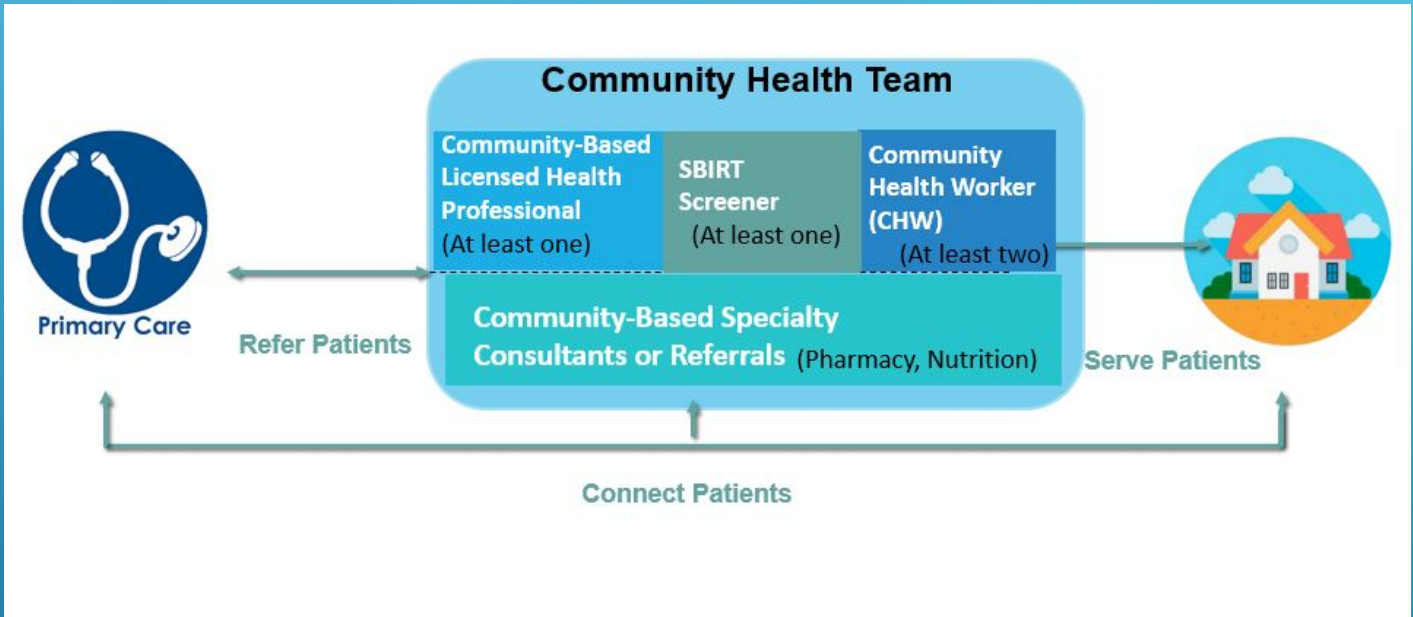
COMMUNITY HEALTH TEAMS OVERVIEW

Care Transformation Collaborative of RI

Linda Cabral

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

COMMUNITY HEALTH TEAM STRUCTURE



- CHT CHW & BH clinicians outreach to high risk patients referred by Primary Care; they assess and address social and behavioral health needs of patients

