

## ***Value Proposition:***

# **Community Health Worker Services**

Minnesota CHW Alliance, Feb 2018

### **CHW Role: Training, Trust and Shared Life Experience**

Community Health Workers (CHWs) are trusted, knowledgeable frontline health personnel who typically come from the communities they serve. As a result of their deep knowledge and understanding of their communities, CHWs are uniquely equipped to bridge barriers related to culture, race, language, literacy, socioeconomic status and other factors; expand access to coverage and care; and improve health outcomes. They apply their shared life experience and training in a variety of roles including patient education, outreach, advocacy, care coordination, coaching and navigation. CHWs help clients prevent and effectively manage a wide range of health conditions including pre-diabetes, diabetes and hypertension. They work with underserved populations of all ages in rural, urban and suburban communities across the United States.

Minnesota is the first state in the nation to offer statewide standardized CHW education through a network of post-secondary schools. Over 700 CHWs have completed the competency-based program that leads to a certificate recognized by payers including the Minnesota Department of Human Services and health plans.

### **CHWs add value to the team**

As critical links between their communities and the health care system, CHWs reduce health disparities; boost health care quality and cultural competence; and empower individuals and communities for better health. They do this by:

- Working within and beyond the clinic and hospital walls, conducting home visits and connecting with clients in other community-based locations.
- Building client capacity for prevention and self-management.
- Addressing key social determinants of health that busy clinicians may overlook in a routine encounter and typically lack the time and expertise to address. Living conditions such as safe and affordable housing and access to nutritious food affect the client's health and ability to carry out the care plan.
- Serving as a liaison in building cultural understanding for both provider and the client.

The importance of the liaison role is often emphasized by new CHW employers. It transforms understanding of the client, improves care and compliance and can change how services are provided.

### **CHWs deliver results**

- Help their employers—providers, local public health, community-based organizations and other agencies--meet the Triple Aim: improved health, improved care and reduced costs.
- Improve provider cultural competence and patient understanding of the health system.
- Reduce waste (e.g. no shows, workflow interruptions, lack of compliance).
- Address financial barriers to accessing health care services.
- Increase patient activation, satisfaction and loyalty.
- Enable other health professionals on the team to work at the top of their licenses.

## **CHW Payment in Minnesota**

Minnesota Health Care Programs (MHCP) including Medical Assistance (Medicaid) and MinnesotaCare cover face-to-face CHW visits to individuals and/or groups for diagnostic-related patient education and self-management services, pursuant to 2007 state legislation and a state plan amendment approved by CMS. Visits may take place in the home, community or provider setting. For services to qualify for payment, CHWs must hold a certificate, enroll with MHCP and work under authorized clinical supervision provided by specific provider types. Coverage applies to MHCP beneficiaries enrolled in managed care plans and those receiving care from providers on a fee-for-service basis. To learn about CHW payment and coverage guidelines, including how to enroll, see the [Minnesota Dept of Human Services \(DHS\) Provider Manual](#).

Across the state, Medicaid Accountable Care Organizations (ACOs), known as Integrated Health Partnerships (IHPs), have grown to 21 in number and now cover over 460,000 beneficiaries. CHW strategies are a good fit for IHPs that are looking for new and better ways to meet quality targets (clinical, utilization and health equity), control costs and coordinate services across sectors under total cost of care shared risk. For more information, visit: [DHS IHP Overview](#).

***“As an emerging workforce, CHWs show great promise toward reaching the Triple Aim. The Minnesota Department of Health Office of Rural Health and Primary Care is committed to supporting the integration of CHWs into the health workforce, in large part because the role is uniquely positioned to address social determinants of health for underserved populations. Where we see CHWs deployed, employers report a much more direct connection between the needs of communities they want to serve better and the goals of the organization.”*** -Will Wilson, Minnesota Dept of Health (MDH) Primary Care Financial & Technical Assistance Programs Supervisor

## **Benefits to Clients, Providers, Payers and Communities**

- Net return of \$3 or better for every \$1 invested in CHW strategies (ASTHO webinar)
- CHWs increase the effectiveness of medical treatment and care.
- CHWs reduce costs related to preventable hospitalizations and unnecessary emergency department use.
- CHWs stabilize clients by addressing the social determinants of health.
- Health and social services professionals working with CHWs report that they greatly appreciate them and come to rely on their expertise on the team.
- Leading health authorities such as the Centers for Disease Control and Prevention and MDH support CHW strategies for effectively addressing costly health conditions such as hypertension and diabetes and for advancing health equity.

