Mini Plenary: Faith-based Workforce: Engaging the Community and the Health System

Jeremy Moseley, M.P.H.

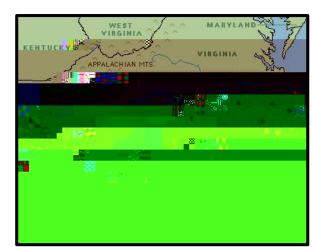
Program Administrator for Community

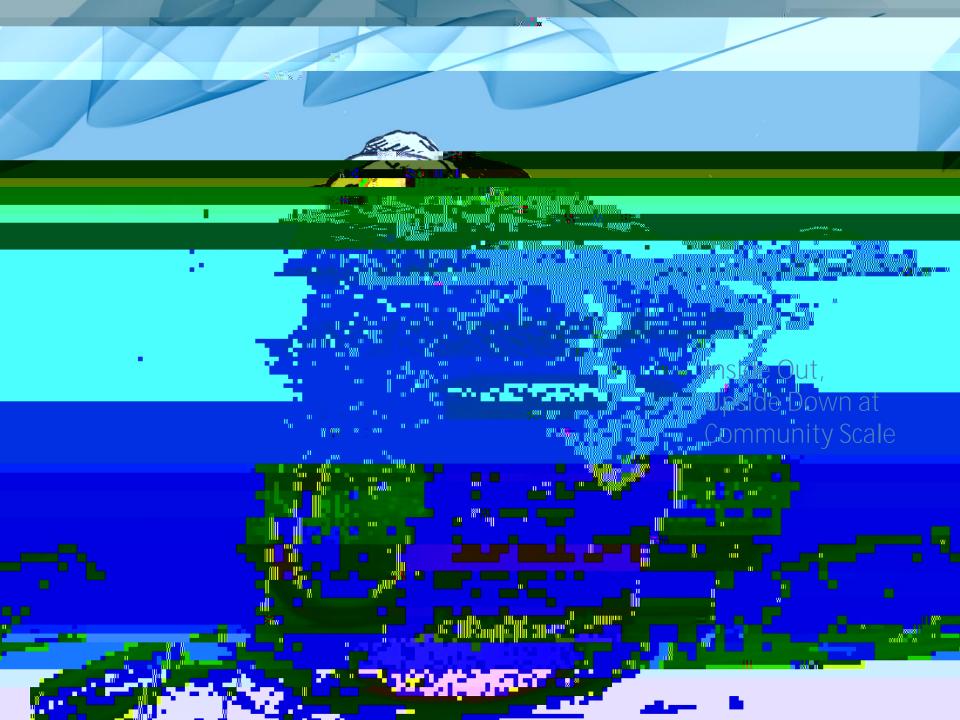


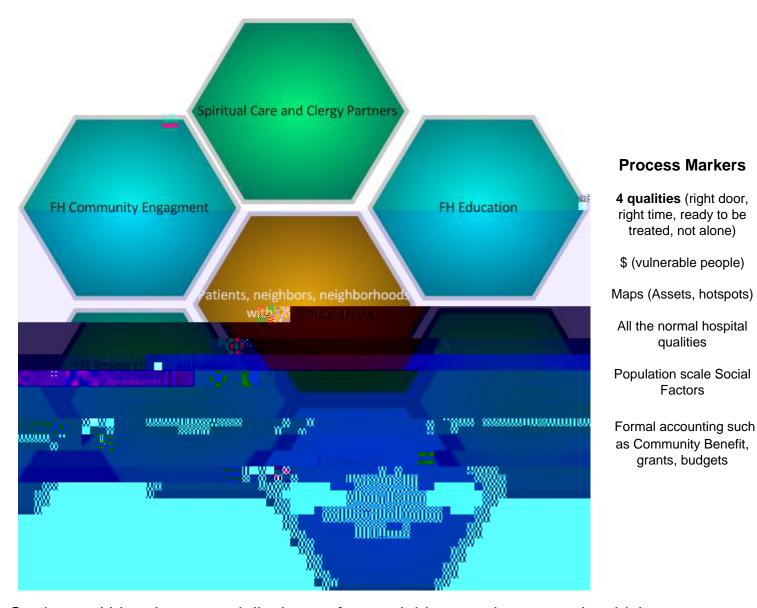
Faith-based Workforce: Engaging the Community and the Health System

Presented as a mini-plenary at "The 31st Annual Rosalynn Carter Symposium on Mental Health Policy"

November 13, 2015







Process Markers

right time, ready to be treated, not alone)

