Eastern Oregon Care Coordination Project

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Care coordination definition:

• “Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.” (AHRQ, 2015)

• “The space between” (Antonelli, 2008)
The Setting

Umatilla County Population: 75,889

Population Density: 24 people per square mile
The Participating Practices

- Recruited 4 primary care practices from the PBRN
- 2-8 clinicians per practice
- 2 clinics had dedicated care coordinators (including one LPN) at the beginning of the project and 2 did not
• Identify local care coordination needs and best practices in Umatilla County

• Identify the scope of care coordination in Umatilla County

• Form policy recommendations for payer

Determined “non-human subjects research” by OHSU IRB: Study00015163 (March 26, 2015)
Project Activities

• Engagement with practices and community
  o In-person meetings at clinics
  o Project-wide learning sessions
  o Webinars
    o Presentations at community meetings
• Practice facilitation to drive quality improvement projects
• Data collection
(a) Scope of services provided by clinic staff and clinicians

(b) Levels of staff and clinician time committed to ALL care coordination and care management tasks
The Spectrum of Care Coordination and Care Management

Care Management
- Medication management
- Self-management Support
- Logistical
- Clinical Monitoring

Clinical Follow-up Care
- Logistical
- Clinical Monitoring

Care Coordination
- Logistical

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# The Care Coordination Measurement Tool

## Medical Home Care Coordination Measurement Tool

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Study Code And Age</th>
<th>Patient Level</th>
<th>Focus</th>
<th>Care Coordination Needs</th>
<th>Activity Code(s)</th>
<th>Outcome(s)</th>
<th>Time Spent*</th>
<th>Staff</th>
<th>Clinical Comp.</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
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<td>1 2 3 4 5 6 7</td>
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</tbody>
</table>

### Patient Level

- **Level Description**
  1. Non-CSCHC, Without Complicating Family or Social Issues
  2. Non-CSCHC, With Complicating Family or Social Issues
  3. CSCHC, Without Complicating Family or Social Issues
  4. CSCHC, With Complicating Family or Social Issues

### Focus of Encounter (choose ONE)

- Mental Health
- Developmental / Behavioral
- Educational / School
- Legal / Legal
- Growth / Nutrition
- Retinal Management
- Clinical / Medical Management
- Social Services (em. housing, food, clothing, etc.)

### Clinical Competence

- C. Clinical Competence required
- M. Clinical Competence not required

### Activities to Fulfill Needs (choose all that apply)

1. Telephone discussion with:
   - Parent
   - Doctor
   - Social Worker
   - Physical/Occupational Therapist
   - Speech Therapist
   - Other (Specify)

2. Shared decision making:
   - Parent
   - Provider
   - Patient
   - Other (Specify)

3. Written report:
   - To family
   - To other agencies
   - To other providers

4. Referral to another service:
   - Home health
   - Physical therapy
   - Occupational therapy
   - Speech therapy
   - Other (Specify)

5. In-home visit:
   - Parent
   - Provider
   - Other (Specify)

### Outcome(s)

- As a result of this care coordination activity, the following was PREVENTED:
  1. Breathing difficulties
  2. Fever
  3. Hospitalization
  4. Visit to Pediatric Office/Clinic
  5. Labs / Tests
  6. Other (Specify)

- As a result of this care coordination activity, the following OCCURRED:
  1. Improved adherence to treatment plan
  2. Increased engagement in self-care activities

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[Logo: ORPRN, Oregon Rural Practice-Based Research Network]  
[Banner: OHSU, Oregon Health & Science University]
The Pilot Process

Training

Round 1

4 Conference calls

Training

Round 2

In person Meeting

Sept. ‘15

Oct. ‘15

Nov. 2015-
Feb. ‘16

Mar. ‘16

Apr. ‘16

June ‘16
Methods

- Complete a separate form for each encounter outside of a visit for a 10 day period
  - Referrals
  - Transitions of care
  - Medication management
## Data Overview

<table>
<thead>
<tr>
<th></th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Encounters</strong></td>
<td>506</td>
<td>520</td>
</tr>
<tr>
<td><strong>Number of Patients Served</strong></td>
<td>406</td>
<td>412</td>
</tr>
</tbody>
</table>

- **Round 1**: October 8 to 30, 2015
- **Round 2**: April 11 to 25, 2016
### Staff Roles

<table>
<thead>
<tr>
<th>Staff Role</th>
<th>Data Collection Period</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Round 1</td>
<td>Round 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>October 8 to 30, 2015</td>
<td>April 11 to 25, 2016</td>
<td></td>
</tr>
<tr>
<td>Front Desk/Back office</td>
<td>11</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Nurse (LPN, RN)</td>
<td>2</td>
<td>2</td>
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</tr>
<tr>
<td>Nurse Practitioner</td>
<td>1</td>
<td>0</td>
<td></td>
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<tr>
<td>Overall</td>
<td>20</td>
<td>17</td>
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</table>
Data Overview

• **75%** of submitted encounters were **referrals** completed by front desk/back office staff.
• **13%** of documented encounters were in-person. Most of the encounters were process oriented.
• The average encounter was **12 minutes**.
Findings

• Often **multiple staff** would participate in initiating a single referral.
• Most encounters (63-84%) resulted in a “pending” outcome, meaning the consultation notes were not received by the practice or the “loop was not closed”.
Findings: Focus of Encounter

Round 2, N = 520 Encounters

82% of encounters were focused on referrals

- Referrals: 426
- Medication Management: 66
- Transitions of Care: 44
Findings: Referral Descriptions

Round 2, N = 426 Encounters

- 90% of referrals for clinical specialists
- 382 Clinical specialist
- 100 Insurance pre-authorization and other
- 10 Alt. health, comm. resources, mental health, tobacco, substance abuse
Key Lesson

- Make time for face time with practices
  - Build trust
  - Discuss the importance and purpose of collecting data
  - Understand the activities delivered at the clinic and then modify the tool to make it relevant
  - Deliver practice sessions to improve data collection efforts
  - Additional key findings through discussion
Acknowledgements

• Four participating practices
• Oregon Educators Benefits Board/Moda Health Grant Program
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Questions?

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