Implementing Evidence-Based Programs in Health Centers and Practices

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Welcome to Webinar Two: Referral Systems that Meet Practice Needs in Support of the Patient

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Webinar Series Learning Objectives

- Recognize and define the role your State Health Department can play in brokering the connection between health care systems and community-based implementation.
- Establish a greater number of partnerships geared toward connecting health care systems to community-based partners.
- Increase reach by brokering partnerships that are cognizant of Patient Centered Medical Home transformation and the role of community-based resources.
- Create a plan for your State Health Department to embed, scale and sustain referrals to community-based partners.

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Topics Covered in Webinar One

- Understand how national statistics on chronic disease and healthcare changes are opportunities for scaling and sustaining programs.
- Define and briefly explore our working terms for this webinar series:
  - Self-Management
  - Self-Management Support
  - Self-Management Education
  - Community-Based Programs
  - Patient Center Medical Home
  - National Committee for Quality Assurance
  - Affordable Care Act
  - Clinical/Medical Care
  - Evidence-Based Programs
- Establish an Action Plan process to be completed before the next webinar.

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Learning Objectives for Webinar Two:

- Address specific Self-Management Support tools for your use in Patient Centered Medical Home transformation and the National Committee for Quality Assurance recognition.
- Recommendations versus active referral systems to connect health care to community-based resources and educational programs.
- Examine the roles State Health Departments, health systems, and community partners play in increasing patient/participant reach within 1)embedded systems, 2)community-based organizations, and 3)hybrid implementation.
- Establish an Action Plan to be completed before the next webinar.

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Review of Homework Assignment

- What bridges already exist in your State?
- What additional connections would you like to see in place?
- What do you see as your role in making these connections successful?
- What can you explore or pursue between now and December 3rd?

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Recommendation or Referral?

- Do referrals take more time?
- Are recommendations as effective?
- What is the incentive?

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Recognition and Referrals

- The incentive is moving toward recognition.

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NCQA PCMH 2011 Standards

PCMHI: Access and Continuity D. Use of Data for Population Management F. Culturally and Linguistically Appropriate Services	**PCMH4: Provide Self-Care Support and Community Resources (Must Pass)** A. Support Self-Care Process B. Document Goals, Ability, Self Management Tools, Referrals to Community Resources
PCMH2: Identify and Manage Patient Populations C. Patient Panels, Comprehensive Health Assessment	**PCMH5: Track and Coordinate Care** B. Referral Tracking and Follow-Up C. Coordinate with Facilities/Care Transitions
PCMH3: Plan and Manage Care B. Identify High-Risk Patients C. Care Management, Pre-Visit Planning, Treatment Plan and Goals, Identify Barriers D. Manage Medications	**PCMH6: Measure and Improve Performance** B. Measure Patient/Family Experience E. Report Performance

CDC 4 Domains

- Domain 1: Epidemiology and Surveillance
- Domain 2:Environmental Approaches
- Domain 3: Health System Interventions
- Domain 4: Strategies to improve community-clinical linkages

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CMS Triple Goals

- Better Care
- Better Health
- Lower Cost

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Clinical/Medical Care

- Care plans
- Self-management goals
- Community resources
- Referrals
- Accountability

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Successful Implementation Models Involving COAW

- Embedded
- Community-based organizations
- Hybrid
- Examples
  - Age Well
  - University Family Medicine
  - Peak Vista

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Referral Systems: Outside or Internal Process?

