2016 Community Health Leadership Award – Nomination

Nominator Name:	Tony McLean, Market President
Organization Being Nominated:	Highline Medical Center
Name of Program:	Highline Health Connections: Care Navigation for Vulnerable Populations (HHC)
Program Contact:	Carolyn Bonner, RN, BSN, Director of Highline Home Health / Susan Bean, Executive Director Highline Medical Center Foundation

Program Description:

The Highline Health Connections: Care Navigation for Vulnerable Populations program is providing comprehensive care to targeted patients within Highline Medical Center's Primary Service Area (PSA) identified as "super-utilizers" (people with chronic medical conditions, low income and health literacy, and high healthcare use). A care team collaborates with each patient's PCP and others to ensure optimal outcomes and a smooth transition to the community setting. The team addresses each patient's needs (medical, mental health, substance abuse, social services, housing, transportation, food, low healthcare literacy, etc.) in an integrated, holistic manner. The program's purpose is to improve the health care outcomes for these vulnerable patients and by doing so, help reduce Highline's costs of caring for them and improve the overall health of the community.

Highline Health Connections is bridging the gaps in the healthcare system and connecting patients to services and resources for better health. This care transitions program links the most vulnerable, underserved populations within Highline's PSA to evidence-based, cost-efficient care and support, with the goals of connecting patients to appropriate levels of healthcare and community services and/or resources, coaching and supporting patients in achieving personal health goals, and reducing overutilization. Highline Health Connections is an excellent example of a medical center working with its staff and its foundation to reach out and support population health.

Population Served:

Highline Health Connections focuses on poverty-level and low and moderate income clients and neighborhoods. The target population for Highline Health Connections is vulnerable patients whom Highline staff identify as "super-utilizers" while they are hospitalized at Highline, using an evidence-based screening tool that calculates the risk of readmission. These patients have chronic, disabling health conditions, which have been shown to be significantly more prevalent among low-income and other disadvantaged populations.

In the first year and a half of this program, the patients served in this program have reflected the demographic make-up of Highline's southwest King County Primary Service Area (PSA) – a population that is significantly more medically underserved, with heavier language and health literacy barriers and more limited financial resources than other areas in King County. Approximately 36% of Highline's patients are minorities (50% more than the King County average). More than 21% are without health insurance (almost double the King County average) and up to 23% meet federal poverty levels (more

than double the King County average). Up to 23% have less than a high school education (almost three times the King County average) and up to 42% are foreign-born (more than double the King County average). Highline's PSA also has higher rates of diabetes deaths and smoking than other areas in King County and has large areas of food "deserts" (limited access to affordable and nutritious foods).

Goal and measure of success:

Highline Health Connections' goals are to connect patients to appropriate levels of healthcare and community resources, reduce overutilization, and coach and support patients in achieving their personal health goals.

Highline Health Connections' intended outcomes/measures of success are to:
• Achieve demonstrated improvements in all three Triple Aim dimensions (Better Health, Better Patient Experience, and Lower Costs per Capita) for enrolled patients
• Increase access to support services, community resources, and primary care for enrolled patients
• Integrate program within CHI Franciscan Health's strategic plan for care transition programs to ensure sustainability
• Create a replicable model that can be scaled across CHI and sustained through demonstrated cost savings

Please see below (data benchmarking) for how Highline is achieving these measures of success.

How did the nominee identify the community's health need, for example, did you use the community health needs assessment?

Highline used the 2013 Community Health Needs Assessment (CHNA) to identify the community health need to be addressed by this program. The data analyzed as part of the CHNA demonstrated that there are significant disparities in health status and outcomes between Highline's PSA and the rest of King County. Other findings included:
• Compared with the rest of King County, the socio-economic demographics of Highline's PSA show lower educational attainment, lower income, and higher rates of uninsured, with residents more likely to be foreign-born and speak a language other than English at home.
• Overall, PSA residents are more likely to engage in non-healthy behaviors such as smoking and have substantially higher rates of chronic diseases such as diabetes, high blood pressure, and high cholesterol.
• Additionally, PSA residents are more likely to experience food deserts and have fewer public spaces for recreational activity, both factors forming a significant barrier to a healthy lifestyle.

