California Health Improvement Project (CHIP)
A Community Health Strategy for the Safety Net

Melissa Marshall, MD
Community Health Center Network, Alameda County, California

Problem Statement and Underlying Causes

Consistent with national trends, a disproportionate share of health care dollars in Alameda County are used to provide care for a relatively small population. In terms of CHCN members, 4% of patients account for 50% of total expenditures. Costs are concentrated in patients that have 1+ hospital admission and 3+ chronic conditions.

Project Description

Community Health Center Network will optimize centralized data analytics and quality improvement efforts so that health care can be appropriately dosed. A Community Health Strategy will be developed to encompass Integrated Behavioral Health, Care Team Transformation, Care Transitions, and an Intensive Outpatient Care program called Care Neighborhood.

Goal and Objectives

Goal: Centralized data analytics will support coordinated care of high-cost patients in more appropriate health care settings.

Output-oriented Objective:

1. Develop a Care Transitions workflow to identify hospitalized high-risk members for high-touch by March 2013.
2. Identify patients at risk for future utilization by April 2014.
3. Enroll 500 patients in Care Neighborhood by June 2015.

Outcome-oriented Objective:

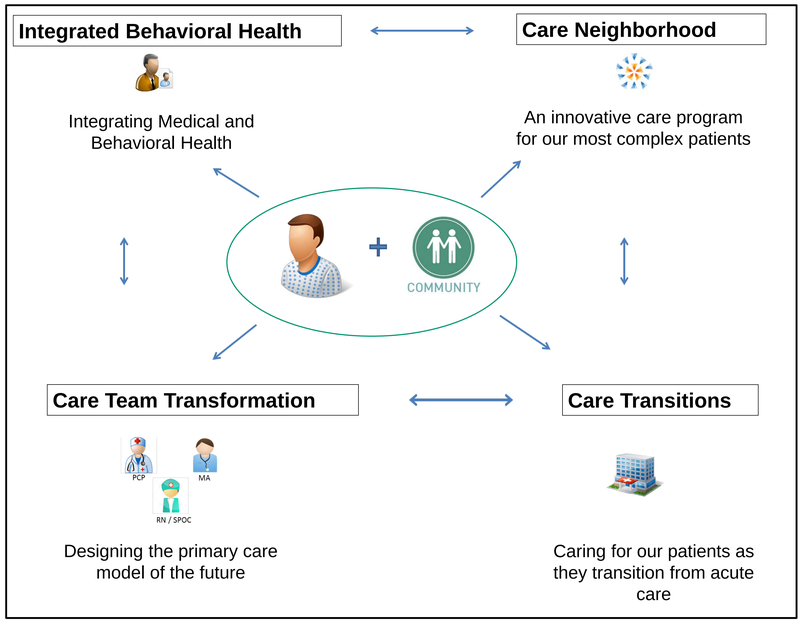
1. Through Care Transitions, reduce hospital readmission rate by 10% by May 2014.
2. Reduce monthly cost of each targeted Care Neighborhood member by 8.6% or $242 per month by month 12 of enrollment.

Outputs & Outcomes

Outputs Achieved

1. Sutter Community Benefit funded three RN Case Managers for Care Transitions at Asian Health Services, Lifelong Medical Care, and La Clinica in March 2013; 2573 Care Transitions managed in year one.
2. More than 500 clinicians were trained in evidence-based behavioral health treatment modalities in two years.

Our Community Health Strategy



Outcomes Achieved For Care Transitions

32% Increase in PCP Follow-Up in 30 days
17% Decrease in ER Use in 30 days
17% Decrease in 30 day Readmissions

Outcomes Achieved For Care Team Transformation

An improvement in 1.3 visits per day for each provider led to $291,491 in increased revenue annually for pilot clinic.

Lessons Learned

Current payment models do not incentivize community health strategies.

Health Centers need more training around changes in healthcare and how to manage a panel which may include potentially unengaged members.

More research could direct which sub-population of the high-utilizers could be impacted most by interventions.

About My Organization

The Community Health Center Network is a partnership of community health centers committed to enhancing our ability to provide comprehensive, cost-effective, and quality care to Alameda County residents through care management and practice improvement.

Our eight health center organizations care for 175,000+ patients at 70 sites including 30 primary care clinics. 100,000 of these patients are managed through Community Health Center Network as the management services organization.

Contact Me

For more information, contact me:

Melissa Marshall, MD
mmarshall@chcnetwork.org

CHCF HEALTH CARE LEADERSHIP PROGRAM

To learn more about CHCF go to:
http://futurehealth.ucsf.edu/