MHD PRIMARY CARE
HEALTH HOME
COMMUNITY HEALTH
WORKER PILOT

OVERSIGHT COMMITTEE
AUGUST 4, 2015
The American Public Health Association defines a Community Health Worker (CHW) as:

- 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.
- A 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.
According to the CDC, “Many interventions that integrate CHW services into health care delivery systems are associated with
- reductions in chronic illnesses,
- better medication adherence,
- increased patient involvement,
- improvements in overall community health, and
- reduced health care costs.”

- Community Health Workers: Expanding the Scope of the Health Care Delivery System. Kristine Goodwin and Laura Tobler, 2008
CDC Cont’d:

- “One study of a CHW outreach program for underserved men found a return on investment ratio of more than $2 for each dollar invested.
- Another study found an annual cost savings using CHWs of around $2,000 per Medicaid patient with diabetes.”

- National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention, A Summary of State Community Health Worker Laws http://www.cdc.gov/dhdsp/pubs/docs/chw_state_laws.pdf
CHW Roles

The National Community Health Advisor Study includes seven basic roles for CHWs:

- Proving cultural mediation between communities and health and human services systems,
- Providing informal counseling and social support,
- Providing culturally appropriate health education,
- Advocating for individual and community needs,
- Ensuring that people obtain necessary services,
- Building individual and community capacity, and
- Providing basic screening services.

- Community Health Workers: Expanding the Scope of the Health Care Delivery System. Kristine Goodwin and Laura Tobler, 2008
MHD CHW Primary Care Health Home Pilot

Purpose

- Fund Community Health Workers in each participating PCHH to work with specifically identified medically and socially complex high-utilizer PCHH patients.
- The CHWs will identify, facilitate and provide this population with the support, resources, and interventions needed to improve and maintain their health status.
- MHD anticipates that this intervention will more quickly reduce the dependence on in-patient hospital and emergency department use by
  - targeted focus on addressing social determinants of health and
  - enhancing the PCHHs efforts to stabilize the patient’s health status on an out-patient basis
Examples of CHW Activities:
- Facilitate appointments (including arranging, coordinating, and facilitating transportation resources)
- Follow up on appointments or other instructions from the health home by making home visits
- Communicate with health homes about barriers to self-management noted during home visits
- Assist in obtaining social and/or community services for participants
- Assist with post-hospitalization or emergency department visit follow-up by attempting to locate participants health home staff have been unable to reach
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- **Examples of CHW Activities:**
  - Participate in health home staff meetings
  - Assist with and advance patient self-management
  - Advance patients health literacy related to their conditions
  - Facilitate medication management and compliance
  - Document in Health Home EHR in a timely manner
  - Exchange of information and coordination with the Community Partnership in a timely manner
  - Identify and connect to community activities, resources, and interventions that could benefit the patient
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- **Partners**
  - A collaborative project, led by Dept. of Social Services, MO HealthNet Division (MHD), that includes:
    - Department of Health and Senior Services (DHSS),
    - Department of Mental Health (DMH),
    - The Family and Community Trust (FACT), and
    - Seven MHD Primary Care Health Homes (PCHH) (including three FQHCs and four hospital-based clinic organizations) in the Kansas City and Southwest Missouri areas (Springfield, Joplin, and Branson).
PCHH Pilot sites

- **Southwest Missouri region:**
  - Access Family Care
  - Cox Health Springfield
  - Cox Health Branson
  - Jordan Valley Community Health Center
  - Ozarks Community Hospital

- **Kansas City region:**
  - Samuel U. Rodgers Health Center
  - Truman Medical Center
Target population

- ‘High Utilizers’ in PCHH provider organizations in the Missouri HCFGKC service area and The Missouri Foundation for Health southwest Missouri service area.
- High utilizers are defined as
  - frequent visits to the emergency department and/or hospital admissions
  - identified through MHD claims data.
- The majority of participants will be adults.
**MHD CHW Primary Care Health Home Pilot**

- **Logistics**
  - Timeline: July 1, 2015 start date; June 30, 2017 pilot end date
  - **Funding**:
    - Missouri Foundation for Health and Health Care Foundation of Greater Kansas City
    - Combined with a portion of the MHD PCHH PMPM
    - All together will cover the costs of the CHWs
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- Logistics
  - CHWs –
    - Will be recruited from the communities served.
    - Salary will be aligned with the pay scales of the PCHH, and with the local/regional wage data for CHW and equivalent occupations.
      - 14 CHWs will be hired, 7 for each region, distributed to the PCHHs based on target population.
      - Each full-time CHW will be assigned up to 75 patients.
      - The PCHH will provide work space, supervision, and all employment related functions.
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**Evaluation**

- Planned analysis of clinical and utilization outcomes
- Development and trending of measures assessing the integration with Community Partnerships and resources
- Qualitative component
MHD CHW Primary Care Health Home Pilot

• Long-Term Goals
  ○ Establish and hone the CHW framework for the medically and socially complex MHD population during this pilot period
  ○ Establish CHWs as an identified service type for specific populations in MHD
  ○ Expand the congealed CHW model to the specified populations in the remainder of the Primary Care Health Homes
  ○ Expand the model to specific identified medically and socially complex MHD populations in managed care and FFS, including the FFS Care Management Pilot program