

# Demonstrating the Value of Non-Licensed Providers

Integrated Behavioral Health Partners  
Jennifer Brya, MA, MPP  
Karen Linkins, PhD

December 2017

# Demonstrating the Value of Non-Licensed Providers

## A. Overview

### **Purpose of the Engagement:**

The goal of this brief is to synthesize learnings and highlight opportunities for alignment across 5 pilot projects from 4 counties that participated in the Health Improvement Partnership Capstone Event as part of the Blue Shield of California Behavioral Health Integration initiative.

The 5 Pilot Projects Featured at the Behavioral Health Integration Capstone Event included the following:

- **Merced County Department of Public Health Data Dashboard and Geo-Mapping High-Risk Patients with Depression and Diabetes:** The Public Health Department, in collaboration with two local FQHCs, developed an environmental analysis of “hot-spot” locations for individuals with the highest prevalence rates of Depression/Diabetes.
- **HOPE Medical Respite Care Program (Merced County):** Peer-lead medical respite care program, created in partnership with Dignity Health -- Mercy Medical Center, for homeless patients in need of a safe, community-based transition option following an ED visit or inpatient hospital stay. Medical respite care includes room and board, case management, transportation, appointment accompaniment, and post-respite field-based case management and aftercare service.
- **Monterey County Whole Person Care Pilot:** Intensive and Comprehensive Nurse Case Management for Monterey County’s most vulnerable Homeless, Medi-Cal recipients with complex medical and behavioral health conditions. The pilot project includes N=4 nurses that will serve a total of 600 patients across the community over 3 years.
- **San Mateo County Integrated Medication Assisted Treatment (IMAT) Program:** Referral and provision of MAT and case management services for San Mateo Medical Center patients with chronic, problematic alcohol use who are motivated to reduce or stop alcohol use. County AOD staff are stationed in the hospital ED and refer patients directly into MAT and assign them a case manager to assist with treatment follow through and provide ongoing support.
- **Santa Cruz County Transitional Behavioral Health Integration Pilot:** Provide community-based behavioral health and substance use recovery support for inpatients at Dominican Hospital to facilitate ongoing mental health and recovery when discharged from the hospital.

***A focus on the role of Non-Licensed Providers<sup>1</sup>***. A common theme, and strength of each of the pilot projects featured during the capstone event was the significant role of community health workers (CHWs) and non-licensed providers (NLPs) in program implementation. This brief documents the evolving role of CHWs in these programs, highlights promising practices for training and supporting this workforce and shares implementation lessons learned related to data sharing and care coordination from the 5 pilot programs.

***Common metrics for demonstrating impact***. This brief also documents how counties are measuring program impact and presents strategies and promising practices that can be leveraged in other statewide integration related initiatives (e.g., Whole Person Care pilots, California Accountable Communities for Health Initiative, 2703 Health Homes and Drug Medi-Cal Organized Delivery System). Each of these initiatives and waiver programs involve coordination, integration and collaboration across the health, behavioral and social service sectors, as well as linkage to community-based organizations and supports.

## B. Background— Shifting toward greater community integration

There is growing recognition of the value of providing community-based interventions that bring care coordination activities to the client – no matter their location or setting. A number of studies have assessed the impact of social factors on health. The literature highlights the reality that health care services only impact 10-15% of population health outcomes, with the social determinants of health largely impacting the remainder<sup>2</sup>.

In an effort to improve population health outcomes, improve patient experience of care and lower costs, there has been an increasing awareness of the value and growing potential of non-licensed service providers. It is now broadly understood that we need to go beyond traditional health care services to address the social and environmental conditions that contribute to poor health. Given limited resources and a shortage of clinical providers, non-licensed providers are rapidly being incorporated into the health care team to address the social determinants of health.

### **Perspectives on the value of NLPs from Stakeholders in the Field**

**“The acuity level of our homeless patients is so great in terms of their mental health, addictions and housing issues, there is no way this work could be done without the support of non-licensed staff. They advocate for them with social services, get them to appointments, follow up on paperwork for benefits and reinforce messages around medication compliance – this is all really significant and important work.” -- Moira Lewis, PHN, MPH, Supervising Public Health Nurse for Whole Person Care**

**“Case managers are the backbone of our program and key to success. Certified AOD counselors are considered non-licensed providers, and their ability to engage individuals in treatment is invaluable.**

---

<sup>1</sup> For the purpose of this brief, the term “Non-Licensed Providers” includes Community Health Workers (CHWs) certified Alcohol and Drug Counselors and Case Managers.

