

Listening Session 2: *Developing Financial Incentives*

Presenters:

Subject Matter Experts

- ❖ Kevin Bozic, MD, MBA, Professor and Chair, Department of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin
- ❖ Ami Bhatt, MD, FACC, Chief Innovation Officer, American College of Cardiology
- ❖ Judy Zerzan-Thul, MD, MPH, Chief Medical Officer, Washington State Health Care Authority
- ❖ Christina Borden, Director, Quality Solutions Group, National Committee for Quality Assurance *and* Brian Outland, PhD, Director, Regulatory Affairs, American College of Physicians (*Previous Submitters*)

Listening Session 2: *Developing Financial Incentives*

Kevin Bozic, MD, MBA

Professor and Chair, Department of Surgery and Perioperative Care
Dell Medical School, The University of Texas at Austin

***MAKING THE
TRANSITION TO VALUE
IN HEALTH CARE:
WHAT, WHY, HOW?***

Kevin J Bozic, MD, MBA
Professor and Chair
Department of Surgery & Perioperative
Care
Dell Medical School at the University of
Texas at Austin

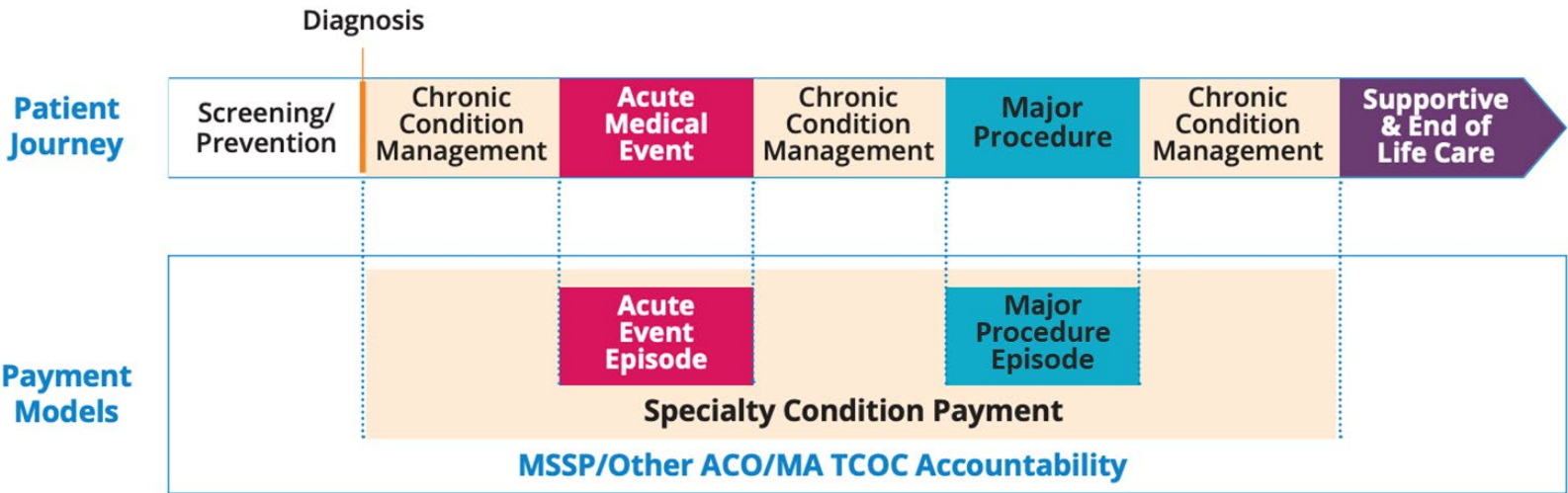


Rethinking care delivery: The UT Health Austin Musculoskeletal Institute



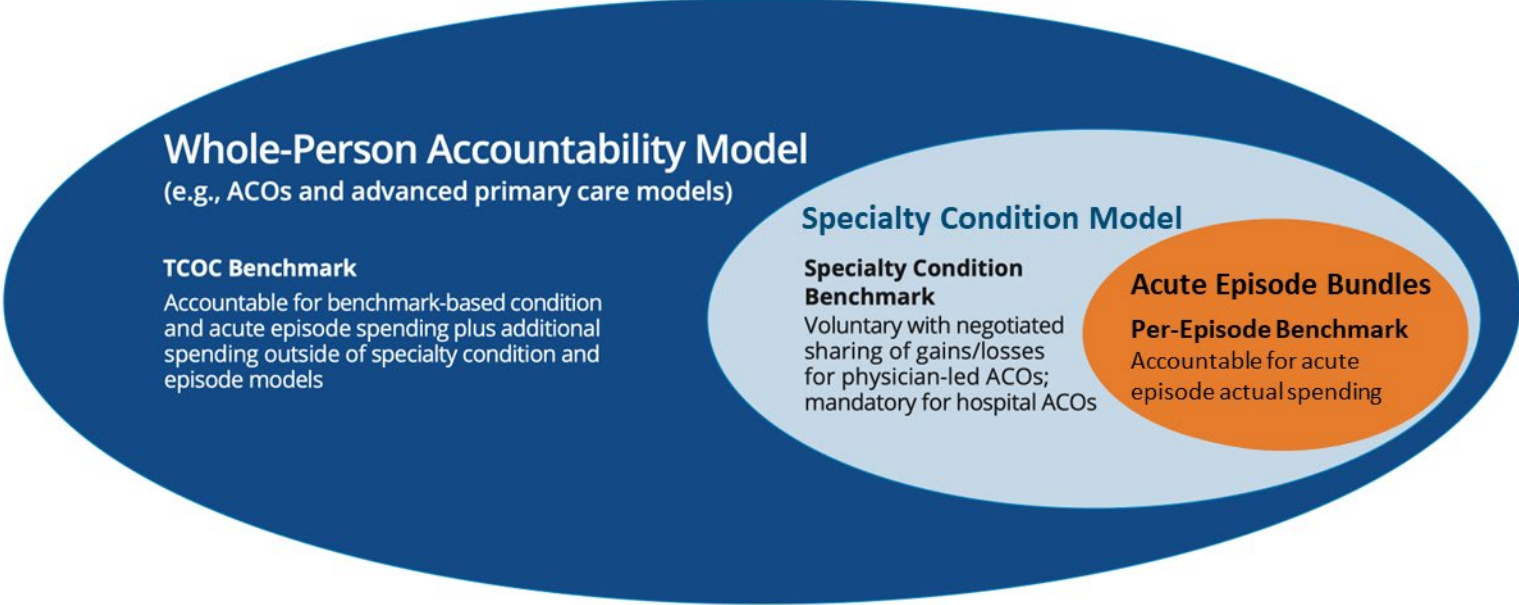
Our multidisciplinary care teams offer a **one-stop musculoskeletal care home** to treat a broad range of musculoskeletal conditions and injuries.

Rethinking bundled payments: condition-based payment models



Nested Structure of Payment Models

Rethinking bundled payments: condition-based payment models



Bridging Accountability through TCOC, Specialty Condition, and Acute Episode Models

Key questions to consider

- What is your organization's **approach to value-based care delivery**? What is an **integrated practice unit** and how has your team employed this model?
- What has been the **reaction from clinicians** to this care delivery model and what are your **approaches to attract/retain talent**?
- What are the **most effective approaches to engage specialists** in population-based total cost of care (PB-TCOC), condition-based, or episode-based models?
- Should **risk for chronic disease management** and acute episodes / procedures be **nested within PB-TCOC models**? Should **risk for the most expensive disease** stages of a specialty condition be placed in a **separate model**? How should risk be structured when providers are managing care for patients with **multiple chronic conditions**?

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Ami Bhatt, MD, FACC

Chief Innovation Officer

American College of Cardiology

Developing Financial Incentives and Performance Measures

PTAC 3/2023: Architecting value-based models in subspecialty care

Ami B. Bhatt, MD, FACC

Chief Innovation Officer, American College of Cardiology

Associate Professor, Harvard Medical School



Advancing Heart Care Worldwide

ACC INNOVATION PROGRAM



Developing Financial Incentives and Performance Measures

- Our Aim at PTAC Today
 - Recommend best practices for developing specialist-focused incentives and performance metrics
 - Encourage engagement with primary care providers and population-based total cost of care (PB-TCOC) models
- Some Facts about Practice Today
 - Total value allocation is modest in specialty care
 - Models will lay the incentive and metric infrastructure for value payments



