MEDS Ed™

# Welcome to:

## Community Health Workers – On the Frontlines of Reducing Health Disparities

# Agenda (approximate timing)

| | |
|---|---|
| **8:00 – 8:45** | CHWs – Outcomes, Equity, and Social Justice |
| **8:45 – 9:30** | CHW Panel – Bridge Builders: Clinic-Based Integration |
| **9:30 – 9:45** | **Break** |
| **9:45 – 10:45** | Mobile Integrated Healthcare & Pharmacy Partnership |
| **10:45 – 11:15** | Liaison Support Role |
| **11:15 – 12:00** | Panelist Q&A Opportunity |

# Core Learning Objectives

- Understanding the Community Health Worker role and how CHWs support health outcomes and equity
- Identify strategies for effectively integrating CHWs into a clinic
- Understanding the unique role of community-based CHWs, and how clinics can partner with Community-Based Organizations for effective collaboration
- Understanding the role of the Traditional Health Worker Liaison within the Coordinated Community Organization (CCO) environments

# Survey Completion for 3.5 Hours CME Credit:

## Surveys will be emailed to all participants – Links will be provided at end of the session

| | | |
|---|---|---|
| **American Academy of Family Physicians – Prescribed credit, American Medical Association (AMA) Physician's Recognition Award (PRA) Category 1 Credits 3.5 hours** | **Oregon Board of Pharmacy – Recognizes credits to toward CE hours requirements for license renewal!**<br><br>**3.5 hours** | **NEW: National Association of Social Workers – LCSW CEU credits**<br><br>**3.5 hours** |

# Join Our Upcoming Session:

## Culture and Illness –
***Implications for Clinicians and Related Health Professionals***

**– December 9th https://bit.ly/3tRdeCL**

**Past sessions on video: http://www.careoregon.org/medsed**

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# Panel Questions & Answers

## Submit questions via Chat feature:

For Jennine: *“How do you…”*

# Community Health Workers: Outcomes, Equity, and Social Justice

**Jennine Smart, MSW – Executive Director**

**Yesi Castro – Workforce Development Director**

Oregon Community Health Workers Association (ORCHWA)

# (Link to ORCHWA presentation)

https://vimeo.com/user472454/review/601544314/66e3c4ab6a

# The Bridge-Builders: Clinic-Based Integration

## Multnomah County Community Health Center

**careoregon.org**
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Multnomah County Health Department

CareOregon

**Juliet Munoz** – Community Health Specialist II, Rockwood Community Health Center

**Jeff Holland** – Community Health Specialist II, Covering all Health Centers

**Leslie Esinga** – Community Health Specialist II, NE Health Center

**Ruby Ibarra**
Community Health Worker Program Supervisor

**Sylvia Ness**
Community Health Worker Program Supervisor

# (Link to CHW Interviews)

https://vimeo.com/user472454/review/602147696/85f7345623

# A CHW in the Making

- Juliet's story
- Leslie's story
- Jeff's story

# History and Growth of CHW Program at Our Health Center

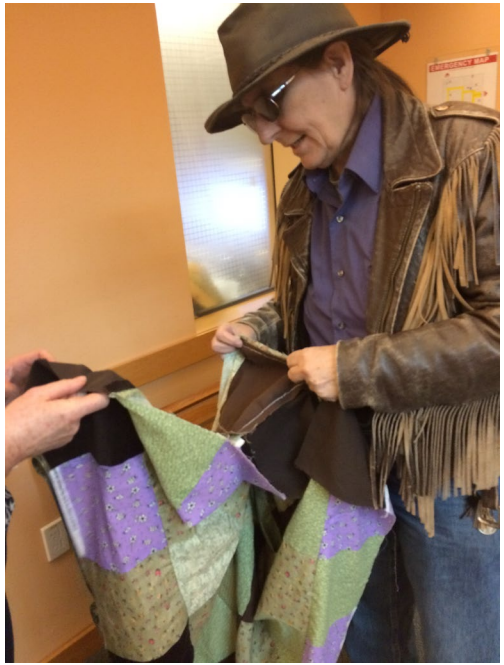
- CHWs prior to 2015 & after
- Introduction of CHW role in Team Based Care
- Professionalization of Role
  - Value of work- Eyes and ears of clinic, navigators, bridge builders, connectors, mentors, ALL wheel drive (community, clinic, specialty providers, CBOs, etc.)
  - Getting paid for value-billing & other value-based payment

# How CHWs Get Their Work

- Referrals from team members
- CHW Program Work

# Getting Healthy Produce to Clients

- History of getting healthy foods to clients/CSA
- CSA Partnerships for Health
- REACH CSA



# Relationships with Team Members

- CHW ability to illuminate client story
  - Client example
- Team Based Care
  - Communicating with all members of the team


Multnomah
County
FOOD WORKS
KALE
FOOD WORKS

# Thank you!

# Please ask your questions in the Chat for our Q&A Segment!


10- “ish” minutes

# Mobile Integrated Healthcare

**Sabrina Ballew**

MIH Supervisor – Mercy Flights, Inc.


