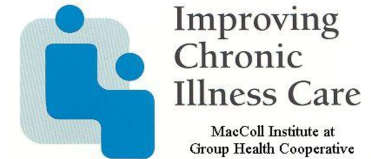
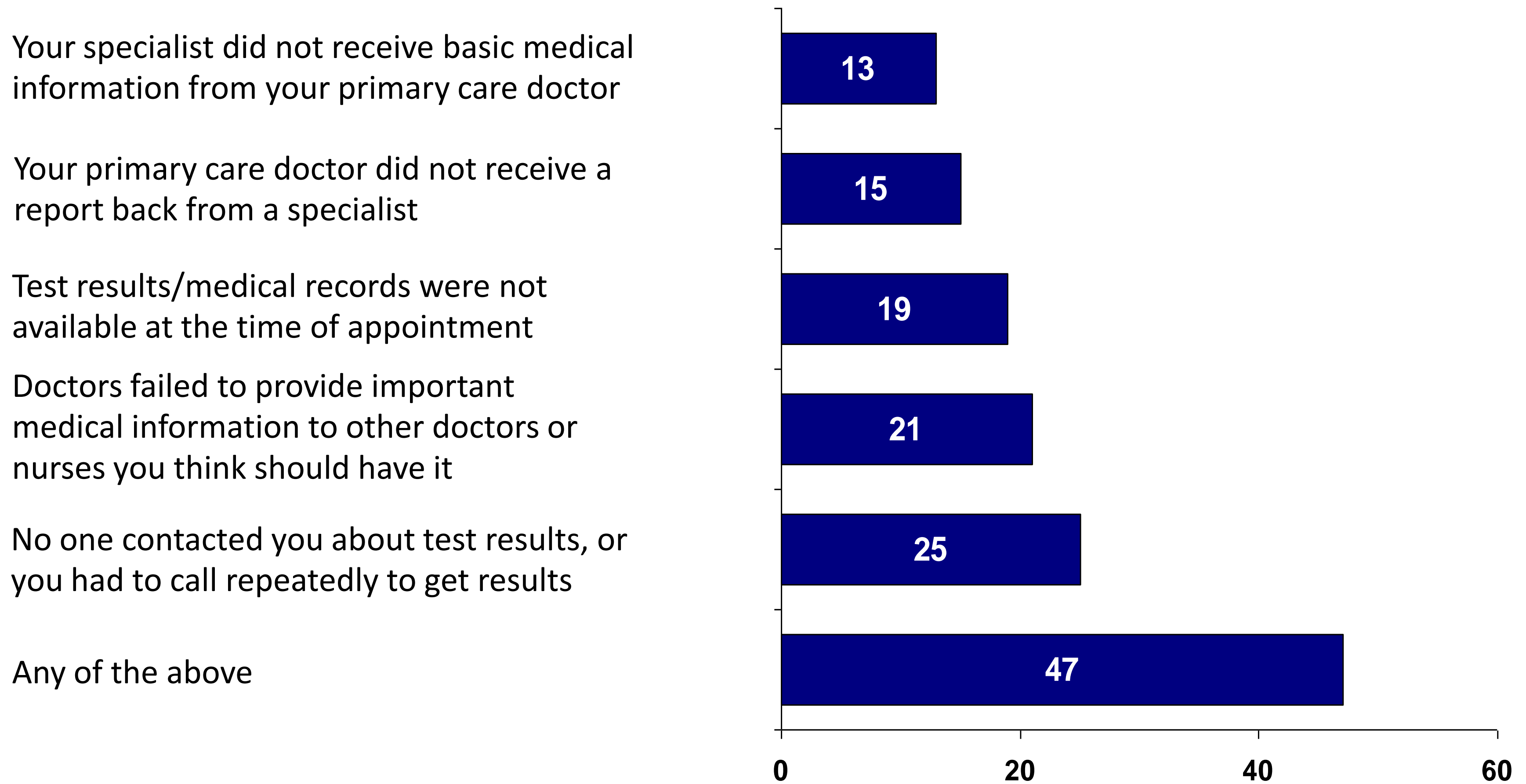


