Building Community Clinical Linkages

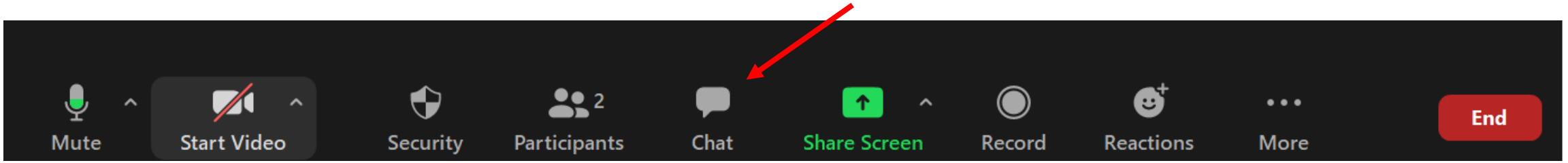
CARE TRANSFORMATION COLLABORATIVE

JANUARY 22, 2021

Zoom

Welcome! Please Chat in:

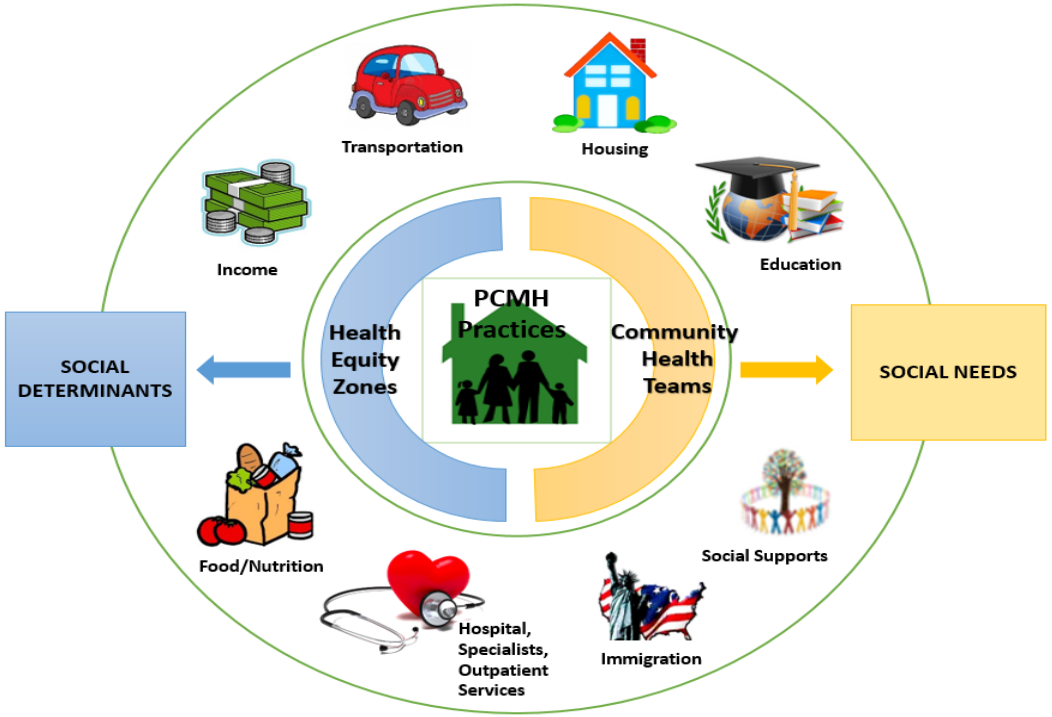
- Your Name and Organization



- ***Please mute yourself when not speaking***
- ***Please use the 'Raise Hand' feature***

CHTs: A flexible and fluid resource to meet population health goals

CHT's work as an **extension of primary care** to address the social, behavioral and environmental determinants for high risk/high cost/high impact patients in order to establish healthier living, improved health and total cost outcomes.



Who is on the team?

CORE:

- **Community Health Workers**
- **Behavioral Health Provider**

ADDED:

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screener**
- **Peer Recovery Specialist (SOR)**
- **Family Care Liaison (RIPIN)**
- **Legal Assistance (MLPB)**

