Health Care Coverage Initiative Medical Home Implementation, Interim Findings: San Diego County

The Health Care Coverage Initiative (HCCI) program in San Diego County provides services to individuals with diabetes and hypertension. This program focuses on the chronic care model using disease management services.

Personal Physician

There are 16 medical homes in the county consisting of a network of Federally Qualified Health Centers (FQHCs) that provide health care services. Enrollment and recruitment into the program is completed by certified application assistants (CAA) who are trained and funded by the county. Most CAAs are located in a specific clinic, but a few clinics share CAAs. Thus, assignment to the medical home is clinic based, and these clinics assign patients to a specific team. The assignment process is not standardized to date, but promoted by the county.

The county educates patients at enrollment about the use of a medical home and its services, but does not enforce adherence to the assigned medical home. To qualify to be a medical home, clinics must be FQHC, use an evidence-based diabetes management program with the full scope of services, have formal referral arrangements with hospitals that have emergency rooms (ER) and offer after-hours care.

Physician-Directed Team-Based Approach

Clinical management of patients is conducted by a provider team, lead by a primary care physician (PCP) and consisting of a nurse educator, registered dietitian and a health educator. Some team members may be assigned to more than one clinic. The teams work with approved clinical guidelines and protocols as directed by the PCPs. Team members communicate with each other and the PCP leader regularly, most often in person, but also via conference calls, email and other communication methods, such as telemedicine applications.

Whole Person Orientation and Care Coordination/ Integration

Each new enrollee is assessed during enrollment for their health status, including clinical, educational and psychosocial aspects of their health. This assessment is done to risk-stratify the patients and determine the level of disease management intervention needed. Although only patients with diabetes and hypertension are enrolled, the program covers their inpatient, outpatient, dental and ancillary care. Patients are seen quarterly for routine follow up.

The team generates and arranges for referrals, referral tracking and follows up post referral. Specialty care referrals are done through a third-party administrator called *AmeriChoice*, which is contracted by the county. For non-medical referrals, such as social, support and community resources, patients may be directed to *2-1-1 San Diego*, a public service in the county.

The primary care physician has access to information that indicates the use of services from other network providers., and also has access to *Hospital-Elect*, a database that includes information on labs, imaging, ER, ancillary and physical and occupational therapy services used.

San Diego County identifies high-utilizers and places them in the *Project Dulce* disease management program.

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Self-Management Support for Chronic Conditions

San Diego County offers disease management through *Project Dulce*. The team is composed of a nurse educator, a registered dietician and a health educator. Disease management services include overall health and nutrition assessment, group health education classes on diabetes and hypertension self-management and treatment plans for patients. Nurses track and health educators monitor patient compliance with care plan goals, which may include behavioral, nutritional, exercise, self-monitoring and clinical follow-up interventions. The group education classes utilize American Diabetes Association accredited criteria and may incorporate peer educators, such as promotoras, for patients with limited English proficiency. The teams utilize educational materials to support self-management by patients. Individual sessions with team members occur when necessary.

Quality Improvement

A physician steering committee is established by the county to standardize clinical protocols and care of enrolled patients. *Project Dulce's* model of care for patients with diabetes, hypertension and hyperlipidemia includes treatment plans and assessments based on clinical performance measures and evidence-based clinical guidelines. Information and training is available to providers through written materials, classes and online tools. New programs such as medical assistant training are under development. There is direct oversight or intervention with PCPs by the medical director. Currently, there is no decision support software available to providers. However, the county utilizes extensive peer review performance and quality outcomes, utilizing HEDIS (Healthcare Effectiveness Data and Information Set) measures and claims data. Patient satisfaction surveys are conducted through *AmeriChoice* and the results are made available to the providers.

The county has also developed a quality assurance plan to manage and analyze patient encounters and clinic operations at the clinic level. Based on national benchmarks, hemoglobin A1c, LDL cholesterol and blood pressure measures are used. These results are provided back to the clinics.

Some clinics have disease registries (including CDEMS and PECS) that are connected to hospital emergency rooms. Others use Web-based portals to register patients and make follow-up appointments from the ER to their clinics. There are registries used for patients with diabetes, hypertension and hyperlipidemia, which are available to all providers.

There is a variation among clinics in terms of electronic patient records that are available to some providers. One example of *e-record* utilization is *i2iTracks*, a population health management software system. Referrals are made through *AmeriChoice* by fax, with calls as needed. There is no electronic prescribing at this time, although a pharmacy benefits management system is available. There is an *e-pharma* management system that generates prescription labels and allergies reporting called *Carepoint GuardianRx* Pharmacy Management System. Planning for an electronic health record (EHR) is also in progress countywide.

Access to Care

Patients can walk in to clinics or schedule appointments. Alternative modes of communication with a primary care physician include group visits, phone follow-ups and limited email communication. These alternative methods of communication are emphasized for the near future.

Patients may call a dedicated toll-free number for information or to set up appointments. There is no dedicated 24/7 nurse advice line. All clinics have after-hours answering service and nurse consultation. Physician consultation is available as needed for back-up. Extended hours and urgent care are limited to certain clinics.

Provider Payment

San Diego County pays PCPs on a global fee-for-service basis at $125 per visit. Specific provider incentives are not used at this time. Specialists are paid at an enhanced rate similar to the County Medical Services program rates.

Future Plans

Specific plans include:

- Partnering with hospitals and clinics to implement *Safety Net Connect*, a public-private partnership to electronically link hospital emergency rooms with FQHC medical homes.
- Increasing availability of extended hours and after-hours clinics.
- Organizing a *Care Coordination Work Group* consisting of county and private providers, and community health stakeholders to build the safety-net network in the area. These meetings include discussion and planning for clinic-wide EHR development and implementation.
- Working with the San Diego Medical Society Foundation to recruit new physicians and to expand the provision of free and/or discounted services to indigent populations in the county, including HCCI enrollees. *Project Access* is a part of this effort and offers surgery services at no cost to the patient.