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Regional Meeting: Improving Care for Patients with Complex Care Needs

California Improvement Network and Center for Care Innovations
Thursday, January 29, 2015
UCLA, Los Angeles

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Improving Care for Patients with Complex Care Needs

Southern California Convening

January 29, 2015

Foundational Elements of Successful Complex Care Management Programs

Pranav Kothari, MD
Renaissance Health

Complex Care Innovation

Paradigm Shifts, Best Practices and Sustainability Planning

January 29, 2015

Los Angeles

Today's discussion

- The Unsustainable Status Quo
- Changing the Care Paradigm
- Building on Best Practices
- An Agile Sustainability Game Plan
- Prototypes and Iterative Process

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Renaissance Health:

Catalyzing improved health – through sustainable interventions

Provider-led Care Models

- Implementing innovative care models with providers for sustainability
- Work across payer sources – strategies for commercial, government payers and self-pay
- Renaissance Health Academy
- E.g. Mosaic Medical, Academic Medical Centers, Humboldt County IPA

Multi-stakeholder Collaboratives

- Organizing and leading collaborative implementations of Complex Care models
- Developing learning communities to share best practices, common challenges
- E.g. Oregon High Value Patient Centered Demonstration, Pacific Business Group on Health

Purchaser and Plan-led Complex Care Models

Complex Care planning and implementation

- Customized approach based on geography, market readiness, payer strategy
- E.g.: The Boeing Company, Oregon CCOs, UnitedHealthcare, etc.

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Targeted analytics, rapid cycle innovation, robust care management training, actionable information transparency strategy, provider change management

Thinking without a box

"Our job is not to make up anybody's mind, but to open minds and to make the agony of the decision making so intense you can escape only by thinking."

- Fred Friendly

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The current model of care is unsustainable

Problem: Little Innovation in Care Process Delivery

"We are carrying the 19th century clinical office into the 21st century world. It's time to retire it."

*- **Donald M. Berwick***

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Let's do something about it

An imperative for care innovation…

- Current model of healthcare delivery leads to suboptimal quality, poor experience and waste of valuable resources
- Current environment has shared pain-points to synchronize stakeholders
- Unique momentum for action towards new models of care/reimbursement
- We need to go beyond tweaking benefits design, adding small bonuses, or putting band aids on the system
- Unique recognition that care delivery redesign will require short term return
- Risk of good innovation being muted due to implementation and operations

The key to successful, sustainable innovation is new, more rational systems of care coupled with reimbursement transformation.

A cluttered experience for Ed

Ed is 53 years old, lives alone and has recently moved to the area. He has long had high blood pressure and high cholesterol, followed sporadically. He also has a history of social anxiety and depression. He was recently diagnosed with diabetes, but was likely long-undiagnosed. During an interview, he highlights several issues he is dealing with:

- Learn about Diabetes and future co-morbidities, worried about the "Silent Killer"
- Coordination of specialist and nutritionist care, and benefits (e.g. is it covered?)
- Managing new medications; missed some meds when not feeling well
- Recognizes need for lifestyle changes – but doesn't know where to start
- Getting calls from a DM nurse – not sure value; why doesn't my doctor know?
- Not feeling well in the evening or weekend – now what?
- Pressure from new work to do overtime; Needs to take days off work for MD appt
- Doesn't have confidence in ability, feeling scared/sad; has few friends
- Doesn't trust his insurance company

Ultimately, when asked what his most significant concern was at the moment, he said:

Widowed mother needs to move to assisted living; lives 600 miles away

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Our current systems are often not best positioned to address the multifaceted medical issues, socio-behavioral risks and coordination needs. Challenged by time, staff, fragmented resources, etc.

A starting point:
how we serve those most in need

- Current System least well-serves the most in need: individuals with persistently complex, chronic conditions, often with poor social conditions and often with behavioral health co-morbidities
- System allows for "over-utilization, while under-serving" – **an actionable paradox**

Complex Patients, Complex Moments

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Our view of population management

Observation:

The health of an individual (and in aggregate the population) happens through hundreds (or thousands) of small decisions throughout a patient's life. Providers are only available for brief moments of guidance.

Recommendation:

Be very intentional in developing a clinical model that ultimately influences individual decisions. Recognize the most significant risks and highest value decisions and be more aggressive in engaging patients in those decisions. Consider population management with an intent to lower risk, one decision at time.

Population Management, One Patient at a time
Patient Management, One Decision at a time

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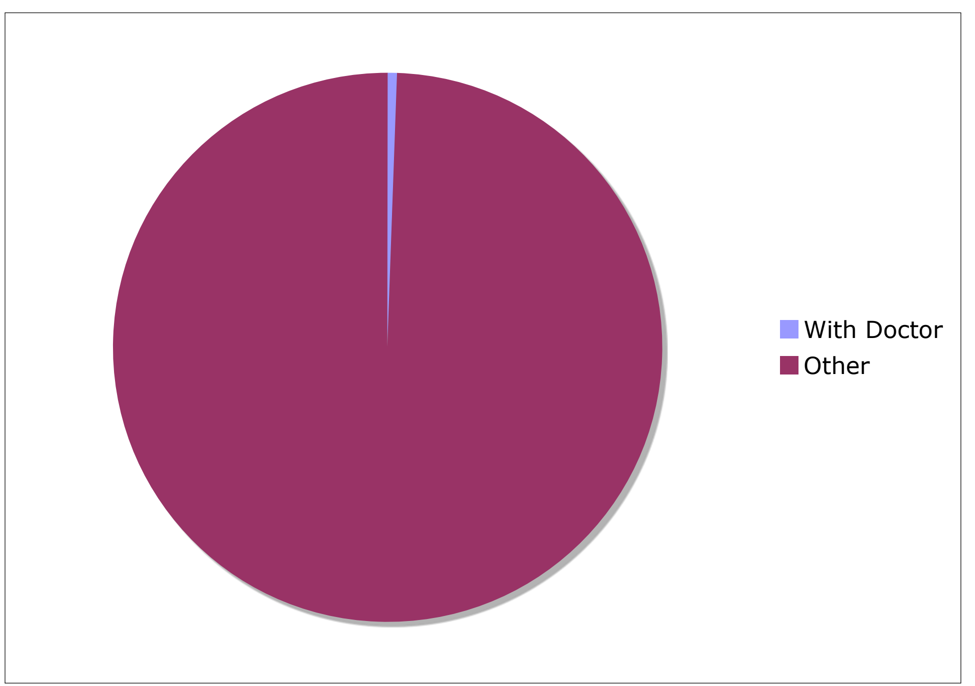
Key principle: change the care paradigm

Our job is to meet the needs of the patient



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Even if a patient sees us for an hour every week of the year, they are spending 99.4% of their life not with us!

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Theme #1

Relationship: key to sustainable outcomes

Drive Decisions and Behavior Change through Relationship

The key element to influencing decisions (especially behavior change) is trust.

Trust evolves through relationship.

The ability of the clinical model to be successful is determined by the strength of the relationship between the provider team and the patient.

Key elements to successful relationship development;

- **Strong Bond:** Tether everyone to primary care within the system
- **Reliability:** Follow-up without fail – develop systems that have a “zero follow-up fail rate”
- **Prioritization:** Prioritize those members with highest needs
- **Service:** Surprise and delight

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Theme #2

Segment in order to target

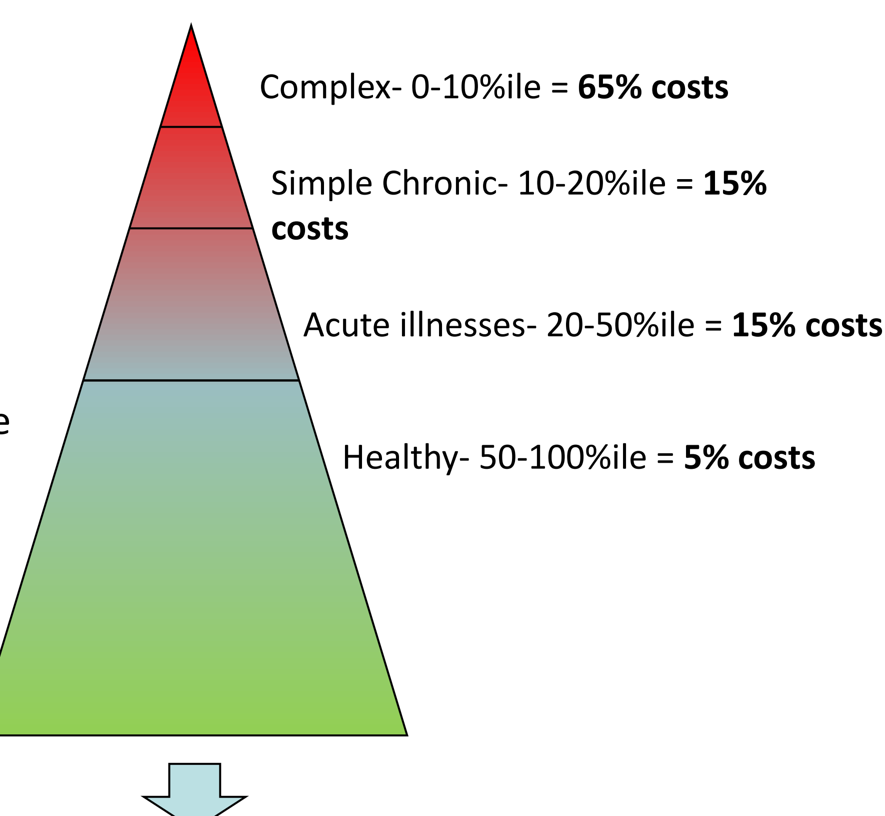
Customize Different Models for Different Population Segments

Dimensions

Complexity – a measurement of risk, inclusive of claims based predictive risk, clinical markers, and clinical opinion

Elasticity – indicated by ability to intervene and alter course/outcome

Activation – assessed by patient's level of engagement, confidence, priority to the areas of risk



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Match the intervention to the population

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Building on best practices and a growing evidence base

Multiple initiatives suggest outcome improvement and cost reduction opportunity in focused complex care: e.g Boeing IOCP, Atlantic City SCC, CareMore, HealthCare Partners, Urban Medical Group, Leon Medical Group

- High levels of quality outcomes – 90th percentile HEDIS measures, improvement on chronic disease markers
- High levels of patient experience (CG-CAHPS), Self-efficacy (SF12)
- 10-20% per capita spending below comparison group or regional average

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Two Primary Complex Models: Centralized and Distributed

Centralized Complex Care Model (Hub)

- Dedicated complex care center (or practice)
- Services for a pre-determined, select population
- Dedicated multidisciplinary team includes PCP, Care Managers, Community Health Workers (Health Coaches), Additional specialized team
- Patients asked to temporarily shift care

Distributed Complex Care Model (Spoke)

- Network of practices delivering outpatient complex care (in addition to broad primary care
- Services provided to pre-determined population via existing primary care relationships
- Team includes patient’s current PCP and additional care management team embedded within primary care process

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No formula, some best practices

Core common themes for evolving models:

- **Innovate the complex care model:** care coordinators lead, socio-behavioral risk oriented, rules based
- **Start with Relationship**
- **Segment and Target:** Data science driven
- **Influence Decisions:** One patient and one decision at a time
- **Develop Team Culture:** Fanaticism for value, generosity
- **Intentional Leadership and Communications**
- **Dive Deep into the Data:** Build, measure, learn feedback loops
- **Manage Non-Primary Care Resources Aggressively:** engage partnerships
- **Partnership Spirit:** Provider, purchaser, payer and patient partnerships necessary
- **No end point:** Iterative process

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Sustainability challenges and opportunities emerging…

Some current value-based models show promise

Payer and legislative signals increasingly supportive

Unique momentum *now* and opportunity for advancing models

Advanced analytics can enable improved care process, staff and resource targeting

Hybrid revenue and compensation models challenging

Pressure for near-term ROI highlights savings "lag" and evaluation challenges

(Often) slow and difficult to change core processes and culture

Ongoing sustainability of value based care models must recognize and address challenges

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Defining Sustainability for Primary Care

- The development of a road map that enables endurance of the organization's principles and processes
- Endurance requires ongoing learning, refinement and innovation sprints – and iterative process
- Focus on outcomes that feed into the overall sustainability:
  - Economic
  - Quality of care
  - Consumer experience
  - Provider team experience
  - Culture
  - Process definition
- Intentionality around scalability and replicability
- End user value critical in terms of sustainability - Patient, Payer, PCPs, CFO, referring providers

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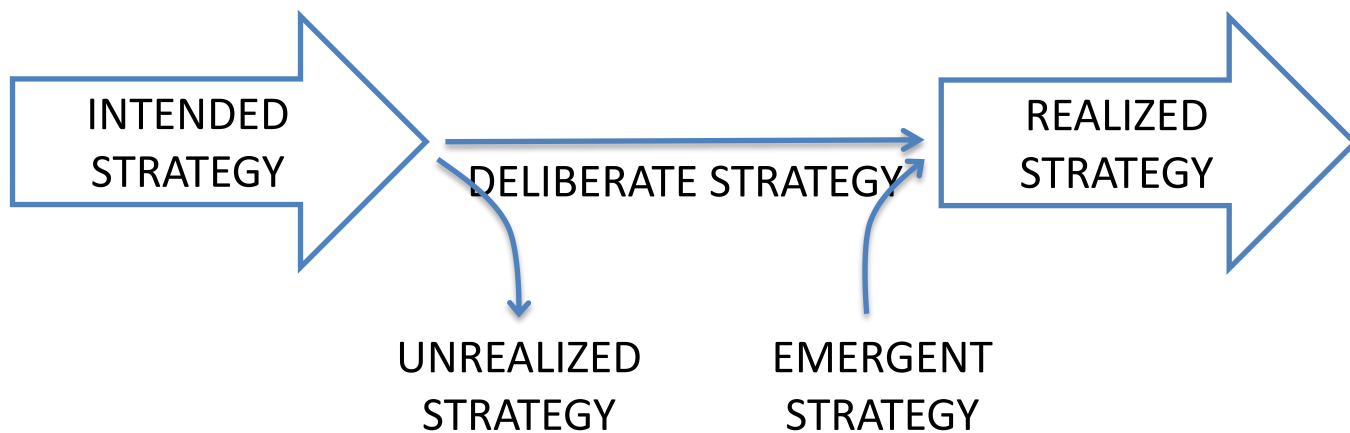
Strategic planning for sustainability

Intended vs. realized

- Deliberate: pre-formulated, realized as intended
- Emergent: realized outside of original intentions
- Real world strategies exist on a continuum



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Traditional notion of strategy is to formulate, then implement. Introduction of emergent elements is result of uncertain environments. Being agile.

