The Rural Health Care Coordination Network Partnership Program: South East Rural Physicians Alliance

This practice brief is part of a series developed by the NORC Walsh Center for Rural Health Analysis and the University of Minnesota Rural Health Research Center to highlight findings from the Evaluation of the Rural Health Care Coordination Network Partnership Program. The Federal Office of Rural Health Policy provided funding support for the program and its evaluation.

RURAL HEALTH CARE COORDINATION NETWORK PARTNERSHIP PROGRAM

Over 50 million people live in rural areas in the United States and are at higher risk for developing chronic illnesses than their urban peers.[1-3] The increasing prevalence of chronic disease in rural areas and the high cost of health care in the U.S. are intensifying the demand for high-quality, high-value services that effectively meet this population's physical and behavioral health needs.

Despite certain barriers (e.g., incompatible electronic health record systems across providers), redesigning health care systems in order to better coordinate patients' care is important.[4] Individuals with complex health conditions often require care from both primary care and specialty providers, and may be unsure how to access or navigate these services. In addition, providers may not always communicate with each other regarding test results, treatment plans, and other aspects of a patient's care.

In response to these concerns, the Federal Office of Rural Health Policy (FORHP) developed the Rural Health Care Coordination Network Partnership Program (Care Coordination Program). Under this program, eight grantees received funding to support the development or expansion of formal rural health networks that focus on coordinating care for three chronic conditions: type 2 diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Grantees are encouraged to develop innovative approaches, demonstrate improved health outcomes, and employ evidence-based care coordination strategies that address the prevalence and management of at least one of the three chronic conditions. The three-year grant program began in September 2015.

The NORC Walsh Center for Rural Health Analysis (NORC), in partnership with the University of Minnesota Rural Health Research Center, is contracted by FORHP to serve as the Care Coordination Program's external evaluator. The evaluation focuses on the implementation, impact, context, and sustainability of the Care Coordination Program. Key grantee-specific findings to date will be shared in a series of practice briefs. The focus of this brief is the Care Coordination Program developed by the South East Rural Physicians Alliance-Independent Physician Association located in Nebraska.

Grantee Program Area Served

- *Large catchment area, spanning 326 miles or approximately 4 hours 43 minutes of drive time across south eastern Nebraska*
- *Aging population*
- *Increasing diversity due, in part, to a growing number of immigrant residents who are employed in meatpacking plants*
- *Numerous health disparities in the population*

GRANTEE BACKGROUND

The South East Rural Physicians Alliance-Independent Physician Association (SERPA-IPA) brings together 124 physician members across central and southeast Nebraska to support a robust system of health care services for rural residents. SERPA-IPA providers face multiple challenges in providing care, including: patient populations with high prevalence of chronic diseases; the retirement of many rural physicians; challenges in recruiting and retaining physicians; and, market shifts from volume-based to value-based payment models.

In response, SERPA-IPA physicians are continually looking for sustainable approaches to delivering cost-effective, high-quality care. SERPA-IPA physician members transformed 16 of their clinics into Patient Centered Medical Homes (PCMH) and formed the SERPA-Accountable Care Organization (ACO) in 2013 as an advance payment ACO in the Medicare Shared Savings Program. The SERPA-ACO provides services in 15 counties across Nebraska.

Seeking to further enhance the quality of care and continuity of services provided by SERPA-ACO members, the 13 SERPA-ACO clinics operating in rural areas partnered and received funding through

the Federal Office of Rural Health Policy's Rural Health Care Coordination Network Partnership Program grant (Care Coordination Program).

The SERPA-ACO Care Coordination Program's main objectives are to:

1) Implement or enhance a care coordination program in participating clinics;
2) Engage high-risk patients with diagnosed diabetes and congestive heart failure in a care coordination program designed to improve health outcomes and to reduce overall health care expenditures; and,
3) Develop and strengthen SERPA-IPA Care Coordination program sustainability by demonstrating positive health and financial outcomes of care coordination in the primary care setting.

In July 2017, program evaluators from the NORC Walsh Center for Rural Health Analysis conducted a two-day site visit, as part of an FORHP evaluation contract, to learn how SERPA-IPA has implemented its care coordination program.

