Integrating Community Health Workers across the Healthcare Continuum

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OBJECTIVES

Identify successful components for funding a community health team

- Solicit and engage key stakeholders and payers to build support
- Develop program criteria
- Design a model that support s the needs of patients with complex care needs

Create systems that build on existing relationships to coordinate care

- Develop Agreements and Compacts that define mutual communication and coordination responsibilities
- Design methods to identify, refer and share information in real time

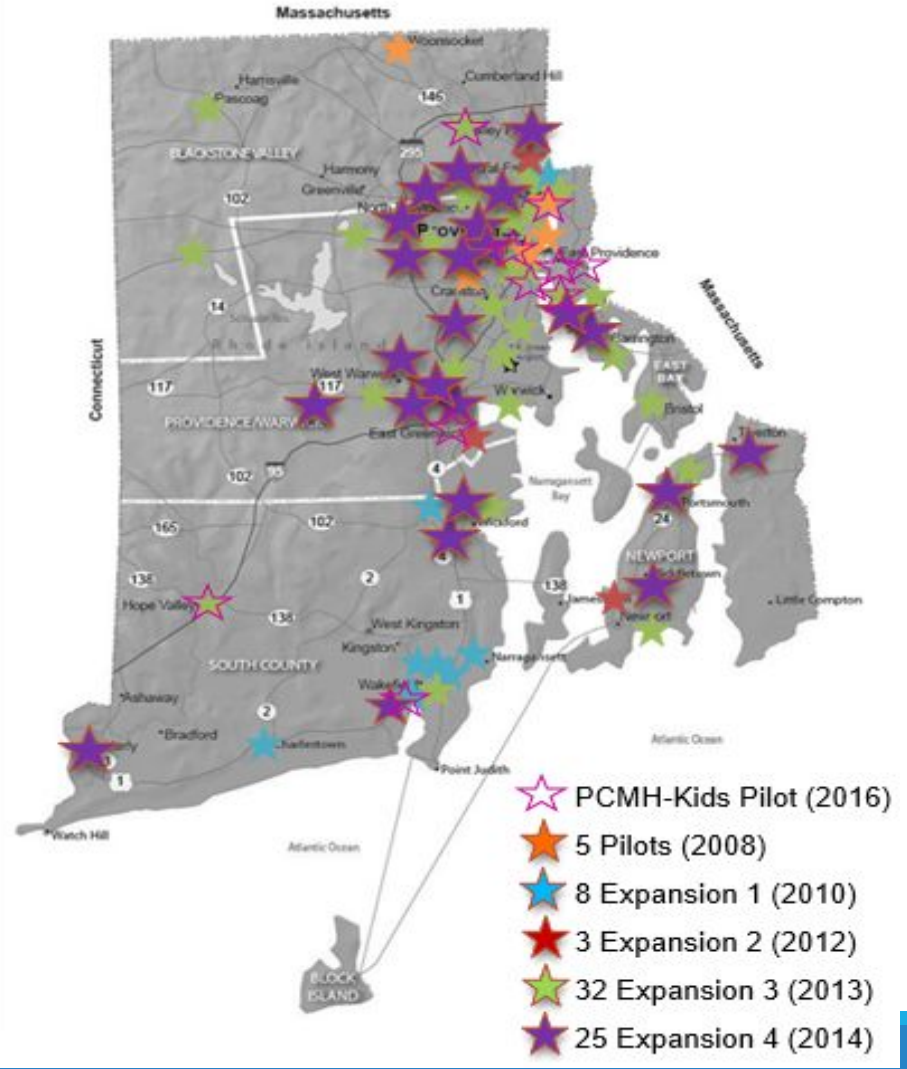
Build innovative solutions for engaging patients/families and measuring success/results

- Develop patient registry, patient care documents and data collection tools
- Define key metrics, establish baselines and implement performance improvement processes
- Identify barriers, and solutions to improve care and achieve patient and program outcomes

CTC-RI

MULTI-PAYER PRIMARY CARE INITIATIVE

Care Transformation Collaborative-RI (CTC-RI) Multi-Payer PCMH Model



5 PCMH Pilots (2008)

8 in Expansion 1 (2010)

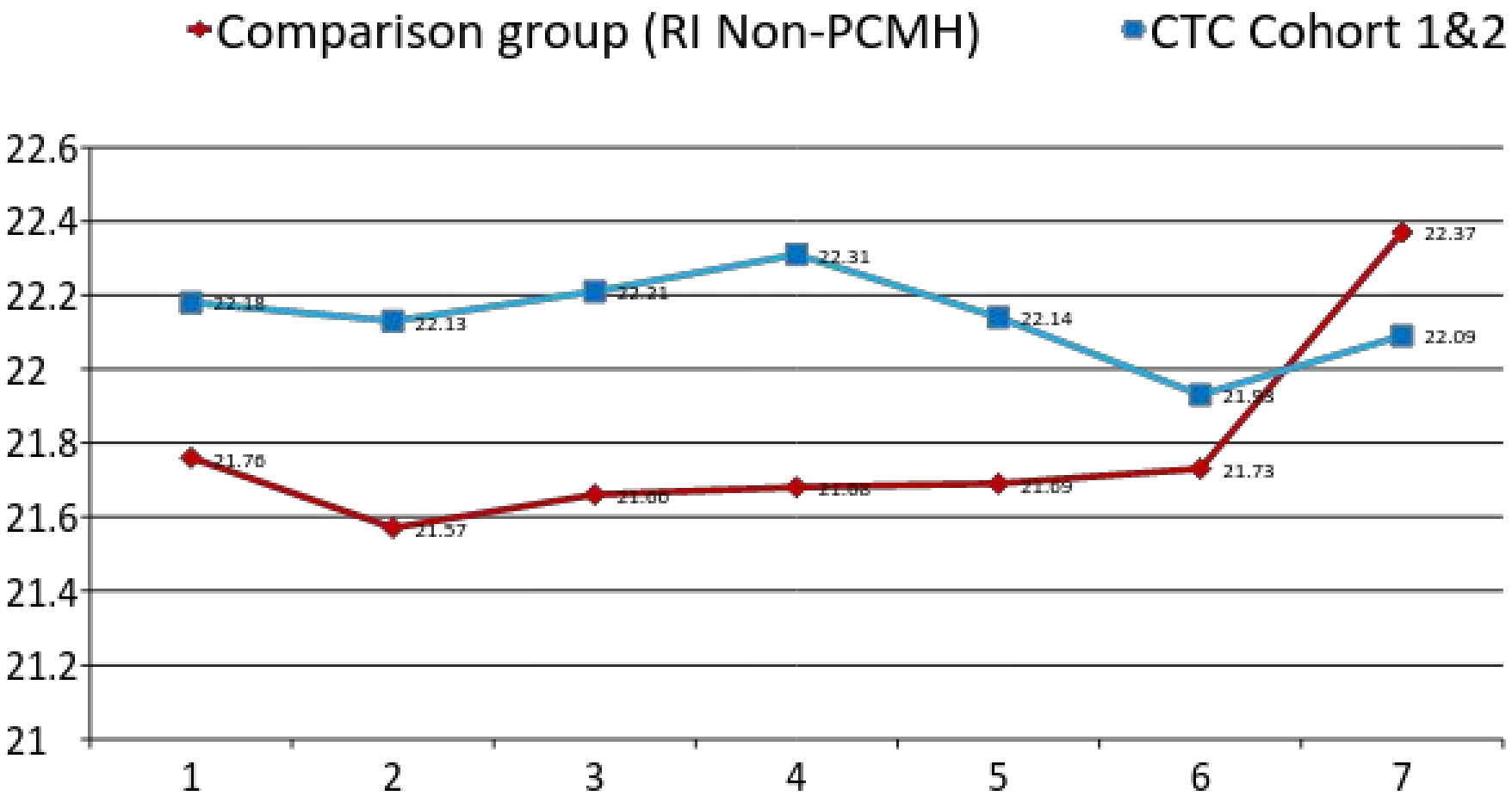
3 in Expansion 2 (2012)

