Care Coordination Toolkit

Introduction

Numerous Medicare accountable care organizations (ACOs) have achieved shared savings since 2012 by using various strategies to improve population health and quality while reducing costs. Recognizing that each ACO has a different approach to successfully providing value-based care, the Centers for Medicare & Medicaid Services (CMS) is developing a series of toolkits that explore different aspects of ACO operations. Through these toolkits, CMS aims to educate the general public about strategies used by ACOs to provide value-based care while also providing actionable ideas to current and prospective ACOs to help them improve or begin operations, particularly as they consider a shift to a two-sided risk model.

This toolkit highlights an array of innovative care coordination strategies that Medicare ACOs use to collaborate with beneficiaries, clinicians, and post-acute care partners to ensure high-quality effective care is provided at the right time and in the right setting. ACOs use a variety of methods to coordinate and manage the care of their diverse beneficiary populations. Approaches to care coordination includes both system-wide initiatives and targeted interventions that support individuals with chronic conditions or recent acute care needs. Some ACOs focus on facilitating the exchange of data between primary care providers (PCPs) and emergency departments (EDs), whereas others establish networks of post-acute care partners to support their mission of improving the quality and effectiveness of care. Others developed initiatives that focus on managing the care of individual beneficiaries, such as launching a home visit program or using information technology to streamline referrals to community organizations.

Overview of the CMS ACO Learning System and Toolkit

Since 2012, CMS has supported ACOs in their efforts to improve the delivery of care for their attributed patient populations through model-specific learning systems. These learning systems provide ACOs with a forum in which they can collaborate with and learn from one another. Across the model-specific learning systems, CMS hosts approximately 70 virtual events and 18 in-person events each year on topics tailored to meet the needs and interests of current ACOs.

This care coordination toolkit describes a variety of strategies used by ACOs to ensure that attributed beneficiaries receive both high-quality and efficient care. By managing transitions across the settings of care, ACOs are able to tailor care to the beneficiaries' unique needs.

This is the first toolkit in a broader series of resources that will explore different aspects of how ACOs operate to provide value-based care. The toolkits will bring together insights gathered during CMS-sponsored learning system events and through focus groups with the ACOs. Through these toolkits, CMS aims to educate the general public about strategies used by ACOs to provide value-based care while also providing actionable ideas to current and prospective ACOs to help them improve or begin operations.

Regardless of how ACOs approach care coordination, the individual beneficiary should always remain at the center of their processes and programs. This toolkit explores the development and implementation of different ACO care coordination strategies. Specifically, this toolkit explains how ACOs support and coordinate care for beneficiaries who:

- Receive emergent care in the ED
- Require treatment in a skilled nursing facility (SNF)
- Have recently been discharged home after a hospital or ED visit
- Have been diagnosed with a chronic condition
- Have conditions affected by the social determinants of health

In exploring how ACOs coordinate care for beneficiaries in these five areas, this toolkit describes ACO strategies to enhance collaboration with post-acute care providers, facilitate the sharing of beneficiary information between clinicians, and leverage community resources for beneficiaries with complex care needs.

To produce this toolkit, the CMS ACO learning system conducted focus groups and individual interviews with representatives from 21 ACOs that participate in the Shared Savings Program, the Next Generation ACO Model, and the Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model.[1] The learning system invited ACOs that had previously shared effective care coordination strategies during past learning system events.[2] During each focus group, the participants described strategies for managing care across different settings and for coordinating care for high-risk, high-need beneficiaries. For a list of the ACOs that contributed strategies to this toolkit, please see page 14.

While many of the ACOs who contributed to this toolkit focused on strategies that yielded positive results, some ACOs candidly discussed programs that were less successful than expected or initiatives that, as of this writing, are in the early stages, so results are not yet available. Lessons learned from attempted interventions are included in the toolkit, along with examples of snapshots that offer current and prospective ACOs a holistic sense of available options and possible implementation challenges.

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[1] Throughout this toolkit, we use the term "ACO" inclusively when discussing strategies mentioned by both ACOs and ESRD Seamless Care Organizations (ESCOs). However, if a strategy was mentioned only by an ESCO, then we indicated it as such. For context, ESCOs are a type of ACO operated by dialysis organizations that focus specifically on beneficiaries diagnosed with ESRD. For more information about CMS's ACO models, see this website: https://innovation.cms.gov/initiatives/aco/

[2] When considering which ACOs to include in the focus groups, we did not limit invitations strictly to ACOs or ESCOs that had consistently achieved shared savings. Doing so could have inadvertently excluded ACOs that were starting out in new, higher risk programs or were making infrastructure investments that created situations in which they accepted short-term losses to position themselves and their beneficiaries for longer-term financial and quality successes.

Care Coordination for Beneficiaries Who Receive Emergent Care in the ED

ACOs emphasized the importance of coordinating care for beneficiaries after an ED visit. Ideally, when an ACO-attributed beneficiary uses ED services, the ED care team relays information from the visit to the ACO and key care team members so that they can determine the appropriateness of care management services and any necessary refinements to patients' care plans. Too often, however, this information is not communicated to the ACO or to key care team members, such as the PCP or care manager. To address this gap in care coordination and ensure the beneficiary's experience and care needs remain the focal point, ACOs have adopted strategies to engage hospital leadership, embed staff within the ED, and encourage communication with ED clinicians.

