Improving Patient Safety Across Michigan and Illinois

Community Health Workers

June 15, 2016
Agenda

• Community Health Networks (Pat Teske)

• Intro to Community Health Workers (Erika Saleski)

• National Programs and Best Practices (Bridget Larson)

• Case Study-KC Care Clinic (Dennis Dunmyer)

• Wrap Up, Next Steps
Highest Utilizers

# READMISSIONS

- PT A: 6
- PT B: 4
- PT C: 2
- PT D: 1
- PT E: 1
- PT F: 1
Making the pieces fit

Challenges

Solutions
COMMUNITY HEALTH WORKERS: LEADING PROGRAMS AND EMERGING BEST PRACTICES

Erika Saleski, MPP, Owner, ES Advisors, LLC
Bridget Larson, MS, Subcontractor, ES Advisors, LLC
Dennis Dunmyer, JD, LCSW, VP of Behavioral Health and Community Programs, KC CARE Clinic
OVERVIEW

- Who are Community Health Workers
  - Definitions
  - Value Added
  - Outcomes
- Kansas City Regional Collaborative and White Paper
- CHW Programs Nationally
- Best Practices for CHW Programs
- Case Study: Kansas City CARE Clinic

www.marc.org/communityhealthworkers
WHO ARE
COMMUNITY HEALTH WORKERS?
Community Health Workers link between and the health and human service system.
A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker 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.

A community health worker also builds 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.

Source: www.apha.org/apha-communities/member-sections/community-health-workers
Qualities

- Develop peer-to-peer relationships of trust.
- Communicates openly.
- Strengthens care teams.
- Addresses social determinants of health.
- Broad scope of practice.
- Variety of program models.

OUTCOMES

- Spectrum Health in Michigan
  - Readmission costs dropped 14%
  - ED use dropped more than 29%
- University of Pennsylvania (Kangovi et. al. JAMA 2014)
  - RCT of CHW intervention post-discharge showed statistically significant outcomes
  - Timely post-hospital primary care follow-up was 1.52 times more likely
- APHA highlights:
  - Diabetes: Study: Saved an estimated $80,000–90,000 per CHW.
  - Denver Study: Return on investment of $2.28 per very $1 spent on CHW services.
- Sources:
KC COLLABORATIVE – WHITE PAPER

- KC Regional CHW Collaborative
- Diverse Membership
- Working Subcommittees
- White Paper
  - Components
  - Methodology
  - Best Practices

www.marc.org/communityhealthworkers
COMMUNITY HEALTH WORKER PROGRAMS NATIONALLY AND BEST PRACTICES
<table>
<thead>
<tr>
<th>Key Element</th>
<th>Rio Grande Valley Salud y Vida</th>
<th>Sinai Asthma Care Partners</th>
<th>Hennepin County Medical Center</th>
<th>UPenn IMPaCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Rio Grande Valley, TX</td>
<td>Chicago, IL</td>
<td>Minneapolis, MN</td>
<td>Philadelphia, PA</td>
</tr>
<tr>
<td>Program Description</td>
<td>Collaborative community evidence-based chronic care management programs</td>
<td>Comprehensive asthma management program. Year long active phase with 6 home visits. 6-month follow-up phase.</td>
<td>Integrated model. CHWs are part of care team based in certified patient-centered “Health Care Home”. Additional model includes community based CHWs.</td>
<td>Evidenced-based model developed with patient input to serve high-risk patients. 3 main programs: 2 hospital based focused on care transitions; 1 primary care based</td>
</tr>
<tr>
<td>Key Element</td>
<td>Rio Grande Valley Salud y Vida</td>
<td>Sinai Asthma Care Partners</td>
<td>Hennepin County Medical Center</td>
<td>UPenn IMPaCT</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Target Population</td>
<td>Adults w/ chronic diabetes</td>
<td>Adults and children with uncontrolled asthma</td>
<td>High risk and Extreme risk patients</td>
<td>High risk in 8 target “hot spot” zip codes</td>
</tr>
<tr>
<td>Point of Access</td>
<td>Referrals by community clinics</td>
<td>Partner MCO identifies and refers patients</td>
<td>Risk stratification</td>
<td>Target zip codes; &gt;3 inpatient admits in 6 mos and ≥2 chronic conditions</td>
</tr>
<tr>
<td>Funding</td>
<td>DSRIP through State 1115 waiver</td>
<td>Grants and partner MCO</td>
<td>State and health system</td>
<td>Penn Medicine</td>
</tr>
</tbody>
</table>
# CHW CHARACTERISTICS

<table>
<thead>
<tr>
<th>Key Element</th>
<th>Rio Grande Valley Salud y Vida</th>
<th>Sinai Asthma Care Partners</th>
<th>Hennepin County Medical Center</th>
<th>UPenn IMPaCT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope of Practice</strong></td>
<td>Home visits; health education, navigation, guidance, referrals to mental health</td>
<td>Home visits; environmental assessment; education on asthma, proper medication use and triggers</td>
<td>Health system care navigation and care plan development in the primary care setting</td>
<td>Care planning and patient centered goal setting using standardized work flows</td>
</tr>
<tr>
<td><strong>Hiring Standards</strong></td>
<td>High school equivalency not required; Spanish language</td>
<td>High school equivalency</td>
<td>High school equivalency; Spanish, Somali, Hmong or Arabic language</td>
<td>High school equivalency</td>
</tr>
</tbody>
</table>
## CHW CHARACTERISTICS

<table>
<thead>
<tr>
<th>Key Element</th>
<th>Rio Grande Valley Salud y Vida</th>
<th>Sinai Asthma Care Partners</th>
<th>Hennepin County Medical Center</th>
<th>UPenn IMPaCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-the-job training</td>
<td>Yes</td>
<td>Yes; 40 hours</td>
<td>Yes</td>
<td>Yes; 140 hours</td>
</tr>
<tr>
<td>Formal CHW education required</td>
<td>Yes; 12-week TX state certification</td>
<td>No</td>
<td>Yes; MN state certification</td>
<td>No, but 140 hrs applies for college credit</td>
</tr>
<tr>
<td>Employed (n, %)</td>
<td>36-42, 100%</td>
<td>3, 100%</td>
<td>25, 100%</td>
<td>23, 100%</td>
</tr>
<tr>
<td>Paid</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Benefits package</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes if over 0.5 FTE</td>
<td>Yes</td>
</tr>
</tbody>
</table>
EMERGING BEST PRACTICES FOR CHW PROGRAMS

**Recruitment and Hiring**
- Use targeted recruitment strategies to identify CHWs with desired soft skills including role-plays or pre-hire workshops

**Training and Supervision**
- Provide hands-on training
- Maintain low supervisor to CHW ratios

**Evaluation and Funding**
- Demonstrate outcomes through rigorous evaluation methods to prove added value
- Transition from grants to payers/employers
REFERENCES AND ACKNOWLEDGEMENTS


- Prepared by ES Advisors, LLC for the Mid-America Regional Council (MARC) with funding from the Healthcare Foundation of Greater Kansas City
CASE STUDY: KANSAS CITY CARE CLINIC
Federally Qualified Health Center

Founded in 1971 as a free health clinic
- By 2012 had become the largest free clinic in the country
- Converted to hybrid model in 2013 and FQHC in 2015
CHWS AT THE KC CARE CLINIC

- Started in 2010 with two CHWs working in “afterhours” of KC area safety net clinics
- 2016: Regional “hub” of 20 CHWs partner with:
  - Four Hospital systems
    - St. Luke’s Health System, KU Medical Center, Research Medical Center, North KC Hospital
  - Seven Safety Net Clinics
  - CBOs – domestic violence shelters, etc.
  - Faith based organizations
KC HEALTH CARE ENVIRONMENT

- NO Medicaid expansion
- No one dominant health care system – biggest system is 22% of market share
- Limited ACO or other risk sharing models
CARE DELIVERY TEAM MEMBERS

- CHWs embedded in care teams at hospitals and clinics
  - Each CHW is onsite in either Emergency Department or Primary Care clinic several days per week
    - Spend balance of time in community, home visits, etc
  - Document in Electronic Health Record of Hospital or Clinic
  - Referrals from nurses, social work and providers
CARE COORDINATION ROLE

- Individualized assessment and care plan developed
- CHWs function as a medical tour guide for patients: walking side-by-side they teach patients to navigate the health care and social service systems
  - Navigate access to primary care and specialty care
  - CHW Attendance at appointments
  - Home/Community visits
  - Facilitate access to needed social services
    - Including application for Medicaid/Medicare, ACA plans
- Motivational interviewing techniques
CARE COORDINATION TASKS

- Assist with navigating health care services
  - Coordinating appointments – primary care and specialty care
  - Accessing medications
- Benefits enrollment
  - Medicaid, Medicare, Marketplace, Disability, etc
- Social services referrals and navigation
- Basic supports
  - Food, housing, etc.
PATIENT ENGAGEMENT

- Patient Education
  - Wellness and disease specific education
- Self management capacity building
  - Ask me three
  - Pre-appointment planning
  - Post-appointment review
- Operationalizing the care team plan
  - Home visits or trips to the grocery store
TRAINING

- Minimum education is high school diploma or equivalent

- Community Health Workers are trained with Metropolitan Community Colleges of KC curriculum
  - 100 classroom hours
  - 60 service learning hours

- By KC CARE
  - Orientation with extensive shadowing time
  - Job specific training – diabetes self management course, medical interpretation course, community resources, HIPAA, documentation and technology training (EHR, CHW database, etc.)
SUPERVISION AND SUPPORT

- KC CARE recruits, hires, trains, supervises and supports CHW team
  - Supervision by people who only supervise CHWs
    - Helps support the work of this unique health care professional
  - Low CHW to supervisor ratio
    - Goal is 6 to 1
HOW IS THIS DIFFERENT? WHAT VALUE?

CHWs are:

- Cultural and Linguistic liaisons
  - This is a peer model intervention. CHWs have a shared lived experience with their clients and connect in ways that the “professionals” in health care team do not
  - Teach patient to work with care team

- Care Team extenders
  - CHWs extend the work of care team and RN and SW case managers into the community, home, and beyond
  - Provide feedback to care team with information otherwise unknown
OUTCOMES

- 91% of patients achieve CHW care plan goals
- 58% of patients report an improvement in their overall health during time working with a CHW
- 82% of patients working with a CHW did not return to the ED within 90 days
- 65% overall reduction in patient use of ED
Next Steps

• Register for the July 20\textsuperscript{th} Integrated Behavioral Health webinar.

• Let us know what topic areas you would like to focus on this Summer!

• \texttt{ihen@team-iha.org}
Email: ihen@team-iha.org

July 20th - Integrated Behavioral Health