Collaborative Care: Coordinating Care In the Medical Neighborhood

James Dom Dera, MD, FAAFP

Nancy Myers, PhD

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James Dom Dera, MD, FAAFP

Advanced Primary Care Medical Director, NewHealth Collaborative, Akron, Ohio; Family physician/Co-owner, Ohio Family Practice Centers, Inc., Fairlawn, Ohio

Dr. Dom Dera earned his medical degree from The Ohio State University College of Medicine and Public Health, Columbus, in 1998 and completed his residency at Summa Health in Akron, Ohio, in 2001. He is a diplomate of the American Board of Family Medicine (ABFM). Immediately after graduation, he joined a small private practice, eventually becoming its co-owner. He has been a pioneer in practice transformation, and his practice was the first in its area to achieve National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition. This experience sparked his interest in advanced primary care (APC) and the power of a team-based approach to improve the lives of patients. He is the Advanced Primary Care Medical Director for NewHealth Collaborative, the accountable care organization (ACO) of Summa Health. He has assisted more than 50 practices with their transformation efforts, leading a team of transformation specialists and engaged practice leaders. Dr. Dom Dera is also active in Comprehensive Primary Care Plus (CPC+), a Centers for Medicare & Medicaid (CMS)-led national APC medical home model that aims to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation. His CPC+ efforts have included participating in statewide CPC+ collaboratives, leading nationwide CPC+ webinars on topics such as risk stratification, and presenting at CPC+ regional and national meetings. In addition, he has helped design and implement two-step risk stratification and behavioral health integration for his own practice and other practices in Northeast Ohio.

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Nancy Myers, PhD

Vice President of Leadership and System Innovation, American Hospital Association, Chicago, Illinois

Dr. Myers has built a career that spans the business and clinical sides of the health care system, focusing on the improvement of outcomes across patient populations. She has worked for a major self-insured employer and within the managed care industry, with responsibilities for contracting and benefits planning, as well as developing and coordinating clinical and service initiatives to improve the health of insured populations. While a full-time faculty member for the Northeast Ohio Medical University (NEOMED) in Rootstown, she taught health systems policy and planning, population health concepts, and epidemiology to undergraduate medical and pharmacy students, as well as medical and pharmacy residents.

In addition to leading the development of initiatives focused on patient safety and quality of care across a multisite health system, Dr. Myers has led the development of an accountable care organization (ACO), with care delivery processes focused on achieving better patient outcomes at lower costs across all settings of care. She has provided leadership and oversight to the development of enterprise-wide clinical transformation projects to improve the delivery of care for patients who have chronic disease, cancer, or acute episodic care needs. In her current role, she leads the development of evidence-based population health and system innovation tools to support a diverse array of hospitals and health systems in their work to improve population outcomes in their communities.

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Learning Objectives

1. Describe the value of comprehensive and coordinated care for both the patient and the practice.

2. Develop a plan for identifying and collaborating with highly utilized specialists and care entities.

3. Identify opportunities and methods for integrating behavioral health into the primary care practices

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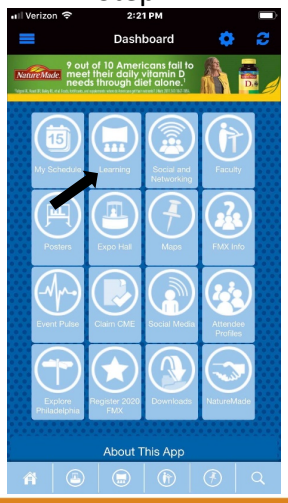
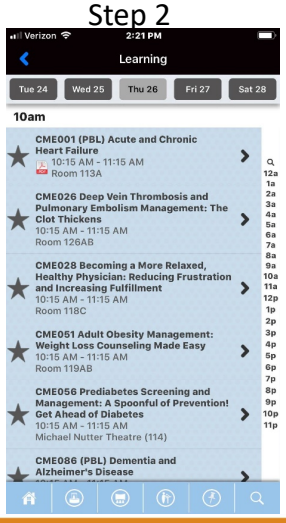
Audience Engagement System

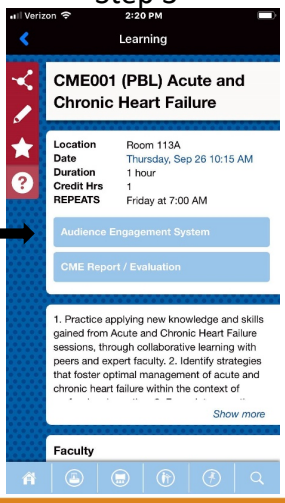
Step 1



Step 2



Step 3



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Health Care:
We've Always Been A Team – of Sorts

Health Care:
We Need a Different Team

Health Care:
We Need a Well Seasoned Team!

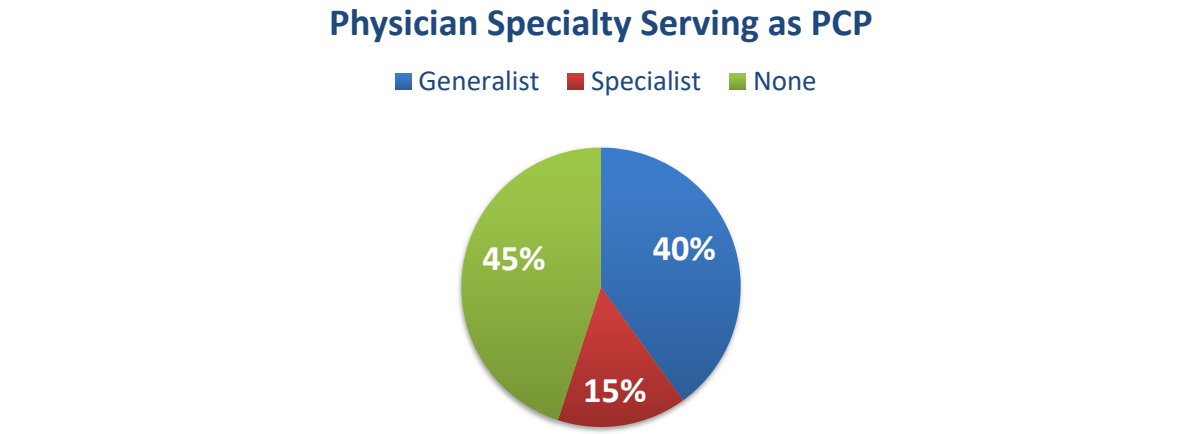
Poll Question 1

Care coordination refers to:

A. A patient-centered approach to managing the care provided across different providers or locations
B. Implementing evidence-based protocols among different providers
C. Development of a clinically integrated network
D. A patient-specific care plan

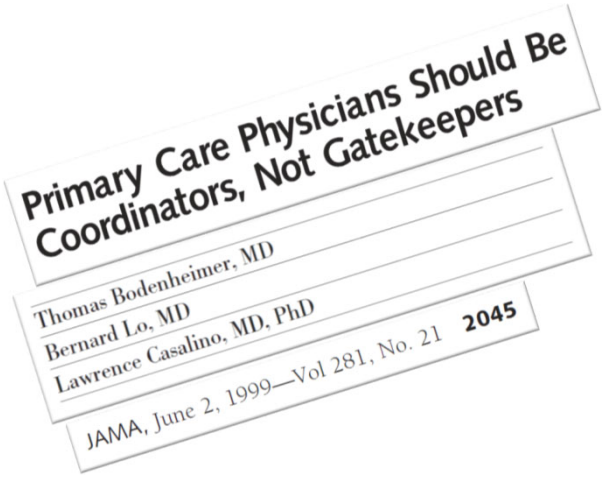
Why are we talking about care coordination?

