the Playbook

Better Care for People with Complex Needs

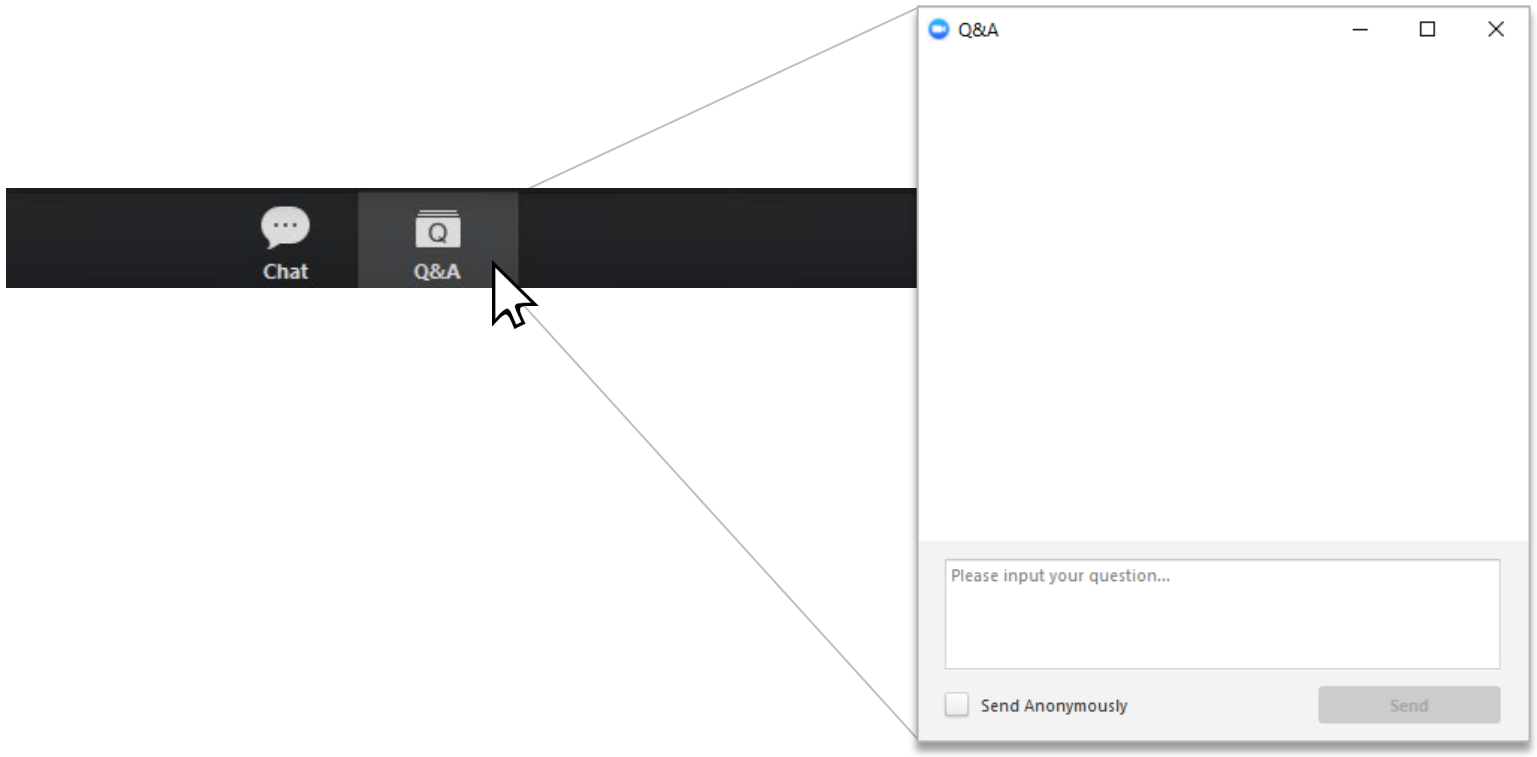
Positioning Community Health and Social Workers to Address Older Adults' Social Needs: Lessons from SCAN Health Plan

April 5, 2022, 2:00-3:00 pm ET

Made possible with support from the Seven Foundation Collaborative – Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, the Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.