Developing Specialist Focused Incentives



Create Team Based Value Incentives



Compensate equally across subdisciplines



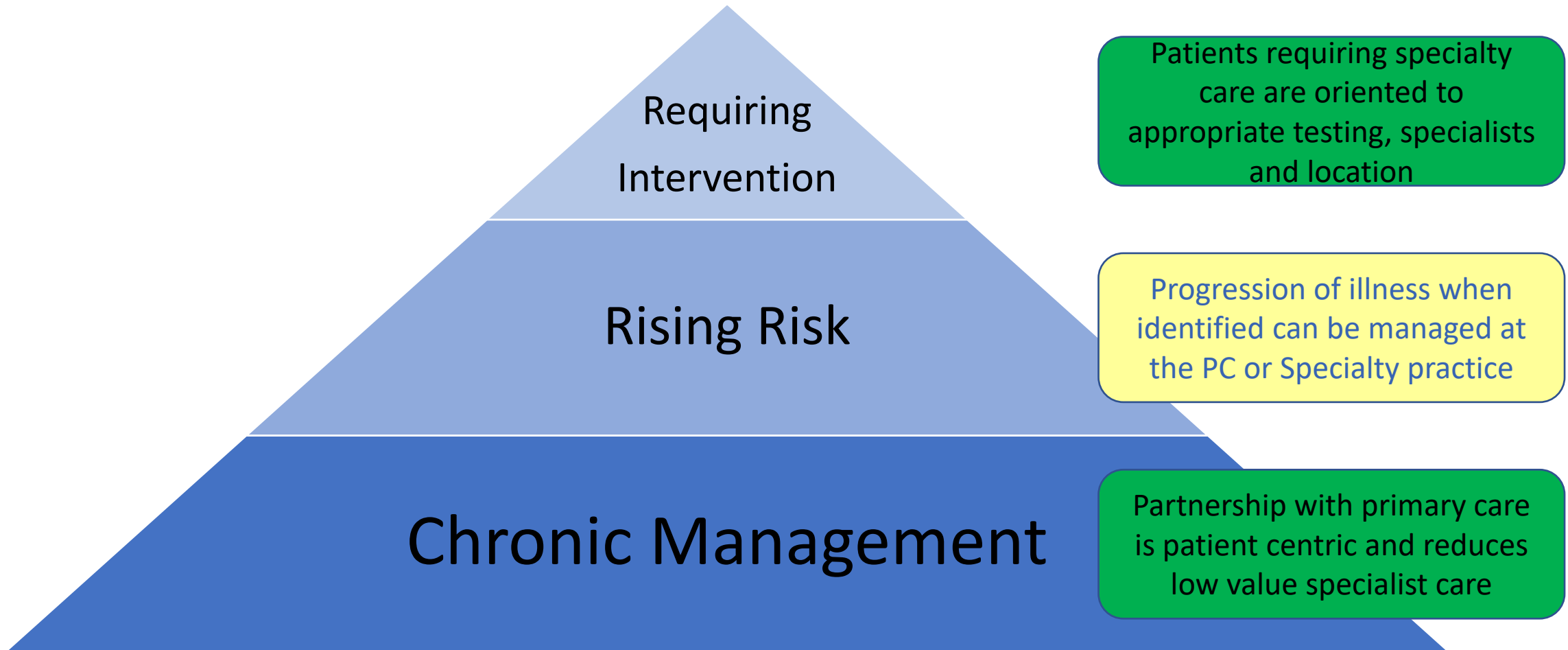
Allocate value to clinically meaningful non-production metrics (trade contradictory incentives for purposeful achievement)



Engage specialists as architects of value-based compensation (build from within for adoption)



The Goal of PB TCOC is to Optimize Patient Care



Clinical Practice is now Continuous, not Episodic: Payment models will need to follow this trend



Asynchronous Communication: PROMs, Electronic Consultation



Blended Care: In-person and Virtual synchronous visits



Clinical remote monitoring, medical grade devices



Digital tracking and wearables, healthcare and social data



Emerging Analyses: Data Analytics and Collaborative Intelligence



Value Based Models with Adequate Infrastructure can address Health Equity

- Incentivize PB TCOC among subspecialists by supporting upstream equity in screening and disease identification and meeting social service needs
- Embed social determinants of health and social vulnerability index into payment models
- In team-based subspecialty care, compensation (up-front, subsidies, and incentives) which is shared across a practice rewards all providers for societal impact



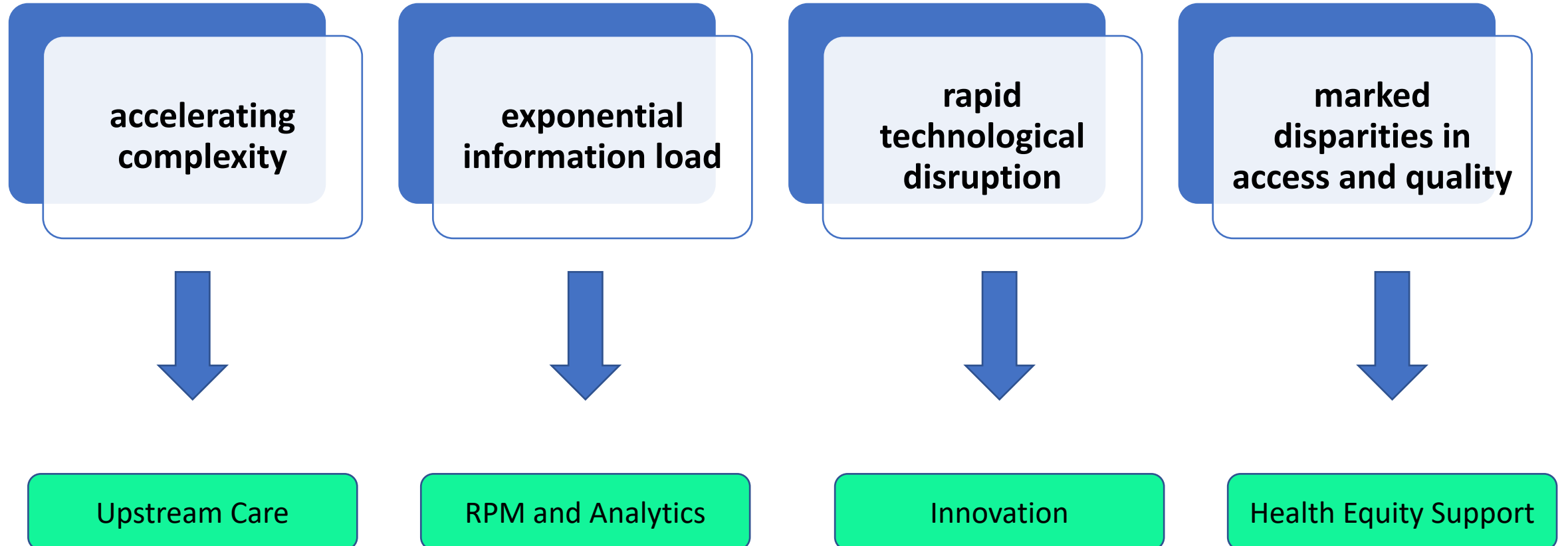
Options for Value Based Subspecialty Models

- Comprehensive condition-based value model – episode of care from treatment to stabilization
- Continuous care value-based model – includes collaboration with primary care, community outreach and addressing health equity

Both models may be necessary to improve access and quality of care



Successful Value Models will Address these Challenges





AMERICAN
COLLEGE *of*
CARDIOLOGY®

The ACC Vision

A world where **innovation**
and **knowledge** optimize
cardiovascular care
and outcomes.

Thank you

Questions for Discussion

- How can technological innovations be used to support improvements in care delivery and specialty integration for managing patients with chronic conditions?
- What are the most effective financial incentives for encouraging specialist engagement in PB-TCOC models and improving specialty integration? What are examples of organizations that have been utilizing these incentives?
- What are some potential opportunities for improving current prospective and retrospective arrangements for managing higher-cost specialty care, such as prospective payment for a bundle of services and/or retrospective reconciliation based on performance?
- How can incentives be structured to address the start-up costs affecting specialists that would like to participate in a PB-TCOC model?
- How can PB-TCOC models incentivize specialists' performance and improvement on measures related to outcomes, quality, utilization and TCOC?
- What kinds of performance measures are appropriate for improving specialty integration? How can specialist performance measurement be standardized across care delivery models?



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Judy Zerzan-Thul, MD, MPH

Chief Medical Officer

Washington State Health Care Authority

Integration of behavioral and physical health in Washington

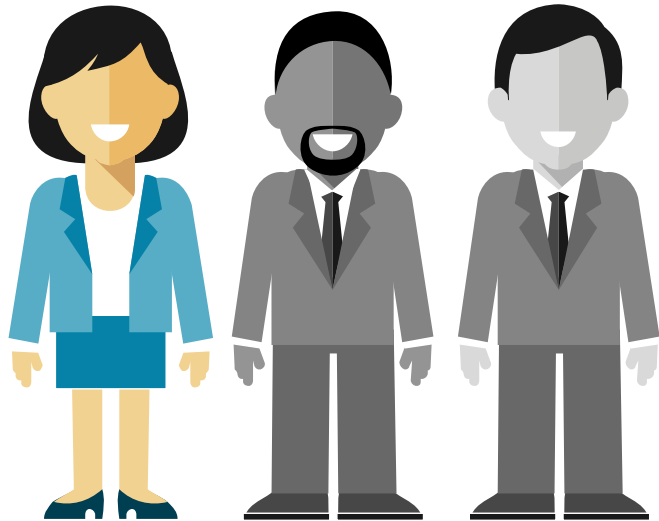
Judy Zerzan-Thul, MD, MPH
Chief Medical Officer

Clinical Quality and Care Transformation

Washington State
Health Care Authority

The state's largest health care purchaser

We purchase care for
1 in 3 non-Medicare
Washington residents.



- ▶ We currently purchase health care for nearly 3 million Washington residents through:
 - ▶ Apple Health
 - ▶ The Public Employees Benefits Board (PEBB) Program
 - ▶ The School Employees Benefits Board (SEBB) Program
- ▶ Designated Single State Authority for Behavioral Health, with services for all state residents

Behavioral Health - Single State Authority (SSA)



- ▶ **Evolution of Behavioral Health in Washington**
 - ▶ In 2009, the Division of Alcohol and Substance Abuse and Mental Health Division combined to become the Division of Behavioral Health and Recovery (DBHR).
 - ▶ In 2018 DBHR moved from the Department of Social and Health Services and became part of HCA.
- ▶ **Integration of Community Behavioral Health services with Medicaid - 2020**
- ▶ **Safety net**
 - ▶ HCA treatment resources are a safety net for those who do not have private insurance to pay for critical treatment services.
 - ▶ Prevention, outreach and engagement, and recovery support services are available to Washingtonians regardless of insurance status.

