Navigating Complex Health and Social Needs

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- Karis Grounds, 2-1-1 San Diego
- Dawn Wiest, Camden Coalition of Healthcare Providers
What problem are we trying to solve?
Outlier patients in the long tail of data

Healthcare hotspotting is the strategic use of data to target evidence-based services to complex patients with high utilization.

These patients are experiencing a mismatch between their needs and the services available.
Designing interventions for patients with complex health and social needs starts by breaking down health and social services silos

**Intervention**
- Coordinate health care and social services across silos, through formation of authentic, “high touch” healing relationships with patients

**Short term outcomes**
- Access to primary care
- Access to behavioral health and addiction services
- Access to needed social supports

**Intermediate outcomes**
- Improved self-management of health conditions
- Reduced use of emergency and crisis services
- Reduced health care waste and duplication
- Reduced utilization of jails, the child welfare system and other public services

**Ultimate outcomes**
- Improved health outcomes
- Reductions in avoidable hospitalizations
- Reduced cost burden for government, payers and public
The Camden Coalition is a leader in the field of complex care management

**Our Vision:** A transformed health care system that ensures every individual receives whole-person care rooted in authentic healing relationships

**Our Mission:** Spark a field and movement that unites communities of caregivers in Camden and across the nation to improve the wellbeing of individuals with complex health and social needs

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**Our Model**

- The Coalition has been successful in scaling proven interventions while innovating on new programs
- These core capabilities are supported by twin pillars of data and convening of diverse stakeholders

**Integration:** operationalizing successful complex care interventions

**Pilots:** innovating new approaches to complex care

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Local, actionable, real-time data

Skilled convening of diverse players
Innovation requires information:
Our complex care management is made possible by local, actionable, real-time data, facilitating communication between historically siloed players

Integration: operationalizing successful complex care interventions

Pilots: innovating new approaches to complex care

Local, actionable, real-time data

Camden HIE
Camden ARISE
My ResourcePal

Skilled convening of diverse players
Care Management Initiatives (CMI)

CMI is our core complex care management intervention and stresses authentic, face-to-face interaction with the highest-need, highest-cost patients

Patient Identification
- Identify at-risk patients from Cooper, Lourdes and Kennedy hospitals using the Camden HIE

Engagement at Hospital
- Hospital-based team conducts initial bedside engagement
- If the patient consents, the team begins the care planning process
- Enrollment averages 10-20 individuals a month

Community-Based Care Management (90 days)
- Conducted by multidisciplinary, community-based teams (nurses, social workers, community health workers and health coaches)
- Intervention includes home visits, accompanied primary care visits, accompanied visits to social service organizations, internal and external case conferences (including with UnitedHealthcare and primary care practices), telephonic outreach, and graduation “celebrations”
Innovative Pilot Programs Currently Under Testing

**Camden Delivers**
- In Camden, nearly 35% of women are admitted to the hospital or visit the emergency department within a year of giving birth, often because of untreated chronic illness.
- Camden Delivers is an adaptation of CMI for mothers, prioritizing “interconception” primary care.

**Camden RESET (Re-Entering Society with Effective Tools)**
- Pilot partnership with the Camden County Re-Entry Committee to help patients avoid arrests and preventable hospital admissions and improve their wellbeing.
- Camden RESET uses real-time data from jails and hospitals to identify people with both frequent hospital readmissions and jail stays.
- We engage eligible candidates at Camden County Jail and offer them the opportunity to participate in our care intervention.

**Accountable Health Communities**
- Model financed by the Center for Medicare and Medicaid Innovation (CMMI) to address health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs.
- Provides funding for screening, referral to community services, navigation services, and promoting alignment between siloed stakeholders.

**Suboxone Gold Card Pilot**
- Partnership with United Healthcare and two local addiction treatment facilities.
- Allows providers to waive prior authorization requirements for Suboxone prescriptions.
Local, Actionable, Real-time Data: The Camden Coalition HIE

The Camden HIE connects previously siloed players to facilitate a comprehensive, coordinated approach to treating complex patients.