32 in Expansion 3 (2013)

25 in Expansion 4 (2014)

9 PCMH-Kids Pilots (2016)

All Cause ED – CTC-RI and Comparison Group
Year Ending Q4 2012-Q2 2014



What else works? CHT Model

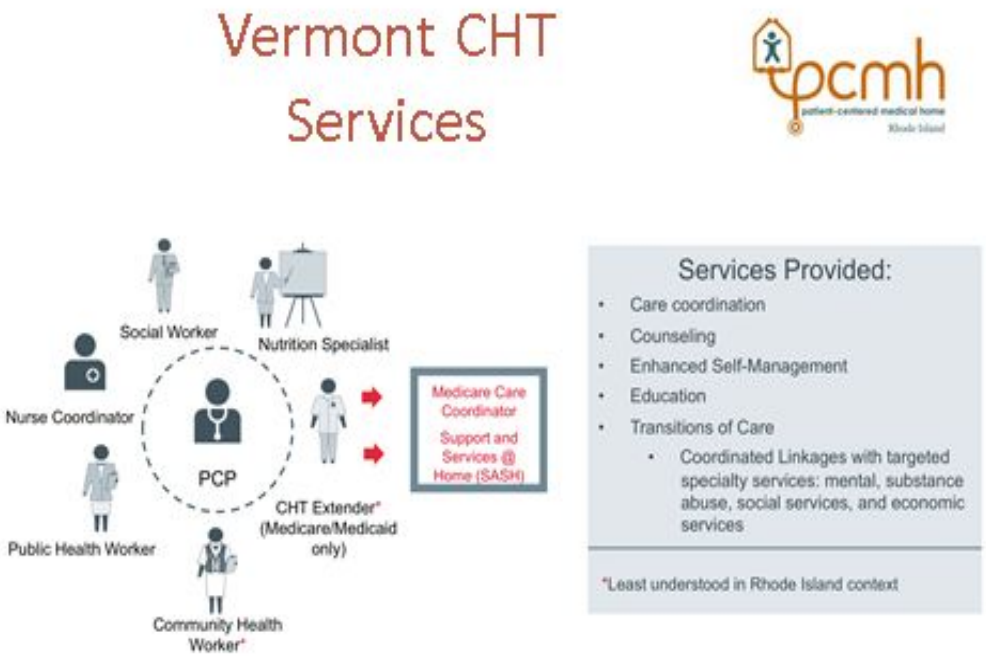
Use care management processes to address patients':

- **Physical health needs**
  - Help accessing PCP, specialists, tests, treatments, medications
- **Behavioral health needs**
  - Short term counseling by CHT and referral to external counseling
- **Health education**
  - Medication management, nutrition, use of the health care system, appointment preparation
- **Social determinants of health needs**
  - Help accessing: safe, affordable housing; home medical equipment; food and food banks; transportation; and completing paperwork for entitlements applications

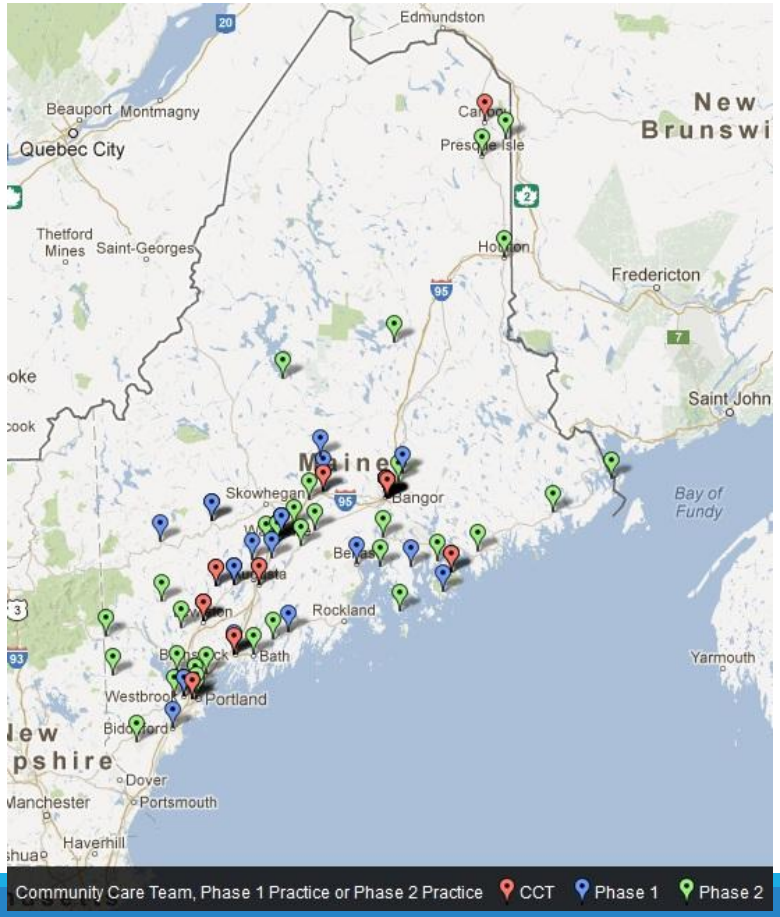
Sources: See references at end of slide set

Learning from Others

Vermont



Maine



Pre-req: Soliciting RI Multi-Payer and CTC-RI Board Support

Charter

Work plan and budget

Community Health Team Committee

Meeting schedule

Metrics

Contracts with CHT entities

Evaluation Plan

Enthusiasm to get started

CTC-RI

COMMUNITY HEALTH TEAM PILOT

CTC-RI CHTs Phase 1
Program Model

CTC-RI CHT program: started in 8/2014

- **Community Health Needs Assessments** by HARI identified **BH care** as an **unmet need** in Pawtucket/Central Falls and South County
- **2 teams:** North - hosted by Blackstone Valley Community Health Care; South - hosted by South County Health
- **Funding:**
  - **Multi-payer** (NHP, United HealthCare, BCBS RI, Tufts) through CTC-RI
  - **RI Foundation grant** to support behavioral health clinicians in year 1
  - **Host agency contributions** (BVCHC, South County Health)

CTC-RI CHTs Phase 1
Program Model

- **CHTs serve as an extension of primary care practices**, work with practice based nurse care managers
- **CHT staff: CHWs, BHCM**, administrative and management support
- **Targeted patients:**
  - Adult patients of participating PCMHs, **HP HR Lists**
  - In top 5% high risk/high cost/ high utilizers
  - **Impactable** by CHT services
- **Goal:** Improve patient care, heath, and satisfaction with care, reduce cost/unnecessary utilization
- **Program Evaluation Mixed-Methods**
  - Goal: Develop recommendations and lessons learned
  - See CTC-RI Community Health Team Pilot Program Final Evaluation Report, February 2016

