How Community Outreach Workers Can Care for Members with Complex Needs

June 26, 2013

We strongly encourage you join the call by receiving a call-back.

If you choose to dial-in, please be sure to use your **attendee #** found under the "Event Info" tab.

California HealthCare Foundation

California Improvement Network
Better Ideas for Care Delivery

A New Community Health Initiative: Community Outreach Teams

Transforming Care for our Costliest Patients by Investing in the Social Determinants of Health

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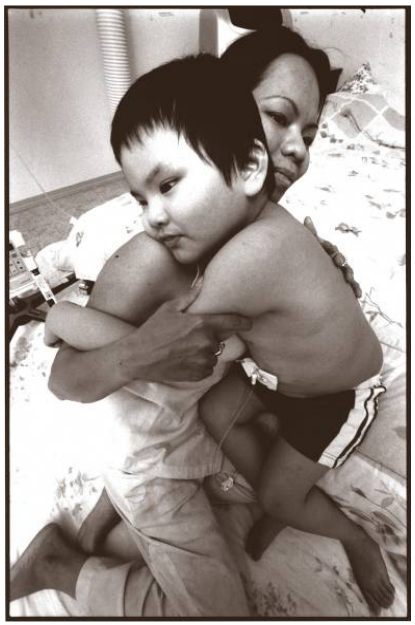
CareOregon

Our Vision: *Healthy Oregonians regardless of their income or social circumstances.*

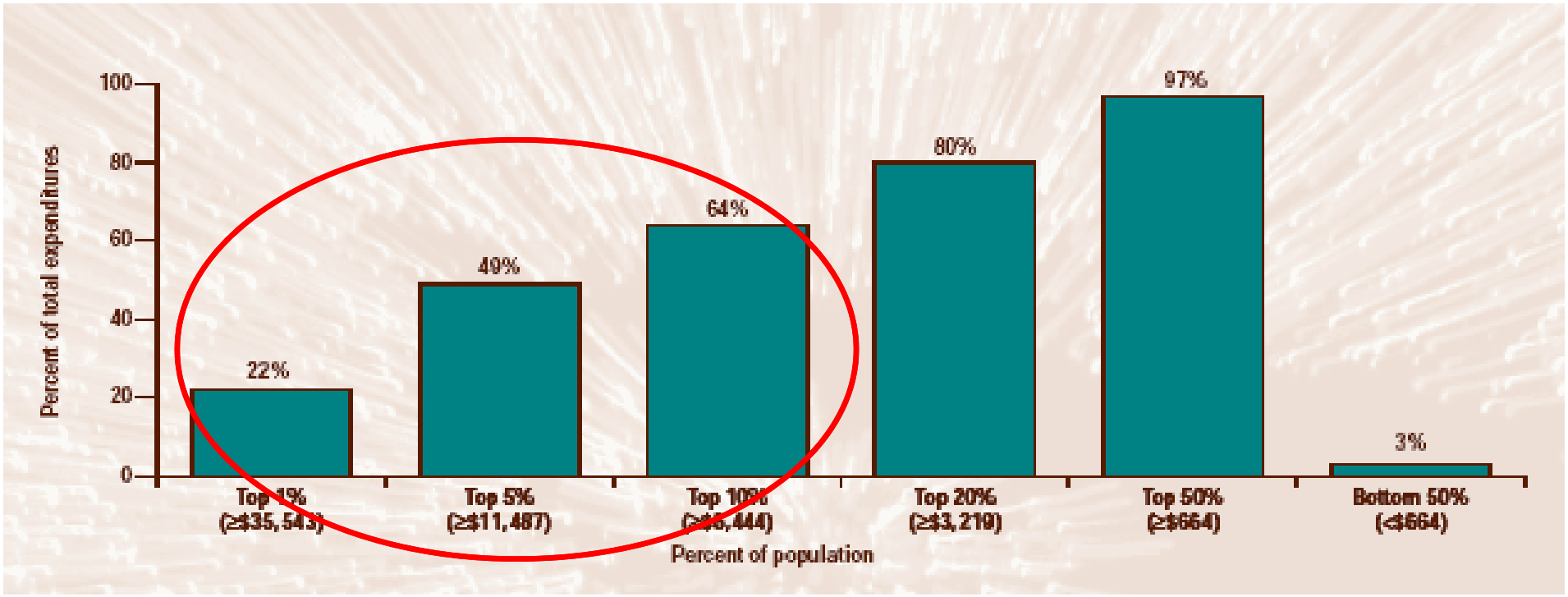
- **Publically financed health plan for low-income citizens**
  - **Medicaid: Mom's and Children, Disabled/ Chronically Ill**
  - **Medicaid/ Medicare "Special Needs" Plan**
- **180,000 Members**
- **Not for Profit**
- **Contracted network**
  - **50% safety-net PCPs**
  - **Diverse private practice PCPs**
  - **Major metro and rural hospitals**



