Community Health Worker (CHW) Learning Community

February 11, 2019
Agenda

• Welcome and introductions

• Penn Center for Community Health Workers – Jill Feldstein, Chief Operating Officer, and Scott Tornek, Chief Strategy Officer

• Question & answer

• Round-robin of state updates:
  • Overview of top priorities in your state (KY, NH, SC, and WA).
  • How has your learning community team expanded/shifted over the course of the first year? How are you soliciting engagement from CHWs?
  • Are CHWs an emerging topic in your states’ legislative sessions?
  • How have/will CHWs align with other policy changes in your state?
Improving health...
through effective, sustainable
community health worker programs
IMPaCT RESEARCH
Improved health and lower cost

- CHRONIC DISEASE CONTROL
- MENTAL HEALTH
- QUALITY OF COMMUNICATION
- REDUCTIONS IN TOTAL HOSPITAL DAYS OF 65%
IMPaCT at Penn Medicine

>8,000 Lower-income patients

$2:1 Return on Investment
IMPaCT DISSEMINATION

>1000
Toolkits downloaded

>25
Client partnerships
POLICY AND FINANCING ENVIRONMENT
MA Ruling May Signal Industry Readiness to Integrate SDH into Traditional Medical Care

EYE ON WASHINGTON: GAIL R. WILENSKY

IT HAS LONG BEEN RECOGNIZED THAT SOCIAL DETERMINANTS OF HEALTH (SDH)—DEFINED AS THE CONDITIONS IN WHICH PEOPLE ARE BORN, LIVE, WORK, AND AGE—HAVE AN IMPORTANT IMPACT ON HEALTH OUTCOMES.
“As part of our efforts to deliver value-based healthcare, we are moving more toward a system where providers can take on more risk. This will, in turn, broaden the opportunities for providers to benefit from addressing social determinants of health....

...What if we went beyond connections and referrals? What if we provided solutions for the whole person, including addressing housing, nutrition and other social needs? What if we gave organizations more flexibility so they could pay a beneficiary’s rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food? If that sounds like an exciting idea . . . I want you to stay tuned to what CMMI is up to.”

-HHS Secretary Alex Azar
WHY DOES IMPaCT WORK?
PROGRAM DESIGN
<table>
<thead>
<tr>
<th>Psychosocial risk</th>
<th>Medical risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hi/Hi</td>
<td>Hi/Low</td>
</tr>
<tr>
<td>Low/Hi</td>
<td>Low/Low</td>
</tr>
</tbody>
</table>

The table above shows a matrix for psychosocial and medical risk, with categories Hi/Hi, Hi/Low, Low/Hi, and Low/Low. The map on the right illustrates the distribution of these risk levels across different areas.
COMMON PITFALLS
Of CHW Programs

- Staff turnover
- Lack of infrastructure
- Disease-centric, clinically focused
- Disconnected from healthcare system
- Poor outcomes measurement
HIRING

- Compelling job description
- Efficient screening tools
- Role plays & case studies to assess for key qualities
ARE YOU A TRusted MEMBer OF YOUR COMMUNITY?

Have you ever helped a family member or friend to get health care services? Are there things harming your community’s health that you feel passionate about changing? ...If the answer is yes, this may be the job for you!

JOB DESCRIPTION:

Every day, we care for low-income patients in our hospitals and doctor’s offices. We try our best to keep them feeling well so that can live their lives to the fullest. But life can be tough, which makes it hard for people to stay healthy and get better when they are sick. Patients have worries such as: “How will I get to the pharmacy to get my prescriptions filled?” “Who will watch my children while I go to the doctor?” and “Will I have food, transportation and housing?”
CASE STUDY #2
Betty is a 51-year-old woman who has lupus, fibromyalgia, diabetes, asthma, COPD, and high blood pressure. Originally from Florida, Betty moved her about a year ago. She was living with her daughter, but they couldn’t get along, so she moved out on her own. She has lots of pain, and also depression, because she is tired of being sick all the time. She said welfare cut her benefits from $775 to $465 a month because she didn’t have a Part D plan. She also said she has old utility bills from when she was
WORK PRACTICE
WORK PRACTICE

YOUR ROLE

STRUCTURE OF IMPaCT

IMPaCT programs follow a standard basic structure:

SET GOALS: As an IMPaCT VIP, you will work with patients and their providers to set health goals that are meaningful and achievable. Then you will help patients create rational action plans that will lead to their goals.

