Bridges to Health: An Innovative Award-Winning Model of Care for the Most Complex, Most Vulnerable Patients

The Free Clinics™
Caring for Our Neighbors in Need

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The Russell J. Sacco Building
The Free Clinics
841 Case Street


The Free Clinics
Used Bike Collection Day
Saturday, November 12
9am-12pm
841 Case St., Hendersonville
Questions: (828) 697-8422

Snapshot of The Free Clinics (TFC)

TFC is a community of 16 board, 23 staff, 250+ volunteers, 180+ healthcare partners, and 700+ donors and funders dedicated to serving our neighbors in need in Henderson and Polk Counties, NC.

- 20 programs in areas of acute care, chronic/specialty care, behavioral health, pharmaceutical support, and community health
- 1,960 unduplicated patients with 34,556 encounters
- 83% of patients less than 100% FPL
- $9,607,042 worth of care in 2017-18, ROI of $8.18 for every dollar invested

By the numbers

CHRONIC & SPECIALTY CARE

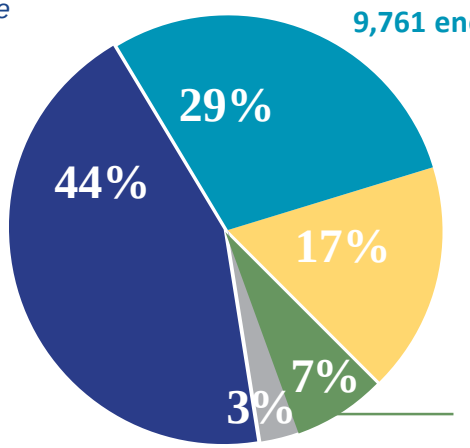
includes all case management, Bridges to Health and specialty clinics

15,085 encounters

ACUTE CARE

Medical clinic and acute case management

1,177 encounters



PHARMACEUTICAL

includes community pharmacy and Medi-Find

9,761 encounters

COMMUNITY HEALTH

includes Community Garden, PHA, HealthWays, Bikes4Life

5,872 encounters

BEHAVIORAL CARE

includes psych clinic, counseling, and psych case management **2,339 encounters**

STELLAR PATIENT OUTCOMES

The Free Clinics consistently outperforms its peers in the traditional health sector. In 2017-18:

67% of patients with hypertension have well-controlled blood pressure

67% of patients showed improvement in "Functional Status"

68% of patients with diabetes have well-controlled A1C's (blood sugar levels)

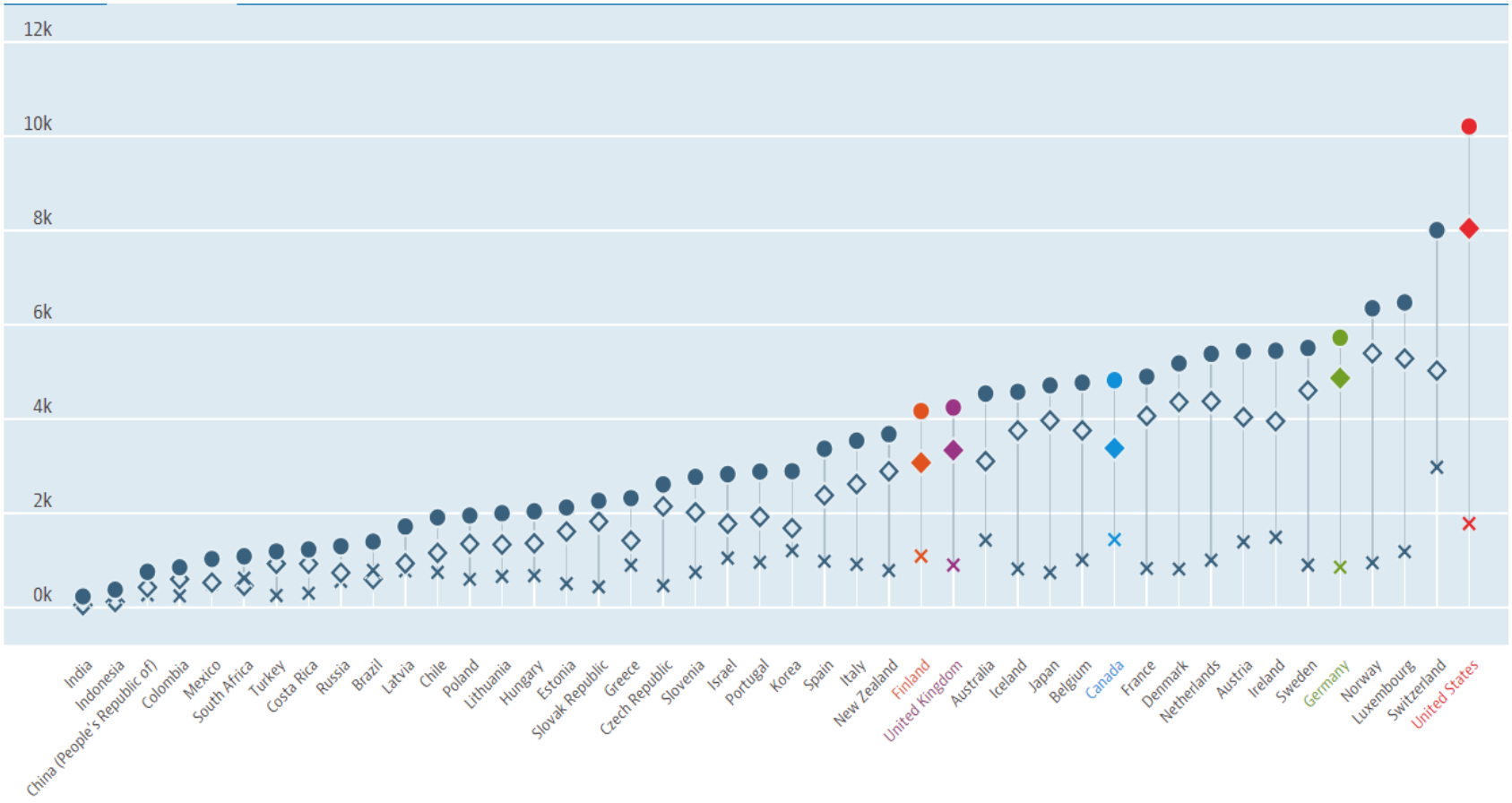
75% of patients refill their prescriptions as written

