Improving Care for Patients with Complex Care Needs
Northern California Convening
July 30, 2014
1111 Broadway, 7th Floor, Oakland CA

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Time	Topic	Speakers
9:00 am	**Welcome**	**Giovanna Giuliani, MBA, MPH**, California HealthCare Foundation
9:15	**Lessons from Bay Area Complex Care Pioneers**	**Dave Moskowitz, MD, MAS,** Hope Center, Alameda Health System **Anna Robert, RN, MSN, DrPH** and **Fern Ebeling, RN, BSN** San Francisco Department of Public Health **Jason Cunningham, DO,** West County Health Centers
10:00	**Selecting and Risk-Stratifying Patients for Complex Care Management Programs**	**Clemens Hong, MD, MPH,** Massachusetts General Hospital
10:50	**Break**	
11:00	**Identifying Patient Needs Through Ethnographic Research**	**Suneel Ratan, MPP** and **Melissa Marshall, MD,** Community Health Center Network of Alameda County
11:15	**Approaches to Patient Engagement and Outreach**	**Rachel Davis, MPA**, Center for Health Care Strategies (CHCS) **Maria Raven, MD, MPH, MSc,** UCSF, San Francisco Health Plan, Complex Care Innovation Lab
12:15 pm	**Lunch**	
1:15	**Lessons from Implementation of the Intensive Outpatient Care Program (IOCP)**	**Lisa Mangiante, MPP, MPH**, Pacific Business Group on Health **Marcus Zachary, DO**, Brown and Toland **Michael Kern, MD,** John Muir Health
2:00	**Approaches to Trauma-Informed Care**	**Rachel Davis, MPA**, Center for Health Care Strategies **Laurie Lockert, MS, LPC**, CareOregon
2:45	**Break**	
3:00	**Measuring the Impact of Our Work**	**Donna Zulman, MD, MS,** VA Palo Alto Health Care System; Stanford Clinical Excellence Research Center
3:30	**Policy and Innovation Funding Landscape**	**Giovanna Giuliani, MBA, MPH,** California HealthCare Foundation **Cari Jarbouai, MPH, MSW,** California State Innovation Model (CalSIM) Project Manager, Health Homes for Patients with Complex Needs
3:50	**Wrap-Up and Evaluation**	**Giovanna Giuliani, MBA, MPH,** California HealthCare Foundation
4:00	**Adjourn**	

Speakers

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Jason Cunningham, DO, West County Health Centers – Dr. Cunningham is the Medical Director of West County Health Centers, a Federally Qualified Health Center serving patients in western Sonoma County. He has been the champion for West County's clinical redesign toward a transformed delivery system and has enjoyed the challenges and opportunities in rethinking Primary Care. West County Health Centers has become a thought leader and innovator in this new healthcare environment and has effectively demonstrated the potential of a dynamic primary care delivery model built on relational, team-based care. Dr. Cunningham is a Family Physician and remains dedicated to patient care. He received his Bachelor of Science from the University of Michigan and medical degree from Kirksville College of Osteopathic Medicine.

Rachel Davis, MPA, Center for Health Care Strategies - Davis is a senior program officer for the Center for Health Care Strategies (CHCS). She is a member of the Complex Populations team, and is currently leading work on the Complex Care Innovation Lab (CCIL) and the Digital Health Initiative. CCIL brings together leading innovators in the field of complex populations to collaborate and test strategies for serving high needs, high cost Medicaid beneficiaries. The Digital Health Initiative seeks to link existing and developing technologies that could support complex populations to policymakers and programs in an effort to improve patient outcomes. Davis also works on the New York State Health Home Learning Collaborative.

Previously, Davis worked for the New York City's Health and Hospitals Corporation (HHC), where she helped lead several care coordination initiatives designed to serve medically and socially complex individuals. She has bachelor degrees in history and Spanish from Washington University in St. Louis, and received her master's in public administration from New York University's Robert F. Wagner Graduate School of Public Service.

Fern Ebeling, RN, BSN, San Francisco Department of Public Health - Ebeling has been a staff nurse in the General Medical Clinic (GMC) since 1983. Along with the nurse manager she helped develop the role of the RN in the first iteration of primary care nursing in the clinic. She also developed the Orientation Clinic, a nurse-run clinic to help new patients navigate the hospital system and initiate health care maintenance and screenings. She served as the Nurse Liaison for Information Systems at SF General Hospital for seven years before returning to the General Medicine Clinic as charge nurse. Together with her team, she launched the Complex Care Management team, an interdisciplinary team that focuses on improving health for GMC's most frequently hospitalized patients. These patients often have complex medical and psychosocial issues, requiring an individualized, comprehensive approach. The Complex Care Management team, composed of a physician lead, medical assistant, coordinator, and social worker in addition to Ebeling, is successfully reducing rates of hospitalization and emergency visits for the patients in the program.

Clemens Hong, MD, MPH, Massachusetts General Hospital - Dr. Hong is a community health center primary care physician and a health services researcher at Massachusetts General Hospital (MGH) in Boston. He focuses on approaches to improving primary care delivery for vulnerable populations with particular interest in the integration of community health workers (CHWs) into primary care delivery models and on primary care-integrated, care management of complex, vulnerable patients. He has studied best practices in leading primary care-integrated complex care management programs across the United States. His work within the practice-based research network at MGH includes the development of risk prediction models that allow for primary care physician input and account for patient's psychosocial complexity.

Dr. Hong is also a co-founder and chief science and innovation officer at a new non-profit organization, Anansi Health. Anansi Health's mission is to support widespread adoption of CHW-integrated care management models through training and technical assistance to health delivery systems seeking to integrate CHWs. He also serves on the executive board of the Transitions Clinic Network, an organization he co-founded, that is working to facilitate national adoption of the Transitions Clinic model. The model, developed in San Francisco, integrates formerly incarcerated CHWs into primary care to address the complex needs of chronically-ill individuals transitioning from prison to home.

Cari Jarbouai, MPH, MSW, CalSIM Project Manager, Health Homes for Patients with Complex Needs - Jarbouai is an independent consultant currently managing Health Homes for Patients with Complex Needs, a key initiative of the California State Innovation Plan. She has a Master's degree in Public Health from the University of California at Berkeley and has experience in both provider and health plan settings related to transitions of care, clinical integration, Meaningful Use, Pay-for-Performance, and HEDIS. Jarbouai also has a Master's degree in Social Work from California State University, Long Beach, and has served as a clinical social worker at the Long Beach VA Hospital and in the older adults unit of Saint Mary's Medical Center.

Michael Kern, MD, John Muir Health - Dr. Kern is a family physician who currently manages quality for John Muir Physician Network. He received his bachelor's degree at Marquette University, his MD at the University of Nebraska, and completed his residency training at the University of Wisconsin, Department of Family Medicine. Dr. Kern had a private practice in Lafayette, California, for 17 years, and during this time became involved in various aspects of care management, eventually being named Senior Vice President & Medical Director at John Muir. He has been involved in many quality activities across the state of California, such as the California Cooperative Healthcare Reporting Initiative (CCHRI) efforts to improve chronic care, and the Integrated Healthcare Association's (IHA) Pay for Performance initiative. Dr. Kern was a member of the Steering Committee for Pay for Performance. He also has been an advisor to CHART, the California Hospital Assessment and Reporting Taskforce. Under his leadership, John Muir has been named one of the top performing groups in the IHA numerous times.

Dr. Kern more recently has focused on improving care for patients with medically complex chronic illness, and children with obesity. In 2010, he started up a Medical Home model, which supports frail elderly patients, and serves our Blue Shield ACO, and both our Medicare Advantage plans and Medicare ACO patients of John Muir. The model currently serves over 90 physician practices throughout the Contra Costa region.

Laurie Lockert, MS, LPC, CareOregon - Lockert received her M.S. in Psychology at Portland State University and has her license as an LPC (Licensed Professional Counselor). She has over 30 years of experience as a clinician, manager and consultant in various settings in the mental health field. In addition, she has provided trainings on Trauma Informed Care for both Human Services and Community Mental Health & Addictions. Her work at CareOregon with the Health Resilience Program has provided the opportunity to support the creation, and further the expansion, of trauma informed care in social service agencies and primary care. Since starting up the Health Resilience Program, she has collaborated with more than 17 Primary Care and Specialty Clinics to embed a Health Resilience Specialist and develop new workflows to incorporate this unique workforce.

Lisa Mangiante, MPP, MPH, Pacific Business Group on Health - Mangiante leads the Intensive Outpatient Care Program (IOCP) at the Pacific Business Group on Health, focusing on care redesign for patients with complex chronic illness. She has experience in health policy, legislative analysis and program development and management, as well as strategies to improve care and prevent avoidable hospital use. Previously Mangiante served as Director of Global Market Access and Policy at Robert Bosch Health Care, managed the Frequent Users of Health Care Initiative and held positions at the California Academy of Family Physicians, California Association of Public Hospitals and Pacific Business Group on Health (prior tenure). She holds master's degrees in public policy and public health from the University of California at Berkeley.

Melissa Marshall, MD, Community Health Center Network of Alameda County - Dr. Marshall is the Chief Medical Officer for Community Health Center Network (CHCN), a managed care and practice management organization for Alameda County's eight community health centers with 100,000 managed care members. Working closely with the medical directors of the health centers, Dr. Marshall leads clinical quality and practice improvement work. She also provides clinical consultation and oversight for CHCN's managed care business including utilization review of in-patient and out-patient services, compliance with clinical aspects of health plans' delegated activities, and maintenance of a robust specialty care network.

Dr. Marshall previously served as the Associate Medical Director for Family Care Health Centers, a community health center in St. Louis, Missouri. At the health center, she provided full-spectrum medical care with an emphasis on maternal and child health. Dr. Marshall also led the Steering Committee of the St. Louis Integrated Health Network which prepared the safety-net for changes related to health care reform and served on the board of the city Maternal Child Family Health Coalition. Dr. Marshall received her undergraduate degree from Stanford University, her medical degree from Washington University in St. Louis, and then completed her Family Medicine residency at the University of California, Davis.

David Moskowitz, MD, MAS, Hope Center, Alameda Health System – Dr. Moskowitz is the medical director of the Hope Center, a complex care management program for high cost, high risk patients at Alameda Health System in Oakland, California. Dr. Moskowitz's work focuses on developing innovative models of care for patients facing urban poverty and chronic disease. He attended the University of Washington for undergraduate studies, medical school, and a residency in internal medicine. He then completed a primary care research fellowship at the University of California San Francisco, based at San Francisco General Hospital. During his fellowship, he earned a master's degree in clinical research. He has published articles in several peer-reviewed medical journals on health care disparities, chronic disease management, and the social environment of poverty.

