Transforming the Workforce to Provide Better Chronic Care: The Role of a Behavioral Health Nurse Care Coordinator in Minnesota

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In 2010, Hennepin Health was authorized by the Minnesota legislature to care for complex, uninsured populations, such as the homeless, covered by the Medicaid expansion provisions in the Affordable Care Act.1

Hennepin Health, which launched in January 2012, is organized as an accountable care organization (ACO)2—a delivery model based on partnerships between providers or organizations to deliver coordinated and integrated health services for a defined population while also sharing the financial risk of controlling costs.3

Coordinated and integrated care is especially valuable for Medicaid patients, particularly homeless patients, who may have limited ability or experience with navigating among medical, behavioral health, and social services within the health care system.4

Homeless individuals constitute a sizeable portion of the Medicaid expansion population. Their unstable housing situations and heavy reliance on emergency departments for health care have contributed to disproportionately high rates of physical and mental health conditions.5

Approximately 42 percent of Hennepin Health’s 8,500 patients have behavioral health needs, 30 percent have one or more chronic conditions, and 32 percent have unstable housing.6 Since Hennepin Health operates under a capitated budget, it has the flexibility to allocate funds to provide integrated primary care and behavioral health services, as well as social services, to address its vulnerable patients’ underlying causes of poor health.

Hennepin Health’s ACO model is rooted in Minnesota’s medical home program, also known as Health Care Homes. The majority of Hennepin Health’s practices have been certified by the state as health
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care homes according to state-developed standards that emphasize patient engagement and care coordination.\(^7\)

Hennepin Health has offered care coordination in its medical settings since its inception. In 2013, Hennepin Health began offering care coordination services at Hennepin County Mental Health Center when it hired a registered nurse to provide patients with initial contact to primary care services while also linking them with other needed services. Hennepin County Mental Health Center provides behavioral health care to adult patients within Hennepin Health.

With a registered nurse fulfilling the role of the behavioral health nurse care coordinator, Hennepin County Mental Health Center is now able to do complete assessments of patients’ medical health, behavioral health, and social needs, as well as provide basic on-site medical triaging and patient education.

“We as policymakers must recognize that a lot of patients that go to Hennepin County Mental Health Center go there for treatment and see that as their primary care home,” says Ross Owen, deputy director of Hennepin Health. Many behavioral health patients prefer to receive primary care where they get the majority of their outpatient services; when this is not available, these patients’ chronic and preventative health needs often go unmet. Owen says that having a registered nurse in the behavioral health setting is a first step toward providing a primary care home for Hennepin County Mental Health Center patients.

As a Medicaid ACO, Hennepin Health is required to collect data related to cost, utilization, quality, and patient satisfaction. These metrics include clinical measures for chronic conditions, patient satisfaction survey data, and utilization measures such as emergency room use and hospital inpatient admissions.

A Day in the Life of Behavioral Health Nurse Care Coordinator Amber Morgan of Hennepin Health

Caring for the health care needs of vulnerable populations has inherent challenges. Doing this in an accountable care organization (ACO), where providers bear financial risk for meeting cost, quality, and patient satisfaction metrics, intensifies the challenges.

When Hennepin Health launched in 2012 to serve as a safety-net ACO for Minnesota’s early Medicaid expansion population, it sought to reinvent the way it identified, engaged, and cared for its vulnerable and homeless populations. This included hiring Amber Morgan to bring primary care to Hennepin County Mental Health Center—where these patients seek most of their services.

Playing Quarterback

Amber Morgan begins each day sorting through numerous telephone and email messages left by the mental health center’s providers asking for help...continued on page 3
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directing, providing, or connecting patients to needed health care services—a role that one psychiatrist described as “quarterbacking.”

Today, this includes a call to a pharmacist about prescription refills and to a county shelter to secure housing for a homeless patient being discharged from a hospital after hip surgery.

As the “quarterback,” Amber consults face-to-face with clinical social workers and psychiatrists to discuss medication management and housing issues. She coordinates referrals for her caseload of patients by making appointments with specialists and briefing the specialists’ offices about the patients’ medical, behavioral health, and social history. In the past 6 months, she has had a “rolling caseload” of about 70 patients.

Her job didn’t start out this way. When Amber began in February 2013, her main responsibility was to find patients with unmet primary care needs. At Hennepin Health, there are community health workers on staff who perform Medicaid outreach and enrollment; Amber’s role is to connect enrolled patients to primary care services. Without this connection, patients will often seek primary care in places like the emergency department or go without any health care services.

