CHW LEADS

Presented by:

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UNM HSC Office for Community Health

HUMAN SERVICES DEPARTMENT

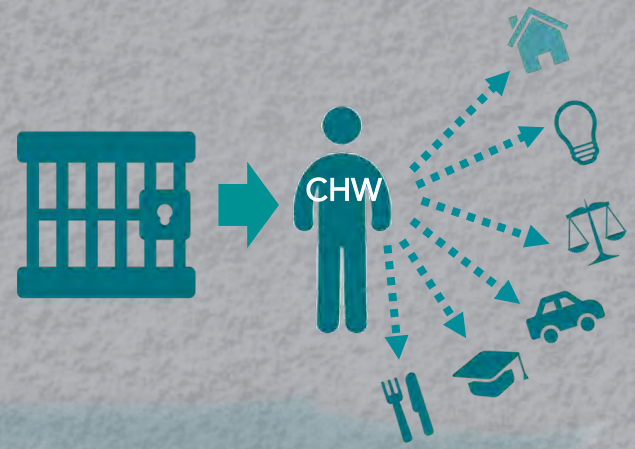
HEALTH SCIENCES
OFFICE FOR COMMUNITY HEALTH

Southwest chi Center for Health Innovation

What is CHW LEADS?

CHW LEADS *integrates CHWs into care teams in patient care and community settings to screen for and address the adverse social determinants of health affecting Medicaid recipients.*

CHW LEADS



Primary Care Clinics

Emergency Department and Pediatric ED

Social Services Agencies and Re-entry Resource Center

COLLABORATION

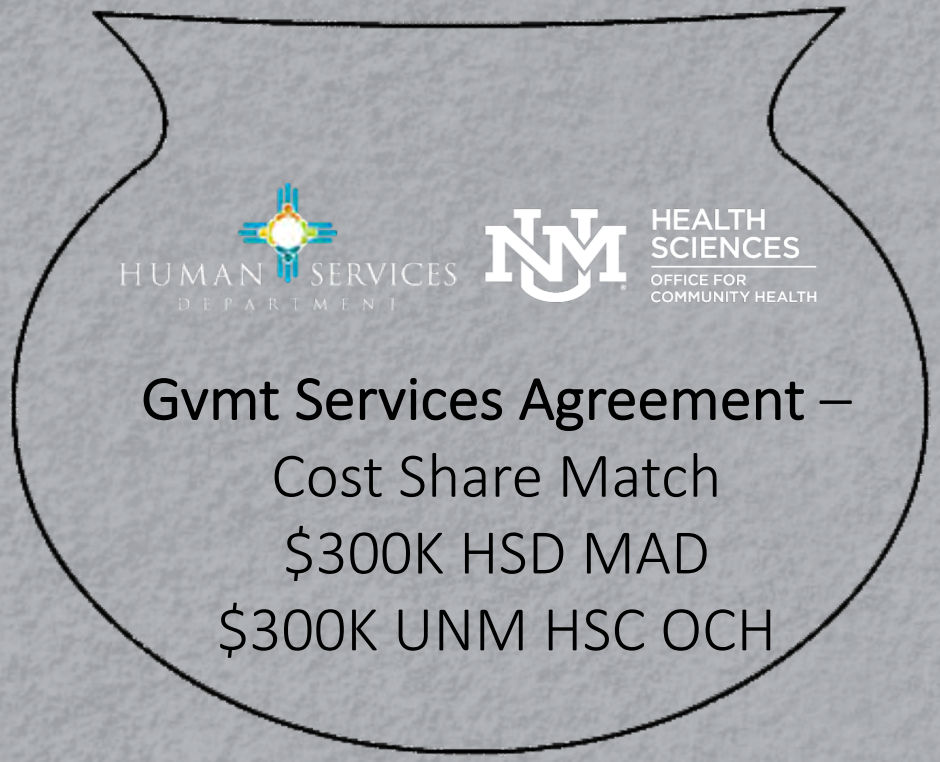
HUMAN SERVICES DEPARTMENT

HEALTH SCIENCES
OFFICE FOR COMMUNITY HEALTH

Southwest chi Center for Health Innovation

The University of New Mexico Health Sciences Center, Office for Community Health (UNM OCH) will collaborate with the Southwest Center for Health Innovation (SWCHI) and the Human Services Department (HSD)/Medical Assistance Division (MAD) to **further develop, evaluate, and disseminate** the model for integration of Community Health Workers (CHW) into patient care sites and communities to improve population health outcomes and reduce healthcare costs for Medicaid recipients.