Recommendations

Phase 2

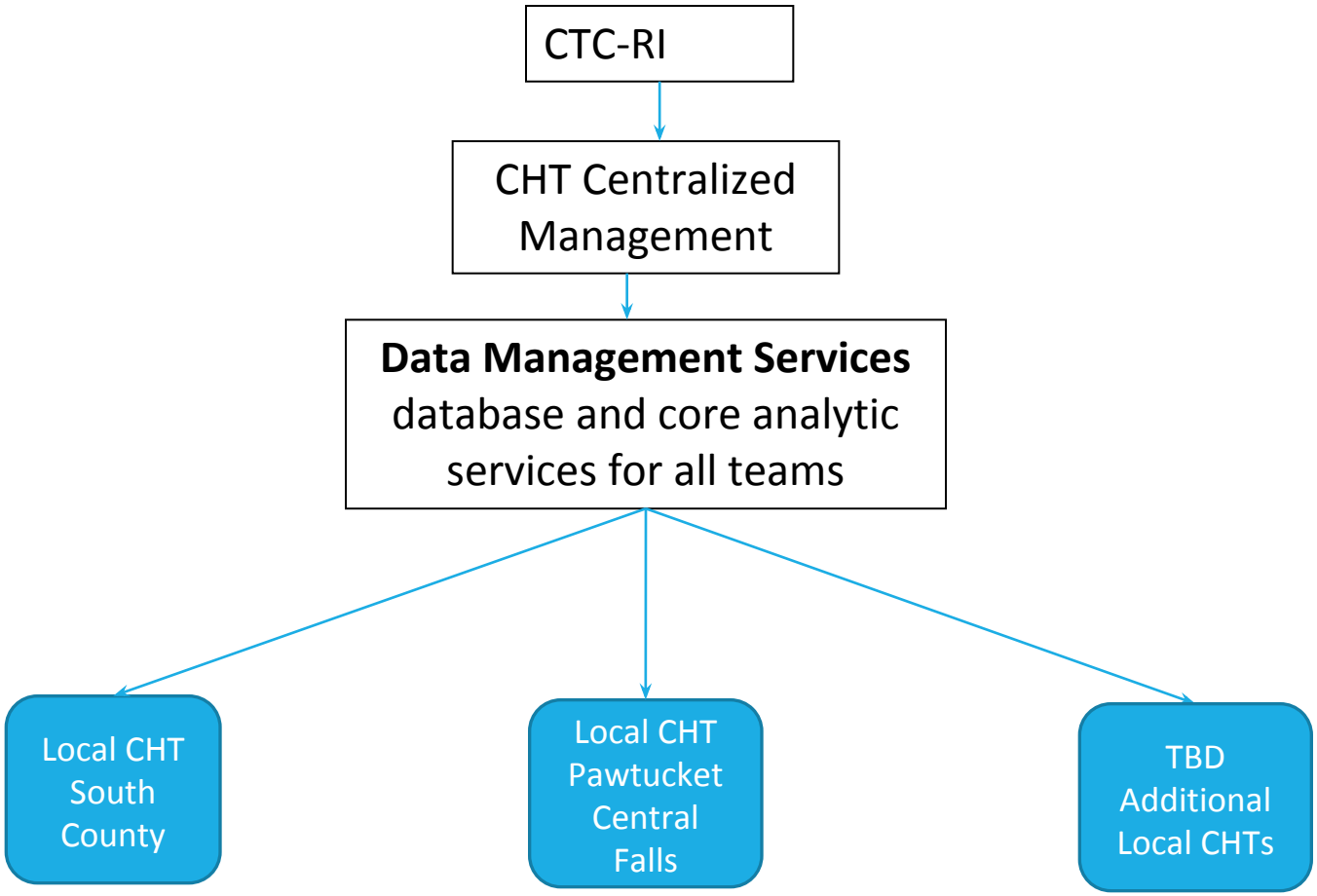
Standardize Operations across Regional Teams

- Standardize policies and procedures
- Allowed teams to establish change control process for the shared database
- Facilitated the development of performance metrics and improvement process

Memorandum of Understanding (MOU) was replaced with Memorandum of Agreement (MOA)

- Strengthen the Agreements MOA/BAA executed between CHT and primary care practices within defined geographic areas
- MOA more explicitly states responsibilities of practices, CHT, and CHT host entity; Health Plans added to agreements 7/1/16
- MOA provides more prescriptive framework for how CHT and practices must work together to manage high risk patients
  - **Explicitly encourages warm handoffs**

CTC New CHT Model Phase 2
Reorganized per Recommendations



SOUTH COUNTY HEALTH

Community Health Program

Primary Care Practices

- Dr. Cunniff
- Dr. DelSesto
- Dr. Demirs
- SC Internal Medicine
- SCMG EG, Wakefield, Westerly
- SC Walk-In and Primary Care
- Thundermist Wakefield
- Wood River Health Services

Centralized Management

- Liz Fortin, LICSW Program Director
- Gail Meisner, Database Manager

Community Health Team

- Marie Padilla, BA, CHW Team Lead
- Cassandra Stukus, LCSW BHCM
- Tonya Pete, CHW
- Stephanie Nacci, CHW
- Savanna Bebe, MSW Intern
- Nicole Faison, MSW Intern

Office Set Up – Woodruff Ave in Narragansett

- Co-located with SC Community Health & Wellness/HEZ Grant
- Washington County Coalition for Children

BLACKSTONE
COMMUNITY HEALTH TEAM

Primary Care Practices

- Affinity Family Medicine
- Blackstone Valley Community Health Care Pawtucket & Central Falls
- Memorial Hospital RI-Family Care
- Memorial Hospital RI-Internal Medicine
- Nardone Medical Associates