78% of patients report a positive change in their health due to our care

88% of crisis behavioral health patients engage in a long- term care plan

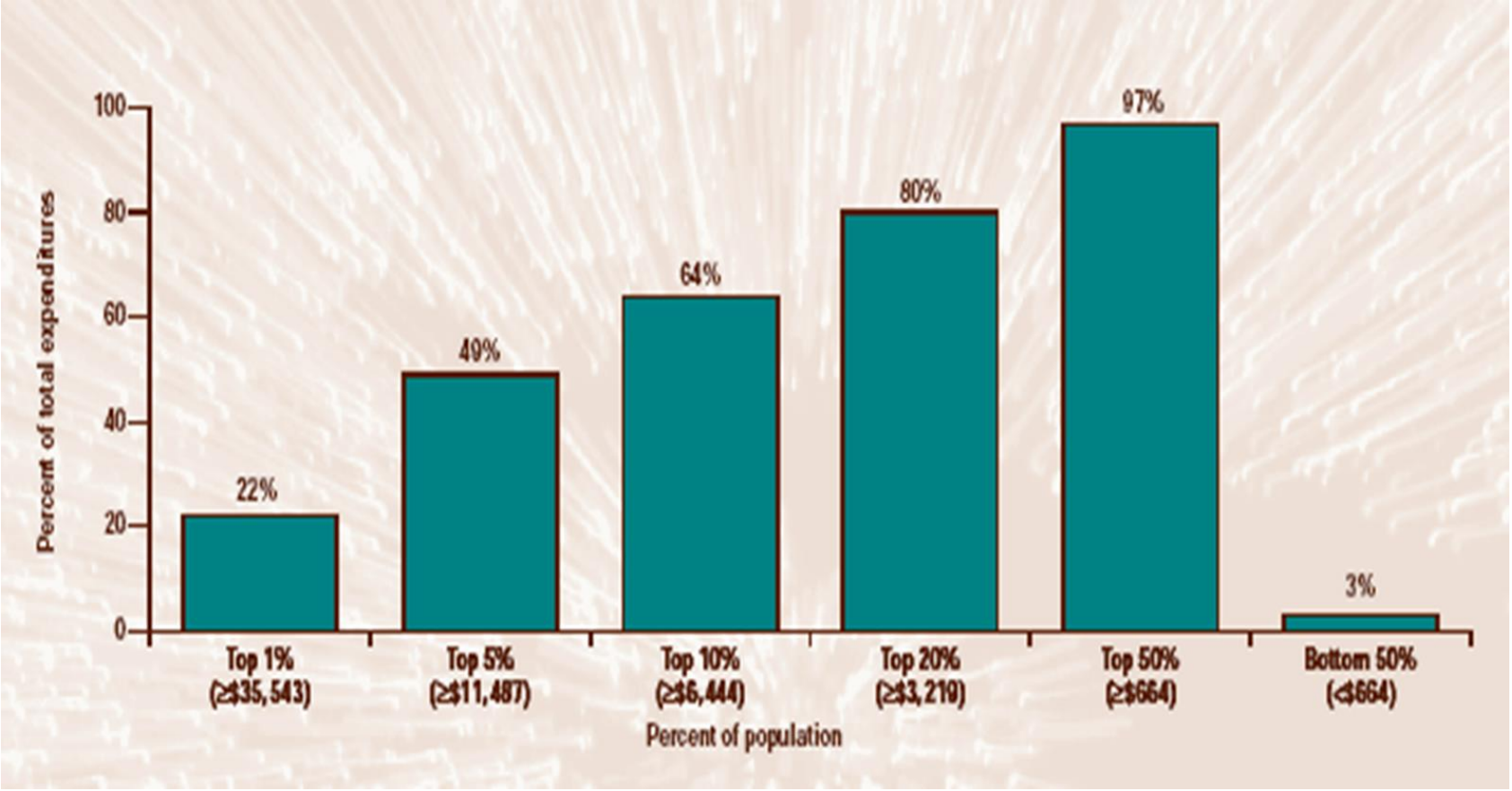
The Unsolvable Problem: Over- and Inappropriate Hospital Utilization by Very Complex, Very Vulnerable Patients

- The US spends significantly more on healthcare than any of our peers.

