

Ushering in the Era of Community-Based Care Coordination



Orion Health White Paper
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Introduction

In the community-based model of care, healthcare professionals treat their patients outside of the traditional boundaries of healthcare facilities, and care coordinators interact with patients and multiple provider groups over the phone or in their patients' homes.

This white paper discusses the challenges of using traditional electronic medical records to support this model of care and proposes a more robust solution that integrates data from a range of services into a centralised repository, enabling a more efficient workflow.

The Problem

Reviewing a patient's discharge instructions as the patient leaves the hospital and then confirming their safe arrival back home via a follow-up phone call, is the traditional approach to managing a patient's transition back into their community. This approach frequently results in negative patient outcomes due to a lack of primary care provider (PCP) follow-up as a result of the PCP not being notified of patient discharge and poor patient understanding of complex medication regimens or other barriers preventing compliance with discharge instructions. Negative patient outcomes are associated with high healthcare costs and evidenced by high rates of 30-day readmissions and adverse events.

Newer care models featuring transition-of-care programs have emerged across the U.S. to address the issues associated with patients transitioning from hospitals back into their homes. Programs have been shown to reduce the rate of 30-day readmissions and other adverse events. These models emphasise active engagement with the patient following

discharge to ensure they are reconnected with their PCP and that any barriers preventing an optimal living situation are addressed. Engagement can include assisting the patient with scheduling follow-up appointments, arranging transportation, and setting up a medication management system. These models have been used to provide ongoing care for patients who live with complex medical conditions and social issues, to provide continuity between their provider visits, and a higher quality of life.

Care coordinators who provide these services are often assigned to multiple providers located across a range of medical groups and private practices, each of which uses its own electronic medical system (EMR). As a result, care coordinators are burdened with documentation challenges. They may have multiple user accounts or no access at all. They may have no way to collaborate with other healthcare professionals, which prompts them to resort to cumbersome tools for patient tracking (e.g., spreadsheets and word documents) and communication (e.g., secure messaging, phone messages, and cutting and pasting into various EMRs). These documentation challenges:

- Waste the care coordinator's time.
- Reduce the number of patients each care coordinator can manage.
- Encumber the care coordinator's ability to communicate effectively with other healthcare professionals, potentially causing a delay in delivering services to the patient.
- Inhibit the measurement of a care coordinator's impact on patient outcomes.

The Standard Approach

Many EMR vendors such as Epic, Cerner, and Allscripts have developed care coordination modules within their solutions. These solutions support a number of tasks and requirements, including:

- **Clinical documentation:** Reporting of patient demographics, assessments, visit notes, and progress notes.
- **Workflow:** Linking clinical functions, like documentation, to administrative functions, like E/M coding and patient billing, in an effort to minimise redundant data entry.
- **Medication reconciliation:** Updating the patient's pre-admission prescriptions to account for the patient's post-discharge prescriptions.
- **Care-plan development:** Developing an action plan that addresses the patient's health goals that are often nursing-oriented and focused on goals related to treatment of medical conditions.
- **Chronic care management tracking:** Documenting patient interventions in compliance with regulatory agencies, such as the CMS guidelines for managing Medicare beneficiaries with multiple significant chronic conditions.

For care coordinators working with patients in the community and providing services on behalf of multiple provider organisations, these solutions are insufficient as documentation tools. They:

- Are typically designed to support clinical workflow for associated patient encounters occurring within the confines of a healthcare facility (i.e., neither over the phone or within the patient's home).
- Support documentation focused on aspects of the patient's medical condition and not on other factors affecting the patient's ability to live productively within their home

environment, such as caregiver support, living conditions, safety hazards, and tools to self-manage their condition.

- Are incapable of integrating with EMR solutions from other vendors, creating silos of patient information within each healthcare facility.

The lack of an integrated patient record, with the ability to incorporate data from multiple sources, limits the efficiency of a care coordinator. Consider the following:

- When a care coordinator works with several healthcare organisations with different practice-based EMR solutions or with providers that can't access hospital-based EMR solutions, they must manage multiple user accounts to document patient activity within each silo and accept limited capacity to efficiently communicate with the patient's multidisciplinary care team.
- An important component of a care coordinator's process is to identify at-risk patients. For patients being discharged, it's those with a high probability for readmission. For patients in the community, it's those with complex medical conditions and/or difficult social situations. In the absence of an integrated patient record, care coordinators must rely on individual referrals or reports generated from single information sources.
- Payer data is a valuable source of patient information. As it crosses all healthcare organisations that provide services to that patient, payer data represents a comprehensive view of the patient's journey. With the proper filtering, payer data contributes significant value to the creation of a longitudinal patient record.