- Suggested workflow chart
- Referral Form
- Report on referrals to the Practice
- Feedback to the Practice from the patient

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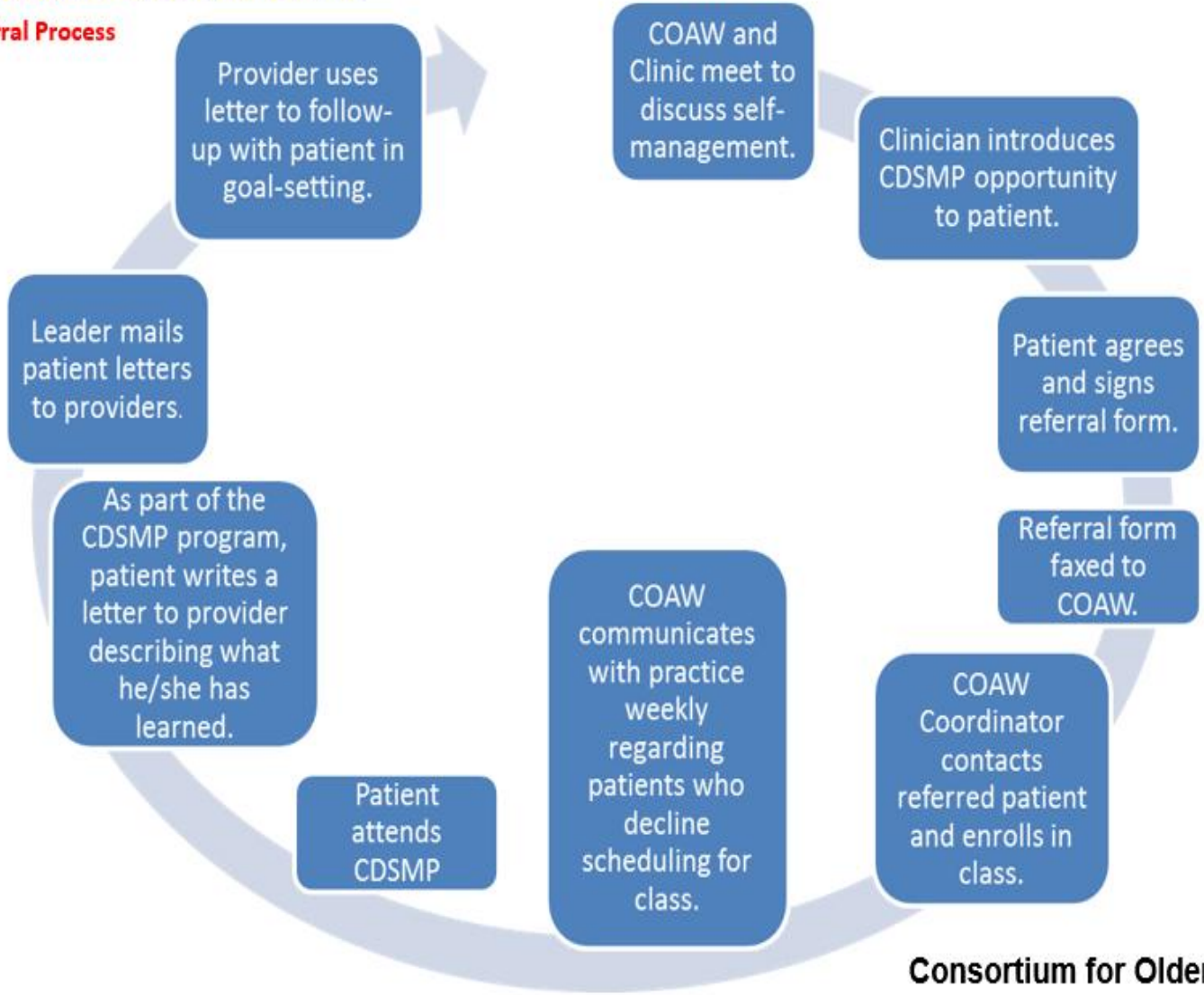
Referral Process



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Lakewood CO 80227
303-984-1845
888-000-2629(COAW)

Centralized Referral Systems

- Collaborative effort to streamline referral process from multiple sources to multiple sites, classes, or programs
- HIPAA Considerations
- Staffing
- Return on Investment?

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Centralized Referral Systems

CENTRALIZED REFERRAL AND FEEDBACK PROCESS FOR MEDICAID CLIENTS

Meet with RCCOs and Clinic staff meet to discuss self-management classes.

