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Getting Started in Your Neighborhood: Piloting Community Health Teams through a Multi-Payer Approach

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Faculty Disclosure

- **Susanne Campbell, RN, MS**
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- **Scott Hewitt, MA**

The presenters have no financial relationships to disclose relating to the subject matter of this presentation.

Disclosure

- The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational use(s) of drugs, products, and/or devices (any use not approved by the U.S. Food and Drug Administration).
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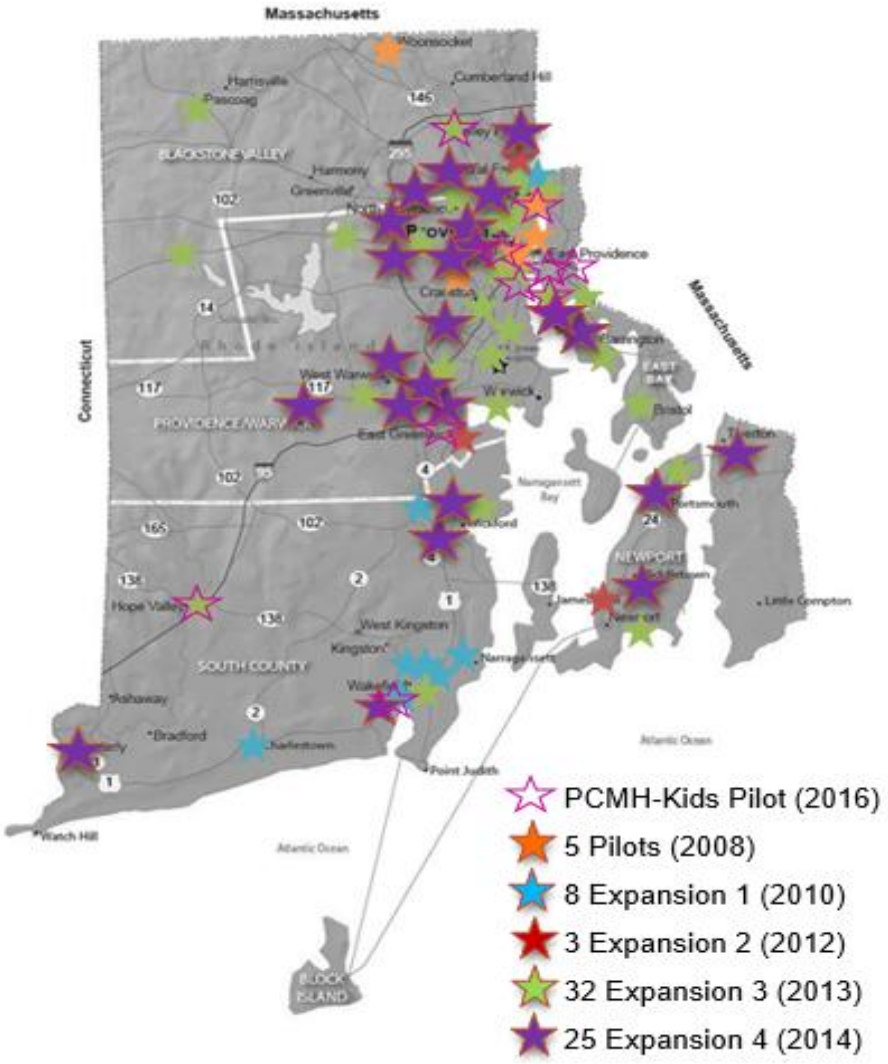
  - This activity has been independently reviewed for balance.

Learning Objectives

- Identify **successful components** for developing a **multi-payer funded CHT pilot program** including soliciting multi-payer support, obtaining PCP participation agreement and creating a responsible CHT.
- Identify **methods for working with PCPs and health plans** to **select high cost, complex patients** who might benefit from CHT supports, and create **systems to coordinate care**.
- Identify **barriers and solutions** for sharing information, engaging patients/families, building community partnerships and evaluating results.

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

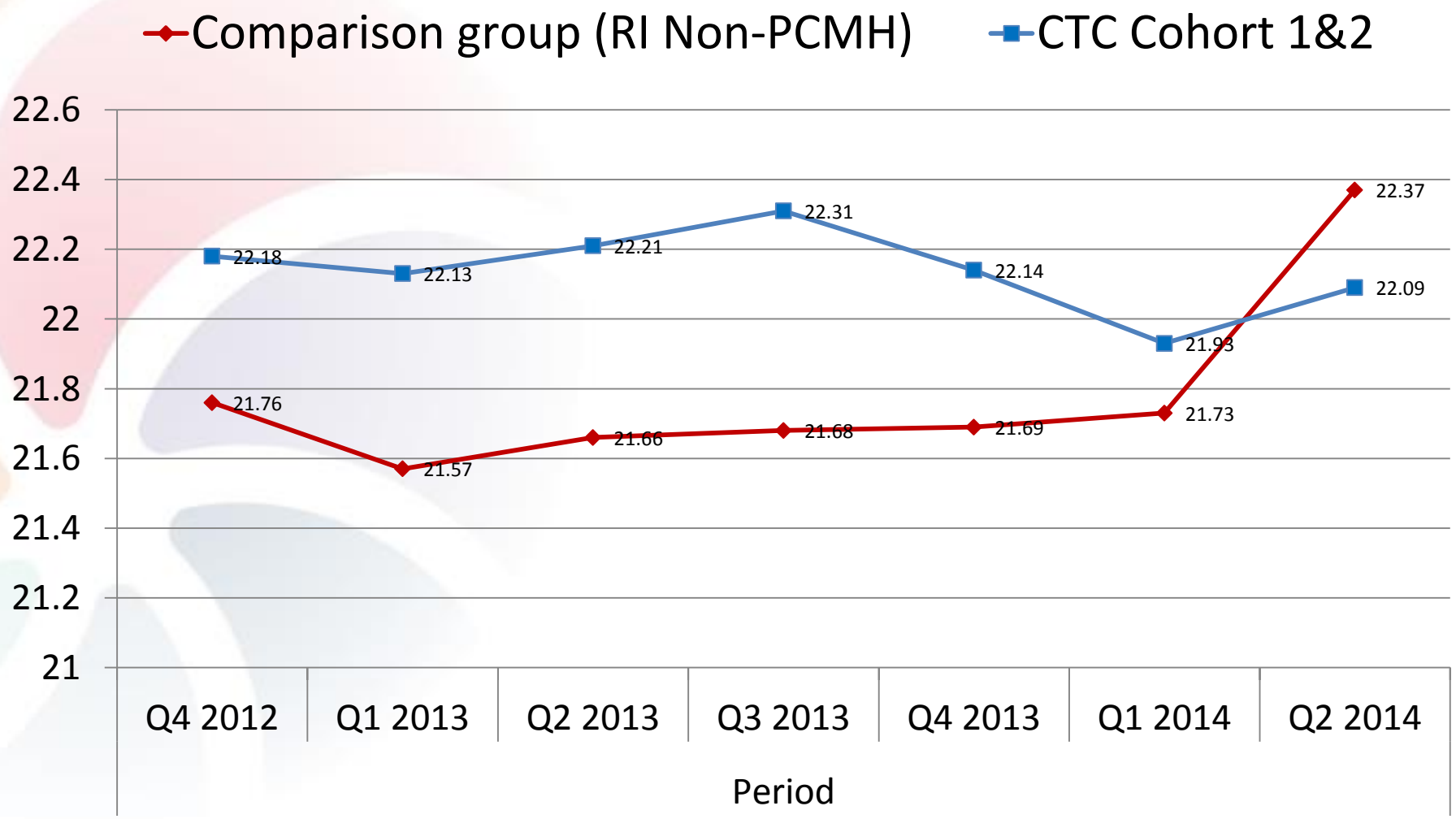


- 5 PCMH Pilots (2008)
- 8 in Expansion 1 (2010)
- 3 in Expansion 2 (2012)
- 32 in Expansion 3 (2013)
- 25 in Expansion 4 (2014)
- 9 PCMH-Kids Pilots (2016)

Community Health Team Pilot Launched in 2014

- South County Team
- North Team

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



Source: CTC-RI internal documentation

Community Health Teams (CHTs) are:

"**Locally based care coordination teams** comprising **multidisciplinary staff** from varied disciplines such as nursing, behavioral health, pharmacy and social services. **In partnership with primary care practices**, **teams connect patients, caregivers, providers and systems** through care coordination, collaborative work, and direct patient engagement."

