Good morning, everyone. The call will begin promptly at 11:00. These slides are available on the event page. If you have not downloaded those, the link is available on your screen. We will mute phone lines after the call has started.

Good morning everyone thank you for joining us. My name is Kate Crump with the New England QIN QIO and I will be your moderator. This webinar is “Enhancing Transitions Through a Collaborative Approach: Supporting Individuals Behavior Health Conditions Using Multidisciplinary Care Management Within the Community.” I will now mute the lines.

A few housekeeping items before we begin: This call will be recorded for training purposes. The presentation, recording and transcript will be posted on our event page. All lines have been placed on mute and they will remain on mute for the duration of the presentation. Please use your manual mute for precaution, but please do not place your line on hold. Lastly, although these lines will be muted, we would like you to actively participate during the session by using the chat function. Make sure to send questions to all participants so the group can benefit from shared knowledge. My colleagues will be monitoring the chat window. Don’t be shy we would love to hear your thoughts about what our speakers are saying. To introduce the speakers, I will turn it over to my colleague, Stephanie Baker.

Good morning, everyone I am the senior program coordinator for Massachusetts. I am involved in the care transitions work for the New England quality innovation network, quality improvement organization. I would like to thank you for joining us today’s webinar entitled “Enhancing Transitions Through a Collaborative Approach.” As Kate said we would like you to be as active as possible so please feel free to chime in any questions you have. It is important to note that today’s speakers have no conflicts of interest to disclose. Our speakers today include program leaders from two Massachusetts healthcare centers, using a collaborative approach to enhance transitions of care for their behavioral health populations. Both programs are supported by funding from the Massachusetts health policy commission, healthcare innovation investment program as a targeted cost initiative.

The healthcare innovation investment program is a unique opportunity for Massachusetts providers, health plans, and partners to implement innovative models that deliver better health and better care at lower cost. Chapter 224 of the Acts of 2012, the state’s landmark cost containment law, established this competitive investment program to support health care innovation and transformation. The first phase of the health investment program was launched in the summer of 2017 through 20 competitively selected awardees across Massachusetts. Awards are divided among three pathways, Targeted Cost Challenge Investment Program, Telemedicine Pilots (two of which we highlighted on a webinar September 21st), and the Mother and Infant Focused Neonatal Abstinence Syndrome Interventions.

Today we will be hearing from two programs with a targeted cost challenge investment program. The goal is to support innovative delivery and payment models poised to be taken to scale and make meaningful impacts on the healthcare costs growth benchmarked in the years to come. Eligible applicants and their partners proposed initiatives that will reduce the cost of care to the health care system while improving quality and access in eight priority areas of high spending.
Our learning objectives for this program are to describe the impact of behavioral health on health care utilization in New England, to explore approaches to addressing health related social needs for patients with behavioral health conditions, and to identify required elements for a successful behavioral health integration and coordination model.

As Kate mentioned earlier, we want you to use the chat feature so we can hear from you. Please chat in with questions and comments on the presentation, and initiatives and experiences, as well as what you might need assistance with. Let’s start by testing this out by seeing who is on the call. Please list your name, organization and the state you are calling in from.

Our speakers today, I will start with Hannah. Hannah Scott, left a career in investment banking to pursue nursing in 2010. Since then, she’s focused her career on the intersection of physical health, behavioral health, and the social determinants of health. Her previous positions include Director of Nursing for the Walden Street School and Director of Care Integration at the Brookline Center for Community Mental Health. Hannah holds bachelor’s degrees in Mathematics, English, and Nursing. She is expected to be awarded her Masters of Nursing with a concentration in family mental health in May of 2018. Dr. Henry White is the clinical Director for Brooklyn community Mental Health Center. He has a particular interest an interface between behavioral healthcare and other community systems. As an innovator and thought leader in behavioral health integration in Massachusetts, Dr. White developed and launched the healthy lives program, an integrated approach to patients at the highest level of complexity and cost. Other current projects include the award-winning school-based model, BRYT that helps students transition back to school after a mental health crisis. Under his leadership, this program has been replicated in 80 Massachusetts high schools. He is author of many papers on community mental health services. And Emily Johnson. Emily is the Director of Community Outreach at Lynn community Health Center, where she supervises a growing team of community health workers and case managers. Prior to her current role, Emily was a clinical supervisor with Eliot Community human services’ Lynn community base flexible support program. In 2015, Emily received the excellence in community health award from Lynn Community Health Center, and in 2016 she received the outstanding CHW supervisor award from the Massachusetts Association of community health workers. Emily graduated cum laude from Salem State University in May 2006, with a bachelor’s degree in social work and holds a current license in social work in Massachusetts.

