

TRANSFORMING COMPLEX CARE PROFILE

AccessHealth Spartanburg

Leveraging community partnerships to improve care for an uninsured population with complex health and social needs

AccessHealth Spartanburg (AHS) is a non-profit program that provides care coordination, navigation, and referral to community-based health and social services for low-income, uninsured adults in Spartanburg, South Carolina, a Robert Wood Johnson Foundation *Culture of Health* Prize awardee. AHS is a partnership of 10 community organizations that combines strong relationships with primary and specialty care providers with high-quality case management services for Spartanburg County's uninsured population. Through a network of physicians who volunteer their time, AHS connects eligible patients to primary care providers, specialists, behavioral health services, and prescription assistance.

Pilot Focus

Building on previous pilots in which community health workers (CHWs) have proven adept at engaging patients and providing care navigation services, AHS is adding a full-time CHW to its care team of nurses, care navigators, and social workers. AHS is also developing a case severity tool that uses 18 weighted medical and psychosocial markers to stratify patients into low-, moderate-, and high-risk categories. This risk stratification will eventually inform the development of standardized case management protocols and interventions.

Pilot Patient Population

AHS serves approximately 3,000 uninsured Spartanburg residents living at or below 150 percent of the federal poverty level. The program receives referrals from providers and emergency departments, as well as self-referrals, for patients with high rates of chronic medical conditions and behavioral health needs, including substance use disorders.

About Transforming Complex Care

These profiles feature participants in *Transforming Complex Care*, a national initiative made possible with support from the Robert Wood Johnson Foundation. The Center for Health Care Strategies is directing this multi-site demonstration to support the development of highly replicable care models for individuals with complex medical and social needs. For more information, visit www.chcs.org.

Key Program Partnerships

The AccessHealth model leverages robust community partnerships to provide patients with the medical and social supports they need. Physicians throughout the county volunteer by treating patients, referred by AHS, in their own offices or at the local free medical clinic. Additional AHS partners include:

- Spartanburg County Detention Facility;
- Spartanburg Vocational Rehabilitation;
- Westgate Family Therapy;
- Miracle Hill, a homeless shelter that runs a substance use disorder program; and
- Spartanburg Public Library System, which provides a neutral meeting space where care team members often meet patients.

Select Features of AHS' Program

Care Model Enhancements

- Developing a case severity tool that takes medical and social needs into account.

Data and Analytics

- Piloting the use of Healthify, a community resource software platform to address patients' social needs at the point of care.

Workforce Development

- Adding a full time CHW to the interdisciplinary care team to address patients' complex social needs and serve as a linkage to primary care.



*SOURCE: Complex Care Domains, from *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. Robert Wood Johnson Foundation and CHCS. October 2015.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

TRANSFORMING COMPLEX CARE PROFILE

Mountain-Pacific Health Quality Foundation

Delivering comprehensive care coordination to rural populations with complex needs

Mountain-Pacific Health Quality Foundation (Mountain-Pacific) is a non-profit Quality Improvement Network-Quality Improvement Organization focused on driving health innovation in Montana, Wyoming, Hawaii, Alaska, Guam, American Samoa, and the Northern Mariana Islands. It partners with providers, insurers, patients, and other stakeholders to improve individual and population health while lowering health care costs. Its quality improvement initiatives include: preventing health care-associated infections and conditions; assisting providers with health information technology and electronic health records; and improving the health of individuals with chronic conditions.

Pilot Focus

In a Montana-based pilot, Mountain-Pacific is creating ReSource Teams, staffed by registered nurses, community health workers (CHWs), volunteers, and a behavioral health consultant, to connect patients in hard-to-reach rural or frontier areas to health care and social services. The ReSource Teams are initially targeting three communities in Montana — Billings, Helena, and Kalispell — to overcome patients' barriers to care, many of which are unique to rural areas. Resource Teams will use a customized care management software platform to track and manage patient care. During home visits, ReSource Team members will use video chat on mobile tablets to link patients with remote providers and coordinate a full range of care, including addressing social needs.

Pilot Patient Population

Mountain-Pacific has identified that one percent of members account for 22 percent of its total health care costs. Building on a prior effort for high-utilizing Medicare patients, the ReSource Teams will serve Medicaid, Indian Health Service, Veterans Administration, and uninsured patients who have been admitted to the hospital twice in the past six months, have two or more chronic conditions, and are identified as potentially benefiting from enhanced primary care.

