States of Change: Expanding the Health Care Workforce and Creating Community-Clinical Partnerships

Thursday, November 7, 2013
12:00 – 1:30 pm ET

Sponsored by Merck Foundation

www.alliancefordiabetes.org
Agenda

- Welcome and Introductions
- State Perspective on Efforts to Improve Care Through Delivery System Reform, Workforce Changes and Community-Clinic Engagements
- The Path to Integrating CHWs Into Clinical Teams in Texas – Licensing, Training and Results
- The Role for States in Creating and Maintaining Community-Clinical Connections
- Panel Discussion: The Role of States in Widespread Adoption of Programs That Address the Needs of Vulnerable, High-Risk Patients
- Audience Q&A
- Closing Remarks
About the Alliance to Reduce Disparities in Diabetes

- National program founded and supported by the Merck Foundation.
- Launched in 2009.
- Implementing comprehensive, evidence-based diabetes programs that are:
  - Applying proven, community-based and collaborative approaches
  - Enhancing patient and HCP communications
  - Mobilizing community partners
  - Disseminating important findings
  - Increasing policy maker awareness at all levels of change to reduce health care disparities in diabetes
  - Promoting collaboration and information exchange
About the National Governors Association

Mission Statement
The National Governors Association (NGA)—the bipartisan organization of the nation's governors—promotes visionary state leadership, shares best practices and speaks with a collective voice on national policy.

What We Do
Through NGA, governors identify priority issues and deal collectively with matters of public policy and governance at the state and national levels.
Areas of Focus for Today’s Discussion

Healthcare Workforce Challenges

ACA and Other Federal and State Requirements and Policies

Health Information Technology and Data Use
Welcome and Introductions

Esther Krofah, MPP
Program Director, Health Division,
National Governors Association

Christine A. Snead, RN, CPHQ
Director of Care Coordination,
Baylor Quality Alliance/Health Texas Provider Network,
Baylor Health Care System

Jeff Levi, PhD
Executive Director
Trust for America’s Health

Marshall Chin, MD, MPH, FACP
Richard Parrillo Family Professor of Healthcare Ethics,
Department of Medicine,
University of Chicago
State Perspective on Efforts to Improve Care Through Delivery System Reform, Workforce Changes and Community-Clinic Engagement

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Program Director, Health Division
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November 7, 2013
NGA Health Workforce Technical Assistance (TA)

• Goal: support states by providing technical assistance in ensuring that the state’s workforce planning supports the state’s health care delivery environment
• Content of TA:
  – One-day in-state retreat with a senior staff member from NGA and a national workforce expert
  – Follow up conference calls with NGA and workforce expert
  – Monthly conference calls with all states
States Receiving Health Workforce Planning TA

Connecticut
Colorado
Hawaii
Illinois
Kentucky
Montana
Nevada
Oklahoma
Vermont
Washington
Health Workforce Challenges

- 13 million more enrolled in Medicaid and CHIP by 2023¹
- 24 million enrolled in the health insurance marketplaces by 2023²
- One-fourth (26.3 percent) active physician workforce over 60³
- One-third of the nursing workforce is older than 50⁴
- More than 6 of every 10 boomers will be managing more than one chronic condition⁵

¹ Congressional Budget Office, Updated Budget Projections, May 2013.
² Ibid.
³ State Physician Workforce Data Book, AAMC, 2011.
⁵ When I'm 64: How Boomers Will Change Health Care, American Hospital Association, 2007.
Key Questions Driving States

- To define current supply, what should the data set be that is collected through the mandatory survey of health professions as part of their licensure or certification? Should data sets vary by profession?

- How can the state use health workforce data and resources to proactively allocate workforce investments that improve access to care, particularly in the context of expanded coverage?

- Which top three health care professions are expected to see the most increased demand?

- Which health care professions will play the biggest role in ensuring access to quality care/services for the currently uninsured, once they transition to some form of comprehensive care?

- What pipeline programs and/or curriculum development is necessary to increase the potential to meet the expected demand?

- What would be the most effective state role in helping prepare for changing workforce skill requirements that leverage the growth of technology, incorporate self-care and promote individuals and families as more engaged participants in a transformed health care system?

- What workforce models will need fiscal or policy intervention in the next Legislative session?

- What regulatory barriers limit or prohibit providers’ ability to practice to the full extent of their licensure?

