NCC Pediatrics Continuity Clinic Curriculum:

PCMH 5: Continuity and Patient Hand-off

Faculty Version

Goals & Objectives:

Upon completion of this module, the learner should be able to:

a. List the benefits of assigning each patient a primary care manager (PCM).
b. Describe the medical home's responsibility to support patients selecting or changing their PCM.
c. Demonstrate how to display and sort your patient panel in Carepoint.
d. Use the IPASS communication method to transition patients between PCMs.

Pre-Meeting Preparation:

Please do the following:

- Read the pre-meeting preparation document.
- Ensure you are able to access Carepoint and Tricare Online. Refer to the continuity module "Medical Home Module 2: Population Health Management" for Carepoint log-on instructions and troubleshooting.
- Skim medical home SOP entitled Continuity in Share Drive [PRIMARY CARE --> Medical Home SOPs --> Signed SOPs -- > Continuity_05-2017]

Conference Agenda:

- Log onto Carepoint to review your patient panel; sort by IBI and RUB. You should have received your patient panel via email prior to meeting. ***https//carepoint.health.mil, access CAC-enabled, use Explorer as browser***
- Departing residents should ensure appropriate handover of their identified patients.

Extra Credit:

- Filter your patient panel to find the patients with low IBI (illness burden index, ie low-risk based on demographics and existing diagnoses) but high RUB (resource utilization band, high resource users.) What type of patient might have a low IBI and high RUB? What considerations are important in the care of this type of patient?
- Log onto Tricare Online and try to change your own PCM and make an appointment with your PCM.
- **More on ACG IBI and RUB available here starting at slide 17.**

WRNMMC Pediatric and Adolescent PCMH

Continuity and Patient Hand-off

Providing and coordinating medical care is one of the cornerstones of the Patient Centered Medical Home (PCMH). Each patient is assigned a designated primary care manager (PCM), and each PCM cares for a designated panel of patients. All patient appointments - including well, acute, follow-up and preventive care – are ideally completed with the patient's PCM or another provider on the PCM's team. Improved PCM continuity is associated with higher quality of care and improved patient and provider satisfaction. The goal for continuity is 70% for PCM continuity and 90% for team continuity.

Patients have the right to choose a PCM, and the PCMH has the responsibility of supporting their decision by providing information about each PCM. In our PCMH, the disease management nurse (Ms. Rhoda Kroeker) calls each newly-enrolled patient to welcome them to our clinic, provide information about how our clinic works, and assist in matching the patient with an appropriate PCM.

Patients can change their PCM choice at any time. The easiest way for them to change PCMs is to log onto TricareOnline.com, which will bring them to the Tricare beneficiary web enrollment site. (If you have never signed onto Tricare Online, do so before you come to the continuity discussion!) They can also speak with any clinic staff member (in person or by phone), who will fill out the PCM change form; this form is also in every exam room drawer for providers and nurses to use during face-to-face visits. The sponsor's signature is not required! The person filling out the form must give the form or send and email to ? who will change the patient's relationship in TriCare Onlinc Secured Messaging and ensure Tricare updates their records. Tricare will mail the family confirmation of the change in PCM.

The size of each provider's panel is based on their "full time equivalent" (FTE), or how many available appointments the PCM has in clinic. By Military Health System standards, we enroll 1100 patients per full-time provider ("1100 per FTE"). Interns start with 50 patients; PGY2/3s start with 99 patients. Staff providers, depending on their clinic availability, have from 200 to 700 patients. Each of the medical home teams has approximately 2500 patients.

Assuming a patient is assigned to your panel, how does the patient actually get an appointment with you? Does the appointment booking process support the relationship between a patient and his/her PCM (i.e. support continuity)? When booking an appointment, the patient may go to our front desk, call, send a TOL secured message, or sign onto Tricare Online. They may book future appointments with their assigned PCM or a provider on the same team; they may not book future appointments with a provider on another team. For acute visits, all booking methods attempt to book patients on their medical home team, but if this is not possible (due to reduced

appointment availability on the team or patient preference), patients can be booked on other teams. Using these booking protocols, our PCM continuity is ~30%, and our team continuity is nearly 100%.

It is helpful to occasionally scrub your panel of patients to ensure: (1) that you are familiar with the complex patients assigned to you, and (2) that the patients you *think* are assigned to you are, in fact, assigned to you. You should reassign unfamiliar complex patients on your panel to a PCM who is more familiar with their medical problems; similarly, you may need to reassign patients that you *are* familiar with to your patient panel.

