CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Overview of Community Health Teams (CHTs)

Care Transformation Collaborative of Rhode Island

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Presentation Overview

- Community Health Team Model
- Clients Served
- How CHTs work with primary care and nurse care managers
- How to access CHTs

CTC-RI Mission:

Co-convened by the Office of the Health Insurance Commissioner and EOHHS, **CTC-RI** is a non-profit, multi-payer collaborative focused on health system transformation.

The Care Transformation Collaborative of Rhode Island's (CTC-RI) mission is to lead the transformation of primary care in Rhode Island in the context of an integrated health care system; and to improve the quality of care, the patient experience of care, the affordability of care and the health of the populations we serve. CTC-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable primary care.

Community Health Team (CHTs) -an extension of primary care

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 needs	Medication management, nutrition, use of health care system, appointment preparation
Health related social needs (HRSNs)	Help access: safe, affordable housing; home medical equipment; food and food banks; transportation, and completing paperwork for entitlements applications

CHTs Serve High Risk Adults With Behavioral and/or Complex Social Needs

Traditionally focused at-risk adults with complex needs such as:

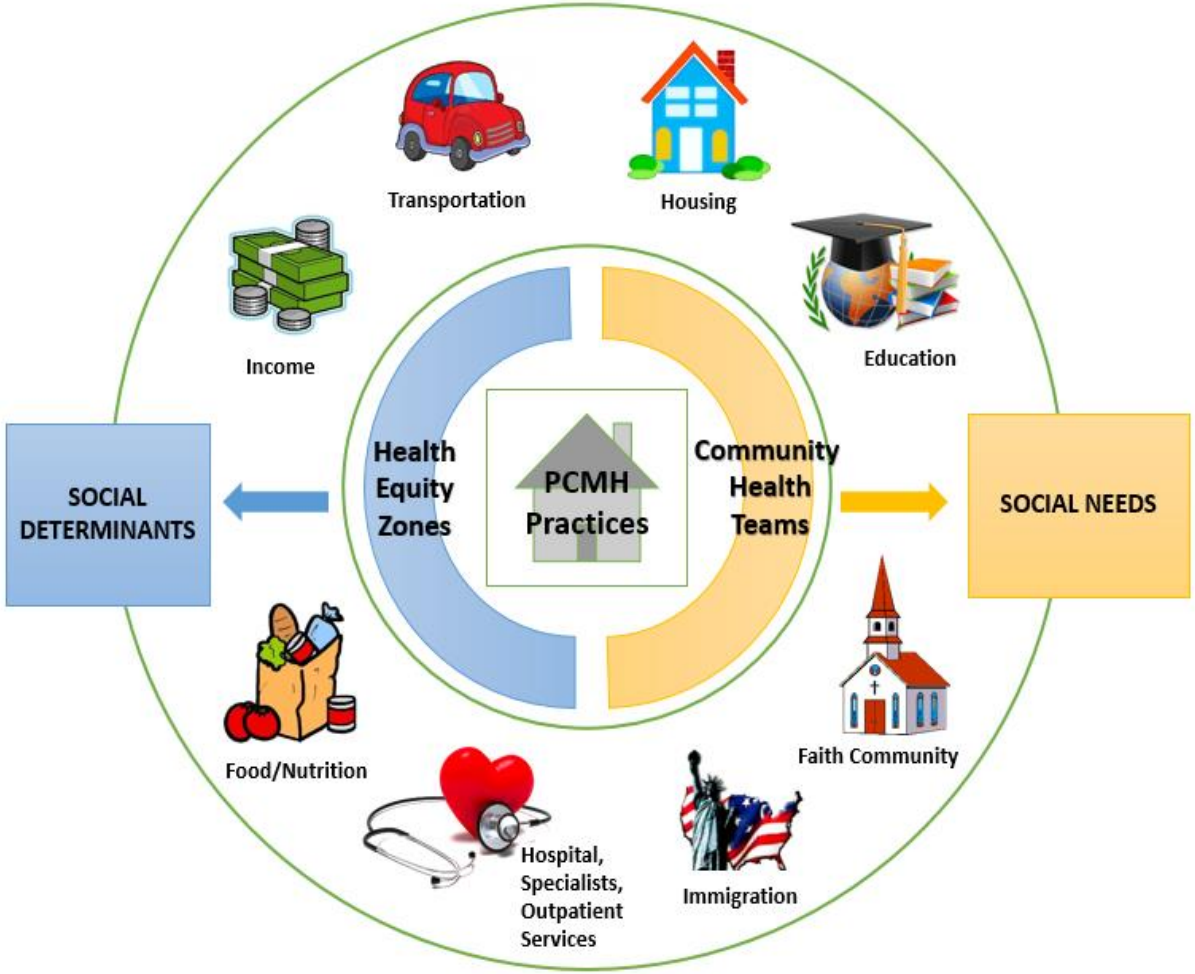
- Poorly controlled high-risk chronic conditions
- Substance use disorder and at least one other co-morbid physical or behavioral health condition
- Irregular access primary care (patient disengagement)
- 2+ inpatient or ED visits within 6 months
- Unmet behavioral health or psycho-social needs

