Revolutionary health care transformation

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IssueBrief

De-fragmented, patient-centered care: Pursuing care coordination, Hudson Valley Initiative fulfills the promise of the medical home

> *"The Hudson Valley Initiative's medical home work has laid a good foundation for understanding that we are going to be responsible for the care of a defined population, not just those who walk in our door. The old ways of doing things–based on visits—is not the same as being responsible for the health of a population."*
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> — PAUL KAYE, MD, VICE PRESIDENT FOR PRACTICE TRANSFORMATION AT HUDSON RIVER HEALTHCARE, MEDICAL DIRECTOR, TIPA AND THINC TREASURER

High quality, efficient care requires the effective coordination of a patient's health care services. Too often, that's just not happening. Examples of poor coordination abound in the literature.[1,2,3,4] Care is frequently uncoordinated and fragmented, leading to higher costs, poor outcomes and negative patient experiences.

Coordinated care is transformative and essential to delivering on the promise of the patient-centered medical home, explained Susan Stuard, executive director of Hudson Valley Initiative founder Taconic Health Information Network and Community (THINC). To move the bar on quality, care *must be coordinated,* she said.

Early on, Hudson Valley leaders recognized this, making it an essential element of the Hudson Valley Initiative patient-centered medical home efforts.

Pediatrician Gregg Rockower, MD, of Clarkstown Pediatrics, is one Hudson Valley physician who has embraced care coordination innovations. "We are a practice that is always ahead of the curve in terms of innovation, and we look forward to taking on a more comprehensive and effective care coordination approach. We feel that if there is anything we can do to make our practice better for our patients, even with some cost to our practice, we are happy to do it. We know that in the end it is a win-win for our patients, their care and our providers."

But more work is needed. "In a community that is working toward an advanced patient-centered medical home, care coordination is rising to the top as the most glaring issue to address, as identified by patient and provider surveys," said A. John Blair III, MD, F.A.C.S., CEO of MedAllies and president of the Taconic Independent Practice Association (TIPA). Recent baseline surveys of Hudson Valley patients and providers found high levels of patient *and* provider satisfaction, but both identified coordination of care as an area of dissatisfaction.[5]

Meaningful change, not a buzzword

Care coordination is a value-driving component of advanced primary care, Blair explained. It is a fundamental component of community transformation.

"Care coordination" cannot just be another buzzword, Kaye said. It involves a variety of very practical tasks, such as:

- Population management (of the general population)
- Referral management (urgent and routine)
- Reducing readmissions
- Care management of the chronically ill
- Transitions coordination
- Coordinating care for special populations

"We have to figure out how to do the right thing for the right person at the right time, in the right setting. The solution won't be the same for all those groups," Kaye explained. "The trick is figuring out which of those activities should be done by whom and at what level of intensity."

New Projects

ON THE CUSP:
Initiatives to support full-scale community adoption

Two projects in the planning stages will further advance care coordination in the Hudson Valley:

- TIPA is participating in the Institute for Healthcare Improvement's Triple Aim program, which advances the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations and reducing per capita costs. TIPA's project will focus on care coordination–most likely, transitions of care. "One of the benefits of working with IHI is that they have tested a series of really specific changes and activities that seem to improve transitions of care and decrease readmission rates. We'll incorporate those lessons in our care coordination work," Kaye said.

- THINC recently received an $8.7 million grant to look at coordinating primary care with mental health providers. The HEAL 17 Mental Health Care Coordination Project will address care coordination among patients with affective disorders, including depression. The funding will help THINC bolster IT capabilities, but at heart it's "about working with providers with high-need patients to discover ways to better coordinate care," Stuard said. She expects to learn more about issues related to patient privacy and transitions between primary care and mental health providers; this will be used to inform the work of other Hudson Valley Initiative sponsoring organizations.

Lessons from the safety net

Hudson Valley Initiative providers can draw on internal resources to develop approaches to care coordination. Hudson Valley's Level 3 PCMH Federally Qualified Health Centers (FQHCs) have taken a leadership role in care coordination efforts and shared their expertise with colleagues, Stuard said.

"Safety net providers have been coordinating people's care forever because they have to. They've already formalized care coordination," explained Kaye. He should know: Hudson River Healthcare is an FQHC and a PCMH. In FQHCs, financial models support such efforts. "Our federal funders like HRSA have always expected us to look at delivery of broader population health, and asked for data that showed that we were addressing priorities in our community."