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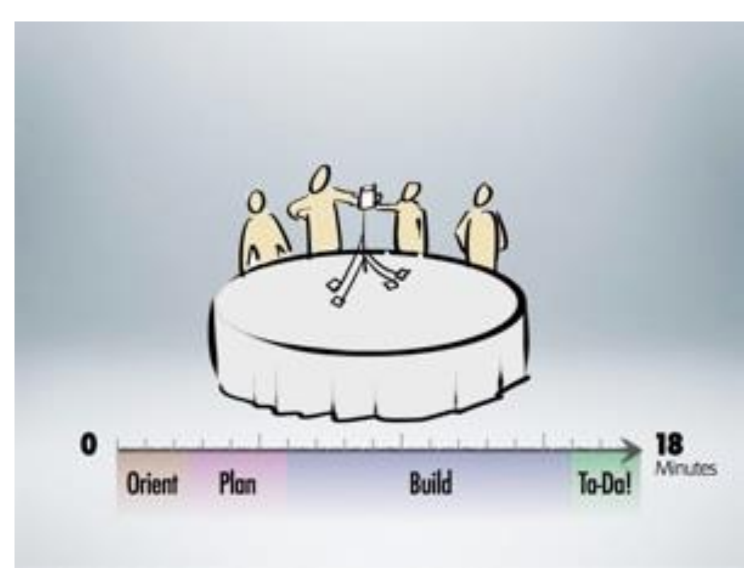
Embrace the startup process – build, measure, learn

- Build prototypes
- Rapid feedback
- Iterative refinement
- Multiple opportunities to fix
- Collaboration allows:
  - Shared experience
  - Common language
  - Prototyping and Facilitation



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Final Thoughts

The only real way to improve the performance of our current health care system is through fundamental redesign of the care process. There is a significant opportunity to build on the national experiences - set high standards to truly shift the paradigm and increase affordability in health care.

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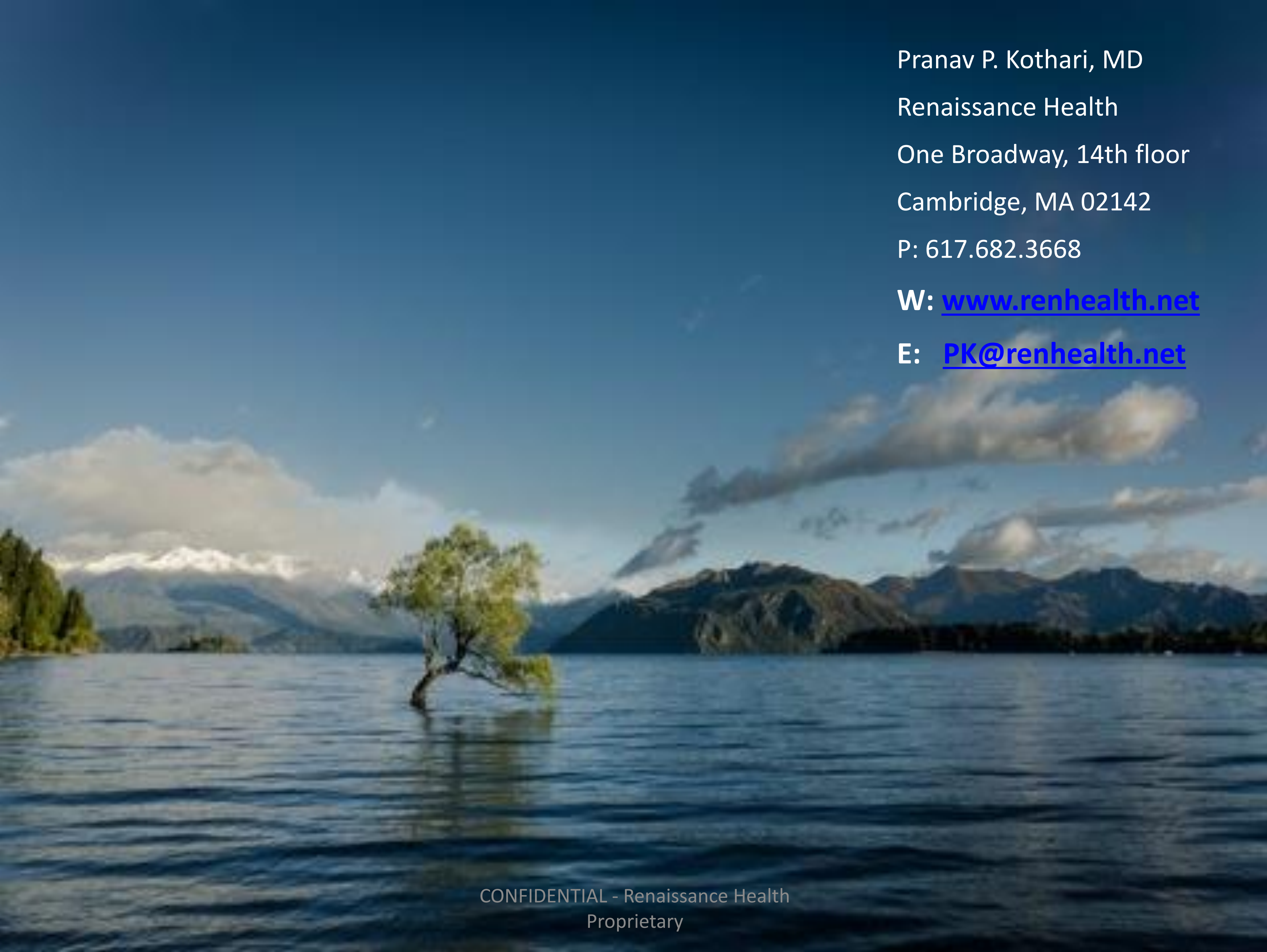
Important Recognitions:

- This transformation is about behavior change; success is dependent on relationship and culture as much as scientific knowledge and technical system designs
- Intentionality (gameplanning) will drive change; the many unknowns cannot slow the preparation. Unique opportunity to leverage health care process innovation momentum
- This will be hard; however, the potential impact is significant



Pranav P. Kothari, MD
Renaissance Health
One Broadway, 14th floor
Cambridge, MA 02142
P: 617.682.3668
W: www.renhealth.net
E: PK@renhealth.net

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Selecting Patients for Complex Care Management

Clemens Hong, MD, MPH
Massachusetts General Hospital, Harvard Medical School

Selecting Patients for Complex Care Management

Clemens Hong MD, MPH

Regional Complex Care Workshop

UCLA, Los Angeles

Thursday, January 29, 2015

Acknowledgements

- Co-Authors: Timothy Ferris & Andrew Hwang
- All interviewees from 20 CCM Programs

- Funding:

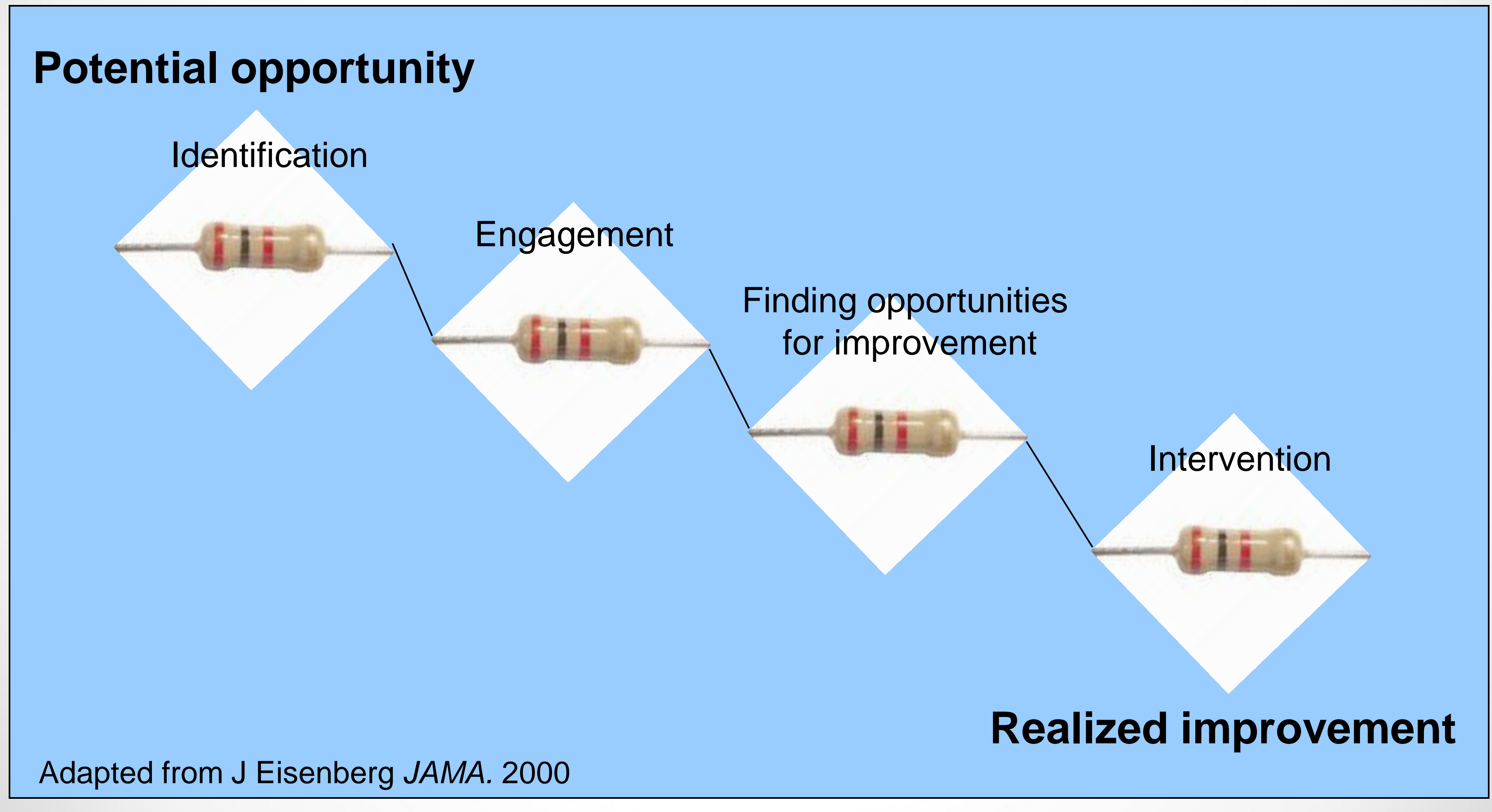
- Program Officer: Giovanna Giuliani

*** No conflicts of interest to report ***

Who would you select for complex care management?

What information do you need to make a decision?

CCM Programs: Drops in Potential



Key Questions for CCM Programs?

- What are our desired program outcomes?
- Over what time frame do we need to achieve them?
- What are the assets and gaps in the health delivery system in which we will embed the program?
- What tools will we pull together in our approach?
- What resources/data are available to identify high-risk patients?
- How will we approach risk-stratification within the population we select?
- How will we go about designing the initial patient selection approach?
- How will we improve our approach?

