COPE HEALTH SOLUTIONS

COPE Monthly Digest

Monthly tips to achieve visionary, market relevant health care solutions

How COPE Health Solutions is Transforming Health Care

Key Takeaways from the Care Coordination Summit

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COPE Health Solutions has enjoyed success with some of our health system partners in deploying Care Navigators to better link high-cost patients to care within the system to enhance success under at-risk contracts, readmission penalties and value-based payments. Such compassionate touch and high quality patient care has become a critical success factor for today's hospitals and health systems. Care Navigators can support more seamless, high touch patient and member care, while making clinicians less frazzled.

We recently convened client-partner health care executives at COPE Health Solution's Care Coordination Summit to discuss how well-trained Care Navigators can support value-based payment trends in a sustainable business strategy. The most frequently stated comment was the need to make the clinician's life easier. We left with these five key takeaways:

1. **Encounter-based reporting requirements continue to incentivize fee-for-service (FFS) 'bean counting' practices versus integrated care contracting.**
   Despite reports of a surge in value-based payment or risk-based contracting, few health systems are seeing significant private value-based or 'accountable care organization (ACO)' contracts. There is a perceived tension with all players – health plans, health systems and physicians – feeling they are between a "rock and a hard place," with the Centers for Medicare and Medicaid Services (CMS) touting population health and value-based payment, while sticking to fee-for-service encounter-based reporting requirements.

   Further, various Affordable Care Act (ACA) initiatives and health plan contracts require risk-adjusted capitation and risk corridors, which rely on plans to collect and completeaccurate encounter data for Covered California, Medicare Advantage, and managed Medi-Cal in order to successfully report enrollee health care costs. For example, the current California duals demonstration pilot requires encounter reporting for Medicare and Medi-Cal separately, even though benefits are considered integrated. This continued reliance on encounter-based reporting undermines current and future integration of care.

2. **Despite the dearth of private risk contracts and ACO contracts, the influence of narrow networks and CMS in pushing risk back on to providers remains a strong strategic influence to better integrate care.**
Developing a caring, diverse and sustainable workforce to support compassionate, high touch, high quality patient care is more than ever a critical success factor for today's hospitals and health systems. Various initiatives both preceding and arising under the ACA seek to transition the majority of health care payments from fee-for-service to value-based payment models, occasioning substantial changes in the health care delivery process and focusing increased emphasis on patient reports on their care experience. Narrow network strategies among private payers are increasingly premised on quality metrics, some relying on better integration of care.

   Additionally, the financial risk of poorly coordinated care is inherent in Medi-Cal and Medicaid patients. As one of our partners stated by way of illustration, "I get paid roughly $30 a visit for Medi-Cal patient and every visit is costing me $90. Yes, we are financially at risk every time a patient is sent to the emergency room as the most convenient place to seek care."

3. **Physicians must see an easing of their practice burdens to value and meaningfully implement care coordination strategies.**
As one of our commentators stated it, "Care navigators must make it easier for providers to do their jobs well." There is pushback to the expectation that doctors or nurses can take on this larger role of coordinating care when it falls outside the regular full-time role of running a private practice. Given that a visit is about 15-20 minutes, it is already too hard to manage all the requirements, codes and regulations within that time frame. Doctors need resources to manage patients outside the doctor's office so the physician can focus on patient care.

   Care coordination services should be provided in a way to make physician lives easier, whether provided at the health plan, IPA or provider office. Physicians are overwhelmed with the expectations around technology and patient management. Independent/private practice physicians often do not have the resources to afford a nurse practitioner or an additional full-time equivalent and do not see the business case to afford the overhead cost of care coordination. So, the solution must be creating lower-cost, well-integrated solutions.

4. **Care coordinators can be a meaningful part of an interdisciplinary care team without a license.**
One successful program our commentators mentioned has put licensed practical nurses in primary care physician offices for coaching. Technically these LPNs have a license, but they weren't using licensed skills. Now, the program is using students in a centralized role at the independent practice association as well. Students can be very successful since a license is not necessary.

   Non-clinically licensed care navigators can be a selling point to clinicians because they know such care navigators will not encroach on a licensed provider's clinical domain but will operate as an adjunct to those services. Programs like this can be a huge physician satisfier; however, problems arise if the providers don't know who they are or what they are doing. This speaks again to the need to minimize duplication and poor communication. Matching a care navigator with a nurse case manager is key in developing a team of providers. This facilitates a direct relationship between the care navigator and the patient.

5. **Medical groups should be primary drivers behind the design and management of Care Navigator programs because they are in a place to best understand what is needed.**
   Ultimately, care coordination responsibility needs to fall with the provider, because the provider will not necessarily know about or support the coaches/navigators offered by health plans. They may contradict the health plan's navigator guidance and discredit them. If the navigator works under the provider, the doctor is more likely to support their efforts because it allows the physician to sanction/own it. It is important for care navigators to speak the language of the doctor/ambulatory system in order to become integrated into the outpatient, ambulatory care setting.

   However, the provider will be more inclined to embrace care coordination if the health plan were to provide navigation resources in a way that makes the provider's life easier. It is important to build a system that caters to every program and that provides a supportive service from health plan or IPA to physician. The solutions built needs to benefit both PCPs and specialists as their goals become aligned.

   We were grateful to receive these insights to ensure that, as we train young people for potential roles as Care Navigators, they are accepted and well-integrated into the system of care. With these key learnings, COPE Health Solutions will continue to improve our commitment to provide care navigators with hands-on experience in key outpatient and ambulatory care settings.

For more information about Care Navigation or Health Care Talent Innovations Services, please contact us at info@copehealthsolutions.org.