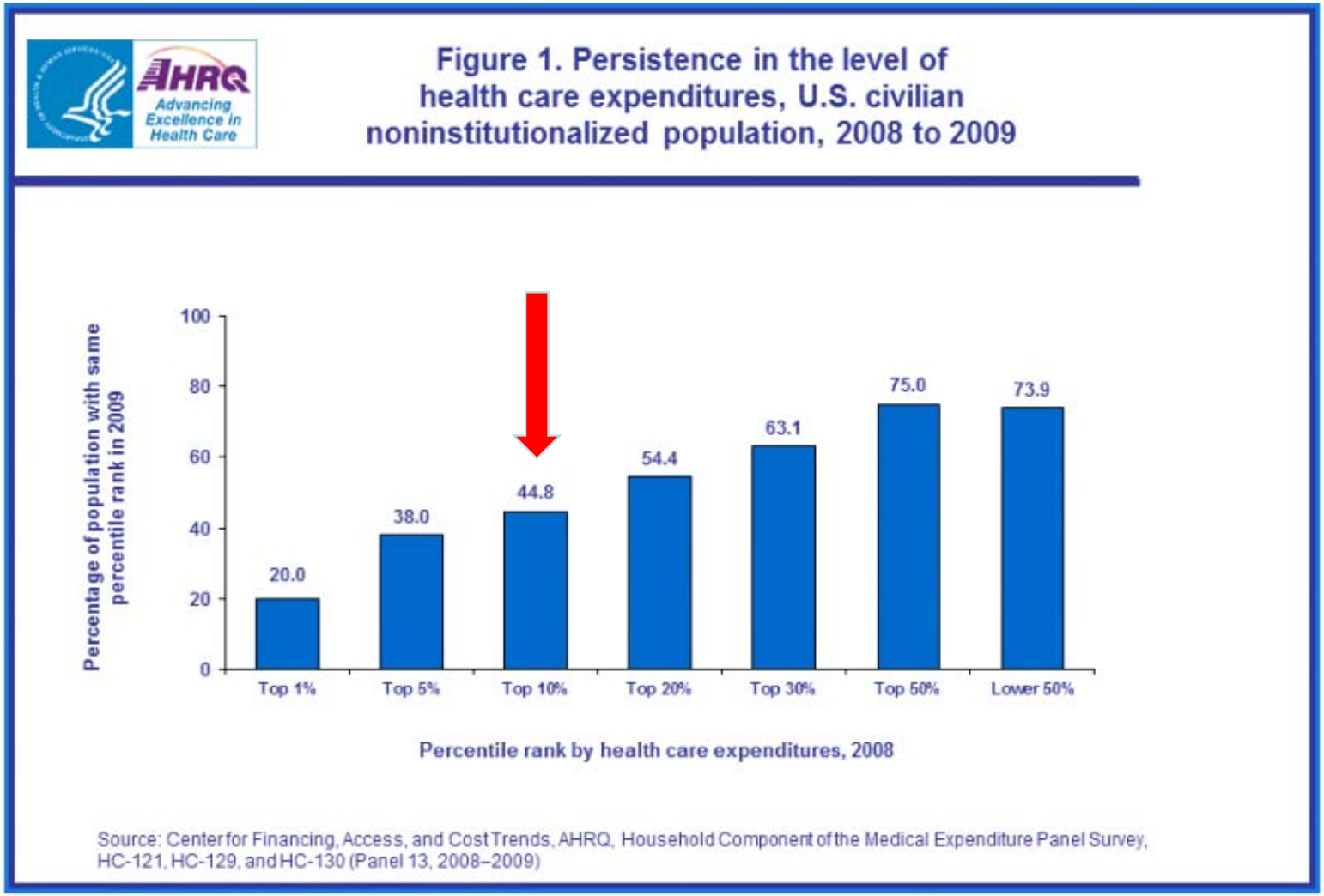
Copyright: Bruce Davidson

- **Began building population programs for complex members in 2003**
- **Participant in IHI Triple Aim Initiative since May 2007**

Percent of Total Health Care Expenses Incurred by Different Percentiles of U.S. Population: 2002