Private practices, however, have not had federal initiatives to support these efforts. For FQHC care coordination successes to translate into the larger medical community, reimbursement models must change.

"That is the beauty of a community collaborative," Stuard said. "We take lessons learned from collaborators like the health centers and apply them to private practice; the rising tide lifts all boats."

Aligning incentives

Adding nurses, coaches, care coordinators or navigators to private practices will work only if reimbursement systems recognize their value and make changes to reflect the added expense, Kaye said.

In the Hudson Valley, most payers recognize care coordination's value. "We have been able to align payers representing 60 to 70 percent of patients in Hudson Valley medical homes," he said.

Payers are paying attention, Stuard said. Facing escalating costs, they must find solutions that let them deliver quality care while dealing with cost issues. The Hudson Valley Initiative offers plans the opportunity to explore innovative models of care coordination that improve quality and control costs–something health plans need and want to do.

Moreover, as payers continue to focus on care coordination, more providers realize that future reimbursement systems may set a premium on coordination of care, she said. This sort of synergy—aligning payer demands with provider rewards—creates sustainable change.

More accountable care

"When paired with the appropriate IT tools, community leadership and changes in reimbursement, we create the ability for communities like the Hudson Valley to be not a bunch of disparate providers, but to set up a virtual collaboration on care coordination across the continuum of care and across all payers," Stuard said.

"We believe this work at a community level—collaborative work on coordination of care—is very supportive of and complementary to efforts that providers in the community may want to take with regard to accountable care organizations," she said, adding that ACOs hold terrific promise. ACOs are provider groups (that can include hospitals, nursing homes and other organizations) that accept responsibility for the cost and quality of care delivered to the group's patient population. "With a strong primary care base and strong IT systems, the Hudson Valley makes an excellent incubator for ACOs and other innovative models of care delivery."

She emphasized, however, that the transformation the Hudson Valley Initiative envisions is broad and deep, encompassing practices of all types and sizes. "We want to make sure that all Hudson Valley providers find a way to collaborate and participate in the discussion and in the advances that might be made. We want to see the whole system transformed across all payers, to include safety net providers."

Transformation—an ongoing process requiring advanced training

Such transformation is indeed possible. The Hudson Valley Initiative, with its high EHR adoption rate and medical home success, has demonstrated its ability to implement patient-centered care. Practices are being trained in care coordination, and are testing innovations that provide coordinated care across the continuum.

For example, nurses from each Hudson Valley medical home practice will become certified in the Johns Hopkins University Guided Care™ program. The first cadre of nurses will be trained by the end of 2010. Training includes best practices in chronic disease management, case management, caregiver education and support, transitional care, and geriatric evaluation and management.

Guided Care is a practical, interdisciplinary model of health care designed to improve the quality of life and efficiency of resource use for individuals with medically complex conditions. Preliminary research finds that it significantly increased patient perceptions of quality, as well as enhanced physician satisfaction, significantly reduced costs and lowered caregiver stress.[6,7] The Guided Care nurse smoothes the patient's path through the continuum and coordinates the efforts of providers across care settings: emergency

The triad

Laying the foundation—technical infrastructure, transformation, transparency

Each of the three organizations that comprise the Hudson Valley Initiative—THINC, TIPA and MedAllies—plays a vital role in advancing care coordination.

- TIPA's medical home transformation work has been an essential building block for care coordination. TIPA, a nearly 4,000-physican IPA, was part of the effort to help 236 Hudson Valley primary care providers become recognized by the National Committee on Quality Assurance as Level 3 patient-centered medical homes—one of the highest concentrations of NCQA medical homes in the nation.
- The technical expertise and ongoing practice support from MedAllies brings with EHR implementation has been essential to creating the virtual integration necessary in a community that lacks a large integrated delivery network. Since 2007, more than 600 Hudson Valley physicians have implemented EHRs to transform their medical practices.
- THINC brings a mission-driven motivation to foster collaboration and encourage transparency in the community, to get players—providers and payers—to the table in a neutral forum that leaves collaborative concerns at the door. It is building on an accountable finance model, and has partnered with six health plans and a major employer (IBM) in a value-based purchasing program to reward physician practices for reaching quality and care coordination benchmarks.

departments, hospitals, rehabilitation facilities, physician offices, nursing homes and at home.

