Promoting Equity through Authentic Partnerships to Improve Community Health

Afternoon Panel
Team Up Take Action Conference
Hanover, New Hampshire
October 2, 2019

Description

Hear from several partners involved in clinical-community collaborations that are successfully integrating health care and addressing social determinants of health in order to reduce health disparities for vulnerable populations (e.g., homeless, chronically ill, students and families, immigrants/refugees, and people with mental health and substance use disorders).

Partners will describe the opportunities that helped start their initiatives, their purpose in working together, and the governance and evaluation processes they use to facilitate effective teamwork and communication. The audience will have opportunities to explore the practical side of building partnerships to improve health equity, such as: What are the barriers to trust and how can you overcome them? How important is consensus and how can you reach it? What are the conditions that make it possible for different organizations to share resources and develop common goals? What are the tough challenges and how are you addressing them?
Objectives

*By the end of this session participants will be able to:*

- Identify at least one strategy to engage cross-sector partners to improve the health of their community
- Name a characteristic or strategy for how partnerships promote health equity
- Describe an element of successful community-clinical partnerships
- Identify at least one example of effective use of data / metrics to measure successful / impactful partnerships

Moderator

Paula Smith, MBA, EdD
Director
Southern NH Area Health Education Center

psmith@snhahec.org
1. The Concord Downtown Clinic: Partnering to Improve Health

The “Downtown Clinic” is an outreach, on-site health clinic, resulting from a collaboration of the NH Dartmouth Family Medicine Residency, the Concord Hospital Family Health Center and Concord Hospital with the Concord Coalition to End Homelessness to bring health care and connection to other services to a population of people who are homeless in Concord, NH.

- Julie Green, Assistant Clinical Director of Programs, Concord Coalition to End Homelessness, julie@concordhomeless.org
- Dominic F. Geffken, MD, MPH, Program Director, NH Dartmouth Family Medicine Residency, Concord Hospital, dgeffken@crhc.org

2. Vermont LEND / Vermont Department of Health Cultural Brokering Program

The Vermont cultural brokering project is a community driven best practice approach to address behavioral health disparities in refugee and immigrant populations. The project is currently a collaboration between the University of Vermont Larner College of Medicine, the Vermont Department of Health, and community based organizations: Association of Africans Living in Vermont, Hindu Temple, and Somali Bantu Association.

- Bidur Dahal, MS, MPH(c), VT LEND Education Coach and Hindu Temple leadership, Bidur.Dahal@med.uvm.edu
- Symphorien Sikyala, MD, VTLEND & SBIRT Cultural Broker, ssenvva@hotmail.com
Community Driven Best Practices to Address Behavioral Health Disparities in Refugee and Immigrant Populations

Symphorien Sikyala & Bidur Dahal
VT LEND, UVM & SBIRT Cultural Brokers

What is SBIRT?

Screening, Brief Intervention, Referral to Treatment
Why SBIRT Cultural Brokers

• Federal System of Care grant helping youth transition to adulthood
• Conducted a Community Needs Assessment by facilitating focus groups with 96 members of different refugee & immigrant communities
• Primary take away: Someone from their communities needs to be providing mental health and substance use intervention services.

Goals of SBIRT Cultural Brokers

• Raise awareness about mental health and substance use within refugee communities
• Implement culturally responsive universal screening models that can reduce stigma associated with mental health and substance abuse treatment
• Connect community members to needed services
Unique elements across all communities

• Openly talking about mental health and substance use is not done let alone the idea of screening.
• When new to the U.S., individuals are repeatedly told NOT to share information about themselves.
• Strong suspicion and fear of what will be done with the information. This is even more true in the current administration.
• Belief that Cultural Brokers may be making a lot of money by screening others.

Elements specific to the Nepali community

• Alcohol, depression, and suicidality are the predominant areas of risk
• Drug use is a particular area of risk among youth
• Significantly older population that is struggling even more to adjust to the American way of life
• Belief that even raising the topic will bring misfortune in that area upon the individual
Elements specific to the Congolese community

• Alcohol is predominant risk
• Individuals tend to be highly educated and more financially secure. Thus, although engaging in risky use, may not identify negative consequences with drinking.

