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

Project Summary: GOLDEN VALLEY HEALTH CENTERS (GVHC)

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1. Project Goal: Decrease hospitalizations and readmissions for high risk high cost (HRHC) individuals through improved systems of care.

2. Project Rationale/Needs Statement:

6% of the population incurs over 50% of all health care expenditures. If we are to control health care costs we must understand the reasons/ determinants behind these expenditures.

Several factors impact costs and ultimately contribute to premature death. Determinants include social, environmental, medical, behavioral and genetic. In addressing the determinants it is important to recognize that the patient, not the provider, largely determine their own outcomes with the context of their lives. There is much talk of patient self management and patient centered care. However there are many barriers to patient self management including social devastation (poverty, access, etc.), health literacy, cultural issues, life skills and behavioral health issues such as depression and anxiety. Data shows that annual hospital admission rates are related to the social determinants of health. Behavioral health co morbidities in the Medi-Cal population double the per capita costs of health care for patients with chronic conditions.

Locally in Merced County, CCAH has identified that 70% of high utilizers have a behavioral health co-diagnosis. Addressing the social determinants of health is complex. This project will focus on identification of high risk high cost individuals with ambulatory care sensitive conditions (ACSC) using AHRQ's definition. Data shows that using ACSC local health care costs can be impacted.

The safety net providers in Merced County are aware of the need to address high risk high cost patient needs. MMCM, CCAH, GVHC and LMG are all actively developing care coordination programs yet there has been no formal collaborative planning. This project proposes to bring the four entities and their programs together to complete a systems look at the current efforts to identify gaps, barriers and redundancy in a collaborative effort to improve overall outcomes that will be measured by the rate of hospital admissions and per capita costs.

3. Description:

Is this a new project, a pilot or expansion of an existing program?

This project focuses on utilizing Behavioral Health interventions and assessments to identify and aid our patients in improving their healthcare and avoiding costly medical services that are often not needed. The project will build on current collaboration between four safety net care providers in Merced County to develop a systematic data based approach to the identification of high risk high cost patients. Partners will work together to map, establish and refine clinical care pathways that begin to address and support a small group of high risk high cost utilizers with a goal of decreased repeat hospital admissions.

4. Project partners and roles:

GVHC, Livingston Medical Group (LMG), Central California Alliance for Healthcare (CCAH) and Mercy Medical Center Merced (MMCM) will decrease hospitalizations and readmissions for high risk high cost (HRHC) individuals through improved systems of care.

Project will build on work from year 1 of BSCF's Safety Net Integration program. An HIE was established between GVHC and MMCM to allow the transfer of electronic patient data from MMCM into GVHC's NextGen EHR. GVHC's staff is alerted to ED visits, admissions and discharges. Additionally, CCAH has developed ED utilization reports for GVHC and LMG. Reports identify high utilizers and patients.

5. Do you have health plan partners? If yes, what is their role?

Yes, CCAH; they will assist by providing data and help track ED utilization of the targeted sub population and measured quarterly.

6. Describe your target population

How do you define your target population? What data/algorithms will be used?

The sub population is patients of GVHC and/or LMG that are high utilizers of emergency room/hospital services who also have a mental health diagnosis (co morbidity). The sub population will also be defined as MCP members who are in the top 5-10% of with the highest overall healthcare expenditures.

Reports will include hospital admissions for Ambulatory Care Sensitive Conditions, healthcare expenditure analysis, NYU calculations;

1. Decreased hospital admissions for Ambulatory Care Sensitive Conditions: Progress will be measured against an overall corporation baseline that is currently provided by CCAH to both GVHC and LMG. In 2012 GVHC had a total of 612 admissions with 20% meeting the Ambulatory Care Sensitive Conditions. Data will be tracked for the targeted sub-population.
2. Decreased health care expenditures by the targeted sub population: CCAH will provide data on top 5 -10% of members with the highest overall healthcare expenditures. The

project will identify a subgroup of this population and follow 5, 25 and ultimately up to 50 members and their associated health care expenditures through the end of the project.

3. Decreased % of preventable ED visits by the target sub population: CCAH provides the data for the entire membership assigned to GVHC and LMG. ED utilization is defined by NYU diagnosis calculated as a rate per 1,000 linked members. ED utilization will be tracked for the targeted sub population and measured quarterly.

7. What is your intervention or model to be implemented?

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

Unsure at this time, however, we want to include Behavioral Health based assessments and interventions; currently researching evidence based practices.

Roles/types of staff involved both at hospital, clinic, health plan

Currently identifying current protocols at the hospital in regards to intake and discharge recommendations; history of barriers.

8. How is data sharing done? (Please describe both low and high tech approaches you will use for data sharing). – This will be determined once pathways are developed.

9. List outcomes you will measure: a) Triple Aim measures:

- Health/utilization: MCP data on highest 5-10% utilizers
- Cost of care: MCP data on highest cost to plan
- Patient experience: Patient survey yet to be determined

b) Other outcomes?

10. Goals you aim to achieve by April 2015:

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4. Improved patient experiences with care: Patient experience tool will be integrated into the project using standard CAPH questions.
5. Improved satisfaction between project partners: Survey will be developed by Project Manager regarding satisfaction with current care coordination and re-administered quarterly during the project.

A cost benefit analysis will be performed by the Project Manager

11. Do you anticipate any challenges?

The primary challenge will be competing priorities at each of the four entities. Health care is in transition placing significant pressures on health care organizations to respond to multiple change efforts simultaneously.

The proposed project was selected by the partners based on a mutual commitment in our strategic plans to address the needs of high cost high risk individuals and simultaneously lower avoidable hospital admissions and readmissions. Merced County Mental Health was not chosen as a partner in this project hence there may be challenges in relation to potential seriously mentally ill patients using the ER/hospital inappropriately and unfortunately we will not be able to gather the necessary data or input from the county's perspective.

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

1) Learned lessons from other clinics/partners that have already implemented Behavioral Health interventions to reduce the high cost/utilization and enhance the patient experience.

2) What were the most prevalent patterns/barriers that have led to HCHR?

3) What strategies were proven most beneficial in the early stages of similar projects?