

## MEDICAL EDUCATION: PART A

## Tool Kit for High Value Care Coordination

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**M**s. M. had waited 2 months for her appointment with Surgeon Z. regarding surgery for a newly diagnosed eye problem. However, as the surgeon perused her records for the first time after coming into the room, he abruptly commented “I do not perform that surgery; you will need to go to XXX Clinic to get that done.”

Mr. J. made an appointment for the endocrinologist as his PCP had asked him to do. After waiting 3 months for the appointment and taking the day off of work for the two-hour drive, the endocrinologist was upset that he did not know why he had been referred. She reported that she had received no records from his PCP before the appointment and that they had just called the PCP but the office was closed that day.

None of us relish this fragmented, disconnected care, but we do not have a widely disseminated system or established template of expectations to guide us in care coordination. (Nor were we trained in communication and care coordination.) The development of the Patient-Centered Medical Home model has done much to help improve care delivery within primary care practice, but without improved connections to the medical neighborhood, the medical home is just a better functioning silo of care.

In January 2013 the American College of Physicians High Value Care Coordination Work Group convened representatives from specialty and primary care organizations and clinicians (including a strong SGIM presence) to develop a High Value Care Coordination (HVCC) Tool Kit and corresponding training curriculum. This effort, enhanced by the participation of patient and family advocates, sought to optimize interdis-

ciplinary communication within the medical neighborhood.

The resulting tool kit includes components designed to ensure a high value referral request and consultant response. Beyond the requisite demographic information, the tool kit includes recommendations for a well formulated clinical question or a summary of the reason for referral along with adequate and pertinent data to support the referral and reduce duplication of testing and other efforts. The latter “Pertinent Data Sets (PDS)” were actually the main focus of the HVCC workgroup efforts, with each specialty society creating one or more such PDS around commonly referred conditions. The selection of what information is needed as preparation for referral for each condition was intended to allow the specialists to do the following:

1. determine if the referral is to the appropriate specialty;
2. triage the urgency of the referral (in essence, to risk stratify the referral needs); and
3. enable the specialist to do something at the first visit whenever possible.

These sets also indicate specific testing that is not necessary or even not recommended (with a link to Choosing Wisely guidelines) along with links to educational items for the patient regarding the referred condition and/or specialty and links to good resources on the condition for the referring physician.

Additional steps to ensure that the referral is patient-centered include: confirmation that the patient and/or their caregiver understands and agrees with the goal of the refer-

ral; provision of information to the specialty practice regarding any special needs or requirements for the patient such as visual, hearing or cognitive impairment; and provision of contact information for patients and their surrogates (such as e-mail address) to facilitate scheduling the appointment and/or helping with pre-appointment forms.

Having the needed information in advance of the referral appointment allows the specialist/specialty practice to more appropriately tailor the consultation in order to meet the needs of the patient. This information also allows referring provider and consultant to evaluate the urgency for the referral and the role to be played by the specialist.

Referral needs can be triaged or “risk stratified” into urgent, subacute/intermediate or routine. This can be specified by the requesting practitioner, however review by the specialist or his/her representative can help ensure appropriate timing of the consultation. Pre-consultation review can serve to ensure that the referral is appropriate, and, if not, allow the referral to be redirected to a more suitable consultant. It can also help ensure that the supporting data is complete and if not, facilitate completion of recommended testing prior to the appointment. Pre-consultation review can open up the lines of communication and collaboration around the referral process, with the requesting clinician and specialist enabled to have an iterative exchange (such as “is this referral appropriate for your specialty?” or “what testing would you like done before the appointment?”). In some health care systems, well developed

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“virtual consults” or “e-consults” serve this function.

The type of referral determines the role of specialist. Depending on the practice, this can be determined by the referring provider, the consultant or a care management coordinator. A cognitive consultation provides advice around diagnosis and/or management and usually requires only one or two visits to the specialist. A procedural consultation provides assessment of the need for a diagnostic, therapeutic or palliative procedure and if needed, provision of the procedure.

Co-management of a condition or set of conditions can be *shared* by the specialist and primary care clinician, with the primary care clinician taking lead and “first call” but assisted by the specialist as needed. Alternatively, the specialist can provide care for a condition or set of conditions, taking first call around any related issues. The role of the specialist in meeting the needs of the patient is fluid, depending on changes in the condition and/or the patient. This allows for patients with stabilized conditions to be graduated out of specialty co-management and

back to management by primary care, opening up specialty care for new patient referrals with greater needs.

Expectations for the consultant include a detailed answer to the clinical question addressing the reason for the referral, and including discussion of the specialist’s thought process. Clarity should also be provided regarding the anticipated next steps for the specialist, the patient and the referring clinician including any recommended follow up.

These items, and more, can be agreed upon in a formal or informal care coordination agreement devised by the primary care practice and the specialty practices that they work with. A template of such an agreement is detailed in the online tool kit as well.

The medical neighborhood is built around a patient-centered model of care, with the primary care medical home providing the hub of care around the patient and specialty (and ancillary) care as an extension of care or helping with care when and as needed. Those referral needs can be better and more expeditiously met

with appropriate information sharing, communication and collaboration connecting the care process for the patients.

### References

1. American College of Physicians. High Value Care Coordination (HVCC) Tool Kit. <https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit>. Accessed December 19, 2016.
2. American College of Physicians. ACP practice advisor module: improve care coordination. <https://www.practiceadvisor.org/Modules/building-the-foundation#>. Accessed December 19, 2016.
3. American College of Physicians. Curriculum for subspecialty fellows. <https://www.acponline.org/clinical-information/high-value-care/medical-educators-resources/curriculum-for-sub-specialty-fellows>. Accessed December 19, 2016.

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