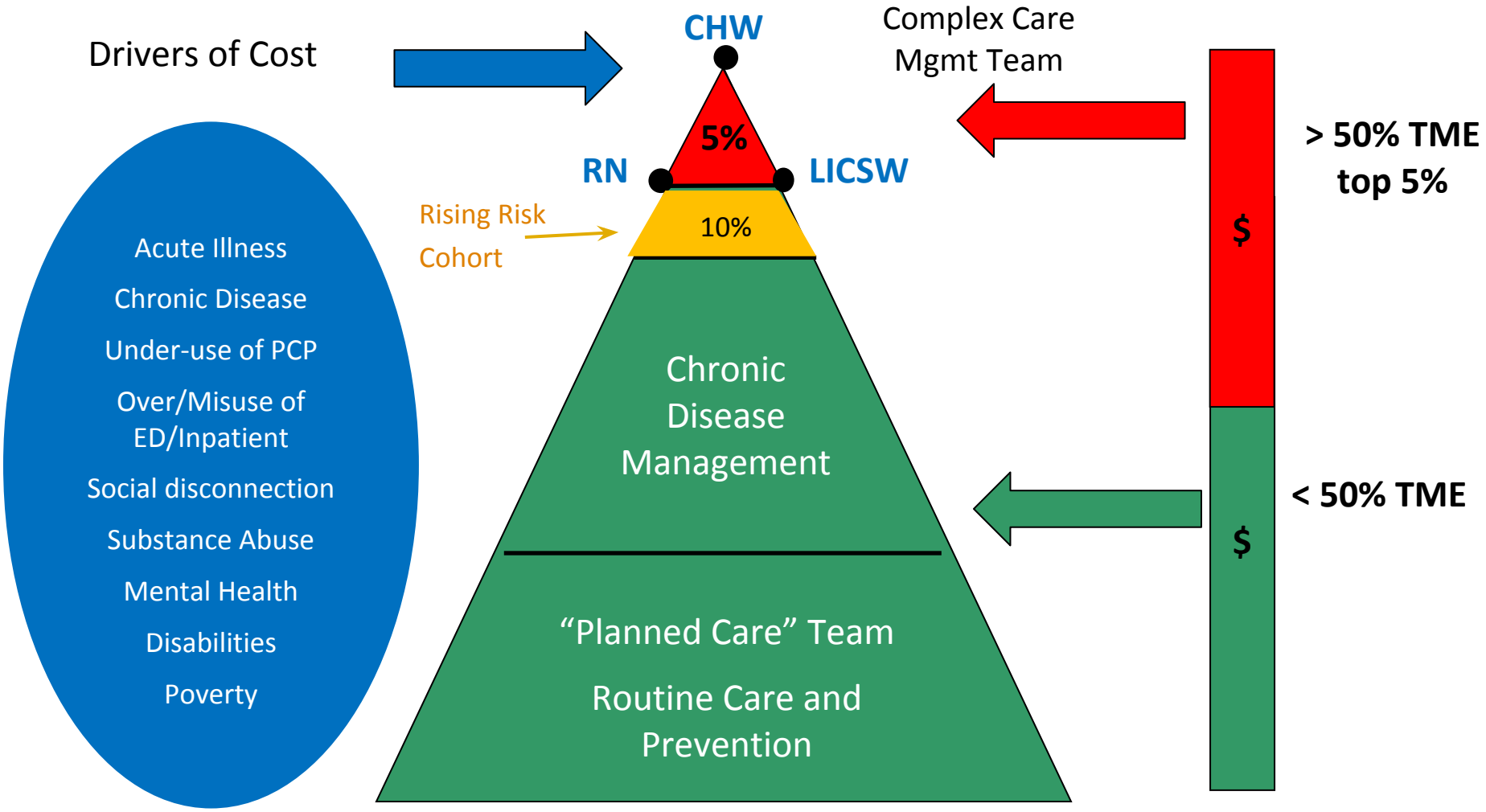
Community Health Team

- Scott Hewitt, MA Program Manager
- Adrian Restrepo, CHW
- Doroteia Andrade, CHW
- Shannan Victorino, RN BH NCM

Hosted by BVCHC

- Located in BVCHC Admin Office in Pawtucket
- Integrated with the Central Falls Neighborhood Health Station

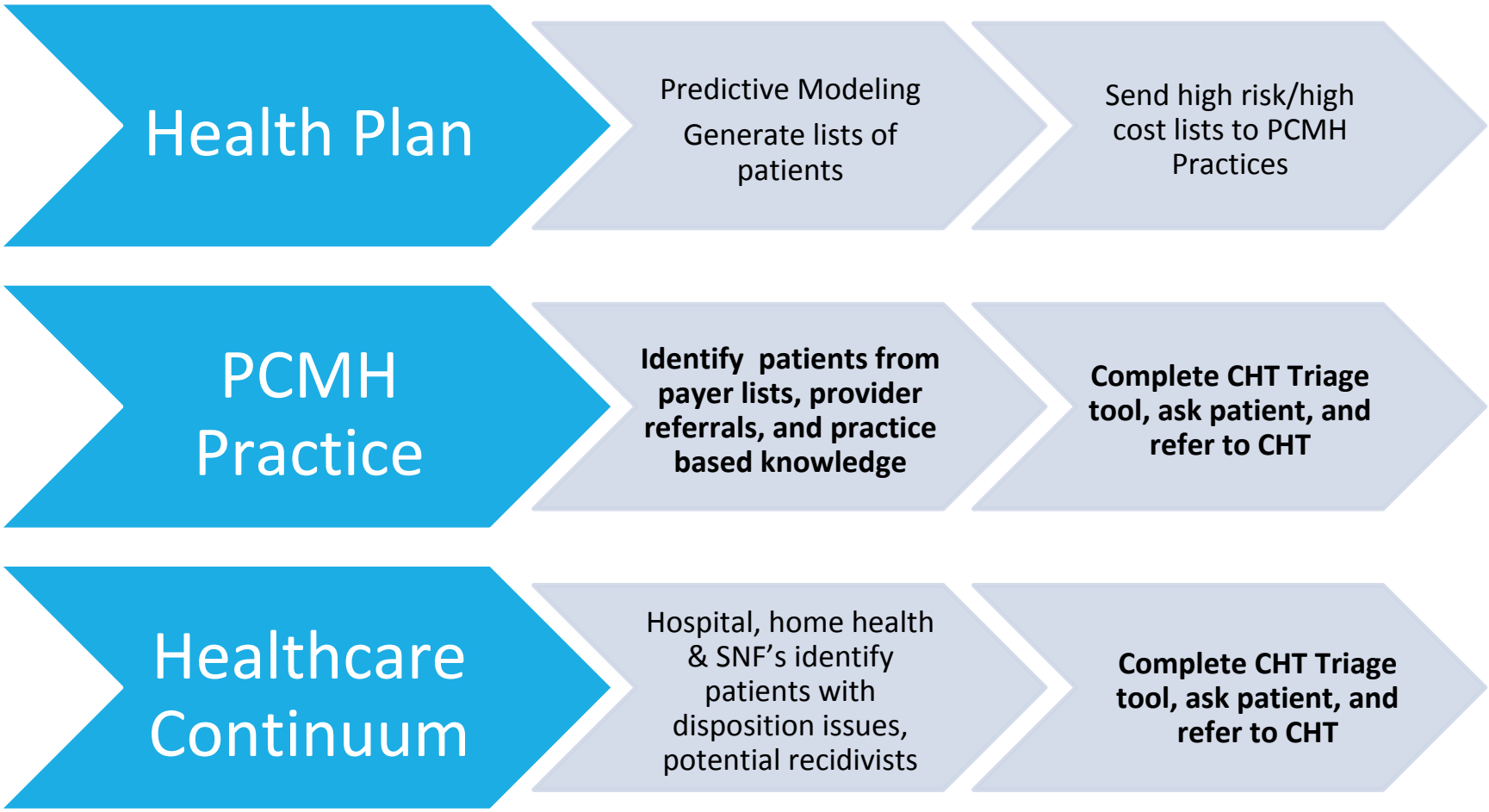
CHT Model – Who are we focused on?



Care Management Staff Model – Top 5 - 10%

Source: Adapted from Carr, E. (2015). Building a Complex Care Management Program to Support Primary Care [PowerPoint slides]. Retrieved from https://www.ctc-ri.org/content/2015-annual-learning-collaborative-presentations-and-additional-resource-materials

Phase 2 – Who is High Risk? Of what?



CTC-RI CHT Referral Triage Tool

Reason for Referral and/ or Desired Outcome:

PLEASE INCLUDE MEDICAL SUMMARY

Higher Risk Drivers (3 Points Each)

0 **Utilization** (medical or psych): (15 Points Max)
- ☐ IP admit in past 30 days **OR**
- ☐ 30-day Readmission in past year **OR**
- ☐ 2+ IP admits in past 6 months **OR**
- ☐ 2+ ED visits in past 6 months
- ☐ Health Plan High Risk Report – impactable costs actual or predictive > $25,000

0 **High Risk of**: (6 Points Max)
- ☐ IP admit/ ED visits in next 6 months
- ☐ Significant decline in functional status/ need for LTC in next 6 months
- ☐ Do you think it likely that pt will pass away in next 12 months **or** Palliative Care Referral Made?– (Levine Score or Palliative Care Screening Tool ≥ 4)

0

Calc Total

Moderate Risk Drivers

0 **Poorly Controlled High Risk Chronic Disease** (2 Points Total) CAD☐ CHF☐ Diabetes☐ COPD☐ Chronic Pain☐ End stage disease: ☐

0 **RX Meds: 8+ active prescriptions OR** recent change in high risk meds (2 Points Total) ☐

0 **Disengagement:** significant, chronic condition(s) and (2 Points Total)
- ☐ inadequate follow-up with PCP, or
- ☐ not following care plan, or
- ☐ specialty care without coordination

0 ☐ **Disability:** significant Physical/ Mental/ Learning disability impacting reasons for referral (2 Points Total)

0 **Psycho-Social risk factors** which prevent adequate mgmt of high risk diseases (2 Points Each/ 6 pts max)
☐ language/literacy ☐ safety ☐ homeless ☐ poor supports
☐ food insecurity ☐ undocumented lega

Microsoft Word 97 - 2003 Document

0 **Substance Abuse:** Actively using, newly sober, motivated to change (2 Points Total)
☐ Alcohol ☐ Opioid ☐ Benzodiazepine ☐ Other

