Community Health Workers and the Future of Chronic Disease Management

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Topics: CHWs in national context

• Getting on the same page: definitions and standards

• Examples of population and individual approaches

• CHW roles in CDM

• Opportunities in the revised Medicaid rule on preventive services
Definitions and standards

GETTING ON THE SAME PAGE
What’s your definition of CHW?
Community Health Worker Definition
American Public Health Association (1)

• The CHW is 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 CHW 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.
Community Health Worker Definition - APHA (2)

• The CHW 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.

APHA Policy Statement 2009-1, November 2009
CHW Roles And Functions (1)

National Community Health Advisor Study (1998):

- Cultural mediation between communities and health and human services system
- Providing culturally appropriate health education and information
- Assuring people get the services they need
- Informal counseling and social support
CHW Roles And Functions (2)

- Advocating for individual and community needs
- Providing direct services, mainly in remote areas, and meeting basic needs
- Building individual and community capacity

http://crh.arizona.edu/sites/crh.arizona.edu/files/pdf/publications/CAHsummaryALL.pdf
What Is Distinctive About CHWs? (1)

- Do not provide clinical care
- Generally do not hold another professional license
- Expertise is based on shared culture and life experience with people served
What Is Distinctive About CHWs? (2)

- Rely on relationships and trust more than on clinical expertise
- Relate to community members as peers rather than purely as clients
- Can achieve certain results that other professionals can’t
CHWs at Work: PROGRAM EXAMPLES
Overview of Core Health

Overview:

Core Health is a continuum-based free 12 month program for adult clients with **Heart Failure** and/or **Diabetes** that:

- Live in Kent County
- Have economic, demographic, or cultural barriers to healthcare
- Are able to participate in a self-management program

**Address barriers to achieve Self Management!**
Case Manager RN/CHW Model

Community Health Worker

Case Manager RN

Medical Home/Specialist

Core Health Program Team
Case Manager RN/CHW Model

Patient Experience - CHW

Weekly to Monthly visits
- Data collection – VS, foot check, self report
- Goals using Motivational Interviewing
- Education
- Referrals – community connections
- Self-Efficacy

Patient Centered - Address barriers of equity and access
Cost Efficiencies – Right Place Care

Emergency Department Visits

<table>
<thead>
<tr>
<th>Condition</th>
<th>Usage Rate BEFORE Core Health</th>
<th>Usage Rate for Core Health Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Only</td>
<td>16.4%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Heart Failure Only</td>
<td>31.1%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Heart Failure AND Diabetes</td>
<td>31.1%</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

Hospital Admissions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Usage Rate BEFORE Core Health</th>
<th>Usage Rate for Core Health Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Only</td>
<td>8.5%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Heart Failure Only</td>
<td>38.2%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Heart Failure AND Diabetes</td>
<td>38.2%</td>
<td>9.3%</td>
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</tbody>
</table>
Community Health Worker Led Diabetes Coaching within the Medical Home

Christine Snead, RN
Erin Kane, MD
Baylor Scott & White Health
Goal: To optimize primary care for “at-risk” patients with diabetes

Tactics:
- Embed community health workers within PCMH
- Train and manage CHWs
- Leverage software for data capture and communication
- Scale to five sites
Shifting Tasks to the CHW

PCP Roles

PCP Tasks
- Clinical exam
- Diagnoses
- Creation of treatment plan
- Prescription of medications

CHW ROLES

PCP Tasks Shifted to CHWs
- Diabetes education*
- Nutritional counseling
- Frequent patient follow-up

Traditional CHW Tasks
- Social support
- Link to community resources*
- Care Navigation
- Patient Activation

- Licensed personnel (RNs, CDEs, SWs) handle more complex cases.
- CHW oversight by licensed program manager (RN or SW) and program Medical Director. Patient specific direction taken from PCP.
A Population View: Glycemic Control Improves

DEP patients with at least two measures within specified period were included in the analysis. Visits listed are quarterly. The most recent measure was used. Data source is the registry used for the DEP. Data extracted January 6, 2014.
A Population View: 
Poor Glycemic Control Decreases

DEP patients with at least two measures within specified period were included in the analysis. Visits listed are quarterly. The most recent measure was used. Data source is the registry used for the DEP. Data extracted January 6, 2014. p<.001.
Patient Feedback: Qualitative Interviews

- Relaxed, safe environment
- Frequent contact
- Relatable and accessible when there are issues

“With the (CHW), you can be part of the conversation in deciding your health.”

“She tells me the truth. I believe she’s honest about things. I feel I can get open with her because she’s the kind of person who will listen to what you’re going to say.”

* Twelve qualitative interviews conducted by BHCS Director of Health Sciences Research Funding, 2012. 
• CHWs improve efficiency and quality of care
  - Build rapport with patients quickly → identify barriers → providers refine medical management
  - Spends more time with patients than providers are able
    • Navigate needed services
    • Hold patients accountable as the driver of improved outcomes
    • Follow up with CHW occurs between provider visits
  - Providers recognized CHW knowledge base which increased professional trust

* Twelve qualitative interviews conducted by BHCS Director of Health Sciences Research Funding, 2012.
- A foundation of medical homes and community health teams that supports coordinated care and linkages with a broad range of services

- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams

- A health information infrastructure that includes electronic health records (EHRs), hospital data sources, a health information exchange network, and a centralized registry

- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact
Traditional Healthcare Workers Join CCO Movement

This work force is intended to help people lead healthier lives, as well as save money

By Amanda Waldroupe

July 1, 2013—Traditional health workers and their impact on Oregon’s healthcare system, particularly the Oregon Health Plan, were the subject of an all-day conference sponsored by Acumenra Health last week.