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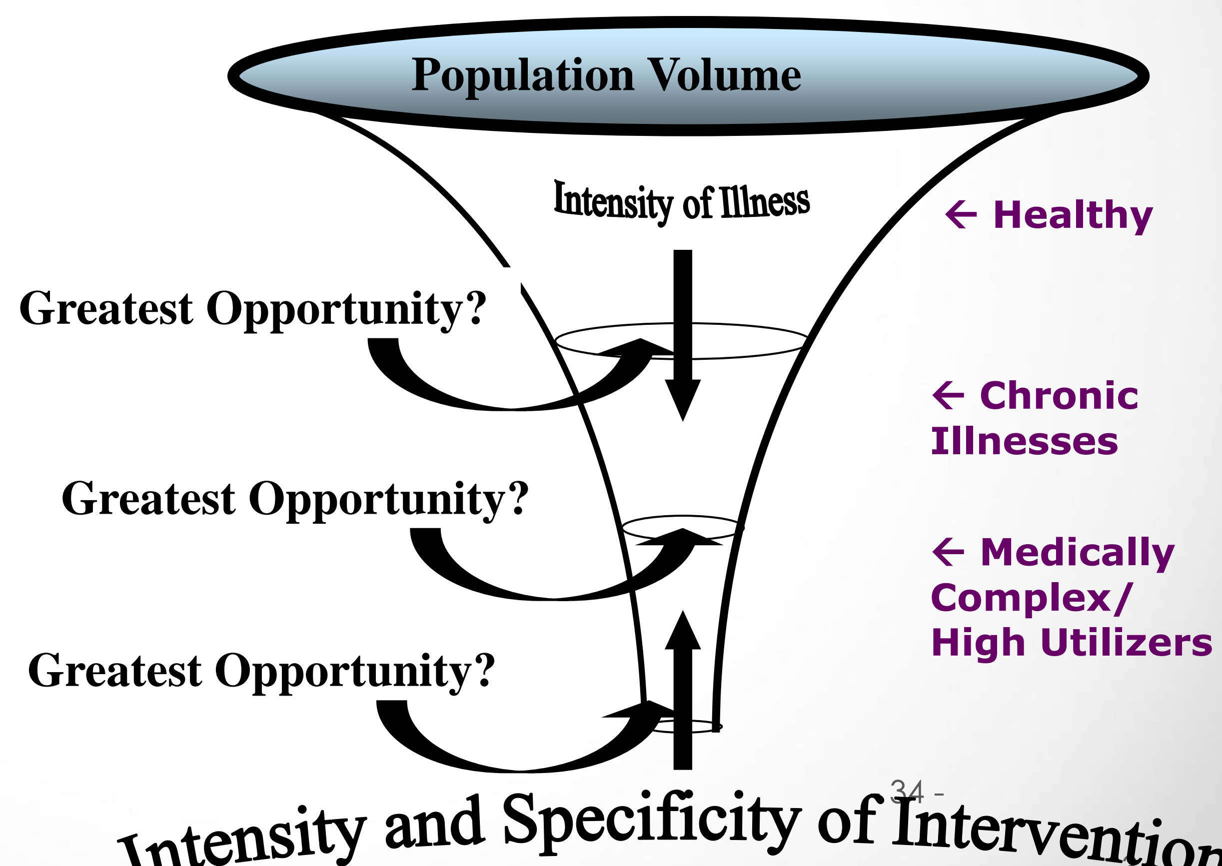
- **Goal: Align Population, Intervention, & Outcomes**
  - Prioritize & agree upon outcomes of interest & the time interval in which outcomes should be achieved
  - Identify the population in which you hope to achieve these outcomes
  - Match the planned staffing/resources and interventions to the target population to achieve the desired outcomes

Goal of Patient Selection

- Search for the Holy Grail
  - Select a population at risk for future poor outcomes & costs for which planned CCM interventions can improve outcomes

Finding the Sweet Spot - Care Sensitivity

- No single approach – align population & intervention
- Identify windows of opportunity for intervention
- Identify care gaps that CCM can address
- Engage the patient



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Key Questions for CCM Programs?

- What tools will we pull together in our approach?
- What resources/data are available to identify high-risk patients?

- **Goal: Apply best available tools to best available data to get started**

- **Tools**
  - **Quantitative**
  - **Qualitative**
  - **Hybrid**
- **Data Sources**
  - **Claims**
  - **Data Warehouses**
  - **Surveys**
  - **Clinicians**

Quantitative Approaches

- Risk prediction OR based on total medical expenditure
- Acute Care Utilization focused
- High-risk condition or medication focused
- Multifactorial Risk Assessment

Qualitative Approaches

- Referral by clinician or care team
- Patient self-referral

Hybrid Approaches

- Quantitative with qualitative gate
- Qualitative with quantitative gate

Key Questions for CCM Programs?

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- How will we go about designing the initial patient selection approach?
- How will we improve our approach?

Key Questions for CCM Programs?

- How will we approach risk-stratification within the population we select?

- **Goal: Prioritize and direct effort towards the highest risk, most care sensitive patients**

- Risk Stratification
  - Clinical assessment
    - Informal
    - Qualitative Tiering
  - Automated

Key Questions for CCM Programs?

- What are our desired program outcomes?
- Over what time frame do we need to achieve them?
- What are the assets and gaps in the health delivery system in which we will embed the program?
- What tools will we pull together in our approach?
- What resources/data are available to identify high-risk patients?
- How will we approach risk-stratification within the population we select?
- **How will we go about designing the initial patient selection approach?**
- **How will we improve our approach?**

Key Questions for CCM Programs?

- How will we go about designing the initial patient selection approach?
- How will we improve our approach?

- **Goal: Use a process that engages stakeholders early & often and continuously improve it**

- Who?
  - Delivery system & program leaders
  - Primary care & CCM teams
  - Analysts

Who would you select for complex care management?

Questions?

Thank you!

Contact: cshong@partners.org

Key Questions for CCM Programs?

- What are our desired program outcomes?
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Southern California Leaders in Complex Care

Rishi Manchanda, MD, MPH
Health Begins, VA Greater Los Angeles Health Care System

Shameka Coles, BSN/RN, MBA, CCM, CMCN
AltaMed Health Services

SIMPLIFY COMPLEXITY:

BUILDING PRIMARY CARE MEDICAL HOMES FOR HOMELESS VETERANS

Rishi Manchanda, MD, MPH

VA Greater Los Angeles, University of California, Los Angeles

Jim

How do we define homelessness?

Veterans who:

- Lack a fixed, regular, and adequate nighttime residence
- Identify a primary nighttime residence that is:
  - A supervised publicly or privately operated shelter designed to provide temporary living accommodations
  - A public or private place that provides temporary residence for individuals intended to be institutionalized
  - A public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human beings

Persons at-risk for homelessness

- The U.S. Department of Housing and Urban Development expanded this definition to include persons at-risk for homelessness:
  - Individuals and families who will imminently lose their primary nighttime residence

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH Act): Defining "Homeless." Federal Register/Vol 76, No. 233/Dec. 5, 2011

The VA aims to end homelessness

- President Obama and the VA
  - Committed to ending homelessness among U.S. Veterans by 2015
  - *Among the top three priorities of the VA*

Balshem H, et al. A Critical Review of the Literature Regarding Homelessness Among Veterans. *VA-ESP Project #05-225*. 2011.

How many Veterans are homeless?

- Point-in-Time Prevalence:

LA

2013 PIT Total	Sheltered	Unsheltered
5,776	1,351	4,425

National

2013 PIT Total	Sheltered	Unsheltered
57,849	34,695	23,154

Department of Housing and Urban Development, Continuum of Care data. (2013).

Note: VHA estimates that 80% of L.A. County falls in GLA's catchment area: the remainder within the areas of Long Beach and Loma Linda VAs.

https://www.hudexchange.info/manage-a-program/coc-housing-inventory-count-reports/

What housing services does Los Angeles VA offer?

- *6736 beds for homeless Veterans in GLA (FY 2013)
  - Housing First (4698 beds)
    - HUD-VA Supportive Housing Program (HUD-VASH)
  - Continuum of Care (2038 beds)
    - Emergency shelter
    - Transitional housing, including Grant Per Diem and Domiciliary programs

*2013 Operations data from VAGLAHS

Veteran vulnerability

- Veterans may be at higher risk for becoming homeless than the civilian population**
  - Combat exposure, military sexual trauma
- Homeless Veterans are a vulnerable population***
  - High rates of medical/mental illness, alcohol, tobacco, and other drug (ATOD) use
  - Fragmented health and social services
  - Age-adjusted mortality is 2-10 times that of housed peers

HUD, The 2013 Annual Homeless Assessment Report [AHAR] to Congress)

**Balshem H, et al. A Critical Review of the Literature Regarding Homelessness Among Veterans. *VA-ESP Project #05-225*. 2011.

***O'Toole TP, et al. Building care systems to improve access for high-risk and vulnerable veteran populations. *JGIM.* 2011

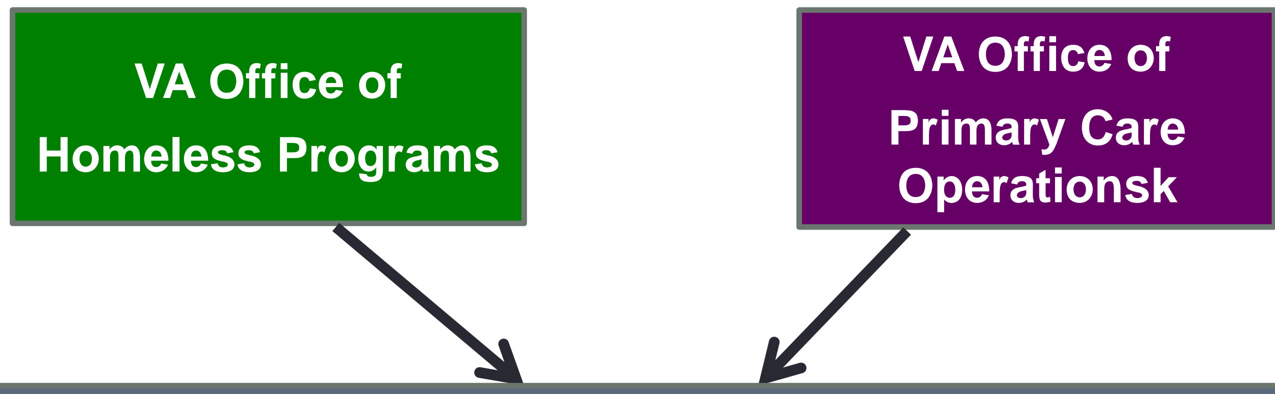
Little is known about best practices in homeless-focused primary care

- Primary care needs are complicated by poor social support and competing priorities
- Homeless-focused VA primary care in Providence, RI** - Pilot
  - Greater improvements in chronic disease outcomes compared to a historical cohort of homeless Veterans in traditional VA primary care clinics
  - Fewer non-acute Emergency Department and inpatient admissions for general medical conditions

*McGuire J, et al. Access to Primary Care for Homeless Veterans with Serious Mental Illness or Substance Abuse: A Follow-up Evaluation of Co-Located Primary Care and Homeless Social Services. *Adm Policy Ment Health*. 2009.
**O'Toole TP, et al. Applying the chronic care model to homeless veterans: effect of a population approach to primary care on utilization and clinical outcomes. *Am J Public Health*. 2010.

The VA lacked a homeless-focused primary care initiative

- The Health Care for Homeless Veterans (HCHV) program already offers a host of services for homeless Veterans



2012: **Homeless Patient-Aligned Care Teams (HPACTs) funded at 32 VA facilities**

(now expanded to 51 Facilities in 2014)

HPACTs are patient-centered medical homes for homeless Veterans

- Three national features
  - Tailor clinical/social services to homeless Veterans
  - Establish processes to identify/refer appropriate Veterans
  - Integrate distinct services

- New programs must fit local contextual factors
  - Space, personnel, infrastructure, institutional/community resources

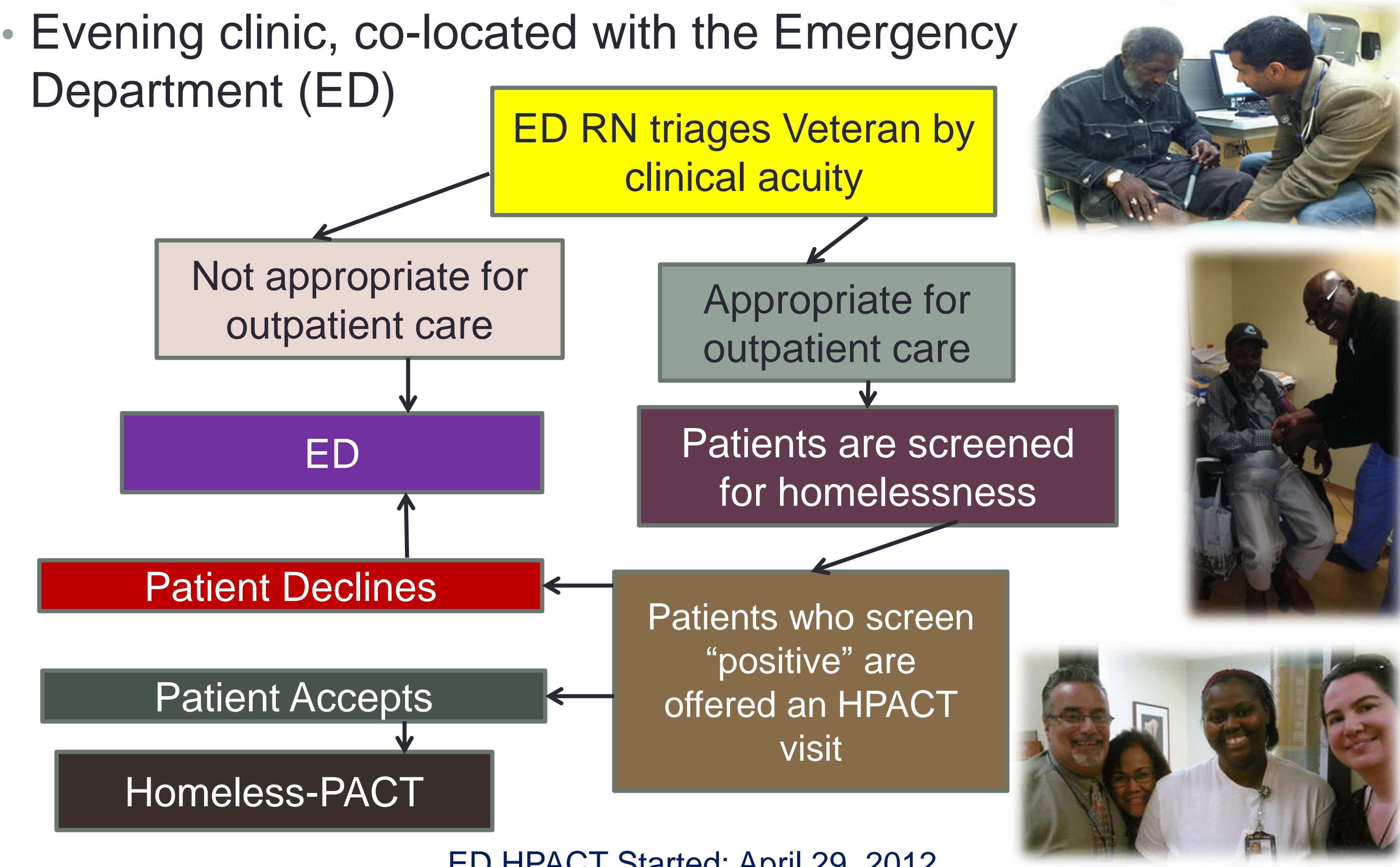
H-PACT Snap Shot

- Patients Actively Enrolled in an H-PACT: **15,697**
- Actively Enrolling Sites: **51**
- **25%** Reduction in Emergency Department Use
- **25%** Reduction in Hospitalizations
- Average number of PCP visits/patient/year: **4.0**
- Average number of Homeless Service Visits: **5.5**
- Percent Receiving Mental Health Services: **84.86%**

