Workforce Innovations in Complex Care Series: Using Community Health Workers and Volunteers to Reach Complex Needs Populations

April 18, 2017, 1:00-2:30 pm ET
For Audio Dial: 888-539-3694
Passcode: 205470

Made possible with support from Kaiser Permanente Community Benefit and the Robert Wood Johnson Foundation
Questions?

To submit a question, please click the question mark icon located in the toolbar at the top of your screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Agenda

- Welcome and Introductions
- Cultivating a Resource Network for Complex Beneficiaries in a Rural Setting
- Leveraging Community Partnerships to Connect East Baltimore Residents to Health and Social Services
- Q&A
Welcome & Introductions
Meet the Team

Rachel Davis,
Associate Director for Program Innovation,
Center for Health Care Strategies

Caitlin Thomas-Henkel,
Senior Program Officer,
Center for Health Care Strategies

David Adler,
Senior Program Officer,
Robert Wood Johnson Foundation
About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans
Complex Care Innovation Lab

Multi-year learning collaborative, supported by Kaiser Permanente Community Benefit, focused on improving care for low-income individuals with complex medical and social needs

Transforming Complex Care

Two-year multi-site pilot demonstration, funded by the Robert Wood Johnson Foundation, aimed at refining and spreading effective care models that address the needs of high-need, high-cost patients
Robert Wood Johnson Foundation’s Culture of Health

CULTURE OF HEALTH ACTION FRAMEWORK

1. Making health a shared value
2. Fostering cross-sector collaboration to improve well-being
3. Creating healthier, more equitable communities
4. Strengthening integration of health services and systems
Cultivating a Resource Network for Complex Beneficiaries in a Rural Setting
Today’s Speakers

Jane Emmert,
Director,
ASSIST

Lara Shadwick,
Program Director,
Mountain-Pacific Quality Health
IMPROVING CARE COORDINATION FOR HIGH-NEED POPULATIONS

Lara Shadwick, MBA
Mountain-Pacific Quality Health
Lara.Shadwick@area-h.hcqis.org

April 18, 2017

This material was developed by Mountain-Pacific Quality Health, the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam, American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. 111SOW-MPQHF-MT-HS-17-02
Who We Are

Mountain-Pacific Quality Health is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for four states and three territories:

- Montana
- Wyoming
- Alaska
- Hawaii
- Guam
- American Samoa
- The Commonwealth of the Northern Mariana Islands
Montana Communities

- Kalispell
  - RN
  - ASSIST
  - Coaches
- Helena
  - RN
  - Keeping You Home
- Billings
  - RN
  - Two CHWs as veteran peers
New Project

• Apply nationally renowned Camden Coalition of Healthcare Providers and Transitional Care Models to rural settings

• Test, fund and deploy **ReSource Teams**, functioning as community outreach teams

• Test, fund and deploy cellular-enabled iPads to work with patients remotely via video chat

• Spread best practices through training and education

• Work with payers to develop sustainable community health teams

• Save $$$$$$
Funding Sources for Pilots

• CMS Special Innovation Project
• Robert Wood Johnson Foundation
• Montana Healthcare Foundation
  ▪ Same criteria but looking beyond Medicare to Medicaid, uninsured and commercial patients
  ▪ Funding allows teams to work with all applicable patients
• Multi-payer/Comprehensive Primary Care Plus (CPC+) Sustainability
Delivery System Models: Community ReSource Teams

- Primary Care
- Coach
- RN
- Community Health Worker
- Community Resources
- BH

Patient
Coming to the Table as a Community

MHIP (Medicaid)
FQHC
Home Options (HHA and Hospice)
Western MT Mental Health
Pathways (IP Psych)
SUMMIT (coaches)
Nursing Home
Hospital Case Management
ASSIST Flathead (volunteer CHWs)
RN
Patient Case Review
INNOVATION AT WORK
iPads and Video Conferencing with Patients

• Build relationship through video chat (HIPPA compliant)
• Cellular enabled for rural area
• iPads go with CHWs to patient home visits and connect RN
• Clinical concerns can be addressed, allows for non-verbals to be recognized
• Makes RNs more efficient with travel time and better able to focus on clinical elements of care
Multi-site Case Conferences

