PRIMARY CARE DEVELOPMENT CORPORATION

Test and Referral Tracking – An Introduction

Deborah Johnson Ingram
Maia Bhirud

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Crossing the Quality Chasm: A New Health System for the 21st Century

Institute of Medicine Report Brief 2001

- **Called** for provision of consistent high quality care
- **Argued** that there is a huge gap – a chasm – between current care and what should be provided

http://www.nap.edu/html/quality_chasm/reportbrief.pdf

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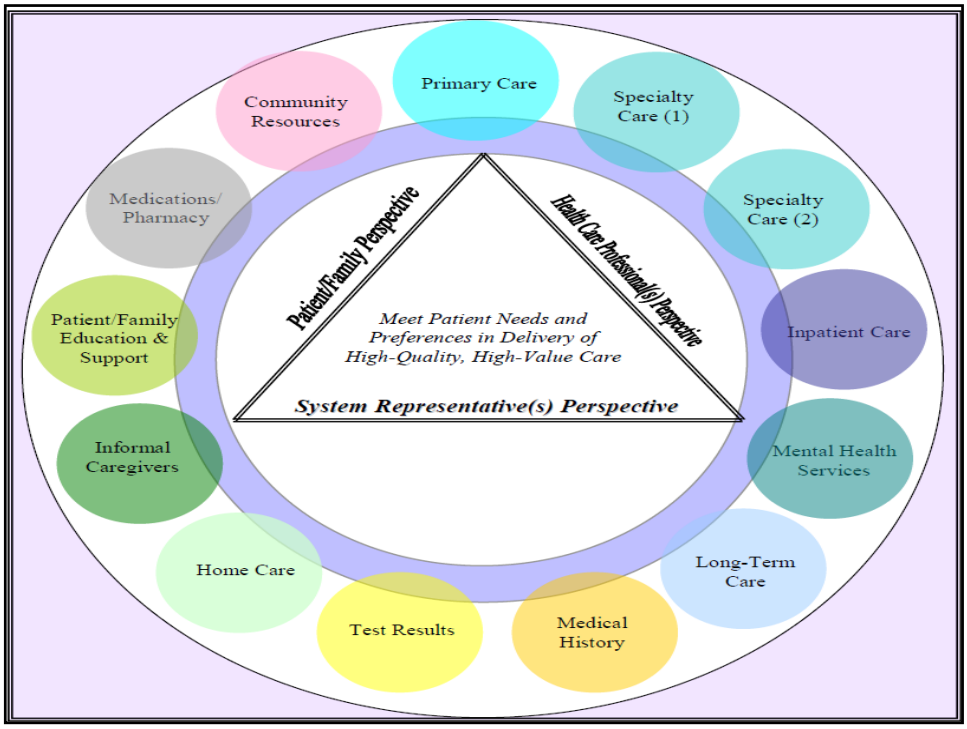

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What is Care Coordination?

- AHRQ Definition:
  - **Care coordination** is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.
  - Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

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Care Coordination – With Whom and How?

JL is a 70 year old female. She has hypertension and as a result of a stroke she walks with a cane and needs assistance with bathing. She lives with her husband who helps with ADLs. Her daughter comes by once a week to check on them. She worries a lot about another stroke and sees a clinical social worker at a community mental health center.

One morning she awakens with difficulty in speaking. Her husband calls an ambulance; she is admitted to the hospital on the neurology service. Her speech clears within six hours of admission, and following diagnostic testing, she is discharged the following day.

- With whom does her PCP need to coordinate?
- How does coordination typically happen?
- How should it ideally happen?

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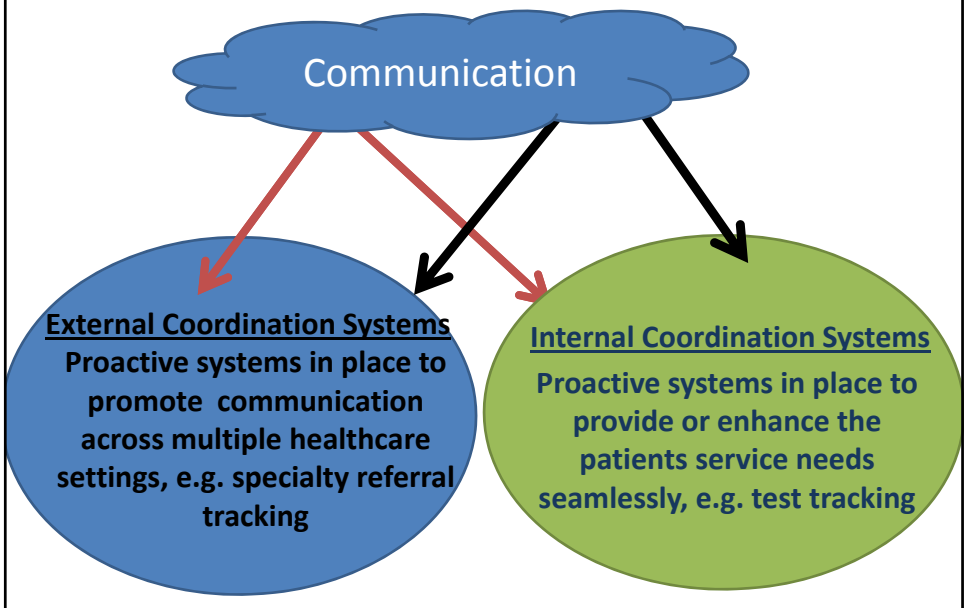
Systems-Based Care Coordination



