

# Section 1: Structure a Comprehensive Onboarding Process

Improving PCP Referrals to Care Management Toolkit

# Population Health Advisor

## Project Director

Eric Sun

## Contributing Consultants

Arman Terzian

## Project Editor

Christina Wild, JD

## Program Director

Megan Clark



### Improving PCP Referrals to Care Management Four-Part Series:

1. Structure a Comprehensive Onboarding Process
2. Demonstrate and Communicate the Value of Care Management
3. Streamline PCP Referral Process
4. Establish Two-Way Feedback with PCPs

This toolkit is part of a custom project to refine care management program design. For more information, please contact us at [PHA@advisory.com](mailto:PHA@advisory.com).

#### LEGAL CAVEAT

The Advisory Board Company has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and The Advisory Board Company cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, The Advisory Board Company is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member's situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither The Advisory Board Company nor its officers, directors, trustees, employees and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by The Advisory Board Company or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by The Advisory Board Company, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

The Advisory Board is a registered trademark of The Advisory Board Company in the United States and other countries. Members are not permitted to use this trademark, or any other Advisory Board trademark, product name, service name, trade name, and logo, without the prior written consent of The Advisory Board Company. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names and logos or images of the same does not necessarily constitute (a) an endorsement by such company of The Advisory Board Company and its products and services, or (b) an endorsement of the company or its products or services by The Advisory Board Company. The Advisory Board Company is not affiliated with any such company. Advisory Board Company is not affiliated with any such company.

#### IMPORTANT: Please read the following.

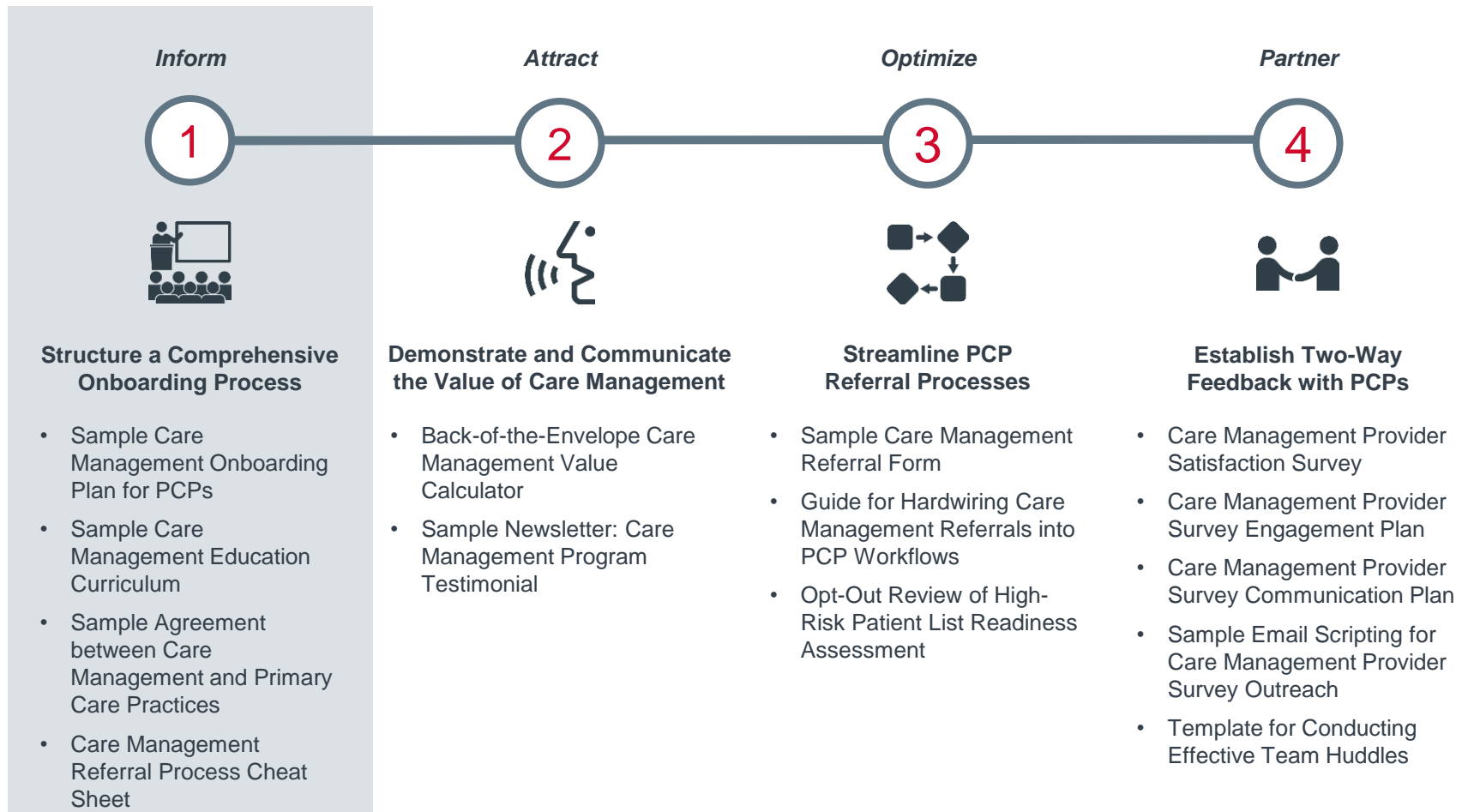
The Advisory Board Company has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the "Report") are confidential and proprietary to The Advisory Board Company. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. The Advisory Board Company owns all right, title and interest in and to this Report. Except as stated herein, no right, license, permission or interest of any kind in this Report is intended to be given, transferred to or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.
2. Each member shall not sell, license, or republish this Report. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.
3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.
4. Each member shall not remove from this Report any confidential markings, copyright notices, and other similar indicia herein.
5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.
6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to The Advisory Board Company.

