The Lehigh Valley Super Utilizer Partnership:

Overview and Impact
June 2015

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"Hope is the thing with feathers
That perches in the soul,
and sings the tune without the words,
and never stops at all…"

~ Emily Dickinson

A Message from Executive Director, Melissa Craig:

When my mind considers the work of the Lehigh Valley Super Utilizer Partnership (LVSUP) I am hopeful. How fortunate we are to live in a community that accepted a vision for a community based solution to a perplexing and important healthcare concern. This demonstration project has been filled with people and organizations that persistently, patiently, and hopefully worked through all the negotiations, re-thinking, and conversations it took to get to the point we are at in June 2015. Not necessarily where we will be, say, in September, and definitely not where we hope to be in July 2016 or further in the future, for sure.

This preliminary report of the Lehigh Valley Super Utilizer Partnership (LVSUP) Demonstration Project, "Sustainable High-Utilization Team Model" reflects the progress achieved to date in developing an innovative care management strategy for high-cost, high-need populations from low-income communities in the Lehigh Valley. One of four funded sites across the country, Neighborhood Health Centers of the Lehigh Valley's (NHCLV) model, an adaptation of Dr. Jeffrey Brenner's work in Camden, NJ, focused on very high users of preventable hospital care with a goal of developing a strategy that reduced preventable hospitalizations while improving patient outcomes. Locally, the design of LVSUP represents a small group of committed individuals with a vision for how a community solution could best support some of our community's most fragile and often sidelined members. The funding helped move the vision from wish to reality; community has supported it since.

The work has been filled with hope, energy, and creativity but it has not been easy. The work involved is hard- for the patients, for the team, and for the system of care that are also our partners. The possibilities though are amazing to behold and we have been fortunate to witness it right here in our local community over the past few years.

We look forward to integrating this community care management model into the NHCLV scope while continuing the data and community level work started by this demonstration opportunity. We are hopeful that the larger community will also continue investing in the next phase- transitioning from innovation into a sustainable community based model that achieves positive patient outcomes while reducing preventable utilization.

On behalf of Neighborhood Health Centers of the Lehigh Valley and the LVSUP team, thank you, for supporting NHCLV as the stewards for this important work.

Background & History

IT ALL STARTED WITH A FEW CONVERSATIONS

We called them sandbox conversations. Who would play in the sandbox to build equity in health care? Who would gather to build a community solution for and with people who slip through the cracks? Inspired by Dr. Jeff Brenner from the Camden Coalition of Health Care Providers, Josh Chisholm from POWER, Kathy Perlow from Community Exchange, Abby Letcher from NHCLV and Deb Gilbert from the Parish Nursing Coalition formed the Lehigh Valley Super Utilizer Partnership (LVSUP) to address the harmful effects of fragmented health systems and economic inequality on vulnerable patients in the Lehigh Valley. We have focused on the super utilizers, people with complex illnesses that cycle in and out of hospitals without improving health status. These patients are the outliers who show us the deepest flaws in our health care systems. Our partnership, drawing on the unique skills and perspectives of each of our organizations, makes all of us stronger. We need that strength, flexibility and support to address root causes of inequity in health and health care in the Lehigh Valley.

BEFORE THERE WAS FUNDING, THERE WAS GUY #1

When Jeff Brenner came to the Lehigh Valley for a POWER event, after presenting data about hotspotting and high utilization, he looked us in the eye and challenged – "You know their names." To understand what issues we were facing on a personal level, we decided to work with one patient and his health care team. A physician partner in the LVHN Emergency Department nominated a patient that they knew all too well. We contacted his PCP and started to meet monthly to talk about the case we called Guy #1. Josh worked with him directly for the better part of a year, drove him to appointments, felt his loneliness, saw his resourcefulness, and helped him define and achieve a goal to work with children. Josh helped arrange for him to talk about smoking with 9 year old children. "You are the same age I was when I started smoking Now I wear this oxygen just to get around." (cont. on next pg.)

1st row seated: Margie "Gigi" Pacheco, Yuriko Delacruz, Elisa Castillo, Deb Gilbert, and Hasshan Batts;
2nd row standing: Joshua Chisholm, Janelle Zelko, Lauren Hicks, Francigna Rodriguez, Carmen Rodriguez, Genay Jackson, Lucy Morales, and Helen Willis.