To help get us started, I would like to share some behavioral information. Up to 20% of Americans have a mental health condition but only 44% of those individuals receive treatment. A brief by the Agency for Healthcare Research and Quality, highlighting trends in the emergency department visits that involve mental and substance use disorders has detailed the sharp increase in emergency department utilization, nationally, from 2006 to 2013, by people experiencing a serious mental illness or other behavioral health condition. This graph shows the number of emergency department visits per 100,000 population aged 15 and older, from 2006 to 2013, that involve mental and substance use disorders. Depression, anxiety, or stress reactions increase steadily from 2006-2013. Substance use disorders increased steadily from 2006-2013 and psychosis and bipolar disorder increase steadily from 2006 to 2013.
Behavioral health affects most Americans. Half will meet criteria for mental health disorder and substance abuse, half know someone in recovery from addiction, and one in four Americans will experience a mental illness. Behavioral health increases the risk for and coexists with other diseases such as HIV, AIDS, STDs, diabetes, cardiovascular disease, obesity and hypertension. The more adverse childhood experiences there are, the more health and behavioral health conditions the individual will have in adulthood. Half of adults’ mental illness begins before age 14 and three quarters before age 24.

This is a table showing the top 11 diagnoses for readmission among fee-for-service Medicare beneficiaries in New England. Those individuals with a diagnosis of mood disorders, alcohol-related disorders and schizophrenia and other psychotic disorders are more apt to have a hospital readmission. To break it down into Medicaid, this table is showing among the Medicaid population in the U.S., mood disorders, schizophrenia and other psychotic disorders as well as alcohol-related disorders and substance related disorders are within the top 10 reasons for all cause 30 day readmissions.

This graph from the Substance Abuse and Mental Health Services Administration is highlighting the cost of Medicaid beneficiaries with a diagnosis of a mental illness and substance use disorder compared to the Medicaid beneficiaries without a severe mental health illness. The importance of using a collaborative approach to improve care transitions for the behavioral health population is clear. The data supports the need for successful intervention to improve the quality and safety of these individuals.

We would like to hear from you. Please chat in how you are addressing your patients' behavioral health needs. Now, I would like to turn it over to Hannah Scott and Dr. Henry White to tell us about their community based care coordination project.

Hello this is Henry White. I am the clinical Director of Brookline Community Mental Health Center, I will be telling you today about the healthy lives program with my colleague Hannah Scott, who directs the program. We have had the privilege of working to develop a program for patients with extraordinarily complex problems over the last five years. And through this work we developed a few insights about what is effective in terms of helping to manage these patients. The challenge is this, as Stephanie noted, many patients, particularly the most costly patients, have a combination of behavioral health and medical problems. It turns out when you actually start to work with patients who are the most costly and complex, in addition to those two domains, many of them actually also have serious challenges in getting their needs met, whether through social, environmental or interpersonal issues. So patients we meet really fit in the intersection of these three domains. People with social determinants, medical challenges, and behavioral health problems. This leads to very bad clinical outcomes. These patients tend to die much sooner than their healthier counterparts and of course have huge implications for costs because they are among the 5% of patients who contribute to 50% of medical costs. As we have begun to work with this population, I think what we found, and it really has policy implications, is that there are really three different systems to manage these social determinants. Community-based organizations, the medical care system, and the behavioral health system has its own dimensions as well. In fact, these three systems don't speak to each other. So, they each have their own culture, their own language, their own funding streams. For those patients who indeed have to transact with all three
systems, often times they fall in the gaps between them. Our program is really designed as a way of helping them navigate to the very resources they need among these three systems. Hannah will describe how we do this.