The Patient Centered Medical Home: Care Coordination

Ed Wagner MD, MPH, MACP

Group Health Research Institute

Poor Coordination: Nearly Half of Consumers Report Failures to Coordinate Care



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

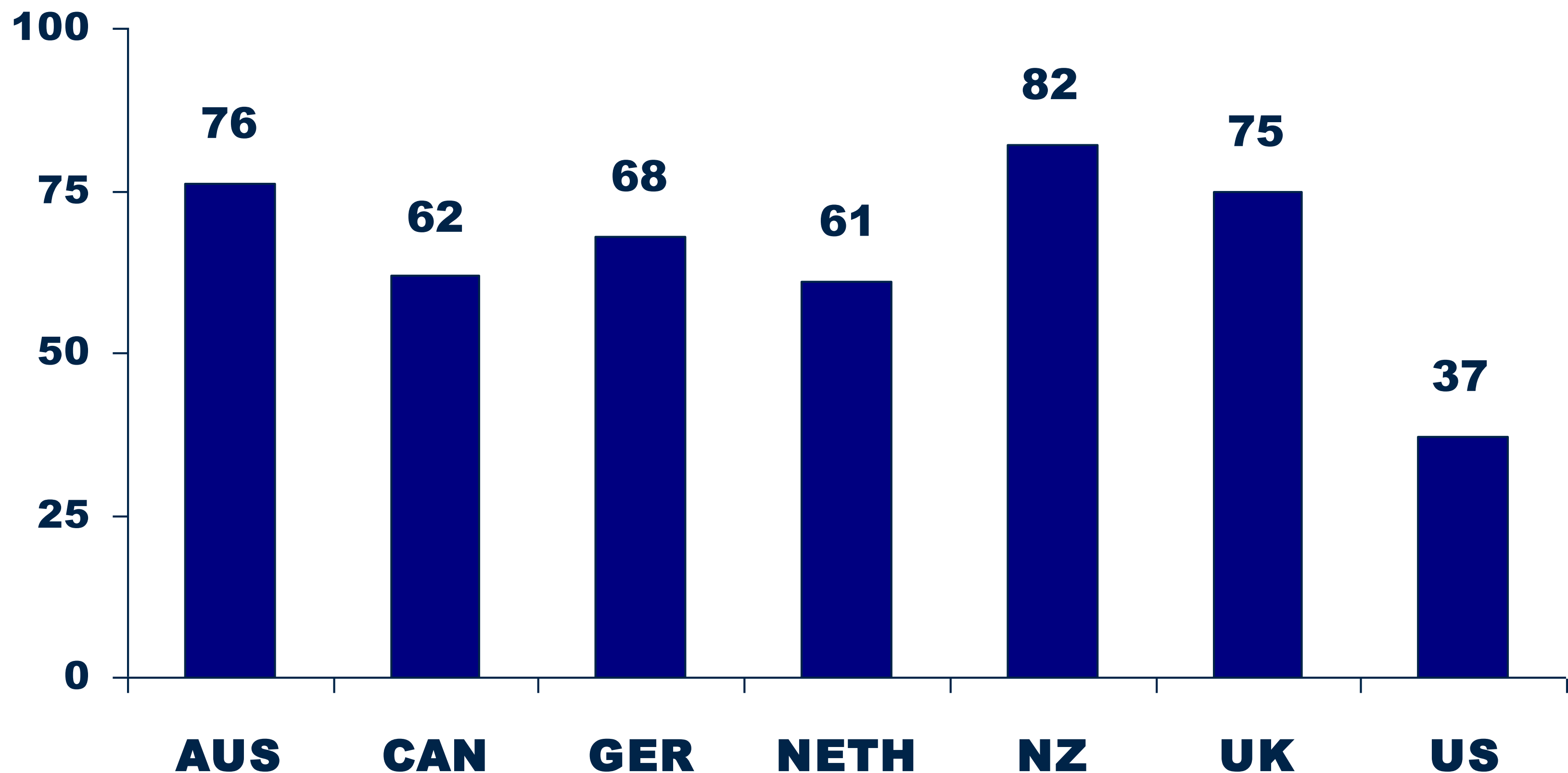
Doctors' Reports of Care Coordination Problems

Percent saying their patients "often/sometimes" experienced:	AUS	CAN	GER	NETH	NZ	UK	US
Records or clinical information not available at time of appointment	28	42	11	16	28	36	40
Tests/procedures repeated because findings unavailable	10	20	5	7	14	27	16
Problems because care was not well coordinated across sites/providers	39	46	22	47	49	65	37

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Commonwealth Survey of Primary Care MDs:

Percent reporting that they receive information back for "almost all" referrals (80% or more) to Other Doctors/Specialists



Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

How often do you get the information you need after referral?

What do you think your patients would say about their experience?

care·co·or·din·a·tion

1. *v.*, 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[1]

2. *adj.*, referring to activities and interventions that attempt to reduce fragmentation and improve the quality of referrals and transitions.

