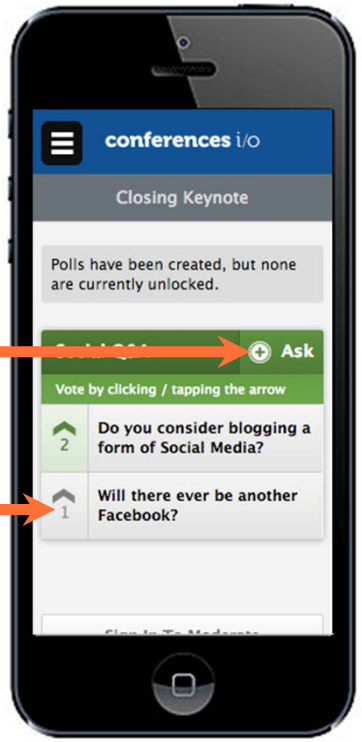
NATIONAL ASSOCIATION OF Community Health Centers®


# Making the Financial Case for CHW's: A CFO Discussion

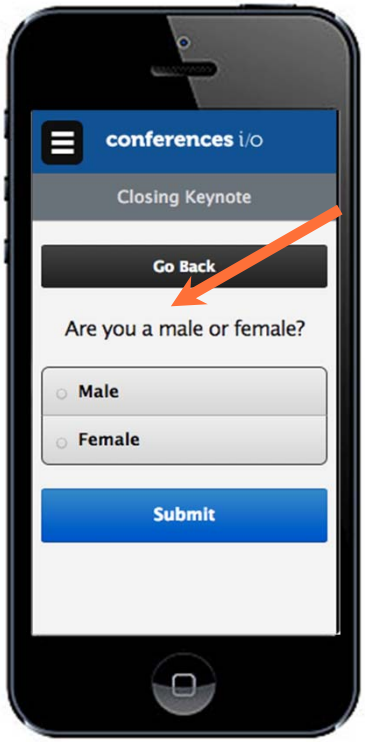
NACHC FOM/IT Conference 2021

# In-Person Participants




Give us Feedback

Up-Vote a Comment




Click on question and then Respond to Polls when they appear

# Vote / Give Feedback/ Respond to Polls

# Virtual Participants

**Chat**
(use to talk with peers)

**Polling/Q&A**
(participate in polls, ask questions to faculty)

# Community Health Workers in the Pandemic

BRIEFING ROOM

## FACT SHEET: Biden-Harris Administration to Invest $7 Billion from American Rescue Plan to Hire and Train Public Health Workers in Response to COVID-19

MAY 13, 2021 • STATEMENTS AND RELEASES

## Strengthening the Community Health Workforce Can Help Improve Healthcare Access for Communities of Color

**CHWs play a key role in connecting communities with healthcare in a trusted and culturally competent way—they need to be fully recognized and integrated into health systems.**

## HHS Announces $250 Million from American Rescue Plan to Develop and Support a Community-Based Workforce to Increase COVID-19 Vaccinations in Underserved Communities

OCTOBER 13, 2021

## Stanford supports community health workers conducting COVID-19 vaccine outreach in area's Latinx community

## $313K grant to help train more community health workers

UH News » Academic News » $313K grant to help...