To date, CHTs have funded by contributions by multiple payers:

- Anyone can be served by a CHT, regardless of insurance type
- CHTs are funded by:
  - Grant dollars
  - Contributions from Rhode Island health insurers

Changes in funding support likely to happen with Medicaid reimbursement of CHW services

Community Health Teams are Regionally Based



CHT Structure

Community health workers and Behavioral Health clinicians' outreach to high-risk patients referred by primary care, or other referral source (i.e. health plan, First Connections). They assess and address social and behavioral health needs of patients.

Who is on the team?

CORE:

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

ADJUNT SUPPORT:

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screener**
- **Peer Recovery Specialist**
- **Family Care Liaison**
- **Legal Information and Rights Education (MLPB)**

Referring Primary Care Practice Relationships

- As an extension of primary care, the Community Health Team establishes relationships and partnerships with local primary care practices to refer clients to the Community Health Team.
- Teams outreach to primary care practices and establish….

Memorandum of Agreement	Business Associate Agreement
Allows referral to be made from the primary care practice to the Community Health Team based on standardized criteria and collaboration on development and implementation of a client's care plan, with regularly scheduled on-site meetings to ensure collaboration and coordination of care.	Agreement between the primary care practice and the Community Health Team. Agencies may use internal templates.

Community Health Team Referral Triage Tool

- Mechanisms by which PCPs identify appropriate referrals to CHTs
- **Eligibility Determination for CHT:**
- >15 = High Risk (offer CHT to patient)
- 8-14= Rising Risk (patient may meet criteria for CHT)
- <8 = Discuss referral with CHT before offering to patient

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	

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 legal status ☐other

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Cont.

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	

Referral/Triage Tool and Process

Referral Made

Nurse care Manager at referring practice completes Referral/Triage Tool and sends to CHT Lead

Triage

Referral is evaluated by CHT Lead, determined if appropriate for CHT intervention

Outreach

Community Health Worker is assigned to the client; attempts to outreach and engage client 3x over 1-2 weeks