The "Good Old" Days



Source: Aiken LH, Lewis CE, Craig J, Mendenhall RC, Blendon RJ, Rogers DE. The contribution of specialists to the delivery of primary care. *N Engl J Med* 1979; 300: 1363-1370

Landmark Article in 1999


Primary Care Physicians Should Be Coordinators, Not Gatekeepers

Thomas Bodenheimer, MD
Bernard Lo, MD
Lawrence Casalino, MD, PhD

JAMA, June 2, 1999—Vol 281, No. 21 2045

- PCP's should "facilitate and not impede" appropriate access to care
- Goal is to improve the care of chronic illness
- ***"Primary Care Physicians must cease acting as gatekeepers and instead serve as coordinators of care"***

Hospitals Are Not Immune

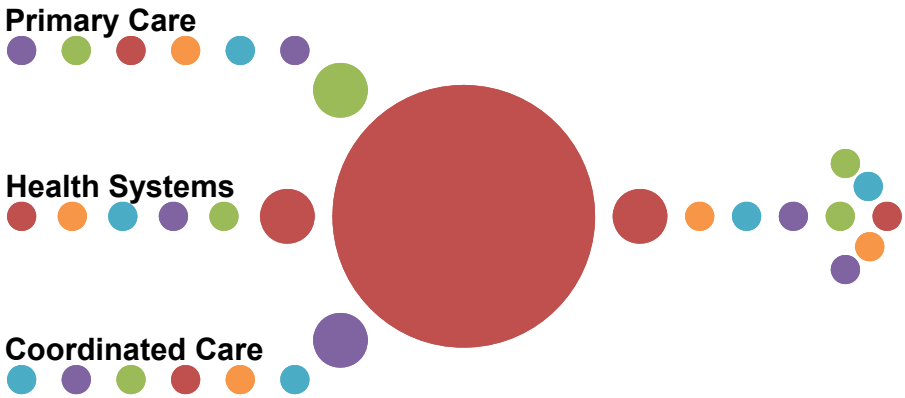
- Those with multiple chronic conditions defined as having ≥2 chronic diagnoses
- >30% had fragmented hospital use in managing their conditions
- Over 40% of patients with ≥4 stays had multiple hospital use.
- **Lack of coordination of care leads to higher fragmented care**

Multiple Chronic Conditions

Poor Care Coordination

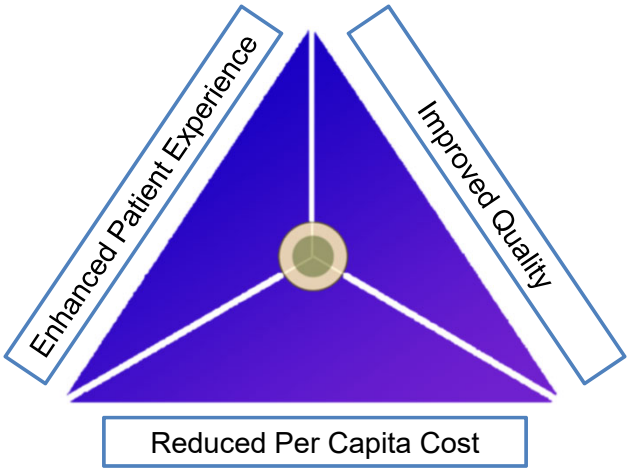
Source: Hempstead, Katherine, PhD, et. al. *The Fragmentation of Hospital Use Among a Cohort of High Utilizers: Implications for Emerging Care Coordination Strategies for Patients With Multiple Chronic Conditions.* Medical Care: March 2014 - Volume 52 - Issue - p S67–S74

Bottom Line



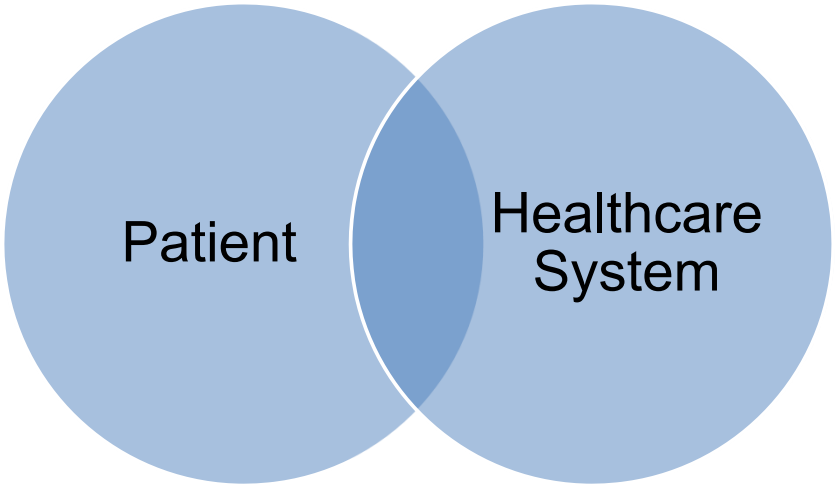
- Higher Quality
- Lower Cost
- Improved Patient Satisfaction

Care Coordination Supports the Triple Aim!



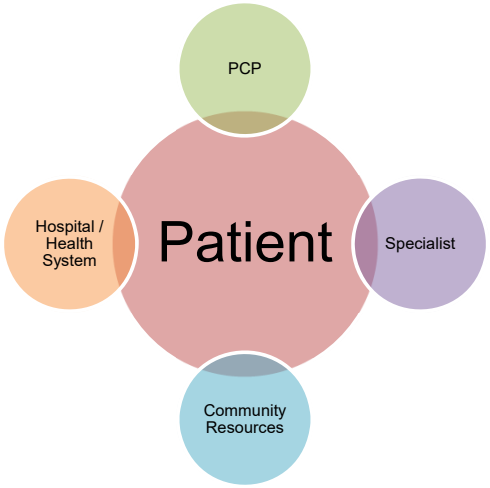
What do we mean when we talk about care coordination?

