“Closing the Referral Loop”
to Coordinate Patient Centered Care

AMA Convened Physician Consortium for Performance Improvement
March 6, 2015

Linda Thomas-Hemak MD, President/CEO,
The Wright Centers for Graduate Medical Education and Medical Group
Discussion Points

• Why focus on ambulatory referrals was a good fit for TWC
• Why partnership with PA DOH and AMA made sense
• “Closing the Referral Loop” Project Goals and Culture
• Structure: Leadership, Project team, Dyads, Coaches
• Activities: Data Collection, Conference Calls, Collaborative Meetings, Site Visits
• Change Strategies
• Greatest Lessons Learned: Crucial Roles of Dynamic Scheduling and Engaged and Activated Patients
• Future Direction
The Wright Center for Graduate Medical Education and Wright Center Medical Group are inextricably linked non-profit corporations in Northeast PA doing business as The Wright Center. The Wright Center’s mission is to continuously improve patient care and education in a collaborative spirit to enhance outcomes, access and affordability.
TWC’s Poise for CRL Leadership

• Proven track record for successful practice transformation with PA DOH’s Multi-Payer Chronic Care Initiative
• NCQA Level 3 Certified Patient Centered Medical Home since 2011
• Meaningful Use Certified EMR and Stage 2 Attesting providers
• Few well-developed, standardized measures of care coordination exist in the ambulatory care setting
• One of thirty practices selected for Robert Wood Johnson Foundation’s national “Primary Care Teams: Learning from Effective Ambulatory Practices,” with highlighted innovations in referral loop tracking
• Graduate Medical Education Consortium that sponsors ACGME/AOA accredited Internal and Family Medicine Residencies and a Cardiology Fellowship
Stewardship of Workforce Development

• The 21st century marks a period of paradigm health care transformation in the United States, intensely driven by an unsustainable economic situation.

• Health care costs have grown exponentially, not paralleled by increases in health care delivery efficiency, public health outcomes or reported care experience satisfaction of either patients or providers.

• There is an undeniable need for a more effective and affordable health care system model which will require workforce with new 21st century skill sets.
“Gaps In Residency Training Should Be Addressed To Better Prepare Doctors For A 21st Century Delivery System

A 2010 Kaiser Permanente Study: Crosson et. al, Health Affairs, 2011

Email survey of 154 department chiefs in 4 clinical departments: Internal Medicine, Pediatrics, General Surgery and Ob-Gyn reported significant deficiencies in:

1. Office based, routine practice competencies inclusive of prevention and chronic disease management
2. Care Coordination
3. Care Continuity
4. Familiarity with Team Based Care Models, Clinical Information Technology and CQI
5. Leadership and Management skills
6. Systems Thinking

Conclusion:

“Workforce will need better preparation to practice in a health system that emphasizes accountability, quality outcomes, cost control and information technology.”
PCMH 21st Century Skill Sets

- Enhanced Access to Care
- Care Continuity
- Comprehensive Care: Preventative and Chronic Disease Management
- Care Coordination
- Team Based Delivery
- Systems Approach and CQI
- Clinical Information Technology for Planned Care at Every Visit and Population Management
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<td>Team Approach</td>
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<td>Information System Approach</td>
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<td>Patient Centered Care</td>
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<td>Treatment of Mental Health Issues</td>
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Validated Survey Assessment Tool

*Dr. Perry Dickinson, University of Colorado*
A Hero Shouldn’t Be Necessary

Dr. Ed Wagner, Group Health, SNMHI

PATIENT-CENTERED MEDICAL HOME

- Accountability
- Patient Support

Relationships & Agreements

- Connectivity

Community Agencies
Hospitals & ERs
Medical Specialists

- Involved providers receive the information they need when they need it
- Practice knows the status of all referrals/transitions involving its panel
- Patients report receiving help in coordinating care

High-quality referrals & transitions for providers & patients
# Why Make Care Coordination a Priority?

*Dr. Ed Wagner, Group Health, SNMHI*

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<th>Happier patients</th>
<th>Patients and families hate it that we can’t make this work.</th>
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<td>Fewer problems</td>
<td>Poor hand-offs lead to delays, lapses in care, adverse drug effects, and other problems that may be dangerous to health.</td>
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<td>Less waste</td>
<td>Enormous waste is associated with duplicate testing, unnecessary referrals, unwanted specialist-to-specialist referrals, and failed transitions from hospitals, EDs, &amp; nursing homes.</td>
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<td>Happier physicians &amp; staff</td>
<td>Clinical practice will be more rewarding.</td>
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Care Coordination: “Closing the loop” through referral tracking is one of the greatest benefits we provide as patient advocates.