**careoregon.org**
twitter.com/careoregon
facebook.com/careoregon

MERCY FLIGHTS
Non-Profit Air and Ground Ambulance Services

CareOregon®

# Pharmacy Partnership – Mobile Integrated Healthcare


**Nick (YoungTae) Kim, PharmD, MBA**
Ambulatory Care Clinical Coordinator – CareOregon

**careoregon.org**
twitter.com/careoregon
facebook.com/careoregon

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# (Link to Sabrina and Nick)

https://vimeo.com/user472454/review/601551872/313472b7dc

# Mercy Flights

- Founded in 1949, by George Milligan. The nation's first nonprofit air ambulance service.
- Air and ground operations
- 2016 Mobile Integrated Health was started.

# Introductions – Sabrina Ballew

Sabrina Ballew is the Supervisor of Mercy Flights Mobile Integrated Healthcare department. She is a Paramedic and a CHW and has been with Mercy Flights since 2013, and in EMS since 2010, she started as an EMT responding to 911 calls.

Sabrina helped create Mercy Flights Mobile Integrated Health program when their focus was helping patients with high levels of Emergency Department calls. She has been instrumental in developing new programs such as Transitions of Care, Rising Risk, and developing strong partnerships with CCOs, clinics, and local hospitals.

Sabrina's previous experience also includes five years as a volunteer firefighter and a lab instructor at Rogue Community College.

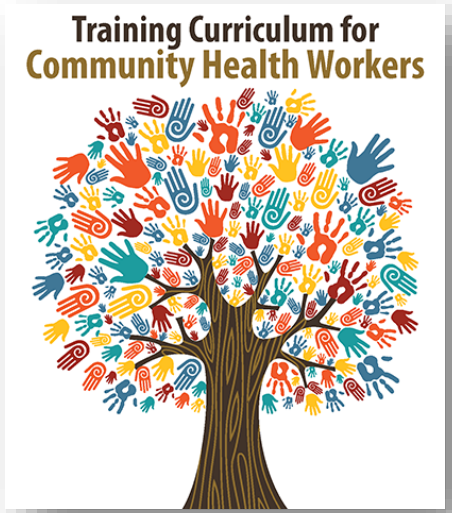
# Introductions – Nick (YoungTae) Kim

- Previously worked in biosimilar/novel drug research and development.
- PGY-1 residency trained clinical PharmD.
- After the training, worked at Providence critical/acute care unit as a clinical PharmD.


**Nick (YoungTae) Kim, PharmD, MBA**
Ambulatory Care Clinical Coordinator – CareOregon

# Mobile Integrated Healthcare


Leveraging EMS System




Training whole patient Care

# MIH Program Timeline

**2016**
- Pilot Program- Focus on High Utilizers

**2017**
- Transitions of Care (TOC) Program Launched

**2018**
- Rising Risk Program Launched

**2020-Current**
- COVID
- Wildfires
- FEMA
- Public Health

MERCY FLIGHTS
Non-Profit Air and Ground Ambulance Services

Jackson Care Connect™

# Patients With Chronic Conditions

| Chronic Conditions | | |
|---|---|---|
| **Percent Members** | **Graduated** | **Declined** |
| Diabetes | 23.6% | 17.1% |
| Heart Failure | 17.1% | 11.5% |
| Pulmonary Disease | 17.1% | 9.1% |
| Frailty | 29.9% | 16.6% |
| Have at least one Chronic Condition | 56.6% | 39.8% |
| Have none | 43.4% | 60.2% |

- Graduated and Declined members were analyzed to see if they had the any of the following chronic conditions at the date of graduation or the date they declined: Diabetes, Heart Failure, COPD, or Frailty.
- The table to the left displays the percentage of members in each category who had that specific chronic condition.

# Behavioral Health / MAT

- We focused on Substance-Use disorders (SUD) as there was the clearest implication that members with SUD diagnoses should be receiving services and would also be the target for MAT treatment.
- First, we identified members in the graduated and declined groups that had SUD diagnoses by looking 1-year back from the date of the intervention for SUD-specific diagnosis codes.
  - 219 Graduated Members (24.6%) had SUD diagnoses
  - 248 Declined Members (28.2%) had SUD diagnoses
- Next, we used this subset of the population to measure SUD treatment and MAT engagement.
  - For both SUD and MAT treatment, we compared engagement for 90-days before the intervention to capture the baseline level of treatment in both populations.

