Communication and Co-Management

AAP Medical Home Implementation Teleconference Series

Christopher J. Stille MD, MPH, FAAP
Jennifer Lail MD, FAAP
Donald Lighter MD, MBA, FAAP

Disclosures

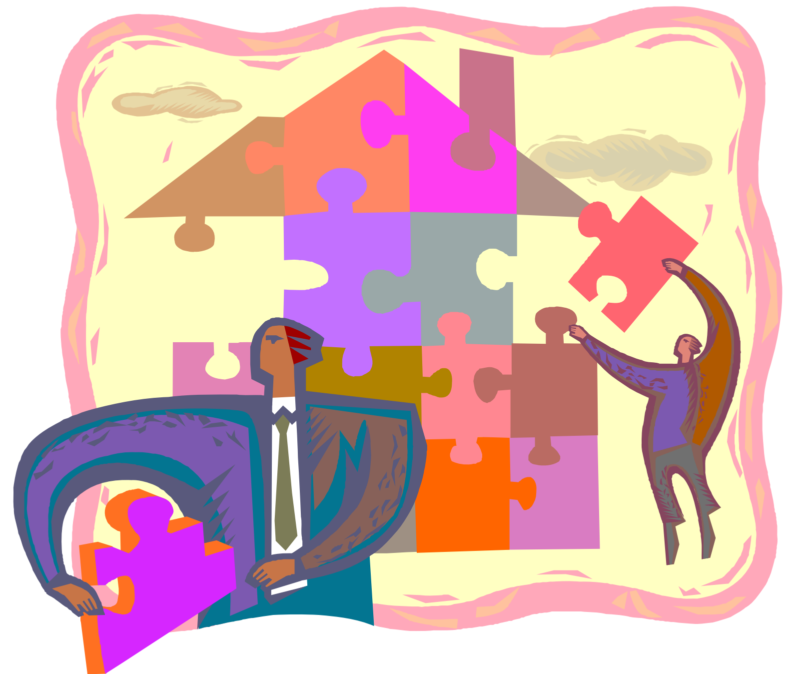
- "I have no relevant financial relationships with the manufacturer(s) of any commercial products and/or provider of commercial services discussed in this CME activity."

- "I do not intend to discuss an unapproved or investigative use of a commercial product/device in my presentation."

Definitions

- Communication = talking together
- Co-management = working together
- CYSHCN= Children and Youth with Special Health Care Needs: any kid with a condition >12 months AND
  - service use more than typical kids, AND/OR
  - Chronic med, AND/OR
  - Limitation of function.

=13% of kids nationwide



Why is communication and co-management important for CYSHCN?

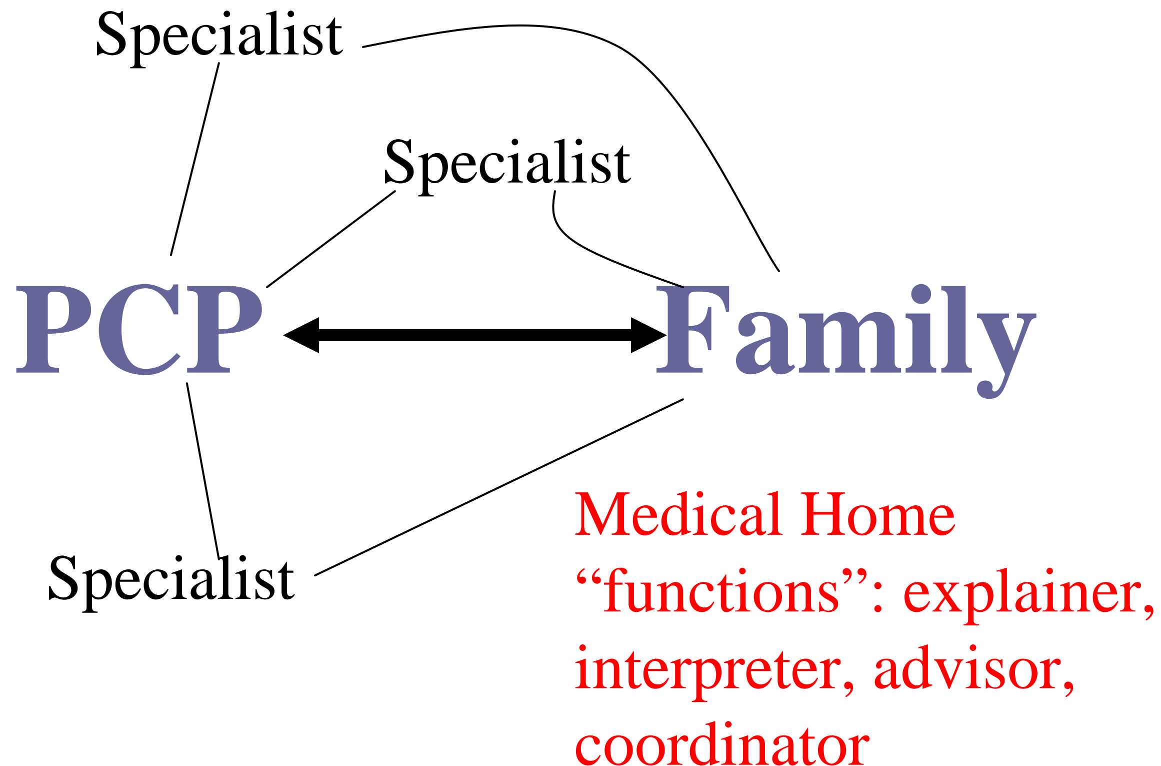
- Half of CYSHCN need specialty care; many have more than two providers involved
- Patients and parents see "the whole package" and expect seamless care
- The current system tends to provide care in "silos"…coordination is secondary
- Specialty care can be harder to access than primary care
- Improved coordination can produce higher quality care (efficient, timely, safe, …)
- Co-management is coordination between professionals who provide similar levels of care (e.g., MD-MD, MD-NP/PA)