Suneel Ratan, MPP, Community Health Center Network of Alameda County – Ratan is Chief Strategy Officer of Community Health Center Network (CHCN) and the Alameda Health Consortium (AHC), which bring together eight Alameda County community health centers serving over 175,000 low-income individuals. His focus is on supporting the transition to value-based purchasing and population health management. Prior to joining CHCN and AHC, Ratan spent a decade focusing on the application of Internet-based technologies to improve the lives, health, and wellbeing of individuals with chronic conditions, older adults, and the disabled. He has also has diverse experiences as an online media executive and as a Washington-based journalist for TIME and FORTUNE magazines. He holds a Master of Public Policy from the Harvard Kennedy School and a bachelor's degree in political science from Columbia University.

Maria Raven, MD, MPH, MSc, UCSF, San Francisco Health Plan, Complex Care Innovation Lab – Dr. Raven is a practicing emergency medicine physician, health services researcher, and Assistant Professor of Emergency Medicine at UCSF. Prior to coming to UCSF in 2011, Dr. Raven had 10 years of experience in the New York City public hospital system where she completed her residency and a research fellowship. She oversaw one of six New York State Department of Health-funded Chronic Illness Demonstration Projects for the New York City Health and Hospitals Corporation and New York State Medicaid. She currently works closely with the San Francisco Health Plan, the largest Medicaid Managed Care Program in the City and County of San Francisco, on programs related to their highest cost members. Dr. Raven works clinically in the Emergency Department at Moffitt-Long and conducts research related to emergency medicine payment policy and frequent users of the health system and social care system.

Anna Robert, RN, MSN, DrPH, San Francisco Department of Public Health – Dr. Robert is the Director of Care Coordination for the Primary Care in the San Francisco Health Network, the healthcare delivery system for the San Francisco Department of Public Health. Dr. Robert develops and directs programs that involve transitions between sites and systems of care for primary care patients, including the Complex Care Management program that targets patients who have had multiple admissions to the San Francisco county hospital. Dr. Robert's work also focuses on ensuring patient access to primary care through innovative approaches. She has led the implementation of nurse-led orientation clinics for new patients and provider telephone visits for patients who are served in the 14 primary care clinics within the San Francisco Health Network. Dr. Robert received her Bachelor's degree in chemistry from Santa Clara University, her Master's degree in nursing from the University of California, San Francisco, and her Doctor of Public Health degree from the Population, Family and Reproductive Health department at Johns Hopkins Bloomberg School of Public Health.

Marcus Zachary, DO, Brown & Toland Medical Group - Dr. Zachary is the senior medical director for quality and population health at Brown & Toland Medical Group (BTMG). He is primarily responsible for the strategic and operational oversight of medical services related to their ambulatory provider network and ACO portfolio that includes the Medicare Pioneer program. Within the organization, Dr. Zachary helps design and drive initiatives linking quality, utilization, and IT in the pursuit of the Triple Aim.

Prior to joining BTMG, Dr. Zachary was the lead physician informaticist for a Dignity hospital in San Francisco. He oversaw the implementation of their hospital electronic medical records system. Dr. Zachary served as a Medical Director for both Cogent-HMG and Galen Inpatient Physicians for their respective Hospital Medicine Programs. He is board certified in internal medicine with over a decade of clinical experience as a hospitalist and is a Fellow of the Society of Hospital Medicine.

Donna Zulman, MD, MS, VA Palo Alto Health Care System, Stanford Clinical Excellence Research Center – Dr. Zulman is a health services researcher and general internist in the Division of General Medical Disciplines at Stanford University and at the Center for Innovation to Implementation in the VA Palo Alto Health Care System. Dr. Zulman received her MD from the University of California, Los Angeles. After completing a residency in Internal Medicine at the University of Michigan, she received a Masters in Health and Health Care Research through the Robert Wood Johnson Clinical Scholars Program at the University of Michigan and the Ann Arbor VA. Her research focuses on improving health care delivery for patients with multiple chronic conditions and complex medical and social needs, and optimizing health-related technology to personalize care and improve outcomes for high-risk patients. She is currently involved in the implementation and evaluation of several intensive management programs for high-risk patients within the VA system. Dr. Zulman is supported by a VA Health Services Research & Development Career Development Award. Her research about patient-provider priority concordance and the inclusion of complex, older adults in clinical trials has been featured in The New York Times.

Community Health Center Network
Community Health Strategy
Ethnographic Research Protocol
Version 0.5 / Draft: February 12, 2013

PROJECT OBJECTIVE: Community Health Center Network (CHCN) is redefining its care and case management approach to increasingly focus on keeping its members healthier as a means of reducing their need for specialty, emergency room, inpatient care, and post-acute care. The initial focus of the project is on individuals who are the highest utilizers – the top 10 percent of our managed-care membership accounts for about 65 percent of spending under our full professional risk contracts. A key line of work is to conduct ethnographic research that is primarily qualitative and observational as a key input to the design process around appropriate and effective care and case management interventions. The purpose of the research is to:

1) Put a human face on our high utilizer members.
2) Drive the development of personas – based on clusters of observed common **patterns** and **characteristics** among sub-groups of those interviewed – to both inform population selection for an initial program and the design of that program.

At the outset, it must be emphasized that the ethnographic research is intended to balance between needing to capture patient stories in a way that can inform a creative design process, vs. the desire to be methodologically rigorous – particularly to the degree that findings will drive a quantitative selection model. For the purposes of the overall project, the team has agreed to place priority on the former imperative of capturing stories to drive design of a program that uniquely 'fits' our members and communities.

DOCUMENT OBJECTIVE: This document represents a protocol embodying an agreed upon set of processes, practices, policies, and procedures to support the ethnographic interviewing process.

PROJECT TEAM:
Interviewers: Celina Ramirez, LCSW, and Saleena Gupte, DrPH
Patient list generation and evaluation: Xiao Chen, CHCN Quality Management Manager
Materials development: Siobhan Sullivan, CHCN Director of Clinical Operations; Dr. Melissa Marshall, CHCN Chief Medical Officer; Rhonda Aubrey, CHCN COO

Project management: Suneel Ratan, CHCN Chief Strategy Officer, and Kristian Lau, interim project manager

PATIENT SELECTION AND OUTREACH METHODOLOGY: The goal is to interview at least 40 members – 26 of whom are high risk/high utilizers, 7 of who are high risk/low utilizers, and 7 of whom are low risk/high utilizers. The latter two groups are being interviewed to understand both individuals who are high risk but managing low levels of utilization, both to understand how they might be doing so successfully, and also to understand why they might become high cost later. We chose the number 40 to ensure that the interviews – selection bias notwithstanding – will accurately represent and capture the diverse personas among our patient population.

The 40 members are being drawn from a list of 120 patients randomly sampled from the pool of about 6,000 members who are in the top 10 percent of CHCN's members in terms of spend between July 1, 2012 and June 30, 2013, and who are still enrolled, as well as high risk / low utilization members drawn randomly from the rest of the membership. The larger number of 120 names has been drawn to reflect the realities that many members will simply decline to participate, are not in a condition to participate (selection bias issue), or may have moved or recently changed phone numbers, and are thus uncontactable.

The list of 120 patients is in turn being randomized and will be equally distributed between the two CHCN staff members principally conducting the interviews: Ms. Ramirez and Dr. Gupte. They will conduct outreach going from the top of their respective lists, stopping at the point at which they have both done their respective 20 interviews.

OUTREACH PROCESS: The process of conducting telephonic outreach to members selected for the interviews is detailed in a document attached to this protocol. An Excel spreadsheet, attached to this document, has been developed for tracking the outreach process.

INTERVIEW METHODOLOGY: Interviews are each intended to go for about two hours, using the interview guide attached to this protocol. Interviews are to be principally conducted in member homes, save in situations in which the member declines to be interviewed in their home environment, or there is an indication that the home environment will not be a safe one for the interviewers

To ensure a relaxed conversation and that interviewers can remain fully present in the conversation, we are hoping to have each interview be recorded either via dedicated recorder or through use of technology that fuses recording and note taking. Interviewers may revert to pure note taking in situations in which a member declines to be interviewed. As interviews will not be reproduced for public consumption, no release for recording should be necessary.

Interviews will loosely follow – based on how they choose to establish rapport with the member – the interview guide that is attached to this protocol. The interview guide is designed at a high level to tease out their stories in a way that will lend itself to discovering patterns and characteristics. At a high level, the areas to be examined are:

- Their life histories
- The stories of their lives today
- The stories of their health

Given the intended nature of the process, we will not using any formal assessments, such as the Patient Activation Measure, at this time.

In addition, interviewers will request at the end of the interview that they be allowed to photograph the member, and that they sign a release for the utilization of their photographs for internal purposes among CHCN and its member health centers. The photo release is attached to this document.

TIMELINE: Outreach is currently scheduled to begin the week of February 17, 2014. Both interviewers also have full-time operating responsibilities to other work and projects. It is therefore hoped that each interviewer can do three interviews a week, which would imply a seven-week schedule for the interviews, concluding on Friday, April 4.

LANGUAGE ISSUES: Dr. Gupte will conduct interviews solely in English, and will 'swap' Spanish-speaking members with Ms. Ramirez, who will conduct interviews in both English and Spanish. Asian Health Services has agreed to provide translation support for interviews with members who speak Cantonese, Mandarin, and Vietnamese.

COORDINATION WITH CHCN HEALTH CENTERS: Dr. Marshall on Friday, February 7, notified the medical directors of the eight CHCN health centers about the ethnographic research. In addition, she has also corresponded with Dr. Susan Huang, medical director of Asian Health Services, about support for Asian language speakers (see above).

CONSIDERATION: Members will be offered a $50 gift card for their participation in the interviews, which will be given to them upon successful completion of an interview.

RISK ASSESSMENT AND TRIAGE: Documents describing the process for risk assessment and escalation / triage of emergent safety and medical issues as appropriate are attached to this document.

INTERVIEWER SAFETY: The processes and procedures for ensuring interviewer safety are described in a document attached to this protocol.

DATA COLLECTION TOOLS AND REPOSITORIES: Interviewers will summarize findings and insights through a post interview questionnaire conducted in a Qualtrics survey.