>> I wanted to tell you a little about the intervention we have developed and we will start with the team. We have a team of providers managed by a nurse care manager or licensed social worker that consists of bachelor’s level community health workers. Sometimes we refer to them as case managers. What we want to stress is staffing is key with this model. We always hire providers who are able to understand the medical, behavioral health and social determinants of health going on with these patients and how they intersect. We also hire providers who are able to work with diverse populations that are patient, determined, and able to solve complex problems. One thing we wanted to note is the model is very efficient. One team consists of either one full-time nurse or one full time social worker (or a half-time nurse and half-time social worker) and two full-time community health workers. This one team can serve a caseload of about 50 patients at any one time. The last point we wanted to make is this model is adaptable. We have implemented teams like this in different settings including community-based community health centers. We collate the teams in health centers, with certain primary care practices and currently have a team co-located inside an ACO. The second thing we want to talk about is the approach our team takes. We really like to begin with patients in their home environment. Our goal is to build a comprehensive understanding of the patient's environment including family, friend, agencies and providers. Some key components include home visiting, as I mentioned. We learn a lot during a home visit. Sometimes we are the only providers on the care team that have been with the patient in the home and interacted in the community. The second is community visits. We attend appointments with providers that not only include medical appointments but social service appointments, appointments with DTA or other transportation agencies and we convene and attempt team meetings which can be a patient is inpatient or bringing the outpatient care team together to discuss things going on.

>> The approach includes a desire to address all the needs of the patients. They are not just limited to medical needs and we ask that the patient identify and prioritize their own needs. Some things we do to help engage patients are, one: we like to identify a quick win when we meet a patient, something we can deliver in the first week of service and we always deliver what we promise. Being clear and truthful with patients, making sure when we follow-up we bring with them what we said we would bring. This is in the service of building a comprehensive understanding of the patient. I can’t stress enough this includes not only all providers and what they are doing but also knowing about the patient, how they feel, what are their behaviors, what are their relationships with people and how are their interactions with the services shape their outcomes. The duration of service is about 6 to 12 months depending on patient need. We will talk more about the intervention. Again, we try to form a team around the patient and the goal is the long-term support to address all the needs of the patient. We do this by thinking about health in the five domains listed here. We use these domains to make sure we are asking comprehensive and diverse questions so we can build an understanding of what is going on to address all of their needs. One other thing to note is it is always an ongoing assessment. We always ask what has
come up since the last meeting and address the treatment plan and adapt it as needed as we go. The goal is to build long-term supports such as supporting transitions to more supportive care, like assisted living or skilled nursing or a group home environment, to build an in-home team around patients living in the community which can include VNA, homemaking services. Sometimes, we submit applications to get additional services to people qualified for those agencies. We submit applications for insurance coverage and sometimes transition patients to hospice care.

>> We wanted to talk about an experience of our patient. This is our patient, Susan. She is typical of folks we see although people have very diverse and different needs. Susan’s social determinants that needed addressing were that she lived on a very low fixed income and was in credit card debt and financial strain. She was in danger of being evicted from supportive housing and isolated and had no social supports. She recently had a couple of death in the family which left her quite alone. Her medical concerns included diabetes, obesity, congestive heart failure, and she is a heavy smoker. Prior to meeting her, she had been hospitalized for over a month due to complications of her congestive heart failure. Behavioral health needs included a bipolar one disorder, she is very distrustful of providers, had not been attending appointments, and had poor executive functioning in terms of getting things done, submitting forms, understanding applications, no access to Internet, and unable to carry out any demands placed upon her in terms of those sorts of things. The interventions we targeted were to consolidate her debts, not something normally medical care coordination team would help with, but we were able to help her locate a financial support and help her with applications to consolidate her debt which helped her be able to pay her rent and in addition we were able to collaborate with housing to make a payment plan and secure her housing so she wasn't evicted. We also connected her to service providers like homemaking and elder service agencies. We set her up with meal planning and meal delivery, helped with her diet and diabetes, helped her implement daily weights to help with her congestive heart failure. Helped her attend appointments by bringing her to some appointments and helping facilitate a relationship with her providers and helped providers understand what it meant to have a positive relationship with her.