COMMUNITY HEALTH TEAM MODEL- AN EXTENSION OF PRIMARY CARE

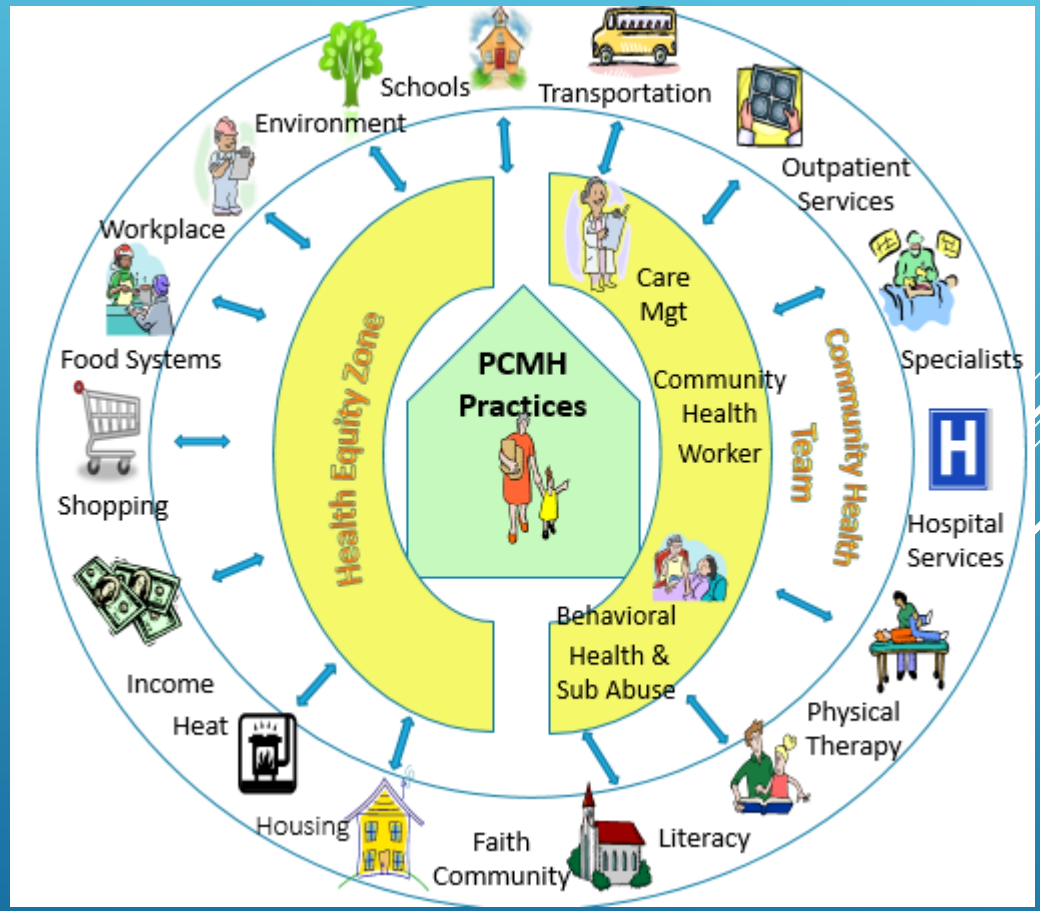
- Use care management process to address
  - Physical health needs

    Help accessing PCP, specialists, tests, treatments, medications
  - Behavioral health/SUD needs

    Short term counseling by CHT and referral to external counseling
  - Health education needs

    Medication management, nutrition, use of the health care system, appointment preparation
  - Social determinants of health needs