Supported Learning Community

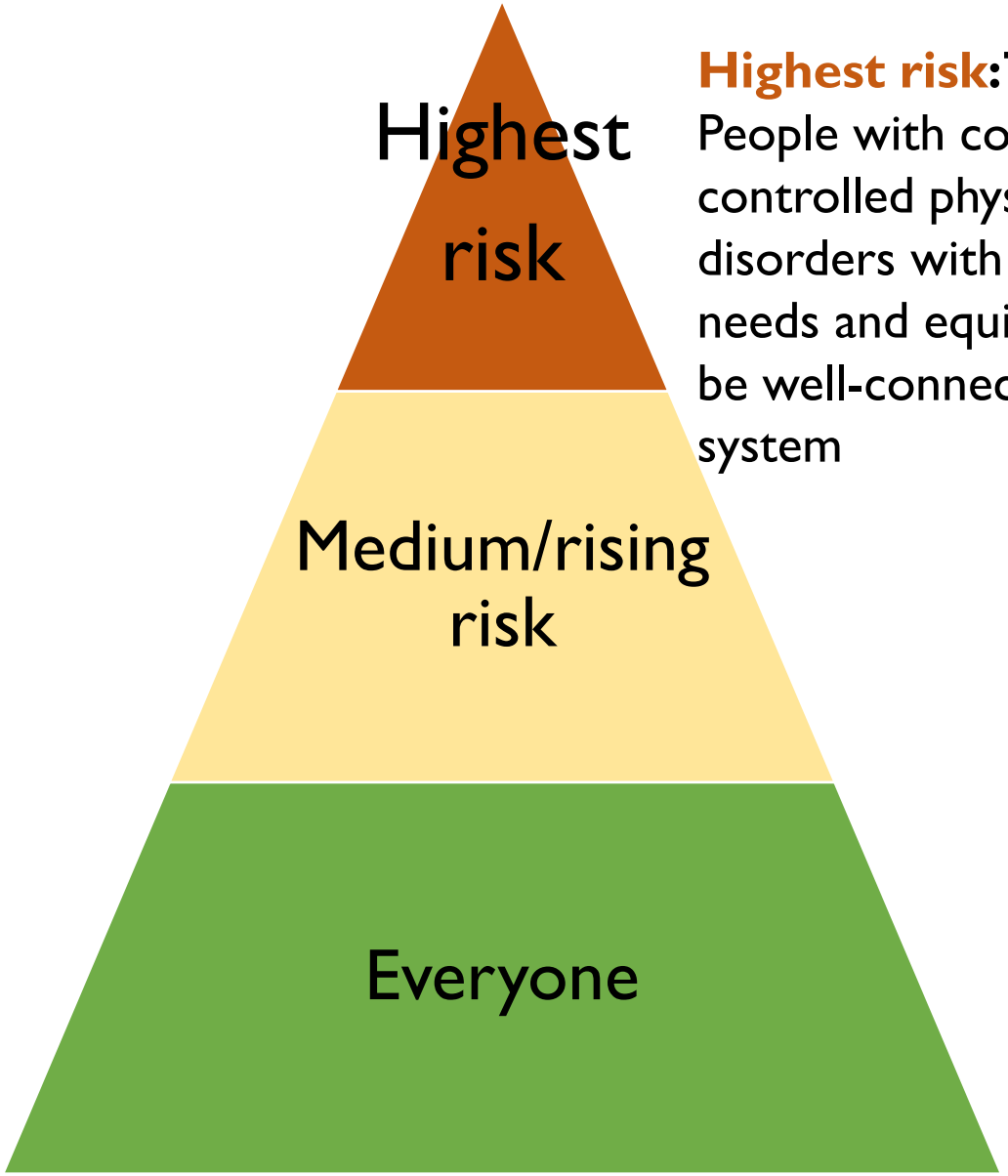
- **Monthly Best Practice meetings**
- **CTC sponsored trainings**
- **Common data elements**

COMMUNITY HEALTH TEAMS

- Community health worker – connect and build trust, whole person orientation, lived experience, connection with community resources
- Behavioral health specialist – address unmet behavioral health needs
- (NP/PA – clinical care needs)

COMMUNITY HEALTH TEAMS

- As a primary engager and caregiver of people who are disconnected who are at highest and medium/rising risk
- As an extender and complement to primary care
- As a trusted intermediary between the health system and community
- As a resource for community multi-sector transformation



Who is in this group?

Highest risk: Top 5%
People with combined poorly controlled physical, mental health disorders with compounding social needs and equity gaps) who may not be well-connected to primary care system

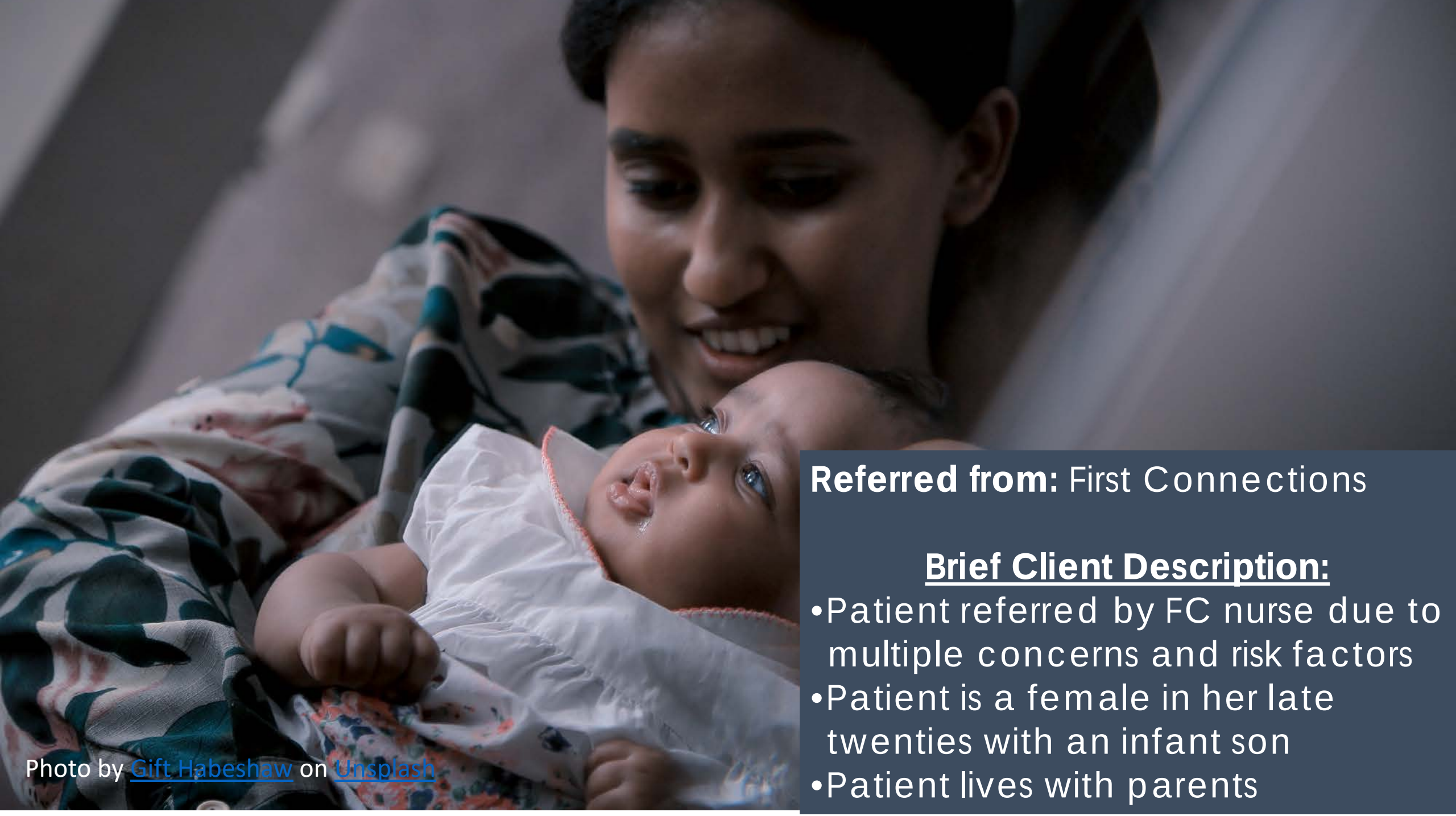


Photo by Gift Habeshaw on Unsplash

Referred from: First Connections

Brief Client Description:

- Patient referred by FC nurse due to multiple concerns and risk factors
- Patient is a female in her late twenties with an infant son
- Patient lives with parents

Family Care Team Case study

Risk Drivers Identified:

- History of Substance Use Disorder, currently on methadone
- Uncontrolled chronic infectious disease
- Poor follow-through with primary care
- Lack of employment; Educational/Vocational needs
- No driver's license
- DCYF involvement
- Recently transitioned to home from residential placement
- Family conflict and poor natural supports

Interventions:

- Patient was referred to the CHT **Behavioral Health clinician** for counseling services and to the CHT Certified **Peer Recovery Specialist** (CPRS) who connected her to meetings (online/in-person)
- Assisted patient to **reinstate her license**; helped complete application and provided transportation to DMV.
- CCHW assisted patient in **completing resume and applying for jobs**
- CCHW assisted patient in **completing housing applications**

Family Goals:

- Finishing Medical Assistant schooling
- Secure employment
- Behavioral health counseling
- Peer Recovery services
- Family Therapy sessions
- License reinstatement for transportation

Care Team:

- Community Health Worker (CCHW)
- Behavioral Health Clinician (LMHC)
- Certified Peer Recovery Specialist (CPRS)

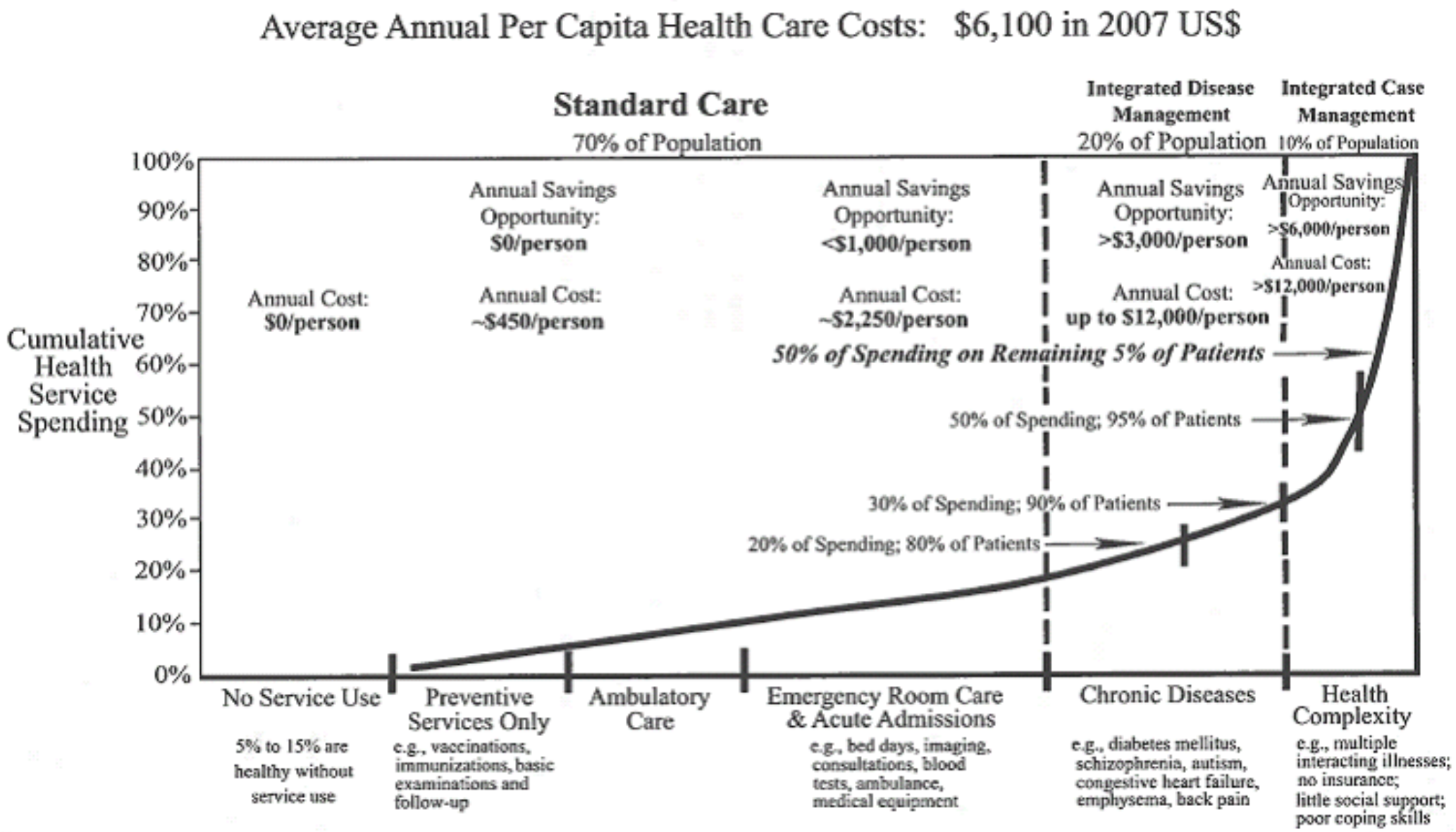
Other Partners/Services:

- Residential treatment center
- DCYF—Now closed
- Opioid Treatment Program—for medication assisted treatment and psychiatric care
- Early Intervention
- Healthy Families America
- Recovery Center

Outcomes:

- Actively attending online recovery meetings/ maintaining sobriety
- Baby is stable, attending all peds appointments, and mother is connected to recommended community providers
- Reporting a decrease in anxiety and improvement in sleep for parent
- Stable housing and relationship with family
- Chronic medical conditions are in control
- Patient has an active license, has been attending all appointments for child and herself
- Actively seeking employment
- DCYF has closed services
- Actively engages in an Early Intervention program.