## **Tools and Assistance for CHW Integration**

In Minnesota, there are tools, resources, best practices, technical assistance services, and learning communities to help health providers, local public health agencies and community-based organizations effectively implement and support CHW programs. ([www.mnchwalliance.org](http://www.mnchwalliance.org) and <http://www.health.state.mn.us/divs/orhpc/workforce/emerging/chw/index.html>)

## Minnesota CHW Case Studies

### Case Study #1: Improvement in Diabetes Management

#### *Background*

According to the Minnesota Department of Health (MDH), the percent of Minnesota adults with diabetes has doubled since 1994 and the number is now at an all-time high. People with low income are 2.5 times more likely to report having diabetes than those with higher incomes (MDH, 2017). As many as 37% of Minnesota adults may have pre-diabetes (CDC, 2014). More than \$1 of every \$5 spent on health care in the US is to care for people with diabetes (MDH, 2017). CHWs play a key role in addressing our diabetes epidemic by fostering improved provider-patient communications, healthy lifestyles, medication adherence and appointment-keeping.

#### *Situation*

A clinic-based Health Coach started working with a 62 year-old woman with diabetes in March, 2016. This client shared a house with her granddaughter and worked at a local meat processing plant. To ensure on-the-job safety, she needed to be healthy and alert because she was working on the line with knives, surrounded by others operating sharp instruments. She had insurance through her employer. The client's A1c level was 10.1 and average blood glucose of 246. The Health Coach educated the client on diet, medications and needed follow-up. During a follow-up visit in April, the client reported that she was occasionally testing blood glucose and taking medications as ordered. The client failed to come to a follow-up appointment. In September 2016 the client was not taking meds as directed or testing blood glucose. A1c was 9.0. The client came for an appointment in October and was still not testing blood glucose. Then the Health Coach lost track of the client when she discontinued coming to scheduled visits.

#### *CHW Intervention and Results*

In January 2017, the Health Coach involved a CHW who reached out to the client. Her A1c was 10.02. She refused home visits so the CHW visited by phone to help the client learn how to take medications and test blood glucose. The CHW attended medical visits with the client and spent time in the clinic lobby coaching her and showing her how to use her glucometer. The CHW learned that the client was resistant to needles and to testing her blood glucose. She also needed supplies, like testing strips, which the CHW secured for her. By April 2017, with 6.5 hours of CHW coaching in her own language, by phone and in person at medical visits, the client was testing her own blood glucose and taking medications as ordered. A1c was 6.6, a 65% reduction, and average blood glucose was 143, the lowest in the client record. CHW interventions yielded cost savings of \$2,740.00.

***“The US Community Preventive Services Task Force (CPSTF) recommends interventions that engage CHWs to help patients manage their diabetes. This finding is based on a systematic review that shows that patients who receive these interventions improve their glycemic and lipid control and reduce their healthcare use. Additionally, the available economic evidence suggests these interventions are cost-effective.”***

***<https://www.thecommunityguide.org/content/community-health-workers-help-patients-manage-diabetes>***

## Case Study #2: Preventing Hospitalization Readmission and Emergency Dept Use

### *Background*

Studies of health care utilization outcomes have found CHW strategies to be effective in reducing emergency room use and hospital readmissions. For example, in a randomized controlled trial, the University of Pennsylvania patient-centered CHW model called IMPaCT improved post-hospital primary care access, discharge communication, patient activation, HCAHPS scores (adult inpatient satisfaction survey required by CMS for all US hospitals), mental health and recurrent readmissions for high-risk hospitalized patients with varied conditions (Kangovi et al., 2014).

### *Situation*

A 36 year-old refugee mother of three young children who lived in subsidized housing struggled with Lupus and related complications. She had access to some health insurance through her employer and was also covered under Medical Assistance. In 2016, she visited the hospital emergency department (ED) nine times and was hospitalized seven times.

### *CHW Intervention and results*

In January 2017, the clinic-based Health Coach referred the client to a CHW. The CHW learned that the client was filling prescriptions but not taking her medications correctly. She was on Coumadin and had failed to show up for the required monitoring visits. She sought additional medication for symptom control at the ED and local rheumatology department. The Health Coach sent the medication list and instructions to the CHW who made home visits to better understand the client's needs, explain the importance of her medications, and teach her how to take them as prescribed. The CHW also provided transportation for the client to specialty appointments in another community 65 miles away. The CHW assessed the client's living situation and helped her find healthier housing for the family, get cash assistance and obtain disability income because the client was unable to work. Altogether these efforts stabilized the client's health and improved her living situation. As a result, she has been able to resume full-time employment. Since starting to work with the CHW, she has had no subsequent ED visits or hospitalizations. CHW services led to cost savings of \$72,000.

