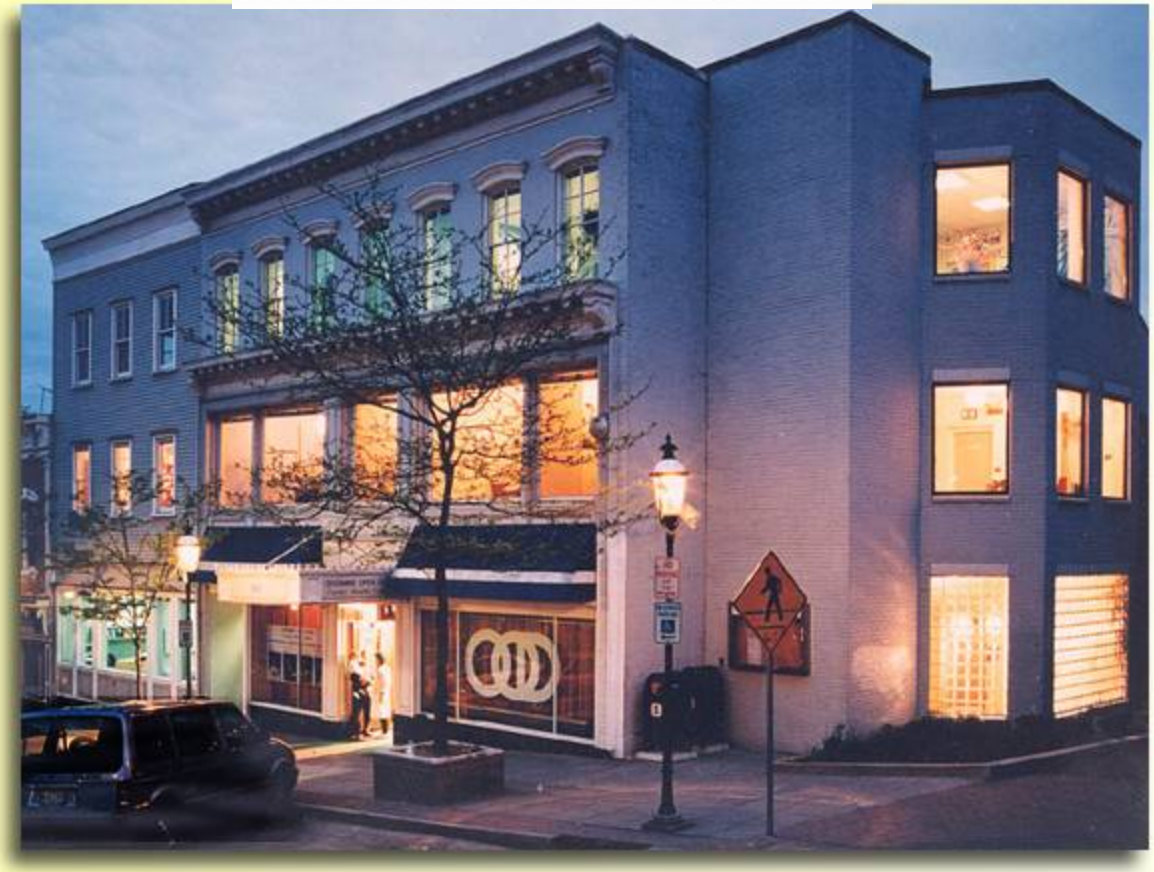
Open Door Family Medical Center Integration of CSP in a Community Health Center's Patient Centered Medical Home Model

OPEN DOOR
FAMILY MEDICAL CENTERS



Ossining - Sleepy Hollow - Port Chester - Brewster
Mount Kisco

History in the Community for Thirty Years

A free clinic in 1972 in a church basement, Open Door has welcomed tens of thousands of Westchester residents into their facilities.

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Open Door Family Medical Centers is a not for profit Community Health Center located in Westchester County New York.

We serve 40,000 clients annually in five communities and five schools providing Primary Medical Care, Dental, Nutrition, Mental Health, Confidential HIV Counseling and Testing, and HIV Care Management and Ob/GYN Services.

Our clients are poor with 66% living below the poverty line.

