

**HRSA Healthy Tomorrows Partnership for Children Program  
Jewish Renaissance Medical Center  
Final Report and Abstract**

**PROJECT IDENTIFICATION INFORMATION**

**Project Title:** Newark School-Based Health Center Program (NSBHC)

**Project/Grant Number:** H17MC23545

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**Project Period:** March 31<sup>st</sup>, 2012 – February 28<sup>th</sup>, 2017

**Total Amount of Grant Awarded:** \$218,725

## **PROGRAM NARRATIVE**

### **1. PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS:**

With HRSA-HTPC funding and working with the Broader-Bolder Approach (BBA) model, JRMC has expanded Behavioral Health Care within the Newark Public Schools Street Community School, located less than a mile from our Central High School location in Newark's Central Ward. By shifting the operations to Newark Public Schools Street Community School, a pre-K through 8 school, it is now easier to conduct counseling sessions as the younger students feel more comfortable in their school environment instead of a large high school setting.

**Addressing the Goals of the *Bright Futures for Infants, Children, and Adolescents* model.** Given the comprehensive nature of NSBHC and the collaborative, multi-sector construct involving healthcare providers, educators, and government, it is very much our contention that the tenets of NSBHC are directly consistent with the “*Bright Futures for Infants, Children, and Adolescents*” model, particularly in respect to addressing children health needs in the context of family and community. Key NSBHC factors that correlate to the Bright Futures model are:

- ✓ *Building Individual Capacity for Self-Care.* Our care management methods are designed to enable our NSBHC children and youth and their parents or caregivers to reduce risk associated with medical or mental illness, while increasing behaviors associated with health and well-being, including understanding signs associated with illness.
- ✓ *Building the Capacity to Self-Advocate.* We are furthering efforts to educate – and empower – our users and their families to self-advocate, i.e., learning how to obtain, organize and utilize multi-systemic resources to address their needs associated with healthcare. This is based on extensive research and literature that finds the direct correlation between building health literacy through developing a sense of self-determination.
- ✓ *Building Correlation of Individual Health to Community Health.* Employing a “*place-based approach*” where the location of our programs, services, and strategies are situated within an ‘inverse pyramid’ model in locating services, i.e., starting from programs that are strategically placed within physical sites that have direct access to target users, including programs and staff situated within public schools and public housing developments on a full-time basis; to target neighborhoods to target municipalities to broader County-wide and regional approaches.

### **2. GOALS AND OBJECTIVES:**

**Progress on Specific Goals.** The initial two core goal statements at the beginning of the report are pertinent to HRSA-HTCP funding are: (1) to increase the quality, access, and effectiveness of the assessment and treatment of medical, mental, and social needs of target children and youth; and (2) to improve the educational and health outcomes of target youth. With respect to our first goal statement, the table below outlines our projected measures versus actual performance:

<b>Specific Objectives</b>	<b>Performance Measures</b>	<b>Actual Performance</b>
<i>Medical Care</i> – To improve the health and wellness of children and youth served.	(1) 100% of all medical patients will be provided with a comprehensive or periodic recall exam.	(1) 100% of all users enrolled within NSBHC have received a comprehensive exam.
<i>Behavioral Care</i> – To directly confront the psycho-social challenges our children and youth face.	(1) 100% of behavioral care patients will be provided with a comprehensive assessment.  (2) Achieve 90% compliance for the number of patients returning for follow-up care in the second and subsequent years.  (3) 40% of the parents of our users will be engaged in the parent engagement/support group component.  (4) 60% of parents will achieve learning objectives associated with parent engagement/support group activities.	(1) 100% of NSBHC’ behavioral care users have completed a comprehensive assessment.  (2) Data not yet available.  (3) The parent engagement/support group component has not been initiated; however, we anticipate the support group being active as we move into the 2015-2016 School Year. The need for individual and small group counseling for the children exhausted all the LCSW's time. While a formal support group was not organized, she individually engaged the parents of the patients whom she counseled. This included increasing their caregiving capacity, particularly with respect to understanding children with emotional and/or behavioral disorders.  (4) Same response as #3 above.
<i>Dental Care</i> – To offer the full system of oral health services to achieve dental health for users.	(1) 100% of dental patients will be provided with a comprehensive or periodic recall oral exam.  (2) Achieve 90% compliance for the number of patients returning for follow-up care in the second and subsequent years.  (3) 80% of users and their parents/caregivers ages will receive patient education for oral health and anticipatory guidance in the medical setting.	(1) 100% of NSBHC’ dental care users have completed a comprehensive assessment.  (2) Data not yet available  (3) 100% of dental care users are provided with one-on-one education and counseling associated with oral health.

<b>Specific Objectives</b>	<b>Performance Measures</b>	<b>Actual Performance</b>
<p>Access – To provide the supports and advocacy to ensure all users and families have the opportunity to access medical insurance and other forms of public assistance and benefits.</p>	<p>Of those users who enter our program without health insurance, 90% of users will be qualified and enrolled into appropriate subsidized insurance program, or enrolled into New Jersey Uncompensated Care system.</p>	<p>100% of all patients without insurance were enrolled in an insurance program through the assistance of a federally-certified navigator or certified application assisters. JRMC is one of five organizations in the state to be awarded a three-year grant from the Centers for Medicaid and Medicare (CMS) to support outreach efforts designed to connect people with local help as they seek to understand the coverage options and financial assistance available at HealthCare.gov. The three year-long Marketplace Navigator grants fuel efforts to help consumers enroll in a health care plan that fits their budget and best meets their family's needs. Navigators and assisters are trained specialists who provide consumers in their communities with in- person help, answering their questions about their health insurance and financial assistance options and assisting them as they complete their application. Navigators and assisters are knowledgeable about the range of health plans available on HealthCare.gov as well as other public health insurance programs offered in their state, including Medicaid and the Children's Health Insurance Program (CHIP).</p>