About Transforming Complex Care

These profiles feature participants in *Transforming Complex Care*, a national initiative made possible with support from the Robert Wood Johnson Foundation. The Center for Health Care Strategies is directing this multi-site demonstration to support the development of highly replicable care models for individuals with complex medical and social needs. For more information, visit www.chcs.org.

Key Program Partnerships

- **Payers:** Medicaid, Blue Cross Blue Shield of Montana, and Pacific Source.
- **State Government:** Governor's office, Department of Health, Montana State Innovation Model.
- **Providers:** Billings Clinic, St. Vincent's Hospital, St. Peter's Hospital, Kalispell Regional Medical Center, nursing homes, home care agencies, community behavioral health centers, federally qualified health centers, and hospices.
- **Universities:** Montana State University and University of Montana.
- **Nonprofit social services agencies:** *ASSIST*, a nonprofit that uses volunteers to connect area residents to social services, and *Keeping You Home*, a nonprofit that uses peers to keep high-risk seniors out of the hospital.

Select Features of Mountain-Pacific's Program

Care Model Enhancements

- Using CrossTx care coordination software to improve communication among providers and community-based organizations.
- Facilitating patient-provider interaction through video chat on mobile tablets.

Workforce Development

- Engaging *ASSIST* and *Keeping You Home* volunteers as community health workers.
- Developing a CHW curriculum and certification process and working with Montana State University College of Nursing to improve care coordination curriculum.
- Adding a veteran CHW given that one in 10 Montanans are veterans.

Governance and Operations

- Creating a steering committee including community members, physical and behavioral health providers, ReSource Team staff, payers, and university representatives to identify sustainable financing and develop trainings and policies.



*SOURCE: Complex Care Domains, from *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. Robert Wood Johnson Foundation and CHCS. October 2015.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

TRANSFORMING COMPLEX CARE PROFILE

OneCare Vermont

Investing in data and clinical strategies to support complex care across a statewide accountable care organization

OneCare Vermont is a statewide accountable care organization (ACO) founded by the University of Vermont Medical Center and Dartmouth-Hitchcock Medical Center in 2012. Building on the strengths of the state's patient-centered medical home model, OneCare is developing a provider-driven, integrated health care delivery system to serve the small cities and rural areas of Vermont. OneCare recently became part of Vermont's All-Payer Accountable Care Organization Model, a new delivery system reform initiative of the state and the Centers for Medicare & Medicaid Services.

Pilot Focus

OneCare Vermont is building on its existing health system reform efforts, including the statewide Integrated Communities Care Management Learning Collaborative and Vermont Blueprint for Health primary care model, to standardize care coordination approaches for patients with complex care needs. OneCare Vermont's pilot effort is also supporting four Vermont communities — Bennington, Berlin, Burlington, and St. Albans — to test care coordination software and facilitate communication through shared care plans accessible to all care team members and providers. The care team includes nurses, social workers, health coaches, and medical assistants as well as behavioral health providers and representatives from local social service agencies. The software is populated with claims data and includes patient demographics, health conditions and key health care utilization metrics. The Johns Hopkins ACG (Adjusted Clinical Groups) risk score is used to stratify the population and determine interventions. The pilot will inform future enhancements and spread of the system statewide.

Pilot Patient Population

OneCare Vermont patients, including Medicaid, Medicare, and commercially insured individuals, who are targeted for care coordination are identified by risk scores based on: recent inpatient hospitalizations, number of chronic conditions, number of specialty visits, gaps in care, polypharmacy, and diagnosis codes. The care coordination software will eventually be used statewide — for the more than 114,000 individuals served by the program.

About Transforming Complex Care

These profiles feature participants in *Transforming Complex Care*, a national initiative made possible with support from the Robert Wood Johnson Foundation. The Center for Health Care Strategies is directing this multi-site demonstration to support the development of highly replicable care models for individuals with complex medical and social needs. For more information, visit www.chcs.org.

