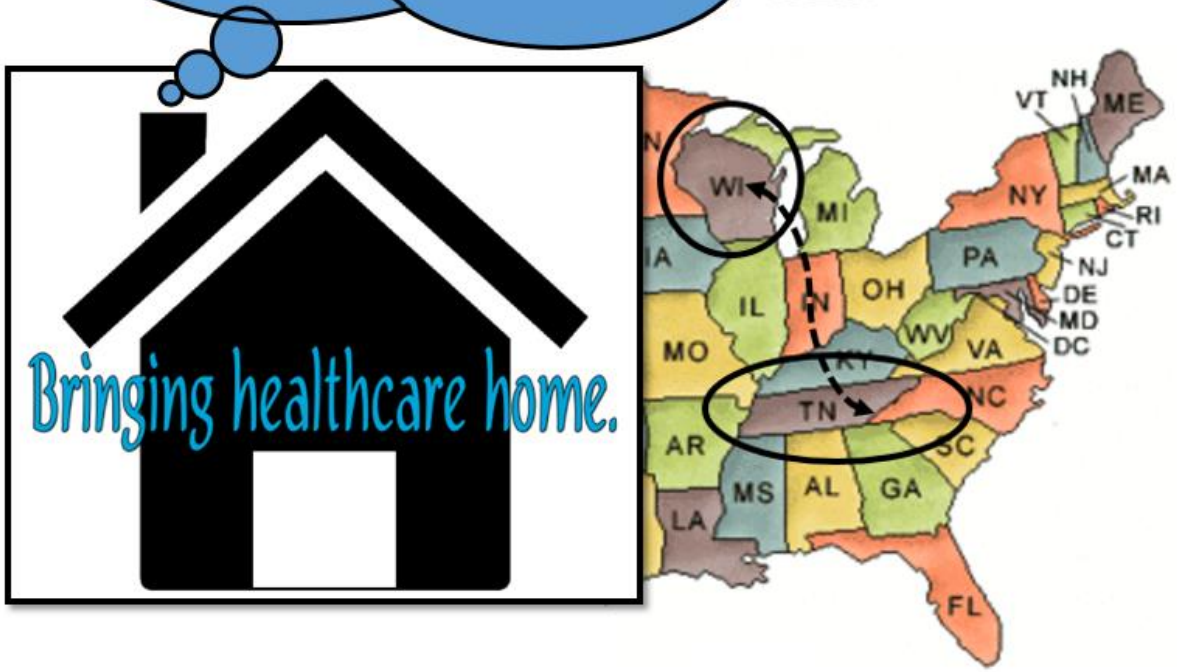
Mapping the Road to Healthcare for Vulnerable Populations



Presenters

Sam Wolfe: M.Ed, Homeless Program Coordinator, City of Chattanooga

Trish Sarvela: Development Director, Partnership Community Health Center

Amber Price: Health Advocate, Partnership Community Health Center

Jana Esden: DNP, APNP, FNP-BC, Partnership Community Health Center

Our Foundation: Who We Are

- Partnership Community Health Center (Appleton, WI) and Homeless Healthcare Center (Chattanooga, TN) both work to **engage individuals in a holistic manner** through various outreach techniques in order to **address barriers to care**

Our Foundation: Homeless Healthcare Center

- 30 year old clinic
- Part of Hamilton County, Tennessee's Health Department
- Serves 3,000 unique individuals per year
- Operates on a walk-in basis
- Offerings include:
  - Primary Healthcare Services
  - Dental Care
  - Behavioral Healthcare
  - Substance Abuse Treatment
  - Case Management

Innovation Leads to Change: "*Bringing Healthcare Home*"

- **Goal: address barriers to care as a primary root cause of poverty**
- On **May 5, 2016, Partnership Community Health Center opened a full-service clinic at COTS (transitional shelter)** in Appleton, WI to provide primary care services to individuals experiencing homelessness or near homelessness:
  - Med checks
  - Physical exams
  - Sick visits
  - Vaccinations/immunizations
  - Follow-up care after ER visits
- This is a **nationally acclaimed best practice!**

Establishing Patient Relationships Through Outreach

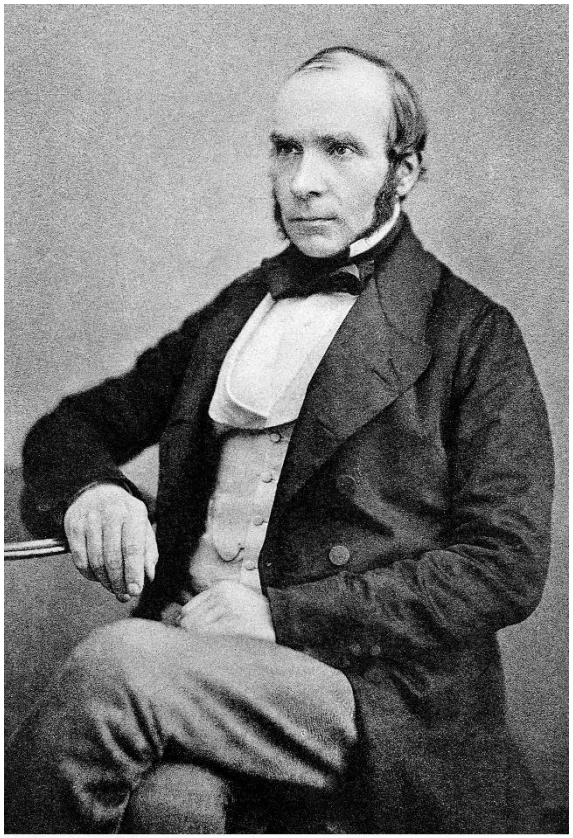
- Through outreach, we **establish a relationship** with potential patients and **educate** them on health services offered
- This is a crucial step in **mapping the road to a patient-centered healthcare "home"**
- **Patients play a key role** on the healthcare team
  - Team members are mindful and accommodate the needs of each individual patient

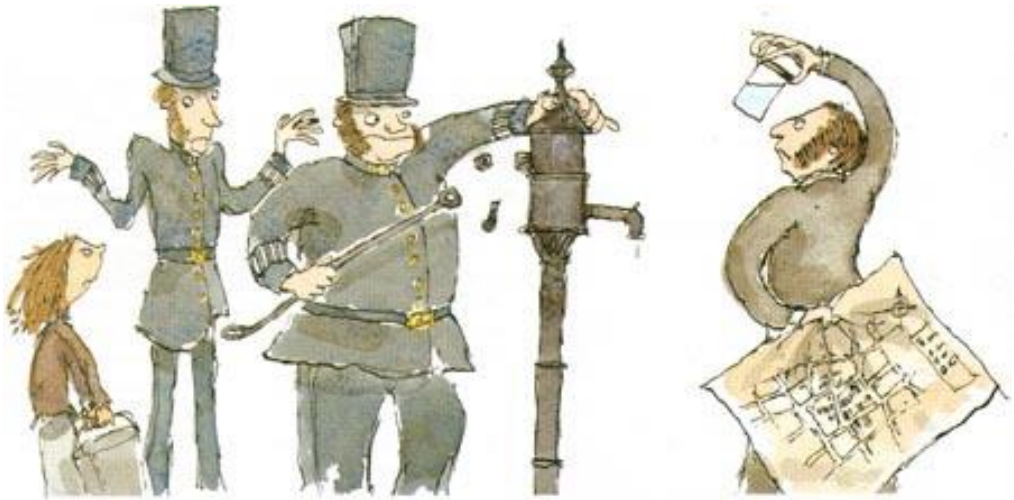
Key Barriers to Care

For the vulnerable populations served by both of these health centers, key barriers to accessing healthcare include the following:

- **Trauma & Adverse Childhood Experiences (ACEs)**
- **Transportation** – no reliable vehicle; depend on public transportation
- **Communication** – difficult to contact due to lack of phone or limited minutes

Identifying the Vector





A Closer Look at Adverse Childhood Experiences and Trauma-Informed Care

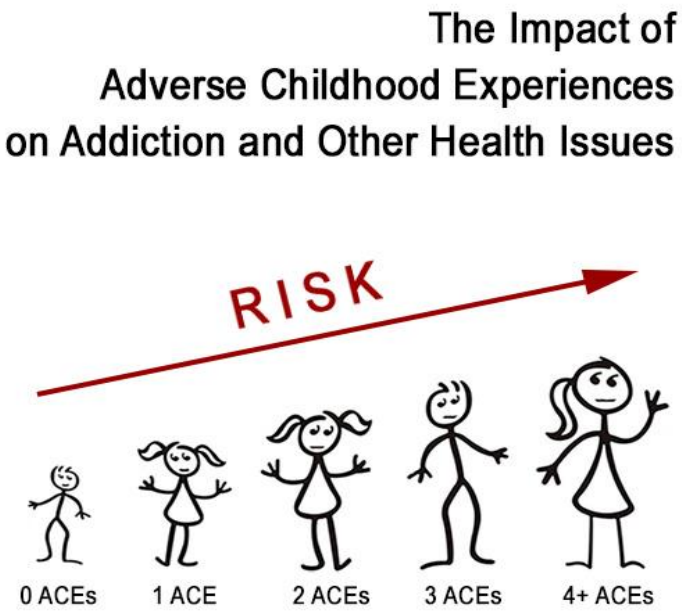
Original ACE Study

KAISER PERMANENTE®

- Published in 1998
- Original ACE Study conducted at Kaiser Permanente from 1995 to 1997
- Over 17,000 HMO members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors
- Numerous additional studies have been published since then with consistent findings

Significance of ACEs

- Over half of the U.S. population has suffered at least one ACE
- A graded relationship exists between number of ACEs and A) health risk behaviors and B) chronic illnesses and mental illness
- ACEs increase risk for disability and early death
- Consequences of ACEs are broad – affecting the individual victim, family, community, and society
- Lifetime economic burden of child maltreatment = $124 billion

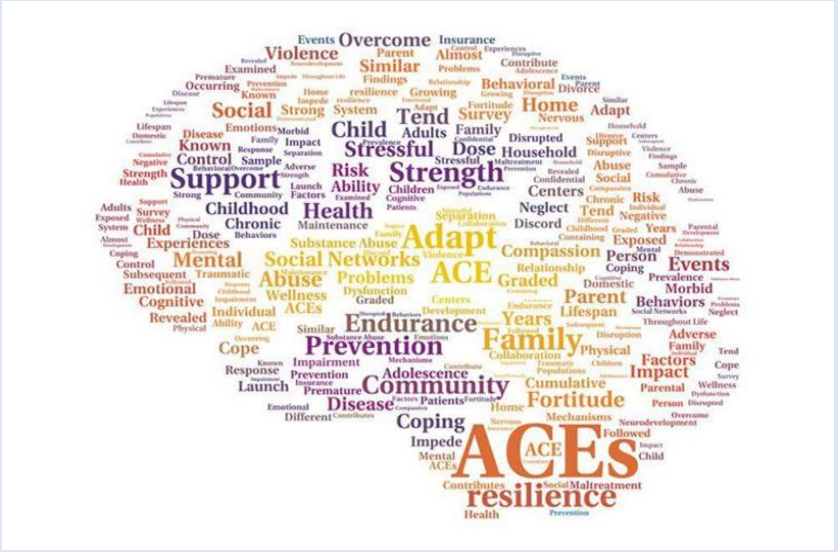


7 Categories of ACEs

- Psychological abuse
- Physical abuse
- Sexual abuse
- Violence against mother
- Living with a substance abuser
- Living with a mentally ill/suicidal person
- Living with a person who has been in prison

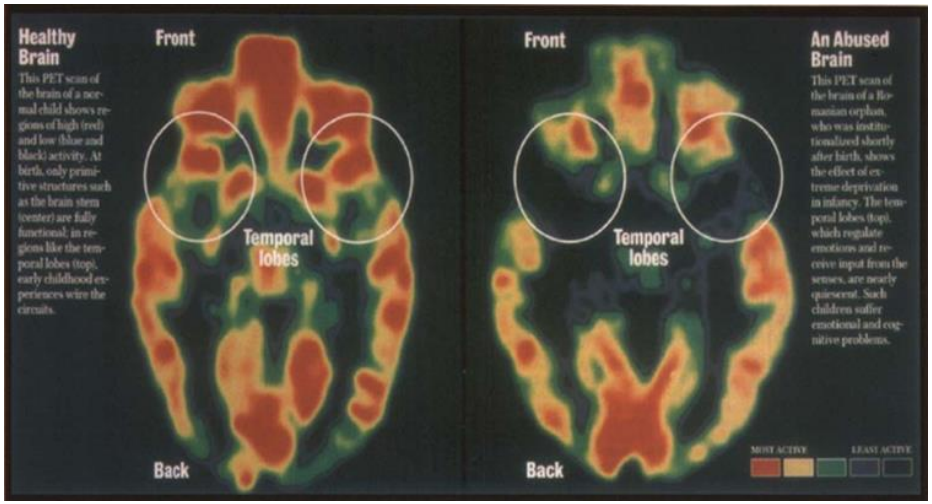
Pathophysiology

- Toxic Stress:
- Changes brain architecture, which influences future behavior, learning, and health
- Continual “fight or flight” changes the brain at a molecular, cellular, and circuitry level
- Alterations in DNA are seen
- Excess cortisol is damaging to the brain



