Redesigning the Health Care Team: Opportunities to Integrate CHWs within the Affordable Care Act

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Sergio Matos
Executive Director
Community Health Worker Network of NYC
President
Health Innovation Associates
The Dilemma

Leading Causes of Death, 1900

- Pneumonia & Influenza
- Tuberculosis
- Diarrhea & Enteritis
- Heart Disease
- Liver Disease
- Injuries
- Cancer
- Senility
- Diphtheria

Leading Causes of Death, 2000

- Heart Disease
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Lung Disease
- Injuries
- Diabetes
- Pneumonia & Influenza
- Alzheimer's Disease
- Kidney Disease
Why CHWs?

- Burgeoning literature demonstrating CHW effectiveness across different conditions
- CHWs address social determinants of health
- Large workforce - 11,000 in NYS - 120,000 nationally
- Patient Protection and Affordable Care Act
  - Several elements of the federal health reform law can be facilitated through strong CHW participation
  - Increase access - Improve quality – Lower costs
- Health reform innovations
  - CHWs play important role in case management, care coordination, health promotion/coaching, system navigation, and home-based support
- CHW role as liaisons within and between healthcare institutions and community
Community Health Workers (CHWs) are **frontline public health workers** who are **trusted** members of and/or have an **unusually close understanding of the community served**. This trusting relationship enables CHWs to serve as a **liaison/link/intermediary** between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also **build individual and community capacity** by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

– American Public Health Association, 2008
What do CHWs Do?

Outreach/Community Mobilizing
- Preparation and dissemination of materials
- Case-finding and recruitment
- Community Strengths/Needs Assessment
- Home visiting
- Promoting health literacy
- Community advocacy

System Navigation
- Translation and interpretation
- Preparation and dissemination of materials
- Promoting health literacy
- Patient navigation
- Addressing basic needs – food, shelter, etc.
- Coaching on problem solving
- Coordination, referrals, and follow-ups
- Documentation

Community/Cultural Liaison
- Community organizing
- Advocacy
- Translation and interpretation

Participatory Research
- Preparation and dissemination of materials
- Engaging participatory research partners
- Facilitating translational research
- Interviewing
- Documentation

Case Management/Care Coordination
- Family engagement
- Individual strengths/needs assessment
- Addressing basic needs – food, shelter, etc.
- Promoting health literacy
- Goal setting, coaching and action planning
- Supportive counseling
- Coordination, referrals, and follow-ups
- Feedback to medical providers
- Treatment adherence promotion
- Documentation

Home-based Support
- Family engagement
- Home visiting
- Environmental assessment
- Promoting health literacy
- Supportive counseling
- Coaching on problem solving
- Action plan implementation
- Treatment adherence promotion
- Documentation

Health Promotion & Coaching
- Translation and interpretation
- Teaching health promotion and prevention
- Treatment adherence promotion
- Coaching on problem solving
- Modeling behavior change
- Promoting health literacy
- Harm Reduction
Service Empowerment

- Improve access to health care and social service resources
- Improve the quality and cultural appropriateness of service systems
- Help people integrate health promotion and disease prevention/management regimens into their daily life
- Organize communities to improve environmental, physical and social wellbeing
- Negotiate cultural & linguistic barriers to wellness
- Help people become active participants in their health
- Community organizing and empowerment
- Combating social isolation and exclusion
Health Home Expectations

Expected Population

- Complex cases and many newly-insured
- May have long-neglected health concerns
- At least two chronic conditions, or
- One chronic condition and at risk for another, or
- One serious and persistent mental health condition

Expected Outcomes

- Actively locate, recruit, engage, activate, retain
- Improve access – understanding and utilization
- Improve outcomes
- Lower costs – share income and share risk
Health Home Core Services

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
4. Individual and family support, which includes authorized representatives
5. Referral to community and social support services, if relevant
6. The use of health information technology (HIT) to link services
<table>
<thead>
<tr>
<th>Health Home core service</th>
<th>Relevant CHW Roles</th>
<th>Relevant CHW Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Care</td>
<td>Care Management</td>
<td>Individual strengths/needs assessment; goal setting and action planning; feedback to medical providers on patient goals; advocating for patient at team meetings; communications bridge re. patient goal achievements and remaining problems; patient navigation to assist in access to all health, behavioral and social services</td>
</tr>
<tr>
<td>Management</td>
<td></td>
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<tr>
<td>Care coordination</td>
<td>Care Coordination and Home Visits</td>
<td>Care coordination of medical, behavioral and social services to align with patient priorities and goals; cross-disciplinary home-based support and follow-up to ensure all care and services are delivered in a coordinated manner</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Health Coaching and Health Education</td>
<td>Promotion of health literacy; cultural translation and interpretation; coaching on problem solving; adherence promotion; health coaching and health education from peer perspective; modeling behavior change; assistance in tailoring adherence to daily routines</td>
</tr>
<tr>
<td>Comprehensive transitional care</td>
<td>System Navigation</td>
<td>System navigation; goal setting and follow-up planning; translation and interpretation; post-discharge home visits and calls; facilitation of care coordination and care management</td>
</tr>
<tr>
<td>Individual and family support</td>
<td>Informal Counseling and Support</td>
<td>Supportive communications and counseling; orientation to patient satisfaction; community advocacy and communication; holistic family-oriented support; individual and group social support</td>
</tr>
<tr>
<td>Referral to community services</td>
<td>Community Liaison and Advocacy</td>
<td>Addressing basic needs; coordinating, making and following through on referrals for housing, welfare, legal, mental health/addiction and social services; patient empowerment through neighborhood-specific information about community programs and services</td>
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<tr>
<td>Use of linked medical records</td>
<td>Documentation and information sharing</td>
<td>Documentation in the medical record of CHW activities, referrals for services, and feedback from the patient; use of alert/feedback protocols to assure all team members are aware of latest patient updates</td>
</tr>
</tbody>
</table>
CIDP Success Factors and CHWs

• High-touch interdisciplinary team that is highly accessible
  • The central purpose of CHWs is to provide high-touch support and coordination. CHWs share a common background with the communities they serve; hence they are perceived as highly accessible and knowledgeable to the population that they serve. CHWs are accessible both in the clinical care setting and in community settings.

• Dedicated housing coordinator
  • Understanding of housing and other social determinants of health is essential to health home success. CHWs coordinate access to social services, including housing.

• Dedicated staff with social service expertise
  • CHWs coordinate access to social services and are often the primary source of information on social services that are available in the community and among care providers. CHWs have often been consumers of social services; consequently they have a firsthand knowledge of the intricacies of accessing these services. They also tend to live or work in the same communities of the population they serve; hence they have a local understanding of the availability of social services.
CIDP Success Factors and CHWs

• Inclusion of peers in the staffing model
  • CHWs are essentially trained peer health workers who have shared life experiences

• Client-centered service delivery model
  • CHWs are trained to provide support for the whole person and tailor service delivery to meet the full range of needs of each individual person.

• Partnerships with community-based organizations
  • The role of CHWs is to develop and maintain partnerships with community-based organizations and connect people to those services as needed.

• Ability to coordinate medical and behavioral health care, as well as social services
  • CHWs coordinate access to behavioral health and social services, including assisting with scheduling appointments for these support services; preparing for visits; escorting people to their appointments; and serving as interpreters.

Note - While other team members may also serve in these roles, the unique attributes of CHWs as trusted, accessible, and resourceful peers make them a valuable member of an interdisciplinary health home team.
CHW Business Case

- **Increase access**
  - Health insurance coverage increased & more consistent for children (RCT in Boston)

- **Lower costs (New York)**
  - 63% reduced hospitalization expenses (asthma)
  - 48% reduced ED expenses (asthma)
  - Reduced HbA1c levels by one point in 6 month intervention (RCT diabetes)

- **Return on Investment**
  - ROI of $2.28 per dollar invested (underserved men in Denver)
  - $7.00 per dollar invested (Denver Health pregnancy testing program)

- **Cost savings**
  - Decreased per capita expenses 97% in an asthma program (Hawaii)
  - $24 million over 9 years in Georgia private corporation
  - Reduce hospitalization denial of payment - Bronx

- **Value added**
  - Increase care team efficiencies & effectiveness
  - Increase consumer satisfaction
  - Improve chronic disease self-management
  - Lower missed appointments
## CHW Returns on Investment

<table>
<thead>
<tr>
<th>Study/site</th>
<th>CHW activities and outcomes</th>
<th>ROI (per year)</th>
<th>Sources for data</th>
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<tbody>
<tr>
<td>Homeless mentally ill</td>
<td>CHW home visits and behavioral change support reducing institutional care costs</td>
<td>1.15</td>
<td>Calculated from case-control data in Wolff et al., 1997, reported in Viswanathan</td>
</tr>
<tr>
<td>Childhood asthma management, Seattle, WA</td>
<td>High intensity CHW intervention w. home visits, reducing urgent visit/hosp costs</td>
<td>1.21</td>
<td>Calculated from pre-post data in Krieger et al, 2005</td>
</tr>
<tr>
<td>Childhood asthma management, New York, NY</td>
<td>CHW provides education and care coordination reducing urgent visits/hosp.</td>
<td>4.01</td>
<td>Calculated from pre-post in Peretz et al., 2012 with additional data from Nieto and Peretz</td>
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<tr>
<td>Theoretical savings for pediatric patients making clinic visits in Harrisonburg, VA</td>
<td>CHW will do primary care triage and manage limited protocol of conditions, reducing clinic visits</td>
<td>1.60</td>
<td>Calculated from comparison data in Garson et al, 2012</td>
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<td>Diabetes control along Texas border</td>
<td>Diabetes education and support in making lifestyle changes, reducing care costs through lower A1c</td>
<td>4.62</td>
<td>Calculated from comparative cost data in Culica et al., 2008</td>
</tr>
<tr>
<td>Employees of Langdale Manufacturing in Lowndes County, Georgia</td>
<td>Case management support to workers with chronic disease, reducing acute care costs and work loss days</td>
<td>4.80</td>
<td>Calculated by Miller, 2011</td>
</tr>
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<td>Chronic illness patients in Denver Health Plan, Colorado</td>
<td>CHW intervention with care management, reduced urgent/hosp costs</td>
<td>2.28</td>
<td>Calculated by Whitley, Everhart &amp; Wright, 2006</td>
</tr>
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<td>Arkansas Medicaid managed care program</td>
<td>CHW community connector program provided by state managed care program</td>
<td>2.92</td>
<td>Calculated by Felix et al, 2011</td>
</tr>
<tr>
<td>Molina Healthcare, Medicaid Managed Care, New Mexico</td>
<td>CHW focuses on the high-user, complex patients, providing navigation, health coaching, and chronic disease management</td>
<td>2.18</td>
<td>Calculated from pre-post data in Johnson, 2011</td>
</tr>
<tr>
<td>Diabetes management for low-income patients in Baltimore, MD</td>
<td>Volunteer CHW educates and provides care coordination, reducing diabetes-related health care costs</td>
<td>6.10</td>
<td>Calculated from pre-post data in Fedder et al, 2003</td>
</tr>
<tr>
<td>Diabetes management for low-income patients, New York, NY</td>
<td>CHW provides education and care coordination, reducing urgent visit/hosp costs</td>
<td>2.32</td>
<td>Calculated from pre-post data supplied to the authors, reported in Findley, Matos &amp; Reich, 2012</td>
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Utilizing CHWs

- Recognize CHWs as social professionals and members of health care teams – be very thoughtful in all credentialing considerations
- Apply the CHW recommendations developed by NYS CHW Initiative
- Integrate CHWs in PCMHs, ACOs, Health Homes and Insurance Marketplaces.
  - Recruitment, Enrollment, Activation, Retention
  - Care coordination
  - Case management
- Use Medicaid Redesign incentives to finance CHW services in complex settings and traditionally difficult to reach populations
  - Complicated treatment regimens
  - Those that require significant lifestyle changes
  - Chronic/Multiple chronic disease interventions
  - Geriatric population
Our Publications


Contact us

Sergio Matos, President
Health Innovation Associates
917-653-9699
sergio.e.matos@gmail.com
www.chwnetwork.org

April Hicks, President
True North Consulting
912-266-3262
april.hicks.nyc@gmail.com