Establishing a Patient Centered Medical Neighborhood

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Regional Cancer Care Associates Company Overview

- RCCA physicians treat **33% of ALL Cancer in NJ**
- The Value Based Leader in Oncology in NJ – Current programs with Horizon/Aetna/CIGNA/UHC/Medicare (1 of 196 practices nationally in CMMI's Oncology Care Model Program)
- Clinically integrating with other independent provider groups and select Hospitals/ACO's to create better outcomes and more coordination
- 85% of our overall payments contain a value based component

- **RCCA Snapshot:**
- >110 physicians in NJ, MD and CT – launched in MD 10/1/15 and CT on 1/1/17
- 29 office locations
- 750+ employees
- 240k patients under disease management

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Objectives

At the end of this session, the following will be met:

- Shared understanding of the medical neighborhood our Practice works within
- Shared understanding of the definition and elements of care coordination and why patient engagement is important to be successful
- Discussion and illustrating why systematizing this process will provide clarity of expectations among primary care team, specialists, hospitals, and others in the medical neighborhood
- Underscore the importance of formal (and informal) agreements between members of the medical neighborhood

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Welcome to the 'hood!

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Care Coordination Defined

The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care service. (McDonald et al., AHRQ, 2007.)

The two fundamental goals of care coordination are:

- To *transfer information*, such as medical history, medication lists, test results, and patient preferences, appropriately from one participant in a patient's care to another.
- To *establish accountability* by clarifying who is responsible for each aspect of a patient's overall care. This includes specifying who is primarily responsible for key care delivery activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants.

Care coordination is an information-rich, patient-centric endeavor that seeks to deliver the right care (and *only* the right care) to the right patient at the right time.

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Elements of Care Coordination

- Follows-up with patients within a few days of an emergency room visit or hospital discharge.
- Provides care management services for high risk patients.
- Tracks and supports patients when they obtain services outside the practice.
- Links patients with community resources to facilitate referrals and respond to social service needs.
- Integrates behavioral health and specialty care into care delivery through co-location or referral protocols.
- Communicates test results and care plans to patients/families.

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Communication Breakdown

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Communication Breakdown

- 25-50% of referring physicians did not know whether their patients had actually seen the specialist to which they were referred
- PCPs report sending a history or reason for a specialist consult nearly 70% of the time
- Specialists report receiving such information only about 35% of the time
- Specialists report sending consult notes and patient advice to primary care physicians 81% of the time
- PCPs report receiving such information only 62% of the time

O'Malley AS, Reschovsky JD. Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground. *Arch Intern Med.* 2011;171(1):56-65.

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Care Coordination Challenges

- Patients with chronic conditions typically see many providers
- Study found Medicare patients visit seven physicians in four different practices annually
- Poor coordination may result in
  - Patients receiving differing advice from various physicians (eg, conflicting prescriptions)
  - Lack of follow-up for new diagnoses, tests, or procedures jeopardizing patient health outcomes
  - Burden of care coordination is high for primary care providers who serve as lead for communication and decision making between patients and all of their providers

Pham HH, et al. *New Engl J Med*. 2007;356:1130-1139. O'Malley AS, et al. *Arch Intern Med*. 2011;171(1):

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Transitional Care Management (TCM) Process Map

Transitional Care Management or TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting to the patient's community setting (home, domicile, rest home, or assisted living)

GOALS: 1. To make phone contact within 2 days 2. Face to face visit with provider by day 7 or 14 (depending on medical complexity of patient) 3. Claim goes out on Day 3

Acute Setting
Acute hospital, rehabilitation hospital, long-term acute care hospital; partial hospital, observation status in a hospital, or skilled nursing facility/ nursing facility

Patient admitted to **Acute Setting**

Shared responsibility
Notification of patient admission
Provision of primary or specialty appointment prior to discharge

INPATIENT DISCHARGE PROTOCOL:
- Medication Reconciliation
- Referrals
- 7day PCP/SP appointment

DISCHARGE CONFIRMATION

- Patient discharge to home with discharge instructions including 7 day appointment date
- Follow-up appointment reminder call

Payer Data/ Reporting made available to PCP/Specialist

PCP/SP provides post-discharge 7 day visit to Acute Setting

Patient tracking system in EMR (can be an Excel Spreadsheet)
Data sources:
- Payer
- Acute setting
- Care management

PCP/Specialist/PCMH (Transition)

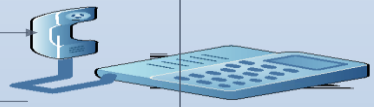
Pre-visit Planning: Prepares Care Plan for Admitted patients Inclusion in Daily huddle

OR

Receives TOC lists Daily from Payer

Is there a decision to be made here?