The current system

- Physicians are paid for episodes of care (visits)
- Coordination generally not reimbursed
- No system for consistent communication
- PCP-specialist communication frequently inadequate
  - Studies: PCP to specialist ~50%, specialist to PCP 50-80%
- Result: fragmentation of otherwise excellent care

Primary care "Medical Home" as hub of communication partnership

PCP= the child's Primary Care PRACTICE
(not just one provider)



Well-functioning Medical Home

Elements of co-management

- Willingness to participate
- Communication
- Development of partnership: shared goals
- Negotiation; division of responsibility
- Agreement
- Accountability

Spectrum of co-management

- Spectrum of PCP's desire/ability to be involved
  - Overwhelmed? - typically uninvolved
  - Energetic, interested? - maybe too involved
  - "Perfect" for patient care: somewhere in between
  - Available non-MD care coordination an important part
- Spectrum of PCP's need to be involved
  - Dependent on needs/conditions of patient

Spectrum of co-management: defining roles on the team

- #1: PCP as primary manager, specialist as consultant
- #2: Specialist as primary manager, PCP less involved
- #3: PCP as co-manager with specialist; care coordination essential here
- "Perfect" model depends on desire/ability of PCP AND needs/conditions of patient

Hack, Pediatric Annals 1997

"PCP/specialist co-management"

Appropriate situations:

- Multiple conditions, varied severity
- Varying strengths of each provider
- Easy access of all providers to family
- OR: Access of specialist to family difficult, but condition more severe/complicated (requires intense commitment from PCP and specialist)
- Care coordination resources available

EXAMPLE: Adolescent with cerebral palsy, asthma, GE reflux, fed by G-tube. All are moderate in severity. 3-4 specialists involved once or twice a year.

Red flags: when is co-management needed urgently?

- Kids whose care seems to "belong" to no one
- Kids with:
  - Multiple ED visits for specialty problems
  - Multiple preventable admissions
  - Multiple "bounce-backs"
- Kids who only come to primary care for urgent visits and don't receive primary care at a specialist
- Kids who miss multiple specialty appointments

"PCP/specialist co-management"

Benefits:

- "Best of both worlds" possible, family can make use of strengths of each provider
- PCP and specialist can both learn from the process, claim "ownership" of the care plan
- PCP and parents can learn from each other

“PCP/specialist co-management”

Be aware:

- Higher potential for conflicting opinions between providers as number of providers increases
- Unexpected provider changes may lead to “care vacuum” if PCP does not supervise care closely
- Poor communication has higher potential for problems with care
  - **duplication of tests or procedures**
  - **implementation of wrong plan**
  - **gaps in care “I assumed…”**

Co-Management strategies

- Initiate communication
- Encourage communication
- Ask questions
- Encourage questions
- Propose roles
- Come to agreement
- Make plans together
- Provide updates and feedback
- Include families as partners
- Be respectful!

Co-management examples

- Encourage communication and questions:

"Please feel free to contact me at..."

