



Trinity Alliance of the Capital Region: The Value, Methods, Rationale and Challenges of Deployable Community Health Workers

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Financial Disclosures

I have no financial relationships to disclose

With Dedication to:

Our neighbors, friends, and teachers



Trinity's Social Care in Context

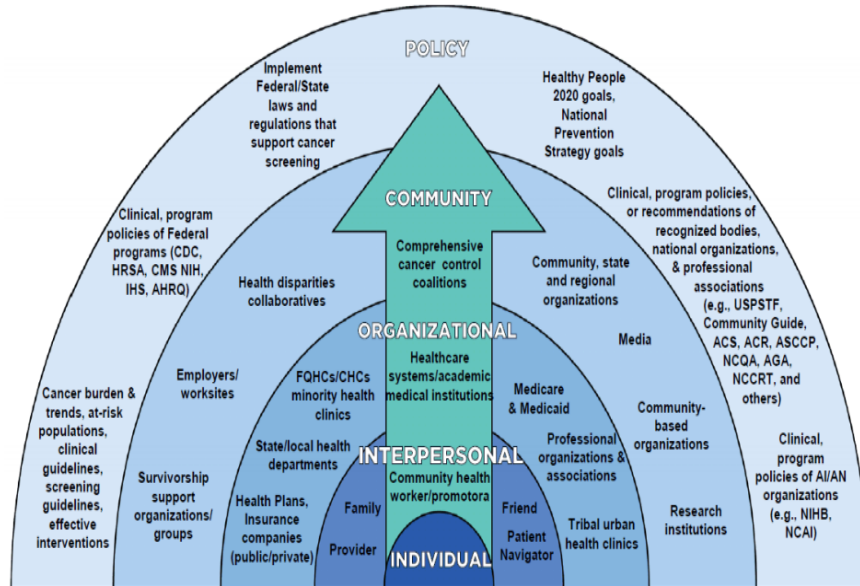
The Healthy People 2020 Approach to Social Determinants of Health (DHHS) advocates a “place-based” organizing framework to address the five key areas of social determinants of health



Trinity Alliance in the Community

- As a 107 year old Settlement House, the notion of a place-based approach to SDOH is part of our historic gene pool: eg. Henry Street Settlement House/ VNA
- Trinity Alliance is strategically placed in key-neighborhood access points, offering grassroots approaches, credibility, and drive to identify, engage, empower in order to improve our health impact by addressing and alleviating all forms of social determinants of health





*Some groups may fit within multiple levels of this model.

- We attack population health & SDOH on a micro-level, family by family, person by person and on a macro-level by undertaking bold communal level change: Swan Street Park, #100 bus line, Capital South Campus Center and ATTAIN Lab, Literacy Zone, supporting the formation and growth of MWBE's
 - We aim to build resilience through reaching a tipping point of positive SDOH prevalence

Our Geographic Footprint: Points of Care

Opportunities/Challenges

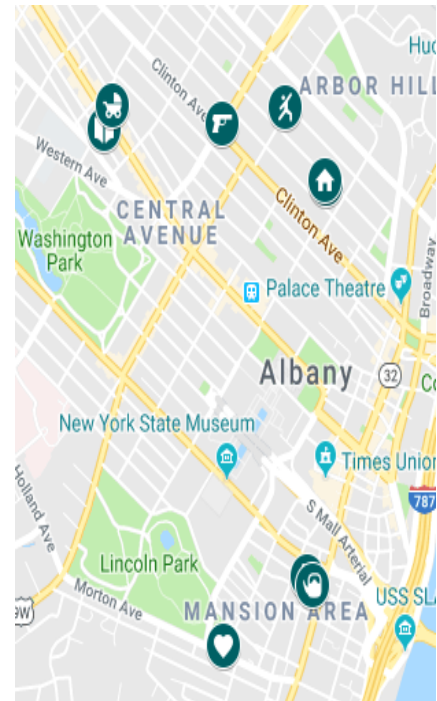
Services Covering:

- Albany
- Rensselaer
- Schenectady

Core Footprint:

- South End
- West Hill
- Arbor Hill

- The Collaboratory
- Refugee Community Health Partnership Program
- Homer Perkins Center
- Albany County Correctional Facility
- Arbor Hill Food Pantry
- 518 SNUG
- Koinonia Primary Care
- South End Food Pantry
- Hospitals




Our Three, Integrated Divisions: A History of SDOH Social Care

Community
Based Network
Services

Alternatives
to
Incarceration

Health and
Wellness



Intentionally designed to reach those who typically intersect with systems of last resort. *

E.g. Shelters, criminal justice, child protective services, emergency rooms

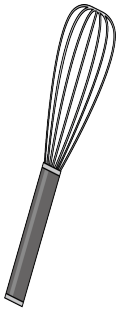
**** Impediments to care utilization: social isolation and stigma, high ACEs prevalence, poor school experiences that carry into adulthood, loss of neighborhood social cohesion, behavioral/substance use disorders, perceived, historic and experienced racism.***

Journey into Medicaid Redesign/DSRIP

- Involved since inception
 - Went through intensive training on its goals
 - Participation agreements & project-specific contracts with each PPS covering Albany
- Trinity was invited to join the BHNNY PAC Executive Committee & Alliance for Better Health Leadership Teams
- Agency transformation to conform with security, compliance, technology, big data emerging requirements

