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Physician Engagement And The Medical Neighborhood

"Leading the Cats to water"

Our Agenda

- Generating Value with a PCMH
- Creating the Medical Neighborhood
- The Care Compact
- Engaging physicians in “Team Work”

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PCMH Results

- The PCPCC Report lists results from 34 programs across the US

http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf

- Every major payer has a PCMH initiative
- PCMHs are delivering on the triple aim
  - Lowering cost
  - Improving the quality of care
  - Improving the patient care experience

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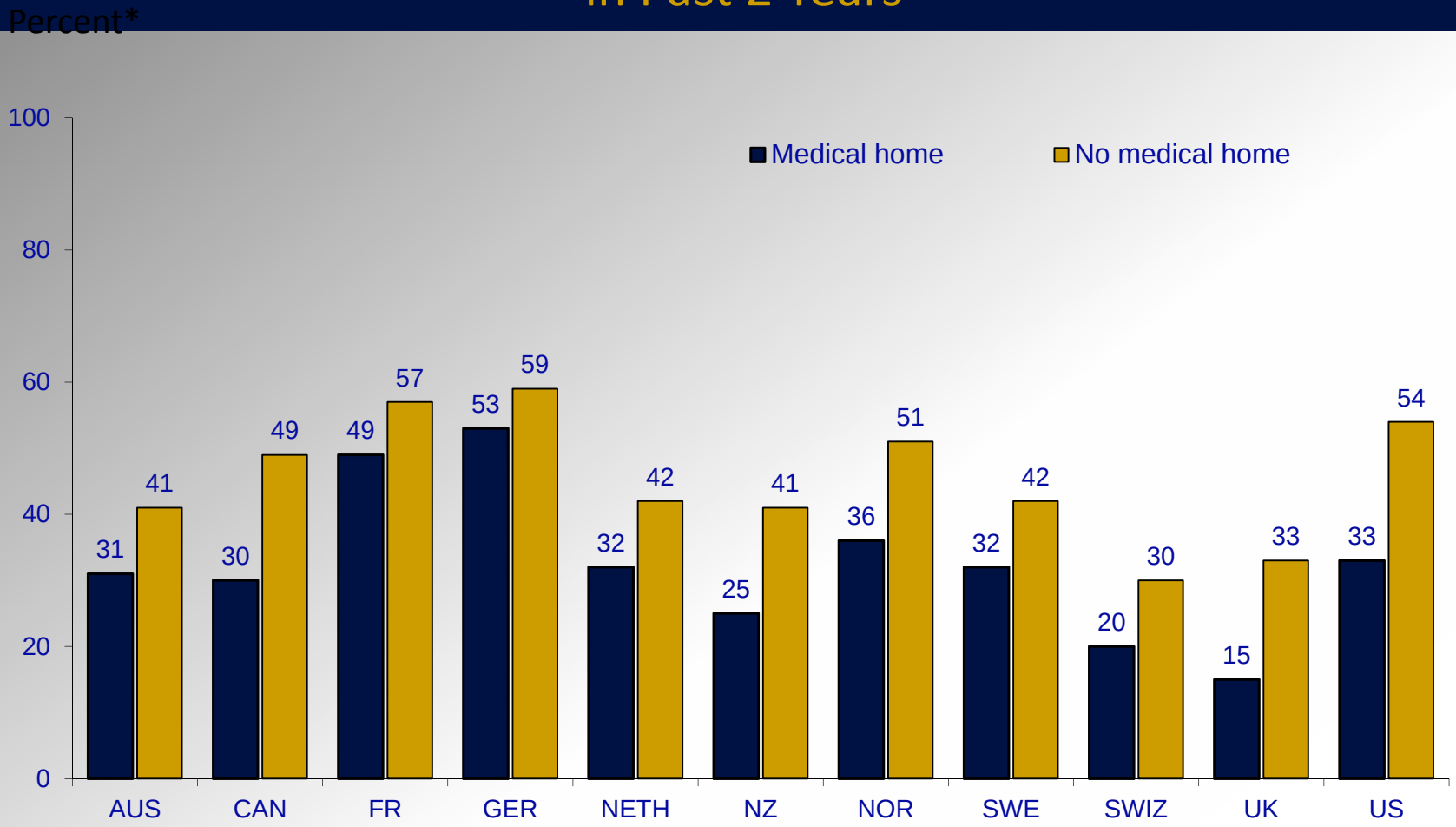
Coordination Gaps With and Without Medical Homes in Past 2 Years



Test results/records not available at time of appointment, doctors ordered test that had already been done, providers failed to share important information with each other, specialist did not have information about medical history, and/or regular doctor not informed about specialist care.

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.

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A Medical Home Without An Integrated Medical Neighborhood

Is Just An Island

PCMH-N (Medical Neighbor)

A clinician that collaborates with a PCMH or another medical neighbor to participate in the **care team** to enhance bi-directional communication and collaboration on behalf and for the benefit of the patient

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Why Doesn't It Work Now?

PCPs Complain

- I don't know the people to whom I'm referring patients.
- The referral doesn't answer the question.
- Patients complain specialist didn't know why s/he was referred.
- Tests already performed are duplicated.
- I don't hear back from a specialist after a consultation.
- My patient doesn't return after a consultation.
- I am unaware my patient was seen in the ER/Hospital.

Specialists Complain

- They don't know the provider that referred the patient
- They aren't clear what question they're supposed to be answering.
- The patient doesn't know why s/he is there.
- They can't access results from tests already performed.
- They don't get follow up on a patient they were concerned about.
- They don't get sufficient information with the referral – (i.e., pertinent history, workup done, etc)

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ECONOMICS

What Do Patients Really Want?