<sup>2</sup> The case for more active policy attention to health promotion. McGinnis JM, Williams-Russo P, Knickman JR, Health Affairs (Millwood). 2002 Mar-Apr; 21(2): 78-93.

**They bring a human lens and not a medical lens by asking ‘What happened to you that brought you here today?’” -- Mary Taylor Fullerton, San Mateo County Alcohol and Drug Services**

## C. Role of Non-Licensed Providers

The non-licensed workforce is uniquely qualified to assist others and encourage resiliency, wellness and self-management of health and behavioral health. Non-licensed providers often have the shared experience of stigma and discrimination, the impact of behavioral health challenges on all life domains, and the knowledge of how these issues affect healthcare access and engagement. With increasing attention focused on improving access to health care, chronic disease management and population health, the role for non-licensed providers has expanded to promote greater health and wellness. County participants in the capstone event identified a comprehensive list of activities non-licensed providers provide in their programs that span outreach, engagement and education, direct services and supports, including:

### **Outreach, Engagement & Education**

- Assertive, community-based outreach/Engagement of hard to serve populations
- Setting expectations, promoting accountability
- Educating patient on PCP selection/assignment
- Persuading clients to engage in specialty treatment (AOD treatment)
- ED based navigators educate on appropriate use
- Provide health education resources

### **Direct Service and Client Support**

- Appointment accompaniment
- Follow up on medication fills to aid in compliance
- Develop psychosocial Action Plan with specified client goals
- Assess Stages of Change/document readiness for treatment
- Benefits assistance with securing necessary documentation
- Cross-System Navigation
- Care Coordination
- Community Resource Connection
- Social Support, Motivation & Activation in Self-Care
- Transportation
- Advocacy

Non-licensed providers (e.g., CHWs, navigators, case managers and AOD counselors) play a significant role in the implementation and success of all five programs featured in this brief. These care team members schedule appointments, provide reminders and transportation, and follow up supports to ensure patient are accessing needed services, which contributes greatly to reducing no-shows, improving medication and treatment compliance and ultimately health outcomes.

## D. Documenting NLP Services and Tracking Process & Outcome Measures

In health care settings, case management and care coordination activities are not reimbursable services under Medi-Cal. Because there is no reimbursement source for case management, most clinic EHRs (that are set up for billing) do not systematically document and track these services. However, in order to demonstrate the value of the care coordination work provided by non-licensed providers (also not reimbursable providers), it is important to establish a system to track these encounters and the impact on patient/client outcomes.

**Set up documentation process in the EHR to align with Medi-Cal case management services that are billable in the County Mental Health system.** In the San Mateo IMAT program, NLPs document case management functions in great detail to capture the specificity and range of services provided to clients. For example, if an encounter includes both an Outreach/Engagement service code and an Assessment Service Code, the NLPs will write two progress notes even if it's in the same encounter. It requires more data entry and documentation but it is part of training NLPs to track services like a billable provider.

Non-licensed staff in the IMAT program also use “Unclaimable” service codes to document 3rd party conversation with a provider, phone messages left for follow up, transportation, and appointment scheduling. Supervisors can still run reports on “Unclaimable” service codes to understand the service time and resource demand associated with these tasks. When trying to demonstrate the value of NLPs, it is important to document the full scope and volume of services required to engage clients in care, connect them to services and support them throughout their treatment course.

**Process and Outcome Measures across the County Programs.** County program representatives acknowledge the importance of collecting a robust set of *both* process and outcome metrics to demonstrate the impact of their programs.

**“The pendulum swings toward outcomes immediately. We had to advocate strongly on collecting process measures to understand what’s working and not working in developing cross-sector processes for referrals and understanding the factors that lead to better client engagement in treatment.” – Lisa Russell, Janus of Santa Cruz**

We gathered information on the metrics each pilot tracks to identify a common set of measures. The following tables illustrate the range of process and outcome measures being tracked across the programs.

**Table 1. Process Measures Tracked by Program**

Measure	Merced DPH	HOPE Medical Respite	Monterey WPC	San Mateo IMAT	Santa Cruz
# of Enrollees	X	X	X	X	X
Referrals	X	X	X	X	X
# of Encounters/Contacts		X	X	X	X
Encounters (minutes)		X			
In-person; Phone Contact		X	X		

Measure	Merced DPH	HOPE Medical Respite	Monterey WPC	San Mateo IMAT	Santa Cruz
Participant Engagement Level		X		X	
Treatment Engagement Rates				X	X
# and Miles of Transport		X	X		
Appointment show-rates		X	X	X	X
% of lost to follow up				X	
# of days from referral to CM contact				X	
# of contacts between hospital discharge and O/P treatment				X	

