AARP Public Policy Institute

Spotlight

Transforming the Workforce to Provide Better Chronic Care: The Role of a Community Health Nurse in a High-Utilizer Program in Oregon

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This is the fifth in a series of case studies exploring the evolving role of nurses in new delivery system models designed to better meet the needs of consumers with chronic health conditions. Each case study provides policy recommendations and showcases the work of a nurse in a new initiative. This study looks at improving care for consumers with chronic conditions through Yamhill Community Care Organization's Community HUB program. This program targets consumers who are high-utilizers of the emergency department, with the goals of reducing inappropriate emergency department use and improving connections to primary care. This study also provides readers with an opportunity to see how the policy decisions that created this initiative influence practice through a "day in the life" of the community health nurse beginning on page 2.

In 2009, the top 5 percent of Medicaid enrollees were responsible for over 50 percent of Medicaid health care expenditures in the United States, according to estimates from the Kaiser Family Foundation.[1] These patients, frequently described as "high-utilizers" or "super-utilizers," often have many chronic conditions and complex behavioral and/or social needs that result in recurrent use of the emergency department.[2]

Developing strategies that more efficiently provide services for high-utilizer populations is essential to holding down rising costs of Medicaid programs. One strategy is to deliver care through accountable care organizations (ACOs), which create partnerships between providers and organizations that deliver integrated health services for a defined population while also sharing the financial risk of controlling costs.[3]

Legislation passed by Oregon in 2011[4] and 2012[5] called for the creation of coordinated care organizations (CCOs)—a unique blend of accountable care with the state's preexisting managed care system.[6] CCOs are regionally-based organizations that are accountable for integrating and coordinating medical, behavioral, and dental care for the Medicaid population in order to control costs and improve quality. Oregon CCOs launched in August 2012; today 16 CCOs operate across the state.

Yamhill Community Care Organization (YCCO) is located in northwest Oregon. Created through a grassroots process that enlisted broad community input, the locally governed CCO brings together stakeholders from Yamhill County Health and Human Services; area medical, behavioral health, and dental practices and hospitals; not-for-profit and other community organizations; and consumers.

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Oregon CCOs operate under a per capita fixed global budget with the opportunity for performance-based quality incentive payments.[7] A global budget provides CCOs with the flexibility to allocate funds as necessary to implement new programs and provide services to meet the needs of their patients. YCCO utilized a portion of its budget, along with matching funds from CareOregon—a Medicaid plan operating in the region—to fund innovative programs like the Community HUB, which focuses on YCCO's high-utilizer population.

The Community HUB, which launched in 2013, is managed by one of YCCO's community partners—Northwest Senior & Disability Services. The HUB team includes a community health nurse and two community health workers. The program targets high-utilizer patients with the goals of reducing frequent emergency department use, fostering connections with primary care and community resources, and

A Day in the Life of Community Health Nurse Emily Williamson

Developing a coordinated care organization in northwest Oregon's Yamhill County presented an opportunity to build an organization that reflected the community's vision for high-quality, more efficient, integrated care for Medicaid beneficiaries.

When assessing the needs of the community, it became clear to Yamhill Community Care Organization's (YCCO's) Clinical Advisory Panel (CAP) that a small percentage of Medicaid beneficiaries with multiple chronic conditions were utilizing emergency department services inappropriately and driving a majority of the costs.

To be successful in meeting cost and quality goals, the CAP recommended the development of the Community HUB program and hiring a team to focus care on this high-utilizer population. Emily Williamson is a key member of this team. As the community health nurse, she works closely with other HUB staff to help identify high-utilizer patients and develop interventions to break the cycle of inappropriate emergency department visits.

Identifying High-Utilizer Patients

At her office based at Northwest Senior & Disability Services, Emily begins her day by checking the fax machine. Although some referrals to the HUB come to her by email and phone, the majority arrive by fax. Referrals come in from emergency department providers, primary care providers, and other community providers. The growing number of provider referrals is indicative of the significant, behind the scenes relationship-building work that Emily has done since the HUB was established.

In the first few months of the program, Emily and her team identified potential patients using data from CareOregon,

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Community health nurse Emily Williamson discusses Community HUB development with one of the program's community health workers, Sara Peterson.

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a Medicaid plan operating in YCCO's region. Subsequent input from emergency department providers and others helped HUB services expand to be more proactive about preventing patients from becoming high-utilizers. Although referrals from providers are now the main source of identifying patients, Emily still sifts through the CareOregon spreadsheets she receives monthly from CareOregon.

Today, Emily receives four new referrals. Emily receives all referrals, and it is her responsibility to triage the referrals to assess whether or not the patient needs a physical health assessment, a behavioral health consultation, or other services. Emily phones a staff coordinator from Project Able to refer two of the patients that need behavioral health support. Project Able is a community resource that provides peer support services to YCCO patients with behavioral health needs and other comorbidities. The partnership between the HUB and Project Able has been invaluable in helping the HUB team expand resources available to patients with behavioral health needs.

