An Integrated Model of Care for Patients at High Risk for Readmissions
Learning Objectives

1. To understand the role of collaboration in a healthcare system’s interdisciplinary team with community health workers in the execution of post discharge planning, care coordination and transitions of care of high risk patients.

2. To define the role of Community Health Workers in the self-management of high risk patients.
Transitions of Care – What are the Challenges?

- Patients experience heightened vulnerability during transitions between settings.

- Quality and patient safety are compromised during transitions period.
Hazards of Poorly Executed Transitions of Care

49% of patients have lapses related to medications, test follow-up, or completion of a planned workup

- High rates of medication errors
- Inappropriate discharge and discharge setting
- Inaccurate care plan information transfer
- Lack of appropriate follow-up care
Outcomes of Poorly Executed Transitions of Care

• Re-hospitalization
• Greater use of hospital services
• Further functional dependency
• Permanent institutionalization
How Can We Improve Transitions of Care?
Collaborative Efforts – Increasing Continuum of Care Systems
Collaborative Efforts – Increasing Continuum of Care Systems

- Several programs aimed at improving transitions across settings
- Coordination of care by a “coordinating” health professional
- Cost limiting
- Coordinating healthcare professional unfamiliar with patient’s social circumstance

Clinical Trials to Improve Outcomes for Elders Discharged From the Hospital

CHOOSE Health: A Community Health Worker Program
State and County Health Statistics

• Approximately **281,591** uninsured adults living in DeKalb and Fulton counties \(^1\)

• DeKalb and Fulton rank 40\(^{th}\) and 41\(^{st}\) in the state for preventable hospital stays \(^1\)

• The leading cause of death in Georgia is **cardiovascular disease**; **diabetes** ranked 7\(^{th}\) among leading causes \(^2\)

Source: US Census Bureau’s Small Area Health Insurance Estimates (SAHIE), 2013.
Emergency Room Use

• There are more than 300,000 preventable emergency department (ED) visits in Greater Atlanta each year

• Preventable ED visits add up to $450 million in excess health care cost.

• The cost of emergency room care is staggering: approximately $1,500 per visit
State and County Health Statistics

Growing need to create innovative programs aimed at:

• Reducing these statistics

• Effective methods of collaboration among community-based providers and social service agencies
So...What Exactly is CHOOSE Health?

Collaborative Partnership

• United Way convenes the program, provides content leadership and serves as primary funder – with additional support from Kaiser Permanente

• Grady Health System

• Gwinnett Medical Center

• Federally Qualified Health Centers:
  • The Family Health Centers of Georgia, Inc.
  • Mercy Care
  • Oakhurst Medical Center
  • Southside Medical Center
So...What Exactly is CHOOSE Health?

**Goal:** Bridge the gap between community-based providers

- FQHCs, community health centers, free clinics, etc.
- Larger healthcare systems

**Outcome:** Increased quality and effectiveness of care and services for the uninsured and the underinsured - at a more affordable cost
CHOOSE Health Program Overview

• Targeting “high utilizers” of Grady Health System’s Emergency Department and patients with high hospital readmission rates

• “High utilizers” identified from zip code analysis; collaborate with FQHCs and Grady’s satellite sites in those zip codes to maximize resources

• CHWs provide home visitation, case management, accompany patients to medical visits, provide medication counseling and health education
The Goals of CHOOSE Health

• Increased patient access to care – linkage to a primary medical home

• Reduction in emergency room visits and/or readmissions for high risk patients

• Patient self-management education for chronic conditions

• Overall improvement in patient health outcomes
CHOOSE Health Patient Population

• **Average age:** 45 years or older

• **Vast majority have the following chronic conditions:** Congestive Heart Failure (CHF), COPD, Hypertension or Pre-diabetes/Diabetes

• **Common social barriers:** benefits assistance (disability, Medicare/Medicaid, SSI, etc.), food assistance, housing, medication affordability, transportation
Inclusion Criteria
• Must meet certain residency requirements (program services DeKalb, Fulton and Gwinnett County residents)
• Frequent utilization of Emergency Department
• Persons considered high risk for readmission based on risk assessment
• Persons capable of making rational decisions in the determination of their health

