

The Rural Health Care Coordination Network Partnership Program: Chautauqua County Health Hospital Network

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 Chautauqua County Health Network in New York.

Grantee Program Area Served

- *Located on Lake Erie in western New York*
- *Aging population with a high prevalence of chronic disease*
- *Designated Health Professional Shortage Area and Medically Underserved Population by the Health Resources and Services Administration*
- *Provider community with a demonstrated commitment to innovation*

GRANTEE BACKGROUND

The Chautauqua County Health Network, Inc. (CCHN) is a mature, rural health network comprised of local health care providers and community-based organizations collaborating to meet the needs of both health care consumers and providers in the region. CCHN brings together local hospitals, primary care practices, public clinics, and hospice. The CCHN is often in the forefront of health care delivery. Major achievements include the establishment of one of the first physician-hospital Independent Practice Associations (IPA) in the state, a new Federally Qualified Health Center (FQHC), and one of the first rural Centers for Medicare & Medicaid Services/Medicare Shared Savings Program Accountable Care Organizations in the nation.

Partners in this network use the Collective Impact Model, which focuses on five strategies: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support. Even with these innovative efforts, however, all four Chautauqua County community hospitals struggle to stay economically viable in a constantly changing market. Changes affecting financial viability include the New York State Medicaid redesign efforts, transformations in the

Medicare reimbursement schedule, and mergers and acquisitions of local hospitals and formerly independent primary care practices.

CCHN recognizes that these market shifts, with an emphasis on quality rather than quantity, necessitate the development and expansion of outpatient services. As a result, CCHN has been a long-standing champion of care coordination within and among network partners. CCHN received two Federal Office of Rural Health Policy (FORHP) grants that set the foundation for the Rural Health Care Coordination Network Partnership Program grant (Care Coordination grant). A 2010 Small Health Care Provider for Quality Improvement grant enabled the development of a care coordination model called Chautauqua Health Connects, whose priorities were strengthening and enhancing case management and referral services, and increasing awareness of the need for affordable home- and community-based services. A 2012 Outreach Program grant allowed CCHN to establish the Johns Hopkins Guided Care Nursing Program in six primary care practices to coordinate care for their most complex, chronically ill patients.

The Care Coordination grant leverages the previous grant efforts to expand care coordination to moderate-risk patients and to refine care coordination workflows. The overarching goal is to provide patients with type 2 diabetes, congestive heart failure (CHF), and/or chronic obstructive pulmonary disease (COPD) with well-coordinated preventive health services and links to community-based services. In June 2017, program evaluators from the NORC Walsh Center for Rural Health Analysis conducted a two-day site visit to better understand how CCHN has implemented its program.

HOW IS THE PROGRAM STRUCTURED?

Target Population

CCHN estimates that there are about 10,000 patients with diabetes, CHF, and/or COPD who

Health Manager Services:

- Develop Self-Management Action Plans
- Monitor hospitalizations
- Conduct monthly (or more frequent) follow-up
- Link individuals with needed resources
- Assist with medication reconciliation
- Ensure wellness visit
- Education regarding disease management
- Communicate with providers and other supports

could benefit from care coordination in their catchment area. The program is primarily intended to reach people who need regular support, but are not medically frail. Most patients receive Medicare and/or Medicaid, but many patients also have private insurance (payer mix varies by practice). Enrollment targets were established at 75 to 100 patients per participating practice.

Partners and Approach

CCHN has engaged all four hospitals in the county, five primary care practices, and the local hospice as partners in the Care Coordination grant. CCHN is the lead organization and provides primary oversight and planning of grant-related activities. A combination of grant funding and in-kind contributions helps support varying levels of the following positions: Executive Director, Administrative Director, Quality Improvement Manager, Data Analyst, Administrative Assistant, and Care Coordinators/Health Managers.

To accomplish grant goals, grant leadership implemented modified versions of two existing care coordination models. The Vermont Blueprint Community Health Team (CHT) program served as the basis for a CCHN-led CHT. The CHT brings stakeholders together to identify ways to increase community-based services by leveraging existing staff and infrastructure. Representatives from each partner meet at least quarterly to discuss associated planning and learning activities as part of the CHT. The ProvenHealth Navigator model guides Health Managers' care coordination activities.