The kids touched his oxygen, they asked questions. They clapped for him. Later with tears in his eyes Guy #1 told Josh that nobody had ever clapped for him before. He passed away soon after. We are grateful to Guy #1 for all he taught us.

BUILDING THE TEAM

In 2012, NHCLV joined Rutgers University's Health Care Innovation Award from the Center for Medicare and Medicaid Innovation to adapt community care coordination pioneered by Dr. Jeffrey Brenner's Camden Coalition of Health Care Providers. With this funding opportunity LVSUP was able to build a team to offer community-based, interdisciplinary team care focusing on coaching and community building through weekly home visits, accompanied primary care and specialist visits, coaching for wellness goals, extensive care coordination and community engagement. We have worked with all of the hospital networks in the area, following patients wherever they need us, with the goal of reducing unnecessary hospital utilization by building stronger ties to primary care, self-management skills and community connection.

LOOKING FORWARD

LVSUP has developed a powerful model of trauma informed, relationship centered, community engaged care that improves lives and can reduce unnecessary hospital utilization. We have built meaningful collaborations with the major health networks and are just starting to have enough data to show the potential of our model. We feel strongly that our community voice is important in representing the needs of the population as a whole, not bounded by a particular network or payer. With community investment to support LVSUP, we can continue to address root causes at the community level and ensure that difficult to engage populations using multiple networks will not be overlooked and underserved.

Patient Demographics

n = 140 patients

56 was the average age of participants upon enrollment.

54% of participants are female; **46%** are male.

6.5 The average number of months commenced patients spent in the program (through March 2015).

About the Lehigh Valley Super Utilizer Partnership:

The Lehigh Valley Super Utilizer Partnership (LVSUP) provides intensive outreach and care coordination for patients with complex illness who have been admitted to the hospital two or more times in the past six months. This program approach has been shown to improve care outcomes and reduce costs for individual patients with high inpatient and emergency department use.

Our goal is to help patients learn to navigate the complicated world of health care, strengthen connections with their clinicians, and set and accomplish goals that improve their quality of life.

The LVSUP is a program of the Neighborhood Health Centers of the Lehigh Valley (NHCLV).

Our Mission:

The mission of the Lehigh Valley Super Utilizer Partnership is Wellness.

Motivated by justice and a vision of a complete community, the LVSUP builds relationships, innovates creative care, and finds collaborative solutions collectively to become a stronger, healthier, more integrated community so that we may all find dignity and use our gifts to enhance wellness in each others' lives.

Core Values:

47% White/Caucasian
14% African-American
16% Multiracial
21% Other

44% Hispanic/Latino
14% Non-Hispanic/Latino
7% Unknown

Health Status

On average, patients have **6** chronic conditions.

77% of patients present have **4 or more** chronic conditions.

On average, patients report **21** out of **30** physically unhealthy days, and **14** out of **30** mentally unhealthy days.

On average, patients reported **17** out of **30** days of limitations in activities due to feeling unhealthy physically and/or mentally.

Top 4 self-reported major impairments or health problems:

Walking problem - **20%**
Heart problem - **11%**
Lung/breathing problem - **10%**
Diabetes - **8%**

WHAT'S AT THE ROOT OF IT ALL?

Barriers, at baseline (n=140)

TRANSPORTATION

88% of patients do not have reliable transportation.

FOOD ACCESS

41% of patients reported trouble affording food.

MENTAL HEALTH

63% of patients report feeling down, depressed, or hopeless two weeks prior to enrollment.

INADEQUATE HOUSING

At least 26% of patients lack stable housing.

Mobility & Assistance

77% of patients report being limited in some way.

82% of patients lack optimal autonomy because of impairments or health problems.

35% of patients report needing help with personal care such as eating, bathing, and dressing.

59% of patients report needing help with routines, such as household chores and shopping.

SOCIAL SUPPORT

44% of patients report inconsistent social support.

FRAGMENTED HEALTH CARE SYSTEM

58% of patients utilize at least 2 different hospital systems.