Key Program Partnerships

- **Health Care Providers:** Primary care, specialists, home health care, hospice, skilled nursing facilities, and Critical Access Hospitals.
- **Behavioral Health Care Providers:** Behavioral health specialty hospitals and designated community mental health centers.
- **Social Service Providers:** Agencies on aging and support and service providers.

Select Features of OneCare's Program

Data and Analytics

- Testing Care Navigator software as a “one-stop shop” for a shared plan of care.
- Connecting the shared care plan to the data warehouse for EHR and other data.

Workforce Development

- Examining opportunities to train and employ community health workers as part of care teams.

Policy and Advocacy

- Exploring new ways to finance health care through an all-payer ACO delivery model that includes requirements to identify patients with complex medical and social needs and coordinate their care. Payment mechanisms, quality measures, financial targets, risk arrangements, and beneficiary attribution will be aligned across Medicare, Medicaid, and commercial payers.



*SOURCE: Complex Care Domains, from *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. Robert Wood Johnson Foundation and CHCS. October 2015.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

TRANSFORMING COMPLEX CARE PROFILE

Redwood Community Health Coalition

Spreading effective complex care management practices across a network of community health centers

Redwood Community Health Coalition (Redwood) provides its 18 community health center members with infrastructure, expertise, and program supports to serve patients in Northern California's Marin, Napa, Sonoma, and Yolo counties. Redwood's health centers, including several federally qualified health centers, operate in 40 sites across the region and independently administer their own complex care programs. Redwood's care coordinators work closely with patients to facilitate care across medical settings, help meet basic needs, connect people with benefits and support services, and engage them in primary care. Redwood was recently named a Medicare Shared Savings Program by the Centers for Medicare & Medicaid Services.

Pilot Focus

Redwood is implementing a learning collaborative with six of its community health centers to develop a standard care management training program for the clinics' multi-disciplinary complex care teams of nurses, social workers, care navigators, community health workers, and other providers. The participating health centers have historically operated their own care models for patients with complex needs, and Redwood is drawing on their experiences to develop and test more unified care management standards that can be customized by site. These best practices will be spread across the entire coalition through a new training program, which will emphasize culturally competent strategies for addressing social determinants of health (SDOH). Redwood is also convening a community advisory committee to engage area resources (e.g., transportation, housing, nutritious food, legal services) outside of the health care sector.

Pilot Patient Population

Redwood health centers serve 220,000 Medicare, Medicaid, and uninsured patients. Health centers receive referrals from hospital partners and use utilization data, Medi-Cal claims data, electronic health records and predictive modeling to identify high-risk patients most likely to benefit from the program. Although programs vary, they generally use the following criteria to identify high-risk patients: (1) serious mental illness or substance use disorders; (2) high

About Transforming Complex Care

These profiles feature participants in *Transforming Complex Care*, a national initiative made possible with support from the Robert Wood Johnson Foundation. The Center for Health Care Strategies is directing this multi-site demonstration to support the development of highly replicable care models for individuals with complex medical and social needs. For more information, visit www.chcs.org.

emergency department or hospital inpatient utilization; (3) prevalence of chronic illnesses and pain; (4) homelessness; or (5) other physician-identified issues regarding patients' needs.

Key Program Partnerships

- **Partnership HealthPlan of California:** Partnership, the sole Medi-Cal managed care organization in the region, shares utilization and cost data with Redwood to refine health centers' care coordination models. Redwood also works with Partnership's quality department to support health center interventions for patients with complex needs.
- **St. Joseph Memorial Hospital and Sutter Hospital:** Health centers regularly convene with these hospitals to improve care coordination, transition workflow, and information exchange.
- **County Departments of Health and Human Services:** Providers of county-funded health and human services work with Redwood and its health centers to support shared populations.

Select Features of Redwood's Program

Data and Analytics

- Improving the collection, analysis, and use of SDOH data.
- Establishing referral pathways and tracking tools to monitor effective coordination and access for patients and reduce hospitalizations.
- Expanding the regional health information exchange to connect with other systems caring for Redwood's complex patients.

Workforce Development

- Implementing training for multidisciplinary care teams, emphasizing culturally appropriate strategies for addressing SDOH.
- Improving sustainability for training and organizing "tracks" for employees to learn basic and advanced complex care skills.