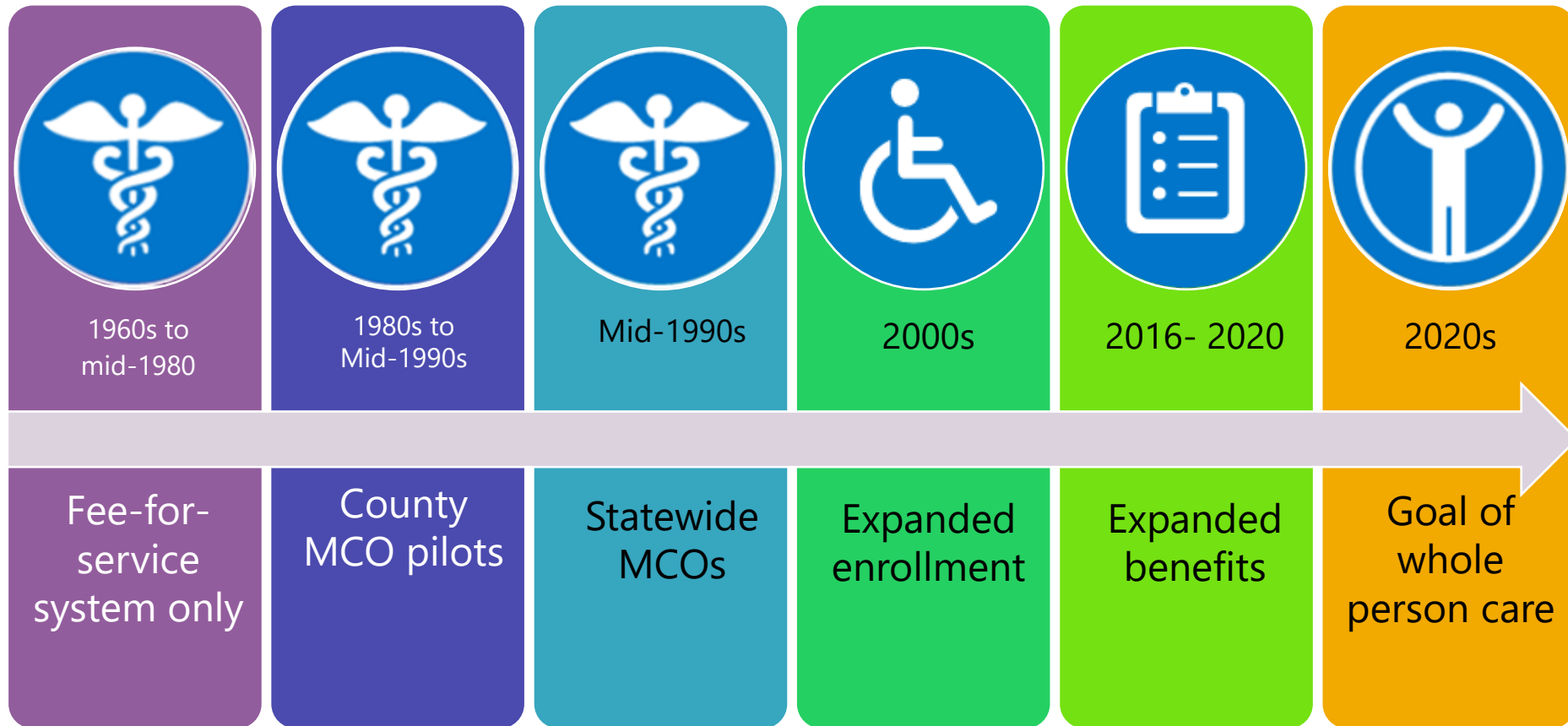
Who did we serve in the Behavioral Health Delivery system in FY 2022?

- ▶ **446,546** individuals received Mental Health treatment services.
- ▶ **89,447** individuals received SUD treatment services.
- ▶ **12,516** individuals received prevention services.



● Mental Health Treatment Services
● Substance Use Disorder Treatment Se
● Substance Use Disorder Prevention Se
1 figure = approx. 3,000 people

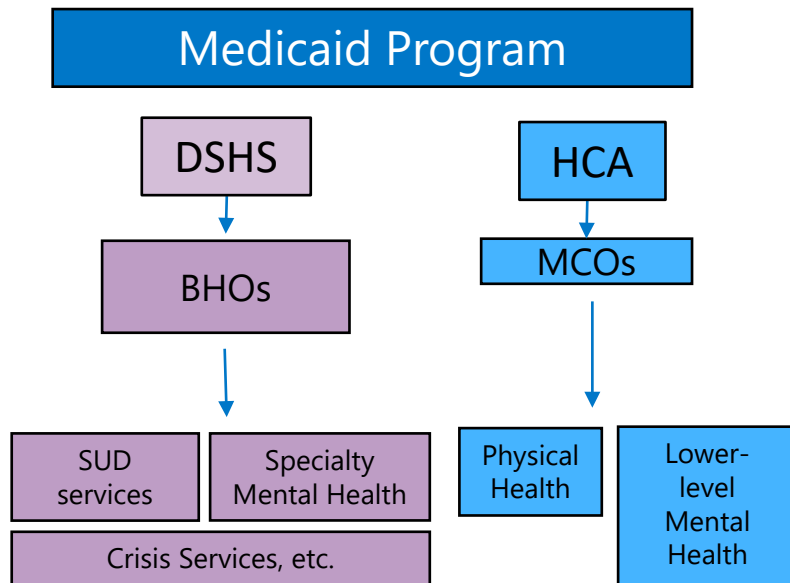
Whole-person care (physical and behavioral health integration – 2016 legislation) – *Timeline to Integrated Care (prior to Covid 19)*



