

INTEGRATION OF COMMUNITY HEALTH WORKERS/PROMOTORES AS MEMBERS OF THE HEALTH CARE TEAM

Margarita Holguin, MPA

Director of Partnership Initiatives, We Support U
Founding Chair and Co-Chair of the San Diego County Promotores Coalition
Founder and President, Consulting Solutions, LLC

www.consultingsolutionsMH.com

TEAM-BASED CARE

Team based care offers the opportunity to improve health care, overcome challenges, and improve population health and health disparities.



“An approach to achieving better health outcomes at lower costs through patient-centered medical homes utilizing team-based care.”

J. Ambulatory Care: Community Health Workers Integration into the Health Care Team Accomplishes the Triple Aim in a Patient Centered Medical Home: Findley, et al 2014 - (1)

Comprehensive and coordinated care improves health outcomes

CHWS & PATIENT CARE TEAMS

- CHWs play an important role in bridging language and cultural gaps
- CHWs bring experience-based expertise
- CHW intervention have been proved to work in chronic disease management
- Chronically ill patients benefit from a care team that includes both clinical skills and self management support skills
- Patients with greater needs benefit from the involvement of CHWs
- CHWs ease the difficulties of caring for vulnerable populations.



CHW CONTRIBUTION TO HEALTH CARE TEAMS

- Strengthen provider –patient communication
- Bring experienced-based expertise
- Removes barriers in accessing and receiving quality care
- Help patient more effectively self manage their illnesses
- Motivate medication adherence
- Facilitate enrollment in health insurance/programs
- Coordinate/Increase access to health and social services
- Increase patient's use of preventive services

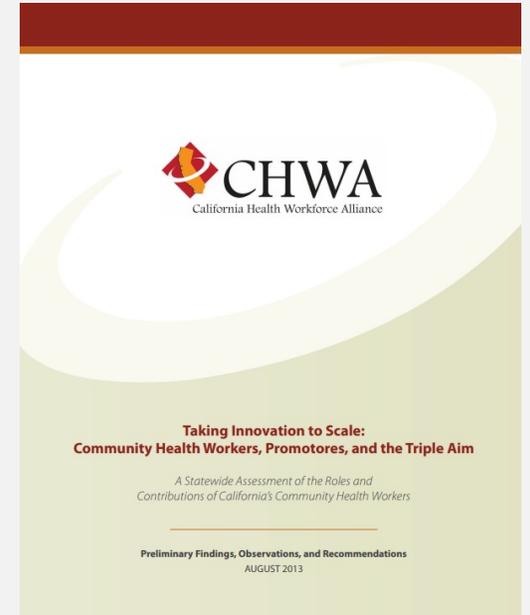


CHWs improve population health and reduce health disparities

California Health Workforce Alliance: Taking Innovation to Scale:
Community Health Workers, Promotores and the Triple Aim (2013) -(3)

CHW CONTRIBUTION TO HEALTH CARE TEAM

- Help patients adopt positive health behaviors
- Promote use of primary and follow up care
- Increase woman's knowledge about prevention practices
- Provide basic health education
- Support the delivery of clinical care services
- Help patients navigate complex health systems



California Health Workforce Alliance: Taking Innovation to Scale:
Community Health Workers, Promotores and the Triple Aim (2013) (3)



“AN INNOVATION THAT IS SHOWING TREMENDOUS GAINS”

... It has produced a return on investment of 4:1 when applied to children with asthma and a return on investment of 3:1 for Medicaid enrollees with unmet long-term care needs (Felix et al., 2011). Among participating patients with HIV, 60 percent achieve undetectable viral loads (Behforouz, 2014). In fact, examples keep emerging from around the country about its effectiveness in improving health outcomes and reducing emergency room visits and hospitalizations (CHWA, 2013; CDC, 2011; ICER, 2013).