Variable Impact of Healthcare on Patients

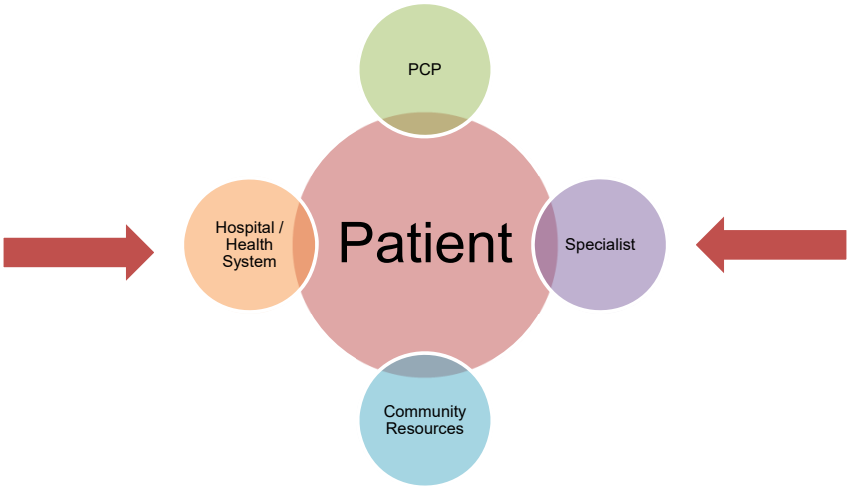


Variable Impact of Healthcare on Patients

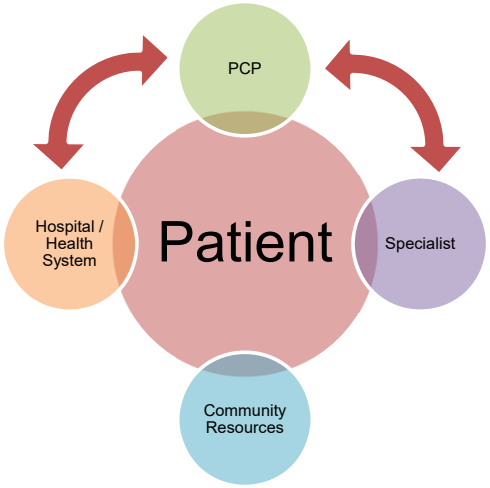
Many different types of providers



We're going to focus on these…

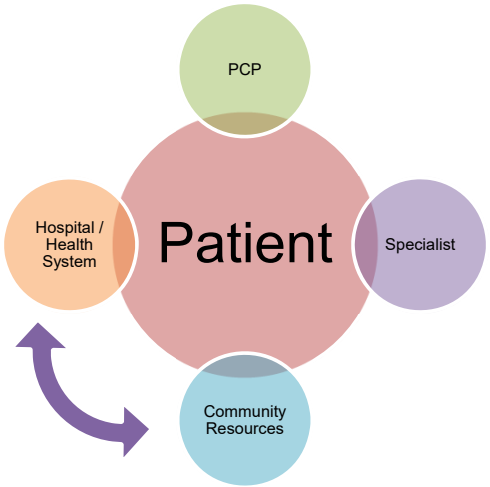


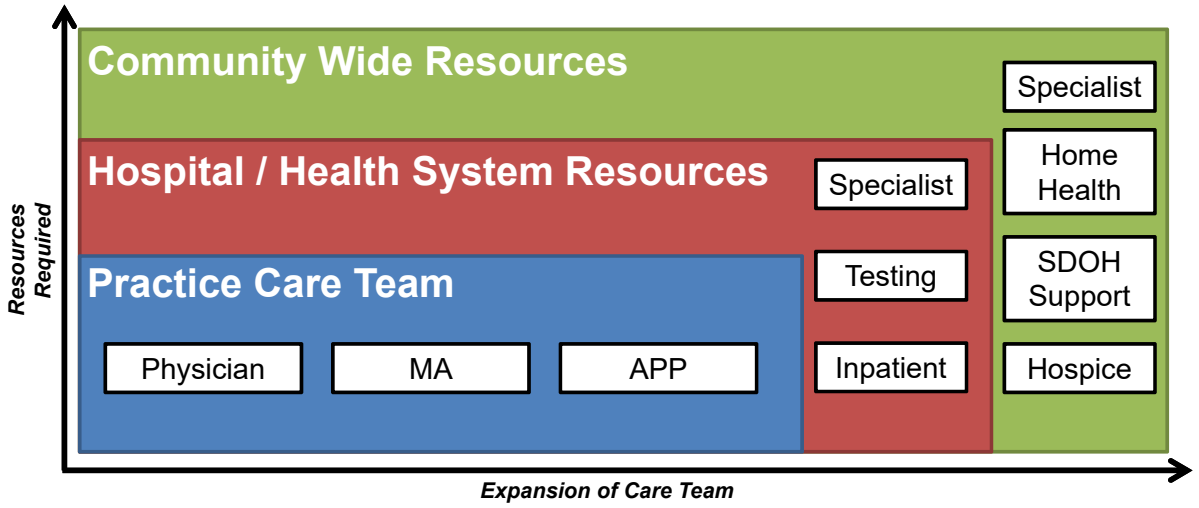
…and coordination of care with Primary Care



…and coordination of care with Primary Care

Health systems increasingly support community resources; that's a value-add for PCP's





Adapted from: Bielamowicz, L, et. al. Benchmarking Medical Home Staff Models: Learning from The Advisory Board's Medical Home Project. http://www.ehcca.com/presentations/medhomesummit3/berra_ms3.pdf. Accessed 23 June 2019

Care Coordination between Primary Care / Specialty Care

Care Coordination: Current Challenges

Access

Clear responsibilities

Relationships

Confirmation

Mutual

Accountability

Robust Referral Process

Seamless

Direct Communication

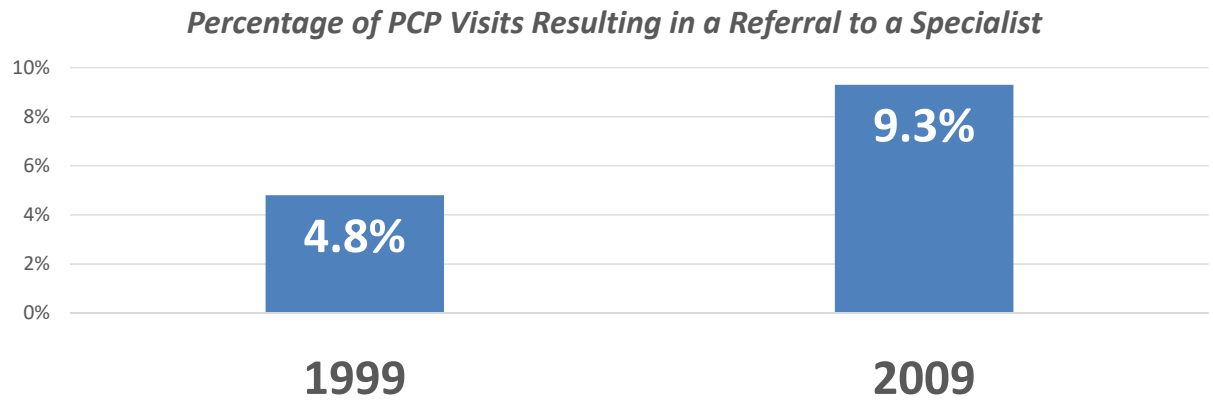
Timely

Patient-Centered

Information

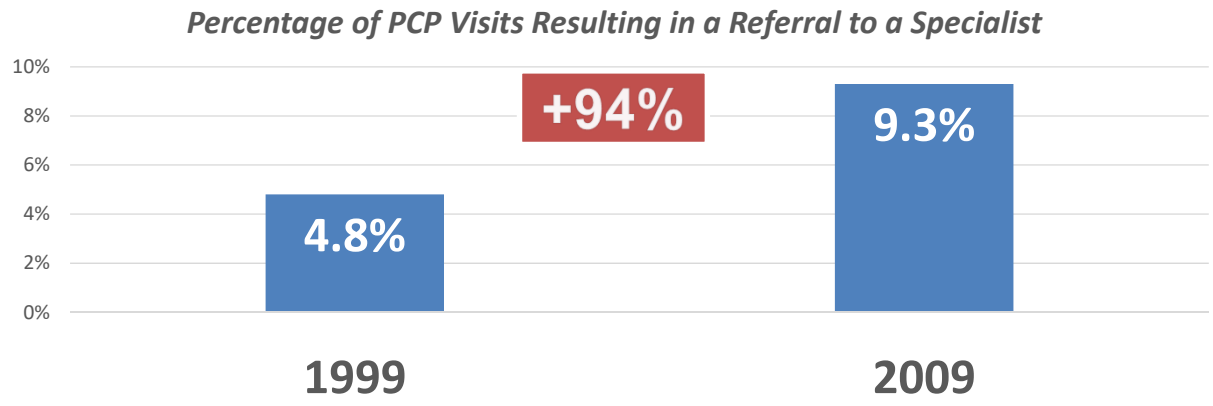
Coordinated care

How often does Primary Care refer?