Medicaid Client is introduced to class opportunity

Medicaid referral from a RCCO, i.e. case manager

Fax, Email, or toll free call

Secured Website – HIPAA Compliant

Staff person takes referral and sees where the closest class would be for client.

Staff person calls class contact to arrange enrollment.

Staff person calls client to invite into class and shares information.

Referring RCCO or provider receives update on client's enrollment status.

Client goes to six-week class and learns self-management skills including action planning, and problem solving.

Six month self-management goals are set and information is sent to patient's PCP and case manager.

Roles and Referral Systems

- What can be addressed only through the State Health Department?
- What can be handled only by a Community-Based Organization?
- What can only be done by the Practice or health system?

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The Intervention Design

What do we bring to the table?

HTW

- Onsite coaching in practices statewide
- Organizational commitment to increasing practice capacity for improving patient self-management support
- Opportunity to work with practices in standardizing referral and patient “action planning” follow up on workflow processes

COAW

- Statewide network of local organizations housing trained lay teachers
- Coordinators working with local organizations on referrals
- Mechanism for tracking referred patient enrollment in classes and communicating with practices
- Centralized data collection

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HTW Coach introduces COAW to the practice.

- Meeting between practice staff, COAW and HTW coach
- Identify “practice champion” on the staff- MA, Office Manager, NP, etc.

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Sample Documents

- Workflow
- Care Compact
- Memorandum of Understanding (MOU)
- On-line Referrals
- Referral Form
- Referral log
- Feedback Letter
- Simple Reports

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Clinical workflow

Front Desk

- Is there a form showing self-management opportunities?

MA Interactions

- Positive conversations, setting the stage for action planning, or introducing the plan.

Provider Time

- Discuss the plan or confirm the plan.
- Reinforce the importance of setting do-able plans.
- Reinforce the importance of patient involvement.
- Referrals.

Document

- Who does the charting?

Check out

- Who hands the patient their copy of their goal ?
- Referrals?
- Logs, brochures, back-up info?

Care Compact

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Creating Medical Home Communities
Systems of Care/Patient Centered Medical Home Initiative

¶

- *Consortium·for·Older·Adult·Wellness-·Primary·Care·Provider·Compact¶*

I.→Purpose¶

- *•→ To·provide·optimal·health·care·for·our·participants·and·patients.¶*
- *•→ To· provide· a· framework· for· better· communication· and· safe· transition· of· care· between·primary·care·and·community·based·organizations.¶*

II.→Principles¶

- *•→ Safe,·effective·and·timely·patient·care·is·our·central·goal.¶*
- *•→ Effective·communication·between·primary·care·and·specialty·care/community·based· organizations· is· key· to· providing· optimal· patient· care· and· to· eliminate· the· waste· and· excess·costs·of·health·care.¶*
- *•→ Mutual·respect·is·essential·to·building·and·sustaining·a·professional·relationship·and·*

¶

Patient·Referrals·¤	
Mutual·Agreement¤	
• Maintain·accurate·and·up-to-date·clinical·record.¶ • Agree·to·standardized·demographic·and·clinical·information·format.¶ • Ensure·safe·and·timely·referral·of·a·prepared·patient.¶ • Ensure·safe·and·timely·updates·on·patient·enrollment·status.¤	
Expectations¤	
Primary·Care¤	COAW¤
☐ PCP·maintains·complete·and·up-to-date·clinical·record·including·demographics.¶ ☐ Transfers·information·as·outlined·on·the·COAW·Referral·Form·or·through·the·COAW·website.¶ ☐ Informs·patient·of·need,·purpose,·expectations,·and·goal·of·the·referral.¶ ☐ Provides·patient·with·COAW·provided·information·and·expected·timeframe·for·contact.¶ ☐ Provides·COAW·with·a·single·referral·contact·person·for·the·PCP.¤	☐ Confirms·receipt·of·referral·and·patient·eligibility·on·a·weekly·basis·via·HIPAA·compliant·communication.·¶ ☐ Provides·single·source·referral·contact·person·for·the·PCP.¶ ☐ Provides·single·source·referral·contact·person·for·the·patient.¶ ☐ Contacts·the·referred·patient·by·the·end·of·the·following·business·day.¶ ☐ Provides·staff·training·and·support·on·making·referrals·to·self-management·programs.¶ ☐ When·PCP·is·uncertain·of·patient·appropriateness,·will·assist·PCP·prior·to·the·referral.¤

