TAHOE FOREST HEALTH SYSTEM

Community Health & Wellness Neighborhood and Care Coordination

wellnessneighborhood

A Service of Tahoe Forest Health System

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JULY, 2016

Community Health & Wellness Neighborhood
Care Coordination
Connecting Services for Population Health Management
Annual Report FY 2016

Departmental Mission: To support and inspire our patients and community members to achieve their best health through coordination/navigation of services and collaborative community-based care and education.

This report outlines department activities that support population health management and describes the role of Community Health & Wellness Neighborhood and Care Coordination in building the bridge between our current health reimbursement system and the future of healthcare reform.

In 2015-16 Community Health & Wellness Neighborhood implemented new strategies for outpatient care management and patient education with care coordination and navigation of services. Community Health & Wellness Neighborhood and Care Coordination staff are the *"Connectors"*: connecting patients to services and providers throughout the health system and connecting our community members and partner agencies to health resources.

We are creating an integrated network of outreach, education and support for our entire community by aligning our programs and services to target community members across the health risk continuum. (Figure 1)

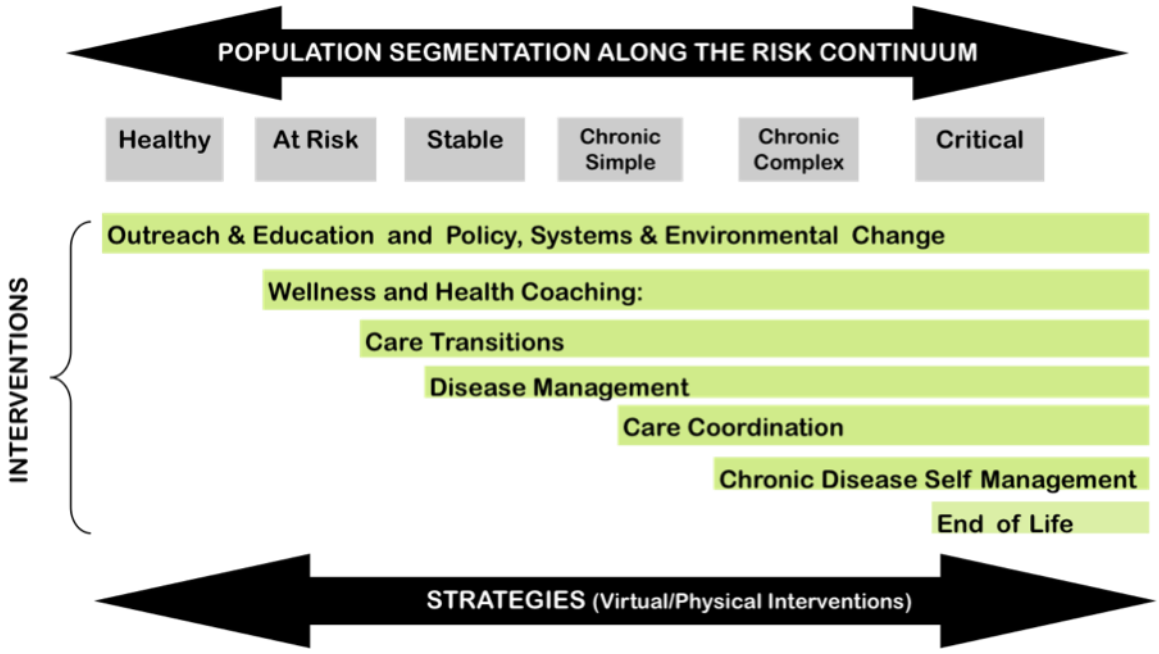


Figure 1.

Ultimately, care coordination/navigation will allow us to achieve the triple aim – improve patient outcomes, reduce healthcare costs, and increase patient satisfaction - by supporting patient self-management and effective collaboration with providers, decreasing waste and redundancy between departments, and promoting the efficient utilization of health care resources. Community Health & Wellness Neighborhood (CH/WN) will implement the programming, education, and outreach to support these goals for our community and for individual patients.

As we move into FY2017 we will continue to integrate seamless referral and navigation pathways within our current work areas and begin duplicating this structure for a variety of other service lines.

Community Health and Wellness Neighborhood Board Initiatives:

- Access to Care and Care Coordination
- Optimize Health and Preventive Services
- Access to Mental and Behavioral Health Resources
- Reduce Substance Use and Abuse

The initiatives and outcomes listed below are intended to highlight CH/WN programming for population health management. These are not an exhaustive lists of all CH/WN programs.