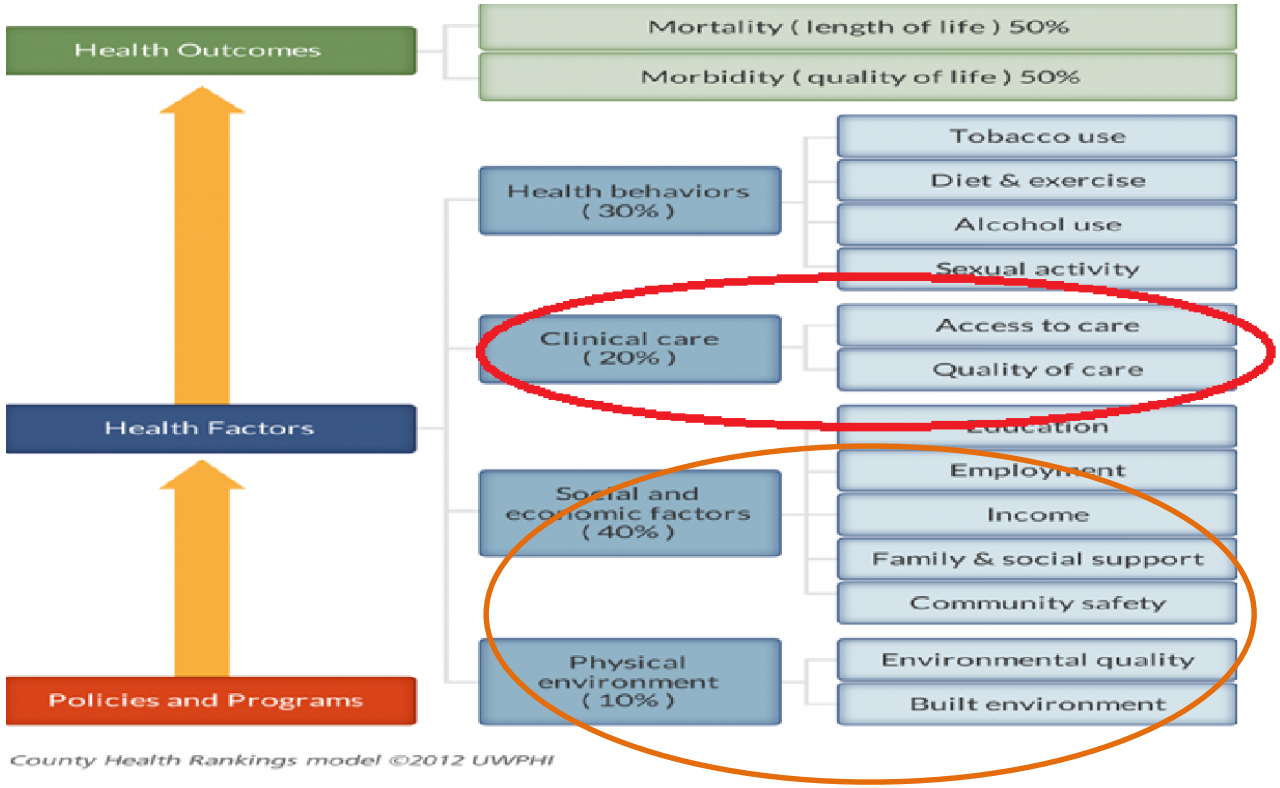


The Unsolvable Problem: Over- and Inappropriate Hospital Utilization by Very Complex, Very Vulnerable Patients

- 1% of the population generates 25% of all healthcare costs.



- Only 20% of health is determined by clinical care. 50% of health is socio-economically driven.



If “unsolvable,” then why bother?

❖ Are we asking the wrong questions?

❖ Do we know what the “real” problem is?

❖ Are we disconnecting between the actual problem and the solutions we offer? In other words, do our solutions actually fit the problem?

Other Considerations:

❖ Provider burnout is significantly high.

❖ Cost of healthcare in US yields abysmal results compared to our peers.

❖ Is there another alternative?

❖ One that addresses the “real” problem, addresses cost and quality, and engages providers in exciting, meaningful engagement with care?

