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

The majority of care for the safety net population is provided by the Ventura County Health Care Agency (HCA). The HCA is an integrated health care delivery network that includes two hospitals (the Ventura County Medical Center (VCMC) and VCMC-Santa Paula), and the Department of Public Health (DPH) and the Behavioral Health Department (BHD). Outpatient services are delivered through three urgent care centers and 29 ambulatory care clinics (primary and specialty care), DPH health care centers and eight BHD clinics. Since the implementation of the Health Care Coverage Initiative (HCCI), HCA has also contracted with Clinicas del Camino Real which is a Federally Qualified Health Center (FQHC). It has nine clinics in the county that are now CI providers. In the second year of the program, Clinicas enabled the provision of dental services for CI enrollees. The HCA works with the various components of the agency to educate the community about the CI program known as ACE (Access, Coverage, Enrollment).

Personal Physician

There are 23 medical homes in the ACE program consisting of 14 primary care clinics and nine FQHC clinics. Individuals are assigned to the clinic upon enrollment to the program. When the patient calls their assigned clinic for a new patient visit, the clinic assigns them to a clinic that has room in their practice. The patients have the choice of remaining with that provider or choosing a new one. Assignment to a clinic is recorded in the electronic enrollment and medical record database maintained by the HCCI staff. The criteria for assigning enrollees to a medical home is: 1) where they live; 2) do they have a current provider; and 3) the closest provider. The county educates patients upon enrollment about the appropriate use of the medical home and its services, but does not enforce adherence to the assigned medical home.

Physician-Directed Team-Based Approach

Clinic teams consist of physicians, nurses and ancillary/support staff. There is also a registered dietician available to consult with patients who travels between clinic sites. Case management staff is assigned to specific clinic sites, and they are responsible for all communication, patient referrals and liaison activities with their clinics. There are five full-time case managers, one of whom is fluent in Spanish.

The Ventura County HCA instituted a collaborative process between the patient, the primary care physician (PCP) and the case management unit that includes assessment, care coordination and follow-up. Communication between the case managers and the providers is usually by fax and phone. The case management staff meets every two weeks with the ambulatory care medical director in-person to review cases. Oversight of cases is by the case manager, the clinical nurse manager and the ambulatory care director. All case management activities are documented and communicated to the PCP by phone or a visit to the clinic. If it is a complicated case, the case manager will meet the patient at their visit time with the PCP to ensure communication and follow-up as needed are accomplished.

There is also ongoing coordination with the VCMC discharge planning committee to ensure the successful discharge of ACE patients. The VCMC Internal Utilization Review (IUR) Committee is comprised of hospital discharge planners, social workers, physical therapists, occupational therapists, the hospitalist, fiscal staff, the director of nursing or designee, the
CFO, the ACE case managers and the ACE clinical nurse manager.

**Whole Person Orientation and Care Coordination/Integration**

The medical home is intended to coordinate all program services including specialty care, ancillary services and acute care. Each provider does their own referrals for their patients. Many of the specialty referrals go through a referral center that coordinates the referral process. The PCP arranges for care with other providers as well.

Many of the specialty referrals are documented in the VCMC Medi-Tech system; otherwise the consultation documentation is sent back to the provider by fax or through the internal mailing system. A registered nurse case manager calls every patient that utilizes the emergency room (ER) over the weekend. If it is a reason the PCP should know, the case manager will call the PCP. All ER visits are documented in Medi-Tech so providers have access to this information.

ACE patients fill out a medical questionnaire at the time of enrollment. This is used to determine the level of care needed by the individual and what support services, such as case management, they may require. There is also a health assessment done at recertification to determine preventive services utilized by enrollees and potential changes in health status.

Over 30% of ACE enrollees have chronic conditions, as self-reported on the health assessments. The conditions targeted for case management are diabetes, hypertension, chronic obstructive pulmonary disease, asthma and coronary artery disease. The case management staff also monitors the use of ERs via review of ER-based daily census or collaboration with ER staff to obtain names of high utilizers.

