AMGA
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AMGA Foundation

Chronic Care Roundtable

Realigning Care in the Time of COVID-19: Prioritizing High-Risk Patients

November 10 & 12, 2020 / Virtual Event

Meeting Summary

AMGA Foundation

Chronic Care Roundtable

The COVID-19 pandemic has illuminated the fact that significant healthcare disparities exist among people of different races and socioeconomic status, and especially among those who suffer from multiple chronic medical conditions. The disadvantage these populations have in achieving and maintaining health in the face of a pandemic is glaringly clear. With this challenge comes an opportunity for health systems and industry partners to work together to realign care for patients whose risk for COVID-19 complications and death are related to these disparities.

On November 10 and 12, 2020, Chronic Care Roundtable (CCR) participants, including industry partners and leaders from health systems and medical groups across the country, convened virtually to identify solutions for providing care to high-risk populations in the time of COVID-19.

Kicked off by Jerry Penso, M.D., M.B.A., president and chief executive officer, AMGA, and moderated by John W. Kennedy, M.D., chief medical officer, AMGA, and president, AMGA Foundation, the meeting highlighted how health systems and medical groups are innovating in response to the pandemic in order to bridge health disparities and provide care for highest risk patients. Stories and statistics from COVID-19 hotspots shed light on how the pandemic has impacted health care in both primary care and specialty settings, as well as the paradigm shifts necessary to realign our healthcare system. Interactive dialogue and ongoing conversation among participants sought to explore and define what the future of chronic diseases may look like in both primary and specialty care settings.

Part 1: November 10, 2020

Realigning Primary Care in the Time of COVID-19

Using an Innovative Care Model to Support Our Patients in the Time of COVID-19

Adnan Munkarah, M.D., *Executive Vice President and Chief Clinical Officer, Henry Ford Health System*

When the pandemic peaked in the Detroit metro region in April 2020, Henry Ford Health System (HFHS) provided care for 900 in-patients with COVID-19, 350 of whom were in intensive care. The health system struggled with a shortage of environmental and Intensive Care Unit (ICU) staff. Additionally, adequate personal protective equipment (PPE) and other essential resources were a concern. The emergency department was strained and the hospital was at maximum capacity.

HFHS pivoted to address the rapidly spreading disease with new policies and workflows, maximizing existing resources and adding new ones. Using tactics to enhance patient safety, ensure hospital capacity during the COVID-19 surge, avoid unnecessary emergency department visits, and maintain the health and well-being of valued staff, HFHS created scalable solutions that will endure for years to come.

In his talk, Dr. Munkarah illuminated some key innovations:

Expanded Telehealth

When COVID-19 peaked, video, telephone, and e-visits became an essential resource, particularly in the management of chronic conditions. HFHS had tried to implement telehealth prior to the crisis, but convincing providers and

patients to participate was a challenge. Currently, HFHS has approximately 11,000 telehealth visits per week—7% of all healthcare visits—compared to less than 200 prior to the surge.

After patients are seen virtually, nursing visits can be arranged for vitals, immunizations, and completion of lab orders. HFHS is working on expanding to other visit types, including virtual Medicare wellness visits, and intends to continue building upon their telehealth model even after the COVID-19 crisis abates.

Temporary changes in government funding need to be made permanent, as the telehealth methods are proving to be effective modes of healthcare delivery.

Q&A: You demonstrated a broad uptake of telehealth, not just among medical specialists and primary care but among surgical subspecialists as well? Any insights you can share?

Munkarah: When COVID-19 hit in the spring, we had no other option. We went to surgical specialists as well as medical specialists and asked them to engage. They identified things they have done before such as chronic care management for patients who have had surgery, and for new patients seeking a surgical opinion. At a time when it was not safe for patients to be in clinics, orthopedic surgeons were able to connect with patients, listen to them, look at some imaging, understand the problem, and provide advice to bridge the care of these patients while waiting to be seen in person.

Healing at Home

In April of 2020, HFHS expanded the Henry Ford Healing at Home Program. This program employs an interdisciplinary team, including the referring provider (virtual), a paramedic from the population health team, and home health nurses as needed to deliver intensive at-home care for patients with chronic conditions who are expected to have COVID-19. Healing at Home has succeeded in averting 25% of HFHS's total emergency department visits. Additionally, the program has been successful in treating patients with COPD or who are at risk for severe diabetes complications. HFHS plans to continue to build on this program for the management of chronic conditions.