ENGAGING HOSPITAL LEADERSHIP IN ED CARE COORDINATION INITIATIVES

Before developing and implementing ED-related care coordination initiatives with frontline staff, some ACOs sought to establish collaborative relationships with hospital leadership and administrators. One ACO noted the value of regular in-person interactions between hospitalists, ED physicians, and community PCPs at recurring meetings of the ACO's board of managers. The presence of hospital leadership at these meetings allowed for open discussions about shared care delivery reform goals and facilitated a more collaborative approach to the co-management of patients. Through the multiple perspectives offered in the meetings, the ACO sought to achieve the following objectives: (1) establish common ground between ED clinicians and PCPs about care improvement strategies; (2) gather insight and information from the frontline clinicians in the ED, hospital, and community-based primary care practices; and (3) foster evolving relationships between urgent care providers and PCPs to encourage increased communication through beneficiaries' care ED visit.

EMBEDDING STAFF WITHIN THE ED TO PROMOTE CARE COORDINATION

Multiple ACOs focused on approaches to embed care managers within the ED in order to provide beneficiaries with timely care coordination. ACOs rely on these embedded care managers to spearhead communication and collaboration between ED clinicians and PCPs. Embedded care managers are able to access information on patients' previous health needs from the EHR to share with ED clinicians and can assist with discharge and transfer from the ED to another care setting or to the home. ACOs noted that embedded care managers are particularly impactful in cases where beneficiaries with ambulatory sensitive conditions require additional support to safely transition back to their home. Embedded care managers also help to close information gaps if an ACO's clinicians and hospitals use EHRs that lack interoperability. To further maximize the investment in embedded staff, some ACOs encourage care managers to support other quality improvement efforts when they are not engaging ED patients, such as conducting utilization reviews and investigating care patterns.

> "Those discussions [with hospital leadership] are pretty painful at first, but I think the more people can talk with each other and put faces with names and voices . . . the more likely they are to reach some successful co-management of patients in a more collaborative way."
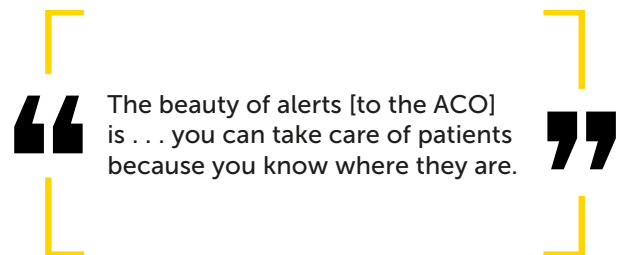
ENCOURAGING COMMUNICATION BETWEEN ED CLINICIANS AND PCPS

ACOs recognized that ED clinicians often do not have access to contact information for patients' PCPs, which impedes ED care coordination efforts. In response, multiple ACOs created wallet-sized cards for beneficiaries that display their ACO attribution status, as well as their PCP's name and phone number. During an ED encounter, the patients give the contact card to an ED clinician, enabling ED staff to inform the PCP of their patient's ED visit. However, some ACOs found this approach to be minimally effective. One ACO discontinued its contact card program after beneficiaries reported that the cards were not well received by their ED clinicians.

As an alternative to disseminating hard copies of beneficiaries' PCP contact information, ACOs looked to electronic alert systems (also known as e-alerts) as a strategy to encourage communication between ED clinicians and PCPs. The e-alerts notify the ED clinician of a patient's attribution to an ACO and include both the PCP's contact information and a reminder to contact the PCP. ACOs pointed to the benefits of e-alert technology that is integrated into the ED's EHR, saving busy ED clinicians the time and effort of logging into another system.

ACOs noted that e-alerts do not necessarily compel ED clinicians to take action. For example, one ESCO recognized that ED clinicians may not directly engage either the PCP or the care manager and so provides beneficiaries access to care managers who are available night and day and can facilitate communication between the ED and PCPs (see ACO Snapshot 1 for more information). Another ACO implemented both an e-alert for ED clinicians and a secondary system using a purchased product that notifies the ACO when an attributed beneficiary is admitted to an ED. When the ACO receives an alert, it calls the ED

to mention the patient's attribution to the ACO (which is also flagged in the EHR). While speaking with ED staff, the ACO describes transitional care services that PCPs can provide to the patient, such as a follow-up telephone call to check on the patient at home and help scheduling a primary care visit. This information is intended to help ED clinicians when they are considering whether a patient should be admitted to an inpatient setting or if they might do better in the community. The ACO also notifies the PCP from the patient's recent ED visit. This ACO anticipates this to be a temporary workflow and that their approach will ultimately normalize increased ED engagement with PCPs and enable the ACO to employ a less active approach in the future.

> " The beauty of alerts [to the ACO] is . . . you can take care of patients because you know where they are. "

ACO Snapshot 1: Empowering Patients to Initiate Care Coordination After an ED Visit

Objective: Create a pathway for beneficiaries to contact the ESCO after seeking urgent care

Tactic: Provide beneficiaries with contact information for the ESCO's care coordination team who are available 24 hours a day, seven days a week

Strategy: The ESCO gives beneficiaries wristbands and wallet-sized cards that have contact information for care coordinators who staff a toll-free telephone line. These care coordinators, who are available 24 hours a day, seven days a week, are also connected to the beneficiaries' dialysis centers so that they have access to patient's health history data. The ESCO encourages beneficiaries to reach out to the on-call care coordinator after an ED visit. The care coordinator then contacts the ED to learn about the beneficiary's care and the reason why they went to ED. The care manager uses this insight to inform the beneficiary's care providers about the urgent care visit and support beneficiaries with ongoing health care needs.