Effect of Toxic Stress

- Impaired cognitive and academic functioning
- Alteration in emotional functioning and behavior patterns



Ramifications of ACEs

Examples of health risk behaviors tied to ACEs:

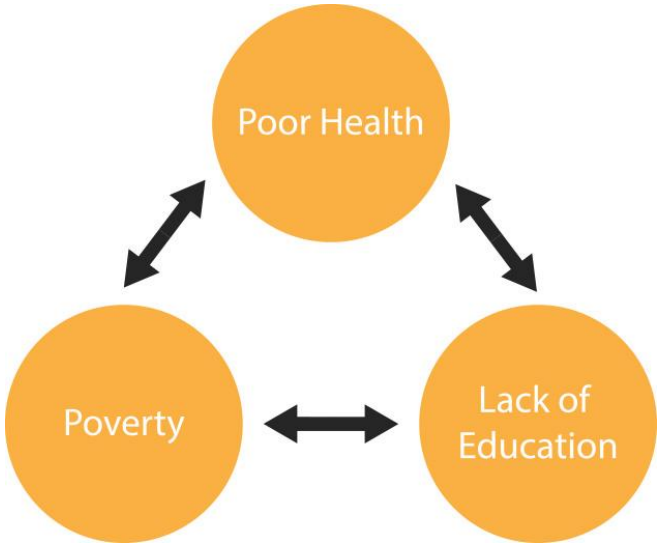
- Alcoholism
- Drug abuse
- Tobacco use
- Overeating
- Suicide attempts
- >50 sex partners

Ramifications of ACEs

Examples of chronic illnesses tied to ACEs:

- Depression
- Ischemic heart disease
- Cancer
- Chronic lung disease
- Skeletal fractures
- Liver disease

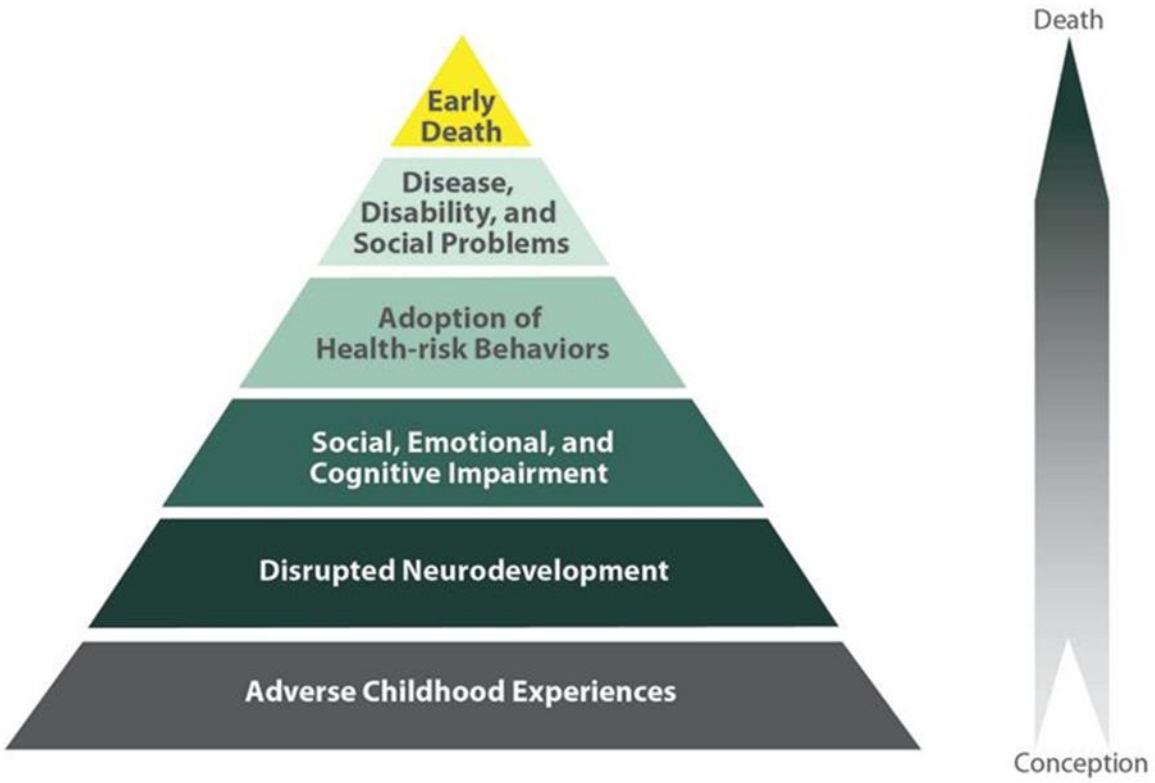
Ramifications of ACEs



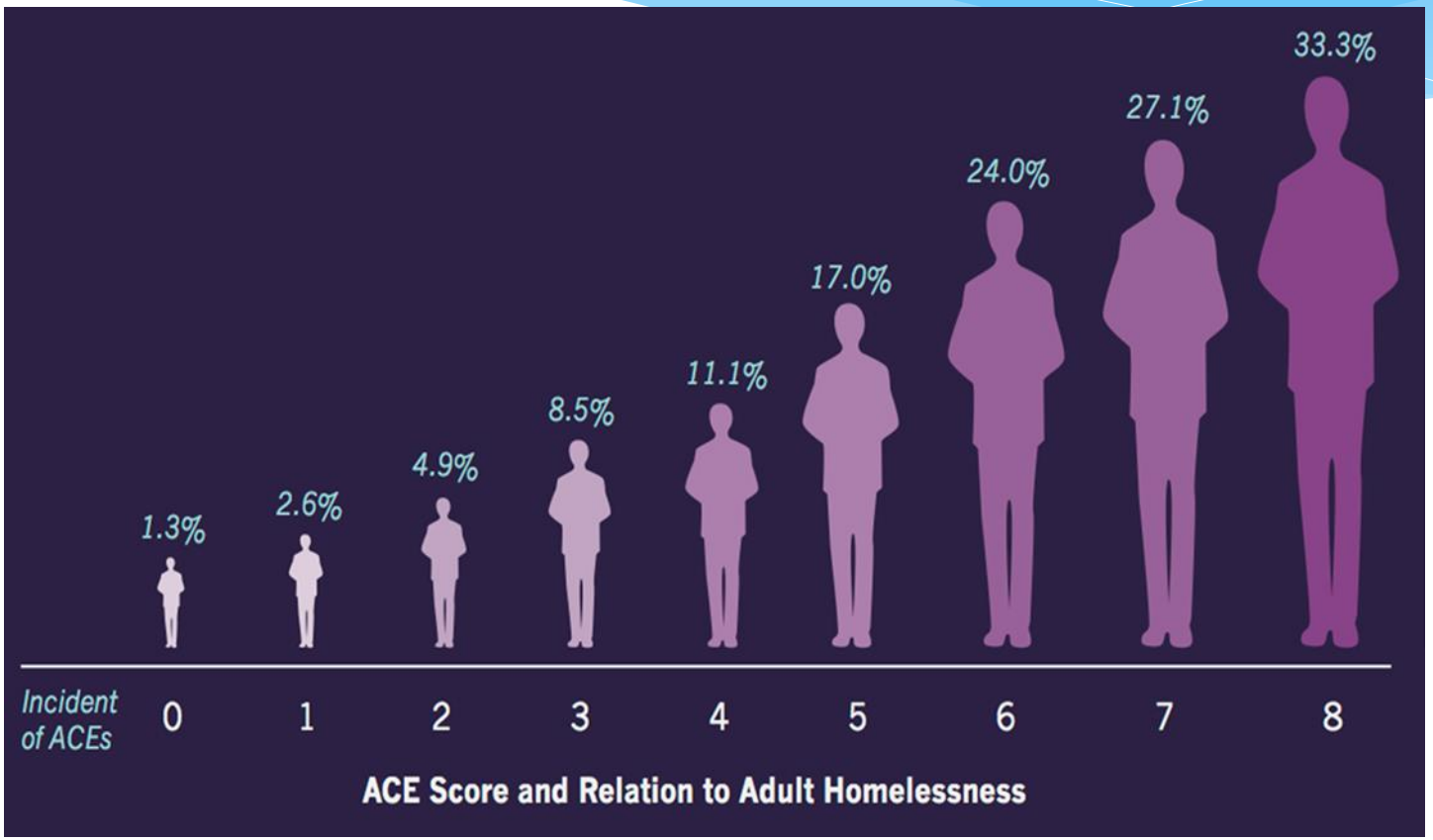
Examples of additional consequences tied to ACEs:

- Disadvantaged socioeconomic status
- Less education
- Increased difficulty maintaining employment
- More likely to report poor health

Ramifications of ACEs



ACEs and Homelessness



Trauma-Informed Approach

- We need to presume the clients we serve have a history of traumatic stress
- We exercise “universal precautions” by creating systems of care that are trauma-informed
- Includes both direct patient care and general services

Trauma-Informed Approach

- We need to treat patients with universal precautions with regards to the possibility of past trauma

- To the provider, the behavior is the problem; to the patient with a history of childhood trauma, it is the solution

Trauma-Informed Approach

- Procedures can trigger patients with a history of childhood trauma
- Use your "trauma lens"

Partnership Community Health Center: “Bringing Healthcare Home”

Removing Barriers to Healthcare

- Removing barriers to healthcare and introducing health literacy programming **empowers patients to become proactive in making necessary changes to improve their health,** ultimately helping them move out of poverty

- Previous **trauma** or adverse childhood experiences (ACEs)
- **Transportation** – no reliable vehicle; depend on public transportation
- **Communication** – difficult to contact due to lack of phone or limited minutes

Key Barriers

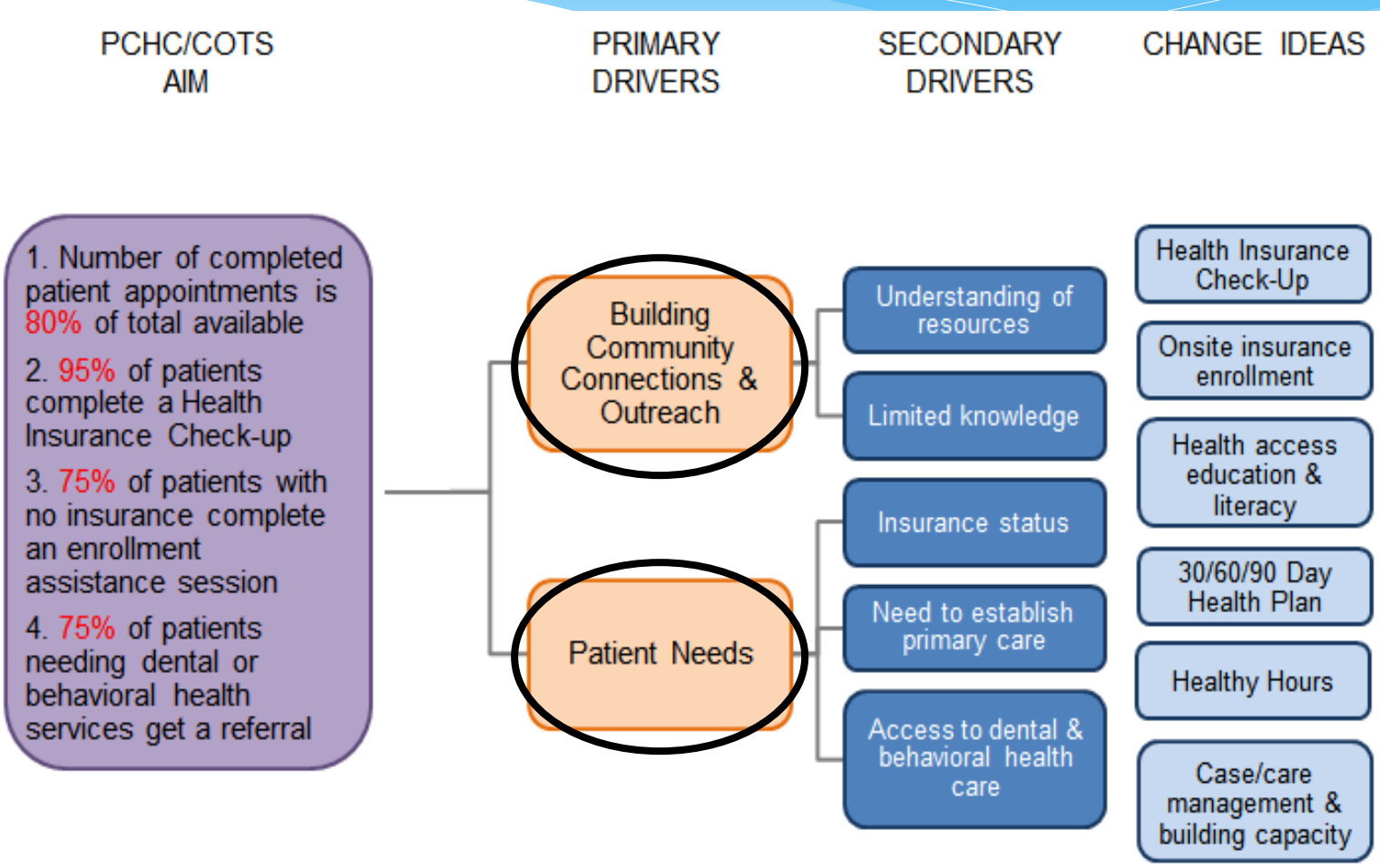
Integrating Primary Care and Behavioral Health

- Most patients seen at the COTS clinic suffer from chronic mental illness that is complicated by a lifetime of trauma and addiction.
- Without addressing this need, their physical health does not improve.
- In **February 2017**, we **began offering substance abuse counseling at COTS.**
- In **August 2017**, we **began offering mental health assessments and counseling at COTS.** This service is integrated with primary care to ensure we are taking a truly holistic approach to patient care.