Persistence In Spending

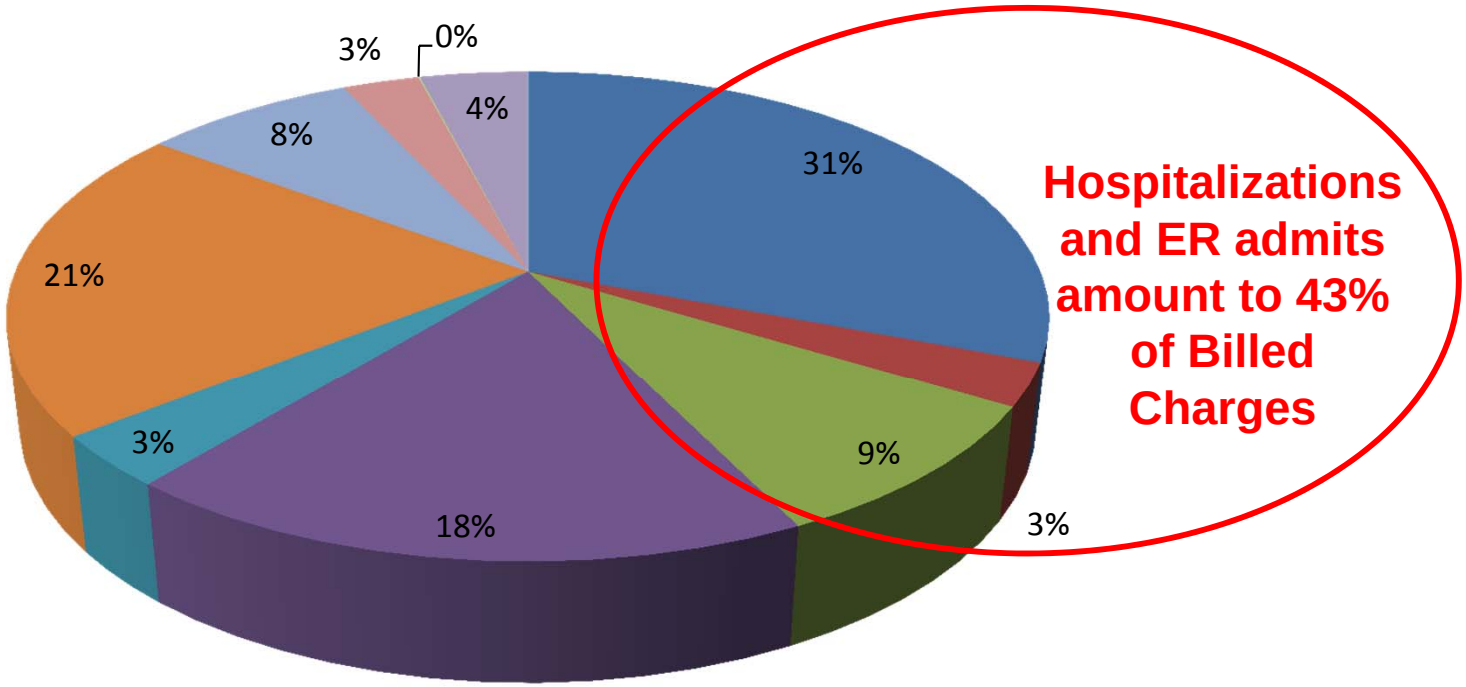


Where Is the $$$ Going?

% of Total Billed Charges by Service

(State of Oregon Medicaid Data)

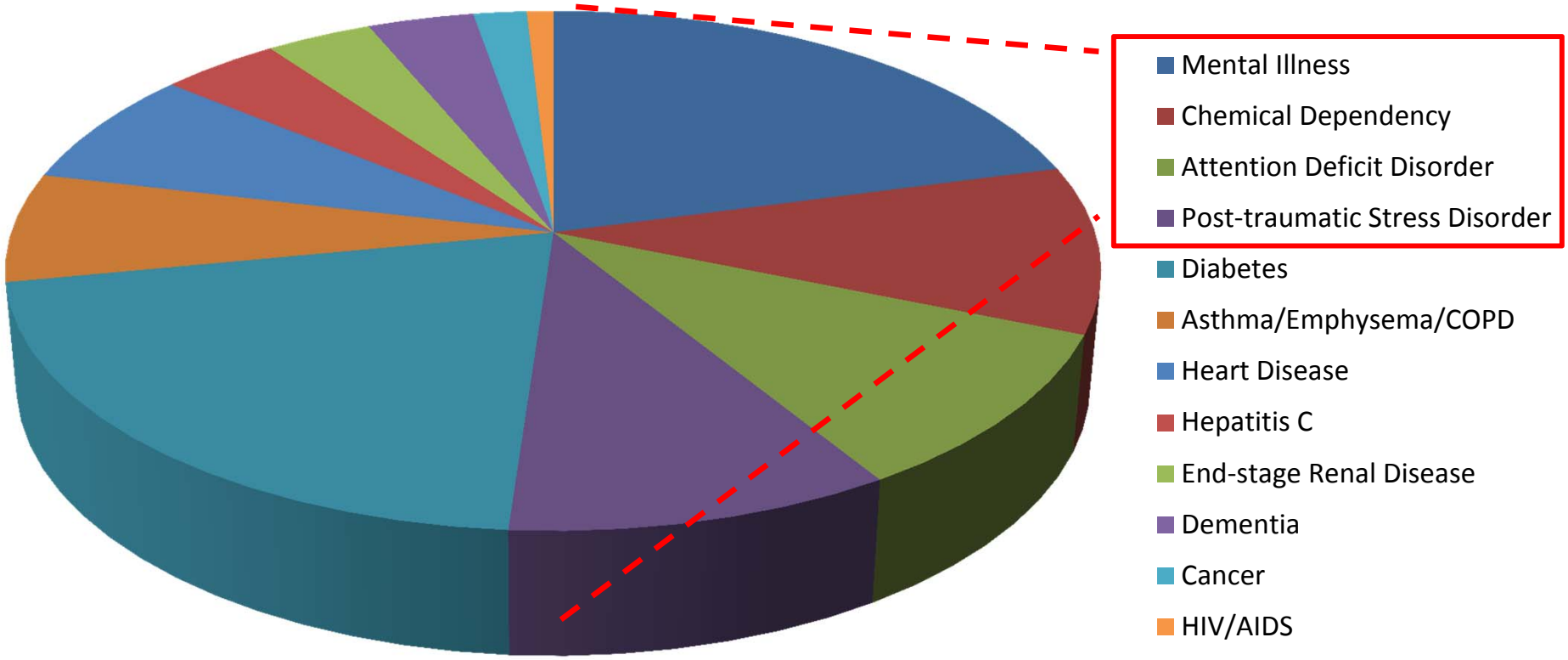
2009 Total Billed Charges = $1,630,851,673



* Outpatient Behavioral includes mental health services and ER and non-ER chemical dependency services

Very High Prevalence of Mental Health and Addictions

(State of Oregon DMAP Data)