From the information gathered for the 2012-2013 CHNA, Highline's Board of Trustees approved the goal of "addressing both prevention of disease and active management for those that already have chronic health conditions."

The 2015 Highline Community Health Needs Assessment Update indicates that these health disparities are only increasing in Highline's PSA and that:
• The leading causes of death in Highline's Primary Service Area remain chronic diseases (at much higher rates than those in King County overall),

• Highline's PSA also experiences higher rates of adult obesity and diabetes,
• A higher percentage of adult residents in Highline's PSA smoke and binge drink alcohol compared to other neighborhoods in King County,
• A higher percentage of adults living in Highline's PSA self-report a lack of unmet medical needs due to costs, compared to other regions of King County, and
• The rate of residents at or below the poverty rate has increased in several of the communities that make up Highline's PSA – and that many of these communities have also experienced worsening rates of unemployment.

Describe how community partners were involved:

Highline Health Connections is collaborating with several agencies that participated in its Community Health Needs Assessment, as well as others that provide outreach and community services to vulnerable populations and have long-standing relationships with Highline. To ensure patients have transportation to medical/social services appointments, Highline links them to low-cost/free community transport or provide transport support through the program budget. Highline also links them with a 24-hour emergency response system. Highline utilizes TAVHealth to track the connections it makes between the patients and needed resources, track measurable outcomes, and help Highline identify and solve social/financial barriers to health in the community setting; Global to Local to use the patients' mobile phone-based diabetes management program with all appropriate participants; and the National Institute for Coordinated Healthcare to train and source bilingual Community Health Workers.

Additionally, Highline is collaborating with the following on this program:
• Qualis (Quality Review Organization) on providing comparative reports (e.g., statewide 30-day readmission rates vs. Highline's PSA vs. enrolled patients)
• Alliance for Healthy Communities for community training and resources, including behavioral health issues and depression screening, as well as appropriate interventions
• Project Access, a nonprofit that coordinates specialty medical care (i.e., orthopedic surgery) for low-income uninsured people regardless of legal residency status
• The National Institute for Coordinated Healthcare to train and source bilingual Community Health Workers from the communities Highline serves, as well as accessing their database and outcome tracking for these communities
• SHAG (Senior Housing Assistance) to help participants obtain affordable and accessible housing
• The Conversation Project to help participants with Advanced Care Planning

Was the Board of Trustees or the Board of Commissioners involved in the program?

The Highline Medical Center Foundation Board, Highline Medical Center Board of Trustees, and Highline Medical Center Executive Committee were all involved in designing the program; all of these boards are unanimously committed to raising funds and supporting additional philanthropy for this program; the program manager provides regular reports on HHC to both of these boards. The HHC program is a high priority for both the Highline Medical Center Foundation Board and the Highline Medical Center Board:
• The Chair of the Highline Medical Center Board and his wife committed $600,000 to the Highline Medical Center Foundation in program support and have committed to help the Foundation raise additional philanthropic support; • The Highline Medical Center Foundation promoted the program as the priority "fund-a-need" at its fall Gala, which resulted in more than $157,000 in donations from 145

individual donors, has secured a major 3-year $1.2 million program grant from the CHI Mission and Ministry Fund, has included it as a priority in its upcoming comprehensive campaign, and has secured smaller grants and donations for the program; and • Highline Medical Center has committed to providing substantial in-kind support.

Did you use data in benchmarking and goal setting? If you didn't use data, how did you evaluate effectiveness? Please describe.

Yes. Highline used data in benchmarking and goal setting.

Highline's projected outputs are:
• Serving 100 participants in Year 1, 130 in Year 2, and 200 in Year 3.

Highline's projected outcomes are to:
 Achieve demonstrated improvements in all three Triple Aim dimensions (Better Health, Better Patient Experience, and Lower Costs per capita) for enrolled patients
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Please see below (under Results) for how Highline is measuring and achieving results towards these outputs and outcomes.

