Care Coordination in Rural Communities:
Preliminary Findings on Strategies used at 3 Safety Net Medical Home Initiative Sites

Moderator:

Nicole Van Borkulo, MEd, Qualis Health

Speaker:

Sarah Derrett, MPH, PhD, Sr Research Fellow, Dept. of Preventive & Social Medicine, Univ. of Otago Harkness Fellow, Univ. of Chicago

Katie Gunter, MPH, MSW, Project Manager, Univ. of Chicago

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Care Coordination in Rural Communities: Preliminary Findings on Strategies used at 3 Safety Net Medical Home Initiative Sites

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Sarah Derrett[1, 2]
Katie Gunter[2]

[1]2011-12 Commonwealth Fund Harkness Fellow from the University of Otago New Zealand
[2]The University of Chicago, Department of General Internal Medicine

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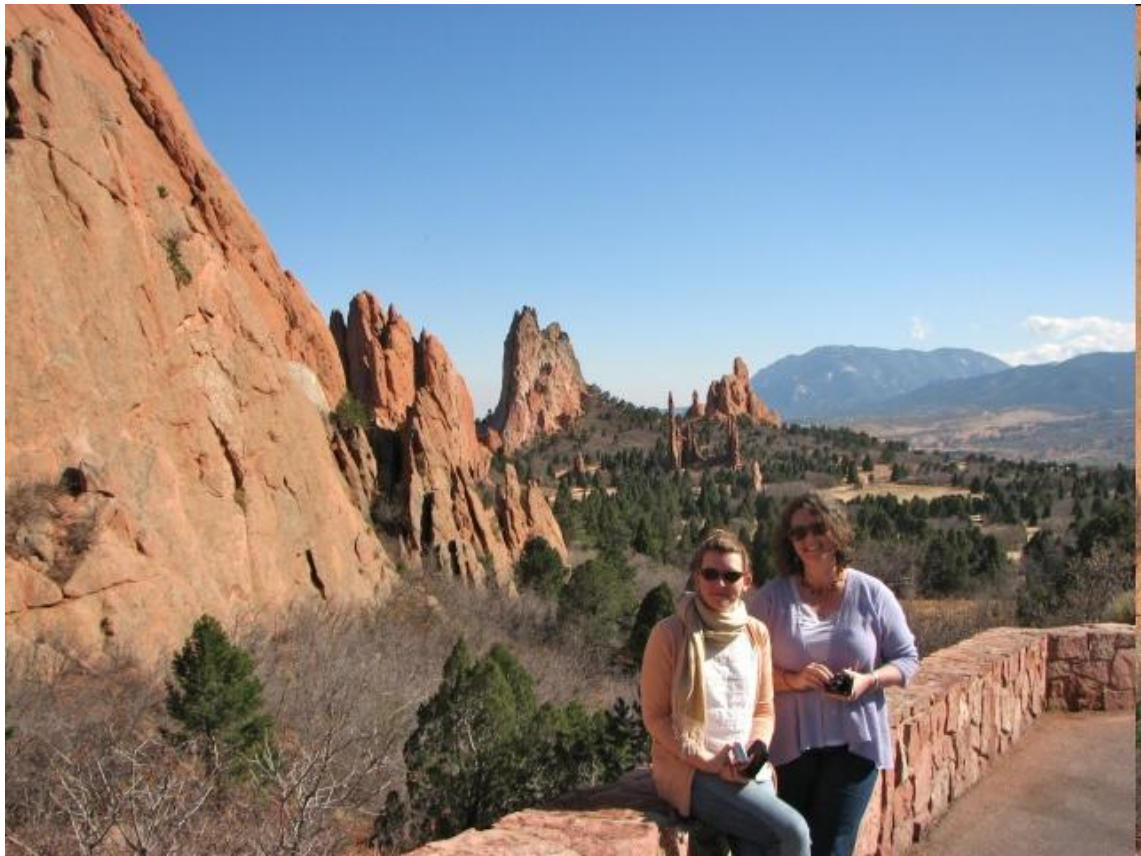
- OHSU Family Medicine at Scappoose
- Eastern Oregon Medical Associates



Purpose

1) Describe key characteristics of the three rural clinics, their teams and specific roles related to care coordination

2) Share key (early) lessons learned

3) Provide some specific examples of care coordination strategies encountered

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Overview

- Rural health
- Care coordination
- The sites & teams
- Examples
- Lessons learned
- Specific strategies
- Discussion

Why care coordination in rural clinics?

