Dignity Health.
St. Joseph's Hospital and Medical Center

# 2014
# 2015

# Arizona Community of Care Network

## The following are the 2014-2015 Communities of Care that were funded through Dignity Health Community Grants:

**Community of Care Title:** C.A.T.C.H (Clients Aligned through Community and Hospital)

**Dignity Health Community Grant Dollars Awarded**: $75,000 (2014, 2013, 2012 Dignity Health Grant Funded)

**Participating Organizations:**

- Duet: Partners in Health & Aging - Duet has an expertise in recruiting, training and managing community volunteers, including parish nurses
- Foundation for Senior Living Programs - FSL's flagship services are client assessments and case management focused on keeping vulnerable seniors at home for prolonged periods
- Keogh Health Connection – Keogh offers trained staff that can identify additional funding support for CATCH pilot patients and assist in submitting applications for AHCCCS, ALTCS, SNAP and other programs.
- Catholic Charities – provides a variety of services which include behavioral health counseling, immigration services, housing and other social services.

**Program Description & Target Population:** Often the most difficult part for patient centered medical homes, such as the IMC, is providing the appropriate community services to complement medical care. (This is especially true for the zip codes indicated below.) Agreement exists on the efficacy of adding community services, but little data exists to validate their impact, resulting in limited funding for services with only anecdotal evidence. The CATCH project for the two years (2013 and 2014) will support a total of 125 chronic care patients chosen from SJHMC's Internal Medicine Clinic. Patients will be extensively case managed for three months to determine community need. Care will then be coordinated across community agencies for another nine months. CATCH will report on the effect that a package of selected community services can have on improving treatment compliance, stabilizing disease indicators and reducing ER visits and hospital readmissions. The IMC will assess results against baseline data for the enrolled CATCH patients. Majority of IMC patients are uninsured or underinsured and difficult to stabilize due to accumulated disadvantages of poverty, low education, insufficient social supports, noncompliant behaviors and multiple comorbidities. Characteristics of this population include:

- High use of ER and IMC
- High hospital readmission rates
- Multiple comorbidities, with high incidence of CHF, AMI, PNEU
- 70% have behavioral health issues
- Social isolation: single, living alone, often no regular caregiver
- Need support to access benefits
- Lack of transportation to IMC appointments

The CATCH program will not enroll homeless or seriously ill patients or those residing more than 10 miles from the IMC.

**Linkage to the Hospital:** Community of Care is working with the Internal Medicine Clinic Director and Staff. The recommendation is concentrate on patients with the following high risk diagnoses: PNEU, CHF and AMI.

**Goals**:

1. 20% Reduction in ER Visits and Admissions
2. 70% Reduced missed/cancelled appointments at the IMC
3. 100% Patient Homes visited jointly by IMC Residents/Faculty/Med Students and Social Work
4. Improved scores of bio-psycho-social indicators

**Community of Care Title:** HSC Collaborative

**Dignity Health Community Grant Dollars Awarded**: $35,000 (2014 Dignity Health Grant Funded)

**Participating Organizations:**

- Human Services Campus LLC (HSC) uses the power of collaboration to create solutions to end homelessness.
- Lodestar Day Resource Center (LDRC) a safe, engaging, holistic community that empowers people to end their homelessness and create positive, long term life changes.
- Community Bridges (CB) – To maintain the dignity of human life. CB provides comprehensive, medically integrated behavioral health programs that include prevention, education and treatment services.

**Target Population:** The collaboration serves homeless, chronically homeless and very low income adults accessing services on the Campus or living in the 85007 zip code. The project will specifically address the needs of homeless individuals who are immediate crisis and extremely vulnerable due to poor physical health issues, serious mental illness, behavioral health concerns and chronic substance abuse.

**Linkage to the Hospital:** In addition to clients encountered at the Campus, St. Joseph's and Circle the City along with other area hospitals provide most of the referrals to the Intensive Engagement Specialist. Since initiating this work 2 1/2 years ago, relationships with hospital staffing have resulted in pre-release coordination which helps to ensure the client exits the hospital to somewhere other than the streets. Stays in shelter are only temporary until housing is obtained. The ability to connect clients to housing is the result of partnership with housing providers like AHI, ABC, HOM and public housing programs.

