Addressing Social Needs at Contra Costa Regional Medical Center's West County Health Center

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Genesis of this Brief:
This profile is based on interviews conducted in winter 2015 with members of the CCRMC leadership team overseeing the Health Leads partnership: Anna Roth, R.N., M.S., Chief Executive Officer; Sara Levin, M.D., Internist; Rajiv Pramanik, M.D., Chief Medical Informatics Officer; and Duffy Newman, M.H.A., Strategic Partnerships. This brief is a "snapshot in time" intended to illustrate how a safety net hospital and its partners used research and other evidence to help inform program development. It is not intended to be a comprehensive analysis of a particular program or partnership.

Contra Costa Regional Medical Center (CCRMC), a public hospital system dedicated to building a culture of continuous improvement, is nationally recognized for its commitment to patient-centered care. In 2014, the nationally acclaimed program Health Leads established its first partnerships in the San Francisco Bay area with CCRMC's West County Health Clinic in San Pablo, California, and with the Kaiser Permanente Medical Center in Richmond, California. Health Leads has been recognized by the Robert Wood Johnson Foundation as ". . . an innovative yet practical approach to removing social barriers to good health." [1]

About Contra Costa Regional Medical Center

Contra Costa County, one of California's original 27 counties, is located in the northern portion of the East Bay area of San Francisco. In 2010, the county had a population of over 1 million people. Income levels vary greatly among county residents—from the extremely affluent in the southern and central parts of the county to very low-income residents, especially in the northern part of the county. Contra Costa's health care market is both highly organized and highly integrated, with 11 hospitals and three large health systems: Kaiser Permanente, John Muir, and Contra Costa Health Services, a department of county government that provides health care and oversees community health. Contra Costa was the first county in the nation to establish a county-based health plan that, today, serves over 180,000 members through a variety of benefit plans.

Contra Costa Regional Medical Center and Health Centers, a division of Contra Costa Health Services, operates a 164-bed hospital in Martinez and 11 community health centers that annually provide over 500,000 outpatient visits and about the same number of mental health visits. Contra Costa's family medicine residency program is affiliated with the University of California at San Francisco's Department of Family and Community Medicine and, for 35 years, has trained physicians committed to caring for the underserved.

As the public health system, Contra Costa Health Services protects the health of all the county's residents through a range of services that includes environmental protection and disaster management. Caring for the county's racially and ethnically diverse low-income populations is a special priority. The family medicine residency program and the county-based health plan have contributed to a physician culture dedicated to improving patient care and building a delivery system that goes beyond clinical care and prescribing medications. About eight years ago, CCRMC's CEO, Anna Roth, R.N., M.S., and the hospital's leadership team instituted a culture of continuous improvement that is the framework of CCRMC's approach to patient-centered care.[2]

The medical teams and leaders of CCRMC face continuing challenges in caring for patients who experience serious barriers to health, such as inadequate housing or lack of nutritious and sufficient food. To address these challenges, Contra Costa Health Services and CCRMC have adopted a range of approaches and tools to help patients. For many years, CCRMC has worked closely with community- based organizations (CBOs) in the county to address patients' social needs. To help patients navigate the health system, the hospital employs health aides and promotoras. The Health Leads model uniquely builds on existing community assets, playing a connecting role among CBOs and the health system. Ms. Roth initiated the partnership with Health Leads in 2014 to continue to identify models that address the social determinants of health and advance CCRMC's commitment to patient-centered care.

About Health Leads

The Health Leads model connects patients to needed resources such as food banks and affordable housing as a patient receives medical care. Health Leads has 16 clinical partners located in five regions of the country as well as 13 university partners. Between them, Contra Costa Health Services and Kaiser serve a large percentage of the county's less affluent residents. Patients with social resource needs may move between Kaiser Permanente's Richmond Medical Center in the western part of the county and CCRMC. In part because of their shared patient population, Kaiser Permanente and CCRMC work strategically in the western part of the county. Kaiser Permanente Community Benefit supports performance and quality improvement in the safety net health system at the national level and has supported both CCRMC's patient-centered improvement agenda and its partnership with Health Leads.

Before the advent of the Health Leads partnership, CCRMC's providers attempted to address the social resource needs of their patients through individual, informal efforts. Health Leads, however, offered a tested model that CCRMC's team adapted to fit the hospital system's well-established commitment to patient-centered care. Under the Health Leads model, trained volunteers become part of the West County Health Center team, enabling providers to write a prescription for resource needs, such as housing or food, and to assist with challenges that can prevent patients from addressing health issues. Volunteers,

called advocates, work with patients to secure needed resources by identifying appropriate county and community agencies, managing the referral process, and following up with patients until the social issue is resolved. Advocates provide regular updates to providers on the progress of their patients.