>> She also attended smoking cessation and cut her smoking in half and for her behavioral health she was part of an integrated care team. We were able to bring her behavioral health providers and home providers and primary care providers into conversation with each other so they could all understand what was going on and how they can support each other. It was really the behavioral health team seeing her most. There was a real focus on relationship building, supporting this patient, so she could maintain relationships with us and her other providers. Lastly, real assistance with concrete tasks. Connecting people with services is complicated, a long process that requires not only determination and dedication, but also a lot of attention to detail and access to resources like e-mail and fax machines.

>> So we will talk about the outcome data. Data we collected from a previous grant. It represents outcomes from about 70 patients. We serve around 300 so far with this intervention. Our current grant cycle, we are seeing a lot of the same trends. There is a decrease in inpatient utilization, a decrease in emergency department utilization, and some positive changes in health outcomes. 86% of patients identified as hypertensive, prior to the intervention, had improved blood pressure. 71% of diabetic
patients had improved A1C with an average change of 2.8%. We also saw decreased no-show appointments. Last we want to talk about cost savings. Cost savings figures are based on inpatient and ED utilization net of cost services. By our calculation based only on inpatient utilization, interventions saved a little over $21,000 per patient, per year.

>> We are very pleased with the good outcomes we have had. What is the context for the work we do? We really see teams using the model we have as focusing on the top of the pyramid. Those patients with most complex and difficult problems. We do see this sits upon a range of other kinds of care coordination, care integration activities for patients with less complicated kinds of issues. For many patients, usual care may be just a single phone call or office intervention. For patients who perhaps have problems in one domain, a resource specialist who can make a call or do outreach may be able to serve populations of up to 1000. Meanwhile, for patients with perhaps problems in two domains can be handled by what is typical care management, mostly telephonic, caseloads of about 100-300 and the healthy lives program those of the most complicated but we have found most people only require this for about eight to 12 months before they can be managed with a less intensive approach. We are confident this can help in multiple settings. Most recently we are working with ACOs that have the less intensive care management so we really serve as a backstop to them for patients who continue to have high utilization despite fairly frequent telephonic contact. We also know it can work in community mental health centers and primary care practices as well. It is really a scalable and adaptable approach.

>> Where we would go from here is seeing there is going to continue to be within the community programs, such as ours, the can focus on patients who indeed are the budget busters and the most impact -- expensive and complex. With the team in place we can bring the three domains together and develop an integrated program for the most challenging and needy patients. Thank you.

>> Thank you very much Hannah and Dr. White. That is a great program you have going on at the Brooklyn community Mental Health Center. Now, we will hear from Emily Johnson on how the Lynn Community Health Center has worked on improving the needs of their patients with the severe mental health illness.