National H-PACT Update, Jan 2015

An AICU model for Los Angeles VA

- Evening clinic, co-located with the Emergency Department (ED)



ED HPACT Started: April 29, 2012

Patient-Staff Huddles

Case Management Tracking Tool

Medical-Legal Partnership

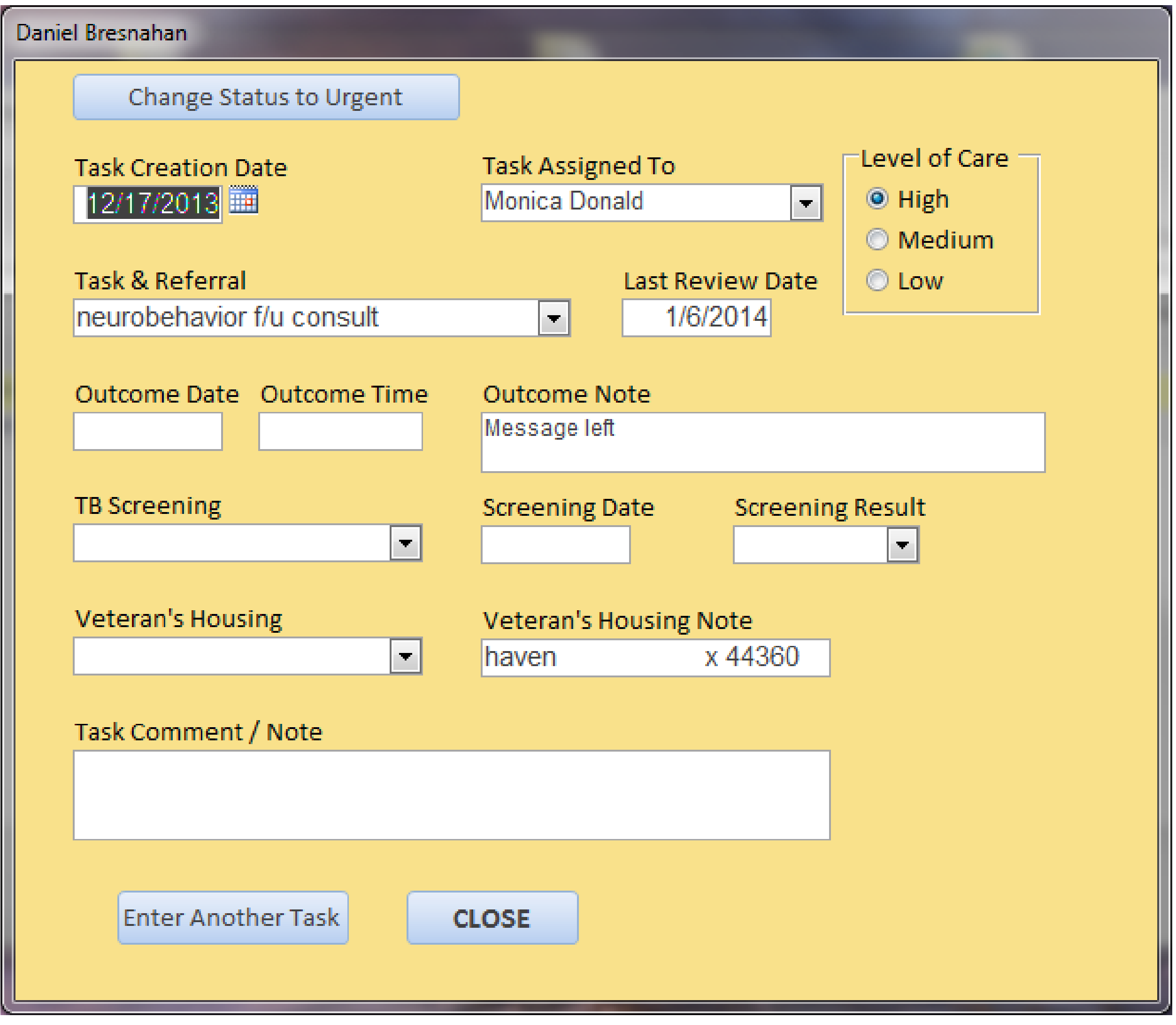
Complex Care Management:

Patient **Huddles**

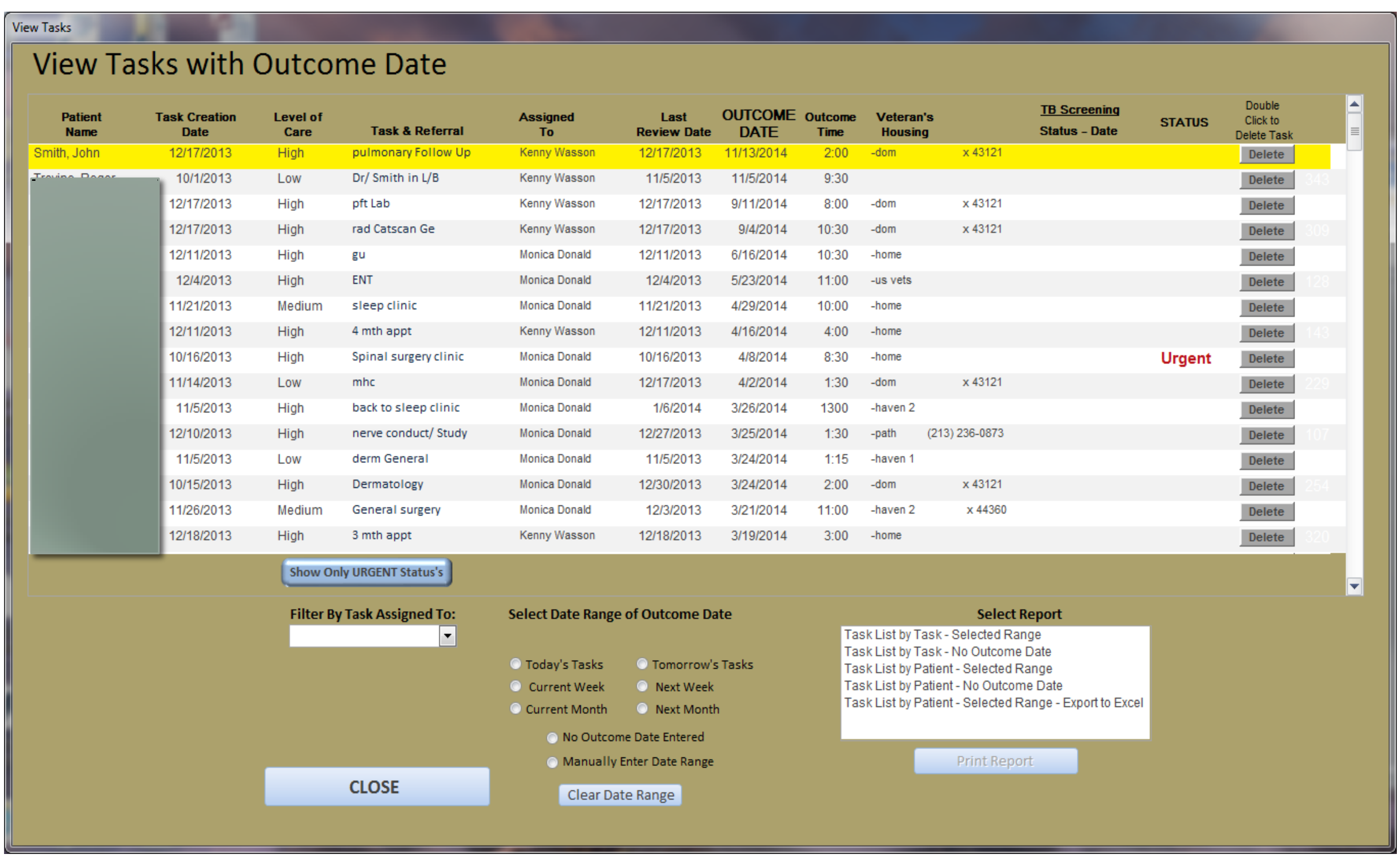
Complex Care Management Tracking Tool

	A	B	C	D	E	F	G	H	I	J
1	NAME	SSN-LAST 4	DATE (TASK CREATED)	LEVEL OF CARE H-High M-Medium L-Low	TASK & REFERRALS	TASK ASSIGNED TO:	DATE OF LAST REVIEW	OUTCOME	COMPLETE	COMPLETED BY: (whoever is coloring the cell pink for completion)
2	Doe, Joe	9359	2/14/13	H	Consult PM&R rollator	Rishi	3/21/13	4.4 @ 1:45 ISSUED	C	KW
3	Doe, Joe	9359	2/14/13	H	consult podiatry	Zenny	2/20/13	3.11 @ 1:40 no-show		KW
4	Doe, Joe	9359	2/14/13	H	consult prosthetic for wedge and ted hose	Zenny	2/20/13	Done		KW
5	Doe, Joe	9359	2/14/13	H	consult gu	Xiaowei	2/14/13	4.22 @ 2:00		KW
6	Doe, Joe	9359	2/20/13	H	make 2 wk f/u	Kenny	2/20/13	3.6 @ 4:00		KW
7	Doe, Joe	9359	3/14/13	H	shot ketorelac	Terrence	3/14/13			KW
8	Doe, Joe	9359	3/14/13	H	make f/u appt	Louis	3/14/13	apt 3.19 @ 7:00		KW
9	Doe, Joe	9359	3/14/13	H	p/u meds	Zenny	3/14/13	Done	C	KW
10	Doe, Joe	9359	3/19/13	H	ortho consult for shoulder	Rishi	4/3/13	4.15 @ 10:00 no show reschedule		KW

Edit Task / Enter New Task



View Task List by Task / Reports



Integrated Community Care Clinic:

- **6 Teamlets**
  - PCP
  - RN
  - Psychiatrist
  - Psychologist
  - Social workers with addiction expertise
  - Outreach worker
  - Medical legal partnership
- Over 4000 homeless and at-risk Veterans empaneled

Segment & Target

Case Type	Assessment	Care Plan	Linkage to Services or Resources	Team Conference	Case Duration
Complex Case Management	NCQA QI 7	Individualized	Assessment and referral	Yes, if applicable	Until goals are met
Care Coordination	Comprehensive	Individualized	Assessment and referral	**Optional	30 – 90 days, until goals are met
Service Coordination	Problem Identification	**	Assessment and referral	**	Episodic, 30 days or less (until issue is resolved)

** If Care Plan/ Team Conference is required, member should be referred to higher level of Case Type

CQC Complex Care Management Toolkit Resource
Shared with permission from CalOptima