0 **Mental Health DX** that is severe, persistent, and uncontrolled: (2 Points Total) ☐ Schizophrenia
☐ Major Depression ☐ Bipolar ☐ Debilitating Anxiety ☐ Other _____

0

Fundamental Risk Drivers (1 Points Each)

0 **Chronic Disease/ Co-morbidities** – not well controlled/ not noted above (1 Point) ☐

0 **Functional Impairments** – Fall risk, impaired ADLs, impaired ambulation, impaired judgment, difficulty getting to appts, unable to follow med regimen (1 Point Each) ☐

0

>15 = High Risk – Offer CHT to patient

8 - 14 = May meet criteria for CHT due to rising risk

<8 = Discuss referral with CHT before offering to patient

Modified with permission from the Cambridge Health Alliance. Updated 12/20/16

Risk Drivers

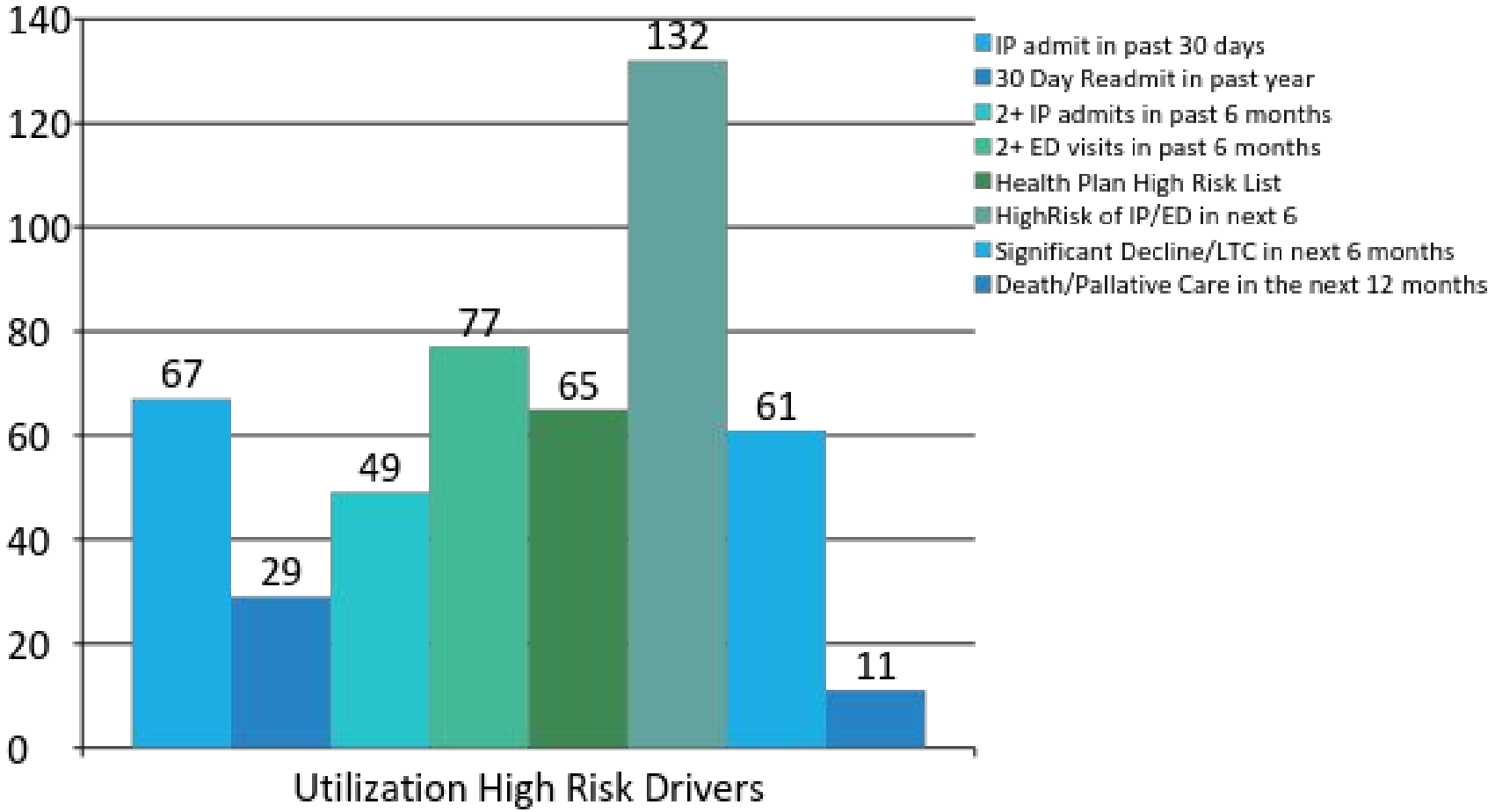
Higher – total cost, super utilizers

Moderate – medically complex

Fundamental – rising risk

Source: Adapted from Cambridge Health Alliance

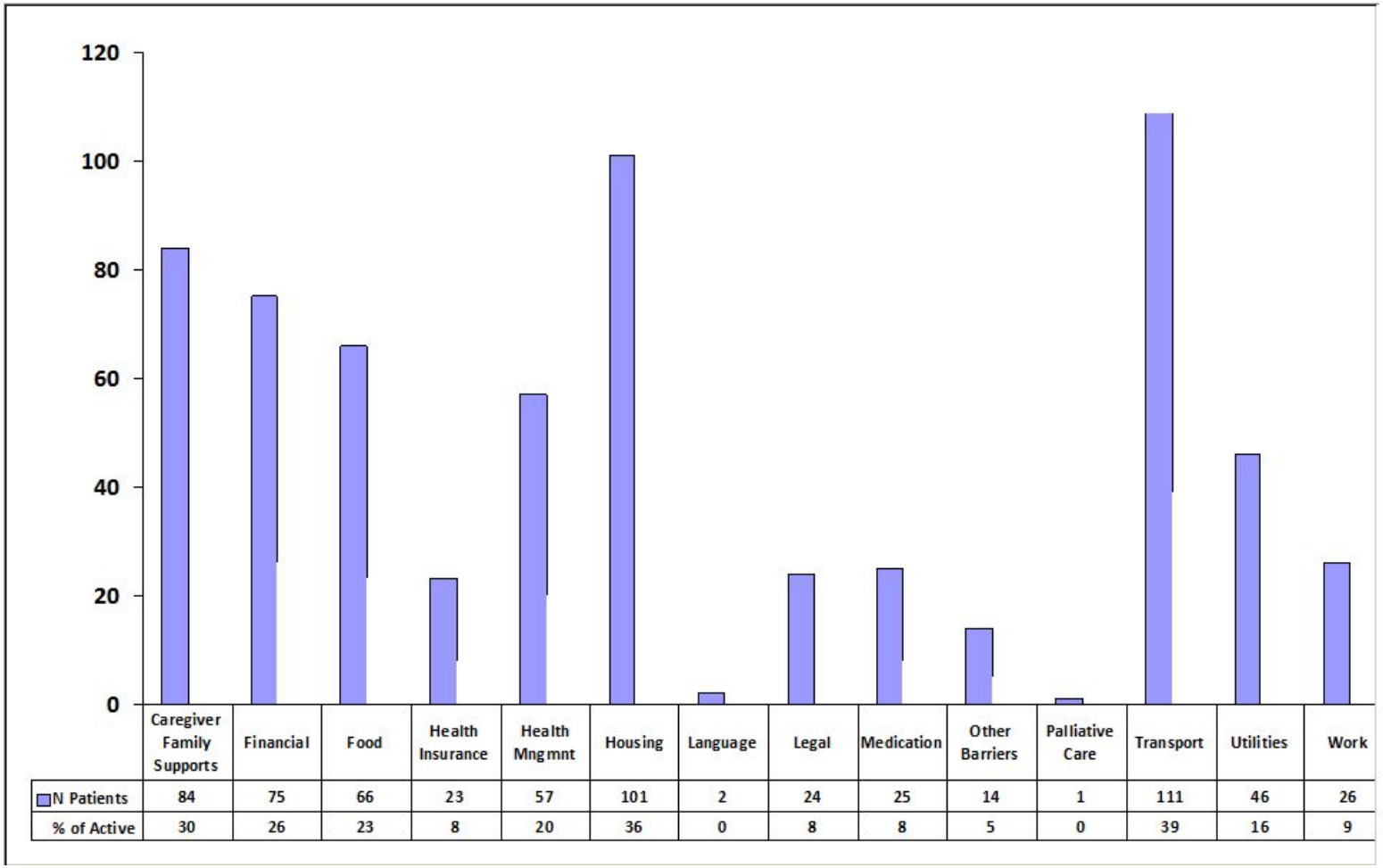
South CHT Referrals with Triage Tool
4/1/16 – 3/31/17
n=266 Patients Served - 195 with at least 1 high risk utilization driver