Addressing Barriers to Care Through Regional Poverty Initiative

- Participation in area-wide Poverty Outcomes & Improvement Network Team (POINT) provided the following opportunities to address barriers to care:
  - **Connection with other area organizations** that are working to reduce poverty, including those sending patients to the COTS clinic
  - Initiate **quality improvement work** that revolves around needs of patients and community engagement

Defining Our Team's POINT Aims and Change Ideas



Community Partners Help Us Advocate for Patients' Needs

- Like our community partners, we hope that our efforts will have an impact on ending homelessness in our area
- The **case managers at the shelters and transitional housing agencies we serve are an extension of the healthcare team**
  - Our community partners may recognize a client's need for healthcare before we can interact through outreach

Building of "Community" Between Care Team and Patients

- **Patients are a key component of our healthcare team,** and barriers to care are addressed at an individual level
- **Individual healthcare needs are determined** during outreach or prior to each patient's first appointment **via a brief survey called a Health Insurance Check-Up (HICU)**
- Based on a patient's HICU responses, we then work to connect them to services at PCHC:
  - Primary care
  - Dental care
  - Insurance enrollment
  - Behavioral health

Health Insurance Check-Up (HICU)

Partnership Community Health Center

COTS

Health Insurance Check-Up

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Phone Number:** _____

I **NEED** health insurance **or** have questions about my health insurance	YES	NO
I **NEED** a primary care/regular doctor	YES	NO
I **HAVE COMPLETED** a dental appointment in the past year	YES	NO
I HAVE concerns about my teeth	YES	NO
I **WOULD LIKE** a Partnership Community Health Center dental appointment	YES	NO
I **HAVE COMPLETED** a counseling appointment in the past year	YES	NO
My appointment was completed at this location: _____		
I **WOULD LIKE** a Partnership Community Health Center counseling appointment	YES	NO

Notes (office use only): _____

HICU Results – Proof that Patients Matter!

Percentage of Patients Completing a Health Insurance Check-Up (HICU)	93%
Percentage of Uninsured Patients Receiving Enrollment Assistance ***(based on number reporting no insurance on HICU)***	89%
Referral Rate for Patients Requesting Dental Services on HICU	96%
Referral Rate for Patients Requesting Behavioral Health Services on HICU	89%

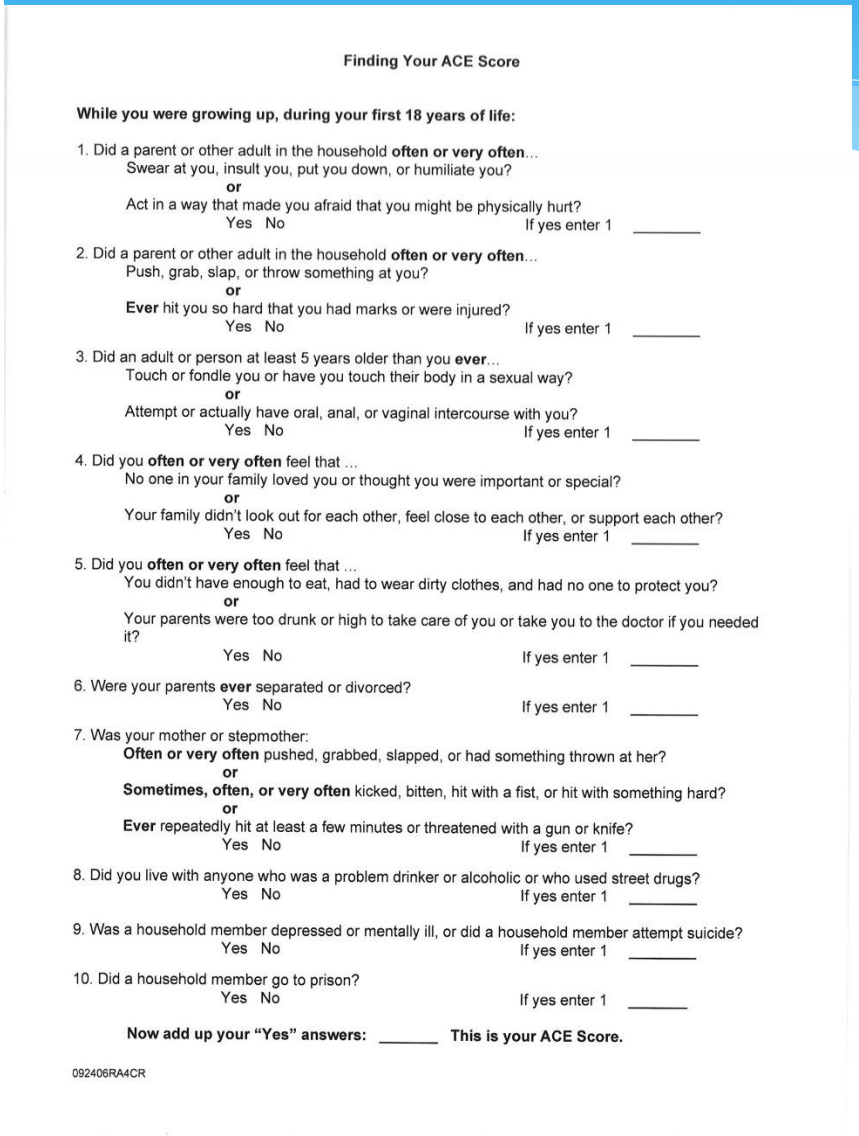
Barriers Provide Learning Opportunities

- **Patient barriers provide opportunities** for our team members **to learn** how they can help provide care
- We **never stop putting the patient first,** but instead ask ourselves what we would do if we were in their shoes

Trauma-Informed Care

- To better understand the impact of early trauma on our patients and their complex medical and behavioral health needs, **we introduced Adverse Childhood Experiences (ACEs) assessments into our intake process.**
- Initial data shows that **<u>many patients at COTS have had significant exposure to trauma.</u>**

ACE Assessment Results



Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

092406RA4CR

- Most common ACEs reported by our patients:
  - **56% -** Parents were separated or divorced
  - **48% -** Lived with someone who was an alcoholic or used drugs
  - **47% -** Parent/adult in household swore, insulted, humiliated or caused fear of physical harm

Scope of our Trauma Lens at COTS

- ACE Questionnaire
- Follow up discussion with provider
- Screening for anxiety, depression, substance use
- Referral for trauma-informed CBT
- Relationship/trust building, empathy
- Tertiary prevention strategies
  - Treatment of chronic illnesses /mental illness
  - Treatment for substance use disorders

Building Trust

- Culture of Caring in the clinic environment
- Acknowledgement of past trauma and how it has affected their lives
- Mutual respect and professionalism
- The patient and provider are on the same level
- Shared decision-making for healthcare decisions

Trust

Behind the Scenes: Patient with Severe Trauma

- 33-year-old female staying in a local inpatient treatment facility for opioid addiction presented initially as a walk in for tooth pain
- Patient with depression, anxiety, PTSD, substance use disorder, and a significant history of childhood trauma (ACE score 9)
- No recent pap, no recent labs, no recent immunizations, one month overdue for depo shot, not currently connected with a counselor, and nearly out of psychiatric medications prescribed from jail. No dentist.
- Can only attend appointments when counselors at treatment facility are available to drive her

What would you do if you were her provider?

Behind the Scenes: Our Approach

- **First visit:** arranged for emergency dental the next day (walk in), arranged an appointment for counseling, drew labs, refilled psychiatric medications and prescribed a non-narcotic pain reliever for tooth pain

- **Next visit (1 week later):** completed a formal history taking, gave her a depo shot, administered immunizations, scheduled her for a physical with pap and placed additional needed referrals
  - Patient didn't complete dental appointment yet because no one was available to drive her for 2 weeks – she had to live with tooth pain during that time due to the restrictions of her living community

Finding Solutions to Communication Barriers

- **Some patients** don't have a phone or run out of minutes and **can't receive automated appointment reminder calls or texts**
- To address this barrier, we use the following tactics:
  - **Face-to-face relationships** with patients during regular shelter outreach
  - **Scheduling** of follow-up appointments **when patient is physically present**
  - **Printed appointment reminder slips** the day prior to an appointment
  - Regular email and phone **communication with shelter and transitional housing staff**

Eliminating Transportation Barriers

- Per our buses and beyond survey, **many patients rely on public transportation** and do not own a reliable vehicle
- Transportation barriers for residents at the COTS men's campus are eliminated due to the clinic being onsite
- To further address this barrier, we use the following tactics:
  - **Educate patients on transportation options**, including MTM (Medical Transportation Management) services for individuals with Medicaid/BadgerCare
  - **Provide bus passes** to patients in need after completion of their COTS clinic appointment
  - **Schedule and pay for a cab ride** when other transportation options aren't feasible

Eliminating Transportation Barriers

- We have **physically tested the bus routes** so that we can speak from first-hand experience when telling patients how to get to the clinic
- We **tested our latest brochure map out with patients and potential patients** so that we could ensure that those we serve could easily locate us

Behind the Scenes: Domestic Abuse Shelter Outreach

- **Patient X** residing in domestic abuse shelter is **experiencing severe tooth pain** and needs dental care ASAP
- Due to no immediate dental openings and patient's work schedule, next day walk in and wait (WIAW) is the only option
- **Numerous barriers to care:**
  - High likelihood of **previous trauma** due to place of residency
  - **Relies on public transportation** but has **no money for bus pass or cab ride** – previously stated she missed scheduled dental appointment due to lack of transportation
  - **No phone –** can't call to follow-up

