Medical Home Connection Project
St. Joseph’s/Candler Health System

Sister Mary-Anne Plaskon, RSM, LCSW
Mohamed Ghaleb, MD, MHSA Candidate
Juanita Pratt, MD, MHSA Candidate
Kasey Houghton, MHSA Candidate
Sabine Schupp, MHSA Candidate
SJCHS MISSION & VALUES:
“ROOTED IN GOD’S LOVE, WE TREAT ILLNESS AND PROMOTE WELLNESS FOR ALL PEOPLE.”

- COMPASSION
- QUALITY
- INTEGRITY
- COURTESY
- ACCOUNTABILITY
- TEAMWORK
Overview

• We are striving to provide improved comprehensive medical services (Medical Homes) for patients with non-emergency medical conditions.
Project Aim & Objectives

• Goal:
  – To encourage and assist SJCHS ED patients, self-pay priority 4 and 5, to find, establish, and maintain a Primary Care Medical Home.

• Objectives:
  – Identify those patients, who use the ED as their medical home.
  – Create a baseline of FY13 & FY14 data as follows:
    • Number of patient visits
    • Number of patients who are priority 4 & 5
  – Determine what resources each patient needs in order to receive care in a stable medical home.
Patients Visiting ED in SJCH are classified according to Triage Level (Priority of Care) from 1-5

- Triage Priority 1, 2, and 3 patients require a high level of care
  - Priority 1 and 2 - emergency care
  - Priority 3 - urgent care

- Triage Priority 4 and 5 patients require a low level of care which reflects non-emergency situations
Self-Pay Patients SJCHS ED

Non Self-Pay Visits - 75% (FY13 & FY14)

Self-Pay Visits - 25% (FY13 & FY14)
Percent of Self-Pay Priority 4 and 5 Visits to ED FY13 & FY14

- 10%

All Other ED Visits (FY13 & FY14)

ED Self-Pay Priority 4 and 5 Visits both ED (FY13 & FY14)
Location
- Majority of patients live within zip code of hospital
  - No Medical Homes within zip code of hospital
  - Limited access to transportation

Pain Management
- A leading complaint of P 4 & 5 SP patients in the ED is pain
  - Medical Homes do not prescribe narcotics

Convenience
- 30% of self-pay patients present on weekends
  - 60% of self-pay patients present between noon and midnight

Financial
- 28% of all P 4 & 5 self-pay patients are unemployed
  - EDs do not demand payment before service is rendered

Education
- Many patients do not understand what constitutes an emergency

More than 10% of ED visits are non-emergencies

Root Cause Analysis:
Reasons Patients Use ED as Medical Home
Medical Home Project Framework

What is a Medical Home?

- A comprehensive approach to care
- Coordinated and/or integrated care among providers and community services. (Adapted from AAMC 2010)

Core Medical Homes:
- St. Mary’s Health Clinic (SJCHS)
- J.C. Lewis Federally Qualified Health Center (FQHC)
- Curtis Cooper (FQHC)
- Good Samaritan (SJCHS) - January 2015
Phase II: Project Aim & Objective (Redefined)

• **Goal:**
  To encourage and assist SJ ED patients, self-pay priority 3, 4 and 5, to find, establish, and maintain a Primary Care Medical Home.

• **Objective:**
  Decrease the frequency of visits of self-pay patients with ED Priority level 3-5 to SJ ED by 25% within 3 years (by 2017).
% of Self-Pay to All Levels of SJ ED Visits
FY 15 - Quarter 1 & 2

- P 3: 52%
- P 4&5: 35%
- P 1&2: 13%
Program Design

• External Partnership:
  – Armstrong State University- Patient Advocates
  – FQHC Medical Homes
  – Community Resources

• Internal Partnerships:
  – SJCHS Staff/Health Services
  – SJCHS Medical Homes
Program Design

• Special Project Licensed Clinical Social Worker
  – 1 Full-time employee
• Armstrong Intern (Graduate Student)
  – 20 hrs./week
• Armstrong Health Coaches (Undergraduate Students)
  – Patient Advocacy Course
  – 3-6 hrs./week per advocate
Process - During ED Visit

- Health Coaches (Patient Advocates)
  - Intercept self-pay P 3, 4 & 5 patients (EMR system)
  - Educate patients on the value of a medical home and what is an emergency
  - Refer patients to a medical home and schedule an appointment
  - Identify social determinants and offer resources to help patients:
    - Bus pass/taxi cab transportation
    - Shelter/Food/Clothing/Behavioral Health Information
Process – Post ED Visit

• Follow up with both the patient and medical home to ensure that patient kept his/her first appointment.