A Health Manager is embedded in each primary care practice. Health Managers are registered nurses (RNs) trained to work with patients on disease prevention and management in a patient-centered manner with providers and community-based services. Health Managers reported that referrals to the care coordination program come from a variety of sources, including practice providers, a "work list" generated by the CCHN Data Analyst, and the review of internal electronic health records (EHR).

WHAT IS THE PROGRAM'S IMPACT?

The CCHN site visit occurred near the end of the second year of the three-year grant period. While it is too early for the CCHN to provide health outcomes at the patient level, providers and Health Managers provided evidence of early successes.

Enhancements in Care

By June 2017, the program had enrolled 289 eligible patients into care coordination. Health Managers

performed a wide range of services to coordinate patient care and improve disease management (see box).

One of the main service gaps identified by the CHT was insufficiently coordinated care for CHF patients with frequent hospitalizations. To address this need, a Cardiac Nurse Navigator Program was established at UPMC Chautauqua WCA Hospital in May 2017. The cardiac nurse works with patients hospitalized at WCA for CHF and links them with community resources, helps implement treatment plans, and educates the patients regarding their diagnosis, medications, tests, and treatments. While most of the program's referrals come from within the hospital, Health Managers are also able to refer primary care patients for additional support and education regarding their CHF diagnosis. By June 2017, the Health Managers had referred six patients to the Cardiac Nurse Program.

Health Managers noted a number of instances of improved care and health outcomes as a result of grant-related services. Examples included successful linkages of patients with assistance in transportation, insurance enrollment, utilities, housing, medication access, and food banks, among other areas. Health Managers also talked about the importance of patients knowing that “someone who cares” will follow-up with them regarding care plan compliance. Complying with recommended tests and medications helps decrease the chances a patient will need costly urgent or emergent care.

The benefits of care coordination extend beyond the patient. The wife of one Health Manager-supported patient diagnosed with diabetes and CHF described her gratitude for having someone at the physician's office easily available for her to call with questions about her husband's care. She also found educational materials on blood sugar readings and medication dosage charts helpful, as were the Health Manager's recommendations for more advanced disease management and referrals for additional services.

Improved Capacity to Offer Care Coordination

CCHN leadership described the training that has been made possible with grant funds. Under the Care Coordination grant, all Health Managers completed the xG Health Solutions training. The curriculum covers patient populations and risk stratifications; work flow redesign; identifying and managing targeted conditions, including diabetes, CHF, and COPD; and managing referrals to services in the medical neighborhood. While the

training was viewed as useful by the Health Managers—particularly its templates for care and sick day plans—the Quality Improvement Manager reported that due to cost considerations, future Health Managers will be trained through the American Academy of Ambulatory Care Nursing on Care Coordination and Transition Management. In addition, all Health Managers reported participating in motivational interviewing training.

Other efforts have also improved care coordination capacity. The Health Managers participated in a monthly, web-based learning collaborative organized by CCHN leadership in which they shared information about new services, program progress, and creative solutions to common problems. The grant has also supported CCHN to facilitate the use of Direct, a universal secure messaging exchange for bi-directional referrals and reports, that will allow network partners to securely share patient-level information and make referrals.

Increased Use of Data

CCHN staff reported that the Care Coordination grant has improved the flow and use of data within and among partner organizations. The Data Analyst aims to compile data on a quarterly basis for practice teams to track key metrics and identify areas of high or low performance. While CCHN does not have longitudinal follow-up data, the Quality Improvement Manager described gathering available baseline data, including rates of diabetic eye exams and high blood sugar levels. In addition, CCHN has collected baseline data for both a Patient Satisfaction Survey and a Provider Satisfaction Survey, as well as baseline Patient Activation Measure (PAM) assessments. All available data have been shared with the partners to help identify strengths and opportunities for improvement.

“I can't say enough about how helpful this has been for me.”

-Wife of Patient Receiving Care Coordination

Strengthened Partnerships

The Care Coordination grant represents the first time CCHN hospitals and primary care providers have joined forces on an initiative. Grant leadership reported increased trust among the participating partners. CCHN works to build consensus around existing resource alignment and strengthen linkages among network partners to improve care for chronically ill patients. The four hospitals and the hospice collaborated on a Resource Services Guide for HM use, which will be updated yearly. In addition to the Cardiac Nurse Navigator Program added by

UPMC Chautauqua WCA Hospital (described above), Westfield Memorial Hospital is planning to increase its Diabetic Education Program. The TLC Health Network, with the assistance of Brooks Memorial Hospital, is considering a Diabetic Exercise/Education Program, and Chautauqua Hospice and Palliative Care is creating a new intake process for Health Managers to use that ensures patients receive appropriate end-of-life services.