Additional supports for the clients are provided by St. Joseph the Worker, Healthcare for the Homeless, Southwest Behavioral, NOVA, St. Vincent de Paul, the VA and other agencies focused on serving homeless men and women.

**Goals**:
Over the year, the LDRC, CB and the HSC anticipate that:

1. 100% of medically needy clients served by the Intensive Engagement Specialist will be connected with appropriate services including housing.
2. 100% of clients in crisis will be immediately treated and connected with services necessary to stabilize such that the client can engage in the housing process and other supportive services.

**Community of Care Title:** Native Health Collaborative

**Dignity Health Community Grant Dollars Awarded**: $75,000 (2014, 2013, 2012, & 2011 Dignity Health Grant Funded)

**Participating Organizations:**

- Native American Connections (NAC) - is improving the lives of individuals and families through Native American culturally appropriate behavioral health, affordable housing, and community development services.
- Native Health (NH) - provides holistic, patient centered, culturally sensitive health and wellness services.
- Phoenix Indian Center (PIC) - develops a strong American Indian community through collaborative partnerships and providing quality, culturally based services.

**Target Population:** Native American chronically homeless, medically needy adults in zip codes 85003, 85004, 85007, 85008, 85009, 85012, 85013, 85014, 85015, 85016, 85017, 85019, 85021, 85025, 85034

**Linkage to the Hospital:** Each partner agency brings their expertise to assure access to housing resources, medical and behavioral healthcare, substance abuse treatment, job placement assistance, help with obtaining benefits or other resources as needed. The Intensive Case Manager coordinates the sharing of information and resources between partners as the client moves through his or her case management goals towards permanent housing, improved health and increased income.

**Goals:** Collaborative Goal: Connect a minimum of 60 chronically homeless Native American clients with medical home, patient education & prevention strategies for those with diabetes & high blood pressure; employment services and benefit assistance; and permanent housing.

Native Health: To encourage clients to establish a medical home in order to access integrated medical, dental & behavioral healthcare inclusive of patient education to better manage ongoing wellness, and self-management of chronic illnesses including diabetes and high blood pressure.

PIC: To connect clients seeking employment with PIC or community resources needed to secure employment or upgrade job skills.

NAC: To connect clients with permanent housing and provide access to behavioral health services including residential treatment as needed.

**Community of Care Title:** Project Independence & Empowerment (PIE)

**Dignity Health Community Grant Dollars Awarded**: 75,000 (2014 Dignity Health Grant Funded)

**Participating Organizations:**

- Arizona Bridge to Independent Living (ABIL) offers and promotes programs designed to empower people with disabilities to take personal responsibility so that they may achieve or continue independent lifestyles within the community. The Sports and Fitness Center for Persons with Disabilities (SpoFit), a program of ABIL, has a mission to provide exceptional adaptive sports, recreation, aquatic and fitness programs that promote the independence, health and overall wellbeing of people with disabilities and their family members.
- The Arizona Spinal Cord Injury Association (AZSCIA) is a nonprofit organization dedicated to enhancing the lives of individuals with spinal cord injuries. Our goal is to promote physical, intellectual, spiritual, emotional and social recovery. The Association focuses on peer and family support, education of consumers, families, caregivers, and professionals, and linking people to vocational, social, and recreational resources.

- The Brain Injury Alliance of Arizona (BIAAZ) is a nonprofit organization dedicated to preventing brain injuries and to improving the lives of individuals with brain injuries through prevention, education, information, and community support.

**Program & Description & Target Population:** When a patient has received services in the rehabilitation continuum (inpatient, outpatient, etc.) at St. Joseph's Hospital and Medical Center, they will be eligible to participate in Project Independence & Empowerment (PIE). The PIE partners will provide services to people with disabilities, and their families, that are transitioning from SJHMC rehabilitation continuum to the community. This population includes people with physical and cognitive disabilities, including spinal cord injury, brain injury, stroke, and those with chronic health conditions. We serve people on a cross disability basis, of all ethnic and cultural backgrounds, including the elderly. Leaving the hospital to the home or community environment is a pivotal stage in the health of individual(s) that have been

impacted by a life changing injury. AzSCIA and BIAAZ will provide free access to community based prevention, education, peer support and opportunities for persons with a variety of disabilities. Patients currently visit SpoFit with SJHMC staff as an introduction to community resources. With this funding, SpoFit can provide more individualized fitness instruction and education, as well as free gym membership, promoting a healthy lifestyle which is vital in this transitional stage. For those patients that leave SJHMC and enter an extended care facility, PIE will conduct outreach to these facilities and educate them about our program. Through the mentors of the Barrow Connection, Connectors, will help patients transition to the program when they are ready. AzSCIA will also provide transportation for participants that are need, including door to door transportation to SpoFit for their initial assessment.