**Table 2. Outcome Measures Tracked by Program**

Measure	HOPE Medical Respite	Monterey WPC	San Mateo IMAT	Santa Cruz
ED visits pre/post program	X	X	X	X
Inpatient hospitalization	X	X	X	X
30-day readmission rates	X	X		X
Health plan costs			X	
Outpatient service utilization		X	X	X
Treatment completion rates			X	
Treatment Engagement Rates			X	X
Housing connection	X	X		
Benefits connection (SSI, SNAP)	X	X		
PHQ-9 score		X		
RX fill		X		
Client Perception of Health (# of “healthy days” reported)	X			
Stages of Change	X			
Goals achieved on care plan	X			
ED Provider Satisfaction	X			

\*The Merced Department of Public Health project is not included in this table because this work is part of a broader strategic initiative. Therefore, the project included process, not outcome measures.

## E. Promising Practices for Training & Supporting NLPs

Access to comprehensive training in a variety of modalities is critical to supporting non-licensed providers. Program representatives from the 4 counties shared a variety of resources and strategies to creating a well-informed, capable and cohesive team of workers that have the skills to work with complex populations in a wide range of community-based settings.

**Require formalized training to provide a consistent standard of practice.** Lack of training leads to variability in skill sets and service delivery. A core component of any CHW training curriculum includes

HIPAA/Privacy training, and Ethics and Boundaries. County program representatives recommended the following CHW/NLP training programs to ensure a baseline set of skills:

- California Consortium of Addiction Programs and Professionals (CCAPP Academy) includes certification process for AOD counselors.
- Texas A&M National CHW Training Center offers an online program, consisting of 160 program hours over 6 months that uses a live webinar format. The program costs \$700, and CHWs receive certification upon completion.
- CASRA CHW Training – 1 module completed weekly for 5 weeks, with a focus on psychosocial rehabilitation services.

***Training in evidence-based practices for enhanced skill development.*** Non-licensed staff are often working with extremely complex populations and therefore require intensive support and education. Additional content specific trainings mentioned by the county program representatives include:

- Motivational Interviewing
- Trauma-Informed Care
- Harm Reduction
- Co-Occurring Disorders
- Strength-Based, Person-Centered training
- Housing First

***Provide training on how NLPs can communicate with clinical professionals/physicians.*** Present brief, mini-trainings using patient vignettes and have NLPs practice developing a 2-minute pitch on how they would convey key information to medical professionals in a concise manner.

***On the job training.*** Providing staff with a myriad of on-the-job training opportunities under the supervision of licensed providers is key to CHWs becoming comfortable in their role working with diverse populations. It is important to use live scenarios and case vignettes facilitated by a social worker/licensed provider to practice engagement techniques, and then slowly build up to working with people 1:1 without supervision.

***Include site tours of various facilities.*** Onsite exposure to various sites such as residential treatment programs, homeless shelters, respite centers and detox facilities helps establish partnerships by building in face-to-face time on partners' home turf. Building these relationships through in person site visits is invaluable when a patient is in crisis and needs a bed. You want to avoid a scenario where your patient is in crisis and needs placement, and you are making cold calls to other providers.

## F. Data Sharing Lessons Learned across the Pilot Programs

***Start small and focus on a few community partners to test out communication and data sharing protocols.*** It is important to go through the necessary steps to obtain clearance with hospital partners to access their data systems to facilitate care coordination and improve hospital to community transitions. In Santa Cruz, the Social Work Department at Dignity Health created an excel spreadsheet to extract data from Cerner system, then shared this information with the community-based program team at

Janus of Santa Cruz. The hospital and CBO partners met weekly to update the data and monthly to confirm the referral process.

***Invest in a database that can capture behavioral and social service data to track case management and care coordination data.*** The HOPE Medical respite program uses APRICOT, a pre-configured database that is pre-programmed with HMIS to support housing assessment and placement, and has modules that can be tailored to create a fully customizable platform to document care coordination and case management services and report outcomes. Most data systems are focused on billing, so there are limited resources dedicated to developing a robust system to capture non-reimbursable services. Organizations are left to cobble together grant funds for this purpose. Creating this infrastructure and standardization for reporting across staff is critical for establishing transparency in case management service delivery, creating accountability and demonstrating the value of CHWs as part of the care team.

***Understand the priorities of your organizational partners to aid in communication and data sharing.*** It is beneficial to provide partners with information that speaks to their priorities as part of the data exchange protocol. In Merced, the Public Health Department requested specific diagnostic and demographic data from their FQHC partners, in return provided analytic reports and information on their patients that would be helpful for clinical intervention. The clinics were able to develop specific educational flyers to target their chronic disease interventions to patients who lived in the identified “hot-spots” so the data request resulted in a mutually beneficial outcome.