Questions?

To submit a question, click the Q&A icon located at the bottom of the screen.



About the Better Care Playbook

Find information. The Playbook is an online resource center for evidence-based and promising practices for people with complex health and social needs.

Learn about first-person perspectives. Read case studies and join webinars highlighting the real-world experiences of providers, payers, community-based organizations, and policymakers to improve care.

Apply the evidence. Find practical implementation tools to inform providers, payers, policymakers, community-based organizations, and others on strategies to improve care.

Inside Complex Care Webinar Series

- Showcases models, programs, and tools with demonstrated evidence
- Takes a practical look at implementation logistics for adaptation to help spread evidence-based and promising strategies

Connecting Provider to Home: A Home-Based Social Intervention Program for Older Adults

Authors: Gerardo Moreno, Carol M. Mangione, Chi-Hong Tseng, Melanie Weir, Rosaneli Loza, Lisa Desai, Jonathan Grotts, Eve Gelb

Source: Journal of the American Geriatrics Society

Peer-Reviewed Article | March 2021

Headline

Home-based social program provided by a community health and social worker reduces acute care use and improves care for older adults with complex health and social needs.

Context

Many older adults with complex medical needs also have unmet social needs, which can lead to poorer quality of care. Interventions that engage community health workers and social workers have demonstrated positive outcomes in addressing health-related social needs and improving clinical outcomes for patients in home- and community-based settings. This study evaluates Connecting Provider to Home, a home-based pilot program led by SCAN Health Plan, a Medicare Advantage plan in California. This program, which is for older adults with multiple chronic conditions and complex social needs, deploys a social worker and community health worker to connect patients to social services and support access to primary care.

Findings

Enrollees in the program experienced significantly reduced emergency department visits and hospitalizations 12 months post-enrollment compared to 12 months before

TOPICS

- Complex Care Interventions
- Care Management
- Interdisciplinary Care Teams
- Health-Related Social Needs

LEVEL OF EVIDENCE

Moderate

What does this mean?

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Agenda

- Welcome and Introductions
- Implementation Considerations for Connecting Provider to Home: Rosaneli Loza and Eve Gelb
- Moderated Q&A

Today's Presenters

Eve Gelb, MPH
Senior Vice President of Health Care Services
SCAN Health Plan

Rosaneli Loza
Geriatric Social Worker
SCAN Health Plan





Connecting Provider to Home

April 5, 2022

Rosaneli Loza and Eve Gelb

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Overview

- The Problem
- Program Description: How It Works
- How to Replicate: Critical Success Factors
- Evaluation Results
- Lessons Learned

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The Problem

The predominant model for caring for seniors is a health-focused medical model rather than a whole person care model. This creates a disconnect between the member at home and the providers' office which leads to poor outcomes.

Program Description: How It Works

The Model

- Target members with complex health and social issues that are not responsive to telephonic case management & experience adherence issues
- Connect a social worker and community health worker to the medical provider team
- Person-centered, goal-oriented, and culturally relevant
- High-touch, on-the-ground, and face-to-face member encounter
- Intervention provided at a level dictated by the complexity and required needs of the member
- Intended to provide long term case management to address both the clinical and non-clinical needs

In-home and in-physician office interventions include:

- ✓ Comprehensive psychosocial assessment
- ✓ Escalating issues that might otherwise get missed
- ✓ Resolving barriers to care plan adherence & member safety
- ✓ Attending doctor appointments to improve members' understanding of the treatment plan
- ✓ Translating the medical plan of care into daily workable activities for the members/caregivers
- ✓ Helping navigate, connect to, and communicate with providers & social service systems
- ✓ Linking members to local, county, & state programs to address SDOH needs

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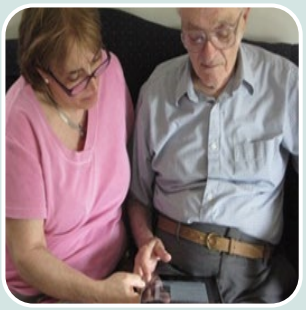
Replication: Critical Success Factors

