Enhancing Complex Care Beyond the Walls of a Clinical Setting Series:

Approaches to Extending Complex Care Models into the Community: Emerging Evidence

August 16, 2018, 12:30-2:00 pm ET

Made possible with support from the Robert Wood Johnson Foundation
To submit a question online, please click the Q&A icon located at the bottom of the screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Agenda

- Welcome and Introductions
- Strategies for Supporting Outreach Workers for Complex Populations
- Q&A
- Building the Business Case for Community-Based Complex Care Interventions
- Q&A
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Multi-site demonstration aimed at **refining and spreading effective care models** that address the complex health and social needs of high-need, high-cost patients

Made possible with support from the Robert Wood Johnson Foundation
Meet Today’s Presenters

Caitlin Thomas-Henkel, Senior Program Officer, Center for Health Care Strategies

Kim Lewis, Program and Community Outreach Coordinator, VCU Health

Derek DeLia, PhD, Director of Health Economics and Health Systems Research, MedStar Health Research Institute

Sandi Groenewold, MD, Expanded Care Team Physician Lead, ThedaCare Health System

Laurie Moore, Project Coordinator, ThedaCare Health System
Strategies for Supporting Outreach Workers for Complex Populations
VCUHS Complex Care Clinic
Take CCARE
(Complex Care Assisting and Reviewing Education)
Beyond the Clinic Walls
VCC Complex Care Clinic

- Model designed to enhance management of patients with five or more chronic conditions.
- Focused on the population with the highest cost and utilization.
- Goal: Achieve the Triple Aim:

- **Better Care:** Decrease readmission rate, inpatient and ED utilization
- **Better Health:** Improve clinical outcomes:
  - HgbA1c
  - Hypertension
  - Cholesterol, BMI
- **Lower Cost:** Reduce total cost of care
VCUHS Complex Care Program Principles

• Coordination across the care continuum
• Access to medication management
• Access to behavioral health services
• Coordination of post-hospital and longitudinal care
• Leverages information technology
• PCMH certification for primary care practices
• Uses data to measures and improves performance
• Develops interventions to address social determinants of health
Complex Care Clinic
Supported by an Interdisciplinary team

Physicians
Nurse Practitioner
Social Worker
Clinical Psychology Fellow
Pharmacist
Clinical Nurse
RN Case Manager
Medical Outreach Worker
Community Health Workers
Community Health Workers

- 2-FTE CHW’s
- VCU Graduates- B.S. Health Sciences
- Certified- State of Virginia

Examples of Required Competencies

- Identifies problems and resources to help patients solve problems with the goal of teaching the patient/family/others how to navigate the health care system independently.

- Works with enrollees to empower them to become an active participant in their health care.

- Utilizes reports including hospital activity and patient engagement to contact and/or visit patients directly to discuss program access, prevention services, and utilization of services.
CHW Engagement Process

- Each day, the team receives reports outlining patients who have arrived at and are discharged from the hospital for in-patient, observational stays and emergency department services. These reports are used by the team to identify patients that may be appropriate for the CHW TakeCCARE Program.

- CHWs engage at the bedside during the hospital encounter to introduce themselves and to schedule a home visit within two business days post discharge to reinforce medical care plans, address social needs and to identify barriers to care.

- After the initial home visit, they call the patient daily for one week (reporting back to the team during the morning huddle).

- With team approval, they perform weekly visits for six weeks up to 12 weeks or until the patient is able to self-manage.

- Patient is transitioned back to the complex care outreach worker.
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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. In the last month, did you ever eat less than you felt you should because there wasn't enough money for food?</td>
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<tr>
<td>1a. Would you like to receive assistance with this need?</td>
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<tr>
<td>1b. Is this need urgent?</td>
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<td>2. In the last month, has your utility company shut off your service for not paying your bills?</td>
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<tr>
<td>2a. Would you like to receive assistance with this need?</td>
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<tr>
<td>2b. Is this need urgent?</td>
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<tr>
<td>3. Are you worried that in the next month, you may not have stable housing?</td>
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</tr>
<tr>
<td>3a. Would you like to receive assistance with this need?</td>
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</table>
Reflection Logs-

**What:** Brief voice recordings used to monitor the outreach workers’ weekly patient interactions, experiences, and needs.

**When:** At the end of each week. Five to eight minute recordings done by each CHW.

**Why:** To capture the weeks experiences and learnings and to help manage employee burnout and stress.

**How:** Uses the voice recorder app on the CHW’s cellphone—saved to shared folder on office computers.

What worked well this week?

What didn’t work well this week?

Did you have any challenges with your technology?

