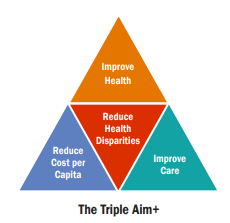
1. **Introduction:**

**Purpose of Pilot**: The purpose of this pilot project is to support existing evidence that Community Health Workers play an integral role in health care teams. Additionally, this project aims to demonstrate the impact that Community Health Workers have on health outcomes for Kentuckians as well as healthcare associated costs.

**Objectives:** This project’s objectives are modeled after the “[Triple Aim](http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/achieving-the-triple-aim.pdf)” cited in “Achieving the Triple Aim: Success with Community Health Workers.” (2015).

1. **Reduce Costs**
   1. At the end of the pilot, Community Health Worker intervention will decrease the hospital readmissions and Emergency Department (ED) visits for a defined population**.**
2. **Improve Health**
   1. At the end of the pilot, Community Health Workers intervention will result in an increase in patient’s self-efficacy.
3. **Improve Quality of Care**
   1. At the end of the pilot Community Health Workers will increase appropriate use of medications needed to manage health conditions.
4. **Return on Investment/Cost Benefit**
   1. At the end of the pilot, a return on investment (ROI) will determine the monetary value of Community Health Workers in Kentucky.
5. **Methods:**
   1. The Kentucky Department for Public Health (KDPH) will collect data from designated Community Health Worker programs. The data will include: hospital/ED usage, self-efficacy, medication management and return on investment. This data will serve as a comparison source for after the pilot.
   2. The participating programs will utilize CHWs to track objectives.
      1. Objectives will be tracked using:
         1. Client assessment forms
         2. Self-efficacy scale (pre and post)
         3. Cost tracking forms (including salary, benefits, travel and supervision)
         4. Sites will document program visits in 30 minute units
   3. Participating programs will send monthly reports to KDPH, as well as participate in an orientation/training, monthly conference calls, and at least two site visits during the pilot program.
      1. Monthly conference calls will be coordinated between KDPH, Medicaid, and all funded pilot sites.
      2. Monthly reports and conference calls will be structured to keep information current with providers and for updates to care plan.
   4. Pilot sites and Medicaid will conduct outreach to hospitals and providers to create the connection from the healthcare providers to the Community Health Workers.
   5. Medicaid will provide sites with potential referrals through MCO Case Managers or Medicaid Regional Nurses.
      1. Referral criteria may include aspects of disease management/control (i.e., blood pressure, A1C, asthma control, preventative screenings, smoking cessation).
         1. Risk stratification which may include ED or hospitalizations in previous 6 months, review of disease controls such as A1C, blood pressure and missed school days for children.
   6. Referrals may also come from hospitals and providers based on the outreach.
   7. At the end of the pilot, KDPH and Medicaid will compile and review the data. The information will be compared to the information provided prior to the pilot to determine the Return on Investment and progress towards objectives.
      1. Medicaid will utilize data to compare costs and outcomes of similar populations of Medicaid patients who have not received any intervention from a Community Health Worker.
         1. KDPH has reviewed the necessary IRB paperwork, and has a “skeleton” version of the forms, however, more information is necessary before we can proceed.
   8. At this time, there will be a discussion regarding further funding of Community Health Workers throughout the state.
6. **Participant Criteria**
   1. ~~Age: 5-65~~ Age: 19-65
   2. Have active Medicaid benefits (non-dual eligible)
   3. Participants in an existing program may qualify for inclusion
   4. May be referred by Medicaid, providers, hospitals, school nurses, etc.
7. **Discharge Criteria**
   1. Appropriate discharge criteria will be developed in collaboration with KDPH and pilot sites.
8. **Average caseload for Community Health Workers**
   1. 20 patients Need to add information about how many people a CHW would see in a year, how long do people spend with CHW, etc.
9. **Estimated Costs Per Site (all costs associated with salary, fringe, supervision, travel, and training are included)**

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| ~~1 Community Health Worker~~ | ~~$5,712 per month~~ |
| ~~2 Community Health Workers~~ | **~~$11,421 per month~~** |

1. **See attachment for budget proposal breakdown of CHW costs.**
2. **Medicaid will review options - including MCO payment - and the State Plan that will not result in the need to create a SPA.**
3. **Pilot Duration**
   1. KDPH and Medicaid will collaborate in order to determine the pilot duration. At the end of the pilot, the outcomes will be evaluated.
4. **Pilot Sites –** This project will be carried out in 2 locations
   1. Specific sites will be chosen because they have the infrastructure and capacity to support Community Health Worker programs. For the purposes of this pilot, only programs that are managed through local health departments will be chosen.
   2. After discussion with Jan Chamness, Director of Montgomery County Health Department who has agreed to mentor the two local health departments, KDPH proposes to pilot the project in Floyd and Fulton Counties (eastern and western counties).
5. **Scalability**: Upon completion of the project, outcomes measures will demonstrate that use of CHW’s statewide will enhance the ability of health systems in Kentucky to improve health and reduce costs to Medicaid.
6. **Evaluation**: KDPH and Medicaid will compile and evaluate all of the data collected during the pilot.

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| **Example of CHW Pilot Timeline for a Six Month Project** | | | | | | | |
| **Preparation 🡪** | **Month 1 🡪** | **Month 2 🡪** | **Month 3 🡪** | **Month 4 🡪** | **Month 5 🡪** | **Month 6 🡪** | **Afterwards** |
| * Objectives and tracking forms are finalized * Finalize contracts or MOUs * Allocation to LHDs * Training for pilot sites * Convene monthly conference calls * KDPH provides technical assistance to participating programs | * Pilot begins * Monthly conference call with KDPH, Medicaid, and participating programs * Referrals and outreach by Medicaid and LHDs | * Monthly conference call * KDPH performs site visits of participating programs | * Monthly conference call with KDPH, Medicaid, and participating programs | * Monthly conference call with KDPH, Medicaid, and participating programs | * Monthly conference call with KDPH, Medicaid, and participating programs * KDPH performs site visits of participating programs | * Monthly conference call with KDPH, Medicaid, and participating programs * End of pilot project * KDPH and Medicaid compile information | * KDPH and Medicaid review outcomes of the Community Health Workers Pilot Project and determine next 6 months |

Kentucky Community Health Worker Program “Fast Facts”

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| **Barren River District Health Department** |  | **Kentucky Homeplace** |
| **Program:** CHWs perform regular home visits and phone calls for support, reinforcement and linkage to needed services; RN provides telephonic disease management. The program aims to reduce hospital and ED usage through better self-management of diabetes, heart failure and/or COPD.  **Population:** Rural  **Length of Program:** 6 – 9 Months  **Self-Management Survey**   * Overall improvement of 22.9% since June of 2016 * Self-Efficacy – 22.1% increase from baseline (on a 10 point scale) * Self-Monitoring – 24.8% increase from baseline * Disease Management – 21.8% increase from baseline   **Change in Blood Pressure (10/16 – 11/17)**   * On average, 77% of patients were meeting the target for controlled blood pressure, compared to national average of 60.42% (2015) * Average decrease in Systolic BP of 11.12 mmHg * Average decrease in Diastolic BP of 3.45 mmHg |  | **Program:** CHWs work to provide access to medical, social, and environmental services for citizens within the 30 county service area. Emphasis is placed on preventive care, health education, and disease self-management.  **Population**: Rural  **Length of Program**: Indefinite  **Hospital and ED Stays**: (10/2016 – 9/2017)   * Decreased by 49% (140 episodes to 71 episodes)   **Chronic Disease Hospital and ED Stays**   * Decreased by 58% (95 episodes to 39 episodes)   **Stroke Survivors Transition Program:** CHWs work with rehabilitation teams to help stroke survivors transition back into their homes. The program has helped nearly 150 people since 2015.  **Participant Hospital and ED Readmissions:**   * Zero 30-day hospital readmissions * 1 ED admission (not stroke related)   **Control Group Hospital and ED Readmissions:**   * 19% were readmitted to the hospital * 8% were readmitted to the ED |
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| **Louisville Health Connections** |  | **Montgomery County Health Department** |
| **Program**: Interdisciplinary team of RN, LPN, Social Worker and CHW. CHWs perform home visits to connect patients with medical home and vital resources, perform health coaching and reinforcement and prepare/accompany patients to MD visits.  **Population**: Urban  **Length of Program**: 90 days  Significant improvements in depression, self-efficacy, and perceptions of case coordination.  **7 Day Returns to the ED**   * Reduction of 2%   **30 Day Hospital Readmissions**   * Reduction by 50%   **Cost Savings:**   * Reduction in hospitalizations and ED visits resulted in a cost savings of $38,000 for inpatient cases and $1,700 for ED case   Out of 424 Graduates:  **Return on Investment of 127%** |  | **Program**: CHWs perform home visits and work with clients to connect them with community resources and reinforce care plan to increase health outcomes.  **Population**: Rural  **Length of Program**: Indefinite  **General and Chronic Disease Self-Efficacy**   * Statistically significant improvement in general and chronic disease management self-efficacy at 3, 6, 9, and 12 months.   **Medication Management**   * Increase adherence from 58% to 66% (9 mo.) and 68% (15 mo.) * Hypertension: Increase adherence from 65% to 84% and 90% (9 and 15 mo.) * Diabetes: Increased adherence from 67% to 85.7% and 88.9% (9 and 15 mo.)   **Returns to ED and Hospital Readmissions**   * Statistically significant reduction in number of returns to the ED and hospital.   **Return on Investment of 1:84:1 (84%)** |
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