

Western Oregon Advanced Health

<i>Name of Project</i>	MEDICAL RESPITE	ACCESS TO REAL-TIME SUPPORT FROM AN RN CARE MANAGER	COMMUNITY PARAMEDIC PROJECT	HEALTHCARE COMMUNITY ONLINE
Stage of Project Development	Implementation and Evaluation	Implementation and Evaluation	Planning	Planning
Identification <i>What is your target population and how did you identify them?</i>	Medically complex homeless patients requiring follow-up care upon discharge from hospital.	Frequent ED utilizers	<ul style="list-style-type: none"> High ED users identified in partnership with hospitals Still determining target groups, possible diagnosis include chf, copd, diabetes. Also will identify people at risk of falls (priority identified through the Community Health Assessment and Improvement Plan process.) 	Risk-stratification tool identifies: <ul style="list-style-type: none"> Patients at high risk for hospitalization and ER visits Patients with avoidable costs at plan level, practice level, or by disease state Quality reporting tool assists with population management.
Intervention <i>Which intervention(s) do you plan to use?</i>	Daily payment to shelter to provide: <ul style="list-style-type: none"> Meals Housing Shower Nursing support is also provided.	On-demand RN care management during office hours. Communication via phone and text.	<ul style="list-style-type: none"> PCPs make referrals to Community Paramedic Project. Paramedic will do in-home evaluation. Program includes transport (to walk-in clinic, PCP office, pharmacy, or ED if emergency), medication delivery, and in-home treatment and safety evaluation to prevent falls. 	<ul style="list-style-type: none"> Allows physicians and case management to target specific care for patients most at risk Provides data to help physicians see performance on quality metrics Communication tool across health care entities
Implementation <i>How do you plan to implement these interventions?</i>	<ul style="list-style-type: none"> Worked with shelter to agree upon rate, intent and scope of service. Physician order is required for this program. 	<ul style="list-style-type: none"> Ensure member has contact number. Accept referrals from physicians and ED WOAH Care Manager works closely with members to identify their unique needs and connect them to resources. CCO Care Managers prioritize participants and respond to calls immediately. 	<ul style="list-style-type: none"> Start with small pilot project w/ 3 PCPs and 20 patients. Plan Do Study Act cycles for 3-6 months and will determine appropriate next steps from there. 	WOAH care management team will: <ul style="list-style-type: none"> Use risk stratification to target case management interventions. Implement tools in pilot PCP offices. Roll out to all participating providers. Quality metrics will include physician-specific reports on OHA incentive measures. Initial data from claims; future plans to pull data directly from clinical records.
Workforce <i>Who in your organization will be implementing the work?</i>	Community Care Management Program	Community Care Management Program	<ul style="list-style-type: none"> Bay City Ambulance Primary care physicians WOAH care managers 	<ul style="list-style-type: none"> Care Managers Physicians IT WOAH medical management staff Eventually all providers of health care
Evaluation <i>How will you be evaluating this work?</i>	<ul style="list-style-type: none"> Early cases show excellent health outcomes. Coordination of care reveals cost savings. 	<ul style="list-style-type: none"> Cost savings from reduced ED and ambulance use. Track ED utilization incentive measure. 	<ul style="list-style-type: none"> Patient satisfaction Physician satisfaction ED use Hospital re-admits 	Evaluation based on: <ul style="list-style-type: none"> Reduction in potentially avoidable costs Reduction in ER use and readmissions Improvement in quality measures Physician satisfaction
Resources <i>How are you funding this work?</i>	CCO Flexible Spending	<ul style="list-style-type: none"> Provide a cell phone if needed using Safe Link, a government-sponsored program that offers a free cell phone for eligible individuals. CCO Flexible Spending funds used for transportation. WOAH funds Care Management time and cell phone. Partnerships increase urgent access to clinic appointments. 	<ul style="list-style-type: none"> During the pilot phase, Bay Cities Ambulance is offering this service free of charge to gather data and develop the program. Ultimately the goal is to achieve shared cost savings which will then provide funding for the program. Grant funding is also being pursued. 	<ul style="list-style-type: none"> Transformation Fund Ongoing funding through cost savings Dr. Tracy Muday <i>Chief Medical Officer, WOAH</i> Yvette Grabow, RN, OCN <i>WOAH Care Manager</i> 541-269-7400, ext. 1 ygrabow@docshp.com Dr. Peter Lund <i>physician champion</i> Caryn Mickelson, RPh <i>Director of Medical Management</i> AT&T, Covisint, Milliman IT managers of community partners
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