- Monthly calls
- De-identified cases are presented
- Experts on the calls
  - Nurse
  - Behavioral Health
  - Pharmacist
  - Peers
- Supportive of the emotional nature of the work
Veterans at Work

• **1 in 10** Montana residents are veterans

• Veterans connect better with those who served

• Hiring medically retired veterans to functions as CHWs

• Career adaptation

• 1+1=a bigger 1

• Flexibility for follow-up medical care
MISSION STATEMENT
Dedicated staff and volunteers connect people to the resources necessary to regain their health and independence.
At ASSIST we believe in the power of volunteers to impact the lives of their neighbors who are trying to regain their health and independence.
How We Began

ASSIST is a 501(c)(3) not-for-profit corporation founded in 2014 by Curtis Lund, a retired business entrepreneur.

As an avid volunteer himself, he knew the benefit of volunteering to the volunteer and well as to the community.
Funding

Mr. Lund funded the program himself for nearly two years and then ASSIST came under the Non-Profit Foundation umbrella of the Kalispell Regional Medical Center in October 2016.
The Referral Process

Our patients (whom we call Care Receivers) are referred to us by medical staff at Kalispell Regional Healthcare, North Valley Hospital and associated clinics who recognize a patient that needs help connecting to community resources.
The Three Departments of ASSIST

The ASSIST Program

Neighbors Helping Neighbors
Volunteers and staff who visit patients in their homes and connect them to resources.

Transportation
Rides to doctor appointments

ASSIST Center
A 10-bed facility that provides non-medical care for patients that need to leave the hospital but aren’t quite ready to go home.
## Neighbors Helping Neighbors

<table>
<thead>
<tr>
<th>Year</th>
<th>People Served</th>
<th>Hours of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>128</td>
<td>380</td>
</tr>
<tr>
<td>2015</td>
<td>220</td>
<td>1,200</td>
</tr>
<tr>
<td>2016</td>
<td>489</td>
<td>3,136</td>
</tr>
</tbody>
</table>

Our average Care Receiver is 66 years old and makes approximately $1350/month.
Our current volunteers are former:

- Teachers
- Physical therapists
- Occupational therapists
- Loggers
- Computer programmers, Bookkeepers
- Nurses
Volunteer Training

• Application, interview, reference check and background check
• 3-hour orientation with the Volunteer Supervisor
• On-the-job training with skills modeled by staff on each visit into Care Receiver’s homes
• Monthly training lunches with presentations by community resource organizations
• Resource manual (over 200 pages) with specific community resource information divided by categories: basic needs, disability, families, financial, food, health care, housing, senior adults, transportation and veterans
Volunteers and staff visit Care Receivers in their homes and LISTEN to their concerns.

Together, we create a Plan of Action.
# PLAN OF ACTION

<table>
<thead>
<tr>
<th>Top Three Concerns and Needs</th>
<th>Care Receiver</th>
<th>ASSIST team</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Apply for Medicaid</td>
<td>Gather 6 months of bank statements, taxes, medical expenses and Soc. Security statement</td>
<td>Pick up Medicaid app and help fill it out with Care Receiver</td>
</tr>
<tr>
<td>2 Food</td>
<td></td>
<td>Refer them to Meals on Wheels and Food Bank</td>
</tr>
<tr>
<td>3 Steep steps to trailer</td>
<td></td>
<td>Contact the mobile home repair team</td>
</tr>
</tbody>
</table>

## ACTIONS TAKEN by ASSIST team

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/17</td>
<td>Helped fill out Medicaid app, but they still need to get bank statements</td>
</tr>
<tr>
<td>3/3/17</td>
<td>Called Meals on Wheels and Food Bank for Senior Commodities. Delivery will start on 3/5/17 for Mon, W and the last Friday of the month for commodities.</td>
</tr>
</tbody>
</table>
We generally are done with intensive involvement within 60-90 days, but we are always available for them to call and ask us for help. Our Care Receivers know that we care about them.
We make a difference because we are face to face with our *Care Receivers* in their homes.
We are Connectors

