Thank you to our sponsors!

Session Sponsor

Presenting Sponsor
COMMUNITY HEALTH WORKERS - UNDERSTANDING THE VALUE

The Greater Detroit Area Health Council, Inc.
September 25, 2014
Detroit, Michigan

Sergio Matos, CHW, Executive Director and Founder
Community Health Worker Network of NYC
WHO ARE CHWS?

Community Health Workers (CHWs) are *frontline public health workers* who are *trusted* members of and/or have an *unusually close understanding of the community served*. This trusting relationship enables CHWs 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. CHWs also *build 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.

– American Public Health Association, 2008
CHW SCOPE OF PRACTICE

**Service**

**Outreach/Community Mobilizing**
- Preparation and dissemination of materials
- Case-finding and recruitment
- Community Strengths/Needs Assessment
- Home visiting
- Promoting health literacy
- Community advocacy

**System Navigation**
- Translation and interpretation
- Preparation and dissemination of materials
- Promoting health literacy
- Patient navigation
- Addressing basic needs – food, shelter, etc.
- Coaching on problem solving
- Coordination, referrals, and follow-ups
- Documentation

**Community/Cultural Liaison**
- Community organizing
- Advocacy
- Translation and interpretation

**Participatory Research**
- Preparation and dissemination of materials
- Engaging participatory research partners
- Facilitating translational research
- Interviewing
- Documentation

**Empowerment**

**Case Management/Care Coordination**
- Family engagement
- Individual strengths/needs assessment
- Addressing basic needs – food, shelter, etc.
- Promoting health literacy
- Goal setting, coaching and action planning
- Supportive counseling
- Coordination, referrals, and follow-ups
- Feedback to medical providers
- Treatment adherence promotion
- Documentation

**Home-based Support**
- Family engagement
- Home visiting
- Environmental assessment
- Promoting health literacy
- Supportive counseling
- Coaching on problem solving
- Action plan implementation
- Treatment adherence promotion
- Documentation

**Health Promotion & Coaching**
- Translation and interpretation
- Teaching health promotion and prevention
- Treatment adherence promotion
- Coaching on problem solving
- Modeling behavior change
- Promoting health literacy
- Harm Reduction
CHW ATTRIBUTES

Shared life experience(s)
Connected to Community
Respectful – Courteous, Honest, Patient
Empathetic - Caring, Compassionate, Kind
Friendly - Outgoing, Sociable
Trustworthy - Dependable, Responsible, Reliable
Resourceful – Creative, Inventive, Clever, Enterprising
Mature - Prudent, Persistent, Developed
Open-minded - Non-judgmental, Relativistic
OPPORTUNITIES FOR CHWS IN HEALTH REFORM

- Patient Centered Medical Homes (PCMH)
- Health Homes (HH)
- Accountable Care Organizations (ACO)
- CMS Ruling on Preventive Services Reimbursement
- Delivery System Reform Incentive Payment Programs (DSRIP)
OPPORTUNITIES FOR INTEGRATING CHWS

Standards for Patient-Centered Medical Homes

- Enhance Access and Continuity of Care
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- Track and Coordinate Care
- Measure and Improve Performance

Core Services for Health Homes

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support, including authorized representatives
- Referral to community and social support services, if relevant
- Use of health information technology (HIT) to link services
<table>
<thead>
<tr>
<th>Core Service</th>
<th>Relevant CHW Roles</th>
<th>Relevant CHW Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Care Management</td>
<td>Care Management</td>
<td>Individual strengths/needs assessment; goal setting and action planning; feedback to medical providers on patient goals; advocating for patient at team meetings; communications bridge re. patient goal achievements and remaining problems; patient navigation to assist in access to all health, behavioral and social services</td>
</tr>
<tr>
<td></td>
<td>Care Coordination and Home Visits</td>
<td>Care coordination of medical, behavioral and social services to align with patient priorities and goals; cross-disciplinary home-based support and follow-up to ensure all care and services are delivered in a coordinated manner</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Health Coaching and Health Education</td>
<td>Promotion of health literacy; cultural translation and interpretation; coaching on problem solving; adherence promotion; health coaching and health education from peer perspective; modeling behavior change; assistance in tailoring adherence to daily routines</td>
</tr>
<tr>
<td>Comprehensive transitional care</td>
<td>System Navigation</td>
<td>System navigation; goal setting and follow-up planning; translation and interpretation; post-discharge home visits and calls; facilitation of care coordination and care management</td>
</tr>
<tr>
<td>Individual and family support</td>
<td>Informal Counseling and Support</td>
<td>Supportive communications and counseling; orientation to patient satisfaction; community advocacy and communication; holistic family-oriented support; individual and group social support</td>
</tr>
<tr>
<td>Referral to community services</td>
<td>Community Liaison and Advocacy</td>
<td>Addressing basic needs; coordinating, making and following through on referrals for housing, welfare, legal, mental health/addiction and social services; patient empowerment through neighborhood-specific information about community programs and services</td>
</tr>
<tr>
<td>Use of linked medical records</td>
<td>Documentation and information sharing</td>
<td>Documentation in the medical record of CHW activities, referrals for services, and feedback from the patient; use of alert/feedback protocols to assure all team members are aware of latest patient updates</td>
</tr>
</tbody>
</table>
MEDICAID REIMBURSEMENT FOR PREVENTIVE SERVICES

