Richmond Engagement and Community Health (REaCH)

A Novel Approach to Transitions of Care

Context

- CareOregon Medicaid identified a group of patients at risk for repeat emergency room visits of hospitalization.
- 25% of CareOregon members constitute 89% of costs – many costs associated with inpatient utilization.
- Need for interventions to reduce inappropriate hospitalization and ED visits.
- Need to reduce preventable hospital readmissions across all populations

Team Roles

- Health Resilience Specialist: Highly trained non-medical team member.
- Care Coordinator/Panel Manager: Primary contact between inpatient and clinic team, coordinates hospital f/u visits, compiles record of patient admitted to and discharge from local hospitals in preparation for weekly team huddles, coordinates communication among team.
- RN Care Manager – Telephonic case manager for patients after hospitalization or long-term care stay, clinic support for 30 days post-discharge based on needs.
- Pharmacist – Medication reconciliation, medication management through clinic pharmacy for bubblepacks or appointment based fills.
- Palliative Care/Advanced Illness Care – Enhanced case management and care planning for patients with life-limiting illness.

Family Medicine at Richmond

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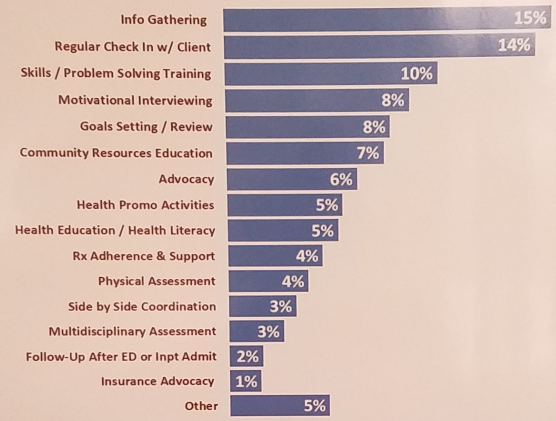
How Do REaCH Team Members Engage with Patients?

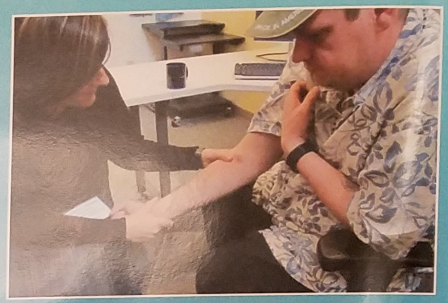


Best Practices Shared Across Clinic

- **Hospital discharge calls: All patients within 72 hours of discharge (RN or Behavioral Health Specialist)**
- **Medication reconciliation (Pharmacy)**
- **PCP or teammate f/u within 1 week of discharge.**
- **Future goals: Enhance quality & consistency of hospital f/u visits.**

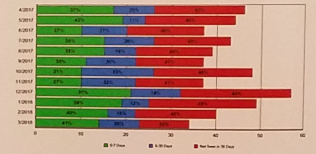
Health Resiliency Quality and Satisfaction Outcomes

	Baseline	Program Graduation	%Change
Received all needed care	35%	58%	↑ 23%
Highly satisfied with overall health care	69%	80%	↑ 11%
Better/same health status compared to 6 months ago	54%	71%	↑ 17%
Medication Adherence	58%	64%	↑ 6%



Program Measurement

- # of Patients Readmitted with and without f/u between discharge and a readmission
- % of Patients with f/u in < 7 days; 8-30 days, or none:



NOTE: Data does not include phone call f/u

- Tracking % of overall readmissions
- Reduced rate of avoidable ED visits; now exploring differences in "Assigned, but Unengaged" vs Established with PCP patients

REFERENCES:

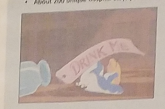
Center for Outcomes Research & Education (CORE) Program Evaluation:

Health Resilience Program Assessment

LifeLong Medical Care

Care Transitions Program

- Covered all adult inpatient hospitalizations at Summit/Alta Bates
- About 200 unique hospital stays per month.