HOW IS THE PROGRAM STRUCTURED?

Target Population

Care coordination services are provided to SERPA-IPA clinics' patients who are diagnosed with type 2 diabetes or congestive heart failure (CHF), two of the most common and costly chronic health issues in Nebraska. In Year 2 of the program, Care Coordinators worked with over 6,500 patients. The patients served tended to be White (80%) and receive Medicare (60%).

Partners and Approach

To meet the objectives described above, the 13 participating primary care clinics employ 18 care coordinators (CCs). A few clinics also support a diabetic educator and/or community health worker (CHW). While most CCs are registered nurses (RNs) or licensed practical nurses (LPNs), a clinical background is not a requirement for the position. As an example, one CC held a Master of Social Work (MSW) degree.

CCs use provider referrals from local clinics or hospitals as well as data from electronic health records (EHRs) to identify high risk patients with type 2 diabetes or CHF who could benefit from care coordination services. Patients are often identified for inclusion if they have not had a recent office visit, lab work, vaccinations, or other indicated medical care, or have demonstrated a pattern of frequent emergency room (ER) and/or hospital use.

To structure care coordination services, SERPA-IPA adapted the MacColl Institute for Healthcare Innovation Care Coordination Model and the North Carolina Coordinated Care model. These models emphasize team-based, patient-centered care and encourage partnerships with hospitals, nursing homes, community services, and other contributors to the care continuum. Once enrolled, patients receive an array of Care Coordination Program services (see Exhibit 1).

Exhibit 1: Care Coordination Program Services

Care Coordination Program Services
• Post-hospital or ER discharge support • Assistance with diet and daily living routines • Medication reconciliation • Monitoring of quality measures • Care planning and monitoring • Pre-diabetes and diabetes management classes • End-of-life advanced care planning

The types of services received and the length of time a patient is enrolled in the program depends on each patient's individual needs; however, transitional care management (TCM) with a focus on reducing hospital readmissions was identified as an early priority by SERPA leadership. TCM includes accurate and timely communication among the patient and providers as care is shifted from one health care setting or provider to another.

WHAT IS THE PROGRAM'S IMPACT?

Enhancements in Care

As of June 2017, the Care Coordination program had served 7,200 patients with type 2 diabetes and 1,600 patients with CHF. Based on ACO performance data provided by the Centers for Medicare & Medicaid Services and Blue Cross Blue Shield, ACO clinic patient participation in the program was associated with a decrease in the ER use and hospital readmissions.

Providers and CCs shared stories that illustrated these findings. One CC described successfully diverting a patient's repeated unnecessary and costly trips to the ER after she discovered that the patient was calling an ambulance because he did not have transportation to access appropriate care. The CC linked the patient with transportation and outpatient services. Another provider described a patient who was admitted to the hospital every three to four months. After enrollment in the Care Coordination Program, the patient was not hospitalized for over a year. The provider attributed

this success to the CC's regular calls and ability to address the patient's symptoms before they progressed.

CCs also cited the benefits of CC-provided diabetes education. One CC described a patient with uncontrolled high blood sugar who stopped drinking sugary sodas following a diabetes self-management education class. As a result, the patient's lab results greatly improved. Providers and CCs relayed that this patient-level improvement was often a result of education and knowledge that someone from the clinic cared and would be an advocate for them.

> *"There is no doubt the care coordination program has helped patients."*
> - Grant Leadership

Improved Capacity to Offer Care Coordination

Transitional Care Management

Interviewees also described program-level improvements in care supported by the program. SERPA leadership reported that many hospitals now alert clinic CCs via phone or e-mail when patients are admitted to or discharged from the hospital. In addition, many of the CCs developed a personal relationship with local hospital care teams and received approval to access relevant hospital and ER records. In addition, patients know they can reach out to the clinic CC with questions post-discharge and that appropriate follow-up care will be arranged and tracked. As needed, CCs perform home visits following discharge, which provides additional understanding of facilitators and barriers to patient health and an opportunity to reconcile medications.