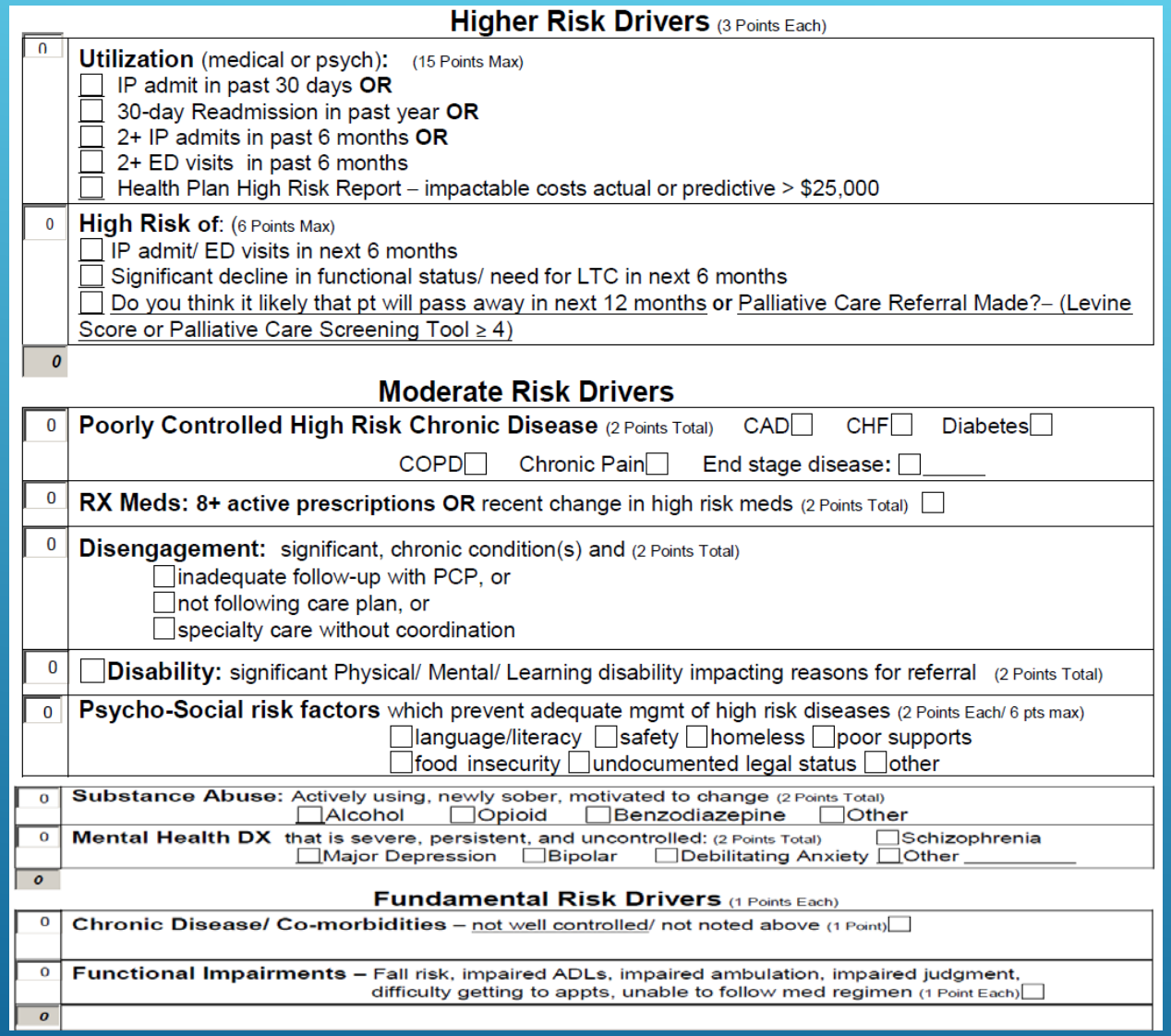
    Help accessing: safe, affordable housing; home medical equipment; food and food banks; transportation; and completing paperwork for entitlements applications



COMMUNITY HEALTH TEAMS ADDRESS HEALTH AND SDOH NEEDS

Traditionally focused at-risk adults who meet the following criteria:

- 18+ years of age
- poorly controlled high-risk, chronic conditions
- 2+ special healthcare needs (8+ medications, functional impairments)
- substance use disorder and at least one other co-morbid physical or behavioral health condition
- irregular access primary care (tx disengagement)
- 2+ inpatient or ED visits w/in 6 months
- unmet behavioral health or psycho-social needs



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)

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

COMMUNITY HEALTH TEAM REFERRAL TRIAGE TOOL

Mechanisms by which PCPs identify appropriate referrals to CHTs

Eligibility Determination for CHT:

>15 = High Risk (offer CHT to patient)

8-14= Rising Risk (patient may meet criteria for CHT)

<8 = Discuss referral with CHT before offering to patient

CARE COORDINATION AND MONTHLY CASE REVIEWS

The Community Health Team will collaborate with referring practices to ensure coordination of care for clients. The Community Health Team will participate in **monthly on-site case review meetings** with referring primary care practice nurse care managers (and other clinicians as needed).

