The Emerging Role of Rural Care Coordination in the Post-ACA Environment

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Focus on Improving Care Coordination

- NORC/UMN developed evidence-based toolkits on rural health topics
- Why are HRSA and ORHP interested in care coordination?
  - Increase in care coordination programs, particularly in new models of care delivery and reimbursement
  - Improve quality of care, reduce costs, and improve health outcomes
- There is a need to identify and disseminate promising practices and resources on care coordination in rural communities

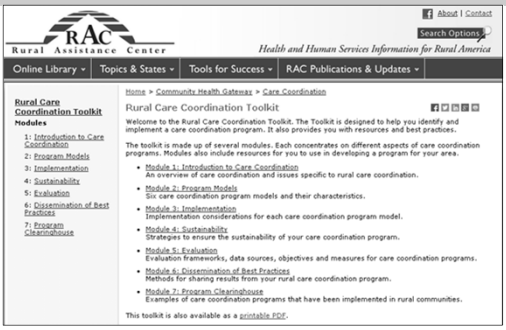
Rural Care Coordination Toolkit

- Project Team
  - Alycia Bayne, Alana Knudson, Alexa Brown, Naomi Hernandez, and Molly Jones
- Project Goals
  - Identify evidence-based and promising models that may benefit grantees, future applicants, and rural communities
  - Document the scope of their use in the field
  - Build an Evidence-Based Model Toolkit around topic areas specific to rural care coordination

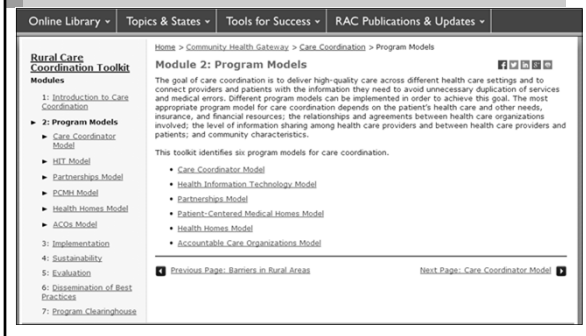
Project Activities

- Reviewed ORHP grantees' applications and the literature to identify evidence-based and promising models to improve rural care coordination
- Conducted semi-structured telephone interviews with six ORHP grantees funded in 2012 and two non-grantees who were implementing care coordination programs
- Developed a toolkit of promising practices, offering resources and guidance about how to conceptualize, plan, implement, and evaluate care coordination programs
- Toolkit is available on the Rural Assistance Center (RAC) Community Health Gateway website: http://www.raconline.org/communityhealth/

RAC Rural Community Health Gateway



Findings: Promising Rural Care Coordination Models



Findings: Promising Rural Care Coordination Models

- **Care coordinator model:** clinical or non-clinical health care workers ("care coordinators") deliver services to patients and help patients overcome barriers to care and treatment
  - Types of care coordinators: health educators, patient navigators, care managers, and community health workers.
- **Health information technology (HIT) model:** strategy that uses electronic health records (EHRs) and other HIT to facilitate the coordination of care between patients, care coordinators, and health care providers
- **Partnerships model:** health care organizations form partnerships with hospitals, clinics, and community partners in order to achieve care coordination goals
  - Many rural programs establish consortia to manage programs

Findings: Promising Rural Care Coordination Models (cont'd)

- **Patient-centered medical home (PCMH)* model:** a model for providing patient care that is comprehensive, patient-centered, coordinated, accessible, and high quality
  - Characteristics include a strong relationship between patient and primary care physician; coordination between PCP and medical care team; coordination of care across settings; and use of HIT
- **Health Homes model:** a comprehensive person-centered system established by Section 2703 of the Affordable Care Act, which coordinates care and services for Medicare-Medicaid dual eligible enrollees who have:
  - Two or more chronic conditions, one chronic condition and are at risk for a second, or one serious and persistent mental health condition

*Defined by HHS Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Primary Care Collaborative

Findings: Promising Rural Care Coordination Models (cont'd)

- **Accountable care organization (ACO) model:** a system of care that integrates people, information, and resources for patient care activities and creates financial incentives for care coordination.
  - Rural providers may form a legal entity with other Medicare providers. Improving care coordination through ACOs may help rural providers to lower costs, reduce fragmentation, and improve quality of care.
  - ACO model is supported by HIT, and some have established a role for care coordinators to help monitor high-risk patients.

Lessons Learned: Facilitators of Success (1)

- Select a Care Coordination model that **meets the unique needs** of the patients, the relationships and agreements between health care providers, the health information technology infrastructure, and community characteristics.
- Develop partnerships across sectors to **address the needs of the "whole" person** including health care, human services, public health, and other community-based organizations.
- Include **diverse disciplines**, such as health care providers, social workers, and behavioral health professionals on the care coordination team.

Lessons Learned: Facilitators of Success (2)

- Engage health care providers before implementation of the care coordination program – **buy-in from the health care team** is essential to the program's success.
- Provide **education to patients and families** about the care coordination program's goals and clearly define roles and responsibilities.

