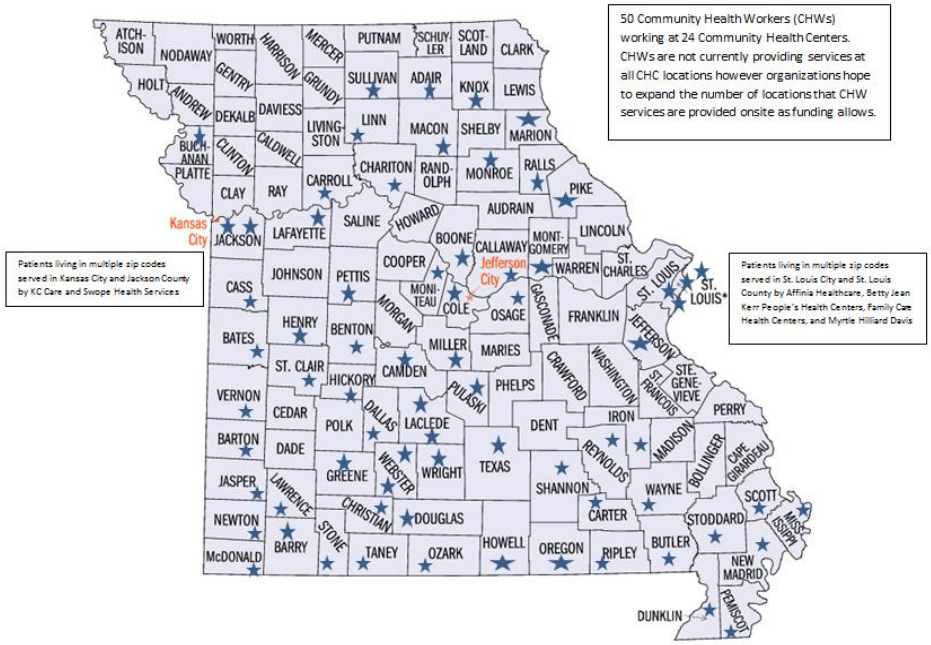
Missouri Community Health Worker Program

Angela Herman-Nestor, MPA, CPHQ, PCMH-CCE
Quality and Performance Improvement Manager

Missouri Community Health Worker Program Overview

- Funding is provided to MO CHCs by the Department of Social Services
- CHW services provided under the contract can be provided to any patient with MO HealthNet coverage.
- 24 CHCs in the CHW program
- 50 CHWs providing services across the state



Missouri Community Health Worker Program

Purpose	Key Outcomes	Core CHW Functions
• Improve patient engagement in preventative, chronic disease management, and self-management services in FQHCs • Connect patients with community based services • Assist patients with addressing social determinants of health (SDOH) needs. • Reduce potentially avoidable emergency room visits • Reduce hospital admissions/readmissions for ambulatory-sensitive conditions	• Improvement in health center quality metrics for MO HealthNet population • Social Determinants of Health (SDOH) assessment, education, referral to community resources to address identified SDOH • Improved patient engagement in care • Improved patient satisfaction/experience • Reduction of avoidable ER visits and inpatient ambulatory sensitive admissions/re-admissions for CHC patients with a focus on the MO HealthNet population	• Empower, coach, and serve as a liaison with the patient, CHC clinical care team, and community partners. • Engage patients in their care including preventative care, chronic dsiease management, and self-management • Assist patients in meeting their identified social determinants of health needs. • Navigation to community based services.

Missouri Community Health Worker Program

Common Settings for CHW Encounters	Key Referrals	Data Collection and Reporting
• Health Center when patient comes in for visit. • Home • Hospital** • Emergency Room** • Community partner/organization • Virtual (phone, patient portal, secure messaging, mail) • **CHWs encountering patients in the hospital and emergency room depend on the resources in your community. Some communities have programs that have staff already in hospitals and emergency rooms so there may be opportunities to partner versus duplicating services.	• Providers (Doctors, Nurse Practitioners, Physicians Assistants) • Nurses • Medical Assistants • Nurse Care Managers • Behavioral Health Consultants • Care Coordinators • Pharmacists • Dieticians • Outreach Staff	• CHW encounter and intervention documentation in EMR in structured fields • PRAPARE Social Determinants of Health assessment completion and documentation in EMR in structured fields • Mapping of PRAPARE to DRVS • DRVS PRAPARE: SDOH registry, Patient Visit Planning Alerts, and Care Management Passport • Future: CHW encounters/intervention information pulled into DRVS