Care Planning

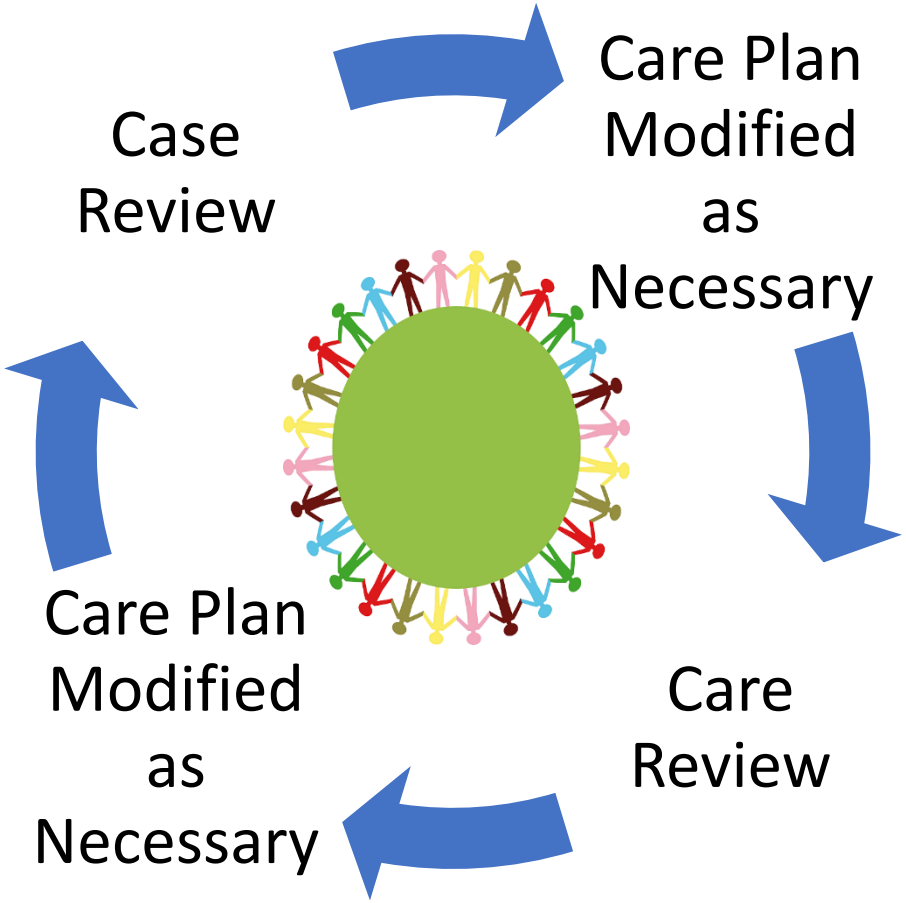
The Community Health Team staff work with the primary care practice to identify health and treatment goals to include in the client's care plan, which is supplemented with goals identified in the initial assessment of the client.

The CHT ensures services are tailored to client needs by….

- Developing an initial Care Plan within two weeks of intake
- Sending initial Care Plan to team lead for review and sharing with referring practice Nurse Care Manager
- Regularly addressing Care Plan progress and content with referring practice Nurse Care Manager
- Setting a Care Plan Review date <6 months from date of initial Care Plan

Care Coordinating and Monthly Case Reviews

The Community Health Team collaborates with referring practices to ensure coordination of care for clients. The Community Health Teams participate in **monthly case review meetings** with referring primary care practice nurse care managers (and other clinicians as needed).



