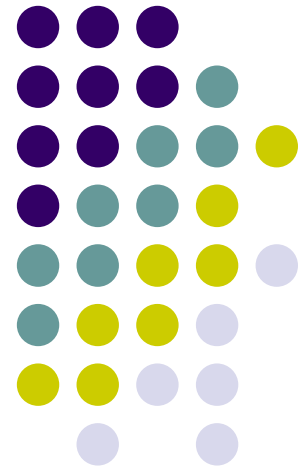
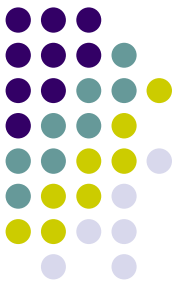


Health Care Homes: Working with Extremely Vulnerable Populations

Brenda Goldstein, MPH
LifeLong Medical Care

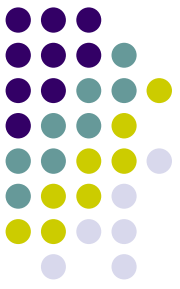


Beyond the Medical Model



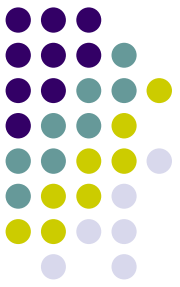
- Recognize that psychosocial issues are a driving factor in chronic disease predicting poor outcomes and ineffective use of the health care system
- Behavioral health, social support and access to resources are key factors impacting health outcomes
- Models that integrate primary care and behavioral health have the most power to create positive change

One Size Does Not Fit All



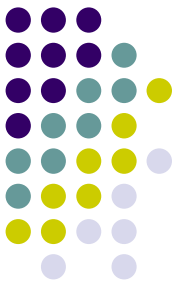
- SPD population is varied and cannot be treated as one population – significant range of need
- Small subset of SPDs are extremely vulnerable, especially those with:
 - Serious mental illness
 - Dementia
 - Homelessness
 - Substance Abuse
- Need predictive models and a variety screening/referral systems to identify appropriate levels of care and effective use of resources

Integrated Medical Homes – A Good Place to Start

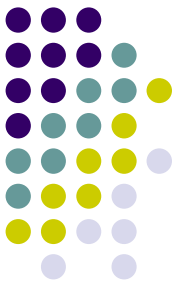


- Key components of integrated primary care and behavioral health:
 - Co-located multidisciplinary staff working as a team
 - Assessment tools to identify behavioral risk factors and needs
 - Seamless services that are client centered
- Expands community capacity for early intervention and triage to appropriate level of services
- Consumers respond well to a holistic approach that addresses the real barriers they face and that is truly tailored to their lives

Serving the Extremely Vulnerable: What Works



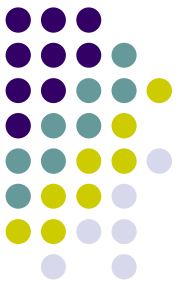
- Intensive engagement strategies – in person and in the community
- Initial focus includes non-medical issues – assessing and addressing immediate needs of the client (e.g. food, housing, transportation)
- Non-licensed staff can be the most effective case managers – hiring from the community can significantly increase system capacity to serve high risk populations in a culturally competent manner
- Provider practices need training (for provider and support staff) on best practice in working with extremely vulnerable clients
- Creating a health care home that provides the needed social support, resource management and continuity of care that has not been available for most clients



Challenges

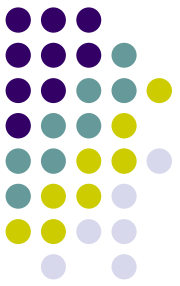
- Change in health outcomes and utilization can take a long time – efforts need to be sustained, relationship based and flexible
- Coordination between agencies, data sharing and access to needed resources can be difficult
- Staff burnout can be high when working with extremely vulnerable populations
- Requires resources which are not currently funded by health care system: low case manager to client ratios and long term engagement

Creating Positive Change in Managed Care



- Develop a variety of screening and identification methods to triage the SPD population
- Understand the provider network and identify providers who have capacity to serve the most vulnerable – match high need clients with best model
- Creating partnerships with community agencies and resources
- Develop creative case management models – not one size fits all (e.g. telephone case management may work well for some consumers, but be useless with others)
- Move beyond a medical model of case management and hire a multi-disciplinary staff – social workers, non-degreed case managers are often more effective for this work than nurse case managers
- Promote growth of integrated models

It Works: Positive Results from the Frequent Users of Health Services Initiative



2 Year Results for the MediCal Population

Two Years In Program Medi-Cal at Enrollment	One Year Pre-Enrollment	One Year In Program	Two Years In Program	% Change Over Two Years
Average ED Visits	12.6	7.8	5.1	↓60%*
Average ED Charges	\$12,650	\$8,470	\$5,673	↓55%*
Average Inpatient Admits	1.8	1.5	.6	↓67%*
Average Inpatient Days	8.5	7.4	2.6	↓69%*
Average Inpatient Charges	\$61,533	\$40,982	\$12,195	↓80%*

**Indicates statistically significant*