Innovations in Clinical Models

High Risk Oversight and Care Navigation

April 18, 2013

Caring for the Community
East Boston Neighborhood Health Center

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Presentation Outline

- Setting the Stage for Change
  - State context
  - Our patients, our programs
  - Clinical Transformation Vision
- High Risk Oversight
- Care Navigation

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What's Up in Massachusetts

- State declares intention to move towards alternative payment strategies
- Wide spectrum among state efforts
- However, major thrust is:
  - Stated intention is system-wide organization (provider/hospital/specialists)
  - Not quite there, yet
  - No incentive to over-produce
- What does this mean for EB?

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The A in ACO

- Who is Accountable?
  - System-wide integration
- For what?
  - Clinical quality
  - Cost Efficiency
  - Patient engagement
- How?
  - Patient Centered Medical Home Model
    - The clinical model that supports *system wide integration*
    - *Bundle of services/processes that wrap around the PCP-patient visit dyad*

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What's Our Role in an Integrated System?

Clinical Activity	Accountability
Visits (modified formats?)	Quality, Efficiency, Engagement
Population Management	
◦ Immunizations	Quality
◦ Preventive care	Quality
◦ Navigation	Quality, Engagement
Event Tracking	
◦ Hospital follow up	Quality, Efficiency
◦ ED follow up	Quality, Efficiency
Disease-specific Education/SMGS	Quality, Efficiency, Engagement
High Risk Oversight/Clinical Care Management	Quality, Efficiency

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Our Patients

- Start by analyzing our patient population
  - Large total number
  - Relatively healthy
  - Vulnerable (challenged by language, socio-economics, education, etc.)
  - Large amount of chronic disease
  - Some at high risk, some at very high risk
- From a cost efficiency perspective:
  - high risk = high cost = high opportunity

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What Do Our Patients Need?

- Visits
- Education
- Help through the health care system
- Coordination between different providers and sites of care
- Lots of additional high level oversight when something major happens

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Two Streams of Clinical Activity

DAILY FLOW

- Visits
- In-basket work
- Support within the practice
- Examples of innovations:
  - MA workflows/screenings
  - Intensive visit prep

- *Predominant daily work now and in the future*

CARE OVERSIGHT

- PCP as Care Team Leader
- Concentrating on high risk patients
- Care team members implement plan of care
- Examples of innovations:
  - High risk list review
  - Clinical Care Management functions

- *Critical to an integrated system*

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Bundle of Wrap-Around Services

- Medical Assistant
  - Standard work, pre-visit screening
- Care Coordinator
  - Community resources
  - Navigation
- Practice Nurse Functions
  - Hospital follow-up workflow
  - ED follow-up workflow
- Care Manager Nurse Functions
  - High risk lists
  - Frequent touches
  - Education and self-management goal setting
  - Liaison with outside partners
  - Could be in the practice or a special program
- NP/PA
  - Intensive clinical management
  - Risk assessment
  - Could be in the practice or a special program
- PCP
  - Leads the whole team!