# COVID-19 Related Funding

$6 Billion from the American Rescue Plan Act

$80 Million for Navigator Funding in Federally-Facilitated Marketplaces

$350 Billion for State and Local Government COVID-19 Response

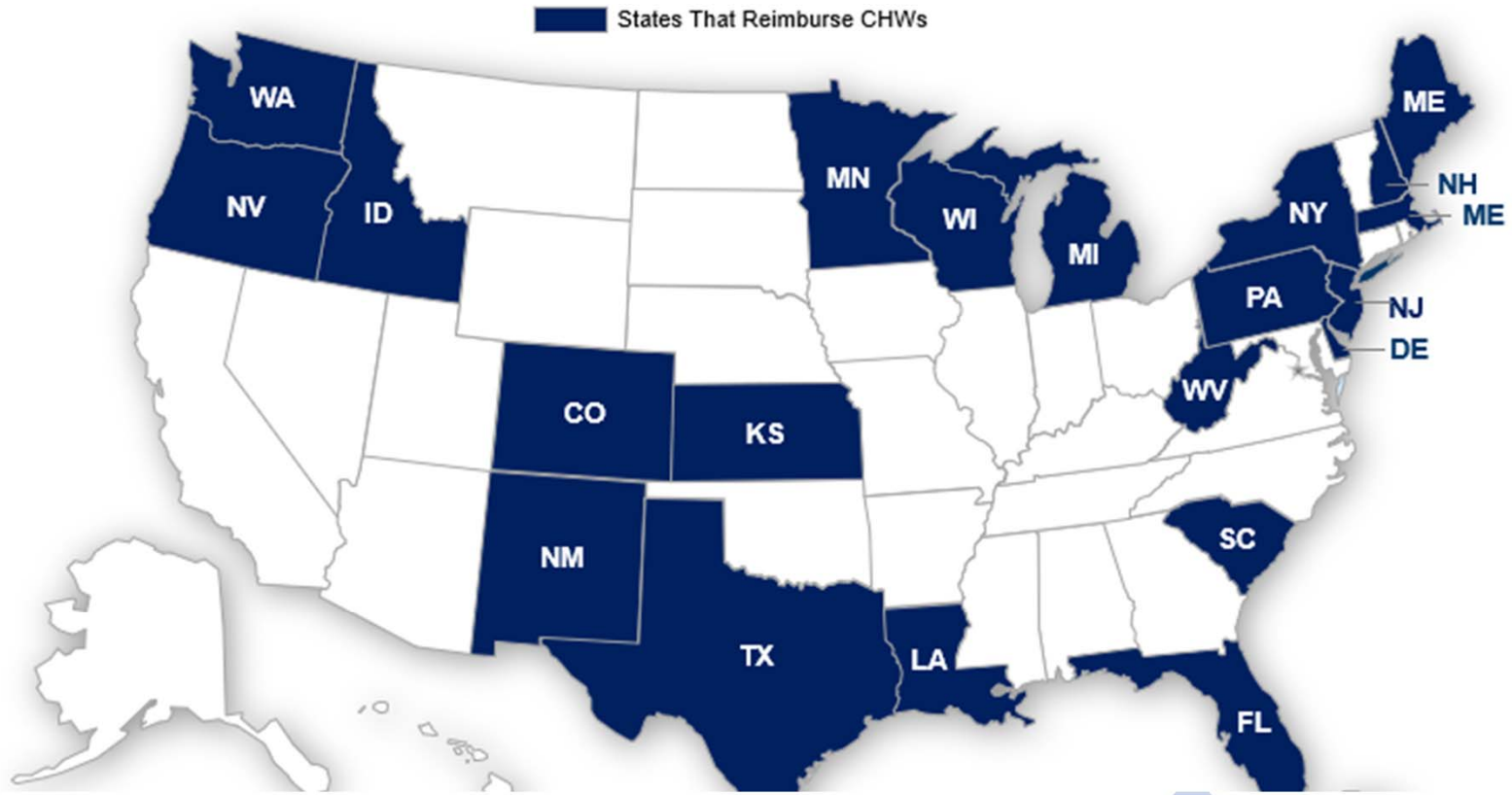
$178 Billion for Provider Relief Fund

$7 Billion for Public Health Workforce

# Community Health Workers in CHCs

- Improving health outcomes for patients by addressing Social Determinants of Health;
- Increasing cultural competency of services as trusted members of the community;
- Acting as a liaison between community members and the health care team;
- Promoting outreach, health education, informal counseling, social support and advocacy;
- Improving adherence to provider care recommendations; and
- Reducing the need for emergency and specialty services.

# States with Reimbursement Models for CHWs



# Reimbursement Models

- State Medicaid Options
  - 1115 waivers
  - State Plan Amendments (SPAs)
  - Alternative Payment Models
- Managed Care Contracts
  - Michigan
- Health Plan Relationships
- State funded Programs
  - North Carolina