"I hope this has answered your questions. I would be happy to discuss Ava's treatment further."

Co-management examples

- Ask questions:

"I would be most interested in your opinion about…":

- Propose roles:

"I will……If possible, I would like you to…."

Co-management examples

- Agreement and making plans in collaboration with parents:

(this might require a phone call!)

"I believe Caleb has ... The parents are considering... If they agree, I plan to... Please contact me to discuss...."

Co-management examples

- Provide updates and feedback:

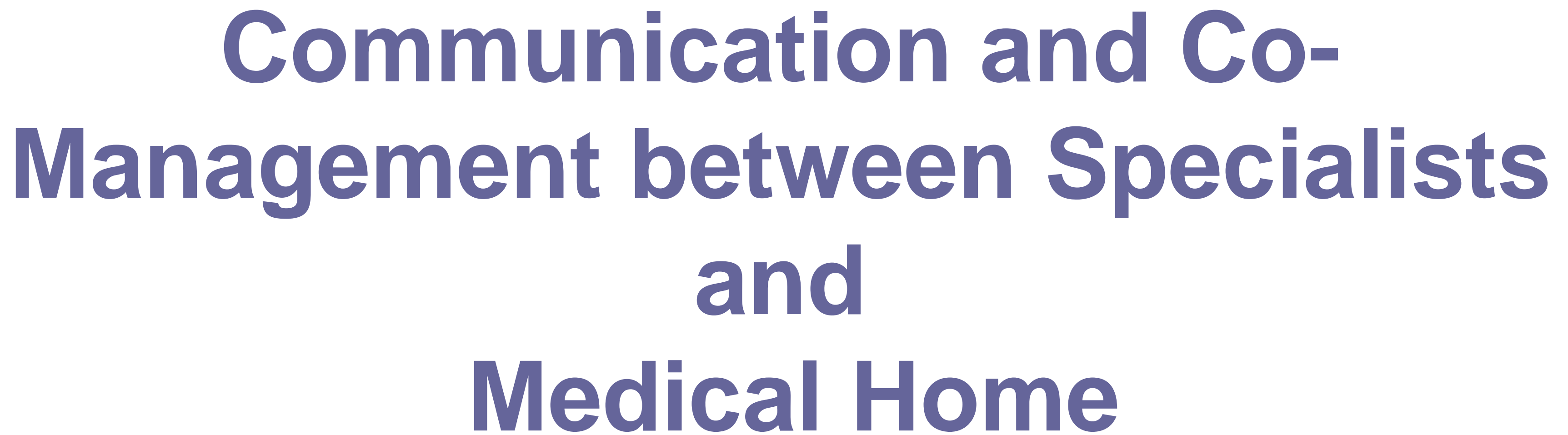
"I appreciate your continued referral of…In the interim, Joshua has… A trial of …. has been largely successful…."

Role of parents and patients

- Include them in communication!
  - …but don't leave them responsible as only way to share information
- Encourage their participation as team members
- Make roles of each team member explicit
  - This helps you decide too!

Points to consider

- Not everyone requires co-management
- Chronic and complex conditions can benefit greatly from pre-emptive management
- Early contact can save time later
- This can be an incredibly powerful tool for specialists to generate referrals



“Making the Connections”

Jennifer Lail, M.D.

Chapel Hill Pediatrics and Adolescents, P.A.

Chapel Hill, NC

AAP Teleconference

March 25, 2009

Welcome to Our Medical Home!

- Suburban Private Practice, 2 offices, self-owned
- Duke University and University of NC Medical Centers within 15 miles
- 12 MD providers, 9 F.T.E.
- 66% Managed Care
- 22% Self Pay
- 12% Medicaid + SCHIP
- >30 year history of collaboration with both medical centers
- Office hours 365 days/year
- Evening/weekend office hours
- Nighttime Nurse triage and daytime advice nurses
- Transition to EMR in fall 2007

Big Goals, Small Steps

- Adequate time for care
- Better planned visits
- Better links with specialists
- Help with referrals and resources
- Family satisfaction
- Fiscal Viability
- *Caution-Don’t wait for consensus~build a team and pilot small changes whose benefits are clear!*

"System Changes? I have patients to see!"

- One in 5 families has a CSHCN
- Survival/Complexity among CSHCN is increasing
- Strategic connections with specialists save time and money
- Retail-based Clinics will erode our acute care base
- Caring for CSHCN is where Pediatricians shine
- To be accepted, changes must show rapid clinical benefit (example: adeq. time for appt.)