Physical & behavioral health integration

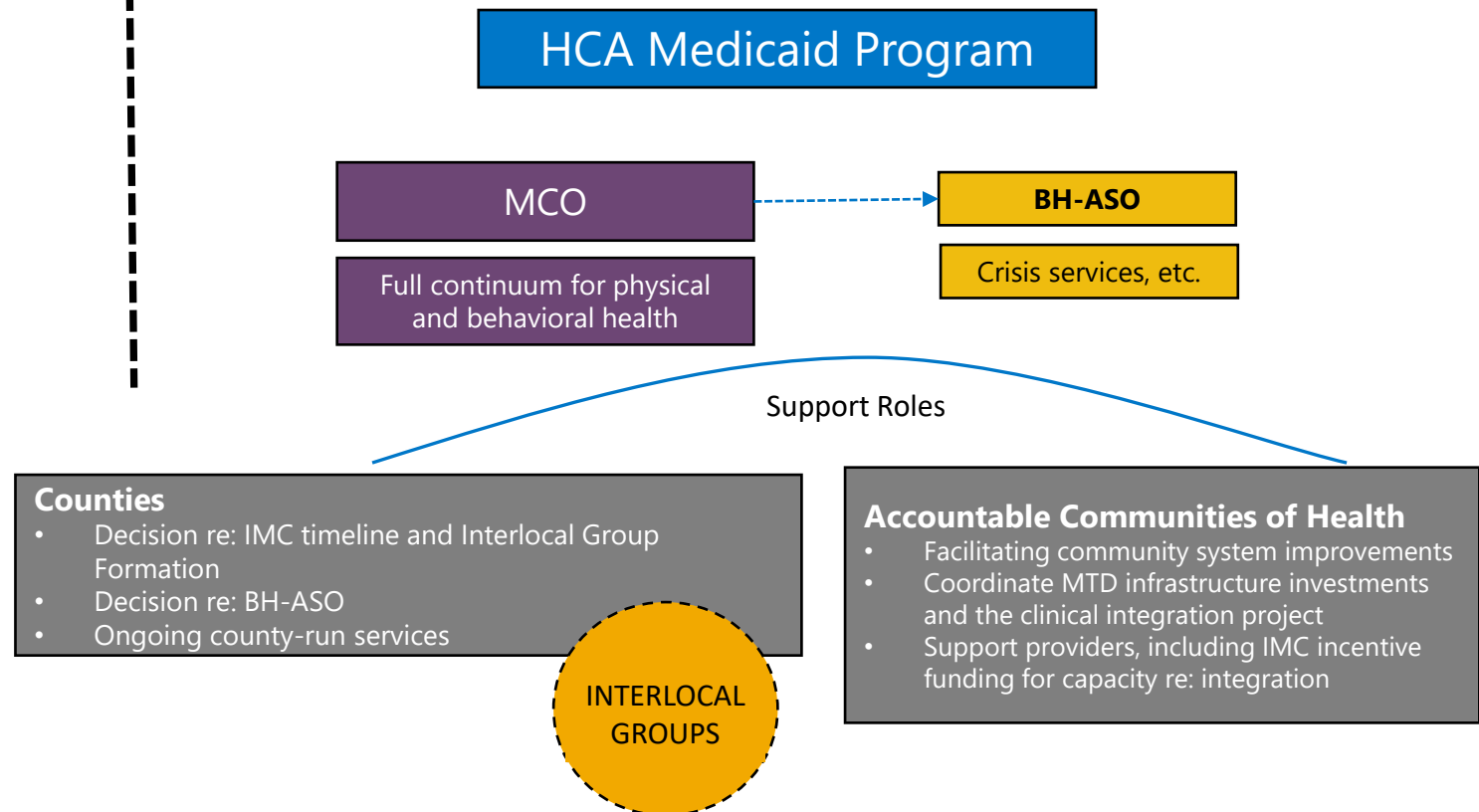
Before integration

No one payer or provider is accountable for the whole person

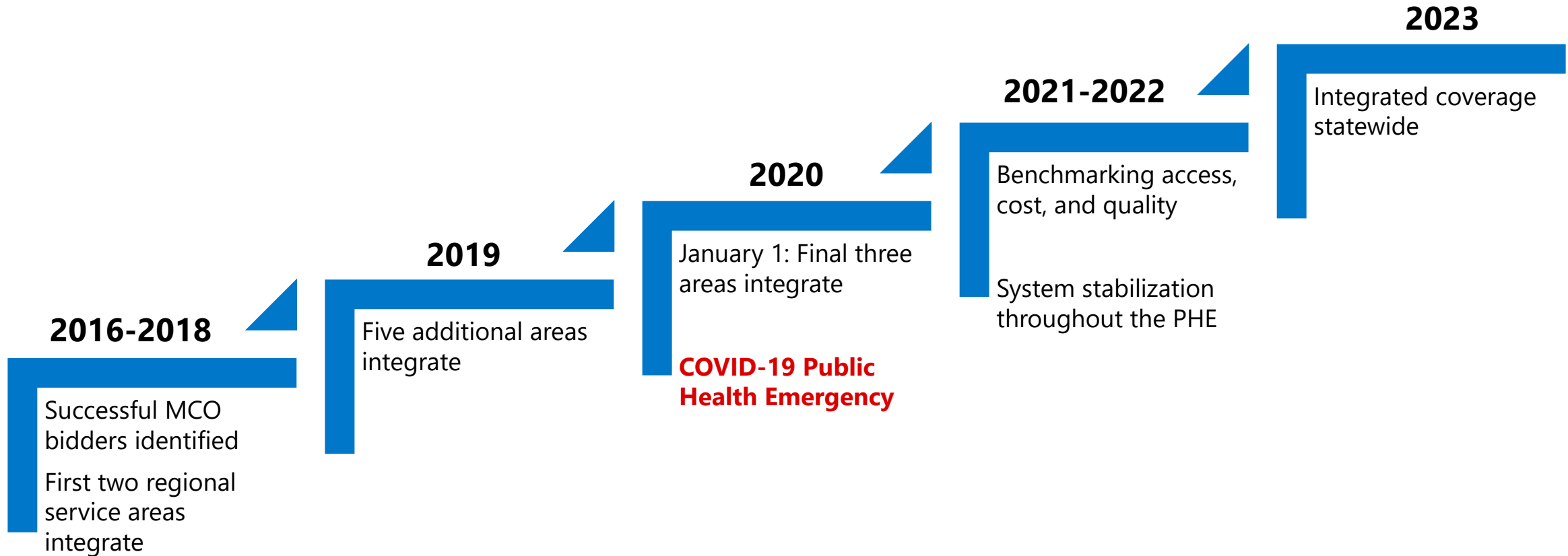


After integration

Whole person care management provided through a single accountable insurance

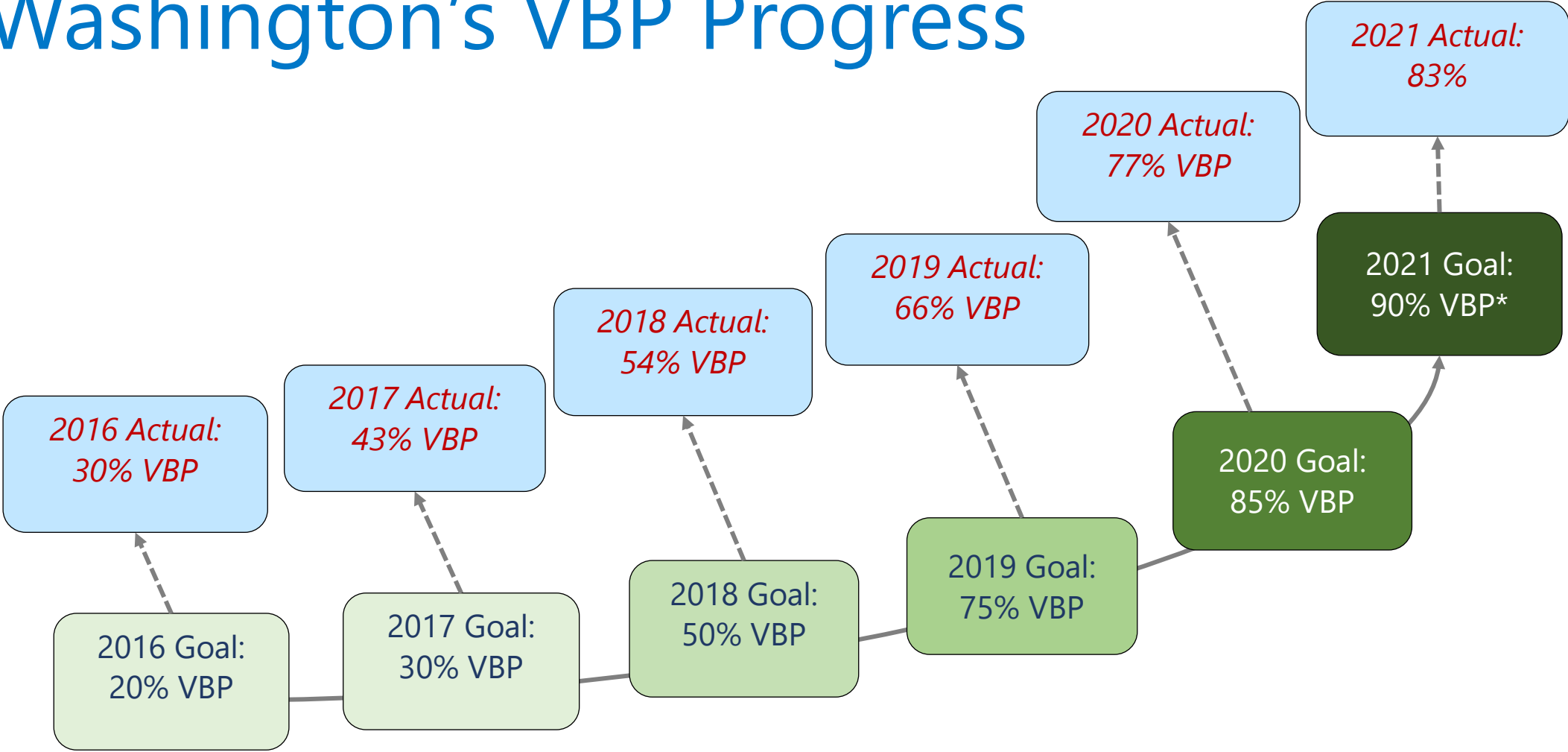


Phased implementation



Value-based purchasing and primary care and system transformation

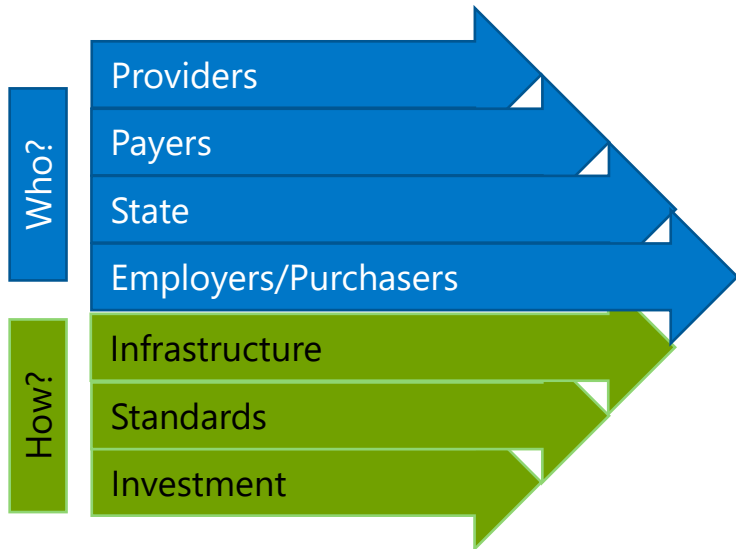
Washington's VBP Progress



**The 2021 VBP MCO target was 85% rather than 90% due to COVID-19.*

Advancing Primary Care and System Transformation

Comprehensive System Alignment



Provider Accountabilities

- 1) Whole person care
- 2) A team for every patient
- 3) Appropriate resource allocation
- 4) Behavioral health screening and follow-up
- 5) Patient support
- 6) Care coordination strategy
- 7) Expanded access
- 8) Culturally attuned care
- 9) Health literacy
- 10) Data informed performance management

State Accountabilities

- Single standardized evaluation to establish common understanding of provider capabilities
- HCA Program Alignment
- Performance standards
- Model participation/Financing
- Practice Supports
- Contract Alignment

Payer Accountabilities

- Aligned Practice Supports
- Shared Quality Standards
- Aligned Payment Models
- Transformation Funding
- Prospective Comprehensive Care Payment
- Quality Incentives

Purchaser Accountabilities

- Aligned Payer Contractual Expectations
- Performance standards
- Model participation
- Practice Supports
- Alignment Through Direct Contracting