**3. METHODOLOGY:**

With respect to HRSA funding, JRMC sought to address the *behavioral care component* within the existing continuum of NSBHC services, in particular, to care for children and youth diagnosed with mental/developmental disorders or displaying persistent signs of same. Working in partnership with Newark Public Schools, parents, and other stakeholders, JRMC set forth a comprehensive framework of interventions, treatment, and service coordination essential to achieve behavioral stability and growth for each child care for in the NSBHC site. Our service flow is outlined below:

- *Evaluation Process* – The school-based Social Worker, in tandem with Teachers and other staff as appropriate, complete a full and individualized pre-placement evaluation of unique educational and behavioral needs for students suspected of having a behavioral disorder. Parents, students, school personnel, and/or JRMC staff may request an evaluation. If not parent-initiated, the student’s parents or legal guardians receive a notice from Newark Public Schools that documents the specific reasons a child has been identified in need of an evaluation, the evaluation procedures, and an explanation of their rights and procedural safeguards. The school and JRMC must have written approval from the parents or guardians before proceeding. Upon approval, a multidisciplinary team that includes at least one teacher, JRMC’s Child Psychiatrist, Newark Public Schools School Child Study Team leader, or other specialist familiar with the suspected

disorder conducts the evaluations. Evaluation results are based on multiple assessment measures related to the suspected disorder. These related areas typically include, as appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. The team reviews assessment results to determine student eligibility for special education, JRMC-based interventions, and related services. After eligibility is determined, parents or legal guardians meet with school and JRMC personnel to discuss the results and the development of the Individual Education Plan (IEP) and appropriate behavioral care provided by JRMC.

- *Individualized Education Program (IEP)* – The IEP is an individualized written document developed by teachers, JRMC, Child Study Team personnel, applicable specialists and parents (collectively referred to as “IEP Team”) to establish learning and developmental goals for the child and specify the instruction and services the school provided. As JRMC’s representative on the IEP team, our Child Psychiatrist is specifically responsible for: (1) helping to ensure that day-to-day activities (in-home, school, and overall) promote mental health and assist staff and parents to practice skills that support healthy mental development; (2) providing recommendations on various appropriate educational resources relevant to mental health for parents and staff; and (3) a regular schedule of on-site mental health consultations for school staff and parents.
- *Assessment Tool and Process* – Upon completion of the IEP and enrollment into JRMC’s behavioral care panel, JRMC employs a more comprehensive family assessment scale to examine the child and caregiver's behavioral, emotional, social, economic and educational determinants. This screening process considers a more intensive analysis of risk factors affecting not only the child, but also the full family unit. Risk factors consider interplay of static biological risk factors (e.g., family history) with psychosocial and economic risk factors (e.g., social supports, traumatic events, economic shifts, etc.) that are more malleable to change. The assessment also compiles an inventory of protective factors that are in place to buffer risk factors, such as a healthy and supportive extended family, and the existence of community supports. To the furthest extent, the intent here is to establish a ‘construct of resilience’ for each child and family. The research basis for our screening process (as well as overall care management approach) is, in significant part, derived from the *asset-based approach*<sup>1</sup>, i.e., building the external and internal assets of children. External assets refer to the structure and systems that surround children, and have such a significant impact in their development and stability. Internal assets refer to the child’s sense of self, and the competence and value system to make healthy decisions. This also refers to the child’s capacity to move from one developmental stage to the next. It should be stressed that the assessment process is fluid and adjusts to the dynamics and significant changes that affect our users. Social Workers utilized this system at the point of intake, and at the point of case transition, i.e., to compare the ratings at the point of intake versus preparing for case closure. Social Workers updated their assessment reports, at minimum, once quarterly, or in response to significant changes or crisis. This system was a vital tool to determine if users and their families are prepared to transition from the JRMC caseload.

Our full assessment process occurs in three interconnected steps: (1) initial response within five days from receiving initial referral (completion of IEP and enrollment into JRMC); (2) initial visit with child and family within 20 days of initial referral; and (3) engagement of full family team. The initial child and family engagement (*steps 1 and 2*) enables the Social Worker to clearly convey our core values and care management principles, while establishing boundaries and expectations as it relates to our commitment and service standards, and as it also relates to the participation levels and guidelines for our users. The

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<sup>1</sup> The summary of internal and external asset development for family is derived from “40 Developmental Assets – Healthy Communities, Healthy Family”. Search Institute, 2006.

Social Worker established from the onset that achieving care management objectives is a team-oriented approach, inclusive of the child, the full family unit plus their respective providers and support system. The Social Worker established an agreed upon schedule for continued engagement, including scheduling the next visits. A signed agreement between the family and the Social Worker formalizes this mutual commitment and program expectations.

The session with the full family team (*step #3*) involves the more intensive assessment that examines the determinants outlined above with the ‘internal’ members of the family (immediate family members, extended family, neighbors, caregivers, etc.). This session begins the process of identifying specific goal development embodied within the Individual Care Management Plan. The purpose of this meeting is to continue the child and family engagement and full disclosure process, the identification of the child’s strengths and needs, and establish a service plan to address the child’s needs. The Social Worker convened family team meetings regularly, including when a team member requests such a meeting. It should be noted that the degree of engagement intensity was not individualized to each child and family, and based on the extent of the respective user’s priority needs. The forming and sustaining of the “family team” may be one of the most crucial elements of our process. The family team comprised of everyone important in the life of the child, including interested immediate and extended family members, foster/adoptive parents, neighbors, and friends as well as representatives from the child’s natural support system, such as schools and current service providers. A team approach to consultation, planning, and decision making became the central to our process.