STATEWIDE COMMUNITY HEALTH TEAM NETWORK- **ENHANCED MODEL**

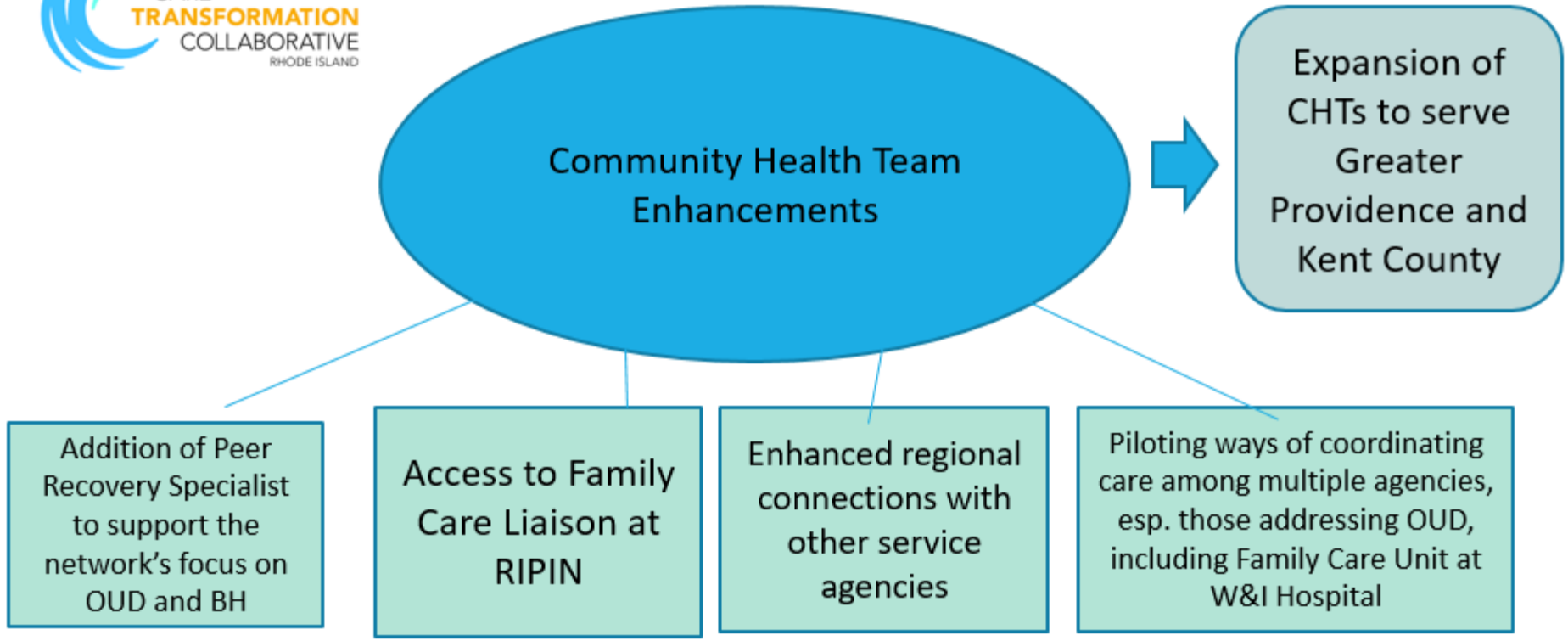
Enhance current statewide Community Health Team (CHT) network serving high risk adults by bringing an "integrated family health" approach to best serving individuals and families who are "high" or "rising" health risk due to significant social and/or behavioral health needs.

- Expand geographic reach and clients served
- Serve families affected by substance use (target those who do not meet requirements for services from Family Home Visiting or other existing programs)
- Add new level of coordination to ensure seamless hand offs to best serving team for specialized support (Family Home Visiting, etc. as needed)
- Tailor existing CHT services/configuration to meet needs of added target populations

RELATIONSHIPS AND RESOURCES

- Primary Care Practices and Accountable Entities/ Systems of Care
- PCMH-Kids
- Women and Infant's Family Care Unit
- OB-GYN Providers/Practices
- MAT Programs
- DCYF - FCCPs
- RIDOH Programs - Family Home Visiting programs & MOMS-PRN
- Medicaid