Source: Takach, M., & Buxbaum, J. (2013). Care management for Medicaid enrollees through community health teams. The Commonwealth Fund. Washington, DC. http://www.commonwealthfund.org/publications/fund-reports/2013/may/care-management

Who Do CHTs Typically Serve?

- Across all payers, ~ 1% of the U.S. population accounts for ~ 22% of U.S. health expenses.
- Top 1% Medicaid super-utilizers:
  - 83% have at least three chronic conditions
  - >60% have 5+ conditions.

CHT programs typically focus on the top 1%-10%.

Source: Cohen, S. Differentials in the concentration of health expenditures across population subgroups in the U.S., 2012. Statistical Brief #448. Rockville, MD. September 2014: Agency for Healthcare Quality and Research.

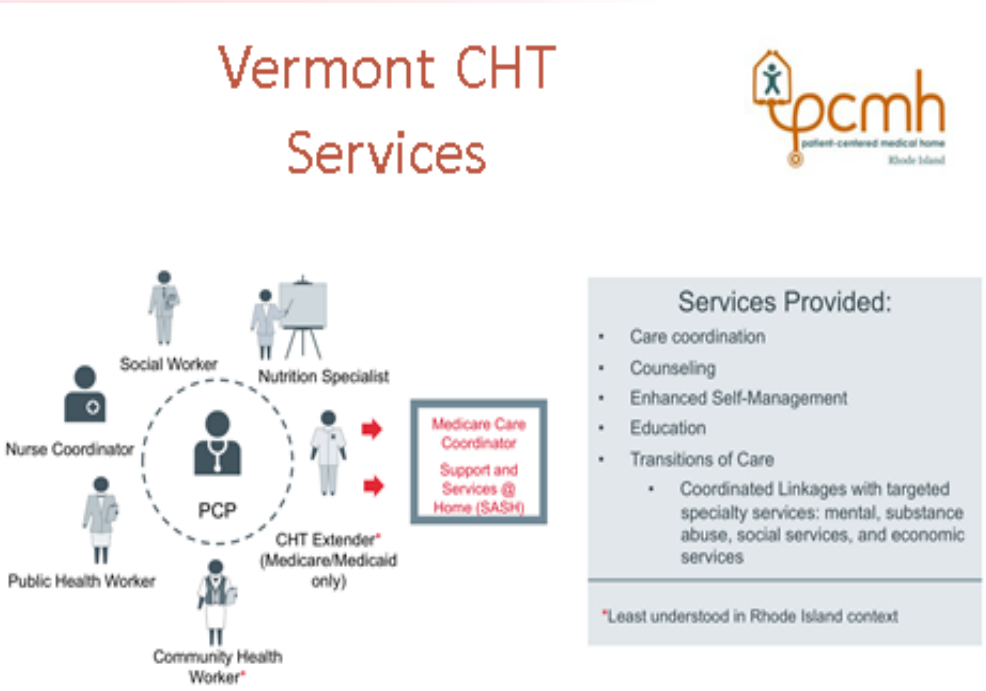
Typical Goals of CHTs in the U.S.

- **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

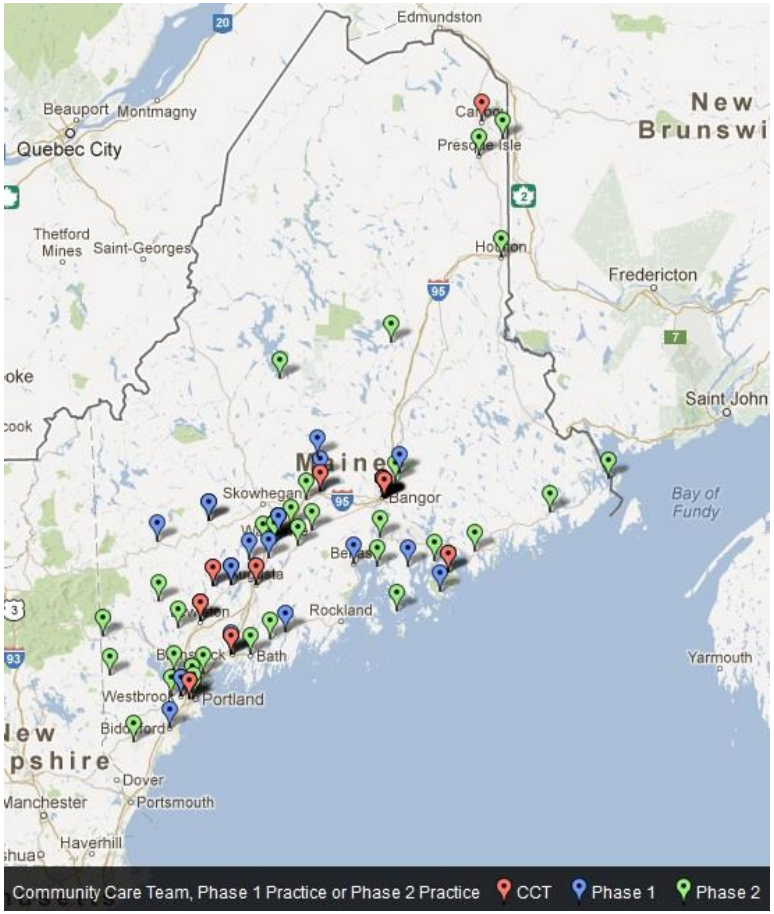
Sources: See references at end of slide set

Learning from Others

Vermont



Maine



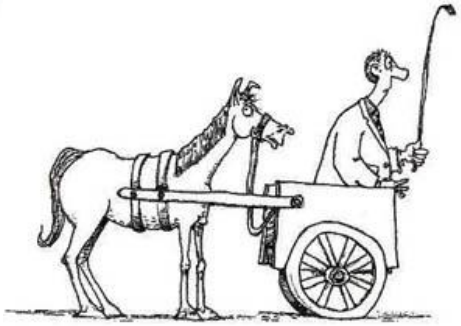
CTC-RI Community Health Team Program Development

- 2014:
  - CTC-RI implemented a CHT pilot with 2 teams: North and South County
- 2015:
  - CTC-RI began evaluation of the pilot
- 2016:
  - CTC-RI is planning for expansion of additional teams to serve other RI regions

To whom are CTC-RI CHTs responsible?

- Multiple stakeholders
  - Insurers: Multi-payer = Multi-stakeholder
  - Practices: Each practice is unique
  - Patients and Families
  - CHT entities (North/South)
  - Program coordinating entity (CTC-RI)

  All within the context of learning while doing. . .