CHCN Network

Default Question Block

The goal of the ethnographic research project is to understand the patterns and common risk factors that drive high utilization of healthcare services, with an emphasis on inpatient admissions and emergency department visits. These patterns will be used to inform development of personas for program design and initial population selection. Filling out the following should take no more than 90 minutes.

What is the anonymous ID for the patient?

What date was the interview conducted? mm/dd/yyyy

Based on the interview, would you classify the patient as which of the following?

- high risk, high utilization
- high risk, low utilization
- low risk, high utilization

Block 1

Please answer the following questions as best you can, drawing upon your notes, and noting key representative quotes:

Module 1: Childhood Origins

	Yes	No
Were they born in the US?	○	○
Did they grow up in poverty?	○	○
Did you get a sense that they experienced trauma in their lives from their family situation or because of some other factors?	○	○
Do they have work skills?	○	○

What was the highest level of education achieved?

- ○ None
- ○ Grade School
- ○ High School
- ○ College/Graduate School

Any other thoughts related to childhood/origins?

Block 2

Module 2: Key Impressions of Life Right Now

	Yes	No
Is the member homeless?	○	○

Is the member lonely?	○	○

Describe the factors in the member's life that might be influencing high utilization of health care.

Describe their living situation (condition of home/apartment) and neighborhood.

Does the member have transportation challenges and issues?

- ○ Yes, if so describe
- ○ No

Describe your sense of the member's social network and social connectedness.

Describe what the member eats and how he/she gets and prepares food.

Did you get a sense that the member was abusing substances?

- ◯ Yes, if so describe
- ◯ No

Describe how the member spends his/her time:

Do the member use technology?

- ◯ Yes, If so describe
- ◯ No

What can the member say about his/her life goals?

Block 3

Module 3: Key Impressions of their health and why or why not they use so much healthcare

Does the member feel healthy or unhealthy?

- ◯ Healthy
- ◯

Unhealthy, If so how long has member felt unhealthy?

What could the member tell you about his/her conditions?

Do the member have functional limitations that limit his/her ability to perform the activities of daily living?

- Yes, If yes describe
- No

What does the member know about how he/she might be able to better manage his/her condition?

Does the member have a lot of prescriptions?

- Yes
- No

Does the member take his/her prescriptions the way the doctor asks him/her to?

- Yes
- No

Did the member talk about feeling stressed?

- ◯ Yes, If so what drives this stress?
- ◯ No

Does the member frequent the emergency department?

- ◯ Yes, if so what drives ER use?
- ◯ No

Does the patient frequent the hospital?

- ◯ Yes, If so what drives hospital use?
- ◯ No

How does the patient feel about the health center he/she goes to?

Does the patient find it hard to get appointments?

- ◯ Yes
- ◯ No

How does the patient feel treated by the health care system?

What do they think the health care system and the government might do to help them be healthier?

Is the patient an imminent high risk? If yes, please fill out imminent high risk form.

- Yes
- No

Block 5

Environmental Health Assessment

Check all of the following

- Close to freeway, name:
- Close to bus stop
- Gate Community
- Apartment
- Shelter
- Hotel
- Single Family Dwelling
- In-law unit
- Lighting
- Sidewalks
- Parks
- Liquor Stores

- [ ] Convenience Stores
- [ ] Full service grocery
- [ ] Nearby Schools, Name:
- [ ] Visible threats
- [ ] Other

Would this member's health be at risk if a paid or natural support person did not show up to provide scheduled services?

- ( ) Yes
- ( ) No

Is this member at risk at home because of any of these conditions?

- [ ] Structural Damage
- [ ] Barriers to accessibility
- [ ] Electrical hazards
- [ ] Signs if careless smoking
- [ ] insects or pests
- [ ] poor lighting
- [ ] insufficient heat
- [ ] fire hazards
- [ ] tripping hazards
- [ ] unsanitary conditions

Comments on environmental conditions

Block 4

Module 4: Finally, sum it up. Name the top reasons in your mind why this person is a high utilizer or not a high utilizer of health care services.

California Improvement Network
Better Ideas for Care Delivery

CCI
CENTER FOR CARE INNOVATIONS

Lessons from Bay Area Complex Care Pioneers

Dave Moskowitz, MD, MAS
Hope Center, Alameda Health System

Anna Robert, RN, MSN, DrPH and Fern Ebeling, RN, BSN
San Francisco Department of Public Health

Jason Cunningham, DO
West County Health Centers

ALAMEDA
HEALTH SYSTEM

1411 East 31st Street
Oakland, CA 94602

Alameda Health System is the public hospital authority for Alameda County. It consists of four ambulatory clinics, Highland Hospital, John George Psychiatric Hospital, and Fairmont Rehabilitation Hospital. San Leandro and Alameda Hospital have recently been acquired by AHS. The ambulatory clinics are staffed with 45 provider FTEs and see approximately 320,000 visits per year. The patient population is 37% Latino, 36% African American, 16% white and 10% Asian.

The Hope Center is Alameda Health System's Ambulatory-ICU. It launched in January 2013. It is funded through the Delivery System Reform Incentive Program (DSRIP), a CMS sponsored program to improve the quality of care at public hospital systems in California.

The Hope Center targets high-cost high-risk patients assigned to AHS medical homes. Patients with three or more hospitalizations for chronic health conditions within the past 12 months are eligible. The program has enrolled 120 patients, with approximately half actively receiving care management. Staff case find at Highland Hospital using data from daily census reports and historical data on admissions. An in-depth intake assessment is performed in a home visit. This informs the development of individualized care plans addressing needs related to social stabilization, care coordination, self-management and behavioral health. The intensity of contact by the care management team is reassessed at weekly team rounds, and de-escalated as patients progress through their care plan.

The Hope Center is staffed by two RN care managers, an LCSW, a community health worker, a medical assistant, and a physician. A psychiatrist and pharmacist each provide consultation at 0.1 FTE. A 0.5FTE project assistant provides data support. The nurse care managers case find and oversee care plans. The LCSW conducts psychosocial assessments of all patients and ongoing counseling for patients as needed. The community health worker provides resource referral and linkages to address patient's health-related social needs. The medical assistant coordinates appointments and referrals, and assists patients in navigation. The physician provides primary care and oversees the team.

Our primary outcomes measures are admissions per patient per year and bed days per patient per year. Currently, we assess these at our affiliated hospitals but hope to examine cost of care and utilization across hospitals through partnerships with Medicaid MCOs.

Hope Center

- Launched January 2013
- Ambulatory-ICU model
- Patients engaged from inpatient at Highland
- 120 enrolled, about half active in case mgmt
- Team includes 2 RN case managers, LCSW, CHW, MA, PCP, as well as other supports
- Outcomes measures include annual admissions, bed days per year

Hope Center Resources

AGREEMENT BETWEEN HOPE CENTER AND PATIENT

The Hope Center agrees to:

- Support you in improving your health and feeling better
- Give you an alternative to the ER
- Coordinate your health care and assist you in navigating the system
- Meet you where you are at and understand your priorities
- Give you easy access to your care team

_____ agrees to:

- Participate in medical care and show commitment to improve your health
- Identify personal goals to improve your health
- Attend regular appointments with your primary care doctor and with other services
- Contact our clinic with medical concerns or questions, even after hours
- If you do need to go to the ER or hospital, go to Highland so we can easily communicate with staff taking care of you

Nurse Care Manager: _____ date: _____

Patient: _____ date: _____

UNENGAGED PATIENTS

Some patients do not have the motivation or engagement to adequately participate in our program. If patients repeatedly demonstrate that they are not engaged in our program, this might not be the right time for us to work with them.

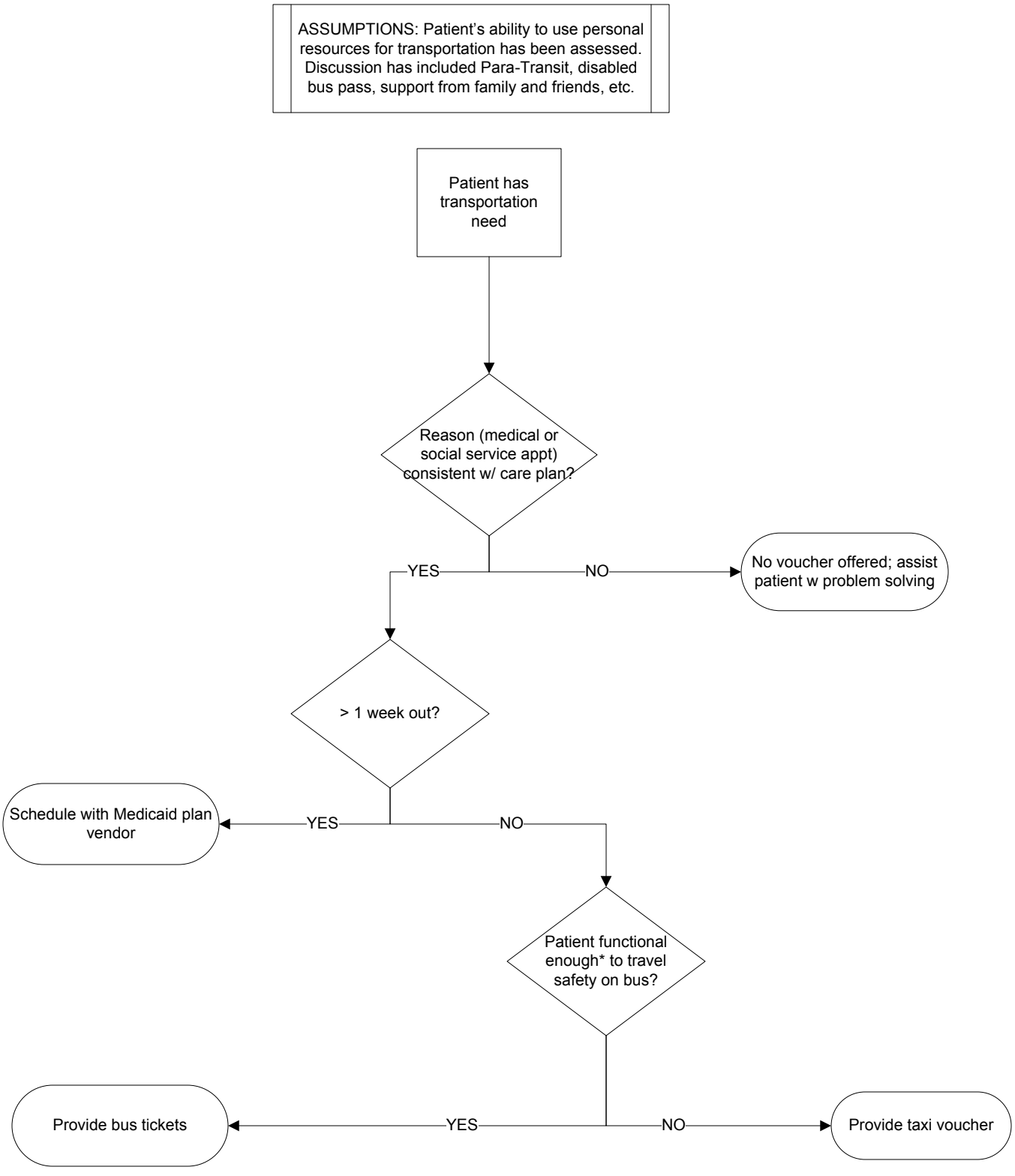
IF: A patient was enrolled/referred but has not responded to outreach (3 phone calls & 1 letter)
THEN: The team should no longer attempt to outreach to the patient. If the patient at a later point decides to reengage, then the team should put forth full effort to work with them.