FIGURE 1.1 Health care cost savings opportunity.



Adapted with permission from Minnesota Medical Association, Physicians' Plan for a Healthy Minnesota: The Minnesota Medical Association's Proposal for Health Care Reform. Supplement to Minnesota Medicine, March 2005, p. 9.

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What is needed to support this population?

Community Health Team

- CHW, nurse care manager, behavioral health specialist) working in the community in partnership with organizations across sectors
- Referrals from diverse sources (EDs. Health plans, Family Home Visiting, etc)

PT IS 52 YEARS OLD AND LIVES IN LOWINCOME HOUSING WITH HER 15 Y.O. DAUGHTER AND 10 Y.O. ADOPTED GRANDDAUGHTER. PT WAS REFERRED TO CHT. PT WAS REFERRED BY SCH ON 11/11/2019, IS DISABLED, HAS POORLY MANAGED DIABETES AND CHF. PT EXHIBITS POOR JUDGEMENT, HAS POOR ADLS AND POOR SUPPORTS. PT IS A FALL RISK AND STRUGGLES TO AMBULATE. PT HAS BEEN HOSPITALIZED RECENTLY FOR FALL RESULTING IN FRACTURED HIP AND SORE ON FOOT. PT CALLS THE AMBULANCE FOR SUPPORT IF SHE FALLS. PT DOES NOT HAVE TRANSPORTATION.

SCH CHT Case Study 2020

Risk Drivers

Utilization: Pt has been hospitalized several times for fall and Diabetes and COPD related symptoms
Health Conditions/Literacy: Diabetes, CHF, broken shoulder, fractured hip, eye problems. Pt is poor historian and has little insight.
Care Coordination: none prior to CHT
Social/Emotional Support: Pt has sister and older daughter who live in the state; somewhat supportive.
Functional Limitations: Pt struggles with ambulating and is a fall risk. Struggles w/ judgement, following through on referrals, memory and organizational skills-forgets appts, etc..
Social/Familial/Environmental:
Family: Pt care for 2 children, her daughter, 15 and adopted granddaughter, 10.
Food Security: SNAP and utilizes food banks.
Housing: Lives in subsidized housing. Sleeps on couch. 2 br apt.
Transportation: Pt takes public transportation or relies on sister.
Insurance: NHP access/ Medicaid
Financial: SSDI $1500/ month.
Behavioral Health: Pt has depression, displays flat affect and apathetic demeanor.
RISK DRIVERS IDENTIFIED FOR OTHER FAMILY MEMBERS:
- Counseling advised for children.
- In home family therapy advised for parenting skills; lack encouragement.

Intervention

Utilization: Pt has in home supports through HH and CHT support. Pt has BH support with BHCM.
Health Conditions/Literacy: has VNA, OT and PT currently and CHT support.
Care Coordination: Coordinated HH diabetes coaching. Pt has 2/x week wound care and meets with OT & PT.
Social/Emotional Support: BHCM meets with pt for weekly support.
Functional Limitations: CHT suggested pt use calendar and phone for scheduling appointments.
Social/Familial/Environmental:
Family: Daughter registered with Big Sister for mentoring and will have intake.
Housing: Pt on waitlist for larger apt. Assisted living advised.
Transportation: no changes
Insurance: no changes
Financial: no changes
Behavioral Health: suggested in home counselor- pt struggles with follow through. Suggested inpatient at Butler to address Depression symptoms.
INTERVENTIONS BENEFITTING OTHER FAMILY MEMBERS
- A Big Sister referral for 10 y.o.
- B FCCP referral; kids did not qualify
- C Seeking in home family therapy

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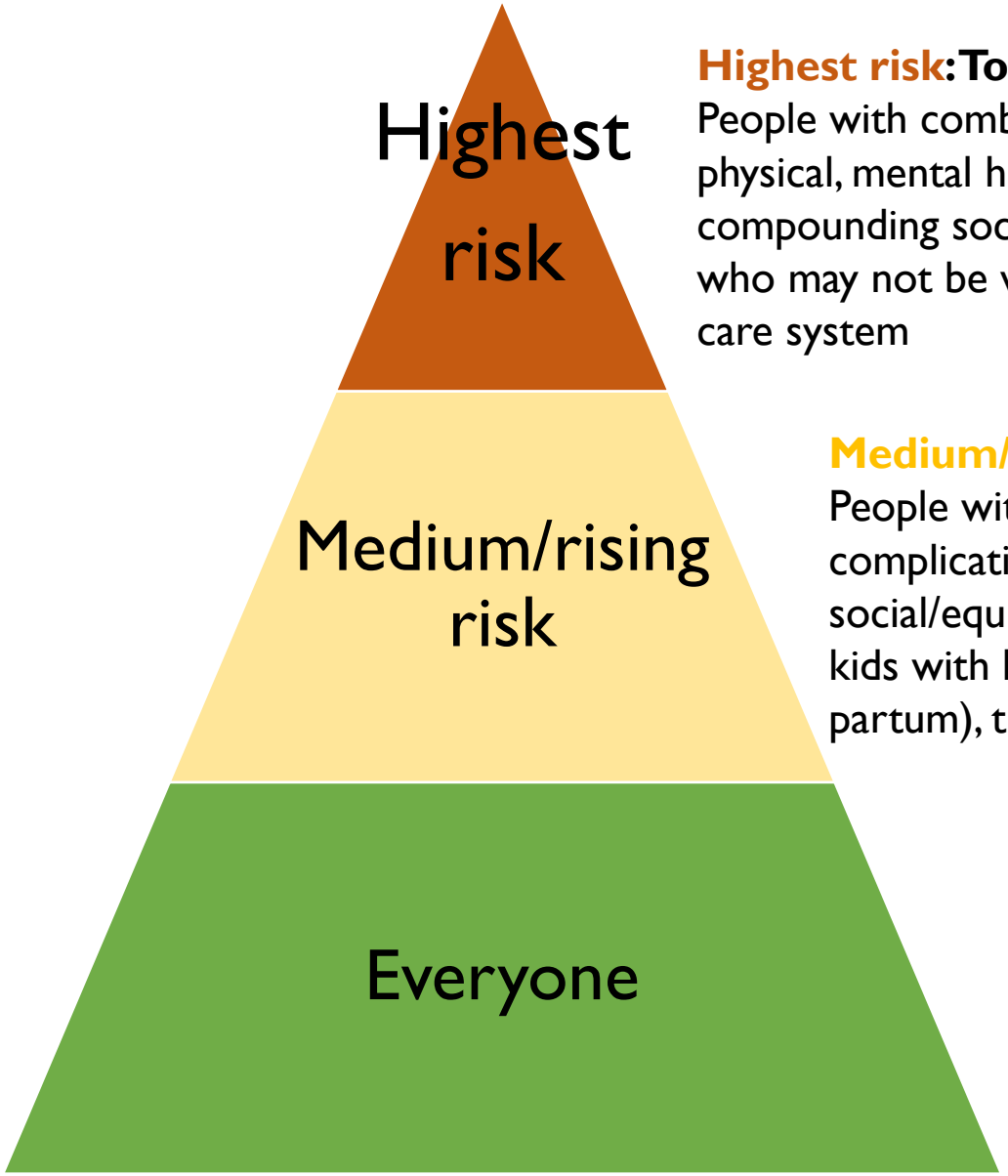