Emily then checks her email and notes a reply from one of the primary care providers who is interested in setting up a meeting with her to learn about the HUB program. Emily often brings one of the HUB's community health workers with her on these informational visits. "It is helpful to make these introductions between the HUB team and the providers early," Emily says. Community health workers often accompany patients to primary care appointments to help support the patient and ensure coordination of services.

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encouraging patient engagement and self-management of health care.

A community health nurse oversees the work of the community health workers. The nurse is responsible for improving the program by participating in YCCO's High-Utilizer Subcommittee meetings, and for engaging primary care and emergency department providers in the program.

"Ultimately, we wanted a registered nurse, like Emily, to manage the Community HUB because she has the clinical skills and experience necessary to both help community health workers triage the needs of patients with complex chronic conditions and communicate with providers to help expand and develop the program," says Charlene Gibb, HUB manager at Northwest Senior & Disability Services.

When the program began, the HUB relied solely on claims data to identify high-utilizer patients. Patients were considered high-utilizers if they had six or more emergency department visits or had multiple emergency department visits and one or more hospital admissions in the preceding 12 months. The HUB is now also receiving referrals from primary care and emergency department providers for their high-utilizer and at-risk patients.

All Oregon CCOs report on 17 performance metrics measuring cost, quality, utilization, and patient satisfaction. The Community HUB program specifically tracks emergency department visits, hospitalizations, and primary care provider visits for YCCO patients participating in the program.

According to the 2013 performance report released by the Oregon Health Authority, emergency department utilization among all CCO patients in 2013 decreased by 17 percent compared with 2011 baseline data.

YCCO decreased emergency department utilization from 77.7 percent in 2011 to 58.9 percent in 2013.[8]

Lessons Learned and Remaining Challenges at YCCO's Community HUB

Staff from the YCCO offer the following recommendations for developing the community health nurse role in a high-utilizer program.

Lessons Learned

- ***Patient engagement is key.*** The HUB program supports patients in meeting their own immediate goals, directly health-related or not. It works to foster patient engagement and to begin to address the upstream causes of health issues, such as unemployment, lack of transportation, and social isolation. The program has found it needs "boots on the ground"—much more than case management by phone—to help develop relationships between the HUB team and patients and between patients and primary care providers.
- ***Keep the program flexible.*** As with any new program, it is important to continuously evaluate initial program elements because they are not all going to work. Regularly engaging outside input (in this case, the High-Utilizer Subcommittee) improves the program along the way.
- ***Use a combination of data and referrals to identify patients.*** In addition to using claims data, the HUB program is implementing a referral program for primary care providers and hospitals in order to expand its program to help complex, high-needs patients avoid becoming high-utilizers of emergency department services.

Overcoming Remaining Challenges

- ***Improve opportunity for more immediate communication with providers.*** The Community HUB program does not yet have live access to providers' electronic medical record systems, which makes it challenging to communicate patient progress with providers. HUB employees currently are emailing and faxing information to providers.
- ***Develop more resources for patients with chronic pain.*** Patients with chronic pain are frequent users of emergency departments, and team members have limited options of services to offer.

Role of State Policy

Oregon has adopted a number of state policies that have shaped the development of the CCO initiative and its ability to develop such unique programs as a high-utilizer program led by a community health nurse. The table below highlights these policies and notes persisting challenges as they relate to the Community HUB.

Table 1
YCCO Community HUB Community Health Nurse Role— State Policy Facilitators and Challenges

	Facilitators	Challenges
Model	All CCOs have community-level focus; YCCO's Community HUB program is led by a community health nurse; the community health nurse educates providers and hospitals about the program, manages and develops the program, and identifies potential high-utilizer patients through claims data and referrals from providers.	Community health nurse funded at only 0.5 full-time equivalent. May need to increase the nurse's time in order to grow program.
Education & Qualifications	Registered nurse licensed in Oregon, with 2–3 years of experience, strong communication and managerial skills, background in health education, and familiarity with Medicaid.	Limited educational opportunities for community health nursing currently in Oregon and generally in nursing curricula; few community-based clinical training sites.
Training & Resource Supports	Weekly team meetings to discuss successes, challenges, and continued program development; learning collaboratives and technical assistance from the Oregon Health Authority Transformation Center; the community health nurse participated in motivational interviewing, peer support specialist, and community health worker certification trainings.	Formerly no language resources to help HUB serve large Hispanic population, but in July 2014, the HUB hired a Spanish-speaking community health worker.
Physician/Staff Acceptance	Outreach to local primary care and emergency department providers is needed to generate referrals to the program and input on how to improve the HUB program; providers participate on the YCCO's Clinical Advisory Panel (CAP) and High-Utilizer Subcommittee.	Takes time to build awareness about the program and develop relationships with providers and clinics.
Financing & Payment	Internal *Invest Forward* grant process, which includes partial funding through YCCO global budget and through CareOregon.	Will ultimately need to find permanent funding source for this program.
Access to Data	Access to Crimson, a CCO-wide data aggregating system for information about YCCO patients across providers, facilitates improved care coordination and population health management; provides access to clinical diagnoses, cost, and utilization data.	No live access to providers' electronic medical record systems makes it difficult to communicate patient progress with providers.
Consumer Input in Model Development	All CCOs are legislatively mandated to form a Community Advisory Council (CAC), which includes Oregon Medicaid patients and families.	The HUB is working with YCCO to review race and ethnicity data so that the HUB and its workforce represent YCCO's population.