# MAKING THE FINANCIAL CASE FOR CHW'S: A CFO DISCUSSION

FOM/IT Conference

Oct 20, 2021

Presented by: Joy Sloan, CFO

# WHO IS COMMUNITYCARE (CUC)?

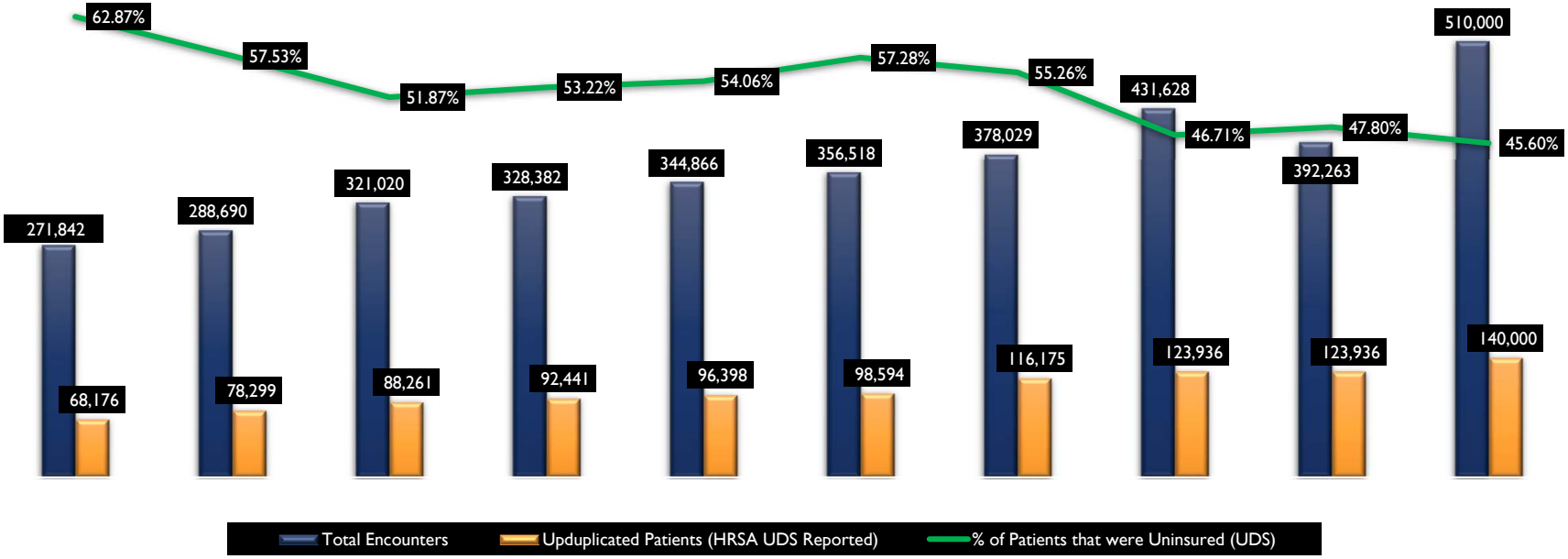
- Started in 1970 when the City of Austin partnered with Travis County Commissioners Court to develop a system of primary care, dental care and family planning clinics.
- In 1992, they became an FQHC Look-alike
- In 2001 they were officially designated an FQHC
- In 2004, the Travis County Healthcare District was created, known as Central Health, moving funding and oversight from the City of Austin to Central Health
- In 2009, CommUnityCare was established as a 501c(3) to operate the health care system.

# CURRENT STATE

- CUC started with 14 clinics
- Today, CUC operates 27 locations throughout Austin and Travis County providing family/pediatric medicine, OB/GYN services, variety of specialty services, dental, behavioral health, PT, OT and SP therapy. We also have 2 convenient care/walk in clinics for urgent care.
  - We offer HIV services through Ryan White grants and have a robust homeless program with mobile teams and a mobile RV unit that sees patients in remote communities.
- Annual operating budget of $178M
- Payer Mix

| | |
|---|---|
| Medicare | 4.5% |
| Medicaid/CHIP | 40.9% |
| Commercial | 6.7% |
| Grants | 2.2% |
| Uninsured | 45.6% |

# 10 YEAR TREND OF PATIENTS/ENCOUNTERS



# CHW - WHERE WE STARTED

- Three Community Health Workers
- Trained by Latino Health Forum
- On boarded as contract employees
- Four sites : North Central, Rundberg, South Austin and Southeast Health & Wellness

## Scope of Work

**Patient Education**

- Diabetes, Hypertension, Asthma
- Medication Management Depression & Stress Management
- Childhood Obesity

**Community Resources**

- Food
- Housing
- Accessing & navigating community services
- Navigating referral process for patients with Private Insurance

## Goals

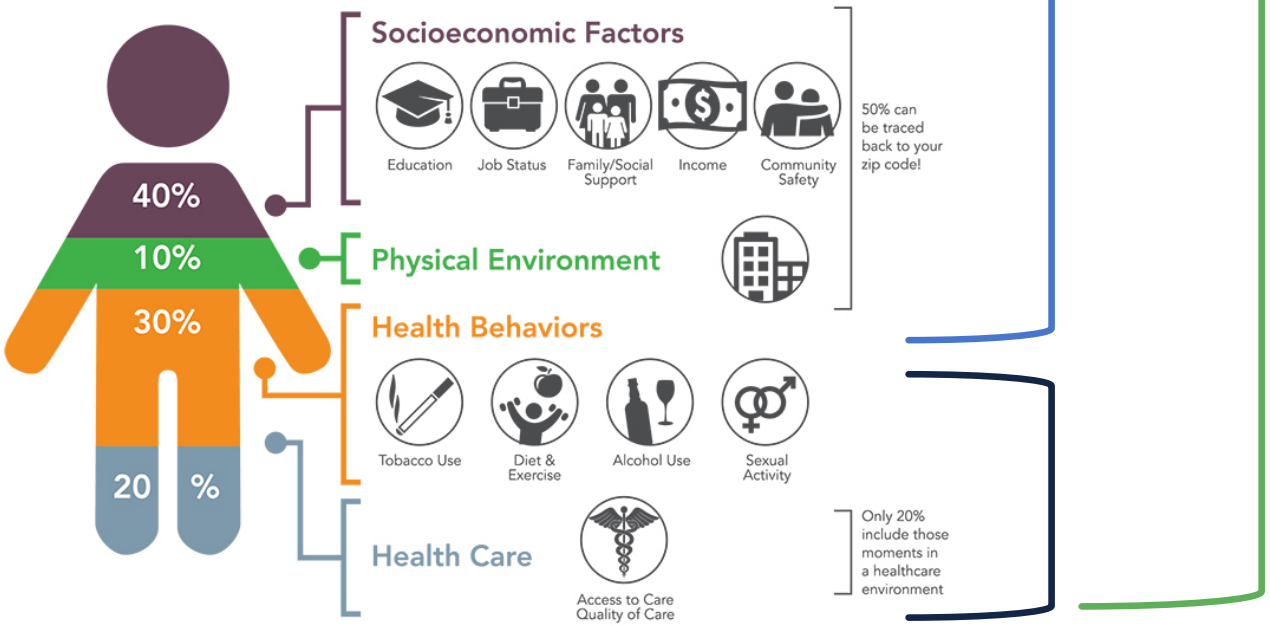
- Learn and acclimate to processes within CUC
- Work primarily in the clinic setting
- Learn, grow and expand the role of the CHW