Care Coordination Strategies for Beneficiaries Who Require Emergent Care in the ED

- Hold in-person meetings with hospital leadership and administrators to establish a collaborative relationship before engaging ED staff

- Embed care management staff within the ED to facilitate timely care coordination between ED clinicians and PCPs

- Flag beneficiaries' ACO attribution status, as well as the name and phone number of their PCP, for ED clinicians using wallet-sized cards or an electronic alert within the EHR

Coordinating Care for Beneficiaries Who Require Treatment in a SNF

ACOs emphasized the importance of coordinating with SNFs to provide ACO-attributed beneficiaries with effective and appropriate post-acute care. To support care coordination efforts with SNFs, ACOs recommend establishing networks of high-performing SNFs, engaging preferred SNFs, and identifying dedicated staff to support care transitions.

ESTABLISHING SNF NETWORKS

Many ACOs engage preferred SNFs by developing networks of high-performing facilities. These networks enable the ACO to establish partnerships with a select set of SNFs that have demonstrated an ability to consistently provide high-quality care and indicated an interest in care delivery reform. Through these networks, ACOs facilitate the implementation of best practices for delivering care, undertake strategies to streamline the beneficiaries' experience as they transition into and out of a SNF, and implement care improvement initiatives (such as the Shared Savings Program and the Next Generation ACO Model waivers[3,4] from the three-day requirement for inpatient stays before patients are admitted to a SNF, also known as the "SNF 3-Day Rule Waiver").

ACOs identify preferred SNFs for the networks based on analyses of publicly available data (such as the CMS Five-Star Quality Rating System on Nursing Home Compare for insight into the relative quality of SNFs in a given geographic area[5]), claims, and SNF-submitted information. By combining these sources, ACOs develop performance metrics related to clinical quality (such as hospital readmission rates and ED use) and operational efficacy (such as staffing levels and EHR use).

After establishing networks, ACOs develop resources that highlight the high-performing facilities in order to support beneficiaries during the SNF selection process. Some ACOs created brochures for beneficiaries and caregivers that feature the facilities that partner with the ACO in

care improvement initiatives. Other ACOs established data analytic tools to communicate with clinicians about SNFs' utilization rates (such as rates of ED utilization and inpatient hospitalizations after SNF admission). These tools enable clinicians to consider a SNF's performance relative to its peers and to discuss available facilities with beneficiaries and caregivers. As noted in ACO Snapshot 2 on the following page, one ACO designed a scorecard for clinicians that ranks the performance of local facilities from highest to lowest based on patient outcomes and length of stay.

ENCOURAGING CONTINUOUS QUALITY IMPROVEMENT

Many ACOs directly engage and collaborate with SNFs in high-performing networks to facilitate continuous quality improvement and use of best practices (such as completing a timely admitting exam soon after a beneficiary transitions into a SNF). Typically, the SNFs in the networks treat a relatively large proportion of the ACOs' attributed beneficiary population, so supporting additional improvement efforts has the potential to meaningfully improve ACO patient outcomes and financial results. To facilitate these efforts, ACOs have developed data analysis tools, identified care management staff to meet with SNFs in person and via telephone, and enabled peer-to-peer knowledge sharing by establishing SNF collaboratives.

Many ACOs schedule regular meetings with SNF staff to (1) identify strategies for smoothing care transitions from the hospital, (2) collaborate on strategies for determining beneficiaries' therapy needs and anticipated length of stay, and (3) discuss analyses of the health outcomes of ACO-attributed beneficiaries who have been discharged from those SNFs. The ACOs may bring dashboards or other analytic tools to these conversations in order to identify strategic improvement opportunities. A few ACOs collaborate with SNFs to define performance targets and develop action plans to achieve specific goals. One ACO described how it removed SNFs that repeatedly fail to

[3] Centers for Medicare & Medicaid Services (CMS). "Medicare Shared Savings Program. SNF 3-Day Rule Waiver, and/or Medicare ACO Track 1+ Model. Notice of Intent to Apply. Guidance Document." Version #3, May 2017. Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-NOI-Memo.pdf. Accessed November 26, 2018.

[4] CMS. "Three-Day Inpatient Hospital Stay Requirement for Care in a Skilled Nursing Facility Admission Waiver." Available at https://innovation.cms.gov/Files/x/nextgenaco-threedaysnfwaiver.pdf. Accessed November 26, 2018.

[5] CMS. "Five-Star Quality Rating System." Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html. Accessed November 26, 2018.

meet performance targets from the high-performance network. Another ACO established a program that assesses SNFs' outcomes and self-reported data to calculate a single performance score for each facility. The ACO uses the scores to place each SNF at a membership level—gold, silver, bronze, or standard. SNFs at the higher levels receive greater access to quality improvement support from the ACO, which motivates SNFs to provide data to the ACO and to maintain the high quality of care.