Access to Care and Care Coordination:
Inform, Consult, Involve, Collaborate, Empower

Goal: Reduce per capita cost of health care by reducing unnecessary ED visits and readmissions. Improve population health by decreasing disease-specific mortality, reducing health disparities based on ethnicity, and increasing medical home enrollment.

PROGRAM	OBJECTIVE	IMPACT
Chronic Care Management	Improve health outcomes and reduce costs for Medicare patients with two or more chronic conditions	Initiated Dec 2015 with TTMG. Case load increased from 15 to 44 patients/month
Transitional Care Management	Improve health outcomes and decrease 30-day readmissions for Medicare patients transitioning from hospital to home.	Averaging 19 patients per month Total of 7 readmissions over six months since inception
Youth Care Management (Strategic Action from the Youth Health Initiative)	Assist youth in accessing primary, reproductive, oral, mental and behavioral health services.	Position filled March 2016 Developed policies and established MOUs with TTUSD Surveyed 255 students on health access and health education needs 3 patient referrals completed
Chronic Disease Self-Management	Empower patients to take greater control of their health. 6-week class series offered for chronic disease and diabetes (English and Spanish)	3 series offer through TFHD and 5 series offered through North Tahoe and Truckee FRC Promotoras, reaching 80 participants Participants demonstrated increased knowledge and confidence in controlling their diseases
Health Promotoras and Family Advocates	Reduce disparities by supporting FRCs of Truckee and North Tahoe in providing community health education and healthcare navigation.	218 community members received health education. 101 community members received assistance with health care navigation (June to Dec 2015)

<u>The following client story exemplifies the success of Care Navigation, Family Advocates and Community Promotoras:</u>

Isabel attended a Promotora community health workshop. During the workshop, she confided in a Promotora that she had been diagnosed with diabetes and HPV, and she was waiting for a biopsy due to abnormal findings during a pap-smear. She was overwhelmed and concerned. She did not understand the process of her biopsy, and she was scared about the HPV diagnosis. The HPV diagnosis was affecting her home life; she and her husband blamed each-other for the appearance of the HPV and they both started to suspect infidelity.*

The Promotora listened attentively, comforted Isabel, and suggested that she make an appointment with a Family Advocate to look for more information and resources to better understand her health.

Isabel met with a Family Advocate. She and her advocate arranged to meet with Tahoe Forest Hospital's Care Coordinator, Jackie Griffin, RN. Jackie discussed with Isabel the meanings of her HPV diagnosis and talked through the process of an abnormal pap-smear and the resulting biopsy. The information that was provided helped her to understand the HPV diagnosis and to alleviate the tension at home.

The coordination between the FRCs and TFHD, helped Isabel access nutrition classes, understand the importance of self-care, and facilitate access to care. Isabel was referred to Tomando Control de Su Salud (Spanish language Chronic Disease Self- Management program) to help her manage the diabetes. She is an excellent leader and hopefully will be able to become a Promotora and peer-guide as a trained Tomando Control Leader.

CDSMP Trained Promotora Leaders

** Isabel's name was changed to protect her privacy.*

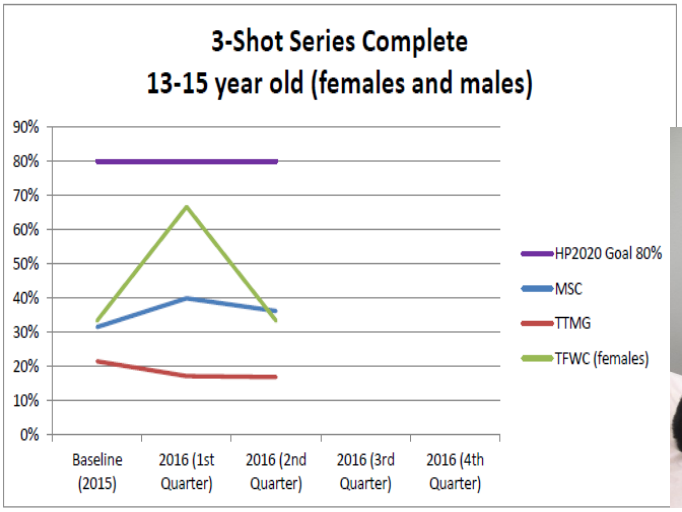
Focus Areas for FY 2017:

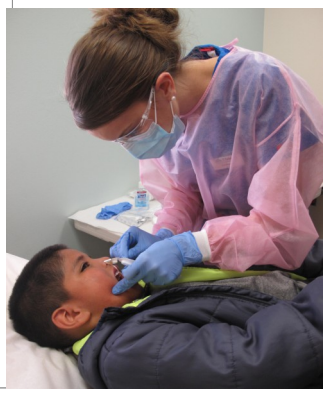
- Improve communication and assure seamless care with nursing case management, home health and ECC
- Initiate Care Coordination in MSC, August 2016.
- Integrate Care Coordination into PRIME Million Hearts and Chronic Non-Malignant Pain initiatives
- Incorporation of Blue Life patient connectivity in Care Coordination (ex: blood pressure and blood glucose tracking)
- Increase referrals to Youth Health Navigator and expand services to charter and private schools
- Improve marketing for CDSMP classes and establish annual class schedule with greater access to classes throughout the year
- Initiate Health Navigation through the Center for Health and Sports Performance

Optimize Health and Preventive Services:
Achieve Your Best Health

Goal: Improve population health by decreasing disease specific mortality, reducing health disparities based on ethnicity, and promoting health supportive behaviors.

PROGRAM	OBJECTIVE	IMPACT
Immunization Coalition	Increase school and HPV immunization rates to Healthy People 2020 goals	Kinder UTD = 87.5% 7th grade T-Dap UTD = 97.6% HPV (see graph below)
Dental Coalition (Strategic Action from the Youth Health Initiative)	Improve dental health for the children of our community	138 Children screened and received fluoride varnish at community events. 200 Children received fluoride varnish in the Multi-Specialty Pediatric Clinic. 0ver 2800 children received Oral health education through B-FIT





Focus Areas for FY 2017:

- HPV Immunization outreach to medical providers, school staff and parents.
- Increase Fluoride Varnish application and community oral health education.

PROGRAM	OBJECTIVE	IMPACT
Rethink Healthy	Increase community knowledge and support a culture of health	23 published articles with a circulation reach of 660,00 347 community outreach events with more than 19,390 contacts
B-FIT	Increase physical activity and support healthy habits for elementary school students	B-FIT Fitness Test results: Pre-Post- <u>% in Healthy Fitness Zone</u> Kings Beach 1st-4th grade: Mile Run: 23.8—29% Arm Hang: 55.9-47.5% BMI: 75.3—78.4% Ave. Activity Bursts/day = 7.63 mins. % teacher participation= 55.5% (range 17% to 80%)
Harvest of the Month	Increase access and preference for fruits and vegetables though nutrition education and tastings in the classroom	Reached over 3650 students per month. Expanded to classes at Incline Elementary, Forest Charter, and Creekside Charter schools
NEOP (Nutrition Education and Obesity prevention grant)	Improve health through nutrition education targeted to the food stamp eligible population	5 week Power Play Curriculum to 4th and 5th grade students at TL and NTS reaching 215 students 6-week Cooking Matters Classes to KB community and school district Pregnant and Parenting teens (STEPP Program) reaching 18 community members and 6 students

Harvest of the Month™

"We made asparagus and tomato salad with honey mustard dressing and shaved asparagus with parmesan dressing. I was a little worried that the kids would not like the asparagus raw, but they loved it in both salads. I think the thing that was most interesting to them was that asparagus could be green, white, or purple."

"We made a beet smoothie using beets, beet greens, oranges, water and lemon, and also made raw beet salad. The variety of tastings was a huge hit with the class with the smoothie being the biggest success, especially when I made the smoothie in the class for students."

SHARE OUR STRENGTH'S COOKING MATTERS NO KID HUNGRY

PROGRAM	OBJECTIVE	IMPACT
Affordable Labs	Improve access to screening, prevention, and education services	Monthly lab draws in Truckee and Incline Village reaching 601 community members Blood Pressure Screening revealed 54% of individuals screened had an elevated BP
Perinatal Education	Increase preparedness, access to resources, and ability to recognize risk factors related to pregnancy/childbirth	Expanded classes to Incline Village 69 couples participated in classes this year Provided 7 financial scholarships
Employee Wellness	Create a health supportive work environment	Designated as a *Fit and Friendly Workplace by the American Heart Association* Established employee Wellness Committee Offered Health Coaching to 24 employees with 2 or more risk factors from the annual HRA 513 Fresh Produce Boxes prepared for 145 unduplicated employees
Blue Life App Integration	Personal tracking, connection, and motivation to support healthy behaviors	*10,000 Steps-a-Day in May* challenge registration and step tracking 109 active participants walked 34,306,328 steps 38 Participants Utilized Health Coaching interface