Source: McDonald, et al. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7 – Care Coordination*, June 2007.

What constitutes a high quality referral or transition?

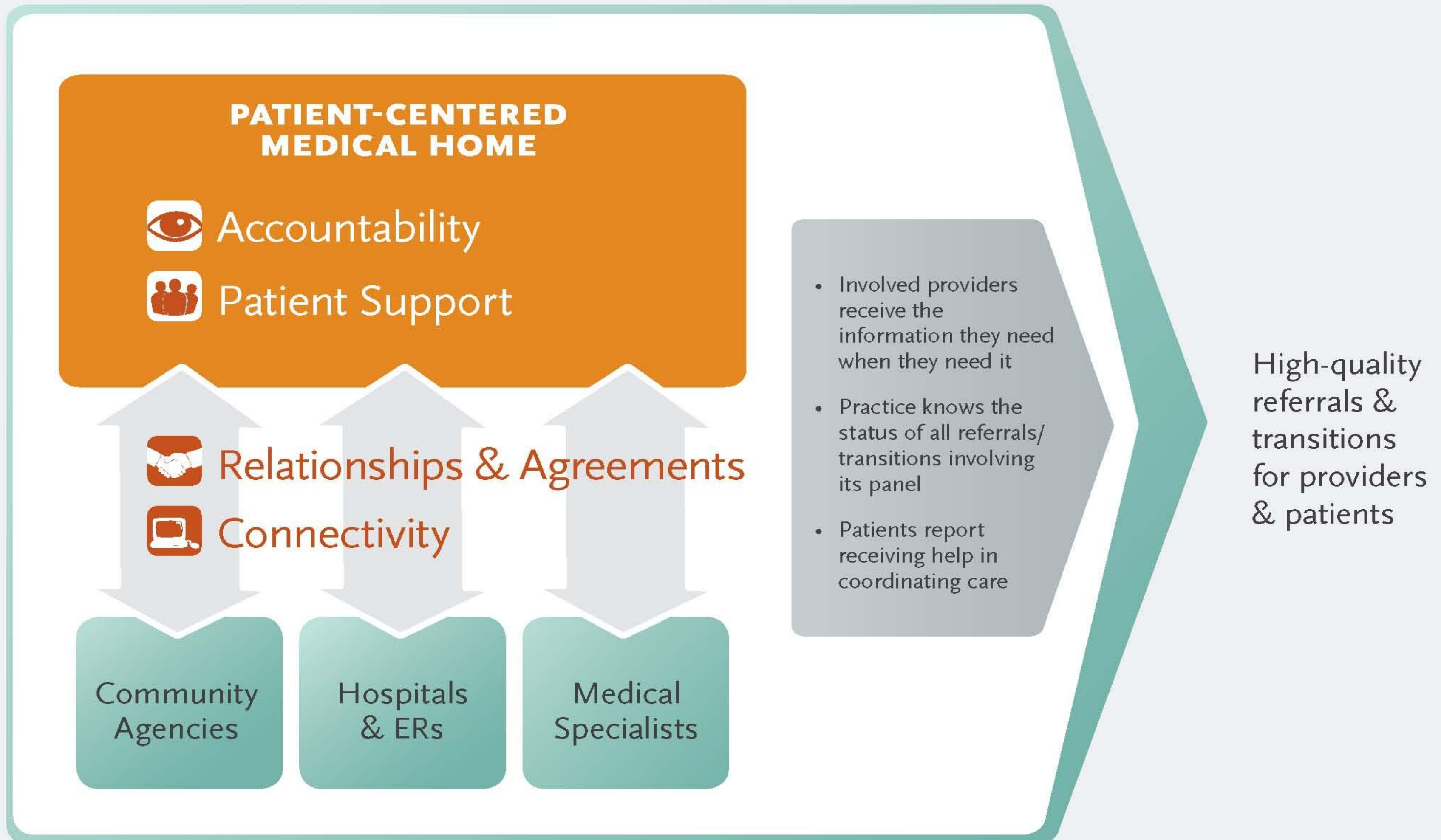
Safe	Planned and managed to prevent harm to patients from medical or administrative errors.
Effective	Based on scientific knowledge, and executed well to maximize their benefit.
Timely	Patients receive needed transitions and consultative services without unnecessary delays.
Patient-centered	Responsive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

Care Coordination in PCMH Practices

- ✓ Link patients with community resources to facilitate referrals and respond to social service needs.
- ✓ Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
- ✓ Proactively track and support patients as they go to and from specialty care, the hospital, and the emergency department.
- ✓ Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- ✓ Test results and care plans are communicated to patients/families.
- ✓ Provide care management services for high risk patients.