>> Good morning, thank you for having me here. First I want to give you a little background about the Lynn Community Health Center our mission is to provide comprehensive healthcare of the highest quality to everyone in community, regardless of their ability to pay. Lynn Community Health Center is a nonprofit, multicultural Community Health Center. We are recognized as a leader in developing new initiatives that results in high-impact, low-cost healthcare. Lynn Community Health Center was established as a small storefront mental health clinic in 1971, in response to an almost complete lack of mental health services in our community. Since then, as the needs of the community have grown and changed we have evolved to meet them. Today we have more than 650 staff and 150 clinicians who provide primary medical care, dental care, behavioral healthcare, eye care, pharmacy services and social services to more than 40,000 patients at 20 locations. People from all walks of life come through our doors. Our target populations are those that experienced the greatest barriers to care. Children and families, the poor, minorities, non-English-speaking, teens and the frail and elderly. Over 90% of the
health center’s patients live at or below 200% of the federal poverty level and over 50% are best served in languages other than English. For the innovation grant, we are aiming to reduce the patient’s total medical expenses otherwise known as TME. We are targeting a patient population with a diagnosed serious mental illness or SMI, more specifically for those who carry a diagnosis of schizophrenia, bipolar disorder or major depression. This target population experiences 3.5 times higher per member, per year cost resulting from highest rates of home health, emergency department use or ED use, inpatient admission and pharmacy expense. Our Innovations Grant is also working with different partner agencies to achieve our primary aim. Lynn Community Health Center has partnered with Eaton Apothecary for pharmacy services including clinical pharmacy consult, filling of the medications into the proper packaging to be used by the remote medication technology. We have also partnered Partners Connected Health who supported developing or relationship with Philips. Philips developed Spencer the remote medication technology that we will be using within the program. In the development of the program we also partnered with Massachusetts Behavioral Health Partnership for utilization and cost data. As well as Neighborhood Health Plan who developed an intensive care coordination model for individuals with SMI, they lent their expertise to use to support the development of our Innovations Grant program. Our primary aim is to reduce overall TME for our target population by reducing home health utilization, ED visits, inpatient admissions and readmissions as well as pharmacy expenses, which we will accomplish through an Intensive Care Coordination program based on a Community Health Worker model with Remote Medications Monitoring and Clinical Pharmacy Consultation.

Our community health worker will complete a comprehensive assessment. The CHW and patient develop a person centered care plan. The CHW will communicate the care plan with the other team members such as the primary care provider, the behavioral health provider, any other specialty providers or outside resources that the individual may be connected with. Our CHW will provide ongoing care coordination for the individuals they are working with and an are in or registered nurse will complete a medication reconciliation. We will also complete a clinical pharmacy consult to simplify medication origins and remote medication monitoring technology. Should we discover a patient is struggling with taking medications as prescribed, we will then provide as needed interventions to support the patient in being able to take their medications as prescribed.

I would like to provide a case example and this is the case we have worked on within this grant. The patient, Mrs. X a 54 -year-old female who suffers from paranoid type schizophrenia, tobacco use, post-traumatic stress disorder, type two diabetes and heart murmur. Since engagement she has shown great dedication and commitment to improving and maintaining her whole health and wellness. On the initial evaluation the patient cut down her use of tobacco and reported needing assistance with housing as she had recently received an eviction notice. The patient also disclosed that she was not taking her medication properly. During the development of the patient person centered care plan, the patient reported she would only smoke when she had nothing else to do or when she felt increased stress. The CHW and the patient created a person-centered care plan to support the patient in developing coping skills to reduce her smoking and increase her stress-management skills. One intervention included daily walks. The CHW continued to assist the patient with weekly appointments in which the patient would
either come to the officer health center or the CHW would visit her at her home. The patient -- excuse me, the CHW - accompanied the patient to a housing board to advocate on her behalf so she was able to maintain her housing. In addition, the CHW was able to reach out to the patient surrounding the patient not taking her medication as prescribed. The PCP ordered an increase in VNA hours to reduce any risk to the patient. Since enrolling she has kept her daily routine of going on walks as well as attending all scheduled appointments. Once our remote medication technology is up and running this patient will be an excellent candidate for the support service which will then reduce, if not eliminate, her visiting nursing cost. The patient has been able to remain in the community and out of the hospital since engaging in our program.

>> Overall our outcomes we have seen have been increased engagement and participation in preventative medical and behavioral healthcare. Patients who have suffered from substance use disorders have entered into detox and being able to maintain sobriety. Our patients have been able to overcome social determinants of health and increase their quality of life. Our patients have reduced the use of the emergency department. We have seen reduced inpatient admissions and reduced readmissions and patients have been able to achieve the goals they have identified. I think the most important lesson learned is to meet the patient where they are and be sure to maintain a person centered approach.