Bridges to Health: Lessons Learned

1. **"Real" Problem: Key driver for most of the most complex patients is trauma** (ACEs, domestic violence, sexual assault, etc.)
2. **Meaningful Treatment: Trauma functions like a brain condition, and there is good treatment for trauma**
3. **Innovative, patient-centered solution: Alternative to "traditional care management" because less than 50% of patients respond to "traditional" practice, with an even lower percentage of more complex patients.**
4. **Critical nature of SUPPORT, both professional and peer-to-peer: There is tremendous power in the group, with fully integrated care team and peers.**
5. **Nurturing patient's agency and voice: It cannot be overstated, the importance of supporting the patient's involvement in their own care and in recommending/designing additional services.**

Bridges to Health (BTH): The Story

2010: "Accidental" data set: 255 patients = $9m+ in uncompensated care at one local hospital in one year, 35% of all uncompensated care. Average of 10+ visits per year.

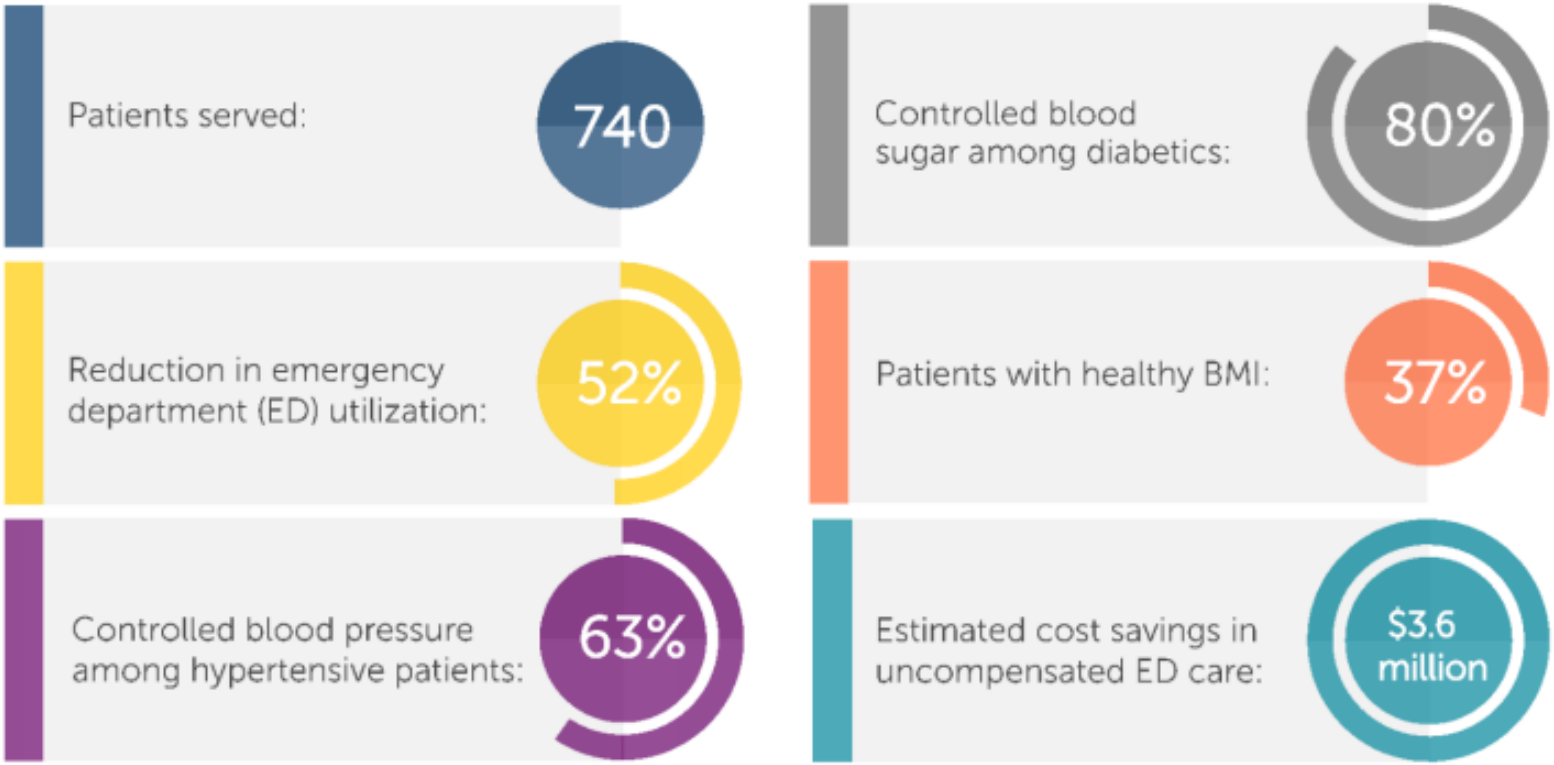
Who: 50% reported a PCP; >70% with history of severe trauma; complex medical; BH concerns; economic deprivation.

What: Data to attempt to understand "real" problem, focus on reducing as many barriers as possible and creating meaningful solution.

