Linkage Mapping Items – June 11 Team Discussion Outputs

June 11, 2015

Area of Focus	Trkg. #	Item Name	Item Description	Recommendations, clarification, guidance	Target Measures
Prevention [Transitions of Care]	28	Clinical Pharmacist	Have pharmacist ingrained throughout health care system to improve patient outcome, improved utilization of resources (ex: Coumadin management, insulin titration, hypertension, poly pharmacy, medication titration) opiate tapper program.	1. Opportunity to seed the program. 2. Staffing model to include pharmacy students. 3. Who would employ? 4. Provide customer / patient education. 5. Initially define scope of program.	1. Improve clinical outcomes (hypertension, diabetes). 2. Provider efficiency. 3. Patient satisfaction.
Communica-tion & HIE	27	Primary Care Access	1. Lack of PCP, unknown PCP, change of PCP. 2. OHA demographic info is not correct (clinics can not outreach appropriately) 3. System navigation by clients. 4. Communication internally (CCOs, Clinics). 5. Communication externally (to clients & partner organizations)	1. OHA demographics info should be overwritten by locally captured info (currently happens backwards). 2. ED / Urgent Care navigators for PCP assignment and knowledge of system. 3. Workflow: "no wrong door" at CCO to get answers re: PCP, BH, dental care. 4. 211--strengthen system for navigation and referral, data input. 5. APM for PCPs.	1. Patient satisfaction (CAPHS) survey. 2. Use of 211 system. 3. ED utilization data (frequent flyers, low acuity)
Communica-tion & HIE	288 & 467	Each patient has a shared care plan managed by the primary care provider team and involving all care providers.	Patients are served best when all care providers are aware of treatment / needs and when patients aren't put in the position of having to coordinate. Coordination allows whole process to move more smoothly (better efficiency and productivity).	1. Key to be involved: EDs, primary care, social service, patients, CCOs. 2. Keep it simple for patients and providers. 3. Test and share.	1. Map the process (how may steps does it take patient from point A to point B?). 2. Is process simpler? How many participants does it have? 4. Patient satisfaction with process. 5. Number of duplicated services patient uses (look at baseline).
Communica-tion [Behavioral Health]	358, 480, 487, 47	Better Communica-tion Between Suppliers	Important information that is not being conveyed to proper channels. It is important information. Incentive to communicate.	Make me more interested in doing it. Barriers preventing from doing it. It isn't convenient for health providers to communicate.	1. Measurement incentives put in place and track them. 2. Receivers of communication and how

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					satisfied are you. 3. Identify 3-5 barriers that prevent communication. 4. Senders info--how easy was it for them?
Transitions of Care	445	Lack of patient engagement with primary care provider following hospital discharge or ED visit	1. Lack of timeliness post hospital discharge in obtaining hospital records. 2. PCP experiencing delays in receiving records. 3. Patient's demographic changed and difficult to locate post discharge. 4. Limited PCP appointment availability. 5. Standardizing follow-up appointment scheduling.	1. Case managers / CHW to attend follow-up office visit with patient. 2. Standardize in hospital bylaws discharge planning (completion of discharge summary in 24-48 hours). 3. Have a designated provider(s) with open access appointments to see unassigned patients with in 5 business days.	1. Readmission rates. 2. Timeliness of discharge summaries. 3. Completion of discharge summaries.
Navigation & Coordina-tion 2	468, 520	Diabetes Management	1. No payment models. 2. Billing codes: can use case management code but not diabetic education code (for non-diabetic nurse). 3. Lack of community-wide diabetes education. 4. Lack of coordinated diagnosis [specific] management [of] care.	1. PMPM 2. APM for care of diabetic (and chronic diagnoses) patient. 3. Public Health (other agency) education model. 4. DME focus of care at CCO or other entity → savings with DME, direct care to client. 5. Comprehensive disease management (define teams). 6. CHWs--environmental scan.	1. APM. 2. Health outcomes: A1Cs, ED utilizations, diabetic complications. 3. Patient engagement and satisfaction. 4. Lower costs for population
Navigation & Coordina-tion 1	9	Prior Authoriza-tions Inefficiencies and Referral Workflows	1. Access to care: Improvements by reducing barriers in timely access to care -- inefficiencies, redundancies, multiple payors → different rules. 2. PCP perspective → a matter of trust with payor to make right decisions vs. $ motivated.	1. Plan needs to understand provider level data and specific targeted actions vs. generalized policy / rules. 2. Plan target timely access and closure of open referrals as measure of performance. 3. Use combined data triggers of many	1. Referral type and length of time to closure (days). 2. Decrease cost of medications. 3. Decrease staff cost spent in redundancies. 4. Value/impact of waiting

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			3. Payor perspective → reduce cost, create rules for few abusive behaviors and applied to whole. 4. Reduce transportation, wait, anxiety, multi-step transactions. 5. Unknown ability to manage patient expectations and mismatch.	events to auto-authorize (algorithm development). 4. PCP and Plan get clear about medication authorization and why. 5. Explore uncovered benefits -- lower cost providers, pain management, ex) massage therapy. 6. Multi-stakeholder [design] team; (plan, provider, patient) id hot spots and establish standard (best practice) educate patients and providers about standard. 7. Develop specialty capacity and invest in areas that are restricted by building natural competitors and or extend skills with PCPs to address shortage.	track patient decision in alternate points of care, i.e. hospital while waiting. 5. Patient and provider satisfaction.