How one FQHC Utilizes ADT Notifications to Support Enhanced Care Management and Improve Care for Vulnerable Populations

Background

Aria Community Health Center (ACHC) is a 20-location, federally qualified health center (FQHC) and Enhanced Care Management (ECM) provider committed to increasing access and improving the health and wellness of underserved and vulnerable patient populations. ACHC achieves this mission by providing personalized, high-touch patient care that addresses individual needs with respect, courtesy, and quality service throughout Fresno, Kings, and Tulare counties.
ACHC goes the extra mile to ensure that their patients get the resources, touchpoints, and follow-up care needed to positively impact their quality of life. The care coordination they provide includes meeting high-risk patients at the hospital if they are admitted so that their care managers can ensure the patients feel supported and get the care and community resources they need. ACHC also partners with the County of Fresno Public Health Department to advance health literacy programs within rural communities and runs a mobile clinic for patients who may not have access to a primary care provider or reliable transportation.

To provide this high-touch, personalized, and coordinated care, ACHC needed more timely and in-depth health information on their patients. ACHC needed a faster and more reliable way than the traditional method of faxing or relying on health plan data to know when their patients were admitted, discharged, or transferred from hospitals. They also wanted more insight into their patients (e.g., lab reports, medication history, and prominent health conditions), especially to address the clinical and non-clinical needs of ECM patients, who require a high level of care coordination from a network of clinical and social service providers.

Solution

ACHC joined the Manifest MedEx (MX) network in April 2022 to access admission, discharge, and transfer (ADT) notifications through MX Notify and longitudinal patient health records through MX Access. ACHC has utilized the MX suite of tools to improve their workflows and provide more timely and better coordinated care for both their ECM population and their full roster of patients.

Enhanced Care Management

ACHC works with two Medi-Cal plans, who are also members of the MX network, to determine an MX Notify patient panel specific for their ECM population. MX ensures ACHC is notified through MX Notify if one of these patients is admitted, discharged, or transferred from a participating hospital, helping to support transitional care, a core service component of ECM.

Receiving real-time ADT notifications prompts the ECM team to send a case manager to the hospital where the patient is being admitted, allowing for in-person, face-to-face interaction with the ECM team, the hospital care team, and the patient. In cases where the case manager is unable to travel to the facility, they follow up immediately by phone.

ADT alerts also help ACHC ensure their patients are accessing care at the appropriate facilities to manage unnecessary ED utilization. For example, the ADT notifications have helped enable case managers to meet patients in the ED, redirect them to outpatient care as needed, and connect patients to additional resources, all while reducing costs associated with high ED utilization.

A Patient Impact Story

A patient with substance abuse disorder and congestive heart failure (CHF) was making almost weekly hospital visits due to patients drug abuse exacerbating his CHF.

Through ACHC's ECM panel in MX Notify, the case managers received real-time notifications each time the patient was admitted, allowing the case managers to meet him almost immediately.

This resulted in multiple opportunities to build rapport and trust with the patient, so much so that he went into rehab and has been stroke-free and sober for 8 months.

ACMC leverages the information in MX Access to improve patient engagement, a core service component of ECM. Because care managers and providers have access to longitudinal patient records, they are able to have sensitive and compassionate conversations (e.g., avoiding asking patients to discuss past traumatic events), fostering trust, and improve patient engagement. They also use MX Access to find up-to-date patient demographic and contact information, which helps them more successfully engage patients and provide more culturally and linguistically appropriate care.

ACHC also runs a mobile clinic to serve rural populations where patients may not have access to a primary care provider or reliable transportation. At these clinics, community health workers use information from MX Access to identify patients who are eligible for ECM and provide education on their benefits. As case managers continue to build those relationships and trust within rural communities, these interpersonal interactions have improved health outcomes, addressed health equity, and closed care gaps for an underserved and under-resourced population.

Full Patient Roster

In addition to the ECM patient panel, ACHC configured a MX Notify panel for their full patient roster to aid in discharge planning. This roster includes patients already connected to an ACHC provider and those that have an established relationship with the case management team. These alerts help ensure there is follow-up after the patient is discharged.

Next Steps

As ACHC continues to enhance care coordination and discharge planning for their patient population, case managers have witnessed progression in patient health literacy, (e.g., understanding the difference between emergency room, urgent care, and outpatient care), enhanced rapport and trust within patient-provider and provider-case manager relationships, resulting in a better patient experience and outcomes; and supported navigating additional services, whether in-person or over the telephone, so that patients get the care and resources they need.

"Sometimes patients feel forgotten and react by not complying with their care plan. Real-time ADT notifications have been extremely helpful in allowing case managers to connect with patients, build trust, and effectively coordinate care. In most cases, these small alerts lead to a saved life and a higher quality of care."

-Samuel Griffith, MHA, ECM/ CS Program Manager

For more information on how federally qualified health centers (FQHCs) can utilize ADT notifications to improve care coordination and post discharge follow-up, please visit us at www.manifestmedex.org or contact us at info@manifestmedex.org.