Geisinger Health System offers another care coordination training partner in the Hudson Valley. Geisinger engages nurse case managers who work as part of the health care team in physician offices. They identify Medicare patients with multiple chronic health conditions, see patients, help develop and manage the patient's care plan, and coordinate care the patient receives from specialists or in the hospital. Geisinger's "ProvenHealth Navigator" approach has been associated with significantly improved outcomes, including lower hospital admissions.[8,9]

Similar results should be possible in the Hudson Valley, Stuard said. But these innovations need to be tested in an open community such as the Hudson Valley, as compared to a "closed" system such as Geisinger.[10] "It is theoretically more difficult to achieve integration, coordination of care, because we don't have the corporate infrastructure to make it happen. It's a community-based, voluntary activity," she said.

Blair agreed: "This open, non-integrated community will be working with an integrated delivery network—Geisinger—to help lift and translate principles and practices they have identified as critical into our transformed patient-centered medical home practices in the Hudson Valley."

PILOT PROJECT: Dedicated care management holds promise

In collaboration with the eHealth Initiative, Hudson Valley Initiative founder Taconic IPA conducted a pilot project to develop and test an operational prototype of care coordination in an EHR-enabled medical home setting–specifically, an embedded care coordinator.[11]

Conducted January to July 2010, the project involved a small private medical home practice coordinating with a large cardiology practice. The project sought to identify the gaps between care settings and to assess how they are best bridged. Its goals were:

(1) to develop and test an operational prototype of care coordination in EHR-enabled medical home primary care settings for patients with type 2 diabetes and co-morbidities;

(2) to enhance cross-provider communications, focusing on the primary care-cardiology interface; and

(3) to support improvements in care with electronic tools.

A full-time registered nurse care coordinator followed the patients selected for the pilot, testing different approaches to successful care coordination.

A full report is expected in October 2010, but several lessons have already emerged. What's particularly significant, Stuard noted, is that the pilot-tested care coordination was not in an integrated environment like Geisinger, but rather took place in the open environment. According to Diane Mullins, RN, TIPA's care coordinator, that's precisely one of the lessons learned from the pilot: Care coordination can be successful in non-integrated medical homes.

Another important lesson is that care coordination can improve patient care through monitoring, educating and coaching the patient. The pilot demonstrated the value of working with patients to set self-management goals, Mullins said. "We have long known that patients need to be a part of setting those goals."

She shared several others lessons learned from the project, among them:

- Setting criteria for risk stratification allows for proper patient selection, allowing care coordination resources to be used wisely.
- Assessing barriers and gaps in care and addressing them with the patient, family/caregiver and provider should be seen as major components of care coordination.
- Trust between the care coordinator and the provider is essential for success.
- The selection of the right individuals to be care coordinators is crucial to success.
- Care coordination will be most successful if there is a team-based approach.
- Access to interfaced EHRs can improve care coordination.
- Care coordination requires open communication between the primary care physician and outside providers and facilities.
- Medication reconciliation is essential, but challenging.

"The pilot revealed significant gaps and that we have a long way to go, but everyone, even the specialists, was enthusiastic. They realize the deficits and want to address them," Blair said. And despite its small size, the pilot helped create a roadmap, identifying where practices could go next to improve care coordination, supported by EHRs. "It's allowing us to start to craft the work plan across our entire Level 3 patient-centered medical home provider base. Based on lessons learned, we are developing an approach to move the community to a dedicated care manager approach in these advanced medical home practices," Blair said.

A unique model for reform: A step-by-step process

Early Hudson Valley success shows that such transformation is within reach. The region has the leadership, technology and training in place, the community involvement and a commitment to transparency and measurement (quality and utilization data as well as patient and provider satisfaction surveys). And a recent pilot, sponsored by the eHealth Initiative in collaboration with the Hudson Valley Initiative's Taconic IPA, demonstrated it *can* be done.

The Hudson Valley Initiative is again blazing a trail providers around the nation can follow–but only those willing to invest the resources and the sweat equity. Doing it right requires complete practice transformation, not simply a minor tweak. "Care coordination is not to be taken lightly," Stuard cautioned. "This requires a major allocation of new resources, but we believe in the long run it can save costs over and above the allocation of resources. We are not talking about just doing some stuff in your extra time. Care coordination is a full-time job."

With that in mind, Hudson Valley leaders are moving ahead.

In addition to the Johns Hopkins training, the Hudson Valley Initiative is working with Geisinger to develop a care coordinator training program. The idea is to train, test and evaluate the changes in preparation for community-wide expansion.