ACO Snapshot 2: Developing a SNF Scorecard to Support Patient Decision Making

Objective: Offer patients and clinicians a clear view of how SNFs are performing relative to peer facilities to support patients in choosing a SNF

Tactic: Build a scorecard that provides information on SNF performance on measurable outcomes

Strategy: A Next Generation ACO that is implementing the SNF 3-Day Rule Waiver developed a scorecard that ranks the facilities' performance from highest to lowest based on three ACO-developed measures: preventing re-hospitalization, improving patient independence, and reducing the length of stay. The ACO calculated the re-hospitalization measure based on the percentage of its attributed beneficiaries who were sent by the SNF back to the hospital, with the idea that beneficiaries whose care needs are properly assessed and treated are less likely to require inpatient care after a SNF admission. The patient independence measure assesses the extent to which a beneficiary's physical functioning had improved (for example, the ability to eat and manage personal hygiene) during their SNF stay. The ACO developed the measure on SNF length of stay based on whether SNFs helped beneficiaries to recuperate within a period appropriate for their condition. The scorecard also includes a special designation for facilities most recommended by patients; the designation is based on feedback collected through a random telephone survey of the ACO's attributed beneficiaries admitted to a given SNF.

Rank*	Facility**	How good are facilities at		
		Preventing re-hospitalization	Improving patient independence	Cost savings (length of stay)
1	SNF 1 ☺	●●●●	●●●●	●●●●●
1	SNF 1 ☺	●●●	●●●	●●●●●
3	SNF 3	●●●	●●●●	●●●●●
4	SNF 4	●●●	●●●●	●●●●
4	SNF 5	●●●●	●●●	●●●●
6	SNF 6	●●	●●●	●●●●●
7	SNF 7	●	●●●	●●●●●
8	SNF 8	●●●●●	●●	●
9	SNF 9	●●●	●●	●
9	SNF 10	●	●●	●●●●●
	SNF 11	These participating facilities aren't ranked because we don't have enough information on their performance yet		
	SNF 12			
	SNF 13			
	SNF 14			
	SNF 15			

●●●●●	High Performance
●●●●	Better than Expected Performance
●●●	Expected Performance
●●	Worse than Expected Performance
●	Low Performance

Special Designations

☺	Most recommended by patients

**Medicare patients may choose any Medicare certified skilled nursing facility. The facilities above participate in the Post-Acute Care Program

*Facilities are listed from highest performing to lowest performing based on the total number of circles. In cases of a tie, facilities that rank the same are listed in alphabetical order. Special designations do not impact facility performance or rank.

Another strategy for promoting continuous quality improvement is to encourage collaboration between SNFs. Some ACOs established workgroups on a particular topic related to skilled nursing care, such as avoiding sepsis or treating chronic conditions (such as diabetes and hypertension). Other ACOs created collaboratives of SNFs to share their knowledge on an array of priority improvement strategies and to consider newly discovered best practices via regular in-person meetings. ACOs look to these meetings as an opportunity to establish collaborative relationships with SNFs by discussing recent analyses of beneficiaries' health outcomes and responding to the SNFs' questions about the policy that governs an ACO's model.

> " [Collaboratives have] been very well received. I think a lot has to do with the SNFs being invited to the medical center . . . [that's] not something that had really been done historically . . . "

DEDICATING STAFF TO COORDINATE CARE WITH SNFS

ACOs often rely on dedicated staff to coordinate care for beneficiaries during the SNF admission and discharge process, as well as throughout the SNF stay. The ACO staff who focus on coordinating this aspect of post-acute care include care managers, registered nurses, and physicians. These staff may be embedded within the clinical setting or available via telephone from a centralized ACO office. Although ACOs acknowledge that dedicated staff are a financial investment, they noted that these staff have meaningfully improved the beneficiary's care experience and lowered the rate of inpatient readmissions.

Some ACOs locate dedicated clinical staff within SNFs to provide hands-on support for beneficiaries throughout their stay. One ACO described how embedded nurses are particularly helpful in addressing the potential complications associated with after-hours or hasty SNF admissions; examples include beneficiaries who need additional support through the transition or whose medications did not arrive with them. Embedded nurses also engage beneficiaries and caregivers in preliminary discussions about discharge planning and call them after discharge to discuss the beneficiaries' self-care instructions.

Multiple ACOs designated a team of care managers to collaborate with SNF staff through telephone calls and in-person visits. ACOs described how these staff provide continuity in care and support communication between clinicians who use multiple EHRs that are not interoperable. Some ACOs have also implemented electronic tools that alert care managers when an attributed beneficiary has been admitted to a SNF, whereas others rely on being notified directly by the partnering SNF. Once a beneficiary has been admitted to a facility, the care manager engages SNF staff in order to streamline the transition and enable beneficiaries to receive timely therapy. Some ACOs have care managers who visit SNFs regularly to review the care provided to beneficiaries and to participate in care team discussions. One ACO noted that the care manager's involvement is particularly impactful in the first 30 days of the beneficiary's SNF stay because it ensures that the care plan reflects the health needs identified by primary care and inpatient clinicians who have treated the beneficiary in the past.

> " . . . with everybody being on different records, [tracking beneficiaries' care] has helped make sure that the intention of the discharging physician from the hospital is actually carried out once the patient gets to the next provider of care. "

Care Coordination Strategies for Beneficiaries Who Require Skilled Nursing Care

- Establish networks of preferred SNFs that consistently provide high-quality care based on available data. Develop communication resources, such as brochures and scorecards, to highlight these high-performing facilities for beneficiaries and clinicians

- Promote continuous quality improvement in the provision of skilled nursing care by meeting regularly with SNF administrative and clinical staff or by establishing workgroups and collaboratives to enable peer-to-peer learning between SNFs

- Identify dedicated staff to oversee the post-acute care plan and coordinate care with SNF clinicians during the SNF admission and discharge process, as well as throughout the SNF stay

Care Coordination for Beneficiaries Discharged Home After a Hospital or ED Visit

ACOs manage their beneficiaries' transitions from an inpatient stay or an ED visit to their homes in an effort to improve beneficiary outcomes and reduce instances of avoidable care, such as readmissions and additional ED visits. Some ACOs implemented care transition management interventions that involve sending nurses, care coordinators, or other staff to the beneficiaries' homes. When in the home, the ACO staff answer the beneficiaries' questions about their condition, confirm that they understand their post-discharge instructions and have the necessary medication and medical equipment, and determine whether they have seen their PCP and continue to receive follow-up care. ACOs also use medication management to make sure that beneficiaries not only use the correct medications once they return home, but also that they avoid contraindications.

