Health Connections

An Interdisciplionary Approach to Improved Care Coordination for Vulnerable Patients

KentuckyOne Health

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Objectives

- Provide an overview of one intervention developed by a participant in the Disparities Leadership Program
- Share the background for addressing health disparities in one community in Kentucky
- Discuss the importance of community engagement in program development
- Review lessons learned, challenges and solutions
- Share current outcomes and improvements in health, quality and cost/value as a result of the program
- Share tools for those interested in the development of a similar program

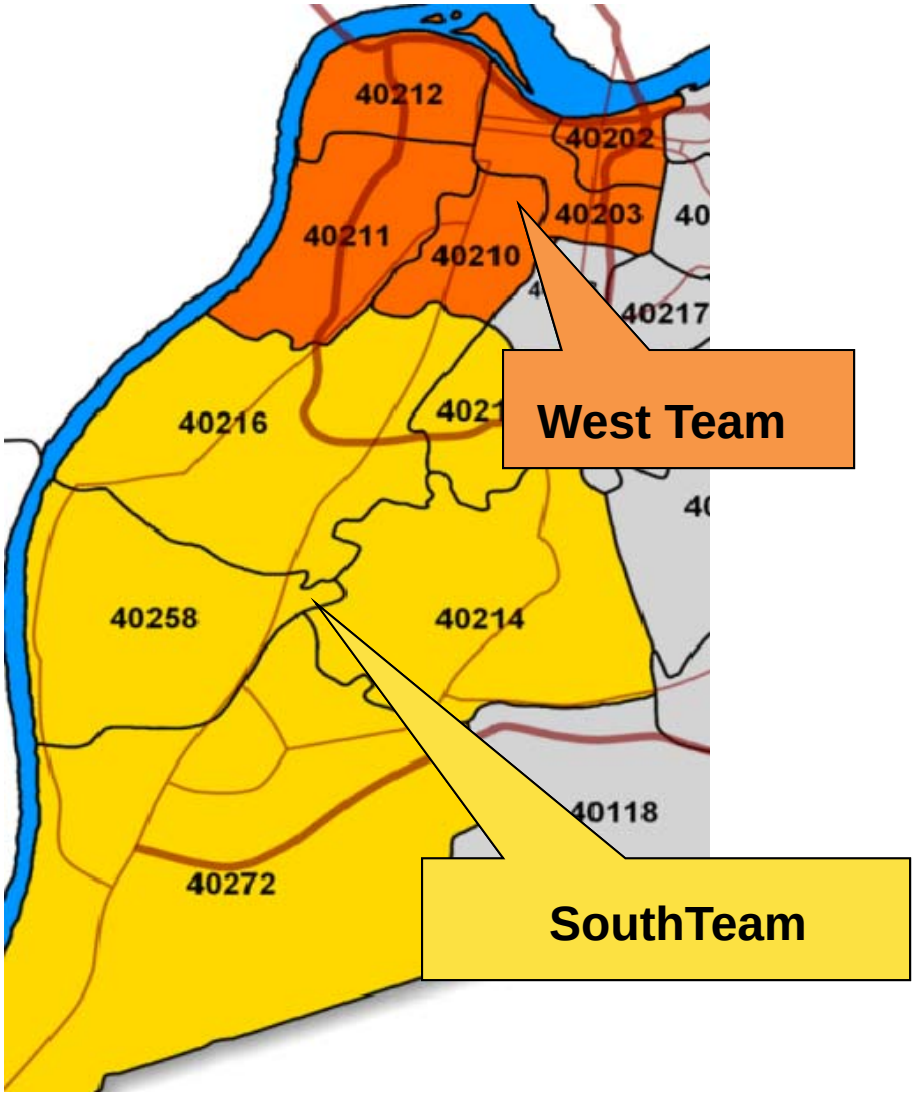
Our Future

To transform the health care communities, care delivery and health care professions so that individuals and families can enjoy the best of health and wellbeing.