Additional Services

While TCM remains the focus of the SERPA-IPA Care Coordination Program, additional services are provided. CCs reported helping patients receive services from food pantries, Area Agencies on Aging, and exercise programs. There has also been an increase in collaboration with outside organizations. For example, CCs have worked with the local health department to provide diabetes education classes, and some clinics have developed relationships with nearby pharmacies to assist with medication reconciliation.

Increased Communication

The Care Coordination grant also provides opportunities for communication and peer learning among the clinics. SERPA-IPA adopted software to support efficient information sharing, including upcoming meeting dates and emerging best practices. A message can be posted on the site and CCs, administrators, and providers can access the notification and add comments. SERPA-IPA leadership also supports meetings for those involved in the grant. This peer learning includes a monthly CC meeting, during which CCs can network, share ideas, and troubleshoot common issues. A quarterly meeting of the "lead" PCPs from each clinic provides an opportunity for PCPs to receive updates on the status of the program and provide feedback to grant leadership. In addition, the use of experienced CCs as mentors to new CCs is emerging as a best practice in supporting CC communication. This mentorship helps ensure that programmatic information is not lost during CC turnover and new CCs receive support in their roles.

SERPA-IPA leadership also reported that this grant has enabled an increase in cooperation and collaboration between providers. Some CCs are able to access EHR-based reports that identify patients who are overdue for wellness visits, diabetic foot or eye exams, lab work and other services, for example. This information is useful for outreach and visit planning. Local hospitals are working with SERPA-IPA clinics to alert them of patients who are admitted and discharged from the hospital. Some clinics have also developed good relationships with local pharmacies to help with medication reconciliation. Local health departments are also collaborating on diabetes education and have paid for CCs to attend conferences on pre-diabetes training and care coordination. Likewise, local social service agencies have also reached out to the clinics to collaborate to meet patients' needs.

Increased Visibility

SERPA-IPA leadership presented the Care Coordination Program at several meetings including: the Nebraska Health Information Management Conference, CIMRO's Quality Conference, and Nebraska's Academy of Family Physicians Learning System for ACOs Region VII &VIII In-Person Learning Collaborative Meeting. These presentations provide SERPA-IPA leadership an opportunity to share their care coordination experience with other stakeholders considering similar programs.

Reimbursement Successes

Offering services that are reimbursable by Medicare and some private payers is an important component of sustainability for the program. Reimbursable Medicare services include transitional care management (TCM), chronic care management (CCM), and end-of-life advanced care planning

(ACP). Many care coordination activities, such as care planning, fit within the bounds of those billable services. One CC described how she focuses on ACP, which is reimbursed by Medicare. The ACP billing codes cover the discussion of advanced directives and the completion of relevant legal forms, such as Living Wills. Notably, this revenue is able to support the CC's position within the clinic. While these billing codes enhance sustainability, they may also be associated with challenges, as discussed below.

Evolving Market Forces

As in other states, there are a large number of practice transformation activities and initiatives in Nebraska promoting the transition to value-based payment models. SERPA-IPA's experience with care coordination well positions it to help clinics respond to these changes. Eight of the clinics were approved in late summer 2017 to join the Comprehensive Primary Care Plus (CPC+) program, a Centers for Medicare and Medicaid Services (CMS) initiative that recently became available in the region. CPC+ focuses heavily on care coordination and uses a medical home model. Clinics that do not become CPC+ approved will continue preparation for national value-based payment models. While these initiatives have exciting potential to transform and improve care, particularly within primary care practices, rural healthcare systems must navigate changes in hospital utilization and revenue. As the program continues, SERPA-IPA also hopes to work with private payers to establish a care coordination fee for members.

WHAT CHALLENGES HAS THE PROGRAM FACED AND WHAT LESSONS HAVE BEEN LEARNED?

Patient Engagement

CCs reported that patient engagement and compliance were challenges. Patients may view care coordination as bringing another person into their personal matters, which can be particularly difficult in small, close-knit rural communities. CCs also noted that the cost of medication, particularly insulin, was a frequent reason for patient non-compliance.