2010-11: Launched model as experiment.

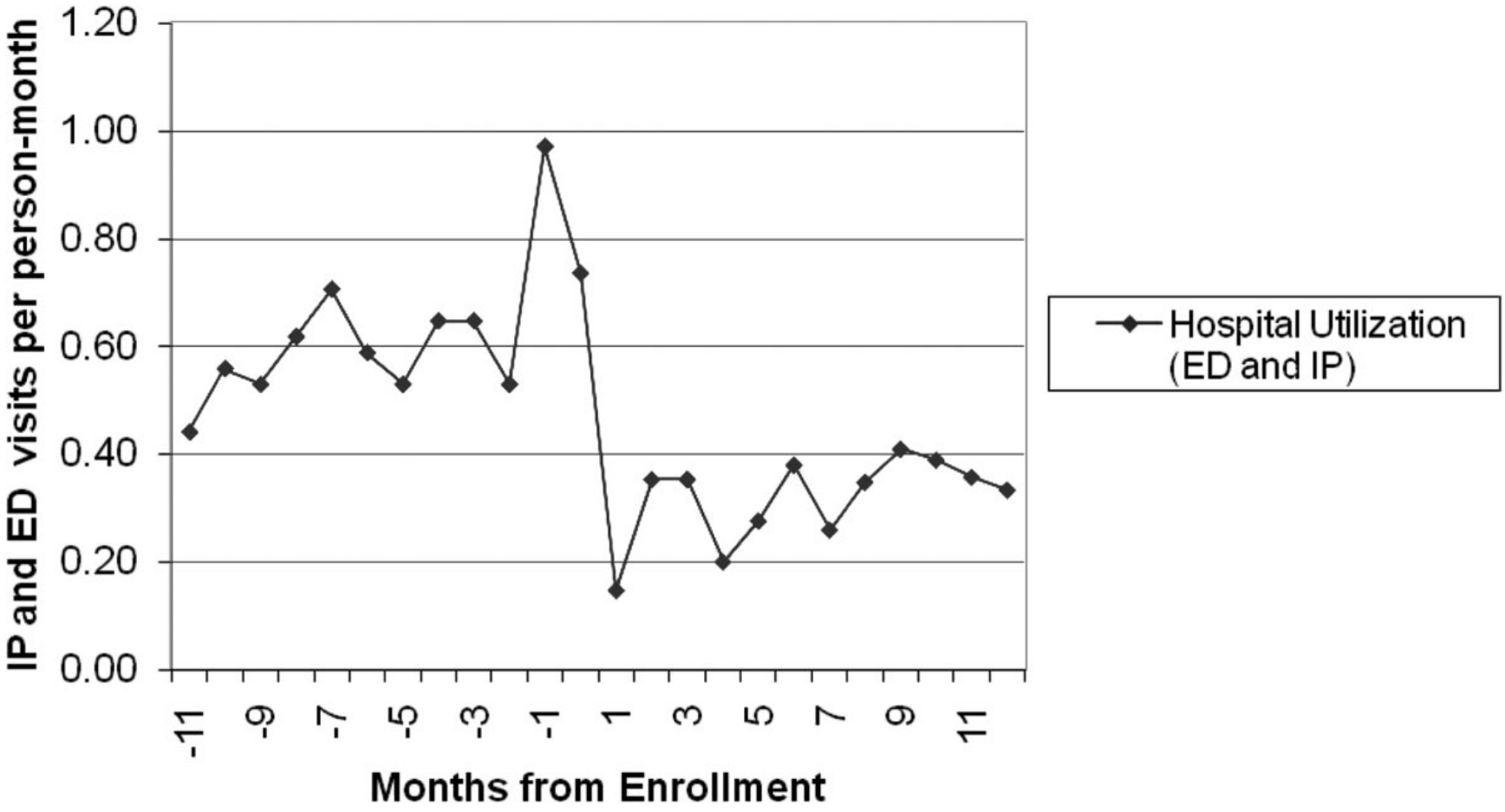
2014-15: Expanded care team and new partner, Blue Ridge Health. Began explicit work on trauma.

Bridges to Health Cumulative Results* 2010 to 2018



**Results are reported by The Free Clinics*

Hospital use before and after BTH



BTH: 10 Year Outcomes

- 52% reduction in hospital utilization
- 94% housed
- 42% employed
- 64% improvement in "functional status" and decision-making
- 61% reduction in PHQ9 in persons with depression
- 80% controlled A1c in persons with diabetes
- 63% controlled BP in persons with hypertension
- 37% with healthy BMI

Comparison Data:

A1c: NC FQHCs in 2017 – 68.4% controlled
NC Free Clinics in 2018 – 70.9% controlled
Medicaid in 2017 – 59.5% controlled
Commercial insurance in 2017 – 68.3% controlled

BP: NC FQHCs in 2017 – 62.9% controlled
NC Free Clinics in 2018 – 63.1% controlled
Medicaid in 2017 – 56.9% controlled
Commercial insurance in 2017 – 62.2% controlled