# Patient SUD Diagnoses

| Member SUD Diagnosis Areas | | |
|---|---|---|
| **Category** | **Graduated Members** | **Declined Members** |
| **Opioid** | **38.4%** | **39.5%** |
| Opioid&Stimulant | 7.3% | 10.5% |
| Opioid&Alcohol | 7.8% | 1.6% |
| Opioid&Other | 4.6% | 3.2% |
| **Stimulant** | **19.6%** | **18.5%** |
| Stimulant&Alcohol | 4.1% | 4.4% |
| Stimulant&Other | 5.9% | 2.8% |
| **Alcohol** | **36.1%** | **34.7%** |
| Alcohol&Other | 5.9% | 3.6% |
| **Other** | **5.9%** | **7.3%** |

SUD diagnosis is based on ICD 10 codes associated with opioid, stimulant, alcohol, or other SUD diagnoses.

Members require at least one claim with a qualifying diagnosis within a year before the intervention date.

Limited to members with at least 3 months pre-/post-intervention enrollment. Dual-eligible members were not included.

# MAT Engagement

| Members Who Engaged with Medication Assisted Treatment | | |
|---|---|---|
| **Engagement Period** | **Graduated Members** | **Declined Members** |
| 90 days before Start Date | 6.8% | 6.0% |
| 30 Days after Start Date | 7.3% | 4.8% |
| 60 Days after Start Date | 12.6% | 7.7% |
| 90 Days after Start Date | 14.1% | 9.3% |

*Out of members who have an SUD diagnosis

MAT engagement is defined as a filled prescription for Medication Assisted Treatment (e.g., buprenorphine).

The Mercy Flights intervention showed a significant impact on MAT engagement. Graduated members more than doubled their pre-intervention MAT engagement, 6.8% to 14.1%, compared to an approximately 50% increase for Declined members.

# Medication Management & Patient Success

- Recent American Association of Respiratory Care Webcast reports nearly
  - 69% of patients are non-compliant with meds
  - 45% of patients have inadequate knowledge of medications
  - 42% of patients are unable to self -manage their care
- Goal is to create a complete medication list including supplements and OTC medications across the continuum of care.

https://www.besler.com/reducing-hospital-readmissions-medication-management/

# Unique Partnership

- JCC Pharmacist and Mercy Flights MIH Program
  - Patients in need of a medication review
  - Connection to JCC Pharmacist
  - Pharmacist Completes Review prior to home visit
  - MIH Provider will confirm medications at home visit
- JCC pharmacist completed 73 deep medication reviews from 3/16/2020-3/17/2020

# Errors Avoided

- Patient discharged with three different strengths of Prednisone
- Patient with four different strengths of Lisinopril-patient taking all of them. MIH intervened and now on correct strength.