- Rural circumstances
  - Poverty
  - Underinsurance
- Access
  - Transportation
- Health professionals
  - Primary health
  - Specialists
  - Tele-health
  - EMR

- Care coordination
  - Little known about implementation & strategies in rural settings

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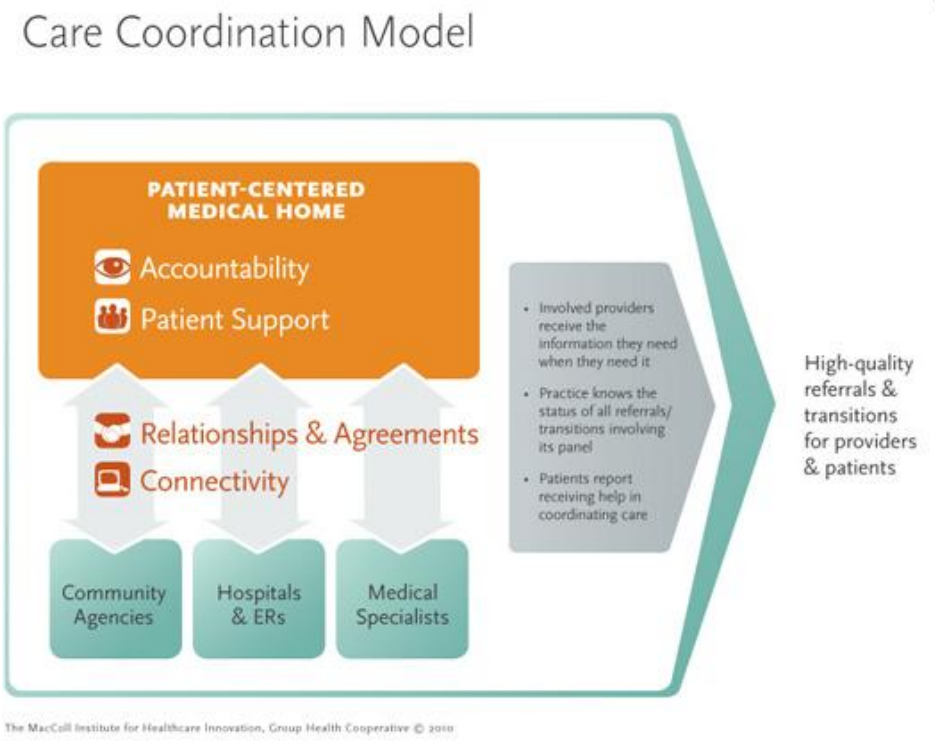
Methods: Case studies

- Qualis Health and MacColl Institute for Health Care Innovation
- Safety Net Medical Home Initiative (SNMHI)
- 65 Safety Net Clinics in 5 States
- The University of Chicago
- Three sites
  - Site visits
  - Interviews



SNMHI Change Concept – Care Coordination

http://www.safetynetmedicalhome.org/change-concepts/care-coordination

- Link patients with community resources
- Integrate behavioural health and specialty care
- Track and support patients to obtain outside services
- Follow-up with patients within a few days of an emergency room visit or hospital discharge
- Communicate test results and care plans to patients

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The Rural Sites:

The Context, The Clinics and The Teams

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High Plains Community Health Center

- Lamar's population: 7,800
- Median income $15,000
- Clinic population: 6-7,000 patients

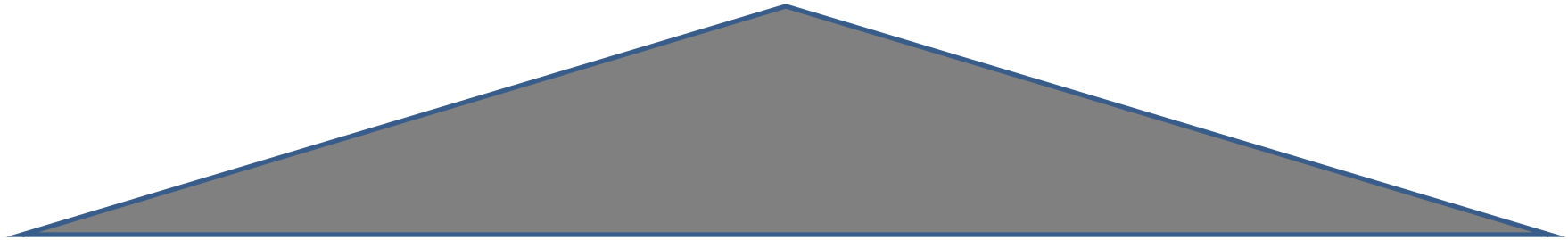
OHSU Family Medicine at Scappoose

- Scappoose's population: 6,500
- Median income $24,500
- Clinic population: 7,800 patients