Governance and Operations

- Creating an advisory group for health centers and community-based organizations serving high-need clients to identify best practices for patient engagement and social service linkage.



*SOURCE: Complex Care Domains, from *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. Robert Wood Johnson Foundation and CHCS. October 2015.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

TRANSFORMING COMPLEX CARE PROFILE

ThedaCare

Addressing social determinants of health through community paramedicine and local partnerships

ThedaCare is a non-profit, community-owned health system, consisting of seven hospitals and 35 health clinics serving 235,000 residents in the Fox Cities region and surrounding counties in northeastern Wisconsin. ThedaCare was recently named a Next Generation Medicare Accountable Care Organization by the Centers for Medicare & Medicaid Services.

Pilot Focus

In 2014, ThedaCare's Internal Medicine Clinic in Appleton began providing home visits, intensive case management, behavioral health care, and social services to high-risk patients. Under its pilot, ThedaCare is extending the reach of its program via a community paramedicine program aimed at further improving health outcomes. The paramedics are referred by providers at the clinic to check on high-risk patients in their homes, conduct routine monitoring, assist with medication regimens, and support self-management. The community paramedics are also authorized to make referrals to community resources to address patients' social needs.

ThedaCare is also convening a community advisory board to support access to non-medical services that can further address patient needs. The board will provide an inventory of available resources for the paramedics, and help inform implementation of the paramedicine program.

Pilot Patient Population

The patients that have been served by ThedaCare's paramedicine program have so far been covered by Medicare, though all patients age 18 or older are eligible to be served by the paramedics. ThedaCare identifies patients for their paramedicine program by referrals from patients' primary care providers and members of the complex care team at the Internal Medicine Clinic. ThedaCare has reached out to other departments within ThedaCare, including wound care and discharge planning, to receive recommendations for patients to be served by the community paramedics, and is developing plans to identify patients from records of emergency department visits.

About Transforming Complex Care

These profiles feature participants in *Transforming Complex Care*, a national initiative made possible with support from the Robert Wood Johnson Foundation. The Center for Health Care Strategies is directing this multi-site demonstration to support the development of highly replicable care models for individuals with complex medical and social needs. For more information, visit www.chcs.org.

Key Program Partnerships

- **Gold Cross Ambulance Service:** Partnering to develop community paramedicine program.
- **LEAVEN:** Faith-based organization provides financial and other assistance to people struggling to meet basic needs.
- **United Way Fox Cities:** Provides connections to social services through its 211 resource line.
- **ThedaCare at Home/Community Paramedic Advisory Board:** Consortium of health care stakeholders.
- **The Aging and Disability Resource Center:** Helps patients maintain independence.
- **Fox Valley Warming Shelter:** Provides temporary shelter and connects clients to community resources.

Select Features of ThedaCare's Program

Workforce Development

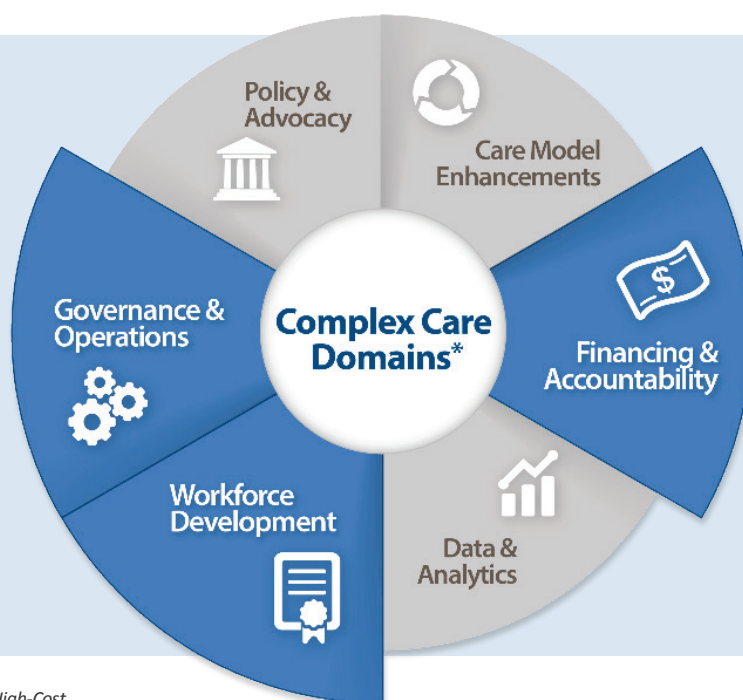
- Partnering with Gold Cross Ambulance Service to employ community paramedics who interact with patients in their homes to help manage their care.