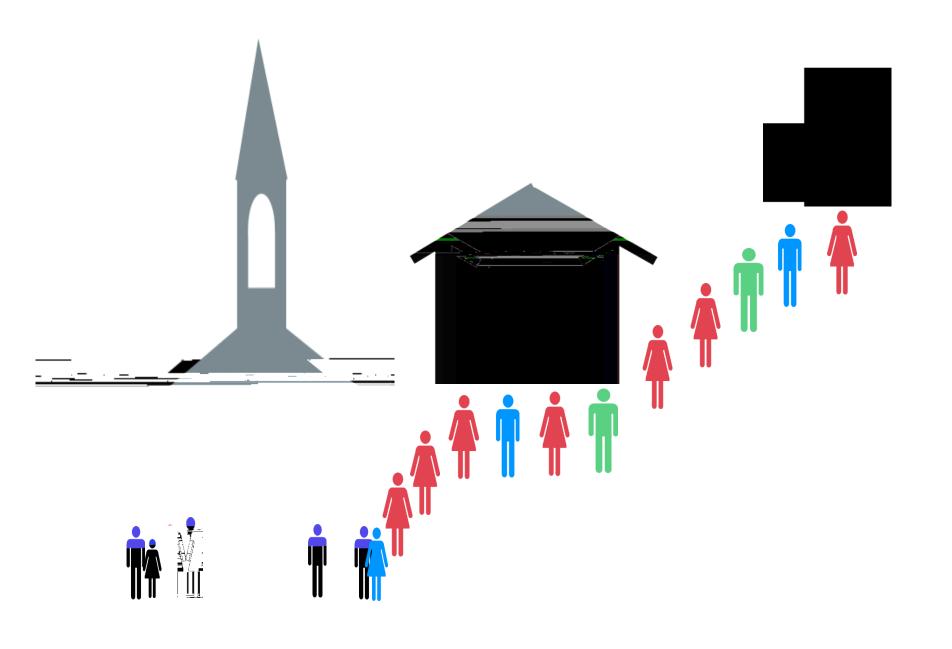
\$ (vulnerable people)

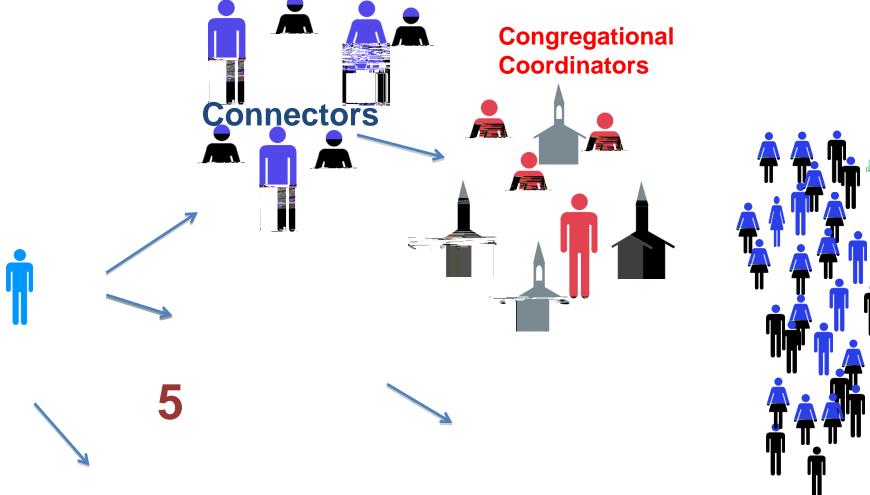
qualities

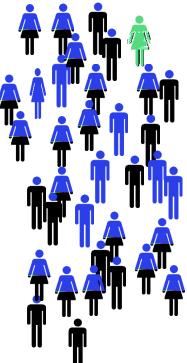
Factors

grants, budgets

Stories and histories, especially those of our neighbors and partners, in which we can see our emergence in living context.