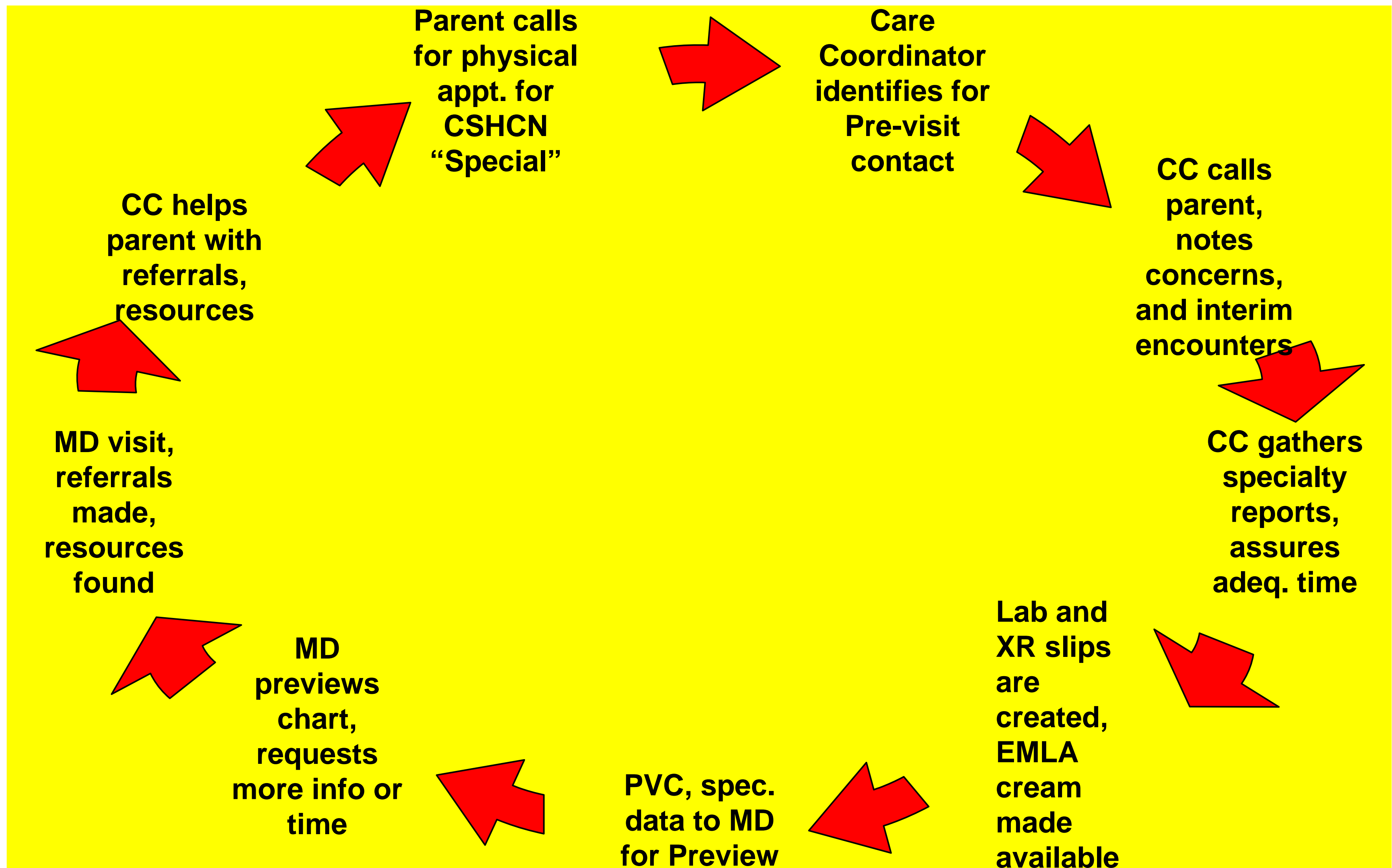
Essential Components of a Medical Home System

- Relationships
- Ready Access
- Registry
- Resources
- Reimbursement
- Recruitment

Imagine:

- Staff recognizing a parent/child when appt. is made
- Adequate time scheduled for that child
- Specialist's records in your hands prior to the visit, including lab and X-ray results
- Parent concerns identified before the visit
- Lab slips ready, and EMLA cream on child prior to visit
- Help by your staff for families with referrals, resources, equipment
- Followup to assure completion of tasks
- How does it work? Checkups? Acute Care?