IF: A patient has care plan in place but has stopped responding to outreach (3 phone calls & 1 letter, 1 attempted home visit)
THEN: The team should pause attempts to outreach to the patient, with the understanding that the patient may either be unengaged or be dealing with a crisis and reengage when it is resolved. If the patient at a later point decides to reengage, then the team should put forth full effort to work with them.

IF: A patient is in communication with the team but is not addressing significant health goals (e.g. care plan)
THEN:

1) The care manager & patient review care plan to assess what progress is being made
2) The care manager works with the patient to: develop a plan to address potential future set-backs, titrate the relationship
3) If the patient persists in not addressing significant health goals, Friday case conferencing focuses on the following questions for the care manager:
    - List all the things you've done for this patient.
    - Are you working harder than the patient?
    - Is this work appropriate for you?
    - Has the patient heard your message?
    - Does the patient think they are getting their needs met?
    - Have you done enough for this patient?
    - Are there other additional steps that can be taken?
4) After this discussion, if the team decides that there is nothing else additional they can do for the patient at this time, the team should no longer attempt to outreach to the patient. Tatient can always reach out to re-engage.

Hope Center Transportation Algorithm



* They have the cognitive ability, behavioral tolerance, and physical ability to navigate the bus system

Stabilization & Coordination Checklist

Days enrolled: ___

- Basic resources
  - ❑ Pt has secure housing
  - ❑ Pt has State ID, Social Security card, birth certificate
  - ❑ Pt has facilitated adequate food through food bank, grocery teaching, or otherwise
  - ❑ A plan is in place for pt when temporary food "runs out"

- Medication Management
  - ❑ Pt can pack medi-set OR this has been arranged through caregiver/community partner
  - ❑ Pt knows follow up/labs that must be done with high risk medications
  - ❑ Pt has a refill organization system

- Pt can negotiate agenda with provider
  - ❑ Pt pre-plans a list of questions for provider
  - ❑ Pt knows to get bloodwork done BEFORE provider visit
  - ❑ Pt can make arrangements necessary for appointment

- Pt can schedule transportation to/from medical events
  - ❑ Pt can call and schedule his/her own transportation
  - ❑ A plan is in place for when normal mode of transportation is not available

- Pt can schedule his/her own medical appointments
  - ❑ Pt has a list of phone numbers/providers for each specialty

- Pt calls our team when:
  - ❑ they have trouble navigating the system
  - ❑ they are thinking of going to the hospital
  - ❑ they are concerned about a health/social need
  - ❑ they have a medical appointment, so that we may accompany them

Ongoing counseling from LSCW needed?

- ❑ Yes
- ❑ No

Remaining barriers:

Disposition

Extended engagement

- ❑ Extended involvement, care management
- ❑ Extended involvement, primarily LCSW

Graduate stabilization & coordination phase

- ❑ Ongoing care management (disease management) by Hope Center
- ❑ Ongoing primary care only by Hope Center
- ❑ Hand off care management to other service
- ❑ Hand off to routine primary care

Note:

HOPE CENTER INTAKE ASSESSMENT WORKSHEET

Name:_____ MRN: _____DOB: _____

Interviewer: _____ Location: _____ Interview Date: _____

HARMS-8:

1. **Health Beliefs**: *Do both the patient and the provider have the same realistic assessment of the patient's health status?*

   In general, how would you rate your current health?
   ☐ Excellent ☐Very Good ☐Good ☐Fair ☐Poor

   For all, **"Why do you rate it that way?"**

2. **Health Knowledge**: *Does the patient really understand their medical regimen and its importance?*

   How many prescription medications are you currently taking every day?
   ☐ None (SKIP to question 3) ☐1-2 ☐3-4 ☐5 or more

   During the past WEEK, how often did you forget to take or decide not to take one or more of these medications?
   ☐ Never ☐Sometimes ☐Usually ☐Always

   How sure are you that you understand the purpose of each medication you are taking?
   ☐ Very Sure ☐ Somewhat Sure ☐ Not very sure

   Unless Never/ Very Sure: **"What is most difficult for you in taking your medications?"**

3. **Physical Functioning**: *Does the patient's functional limitations put them at risk in their current living situation?*

   Think about your usual daily activities, such as bathing, toileting, dressing, grooming, feeding, housework, family or leisure activities. Which of the following best describes your situation in the last MONTH:
   ☐ I have no problems with performing my usual activities.

☐ I have some problems with performing my usual activities without assistance.
☐ I am unable to perform my usual activities without assistance.

Unless no problems: **"Do you think you need help managing at home? If so, what kind?"**

4. **Problem Solving**: *Is the patient able to think through problems as they arise?*

In the last MONTH, how often did you have trouble with remembering or thinking clearly?

☐ Never ☐Sometimes ☐Usually ☐Always

Unless Never, **"What do you do when that happens?"**

5. **Social Support**: *Does the patient have critical supports in case problems arise and they need help?*

If you needed immediate help for a health problem, how many friends or relatives do you feel close to such that you could call on them for help?

☐ None ☐1 ☐2 ☐3 or more

a) Who are they?

b) How often do you communicate with them?

If none or unclear, **"Is there someone who might be willing to help if they were asked?"**

6. **Self Confidence**. *Is the patient comfortable managing their medical conditions?*

Think about your current medical conditions. How confident are you that you can manage these medical conditions day-to-day?

☐ Very confident ☐ Somewhat confident
☐ Not very confident ☐ I don't have any health problems

Unless Very confident: **"What is most challenging for you about your health?"**

7. **Resilience**: *How well is the patient actually managing without feeling overwhelmed?*

   If not known: During the past 6 months, how many times did you go to the emergency room?

   ☐ None (SKIP to question 8) ☐ 1 or more times

   If any ED use in last 6 months: Do you think it is likely you will need to go to the emergency room again in the next 6 months?

   ☐ Not likely ☐Somewhat likely ☐Very likely

   Unless Not likely, **"What do you think would help to keep you from needing to go to the emergency room?"**

8. **Stability**: How well is the patient actually managing without the need for hospital care?

   If not known: During the past 6 months, how many times did you stay in the hospital overnight as a patient?

   ☐ None (END) ☐ 1 or more times

   If any hospitalizations in last 6 months: **Do you think it is likely you will need to be hospitalized again in the next 6 months?**

   ☐ Not likely ☐Somewhat likely ☐Very likely

   Unless Not Likely: **"What do you think causes your condition to get so bad you need to be in the hospital?"**

Medication Reconciliation:

Use separate medication reconciliation worksheet

Substance Use:

When thinking about drug use, include illegal drug use and use prescription drug use other than prescribed.

1. Have you ever felt that you ought to cut down on your drinking or drug use?
   ☐ Yes ☐ No

2. Have people annoyed you by criticizing your drinking or drug use?

☐ Yes ☐ No

3. Have you ever felt bad or guilty about your drinking or drug use?
   ☐ Yes ☐ No

4. Have you ever had a drink or use drugs first thing in the morning to study your nerves or get rid of a hangover?
   ☐ Yes ☐ No

SCORE (# "yes"): _____

Social Needs Screener:

HOUSING

Where are you living right now?

☐ House/Apartment/Room
☐ With friend/relative
☐ Shelter/boarding home
☐ Streets/abandoned home
☐ Other: _____
☐ Prefer not to say

EMPLOYMENT/FINANCIAL

How do you make money? (Check All That Apply)

☐ Work, "on the books" (earned income)
☐ Work, "off the books" (under the table income)
☐ Supplemental Security Income (SSI)
☐ Social Security Disability Insurance (SSDI/SSA)
☐ SNAP/Food Stamps
☐ Unemployment (EDD)
☐ Plasma Center
State Disability Insurance (SDI)
☐ General Assistance
☐ CalWORKs
☐ Pension/Retirement
☐ Sex Work/Trade
☐ Drug Trade
☐ Recycling/Scrapping
☐ Panhandling
☐ Veteran's Administration (VA) Benefits
☐ No Income
☐ Other: _____

Are you having problems with health insurance – been cut off / it won't pay for something / not having it in the past year?

☐ Yes ☐ No

Do you have trouble affording food on a regular basis?

☐ Yes ☐ No ☐ Not Sure ☐ Prefer Not to Say

Notes:

TRANSPORTATION

How do you get around? (Check All That Apply)

☐ I drive a car.
☐ I walk, ride a bike, or ride a scooter.

☐ My friends or family drive me.
☐ I take public transportation.
☐ I cannot get around easily.
☐ Other: _____

How do you get to your medical appointments? (Check All That Apply)

☐ I drive a car.
☐ My friends or family drive me.
☐ I take public transportation.
☐ I walk, ride a bike, or ride a scooter.
☐ I cannot get to my medical appointments.
☐ Other: _____

Notes:

SUPPORT SERVICES

Are you receiving any of the following support services? (Check All That Apply)

☐ Visiting nurse
☐ Home health aid
☐ Speech therapy
☐ Physical therapy
☐ Occupational therapy
☐ Social worker
☐ Adult daycare
☐ Home delivered meals
☐ None of the above services
☐ Other: _____

If any of the above are checked, please list agency/provider for each:

Exit Questions:

Summarize conclusions from visit and next steps.

What are good times to reach you? (Note patients schedule including dialysis days/times)

What is the best way to reach you?