CHW Program Reporting

- Quarterly Reporting
- Qualitative Report that identifies patient stories, barriers, successes, training/technical assistance needs.
- Track Social Determinants of Health Assessment utilizing PRAPARE tool: number of patients screened
- Track CHW Encounter Information
  - Length of CHW encounters this quarter (number encounters by length)
  - CHW Patient Appointment Location this quarter (Number of Encounters by Location):
  - CHW Contact Type by encounter this quarter: (number of contact types for encounters this quarter)
  - Presenting Issue (s) for Encounters this quarter (number by presenting issue this quarter)

MPCA

HP2020 SDOH Categories

Economic Stability	Education	Health and Healthcare	Social and Community Context	Neighborhood and Built Environment
• Employment • Food Insecurity • Housing Instability • Poverty	• Early Childhood Education and Development • Enrollment in Higher Education • High School Graduation • Language and Literacy	• Access to Health Care • Access to Primary Care • Health Literacy	• Civic Participation • Discrimination • Incarceration • Social Cohesion	• Access to Foods that Support Healthy Eating Patterns • Crime and Violence • Environmental Conditions • Quality of Housing

Each of these five determinant areas reflects a number of key issues that make up the underlying factors in the arena of SDOH.

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

NATIONAL ASSOCIATION OF Community Health Centers

AAPCHO
Association of Asian Pacific Community Health Organizations

OPCA
Oregon Primary Care Association

Institute for Alternative Futures

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

- What is PRAPARE?
  - national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health.
  - consists of a set of national core measures as well as a set of optional measures for community priorities.
  - informed by research, the experience of existing social risk assessments, and stakeholder engagement
  - aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System (UDS).
  - PRAPARE emphasizes measures that are actionable
  - PRAPARE Electronic Health Record templates have been developed or are currently under development.

MPCA

PRAPARE Measures

PRAPARE Core Measures

Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/Neighborhood	Stress

PRAPARE Optional Measures

Incarceration History	Safety
Refugee Status	Domestic Violence

MPCA

PRAPARE

- PRAPARE is the dominant social risk identification strategy used by health centers nationally to improve patient and population health and is also being used by many other health care providers and systems. PRAPARE is unique in that:
- It is **FREE** and is paired with a free PRAPARE Implementation and Action Toolkit (www.nachc.org/prapare) to guide users on how to implement PRAPARE in various workflows and respond to needs as they are identified.
- It is both evidence based and stakeholder driven—developed and tested by health centers and designed to fit within existing workflows.
- It is one of the only standardized social determinant of health screening tool built into multiple Electronic Health Record platforms.

MPCA

PRAPARE Questions/Data Elements

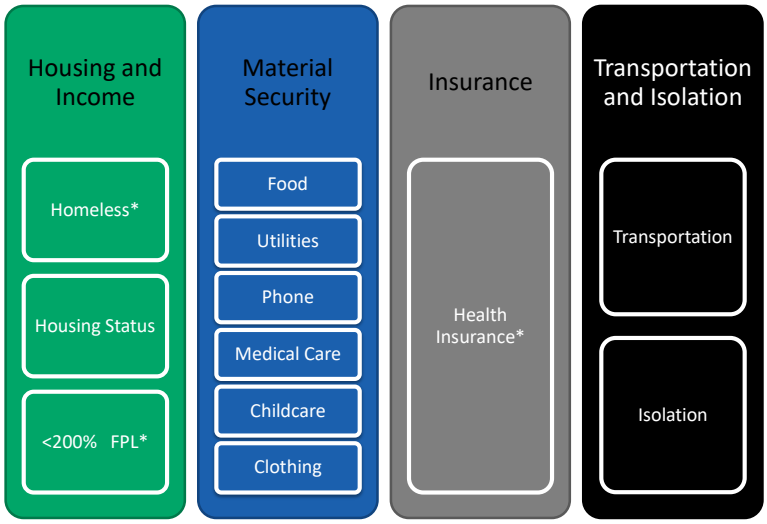
azara healthcare

1. Homeless*
2. Housing Status
3. <200% FPL*
Material Security
4. Food
5. Utilities
6. Phone
7. Insurance*
8. Medicine/ Medical Care
9. Childcare
10. Clothing
11. Transportation
12. Isolation
13. Safety
14. Domestic Violence
15. Stress
16. Employment
17. Education
18. Race*
19. Ethnicity*
20. Language*
21. Refugee*
22. Migrant*
23. Veteran Status*
24. Incarceration
25. Neighborhood (No geocoding)

