2014 Gage Awards

Reference #	7485615
Status	Complete
Name of hospital or health system	Truman Medical Centers
Name of project	Answering the Health Care Innovation Challenge
CEO name	John W. Bluford
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
Submitter name (first and last)	Denise Haye
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Within which of the two categories does your application best align?	Population Health

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	According to the Center for Health Care Strategies, approximately 5% of Medicaid recipients account for nearly 50% of the program's cost. Eighty percent of recipients are reported to have three or more chronic conditions that require on-going medial care. Many live daily with a complex "array" of social barriers including homelessness, substance abuse, poverty and chaotic living conditions. (Dianne Hasselman, Center for Health Care Strategies, Oct. 2013). Working in cooperation with Rutgers University Center for State Health Policy and through an award funded by the Center for Medicare and Medicaid Innovation, Truman Medical Centers (TMC) is designing and implementing processes to address the needs of this high-utilizer population. With guidance from Dr. Jeffrey Brenner, founder and Executive Director of the Camden Coalition of Healthcare Providers, we are creating a model of health care delivery that teaches patients to better understand and manage their complex chronic conditions, and to navigate the health care system. www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande As one of four clinical sites nationally participating in the Rutgers learning collaborative, TMC, a quality net hospital serving Kansas City's urban poor and uninsured population, is the only hospital system in the multi-site study. Working within the scope of the project the objectives for Truman are to: •improve patient care •improve health outcomes •reduce avoidable hospital utilization Multidisciplinary teams consisting of Health Coach RN's, community-based Licensed Clinical Social Workers (LCSW), Community Client Liaisons (CCL's), and Community Health Advocates (CHA's), wrap services around patients meeting the high utilization criteria. The CCL's and CHA's are recruited from the local community and have prior experience as advocates. Additionally, patients may receive assistance from the Nurse Practitioner and Psychologist assigned to the project. Eligibility criteria include two inpatient admissions in six months or three in a year, at least one chronic disease, and living within identified zip code areas. The teams teach the patients "navigation skills" such as bringing a list of questions to the doctor or logging daily blood pressures, and also help them to identify and utilize the resources needed to overcome social barriers to improved health, such as finding adequate housing for those who are homeless. Data are retrieved from internal claims and utilization sources. Other data specific to the project are tracked and reported separately. To date, staff have completed more than 2,398 phone calls to patients, made more than 597 home visits, 1,134 hospital or clinic visits and another 119 visits to public/private assistance sites such as nursing homes, shelters and treatment centers. Truman has witnessed a marked reduction in both emergency room and inpatient visits by the high-utilizer patients enrolled in the program, resulting in a significant

	cost savings to Medicaid and offering increased health and social benefits to patients.
1A. Attachment, if applicable (Applicable examples include a peer reviewed journal article, other content published in the literature, or a presentation at a national meeting)	HotSpotters110124fa_fact_gaw.pdf (127k)
2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	TMC is building on over a decade of efforts to serve the community through care-management of high need patients with medical and social complexity, and continuing on a journey of excellence in chronic disease management. In this project, Health Coach RN's complete a daily triage through the hospital census to identify patients who qualify for the program. Once identified, patients are visited at the bedside by one of these RN's, receive an overview of the program and are offered assistance. If the patient agrees to enroll a home visit is scheduled with the CCL's and CHA's. At this visit, team members complete enrollment paperwork and begin establishing a relationship with the patient. Priority health care and social needs are addressed. The CCL helps to organize medications, connect the patient with needed resources, and reports updated information back to the Health Coach RN and LCSW. A 3 to 7 day follow-up visit is scheduled with the team Nurse Practitioner and Psychologist within 3 to 7 days from the initial home visit. During the home visit, the patient is introduced to the Patient Navigation Measures©, a list of patient skills developed by the team to assist the patient with managing their health care needs. A check of the Social Navigation Measures© (also developed by the team) is reviewed to determine any social barriers that need to be addressed. These measures include barriers that range from lack of housing to acquisition of needed documentation to apply for support services. Progress in addressing measures is reviewed with the patient every thirty days and tracked to determine a patient's readiness for graduation. The project teams' services are offered between the patient's medical visits though team members who sometimes also attend these visits with patients to encourage their participation and to model behavior (e.g., how to ask questions of the doctor). Frequent home visits by the community team (CHAs, CCLs, LCSWs), education and support within the hospital and outpatient clinic settings by the Health Coach RN's and treatment for issues such as depression by the team Psychologist are all a part of the process. The Nurse Practitioner serves to meet any immediate needs that may arise for the patient, coordinate health services and act as a bridge to the patient's Primary Care Provider. Patients actively engaged with the team stay with the program until such time as they accomplish the goals for graduation or are transitioned to long-term care. Once ready for graduation, patients are referred to the medical home associated with their Primary Care Provider.