Approaches & Techniques

The LVSUP utilizes a trauma-informed care approach to patient care. All patients complete the Adverse Childhood Experiences (ACE) survey and contribute to developing a trauma sensitive care plan. Patients that report a history of trauma have access to behavioral health services to support them in their healing and recovery. All LVSUP services and assessments are sensitive to the impact traumatic experiences have on human development, functioning and decision making. Our team practices trauma sensitive approaches with every patient encounter, focusing on honoring patient and staff safety, trust, respect, collaboration, choice and empowerment. Staff accomplish this by focusing on a relationship oriented model and treating all patients with dignity and non-judgement.

Relationship Centered Care suggests that healing occurs in the context of relationships. LVSUP staff focuses their first few visits on developing trust, understanding and communication to foster a relationship built on acceptance, dignity and respect. We believe that establishing relationships that include familiarity with our patients' passions, experiences, living conditions and family structure assist us in providing and advocating for care that places the patient at the center. We utilize models of care and compassion to educate and support patients in maximizing their potential, achieving wellness, managing their diseases and utilizing community resources to improve their lives.

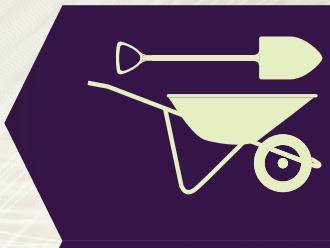
The barriers that patients face are multiple and complex, requiring partnerships with various community-based organizations to address these barriers.

A strength-based approach views individuals as having resources to be enhanced upon rather than shortcomings to be remedied. This promotes self-determination by involving the individual in decision-making, which is extremely important for their well-being with regard to self-esteem.

Traditionally, healthcare providers have committed to cultural competency, which focuses on increasing knowledge and understanding of different cultures and how those differences impact our work with patients. Cultural humility suggests providers are responsible for forgoing stereotypes and acknowledging the uniqueness of every patient's cultural expressions. The LVSUP utilizes cultural humility by seeking to understand the identity, needs, and preferences of patients by asking them what is important to them. Cultural humility begins with self-awareness and a willingness to listen attentively to patients' cultural needs and preferences. By acknowledging that we as providers may bring assumptions, prejudices, and blind spots to our work, we minimize the harm we may cause in our interactions with patients and we create an environment conducive to learning and equity.

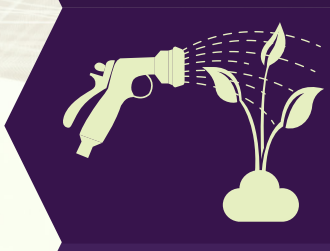
- Trauma-Informed Care
- Relationship-Centered Care
- Strength-Based Approach
- Community Solutions
- Cultural Humility

Strategies & Tools



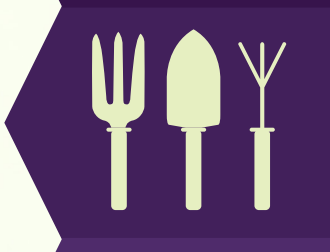
COACHING

Ensure that patients keep record of medical appointments, refill prescriptions as needed, and satisfy identified wellness goals.



MODELING

Demonstrate appropriate interactions and communications with healthcare providers, social service organizations, and other community resources.

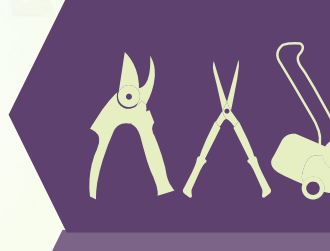


CARE COORDINATION

Coordinate efforts to fulfill patients' medical and social needs.

ENCOURAGEMENT

Provide positive reinforcement to patients throughout the intervention.



HOME VISITS

Establish a personal connection with patients in their homes with weekly visits.

WELLNESS PHONE CALLS

Maintain frequent contact with patients, including phone calls at the beginning and end of each business week during the intervention and then phone calls every 30 days once patients commence from the program.

ACCOMPANIMENT TO MEDICAL APPOINTMENTS

Attend medical appointments with patients to foster empowerment and enhance communication with providers.

Outcomes

HEALTH & ACTIVATION

The following data is for patients with follow up data at or after commencement.

16 out of 28 patients reported an improved health rating.

