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Integrating Community Health Workers across the Healthcare Continuum

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Integrating Community Health Workers across the Healthcare Continuum

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MARIE PADILLA, BA COMMUNITY HEALTH TEAM LEAD
MAY 11, 2017
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 supports 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
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

- Comparison group (RI Non-PCMH)  
  CTC Cohort 1&2

Graph showing trends from Q1 2012 to Q2 2014, comparing the ED rates of the comparison group (RI Non-PCMH) and the CTC Cohort 1&2.
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

Vermont CHT Services

Services Provided:
- Care coordination
- Counseling
- Enhanced Self-Management
- Education
- Transitions of Care
  - Coordinated Linkages with targeted specialty services: mental, substance abuse, social services, and economic services

*Least understood in Rhode Island context

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, health, 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

CTC-RI

CHT Centralized Management

Data Management Services
database and core analytic services for all teams

Local CHT South County

Local CHT Pawtucket Central Falls

TBD Additional Local CHTs
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
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?

Drivers of Cost

- Acute Illness
- Chronic Disease
- Under-use of PCP
- Over/Misuse of ED/Inpatient
- Social disconnection
- Substance Abuse
- Mental Health
- Disabilities
- Poverty

Care Management Staff Model – Top 5 - 10%

Phase 2 – Who is High Risk? Of what?

Health Plan

Predictive Modeling
Generate lists of patients

Send high risk/high cost lists to PCMH Practices

PCMH Practice

Identify patients from payer lists, provider referrals, and practice based knowledge

Complete CHT Triage tool, ask patient, and refer to CHT

Healthcare Continuum

Hospital, home health & SNF’s identify patients with disposition issues, potential recidivists

Complete CHT Triage tool, ask patient, and refer to CHT
### CTC-RI CHT

**Referral Triage Tool**

#### Risk Drivers

- **Higher** – total cost, super utilizers
- **Moderate** – medically complex
- **Fundamental** – rising risk

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**Higher Risk Drivers (3 Points Each)**

<table>
<thead>
<tr>
<th>Utilization</th>
<th>(15 Points Max)</th>
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</thead>
<tbody>
<tr>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

| Health Plan High Risk Report – impactable costs actual or predictive > $25,000 |

<table>
<thead>
<tr>
<th>High Risk of: (6 Points Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP admit/ED visits in next 6 months</td>
</tr>
<tr>
<td>Significant decline in functional status/need for LTC in next 6 months</td>
</tr>
<tr>
<td>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 &gt; 4)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Moderate Risk Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorly Controlled High Risk Chronic Disease (2 Points Total)</td>
</tr>
<tr>
<td>CPD Chronic Pain End stage disease:</td>
</tr>
<tr>
<td>RX Meds: 8+ active prescriptions OR recent change in high risk meds (2 Points Total)</td>
</tr>
</tbody>
</table>

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

| Disability: significant Physical/Mental/Learning disability impacting reasons for referral (2 Points Total) |
| 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 leg |

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

| Mental Health DX that is severe, persistent, and uncontrolled (2 Points Total) |
| Major Depression | Bipolar | Debilitating Anxiety | Other |

| Fundamental Risk Drivers (1 Point Each) |
| Chronic Disease/Co-morbidities – not well controlled/not noted above (1 Point) |

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

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**Source:** Adapted from Cambridge Health Alliance

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

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<th># of Barriers</th>
<th>120</th>
<th>100</th>
<th>80</th>
<th>60</th>
<th>40</th>
<th>20</th>
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<td>Coregiver / Family Support</td>
<td>84</td>
<td>75</td>
<td>66</td>
<td>23</td>
<td>57</td>
<td>101</td>
<td>2</td>
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<tr>
<td>Financial</td>
<td>24</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>14</td>
<td>1</td>
<td>111</td>
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<tr>
<td>Food</td>
<td>23</td>
<td>23</td>
<td>8</td>
<td>8</td>
<td>8</td>
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<td>5</td>
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<td>Health Insurance</td>
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<td>Housing</td>
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<td>Legal</td>
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<td>Medication</td>
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<td>1</td>
<td>1</td>
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<td>1</td>
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<td>Other Barriers</td>
<td>111</td>
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<td>111</td>
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<tr>
<td>Palliative Care</td>
<td>46</td>
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<td>Work</td>
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<td>16</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

