



Health Affairs **Blog**

Diffusion Of Community Health Workers Within Medicaid Managed Care: A Strategy To Address Social Determinants Of Health

Carolina Nkouaga, Arthur Kaufman, Charlie Alfero, and Claudia Medina

July 25, 2017



Clinic notes from a Community Health Worker:

A 63 year old client and her 70 year old husband had been evicted from their apartment while they were hospitalized and were living in a motel. I was able to assist the elderly couple in finding a new apartment, help them find jobs, and medical homes, no longer living in a motel. The client was sober for one month, attending church, and was no longer a victim of human trafficking... We then helped them obtain affordable legal help. We... from witnessing family violence while they were in their clothing.

Social determinants of health (SDH), including educational attainment, their access to afford...

Clipped to 0250 ASTHO

Diffusion Of Community Health Workers Within Med...

Share

Related Notes Clips from healthaffairs.org

ASTHO webinar 9/9/15
Sept 16th, 2015

inclusion, have a greater impact on health than surveying patients attending primary care clinics on social determinants but their providers were not addressing SDH. Yet, despite the importance and prevalence of SDH, the predominant fee-for-service incentive system has pushed “downstream” medical care at the expense of social services, where adverse SDH could be addressed.

Addressing SDH in clinical settings under the current primary care providers recognize that social determinants are ill-equipped to address them. And resources are

generally insufficient to address the enormity of adverse social determinants once uncovered. Is there a viable health service approach in which “downstream” resources are re-allocated “upstream” to address social needs?

Michigan Department of Health and Human Services Division of Medicaid and Community Care Medicaid Managed Care Unit 1111 Michigan Avenue, Room 1111 Lansing, MI 48201 Phone: (313) 237-1000 Fax: (313) 237-1000 www.michigan.gov/dhhs	Michigan Department of Health and Human Services Division of Medicaid and Community Care Medicaid Managed Care Unit 1111 Michigan Avenue, Room 1111 Lansing, MI 48201 Phone: (313) 237-1000 Fax: (313) 237-1000 www.michigan.gov/dhhs
--	--

Medicaid Prevention Pat... April 25th, 2017

Susan Moran, MDHHS -
morans@michigan.gov MI -
integration of CHWs into MCO
contracts has expanded to 18
counties MCO contracting (new

The Medicaid Managed ...
May 6th, 2016 commonwealth...
The Medicaid Managed Care
Rule: The Major Challenges
States Face Toplines The
Centers for Medicare and
Medicaid Services last week

Community Health Workers And Medicaid Managed Care: A New Approach

We found an answer in an expanded role for community health workers (CHWs). They are culturally and linguistically competent individuals from the communities served who focus on identifying and addressing adverse social determinants of health for patients. CHWs are ubiquitous in poor villages of many developing countries, in the US-Mexican Border region, and within Native American communities. But they are usually based out in communities, mostly unknown to the health care system in the U.S.

The integration of CHWs into the health care system in New Mexico began almost a decade ago when a relationship between the University of New Mexico Health Sciences Center (UNMHSC) and the New Mexico Medicaid system was born. As a capitated managed care system, the Medicaid program contracted with insurance companies, which saved money by keeping Medicaid patients healthy and out of hospitals and emergency rooms. However, many of their newly insured Medicaid members, who were automatically assigned to insurance companies and unfamiliar with health insurance, continued to use the emergency room as a primary care provider (PCP) and ran up costs for preventable emergency department visits and hospitalizations. One Managed Care Organization (MCO) wanted to offer case management to these high-user enrollees but could not find many of them. The MCO approached UNMHSC for help.

The university hired a group of CHWs who quickly found most members because of their intimate knowledge of the community and the trust communities had in them. Surprisingly, the CHWs discovered most members they found didn't need to meet with the MCO's case managers. The CHWs in the field could handle members' needs, which included understanding their benefits, learning the value of having their own PCP, and help with transportation to their assigned clinics. The clinics provided access to food pantries and help with health literacy.