>> Great. Thank you so much, Emily. We have heard from two great programs really working on integrating behavioral health across the continuum. At this time, we would actually like to open it up for discussion and questions. Can you remind everyone how to unmute their lines?

>> If you'd like to ask a question you need to unmute yourself by pressing pound or #6 and the lines will be open for you to join us. Be forewarned you need to use your manual mute button to put yourself back on mute once you have asked your questions. While we wait for folks to join us on the phone line, let's check in for any questions in chat.

>> Thank you. We have a few questions in chat. The first comes from Doreen, directed toward Dr. White and Hannah: How long have you had this grant and how did you collect the outcome data?

>> We have had this grant now for seven years. It is giving us the opportunity to explore in different domains. Most recently, we are very privileged to have received a grant from the health policy commission that was referenced earlier in the webinar, that has allowed us to build a team that is collocated in the care management suite of an ACO. Prior to that received funding or merely from Blue Cross of Massachusetts foundation that enabled us to locate teams within primary care practices at a Community Health Center. We collected the data in a combination of ways some patient reports, some provider rating scales and finally we have access to the patient's medical record which I should say parenthetically is a key important feature of our program. From that we are able to extract some of the patient data we reported.

>> The data we reported in the presentation is all from the patient medical record.
Right. We have another question. How do you balance the amount of care/support devoted to a high utilizer that remains noncompliant?

This is Hannah from Brookline. I think the majority of our patients have some sort of issue with non-adherence or noncompliance. For us it’s really having a team that can commit time and understanding to figure out why the non-adherence is happening. Usually, we are able to come after building a relationship and understanding the person over time, figure out some strategies to help with non-adherence and noncompliance. For us, we take time to build a relationship first. To really get an understanding of the patient. One example of this we had a patient who was not going to the health center all that often but had uncontrolled hypertension which caused kidney failure, needing to get on the transplant list because the kidney failure was so advanced. He wasn’t taking any medications. We went out and, another thing we do is we are very flexible. This is a person who did not want us coming into the home, had a complex situation going on with the girlfriend renting a room, other roommates in the area so we went out, met in my car, had him bring his medications and really talk to him about what was going on. He laid out medications and we figured out after a few times of meeting with him that he could not read. He could not read enough to know what the medications were or how he was supposed to take them, and that is the reason he wasn’t taking them. To that point, that was a pretty blatant example of an intervention we could come and identify quickly. The other thing he was on 14 medications a day. Multiple pills for some medication so a total of 22 a day and 17 were white and looked almost identical to each other. To have an understanding of what people are going through and to walk through it with them is really helpful. Just hanging in there, with these patients, you have to have flexibility and you have to devote time to them in order to understand. I think dedication and small caseloads help with that.

Thanks, Hannah. I have a couple of questions for Emily. First, which assessments to your community health workers use?

The assessment we developed in-house or modeled after some of the assessments within the Massachusetts standardized documentation program that can be found online and SDP forms. We also tailor them for specific need areas that we were looking for through the community that we serve.

Great. And the follow-up question to that is, do you have statistics for reduced emergency department visits?

The way we are able to obtain the data for the reduced ED visits is patient reports as well as through our claims data we receive. As well as an integrated medical electronic medical record system. If the facility is on the same system and the patient signed up for what is called care everywhere, we are also able to see, in the medical records, if the patient has been seeing in the emergency department and what they were seen for. I don't have a hard factor number for you, we are still collecting that information to get final numbers.
Great. Thank you. Also, another question for you, Emily, from Linda, can you talk about the training background and skill level of the community health workers in terms of assessing patients with SMI? Any recommendations about types of staff you think will be most successful?