# WHY CHW'S

CommUnityCare HEALTH CENTERS

## Social Determinants of Health

*The drivers of health are complex and interconnected*




Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

# COMMUNITY HEALTH WORKERS: ROLES

Community Health Workers

Patient Engagement

Remove barriers to care and preventive health screenings, *i.e. transportation, difficulty obtaining medication*

Coordinated population health education approach

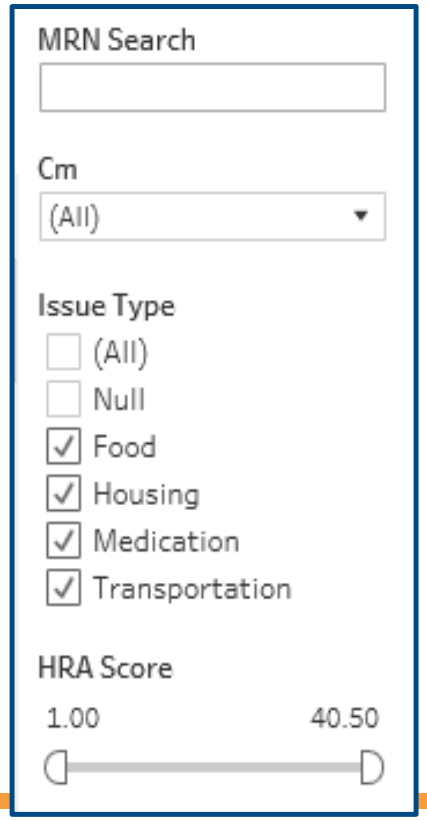
- Special population's role –
  - Individual with particular training (in addition to their CHW certification) that facilitates interventions tailored to a specific population – *hospital transitions, homeless and OB patients*
- Team Based Care Role –
  - Providing comprehensive services to individuals by working collaboratively along with patients, family caregivers, and community services
- In Patient Setting Role –
  - Imbedded within primary care team, individual intervenes by addressing social barriers such as health literacy, food insecurity and transportation
- Educational Class Role –
  - Coordinates group classes including recruitment, retention, creation of lesson plans and facilitates classes – *Currently leading healthy cooking, weight loss and diabetes classes*
- Community Setting Role –
  - Engaging with patients to create awareness of services available while building relationships and serving as patient advocates – *patient portal enrollments, marketing material development*

