OUTSIDE THE LINES

CARE COORDINATION ACROSS THE CONTINUUM

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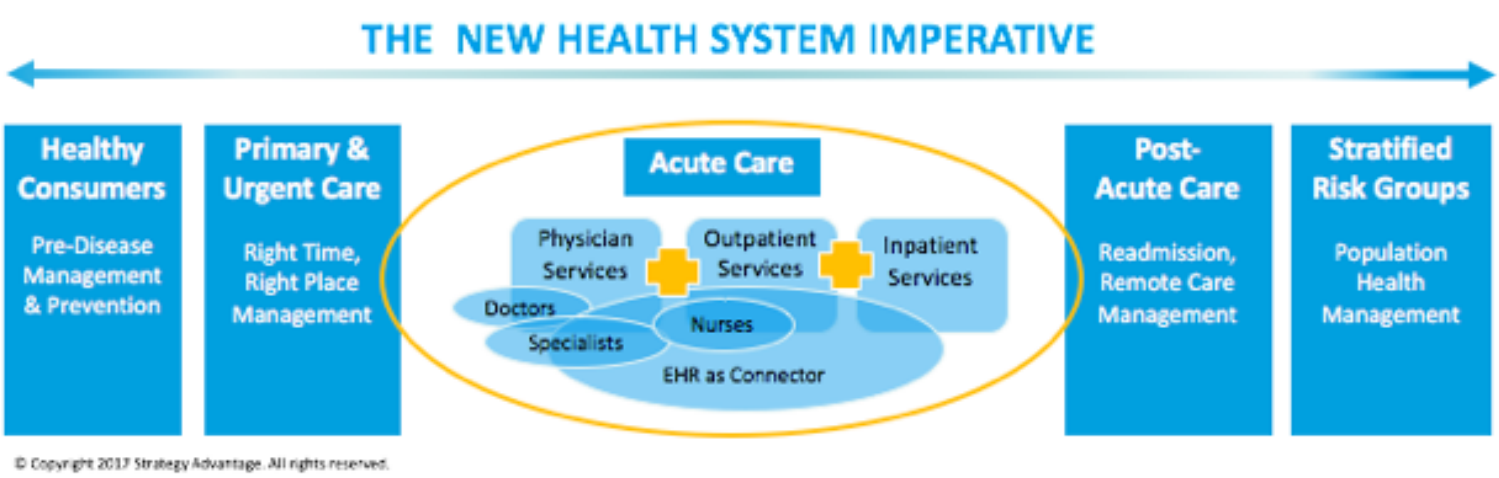
This is the 3rd issue in a 4-part series titled: Pushing the Boundaries: Healthcare's Front Doors. This series features healthcare leaders who are making progress toward the goals of addressing the healthcare consumer, access, care coordination and care experiences. Click here to access the entire series or to review other Outside the Lines series we've published.

More than 15 years ago, in 2001 – on the heels of its *To Err is Human* report – the Institute of Medicine (IOM) published another landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. It called for sweeping change, noting: "The U.S. healthcare delivery system does not provide consistent, high-quality medical care to all people … between the healthcare that we now have and the healthcare that we could have lies not just a gap, but a chasm."



Among many recommendations, the report featured care continuity and coordination in its 10 Rules for Redesign. Rule #1 noted that care is based on continuous healing relationships, and that patients should receive care whenever they need it and in many forms, not just face-to-face visits. Rule #10 emphasized that cooperation among clinicians is a priority to ensure an appropriate exchange of information and coordination of care.

Today, the challenge to redesign healthcare and improve quality is as pressing as ever, and care coordination is a major focus. In fact, over the years, the National Quality Forum has led several projects to provide guidance and measurement of care coordination, including its newest 2016-2017 project.

This Outside the Lines issue continues a series titled “Pushing the Boundaries: Healthcare’s Front Doors.” This week, we cover the topic of care coordination, featuring healthcare leaders who are making progress toward this goal. This is a complicated topic, and process changes inside of health systems that really make a difference in care management and coordination are tough to execute. That said, coordination is fundamental to quality care and key to crossing the chasm for success in the value-based model. Also, as the health system continuum of care expands, the realm of coordination broadens beyond acute care. It further encompasses “healthy consumer” and “primary & urgent care” coordination, and as well, “post-acute care” transitions and “stratified risk groups” management.

How are health systems, providers and others finding success in care coordination? We can only scratch the surface as we point to some examples, but the following are interesting and are showing proof in their outcomes:

- Healthy Consumers: Many health systems, health plans, employers and others are building up their care management services geared for members, employees and people in their communities who are well, but at risk for disease. Three digital

health companies that we have mentioned before in Outside the Lines are evolving, reporting outcomes from their programs and partnering with traditional providers and insurers. For example, Canary Health – with its Diabetes Prevention Program and Chronic Disease Self-Management Program – reports an 80% reduction in diabetes cases along with reduced outpatient, inpatient and ER utilization. Noom reports 18 pounds, on average, of weight loss for people in its program. Omada Health says that its participants, on average, lower their 5-year risk for Type 2 Diabetes by 30%, for stroke by 16% and for heart disease by 13%. In June 2017, Cigna became a strategic investor (part of a $50 million funding round) in Omada Health and added Omada's CDC-certified diabetes management program into its suite of health improvement services.