Client Video

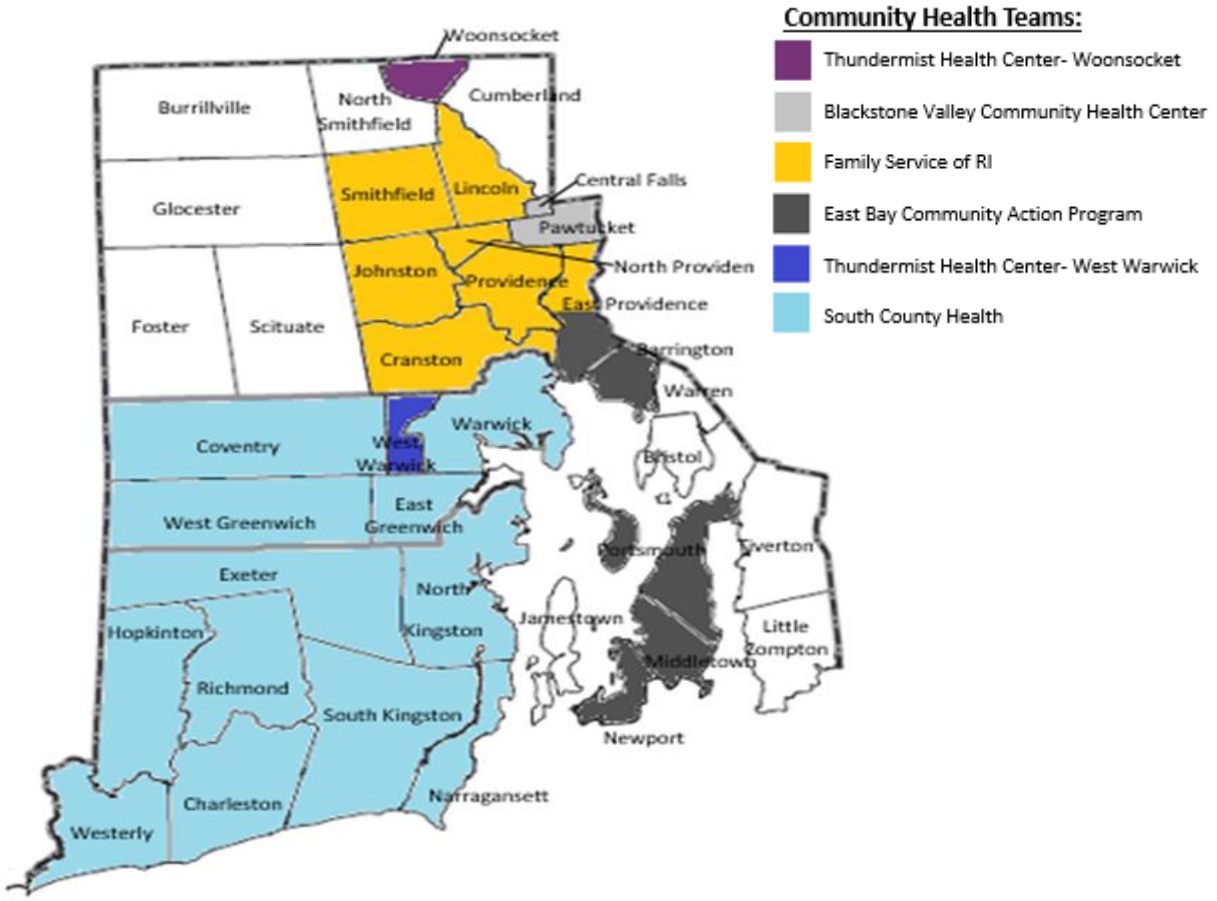
Current: CHT Relationships and Reach

6 Geographically based teams

32 Practices across the state have referring relationships with Community Health Teams

326 Providers across all partnering practices have referring relationships with Community Health Teams

3000 Adult patients directly served by CTC-RI Community Health Teams in FY 19



Current CHTs

South County Health

Blackstone Valley Community Health Care

Thundermist Health Center

FSRI Family Service of Rhode Island
healthy families · strong communities

east bay community action program

Expanded team serving Washington County and Kent County; serving multiple practices in the region;

Team serving Pawtucket/Central Falls; primarily serving their own patients

Combined funding for teams in Woonsocket and West Warwick; primarily serving their own patients

Expanded team serving Greater Providence region; serving multiple practices

Team serving primarily internal clients in Newport and a small number in East Providence

