October 2018

Care Neighborhood White Paper

Care Neighborhood: Harnessing the Power of Social Justice and Managed Care to Address the Social Determinants of Health

TABLE OF CONTENTS

Abstract 2
Keywords 2
Introduction 3
The Need for this Program 4
Overview of Care Neighborhood 4
Intensive Community Health Worker (CHW) Training 5
Care Neighborhood Technology 6
Successes 7
Challenges 10
Addressing Challenges 10

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Abstract

Most of healthcare spending is concentrated in the small percentage of members who frequently use the hospital. These “high utilizer” members have complex medical, behavioral and social needs. Complex case management programs exist at health plans but have had challenges outreaching and engaging these members.

Community Health Center Network (CHCN) is a nonprofit management services organization (MSO) made up of eight federally qualified health centers (FQHC). CHCN and the eight FQHCs provide access to primary and specialty care services to low income, vulnerable community members and continue to advocate for these members. As a MSO, CHCN provides a range of services including utilization management, provider relations, eligibility management, claims adjudication, inpatient/concurrent review, and special projects, and maintains data to reflect the progress of each service.

Because of CHCN’s embedded role in the safety net community and its access to data, it was able to establish Care Neighborhood (CN), a complex case management program within the eight FQHCs. CN helps high-risk, high needs members to prevent unnecessary hospitalizations and become connected to local resources by addressing their social determinants of health and empowering them to improve their health. This paper provides insight into the CN whole-person framework including trauma-informed care and strength-based language, intensive community health worker (CHW) training, data collection, and its case management platform. The paper will also provide overview on how CN has effectively demonstrated the program’s total cost of care savings and plans to expand.

Keywords

Case management, social determinants of health, safety net, complex, high needs, high risks, federally qualified health centers, FQHC

Introduction

Community Health Center Network (CHCN) is a nonprofit management services organization (MSO) made up of eight federally qualified health centers (FQHCs) in Alameda and Contra Costa Counties: Asian Health Services, Native American Health Center, LifeLong Medical Care, Axis Community Health, La Clínica De La Raza, Tri-City Health Center, Tiburcio Vasquez Health Center, and West Oakland Health Council. The Community Health Movement of the 1960's and 1970's was a local response to poverty and inequity in underserved neighborhoods[1]. The community health center model helped to address root causes of health inequities by combining local community leadership and federal funding to provide specific population needs and medical care and addressing the social needs and root causes of illness[2]. This model empowers communities to provide direct medical care that is culturally and linguistically appropriate while providing services to low-income and underserved communities that are often referred to as the "safety net" population. Community-based federally qualified health centers now provide access to affordable, high quality health care regardless of income, education, insurance status, race, ethnicity, and immigration status.

These eight health center organizations came together to form CHCN in 1996 to assist with the mandated managed Medi-Cal model. As an MSO, CHCN is a delegate of two health plans: Alameda Alliance for Health and Anthem Blue Cross. As such, CHCN provides a range of services including utilization management, provider relations, eligibility, claims, inpatient/concurrent review, special projects and data analysis to reflect the progress of each service. In 2017, CHCN member health centers served 265,560 patients with 1,176,786 visits. Combining both the historical mission of addressing health inequities at the local level along with claims-based financial management gives CHCN a unique advantage to providing services to members.

Claims analysis from 2017 data provided clear evidence that a small subset of population, about 5%, is the recipient of about 70% of healthcare spending. This is similar data that many other Medicaid managed care providers have found as well[3]. Addressing the social determinants of health is also not a new idea. Indeed, the community health center movement recognized and addressed social determinants from its inception. CHCN's unique view into claims and the deep connection to Community Health Centers' missions and core beliefs gave rise to Care Neighborhood (CN).

The Need for this Program

The uniqueness of the community health centers involved in CN is vitally important. They know their communities are the key to solving the inequities they face. These communities often have within them the resources they need. However, navigating the medical, social, eligibility, housing and transportation systems can be a challenge. There is unequal access to information, broken systems, racial biases, and other systematic barriers that create insurmountable obstacles for individuals alone.

When neighborhoods and specific populations face decades of poverty, incarceration, violence, untreated mental health issues, racism and pollution, they are more likely to have increased poor health outcomes and earlier death. In Oakland alone, there is a 10-15 year difference in life-span that is directly related to which side of the 580 freeway a person lives on. This divide reflects inequities based in racism and unequal access to the social determinants of health[4].