KentuckyOne Health™

Background

- Persistent disparities in health care underscore the urgent for more effective interventions.
- ***Unnatural Causes*** documentary illustrated the impact of social determinants of health in a east-to-west drive across Louisville.

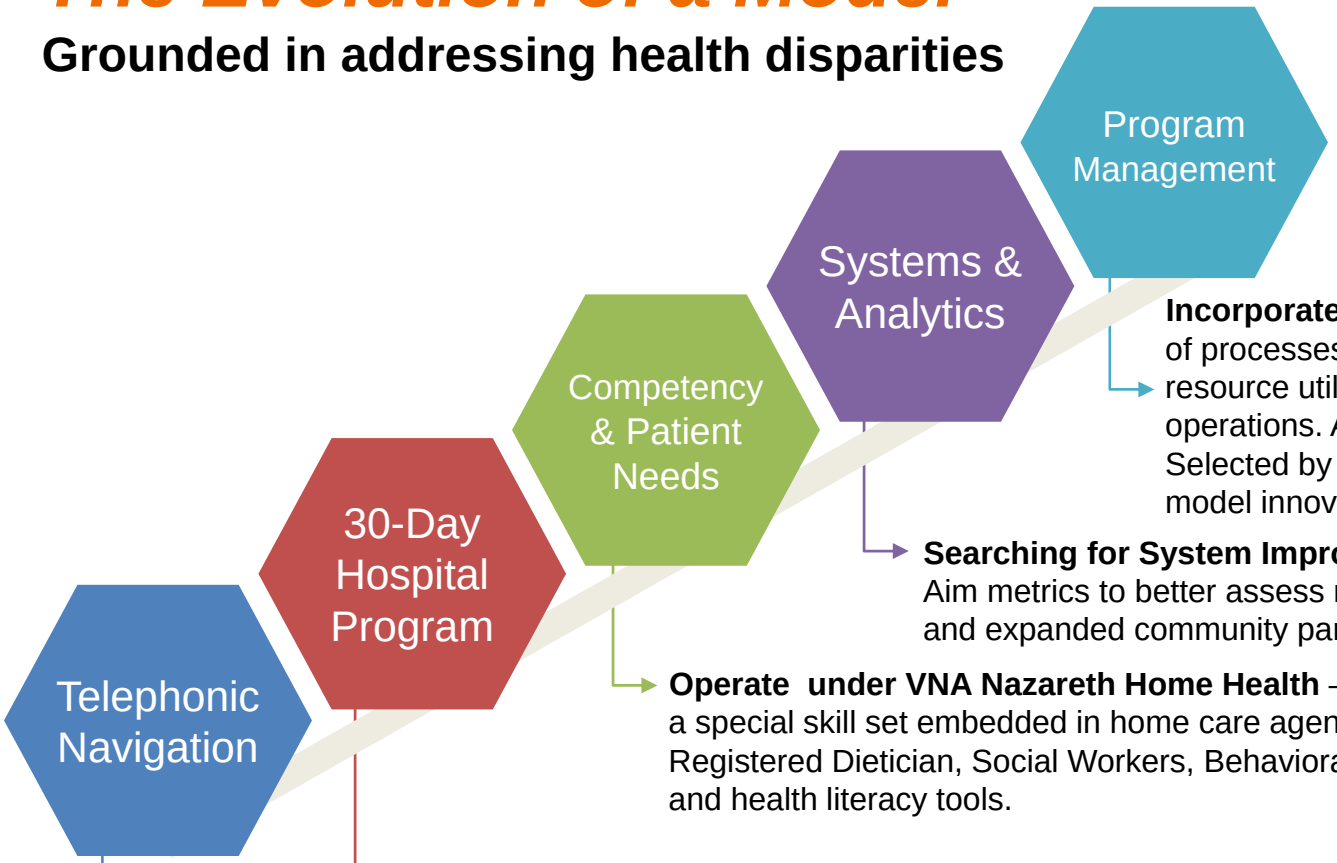


Upstream to Equity to Health Connections Initiative

- In 2010, Jewish Hospital forged a **community partnership** with the residents of the challenged neighborhoods and the Louisville Metro Department of Health and it's Center for Health Equity to identify needs, establish priorities, and develop an action plan to promote improved health status, effective health care with a goal to move "**upstream**" to achieve health **equity** for all.
- In 2011 and 2012, one stakeholder from each agency participated as a team in the one year Disparities Leadership Program
- The goal was to develop a project that would support a collaborative improved community care transitions program, **study** the problem and develop an intervention that would result in improved patient outcomes and health equity.
- This project established as a result of participation in the DLP has evolved between 2011 and 2015 to an effective Interdisciplinary Outreach Care Team model that has been scaled to other facilities across the country.

The Evolution of a Model

Grounded in addressing health disparities



Move the RN to the Hospital – A personal visit established a relationship with the patient.

Add CHW's in the Home and Expand to 90 Days – 30 days were not enough for complex patients with extensive social needs. Worked with Health Department to employ CHWs to reach out to patients in their homes.

Operate under VNA Nazareth Home Health – Working in the home requires a special skill set embedded in home care agencies. Added an LPN, Registered Dietician, Social Workers, Behavioral Peer Support Specialists and health literacy tools.

Searching for System Improvements – Developed Triple Aim metrics to better assess results for complex patients and expanded community partners.

Incorporate Learning – Continuous monitoring of processes and practices around budgeting, resource utilization, communication, and operations. Accenture conducted ROI analysis. Selected by UCLA's Global Lab for Health as model innovation.