Source: Barnett ML, et. al, "Trends in Physician Referrals in the United States, 1999-2009" *Arch Intern Med.* 2012;172(2):163-170.

How often does Primary Care refer?



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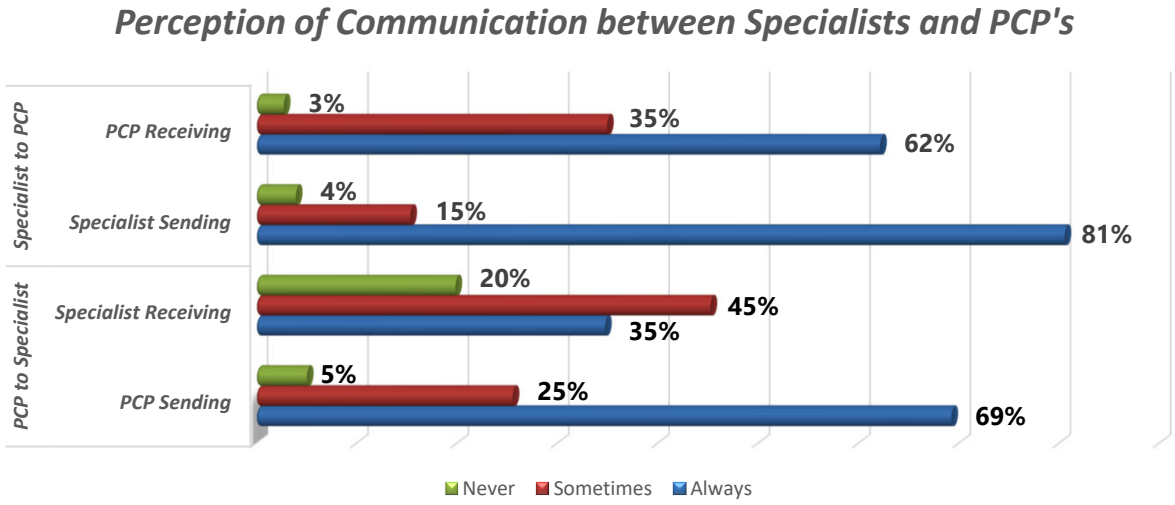
Communication: Specialists & PCP's



Source: O'Malley AS, Rechovsky JD, "Referral and Consultation Communication Between Primary Care and Specialist Physicians" *Arch Intern Med.* 2011; 171(1):56-65

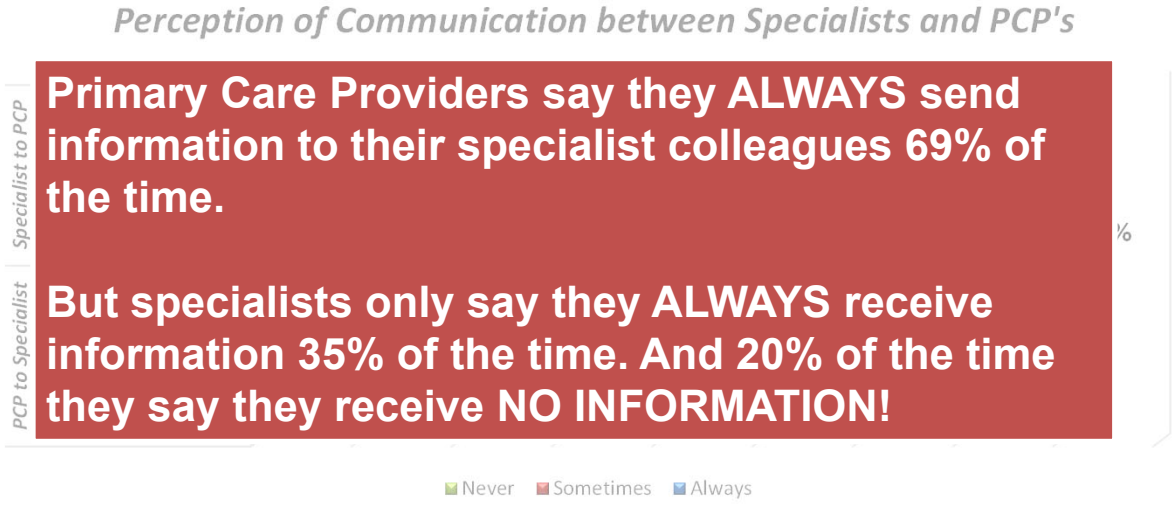
Communication: Specialists & PCP's

Specialists say they ALWAYS send information to Primary Care Providers 81% of the time.

But PCP's only say we ALWAYS receive information 62% of the time

Source: O'Malley AS, Rechovsky JD, "Referral and Consultation Communication Between Primary Care and Specialist Physicians" *Arch Intern Med.* 2011; 171(1):56-65

Communication: Specialists & PCP's



Primary Care Providers say they ALWAYS send information to their specialist colleagues 69% of the time.

But specialists only say they ALWAYS receive information 35% of the time. And 20% of the time they say they receive NO INFORMATION!

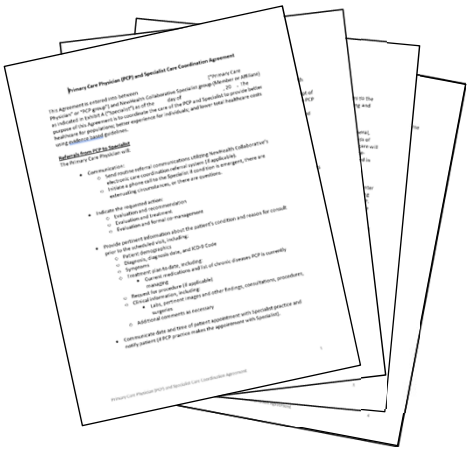
Source: O'Malley AS, Rechovsky JD, "Referral and Consultation Communication Between Primary Care and Specialist Physicians" *Arch Intern Med.* 2011; 171(1):56-65

What if ….

Access	✓Our patients could be seen when they needed to be seen?
PCP	✓Primary care providers clearly asked the specialist what's needed of the consult?
Specialist	✓Specialists answered the question and clearly spelled out next steps?
Info	✓Everyone knows what's going on because all relevant information is shared?

Care Coordination Agreements

- Traditionally took on the format of a contract between two parties
- Laid out expectations between PCP and Specialist
- By themselves don't do anything to foster a **culture of coordination**



Service Agreements


SERVICE AGREEMENT TEMPLATE

Access

Urgent:

Semi-urgent (within 7-10 days):

Routine:

Information exchange

Pre-consultation:

Post-consultation:

Special considerations

Ultimate responsibility for care

Need for further referral

Clinical areas needing improvement

Contact

Lead contact for each group:

Follow up

Date of next meeting to discuss how the arrangement is working:

AAFP FPM

- Less formal agreement between a specialist and PCP
- Has a built-in mechanism to revisit how the agreement is functioning
- Safford B. *How Service Agreements Can Improve Referrals and Shrink the Medical Neighborhood*. Fam Pract Manag. 2018 Sep-Oct;25(5):18-22.