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

Rhode Island SIM Healthcare Transformation Project
as of Feb 12, 2016

RI SIM THEORY OF CHANGE—
Rhode Island’s payment system is changing to focus more on value and less on volume. IF SIM makes investments to support providers and empower patients to adapt to these changes, and we address the social and environmental determinants of health, THEN we will improve our Population Health and move toward our vision of the Triple Aim.
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
# Measuring Consistency & Efficiency

## Measurement Specifications

<table>
<thead>
<tr>
<th>Metric ID</th>
<th>Domain</th>
<th>Patient Population</th>
<th>Measure</th>
<th>Num</th>
<th>Den</th>
<th>Inclusions/Exclusions</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHT Metric 2.00</strong></td>
<td>Volume</td>
<td>Patients served in the CHT program by any member of the community health team during the measurement period.</td>
<td>Unique # Patients <strong>SERVED</strong></td>
<td></td>
<td></td>
<td><strong>SERVED</strong> = 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)</td>
<td>150/quarter, 200/year</td>
</tr>
<tr>
<td><strong>CHT Metric 2.00a</strong></td>
<td>Volume</td>
<td>Patients served in the CHT program by any member of the community health team during the measurement period.</td>
<td>Unique Patients <strong>SERVED</strong> per Team Member</td>
<td></td>
<td></td>
<td><strong>SERVED</strong> = Excludes patients with BHCM activities of CASE REVIEW ONLY or ED/INPATIENT Notifications ONLY</td>
<td>50</td>
</tr>
<tr>
<td><strong>CHT Metric 2.00b</strong></td>
<td>Volume</td>
<td>Patients served in the CHT program by a BH Specialist during the measurement period.</td>
<td>Unique patients <strong>SERVED</strong> per BHCM</td>
<td></td>
<td></td>
<td><strong>SERVED</strong> = Excludes patients with BHCM activities of CASE REVIEW ONLY or ED/INPATIENT Notifications ONLY</td>
<td>50</td>
</tr>
<tr>
<td><strong>CHT Metric 2.01a</strong></td>
<td>Quality</td>
<td>Patients served in the CHT program by any member of the community health team during the measurement period.</td>
<td>Percent of ELIGIBLE patients receiving at least one Case Review activity</td>
<td></td>
<td></td>
<td>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</td>
<td>90%</td>
</tr>
<tr>
<td><strong>CHT Metric 2.01b</strong></td>
<td>Quality</td>
<td>Patients served in the CHT program by any member of the community health team during the measurement period.</td>
<td>Percent of Eligible patients <strong>ACCEPTING</strong> services</td>
<td></td>
<td></td>
<td>Numerator excludes UNABLE TO CONTACT, DECLINED , PREOUTREACH, OUTREACH.</td>
<td>75%</td>
</tr>
</tbody>
</table>
CHT Care Plan Outcomes

- # of Problems

- Declined
- In Progress
- Not Addressed
- Partially
- Successful
- Successful
- Unsuccessful
CHT WORKFLOW
CTC-RI CHT
Referral Triage Tool

Risk Drivers
Higher – total cost, super utilizers
Moderate – medically complex
Fundamental – rising risk

Source: Adapted from Cambridge Health Alliance
CHT Intervention

- Outreach
- Engagement
- Releases
- Assessment
- Standardized Screens
- Referral Reason
- Care Plan Outcomes
- Summary of Success
- Advocacy
- Health Coaching
- Case Management
- Care Coordination
- Crisis Intervention
- Barriers problems
- Interventions
- Follow up
- Outcomes

Assessments

Care Plan

Activities

Discharge Summary
## Extension of PCMH Team Roles and Responsibilities

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

“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