INNOVATION IN HEALTH CARE AWARD

SIERRA NEVADA MEMORIAL HOSPITAL: INTEGRATED CARE COORDINATION FOR FAMILY WELLNESS

Sierra Nevada Memorial Hospital (SNMH), FREED (an Aging and Disability Resource Connection), Community Recovery Resources (CoRR), and the Western Sierra Medical Clinic (WSMC) came together to create the Integrated Care Coordination for Family Wellness partnership. The partnership connects providers across the continuum, including community-based organizations providing services and supports through navigation services and care transitions coaching using the Coleman Care Transitions Intervention (CTI). Beginning in the hospital or clinic setting, CTI links medically at-risk individuals in the community to needed services. This includes behavioral health, disease management and prevention, primary care, and substance use disorder treatment. By improving access and coordination, the partnership strives to achieve better health outcomes, lower readmission rates, and lower overall health care spending.

RESULTS

- Over 700 individuals served in the first half of 2017.
- Increased access to primary care, behavioral health services, and specialty care.
- Average wait times for an appointment at WSMC reduced from five days to three days.
- Improved individuals' self-sufficiency to manage their own care needs after hospital discharge.

SIERRA NEVADA:

"By having multiple partners that serve this high-risk population, it is truly a community-wide effort that is capable of achieving greater, lasting results."

INSPIRATION

Medically at-risk individuals, such as those with chronic illness, complex conditions, chemical dependence, or low income are often high utilizers of health care services – including hospital care – and account for a significant portion of health care spending. These individuals experience poorer health outcomes than others, especially at the time of hospital transition when additional services and supports are needed to reduce complication risks.

The partners recognized an opportunity to work together to develop and implement a coordinated care transition intervention that proactively links individuals to the services and supports required to go from the hospital to home, or to prevent the hospital stay altogether by linking to the necessary support while in the clinical setting and decreasing complications.

ORGANIZATIONS INVOLVED

The partnership began in 2012 with SNMH and FREED. In 2014, seeking to incorporate additional care settings and services as well as to reach a greater number of high-risk individuals, the partnership grew to include CoRR and WSMC.

PARTNERSHIP STRUCTURE

The partnership is a grant-based relationship, in which SNMH has provided a grant to the other partners involved to participate in the program. The grant was initiated by SNMH's community grant program, which aims to provide grants to selected organizations to develop collaborative partnerships that enhance the continuum of care for populations with high needs. Though the grant program typically provides annual grants, SNMH chose to award a multi-year grant for this partnership, recognizing the time required to build relationships and integrate services. Through the grant, the partners enter into an annual grant agreement. This agreement requires the community partners to provide quarterly and final reports to SNMH.

MODEL DESIGN

The key goal of the intervention is to streamline and coordinate access to the services provided by each of the partners involved. To do this, SNMH and WSMC first identify eligible individuals. Once identified, FREED and CoRR work together to coordinate services and deliver needed services. CoRR provides services for substance use disorder treatment, including Medication Assisted Treatment (MAT) and mental health services. FREED provides CTI coaching and navigation, linking individuals to behavioral health care and aging and disability long-term services and support. FREED also provides individuals with services such as application assistance, disease prevention management, medication self-management guidance, and personal health record development.

When needed, WSMC provides primary care services. WSMC and CoRR have even developed a co-location by adding primary care to the CoRR campus to further coordinate care delivery. By doing this, the partners seek to reduce the wait times for individuals requiring primary care services in the intervention.

FUNDING MECHANISM

The primary source of funding for the partnership comes from the community grant program that SNMH awards to the partners annually. This community grant program is derived from the hospital's community benefit program. Though the services provided through the partnership utilize fee-for-service reimbursements (e.g., Medicare), when possible, the intent of the grant funding is to look beyond reimbursable services to meet the needs of the individuals served.

LESSONS LEARNED

- Having partners educate one another on their services and expertise builds more options for the collective care they provide individuals.
- Creating standardized forms leads to efficiency and good communication between partners.
- It is essential to identify key contacts for each partner, as well as establish a clear feedback loop, which allows for consistent and frequent communication among partners.

FUTURE

To achieve future growth, the partners are pursuing sustainable funding sources through contracts with additional health care entities, such as health care payers. To gain the interest of these entities, the partners are currently working to improve the data collection and analysis process of the intervention, seeking to tie reduced readmissions and other outcomes to a potential return on investment.