Critical Success Factors

Provider & Community Engagement

Staff Competency, Hiring Tactics & Training

Appropriate Targeting



Effective Systems, Tools, Resources

Appropriate Funding

Provider Engagement

- Gain providers' buy-in before implementing the program
- Identify best methods for communicating and sharing patient progress
- Create bridges between social and medical care
- Support the providers/office staff in the way they want to work best
- Increase provider and patient satisfaction
- Provider recognizes the value of the team

Hire People with Incredible Potential

Staff Core Competencies

- Interpersonal Relationship Building
- Empathy & Compassion
- Motivational & Leadership
- Insightful & Creative Problem-Solving Ability
- Advocacy, Tenacity & Proactiveness
- Cultural Connection/Relationship to the Community

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Using "Case Study" samples in interviews for candidates to showcase unique skills and abilities

Patient Information and Referral Reason:

- Member is a 53-year-old Caucasian male who was referred to CP2H because of multiple ER/hospital admissions for chest pain, cerebral infarction, HTN, COPD & not engaged

Diagnosis:

- HTN, High cholesterol, COPD, CVA with right side paralysis, HX of smoking, Shingles, HX of skin fungal infections, and depression/anxiety

Provider Report: PCP reports Mr. E. has been challenged and is requesting case management services. He sees Mr. E. as non-compliant, emotionally unstable, with poor hygiene, and not effective in managing his multiple chronic conditions. PCP authorized Speech and Physical Therapy for Mr. E. over three months ago, which Mr. E. has still not started. PCP expressed that Mr. E. takes a lot of his time, but still does not follow through. PCP is unaware that Mr. E is homeless & lives in an RV with no running water or electricity.

Activity: Mr. E. has an upcoming PCP appointment, and the CM will be accompanying him.

- Identify how you and Mr. E will prepare for the visit & prioritize what needs to be addressed during this visit
- Identify how you plan on addressing communication barriers between Mr. E and the provider
- Identify what type of information you find essential to share with the provider (with Mr. E's permission) to better tailor the treatment plan to meet Mr. E's lifestyle and abilities
- Identify what communication techniques/skills you plan on using to empower Mr. E to speak up at this appointment

Training Curriculum

Train to use creative solutions through interactive training

First Week of Training

- Robust SCAN benefit training for all plans
- Motivational Interviewing
- Time Management-creating organization system
- Field Safety Training
- Establishing healthy boundaries
- Basic training on chronic conditions
- Guide to how to prepare for effective home visits & provider appointments
- Guidelines for protecting PHI

3- Month Intensive Training

- Face sheet: Robust pre-call review
- Review of Medical Records
- Assessments (PHQ-9, SLUMS, Assess for Suicide Risk, Home Safety, Medical History, Medication Review, SDOH Needs)
- Problem-solve techniques to address & remove barriers to care
- Creating & providing health tools & education to address health literacy gaps
- Documentation
- Adult Protective Services
- Advanced Care Planning
- Navigating Community Resources
- Shadow visits (peer-to-peer training)
- Networking opportunities – outreach to local CBOs

Coaching and Supervision

- Monthly Audits – Review outcome during 1:1's
- Field Observations – Quarterly
- 15-minute Case Consultation
- Monthly Team Meetings
- Staff Acknowledgement through "Success Story" sharing
- Share resources in a team environment
- Staff development opportunities
- Review what's working and what's not – implement changes recommended by the team

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Robust Training on Community Resources

- Cal-Fresh Benefits / Food Banks / Pantries / MOW's
- Medi-Cal
- IHSS
- SSA/SSI/SSDI
- Grants for essentials
- Utility assistant programs
- Access to a free wireless phone
- Veteran benefits
- Housing resources
- Transportation

On-going Online Training

- NCLER training
- Personal Assistance Services Council (PACS)
- LAHSA
- SOAR online courses

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Targeting & Member Identification

- Reserved for the highest-need individuals, but not restricted to just the “super-utilizers”

Pathways through which a member can be identified for the program

- ❑ Physician Identification
- ❑ Case Managers
- ❑ Hospitalists
- ❑ UM Teams
- ❑ Community Partners