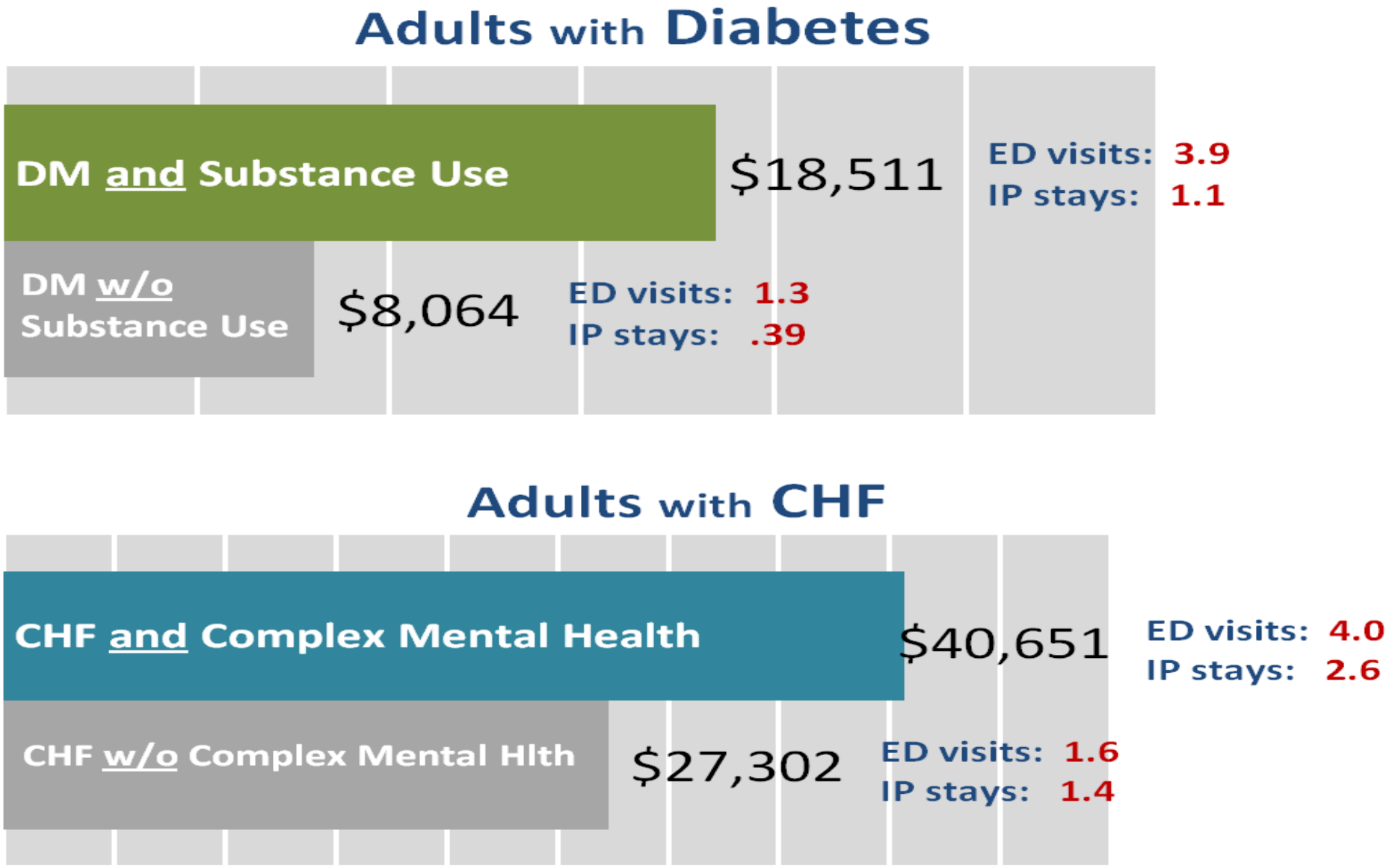
CareOregon Tri County Claims Data: 21% Adults have 1+ chronic condition PLUS substance abuse or schizophrenia ± bipolar disorder; 3%, both.

Based on HSO 160,000 members (40% Adult). 21% Adults = 13,440; 3% Adults = 1920 (no FFS)

Effect of Substance Use and Mental Illness on Cost/Utilization

CareOregon

Average 12 mos TOTAL cost, ED and Hosp utilization by group



Target Medicaid and Dual Population: Pilot Clinic

Multnomah County Health Department-NE Clinic Population

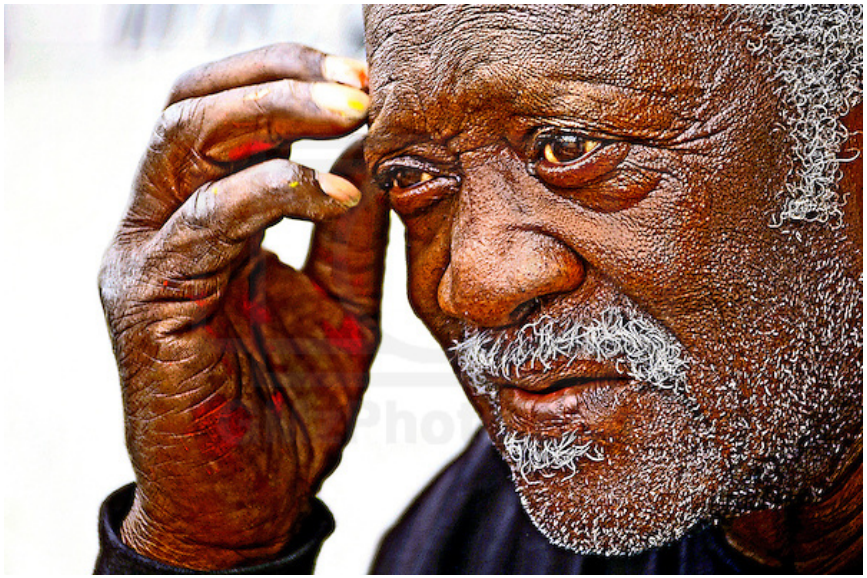
Population Segment	# Members	% Members	Avg Total Paid Cost per Member/ 12 mos	% Paid Cost/ 12 mos of Segment	# ED visits	# IP Admits
No inpatient/ 6+ ED visits	**81**	**3%**	**$8743**	**5%**	**786**	**0**
1 Non-OB inpatient and 0-5 ED visits	**97**	**4%**	**$18,767**	**14%**	**147**	**97**
2+ Non-OB inpatient OR 1 Non-OB inpatient AND 6+ ED visits	**71**	**3%**	**$59,440**	**32%**	**383**	**189**

10% mbrs = 51% Total Paid Cost/12 mos

William

Chronic Heart Failure

History of Addiction to IV Drugs and Alcohol



COPD

Developmental Disorder

Schizoaffective Disorder

Hepatitis C

Intermittent Homelessness

October 2011:
Admitted to the hospital for almost a month for acute complications of his Chronic Heart Failure. Had a previous 25-day admission 5 months earlier.