Q&A: How were you able to take a small program and really expand it and scale it across the system—what type of professionals are staffing it and does that information integrate into your electronic health records?

Munkarah: Even prior to our COVID-19 crisis, we were looking at ways to manage our patients at home. We contracted to send paramedics to the patients' houses and connect them to hospitalists and primary care physicians—what we call "virtualists." They coordinate care and huddle on a daily basis. We established connectivity between that program and the Epic electronic health record platform. The primary care physician has documentation of these visits and care at home.

Free In-Home Delivery with Medications

Changes in emergency regulations helped HFHS operationalize free in-home delivery of medications for patients with chronic conditions who were at high risk for becoming non-adherent to medications due to the pandemic. Patient medication quantities were increased from 30-day to 90-day supply with permission from payers and providers, and pharmacists were allowed to add a refill to expired chronic use drug prescriptions. This program has led to a 79% increase in home delivery of these medications, as well as increased patient satisfaction. This service has been particularly beneficial to elderly patients with chronic diseases.

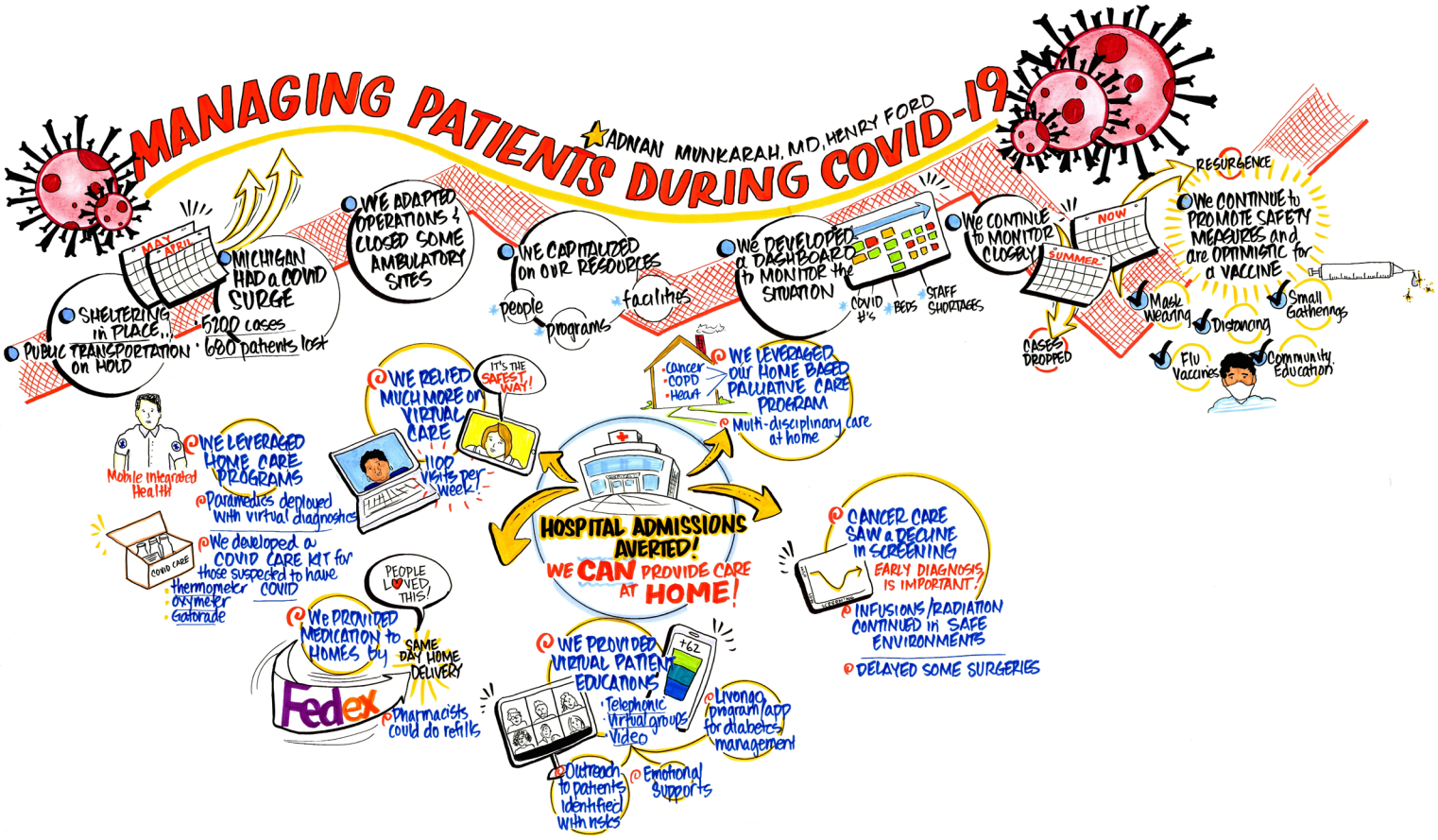
Oncologist First Call

The COVID-19 pandemic highlighted the need to make cancer screening and consultations for cancer patients convenient and accessible to patients. In response to this need, HFHS is piloting Oncologist First Call. This program enhances real-time access to cancer care by offering newly diagnosed patients the option to quickly connect with a physician who specializes in their type of cancer. It bridges the gap between a patient's initial diagnosis and their first meeting with their cancer treatment team, virtually connecting them with a physician within a day or two of being diagnosed.

Other Programs

Other programs and initiatives also proved highly effective during the surge of the pandemic. The Livongo digital diabetes management program gives patients with diabetes 24-hour access to the support they need to stay motivated and manage their condition. Launched in early 2020, the home-based palliative care program reduced hospitalizations by 80% for the high-risk population it serves during the pandemic.

What's next for HFHS? While optimistic about the prospect of a COVID-19 vaccine, Dr. Munkarah forecasted continued community education on mitigation measures such as social distancing, mask wearing, and getting the flu vaccination. HFHS is also working to ensure that, once the vaccine does become available, their patients have access to it.



Realigning Primary Care in the Time of COVID-19: Focusing on the Root Cause of Disease

Tony Hampton, M.D., M.B.A., CPE, ABOM, *Medical Director, Advocate Aurora Health*