The type of staff most successful are the ones truly dedicated to patient care. The definition of a community health worker is not necessary to have a bachelor’s degree but necessary to be involved and invested within the community and the population you are serving. As far as training is concerned all of my team members and community health workers attend a community health education outreach training offered through the Boston Public Health Department we call that a “check” training because it is the Community Health Education Center they attend this training at. It is about it six to eight-week training that completes core competencies such as community advocacy, motivational interviewing, documentation and after core competencies are completed they then receive training in surrounding different health modules. Some include mental health, substance use disorders sexual and reproductive health, hypertension, diabetes. So the community health worker is able to attend those health modules that will best support them in serving their patients. And we do in-house training as well surrounding community resources.

I think the next question can be for either group. How long our patients enrolled and what is the frequency of contacts with the patient?

For Lynn Community Health Center, our patients are enrolled for more or less as long as they need for the duration of the program. As mentioned by Brookline we are typically able to see patients meeting their goals within six months to a year. Sometimes it may take a little longer when working with concrete goals such as obtaining subsidized housing.

Thank you. Anything else to add?

This is Hannah from Brookline. I would completely agree with the timeline, especially the point about subsidized housing in concrete goals needing more than 12 months. Initially when we enroll folks the contact is much more frequent. We tried to do a home visit or community visit at least weekly for the first few months and in between those face-to-face visits there is certainly a lot of telephone contact. The other thing is that there is much more provider contact involved as well. During the duration of engagement, we are in frequent contact with the primary care provider and the patient’s in home care team as well.

Thank you. We have another question, what is the caseload number for each community health worker?

For Lynn Community Health Center of the caseload is 20-25. That way they are able to provide intensive care coordination service, weekly visits as well as telephone communication with the patient and other providers.

Thank you.
>> I was just going to check to see if there was anybody on the phone line that has a question? To unmute yourself press pound six. No? Go ahead.

>> I was going to ask a general question to either group, how are you planning to sustain the program once the grant funding has ended?

>> Following the grant funding we are hoping to take the cost data and show our successes within the program. And in Massachusetts we are also entering into, as mentioned before, an Accountable Care Organizations. As part of that there is a behavioral health community partnership doing similar work to what we are doing now within this grant.

>> For us, in Massachusetts the behavioral community partnership will certainly play a role. We are serving in that capacity. In addition, we do believe that ACOs will be making substantial investments leading to managed complex populations from a cost point of view and with value based contracting, managing those 5% population with the high cost high need dimensions is going to be of critical importance to stay within the risk profile that can be managed. We do believe there will be a substantial intervention in promising conversations with ACO’s around that. In particular, we see ourselves evolving from direct service in providing nurses and care managers to one in which we will be providing training and technical assistance to ACOs regionally who are interested in developing teams based on the model we have built.

>> Great, thank you. We have another question: in a couple of examples shared, patients were given assistance with financial difficulties such as debt consolidation. Were employees provided this in-house and with backgrounds in financial social work?

>> No. What we do is we try to connect patients to other professional providers. We will help them identify debt-consolidation services and help them connect with those services.

>> Great. Are there any questions on the phone line before we go to the next chat question? We will continue with chat.

>> We have another question; do you use a classic costing system to determine net cost savings?

>> No. We use basically claims data in order to do that. It has proven difficult sometimes to get claims data and particularly to get total medical expenditures for the patients we are providing care for. Partly because often they are being cared for in multiple systems. They may have some other ED visits under one ACO hospital system and another ED visit in another hospital system. Getting good cost data has proven to be one of the most important questions and also one of the most challenging ones.

>> Thank you. Another question from chat, do you have difficulties in getting patient services in a timely way, such as group home placement or assisted living?

>> Yes. Definitely. I think Emily may agree with this. I think that is one of the reasons why we expect we will have a long duration of engagement because it is difficult to locate these services and often there is
a waiting list or other obstacles that have to be overcome before somebody can be transitioned into something like a group home. Certainly I think housing of any sort is our longest and most lengthy and complicated task to accomplish with any patient. Anything in that arena we know will take us a while.