Analyzes and perform pre-call



Nurse/staff makes call to patient within 2 days of discharge: reminder to keep appointment, medication reconciliation (TCM code initiation)

PCP/Specialist (Nurse Navigator (NN) /Care Manager CM)

NN/CM perform medical record review, assessment, calls patient

Pre-visit planning (NN/CM) Assess if patient meets Chronic Care Management (CCM) services

Patient comes in

Provider Office Visit within 7-14 Days

Office Submits TCM bill:
- **completion of day 2 phone call**
- **completion of patient office visit**

NN/CM meets with patient and obtains consent for CCM services

CCM services commences Office submits CCM bill

The Importance of Practice Agreements

- Develop agreements to:
  - Standardize information shared between primary care practices and specialty care providers, hospitals, others
  - Establish and set expectations
  - Develop and enhance relationships
  - Delineate responsibilities which may include
    - Primary contact for patient regarding medical issues, medication management, referral management, testing, patient education, patient follow-up/ communications, monitoring/management other medical concerns

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Sample Collaboration Agreement

For consults requests from our primary care practice to your specialty practice, we the primary care physician will do the following:

- Attempt to send the clinical question we want answered and need for consult prior to the scheduled visit, including pertinent information about the patient's condition such as:
  - Medical History/problems, diagnosis, Current Care plan
  - Current medication list, allergies
  - Pertinent labs, radiology or other diagnostic tests if available
  - Other specialist workups who evaluated the patient
- Have the patient well conformed about the expectations and the goals of the consult visit
- Track the referral made to you and ensure that follow up with us is arranged
- Therapy or care according to evidence based guidelines
- Initiate a phone call, direct message or text if the condition is emergent, or if there are extenuating circumstances or questions

Our expectations of you as the specialist care provider include:

- Timely access to referral appointments, consult visit within 1 week for non-urgent cases and within 48 hours for urgent
- Your consult information will be sent back to our office within 48 hours by fax or other electronic method including test results
- A phone call to PCP if finding is critical
- No consults to other specialists without PCP input
- Details of requested testing and procedures that will be ordered by you
- Consult will include management plan that outlines what you would like us to follow, treatment goals, and follow up plan

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Using Data to Build the Neighborhood

- RCCA's value based care arrangements are all based on the Total Cost of Care for patients we treat
- This includes, not only our cost and utilization, but hospital, imaging, lab, other physicians, etc.

Things we have found:

- 2/3 of patients who visit an ER with cancer will be admitted
- NJ subacute costs are double than national averages
- Site of service differentials are staggering for commercial plans
- Out of Network costs remain an issue
- End of Life Care needs drastic improvement (not just an NJ issue)

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Real World Examples of the 'hood in Action

There are 2 categories that require action

1. What can we do better ourselves?
2. How can we find other providers who practice patient centered/cost effective care?

Internal Areas of Focus

- RCCA Standardized Pathways (Lab/Imaging/Drug choices)
- Enhanced same day access to avoid ER visits
- Shared care coordination for patients with co-morbid conditions (impacts end of life)

External Providers

- Develop our own narrow network based on the data (ex: instead of referring to 30 SNF's, partner with 10)
- Review ETG scoring for other physicians to identify outliers (ex. In network Surgeon using out of network anesthesia group or surgery center)
- Partner with those willing to discuss treatment plans for shared patients

Key Takeaway: Clinical Integration doesn't have to mean technological integration

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Why Are We Doing All of This?

- The market is moving in this direction with or without RCCA. Medicare and private plans have made announcements to pay 50-80% of care based on value
- MIPS is basically 2 sided risk in 2019. It's a budget neutral program that adjusts Medicare reimbursement +/- 4% based on performance
- The data we can get is invaluable – shows us life outside of our walls, any gaps and best treatments by type of condition along with **variation by physician**
- **Patients get better care**, especially when they have other co-morbidities
- Enables us to keep our patients in our communities. We have new market entrants from other states who would like patients to go to Philly/NY.
- Narrow networks are becoming more important – providers have to continually show value to be included.

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Questions?

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5/18/17 12:00 PM – 1:00 PM EST

Patient and Family Engagement with

Steven H. Landers, MD, MPH
VNA Health Group

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hosted by NJII and the New Jersey Health Care Quality Institute

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June 22, 2017 from 8:30 am to 4:30 pm

NJIT Campus Center

Registration will be complimentary for all GPTN members, Quality Institute members, NJAFP members, NJII External Advisory Board members, and Health IT Connections Entrepreneurs and Partners

Invitation and details to follow

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