Lessons Learned from Integrating CHW's into Primary Care Medical Homes

Nicole Kowalski, Manager-Health Access, St. Vincent Health

Jane Clawson, Health Access Worker, St. Vincent Health: Williamsport

Indiana Primary Care Symposium

Enhancing Care with Community Health Workers

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9:00 – 4:30

Indiana Government Center South

402 West Washington

Indianapolis, IN

RUAH
Rural and Urban Access to Health

Purpose:

To connect our friends, family, and neighbors to a comprehensive, integrated delivery network of health, human and social services resulting in improved access and removal of barriers to needed resources.

Meaning and Mission:

The word R*uah*, in Yiddish

means **"Breath of Life."**

The Goal?

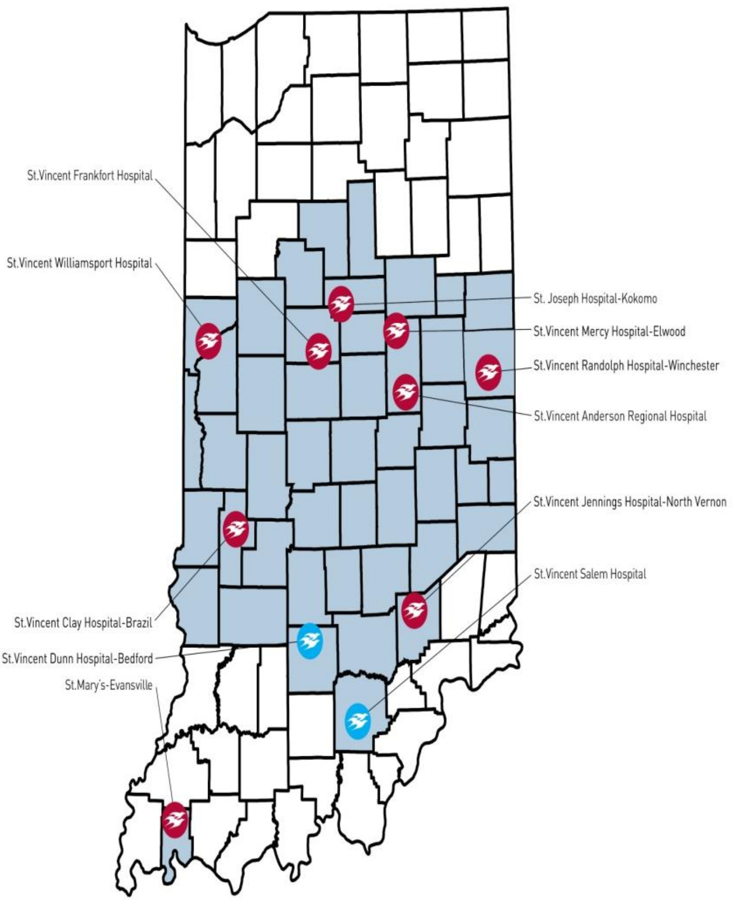
…to breathe new life into a

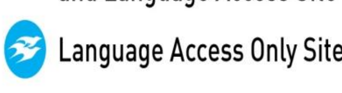
health care system that will we serve our most vulnerable community members compassionately, with quality and efficiency

RUAH "from the start" (a little history)

- RUAH Partnership initiated: 2000
  - SV Health
  - Indiana Health Centers, Inc.
  - Health and Hospital Corporation of Marion County
  - ADVANTAGE Health Plans, Inc.
  - Butler College of Pharmacy, later added
  - Community Interface Groups: local partner groups responsible for program implementation.
- Funded by HRSA, Ascension Health from 2001-2005
- Additional private funding through the Anthem Foundation: establish 3 additional sites
- Sustained through local hospital funding and captured reimbursement through enrollment efforts

