Care Coordination Comparative Matrix

Technical Assistance of the Rural Health Information Technology Network Development (RHITND) Grantees

August 2014

NATIONAL RURAL HEALTH RESOURCE CENTER

600 East Superior Street, Suite 404 | Duluth, Minnesota 55802
Phone: 218-727-9390 | info@ruralcenter.org
Get to know us better: www.ruralcenter.org

This is a publication of the National Rural Health Resource Center. The project described was supported by Contract Number HHSH250201100027C from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy.

PURPOSE

Through the National Rural Health Resource Center's (The Center) work with the Rural Health Information Network Development (RHITND) program and in recognition of the accelerating pace of change in the American health care system in its transition from volume to value-based reimbursement, The Center identified a need to support rural health networks in awareness and understanding of emerging care coordination models. These emerging models are innovative and strategic solutions that address network members' need to transition toward value-based reimbursement.

The Center identified rural health networks that are developing or implementing value-based models and conducted brief interviews with the network leaders that are implementing or developing care coordination initiatives. These profiles create a matrix that allows for comparison of the various models and features, such as, the primary focus of the model and demographics, different combinations of the care coordination team roles, aspects of the HIT infrastructure and lessons that these rural health network innovators have learned during the design and implementation of the models.

The Center used the care coordination definition crafted by the Certification Commission for Health Information Technology (CCHIT) which is provided below, and also asked the network's for their own definitions:

> *Care coordination involves two different but related aspects of patient care. One provides information to the clinician who must be able to access from and provide relevant clinical data to multiple sources in order to determine and provide for appropriate next steps in diagnosis or treatment. The other is to assure that patients are in the appropriate setting as they transition among multiple levels of care. Both are important for providing high quality care as well as mitigating excess, both must incorporate patient needs and preferences, and both are highly dependent on the ability to quickly and easily send and query health information on a given patient to and from multiple electronic sources.*

The goal of the rural health network Care Coordination Model Comparative Matrix is to capture and communicate this emerging knowledge to share with other rural health networks. The matrix can be used by any rural health network to consider aspects of the various models in order to support their own work in preparing their members for a transition to value-based reimbursement.

METHODS

The Comparative Matrix chart includes a brief profile of various care coordination models that are emerging across the country. Features highlighted in the profile include: network description, focus population, care team members, collaboration partners, HIT, patient/family engagement and business model examples needed for care coordination. It also includes insights on challenges and lessons learned by each model from the perspective of implementing solutions for network members. The information was collected through informational interviews with rural health network leaders across the nation that are currently implementing or designing care coordination solutions for their members.

These interviews were conducted by Terry Hill, MPA, Senior Advisor for Rural Health Leadership and Policy at the National Rural Health Resource Center. Each voluntary interview was about an hour in length. The interviews were summarized by the RHITND Technical Assistance (TA) Team to fit within the matrix chart to provide an opportunity to compare the various models. The organization and interviewee are identified for each network profile.

Five of the nine interviews are RHITND grantee networks. Each of these grantees utilized RHITND funds to implement HIT and network infrastructure that supports the design and implementation of their care coordination model. The other four networks were identified through The Center's TA work with rural hospitals and clinics across the country within the Technical Assistance Service Center (TASC) and Rural Hospital Performance Improvement (RHPI) programs.

Care Coordination Profile Interview Questions

1) What is your definition of care coordination?
2) How would you describe your network?
3) What population is the focus of the care coordination?
4) Who is on your care team? (Workforce roles?)
5) Who are you partnering with to provide care? (Partner organizations?)
6) How are you using HIT to facilitate documentation of care coordination activities, care plans, communication and data analysis?
7) How are you engaging patients and families/caregivers in the care coordination model?
8) What is the business model? (How will you be paid?)
9) What are the greatest challenges and/or lessons learned you have encountered during the planning and/or implementation?
10) How did you or are you overcoming these challenges?