2010 2015

A Lessons Learned Model

- Executive Leadership – VP of Healthy Communities
- Stakeholder Coordinating Committee (internal team)
  - Informatics: Identify systems and metrics
  - Finance: Develop budget
  - Nursing: Touches on all patients
  - Case Management: Transitions of care and patient identification
  - Language & Cultural Services: Multi-cultural needs
  - Home Care: Program operator with key competencies and understanding of community programs, barriers and resources

Community as Partners – Steering Committee

Community partnerships are essential in program development and ongoing communication related to access and elimination of barriers to community resource needs.

- Federally Qualified Health Centers
- Patient Centered Medical Homes / PCP Group Practices
- Behavioral Health
- Payers / Managed Care Medicaid
- Emergency Medical Services
- Faith Ministries / Mission Leader
- Community focus groups

Interoperable Systems

Interoperable computer systems are critical. Perform an inventory to identify systems and determine if they will meet the needs:

- Patient referral identification
- Risk stratification
- Documentation of services provided
- Team member communication
- Dashboards –monthly report on Triple Aim metrics

Designing A Program – The Team of Experts

A team of subject matter experts is needed short-term to develop the program, outline the process and identify work tools.

- Benchmark best practice models (Camden, Eric Coleman)
- Use evidence based tools
  - PHQ9, - Depression
  - Stanford – Self Efficacy
  - CPCQ – Coordination and Patient Experience
- Build on “lessons learned” by others
- Develop a process flow diagram; use it and revisit periodically

Talent Management

- Recruit and hire the right people.
- Community Health Workers are one of the most successful components of the program.
- Continuous training is critical.

Key Takeaways

- Build trust and develop relationships
- Set patient-centered goals
- Coach for disease management
- Handoff to the Community Health Worker
- Identify the need for behavioral health
- Conduct social needs assessment and interventions
- Engage patients through Motivational Interviewing
- The MD is a partner
- **Tell the story in the words of the patient**