20 out of 28 patients reported an improvement in number of physical healthy days.

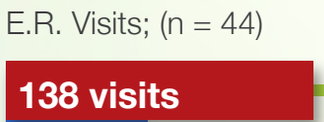
13 out of 28 patients reported an improvement in number of mental healthy days.

23 out of 34 patients had improved patient activation scores.

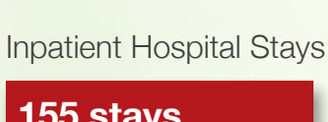
E.R. VISITS, HOSPITALIZATION & LENGTH OF STAY

The following information is for 44 patients who successfully commenced from LVSUP and had at least 6 months post-intervention data by the end of March 2015.

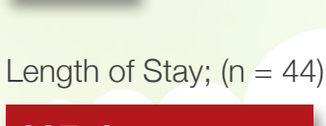
E.R. Visits; (n = 44)



Inpatient Hospital Stays; (n = 44)



Length of Stay; (n = 44)



6 months prior
6 months post

When applying the Agency for Healthcare Research and Quality hospital stay cost estimates, the LVSUP has saved $773,500.

Patient Story: Flor

6 months before starting LVSUP, Flor visited the emergency room once and had two inpatient stays lasting 8 days in total.

Flor was enrolled in the LVSUP on 3.4.2013

That's a **54%** decrease in the number of E.R. visits . . .

. . . a **59%** decrease in the number of hosital stays . . .

. . . and a **51%** decrease in the average length of stay!

COMMUNITY BUILDING

28 patients have been enrolled in Community Exchange.

21 patients have been active in Community Exchange from June 2014 through March 2015.

For these patients, there have been:

396 total exchanges
536 total hours earned
220.75 total hours spent
756.75 total hours transacted

7 spouses and community members have enrolled in Community Exchange.

For these participants, there have been:

60 total exchanges
75 total hours earned
30.5 total hours spent
105.50 total hours transacted

She did not have any hospitalizations or emergency room visits throughout her time in the program.

She successfully commenced from the program in August 2, 2013.

Flor joined Community Exchange in November 2013, and has transacted over 300 hours to date.

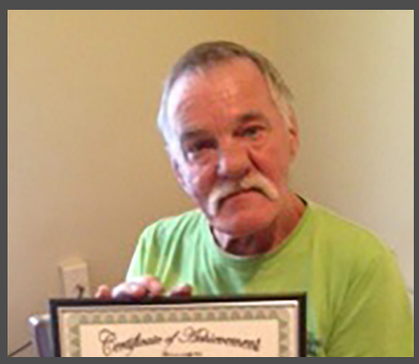
Lawrence

Lawrence was one of our first teachers. Lawrence presented with over 8 chronic conditions, bi-monthly hospitalizations, challenges with mobility, and unreliable transportation to dialysis. Prior to developing a team, the founding LVSUP partners enrolled the program's first four patients including, Lawrence. When asked what was his most pressing need, Lawrence humbly responded, "a doorbell." The partners later learned that LANta van drivers would only beep their horns when they pulled up to Lawrence's house, despite his immobility. Lawrence's health took a turn for the worse when he was hospitalized due to a snowstorm and LANta policy prevented the drivers from transporting patients when they could not reach the curbside. Lawrence's subsequent hospitalization exceeded $70,000. Working with Lawrence helped the partners learn about the complications involved with working with complex patients. The team's understanding of the need for collaboration increased through working with Angela, a social worker at Fresenius, to partner with Lawrence in recognizing his strengths, making significant health behavior changes, and achieving true success.

Lydia

Lydia was in a nursing home completing rehabilitation due to multiple chronic conditions and poorly managed diabetes. She was unable to be discharged due to homelessness and was unable to secure housing due to immobility. LVSUP staff was able to locate and secure an apartment for Lydia, as well as support her in enrolling in meal and grocery delivery services, securing transportation services to dialysis and medical appointments, enrolling in the kidney transplant list, and joining Community Exchange.

Dennis



Dennis was wrestling with homelessness, multiple chronic health conditions, lack of transportation to medical appointments, and no social support or method of communication when he was referred to LVSUP. Once joining the team, Dennis was able to identify and achieve his goals of securing housing, food assistance, a cellphone, and medical transportation to doctors' appointments.