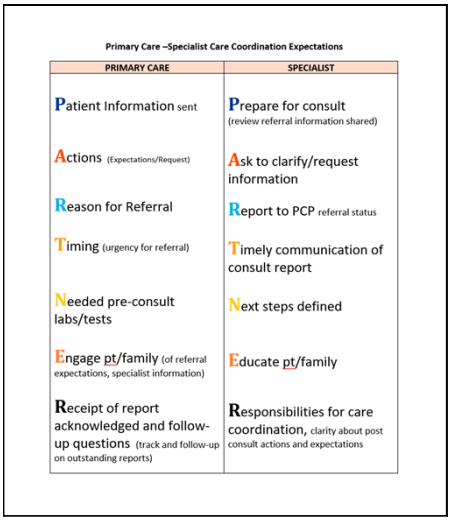
PARTNER Program: A Novel Approach

PARTNER

- It's a Care Compact (not agreement) between PCP and Specialty Care
  - One Page
  - Bullet Points
- **Also include efforts to:**
  - Reshape the culture of care coordination
  - Redesign processes and workflows in offices
  - Educate clinical and ancillary staff on the importance of care coordination

Expectations: Primary Care

- **P**atient Information sent
- **A**ctions (Expectations/Request)
- **R**eason for Referral
- **T**iming (urgency for referral)
- **N**eeded pre-consult labs/tests
- **E**ngage pt/family (of referral expectations, specialist information)
- **R**eceipt of report acknowledged and follow-up questions (track and follow-up on outstanding reports)



Primary Care –Specialist Care Coordination Expectations

PRIMARY CARE	SPECIALIST
Patient Information sent	**P**repare for consult (review referral information shared)
Actions (Expectations/Request)	**A**sk to clarify/request information
Reason for Referral	**R**eport to PCP referral status
Timing (urgency for referral)	**T**imely communication of consult report
Needed pre-consult labs/tests	**N**ext steps defined
Engage pt/family (of referral expectations, specialist information)	**E**ducate pt/family
Receipt of report acknowledged and follow-up questions (track and follow-up on outstanding reports)	**R**esponsibilities for care coordination, clarity about post consult actions and expectations

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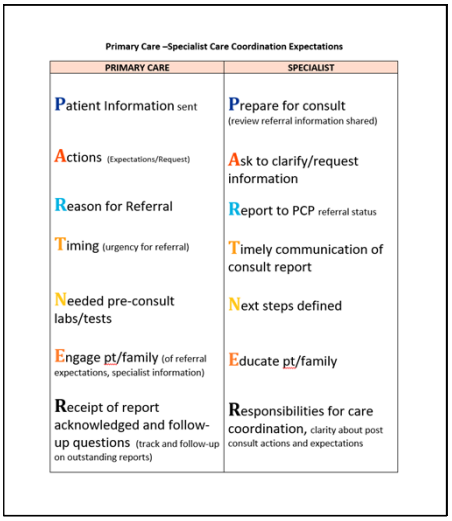

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Processes

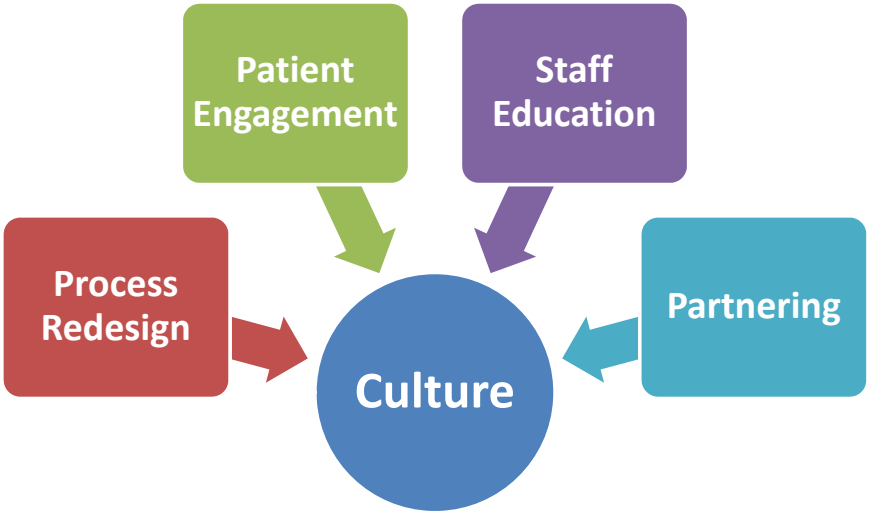
Primary Care

- Sending Referrals
- Confirming pre-consult tests/information
- Engaging pt/family
- Interacting and communicating with specialists
- Closing the referral loop
- Coordinating next steps
- Follow-up with patient
- Post consult care coordination

Specialist

- Referral receipt
- Notification of pre-consult requirements
- Review referral information
- Interacting and communicating with referring providers
- Notifying PCP of referral status
- Sending consult reports
- Coordinating next steps
- Secondary referrals
- Educating pt/family
- Post consult care coordination

Successful Care Coordination Requires a Culture Change



Steps for Successful Care Coordination

Smaller / Independent Practices

- Identify high-volume specialists
- Meet with specialists to introduce / agree on common features to shared patient care (i.e. access, data sharing, etc.)
- Work within your office to redesign the workflow around referral management
- Educate providers and staff around the importance of care coordination
- Engage specialists on a routine basis to foster a culture of collaboration
- Discuss care coordination with your PFAC

Larger Practices / Affiliated Practices

- Identify high-volume specialists
- Meet with specialists to introduce / agree on common features to shared patient care (i.e. access, data sharing, etc.)
- Work within both primary care and specialty offices to redesign the workflow around referral management
- Develop workgroups around provider education, staff engagement, and the like
- Consider adding referral metrics to monitor implementation.

Poll Question 2

High-value Primary Care Practices do which of the following:

A. Coordinate care
B. Risk stratified care management
C. Clinical decision support using evidenced-based protocols
D. All of the above

High-Value Practices Do Care Coordination

- High-Value practices are defined as those that score "favorably on both quality and low total annual per capita health care spending“
- Six common attributes to high-value primary care practices

➢ Milstein A., et. al. *Exploring Attributes of High-Value Primary Care*. Ann Fam Med November/December 2017 vol. 15 no. 6. pp 529-534

Higher risk patients require more care coordination

1. **Primary Prevention**
   Healthy patient
2. **Primary Prevention**
   Healthy patient with risk factors
3. **Secondary Prevention**
   Stable chronic disease
4. **Secondary Prevention**
   Unstable chronic disease
5. **Tertiary Prevention**
   Multiple chronic diseases with significant comorbidities
6. **Catastrophic Care**
   Palliation of disease processes

- Various risk stratification models exist
- Identify higher risk patients and wrap resources around them primarily
- Care coordination is critical for higher risk patients

Behavioral Health Integration and Social Determinants of Health

Poll Question 3

Social determinants of health (SDOH) are:

A. The new term for social history
B. A tool for measuring social anxiety levels
C. An assessment of the non-medical barriers and health disparities faced by our patients
D. Uncommon and therefore unnecessary