Elements specific to the Somali community

• Alcohol and marijuana are the predominant areas of risk for males
• Depression and hookah are the predominant areas of risk for females
• Given Muslim faith, it can be even more challenging to raise topic of alcohol and/or drug use for fear of being rejected by community.
Specific Culturally Sensitive ways of doing SBIRT

- Need to build the relationship and trust
- Provide good rationale of how it will benefit the individual and their community
- Emphasize and re-emphasize confidentiality
- Preface request for individuals to not be offended and explain why
- Be flexible with approach to adjust screening so person feels comfortable.

Value added of SBIRT Cultural Brokers

1. Members of own communities providing services ensuring CALC.
2. SBIRT provides a way of addressing struggles with alcohol and drug use our communities are facing since coming to this country
3. SBIRT helps to normalize talking about alcohol and drug use, and even depression.
4. SBIRT gives much needed basic information about alcohol and drugs in our communities. For many members, this is the first time they are getting this information and it also gives them a place to ask questions.
5. When people are struggling, it gives us a way to identify it and help them get the resources they need to change.
Value added of SBIRT Cultural Brokers

6. The flexibility of our approach allows us to help someone get the services they need
7. We collaborate with other providers.
8. We can help support family members when they are struggling to cope with a loved one’s use or have concerns about their mental health.
9. Often we end up helping them with other issues such as health care coverage, housing and fuel assistance in the winter.

Questions?

Thank you!
3. **Ways2Wellness CONNECT in the North Country**

Ways2Wellness CONNECT (W2WC) is North Country Health Consortium’s partnership with hospitals, health centers, Northern Human Services, and social service organizations to provide Community Health Workers (CHWs) to patients/clients 55+ with chronic diseases. The program links CHWs with patients who are struggling with unmanaged chronic disease and experiencing barriers to achieving overall health and wellness - often the social determinants of health such as food, transportation and housing. The strongest partnership is with Weeks Medical Center, with over 130 patients referred to the W2WC program.

- Annette Carbonneau, Program Manager, North Country Health Consortium, Acarbonate@nchcnh.org
- Alison Breault, RN, BSN, RN Care Coordinator, Weeks Medical Center, Alison.Breault@weeksmedical.org

**CHW Services:**
The Ways2Wellness CONNECT CHWs serve patients ages 55 +

- Participate in discharge planning to provide on-going support after hospitalization.
- Help to better understand provider instructions and medications
- Communicate and provide feedback to providers regarding changes in health status.
- Help manage chronic conditions to reduce ED utilization and re-hospitalization.
Effectiveness and Return on Investment

Many states have reported ROI resulting from integration of CHWs in health systems to help in managing patients with complex needs and frequent ED utilization.

States Reporting Cost Savings

*Savings : Cost*

- Pennsylvania- $1.80:1
- New Mexico- $3.92:1
- Texas- ranging from $3:1 to $15:1

*Community Health Worker Toolkit, a guide for the employer, Minnesota Department of Health, Office of Rural Health and Primary Care.

Care Coordination with Community Health Workers

CHW and WMC Partnership
- Identifying the need for Community health workers
- Coordination with Chronic Care Management
- Referral Process

Community Health Workers benefit the patient and provider:
- Care Coordination
- Improving quality indicators
- Assist in achieving goals
Impacted quality Indicators

- CHW have directly impacted our Quality Indicators
  - Improved patient satisfaction
  - Improved medication compliance and keeping follow up appointments
  - Decreased 30-day readmission rates
  - Decreased ED utilization
  - Improved Transitions of Care from hospital to home

- Benefits of CHW:
  - EASY referral process with prompt follow up
  - Receive phone call with intake meeting date
  - Receive prompt notes
  - Consistent and open lines of communication

