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Session: A108 Evaluation of Symptoms and Novel Strategies in Patient and Family Care
Abstract Presentation Time: May 20, 2:15 p.m. PST
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Multidisciplinary Lung Health Clinic Helps Low-Income Patients

ATS 2018, San Diego, CA – A new study demonstrates that a comprehensive and multidisciplinary clinic for low-income and homeless individuals with respiratory disease can decrease no-show rates and provide quality care that is highly satisfying to the individuals treated. The study was presented at the 2018 American Thoracic Society International Conference.

"Beyond our own institution's walls, we have demonstrated that creating an interdisciplinary learning health care clinic can lead to improved structure, process and patient outcomes," said lead author Lisa C. Cicutto, PhD, of National Jewish Health, Denver, Colorado. "Within our own institution, we have also learned and recognized the importance of teams and having patient navigators and a nurse practitioner who can lead the clinic."

Dr. Cicutto and colleagues developed the Comprehensive Respiratory Care Clinic (CRCC) for homeless and low-income adults living with lung conditions to meet the needs of both these patients and local primary health care providers. She noted that low-income individuals with conditions like uncontrolled asthma and chronic obstructive pulmonary disease have unique needs that extend beyond their primary diagnoses. Access to specialty care, attending health care visits and practicing effective self-care strategies can be significant challenges.

"We wanted to create a clinic model that provides quality, seamless care that integrates primary and specialty care for low-income individuals who have these challenges, and make sure they don't 'fall between the cracks' of the health care system," said Dr. Cicutto.

The CRCC team met or exceeded most of their goals. For example, at 16 months, they were able to significantly reduce the percentage of "no-shows," from 50 percent to 15 percent. Patient and referring physician satisfaction rates were, respectively, 95 percent and 94 percent at the end of the study period. At the study's baseline, 50 percent of patients used their asthma inhalers properly, while 87 percent demonstrated proper use at the end of the 16 months.

A number of best practices were adopted by the CRCC to achieve these and other significant results. These included creating an interdisciplinary team that included patient navigators – who provided support, education and developed trusting relationships with all patients. The CCRC also used team huddles, strategies to identify high-risk patients, and the provision of walk-in services, among other practices.

Members of the National Jewish Health team immersed themselves in research before opening the CRCC in order to identify best practices and community needs. They reviewed previous studies, ran focus groups and conducted interviews with key individuals. They then developed a clinical care team consisting of two patient navigators, two nurses, a nurse practitioner, a pulmonologist medical director and eight rotating pulmonologists, and trained them on the issues that typically affect community members, as well as how to address these needs in an outpatient clinic.

The team worked closely with primary care providers, including existing safety-net clinics, to identify the needs of these individuals, and to establish lines of communication and ensure that the care patients received was well coordinated. At the time the study abstract (see below) was submitted, 390 individuals had been seen in the CRCC, with a total of 1,094 visits.

"I believe that clinics in other cities can apply our program elements," said Dr. Cicutto. "That includes understanding the needs of the local community and identifying strategies that will work with the local scene. Every community has different challenges and strengths that need to be understood to inform and evaluate implemented strategies."

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Title: Development and Initial Evaluation of a Comprehensive Respiratory Care Clinic (CRCC) for Homeless and Low Income Adults Living with Lung Conditions

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Background: Low-income individuals with respiratory conditions, such as uncontrolled asthma and chronic obstructive pulmonary disease, have unique needs that extend beyond their primary diagnoses. Access to specialty care, attending health care visits and practicing effective self-care strategies are significant challenges. Purpose: To create and implement an outpatient clinic model for quality, seamless, integrated care between primary care and respiratory care for low-income adults affected by lung disease that meets the needs of patients and health providers. **Methods:** CRCC development consisted of an environmental scan review of literature, focus groups and key informant interviews) with results informing model development and implementation. Prior to implementation, clinical care team (2 patient navigators, 2 nurses, a nurse practitioner, a pulmonologist medical director and 8 rotating pulmonologists) training occurred. Evaluation focused on quality of care, patient and provider satisfaction, process of care sheets, and aggregate reports from the electronic databases. A continuous quality improvement process implemented. **Results:** Participants from 10 stakeholder health organizations focusing on the care of low-income and medically underserved populations participated in key informant or focus group interviews. As community safety-net clinics do not apply uniform care delivery models, best practices were identified and included: creation of interdisciplinary care teams that included a patient navigator, the use of team huddles, strategies to identify high-risk patients, avoidance of scheduling patient visits beyond 4 weeks, general overbooking of visits, and the provision of walk-in services. The need for regular communication and care coordination was a strong message from primary care providers. Care coordination and communication strategies proposed included: a CRCC communications point-person to help primary care providers navigate our specialty health care organization, near-immediate written communication regarding the visit/consult, more clinically useful consult notes, quick specialty consult access, and formation of care partnerships. To date, 390 adults were provided 1,094 visits. Table 1 displays quality indicators, benchmarks, baseline and average level of provision/attainment over 16 months, as well as, high-low ranges over time. **Conclusion:** Our experience suggests that a comprehensive and multi-disciplinary team approach can decrease no show rates and provide quality care that is highly satisfying to patients. Additional indicators of benefit include urgent care visits and hospitalizations and will be analyzed and reported for the May meeting.

Table 1: Quality Indicators and Provision/Attainment Levels

Quality Indicators	Benchmark	Baseline	Post Average for 16 Months	Quarterly Ranges
Consult note sent to PCP	90% within 3 business days	7 days	1 day (91%)	1-10 days
No show rate	15%	50%	15%	11-50%
Financial assistance for patients	70% access meds. and equipment	50%	90%	50-95%
Address transportation needs: - Reason for missed visit	>20% report transportation	33%	0%	0-33%

Patients needing a medical home will be referred to one	100%	0	100%	0-100%
Favorable patient satisfaction	≥ 80%	4.4/90%	4.8/95%	4.4-4.9
Favorable referring provider satisfaction	≥ 80%	2.4	2.8/94%	2.4-4.8
Vaccinations up to date – flu, pneumococcal	≥ 85%	9%	61%	9-62%
Vaccinations – Note sent to PCP		57%	100%	57-100%
Inhaler technique	≥ 80%	50%	87%	50-97%
Patient teaching	100%	77%	89%	74-90%