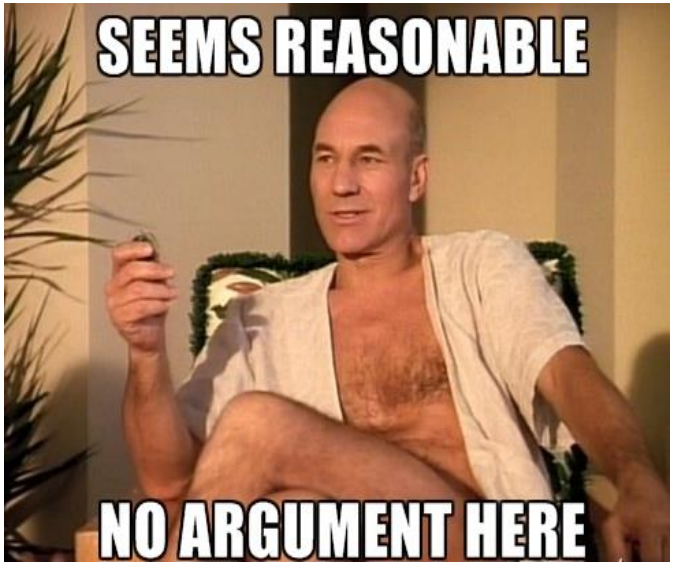
Pre-req: Soliciting RI Multi-Payer and CTC-RI Board Support

- Charter
- Work plan and budget
- Community Health Team Committee
- Meeting schedule
- Metrics
- Contracts with CHT entities
- Evaluation Plan
- Enthusiasm to get started

Pre-req: Obtaining Practice Participation

- Memorandum of Understanding (MOU)
- BAA with Practices
- Kick-off meeting at sites
- Individual site visits
- No financial obligation to practices
- Help for high risk patients

- Practice concern:
  Time required to collaborate with CHT

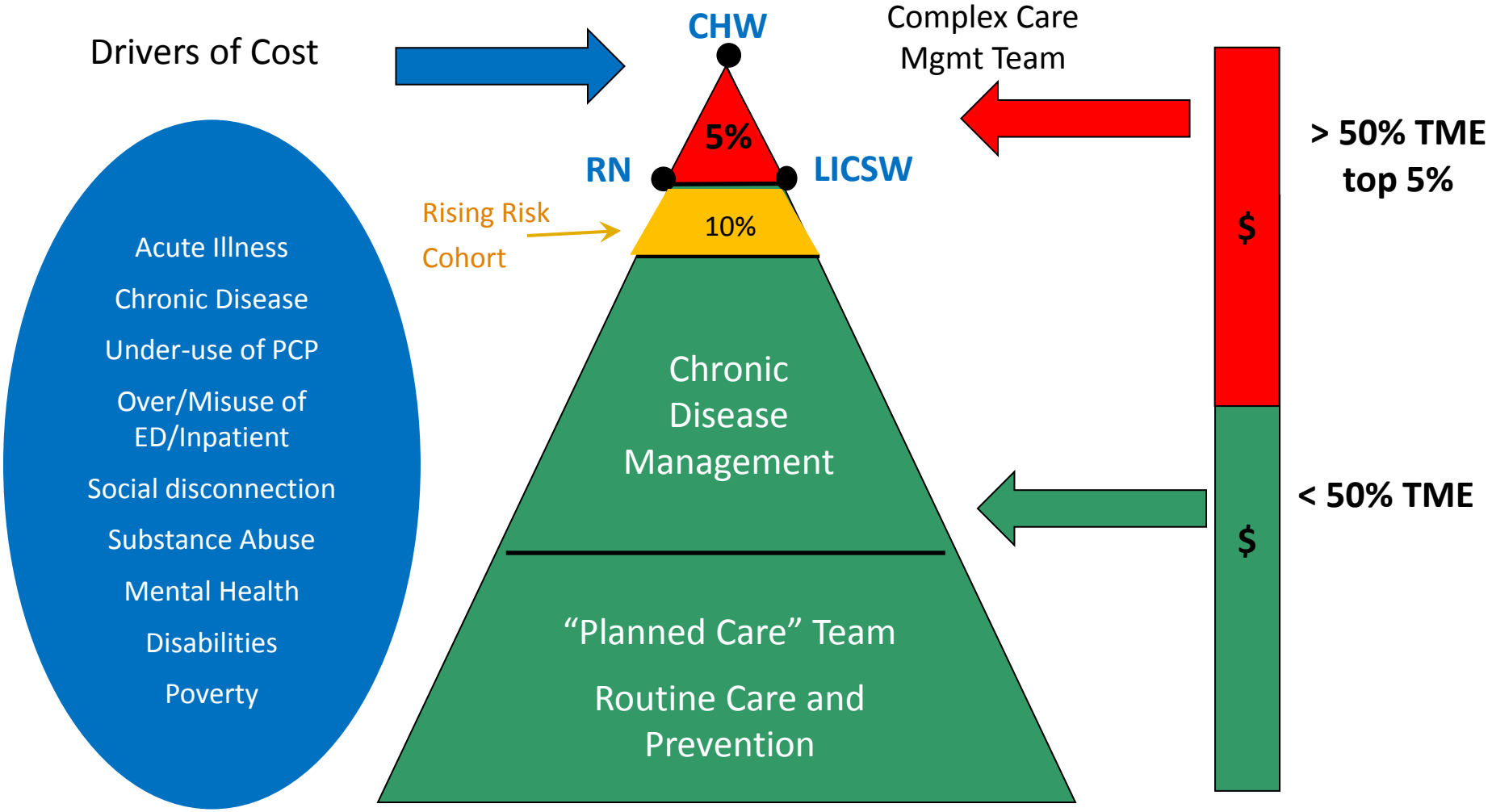


CTC-RI Pilot: Phase I
CHT Program Description

CTC-RI CHT Pilot: Phase 1 Description

- **Staff composition of RI CHTs:**
  - Community Resource Specialists (CRSs)
  - Behavioral Health Specialist
  - IT specialist
  - Managers
- **Targeted patients for RI pilot:**
  - Patients of participating PCMHs
  - In **top 5%** high risk / high cost / high utilizers
  - *Impactable by CHT services*