***Client consent and cross-sector data sharing.*** Client consent is key to data sharing but having legal support and County Council buy-in to processes settles many debates when organizations use different consent forms because no universal consent form is recognized across partners. In Merced County, in order to obtain EHR data from their FQHC partners, the Public Health Department modeled their Data Sharing Agreement (DSA) with the FQHCs Process of getting data from clinic — modeled DSA after OSHPD data sharing agreement for HIPAA compliance. This template helped streamline the process of getting patient level clinical and demographic data from their clinic partners to develop the prevalence dashboards and map chronic disease “hot-spots” at the neighborhood level.

***Information can be shared during medical and psychiatric emergencies at the hospital ED.*** The IMAT team in San Mateo finds a way to provide services and share vital information with their partners, even in the middle of a medical emergency. During a patient medical or psychiatric emergency at San Mateo Medical Center, the IMAT team takes action and shares information with pertinent provider by sending an email notification to the physician/nurse that the patient was in a psychiatric or medical emergency and needs to link back to PCP for follow up. The team uses the emergency situation in the ED as the rationale for immediate coordination, communication and linkage to provider, but the team cannot re-disclose information related to the ED visit after the crisis.

## F. Conclusion -- Opportunities to Support Community Health Integration

The projects featured in this brief are demonstrating the value of care coordination as a core component of community health integration. Much has been learned regarding strategies for effectively providing care coordination, including the types of services, skill sets, and data tracking, as well as the vital role the



non-licensed workforce plays. There are several opportunities to scale up and spread these learnings to improve community health integration across California:

**Leverage State Initiatives.** Currently, there are several Medi-Cal (e.g., Drug Medi-Cal Organized Delivery System, Whole Person Care, Health Homes) and Foundation (e.g., CACHI) funded state-wide initiatives being planned or are underway that involve CHWs and NLPs to address the needs of complex populations through cross-sector outreach, care coordination and case management functions. There are opportunities to document and spread best practices across these initiatives, as well as align outcome measurement and return on investment strategies, to demonstrate the value of both care coordination and the non-licensed workforce in better serving complex populations.

**Role of Foundations.** Foundations play a critical role in building capacity within the safety net system of care to enhance care coordination, data sharing and population health management to reduce disparities and improve outcomes for vulnerable populations. The following are recommendations for foundations to consider as they continue to advance and improve community health integration and promote the role of the non-licensed workforce:

- Organize Medi-Cal Managed Care Organizations (MCOs) to develop a common strategy for documenting and assessing population health for the Medi-Cal population at the State and county levels. This will require a strong data collection and analytic strategy that can be supported by foundations as the neutral convener.
- Support technical assistance for local, cross-sector safety net providers and systems to implement consistent approaches for documenting and analyzing care coordination effectiveness and value. Typically this is evaluated project by project by external entities, rather than building capacity within organizations for consistent quality improvement measurement and outcome monitoring.
- Support implementation training in communities that focuses on the key operational aspects of developing and aligning measurement systems, protocols and data sharing agreements, and then using data to address key stakeholder interests.
- Support community partners in convening and strategic planning to advance the infrastructure and capacity for community health integration and care coordination. This includes ensuring that partners in different sectors understand the funding and reimbursement environment, and associated requirements that shape the health care ecosystem. “The business of health care is very different from the delivery of health care. Our partners are very smart about business. Direct service providers and CBOs often lead from compassion and want to educate and collaborate, but we need to understand the business drivers that influence cross-sector partnerships.” *Jason West, Hope Medical Respite Program*

## F. Acknowledgements

IBHP would like to thank the community stakeholders across the five pilot projects that offered their time to share their knowledge and experience of program implementation. We would also like to acknowledge and thank Shelly Barker and the Health Improvement Partnership for their passion and commitment to advancing community health integration and cross-sector partnership across the central California region.

<i>Moira Lewis, RN, PHN</i>	Monterey County Health Department
<i>Kathleen Grassi, RD, MPH</i>	Merced County Department of Public Health
<i>Kristynn Sullivan</i>	Merced County Department of Public Health
<i>Lisa Russell, PhD</i>	Janus of Santa Cruz
<i>Jen Hastings, MD</i>	Health Improvement Partnership
<i>Elisa Dakiwag, LMFT</i>	Janus of Santa Cruz
<i>Mary Fullerton, MFT</i>	County of San Mateo
<i>Jason West, MPH</i>	Merced County Rescue Mission