

Case STUDY

 **Learning Systems**
for Accountable Care Organizations

Rocky Mountain ACO's Approach to Care Coordination in Rural Areas

This case study describes the care coordination initiative for rural providers developed by Rocky Mountain Accountable Care Organization (RMACO). RMACO began this effort after recognizing that participating practices had strong relationships with their patients, and practices could leverage these relationships to provide effective care coordination. However, practices had few resources to invest in improving population health and their staff had limited experience with formalizing care coordination and had varying credentials and training. RMACO's care coordination initiative supports practice-based staff who serve as care coordinators for high-risk beneficiaries. The support includes the areas of reimbursement, education, and resources. RMACO funds the initiative with pre-paid shared savings from the ACO Investment Model (AIM) and is working to create a sustainable funding model, such as by using appropriate Medicare reimbursement codes. ACOs seeking to implement or refine care coordination strategies, especially in rural areas, may consider RMACO's experience.

ABOUT RMACO

RMACO started as an AIM participant in Track 1 of the Medicare Shared Savings Program in 2016. The ACO is located in rural regions of Washington State and western Colorado. It includes nine critical access hospitals and 20 rural health clinics that are affiliated with those hospitals, two independent practices, and a federally qualified health center. In total, the ACO has about 250 physicians and cares for about 13,500 beneficiaries. RMACO receives management and support services from the Community Care Alliance (CCA). The Western Healthcare Alliance, a network of rural healthcare organizations, founded the CCA to help its members transition to value-based care.

PROGRAM BACKGROUND

Based on research into value-based contracts and discussions with practices, RMACO leadership identified care coordination for beneficiaries with complex care needs as a high-priority opportunity to improve quality and reduce costs. RMACO designed its care coordination strategy in consideration of participating practices' observed strengths and challenges, such as the following:

- **Strong relationships with beneficiaries.** The practices established strong, trust-based relationships with their patients, which they wanted to leverage to enhance care coordination. The ACO's practices and leadership anticipated that care coordination performed by practice-based staff would be effective at achieving program goals.

“The practices in our ACO felt that they had strong relationships with their patients, and they therefore wanted care coordination to take place locally, within the practices themselves. They thought it was important to have a team-based care approach, using staff in their own practices.”

—Marnell Bradfield, RMACO Director of Operations

- **Diverse staff backgrounds, limited staffing pools, and limited resources.** Staff credentials, backgrounds, and training varied across practices. In addition, practices encountered challenges when recruiting new staff, given limited availability of qualified candidates in rural areas and financial resources to fund new hires.
- **Geographic dispersion.** The ACO’s practices are dispersed over a large geographic area. Therefore, a particular practice might not serve enough high-risk beneficiaries to warrant hiring a full-time care coordinator. In-person trainings for practice-based care coordinators would also be challenging.

With these considerations in mind, RMACO developed a decentralized model for care coordination that leverages and

