Care Coordination for High-Risk Diabetes Patients

Appalachian Regional Commission (ARC) Project Description: The purpose of this project is to establish a model for care coordination of high-risk diabetes patients that includes community health workers (CHWs) on the team. We aim to build a business case for reimbursement of care coordination that provides sustainable funding for the CHW workforce.

Project Administrators: Grant received by Marshall University School of Medicine: Principal Investigator Dr. Richard Crespo and Co-Principal Investigator Dr. Dick Wittberg.

Project Funders: ARC POWER (Partnerships for Opportunity and Workforce and Economic Revitalization) grant, with matching funds provided by the Claude Worthington Benedum Foundation, the Sisters Health Foundation, the Pallottine Foundation and the Merck Foundation.

History in West Virginia

Marshall University, in collaboration with Duke University and Williamson Health and Wellness Center, a federally-qualified health center in Mingo County, West Virginia, developed a model of care coordination that included CHWs on the team. This model was originally funded by the Center for Medicare & Medicaid Innovation (CMMI) through a Health Care Innovation Award; the project title was *From Clinic to Community: Achieving Health Equity in the Southern United States*. High-risk patients were selected using a risk algorithm developed by Duke University, but generally high-risk means multiple chronic conditions and frequent emergency department visits and/or hospitalizations. These are costly patients that utilize a disproportionate amount of health care resources.

This model demonstrated an average A1C reduction of 2.5 percentage points within six months for 149 patients; the average A1C baseline score was 10% and it declined to 7.5%. Similarly, there were substantial reductions in hospital and emergency department visits.

Current Project Detail

This model is being replicated in rural Appalachia; specifically, in 10 counties in West Virginia, five in Kentucky and four in Ohio, by 15 rural health care agencies. Funding comes from HRSA, six private foundations, the ARC POWER grant and the Merck Foundation.

Care coordination is provided by a team that involves a mid-level provider, a nurse and CHWs. The role of the team is to receive referrals from providers, assess patients' level

of risk and enroll eligible patients in intensive care coordination. Once enrolled the team conducts assessments of patients' health status, creates care plans and follows up with patients on a weekly basis. The team is led by the mid-level provider. The nurse on the team manages the clinical side of care coordination, such as making referrals, contacting patients' primary care providers and helping to set up clinical appointments. The CHWs link patients with community services and conduct regular home visits to assist patients with medication adherence, chronic disease self-management, healthy eating and active living goals. The CHWs receive their instructions for patient care at a weekly care coordination meeting and are in regular contact with the team nurse. The CHWs are full-time permanent, employees of the sponsoring health care agencies.

Sustainable Reimbursement

In this project, we are engaging health insurance companies to reimburse primary care agencies and rural hospitals for improved outcomes of their high-risk diabetes patients. We meet quarterly with six health insurers in West Virginia to discuss the care coordination model, its history and success and identify the steps in forming a partnership. The companies are: Humana; the Public Employees Insurance Agency; The Health Plan; Highmark Blue Cross Blue Shield; UniCare and Aetna. We have met with four insurance companies in Ohio, and all have expressed interest in helping us with the model. These companies are: CareSource; Molina Health Care; United Healthcare and The Health Plan.

We are continuing to engage with Medicare to involve them as an active partner in the model. In doing so, we f**irst** are seeking a representative from Medicare to participate in meetings with private insurers as we examine health benefits and cost savings, and build a business case for reimbursing care coordination.

Second, we would like to request Medicare's guidance and collaboration in developing alternative payment models that can provide sustainable reimbursement, especially for the CHWs on the care coordination teams.

Points of Contact

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