KentuckyOne Health®

Health Connections Initiative

An Evidence Based Community Care Transitions Intervention Program Providing Assistance to a Low Income Patient Population

Health Connections Initiative is a pilot program funded by Catholic Health Initiatives Mission & Ministry Fund to test an evidence-based community care management transition model to support the most challenged, challenging, complex and vulnerable patients.

Support is provided through home visits by an interdisciplinary team for up to 90 days at no charge to the patient. The Outreach team addresses both the medical and social needs of the patient. The team includes a Lead RN, a Social Worker, an LPN and Community Health Worker. Health Connections Initiative is based on strong evidence that a large number of ED visits and hospital admissions of "super-utilizing" patients could be prevented by relatively inexpensive and coordinated early intervention.

Key Steps in Model Development

- **Identification of the patient population using a evidence-based mapping process** (Figure 1).
- **Define participation criteria**
- **LACE scores of 11 or greater** (Figure 2)
  A readmission risk assessment tool measured by length of stay, acuity, co-morbidities and ED visits
- **Payer source of Medicare, Medicaid or Uninsured** (Fig. 3)
- **Lives in the identified zip code** (Fig. 4)

Evidence Based Tools

- Ottawa LACE Readmission Risk Assessment Survey - Performed by the hospital based team
- PHQ9 Depression Screen - A pre-survey and post-survey performed by the Lead RN and LPN
- Stanford Survey - A self-efficacy pre-survey and post-survey performed by the Lead RN and LPN
- Client Perception of Care Coordination (CPCQ) - A pre-survey and post-survey performed by the Social Worker
- IHI Root Cause Analysis Tool for Review of Readmissions - A survey tool performed on all 30 day readmissions

Measuring Success by the Triple Aim of Care

- Better Health (Fig. 5)
- Better Patient Experience (Fig. 6)
- Lower Per Capita Cost (Fig. 7, 8 , 9, 10)

Key Competencies for the Multidisciplinary Community Care Transitions Team

- Cultural Competency
- Health Literacy Screening and Use of Health Literate Teaching Aides
- Chronic Disease Management with Motivational Interviewing
- Health Coaching and Use of Teach Back

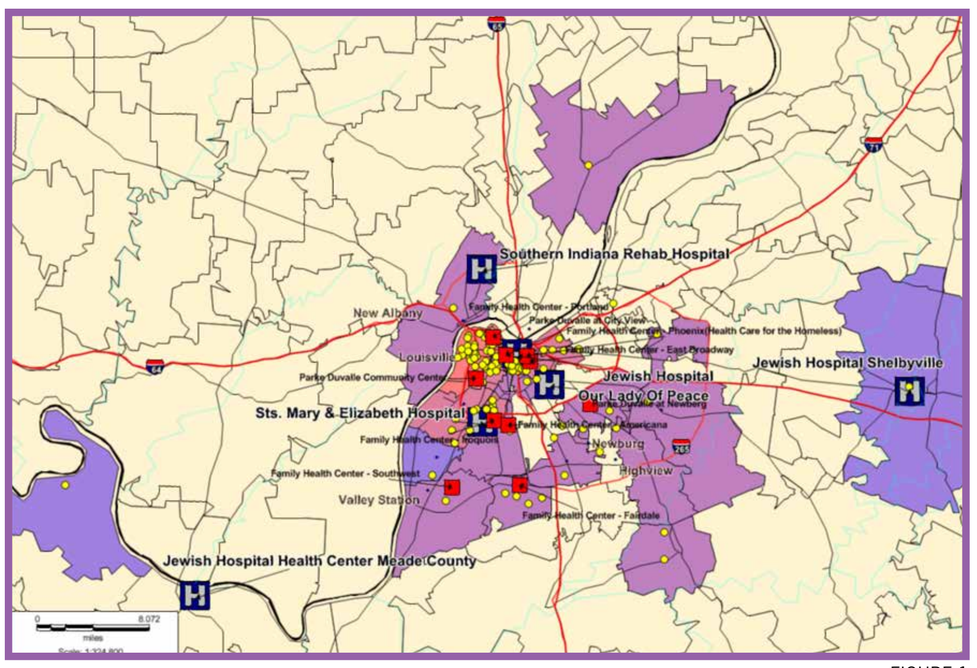
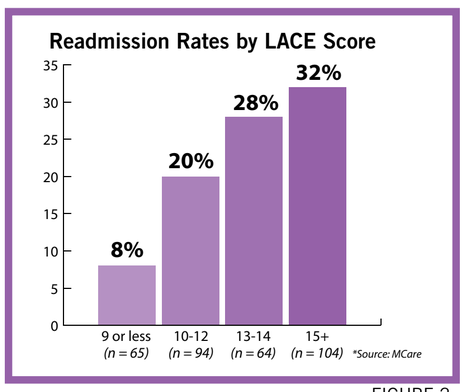