• Monthly follow-up with patient (up to 6 months)
  – Identify barriers that prevented patient from keeping appointment
  – Reschedule appointments
Key Performance Indicators

- Number of patients *Seen* by Health Coach and the Number *Actually Referred* to a Medical Home

- Number of patients that *Kept* their first appointment

- Number of *Return Visits* to SJCHS ED by referred patients
**Implementation**

<table>
<thead>
<tr>
<th>Patients Seen in SJ ED</th>
<th>3,627</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients seen by Health Coach</td>
<td>317</td>
</tr>
<tr>
<td>Patients Referred to Core Medical Homes</td>
<td>196</td>
</tr>
<tr>
<td>Patients Referred to Other Medical Homes</td>
<td>34</td>
</tr>
<tr>
<td>Other Referral Types</td>
<td>87</td>
</tr>
</tbody>
</table>

* September 15, 2014 thru March 1, 2015 - 24 Weeks
ED Project Patient Referral Rate

- Core Medical Homes: 63%
- Other Medical Homes: 10%
- Other Referral Types: 27%
Patients seen in SJ ED by Health Coaches

- 11% P 3, 4, 5 (15% P4_5 and 8% P3) SP patients seen by Health Coach in SJ ED (Excluding weeks 14-20)
ED Project – Patient Demographics

317 Patients

- Gender:
  - 193 Female
  - 124 Male

- Age Range:
  - 7 months – 71 y/o
Distribution of ED Project Patients by Employment Type

- Unemployed: 41%
- Employed: 21%
- Disabled: 8%
- Student: 11%
- NA: 19%
Distribution of ED Project Patients by Financial Class

Percentage

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Pay</td>
<td>70%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>13%</td>
</tr>
<tr>
<td>Commercial</td>
<td>10%</td>
</tr>
<tr>
<td>Medicare</td>
<td>7%</td>
</tr>
</tbody>
</table>
Top ICD 9 Diagnosis of ED Project Patients

- DENTAL DISORDERS
- LUMBAGO
- BRONCHITIS NOS
- PAIN IN LUMB
- SPRAIN LUMBAR REGION
- SPRAIN OF ANKLE NOS
- ACUTE BRONCHITIS
- ACUTE PHARYNGITIS
- ABDOMINAL PAIN, OTHER SPECIFIED SITE

Number of Patients

ICD 9 Diagnosis
# Medical Home Distributions

<table>
<thead>
<tr>
<th>St Mary's</th>
<th>Good Sam</th>
<th>Curtis Cooper</th>
<th>J.C. Lewis</th>
<th>Other MH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Patients Referred</strong></td>
<td>87</td>
<td>7</td>
<td>16</td>
<td>84</td>
</tr>
<tr>
<td><strong>Total First MH Appointments Kept</strong></td>
<td>44</td>
<td>3</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td><strong>% of Patients Kept 1st Appointment</strong></td>
<td>51%</td>
<td>43%</td>
<td>50%</td>
<td>33%</td>
</tr>
</tbody>
</table>
Distribution of Referred Patients by Core Medical Home

- St. Mary's: 45%
- J.C. Lewis: 43%
- Good Samaritan: 4%
- Curtis V. Cooper: 8%
Patients Kept 1st Medical Home Appointment  P3, 4, & 5

% of Patients Kept 1st Medical Home Appointment

Weeks

Goal: 25%
Kept 1\textsuperscript{st} Appointment by Age Distribution

<table>
<thead>
<tr>
<th>Age Group</th>
<th># Appt. Made</th>
<th># Kept 1\textsuperscript{st} Appt.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 18</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>19 - 26</td>
<td>49</td>
<td>17</td>
</tr>
<tr>
<td>27 - 40</td>
<td>98</td>
<td>41</td>
</tr>
<tr>
<td>&gt; 40</td>
<td>49</td>
<td>22</td>
</tr>
</tbody>
</table>

![Graph showing percentage of kept appointments by age group.](image-url)
## Medical Home Effectiveness

<table>
<thead>
<tr>
<th></th>
<th>SMHC</th>
<th>JCL</th>
<th>CVC</th>
<th>GS (Since 1/2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients</td>
<td>72</td>
<td>64</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Referred to MH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Referred</td>
<td>28</td>
<td>32</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Patients return to SJ ED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Patients</td>
<td>62%</td>
<td>50%</td>
<td>57%</td>
<td>0%</td>
</tr>
<tr>
<td>who <em>did not return</em> to ED (Candler or SJ)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Data as of Week 20*
Challenges

• Medicaid or some insured patients with ED Priority Level 3, 4 and 5, (frequent ED visits >6)
• Identifying key motivational factors for keeping the first scheduled appointment
• Health Coach Consult Order
• Consistent and timely feedback from the Medical Homes confirming kept appointments
Questions?