Meeting the Needs of Vulnerable Patients at Discharge

Institute for Health Care Improvement - Annual Conference
December 12th, 2017

Presented by
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Disclaimers

- We have no conflicts to report
- We have nothing to disclose
- We have nothing to confess
Objectives

- Illustrate steps to successfully design a program to address social needs impacting safe and secure discharge

- Develop an understanding of the benefits to the patients, and an organization, from a discharge support program

- Demonstrate an effective approach to tackling a systematic problem and program implementation across multiple hospitals

- Provide a “How To” effectively partner with a community based organization to address health related social needs and connect patients to needed resources

- Participants will leave equipped to create their own action plan
Providence St. Joseph Health is a faith-based multi-state not-for-profit health system representing 50 hospitals and 829 clinics.

Focused on a singular commitment to improve the health of everyone in our communities, especially those who are poor and vulnerable.

Providence has served Oregon for 160 years with our 8 acute care hospitals, over 100 clinics and a regional health plan.
We start with Providence heritage...

Our traditions call us to focus on the “poor and vulnerable” in our communities. Our organization started as a ministry to provide shelter and food to those in immediate need. Women and orphans who needed food and shelter.

Health related “social determinants” aren’t foreign concepts to us, they are part of who we are.

It is an exercise of the heart and mind…
Where We Started – Patient Support Redesign

- **Mission** - Serving a large patient population with health related social needs impacting safe and secure discharge

- **Business** - Patients can get “stuck” in a level of care that they don’t need because they lack the resources to be safely discharged.

- **Regulatory issues** – Strict guidelines and limitations for helping patients with their non-medical needs

- **Compliance concerns** - Internal audit identified risks in the way we were assisting patients with basic supports

- **No standardization** - Eight hospitals –menu of services or access to supports
Steps for Success

Have a vision of what your working towards – Long term vision, leadership invested

Understand the problem, spend time on this

Determine criteria for selecting a strong community partner

Internal Program Development
- Resource with Senior Project Manager
- Create cross organization work teams & steering committee
- Engage end users and community partner in program design & evaluation
- Determine the program framework

Utilize data and evaluation to secure/sustain funding and inform improvement work.
Understand the Problem - Identifying the real issues;
Criteria for Selecting a Community Partner

- Pre-existing Relationship
- Proven track record/respected in the community
- Knowledge of or experience working with Health Systems
- Willing and eager to do cross sector work

- Services area compatibility
- Mission and Core Values
- Willing to accept technical assistance/consultation if needed
- Desire to co-design/collaborate
About Project Access NOW

**Project Access NOW’s Mission**
To improve the health and well-being of our communities by creating access to care, services and resources for those most in need.

**The Solution**
*Project Access NOW turns community health visions into community-wide solutions.*

Providence has partnered with Project Access NOW since 2007 to target the obstacles people face accessing care and services along with other health care, government, and community partners. Project Access NOW is committed to making the most of existing resources and promoting systemic solutions. The intent is to promote alignment, efficiency and effectiveness.

**Impact**
Since 2008, Project Access NOW has:
- Connected more than 20,000 individual cases to donated health care worth over $40M.
- Helped more than 40,000 people enroll in health insurance.
- Filled more than 40,000 prescriptions at a $4 copay or less.
- Helped pay the insurance premiums of more than 1,000 people.
- Helped more than 15,000 people safely discharge from the hospital by providing non-medical assistance.