How many of you are trying things like this?

Care Coordination Model



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Key Changes

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

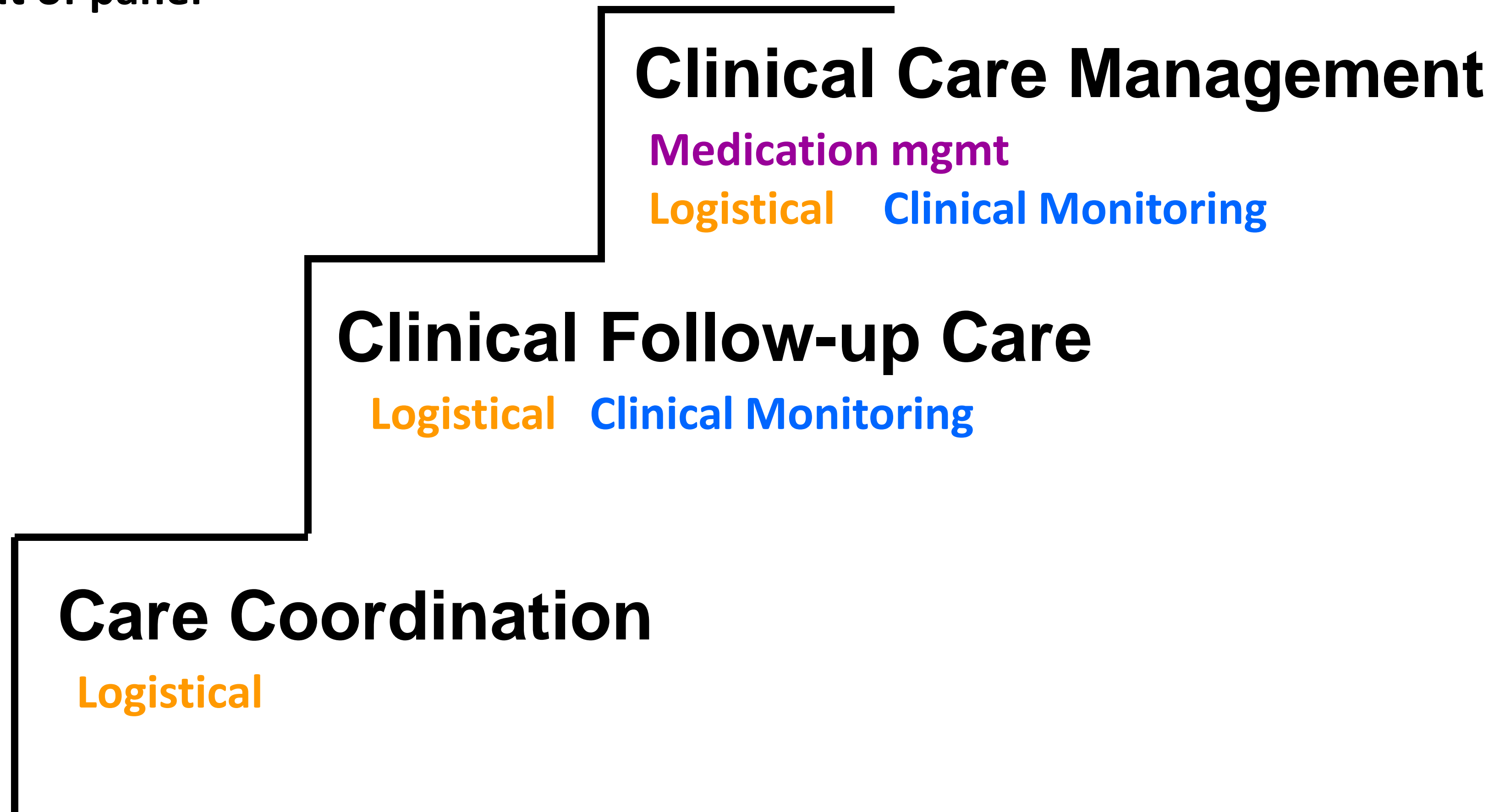
Assume Accountability

- Initiating conversations with key consultants, ERs, hospitals, and community service agencies
- Setting up an infrastructure to track and support patients going outside the PCMH for care

Provide Patient Support

- Help patients identify sources of service—especially community resources
- Help make appointments
- Track referrals
- Assure transfer of information
- Monitor hospital and ER utilization reports
- Manage e-referral system

Relationship Between Care Coordination and Care Management Activities in Primary Care



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Build Relationships and Agreements

- Primary care leaders initiate conversations with key specialists, hospitals and community services around mutual expectations
- Specialists have legitimate concerns about inappropriate or unclear reasons for referral, inadequate prior testing etc.
- Agreements are sometimes put in writing or incorporated into e-referral systems.