Quarterly Measurement

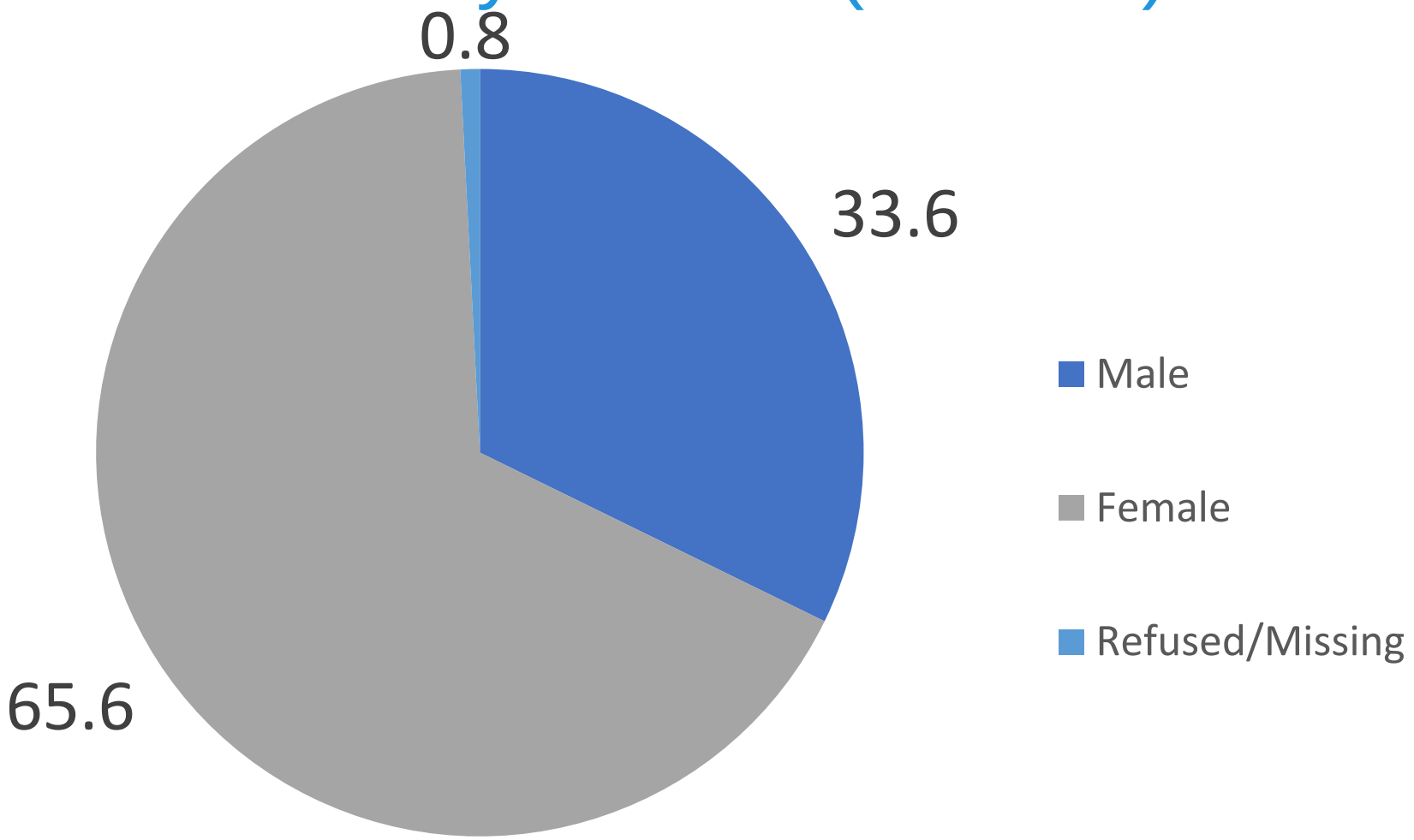
The Community Health Team tracks data to report quarterly performance metrics on key activities

- Number of Referrals
- Number of Intakes
- Number Served
- Number of Face-to-Face Visits
- Patient Level Demographics
- Risk Scores
- Assessment of Health Related Social Needs(transportation, food/nutrition, interpersonal violence, utility assistance)
- Behavioral Health
- Quality of Life Metrics
- Patient experience/satisfaction

CHT Client Demographics (N=1,467 - 7/1/19 – 6/30/2021)

Age	CHT Clients M = 55 years	2020 RI Census M=40
Non-English Speaking	18.8%	--
White, NonHispanic	46.0%	68.7%
Hispanic/Latino	40.6%	16.6%
Black, NonHispanic	7.4%	5%
2 or more, NonHisp.	0.7%	4.8%

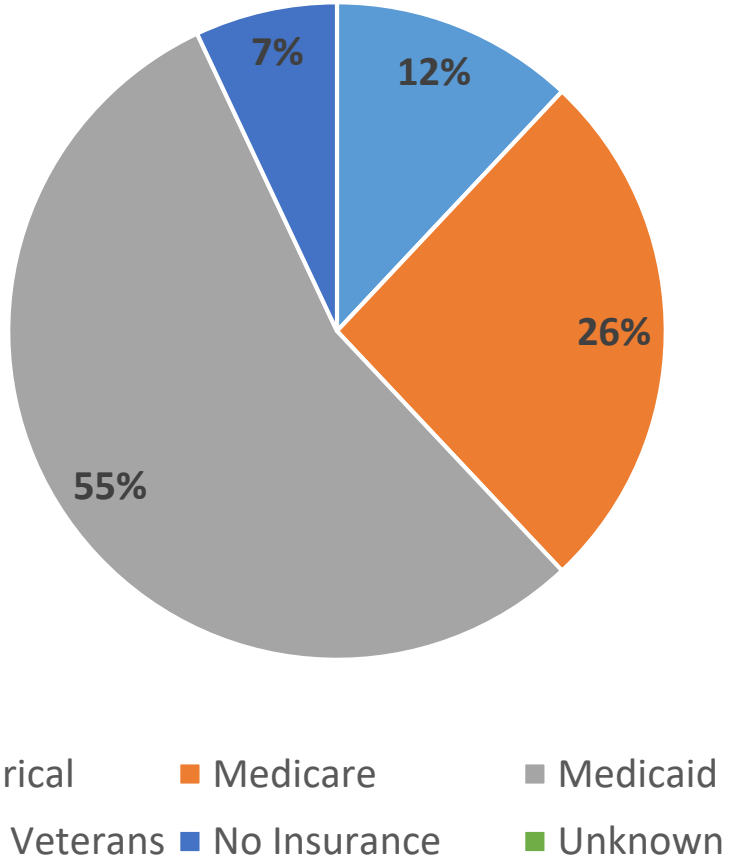
CHTs Clients Served by Gender (n=1467)