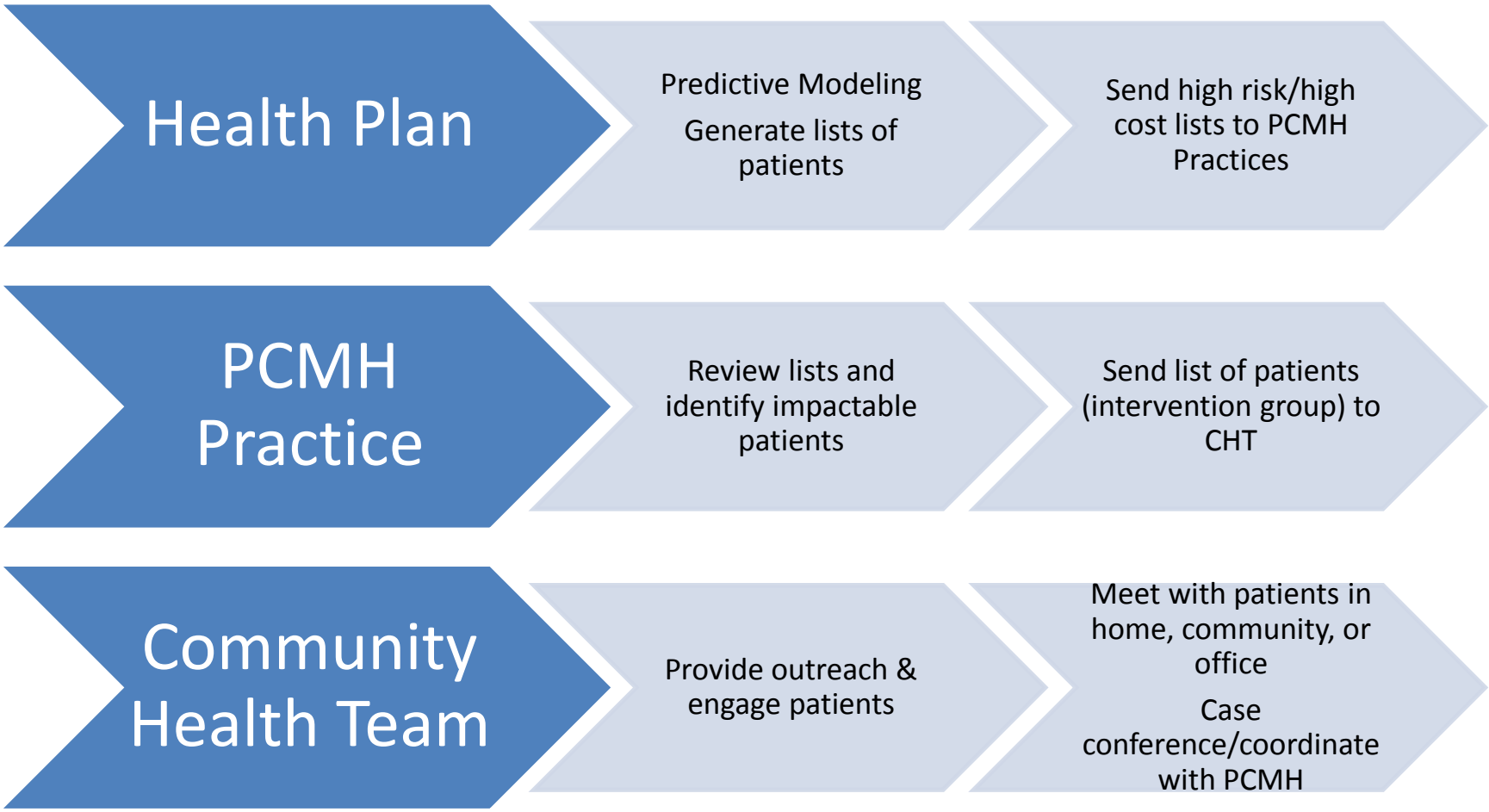
CHT Model – Who are we focused on?



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

CHT Pilot: Phase 1 Work flow

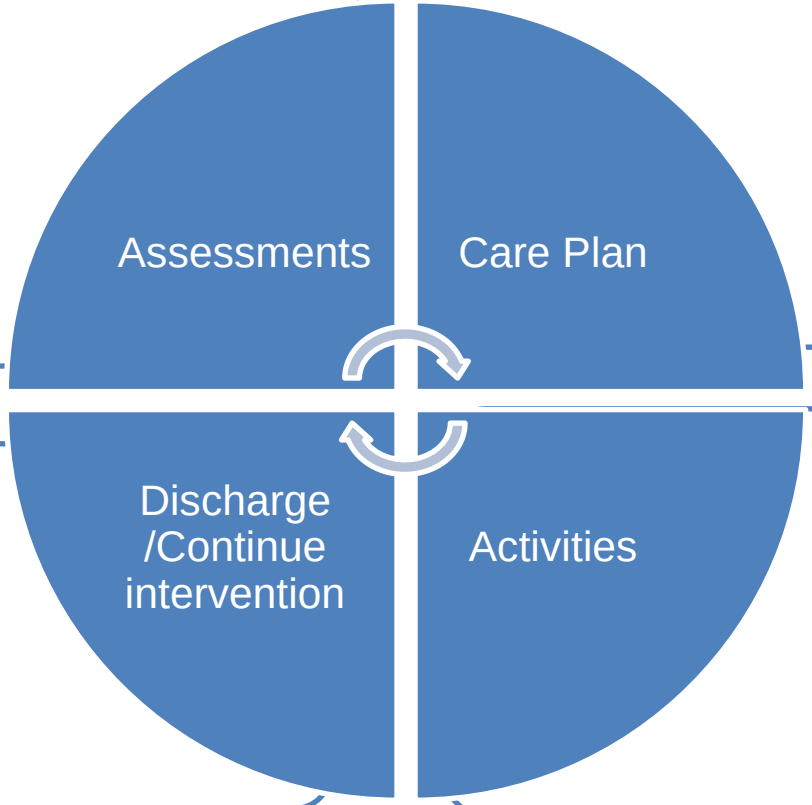


Roles and Responsibilities

- CHT Behavioral Health and Community Resource Specialist team up with Nurse Care Manager embedded at the PCMH practice site to provide care management.
- CHT team functions as an extension to the primary care practices

CTC-RI CHT Intervention

- Outreach
- Engagement
- Releases
- Assessment



- Identify barriers/problems
- Interventions
- Follow up
- Outcomes

- Referral reason
- Care plan template under development
- Summary of success

- Advocacy
- Health coaching
- Case management
- Care coordination
- Crisis intervention
- Connect to resources

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Brief Overview of CTC-RI CHT Pilot Phase 1 Evaluation Results

Mixed-Methods CTC-RI CHT Pilot

- **Goal: Develop recommendations and lessons learned for application to potential RI state-wide CHT program expansion**
- Describe the structure and work processes of pilot CHTs
- Comprehensive literature review

- **Collect mixed methods data about CHT functioning from:**
  - Patients who received CHT services (interviews and survey)
  - CHT staff (interviews and survey)
  - Representatives of insurance payers and CRS employer (interviews)
  - Clinicians at the participating practices (survey and NCM interviews)
  - Collect service documentation data from the CHTs

Source: CTC-RI Community Health Team Pilot Program Evaluation Report, 2016

CHT adds value to the NCM's work

- "I recently sent a quick synopsis of at least three patients that the team has dealt with over the course of this past year that we have seen systematic decrease in utilization. And [patients] seem more content with their healthcare. . . . The health team helped him identify what the problems were, identify a plan and act on it. And he seemed to really kind of settle down after that. We didn't get as many phone calls."

Why?

- "Somebody in healthcare taking the time to listen, to hear and to help that patient set their own agenda as opposed to agenda that the physician or even myself might have."

Source: NCM interviewed for CTC-RI Community Health Team Pilot Program Evaluation Report, 2016

Communication between CHT and NCM is critical

CHT helped a NCM by checking in with a patient who frequently wanted to go to the ED:

- "That CHT person was checking in. And [the patient] had multiple clinical issues that she thinks she should go to the ER for. And [the CHT] communicated with us again. They said, 'Well, this is what's happening now.' And so we were able to bring her in [to the clinic]. So kind of like a back and forth -- we're working here to advocate for [patients] with the clinic, but they're out there in the field, and they can see what's going on in the home. **And that communication piece is pretty crucial with keeping [patients] out of the hospital.**"

Source: NCM interviewed for CTC-RI Community Health Team Pilot Program Evaluation Report, 2016

Patients Say CHT Helped Them Acquire:

- Whatever was needed:

"Pointing me in the right direction for just everything, everything. I mean supplies and just food and financial and just whatever I would need was amazing to me. Like if they didn't know somebody, they knew somebody that knew somebody."