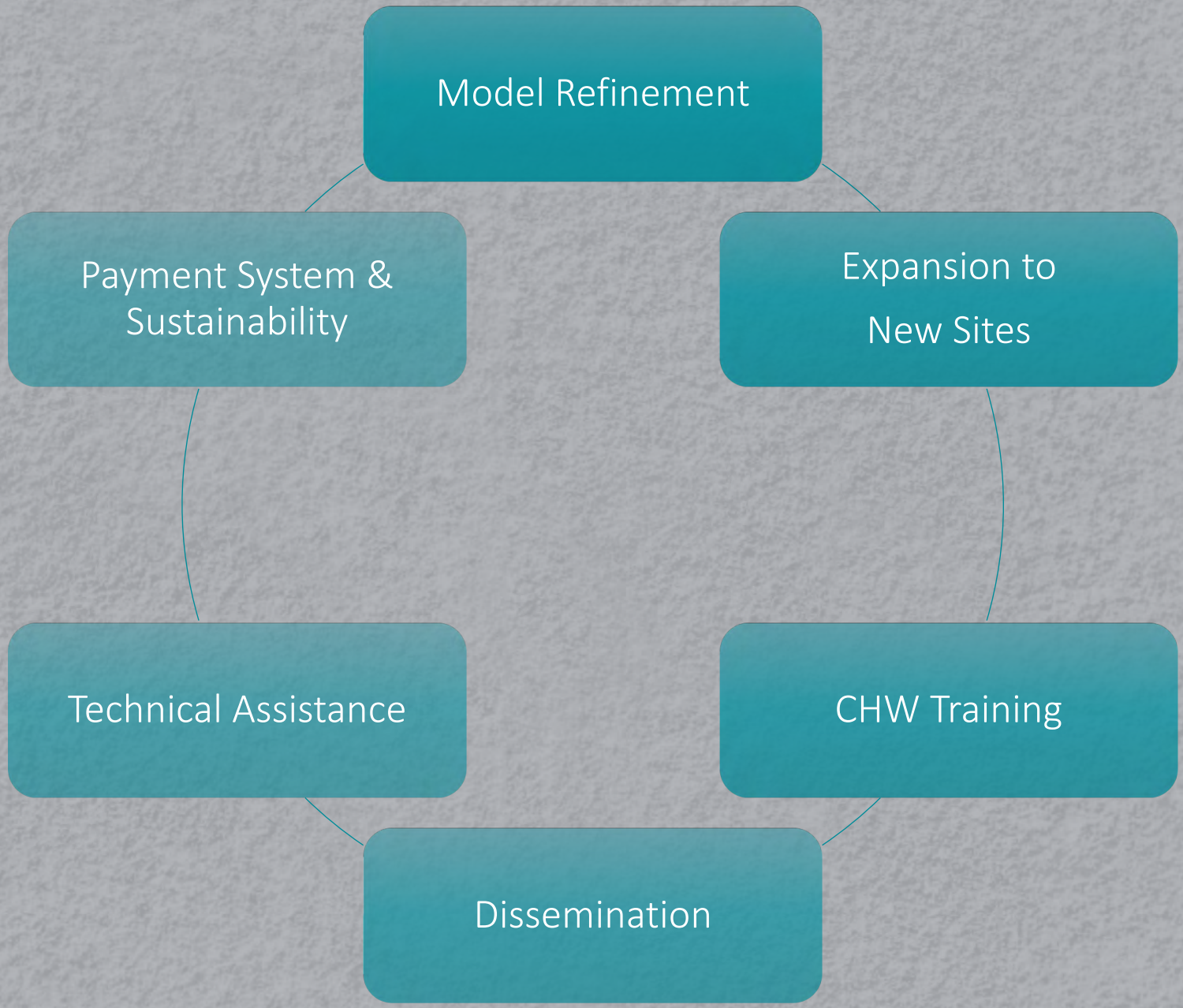
FUNDING



"think tank", model development, evaluation, dissemination, training

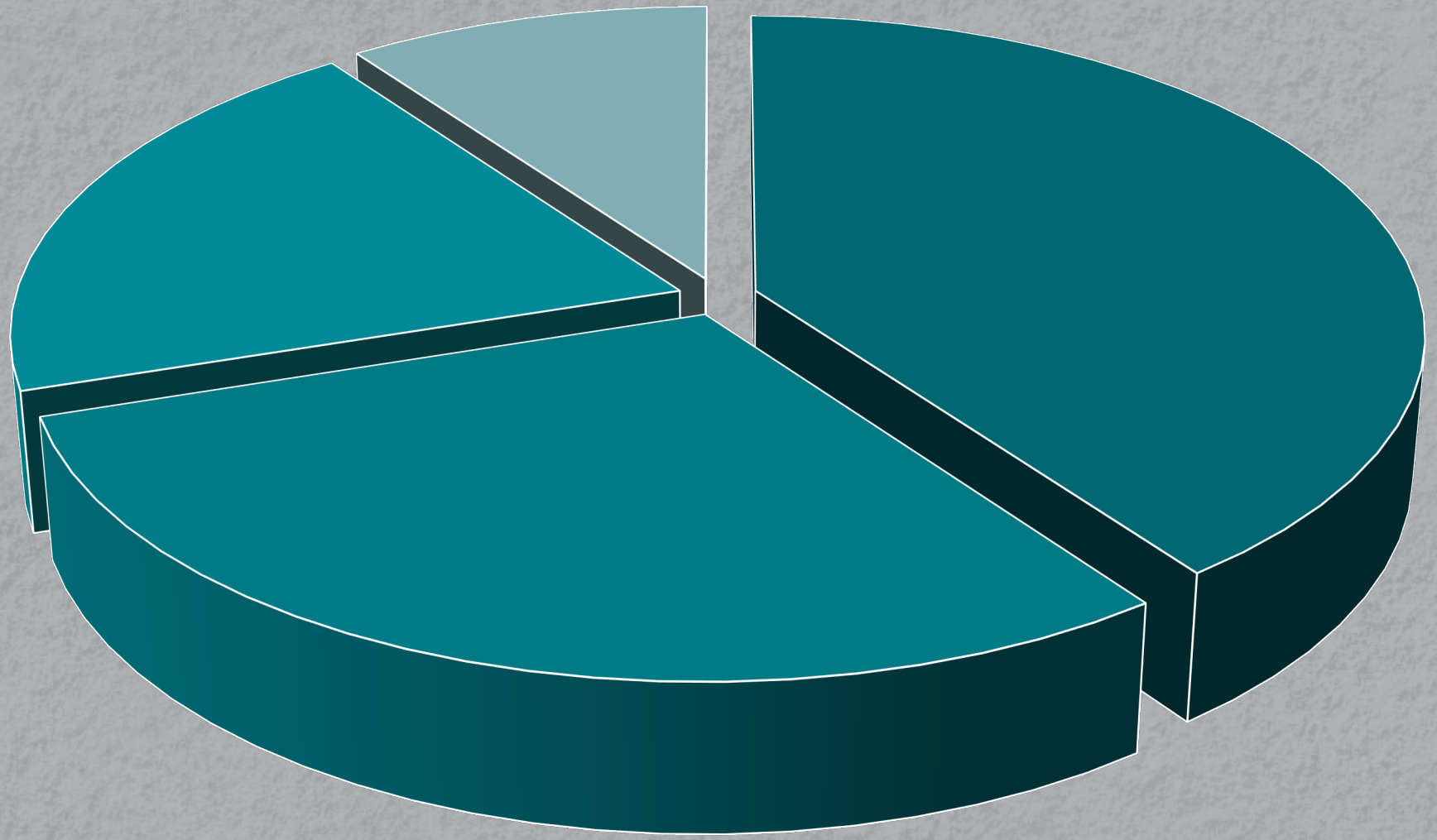