FIGURE 1



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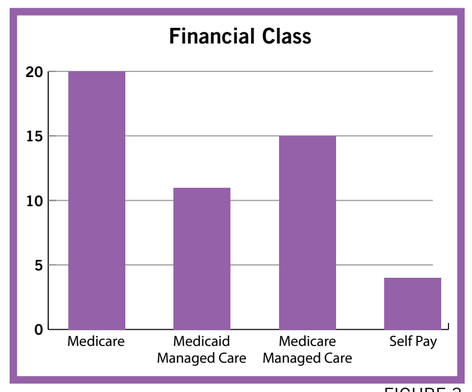

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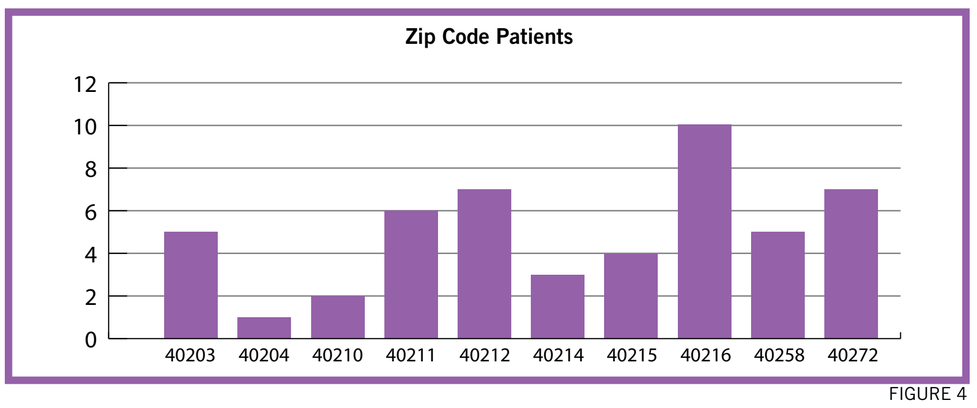

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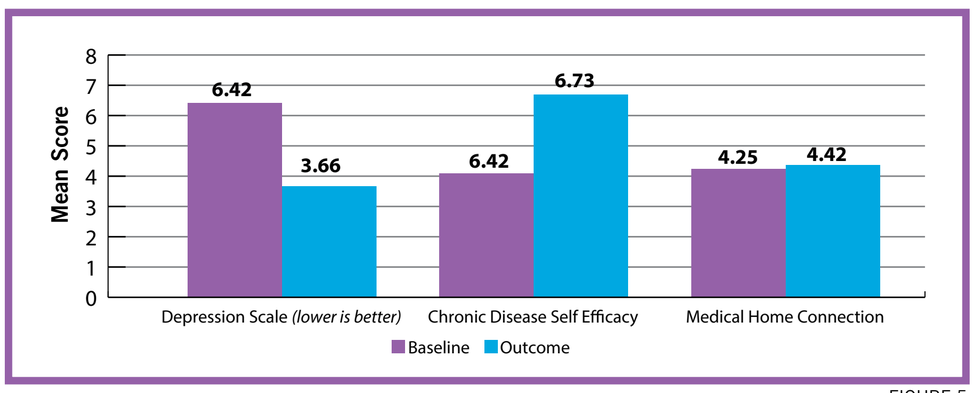