BTH: The Model

❖ **Drop-in Group Medical Visit/DIGMA:**

- Barrier of appointments removed
- Barrier of care silos removed with integrated, team-based care
- Consistency of team-based care
- Peer-to-peer support
- Free visits, copays covered at FQ sites
- Developing power of agency and voice by speaking/sharing in group
- Listening/hearing stories and experiences of others

❖ **Location and Incentives:**

- Away from hospital campus
- Close to patients, in the community where they are
- Bus pass if needed to enable access
- Food coupon at local co-op for healthy mean (and no tobacco or alcohol)

The Model continued

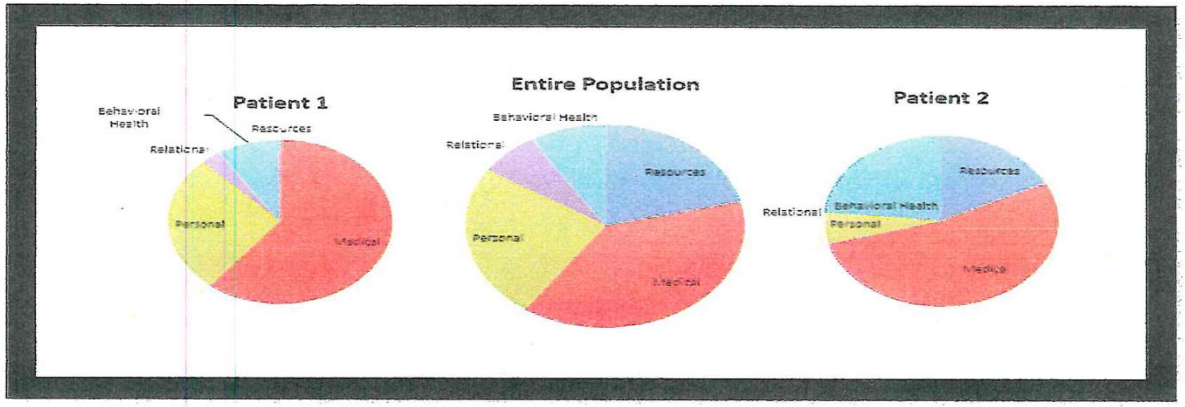
❖ **Instant Access:**

- Open meetings now 4x week in three locations (plus detention center)
- RN Case Managers with cell phone for “low impulse moments”
- Immediate access to provider team through RN Case Managers
- Ability to drop-in to any group (though recommend that patients have a “regular group home”)
- Full access to all care needs—pharmacy, specialty care, BH, diagnostics, etc

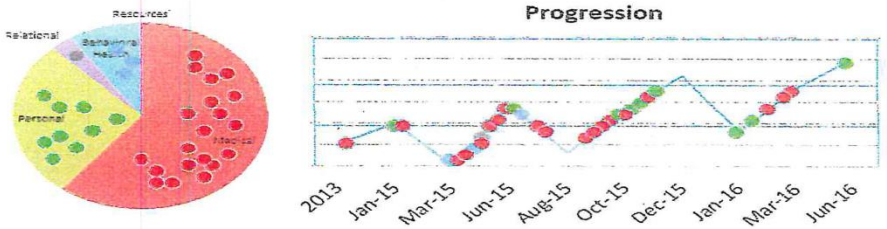
❖ **Patient Involvement in Own Care & Driver of Own Health:**

- Intake focuses heavily on goal-setting with patient
- Study: 5 types of goals: medical, behavioral health, relational, resource, personal
- Type of goals and patient engagement most significant dimension

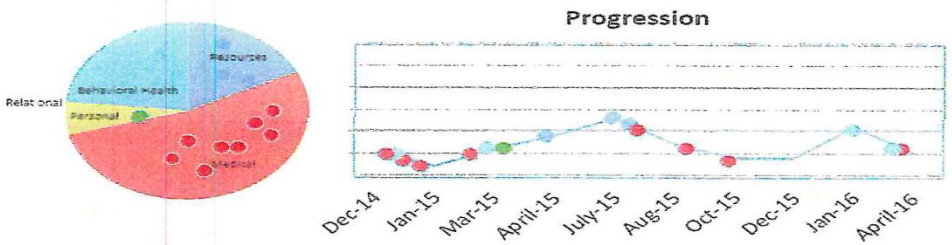
Patient Goals



Patient 1



Patient 2



Model continued

❖**Team-Based Care:**

- Fully integrated care team includes: MD/DO/FNP, RN, LCAS/Psychologist, PharmD, OT, Patient Health Advocate (PHA)
- Each group has own care team, functions as alternative primary care home
- Monthly meeting of all teams: case presentations and counsel, administrative discussions, exploration of learnings from model
- All voices on team equal, respected, honored

BTH: Return on Investment

- **Start:** 255 patients = $9m+ uncompensated, 10+ visits/year
  The 1% that drive 25% of all healthcare costs.