Success Story

- 79 year old female patient living alone with poor medication compliance
- Referred to CHW after her labs came back showing a TSH level of 100.4 (Normal is 0.4-4)
- After Amber, CHW, worked with patient to set up med planner and pick up meds from pharmacy her TSH returned to normal levels
- Note from PCP:
  "This is the best I’ve seen the patient in years. So happy, bright, and very talkative!
  No more confusion or fatigue noted"
4. Leveraging Educational Homes to Maximize Health and Wellness in Manchester

The City of Manchester Health Department partnered with Amoskeag Health and three of the City’s most impoverished public schools and neighborhoods to create “community schools” to increase authentic resident engagement, social connectedness and the community’s sense of safety. In addition to being places of learning, these revamped schools and neighborhoods are becoming destinations where area residents can access a host of supports that improve community health: educational opportunities for residents of all ages, linkages to physical and mental health services, access to social services, leadership training, immunizations, health screenings, and community events.

- Anna Thomas, MPH, Public Health Director, City of Manchester Health Department, athomas@manchesternh.gov
- Kris McCracken, MBA, President/CEO, Amoskeag Health, kmccracken@AmoskeagHealth.org
A Long History of Partnering: Amoskeag Health and Manchester Health Department

- 1998 - Current: Amoskeag Health and Manchester Health Department coordinate refugee health services
- 2000 - Current: Amoskeag places Adolescent Preventive Services programs in the middle and high schools in Manchester
- 2005 - Current: Lease of CMO (Chief Medical Officer) as Manchester Health Department Medical Director
- 2006-2008: MSAP (Manchester Sustainable Access Project) Community Schools started by Manchester Health Department 2012
- 2013-CURRENT: Neighborhood Health Improvement Strategy Healthy Start Program
- 2014: Amoskeag Health joins Community Schools with CHW’s (Community Health Workers)
- 2016: Amoskeag Health adds BHC’s (Behavioral Health Consultants) to Community Schools in 2016
- 2017 - Current: Asthma Collaboration, now adding in diabetes and cardiovascular disease
- 2019-Current: Five Year Strategic Plan for Young Children and Families: LAUNCH Manchester (click here to download: https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3A17f2a9f3b-66b2-4e85-8e1f-66f6a34c722g)
- 2021: Future: School Based Health Center(s) Umbrella to bring together all of the related community schools and neighborhood activities

What is a community school?

- A community school is both a place and a set of partnerships between the school and other community resources.
- Its integrated focus on academics, health and social services, youth and community development and community engagement leads to improved student learning, stronger families and healthier communities.
- Community schools offer a personalized curriculum that emphasizes real-world learning and community problem-solving.
- Schools become centers of the community and are open to everyone – all day, every day, evenings and weekends
Or think about community schools this way...

Most people think of schools today as serving a single purpose: a binary, analog-system of delivery - teachers teach and students learn.

Community schools are more akin to smartphones. Schools and communities connect, collaborate, and create. Children and families have an array of supports from community partners right at their school.

Communities and schools leverage their shared physical and human assets to help kids succeed.

Community schools contain a host of built-in opportunities and supports that give students and parents all the tools they need to learn and grow.

Selected Highlights of NHIS Work Within Community Schools

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<thead>
<tr>
<th>NHIS Recommendation</th>
<th>Community Care Coordination</th>
<th>Key Accomplishments</th>
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</table>
| Early Childhood Development and Family Supports | - Initiated home visits for high-risk expectant mothers who are patients of the Manchester Community Health Center as an extension of the Center’s clinical team  
- Provide free childbirth education classes to all prenatal patients  
**Primary Partner: Manchester Community Health Center** | Ensuring a healthy start via 230 visits for 54 patients since January 2016  
- 100% of newborns are born at a healthy weight and 86% are full-term births  
- 100% of newborns are attending their 1st well child check visit after delivery, and 100% of mothers are attending their postpartum follow-up visit |
| Community Care Coordination: Strategically align and connect the health care delivery system with community and public health services to improve individual outcomes and overall neighborhood health through care coordination/case management in the elementary school environment | - Implemented a Community Health Worker approach by adding full-time staff to four elementary schools.  
  - Provide navigation support for families to community resources - connecting the school, medical, and neighborhood homes.  
  - Address barriers to accessing services, such as language/literacy, affordability, accessibility  
**Primary Partner: Manchester Community Health Center** | Assisted 362 families from September 2016 through June 2017  
- Approximately 25% of the families needed assistance in connecting or reestablishing with a medical home and/or health insurance  
*Estimated ROI for averted uncompensated medical expenses in high cost care points (such as emergency rooms)  
  - $2,000 per average ED visit x 90 families  
  - (3) 1.0 FTE CHWs with benefits = $110,000  
  - Total potential averted costs (after CHW salary) > $220,000 |
### Behavioral/Mental Health Systems Integration