Focus Areas for FY 2017:

- Integration of Center wellness programming and community health education.
- Center Health Navigation – "one stop shop" for wellness services.
- PRIME Million Hearts: policy, systems, and environmental change to support cardiovascular disease risk reduction.
- B-FIT Activity Burst re-engagement/expansion in elementary schools for 2016-17 school year.

Sample Employee Produce Box

Mental and Behavioral Health:

Goal: Increase screening and identification of mental health needs and access to mental health care. Reduce disparities in access to mental health. Reduce suicide rate in our community.

PROGRAM	OBJECTIVE	IMPACT
Suicide Prevention Coalition	Increase awareness of the warning signs of emotional pain or suicidal thoughts and knowledge of where to seek help.	Mental Health in the Mountains Community events TFH *Behavioral Health Assistance in Out-patient Clinics* Policy 26 Know the Signs presentations
Youth Stress Reduction	Equip students with tools to mitigate stress/ anxiety, improve mood, and reduce negative emotions.	Reached 747 students in 23 classes during the 2015-16 school year 72 % of students said they would use breathing techniques and 43% would use meditation for stress reduction
Mental Health Directory	Increase awareness of local mental and behavioral health resources.	Created resource list of Medicare/Medi-Cal providers 208 Downloads of the directory from TFHS website (Nov 2015 to June 2016)
Gateway Mountain Center	Increase access to mental and behavioral health direct services for youth.	Supported therapeutic mentoring treatment for 12 youth who had no other funding resources.
Crisis Team Reporting (collaboration with Nevada, Placer, and Sierra Counties)	Support crisis team in making informed decisions regarding ED demand for mental health services	Counties implemented contract (AMR and First Responder) for prompt transportation to psychiatric treatment facility.

Client 2: *SB is a 19 year old male, Truckee resident. He was on our case load in 2012-2013, but had been stable until late autumn 2015. He suffered a psychotic break, potentially associated with chronic use of drugs. He spent time in the Tahoe Forest ER with a 5150, and spent a week in a psychiatric hospital. Mentored by Rob Steffke MFT, and Greg Bernstein. We supported SB for two months upon his release, until he became stabilized, late February 2016.*

<u>Focus Areas for FY 2017:</u>

- Oversee Suicide Prevention Coalition grant and provide staff for the outreach component.
- Implement Depression screening in Primary Care and provide behavioral health Care Coordination referrals to high risk patients

Reduce Substance Use and Abuse:

Goal: Reduce substance abuse in the community and reduce the normalization of drug use community-wide with a specific emphasis on school-aged children. Educate population on dangers of alcohol, prescription and recreational drug abuse.

PROGRAM	OBJECTIVE	IMPACT
Alcohol EDU	Reduce youth substance use and abuse	Reached 309 TTUSD High school students. 257 students completed the program and received certification
TTFWDD (Tahoe Truckee Future Without Drug Dependence)	To build a community free from drug and alcohol abuse.	Supported community *Rx Take Back* events Provided CME on marijuana
Athlete Committed	Reinforce the value of good training habits, proper nutrition, strong communication skills, model citizenship and a drug free lifestyle.	Reached 225 student athletes, coaches, and parents with resources on proper nutrition during sports
Safe Prescribe Practices	Reduce deaths and addiction due to prescription drugs.	Established Chronic Pain Advisory Group Unified Medication Agreement completed and approved by committee Offered 3 CME presentations on Prescription Drug Monitoring Program (PDMP) for NV and CA

<u>Focus Areas for FY 2017:</u>

- Implement PRIME Chronic Non-malignant Pain Intervention
- Adopt evidence-based chronic pain management guidelines

Conclusion:

The range of activities and results presented in this report demonstrate our investment in population health management and our commitment to provide interventions across the health risk continuum.

The Director of Post Acute Services and the Director of Community Health & Wellness Neighborhood and Care Coordination extend our deep appreciation to our department staff, the medical directors/advisors within TFHD, our community partners , and our volunteers, who have worked tirelessly to execute these programs and services and support the vision of optimal health for our entire community.