C.A.R.E. Clinic

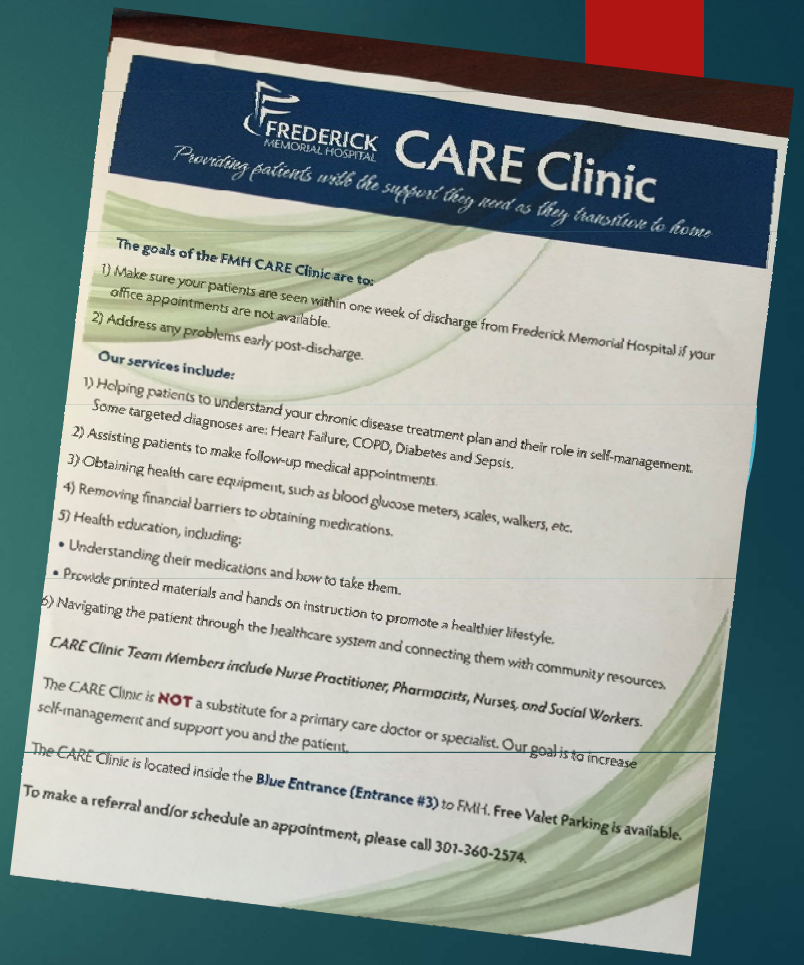
SEPTEMBER 2016

The CARE Clinic is:

- An environment in which individuals who are high risk can safely transition from the hospital to the community

- A clinic setting in which individuals with chronic conditions can receive comprehensive high quality and affordable services from our multidisciplinary team
  - Focus on PQI diagnosis
  - Avoiding admissions and readmissions

- Provide care and services that are patient centered and integrated across sites of care:
  - ED, Inpatient, PCP, Dental Clinic, Mission of Mercy, FCAA clinic, etc.



Who are our patients:

- Mix of chronic conditions and “high risk” discharges
  - Heart Failure
  - COPD
  - Sepsis
  - Diabetes
  - “other”
- Medical follow up, medication management, navigation and care coordination, and disease management education for improved self management

Expectations and Outcomes

- Clinic "go-live" February:
  - Concentrated effort on increasing services for high risk populations
  - Formalized coordination with community providers
  - Implementation of billing processes
  - Planning a transition to NextGen to better support workflow and practice operations.
- Average capacity is 12 patients per day; however can vary depending on the "mix"
- 35% "no show/cancelation" rate
- 4.8% 30 day readmission rate for patients seen in the clinic *(overall RA rate for FMH = 9.52%)*

What's next:

- Education to community providers with high rates of *PQI* visits to encourage the use of the Clinic for support beyond medical management
  - Work with FIHN care managers to encourage use of CARE Clinic for education, medication management etc. – collaboration with physician
- Expansion of CARE Clinic thru grant support:
  - Mobile clinic – High Utilizer and or under served areas such as Brunswick, Thurmont, Motter Avenue low income senior living apartments
  - Support adding additional team members, including a dietician or CDE and behavioral health/substance abuse specialist
  - Integration of Community Health Workers
- Would like to see more community referrals to the clinic for education and coordination of services – particularly focused on PQI diagnosis
  - Approximately 98% of referrals to the clinic are generated from the care management team