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Overview of Care Neighborhood

CN is a complex case management program with Community Health Workers (CHWs) embedded in CHCN partner health centers. Identification of the target member population includes using the ACG (Adjusted Clinical Groups) algorithm from Johns Hopkins based on claims data to identify members at high risk of hospitalization in the next six months[5]. CHWs reach out to these members and develop a patient-centered care plan. Care plans include goals around food access, transportation benefits, legal issues, behavioral health care and education on chronic disease management. Other areas include personal goals, and housing; however the housing crisis in Alameda County makes this a very difficult determinant to impact. The CHWs connect members to the right community resources, helping to break down the barriers to services and empower them to improve their own health.

CN CHWs are employees of the clinics in which they work and are valued members of the communities they serve. They are cultural brokers; they are able to speak the languages and understand the value system of their communities. They are also highly trained by CHCN in case management best practices, health coaching, resource building, professional skills and person-centered care. Building relationships between the members and health center providers, along with resource navigation, are the main interventions that the CN CHWs provide. These services are not reimbursable in FQHCs as prospective payment system eligible visits, however, they are essential in the fractured and difficult-to-navigate system. CN has demonstrated that this dedicated, resourceful and trained workforce is cost effective.

Continued: Overview of Care Neighborhood

CN uses clinical data from claims to help identify eligible members. However, claims data may not tell the whole story. Primary care providers (PCPs) and clinics' staff know their members very well and understand when there is a need for additional support. CN developed case management criteria for primary care providers, CHWs, and other clinic staff to determine a member's candidacy for CN. Generally, a member is a good fit if they demonstrate high utilization -- at least one inpatient admission in last 12 months -- or is highly likely to be admitted in the next 30-60 days, and have both multiple chronic health conditions and evidence of need for connections around the social determinants of health.

CN has two levels of case management, Active and Full. Before a CHW reaches out to an eligible member, they do a pre-outreach review to get a better understanding of the medical and social obstacles a member may be facing that are impacting their ability to receive care. The CHW then meets the member at a medical appointment or during a hospitalization and asks a series of five questions designed to elicit a conversation around needs. The CHWs are trained to weave in information from the medical history to make the questions personal and informed. From there, the patient will be offered a lower or higher level of case management depending on the goals identified and how engaged the patient is with the CHW. Those who have more than three goals to work on are invited to a longer meeting to have a full bio-psychosocial assessment and up to six months of case management. Those who have only three or fewer goals will be supported with those goals quickly. Others may decline services or be referred out to specialty programs that are a better fit for their needs. These specialty programs may be for those experiencing homelessness, addictions, dementia, or acute mental health issues that are out of scope and better served by other programs. Connecting patients to the right level of service is a key to CN's success. It's important to note that CN is not creating new services, but rather breaking down barriers to existing clinic and community resources and supporting patients with their own health and personal goals.

Intensive Community Health Worker (CHW) Training

When a CHW begins with CN, they receive up to three months of training. Much of this is provided on a one-on-one basis with CN social workers and nurse, some of it is provided by their clinic's staff, some is on-the-job training in the clinic and in the community alongside of CN staff, and the rest is provided by seasoned CN CHWs via shadowing. CN has a comprehensive training checklist that covers case management guidelines, workflows, documentation, community resources, crisis intervention, mandated reporting, health coaching, and specific tools and techniques to enhance communication and help develop interpersonal skills. These techniques include Motivational Interviewing, Trauma-Informed Care, strengths-based approach, structural competency, and cultural humility.

Continued: Intensive Community Health Worker (CHW) Training

CHWs continue to have regular support and mentoring from CN social workers and nurse. The entire CN team, including CHWs, social workers, nurses, physicians and support staff meet for a half day weekly for ongoing training, to discuss cases, to share resources and build relationships with outside organizations, and to give space for self-care and mutual aid.

CHCN CN social workers and nurses also accompany CHWs in the field to provide home, hospital and community visits. A CHCN CN social worker meets with the CHW and the home clinic's identified interdisciplinary team to discuss cases on a weekly basis. CHCN CN social workers and nurses provide as-needed basis for consultation and also provide feedback on documentation.

Care Neighborhood Technology

CHCN leveraged many unique data streams to create this innovative program. When in pilot phase, CN used an Excel front-end, SQL back-end workbook to pull together multiple streams of information. At present, CN uses a cloud-based tool called Welkin as the program's case management platform. Data is pulled from NextGen (the health center electronic record) as well as from claims and real time inpatient authorization and RN notes, and presented to the CHWs in Welkin.

In Welkin, CHWs record their notes, care plan goals and assessments and track their progress with patients in CN. In addition, CHWs can review a patient's record with the short summary of the patient information in Welkin. The short summary includes the number of PCP visits, hospital visits, ER visits, and risk score for the patient.

In addition, CN uses Tableau, a data visualization program, to present CN information. Tableau pulls data from Welkin and demonstrates the growth of CN over time, the number and type of social determinant goals CHWs have created with patients, as well as the current case load per CHW. This enables CN to compare performance across multiple clinic sites and helps maintain fidelity to the model.