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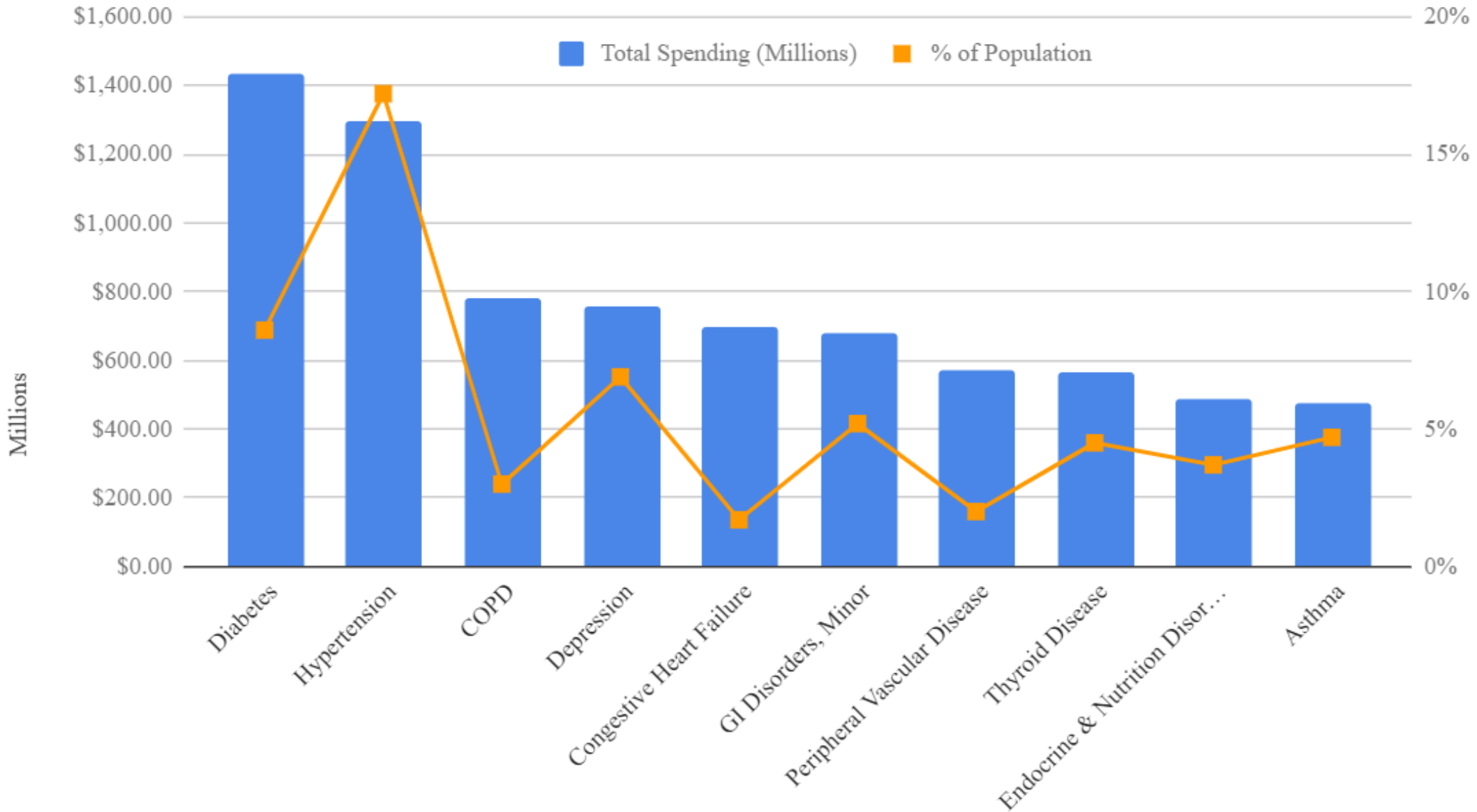
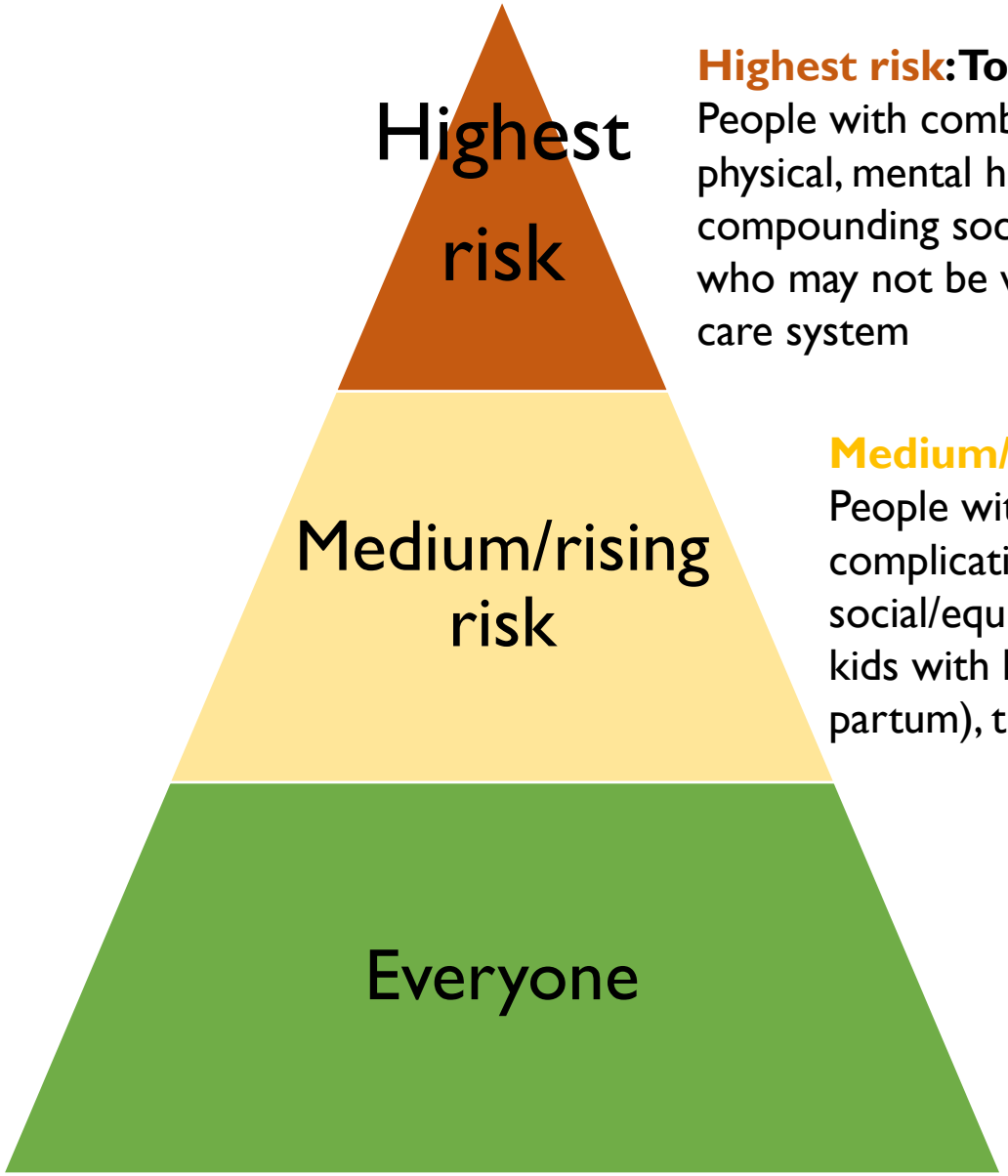
Medium/rising risk: (20-30%)
People with controlled chronic medical conditions, complicating behavioral health (eg, addiction) OR social/equity gap (people who are housing insecure, kids with high ACE scores, black mothers post-partum), those who are not connected to PC

