TVCCA CONNECT

by Thames Valley Council for Community Action (TVCCA)

Region 1 • Jewett City, Connecticut
tvcca.org

Health • Medical

INITIATIVE OVERVIEW

TVCCA's Connect Program is designed to demonstrate that building direct linkages between healthcare providers and the Community Action social service network will result in improved outcomes for the patient and reduced costs to the Medicare system.

TVCCA employs a Community Health Manager who works with individuals referred by Lawrence + Memorial Hospital (L+M), the Visiting Nurses Association of Southeastern CT, or the Northeast Medical Group. A dedicated cell phone quickly links healthcare professionals to a TVCCA Case Manager. Services are based on Social Determinant of Health needs identified by hospital social worker/nursing staff, or self-reported as part of the universal intake. A Service Plan drives TVCCA Connect Case Management Services and follow-up is provided based on the needs established in the plan.

LOCAL NEED ADDRESSED BY INITIATIVE

In April 2015, TVCCA was invited to a meeting being held by the Southeastern CT Visiting Nurse Association, an affiliate of Lawrence + Memorial Hospital (L+ M). The impetus for the meeting stemmed from the 2013 Centers for Medicare & Medicaid Services (CMS) grant, which formed the New England Quality Innovation Network-Quality Improvement Organization (NE QIN-QIO). NE QUIN-QIO is a collaborative effort, administered by Healthcentric Advisors and Qualidigm, to improve the experience, care and health outcomes for all Medicare beneficiaries in New England. Qualidigm led a regional approach to working with hospitals,

nursing homes, physician offices, home health and other healthcare stakeholders to enhance care, experience, and outcomes for Medicare beneficiaries. In Southern New London County, high readmission rates were identified as an area of concern for skilled nursing facilities (SNFs) and the hospital. Health care transitions, such as transfers from skilled nursing facilities to home, are cited as events when seniors are particularly vulnerable to factors putting them at risk of re-admission.

Through consistent participation in these meetings, the TVCCA Chief Operations Officer realized that the social determinants of health (SDOH) needed to be considered if regional providers hoped to improve the issue of high readmissions. TVCCA recognized a direct link between the specialized human services we are contracted to provide and the new expectations being placed on the healthcare community. The services available through TVCCA could offer the critical long-term supports needed to make patient transitions

to home successful. By becoming part of the Skilled Nursing Facility discharge planning process and the "bundled" care process, TVCCA Connect is poised to address many of the social determinants of health facing this population. By assessing and addressing the social determinants of health that negatively impact clients' lives, this project seeks to prove that social service interventions in healthcare can significantly improve overall outcomes.

TVCCA Connect was developed to bridge the gap between the medical community and community-based organizations. Real-time experience and identification of what is truly happening in the home/community cannot be minimized or marginalized. The labor-intensive nature of these types of interventions cannot be achieved in a traditional case management model, and therefore requires designated staff to serve as a link between medical providers, their patients, and community SDOH services.

ROLE OF CSBG FUNDS

The staff that developed, managed, and implemented this program, specifically the Chief Operations Officer and the Director of Community Services, are funded in whole or in part through CSBG funds. Additionally, the planning and administrative functions of our agency, both of which contributed to the planning and management of this program, are funded in part by CSBG. Before the program began to receive funding through the Connecticut Department of Social Services, existing CSBG-funded staff began implementing the pilot project as proof of concept to secure additional funding.

TRANSFORMATIVE IMPACT

TVCCA Connect is directly led by TVCCA, which has partnered with area healthcare providers to create measurable community level improvement in New London County by targeting social determinants of health interventions for low-income individuals. Social determinants of health are "the structural determinants and conditions in which people are born, grow, live, work and age". They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care.