Type 2 Diabetes

66-Year-Old African American Man

Enhanced Primary Care Support Systems for HR/HC Patients

- A high-cost intensive model that is supported by nurse care management (among other resources) along with primary care that often limits their work to a relatively small panel of patients. (Ambulatory ICU)
- A model that primarily focuses on the redesign and retraining of the primary care team. (Southcentral Foundation)
- A model that enhances really good primary care with a new skillset – non-traditional health care workers that take their assistance into the community for HR/HC patients. (CareOregon)

Community outreach workers are paired with primary health homes and specialty practices to enhance the practices' ability to provide individualized "high-touch" support to patients with exceptional utilization

*Staff are hired for engagement skills, compassion, non-judgmental attitude, outreach experience

*Focus is on the social determinants that drive high-cost medical utilization

*Outreach worker is incorporated as part of the practice team, but also has identity with a larger community of practice

* High PCP/Specialist involvement
* Documentation occurs in the practice's EMR; population view and process metrics stored in a community care registry

*Voluntary program

The Secret Ingredients

1. Transparency
   - An open/honest conversation changes both participants
2. Trust
   - Reducing the hierarchy in the relationship makes it safer
3. Time
   - We can only improve on the current system
   - You have to know me to help me
4. Tailoring to the Client
   - Lack of a conventional agenda driven by payment; regulatory relief

Outreach Worker Interventions

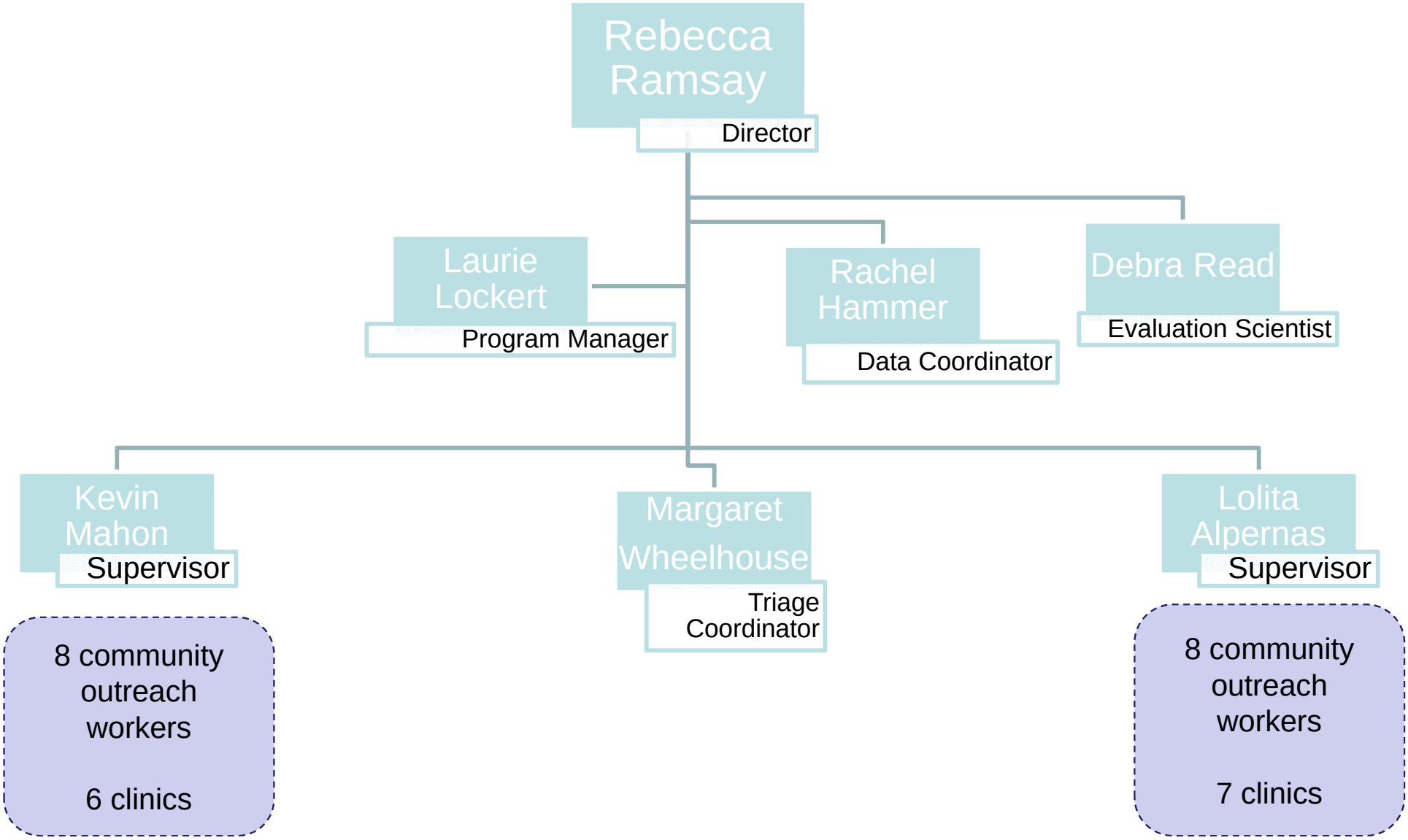
- Motivational Interviewing to resolve ambivalence about health-related behavior change
- Client advocacy within and among multiple systems
- Role modeling advocacy and relational skills
- Assistance in navigating health care system
- Care coordination
- Health literacy education
- Self management skill development
- Assistance with complex problem solving related to living in poverty with multiple health issues
- Providing opportunities to identify as something other than a "*patient*"
- Providing opportunities to experience success and feel confident
- Deep listening, acknowledgment and respect for each individual

