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

Project Summary: MONTEREY COUNTY HEALTH DEPARTMENT

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1. Project Goal:
To advance care coordination and integration between community health centers (CHCs) and hospitals to achieve the Triple Aim of improving population health, enhancing the patient experience, and reducing or controlling costs.

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

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

   It is an expansion of an existing program.

3. Project Description:

   Monterey County’s (MC) safety net clinics and hospitals participated in the MC Safety Net Integration Council in 2011 to develop an integrated system of care to seamlessly serve safety-net residents county-wide. All agreed to participate in PHIL (our local HIE) and to integrate patient data through EMR data interfaces. An HIE Data Integration subcommittee was convened to integrate EMRs into the HIE. Building this model has taken longer than expected, but MC is on track. In 2013, work to integrate the data has been steady & the complexities are being worked out. Although behind on our timeline, MC is optimistic about completing all tasks therein. We further propose to invest in refining the integration software to support and automated report generation of selected patient risk factors to streamline the referral process for case management. MC developed the Monterey Integrated Risk Assessment (MIHRA) a “Health Score” baseline tool that reflects a patient’s physical & mental & social emotional/resiliency funded by Blue Shield LIHP Implementation Grant, 2012). After the provider inputs the data fields, our goal is an automatic referral need report that will promote rapid provision of case management of high risk patients, including frequent ER users.

4. Project partners and roles:

   Our project partners include Monterey County Behavioral Health (BH), Monterey County Clinic Services (CS), Natividad Medical Center (NMC), Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Memorial Hospital (SVMH), and George L. Mee Memorial Hospital, along with all the Safety Net Clinics in based in Monterey County.

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

   Yes, Central California Alliance for Health (CCAH) is our primary health plan partner; the roles of each participating health partner is to provide data, help identify high users of unplanned
care services, and to use this data to help coordinate care for these individuals across multiple dimensions of their whole health and wellness.

6. Describe your target population

Our target population includes all Safety Net patients, including those with high cost, high risk co-morbidities who lack a medical home and frequently access emergency departments for delayed healthcare interventions. This population is primarily comprised of Hispanic and Mexican indigenous residents. There are an estimated 85,000 uninsured people in Monterey County, and over 100,000 CCAH members, who primarily access their care through Safety Net providers. CCAH is the Managed Care Medi-Cal Plan for the County of Monterey. While approximately 52,000 of the currently uninsured will be eligible for expanded Medi-Cal or insurance exchange coverage as a result of the ACA, an estimated 60,000 residents will remain uninsured in Monterey County. Safety Net delivery system integration will support safety net patient access to seamless, coordinated, high quality health care across the continuum.

Data from our project partners will be crucial in effectively engaging our target population. Data regarding patient conditions and comorbidities, clinic assignment, and unplanned care use, and data on specific interventions will come from Monterey County Clinic Services, Monterey County Behavioral Health, CCAH, and our local hospitals (CHOMP, SVMH, NMC, and Mee Memorial).

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?)

MCHD currently has integrated behavior health services into our primary care sites, and we have also opened primary care sites in behavioral health locations that serve seriously mentally ill adults. We propose to expand the scope of these clinics to include primary care treatment of frequent ER users with co-morbid physical and mental health diagnoses. These patients would be prioritized for follow up appointments with a primary care provider, would be assigned a Wellness Navigator to aid in overcoming the socioeconomic and psycho-social barriers that impact both access to care and compliance with medical courses of treatment.

CCAH will send lists monthly of ED visits to the Clinic Services Compliance Nurse.

The CS Compliance RN will set up referral parameters from the hospital EDS for patients who need primary care follow up and, as appropriate, diversion from seeking services at the ED. The EDS will be oriented and trained in this referral process.

The ED visit information will be inputted by the CS Compliance RN into the patient’s EMR and the referral will be prepared for the Wellness Navigator. At this time, the MIHRA Risk Assessment will be done by the Compliance RN or her designee (manually until it is fully automatic).

All the needed information will be forwarded to the Wellness Navigator by the Compliance Nurse, and the Wellness Navigator will coordinate development of the Care Plan and be
responsible for its implementation and for working with the patient in a motivational manner to provide the resources and encouragement to change access and compliance behaviors.

Transportation resources will be arranged as needed, as this has been found to be a barrier to people getting to clinics during their hours of operation.

Texting capacity will be piloted to support patients in getting to appointments and for appropriate disease management and health education reminders.

The basic assumption is that we will accept up to 20 new patients per month for this service in Salinas, plus another 20 per month from the Monterey Peninsula, which would be a total of 480 patients for the year.

While the assistance of the Wellness Navigator will be available to patients for as long as there is a need, part of the role of the Wellness Navigator is to equip and empower high-need patients with the tools it takes for them to utilize appropriate primary care services on their own. While this need will differ according to the situation of each individual, navigation services are intended as an education tool to train patients on effective use of the resources available to them with the eventual goal of independent service utilization. This both increases the impact of the program on an individual level by enabling patients to take charge of their health and manage it in the community, and also increases the productivity of the program itself, as some level of patient turnover will enable us to see a greater volume of patients.