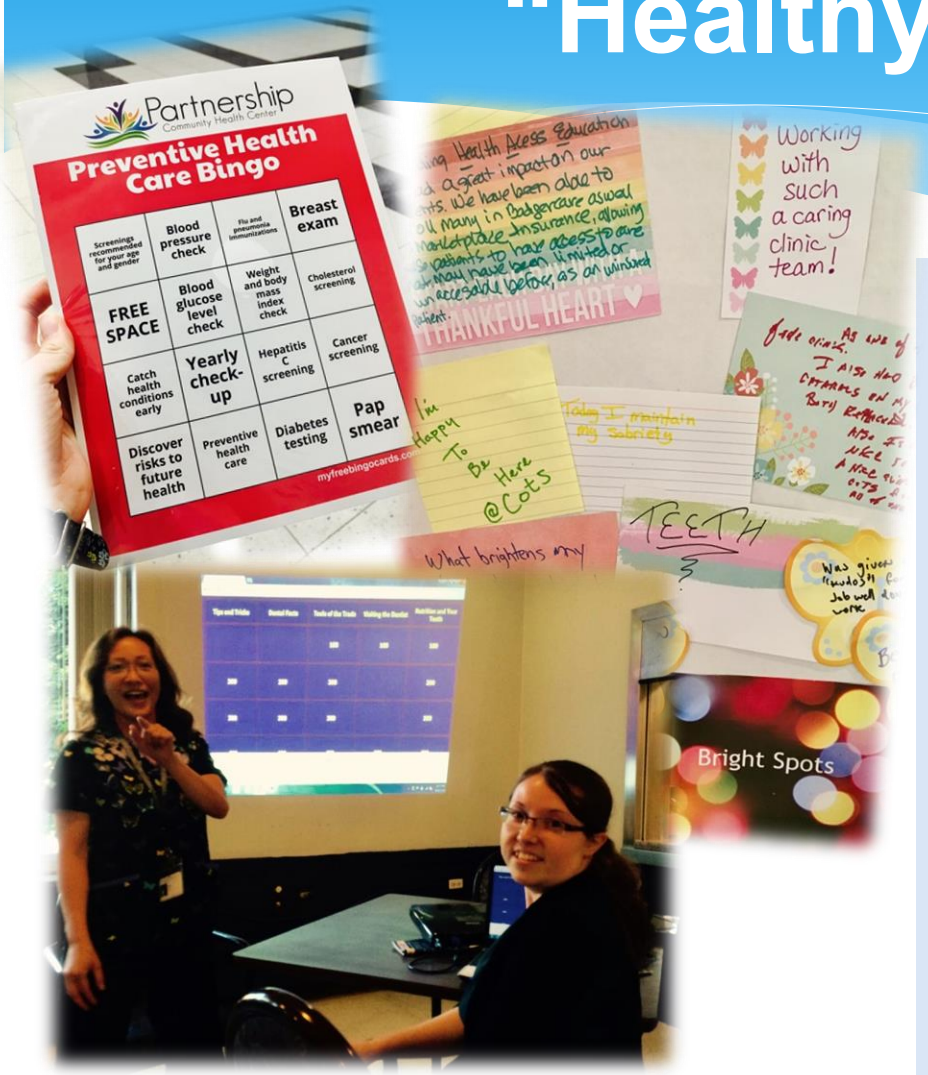
Harbor House
HAVEN • HELP • HOPE

What would you do to ensure this patient receives care?

Modifying Outreach Services to Fit Individual Patient Barriers

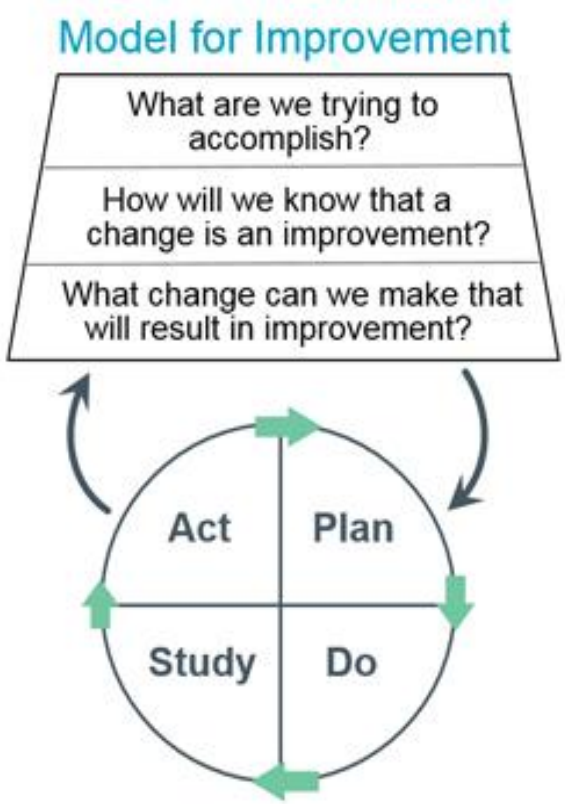
- **For Patient X, we took the following measures to connect her to care:**
  - Scheduled and paid for a next-day cab ride so she could do WIAW
  - Gave info on future transportation options
  - After meeting with patient during outreach, connected with schedulers and booked a last minute dental opening that lined up with expected arrival time via cab
  - Confirmed with PCHC dental facility that patient arrived for visit

Addressing Barriers Through "Healthy Hours"



- To further address barriers to care, we provide patients with **health literacy education through "healthy hours"**
- Some of our healthy hour topics/activities have included:
  - Marketplace Bingo
  - Dental Jeopardy
  - Celebrating Bright Spots
  - Counseling Fact or Crap
  - Preventive Health Care Bingo
  - Prescription Assistance
  - Medical Transportation

Improving Our Work One PDSA at a Time



- For every new barrier to care that we come across, we start a new PDSA cycle in order to find the best solution

PDSA: Quality improvement tool to test a small-scale change (plan, do, study, act)

Expanding Our Nurse Practitioner Hours at COTS

- The findings from our initial PDSA cycles guided the interventions for expansion of the COTS clinic project
- In **March 2017**, we **extended the hours of one of our nurse practitioners** and are now seeing patients 2 full days per week, instead of 1.5 days
- In response to the need to grow our patient base, we began providing **onsite blood pressure checks and appointment scheduling at a local emergency shelter**

FOX VALLEY
WARMING SHELTER

Objective of this PDSA Cycle: Book Warming Shelter patients for COTS clinic appointments and PCHC dental appointments as a result of onsite appointment scheduling and blood pressure checks.

The Change or Idea:
We would like to expand our patient base at COTS. We have also been seeing a big need for dental services and are seeking to cut down on communication barriers to care. Many at Warming Shelter don't have a phone to schedule an appointment.

ACT:

Because having access to scheduling dental appts onsite was such a huge success, we will try to coordinate this on a monthly basis with our regular outreach efforts at Warming Shelter.

PLAN:

Amber, Trish, Jill and Brigette will do outreach at Warming Shelter on 7/17/17 in order to address needs for primary care and dental services. HICUs will be handed out to determine these needs. Amber will schedule COTS clinic appts & Brigette will schedule dental appts. Jill will do blood pressure checks.

STUDY:

The signs and use of 2 different tables helped us to stay more organized than at previous outreach sessions. **We scheduled 5 COTS clinic appointments (4 new patients) and 6 new patient dental appointments.** One individual commented that he would not have called on his own to schedule a dental appt. This additional scheduling was well-received.

DO:

Tables were set up at Warming Shelter for blood pressure checks and appointment scheduling. HICU responses helped us determine which type of appt we needed to schedule. We placed signs out to point people in the direction of the service they wanted.

Plan to collect data to answer questions:
Amber will track new patient appointments as she books them. Brigette will track dental appointments booked and will report this number to Amber.

What question(s) do we want to answer? By providing appt scheduling & blood pressure checks onsite, can we persuade Warming Shelter clients to seek care?

Prediction (s): We will book at least 3 appointments at the COTS clinic and 3 new patient dental appointments.

Success by the Numbers

Each patient seen = 1 or more barriers to care addressed!

Cumulative COTS Clinic Outcomes *(5/5/2016-3/31/2018)*	
Primary Care Appointments Completed	1,210
Primary Care Patients Seen	315
Health Access Education Sessions Completed	360
Number of Clients Receiving Health Access Education	158
Number Gaining Insurance or Prevented from Loss of Coverage	64
Counseling Appointments Completed *(Note: Began offering counseling at COTS on 8/24/17)*	76
Counseling Patients Seen	36

Survey Results Confirm Patient Involvement and Mindful Care Team

- 93% of primary care patients agree that their healthcare team involved them in decisions about their care!

Excellent care; I am treated as a person and not a chart.

I like the fact that I'm not treated different because of income status.

My doctor and I have worked together to change how I feel.

They are down to earth, very friendly and made me laugh a lot. It put me at ease.

Gave honesty, kindness and options, along with respect towards my wishes.

Teaching Patients How to Advocate for Their Healthcare Needs

While addressing barriers, we teach patients how to advocate for themselves!

- **WI State Representative Jim Steineke visited the COTS clinic**
- Patients talked to him about addressing barriers to healthcare

- Patient **attended BadgerCare waiver hearing** to voice concerns

- Patients **communicated with members of Congress** about the importance of our services in an effort **to fix the Health Center Funding Cliff**

Homeless Healthcare

Chattanooga, TN

Starting Fresh

- Started in August 2016
- 2016 PIT unsheltered count = 77
- Little to no outreach presence in encampments

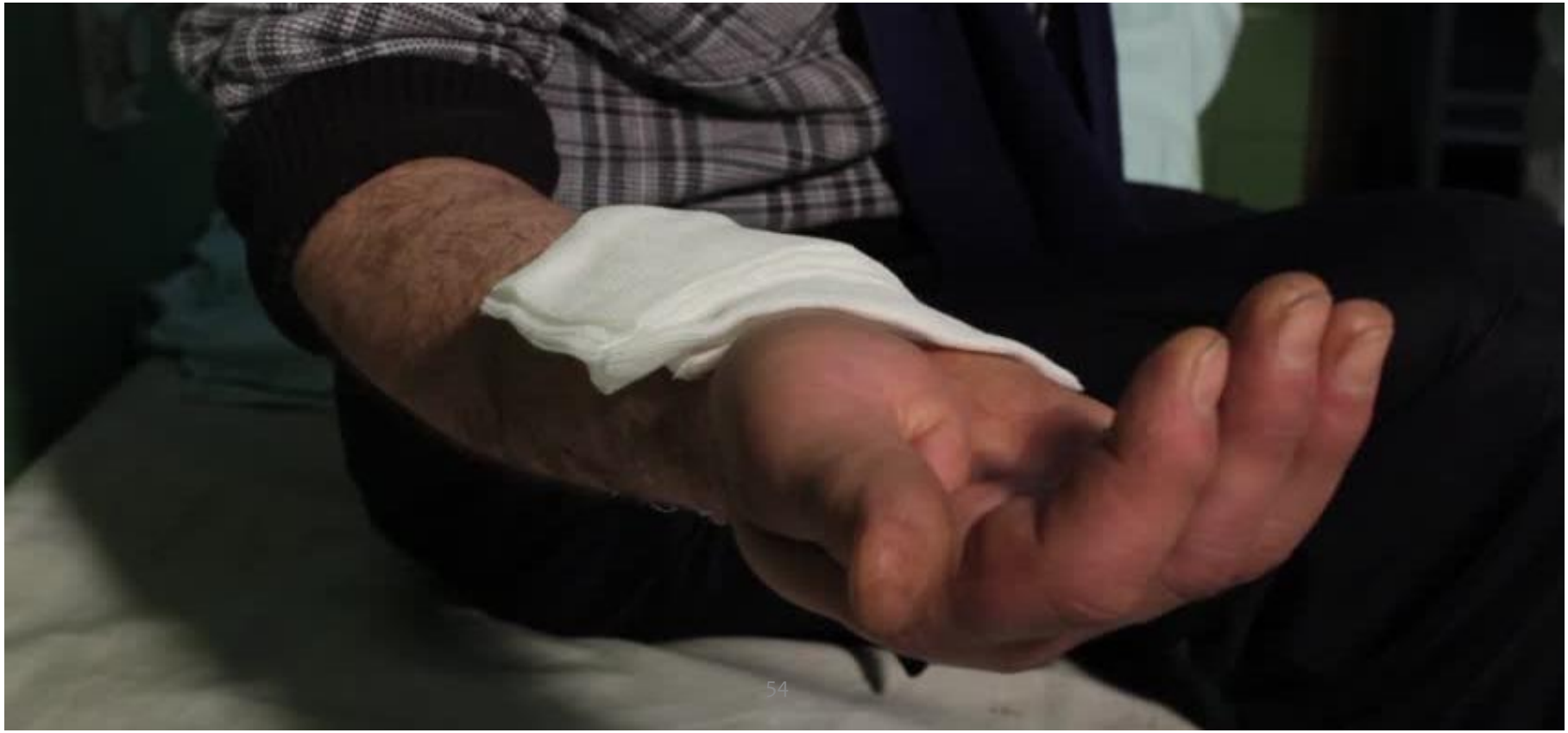
Service Area

- Hamilton County, TN
- Southeast Tennessee
- 576 square miles
- Over 350,000 population
- Includes both urban and rural areas

Making Mistakes

- Wasted a lot of time
- Found very little people
- Didn't know what to say when we found them

You Never Know What You Will Find



The Importance of Outreach

- People don't always come to you for help
- Waiting for the clients to come to you can be fatal

Team Effort

- All staff can have an outreach attitude
  - Don’t go through the world with blinders on
- We begin to learn how ineffective we can be
  - Be mindful of the best use of your time

Story of Bobby

How Did He Get There?

- In and out of jail and the Emergency Room
- Lack of communication between systems
- Fallen through the cracks

What Did We Do?

