Hennepin Health/Hennepin County Medical Center Community Health Worker Program

NYU-CUNY Prevention Research Center
Integrating CHWs into Healthcare Systems
October, 1, 2015
What is Hennepin Health?

- Defined Provider Network, Shared Electronic Health Record
- Risk-Sharing Funding Model, Alignment of Finances
- Integration of Medical and Social Services to Address Social Determinants
- Consensus-Based Governance Model

Prospective enrollment via managed care choice or default

Capitated Reimbursement from State Medicaid Agency

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Population Served

- Current Enrollment ~ 11,000 members
- Medicaid Expansion in Hennepin County
- 21 - 64 year-old Adults, without Dependent Children
  - 67% Male
  - 63% Racial/Ethnic Minority
- At or Below 133% of the Federal Poverty Level (≤ 75% prior to 2014)
- Not Certified as Disabled
- Common Overlapping Conditions:
  - Mental Health
  - Chemical Dependency
  - Homelessness/Unstable Housing
  - Chronic Physical Conditions
  - Lack of Social Support
Factors Influencing Health Outcomes

20% - Access to and Quality of Health Care

80%
- Social and Economic Factors (40%)
- Health Behaviors (30%)
- Built Environment (10%)

Adapted from <http://www.countyhealthrankings.org/our-approach>
• Need to Meet Individuals’ Basic Needs Before We Can Meaningfully Impact Health

• Social Challenges Often Result in Poor Health Management and Costly “Revolving Door” Care

• By Financially Aligning and Coordinating Systems, we can Improve Health Outcomes and Reduce Costs
Outcomes: Program-Wide Utilization

Income criterion for eligibility increases from 75% of FPL to 133% of FPL with full Medicaid Expansion
Outcomes: Continuously Enrolled Members

Jan 2013 – Jun 2014 (n=932); Epic EHR Data

ED Visits per 1000 Members

IP Admissions per 1000 Members
Outcomes: Quality and Patient Satisfaction

- Optimal Care for Chronic Conditions (MN Community Measurement)
  - Improving in Line with System-Wide Results
  - Observed Disparity
- Patient Satisfaction (Press Ganey Survey Results)
  - “Likelihood to Recommend” Consistently High and Similar to System-Wide Results
Care Model: Care Coordination

- Based on a Primary Care Medical Home
- Focus on social determinants of health
- Referral to “Ambulatory ICU” Clinic for Most Complex
- Documenting and Communicating in Shared Electronic Health Record (EHR)
- Integrated social and community services
  - Employment assistance
  - ED In-Reach
  - Housing Navigation
  - Intensive Behavioral Case Management
  - Transportation

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Primary Coordinator

Relationship based accountability model for each patient. Role assuming Primary Coordination is based on primary patient needs.

COMMUNITY HEALTH WORKER
1. Stable chronic disease and social situations,
2. New patients with no identified medical or psychosocial problems.
3. Cultural or language barriers needing navigation and/or education.
4. Frequent ED use for primary care (e.g. sore throat, cough).
5. Hospitalization due to elective surgeries/procedures and medically stable

CLINICAL COORDINATOR AND/OR NURSING STAFF
1. Acute medically complex patient discharging from inpatient setting.
2. Unstable chronic disease or diseases.
3. Acute medical complex condition in the outpatient setting.
4. Frequent ED use for medical reasons.

SOCIAL WORKER
1. Acute and unstable mental health, chemical health
2. Acute psychiatry discharge from inpatient setting.
3. Frequent ED use for chemical health or mental health reasons
5. Homeless or at risk for losing housing.
Community Health Workers

- 26 Community Health Workers
  - 19 clinic-based
  - 4 community-based
  - 2 Emergency Department
  - 1 Inpatient
- 6 countries of origin, 5 languages
- Care coordination, navigation, education and outreach services
• Cultural and language specific navigation of the system
• Develop trusting and loyal relationships with patients
• Provide coordination and follow-up with patients
• Provide health education, goal setting and coaching to improve health outcomes
• Patient and family centered medical home model- access, care coordination, registries, quality improvement, care planning
<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Tasks</th>
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<tbody>
<tr>
<td>Care Planning / Enrollment</td>
<td>Notify patient of participation in Health Care Home, provider, care team and patient/family establish a care plan and set patient-centered goals.</td>
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<tr>
<td>Encouragement Support / Barriers</td>
<td>Work with patient to address goal progress and barriers to care including changes in housing, insurance, ability to fill medications, etc.</td>
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<td>Admission Transitions</td>
<td>Contact patient post discharge to assist with scheduling appointments, ensure patient has supplies/services, and transfer medical questions to care team.</td>
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<tr>
<td>Pre-Visit Planning (Gaps in Care)</td>
<td>Alert provider of critical information prior to clinic visits</td>
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<tr>
<td>Appointment Compliance / Referrals</td>
<td>Follow-up with patients if they miss appointments, try to help reschedule, coordinate transportation if necessary. Close the loop on referrals.</td>
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Addressing Social Factors