* UDS/Demographic Data

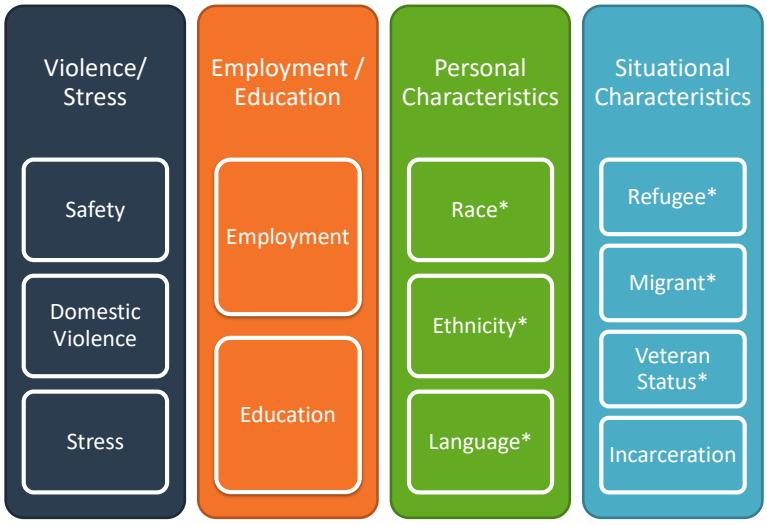
12

8 Categories of SDOH in DRVS – Part 1



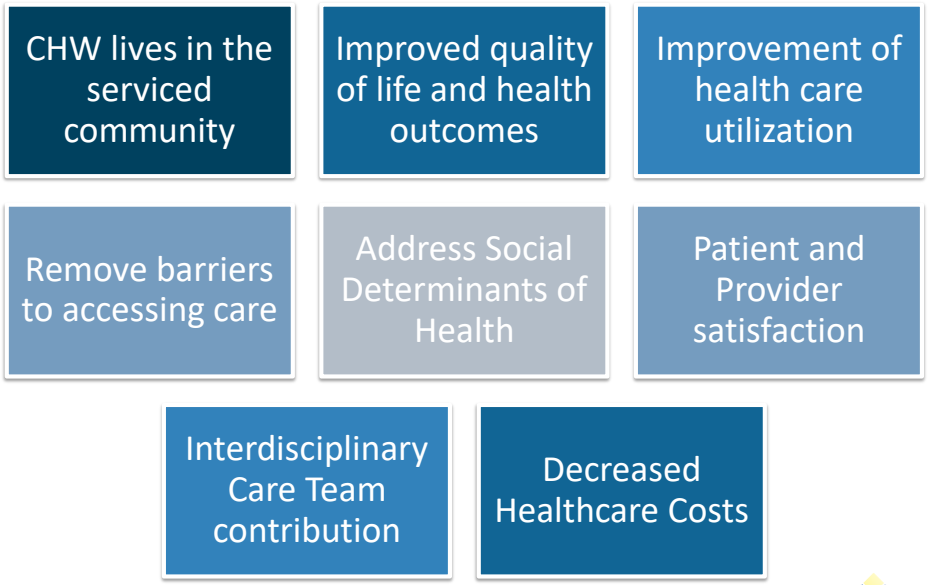
* UDS/Demographic Data

8 Categories of SDOH in DRVS – Part 2



* UDS/Demographic Data

Community Health Workers Advance Population Health



15

MPCA

CHW Resources

- Missouri Primary Care Association CHW section of website: www.mo-pca.org/chw
- The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills, and Qualities
- Making The Case For Community Health Workers On Clinical Care Teams: A Toolkit
- Michigan Primary Care Association Community Health Worker Toolkit: http://www.mpca.net/page/chwtoolkit

MPCA

Contact Information

Angela Herman-Nestor, MPA, CPHQ, PCMH-CCE
Quality and Performance Improvement Manager
3325 Emerald Lane
Jefferson City, MO 65109
573-636-4222
aherman@mo-pca.org