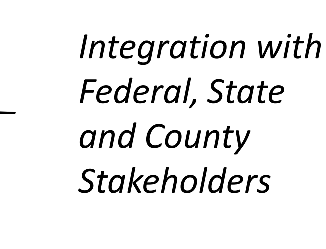
RUAH Access Sites





Program Outcomes

- Four community programs expand to Eight community programs
- 2013: Managed Medicaid Funded HAW: SVMG office
- Outcome Focused: Pathway Model Integration
  - 6 Pathways implemented
  - Data reporting effective 9/11
  - Used to count what we did "to/for" clients vs. outcomes!
- AHRQ Innovation Site
- Community Care Coordination Learning Network Site
- National Institute of Health Research Partner
- Indiana CHIPRA grantee



- $45.5 million worth of low/no cost drugs provided
- Language Access
  - 1396 interpreters trained through Bridging the Gap
  - 1127 documents translated

How RUAH addresses ACCESS

- **Health Access Workers**
  - client advocates & “system navigators”
- **Pharmacy** – access to low or no cost drugs through Medication Access Workers (MAC’s) (RXASSIST+; Dispensary of Hope; Vouchers ;etc.)
- Creation of **“Medical Homes”** for the underserved
- Reduction of inappropriate **Emergency Room utilization**
- Access to **Specialty Care** for the underserved
- **Program enrollment** (financial resource review and application assistance)
- Assistance with **supportive social services** (“wrap around”)
- **Outcome Based Measurement** Work
  - Pathway Model
  - Community “Hub”
- **Diversity** – translation of core documents, medical interpretation, key signage, development of health equity teams, LEP Assessment

Medical Home Pathway

Initiation Step

Any client and/or caregiver determined not to have medical home. (on-going primary care services by a provider or clinic)

↓

Educate client and/or caregiver about the importance of a medical home and keeping appointments.

↓

Determine payment source.

↓

Identify and eliminate barriers to obtaining a medical home.

↓

Appointment scheduled with primary medical provider or clinic.

↓

Completion Step

Verify with medical home that appointment was kept.
Document in client's record.

____
Community Worker

_______________________ _____________________________ ___________
Client Name **Date of Birth** **SSN**

Medical Home Pathway

Any client and/or caregiver determined not to have a medical home.
(on-going primary care services by a provider or clinic)

____
Date initiated

↓

Educate client and/or caregiver about the importance of a medical home and keeping appointments.

Materials Given:

- ☐ Provider Contact Information ________________________________
- ☐ Other ____

____
Education Date

↓

Payment Source

- ☐ Hoosier Healthwise (SCHIP)
- ☐ Private Insurance
- ☐ HIP
- ☐ Self-Pay
- ☐ Medicare
- ☐ Dually Eligible Medicare/Medicaid
- ☐ Other Public Assistance

↓

Identify and eliminate barriers to obtaining a medical home.

____
Barrier(s) Code

↓

Appointment

___________ _______________ ______________
Date Time Provider

↓

Completion Step

Verify with medical home that appointment was kept.

____________________________ ___________________________
Date of Verification Method of Verification

Finished
Incomplete
☐

Medical Home Pathway Education Checklist

□ Provide patient with overview of primary care:

- Primary care focuses on the person as a whole, while specialty care focuses on specific diseases, conditions, or organ systems
- Primary care is the “entry point” or “portal” to the health care system
- Primary care providers provide ongoing care and coordinate various services including: wellness and preventive care, diagnosis, treatment, referral, monitoring, and follow-up

□ Discuss with the patient/family the importance of establishing a medical home as a regular source of primary care:

- To ensure that your health can be checked regularly and to catch problems early on
- To prevent sickness, manage chronic illnesses, and reduce the need for avoidable costlier care such as Emergency Department visits or hospitalizations
- For referrals to a specialist if you have a more serious or unusual medical problem.

□ If patient is uninsured and may qualify for a public health insurance program, open an Enrollment Pathway and assist with the application and enrollment process.

□ If patient is uninsured, explain financial assistance application process:

- You will help patient apply for financial assistance, by helping patient fill out application, gathering needed documents, and submitting all materials to Revenue Cycle
- You will provide advocacy and support as needed throughout this process

Medical Home Pathway Education Checklist

□ Scheduling

- Explain to patient that you will be helping to schedule their first appointment and following up to make sure appointment was kept.
- Encourage patient to be on time and keep appointment

□ Communication

- Encourage patient to communicate with their provider using the Ask Me 3™[1] model:
  1. What is my main problem?
  2. What do I need to do?
  3. Why is it important for me to do this?

