MHD PRIMARY CARE HEALTH HOME COMMUNITY HEALTH WORKER PILOT

OVERSIGHT COMMITTEE
AUGUST 4, 2015

Definition

- The American Public Health Association defines a Community Health Worker (CHW) as:
  - A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.
  - This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
  - A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy

Background

- **According to the CDC, "Many interventions that integrate** CHW services into health care delivery systems are associated with
  - reductions in chronic illnesses,
  - better medication adherence,
  - increased patient involvement,
  - improvements in overall community health, and
  - reduced health care costs."

- Sjöström, C. D., Lissner, L., Wedel, H. and Sjöström, L. (1999), Reduction in Incidence of Diabetes, Hypertension and Lipid Disturbances after Intentional Weight Loss Induced by Bariatric Surgery: the SOS Intervention Study. Obesity Research, 7: 477–484. doi: 10.1002/j.1550-8528.1999.tb00436.x

- Sjöström, C. D., Lissner, L., Wedel, H. and Sjöström, L. (1999), Reduction in Incidence of Diabetes, Hypertension and Lipid Disturbances after Intentional Weight Loss Induced by Bariatric Surgery: the SOS Intervention Study. Obesity Research, 7: 477–484. doi: 10.1002/j.1550-8528.1999.tb00436.x

- Buchwald, H. MD, PhD; Avidor, Y. MD; Braunwald, E. MD, et al. (2004) Bariatric Surgery: : A Systematic Review and Meta-analysis. ***JAMA.*** 2004; 292(14):1724-1737. doi:10.1001/jama.292.14.1724
- Community Health Workers: Expanding the Scope of the Health Care Delivery System. Kristine Goodwin and Laura Tobler, 2008
- **Robert Wood Johnson Foundation. Bending the Obesity Cost Curve in Missouri. Washington, DC: Trust for America's Health,** 2012.
- Finkelstein EA, Trogdon JG, Cohen JW, DietzW. Annual medical spending attributable to obesity: Payer-and service-specific estimates. Health Affairs. September/October 2009;28(5):w822-w831. doi: 10.1377/hlthaff.28.5.w822.

Background

- **CDC Cont'd:**
  - "**One** study of a CHW outreach program for underserved men found a return on investment ratio of more than $2 for each dollar invested.
  - Another study found an annual cost savings using CHWs of around $2,000 per Medicaid patient with diabetes."

- Robert Wood Johnson Foundation. Bending the Obesity Cost Curve in Missouri. Washington, DC: Trust for America's Health, 2012.
- Finkelstein EA, Trogdon JG, Cohen JW, DietzW. Annual medical spending attributable to obesity: Payer-and service-specific estimates. Health Affairs. September/October 2009;28(5):w822-w831. doi: 10.1377/hlthaff.28.5.w822.
- National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention, A Summary of State Community Health Worker Laws http://www.cdc.gov/dhdsp/pubs/docs/chw_state_laws.pdf

CHW Roles

- The National Community Health Advisor Study includes seven basic roles for CHWs:
  - Proving cultural mediation between communities and health and human services systems,
  - Providing informal counseling and social support,
  - Providing culturally appropriate health education,
  - Advocating for individual and community needs,
  - Ensuring that people obtain necessary services,
  - Building individual and community capacity, and
  - Providing basic screening services.

- Community Health Workers: Expanding the Scope of the Health Care Delivery System. Kristine Goodwin and Laura Tobler, 2008
- Rosenthal et al., The Final Report of the National Community Health Advisor Study: Weaving the Future (Tucson: University of Arizona, 1998)

- Purpose
  - Fund Community Health Workers in each participating PCHH to work with specifically identified medically and socially complex high-utilizer PCHH patients.
  - The CHWs will identify, facilitate and provide this population with the support, resources, and interventions needed to improve and maintain their health status.
  - MHD anticipates that this intervention will more quickly reduce the dependence on in-patient hospital and emergency department use by
    - targeted focus on addressing social determinants of health and
    - **enhancing the PCHHs efforts to stabilize the patient's health** status on an out-patient basis

MHD CHW Primary Care Health Home Pilot

- Examples of CHW Activities:
  - Facilitate appointments (including arranging, coordinating, and facilitating transportation resources)
  - Follow up on appointments or other instructions from the health home by making home visits
  - Communicate with health homes about barriers to self-management noted during home visits
  - Assist in obtaining social and/or community services for participants
  - Assist with post-hospitalization or emergency department visit follow-up by attempting to locate participants health home staff have been unable to reach

MHD CHW Primary Care Health Home Pilot

- Examples of CHW Activities:
  - Participate in health home staff meetings
  - Assist with and advance patient self-management
  - Advance patients health literacy related to their conditions
  - Facilitate medication management and compliance
  - Document in Health Home EHR in a timely manner
  - Exchange of information and coordination with the Community Partnership in a timely manner
  - Identify and connect to community activities, resources, and interventions that could benefit the patient

MHD CHW Primary Care Health Home Pilot

- Partners
  - A collaborative project, led by Dept. of Social Services, MO HealthNet Division (MHD), that includes:
    - Department of Health and Senior Services (DHSS),
    - Department of Mental Health (DMH),
    - The Family and Community Trust (FACT), and
    - Seven MHD Primary Care Health Homes (PCHH) (including three FQHCs and four hospital-based clinic organizations) in the Kansas City and Southwest Missouri areas (Springfield, Joplin, and Branson).

MHD CHW Primary Care Health Home Pilot

- PCHH Pilot sites
  - **Southwest Missouri region**:
    - Access Family Care
    - Cox Health Springfield
    - Cox Health Branson
    - Jordan Valley Community Health Center
    - Ozarks Community Hospital
  - **Kansas City region**:
    - Samuel U. Rodgers Health Center
    - Truman Medical Center

MHD CHW Primary Care Health Home Pilot

- Target population
  - 'High Utilizers' **in PCHH provider organizations in the** Missouri HCFGKC service area and The Missouri Foundation for Health southwest Missouri service area.
  - High utilizers are defined as
    - frequent visits to the emergency department and/or hospital admissions
    - identified through MHD claims data.
  - The majority of participants will be adults.

MHD CHW Primary Care Health Home Pilot

- Logistics
  - Timeline- July 1, 2015 start date; June 30, 2017 pilot end date
  - Funding –
    - Missouri Foundation for Health and Health Care Foundation of Greater Kansas City
    - Combined with a portion of the MHD PCHH PMPM
    - All together will cover the costs of the CHWs

MHD CHW Primary Care Health Home Pilot

- Logistics
  - CHWs –
    - Will be recruited from the communities served.
    - Salary will be aligned with the pay scales of the PCHH, and with the local/regional wage data for CHW and equivalent occupations.
      - 14 CHWs will be hired, 7 for each region, distributed to the PCHHs based on target population.
      - Each full-time CHW will be assigned up to 75 patients.
      - The PCHH will provide work space, supervision, and all employment related functions.

MHD CHW Primary Care Health Home Pilot

- Evaluation
  - Planned analysis of clinical and utilization outcomes
  - Development and trending of measures assessing the integration with Community Partnerships and resources
  - Qualitative component

MHD CHW Primary Care Health Home Pilot

- Long-Term Goals
  - Establish and hone the CHW framework for the medically and socially complex MHD population during this pilot period
  - Establish CHWs as an identified service type for specific populations in MHD
  - Expand the congealed CHW model to the specified populations in the remainder of the Primary Care Health Homes
  - Expand the model to specific identified medically and socially complex MHD populations in managed care and FFS, including the FFS Care Management Pilot program