Provider Engagement

Grant leadership reported that not all providers were initially supportive of care coordination. They cited a lack of willingness to change workflows, particularly among providers who viewed care coordination as additional work in their overburdened schedules. As an example, less than a third of the PCPs are billing for CCM services because of the time-intensive nature of care planning. Providers expressed concern that formal care planning did not provide enough benefit to the patient to warrant taking time away from already brief appointments.

An important emerging best practice for building provider engagement is to hold monthly meetings focused on quality with all clinic staff. The goal is to help all care team members understand and appreciate why they are being asked to change their approaches to care. Grant leadership also cited the importance of ensuring that the CCs are active members of the care team and that their efforts are well documented so that providers can see the benefits of their involvement. Providers reportedly became supportive of this program after observing improvements in patient care and outcomes.

Staffing

CCs reported concern regarding having enough time in their schedules to provide care coordination while navigating strict rules regarding the timing of services. Mondays were described as particularly busy because patients who were admitted or discharged over the weekend need follow-up.

Selecting the right CCs is also important. Successful CCs should be self-motivated, flexible, and able to develop rapport with patients. Initiative and the ability to troubleshoot issues on the phone were also mentioned as important CC characteristics. Furthermore, both CCs and providers noted that while nursing skills are beneficial, a CC must be comfortable departing from the typical clinical, office-based patient interaction.

Reimbursement

As described above, reimbursement for certain care coordination services offers important opportunities for program sustainment; however, billing rules and regulations may be complicated and time-intensive to navigate. One clinic administrator expressed frustration regarding the difficulty of instituting per-member, per-month payments that correctly reflect patient risk, and noted the extensive effort it takes to document staff time spent on TCM and CCM to ensure correct billing.

While many care coordination services are billable, they frequently require extra appointments and phone calls with patients. Though the TCM and CCM include a patient cost-sharing component that is often covered by Medicare supplement plans, the cost was perceived as a potential barrier to patient engagement. Patient education is needed to clarify what TCM and CCM provides and what to expect

regarding cost. CCs also noted that not all care coordination services are covered. They cited diabetes education programs and working with clinical pharmacists on medication reconciliation as two areas in need of additional financial support.

Tracking Services

Tracking care coordination services can be challenging, and grant leadership is working with the CCs to create low-burden methods for capturing these efforts. Documentation varies across the 13 clinics, with eight different EHR systems. Most clinics have been able to create templates to capture CCM and TCM services; however, tracking extra activities, such as phone calls, can often be difficult and onerous for CCs.

In addition, tracking the work of providers outside clinics and hospitals with existing information sharing arrangements can be challenging. For example, CCs reported spending time collecting documentation on diabetic eye exams from ophthalmologists. To help streamline the data collection process, one CC developed a card for patients to present to outside providers that requests appropriate information is forwarded to the CC's clinic.

Tracking Outcomes

Tracking outcomes across multiple clinics and EHRs is a challenge. Grant leadership reported that it continues to look for a vendor that can support data standardization and analysis. By July 2017, grant leadership had investigated five different population-health analytical tools, but had not yet identified a vendor that can provide the needed functionality. It will continue to explore vendor options.

CONCLUSION

SERPA-IPA developed a large network of CCs that has meaningfully improved transitions of care for patients and caregivers, and enhanced communication between patients and care teams. SERPA-IPA's experience with reimbursement for care coordination services highlights some of the key benefits and challenges in sustaining care coordination services. Supporting patients through TCM when they are discharged from inpatient hospital stays and ER visits is an effective approach for providing Medicare-reimbursable care coordination services and improving patient care and outcomes. However, while CCM is important for ongoing management of chronic conditions, it is often difficult to bring providers and patients on board due to perceived administrative and financial burdens. Understanding the opportunities and challenges of Medicare reimbursement are key to grant leadership as it seeks to secure similar contracts with other payers, and may be useful to other rural networks considering care coordination in their communities.

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For More Information:

FORHP Care Coordination Grant Funding Announcement: https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx?id=e3af9abe-a716-4a40-be96-b8273fac43f6

Rural Health Information Hub Rural Care Coordination Toolkit: https://www.ruralhealthinfo.org/community-health/care-coordination

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