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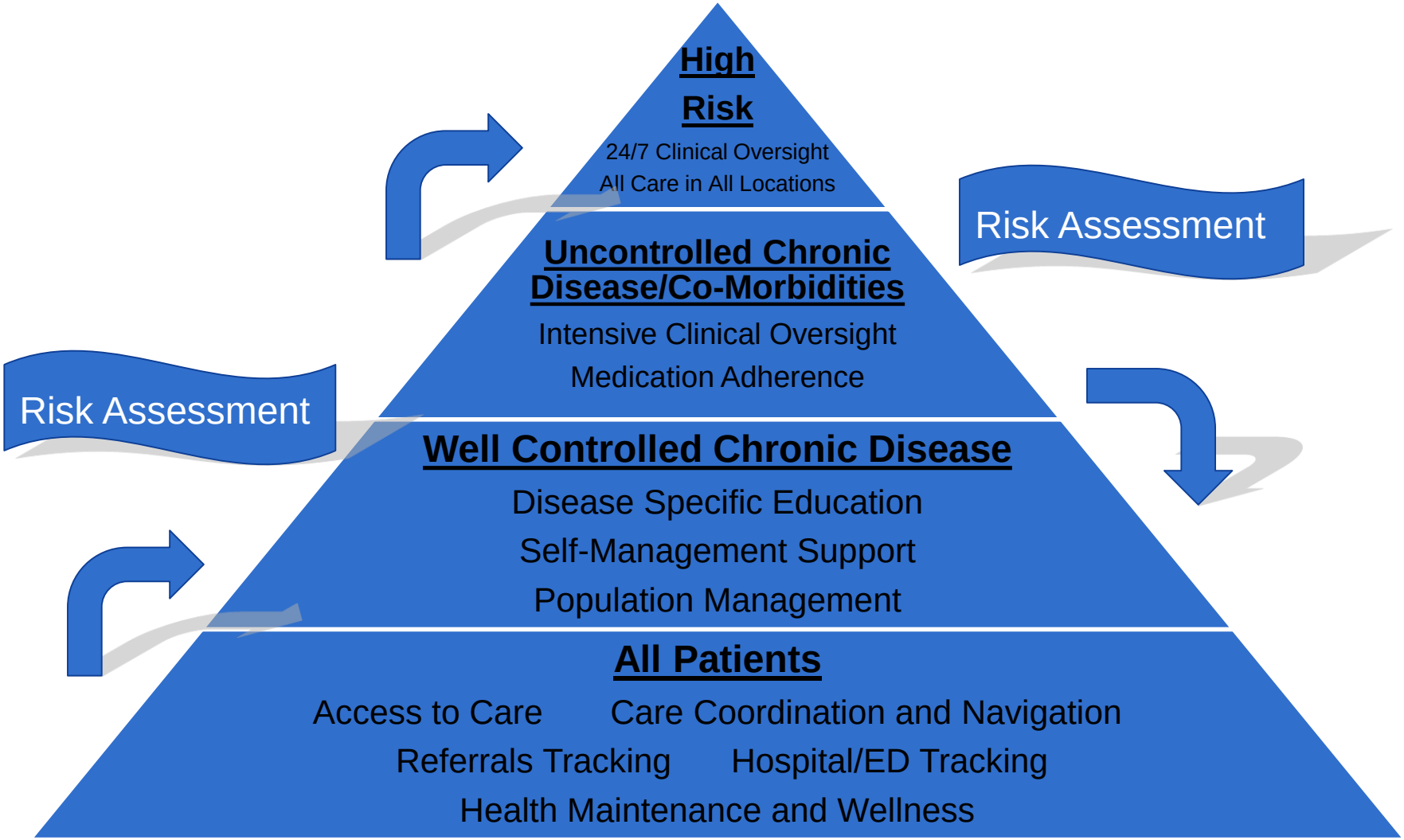
The Medical Home Pyramid



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Vision of Clinical Transformation

Develop a *high quality*, *efficient* clinical model that that will *improve patient engagement and outcomes*, *reduce provider burden* by leveraging *the entire team*, and prepares us for *future payment models*.

The team =

everyone at EBNHC, including the Board of Directors, and beyond

Who Does What on the Team?

- *New Functions* – bundle of wrap-around services
  - *Care Coordinators*
    - Identify community resources
    - Navigate care through different settings or providers
  - *Clinical Care Managers*
    - Clinical assessment
    - Frequent touches
    - Medication review/reconciliation
    - Communication with different care team members or settings
    - Self-management support
- Advisory Board – Health Coach Model
  - *Wrap-around functions* accomplished care team members under the guidance of the PCP
- Develop *functions* across multiple *roles*

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Clinical Care Management

- Hospital follow up
  - Workflow for everyone who has this event
  - Clinical review
- ED visit follow up
  - Workflow for everyone who has this event
  - Clinical review
- **High risk oversight**

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High Risk Oversight

- Start with the universe of high risk
- Complete a clinical review
- **Identify who is high risk**
  - **Tag/label**
  - **Plan of care**
  - **Bundle of services**
  - **Care team resources**
  - **Tracking**
- Identify who is just *at* risk
  - Periodic assessments

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Identify Who is High Risk

- Tag/label
  - On the Problem List
  - Sub-categories that describe risk
- Plan of care
  - Care coordination note
- Bundle of services
  - Discrete description of the clinical standard/protocol
  - Ties to quality measures
- Care team resources
  - NP/PA, RN, CC, MA, etc.
- Tracking
  - High Risk Care Oversight encounter or RFV?