SUPPORT: Throughout the program, you will provide hands-on support towards helping patients achieve their goals.

CONNECT: You will also work to connect patients to resources of long-term support in order to prevent the relapse drop that often occurs after an intensive program.

You are working in the intervention program, the IMPaCT program targeted towards patients seen in the doctor’s office. You will enroll new patients in the doctor’s office, also in the clinic for six months through weekly visits and calls, and help them connect with a group of other patients.

Clinic

Weekly Follow-up

Group
# TAILORED PATIENT SUPPORT

<table>
<thead>
<tr>
<th>Category</th>
<th>Patient Example</th>
<th>Root Cause</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial</td>
<td>35 year-old gunshot victim who came to the ED when his wounds got infected</td>
<td>Depression from recent paralysis</td>
<td>Connect to wheelchair basketball</td>
</tr>
<tr>
<td>Resource/Advocacy</td>
<td>32 year-old single mom with COPD who came to the ED with shortness of breath</td>
<td>Living in moldy shelter basement with no elevator</td>
<td>Advocate for patient to move to 1&lt;sup&gt;st&lt;/sup&gt; floor with a window</td>
</tr>
<tr>
<td>Navigation</td>
<td>46 year-old man with hypertension who came to the ED with high blood pressure</td>
<td>Cannot afford co-pay on blood pressure meds</td>
<td>Coordinate with physician to prescribe zero co-pay alternative</td>
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</table>
TRAINING & CERTIFICATION
Based on core competencies for each role

Director  CHW  Manager  Certification
## EASY TO USE TECHNOLOGY

<table>
<thead>
<tr>
<th>Subject</th>
<th>Source</th>
<th>Date of Admission</th>
<th>First Name</th>
<th>Last Name</th>
<th>Hospital</th>
<th>Unit and Room Number</th>
<th>CHW assigned to enroll patient</th>
<th>Did patient get a CHW?</th>
<th>If not, why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6442</td>
<td>Referral</td>
<td>8-16-18</td>
<td>Reggie</td>
<td>Brenner</td>
<td>LGH</td>
<td>Silver 201</td>
<td>Kendra</td>
<td>No</td>
<td>Patient unavailable (sleeping, off floor, needs time to think about it), but try again tomorrow</td>
</tr>
<tr>
<td>6448</td>
<td>Referral</td>
<td>8-16-18</td>
<td>Katherine</td>
<td>Walters</td>
<td>LGH</td>
<td>Silver 322B</td>
<td>Robert</td>
<td>No</td>
<td>Patient unavailable (sleeping, off floor, needs time to think about it), but try again tomorrow</td>
</tr>
<tr>
<td>6451</td>
<td>Referral</td>
<td>8-16-18</td>
<td>Frannie</td>
<td>White</td>
<td>LGH</td>
<td>Bobst 139</td>
<td>Kendra</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6446</td>
<td>Target List</td>
<td>8-16-18</td>
<td>Derick</td>
<td>Booker</td>
<td>Washington</td>
<td>Hill 215B</td>
<td>Sherry</td>
<td>No</td>
<td>Caseload targets met for today, but try again tomorrow</td>
</tr>
</tbody>
</table>
### Next Steps

**Roadmap 1 - Addresses Root Cause**

Co-bowling to get some fun in patient’s life

Next Steps:
- [x] 8/23 CHW will reach out to Lloyd about possible dates for bowling
- [x] 8/23 CHW will call Lucky Strike to reserve lane
- [x] By 8/23 CHW and patient will go bowling on discount day

Resolved: Yes

**Roadmap 2 -**

Get patient a new primary care doctor that he likes

Next Steps:
- [x] 8/26 CHW and patient will call pts insurance and get a list of primary care doctors in the area, pt will choose one
- [x] 8/26 CHW and patient will call to schedule an appointment and change PCP on patient’s insurance card
- [ ] 9/3 CHW will call to remind patient of his new primary care appointment with Dr. Carols on 9/4 at 2pm and plan to attend with him