CHTs are serving individuals with multiple SDOHs and are able to address their needs

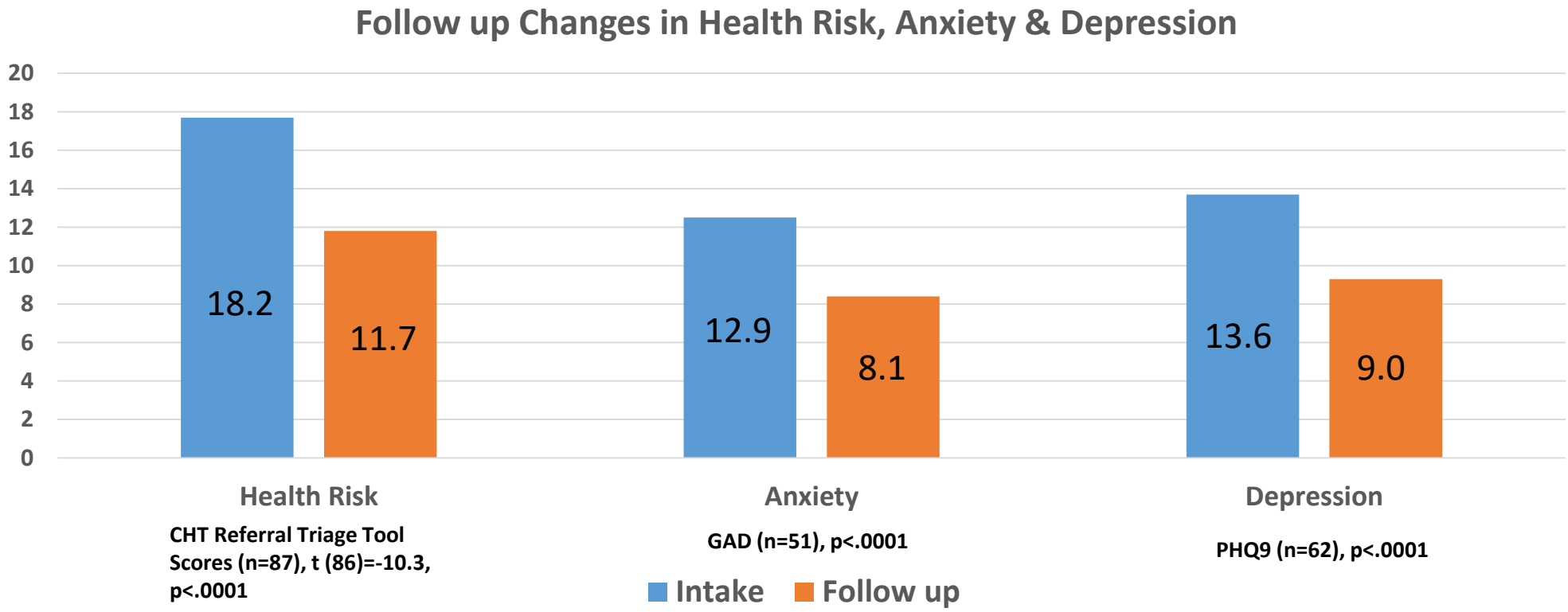
	% reporting issue at intake	% no longer reporting issue at follow-up
Housing*	**33.5%**	62.8%
Food Insecurity*	**27.7%**	73.4%
Transportation*	**26.3%**	58.4%
Interpersonal Violence*	**15.9%**	70.3%
Utilities**	**9.4%**	84.3%

