CHCS Center for Health Care Strategies, Inc.

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.**

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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**.