# Strong PCP Partnerships Maximize Referrals to Care Management

## Integrate PCPs into Care Management Program in Four Key Steps

### Tools to Facilitate Effective PCP Education on Care Management and Improved Referrals



# Outline Goals of PCP Onboarding to Improve Effectiveness of Education

## Sample Care Management Onboarding Plan for PCPs

### TOOL OVERVIEW



#### Purpose

Design PCP onboarding process



#### Suggested Users

- Primary care or population health strategic leadership
- Care management leadership



#### Type of Tool

Overview and customizable framework for training



#### When to Use

- Initial program development and early planning stages
- Review annually to accommodate changes to the care management program

	Initiative	Completion Timeframe	Goals
<b>Staff Education</b> 	Update care management referral materials to reflect full spectrum of patient support services under the integrated model	<i>Up to 3 months</i>	A care management education program should foster awareness of the services care management provides and clearly define how care manager responsibilities will complement primary care services
	Develop curriculum for onboarding PCPs to care management process	<i>Up to 3 months</i>	
	Educate clinical and practice staff about the services care management provides to patients	<i>Up to 6 months</i>	
<b>Logistics</b> 	Provide care managers with total EMR access to review patient history, schedules, and facilitate communication with providers	<i>Up to 9 months</i>	Incorporate care management into the health IT infrastructure of the primary care practice to facilitate comprehensive documentation and streamlined referral processes
	Automate physician referrals to care management by building tasks in EMR that providers can send to care management staff	<i>Up to 9 months</i>	
	Develop shared patient care plan for care manager and physician	<i>Up to 3 months</i>	
<b>Workflow</b> 	Include care managers in staff meetings and team huddles	<i>Up to 1 month</i>	Integrate care management into practice culture and actively involve care managers in providing patient care and developing comprehensive treatment plans
	Organize regular meetings among care managers, physicians, and other staff to discuss difficult cases	<i>Up to 1 month</i>	



A customizable template for a PCP care management onboarding plan is available in the appendix.

# Focus Curriculum on Patient Eligibility, Referral Pathway

## Sample Care Management Education Curriculum

### TOOL OVERVIEW



#### Purpose

Guide care management curriculum planning for PCPs



#### Suggested Audience

- Primary care or population health strategic leadership
- Care management leadership



#### Type of Tool

Sample curriculum



#### When to Use

- Initial program development and early planning stages
- Update curriculum as care management program changes

Topics	Topic Overview	Sample Lessons
<i>Role and Function of Care Managers (CMs) in Primary Care Clinics</i>	Educate PCPs about the services care managers provide patients to facilitate optimal working relationships	<ul style="list-style-type: none"> <li>• Review the return on investment of care management</li> <li>• Review “a day in the life of a care manager”</li> </ul>
<i>Patient Eligibility for Care Management</i>	<ul style="list-style-type: none"> <li>• Review patient eligibility requirements, exceptions</li> <li>• Identify a designated clinic team member to ensure appropriate referrals</li> </ul>	Develop workshop on patient eligibility for care management; led by care management leadership and attended by PCPs and additional clinic staff
<i>Navigating the Care Management Referral Pathway</i>	After care management and clinic leadership agree upon referral pathways for staff members, review proper referral paths with primary care clinic staff	Care management leadership provides a workshop for the entire clinic team that outlines care management referral pathway for each staff type
<i>Integrating Care Management into the PCP Workflow</i>	Emphasize the importance of making the practice’s patient information system accessible to care managers, integrating care managers into team activities, and promoting care management services to eligible patients	<ul style="list-style-type: none"> <li>• Clarify schedule for care team huddles between PCPs, RNs, and care managers</li> <li>• Demonstrate educational tools and techniques care managers use to educate patients about care management</li> </ul>

