HealthInfoNet Analytics

Use Case Report

Federally Qualified Health Center
Care Management

Care Management Model

Hometown Health Center is a Federally Qualified Health Center in central Maine with 4 practice locations, 9 primary care providers (PCP), serving 992 MaineCare (Medicaid) Health Home enrolled patients, and 2,823 MaineCare members as of August 2017. MaineCare comprises 50% of the center's patient payer mix. Hometown Health is also a member of the Community Care Partnership of Maine (CCPM) Accountable Care Organization.

HOMETOWN Health Center

Hometown Health Center uses a centralized care management model as opposed to on-site care managers. There is a Medical Assistant and Registered Nurse that are assigned to care management services for all locations of care. The care management interventions focus primarily on post-acute care follow-up for primary care services.

Care Management Workflow

Hometown Health Center care managers have been using the HealthInfoNet Analytics and Reporting Platform (HARP) to identify patients at risk for post-acute care follow-up and prevention management since May of 2017.

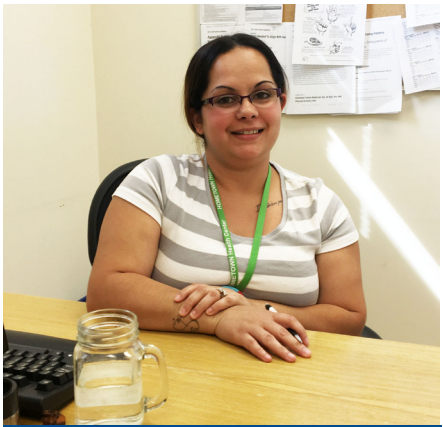
The following process is performed daily Monday-Friday:

1. Each morning, one of the care managers accesses HARP to pull the list of their patients discharged from the Emergency Department (ED) or admitted/discharged to a hospital in the last 24 hours.
3. The list is divided by ED vs. hospitalized patients.
4. Follow-up calls are made to assess care plan questions:
    - Is a primary care appointment required?
    - Are community supports required?
    - Are home care services required?
    - What assessments are needed to qualify for a higher level of care?

Care Management Documentation

Once a patient has been identified as being high-risk in HARP, Hometown Health Center staff will document a care plan in the Electronic Health Record (EHR) "Care Management Note", which is flagged for the PCP to review.

The note will include the risk score for acute care utilization and what the current needs/status of the patient is, the care plan, and patient's response. The PCP uses this note to follow-up on referrals, at the next office visit, team meetings, etc.



"This tool has increased our Care Management referrals by 40 to 50% resulting in better care for our patients - without question."
- Melissa Phillips, RN Care Coordinator

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Quality Impact

Increases in patients identified: HARP has led to an increase in care management referrals by **40-50%** on average per day by identifying patients in near real-time that they would not have known about before. Previously, care managers would have learned out about admissions weeks later leading to delays in providing patients with necessary referrals and resources.

High Utilizer Case Review: The highest utilizer patients are discussed at monthly mulit-disciplinary meetings that cover an average of 10 patients per month. This patient population is also discussed at the monthly MaineCare ED collaborative meetings for those patients with MaineCare coverage. This meeting is used to develop appropriate treatment plans and creative intervention solutions for complex cases - ultimately leading to better outcomes that decrease the need for ED visits and hospital admissions.

Patient and Provider response

The response of PCPs has been positive due to the timeliness of HARP to identify patients at high-risk which allows for quick follow-up care. PCPs are able to see their patients in the practice for follow-up visits to address their risks, discuss their gaps in care, develop a care plan to reduce their hospital/ED visits when this is a pattern. The PCPs are pleased to have more complete information about the patients before their follow-up visits, especially the medication history available in HealthInfoNet.

Hometown Health Center staff noted patients are very receptive to hearing from the care managers after their ED/hospital visit. The patients often have questions about tests, medications, instructions, and next steps. The phone calls allow a patient's plan of care to continue and PCP visits are scheduled at that time if necessary. Patients are also engaged in social services and community-based supports such as functional assessments and home care options.

Intervention Examples

• Care managers used HARP to identify a patient with anxiety and a mental health diagnosis that was using the ED heavily. The patient indicated they needed to go to the ED because they were unable to afford PCP visits. The care manager determined that the patient did have MaineCare coverage, informed MaineCare of this high utilizer, and counseled the patient about when to use the ED vs. primary care.

• Care managers also use HARP to identify and monitor behavior patterns of patients who are going to multiple EDs and have been able to intervene and council on appropriate ED use vs. other ambulatory options.

"Sometimes it's what you don't see that tells the story. I was researching one of our patients who had been in the ED and noticed there weren't any Cardiology visit notes or labs in his record which meant that he hadn't done the necessary follow-up from a previous visit. Noticing this gap allowed our staff to intervene and get his care back on schedule."

- Betty Ellis, Medical Assistant