Many ACOs noted that the home visit ideally occurs within three to five days after discharge, although some ACOs try to schedule the visit as early as 24 hours after discharge. Nurses commonly conduct the home visit, although some ACOs send physicians, care coordinators, or social workers. The visit often includes a functional assessment to evaluate the beneficiary's ability to manage daily activities, an environmental assessment to identify structural safety risks in the home, and a social assessment to understand the support network available to beneficiaries. The visit also includes reviewing discharge instructions with beneficiaries and caregivers, and explaining how they can manage any chronic conditions. Through these assessments and discussions, home visiting staff may also identify the challenges that face beneficiaries with respect to the social determinants of health, such as food insecurity or limited access to transportation, which the ACO can address through a referral to its community partners.

Many ACOs use medication management after a hospital or ED visit to increase their beneficiaries' adherence to prescription drugs and to reduce readmission rates. Nurses,

> " With our care management program, we've shifted over the last few years away from just chronic disease management, more towards the focus on complex, high-cost/high-need patients. Our model follows a care transition intervention, where we identify a patient who has been discharged recently or had ED utilization, and try to get to the patient's home. A home visit really is our key. "

pharmacists, and pharmacy technicians offer the following medication management services for ACO-attributed beneficiaries: medication reconciliation, education on medication dosage and side effects, and outreach to encourage adherence to a medication regimen. ACOs aim to complete a medication reconciliation within a week of discharge and during an office visit, in a home visit, or by telephone. For example, nurse care managers based at one ESCO's dialysis facility perform medication reconciliation during office visits that are scheduled within 48 hours of hospital discharge. The care managers ask beneficiaries to bring their medications to these visits so that the managers can compare them with the medications listed in the discharge summary. A nurse practitioner at this ESCO performs a second medication reconciliation within the next few days of the visit to confirm that all prescribed medications were accounted for during the initial reconciliation and to make corrections as needed. A different ACO looks to a team of pharmacists employed to conduct medication reconciliation for beneficiaries discharged from the hospital. The goal is to complete the reconciliation before the beneficiaries' follow-up visits with their PCPs. The pharmacy team also calls beneficiaries to encourage them to take their medications as prescribed.

Care Coordination Strategies for Patients Discharged Home After a Hospital or ED Visit

- Engage beneficiaries who received inpatient care no more than five days post discharge by scheduling home visits to conduct functional, social, and environmental assessments. These visits also provide an opportunity to review discharge instructions with the beneficiary and caregivers

- Use post-discharge medication management, which includes both medication reconciliation and beneficiary education, to increase beneficiaries' adherence to their medication regimens

Care Coordination for Beneficiaries with Chronic Conditions

ACOs develop care management strategies targeted to the needs of beneficiaries diagnosed with chronic conditions. When poorly managed, these conditions can result in poor outcomes for beneficiaries, increased utilization, and high health care costs. Shared Savings Program and Next Generation ACOs have programs focused on high-risk, high-cost beneficiaries with chronic obstructive pulmonary disease (COPD) and diabetes, among other conditions. ESCOs developed care management strategies to manage their ESRD beneficiary population with additional health-related challenges. The ACOs' care management strategies provide beneficiaries with education about the condition, consider barriers to accessing care, and address potential contraindications or gaps in prescribed medications. Many care management programs also encourage beneficiaries to practice self-care strategies and adhere to prescribed treatment.

To support beneficiaries with COPD, ACOs developed strategies designed to ensure that beneficiaries have the necessary understanding and resources to manage their condition, and effectively respond to urgent care needs. ACOs look to all members of the care team, from clinicians to support staff, to educate beneficiaries about their condi-

tion, promote effective self-care strategies, and highlight available resources if additional support is necessary (see ACO Snapshot 3 for a specific example). These opportunities for the care team to engage beneficiaries may occur in an office setting or in the comfort of the beneficiary's residence. For example, one ACO described a pilot program that couples beneficiary education about COPD with an emphasis on clinical best practices. ACO staff engage with beneficiaries to demonstrate the proper use of inhalers and to point beneficiaries to print and video resources related to COPD. In addition, the ACO encourages clinicians to use a medication algorithm based on a beneficiary's Modified Medical Research Council dyspnea scale,[6] provides training for clinicians and staff on best practices in caring for COPD patients, and facilitates the adoption of EHR-based decision-support tools. Preliminary results from the pilot indicated both an increase in the share of beneficiaries who receive care according to clinical guidelines and a reduction in both COPD-related and overall ED visits.

