MiCMRC Self-Study Module

The Medical Neighborhood

The Michigan Care Management Resource Center

Medical Neighborhood Learning Objectives

- Describe a Medical Neighborhood and the goals of a Medical Neighborhood
- Identify the Functions of a High Functioning Medical Neighborhood
- Knowledge of the Potential Barriers to a High Functioning Medical Neighborhood

Medical Neighborhood Defined

Clinical-community partnership that includes the medical and social supports necessary to enhance health, with the PCMH serving as the patient's primary **"hub"** and coordinator of health care delivery.

https://www.pcpcc.org/content/medical-neighborhood

Goals of a Medical Neighborhood

- The goals of a high-functioning PCMH include collaborating with these various “medical neighbors” to encourage the flow of information across and between clinicians and patients, to include specialists, hospitals, home health, long term care, and other clinical providers.

- Actively promote care coordination, fitness, healthy behaviors, proper nutrition, as well as healthy environments and workplaces.

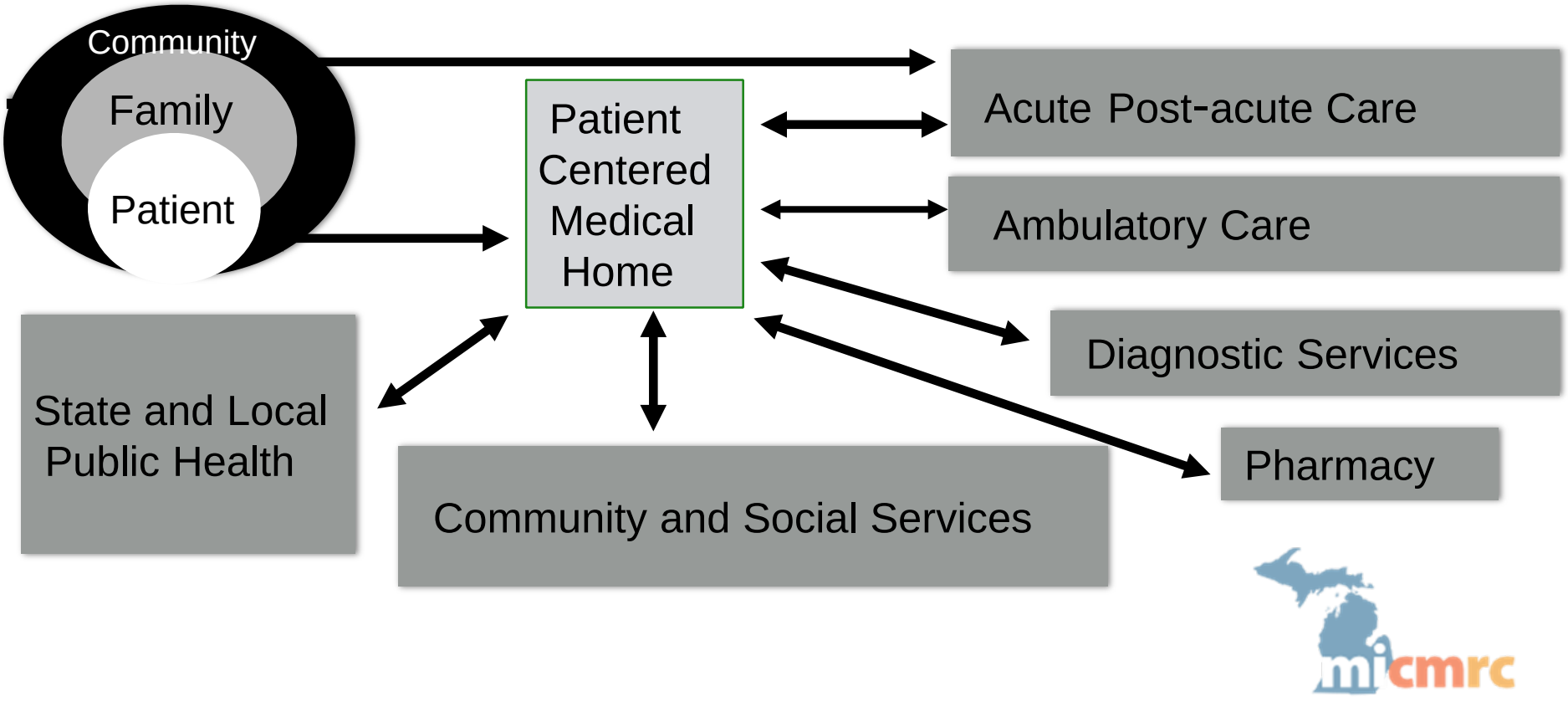
- Focus on meeting the needs of the individual patient, but also incorporate aspects of population health and overall community health needs.