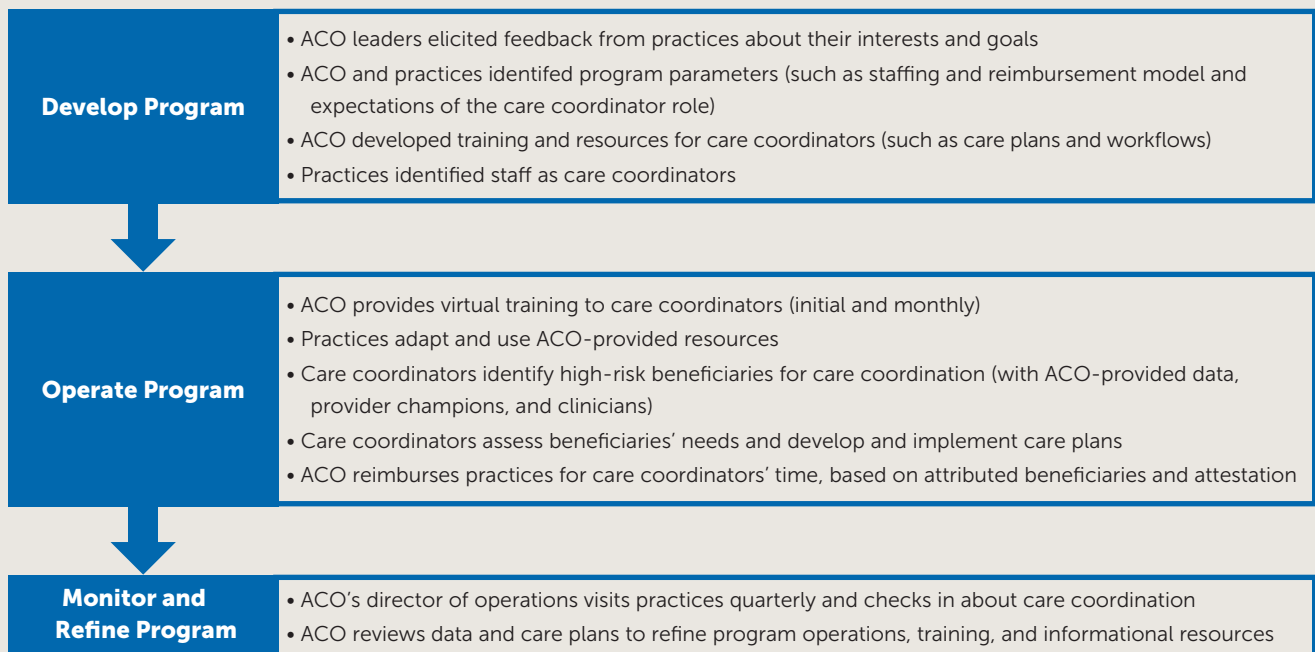
enhances the capacity of staff across the ACO’s practices. It sought to improve the quality of care for beneficiaries for whom care coordination could have the most impact. The ACO anticipated that connecting beneficiaries to care in appropriate settings would reduce the total cost of their care (for example, by reducing avoidable hospital admissions and emergency department [ED] use). The ACO funded its care coordination initiative using pre-paid shared savings from AIM participation. RMACO leadership noted that AIM funds enabled the organization to formalize its care coordination initiative, obtain staff buy-in, and assess the impact of the initiative—with the goal of developing a sustainable model by the end of the ACO’s third year, when RMACO can no longer expend AIM funding.

PROGRAM STRUCTURE

RMACO’s care coordination initiative provides reimbursement, training, and informational resources to practice-based staff who support high-risk ACO beneficiaries. The ACO reimburses practices for the time staff members spend on coordinating care. RMACO also provides extensive virtual training and other informational resources for care coordinators. The ACO’s director of operations was central to developing the initiative and provides ongoing oversight. Figure A summarizes the steps that RMACO took to develop and implement its care coordination initiative.

Figure A

Key steps to developing and implementing RMACO’s care coordination initiative



Staffing and reimbursement

Each practice in RMACO must commit the time of a designated care coordinator staff member, based on the number of ACO beneficiaries attributed to the practice (using the ratio of one full-time equivalent [FTE] care coordinator for approximately 1,000 attributed ACO beneficiaries). RMACO does not prescribe the required discipline or credentialing for care coordinators, but suggests that coordinators have a minimum of two years of experience in a clinical or health care-related setting. Most care coordinators are registered nurses, with some practices selecting medical assistants, physician assistants, or staff with nonclinical roles. By the end of 2017, RMACO had 30 designated care coordinators, totaling about 13 FTEs.

“We felt that out of respect for the diversity of every community and the culture of each practice, we weren’t going to prescribe a discipline for our care coordinators. However, with that disparity in staffing, we also felt it was very important to ensure that we were all on the same footing, and so we developed a lot of training and informational resources for care coordinators.”

—Marnell Bradfield, RMACO Director of Operations

The ACO reimburses practices for care coordinator services based on attestation of time spent on care coordination for the ACO’s beneficiaries, up to the practice’s FTE allocation (which is based on preliminary beneficiary attribution). Over time, some practices have recognized the value of care coordinators and expanded their role to serve additional populations beyond the ACO’s beneficiaries. However, most practices have minimal resources to support care coordination and care coordinators for the ACO often serve multiple roles within their respective practices.

ACO leadership and practice-based staff who are ACO champions support care coordinators. Each practice designates staff members as practice and provider champions for the ACO. Practice champions function as project managers for ACO-related activities and they communicate regularly with care coordinators about any challenges faced or supports needed. Provider champions meet with care coordinators to discuss beneficiaries who receive care coordination and help to implement care coordination-related workflows. The ACO reimburses for some provider champion time. The ACO’s director of operations meets quarterly with practices (ideally with the care coordinator, practice champion, and provider champion), checking in on care coordination and whether care coordinators need further assistance from the ACO (for example, additional training).