**Linkage to the Hospital:** PIE partners will attend monthly community resource classes offered in the inpatient rehabilitation unit. This will initiate integrating in the continuum of care. However, if a patient is not treated in the inpatient department or does not attend the class, outreach efforts will be made to ensure patients in the continuum are educated on the PIE program. PIE has a network of disability related partners at the Disability Empowerment Center, enhancing the seamless continuum of care.

**Goals:** Through the Community of Care Program, the PIE program will assist SJHMC rehabilitation patients with a seamless transition from the hospital to the community setting. Among adults with disabilities, through health, fitness & nutrition education/activities; socialization opportunities; peer support; and community transition resources our overall program goals are:

ABIL has the specific goals utilizing Spofit:

1. Participants will have an increase of exercise participation after starting the PIE program.
2. Participants will have an improvement through basic health assessments:
    a. Decrease in BMI
    b. Improvement in blood pressure
    c. Appropriate weight loss or gain
    d. Reduction in contradicting health activities
    e. Quit smoking
    f. Alcohol consumption reduction

AzSCIA Goals:

1. Participants will participate in increased educational and socialization opportunities which reduces isolation after an injury and fosters peer relationships.
2. Participants will have improved transportation available to them which allows for: independence, participation in educational, social and recreational events, and regular visits to Spofit.
3. Participants will have increased access to community resources and information to assist with their transition from the hospital to the community.

BIAAZ Goals:

1. Participants will have an improved understanding of brain injury and symptom management.
2. Participants will have an increased knowledge base of community resources available to enhance quality of life.
3. Through education courses participants will demonstrate healthier lifestyle choices, including food selection, physical movements, and relaxation techniques designed to optimize brain function.

**Community of Care Title:** Smooth Way Home

**Dignity Health Community Grant Dollars Awarded**: $60,000 (2014, 2013, 2012, 2011 Dignity Health Grant Funded)

**Participating Organizations:**

- Southwest Human Development (SWHD) - vision is a positive future for every child. Our mission is to strengthen the foundation Arizona's children need for a great start in life. We are Arizona's largest nonprofit dedicated to early childhood development with a staff of over 800, serving more than 135,000 young children and their families each year. The agency's overall goal is to help children establish a healthy foundation by preventing problems before they arise, or when they already exist, intervening as early and effectively as possible. Southwest Human Development will serve as the backbone agency for this Community of Care.
- Raising Special Kids (RSK) – mission is to improve the lives of children with the full range of disabilities, from birth to age 26, by providing support, training, information and individual assistance so families can become effective advocates for their children.
- Feeding Matters (FM) – mission is to bring pediatric feeding struggles to the forefront so infants and children are identified early, families' voices are heard, and medical professionals are equipped to deliver collaborative care. Feeding Matters is recognized at the local and national level for its innovative work and has created a Medical Professional Council of Internationally recognized feeding experts. This Council developed the Infant and Child Feeding Questionnaire© to help identify children at risk for eating/feeding challenges, and to provide guidance regarding this critical area of development.
- Arizona Postpartum Wellness Coalition (APWC) – mission is to improve the pregnancy and postpartum experience for Arizona families through providing support for families and professionals, increasing awareness of the serious nature of perinatal mood disorders, and improving access to available screening methods, treatment options and resources in Arizona.

**Program Description & Target Population :** The target population for Smooth Way Home (SWH) is fragile infants and their parents who are transitioning from SJHMC's NyICU back home.