Insurance Coverage on Clients Served, FY 21, N=3380



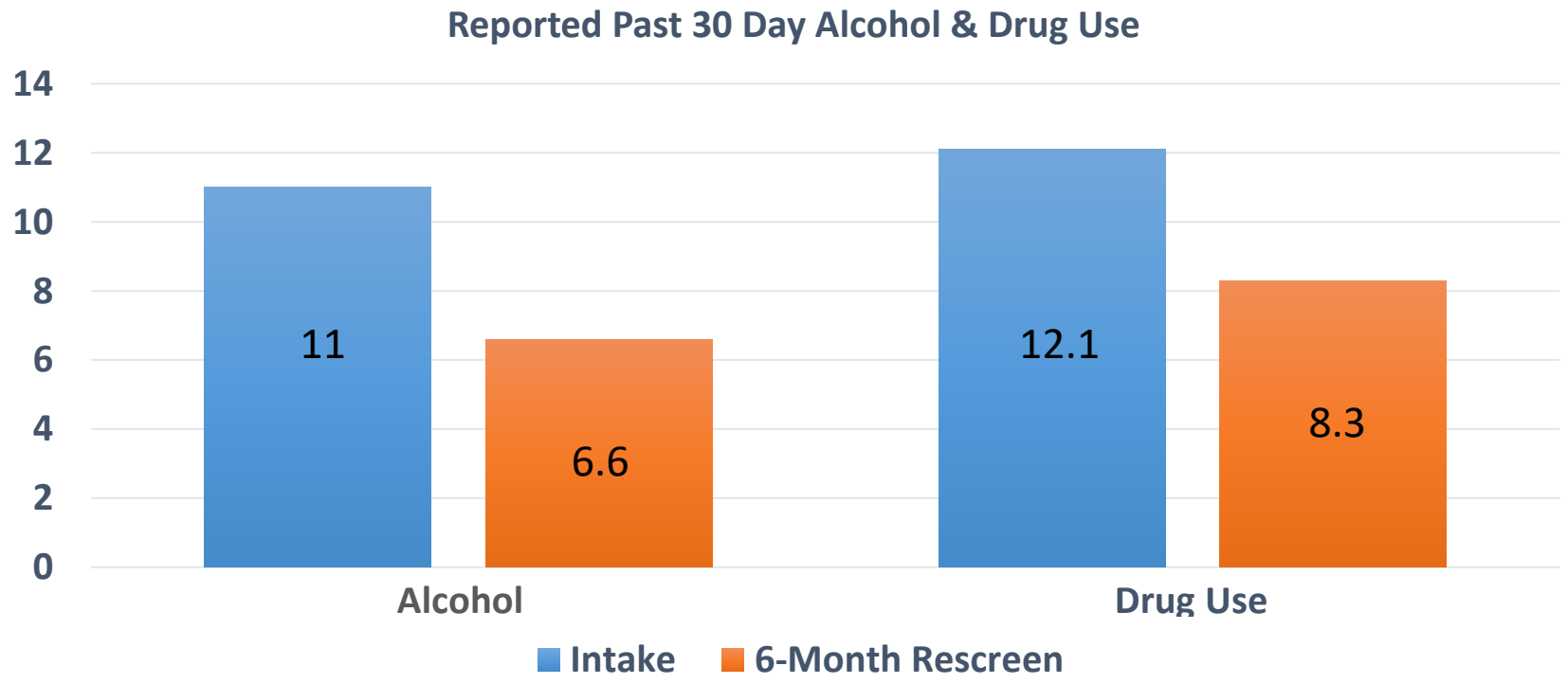
Reduction in Risk Scores

2019 analysis shows clinically and statistically significant reductions in patient health risk, depression, and anxiety after less than 5 months in care