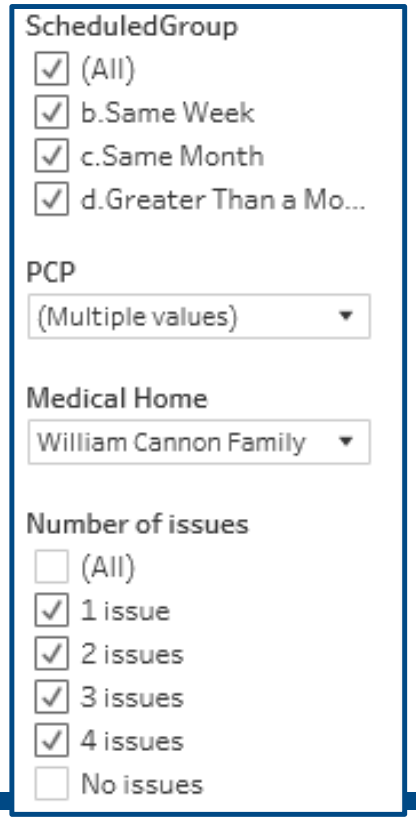
# CHW SDOH DASHBOARD

**SDOH Dashboard**

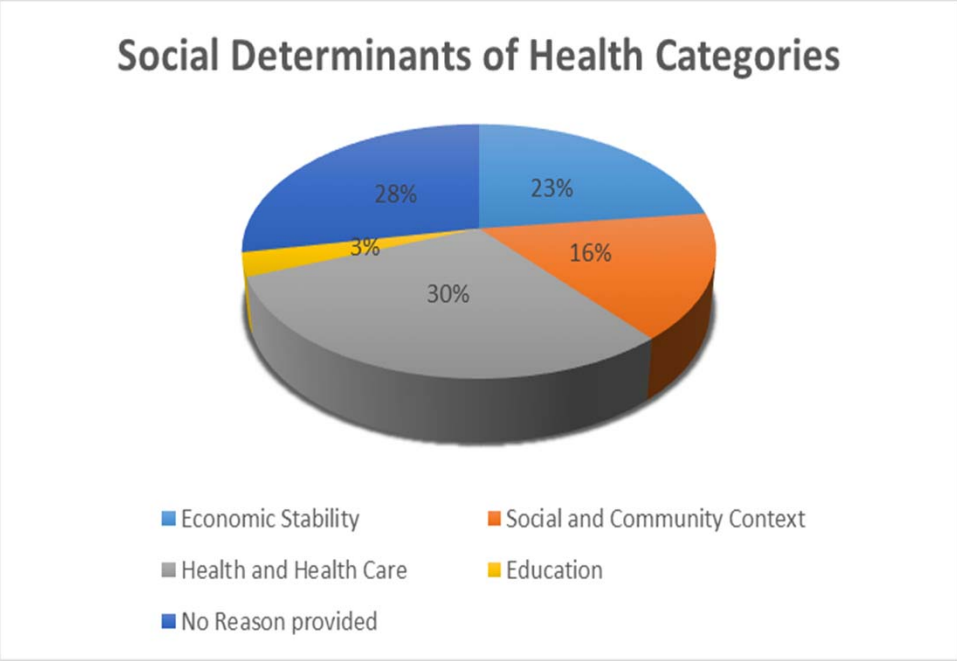
*Live July 15th*

- Utilizing HRA data
- Targeting 4 SDOH's
  - Transportation
  - Food Insecurity
  - Difficulty Paying for Medications
  - Housing Instability
- Prioritizing efforts to address needs of most vulnerable in a proactive manner



# PERCENTAGE OF REFERRALS BY SOCIAL DETERMINANTS HEALTH CATEGORIES




| Economic Stability | Education | Social and Community Context | Health and Health Care |
|---|---|---|---|
| food Insecurity | early childhood education and development | transportation | care coordination |
| medication affordability | language and literacy | community resource linkage | health literacy |
| utility assistance | | social resouce referrals for social needs | health navigation |
| Finances | | | health promotion activities |
| employment/employment status | | | home health assistance for medical needs |
| health care affordability | | | insurance issues |
| housing Instability | | | lost to care |
| rent assistance | | | medical referral navigation |

Healthy People 2020 Approach to Social Determinants of Health https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

# RESULTS – SOCIAL DETERMINANTS OF HEALTH QUESTIONNAIRE

- In the past 6 months, have you missed any medical appointments because of problems with transportation?

  → **16%** of patients answered yes

- In the past 6 months, have you had any problems paying for food for you and your family?

  → **19%** of patients answered yes

- In the past 6 months, have you had problems paying for medicines prescribed to you by your doctor?

  → **22%** of patients answered yes

# COVID-19 HOSPITAL TRANSITION OF CARE PROGRAM

## Purpose

High-quality transitional care defined as numerous time-limited interventions designed to ensure uninterrupted access to health care services.

With the goal to prevent poor outcomes among vulnerable populations, promote the safe and timely transfer of patients between care settings.

## By the Numbers

- First patient contact on **April 22, 2020**
- **309** total patient referrals received since onset of program
- Average weekly referrals are between **6 to 11**
- Average weekly discharges are between **3 to 7**
- Average time of services rendered is **2 to 3 weeks**
- **81 or 26%** of patients were unestablished with a primary care provider
- **148 or 48%** presented with social determinant of health need requiring a Community Health Worker referral
- **139 or 45%** were unfunded and required a financial screening appointment
- **45 or 15%** required a medication affordability and management intervention
- **41 or 13%** were positive on phq9 assessment and required a behavioral health intervention
- **25 or 11%** of the **233** discharged patients were transitioned into Care Management Services

# CHW SPECIAL POPULATIONS - CARE CONNECTIONS

**Community Health Worker**

Connects directly with patients in the hospital (30% of time at hospital)

- 239 CHW encounters
- CHW meet and greets
- Telephonic outreach and engagement
- Addressing barriers to care such as transportation and other SDOH's

