COORDINATED™
CARE
CONTINUUM

JANUARY 2020

INTELLIGENT
REFERRAL MANAGEMENT

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What is Wrong with The Referral Process?

The value-based care approach is a holistic, integrated, care-delivery model centered around primary physicians and their relationship to their patients. More than 83% of Medicare Advantage patients live with at least 2 chronic medical conditions and require coordination of multiple specialists in their care.

As health care becomes more complex and diverse, patients, families and providers are increasingly tasked with navigating a health care system that is disconnected, fragmented and offers little to no coordination of the health care services a patient receives. This fragmentation of care poses a significant risk to patient safety as well as increasing costs through needless or duplicate services.

Care coordination is described as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services." (AHRQ, 2007). Care coordination can reduce fragmentation and improve overall patient experience and safety.

THE HEALTHCARE ECOSYSTEM

Patients transition across settings, across providers and throughout the stages of their lives. The visual here offers insight into the diversity and challenges of care coordination. Each of these stages offers different touch points and different players that require careful planning and follow up to avoid fragmented care. The 3C Care Coordination Platform is a bidirectional collaboration platform that aims to enhance communication between providers and patients.

By sharing preferences and expectations around the referral process, 3C facilitates effective care management and coordination across the continuum. This document provides guidelines regarding the referral process and coordination of care. It serves as a reference for PCP and Specialty Providers to support the adoption of 3C and facilitate optimal care coordination activities.

Many of the goals of the patient-centered medical home (PCMH) rely on a high functioning healthcare ecosystem that shares the goals of effective, two way communication, appropriate and timely care, effective management of patients and a patient-centered approach to care delivery.

