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

Project Summary: MOUNTAIN VALLEY HEALTH CENTERS (MVHC)

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1. Project Goal:

MVHC will continue to develop an organizational-wide Hospital-to-Primary Care Transition Program that coordinates with the nine regional hospitals that provide the majority of hospital care to their patients. Additionally, MVHC will continue to develop the internal Transition of Care Program (TOC) that will provide MVHC patients with needed primary care follow-up after discharge from the hospital.

2. Project Rationale/Needs Statement:

MVHC needs to develop and sustain an effective follow up program for patients who have an ED visit or inpatient hospital stay in order to guarantee continuity of care by their primary care provider. This would insure the best possible outcome for our patients.

3. Description:

MVHC’s TOC Program will:

- Develop standardized practices for utilizing admission notifications and discharge plans for patient contact and the scheduling of follow-up appointments; begin implementing new processes in all MVHC sites for roughly 700 estimated patients annually.
- Develop a system to track patients who present to an MVHC clinic as having a hospital stay and for which MVHC did not receive an admission or discharge notification.
- Refine the admission and discharge notification process with the nine hospital partners to ensure data is received in a timely, secure manner.
- Integrate care transitions work into MVHC’s EHR workflow and quality improvement process.

Is this a new project, a pilot or expansion of an existing program? - It is the expansion of an existing program funded by Blue Shield of California Foundation.

4. Project partners and roles:

- Banner Lassen Medical Center, Susanville, CA
- Dignity Health, Mercy Medical Center Mt. Shasta, Mt. Shasta, CA
- Dignity Health, Mercy Medical Center, Redding, CA
- Dignity Health, St. Elizabeth Community Hospital, Red Bluff, CA
- Fairchild Medical Center, Yreka, CA
- Mayer Memorial Hospital, Fall River Mills, CA
- Modoc Medical Center, Alturas, CA
- Shasta Regional Medical Center, Redding, CA
- Sky Lakes Medical Center, Klamath Falls, OR

The role of the hospitals is to develop processes to provide MVHC with admit notifications, discharge plans, and related reports in an effort to assure that MVHC patients receive the
needed follow up care as dictated on the patient’s discharge plan. This continuity will decrease hospitalizations, and increase patient wellness.

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

No, MVHC does not currently have any health plan partners. However, MVHC is considering contacting Partnership HealthPlan of California to see if they have the capacity to provide MVHC with hospital visit and admission data.

6. Describe your target population

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

MVHC’s target population is all MVHC patients who have had an ED visit or inpatient stay at a hospital. This totals about 3,000 patients annually.

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

MVHC has developed an organizational-wide process for utilization of the admission notifications and the discharge plans. The process includes:

- Provider buy-in, and training in the use of TOC records.
- Records are received routinely either electronically, or by logging onto the hospital’s web portal.
- Appropriate filing of these records into the EHR and routed to the PCP’s attention.
- Patient’s home clinic notifies patient of necessary follow up, and arranges an appointment.
- Patients are instructed to bring all medicines including over the counter medications or supplements to the follow up visit.
- Medication reconciliation is completed at the PCP visit, or over the phone, if there are any questions.
- The current Transition Coordinator serves all five clinic locations. Under the new grant, we plan to embed a Transition Coordinator in our northern clinics.

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

MVHC will share program outcomes and lessons learned with all regional primary care providers through the region’s CA299 Health Collaborative membership meeting and the Health Alliance of Northern California (HANC) membership meeting, as well as through the HANC’s regional HIE network development program meetings. This information could be invaluable to other area primary care providers whose patients utilize the same regional and local hospitals as they may be able to easily join the processes developed through MVHC’s work to fast-track their own hospital-to-primary care transition program.

The process developed and lessons learned will be invaluable to all rural health care providers and as such would potentially be an accepted session at the annual conferences for the California State Rural Health Association (CSRHA), the California Association of Rural Health Centers (CARHC), and a rural tract for the California Primary Care Association (CPCA).
9. List outcomes you will measure:  a) Triple Aim measures:
   - Health/utilization:
     - complete medication reconciliation within 4 days of hospital discharge
     - Hospital admissions and re-admissions
     - ED visits
   - Cost of care:
   - Patient experience:
   - b) Other outcomes?
     - Decrease the percentage of patients who present to the clinic whose admit notification or discharge records were not received.

10. Goals you aim to achieve by April 2015:

- Currently we have patients who present at the front desk who are asked if they had a recent ED visit or hospital stay. These patients who respond yes to this question then have to have records tracked down for the visit. We hope to reduce the number of these patients who present to a clinic appointment that MVHC did not know they had an ER visit or hospitalization.
- In the first phase of this project we struggled to get records from the most northern hospital, located in Oregon. Our goal now is to improve our contact with the hospital, embed a dedicated staff member into the northern sites to help facilitate a relationship with the Sky Lakes Medical Records staff, and to educate our patients about sharing their PCP information with the hospital so they will send discharge records to the PCP.
- Set measures to track for quality improvement work throughout the grant cycle, such as: Routinely complete medication reconciliation within 4 days of hospital discharge.
  Decrease the percentage of patients who present to the clinic whose admit notification or discharge records were not received.

11. Do you anticipate any challenges?

One challenge we cannot control is staff turnover at the area hospitals. Hospitals require constant education to remind them of the importance of sharing discharge records. A prime example is if the transcriptionist does not list the name of the PCP, the hospital will not forward the record, this requires extra work for us to locate studies.

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

We want to know how other clinics handle the Transition of Care from hospital to clinic. Also, what tracking measures are other teams using that would be helpful to measure our program outcomes?