South CHT Self Reported Barriers

4/1/16 – 3/31/17

n= 266



	Caregiver Family Supports	Financial	Food	Health Insurance	Health Mngmnt	Housing	Language	Legal	Medication	Other Barriers	Palliative Care	Transport	Utilities	Work
N Patients	84	75	66	23	57	101	2	24	25	14	1	111	46	26
% of Active	30	26	23	8	20	36	0	8	8	5	0	39	16	9

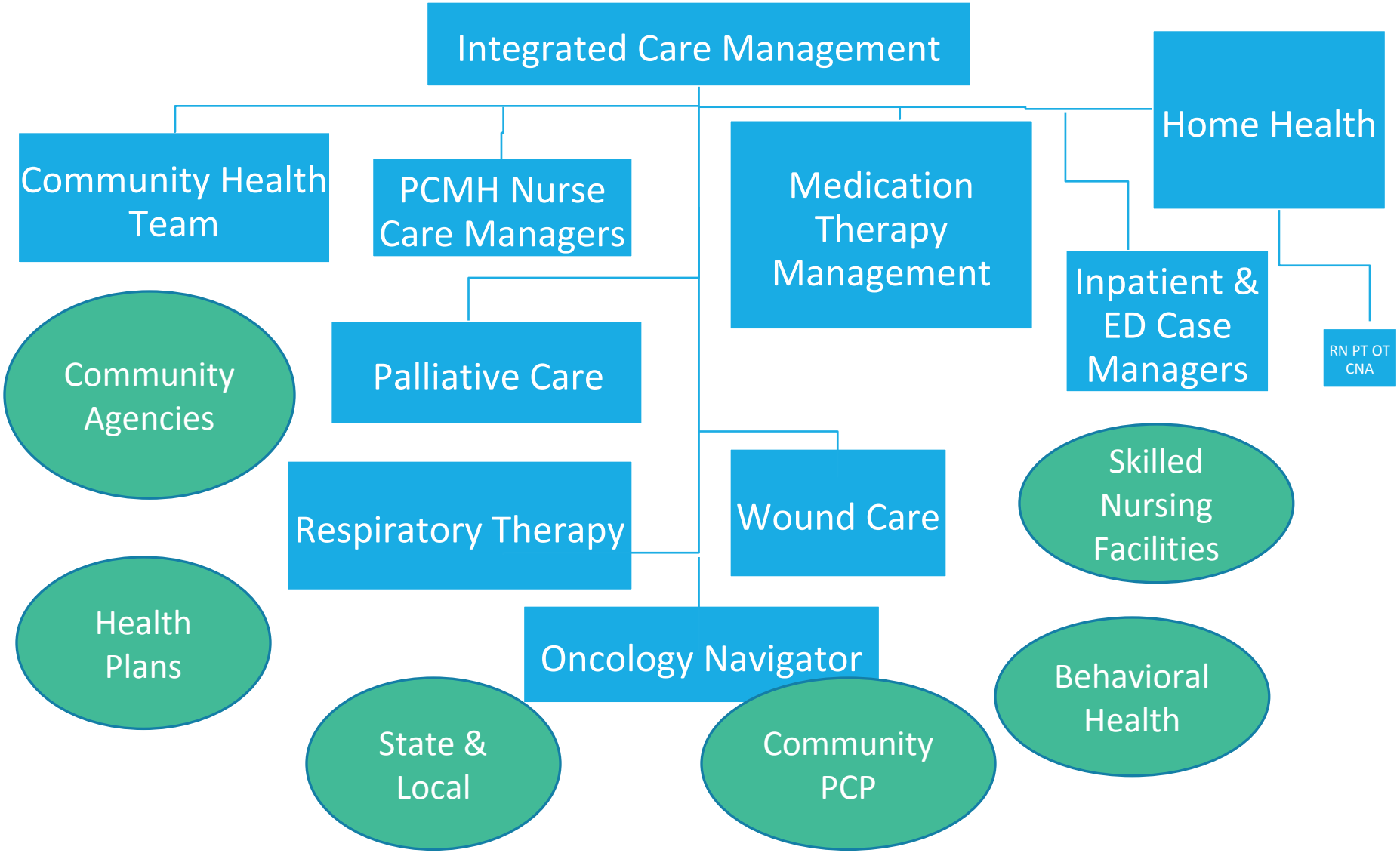
South County Health

CARE CONTINUUM

SOUTH COUNTY HEALTH VISION:

TO FORGE EXTRAORDINARY CONNECTIONS WITH OUR COMMUNITY THAT SUPPORT HEALTH AT EVERY STAGE OF LIFE

South County Health Care Continuum



Vulnerable Populations Conference

High risk individuals cycling in and out of levels of care related to medical issues, deplorable living situations, lack of adequate supports, potential self-neglect or abuse

PARTICIPANTS

Collaborative Team Members

Invited community representatives with a role in taking care of vulnerable individuals

Panelists provided overview of his/her role and experiences in supporting the community and/or vulnerable patient populations.