Resolved: No

**Roadmap 3 -**

Find patient affordable housing

Next Steps:
- [ ] By 9/4 CHW and patient will fill out housing authority application
- [ ] By 9/4 CHW will bring apartment listings in neighborhoods patient prefers less than $650 / month

Resolved: No

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<table>
<thead>
<tr>
<th></th>
<th>Metal Filled</th>
<th>Followup Appt Not Completed</th>
<th>Home Care Completed</th>
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</thead>
<tbody>
<tr>
<td><strong>Discharge:</strong></td>
<td>2018-08-23</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target Close Out Date:</strong></td>
<td>2018-05-17</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong># 3692</strong></td>
<td>Reggie</td>
<td>Dr. Carols, 215-030-3945</td>
<td>Run down, needs joy</td>
</tr>
</tbody>
</table>
CARE TEAM INTEGRATION

BRENNER, REGGIE
MRN: 12345678   DOB: 01-13-68
IMPaCT number: #2121
CHW partner: Mykia Babcock
(215-555-1234; mbabcock@health.org)
Start: 2018-8-17   end: 2018-9-17
Roadmaps
1. Go bowling to get fun in patient’s life   RESOLVED
2. Pick new PCP and make appointment   RESOLVED
3. Find affordable housing for patient   IN PROGRESS
# MEASURING PERFORMANCE

### Summary for active patients
- 9 patients (in past 12 months)
- 56% roadmaps complete
- 88% of patients got discharge meds
- 33% of patients had CHW present at discharge
- 44% of patients completed PCP appt
- 33% of patients completed PCP appt within 2 weeks
- 0 readmission rate

### Summary for inactive patients
- 12 patients (in past 12 months)
- 92% roadmaps complete
- 100% of patients got discharge meds
- 33% of patients had CHW present at discharge
- 75% of patients completed PCP appt
- 8% of patients completed PCP appt within 2 weeks
- 0 readmission rate

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Name</th>
<th>Start Date</th>
<th>Discharge or Rehab Date</th>
<th>Latest Review</th>
<th>Roadmaps Resolved</th>
<th>D/C Document</th>
<th>CHW at D/C</th>
<th>Meds Filled</th>
<th>Calendar received</th>
<th>Appt Complete</th>
<th>D/C till Appt</th>
<th>30d Readmissions</th>
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<tbody>
<tr>
<td>3801</td>
<td>Sally Stewart</td>
<td>8-30-18</td>
<td>9-3-18</td>
<td>9-6-18</td>
<td>33% (1/3)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>1</td>
</tr>
<tr>
<td>3682</td>
<td>Reggie Brenner</td>
<td>8-17-18</td>
<td>8-23-18</td>
<td>9-5-18</td>
<td>50% (1/2)</td>
<td>✗</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>1324</td>
<td>Felicia Storm</td>
<td>8-9-18</td>
<td>8-16-18</td>
<td>8-30-18</td>
<td>100% (2/2)</td>
<td>✔</td>
<td>✗</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>4</td>
</tr>
</tbody>
</table>
RIGOROUSLY MEASURE RESULTS

JAMA Internal Medicine, 2018
IMPaCT at Penn Medicine delivers $2 ROI for every $1 spent
# STATE-LEVEL SUPPORT

| Hiring          | • Attestation of demographic mirror  
|                | • Annual turnover rate               |
| Program infrastructure | • Work practice manuals           
|                | • Draw from evidence-based interventions |
| Training       | • Certification at all levels       |
| Evaluation     | • Evaluation plan                  
|                | • Annual outcomes                  |
HOW WE HELP HEALTHCARE ORGS

- Blueprint
- Training and Certification Membership
- Custom Build
- HOMEBASE
Thank you!

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http://chw.upenn.edu/
State Updates

Overview of top priorities

How have your team’s focus areas shifted over the past year?

How are you soliciting engagement from CHWs?

Are CHWs an emerging topic in your states’ legislative sessions?

How have/will CHWs align with other policy changes in your states?
Thank you!

ASTHO:

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• Carl Rush, MRP, Community Resources, LLC (carl@chrllc.net)
• Geoffrey Wilkinson, MSW, Boston University School of Social Work (gww@bu.edu)

CHW resources and presentations available at: www.astho.org/community-health-workers