When first hired, Amber began with cold calling potential patients to come into the mental health center so that she could assess their medical, dental, social, and behavioral health needs. But this effort turned out to be mostly unsuccessful. She changed strategies and more strongly promoted her role and service options to the clinical staff. She also began co-facilitating a group for homeless men, called “Connections,” two times per...continued on page 5

After one full year, early data show that since the behavioral health nurse care coordinator was hired, inpatient hospitalizations and the use of the emergency department among behavioral health patients have decreased.8

Lessons Learned and Remaining Challenges at Hennepin Health

Staff at Hennepin Health and Hennepin County Mental Health Center offer the following recommendations for developing a behavioral health nurse care coordinator position within an ACO:

Lessons Learned

- Serve patients where they receive the majority of their outpatient services. The behavioral health nurse care coordinator provides a point of first contact with primary care for predominantly severe and persistent mental illness (SPMI) and homeless populations while also facilitating additional linkages with medical, dental, housing, and social services resources.

- Leverage local partners to offer a complete spectrum of health care services, including social services, through an ACO. As a Medicaid ACO, Hennepin Health can offer flexibility in providing a package of services, including “housing navigation,” to meet the changing and complex needs of its patients. The behavioral health nurse care coordinator is able to take a broad view, leverage partnerships created under the ACO umbrella, and connect high-need, high-cost patients with a range of services appropriate for their unique situations.

Overcoming Remaining Challenges

- Secure a permanent funding source for the behavioral health nurse care coordinator. Although initially grant funded, Hennepin Health is...
sustaining this position through use of its reinvestment funds—savings generated by the ACO based on its fixed budget from the previous year—at 0.7 full-time equivalent. Future funding will be contingent on annual renewal of reinvestment funding or finding another permanent funding source.

- **Co-locate primary care in behavioral health settings.** A behavioral nurse health care coordinator is a first step toward the integration of primary care into behavioral health settings. Hennepin County Mental Health Center ultimately aims to co-locate primary care providers into its clinic and become certified as a Minnesota Health Care Home.

### The Role of State Policy

Minnesota has adopted state policies that have shaped the development of Hennepin Health and its use of care coordinators in both medical and behavioral health settings. Table 1 highlights these policies and notes persisting challenges related to the behavioral health nurse care coordinator.

### Table 1

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<th>Behavioral Health Nurse Care Coordinator Role–State Policy Facilitators and Challenges</th>
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week with a clinical social worker. This group allowed her to meet and link with potential patients. Amber added “drop-in” hours directly following each meeting, and these now allow her to meet with patients while they are already at the mental health center.

Amber’s first patient of the day is having total hip surgery in 2 days. She reviews his pre-op directions and gives him a bus pass to get to the hospital. Her second patient is an uncontrolled diabetic, who is now seeing dramatic improvement in his blood sugar levels after making dietary changes. Amber provides dietary counseling routinely to patients, but she also offers counseling to the mental health center staff to promote “a culture of wellness” for the patients.

Afterward a social worker asks Amber to evaluate a patient scheduled for later in the day who has been complaining of vision changes. Integrating a care coordinator into the team at the mental health center took a little time, but now, according to the social worker, the team sees the value of having a behavioral health nurse care coordinator in the office. “Amber is here for the warm handoff. With our population, you will lose them if you don’t make the connection right away,” the social worker explains.

Now that the mental health center has Amber on staff, referrals from psychologists, psychiatrists, and others...
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on staff have also increased; emergency department services are down; and primary care visits are up. No-show rates at both the mental health center and primary care practices have fallen since Amber joined the team.

Next, Amber quickly makes a connection with a new patient who has been waiting to see her. This patient has been referred by his therapist and has been complaining of chest pain. She takes his vital signs and completes an assessment, during which the patient denies current symptoms, but acknowledges discomfort several days before. She determines that he can wait to be seen by a primary care provider until later in the week. She makes the appointment for him, sets up transportation services through Medicaid, and reviews with him an emergency plan should his symptoms recur or worsen.

Running the Drop-In Clinic

The drop-in clinic that follows the homeless men’s “Connections” group has been an important source for identifying patients in need of brief primary care interventions. After these brief drop-in visits, Amber will often set up a subsequent 1-hour appointment to perform a comprehensive health and lifestyle assessment or to provide educational counseling about medication adherence.