How do we transform primary care from a disease management model to one that focuses on helping our patients heal? As Regional Medical Director for the South Region of Advocate Aurora Health (AAH), Dr. Tony Hampton is driving change in a Chicago community plagued by a higher incidence of chronic conditions, lower life expectancy, and other health disparities. COVID-19 has shined a light on these persisting disparities and the food insecurity, poor housing, and trauma that perpetuate them. By educating patients and providers to "control the controllable"—such as nutrition, exercise, sleep, and thinking positively—and through unique partnerships that connect patients to the care and resources they need, AAH is addressing the root cause of disease and disparities in their community.

In his talk, Dr. Hampton outlined his roadmap for helping patients heal:

Understand the Root Cause of a Patient's Condition

According to Dr. Hampton, the provider must "become a detective." Many of the illnesses Advocate Aurora's patients suffer from are related to metabolic syndrome. Created by Dr. Hampton, the N.E.S.T.R.O.P.E. acronym represents eight core components that are the basis of health. An imbalance in any of these areas can be the root cause of disease. This model of care has been referenced in a recently published book by Michelle Hurn, RD, LD: *The Dietitian's Dilemma: What Would You Do if Your Health Was Restored by Doing the Opposite of Everything You Were Taught?* It is also a prominent theme in Dr. Hampton's podcast series, *Protecting Your Nest*.

N	Nutrition
E	Exercise
S	Sleep/Stress
T	Trauma/Thinking
R	Relationships
O	Organisms
P	Pollution
E	Emotions

Address Social Determinants of Health

Once the root cause of the patient's disease has been identified, providers should address any social determinants of health. Ask the right questions to determine what makes the patient struggle—even at 5 p.m. on a Friday.

For example, living in an area infested with environmental pollutants—such as factories, human sewage, marine dumping, mining, and even household chemicals—can reduce life expectancy significantly. According to an analysis by the Department of Population Health at NYU School of Medicine, using data from the City Health Dashboard, individuals who live in an ethnically segregated, industrial neighborhood on the Southside of Chicago live an average of 30 years less than those who live only 9 miles north.

Positive relationships, or the lack thereof, is another determinant of health. Social support plus social integration equals decreased stress and improved mental health. If a patient does not have these supports, they are at higher risk for diabetes and other chronic conditions. This is one reason that diabetes prevention programs have a social integration component.

Q&A: How do you address access issues in the underserved communities?