Open Door's History

- In 2002 Open Door implemented a Chronic Disease Case Management (CDCM) program that embeds specially trained "care model process leaders" (they are now called patient Advocates) into patient care teams at each site. These patient advocates utilize their expertise in chronic disease management and performance improvement to support care teams at the point of care; they also provide case management services and patient education directly to patients and have time to spend with patients and their family members. In this way they are an interface between the patient and the provider assessing and enhancing the patient's health literacy and ensuring that care is indeed patient centered.

- Originally these services were designed for Diabetes patients and were then expanded to patients with Asthma, Hypertension and Cancer Screening.
- The care team was using an electronic database PECS provided by the BPHC to track patient's.

Open Door's Planned Care History

- <u>Developing a Model for Planned Cancer Screening:</u> In 2005 Open Door was one of just four community health centers in the Northeast region that was invited by the Bureau of Primary Health Care to participate in a demonstration project to develop a model for planned cancer screening and cancer care.
- As one of the health centers asked to be involved in this project, Open Door was been recognized as a health center with significant experience in planned care and with sufficient information technology capacity to screen and track patients on a population-wide basis.
- The first hurdle was to get all of our patients into the PECS database. Not just 1000 diabetics or 2000 asthmatics but thousands and thousands of patients who required cancer screening.

History with CSP

- In 2005, supported in part by funding from the Susan B. Komen Foundation, and with support from the Cancer Collaborative Open Door expanded the CDCM to include patients in need of cancer screening. At that time Open Door did not yet have an electronic medical record and used the PECs registry to manage over 10,000 adults (women over 21 and men and women over 50).
- It was at this time that Open Door really became an active participant in the Cancer Services Program (CSP). (The CSP is a NYSDOH program that promotes and provides breast, cervical and colorectal cancer screening and diagnostic services for uninsured and underinsured clients.)
- Open Door asked and was allowed to enroll eligible patients into the CSP at the Health Centers. We formed a Cancer Coalition of Cancer Providers in our area. We either did the screenings ourselves or scheduled them locally. The results returned to the PCP and were then sent to the CSP for data entry. We became true partners.

- In 2007 Open Door Transitioned to an electronic medical record Eclinicalworks. With electronic ordering and tracking the system alerts the provider to required screenings.

- The eCW EMR with it's up to date screening history, self management goals and care recommendations ensure that providers can make care decisions that are safe and based on a complete and accurate medical history.
- For patients that are diabetic or asthmatic and in need of cancer screening all the care history and recommendations are combined in to one visit note" thus facilitating both safe and comprehensive care.
- Women who came to the center for a sick visit but have not had a PAP test or Mammography are referred to the case manager for education about the importance of screening and assistance with making appointments and enrolling in programs to facilitate free screening (CSP).
- Men and women over 50 are referred to the case manager for assistance in obtaining colorectal screening.
- The database provides for the opportunity to reach out to patients who had not received screening by phone or mail or text messaging.
- Patient Advocates establish trust and a rapport with patients, who have successfully self managed and obtained the appropriate screening, by sending letters to inform patients of their results

- As the program changed and focused more on women over 40 and 50 our Cancer Coalition became more and more important to assist with patient no longer covered by CSP.
- The three Health Centers have sites in all five counties covered by the grant. Little by little the program is working to have patients enrolled through a primary care provider. If the patient does not have one they are referred to a health center.
- The cancer screening services are folded into the primary care of the patient. The Health center staff, providers, and advocates work with the CSP staff to provide comprehensive seamless patient care.

Process

- A health center patient who requires cancer screening services is assessed for eligibility by a patient advocate. Patient is enrolled and consents are signed. Advocates have access to the CSP data system to assess eligibility.
- Patients receive their PAP smear, or CBE or FIT test kit at the center and are assisted with appointments for mammogram or colonoscopy or other screening services by the patient advocate.
- Results come back to the PCP and then forwarded to CSP.
- Patients who need additional screening or follow up are transitioned for case management to the CSP Care Coordinator located at each Health Center.
- The primary care provider and the Patient advocates remain involved and connected with diagnosed patients throughout treatment and care.

- If a non health center patient is interested in the CSP program, they call the program. They are screened for eligibility over the phone and consents are faxed or sent back and forth. Appointments are made at either a health center or any partnership provider.
- Results are sent to their PCP.
- If patients don't have a PCP they are encouraged to register at a Health Center.
- The new patient navigator will track and manage these patients as the patient advocates do for health center patients.

Together, we can keep our promise to those we serve and in doing so, strengthen and expand the Open Door brand.

Building stronger, healthier communities… One patient at a time