Addressing Social Determinants of Health: West County Health Center and Health Leads

The Health Leads team at CCRMC is led by a steering committee that includes Sara Levin, M.D., and Rajiv Pramanik, M.D., chief medical informatics officer, as well as representation from nursing, social work, Contra Costa Public Health, and the Contra Costa Health Plan. A working group oversees the operation of Health Leads at the West County Health Center, which cares for about 100,000 patients annually, mostly in primary care and in a few specialty areas as well. The working group includes nurses, social workers, clinic service managers, and front-line patient care staff. Within the CCRMC leadership, Duffy Newman, M.H.A., supports the executive team in building system performance, understanding strategic priorities, and vetting initiatives to determine organizational support. Ms. Newman's central role with Health Leads is to connect the initiative to CCRMC's strategic goals, facilitate the removal of barriers to implementation, and keep the Health Leads pilot program on track.

Contra Costa Health Services leaders believed that the Health Leads model supported CCRMC's commitment to patient-centered care and continuous quality improvement. In establishing the partnership, CCRMC valued Health Leads's operational strength and infrastructure but has tailored the approach to further CCRMC's organizational priorities. Health Leads has a well-developed, comprehensive process for mapping a community's resources. At West County, the Health Leads team built out the existing database of community services that served the county's toll-free, emergency community resources line. In collaboration with social service agencies in Contra Costa County, Health Leads was able to map resources in detail, by, for example, identifying local food banks, what food each bank provided, hours of operation, and other information such as languages spoken by staff.

The CCRMC steering committee worked closely with Health Leads to align key operational components of the program with CCRMC's organizational structure and strategic initiatives and consequently forged an effective partnership between the national model and the local health care delivery system. At the outset, a transitional period allowed Health Leads to train staff and design the program's infrastructure to fit within the West County Health Center's patient screening process, operational flow, physical space, and existing staff resources. Additional Health Leads staff was available during the initial planning and orientation periods.

At present, a Health Leads desk is located in the West County Health Center and staffed by 19 undergraduate student volunteers from the University of California at Berkeley. The program manager for the Health Leads desk is a clinical psychologist who oversees the student volunteers or advocates, and, along with a peer at Kaiser Permanente, reports to the Health Leads regional staff. The volunteers receive intensive training in working with patients, understanding the array of available social service resources, and advocating for patients. In the process, Health Leads advocates and staff continue to build and refine the database of community social service resources through a process that feeds data from referral connections and outcomes into the database. Each advocate works eight hours per week, staffing the desk, meeting with other volunteers, and spending two hours following up with a caseload of 15 patients each.

Patient referrals to Health Leads begin with a screening procedure integrated into the clinic's overall patient flow process. At registration, a patient is asked about resource needs and, if needed, is referred to the Health Leads desk. In addition, clinicians prescribe Health Leads services, and patients may self-refer. CCRMC tries to employ a "warm handoff" during the intake process: a nurse alerts a patient advocate to the need for patient assistance, and the advocate walks the patient to the Health Leads desk. It is common during the intake process for a patient to evidence several resource needs. Part of the advocate's role is to set priorities among the patient's needs and to eliminate those that fall beyond the scope of Health Leads. Under the Health Leads model, the advocate assigned to a patient's case stays with the case until it is closed, at which time the advocate has either secured assistance, or the patient decides to pursue resources on his/her own or to leave the system. The Health Leads model offers a start-to-finish commitment to the patient until the resource need is resolved.

The Role of Research in the Partnership

The CCRMC team noted that research, defined broadly, was an important factor in designing a program that addressed their patients' social and medical needs. The leadership team described its research as comprehensive but unstructured, conducted through informal literature reviews, Google searches, and discussions with peers in similar organizations. The leadership team was familiar with the literature on the social determinants of health, but, as one leader noted, there are no clear models for integrating the delivery of health care while addressing a patient's social resource issues. In fact, before deciding to form the Health Leads partnership, the team engaged in extensive discussions about which approach would be most effective for CCRMC's patients. The team studied existing models such as the use of community health workers, patient navigators, and the county's 211 system. Individual clinicians also noted what approaches were effective with their own patients.

In the end, the team designed its own process for assessing patient needs, identifying the initial patient target population, and determining the model best suited to delivering aligned care. Patient assessments were conducted at the West County Health Center through surveys of approximately 230 patients. Sixty percent of patients identified lack of sufficient food as their most critical resource need (rather than a particular health issue) followed by housing, employment, mental health needs, and legal issues. At the outset, the team considered a home-grown model but decided that an established and tested model would help the organization avoid bureaucratic and procedural pitfalls. The CCRMC team concurred that Health Leads's fully developed model, with a track record and infrastructure, would facilitate implementation at the West County Health Center in a reasonable time frame.