Leading Outpatient Behavioral Health Integration (BI) Models

Integrated
- Located at the PCMH site
- Integrated into the care team

Co-located
- In the same physical location or building as the PCMH site
- Works with the care team

Affiliated
- Physically located at another location
- Works with the PCMH via care coordination agreement

CPC+ Outpatient BI Models

Primary Care Behaviorist Model

- Co-located care by BH specialist (e.g. RN, LISW, PhD, etc)
- Implement EBM protocols
- Identify warm-handoff workflows
- Patients are typically high-risk either due to BH or medical condition

Care Management for Mental Illness

- Practice identifies high-risk BH conditions
- Implement EBM protocols
- Identify team member (RN or BH specialist) to provide care management

Social Determinants of Health (SDOH)

"Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health."

https://www.cdc.gov/socialdeterminants/Accessed 15 July 2018

SDOH

- SDOH help explain the barriers our patients' face
- Health disparities and equity are also part of SDOH
- Understanding the needs of your population must include an assessment of non-clinical factors
- AAFP has a screening tool called *"The EveryONE Project"*
- Examples:
  - Economic Stability
  - Education
  - Social and Community Context
  - Health and Health Care
  - Neighborhood and Built Environment
  - Housing
  - Food

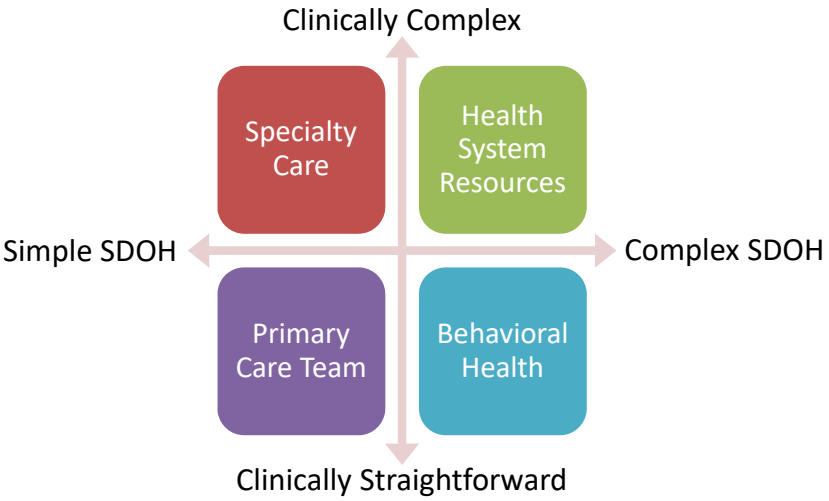
AAFP EveryONE Project

The EveryONE Project™

Advancing health equity in every community

https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html Accessed 15 July 2018

Role of SDOH and Care Coordination



Care Coordination between Primary Care / Health Systems

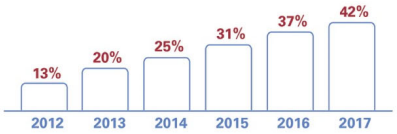
Poll Question 4

Hospitals and Health Systems:

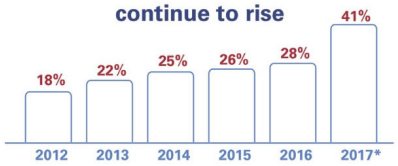
A. Are not participating in accountable care organizations (ACOs) and other value-based arrangements
B. Are helping to connect patients and providers with community resources
C. Have given up on supporting primary care transformation efforts, such as PCMH
D. Are focused on IT strategies over Population Health Strategies

Value: Trends in Delivery Models

Hospitals participating in an ACO have steadily increased

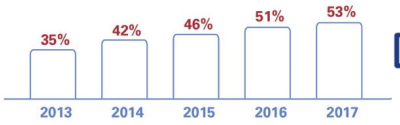


Hospitals participating in a medical home continue to rise



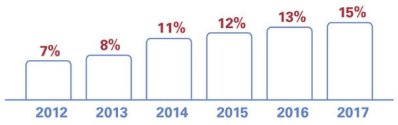
*2017 Survey question is re-worded and not directly comparable to prior years

More hospital payment contracts with commercial payers are tied to quality/safety performance



American Hospital Association™
Advancing Health in America

Hospitals are taking on more risk

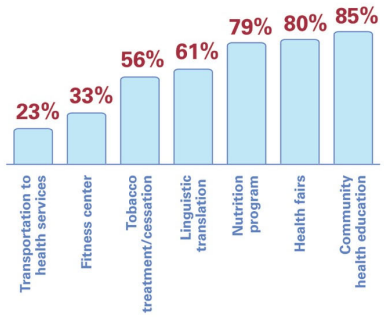


Source: *"Caring for Communities: How Hospitals are Engaging in New Payment Models and Addressing Community Needs,"* AHA Hospital Statistics, 2018, Health Forum LLC, an affiliate of the American Hospital Association; AHA Annual Survey Data, 2017, for community hospitals

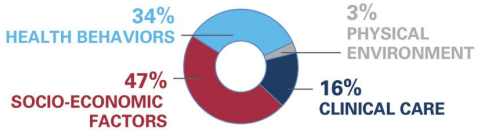
Hospitals connecting care with community

Hospitals and communities

88 percent of hospitals screen for social needs



Contributions to health outcomes



American Hospital Association™
Advancing Health in America

Source: *"Caring for Communities: How Hospitals are Engaging in New Payment Models and Addressing Community Needs,"* AHA Hospital Statistics, 2018, Health Forum LLC, an affiliate of the American Hospital Association; *"County Health Rankings: Relationships Between Determinant Factors and Health Outcome,"* Carlyn M. Hood, MPA, MPH, et al., American Journal of Preventive Medicine, Vol 50., Issue 2, pp 129-135, February 2016