The legislation creating coordinated care organizations (CCOs) requires them to use three types of traditional healthcare workers: community health workers, peer wellness specialists and patient navigators. Doulas, and other types of workers, can also be used.
AADE POSITION STATEMENT
Community Health Workers in Diabetes Management and Prevention

Ann Albright, PhD, RD; Racheal Araujo; Carol Brownson, MSPH, PHLC; Dawn Heffernan, RN, MS; Darrel Iron Shield, Melinda Maryniuk, MEd, RD, CDE; Laurie Ruggiero PhD; Phyllis Secraw, RNC, CDE

Acknowledgement: Kris Ernst, RN, CDE

Introduction
A complex set of social, political, historical, environmental, and behavioral factors influence both the onset of type 2 diabetes and the sustainability of diabetes self-care practices. No single set of interventions is capable of addressing all of these influences. Rather, multiple approaches that include education, social support, policies, and community programs are needed. These approaches should also be directed at multiple levels, including individuals, families, communities, healthcare providers, and policy makers. To strengthen the links between healthcare providers and community members, many health promotion and diabetes programs are engaging community health workers (CHW).

CHWs are uniquely positioned to collaborate with diabetes educators and other health care providers to improve the quality of diabetes education, care, and prevention in communities. CHWs who are dedicated to diabetes education and care should also be mandated to complete specialized training in this area, especially...
Addressing Chronic Disease through Community Health Workers: A POLICY AND SYSTEMS-LEVEL APPROACH

A POLICY BRIEF ON COMMUNITY HEALTH WORKERS

This document provides guidance and resources for implementing recommendations to integrate community health workers (CHWs) into community-based efforts to prevent chronic disease. After providing general information on CHWs in the United States, it sets forth evidence demonstrating the value and impact of CHWs in preventing and managing a variety of chronic diseases, including heart disease and stroke, diabetes, and cancer. In addition, descriptions are offered of chronic disease programs that are engaging CHWs, examples of state legislative action are provided, recommendations are made for comprehensive polices to build capacity for an integrated and sustainable CHW workforce in the public health arena, and resources are described that can assist state health departments and others in making progress with CHWs.
(Seattle-King County)

COMMUNICATION WITH SCHOOL AND OTHER CAREGIVERS
CAS GUIDELINES

Key Messages:

• Good asthma management means that your child can do everything other kids do.
• Work closely with the school nurse, your child’s teachers, and/or childcare provider to be sure that your child is able to take participate fully in learning, physical education, and other school activities.
• The childcare provider or school must have an Action Plan and Asthma at School/Childcare letter signed by your health care provider to be able to give any medicine to your child or for your child to be able to keep her own medicine.
• Know when to keep your child home from childcare or school. Try not to let your child miss school because of asthma.

Assessment

• Determine what school, childcare, and/or other activity (such as after school programs) child attends.
• Determine who the caregivers are (school nurse at school and/or childcare provider).
• Check to see if parent/caregiver has brought “Asthma at School/Childcare” letter, copy of activities and directions to keep in contact with school nurse.

1/20/15
Versatile and adaptable
CHW roles in CDM
CHWs play multiple roles in CDM (1)

- Basic education on conditions, prevention and management techniques: community and individual level
- Starting/leading classes: exercise, shopping, cooking
- Use of equipment: BP, blood glucose, peak flow meters (asthma)
- Longer-term support and coaching
  - Enlisting social support networks
CHWs play multiple roles in CDM (2)

- Connecting to community resources
- Patient-provider communication
- Health literacy
- Appointment keeping
- Routine follow-up
CHW have had success in various CDM models

- Project Dulce, DEEP
- Healthy Homes
- National Diabetes Education Program
- Merck Childhood Asthma Network
- Your Heart, Your Life / Su Corazón, Su Vida Salud Para Su Corazón
- Stanford CDSMP model
  - CHW roles can include Master Trainers
State and Federal POLICY DEVELOPMENTS
States are pursuing various strategies in CHW policy innovation

- **Legislative**: Texas, Ohio, Massachusetts, New Mexico, Illinois, Maryland

- **Medicaid rules**: Minnesota, Wisconsin, DC

- **Policy driven by specific health reform initiatives**: New York, Oregon, South Carolina + SIM states

- **Broad-based coalition process**: Arizona, Florida, Michigan
CHW credentialing is gradually gaining traction

- SoP formally adopted only in MA, MN, NM
- States with early certification (TX, OH) currently have broader definitions
- Certification also in place now in OR, FL and SC, this Spring in MA
- On “fast track” in NM, IL, MD, ID... more?
Medicaid Breakthru: Preventive Services

  § 440.130 Diagnostic, screening, preventive, and rehabilitative service

  “Preventive services means services recommended by a physician or other licensed practitioner...” (previously read “provided by”)

- Brings rules into conformance with ACA

- Commentary clearly reflects interest in funding services by CHWs and other “non-licensed” providers

- Payment for CHW services will no longer need to be treated as admin costs
Taking Advantage of Medicaid Rule Change

• Requires State Plan Amendment (not a waiver): not required to be budget-neutral

• Must specify what non-licensed occupations are covered and their qualifications (skill requirements) – not necessarily certification

• Must specify what services will be paid for (CPT codes) and which Medicaid recipients are eligible

• Must specify rates of payment and payment mechanism (FFS, MCO, bundled payment etc.)
Thank you!

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