Financing and Accountability

- Leveraging financial incentives under value-based purchasing arrangements to support investments in community paramedicine and team-based care.

Governance and Operations

- Engaging in continuous quality improvement for its complex care programs through a rigorous commitment to LEAN management principles.



* SOURCE: Complex Care Domains, from *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. Robert Wood Johnson Foundation and CHCS. October 2015.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

TRANSFORMING COMPLEX CARE PROFILE

The Complex Care Clinic at VCU Health System

Using outreach workers to extend complex care into high-opportunity neighborhoods

The Complex Care Clinic (CCC), part of the Virginia Commonwealth University (VCU) Health System, is focused on improving care for uninsured patients with complex needs in the Richmond Metropolitan Area. CCC's team includes physicians, nurse practitioners and case managers, psychologists, a pharmacist, a social worker, and medical outreach workers. CCC uses hot-spotting — identifying where patients with complex needs live — and cold-spotting — identifying areas that lack social services — to discover high-opportunity neighborhoods for intervention in the Richmond Metropolitan Area. It uses health system utilization as well as health opportunity index and census data from the Virginia Department of Health to further refine high-priority areas.

Pilot Focus

Through its hot- and cold-spotting analyses, CCC is refining its complex care outreach program to serve Richmond's East End, which has been identified as a particularly high-opportunity neighborhood. The program, TakeCCARE (Complex Care Assisting and Reviewing Education), is hiring and training outreach workers to: (1) conduct home visits and accompany patients to medical appointments to address barriers to successful self-management and reinforce care plans; (2) connect patients with community-based partners to address unmet social needs; and (3) proactively identify other issues that may influence outcomes. The outreach workers will meet regularly with other VCU Health System staff to share patient status, enhance care coordination, improve patient and staff experience, and maximize efficiency. CCC also engages patients through an advisory panel that serves to inform the clinic of patient needs and identifies available community resources.

Pilot Patient Population

To be eligible for the complex care pilot, patients, who are uninsured, must have an income below 100 percent of the federal poverty, reside in the East End of Richmond; and have two or more hospitalizations within three months and/or three or more emergency department visits over the past three months.

About Transforming Complex Care

These profiles feature participants in *Transforming Complex Care*, a national initiative made possible with support from the Robert Wood Johnson Foundation. The Center for Health Care Strategies is directing this multi-site demonstration to support the development of highly replicable care models for individuals with complex medical and social needs. For more information, visit www.chcs.org.

Key Program Partnerships

- **Peter Paul Development Center:** Community center that provides food distribution, exercise classes, and meeting space for CHWs and patients.
- **YMCA:** CHWs can “prescribe” YMCA pre-diabetes and diabetes education classes and fitness activities and CCC covers a portion of the costs.
- **The Daily Planet:** A federally qualified health center that provides comprehensive and integrated care to those who are homeless or at risk of homelessness and connections to housing supports.
- **Richmond Behavioral Health Authority:** Local community service board that provides services for people with mental health, intellectual disabilities, and substance use disorders for CCC patients.

Select Features of CCC's Program

Care Model Enhancements

- Implementing home visit and “accompaniment model” in which outreach workers attend appointments with patients to help them navigate the health care system.
- Using weekly staff audio logs of patient challenges and opportunities to inform care coordination.

Data and Analytics

- Adding an electronic data dashboard to aggregate clinical data, monitor CHW caseloads, and track care coordination referrals.
- Using a patient encounter form to track social needs and referrals.
- Introducing the Patient Activation Measure along with outreach worker and clinical feedback to determine a patient’s readiness to graduate from the program.

Workforce Development

- Training outreach workers in motivational interviewing, disease-specific education, personal safety, trauma-informed care, and data integrity.
- Instituting a multi-level support system for outreach workers, addressing professional and emotional needs.



* SOURCE: Complex Care Domains, from *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. Robert Wood Johnson Foundation and CHCS. October 2015.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.