- Through a team effort, we were able to apply for benefits and place him in a nursing home
- Needed to know where to look for him

Learned Approach

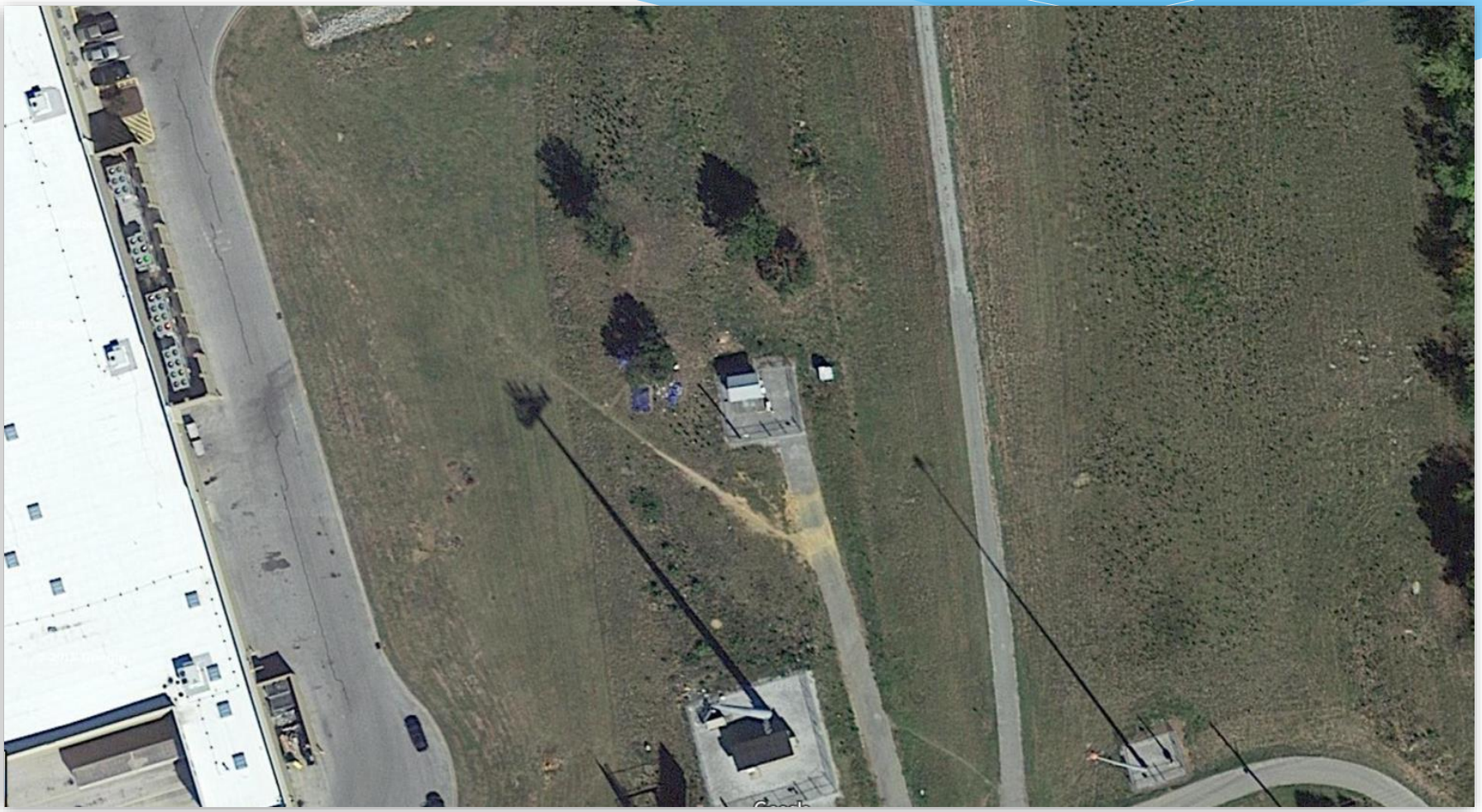
- Provide information
  - leave cards
- Give respect and distance to people
  - Ask to approach

Learned Context

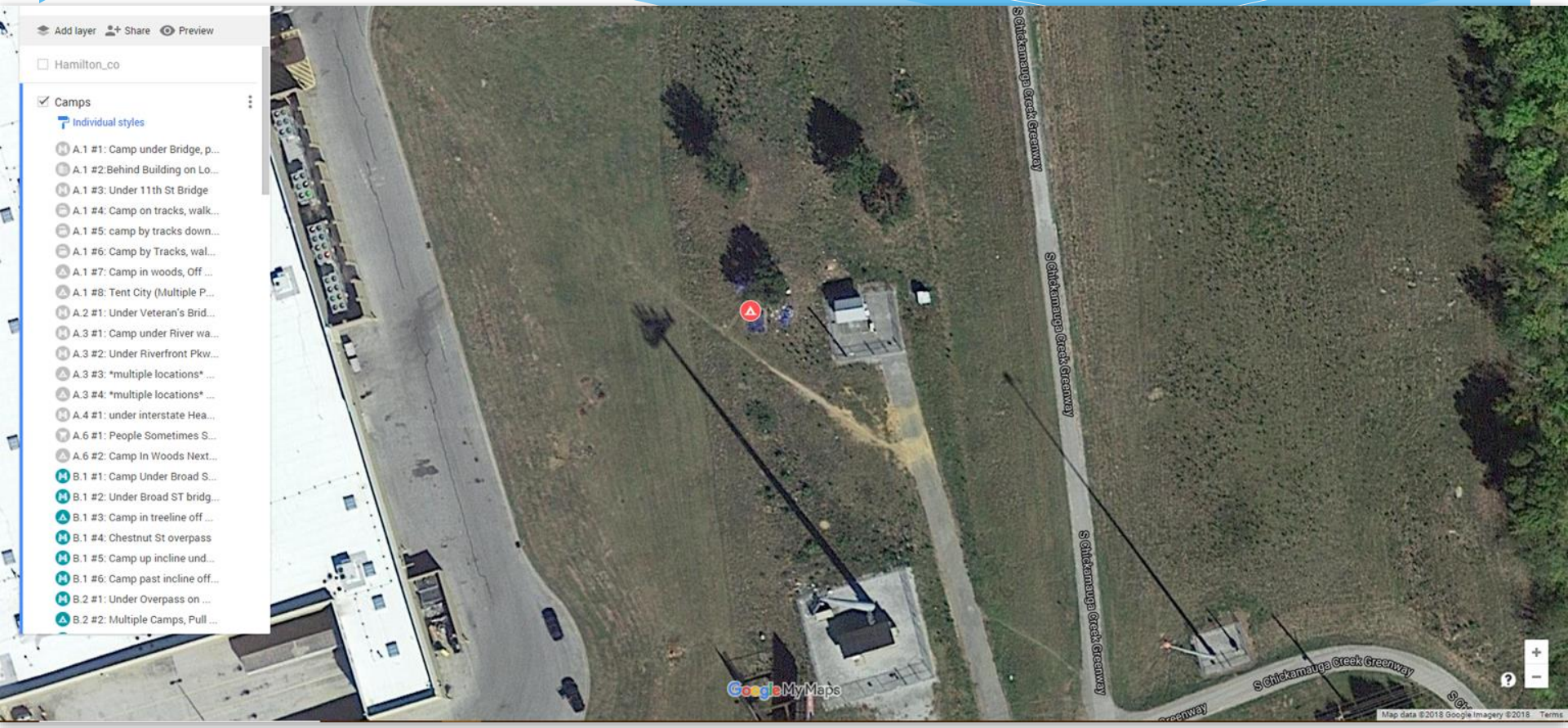
- Outreach puts people in their own context
  - Better understand the story of the individual
  - Agency reputation comes heavily into play

