Integrating Care Coordination into a Patient-Centered Medical Home: Provider-Led Delegated Care Coordination Model

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Introduction and Background

The concept of care coordination is not new. The principles of a medical home, including care coordination, date back to the late 1960's when the American Academy of Pediatrics was developing a model of care for special needs patients (*Audet & Patel,* 2012). Since then, coordinated care has become part of the lexicon of models for care delivery designed to address chronic conditions, evolving from Wagner's Chronic Care Model to the Patient-Centered Medical Home (PCMH) model of care delivery (*Defining the PCMH,* 2021). A newer health care model, the PCMH plays a major role in providing value-based care, which connects payment to patient health outcomes in order to lower costs, increase patient satisfaction, and improve health metrics (Teisberg, Wallace, & O'Hara, 2020).

Overall, the goal of care coordination is to improve overall care delivery and patient wellness by providing cost effective, non-duplicative services. The care coordinator works across various service providers and stakeholders including the pharmacy, behavioral health team, primary care providers, dentists, social service agencies, and specialists to make transitions of care and overall access to services more seamless for patients. Of critical importance, especially as changes continue throughout this pandemic era, is collaboration with benefit specialists to address assistance with enrolling, maintaining, and leveraging benefits – whether they relate to support for social needs such as transportation, or enrolling in Medicaid and other types of insurance.

Introduction and Background Cont.

In 2015, Access Community Health Network (ACCESS) – the largest network of federally qualified health centers in Illinois – formally adopted PCMH as its framework for care delivery to support its value-based care model. There are five key elements of PCMH in primary care according to the Agency for Healthcare Research and Quality (AHRQ):

1. Comprehensive care
2. Patient-centered care
3. Coordinated care
4. Accessible services
5. Patient safety

While components of PCMH had already been part of ACCESS' care delivery, implementation of the complete PCMH framework allowed ACCESS to focus on full integration in key areas. Of particular importance was ACCESS' care coordination model, which has evolved in a number of different ways through various projects: 1) patient navigation for breast and cervical cancer patients, 2) Strong Start, a maternal child health demonstration project where the care manager was combined with two roles – a Registered Nurse and social worker, and 3) through a demonstration project that moved HIV care from siloed, specialty care to primary care, with a care coordinator to bridge the divide. In all cases, this care coordination role was found to be useful in addressing a variety of needs: education, visit follow-up, and navigation across primary/specialty care, social services, and health systems (including secondary and tertiary care).

ACCESS wanted to take the learnings from these three programs and formally embed care coordinators as part of the larger ACCESS system, so this service would be available to all patients in need of an enhanced care team. As ACCESS and other health systems began to transition towards integrating PCMH and value-based care, the question became: How would a provider-led, embedded care coordinator model impact key quality and cost measures while still addressing the complex care needs of patients within an FQHC setting?

To transition to this full model of integrated care coordination to serve all patients regardless of their insurance status, ACCESS first needed to show that a delegated and integrated care coordination model would be more effective, both from a financial perspective and a quality health outcome perspective, than models where care coordination was provided outside the health system through insurance companies. This 'delegated' care coordination team primarily serves Medicaid managed care patients, who comprise roughly 30 percent of ACCESS' total patient population. Delegated care coordination works both internally and externally, acting as a link between the patient, provider, and payor to ensure seamless delivery of care.

Additionally, by adapting the PCMH standards, ACCESS has received Level 3 recognition for PCMH and a three-year Case Management Accreditation from the National Committee for Quality Assurance (NCQA). NCQA is considered to be the top health care accreditation organization in the U.S. ACCESS' recognitions are their highest accreditations. NCQA accreditation standards are intended to help organizations, like ACCESS, achieve the highest level of performance possible to create an environment of continuous improvement.