What Makes a Successful Community Outreach Worker

First and foremost, you have to understand the needs of your high-acuity/high-cost population. Given ours, we need:

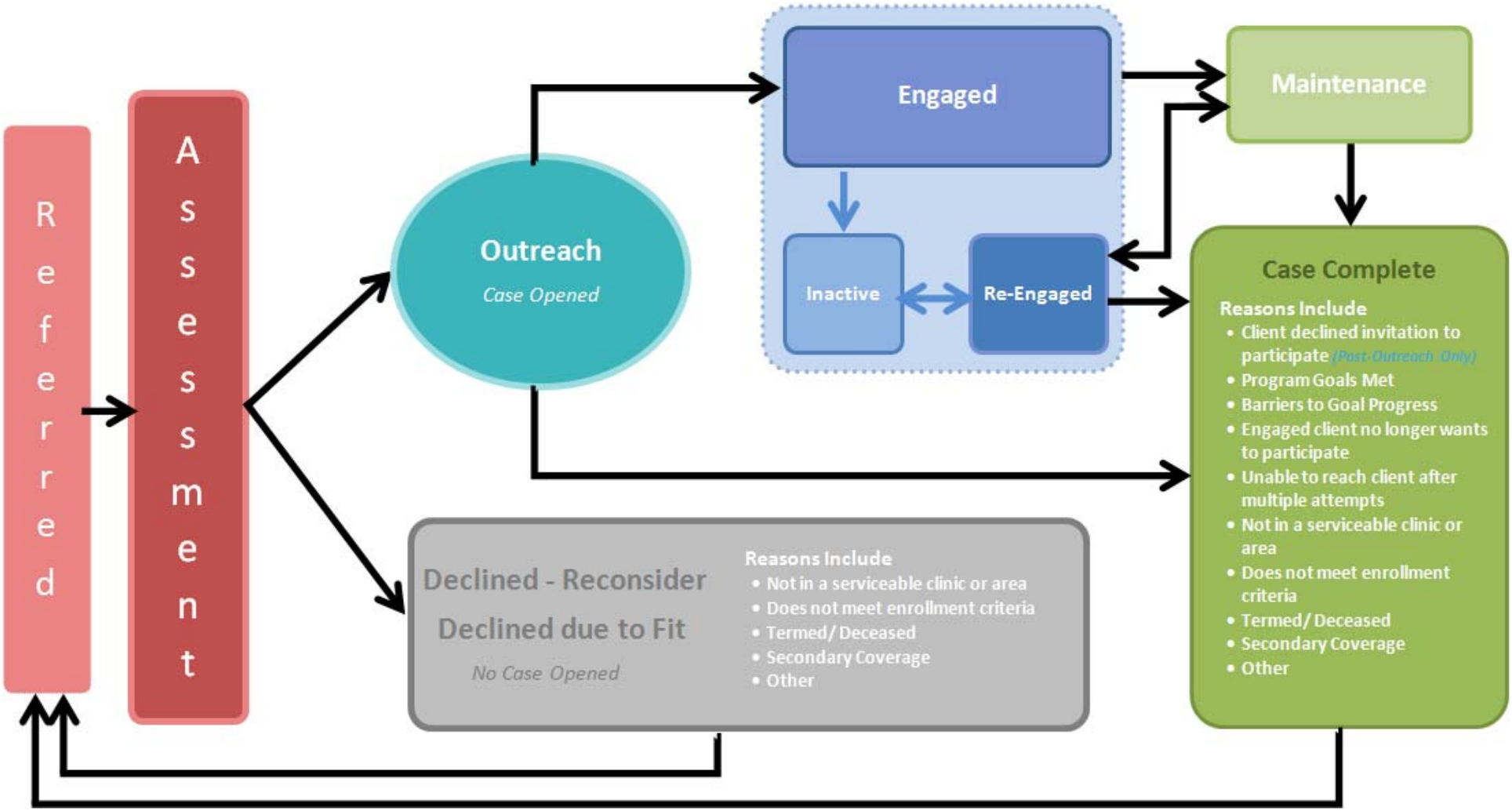
- Comfort and experience with mental health conditions, addiction and substance abuse, poverty, and trauma
- Excellent interpersonal skills, professional boundaries, and enough confidence and experience to communicate/advocate with medical professionals
- Compassion, non-judgmental attitude, cultural agility, and commitment to social justice principles
- Experience doing home visits – often will visit shelters, group homes, and SNF/Assisted Living sites as well
- Understanding of our community and its resources