ACOs also offer health coaching and educational supports to beneficiaries who have diabetes, and described the valuable contribution made by pharmacists to these

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ACO Snapshot 3: Improving Health Outcomes for Beneficiaries with Chronic Conditions

Objective: Reduce readmissions among beneficiaries with chronic respiratory and cardiac conditions

Tactic: Visit beneficiaries at home to evaluate environmental safety and encourage self-management by providing education and support

Strategy: The Shared Savings Program ACO developed a program to improve health care outcomes for beneficiaries who receive hospital care for conditions related to a chronic respiratory diagnosis or congestive heart failure. The ACO's inpatient care manager contacts an ambulance service partner, who sends staff to the beneficiary's home within a day of discharge to conduct a home safety evaluation. The staff make sure that beneficiaries have filled their prescriptions, have nebulizers and other equipment needed to manage their condition, and understand their post-discharge instructions. In addition, for beneficiaries with COPD, the ACO's respiratory therapist visits with beneficiaries in their homes to inform them about effective self-care management. The therapist also confirms that the beneficiaries are receiving ongoing care from a PCP or pulmonologist, have an emergency medicine pack in their homes, and know about a dedicated telephone number that the ACO operates for beneficiaries with COPD. If beneficiaries call this number, ACO staff assess the beneficiaries' needs and then connect them to a population health coach, a PCP, or the ED if there is a true emergency. Although the ACO implemented the program recently, beneficiaries have already reported feeling safer and less anxious about managing their conditions.

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[6] Medical Research Council. "MRC Dyspnea scale/MRC Breathlessness Scale." Available at https://mrc.ukri.org/research/facilities-and-resources-for-researchers/mrc-scales/mrc-dyspnoea-scale-mrc-breathlessness-scale/. Accessed December 4, 2018.

conversations. For example, one ACO partnered with pharmacies to implement a program intended to help beneficiaries adhere to complicated medication regimens. For each beneficiary, a pharmacist completes a medication reconciliation and then fills all of the beneficiary's prescriptions at once for a 28-day cycle. The pharmacist delivers the medications to the beneficiary's home, with each individual dose carefully labeled to note the day and time that the beneficiary should take the medication. One week later, the pharmacist meets with the beneficiary to assess his or her adherence to the medication regimen and relays any concerns to the PCP. After implementing this medication management program, the ACO observed improvements in beneficiaries' hemoglobin A1C and cholesterol results, and it has expanded enrollment in the program to additional beneficiaries with diabetes.

ESCOs developed a variety of care management approaches, described below, to meet the unique needs of ESRD and pre-ESRD populations:

- **Beneficiary education.** Many ESCOs develop pamphlets and encourage meetings between beneficiaries and care coordinators or nurses to improve a beneficiary's understanding of effective self-care strategies. These engagement initiatives often focus on beneficiaries diagnosed with ESRD, with a few ESCOs targeting patients with stage 4 chronic kidney disease (CKD) who have not yet been diagnosed with ESRD and who consequently are not yet aligned to the ESCO. By working with patients in the later stages of CKD, ESCOs can encourage them to put a permanent vascular access in place before starting dialysis rather than relying on catheters. Early intervention with CKD patients also gives ESCOs an opportunity to educate them about the potential benefits of home dialysis options, since it can be difficult to get patients to switch from in-center hemodialysis to a home option.

- **Medication reconciliation.** Some ESCOs use a team-based medication reconciliation strategy for ESRD beneficiaries. ESCOs often look to a pharmacist or nurse to reconcile medications, with a primary care nephrologist reviewing and confirming the pharmacist's or nurse's conclusions. One ESCO, recognizing that nephrologists may not be familiar with all of a beneficiary's medications, relies on care coordinators to speak with specialists about a beneficiary's medications.

- **Co-located health professionals.** ESCOs also noted that care management programs are particularly effective when services are located in the dialysis facility because beneficiaries spend substantial time receiving dialysis, which leaves little time for additional medical appointments. One ESCO partners with podiatrists to perform diabetic foot screenings while beneficiaries receive dialysis to more easily identify beneficiaries who need follow-up care to avoid complications. Beneficiaries and their clinicians responded so positively to the onsite podiatrist screenings that the ESCO plans to co-locate podiatrists at its facilities.

> "We knew, in launching ESCOs, that to be successful and truly change care for patients, we needed to work upstream before ESRD. We provide pre-dialysis, pre-ESRD chronic kidney disease management . . . [through] one-on-one, in-person care coordination and education. It's not a one-and-done education session. It's active care coordination for the patient [and] with the referring nephrologist."

Care Coordination Strategies for Beneficiaries with Chronic Conditions

- Develop care management strategies that target beneficiaries' needs related to their diagnosed chronic conditions; the strategies can include home visits and hands-on coaching to address barriers to accessing care

- To help beneficiaries adhere to complicated medication regimens, use a team-based medication reconciliation strategy that includes pharmacists, specialists, and care coordinators

- Look to all members of the care team, from clinicians to support staff, to educate beneficiaries about their condition, promote effective self-care strategies, and highlight resources for additional support as necessary

Care Coordination for Beneficiaries with Conditions Affected by Social Determinants of Health

ACOs have a growing understanding of the links between beneficiaries' health outcomes and the social determinants of health, including limited access to transportation, social isolation, housing instability, food insecurity, and an inability to access or afford medications. Clinicians adjust their care decisions based on these environmental, social, and financial challenges, but they are limited in what they can do to effectively ameliorate them in the clinical setting. To better manage beneficiaries' social determinants of health, ACOs develop partnerships with community organizations that can engage and assist beneficiaries with their needs beyond health care. ACOs enhance these relationships by collecting data on the challenges faced by beneficiaries and use the resulting insight to make referrals to appropriate partner organizations.