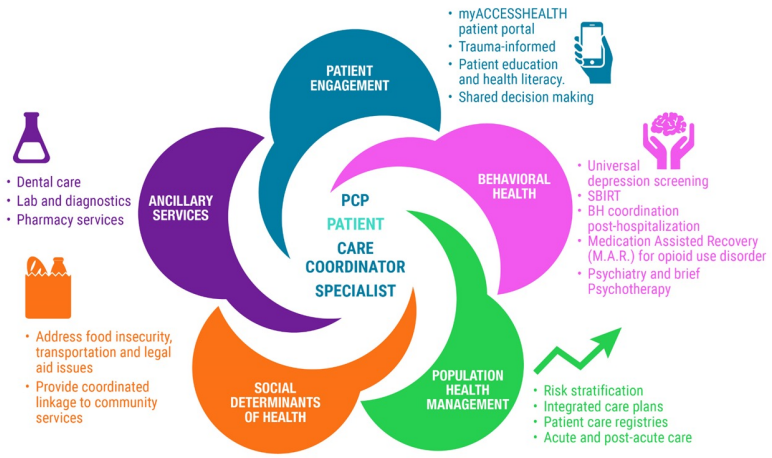
Introduction and Background Cont.

Our care coordination model uses several key strategies to ensure delivery of quality, value-based care management within the PCMH. Through an integrated care delivery system, ACCESS care coordinators are embedded into the PCMH model and provide case management, disease management, and complex case management. This provider-led model is grounded in a primary care-centered approach driven by the primary care physician (PCP) and care coordinator, with the patient at the center as an engaged partner in their care. Our model engages service providers and other stakeholders to keep patients healthy and avoid illness and unnecessary hospitalization.

There are specific care and financial impact goals for the delegated care coordination program as it is embedded within ACCESS' Population Health and Quality department:

1. Reduce emergency department utilization
2. Improve patient engagement with providers and care teams through high levels of patient empanelment
3. Improve quality metrics such as HEDIS
4. Improve the total cost of care/medical loss ratio

Diagram 1. The ACCESS Patient-Centered Medical Home Model



At the foundation of the care coordination model is the integrated care team, which is led by the PCP and includes the care coordinator, an ACCESS Behavioral Health Consultant, Community Health Worker, and health center staff. This team is continuously monitored through performance metrics in order to ensure an optimized workflow and continuous improvement. Metrics are determined annually based on Healthcare Effectiveness Data and Information Set (HEDIS) and Uniform Data System (UDS), as well as organizational metrics. These metrics are tracked in ACCESS' electronic health record (EHR), Epic, and reported on by the ACCESS Enterprise Data Analytics and Population Health and Quality teams. The integrated care team then holds weekly meetings to review metrics, troubleshoot problems, and discuss strengths and weaknesses.

[2] Each Likert Scale response has a corresponding score (i.e. 1= strongly disagree, 2= disagree, etc.) and those scores were averaged to rank change concepts goals.

Standardized Workflow

The care coordination workflow is standardized across ACCESS to ensure that patients are receiving the best, most efficient care. ACCESS identifies patient populations that could benefit from care coordination services through a risk stratification process. This assessment is done through screening tools, predictive modeling or high utilizer reports, social determinants, and other clinical indicators. High and moderate risk patients are then assigned a care coordinator, who works in partnership with the patient through shared decision making to develop a longitudinal plan of care. This plan is tailored to the patient's risk level, preventative needs, and individual goals. The plan may include clinical and non-clinical components such as prevention and health maintenance activities, patient education, or resource information. In line with this plan, care coordinators provide patient referrals regarding key social determinants of health including legal assistance, transportation assistance, food resources, and other critical needs. Through this supportive model of tracking patient needs, care coordinators can identify gaps in care and collaborate with the entire care team to create solutions.

This plan of care is created within Epic, shared with the PCP for edits, and can be accessed by all care team members and the patient. In addition to frequent contacts between the care coordinator and patient, Epic facilitates bi-directional communication between the care coordinator, patient, and PCP. Care coordinators communicate directly with members through the patient portal, myACCESSHEALTH, and then communicate with the provider either in-person or through Epic. Given the key role the EHR plays in care coordination, ACCESS' Enterprise Data Analytics and Epic Clinical Applications teams partner with the Care Coordination department to provide ongoing electronic support. The care coordination dashboard, care plan template, and audit tool are all optimized in Epic to display key metrics and ensure staff are capturing care plan requirements. All components of care coordination are reportable and can be monitored through a workflow.

Critical Role of the Care Coordinator in a Physician-Led Delegated Care Model

In addition to their role connecting the patient to their provider, the care coordinator also acts as a conduit between the patient and their insurance plan.

This demonstrates why the delegated model is essential to our care coordination program. Because the care coordinator is connected to both the patient and provider, they can then connect the patient to their insurance's services, including the payor care coordinator and care management.

