Care Transitions in Oregon's Aging and Disability Resource Centers

Who

The Multnomah County Aging and Disability Resource Center (ADRC), which is part of the Oregon Wellness Network (a network lead entity/community hub), partners with Providence Health System to offer hospital-to-home transitions in four counties (Multnomah, Washington, Clackamas, and Yamhill), as of 2021.

What

Multnomah County ADRC uses the CTI® Model for their care transitions program. Each participant is matched with a care transitions coach who provides services based on the program model. The transition coach team includes social workers, case managers, and health coaches, all of whom are trained on the intervention model. The hospital pays a fixed fee for a 30-day care transition intervention and Multnomah County ADRC receives full compensation for every eligible person they provide care transition services for, regardless of their readmission status. The hospital continually reviews the program outcomes and performance. Multnomah County ADRC presents the following outcomes and process measures to the hospital: 30-day readmission rate, as well as number of persons offered, who accepted, and completed the program.

How

During their participation in the CMS Community-based Care Transitions Program (CCTP), Multnomah County ADRC realized they could not be as effective in their role supporting safe transitions without access to the electronic health record (EHR). Subsequently, they included the requirement for continued access to the EHR in all negotiations and contracts with the hospital administration. Now, the care transitions coaches have remote "read only" access to the EHR, which is managed by Providence Health System. They are trained to access the EHR on a need-to-know basis (e.g., only information regarding the patient's care) and the use of the system is continually monitored by Providence.

One of the biggest challenges Multnomah County ADRC faces is developing a community-based information technology system that integrates with the health system and physician-based EHRs, which is beyond the scope of most community-based organizations (CBOs). To help address this challenge, the ACL transitions technical assistance (TA) team has been working with the Oregon Wellness Network (OWN) and Comagine (the quality improvement organization) to support the CBO network with social care referrals. Unite Us was identified as the primary technology solution for referrals to address social determinants of health (SDOH). However, OWN and Comagine identified multiple issues with the Unite Us platform and met with Unite Us to discuss these shortcomings. As a result of the meeting, Unite Us committed their Oregon leadership team, including IT development staff, to participate in monthly meetings with the CBO network to co-design the operational flow of SDOH referrals and the role of the technology. Unite Us and the CBOs will also modify the user functions of their platform and establish workflows to maximize the opportunity for CBOs to secure reimbursement for social care services.

Where

Multnomah County ADRC and OWN would like to offer the same care transitions program model to hospitals statewide. The ACL transitions TA team is assisting OWN in expanding the current care transitions contract with Providence Health System across the state and is exploring any potential application of return-on-investment analysis to this work.