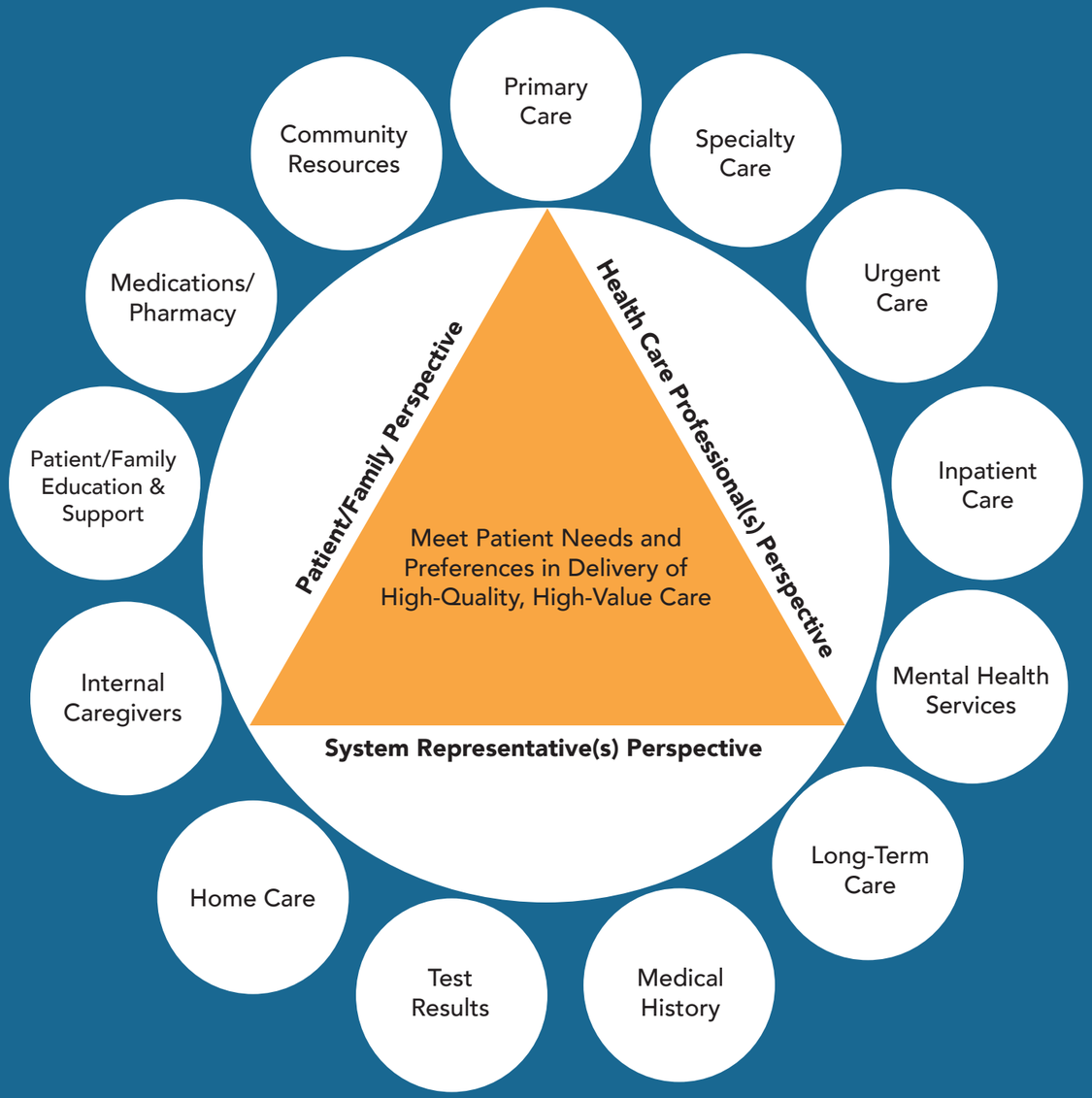
TRANSITIONS OVER TIME

- Between episodes of care (i.e., initial visit and follow up visit)
- Across lifespan (e.g., pediatric developmental stages, women's changing reproductive cycle, geriatric care needs)
- Across trajectory of illness and changing levels of coordination need

TRANSITIONS INVOLVING ENTITIES

- Among members of one care team (receptionist, nurse, Physician, radiologist, labs)
- Between patient care teams
- Between patients/informal caregivers and professional caregivers
- Across settings (primary care, specialty care, inpatient, emergency department, imaging centers)
- Between health care organizations

CARE COORDINATION RING



INTRODUCTION | 3C Care Coordination Platform

The 3C Care Coordination Platform™ is aimed at extending support for primary care-focused initiatives by adopting the principles of "The Patient-Centered Medical-Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Sub-specialty Practices," as published by the ACP. Keeping this principle in mind, 3C strives to achieve the collaboration between the PCP and specialists within the broader healthcare ecosystem.

Characteristics of a good healthcare ecosystem include:

- Supporting the PCMH practice as the "hub" of care
- Communicating, coordinating and integrating bidirectionally with the PCMH, patient, and payer
- Ensuring appropriate and timely consultations and referrals
- Ensuring accurate and effective flow of information
- Addressing responsibility in co-management situations
- Supporting patient-centered care

3C | Coordinated Care Continuum

Many of the elements listed above can be addressed systematically with the implementation of the 3C Care Coordination Platform. 3C is a collaboration platform between the specialty provider and the primary care physician (PCP), regarding co-management responsibilities, referral coordination, expectations, and information exchange. It provides a framework for better communication and safe transition of care and defines various types of care episodes in order to set roles and responsibilities.

The 3C Platform

- Supports the concept of providing the patient with access to the right care, at the right time, in the right place
- Provides a foundation and set of standardized processes that providers can modify and customize to ensure the success of the healthcare ecosystem model within their organizations
- Is not a prescription for how specialty providers and PCPs must interact and engage with each other, but rather a guide for effective communication and shared management of patients
- Should be considered a "living platform" that will evolve over time as specialty providers and PCPs build upon existing coordination processes and identify new areas for improvement

Healthy Hand-Offs and Coordination of Care

Care coordination serves to clearly define the role of the PCPs, specialist providers and potentially other providers within the care team who serve a given patient. We like to refer to this as a healthy hand-off. Providers must be jointly committed to patient-centered care transformation and agree on key interactions and responsibilities that support comprehensive sustained care coordination. Communication between specialists, PCPs, other providers, and patients/family/caregivers needs to encompass more than just an exchange of information. The 3C Care Coordination Platform assists practices with integrating and implementing 3C, transforming the practice, and coordinating care effectively.

Assessment | Patient-Centered Transformation

Understanding provider capabilities is a key component of The 3C Care Coordination Platform. This section provides additional information to guide the specialist providers and the PCP in assessing their infrastructure. An evaluation of their landscapes will help to determine staffing needs, roles and responsibilities, capabilities, referral patterns, processes, commonalities, and changes that may be needed for patient-centered transformation and sustained coordination of care with the healthcare ecosystem. Below is an outline of a pathway to assess current infrastructure and support around care coordination and the implementation of 3C, or collaborative care agreements. This assessment pathway includes evaluating the following elements:

Referral Tracking	Identify the characteristics of any agreements between providers, payers, and patients
Care Team	Understand characteristics of the care team within your practice
Care Planning and Patient Supports	Determine the practice processes in place that support care planning and patient communication
Care Plan Documentation	Identify processes in place for coordination of sharing information
Pre-Visit Planning	Practice takes outline steps to prepare for patient visits
Tracking Clinical Information	Define systems & processes in place to track appropriate clinical information & activities

*Assessing the current state of each of these elements will help all parties understand and **meet the needs** of specialty practices and provide targeted resources to facilitate 3C implementation.*

Implementing 3C Referrals™

One of the main components of care coordination is a patient-centered referral process. 3C Referrals™ aims to enhance this component through the implementation of the 3C Referral Guideline while focusing on the following goals:

- Identify priority PCPs to collaborate with and connect specialty providers who are committed to patient-centered care transformation
- Assess current care coordination capabilities with PCP partners. Capabilities may vary by PCP partner
- Adapt the 3C Referral Guideline elements to existing referral processes and procedures. 3C should be customized to serve the unique needs, technological capabilities and organization of specific provider practices
- Share best practices related to the 3C Referral Guidelines implementation and general care coordination activities

INTRODUCING

3C Referrals™

Referrals have burdened providers, payers and patients for too long. 3C breaks down the referral process to its most simplest form and defines each step and its value to the end goal, patient outcomes. 3C Referrals™ provides the key foundational elements to improve the referral process. Time is most valuable for both the care team and the patient. Consolidating, automating, and optimizing the referral processing workflow gives the time, energy, and money back to the care team to use on the patient. With 3C, referrals take hours to process, not days.