Wellness Advocates Linking Communities

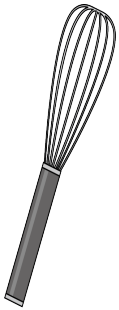
- Launched January 2018
- Team of Community Health Workers (CHWs)
 - Goal: Effectively engage residents in the City of Albany in the preventive healthcare system, particularly those who are lost to/disconnected from care
- Our Recipe – strategic and targeted alleviation of social determinant of health as the pathway toward **continued, meaningful** engagement with the healthcare system
 - Heavy focus on health outcomes as our measurement for success!
- Leveraged strategic partnerships to build our recipe for positive health outcomes
- * Albany College of Pharmacy and Health Sciences: The Collaboratory
- * Refugee Community Health Partnership Program
- * Koinonia Primary Care
- * Hospital discharge planning and after-care



Recipe for:



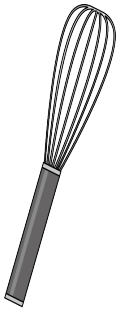
<i>Ingredient – Engagement</i>	<i>Directions</i>
<ul style="list-style-type: none">• Street Outreach• Walk Ins• Referrals	<p>Network with community members and community partners often (at least weekly)</p> <p>Establish consistent presence within hubs in the community</p> <p>Know where community members congregate and will be receptive to services</p> <p>Always keep a CHW available for deployment</p>



Recipe for:



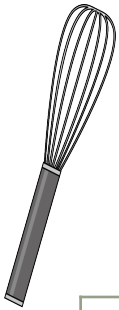
<i>Ingredients – Intake</i>	<i>Directions</i>
<ul style="list-style-type: none">• Social Determinant of Health Assessment• Health Insurance Assessment• Primary Care Assessment• Pharmacy Assessment• Health Literacy• Forms: Notice of Privacy Practices, Hixny, Releases	<p>Use motivational interviewing to identify most current, pressing, high yield interventions</p> <p>If crisis occurring, address crisis and re-visit healthcare assessment during next meeting</p>



Recipe for:



<i>Ingredients – Achieve Outcomes</i>	<i>Directions</i>
<ul style="list-style-type: none">• Active Health Insurance• Annual Wellness Visit• Follow Up Visits• Medication Compliance• Specialist Visits• Preventive Health Screenings	<p>Enroll community member in health insurance on the spot</p> <p>Schedule primary care appointment. Arrange transportation. Offer to accompany.</p> <p>Remind community member of appointment day before</p> <p>Follow up within 24 hours after appointment</p> <p>Joint meeting with ACPHS Public Health Pharmacy Team</p>



Recipe for:



<i>Ingredients – Ensure Continuity of Care</i>	<i>Directions</i>
<ul style="list-style-type: none">• Alleviate Social Needs	<p>After healthcare outcomes met, continue follow up contacts – 2 x per month for 4 months</p> <p>Continue to work through social needs</p> <p>After 4 months of no intervention needed, discharge</p>

Integration in Clinical Settings

Koinoina	Public Health Pharmacy Team
<ul style="list-style-type: none">- Trinity staff have access to Koinoina EHR for referrals and to make notes- Trinity staff attend weekly Koinoina staff meetings- Trinity Alliance staff are physically stationed at Koinoina- Electronic Health Records connected via HISP	<ul style="list-style-type: none">- Developed collaborative model in partnership with one another- Co-located and integrated- Shared workflows- Agreements allowing for shared consent forms and other intake documentation- Focus on improving customer experience

Bake for: 1 year



Results

- In first year of start up, we applied this recipe to 591 unique individuals
- Among those individuals, over 2,500 social needs were alleviated
- This includes approximately four months of 'start up' time (hiring, scaling up, building IT infrastructure, etc.)

Outcomes Achieved in 6 Months

- Primary Care Outcomes - 112
- Health Insurance Outcomes - 120
- Pharmacy Outcomes - 73
- Specialist Outcomes - 145
- Housing Outcomes - 65
- Transportation Outcomes - 193
- Financial Outcomes - 76
- Food Outcomes - 89
- Legal Outcomes - 58
- Education Outcomes - 22
- Health Literacy Outcomes - 145
- Employment Outcomes - 16
- Other Outcomes - 83

Select Outcomes

WIC Obtained

Health insurance obtained –
Medicaid MCO

New primary care
appointment (previously
disengaged)

Eviction avoided

Annual wellness visit –
at risk of
disengagement

Financial Counseling

MAS transportation
booked & received

Medication review
(by provider)

Employment
Obtained

Review mail

Emergency food
received

SNAP obtained

Utilities Restored

Primary care follow up
- attended

HEAP Obtained

ID
Obtained

Obtained
medication

Thank you!

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Medicaid Redesign Inspired Projects

- 2017 – Meeting with PPS Leadership, led to major award
 - Vision for neighborhood nodes based on public health model
 - Data driven → known lost-to-care geographic ‘epicenters’
- 2018 - successfully moved into the HCBS world with state approvals for 7 HARP services and Health Home Care Management
- 2019 – Launch of Care Management Agency status with St. Peter’s Health Partners Health Home (Capital Region Health Connections)
- 2019/2020 – Launch of first VBP and VBP-like contracts with Managed Care Organizations