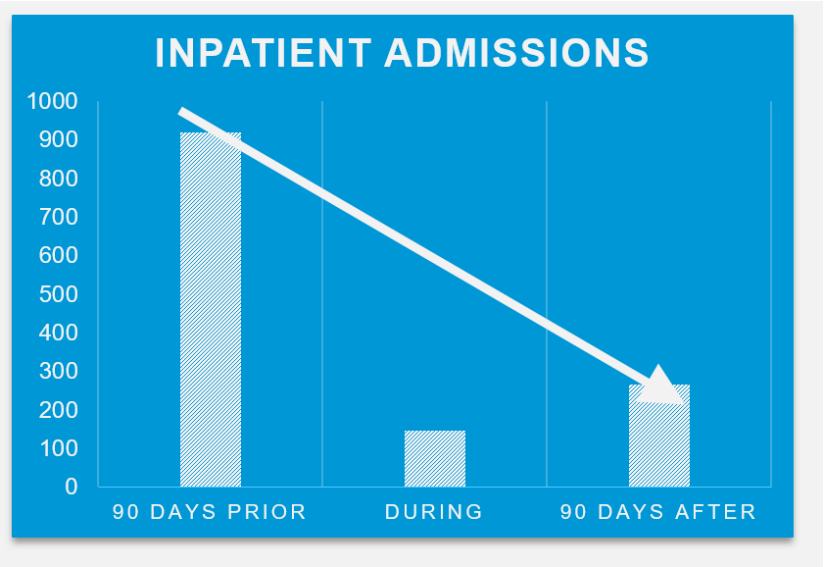
# Measures of Success TOC

## Goal #1: Patient Education

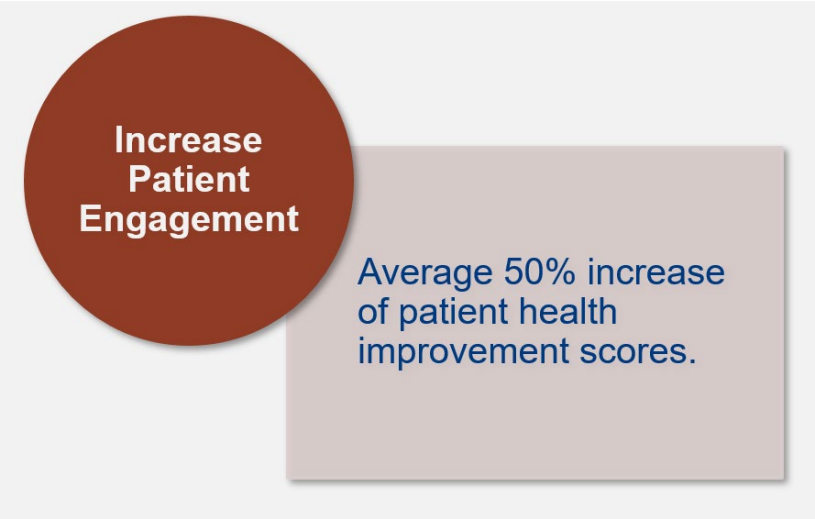
- Protocols in place to educate on each health outcome.
- Full medication reviews.

## Goal #2: Utilization Reduction

- 71% Inpatient readmission. Cost reduction of over $9 million.
- 48% reduction ED Services. Cost reduction of close to $880,000.



# Measures of Success RRP




# 2020 Wildfires

- MIH Team works through the emergency assisting in evacuations
- Worked the months after with those effected by the wildfires.
- Food box delivery for those effected
- Connected patients with needed
- Medications
- DME

# COVID-19 Testing & Vaccines

- Mobile Testing for COVID for homebound in partnership with Public Health
- In-Home vaccinations and drive through clinic provide
- 3000+ vaccines given to date

# Patient case – 1

- MC is a 31 yo male, with a history of multiple sclerosis who presented to the emergency department with 9-day history of loss of central vision. The patient was diagnosed with MS flare/exacerbation and was given a gram of Solu-Medrol.
- MC referral to me the day prior to the MF/JCC huddle on 8/9/2020. His medications and the medical records were reviewed. The patient stated that after 3 days of Solu-Medrol, his left-hand paresthesia is unchanged as is his vision.
- The case was consulted internally with medical director and clinical pharmacy supervisor and concluded to refer to the patient to OHSU neurology.
- MF MIH facilitated with obtaining a referral from the patient's PCP.

# Patient case – 2

- AO is a 35 YO male with history of HTN, EtOH abuse. The most of the patient's ED utilization was due to an alcohol intoxication.
- AO referral to me the day prior to the MF/JCC huddle on 2/4/2021. His medications were reviewed, and the case was assigned to our Behavior Health Care Coordinator, needing assistance with housing, dental and BH support.
- Had Spanish speaking JCC staff contact member to help with getting him connected to dental and housing support.  AO agreed to reach out to dentist and FEMA
- MF MIH requested for help with Translink, needing more time to get his PCP appt, documentation of his disability. JCC staff reach out to Translink, and they approved an extra month's time to get the documentation in.

# Success Stories

- Patient recently discharged from stay at a Skilled Nursing Facility with 36 different medications-at-home visit MIH provider was able to work with Pharmacist and do a thorough medication review. The patient's medications were adjusted down to only 17.
- 41 YO Male-Houseless TBI, Seizure disorder-MIH met him his Heart rate was in the 40’s. He was admitted and stabilized, with the combined effort of MIH, Pharmacist, Local Urban Campground we were able to get him his medications and into a safe space.

# Moving Forward

# Please ask your questions in the Chat for our Q&A Segment!

# Liaison Support

**Susan Palmer – Traditional Health Worker Liaison**
**Cliff Juno – Traditional Health Worker Liaison**
CareOregon



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# (Link to Susan and Cliff)

https://vimeo.com/user472454/review/601542339/8737eef3cd

# Traditional Health Worker Liaison

- Increase member access to THWs
- Inform alternative payment models to create sustainable programs
- Collaborate with the OHA THW Commission to share workforce needs
- All CCOs are required to have a THW Liaison

# Traditional Health Worker Liaison

## Support for THWs and Organizations

- Increase education opportunities
  - Initial education for certification
  - Learning Collaboratives/Trainings
  - Continuing education
  - Formation Community of Practice

# Contact us!

Susan Palmer palmers@careoregon.org

Cliff Juno junoc@careoregon.org

**Thank you!**

(see you at the Q&A!)

# Panel Questions & Answers

## Questions submitted via Chat feature

# CME/CEU Credit:

- Survey will be emailed to all enrolled participants

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