"I pleaded with the electric company. 'My mom will die without her oxygen. What am I supposed to do?' And they're like, 'Not our problem.' So I called [CHT staff]. I was basically panicking. And she was like, 'Nope, just let me handle it.' And she just called them, *and twenty minutes later the guy was right back* -- turned it right back on."

- Psychological and substance abuse counseling

"[CHT staff person] just called all kinds of therapists until she could find one that had an opening that would take me because they're all, 'Oh we're not taking new clients.'"

- Food
- Clothing
- Furniture
- Medical equipment
- Correctly sized wheelchair
- Nutrition information
- Adult day care
- Parenting classes
- CNA
- Legal representation
- Affordable medication
- Safer, nicer housing
- Transportation
- Medical information
- Medical appointments
- Benefits
- Resources for family members
- Utilities payment assistance

Source: CTC-RI Community Health Team Pilot Program Evaluation Report, 2016

Patients Received Directly from CHT:

- Explanation of benefits
- Completion of paperwork

Housing, health insurance, financial, social security, 'welfare', 'food stamps', long-term disability, medication assistance

- Coaching to deal with medical system and speak to providers

"Without [CHT], I wouldn't have been as extroverted in being able to just speak out and say, 'Hey listen, I'm having a problem with not knowing this information.'"

- Home contact following ED visit or hospitalization
- ED avoidance strategies
- Information from clinicians
- Food, clothing, blankets
- Individual and marital counseling
- **Encouragement to ask for help**

"You sort of get old, and you don't realize you're there already and all these things are available to you. *I've never in my life asked for help from anybody*."

"And my right knee still buckled up from under me a lot. So she said, 'I don't like that; you need a CNA in here. Do you have one?' I says 'No, I don't. *I'm trying to do everything myself.'"*

Source: CTC-RI Community Health Team Pilot Program Evaluation Report, 2016

Patients Received Directly from CHT:

- **Moral support and anxiety reduction** via:

  home visits, phone calls, preparing patients for medical visits, accompanying patients at medical and legal appointments

  – "What I love is that anytime if I want to call her she will listen, and she will give ideas on how I can cope with that or places I can find that information or the help that I would need."

  – "I have somebody to talk to, or I know that I can in a week or so. And they give me some new point of view too. That's important. 'Oh, I didn't think of that. My problems are not unique', which we all think they are."

  "She cares about me."

Source: CTC-RI Community Health Team Pilot Program Evaluation Report, 2016

CHT Intervention Story from the Field

"So a Nurse Care Manager asked a Community Resource Specialist to reach out to a man with high utilization and multiple chronic conditions . . ."

CHT story from the field

Patient:

- Single man, late 50's, living alone, own home
- History of working full time; unemployed for years due to back injury
- Family lives close by
- 14 year history of multiple acute care episodes for ETOH, pancreatitis, uncontrolled diabetes, GI bleeds, Afib
- Commercial insurance

Utilization:

- **17 ED and 7 inpatient admissions in 2014:** difficulties regulating diabetes; alcohol abuse; complicated by chronic pain
- **18 ED and 10 inpatient admissions in 2015**: non-adherence with self care; poor follow-through with home-based skilled nursing; lost part of foot due to inadequate wound self care

Primary care:

- NCM/PCP diabetes management using pharmacy team and diabetes clinic
- Pain management adequate; seeking specialist for longer term solution

CHT story from the field, continued

CHT Involvement:

- **Began February 2015:** patient engagement around self care, diet, nutrition, disability application and overall treatment adherence and ETOH abstinence
- Frequent family meetings to involve family in supporting patient in his home
- CHT monthly visits, educate to better self management.

Health, Utilization and QOL Outcomes:

- Patient became more cooperative with in-home skilled nursing, wound care and physical therapy
- CDIFF resolved and surgical amputation healed
- Abstinent since November 2015
- Compliant with insulin regime; fewer hypo/hyperglycemia episodes
- **Utilization reduce: 3 ED and 0 inpatient admissions in 2016**
- Prides himself on having re-established a vegetable garden in 2015
- Received SSDI award
- Now has ADA and purchased a laptop/internet access
- Considering taking adult learning classes

Evaluation Recommendations and Phase II Modifications

Enhancing processes to "Provide the right services to the right patients at the right time."

Source: CTC-RI Community Health Team Pilot Program Evaluation Report, 2016

Recommendation:

Identify the Right Patients

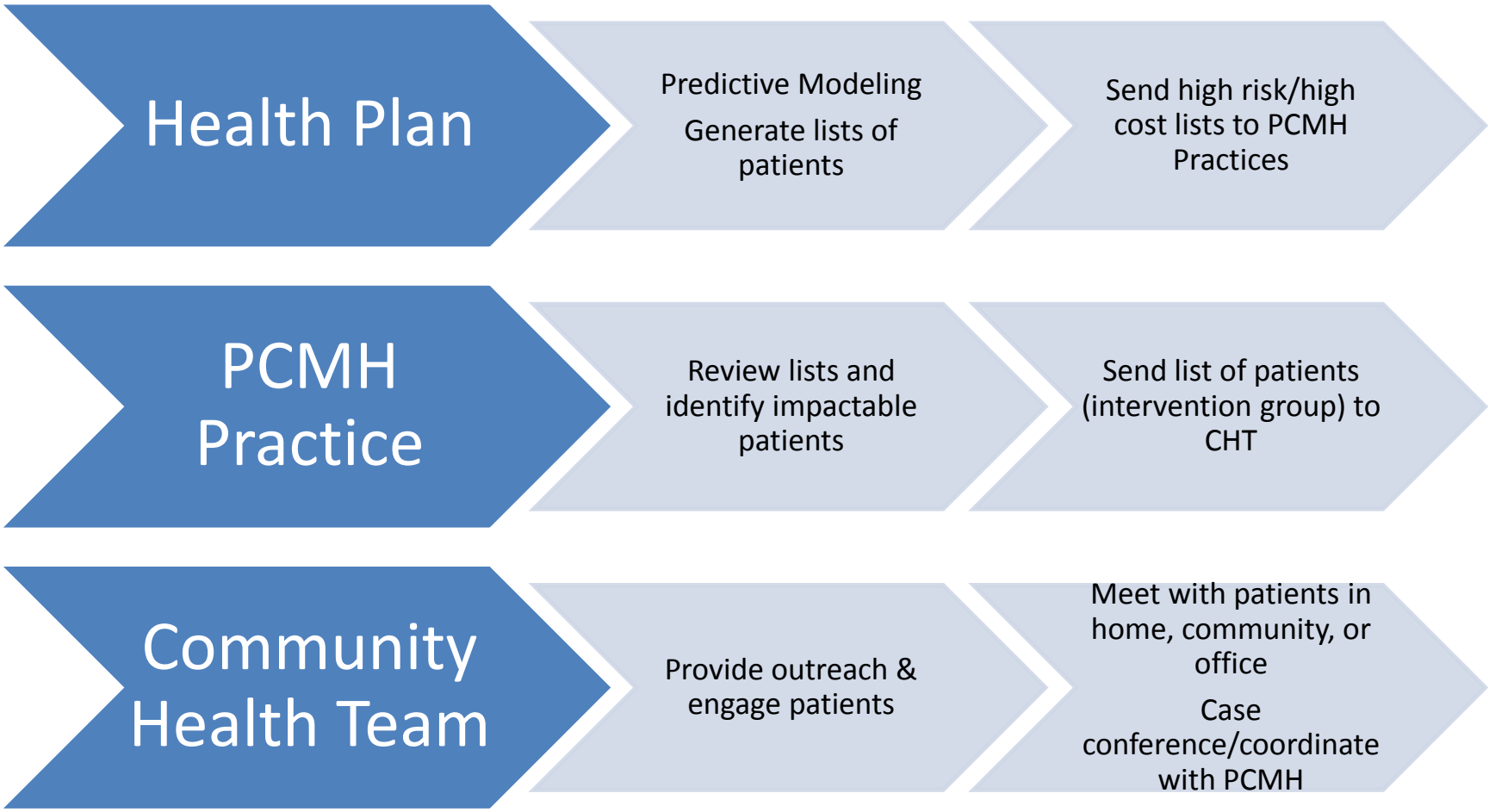
Types of High Utilizers

1. Patients with advanced illness
2. Patients with episodic high spending
3. Patients with persistent high spending patterns