The assessment process forms the basis of a Final Evaluation Report (*FER*) for each child. The FER is the basis in assembling an Individual Care Management Plan (ICMP) that outlines behavioral care treatment and services that confront identified risk factors for each user; builds upon and maximize users’ strengths and assets within their socio-economic dynamics; matches services and interventions that address users’ priority needs; and ascertains the level and extent of the child’s safety, permanency and overall well-being. Specific intervention methods include:

- *Individual Counseling* – Our participants meet with their assigned clinical Social Worker on a regular basis. These individual sessions serve as a ‘check-in’, and allow participants to communicate recent challenges, concerns, and dynamics, particularly any significant social, familial, and/or community changes. *The lifeblood of our behavioral care approach is the provision of care management.* In addition to coordinating the direct provision of direct services or interventions, the principle role of our Social Workers is to function as the facilitator and monitor of our children’s care management plan – this also includes working closely with parents and caregivers to monitor adherence to treatment compliance and individual care objectives.
- *Parent Engagement and Support* – As stated throughout this proposal, JRMC emphasizes a family-centered perspective that embraces children’s caregivers as the principal influence in the child’s health and well-being. JRMC believes that a strong, positive parent-relationship is perhaps the most critical factor in promoting the child’s mental health. JRMC’s core care management principles are to *form relationships with caregivers aimed* at improving the conditions and quality of the child’s life; *help caregivers identify and use resources* to support them in realizing care objectives; *advocating with caregivers* for services and systems that are fair, responsive, and accountable to the children/caregivers served; and *mobilize formal and informal resources* to support care objectives and overall child development. Within this context, JRMC instituted a comprehensive parent education and engagement strategy relevant to building a system of support, mentorship, and networking for parents and caregivers of children who have mental disorders or exhibiting signs of potential mental disorders. JRMC designed and employed a well-structured parental support group that sought to build parental capacity, particularly with respect to the understanding, detection, and effective care-giving for children with emotional

and/or behavioral disorders. Working from an educational framework established by the *New Jersey Mental Health Institute* (NJMHI) and within a Diffusion in Effective Behavioral Interventions (DEBI) based curriculum<sup>2</sup>, this support group enable sour parents to build their own social-cognitive skills, including their own self-efficacy, to better understand their children’s behaviors or standard signs symptomatic of prospective behavioral and/or development disorders, and to build their capacity as effective caregivers for children with disorders. Parents themselves discuss and develop new skills and behaviors by practicing and modeling these new skills within these small groups.

**Description of linkages.** The delivery of behavioral health services and care, in great part, is structured on a collaborative context. JRMC has worked diligently to further the collaborative structure of the program through aggressive outreach and relationship building. We have reciprocal referrals and service coordination agreements that have contributed to our user volume and addressed the inter-related needs of our patients and their families. We have dozens of key collaborations. A few to highlight:

- *Newark Public Schools* - The local school district works closely to connect public school students to JRMC’s scope of healthcare. Newark Public Schools (NPS) provides with JRMC with space and associated costs of maintenance, utilities, and administrative equipment at no cost to the seven (7) schools where JRMC administers its health centers. In addition, JRMC has strong working relationships and communication with school personnel for purposes of referrals and shared case management, access to student files, and crisis intervention protocol. With respect to behavioral care, JRMC serves as one of the providers on NPS’ Child Study Teams assigned to the Central Ward schools where our clinical personnel work in tandem with School clinicians to develop and manage the Individual Education Plans for designated students with special needs.
- *Maternal and Child Health Partnership.* JRMC works closely with the Newark-based Northern New Jersey Maternal and Child Health Consortium, in particular, to connect our pregnant users (especially our first-time pregnancies or pregnancies in high risk of maternal or fetal complications) to NNJMCHC’s home-based assessment and care management.
- *Strong and Healthy Communities Initiative (SHCI)* - SHCI is an inter-organizational alliance working together to improve the educational and health outcomes of Newark’s most distressed neighborhoods with JRMC’s NSBHCs as a focal point. SHCI provides technical assistance, training, funding and access to quality program partners. SHCI is comprised of several grant makers and key stakeholders in Newark. JRMC is fortunate to be a part of such a game-changing alliance.
- *Greater Newark Health Care Coalition (GNHCC) - Primary Care Initiative* - Comprised of high-level representatives of Newark-area entities concerned with access to high-quality care in the greater Newark area. Includes representatives from hospitals, primary health care, educational institutions, advocacy organizations, behavioral health organizations, visiting nurses organizations, New Jersey and Newark health departments, and others. Of particular note is their work to improve the economics for sustainable primary care practice by advocating for new financial models for primary care services including Medicaid equalization/parity to Medicare fee and transition of care and care coordination models.
- *Hospital Partners* -Patients in all of our NSBHC sites who require specialized care, radiological, hospitalization, surgery, or other care beyond our scope have direct access to the clinical capacity

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<sup>2</sup> "DEBI" refers to Diffusion in Effective Behavioral Interventions, science-based interventions identified in the "[Compendium of Prevention Interventions with Evidence of Effectiveness](#)", developed and disseminated by the Center for Disease Control and Prevention.

of several hospital providers through referral agreements. Referral agreements are also in place to address behavioral care factors and drug addiction. Referral agreements are in place with Newark Beth Israel Medical Center (NBIMC), St. Michael’s Medical Center, UMDNJ, and Trinitas Hospital. To better address our high-risk pregnancies, JRMC has significantly expanded its relationship with NBIMC. Operating one of the most sophisticated maternity programs in New Jersey, NBIMC also administers one of the largest and most advanced neonatal intensive care units in the country as part of the hospital’s state-designation as a Regional Perinatal Center. This includes a Neonatal Intensive Care Unit (NICU) that provides comprehensive services from their staff of specialists, including neonatal physicians, nurses, pharmacists, respiratory therapists and others