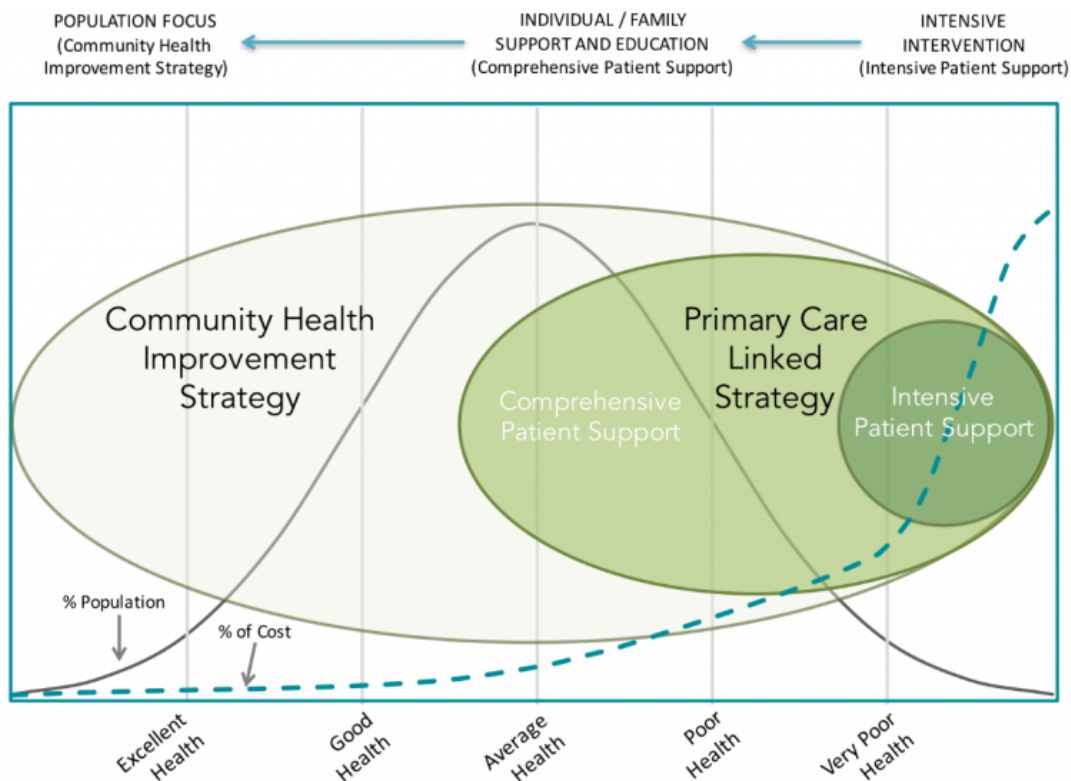
The prevalence of adverse SDH was gauged among patients attending primary clinics at the University of New Mexico and First Choice Community Healthcare, a Federally Qualified Health Center in Albuquerque, NM. Local CHWs helped design a questionnaire asking about the 11 most common social determinants of health. Of the more than 3,000 consecutive patients surveyed, approximately half had at least one adverse social determinant and half of those had more than one. These problems were virtually unknown to the clinic, for they are typically not addressed in a routine clinical encounter.

Word spread to the other MCOs about the value of clinic-integrated CHWs working on social determinants. All reached out to the University of New Mexico for assistance. Bringing CHWs

into clinical settings was a challenge, for they have neither diplomas nor certificates and had no formal training with other health professional students. But their presence sold itself to the health care team, which came to rely on the CHWs' contributions. What's more, the CHWs taught other health team members about social determinants. As the use of CHWs diffused horizontally across the other four MCOs serving New Mexico's Medicaid program (known as Centennial Care), interest in the role of CHWs on the health care team moved vertically up to the leadership of the New Mexico Human Services Department's Medicaid Assistance Division. Medicaid was interested in expanding the model and disseminating its findings across the state to other health care systems.

The NM State Medicaid Division invested directly in the development of the model, and in technical assistance to those organizations implementing the integration of CHWs into their clinical settings. Building upon lessons learned from CHW interventions with high-risk patients, the Integrated Primary Care and Community Support (I-PaCS) initiative was born. The initiative continued to provide very intensive intervention for those with the highest health needs and highest costs. At the same time, it provided comprehensive individual and family support for all patients in poor health (not just those with adverse social determinants) and adopted a population health strategy for the entire population in which CHWs intervened at each level of care, aiming to prevent health status from worsening.

Figure 1: Levels And Types Of CHW Intervention In Medicaid Managed Care Population



While the cost of health care skyrockets for those in poor or very poor health, the top 5 percent of patients with the worst health account for 50 percent of the costs. A single-minded focus on that population can reduce costs in the short run but does little to prevent enrollees with neglected risk from becoming high cost in the future. So, in the I-PaCS model, specific interventions to the left of the curve include: screening patients for the social determinants of health, connecting patients with resources to address those social determinants, assisting patients to navigate health and social services systems, and empowering patients to be active members in the process. Each patient is screened for adverse social determinants; those that

screen positive are referred to the community health worker for services and depending on their health and social needs of the patient, receive varying levels of CHW support. All the data collected from the screening tools is then compiled and used in summary form to better understand the broad social issues impacting the community served by the clinic, informing a broader community health improvement strategy led by local health extension, community organizations, and those working on policy efforts.

Diffusion Of Innovation

The diffusion of clinically integrated CHWs throughout New Mexico's Medicaid system was sustained by incorporating the cost into the capitated payment to the MCOs. Moreover, hiring and incorporating CHWs into clinical care became a required component within the contracts of state Medicaid with MCOs. Acknowledging the success of the CHW model, in 2017, New Mexico Medicaid required all managed care organizations to increase their CHW contacts with clients by 20 percent. Because three of the four MCOs are national, the CHW model begun in New Mexico has been deployed in 12 states. This has also led to interest from Federal granting agencies including the Agency for Healthcare Research and Quality (AHRQ), the Health Resources and Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS).