Total Spending (Millions) for Patients with Each Condition and Percent of Population with Each Condition



Spending on chronic conditions in Rhode Island

https://health.ri.gov/data/chronicconditions/



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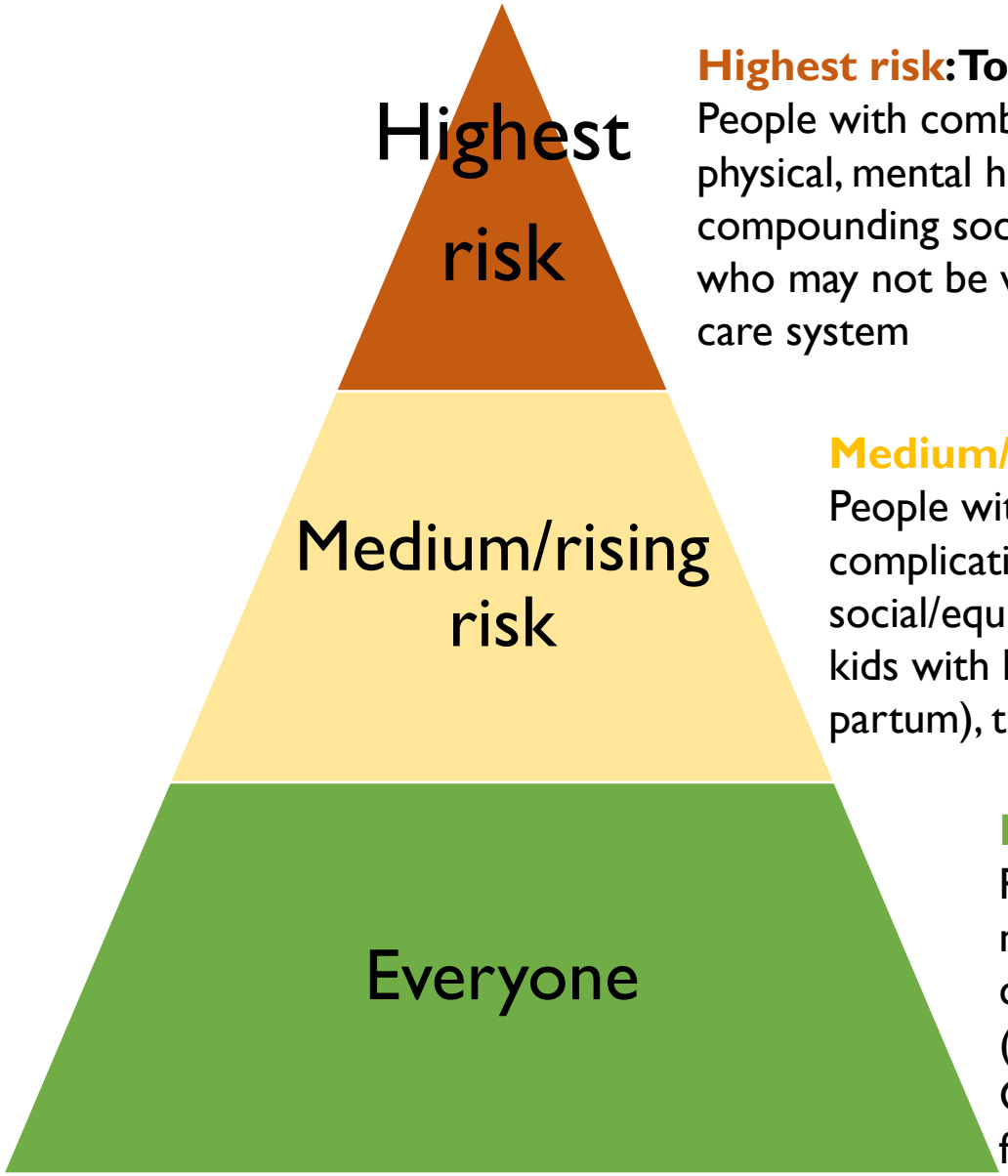
What is needed to support?