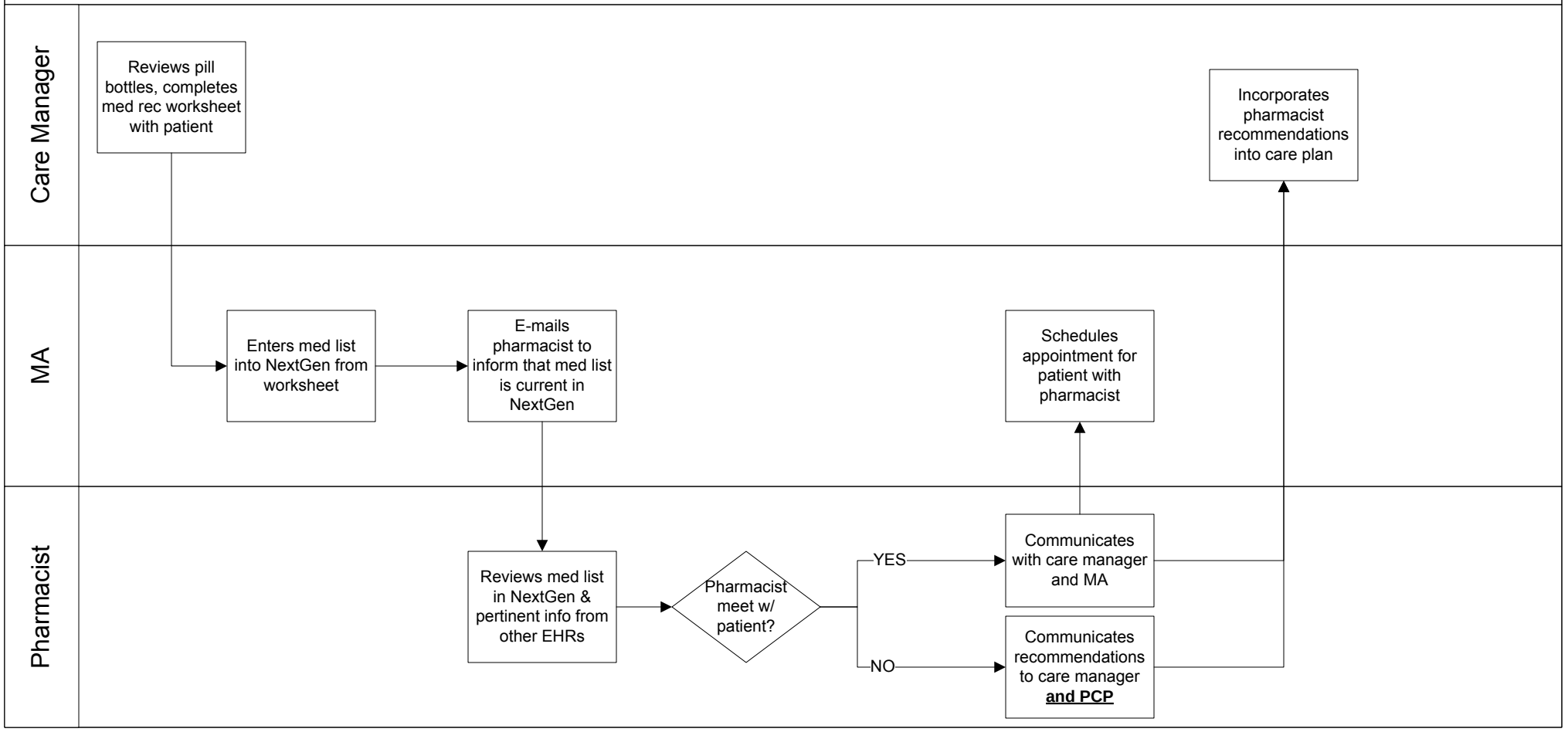
Checklist:

Patient has:

- ❑ **Received welcome packet & card**
- ❑ **Signed release of information forms**
- ❑ **Programmed Hope Center phone # in phone**
- ❑ **Activated voicemail on phone**
- ❑ **Primary care appointment scheduled**

Initial medication reconciliation (sub-process of Hope Center intake)

Updated 8/29/13



PURPOSE: To define processes for pharmacist involvement in initial medication reconciliation during the intake process
START DATE:7/16/13
RE-EVALUATE DATE: 8/20/13 Changes made: added notification of PCP that med list had been updated

Early Intervention Timeline

Timing	Who	What	Where	Decision point
Enrollment	RN & CHW	Approach eligible patient, hear their story, describe program	In hospital	N/A
Within 3 days of discharge	RN	Intake	Home visit	Care plan goals
Within 10 days of discharge[1]	MD & RN	PCP appointment	Clinic	Medical management & Rx/refer/test
Within 10 days of discharge[1]	LCSW	Behavioral health assessment	Clinic	Intensity of BH need & refer/provide counseling
Weekly for 30 days, then space to biweekly	CHW	Social Stabilization/Care Coordination activities	Home visit or in community	Needs/barriers that need escalation to RN or LCSW?
90 day intervals following enrollment	Team (RN leads)	Evaluation of patient progress	Rounds	De-escalate/graduate/adjust care plan?

[1] Scheduled for adjacent time slots if patient gets primary care in Hope

CHOW Role in Hope Center

Goals:

The CHW Provides:

- Client advocacy within and among multiple systems
- Assistance with complex problem solving related to living in poverty with multiple health issues
- Motivational Interviewing to resolve ambivalence about health-related behavior change
- Opportunities for patient to identify as something other than a "patient"
- Opportunities for patient to experience success and feel confident
- Role modeling advocacy and relational skills

Objectives:

Assist with system navigation/self-advocacy to ensure that:

- Pt can negotiate an agenda with the provider
- Pt can schedule transportation to/from medical events
- Pt can schedule his/her own medical appointments
- Pt calls our team when: they have trouble navigating the system or they are thinking of going to the hospital

Follow up on social service referrals to ensure that:

- Pt has secure housing
- Pt has State ID, Social Security card, birth certificate
- Pt has facilitated adequate food through food bank, grocery teaching, or otherwise
- A plan is in place for pt when temporary food "runs out"

Tactics:

- Meet with RN immediately after patient intake to discuss care plan & what parts the CHW will be responsible for
- Meet with patients weekly for first month they are enrolled, then can de-escalate to every other week after discussion with RN
- Document – briefly! – each encounter in Nextgen
- If facing barrier or have question about patient, alert RN or LCSW
- Close loop on all communications initiated by other team members by email or in person

Organization information

County system with 14 primary care FQHCs – 4 hospital-based, 10 community health centers
Providers: Approx 91 FTEs (MDs/NPs/PAs/Residents)
Patients in care: 70,000 patients
Patient demographics: 53% Female, 47% Male; Race: 32% Hispanic, 24% Asian, 20% White, 19% Black, 4% other; Median age: 45; Insurance status: 64% public insurance, 35% uninsured

Our complex care program

The first of three San Francisco Health Network Complex Care Management programs launched in a hospital-based primary care clinic in February 2012. The San Francisco Health Network has recently integrated these three programs to work under the same leadership, protocols, and data collection processes. The teams care for patients at 4 clinic locations, with plans to expand to a 5th clinic this year. The program model is primary-care-embedded.
Target population: Patients with three or more admissions in the last 12 months, who do not have other intensive case management.
Program Capacity/Goals: Active patients: 200-250; **Graduated patients:** 200-250 annually

Team members:

- Nurse Care Manager - 4 FTEs, +1 Vacant
- Health Coach (MEA or Health Worker) – 3 FTE, +2 Vacant
- Patient/family
- Social Worker (for consultation and small caseload) – 1.2 FTE
- Program Coordinator – 0.2 FTE (hope to increase to 1 FTE)
- PCP – as needed
- Nurse Manager – 1 FTE (vacant)
- Medical Director – 0.3 FTE

Data sources used to identify patients: Primary admitting hospital admission data; Provider referral; Referrals/data from our Medicaid managed care plan partner.

Key program evaluation outcomes measures:

- Hospital days pre- and post-enrollment
- Emergency Department visits pre and post enrollment
- Patient satisfaction
- Provider satisfaction

Lessons learned during program integration process:

- Select patient populations for whom you can demonstrate return on investment.
- Volume of target population within a clinic's overall population must be high.
- Active recruitment of patients is necessary.
- Engaged management teams are very important.
- There are advantages to co-location in a primary care clinic.

Funding: Budgeted SFHN program

San Francisco Health Network Resources

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Template Email:

Hi [provider name],

The [Clinic] Complex Care Management program is recruiting new patients. Our goal is to reduce admissions in [Clinic]'s highest risk patients by supporting them with an interdisciplinary team. To that end, we have identified the following patients of yours as people who might be good candidates for our program because they have had three or more admissions in the past year. Good candidates for our program are people who have chronic diseases and other comorbidities, who are at risk of future hospitalization, and who are not already in a case management program. If the patients below fit this description, please refer them. You are also welcome to refer other patients, but please limit your referrals to the highest risk 3% of your panel. Here are some questions that can help guide you:

Who is on a steady health decline trajectory?
Who, without more intensive assistance NOW, is going end up in the ED or the hospital?
Who keeps you up at night?

When you refer, please let us know your referral reason and goals. For more information about our program, please see our FAQs (attached and below). Julia Finch, program coordinator, will be managing complex care management referrals so please direct your responses to her. If this process generates a large wait list, we will prioritize patients with acute issues, such as hospitalization.

Thank you,

Team member	Roles
RN Care Manager	• Initial assessment and Care Plan • Complex clinical issues and medication issues • Clinical back-up for Health Coach
MEA/HW Health Coach	• Outreach to patients • Coaching toward care plan goals • Focus on self-management • Primary point of contact for patients
PCP	• Refer patients • Collaborate with CM team • Titrate medications, plan diagnostic work ups
Coordinator	• Manages referrals, data tracking, reporting
Social Worker	• Consultant to team about referrals (entitlements and community-based programs), mental health, and addiction • If >0.5FTE, case load with primary behavioral health issues
Nurse Manager	• Ensure CCM model is utilized by the teams • Track progress toward program goals • Day to day supervision
Medical Director	• Program development and evaluation • Clinical back-up to team • Lead quality improvement

Complex Care Management Program: Enrollment and Levels of Care

ASSESSMENT: The team RN or SW and health coach conduct a comprehensive assessment, usually in the home. From this information, they develop a care plan and assign the patient a level of care.

LEVELS OF CARE: The assigned level of care determines the intensity of our care management for each patient. Patients can move up and down the levels of care at any time depending on need.