Hampton: At Advocate Aurora we have an acute care clinic for patients who struggle. This increases access in two ways: By providing transportation for patients to and from appointments and by allowing providers to spend as much time as they need with each patient. The clinic includes physicians, physical therapists, pharmacists, nutritionists, and behavioral health professionals. We also have our clinical integration clinics that assure high-quality care for complex patients with multiple chronic conditions. These clinics are conveniently located on the first floor for preventative care patients who might be able to get what they need in one visit, for example flu shots and eye exams. As a result of these clinics, a patient doesn't have to go to multiple appointments or locations to receive comprehensive quality care.

Provide the Right Resources to Bridge This Gap

Through robust community partnerships, AAH is able to reduce disparities among Chicago's most underserved communities, providing individuals with the tools they need to address and overcome certain barriers to health.

- **National Diabetes Prevention Program:** This year-long program involves weekly meetings with a curriculum created and sponsored by the Centers for Disease Control and Prevention (CDC) to help patients reduce their risk for Type 2 diabetes. The program provides access to healthy foods in partnership with neighborhood churches and the YMCA.
- **Healthy Living Food Farmacy:** This food pantry access program is a collaboration with the Greater Chicago Food Depository, offering identified patients an opportunity to secure healthy food options bi-weekly, as well as healthy cooking classes.
- **Healthy Living Events:** A partnership with Salvation Army Center makes these educational events possible for up to 200-300 people. AAH engages the audience by showing cooking videos, made specifically for these events, featuring providers the patients know and trust instructing on how to prepare the foods that they recommend their patients eat. During the pandemic, the events are virtual.
- **Workforce Development:** AAH partners with companies, such as Chase Bank and others, to provide job and internship opportunities within the health system or at the partnering company. In 2017, 50 participants completed the AAH Workforce Initiative program and 40% found employment. Plus, 27 interns were accepted at AAH's Trinity Hospital, 7% of whom were employed by the hospital within a year.
- **Partnership with Imani Village:** Imani Village is a social enterprise that addresses the diverse needs of the community through better access to health, green housing, and educational and workforce opportunities. AAH has a community Federally Qualified Health Center on the premises and collaborates on an apprenticeship program for high school students, who will learn about environmental health, green spaces, community gardens, and community health improvement.

Q&A: What lessons have you learned from the intersection of obesity and COVID-19?

Hampton: We all went into medicine to be healers and if we focus on management only, then we will fail. Managing disease not only will frustrate the clinician but also the patients. If we only manage the disease, patients will be on medicines with side effects for the rest of their lives. Physicians need to find two to three minutes to communicate to patients: This is what I care about, here is a handout, website, etc., that may help you. You cannot heal people through medication—you have to address lifestyle. It might take a few years to generate traction, but we need to make sure to keep informing patients.

Part 2: November 12, 2020

Realigning Specialty Care in the Time of COVID-19

The Pandemic Unmasked Our Resilience: Care Realignment in the Time of COVID-19

Sanjay Doddamani, M.D., M.B.A., *Executive Vice President, Chief Physician Executive & Chief Operating Officer, Southwestern Health Resources*

The COVID-19 pandemic has disrupted healthcare institutions everywhere, with effects ranging from increased hospitalizations and mortality rates in the short term to later presentations of undiagnosed cancers and unmanaged chronic conditions in the long term. In addition, it has exposed the inflexibility and unsustainability of a fee-for-service payment model, which focuses on the over-dependency on volume as opposed to the efficiency and outcomes in a value-based model.

Southwestern Health Resources (SWHR), a Texas-based, clinically-integrated network of UT Southwestern and Texas Health Resources—along with roughly 5,500 physicians including a large community network—has maintained its ability to pivot and realign care in the time of COVID-19 largely because of its value-based arrangements.

In his talk, Dr. Doddamani shared these strategies that enable SWHR network physicians to provide meaningful care and continue to drive positive patient outcomes, despite the prolonged pandemic:

Minimize Fee-For-Service in Favor of Alternative Payment Models (APM)

- **Create a functional network of primary care physicians and specialists** who have a significant portion of their patients attributed to an APM. This simplifies referrals, reduces unnecessary care and/or unwarranted procedures, streamlines pharmacy processes, and provides a clearer picture of the total cost of care.
- **Align financial incentives for both primary care providers and specialists** with goals to close gaps and optimize quality, enhance care delivery (including optimal post-acute care), capture accurate chronic condition documentation, and increase network efficiency.
- **Aim to qualify for Centers for Medicare & Medicaid Services (CMS) APMs**, which can lead to Qualified Participant (QP) status and additional bonuses to create better value in the care delivered.