Flow of Data in the Camden Coalition HIE

- **MCOs**
  - MPI
  - ADT
  - Lab/Radiology Results
  - Discharge Summaries
  - Medication List
  - Problem List
  - Allergy List

- **Labs**

- **Hospitals**

- **Camden Coalition**

- **Other Connected HIE**

- **FQHCs**
- **PCPs**
- **Community Partners**
- **Faith in Prevention**
Thank you!

Questions?

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Navigating Care for Complex Needs

Karis Grounds, Director of Health and Partner Integration
Traditionally Information and Referral Network

Resource Database

Multiple Languages offered

24/7 365 days a year

Many moving towards navigation and care coordination
Navigation

Information and Assistance

Information and Referrals
Food
Benefits and Enrollment

Veterans
Courage to Call

Health
Health Navigation

Disaster
Emergency Response
2-1-1 San Diego is the only organization nationwide equipped to electronically submit Medi-Cal and CalFresh applications to the county for review with a legally valid, telephonic signature.

Medi-Cal and CalFresh application assistance is provided by arranging over-the-phone appointments to clients who were pre-screened and referred by our phone center staff.

Allows clients who have difficulty applying in person an additional method of accessing these benefits for themselves and their family.

In the last year, 2-1-1 San Diego connected over 7,000 families to CalFresh benefits.

Approved applications provide an average of $185 in monthly benefits per family, which equates to $1.9M in total annual benefits.

CalFresh benefits also stimulate the economy, which brings the total impact to $25.5M in economic stimulus to San Diego County.
Courage to Call is a program funded by the County of San Diego HHSA Mental Health Services, in collaboration with Mental Health Systems, Veterans Village of San Diego and 2-1-1 San Diego.

Courage to Call is the single access point for information, referrals, navigation, and ongoing care coordination for active duty military, veterans, and their families.

Supported by strengths-based case management and care coordination services offered through masters-level Veteran social workers.

In the last year, about 3,500 military and veteran clients connected to a Courage to Call peer-to-peer support specialist.

73% of clients were empowered by 2-1-1 San Diego to contact the referral they were provided.

90% or more of clients believe they are better able to handle things and know where to get help when they need it.
Health Navigation

Serves as a single access point for anyone in need of health services, addressing the health and social needs of the whole person by better connecting, empowering, educating, and advocating for clients with health needs.

Address risk factors and social determinants of health to help clients achieve a better quality of life and health outcomes.

Complete an in-depth holistic assessment and establish a care plan to address the needs of each client.

In the last year, Health Navigation provided in-depth services to about 2,700 clients.

Health Navigators assisted nearly 200 vulnerable senior clients, empowering 80% to feel more secure in their home and enabling 86% to feel more able to manage their care.

Successfully enrolled 81% of prenatal women in Medi-Cal and 98% of clients were connected to prenatal care.

OUR IMPACT
Community Information Exchange
Community Information Exchange

Network Partners
Collective approach with shared Participation Agreement, Business Associates Agreement and Consent/Authorization

Social Determinants of Health
14 Domains Risk Rating Continuum Crisis, Critical, Vulnerable, Stable, Safe Thriving.

Bidirectional Information Sharing
Ability to Accept and Return Referrals Ability to provide outcomes and Program Enrollment.

Technology Platform
Salesforce software with MDM middleware Informatica to Integrate with other technology platforms. Access to other providers.

Resource Database
Updated resource database of community, health and social service providers.

Community Care Coordination
Communication Feed with Care Team, Relationships, Program Enrollment, Referrals and Goals
Person Centered Model

- Housing Provider
- Transportation Provider
- Income and benefits Provider
- Food Provider
- Healthcare Provider
14 Social Determinants of Health/Wellness

- Housing Stability
- Food & Nutrition
- Primary Care & Prevention
- Health Management
- Social & Community Connection
- Activities of Daily Living
- Legal & Criminal Justice
- Financial Wellness & Benefits
- Employment Development
- Transportation
- Personal Care & Household Goods
- Utility & Technology
- Safety & Disaster
- Education & Human Development
Wellness is directly impacted by:

- Poverty
- Health Inequities (Race, Ethnicity, Language)
- Adverse Childhood Events
- Environment
- Genetic Make-up
Risk Indicators:

- Medi-Cal/Unfunded/Underfunded
- Food Insecurity
- Multiple readmissions or ER utilization
- Lack of social supports
Navigation for Social Needs:

Bridging gaps between social and health services
Care Transitions Intervention (CTI): Care to Community Connections

Partners:
• Feeding San Diego
• Grossmont Hospital Foundation
• Sharp Healthcare
• Sharp Grossmont Hospital
• 2-1-1 San Diego

Shared Goal: Assist in the transition from hospital discharge to medical home and connection to social services.