CRITICAL	Intensive case mgmt in 1st and 2nd wk post-discharge.
LEVEL 1	> or = 1x/wk check-ins
LEVEL 2	Check-ins every 2 wks
LEVEL 3	Check-ins every 3 wks
LEVEL 4	Monthly check-ins
LEVEL 5	Pt calls team PRN
GRADUATE	Pt graduated from program

SF HEALTH NETWORK
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Care Management Health Coach Tasks

Daily

- Check voicemail
- Check LCR task list for admissions or discharges from SFGH
    - Update Access database accordingly
- Appointment reminders for the next day's appointments

Weekly

- Copy any new patient appointments from the LCR into the weekly planner
- Check each patient's visit history for ED visits
- Prepare and print documents for weekly team meeting (see directions below)
- Update the team calendar with any home visits or scheduled clinic visits
- Print and hang the weekly Clinic Provider schedule for reference

Monthly

- Add patient birthdays to the calendar from the "Birthdays this Month" report in the data tab of the Access database

Quarterly

- Make a back-up copy of the Access Database
- Update utilization data

Yearly

- Create annual report
- Schedule and plan team retreat

Continuous Projects

- Outreach to new patients
- Maintain database and waitlist
- Research and create patient education materials

Documents for Weekly Team Meetings

Dashboard

The Weekly Dashboard gives the team an overview of what is happening throughout the week. To start a new dashboard open the most recent dashboard and save it as a new week. Follow the steps below for each section to update the information:

A. *Activity Table*: Delete date in the 4 wks ago column and shift the remaining data to the left. To add in new data, open Access. In the "Data" tab, click the "Dashboard Activity Data" button to open the report. Add together the phone calls and use the other categories to fill out the consults and clinic visits boxes. Leave the hospitalization and home visit boxes blank for now.
B. *New Hospitalizations*: Use the LCR Tracking List to see how many enrolled patients have been admitted over the previous week. Check this with the "Patients in the Hospital" report in Access. Count up the number of enrolled patients who have been admitted over the last week. Place this number in the Activity table as well.
C. *Home Visits*: Look at the calendar and "Dashboard Activity Data" to see how many home visits there were. Place the correct number here and in the Activity Table.
D. *What's coming up?*: Keep this section updated with upcoming events, team members on vacation, etc.
E. *New Patients*: List the names and date of assessments of any patients enrolled in the previous two weeks.
F. *Who's in the hospital?:* List the names and dates of admissions for hospitalized patients. If a patient was discharged within the last week, write "DISCHARGED" in front of their name and add the date of discharge. If the patient is not at SFGH, note which hospital.
G. *Level breakdown*: In the Access database, go to the data tab and click "Number of Patients by Level" to get these numbers. When entered into excel, the Totals on the right will automatically update.
H. *Care Plan Review:* Choose two care plans of patients (either from rotating list or a team member request) and summarize the mail goals on this section of the dashboard. Print a copy of the complete care plan from LCR.
I. ***Don't forget -*** change the date of the week in the header!!

Active Patient List

For the team meetings, the active patient list organizes patients by acuity and allows the team to focus their attention on the highest acuity patients. On the Data tab in the database, click the "by Status" button under Active Patient Lists.

Care Plans

Print copies of each care plan under review from the LCR.

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Frequently Asked Questions

What is the goal of Complex Care Management?
The care management program aims to prevent hospitalizations and improve health in our highest risk patients.

How does Complex Care Management help my patient?
Your patient will have a comprehensive home visit assessment by [Name of RN/SW] and one of our health coaches [Name of Health Coach]. Then [RN/SW] and the health coach will develop a patient-centered care plan. They will communicate with you throughout this process to make sure that the care plan is on target. Patients will have regular contact with [RN/SW] and their health coach to monitor progress toward their care plan goals. Patients will also have direct access to their care managers when they have a question or concern. Through this structured support and coordination, patients will gain skills to improve their health and function while avoiding preventable ED visits and hospital admissions. The team assigns each patient to one of five levels of care. This level determines the intensity of care and the frequency of contact with the patient. As patients meet their goals and stabilize, they graduate to increasingly lower levels of intensity until they fully graduate from the program. If patients have deterioration in their clinical status, especially if admitted or seen in the ED, then they will be moved to the most intensive level of care until they are stabilized.

What do I tell my patient when I tell them about the program?
Explain that the Care Management program will pair an RN and Health Coach with your patient to try to help them improve their health. Once in the program, the RN and Health Coach will meet your patient at home **one** time to talk about their health concerns. If your patient does not want anyone to come to their home, that is okay, we could meet in clinic instead. The team will stay in touch with your patient to provide encouragement and support. Your patient will have access to the Care Management team directly by phone. Please mention that the referral process may take a few weeks.

Who should I refer?
The focus of the program is to reduce admissions, so please refer patients who are at risk of future hospitalizations. While usually these are people who have been hospitalized in the past, you could also refer a patient who is at risk of future hospitalization but who hasn't had been hospitalized very recently.

What will happen after I refer?
Our program coordinator [Julia] will confirm that she has received your referral. When we enroll your patient, the Care Management team will contact you by email to discuss your patient. From there, we will contact the patient directly to schedule a home visit. After the assessment, we will contact you to get your input on your patient's care plan. We will work with your patient to achieve the goals on the care plan. We will document our visits in eCW. We hope to graduate patients from the program after they meet the goals laid out in their care plan.

How do I decide whether to refer to you or ED Case Management? EDCM entry criteria is >5 ED admits in one year. They are a great resource for patients who are in the ED frequently, are homeless, are not connected to services, and would benefit from street outreach. Our program is less intensive than EDCM, and is better suited for patients who are complex, but are already connected to housing and don't need street outreach. If you are unsure about which program is better, refer to us and we will touch base with EDCM if we feel the patient would be more appropriate with them.

Additional questions? Contact Liz Davis at davise@medsfgh.ucsf.edu, Julia Finch at Julia.finch@sfdph.org, or Anna Robert at anna.robert@sfdph.org

Patient Admission

Complex Care Management Program
San Francisco Health Network

Pt Name: _____

MRN: _____

Date: _____

1. Reason for patient's admission:_____Date of Admission: _____

2. Location: _____ PCP: _____

3. Did you visit the patient in-house? ☐ Yes ☐ No

If no, why not? _____

If yes, names of Care Managers who visited pt: Fern Ebeling Julia Finch Lisa Tang

4. Is this an active patient? ☐ Yes ☐ No

Current CM level status prior to admission: _____

5. Do you plan to schedule a home visit post-discharge? ☐ Yes ☐ No ☐ Don't Know

Why or why not? _____

6. Pager number of medical team: _____

Names of medical team, if possible: _____

7. Were you able to talk to anyone caring for pt? (SW, med team, nurse, etc.) ☐ Yes ☐ No

Nurse: _____SW: _____ Other: _____

List names and relevant information:

- _____
- _____
- _____
- _____
- _____

8. Please note any important information from talking to the patient:

- _____
- _____
- _____
- _____
- _____
- _____

9. Does the patient have our contact information? ☐ Yes ☐ No

10. Did you email the medical team (cc PCP & Liz)? ☐ Yes ☐ No

Details: _____

Patient Admission

Complex Care Management Program
San Francisco Health Network

Pt Name: _____

MRN: _____

Date: _____

Post Discharge

1. Date of discharge: _____

2. Does patient have a follow-up GMC appt? ☐ Yes ☐ No

If yes, date: _____

If no, pls schedule appt and list date: _____

4. If patient needs a home visit, has this been scheduled? ☐ Yes ☐ No ☐ N/A

If yes, date: _____

5. Please contact patient and complete the following within 72 hours of discharge. Check off and date when the following have been completed:

☐ General check-in Date: _____

☐ Med Reconcilliation Date: _____

Notes:

West County Health Centers

- Western Sonoma County
- Non-profit FQHC with 7 clinic sites
- 13,000 patients
- Primary care, dental, mental health, wellness, teen, HIV
- Staff: 119 FTEs, 26 medical providers
- $1M+ uncompensated care, 2012
- 40% patients at or below FPL

West County Health Centers

Caring for our Communities

a california health+ center

Complex Care Management

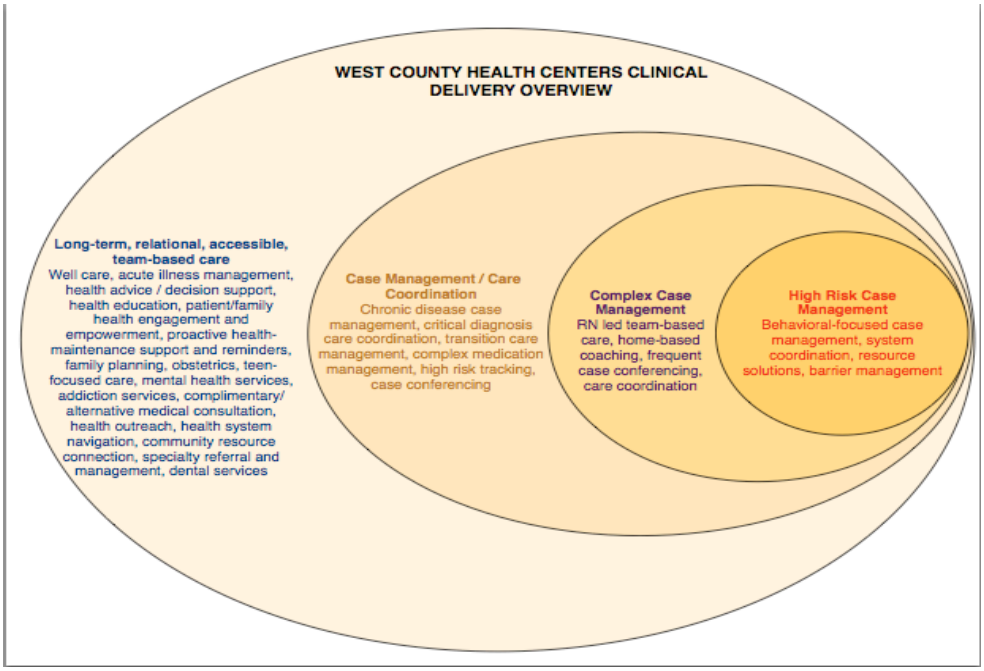
- Primary care-embedded, no separate enrollment
- Team: provider, MA, coordinator, RN case manager, behavioral health, patient navigator
- Patients: high utilization, high total cost of care
- 5 – 10 patients per team in complex care services
- Intake includes a home visit
- Care includes acuity score, reassessed monthly
- Case conferences are important part of team's work to support patients

West County Health Centers
Caring for our Communities
a california health+ center

West County Health Centers
Caring for our Communities
a californiahealthcenter

West County Health Centers Complex/High Risk Care Management

In anticipation of a health system transition toward a value-based reimbursement model, West County Health Centers has strategically moved toward a care delivery model that focuses on relational, continuous, accessible, team-based care. The approach provides both diagnosis and treatment across the spectrum of disease acuity and additionally offers proactive preventative care, self-management support, care coordination, chronic disease case management and focused behavioral modification support for complex outliers.