Rural Network Care Coordination Models: Comparative Matrix

	Allevant based on Mayo Post-Acute Care model	**Community Health IT Network** Rural Health Partnerships	**Critical Access Hospitals Network** Rural HIT Project
Contact/ Location	Jordan Tenenbaum and Mark Lindsay, MD Started in Wisconsin,Minnesota,Iowa	Kendra Siler-Marsiglio and David Willis MD Florida	Sue Dietz Washington
Care Coordination Definition	-Very broadly: Teamwork: culture, communication and collaboration -It is process focused and involves training, education, measurement and transparency, with the goal of getting patients to highest level of independence, effectively and efficiently	-Looking to improve communication between providers and institutions as patients are be moved -Patient also gets the information that the provider receives (longitudinal care records) so they can also be engaged	-Activities of a diverse group of individuals (patients, payers, providers that serve a certain population) that work together to achieve quality outcomes. This happens through various activities.
Network Description	-Multi-county and multi-state region • Clinics • 12 CAHs in MN, WI, and IA	-Multi-county (10) in north central Florida -They are 1 of 9 recognized Florida healthcare networks that include primary care safety net organizations • FQHCs • Rural Health Clinics • CAHs • Rural Hospitals • Behavioral Health providers • AHEC • Community colleges and universities • Workforce development boards • Local government boards and businesses	-Multi-county (5) in eastern Washington -7 public hospital districts -6 CAHs and 1 PPS hospital -Shared network services promote operational efficiencies and include IT infrastructures, operation infrastructures, etc. -Considering Medicare patients through an ACO
Focus Population	-Post-acute care patients including ventilator patients -Focus on utilizing swing bed program for post-acute care -Started model in Eau Claire, WI with focus on establishing a transitional model and post-acute care program then expanded to other states and CAHs	-Starting with diabetes patients, mental health patients, primary care patients -Considering VA patients	-Chronic disease patients -Some Medicaid population (mostly under SIM grant) -High needs and high health care utilizers -Comorbidities and mental health
Care Team Members	-Transitional Nurse Care Coordinator (center piece to care coordination) -Physician, Nurse Practitioner or Physician Assistant -Nursing Assistant -Therapies: Respiratory, speech and physical -Social Services -Dietician -Chaplin -Families and Patients	-Case Managers for information -Modeled after clinical integration organization	-Primary care providers -Care Coordinators (primarily nurses) -Clinic staff (MA, RN) -Therapists -Mental Health -Social Workers
Partner Organizations	-Mayo Health System	-Network members (see above) -County Health Department -Florida Office of Rural Health	-County Health Departments -Aging and LTC agencies -Social Services -Rural Resource Agencies -Agencies supporting program improvement (DOH, etc.) -Regional Partners -State Office of Rural Health

	Allevant based on Mayo Post-Acute Care model	Community Health IT Network Rural Health Partnerships	Critical Access Hospitals Network Rural HIT Project
HIT	-Web-based patient database -IT portal used for team role training and education -IT used for measurement tracking with a focus on reducing readmissions and improving quality	-HIE use • Combination of a longitudinal health record and a patient portal • Information is the same for both patient and provider • Provider can message out to patients, prescriptions requests, billable (by four insurers) online web visits that are email based • Audit log to ensure transparency, privacy and security -Makes a robust longitudinal record to ensure quality data care and fantastic data source -Looking into tele-health and use in the exchange	-Used federal Rural Health Information Technology grant funding to implement -Aggregating data as a region and supporting population health analysis • Sorting by demographics, payers, clinical indicators, etc. to help see the gaps and who needs tracking, follow up, etc. • Some data used for staff performance reviews in some hospitals -State HIE under development -Tele-mental health -Exploring use of robots to support sicker patients in rural areas; tele-remote modeling
Patient/ Family Engagement	-Patients and family have been involved since day one -Patients are introduced to key processes by nurse care coordinator -Nurse care coordinator is engaged to know the plan of care -At the end of bedside rounds, patient is asked a patient centered, open-ended question	-Patients and families are integral to the model - Patient engagement happens through internet, phone, video, etc.) -Caregiver access to parents of children, adults to their parents, spouses, etc. -Doing patient readiness assessments	-In development stages -More of a clinic function than network function -Use of patient portals, but the patients still can't see the data in a clean way that makes sense -Considering: more patient education tools
Business Model	-Replicated throughout Mayo rural hospital system and expanding throughout the nation -Positive financial and quality outcomes for both CAHs and referral centers -Developing a new revenue source for CAHs to increase census and financial viability with increased margin and efficiency -Can see revenue increases of $1 million with 15-55% net margin using existing resources without adding new staff. • Documented a 20:1 ratio of investment to return	-Planning a subscription model -Acting as the regional health information exchange -Fee for service HIT assistance -Grants and contracts	-Non-profit -Minimal membership dues -Heavily grant funded to date; such as SIM grants to support shift to value based reimbursement -Eventually user fees and service charges
Challenges/ Lessons Learned	Challenges: • Cultural resistance to change in CAHs, and fear of letting go of the past • Instilling care coordination teams in hospitals • Breaking down the silos in the communities Lessons: • CAHs served many more post-acute care patients when implementing these programs • Financial and quality outcomes were better for both CAHs and referral centers. • Measurement and benchmarking is important Referral centers will refer to CAHs for post-acute care coordination if the necessary work is done in the CAH	Challenges: • Getting people excited is easy, but getting them to "sign on the dotted line" is not • When rural entities are owned by a large health system, it can be difficult to get them engages in community health projects Lessons: • Engage community partners, businesses and patients early on: • Do not take a top-down approach. • Getting physicians involved and understanding the "why" is key to success • Easy patient access to medical information is essential Local businesses are important partners and can purchase services	Challenges: • Breaking down barriers between hospitals and mental health providers, and developing better communication • Having to go through hospital boards for permission to participate in programs • More than one care coordinator from different entities being assigned to the same patients • Funding for development and implementation • Facing the unknown and the profound changes occurring in the market • Lack of IT and data analytics knowledge in the rural facilities Lessons: • Need to build trust and communication between mental health and hospitals/physicians • Networks need to increase member awareness of changes, help connect the members to needed resources • The data isn't always clean or clear; it takes work to clean it up so that it's useful; Standardization of data into one system is important