- **Year One:** $55k grant and $10k hospital investment ($65k) with 70.4% reduction in hospital utilization and costs, totaling $346k.

- **ROI:** for every $1 invested in program yields **$5.32 in hospital savings**

- **Plus better care for persons and strong health outcomes**

How to Begin?

- Started with list of 255 from original “accidental” data set.
- Attempted to contact all, reached 147. Of those, 70 expressed interest and 36 actually attended

- Since original outreach, word of mouth among patients and providers (including BH community, hospitals, detention center, parole, etc.)

Bridges to Health: Lessons Learned, Redux

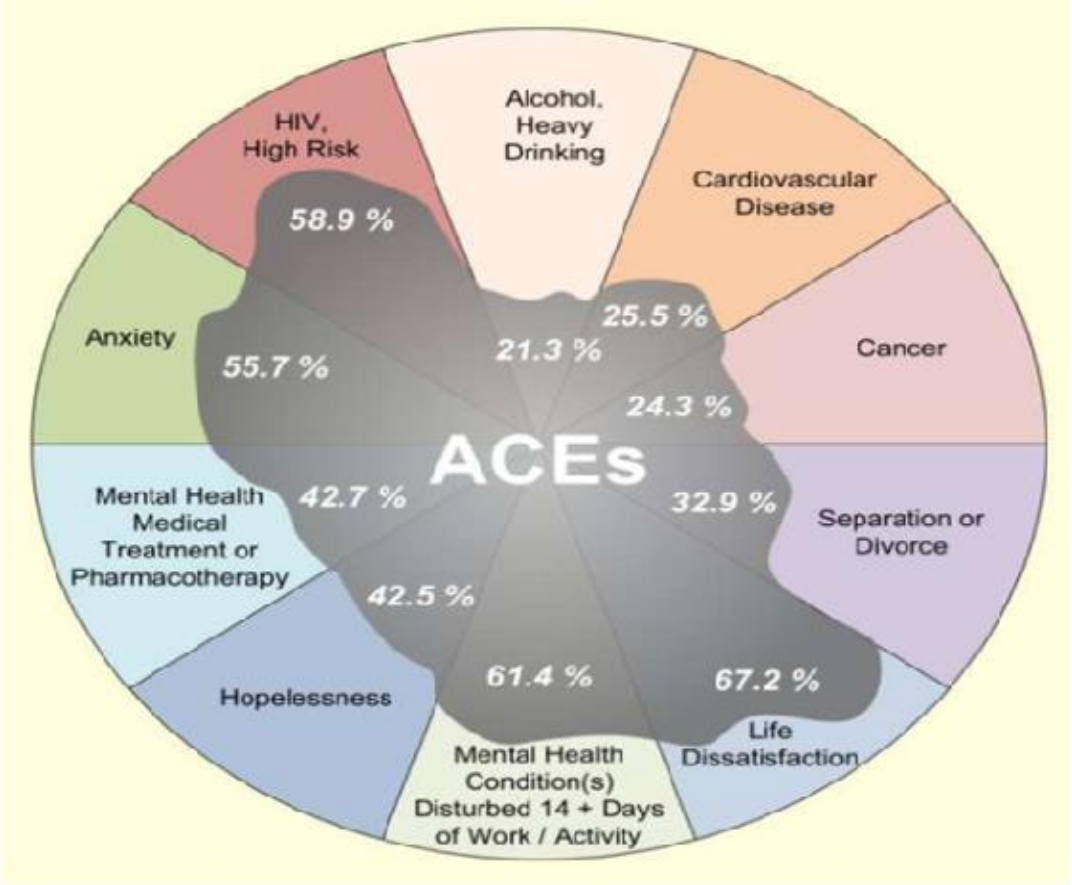
1. **"Real" Problem: Key driver for most of the most complex patients is trauma** (ACEs, domestic violence, sexual assault, etc.)

- Review of original data-set, lots of BH, SA
- ACEs explicitly introduced five years ago in 2014.
- We do not "screen" for ACEs. Just ends up as another check-box in the EHR.
- Rather ask two key questions:
- "What is important to you?"
- "What happened to you?"
- Found the ACEs score itself is not as important as exploration of trauma and focusing on resources for supporting and nurturing resiliency.

The role of ACEs on Health Outcomes

ACE reduction reliably predicts simultaneous decrease in all of these conditions.

Population attributable risk



Bridges to Health: Lessons Learned, Redux

2. Meaningful Treatment: Trauma functions like a brain condition, and there is good treatment for trauma

- There is good treatment for trauma.
- Team focused on understanding impact on the brain.
- Team training in key to understand trauma; trauma-informed care.
- Describe our BTH work as "DBT Light". DBT is dialetical behavior therapy, which focuses on core mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness.
- Intentionally "push" on inherent resiliency of patients.
- Recognize and nurture that some of the most resilient people because still working towards health and hope despite trauma they have experienced.
- Starts with compassion and empathy; deep listening.
- "First time someone ever asked me what matters to me and then listened to me."