- Category 3 entails patients' persistent high utilization of costly health services, including repeat ED visits and inpatient hospitalizations.
- Category 3 likely the most impactable by CHT outreach programs.

Sources: See references at end of slide set

Identifying the Right Patients:
Initial Method



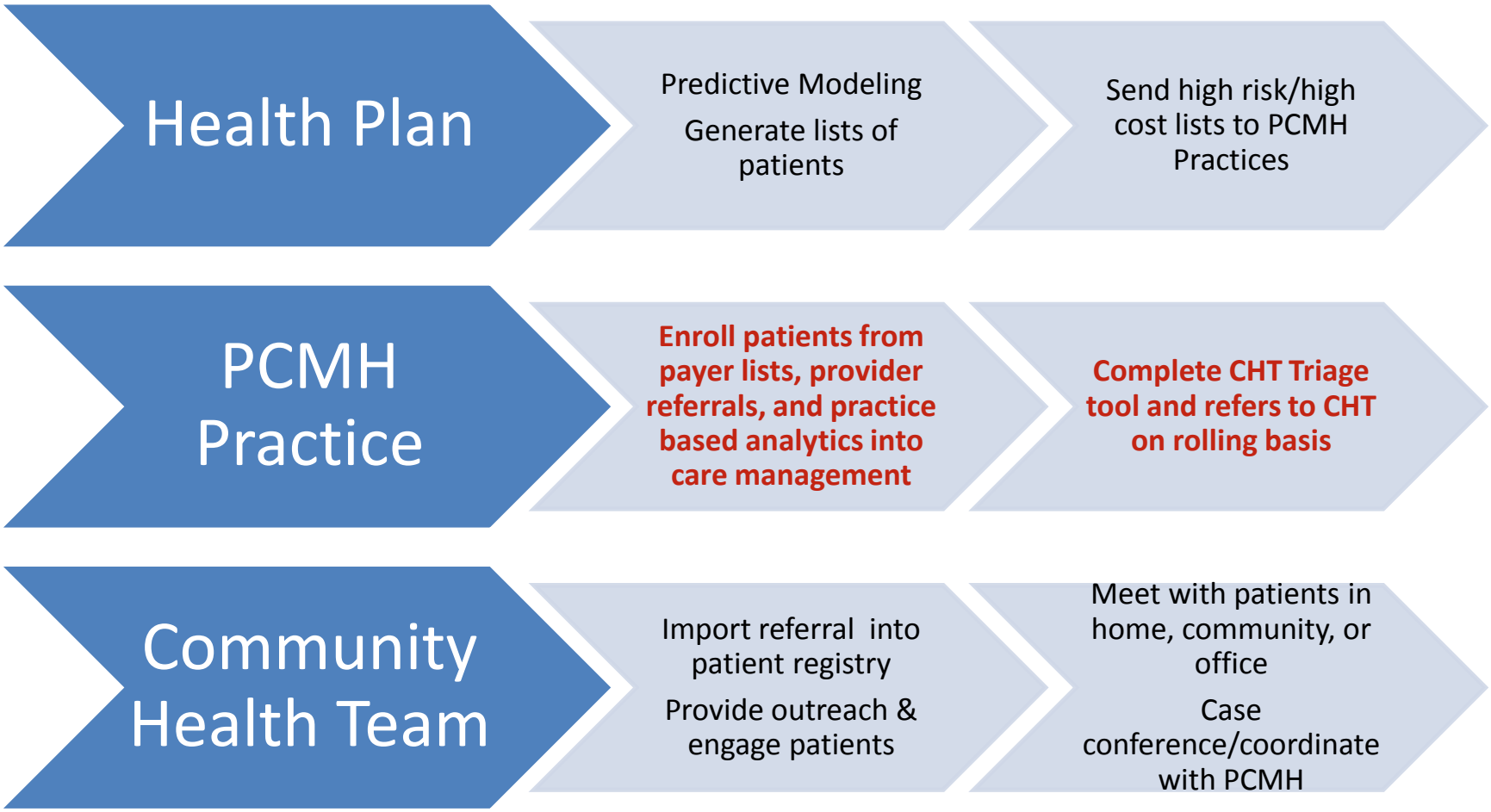
Identifying the Right Patients

Initial method was not very successful

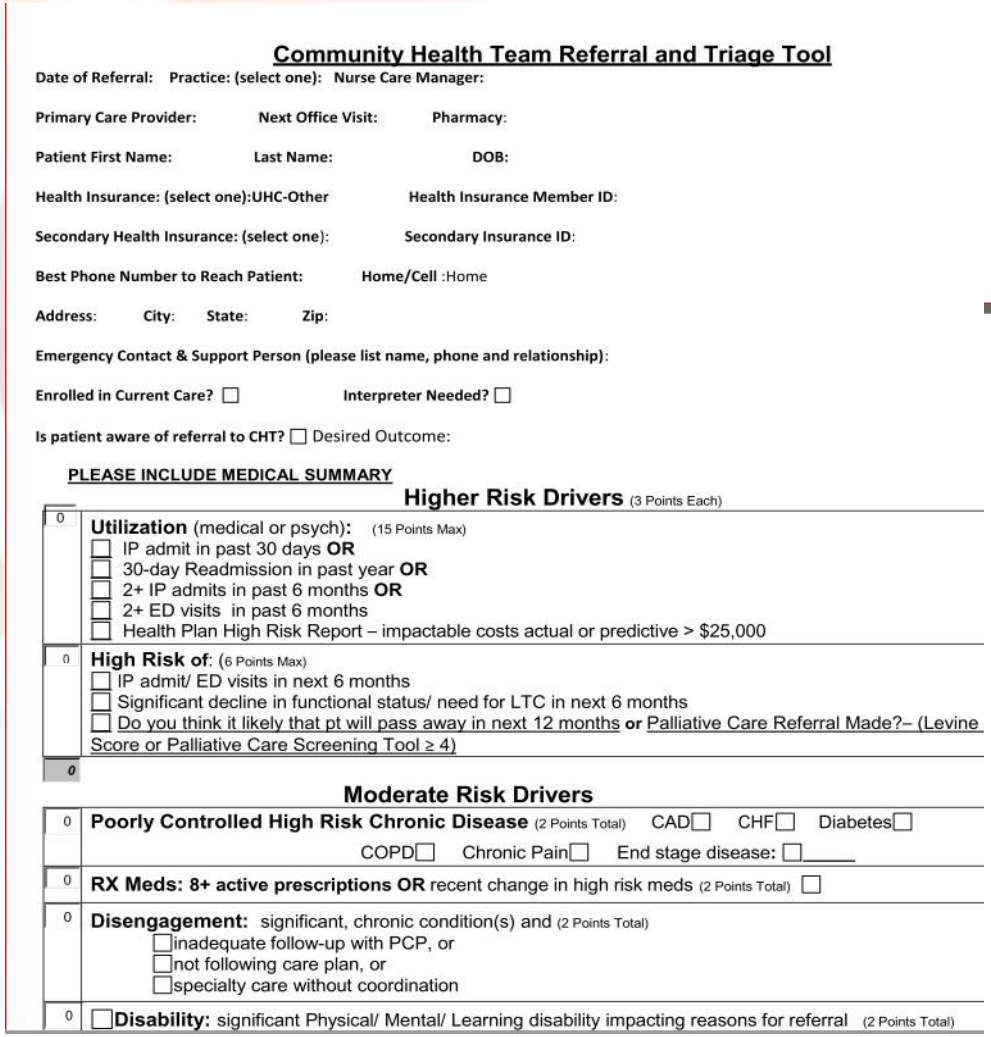
- Patients identified from claims data: Lag time
- Different predictive models used among payers
- Predictive models not sophisticated enough
- PCMH NCMs not familiar with patients on payer-generated lists
- Lists were not part of PCMH work flows
- Provider resentment

