Building the Bridge-Enhancing PCP: Specialist Coordination

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ACOs will look very different, but a few characteristics are essential

1. Can provide or manage continuum of care as a real or virtually integrated delivery system

2. Are of a sufficient size to support comprehensive performance measurement

3. Are capable of prospectively planning budgets and resource needs
Comprehensive Aligned Resources
Comprehensive (Mis)Aligned Resources
Failures in care coordination are common and can create serious quality concerns.  

*Bodenheimer*  *NEJM* 2008

**For referred patients:**

- **68% of specialists** reported receiving *no information* from the primary care provider prior to referral visits:
- **25% of primary care providers** had received *no information* from specialists *4 weeks after* referral visits:
- **28% of primary care and 43% of specialists** are *dissatisfied with the information* they receive from each other.  *Gandi et. al. J Gen. Int. Med. 2000*

Referral and Consultation Communication Between Primary Care and Specialist Physicians

**Perception**

- 69.3% of PCPs reported they "always" or "most of the time" send notification of a patient's history and reason for consultation to specialists.

- 80.6% of specialists said they "always" or "most of the time" send consultation results to the referring PCP

**Reality**

- 34.8% of specialists said they receive it "always" or "most of the time."

- SOC/PCMH Poll indicates 37% of specialists receive necessary information

- 62.2% of PCPs reported getting it "always" or "most of the time."

- SOC/PCMH Poll indicates PCPs receive info 52% of time.

Causes of Poor Alignment

• Lack of
  • Financial incentives
  • Communication infrastructure
  • Communication best-practices/standards
U.S. Health Care

• Great Skills
• Great Science

• NO SYSTEM, no “grid”
  • No curriculum for communication/care coordination
  • No professional norms for communication or care coordination (documentation vs communication)
  • “consultation” = whatever you want it to be
We need a way to work together

- We need better
  - Hand-offs
    - *Communication* (more than information exchange)
  - **Shared Care Plans (Patient-Centered Care)**
    - *Coordinated Care*
    - Integrated with patient self-management /crisis care plans
THE PATIENT-CENTERED MEDICAL HOME NEIGHBOR
THE INTERFACE OF THE PATIENT-CENTERED MEDICAL HOME WITH SPECIALTY/SUBSPECIALTY PRACTICES

American College of Physicians
A Position Paper
2010

http://www.acponline.org/advocacy/where_we_stand/policy/
PCMH-Neighbor Model/Policy Paper

• **Definition** of PCMH-Neighbor

• **Principles Care Coordination Agreements**
  - An infra-structure or *framework* to support Care Integration and Information Exchange
  - Improve Care Transfers and Transitions to enhance Safety and Stewardship
  - Restore Professional Interactions needed for Patient Centered Care
Care Coordination Agreement

• Platform that everyone agrees to work from (system)
  - *Standardized* Definitions/Formats/Expectations

• Care Plan (Comprehensive)
  • Coordinated Care (practice & patient)
    - *Individualized* Care
## Defining Roles/Bilateral Expectation

<table>
<thead>
<tr>
<th>CLINICAL ROLE</th>
<th>RESPONSABILITIES</th>
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<tbody>
<tr>
<td>Cognitive Consultation</td>
<td>Make recommendations</td>
</tr>
<tr>
<td>Procedural Consultation</td>
<td>Perform procedure</td>
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<tr>
<td>Co-Management with Shared Care</td>
<td>Share long-term management for patient’s referred health problem</td>
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<tr>
<td>Co-Management with Principal Care</td>
<td>Assume total responsibility for long-term management of referred health problem</td>
</tr>
<tr>
<td>Primary Care</td>
<td>See “Medical Home” model</td>
</tr>
</tbody>
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Forrest, Christopher B. “A Typology of Specialist’s Clinical Roles.” Archives of Internal Medicine; 169(No. 11), June 8, 2009: pp. 1062-1068.
Co-Management
(for ONGOING management of a patient’s unstable medical condition)

- Shared Care for the disease (PCP “first call” and responsible for Elements of Care)
- Principal care for the disease. (Specialist “first call” and responsible for Elements of Care for that disorder or set of disorders)
- Principal care of the patient for a consuming illness for a limited period of time (specialist serves as first contact but patient maintains PCP as Home)
Questions from Primary Care Practices

• How can I engage the specialists?
  • Care Compacts are one option but don’t always work as they have a hard time seeing the value.

• How do you get communication going & get agreement on what’s going to take place?
PCP Steps to Improve

1. Start with agreements w/ specialists
   - When possible → Direct specialist discussion
   - When not possible → recognized templates

2. Better prepare your patients

3. Process solutions
I am referring this patient for:

• ___Medical Consultation: Evaluate and advise with recommendations for management sent back to me
• ___Procedural Consultation
• ___Co-management: I prefer to share the care for the referred condition (PCP lead, first call)
• ___Co-management: Please assume principal care for the referred condition (Specialist assumes care, first call)
Wanted: Better Solutions

Supporting data

Referral by fax

Received confirmation

Requesting more data

Cancellations

Electronic referrals

No shows

Is there a clinical question?

The referral request sent
Practical Implementation Tips

• Emphasize benefits to **quality of care and practice** (as opposed to mandate)
• Agreements
  • Not compacts or contracts
• Seek physician-led, organic, “bottom-up” approach to implementation
• Start conversation with broad health care constituencies
Summary

• Coordination between PCP and Specialists needs overhaul
• The root causes of misalignment must be addressed
• Resources to improve are available
• Pursue agreements, not contracts
• Create bottom-down solutions that solve problems for providers and patients.
Thank You.