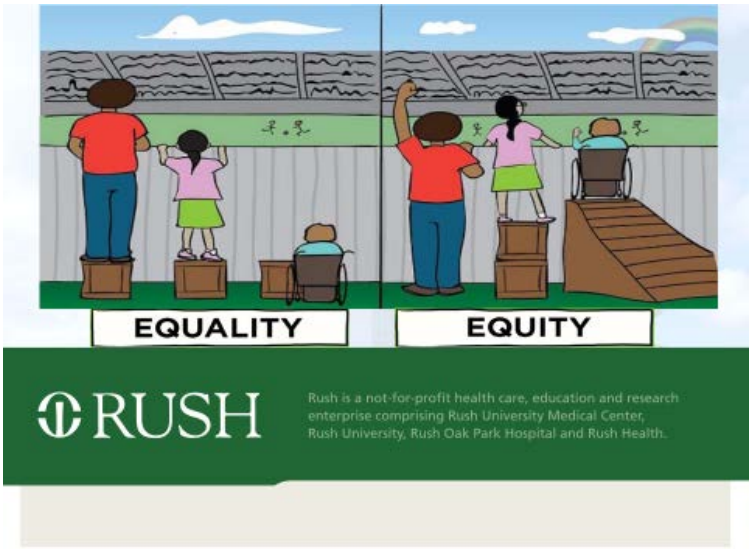
GLPTN Spotlight: Rush University Medical Center

Addressing the whole patient



Rush University Medical Center joined Great Lakes Practice Transformation Network (GLPTN) in part to work on addressing the needs of its patients who are high utilizers of health care. Located on the west side of Chicago, Rush clinics serve a mix of patients, including those with Medicare or Medicaid, private insurance, or no insurance at all. Pursuing equity is always front and center for Rush, shaping the way the health center operates.

As a clinical quality consultant who is also a registered nurse, Christine O'Donnell is working with Rush on the GLPTN initiative. At the beginning, she helped Rush identify GLPTN goals, which are to lower hemoglobin A1c values in diabetics, lower blood pressures in hypertensive patients, and reduce atherosclerotic cardiovascular disease (ASCVD) modifiable risk factors. In addition, the team has prioritized addressing patient social determinants of health (SDOH) needs.

One of the team's recent initiatives focuses on implementing a SDOH screening tool. The screener, created with support from GLPTN and the Institute for Healthcare Improvement (IHI), is comprised of seven questions designed to gauge patient access to food, utilities, transportation, housing, primary care, and insurance. These factors are directly related to health; for example, if a patient doesn't have a primary care physician, she may utilize the emergency room more often. Or, if a patient doesn't have reliable transportation, he may be less likely to take advantage of regular blood pressure checkups.

Assessing patients for outside risk factors provides clinicians with valuable information that can help them deliver more holistic care. Additionally, patient utilization of specialty care can be limited, so "addressing the whole patient helps ensure each has the resources to self-manage their health problems when appropriate," explains Christine.

The tool is now embedded in Rush's Epic electronic health record (EHR) system. If proved to be successful, the screener eventually can be used by all physicians, front desk personnel, medical assistants (MAs), and other staff.

To test its effectiveness, the tool first was piloted in the emergency room by a "multidisciplinary team who could address any hiccups." Now, four physicians are rolling out the tool to a random selection of

patients. After successfully completing pilot testing, the final screener will be employed by all Rush University Medical Group GLTPN practices at Rush.

To test workflows for implementing the new screener, the team is using Plan-Do-Study-Act (PDSA). They have found MAs administering the questionnaire at the same time as the depression screener already in place helps streamline processes and reduce administrative burden. Education has also been a big part of the assessment's roll out. Everyone from navigators to physicians have been coached on asking the questions without alienating patients, as well as reading body language and non-verbal signals. Christine explains, "We wanted to make sure patients feel they can confide in us and not feel belittled."

Over the pilot's two-week span, 10 patients were randomly pulled from the EHR to complete the tool, with four screening positive for three or more risk factors. This completed the first PDSA and a few changes were made to the workflow based on the PDSA findings. A second PDSA was initiated to incorporate four physicians in various primary care practices. Each physician had 10 patients pulled for screening. The patients were already scheduled for appointments and chosen for screening if they were a member of the TCPI registry and insured under CMS. To date, two patients have screened positive and provided with resources to help their needs be met.

When patients screen positive, they receive resources provided by Rush partners NowPow (powering communities with knowledge) and Lyft (transportation services). Linking patients with appropriate resources and matching them with social workers are the first steps to addressing some of the root causes of their health problems. The hope is that by providing needed resources and increasing the frequency in which patients are seen in the primary care clinical arena, chronic conditions can be better managed, specifically type II diabetes, hypertension and Atherosclerotic Cardiovascular Disease (ASCVD) risk. The goal is to lower hemoglobin A1c values for type II diabetics and blood pressure in hypertensive patients along with addressing ASCVD modifiable risk factors in both patient populations. When patients are provided with the resources they need, access to care likely will be increased, treatment plans may be followed more closely, and overall health may improve.