The ACE case management team developed their policies and procedures, forms, and criteria for referral in January 2008. Each member of the team is assigned to specific clinics, and the information, including policies and procedures, are disseminated to the clinics. Case managers also distribute resources such as glucometers, test strips and other materials. ACE services are outlined in the *ACE Program Case Management* newsletter that is sent biannually to all ambulatory care clinics and ACE enrollees.

**Self-Management Support for Chronic Conditions**

The case management nursing staff developed policies and procedures for the program, incorporating clinical protocols, and a telephone script for staff who contact patients. Thirty percent of enrollees in case management are Spanish-speaking only. The staff has a list of these enrollees and calls them on a regular basis determined by the patient’s needs—usually one to three calls per month. The case management staff works with enrollees via telephone or in-person at clinics. The registered dietician works with clients who have diabetes, coronary artery disease, hypertension, congestive heart failure, hypercholesterolemia, hyperlipidemia, obesity with co-morbidities and chronic kidney disease (non-dialysis), as well as those in need of education for a therapeutic diet, unexplained weight loss, and requiring weight loss as a condition for transplant consideration. The dietician instructs patients in the appropriate diet and nutrition to manage their condition.

Educational materials are either downloaded from reputable sites (such as Centers for Disease Control and Prevention (CDC), American Diabetes Association (ADA) or American Lung Association (ALA)) or prepared in-house. The case managers use *Healthy Interactions* developed by the American Diabetes Association and have received training on the use of this tool. The case managers also collaborate with the local chapter of the American Lung Association for education in adult asthma.

**Quality Improvement**

Quality of care measurement is based on HEDIS (Healthcare Effectiveness Data and Information Set) measurement and the use of claims data, but measurement activities are not yet implemented. The Ventura County HCA uses Medi-Tech claims data to review practice patterns, including utilization for labs and prescriptions. The Medi-Tech system does include some patient information if VCMC providers dictate it into the system. If a patient is hospitalized, or has labs or radiology, reports are also available.
The county uses Press Ganey Associates to conduct patient satisfaction surveys at ambulatory care clinics, although the surveys are not specific to the ACE program. Survey results are reviewed by the ambulatory care administration staff and shared with clinic managers and medical directors of the clinics. HCA also reviews enrollee complaints. The clinical nurse manager reviews complaints and works with the ambulatory care medical director to resolve issues.

Clinical decision support software was recently purchased from Milliman called Clinical Guidelines, but is not implemented yet. Providers have on-line access to clinical guidelines. The medical director has direct oversight of providers to encourage adherence to guidelines.

Some clinics utilize a PECS registry for diabetes; however, very few providers have entered the data. The county has centralized the data entry and will start entering the data into PECS by June, 2009.

For case management, the nursing staff plans to document patient data in an electronic application that is a homegrown system called Nursing Referral System. The system is being upgraded to address the HCCI program needs and will include a disease management component. This system will be effective this summer.

Electronic medical records and e-prescribing systems are not currently in place. The county is developing an e-referral system in conjunction with a Specialty Care Access Initiative grant from the Kaiser Permanente Community Benefit Program.

Access to Care

The Ventura County HCA monitors access to ensure that ACE enrollees are able to obtain an appointment in a timely manner; follow up appointments exceeding four weeks are considered to be outside of acceptable limits. Walk-in appointments are not available, but extended hours and urgent care are available at some clinics. The county does not have a dedicated phone line, 24/7 access to clinical advice or open access scheduling in every clinic. However, patients can obtain same day appointments for non-urgent care if appointments are available. Alternative modes of communication with providers are not available.

Provider Payment

A contractual relationship exists between the ACE program and each medical home. The reimbursement mechanisms for the ambulatory primary care clinics are tied to VCMC and are fee-for-service. The nine FQHC clinics are reimbursed $110 for each primary care and/or dental visit. Incentives are not used and payment for specialists is not enhanced.

Future Plans

Specific plans include:

- A disease management program for ACE is under development. There is a chronic disease management committee, and they are considering naming a director to work more closely with the community.
- An electronic referral system is under development for specialty care access through the Kaiser Permanente Specialty Care Access Initiative.