model testing & implementation

MAIN ELEMENTS OF COLLABORATION



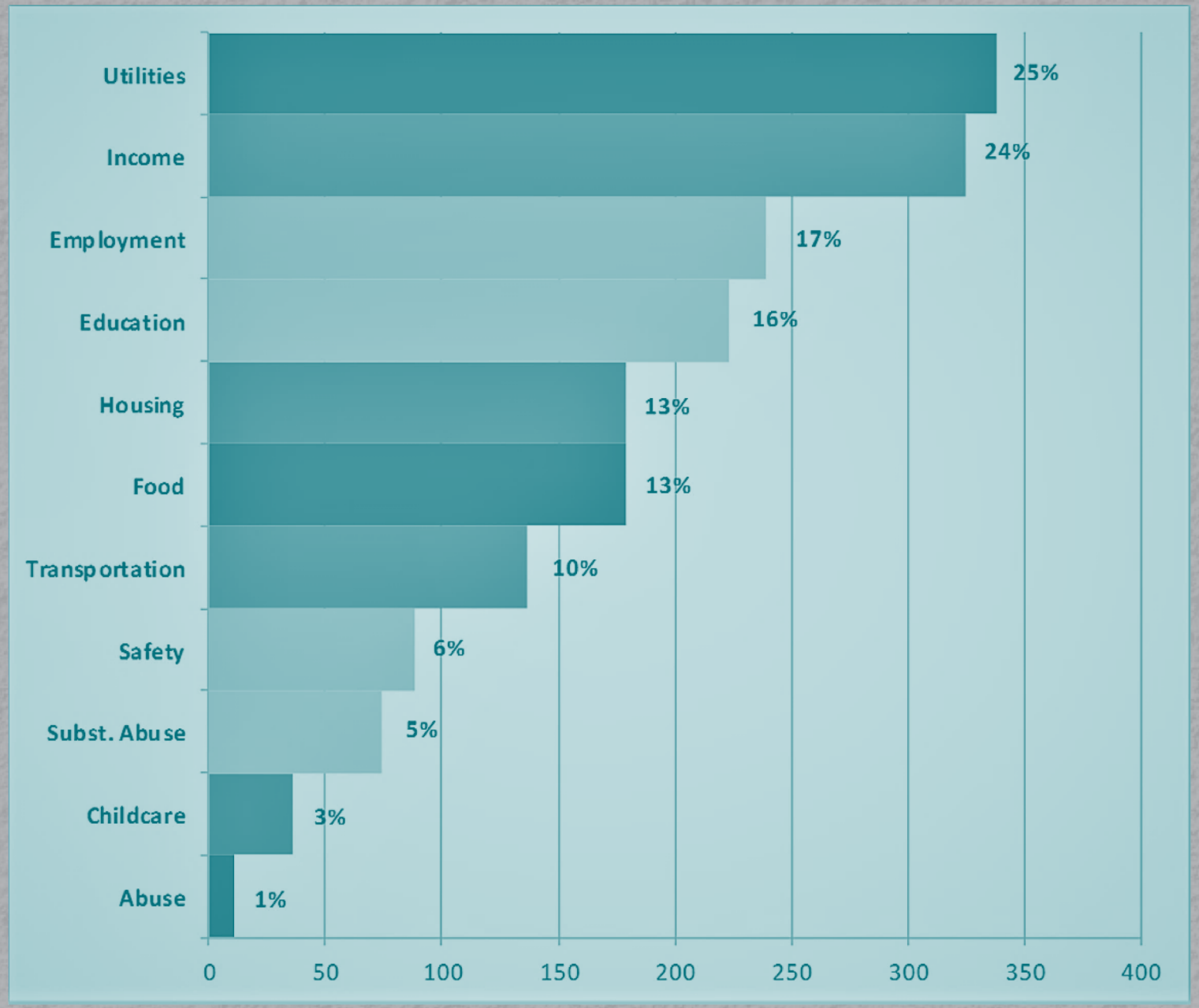
WHY IS THIS MODEL IMPORTANT?