Successes

An initial pilot program for CN showed very promising results. The data from 2016 shows 43% fewer inpatient admissions, 21% fewer ER visits and an increase in specialty and primary care visits. This is based on 41 patients enrolled in CN for seven months, compared to a control of 80 matched members with pre and post enrollment comparison.

Initial pilots have shown improvement across several measures with positive feedback from providers and members

	Control	Care Neighborhood	Change from expected utilization without treatment
Inpatient Admission	+2%	-41%	43% less utilization
ER visits	-20%	-41%	21% fewer ER visits
Specialty Visits	-17%	+11%	28% more specialty visits
PCP appts.	-34%	-2%	32% more PCP visits

"My experience with Care Neighborhood has been very impressive. My case manager empowered me to take on a more active role in my rehabilitation. She allowed me to realize the importance of taking charge of my own health, while at the same time, offering guidance in avenues where I may need some extra support."

- Care Neighborhood Member

"Having more staff besides medical providers serving our members has been helpful. We appreciate support from others. Members appreciate the attention they receive."

- Provider, LifeLong Medical Care

Control = 80 propensity score matched members
N = 41 members enrolled in Care Neighborhood at least 7 months
Pre = 1-180 days before enrollment; Post = 31-210 days after enrollment

6

Continued: Successes

In the most recent analysis completed by CHCN's data team on the total cost of care for CN members with Alameda Alliance for Health there was a very significant decrease in plan spending. The analysis demonstrates that with the CN intervention, there is a savings of $688.90 Per Member Per Month (PMPM). Moreover, this indicates a savings of $8,266.80 Per Member Per Year (PMPY).

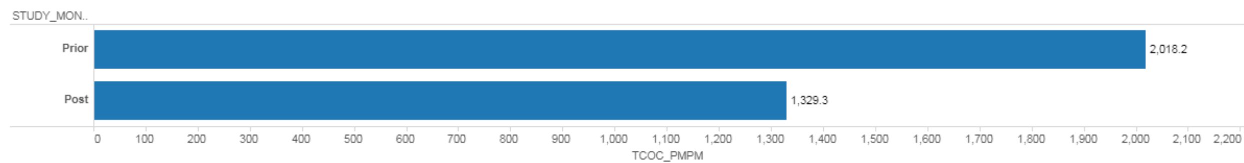
Care Neighborhood (CN) Program Evaluation
Compare the Total Cost of Care Prior and Post Enrollment
AA Members Enrolled in CN Program by 2017-09-30

Considering the Total Cost of Care File having 4-Month Lag, the Latest Enrollment Date Included in Evaluation + Study Month shall be 4-Month Prior to the Current Month (Please Check D_DataAvailability for Available TCOC Data)

Data Source: Welkin_Demographics_V, AA_TCOC_V, xc_Cap_MM_Hist_Vs
Author: Xiao Chen

Latest Enrollment Date Included in Evaluation: 2017-09-30
STUDY_MONTH: 5
CLINIC: (All)

Total Cost of Care Per Member Per Month, All Active and Complete Enrollee, Compare 5 Months Prior and Post Enrollment, All Clinic
Data Update: 10/16/2018 9:00:09 AM



Methodology for Program Evaluation: Total Cost of Care

- Total cost of care data for **ALL health centers** involved with CN.
- Data for Alameda Alliance for Health members only
- 5 months pre and 5 months post
- Members enrolled in CN by September 30, 2017
- Total number of members represented in this analysis: 577 members

Care Neighborhood (CN) Program Evaluation
AA Members Enrolled in CN Program by 2017-09-30
Member Detail

Considering the Total Cost of Care File having 4-Month Lag, the Latest Enrollment Date Included in Evaluation + Study Month shall be 4-Month Prior to the Current Month

Data Source: Welkin_Demographics_V, AA_TCOC_V, xc_Cap_MM_Hist_Vs
Author: Xiao Chen

Latest Enrollment Date Included in Evaluation: 2017-09-30
STUDY_MONTH: 5
CLINIC: (All)

Total Cost of Care Per Member Per Month, By Program Phase
Compare 5 Months Prior and Post Enrollment, All Clinic
Data Update Time: 10/16/2018 9:00:09 AM

	Active (<4 goals)		Active Full (>= 4 goals)		Completed (< 4 goals)		Completed Full (>= 4 goals)	
	Prior	Post	Prior	Post	Prior	Post	Prior	Post
MEMBER	4	5	7	7	421	426	145	147
Member Month	20	24	35	35	2,049	2,085	687	717
TCOC_PMPM	446	223	117	828	1,545	1,183	3,573	1,817

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COMMUNITY HEALTH CENTER NETWORK

In the comparison analysis of utilization costs for CN members prior and post CN enrollment, CHCN's data team found that CN members experienced a PMPM reduction in Fee-For-Service (FFS) Cost, IP admissions and bed days, ER visits, and specialist visits and a PMPM increase in PCP visits after CN enrollment. This report indicates that after enrolling in CN, members' overall utilization costs decreased while their use of primary care services increased.