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High Risk Cohorts

Cohort Tag	Plan of Care	Bundle of Services	Resources	Tracking
Asthma	Problem List Overview	• Education • Hospital/ED FU • Intensive clinical management • Frequent touches	• Asthma NP • Care coordinator	• Follow-up Interval • Tools for tracking
Diabetes	Problem List Overview	• Education • Hospital/ED FU • Intensive clinical management • Frequent touches	• CDEM NP/RN • Care coordinator	• Follow-up Interval • Tools for tracking
Geriatrics	Problem List Overview	• Education • Hospital/ED FU • Intensive clinical management • Frequent touches	• SCO NP/RN	• Follow-up Interval • Tools for tracking
HR NOS	Problem List Overview	• Education • Frequent touches	• Practice nurse acting as clinical care manager	• Follow-up Interval • Tools for tracking

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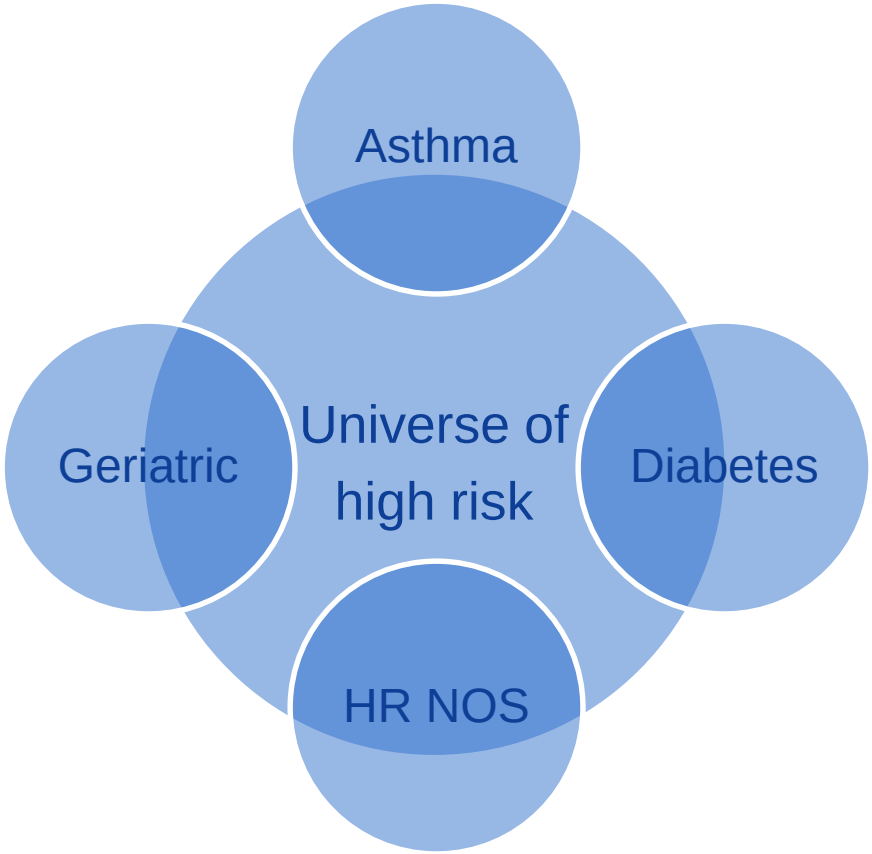
The High Risk Universe