Secondary target is fragile infants and families at other participating SWH NICUs (8 Level 2 and 3 NICUs). These include babies with conditions such as extreme prematurity, very low birth weight, failure to thrive, Broncho pulmonary dysplasia, IVH, chromosomal disorders, substance exposure, and CNS damage. They are at known risk for future medical & developmental problems as well as frequent hospital readmission and Shaken Baby Syndrome. Over 50% of these babies have feeding/eating problems by 6 mos. of age and over 20% are failure to thrive by 8 mos. Their parents have a 38% + risk of experiencing perinatal mood disorders (postpartum depression and anxiety, PTSD, OCD, and psychosis.) These mental health problems can also have serious health and developmental consequences for the babies. The service area includes all priority CNI zip codes for this Dignity Health Community Grant. SWH teams are established in the hospitals that serve Central Phoenix (SJHMC, Maricopa Medical Center, & Good Samaritan Hospital). The proposed outpatient NICU Parent Support Groups will be held at SJHMC and open to any family: they will, therefore, be readily available to families from the Central Phoenix zip codes. SWH targets families who are disproportionately burdened by poor health due to (1) their infant's medical status as described above; (2) lack of access to a medical home; (3) high incidence of poverty and other social risk factors; and (4) unavailability of resources and supports which address significant perinatal parental mental health problems.

**Linkage to the Hospital:** SWH GOAL: Babies' & families' needs are identified & plans made to address them prior to discharge from the NICU. Families are connected with health related and other community services. STRATEGIES: implementation of SWH Clinical Pathway for Discharge Planning which provides a road map for collaboration between NICU & community providers, and outreach & support to families while in the NICU. SWH strengthens connections between NICU staff, state agencies, families, and community services.

**Goals:** The shared goals of the Smooth Way Home Community of Care are as follows:

1. Increase NICU staff and community providers' awareness of and knowledge about (1) perinatal mood disorders experienced by NICU parents and (2) feeding challenges of NICU babies. (3) Increase these providers' familiarity with and ability to use the NICU Parent Resource Manual.
2. Enhance Smooth Way Home Clinical Pathway for Discharge Planning by addition of a Feeding Plan and screening for perinatal mood disorders. Support implementation of Clinical Pathway in its entirety in participating NICUs. Promote expansion of SWH Program to additional NICUs in Maricopa County.
3. To offer NICU families the education, resources, & support needed to address postpartum mental health disorders for which they are at very high risk & which can significantly impact their child's future health, growth, and development. These include postpartum depression, PTSD, OCD, and psychosis. SWH will continue to offer resource support to NICU parents as they transition home through use of the NICU Parent Resource Manual and by connecting them to RSK & their trained NICU parent mentors.

**Community of Care Title:** SOAR Into Housing

**Dignity Health Community Grant Dollars Awarded**: $55,000 (2014 Dignity Health Grant Funded)

**Participating Organizations:**

- Human Services Campus (HSC) mission is to use the power of collaboration to create solutions to end Homelessness. The HSC provides centralized intake and coordinated assessment for homeless single adults in Maricopa County, along with ensuring ongoing diversion coordination to more appropriate systems of care for victims of domestic violence, veterans, youth and families
- Circle the City (CTC) mission is to provide a time and place to heal for homeless individuals experiencing illness or injury as they journey towards healthy, independent living. To achieve this, Circle the City provides each patient with compassionate medical care and highly effective human services to address the holistic needs of the individual, including the underlying causes of his or her homelessness.
- Lodestar Day Resource Center mission is to provide a safe, engaging, holistic community that empowers people to end their homelessness and create positive, long-term life changes. Services include case management, access to an array of supportive services, and housing assistance.

**Program Description & Target Population:** The focus of SOAR Into Housing is to leverage mainstream resources to assist high acuity individuals experiencing homelessness with appropriate housing resources. To accomplish this, the partners will utilize SSI/SSDI Outreach, Access, and Recovery (SOAR). Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), SOAR is designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder. This includes social security (SSI) and social security disability (SSDI) benefits. Providing a SOAR navigator onsite at CTC will increase the positive housing outcomes of the individuals receiving care and connect them more rapidly with appropriate resources. A pre-screen assessment will be conducted to determine the clients who are most appropriate for the SOAR program. Once benefits are received, the partners will work together to connect the client with housing.