**Programs**
- **Classic Care Coordination**
- **Outreach, Enrollment & Access**
- **Community Pathways Network**
- **Community Assistance Program – Patient Support Program**
Determine program framework

Legal and Compliance

Engage end users and CP in program design & evaluation

Create cross organization work teams & steering committee

Evaluation & Reporting

Senior Project manager
Patient Support Program – Program Framework

Community Partner Administered Program
- Vendor contracts
- Eligibility Criteria
- Exceptions Requests/”Other”

Web Application
- Performs the needs determination
- Collects details for the specific assistance including demographics
- Prints required vouchers in real time

Standardization
- Menu of services
- Eligibility criteria
- Reporting and data collection across entire Oregon Region (8 hospitals)
Patient Support Program – Sample Services

- **Diabetic Supplies – 90 Days**
- **Regular/Premie/Car bed**
- **Multiple transportation options**
- **Full cost or Co-Pay only**
- **Guest Housing, Hotels, Recovery Friendly, Medical Respite**
Patient Support Program – Program Framework

Intended for very low income patients or patients facing financial hardship, that have no other options

Services provided through this program are intended to be a short-term bridge - typically 30 days or less

Also used to support patients during their stay or for an acute/time-limited need while undergoing treatment at a hospital based clinic or department

Central Oversight by Regional Community health Division (1.25 internal FTE)

Funded by Community Benefit and Hospital Foundations
Patient Support Program – Program Framework

- **550** Caregivers are trained and can access the program
- **12,000** Patients were assisted within the first 2 years
- **20,000** Total assistance items have been requested

**TOP REQUESTED SERVICES**

*Transportation, Medication, Temporary Housing*
Sample Voucher

Key Departments

- Inpatient CM
- Emergency
- L&D/NICU
- Behavioral Health
- Oncology

[Image of a voucher form with details about a service authorized by Project Access NOW, including name, service type, account, phone number, and address.]
Patient Support Program – MOW Pilot

Who are we helping?
- Patients 50 years or older
- Eligible for Patient Support Program – Low Income
- Discharging to an independent living situation
- Access to food, ability to pay for food and/or ability to prepare meals, immediately post discharge, is a concern or worry

**Situation:** Edith, age 55, lives alone and was admitted with a complex ankle fracture that required surgery & multiple pins. After several days in the hospital, Edith was discharged with strict “non-weight bearing” instructions. Knowing Edith was already stretching her food stamps prior to surgery, the Nurse Care Manager was concerned that good nutrition and having enough food could complicate her recovery. In addition, Edith reported that she had no support system to help her shop or cook meals.

**Outcome:** Thanks to the Peterson Project, the normal age limit of 60 for Meals on Wheels didn’t apply here*. Edith was enrolled in MOW while still in the hospital and started receiving prepared meals the day after she arrived home. Edith called the program a life saver and was especially grateful when she was approved for 2 extra weeks (6 wks. Total) of meals – supporting her until she could put some weight on her ankle and was able to move around her apartment safely.
Patient Support Program – Data & Reporting
Patient Support Program – Data & Reporting

OVERALL

INDIVIDUAL
CLIENTS SERVED (n) 485

VOUCHERS
APPROVED (n) 718

TOTAL
COST ($) 

PATIENT PROFILE

GENDER

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>40.2%</td>
</tr>
<tr>
<td>Male</td>
<td>59.8%</td>
</tr>
<tr>
<td>Transgender</td>
<td>-%</td>
</tr>
<tr>
<td>Unknown</td>
<td>-%</td>
</tr>
<tr>
<td>Homeless</td>
<td>24.7%</td>
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</table>

INCOME (% Federal Poverty Level)

<table>
<thead>
<tr>
<th>Income Range</th>
<th>%</th>
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<tbody>
<tr>
<td>0%</td>
<td>27.8%</td>
</tr>
<tr>
<td>1-100%</td>
<td>46.6%</td>
</tr>
<tr>
<td>10-250%</td>
<td>20.0%</td>
</tr>
<tr>
<td>&gt;250%</td>
<td>6.6%</td>
</tr>
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RACE

<table>
<thead>
<tr>
<th>Race</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>White</td>
<td>82.5%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>1.6%</td>
</tr>
<tr>
<td>American Indian</td>
<td>0.6%</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>0.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>0.4%</td>
</tr>
<tr>
<td>Bir or Multiracial</td>
<td>0.6%</td>
</tr>
<tr>
<td>Eastern European</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>13.0%</td>
</tr>
<tr>
<td>Patient Refused</td>
<td>0.8%</td>
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INSURANCE TYPE