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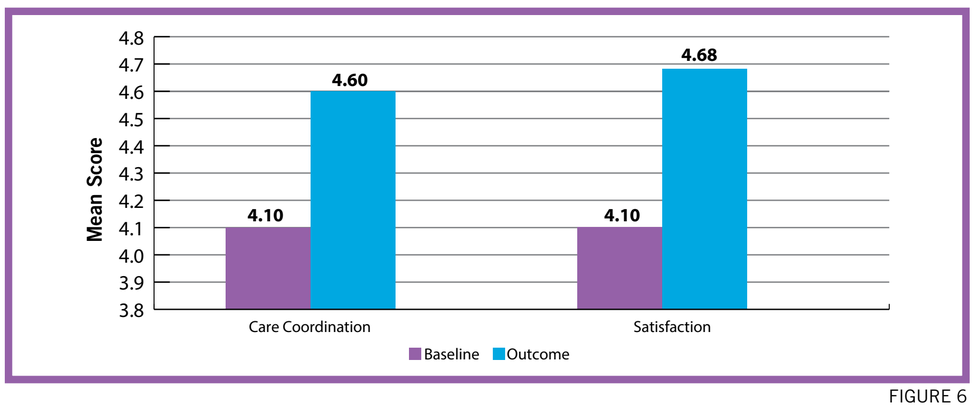

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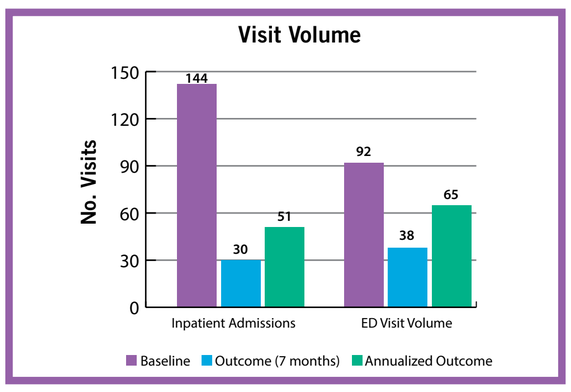

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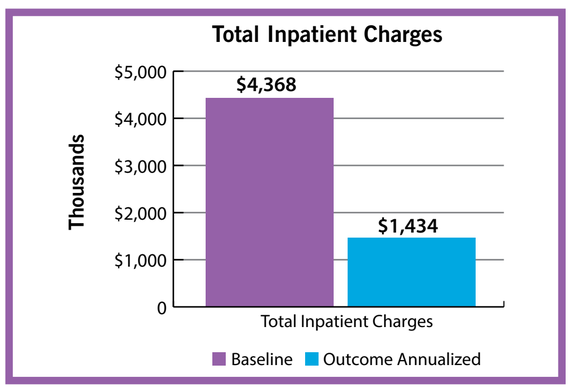

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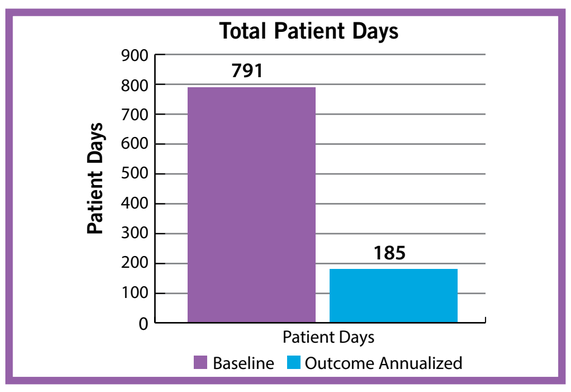

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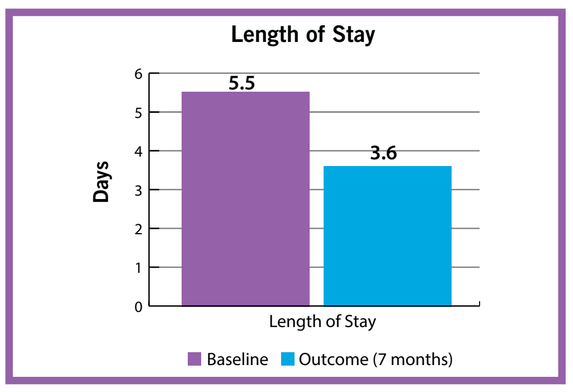

FIGURE 10