IDENTIFYING BENEFICIARY CHALLENGES

Multiple ACOs systematically identify their beneficiaries' challenges related to the social determinants of health and disseminate that information to the PCPs, specialists, and care coordinators who interact with them. For example, ACOs embed social risk-assessment tools into EHRs, which allows clinicians or care coordinators to screen the beneficiary at the point of care by using a standardized data collection tool. The clinicians and care coordinators can then review the results of the screening tool within the beneficiary's medical record. One ACO encourages care coordinators to complete the assessment at the start of the office visit so that the clinician can account for the social determinants of health when developing a care plan. In addition, a care coordinator can use the assessment data to refer the beneficary to a social worker or to make direct referrals to community partners (see ACO Snapshot 4 below for more information).
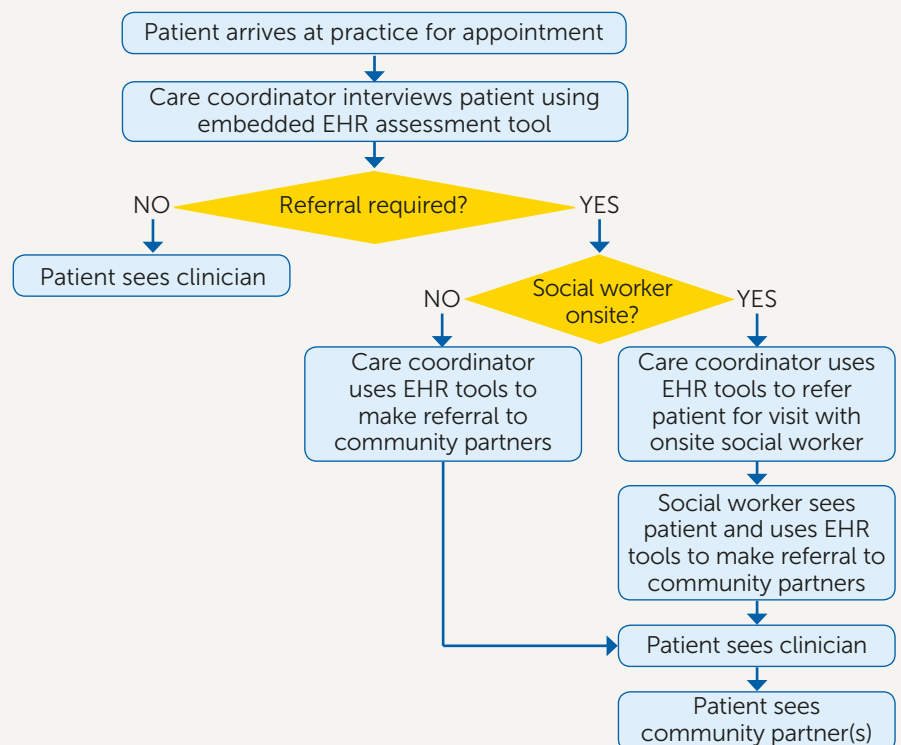
ACOs can also use the assessment data in the EHR to guide interventions. For instance, recognizing that beneficiaries may struggle with multiple challenges related to the social determinants of health, one ACO purchased a program that analyzes and ranks the challenges that emerged from the assessment. This ranking allows ACO staff to

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ACO Snapshot 4: Leveraging the ACO's EHR to Address Social Determinants of Health

Objective: Streamline the process for identifying and addressing beneficiaries' needs related to social determinants of health

Tactic: Build tools into the EHR to collect information on beneficiaries' needs and make referrals to community organization partners

