Triangle Interprofessional Partners for Prevention (TIPP) "Hotspotting" Case Studies

Jessica Himmelstein, Katherine Barron, Trudy Li, Meredith Park, Morgan Noel, Rita Kuwahara, MD, MIH, Meg Zomorodi, PhD, RN, CNL, Anne Jones Ph.D, MSW and Amy Weil, MD

INTRODUCTION

Triangle Interprofessional Partners for Prevention (TIPP) works with patients with recurrent hospitalizations and complex health and social needs who face challenges navigating the healthcare system.

According to the Agency for Healthcare Research and Quality (AHRQ), the top 1% of patients with recurrent hospitalizations account for **21.8%** of the total **$2.9 trillion** spent annually on US healthcare costs.1

OBJECTIVES

- Teams of 2-3 students partner with each patient over a 6 month period
- Seven patients served as of May 2016
- TIPP teams consist of interprofessional UNC students from backgrounds such as:
  - *Nursing*
  - *Public Health*
  - *Medicine*
  - *Social Work*
  - *Pharmacy*
  - *Undergraduate*

TIPP Team Goals:

- Build trust and relationship with patients
- Establish and achieve patient and team health goals
- Offer assistance based on patients' needs
- Maintain frequent communication with enrolled patients
- Each team aims to achieve goals prior to "graduating" the patient from the TIPP program

North Carolina Albert Schweitzer Fellowship

North Carolina Albert Schweitzer Fellow: Rita Kuwahara
Institution: University of North Carolina at Chapel Hill School of Medicine
North Carolina Albert Schweitzer Fellowship Year: 2015-2016

CASE REPORTS

Mr. S.

- 47 y.o. male
- Congestive heart failure with an automatic implantable cardioverter-defibrillator
- Chronic kidney disease
- Gout
- Hypothyroidism
- Diet-controlled type 2 diabetes after 100 lb weight loss.
- Relocated to NC from Las Vegas in 2015
- Sisters live in the area
- College graduate
- Five children

Mr. C.

- 53 y.o. male
- Paraplegia due to a gun shot wound
- End colostomy with a recurrent enterocutaneous fistula
- Neurogenic bladder with recurrent urinary tract infections
- Bilateral stage 4 pressure ulcers
- Type 2 diabetes
- Lives alone in public housing
- No known children
- Limited social support
- Worked for 14 years after becoming paraplegic
- Currently unemployed on social security disability income

Barriers to Care

- Financial concerns
- Need to establish care for multiple comorbidities
- Lives far with limited driving ability
- Requires diet with low sodium and protein
- Unable to call 911 for home safety concerns

Barriers to Care

- Poorly equipped and understaffed outpatient facilities
- Limited access to optimal treatments
- Cap on Medicare coverage
- Poor transitional coordination of care between multiple specialty providers

CASE REPORT SUCCESSES

Care Coordination

- Visited in hospital for each admission
- Attended outpatient appointments
- Established primary pharmacy
- Established primary care provider
- Established cardiology and rheumatology specialty care
- Home Visit

Care Coordination

- Assessment and aftercare planning for each hospital admission
- Advocacy and coordination of care at skilled nursing facility
- Attended outpatient facility care plan meetings
- Facilitated primary care provider communication

LESSONS LEARNED

The past year highlighted the obstacles and opportunities of working in interdisciplinary teams.

- Uncovered and addressed logistical scheduling challenges
- Streamlined processes to identify patients
- Optimized the team's strengths to find patient resources

Health Systems Observations:

- Care often provided in siloes
- Need to address structural barriers to care and improve health systems communication

CONCLUSION

- We hope to continue working with high utilizing patients, build interdisciplinary communication and cohesion, and integrate this process into each school's curriculum.
- Pre-program surveys demonstrated strong readiness for interprofessional work, and post surveys indicate continued commitment to this work.
- As medicine becomes increasingly team-based, these experiences will result in a more collaborative culture to better serve our patients.

REFERENCES AND ACKNOWLEDGEMENTS

1. Cohen, S. and Yu, W. The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-09. Statistical Brief #354. January 2012, Agency for Healthcare Research and Quality, Rockville, MD.

This project was based on the model of "Hotspotting" developed by the Camden Coalition of Healthcare Providers and supported by a North Carolina Albert Schweitzer Fellowship received by Rita Kuwahara, an AHEC Innovations and Apples Grants received by Dr. Amy Weil, and by the UNC Internal Medicine Clinic and UNC Schools of Medicine, Nursing, Social Work and Public Health.

Contact Info: www.Schweitzerfellowship.org
(704) 895-6596