Save the Date!

For all of the latest conference planning details, go to:

http://www.iienet2.org/SHS/Conference/

To get involved and volunteer on the planning committee, email:

SHS.HSPIC@gmail.com
Educational Sessions:
• Facility Tour at Nemours Children’s Hospital (Wednesday, March 1)
• Keynote Address by Julie Ginn Moretz on Thursday, March 2
• Keynote Address by Donald J. Wheeler on Friday, March 3
• Process Improvement, Change Management, Operations Research, Quality and Safety, Research & Human Factors Sessions
• Expert Panel Discussions

Social & Networking Events:
• Student Welcome Reception (Wednesday, March 1)
• Speed Networking Event (Wednesday, March 1)
• General Welcome Reception (Wednesday, March 1)
• Young Professionals Social/Networking Event (Thursday, March 2)
• Dutch Treat Dinners (Thursday, March 2)
• Lean Cocktails Event (Friday, March 3)
At the 2016 HSPI Conference, Dr. Rawson challenged SHS members to quantify the value they are providing to health systems across the country. Members of the SHS Young Professionals/Early Career committee are leading the call to action by gathering and analyzing information from SHS Members and will deliver the results of the data collection and analysis at the 2017 HSPI Conference.

In order to quantify the value of the SHS community we need you to complete a short form defining project work you have done. Please complete and submit this form: https://goo.gl/forms/UdKz440R1vuT1SOg1

We will be collecting data from October to December of 2016.

If you have any issues completing the form or general questions, please reach out to the following:

SHS Young Professionals/Early Career Vice-Chair Laura Silvoy at lsilvoy@array-advisors.com
SHS Young Professionals/Early Career Vice-Chair Amy Slovacek at amy.slovacek@LSSLiving.org
The Care One Clinic

Robert Leverence MD, Deepa Borde MD, Jacqueline Pinkney LCSW, Joy Wright PharmD, Robin Rocks RN

November 15, 2016
Agenda

- Introduction
- Clinic Overview
- Demographic Data and Outcomes
- Lessons Learned
Expenses Incurred by Different Percentiles of U.S. Population: 2002

Research in Action, Issue 19

Characteristics of SU population

- High burden of medical illness and high mortality
- Both uninsured and publicly insured
- Mental Illness
- Substance Abuse
- Childhood trauma (ACEs)
Barriers to Care

- Frequent ED Visits and Admits
- Homelessness
- Medically Frail
- Lack of Insurance/PCP
- Mental Illness
- Low Health Literacy
- Pain and Addiction

Resulting in:

- Poor Health Outcomes
- Higher Healthcare Costs
Super-Utilizer Summit

- Build Relationships and Trust
  - Medication Reconciliation
  - Frequent face-to-face encounters
  - 24/7 access
  - Pain Management
  - Substance Abuse Treatment
  - Linkage to Primary Care
  - Timely Post Discharge Follow up
  - Housing
  - Self Management Education

UF Health
Agenda

- Introduction
- Clinic Overview
- Demographic Data and Outcomes
- Lessons Learned & Solutions
Why Care One?

- Reduce over-utilization of the ED and hospital
- Improve coordination of care and quality of care
- Facilitate safer transitions of care from ED/Hospital to PCP
Background

- University of New Mexico: Similar program yielded: 70% reduction in ED visits

- Many other programs have had similar success
  - Spectrum Health, Grand Rapids, MI
  - Camden Coalition, Camden, NJ

- LIP: Awarded UF Health $660,000 over 2 years

- Opened November 2012
Care One Clinic

- 5 Half-days per week
- Staffed by:
  - Hospitalist
  - Social Worker (Case Management)
  - RN
  - Pharmacist
  - Financial Reps/ Clinic check-in
- Pain/Addiction: 2 afternoons per week
- Clinical Psychologist 1 morning per week
  - Group and Individual counseling
Complex Care Management

- Health Plan Model
- Primary Care Model
- aICU (ambulatory ICU) Model
- Hospital Discharge Model
- Emergency Department–Based Model
- Home–Based Model
- Housing First Model
- Community–Based
Criteria for Care One Referral:

- **Frequent Visitors**
  - Patients with 4 or more ED visits in 6 months (even if they have a PCP)

  404 patients on first FV List

- **Post Discharge from Hospital or ED:**
  - unable to get timely PCP follow up
  - no PCP and require close follow up and coordination of care
Case

- 50 y/o Male Medicaid patient with h/o hypopituitarism, prior IV drug use, depression and behavioral issues related to pain medications;
- 16 visits in the 12 months prior to Care One

Step 1
- RN investigates

Step 2
- SW screens for barriers

Step 3
- Pharmacist reviews medications, cost, and compliance
Case

Discharged from PCP

Missed Appointments

Addiction

Severe Depression

Son killed in MVA and Low Testosterone

Step 4
- Hospitalist listens to team and patient
Case

- Medical Management
  - Treated depression, resumed Synthroid
  - Referred to Endocrinology

- SW called to request placement one of our Family Medicine clinics

- Accepted and zero ED visits since

Step 5
- Care Plan is developed

Step 6
- Patient graduates once barriers addressed
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Demographic Data

- 186 FV (4+ ED visits/ 6 months before enrollment)
- 449 Post Discharge Patients
- 93% Psychiatric diagnosis
- 66% Substance Abuse
- 35% Low Health Literacy (REALM-SF < 7).
Care One Payor Mix

- Commercial/Other: 38%
- Medicaid: 42%
- Medicare: 17%
- Self-Pay (Uninsured): 3%
Care One Outcomes

Average Hospitalizations per patient

Pre: 3.0 | Post: 2.3

Average Hospital Days per patient

Pre: 13.8 | Post: 10.6

Average ED visits per patient

Pre: 4.5 | Post: 4.0
Cost Savings

- Reduction in 206 unfunded hospitalizations
- Average reimbursement per hospitalization (including self pay) = $8,780
- $1.8 Million in potential savings
- Operating cost of the clinic during this time period = $700,000
Agenda

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- Lessons Learned & Solutions
## Lessons Learned

<table>
<thead>
<tr>
<th>Problems</th>
<th>Solutions</th>
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</thead>
<tbody>
<tr>
<td>Fragmented Care</td>
<td>Embed care team and time into Medical Home</td>
</tr>
<tr>
<td>Lack of impact on highest users and Medicaid</td>
<td>Team Care Plan BPA Partner with Medicaid CM</td>
</tr>
<tr>
<td>Enrollment</td>
<td>Meet/ enroll at bedside Patient readiness to participate</td>
</tr>
</tbody>
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## Lessons Learned

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<td>Chronic Pain/ Addiction</td>
<td>Set limits</td>
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<tr>
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<td>Close Monitoring</td>
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<tr>
<td>Lack of appropriate primary care options</td>
<td></td>
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<tr>
<td>High Cost of Medications</td>
<td>Charity Care</td>
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<tr>
<td></td>
<td>Patient Assistance Programs</td>
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Thank You