Care coordinator role

RMACO care coordinators focus on high-risk and high-cost beneficiaries who are expected to benefit most from care coordination. RMACO initially suggested that care coordinators target about 10 percent of their practice’s ACO beneficiaries, but now encourages care coordinators and provider champions to determine how many beneficiaries to engage. To help identify such beneficiaries, RMACO provides each practice with data on the practice’s 40 ACO beneficiaries who have the highest risk scores (using Johns Hopkins Adjusted Clinical Groups [ACG®] System scores) and the practice’s 25 most frequent ED users. Care coordinators and practice champions review the beneficiary-specific data and discuss for whom to coordinate care, based on the expected impact on beneficiaries’ outcomes and costs. Care coordinators also often find referrals from clinicians in their practices to be very helpful in identifying beneficiaries.

RMACO’s care coordinators develop and implement patient-centered care plans for beneficiaries. The ACO provides an adaptable care plan template to support consistent documentation of care plans, which care coordinators use within their practice’s electronic health record (EHR) or as a paper form. The template replaced a previous approach of requiring that care coordinators document care plans in a centralized application, which led to inefficiencies and duplication. The ACO’s director of operations reviews care plans during her quarterly visits to practices, with a strong interest in assuring that care plans contain patient-centered goals. Such goals indicate to her that the patient and care coordinator partnered to create and work on the care plan.

Story from the field:

While following up with a beneficiary after a hospital discharge, a care coordinator identified a beneficiary who was upset about the continuity of her primary care. The care coordinator met with the beneficiary on an ongoing basis. They discussed that the beneficiary called her primary care clinic when she had concerns, received care in the next available appointment, and therefore received care from a variety of clinicians. The beneficiary also noted having difficulty communicating her concerns clearly to clinicians in these appointments.

The care coordinator and beneficiary developed a strategy in which the beneficiary would request appointments with her primary care provider, when possible. The care coordinator also joined several clinic appointments to facilitate communication between the beneficiary and her primary care provider and help the beneficiary understand her plan of care. After implementing the strategy, the beneficiary received consistent follow-up with both primary care and appropriate specialists. She now often calls the care coordinator first if she has concerns or questions, and noted that she is pleased with care coordination and the health care she receives.

Care coordinators work with beneficiaries to implement the care plan and provide services based on a beneficiary’s needs, including coordinating referrals, providing self-management education, or connecting with social services. Care coordinators most commonly meet with beneficiaries in person within the practice, though they will also speak with beneficiaries via telephone. Being situated within the practice enables care coordinators to work very closely with both beneficiaries and primary care providers.

Training and resources

Formalized care coordination was new to the staff of many of RMACO’s practices and education has helped to develop a common understanding and competencies across practices. Given care coordinators varied backgrounds and dispersed locations, RMACO developed robust virtual trainings and extensive informational resources to meet their diverse needs.

RMACO developed a curriculum for its virtual trainings in collaboration with a company that has expertise in care coordination in rural areas. For all virtual trainings, RMACO uses a web-based platform that enables care coordinators to see one another using web-based cameras. The ACO found this platform effectively engaged care coordinators and encouraged peer-to-peer interaction. RMACO offers the following two types of virtual trainings:

- 1. Initial core training.** New care coordinators participate in eight virtual training sessions, each three hours long, over 16 weeks. Two cohorts of care coordinators completed these sets of initial trainings in real time and care coordinators who started at later dates could access recordings of the sessions. The sessions covered topics such as population health management, comprehensive assessment and care planning, coaching skills, and community resource knowledge.
- 2. Monthly care coordinator networking calls.** RMACO conducts monthly, hour-long networking calls to further train care coordinators and facilitate communication among them. Calls may include a care coordinator presenting about a best practice, discussions among care coordinators (such as about challenges and lessons learned), and formal training about care coordination. The calls focus on topics of interest to care coordinators, such as motivational interview training and engaging beneficiaries in annual wellness visits. RMACO makes call recordings and slides available to care coordinators.

RMACO also developed written materials and resources to supplement virtual trainings and support care coordinators, such as the following:

- **Toolkits.** With feedback from practices, ACO leadership developed toolkits about topics such as chronic care management

(CCM), provider engagement, and quality reporting. Toolkits contain resources such as policy descriptions, technical guidance, and sample documents that practices adapt to meet their needs (such as care plans and beneficiary outreach letters). Figure B describes the contents of a sample toolkit.