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Working as a Team

Sara, one of the community health workers, comes to Emily to discuss a new patient. The patient has been treated for chronic back pain in the emergency department numerous times over the past few months. The patient does not have a regular source of primary care and is generally distrustful of the medical system. Recently YCCO engaged a naturopathic practice in its network to provide its patients with an alternative source for primary care. The two agree that Sara should discuss this option with the patient.

Emily calls to check in with one of her patients who has a history of chronic obstructive pulmonary disease and pneumonia. The patient has had more than 15 hospitalizations and emergency department visits over the past year. The patient does not qualify for home visiting and is too independent to move into an assisted living facility; therefore, Emily has been working with the patient to develop her self-management skills. The patient wanted to focus on quitting smoking and becoming more active. Emily asks the patient about her smoking cessation goals. She also asks how many times the patient has been able to go up or down the stairs each day. The patient describes how she is managing her cravings and says that she is now using the stairs five times a day, up from three times a day last week.

Emily then heads to the monthly meeting of the Yamhill High-Utilizer Subcommittee. Approximately 15 people have gathered around the table today, including CCO staff, an Oregon Health Authority Innovator Agent,[9] a community health worker, emergency department providers, and community stakeholders. The purpose of this subcommittee is to review and analyze high-utilizer data and coordinate overall efforts for high-utilizer patients. Today there are no complex patient cases that need to be discussed. The subcommittee spends considerable time discussing how to improve the HUB's referral form to make it more useful to providers.

Empowering Patients

After lunch, Emily drives to a primary care clinic to meet a patient, along with his behavioral health specialist and primary care provider. Fostering connections between high-utilizer patients and primary care providers is paramount to the HUB's work. "Getting the patient to the primary care provider's office is often a significant success," says Emily. "We need to be willing to celebrate these steps with the patient."

The patient, Emily, the behavioral health specialist, and the primary care provider discuss the next steps. They review findings from a survey the patient previously took using the Patient Activation Measurement tool.[10] This tool measures patient engagement in care as well as self-management capabilities. Together, they develop the patient's action plan based on his self-identified goals. "Everybody has a potential solution," Emily notes after the visit, "but the real solution has to come from the patient. He needs to tell us how we can make the plan work for him. We can tell him that we want him to be healthy, but ultimately he needs to have some control."

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After leaving the office, Emily gets a call from a patient who she has been working with for a couple of months. Despite being well connected with a primary care provider, the patient has been in the emergency department between 20 and 30 times in the past month. Emily says the patient calls the emergency department "her comfort zone." After the call, Emily wonders, "What is she getting in the emergency department that she is not getting at home or from her primary care provider? She's stuck in this behavior pattern and has created a community that's inappropriate for what she needs."

Emily has connected this patient with Project Able, and the patient is writing in a diary to try to identify "triggers" that send her to the emergency department. Emily asked the patient to call her the next time she felt the urge to go to the emergency department and Emily would accompany her on the visit. That call came today. Emily heads out the door to meet the patient at the hospital and takes a further step in trying to break this patient's cycle of inappropriate emergency department use.

Endnotes

[1] The Kaiser Commission on Medicaid and the Uninsured, "Chartpack: Medicaid and Its Role in State/Federal Budgets & Health Reform," 2013. Accessed at http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8162-03.pdf.

[2] Dianne Hasselman, "Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs," 2013. Accessed at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407990.

[3] Valerie A. Lewis et al., "The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles," *Health Affairs* 31, no. 8 (2012): 1777–1785.

[4] Oregon House Bill 3650 (2011). Accessed at http://www.oregon.gov/oha/OHPR/PSDM/HB3650.pdf.

[5] Oregon Senate Bill 1580 (2012). Accessed at https://olis.leg.state.or.us/liz/2012R1/Downloads/MeasureDocument/SB1580/Introduced.

[6] Trish McGinnis and Amanda Van Vleet, "Core Considerations for Implementing Medicaid Accountable Care Organizations," 2012. Accessed at http://www.chcs.org/media/CoreConsiderationsforMedicaidACO__Final.pdf. Originally cited in Oregon Health Plan (OHP) Section 1115 Demonstration Waiver. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf.

[7] Oregon Health Policy Board, "Coordinated Care Organizations Implementation Proposal," 2012. Accessed at www.oregon.gov/oha/legactivity/2012/cco-implementation-proposal.pdf.

[8] Oregon Health Authority, "Oregon's Health System Transformation: 2013 Performance Report," 2014. Accessed at http://www.oregon.gov/oha/Metrics/Documents/2013%20Performance%20Report.pdf.

[9] For more information about Oregon Health Authority Innovator Agents, see http://transformationcenter.org/innovator-agents/.

[10] Insignia Health, Patient Activation Measure™. Accessed on December 2, 2014, at http://www.insigniahealth.com/ha/measure.html.

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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 or http://www.NASHP.org.

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