CT Primary Care Payment Reform
Draft Capabilities Skeleton: Phone/Text/Email Asynchronous Communications
This Draft: July 17

Understanding the Need

The Problem:
Patient-care team communications gaps can result in unnecessary pain, avoidable deaths, poor health outcomes, prolonged illness, and unnecessary spending (Pressman & Dickinson, 2016). Without adequate patient-care team interaction outside of a typical care setting, the care team is unable to address gaps in lifestyle or discharge planning for patients who have difficulty with self-care, identify new health issues arising in the patient's home setting, and address patient concerns or questions about care plan or change in condition in a timely manner. These issues can result in hospital admissions or readmissions increasing avoidable costs to the system (Greysen et. al, 2016). Contributing factors include: availability of care team members to address patient needs, lack of established communication platforms between patients and care teams, and a lack of care team training on how to identify and address patient needs via communication platforms (Center for Connected Health Policy, 2017).

> **Please go to the survey to rate this capability's impact as high, medium or low on the following criteria:**
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> | |
> |---|
> | Aim |
> | Health promotion/prevention |
> | Improved quality and outcomes |
> | Patient experience |
> | Provider satisfaction |
> | Lower Cost |

Proven Strategy:
Name: Asynchronous communications via phone calls, text messages, and e-mails

Definition: Asynchronous communications through phone calls, text messages and emails are used in non-urgent situations between patients and an established care team to address patient needs outside of the office settings. These services can be available to all patients, but may be most beneficial to patients managing chronic conditions and best if managed by a point person on the care team, such as a patient navigator.

Intended Outcomes:
- Provide short term patient care by extending the continuum of evaluation and management services offered by the care team
- Improve quality of care through addressing needs of the patient in a timely manner
- Identify potential costly issues before they occur
- Reduce patient readmissions rates through patient navigator follow-up (Bradley, et. al, 2015)
- Improve immunization rates through patient reminder and recall interventions (Jacobson Vann et. al, 2018)

Consumer Needs:
- More efficient and convenient way for consumers to get questions answered without the need for a face to face visit
- Wait times are too long, especially in rural and underserved areas
- Address barriers to office care like transportation, childcare and needing time off of work or away from family
- Resources for lifestyle changes can be costly and difficult to access

- Caregivers can access relevant information through care team interactions
- Opportunity to provide necessary follow-up and support regarding complex instructions about treatment or lifestyle changes

Health Equity Lens:
- Poor access to clinician guidance and limited ability to attend in-person appointments contributes to health disparities
- Alternative ways to connect to primary care outside of the office setting reduce access barriers due to transportation and lack of availability to attend in-person for populations with geographical barriers, disabilities, and financial hardship.

Implementing the Strategy

Example Scenario: A primary care team sees a patient with newly diagnosed asthma and sends him home with instructions on how to use several inhalers based on the patient's level of distress. The patient uses inhalers as specified for a few weeks without improvement and e-mails the care team detailing the usage. The care team responds within 24 hours and sends clarifying instructions to correct use and asks the patient to check in following another week of use. After a week, the care team calls the patient and schedules a follow-up appointment if asthmatic symptoms have not improved.

HIT Requirements:
- Secure web-based platform where sensitive patient information can be exchanged between the patient and their care team
- Electronic health record where the care team can detail asynchronous communication encounters
- Access to secure messaging system and e-mail

Implementation Concerns[1]:
- Gaps in access to necessary technology
- Training of care team and patient education on use of communications platforms
- May result in face-to-face visits; not appropriate for critically urgent matters
- Increased burden on care team to be available to respond to patient needs as they emerge
- Practice's ability to monitor communications 24/7

Impact

Aim	Summary of Evidence
Health promotion/prevention	Studies demonstrate two single-method telecommunications reminders, text messaging and telephone calls improve receipt of immunizations (Jacobson Vann et. al, 2018).
Improved quality and outcomes	A study on pediatric readmissions post-discharge finds an overall reduction of 20% in readmissions rates associated with post-