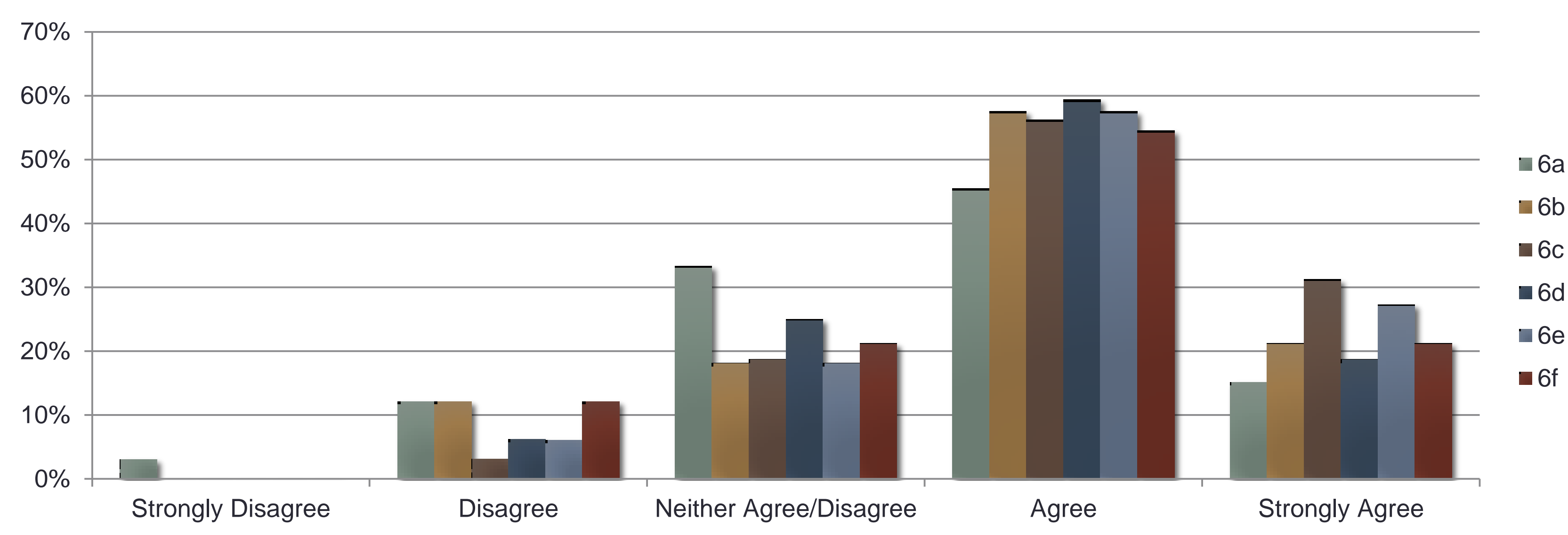
VA Supportive Housing Acuity Scale

56 total		GLA VASH Veteran Acuity Scale - Revision 6		Amount of work going into	Veteran
Dimensions	**0-Excellent= little/no needs**	**1 - Good= few needs**	**2 - Fair = moderate needs**	**3 - Poor = multiple needs**	**4- Serious = acute needs**
Medical Care X 2	No medical problems or attends medical appointments as recommended, in community setting. Rare no shows (1= or <)	Attends most recommended appointments in community setting. Medical problems are being addressed.	Attends half of needed medical appointments, or in current inpatient program.	Non-compliance with medical appointments and/or medications. Mild or cognitive issue.	Serious health issues but no documented/known medical care; Overt TBI or Cognitive issues
Mental Health X 2	Adheres to psychiatric appts and medications; No psychiatric symptoms noted or documented. No Mental Health history	Attends most psych appts. No inpatient admits or ER within the past 3 years. Asymptomatic or minimal symptoms noted. Little to no impact on quality of life.	Attends 50% of psych appointments; poor-medication compliance. Psych symptoms present and/or History of inpatient admit in past 3 years.	Significant Psychiatric symptoms (i.e. active SMI; moderate level impulse control disorder), difficuilties with social interaction and/or no friends. 1 SA in 12mos	MI involving severe symptoms (i.e. SMI or ICD) and unwilling to accept MH Care. Multiple psychiatric ER visits or admissions within 1 yr
Family/Social Support	Highly satisfactory social support from family and/or friends.	Satisfactory and meaningful relationships with others	Occasional contact witih family and/or friends; moderate interpersonal difficulty	Minimal contact with any family members or friend. Re;lationships are unsatisfactory	Major impairment in social functioning. Socially isolated, antisocial behavior evident
Housing	Maintained stable housing over a year in the past 2 years	Maintained stable housing for 6-12 months in past 2 yrs	maintained stable housing < 6 months in the past 2 years	1 yr w/o housing; 4 separate episodes of homelessness in 3 yrs	2 yrs w/o housing; > 5 episodes of homelessness in the past 3 yrs
Emergency Room/Hospitalizations	No ER visits within a year	ER visit unrelated to non-compliance w/ medication, sobriety, or drugs	2 or less ER visits per year; 1 hospitalization or <	3 ER visits per year with hospitalization	Frequent ER visits that are related to substance use and/or psychiatric symptoms
Legal History	No Arrest History	Infrequent contact w/law enforcement, Incarceration less than 1 year over lifetime; 59 days < in the past year	Occasional jail terms, or past prison history. Total lifetime incarceration less then 4 years. 2-11 months in the past yr	Recent release from prison term. Total lifetime incarceration > 4 years; Recent incarceration 1-2 years	Recent release from prison/ multiple prison history. Total lifetime incarceration > 4 years; Recent incarceration > 2 years
Employment / Education	Maintained competitive employment for over the past year. Long term planning demonstrated. Current student for 1 year or more w/1 to no dropped classes; retired and/or disabled	Maintained competitive employment for at least 12 months in the past 2 years. Long term planning evident. Current student w/ ≥ 2 dropped classes	12 months of Competitive employment within the past three years. Current student w/ 25-30% dropped or repeated classes. Temporarily disabled, ambivalence in returning to work.	Loss of employment AND not actively seeking. Sporadic work history in the past 5 years. Poor long-term planning. Student w/multiple dropped or repeated classes	No competitive work history in the last 5 years. Difficulties with long-term and short-term decision-making. Attempts at schooling with no completed courses
Substance Use	no present or past use of substances	Current sobriety for 2 years or more outside controlled environment	Sober 6 mo-1 yr and 11 mos ; sobriety maintenance 1 yr+ in last 3 yrs outside controlled env	Sober <6 mos, some clean time in the past three years; has entered residential tx at least once	Current substance abuse or dependence ; non compliance with tx due to unwillingness to seek tx
History of Substance Use	No history of substance abuse over lifetime	Less than 5 years of use over lifetime	5 or more years of use over lifetime	5 or more years of use over lifetime. Began use age 11-18	Began use age 10 or under
ADLs & IADLs	Capable of performing ADLs & IADLs independently.	Have difficulties performing some ADLs & IADLS, but able to perform independently.	Has difficulties performing ADLs & IADLS and has assistance i.e., (family, friends, care provider)	Has difficulties performing ADLs & IADLS; Minimal social support (family & friends inconsistency); resources required	Serious difficulties with no assistance. Has refused referrals when presented. Necessitates help to maintain housing.
Social and Community Resources	Currently demonstrates ability to access community resources and utilizes without assistance.	Able to access community resources; utilizes supports in the community with assistance	Some difficulty w/ community socialization, accessing community resources, utilizing supports.	Needs on-going assistance to function in community; difficulty accessing community resources or supports.	Client has history of alienating resources and services in the community.
Monthly $	Income over $1800-2700	$901-1799	$900 for single adult; $1215 for two person household	$450 - 899 for single adult	Less than $449/mo for single adult
	Total: Medical Care (x2) + Mental Health (x2) +Support+ Housing+ ER+ Legal hx+ Employment/Edu+ Substance Use+ Hx of SUD+ ADLS+ Social+ Income = 0 - 56				

Domains

- Medical Care
- Mental Health
- Family/Social Support
- Housing
- Emergency Room/Hospitalizations
- Legal History
- Employment / Education
- Substance Use
- History of Substance Use
- ADLs & IADLs
- Social and Community Resources
- Monthly Income

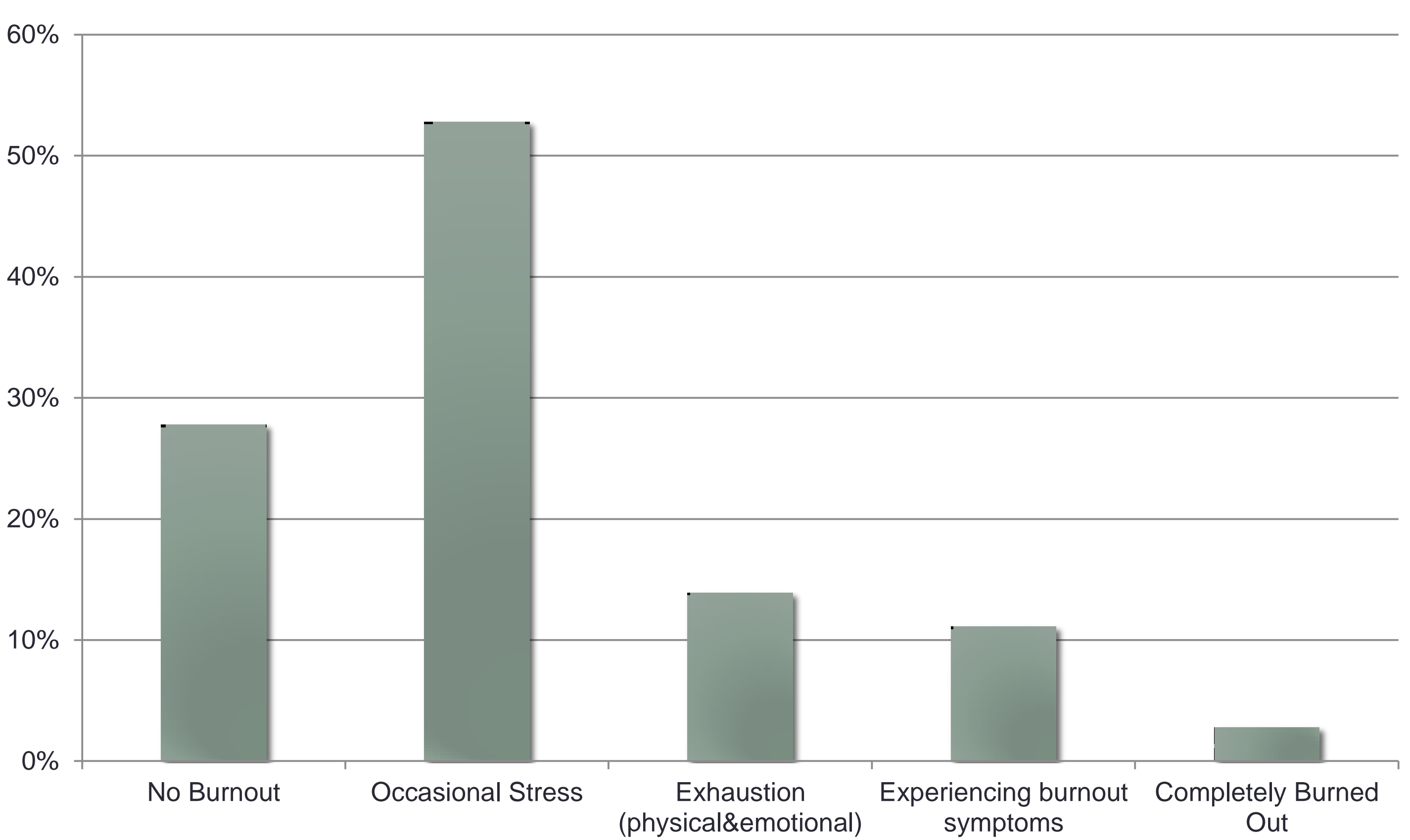
Care Management Self-Assessment



Our clinic

- has a good system for identifying patients at high-risk for poor outcomes
- intensifies services for patients at high-risk for poor outcomes
- individualizes services to different patients with different needs
- is effective in helping patients self-manage their chronic illness
- is coordinated well among physicians, nurses, and clinical staff within our clinic
- effectively utilizes community resources to help meet the health care needs of our patients

Provider Burnout



AltaMed

COORDINATED CARE TEAMS

ALTAMED HEALTH SERVICES

AltaMed has delivered quality care to the underserved communities of Southern California for more than 40 years.

- First entity designated by the Joint Commission as a Primary Care Medical Home (PCMH)
- AltaMed is the largest independent Federally Qualified Community Health Center in the U.S. delivering more than 930,000 annual patient visits
- 43 sites in Los Angeles and Orange Counties

ALTAMED HEALTH SERVICES

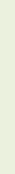
Comprehensive Services: Birth Through the Senior Years

- Primary medical care
- Dental clinics
- Senior long-term care services
- Program of All Inclusive Care for the Elderly (PACE).
- Disease management programs
- Health education
- Youth services
- HIV/AIDS care
- Substance abuse treatment
- Obesity services
- Behavioral Health

ALTAMED HEALTH SERVICES

Quality Care Without Exception

- California CAPE Silver Recognition
- 4 Star CMS Ratings (as measured by IHA)
- Commercial IHA Ranking –top third
- LA Care 75th percentile for safety net groups



PHASES OF DEVELOPMENT AND CHALLENGES

PHASE 1: JULY-SEPT 2014

- Understanding the Population
- Population Engagement
- Understanding the Health Plan expectations
- Developing the Care Management Model
  - Model aligned with corporate goals, PCMH, and the Triple Aim
- Training staff on the CalMediconnect line of business
- Care Management System to support CCT

HEALTH PLAN REQUIREMENTS

- Members are stratified based on predictive modeling tools at the Health Plan level. The level of intervention varies based on the designation of High, Moderate, or Low risk.
  - A RN CM is assigned to all risk levels
- Interdisciplinary Care Plan
- Interdisciplinary Care Team
- Initial Health Assessments

COORDINATED CARE TEAM MODEL

Coordinated Care teams are multi-disciplinary, patient-centered care teams assembled to managed the multi-faceted, dual-eligible patient population

- MEMBER
  - MEDICAL DIRECTOR
    - PRIMARY CASE MANAGER
      - INPATIENT NURSE
        - CARE COORDINATOR
        - CLINIC PATIENT NAVIGATOR
        - TRANSITIONS COACH
      - CLINIC NURSE
      - HOSPITALISTS
    - SOCIAL WORKER
  - PRIMARY CARE PHYSICIAN

COORDINATED CARE TEAM CORE FUNCTIONS

Member

- Completing Health Risk Assessment
- Identifying Self Management Plan
- Active Participation in ICT and ICP

Primary Care

- Review of HRA
- Active Participation in ICT and ICP
- IHA

Medical Director

- Collaboration with Primary / Specialty Care Office for member needs
- ICT
- Ensure Health Plan Compliance

Primary Case Manager

- Integration of Self Management and HRA into the ICP
- Care coordination amongst all disciplines
- ICT

Social Worker

- LTSS Coordination and referral
- Behavioral Health Coordination
- Psychosocial Needs

MEDICAL MANAGEMENT

COORDINATED CARE TEAM CORE FUNCTIONS

Inpatient Nurse

- Concurrent Review when hospitalized-OON management
- Facilitate Discharge Needs
- SBAR with coordinator for Transition Planning and Appointment Scheduling

Hospitalist

- Exchange of Information with Primary Care
- Inpatient Rounds
- Discharge Summary
- ER Diversion

Clinic Nurse

- Episodic ICT with Primary Care
- Coordinate care for Linked Services (i.e., ESRD, Transplants)

Care Coordinator

- Facilitate exchange of information throughout continuum
- Contacts member for Self Management Planning, ICT scheduling, Introduction to CM
- ICT Preparation

Patient Navigator

- Patient relations and navigation of healthcare system
- Specialist coordination (scheduling/consultation documentation)
- Clinic ICT Preparation with Primary Care

Care Transition Coach

- Home visit for High Risk Discharges
- Appointment scheduling
- Implementation of Discharge Instructions

PCMH

ALIGNMENT WITH PCMH

PERSONAL PROVIDER

Ongoing relationship with a personal provider trained to provide first contact, and continuous and comprehensive care

COORDINATED AND INTEGRATED CARE

Care is coordinated across all elements of the complex health care system

PROVIDER DIRECTED MEDICAL PRACTICE

Personal provider leads a team of individuals who collectively take responsibility for the ongoing care of each patient

QUALITY AND SAFETY

Quality Monitoring and Improvement programs

WHOLE PERSON ORIENTATION

Provide holistic health approach

ENHANCED ACCESS

Open scheduling, expanded hours and new options for communication between patients, their personal provider, and practice staff

ALIGNMENT WITH THE TRIPLE AIM

Improving the Experience of Care

Improving the Health of Populations

Reducing the Per Capita Costs

TRIPLE AIM

ALIGNMENT WITH THE STRATEGIC STATEMENT

New Strategy Statement:

Be a 4.5 Star CMS Provider while growing to 350,000 members by 2020 by delivering integrated, evidence based, culturally and linguistically competent care for Latino, multi-ethnic and underserved families to reduce healthcare disparities in Southern California.