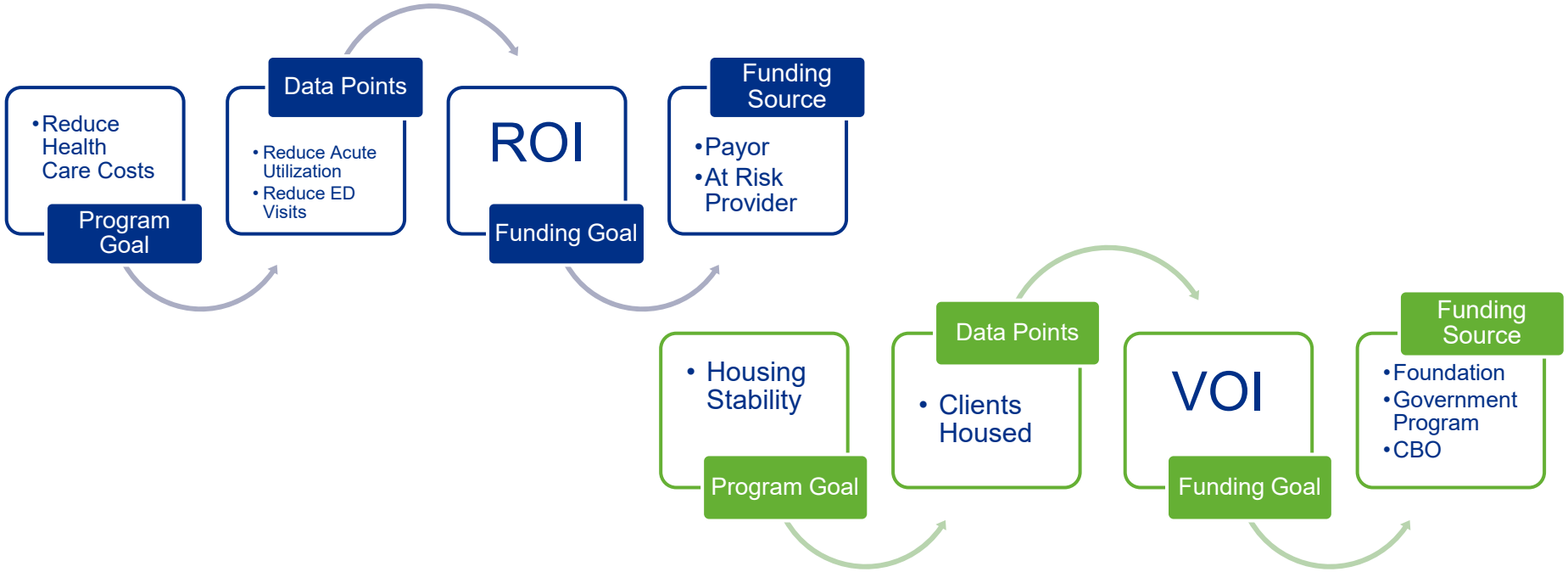
- Critical to include the doctor, care management team, and office staff throughout the process, for the program to be successful

Effective Systems, Tools, Resources & Caseload

- Assessments
  - SDOH Needs, PHQ-9, SLUMS
  - Chronic conditions and medication review
  - Home safety
- Health/Community
  - UpToDate
  - Find Help (community referral platform)
  - Robust engagement & collaboration with CBOs
  - Access to medical records, lab records, authorizations, upcoming provider appointments
- Health Communication Tools
  - Provide materials in relatable visuals and preferred languages
- Caseload
  - Between 50-60 members per team

Appropriate Funding Depends on Your Goals

- Value of investment is not the same as return on investment



- Our seed funding was based on VOI (try, learn, scale)
- But we built in ROI evaluation because we knew that is what would be needed to scale initially

Program Outcomes

Survey Results: Patient and Provider Satisfaction

- 99% of members felt the program **improved their health**
- 100% of members would **recommend this program**
- Aggregate member satisfaction score of 4.85 out of 5

- Physicians and office staff expressed program significantly improved patient health outcomes **without** placing additional work on medical team