The Care Team Model

We hold strong to the principle that a trusting, long-term, continuous relationship with our patients is our most important product and the most valuable tool to engage patients in behavior change. Trust is established over time and often during times of increased health needs. We have all of our care delivery occur within the context of the Care Team - including care management. Patients are not enrolled or dis-enrolled in a program - the care team simply provides different levels of care for patients at different levels of health needs.

Care Team:

- Medical Provider, Medical Assistant, Front Office Coordinator, RN Case Manager, Behavioral Health/Mental Health, Patient Navigator
- Ratio to Provider - MA (1.5:1), FO (1.5:1), RN (1:1). Behavioral Health/Mental Health, Navigator shared across the site.

Patient Selection

- Lists of patients with high utilization or high annual total cost of care are provided to Care Teams to choose patients that may be appropriate for Complex Care Management. Lists are obtained from our managed MediCal health plan (Partnership Health Plan) and CMS. Current patients have a high mental health, addiction, chronic pain prevalence.
- Teams manage 5-10 patients at a time.

Intake

- Home visit with comprehensive intake questionnaire, SF12, PHQ9, Patient Activation Measure, Hope Spiritual Assessment, Patient identified goal for focus, caregiver input.

Case Conference

- 1 1/2 hour case conference designed to identify areas of focus and facilitated using brainstorming techniques learned from an innovation firm. Designed to lead the team toward a patient-focused "outside-the-box" approach to care.
- Participants - entire care team, relevant care providers (ER staff, county mental health, law enforcement, specialists, other).
- Care plan created from this conference identifying 1-3 areas of focus for "nudging" patents toward improved health and improved care utilization.

"Interventions"

- Motivational interviewing, care coordination, addiction management, trust building, self-management support, mental health support, frequent touches, access support, other.

Ongoing Management

- Regular care team check-ins. q 6 month: 1/2 hour case conference, repeat SF12, PHQ9, PAM
- Patients are assigned an "acuity score" based on amount of work or contacts required for care. Acuity score is reassessed monthly and reviewed with care team and site management to assess ability to take on new patients in this type of care.

West County Health Centers

- Federally Qualified Health Center - Primary care: Sebastopol, Occidental, Guerneville CA. Dental (Guerneville) Teen clinic (Forestville), Wellness Center (Forestville), Day Labor Outreach (Graton)
- Patients: 12,990, 85% under 200% Poverty (2013)
- Budget: $12.2 million. 70% patient fees, 30% grants, contracts, fundraisers. (2013)
- Staff: 145 employees, 119 FTE. 26 medical providers, 2 dentists, 7 mental health counselors, 3 Behavioral Health Specialists, 2 Patient Navigators, 0.6 FTE psychiatrist (2013)

West County Health Centers Resources

West County Health Centers

Caring for our Communities

a california health+ center

Appendix C: Acuity Scale

Partnership Health Plan of California Intensity Scale

ACUITY	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
PATIENT CONDITION	Independently accessing services, highest level of self management	Increasing Independence, high level of self mgmt	Dependent but Stabilizing medical and psychosocial needs	Dependent/ High Risk for ER/Hospitalization	Dependent/Critical Complex Conditions
FREQUENCY OF CONTACT	**1 Phone call q 2 months** case remains open to RN Case Manager, telephonic contact completed by Guide/Navigator	1 phone call q month	Call Weekly Visit Monthly	Call Weekly Visit q 1-2 weeks	Call Daily Visit Weekly or more
ACUITY SCORE	0.05	0.1	1	1.5	3

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) NO supervision, direction or personal assistance	**Dependence** (0 Points) WITH supervision, direction, personal assistance or total care
BATHING Points: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	(0 POINTS)Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

Total Points: _____

Score of 6 = High, Patient is independent.
Score of 0 = Low, patient is very dependent.

**Slightly adapted. Katz S., Down, TD, Cash, HR, et al. (1970) progress in the development of the index of ADL. *Gerontologist* 10:20-30.

West County Health Centers
Caring for our Communities

Hospital Transition Intake

Patient:_____DOB_____

Intake RN Care Manager:_____ **Date:_____**

PAM Survey Completed:_____

MEDICATION:

DISCHARGE MEDICATION RECONCILIATION:

O Medications reconciled without changes O New medications identified

O Discontinued medications identified O Discontinued medications properly disposed

NEW MEDS	*DISCONTINUED MEDS*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATION EDUCATION

O Patient able to list new medications O understands reason for medication and potential side effects

O education given about new medications O questions answered about medication

O further education needed

MEDICATION MANAGEMENT:

O No assistance needed for medication management O Mediset started for medication management

O Medication list provided O Dosing chart provided O Alarm reminder set up and demonstrated

O Further education needed

MEDICATION REFILLS:

O No refills needed at this time O Medications refilled O Barriers present to ongoing refills

PERSONAL HEALTH RECORD:

PHR UPDATED:

O Medication list updated O Allergies updated O Medication problem list updated

O Surgical History updated O Social History updated O Vaccinations updated

O Family Medical History updated

Notes:

_____

_____

_____

EDUCATION:

O Education given about the importance of the PHR O Encouragement given about bringing the PHR to future visits

WEB PORTAL:

O Patient expressed interest in web portal O Family members or care giver interested in web portal
O Patient signed up for the web portal O More education needed

MEDICAL CARE:

FOLLOW UP:

O Follow up visit established with PCP O Follow up visit established with specialist O Follow up visit established with OT O Follow up visit established with home health O Follow up visit established with Mental Health

O Barrier to care identified

LAB:

O Follow up lab needed O No labs needed O Barrier to care identified

DIAGNOSTIC IMAGING:

O Pending DI needed and appointment made O No DI needed O Barrier to care identified

PROCEDURE:

O Medical procedure needed and appointment made O No procedure indicated O Barrier to care identified

EDUCATION:

O Role play provided for appointment scheduling O Role play provided for medical encounter

O Questions developed for PCP or specialist O Agenda setting explained O Further education needed

RISK REDUCTION:

DISCHARGE INSTRUCTIONS:

O Discharge instructions reviewed O Patient unclear of instruction

O Patient not given instructions prior to discharge

SELF MANAGEMENT

O Self-management discussed O Areas of poor self-management identified

O Further self-management support needed O Support needed for care giver

RED FLAGS:

O Potential medication adverse events discussed O Symptoms of worsening disease reviewed O Intervention plan discussed for adverse events or worsening disease O Discussed when PCP or Care Team should be notified

SYMPTOM MANAGEMENT:

O Pain management plan established O Bowel care regimen discussed

RISK FACTORS:

O Fall risk elevated-education given and plan established O Mental Health risk identified-education and plan established O Sedation risk-education given and plan established

REFERRAL/OTHER:

DURABLE MEDICAL EQUIPMENT

O Order submitted for adaptive device O Order submitted for bedside commode O Order submitted for catheter supplies O Order submitted for hospital bed O Order submitted for ostomy supplies

O Order submitted for shower bench/chair O Order submitted for walker O Order submitted for wheelchair

O Order submitted for wound care supplies O No DME needed

COMMUNITY RESOURCES:

O Referral made for aging services O Rererral made for Hospice services O Referral made for IHSS

O Referral made for spiritual support/resources O Referral made for transportation services O No Referral needed

HOME HEALTH:

O Referral made for home nursing evaluation O Referral made for home PT

O Referral made for home OT evaluation O Referral made for frail elderly program O No Referral made

Home Visit Log

Date	CCM	Transition	Nurse /cell phone	Pt name and address	Time out	Time in

Home Visit Log

West County Health Centers
Caring for our Communities

CCM Intake

Date: _____
RN: _____
Pt Name:_____
Pt DOB:_____

MEDICAL

O Overwhelmed by disease O Affected by co-morbid medical conditions
O Needs help with managing medical conditions
Notes:_____
_____

MEDICAL LITERACY

O Not well versed or doesn't recall much info previously given
O Has adequate understanding of disease process O Feels comfortable with knowledge of disease
O New diagnosis - needs lots of education O Has interest in alternative therapies
O Has some basic understanding. Needs more education O Not much understanding of disease process
O Interested in more education O Able to fill out medical forms and applications O Not discussed
Notes:_____
_____

MEDICATION

O Complex medical regimen O Confused about medication O Frequently misses doses
O Takes medications other than prescribed O Has help organizing medications O Would like help organizing medication O Would like education about medication O Would use mail order pharmacy
O Difficulty getting to the pharmacy O Financial barrier to medication compliance
O Meds not matching diet / lifestyle patterns O Takes meds regularly O Starting meds today
Notes:_____
_____

CONNECTION TO HEALTH TEAM

O Appropriate connection with the health system O Doesn't feel comfortable with or trust current medical care
O Feels supported by medical provider/team O Communicates effectively with medical provider/team
O Difficulty with communication with medical team O Doesn't always respond to health center phone calls
O Appropriate in communication but doesn't always follow-through on recommendations O not discussed
Notes:_____
_____

TRANSPORTATION

O unable to secure reliable transportation O has reliable transportation O has own car
O uses public transportation O would like assistance with transportation
O lives more than 20 miles from health center O not discussed
Notes:_____
_____

HOSPITALIZATION

O Recent hospitalization O Frequent hospitalization O Not discussed

Notes:_____

_____

SPECIALTY CARE

O No specialty care O Specialty care coordination needed O Unaware of specialists

O Concerned about connection to specialty care O Barriers to access of specialty care O Not discussed

Notes:_____

_____

INSURANCE

O CMSP O Partnership MediCal O Medi-Medi O Medicare O private insurance

O concern with current insurance O needs assistance with insurance O un-insured O unstable insurance

O Application for insurance pending O Not discussed

Notes:_____

_____

SOCIAL SUPPORT

O Friends O Partner/spouse O Family O Limited personal support O Organizational support

O Religious community O Doesn't reach out for support when depressed O Social support system lacking