Do you need any additional supplies or equipment?
Reflection Logs: The Evolution

What would you consider a particular success this week?

Was there a particular situation this week that required more of your time than you expected? If so, what was it and what was the outcome?

Did anything happen this week that made you feel especially stressed or frustrated with your work?

Did anything happen this week that left you feeling especially proud or enthusiastic about your work?
In Her Own Words….  

**Briana**

Did anything happen this week that left you feeling especially proud or enthusiastic about your work?

“I was most proud of the fact that the patient listened to me! When I saw that he didn’t look good and didn’t seem like he was feeling well, I called our nurse. She said to tell him to go to the ED and he listened to me. I found out later that while he wasn’t admitted, his blood sugar had been elevated—I’m glad he listened, they don’t always.”
## CHW Productivity

<table>
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<tr>
<th>Task(s)</th>
<th>Hours</th>
<th>Weeks</th>
<th>Hours/Week</th>
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<tr>
<td>Care Coordination, Navigation, Advocacy</td>
<td>28</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Inreach/Outreach</td>
<td>58</td>
<td>4</td>
<td>15</td>
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<tr>
<td>Patient Education</td>
<td>17</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Patient Case Management</td>
<td>33</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Development, Team-Building, and Collaboration</td>
<td>16</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>PTO</td>
<td>8</td>
<td>4</td>
<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td>160</td>
<td>4</td>
<td><strong>40</strong></td>
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### Pie Chart - CHW Productivity

- **Care Coordination, Navigation, Advocacy:** 36% (17% of total hours)
- **Inreach/Outreach:** 21% (10% of total hours)
- **Patient Education:** 11% (6% of total hours)
- **Patient Case Management:** 10% (5% of total hours)
- **PTO:** 5% (3% of total hours)
- **Development, Team-Building, and Collaboration:** 10% (5% of total hours)

*VCU Health*
CHW Support

- Teambuilding with other outreach workers
- Educational opportunities at the individual and organizational level
- Staff recognition
- One-on-one discussions
- Reflection follow-up and coaching
- Special projects
Preliminary Evaluation Findings for VCU Health System

Derek DeLia, PhD
Director of Health Economics and Health Systems Research
V CUHS

• Preliminary quantitative evaluation
  – Available data from VCU records
  – Enrollment period: Aug 2016 - Jul 2017
  – Comparison group: Historical, Aug 2015 - Jul 2016
  – Observation: 6 months pre/post enrollment, baseline & 3-month social determinant measures

• Brief highlights from qualitative evaluation
  – In-person interviews conducted in June 2017
  – Recorded, transcribed, & analyzed independently by two evaluators
VCUHS – Patient Characteristics

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<tr>
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<th>Gender</th>
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<thead>
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<th>%</th>
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<td>24</td>
<td>Medicare</td>
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<tr>
<td>20</td>
<td>Dual Eligible</td>
</tr>
<tr>
<td>19</td>
<td>Uninsured</td>
</tr>
</tbody>
</table>

- 59 patients from August 2016-July 2017
Changes in Hospital Use at VCUHS

Intervention N=39
Comparison N=207

**ED visits per person**

- **Intervention:** 1.2
- **Comparison:** 0.8

**Admissions per person**

- **Intervention:** 2.2
- **Comparison:** 1.5

6 months before vs. 6 months after.
## Patient Activation and Social Service Needs: Intervention Patients at VCUHS

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<tr>
<th></th>
<th>At enrollment</th>
<th>At exit (3 months)</th>
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<tbody>
<tr>
<td><strong>PAM score</strong></td>
<td>54.2</td>
<td>62.1</td>
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<tr>
<td><strong>N=25 patients at both time points.</strong></td>
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<tr>
<td><strong>PAM</strong>: Patient activation measure.</td>
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<tr>
<td><strong>Food insecurity</strong></td>
<td>25%</td>
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<td><strong>Utility needs</strong></td>
<td>0%</td>
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<td><strong>Housing Stability</strong></td>
<td>10%</td>
<td>5%</td>
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<td><strong>Child Care</strong></td>
<td>5%</td>
<td>0%</td>
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<tr>
<td><strong>Financial Issues</strong></td>
<td>0%</td>
<td>5%</td>
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<td><strong>Transportation</strong></td>
<td>25%</td>
<td>0%</td>
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<tr>
<td><strong>Literacy</strong></td>
<td>20%</td>
<td>10%</td>
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<tr>
<td><strong>Safety</strong></td>
<td>5%</td>
<td>0%</td>
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<tr>
<td><strong>N=20 patients at both time points.</strong></td>
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Qualitative findings for VCUHS

• MOWs **extend clinic services** into patients’ homes, **provide early warnings** to clinicians about breakdowns in patient care plans, and **address idiosyncratic problems**.