AHRQ's EvidenceNOW initiative funds seven regional collaboratives which help small-to-moderate sized primary care clinics implement evidence-based cardiovascular disease prevention guidelines in their practices. Based on the New Mexico group's theory that adverse social determinants of health hinder patient's adherence to guidelines, many of these practices also incorporate screening for these determinants, employing CHWs to address discovered needs. HRSA's Health Careers Opportunity Program in New Mexico supports the decentralized training of CHWs in regional community colleges by subsidizing the tuition and fees of students enrolled in the state's approved CHW certification curriculum. CMS' Accountable Health Communities is funding regional consortiums which pair health centers with social service agencies to screen patients for health-related social needs, determining whether addressing these needs improves care quality and reduces cost. New Mexico's Accountable Health Communities consortium is deploying CHWs to screen for and intervene in addressing these discovered needs and in this way, pairing social services with health centers.

The integrated CHW model has also spread to different types of clinical sites in New Mexico. Pilot programs have placed CHWs in urban hospital emergency rooms, to better link patients with primary care providers and needed local resources to address their social needs. In addition, rural hospitals in resource-poor areas of the state are looking to implement this model, to reduce costs and improve health outcomes. New Mexico's Bernalillo County has funded two innovative programs based on an even broader use of CHWs — one to reduce child abuse and the other to reduce the high rate of recidivism of inmates released from the county jail.

Drivers Of The Innovation And Its Spread

New Mexico's expansion of its Medicaid program under the ACA brought with it inherent challenges because the state suffers from extreme health professions shortages and extreme poverty. At the same time, Centennial Care contains a strong population health management requirement. These challenges acted as a catalyst, peaking the interest of the MCOs in innovative models that could improve health outcomes while lowering costs, without relying solely upon costly licensed professionals who are in short supply.

These catalytic challenges drove the model and its diffusion toward success. Another key reason for its successful diffusion was that it included a broad set of stakeholders from the beginning.

The state Medicaid office, MCOs, and health clinic providers and administrators worked together to conceptualize and design the more integrated CHW model. This was facilitated by a pre-existing, long-term partnership between MCOs and the State Medicaid Office.

Finally, a key external driver to program development was the statewide and national interest in the role of community health workers and the development of certification programs, standardized roles, and dissemination of innovative programs that deployed CHWs in promising ways. Economically deprived rural and urban communities in New Mexico became highly supportive of “their” CHWs. Not only were CHWs seen as community advocates within large health systems, but their pay range brought good jobs to poor communities. In New Mexico, an increased interest in training and certifying CHWs led to more sustainable employment for this workforce.

A health system that ignores the social needs of patients does not just miss an opportunity to improve patient health but also places an avoidable burden on primary care providers. Screening for social determinants at the beginning of every visit uncovers important needs otherwise missed. Immediate referral to a CHW, skilled in assisting the patient in addressing such uncovered needs, expands a primary care clinic’s ability to care for patients.

As the value of CHWs became recognized within the health care system, a growing variety of employers emerged. In addition to Medicaid Managed Care organizations, hospitals, and community health centers, tribal communities and counties now hire CHWs, providing an expanding, sustainable financial resource. Initially focused on serving primary care practices, CHWs now provide services in emergency departments, newborn nurseries, mental health centers, and long-term care facilities.

CHW employment itself addresses a major social determinant — poverty. Most CHWs have only a high school diploma or GED. Yet, they are of such recognized value that their pay is double the state’s minimum wage, bringing needed, good paying jobs to economically depressed communities. The drivers of the emergence of CHWs as a growing force within health care included a recognition that unaddressed adverse social determinants of health cost health care systems dearly; an acknowledgment that adverse social determinants cannot be addressed adequately by traditional, “downstream” investment alone; an understanding that the effectiveness of CHWs in reducing high health care costs are best achieved by addressing needs of the whole patient population rather than just the highest users; and finally, the advent of a growing alliance between different health-related stakeholders including government, payers, employers, and communities. The above elements created fertile soil for the growth of CHWs within Medicaid Managed Care and within the nation’s health care system.

Authors’ Note

The development and implementation of this clinic-integrated CHW model took place through a collaboration between the University of New Mexico Health Sciences Center and the Southwest Center for Health Innovation. Support from the New Mexico Human Services Department Medicaid Assistance Division, Blue Cross Blue Shield of New Mexico and Molina Healthcare of New Mexico made this collaboration possible. Special thanks to the clinical sites that piloted this model at University of New Mexico Hospital, Hidalgo Medical Services, and First Choice Health Care.

DIFFUSION OF INNOVATION

ASSOCIATED TOPICS: MEDICAID AND CHIP, ORGANIZATION AND DELIVERY, POPULATION HEALTH, PUBLIC HEALTH, QUALITY

TAGS: MEDICAID MANAGED CARE, SOCIAL DETERMINANTS OF HEALTH

Copyright 1995 - 2017 by Project HOPE: The People-to-People Health Foundation, Inc., eISSN 1544-5208. *Health Affairs* gratefully acknowledges the support of many funders.

[Privacy Policy](#)