<table>
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<tr>
<th>NHS Recommendation</th>
<th>Strategies</th>
<th>Key Accomplishments</th>
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| Mentoring: Provide intensive community services and programming for at-risk elementary-aged youth and their families to prevent truancy and promote attendance. | - Facilitated Pre-Attendance Campaigns (daily phone calls home, referrals for follow-up, importance of attendance)  
  - Bolstered social worker capacity to provide:  
    - Mentoring students who are missing 10% or more of school and/or experiencing trauma  
    - **Primary Partner:** Manchester Community Health Center | - Improved attendance and classroom behavior among 72 students at Beech Street and Gossler Park Elementary Schools (FY '16-'17)  
  - Nearly 1,100 visits total (~15 visits/student)  
  - 42% improvement in daily attendance  
  - 72% improvement in classroom/school behavior |
| Comprehensive School Behavioral Health: Strengthen the focus of behavioral/mental health care by co-locating providers in the elementary school environment. | - Initiated family intake assessment services in elementary schools to facilitate better access to the Mental/Behavioral Health Services  
  - **Primary partner:** Mental Health Center of Greater Manchester | - Increased access to behavioral/mental health services  
  - 127 Intakes completed and 136 Consultations at Beech and Gossler (Sept. '14-June '17) |

### Child/Family Resiliency & Wellbeing

<table>
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<tr>
<th>NHS Recommendation</th>
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| Resident Engagement and Empowerment: Create resident leadership training opportunities for youth and families to be engaged and empowered to lead/participate in efforts to improve neighborhood safety and overall quality of life. | - Implemented programming to increase skill development in children that fosters resiliency and leadership, such as The Leader in Me and Dovetail Toolbox  
  - Created opportunities for children to demonstrate leadership skills, such as an Earn-A-Bike Program  
  - **Primary partner:** DC Bike Collective | - Establishing culture change to support youth leadership development  
  - Nearly 1,100 elementary school children impacted at Beech and Gossler  
  - Since FY '15-'16, approximately 300 refurbished bike packages were earned by 4th and 5th grade students. |
| Employment and Financial Literacy: Reduce barriers to improving employability and financial literacy by developing capacity to coordinate/provide intensive community services and programming for families directly within neighborhoods.  
  - Resident Engagement and Empowerment: Create resident leadership training opportunities for youth and families to be engaged and empowered to lead/participate in efforts to improve neighborhood safety and overall quality of life. | - Initiated school-based programming to increase employability, financial literacy, parenting skills, and resident leadership to improve accessibility and affordability  
  - Free Volunteer Income Tax Assistance  
  - Free Hi-SET preparation programs  
  - Financial workshops (Common Cents in Uncommon Times)  
  - Parent/Caregiver support groups and classes, as well as family nights  
  - Resident leadership development programs and groups  
  - **Primary partners:** Easterseals NH and NeighborWorks Southern NH | - Increased employability  
  - 82 Hi-SET participants with 25 successfully completing the exam (since April 2016)  
  - Increased financial stability & literacy  
  - Over $14,000 in refunds in 2017  
  - Nearly $10,000 in EITC funds or Advanced Child Tax Credits in 2017  
  - 5 school-based financial literacy programs offered (2 in Spanish) for approximately 30 residents in FY ’16-’17 |
| Enhanced Places for Physical Activity: Invest resources in improving municipal parks/trails/school playgrounds and indoor recreational facilities to increase year round access to safe and affordable places for physical activity for residents of all ages. | - Constructed new Playground facilities at Beech Street Elementary School with funding support from Elliot Health System  
  - Constructing new Playground facilities at Gossler Park Elementary School with funding support from an anonymous donor at NH Charitable Foundation, City of Manchester School District, and NFPF/Disney grant award  
  - Implemented Playworks, an evidence-based recess model to increase physical activity and prevent bullying  
  - **Primary partner:** City Year New Hampshire (Playworks) | - Increased physical activity during daily recess at Beech Street Elementary School  
  - From 12 minutes to 17 minutes of active play time during a 20-minute daily recess  
  - Beach currently runs a 30-minute recess for 27 minutes of active play time/day  
  - **Improving inclusive play at Gossler Park Elementary School**  
  - Playground construction (Oct 2017) includes equipment to support play for all |
Coordination Across "Home" Environments