- Instead, despite the promise this innovation has shown for years—and recognition from the Institute of Medicine (IOM, 2010), the Affordable Care Act, and the Department of Labor—it still has not been widely replicated or brought into the mainstream of U.S. health care delivery.
- The innovation is the use of community health workers (CHWs), and, **more specifically, their integration into team-based primary care.** The potential to improve care for vulnerable populations, help achieve the Triple Aim of better care, better health and lower costs, and advance population health **is too promising to be deterred.**

PENN'S COMMUNITY HEALTH WORKER PROGRAM YIELDS \$2.47 FOR EVERY \$1 INVESTED ANNUALLY BY MEDICAID (HEALTH AFFAIRS – 2/7/2021) (4)

PHILADELPHIA —Every dollar spent on patients receiving support from Penn Medicine's community health worker (CHW) program resulted in an **annual return on investment (ROI) of \$2.47 for every dollar** invested annually by Medicaid,

The savings are generated by reducing hospitalizations.

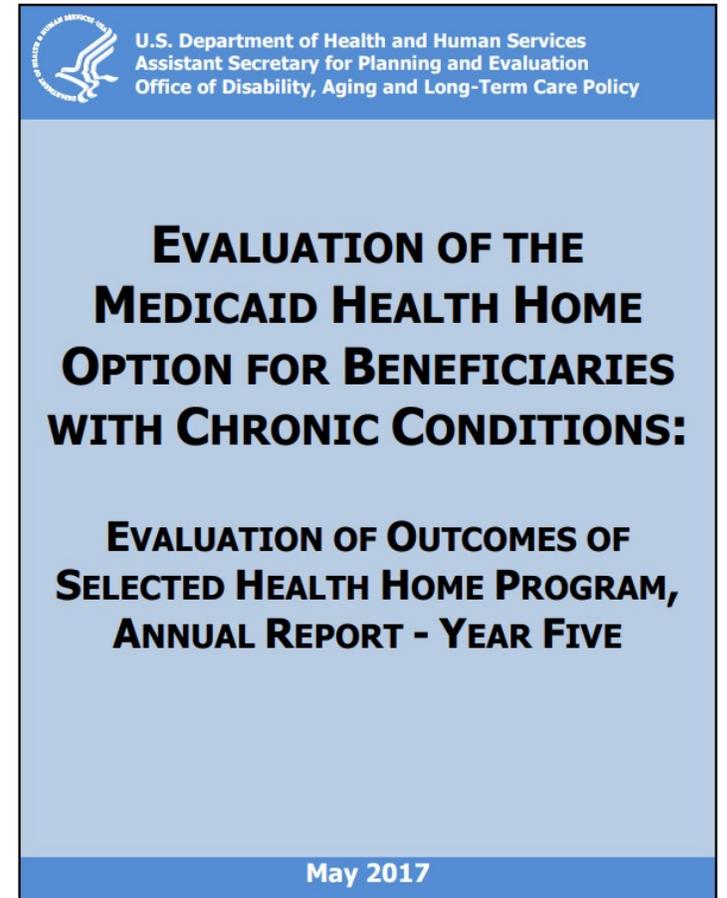
- Developed at Penn, IMPaCT (Individualized Management for Patient-Centered Targets) addresses unmet social needs such as housing and food insecurity and transportation needs in underserved populations with the goal of improving health. The evidence-based program hires, and trains trusted neighborhood residents to become CHWs who carry out culturally appropriate outreach activities, social support, patient advocacy, and health system navigation.



HEALTH HOMES PROGRAM

- No significant savings were indicated...
- But, for (Medicaid) enrollees with greater program exposure, both total spending and spending on services other than facility-based care was nearly \$200 less.