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Implementing Healthcare Changes • Transforming Prevention and Wellness

- Home
- Our Mission
- New Visions in Aging
- All About COAW
- Classes for the Public
- The Academy
- Registration
- Newsletters
- Refer Your Patient
- Contact Us

Choose text size A A A




Bringing COAW to You

Have questions? Whether by webinar or in person at your site, our COAW expertise, trainings, or speakers are available to you and your organization. *click for more...*

Preventing Falls

New techniques, trainings, and best practices in Falls Prevention including information on our new **Community Falls Prevention Specialist Certificate.** *click for more...*

Refer Your Patients

Classes in Chronic Disease Self-Management for your patients are just a couple of clicks away. *click for more...*

Community Connections

Colorado's new Statewide CDSMP Collaborative is creating a buzz. *click for more...*

Embedding Self-Management in a Medical Practice

Implementing CDSMP in a PCMH

Register now for this new 2-day workshop to be held in Lakewood, Colorado June 1-2, 2013. A Pre-Workshop Virtual Site Visit is included on May 31, 2013.

Click for details...

Register by clicking the REGISTRATION tab.

May 30 - June 4, 2013 is the next **Academy for Older Adult Wellness.**

Click for details...

Register online by clicking the REGISTRATION tab from the menu bar on the left or print the registration form here for fax or mail. *click for more...*

AUTHORIZED IACET PROVIDER

Consortium for Older Adult Wellness

changing healthcare to include prevention and wellness

Choose text size

A A A

Choose A Method:

All Three Methods Are HIPAA-Compliant

EHR - Electronic Health Records

If your practice has an EHR system, simply use it to generate the referral, and send it to our secure email address:

Referral@Secure.COAW.org

FAX

If you would like to fax the referral, click this button to get the form:

Download the Form

Fill out the form, then fax it to:

303-984-5962

Online

To enter the referral online, click the button:

Enter Referral Online

Referral Form

Healthier Living Colorado™
a self-management class for your patients with chronic conditions

Fax Referrals to: 303-984-5962
Questions? Lynnzy@COAW.org or 303-475-2183

PATIENT INFORMATION

Patient Name_____

Date of Birth ___/___/____ Gender ☐ Male ☐ Female

I understand that COAW will inform my provider about my participation in Healthier Living Colorado™.