**4. EVALUATION**

JRMC has made a particularly unique and extensive commitment to embracing the significance of performance review, and establishing the highest quality and structured set of accountability systems essential to measure performance and overall impact. Outcome-based evaluation activities measure the direct ‘cause-and-affect’ of program activities, and progress towards the stated outcome objectives. JRMC utilizes an electronic medical records system (known as “Centricity”) to collect and store demographic data, user diagnosis, and impact of care. This database framework also stores additional codes that categorize our cases in accordance with certain data sectors, such as “Child of Teen Parent” or “Developmentally Disabled”. ‘Process-based’ evaluation activities examine level of service and utilization. In addition to tracking utilization rates and child outcomes, the Centricity system also has a tickler system that tracks child referral and recall activities, including follow-up visits, medical history, specialized care, medical record and peer reviews, and clinical tracking systems, particularly with respect to clinical outcome measures. Child outcomes are also assessed through reviews of clinical records as well as follow-up contacts. A representative sample of clinical records is reviewed to assure the validity of any studies performed. The following table provides an overview of the form of clinical data collected within this system:

<b><i>Data Factor</i></b>	<b><i>Data Indicators</i></b>
Treatment Impact (outcome-based evaluation)	<ul style="list-style-type: none"> <li>✓ <i>Situational analysis</i> – Describe the child’s circumstances and presenting conditions/issues upon first contact with JRMC.</li> <li>✓ <i>Actions</i> – Actions/interventions during course of the child’s involvement with JRMC.</li> <li>✓ <i>Outcomes</i> - Results for the child from their involvement in the program. In other words, how has the child’s situation been impacted by JRMC?</li> </ul>
Service Utilization (per facility and per service category)	<ul style="list-style-type: none"> <li>✓ Number of encounters</li> <li>✓ Forms of treatment</li> <li>✓ Costs of service</li> <li>✓ Sources of referral</li> <li>✓ Referral for treatment or service</li> <li>✓ Volume and forms of enabling services</li> <li>✓ Provider productivity</li> </ul>
Child Demographics	<ul style="list-style-type: none"> <li>✓ Ethnic and racial composition</li> <li>✓ Language (s) spoken</li> <li>✓ Residency</li> <li>✓ Income levels</li> <li>✓ Age composition</li> <li>✓ Housing situation (type of housing and household composition)</li> </ul>

<i>Data Factor</i>	<i>Data Indicators</i>
Healthcare Risk Indicators	✓ Pre-existing conditions or co-morbidity factors

*Quality Assurance Program:* JRMC’s Clinical Quality Improvement (CQI) system consistently monitors the progress and quality of our overall services, as well as a stable system of communication and exchange between and among our management team, pertinent staff, and pertinent stakeholders. With respect to the NSBHC initiative, the *Quality Assurance Committee* will meet on a monthly basis to discuss and share issues or concerns, particularly with respect to children exhibiting the most challenging factors. This Committee will work collectively to develop care/treatment strategies to be implemented in the classroom, health center, and in the home, and to ensure appropriate services and interventions are responding accordingly. A journal will be maintained to document topics discussed and actions taken. In addition, standard CQI exercises will involve regular review of children’s case files, and periodic observations of NSBHC activities (e.g., observation of counseling activities performed by the Social Worker).

## **5. RESULTS/OUTCOMES**

*Exceeding Level of Service* – For the reporting period, JRMC reached a total of over 8,298 users. Based on current utilization patterns, we served over 2,009 behavioral health patients.

### **Additional key accomplishments include:**

- *Hiring the LCSW* – Utilizing HTPC funding to partially cover costs of full-time LCSW
- *Partnered with Newark Global Village School Zone* for reporting period of 2012 to 2013 – JRMC functions as one of the active providers connected to the NGVSZ network of services, along with utilizing the network as our primary referral base for certain social, family, and other related supports essential for our users that are outside our scope of services. This network surrounds our users with a strong framework of integrated services and treatment. A representative sample of provider/referral partners within the NGVSZ include the International Youth Organization, Salvation Army West Side Center, Tri-City Peoples Corporation, New Community Corporation, Greater Life Community Outreach Center, United Community Corporation, and the Urban League of Essex County.
- *Strong & Healthy Communities Initiative.* In 2013, one of the more significant developments in the expansion of our NSBHC program overall has been our involvement with the Strong and Healthy Communities Initiative. An estimated \$1 million is allocated to JRMC to support establishing and/or expanding up to five additional Newark School-Based Health Center (NSBHC) sites – inclusive of the capital improvements to Central High School.
- *Empowering Sisters Program* - On June 6<sup>th</sup>, 2013, JRMC, in partnership with Newark Public Schools, held the Empowering Sisters Program funded by the March of Dimes at the Central High School in Newark. Approximately 400 girls, aged 14 to 18, attended a daylong seminar covering topics related to pre-conception and pre-natal health. Facilitated by Leslie Morris, ESP's lead consultant, a team of 20 CHS female students along with staff of JRMC and Central High School formed the leadership committee to guide the organizing of the conference. Towanda McEachern, the event's keynote speaker, provided powerful and inspirational messaging for the young ladies attending. She spoke of the challenges of being born to a 13 year old mother, being a domestic violence victim survivor, and the importance of girls recognizing their own self-worth and respect of their own bodies. A second Empowering Sisters seminar is scheduled to occur at Malcolm X Shabazz High School in May, 2015. JRMC will share the pre- and post-program surveys upon request. On June 15, 2015, JRMC, in partnership with the Newark Public School and the Parent Teacher Organization, hosted the 2nd part

of the **Empowering Sisters Program** at Shabazz High School. More than 300 young ladies, aged 14 to 18 years old, attended a daylong conference on pre- conception, positive body image, emotional stability and health education. Featuring dynamic workshop presenters, lecturers, and interactive sessions, the girls learned a great deal as captured in the pre- and post-questionnaires. The day culminated in an energetic step show and high tea.