BUSINESS OBJECTIVES

CORPORATE GOALS

Leadership Evaluation Management (LEM) Goals *List not all-inclusive*

- Increase overall patient satisfaction with Providers by 3 % for CGCAHPS Survey (Medical Services) by the end of FY 2014-2015
  - Internal Patient Satisfaction Tool to measure Satisfaction with UM Process, Care Management Process, and Provider
- Increase Net Income by 47% (for all LOB)
  - Reduce readmissions
  - Reduce out of network utilization
  - Reduce ER Visits
- Maintain Medicare Hospital Beddays below 942
- Increase Colon Cancer screening rate (HEDIS) by 9%.
- Increase 4 STAR TO 4.5 STAR rating

BUSINESS OBJECTIVES

Contribution to Strategic Goals

- **SERVICE**
  - IMPROVES PATIENT EXPERIENCE
- **QUALITY**
  - IMPROVES CLINICAL OUTCOMES
- **PEOPLE**
  - EMPLOYEES TAKE A TEAM APPROACH TO IMPROVE ENGAGEMENT
- **COMMUNITY**
  - SOCIAL RESPONSIBILITY TO HIGH RISK POPULATION
- **FINANCE**
  - MARKETING SUCCESSFUL CARE TEAMS TO HEALTH PLANS
  - DECREASE UTILIZATION COSTS
  - IMPROVE HEDIS AND STAR RATINGS
  - MAXIMIZE HEALTH PLAN BONUSES

GENERAL TRAINING

COORDINATED CARE TEAM

- Understanding CalMediconnect
- Phases of Development
  - Objectives of Coordinated Care Team
  - Technology: Care Management Module

PHASES OF DEVELOPMENT AND CHALLENGES

PHASE 2: OCT-DEC 2014

- Development of Training Modules
  - End to End Workflows
- Staffing Plan
- Developing Staffing Assessment
- Determine effectiveness of CCT model
  - Model revisions, Role revisions
- Marketing Retention

TRAINING MODULES

Training Modules and Workflows

- Educator Hired
- Core Health Plan Requirements
  - IHA
  - ICT
  - ICP
  - HRA
- Care Management System Use
  - Integration of EMR
- Patient Navigator
- Integration of Behavioral Health and LTSS
- POD Management
- HCC Coding
  - Technology for code capture and submission

STAFFING RATIOS

Challenges in Program Development

- New Program Lacking Evidence based support for program elements
- Health Plan Staffing Ratio Recommendation
  - Different Risk Stratification Models
  - Different Recommendations
    - Example: Moderate 1:500 versus 1:100
- Lack of industry standard for Defining Staffing Ratio
- HP Recommendations did not include evidenced based support due to administrative variations in program design
- Population Challenges
  - Contact information
  - Member Comprehension of CMC

STAFFING RATIOS

Challenges in defining Staffing Ratios

- New Program
- Health Plan Staffing Ratio Recommendation
  - Different Risk Stratification Models
  - Different Recommendations
    - Example: Moderate 1:500 versus 1:100
- Lack of industry standard for Defining Staffing Ratio
- HP Recommendations did not include evidenced based support due to administrative variations in program design
- Population Challenges
  - Contact information
  - Member Comprehension of CMC

STAFFING RATIOS

Staffing Ratios

- Defined Staffing Ratios based on
  - Health Plan Requirements
  - AltaMed Standard of Excellence
- Health Plan Recommendations as a Guide
- Considerations for Technological Efficiencies
- Basic Quarterly Assessment versus Annual Program Assessment

STAFFING RATIOS

Staffing Ratios

	High	Moderate	Low
RN CM	1:50	1:300	1:1000
Care Coordinator	1:400	1:400	1:400
Social Worker	1:1000	1:1000	N/A
Transition Coach I	1:3000	1:3000	1:3000
Transition Coach II	1:30	1:30	1:30
Clinic Nurse*	1: 1000	1:1000	1:1000
Patient Navigator*	1: 3000	1:3000	1:3000
Medical Director			

PHASE 2 LESSONS LEARNED

- Communication
- RN CM and Inpatient Nurse Role
- Transition Coach I role
- Scope of Coordinator
- Huddles
- POD and Clinic Integration

PHASES OF DEVELOPMENT AND CHALLENGES

PHASE 3: JAN-MAR 2015

- Development of Training Modules
  - End to End Workflows by Role
- Developing Staffing Assessment-Ongoing
- Determine effectiveness of CCT model-Ongoing
  - Model revisions, Role revisions
- Marketing Retention-Ongoing
- Return on Investment
- Population Assessment
- Program Assessment
- Assessment of Service Development and Integration

PHASES OF DEVELOPMENT AND CHALLENGES

PHASE 4: APR-JUNE 2015

- Strategic Questions for Sustainability and Growth
- Return on Investment
- Program Assessment
- Assessment of Service Development and Integration

Trauma-Informed Care

Rachel Davis, MPA
Center for Health Care Strategies

Laurie Lockert, MS, LPC
CareOregon

Approaches to Trauma Informed Care

Presenters:
Rachel Davis, Center for Health Care Strategies
Laurie Lockert, CareOregon

CHCS Center for Health Care Strategies, Inc.

Advancing access, quality, and cost-effectiveness in publicly financed health care

Trauma Informed Care: *Overview and National Case Studies*

Southern California Regional Convening:

Improving Care for Patients with Complex Care Needs

Los Angeles, California

January 29th, 2015

Rachel Davis

Senior Program Officer, Center for Health Care Strategies

About the Center for Health Care Strategies

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

Collaborative learning

Technical assistance

Best practice synthesis/dissemination

Leadership and capacity building

CHCS Priorities

Enhancing access to coverage and services

Integrating care for individuals with complex needs

Advancing quality, delivery system, and payment reform

NEW CHCS INITIATIVE

Promoting Trauma Informed Care

FUNDER	• Robert Wood Johnson Foundation (three-year initiative)
OBJECTIVES	• Promote awareness and understanding of trauma-informed approaches to care • Identify and disseminate best practices
ACTIVITIES	• Conduct a learning collaborative comprised of TIC stakeholders • Provide funding support and technical assistance to six pilot sites implementing TIC practices • Disseminate lessons and best practices to a national audience

What is Trauma Informed Care?

- Instead of asking "What's wrong with you?" asks: "What happened to you?"
- Recognizes that trauma has effects on physical health outcomes, behavior patterns, and the physiological ways that information gets processed
- Acknowledges that many "problem" behaviors survivors exhibit are actually coping mechanisms
- Guides systems in how to avoid re-traumatizing individuals

Trauma Informed Care vs. Trauma Treatment

- **Trauma informed care** is a lens that organizations or staff can adopt to better understand their members' behaviors and work more skillfully with them
- **Trauma treatments** are actual clinical approaches utilized by trained professionals to treat the symptoms of trauma
- Can you have one without the other…?

Trauma Treatments

Treatment	Features	Results
Eye Movement Desensitization and Reprocessing (EMDR)	Uses bilateral stimulation (moving eyes back and forth) to rewire the way that traumatic memories are processed	RCT found that 84-100% of single trauma victims were PTSD-free after 3 sessions
Prolonged Exposure (PE) Therapy	Desensitizes individuals to trauma by repeatedly revisiting the memory	Average PE patient had better outcomes than 86% of counterparts in control group
Seeking Safety	Integrated approach to treating PTSD and substance use, focuses on creating sense of safety	Positive outcomes for multiple populations
Sanctuary Model	Framework for treating organizational trauma by creating a healing environment	Designated a "promising practice" by the California Evidence-Based Clearinghouse for Child Welfare

Trauma and Complex Populations

- The experience of trauma crosses gender, socio-economic, ethnic, and racial lines, but…
- Many “complex” Medicaid beneficiaries display symptoms associated with trauma:
  - Higher disease rates
  - Higher rates of substance use and behavioral health disorders
  - Poorer social outcomes
- TIC as a different way to successfully engage them?

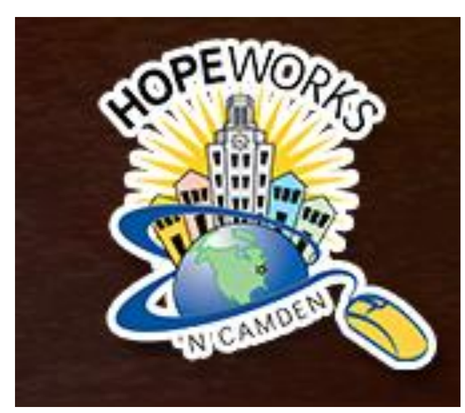
CASE STUDY

Southcentral Foundation (SCF)

- Alaska Native-owned non-profit health care organization serving Alaska Native and American Indian people throughout Alaska, covering 107,000 square miles and including 55 rural villages
- Native Alaskans display effects of "historical trauma"
- Family Wellness Warriors Initiative: training and modeling
- SCF pays for all staff to attend first week of training

CASE STUDY

Camden Coalition of Healthcare Providers



- Seeks to improve the quality of care provided Camden, NJ residents
- Interviews with program enrollees revealed high degree of childhood trauma
- Engaging the broader Camden community in discussions through city-wide trauma summits
- The Healing 10: ten organizations in Camden seeking “Sanctuary Certification” in Sanctuary Model (multi-year certification process)

CASE STUDY

Commonwealth Care Alliance

- A non-profit care delivery system for Medicaid and Medicare beneficiaries with complex needs in and around Boston, MA
- Piloted TIC intervention for patients with history of trauma
- LCSW joined daily rounds to bring TIC perspective to discussions
- Clinicians gained insight into how they interacted with patients, increased emphasis on patient history
- Next steps: TIC or trauma treatment?

Food for Thought

- Buy-in from leadership is critical
- Should be a systems-wide approach: “in the water” so that all staff in an organization understand and support its importance
- Staff should receive comprehensive and on-going training
- Educating clinicians and community partners about trauma, its effects, and how to incorporate a trauma informed care lens in their work is a challenge, but also valuable
- More data is needed for complex populations

CCI Regional Meeting: Improving Care for Patients with Complex Care Needs

January 29, 2015

Trauma-Informed Care

Laurie Lockert MS, LPC

Manager Health Resilience Program, CareOregon

Who is Jake?