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND



GOAL: Develop and implement a patient-centered, comprehensive, aligned, value based, sustainably funded program to support a multi-payer, statewide CHT network. Through an "integrated family health" approach, work with existing resources, individuals (adults/children) and families who are "high" or "rising" health risk due to significant social and/or behavioral health needs. Use braided funding from HSTP, SOR, SBIRT and CTC multi-payer contributions to expand the geographic reach of the existing CHT's to cover a larger geographic area, strengthen connections with Medicaid Accountable Entities, add recovery coaches to the team to better serve the needs of individuals and families, and; develop stronger relationships with pre-natal providers, hospitals, home visiting services and pediatric referral systems. Utilize CTC-RI as a central, coordinating body in this work.

CURRENT: CHT RELATIONSHIPS AND REACH

- Geographically based Teams
  - 32 practices across the state have referring relationships with Community Health Teams
  - 326 providers across all partnering practices have referring relationships with Community Health Teams
  - Approximately 1500 adult patients are served by CTC-RI Community Health Teams each quarter

CURRENT COMMUNITY HEALTH TEAMS

Team serving Washington County; serving multiple practices in the region; expanding to Kent County 10/1/19

South County Health

1 team serving Pawtucket/Central Falls; serving BVCHC and other practices in the region

Blackstone Valley Community Health Care

Using funding for 1 team to support 2 teams - W. Warwick and Woonsocket; primarily serving their own patients