### Multiple Avenues to Deliver Care Management Education to PCPs

#### Clinic-Wide Orientation



Care management director outlines details and expectations of care management program

#### Daily Huddles



Providers and care management team participate in huddles to review patients and referral criteria

#### Mentorship




Experienced PCPs or team members orient new staff to care management team and referral process

# Care Management Agreement Outlines PCP and Care Manager Responsibilities

## Sample Agreement between Care Management and Primary Care Practices

**TOOL OVERVIEW**

**Purpose**  
 Agreement that outlines care management and physician responsibilities in the integrated care team




**Suggested Parties**  


- Primary care physicians
- Primary care clinic staff
- Care managers

**Type of Tool**  
 Sample working agreement

**When to Use**  


- Throughout care management integration process
- Update agreement as care manager and PCP responsibilities change

Care Team Function	PCP/Clinic Staff Responsibilities	Care Manager Responsibilities	Practice Responsibilities
 <b>Patient Enrollment</b>	<ul style="list-style-type: none"> <li>❑ Identify appropriate patients for care management based on established care management eligibility criteria</li> <li>❑ Assess medical needs and collaborate with other clinical staff to develop care plan</li> </ul>	<ul style="list-style-type: none"> <li>❑ Provide initial contact with patient and review care management program service offerings</li> <li>❑ Assess social, behavioral, care coordination, and education needs</li> </ul>	<ul style="list-style-type: none"> <li>❑ Provide a space for care managers to work and meet with patients</li> </ul>
 <b>Patient Documentation</b>	<ul style="list-style-type: none"> <li>❑ Enter diagnosis and care plan into EMR or paper records for care management and other clinical staff to access</li> </ul>	<ul style="list-style-type: none"> <li>❑ Document patient care plan, medication changes, and psychosocial needs in the EMR or paper records</li> </ul>	<ul style="list-style-type: none"> <li>❑ Authorize care management team to access patient registries and medical health records</li> </ul>
 <b>Patient Care</b>	<ul style="list-style-type: none"> <li>❑ Include care managers in visits with patients who require care management services</li> <li>❑ Involve care managers in team huddles and discussions of challenging patients</li> </ul>	<ul style="list-style-type: none"> <li>❑ Meet regularly with providers</li> <li>❑ Coordinate care across the continuum</li> <li>❑ Provide patients with clinical education, focusing on self-management skills and medication adherence</li> </ul>	<ul style="list-style-type: none"> <li>❑ Support administration of patient satisfaction questionnaire and surveys of practice staff to identify opportunities to improve care management processes and patient experience</li> </ul>



A sample care management agreement from Lehigh Valley Health Network is available in the appendix.

# Each Primary Care Clinic Staff Member Can Help Identify Eligible Patients

## Care Management Referral Process Cheat Sheet

### TOOL OVERVIEW



#### Purpose

Provide an overview of care management referral pathways for different team members



#### Suggested Users

- Primary care or population health strategic leadership
- Care management leadership
- Practice managers



#### Type of Tool

Sample cheat sheet



#### When to Use

- Throughout care management education process
- Update as care team responsibilities change

A customizable template for a care management referral process cheat sheet is available in the appendix.

### Referral Guidelines



#### Primary Care Physicians

#### Patient Inclusion Criteria

Two inpatient admissions in 30 days, two ED visits in 30 days, using over five medications, multiple comorbidities, elderly or frail, or over six PCP visits in one year

#### Referral Step 1

Fill out care management referral form in EMR

#### Referral Step 2

Invite care manager to document patient-specific notes as needed (e.g., no air conditioning)

#### Referral Step 3

Discuss patient needs during bi-weekly care management huddle

#### Key Contact

Jane Doe, RN; 202-XXX-XXXX; [janedoe@healthsystem.org](mailto:janedoe@healthsystem.org)

### Referral Guidelines



#### Other Clinical Staff (RNs, SWs, MAs, PAs)

#### Patient Inclusion Criteria

Two inpatient admissions in 30 days, two ED visits in 30 days, using over five medications, multiple comorbidities, elderly or frail, or over six PCP visits in one year

#### Referral Step 1

Review care management eligibility with RN care manager

#### Referral Step 2

Fill out care management referral form in EMR

#### Referral Step 3

Notify PCP of care management referral via task in EMR

#### Key Contact

Jane Doe, RN; 202-XXX-XXXX; [janedoe@healthsystem.org](mailto:janedoe@healthsystem.org)