2-1-1’s Role: 2-1-1 Health Navigators receive referrals from Sharp health educators and social workers to assess and address risks of social determinants of health by connecting to resources in the community.
Evidence for Success

Reduction on hospital readmission

Decrease in vulnerability risk rating scale

Improved Self-Efficacy
More confident in ability to manage their health

Client Satisfaction
Health Plan Satisfaction
**CY 2016-2017:**

- 92% decreased vulnerability
- 92% felt confident in the ability to manage their health

**Patient Needs**

(n = 71)

- Activities of Daily Living: 2%
- Disaster and Safety: 1%
- Legal: 4%
- Employment: 7%
- Human Dev & Education: 7%
- Personal Hygiene HH Goods: 2%
- Primary Care: 4%
- Health Condition Management: 4%
- Financial Wellness: 8%
- Social Community Connection: 7%
- Transportation: 10%
- Utility and Technology: 4%
- Food and Nutrition: 18%
- Housing: 22%

**Hospital Readmission Rates**

- 211 Patients: 9.6%
- Comparison Group: 30.0%
Anticipated ROI:

• CTI program dramatically reduces preventable hospital readmissions for high-risk, vulnerable patients
• Avoidable inpatient admissions ~ $17,564 per admission, and ER readmissions ~ $1,387\(^1\); higher costs estimated for unfunded population

\(^1\)Source: American Journal of Managed Care, 2011
2-1-1 receives fax referral via EHR from social worker/discharge with information and specific notes

Health Navigator assigned to case and sends e-mail confirmation with Health Navigator assignment to social worker

Health Navigator begins case planning based on social worker/discharge planner case notes and patient information

Health Navigator connects with patient within one business day of referral receipt to complete assessment and identify care plan and schedule follow-up appointment

Health Navigator will follow-up with client on care plan with frequency based on need

Continued communication and outcome information will be provided to social worker/discharge planner via encrypted e-mail, on a bi-monthly to monthly basis
City of San Diego EMS: Reverse 2-1-1

Partners:

- City of San Diego
- San Diego Rural Metro Medical Services
- 2-1-1 San Diego

**Shared Goal:** Providing proactive engagement to high utilizers of emergency services to connect clients to available resources including benefits, insurance, medical homes, and social service programs.

**2-1-1’s Role:** Receive at-risk, medic identified electronic referrals through Street Connect with consent of the patient, to reach out and engage with clients to provide referrals to resources in the community to address health concerns/needs.

**Measures:** Number of clients receiving follow-up assistance on basic needs after an emergency visit, decrease in the number of repeat emergency calls, improvements on risk rating scale
Clinical-Community Integration for Wellbeing

Partners:
- American Council on Exercise (ACE)
- Children’s Primary Care Medical Group (CPCMG)
- Community Health Improvement Partners (CHIP)
- County of San Diego HHSA
- Hunger Coalition
- Rady Children's Hospital for Healthier Communities (CHC)
- UCSD Center for Community Health
- 2-1-1 San Diego

Shared Goal: Increase access to healthy food, exercise and other basic needs by connecting at-risk and obese children to resources in the community.

2-1-1’s Role: Receive referrals from participating clinics to address families with children who are obese or at-risk to help educate and connect to healthy resources and social supports in the community.

Outcome measures: Number of children connected to health-related resources; Percent educated and improved healthy habits based on 5-2-1-0; Decrease in food insecurity among enrolled
Levels of Intervention for Complexity of Care

- Social Navigation
  - Navigating community resources and access to services

- Medical Care Navigation
  - Connecting to follow-up care for health condition

- Community Information Exchange
  - Shared record across agencies for opportunity for engagement
Lessons Learned:

• Measure outcomes outside of health care costs
• Resource linkages must be patient/person-centric
• Organizational champions
• Outcomes tracking with feedback loop to providers
• Tailor interventions for complex health and social need patients