• MOWs **translate medical information** and have **more open conversations** than patients could have with clinicians.

• Barriers faced by TakeCCARE enrollees involve **health literacy**, **medical transportation**, and **access to healthy food**.

• Patients best suited for TakeCCARE are those who have **low health literacy but high motivation** and **adequate family support**.

• Relative to other CHW-type interventions, MOWs require a higher level of **health system skills** and draw significantly upon their **college education**.

• MOWs have **substantial autonomy** in how they manage their patient responsibilities.

• The time and criteria needed for patients to complete the TakeCCARE program are **patient-specific** and **continue to evolve**.
To submit a question online, please click the Q&A icon located at the bottom of the screen.

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Building the Business Case for Community-Based Complex Care Interventions
Our Organization

• 7 hospitals
• 34 clinics
• 85+ onsite clinics
• 7,000 team members
• 240,000 patients annually
Our Background in Complex Care

Team Based Care Model

Decentralized

Pharmacist

Behaviorist

Physician

Nurse/Medical Assistant

Care Coordinator

NP/PA

ThedaCare
Gap Analysis

• Helped identify what type of program to create based on needs not currently being met by existing programs.

• Avoided duplicating services already in place
Our Community Paramedic Program

**Our Vision:** To identify and fill the gaps in the current care delivery systems through creation of a Community Paramedic (CP) program utilizing non-emergent, team-based, patient-centered, mobile resources.

- The CP is **part of the patient care team**
- The CP presents in uniform and an identified vehicle – **not an ambulance**
- Does **not compete on any level** with existing internal or community services
Best Use

In partnership with patients...

- **Services performed at a visit:**
  - Assessment for social determinants of health
  - Life and home risk evaluation
  - Chronic disease management education and support
  - Medication review
  - Referral to ThedaCare and community services

- **With the purpose of:**
  - Readmission prevention
  - ED utilization reduction
  - HbA1c improvement
  - Better medication management
  - Bridging to/from Home Services
  - Connecting to community resources
  - Increased patient independence
Our Electronic Connection

- Referral department
- Encounter posted as “patient outreach”
- Complete visit note
- Use of staff message and in-basket
Social Determinants of Health

(Sample questions)

17. New barriers identified
   - No barriers
   - Financial
   - Caregiver
   - Transportation
   - Cognitive disability
   - Language
   - Vision
   - Emotional
   - Cultural
   - Disease state
   - Family
   - Pain
   - Other

18. Life hazards
   - No employment
   - No home
   - No community
   - No transportation
   - Inhalants (employment)
   - Noise (employment)
   - Fire concerns (home)
   - Air pollution (home)
   - Clutter (home)
   - Noise (community)
   - Clean water (community)
   - Air pollution (community)
   - Seatbelt use (transportation)
   - Vision (transportation)
   - Vehicle (transportation)
Taking a trauma-informed approach to care, using motivational interviewing to learn what is important to patients and identify their health care and personal life goals.
‘Engaging’ Leadership through Data

- Quantitative data supported by qualitative data
  - Comparison group data
  - Baseline comparison data (pre/pre-post intervention)
  - Program data
  - Financial data
‘Engaging’ Leadership through Data

• Quantitative data supported by qualitative data
  – Wins and great stories
  – Testimonials from patients, families, physicians
  – Program plan and approach
Qualitative Data

Recent case study success with cost reduction

Patient X History:
• Prior to working with CP program, HbA1C ranged from best 9.9, to worst 11.6. Last controlled HbA1c was May 2015.

Paramedic actions at home visit:
• Full med-review
• Education
• Goal setting 100% from the patient using the Spirit of Motivational Interviewing

Current state:
• First reading post-enrollment: 6.7
• Second reading post enrollment: 6.2
• Discontinued Trulicity ($8400/year)
• Discontinued Lantus ($3600/year)
Testimonials

“There’s no way I would have been able to do this on my own. There’s no way!”
- Patient

“I can leave him alone now and go to my own appointments.”
- Patient’s wife

“This has created tighter connections between the clinic and home life and helps reiterate what we do.”
- Complex Care RN

“Having eyes on a patient in their home environment assists in finally breaking down barriers that have prevented us from reaching ideal goals for patients.”
- Physician

“This is the most confident I have felt with my care team in years.”
- Patient

“I am able to go back to church!”
- Patient
Building the Business Case

Aligned our work with other current system initiatives

- Transitions of care management
- Value-based payment models (ACOs)
- Primary care redesign
- Physician engagement
Alignment with Systems of Care:

Outpatient Care Management

[Diagram showing various healthcare professionals and roles related to patient care.]
Aligning with the ACO

• Have numbers to show them
• Actual case studies with cost savings
• Identifying patient population Served — Medicare/Medicaid/dually eligible
• Partner with ACO in identifying potential populations that we could/should serve
• Proforma
Aligning with the ACO – Need Their Data Too!