**OUTCOMES**

**72% Show Rate** for patients for coordinated post-discharge planning and follow up

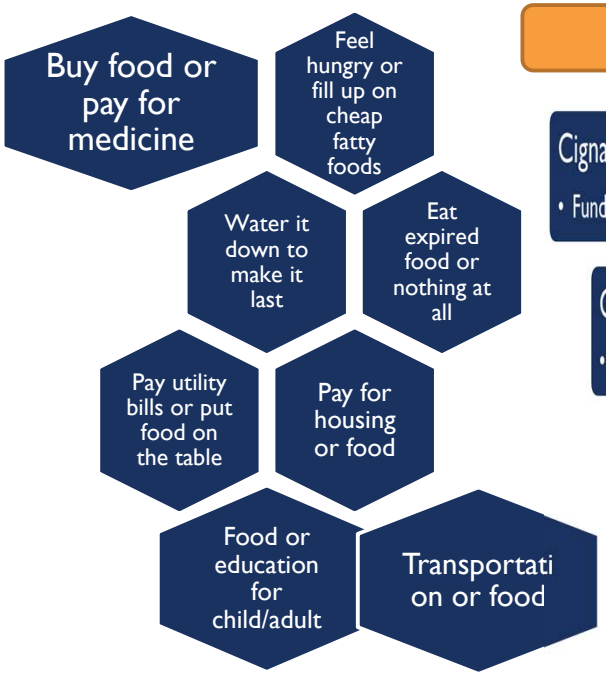
**Linkage to Services**

- Wound Care & Foot Care
- Hepatitis C tx
- Paracentesis
- Care Management
- MAT
- ECHO onsite
- On site Psychiatry (Integral Care)
- Linkage to SOAR


*Utilizing the Community Health Worker to help facilitate the right transitions of care to avoid preventable readmissions.*

# PROJECT – FOOD INSECURITY

## Tough Choices…




Source: https://www.huffingtonpost.com/2014/10/23/hunger-statistics-us_n_6029332.html

PARTNERS

**Cigna**
- Funds

**Central Texas Food Bank**
- Packaging

**CommUnityCare Rundberg**
- Distribution

- Start Date: 8/21/18
- Total days: Approximately **50** business days*
- # of food boxes distributed: **548 boxes** (as of 11/19/18)
  - 55% with chronic conditions
  - 78% between ages19-59
  - 24 linked to food pantry resources
- Approximately 1200 more boxes to distribute

*About 20 business days were missed due to boxes having to be repackaged.

# COMMUNITY HEALTH WORKER SCOPE IN RELATION TO COVID-19

**Objective**: Provide food delivery to households quarantined as a result of COVID-19

**Collaborative Effort Between**

- CommUnityCare –patient identification and project coordination
- Central Health- delivery of food boxes
- El Buen Samaritano- food box supplier
- Austin Public Health- food box supplier

**Project Details**

- First food delivery on March 30, 2020
- Minimum of 3 weeks of food deliveries and up to 6 weeks
- Food boxes delivered weekly
- Provide sufficient food for every member of the household
- Boxes of 20 to 30 lbs. of non-perishable items
- Delivery locations include: Austin, Del Valle, Manor, Creedmoor, Elgin and Leander.

**Project Data**

- Families served
  **78**
- Food boxes delivered
  **306**
- Above data is current up to August 10, 2020

# FINANCIAL SUPPORT FOR CHW'S

- We receive some funding from our local healthcare taxing district
  - Our ability to impact health outcomes, assist with referral needs and provide hospital transition of care services positivity impacts costs on their indigent care program.
- Austin Public Health has reached out to help fund CHW's as a subaward for a grant they received
- As we move to valued based reimbursement models, we can demonstrate the positive impact of CHW's

# FUTURE STATE: CHW SCOPE OF WORK


# MAKING THE FINANCIAL CASE FOR COMMUNITY HEALTH WORKERS: A CFO DISCUSSION

Presented by:
Teresa Dotson, MBA
Director of Financial Affairs
Mountain Comprehensive Health Corporation

# COMMUNITY HEALTH WORKER PROGRAM

- Marshall University managed, funded by the Merck Foundation
- In 2017, MCHC began the Diabetes Community Healthcare Worker Program in partnership with Marshall
- Goal of program is to improve health outcomes and quality of life of adults living with Diabetes



# COMMUNITY HEALTH WORKER PROGRAM

- Our CHW's:
  - Work with diabetic nurse practitioner to formulate treatment plan
  - Monitor:
    - blood sugar
    - Weight
    - Blood pressure
  - Explain new and old prescriptions
  - Encourage healthy eating and exercises
  - Schedule and remind of appointments
  - Arrange transportation
  - Set goals and address barriers to healthcare

# COMMUNITY HEALTH WORKER PROGRAM

- The patient in turn agrees to:
  - Check blood sugar
  - Keep a log
  - Stick to medication plan
  - Ask questions
  - Keep the CHW informed of any issues, hospitalizations, or emergency room visits
- The patient is provided with the CHW's phone number

# SOCIAL DETERMINANTS IMPACT HEALTH HOW CHW'S CAN HELP

- With some patients, transportation is an issue, our CHWs will assist the patient with:
  - Arranging mail order medicine
  - Getting patients the needed supplies
  - Assist in getting transportation to needed destinations
- Who could be worried about A1c when you don't have a fridge to keep insulin in?
  - Our CHW's assisted patient in getting the fridge, in turn that patient's A1c score went down

# SOCIAL DETERMINANTS IMPACT HEALTH HOW CHW'S CAN HELP

- Often it is just having a friendly person to talk to is what can help the most
- Visiting a patient in their home can help CHW's determine what social determinants are keeping patient from focusing on physical health
- Building a relationship and getting to know patient is key

