Section 1: Structure a Comprehensive Onboarding Process

Improving PCP Referrals to Care Management Toolkit

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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.

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

Inform

1

Structure a Comprehensive Onboarding Process

- Sample Care Management Onboarding Plan for PCPs
- Sample Care Management Education Curriculum
- Sample Agreement between Care Management and Primary Care Practices
- Care Management Referral Process Cheat Sheet

Attract

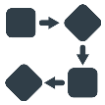
2

Demonstrate and Communicate the Value of Care Management

- Back-of-the-Envelope Care Management Value Calculator
- Sample Newsletter: Care Management Program Testimonial

Optimize

3



Streamline PCP Referral Processes

- Sample Care Management Referral Form
- Guide for Hardwiring Care Management Referrals into PCP Workflows
- Opt-Out Review of High-Risk Patient List Readiness Assessment

Partner

4

Establish Two-Way Feedback with PCPs

- Care Management Provider Satisfaction Survey
- Care Management Provider Survey Engagement Plan
- Care Management Provider Survey Communication Plan
- Sample Email Scripting for Care Management Provider Survey Outreach
- Template for Conducting Effective Team Huddles

Outline Goals of PCP Onboarding to Improve Effectiveness of Education

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

Sample Care Management Onboarding Plan for PCPs

	Initiative	Completion Timeframe	Goals
Staff Education	Update care management referral materials to reflect full spectrum of patient support services under the integrated model	*Up to 3 months*	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	*Up to 3 months*	
	Educate clinical and practice staff about the services care management provides to patients	*Up to 6 months*	
Logistics	Provide care managers with total EMR access to review patient history, schedules, and facilitate communication with providers	*Up to 9 months*	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	*Up to 9 months*	
	Develop shared patient care plan for care manager and physician	*Up to 3 months*	
Workflow	Include care managers in staff meetings and team huddles	*Up to 1 month*	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	*Up to 1 month*	

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

Source: Population Health Advisor research and analysis.

Focus Curriculum on Patient Eligibility, Referral Pathway

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

Sample Care Management Education Curriculum

Topics	Topic Overview	Sample Lessons
Role and Function of Care Managers (CMs) in Primary Care Clinics	Educate PCPs about the services care managers provide patients to facilitate optimal working relationships	• Review the return on investment of care management • Review "a day in the life of a care manager"
Patient Eligibility for Care Management	• Review patient eligibility requirements, exceptions • Identify a designated clinic team member to ensure appropriate referrals	Develop workshop on patient eligibility for care management; led by care management leadership and attended by PCPs and additional clinic staff
Navigating the Care Management Referral Pathway	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
Integrating Care Management into the PCP Workflow	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	• Clarify schedule for care team huddles between PCPs, RNs, and care managers • Demonstrate educational tools and techniques care managers use to educate patients about care management

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

Source: Population Health Advisor research and analysis.

Care Management Agreement Outlines PCP and Care Manager Responsibilities

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

Sample Agreement between Care Management and Primary Care Practices

Care Team Function	PCP/Clinic Staff Responsibilities	Care Manager Responsibilities	Practice Responsibilities
Patient Enrollment	❑ Identify appropriate patients for care management based on established care management eligibility criteria ❑ Assess medical needs and collaborate with other clinical staff to develop care plan	❑ Provide initial contact with patient and review care management program service offerings ❑ Assess social, behavioral, care coordination, and education needs	❑ Provide a space for care managers to work and meet with patients
Patient Documentation	❑ Enter diagnosis and care plan into EMR or paper records for care management and other clinical staff to access	❑ Document patient care plan, medication changes, and psychosocial needs in the EMR or paper records	❑ Authorize care management team to access patient registries and medical health records
Patient Care	❑ Include care managers in visits with patients who require care management services ❑ Involve care managers in team huddles and discussions of challenging patients	❑ Meet regularly with providers ❑ Coordinate care across the continuum ❑ Provide patients with clinical education, focusing on self-management skills and medication adherence	❑ Support administration of patient satisfaction questionnaire and surveys of practice staff to identify opportunities to improve care management processes and patient experience

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

Source: Population Health Advisor research and analysis.

Each Primary Care Clinic Staff Member Can Help Identify Eligible Patients

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.

Care Management Referral Process Cheat Sheet

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

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

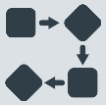
Referral Guidelines	Non-clinical Staff (Receptionists, Schedulers, etc.)
Patient Inclusion Criteria	Two inpatient admissions in 30 days, two ED visits in 30 days, using over five medications, multiple comorbidities, elderly or frail, or over six PCP visits in one year
Referral Step 1	Review care management 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

Source: Population Health Advisor research and analysis.

