Wrapping Services Around Your Patient in a Primary Care Home

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Today, we will discuss...

• The benefits of pairing Community Health Workers with Registered Nurse Care Coordinators in a primary care setting
• The integration of primary care and mental health services in a patient-centered primary care home
• The potential use of Public Health Nurses and Community Health Workers in a Public Health setting

What is a “Patient-Centered Primary Care Home?”

• Emphasizes care coordination and communication to transform primary care into “what patients want it to be.” (NCQA)
• Founded on the model of “Team-Based Care”
  • The idea that all of the personnel who interact with the patient during a visit are part of the “Care Team” for that patient
Team-Based Care

- Care Team may include:
  - Provider
  - MA
  - RN Care Coordinator
  - “Traditional Health Worker”
  - Pharmacist...Behaviorist...Client Services...
- Using each care team member at the “top” of their license or skill set

What is a Community Health Worker (CHW)?

- **Trusted** member of the community being served
- Shares similar characteristics
  - Language, culture
  - Socioeconomic circumstances
  - Chronic disease condition
  - Mental health consumer
- “Someone who looks like me...”
- May also be called lay health advisor, promotor/o, health promoter, navigator
What is a “Traditional health worker” (THW)?

- Senate Bill 1580 – set rules for CCOs
- Coordinated Care Organizations
- Requires CCOs to use THWs
- Community Health Workers
- Peer Wellness Specialists
- Peer Support Specialists
- Personal Health Navigators
- Doulas

Community Health Workers:
Traditional Roles

- Non-clinically trained
- Outreach, community advocacy, empowerment
- Health education
- Access to health care and social service system
  - Referral to community services & resources
    - Medicaid, SNAP, WIC, housing & educational programs
- Coordinate community events
- Resource & health fairs
- Cultural brokers
- “Barrier Busters”

Community Health Worker:
Clinical Roles

- Integral member of the primary care team
- Help clients navigate the healthcare system
- Focus on utilization of services
  - Clinical system navigation
  - Care coordination
  - Patient advocacy
- Provides
  - Chronic disease prevention
  - Self-management education and support
  - Nutrition and exercise coaching
CHW Training Topics

- Outreach and mobilization
- Community and cultural liaising
- Health promotion and coaching
- Ethics
- Disease-specific education
- Motivational interviewing
- Popular education
- Health literacy
- Case management, care coordination, and system navigation
Why use a CHW?

- Increased connection to patients
- Decreased “power differential”
- Improved communication between patient and provider
- Increased patient engagement and “activation”
- Higher likelihood of adherence to self-management goals and protocol
- CHW able to address barriers to care
  - Transportation, language, culture, finances

Coordinating Care beyond the clinic walls: RNs and CHWS a perfect match

- Best use of skills for each worker
- Each practicing at the “top of licensure”
- Each worker has a role to play in the care coordination/case management of clients
- Best scenario includes a “loop-back” between CHW, RN, and primary care providers to ensure all parties informed

Relationship of RN/CHW

- Taking time to build:
  - Understanding, communication, trust
- Frequent and regular check-ins
  - Especially at first, when trust and communication are being built
- Appreciation by RN for the unique skills and qualities of a CHW
  - They are more than a “nurse-extender”
**Benefits of RN-CHW model**

- Allows RN to focus on families/clients that truly need the RN expertise
- Allows for more families to be served by the appropriate level of health worker
- CHW training in popular education, motivational interviewing, and chronic disease self-management allows for individual AND group education opportunities
- Improves cultural connection to the community
  - Builds relationships and increases trust of marginalized populations in health care system

**Supervision of CHWs**

- At BCHD, Program Manager is MPH, has extensive experience working with CHWs
- RN Care Coordinator provides clinical oversight
- Supervisor should understand unique nature of CHWs
- Appreciate the qualities and community perspective that a CHW brings to the care team

**Case Management or Care Coordination?**

Care coordination and case management are terms used interchangeably to describe an array of activities that are designed to:

- Strengthen connections between families and providers
- Link families to services
- Improve access to needed services
- Avoid duplication of effort
- Improve health outcomes
  - MCH Library and Johnson Group. Care Coordination/Case Management (CC/CM) and Interagency Agreements.
Case Management or Care Coordination?

- Case Management:
  - Promote coordination and communication across disciplines within the organization delivering medical care

- Care Coordination:
  - Promote coordination of social support and medical services across different organizations and providers
  - Rosenbach and Young. 2000. Care Coordination and Medicaid Managed Care.

Level of Care Matrix

(Using the example of a client with diabetes...)