- Primary & Urgent Care: The patient-centered medical home (PCMH) has been around for decades, making its mark on primary care across the country. It is a model of care that is patient-centered, team-based and coordinated. Today, about 17% of primary care practices (representing about 55,000 clinicians) carry NCQA's PCMH designation, according to the National Committee for Quality Assurance. This is an increase from 100 clinicians when the designation was first introduced in 2008. At Carolinas HealthCare System, the medical home is being applied in a new way. For its Anson Community Hospital in Wadesboro, N.C. – a rural hospital serving a community of about 26,000 people – the system decided to embed primary-care physicians in the ED to care for non-emergency needs of visitors and to better address underlying chronic health conditions that are at the root of repeat emergency visits. The number of ED visits declined 7% in 2014, the first year Carolinas HealthCare's Anson facility began the new model, and there have been moderate annual declines in ED visits since.
- Post-Acute Care: One of the many metrics for value-based care is readmission rates. As a result, care transition and post-acute care strategies are pivotal in the context of a broader care coordination solution. Spectrum Health in Michigan is one health system that has revised processes and culture focused on post-acute care. The system developed a comprehensive RN care management transition program that uses a telephonic model and data tools to bridge care from the acute care setting to skilled nursing facilities (SNFs). The program has resulted in reduced SNF days per 1,000 from 966 to 640, improved quality, enhanced experience of care for patients and reduction of costs.
- Stratified Risk Groups: According to a February 2017 Harvard Business Review piece titled "Redesigning Care for High-Cost, High-Risk Patients," almost half of the nation's healthcare spending is driven by the top 5% of the population with the highest spending, while the top 1% account for more than 20% of total healthcare

costs. According to the article, “to build a better model of care, physicians and leaders of care organizations must begin by asking where we should care for these patients, how we should care for them, and, ultimately, why we care for them.” The article points to the CareMore Health System model which pioneered early intensive chronic-disease management in neighborhood-based care centers, including Extensivists who follow high-risk patients across multiple settings. Other health systems are adding innovative programs designed for at-risk patients. For example, AMITA Health in Chicago – working with TapCloud, a technology app that monitors and follows patients via remote connections – provides its AMITA Health Check mobile app to physicians and their patients being treated for joint replacement, anxiety, depression, stroke and bariatrics. According to AMITA Health, the app was initially tested across a 7-month period including more than 200 total joint replacement patients, resulting in a 0% readmission rate, an improvement over its anticipated 5% readmission rate.

Across the continuum of care, health systems and others are addressing the “crossing the chasm” challenge via care coordination strategies, including both traditional and non-traditional solutions. Although more than 15 years old, the IOM report focuses broadly on how health systems can be reinvented to foster innovation and improve the delivery of care. It was a call to action in 2001, and it is still relevant today. Perhaps you want to dust off the report and give it another read.

Always looking ahead,

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DO YOU KNOW...

Since 2015, CMS has been paying physicians an average of $42 PMPM for care coordination services for patients with chronic diseases. However, as of early 2017, CMS reports that its care management billing codes have not been widely used by physicians due to a lack of awareness and/or because of pushback from patients who do not want to pay a co-payment when their physicians bill for these services. According to CMS estimates, 70% of Medicare beneficiaries – about 35 million people – have two or more

chronic conditions (which is the eligibility standard for doctors to get paid for chronic care services), but as of the end of 2016, CMS received chronic care claims for only about 500,000 beneficiaries, indicating that doctors are not taking advantage of the funds. CMS has launched a national campaign to promote the program.

DO YOU KNOW ABOUT...

PatientPing is another care coordination technology company that is connecting hospitals and providers, and transforming care transition models. Different from others, though, its focus is on statewide data-sharing initiatives and a national care coordination community. While PatientPing started only a few years ago in 2013, tens of thousands of providers, hundreds of hospitals and care facilities, and nearly a dozen states have joined together on the PatientPing network to coordinate patient care. PatientPing is one of the innovator companies we have researched and profiled in our ZIGZAG Healthcare library; join us to learn more about PatientPing and other innovators to spark your thinking as you develop your growth and transformation strategies. Also, interestingly, WellStar Health System in Georgia just announced a partnership with PatientPing that integrates the technology across WellStar's 11 hospitals, 8 urgent care centers, 3 skilled nursing facilities, 3 inpatient hospices and other locations. As a result of this partnership, via PatientPing, providers across the state will be notified when their patients are admitted, discharged or transferred to and from a WellStar facility.

A "LEADING" LEADER IN HEALTHCARE ...

One healthcare leader, Dr. Thomas H. Lee, has for many years been a proponent of change, recommending many avenues for thinking about and doing healthcare differently, and usually emphasizing the importance of care coordination, or "tying it all together" as he puts it. In a 2016 TEDMED talk, he notes that while there is "so much more that we can do today … it oftentimes feels like there is *too much* to do, *too many* people involved with narrower focuses and that no one is taking full responsibility and accountability for what is happening to patients." In 2013, Dr. Lee, with Michael Porter, authored a *Harvard Business Review* article, titled "The Strategy That Will Fix Health Care." The first line read: "In healthcare, the days of business as usual are over." The authors further write: "At the core of the value transformation is changing the way clinicians are organized to deliver care. The first principle in structuring any organization or business is to organize around the customer and the need. In healthcare, that requires a shift from today's siloed organization

by specialty department and discrete service to organizing around the patient's medical condition."