Tell the Story

Catholic Health World

Eli's Home Care Week

Readmissions News

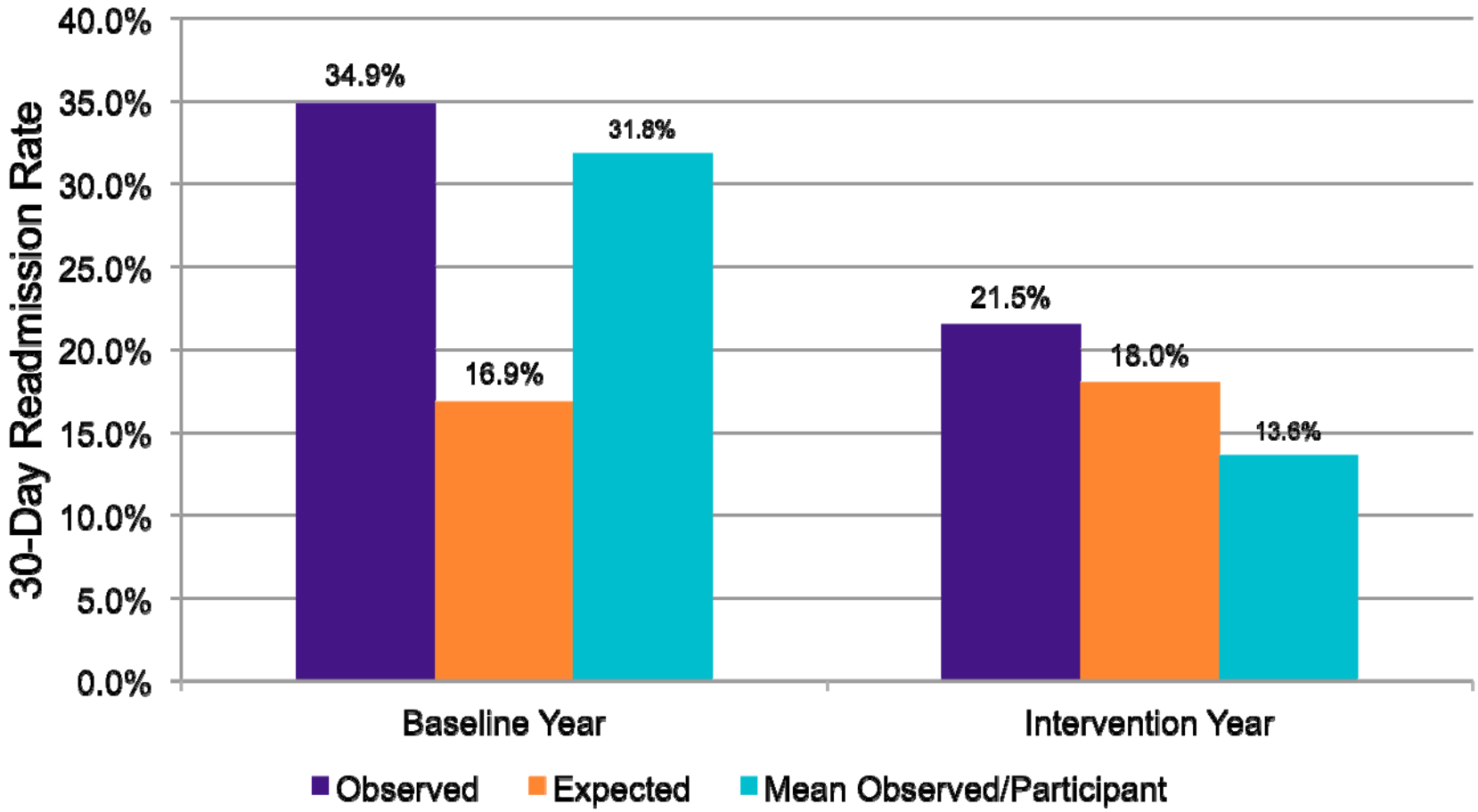
The Courier-Journal

A GANNETT COMPANY

