2014 Gage Awards

Reference #	7490435
Status	Complete
Name of hospital or health system	Alameda Health System
Name of project	Hope Center
CEO name	Wright Lassiter, III
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)	David Moskowitz, MD
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Within which of the two categories does your application best align?	Quality

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.)	At Alameda Health System (AHS), five percent of patients are responsible for 20% of acute care admissions. For all patients admitted in 2012, the median number of bed days was 3 and the median payment amount was $4,055. Among the 5% of patients with the highest number of admissions, the median number of bed days was 16 and the median payment was $25,766, representing a five-fold and six-fold increase respectively. Ambulatory sites at AHS have limited access to primary care for new patients. Therefore, patients who are assigned to AHS by their health plan frequently wait several months before being seen. As an “ambulatory-ICU,” the Hope Center provides complex care management with tight linkages to primary care for super-utilizers seen at Alameda Health System (AHS). We target patients with three or more hospitalizations during the past 12 months. Besides their medical complexity, these patients face significant social factors including substance use and the sequelae of multigenerational urban poverty. We identify eligible patients in real time using administrative data and daily census reports. We first meet with patients while they are hospitalized, then develop a comprehensive care plan at a post-discharge home visit. We address factors related to social stabilization, care coordination, disease management and behavioral health. Patients who enroll in our program and do not already have ongoing primary care receive primary care through the Hope Center. Our goals are to simultaneously decrease costly patterns of utilization while improving patients’ functional status and self rated health. We began enrolling patienpatients in February 2013. Our efforts are ongoing, with funding through 2015.

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	The Hope Center team consists of two nurse care managers, a medical assistant, an LCSW, a 0.5 FTE project assistant, a 0.1 FTE pharmacist, a 0.1 FTE psychiatrist and the medical director. One care manager is an employee of Alameda Alliance for Health and has been embedded in our clinic to assist with their covered patients. Nurse care managers enroll eligible patients while they are hospitalized, perform intake assessment home visits and are primarily responsible for carrying out care plans. The LCSW primarily performs behavioral health assessment and ongoing counseling as well as connecting patients to resources to address social needs. The medical assistant answers phone calls, coordinates transportation and referrals as well as performing panel management. The project assistant manages data systems and reports. The medical director supervises the team and provides primary care for eligible patients. The psychiatrist has reserved clinic slots for Hope Center patients. The pharmacist assists with patient's initial and ongoing medication reconciliation's. The team has weekly rounds in which patients are discussed. We have leveraged features of various data systems to develop a tracking methodology for patients enrolled in the Hope Center as well as eligible patients. We developed processes for cross-referencing lists of eligible patients with the daily census, giving nurse care managers "real-time" lists through which they could target enrollment.
3. Describe the results of the project. What data was used to support improvement results?	We have demonstrated an improvement in functional status, as measured by number of unhealthy days out of 30, and comparing measures at enrollment to those after 3 months. Unhealthy days due to physical health decreased by 16%, unhealthy days due to mental health decreased by 30% and unhealthy days due to disability by 32%. We have demonstrated an improvement in the number of enrolled patients with a usual source of primary care. We do not yet have data on changes in admission rates that we are confident in reporting.

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?	We are continuing to refine our program to incorporate a 90 day reevaluation cycle for enrolled patients to improve our throughput. Additionally, we have identified that a portion of the work may be best carried out by community health worker (CHW), and will shortly be adding a CHW to our team. A key challenge we see is balancing the intensiveness of our intervention against the need to enroll more patients in order to have an impact on cost and utilization that is appreciable at the population level. Additionally, we have observed that our patients are frequently hospitalized elsewhere in the community. We are in discussion with several other hospitals and health plans to develop ways to track this in actionable ways.
5. Describe how patients, families, and if appropriate, community was included in the work.	We plan to conduct focus groups of currently enrolled patients and to sdevelop a patient advisory group specific to this clinic in the next six months.
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