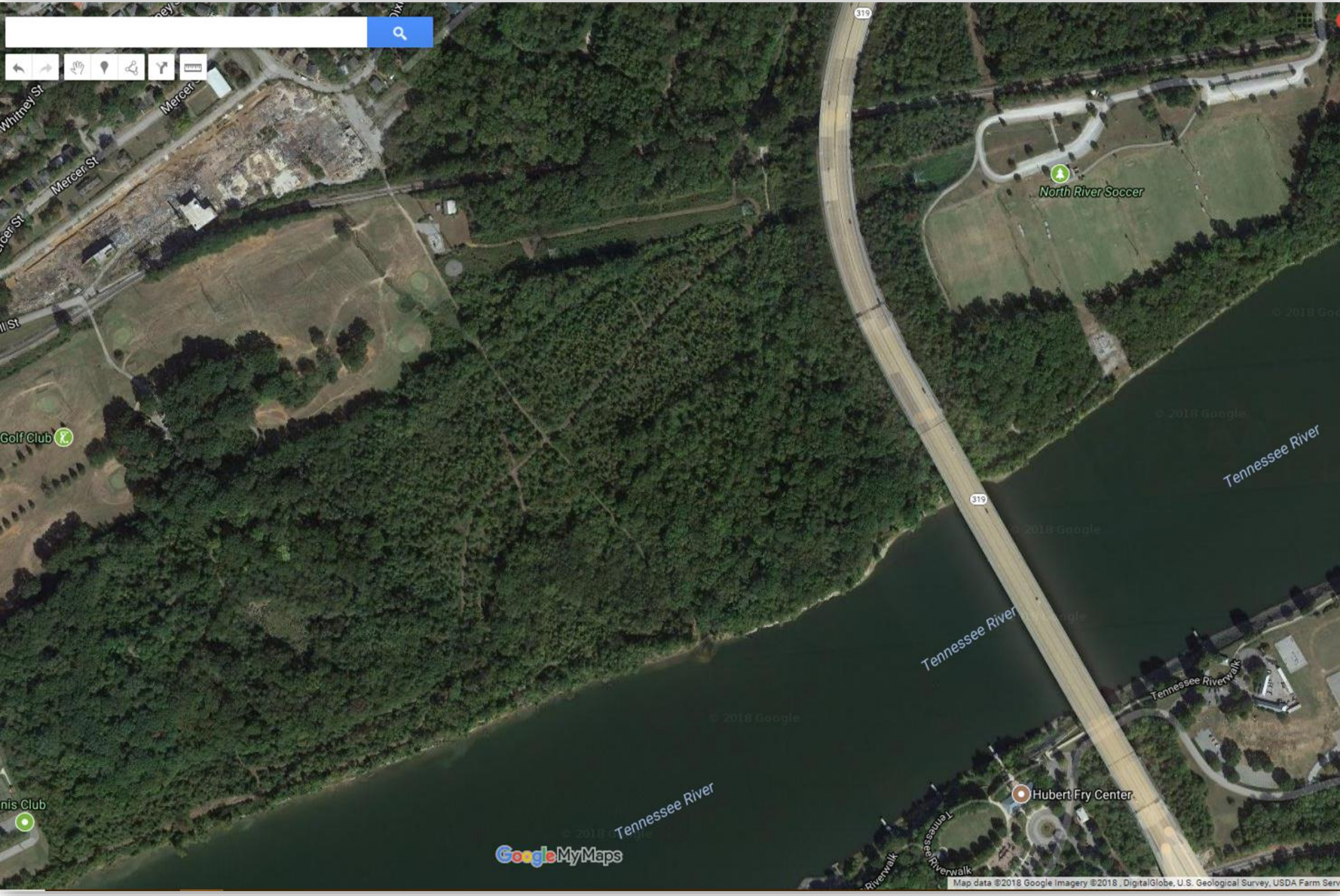
Remembering Where You Went

Dropped Pin



Putting Everything Together

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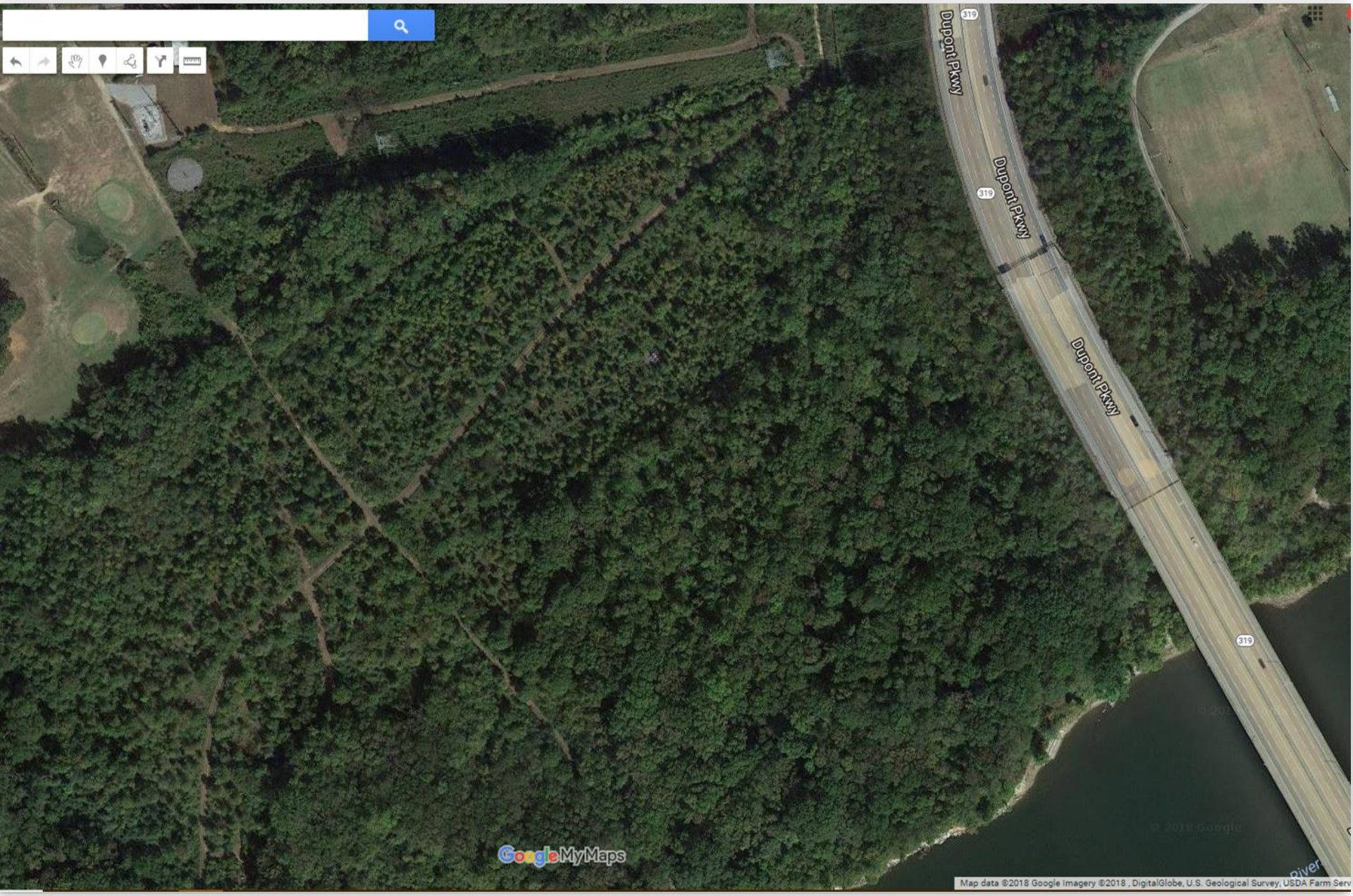
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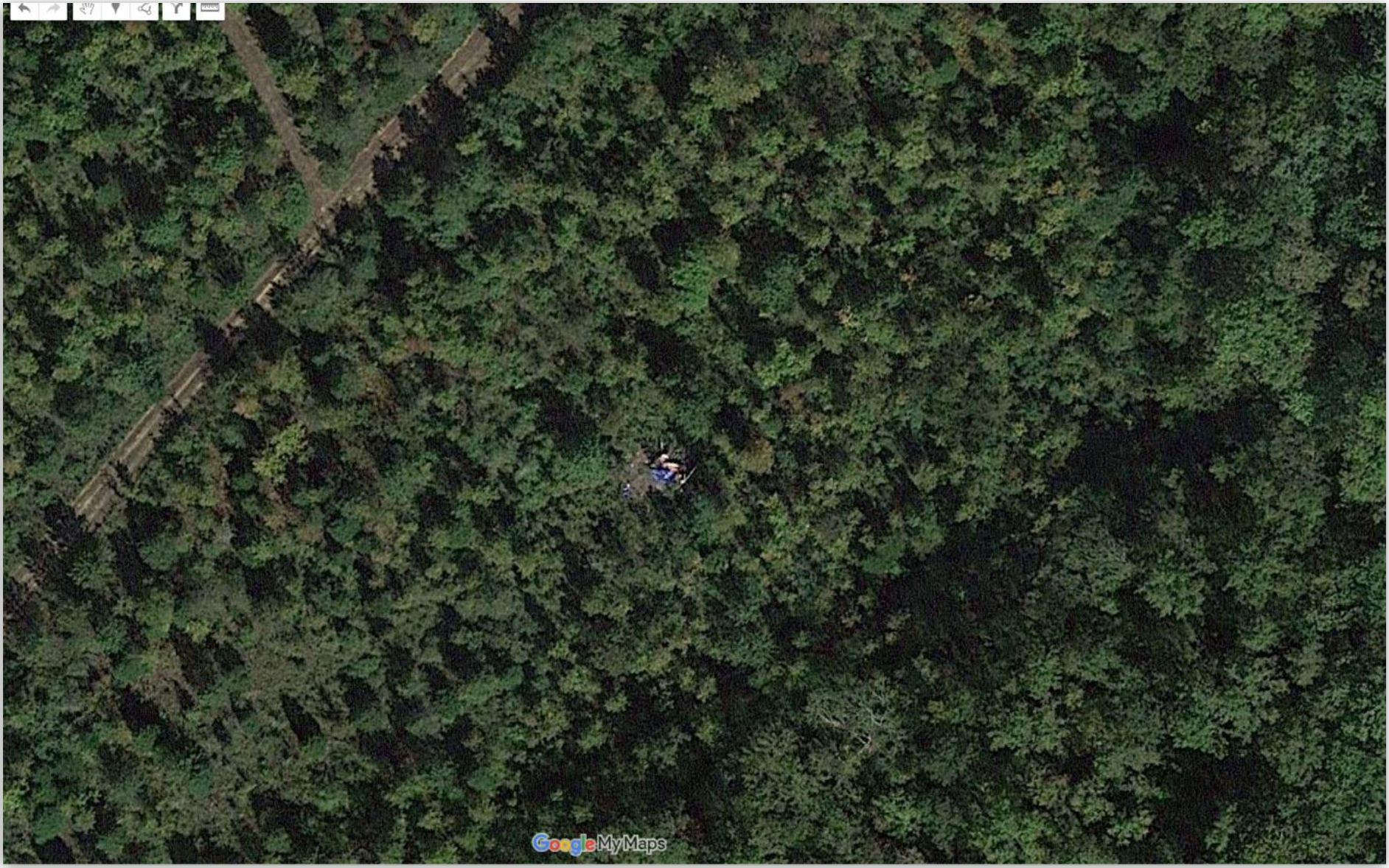
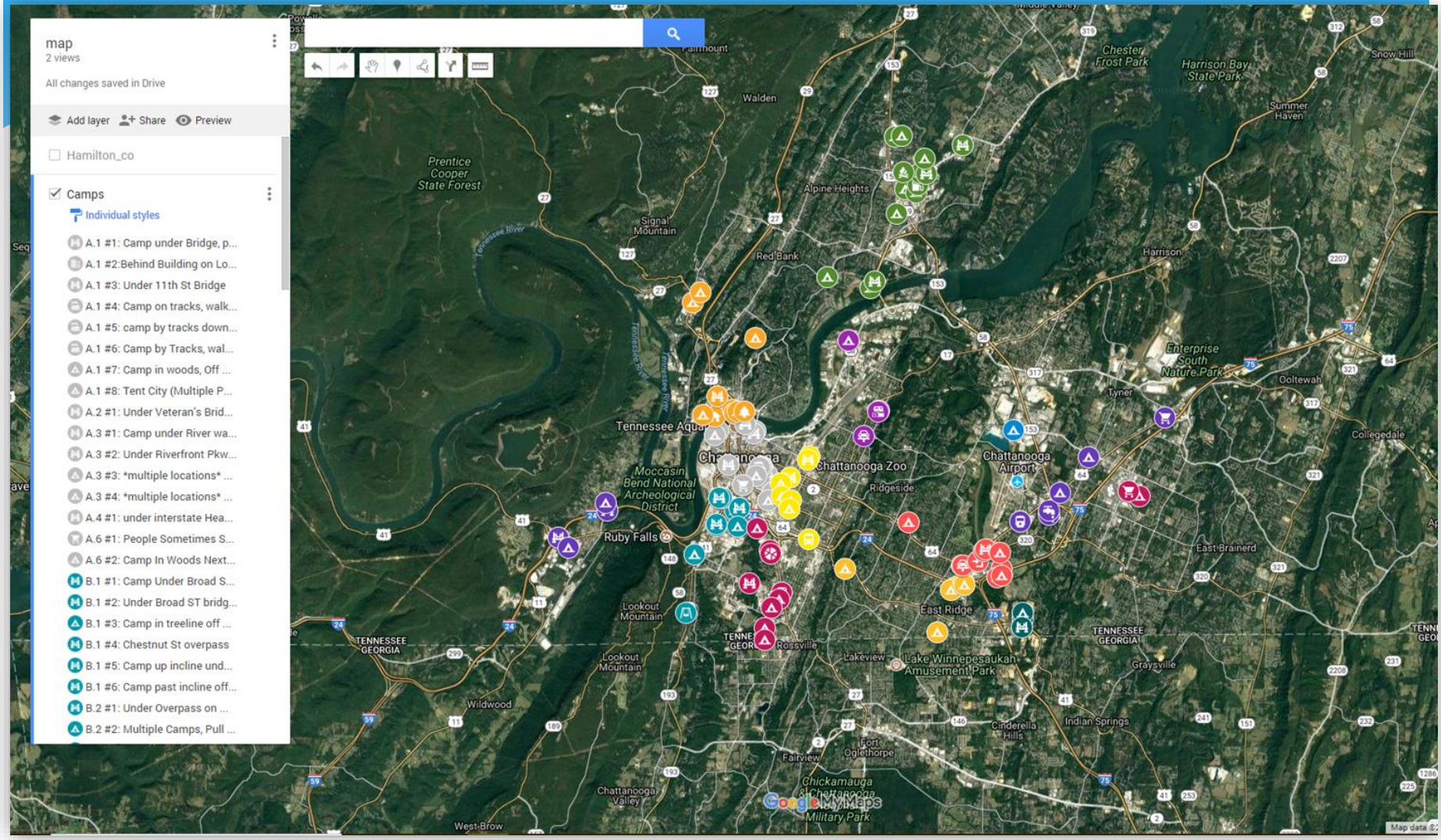
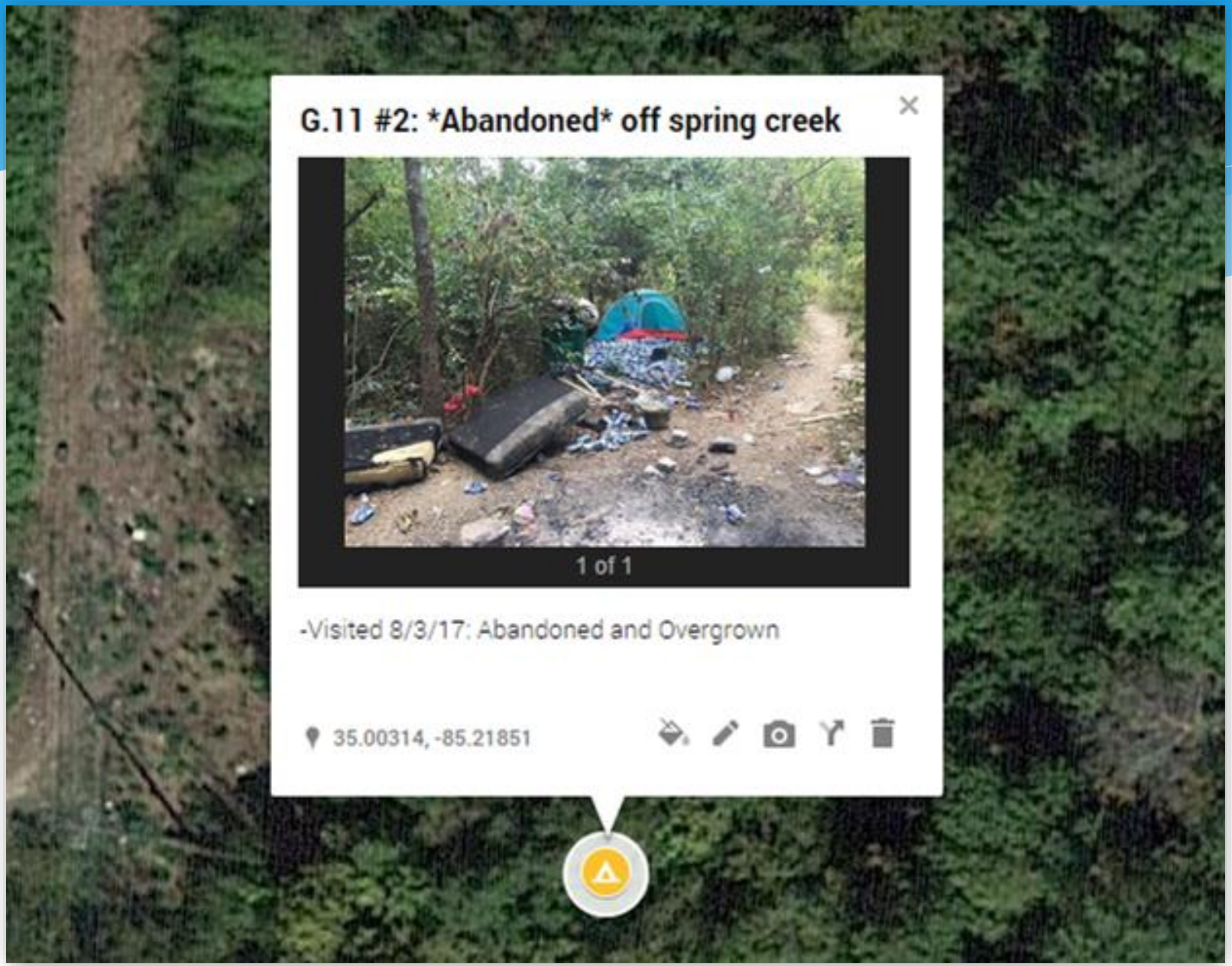
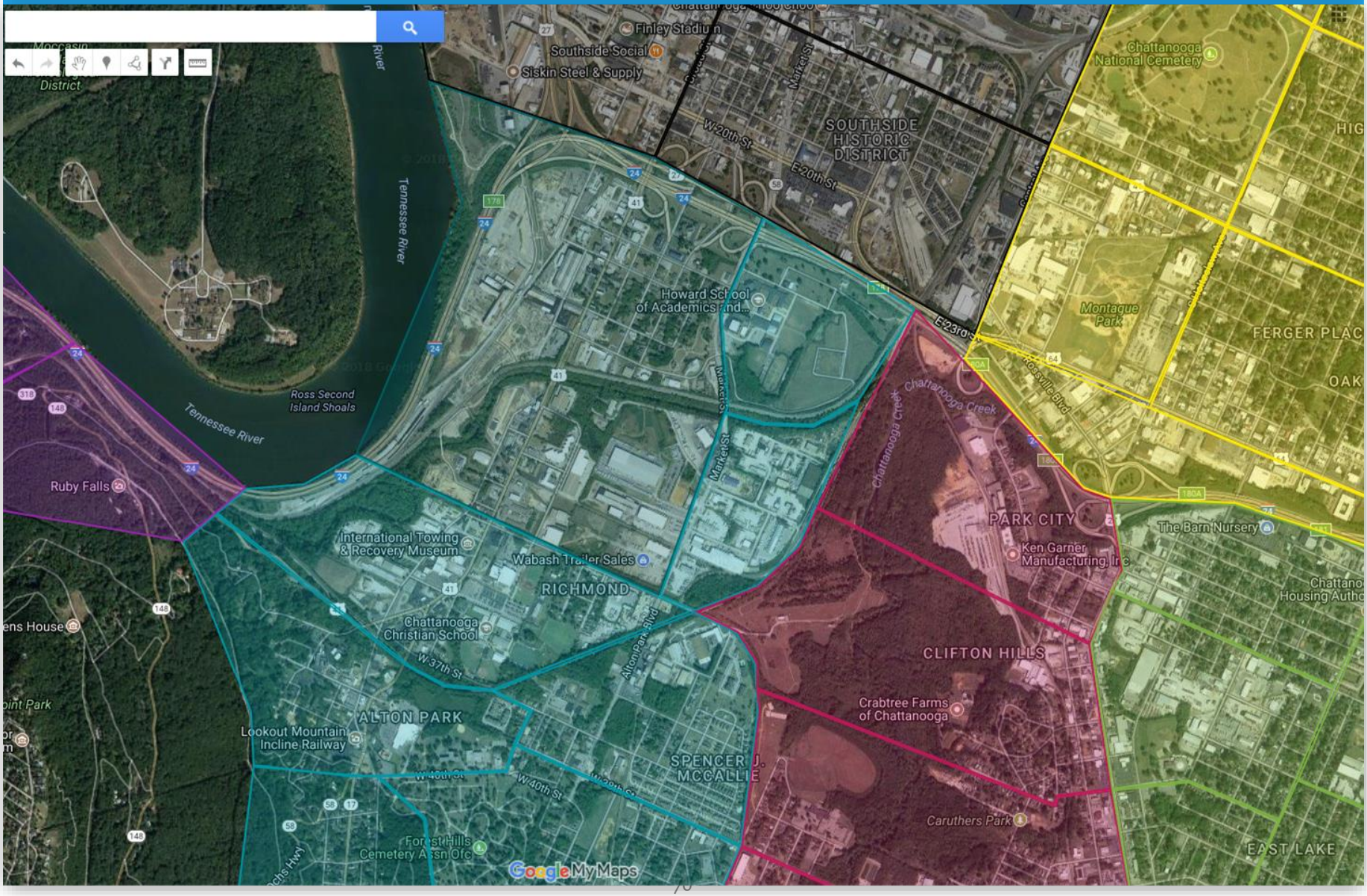
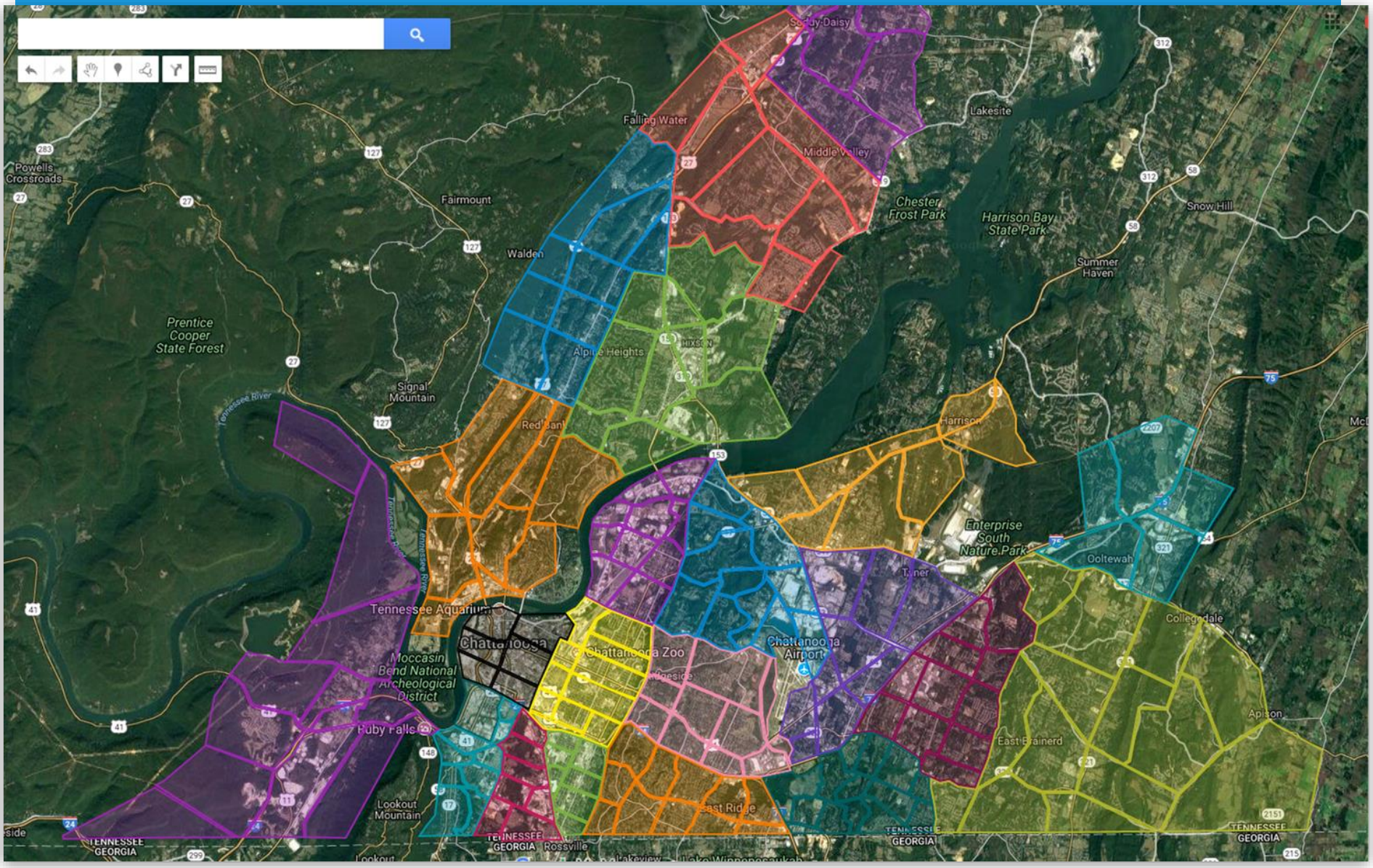