Close Quality and Care Gaps with Network-Wide Collaboration

During the pandemic, SWHR identified and proceeded to close approximately 14,000 persistent quality gaps in testing for various conditions such as diabetes complications and delivering age-appropriate cancer screening. SWHR closed 99% of these gaps in the first two months by engaging physicians and patients, as well as utilizing vendors to provide these services when needed. Dr. Doddamani made recommendations to replicate this success:

- **Provide physicians with financial incentives** to close gaps, which helps to support them during the pandemic.
- **Develop a provider toolkit** to help physicians engage with patients to complete quality screening and tests while maintaining personal safety and reassurance about the test environments.

- **Inform and encourage patients about safety measures and precautions** through social media, direct mail reminders, and automated texts. SWHR sent targeted messages to thousands of at-risk and disproportionately affected communities. Emergency services personnel commented that these communications continue to save dozens of lives.
- **Leverage in-home care**, sending test kits to patients' homes whenever possible to avoid travel and exposure risk. SWHR found that eye exams and blood tests could be done safely and efficiently in the home and arranged for mammography testing at preferred sites within the network.
- **Mobilize telehealth education and resources** for physicians to ensure that patients have continued access while in-office visits are restored.

Q&A: How do you incentivize physicians at a granular level to close care gaps?

Doddamani: Our pilot focused on commercial beneficiaries, and during that phase, we paid our physicians an incentive for the time it took them to engage with patients to successfully close care gaps—since a lot of this work was accomplished outside of their busy schedules and after hours. We also paid vendors to complete tests and provide services, including in-home testing for retinal scans, blood pressure measurements, and fecal immunochemical testing (FIT). When necessary, patients were referred to nearby centers to obtain mammograms and colonoscopies. Nationwide there has been an 80% reduction in mammograms and 90% reduction in colonoscopies, while during the same period, we only saw a 2% drop.

Recognize the Complex Needs of the Most Medically Dependent Patients

SWHR recognizes the difficulties experienced by the top 10% of high-cost, high-need patients. To address unmet care needs, SWHR continues to partner and develop wraparound services for both urgent and longitudinal care. The demand for in-home services has gone up significantly with the pandemic, causing SWHR to evolve and refine its response.

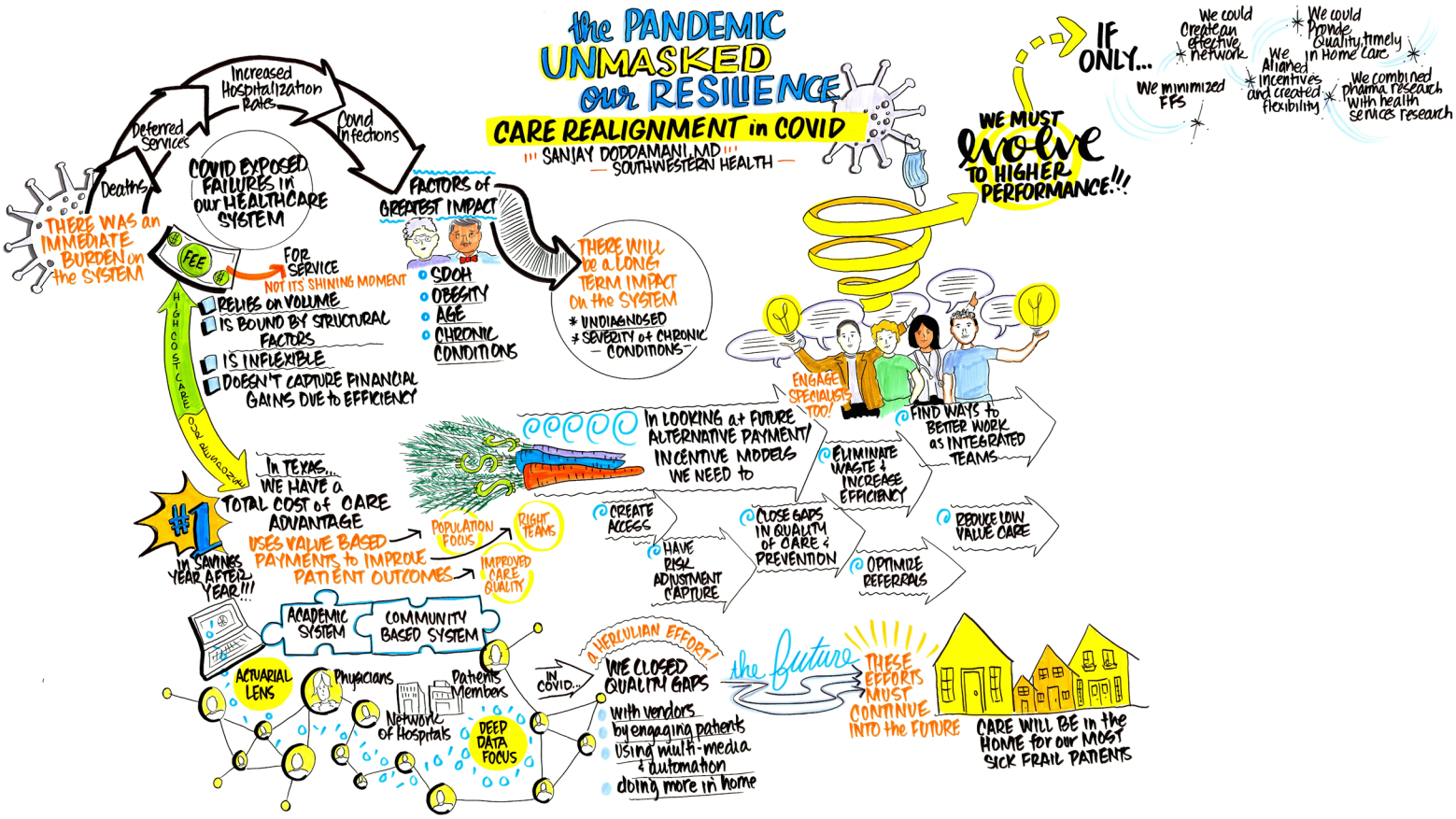
Important considerations with this model include:

- Developing eligibility criteria based on high dependency and unmet needs
- Addressing social determinants and isolation
- Optimizing resources to deliver timely, medically complex care
- Managing symptoms and improving medical therapies through reductions in polypharmacy
- Including palliative care and addressing end-of-life issues
- Integrating behavioral health care

Q&A: Provide an example of the type of patients that can benefit from these advanced services that five years ago would have needed in-person care.

Doddamani: It is important to find alignment among the right patient, the right acuity, and the right site of care. For example, if a patient presents with pneumonia limited to two or less lobes without hypoxia, then technically, the person can be at home receiving antibiotics and get their care with an urgent home visit instead of in the emergency room. Those with multiple chronic conditions, such as uncontrolled diabetes, can be taken care of in the home with an integrated care team and experience superior results and experience. The pandemic has exerted pressure on the hospitals to find solutions outside of their four walls, whether this is at home or a skilled facility in the pre-acute setting.

Using these lessons learned from COVID-19, Dr. Doddamani believes that healthcare institutions have an opportunity to transform care delivery in the U.S.



Part 2: November 12, 2020 | **Realigning Specialty Care in the Time of COVID-19** *(continued)*

Telehealth: Temporary Solution or Permanent Disruptor

Scott Hines, M.D., *Chief Quality Officer, Crystal Run Healthcare*

Crystal Run Health Care (CRHC) was hit early and hard by COVID-19. The first positive case was on March 11. By March 27, New York State ranked eighth in the world and Orange County, where CRHC is located, ranked 42nd in the world for cases. Guided by the primary principle to keep staff and patients safe, CRHC engaged a number of tactics. Their biggest effort, however, was to implement a cross-specialty telehealth program from scratch.

In his talk, Dr. Hines discussed how CRHC went from zero to more than 2,000 telehealth visits per day—approximately 45% of patient visits—over the course of a month through intensive patient and provider education and other key strategies. He illustrated the significant benefits of telehealth for chronic disease management, sharing outcomes before and after telehealth was implemented at CRHC. He addressed the challenges that CRHC, providers, and patients have experienced with telehealth and the solutions that have been most successful.

Tactics for Telehealth Launch Success

CRHC tried to launch telehealth five years ago, but there was no demand by patients. Before the pandemic, providers and patients had no experience, which meant that CRHC had to double down on education. Other than education, the challenges that CRHC experienced when implementing telehealth were mainly technical, including ensuring that patients get lab work to detect A1c, cholesterol, urine microalbumin, and more. In addition, setting patients up with continuous glucose monitoring (CGM) and other devices is difficult to do virtually.