Exclusion Criteria
• Persons that have a primary psychiatric diagnosis
• Persons diagnosed as suicidal or homicidal
• Person considered chronically homeless
Integration of CHOOSE Health and Grady Health System’s ACE Interdisciplinary Team
Acute Care for the Elderly (ACE) Interdisciplinary Team

- Geriatrician – Chief Physician
- ACE Program Coordinator
- Case Manager
- CHOOSE Health Community Health Workers
- CHW Data Specialist
- iCARE Community Health Worker
- Nutritionist
- Occupational Therapist
- Pharmacist
- Physical Therapist
- Volunteer Services
- Unit Nurses
Collaborative Integration

• CHWs participate in IDT rounds
• Interdisciplinary team discuss clinical and social issues of patients
• CHW Data specialist discusses appropriateness of patient selection
• Care plan development - addresses social and clinical issues
• CHW: follow up on care plan with patient
• Feedback by CHW to IDT team
CHOOSE Health Referral Process

- Case Managers/Social Workers
- 30-Day Readmission Data
- High Utilizers of the Emergency Room
- ACE Interdisciplinary Team

CHOOSE Health
CHW Intervention Methods

Home Visitation – conducted in the home or neutral place safe to the patient and CHW

PCP Accompaniment – serves as the link between provider and patient

Social Services & Community Resources – accompany patients to social service appointments (SNAP/WIC, SSI, Disability, etc.)
CHW Intervention Methods

**Case Management** – ensure patients receive health education, coaching and advocacy services

**Self-Management Education**: based on patient chronic condition

CHWs work with patients to establish goals—includes health and social needs
CHW Intervention Pipeline

**CHW intervention period**: 6 months

Intervention pipeline based on needs of the patient

- Intensive Intervention
- Moderate Intervention
- Light Intervention
Hospital-to-Home

• Provides transitional housing for frequent utilizers who are chronically homeless

• Individuals are connected to healthcare resources and case managers

• Additionally, individuals can receive mental health and substance abuse services through program partner Mercy Care
The Burning Question:
“So....What Does Your Data Look Like?”

I LIKE BIG DATA & I CANNOT LIE

YOUR DATA
2015 Program Results

83.9%
Patients reduced ER visits while in the program

76.6%
Patients maintain zero readmission rate while in the program

86.6%
Patients Linked to PCP through the program

JC, a 58 yr. old male with a history of diabetes, congested heart failure, Venus Stasis Ulcer:
- No insurance
- Frequent utilizer of ER services
- Edema of the feet (could not wear shoes) and groin

Interventions with CHW:
- Compliance with PCP appointments
- Medication adherence counseling
- Assistance with disability and Medicaid Spend Down Application

Results:
- Reduced edema (patient can wear closed toe shoes and jeans)
- Medicaid spend down reduction of hospital cost by $100,000
Client and Provider Responses to CHW Collaborative Interventions

Dr. An-Kwok Ian Wong, Primary Care - “Aisha Henry, CHW has been pivotal in maintaining health and preventing hospital admissions. Over the course of my year with Ms. BC, we admitted her several times for complications with diabetes. Aisha visited her frequently, helping better characterize her needs and support structures. Aisha went above and beyond when checking on Ms. BC after we were unable to contact her. I wouldn't be able to keep Ms. BC healthy without Aisha!”

“When I was hospitalized and had run out of money and benefits, my hospital bill was more than I could ever afford. I started not keeping my appointments because I couldn’t afford them. Mr. McClarn took me to his office, reviewed my case and assisted me in getting a Grady Card and with getting my disability. He also got me Spin Down from Medicaid which took care of my hospital bill. I don’t know what I would have done without him.”

CM
For more information on the CHOOSE Health CHW Program:
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THANK YOU

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United Way of Greater Atlanta