Strategy: The Shared Savings Program ACO began with a paper-based assessment that providers use to learn about beneficiaries' risks related to social determinants of health and embedded the assessment into the EHR. The ACO also built tools into the EHR to streamline the referral process to community partners. As shown in the workflow, when a patient visits a primary care practice, she meets with a care coordinator to complete the assessment before seeing the provider. If the assessment flags major unmet needs related to social determinants, the care coordinator can use the EHR to generate a referral to a social worker within the practice. If the social worker is not on site, the care coordinator can use the EHR to pull up a menu of social service resources and make direct referrals to the community partner.

```
Patient arrives at practice for appointment
        ↓
Care coordinator interviews patient using
     embedded EHR assessment tool
        ↓
   ◇ Referral required? ◇
   NO ←        → YES
   ↓                ↓
Patient sees     ◇ Social worker onsite? ◇
clinician        NO ←        → YES
                 ↓                ↓
          Care coordinator   Care coordinator uses
          uses EHR tools to  EHR tools to refer
          make referral to   patient for visit with
          community partners onsite social worker
                 │                ↓
                 │           Social worker sees
                 │           patient and uses EHR
                 │           tools to make referral to
                 │           community partners
                 │                ↓
                 └──────→  Patient sees clinician
                                  ↓
                          Patient sees
                          community partner(s)
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decide which challenges to make top priority and which to address at a later date. Another ACO uses an algorithm to comb through assessment data in the EHR and identify high-risk patients. The ACO conveys information about these patients to case managers, who help to connect the patients to community partners that can assist them.

> " Questions [on social determinants of health] are standardized across the health system. Anyone who asks those questions, whether it's the inpatient, ambulatory, a care manager, [or] a home health nurse . . . , that response is pulled into the longitudinal primary care [record] and presented for all care team members to see . . . . So [from] the primary care physician who sees the patient frequently to the cardiologist who's just doing a one-time consult, the provider can see that this patient has medication affordability issues. "

LEVERAGING TECHNOLOGY TO STREAMLINE REFERRALS TO COMMUNITY PARTNERS

In addition to capturing data on beneficiaries' challenges, information technology can also streamline referrals at the point of care and improve beneficiaries' access to partners' services. Some ACOs built tools that allow clinicians and care coordinators to use their computers to identify and make direct referrals to community partners. For example, after developing a partnership with a community organization focused on food security, an ACO added a link in its staff's computers to the organization's website to encourage direct referrals for patients who do not have reliable access to nutritious food. This ACO plans to add similar links to organizations dealing with housing and other issues as partnerships develop. Another ACO has referral capabilities built directly into its EHR and into the same screen that displays the results of patients' risk assessments. This allows care coordinators, social workers, or physicians to review the risks flagged by the assessment and to make referrals during the same appointment. A third ACO developed an online tool similar to a crowd-sourced review website (such as Yelp or Angie's List) that allows ACO care coordinators, social workers, and other personnel to search for and rate community partners. The ACO staff who make referrals can use

the ratings to find the community partners that best meet the needs of their patients.

ACOs underscored the importance of establishing partnerships with a wide range of community organizations to address the diverse needs of beneficiaries related to the social determinants of health. For instance, ACOs have sought out partners such as Area Agencies on Aging, local housing coalitions, food banks, community pharmacies, and transportation providers. These partnerships often go beyond simply placing an organization on a referral list. ACOs work with the partners to develop interventions designed to meet the most pressing needs of their beneficiaries. For example, one ACO enlisted the local Area Agency on Aging to provide bundles of services to beneficiaries in 30- and 60-day increments. The services included home safety evaluations, medication reconciliation, delivered food, home alert systems, and caregiver support. Another ACO found that beneficiaries went to the ED for urgent medical care whose health needs actually related to isolation, loneliness, and anxiety. This ACO partnered with a local faith-based provider to create a buddy program that supports these beneficiaries (see ACO Snapshot 5 on the following page for more information). A third ACO learned that some of its beneficiaries live in homes that had either been condemned or were in need of major repairs. In response, the ACO partnered with the local housing coalition to refurbish the homes. Over time, the ACO worked with the housing coalition to expand the program from one small area of the community to an entire county.

> " We are really moving toward more holistic assessment and stratification of the population of patients. And then we are aligning very closely with our community health and well-being programs to make sure that we are not just within the four walls of the hospital system, but [that] we are reaching into the community to develop these close partnerships to address the various social determinants of health. "

STRENGTHENING COMMUNITY PARTNERSHIPS

Once the partnerships are established, ACOs then invest in deepening and sustaining them to ensure that attributed

ACO Snapshot 5: Engaging Community Partners to Address Beneficiaries' Social Isolation

Objective: Reduce unnecessary ED visits for patients who are lonely and anxious but do not have emergent medical conditions

Tactic: Partner with faith-based organizations to establish a "buddy" program

Strategy: The rural Shared Savings Program ACO identified a number of elderly patients who visited the ED on a regular basis for non-emergent problems. These patients described how their living environment left them feeling socially isolated, and they went to the ED to address medical issues that were compounded by a sense of loneliness and anxiety. To prevent avoidable ED use, the ACO partnered with local faith-based organizations to establish a senior "buddy" program and then asked its primary care practices to discuss the program with elderly ACO beneficiaries who had high ED use. If the beneficiaries were interested, the faith-based partner organizations matched them with volunteers and initiated a series of regular buddy visits. Though only a handful of beneficiaries currently participate in the buddy program, their ED visits have dropped by 50 percent relative to what it was before the program began. Given this early success, the ACO plans to expand the program.

beneficiaries continue to have their needs addressed related to the social determinants of health. For example, one ACO distributes a portion of its shared savings to community organizations when funds are available in order to promote the overall health of the community. Another ACO formed regional care coordination teams that include representatives from community partner organizations, primary care clinicians, hospitals, and community health workers. The teams meet monthly to discuss the referral process, including workflows, staffing models, and challenges. This ACO purchased a cloud-based care coordination platform so that team members can share information as a way to understand each other's roles and contributions to addressing the beneficiaries' social determinants of health.

When considering the array of beneficiaries' needs related to the social determinants of health, several ACOs identified limited access to transportation for medical appointments as a key risk area and adopted innovative approaches to providing beneficiaries with options. One ACO collaborated with a medical transportation company to develop a smartphone application that allows beneficiaries to arrange for transportation to their appointments. Beneficiaries with recurring appointments can request the same driver for each trip, which builds rapport between the beneficiary and the driver. Other ACOs looked beyond traditional medical transportation services and partnered with commercial ride-sharing companies. One company gives ACO staff access to a portal that allows them to schedule rides on behalf of the beneficiaries, which enables the ACO to confirm that the services are being used appropriately. One ACO established a philanthropy fund for its clinic, and a team of social workers uses the fund to pay for the transportation services—ranging from ride-sharing, to taxis, to bus tickets—that best meet the needs of their beneficiaries.

Care Coordination Strategies to Address Social Determinants of Health

- Embed tools to assess social risk within EHRs and make these assessments part of the standard workflows for clinician office visits

- Build digital tools that allow care coordinators, social workers, and providers to identify community partners that address social determinants of health and make direct referrals

- Develop partnerships with community organizations in order to address a broad range of social determinants of health

- Consider using innovative partnerships to address beneficiaries' transportation challenges (e.g., engage a commercial ride sharing company)