O Not discussed

Notes:_____

_____

HOUSING

O Stable housing O Non-permanently housed O Unstable housing O Institutionalized

O not discussed

Notes:_____

_____

INCOME

O employed O temporary employment O day labor O unemployed O unemployment insurance

O on SSI O on SSDI O on general assistance O family member unemployed O Not discussed

Notes:_____

_____

ACTIVITIES OF DAILY LIVING

O Able to complete needed ADLs O Concern with fine motor skills O Concern with gross motor skills

O Concern with dressing skills O Concern with eating skills O Concern with cognitive tasks

O Concern with receptive language O Concern with time and orientation O Concern with money related skills

O Concern with instrumental activities O Concern with social interaction O not discussed

Notes:_____

_____

NUTRITION

O Does not have concerns about food security O Is concerned about food security O Would benefit from nutritional consult O Interested in referral to FWC O Would benefit from meal service

O Unclear of connection of nutrition and disease O Nutrition is an important barrier to health

O Meal planning education needed O Barrier to nutrition identified O Care giver education needed

O Not discussed

Notes:_____

_____

LEGAL

O No concerns with legal issues O Recent legal concerns O Undocumented O Court appearance pending

O Recent incarceration O Has probation officer O Not discussed

Notes:_____

_____

LANGUAGE

O No language barriers or concerns O Language barriers or concerns present O Spanish speaking only

O Speaks both English and Spanish well O Will need translator for visits O Not discussed

Notes:_____

_____

EDUCATION/LITERACY

O No literacy issues identified O Literacy issues identified O Communication barriers identified O Requires help completing forms O completed: grade school O high school O GED O college O Not discussed

Notes:_____

_____

DENTAL CARE

O Dental concerns identified O Has a dental provider O Does not have a current dental provider

O Does not have dental insurance O Has dental insurance O last dental exam was > 1yr ago

O last dental exam was < 1 yr ago O Not discussed

Notes:_____

_____

COMMUNITY RESOURCES

O Need appropriate list here

Notes:_____

_____

SOCIAL HISTORY (enter into eCW Social History):

Smoking history: _____

Alcohol use: _____

Drug use: _____

H.O.P.E. Spiritual Assessment

Sources of **H**ope, meaning, comfort, strength, peace, love:

O What are your sources of hope, meaning, strength, comfort and peace?

_____

O What sustains you and keeps you going?

_____

O What do you hold on to during difficult times?

_____

O What is there in your life that gives you internal support?

_____

Organized religion

O Are you part of a religious or spiritual community? Does it help you? How?

_____

O What aspects of your religion are helpful and not so helpful to you?

_____

O Do you consider yourself part of and organized religion? How important is this for you?

_____

Personal spirituality practices

O What aspects of your spirituality or spiritual practices do you find most helpful to you personally?

_____

O Do you believe in God? What kind of relationship do you have with God?

_____

O Do you have personal spiritual beliefs that are independent of organized religion?

_____

Affects on medical care and **E**nd-of-life issues

O Are there any specific practices or restrictions we should now about in providing your medical care?

_____

O Would it be helpful for you to speak with a clinical chaplain/community spiritual leader?

_____

O Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?

_____

O Has being sick affected your ability to do the things that usually help you spiritually (or affected your relationship with God)?

_____

O As your medical team is there anything that we can do to help you access the resources that usually help you?

_____

PATIENT GOALS (Top Two things patient wishes to focus on)

1, _____

2. _____

3. _____

THOUGHTS ABOUT CHOOSING YOUR CCM PATIENTS

- This is an opportunity to approach the care of these patients differently.
    - Consider choosing patients who are failing in our current system. The patients who are "non-compliant", frequent no-shows, difficult to reach, "resistant to care" may actually be great candidates for this type of care.
- Changing the cost curve for these patients is one of the main goals of this intervention. Look at total cost and utilization data and consider choosing patients who have high costs that are modifiable.
    - Examples of non-modifiable costs - needed medication, dialysis, recent transplant, high cost admission that is not likely to recur.
    - Examples of modifiable costs – frequent admissions, frequent ER visits, complex care coordination, high cost but modifiable medications.
    - Focus on hospitalizations – this is typically the most significant variable in high total cost of care.
- You should consider continuing to manage those patients who are on your 2012-2013 CCM patient list if they would still benefit from this type of care. You have done extensive work and relationship building – keep it going.
- You may consider adding patients who are not on either the 2012-2013 CCM Patient list or the new list from PHP - but since cost is the main outcome for this study – consider choosing from the high cost list.

Chart Review for Home Visit Safety

WHO: RN will screen chart of patient for safety assessment

WHEN: Before scheduling a home visit for any patient

WHAT: A "red flag" search of the chart for history of illegal drug use/activities, history of incarceration, domestic violence, presence of a Behavior Contract on file, serious mental health diagnoses, e.g. schizophrenia, out of control bipolar, unstable psychosis, etc.

This can be done by scanning:

*problem list

* social history

*"sticky notes" (at the top of a progress note screen)

* billing alerts

The RN will review with the provider to decide the suitability for a home visit, considering safety issues to make a final decision and plan.

Documentation of home visit suitability:

When the care team decides to either not do a home visit, to do a modified (two person) home visit, or visit at a neutral location outside of the home and office, The CTRN will date and note the detailed decision in the Billing Alerts (No home visit, Modified home visit, two person, neutral location, etc).

Date of chart review:_____

Patient Name:_____DOB_____

RN:_____

RN CCM To-Do Checklist

☐ **BEFORE INTAKE:**
- Warm hand-off by provider or outreach by nurse to pitch higher level of coordinated care service
- RN Intake scheduled and TE sent to your front office manager (Minda for RRHC, Marlo for SCHC and Shannon for OAHC) with information about who you want invited to the case conference. Please include dates that do not work and whether MH or BH/Navigator needs to be included.
- Continuing pts do not need a new intake but they do need new surveys

☐ **DURING INTAKE:**
- Intake on paper or in 'RN-Complex Case Management Intake' template
- SF12, PAM , PHQ9 and acuity score

☐ **AFTER INTAKE:**
- Complete SF12 scoring on amihealthy.com
- Complete PAM score on PAM spread sheet in RN docshare
- Complete PHQ9 Depression screening score
- Dummy lab orders for PAM, PHQ9 Depression Screen and SF12 created and scores entered
- All forms scanned into pt's eCW chart in CCM/Transition section
- Document miles on mileage log and submit to RN Supervisor monthly

☐ **CASE CONFERENCE:**
- Write four to five sentences summarizing patient and email it to CCM facilitator (Minda, Shannon and Diana H) prior to the case conference
- Present case based on intake and surveys to everyone at the beginning of the case conference

AFTER CASE CONFERENCE AND ONGOING:

☐ Action plan that resulted from the case conference started. Each new action can be documented in a TE.

☐ Referrals to AC/MH/BH/ Navigator and/or outside resources for ongoing support completed.

☐ RN met with patient either in office or in home for "PAM Coaching for Activation" self management action plan. Ongoing communication with pt determined by acuity score, PAM level and agreement with patient.

☐ By the 25th of each month, enter acuity score in excel spreadsheet labeled 'WCHC CCM final list 2014' on the acuity score tab. This document can be found in DocShare→RN protocols→Partnership High Risk CM. A reminder should be on your Outlook Calendar.

☐ Six months from date of case conference and then again six months later:
- Update PAM, SF12 and PHQ9
- Complete SF12 scoring on amihealthy.com
- Create dummy labs for the three surveys and enter scores

- Have the surveys scanned
- Enter scores into the 'WCHC CCM final list 2014' excel spreadsheet
- Case conferences

*You may want to put a note for yourself on your Outlook Calendar 6 months from the date of the case conference and then 12 months from the date of the case conference as a reminder to do the above steps.

☐ Transition Care on CCM patients. Documentation needs to be completed in the Transition Care Template. Be sure to document how the hospitalization could have been prevented. Each transiton care should include a Transition Care Risk Score.

☐ Disenrollment – Document in excel spreadsheet, 'WCHC CCM final list 2014' on disenrollment tab

West County Health Centers, Inc.
Clinical Protocol

Clinical Protocol:	Application for funds for CCM patient	Category:
Staff Role:	Nursing	Page: 1 of 1

Protocol Summary: Protocol for application and distribution of funds for use within the Complex Care Management program to facilitate reduction in significant barrier to care or assistance with a specific self-management goal.

- RN Care Manager completes the "Application for funds" which includes:
  - Name of the patient
  - Reason for the funds
  - Amount of the request
  - And category of the request (assistance with significant barrier, assistance with self-management goal, or other)
- RN Supervisor reviews the request and approves or denies the funds
- Approved funds are to be distributed to the patient using cash from the site's "Resource Fund." The staff member distributing the funds and the patient sign for the receipt of funds.
- The original application is attached to the CCM disbursement log at the Site Level, and is treated in the same way as the hardship fund,
- When the fund needs to be replenished, a copy of the log and supporting "Application of Funds" is to be sent to the Finance Department and the fund will be restored.
- A budget recording of the sites available fund and distribution history will be kept by the Finance Department.
- A site budget total of $30 per CCM patient per year is available for use. The amount for each patient use is determined by the need of the patient and can exceed $30 per occurrence. The total budget for all of the patients is managed at the site level.

General note: This money should be used to empower patients in their own self-management, assist with reducing a barrier that is a single event or for which specific assistance with allow for a sustainable solution. Every effort should be made to assist the patient in creating his or her own solution to a particular barrier or self-management goal. This money should not be used to assist with a recurring financial problem or barrier.

Effective Date: 5/15/2013	Revision Date:
Supervisor Approval: *Initial*	Medical Director Approval: __JLC 5/2013 *Initial*

CareOregon

Case Presentation Form for the Huddle

Presenter

Client: Age, Gender

Health Markers

Social Determinants of Health and Co-morbidity (substance abuse/dependence issues, Mental Health concerns, cognitive abilities, family system, environmental factors)

Risk/safety issues

Natural Supports

Clients' strengths

What drives utilization? Why do they go to hospitals?

What other agencies/systems are involved?

What is the identified concern?

What Interventions have been attempted?

What are the barriers to successful resolution?

Other pertinent information

What questions do you have for the group?

Ideas for the goals and successful interventions. Next steps?

Follow up with the group in 2 weeks.

CareOregon

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Other pertinent information

What questions do you have for the group?

Ideas for the goals and successful interventions. Next steps?

Follow up with the group in 2 weeks.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005 Source: http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005 Source: http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf