Community Health Workers:
Engagement from the Payor Perspective
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Agenda

Healthfirst Clinical Partnerships Overview

CHW Initiatives at Healthfirst

The Future
1. Healthfirst Clinical Partnerships
About Healthfirst

Established in 1993, Healthfirst is a not-for-profit health HMO sponsored by New York not-for-profit and public hospitals

Who We Are

- Healthfirst works in partnership with providers to maximize outcomes
- Large and diverse network of health centers, community physicians, and hospital-based clinicians
- We have 1.1 million members in NYC, Nassau, Suffolk, and Westchester
  - 127,000 Medicare
  - 987,000 Medicaid and Child Health Plus
- Our membership is linguistically and ethnically diverse
  - Members speak more than 80 languages; 52% of Medicare members have primary language other than English
  - HF members self-identify as 44% Hispanic, 28% Black, and 12% Asian
Addressing the Triple Aim

The IHI Triple Aim

Population Health
- Experience of Care
- Per Capita Cost

Health of the Population
- Social Determinants

Engagement
- Experience of Care

Efficiency
- Ability to meet needs of population

Optimal Outcomes
Clinical Partnerships

Partner Engagement
- Relationship building with Medical Directors and stakeholder Clinical Leadership to promote Triple Aim and EBM Programs and Practice based initiatives

Collaboratives and Advisories
- Promoting shared strategies for implementing systemwide practice and performance improvement

Healthfirst Institute
- Symposia
  - Continuing Medical Education (CME)
  - Healthfirst Institute trainings (SBIRT, ALA, ADA)
  - Care to Coding sessions
  - Patient Experience Workshops

Grant Portfolio
- Value-based Payment Addressing Disparities
Healthfirst is collaborating with our sponsors and stakeholders to implement studies and grant-based projects that are testing new ground in healthcare delivery system innovation.

**Vision**

**TODAY:** Pilot and evaluate innovative new practices that engage our members and providers, and move toward the Triple Aim.

**SHORT TERM:** Identify the best innovations

**LONG TERM:** Use study data to improve performance
2. CHWs and Innovation
Role of CHWs

2015-16 Areas of Investigation:
- Maternal health
- HIV
- Hypertension
- Asthma
- Diabetes
- Behavioral Health

How we help:
- Data to find eligible populations that may benefit from CHW interventions
- Data to understand impact on health and costs
- Connecting with members
- Outreach to providers
1. Reducing Disparities in Care for High-Risk Postpartum Women

Many women from low income households with chronic illness do not get appropriate medical follow up postpartum (short and long term consequences).

A combination of Social Workers and Community Health Workers engage women and increase the rate of postpartum care.

Hypothesis: increase in postpartum visit rates, fewer ER and inpatient admissions; cost savings.

Follow up by Community Health Worker and/or Social Worker

Increase rates of postpartum visits and improve long term health outcomes.

Provider Incentives

Healthfirst role:
- Women in study are all HF members
- Data to show impact of intervention (cost, ER visits, inpatient visits, postpartum visit claims)
- Provider incentives

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2. iCARE Maternal Health Grant
Central Brooklyn

1. Community Data: Higher rate of adverse perinatal outcomes as compared to surrounding Brooklyn neighborhoods

2. Healthfirst data:
   - Lower engagement in **prenatal care**
   - Significantly lower rates of engagement in **postpartum care**
   - Higher rates of high risk pregnancies

2. iCARE: Planned for 2016

Proposed Healthfirst → CHW workflow

1. Healthfirst finds out about members' pregnancy via claims

2. Immediate outreach by Healthfirst coordinators/case managers (screening, education, prenatal & postpartum milestones)

3. If member cannot be reached by Healthfirst in 30 days, member information can be forwarded to CAMBA

4. CAMBA conducts an initial assessment; warm connection to Healthfirst case managers for high risk cases

Provide patient education in key areas of need

Improve prenatal visit rates

Improve postpartum visit rates

Reduce complications that result in hospitalizations and ER visits or impact the baby's health

CHW Planned Activities for 2016
2. iCARE: Planned for 2016

What is iCARE?
Healthy Women... Healthy Babies... Healthy Families

iCARE is a comprehensive program that helps individuals and families understand the importance of a healthy lifestyle and prepare for the future. We want to ensure that women receive great well-woman care and Brooklyn babies get a healthy start in life.

iCARE is unique—and so are you!

Maintaining a healthy lifestyle while raising a family can be challenging. Through prevention, support and education, our services empower you to take charge of your health and reproductive lives. We want to make sure you obtain health insurance, family planning benefits and services, access health care regularly, connect with community-based programs and identify and reduce risky behaviors. Maintaining good health is important for all woman and men whether you chose to have a baby or not.

How Can iCARE Help Me?
Every woman and her family has different needs.

Every woman deserves to live a healthy lifestyle and we understand this can be challenging.

When you enroll in iCARE, our trained Community Health Workers will meet with you and discuss how we can best help you and your family. Our many services can include:

- Healthcare coordination, advocacy and support
- Health insurance education, referral and enrollment services
- Free educational workshops on health-related topics
- Reproductive life planning
- Home visiting services
- Referral services: We are aware that a big issue many people face is that they do not know what services are available to them and they do not know how to access them. We serve as a referral source and guide to essential community support services such as:
  - On-going health and pediatric care services (including dental and vision care)
  - Counseling services
  - Job placement program
  - Essential maternity and newborn items

- Emergency food and shelter
- GED programs
- WIC and nutrition benefits
- SNAP benefits
- Early intervention and early childhood education services
- Follow-up services: Once referred, we offer follow up services to you. As you know, just because you’ve been referred somewhere doesn’t always mean things are taken care of. After you receive follow up services, we contact you to see how things went and help address any problems you incurred with a referral.
- Help dealing with a multitude of issues ranging from intimate partner violence, depression, substance abuse, chronic illnesses, mental health, STD’s, child development and more.
3. HIV Viral Load Suppression Project
“End the Epidemic” – Planned for 2016

GOAL:
Through high rates $\geq (90\%)$ of adherence to antiretroviral medications, many HIV+ individuals can achieve viral load suppression, which has the following benefits:

- Longevity with fewer complications
- Reduce HIV transmission rates

However, a minority of members have not attained viral load suppression.

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**Drivers**
- Social stigma
- insurance access
- Housing, transportation
- Self efficacy
- Health Literacy
- Comorbid conditions
- Substance abuse
- ?

**Barriers**
- SHS

**Proposed Solution:**
Partner with existing HIV organizations to conduct outreach by peers to connect people back to the healthcare system.

**Important data points:**
- Contact information
- Pharmacy
- Sites where member receives care

**Connections:**
- Evidence-based programs
- Health Homes

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4. Project IMPACT

Implementing Million Hearts for Provider and Community Transformation

Hypertension and Diabetes in NYC Asian Community

- South Asian NYC residents have higher hypertension and diabetes levels than non-Hispanic white NYC residents
  - More hypertension (27% vs 23%)
  - More diabetes (14% vs 7%)
  - Hypertension at younger ages (avg: 50 vs 62 years old) and at lower BMI

Healthfirst has more than 30,000 South Asian members
4. Project IMPACT

Intervention with community-based practices that serve South Asian members

- Clinical Decision Support
  - Alerts
  - Registries
- Tracking patients’ progress over time

EHR intervention (all practices)

- In-language education and outreach
- Perform registry queries
- Schedule appointments for patients with gaps in care

Community Health Worker intervention (phased-in interested practices over time)

Improve Hypertension Control in practice population
4. Project IMPACT

Healthfirst role:

Measuring IMPACT

- Blood Pressure Control, other metrics from EHR
- Healthfirst member utilization
  - ER use and admissions
- Continuing Medical Education – for providers who serve the target population, highlighting:
  - Million Hearts® initiative
  - 2014 guidelines on hypertension management (JNC 8)
  - Hypertension and cardiovascular risk
  - Using culturally tailored education and electronic medical records to improve hypertension control in community-based practices
  - Evidence base of community health workers to improve control of hypertension and diabetes
5. Harlem Health Advocacy Partners

Partner: NYC Dept. of Health, Center for Health Equity
Location: public housing in East Harlem

Planned Collaboration 2015-16

- CHWs are also public housing residents
- Participants have one or more of the following conditions: diabetes, hypertension, asthma; behavioral health (e.g. substance abuse, depression also common)
- Healthfirst role:
  - Help find eligible population (many residents are members)
  - Data to understand impact on health and costs
  - Provider outreach and education (Continuing Medical Education)

Analysis Credit: Center for Health Equity

A “hotspot” map generated using data from the A1c Registry shows the areas where the greatest numbers of people with A1c results >9% . The hotspot displayed here represents 900 people with uncontrolled diabetes.
3. The Future
What we can learn

Community Health Worker Models

- Hospitals
- Health Homes
- Stand-alone
- Place based (public housing)
- Community Physician-based
- Diabetes
- Hypertension
- Asthma
- HIV
- Postpartum
- HIV

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Challenges ahead

CHW credentialing

Reimbursement Streams

• Value based payment
• Patient Centered Medical Home
• Advanced Medical Home
Contact Information

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