Hipping the power dynamics between

Supporter Expertise

Relational, Life Experiences

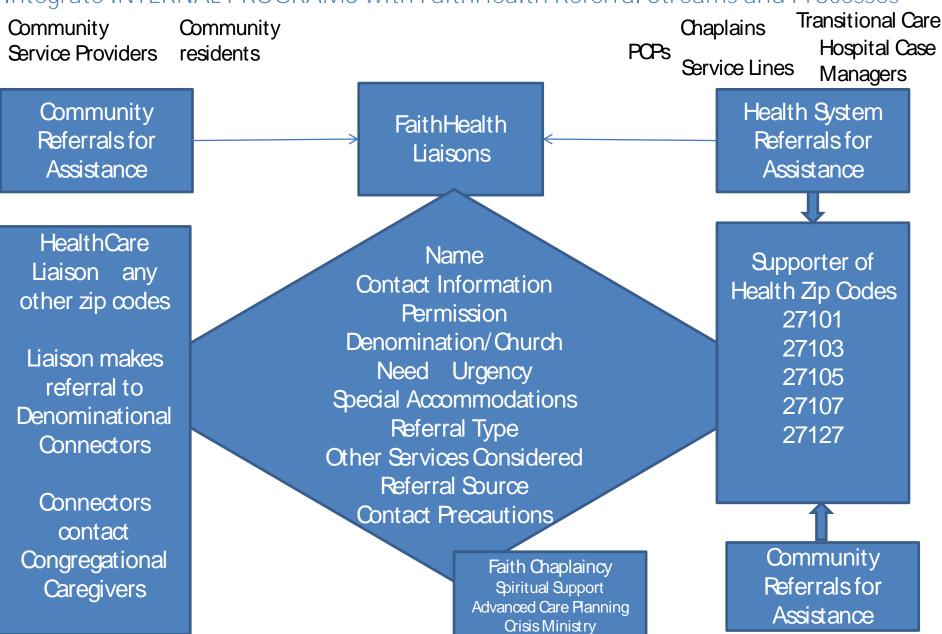
Medical resources and health information

Behavioral health resources and basic assessment

Social and community resources and referral processes

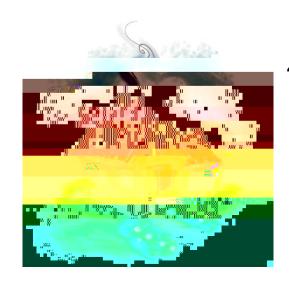
Spiritual support and connection

Integrate INTERNAL PROGRAMS with FaithHealth Referral Streams and Processes



SUPPORTERS OF HEALTH ACTIVITIES: Embedded Formative Evaluation: First 18 months

928 PHONE CALLS



458 HOMEVISTS

1484 TOTAL ENCOUNTERS

98 HOSPITAL VISITS

Two Tiered Data Approach

Supporters of Health Cohort

Measure impact of the Supporters of Health work, within their small cohort: process and financial metrics (with

Case studies, combining qualitative and quantitative data

Overall
Charity Care

Measure Overall Aggregate Self-Pay Costs to the system, trending by FY, comparing our 5 target zip codes to other zip codes

Supporters 18 Month Findings

Encounters: Supporters have had 320 encounters (287 unique persons)

Referral Sources: 73% of referrals come from the community and 27% are from internal health system staff

Past Hospitalizations: 90% of the referrals have been seen in the Wake Forest system within the last 5 years.

Readmission rates are 10%

Majority (93%) claim no faith home

Primary needs met: healthcare coverage, food, home care assistance, utility/bill assistance Payer Status: Un-insured (62%), Medicaid (16 %), Dual (9%), Medicare (8%), 3rd Party (5%)

Medicaid, potential ROI: Enrolling persons for Medicaid was a large part of service, especially collaborating with Patient Financial Services. Estimated potential ~\$145, 431 in revenue, based on benchmarking one future annual inpatient encounter of self-pay patient (\$318) vs. average Medicaid payment per inpatient encounter (\$4,725).

http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?List=7d1 126ec-8f63-4a3b-9926-c44ea3036813&ID=111

	6 Months Prior to Enrollment	6 Months After Enrollment
Total Encounters	875	877
Patients	132	130
Average Encounters Per Patient	6.6	6.7
Average Cost Per Encounter	\$2,208	\$1,846 (16%)
Average Cost Per Patient	\$14,634	\$12,451 (15%)
Charges	\$5,514,374	\$4,624,047 (16%)
Charges Per Inpatient Encounter	\$19,293	\$18,794 (3%)
Charges Per Outpatient Encounter	\$1,927	\$1,741 (10%)

Place-Based Charity Care Findings

FY12-15 Self Pay Patients Only: 5 target zip codes

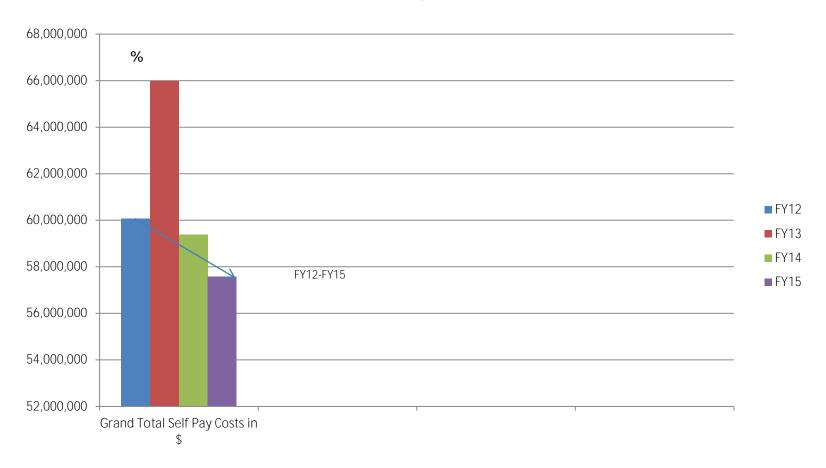
Total self pay patient costs represented ~\$60m in FY12 5 Winston-Salem zips accounted for roughly 30% of those losses

