HIMSS

Continuity of Care Guide
for Ambulatory Medical Practices

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Purpose: *This guide serves as a reference and check list for practice*

- Identify evidence-based guidelines of care.
- Define the work we do in our practice to ensure that patients receive care according to the evidence-based guidelines of care we select to follow.
- Identify who in our practice does the work.
- Define titles and create or update corresponding position description.
- Create or edit corresponding protocols.
- Evaluate health information technology - EHR, Registry and/or Population Health Management Systems.

Who might use this guide:

- Practice leaders and managers - clinical and operations
- Quality Improvement staff
- Care coordinators, case managers, referral managers

Introduction:

Health care reform[1] and CMS[2] reimbursement innovation strategies have increased incentives for practices to shift from volume-based reimbursement to value-based care. This shift requires a focus on population-based management, preventive care and continuity of care. Value-based payment methods will focus on care management, quality outcomes and patient-centered medical home criteria. Practices that participate in Accountable Care Organizations (ACO) must also understand the inter-dependence of HIT applications to leverage optimal continuity of care.

This Continuity of Care Guide (CCG), developed by the HIMSS Continuity of Care Task Force, will help ambulatory care practices optimize Health Information Technology (HIT) and Electronic Health Records (EHR) capabilities to support the continuity of care for patients. The CCG will help your primary care practice develop a foundation of basic care planning for patient transitions of care and hand-offs with specialists and other providers.

The CCG builds on industry work, such as eHealth Initiative (eHI) Care Coordination project and recent report: *"Centering on the Patient: How Electronic Health Records Enable Care Coordination"* [3]. This project identified gaps in care coordination between primary care medical homes and specialists in an effort to identify and build tools that would address those areas. Two key objectives of the eHI Care Coordination project are also priorities for many HIMSS Members:

1. Enhance cross-provider communications with a focus on primary care practices
2. Support improvements in the quality, safety and efficiency of care, with electronic tools

Focus:

By focusing on the major aspects of continuity of care in an ambulatory practice (including Meaningful Use and medical home measures), this guide is designed to facilitate team-based care coordination and provide guidance in four practice management areas:

1. Staff training on care coordinator roles and responsibilities
2. Work flow process redesign to increase office efficiency
3. Identifying and ensure evidence-based standards of preventive and chronic disease care are followed
4. Determine the planning process to optimize Electronic Medial Record (EMR)/EHR capabilities or functional requirements for continuity of care and how to discuss with theses with vendors

While the eHealth Initiative recognized that nurses and allied health professionals perform most care coordination functions in a primary care practice, this guide will help your practice map current responsibilities and identify potential gaps in practice workflow or staff capabilities. This tool will help to create an infrastructure for:

- Care integration across multiple practice settings
- Population-based care management
- Leveraging HIT for continuity of care and improve quality of care

Please consider additional documents at http://www.himss.org/ASP/topics_FocusDynamic.asp?faid=191 as you begin or continue your efforts to ensure continuity of care for your patients and families.

This guide will be updated annually.

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[1] *http://www.healthcare.gov/*

[2] *Centers for Medicare and Medicaid Services, www.cms.gov*

[3] *http://www.ehealthinitiative.org/issues/care-coordination/care-coordination-report.html*

ROLES AND RESPONSIBILITIES		PCMH		PAYER/ACO	PCMH NEIGHBOR		NCQA	MEANINGFUL USE
Tasks - 'x' indicates responsible role	**Patient**	**PCP**	**Care Coordinator**	**Central Care Coordinator**	**Specialist**	**Care Coordinator**		
General assessment of patient's health, wellness, readiness/ability to learn	X	X			X			
Assessment of patient's medical problems	X	X			X			
Medication reconciliation - At each visit and transition of care; give patient copy	X	X			X			X
Tests and Procedures								
Coordinate laboratory and diagnostic testing ordered by the PCP and Specialist with the patient	X		X			X		
Track: results received			X			X		
Communicate with Patients		X	X		X	X		
Coordinate additional testing with PCP Avoid duplication and other inefficiencies						X		
Appointments								
Set time interval for next appointment		X			X			
Follow up to ensure patient has appointment at set interval	X		X			X		
Patient Centered Medical Home - Population Management								
Identify evidence-based clinical guidelines/ best practices of care and corresponding outcomes measures/gaps in care		X	X	X				
NCQA Standards: 3 chronic care services, 3 preventive care services		X	X	X			X	Stage 2 Core
Set up and follow process to deliver care following guidelines/ best practices and risk stratification			X	X			X	
Identify populations of patients for each chronic care and preventive care service (see sheet: Pro-Active Work with Patients)			X	X			X	
Recall those in need of service; track recall or systems reminders	X		X	X				Stage 2 Core
Use a CQI approach to continuously evaluate process, identify barriers, and propose process improvement strategies to enhance PCPC/PCMH model of care		X	X				X	
Demonstrate continuous quality improvement - set target goals; track and report outcomes measures		X	X	X			X	