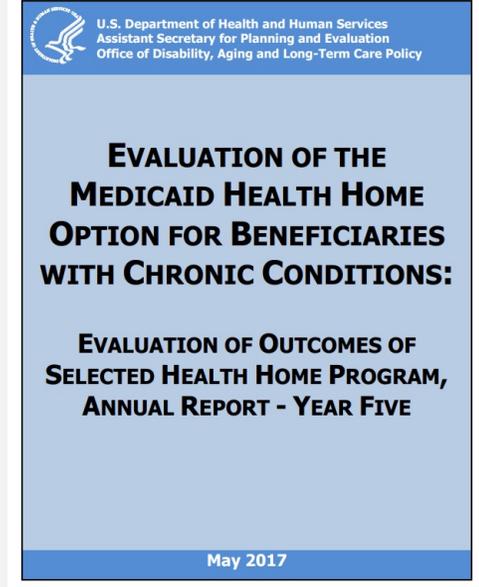
<https://aspe.hhs.gov/system/files/pdf/258871/HHOption5.pdf> (6)



HEALTH HOMES PROGRAM

- For dually eligible enrollees, total Medicaid spending was significantly lower (higher Medicare cost). The decline for primary care enrollees was about \$100, compared with more than \$250 for all enrollees, **and nearly \$400 for enrollees with greater exposure.**
- There was no significant change in total combined Medicaid and Medicare spending for enrollees, but **combined spending was about \$150 lower for enrollees with greater health home exposure.**

<https://aspe.hhs.gov/system/files/pdf/258871/HHOption5.pdf> (6)



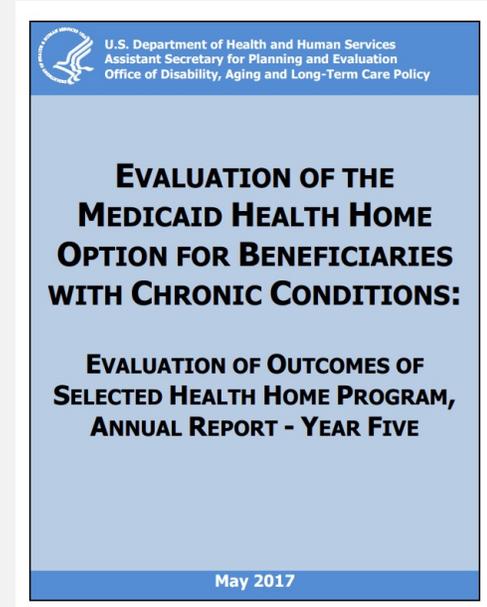


HEALTH HOMES PROGRAM

Conclusion:

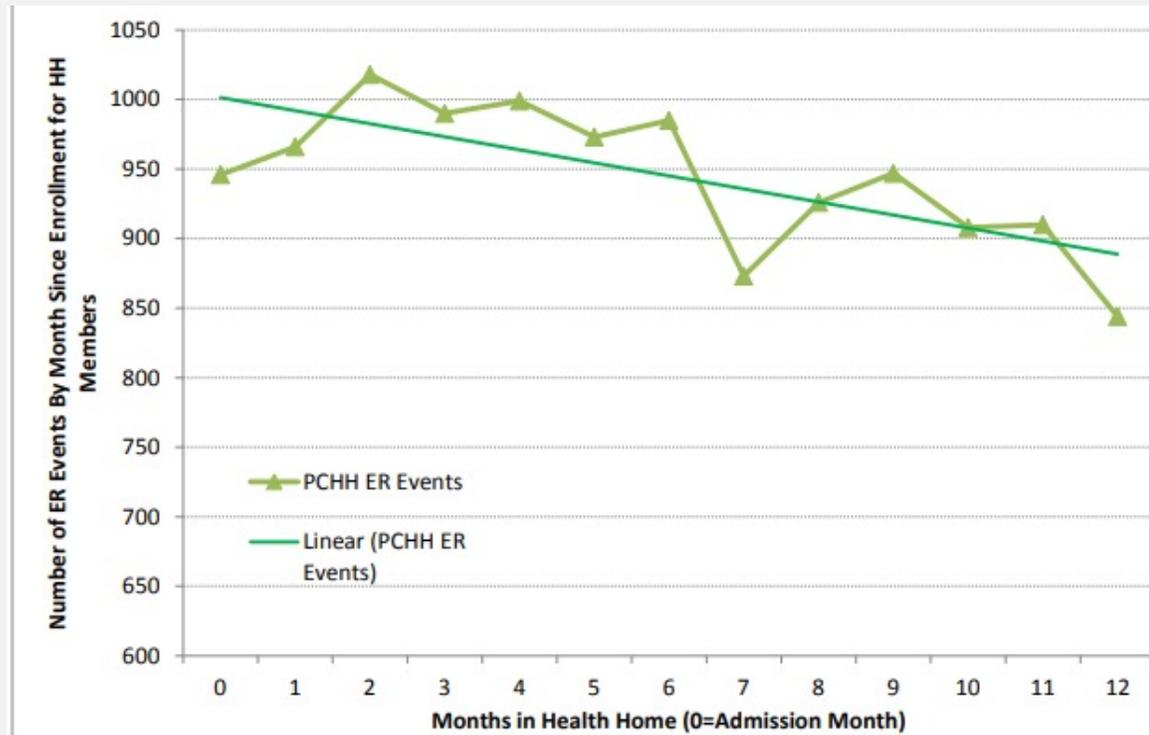
“Quantitative analysis did not generally find that health home enrollment was associated with reductions in spending, But when we limited the analysis to the subset of enrollees who had longer and more stable health home exposure, we found large **significant** reductions in overall Medicaid spending, suggesting that the ability of health homes to gain and maintain **enrollee engagement is a key factor in health home performance.**”

<https://aspe.hhs.gov/system/files/pdf/258871/HHOption5.pdf> (6)