Goal: 12% of total health system spending is for primary care services

Washington Integrated Care Assessment

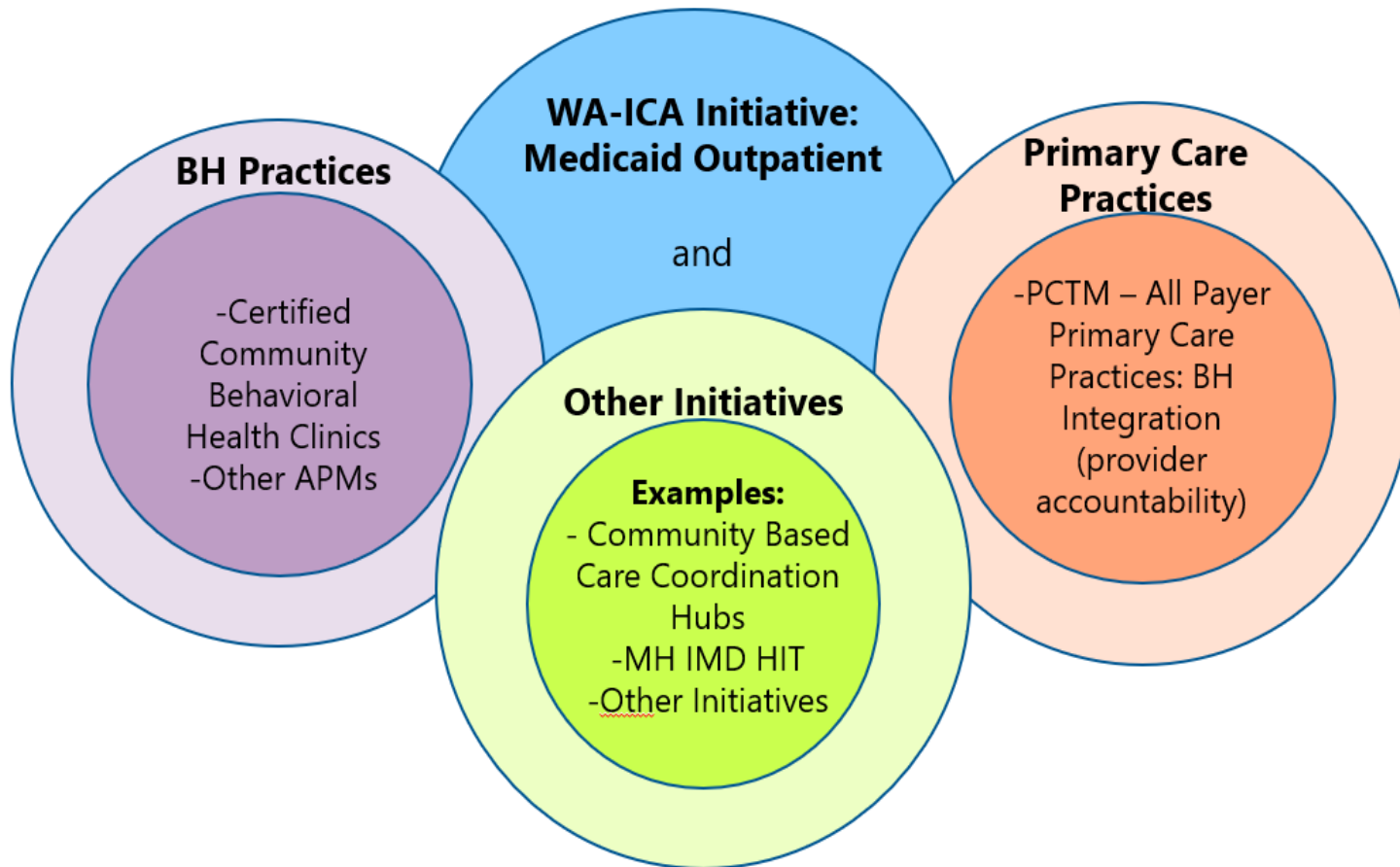
Purpose

- ▶ Develop and implement a statewide, standardized assessment tool and approach for advancing bidirectional clinical integration in outpatient behavioral health and physical health practices

Importance

- ▶ Creates a collaborative, coordinated and standardized approach across Managed Care Organizations (MCOs) and Accountable Communities of Health (ACHs).
- ▶ Equally supports physical health and behavioral health practices in their efforts to advance integration.
 - ▶ The selected tool (WA-ICA) is a companion tool set: one version developed specifically for primary care and one version developed specifically for behavioral health practices.
- ▶ Provides a structure/roadmap for advancing bi-directional clinical integration that can be leveraged across multiple HCA Initiatives, including payment models (e.g., Primary Care Transformation Model (PCTM)) and service delivery models (e.g., Certified Community Behavioral Health Clinics (CCBHCs)).
- ▶ Provides regional and statewide data to drive technical/coaching support and policy/funding decisions.

Overlap across initiatives



TOPICS:

- Identifying opportunities for advancing/aligning bi-directional clinical integration across HCA Initiatives, including use of Health IT and health Information Exchange
- Linking funding / activities across initiatives
- Identifying and tracking co-participation across initiatives
- Data Use and Improvement: Identifying Medicaid primary care and BH practices (who/where) across the state



Questions?

Contact us



hca.wa.gov

[@WAHealthCareAuthority](https://twitter.com/WAHealthCareAuthority)

[@WA_Health_Care](https://twitter.com/WA_Health_Care)

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Christina Borden

Director, Quality Solutions Group

National Committee for Quality Assurance (NCQA)

and

Brian E. Outland, PhD

Director, Regulatory Affairs

American College of Physicians (ACP)

(Previous Submitters)

Listening Session on Improving Care Delivery and Integrating Specialty Care in Population-Based Models PTAC Public Meeting, March 3, 2023

Brian E. Outland, Ph.D., Director, Regulatory Affairs, ACP
Christina M. Borden, Director, Quality Solutions Group, NCQA

ACP/NCQA submitted the Medical Neighborhood Advanced Alternative Payment Model to PTAC

- The [Medical Neighborhood Model \(MNM\)](#) is a five-year, multi-payer pilot that seeks to improve coordination between specialty practices and primary care practices who refer patients to them and provide advanced support to their patients.
- MNM seeks to improve coordination by connecting primary care practices participating in advanced primary care models with specialty practices that meet rigorous clinical transformation and care coordination criteria – including establishing and maintaining agreements with referring primary care practices on how they will share information and coordinate care before, during, and after referrals.
- PTAC [recommended](#) the MNM proposal to the Secretary for testing to inform payment model development, noting that the Committee found that the proposal met all 10 of the Secretary's criteria

Critical Features of a Collaborative Care Agreement

- Utilize care coordination agreements between primary care (PC) and specialty care (SC) practices that allow for all involved in the patient's care to understand their role and expectations
 - Clarify when the specialty clinician is acting as the patient's primary clinician, or the PC and SC agree to co-manage a patient's care
 - Communication and data-sharing protocols should be clearly established within these agreements, including mechanisms that ensure notifications are prioritized based on urgency
 - Ensure clarity when the handoff needs to occur back to PC, including templates for these transitions of care (allowing for patient preferences)
 - Each practice should establish an internal plan that defines team members for all clinical and care coordination tasks

Spectrum of Primary and Specialty Care Collaboration

- Consultations
- Co-Management with Shared Care - A SC clinician shares long-term management of a referred disorder or set of disorders with a PC clinician (or other requesting clinician) for a patient's referred health condition, with the PC clinician providing a medical home.
- Co-Management with Principal Care of a Disorder or Set of Disorders - Both the PC and SC practice are concurrently active in the patient's ongoing/long-term/chronic (not just an episode of care) treatment
- Co-Management with Principal Care of a Consuming Illness - A consuming illness (CI) is a critical illness or a worsening of a chronic condition of high acuity that requires continuous care by a single SC clinician and care team.
- Transfer of Care from One Practice to a Similar Practice
- Transition of Management of a Condition back to PC from SC

Each Type of Shared Care Has Unique Elements – e.g., Co-Management with Principal Care of a Consuming Illness

- Principles
 - E.g., A single specialty care team should have primary responsibility for care coordination.
- Shared Expectations
 - E.g., Once a consuming illness that requires principal care co-management by a specialty care team is identified, the appropriate specialty care team lead will need to be established
- Critical Elements
 - E.g., Advance care directives, if available, are included with information from the primary care clinician
- Helpful Elements
 - E.g., Electronic templates for the consuming illness plan of care and status updates should be drafted and used to facilitate communication between clinical care teams

Source: https://assets.acponline.org/acp_policy/policies/beyond_the_referral_playbook_2022.pdf

How to Encourage Specialty Engagement?

- Models must be scalable to different types of specialties while being built on a fundamentally similar framework, which allows it to be understandable and predictable to both the PC practices and the specialty practices – the Medical Neighborhood Model allows for this
- Communication and information sharing is critical – specialty clinician (SC)/practice should be involved in pre-screening all referrals and accompanying documentation
- Care coordination agreements!
- Reimbursement structure must support SC engagement and unnecessary and duplicative work/administrative burden must be reduced
 - Critical to triage all referrals!
- TCOC models should incorporate incentives for patients to engage participating specialists – transportation, copay waivers, etc.
- TCOC can be reviewed and aggregated at each practice and across both the PC and SC practices (excluding any cost attributed to specialists outside the model)

How to operationalize this?

Critical Elements of the Referral

- **Prepared Patient**

- **Patient Demographics and Scheduling Information**

- Include any special considerations such as language needs, vision/hearing/cognitive impairments, need for caregiver assistance, etc.

- **Referral Information**

- *Clinical Question / Detailed Reason for Referral*
 - Summary of pertinent details
 - Patient goals
 - Urgency (referral priority status)
- *Supporting Pertinent data*
- *Referral type (role for specialty care)*

Patient's Core Data Set

- Active problem list
- Past medical and surgical history
- Medication list
- Medical allergies
- Preventive care (e.g. vaccines and diagnostic test)
- Family history
- Habits / social history
- List of providers (care team) (other specialists caring for patient)
- Advance directive
- Overall current care plan and goals of care
- Any pain agreement, Care Management and /or Behavioral Health contacts

Core Coordination / Referral Tracking

Referral request sent, logged and tracked and acted on

https://www.acponline.org/acp_policy/policies/beyond_the_referral_position_paper_2022.pdf

How to operationalize this?

A High Value Referral Response

- **Answer the clinical question / address the reason for referral**
 - Summary (include some thought process)
- Agree with or Recommend type of referral / **role of specialty care**
- Confirm new, existing, or changed **diagnoses**
 - Include “ruled out”
- **Medication / Equipment changes**
- **Testing** results, testing pending, scheduled or recommended
 - including how / who to order
- **Procedures** completed, scheduled or recommended
- **Education** completed, scheduled or recommended
- Any “**secondary**” referrals made
 - Confer with and/or copy PCP on all
- Any **recommended services or actions to be done by the PCP/PCMH**
- **Follow up** scheduled or recommended
- Clear indication of
 - What specialty care is going to do
 - What the patient is instructed to do
 - What the referring physician needs to do and when
- Easy to find and refer to in the response note

https://www.acponline.org/acp_policy/policies/beyond_the_referral_position_paper_2022.pdf

**Care Coordination With
Primary Care and Other
Referring Clinicians.**

The practice coordinates with primary care and referring clinicians to ensure timely exchange of information.