>> I absolutely agree. Especially surrounding the housing peace. The majority of patients we serve are either homeless or under housed or living in overcrowded conditions and housing is a large need. I always frame it as if you are diabetic and homeless how are you able to prepare appropriate meals. We need to really address the most basic needs first before getting up on the higher level, just like the hierarchy of needs. Due to limited resources, this does take time to make that is why patients stay within the program for a longer duration.

>> We have another question, when Emily said in meet the patient where they are, can Emily explain a little more on what she means by that?

>> Absolutely. We take a person centered approach. My corny saying is that the patient is the captain of the ship and we are there crew. They dictate and determine the areas they want to address first. For example, if a patient has, again I will use diabetes, if they have diabetes the provider's goal may be to reduce the A1C. The patient however it may see it as well I need to get a job so I am able to purchase fresh fruits and vegetables I need to maintain a diabetic appropriate diet. We support the patient with working to obtain that employment opportunity or increase their income or resources while then also working in reinforcing the treatment recommendations. The patient is the lead and they dictate the work that is going to be done.

>> Are there any questions from the phones before I continue? We’re hearing some noise so if that person could put themselves on mute please, we can hear you. Continuing on, we have a question, what is your provider response rate for your intervention?

>> At Lynn we have huge provider by an. Our providers are constantly checking with me to see if patients are eligible for the program. Our providers recognize our patients need a higher level of support and care. We have had providers respond greatly with much enthusiasm and received wonderful feedback from our providers.

>> We have some similar enthusiasm from providers. We are in a little different situation. Some of our programs run outside the health center for instance we have a team who works with healthcare Associates, a huge practice with residents coming in as well. Often the primary care provider has never heard of us or is new to the practice or new to the patient. We find once we engage the patient to shoot an e-mail to the primary care provider and let them know we have been in the home and areas we have identified in the patient has identified they want to work on. As soon as we start working with the patient, providers are extremely appreciative that we are able to provide the care we are. These are often patients that are very well known to providers and providers really want to make a big difference to help these patients. But don’t have the luxury of giving them the time they need in order to make changes. To have providers like us to have the flexibility and time to vote to these patients is something that providers really appreciate and really need in order to feel supported and care for these patients.
Thank you I think we have time for a couple more questions. If a community health worker manages 20-25 patients at one time, how do you manage incoming referrals if you are already at capacity?

At Lynn, I am not yet at capacity because they are four full-time community health workers in the program from a currently they all have about 15 caseloads and are actively working to ramp up their caseload. Should we hit capacity, I will then be generating a waiting list. While that person is on the waiting list we are going to try to connect them with other resources that will be supportive in meeting their needs while waiting to get the more intensive care coordination and case management.

Thank you.

In Brookline, we unfortunately do have a waiting list although we try to keep it under 10 patients. What we do to manage the wait list is when we get a referral we reach out to the primary care provider and do a chart review for the patient and see if there are additional services or ideas we can offer to the primary care provider or other providers we can think to bring in to the team before we are able to enroll them in we just continue to check back with providers and let them know a timeline for when we can engage the patient.

I would add that we actively manage the caseload so at any given time of the 25 patients there may be six who are acute and in need multiple contacts per week but there are some of the other and moving to graduation so we tried to move those along and always making sure whatever level of service we are getting is appropriate at that given time and looking for other community resources that can pick up some of the services so we can begin to back off and take on new patients.

Right. I think we are pretty much out of time for questions. If there are any others in chat, we will make sure they are answered via email. I will turn the presentation back over to Stephanie.

Thank you all for your great questions. We really appreciate your time, and hope you found the information helpful. When you close out of the webinar, an evaluation will automatically pop up on your computer. If you could fill that out, we would really appreciate it. If you need more information, reach out to your state lead, their information is on this page. Follow us on Facebook, LinkedIn and YouTube for important news, resources and updates. That concludes our webinar, have a great day, everyone.

Thank you. [Event concluded]