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PCMH Care Coordination

INTERNAL COORDINATION

Internal Care Coordination: Appointments

Dr. James sees a patient, orders fasting blood work, an ECG, and a visit with her dietitian. The following day patient's blood is drawn and an ECG is done. The patient does not keep her appointment with the dietitian.

- What coordination is needed within the practice?
- How does this typically happen?
- How *should* it happen?

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Appointments Tracking Recommendations

- Make the follow up appointment while the patients is onsite **or arranged "due back" reminders** - *(leaves unclogged schedule)*
- Remind the patient of the appointment and of the cancellation/no-show policy
- Route information regarding cancellations/no-shows to the PCP

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Sample CC: Patient Centered Access

MISSED APPOINTMENTS

The SFHN clinics utilize a Phone Tree system that calls each booked patient 48 - 72 hours before his or her scheduled appointment to confirm date, time and place of appointment. The Phone Tree system tracks all received call reminders. A print out of the calls is maintained in a separate log with the call center at each clinic.

1st Missed Appointment: If a patient does not show up for an appointment, the receptionist/ MA will call the patient on the day of the missed appointment to reinforce the importance of keeping scheduled appointments and will reschedule the missed appointment. A note is made in the patients record by the call center staff in the patient's chart of the No Show and be discussed with the patient at their next scheduled visit.

2nd Missed Appointment: Same steps as above plus a Formal Warning Letter will be generated by the clerical staff warning the patient that if they miss one more appointments within the three year

TRACKING CONSULTATIONS AND DIAGNOSTIC PROCEDURES

The SFHN Nurse/MA will complete referrals within 5 working days of the provider's request. This timeline is driven by insurance authorization, lab test results, diagnostic test results, and the completion of the provider's documentation of care (the signed note). For Stat referrals the nurse will notify patient when referral is done. For routine referrals, the referral clerk will notify the patient when the referral is done. Some specialty offices in town prefer to contact the patient directly. SFHN nurses or booking clerks will document in patient's EMR chart date the time/date of notification and the date/time/location of the appointment. Once the office receives consult from referring physician, it will be scanned and uploaded into to appropriate chart.

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Internal Coordination: Test Tracking

- Test Tracking, Labs, Images including timing for follow up
- Abnormal results are flagged so the provider is aware
- Un-reconciled results are tracked… If you ordered it then it should be resulted
- Patient notification of results, normal and abnormal… Stay away from "if you don't hear from us then everything is ok!"
- Use of HIT, order and results. Electronically…
  - a. Communicates w/ labs
  - b. Communicates w/ Diagnostic Imaging
  - c. Incorporate results into structured fields in EMR
  - d. Incorporate imaging results into EMR

Internal Coordination

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Sample CC: Patient Centered Test Tracking

1. Test Tracking, Labs, Images including timing for follow up
2. Abnormal results are flagged so the provider is aware
3. Un-reconciled results are tracked
4. Patient notification of results, normal and abnormal
5. Use of HIT, order and results. Electronically…
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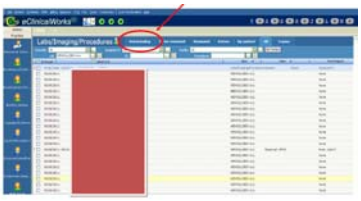

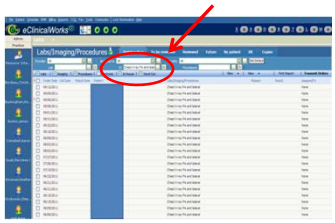

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PCMH in the Neighborhood

EXTERNAL CARE COORDINATION

External Care Coordination

Systems/processes needed for coordination with:

- Diagnostics providers
- Pharmacies
- Specialists, including behavioral health/social services providers
- Hospitals
- Patient/family/caregiver

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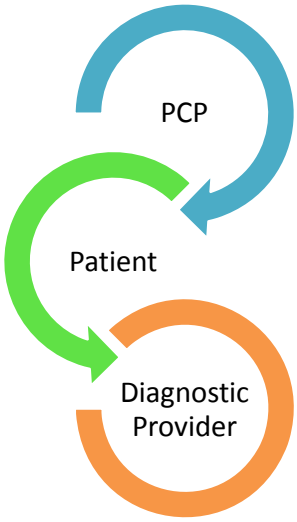
Diagnostics Providers