Use the attached instructions to view your patient panel in Carepoint, and filter the panel by "ACG IBI" (Adjusted Clinical Groups Illness Burden Index). The IBI is the most widely-used and -tested system for stratifying patients by illness severity using demographic, utilization, and pharmacy data. Ill patients have a higher IBI. Filter your panel of patients by IBI by clicking on the column header "ACG IBI" then clicking on the triangle. Your high IBI patients will appear at the top of the spreadsheet.

When combined with resource use relative to the US population, the ACG IBI can be used to calculate the ACG RUB (Resource Utilization Band). RUB is calculated on a 7-point system as follows:

- No data (patient has not been enrolled for an entire year)
- 0 = non user
- 1 = healthy
- 2 = low
- 3 = moderate
- 4 = high
- 5 = very high

Filter your patient panel by RUB by clicking on the column header, then clicking on the triangle. Patients with high utilization of medical resources appear at the top of the spreadsheet.

As you review your patients, remember that we have new resources available in the clinic that we may not have had when you last scrubbed your panel. For example, do you have patients that might benefit from Dr. Elmore's ADHD class? Do you have patients with poorly controlled asthma and high RUB that might benefit from a visit with our nurse educator? Consider talking with the patient's new PCM about these resources and/or discussing it with the parent directly and placing a consult into AHLTA.

For rising PGY2/3s and staff remaining at WR for the next year: During this continuity clinic or over the next few weeks, identify high-IBI and "very high"/"high" RUB patients that you do not follow. Download your panel and use the spreadsheet to indicate patient demographics and to which PCM the patient should be moved, or use the attached spreadsheet and fill out by hand.

(This may require checking AHLTA to see which provider the complex patient usually sees.) Provide this list to Dr. Carr by 6 June 2022.

For departing providers (staff, interns, and residents): All of your patients must be reassigned to another clinic provider. For your high-IBI and "very high"/"high" RUB patients, you will complete a verbal and written turnover **before** you leave the hospital using the IPASS sheet in this module. You may also choose to hand off healthy patients that you know well. Download your panel and use the spreadsheet to indicate patient demographics and to which PCM the patient should be moved, or use the attached spreadsheet and fill out by hand. Provide this list to Cassie Carr by 6 June 2022. (Note: there is no patient approval needed – the patients will all be reassigned no matter what!)

Notes for the 2022-2023 Academic Year

Residents transitioned to an all resident team this past year. All the residents are assigned to the Blue Team. There are also Red and Green medical home teams that contain staff providers only.

The goal is for Continuity Clinic appointments to be reserved for well visits only, but in some cases unfilled wells may be changed to acute appointments.

Every resident will have an assigned clinic administrator in charge of resident schedule templating, secure messaging, etcetera. Specific assignments for academic year 2022-2023 are pending.

Residents rotating on their clinic block will be responsible for the bulk of acute visits.