MISSOURI – HEALTH HOMES PROGRAM

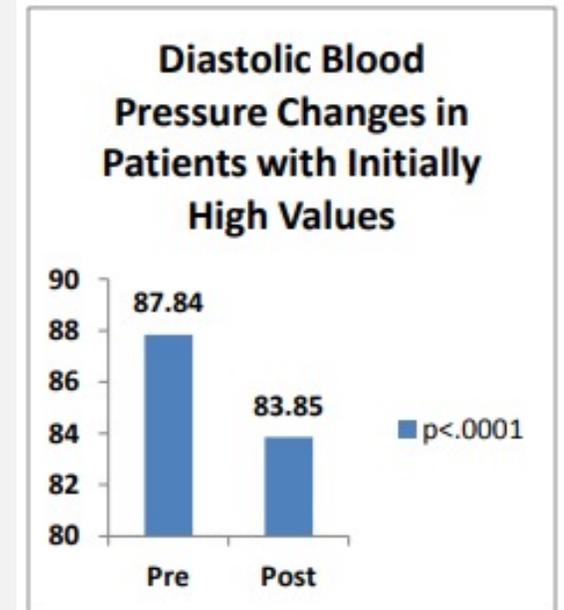
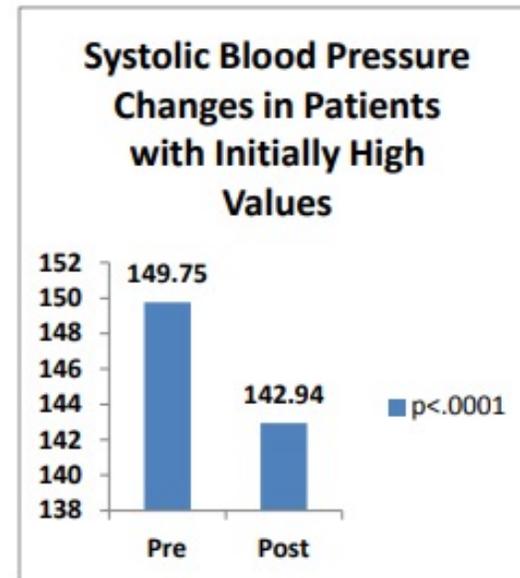
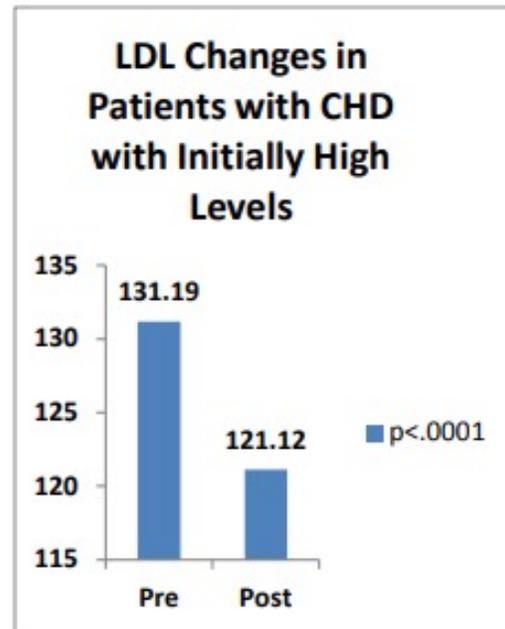
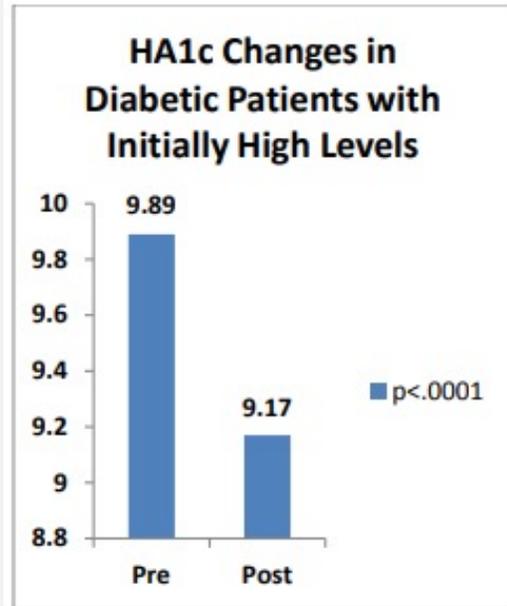
Number of people who visited the Emergency department **decreased** for members with at least 8 months of services



https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/mo_healthnet_primary_care_hh_interim_evaluation_report_summary.pdf (7)

MISSOURI – HEALTH HOMES PROGRAM

Achieved improved health outcomes



https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/mo_healthnet_primary_care_hh_interim_evaluation_report_summary.pdf (7)

RETURN ON INVESTMENT STUDIES

Maryland CHW Outreach Program on Healthcare Utilization

Patients saw savings of \$2,245 per year with a total saving of \$262,080 across 117 patients per year.

Denver Health Community Voices Program Piloted a CHW Outreach Program for 590 Men

The ROI was \$2.28 for every \$1 spent with a total annual savings of \$95,941.

East Texas ROI From Employment of CHWs in Two Hospitals Working with Emergency Department Patients

There was an ROI ranging from 3:1 to over 15:1.

Community health workers (CHWs) are critical to improving individual and community health through their ability to build trust and relationships and deepen communication between patients and providers. CHWs have a deep understanding of their communities through lived experience, which makes them uniquely qualified to address social and behavioral determinants of health.

Nevada CHW ROI Study: Health Plan Hired Three CHWs to Work With an Average of 37 Patients Each for 30-60 Days

Average medical costs decreased from \$1,223 pre-intervention to \$983 post-intervention.

Kentucky Homeplace Program ROI Study Rural Health Information Hub

The ROI was \$11.20 saved for every \$1 spent on CHW training.