Highline is using the following evidence-based and other methods to measure these outcomes:
 Better Health: Care team members conduct baseline screening for participants using an evidence-based screening tool (the LACE Index Scoring Tool for Risk Assessment of Death) that calculates the risk of readmission. Highline is using the following evidence-based tools to assess improved health for each enrolled patient: Self-Efficacy For Managing Chronic Disease (Stanford), Personal Health Questionnaire Depression Scale, LACE Index Scoring Tool for Risk Assessment of Readmission, Diabetic SMART Goal, RCA Hospital Re-Admission Root Cause Analysis. Highline is also measuring the improvement in patient healthcare outcomes correlated to participating in Highline Health Connections (HHC) alone vs. being provided services by Highline Home Health along with Highline Health Connections.
 Increased Access: Highline is using the Client Perception of Coordination Questionnaire and Participant Satisfaction Tool to assess the patients' perception of increased access to community and social services.
 Better Patient Experience: Highline is using the Client Perception of Coordination Questionnaire and Participant Satisfaction Tool to assess the patients' perception of improvement in their care due to participation in Highline Health Connections
 Lower Costs: Highline is working closely with CHI Franciscan Health to document the cost-savings realized in overall cost of care for participants as evidenced by reduced hospitalizations and emergency department (ED) visits.
 Integrate Program within CHI Franciscan Health's Strategic Plan: Highline is sharing program results with CHI Franciscan Health Regional Care Management, the Clinically Integrated Care Committee, and

the CHI Franciscan Health Leadership team.
 Create a Replicable Model: Highline is working to demonstrate program success and scalability by: achieving stated outcomes and goals; sharing results through CHI Learning Lab monthly meetings; and reporting on the program's activities and results at least quarterly to: the Highline and CHI Franciscan Health Leadership; the Highline Medical Center Hospital Board; the Highline Medical Center Foundation Board; the Highline Health Connections Community Steering Committee; CHI Franciscan Health Regional Care Management; the Clinically Integrated Care Committee; and the Regional Alliance for Healthy Communities.

Highline is measuring the following outcome goals for enrolled participants:
• 30-Day Readmission Rate: Reduce 30-day hospitalization readmissions for enrolled patients by one readmission per year
• Reduce patients' hospital length of stay by ½ day for each hospitalization
• Reduce number of ED visits in 6 months by 50% for enrolled patients
• Reduce Highline write-offs (hospitalizations and ED visits) for enrolled patients by 50%
• Patient Goals Achieved: At least 50% of enrolled patients achieve agreed-upon health goals within one year and "graduate from program"
• Participant Satisfaction Results: At least 50% of enrolled patients note improvement in perception of coordination of care (using "Participant Perception of Coordination Questionnaire")

Specific clinical outcomes are being measured in connection with the specific mobile technology strategies implemented. For example, for implementation of the Diabetic Mobile Software, the participants will have their HbA1c measured to demonstrate the positive health outcomes with the use of this technology.

How did this project help to advance the cause of Equity of Care in Washington State?

Highline Health Connections addresses the needs identified in the State of Washington's five-year Health Care Innovation Plan, which was developed by a wide variety of stakeholders around the state. The plan calls for "caring for the state's most vulnerable; engaging individuals in their own health; addressing the needs of rural and underserved communities; and preventing illness, injury, and disease," as well as a transformed health care system, and aligns directly with Highline Health Connections' goals:
• The integration of physical and behavioral health care services
• Health systems positioned to address prevention and social determinants of health as part of the broader community of health
• Support at the state and local levels for practice transformation that emphasizes team-based care
• An emphasis on regionally responsive payment and delivery systems, driven by integrated purchasing of physical and behavioral healthcare
• A transparent system of accountability, allowing purchasers, consumers, providers, and plans to make informed choices

Highline is participating in Healthier Washington in several ways:
• The Highline Health Connections Program Director is attending meetings of the King County Accountable Communities of Health (ACH), which is playing a major role at the local level to change the

healthcare delivery model for Medicaid and other public program enrollees. ACH is charged with improving patient outcomes, reducing barriers to care, and integrating care between physical health, mental health, and chemical dependency. Many community providers and managed care plans participate in these meetings. Highline Health Connections directly addresses this initiative's objectives.
• The Highline Health Connections Program Director participated in a conference call with the Home Care Association and the leadership overseeing the ACHs in Washington State.
• The Highline Health Connections Program Director attended the public forums that are being held to obtain input on the Medicaid Transformation. The State has applied for a waiver with the Centers for Medicare & Medicaid Services (CMS) to allow innovative use of federal funds to re-design the health care delivery system. After the meeting the Highline Health Connections Program Director provided an overview of Highline's program, explaining to the Health Care Authority Medicaid Director how Highline Health Connections is transforming health care in the community through private donations and grant funding. This led to the Medicaid Director requesting a meeting to learn more about Highline's program.