ASSIST Volunteers connect the Care Receivers to agencies that provide needed services.
Volunteers may help Care Receivers fill out financial assistance forms or help them apply for Medicaid, Medicare or Social Security Disability resources.
Or connect them to home care or homemaker services through organizations like the Agency on Aging.
Or connect them with public transportation or the ASSIST shuttle for rides to doctor appointments. Sometimes we ride along to teach them to use the transportation system.
Assist Transportation

- Three wheelchair accessible vehicles
- Providing over 350 rides per month, many of which are 50+ miles round trip (and still turning down 30-40 ride requests because we’re already booked.)
- Ride of last resort (always encouraging use of public transport where available.)
WE DO NOT PROVIDE:

Personal Care
Financial Assistance
Medical Care
Housekeeping

But we may CONNECT our Care Receivers to those resources.
<table>
<thead>
<tr>
<th>Resource Connections</th>
<th>2016 Statistics</th>
<th>Medical Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>113</td>
<td>COPD</td>
</tr>
<tr>
<td>Housing</td>
<td>133</td>
<td>Cardio Disease</td>
</tr>
<tr>
<td>Medicaid</td>
<td>144</td>
<td>Depression</td>
</tr>
<tr>
<td>Personal Care/Respite</td>
<td>110</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Practical Help</td>
<td>124</td>
<td>Liver Failure</td>
</tr>
<tr>
<td>Transport</td>
<td>116</td>
<td>Obesity</td>
</tr>
<tr>
<td>Disability</td>
<td>57</td>
<td>Diabetes</td>
</tr>
<tr>
<td>End of Life</td>
<td>50</td>
<td>CVAStroke</td>
</tr>
<tr>
<td>Energy Assistance</td>
<td>50</td>
<td>Cancer</td>
</tr>
<tr>
<td>Food</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Agency on Aging Homemaker Services</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Legal Help</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Medical/RX</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Organizational</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Wellness calls</td>
<td>65</td>
<td></td>
</tr>
</tbody>
</table>
What Works for the Flathead Valley

Northwest Montana Care Transitions Coalition

- Diverse community representation
- Monthly Meetings for networking and educational presentations
- CMS Grant for an RN and Community Health Worker role (fulfilled by ASSIST) called the “ReSource Program”
- iPad technology
The ASSIST Center

10-bed, non-medical, short stay facility.
The greatest gift we provide is the gift of spending time and LISTENING.

- That means we can’t be in a hurry.
- We get to slow down...and listen.
- We build relationships that may allow us to speak honestly to them in a future situation.
Our Website

www.assistflathead.org

When families face a medical crisis they frequently don’t know where to start looking for the help they need. The ASSIST website provides information about community resources and makes information readily available for our volunteers and community members.
Neighbors Helping Neighbors!
Community Resources

- View Clothing Resources
- View Disability & Self Sufficiency Resources
- View Emergency Shelter Resources
- View Financial Assistance Resources
- View Food Resources
- View Housing Resources
- View Medical Equipment Resources
- View Senior Care Resources
- View Transportation Resources
- View Veteran's Resources
Senior Care Services

Adult Day Care and Respite Care

<table>
<thead>
<tr>
<th>Organization</th>
<th>How they Help</th>
<th>Contact info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendship House</td>
<td>Assisted living for adults who can no longer live safely at home. Short term respite care, 24 hour care, adult day care.</td>
<td>606 2nd Ave. W. Kalispell, MT 59901 Phone: 406-257-8375</td>
</tr>
<tr>
<td>The Springs at Whitefish</td>
<td>Assisted Living</td>
<td>1001 River Lakes Parkway Whitefish, MT 59937 Phone: 406-862-6322 Website: <a href="http://www.thespringsliving.com/senior_living/">http://www.thespringsliving.com/senior_living/</a></td>
</tr>
<tr>
<td>Buffalo Hill Terrace</td>
<td>Assisted Living</td>
<td>40 Claremont St. Kalispell, MT 59901 Phone: 406-752-9624 Website: <a href="http://www.easthaven.org/us/contact">www.easthaven.org/us/contact</a></td>
</tr>
<tr>
<td>Edgewood Vista</td>
<td>Assisted Living</td>
<td>141 Interstate Lane Kalispell, MT 59901 Phone: 406-755-3240 Website: <a href="http://www.assistedlivingfacilities.org/search/">http://www.assistedlivingfacilities.org/search/</a></td>
</tr>
</tbody>
</table>