Develop Connectivity

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

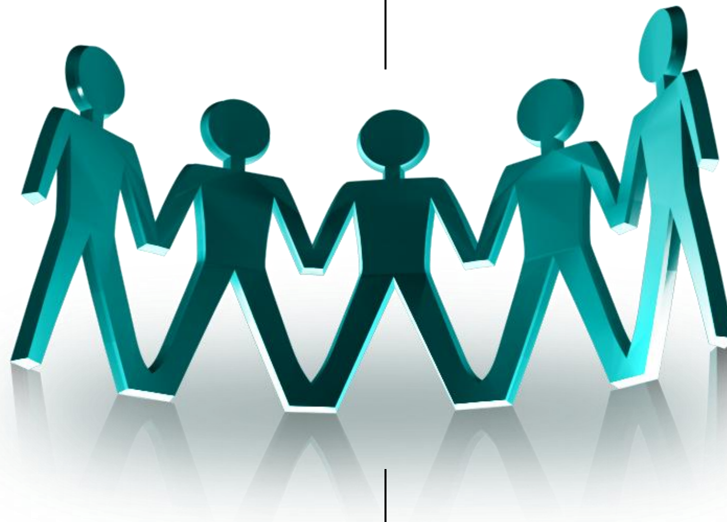
Primary Care – Specialist Interaction Improves Outcomes!

- Foy et al. studied planned collaborative arrangements between primary care and specialty that included interactive communication about individual patients' care.
- Looked at diabetes and mental health care
- Interactive communication included 2-way interactions in person, by phone, by shared record, by e-mail.
- Effect sizes lager than those seen in drug trials (e.g., average HbA1c reduction of 1.4%).

Why work on Care Coordination?

Patient experience

Safety & quality



Resources

Practice environment

Where might you start?

Community Agencies?

Tracking & following up on lab/imagining results;
Identification & tracking of linkages to community resources.

Medical Specialists?

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

EDs/ Hospitals?

Notification of visit/admission and discharge;
Medication reconciliation after transition;
Involvement of PCMH in post-discharge care.

PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity	Pts
A. **Access During Office Hours****	**4**
B. After-Hours Access	4
C. Electronic Access	2
D. Continuity	2
E. Medical Home Responsibilities	2
F. Culturally and Linguistically Appropriate Services	2
G. Practice Team	4
	20

PCMH2: Identify and Manage Patient Populations	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. Use Data for Population Management**	**5**
	16

PCMH3: Plan and Manage Care	Pts
A. Implement Evidence-Based Guidelines	4
B. Identify High-Risk Patients	3
C. Care Management**	**4**
D. Manage Medications	3
E. Use Electronic Prescribing	3
	17

PCMH4: Provide Self-Care Support and Community Resources	Pts
A. Support Self-Care Process**	**6**
B. Provide Referrals to Community Resources	3
	9

PCMH5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. Referral Tracking and Follow-Up**	**6**
C. Coordinate with Facilities/Care Transitions	6
	18

PCMH6: Measure and Improve Performance	Pts
A. Measure Performance	4
B. Measure Patient/Family Experience	4
C. Implement Continuously Quality Improvement**	**4**
D. Demonstrate Continuous Quality Improvement	3
E. Report Performance	3
F. Report Data Externally	2
	20

**Must Pass Elements

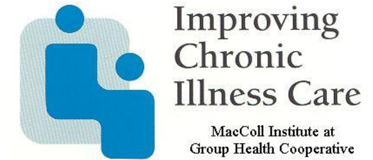
PCMH 5: Track and Coordinate Care

Intent of Standard

- Track and follow-up on lab and imaging results
- Track and follow-up on referrals
- Coordinates care received at hospitals and other facilities

Meaningful Use Criteria

- Incorporate clinical lab test results into the medical record
- Electronically exchange of clinical information with other clinicians and facilities
- Provide electronic summary of care record for referrals and care transitions



For more information:

www.qhmedicalhome.org

www.improvingchroniccare.org