- Trusting Relationship with Care Team
  - "I can reach someone who knows me, knows my history, can advise me and cares about my issues"
- Service
  - "I can get care or contact with someone when I feel I need to, without having to always come in"
  - "Less waiting in general" – during visits, for test results, for referrals, for refills, etc.
- Reliable, Coordinated Care
  - "My care is coordinated" – between providers, hospital/ER, home health, behavioral health, etc

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IT'S ALL ABOUT TEAM!!

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Beginning The Discussion

Start with areas of agreement

- Acknowledgement of a flawed system
- Longing for more “professionalism”
  - Better communication, consideration, cooperation and integration
- We Agree to always support Patient Centered Care
- Agree to resist and solve the economic barriers

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The Care Compact

- Aka “Collaborative Care Agreement”
- A Non-economic contract to agree on how patients will be treated
- Two parts
  - Master relationship
  - Patient specific referral
- Imperatives
  - Communication protocol
  - Defining responsibilities
  - Data / information exchange
  - Establishing personal relationships

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Elements Of The Agreement

- Transition of care – the hand off
- Access and service level
- Collaboration/Communication around care management
- Patient communication

Established for each element:

- Mutual agreement
- Expectations of the PCP
- Expectations of the Specialist

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The Relationship Unfolds In Layers

- Concepts and principles
- Performance obligations
- Narrowing choices

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The Relationship Unfolds In Layers

- **Concepts and principles**
  - Mutual respect of what each brings to the table
  - Recognition of the value of role differentiation
  - Appreciation of primary care as foundation
  - Specialty skill sets as complimentary
  - Patient/Family centric
  - Reducing variation along clinical processes
- Performance obligations
- Narrowing choices

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The Relationship Unfolds In Layers

- Concepts and principles
- **Performance obligations**
  - Agreement on referral types
    - Advise/Consult
    - Evaluate and treat
    - Co-management
    - Transfer of care
  - Do not refer on
  - Do not admit
  - Follow the EBG / Treatment plan for each patient
  - Clinical information transfer
- Narrowing choices

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    The backbone of Referral Specific Communications
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The Relationship Unfolds In Layers

- Concepts and principles
- Performance obligations
- **Narrowing choices**
  - Use formal and informal data to measure performance
  - Quite steerage
  - Consider financial engagement

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Further Evolution

- Building a community record (HIE)
- Building new intervention strategies
  - Population based view
  - Developed out of real experience
  - Decisions based on data
- Financial integration
  - Commercial relationships
  - Leased time
  - Savings sharing

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Moving Beyond Physician to Physician

- Hospitals / Facilities
  - Acute care
  - Sub-acute care
  - Surgical/interventional support
  - Key: understanding and influencing the real decision pathway
- HH / Hospice / Rehab / Transportation
- Community resources

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Behavioral Health

- This is special relationship
- Overlapping specialty and primary care
- Tendency should be toward integrating with primary care
- Start with a good partner

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Implementation

- Establish a “Medical Home Provider” (MHP)
- Start the discussion with PCPs
- Practice with internal specialists
- Balance speed with clarity
- External conversations, start with least political
- Drive data into the conversation at all levels
  - Number of patients
  - Cost performance against expectation

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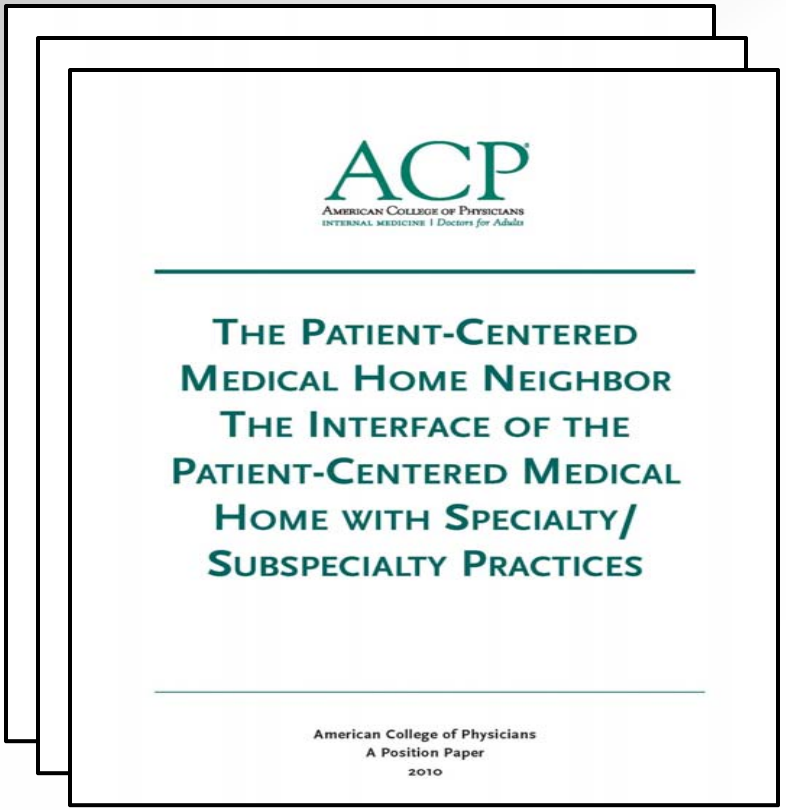
For Further Information

www.acponline.org

www.PCPCC.org

www.ehcca.com/presentations/medhomewest1/gallegos_ms2.pdf



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