Stories & Accomplishments

Worked with 74 Primary Care Physicians.

Founding member of the South Central Pennsylvania High Utilizer Learning Collaborative.

Collaboration between 3 hospitals; with combined data from 2 hospitals so far.

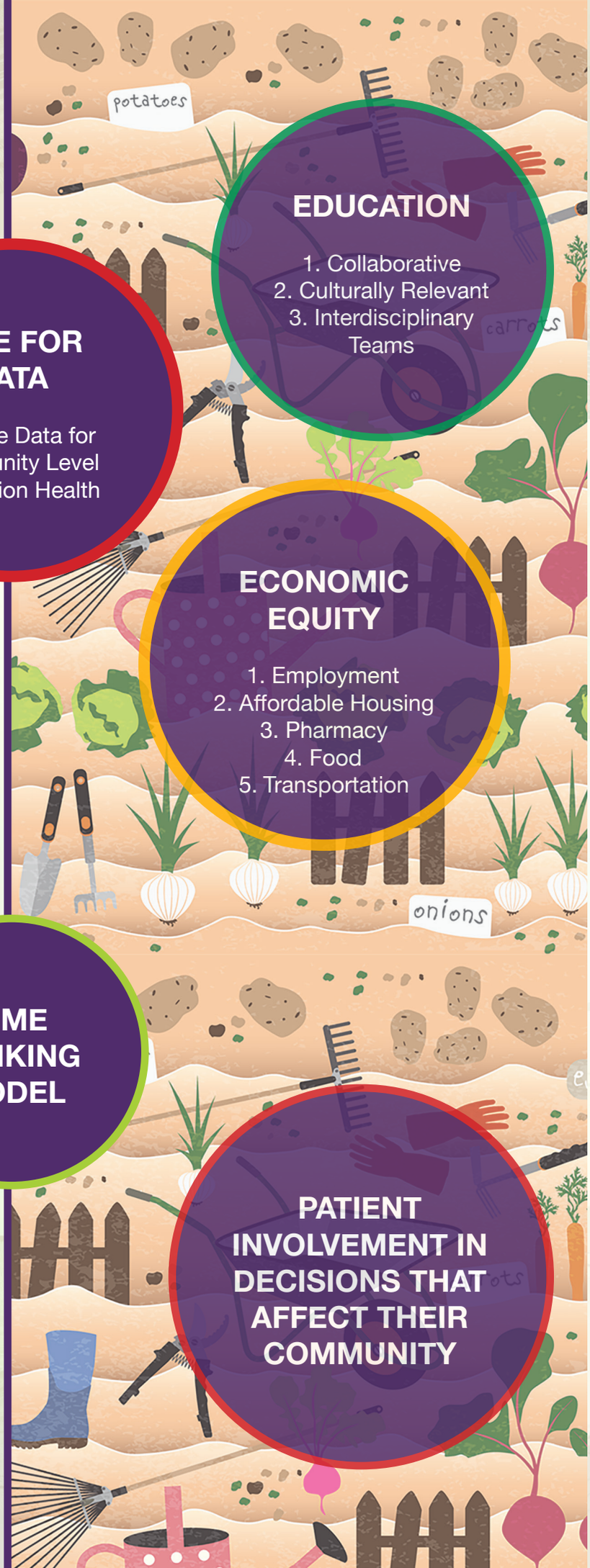
Carlo

Carlo was living in single room occupancy (bedroom with a shared kitchen & bathroom). While enrolled in the program, Carlo was able to secure an apartment, receive assistance with unpaid medical bills, reduce pending motor vehicle violations and fines, and receive home-delivered oxygen. Carlo also joined Community Exchange and has been contributing to his community by providing rides to his neighbors and participating in community events.

"You gave your time to me, to help me get things right, and I can tell you seriously, I'm beginning to see the light."