ROLES AND RESPONSIBILITIES		PCMH		PAYER/ACO	PCMH NEIGHBOR		NCQA	MEANINGFUL USE
Tasks - 'x' indicates responsible role	**Patient**	**PCP**	**Care Coordinator**	**Central Care Coordinator**	**Specialist**	**Care Coordinator**		
Referrals								
Track referral to ensure appointments are scheduled and kept; information is sent to specialist; approval is received from payer (as needed) and consult report received	X		X				X	X
Ensure information is received from PCP and consult report sent to PCP			X			X		
Coordinate with PCP if patient does not keep appointment and does not reschedule	X		X			X		
Coordinate secondary referrals with the PCP			X			X		
Patient Self Management - Engage Patient and Families								
Provide clinical summaries/personal health notes for patients for each office visit.	X		X	X		X		X
Offer resources/references - supplemental learning materials, referral to community resources, web sites			X			X		

PRACTICE PROACTIVE WORK WITH PATIENTS CONTINUITY OF CARE MAY INCLUDE PROACTIVE WORK WITH PATIENTS TO ENSURE THEY RECEIVE:	
Prevention/Screening	
	Annual Visit
	Breast Cancer
	Cervical Cancer
Immunizations	
	Influenza
	Pneumonia
	HPV
Osteoporosis	
	Bone Density
Disease Management	
Congestive Heart Failure	
	F/U Visit Frequency
	ACE/ARB/Beta Blocker Therapy
Coronary Artery Disease	
	F/U Visit Frequency
	Anti-platelet Therapy
Diabetes	
	F/U Visit Frequency
	HgA1c frequency
	HgA1c Level Control
	BP Level Control
	Eye exam
	Foot Exam
Hyperlipidemia	
	F/U Visit Frequency
	LDL Frequency
	LDL Level Control
Asthma	
	F/U Visit Frequency
	Appropriate Pharmacologic Therapy
COPD	
	F/U Visit Frequency

HIT EVALUATION FOR CONTINUITY OF CARE WORK		
	EHR System	**Population Health Management System**
Registry Reporting		
Create a report for a defined population of patients with one variable. *Example: Patients with diagnosis of diabetes, variable - no HgA1c within x time period*		
From the initial report, create a report of a sub populations with another variable *Example: Identify those with HbA1c >9*		
Create a report of a defined population of patients with multiple variables *Example: Active patients with diagnosis of diabetes; displaying % with HgA1c, LDL and BP values within defined ranges.*		
Sub populations of above search stratified by age, gender, race, ethnicity and/or payer.		
Communicate with Patients		
Communicate with individual patients - one at a time *Example: Patient with change in BP medication, check in 3 days later to see how they are doing*		
Letters		
Emails		
Text		
Phone		
Automatic batch communicate with defined group of patients in report *Example: Identify active patients haven't had flu shot in past 10 months; age x to y and a to b;*		
Letters		
Emails		
Text		
Phone		
Recall populations of patients		
Create a recall campaign for defined population of patients *Example: At regular intervals, query for patients in need of annual exam or well child exam*		
Track and report number of letters, emails and text's sent		
Method to identify non-responders		
Send 2nd and 3rd letter, email or text at prescheduled intervals to non responders		
Able to track action taken related to communication (i.e. appointment made, test completed)		
Alert or Reminders		
Set reminders or alerts for specific patients		
Set up reminders or alerts for populations of patients		

HIT EVALUATION FOR CONTINUITY OF CARE WORK		
	EHR System	**Population Health Management System**
Referral Management		
Create referral and send to specialist, etc. - print and mail or fax		
Record and track status of referral		
Batch processes - identify referrals by variable in order to work like referrals *Example: Identify all outstanding referrals pending authorization by Blue Shield* *Example: Identify all referrals for mammogram who have an appointment on previous date to today and no result received and it's been a week*		
Create report to track referral statistics (i.e. Referred by; Referred to; Payer; Dates of Referral)		
Support Pre-planning for clinic/practice session		
Identify populations of patients scheduled for session by chronic disease or condition		
Identify outstanding care or care that is due for each patient		
Print condition/diagnosis specific patient summary - data related to agreed upon standards of care indicators		
Set up 'Tracking Types' - assign management protocol based on specific criteria *Example: Patients with diabetes and measures associated with agreed upon standards of care*		
Patients automatically included in 'Tracking Type' based on criteria (e.g. diagnosis, age/gender)		
See overdue protocol indicators for entire population included in 'Tracking Type'		
Population Health Supervisor/Manager		
Assign tasks and see status of tasks by person assigned		
Print visit summary		
Referral		
Follow-up		
Recall		
Abnormal test results		
Correspondence - letters, emails		

HIT EVALUATION FOR CONTINUITY OF CARE WORK		
Skill Level for Reporting	**EHR System**	**Population Health Management System**
Patient Search and Query		
Skill level to write Patient Search Query		
Skill level to run Patient Search Query		
Ease of producing follow-up Patient Search Query		
Ability to run query without slowing the system down		
User reported reporting limitations		
Reporting on Populations of Patients - Advanced		
Skill level to write reports		
Skill level to run reports		
Ease of producing follow-up report		
Setting and displaying goals for each measure		

Sample Use Case

Closing the Loop: Continuity of Care Within and Between Practices

The following sample case focuses on the work that happens in a primary care practice to ensure that patients receive chronic disease and preventive care according to nationally recognized standards of care. The case is by no means comprehensive and users are encouraged to discover uses of the HIMSS tool that work best for them. It is intended as an illustration of the way the HIMSS tool, "Continuity of Care Guide Within and Between Practices", can be used.