2018:

- 2 full time RN and 2 full time liaisons (RN assistant)
- Cover EG, two counties, mom & baby, and inpatient across 8 different hospitals
- About 300 ED visits, 250 inpatient admissions, and 50 new moms and their babies every month.

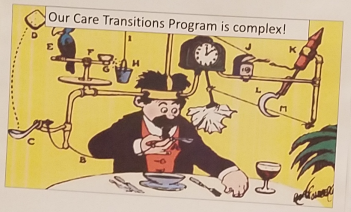
Care Transitions Process

- Reach into Epic for patient lists.
- Be "SPOC" (single point of contact) for all hospitals.
- Advocate to hospital staff on patient's behalf.
- Alert providers that their patient was hospitalized.
- Ensure patient has follow up appointment (when needed) at their home clinic. (7-10 days)

What surprised us...

Failure of ED Navigator program:

- Sutter thought this would solve problem of inappropriate ED use.
- Difficult to have external staff embedded at a hospital.
- FQHC salary vs Sutter salary....
- ED navigator never felt really like a part of the team.



What we would do differently....

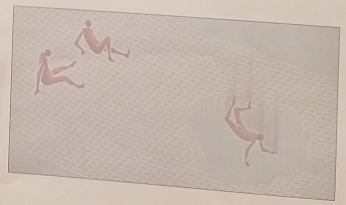
- Start small!
- We scaled quickly for Contra Costa County and didn't have time to work on best method for data collection.
- Very detailed Excel spreadsheet that requires a lot of daily updating; 5 years in, we still don't have a good way to pull data straight out of EHR.

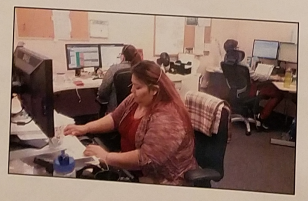
One year from now...

- Have a solid staff that is satisfied with their work.
- Have clear definition of roles and division of labor.

Five years from now...

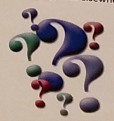
- Robust social services program to support patients more fully.
- Elephant in the room: health outcomes in the United States primarily stem from socioeconomic status.