Rural Care Coordination Models: Comparative Matrix

	Fort Drum Regional Health Planning Org. North Country Health Information Partnership	Heath Care Collaborative of Rural Missouri HIT Network	Illinois Critical Access Hospital Network
Contact/ Location	Corey Zeigler and Patricia Fralick New York	Toniann Richard Missouri	Angie Charlet Illinois
Care Coordination Definition	-Focusing on hand-offs of patient between providers of the care continuum, and involving patient and families and focusing on the improving processes	-Establishing integrative health by having working teams across the network to maximize the current payment system, and work with patients and providers in creating a different payment model based on value	-Care coordination that is patient centered, high quality and cost effective
Network Description	-Multi-county, (3) in northern New York -About 200,000 people -6 hospitals, 22 primary care providers and 6 specialty practices -Clinically integrated network with focus on primary care and behavioral health -Social Service Agencies	-Multi-county in northeastern Missouri -Members including: • 4 hospitals • 2 FQHCs • Department of Mental Health • Agency on Aging • Health Department • Economic development	-Multi-county across Illinois -24 of 53 ICAHN CAHs
Focus Population	-Chronic conditions, preventable (re)admissions, ER utilization, etc. -Diabetes and Cardiovascular Disease -Medicaid and Behavioral health -Medicare -Private payer populations	-Primarily diabetes and co-morbidity of diabetes and depression -Considering cardiovascular disease patients -700 patients enrolled	-Multiple chronic illness patients • CHF and heart disease • Diabetes • Obesity -Private payer populations, e.g. BCBS -Medicare patients as part of an ACO
Care Team Members	-Care Coaches (typically non-nurse) modeling behaviors, using empowerment of the patient to be more engaged (pilot Coleman model) -Considering Social Workers, Behavioral Health and nurses -Physicians and Nurses	-Nurse (community outreach focus) -Nurse Practitioner -Physician -Dental Hygienist -Clinical Social Worker, -Psychologist, -Psychiatrist and Sociologist (focus on rural cultural competency issues) -Patient educators	-Physicians -Case Managers -Nurses -IT -Informaticists -Community Health Workers -Social Workers
Partner Organizations	-Hospitals -Primary care clinics -Physicians -Substance abuse and Behavioral Health -Public Health -Area Agency on Aging	-Mental Health Organizations -Multi-county community action agencies -Migrant Farm Workers -Probation Referral -Kansas University research -REACH Foundation	-Rural hospitals -Exploring partnerships with private third party payers