The care coordinator is also responsible for assisting with transition of care and discharge planning. At our hospital partners, ACCESS has onsite care coordinators who identify patients in the emergency department (ED). These embedded care coordinators then work with the hospital discharge team to connect the patient back to their PCP or assigned care coordinator. The assigned care coordinator is responsible for assisting with patient needs during discharge and transition of care, including follow-up appointments with the PCP. Moreover, if the patient does not have a care coordinator, this is an opportunity to enroll in the program. The role of the embedded care coordinator in the ED is essential because it allows us to capture our hard-to-reach patients or patients who previously declined care coordination. ACCESS partners with high volume hospitals including Mount Sinai Hospital, Holy Cross Hospital, and University of Chicago to ensure that these patients are not falling through the gaps.

Results

Our provider-led delegated care model shows that it is possible to improve value and financial measures while also improving quality metrics. Through the success of our care coordination program, ACCESS has outperformed both our own internal targets as well as CountyCare HEDIS metrics.

Regarding process metrics, ACCESS is performing beyond our target levels for multiple indicators. Our health risk screening rate within 60 days of enrollment is 70%, and our 12-month reassessment rate is 80%. For high-risk patients, 75% receive a care plan review every 30 days, and 80% receive a care plan review every 90 days.

Since incorporating delegated care coordination, there has been significant progress on goals set for the program. In terms of our revenue, we are seeing changes in our medical loss ratio (MLR) – the percent of revenue spent on health care and quality improvement vs. administrative costs – that reflect our goal of optimizing spending on quality and care. In 2021, the ACCESS MLR was 81%, which is lower than our MLR from 2020 and 2019. As we have decreased our MLR, our quality metrics have continued to exceed targets.

Overall quality improvement goals for the care coordination program are to reduce ED utilization, improve patient quality of life and functional status, and improve quality metrics. Since the program began, we have seen a decrease in ED visits and inpatient admission among our CountyCare population. Furthermore, in 2021, ACCESS exceeded the CountyCare rate in multiple performance measures including annual ambulatory preventive visits, annual dental visits, comprehensive diabetes care, initiation and engagement of substance dependence treatment, and well-child visits (Table 1).

Table 1. ACCESS HEDIS Measure Performance Report

Metrics	ACCESS 2021 Final Rate	CountyCare Final Health Plan Rate
Adult Access to Preventative/Ambulatory Services	77.82%	71.38%
Annual Dental Visit	56.10%	52.15%
Breast Cancer Screening	51.35%	50.86%
Cervical Cancer Screening	59.53%	52.36%
Comprehensive Diabetes Care	88.82%	84.93%
Childhood Immunization Status	34.69%	30.77%
Follow-Up Within 30 days After Emergency Department Visit for Mental Illness	58.43%	49.79%
Initiation of Alcohol and Other Drug Dependence Treatment	67.68%	63.20%
Engagement of Alcohol and Other Drug Dependence Treatment	11.09%	12.93%
Prenatal and Postpartum Care Timeliness	80.86%	76.61%
Well-Child Visits in the First 15 Months of Life	67.60%	51.73%
Well-Child Visits in the First 30 Months of Life	69.61%	59.53%
Child and Adolescent Well-Care Visits	56.31%	53.88%

Discussion

Overall, ACCESS' successful implementation of care coordination and our improvement in quality metrics, as well as cost measures, illustrate the value of this model to both patients and the health care system. Patients develop relationships with the entire care team, who are then able to coordinate within the primary care home to assess needs and respond rapidly with medical care, social services and other wraparound needs.

There are several critical components that need to happen for this level of success:

1. Care coordination should not sit outside the primary care home, but squarely in the center. Care coordination that is led by the provider institution is more effective than when care coordinators sit outside of the primary care institution. If relationships with patients are central, so are relationships with the care team. This is nearly impossible to create if the care coordinator is not part of the medical home and has the same rapport with providers and support staff as the patient would expect.
2. The care coordinator must be a licensed professional with experience. Collaborating across multiple care team members and agencies in the care continuum takes practice. Developing trust with complex patients means understanding how to address both immediate and long-term needs, as well as the environment in which a patient lives. This may include other family members and relationships. Experience in multiple situations and commitment to this integrated care model is key.
3. Integrated workflows and delineation of roles is important for the model to work. Most health care systems are very complicated to navigate. Clearly defining what the care coordinator does and how they integrate with the regular flow of patient care is critical for warm handoffs, documentation, and better outcomes.
4. Regularly reviewing key measures of process is important, as is utilizing data to support workflows and understand where breakdowns between transitions might be occurring. This model is predicated on understanding where patients and care gaps are – then addressing those up front. This is where care coordination can make the biggest difference for patients.
5. Time is possibly the most important factor in the model. Patients, providers, and care coordinators need time to develop trusted relationships with each other. For care coordinators to do their work effectively, they need to establish trust with their patients. This is something that may not happen immediately and needs to be considered when determining timeframes for measuring success. The hardest to reach patients – and the most vulnerable – may not have their health as their highest priority. Taking the time to get to know the patient, understand their situation and meet them where they are is the key to moving the needle for individuals and populations.
6. Establishing a successful Transition of Care Program with embedded care coordinators at high-volume hospital partners, and linking patients that may be hard to reach, back to the care coordinator and medical home, has proven to be another key factor in program success.

Challenges

Though care coordination has been embedded into the PCMH workflow, there are still strides to be made in achieving full integration of care coordinators into the care team. ACCESS is continuing to develop standardized communication strategies between the care coordinator and rest of the care team to ensure that care coordinators are fully integrated into the existing health center workflow. This includes constant re-education for care teams regarding care coordination, as well as ongoing training on the value of care coordination and how to best utilize this program.

Another challenge has been building data and analytics for key monitoring of different metrics. Having a dedicated IS and Epic clinical support team has been essential for appropriate documentation and data extraction, but remains an ongoing challenge due to the scope of the program and difficulty of integrating our data flow with the payor side. For our administrative team, there has been increased burden due to requests from multiple payors regarding health care requirements, audits, and reporting. Though delegated care coordination has allowed us to optimize our financial measures and improve quality metrics, acting as a delegated entity has increased the burden on ACCESS due to this volume of administrative requirements.

Furthermore, the COVID-19 pandemic and ensuing remote work has impacted the health centers, particularly for care coordination. The pandemic has been disruptive to both communication between the care coordinator and health center staff, as well as between the care coordinator and patient. Prior to the pandemic, care coordinators would rely on face-to-face interactions and meetings with patients for health risk assessments and care plan creation. Hesitancy to meet in person during the pandemic has disrupted this relationship-building, which can limit the amount of buy-in from patients in the creation and implementation of their individualized care plans.

However, despite these difficulties, having an established care coordination model has aided ACCESS in supporting patients throughout the pandemic. Because care coordinators assist patients with both health care needs and the social determinants of health, they have been able to refer patients to supportive services including transportation, help with meals, legal assistance, and more. Now, care coordinators are returning to the flow of meeting patients at the health centers to rebuild those relationships and re-establish the patients' goals.

Next Steps

As the care coordination program at ACCESS continues to grow, there are several next steps to building and implementing a fully realized model:

- While care coordination is available to most ACCESS patients, since it is primarily a delegated model, patients without insurance do not necessarily have the same level of available support through care coordination. ACCESS is working to extend the model to all patients, regardless of insurance status. This would require an evaluation of staffing ratios for care coordination from the care coordination management team.

Next Steps Cont.

- Evaluation of the model and its long-term impact on health outcomes is ongoing. There are certainly short-term gains for patients in transitions of care and linkage to services. Though the long-term impact overall seems to be positive, it is still unknown, because this program is relatively new and our quality metrics focus on process measures (i.e., completion of screenings). In the future, our goal will be to link these activities to longitudinal understanding of the impact.
- Dashboards of transitions of care and documentation of support or barriers to care are important for sharing information outside of ACCESS. While ACCESS is continuing to build our care coordination program, we are also dependent on other strategic partners. Documenting and monitoring improvement in specific measures, such as appointment time or scheduling of follow-ups, should be part of the overall reporting and used to enhance partnerships.
- Continuous adaptation to new projects and initiatives with the payor and other key stakeholders is important to keep in mind. In particular, the integration of admissions, discharge, and transfer system, payor claims data, as well as optimizing the Epic Population Health Payor platform will be an ongoing focus to enhance this integrated care coordination model.

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