# SOCIAL DETERMINANTS IMPACT HEALTH
# HOW CHW'S CAN HELP

- A newly diagnosed patient began program with an A1c of 13.2
- CHW got to know patient and discovered he was illiterate and unable to read pill bottles or instructions
- CHW assisted with medications, developing system to mark where to draw meds up in the syringe
- After CHW assistance, patient has reached and maintained an A1c of less than 6.0% since September 2019

# COMMUNITY HEALTH WORKERS DURING THE PANDEMIC

- The pandemic has brought new challenges for CHW's
- CHW's have been able to adapt to this by:
  - Conducting visits by telephone and socially distanced on patient's porches
  - Dropping off medications, food boxes, and supplies on door steps
  - Assisting in coordinating telehealth visits with providers and addressing the patient's feelings of isolation

# OUTCOMES - EVERYBODY WINS

- Patients:
  - Better health outcomes
  - Improved health equals higher quality of life
- Insurance Company:
  - Cost savings
  - Reduced over utilization of unnecessary healthcare services
  - Reduced medication requirements
  - Reduced costly complications
- Win-Win situation for both the financial and health sides of care

# HEALTH OUTCOMES

- Literature shows social determinants adversely affect patient's ability to manage their conditions optimally
- One of the primary roles of the Community Health Worker has always been to identify social needs of the patient and link them with community and other resources to assist in optimal compliance with their clinical care plan
- Hiring a CHW that is embedded in the community in which they serve is critical
- Allows the CHW to be familiar with the community and vast resources available
- Being a neighbor also facilitates that kinship (the magic) that happens while building rapport with patients in the rural setting

# DATA – A1C & HEALTH OUTCOMES

| *Table 1: Mean Change in A1c Baseline to Follow-up N=244* | | | | | |
|---|---|---|---|---|---|
| | No. Of Patients | Percent of Cohort | Mean Baseline A1c | Mean Last A1c | Percentage Point Difference |
| Improved A1c | 133 | 55% | 9.51 | 7.4 | -2.11 |
| Increased A1c | 92 | 38% | 7.63 | 8.98 | 1.35 |
| No Change | 19 | 8% | 8.26 | 8.26 | 0 |
| Baseline A1c ≥ 10% that Lowered to <10% | 43 | 18% | 12.26 | 7.67 | -4.59 |

- For every 1% reduction in A1c – complications can be reduced by as much as 30%
- 133 patients (55%) decreased their A1c
- 43 patients (18%) who started out with an A1c over 10 lowered it to under 19

Source: Marshall University

# HEALTH OUTCOMES

- Huge reductions in ER visits and Hospital visits
- Over an 18 month period ER visits dropped 93% compared to the first 6 months after enrolling
- Over an 18 month period Hospital visits dropped 82% compared to the first 6 months after enrolling

# DATA – HEALTH OUTCOMES

*Table 2: Change in Utilization of ER and Hospital Visits over 18 months*

| ER Visits: 18 Months Oct 2019 - July 2021 | 1st 6 Months | 2nd 6 Months | 3rd 6 Months | % Difference (1st vs 2nd) | % Difference (1st vs 3rd) |
|---|---|---|---|---|---|
| Enrollment | 22 | 22 | 22 | | |
| Total ER Visits | 27 | 3 | 2 | -89% | -93% |
| Avg ER Visits Per Month | 4.5 | 0.5 | 0.3 | -89% | -93% |

| Hospital Visits: 18 Months Oct 2019 - July 2021 | 1st 6 Months | 2nd 6 Months | 3rd 6 Months | % Difference (1st vs 2nd) | % Difference (1st vs 3rd) |
|---|---|---|---|---|---|
| Enrollment | 23 | 23 | 23 | | |
| Total Hospital Visits | 28 | 6 | 5 | -79% | -82% |
| Avg Hospital Visit Per Month | 4.67 | 1 | 0.83 | -79% | -82% |

Source: Marshall University

# DATA – HEALTH OUTCOMES

- MCHC CHW program results January – December 2020:
  - 21 of 37 (57%) patients with at least two A1c tests lowered their A1c by -2.1 percentage points
  - 15 of 37 (41%) patients with at least two A1c tests increased their A1c by 1 percentage point
  - 1 of 37 (3%) patients with at least two A1c tests showed no change in A1c percentage points

| 2020 View | | | |
|---|---|---|---|
| Dates | Lowered Their A1C | A1c Increased | No Change |
| Jan - June 2020 | 65% | 30% | 5% |
| Jan - Sep 2020 | 58% | 33% | 8% |
| Jan - Dec 2020 | 57% | 41% | 3% |
| Note: Data is cumulative | | | |

# THE FINANCIAL SIDE

- Value-based medicine is here!
- Health systems are more focused than ever on positive clinic outcomes as it relates to reimbursement
- Community Health workers are key players on the clinical care team
- CHW's regular interaction with patients that promote basic chronic disease education, problem solving, decision making, developing action plans and self-management skills show significant positive trends in clinical outcomes

