Regional Center for Border Health, Inc.
San Luis Walk-In Clinic, Inc.

“Community-Based Family Care Coordinator & Inter-Professional Patient Centered Care Model Initiative”

Amanda Aguirre, President & CEO
40th Annual Rural Health Conference
August 21, 2013
Prescott, Arizona
“Committed to improving the quality of life of the residents along the U.S.-Mexico Border by increasing accessibility to quality training and affordable healthcare”
Mission: “Provide convenient access to efficient and quality health services to the border region, including provision of medical diagnosis, care and treatment to and for the benefit of the communities and residents of the Southwestern Arizona border region, including, without limitation, persons who are unable to afford such services”
SLWIC Medical Home
Primary Care Center

The SLWIC defines “medical home” as primary medical care that is accessible, continuous, comprehensive, family/patient-centered coordinated and compassionate care that is culturally and cost effective.
Community-Based Family Care Coordinator
Integrated Centered Patient Care

Evidence Based
Continuity of Care
PCP

Patient Continuity of Care
Pt. Appointment Schedule w/Primary Care Provider
"Medical Home" Visit

Community-Based
Patient Centered Care
"Medical Home"

Case Management
Medical Records and Patient Follow Up

Health Education
Disease Prevention and Control
Group & One to One Education
SLWIC Interprofessional Training Program

Family Medicine

Community-Based Patient Centered Care “Medical Home”

Family Care Coordinator

Pediatric

OB/GYN

Family Care Coordinator

Social Work

Pharmacy

Family Care Coordinator

Mental Health

Community Health Mobile Unit (Mental Health, Cocopah Indian Reservation)
RCBH/SLWIC Family Care Coordinator Curriculum Training 2011
(4-week training/120 hours)

• Promotora de Salud – 100 hours
• Patient Navigator - 120 hours
• Direct Care Worker/Caregiver 100 hours
  • Direct Care Worker Program licensed by AHCCCS
• Stanford Chronic Disease Self Management Program – 40 hours
Care Opportunities and Follow Up Community Outreach

• Perform care coordination of High Risk Target Groups
  • EPSDT
  • Women’s Health
  • Heart Disease Prevention (Hypertension/Cholesterol)
  • Diabetes
  • Asthma (asthma camp)
  • COPD patient care
Care Opportunities and Follow Up
Family Care Coordinator

- Hospital Discharge Team coordination
- Patient follow up
- Home visits
- Wireless note pad to make onsite follow up appointments
Goal: Reduce Medicare Inpatient Admits/1000 by 15%
Status: Goal met, reduced by 45%

<table>
<thead>
<tr>
<th>SAN LUIS MEDICARE ADMISSIONS (HOSPITAL)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Since Inception</td>
<td>Prior Total</td>
<td>Current Total</td>
</tr>
<tr>
<td>Raw Admissions</td>
<td>38</td>
<td>22</td>
</tr>
<tr>
<td>Admits/1,000</td>
<td>360</td>
<td>197</td>
</tr>
</tbody>
</table>

Medicare Admits/1,000 Result to Date Meeting Goal -45.3%

<table>
<thead>
<tr>
<th>SAN LUIS MEDICARE DAYS TOTALS</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Since Inception</td>
<td>Prior Total</td>
<td>Current Total</td>
</tr>
<tr>
<td>Raw Days</td>
<td>162</td>
<td>128</td>
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<tr>
<td>Days/1,000</td>
<td>1537</td>
<td>1146</td>
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</table>

Medicare Days/1,000 Result to Date Meeting Goal -25.4%
## Inpatient Readmissions

<table>
<thead>
<tr>
<th>Inpatient Readmissions</th>
<th>Medicare</th>
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</thead>
<tbody>
<tr>
<td><strong>30 Day Re-admits</strong></td>
<td></td>
</tr>
<tr>
<td>Previous 12 months</td>
<td>10</td>
</tr>
<tr>
<td>Current 12 months</td>
<td>6</td>
</tr>
<tr>
<td>Goal Change - 20%</td>
<td>-40.0%</td>
</tr>
<tr>
<td><strong>60 Day Re-admits</strong></td>
<td></td>
</tr>
<tr>
<td>Previous 12 months</td>
<td>11</td>
</tr>
<tr>
<td>Current 12 months</td>
<td>6</td>
</tr>
<tr>
<td>Goal Change -50%</td>
<td>-45.5%</td>
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<tr>
<td><strong>90 Day Re-admits</strong></td>
<td></td>
</tr>
<tr>
<td>Previous 12 months</td>
<td>13</td>
</tr>
<tr>
<td>Current 12 months</td>
<td>6</td>
</tr>
<tr>
<td>Goal Change -50%</td>
<td>-53.8%</td>
</tr>
</tbody>
</table>
# Economic Impact

## Family Care Coordinator Initiative

<table>
<thead>
<tr>
<th>Care Opportunities at San Luis Walk-In Clinic, Inc.</th>
<th>Estimated Economic Impact on Clinic Increased Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Access to Care</td>
<td>$84.49 x 4,264</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Outreach and Follow Up</th>
<th>Estimated Economic Value of Avoided Costs For Medicaid and Medicare Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Avoidable Hospital Admissions &amp; Readmissions</td>
<td>$11,400 x 49</td>
</tr>
<tr>
<td>Reduce Non-Emergent ER Visits</td>
<td>$430 x 255</td>
</tr>
</tbody>
</table>

**TOTAL (Avoided Cost)**: $668,250.00
Problem: How to View 3 Data Sets: Clinical + Lifestyle + Psycho-Social?

- Easy to understand, all data on one page
- Many years, months, weeks, or days of data viewable at a glance
- Web access for authorized users, 24/7
- Ability for patient and family caregivers to self-manage
- Management able to measure outcomes
Not only useful for the Family Care Coordinator / Community Health Worker

✓ Physicians, Specialists, Pharmacists, RNs, and the rest of the care team who may be overloaded with work

✓ View background information not normally captured or easily displayed in a clinical EHR

✓ Clinical + Lifestyle + Psycho-Social tells the patient story