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Maximizing our Resources

	Clinical Description	Current Programs	Bundle of Services	Care Team Resources
High Risk Cohorts	**▪Complex chronic diseases – Diabetes, Cardiac, Pulmonary** **▪Pediatric Asthma** **▪Frail elders** **▪Behavioral health** **▪Frequent ED/Hospitalization** **▪Functional deficit (high risk NOS)**	**▪Catch** **▪CDEM** **▪Developmental Clinic** **▪SCO** **▪Pediatric Asthma** **▪Primary Care** **▪ESP – exclusively high risk cohort**	**▪Tagged as high risk in Epic** **▪Plan of care described (.healthcarehome)** **▪Interval for periodic review described** **▪Intense clinical management** **▪Frequent touches by nurse care manager and/or care coordinator** **▪Additional, cohort-specific bundle of services** **▪Event-based support** **▪ ESP – Staff model, 24/7 care**	**▪Catch team** **▪CDEM RNs and NP/PAs** **▪Care Coordinators** **▪SCO RNs, NP/PAs** **▪Pediatric Asthma NP** **▪Primary Care nurses acting as nurse care managers** **▪Mental Health providers** **▪ESP – Interdisciplinary Team**
At Risk Cohorts	▪Stable chronic disease ▪Non-frail elders ▪Health-related events (eg. hospitalization, ED visit) ▪At risk for a change in health status ▪*functional status* ▪*social circumstances* ▪*increased hospitalizations, etc.*	▪Catch ▪CDEM ▪Developmental Clinic ▪SCO ▪Pediatric Asthma ▪Primary Care	▪Education & self-mgmt support ▪Periodic assessment of risk factors ▪Care coordination ▪Event-based support ▪*Hospital follow-up* ▪*ED follow-up*	▪Catch team ▪CDEM RNs and NP/PAs ▪Care Coordinators ▪SCO RNs, NP/PAs ▪Pediatric Asthma NP ▪Primary Care nurses acting as nurse care managers ▪Mental Health providers
Normal Care	▪Visits ▪Health Maintenance	▪Primary Care	▪Standard care (includes ARM) ▪Ad-hoc care coordination	▪Primary Care ▪Care Coordinators

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Care Navigators - Job Description

The Care Navigators provide…

- Community resources and wellness activities
- Department/Health Center orientation
- Outreach to patient to facilitate access to care
- Special assistance and guidance in navigation of the Health Care System
  - Service is provided, upon referral, when customary approaches to guiding/planning care have been insufficient in overcoming barriers/obstacles
  - Examples include:
    - Appointment reminders
    - Streamlining outside appointments
    - Assistance with forms/applications

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The Litmus test:

- *Refer to the Americorps staff when:*
  - *you can't think of a person or service that the Health Center already has that does what you are asking for for the patient, or*
  - *when our usual service is not working for the patient*

Community Resources

→ Available in English and Spanish (including EPIC Smart Phrases)
- .RESOURCES
  - Ex: Adult Education
    .RESOURCESADULTEDUCATION2011
    .RESOURCESADULTEDUCATIONSPANISH2011

→ Link on Home page
HOME > Health Center Resources > Community and Concrete Assistance Resources

→ Updated periodically

Currently 16 Resource Lists:

*Adult Education
*Child Care
*Dental Services
Domestic Violence
Exercise
*Food
*Heating & Gas
*Housing & Shelters
Job Assistance
*Legal & Immigration
LGBT
Medical Supplies
Mental Health/Substance Abuse
Pregnancy Termination
Rape Crisis Centers
Transportation

**Smart Phrases Available*

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Community Resources

New Patient Orientations

- Welcome packet for new HC patients
  1) **Orient** patient to HC
  2) **Introduce** Care Coordinator services
  3) **Assess** for need of community resources
  4) **Educate** patients on how to access care
  5) **Verify** demographics
  6) **Provide** follow-up and case management

Referral

- Provider generates referral request for resources needed

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Navigating Health Care System

- Appointments
  - Assist patient with rescheduling outside appointments & booking interpreters if needed
  - Accompany patients to outside appointments, assess understanding of navigation of hospital facility, transportation and other
  - Keep track of appointments, make reminder calls
- Instructions of navigation
  - Renal Clinic at BMC
- Health Center
  - Walk patients to different areas of the center and point them to services appropriate for their needs
- Insurance
  - Helping patients troubleshoot insurance issues
    - E.g: following up on insurance status, connecting patients to Enrollment when necessary, verifying benefits

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Support High Risk Populations

Pediatrics

- Attend weekly/monthly meeting for review of high risk population
- Discharge follow up calls for pediatric Asthma patients
- Assist with the coordination of care for all pediatric patients
  - Developmental clinic patients
    - Serve as a liaison between school, clinic, and parents
  - Provide case management and non-medical follow-up care
- Address incoming referrals and outreach to patients