Roles/types of staff involved both at hospital, clinic, health plan
- Primary Care Providers
- Medical Assistants
- Integration Coordinator
- LCSW
- MSW Intern
- Wellness Navigators
- Compliance RN

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

How often is data shared?

Data is shared on a weekly basis between primary and behavioral health providers following the clinic visits to Bienestar, and on a monthly basis between emergency care and clinic services by way of CCAH monthly lists of inappropriate ER usage.

What are the roles/type of staff involved in data sharing among project partners?

Data sharing will be done by a variety of staff, including both clinical and administrative. In primary and behavioral health settings data sharing is done by the Medical Assistant, Wellness Navigators, and Integration Coordinator, ensuring that all pertinent records are obtained, all consents signed, and all records scanned into the appropriate chart. Administrative staff from CCAH will be responsible for sending out monthly lists to the Clinic Compliance Nurse detailing inappropriate ER incidents. The Compliance Nurse will then be responsible for inputting ED
services into the client's chart and setting up appropriate referral parameters for primary and behavioral healthcare.

Staff at the hospitals and safety net clinics, including all the above-mentioned staff members, will be collecting MIHRA data and inputting data into PHIL to facilitate care coordination data exchange, in addition to sharing of all other medical data. The use of PHIL will enable sharing of real-time data, whereas other data is only shared on a weekly or monthly basis.

9. Outcomes measured:

a) Triple Aim measures: Health/utilization:
- Appropriate healthcare utilization will be improved by the implementation of PHIL as ED high-users are identified and steered toward the proper services. This will increase the efficiency of all Monterey County healthcare services as patients with chronic conditions begin to utilize primary care services, and patients with high-risk comorbidities become engaged with Wellness Navigators and care managers.
- Health and utilization data will be contributed from our safety net partners here in Monterey County. Monthly lists of service utilization will be shared monthly by all safety net clinics in the area, and a monthly list of emergency service utilization will be generated by CCAH and shared with all safety net partners.

Cost of care:
- Overall care costs will be reduced as ED frequent users engage with primary care services to manage their chronic conditions, rather than instead utilizing costly unplanned care services. The goal is to reduce emergency care expenditures in Monterey County, allowing a greater portion of the budget to be used for primary care services to the safety net.
  The above-mentioned lists of service utilization to be shared monthly among all safety net partners will include costs and charges for services performed, enabling us to track cost of care over the span of the grant.

Patient experience:
- One goal is to improve patient experience across the entire continuum of care as primary care and emergency services are utilized in the appropriate contexts, smoothing clinic flow and expediting emergency care for patients in crisis, furthermore reducing ER expenditures to allow for greater funding to expand primary care services. Another patient experience goal is to improve individual patient’s health outcomes. As individuals with chronic conditions learn to manage their health effectively through regular primary care, rather than overdue unplanned services, individuals can experience a drastic improvement in their quality of life. Also, patients with high-risk co-morbidities will enjoy the services of a Wellness Navigator to help them access all the different services they need, resulting in improvements to patients’ health and comfort in navigating a complex health system of care.
- Patient experience will be measured using data collected via a consumer survey to be administered every six months following enrollment. We are already implementing a similar evaluation in Bienestar, which we plan to apply to beneficiaries of this grant also.
10. Goals to be achieved by April 2015:

By May 31, 2014, begin receiving monthly reports from Central Community Health Alliance on emergency department utilization and develop referral and communication patterns between Natividad Medical Center and Community Hospital of Monterey Peninsula and compliance nurses in Monterey County Health Department Clinics.

By June 30, 2014, identify and train wellness navigators at Salinas and Seaside community health centers in care management; develop a care plan format based on the Monterey Integrated Health Risk Assessment tool and train them on its implementation.

By July 31, 2014, develop a strategy to implement texting into care management.

By November 30, 2014, develop software and train providers to electronically generate a “Health Score” and integrate it into care management procedures.

11. Anticipated challenges?

Safety net providers have a long history of formal and informal collaboration to improve the health status of under and uninsured people in Monterey County. PHIL has given us an opportunity to engage and work together to improve population & individual health outcomes. The safety net partners continue to work to overcome technological silos of different EMRs and clinical cultures. While the technological challenges are huge, it has become clear in the past year that the cultural challenges are equally daunting. On the positive side, partnerships have blossomed between some providers, while other partnerships are challenged with funding, time, technology, and historically competitive considerations. The time that it takes to develop the contracts for technological interfaces was underestimated, and while progress is being made, the complexity of inter-relating technological systems is new to many and caution is being exercised, especially in relation to maintaining PHI security.

Safety Net Council members are eager to see the effective operation of PHIL, sadly at a time when resources are scarce and demands on staff time are extremely high. Given these demands, frustration with slow processes can dampen enthusiasm & optimism. Enthusiasm for integration of PHI remains high, but frustration also exists. Partners are at different stages of EMR implementation, some at Level II Meaningful Use and others just beginning Level 1. Meeting all partners’ needs is a challenge as we work to tie all the information into PHIL & coordinate it into a standard process for risk assessment and care management. The process will be a lengthy, & it is critical that partners feel that this laborious process continues to move forward. We are committed to creating a seamless, integrated, safety net system that is unmatched and exemplifies best practices.

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

What the other grantees are doing; potential for sharing best practices and existing policies and procedures.