- Lydia

FUTURE DIRECTION OF THE LVSUP



EDUCATION

1. Collaborative
2. Culturally Relevant
3. Interdisciplinary Teams

TIME FOR DATA

1. Share Data for Community Level Population Health

ECONOMIC EQUITY

1. Employment
2. Affordable Housing
3. Pharmacy
4. Food
5. Transportation

INVESTMENT

1. Peer Support
2. Community Health Workers
3. Integrated Physical and Behavioral Health & Substance Abuse Services
4. Trauma Informed Care
5. Relationship Centered Care

TIME BANKING MODEL

PATIENT INVOLVEMENT IN DECISIONS THAT AFFECT THEIR COMMUNITY

COLLABORATION BETWEEN HOSPITAL NETWORKS

Testimonials

"When I think about the Neighborhood Health Centers of the Lehigh Valley and the Super Utilizer Partnership, my faith in the simplicity of coming alongside of another human being and lending a hand is restored. Too often in day to day health care the needs of "the patient" are reduced to the bare science of lab values, medications and surgery. The medical model often overlooks the barriers the average patient faces on a daily basis in access, feasibility and emotional struggles. Often times, I see patients become depressed and complacent about managing their chronic diseases, which can become a daily battle. It is difficult to keep your blood sugar in check if you're not sure where you will sleep tonight. Hospitals can often overlook matters like this, we're here to treat you medically but we can't help with your overwhelming social problems. Even when problems are identified, they are too vast for a hospital discharge planner to address all the needs in a brief encounter just prior to discharge. The Neighborhood Health Centers comes along side the patient and becomes an encourager, partner and practitioner all in one. They provide education and practical support that allows people to set their own goals and actually accomplish them. Health care goals are accomplished because the person's day to day life becomes less chaotic and they have someone to share in their stressors. They have someone to call who cares about them. Often times the road to helping chronically ill patients with social problems can be a long and winding road, but the NHCLV is willing to accept the challenge and navigate complex needs."

Rebecca Pagliarulo MSW, LSW / Social Work Case Manager
St. Luke's Hospital and Health Network Allentown Campus

"The LVSUP is a great community resource. I have referred two high utilizers and hospital admissions were decreased since enrollment to the program. My experience with the program has been positive; the involvement of the Community Health Workers with the patients is outstanding. My two patients had multiple comorbidities, high anxiety, depression, history of substance abuse, had a cancer diagnosis and lacked social/family support. When it was time to discharge them from Navigation Services, I was thankful to find the support and resources available through LVSUP. My patients received the support they needed and they were also empowered to take charge of their lives. They were given the tools to function in society, guidance and emotional support was also provided."

Maritza Chicas / Oncology Nurse Navigator
Lehigh Valley Health Network

Testimonials

"I have referred about five patients to your program over the past two years. I think the most prevalent common theme in all of our patients that LVSUP has worked with, is that there was a remarkably dramatic improvement in how each patient valued themselves. There was also a significant improvement in each patient's ability to manage and organize their health care needs. I had a few patients that transitioned from being very dependent on health care staff to manage their care for them and they'd often miss treatments, miss rides to dialysis, miss other medical appointments and consequently they would end up being hospitalized repeatedly. I do feel strongly that LVSUP does an amazing job showing compassion, empathy and skilled medical care to some of our "toughest" to reach patients. It seems that the additional time and support, along with helping patients to develop organizational and self advocacy skills, really helps them to invest more of their own time and energy into improving their health. The patients that have worked with LVSUP are all much more skilled at calling our clinic when they have a schedule conflict, they are more determined to communicate their needs and they are much more invested in being a part of their health care. Thank you again to LVSUP for making such a positive difference to all of these patients. The multidisciplinary team approach of LVSUP seems to have had a very positive impact on the physical, mental and spiritual health of each of these patients."

Angela L. Garner, MSW, LSW,
Fresenius Medical Care

Acknowledgements*

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Senior Solutions

South Central Pennsylvania High Utilizer Learning Collaborative

Treatment Trends

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University of Southern California

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West Chester University of Pennsylvania

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The Neighborhood Health Centers of the Lehigh Valley is a Federally Qualified Health Center whose mission is to provide primary and preventive health and wellness services in the Lehigh Valley, regardless of ability to pay. We strive to do this directly and in partnership with other organizations, with a goal of creating a primary health care home for an underserved community.

To keep up with the Lehigh Valley Super Utilizer Partnership, and for a more in-depth review of their work, please visit:

www.nhclv.org/lvsupprogramreport/

Production by:

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