- **Mobile Care.** Within the grant period, JRMC deployed its Project Dental Opportunities Made for Everyone (DOME) mobile unit for the NSBHC program. Project DOME is a fully fabricated mobile medical command unit equipped with two dental chairs/operators that provides dental and medical care within the vehicle (with dental care as the focus). During the report period of 2012-2013, JRMC provided dental care for 130 NSBHC patients in the DOME vehicle alone. **Deployment of the second mobile unit** 2015 began at the Sussex Avenue School (K-8 school located in the Central Ward) two days a week, Barringer High School (traditional high school in North Ward) one day a week and BRICK Avon Academy School (K-8 school located in South Ward) two days a week.



- Through a **new partnership with the Head Start Program** in Newark more than 1,000 three and four year low-income preschoolers will receive a comprehensive vision, hearing, dental and medical screening through the use of the mobile unit.
- **Elegant Eyes** - In 2012-2013, RCM secured an agreement with Elegant Eyes – a Newark-based optical center – related to providing NSBHC users with free or discounted eyeglasses, eye contact, or other prescription lenses. In 2016, the Hoffman Foundation generously supported a **new initiative to supply prescription eye glasses** to students who needed them at Newark Public Schools Street Community School. This program further solidified JRMC's role as a full-service medical home for children and their families.
- **Let's Move In the Community** - In 2012-2013, JRMC was selected as one of the provider partners within the New Jersey Alliance for Healthy Generations – a collaboration of the Robert Wood Johnson Foundation, Tri-State YMCA, Newark Beth Israel Medical Center, and several providers (inclusive of JRMC). With the Central Ward as our focus, this will enable JRMC to institute the “Let’s Move in the Community” Toolkit within our NSBHC and Newark Public Schools Street Community School location (pre-K-5 school also situated in the Central Ward). The LMC model is a comprehensive framework to integrate healthy eating and exercise as standard elements of our users’ treatment regimen, particularly for children and youth who are overweight or obese.
- **Partnership with the National Assembly for School-Based Health Care** –JRMC engaged the National Assembly for School-Based Health Care – the nation’s leading advocacy and capacity building organization specific to school-based health care – to develop a comprehensive systems and infrastructure analysis of our existing sites that, in turn, will lead to shaping and forming a strategic business plan for NSBHC overall, inclusive of our new sites. This vital plan provides the framework in the continued growth and stabilization of our NSBHC program.

- *Awarded Victoria Foundation Grant* - JRMC received a grant from the Victoria Foundation to increase its capacity to deliver behavioral care services at the Central High School location. These services will be expanded for children, students at the school and adults in local communities through individual counseling and group sessions.
- *Certification Status* - JRMC did achieve PCMH Level I certification status. Currently striving to achieve Level 3 status by December 31, 2017 for all sites. An important element of our PCMH certification is our ability to institute open access scheduling to allow for greater capacity for improved patient flow, inclusive of same- and next-day appointment scheduling.
- *Assessment Processes* - Built in PHQ-2 and PHQ-9 assessment processes for depression and anxiety in order to better integrate behavioral health with medical care. Overall, JRMC expanded our capacity as a behavioral health provider that is reflected in the increase in the number of patients with mental health and substance abuse conditions.
- *Targeted Chronic Conditions* - Increased focus on addressing certain target chronic conditions. The results are the following: 14% increase in the number of asthma patients; 3% increase in the number of diabetes patients; 21% increase in the number of heart disease patients. We have seen a particularly large increase in the number of overweight/obese patients, i.e., a 42% increase. In great part, this is due to JRMC's selection as a provider partner with the New Jersey Partnership for Healthy Kids' "Let's Move in the Community" initiative.
- *Vaccination Campaign* - Set forth vaccination campaign throughout the Newark service area resulting in a 13% increase in the number of immunizations administered for children and youth from the prior years. We have seen an especially dramatic increase in the seasonal flu vaccine administered.

**Program Impact.** Working from PCMH standards, JRMC has made progress with integrating the Unified Primary Care and Behavioral Health model (UPCBH) within our NSBHC program. Serving all age levels and levels of needs, the UPCBH model ties in directly with the Four Quadrant Clinical Integration approach to behavioral health (as determined by the National Council for Community Behavioral Healthcare). Childhood exposure to traumatic events is a major public health problem in Newark. Many of our patients have witnessed or experienced physical or sexual abuse, violence in their homes and communities, the loss of a loved one, refugee and war experiences, or living with a family member whose caregiving ability is impaired due to drugs, alcohol or mental health issues. With each increase in the number of types of traumatic events experienced, our patients show signs of depression, anxiety, aggression, or rule-breaking behavior. Those are the students frequently referred by the school staff for counseling. With on-going individual and family counseling and carefully prescribed medication, our patients have:

- *Better behavioral and emotional health*
- *Fewer thoughts of harming themselves or others*
- *Better school attendance and grades, and fewer school problems.*
- *Fewer incidents of delinquent behavior. The rate of suspension with our patients has also decreased.*
- *Reduced symptoms of posttraumatic stress disorder (PTSD) with trauma*

**Performance Measures – Family Participation.** JRMC emphasizes a family-centered perspective that embraces children's caregivers as the principal influence in the child's health and well-being. Key activities within the grant period relevant to family participation include:

- ✓ *One-On-One Parent/Caregiver Engagement.* Our Social Worker and Child Psychiatrist expended significant time in engaging the parents/caregivers of our users on a one-to-one basis in order to build parental capacity, particularly with respect to the understanding, detection, and effective care-giving for children with emotional and/or behavioral disorders. The individual sessions have sought to build the social-cognitive skills of our users' parents, including their own self-efficacy, to better understand their children's behaviors or standard signs symptomatic of prospective behavioral and/or development disorders, and to build their capacity as effective caregivers for children with disorders. In our next grant period, we will seek to institute the structured support group sessions where parents themselves will discuss and develop these new skills and behaviors along with actually practicing and modeling these new skills within these small groups.
- ✓ *Engaging Student Leaders.* With respect to the aforementioned "Empowering Sisters Project", our plan is to engage an ESP Planning Committee comprised of, at minimum, the Newark School System, the March of Dimes, members of the "Healthy Babies are Worth the Wait" (HBWW) Advisory Committee (administered by the March of Dimes), and the students themselves in the planning, organizing, delivery, and evaluation of the two all-day workshops in these two schools. Engaging the students allows for a peer-to-peer approach that has a better chance of eliciting the interest and participation of our target students as well as producing long term positive outcomes of the workshop participants. We will also utilize the student members of our planning committee to function as peer mentors. The mentors will be identified by school personnel. The mentors will be tasked with helping to finalize the workshop subjects, selecting conference colors, assisting with décor, assisting with logo development, promotion, selecting the lunch menu and will provide input on the workshop agenda. In addition, these students will assist in a variety of administrative and hosting activities the day of the workshop. We will, at minimum, involve 4-6 female student leaders who are currently enrolled in Central High School.
- ✓ *Parent/Family Asthma Education.* With CATCH funding provided by the American Academy for Pediatrics, JRMC will facilitate a customized workshop series targeting NSBHC parents with asthmatic children that provides education on self-management associated with asthma. An important element of the educational program is to conduct an assessment process of parents/caregivers from the onset to measure their 'self-care' capacity, i.e., the extent and depth of their understanding in how to effectively care for their asthmatic child(ren). The assessment process will also examine barriers and factors that adversely affect our parents' ability to ensure consistent follow-up in asthma care. For the upcoming grant period, JRMC anticipates a minimum of 48 target parents will participate in this CATCH program.

**Performance Measures – Cultural Competency.** The core elements of our commitment to a culturally competent service delivery system are as follows:

*Communication.* For patients who primarily speak in their native tongue, from the initial screening to diagnosis, JRMC facilitates the full protocol of care in their native language, inclusive of our written tools, materials and correspondence. This includes utilization of medical translation services to alleviate the margin of error in communicating medical terminology in a non-English language. We measure this in a twofold manner: (1) the composition of our users. Nearly 90% of our user base is of ethnic-minority descent with nearly one-third who speaks a non-English language; and (2) the duration of the provider/patient relationship with our ethnic-minority users. The majority of our ethnic-minority users remain in our care for two years or longer.

*Diverse Personnel.* The most vital aspect of our commitment to culturally competent care is to ensure that we employ an adequate level of personnel who are bilingual and/or bicultural. It should be noted that 58% of our staff are persons of color, primarily Latino, Asian-Indian, and/or African-American. Of our

clinical and medical personnel, 49% are of minority descent – the majority of which speak fluent or medical Spanish. All of our executive staff are all of color. The President and Founder of JRMC is a consultant in cultural competence for Georgetown University based in Washington, DC, a further indication as to JRMC's organization-wide commitment and competence in multiculturalism.

*Professional Development.* JRMC organizes a regular schedule of mandatory, in-service training for all staff with respect to culturally competent care. The impact of this training is measured in the following manner: (1) to realize clinical performance measures with each major domain of care for our ethnic-minority users; and (2) achieve patient satisfaction rating among our ethnic-minority users of a minimum score of 90 (based on patient satisfaction surveys distributed pre- and post-medical visits). This data and the tabulation of survey results are currently being reconciled and will be available by or about April 30, 2013.

**Performance Measures – Sustainability.** JRMC's multidisciplinary continuum of care has resulted in blending costs by integrating visits and through the Care Team addressing concurrent needs of patients collectively. However, the increased level of engagement, with more intensive care management and follow-up, has increased the frequency of clinical visits, in turn, increasing our per patient costs slightly greater than anticipated. In addition, the shift to the PCMH model of care in addressing both clinical and non-clinical factors in a comprehensive fashion has also impacted our expenses. In moving from this transitional to operational status, these costs will begin to normalize in this and subsequent program years. We have purposely increased our efforts to address the multiple social and economic barriers to care that our patients face, including transportation access, financial constraints, and a range of unmet basic needs. Meeting these immediate needs has a direct impact in our ability to deliver care and for our patients to adhere to Individual Care Plan (ICP) objectives. In addition, we have also significantly increased our health education/literacy efforts, in particular, to foster patients' ability to self-care. As a result, this has resulted in per visit costs slightly than anticipated. Moving forward, JRMC will continue to employ cost control measures to ensure efficiencies with procurement processes, automation, preventive maintenance on equipment and supplies, and seeking out in-kind contributions. Additional key strategies:

- In monitoring regular cash flow forecasting, we will establish advanced spending plans in anticipation of delayed receivables and to ensure no interruption in service or quality of care.
- Continue to employ an aggressive resource development strategy to secure additional grant funding in order to cover the full costs of treatment while providing more diverse income sources to address program and operating costs.
- Initiate board-driven process of relationship building and cultivation, engagement of existing donors, and grant writing to secure annual grant income goal.
- Our Care Team, in particular our Nurse Care Manager, will work hard to ensure patients adhere to their ICPs and overall care compliance. Treatment adherence will in turn increase the number of billable visits per patient in turn yielding essential patient revenue.
- Implement a steady schedule of asset maintenance and replacement when essential. We will be sure that medical equipment and technology are advanced and meet current evidence-based guidelines of care.

## **6. PUBLICATIONS/PRODUCTS**

Non-applicable.

## **7. DISSEMINATION UTILIZATION OF RESULTS**

Non-applicable.