For Residents Leaving the Program

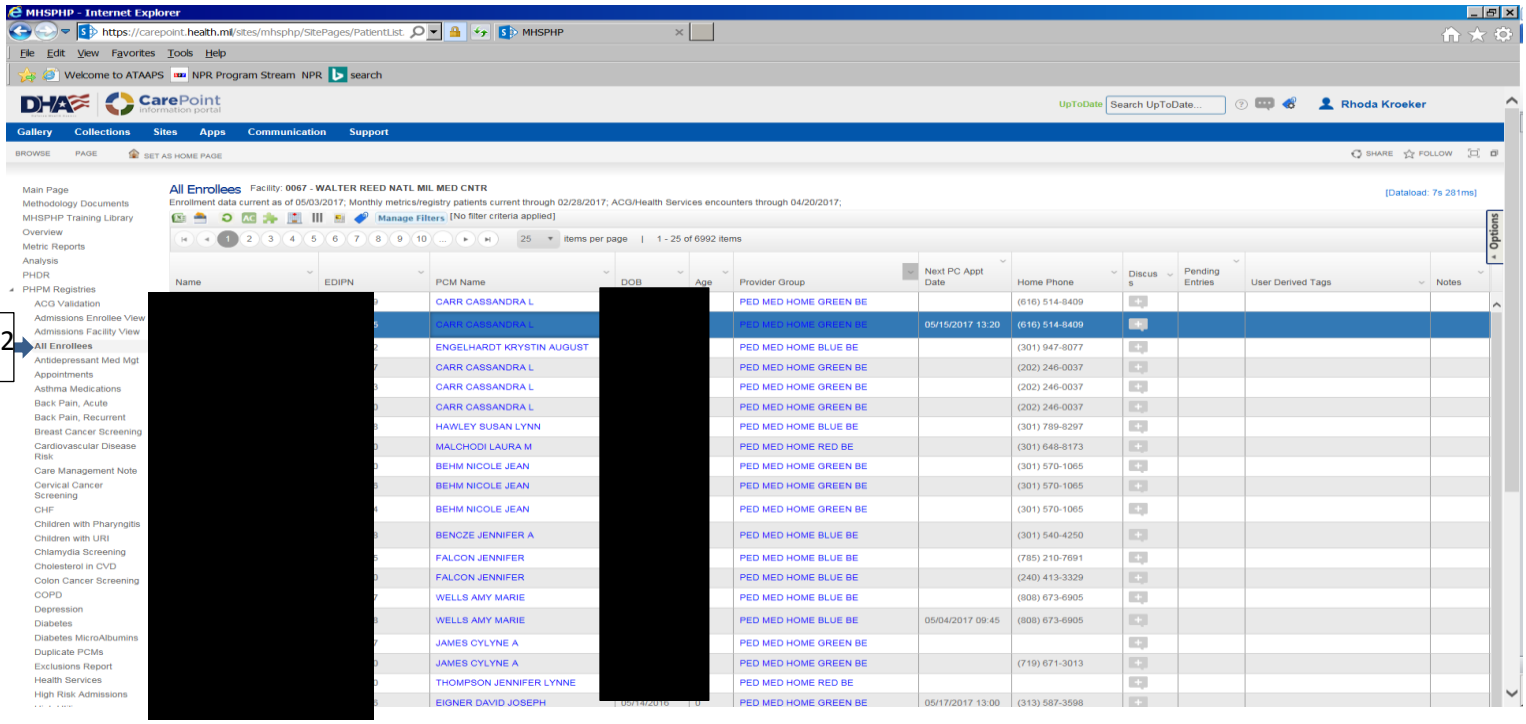
Please review your patient lists in Carepoint. If there are complex patients you follow who are not on your patient list, please add them. Please identify a new resident PCM for your complex patients, perform an I-PASS handover for that patient with the new PCM, and email the new assignments to cassie.carr@nccpeds.com. Patients not specified will be transferred en bloc to an incoming PGY-1.

Walter Reed Pediatric Residency
Continuity Clinic Schedule AY 22-23

PGY Year	Monday	Tuesday	Wednesday	Thursday	Friday
PGY-1	Amy Davis Lisa Sukenaga	Samantha Hanciles	Connor Liggett	Nicole Martin Andrew Warren	Colin McNamara Kevin Westbrook
PGY-2	Marianna Caballero Bailey Howard	Emily Ferraro Anthony Lucido	Alexis Ghersi Rob Crutcher	Maggie Hasler Noelle Molter	Taylor Meyers Suhani Patel
PGY-3	Billy Bennett Ben Jack	Peter Broughton Nick Kondiles Alex Mauro	Sharen Wilson Elizabeth Rahman	Jack Goetzman Elise Reddington	Brian Graziose Sidney Zven

HOW TO PULL PROVIDER PATIENT PANELS IN CAREPOINT (5 easy steps)