Medicaid is piloting Community- or Patient-Centered Health Homes in designated areas of the State, but not yet in King County (Highline's PSA). Highline plans for Highline Health Connections to participate in one of the innovative projects that the State plans to pilot in King County. This may be a Health Home model or other models like the HHC program that transform healthcare for the community. Highline is currently working closely with its physician group as part of two Primary Care Medical Homes; through this project Highline plans to obtain referrals from and to these Primary Care Medical Homes as the program evolves.

Highline believes that this project is the future of creating an innovative health care model that will serve the most vulnerable populations efficiently and with compassion. After Highline completes the 3-year initial pilot project, Highline Medical Center is committed to improving on it and integrating it into Highline's overall strategic plan for care transition programs.

What results are you seeing? What difference has this program made in the community?

Highline served 172 patients within the first year and a half of the program, exceeding its projected output.

In the first year and a half of the program, Highline is seeing successful outcomes in several areas:

TRIPLE AIM DIMENSIONS (Better Health, Better Patient Experience, and Lower Costs per capita)

BETTER HEALTH
Self-Efficacy For Managing Chronic Disease (Stanford): Participants' scores are demonstrating positive results, with participants' average scores starting at 5.99 and increasing to 7.76 after program involvement.

Personal Health Questionnaire Depression Scale: Participants' scores are demonstrating positive results, with participants' average scores starting at 8.70 and reducing to 4.79 after program involvement.

Index Scoring Tool for Risk Assessment of Readmission: Lace scores, which indicate the risk of

readmission, have remained consistent throughout the program. Most of the participants had significantly high LACE scores, as expected: 80% of the participants had LACE scores greater than 11; 44% of the participants had LACE scores between 16 and 20.

Diabetic SMART Goal: At graduation, the participants are achieving the majority of their SMART Goals identified by each participant.

RCA Hospital Re-Admission Root Cause Analysis: In the last six months there were a total of 67 readmissions to the hospital: 41 unavoidable and 26 avoidable (per HHC staff analysis); 42 occurred within 30 days of hospital release. The most common reasons for avoidable readmission:
• Non adherence to self-care
• Inadequate social support
• Patient's unrealistic expectations of ability to manage care
• Medication discrepancies
• Social and environmental barriers.

In order to reduce potential readmissions, HHC staff has analyzed these readmissions. This led to the following program changes:
• Team completes a safety plan with each participant that includes informal and formal supports.
• Team initiated increased communication with participant's primary care provider.
• Community Health Worker contacts each participant on Friday to assess for potential issues in order to prevent readmissions on the weekend which was a frequent occurrence.

Healthcare outcomes for participants receiving Highline Home Health and HHC vs. HHC only: Using TAV (Program Record and Tracking System), Highline is tracking whether participants have Home Health: 45% of participants received Home Health.

Graduation Comparison between these groups: 41% of these participants with Home Health met care plan goals and graduated from the program vs. 49% of participants without Home Health who met care plan goals and graduated the Health Connections program.

Therefore a higher percentage of participants without Home Health graduated than those participants with Home Health. This may be attributed to a higher medical acuity and complexity for those participants that required Home Health with HHC.

BETTER PATIENT EXPERIENCE
Participant Satisfaction Survey: The responses to the questions were primarily positive, meaning the participants selected "Agree" or "Strongly Agree" 92% of the time.

Client Perception of Coordination Questionnaire: Scores demonstrated positive results.
• Working with Primary Care Provider: Scores increased from 63.6% to 81.1%
• Care Coordination: Scores increased from 79.1% to 90.9%

LOWER COSTS

All participants have had a significant reduction in utilization after entering the program and have demonstrated continued reductions since completion.
• Graduate Utilization Trends: 86% reduction of ED visits and hospital admissions.
• Non Graduate Utilization Trends: 70% reduction ED visits and hospital admissions.

Highline's most recent cohort of 32 program participants show the following reductions in ED visits/hospitalization and related costs:
• Six months prior to participation, these 32 patients had a total of 346 ED visits or hospitalizations; during participation, they had 100; six months post-graduation, they had just 45.
• Prior to participation, the patients' cost of care was $1,013,434; during participation it was $54,045; post-graduation it was $52,023.