SCHOOL  MEDICAL  NEIGHBORHOOD
Healthy Start Home Visiting Program

- Modeled after the Nurse Family Partnership Program
- Started in 2015
- 1 Part-time maternal/child health home visiting nurse
- Serves Amoskeag Health pregnant patients
- Employed by Manchester Health Department
- Access to Amoskeag's EMR and participates in Amoskeag’s Prenatal Case Conference
- Funded by Elliot Hospital (where we deliver our patients)
Structure of Program

- Minimum of 3 home visits or as needed for special circumstances
- Visits last between 1-2 hours depending on patient needs
- Visits are conducted in the home or at the Manchester Health Department
- Participation is voluntary
- Referrals are made by Amoskeag Health
- Patients receive a $50 gift card and supplies after completion of the program

Role of Nurse Home Visitor:

- Provides information about fetal and child development, as well as childbirth education
- Provides answers to questions from medical appointments and consistent linkage back to the clinical team
- Assists in setting and meeting life course goals
- Provides information about care of newborn through handouts and demonstrations, including home assessments to prepare for birth
- Collaborates with Amoskeag Health providers as an extension of the clinical team
Outcomes to Date

- 73 high-risk, expectant mothers since the program’s inception in March 2016
- 30% speak a language other than English (47% Spanish)
- 76% have health insurance (24% charitable care)
- 60% have a chronic condition (including mental/behavioral health)
- 26 clients completed all aspects of the program (36% completion rate)
- 73% have positive CLS scores at discharge
- 91% full-term births
- 88% births at a healthy weight
- 95% attended their first pp OB visit
- 93% attended the first well child check-up

Asthma Program

- The Manchester Health Department receives referrals for high risk patients (based on things like ED visits, health insurance risk scores, etc) from Amoskeag Health and Elliot Primary Care. The CHWs assist Kathi with these visits as well.
- The Health Department has received 38 referrals to the Asthma home visitation program, of which 27 patients enrolled in the program. Of those enrolled, 20 patients have received at least 2 home visits (74%). Asthma trigger mitigation supplies (mattress covers, etc) were provided to 11 patients.
- Of the 11 patients who failed their first SAAM (self-demonstration of medication use) upon intake AND had at least two home visits, 7 patients improved from fail to pass (64%). Of the 16 patients for whom we have complete follow-up data at 6+months, 10 (63%) showed improvements in their ACT scores (asthma symptoms).
5. Community Care Teams with Connections for Health in Rockingham and Strafford Counties

A community of 50+ clinical and social service providers, including 4 hospitals and their primary care systems, meeting regularly in three settings across the region, sharing one Release of Information, and creating shared care plans for the region’s most vulnerable populations. Connections for Health / IDN Region 6 facilitates and promotes the regional Community Care Teams (CCTs).