Social Determinants of Health



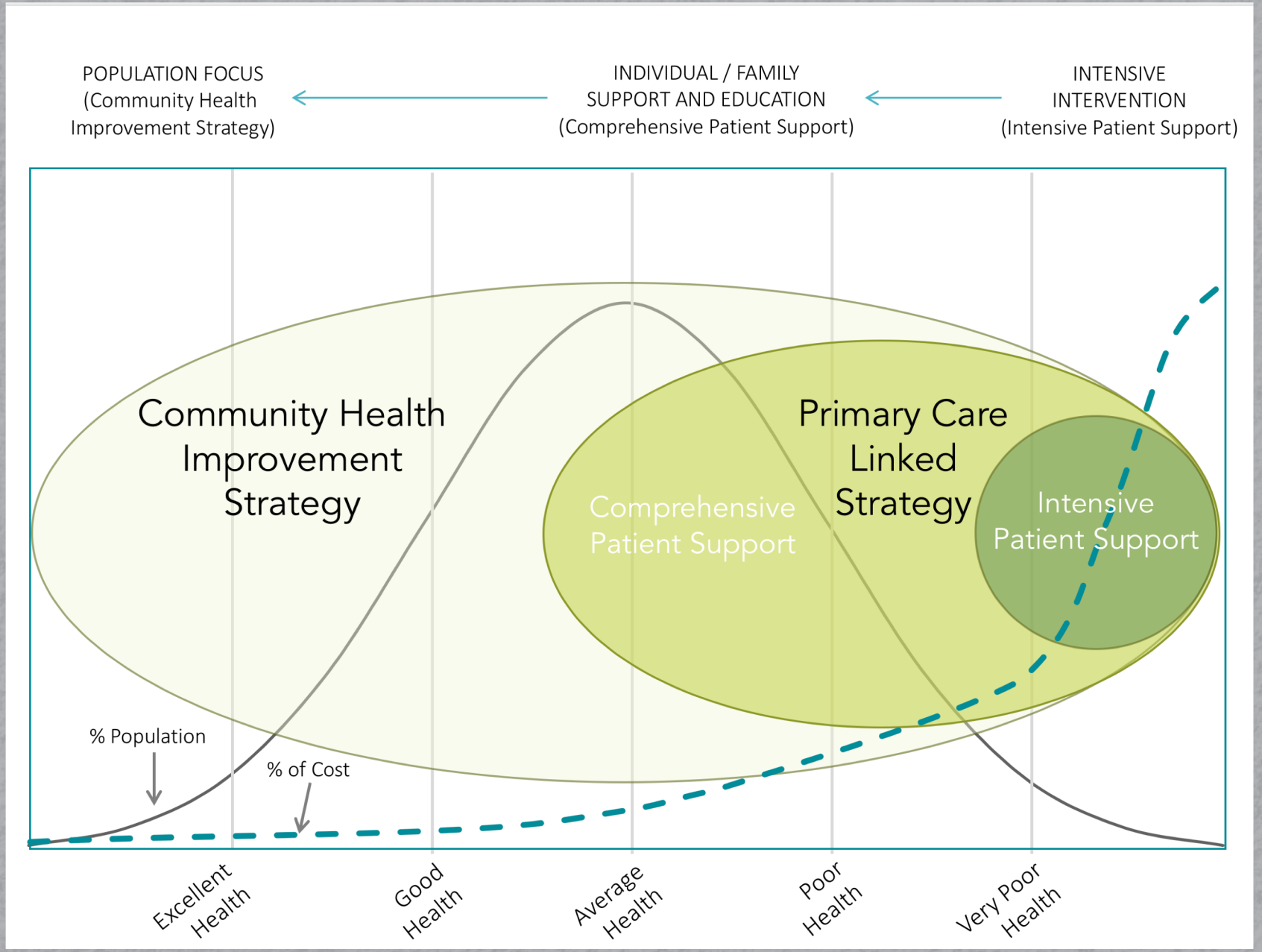
Source: WI Public Health Institute

ADVERSE Social Determinants of Health

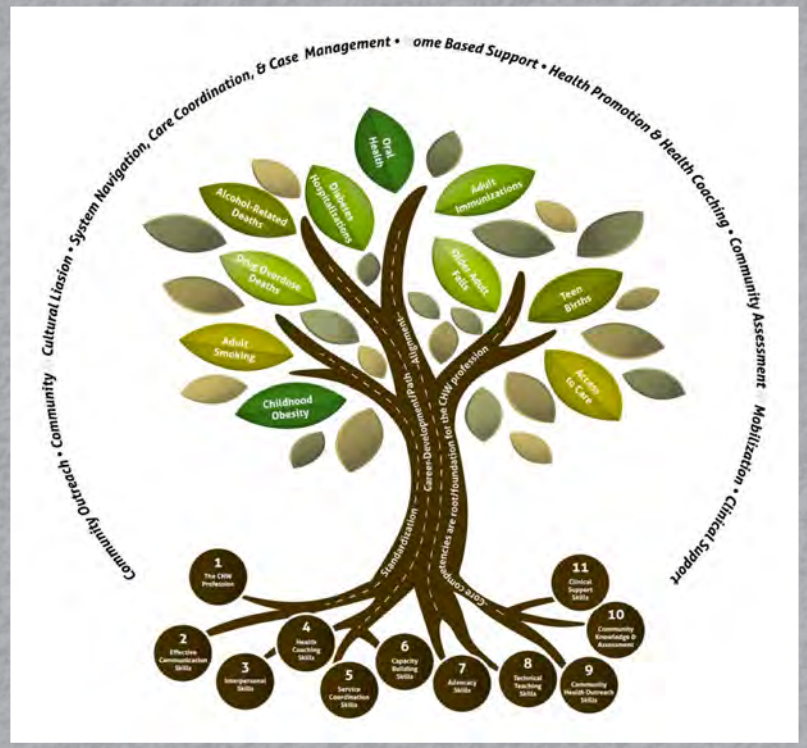


Well Rx Survey Responses (N = 3,048)