Google MyMaps

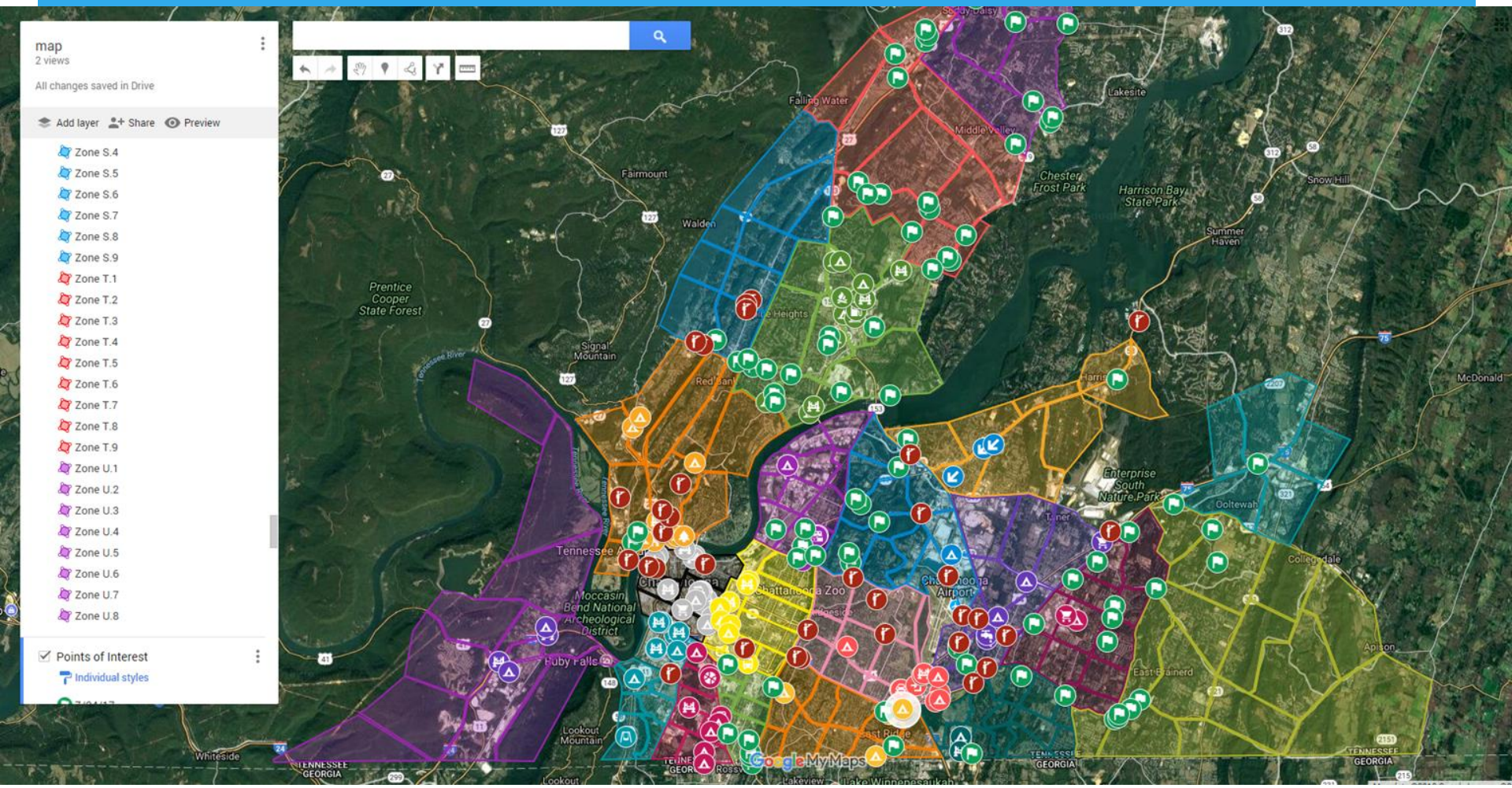
Mapping Encampments




G.11 #2: *Abandoned* off spring creek
1 of 1
-Visited 8/3/17: Abandoned and Overgrown
35.00314, -85.21851