NEIGHBORHOOD NAVIGATOR MODEL

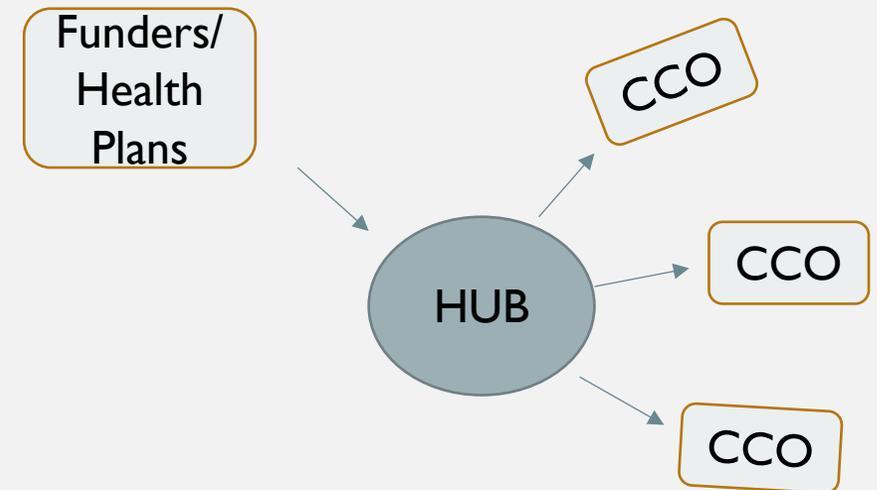
SAN DIEGO HEALTH CARE QUALITY
COLLABORATIVE / BETHERE SAN DIEGO
AND
CHULAVISTA COMMUNITY
COLLABORATIVE



**NEIGHBORHOOD
NETWORKS**

NEIGHBORHOOD NAVIGATOR MODEL - SAN DIEGO

- Health Homes Program
- Partnership and collaboration
- Contract with health plans
- Local organization serves as the HUB
 - Manages the program
 - Billing and reimbursements
 - Data sharing agreements and compliance
 - Training
 - Contracts with Community Care Organizations

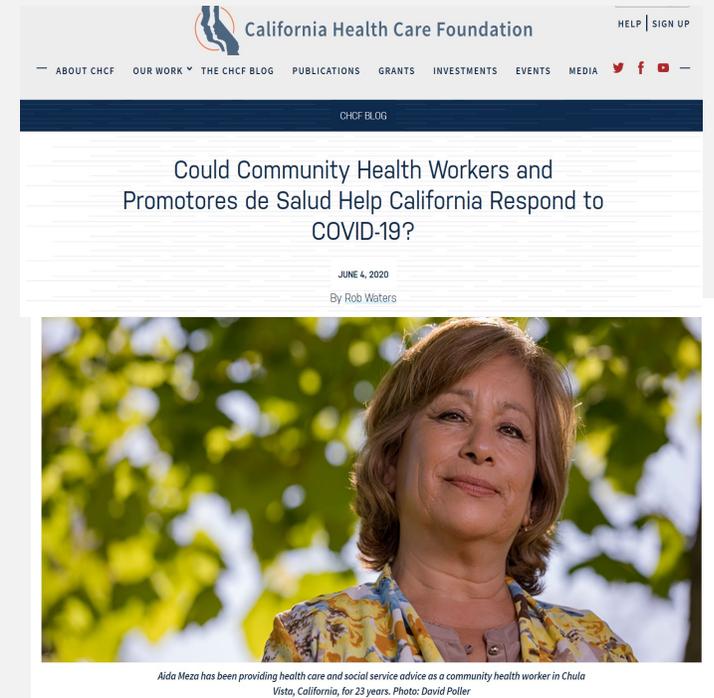


STRENGTHS

- Utilize evidence-based and standardized practices
- Based on Community Health Worker model
- Focus on engagement and strong in-person relationships
- Navigator comprehensive training
- Clinical Support – part of the team
- Provide a variety of services, from closing care gaps to complex case management
- Navigators are advocates for each client
- Team approach

NEIGHBORHOOD NAVIGATORS

- Are based in the communities they served
- Reflect the community/Peers
- Build trusted relationships
- Identify and address unmet health-related social needs
- Connect clients with local resources
- Provide follow up
- Track outcomes in centralized system
- Provide feedback to health plan



For more information about
Neighborhood Networks,
please contact Kitty Bailey at
(760) 707-9256 or
kitty@bethersandiego.org.