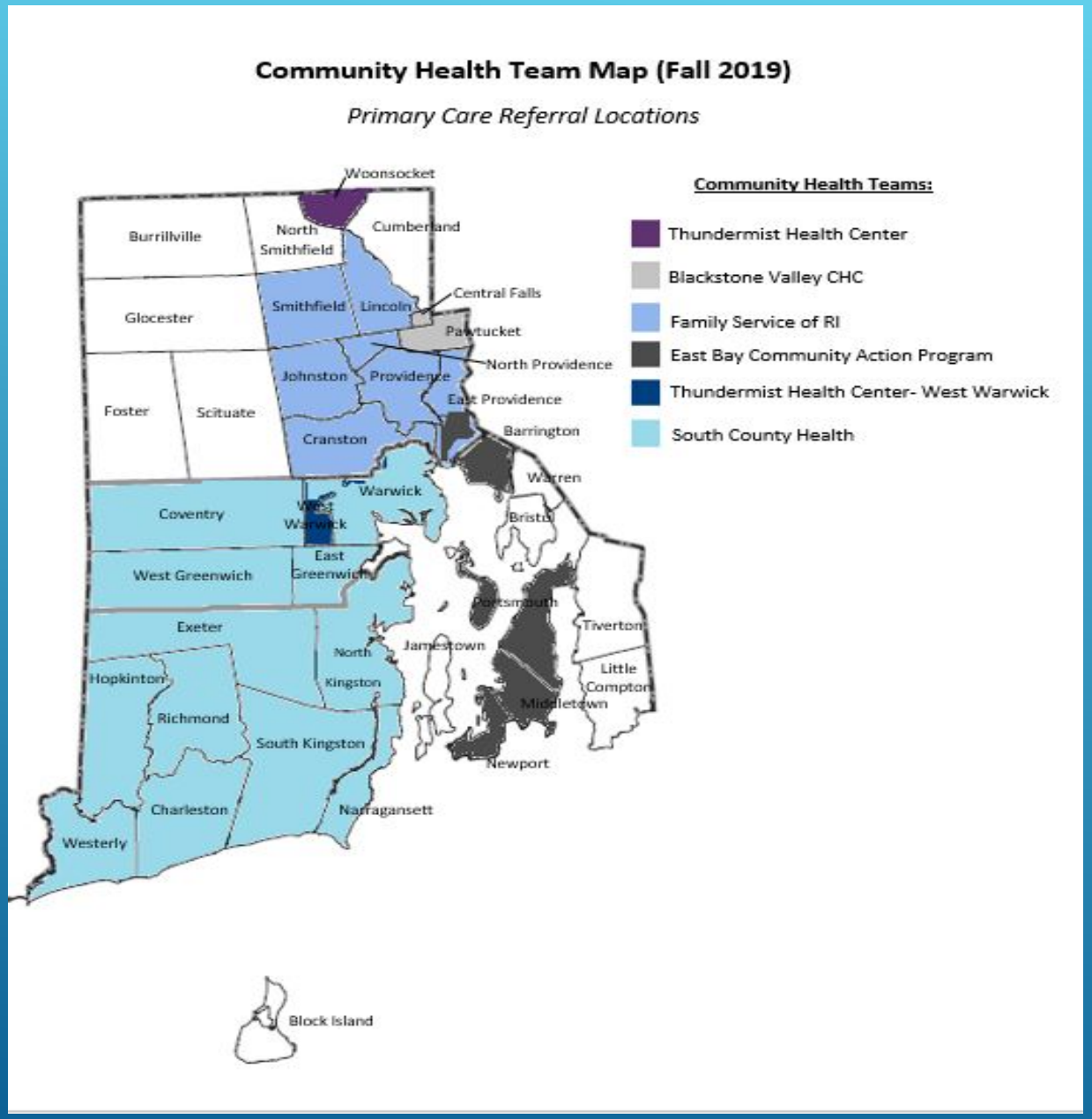
Thundermist Health Center

Expanded to two teams to serve Greater Providence region; serving multiple practices

FSRI Family Service of Rhode Island
healthy families · strong communities

1 team serving primarily internal clients in Newport and a small number in East Providence

east bay community action program



COMMUNITY HEALTH TEAM MAP- FALL 2019

- Expanded to 7 geographic, place based teams in 5 serve more patients in Greater Providence and Kent County
- Teams include CHWs, BH providers, and Peer Recovery Specialist
- RIPIN Family Care Liaison partner to meet family needs
- Multiple funding sources
- Centralized network and data management team supporting all CHTs

COMMUNITY HEALTH TEAMS SERVE A DIVERSE POPULATION

Age	M = 54 years (sd = 17)
Non-English Speaking	21%
White, Nonhispanic	60%
Hispanic/Latinx	26%
Black/African American, Nonhispanic	8%
Other	6%