Program Structure

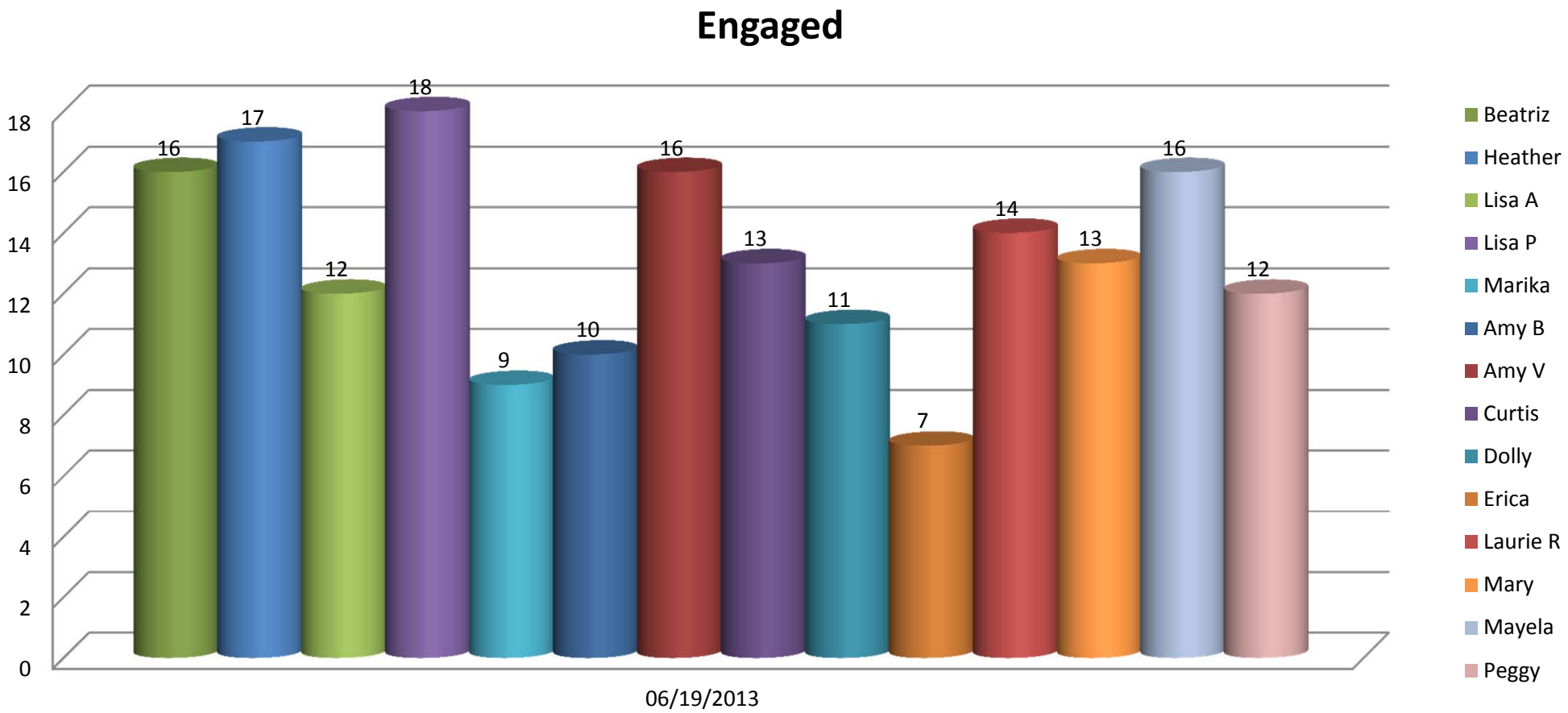


Health Commons Community Care Program – Client Status Mapping

v.5 updated April 8, 2013



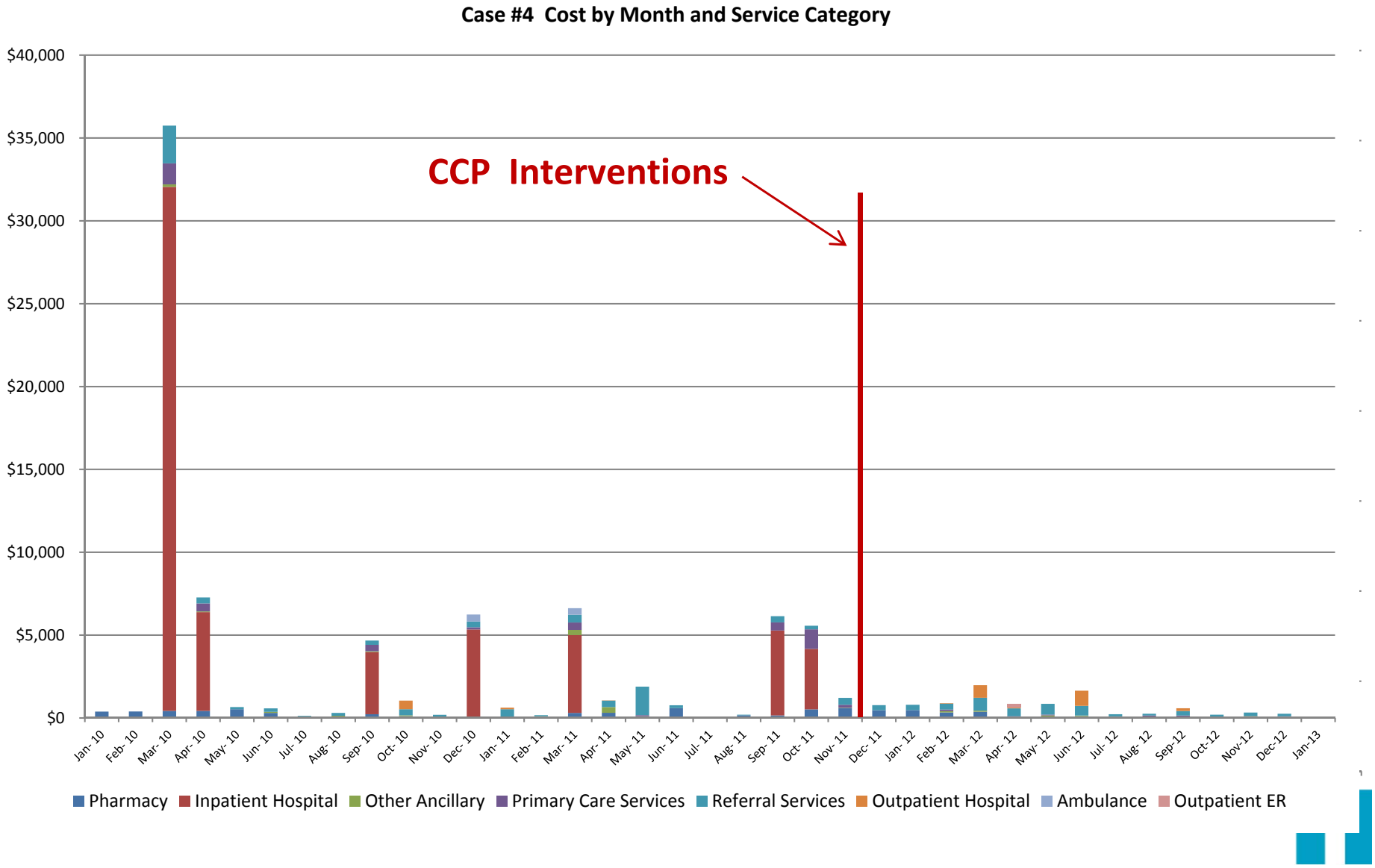
Outreach Worker Caseloads



Workforce Development

- Motivational Interviewing
- Trauma-Informed Care
- Addiction and Treatment Modalities
- Chronic Dz Fundamentals – Diabetes, CHF, COPD, Liver Disease, Depression
- Severe Mental Health Conditions and Psychotropic Medication Treatment – Schizophrenia, Bipolar, Personality Disorder
- Developmental Disabilities
- Preventing Burnout, Grieving, and Dealing with Death

William's Cost Trend



Community Care Program – Interim Utilization Evaluation, January 2013

To allow for at least 60 days claims “run out”

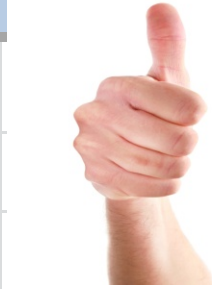
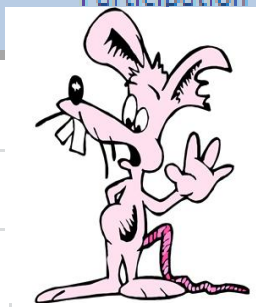
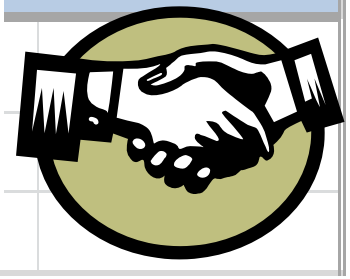
- Cases Completed before Nov 1, 2012
- Case Currently Active on Oct 1, 2012

Community Care Program

Cases Closed prior to Nov 1, 2012

OR

Currently Engaged as of Oct 1, 2012

	GROUP #1 Engaged actively / Case Completed with Goals Met	GROUP #2 Engaged for a time but stopping Participating	GROUP #3 Never Engaged / Actively Declined Participation	GROUP #4 Actively Engaged when Data Extracted
				
Number Participants w/ Adequate Months Pre & Post				
Aver PRE Months per person				
Aver POST Months per person				
ED Visits per Person per Year				
PRE	7.3	21.5	10.6	18.2
POST	5.0	17.5	9.1	9.0
	32%	19%	⊘	50%
Inpt Admits per Person per Year				
PRE	2.5	3.3	2.7	2.4
