Highline Health Connections: Care Navigation for Vulnerable Populations

WSHA Readmissions Safe Table - Feb 14, 2017

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Home Health, Health Connections, Cancer Center, Sleep Center
CHI Franciscan
Highline Medical Center

• Community Non-Profit medical center located in Burien, WA
• Part of CHI Franciscan Health, an eight-hospital system including a regional network of primary care and specialty clinics
• Comprehensive Cancer Center
• Primary Stroke Center
• Heart Failure Accreditation
• Family Birth Center with OB & Midwife support
• Home Health, Hospice, Wound Center, Sleep Center and more!
Highline’s Vulnerable Population

Primary Service Area: Burien, Des Moines, SeaTac, Tukwila, White Center, West Seattle

• Most diverse population in Puget Sound
• Significantly more medically underserved
• Heavier language and health literacy barriers
• Limited financial resources
Increasing number of individuals with multiple chronic health conditions creating incredible demands on health system

Highline had 1109 super utilizers:

• 117,548 billing episodes during 2 year period
• Avg. of 106 episodes per patient

Patients with complex health care and psychosocial needs requiring specific services and support

Led to initial start up grant
Hospital Mission:
Access to Care for All

Highline Health Connections Program Goals

• Develop an innovative program that focuses on the most challenged, complex and vulnerable individuals in our community

• Assist participants in achieving personal health goals and preventing avoidable hospitalizations and emergency room visits

• Improve the overall health of our community while reducing overall health care costs
Determine Hospital and ER Utilization

- Review Claims Data
- Diagnoses
- Payer Source especially Medicaid & Charity Care/Non-Insured
- Utilization Patterns
- Zip Codes
- Hot Spotting
Community Health Needs Assessment

- Provided by Outside Source (Health Facilities Planning & Development)
- Demographics
- Health Status
- Socioeconomic Factors
- Leading Causes of Death
- Unmet Medical Needs
- Access to Care and Services
- Behavioral Risk Factors
Community Involvement and Outreach

Identifying Community Partners and Supporters:

• Social Service Agencies
• Behavioral Health
• Mental Health
• Parish Nurses
• Fire Department
• Any Community Group that works with Designated Population
Community Involvement
Steering Committee Membership

- Global To Local
- Highline Community College
- The National Institute for Coordinated Healthcare
- Project Access Northwest
- Alliance for Healthy Communities
- Highline United Methodist Church
- Filipino Chamber of Commerce of the Pacific Northwest
- Medical Management Coordinated Care
- CHI Franciscan Care Management
- Highline Medical Center Foundation
Program Model

Target population and service area decisions

Site visits to other similar programs

Services Provided:

• Nursing (RN, LPN)
• Social Worker
• Community Health Worker (CHW)
• Dietician
Program Model

Program Liaison

• Primary responsibility for participant enrollment typically in the inpatient setting
• Engages participants and coordinates care with Care Management/Hospitalist
• Coordinates with team members to connect the patient with various health and social resources
• Initiates care plan development and smooth transition to community setting
Program Model

Admission RN

- Responsibility for the admissions of participants
- Assesses the clinical needs & determines need for other levels of care like Home Health skilled care
- Develops initial care plan & coordinates with Health Connection (HC) Team to develop holistic plan
- Coordinates with other community providers to obtain resources
Program Model

Social Worker

• Identifies individual-specific needs, resources, strengths, and barriers

• Develops a participant-centered plan of care w/ team

• Coordinates closely with HC Team to assure that participant’s social, emotional, environment, and living needs are met

• Provides support and counseling to participant and caregivers
Program Model

Community Health Worker (CHW)

- Core of the Program
- Performs day-to-day activities with participants
- Performs health coaching to assist participant in meeting personal health goals
- Prefer member of the community being served (i.e. bilingual)
- Opportunity for CHW to gain exposure and future career in healthcare
Program Model

Dietician

• Engages participant with Diet Management
• Works closely with Participant on food choices when shopping
• Coordinates closely with HCC Team regarding dietary Issues

Mobile Technology

• Diabetic Management Application (Smart Phone)
• Heart Health Application (Smart Phone)
• Heart Care Health & Diet Tops by Data Recovery Software
• Health Navigation Software to promote linking w/CHW
**Program Model**

**Participant Identification**

- **LACE** (LOS, Acuity, Co-Morbidity, ER). Screening tool is used to determine risk for re-hospitalization and score over 12 is key indicator.

- Discussions with Care Management/Discharge Planning

- Hospitalist or Emergency Room Provider input

- Qualified participants have social, environmental, behavioral and financial issues that impact ability to be successful in meeting health care needs

- Participant who refuses to work on health goals or has significant addiction issues not appropriate
Participant Scenario
Before Health Connections

High Risk Member of Community Experiences Medical Problem

Seeks help in ER

Discharged Home or Admitted to Hospital

Seek help in ER

Experiences Medical Problem

Cycle Continues
Participant Scenario
After Health Connections

Health Connections Team + Participant

- Link to Provider
- Obtaining Insurance Coverage
- Arranging Transportation
- Increases In-Home Support
- Obtaining Supplies and Medications
- Instructions for Healthcare and Medication
- Arrange Mental Health Services
- Obtain Financial Assistance
Program Records and Resources

TAV Connect

• Information System designed to connect people, families, caregivers, providers and local community resource

• Community Resource Data Base

• Enter care plan & flags solutions to barriers

• Analytical Reporting including activities, results & outcomes

• Social networking/documentation rather than typical medical record
Program Size and Growth Plans

• Philanthropic gift of $600K donated to hospital foundation to provide seed funding to begin the program

