

Learn More

- Email practices@kfmc.org
- Visit our webpage https://www.kfmc.org/practice-transformation

Next Session-December 1

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- Improve collaboration with other providers
- ***Engage patients in their care***
- ***Leverage data to drive improvement activities***

Our Team

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Post-Event Survey