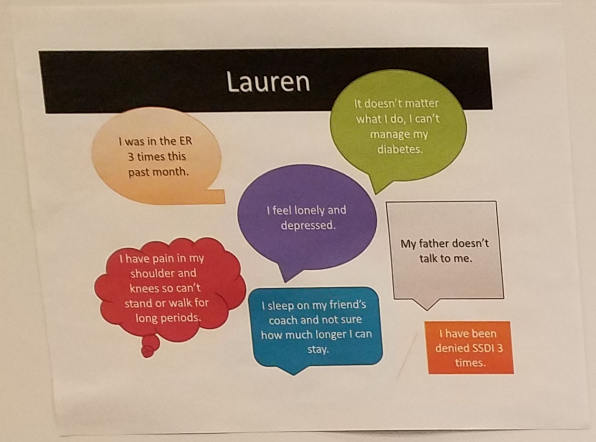


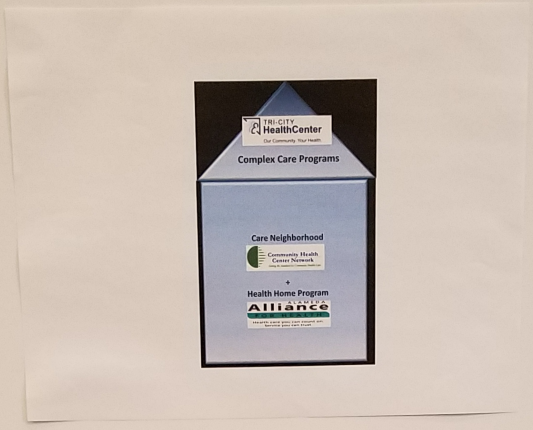


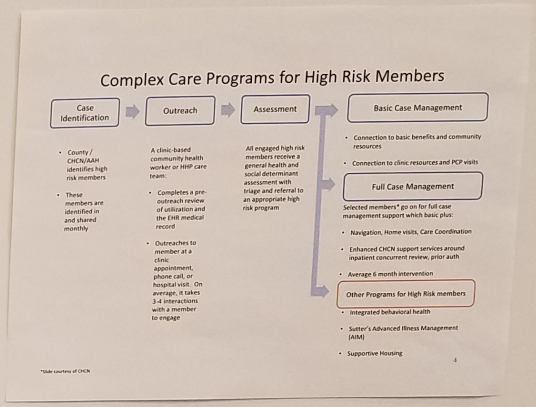
Looking for feedback

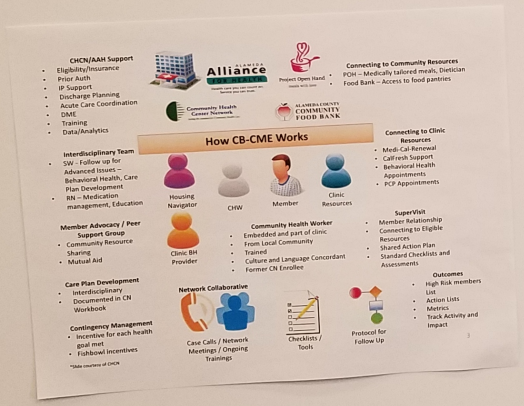
- Similar programs elsewhere?

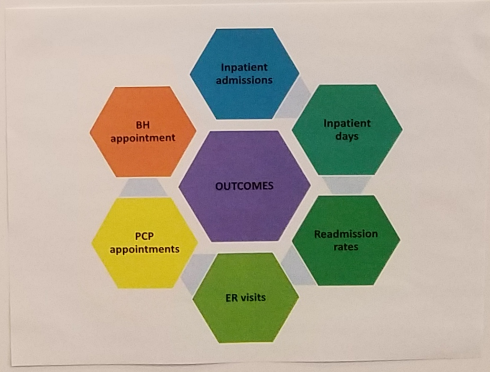












Tri-City Health Center

Care Coordination

Santa Rosa Community Health
All of us. For all of you.
a catholic healthcare center

Organization Context

Organization Model: FQHC

Number of Sites: 12

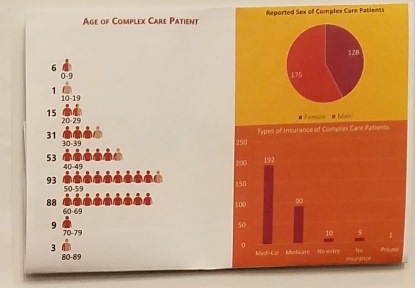
Types of Services Offered: Medical, Dental, Behavioral Health, Complex Care, Specialty, Pharmacy, Lab

Number of Patients: approx. 42,000/ year

Payer Mix: 49% Medi-Cal, 26% Uninsured, 15% Private Insurance, 10% Medicare

EHR Used: eClinicalWorks

Care Team Structure: 1 PCP : 1.5 MA : 0.5 Nurse



Lessons Learned

1) Biggest Surprise- Getting patients engaged. One tactic doesn't work for all patients. Some patients are dealing with MH issues, substance abuse, experiencing homelessness, or complex medical issues. Each of these requires a different tactic, as does each unique individual. We needed to deliver TRULY individualized care.

2) If we could go back... we would work on initially engaging our patients instead of enabling them. That way we are not "crisis managers" but health facilitators. This prevents a lot of stress and burnout due to trying to drop everything to assist in something we could engage the patient to do themselves.

Next Steps: Ideal world

In 1 year –

- There would be a beginning to integration into all our medical campuses. One nurse would be on site doing exclusively complex care management.
- Providers would have an understanding of what the complex care team does and how it can help them and their patients.

In 5 years –

- There would be full integration into all medical campuses. Each TEAM would have a nurse dedicated to complex care management.
- There would be visibility of the outcomes from complex care management for all staff to see.
- All staff would have an understanding of what the complex care team does and how it helps them and their patients.

Discussion Questions:
Our Challenges

- What quality metrics are you tracking and how do you get the data out? What does your "dashboard" look like?
- How do you engage/educate providers on the work you do?