- To manage patients in a home environment, care coordinators take a holistic approach. Plans of care that are structured around specific diseases are inadequate in this situation. Regardless of the patient's medical condition, their ability to maintain a high quality of life depends on a safe home environment, connection to appropriate community resources, an effective medication management system, and a reliable support system.

A Better Solution

To address both the challenges of care coordination and interoperability, healthcare organisations must utilise a more comprehensive solution than the traditional EMR, one that offers the following features:

- Support for the full range of interoperability standards, including HL7, Clinical Document Architecture (CDA), and EDI 837. This allows for the creation of a centralised repository that sends and receives patient information from a variety of data sources.
- An analytics engine that monitors the centralised repository to identify high-risk patients using a robust set of criteria that include risk scores, chronic conditions, demographics, and history of health services utilisation. The solution should automatically attribute patients to the appropriate care coordinator based on such factors such as PCP, discharging facility, or insurance. Patient lists should alert care coordinators to new assignments and be automatically generated.
- A structured documentation solution that incorporates community-based models of care. Two generic workflows are needed - transitioning back into their home environment (e.g., Coleman's Care Transition Program) and ongoing management of patients with complex situations within their home environment (e.g., The Chronic Care Model). Both workflows concentrate on important issues for managing patients in their homes. Patient interventions are automatically scheduled based on these models and adjusted based on the acuity level of individual patients. Disease-specific modules such as proper nutrition and stoplight tools for signs and symptoms should be included in patient education materials.
- A library of standardised assessment tools that measure patient well-being (e.g., PHQ, VR-12, Katz) and patient risk (e.g., LACE, CAGE, AUDIT-C). These tools are critical for tracking patient outcomes and measuring the impact of care coordination services.
- Patient engagement tools that enable secure communication with care coordinators, online submission of completed assessments, and questionnaires and active engagement in care planning activities. The ability to transmit patient-generated data from mobile and other devices such as activity trackers and weight scales should be supported.
- The ability to comply with regulations like CMS's guidelines for transition and chronic care management. In order to receive reimbursement, care coordinators working under the supervision of providers must submit documentation of services rendered.
- An affordable cost structure for incrementally adding clinical users to the solution.

The Business Benefits

A number of critical business benefits, which have been difficult or even impossible to achieve with traditional, EMR-centric systems, can be realised with the implementation of a community-based care coordination solution like the one described above.

- **Efficiency through analytics.** Automated detection of high-risk patients using a robust set of criteria and attribution models enables care coordinators to manage a high volume of patients. This eliminates inefficient tracking tools and allows more time for patient interaction.
- **HIE.** With the base infrastructure provided by a comprehensive care coordination solution, a care coordinator can retrieve data from an HIE without having to waste valuable time searching through patient charts on different systems.
- **Reimbursements.** An interoperable care coordination solution enhances a provider's Medicare reimbursement rate for chronic and transition care management through automated transmission of care coordinator services.
- **Network scalability.** Organisations like ACOs and CINs that are looking to augment revenue by attracting providers to their network can cite their comprehensive care coordination solution as a key benefit to membership.
- **Quality metrics.** A comprehensive care coordination solution can do much more than contribute to the reduction of readmission rates simply due to the fact that it can minimise adverse events related to ED visits; it can yield a significant cost savings that can be reflected in quality metrics.
- **User experience.** EMR-centric care coordination modules generally display GUIs filled with buttons and columns that are difficult to navigate and inhibit user efficiency, while a comprehensive care coordination solution offers the slick, clean, concise summaries modern users have come to expect.
- **Multidisciplinary and circle-of-care focus.** A comprehensive care coordination solution will heighten operational efficiency by supporting—and generating individual tasks and assignments for—many different disciplines and roles along the care pathway as well as a patient's circle of care.
- **Privacy.** The robust privacy tools of a comprehensive care coordination solution will prevent the viewing of sensitive data by personnel who can effectively administer treatment without it, safeguarding an organisation against costly HIPAA violations.

Summary

A community-based model of care demands much more than that which traditional EMR systems can offer.

It demands a solution that supports the full range of interoperability standards, comprehensively addresses the issues associated with patients transitioning back into their homes, utilises an analytics engine to minimise negative patient outcomes associated with high rates of 30-day readmissions and adverse events, supports newer care models that emphasise post-discharge patient engagement, and frees care coordinators from the burden of documentation challenges related to government regulations and quality metrics.

Healthcare organisations that deploy this solution can expect a number of business benefits including enhanced efficiency, greater scalability, an improved user experience, tighter multidisciplinary and circle-of-care focus, and stronger privacy, while those that continue to rely on traditional EMR systems can expect to endure the risks those systems continue to create, miss the opportunities those systems cannot help them take advantage of, and deliver a level of care that falls far short of what today's patients truly deserve.