***“The Twin Cities Medical Society supports the role of community health workers in the coordinated delivery of care in multiple health settings. Integration of community health workers as team members supports improved patient experience, improved health and reducing overall costs of health care services going forward. We encourage any applicable organizations to consider and implement CHW workforce strategies in their health care delivery systems.”*** – TCMS Board Resolution, May 20, 2013



## References & Resources

- Association of State and Territorial Health Officials. Issue Brief: CHW Successes and Opportunities for States, 2017. <http://www.astho.org/Prevention/Heart-Disease-and-Stroke/Tools-for-Change/Community-Health-Worker-Issue-Brief/>
- Association of State and Territorial Health Officials. Webinar: CHW Financing, August 2, 2017. <http://www.astho.org/Community-Health-Workers/CHW-Financing-Presentation-Slides/>
- Centers for Disease Control and Prevention. Video (3 minutes): [Making the Business Case: Community Health Workers Bridging the Health Care Gap, 2015](#).
- Centers for Disease Control and Prevention. (2014). National Diabetes Statistic Report. Retrieved on February 26, 2018 from <https://www.cdc.gov/diabetes/pdfs/data/2014-report-estimates-of-diabetes-and-its-burden-in-the-united-states.pdf>
- Centers for Disease Control and Prevention. Q & A from Webinar: CHWs: [Their Role in Preventing and Controlling Chronic Conditions](#).
- Community Prevention Services Task Force. Cardiovascular Disease: Interventions Engaging Community Health Workers, 2015. <https://www.thecommunityguide.org/findings/cardiovascular-disease-prevention-and-control-interventions-engaging-community-health>
- Community Prevention Services Task Force Summary Evidence Table Economic Review: Diabetes Prevention, Interventions Engaging CHWs, 2017. <https://www.thecommunityguide.org/sites/default/files/assets/SET-Diabetes-Prevention-CHW-Econ.pdf>
- Connecticut Health Foundation. [Policy Brief: Community Health Workers: A Positive Return on Investment for Connecticut, April 2017](#).
- Families USA: [Blueprint for Health Care Advocacy: How Community Health Workers Are Driving Health Equity and Value in New Mexico](#)
- [Improving Blood Pressure Control and Health Systems with Community Health Workers](#), Journal of the American Medical Association, 2017.
- Johnson D, Saavedra P, Sun E et al. [Community Health Workers and Medicaid Managed Care in New Mexico](#). *J of Community Health*, 2011; DOI 10.1007/s10900-011-0484-1
- Kangovi S et al. Community Health Worker Support for Disadvantaged Patients with Multiple Chronic Diseases, A Randomized Clinical Trial. *American Journal of Public Health*, October 2017. <http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.303985>
- Kangovi S et al. (2014). Patient-Centered Community Health Worker Intervention to Improve Post-Hospital Outcomes, A Randomized Clinical Trial. Retrieved on February 26, 2018 from <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1828743>
- Michigan CHW Alliance. [CHW Impact on Diabetes, 2017](#).
- Minnesota Dept of Health. (2017). Diabetes Hospitalization in Minnesota 2006-2014. Retrieved on February 26, 2018 from <http://www.health.state.mn.us/divs/healthimprovement/content/documents-diabetes/12.13.2017DiabetesHospitalizationReport.pdf>
- Minnesota Dept of Health, [Community Health Worker Tool Kit: A Guide for Employers, 2016](#).

Redding S et al. [Pathways Community Care Coordination in Low Birth Weight Prevention](#). Maternal and Child Health Journal, 2015 Mar 19(3) 643-650.

Rethink Health. [Leading with a Value Proposition: Making the Case for Change](#), June 28, 2017.

Rush C. [Return on Investment from Employment of Community Health Workers](#). J of Ambulatory Care Management, Vol 35, No 2, pp 133-137, 2012.

[Social Return on Investment: CHWs in Cancer Outreach](#), A Tool Kit developed for the American Cancer Society, Midwest Division. Wilder Research Center, 2012.

[Stakeholder Health CHW Magazine](#), 2015.

## About the Minnesota Community Health Worker Alliance

Committed to equitable and optimal health outcomes for all communities, the Alliance serves as a catalyst, leader, and resource to build community and systems' capacity for better health through the integration of CHW models. For more information, visit: [www.mnchwalliance.org](http://www.mnchwalliance.org).

*This resource was prepared in 2017 by the Minnesota Community Health Worker Alliance under a contract with the Minnesota Department of Health in support of the Community Wellness Grant with funding from the US Centers for Disease Control and Prevention. Please use with attribution.*



### End Notes

Our thanks to the CHWs and their Community Wellness Grant team at Des Moines Valley Health and Human Services and Nobles County (MN) Community Services Department for providing the client stories that are featured in the two case studies.

#### Case Study #1:

Overall health care costs for people with good blood glucose control (A1c <7) are 20% less than those with poor diabetes control (A1c >9). (CDC, 2012)

People with diabetes incur \$13,700 in medical costs on average per year (ADA, 2017).

Cost Savings:  $\$13,700 \times 20\% = \$2,740$ . Program cost for 6.5 hours = \$247.55.

#### Case Study #2:

The average cost of an ED visit is \$1,423 (MEPS 2013). ED cost savings: \$12,807 ( $\$1,423 \times 9$ ).

Average cost of medical hospitalization in 2012 was \$8,500 (AHRQ, 2014).

Hospitalization cost savings: \$59,500 ( $\$8,500 \times 7$ ). Program Cost for 7 hours = \$266.49.