	Fort Drum Regional Health Planning Org. North Country Health Information Partnership	Heath Care Collaborative of Rural Missouri HIT Network	Illinois Critical Access Hospital Network
HIT	-Have HIE capabilities, but communicating timely and accurate information can be challenging -Working on population health management registry -Telehealth use in products like Jabber: secure video system for tele-psychiatry	-HIE use • Data sharing is relatively easy with use of associate agreements, etc. • Multiple HIE's, but they're interlinked -Telehealth • ED coverage for mental health -Direct email use	-HIE use: statewide -Different EHRs, some haven't reached meaningful use -Claims data will be key -Telehealth-mostly tele-psychiatry but envisions expanded use
Patient/ Family Engagement	-Home visits are effective for patient engagement -Patient empowerment and role modeling (pilot) -Using the Coleman model of patient engagement	-Patient education focuses on diet and healthy living -Small group work is effective as a diabetic focus -Integrated health is focused on the patient: teams working across disciplines	-Still in development stages but is expected to include education and patient engagement
Business Model	-Currently relying on short term funding sources -Developing approach to private payers to do care coordination and patient education and empowerment -Medicare shared savings program -Preparing for pay for value by improving quality, engaging patients in their own care and reducing costs	-Federal, state and private foundation grants -Investments and dues from partners -Considering shared savings models, shared costs and ACO models	-ACO business models built on shared savings and high quality -BCBS negotiations for coordinating care for BCBS populations -Grants and contracts
Challenges/ Lessons Learned	Challenges: • Getting support from all partner hospitals on a common program or strategic direction • Getting patients to accept coaches in homes, but once they do they want them to come again • Care coaches may not have clinical background to see med errors, emergencies, etc. • Accessing information in a timely manner • Doctors are sometimes reluctant to go out of their way to use a portal. It has to be easy Lessons: • It's really important to get everyone in the network to agree on something in the beginning • Get buy in and support for network value strategies • There is a lot of attachment to individual silos and cultures that must be overcome • It makes most sense to do care coordination for everyone, not just small groups Different providers have different skills and should work as a team to the top of their licenses	Challenges: • Broadband connectivity issues limit use of telehealth • Organizing different types of service organizations is hard • Having "tough conversations" with partner organizations (payments, systems, outcomes, etc.) • Identifying a specific patient population to focus on • Finding adequate funding to drive health initiatives Lessons: • It's important to identify a specific population to work with • Hiring the right staff that are passionate about population health is key Broad involvement of community providers, businesses and patients provides a good foundation for value	Challenges • Not knowing what it's going to look like so you end up putting it together as you go • Different information technology and lack of reliable informatics still a problem • CAH lack of awareness of rapidly changing health industry; sometimes resistance to these changes • Finding the funding to go forward, and finding a way to get paid for development and implementation of care coordination • Rural hospitals don't have experience practicing evidence based medicine Lessons Learned • Rural hospitals are probably more prepared than they think they are, but general awareness of value and care coordination is lacking • Conducting readiness assessments before implementation of care coordination is important • Thinning the referral networks will be important to achieve high quality at low cost There is greater financial safety and shared knowledge when approaching care coordination as a network of hospitals

Rural Care Coordination Models: Comparative Matrix

	Monida Healthcare Network	National Rural ACO	PrimeWest Health
Contact/ Location	Greg Drapes and Amber Rogers Montana	Lynn Barr and Mary Bittner California, Indian Michigan	Jim Przybilla and Karen Rau Minnesota
Care Coordination Definition	-To help the physician or provider implement the prescribed plan of care -Part of a larger strategy of clinical integration Partnering with a payer organization to lower cost and improve care	-Organizing patient activities between care coordinator coach, patient and care giver to ensure effective facilitation and delivery of health care services within the continuum, done in a patient and family centered manner -An integrated approach, not one-size-fits all	-The right service, at the right time, right place, and at the right price -Finding the correct definition of ”right” Primary care focused with patient-centered coordination
Network Description	-Multi-county in southwestern Montana -7 CAHS -Tertiary Referral Center -300 Physicians -300 Non-physician providers	-National scope -7 member hospital communities • 7 CAHs in CA, MI, IN • 9 FQHCs in MI • 1 PPS Hospital -Plan for expansion 2015 • Average size: 10,000 lives • 7 ACOs • 9 states • 22 communities	-Multi-county health plan (enabled by special Minnesota legislation) -Managed care role (having a foot in both the provider and the payer worlds) -CAHs -Rural hospitals -Community medical centers -Regional referral center
Focus Population	-Primarily diabetes, COPD, CHF and heart disease, most have comorbidities -Focus on decreasing ER admissions and hospitalizations -Considering Medicare advantage plan members	-Patients who do not have a regular primary care physician -“High use ER patients -High risk heart disease patient -High cost patients with multiple chronic illnesses	-Medicaid complex care patients -Those with frequent ER visits/high utilizers -Senior population -All PrimeWest health plan members
Care Team Members	-Care Coordinator (patient coach, not always a nurse) -Nurse Leadership -Primary Care Providers -Pharmacists -Dieticians -Community Case Workers -Behavioral Health -Pharmacists -Social workers	-Nurse leader -Social Workers -Pharmacists -Dieticians, diabetic educators -Physician leader -Patient connection role; with unlicensed care staff	-2 Care Navigators -Primary Care Providers -RN Care Coordinators -County contracted Public Health & Human Service -Human Services -County Case Manager -Mental Health and Chemical Dependency—Rule 25 assessment and MH TCM -Providers working at the top of their license
Partner Organizations	-Third party payer organization -Financial management party	-Public health -Long term care organizations -IHS -Mental Health -Public health	-Medical home (ACMC), share a 24/7 nurse hotline -Hospitals -Clinics -Public Health -Mental Health -County Health and Human services