- Sandi Denoncour, BA, ASN, RN, Director of Care Coordination, Connections for Health, sdenoncour@co.strafford.nh.us
- Tory Jennison, PhD, RN, Director of Population Health, Connections for Health, tjennison@co.strafford.nh.us
Connections For Health
Region 6 Integrated Delivery Network

- Administrative Lead: **Strafford County**
  - Seacoast & Strafford Public Health Networks (36 cities/towns)
  - 30,100 attributed lives (Dec 01, 2018)
  - Key Clinical Partners
    - 2 CMHCS (Community Partners & Seacoast Mental Health Center)
    - 3 Federally Qualified Health Centers
    - 4 Hospitals & affiliated primary care practices
    - Multiple SUD providers
    - 1 Doorway provider
How We Started

- Started slowly in Fall 2015
  - Greater Seacoast Coalition to End Homelessness convened a Community Care Team in Portsmouth (approx. 10 partners)
  - Based on Middlesex, CT Model to address Homelessness
  - Modest group of agencies and organizations scheduled a meeting Date and.....

- Biggest Lifts:
  - Shared/Common Release of Information
  - Case Presentation format (paper & in person)

How we think it works in our Agency & How clients THINK it works with everyone....

.... as a choreographed, executed effort by people working as a recognizable team...

How it actually works...

...a chaotic free-for-all with individuals who look like they MIGHT be on the same team, but no one is sure what the game is...
**CCT Guiding Principles**

- **Objective**
  To provide person-centered care and improve outcomes by developing wrap-around services through multi-agency partnership and care planning.

- **Core Belief**
  Community collaboration is necessary to improve health outcomes.

- **Core Understanding**
  Complex Bio-Psycho-Social problems are community problems. **No one entity alone can effectively improve outcomes for complex and vulnerable populations.**
Where we are today

- **237** Individuals discussed in 36 months
- **216** Currently considered active
  - 58% are Medicaid beneficiaries
  - 29% are Medicare beneficiaries
  - 63% had a PCP when referred to the CCT
  - 51% homeless
    - Additional 15% are unstably housed
  - 54% have a diagnosed or suspected mental health condition
  - 45% have a diagnosed or suspected substance use disorder
  - 52% are engaged with 1 or more organizations

Where we are today

- Release of Information & Confidentiality Agreement - 58 agencies (& script)
  - (Members & Visitors)

- Process Improvements
  - Communication
    - Meeting Facilitation
    - Shared Care Plan/Event Notification solutions
  - Case Template

- Meet monthly in Portsmouth since 2016
- Meet every 2 weeks in Strafford County since March 2018
- Meet monthly in Exeter since January 2019
How We Do It

<table>
<thead>
<tr>
<th>REFERRAL NAME</th>
<th>Date of Birth</th>
<th>Insurance</th>
<th>Military Service?</th>
<th>Primary Care Provider and Visit History</th>
<th>Emergency Dept History (if applicable)</th>
<th>Other providers with whom patient/client is engaged</th>
<th>Housing Status</th>
<th>Income</th>
<th>PHONE</th>
</tr>
</thead>
</table>

Presenting medical/psychosocial issues and any significant health and social determinant status and/or history.

