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 86% 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 flu 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.

**Program Measurement**
- # of Patients Readmitted with and without flu between discharge and a readmission.
- % of Patients with flu in < 7 days; 8-30 days, or none.

NOTE: Data does not include phone call flu

**Health Resiliency Quality and Satisfaction Outcomes**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Program Graduation</th>
<th>% Change</th>
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<tbody>
<tr>
<td>Received all needed care</td>
<td>35%</td>
<td>58%</td>
<td>23%</td>
</tr>
<tr>
<td>Highly satisfied with overall health care</td>
<td>69%</td>
<td>80%</td>
<td>11%</td>
</tr>
<tr>
<td>Better/same health status compared to 6 months ago</td>
<td>54%</td>
<td>71%</td>
<td>17%</td>
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<tr>
<td>Medication Adherence</td>
<td>58%</td>
<td>64%</td>
<td>6%</td>
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**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 flu within 1 week of discharge.
- Future goals: Enhance quality & consistency of hospital flu visits.

**REFERENCES:**
- Center for Outcomes Research & Education (CORE) Program Evaluation:
  - Health Resilience Program Assessment
Care Transitions Process

- Reach into EP for patient info
  - be “MVP” single point of contact for all hospitals
- Advocate to hospital staff on patient’s behalf
- AARP predicts that their audience will hospitals
- Ensure patient has follow up appointment (when needed) at their home clinic (~60 days)

What we would do differently....

- Start small
- We scaled quickly for County and didn’t have time to work on best method for data collection.
- We have outlined each component that requires a lot of daily updating; 5 years in, we still don’t have a good way to pull data straight out of the system.

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
- Empower local health authorities

Looking for feedback

- Similar programs elsewhere?
Care Coordination

Organization Context

- Number of Sites: 12
- Types of Services: Shared Medical, Dental, Behavioral Health, Complex Case, Specialty, Pharmacy, Lab
- Number of Patients: approx. 42,000 year
- Payment Mix: 40% Medi-Cal, 30% Uninsured, 15% Private Insurance, 15% Medicare
- EHR Used: eCitationWorks
- Care Team Structure: 1 PCP: 1.5 MA: 0.3 RN

Lessons Learned

1. Biggest lesson: getting patients engaged. One tactic doesn't work for all patients. Some patients are dealing with HIV issues, some patients are dealing with substance use disorders, and complex medical issues. Each of these requires a different tactic. We need to tailor the intervention to the individual's needs.

2. If we were to go back, we would be more actively engaging our patients and families in the design. There may be a better way to package the data. We need to figure out how to give the patient access to this information in a way that's meaningful, something we could engage the patient to do themselves.

Discussion Questions:

- 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?

Next Steps: Ideal world

In 1 year:
- There would be beginning to integration into all our medical practices. Our team would be working closely with the physician to help them understand what the complex care from a payer and clinical side helps us and our patients.

In 5 years:
- There would be full integration into all medical camps. Each patient would have a nurse dedicated to complex case management.

There would be visibility of the services from complex care management for all stakeholders.

All staff would have an understanding of what the complex care from them and how vital they are to their patients.