In order to get telehealth off the ground, CRHC addressed provider and patient challenges in these innovative ways:

For providers

- Established frequent provider education opportunities, including live demos, FAQ webinars, and weekly email updates on telehealth including changes in workflow, enhancements, and more
- Created a telehealth command bridge to enable providers to easily access the IT team who would troubleshoot any issues in real-time
- Standardized workflows across specialties and shared with providers and nursing staff
- Activated physician and nurse champions, termed “super users,” who were well versed in using the telehealth platform to assist their colleagues

For patients

- Implemented educational videos on website
- Instituted a pre-visit planning call during which clinical teams conducted medication reconciliation and screening, and ensured patients had downloaded and were comfortable with Zoom app

- Launched a social media campaign stressing the benefits of telehealth: safety, convenience, and no cost-sharing
- Empowered the care optimization team to schedule telehealth appointments with patients who they called to monitor gaps in care
- Addressed the issue of completing lab work prescribed at virtual visits by developing outdoor lab sites for patients who were either symptomatic or nervous about COVID-19 spread—thereby assuring patients that extreme precautions were being taken to keep the indoor lab safe
- Encouraged diabetic patients using devices such as pumps or CGM to start with an in-person visit and then follow up with telehealth

Telehealth Benefits for Patients with Chronic Conditions, Especially Diabetes

Dr. Hines illustrated the benefits of telehealth for patients with chronic conditions with a case study following a 62-year-old male patient who has had Type 2 diabetes for more than 15 years. This patient, who is being treated with insulin and oral hypoglycemic medications, has had complications due to his diabetes including mild retinopathy and nephropathy. Prior to telehealth, he was seen consistently every 3 months, but not more frequently as advised due to copays. His A1c ranged from 8.5 to 9.5.

With the implementation of telehealth, this patient's diabetes got better. He was seen every 2-3 weeks and there was more frequent titration of medications. He was given tips on insulin administration and even saw a nutritionist. His most recent A1c was 7.6—the lowest it has been in years.

Major benefits of telehealth include:

- **Patients can be seen more frequently**, creating more accountability for the management of their diabetes through diet, exercise, and medication adherence.
- **Care is more convenient** because patients don't have to come to the office and visit times are shorter due to the elimination of travel and checking in and out.
- **The barrier of the co-pay to see a specialist is eliminated** (temporarily) due to the cost-sharing waivers.
- **Providers can assess the patient's home environment**, provide accurate medication reconciliation, and observe insulin administration.

Q&A: Which chronic care conditions are well-suited to telehealth other than diabetes?

Hines: There are a lot, such as hypertension, depression, anxiety, and thyroid disease. Any condition where you can make an impact by talking to the patient and have frequent communications. The key isn't always a diagnostic test or physical exam. With telehealth, the patient's condition can be assessed more frequently, and they have a place to turn when they have questions.

Future of Telehealth at CRHC

Despite the clear benefits of telehealth for patients with chronic conditions, CRHC must address some systematic challenges in order to maintain telehealth success. The cost-sharing waiver and payment parity, which allows providers

to bill telehealth visits equal to in-person visits, may not continue. Providers may not be able to obtain emergency licensures for telehealth purposes. Additionally, the geographic requirement waiver needs to be sustained in order for providers to continue to practice across state lines and provide telehealth services to patients in rural communities.

According to Dr. Hines, the future of telehealth at CRHC depends on overcoming these systematic challenges as well as several other considerations including:

- **Quality outcomes:** CRHC will examine objective data to determine if telehealth and in-person care have the same outcomes.
- **Access to care:** CRHC will determine whether or not it is possible for providers in the busiest specialties to see additional patients each day due to the time saved by telehealth.
- **Cost of care data:** CRHC will analyze how telehealth helps patients better manage chronic diseases, keeping them out of the emergency room and hospital and, thus, reducing costs.