Patient Signature _____ Date _____

Address _____

City _____ State ____ Zip Code _____

Best Phone number to reach you: _____

Best time of day to contact you: _____

May we leave a message ☐ Yes ☐ No

Language ☐ English ☐ Spanish Other (specify) _____

Type of Insurance _____

PROVIDER INFORMATION

Provider Name: _____ Email: _____

Clinic: _____

Phone: _____ **Fax:** _____

Referral Log

Tue May 14 1:22 PM

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HLC Referral Log

Participant	Address	Enrolled	Calls	
Chicken, Spring	222 Skippy Court YoungAtHeart, CO 00007 111-111-2222 111-222-2323 Born 05-10-2045		05-06-2013 Josh	No Answer.
			05-10-2013 Josh	No Answer.
Doe, Jane	456 Healthy Circle FiberTown, CO 00001 970-970-9707 970-970-9000 Born 04-06-1950		05-06-2013 Josh	Discussed class. Would like call back tomorrow morning.
			05-07-2013 Josh	Called back. Left voice mail.
			05-09-2013 Josh	Left voice mail regarding class.
Doo, Scooby	9951 Food St. SnackTown, CO 00003 000-000-0000 Born 05-01-2044	05-10-13 Sunrise Loveland Community Health Center	05-07-2013 Josh	Scooby was eating and said he would call back. Left name and number to reach me.
			05-06-2013 Josh	Left voice mail re: class.
			05-10-2013 Josh	Discussed nutrition topics. Scooby expressed concern with his health and registered for class.
Jetson, George	554 Super Ave. SugarTown, CO 00002 970-970-9705 970-970-9708 Born 01-01-1940	05-10-13 Sunrise Loveland Community Health Center George is bringing his wife, Jane.	05-07-2013 Josh	Left Voice Mail re: class.
			05-09-2013 Josh	George registered for class and would like to bring his wife.
Winter, Oldman	8888 Brr Street ColdTown, CO 80008 111-111-1111 112-112-1122 Born 06-07-1977		05-07-2013 Josh	Left Voice Mail re: referral to class.
			05-09-2013 Josh	Left Voice Mail re: referral to class.

Feedback Form

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My Name Mary Smith **Today's Date** January 8, 2012

Dear Health Care Providers,

I wanted to let you know that I have been attending the **Healthier Living Colorado™** class to help me better manage my own health. Today we are in our final class of the 6 weekly sessions and we are sending you our thoughts about our chronic conditions, taking care of ourselves, and what we want our Health Care Providers to know about what we are learning and doing.

What I have learned about my health is:
This isn't going to go away just because I take a pill three times a day. I can make some changes in how I deal with the pain. Eating a few more fruits has helped my digestion.

I didn't know that my chronic condition was affected by:
Worrying about what I can't do won't help me any. I need to fix my sights on what I enjoy doing. I am working on being more positive. It has been nice to talk with others with similar concerns.

The things that have helped me the most to manage my chronic conditions are:
Exercising a little more has helped my knees. I am going to keep with it and maybe take a water exercise class. I've been using a pill box so I keep track of when I am taking the pills better—I didn't know it would hurt me to skip some.

My Action Plan for the next six months is:
Long term goal:
This is my life and I want to stay as healthy as I can for as long as I can. I want to lower my blood pressure so I can be here to see my grandkids graduate from college

Specific action step:
Walk with a neighbor to the library and back.

How much/often? *3 times a week* **When?** *Monday, Wednesday and Saturday*

Confidence Level (0-10): *9*

COAW will forward this letter to your provider listed below:
My health care provider's name and address is: Dr. Smart 1234 Main St. Denver 80202

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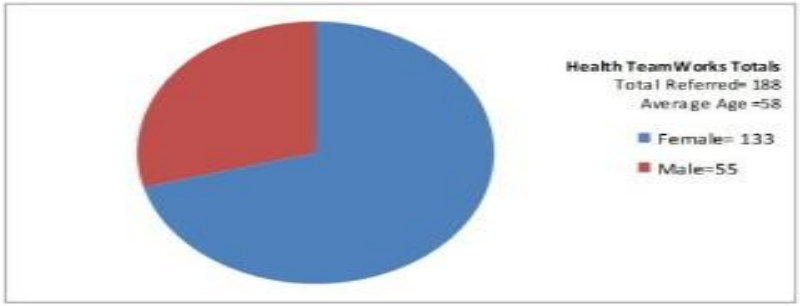
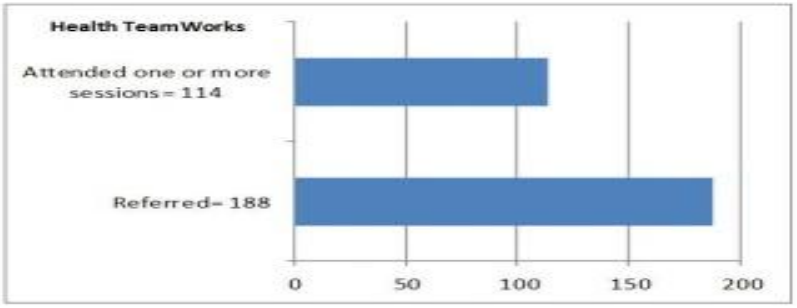
2575 S. Wadsworth Blvd. Lakewood, CO 80227 888-900-COAW(2629) Fax: 303-984-5962 info@COAW.org