Populations in these neighborhoods growing, median income dropping, and, we are getting a large share of the growth in terms of unique patients and total encounters

Overall FY self-pay costs have decreased 4% for the system

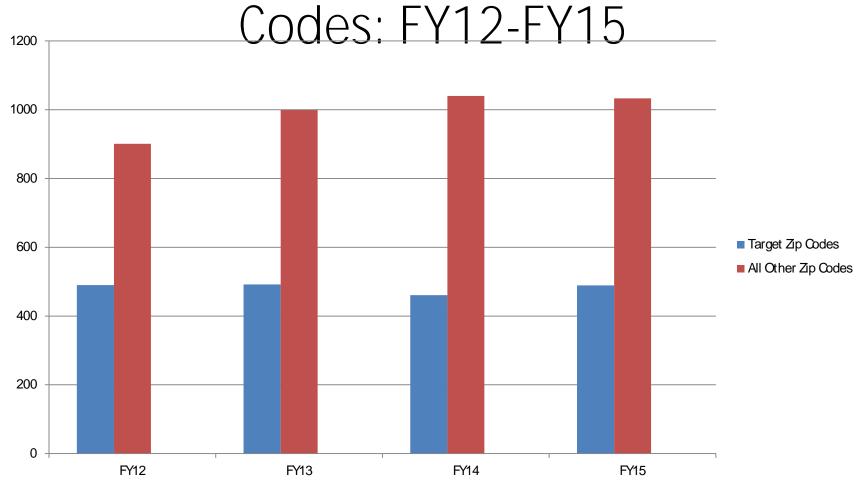
Data compiled by Greg Bray and Justin Meier, Wake Forest Baptist Medical Center

Grand Total Self-Pay Costs from FY12-FY15



Overall total self-pay costs to the system have dropped by 4% from FY12 to FY15, resulting in a savings of \$2,508, 460

Self-Pay Costs (\$) Per Encounters for 5 Target Zip Codes vs. All Other Zip



4 Year Charity Care Findings in 5 Zip Codes



Expanding the Supporters of Health

2015: AHEC grant awarded to FaithHealth to refine curriculum and train 30 more Supporters statewide, across many counties, including:

Forsyth

Davidson

Surry

Randolph

Wilkes



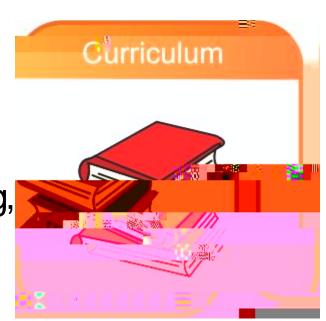
Curriculum Design

Built upon wisdom of current Supporters

Values relationships and building trust

Integrates care management skills, community health advocate training, motivational interviewing, basic health/behavioral health management (pain management, sleep)

Promotes building relationships with safety net resources including faith communities

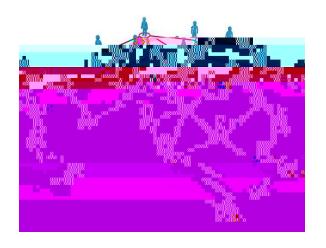


Pedagogy

Liberating Structures
Case Studies

Role Plays/Practice

Hands on networking







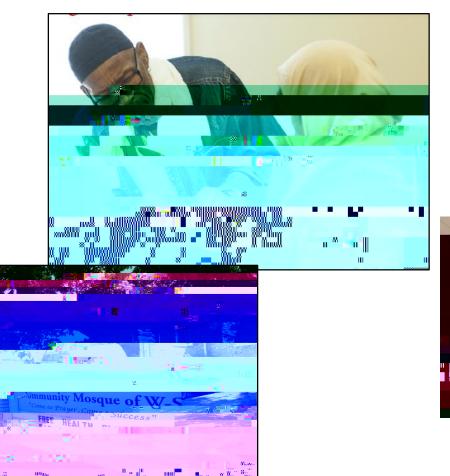


Ongoing Questions

be taught? (How much of their success is personality-driven?)

What will be learned and/or need to be refined from the educational mix offered?

Next Steps: Chronic Care Management clinics in partnering faith communities, building on Triad Free Health Clinic





Join us as we all work toward creating Optimal Health in our Communities!

THANKS for Being a Leader in this work!



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