Undeniably, a direct correlation can be drawn between poverty and the social determinants of health. By addressing these causes and conditions of poverty, TVCCA Connect can have a significant impact on the health challenges and outcomes of many community members. By implementing changes to the way vulnerable patients are discharged, TVCCA and its partners have observed lower rates of re-hospitalization and a reduction in emergency room visits. Short-term outcome measures used in regular reporting for TVCCA Connect include the number/percent of TVCCA Connect clients who:

- Either obtained or retained existing housing
- Successfully obtained food, clothing, fuel assistance, shelter, and other basic needs
- Received eligible public assistance benefits
- Demonstrated improved health and well-being
- If elderly, maintained an independent living situation
- If disabled, maintained an independent living situation
- With chronic illness(es), maintained an independent living situation

Long-term, measurable outcomes include:

- Reduction in hospital readmissions
- Reductions in emergency room visits
- Lower health care costs

EVIDENCE-BASED OUTCOMES

After 20 months of this initiative, 60% of referrals are single adults possessing 2 or more comorbidities (Diabetes, CHF, and Hypertension). Family support is often minimal to non-existent, and socialization and support from friends have waned due to the complex medical and social needs of the individuals(s).

TVCCA Connect home visits often identify patients living in unsafe housing conditions, condemned homes, homes without utilities, or experiencing a lack of access to medical appointments, prescriptions, or groceries. Five cases required intense SDOH interventions, and upon determination that the individual could not maintain medical stability

for themselves, a request was made to local law enforcement to conduct safety checks, and eventually, referral to Elder Protective Services.

These individuals often functioned under the radar as their conditions worsened, resulting in more frequent trips to the ED, missed appointments with the hospital/medical Provider, and designation as a non-compliant patient. With deeper insight, we know that 80% of cases of non-compliance result from a lack of SDOH resources.

Client outcomes are tracked in the TVCCA Tribeware data management software and include demographic information, assessment, and client "service plans" that identify specific client SDOH to be addressed by the client and case manager. TVCCA Connect targets patients afflicted with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Diabetes. By focusing on this specific patient population, TVCCA has been able to better quantify long-term outcomes over the life of the project. TVCCA has been granted access to the Yale New Haven Health System electronic medical record (EMR), EpicCare, which provides access to data on hospital/emergency room usage (all current healthcare partners are part of Yale New Haven Health System). The project is also working with hospital staff to gain additional access to cost information, so that TVCCA can calculate a Return on Investment (ROI) in terms of Medicaid savings.

TVCCA recognizes the impact of inequity in the existing healthcare system and has the tools to analyze the results of TVCCA Connect on different ethnic groups in the community.

As a federally recognized Community Action Agency, TVCCA is required to file a yearly report of National Performance Indicators (NPI). There is a direct correlation between services that will be provided through TVCCA CONNECT and these NPIs, including NPI 2.2 (Community Quality of Life and Assets), 6.1 (Independent Living), 6.2 (Emergency Assistance), 6.4 (Family Supports), and 6.5 (Service Counts). Results of interventions provided through TVCCA Connect will positively impact NPI service counts while increasing the quality of life for members of our community.

EQUITY LENS

TVCCA recognizes the impact of inequity in the existing healthcare system and has the tools to analyze the results of TVCCA Connect on different ethnic groups in the community. TVCCA's secure, internal customer database captures data on race, ethnicity, and insurance source, all of which may be used to measure the direct impact of TVCCA Connect on a specific customer demographic. TVCCA Connect staff is also trained in Health Equity as part of Community Health Worker certification process.

CUSTOMER VOICE

TVCCA Connect utilizes a Customer Satisfaction Survey, available electronically and on paper, to gather community input on specific services. We also provide our program director's contact information, offering participants the opportunity for direct communication. Results of the Surveys and the identification of population-specific needs are utilized to further develop processes and resources that will advance the impact of TVCCA Connect services.

Through participant surveys and anecdotal evidence provided by our customers (patients and medical staff), TVCCA identified a lack of resources to address immediate access to supplies and equipment upon discharge. As a result, TVCCA sought out and established unrestricted emergency funds through private foundations. These funds have been used to purchase grab bars, safety bars, canes, walkers, portable commodes, automatic pill distribution, co-pays prescription, short-term transportation, food, pest control, linens, and TracFone phones and minutes.

An expedited process for patient referral was also identified: Referrals and access to patient information were streamlined when the medical system granted access to EPIC, the electronic medical record. TVCCA Connect staff members can now more realistically evaluate the home environment based on EPIC

diagnoses, treatment, and discharge notes. Staff is also able to communicate directly with the discharge planner to facilitate next steps.

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