POST	1.3 (0.6)	1.5	4.6	2.8
	48%	54%	↑	⊘
Acute Events per Person per Year (ED & Inpt combined)				
PRE	9.8	24.8	13.3	20.6
POST	6.3	19.0	13.6	11.8
	↓	↓	⊘	↓
PCP Visits per Person per Year				
PRE	11.6	13.8	11.2	26.7
POST	8.2	12.3	12.6	23.5

Community Care Program Cases Closed prior to Nov 1, 2012 OR Currently Engaged as of Oct 1, 2012	TOTAL
Number Participants w/ Adequate Months Pre & Post	46
Aver PRE Months per person	11.5 mos
Aver POST Months per person	7.7 mos
ED Visits per Person per Year	
PRE	14.7
POST	10.2
PRE	2.7
POST	2.5
t combined)	
PRE	17.4
POST	12.7
PCP Visits per Person per Year	
PRE	16.3
POST	14.4

31%

⊘

27%

12%

This may be an artifact of the 13 people included in this analysis that have only a few months of exposure to the intervention. We have also witnessed LOS decrease but need to analyze the data further.

Additional Evaluation Components

- Health status and care experience surveys are mailed (with incentive) to most clients at graduation from the program. Survey was developed by research and evaluation team with a decade of experience surveying Medicaid population.
- Qualitative interviews are conducted with staff and a sample of carefully selected clients on a yearly basis.

Thanks!

- Rebecca Ramsay
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Thank you for joining our call today!

For more information about the California Improvement Network, go to www.chcf.org/cin

Today's webinar slides and recording will be available at that site within a week.

California Improvement Network Better Ideas for Care Delivery