# DATA – FINANCIAL OUTCOMES

| Patient # | Enrollment Date | Discharge (date) | Time Frame in program | Report Begin Date Thru 09/01/21 | Claim Amount Before Program | Claim Amount After Program | $ Difference | Savings |
|---|---|---|---|---|---|---|---|---|
| 1 | 5/4/2021 | | 4 months | 1/1/2021 | $ 568.00 | $ 256.72 | $ 311.28 | After program |
| 2 | 5/24/2019 | | 16 months | 1/1/2018 | $ 3,209.58 | $ 4,946.71 | $(1,737.13) | Before program |
| 3 | 10/11/2019 | | 23 months | 9/1/2017 | $ 3,721.10 | $ 1,805.97 | $ 1,915.13 | After program |
| 4 | 11/4/2019 | | 22 months | 10/1/2017 | $ 1,103.73 | $ 190.90 | $ 912.83 | After program |
| 5 | 7/11/2019 | | 26 months | 5/1/2017 | $ 1,292.38 | $ 5,737.11 | $(4,444.73) | Before program |
| 6 | 11/4/2019 | | 22 months | 9/1/2017 | $ 24,148.24 | $ 21,467.21 | $ 2,681.03 | After program |
| 7 | 3/31/2021 | | 6 months | 9/1/2020 | $ 5,028.71 | $ 1,943.99 | $ 3,084.72 | After program |
| 8 | 7/25/2019 | | 26 months | 5/1/2017 | $ 6,738.40 | $ 7,154.84 | $ (416.44) | Before program |
| 9 | 12/27/2017 | | 45 months | 3/1/2014 | $ 720.40 | $ 204.26 | $ 516.14 | After program |
| 10 | 9/17/2019 | | 24 months | 9/1/2017 | $ 4,169.79 | $ 4,151.55 | $ 18.24 | Before program |
| 11 | 5/20/2019 | | 16 months | 1/1/2018 | $ 1,795.81 | $ 2,781.93 | $ (986.12) | After program |
| 12 | 1/25/2018 | | 44 months | 5/1/2014 | $ 13,485.44 | $ 12,606.31 | $ 879.13 | After program |
| 13 | 5/13/2021 | | 4 months | 1/1/2021 | $ 1,303.04 | $ 621.47 | $ 681.57 | After program |
| 14 | 8/28/2018 | | 37 months | 7/1/2015 | $ 2,142.70 | $ 1,186.65 | $ 956.05 | After program |
| 15 | 7/9/2019 | | 26 months | 5/1/2017 | $ 2,798.81 | $ 3,030.97 | $ (232.16) | Before program |
| 16 | 4/23/2018 | | 41 months | 11/1/2014 | $ 12,829.37 | $ 7,494.07 | $ 5,335.30 | After program |
| 17 | 1/25/2018 | | 44 months | 5/1/2014 | $ 3,911.05 | $ 4,069.83 | $ (158.78) | Before program |
| 18 | 7/22/2019 | 12/9/2020 | 17 months | 2/1/2018 | $ 3,259.74 | $ 1,836.72 | $ 1,423.02 | After program |
| 19 | 8/8/2019 | 7/16/2020 | 11 months | 7/1/2018 | $ 729.67 | $ 2,453.17 | $(1,723.50) | Before program |
| | | | | **TOTAL:** | **$ 92,955.96** | **$ 83,940.38** | **$ 9,015.58** | |

Source: Payer data provided to MCHC

# FINANCIAL OUTCOMES

- In West Virginia, payer – health systems partnerships have been establishing since 2018
- Per the agreement, at the end of year 1, the payer will conduct an actuarial study to determine cost savings (12 months pre enrollment and 12 months post enrollment into the CHW program)
- Consistently, there has been a 46%-47% cost reduction in the cohort of patients that have regular contact with the CHWs
- This translates into approximately $500 PMPM savings

Source: Marshall University

# FINANCIAL OUTCOMES

- These payment structure have become standard with the three MCO's that are making payments in WV.
- All using a in home visitation code at a rate of $12.78/15 min unit (with no cap on quantity of units that may be billed)
- Example of how the multiplier effect has the potential to generate revenue from a per-member per-month (PMPM) payment:
  - With a PMPM of $205 (this is the PMPM that is currently being received in WV), one health system, with 222 members enrolled, has the potential for a monthly payment of $45,394.60, or an annual payment of $544,734.00.

***This payment is **<u>in addition</u>** to existing standard medical claims or TCM/CCM billing***

Source: Marshall University

# FARMACY PROGRAM

- MCHC's FARMACY Program is a "Produce Prescription" program that provides access to healthy foods for patients with a number of diet-related health conditions, such as Diabetes, Hypertension and Obesity.
- Since 2015, we have served 1,294 households and a total of 2,434 patients
- MCHC partners with local Farmer's Markets and County Extension Offices to provide the fresh produce for the program.
- CHW's use Farmer's Market produce to make patients a food box

# FARMACY PROGRAM

# MCHC COMMUNITY HEALTH WORKER VIDEO