"We need to step up and train a cadre of care managers and create a management infrastructure to support them. We need to be really invested in the next 12 months in hiring and training the right people, deploying them at test sites and tweaking the dedicated care manager model," Stuard said. From there, she anticipates a larger care coordination program rollout: The goal is to implement a dedicated care manager program across all advanced primary care practices, with an initial focus on high-risk patients—where there's the greatest opportunity to improve the quality of care and control costs, she explained.

The implications of the Hudson Valley effort becoming a model for broader health reform are tremendous, said Stuard. "The real opportunity is to demonstrate that a dedicated care management resource can really make a difference in an open community like this. If we are successful in bringing all the parties together, it will be a unique model for health care reform: A community—across all payer types—can self-organize and make a difference."

Susan Stuard, MBA, *executive director, THINC*

Stuard leads the not-for-profit convening organization that establishes research-based criteria to enhance health care quality and value in the Hudson Valley. Prior to THINC, Stuard was the director for technology policy development at the New York-Presbyterian Hospital. She was also the vice president of regulatory affairs for the Greater New York Hospital Association (GNYHA) where she led GNYHA's efforts with respect to clinical information technology and the HIPAA privacy and security rules. She holds a Master's of Business Administration from the Yale School of Management and a bachelor's degree from Hamilton College.

Paul Kaye, MD, *medical director, TIPA; vice president, practice transformation for Hudson River HealthCare; and treasurer of THINC*

Kaye has been a pediatrician for 30 years. He serves as part-time medical director for Taconic IPA and has provided medical leadership to a community health center network that serves over 45,000 patients at 14 sites. He also serves on the Technical Advisory Panel for the Commonwealth Fund's Transforming Safety Net Clinics into Medical Homes project. Kaye is a graduate of SUNY Upstate Medical Center and did his pediatric residency at University of Wisconsin Hospital in Madison.

A. John Blair III, MD, *CEO of MedAllies, Inc. and president of Taconic IPA*

Blair is a board-certified general surgeon who spent 15 years in academic medicine and private practice before becoming president of TIPA, and then CEO of MedAllies. He serves on the Privacy and Security Workgroup and the NHIN Workgroup of the Policy Committee of the Office of the National Coordinator and is co-chair for the HIE Workgroup for the Certification Commission for Health Information Technology (CCHIT). He is a member of the National Committee on Quality Assurance (NCQA) Committee on Performance Measurement, and serves on the Health Information Technology Advisory Committee (HITAC) for the National Quality Forum.

ENDNOTES

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5. Presentation by Lisa M. Kern, MD, M.P.H., associate professor of public health and medicine at Weill Cornell Medical College, at the July 22 Patient-Centered Primary Care Collaborative stakeholders' meeting.

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7. The Agency for Healthcare Research and Quality recently posted findings for several Guided Care studies. They are available at http://www.ahrq.gov/research/sep10/0910RA19.htm.

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10. In a closed, integrated system, members receive all services— preventive medicine and primary care to surgery and hospitalization— from the same entity; Kaiser Permanente is another example.

11. A multi-center Connecticut FQHC also participated in the pilot. Instead of a dedicated care manager approach, it used a centralized care coordinator, with nurses in the center performing care coordination functions.

About the Hudson Valley Initiative

The **Hudson Valley Initiative** is an effort among three organizations—Taconic IPA, Taconic Health Information Network and Community and MedAllies—to revolutionize health care delivery through a shared vision to improve the quality, safety and efficiency of health care in the community. We leverage health information technology, physician practice transformation and value-based purchasing in pursuit of care delivery that is patient-centered, coordinated, accessible, high quality, and efficiently delivered through sustainable financial models. For more information go to **www.hudsonvalleyinitiative.com.**

Taconic IPA

Taconic IPA is the nearly 4,000-member strong physician leadership organization focused on innovative initiatives to transform medical practices and improve health care quality. For more information go to **www.taconicipa.com.**

THiNC

THINC is the not-for-profit convening organization that defines and sponsors research to advance improved patient care delivery models using health information technology; structures and implements pay-for-performance criteria associated with physician practice quality initiatives; and governs the region's secure health information exchange network. For information go to **www.thinc.org.**

MedAllies

MedAllies is the health information services provider that facilitates physician practice redesign to improve efficiency and effectiveness of health care through health information technology, and operates the technical backbone for health information exchange. For more information go to **www.medallies.com.**

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