Caring for the most complex and high-utilizing patients

Emerging program models in California primary care clinics

Melissa Barajas, RN, BSN, PHN and Loreta Villemez, Neighborhood HealthCare
Fern Ebeling, RN, BSN, San Francisco Health Network
Barbara Scherrer, RN, BSN, Santa Rosa Community Health Centers
Hunter Gatewood, MSW, LCSW, Center for Care Innovations

Program design

- Patient identification
- Patient recruitment
- Business case
- Care team development
- Community partnerships
- Scaling up

Program design

- Patient identification: mixed method
- Patient recruitment
- Business case
- Care team development
- Community partnerships
- Scaling up

Program design

- Patient identification
- Patient recruitment: safety, priorities
- Business case
- Care team development
- Community partnerships
- Scaling up

Program design

- **Patient identification**
- **Patient recruitment**
- **Business case: payor pain**
- **Care team development**
- **Community partnerships**
- **Scaling up**

Program design

- Patient identification
- Patient recruitment
- Business case
- Care team development: built around patient needs
- Community partnerships
- Scaling up

Program design

- Patient identification
- Patient recruitment
- Business case
- Care team development
- Community partnerships: not all about us
- Scaling up

Program design

- Patient identification
- Patient recruitment
- Business case
- Care team development
- Community partnerships
- Scaling up: start with end in mind

FQHC with 9 primary care sites with BH integrated, 3 dental, 1 BH specific site

Providers: ~ 55 FTEs (MDs/NPs/PAs/BH)

Patients: 62,000; **Visits**: 253,000

Age: 31% 0-18; 5% 65+

80% at or below 100% FPL

33% Uninsured; 48% Medicaid; 14% Medicare

Language (indicator of culture): 70% English; 20% Spanish; 9% Middle Eastern

Our Approach

Start with what is reasonable, build to what is possible, then grow to what is imaginable

Key program evaluation outcomes measures

- Number of Inpatient/ER Visits Pre- and Post-Participation
- Number of Encounters with Care Team
- % of Goals Reached
- Provider and Staff Satisfaction

Program Capacity/Goals: 250 Active patients

Payer Partners: Community Health Group, Molina

Target population Defined

From Payer Data, Total Cost >=$10,000, AND

either >1 IP Admission or >1 ER visit in the past 12 mos

Prioritized

1st Tier – Payer identified and based on frequency of ER visits (actionable variable);

2nd Tier – PCP request

"Notes to Self"

<u>Things to keep in mind during implementation</u>

- Need to deploy motivational efforts targeted toward patients (engagement) AND staff (education)
- Need to continually visit VOC (Voice of the Customer) to maintain relevant interventions
- Need to continually visit VOB (Voice of the Business) to keep program a strategic priority

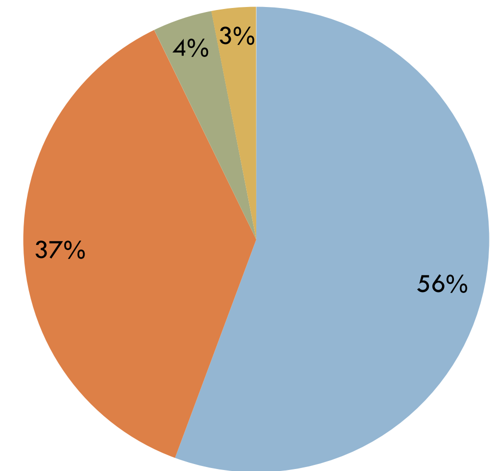
CARE COORDINATION PROGRAM

Overview

Santa Rosa Community Health Centers

5 Sites including primary care, dental, and behavioral health services.

- 44,893 Patients
- 212,724 Visits
  - 13,390 (30%)Uninsured
  - 23,120 (52%) Medicaid
  - 3,496 (7%) Medicare



HX of Care Coordination Program

- Started in 2011 with 2 pilot projects
- Current program 4 different funding sources & consist of care transitions and intensive case management.
- Current # active participants in program:132
- Goal over 12 months 300 enrolled
- Development of quality dashboard
- Use of technology

Care Coordination Program extension of the primary care team

Care Management

- Home visits
- Physical assessment
- Medication management
- Disease self management
- Health Coaching
- Hospital to home transition of care
- Coordinate medical services
- Links to programs and services
- Help with housing, transportation & benefits

All documentation in electronic health record

Santa Rosa Community Health Centers

Population we serve

- Chronically ill adult patients
  - Over 18
  - Multiple Chronic Illnesses
  - Mental Illness
  - Substance Abuse
  - High Hospital and ER Utilization
  - Health Disparities
  - Experience Social Determinates to Health

Santa Rosa Community Health Centers

Care Coordination Program Staff

Staffing: Nurse Care Mangers, Care Coordinators & Social worker

- Nurses focus on medical case management.
- Care Coordinators focus on social needs.
- Social worker consults with PCP and the rest of the care team.

San Francisco Health Network

- County system with 14 primary care clinics, hospital-based and community-based
- Approx. 91 provider FTEs
- 70,000 patients
  - 32% Hispanic, 24% Asian, 20% White, 19% Black, 4% other
  - Median age: 45
  - Insurance status: 64% public insurance, 35% uninsured

Complex Care Management

- First program launched February 2012
- Recent merger of 3 programs into one
- Primary care embedded at 4 sites, plans for 5
- Population: 3 or more admissions in 12 mos
- Capacity/goals: 200-250 active, 200-250 graduates/year
- Outcomes measures include hospital days pre/post, ED visits pre/post, patient and provider satisfaction

Keep the conversation going.

Get contact info from panelists
Or contact
hunter@signalkey.com