MAY 2016 – MAY 2018

RCHC's Transforming Complex Care Learning Collaborative

Program Participants

1. Alexander Valley Healthcare
2. Marin Community Clinics
3. Petaluma Health Center
4. Santa Rosa Community Health
5. Sonoma Valley Community Health Centers
6. West County Health Centers

"The best thing about the Collaborative is that it has allowed us to get together and learn from each other about effective case management strategies."

–Learning Collaborative Participant

REDWOOD HEALTH COMMUNITY COALITION

"I am new to clinical nursing. All I've learned today [during the Introduction to Case Management & Communication Training] will help me work with the homeless population more effectively."

–Learning Collaborative Participant

Overview

In May 2016, Redwood Community Health Coalition (RCHC) was awarded a grant from the Robert Wood Johnson Foundation to strengthen and align complex care management for high-need, high-cost patients across six member health centers. RCHC utilized the nearly $250,000 in funding over a two year project period to establish an intensive Learning Collaborative, leverage existing efforts to improve the collection, mapping, analysis and practical use of social determinants of health data, and develop and pilot test standardized tools for patient care planning and risk stratification. This Project Close-Out Report highlights key program accomplishments and includes quotes and commentary from select individuals who participated in focus groups at project end.

Learning Collaborative

RCHC established a Learning Collaborative of intensive face-to-face trainings*, webinars and conference calls designed to increase health center capacity to treat patients with complex needs. Over the project period, RCHC conducted seven trainings targeting front-line staff providing care coordination within each health center:

- *Introduction to Case Management & Communication, 12 attendees, 67% received CEUs;*
- *Cultural Humility, 6 attendees, 17% received CEUs;*
- *Health Coaching, 20 attendees, 15% received CEUs;*
- *Responding to Social Determinants of Health Using the Purple Binder, 6 attendees, no CEUs were offered;*
- *Advance Care Planning, 9 attendees, no CEUs were offered;*
- *Home Visiting Safety & De-escalation Skills, 14 attendees, 28% received CEUs; and*
- *Trauma Informed Care, 27 attendees, 66% received CEUs.*

Additionally, RCHC developed a self-guided learning module to help care team members fill in gaps in their knowledge of chronic health conditions such as diabetes, hypertension, and COPD.

Participants completed training evaluation surveys and the overall response was quite positive. Respondents reported that the trainings provided were of "high quality" and focused on "core subject matter areas."

*Training Resources are available in our shared Complex Care Dropbox folder.

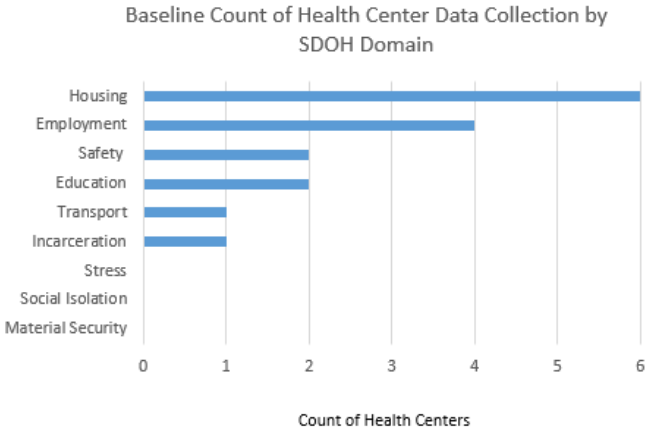
Social Determinants of Health (SDOH)

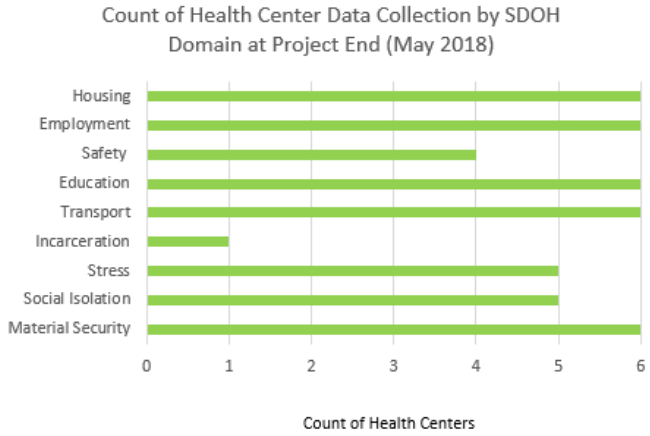
The Robert Wood Johnson Transforming Complex Care Grant served as the original impetus for founding our Social Determinants of Health (SDOH) Workgroup in December 2016. RCHC facilitated nine SDOH Workgroup meetings over the project period. At project end, five out of six participating health centers had piloted all core questions of the PRAPARE tool. Due to resource limitations, one health center implemented four of the core questions. Over the grant period, participating health centers completed 4,557 PRAPARE surveys. Two health centers have leveraged PRAPARE data to secure additional funding in this area.

Resources from the SDOH Workgroup are available in our shared dropbox folder.

Parallel to the PRAPARE implementation process, RCHC worked with participating health centers to conduct a 6-month assessment of community resource directory and referral vendor platforms that would allow health centers to refer patients to the appropriate social services. We will be implementing the Aunt Bertha platform under the brand name NorCal Resources in our four county region beginning in September 2018.

The bar charts below illustrate the increase in SDOH data collection by domain from project start to project end. Domains include both PRAPARE core and optional questions.





Care Planning and Risk Stratification

RCHC developed a comprehensive Care Plan that met the criteria for a variety of case management programs health centers plan to participate in (e.g. IOPCM, Whole Person Care, Health Homes). RCHC recommended health centers pilot the Care Plan in conjunction with a Health Risk Assessment and Health Action Plan currently required for Partnership HealthPlan's IOPCM Program. Health center staff piloted the Care Plan with a minimum of 10 patients. When asked about methods to improve the Care Plan, one health center indicated that the EHR template they were using was "clunky" and should be edited prior to spread, and that the Care Plan lacked a section for outlining patient goals, priorities, and next steps. Although this information is available in the Health Action Plan, we recognize it could be useful to merge the two documents and will take this into consideration when developing future iterations of the Care Plan.

RCHC staff also developed a "home-grown" risk stratification model that utilized clinical, social, and hospital utilization data to identify patients who may benefit from more intensive case management. Petaluma Health Center pilot tested this risk model and the final version will be made available in Relevant Analytics for other health centers to use.