The annualized savings (extrapolated to 172 program participants) for Highline Medical Center is $1,009,560.

INCREASED ACCESS
Scores demonstrated positive results regarding general care:
• Working with Primary Care Provider: Scores increased from 63.6% to 81.1%
• Care Coordination: Scores increased from 79.1% to 90.9%

INTEGRATE PROGRAM WITHIN CHI FRANCISCAN HEALTH AND CREATE A REPLICABLE MODEL
• The HHC Program Director, Highline Medical Center Foundation Executive Director, and HHC Program Manager have regular conference call meetings with Tamara Cull, National Director, Value-Based Care Management Programs and Operations, Catholic Health Initiatives, regarding program status and progress.
• HHC team participates in User Group Meetings with CHI KentuckyOne Health and CHI St. Vincent Infirmary.
• Presentation to Home Care Association of Washington regarding HHC at two Annual Meetings, April 15, 2015 and April 20, 2016.
• Presentation at CHI Franciscan Care Management Steering Committee, September 18, 2015.
• Sherri Alliotta, Associate Vice President, Care Management, CHI Franciscan Health, is a member of HHC Steering Committee.
• Presentation to CHI Franciscan Payer Contracting Committee on December 8, 2015.
• Presentations to the Washington State Hospital Association Readmissions Steering Committee on October 6, 2015 and December 10, 2015.
• Presentation to the Washington State Health Care Authority Director on October 6, 2015.
• Several meetings with HMSO (payer with risk contracts) which has used HHC services with positive results.
• HHC team participates in monthly meetings of the King County Accountable Community of Health Committee, which is part of the Washington State "Healthier Washington Initiative."
• In December 10, 2015, the HHC team met with Teresita Batayola, CEO of International Community Health Services, and Elisa Del Rosario, Deputy Director of the Asian Counseling and Referral Services, to discuss potential partnerships for the services they provide, particularly in the area of behavioral health,

for HHC patients. Because of their connections, they can also help us access additional patients of color in Highline's PSA.
• Presentation at Regional Care Transitions Improvements Meeting, March 2, 2016.
• Presentations to the Washington State Hospital Association Readmissions Safe Table Seminar on May 11, 2016.
• Added a HMSO Representative (local payer with risk contracts) to the Health Committee Steering Committee Membership.
• Quarterly Community Steering Committee meetings held to evaluate and provide input to program.
• Regular reports to both the medical center and foundation boards on program progress and outcomes.
• Successfully expanded the Highline Health Connections program to another hospital within the CHI system – 29 participants from St. Francis Medical Center in Federal Way have participated in HHC.

PROGRAM OBJECTIVES

TAVHEALTH (TAV)
Highline has trained eight case managers and eight social workers who currently have access and are using TAV to obtain HHC participant information. Social workers report that using TAV has improved their knowledge of the HHC patients' status and circumstances. This has also improved discharge planning for HHC participants.

ACCESS TO PRIMARY CARE
HHC team members are attending the majority of provider appointments with HHC participants. Prior to any appointment, the HHC team assists the participant in completing the "Preparing for Doctor Appointment Form" prior to the appointment. The HHC team also reviews Provider recommendations and care revisions after each visit.
• HHC staff have attended 70 provider appointments.
• HHC staff have linked participants to a provider 82 times.

Effective September 2015, HHC staff initiated tracking the number of provider appointments post hospital discharge that were performed according to discharge instructions. HHC has ensured that participants scheduled and attend a post hospital discharge provider visit. 84% of participants have attended their 1st provider appointment post hospital discharge.

SAFE AND SUPPORTIVE HOME ENVIRONMENT
HHC team members identified and provided solutions for 194 separate participant barriers towards achieving a safe and stable home environment.

COMMUNITY RESOURCES
Since July 2015 HHC team members have identified 805 barriers and assisted participants with solutions to these barriers 1,070 times, primarily by connecting them to community resources and participant education and coaching.

HHC staff were often able to identify and provide participants with more than one solution to barriers,

leading to a greater than 100% connection rate (1,070 solutions provided for 805 barriers).