Conceptual Model



COMMUNITY & CAMPUS-BASED TRAINING



Enter/Re-enter Workforce

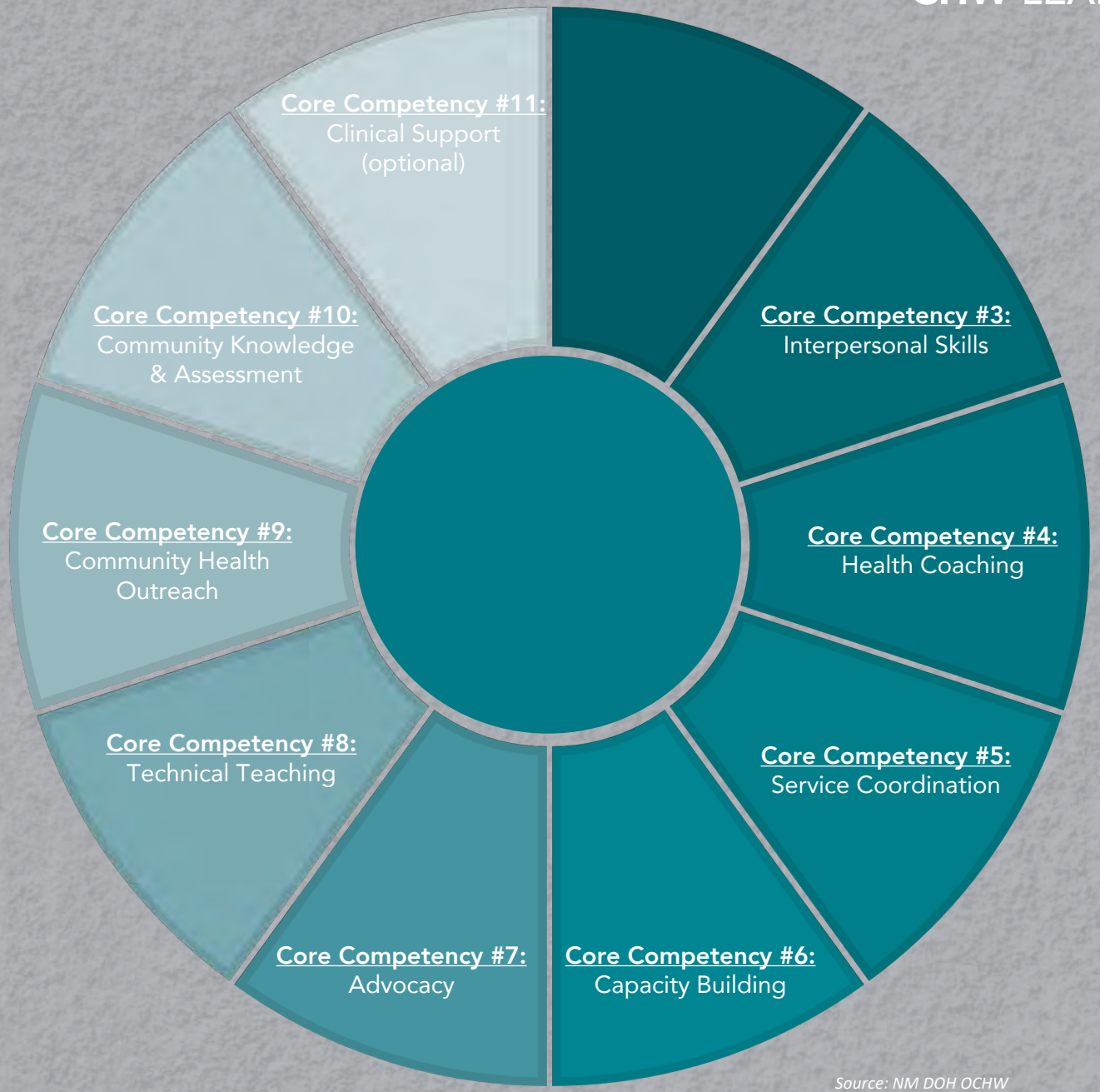
Enter/Re-enter Workforce

EDUCATIONAL LADDERS and CAREER PATHWAYS

Health Careers Exploration	Certificate in Community Health	Associates Degrees	Bachelors Programs	Graduate and Professional Health Sciences Programs
Rural YEP/UNM-H • Dual enrollment • Summer institute • Linked to STEM, HOSA	**CHW Core Training** • Aligned w/state certification standards; • Aligned w/national C3 (common core) standards **Optional additional training/certification** (CNA, EMT, LADAC)	• Community and Public Health • Human Services	• Health Education • Social Work • Public Health • Family & Consumer Sciences	• Masters and PhD Programs

Nursing, Allied Health, & Other Clinical Educational Pathways

CHW SCOPE AND COMPETENCIES IN NEW MEXICO



Source: NM DOH OCHW

HOW ARE CHWs FUNDED?

PAYMENT MODELS

Not Desirable

Fee for Service

High Volume/Low Quality

Not Desirable

Cost Based Reimbursement

Averages don't allow for high-needs patients

Desirable

Budget Models/ PMPM/ Bundled Payment

Predictable Staffing with Ability to Address Population Health

CHW LEADS models, separate from the medical payment system, can focus on OUTCOMES vs VOLUME

RESOURCES

- Government grants and contracts
- Foundation grants
- General operating dollars

IMPORTANCE OF INTEGRATING CHWS INTO CLINICAL SETTINGS

↑EXPERTISE/ ↓BURDEN ON THE CLINICAL TEAM

ADDRESSING SOCIAL NEEDS

Social Determinants Rx

Name _____ Age _____

Address _____ Date _____

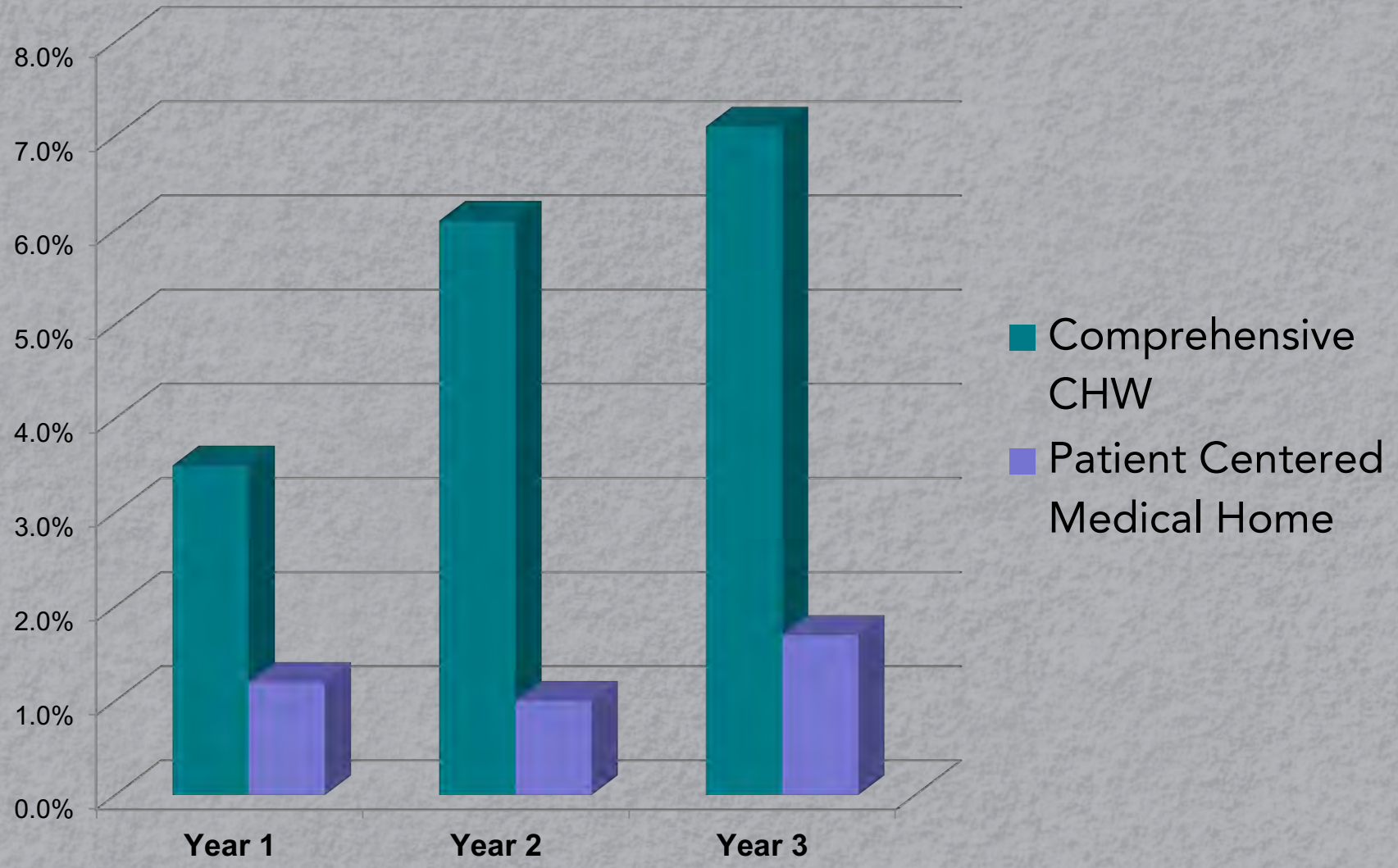
Referral to Community Health Worker for:

- ❑ Food Assistance
- ❑ Housing Assistance
- ❑ Utilities Assistance
- ❑ Transportation Assistance
- ❑ Daycare Assistance
- ❑ Legal Assistance
- ❑ Employment Assistance
- ❑ Education Assistance
- ❑ Substance Abuse Assistance
- ❑ Safety Assistance
- ❑ Domestic Violence Assistance
- ❑ Other

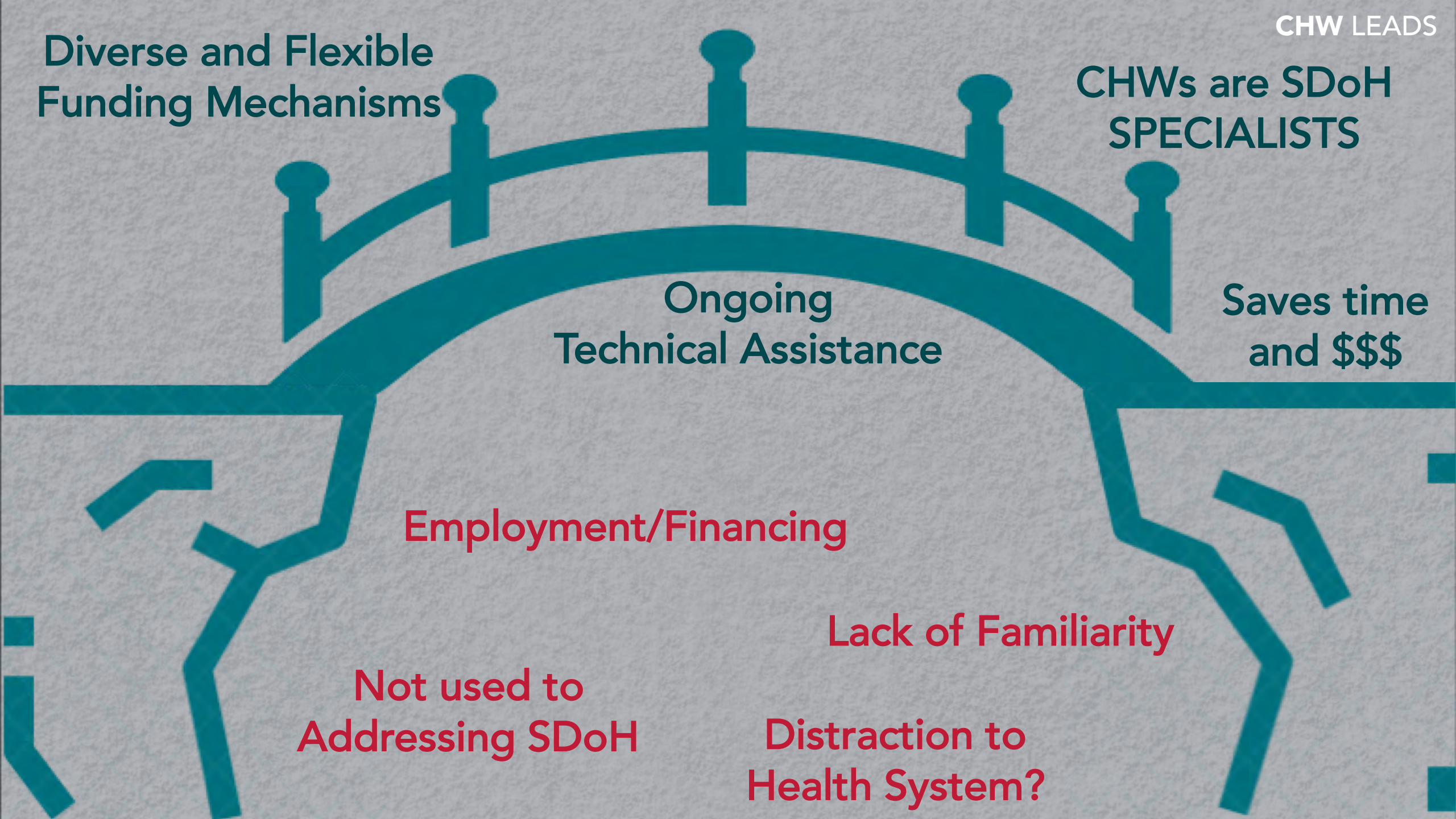
_____

Provider Signature

COST SAVINGS



WHAT ARE THE BARRIERS?


CHW LEADS
Diverse and Flexible Funding Mechanisms
CHWs are SDoH SPECIALISTS
Ongoing Technical Assistance
Saves time and $$$
Employment/Financing
Lack of Familiarity
Not used to Addressing SDoH
Distraction to Health System?

QUESTIONS?

EVIDENCE AND RESOURCES

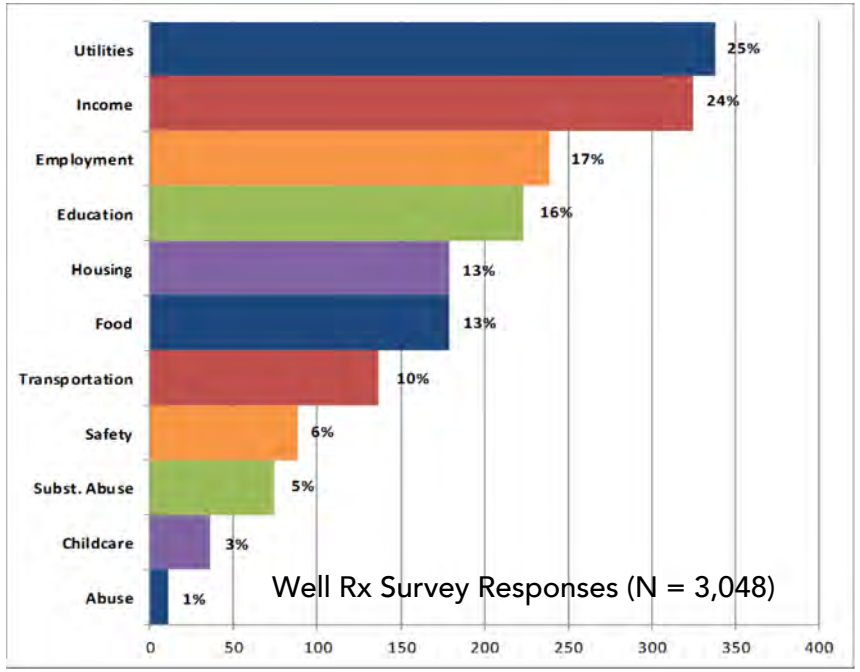
Evidence Handout Slides:

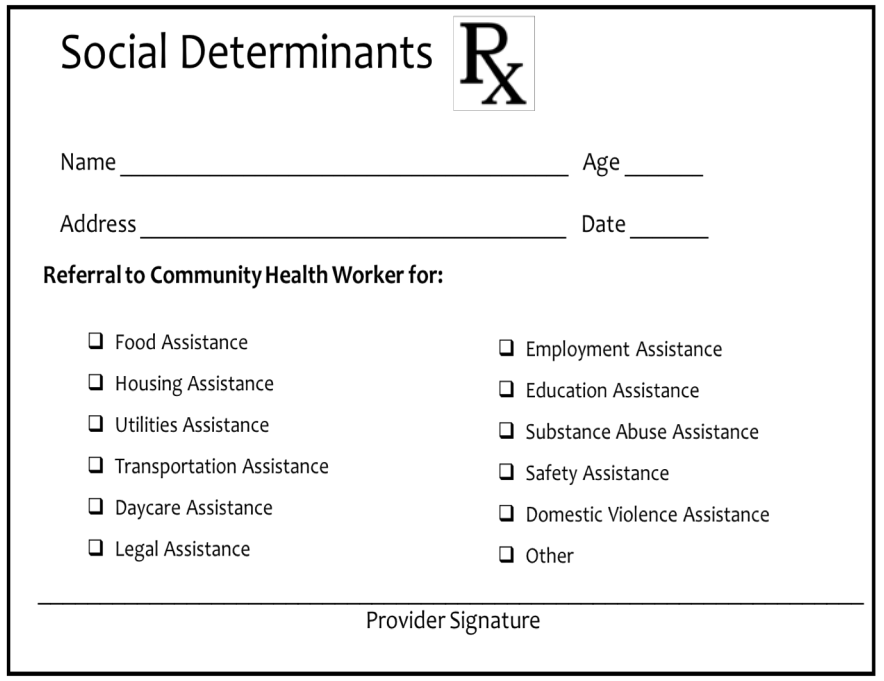
WellRx

ROI

CDC

Other Sources





Social Determinants Rx

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- ❑ Safety Assistance
- ❑ Domestic Violence Assistance
- ❑ Other

_____

Provider Signature

WellRx:

11-question instrument used to screen 3048 patients for social determinants in 3 family medicine clinics over a 90-day period.

Results:

- **46%** of patients screened positive for at least 1 area of social need
- **63%** of those had multiple needs.

The WellRx pilot demonstrated that it is feasible for a clinic to implement such an assessment system, that the assessment can reveal important information, and that having information about patients' social needs improves provider ease of practice.

Page-Reeves, et al. (2016). Addressing social determinants of health in a clinic setting: The WellRx Pilot in Albuquerque, New Mexico. *The Journal of the American Board of Family Medicine*, *29*(3), 414-418.

Evidence Handout Slides:

WellRx

ROI

CDC

Other Sources

The Patient-Centered Medical Home (PCMH) model demonstrated that processes of care can be improved while unnecessary care, such as preventable emergency department utilization, can be reduced through better care coordination.

CHW Leads, or the "Integrated Primary Care and Community Support (I-PaCS)" model, which integrates community health workers (CHWs) into primary care settings, functions beyond improved coordination of primary medical care to include management of the social determinants of health.

The expected cost impact of the I-PACS CHW model suggests that:

- hospital costs decrease approximately 70% for the high-risk patients, 40% for moderate risk individuals;
- decrease in emergency services of 61% for high-risk, 25% for moderate-risk, and 10% for low-risk patients;
- increased utilization of primary care services with costs projected to increase 20% for primary care and 10% for specialty care. Laboratory services are expected to increase with increased monitoring of clinical measures.

In sum, the Figure projects the anticipated annual savings by the third year at 1.4% for the PCMH and 7.0% for the I-PaCS CHW model. Our estimates indicate that the PCMH and CHW models can be complementary, the latter helping the former realize a far greater cost savings.

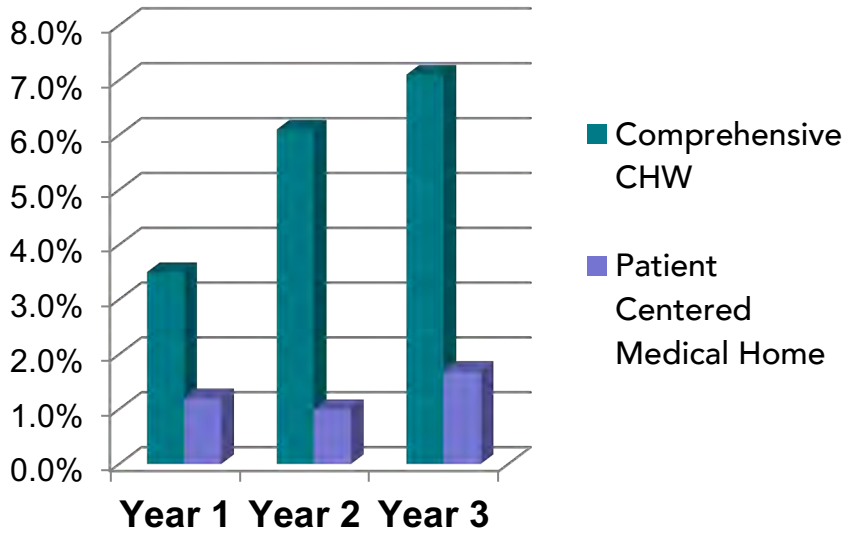

Table 1 Expected impact and magnitude of cost effect by service category

Service category	PCMH (%)	Comprehensive CHW (%)
Inpatient hospital	−1.0	−19.0
Outpatient hospital	−1.0	−19.0
Emergency services	−3.4	−19.6
Professional primary care	+0.5	+20.0
Professional specialty care	+0.5	+10.0
Laboratory services	0.0	+10.0
Other (capture costs)	0.0	+5.0
Prescription drugs (outpatient)	+2.0	+2.0

Moffett, M. L., Kaufman, A., & Bazemore, A. (2018). Community Health Workers Bring Cost Savings to Patient-Centered Medical Homes. Journal of community health, 43(1), 1-3.