This afternoon, Amber has a 1-hour scheduled appointment to review blood sugar glucometer readers with a patient that she has been seeing for a few months. The patient has been making steady progress with checking his blood sugar several times a day. She provides him with positive feedback about his blood sugar monitoring and listens to him as he talks about how he thinks he is ready to find a job. She makes a note about getting a referral for an “Employment” group and schedules the next visit before the patient leaves. She tells the patient he will receive a gift card as an incentive to return. “Offering bus tokens and gift cards,” explains Amber, “can be an enormous incentive to connect patients to needed services.”

The steady stream of patients continues, and Amber makes time to see the patient whom the social worker described as having vision changes. Amber performs an exam that includes checking the patient’s blood glucose and taking her blood pressure. The patient’s blood glucose and blood pressure are both above normal. Amber picks up the phone and makes a prompt referral to a primary care practice and sends the patient on her way with a cab voucher.

“Working in this position has been eye-opening for me,” says Amber. “It has been rewarding and intense. It requires me to problem solve and think creatively to keep patients engaged and keep them coming back.”

“As a behavioral health care coordinator, I try to resolve urgent needs as necessary. For ongoing concerns, I make the connections to get them on the road to health. Whether or not I can solve the problem, patients are reassured simply by knowing someone is there to help.”
Endnotes

1 Minnesota Laws 2010, Art. 16, Sect. 20, M.S. § 256B.0756.

2 Hennepin Health is operated through a partnership of Hennepin County Medical Center, the county’s Human Services and Public Health Department, NorthPoint Health and Wellness Center, and Metropolitan Health Plan, a not-for-profit, county-owned managed care organization (MCO). For more information on Hennepin Health, see http://www.hennepin.us/healthcare.


4 Ibid.


8 Ross Owen and Julie Bluhm, Interview, March 25, 2014.

9 For more information on Health Care Home certification, see the “Health Care Homes Certification Assessment Tool” on the Minnesota Department of Health website, http://www.health.state.mn.us/healthreform/homes/certification/.

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About This Series

Transforming the Workforce to Provide Better Chronic Care:
The Role of Registered Nurses

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This series explores the evolution of primary care systems to better meet the needs of consumers with complex health conditions. It demonstrates that changes in the workforce are required to empower consumers to better manage their health.

The series is a collaboration of the National Academy for State Health Policy and the AARP Public Policy Institute. We recognize that it takes a team of skilled professionals to deliver improved chronic care. In this series, we focus on how registered nurses—who make up the largest segment of the health care workforce—are being deployed in ambulatory delivery systems to take on new roles. Future series will focus on other members of the health care team.

We selected six initiatives that offer replicable policy strategies to develop, implement, and sustain patient-centered approaches to care. Each case study highlights one of these initiatives and provides policy recommendations and an “on-the-ground” look at the work of its nurses.

We conducted site visits to:

- **Rhode Island’s Chronic Care Sustainability Initiative**: a multipayer medical home initiative that supports an embedded nurse care manager in each primary care practice.
- **North Carolina’s Pregnancy Medical Home Program**: a medical home program for high-risk pregnant Medicaid beneficiaries where obstetric nurse coordinators oversee program operation and quality improvement.
- **Minnesota’s Health Care Homes**: a multipayer medical home initiative where nurses play a crucial role ensuring that primary care practices meet state standards.
- **Hennepin Health (MN)**: an accountable care organization where a behavioral health nurse care coordinator orchestrates care among primary care, behavioral health, and social service agencies.
- **Yamhill (OR) Community Care Organization’s Community HUB**: an accountable care organization where a nurse leads a program to improve care for super-utilizer patients.
- **CareFirst’s (MD) Patient-Centered Medical Home Program**: a commercial medical home program using nurse care coordinators to help consumers better manage their chronic conditions. CareFirst is also piloting this program with Medicare consumers through an Affordable Care Act “Health Care Innovation Award.”

These six initiatives offer replicable opportunities and lessons for other states and/or payers that are developing or considering patient-centered models of primary care delivery. All of these initiatives support consumer navigation of complex care systems, understanding of illnesses, and learning self-management skills.

Additionally, all of these initiatives have policies in place that facilitate roles where nurses are supporting practices to be more responsive to consumer needs. The final paper of this series will synthesize lessons learned across all cases studies and offer recommendations for states, policy makers, and educators.

For more information please visit our websites: [http://www.aarp.org/transformingtheworkforce](http://www.aarp.org/transformingtheworkforce) or [http://www.NASHP.org](http://www.NASHP.org).