Sample Practice Report

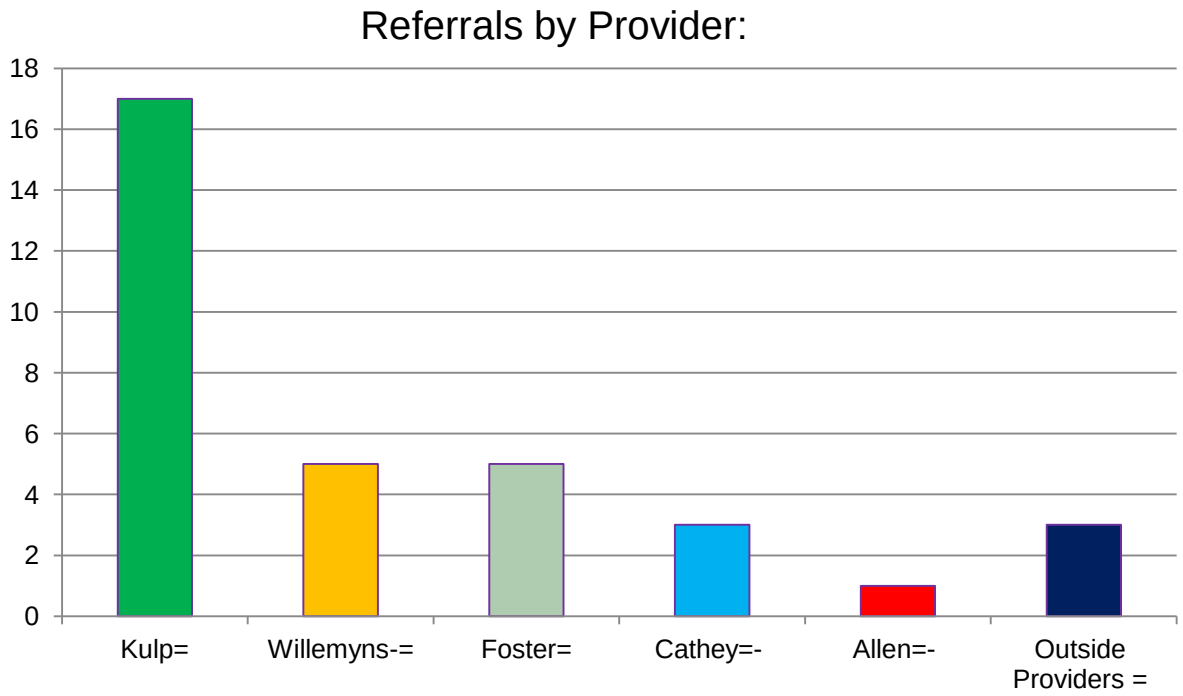




AgeWell Medical Associates Class Summary

- Referrals: 34 total referral names were faxed to COAW by March 2013
  - 11 responded YES to the April class;
  - 7 responded YES to the May class;
  - 6 responded YES to March class