The target population is homeless individuals living at or near the Human Services Campus located in downtown Phoenix within zip code 85007. The target population will specifically address homeless and chronically homeless individuals with physical and mental health issues along with disabilities that utilize crisis services including St. Joseph's hospital resources.

Human Services Campus, Lodestar Day Resource Center and Circle the City. Many will be current or former patients of St. Joseph's Hospital.

**Linkage to the Hospital:** Having worked together for three years, the partners have created a system of care that supports clients as they move between the streets, the hospital, respite care and housing. In constant communication, the Campus Intensive Engagement Specialists, Navigators, Housing specialists and new this year, the SOAR Benefits Specialist are able to identify needed resources and respond in a timely and effective manner in order to increase the client's health and wellness along with housing stability.

**Goals**: The goal of the SOAR Into Housing Collaborative is to help medically vulnerable, homeless individuals gain social security/disability benefits in order to secure the income needed for permanent housing.

- CTC goal is to obtain social security or social security disability on behalf of eligible homeless clients.
- LDRC goal is to increase the community capacity to end homelessness by providing SOAR training and technical assistance.
- HSC goal is to ensure coordination of services and training between the partner agencies and that all work aligns with coordinated assessment and service prioritization.

**Community of Care Title:** Welcome Home: Prioritizing Medically Vulnerable Individuals for Housing

**Funding:** 50,000 (2014 Dignity Health Grant Funded)

**Collaborating Organizations:**

- Circle the City (CTC) – Everyone deserves a time and place to heal. Circle the City embraces people experiencing homelessness with compassionate medical care and meaningful human services as they journey toward healthy, independent living. For those in our community experiencing illness and homelessness, there will always be a place to heal, recover and realize a better life.
- CSH's – mission is to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities.
- The Continuum of Care Regional Committee on Homelessness – promotes community wide commitment to the goal of ending homelessness; Facilitates access to funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promotes access to and effect utilization of mainstream programs by homeless individuals and families; and optimizes self-sufficiency among individuals and families experiencing homelessness.

**Program Description & Target Population:** Welcome Home, an outgrowth of the Frequent User Service Enhancement (FUSE) pilot, will develop/implement a process to identify, assess, treat & prioritize medically vulnerable homeless persons for finite SH resources. FUSE successfully engaged, treated, stabilized & housed 15 medically vulnerable homeless persons & resulted in significant reductions in ER & inpatient costs and substantial increases in client self-sufficiency. FUSE participant identification, however, was imprecise & labor intensive, resulting in the need for a system wide methodology to ensure accurate identification & prioritization of the target population for SH. Each year, the Maricopa County region draws down $25M in HUD funding for homeless housing and services. Unfortunately, funds are not prioritized to the most medically vulnerable people. The Service Prioritization Decision Assistance Tool (SPDAT) has been piloted in the general homeless population to better target resources; However, it is not known if the tool is sensitive enough to identify medically vulnerable persons. Also, the process by which the tool is administered may negatively impact the target population. For instance, the length and location of the interview may discourage or even prohibit individuals from participating. Welcome Home will test the SPDAT on medically vulnerable homeless persons at SJHMC & CTC. If the tool is not sensitive enough to identify the target population, a process &/or tool will be developed to identify medically vulnerable homeless individuals. Welcome Home will also develop a process to administer the tool/process in order to maximize

engagement of the target population & to develop a process to prioritize & expedite access to SH.

**Linkage to the Hospital:** Maricopa Association of Governments is piloting the SPDAT & coordinated assessment process for individuals on the homeless campus. There is no process, however, to identify, prioritize, serve & track medically vulnerable homeless individuals. CTC will serve as the medical hub for SPDAT assessment, stabilization and treatment & will inform the development of the identification/prioritization process. CSH will work with MAG to implement a system wide process for identifying/prioritizing homeless individuals for limited SH.

**Goals:** The partner goals are focused on improving access to SH, including appropriate medical care for homeless medically vulnerable individuals:

1. Develop a method/process to effectively identify medically vulnerable homeless individuals.
2. Medically vulnerable homeless individuals will have improved access to and more appropriate utilization of health care, resulting in improved health outcomes.
3. Medically vulnerable homeless individuals will demonstrate greater self-sufficiency in both social emotional and economic domains.