Uncoordinated, “reactive” care

- Causes patient and provider frustration & anxiety
- Diminishes health outcomes
- Redundant & reactive work; duplicative tests; unnecessary visits and hospitalizations

Strategic referral tracking

- Care utilization & compliance are enhanced
- Barriers to care are identified & mitigated
- Patients appreciate the organized effort!
Why Pennsylvania Department of Health?

A successful convening platform for a Multi-Payer sponsored statewide Chronic Care Initiative that:

- leveraged national Quality expertise around the Chronic Care Model platform
- ignited statewide primary care practice transformation
- stimulated NCQA Patient Centered Medical Home certification
- promoted EMR integration and Meaningful Use functionality
- built a statewide primary care provider network
- fueled paradigm frame of reference transformation of Wright Center physician leadership
Why the American Medical Association?

- Unifying Professional Agency for Primary and Specialty Care Physicians
- Physician Consortium on Performance Improvement’s focus on QI
- Convener of Content Experts on Care Coordination and Referral Tracking
Leadership Team

- Dana Richardson – American Medical Association
- Connie Sixta – Quality Improvement Leader
- Marcela Myers – PA Department of Health
- Linda Thomas-Hemak – TWC President/CEO and Content Expert
- Samir Pancholy – TWC Cardiology Fellowship Director and Specialty Provider
- Jignesh Sheth – TWC VP of Mission Accountability and PCP, Physician Project Lead
- Linda Thomas-Hemak – TWC VP of Mission Accountability and PCP, Physician Project Lead
- John Janosky – TWC VP Information Technology & Innovations, Data Support
- Brian Ebersole – TWC VP of Mission Delivery

Project Team

- Connie Sixta – Quality Improvement Leader
- Jignesh Sheth – TWC VP of Mission Accountability and PCP, Physician Project Lead
- Tiffany Elkins – TWC EMR Application Specialist, Practice Coach
- Courtney Dempsey – TWC Clinical Innovations Specialist, Practice Coach
- Dhara Thaker – TWC Project Manager
CRL Collaborative Culture, Aims and Goals

• Organized intentionally without any incentives other than patient advocacy and desire for high performance
• Aims to improve the process of physician to physician referrals in the ambulatory setting by establishing accountability and improving office system processes for exchange of patient information
• Focus: Posing, communicating and answering the Clinical Question
• Desired outcomes: enhanced understanding of and satisfaction with the referral process by patients and physicians
Platform: IHI’s Collaborative Model

• Institute for Healthcare Improvement’s Learning Collaborative Model to test interventions and approaches that improve the referral process within individual health care systems

• Intervention examples:
  ▫ Defining specific staff roles for tracking referrals
  ▫ Health information technology functionality, utility and innovations
  ▫ Shared Care Agreements between primary and specialist physicians
  ▫ Better illuminating and evolving the role of patients
CRL Specific Goals

• Clarify and document expectations to enhance communication between a PCP and Specialist “Dyad” that have a well established referral relationship
• Develop and leverage EMR functionality and utility for referral management
  ▫ Software and vendors
  ▫ Office workflow process map
  ▫ Staff development for lean workflow
  ▫ Time stratified referrals
  ▫ Empowering ability to generate reports for data and exception reports
    • open referrals, timeliness/effectiveness of referrals and satisfaction of patients/providers
• Formalize Shared Care Compacts
• Better understand the “No show” phenomenon
• Stimulate PDSA based QI and innovations
Specific Cross-Cutting Improvement Opportunities

- Focus on “Closing the Referral Loop” as a first project in a long-term commitment to improving care coordination nationally
- Demonstrate meaningful improvements in care coordination through a small scale collaborative with measurable impact promoting the Quadruple Aim
- Conduct the “Closing the Referral Loop” campaign and collaborative and determine if it should be expanded
- Engage in evolving conversations about EMR Meaningful Use Standards
- Explore opportunities for greater scale and impact
CRL Founding Objectives