Low Risk
- Oral medications
- Stable or no insulin
- High A1c <7
- None or stable comorbidities

Moderate Risk
- Stable insulin dosing
- High A1c >8
- Food insecurity
- Limited English proficiency
- Unemployment
- Social isolation
- Transportation barriers
- Medical or mental health condition that has potential to put client’s health at risk

High Risk
- High A1c >9
- High insulin dose
- Adjusting insulin dose
- Unstable comorbidities
- New diagnosis
- Mental health concerns
- Substance abuse

Level of Care Matrix

Low Risk
- Oral medications
- Stable or no insulin
- High A1c <7
- None or stable comorbidities

Moderate Risk
- Stable insulin dosing
- High A1c >8
- Unstable housing
- Food insecurity
- Limited English proficiency
- Unemployment
- Social isolation
- Transportation barriers
- Medical or mental health condition that has potential to put client’s health at risk

High Risk
- High A1c >9
- High insulin dose
- Adjusting insulin dose
- Unstable comorbidities
- New diagnosis
- Mental health concerns
- Substance abuse
 RN and CHW roles within the continuum of care

**Clinical Case Management:** RN
- Clinical monitoring
- Medication management
- Logistical
- Self-management support

**Clinical Follow-up Care:** RN or Health Navigator
- Logistical
- Self-Management Support (Health Navigator under supervision of RN)

**Care Coordination:** Health Navigator
- Transportation assistance
- Social Services resource connection
- "Barrier-Busting" Phone calls
- Work with Referral Specialist
- Assistance filling out paperwork and documents
- Chart review to assess need (under supervision of RN)
Care Coordination

with

Mental Health Comorbidities

2 separate worlds?

- Mental Health and Primary Care
- Have traditionally been separate entities.
- Each one cared for the patient in a vacuum
- Fragmented/ uncoordinated care
- Created gaps in patient care
- Patients with chronic conditions need services that will keep them healthy
- Collaboration possible with CCO
Seamless Integration

One team with the same goal
- Collaboration is necessary
- Identify patients with both mental health and medical diagnosis that need managing
- All team members meet together
- Develop a plan unique to the patient
- RN Care Coordinator is the lead on all medical issues
- Communication is the key!

Mental Health Patients
- Mental Health patients are a unique population
- Often have multiple comorbidities
- Fear of medications can be challenging
- The MH therapists are not geared toward medical issues
- Only see Primary Care when medical problems surface
- RN Care Coordinator has a view of both worlds
What is needed?

• Can be very different between patients.
• May require home visits.
• May require outreach from Mental Health/RNCC, or both.
• Check in with team often for problems

A Test Case

• A MH patient was moving from a facility where medications were managed, to a home where the patient would be responsible for their own insulin injections.
• Met with patient and determined their knowledge base.
• Met with MH, RNCC, and Pharmacist.
• Multiple meetings prior to move.
• Patient is successful and managing their medications.

Primary Care from a Public Health Perspective

• Public Health Nurse Generalists. Where did they go?

• RN Care Coordinators, Integral to the Care Team
  • Provide Case Management
  • Can see patient in the clinic
  • Able to make home visits
RN Care Coordinators

- Address the whole person not just the illness they are being seen for:
  - Resources
  - Barriers client is experiencing
  - Strengths (Let’s build on these!)
  - Working top of the license
    - Collaborating with Community Health Worker
  - Keeping Care Team/PCP in the loop.

Integrating Public Health Programs into Primary Care

- How do it if not co-located?
  - Building relationships & Communication
  - Help providers see PH as an extension of their practice
  - CaCoon & Local Pediatric Providers
  - Maternity Case Management and local OB Providers
  - Care coordination betw cacoon and PCPs
  - Direct line from family planning to MCM

Public Health Nurse, Part of the Care Team

- When Co-Located PHN can be seen as part of the care team.
  - PHN Can easily report back to PCP/Care Team after a home visit.
  - Care Team can ask PHN to do a home visit to help get complete picture.
  - Women’s health services & MCM
Public Health Nursing & CHW’s

- Want to make sure everyone is working at the top of their license/skill set.
- Who will better meet the needs of the client?

Level of Care Matrix

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<thead>
<tr>
<th>Community Health Worker</th>
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<tbody>
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<td>Low Risk</td>
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- Osteo social lo
- First pregnancy
- No substance use
- No smoking
- No alcohol abuse
- Mild depression
- Unstable housing
- Past history of domestic violence
- Food insecurity
- Limited English proficiency
- Unemployment
- Single/mother
- Transportation barriers
- Medical or mental health condition that has potential to put pregnancy at risk
- Teen moms
- Substance abuse
- Mental health concerns
- Current domestic violence
- Medical condition or pregnancy at high risk

CCO’s and Public Health Nursing

- Each County’s relationship with their CCO is different.
- PHN has the expertise that CCO’s are looking for.
  - Experts at engaging the difficult to engage
  - Target population is highest risk
- Payment change
- Be at the table with your CCO.
- DMAP leaving it to the Public Health Departments and the CCO’s to negotiate contracts.
Summary...

RNs and CHWs can work very effectively together to provide improved case management and care coordination.

Questions?

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