Care Delivery and Payment Landscape

AHA Member Survey

Overall Summary Results: 2017-2018 vs. 2016

American Hospital Association™

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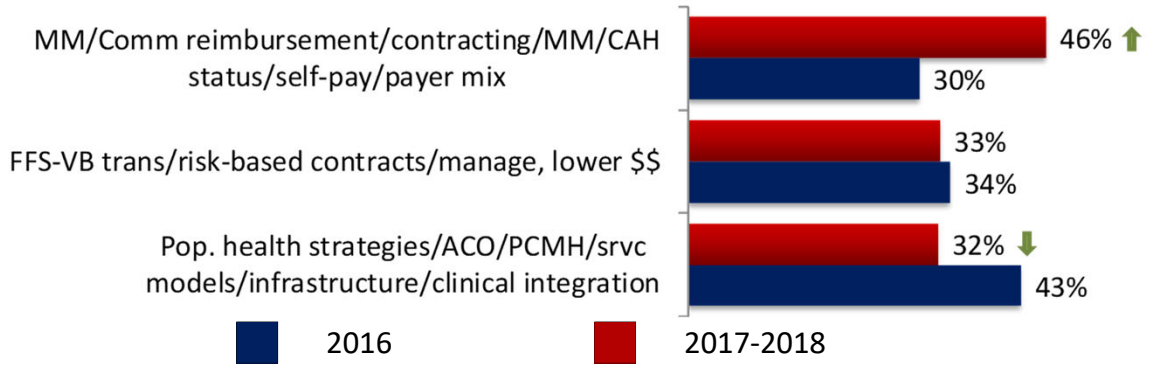
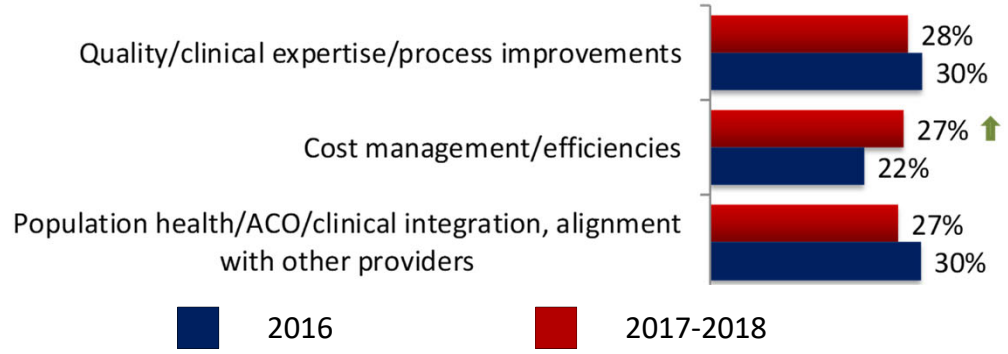
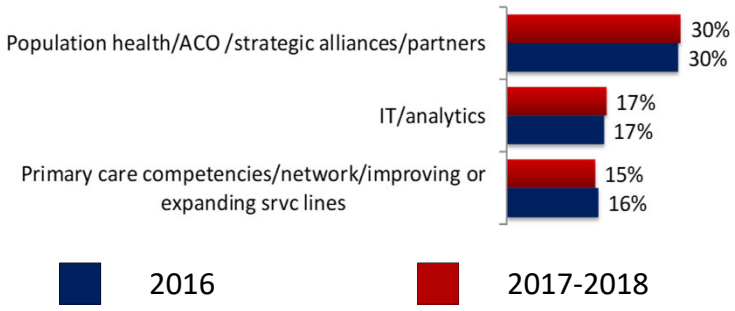
QUESTION: Overall, what are your organization's top 1-2 care delivery and payment landscape challenges in the next 2 years?

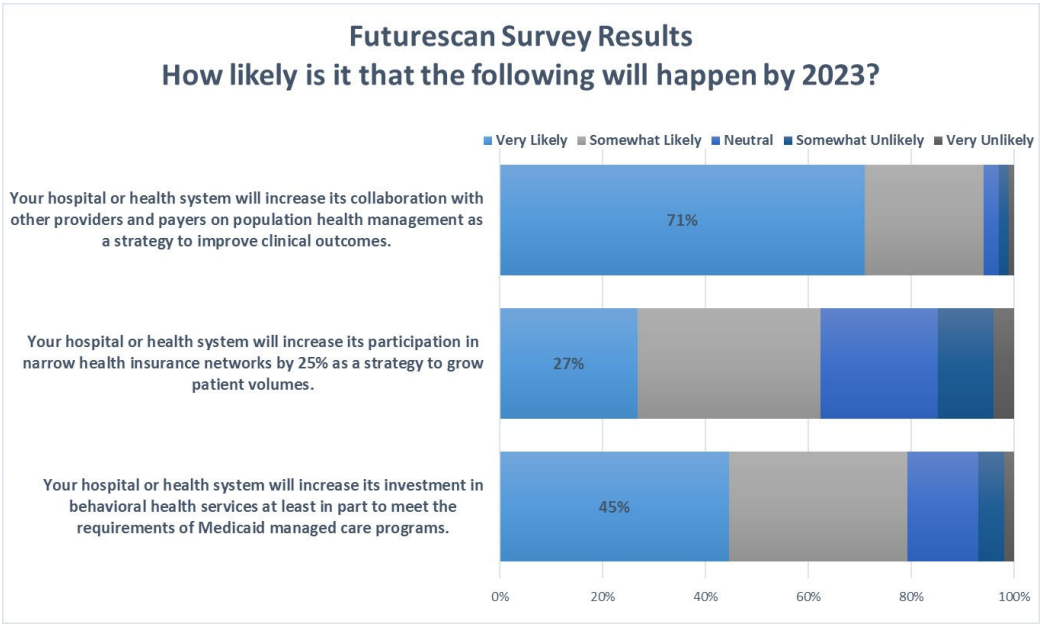


QUESTION: Which existing organizational competencies are you strengthening to prepare for the next 2 years?



QUESTION: [If you are developing new organization competencies to position your organization for the future] what are you developing?

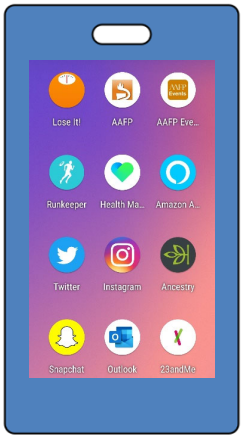




Partners: Consumer Trends

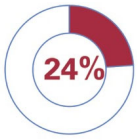
There's an app for that…

- 75% of consumers say tech is important to managing their health
- 48% are using mobile health apps
- Wearables tech has tripled since 2014, from 9% to 33%
- 90% are willing to share data with their providers



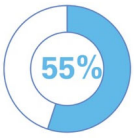
Partners: Consumer Trends

Smart speakers



2018

24 percent of U.S. households own a voice-activated smart speaker



2022

55 percent of U.S. households will have smart speakers

Personal genetic data

One in 25 American adults has access to personal genetic data

Digital Innovation: Hospitals and Health Systems

Digital innovation priorities

The **top five** digital innovation priorities for health systems:

- ✓ Patient-generated data and customized services
- ✓ Network utilization and management
- ✓ Referral management and in-network retention
- ✓ Social community support
- ✓ Convenient patient access, including telemedicine

Factors accelerating digital innovation

Four factors significantly accelerate digital innovation in hospitals and health systems:

- ✓ Providing sufficient IT resources
- ✓ Creating a flexible budget cycle
- ✓ Dedicating a funding pool
- ✓ Reserving a portion of each service line leader's budget for digital innovation

When all four factors are present, innovation occurs 52 percent faster.

Maturity Framework for New Care Models / Risk-sharing Arrangements

Care Continuum / Provider Network Management

- **Network**: Gaps in assets
- **Affiliation Requirements**: limited to none
- **Quality Improvements**: no link between quality and value