Working with Health Leads has provided another opportunity for CCRMC to test a social determinants approach from the perspective of the delivery system, to learn what tools are effective in meeting patient needs, and to understand whether the model is scalable. As one of the physicians leading CCRMC's Health Leads partnership pointed out, most of the resources in safety net institutions go to the delivery of care and are not available to support research on the quality or efficacy of an approach. The lack of resources often means that program design is driven by an opportunity rather than by a planned research design. Before approaching Health Leads, the steering committee researched various models that offered an approach to connecting a patient's social and medical needs but found few resources that described available models, explained the return on investment (ROI), and offered guidance as to which models were appropriate for CCRMC. The steering committee selected Health Leads because of its track record and its ability to provide an infrastructure and a logic model consistent with CCRMC's priorities.

Where Research Could Help

Evaluation

As of early March 2015, the West County Health Center had screened 1,732 patients for a resource need and identified 1,074 patients (62 percent) with one or more needs. Of those 1,074 patients referred to the Health Leads team, 684 (67 percent) became unique clients. Of those unique clients, 96 percent of cases closed either because of resolution of the need (50 percent) or clients' ability to solve the need on their own (46 percent). At present, what is needed is the research capacity to evaluate whether the Health Leads initiative is improving the care provided to patients in the West County Health Center. Evaluation of the Health Leads model is important both to improve the approach and the patient experience and to understand how to expand the model to serve the many additional patients in need.

The CCRMC team has identified several programmatic areas that would benefit from program evaluation. Health Leads regularly provides a dashboard that looks at the total number of referrals and identifies the most "successful" referrals based on the most "successful" connections. Without research capacity, however, the West County Health Center team is unable to determine whether the referrals matched patients with the correct resource and whether the referred resource was instrumental in improving the health status of the referred patients. Without follow-up evaluation of the assistance provided by Health Leads, it is unclear whether a patient's social resource needs are met, whether a patient's priorities change, or whether a patient resolves an issue independently.

The lack of evaluation capacity also hampers CCRMC's ability to determine the cost of referrals and whether the health system is the most effective and appropriate institution to manage referrals to CBOs in the CCRMC/Health Leads network. In addition, the team lacks the capacity to ensure that participating CBOs and other resources are used effectively and efficiently.

Expanding and Sustaining the Program

Health Leads at CCRMC is in operation only at the West County Health Center, one of the system's 11 clinics. Given that West County serves only a limited number of the patients in need in Contra Costa County, the leadership team is working to understand how to expand the Health Leads program to provide integrated service throughout the county health system. Simply stated, research is needed to determine whether the Health Leads model should serve the entire county health system and to address whether the health system should continue to take the lead in resolving a patient's social resource needs. Additional research is needed to determine if the program as currently designed is most effective. For example, would the county be better served in terms of sustainability employing community health workers and students trained by local community colleges? Finally, research is needed to determine if the model meets a patient's needs for the long term and produces a sustained impact on a patient's health and well-being.

Integrating Data Systems

An important challenge with the Health Leads partnership has been integrating the data systems of the respective organizations. As with most mergers, partners may differ on important operational goals even as their missions align. Dr. Pramanik noted that an important focus for the Health Leads data system is to build and showcase the tools they use to map social resources in a community. CCRMC's principal goal for the Health Leads initiative is improved health of the system's patients.

The Health Leads Model and the Safety Net

The CCRMC team emphasized the importance of embedding researchers in the organization and dedicating them to the priorities of the safety net health care delivery system. The team described the limitations inherent in extrapolating research conducted in non-safety net settings to safety net populations, noting that delivery system research and even drug studies often do not translate to safety net patients. Research grounded in the safety net can validate what often now can be understood only anecdotally. Without a planned research design, initiatives are likely to develop in response to organizational opportunities and rely on accessible, outside research or a "gestalt" about the correct approach.

About the Author

Linda C. Cummings, Ph.D., of Health Services Research LLC, provides research and program development consultation focused on the health status and health care of underserved populations. Dr. Cummings was formerly Vice President for Research at America's Essential Hospitals, where she directed the Essential Hospitals Institute. In that capacity, she developed the organization's research agenda around system redesign, quality performance and improvement in patient care, health disparities, and the financial and operational characteristics of safety net hospitals. Dr. Cummings served as an Innovator-in-Residence at AcademyHealth from January to March of 2015.

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Endnotes

1. For more on the Robert Wood Johnson Foundation's support of Health Leads, see: http://www.rwjf.org/en/how-we-work/grants/grantees/Health_Leads.html

2. For more on the Contra Costa Health Services Culture of Continuous Improvement, see: http://cchealth.org/medicalcenter/culture/