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

24 July 2012

Sarah Derrett¹, ²
Katie Gunter²

¹2011-12 Commonwealth Fund Harkness Fellow from the University of Otago New Zealand
²The University of Chicago, Department of General Internal Medicine
Acknowledgements

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• The Commonwealth Fund

• Professor Marshall Chin and team at The University of Chicago

• Professor Tom Bodenheimer

• High Plains Community Health Center

• 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
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
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
The Rural Sites:

The Context, The Clinics and The Teams
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

<table>
<thead>
<tr>
<th>High Plains</th>
<th>OHSU Scappoose</th>
<th>EOMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/NP/PA</td>
<td>MD</td>
<td>MD</td>
</tr>
<tr>
<td>Patient Facilitator</td>
<td>NP/PA</td>
<td>Medical Assistant</td>
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<td>Patient Facilitator</td>
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<tr>
<td>Patient Facilitator</td>
<td></td>
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<tr>
<td>Health Coach</td>
<td>Team Coordinator</td>
<td>Referral Coordinator</td>
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Care Coordination Change Concept Implemented

Similarities, Differences & Highlights
1. Linking patients with community resources

High Plains CHC:
- Health coaches
- Local partnerships

OHSU Scappoose:
- Social worker links to community resources

EOMA:
- Nurse Care Manager
- MA Care Coordinator
2. Integrating specialty/behavioral health care

High Plains:
- Behavioral health co-location

OHSU Scappoose:
- Affiliated
- Behavioral health on-site

EOMA:
- Specialty care clinics
- Multidisciplinary meetings
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
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

EOMA:
- Community Hospital
- Daily reports from hospital
5. Communicate test results and care plans

High Plains:
- Care plans
- Health Coaches

OHSU Scappoose:
- Patient portal
- Licensed Practical Nurses

EOMA:
- Provider and team

Communicate test results & care plans with patients
Care Coordination Roles:

Different roles and responsibilities
Unique Roles and Care Coordination

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Patient Facilitators</strong></td>
<td><strong>Team Coordinators</strong></td>
</tr>
<tr>
<td>• Direct patient care</td>
<td>• Initiate encounter record</td>
</tr>
<tr>
<td>• Front office/back office – rooming – following up after office visits – referrals</td>
<td>• Assist with referrals</td>
</tr>
<tr>
<td><strong>Health Coaches</strong></td>
<td>• Team schedules, inboxes, follows up between visits</td>
</tr>
<tr>
<td>• Follow up on provider visits</td>
<td><strong>Licensed Practical Nurses</strong></td>
</tr>
<tr>
<td>• Visit summary &amp; goal-setting</td>
<td>• Care coordinators</td>
</tr>
<tr>
<td>• Refer patients to community agencies, activities and groups</td>
<td>• Resource for clinic</td>
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</tbody>
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<table>
<thead>
<tr>
<th>EOMA</th>
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<tbody>
<tr>
<td><strong>RN Nurse Care Manager &amp; MA Care Coordinator</strong></td>
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<tr>
<td>• RN does detailed initial assessment &amp; medication review, depression screening, fall risk, dementia etc</td>
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<tr>
<td>• MA does follow up, links patient with resources designated by care mgr, handles logistics/next steps</td>
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<tr>
<td><strong>Registered Nurses</strong></td>
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<tr>
<td>• Triage</td>
</tr>
<tr>
<td>• Patients visits</td>
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<tr>
<td>• Co-located nurse navigator</td>
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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
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)
Direct Insights from the Rural Clinics

Mary Stearns
Dawn Hammel
Renee Daly
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
Care Coordination in Rural Communities:

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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