Clinical / Care Management

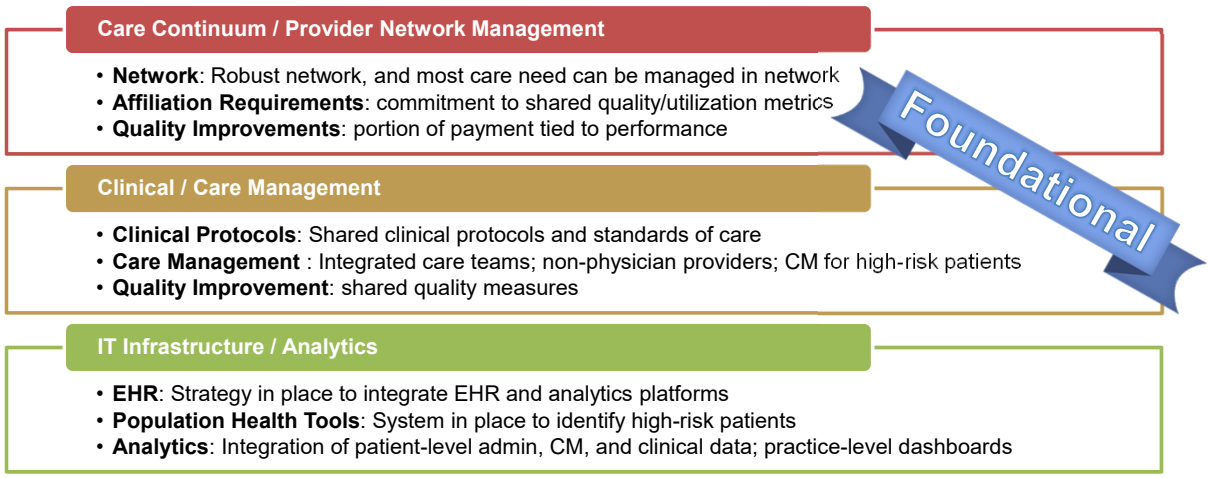
- **Clinical Protocols**: No standardization
- **Care Management** : limited, if any
- **Quality Improvement**: may exist, but not coordinated across the system

IT Infrastructure / Analytics

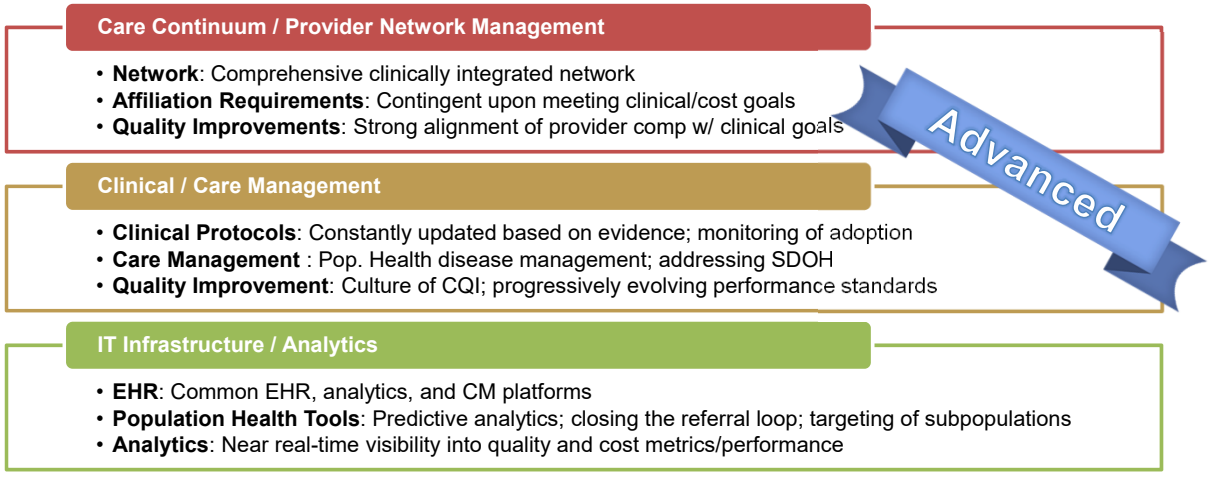
- **EHR**: Functional, but limited interaction with other affiliates
- **Population Health Tools**: use of disease registries / reporting
- **Analytics**: Some ability to track performance against quality/utilization benchmarks

Basic

Maturity Framework for New Care Models / Risk-sharing Arrangements



Maturity Framework for New Care Models / Risk-sharing Arrangements



Shared Foundations

- Information transfer for care coordination
- Data analytics to identify/track at risk pts
- Integrated care coordination support
- Development of community partnerships and referral processes
- Integration of digital/telehealth capabilities

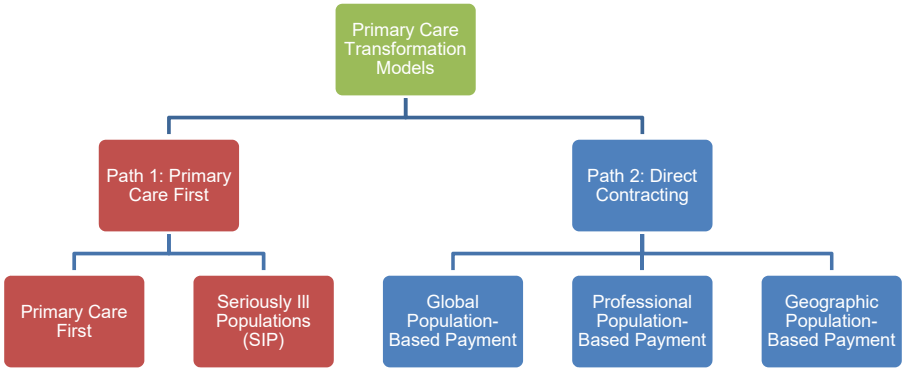
Poll Question 5

Common features for success in future value-based payment models include:

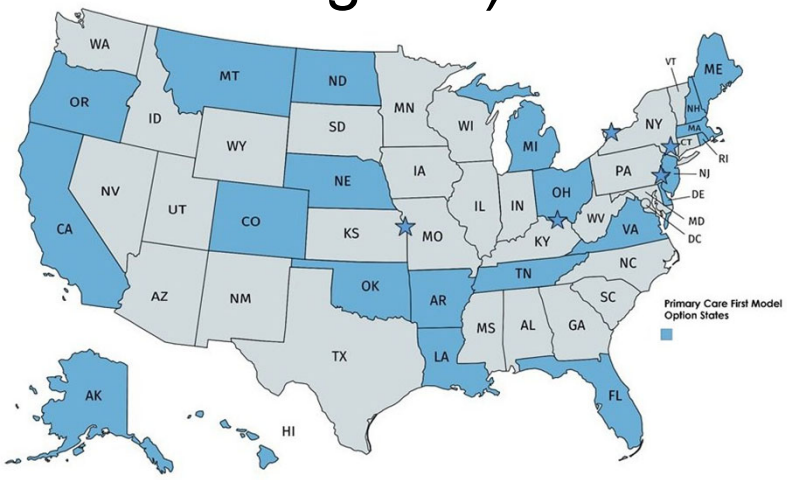
A. Attention to Information transfer and support of care coordination
B. No to minimal data analytics
C. Pursuit of fee-for-service reimbursement opportunities
D. Lack of community partnership
E. Lack of alternative visit types, such as telehealth

Conclusion

New CMMI Payment Models Announced



Nationwide (expanding on 18 CPC+ regions)



Payment under Primary Care First

Total Medicare payments

Total primary care payment + **Performance-based adjustment**

Professional Population-Based Payment

Flat Primary Care Visit Fee

Opportunity for practices to **increase revenue by up to 50%** of their total primary care payment based on key performance measures, including acute hospital utilization (AHU).

1. National adjustment
2. Cohort adjustment
3. Continuous improvement adjustment

NOTE: Up to 10% penalty for underperforming practices

Practice Recommendations

1. Care coordination is an important tool in improving patient outcomes
2. Employ a team-based approach when it comes to care coordination: workflow redesign and provider/staff education
3. Work with specialists to develop care coordination compacts, and continue to support the culture of care coordination
4. Local health systems can be valuable resource in your care coordination, as well has helping to connect to community resource
5. Success in current and future payment models will be impossible without highly coordinated care

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Questions