- Utilizations outside your EMR and ability to capture on your own
- Payer specific interpretations of avoidable/preventable
- May validate what your own data and impressions are telling you

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<th>Number of High Utilizer Patients (&gt;=6 ED Visits/Year)</th>
<th>Number of ED Visits</th>
<th>Number of Non-ThedaCare ED Visits</th>
<th>Number of Potentially Avoidable ED Visits</th>
<th>Diabetes Dx</th>
<th>CHF Dx</th>
<th>CAD Dx</th>
<th>COPD Dx</th>
<th>Substance Abuse Dx</th>
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<td>285</td>
<td>100</td>
<td>34</td>
<td>3</td>
<td>1</td>
<td>2</td>
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<td>61</td>
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<td>36</td>
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<td>22</td>
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Aligning with the ACO – The Proforma

- Understand the opportunities

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<td>12,000,000</td>
<td>80%</td>
<td>6,000,000</td>
<td>50%</td>
<td>3,000,000</td>
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<td>6,000</td>
<td>71%</td>
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<td>3,000</td>
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<td>7%</td>
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<td>143</td>
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<td>0 $ 48</td>
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<td>104 $ 13,810</td>
<td>86 $ 11,429</td>
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Total Savings of Avoided Cases: 5,524
Cost / FTE: 90,000
Net Impact: (314)

Financial Return of Avoided Encounter

1 $ 5,214 17.2 $ 89,686 - $ - 10 $ 52,143

1 $ 310 - $ - 290 $ 89,762 240 $ 74,286

Net Impact: (314) (238) 36,429

ThedaCare™
Aligning with the ACO

• Understand their ‘world’
• Have ACO leader present at key meetings
• Have ACO share results with payers
• Prepare to take referrals from ACO push
Thank You!
Preliminary Evaluation Findings for ThedaCare Health System

Derek DeLia, PhD
Director of Health Economics and Health Systems Research
• Preliminary quantitative evaluation
  – Available data from ThedaCare records
  – Enrollment period: Jan - Aug 2017
  – Comparison groups: Neenah IM patients, matched controls for diabetics
  – Observation: Six months pre/post enrollment for utilization, 3-4 months for A1c measures

• Brief highlights from qualitative evaluation
  – In-person interviews conducted in July 2017
  – Recorded, transcribed, & analyzed independently by two evaluators
### ThedaCare – Patient Characteristics

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<th>%</th>
<th>Gender</th>
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<tr>
<td>57</td>
<td>Female</td>
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<tr>
<td>43</td>
<td>Male</td>
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<th>%</th>
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<td>34</td>
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<tr>
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<tr>
<td>62</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

* Each includes Dual Eligibles due to small cell sizes
18 intervention patients matched with 18 comparison patients based on initial A1c level (all>9), age, & sex.
Changes in Hospital Use for Patients at ThedaCare with a History of High ED Use

High ED utilization defined as 3+ ED visits in 6 months

Intervention N=19
Comparison N=20

![Bar charts showing changes in ED visits and admissions per person between Intervention and Comparison groups before and after 180 days.](#)

Knowledge and Compassion *Focused on You*
Qualitative Findings for ThedaCare

• CPs are deployed when ThedaCare clinicians sense a gap in patient care or compliance that requires detailed investigation that cannot be done in the clinic setting.

• CPs often address medication issues such as compliance, reconciliation, and dosage optimization.

• The paramedic uniform appears widely respected by patients and contributes to CP effectiveness in motivating patients to engage in healthy and medically compliant behaviors.

• CPs utilize some paramedic skills but must have a different temperament and learn different skills relative to traditional paramedics.

• The workflow for CP communication with the complex care team at ThedaCare depends heavily on their fully functioning EHR.
To submit a question online, please click the Q&A icon located at the bottom of the screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Part Two in the Series

- Addressing Social Determinants of Health: Connecting People with Complex Needs to Community Resources
  - September 10, 2018, 2:00 – 3:30 PM ET
  - Registration link will be sent to today’s attendees

- Related resources
  - ThedaCare: Leveraging Community Paramedics to Bridge Persistent Gaps in Care
  - Virginia Commonwealth University Health System: Beyond the Walls and Into Communities
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