Eastern Oregon Medical Associates

- Town population: 9,400
- Median income $17,000
- Clinic population: 10,000 patients

The Teams



High Plains	OHSU Scappoose		EOMA	
MD/NP/PA	MD	Medical Assistant	MD	Medical Assistant
Patient Facilitator	NP/PA	Medical Assistant	MD	Medical Assistant
Patient Facilitator			NP/PA	Medical Assistant
Patient Facilitator			Registered Nurse	
Health Coach	Team Coordinator		Referral Coordinator	

MD=Physician; NP= Advanced Nurse/Family Practitioner;
PA=Physician's Assistant

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Care Coordination Change Concept Implemented

Similarities, Differences & Highlights

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1. Linking patients with community resources

High Plains CHC:
- **Health coaches**
- **Local partnerships**

OHSU Scappoose:
- **Social worker links to community resources**

Link patients with community resources

EOMA:
- **Nurse Care Manager**
- **MA Care Coordinator**

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2. Integrating specialty/behavioral health care

High Plains:

- Behavioral health co-location

OHSU Scappoose:

- Affiliated
- Behavioral health on-site

Integrating specialty / behavioral health care

EOMA:

- Specialty care clinics
- Multidisciplinary meetings

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3. Tracking and supporting

High Plains:

- **Patient facilitators**

OHSU Scappoose:

- **Referral coordinator**
- **Team coordinator**

Track & support patients with outside services

EOMA:

- **Medical records and referral coordinators**

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4. Follow up after emergency room or hospital

High Plains:

- Care Coordinator
- Pre-discharge planning

OHSU Scappoose:

- Software that facilitates shared medical records across systems

Follow up after ER visits / hospitalizations

EOMA:

- Community Hospital
- Daily reports from hospital

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5. Communicate test results and care plans

High Plains:
- Care plans
- Health Coaches

OHSU Scappoose:
- Patient portal
- Licensed Practical Nurses

Communicate test results & care plans with patients

EOMA:
- Provider and team

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Care Coordination Roles:

Different roles and responsibilities

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Unique Roles and Care Coordination

High Plains	
Patient Facilitators	• Direct patient care • Front office/back office – rooming –following up after office visits – referrals
Health Coaches	• Follow up on provider visits • Visit summary & goal-setting • Refer patients to community agencies, activities and groups

OHSU Scappoose	
Team Coordinators	• Initiate encounter record • Assist with referrals • Team schedules, inboxes, follows up between visits
Licensed Practical Nurses	• Care coordinators • Resource for clinic • Care management/ER • Some delegation of follow-up to team members

EOMA	
RN Nurse Care Manager & MA Care Coordinator	• RN does detailed initial assessment & medication review, depression screening, fall risk, dementia etc • MA does follow up, links patient with resources designated by care mgr, handles logistics/ next steps
Registered Nurses	• Triage • Patients visits • Co-located nurse navigator

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Lessons Learned

- Understanding the medical home model organization-wide:
  - Providers
  - Staff
  - Patients
- Time and workload:
  - Busier
  - Better for patients, better for team
- Financial:
  - Reimbursable activities
  - Access to specialists

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Strategies

- Understanding the medical home model organization-wide:
  - Providers (time to adjust, empanelment is key)
  - Staff (organizational exercise, PIC work group)
  - Patients (provider role)

- Time and workload:
  - Busier (teams, proactive care)
  - Better for patients, better for team

- Financial:
  - Reimbursable activities (grants, team reorganization)
  - Access to specialists (specialty clinics)

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Direct Insights from the Rural Clinics

Mary Stearns
Dawn Hammel
Renee Daly

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Summary: Rural Care Coordination

- Examples of innovation, responsiveness and connection
- Change has been and is ongoing
- Staff satisfaction high, despite high workload
- Innovative strategies implemented by health centers
- Care coordination also requires action beyond the individual health centers

Questions/Discussion

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If you would like further information or have any questions, please contact us at:

Sarah Derrett - sarah.derrett@otago.ac.nz
Katie Gunter – kgunter@medicine.bsd.uchicago.edu