3. Describe the results of the project. What data was used to support improvement results?	The project is ongoing and continuously evolving as we progress toward improved services to Truman's high-utilizer population. To date: •One hundred thirty six patients have enrolled in the project. •Five patients who were homeless at the time of enrollment have been placed into apartments; one into transitional living; and one has been reunited with family and is now off the streets. •One patient has left a violent partner and continues to enforce healthy boundaries. •Six patients have been transitioned to long-term care or to long-term Veterans Administration care. •Nineteen patients have successfully graduated from the program. •Eight patients have died. Cost data indicate a significant drop in both inpatient and emergency room visits: Before (Data reflects 1 year Prior to Enrollment Date) 118 Patients TotalAfter (Data Reflects Since Enrolment Date) Patients enrolled 12/12/12-9/30/13 118 Patients Total Row LabelsCount of Check-in DateSum of ChargesCount of Check-in DateSum of Charges Emergency Room1,420$2,263,010.45484$759,703.08 Inpatient494$5,959,617.54192$2,688,416.95 Outpatient1,780$1,070,747.09970$553,047.97 Grand Total3,694$9,293,375.081,646$4,001,168.00 The greatest lesson reinforced by this project is that relationships are critical. Many of the individuals serviced through the project live with poverty, multiple diseases and history of psychological, physical, or sexual trauma. Trust is crucial to the success of a patient's willingness to becoming an active partner with the team. The patient quote below illustrates this point: "Before the team was involved, I asked very few questions. I went to my appointments, saw the doctor and got out of there. I did not think anything of it. The team has given me the enthusiasm to ask questions and find out if this (whatever the doctors suggested) is something that I really need. Things that I don't agree with I have been able to express it. The team has given me a voice. They have inspired me to say what's on my mind and not be afraid to say it. When they come to my house there is nothing I can't say to them. They have given me confidence and told me that they will not judge me by what I say. They are good friends and I would hate to lose them at this point. I know that everyone has to graduate from the program including me. They assured me that they will still be around for me even after I graduate." (High-utilizer patient)
3A. Attachment, if applicable (Only graphically displayed data such as charts will be accepted. Data should include baseline and improvement data)	BeforeandAfterData.docx (12k)

4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	Numerous analyses in various urban areas of the country show pockets of high health care utilization, reflecting the need for new and different approaches to serving these individuals. As the data above indicate, increased personal involvement with patients that meets a patient where they are and offers a trusting partnership to empower these individuals with navigating their social and medical obstacles results in decreased utilization of the emergency department and inpatient services. While this specific project is time limited, we will identify best practices and incorporate them into the overall care management strategy at TMC. We already work closely with other care management programs in the health system to develop a process for a “warm hand-off” during transitions and once the patient is eligible for graduation. Processes have also been developed for the Nurse Practitioner to “bridge” services with the patient’s Primary Care Provider and to define the team roles for coordination with inpatient staff from the time a patient enters the hospital until discharge back into the community. Team members are working with staff from other areas of the hospital (inpatient, ambulatory care and behavioral health) to provide continuous and sustainable improvement to service delivery for the patients we serve. We will continue to learn new lessons in chronic disease management excellence; one of the top three business priorities for our health system. We are finding that others have already begun to adopt processes we are testing in this project. Our electronic record has been modified to allow for the shared recording of information such as submissions of patient goals from both medical and social work staff, information on current trending of test results and links to best practice guidelines. These improvements represent some of the ways that the project has improved the TMC systems of care for patients with chronic disease. With appropriate in-service of staff related to the social barriers common to high-utilizer populations and an emphasis on quality measures related to chronic disease, duplication of the processes involved within the project would be easily adapted and implemented within other health systems.

5. Describe how patients, families, and if appropriate, community was included in the work.	Empowering patients toward increased control over their health care experience occurs largely outside the health care system, so it “takes a village” to support the patients on their journey. Community engagement and partnerships are critical in promoting the health of area residents. We have partnered with Communities Creating Opportunities (CCO), the Kansas City affiliate of People Improving Communities through Organizing (PICO), a faith-based organization. CCO’s objective surrounding this project is to uncover and address local barriers to the health care needs of area residents. CCO conducts interviews and gathers patient stories throughout the surrounding geographic areas as well as directly with Truman patients to uncover barriers to quality health care experiences. CCO has currently identified transportation as a local issue of concern and is working with local transportation agencies for resolution strategies. Truman and CCO staff members meet monthly to discuss the identified issues and plan for intervention. Additionally, TMC has partnered with Samuel U. Rodger’s Federally Qualified Health Center to improve communication and coordination for high-utilizer patients we mutually serve, and has reached out to local homeless shelters to coordinate communication and service delivery for the homeless. Team members are currently meeting with local clinics to establish a working partnership to provide services to patients whose primary care providers operate outside of the Truman clinics. Stories of the patients in this project provide powerful catalyst to increasing awareness and bringing about improvement changes in services. These stories are shared in many ways, including interviews, presentations, written materials, and conferences.
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