• Demonstrate measureable, meaningful impact on specific cross-cutting improvement opportunities
• Test a model for QI spread that includes “intermediate” collaborative organizational support without direct incentives
• Build collaborative relationships with organizations that have complimentary improvement expertise and infrastructure
• Grow the number of “Closing the Referral Loop” experts and build a scalable learning community
• If the pilot project is successful, expand the CRL project with external funding
Primary and Specialty Provider Dyad Team

- Established rapport and mutualism
- Champion physician/provider
- Day-to-day leader/administrative contact
- EMR super user clinical/technical
- Other team members
Holistic Needs Driven Focus

• Did the referring provider pose and get the answer to their clinical question? Did they communicate and get the help they needed?
• Did the specialty provider get what they needed to provide the answer and complete the referral?
• Did the patient feel that the care was coordinated and did they get what they needed?
Data Repository

- Developed by TWC IT department under direction of physician project lead
- Secure, password protected, Google based website platform for broad long-term application and accessibility
- Straightforward utility empowering practices to self collect, de-identify and report
- Data collected, de-identified and reported on a monthly basis
- Designed for outcomes analyses to be conducted by TWC IT department with functionality that could eventually be transitioned to the practices for self oversight with minimal overhead
Monthly Conference Call Topics

- CRL pre-work and data webpage
- Process mapping referral management
- Current EMR functionality, utility and innovation opportunities
- Staff development for process improvement
- Communicating the clinical question and answer
- Sharing best practices
- Formal Shared Care Compacts
- Sustaining and spreading the referral process
- CRL Measures, Data and EMR Tracking
- Conversation: ONC HITECH eCQM Development for Care Coordination and Electronic Health Record Systems
- Patient Satisfaction assessments
Learning Collaborative

- By consensus, conducted twice a year
- Expectation that all dyads would be represented by the provider champion in-person with others welcome
- Living story boards in standard format that highlighted:
  - CRL status
  - Quality improvement efforts
  - Outcomes
  - Challenges and Mitigation Strategies
  - Lessons learned
Dyad Team Specific Coaching

- Project coaching calls with QI Project Director and Clinical Innovations Specialist
- Practice on site coaching once during the first year with EMR Application and Clinical Innovations Specialists

Key Intervention Areas

- Accountability
- Relationships, expectations and formal Shared Care Compacts
- EMR data reporting, connectivity and challenges
- Patient engagement and satisfaction assessment
“Turning Doctors into Leaders”


“Working in teams does not come easily to physicians, who still often see themselves as heroic lone healers. A senior leader’s appeal to doing “the right thing” can overcome physicians’ resistance.”

- Improvements in performance require teamwork
- Articulating Vision and Values
- Organizing for Performance
- Developing a Measurement System and Improving Systems
- Dismantling Cultural Barriers
- **Define strategy around patients’ needs**
Dynamic Scheduling

• Benefits
  ▫ More satisfied patients lead to higher patient retention rates
  ▫ More satisfied patients can also lead to reduced no-show rates
  ▫ Helps to maintain the continuity of care and improve patient health outcomes

• Challenges
  ▫ Obvious operational challenges for the clinic
  ▫ Carefully choose the level of flexibility offered to the patients while taking into account the operational consequences
  ▫ Results in high variability in the daily load of a clinic
No-Show vs. Preference

• Scheduling flexibility regarding how, when and where to receive treatment is prudent, but probably not enough
• United Kingdom’s Health Service’s electronic “Choose and Book”
• Online scheduling is increasingly being adopted in the U.S.
• Patients’ experience of and knowledgeable engagement in care delivery is crucial
• “Noncompliance” and “No Shows” have negative connotations. These terms tether us to an outdated expert centered framework of healthcare delivery.
• Shared Decision Making should guide patients to co-create and deliver clinical questions and answers that are the substance of referrals.
• If a patient can’t or don’t do this, perhaps we haven’t reached them or addressed his/her health literacy.
• Patients are entitled to their frame of reference and choices.
“The Quickest Road Out is the Way Back In”

“Insanity is doing the same thing over and over and expecting different results.” Albert Einstein

“Every system is perfectly designed to get the results it gets.” W. Edwards Deming

“Culture eats strategy for breakfast.” Peter Drucker
We need to be really mindful to intentionally ensure an authentic patient centered frame of reference is at the heart of all of our innovations in health care. This mandates health literacy be appreciated and addressed so that patients can be activated and knowledgeably engaged for meaningful contributions to their care. Perhaps, patients should carry the clinical questions and answers to optimize the referral process. This may reduce “No Shows” and also enhance patient satisfaction.