Case studies presented by CHT

Robust discussion

OUTCOME

Rich list of ideas to pursue for existing cases

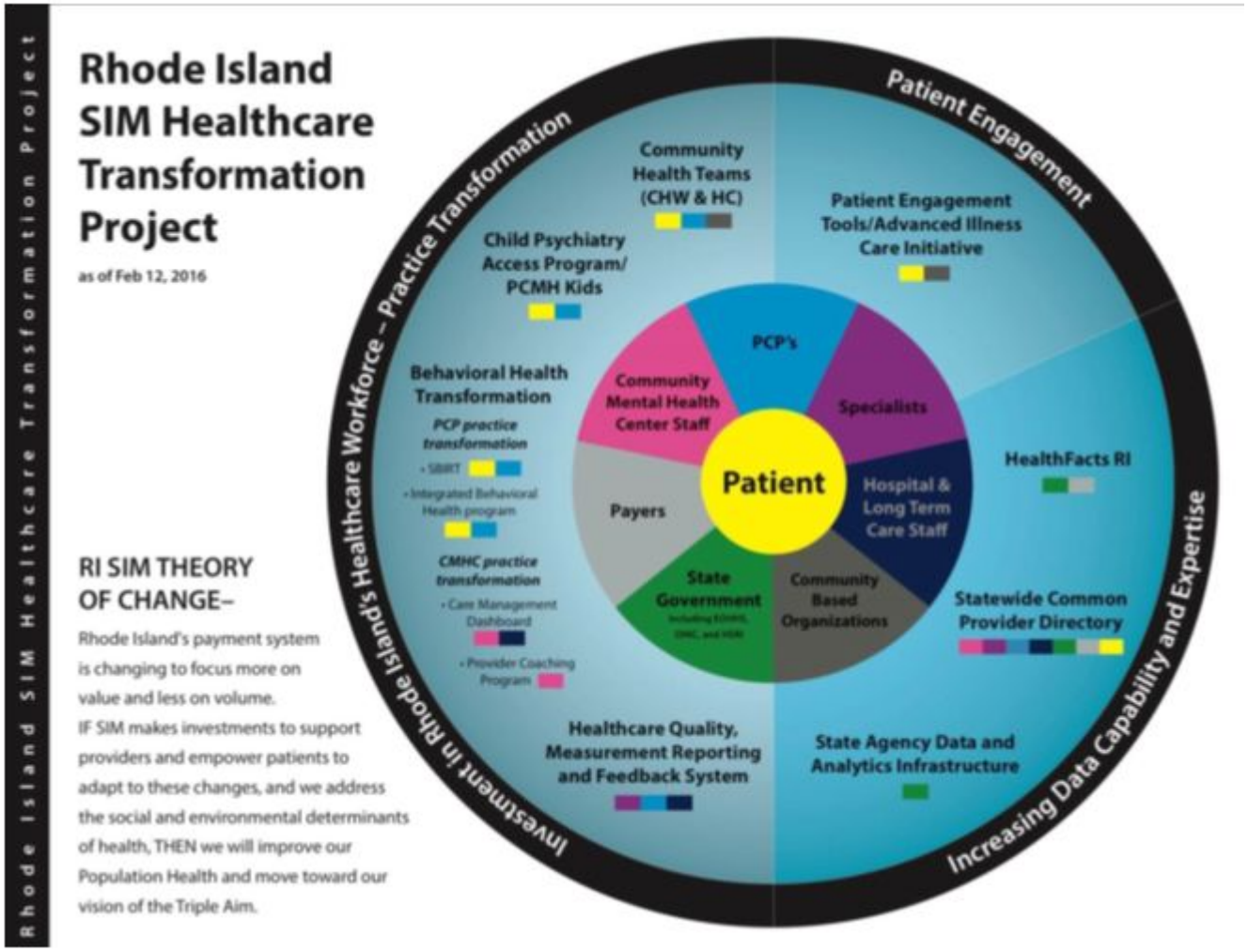
Networking/sharing contacts

Suggestion to form SWAT team follow-up

Group interest in future conferences

Recommendations to expand participants

Statewide Synergies
Power of Integration




BUT IF WE DIDN'T MEASURE THINGS WE WOULDN'T KNOW HOW GOOD WE WERE AT MEASURING THE THINGS THAT WE'RE MEASURING!
BUMP!
GP

CHT Program

Evidence Based Practice

CHW TRAINING

RIDOH CHW Certification Program

Training /Education to 9 Domains Competencies – 70 hours

Experience – Six months or 1000 hours of paid/volunteer work

Supervision hours

Recertification every 2 years

20 hours of education

Mental Health First Aid (MHFA)

Question Persuade Refer (QPR)

TOOLS

BH Screens and Referrals

PHQ;GAD;CAGE-AID

BH Assessment

- Psychosocial & Mental Status Exam

Health Coaching using ProChange-Trans-theoretical Model

Preventing unnecessary Hospitalization

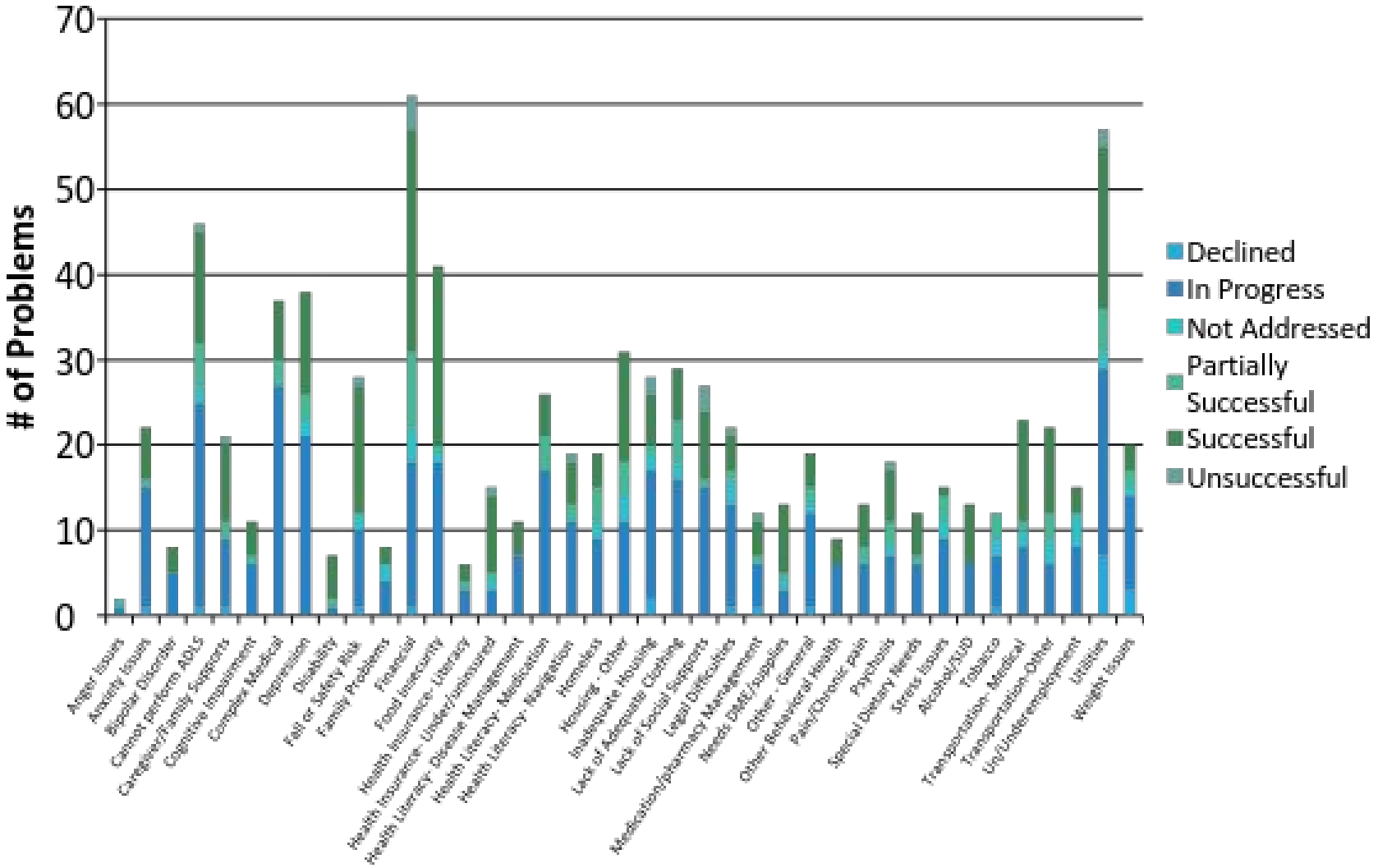
- Transitions of Care
- Fall Prevention
- Caregiver supports
- Environmental modifications
- Long Term Services & Supports

