Advancing Care Coordination and Integration between Community Health Centers & Hospitals to Achieve the Triple Aim

Project Summary: OPEN DOOR COMMUNITY HEALTH CENTERS (ODCHC)

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1. Project Goal: To develop a patient-centered coordination-of-care system that facilitates a smooth transition between primary care, inpatient hospital, ER and specialty care services that meets the Triple Aim objectives.

2. Project Rationale/Needs Statement vis-à-vis care coordination:

Is this a new project, a pilot or expansion of an existing program? This is a continuation of a "Superutilizer" Care Transitions project with St. Joseph Hospital in Eureka and Redwood Memorial Hospital in Fortuna, which we are expanding to Mad River Community Hospital in Arcata and Sutter Coast Hospital in Crescent City. We are also developing new systems for tracking specialist referrals with Humboldt Medical Specialists.

3. Project Description: Develop patient-centered care transitions between ODCHC primary care services, inpatient hospital and ER services, as well as specialist services using advanced technology where available. We are developing our "Health Connections" program with a nurse program manager and health coaches who support the patient's care team.

4. Project partners and roles:

St. Joseph Hospital and Redwood Memorial Hospital

- Continue to use OCHIN Link to identify ODCHC patients and view their medical information for treatment and care coordination.
- Participate in weekly huddles to discuss care coordination and treatment plans.
- Implement process of sending ADT (admit, discharge, transfer) messages electronically.
- Implement process of sending electronic copies of specific medical records.

Mad River Community Hospital

- Continue to use OCHIN Link to identify ODCHC patients and view their medical information for treatment and care coordination.
- Participate in weekly huddles to discuss care coordination and treatment plans.
- Continue process of sending ADT messages electronically.
- Implement process of sending electronic copies of specific medical records.

Sutter Coast Hospital Crescent City

- Continue to use OCHIN Link to identify ODCHC patients and view their medical information for treatment and care coordination.
- Continue to use Care Everywhere to obtain medical records of ODCHC patients.

Humboldt County Mental Health Department

- Implement OCHIN Link to identify ODCHC patients and view their medical information for treatment and care coordination.

- Participate in weekly huddles to discuss care coordination and treatment plans.

Humboldt Medical Specialists

- Continue to use OCHIN Link to identify ODCHC patients and view their medical information for treatment and care coordination.
- Assist with development and implementation of a more robust referral tracking system.

North Coast Health Information Network

- Continue to process/support ADT feed submissions.
- Continue to develop and implement process for sending electronic copies of specific medical records from MRCH and SJH/RMH to ODCHC.

5. Do you have health plan partners? Yes, Partnership Healthplan of California (PHC), the Managed Medicaid provider for Humboldt and Del Norte counties.

If yes, what is their role? They provide an online service with inpatient hospital and ER visit dates for our patients covered by PHC. We are working together to make this a more useable system. We also hope to receive cost data on our PHC "Superutilizer" patients.

6. Describe your target population. Our primary focus is on patients who have:

- two or more ER visits in six months
- a primary medical diagnosis
- not already been connected with service
- an identifiable service gap

We also accept referrals from our health plan partner, PHC, and from clinicians.

How do you define your target population? See above. We receive ADT information electronically to collect the number of ER visits.

What data/algorithms will be used? See above.

7. What is your intervention or model to be implemented? We are primarily using the "Nine Best Practices" from the Camden Coalition. One of our partner hospitals uses the Coleman "Care Transitions" model so we are on the receiving end of that care coordination.

Details on specific practices you will implement (e.g. how will you address medication management?)

- Use of the "MyChart" patient portal for both information and communication
- Personal health record to track medications and other health information
- At intake and periodically, assess the patient using the PAM (Patient Activation Measure)
- At intake and periodically, assess the patient using the PHQ9

Roles/types of staff involved both at hospital, clinic, health plan? There are a variety of types of staff involved, based on the project partner. We are working with nurses, discharge planners, behavioral health staff, database programmers, office managers and others as needed.

8. How is data sharing done? (Please describe both low and high tech approaches you will use for data sharing).

- OCHIN Link read-only access to ODCHC electronic medical record.
- Care Everywhere for other EPIC users (Sutter Coast) to share medical records.
- Fax
- Telephone
- Face-to-face care team huddles
- Secure remote video access
- Secure email

How often is data shared? Inpatient hospital admissions and ER visit electronic alerts are received daily from two of healthcare partners (SJH/RMH and MRCH). Faxes and telephone calls are received daily.

What are the roles/type of staff involved in data sharing among project partners? We are working with nurses, discharge planners, behavioral health staff, database programmers, office managers and others as needed, all of whom share data in one format or another.

9. Outcomes measured:

a) Triple Aim measures:

- Health/utilization: PAM score
- Cost of care: Number of ER visits
- Patient experience: Survey of the Health Connections program services

b) Other outcomes?

- Enhanced relationships with our project partners.
- Improved quality and consistency of chronic pain patient management.
- Widespread use of motivational interviewing Clinician-wide training

10. Goals to be achieved by April 2015:

- Health/utilization: PAM score - decrease average patient score by 1 point
- Cost of care: Number of ER visits – decrease by 3% from baseline
- Patient experience: Health Connections patient surveys – 80% “Strongly Agree” score

11. Anticipated challenges?

- Ability to keep partners engaged during the entire project period.
- Consistency and accuracy of data for measurement.
- Access to specialists willing to participate in case review.

12. What would you like to learn about/discuss at the first Learning Session?

- How are others providing staff training?
- What tools are others using?
- How are other teams communicating with primary and specialty care providers?
- How are time/resources being managed?
- What support/information are others getting from their health plan partners?