- Life Style Overview – screening tool to understand needs
- Informs services - housing, social services, etc.
- Guides care plan, health coaching, goal setting
- Used to inform new programs and services
- Meet patients where they are at – clinic, home, community
### Care Coordination Workflows

<table>
<thead>
<tr>
<th>Workflow</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Patient Registry</strong></td>
<td>• Monitor population health dashboard for high/extreme risk patients in the system: ED, inpatient or appointments</td>
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<tr>
<td><strong>Daily Huddle</strong></td>
<td>• Care Coordination team huddle to discuss cases and assign primary coordinator</td>
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<tr>
<td><strong>Identify candidates</strong></td>
<td>• Identify candidates for care coordination</td>
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<td></td>
<td>• Outreach and follow-up</td>
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<tr>
<td><strong>Lifestyle Overview Survey</strong></td>
<td>• Intake survey used to identify needs, inform goals, care plan and referrals</td>
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<td></td>
<td>• Flowsheet - automatically scored risk for each domain</td>
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<tr>
<td><strong>Goal Setting and Care Plan</strong></td>
<td>• Health coaching for individualized patient goals</td>
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<tr>
<td></td>
<td>• Care plan and action plan in progress note and problem list</td>
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<tr>
<td><strong>Follow-up and ongoing coordination</strong></td>
<td>• Care plan, goals and referrals</td>
</tr>
<tr>
<td></td>
<td>• ED/Inpatient admissions, appointments</td>
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Program Outcomes

Analysis of patients enrolled in care coordination for at least 3 months:
• Inpatient rates decreased from 2.6 to 2.0 (IP Admission/1000)
• ED rates decreased from 8.4 to 7.4 (ED Visit/1000)
• Outpatient visits increased by 8%

3,058 patients included in analysis. 338 patients met criteria of pre and post period utilization for the study during period of 2012-2014.
Outreach CHWs

• Meet with patients in the community
• Identify barriers to care
• Schedule medical and dental appointments
• Assist with navigating transportation and other health & human services
• Coordinate care with other Hennepin Health service providers
• Provide basic health education to members
CHW Outreach Sites

- Homeless Shelters/Day Centers
- MHP office/lobby
- Urban Ventures Men’s Program
- Adult Correctional Facility
- Emergency Department/Urgent Care
- Inpatient/Outpatient Psych
- Hennepin Health Access Clinic
April 2014-June 2015
• 5,479 patient encounters
• 651 appointments scheduled
• Appointment Completion Rates
  – Medical: 64%
  – Dental: 42%
  – Psych: 56%
• 138 Life Style Overviews completed
Implementation Success Factors

• Start-up grant funding
• Piloted CHW models
• Hennepin Health
  – Care Model implementation
  – Reinvestment funding
  – Governance
  – Metrics and outcomes
  – Data sharing/data warehouse
• EHR tools – registries and dashboards
• Training & orientation program development
• Centralized hiring, training and supervision
Implementation Challenges

- Change management
- Role delineation
- Multi-disciplinary team building
- CHW – new role in health care
- Billing and reimbursement
- Establishing CHWs as “providers” in EHR
- Training and supervision
- Compassion fatigue and staff burn-out
Lessons Learned

- We need to meet patients’ basic needs before anything else
- Connecting patients to primary care is more than making appointments
- Building trust, relationships, and understanding patient priorities are foundational
- Ongoing role delineation and team building is key to successful teams
- Need to support patients in the decisions they make
- CHWs play a key role in connecting patients to appropriate health and human services
CHWs play an integral role in Health Reform

- Champion strategies from the ground up
- Pilot interventions that impact quality, satisfaction, utilization
- Demonstrate value of care coordination teams
- Address social factors of health
- Build relationships, bridge gaps
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Hennepin Health Videos

• Hennepin Health – TPT (PBS) Broadcast Redesigning MN: Prescription for Health
  http://www.mnvideovault.org/mvvPlayer/customPlaylist2.php?id=24666&select_index=0&popup=yes#4

• Jame’s Story
  http://www.mhp4life.org/about-us/about-hennepin-health