XLSX File

Measuring Consistency & Efficiency

		Measurement Specifications					
Metric ID	**Domain**	**Patient Population**	**Measure**	**Num**	**Den**	**Inclusions/Exclusions**	**Target**
		Patients Served by Community Health Team					
CHT Metric 2.00	Volume	Patients served in the CHT program by any member of the community health team during the measurement period.	Unique # Patients ***SERVED***	Unique # Patients ***SERVED***		***SERVED*** = 1) anyone with a status of ACTIVE with a Referral Date BEFORE the end of the reporting date range, or 2) anyone with a Referral Date within the reporting date range, or 3) anyone with one or more encounter (DETAIL activity) within the reporting date range. EXCLUSIONS: Patients discharged before the start of the reporting period ***OR*** **Patients with only Hospital, SNF or ED Notification Activity (no case review or follow-up)**	150/quarter; 200/year
CHT Metric 2.00a	Volume	Patients served in the CHT program by any member of the community health team during the measurement period.	Unique Patients ***SERVED*** per Team Member	Unique # patients ***SERVED***	Total # of FTE counts during the reporting period		50
CHT Metric 2.00b	Volume	Patients served in the CHT program by a BH Specialist during the measurement period.	Unique patients ***SERVED*** per BHCM	Unique # patients with an encounter by the BHCM during the reporting period	Total # of BHCM FTE counts during the reporting period	***Excludes*** patients with BHCM activities of ***CASE REVIEW ONLY*** or ***ED/INPATIENT*** Notifications ***ONLY***	50
CHT Metric 2.01a	Quality	Patients served in the CHT program by any member of the community health team during the measurement period.	Percent of ***ELIGIBLE*** patients receiving at least one Case Review activity	Unique # of Eligible patients with at least one ***CASE REVIEW*** activity	Number of patients who meet ***ELIGIBILITY*** criteria	Numerator includes all served patients with a Case Review activity. Denominator includes patient served with ***Impactable risk drivers***. Excludes patients with program status of ***INELIGIBLE OR NOT APPROPRIATE***	90%
CHT Metric 2.01b	Quality	Patients served in the CHT program by any member of the community health team during the measurement period.	Percent of Eligible patients ***ACCEPTING*** services	Unique # of patients ***ACCEPTING*** services	Number of patients who meet ***ELIGIBILITY*** criteria	Numerator excludes UNABLE TO CONTACT, DECLINED , PREOUTREACH, OUTREACH.	75%

CHT Care Plan Outcomes



CHT WORKFLOW

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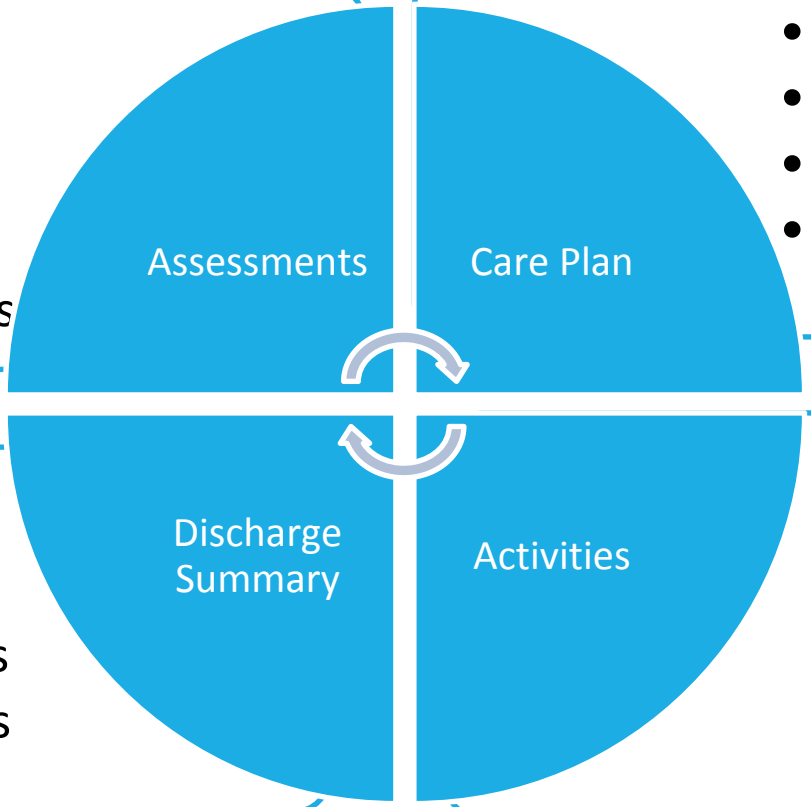
CHT Intervention

- Outreach
- Engagement
- Releases
- Assessment
- Standardized Screens



- Barriers problems
- Interventions
- Follow up
- Outcomes

- Referral Reason
- Care Plan Outcomes
- Summary of Success

- Advocacy
- Health Coaching
- Case Management
- Care Coordination
- Crisis Intervention

Extension of PCMH Team Roles and Responsibilities

Behavioral Health Care Manager	Community Health Worker	Nurse Care Manager
Assess substance use, mental health needs and assess patient readiness for change	Meet with patient during hospitalization	Care plan development
Address anxiety, depression and substance use needs	Arrange post-acute home visit and other home visits as needed	Integrate care among various providers
Coach behavior change	Appointment reminders and accompaniment	Assess degree of support required : diabetes, COPD, etc.
Address systemic barriers to care	Arrange transportation	Arrange consults for nutrition, pulmonary, etc.
Integrated care among various providers especially BH providers	Arrange entitlements	Arrange and coordinate care with VNA, assisted living, post-acute care
Care plan development	Link to community resources	Coach patient re: med adherence and self-care strategies
	Teach patients self-monitoring strategies	
	Care Plan development	

Local Hope Valley resident brought back on his feet with South County Health

"I wouldn't be living here at this point if it wasn't for her."

That's Paul Wilms, a 65 year old resident of Hope Valley and patient of Marie Padilla of the Community Health Team. Paul has been a patient with the CHT for 3 years. He had been down and out when it came to his health. After having issues getting appointments, being dropped from insurance more than 10 times, and suffering two strokes, Paul was ready to give up; until he started working with the CHT and Marie.

"Marie has helped me sort through all of the paperwork and politics of insurance which has been very helpful", said Paul

Paul Wilms hands his donation to South County Community Health Team **CHW** *Marie Padilla.*

"This team was receptive enough to when I should and shouldn't do things for myself or when I would need advice and counsel. They weren't trying to control everything" They encouraged me to be more productive and self aware and solve problems for myself," said Paul.

A grateful patient, Paul wanted to help others facing similar hardship, donating $100 to the CHT. "I suspect a lot of people are shutting down and giving up out there. I hope they get to use this opportunity locally with South County Hospital.

Housing to Home

3RD FLOOR – 1 ROOM

SUBSIDIZED APARTMENT

What's next?

SUSTAINABILITY

- Total Cost of Care Analysis
- Value Proposition or Business Model for stakeholder groups
  - Health plans
  - CHT Entity
  - PCP
  - Patients & families
  - Community
- State Expansion
  - CMS State Innovation Model
  - SAMHSA SBIRT
- Models of Reimbursement
  - ACO
  - Other Value Based options

Acknowledgements

Blue Cross and Blue Shield of RI

Neighborhood Health Plan of RI

Tufts Health Plan

UnitedHealthcare

CTC-RI “North” Team staff and Blackstone Valley Community Health Care Inc.

CTC-RI “South County” Team staff and South County Health

CTC Community Health Team Committee and Board of Directors

Rhode Island Department of Health,

Rhode Island Office of Health & Human Services

Warren Alpert School of Medicine of Brown University,

RI Foundation

CTC-RI Co-Directors: Debra Hurwitz, RN, MBA and Pano Yeracaris, MD, MPH

Evaluation Team: Roberta Goldman, PhD; Mardia Coleman, MS; Marisa Sklar, PhD

Link to CTC-RI CHT Resources

HTTPS://WWW.CTC-RI.ORG/PRACTICE-RESOURCES-AND-TOOLS/COMMUNITY-HEALTH-TEAMS

Questions?

THANK YOU