https://www.pcpcc.org/content/medical-neighborhood

Examples of Medical Neighbors

- Specialists
- Hospitals
- Home health
- Long term care
- Community centers
- Faith-based organizations
- Schools
- Employers
- Public health agencies
- YMCA's
- Meals on Wheels

Key Actors and Flow of Information in the Medical Neighborhood



A High Functioning Medical Neighborhood

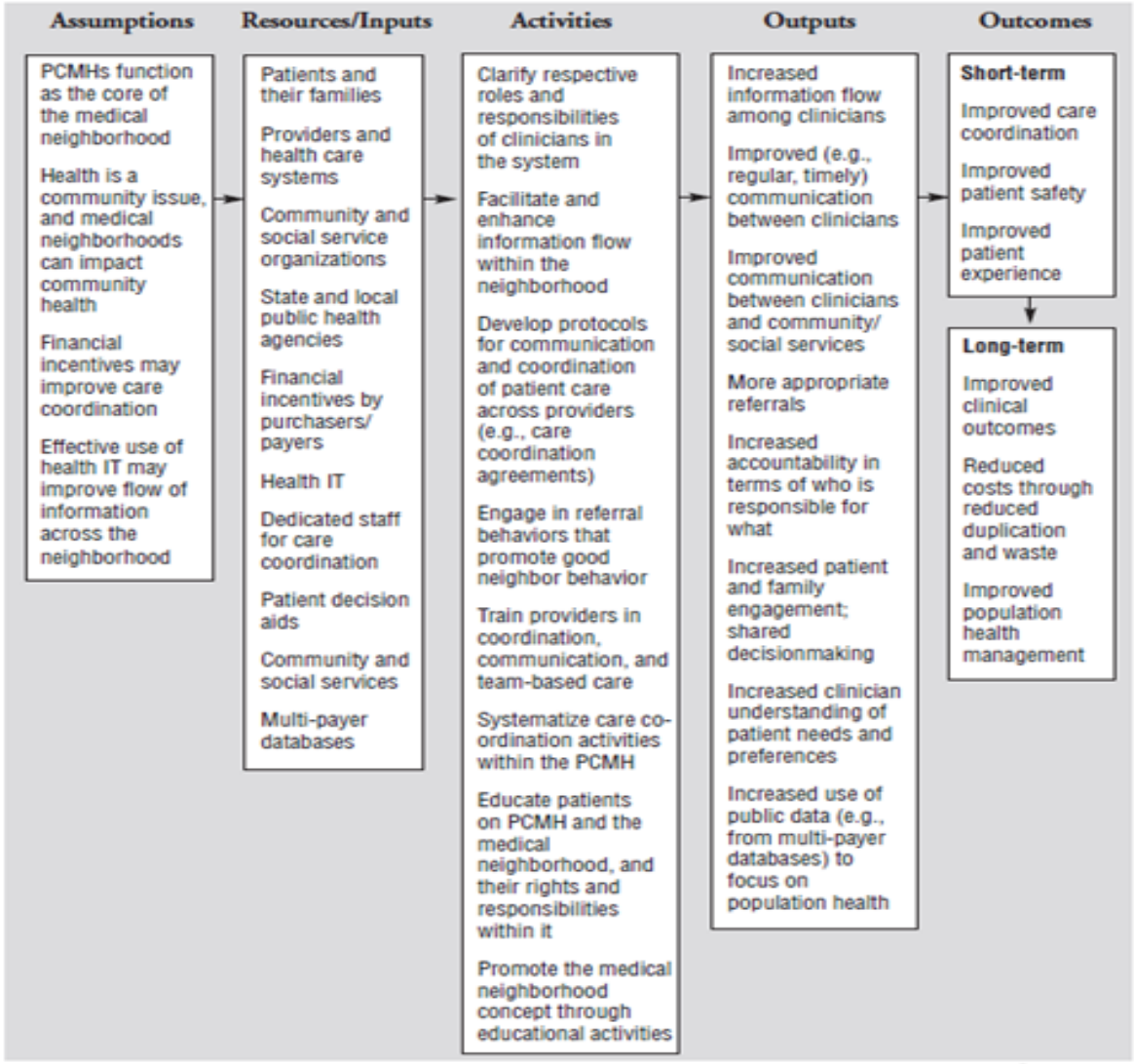
- Ensure effective communication, coordination and integration with PCMH practices
- Ensure efficient flow of information, including timely consultations and referrals
- Effectively guide the determination of responsibility in co-management situations
- Support enhanced access and patient-centered, high-quality care
- Provide full person primary care

http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog/specialists/participating-in-pgip.html

Desired Outcomes of a Highly Functioning Medical Neighborhood

- Improved Patient Outcomes
- Patient Safety
- Patient Experience
- Right Cost, Right Time, Right Place for Care
- Delivery of Evidence-based Care and Improved Population Health