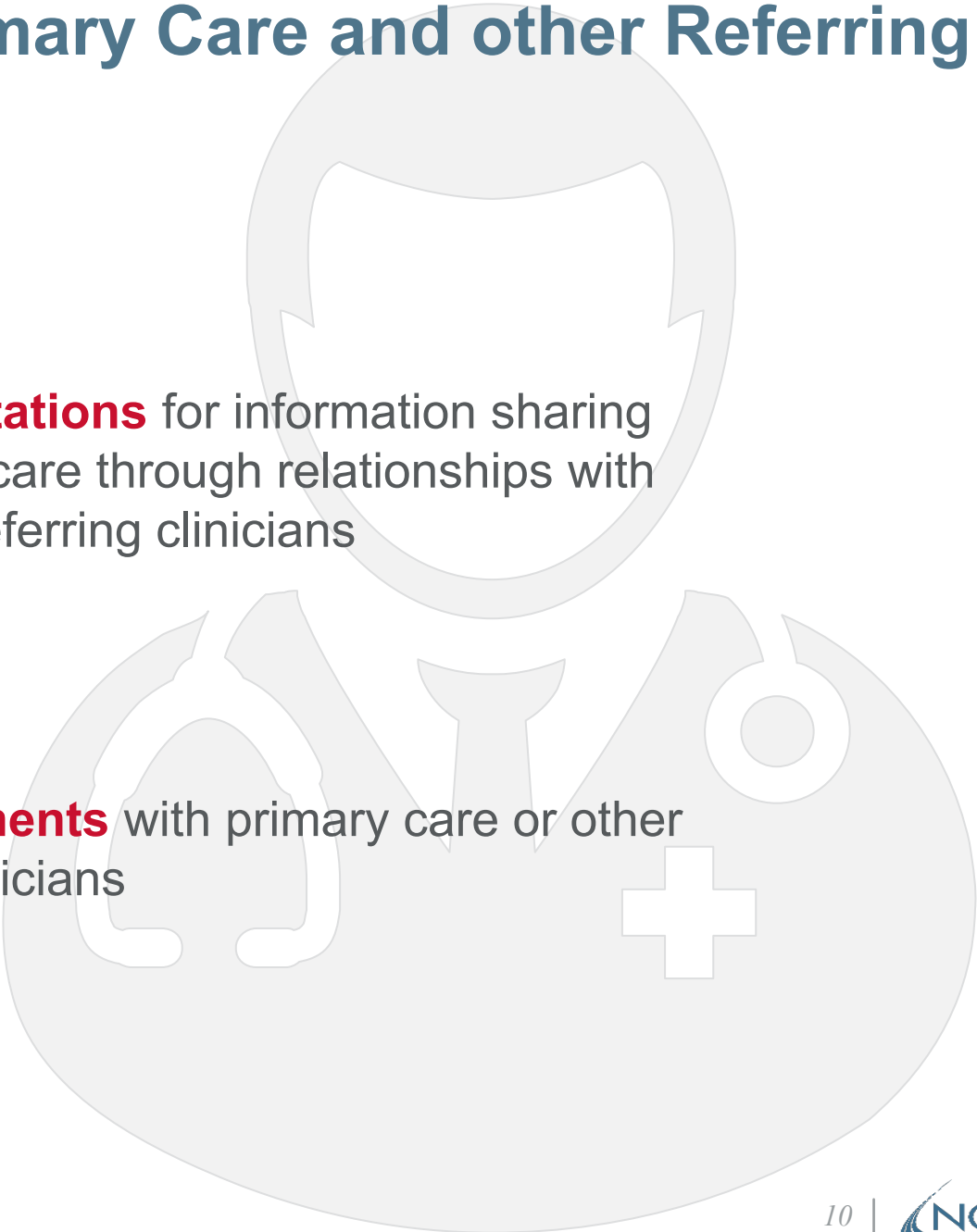
Establishing Relationships with Primary Care and other Referring Clinicians



Sets expectations for information sharing and patient care through relationships with frequently referring clinicians



Has agreements with primary care or other referring clinicians



Example

Collaborative Care Management	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • Define responsibilities between PCP, specialist and patient. • Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up). • Maintain competency and skills within scope of work and standard of care. • Give and accept respectful feedback when expectations, guidelines or standard of care are not met • Agree on type of care that best fits the patient's needs. 	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Follows the principles of the Patient Centered Medical Home or Medical Home Index. <input type="checkbox"/> Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills. <input type="checkbox"/> Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. <input type="checkbox"/> Resumes care of patient as outlined by specialist, assumes responsibility and incorporates care plan recommendations into the overall care of the patient. <input type="checkbox"/> Shares data with specialist in timely manner including pertinent consultations or care plans from other care providers. 	<ul style="list-style-type: none"> <input type="checkbox"/> Reviews information sent by PCP and addresses provider and patient concerns. <input type="checkbox"/> Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. <input type="checkbox"/> Confers with PCP before refers to secondary/tertiary specialists for problems within the PCP scope of care and , when appropriate, uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization when needed. <input type="checkbox"/> Sends timely reports to PCP and shares data with care team as outlined in the Transition of Care Record. <input type="checkbox"/> Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations. <input type="checkbox"/> Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs. <input type="checkbox"/> Provides useful and necessary education/guidelines/protocols to PCP, as needed

Transition of Care	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • Maintain accurate and up-to-date clinical record. • When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD] • Ensure safe and timely transfer of care of a prepared patient. 	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> PCP maintains complete and up-to-date clinical record including demographics. <input type="checkbox"/> Transfers information as outlined in Patient Transition Record. <input type="checkbox"/> Orders appropriate studies that would facilitate the specialty visit. <input type="checkbox"/> Provides patient with specialist contact information and expected timeframe for appointment. <input type="checkbox"/> Informs patient of need, purpose (specific question), expectations and goals of the specialty visit <input type="checkbox"/> Patient/family in agreement with referral, type of referral and selection of specialist 	<ul style="list-style-type: none"> <input type="checkbox"/> Determines and/or confirms insurance eligibility <input type="checkbox"/> Identifies a specific referral contact person to communicate with the PCMH <input type="checkbox"/> When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up. <input type="checkbox"/> Informs patient of need, purpose, expectations and goals of hospitalization or other transfers. <input type="checkbox"/> Notifies referring provider of inappropriate referrals and explains reasons.

Source: Colorado Systems of Care/Patient Centered Medical Home Initiative. https://www.integration.samhsa.gov/operations-administration/Colorado_Primary_Care_-_Specialty_Care_Compact.pdf

Actively communicates receipt and status of referral requests



We have received a referral request from your practice,

<Insert Practice Name> for

<Insert Patient Name and DOB> (MM/DD/YYYY)

The appointment is scheduled for MM/DD/YY at 12:00 PM

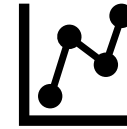
After the appointment, you can expect summary of care, including lab and imaging results if applicable, 8 business days after the appointment.

- ✓ Confirm the receipt & acceptance of referral
- ✓ Date and time of appointment.
- ✓ Information the referring clinician can expect in the referral response.

Verifying the receipt of information sent by referring clinicians and following up if information is not received.

Example:

Referral Form	
Date:	
Referring Clinician:	
Timing:	<input type="checkbox"/> STAT (same day) <input type="checkbox"/> Urgent (< 48 Hours) <input type="checkbox"/> Routine (>48 Hours)
Service Requested:	
Reason for Referral (Clinical Question):	_____
Type of Service Requested:	<input type="checkbox"/> Consult <input type="checkbox"/> Follow-up <input type="checkbox"/> Transfer of Care
Clinical Information:	
First Name: _____ MI: _____ Last Name: _____ DOB: _____	
Referral Diagnosis: _____	
Primary Language: _____ Interpreter required? _____	
The following information has been sent with this referral	
<input type="checkbox"/> Pertinent Labs <input type="checkbox"/> Pertinent Imaging <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> Plan of care	



Track

- ✓ Clinical Question
- ✓ Referral Type
- ✓ Timeframe
- ✓ Patient Demographics
- ✓ Clinical Data
- ✓ Test Results
- ✓ Care Plan



Assess

If clinical question is within the practice's scope



Identify

who is responsible for communicating with patients/families/caregivers

Case Study 1:


- An endocrinology practice in Colorado led by an ACP member and consultant deployed appropriate referral criteria through a CCA.
- As a result, receipt of a clinical question increased from 0% to 75% and receipt of adequate supporting data increased from 30% to 60% within six months and continued to improve.
- The percentage of patients with insufficient information at their referral appointment declined from 70% to less than 5%, allowing the practice to essentially eliminate duplicate testing and the associated follow-up appointments, which saved costs.
- By receiving more complete referral information and utilizing pre-consultation review, the practice reduced inappropriate referrals from 20% to nearly 0%, saving patients time and money and allowing the practice to reduce wait times by more than two months and see urgent cases sooner. These changes encourage improved patient outcomes and saving downstream system costs by avoiding unnecessary emergency room visits.

Case Study 2:

- A 2001 study of an e-consultation intervention in a rheumatology practice found that at least 4 in 10 patients did not actually require a rheumatology consultation for appropriate care.
- According to the study, some issues were “rapidly resolved” without consultation by the specialist.
- In certain cases, other specialty consultation or continuing prior care were more appropriate and did not compromise patient outcomes.
- Appropriate referrals improved practice access and efficiency and profitability was maintained because the proper patients could be scheduled and seen sooner.
- The study concluded that new patient pre-appointment management should be a “key strategy” for reducing health care costs, addressing personnel shortages and improving access to and coordination of rheumatic disease care. Participants were also held financially accountable for quality and cost outcomes

Payment is Critical: The Medical Neighborhood Advanced Alternative Payment Model

Patient-Physician collaboration – agree that a specialty referral is appropriate



Referral to a specialty practice



Specialty practice pre-screens referral and accompanying documentation



Visit – triggers and “active phase” of attribution



Specialty practice role may vary – could co-manage the patient’s treatment or be the primary manager

