

ACCEL

ACCESS EL DORADO
Health Care Access That Works. Simpler. Better.

Hospitals:

Barton Memorial & Marshall Medical

Clinics:

El Dorado County Community Health, Barton Community, Divide Wellness, Tribal Health, Marshall Physician Services, Tahoe Family Physicians

County:

Department of Public Health & Department of Mental Health



About El Dorado County



- Situated in East Central California's Sierra mountains
- Topographically two zones: Lake Tahoe Basin & Western Slope
- Approximately 178,000 people

ACCEL Care Pathways

ACCEL has developed six Care Pathways to improve access to medical care for children. These pathways are:

- Securing Newborn Health Care Coverage
- (Newborns) Utilizing a Medical Home
- Securing Health Care Coverage
- Annual Eligibility Review (Insurance)
- Obtaining a Medical Home
- Pediatric Mental Health Consult

Community Health Workers assist each person entering a pathway. The Community Health Worker acts as a personal guide and advocate for their client, assisting them to overcome barriers to health care, providing health information, and working with medical establishments on behalf of the client. Patient hand offs occur seamlessly between agencies depending upon where a patient is in a given pathway. Standardized steps with patients are understood and agreed to between partner agencies.



ACCEL's phased strategy for Health Information Technology

▶ Phase 1: Care Pathways

- Serves children at or below 300% FPL with emphasis upon access to care issues for the un/ underinsured
- Outcomes-driven cross agency Patient Case Management program
- Web technology in use countywide
- NPP implemented simultaneously

➔ Phase 2: (EMPI) Electronic Master Patient Index

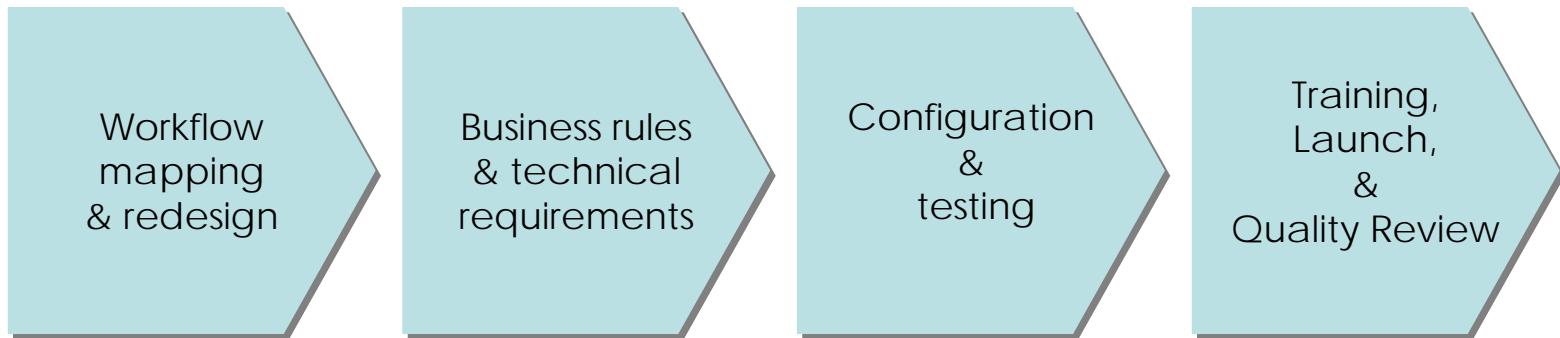
- Demonstration project 2008 with initial demographic data sharing
- Supports pre-population of patient demo data into Care Pathways & more efficient patient registration experience
- Supports NPP patient status tracking and will support HIE connectivity
- Necessary Privacy & Security policies and procedures effected

➔ Phase 3: Health Information Exchange

- Business Case completed and high level clinical data identified
- Steering committee actively engaged
- Technology alternatives explored
- 1st Gen demonstration project explored
- Will serve all El Dorado County patients