USE OF TECHNOLOGY

• In the last six months, HHC referred 33 participants to a Global to Local (G2L) Diabetic program.
• HHC developed a system with G2L to track participants' engagement in the program.
• G2L were unable to provide the mobile phone due to funding changes so this has limited the amount of participants utilizing this program.
• HHC also identified other mobile applications that might be used by participants with heart failure and HHC is planning on implementing these applications as appropriate within FY 2017.
• HHC staff also assisted participants to explore internet resources including the CHI website for heart failure and diabetes education.

DESIGNING AND IMPLEMENTING PROGRAM

The HHC team has designed and initiated the implementation of a comprehensive, coordinated healthcare delivery program to address the needs of "super-utilizers." Highline has successfully expanded the Highline Health Connections program to another hospital within the CHI system – St. Francis. This program is clearly improving outcomes and significantly reducing St. Francis and Highline Medical Centers' cost of caring for these high utilizers. As noted above (under Results), all participants have had a significant reduction in utilization after entering the program and have demonstrated continued reductions since completion. The annualized savings (extrapolated to 172 program participants) for Highline Medical Center so far is more than $1,000,000.

Has this program been awarded or recognized by others?

The Highline Health Connections program was recognized by the national CHI Franciscan Health organization with a $1.2 million grant from its highly competitive Mission and Ministry Fund.

Who else was involved in making this successful?

Highline Health Connections is unique because of the early involvement and partnership with donors, Highline Medical Center Foundation board members, and Highline Medical Center board members during the inception of the program and because of their corresponding commitment to the program's success and sustainability. The Highline Medical Center Foundation has committed to serving as a true partner with the Highline Medical Center and the community not only to make this project a reality but to sustain it going forward. The strength of this Highline Medical Center Foundation / Highline Medical Center / community partnership is unique among the local community as well as CHI-supported programs nationwide.

Anything else you want to add about this program?

Just a few patient stories demonstrate the impact of this program at the individual level:

• A 47-year-old single mother of four children, with limited English proficiency, was diagnosed with severe asthma, respiratory failure, seizure disorder, significant depression, and anxiety. She had very limited finances (no insurance coverage), needed mental health care, had no transportation, had a lack of knowledge re: health care and medications, and required interpretation or Spanish-speaking services. Her HHC team enrolled her in Medicaid, connected her to culturally appropriate, Spanish-speaking

providers (including mental health) and services, provided her with social and emotional support. She is now able to understand her medical conditions and follow her providers' instructions, including taking medications as ordered; she is also now linked with financial resources for food, rent, and transportation assistance. Prior to enrollment in HHC she had four ED visits and one hospitalization; since enrollment and graduation from the program, she has had NO hospital or ED visits.

- A 70-year-old immigrant male living with his wife was diagnosed with diabetes, chronic kidney disease, high blood pressure, congestive failure, stroke, and cancer. In the previous six months, he had six hospitalizations and nine ED visits. Since HHC involvement, he has had NO hospital or ED visits.
- A 54-year-old male who was homeless at the time of hospital admission was diagnosed with end-stage renal disease, hypertension, hypothyroidism, post-traumatic stress syndrome, arthritis, atrial fibrillation, tobacco abuse, bipolar disorder, and diabetes. In the previous six months, he had nine hospitalizations and 16 ED visits. Since HHC involvement, he has had one hospitalization and three ED visits. All of these were unavoidable.
- A 61-year-old male had been diagnosed with diabetes, sepsis, pneumonia, acute renal failure, and altered mental status. No medical care for many years led to a 1-month hospitalization. Since enrolling in the HHC program, he has had no further hospitalizations or ED visits.
- An 83-year-old female was diagnosed with COPD, hypertension, rheumatoid arthritis, and chronic back pain. In the previous six months, she had six hospitalizations and three ED visits. Since HHC involvement she has had NO hospital or ED visits.

HHC participants report the following:

"It's very helpful to have the Community Health Worker come to my doctor appointments. My doctor doesn't usually listen to me, but it was different when the Community Health Worker was there advocating for me and asking questions."

"There needs to be more programs like yours available to people. There are so many resources out there that I just don't have the time to find on my own. A lot of people say they're going to help, but you guys have actually made things happen."

"I love my health binder! It helps me stay organized and keep track of my medical information. I take it with me wherever I go!"