- 30 yr old male
- New to health plan
- At time of engagement:
  - Homeless
  - 19 ER visits in 3mos
  - EMR Note stating "Aggressive Behavior"

Jake's "Problem List"

Alcohol dependence in remission

Self-injurious behavior

Hand Pain

Renal calculi

Cannabis abuse

Antisocial personality disorder

Vaccine refused by patient

Benzodiazepine abuse, continuous

GAD (generalized anxiety disorder)

Noncompliance with medication treatment due to overuse of medication

Acute bronchitis

Hx of suicidal ideation

Bipolar disease, manic

Drug-seeking behavior

Hand fracture

Panic disorder

PTSD (post-traumatic stress disorder)

What Lisa learned from Jake…
…outside of Jake's Medical Record

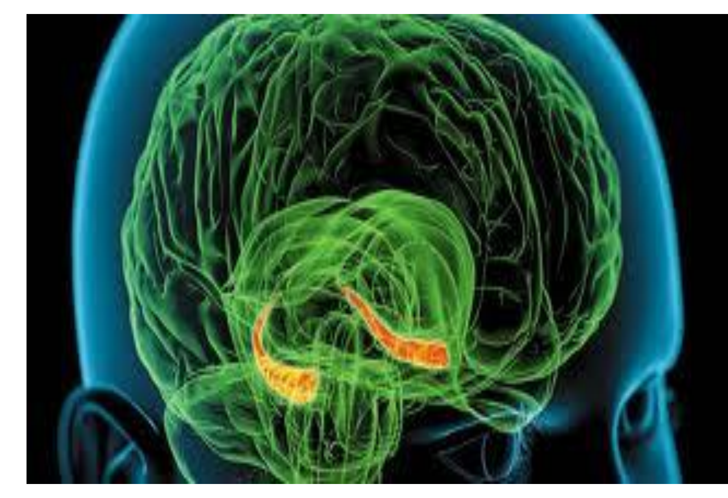
Passions and Interests

- He loves dogs and likes to help elderly people
- He is meticulous in grooming and keeping his surroundings clean
- He enjoys landscaping and yard work
- He would ask to walk on the street side of Lisa so she would not be splashed
- He insisted on opening doors for her "my mom taught me to be respectful"

Life Experiences

- Joined white supremacy group which provided a place where he could belong
- DX of borderline intellectual functioning in elementary school
- Acknowledged substance abuse to address mental health symptoms
- He and his mother were physically & verbally abused by an alcoholic father – he requested a female provider due to this abuse ("it is hard not to freak out when guys touch me")
- Easily overwhelmed by loud voices, large numbers of people and language that is "over my head"

Effects of Trauma



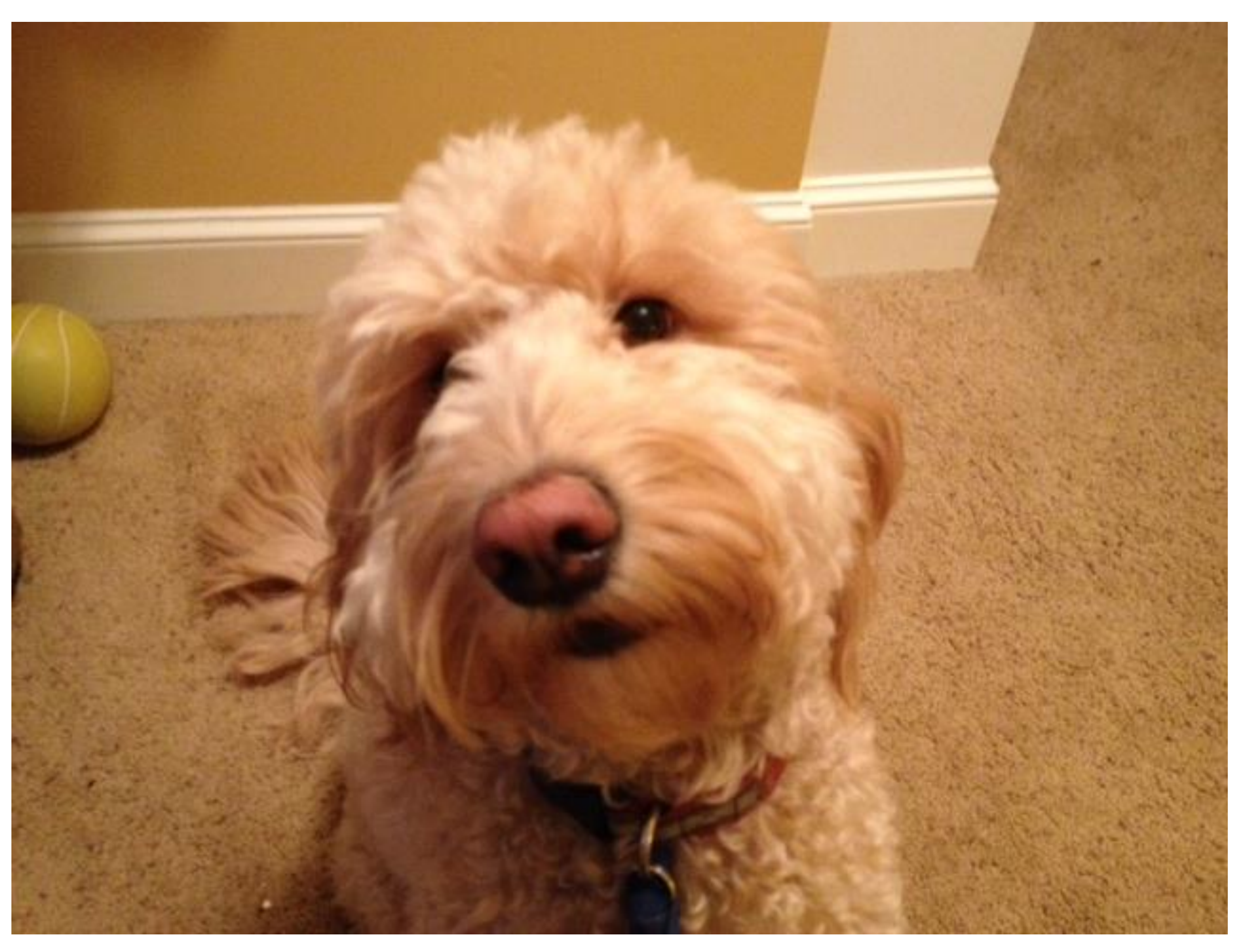
- Changes in brain neurobiology
- Social, emotional, and cognitive impairment
- Adoption of maladaptive, injurious coping strategies
- Oftentimes health and social problems, including early death
- Impairment in forming relationships

http://developingchild.harvard.edu/resources/multimedia/videos/three_core_concepts/toxic_stress

Adopting TIC approach

- Our systems 'trigger' people
- How do we work with Jake?
- 3 Principles of TIC
  - Create safe context
  - Empower
  - Respect
- <u>Let</u> people say 'no' to us
- "They don't want to work with us!" "We are harassing them!"
- "They are aggressive, rude, disrespectful", etc.

Questions?



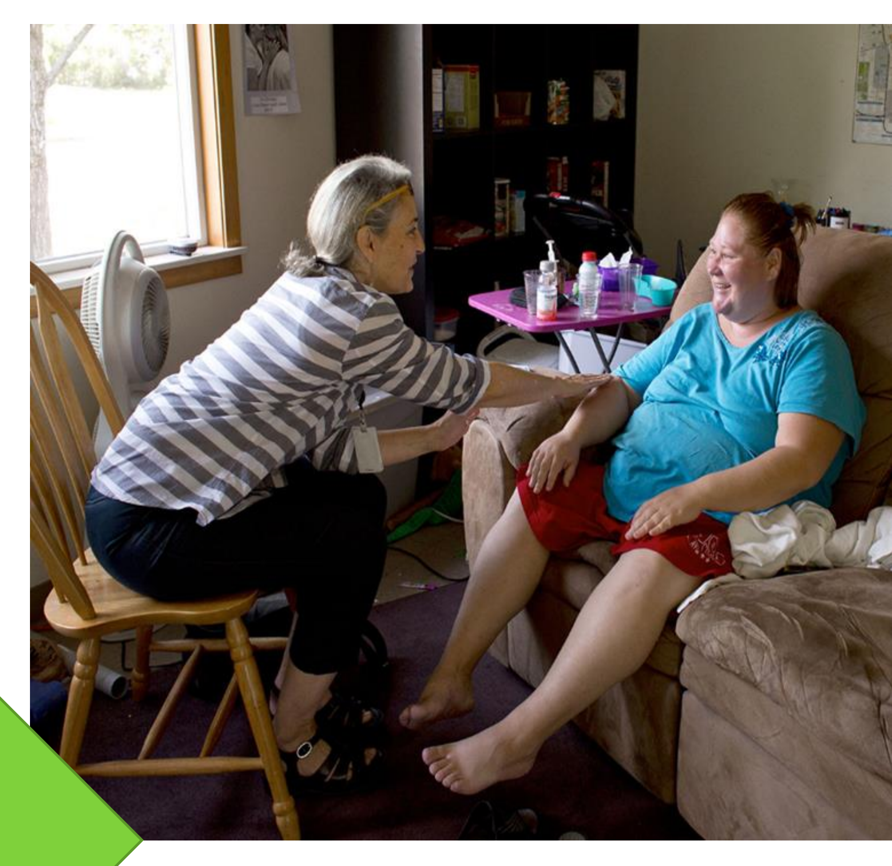
Client Engagement Begins at Home

History **Hiring** **Critical Trainings** **Orienting**

Learning from weekly “Huddles”

Gathering the stories and their impact on staff

Learning how to hire for the work



And the workflows

What Happened?

Built trust : listened, transparency, client's pace

Identified goals: new PCP and stable housing

Small chunks of information

Plan ahead: communicate future steps

check for understanding

New Understandings

Client Level:

Capturing not *just any* “high utilizer” but a Population with Extensive Trauma Histories

Staff Level:

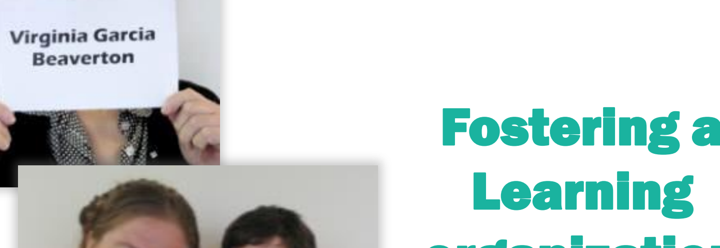
Master’s training: prepared to work with trauma behaviors & safety issues

Presentation Overview

JOHNS HOPKINS MEDICINE

- Why Tumaini?
- Social and Environmental Context
- Overview of the Tumaini (Hope) for Health program
  - Mission
  - Core Implementation Principles
  - Conceptual Model
  - Partnership Processes
- Tumaini Neighborhood Navigators
  - A Day in the Life of a Neighborhood Navigator
  - The Neighborhood Navigator Model
  - Neighborhood Navigator Training
- Tumaini Community Health Worker Case Managers
  - A Day in the Life of a Community Health Worker Case Manager
  - The Community Health Worker Case Manager Model
  - Community Health Worker Case Manager Training
- Partnership Barriers
- Partnership Successes

Sustaining Our Culture



Fostering a Learning organization

TIC Leadership

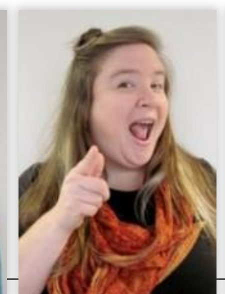
MCHD
Northeast
Clinic

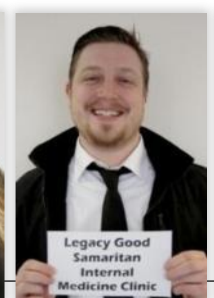
Tell the stories

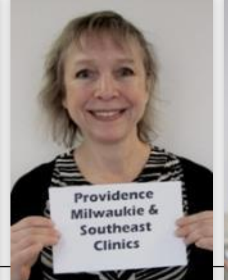
Transparent Management style

Legacy Emanuel
Internal
Medicine Clinic

Incorporate **meditation** & **gratitudes**







Changing Course, Asking Questions

Target Population ....How will this change workforce needs? Expanding into rural settings...what adaptations?

Ongoing medical consultation in Huddle

How do we keep our workforce from burning out?

How do we build a long-term “**Recovery Pathway**”?

Working with Peer Services: a warm handoff

How do we keep our team connection?

Patient Engagement and Outreach

Laurie Lockert, MS, LPC
CareOregon

Linda Dunbar, PhD
Division of Population Health, Johns Hopkins University,
Bloomberg School of Public Health

Patient Engagement Training

Linda Dunbar PhD RN

Vice President Population Health, Care Management

Johns Hopkins Medicine

Stephen T. Wegener, PhD, ABPP

Dept. of Physical Medicine and Rehabilitation JHUSOM

Dept. of Health Policy and Management JHU Bloomberg School of Public Health

and

The JCHiP Patient Engagement Team

Regional Meeting: Improving Care for Patients with Complex Needs

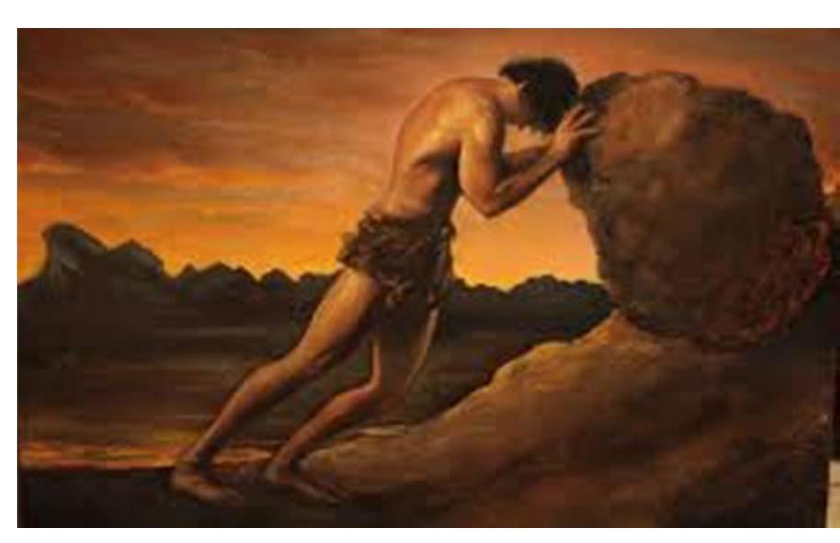
Thursday, January 29, 2015

Johns Hopkins Medicine: Transformation Goals

"….change behavior in health care teams…"

"….assist patients in making better health care choices" and….