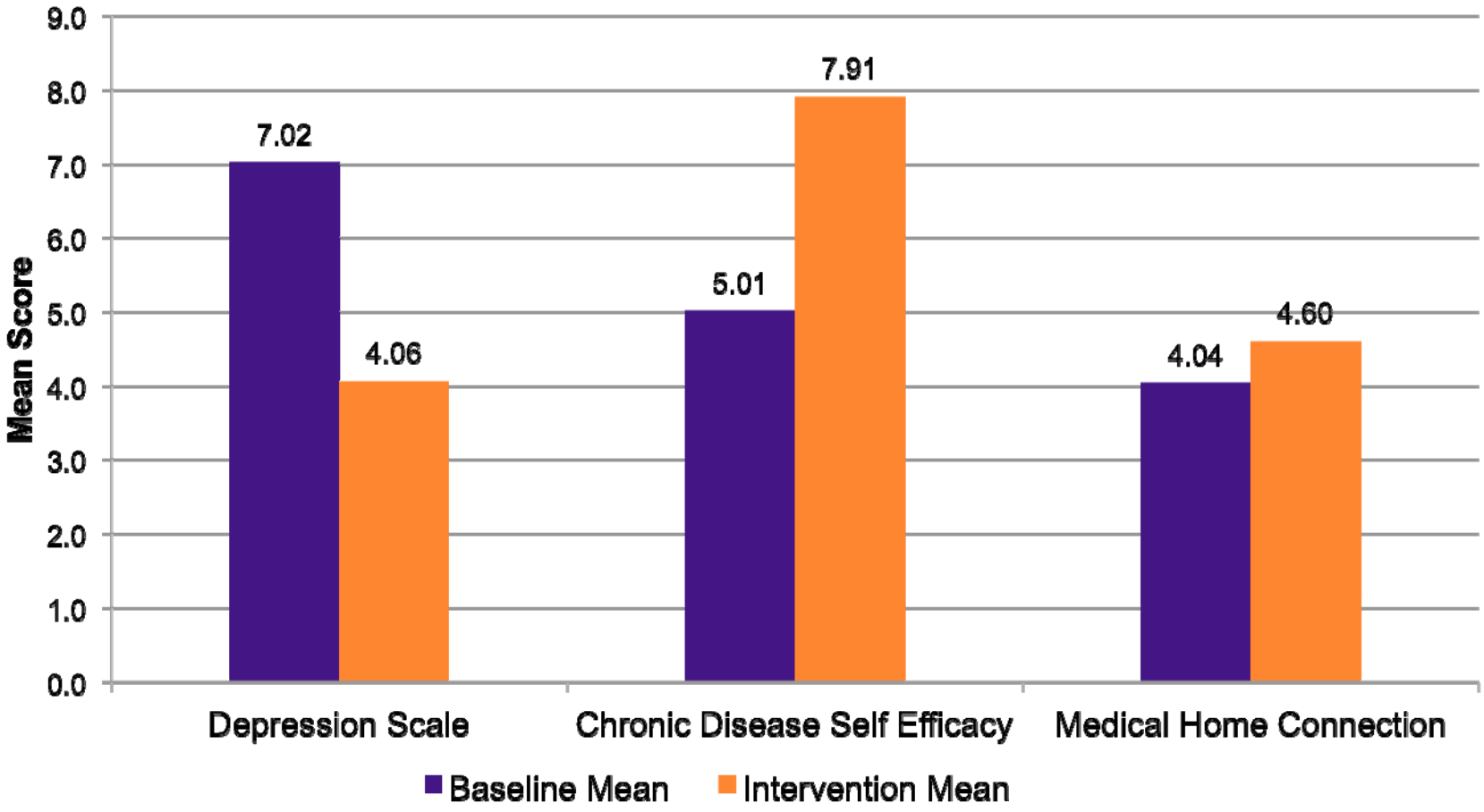
SERVING THE CATHOLIC COMMUNITY IN CENTRAL KENTUCKY FOR 135 YEARS

THE RECORD

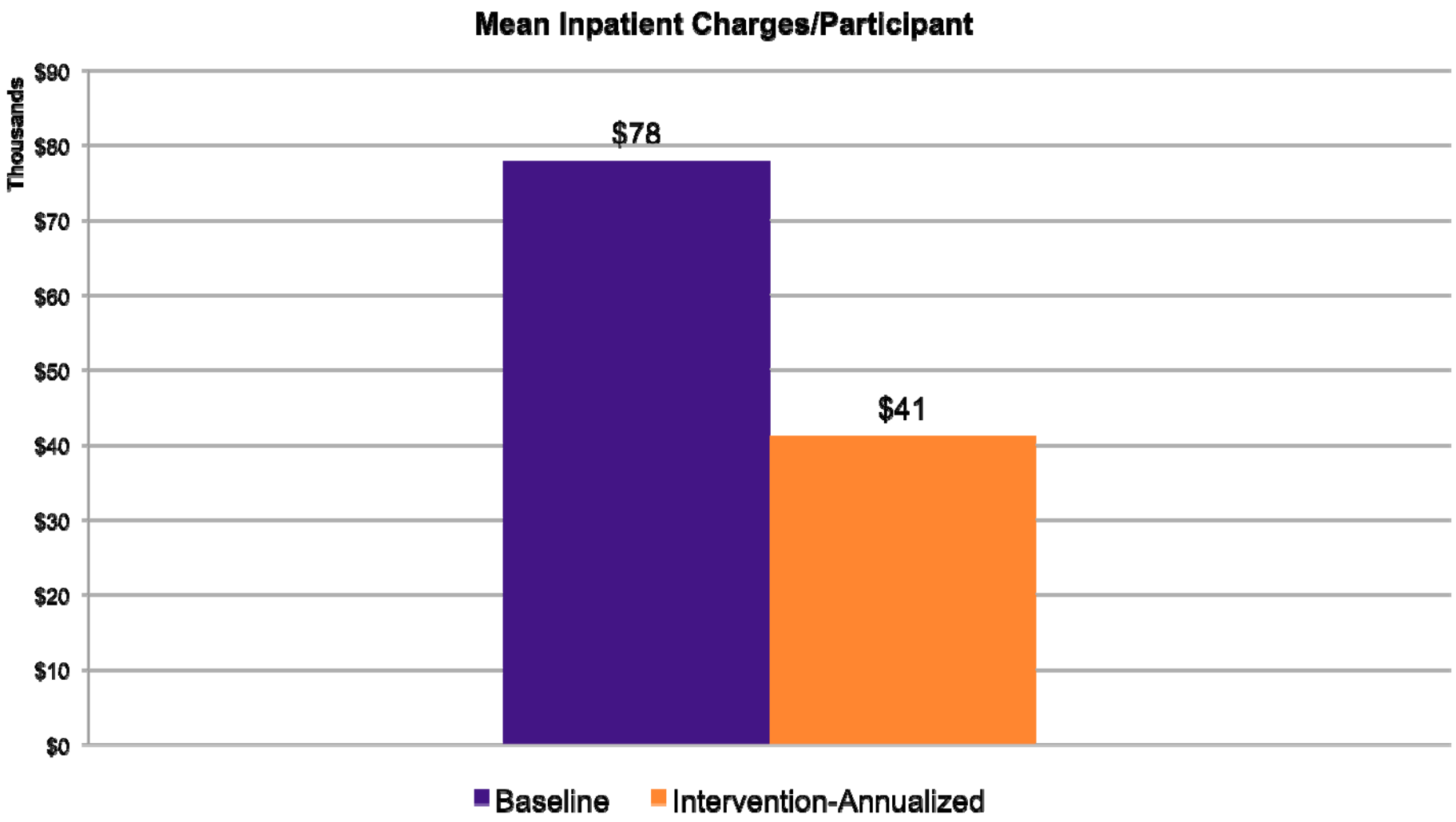
Outcomes: Better Health



Outcomes: Quality



Outcomes: Cost/Value



Keys to Success

- ✓ Eyes in the home
- ✓ A team with a heart for the work
- ✓ Love and support