Planned Care for Checkups PVC = Productive Visit



J.L., 4 year old girl with MR of ? etiology, severe sz disorder, osteopenia, GTube, recent adm. for spont. hip fx and post-op pneumonia. . .
(Neuro, Ortho, Endocrine, Surgery are consults)

Calls for appt. for fever and cough. . .

- Extra time is scheduled for J.L. ☑
- Front desk knows she's in wheelchair and watches for her arrival with her 2 sibs ☑
- Discharge summary is on chart for your review☑
- You ask CC to get most recent XR results and labs from on-line connection with Med Center EMR☑
- Your clinical dx: pneumonia rx: antibiotics and fup 1 day ☑
- Mom reports she has bisphosphonate infusion in 2 weeks at hospital; consultants #'s are in your pocket. ☑
- Phone call to Pulm. CC arranges consult on infusion day to eval. and consider vibratory vest. ☑
- CC tracks referrals and sends you reminder of visit ☑
- Pulm. sends on-line report about consult☑
- ED visit, admission are avoided; fup care is synchonized for patient, and Pulmonary advice/care prevents further pneumonias

To Register a CSHCN

- Paper: MD completes Form with CS
  Form to Care Coordinator (CC)
  CC enters into Registry
  CC marks as “Special” in Admin.

- EMR: Patient Message to Care Coord.
  MD completes Autotext Form w/ CS
  CC enters into Registry
  CC marks as “Special” in Admin/EMR

Risk Stratification = Complexity Scores

- More time?
- Communication devices?
- Technological support?
- Translator?
- Pre-Visit Contact?

REGISTER YOUR PATIENT WITH SPECIAL HEALTH CARE NEEDS-*completed form to Peggy*

Name:______________________________Race___________
Sex__________Birthdate_______________Chart #_______________
Insurer:_______________________________
Primary CHP Provider: SBH MI CM JO AD SVH
RMC KS JL RSW KM

Diagnoses: 1)
2)
3)
4)

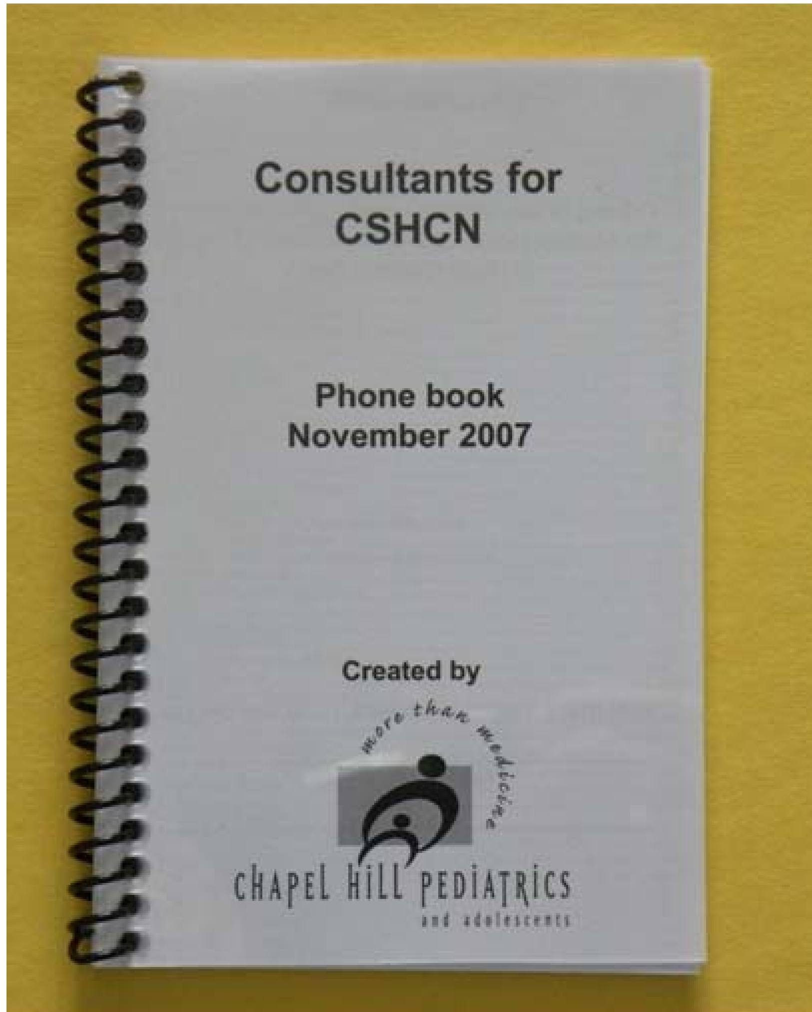
CSHCN Complexity Rating	Description	Examples
1	1 chronic condition, well-controlled OR Significant PMH, quiescent or resolved	Asthma, mild per. Repaired VSD
2	1 evolving chronic condition, unstable OR 2 chronic conditions, both well-controlled	Asthma PCOS +Type 2 DM Asthma +ADHD
3	2 or more chronic conditions, with either unstable	GERD Asthma w/ER visit
4	Any tech. dependent pt. Mod./severe cognitive delays	(wheelchair, walker, GT, Trach) MR, Autism, Group Home res.
+1	Language barrier	Non-English speaker
+1	Behavioral Disorder	OCD, Anxiety in addition to above
+1	Family/Social Complications	Divorce, Horizons
	Total complexity score	