Community Health Team

- (CHW, nurse care manager, behavioral health specialist) working in the community in partnership with organizations across sectors
- Referrals from diverse sources (EDs. Health plans, Family Home Visiting, etc)

Community health teams embedded in either CHTs or other primary care/AE based care management with ability to reach out into the community or in the community to address needs beyond PC



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Everyone
People who would benefit from navigation for routine care and connection to social/equity needs (eg, immigrants who do not seek COVID testing or vaccination due to fear of public charge)

What is needed to support them?

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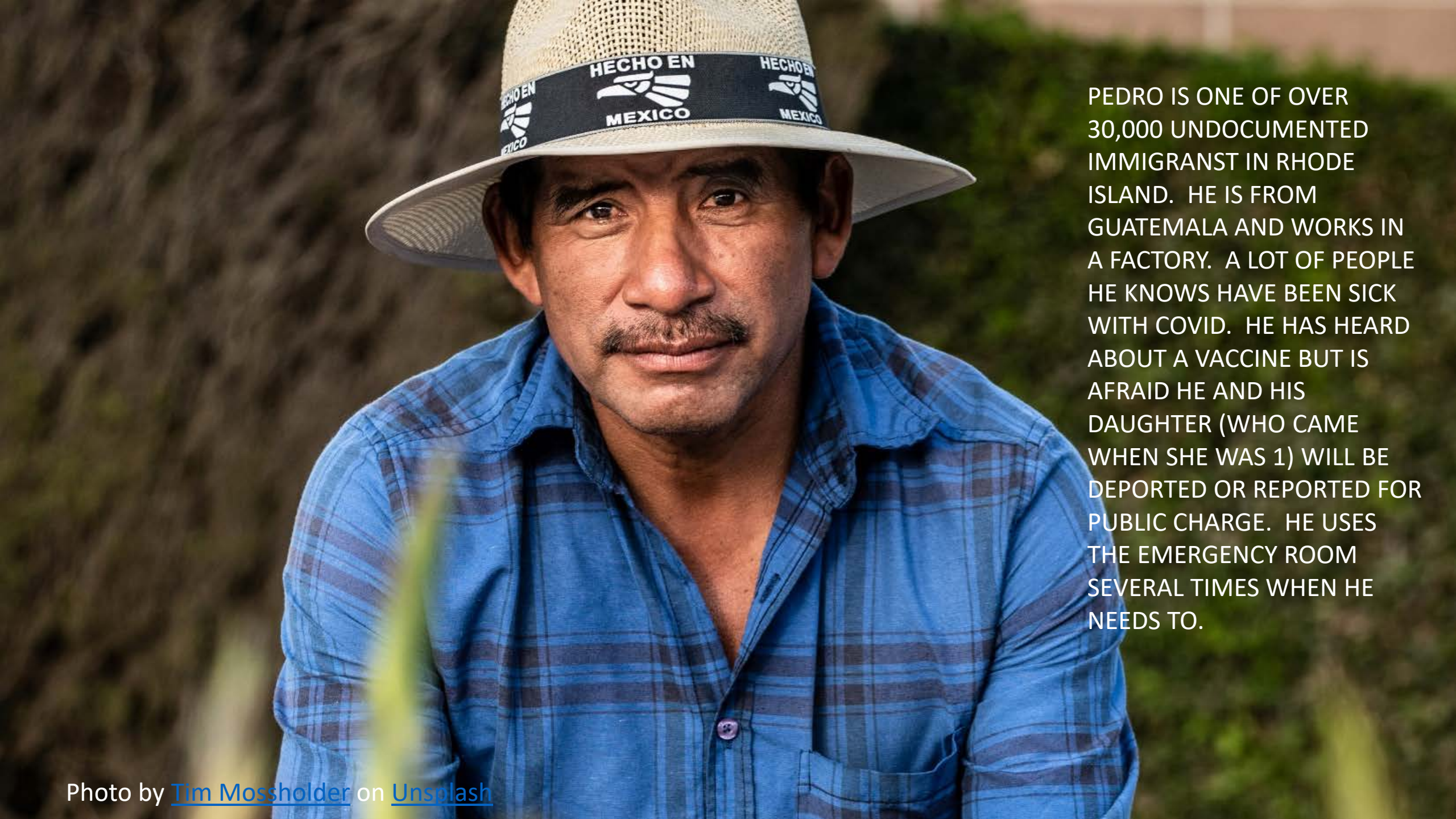
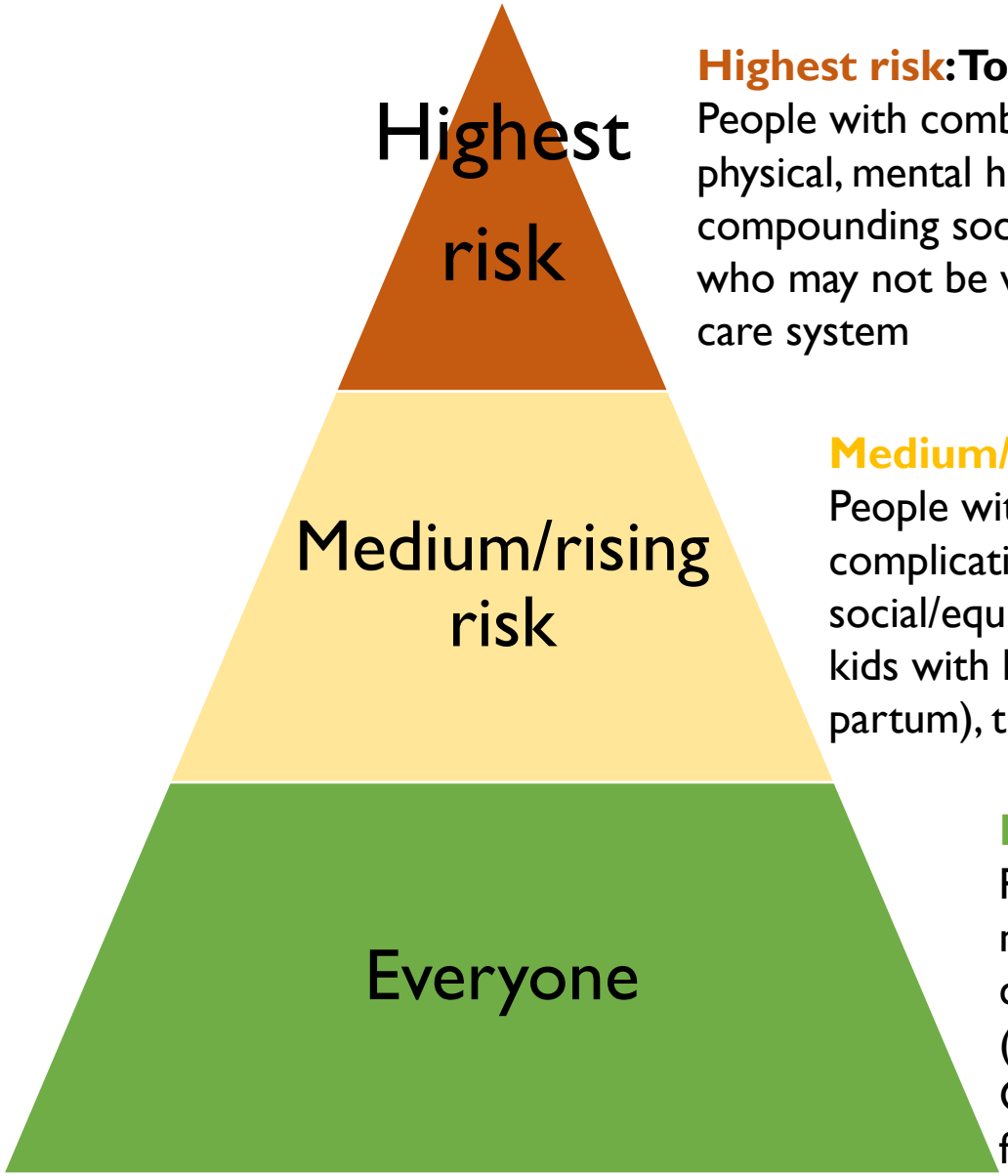