Nursing Homes

<table>
<thead>
<tr>
<th>Organization</th>
<th>How they Help</th>
<th>Contact info</th>
</tr>
</thead>
</table>

Upcoming Events

- April 24: ASSIST Presentation
- May 6, 7: Governor’s Conference on Aging
- May 20: Alzheimer’s Education at Prestige Assisted Living Center

News & Updates

- KOFI Radio Interview “Volunteering with ASSIST”
- KOFI Radio Interview “About ASSIST”
- Only 1 in 3 seniors who qualify for SNAP...
ASSIST is UNIQUE because we are:

• A volunteer-based organization
• We go into people’s homes and listen to their concerns and needs
• Volunteers are trained to understand the resources available in our communities
• We connect our Care Receivers to those resources
• Our services are FREE.
Financial Value

- Hospital charge/day
- Readmission Reductions
- Better use of medical services (go to PCP or urgent care before ER)

ReSource Program example (RN and CHW): A super-utilizer with chronic COPD who cost the hospital $100,000 in Medicare costs in 3 months stayed in the ASSIST Center, got connected to community resources and only had 1 ER visit in 4 months.

To the people we help, our services are PRICELESS and that is our most important goal.
CONTACT INFORMATION:
Jane Emmert, Director

jemmert@krmc.org
www.assistflathead.org
Leveraging Community Partnerships to Connect East Baltimore Residents to Health and Social Services
Today’s Speakers

Linda Dunbar, 
Vice President, 
Population Health & Care Management, 
Johns Hopkins Healthcare

Demetrius Frazier, 
Program Manager, 
Sisters Together and Reaching, Inc.

Will Torriente, 
Community Health Worker Supervisor, 
Sisters Together and Reaching, Inc.

Reverend Debra Hickman, 
Co-Founder and CEO, 
Sisters Together and Reaching, Inc.
Community Partnerships and Social Determinants Interventions

April 18, 2017

Dr. Linda Dunbar, Johns Hopkins Medicine
Rev. Debra Hickman, Demetrius Frazier, and Will Torriente,
Sisters Together and Reaching
JCHiP: Johns Hopkins Community Health Partnership

- Launched in 2012 and built on existing programs
- Transforms across continuum: clinics, SNFs, hospitals, home, community and EDs
- Catalyzed by CMMI HCIA Award
- East Baltimore Community is the “Core”: 7 zip codes
Who Did J-CHiP “Touch” and what were the outcomes of J-CHiP?

- About 1,000 adult Medicaid and 2,000 adult Medicare patients with mental illness, substance use disorder and chronic illness receiving local community care were enrolled.

- **Outcomes:**
  - Reduction in total quarterly cost of care (-$1,756 per beneficiary, Medicaid)
  - Decrease in hospitalizations and ED visits (-17 and -16 per 1,000 Medicare beneficiaries per quarter, respectively)
  - Decrease in hospitalizations and ED visits (-31 and -48 per 1,000 Medicaid beneficiaries per quarter, respectively)
  - 82% of respondents report that they spoke with clinic staff about how to take care of themselves
  - **Most respondents report that they trust their community health worker (CHW) and would recommend their provider to family and friends**
Community Heath Partnership of Baltimore, July 2016
Transform Maryland’s health care system to be highly reliable, highly efficient, and patient-centered. HSCRC and DHMH envision a health care system in which multi-disciplinary teams can work with high need/high-resource patients to manage chronic conditions in order to improve outcomes, lower costs, and enhance patient experience. Through aligned collaboration at the regional and state levels, the state and regional partnerships can work together to improve the health and well-being of the population.
Community Care Teams
CCT Overview

- CCTs expand upon existing services of primary care providers to meet the needs of the high-risk population and coordinate care

- 10 regional teams consisting of:
  - Case Managers (CM)
  - Community Health Workers (CHWs) from Sisters Together and Reaching
  - Health Behavior Specialists (HBS)

- Regular rounding sessions and communication with providers
Tumaini (Hope) for Health

- Collaborative effort within JCHiP involving Sisters Together and Reaching (STAR), and the Men and Families Center, Inc. (MFC)
- A multilevel community health worker program
- Aims to reduce barriers to accessing health care and facilitate uptake of social and health services
- Targets 19 zip codes in Baltimore City
- Composed of two intersecting interventions:
  - Neighborhood Navigators, volunteers trained and overseen by the Men and Families Center
  - Community Health Workers, trained and employed by Sisters Together and Reaching
Who Are The CHWs?