DO YOU WANT A PVC DONE? ☐ YES ☐ NO

Registry and Complexity Scores Promote Planned Care

- Proactive care for chronic conditions (flu shots, checkups, Synagis)
- Planned care
  - adequate appt. time (per CS)
  - pre-visit contacts (CS>2)
  - alerts staff and providers to special needs
- Parent-to-Parent interaction around diagnosis
- Potential for help in Disasters (CS 4, tech. dep.)

Community Resources Directory “answers in our pockets”



- Ask MD’s to submit their favorites from all disciplines
- MD’s who respond get a copy!!
- Parent Partner and Care Coordinator add Local Resources
- Every Fall, update from margin notes and new mailings
- Pocket size fits Lab coat

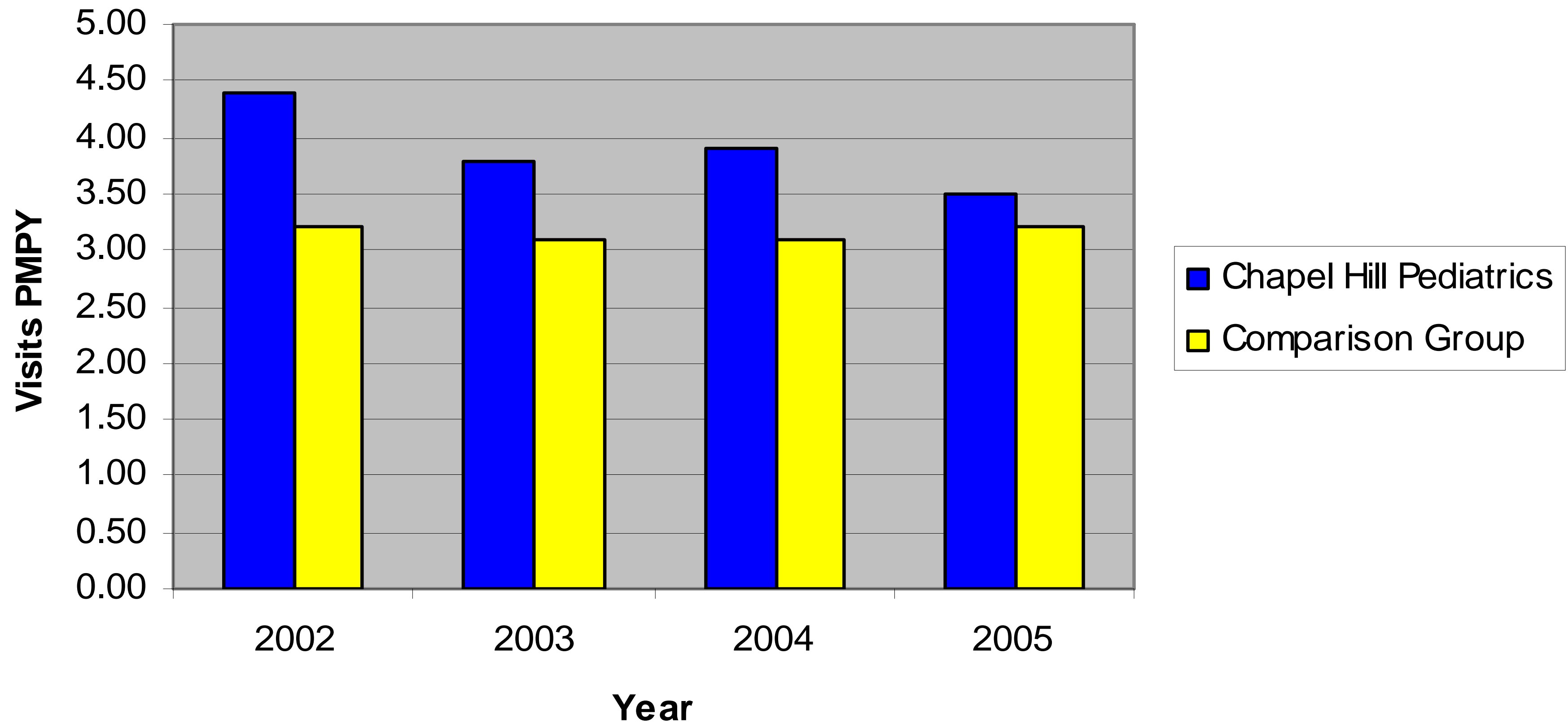
Community Resources

- State Programs for CSHCN
- Alternative Medicine
- Audiology
- Augm. Comm./Asst.Technology
- Autism
- Baby Nurses
- Carseats for CSHCN
- Child Abuse
- Child Psychiatry/Psychology
- Community MD's
- Compounding Pharmacies
- Dentistry
- Devel. Eval and Therapy
- Domestic Violence
- Early Intervention
- Eating Disorders
- G-tube and Trach care
- Genetic Testing
- Grief Counseling/Hospice
- Group Homes
- Gynecology
- Handicapped Parking
- Health Depts.
- Home Health Care/Eqpt.
- Lactation Services
- Nutrition
- Orthotics
- OT/Feeding
- Parent-to-Parent
- Podiatry
- PT
- PT Sports/Injury
- Rare Disorders
- Recreation for CSHCN
- Rehabilitation Specialists
- Respite/Residential Care
- School Systems
- Social Services
- Smoking Cessation
- Speech
- SSI
- Substance Abuse
- Travel for CSHCN
- Voc. Rehab.
- Misc.

Family Perception of Medical Home

	CSHCN	Others
Preventive care in last 12 months	95%	83%
No missed school or work in previous 3 months	85%	80%
"Not difficult" to access specialist	84%	61%
Response for phone help or advice	98%	93%
Small or no problem to obtain special services	93%	70%

Better Communication..?Fewer Visits???



The Big Picture – A Systems View of Medical Home

Donald E. Lighter, MD

Systems Thinking in Healthcare

- Each part combines to affect the whole
- Macro-system