Identifying the Right Patients

Revised, Current Method



Identifying the Right Patients
CHT Triage Tool



Community Health Team Referral and Triage Tool

Date of Referral: **Practice: (select one):** **Nurse Care Manager:**

Primary Care Provider: **Next Office Visit:** **Pharmacy:**

Patient First Name: **Last Name:** **DOB:**

Health Insurance: (select one):UHC-Other **Health Insurance Member ID:**

Secondary Health Insurance: (select one): **Secondary Insurance ID:**

Best Phone Number to Reach Patient: **Home/Cell** :Home

Address: **City:** **State:** **Zip:**

Emergency Contact & Support Person (please list name, phone and relationship):

Enrolled in Current Care? ☐ **Interpreter Needed?** ☐

Is patient aware of referral to CHT? ☐ 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

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)

☐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

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

Calc Total 0

>15 = High Risk – Offer Complex CM

<15 = Does not meet criteria of Complex CM

Disposition Plan: _____

Source: Adapted from Cambridge Health Alliance

Recommendation:
Clarify Roles and Responsibilities of Participants in CHT Program

- MOU was replaced with **MOA**
  - MOA more explicitly states responsibilities of practices, CHT, and CHT host entity
  - MOA provides more prescriptive framework for how CHT and primary care practice must work together to manage high risk patients
    - Explicitly encourages warm handoffs

Clarify Roles and Responsibilities

Assign resources based on patient's needs

Behavioral Health Care Manager	Community Resource Specialist	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
	Teach patients self-monitoring strategies	
	Care Plan development	

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

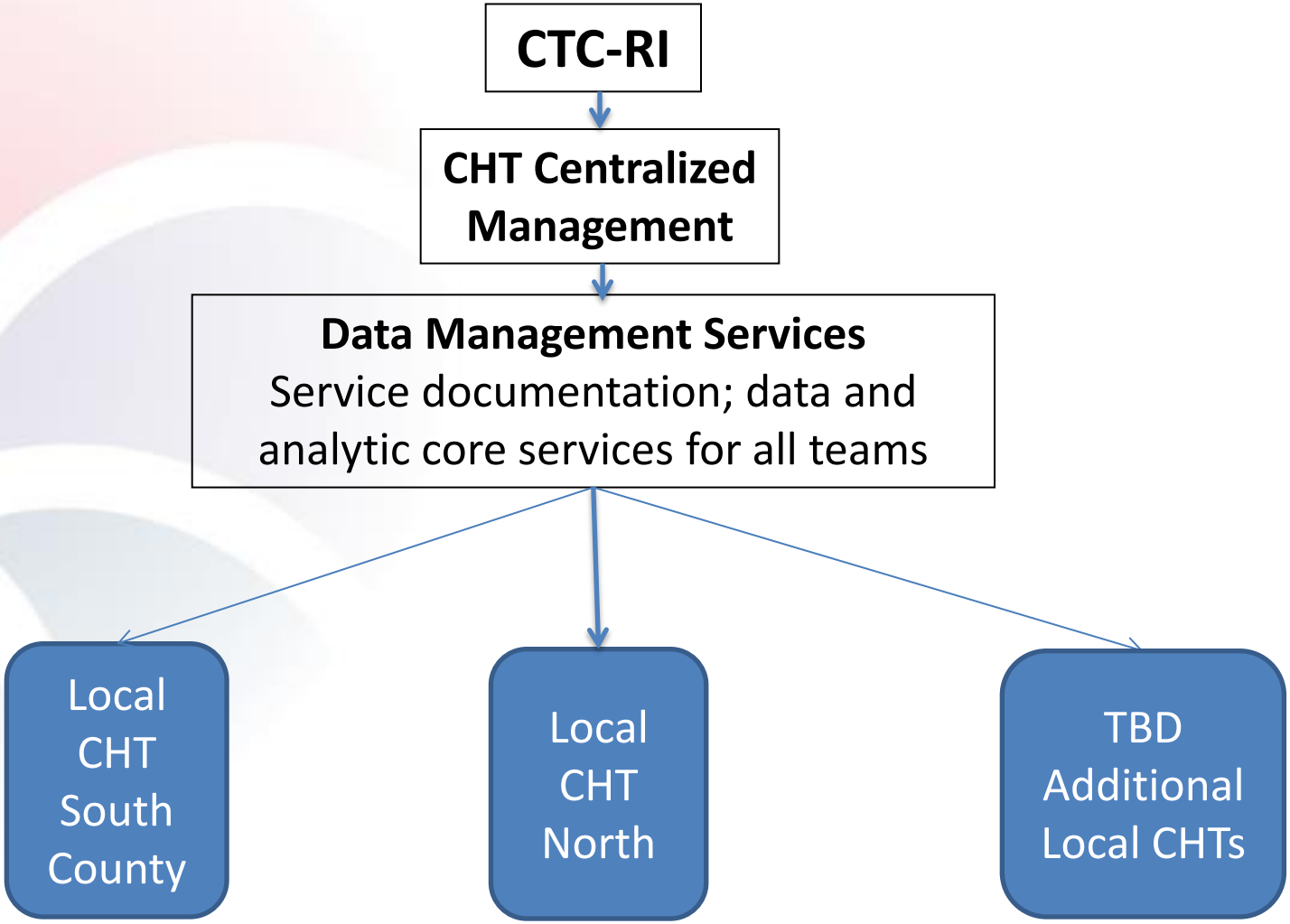
Recommendation: Improve Timely Communication for Rapid Response

- MOU to permit direct communication between **health plans, practices and CHT**
- CHT gained access to Rhode Island's **Health Information Exchange**
  - Real time ED and IP admission notifications
  - Clear picture of which patient is receiving care, and where (minus behavioral health)

Recommendation: Standardize Operations across Regional Teams

- Increase program consistency and efficiency for statewide scalability (consistent with evidence based best practices)
- Standardize policies and procedures
  - However, create *procedural mechanisms for modification* as appropriate to particular sites
- Centralize project and data management