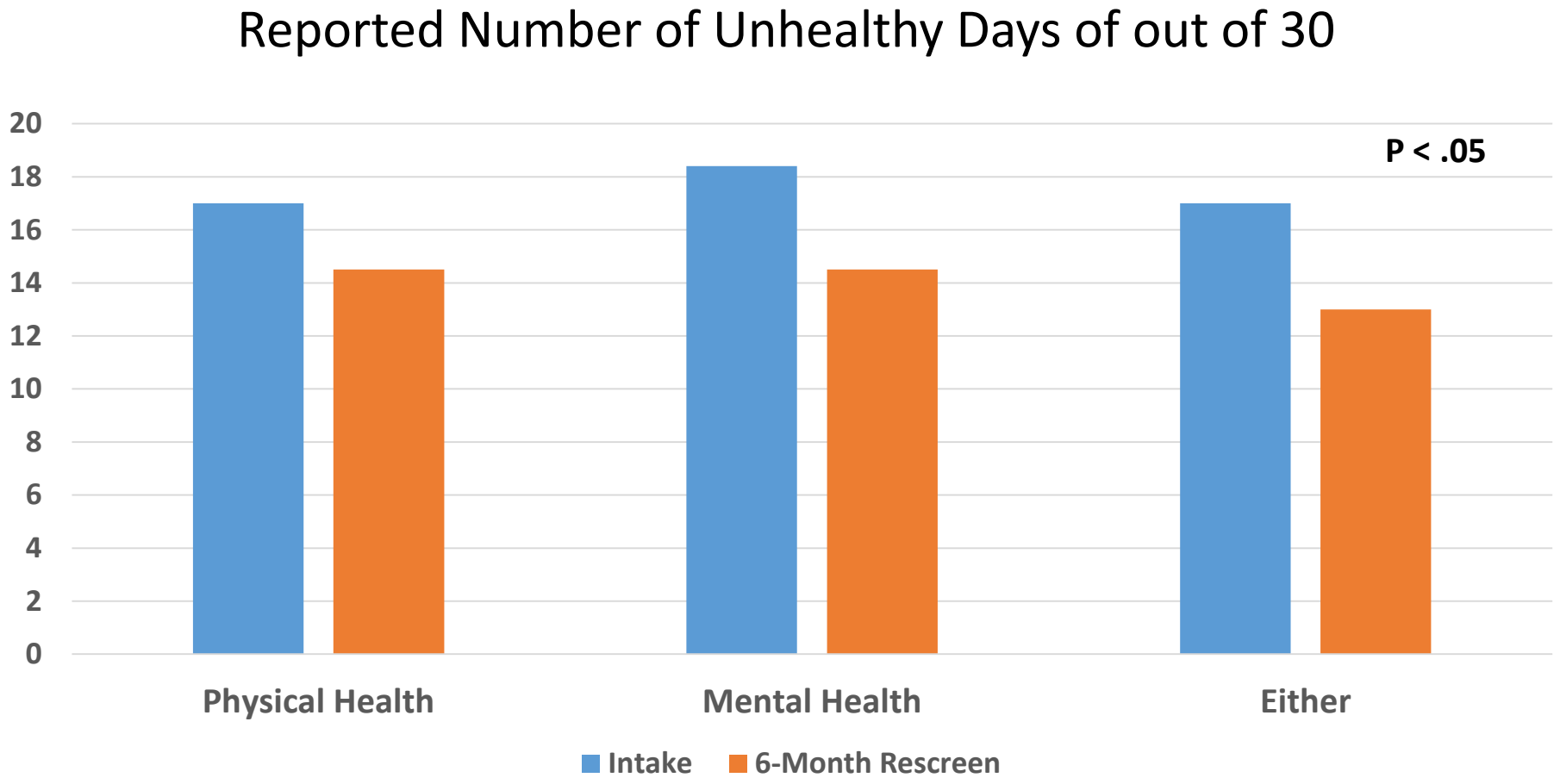


Reduction in Alcohol + Drug Use

Community Health Teams are participating RI-SBIRT and screening all clients for alcohol and drug use. Of those individuals who screened positive for risky alcohol and/or drug use and agreed to participate in the program evaluation, 10% were randomly selected to be interviewed 6 months later. Results indicated a 30-40% reduction in the number of days using alcohol and drugs when CHT patients are re-screened 6 months later.



Quality of Life- Decrease in the Number of Unhealthy Days from Intake to Follow up



Questions?

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