Two Tracks of Payment for the Medical Neighborhood Model

Table 1: Summary of Payments Under the Medical Neighborhood Model

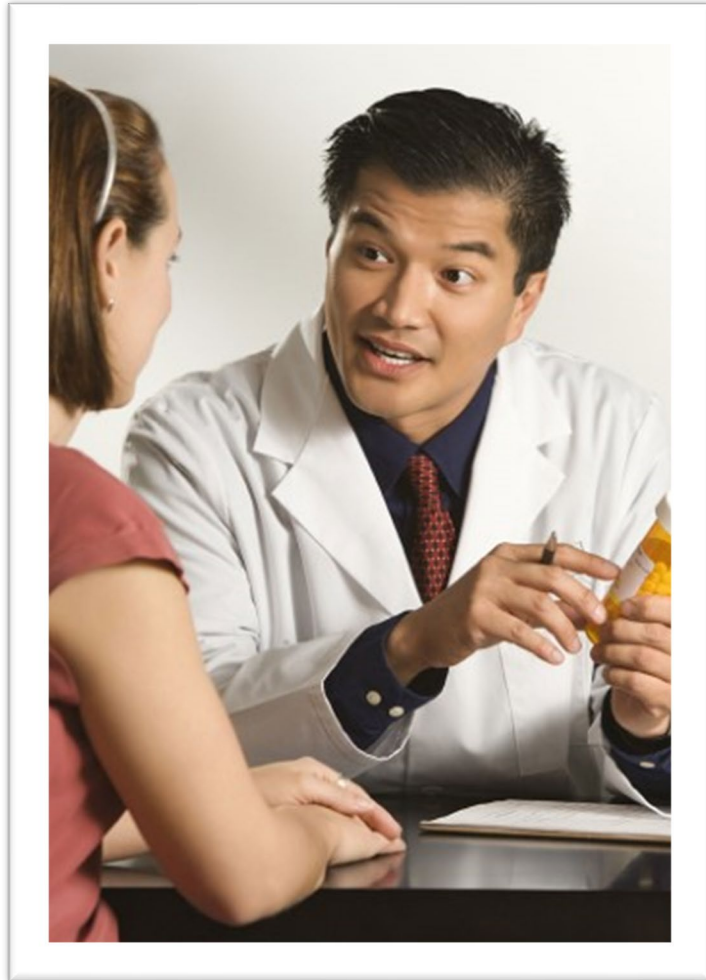
Track	Care Coordination Fee (CCF) \$37	Performance-Based Payment Adjustment (PBPA)	Medicare Physician Fee Schedule	Comprehensive Specialty Care Payment (CSCP)
1	Risk-adjusted per beneficiary per month fee to support enhanced care coordination supports	Annually retroactively assessed based on performance against financial benchmark and quality and utilization targets; paid/ owed quarterly in the final three quarters of the subsequent performance year.	Regular fee-for-service	none
2	Risk-adjusted per beneficiary per month fee to support enhanced care coordination supports	Annually retroactively assessed based on performance against financial benchmark and quality and utilization targets; paid/owed on a quarterly basis in the final three quarters of the subsequent performance year.	Paid at reduced rate of 75% based on 110% of Physician Fee Schedule rates.	Quarterly prospective lump sum payments based on 25% of anticipated fee-for-service revenue at 110% of Physician Fee Schedule rates. Payments are retroactively reconciled and paid out quarterly in the final three quarters of the subsequent year along with PBPAs.

Questions?



Appendix

Initial Referral Management



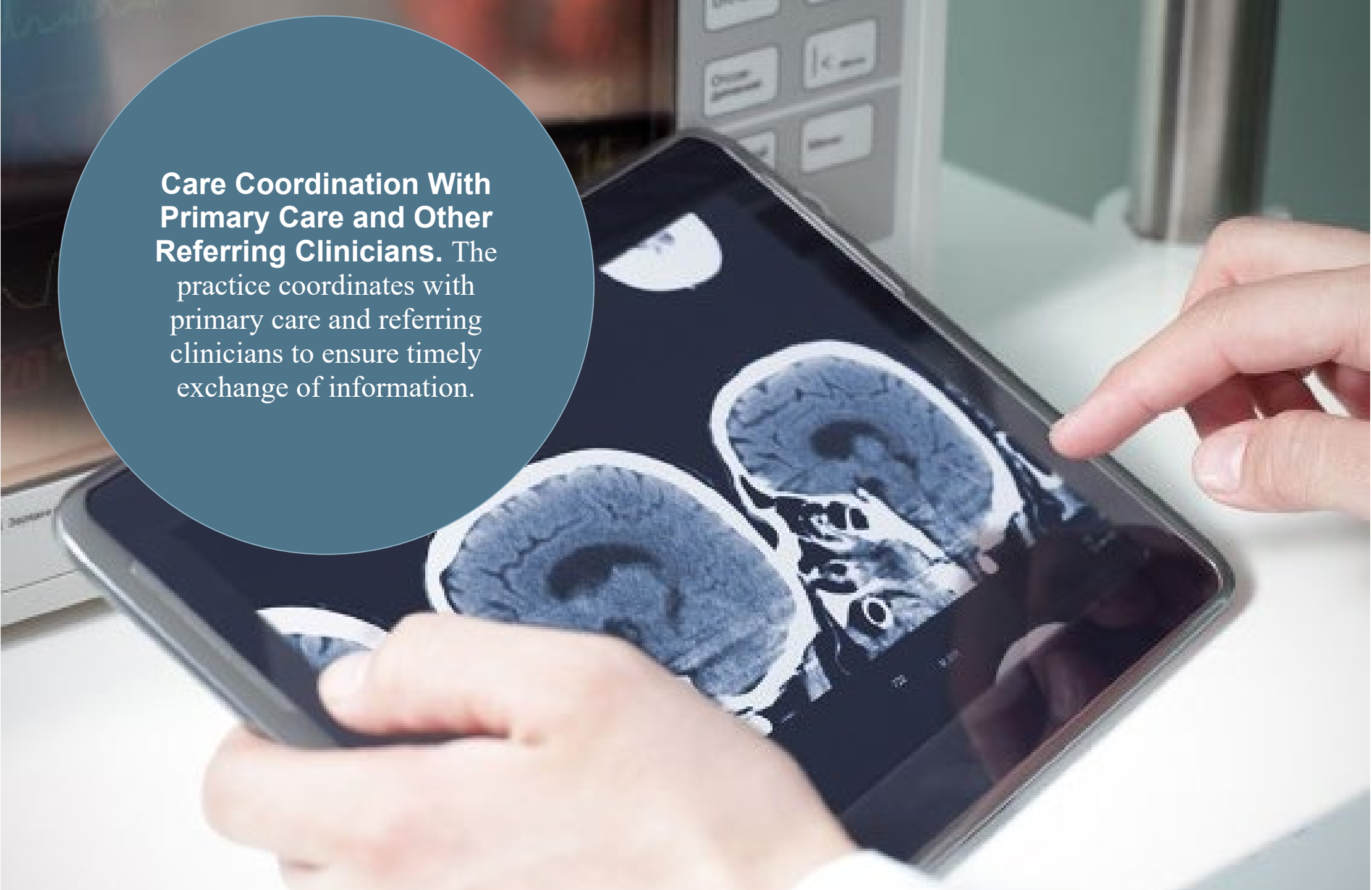
Care Coordination With
Primary Care and Other
Referring Clinicians.

Practice Response to Initial
Referrals.

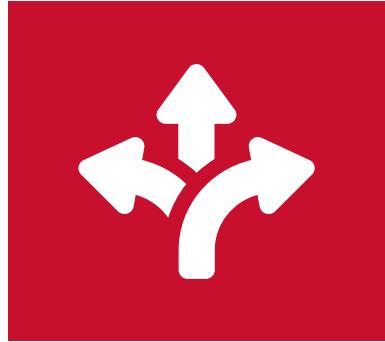
Connecting Patients With
Primary Care.

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<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Follows the principles of the Patient Centered Medical Home or Medical Home Index. <input type="checkbox"/> Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills. <input type="checkbox"/> Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. <input type="checkbox"/> Resumes care of patient as outlined by specialist, assumes responsibility and incorporates care plan recommendations into the overall care of the patient. <input type="checkbox"/> Shares data with specialist in timely manner including pertinent consultations or care plans from other care providers. 	<ul style="list-style-type: none"> <input type="checkbox"/> Reviews information sent by PCP and addresses provider and patient concerns. <input type="checkbox"/> Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. <input type="checkbox"/> Confers with PCP before refers to secondary/tertiary specialists for problems within the PCP scope of care and , when appropriate, uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization when needed. <input type="checkbox"/> Sends timely reports to PCP and shares data with care team as outlined in the Transition of Care Record. <input type="checkbox"/> Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations. <input type="checkbox"/> Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs. <input type="checkbox"/> Provides useful and necessary education/guidelines/protocols to PCP, as needed

Transition of Care	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • Maintain accurate and up-to-date clinical record. • When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD] • Ensure safe and timely transfer of care of a prepared patient. 	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> PCP maintains complete and up-to-date clinical record including demographics. <input type="checkbox"/> Transfers information as outlined in Patient Transition Record. <input type="checkbox"/> Orders appropriate studies that would facilitate the specialty visit. <input type="checkbox"/> Provides patient with specialist contact information and expected timeframe for appointment. <input type="checkbox"/> Informs patient of need, purpose (specific question), expectations and goals of the specialty visit <input type="checkbox"/> Patient/family in agreement with referral, type of referral and selection of specialist 	<ul style="list-style-type: none"> <input type="checkbox"/> Determines and/or confirms insurance eligibility <input type="checkbox"/> Identifies a specific referral contact person to communicate with the PCMH <input type="checkbox"/> When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up. <input type="checkbox"/> Informs patient of need, purpose, expectations and goals of hospitalization or other transfers. <input type="checkbox"/> Notifies referring provider of inappropriate referrals and explains reasons.

Source: Colorado Systems of Care/Patient Centered Medical Home Initiative. https://www.integration.samhsa.gov/operations-administration/Colorado_Primary_Care_-_Specialty_Care_Compact.pdf

Actively communicates receipt and status of referral requests



We have received a referral request from your practice,

<Insert Practice Name> for

<Insert Patient Name and DOB> (MM/DD/YYYY)

The appointment is scheduled for MM/DD/YY at 12:00 PM

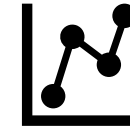
After the appointment, you can expect summary of care, including lab and imaging results if applicable, 8 business days after the appointment.

- ✓ Confirm the receipt & acceptance of referral
- ✓ Date and time of appointment.
- ✓ Information the referring clinician can expect in the referral response.

Verifying the receipt of information sent by referring clinicians and following up if information is not received.