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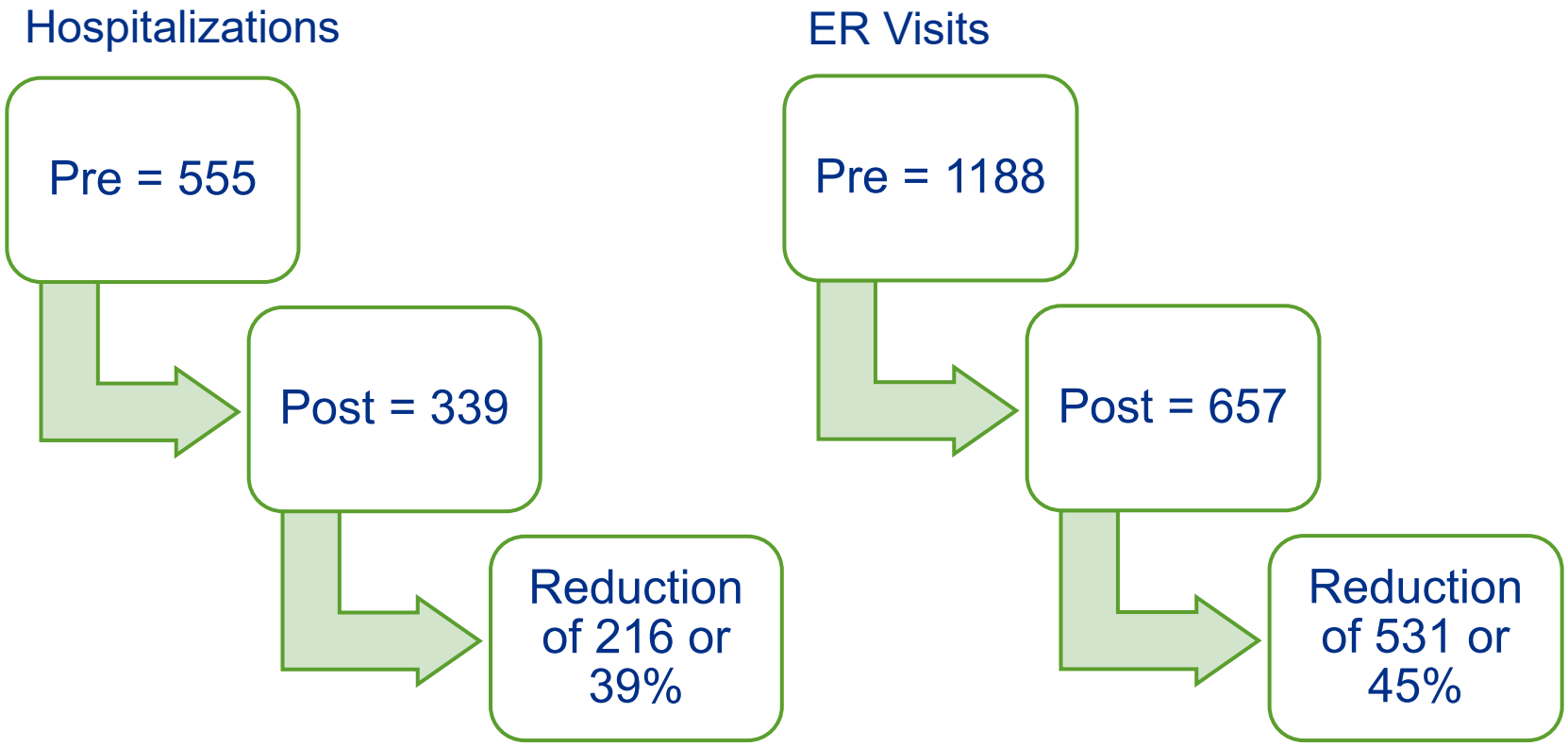