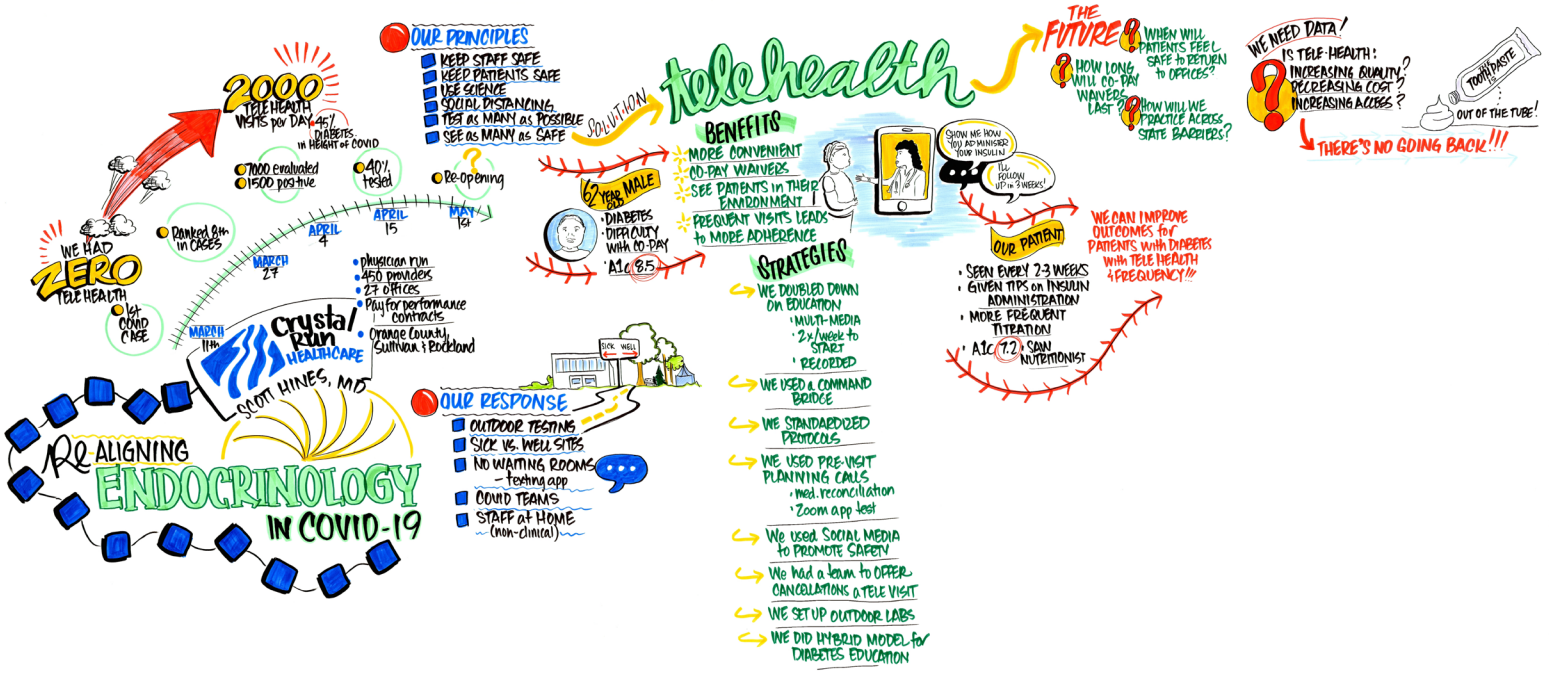
Q&A: The next wave of COVID-19 is likely to be different than the first. Where do you see the future headed for this COVID-19 crisis over the next winter?

Hines: I think patients will be more willing to come in, potentially. However, if the number of cases continue to rise, many will continue to opt for virtual visits at home. We will do more telehealth in the late fall and winter than we are doing right now, but not as much as when the pandemic first started.

Q&A: What has been your experience with emerging therapies?

Hines: One of the challenges with the antibodies is obtaining and administering them to people who have COVID-19. We will need full PPE and to decontaminate the room after every visit. The infusion takes about an hour and then you have to monitor the patient. How many patients can you reasonably provide this treatment to during a day? How do you logistically pull this off? We anxiously await guidance from CDC and Departments of Health regarding the distribution plan.

It will take time to determine if telehealth is a temporary solution or a permanent disruptor. One thing is for certain: Now that patients and providers have gotten used to telehealth, there's no going back. The toothpaste is not going back in the tube!



Closing

At the conclusion of the meeting, Dr. Kennedy thanked all the speakers and participants and stated, "One of the biggest takeaways for me from this meeting has been the clear momentum and progress in improving access to care, whether through patient education, telehealth, or care at home. While COVID-19 has revealed disparities and gaps in care, it has also revealed resiliency and hidden flexibilities within the American healthcare system."

CCR participants will meet again in spring 2021 to discuss and find solutions for disparities impacting patients with multiple chronic conditions, particularly as COVID-19 has exacerbated many of the care gaps experienced by these patients.

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