	Monida Healthcare Network	National Rural ACO	PrimeWest Health
HIT	-6 different ambulatory EHRs -3 main hospital system EHRs -Get claims data from their third party payer partner -No central registry at this time -Created an access database with all the information, but requires double documentation -Have ability to do telehealth, but need to find ways for better ROI. They get reimbursed the same as face-to-face encounters, but must add in the line charges and staffing costs.	-Single data warehouse for claims data • ID areas of high cost or low quality concern • Benchmarking • Utilization -Everyone on separate EHRs -Tele-health -Tele-psychiatry	-Electronic care plan for documentation, acts as an HIE • Care plan platform • Progress notes (from patient assessment) • Accessed by all members of the care team • Can attach elements to it -Access to PrimeWest cloud-based claims data -Tele psychiatry/psychology • Connected in 13 counties and established reimbursement -Video units in distant communities for medication therapy management of elderly population and consultation function between psych and PCP
Patient/ Family Engagement	-In development stages -Are using motivational interviewing to engage patients -Can teach the class but have no way to monitor use by the physicians	-In development stages -Patient education and engagement -Self-management and motivational interviewing techniques	-Seniors and disabled members each assigned a county case manager and a health plan care coordinator • Proved those assigned a case manager have better outcomes overall -Care navigators: outreach, help make appointments and also help get patients in
Business Model	-Get payment from the third party payer by fee for service (FFS) use of certain CPT billing codes -Employers would not participate in a managed care plan, so they now do FFS based on CPT amounts, and Monida gets a percentage back to them -Care coordinator contracted from network, or hired directly by network member -Currently not taking on financial risk	-Cost: $120,000 per year per hospital -Shared savings models to repay investment -Future ideas: assuming risk for savings and quality	-Care coordination fees through PrimeWest -Shared savings through better care coordination
Challenges/ Lessons Learned	Challenges: • Some providers get excited about care coordination, but the payment mechanism needs to catch up to the excitement "You can care coordination yourself into bankruptcy" • Finding a way for the HIE to work with the diverse EHRs • Keeping everyone engaged in the process over time is difficult • Facilitating a complete change in culture is necessary for the new payment models • Finding the funding to facilitate development of new models Lessons: • Some people will gain more control during the care coordination process while others may lose control • Physicians do not always want to do new work on top of their own. They must understand the "why". • Education alone does not change behaviors, it takes altered processes, culture change and resiliency • It may be necessary to thin out the referral network, which is difficult in very rural areas	Challenges: • All members having different EHRs • The huge start-up costs, • Initial reduction in utilization for hospitals still having to live under old payments • Crossing the "shaky bridge" between payment models • Concern of physician disillusionment during the change process Lessons: • Find scalable efficiencies and quick wins • FQHCs have longer history of care coordination and are generally ahead of hospitals • Claims data is hugely important to reduce cost and identify quality providers • Can't use a one-size-fits-all approach; every hospital and community is different • Care coordination across community services is difficult because of historic lack of communication, and health services silos. Hospital coordinators sometimes reluctant to engage mental health or aging services	Challenges: • Not all EHRs in their network are programmed the same: coordinators may have access to see a part of a record in one clinic, but not in another (even under the same EHR system) • They are doing most of the data analysis on their own, because health facilities don't have the knowledge, skill and abilities on staff • Less autonomy to act at a community level when metropolitan based systems are involved Lessons: • All of the data can really help providers, if they are willing to use it to improve quality and reduce cost • They must provide expert technical assistance, adequate support and technical consulting when entering into shared savings with providers because they may not be accustomed to seeing/analyzing health plan data • The challenges and requirements of effective care coordination are often unknown or underestimated by hospitals and clinics