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

Project Summary: SOUTHSIDE COALITION OF COMMUNITY HEALTH CENTERS

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1. Project Goal: To implement and pilot test a care coordination model in collaboration with one safety net hospitals and eight federally qualified health centers in order to improve the quality of care and the appropriate utilization of health care resources for South Los Angeles.

2. Project Rationale/Needs Statement: There are no formal care coordination activities that exist between community clinics and the safety net hospitals serving South Los Angeles that could circumvent the inappropriate utilization of hospital based care. Much of the time, primary care providers (PCPs) in the Southside network are unaware of patient visits to the ED or hospital admissions and only learn of this when a patient returns for a visit and informs the provider. Additionally, PCPs rarely receive any communication about the outcome of a patient’s visit to a hospital such as instructions for follow up care, new medications or changes to prescriptions, treatment provided or lab and diagnostic test results. The fragmented care that currently exists between PCPs and the hospital safety net must be addressed and we believe that we are in the right environment and have the willingness to begin to build a successful model.

3. Description:

Through a partnership with St. Francis Medical Center the Southside Coalition is piloting a care coordination model between the primary care safety net clinics in South Los Angeles and patients that are utilizing the hospital emergency department or have been admitted/hospitalized. Care coordination activities are directed by a team of Patient Navigators who are located inside of the hospital and are focused on discharge planning and care transitions into appropriate hospital based services and back into a primary care medical home, providing patient education on the importance of maintaining primary care medical homes, targeting high utilizers to provide education on the appropriate use of health care services, and to improve communication about patient utilization so that primary care providers are notified when a patient presents at SFMC. In order to identify Southside Coalition patients, we have developed an information technology infrastructure called HIE*Lite which compiles a patient master index from all primary care clinic sites and queries in real time patient demographic information within the hospital information technology systems in order to match Southside patients that have registered in the emergency room or have been admitted. The system then guides the Navigator team through a discharge planning process resulting in a follow up appointment booked for the patient to return to their primary care provider once discharged from the hospital. Finally, all pertinent medical records are automatically sent to the primary care provider post patient discharge.

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

This is a new project to pilot test the model we have developed.
4. Project partners and roles:

Southside Coalition of Community Health Centers is a non-profit organization serving as the lead agency of this initiative. The Southside Coalition is a consortia of 8 Federally Qualified Health Centers, who collectively operate 45 health center sites throughout the South Los Angeles region. The Coalition’s role in this effort is to coordinate all partners by facilitating working group meetings, providing direction to consultants and vendors on the development of IT systems and evaluation efforts, assisting with the recruitment and hiring of the Navigator team, continuous monitoring and adjusting of the workflow model, and completion all budget and grant reporting requirements.

All eight members of the Southside Coalition are participating in this project. Health centers are uploading their patient data into the IT system on a monthly basis and have identified care coordination leads at each site to work with the Navigator team to book follow up appointments and to serve as the liaison with their PCPs. Health centers are also actively participating in all working group meetings. Those health centers are:

- Central City Community Health Center
- Eisner Pediatric & Family Medical Center
- South Bay Family Health Care
- South Central Family Health Center
- St. John’s Well Child and Family Center
- T.H.E. Health and Wellness Centers
- UMMA Community Clinic
- Watts Healthcare Corporation

St. Francis Medical Center is serving as the hospital partners in this effort. Their leadership team serves on the working group to help inform the workflow of the project and to assure all information technology infrastructure on the hospital side is connecting to HIE*Lite. The hospital is also employer for the Navigators and responsible for all supervision and training of staff.

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

All of the Southside Coalition members belong to Health Care LA IPA, for Medi-Cal Managed Care lives. This IPA also shares risk with St. Francis Medical Center as a plan partner for the IPA lives. The IPA and its MSO have staff representatives that participate in an advisory capacity.

6. Describe your target population

The population to be served by this project is patients seeking health care services within the health care safety-net (i.e. community health centers and hospitals) located in South Los Angeles, California. Specifically, our project will use technology to identify established patients within the Southside Coalition membership for care coordination activities. We will provide navigation and care coordination services to all patients regardless of their health insurance status. South Los Angeles has the highest rates of uninsured adults and children (32.9 and 9.7 percent – LA County average is 22 and 7 percent) and the highest number of residents reporting difficulty in accessing medical care (38.8 percent-County average 27.3). Thus, the need for well-coordinated and accessible health care services within this community is significant and will be addressed within this project.