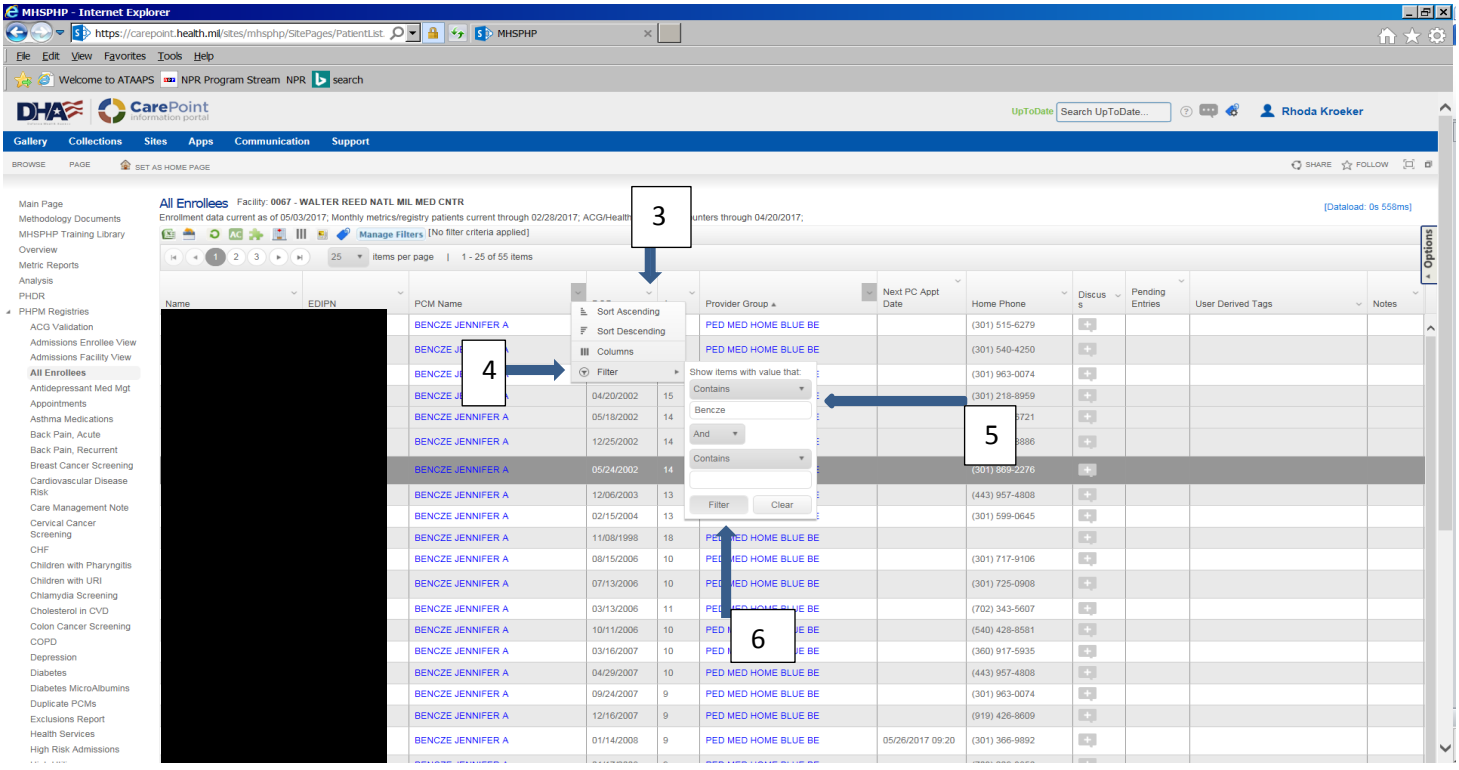
1) LOG INTO CAREPOINT. GO TO “APPS” AT THE TOP, THEN “ALL APPS”, THEN OPEN MHSPSP. CONSIDER ADDING MHSPSP AS A FAVORITE FOR EASY ACCESS NEXT TIME.
2) CLICK ON “PHPM REGISTRIES”, THEN “ALL ENROLLEES”.



3.) CLICK ON THE DOWN ARROW BY PCM NAME. (You may have to press the right Keyboard arrow or click and drag right to view the column for provider group.)

4) HOVER CURSOR OVER THE WORD “FILTER”

5) IN THE “CONTAINS” BOX, WRITE “LAST NAME FIRST NAME” (LIKE “RICHARDS AUTUMN”). CLICK ON FILTER.



PCMH Patient Transfer

	Last Name	First Name	DOB	FMP/Last four	Current PCM	Current team	New PCM	New Team
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								

I-PASS Handoff

- **Departing residents and staff will prepare handoffs for *ALL* of their chronic/high utilization patients, and complete verbal and written handoff before leaving the hospital for a new duty station.**

I	**Patient ID & Illness Severity** (stable vs. "watcher")
P	**Patient Summary** (organize by problems or systems, with plan for each item)
A	**Action List** ("To-Do" list with timeline—consults, follow-up appts/studies/education needed)
S	**Situation Awareness & Contingency Planning** (plan for what might happen; social issues)
S	**Synthesis by Receiver** ("read-back" and questions)