PEDRO IS ONE OF OVER 30,000 UNDOCUMENTED IMMIGRANST IN RHODE ISLAND. HE IS FROM GUATEMALA AND WORKS IN A FACTORY. A LOT OF PEOPLE HE KNOWS HAVE BEEN SICK WITH COVID. HE HAS HEARD ABOUT A VACCINE BUT IS AFRAID HE AND HIS DAUGHTER (WHO CAME WHEN SHE WAS 1) WILL BE DEPORTED OR REPORTED FOR PUBLIC CHARGE. HE USES THE EMERGENCY ROOM SEVERAL TIMES WHEN HE NEEDS TO.



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Navigators/community health workers who can connect people in primary care and navigate people to routine health and social services

CHARACTERISTICS OF COMMUNITY HEALTH WORKER SUPPORT SYSTEM

1. **Place-based** - Community health workers that are sourced from and serve a particular geography can do much more than those assigned based solely on a clinical affiliation.
2. **Comprehensive** – Rather than parsing CHW workforce by individual diseases, it is far more efficient and effective to consider them a part of a comprehensive health improvement strategy to address the mental, physical, and social needs of people and communities and organize them based on highest risk, medium/rising risk, and prevention.
3. **Connected** - Community health workers are far more effective when they are part of health teams that are connected with health care and community-based partners across sectors in their geography. This may require access to technology supports, internet and broadband as well as regular processes of connecting with teams..

Why Geographic Direct Contracting?

The Geographic Direct Contracting Model seeks to provide beneficiary choice with more universal care coordination and enhanced benefits in a cost effective manner.

Current Medicare FFS	Geographic Direct Contracting Model
No incentives for coordinated care	Significant incentives for coordinated care
No enhanced benefits	Significant opportunity for enhanced benefits
No incentives for Social Determinants of Health (SDOH)	Significant incentives for SDOH
Traditional Medicare deductibles, copays, and premiums	Potential for lower deductibles, copays, and premiums

SUSTAINABLE MULTI-SECTOR PAYMENT STRATEGIES TO SUPPORT COMMUNITY HEALTH TEAMS ACROSS THE NATION

- As part of usual clinical care through Medicaid, MCOs and other payers across sectors
  - Clinical care base payment (fee for service)
  - Quality payments
  - As part of capitation/shared savings payments
  - As part of MCO administrative costs
  - Pay for outcomes payments
- Through grants/demonstration funding, state funding (eg, SIM, public health grants) until shared savings are demonstrated → maintained after that as investments in quality and equity
- Through multi-sector payments (eg, via Pathways hubs)