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
Staff Education 			
Logistics 			
Workflow 			

Source: Population Health Advisor research and analysis.

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:

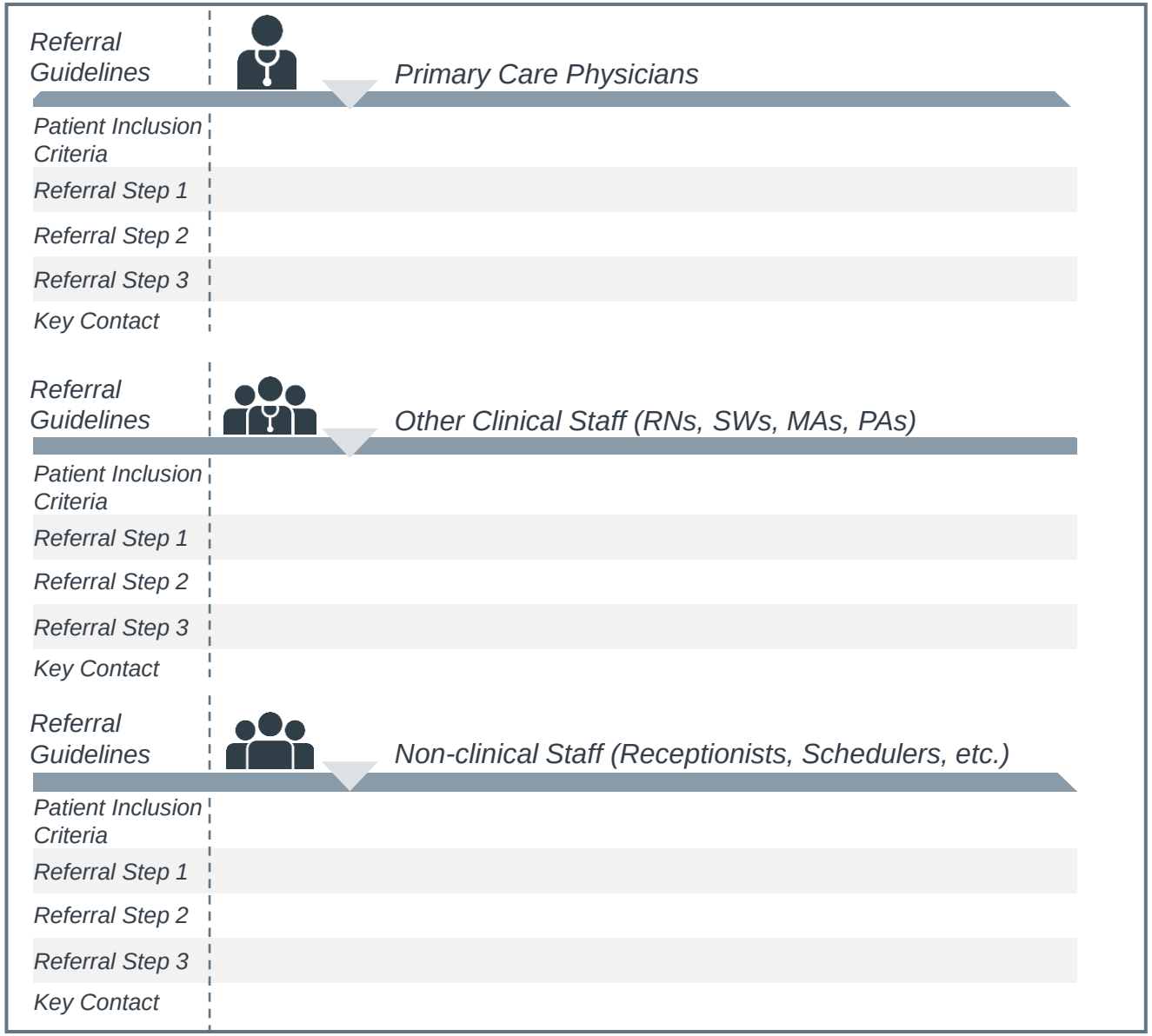
- Provide access to their practice wireless network.
- Maintain all practice equipment and infrastructure.
- Notify CCT Team of any changes in log-in procedures.
- Provide interface with practice I/S liaison and LVH I/S if needed.

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

Source: Lehigh Valley Health Network, Allentown, PA; Population Health Advisor interviews and analysis.

Template for Care Management Referral Process Cheat Sheet



Source: Population Health Advisor research and analysis.