  - Overall system of care
  - National or international focus
  - Large scale measures, e.g. U.S. infant mortality rates, U.K. deaths from medical errors
  - Capable of being broken down into smaller components

Systems thinking…

- Microsystem
  - Batalden, et. al. at Dartmouth:
    - *"…small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, shared information environment, and produces performance outcomes. They evolve over time and are (often) embedded in larger organizations…"*
  - *One of the smaller divisions of the macrosystem*

Your practice as a microsystem

- Each practitioner and associated team members can be considered a microsystem
- What does that mean?
  - Efficiency and effectiveness at micro level
  - Measurements within each microsystem roll up to the larger system and finally to national level
  - What you do counts not just for your patient, but also for the larger system

Systems thinking

- Understanding how changes in one part of the system affect other parts of the system – everything is connected
- Butterfly effect
  - "When a butterfly flaps its wings in Japan, the downstream effect is a tornado in Kansas"
  - Chaos theory - *sensitive dependence on initial conditions*, i.e. small changes in one part of a system may cause large changes in outcomes

So how does it apply to Medical Home?

- Clinical microsystems deliver care
- Avoidance of a medical error or preventable complication through improved PCP/specialist communication
  - Improved quality of care for that patient
  - Reduced legal liability/risk for providers
  - Reduced cost of care for that patient
  - Improved patient satisfaction for those providers

Downstream effects

- Improved quality for individual patient
  - Learned behaviors by patient and providers
  - Occasionally learning for others, as well
  - How is learning shared?
- Reduced legal risk for providers
  - Reduced litigation and associated costs
  - Learning disseminated to others, reducing risk in broader sections of the industry
  - Cost and quality improvements expanded