□ Teach back: Explain to patient that you'd like to check to make sure he/she understands next steps by asking a few questions. Then ask patient: Can you tell me what doctor I'm referring you to? How will patient access the service (location, appointment time, contact person, if appropriate)? What are the next steps at this point in the referral process? What questions should patient ask his/her provider? Why is it important to have a regular source of primary care?

1. Ask Me 3™ is a registered trademark licensed to the National Patient Safety Foundation.

Medical Home: Then and Now

- Initially:
  - Finding a provider to see the patient
  - Make appointments
  - Verify appointment
- Work-in-Progress:
  - Work with Primary Care Team to make sure the patient is seen by the Provider
  - Supportive Services are identified and becomes part of the plan of care to address basic health and social needs.

The Primary Care Medical Home Model

The Agency for Healthcare Research and Quality (AHRQ) defines a medical home ***not simply as a place*** *but as a model of the organization of primary care that delivers the core functions of primary health care.*

Comprehensive Care

Patient-Centered

Coordinated Care

Accessible Services

Quality and Safety

The Cultural Shift

Hospital and Provider Team Member Role

The Emergency Room at St. Vincent Williamsport contacts Jane for individuals who do not have a Primary Doctor (Medical Home), needs assistance with obtaining prescribed medications, or have other social service needs.

Community Integration

As part of her job with RUAH, Jane visits other Social Service Agencies, Family and Social Services Offices, Drug Stores, physician's offices, schools, health departments, Senior Centers, county fairs, health fairs on a regular basis to insure all organizations have her contact information and are aware of the services she can provide.

Scope of Work

As Health Access and Medication Access worker, a comprehensive assessment is completed on each referral Jane receives from the hospital, medical offices, community, businesses, and other social service agencies. This assessment allows Jane to obtain patient information, # in household, income, general health needs, medical history, current medications, risk factors and psychosocial information. The five Pathways are the focus for client interaction.

The Cultural Shift

Site of Service

Jane is located within the clinics for St. Vincent Williamsport Hospital. The ability to meet individuals in the community, in their home or at their medical facility allows flexibility for the individuals we serve.

Communication and Information Sharing Structure

Communication is a key component for all Health Access and Medication Access Workers with the medical providers as well as the individuals we serve. Physicians come to Jane throughout the day and have my contact information at all times.

Stakeholder Focus

The goal of each RUAH staff member is to insure comprehensive, integrated delivery of health, human and social services that result in improved access and removal of barriers to services that are needed.

Accountability Structure

Each RUAH worker enters all information into a system called E-CAP. This system allows us to enter Pathways (there are currently five); barriers and the success or non success of each Pathway. RX Assist Plus is used for the medication worker to enter all Prescription Assistance documentation.

Stories from the field

- *“In June of this year I had the pleasure of meeting and working with a 41 year old who had no primary care physician and informed me she was an insulin dependent diabetic who was without insulin. I was able to get her into a clinic the same day we met and the clinic made sure this individual had insulin until her prescription assistance medication could arrive at the clinic. Programs were applied for since this person had no insurance.”*

- *“For the past few years I have worked with an individual who is self employed and has been denied Medicaid, Social Security Disability as well as private insurance due to a medical condition. Recently this individual became ill with a serious infection in the right foot. We were able to find a specialist to work with this individual at a reduced cost and the foot was saved and the infection is now gone. This individual relies on Prescription Assistance for the most expensive medications and can see a physician on regular basis with the help of a financial program.”*

Lessons Learned

- Finding a Medical Home for a patient offers new opportunities for monitoring the basic unmet needs and linking the patient to community services.
- RUAH Health Access Workers have found that through the years, you must always be an attentive listener and be willing to meet an individual without any preconceived plans.
- Most importantly always be an advocate for those you serve.

Questions?

Contact Information

Nicole Kowalski

nkowalsk@stvincent.org

317-583-3218

Jane Clawson

jlclawso@stvincent.org

765-585-4483