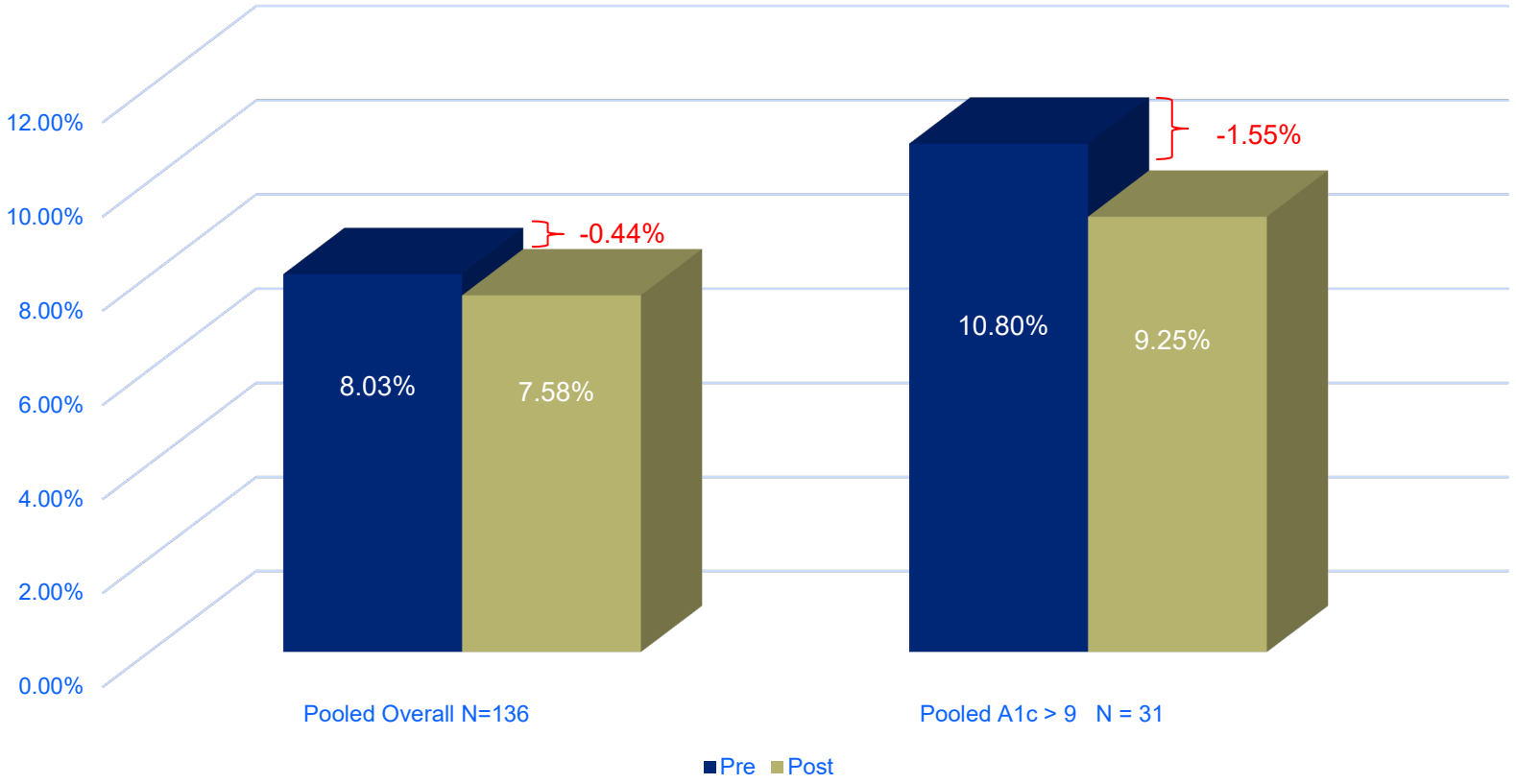
Utilization Evaluation Results – Raw Counts