- Labs
  - Test ordering
  - Results reporting
    - Pending results
    - Final results
- Imaging/other
  - Often do not have electronic communications of results or actual images
  - If not, rely on internal systems
    - Fax does not create a closed loop without an internal system
    - Patients should not have to coordinate their own care



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Pharmacies

- Policies
  - Number of refills prior to return visit
  - Patient refill request through pharmacy
- Systems
  - Medication list
    - Most practices don't have electronic interchange that creates this, so need to update with each patient visit
    - Enables refill policy
  - E-prescriptions
    - Safety
    - Efficiency/convenience

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Specialists And Others

Consultations

- Two way communication:
  - Baseline information and reason for referral
  - Consultation report
- If not in integrated system with specialist, need interna receipt of consultation report

Shared care – specialists, mental health/social services providers

- Email-type communications are ideal

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Hospitals and Other Facilities

- Electronic system for Identifying patients with hospital admissions or ED visit-
  - PCP notification, phone fax, email, text
- Obtaining discharge summaries and care plans
- Medication Reconciliation
  - Also MU measure
- Communicating with home health providers
  - Shared care – email-type communications are ideas

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Patients/Family/Caregivers

Patient portals are indispensable for coordinating with patients

- Care plans
- Self-monitoring information
- Patient reminders
- Email communications

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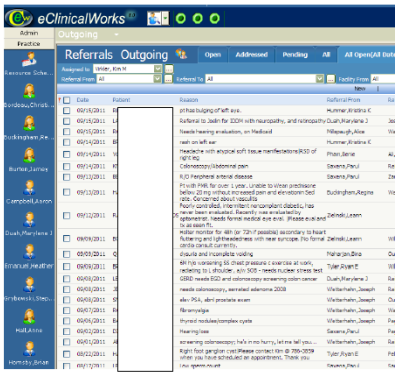
Sample CC: Patient Centered Referral Tracking

- Seamless hand-off, present patient with all the clinical information relevant to the receiver setting
- Tracking handoffs (when, where, why, expected time of receiving report/patient back to practice)
- Follow- up with, patient, Specialty provider if no communication/ report etc.
- Provision of timely exchange of patient information
- Inquiry & Tracking of patient Self referrals, alternative community resources



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Effectiveness of Care Coordination

Perspective	Effectiveness
PATIENT/FAMILY	• Patient report of satisfaction with coordination of care • Family report of confusion or hassle (e.g., number of contacts needed to schedule a clinic visit)
HEALTH CARE PROFESSIONAL(S)	• Nurses reports of confusion or hassle (e.g., time spent coordinating referrals) • Physician survey on effectiveness of medication management process at averting drug interaction complications
SYSTEM REPRESENTATIVE(S)	• Quality of care (STEEPE) measured through analysis of medical chart data, electronic health record, or administrative data • Health care utilization by a group of patients (e.g., hospital readmissions, emergency room visits)

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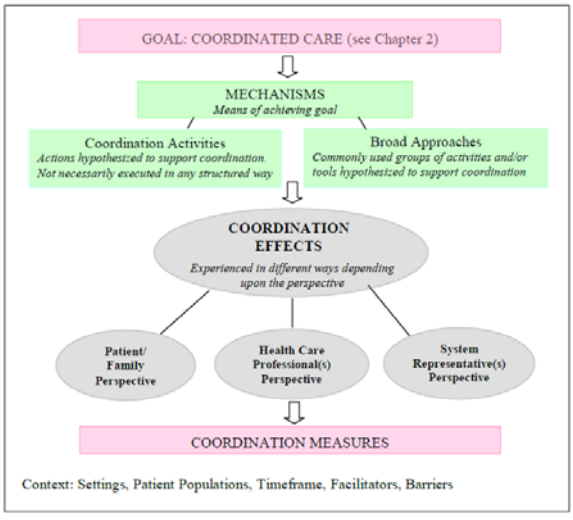
Care Coordination Measures

When measuring CC one must consider,

- the context of your service
- the accountability
- potential facilitators or barriers

in order to achieve your goal



http://pcmh.ahrq.gov/sites/default/files/attachments/care%20coord%20account%20measures%20for%20pc.pdf

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Care Coordination Activities

- Communication
  - Interpersonal communication
  - Information transfer
- Facilitate transitions
  - Across settings
  - As coordination needs change
- Assess needs and goals
- Create a proactive plan of care
- Monitor, follow up, and respond to change
- Support self-management goals
- Link to community resources
- Align resources with patient and population needs

http://archive.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/care-coordination-measures-atlas.pdf

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Care Coordination Measures PCMH 6B1

- Communication
  - % of referrals with loop closed (consult in chart) within a certain time frame
- Facilitate transitions
  - Timely follow-up with patients post discharge from the ER or hospital
  - Medication reconciliation: Reviews and reconciles medications for patients after care transitions

http://archive.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/care-coordination-measures-atlas.pdf

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www.pcdc.org