CHWS/PS AND COVID

- Continue to serve community
- Forefront of the pandemic
- Wellness Calls
- Mask Mondays
- Telehealth programs
- Food Distribution
- Testing information and assistance
- Vaccine information and assistance



TRUE INTEGRATION

- CHWs/P provide a value
- Help understand the “real barriers” faced by patient/client
- They provide cultural mediation
- They do much more than provide education to the patient
- Be a valued member of the team!

Patients have a better chance when the
CHW/P has a seat at the table!



HOW TO PAY FOR IT



California Health Care Foundation

- **Health Homes Program:** Explicitly focused on care coordination, referrals, case management, and transitional care.
- **Whole Person Care:** Increase integration and improve coordination for vulnerable Medi-Cal beneficiaries
- **Flipped visits:** Patient meets first with CHW then with Provider
- **Managed Care Organization/Health Plans:** Willing to pay for improved outcomes

How to Pay for it. Financing Community Health Workers in Transition Care: <https://www.chcf.org/wp-content/uploads/2018/11/HowToPayForCommunityHealthWorker.pdf> (9)

NEXT STEPS

- Improve health outcomes by integrating CHWs in your health care teams!!
- Learn about the model and how it best fits your organization to achieve optimal health outcomes!
- Training for **Agencies** and **CHWs/Ps**
 - **Health Basics: High Blood Pressure (English), 6/10/21 (10-12 pm)**
 - **Health Basics: High Blood Pressure (Spanish), 6/15/21 (1-3 pm)**
 - **Care Coordination, 6/30/21 (10-12 pm)**
 - **Starting a CHW Program 101, 7/08/21 (10-12 pm)**
 - **CHW/P program HR Basics, 7/29/21 (10-12 pm)**



SOURCES:

1. J.Ambulatory Care: Community Health Workers Integration into the Health Care Team Accomplishes the Triple Aim in a Patient Centered Medical Home: Findley, et al 2014 https://chwcentral.org/wp-content/uploads/2013/12/Community_Health_Worker_Integration_Into_the.10.pdf
2. BMJ. The role of patient care teams in chronic disease management. Wagner EH <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117605/>
3. California Health Workforce Alliance: Taking Innovation to Scale: Community Health Workers, Promotores and the Tripe Aim (2013) https://nachw.org/wp-content/uploads/2020/07/NACDD/CAI_CA%20Health%20Workforce%20Alliance%20report%20Aug%202013.pdf
4. National Academy of Pediatrics: Bringing Community Health Workers into the Mainstream of U.S. Health Care: Mary Pittman, Anne Sunderland, Andrew Broderick, Kevin Barnett: February 4, 2015 | Discussion Paper <https://nam.edu/perspectives-2015-bringing-community-health-workers-into-the-mainstream-of-u-s-health-care-2/>
5. Penn Medicine News: <https://www.penmedicine.org/news/news-releases/2020/february/penns-community-health-worker-program-yields-247-for-every-1-invested-annually-by-medicaid>
6. Health Homes Program Evaluation: <https://aspe.hhs.gov/system/files/pdf/258871/HHOption5.pdf>
7. Missouri Health Homes Program: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/mo_healthnet_primary_care_hh_interim_evaluation_report_summary.pdf
8. Association of States and Territorial Health Officials. <https://www.astho.org/Programs/Clinical-to-Community-Connections/Documents/CHW-Evidence-of-Effectiveness/>
9. How to Pay for it. Financing Community Health Workers in Transition Care: <https://www.chcf.org/wp-content/uploads/2018/11/HowToPayForCommunityHealthWorker.pdf>