<table>
<thead>
<tr>
<th>Type</th>
<th>%</th>
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<tbody>
<tr>
<td>CHIP/Medicaid</td>
<td>17.3%</td>
</tr>
<tr>
<td>Medicare</td>
<td>40.1%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>18.6%</td>
</tr>
<tr>
<td>Commercial</td>
<td>4.9%</td>
</tr>
<tr>
<td>CAMEL City</td>
<td>0.4%</td>
</tr>
<tr>
<td>Veterans Affairs HCC</td>
<td>3.7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>-%</td>
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ETHNICITY

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>%</th>
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<tbody>
<tr>
<td>Non Hispanic/Latino</td>
<td>73.2%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

LANGUAGE

<table>
<thead>
<tr>
<th>Language</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>85.4%</td>
</tr>
<tr>
<td>Spanish</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>13.8%</td>
</tr>
</tbody>
</table>
## Patient Support Program – Data and Reporting

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>VOUCHERS APPROVED (n)</th>
<th>% of TOTAL VOUCHERS APPROVED</th>
<th>RANK</th>
<th>COST ($)</th>
<th>% of TOTAL COST</th>
<th>COST RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airplane Ticket</td>
<td>4</td>
<td>0.0 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Long Distance Bus/Train Ride</td>
<td>57</td>
<td>0.5 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Local Transportation (Ambulance, Cab Ride, Secure Transportation)</td>
<td>5,568</td>
<td>48.9 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Medication (100% payment)</td>
<td>3,014</td>
<td>26.5 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Medication Co-payment</td>
<td>172</td>
<td>1.5 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Surplus Medication</td>
<td>122</td>
<td>1.1 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>21</td>
<td>0.2 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>22</td>
<td>0.2 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Cafeteria Services</td>
<td>1,209</td>
<td>10.6 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Guest Housing/Hotel/Motel/Shelter</td>
<td>612</td>
<td>5.4 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Recovery Housing Program (clean and sober)</td>
<td>26</td>
<td>0.2 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Recuperative Care Program</td>
<td>23</td>
<td>0.2 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Infant Car Seat</td>
<td>333</td>
<td>2.9 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Other Assistance (special requests)</td>
<td>193</td>
<td>1.7 %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Tri-Met Passes †</td>
<td>333</td>
<td>- %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
<tr>
<td>Shelter Coupons †</td>
<td>333</td>
<td>- %</td>
<td></td>
<td>$ -</td>
<td>- %</td>
<td></td>
</tr>
</tbody>
</table>

† These vouchers are NOT included in the total VOUCHERS APPROVED above because they are not captured in the CLARA data source.
Future State – Impact Study

- Providence’s Center For Outcome Research and Education (CORE) is overseeing evaluation activities
- Study will include housing and Meals on Wheels voucher recipients

Methods:
- Patient Surveys
- In depth qualitative interviews
- Analysis on readmissions and re-visits to the emergency department of participants
Future State - Next Steps:

**Addressing Immediate and Some Intermediate Health Related Social Needs after Discharge, in the Community**

**Screen**
Hospital Discharge Planner screens early for discharge barriers

**Refer**
Use web based tool to request services for patient

**Triage**
PANOW identifies external resource and approves

**Connect**
A network of agencies working with individuals & families on achieving shared, targeted outcomes (Home or Community)
Regional Social Determinants of Health Network will provide “one door” into a more coordinated, culturally aligned, social service system.

“Pathways” are protocols that will provide outcomes-based partial payments to navigation agencies as each “step” in the process is completed. Examples of “pathways” include housing, insurance enrollment, connection to a medical home, nutrition and employment assistances.
Summary

- Thorough understanding of the problem to solve & the needs
- Identify key stakeholders and funders
- Identify well positioned community partner
- Co-Design with community partner and end users
- Resource appropriately, including with the community partner
- Use reports for monitoring, improvements, and to inform investments
- Keep thinking about the future