SHARED CARE: Back to the future

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October 13, 2014
Outline

• Case examples
• Changing patterns and problems with specialty care referral
• Model for Shared Care between PCPs and GI specialists at Boston Children’s Hospital
Case examples: Phone advice to PCPs

4 month old with GER- phone advice to change formula, appt booked, but cancelled when pt improved

Constipation- plan for “clean out” initiated via phone, appt scheduled for GI consultation in 1 week
Case examples: rapid access

• 12 yr old with pain/diarrhea, Fhx IBD, ?IBD vs IBS- urgent appt in 48 hr and fast track to endoscopy, ruled out IBD
• 8 yr old with abd pain, decreased wgt gain, TTG 40, anxious family- urgent appt and EGD booked in advance, confirmed celiac
Specialty referral in the Past

- Small practice groups
- Referral patterns driven by providers
- Practices not driven by volume
Referral in the Present

- Large specialty groups and “systems”
- Referral patterns often driven by payers
- Practices are volume driven
- Sub-subspecialization
- Changing and uncertain reimbursement models
Preparing for the Future

• Focus on cost reduction
• Maintain quality/improve value
• Shared risk reimbursement structures
• Universal conversion to electronic records
Shared Care: Objectives

• Enhance personal relationships between PCPs and specialists (SCPs)
• Establish systems to improve communication and accessibility
• Joint commitment between PCPs and SCPs to improve care
Enhance PCP-SCP relationships

- Collaborate to develop algorithms for common problems
- Arrange education sessions at practice level
- Use of technology to improve access of records between groups
Red Flags/Alarm Signs

Also,

- Hirschsprung disease, bowel malformation, volvulus, sepsis:
  - Constipation that begins in first 1 month of age
  - Ribbon stools
  - Blood without fissures
  - Bilious vomiting
  - Fever

- Botulism
  - Facial droop/bulbar weakness

- Hypothyroid
  - Abnormal thyroid gland
  - Failure to thrive

- Sexual abuse
  - Extreme fear during perianal exam
  - Anal scars
Infants

• Under 6 months
  – Breastfed: reassure unless hard stools
  – Formula: Review and counsel re: diet, Prune juice, occasional glycerin

• Over 6 months
  – Review and counsel re: diet
  – Prune Juice
  – Miralax 0.4g/kg/day
    (4g = 1 tsp = 1/4cap for 10kg pt)
Children

- Assess for impaction
  - <2 stools per week
  - Palpable mass (abd/rectal)
  - Overflow incontinence
- Disimpact as needed
  - PO (preferred)
    - PEG 3350 1.5g/kg/day PLUS senna 15mg daily for 2-4 days
  - Rectal
    - Saline enema 10ml/kg or bisacodyl 0.25mg/kg
- Maintenance
  - Diet
    - Fiber: Age + (5-10)g
  - Hydration
  - Behavior
    - Daily sitting: twice a day after meals
    - Calendar, Incentives
    - Exercise
  - Laxatives
    - PEG 3350 0.5g/kg/day
    - Rescue: senna 8-15mg/day PRN no stool in 2 days
- Disimpact as needed
Communication and Access

• Rapid Response line for urgent ("synchronous") requests for appointments or advice
  – Response time 30 minutes or as arranged

• Email access for less urgent ("asynchronous") requests
  – Response time within 24 hours
Improve quality

• Education
• Track outcomes
• Provide mutual feedback
Does it work: Can pre-referral management impact practice?

• Referrals tracked pre- and post-implementation of Shared Care
• Chart review of 90 pre- and 60 post roll out
• Even though no significant change in pre-referral management, there was decreased referral rate and increased time to referral

• Mallon et. al., presented at NASPGHAN, 2013.
Back to the future?

- Return focus of care to PCP/Medical home
- Use technology to improve communication and PCP/SCP relationships
- Reduce cost and add value through collaboration and planning of the referral process
Care Coordination Information

For more information on Care Coordination or to review slides, please visit:

http://www.childrenshospital.org/care-coordination-curriculum/care-coordination-measurement

For additional questions, please email:
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