## **8. FUTURE PLANS/SUSTAINABILITY**

**Sustainability efforts** At the point of application, JRMC did secure \$275,000 from the Healthcare Foundation of New Jersey; \$120,000 from the City of Newark; \$150,000 from the Merck Foundation (specifically to support the BBA model); and \$50,000 from the Nicholson Foundation to support the new site, i.e., \$595,000 in total operating support. As discussed above, JRMC also secured funding through the “Strong and Healthy Communities Initiative” to cover the initial ramp-up costs of equipment, supplies, technology, and capital improvements. As of this writing, additional funding commitments and their amounts are indicated as follows:

- ✓ As stated above, we secured a \$25,000 grant from the March of Dimes to implement the “Empowering Sisters Project” based on the “Healthy Babies are Worth the Wait” model.
- ✓ Secured a \$12,000 grant from the American Academy for Pediatricians (AAP) under the Community Access to Children’s Health (CATCH program). With this funding, we will be able to integrate asthma education into the NSBHC program.
- ✓ Awarded \$75,000 from the Healthcare Foundation of New Jersey for the hire of an Outreach and Enrollment Coordinator and minor renovations at Newark Public Schools Street Community School's health center.
- ✓ Secured a \$30,000 grant from the Victoria Foundation to further expand the behavioral care component of our NSBHC, in particular, to partially cover the costs of our Child Psychiatrist.
- ✓ Secured a \$100,000 grant from the Horizon Foundation to fund a second Mobile Medical Unit.
- ✓ Hearst Foundation grant in the amount of \$40,000 to expand asthma education and treatment for NSBHC patients.
- ✓ Hoffman Foundation grant in the amount of \$20,000 to expand vision care for NSBHC patients.
- ✓ HRSA Services Expansion grant in the amount of \$279,000. Of this amount, we are applying for a rotating Pediatric Provider to be deployed at all of NSBHC sites. We have also used these dollars to hire our first Behavioral Health Director to function as our senior BH administrator for all of our sites.
- ✓ Through greater efforts to engage greater participation for local pharmacies, JRMC projects generating projected income of \$170,000 from our 340(B) discount program – this is nearly a threefold increase from the prior year.

Beyond grant income, with the continued rise in users, JRMC's income ratio continues to grow more towards patient revenue. As a result, JRMC has lessened its dependence upon grant income. JRMC's ability to reach patient projections that, in turn, generate adequate patient revenue and our projected payer mix, makes up for over 70% of our total income for JRMC services. As a certified Medicaid Fee for Service provider, JRMC participates with most participating Medicaid MCOs in New Jersey, including Amerigroup, AmeriChoice, Horizon Health, United Health Plan, and HealthNet. JRMC employs on-site

Financial Specialists who work with incoming patients to access and be enrolled into JRMC's patient panel. Our Financial Specialists, if and when essential, also work to enroll patients into the appropriate subsidized insurance program, particularly the Medicaid, NJ FamilyCare/NJ KidCare (funded by CHIP) and the New Jersey Uncompensated Care (Charity Care system) programs. Working from this business model, grant income primary functions as addressing the funding gap between our insurance payers and the actual costs of treatment.

It should be noted, however, JRMC receives reimbursement based strictly on a per visit basis, not based on the type or form of treatment, diagnosis, or particular procedure. Given increasing medical costs and our insurance reimbursement rates remaining stagnant, there is a growing chasm between actual reimbursements and costs for treatment. It should also be stressed that patient revenue projections are based strictly on billable services that our insurance providers approve. With respect to behavioral care, the extent of eligible diagnosis approvable by Medicaid is severely limited – in fact, our State Medicaid system has only approved six forms of eligible diagnoses. In addition, our State no longer allows Charity Care to cover behavioral care visits. While most of our pediatric users are in the Medicaid and CHIP systems, we are experiencing a steady increase of enrolling uninsured children. This restriction in particular affects our ability to care for uninsured adults with behavioral disorders or showing signs of same. Given our family-based approach within NSBHC, it is vital that we direct care and treatment that benefits the full family unit of the children served, along with employing treatment interventions directed within a family context.

This is why our grant income is becoming far more significant. This is why JRMC has set forth an aggressive and comprehensive resource development strategy to secure less restrictive, direct subsidy in the form of grants, advertising revenue, vending income, and other income-generators to support the full scope of this CHSSS approach.

The resource development capacity of the SHCI collaboration should also be emphasized. Given that SHCI is made up of diverse program elements, this broadens the horizon of prospective funding sources. In addition, there are several grant makers who serve on the SHCI Steering Committee, including the Prudential Foundation, Healthcare Foundation of New Jersey, Robert Wood Johnson Foundation, and the Newark Affinity Group (consortium of eight Newark-based philanthropic organizations). These grant making entities provide valuable advice and direction in the form and implementation of SHCI's resource development plan, including connecting SHCI to an array of resource opportunities.

Given the multi-faceted organizational structure of the Jewish Renaissance Medical Center, our multi-disciplinary system of service delivery has established a wraparound approach in surrounding our users with a spectrum of services and treatment. This is the core basis of the NSBHC program. This approach, however, requires JRMC to bring in a far more extensive spectrum of skill and perspectives – the skilled clinicians, administrators and support staff of JRMC are the lifeblood of our work. Our budget provides JRMC the capability to recruit and retain the most qualified clinical and professional staff, while working within a budget framework that fosters centralization. With this stated, additional key factors associated with our sustainability plan are:

*Greater Efficiencies.* JRMC's continued shift to a multidisciplinary, integrated continuum of care will result in blending costs by integrating visits and through the integrated care team approach addressing concurrent needs of patients collectively and more efficiently. In addition to addressing changing roles and systems, the efforts discussed here speaks to our commitment to expend sufficient time and effort to secure greater and more consistent buy-in at all levels – from the Board and senior-level management to direct clinical care and administrative personnel. This also includes expending effort to improve the working integration of clinical and non-clinical functions – or more directly, to improve the working relationship and outcomes of our clinical staff with non-clinical personnel. This 'buy-in' and maximizing

cross-unit and cross-departmental operations will dramatically improve both horizontal and vertical communication with respect to team-based care standards and working collectively to address patient-specific strategies. For the clinical portion of our work, given that the majority of patient revenue will come from the Medicaid system or from a similar patient revenue source, this sustained shift to integrated care in addressing both clinical and non-clinical factors in a comprehensive fashion will continue to realize reductions in per patient and per visit costs. For HRSA-HTPC patients specifically, while we have yet to determine the precise cost-savings, we do anticipate increasing the number of visits from the current average of 3.6 visits per patient to 6 for this cohort. The increased level of patient engagement with more intensive care management and follow-up will increase the frequency of billable visits. The movement towards more sustained care better enables JRMC to more directly function as the medical home for our patients. This also will generate additional PCMH-based incentives through HRSA and our individual payers.