7. What is your intervention or model to be implemented? - See attached workflow plan.
8. How is data sharing done? (Please describe both low and high tech approaches you will use).

Data sharing is under development with our IT vendor and with our hospital partners. The HIE*Lite system is being developed to provide comprehensive automated reports about patient utilization by agency and outcomes for follow up appointments with the PCPs post discharge. However, this system does not track any clinical data so we are working with our hospital partner to determine whether we can obtain automated reports on discharge diagnosis/reason for visit.

Our goal is to share data with our partners on a monthly basis once we have all of the systems up and running and to provide user access to the PCPs so they can run individual reports for their agency. Currently, the IT vendor is running reports and sharing them with the Southside Coalition to distribute. On the hospital side we are working with leadership to identify who will be responsible for providing data.

9. List outcomes you will measure: See attached document. We will also include a patient feedback/experience survey.

10. Goals you aim to achieve by October 2014:
- Complete the planning phase for a care coordination pilot project to be executed by Southside Coalition and its members and St. Francis Medical Center.
- Implement a care coordination pilot at St. Francis Medical Center in order to reduce unnecessary emergency department visits and preventable hospital admissions/readmissions.
- Develop and implement an electronic system (HIE*Lite) through which care coordination activities will be tracked and managed across Southside Coalition members and St. Francis Medical Center.
- Describe whether the integration strategy advances population health, reduces the per capita cost of care, and improves care for patients, and describe the data used for analysis.
- Work with Blue Shield of California Foundation to identify, publish and disseminate lessons learned about the integration strategy, including lessons learned, if any, about payment structures that facilitate or are necessary to support the integration strategy.

11. Do you anticipate any challenges?

We anticipated that there would be a challenge with the capacity of 1.75FTE patient navigators to fully manage our total patient population. We were challenged to project our needs as there were concerns about our baseline data not including our entire patient population (and several contractual changes between the IPA/Hospital post baseline data and pre implementation resulting in an increase of patients utilizing this facility). Additionally funding was insufficient to fully staff the navigators for this project at the 2FTE rate we had hoped.

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

1) How are others planning to measure cost savings as a result of their intervention—whether their projects can develop enough cost savings to make the case for hospitals to be responsible for sustaining the program over the long term? 2) What type of technology are others using to share information across care continuums?
Communication Workflows between Hospital and PCP Clinics

1) Notification to PCP that Patient is at St. Francis

- Patient is confirmed as a Southside patient by PCN upon admission/registration at St. Francis

2) Patient to be scheduled for return appointment at PCP

- PCN Initiates TRACE
- PCN Uploads the Patient Face Sheet into TRACE
- Face Sheet is transmitted to PCP Coordinator
- Face Sheet is received by PCP Coordinator via Secured Email/Fax
- PCP Coordinator Enters note/notification to PCP into EHR and uploads face sheet to EHR

3) Patient is Discharged, clinical data related to hospital/ED visit is sent to PCP

- PCN Prompts to initiate Discharge Plan for Patient.
- PCN Calls PCP Coordinator to schedule appointment
- Does CC answer phone?
  - Yes
    - PCP CC schedules return appointment
    - 2 days for high risk pts
    - 3 days for non high-risk pts
  - No
    - PCN Sends secured email to notify CC that patient requires DC appt
- PCP CC Contacts PCN
- PCN Sends secured email to notify CC that patient requires DC appt

4) Patient is Discharged with DC instructions

- Within 24 hours of Discharge
  - PCN uploads patient info into TRACE:
    - ED Visit: Copy of ED Notes, lab/studies results
    - Hospital Admission: DC Summary, DC Instructions, Meds, lab/studies results
    - Home Health/Hospice: Above plus advance directives, POLST forms

- Clinical Information transmitted to PCP Coordinator
- Information is received by PCP Coordinator via Secured Email/Fax
- PCP Coordinator Enters note/notification to PCP into EHR and uploads face sheet to EHR

- PCP CC Contacts PCN
- Appointment date/time given to PCN
- PCN sends secured email to notify CC that patient requires DC appt
- PCN follows up appt info into HIE*Lite
- PCP CC Contacts PCN
- PCP CC Contacts PCN
- PCP CC Contacts PCN
- PCP CC Contacts PCN