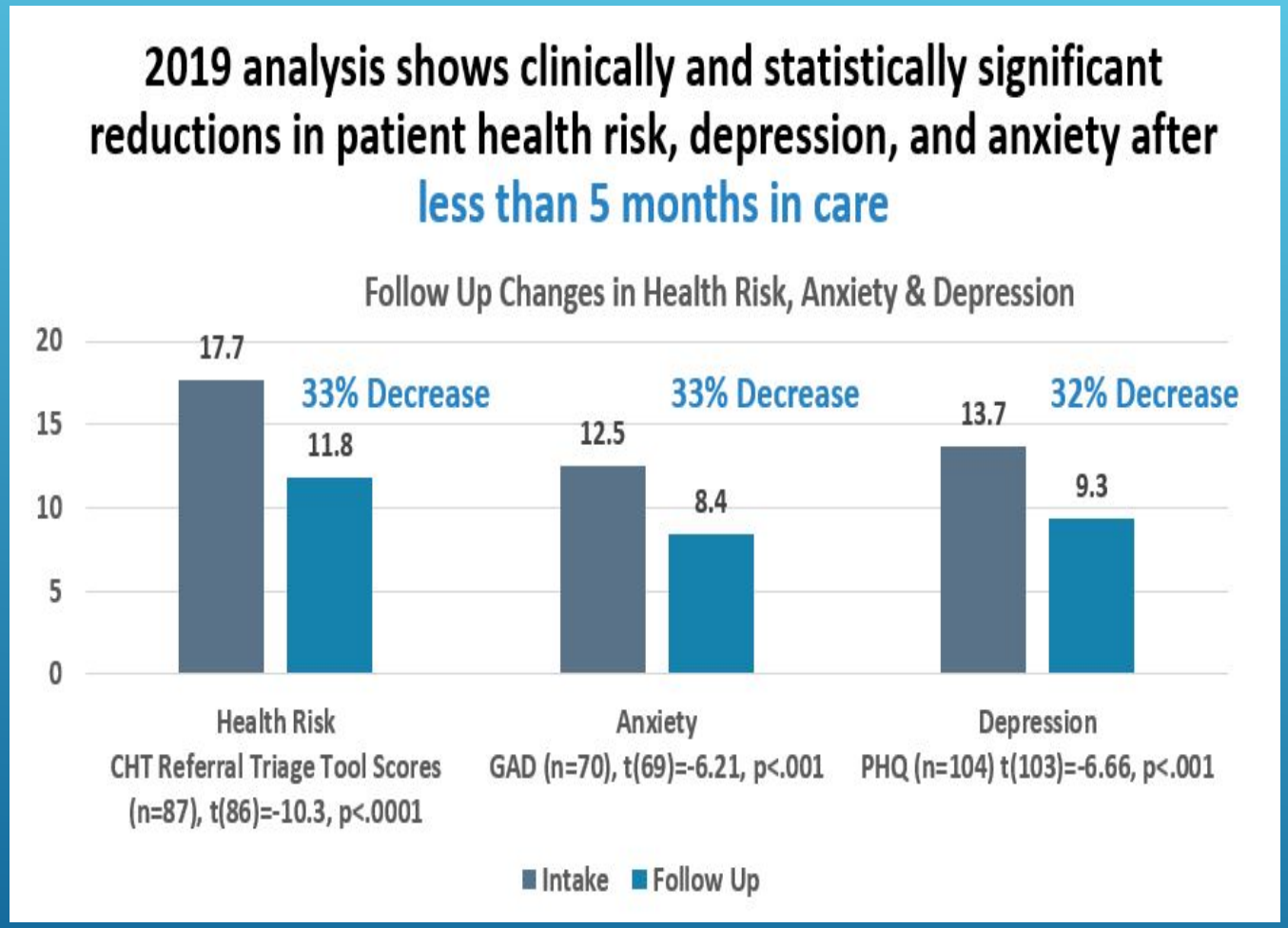
INSURANCE COVERAGE ON CLIENTS SERVED 7/1/18-6/30/19

	# of Patients Served	Percent
Commercial		**15%**
Blue Cross	159	5%
United	16	1%
Tufts	8	0%
NHP	17	1%
Other	249	8%
Medicare		**16%**
Blue Cross	77	3%
United	62	2%
FFS	310	11%
Medicaid		**63%**
NHP Medicaid /Dual Eligible	1187	40%
United	518	18%
Tufts	47	2%
FFS	115	4%
Other		
No Insurance	187	**6%**

COMMUNITY HEALTH TEAMS ARE SERVING INDIVIDUALS WITH MULTIPLE SDOHS AND ARE ABLE TO ADDRESS THEIR NEEDS

	% reporting issue at intake	% no longer reporting issue at follow-up
Housing	**41.4%**	56.7%
Finance/ Utilities	**39.0%**	66.7%
Food Insecurity	**32.9%**	63.5%
Transportation	**31.0%**	44.9%
Caregiver Support	**22.2%**	50.0%
Interpersonal Violence	**19.3%**	71.4%

REDUCTIONS IN RISK SCORES



QUESTIONS?

COMMUNITY HEALTH TEAMS SERVING YOUR PRACTICE'S AREA

Practice Name	Address	Community Health Team
Blackstone Valley Community Health Care	39 East Ave, Pawtucket	Blackstone Valley Community Health Center
Brown Medicine Primary Care - Warwick	43 Jefferson Blvd, Warwick	South County Health
CharterCare Medical Associates	6 Blackstone Valley Place, Lincoln	Family Service of RI
PCHC - Central	239 Cranston St, Providence	Family Service of RI
PCHC - Crossroads	160 Broad Street, Providence	Family Service of RI
PCHC – Randall Sq	One Randall Square, Providence	Family Service of RI
Tri-County	33 Maple Avenue, North Providence	Family Service of RI
Women's Medicine Collaborative Primary Care	146 West River Street, Providence	Family Service of RI