Evidence Handout Slides:

WellRx

ROI

CDC

Other Sources

The evidence base demonstrating the effectiveness of integrating CHWs on clinical care teams is very strong. Research studies examining this intervention have had strong internal and external validity, the Community Preventive Services Task Force concluded that integrating CHWs on clinical care teams is effective, and trials of interventions that integrated CHWs have been replicated with positive results.

Health Impact

Integrating CHWs on clinical care teams or in the community as part of cardiovascular disease (CVD) prevention programs can help program participants lower their blood pressure, cholesterol, and blood sugar levels; reduce their CVD risks; be more physically active; and stop smoking.[2] It can also improve patient knowledge and adherence to medication regimens and improve health care services.[2]

Health Disparity Impact

By design, the CHW model seeks to eliminate health disparities because the populations served usually include people who have more barriers to care.[3] A Community Preventive Services Task Force review found that most studies on CHWs focused on underserved populations and concluded that the CHW model can be effective in improving health and reducing health disparities related to CVD.[2]

Economic Impact

A review by the Community Preventive Services Task Force concluded that interventions that integrate CHWs on clinical care teams to prevent CVD are cost-effective.[2] The median cost of intervention was $329 (range: $98 to $422) per person per year, with the main cost drivers being CHW time, costs for training and supervision of CHWs, and cost for any additional interventions or staff. The median change in health care costs after a CHW intervention was a reduction of $82 (range: -$415 to $14) per person per year.

LINK: CDC COMMUNITY HEALTH WORKER TOOLKIT

https://www.cdc.gov/dhdsp/pubs/guides/best-practices/chw.htm
https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm

Evidence Handout Slides:

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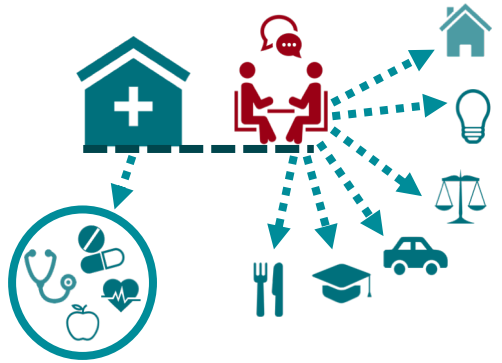
ROI

CDC

Other Sources

CHWs and Medicaid Managed Care in NM



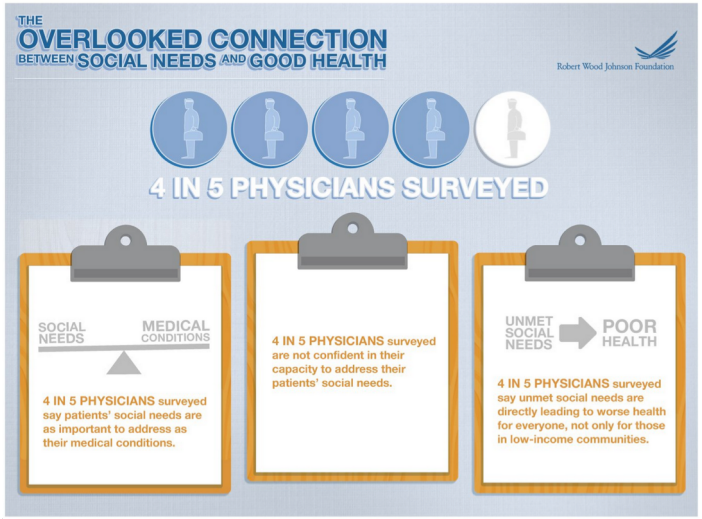
We conducted a retrospective study on a sample of 448 enrollees who were assigned to field-based CHWs in 11 of New Mexico's 33 counties. The CHWs provided patients education, advocacy and social support for a period up to 6 months. Utilization and payments in the emergency department, inpatient service, non-narcotic and narcotic prescriptions as well as outpatient primary care and specialty care were collected on each patient for a 6 month period before, for 6 months during and for 6 months after the intervention. For comparison, data was collected on another group of 448 enrollees who were also high consumers of health resources but who did not receive CHW intervention.

cost.

For all measures, there was a significant reduction in both numbers of claims and payments after the community health worker intervention. Costs also declined in the non-CHW group on all measures, but to a more modest degree, with a greater reduction than in the CHW group in use of ambulatory services. **The incorporation of field-based, community health workers as part of Medicaid managed care to provide supportive services to high resource-consuming enrollees can improve access to preventive and social services and may reduce resource utilization and cost.**

Johnson, D., Saavedra, P., Sun, E., Stageman, A., Grovet, D., Alfero, C., ... & Kaufman, A. (2012). Community health workers and Medicaid managed care in New Mexico. Journal of community health, 37(3), 563-571

Health Care's Blind Side - RWJF



Within the current health care system, physicians do not have the time or sufficient staff support to address patients' social needs.

Physicians surveyed feel so strongly about the connection between social needs and good health that 3 in 4 wish the health care system would pay for the costs associated with connecting patients to services that address their social needs if a physician deems it important for their overall health. Results also revealed that, if physicians had the power to write prescriptions for social needs, they would prescribe fitness programs, nutritional food and transportation assistance. Physicians whose patients are mostly urban and low-income also wish they could write prescriptions for employment assistance, adult education and housing assistance.

https://www.rwjf.org/en/library/research/2011/12/health-care-s-blind-side.html

RESOURCES

Health Extension Toolkit:

healthextensiontoolkit.org/quick-find/ipacs/

Peer-Reviewed Articles:

Page-Reeves, et al. (2016). Addressing social determinants of health in a clinic setting: The WellRx Pilot in Albuquerque, New Mexico. The Journal of the American Board of Family Medicine, 29(3), 414-418.

LaForge, K., Gold, R., Cottrell, E., Bunce, A. E., Proser, M., Hollombe, C., ... & Clark, K. D. (2018). How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care: An Overview. The Journal of ambulatory c

Moffett, M. L., Kaufman, A., & Bazemore, A. (2018). Community Health Workers Bring Cost Savings to Patient-Centered Medical Homes. Journal of community health, 43(1), 1-3.

Johnson, D., Saavedra, P., Sun, E., Stageman, A., Grovet, D., Alfero, C., ... & Kaufman, A. (2012). Community health workers and Medicaid managed care in New Mexico. Journal of community health, 37(3), 563-571

Other:

https://www.cdc.gov/dhdsp/pubs/guides/best-practices/chw.htm

https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm

https://www.rwjf.org/en/library/research/2011/12/health-care-s-blind-side.html