Bridges to Health: Lessons Learned, Redux

3. Innovative, patient-centered solution: Alternative to "traditional care management" because less than 50% of patients respond to "traditional" practice, with an even lower percentage of more complex patients.

- Remove as many barriers as possible—cost to patient, transportation, silos of care, appointments, access to additional care.
- Patient drives their own care with intensive case management and committed team of providers.
- Focus on the opportunity and invitation to think differently about life and health and hope.

Bridges to Health: Lessons Learned, Redux

4. Critical nature of SUPPORT, both professional and peer-to-peer:
There is tremendous power in the group, with fully integrated care team and peers.

- Each patient speaks for 5-7 minutes with the total floor of peers and providers.
- Response to concerns can come from anyone present—any of care team or peers.
- Peers often have the most meaningful response; care team has learned to pause and wait for peer response before giving clinical response.
- Humility of team to learn from patients before bringing clinical response.
- "Doing this work has changed the way I provide care in all other settings, the way I engage and listen to wisdom of patients."

Bridges to Health: Lessons Learned, Redux

5. Nurturing patient's agency and voice: It cannot be overstated, the importance of supporting the patient's involvement in their own care and in recommending/designing additional services.

- The critical nature of patients own goals.
- Open door of care team to listen for suggestions for programs to meet problems they encounter: community garden (Henry), bikes 4 life (Will), HealthWays (Esther)
- Creation of Patient Advisory Counsel to explicitly seek patient input.
- Jimmy's story: most challenging patient to embrace of "poverty kills" to CHA in 2015

BTH Model: National Recognition

- Journal of Board of Family Medicine article March/April 2012
- Two national awards: KBR Innovations in Rural Health Finalist 2016; RWJ Health Equity Leader 2017
- American Public Health Association 2018 Annual Meeting
- RWJ Culture of Health Blog 2018
- National Governors Association Center of Excellence in Health 2019

So why bother with "Unsolvable Problem?"

- US spends the most on healthcare of developing world and has worst results.
- Current system is clearly not working.
- Population/community health—to bend the curve, we need to focus on the most challenging patients: behavioral health/substance abuse, homeless, dying from poor care.
- The "unsolvable problem" is the important problem and addressing it can save money, improve health and hope, and prevent further burnout of providers.
- Also a theological question of whether people are valuable and worthy of our care.

- We are here because we went into healthcare to improve lives. There is a way that can be exciting for everyone.
- It is all about focus—what do we choose to focus on: the barriers and problems or the opportunity/invitation to hope and health—for patients and communities.

The essential lesson: Authentic Patient-Centered Care

- Authentic Patient-Centered Care is the most important dimension.

Authentic person-centered care begins by respecting and embracing the life, history, and context of the individual. At its core, authentic person-centered care is a trusting relationship between an engaged, empowered person and humble, expert providers who journey together toward hope and health.

Another Program Model of Person-Centered Care: PHA

- In 2015, approached by new funder to create new program to focus on barriers to health (SDH).
- Based upon BTH, knew that goal-setting and patient agency were **critical.**
- All patients screened for food insecurity, housing, and transportation; created own questions because no tools yet available.
- 569 patients served in 3.5 years; approximately 10% of all TFC serves.
- Patient-centered; not merely linkage to resources. Goal-setting critical.
- Time break-down: 36% linking to resources, 18% patient readiness; 41% goal setting and coaching; 5% miscellaneous.
- In 2018, 31% of TFC patients need housing assistance, 15% report no reliable transportation, 25% experienced food insecurity.
- Results:
  - 2016 – 85% demonstrated health improvements
  - 2017 – 93% demonstrated health improvements
  - 2018 – 90% demonstrated health improvements
  - Overall: 87% self-report improvements in their health thanks to PHA

What is our challenge? Today's epidemics

Diseases that kill us

- Suicide
- Substance use disorder
- Alcohol

Diseases that sicken us

- Obesity
- Heart disease/stroke
- Diabetes

What are the drivers?

- **Trauma (ACEs)**
  - Recognized as a key driver in a number of health indicators; SUD, smoking, risky sexual behavior, nutrition. Higher the dose, more lethal effect; inheritable.
- **Inequality of educational opportunity and attainment**
  - School quality directly correlated to local context; funding, expectations
- **Inequality in employment/income opportunity**
  - Growing inequality; now on par with the "Gilded Age". Hollowing out of rural communities and "tourist" economies. Areas that have kept pace are technology hubs and oil producing regions.
- **Access to appropriate services**
  - Primary care crisis; economics reward volume/"click box" intervention, and not engaging the 5% population that drive 50% of health care cost.

What is our best response?

- Authentic Patient-Centered Care
- Relationships that listen and empower
- Engagement of patient to set own meaningful goals
- Support of humble expert care team and peers

- No one model fits all.
- Models built on essential core need to be tailored to unique community needs and assets.

Thank You!

Questions?

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