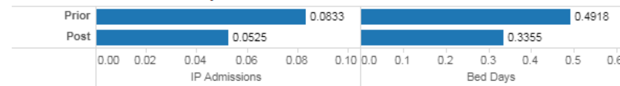
Care Neighborhood (CN) Program Evaluation
Compare the Utilization Prior and Post Enrollment
All CHCN Members Enrolled in CN Program by 2017-09-30
Considering the Medical Claim File having 2-Month Lag, the Latest Enrollment Date Included in Evaluation + Study Month shall be 2-Month Prior to the Current Month (Please Check D_DataAvailability for Available Utilization Data)
Data Source: Welkin_Demographics_V, xc_IP_Visit_Since2013, xc_ER_Visit_Since2013, xc_EM_Visit_Since2013, xc_Cap_MM_Hist_Vs
Author: Xiao Chen
Note: Current Program Phase is used, Historic Line of Business is used

Latest Enrollment Date Included in Evaluation: 2017-09-30
# of Months Prior & Post Evaluated: 5
CLINIC: (All)
HP: (All)

All Active and Complete Enrollee, Compare 5 Months Prior and Post Enrollment, Clinic: All, Health Plan: All

CHCN FFS Cost PMPM
Data Update: 10/16/2018 9:05:43 AM

IP Admissions and Bed Days PMPM



ER Visits PMPM

SP Visits PMPM

PCP Visits PMPM

Methodology for Program Evaluation: Utilization Prior and Post Enrollment

- Total cost of care data for **ALL health centers** involved with CN.
- Data for Alameda Alliance for Health and Anthem Blue Cross members.
- 5 months pre and 5 months post
- Members enrolled in CN by September 30, 2017.
- Total number of members represented in this analysis: 732 members

Challenges

CN is addressing ongoing challenges:

- CN is in the process of pivoting to a more sustainable funding with program like Health Homes (Section 2703 of the ACA).
- CN support the CHWs but it has been a challenge to retain them. Community health work can be daunting and emotionally exhausting, so it is important to prevent and address CHW burnout and to ensure that CHWs feel supported and appreciated to continue their everyday work.
- CN seeks smoother transitions between former and new CHW at a single site: When one CHW leaves a clinic and another fills the position two months later, existing patient relationships are left in limbo.
- Support and bandwidth from clinics: While CN has received growing support from our health centers, it can be a challenge to establish a CHW at a new site. Staff may have busy schedules and cannot to be a part of the CN Interdisciplinary Team to support the CHW.

In 2018, CN will expand from 12 to 20 CHWs with health plan financial support. With this major expansion underway, training must remain effective and comprehensive such that CN can ensure that each CHW is consistently trained and has steady support from the CHCN team and their home clinic. CN plans for sustainability as it grows by reflecting on these questions:

- How does CN prevent CHW burnout and keep up CHW morale?
- How does CN educate and advocate with clinic staff in our new expansion sites to create positive and collaborative work environments?
- How does CN maintain its ROI and assure continuous funding?

Addressing Challenges

During summer 2018, CN had several CHW transitions and turnovers. Experienced CHWs moved on to graduate schools and expansion sites became established with clinic interdisciplinary teams and new CHW hires. It was an excellent time to (1) review and update existing current CN documents/workflows, (2) consolidate training of CHWs who have been in program longest, (3) empower seasoned CHWs to train new CHWs, and (4) outreach to clinic teams once again to increase awareness and understanding of CN and its eligibility criteria for all staff.

Notes

1) Alameda Health Consortium. Available at: https://www.alamedahealthconsortium.org/about/history/. Accessed May 11, 2018

2) National Association of Community Health Centers. Available at: http://www.nachc.org/about-our-health-centers/. Accessed May 11, 2018

3) Alfero C, Kaufman A, Medina C, et al. (2017) Diffusion of Community Health Workers Within Medicaid Managed Care: A Strategy to Address Social Determinants of Health. Health Affairs Blog. Available at: https://www.healthaffairs.org/do/10.1377/hblog20170725.061194/full/ . Accessed May 11, 2018

4) Beyers M, Brown J, Cho S, et al. Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County. Oakland, Calif: Alameda County Public Health Department; 2008. Available at: http://www.acpd.org/AXBYCZ/Admin/DataReports/00_2008_full_report.pdf. Accessed May 11, 2018

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