Recently expanded to include those services provided by non-physician staff

States must apply to CMS through a State Plan Amendment

- List job titles to be reimbursed
- Identify qualifications for those titles to be reimbursed
- Determine reimbursement rates and payment process(es)
- Identify service codes – CPT4 codes (Current Procedural Terminology)
CHW BUSINESS CASE

Value added - Increase coverage
- Health insurance coverage increased & more consistent for children (RCT in Boston)
- Improve patient self-confidence and ability to manage their health
- Improved retention rates, customer satisfaction
- Earlier case-finding – chronic illnesses, maternal/child health, EPSDT, screenings

Lower costs
- 63% reduced hospitalization expenses (asthma program in Manhattan)
- 48% reduced ED expenses (asthma program in Manhattan)
- Reduced HbA1c levels by one point in 6 month intervention (Quasi RCT diabetes in the Bronx)

Return on Investment (range $1.15 – $6.10)
- ROI of $2.28 per dollar invested (underserved men in Denver)
- Estimated ROI of $2.30 per dollar invested (Diabetes management program in the Bronx)
- Estimated ROI of $4.01 per dollar invested (Asthma management program in Manhattan)

Cost savings
- Earlier case finding and connection to care - screening
- Decreased per capita expenses 97% in an asthma program (Hawaii)
- $24 million saved over 9 years in private corporation (Georgia)
- Reduced hospitalization denial of payment (the Bronx)
- Increased Quality Assurance Reporting Requirements (QARR) scores – automatic enrollments
Community Health Worker Integration Into the Health Care Team Accomplishes the Triple Aim in a Patient-Centered Medical Home

A Bronx Tale

Sally Findley, PhD; Sergio Matos, BS; April Hicks, MSW; Ji Chang, MA; Douglas Reich, MD, MPH

Available at www.chwnetwork.org/resources
DIFFERENT PROFESSIONS HAVE DIFFERENT VALUES

Technical – medical, dental, nursing, allied health
   Values - academic achievement, credentials, accreditations
titles, status, position
   Purpose - service delivery
   Character - prescriptive relationships - dualistic

Skilled – plumbers, carpenters, actors, iron workers, athletes
   Values - ability, creativity, performance, talent, efficiency
   Purpose – product
   Character - cooperative relationships

Social – clergy, civic leaders, community organizers, CHWs
   Values - trustworthiness, integrity, ethic, understanding, compassion,
dedication, honesty, resourcefulness, empowerment, self-efficacy
   Purpose – empowerment, building community and social capital
   Character - peer relationships – relativistic, humanistic
CHW TRAINING PEDAGOGY
CONSIDERATIONS

Embrace CHW scope of practice - roles
Preserve CHW character - integrity
Preserve nature of CHW interaction - relational
Recognize empowerment approach of CHW work – not just service
Avoid irrelevant or inappropriate regulatory constraints – training/certification/recertification
Provide appropriate supervision/management
Findley S, Matos S, Hicks A, Chang J, Reich D. Community Health Worker Integration into the Health Care Team Accomplishes the Triple Aim in a Patient-Centered Medical Home: A Bronx Tale. (J Ambulatory Care Manage, Vol.37, No.1, pp.82-91.


Thank You!

Sergio Matos, CHW

sergio@chwnetwork.org

www.chwnetwork.org
Thank you to our sponsors!

Coffee & Controversy

Session Sponsor

Presenting Sponsor