"assist population to work to stay healthy"



The Community Health Partnership (also called “J-CHiP”)

- On **January 27th**, 2012 JHM submitted a **$30M** proposal in response to a CMMI funding opportunity, to create **“J-CHiP”** that spans the **care continuum**:
  - **Community**
  - **Ambulatory Clinics**
  - **Emergency Departments**
  - **Hospitals**
  - **Skilled Nursing Facilities**

- In **June**, a JHM award of **$19.9M** was announced.

The project described was supported by Funding Opportunity Number CMS-1C1-12-0001 from Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation.
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies

Evolution: "Usual Care" to JCHiP

- **4 components** (*Community, JHHS Readmissions, JHBMC, and SNF*) -> **1 program**.
- **JHM Partners included**: JHU (School of Medicine, Nursing, Public Health), Academic Hospitals, Community Physicians, Home Care, Health Plan, Urban Health Institute, Sisters Together and Reaching (STAR) and Men and Families Center .
- **Dozens** of faculty, administrators, physicians, nurses, and other team members at the table.

JCHiP: A MultiModal Approach

- Case Management, Community Health Workers, Health Behavior Specialists, Pharmacists, Transition Guides, Neighborhood Navigators
- Intervention Protocols
- Care Teams
- Patient Support (Patient Access Line)
- …..and other initiatives

JCHiP: A MultiModal Approach

Are the staff skills present to achieve the goal of behavior change by informed activated, engaged patients?

JCHiP A MultiModal Approach

The principles and skills of Motivational Interviewing (MI) were identified as a component in achieving behavior change by providers and patients.

- The potential contribution was recognized by JCHiP leadership and initial training was conducted early in the development of J-CHiP.
- As the program rolled out, it became clear that this initial training would not be sufficient to achieve the goals of the program.
- Engaged Dr. Stephen Wegener to redesign our approach.

JCHiP Patient Engagement Training
3 Phases

JOHNS HOPKINS MEDICINE

- Phase 1 – Needs Assessment
- Phase 2 – Initial Training
- Phase 3 – Skill Building and Maintenance

JCHiP Patient Engagement Training Phase 1

Method: A series of interviews and observations of various components of the J-CHiP team were conducted over the period of two months.

- **Findings--Strengths:**
  – Widespread commitment to the goals of J-CHiP
  – Interested in acquiring skills to assist them in working with the challenging patients who J-CHIP serves
  – Health Behavior Specialists are a reservoir of enthusiasm and skills for behavior change training.

JCHiP Patient Engagement Training Phase 1

- **Findings-- Challenges/Opportunities:**
  - Inconsistent MI training of JCHIP members.
  - Teams not clear that MI is the main essential tool to assist patients in engaging in appropriate health care behaviors and build lasting relationships.
  - Tendency by some team members to view the use of MI as skills practiced by other team members and not central to their own skill set.
  - Need a range of training methods to make the skill building available to all staff

What is Patient Engagement Training?

Based on principles and skills of motivational interviewing:

Motivational interviewing is a collaborative, person – centered form of guiding to elicit and strengthen motivation for change.

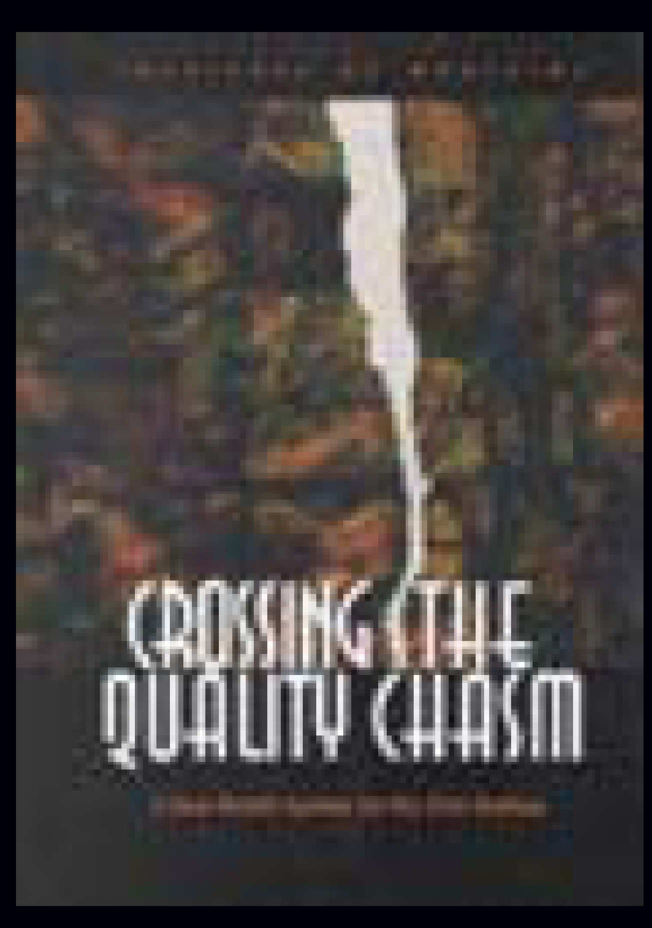
What is Patient Engagement Training?

JOHNS HOPKINS MEDICINE

- Evidenced based approach shown to change behaviors and increase engagement in many patient populations
- Can be integrated into current practice as it can be done in a time efficient manner
- Can be taught to a wide range of providers

Redefined the principles and skill set of MI as Patient Engagement Training

Patient Engagement Training Embodies Core Values of Patient Centered Care



- ✓ Recognizes patients are the central health care workers. This work is untrained, unpaid and unacknowledged.
- ✓ Trains providers to help patients become active participants in their own care.

JCHiP Patient Engagement Training Phase 2

JOHNS HOPKINS MEDICINE

Training across the entire J-CHiP Program

- 8 hour Basic Training
- 2 hour Refresher Course
- Supervisor Training
- To date 136 individuals have participated (30 scheduled for 8-hour course and 80 for 2-hour course in January)
- Participant evaluations are very positive.

JCHiP Patient Engagement Training Phase 3

JOHNS HOPKINS MEDICINE

- Established a PET champion on each team.
- Each clinical and role team has established a PET Plan.
- Broadcast email to distribute "J-CHiP PET Tip of the Month" to maintain focus on principles and build skills.
- Rating form for PET self-assessment and supervisors use to evaluate skills semi-annually.
- Coaching team champions and monitoring of plan implementation.

JCHiP and PET

- JCHiP seeks to implement processes and strategies that improve outcomes in challenged populations and document their value
- To achieve this goal we need to change provider and patient behavior
- JHM is at the forefront of integrating this behavior change technology across a health care system

Patient Engagement Training - Challenges

- Need to engage physicians in this initiative
- J-MAP: Johns Hopkins Medicine Alliance for Patients (Medicare Shared Savings Plan, Medicare ACO 38,000 members)
- Need to establish metrics to access both PET process and outcomes
- Need to establish partnerships and resources to scale up the initiative

Johns Hopkins Medicine
PET: The New Handwashing

HANDWASHING

Comments….Questions

Effective Community Partnerships: The East Baltimore Story

Linda Dunbar, PhD, RN
Johns Hopkins Medicine

Desiree de la Torre, MPH, MBA
Johns Hopkins Medicine

Leon Purnell, MA
Men and Families Center

Debra Hickman, M.Div.
Sisters Together and Reaching, Inc.

Effective Community Partnerships:
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Regional Meeting: Improving Care for Patients with Complex Needs
Thursday, January 29, 2015

Presentation Overview

JOHNS HOPKINS MEDICINE

- Why Tumaini?
- Social and Environmental Context
- Overview of the Tumaini (Hope) for Health program
  - Mission
  - Core Implementation Principles
  - Conceptual Model
  - Partnership Processes
- Tumaini Neighborhood Navigators
  - A Day in the Life of a Neighborhood Navigator
  - The Neighborhood Navigator Model
  - Neighborhood Navigator Training
- Tumaini Community Health Worker Case Managers
  - A Day in the Life of a Community Health Worker Case Manager
  - The Community Health Worker Case Manager Model
  - Community Health Worker Case Manager Training
- Partnership Barriers
- Partnership Successes

Why Tumaini?
A Perfect Storm

- Parallel development of two initiatives
  - System-wide reforms in the delivery of care, across the care continuum, throughout Johns Hopkins Medicine
  - East Baltimore Health Enterprise Zone (EBHEZ)

- Local and national changes in health care delivery
  - Changes in incentive structures for health systems
  - State and federal funding to support innovative programs

Social and Environmental Context

- Poor relationship between predominantly low-income African American communities in East Baltimore and Johns Hopkins
- Neighborhoods characterized by:
  - Concentrated poverty and deprivation
  - Disparate health outcomes in comparison to more affluent communities
  - Strong network of community-based, community-placed resources, partnerships, and lifelong citizens
- Fractured health system

Tumaini (Hope) for Health
Overview

- Collaborative effort between Johns Hopkins Medicine, Sisters Together and Reaching (STAR), and the Men and Families Center, Inc. (MFC)
- A multilevel community health worker program
- Aims to reduce barriers to accessing health care and facilitate uptake of social and health services
- Targets 3 zip codes: 21202, 21205, and 21213
- Composed of two intersecting interventions:
  - Neighborhood Navigators, volunteers trained and overseen by the Men and Families Center
  - Community Health Workers, trained and employed by Sisters Together and Reaching

Sisters Together and Reaching, Inc. (STAR)
"Advocating and Providing Optimal Health and Wellness"

Tumaini Mission

Our mission is to expand access to health care and supportive services for underserved communities of Historic East Baltimore.

Core Implementation Principles

- Using ***community-based, community-placed*** strategies to improve patient health and well-being
  - Community-based staff recruitment
  - Community ownership and involvement
- Partnership for program infrastructure
  - Equipment and supplies
  - Documentation and information management
  - Development of referral system
  - Development of linkages to Johns Hopkins Medicine's staff
- Strong supervision and oversight
  - Individual performance evaluation
  - Ongoing training
- Developing strong linkages to the health system
- Program performance monitoring and evaluation

Provider

RN Case Manager

Behavioral Health

Family & Social Network

PATIENT

CHW

Social Work

NN

- Produce better outcomes
- Coordinate care and reduce cost
- Find coverage options for the uninsured
- Educate, empower, and activate patients for better health outcomes
- Deliver culturally sensitive services
- Reach the vulnerable, underserved, and/or isolated
- Effectively tackle health disparities
- Link patients to community services and organizations

Partnership Processes

- Development of shared goals and objectives
- Consistent meetings to build trust and rapport
- Open, honest communication
- Collaborative development of data collection tools and program monitoring and evaluation plan

A Day in the Life of a Tumaini Neighborhood Navigator

http://goo.gl/hxnT0D

Tumaini (Hope) for Health
Neighborhood Navigators

- Adopts a “Block-by-Block” approach for community organizing for health
- Combines features of community health worker and peer advocate/mentor models
- Trained and overseen by the Men and Families Center
  - 40 residents trained; 30 retained for final deployment
- Reside in specific neighborhoods within the Madison-East End Community Statistical area, located in the 21205 zip code
- Compensated through stipends based on living wage
- Document work through a telephone-based monitoring system developed by Johns Hopkins Health System and adapted for use for the Navigators

Tumaini (Hope) for Health – Neighborhood Navigators *(continued)*

- Serve four primary roles:
  - General neighborhood education and outreach *(neighborhood-wide)*
  - Informal monitoring and surveillance of unmet needs related to access to health care and social services *(neighborhood-wide)*
  - Regular home visits to provide social support and promote engagement with care among a small caseload of high-risk patients
  - Capacity-building and mobilization of neighborhood residents through regular participation in and presentation to neighborhood association meetings

Training for NNs

- Introduction to Johns Hopkins Health System, Tumaini, and NN and CHW roles
- Outreach and patient engagement
- Patient interviewing
- Means-tested benefit and health insurance eligibility
- Community resource identification, referral, and navigation
- Documentation of patients' needs and referrals
- Social and economic determinants of health
- Introduction to Mental Health First Aid
- CPR

A Day in the Life of a Tumaini Community Health Worker Case Manager

http://goo.gl/hxnT0D

Tumaini (Hope) for Health

Community Health Worker Case Managers (CHWCMs)

- Five CHWs trained and employed by STAR
- Engage in intensive, ongoing community-based case management to mitigate barriers to accessing care
- Support neighborhood-based monitoring of adherence to, and engagement with, prescribed care
- Overseen by a Nurse Case Manager and a CHW Supervisor
- Outreach a defined population of high-risk patients in the 3 target zip codes
- Reside in the East Baltimore neighborhoods where their patients live
- Document work in the Tumaini case management database, created in partnership with Johns Hopkins Health System

Training for CHWCMs

- Medical
  - Hepatitis C
  - HIV/AIDS
  - CPR & First Aid
  - Health and Fitness
  - Hospice and Palliative Care
  - Chronic diseases
  - Adherence
- Introduction to public health principles
- Resource identification
- Case management
- Communication
- Cultural competency
- Skill-building

Partnership Barriers

- Underestimating the amount of time taken to establish program infrastructure, particularly IT systems
- Consummating the relationship between the medical model and the public health model *(develop trust)*
- Tension between new model of care delivery and prevailing model
- Financial constraints

Partnership Successes

- Largest single investment to-date by Hopkins in community-based care delivery by community-based organizations
- Enhanced capacity, through this partnership, to mitigate social determinants of health
- Leveraged the assets of all organizations involved to improve community health
- Identified and shared resources with the community regarding health education
- Employed culturally appropriate strategies to support populations that have been lost to care
- Development of a conceptual model that is geared toward achieving improved population health by providing **the right care, at the right time, at the right place**

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Thank you!

Improving Care for Patients with Complex Care Needs

Southern California Convening
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