Care plan from earlier referrals
Who We Do It With

<table>
<thead>
<tr>
<th>IDN CCT members:</th>
<th>OneSky Community Services</th>
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<tbody>
<tr>
<td>Amedisys</td>
<td>Portsmouth Community Services</td>
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<tr>
<td>Beacon Health Strategies*</td>
<td>Portsmouth Regional Hospital</td>
</tr>
<tr>
<td>Child &amp; Family Services of NH</td>
<td>Region 6 Integrated Delivery Network</td>
</tr>
<tr>
<td>Community Action Partnership of Strafford County</td>
<td>Rochester Community Recovery Center</td>
</tr>
<tr>
<td>Community Partners</td>
<td>Rochester Housing Authority</td>
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<tr>
<td>Connections Peer Support Center</td>
<td>Rockingham Community Action</td>
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<tr>
<td>Cornerstone VNA</td>
<td>Rockingham VNA</td>
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<tr>
<td>Cross Roads House</td>
<td>Safe Harbor Recovery Center</td>
</tr>
<tr>
<td>Crooked Mountain Community Care</td>
<td>Salvation Army, Portsmouth</td>
</tr>
<tr>
<td>Dover Housing Authority</td>
<td>Seacoast Mental Health Center</td>
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<tr>
<td>Easter Seals of NH</td>
<td>Seacoast Pathways (Granite Pathways)</td>
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<tr>
<td>Exeter Health Resources</td>
<td>ServiceLink of Rockingham County</td>
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<tr>
<td>Families First of the Greater Seacoast</td>
<td>ServiceLink of Strafford County</td>
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<tr>
<td>Families in Transition (FIT)</td>
<td>Somersworth Housing Authority</td>
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<tr>
<td>Frisbie Memorial Hospital</td>
<td>SOS Recovery Community Organization</td>
</tr>
<tr>
<td>Goodwin Community Health</td>
<td>Southeastern NH Services</td>
</tr>
<tr>
<td>Granite Pathways</td>
<td>St. Vincent dePaul Society</td>
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<tr>
<td>Granite State Independent Living</td>
<td>Tri-City Consumers’ Action Co-operative</td>
</tr>
<tr>
<td>Greater Seacoast Coalition to End Homelessness</td>
<td>Veterans, Inc.</td>
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<tr>
<td>Haven</td>
<td>Welfare Department, City of Dover</td>
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<tr>
<td>Homeless Center for Strafford County</td>
<td>Welfare Department, City of Portsmouth</td>
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<tr>
<td>Hope on Haven Hill</td>
<td>Welfare Department, City of Rochester</td>
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<tr>
<td>The Homemakers Services</td>
<td>Welfare Department, City of Somersworth</td>
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<tr>
<td>My Friend’s Place</td>
<td>WellSense Healthplan*</td>
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<tr>
<td>NH DHHS Bureau of Elderly and Adult Services</td>
<td>Wentworth-Douglass Hospital</td>
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<tr>
<td>NH Healthy Families*</td>
<td>Wentworth Home Care and Hospice/Amedisys</td>
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<td>NH Housing Finance Authority</td>
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Evaluation: Process Challenges

- Efficiency
  - Introductions (staff turnover/new representatives)
- Plenty of notice of the cases scheduled for discussion
- Everyone MUST come prepared
- Ensuring the meeting isn’t dominated by discussion of one case
- Structure for follow-up and accountability
  - Consistent communication between/after meetings
    - Still phone, most often
    - Email limited by PHI/security risk
    - Beta-testing shared care plan
Evaluation – Values/Benefits

COLLABORATION
- Real-time, multi-agency group interaction on solutions/resources - efficiency
- Collaboratively develop and align care plans that result in closing gaps and improving outcomes
- Identifying resources – no one is alone in this
- Learning about partner agency operations

NETWORKING
- Building my network of providers
- Helping me see the big picture and how the pieces fit together
- Opportunity to network with other providers and gather and give information.

MORE COMPLETE PICTURE OF CLIENT
- Putting pieces of the puzzle together, including behavior patterns.

Evaluation: Outcomes Tracking

**Patient:**
- Decreased Vulnerability/Risk
- Improved quality of life:
  - Recovery
  - Mental health stabilization
  - Reduced homelessness
  - Re-entry to workforce
  - Re-connection with family
  - Achievement of feelings of self-worth and respect
- Linkages to:
  - Primary care physicians, psychiatrists, specialists, etc.
  - Housing & Community Services
  - Appropriate outpatient services

**Collaborative:**
- Improved patient care
- Improved agency-specific care plans
- Improved inter-agency communication and relationships

**Community/Social:**
- Prevention and response Infrastructure
- Increase in safety to all
- Reduction in Medicaid & Medicare costs
- Increased community capital
✓ IS NOT always case based

✓ IS facilitated reflection on what it takes to collaboratively meet group objectives with consistent, affirmative client focus.