Finley Stadium
Southside Social
Siskin Steel & Supply
SOUTHSIDE HISTORIC DISTRICT
W 20th St
E 20th St
Market St
Chattanooga National Cemetery
Montague Park
FERGER PLAC
OAK
Howard School of Academics and...
Tennessee River
Ross Second Island Shoals
Ruby Falls
Rossville Blvd
Chattanooga Creek
PARK CITY
Ken Garner Manufacturing, Inc
The Barn Nursery
International Towing & Recovery Museum
Wabash Trailer Sales
RICHMOND
Chattanooga Christian School
W 37th St
Alton Park Blvd
CLIFTON HILLS
Crabtree Farms of Chattanooga
ALTON PARK
Lookout Mountain Incline Railway
SPENCER J. MCCALLIE
W 40th St
Caruthers Park
Forest Hills Cemetery Assn Ofc
EAST LAKE
Google My Maps


Powells Crossroads
Fairmount
Falling Water
Middle Valley
Lakesite
Chester Frost Park
Harrison Bay State Park
Snow Hill
Summer Haven
Walden
Prentice Cooper State Forest
Alpine Heights
Signal Mountain
Tennessee River
Red Bank
Harrison
Enterprise South Nature Park
Ooltewah
Tennessee Aquarium
Chattanooga
Chattanooga Zoo
Chattanooga Airport
Moccasin Bend National Archeological District
Ruby Falls
Lookout Mountain
East Brainerd
Collegedale
Apison
East Ridge
Rossville
TENNESSEE
GEORGIA


map
2 views
All changes saved in Drive
Add layer
Share
Preview
Zone S.4
Zone S.5
Zone S.6
Zone S.7
Zone S.8
Zone S.9
Zone T.1
Zone T.2
Zone T.3
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Zone T.5
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Zone T.8
Zone T.9
Zone U.1
Zone U.2
Zone U.3
Zone U.4
Zone U.5
Zone U.6
Zone U.7
Zone U.8
Points of Interest
Individual styles
Falling Water
Lakesite
Middle Valley
Fairmount
Chester Frost Park
Harrison Bay State Park
Snow Hill
Summer Haven
Walden
Prentice Cooper State Forest
Signal Mountain
Red Bank
McDonald
Enterprise South Nature Park
Ooltewah
Tennessee River
Moccasin Bend National Archeological District
Ruby Falls
Chattanooga Zoo
Chattanooga Airport
Collegedale
Apison
East Brainerd
Lookout Mountain
Whiteside
TENNESSEE
GEORGIA
Google My Maps

Planning

- Map allows outreach workers to plan out their routes
- Other people know exactly where you will be in the event of an emergency

Coordinate Outreach Efforts

- Use zones to split up coverage of large locations
- Share information in an easy to understand way

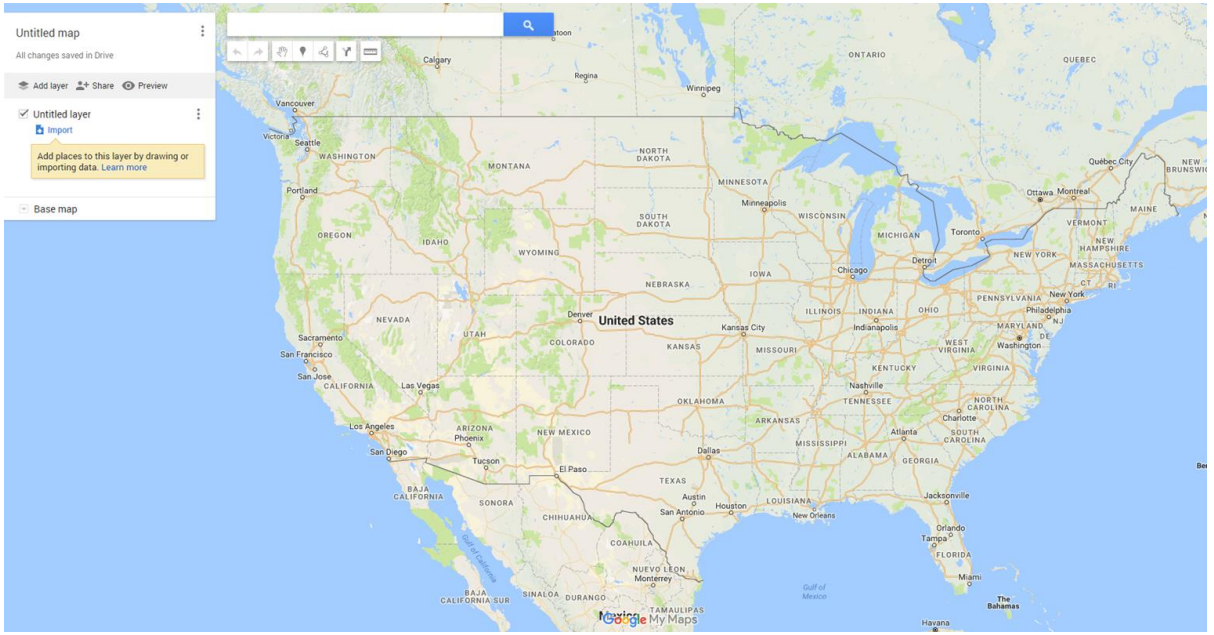
Track Trends in Location

- Coordinates from locations allow Outreach workers to look at a client's location over time
- Plan locations for other services

Finding New People

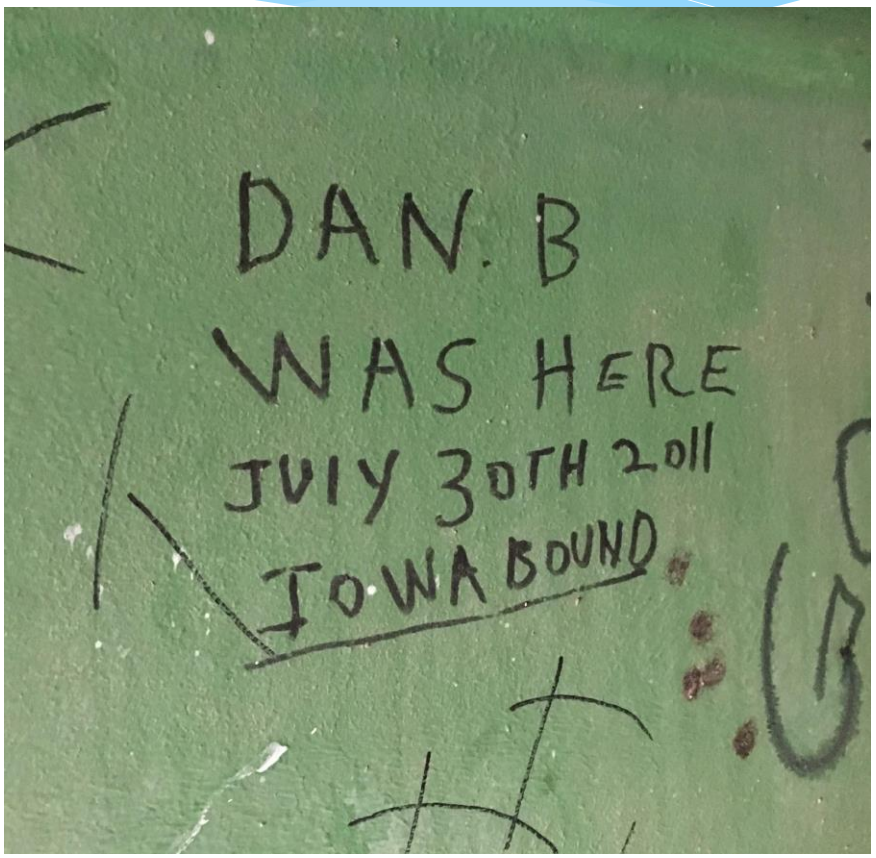
Make Your Own

- Free software
- Relatively easy to use



Results From Efforts

- Total unsheltered for 2017 - 217
- Network and mapping system established for future outreach workers
- People found and their stories heard



Lessons Learned: Understand the Context of Your Clients

- People's lives don't start and stop when they come into your office
- People have stories that often are not shared

Context

Lessons Learned: Remember to Pass on What Works

- A program is only as good as its longevity
- Who is going to carry on the work once you leave?

Longevity

Lessons Learned: Our Patients Experience Several Barriers to Care

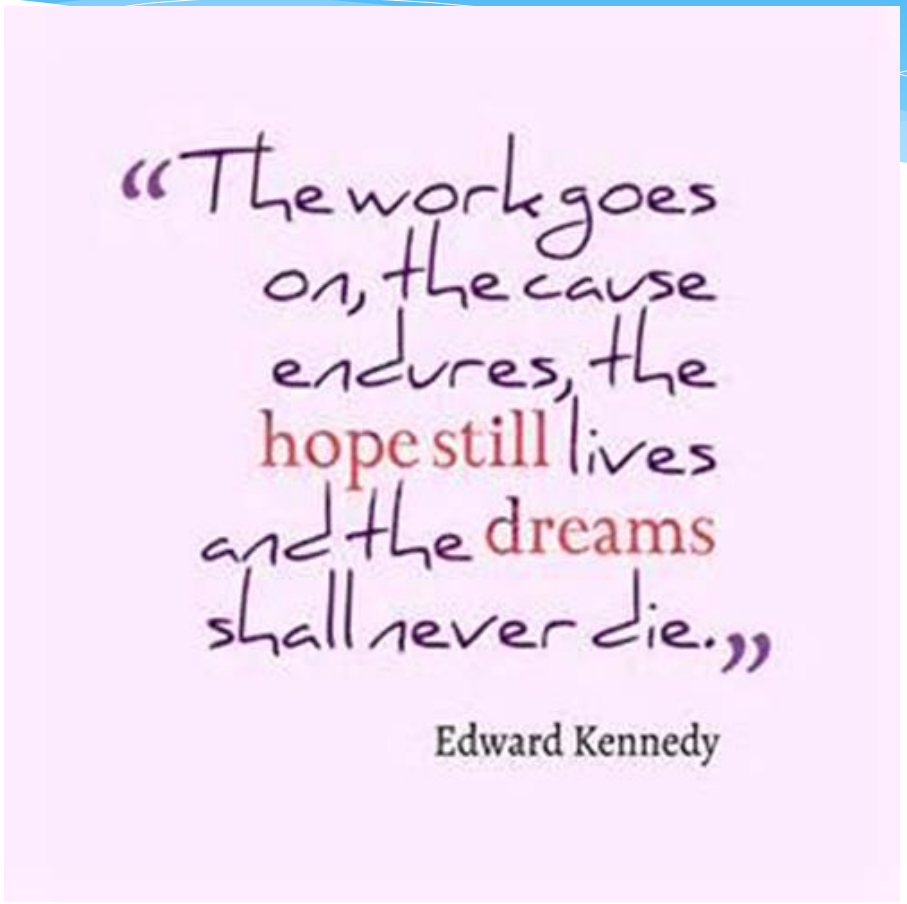
- Before we connect individuals to care, we **need to address the key barriers that are preventing them from receiving care**
  - Trauma/ACEs
  - Communication
  - Transportation
- **Just because we schedule someone for an appointment doesn't mean that we have successfully connected them to care**
  - **Patients need someone to advocate for them until they learn how to advocate for themselves**, whether it's leaving an appointment reminder, scheduling a cab ride, etc.
- The best appointment completion results have occurred when team members follow up to address any barriers

Lessons Learned: Relationships with Patients and Community Partners Matter

- **Relationships between patients and their care team are extremely important,** especially for those with past trauma
  - **Patients are an important part of the care team** – ask them what their needs are and how you can help
  - **When patients feel valued and listened to, they are more likely to come back** for a follow-up appointment
- **Relationships with community partners need to be maintained** in order to ensure that patients are receiving the care they need
  - When patients have a communication barrier to care, relationships with shelter staff can help to bridge the gap

Lessons Learned: Improvement Work Never Ends

- **Initial failure lays the groundwork for future success**
- It takes failing multiple times before you recognize something as a barrier to care
- There's always something we can change to get better results
  - When one PDSA/improvement cycle ends, another one begins
- **The day we stop trying to improve our work is the day we stop caring for our patients**


"The work goes on, the cause endures, the hope still lives and the dreams shall never die."
Edward Kennedy

Questions?

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