CHCS Center for Health Care Strategies, Inc.

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.**

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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**.