For the use of this tool and sample case, "Continuity of Care" is the work done to ensure patients receive chronic disease and preventive care within the medical office. The continuum of care across other settings, such as when a patient is admitted to the hospital or sees a specialist, is not addressed in this guide and will be considered for a companion tool in the future.

The Internal Medicine/Family Practice Office

Case: Pinebrook Medical Group is a medium-sized internal medicine practice operating with two physicians, one nurse practitioner, two nurses (LPNs) and two medical assistants. The front office staff includes a practice manager and two office support staff for managing patients arriving, leaving, and billing matters. Two major incentives have prompted the adoption of an Electronic Health Record (EHR): the CMS Meaningful Use initiative[2] and a local insurer's incentive for achieving NCQA[3] Patient Centered Medical Home (PCMH) recognition. The HIMSS companion tool to this case helps them identify tasks that perhaps were not done in the past, redefine some roles, responsibilities and corresponding job descriptions, and restructure workflows – all necessary to develop the infrastructure for participation in these incentive programs and receive associated revenue.

Ensure Continuity of Preventive and Chronic Disease Care

Much of chronic disease and preventive care is routine and can be delegated by the primary care provider to their care team members to initiate, monitor and ensure it is done. This frees valuable provider time for those tasks and decisions only they are qualified to do and/or make.

Getting Started: Forming teams around key conditions

The practice agrees there will be three care teams, each with a provider as lead and one LPN or medical assistant assigned to a team. This team works together for the care of their panel of patients. One LPN or medical assistant floats, assisting teams as needed.

- The three providers meet and agree on standards of care that govern the most common chronic diseases managed in the office – diabetes mellitus (DM), hypertension (HTN), coronary artery disease (CAD), chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), congestive health failure (CHF) and preventive care services.
- Working with the EHR vendor, they made sure key elements of the standards are accessible and easily identifiable when documenting a patient encounter.
- They identify the corresponding outcomes measures for managing these conditions and preventive care services (i.e. how the practice knows whether the standards of care are met for the applicable patient; a lab value, immunization or referral completed by patient).
- Protocols of care are designed so that routine care can be delegated to the nurses and medical assistants by providers.
- Care team members are educated regarding the agreed upon standards of care, corresponding protocols and the roles and responsibilities of each team member including training for front office staff and appointment scheduling.
- Workflows are mapped out and staff trained regarding the following:
  - Pre-visit planning huddle – at least 15 minutes for each session
  - Chronic care periodic visit
  - Preventive care/annual visit

[2] *https://www.cms.gov/EHRIncentivePrograms/*
[3] *National Committee for Quality Assurance: http://www.ncqa.org/*

- Lab and diagnostic test and procedure results management
- Referral management
- Medication reconciliation and refill processes
- Same day appointments and group visits

- Position descriptions are updated to reflect these changes and assure that all staff participates in making suggestions for continuous improvement.
- Monthly all staff meetings are started to share learning experiences across the care teams, encourage continued training, reward excellent performers and celebrate early success stories.

Closing the loop: Using monitoring tools effectively

Before the patient visit…

- The nurse or medical assistant on each team uses the EHR, Registry and/or a Population Health Management (PHM) system to identify what is due for each patient with a chronic disease as well as any needed preventive care services in the next session.
  - The EHR or PHM may generate lists of patients scheduled for the next session, including services due or overdue.
  - The patients health plan may provide care alerts/reminders for chronic conditions and preventive services that appear as a "pop-up box" when eligibility is checked (a multi-payer web portal).
  - If the list does not include what is due, each patient's record may need to be reviewed in order to identify services due or overdue according to the practice's agreed upon standards of care.
- The care team uses this information in their pre-visit huddle, to prepare for and ensure services are received.

When tests are ordered…

- Tests, procedures and referrals are ordered following the standards of care, protocols and workflows.
- The nurse or medical assistant on each team tracks outstanding orders to monitor that results of tests and procedures ordered and reports for referrals are received.
  - The EHR and/or PHM may be used to support this tracking.
  - Referral management may include obtaining prior authorization from the payer, coordinating with the specialist and the patient for appointment times and any further testing needed, and obtaining report from specialist on time.

When visits are missed…

- The nurse or medical assistant on each team routinely runs registry queries in the EHR or PHM to identify and contact (mail, email or telephone) patients due for or missing key services or appointments.
- These patients are tracked to determine those that do not respond to an initial contact and, depending on the service a second contact is made (i.e. women due for annual cancer screening.)

By this point, you've identified many of the ways that your practice needs to change in order to ensure that the patients you partner with receive care according to nationally recognized evidenced based guidelines of care. We envision that your practice no longer relies solely on the primary care provider to identify and track what each patient with a chronic disease and those needing preventive care need. It takes a team, led by the primary care provider, and partnering with the patient to ensure continuity of care.