Collaborative Care: Coordinating Care In the Medical Neighborhood

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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.
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.

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.
Audience Engagement System

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

Physician Specialty Serving as PCP

- Generalist
- Specialist
- None

45% 40% 15%


Landmark Article in 1999

- 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**

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

Community

Patient

Healthcare System

Patient

Healthcare System
Many different types of providers

We’re going to focus on these…
…and coordination of care with Primary Care

Health systems increasingly support community resources; that’s a value-add for PCP’s
Expansion of Care Team

Resources Required

Community Wide Resources

Hospital / Health System Resources

Practice Care Team

Physician  MA  APP

Testing  Inpatient

Specialist  Home Health  SDOH Support  Hospice


Care Coordination between Primary Care / Specialty Care
Care Coordination: Current Challenges

Robust Referral Process

How often does Primary Care refer?

Percentage of PCP Visits Resulting in a Referral to a Specialist

How often does Primary Care refer?

**Percentage of PCP Visits Resulting in a Referral to a Specialist**

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP to Specialist Sending</td>
<td>4.8%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Specialist to PCP Receiving</td>
<td>+94%</td>
<td></td>
</tr>
</tbody>
</table>


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**Communication: Specialists & PCP's**

**Perception of Communication between Specialists and PCP’s**

<table>
<thead>
<tr>
<th>Type</th>
<th>PCP Receiving</th>
<th>Specialist Sending</th>
<th>PCP Sending</th>
<th>Specialist Receiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3%</td>
<td>4%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>35%</td>
<td>15%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Always</td>
<td>62%</td>
<td>81%</td>
<td>69%</td>
<td>45%</td>
</tr>
</tbody>
</table>

**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

Perception of Communication between Specialists and 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

Perception of Communication between Specialists and 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

- Less formal agreement between a specialist and PCP
- Has a built-in mechanism to revisit how the agreement is functioning

PARTNER Program: A Novel Approach

- 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)

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
<th>SPECIALIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Information sent</td>
<td>Prepare for consult (review referral information shared)</td>
</tr>
<tr>
<td>Actions (Expectations/Request)</td>
<td>Ask to clarify/request information</td>
</tr>
<tr>
<td>Reason for Referral</td>
<td>Report to PCP referral status</td>
</tr>
<tr>
<td>Timing (urgency for referral)</td>
<td>Timely communication of consult report</td>
</tr>
<tr>
<td>Needed pre-consult labs/tests</td>
<td>Next steps defined</td>
</tr>
<tr>
<td>Engage pt/family (of referral expectations, specialist information)</td>
<td>Educate pt/family</td>
</tr>
<tr>
<td>Receipt of report acknowledged and follow-up questions (track and follow-up on outstanding reports)</td>
<td>Responsibilities for care coordination, clarity about post consult actions and expectations</td>
</tr>
</tbody>
</table>

Expectations: Specialist

- **P**repare for consult
- **A**sk to clarify/request information
- **R**eport to PCP referral status
- **T**imely communication of consult report
- **N**ext steps defined
- **E**ducate pt/family
- **R**esponsibilities for care coordination, clarity about post consult actions and expectations
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**

- **Patient Engagement**
- **Staff Education**
- **Process Redesign**
- **Partnering**

**Culture**
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


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

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

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

Care Delivery and Payment Landscape

AHA Member Survey

Overall Summary Results: 2017-2018 vs. 2016

American Hospital Association™
Advancing Health in America

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

<table>
<thead>
<tr>
<th>Challenge</th>
<th>2016</th>
<th>2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/Comm reimbursement/contracting/MM/CAH status/self-pay/payer mix</td>
<td>30%</td>
<td>46% 🟢</td>
</tr>
<tr>
<td>FFS-VB trans/risk-based contracts/manage, lower $$</td>
<td>33%</td>
<td>34% 🟢</td>
</tr>
<tr>
<td>Pop. health strategies/ACO/PCMH/srvc models/infrastructure/clinical integration</td>
<td>32%</td>
<td>43% 🟢</td>
</tr>
</tbody>
</table>
QUESTION: Which existing organizational competencies are you strengthening to prepare for the next 2 years?

- Quality/clinical expertise/process improvements: 2016 - 30%, 2017-2018 - 28%
- Population health/ACO/clinical integration, alignment with other providers: 2016 - 22%, 2017-2018 - 27%

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

- Population health/ACO/strategic alliances/partners: 2016 - 30%, 2017-2018 - 30%
- IT/analytics: 2016 - 17%, 2017-2018 - 17%
- Primary care competencies/network/improving or expanding svc lines: 2016 - 15%, 2017-2018 - 16%
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

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
Maturity Framework for New Care Models / Risk-sharing Arrangements

**Care Continuum / Provider Network Management**
- Network: Robust network, and most care need can be managed in network
- Affiliation Requirements: commitment to shared quality/utilization metrics
- Quality Improvements: portion of payment tied to performance

**Clinical / Care Management**
- Clinical Protocols: Shared clinical protocols and standards of care
- Care Management: Integrated care teams; non-physician providers; CM for high-risk patients
- Quality Improvement: shared quality measures

**IT Infrastructure / Analytics**
- EHR: Strategy in place to integrate EHR and analytics platforms
- Population Health Tools: System in place to identify high-risk patients
- Analytics: Integration of patient-level admin, CM, and clinical data; practice-level dashboards

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**Maturity Framework for New Care Models / Risk-sharing Arrangements**

**Care Continuum / Provider Network Management**
- Network: Comprehensive clinically integrated network
- Affiliation Requirements: Contingent upon meeting clinical/cost goals
- Quality Improvements: Strong alignment of provider comp w/ clinical goals

**Clinical / Care Management**
- Clinical Protocols: Constantly updated based on evidence; monitoring of adoption
- Care Management: Pop. Health disease management; addressing SDOH
- Quality Improvement: Culture of CQI; progressively evolving performance standards

**IT Infrastructure / Analytics**
- EHR: Common EHR, analytics, and CM platforms
- Population Health Tools: Predictive analytics; closing the referral loop; targeting of subpopulations
- Analytics: Near real-time visibility into quality and cost metrics/performance
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

- Primary Care Transformation Models
  - Path 1: Primary Care First
    - Primary Care First
    - Seriously Ill Populations (SIP)
  - Path 2: Direct Contracting
    - Global Population-Based Payment
    - Professional Population-Based Payment
    - Geographic Population-Based Payment
Nationwide (expanding on 18 CPC+ regions)

Payment under Primary Care First

Total Medicare payments

Total primary care payment + Performance-based adjustment

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 as helping to connect to community resource
5. Success in current and future payment models will be impossible without highly coordinated care

Contact Information

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Nancy Myers – nmyers@aha.org
Questions