Outcome Goals



Coordination of Care

- Specialist notify primary providers (PCP) of routine care needs after surgery or course of treatment
- PCP's make appropriate referrals and provide specialist with appropriate background, data, and goals of the consultation
- Hospitals notify PCP's when their patients are in the hospital or visit the ED
- **Overall, PCP's and other team members assist in coordinating care, help the patient navigate in the complex healthcare system, and ensure treatment plans of different specialist work together as a whole**

Barriers to a High Functioning Medical Neighborhood

- No (or few) financial incentives or requirements for care coordination
- Lack of staff and time for investment in coordination (at the practice and broader community levels)
- Limited Primary Care Clinican involvement in inpatient care
- Fragmented, diverse services, rather than an integrated delivery system
- Limited financial integration across most providers
- Limited health IT infrastructure and interoperability
- Practice norms that encourage clinicians to act in silos rather than coordinate with each other
- Complexity of coordination for patients with high levels of need and/or frequent self-referrals
- Patient self-referrals about which the PCMH is unaware
- Misperceptions regarding HIPAA provisions and limits to information exchange

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https://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms-table-1

Strategies to Improve the Medical Neighborhood

- Workforce/Workflow Approaches (All Clinicians)
  - Dedicated care coordination staff in the PCMH
  - Systematizing care coordination activities within the PCMH
  - Getting Primary Care Clinician's more involved in inpatient care

https://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms-table-2

Strategies to Improve the Medical Neighborhood

- Referral Practices and Care Coordination Among Clinicians (Primary Care Clinicians)
  - Referring to good neighbors
  - Appropriate referrals
  - Referral tracking systems
  - Establishing care coordination agreements

https://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms-table-2

Strategies to Improve the Medical Neighborhood

- Patient and Family Engagement and Education (All Clinicians, Patients, and their Families)
  - Patient education (through print or other materials) on medical home approach, referral process, etc.
  - Discussions with patients about their responsibilities in the PCMH
  - Use of decision aids about treatment options
  - Incorporating patient perspectives in the medical neighborhood

https://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms-table-2

Measuring Success

Performance Measure	Relevance to the Medical Neighborhood
Structural measures Evidence of the meaningful use of health IT, such as electronic medical records (EMRs), e-prescribing, or health information exchange Evidence of care coordination agreements between clinicians	Provides evidence that physician practices in the medical neighborhood have the capacity for enhanced communication and access to patient information through health IT Provides evidence that clinicians are aware of who their "neighbors" are and have jointly developed proactive approaches for sharing information and care responsibilities
Process measures Development and implementation of care plans Frequency of communication with other clinicians Transfer of appropriate patient history and lab information upon referral to specialist by PCCs Timeliness and quality of consultation notes by specialists to PCCs	Provides evidence that practices are developing care plans for patients and providing communication to other clinicians to enhance care coordination in the medical neighborhood Moves beyond structural measures of capacity (above) to assess whether adequate information flow and sharing of care responsibilities actually occurs for individual patients
Appropriateness, Overuse, or Efficiency measures Duplication of services Provision of unnecessary/ efficient services	Indicates the extent to which clinicians can share existing lab and imaging results rather reordering tests based simply on current convenience Provides evidence that clinicians share all relevant clinical information and best practices to avoid unnecessary services
Outcome measures Rates of hospitalizations for ambulatory sensitive conditions Rates of preventable readmissions	More highly functional medical neighborhoods with improved care coordination should achieve lower rates of preventable hospitalizations and readmissions
Patient experience measures Patient reports on care coordination Patient reports on care transitions	Patients in well-functioning medical neighborhoods should be more likely to report care coordination and care transition management efforts

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https://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms-table-4

Patient Centered Medical Neighborhood

Michigan Care Management Resource Center Website micmrc.org

Care Management 101 is a web based self study opportunity

- a suggested road map of staged content for the new Care Manager
- may be utilized to create customized curriculum for self-study based on the CM's self-assessment
  - Care managers may identify their areas of strengths and gaps
  - Review CM 101 content to select recorded webinars, tools, resources

Access Care Management 101: www.micmrc.org

Access your specific program information

View CE approved Webinars

Share your success as a care manager and practice team

View best practice stories and tools

View multiple webinars on various clinical topics

Michigan Care Management Resource Center Website micmrc.org

Topics for Care Managers Include:

- Advance Care Planning
- Palliative Care
- Pediatrics
- Medication Management
- Transitions of Care
- Patient Centered Medical Home & Team Based Care
- Chronic Conditions
- Quality and Population Health Management
- Elderly Population
- Behavioral Health

Thank You!

- Questions?
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