Preparation for Value-Based Payment Models

CCHN leadership has worked with the grant partners to improve understanding of how care coordination helps bridge the gap between the current fee-for-service environment and new value-based payment structures. Most partners operate on thin or negative margins, with little ability to invest in innovation on their own. The Care Coordination grant funding has provided resources enabling the practices to more fully advance their care coordination efforts. Ultimately, this development of care coordination structure, processes, and staffing increases the long-term viability of the partner organizations.

"[Care Coordination] might not pay today, but it certainly is going to pay tomorrow."

—Hospital Administrator

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

Patient Engagement

Health Managers described a number of barriers to connecting with patients and providing access to services. Patients who would benefit from disease education and management are often difficult to engage. Young adults, especially, are frequently transient and hard to contact. When patients are engaged, there still may be difficulties in linking them with services. Health Managers often focus efforts on disease management education and medication reconciliation, because medication non-compliance often is a result of a lack of "health literacy." Transportation is also often a challenge for patients when partner-provided classes and specialists may be more than an hour's drive away.

Time Required for Building Program

At the network level, grant leadership noted that it takes time to build a robust care coordination program. This includes time to develop a structure for the program and to gain buy-in from

administrators and providers within the partner organizations. CCHN supported a series of meetings to help partners identify care coordination needs and strategize solutions to build this program.

CCHN also reported that it takes time to identify staff to fill Health Manager positions due to the limited capacity of the primary care practices. Once Health Managers are selected, additional time is needed to arrange for care coordination training. As a result, patient enrollment in the program began in summer 2016, months later than planned.

Staffing

Staffing is a central challenge to program success. CCHN reported that personnel shortages in other areas of the primary care practices complicated HMs' ability to focus on care coordination. Grant leadership also noted the extra effort required to identify and train replacement Health Managers. Successful Health Managers need strong communication skills, the ability to build rapport with patients, patience with slow or no progress in patient behavior change, and a solid understanding of the social determinants of health. Health Managers also pointed out that their advanced clinical knowledge as RNs enabled them to assess and address patients' health concerns and treatment plans.

Both Health Managers and grant leadership described the competing priorities Health Managers balance within busy primary care practices. While this embedded structure has many benefits, including ready access to both patients and their care providers, it also has drawbacks. The Quality Improvement Manager described how the Health Managers sometimes struggle protecting their time for care coordination activities, such as monthly follow-up calls. In year two of the Care Coordination grant, one of the six practices determined that it could no longer participate because the cost of allocating staff time for care coordination was too high. Despite this challenge, through ongoing discussion with administration and providers, CCHN has helped the other five practices realize the benefits of the program for patient care and the financial bottom line.

Tracking and Utilizing Data

Almost everyone interviewed described challenges related to data. Among the five participating primary care practices, there are three different electronic health record (EHR) software packages, and each hospital has its own platform. The Data Analyst conducted a review of clinical measures across EHR platforms and identified gaps in structured data required for reporting. The Data Analyst and Quality

Improvement Manager both reported that chart reviews will be needed to capture data that are not accessible within an EHR.

The Data Analyst also highlighted the challenge of having to report requirements for the grant and payers that do not align. For example, spirometry is a FORHP grant-reporting requirement but is no longer a requirement for Medicaid Shared Savings reimbursement due to the reporting burden. The Data Analyst reported that, ideally, there would be better alignment in reporting requirements among all programs and payers.

Evolving Market Forces

While partners understand the shift to value-based payment models and the role of care coordination in improving quality, the CCHN staff stated that ongoing hospital mergers and large organizations acquiring independent primary care practices have been a distraction for some partners. These changes in ownership are most evident in the slow creation of new services identified in the CHT gap analysis. CCHN continues to monitor federal and state reform initiatives to align network activities to mitigate competing priorities and leverage opportunities that may propel all partners toward better patient care and improved financial viability.

CONCLUSION

CCHN has developed a robust care coordination program that providers, patients, and caregivers value. Despite challenges inherent in the evolving health care market, early indications are that the Care Coordination grant has helped this community achieve potentially long-lasting patient- and provider-level improvements. As other rural providers and networks explore care coordination models, CCHN's approach may provide a feasible path forward.

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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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