Adult Medicine and CDEM

- Attend weekly/monthly meeting for review of high risk population
- Maintain continuous communication among members of the patients care team
- Provide case management and non-medical follow-up care
- Address incoming referrals and outreach to patients
- Assist with accessing community resources

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Advocacy and Care Navigation

Edith

Serve as an advocate for Edith, who is legally blind, and assist with navigating outside services such as BPS, hospital/medical visits, and social services

- Medical: coordinated BMC appointments and accompanied Edith with her mother, Lucia, to appointments, staying in the exam room as support. Clarified any questions and made sure Lucia understood – encouraged her to ask questions. Looked over and explained any paper documents (appointment slips, reminders, health insurance statuses) as Lucia is not literate and only speaks Spanish.
- School: accompanied pt and mom for initial assessments and complete enrollment into a BPS school. Advocated on mom's behalf to obtain door-to-door transportation for school and accompanied both to visit English High School and for special education evaluation meetings. Also helped pt with releasing appropriate medical records to her school and making sure all information needed was received in order for her to obtain the right services. Attended pt's IEP meeting with mom. Continuously helping mom to become more independent and involved in pt's care at the clinic/hospital and at school.
- Social services: currently working with pt's Massachusetts's Commission for the Blind Case Worker to make sure she receives the right support and services from them, such as a talking glucometer, and rehabilitation teaching for future independent living. Also working with pt and mom to complete an EAEDC application that will help them financially

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Advocacy and Care Navigation

Monica

- Appointment Assistance
  - "Met pt before her appt at the BMC Renal Clinic. We took the shuttle bus to BMC and I showed her which building and floor the clinic is on. I let her check in herself but was there for her because she was insecure about not speaking English. Went into the appointment with her and took notes on what the doctor told her in case she had trouble understanding or had questions. I made sure that a Spanish interpreter was used, in most cases it has been a phone interpreter. I made sure that the pt had space to ask questions or express concerns. After the visit, I helped her speak with the receptionist to book next appts."
- Appointment Coordination
  - "I try to advocate for and empower pt. I asked pt about the barriers she faces that prevent her from going to appts. She said it is difficult to find someone to watch the kids, transportation is difficult, she has trouble moving, she fears going to the hospital, and there are a lot of appts to remember between herself and her children. She told me that afternoon appts are better for her because her husband is normally home to watch the kids. Pt has many appts to coordinate: Renal Clinic, BMC General Surgery, EBNHC Family Medicine and OBGYN, social work, as well as appts for her kids: Hailey (pt's 8 month daughter) - Early Intervention and Healthy Baby Healthy Child home visits, Children's Hospital Audiology, Surgery, GI, ophthalmology and PCP."
- Outside Resources
  - "Also have been coordinating appts for pt's son Anthony who had an early intervention evaluation and has an audiology appt and PCP appt with pt's other son Joseph with PCP. I went to pt's house to shadow this evaluation and support pt. Also assisting pt in trying to find childcare resources for an upcoming surgery. Also I have been trying to work with pt to exercise because her surgeon told her that losing 8-10 lbs would be helpful for the surgery. I have obtained a monthly YMCA pass but pt has been unable to use it because she has been so busy with appts. I worked with Michael Nicastro to get car seats for pt's children. I make several phone calls to pt a week to remind her of her appts for herself or children. Pt has a hard time remembering appts. I made a calendar for pt to use, but she says the most helpful is to have me call her. Trying to brainstorm new ways to empower patient."

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Other Services

- Education
  - Nutrition Education Flyers
  - Diabetes Walk 2011
  - Diabetes Alert Day 2011
- Forms/Applications
  - Work with patients who need assistance filling out forms such as:
    - Disability/DTA benefits
    - Food assistance
    - The RIDE

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Restrictions

- Interpreting
  - Support patients during appointments but not as the interpreter
- AmeriCorps
  - Federally funded: no abortion resources, political/religious related activities, etc
  - Not an employee of the HC: unable to do a job that someone else at the clinic already does
    - Ex: subbing in and answering the phone for a secretary, making appointments

Contact Information

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