THE "NIGHTMARE" REFERRAL PROCESS

PRIMARY CARE

- PCP makes urgent referral to specialist unknown to them in-network
- Patient record sent to specialist office, but it gets misdirected via fax
- PCP has no tracking system in place to ensure patient followed through visit

PATIENT

- Patient responsible for making appointment
- Patient uncertain about referral reason
- Patient is the historian of own health status

SPECIALIST PROVIDER

- Physician unclear about referral reason
- No clinical information available at time of appointment
- Orders complete work-up and baseline diagnostic tests
- Specialist consults with patient and makes care recommendations
- Refers patient to additional specialist for further consultation

Key Changes Needed

- Clear and mutual expectations between clinicians involved
- Information available at the point of care
- Organization of staff around care coordination activities
- Accountability for next steps clearly identified for all stakeholders
- Ensure patient is an active participant in care

THE "DREAM" REFERRAL PROCESS

MEDICAL HOME

- PCMH makes referral to a specialist through the 3C EHR integrated platform
- 3C seamlessly gathers all CDA documents using its FHIR based application
- 3C automates eligibility check and prior authorization without the need for manual portal entry or faxing & also manages appeals
- 3C routes patients to the most appropriate high-quality clinician in the community using inbuilt AI, rule-based engine TruMatch™
- 3C automatically sends over relevant clinical record, diagnostics, current care plan, referral reason, and level of appointment urgency
- PCMH Care coordinator tracks status of appointment and follow up

PATIENT

- The 3C Patient App prepares the patient for specialist consultation by PCP
- Patient makes appointment through the 3C Patient App and is seen based on urgency of condition
- Roles & responsibility of PCP and Specialist are clearly explained
- Patient medications are reconciled at each transition
- Patient has a robust , comprehensive care plan that includes PCMH, Specialist and their own input to manage through the 3C App at home
- Patient is provided appropriate educational and community resources through the 3C App

SPECIALIST PROVIDER

- 3C provides a powerful dashboard to view all in coming referrals
- Care coordinator tracks referral ensuring all agreed upon information is received prior to visit
- Assess the necessity for an office visit based on the presented information /
- 3C's instant messaging feature allows specialists & PCP to communicate in real-time
- Specialist consults with patient and makes recommendations that aligns with PCMH care plan and patient goals
- Consult summary and care plan recommendations sent back to PCMH through the 3C platform
- Consult with PCP before secondary referral to a specialist through the 3C platform

BORDERLESS
ACCESS TO CARE

Provider Network

Being a part of 3C means physicians and other qualified healthcare professionals will have complete medical information from your referring providers … a single, personal, centralized health record. This means less time waiting, searching, duplicating, calling, faxing or mailing.

Virtual Consultations

Another strategy to improve access to specialists is to use "virtual" consultations by way of video-conference based telehealth visits. 3C brings in promising innovations that would allow the transfer of sophisticated biometric data and high-resolution images through its iCARE™ telehealth technology. A "virtual consultation," creates less separation between the referring physician and the specialist, and the referring provider and the patient might even be able to visit the special-

Episode-Based Payments

Currently, specialists must physically see the patient and bill for a separate visit in order to receive payment. Bundled, or "episode-based," payments have been proposed by health policy experts as a means of reducing the number of inappropriate referrals. Under this payment approach, payments are bundled across providers within organizations that share care for a specific "episode of care" or illness. Like capitation the premise is that such a payment method might discourage unnecessary referrals because the organization receiving the payment will bear the costs of those referrals. Also, without a financial reason for specialists to physically see the patient, novel methods of consultation (e.g., electronic referrals) might be more possible.

Conclusion

The primary care system and the specialty care system appear to operate in parallel with little integration beyond the patient as the intermediary. This weak integration contributes to inefficient care and dissatisfaction by PCPs, specialists, and patients alike. Between an increasing elderly population in the U.S., the increasing demand for specialist care, and the increasing provider burn-out rate, improving the specialty-referral process is not an option, it's a obligation.

Who is 3C™?

We have one vision, and that is to help improve quality of care . It's why we exist and it's what we care passionately about. Our services are wholly designed to focus on the patient experience and what really makes a difference to them. Being seen in the right place, at the right time, by the right clinician. It's exactly what a patient needs, a true coordinated care continuum.

To learn how The 3C Care Coordination Platform can help you proactively and intelligently manage patients care across the health care ecosystem:

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Visit
www.3C.health