- 71% return on referrals



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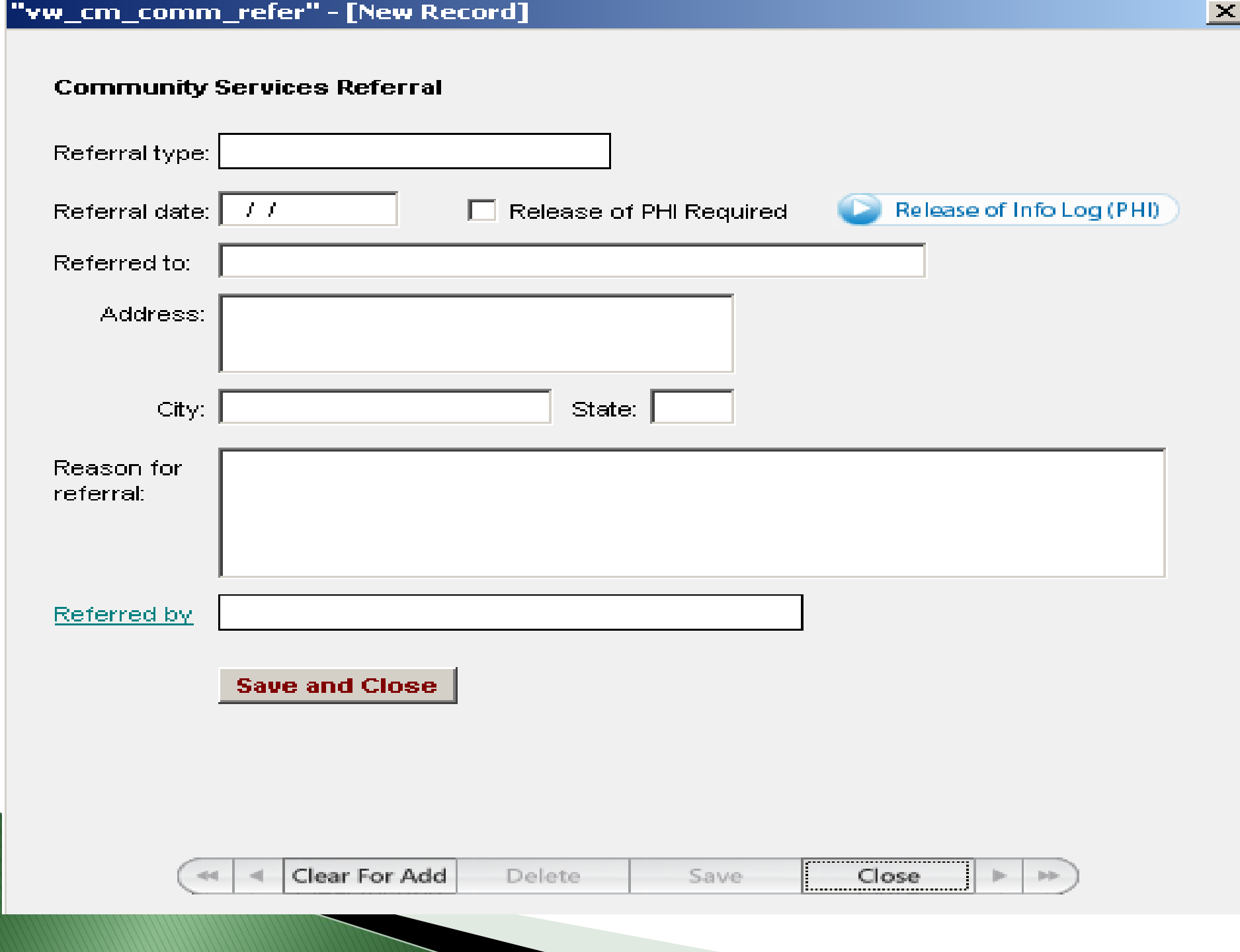
"vw_cm_comm_refer" - [New Record]
Community Services Referral
Referral type:
Referral date: / /
Release of PHI Required
Release of Info Log (PHI)
Referred to:
Address:
City:
State:
Reason for referral:
Referred by
Save and Close
Clear For Add
Delete
Save
Close