### Referral Guidelines



#### Non-clinical Staff (Receptionists, Schedulers, etc.)

#### Patient Inclusion Criteria

Two inpatient admissions in 30 days, two ED visits in 30 days, using over five medications, multiple comorbidities, elderly or frail, or over six PCP visits in one year

#### Referral Step 1

Review care management eligibility with RN care manager

#### Referral Step 2

Fill out care management referral in EMR

#### Referral Step 3

Notify PCP of care management referral via task in EMR

#### Key Contact

Jane Doe, RN; 202-XXX-XXXX; [janedoe@healthsystem.org](mailto:janedoe@healthsystem.org)






---

## Appendix

- PCP Onboarding Plan Template
- Lehigh Valley Health Network: Community Care Team Compact
- Care Management Referral Process Cheat Sheet



# Template for Care Management Onboarding Plan for PCPs

	Initiative	Development Timeframe	Goals
<b>Staff Education</b> 			
<b>Logistics</b> 			
<b>Workflow</b> 			

# Lehigh Valley Health Network: Community Care Team Compact

## Care Coordination and Care Collaboration Between Primary Care Practice (PCP) and Lehigh Valley Health Network (LVHN) Community Care Team (CCT) Guidelines for Participation

This understanding is designed to coordinate team roles between the PCP and the LVHN CCT to ensure high quality, efficient, collaborative care for identified patients.

### The Community Care Team (CCT) agrees to the following:

- Perform discharge follow-up calls to patients identified as high risk within 24-48 hours of hospital and or SNF stay.
- Document patient encounters in electronic medical record or paper record.
- Assess patient needs and barriers to optimize self-management.
- Provide two tiers of support: initial contact and ongoing planning.
- Complete an assessment of social, behavioral health, care coordination and education needs.
- Provide clinical education (disease process, medications, treatment, etc.).
- Coordinate care across the care continuum.
- Meet monthly with practice providers.
- Act as a resource for the development of the practice care manager/care coordinator.

### The Primary Care Practice (PCP) agrees to the following:

#### Provider

- Review the high risk registry prior to implementation of the CCT.
- Refer the following patients to the CCT:
  - Identified on the high risk registry.
  - Have an identified need.
    - Identified as ready to change.
- Provide pertinent information about the patient's condition and need for referral.
- Appoint a provider to serve as a point person for the CCT.
- Meet monthly with CCT members.

#### Practice

- Provide space for CCT member(s).
- Appoint a practice care manager/coordinator/practice designee to serve as a point of contact.
- Authorize CCT to have access to registries and the medical health record.
- Participate in evaluation of CCT model; support administration of patient satisfaction questionnaire and practice staff survey.
- Review and support NCQA elements and standards.
- Participate in Matrix Learning Modules.

### Non-LVPG Practices engaged in Community Care Team will:




- Provide access to their practice wireless network.
- Maintain all practice equipment and infrastructure.
- Notify CCT Team of any changes in log-in procedures.
- Provide interface with practice I/S liaison and LVH I/S if needed.



### Case in Brief: Lehigh Valley Health Network

- Integrated health system based in Allentown, Pennsylvania, with a combined 764 beds across 3 acute hospitals, 33 primary care clinics, and over 630 employed physicians
- Developed comprehensive clinic onboarding process in response to initial resistance to and misunderstanding of care management from clinic staff and leaders
- At initial orientation, all providers must be present and agree to accept care management services before program agrees to work with the clinic
- Clinics sign a contract outlining expectations and responsibilities before starting care management

# Template for Care Management Referral Process Cheat Sheet

<i>Referral Guidelines</i>		<i>Primary Care Physicians</i>
<i>Patient Inclusion Criteria</i>		
<i>Referral Step 1</i>		
<i>Referral Step 2</i>		
<i>Referral Step 3</i>		
<i>Key Contact</i>		
<i>Referral Guidelines</i>		<i>Other Clinical Staff (RNs, SWs, MAs, PAs)</i>
<i>Patient Inclusion Criteria</i>		
<i>Referral Step 1</i>		
<i>Referral Step 2</i>		
<i>Referral Step 3</i>		
<i>Key Contact</i>		
<i>Referral Guidelines</i>		<i>Non-clinical Staff (Receptionists, Schedulers, etc.)</i>
<i>Patient Inclusion Criteria</i>		
<i>Referral Step 1</i>		
<i>Referral Step 2</i>		
<i>Referral Step 3</i>		
<i>Key Contact</i>		