- **Roles and responsibilities document.** RMACO documented care coordinators’ expected roles and responsibilities related to activities such as care management, beneficiary education, and continuous quality improvement. However, the ACO did not prescribe a formal job description and practices adapted the roles and responsibilities to meet their needs.
- **Workflow.** RMACO developed a suggested sample workflow for care coordination, which includes beneficiary identification, assessment of beneficiary need, care planning, care coordination, and ongoing monitoring and follow-up. The ACO encourages care coordinators to adapt the workflow, available in Appendix A, to their own respective practices.

Figure B
CCM toolkit—Overview of contents

- 1. Overview, Billing and Documentation** (including key definitions, billing requirements, service elements, documentation, and sample participation agreement and consent agreement)
- 2. Implementation**
 - a. Step 1—Identify Eligible Patients
 - b. Step 2—Recruit Patients
 - c. Step 3—Coordinate Care of Patients (including resource such as sample risk-stratification tools, sample letters to patients, step-by-step approach to care planning, sample care plans, and care plan checklist)
 - d. Step 4—Documentation and Billing for Reimbursement (including time capture tools)
- 3. CCM Considerations and Best Practices** (including information on medication management, sample hospital admission/discharge communication tool)
- 4. Sample CCM Workflows** (including registration workflow, administrative and billing workflow)

RESULTS

RMACO has received positive qualitative feedback about its care coordination initiative from ACO beneficiaries, clinicians, and care coordinators. Clinicians in some practices often rely on care coordinators and link them to beneficiaries with complex care needs. Some clinicians also report that care coordinators’ support enabled them to care for additional patients.

“As a provider, having a care coordinator really replaces episodic care with coordinated care. They are creating a more personalized, effective, and efficient way of taking care of the patient and always trying to put the patient in the center of every decision that is made.”

—RMACO clinician

RMACO plans to analyze outcomes in order to assess the impact of care coordination, but does not yet have sufficient utilization data, given that the first year of the initiative focused on identifying and training care coordinators. The ACO’s preliminary analysis of 2017 data indicated possible reductions in hospital admission rates and ED visits. The ACO will further analyze utilization data as they become available.

LESSONS LEARNED

Flexibility, especially in relation to cross-practice differences, has been key to the success of RMACO’s care coordination initiative. The ACO created an adaptable approach to care coordination that enabled practices to develop staffing models that meets their needs. The ACO’s implementation experience also further reinforced the need for flexibility. For example, after learning that documenting care plans centrally was overly burdensome for care coordinators, largely due to practices’ differing EHR platforms, the ACO shifted to allowing local documentation of care plans. Accounting for cross-practice differences and allowing practices to adapt aspects of the model has helped staff across practices to accept care coordination.

The ACO learned that some care coordinators struggle when balancing multiple roles, as most have only part of their time allocated for ACO care coordination. Practices also sometimes want care coordinators to do ACO-related work beyond the core focus of care coordination for high-risk beneficiaries, such as identifying gaps in care for beneficiaries who are not at high risk. Although such roles are valuable, RMACO has realized that care coordinators’ greatest added value is coordinating care for high-risk beneficiaries. Ongoing communication among ACO leadership, practice champions, and care coordinators has helped identify possible additional support for care coordinators and practices. For example, the ACO is considering providing reports to practices about beneficiaries’ gaps in care.

NEXT STEPS

In 2018, RMACO plans to continue to assess the care coordination initiative, identify additional areas for improvement, and support development of sustainable revenue streams. RMACO is developing formal processes for care coordinators to appropriately use Medicare reimbursement codes (for CCM, annual wellness visits, transitional care management, and advance care planning services) to establish additional mechanisms to sustain practice-based care coordination as the ACO matures. For example, the ACO has developed sample workflows, shared best practices, and educated staff about billing requirements, including those for rural health clinics. The ACO will collect and closely monitor practice-specific, quarterly measures related to care coordination (for example, data on the number of care plans created or revised, and data on providing the aforementioned Medicare services, such as CCM). The ACO also expects to request care coordinators to submit care plans each quarter to further the monitoring effort, and it is considering strategies to efficiently transition back to documenting care plans centrally.

ABOUT THE ACO LEARNING SYSTEMS PROJECT

This case study was prepared on behalf of CMS’s Innovation Center by Rivka Weiser of Mathematica Policy Research under the Learning Systems for ACOs contract (HHSM-500-2014-00034I/HHSM-500-T0006). CMS released this case study in March 2018. We are tremendously grateful to the many staff from Rocky Mountain ACO for participating in this case study.

For more information, contact the Learning System at ACOLearningActivities@mathematica-mpr.com.

Appendix A

Sample care management and coordination workflow