Lessons Learned: Challenges and Evaluation

- **Challenges:** Common challenges are related to funding and workforce
  - Recruitment, retention, and training of appropriate, qualified staff
- **Evaluation:** Communities are engaged in evaluation activities to document the success of their programs, but measuring impact is difficult

Background ~ Montana Frontier Community Health Care Coordination Demonstration Grant

- A demonstration project funded by the U.S. Department of Health and Human Services Office of Rural Health Policy through the Montana Department of Public Health and Human Services, subcontracted to MHA's Montana Health Research and Education Foundation
- Montana Frontier Community Health Care Coordination Demonstration Grant was awarded in 2012.
- The purpose of this grant is to improve the health status of clients with multiple chronic conditions who are Medicare and Medicaid beneficiaries living in frontier areas

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What is a Frontier Area?

- To participate in this grant each facility has a population density of less than 6 people per square mile
- There are 11 facilities that participate in the Community Health Worker demonstration
- Of the 11 facilities, six have less than 4,000 people in the county. Four of the facilities have less than 6,000 people in the county and only one has 10,000 people.

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Structure of Project

- Training, overall project supervision from MHREF
  - Heidi Blossom, RN, MSN, Care Transitions Coordinator
- Direct supervision from the hiring healthcare facility
- Generally, no hospital offices or equipment available to support Community Health Workers
- CHWs are part-time (10 hours per week)
  - Wage is $10-$12/hour
  - No benefits
- Profile of CHWs: usually retired; limited health care training; some affiliated with the healthcare facilities in other capacities (e.g., CNA, medical records, administrative support)

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Project structure, cont.

- Curriculum modeled on Minnesota's CHW Program
- Emphasis is on non-clinical intervention and care coordination
- Multiple trainings offered to enhance skills
  - Ad hoc trainings accommodate turn-over in CHWs
  - Topic specific trainings address evolving client needs/issues

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Community Health Workers

CHWs are paraprofessionals who work directly with members of the community with chronic conditions, preferably Medicare or Medicaid beneficiaries.

CHWs support clients in improving their health, reducing avoidable hospitalizations and readmissions, and link these individuals with health and social services needed to achieve wellness.

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What do the CHWs Do?

- Provide face-to-face and phone consultations
- Support clients in medication management and adherence; exercise; nutrition; health care system navigation; health promotion and management of chronic illnesses.
- Provide support and communicate with the clinical team and program manager regarding changes in: behavior, medication compliance, and other issues as related to the established care plans.
- Help coordinate patient transportation and accompany patients, as needed, to scheduled appointments.

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What CHWs Do, cont.

- Assure patients get appropriate and timely services by motivating/teaching people to seek care.
- Participate in regularly scheduled staff development training to improve self-knowledge of chronic illness
- Communicate concerns to the Care Transition Coordinator.
- Facilitate communication between patients, families, and providers regarding patient's health care goals.
- Create a non-judgmental atmosphere in interactions with individuals and their families

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Community Outreach Activities

- Red Hat Ladies
- Pot-Luck Dinners
- Transportation Coordination
- "Stepping On Program"
- City Planning

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Who Provides Referrals?

- Providers
- Senior Centers
- Low Income Housing Directors
- Sheriffs
- Communities of Faith
- Families and Friends

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Barriers

- Clients
  - Content with current situation
  - Concern about an "outsider"
  - Will not participate because this is a federal grant
- Facilities
  - Motivation to participate unclear
  - Concern about success of this program will negatively affect financial viability (e.g., reduce revenue)
  - Lack of infrastructure support for CHWs
  - Limited communication between the CEO and the providers
  - Need a champion for the program
  - Communities look out for their "own"

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Barriers

- Providers
  - Believe that anyone on the health care team who is working with "patients" should have a health care background
  - Concern about government intervention
  - Lack of control
  - Concern that success of this program will impact the bottom line (e.g., reduce revenue)

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Examples of Successful Client Interventions

- Prevented elder abuse
- Prevented disaster
- Lowered # of ER visits and EMS calls
- Assisted clients in receiving needed care
- Assisted clients in learning about treatment options
- Helped clients understand their chronic conditions
  - Medication support is important!
- Provided support during care transitions
- Identify strategies to mitigate isolation

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Lessons Learned

- Identify a champion in each facility
- Incorporate CHWs into a broader reimbursement model
- Create statewide consensus
  - CHW definition
  - Standardized curriculum
  - Pay scale
- CHWs should be from the community they serve
- Turn-over is a constant
- Include a pharmacist as a resource
- Recognize that EHRs may not provide timely, actionable information

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Overall Care Coordination Lessons Learned

- Behavioral health and substance abuse issues present unique challenges
- Medication reconciliation and management, particularly during transitions is critical
- Providers appreciate “eyes and ears” in the clients’ homes
- Transportation is an ongoing issue
- Timely communication between primary care providers and specialists is essential
  - Need incentive, “oughta wanna not good enough”!
- Health information exchange holds promise – not there yet!
- Human service infrastructure is limited

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Thank You!

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