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[1] Payment methods to support new capabilities will be considered as part of the payment model options

	discharge phone calls to fill gaps in discharge planning and address patient issues in the home setting (Flippo et al, 2015).
Patient experience	Patients reported that asynchronous communication complements care received at visits, empowers patients to manage chronic conditions, clarifies the plan of care, and provides a health archive via secure messaging (Eschler et. al, 2015).
Provider satisfaction	Provider productivity increased by 10% for those using a secure web messaging system with patients when compared to those who did not. An increase in productivity was also seen when compared with standard e-mailing (Liederman et al, 2005).
Lower Cost	Evaluation of cost savings of asynchronous communication include other elements of telehealth and therefore further investigation is needed for phone/text/email platforms.

Please complete the <u>survey</u> on this capability.

APPENDIX

<u>**Learning from Others**</u>

Case Study: In 2002 the University of California Davis Health System introduced a web messaging system through which patients, providers, and staff used a secure system to communicate on prescription refill requests, appointment requests, and test result requests (Liederman et al, 2005). Messages were routed to appropriate care team members based on the request. The study analyzed the productivity of internal and family medicine providers at six clinics in California.

Results
- Intervention physician care teams conducted 11.1% more visits per day than the control group associated with web messaging efficiency
- Intervention physician care teams therefore saw 2.54 more patients per physician per day
- Intervention physicians saw an increase of 10.1% RVUs per day than the control group
- Intervention physicians increased revenue by $95.34 per physician per day

Lessons Learned
- Significant results were not seen in the productivity of OB/GYN physicians at two sites, therefore this specialty should be investigated further
- There was no significant result when RVUs earned per visit were used as a proxy to understand if intensity of office visits changed
- Over time care teams chose to shift work time by messaging patients before or after regular work hours, resulting in increased access to the care team outside of regular hours

<u>**Additional Reading:**</u>

Bradley, E. H., Sipsma, H., Horwitz, L. I., Ndumele, C. D., Brewster, A. L., Curry, L. A., & Krumholz, H. M. (2014). Hospital Strategy Uptake and Reductions in Unplanned Readmission Rates for Patients with

Heart Failure: A Prospective Study. J GEN INTERN MED Journal of General Internal Medicine, 30(5), 605-611.

Center for Connected Health Policy. (2016, March). What is Telehealth. Retrieved from Center for Connected Health Policy: http://cchpca.org/what-is-telehealth

Eschler, J., Liu, L. S., Vizer, L. M., McClure, J. B., Lozano, P., Pratt, W., & Ralston, J. D. (2015). Designing Asynchronous Communication Tools for Optimization of Patient-Clinician Coordination. Retrieved from https://ncbi.nlm.nih.gov/pmc/articles/PMC4765629/

Flippo, R., Nesmith, E., Stark, N., Joshua, T., & Hoehn, M. (2015). Reduction of 30-Day Preventable Pediatric Readmission Rates With Postdischarge Phone Calls Utilizing a Patient- and Family-Centered Care Approach. Journal of Pediatric Health Care, 29(6), 492-500.

Greysen, S. R., Harrison, J. D., Kripalani, S., Vasilevskis, E., Robinson, E., Metlay, J., . . . Auerbach, A. D. (2016). Understanding patient-centred readmission factors: A multi-site, mixed-methods study. BMJ Qual Saf BMJ Quality & Safety. doi:10.1136/bmjqs-2015-004570

Jacobson Vann, J. C., Jacobson, R. M., Coyne-Beasley, T., Asafu-Adjei, J. K., & Szilagyi, P. G. (2018, January 18). Patient reminder and recall interventions to improve immunization rates. Retrieved from http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD003941.pub3/abstract;jsessionid=C36AEC6A81140B9166662267736 6C0CB2.f04t04

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Pressman, H., & Dickinson, R. (2016, June 6). The Cost Consequences of Unsuccessful Patient Communication. Retrieved from http://www.patientprovidercommunication.org/pdf/62.pdf