Intervention Group N = 416



The impact on Hemoglobin A1c



Lessons Learned

Our learnings can be applied across any case management program

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Program Adaptations

Connecting Provider to Home (CP2H)

- Focused on perfecting the model
- Community Based
- Funded by SCAN's CBO Independence at Home

Shared Risk CP2H

- Focused on reducing unnecessary acute utilization
- Internal health plan program where SCAN has financial risk
- Funded by health plan

Provider Based CP2H

- Focused on reducing unnecessary acute utilization
- Provider delivered Provider funded

Insulin Advisors

- Focused on improving HgA1C
- Health plan staff
- Health plan funded

Homelessness Care Management

- Focused on housing members and reducing housing insecurity
- Health plan staff
- Health plan funded as part of CalAIM Enhanced Care Management and Community Supports

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Thank you!

Question & Answer

Questions?

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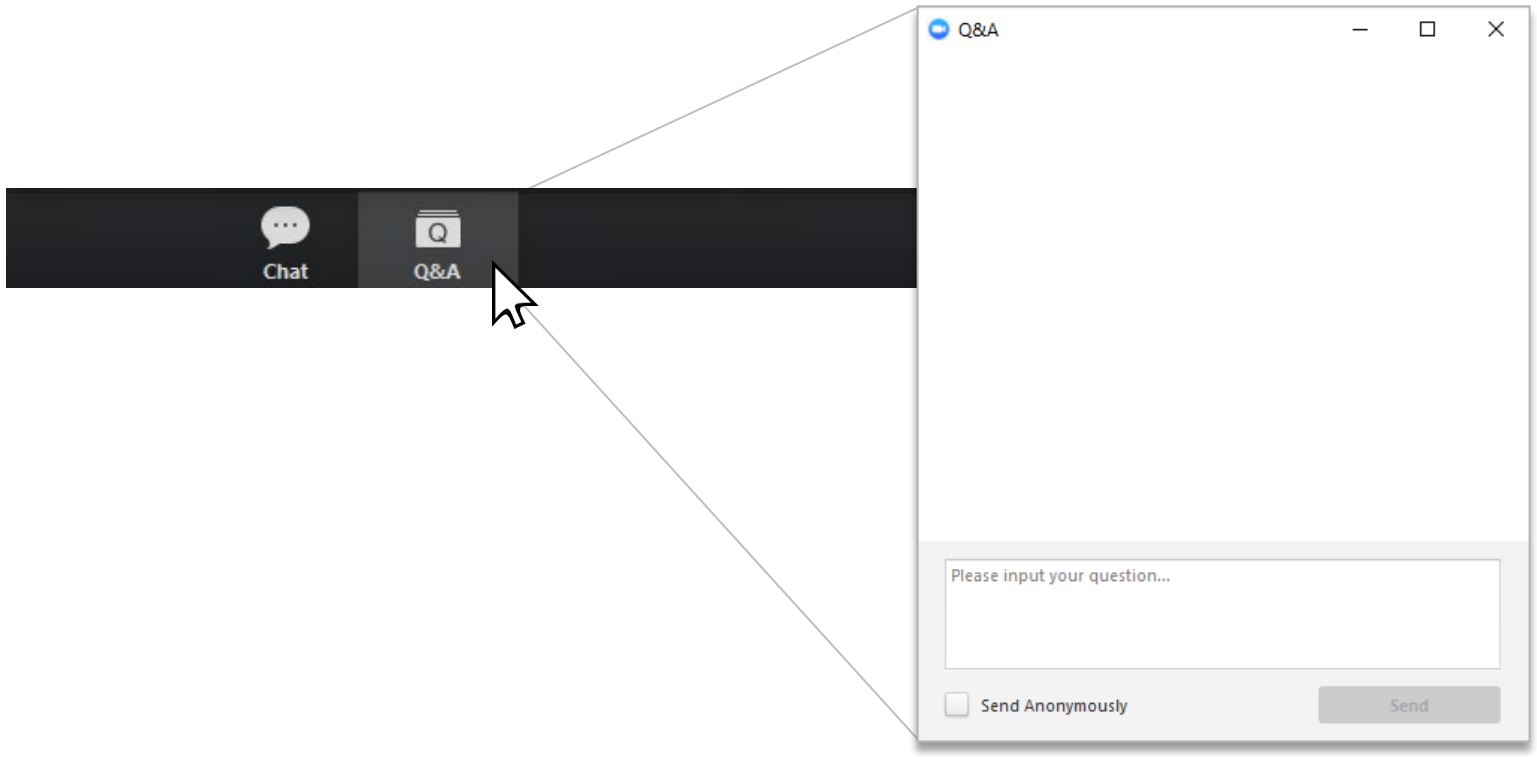

Share Your Successes on the Playbook

- **Have you established a promising practice?**
- **Published a study about your complex care program?**

The Playbook welcomes content submissions to help spread best practices in complex care.

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Thank you!

Please submit your evaluation survey.