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served.

This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

American Public Health Association, 2008
Tumaini CHW Qualities

Shared life experiences
Most essential element considered by employers
Socio-economic, educational, racial/ethnic
Single largest contributor to success

Personal Attributes
Essential to CHW work – relational experiences
Not just anyone can be a CHW

Work Experience
Roles, Tasks, Skills

CHW Training
Core competencies
Specialty topics
Least important

Connected to Community
Resourceful, Creative
Mature, Prudent, Persistent
Empathetic, Caring, and Compassionate
Open-minded, Non-judgmental, Relativistic
Respectful, Honest, Patient
Friendly, Outgoing, Sociable
Dependable, Responsible, Reliable
Tumaini CHW’s Responsibilities

• **Outreach/Community Mobilizing**
  - Preparation and dissemination of materials
  - Case-finding and recruitment
  - Community Strengths/Needs Assessment
  - Home visiting
  - Promoting health literacy
  - Community advocacy

• **System Navigation**
  - Translation and interpretation
  - Preparation and dissemination of materials
  - Promoting health literacy
  - Patient navigation
  - Addressing basic needs – food, shelter, etc.
  - Coaching on problem solving
  - Coordination, referrals, and follow-ups
  - Documentation
Tumaini CHW’s Responsibilities

**Case Management/Care Coordination**
- Family engagement
- Individual strengths/needs assessment
- Addressing basic needs – food, shelter, etc.
- Promoting health literacy
- Goal setting, coaching and action planning
- Supportive counseling
- Coordination, referrals, and follow-ups
- Feedback to medical providers
- Treatment adherence promotion
- Documentation

**Home-based Support**
- Family engagement
- Home visiting
- Environmental assessment
- Promoting health literacy
- Supportive counseling
- Coaching on problem solving
- Action plan implementation
- Treatment adherence promotion
- Documentation

**Health Promotion & Coaching**
- Translation and interpretation
- Teaching health promotion and prevention
- Treatment adherence promotion
- Coaching on problem solving
- Modeling behavior change
- Promoting health literacy
- Harm Reduction

**Community/Cultural Liaison**
- Community organizing
- Advocacy
- Translation and interpretation
Tumaini (Hope) for Health

Neighborhood Navigators

- Adopts a “Block-by-Block” approach for community organizing for health
- Combines features of community health worker and peer advocate/mentor models
- Trained and overseen by the Men and Families Center
  - 40 residents trained; 30 retained for final deployment
- Reside in specific neighborhoods within the Madison-East End Community Statistical area, located in the 21205 zip code
- Compensated through stipends based on living wage
- Document work through RedCap
Tumaini (Hope) for Health – Neighborhood Navigators (continued)

• Serve four primary roles:
  – General neighborhood education and outreach (*neighborhood-wide*)
  – Informal monitoring and surveillance of unmet needs related to access to health care and social services (*neighborhood-wide*)
  – Regular home visits to provide social support and promote engagement with care among a small caseload of high-risk patients
  – Capacity-building and mobilization of neighborhood residents through regular participation in and presentation to neighborhood association meetings
Training for NNs

- Introduction to Johns Hopkins Health System, Tumaini, and NN and CHW roles
- Outreach and patient engagement
- Patient interviewing
- Means-tested benefit and health insurance eligibility
- Community resource identification, referral, and navigation
- Documentation of patients’ needs and referrals
- Social and economic determinants of health
- Introduction to Mental Health First Aid
- CPR
Questions?

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Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Look for Parts II and III of this Series

*Community Paramedicine: A New Approach to Serving Complex Populations*

May 11, 2017, 1:30-3:00 pm ET

*Integrating Community Pharmacists into Complex Care Management Programs*

June 22, 2017, 12:00-1:30 pm ET
Visit CHCS.org to...

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