Better Care for Complex Patients

At KentuckyOne Health, our tradition teaches that preferential treatment of the poor and vulnerable is our obligation. This moral imperative compels us to implement new care management models to deliver compassionate, coordinated, and comprehensive care to our most challenged and challenging patients.

To that end, we have implemented an innovative pilot program called **Health Connections**. Thanks to a grant from Catholic Health Initiatives' Mission and Ministry Fund, this project employs a multi-disciplinary team under the umbrella of VNA Health at Home to better serve our patients who have high medical needs, disjointed health care and, subsequently, high medical costs. It 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 early and coordinated interventions.

How it Works

Potential participants are identified while they are hospitalized at Sts. Mary & Elizabeth, Jewish Hospital and University of Louisville Hospital using a tool that calculates the risk of readmission. Those scoring very high and living in one of several low-income neighborhoods are invited to enroll in the free program which entails frequent home visits over a period of up to 90 days. The team works with the patient to set goals for health improvement, to identify any barriers to good health, and to work together to overcome them.

Home visits focus on medical and social-support service delivery, with the ultimate goal of promoting self-management and transitioning the participant to a medical home.

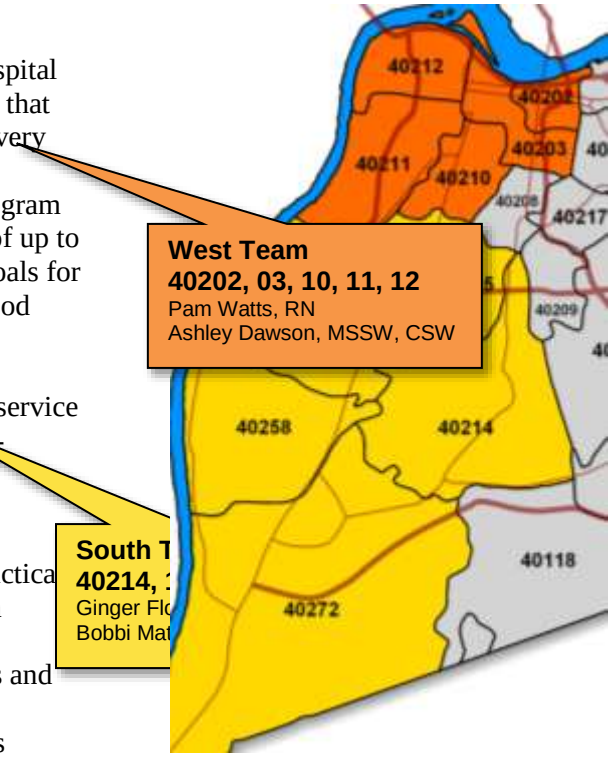
Each care team includes a lead RN, a licensed practical nurse, a social worker, and two community health workers. They collaborate with each participant's primary care provider to ensure optimal outcomes and the smooth transition to a medical home. Some participants in the non-skilled Health Connections program simultaneously receive traditional VNA skilled care.

The Health Connections teams address participant needs holistically, recognizing that to impact intractable medical problems you must address basic needs like housing, transportation, food insecurity, and low literacy. They can also access nutrition counseling through a registered dietitian from VNA or mental health/substance abuse services through a peer counselor from Seven Counties Services.

Physician Support is Crucial

Because a key goal of the program is to connect participants with a medical home and enhance their skill in managing their condition, partnering with physicians is critical. We want to support your care plan for your patients to bring about the best health outcomes.

To that end, a member of our care team accompanies each participant to physician appointments following hospital discharge. We help participants prepare for doctor visits with questions; and with physician and patient permission, we will sit in on the visit to listen and help reinforce your communication. This is very beneficial to patients who are often overwhelmed or who have low health literacy, helping them adhere to the plan of care.



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