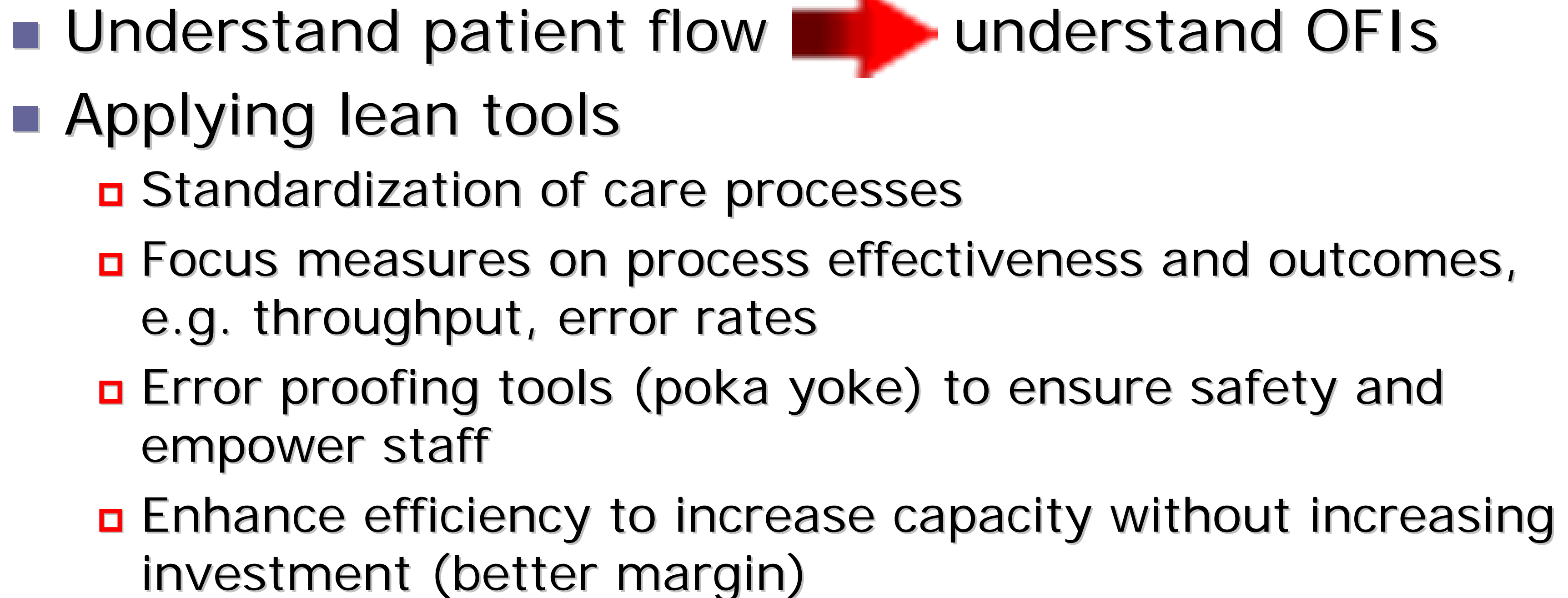
Downstream effects...

- Reduced cost of care
  - Avoidance of complications and errors
    - P4P
    - noP4noP
  - Learning disseminated, costs reduced in other patient/provider dyads
  - Net effect magnified many times

Downstream effects...

- Patient satisfaction with provider
  - Reduction in legal risk
  - Improved patient recruitment – translates into better market share
  - Improved revenue from market share improvements
  - Improved revenue from P4P programs
  - Emulation across the system – improved public satisfaction with delivery system

Tools for improving through MH



- Lean programs
  - Understand patient flow → understand OFIs
  - Applying lean tools
    - Standardization of care processes
    - Focus measures on process effectiveness and outcomes, e.g. throughput, error rates
    - Error proofing tools (poka yoke) to ensure safety and empower staff
    - Enhance efficiency to increase capacity without increasing investment (better margin)

Why is it important to measure?

- “Can’t manage if you don’t measure”
- Society demands better from us
- Medical risk and liability will depend on our effectiveness
- It’s the right thing to do…

How can we start?

- Use these approaches to improve health care in our microsystems
  - Engage staff
  - Multidisciplinary teams
  - Use data, not supposition and guesswork
  - Empower staff – nobody has all the answers
- Move immediately to evidence based <u>medicine</u> AND evidence based <u>management</u>

Applying the tools we have

- Lean and six sigma approaches
- Information technology
  - Critical to creating measures that will affect clinical care
  - Systems are available – not being used
  - Pushing forward in next 4 – 8 years
  - Reduced cost of collecting data
- Systems view – consider the consequences of each action we take

We have the tools…

The incentives are coming…

Let's do it for the kids…

Available Resources

- www.medicalhomeinfo.org
- Medical Home Toolkit
  - Previsit Contact Form
  - Fax Back Form
  - Co-management Agreement