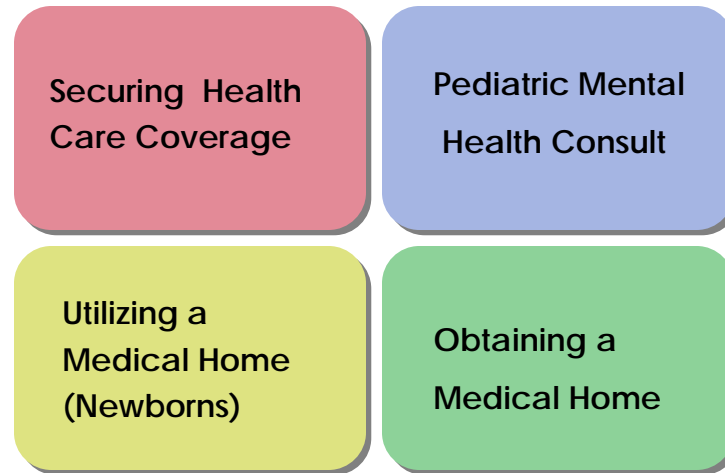
Converting pathways from paper-based system to shared electronic records

Multi disciplinary team from ACCEL's participating organizations, staffed by project managers with technical expertise, was formed to oversee development and implementation of electronic pathways



ACCEL Steering Committee adopted policies and procedures developed by Privacy and Security workgroup, including common language for NPP.

Care Pathways Dashboard



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- ACCEL Dashboard offers a 30,000 ft view
 - Each Pathway is distinct: the problem addressed, the clients served, the outcomes measured, completion timeframes vary due to the complexity of the problem being addressed
 - Detailed trending QA reports to support (agency site issues, user compliance, etc.) will be available beginning in October



Securing Health Care Coverage (WS & SLT) 89% completed successfully

Demo Start	May 2006
Client Criteria	Birth - 18 years, <300%FPL
Referral Source	Clinics, ER, Schools, 1-800
# of Clients	1451
Outcome	Insured in MediCal, Healthy Families, Healthy Kids CAL Kids, Kaiser
% Successful	89% (1291 kids)
Pending	6% (82 kids)
Barriers □	Moved out of area, no consent, lack of follow thru



Pediatric Mental Health Consult

51% completed successfully

Demo Start	January 2006
Client Criteria	MediCal, Healthy Families needing MH consult
Referral Source	ACCEL provider network
# of Clients	77
Outcome	MH initial and MD assessment, consult report to referring provider
% Successful	51% (39 kids)
% Unsuccessful	33% (26 kids)
Pending	16% (12 kids)
Barriers □	Family preference (refuses MH), relocated, out of county MediCal



(Newborns) Utilizing a Medical Home

56% completed successfully

Demo Start	January 2007
Client Criteria	No-Doc newborn, first time mom on MediCal
Referral Source	Marshall OB
# of Clients	142
Outcome	Medical home with 4 well baby visits, 3 Izs in 8 month time frame
% Successful	56% (80 infants)
% Unsuccessful	16% (22 infants)
Pending	28% (40 infants)
Barriers □	Moved out of area, no consent, lost contact

Obtaining a Medical Home

83% completed successfully

Demo Start	August 2006
Client Criteria	Pediatric non urgent pt presenting at ER w/o home
Referral Source	Marshall ER
# of Clients	294
Outcome	Medical home secured w/1 visit post ER for kids >1
% Successful	83% (244 kids)
Pending	4% (9 kids)
Barriers □	Parent doesn't respond to msgs; no shows at clinics; no parent follow through, moved out of county

Lessons Learned from Care Pathways

It's hard, it takes time: and now collaboration is the norm.

- Solid upfront commitment from senior leaders is essential
- Educate, communicate, educate, communicate -- it's a continuous process
- Transparency and allowing for airing differing views helps build a team
- Decentralized implementation model focusing on common outcomes goals respects differences among participants
- Clearly defined workgroup charters, processes, and processes for issue escalation helps manage scope creep
- Approaching work incrementally helps to mitigate the "overwhelm" factor

Winter can make travel tough!



Care Pathways is a methodology which promotes working together



We need to squeeze, ferment, and share!



Thank You

ACCEL

<http://www.accedc.org/index.asp>

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