Example:

Referral Form
Date: _____
Referring Clinician: _____
Timing: <input type="checkbox"/> STAT (same day) <input type="checkbox"/> Urgent (< 48 Hours) <input type="checkbox"/> Routine (>48 Hours)
Service Requested: Reason for Referral (Clinical Question): _____
Type of Service Requested: <input type="checkbox"/> Consult <input type="checkbox"/> Follow-up <input type="checkbox"/> Transfer of Care
Clinical Information: First Name: _____ MI: _____ Last Name: _____ DOB: _____ Referral Diagnosis: _____ Primary Language: _____ Interpreter required? _____ The following information has been sent with this referral <input type="checkbox"/> Pertinent Labs <input type="checkbox"/> Pertinent Imaging <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> Plan of care



Track

- ✓ Clinical Question
- ✓ Referral Type
- ✓ Timeframe
- ✓ Patient Demographics
- ✓ Clinical Data
- ✓ Test Results
- ✓ Care Plan



Assess

If clinical question is within the practice's scope



Identify

who is responsible for communicating with patients/families/caregivers

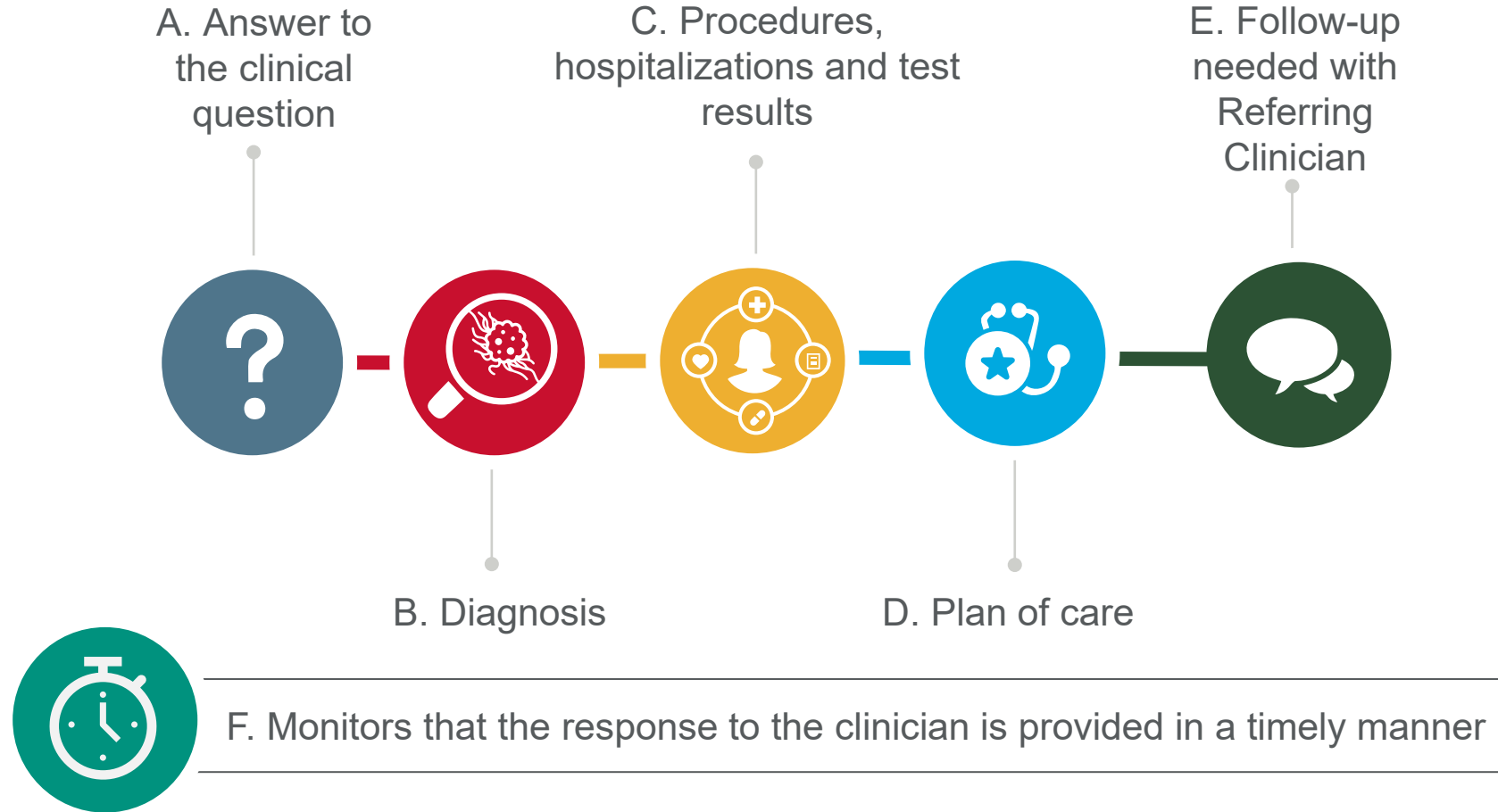


Practice Response to Initial Referrals. The practice facilitates comprehensive care coordination by providing timely, complete and relevant responses to primary care providers and referring clinicians.

Follow-Up after missed or cancelled appointments

Missed Appointment Log- Week of 6/10-6/14							
<i>Team Note: The referring provider must be contacted if a patient misses initial visit.</i>							
Patient Name	Appt Date	Provider Name	Visit Type	Visit Status	Referring provider contacted?	Scheduled By	Visit Status Note
#####	06/10/2019 3:30PM	Dr. Delva	Initial Visit	Patient Cancelled	Yes	Katy McBride	Patient in the hospital, will reschedule post discharge
#####	6/12/2019 11:00 AM	Dr. Prospect	Maintenance Visit	Patient Cancelled	Yes	Katy McBride	Patient unable to get a ride to appointment
#####	6/13/2019 9:00 AM	Dr. Alvia	Initial Visit	No Show	Yes	Sarah Tumi	Unable to contact with the patient, contacted their PCP, Dr. Snerman
#####	6/13/2019 2:00PM	Dr. Montez	Initial Visit	Patient Cancelled	Yes	Carrie Bader	Could not get childcare
#####	06/14/2019 10:00PM	Bradley Murray, PA	Maintenance Visit	No Show	No	Sarah Tumi	Patient forgot, rescheduled for next week.


Monitors that the outgoing response to primary care and referring clinicians includes:



Example

Appointment Date	Answer to clinical questions sent	Diagnosis sent	PX, Test Results Sent	Plan Sent [include med list]	Follow-up communicated to Provider?	Number of days referral response outstanding Policy: 14 days
6/2/2019 9:20 AM	6/26/2019	6/26/2019	6/26/2019	6/26/2019	6/26/2019	25
6/4/2019 1:20 PM	6/22/2019	6/22/2019	6/22/2019	6/22/2019	6/22/2019	18
6/4/2019 3:00 PM	6/6/2019	6/6/2019	6/6/2019		6/6/2019	4
6/2/2019 3:40 PM	6/15/2019	6/15/2019		6/15/2019	6/15/2019	24
6/3/2019 9:20 AM	6/4/2019	6/4/2019	6/4/2019	6/4/2019	6/4/2019	1
6/4/2019 8:20 AM	6/11/2019	6/11/2019	6/11/2019	6/11/2019	6/11/2019	7
6/4/2019 10:20 AM	6/4/2019	6/4/2019	6/4/2019	6/4/2019	6/4/2019	0
6/4/2019 2:40 PM	6/15/2019	6/15/2019		6/15/2019	6/15/2019	11
6/8/2019 9:00 AM	6/8/2019	6/8/2019	6/8/2019	6/8/2019	6/8/2019	0
6/8/2019 4:40 PM	6/15/2019	6/15/2019	6/15/2019	6/15/2019	6/15/2019	7
6/9/2019 9:20 AM	6/11/2019	6/11/2019	6/11/2019	6/11/2019	6/11/2019	2
6/9/2019 11:40 AM	6/11/2019	6/11/2019	6/11/2019	6/11/2019	6/11/2019	2
6/9/2019 3:00 PM	6/17/2019	6/17/2019	6/17/2019	6/17/2019	6/17/2019	8

Sent to Referring Provider:	13	13	11	12	13	10
Number of Referrals:	13	13	13	13	13	13
Percent:	100%	100%	85%	92%	100%	77%

A person wearing a white lab coat is shown from the chest down, holding a clipboard with a pen in their right hand. The background is a blurred office or clinical setting. A teal circular overlay is positioned on the right side of the image, containing white text.

Connecting Patients With Primary Care. The practice works with primary care clinicians to share information and connect patients with primary care clinicians if they do not have a usual source of primary care.

Communicating the Importance of Follow-Up with Primary Care

Implemented October 31,
2019

Patients should consistently see their primary care clinician in addition to their cardiologist. If a patient, particularly a self-referred patient, does not have a primary care physician, a handout is given providing the importance of obtaining one. This handout explains that preventive care is an important factor in maintaining overall health and wellness, how it coordinates the patient's care centrally and how it manages chronic conditions among other providers. The handout includes a list of available primary care providers in the area.

Connecting Patients with Primary Care

ACME Cardiology

Location 1
1234 Valley Road
Anywhere, USA

Location 2
4321 Ravine Road
Anywhere, USA

Phone: (123) 456-7890 Fax: (123) 456-7891


Establishing with a primary care provider is an important factor in maintaining better overall health and wellness. It allows you to coordinate your care all in one place, and allows for management of conditions or diseases by determining at what point a specialty physician is needed.

Primary care providers accepting new patients in your area (sorted by county):

Mountain County

Primary Care Practice #1 (234) 567-8901 9876 Creek Street Anywhere, USA Dr. Jane Smith, MD	Primary Care Practice #2 (345) 678-9012 4567 River Road Anywhere, USA Dr. Mary Jones, MD
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Contacting the Primary Care Clinician Prior to Treatment

 PCP Communication				
PCP Phone Call	PCP Name:	Call Date & Time	Call Attempted:	Call Status:
	Dr.	9/14/2019 12:33:00	Yes	Successful Call
	Call Notes: Spoke with Dr. about 's chronic obstructive bronchitis. His office will fax a referral to pulmonology and follow-up directly with about getting that visit scheduled.			
Specialist Phone	Specialist Name:	Call Date & Time	Call Attempted:	Call Status:

Initial Referral Management Recap

Coordinate with primary care and referring clinicians throughout the patient's care.

Delivering high quality, coordinated care for referrals and care transitions

Connect to primary care

Receives clinical information from providers

Communicate to reduce redundancies