*Electronic Health Records (EHR) Improvements.* JRMC has secured resources through HRSA's Delivery System Health Information Investment (DSHII) and Health Centers Control Network (HCCN) programs and the New Jersey Department of Health's Team-based care/Electronic health record Enhancement (TEE) assessment program (funded under NJDOH's New Jersey Heart Disease and Stroke Prevention Program). With these funds, JRMC is currently undergoing a substantial overhaul of our current electronic health records (EHR) systems from the design and functionality of the system itself to its usage, applications and reports/data generation. EHR modifications and improvements will result in enhanced and more accurate data that in turn will significantly impact our revenue generation capacity, inclusive of, at minimum, our clinical quality measures, HEDIS, PCMH standards, and Meaningful Use attestation.

*Population Health.* We will purposely increase our efforts to fully internalize the population health model addressing the multiple social and economic barriers to care that our patients face, including transportation access, financial constraints, health education/literacy, and a range of unmet basic needs. Building the population health capacity of our EHR system will also further our accuracy and ability to identify subsets of the highest-risk participants not only based on risk factors but also based on 'program dosage', i.e., the specific programs and services utilized by each participant. This will enable JRMC's integrated care team to more efficiently deploy available resources. Over the next two years, the shift to integrated care will enable JRMC to work with our Health Plans and our hospital systems to employ metrics associated by two predictive models, i.e., initial ER visits and initial in-patient admissions. Working from a quasi-empirical standpoint, we will compare our HRSA-HTPC population against data associated with the universe of numerous Newark residents who are uninsured or in the Medicaid system. From a clinical standpoint, the predictive model results along with the specific risk drivers would enable care managers and clinicians to target the highest risk impactable participants with interventions based upon the specific issues driving the risk.

*HEDIS.* Improvements to our EHR system and the integrated model of care will also improve the amount and frequency of securing financial incentives associated with Healthcare Effectiveness Data and Information Set (HEDIS) measures and our Health Plans moving away from the capitation model to the value-based model. We have formal commitments from all of our Health Plans that result in enhanced reimbursements for realizing HEDIS measures.

*340B Drug Pricing Program.* Administered at the federal level, the 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price. The 340B price is a "ceiling price" meaning it is the highest price that JRMC, as the covered entity, has to pay for select outpatient and over-the-counter drugs and the minimum savings the manufacturer must provide. From there, JRMC sells eligible medications to participating pharmacies who dispense the drugs to patients with nominal patient costs and co-pays – typically at no cost to the patient, or 40-60% discounts on certain medications. Participation in this

program is particularly valuable for patients that lack health insurance and regular access to medication. JRMC splits the dispensing fee with participating pharmacies.

*Improving Billing Procedures.* Given the current political climate and Health Plans shifting away from capitation to value-based payments, JRMC has worked incredibly hard over the last two years to dramatically improve our billing systems and collections rates. This includes outsourcing a significant portion of our billing processes to an external billing agency along with having the same agency conducting a thorough analysis of our billing capacity – from management to staffing to procedures & systems. The outcomes of this analysis will be supplied upon request. With the billing agency's involvement, we are performing regular schedule of internal audits and reports to ensure completion and compliance of patient files, data entry, file storage, and other administrative factors. The above mentioned enhancements to our EHR system in great part involves the interface our data generation corresponds to our billing systems. We have also worked hard to strengthen communications and coordination with Health Plans to not only improve collection rates, but also to ensure attribution reports are current and accurate. At minimum, the following key factors are being addressed: (1) ensuring responsible staff adequately prepare, collect, and/or update all necessary documentation and patient information to facilitate payment from the various insurance carriers; (2) ensuring regular communication between providers and clinical staff to ensure coding is current, complete and tracked appropriately. This includes that certain claims are assigned more effectively (e.g., immunizations coinciding with a medical visit) along with improving how we 'carve in' certain claims (such as covering lab report expenses); (3) making adjustments to the computer classification of claims to most accurately reflect the expected pay source. This now includes tracking ancillary and incentive-based payments, particularly through HEDIS measures; (4) improving how we facilitate daily cash collections, inclusive of maintaining daily log of uncompensated care applications and other state and local governmental applications; and (5) consistently training and educating all staff to understand the eligibility, application, and enrollment in the health insurance options available to our patients.

*Correlation of Health and Rebuilding Neighborhoods.* A growing base of research finds the recent shifts in the nonprofit sector moving from measuring productivity based strictly on "level of service" (i.e., number of people served) to broader social development initiatives that streamlines social, economic and human capital projects within the broader context of neighborhood rebuilding (*Franzini, Luisa PhD, "Influences of Physical and Social Neighborhood Environments on Children's Physical Activity and Obesity", American Journal of Public Health, February, 2009*). Literature review also finds the linkage between neighborhood environments and the health and well-being of communities. There is growing evidence of the correlation of not only physical and environmental factors impacting health conditions (such as traffic, population density, environmental challenges, and other similar factors) but also social environment factors. JRMC's shift to working within the context of neighborhood building enables JRMC to move from being viewed strictly as a "community provider" to that of a "community partner". This commitment to a neighborhood-based approach will also contribute to expanding our funding opportunities and our base of users.