• Program size primarily based on funding rather than need

• One small team initially

• First month re-evaluate systems and process after first couple cases

• Additional funding ($1.2 million CHI Mission & Ministries grant) funded 2-3 staff teams (3 years with 80-100 participants per year)
Program Targets

First Year (Completed June 30, 2016)
172 participants served with target of 100

Remaining years of grant funding
Based on 3 teams serving South King & North Pierce Counties (Highline & St. Francis Service Areas):
Year Two (Current): 200 participants
  (142 served mid-year so exceeding target)
Year Three: 200 participants
Program Funding

• Early attempts at initial start up without grants or outside funding
• Angel investor willing to donate $600K for program
• Interest in innovative program that would impact local community
• Catalyst for additional funding:
  • -$1.2M grant from CHI Mission & Ministries
• Positioning for Population Health
• One of several demonstration projects within CHI
• Focus of Highline Foundation Gala Oct 2015 resulting in $132K
Sustainability Strategies

- Reduction in write offs for Uninsured or Underinsured
- Reduction in Re-hospitalization and Emergency Room Penalties
- Increase in Volume and Financial Benefit due to high patient satisfaction
- Health Home Contracts with Payers to improve health care status & reduce utilization & costs
- Potential Opportunities with Healthier Washington Initiative & Accountable Communities of Health
- Health Care Trends: Population Health and Value Based Purchase
Program Evaluation

Define outcome measures based on Triple AIM

**Better Health**

- Self efficacy for managing disease
- Achievement of personal health goals
- Advanced Care Planning performed

**Lower Costs**

- Reduction in hospitalizations
- Reduction in Emergency Room visits
- Reduction in un-insured patients & write offs for hospital
Program Evaluation – cont’d.

Better Patient Experience

• Client Perception of Coordination of Care
• Participant Satisfaction Tool

Remember: Include Community Involvement in program evaluation.

Community Satisfaction Survey and/or feedback is critical

Anecdotal Stories Important for Program Support including

Philanthropy, Board Support and Community Support
Participants’ Perception of Care Coordination*
95 Participants

Presented at WSHA-ASHNHA Partnership for Patients Safe Table – February 14, 2017
Participants’ Perception Regarding Relationship With Provider

95 Participants

% of positive responses (always or mostly)

Before Health Connections: 67%
After Health Connections: 84%

Presented at WSHA-ASHNHA Partnership for Patients Safe Table – February 14, 2017
Participants’ Perception of Ability to Manage Their Own Health* 
106 Participants

Before Health Connections
After Health Connections
5.79
7.28
Scale 1 -10
10 = most confident
1 = not confident
Participants’ Depression Score*

112 Participants

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<th>Before Health Connections</th>
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Scale
1-4 Minimal
5-9 Mild
10-14 Moderate
15-19 Moderately Severe
Participants’ Experience

Participants Overall Satisfaction with Program
92% Positive Responses (Agree or Strongly Agree)

Quotes from Participants

“It's very helpful to have the community health worker come to my doctor appointments. My doctor doesn't usually listen to me, but it was different when the Community Health worker was there advocating for me and asking questions.”

“There needs to be more programs like yours available to people. There are so many resources out there that I just don't have the time to find on my own. A lot of people say they're going to help, but you guys have actually made things happen.”

“I love my health binder! It helps me stay organized and keep track of my medical information. I take it with me wherever I go!”
Financial Impact
Utilization Trends
Program Completion
* 76 Participants

Presented at WSHA-ASHNHA Partnership for Patients Safe Table – February 14, 2017
Utilization Trends
Partial Program Completion
* 55 Participants

ED & Hsp Before 301

$847,885.11

ED and Hsp After 144

$481,923.07

6 Months Before

6 Months After
Alma’s Story

Alma: 47 years old, limited English proficiency, single mother of four children

Diagnoses: Severe Asthma, Respiratory Failure, Seizure Disorder, Significant Depression and Anxiety (primary disabling co-morbidities)

Barriers:
Limited finances (no insurance coverage)
Need for mental health care
Lack of knowledge re: health care & medications
No transportation
Required interpretation or Spanish speaking services
Impact on Alma

• Enrolled in Medicaid for previous hospitalization and ongoing care
• Connected to culturally appropriate providers & services (including Spanish speaking)
• Provided social & emotional support
• Connected to mental health provider (Spanish speaking)
• Now able to understand her medical conditions and follows providers instructions
  including taking medications as ordered
• Now linked with financial resources for food, rent, and transportation assistance

Before Program          After Program
4 Emergency Room Visits  No Emergency Room Visits
1 Hospitalization       No Hospitalizations
**Financial Impact on CHI Franciscan Health**

This program has demonstrated an ability to influence utilization for the highest utilizers of the Emergency Room and Hospital.

30 Day Hospital Re-admission Rates Reductions for 61 participants:
- Medicare 47%
- Medicaid 63%

Avoiding Re-admission and shorter LOS makes beds available for other patients and increases revenue.

Uninsured patients obtained coverage saving 100K in 6 months.
Benefits of Combined Program: Care Management and Medicare Certified Home Health

- Promotes improved transitions and seamless care delivery while preventing duplication of services
- Effective model utilizing existing resources and expertise of home health agency staff
- Comprehensive, yet allows flexibility and appropriate utilization of staff resources
- Focus is Patient Centered & Achieving Health Care Outcomes & not regulatory
- Historically this type of model was not covered by Medicare or Health Insurance Plans
- Plans are now interested in Population Health & Paying for Outcomes
- Provides opportunity for Home Health to demonstrate the value of a combined program for payers
- Provides a new patient centered model of care for home health agencies to replicate and implement in conjunction with payers.

Presented at WSHA-ASHNHA Partnership for Patients Safe Table – February 14, 2017
QUESTIONS?

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