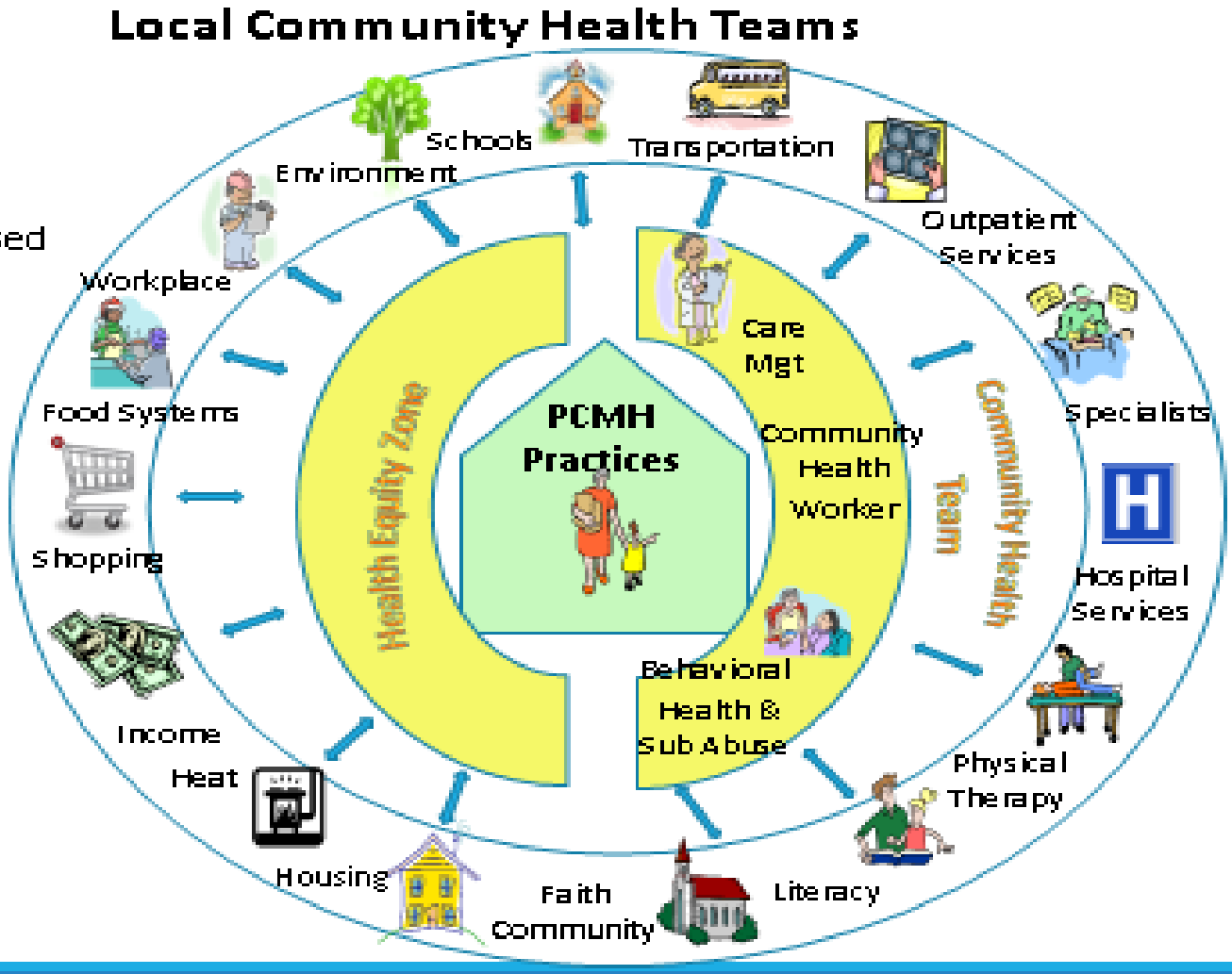
CTC-RI Phase II CHT Model Reorganized to Centralize and Standardize Operations Across CHTs



New CTC-RI
Community Health Team Model

Local Teams
- Community Based

CHT connected to
- Health Plans
- PCP



Source: Adapted from Maine Quality Counts

Recommendation:
Obtain Better Data to Track ROI

- Hospital Utilization and Total Cost of Care
  - Health plan data (limited by small sample size – but used as directional indicator)
  - APCD data (not available for Pilot-Phase 1, but pursuing for Phase 2)
  - Crisis intervention and ED Avoidance (cited by CHTs and practices as evidence of success and cost savings)

Cost Avoidance
Over 19 Month Operations

CHT		Crisis Interventions	ED Diversions	Ave $/ IP Admission	Ave$/ ED Visit	IP Cost Avoidance	ED Cost Avoidance	Total Cost Avoidance
South Co		25	10	$ 12,000	$ 700	$ 300,000	$ 7,000	$ 307,000
North Co		5	17	$ 12,000	$ 700	$ 60,000	$ 11,900	$ 71,900
Total Cost Avoidance		30	27	$ 12,000	$ 700	$ 360,000	$ 18,900	$ 378,900

- After 19 months, the CHTs estimated $379k in cost avoidance
- Reached a 0.6 ROI
- We expect to breakeven and move to positive ROI next year by:
  - Improving speed of engagement with patients
  - targeting not just high risk, but **high impact** patients

Source: CTC Community Health Team internal report

Recommendation:
Enhance CHT Structure

- Increase staffing, including behavioral health availability and additional expertise, e.g. nutrition
- Streamline CHT staff supervision
- Design CHT regions for economy of scale and evaluation
- Establish sustainable funding

Recommendation: Strengthen CHT Operations

- Periodically review patients' needs
- Periodically remind patients and practices about CHT services
- Inform patients about methods of CHT contact
- Enhance CRS role in patient education
  - Pilot interactive web-based health coaching
  - Disease education trainings for CRS'
- Reduce redundancy: Coordinate between CHTs and external case managers
- Increase communication across teams
- Compile geographic-specific resource/contact lists

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Importance of a Multi-Payer Approach to CHT Programming

Multi-Payer Approach to CHTs

- Central to the RI State Innovation Model (SIM) population health plan
- Central to RI DOH population health initiatives
- Improves population health at the community level
- Shares value and cost

CTC-RI CHT Tools and Resources

Links to CTC-RI CHT Resources

- CHT Planning Charter
- CHT Memorandum of Understanding (CHT/Practice)
- CHT MOA with Health Plans, CHT and Practices
- Referral/Intake form
- CTC-RI Community Health Team Pilot Program Final Evaluation Report, February 2016
- CTC-RI Community Health Team Pilot Program Literature Review Part I: Community Health Teams and Complex Care Management for High-Risk Patients, 2016
- CTC-RI Community Health Team Pilot Program Literature review Part II: Overview of Vermont's Comprehensive Approach to Care Management and Improving Health Outcomes, 2016

For more information, contact: Susanne.Campbell@umassmed.edu

Acknowledgements

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- CTC-RI “South County” Team staff and South County Health
- CTC Community Health Team Committee and Board of Directors
- Rhode Island Department of Health
- CTC-RI Co-Directors: Debra Hurwitz, RN, MBA and Pano Yeracaris, MD, MPH
- Evaluation Team: Mardia Coleman, MS; Marisa Sklar, PhD

References for Typical Goals of CHTs

- 42 U.S. Code § 256a–1 - Establishing community health teams to support the patient-centered medical home. Retrieved from https://www.law.cornell.edu/uscode/text/42/256a-1
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References for Types of High Utilizers

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Questions?