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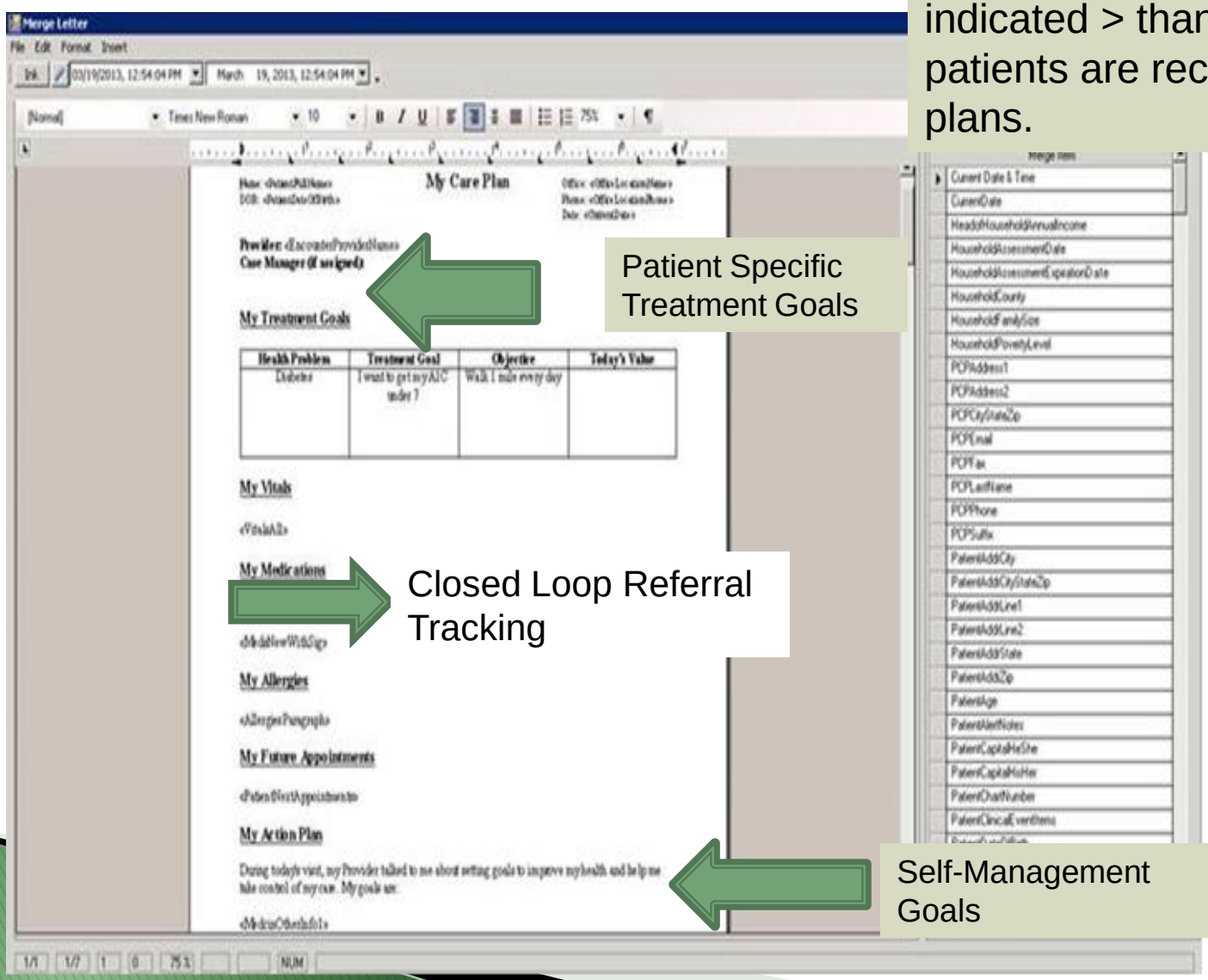
colorado communityhealth network

Plains Action Plans

Most recent report indicated > than 60% of patients are receiving care plans.



Stages of Readiness

- State Health Department
- Community Based Organization Level
- Health System Level
- Practice Level

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Work Flow and Work Style

- How much time do you need to get a class in place?
- How much will a class cost?
- How many referrals can you handle?

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Explanation of Homework Assignment

- Are you currently involved in a live referral system?
- Do you have partnerships in place to help develop or expand a referral system?
- What do you see as your role in making a referral system successful?
- What additional support do you need to develop or expand referral systems?
- What can you explore or pursue between now and January 7th?

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Action Plan for December

- What do you want to do?
- Is it achievable?
- When, where, how much?
- How sure are you that you can get this step done on a scale of 1-10?

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Lynnzy McIntosh

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