**Data Collection and Analysis 13%**

**Composition of the Workforce 10%**

**Training New Workforce 26%**

**Regulatory Changes 18%**
CMMI: Where Innovation is Happening, ACOs, PCMH...
Shift in Core Skillsets, Competencies and Roles

Core Skillsets
- Prevention
- Care Coordination
- Case Management
- Health Coaching
- Team-based Care
- Patient Education and Engagement
- Use of Data to Support Care Delivery
- Patient Navigation
- Health IT

Emerging Occupations
- Community Health Worker
- Patient Navigator
- Community Paramedics
- Social Workers
- RNs
- Nurse Case Managers
- Care Coordinators
- Home Health Aids
- Care Transition Specialists
- Peer and Family Mentors
- Living Skills Specialists

Lack of Clarity
Common Issues and Challenges

• Data collection and analysis
• Silos and turf wars
• Cultural change and leadership
• Number of job titles for allied health occupations, lack of standardization in training, credentialing, and funding
• Re-training existing workforce
• Faculty and training site shortages
• Recruiting and retaining primary care physicians
• K-12 math and science education
• Scope of practice
Strategies and Recommendations

• Implement data collection and analysis systems (7)
• Examine paraprofessional workforce required for new models of care (6)
• Develop taskforce to support regional and focused planning (6)
• Develop recruitment and retention strategies (e.g., loan repayment) (5)
• Support interprofessional (IPE) training (4)
• Examine scope of practice (4)
• Expand clinical training capacity (3)
State Policy Levers

Governors as Conveners and Consensus Builders
State Purchasing Power
State Wellness and Prevention Efforts
State Health Care Regulation
Education and Workforce
Market Competition and Consumer Choice

State Health Policy Levers

National Governors Association
Building Strategies Into Ongoing Efforts

- State Innovation Model Plan
- State Health Workforce Strategic Plan
- Health Workforce Planning Committee
- Legislative Plan
QUESTIONS?

Contact:
Esther Krofah, Program Director

ekrofah@nga.org
The Path to Integrating CHWs Into Clinical Teams in Texas – Certification, Training and Results

Christine A. Snead, RN, CPHQ
Director of Care Coordination
Baylor Quality Alliance/Health Texas Provider Network
Baylor Health Care System

www.alliancefordiabetes.org
Background

- **Diabetes Equity Project**
  - Designed with Baylor Health Care System & Dallas County Medical Society - Project Access Dallas

- **Baylor Community Care**
  - Primary care service line for the uninsured (high utilizers)
  - 6/7 practices are Patient Centered Medical Homes
  - Challenges
    - Patient volume outweighs capacity of PCPs
    - Additional patient navigation, education and support needed for high-risk diabetic patients
    - Limited budget
Community Health Workers in Texas

- Community Health Worker: A new and emerging health care worker
  - Trusted patient peer*
  - Culturally competent
  - Supports patient **navigation and health education**
- Certification: 160 hour program via DSHS approved entities building competencies in:
  - Communication skills - Interpersonal skills
  - Service coordination - Capacity-building
  - Advocacy - Teaching skills
  - Organizational skills - Knowledge base
- Continuing education requirements: 20 hours/2 years

[http://www.dshs.state.tx.us/mch/chw.shtm](http://www.dshs.state.tx.us/mch/chw.shtm)
Perspective

Community Health Workers — A Local Solution to a Global Problem

Proshan Singh, M.D., Ph.D., and Dave A. Chokshi, M.D.

Community Health Workers (CHWs) are community-based health care professionals who are trained to work alongside health care providers to improve health outcomes. CHWs are often recruited from the community they serve, and their role is to bridge the gap between community members and the formal health care system. They are trained in health education, health promotion, and disease prevention, and they work with families and communities to improve health outcomes.

Management entities, organizations dedicated to CHWs that are integrated with clinical and community organizations, are oriented around financial sustainability, population health, and environmental health goals, and local workforce development.
Have You Heard the News?

CMS’s Final Rule Expands Reimbursement for Preventive Services

Medicaid Will Allow Reimbursement for Community Health Worker Preventive Services!

Community Health Worker (CHW) Health Disparities Initiative partners -- have you heard about the CMS ruling announced last month? The Centers for Medicare and Medicaid Services (CMS) created a new rule which allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state’s clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner. The new rule for the first time offers state Medicaid agencies the option to reimburse for more community-based preventive services, including those of CHWs. The rule goes into effect on January 1, 2014.
The new rule now states,

"(c) Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—

1. Prevent disease, disability, and other health conditions or their progression;

2. Prolong life; and

3. Promote physical and mental health and efficiency."

The citation for the ruling is:


The Rule can be found here: PDF

To visit the CHW Health Disparities Initiative website: http://www.nhibi.nih.gov/health/healthdisp
CHWs at Baylor Health Care System: Two Programs Emerge

Diabetes Equity Project*
- Embed CHWs in PCMHs
- Adapt Community Diabetes Education (CoDE) Program
- Leverage customized application software for enhanced data capture, decision support, and communication
- Scaled to 7 sites

Community Care Navigation
- Hospital to primary care navigation
- Reduce barriers to effective care (meds, transportation, appts)
- Create patient activation
- Leverage software for data capture, decision support, and communication by CHW
- Scaled to 4 sites

Acknowledgement: This project is supported by a grant from the Merck Foundation as part of its Alliance to Reduce Disparities in Diabetes.
CHW as PCMH Team Member

PCP Roles

PCP Tasks
- Clinical exam
- Diagnoses
- Creation of treatment plan
- Prescription of medications

PCP Roles

PCP Tasks Shifted to CHWs
- Diabetes education*
- Nutritional counseling
- Frequent patient follow-up

Traditional CHW Tasks
- Social support
- Link to community resources*
- Care Navigation
- Patient Activation

- Licensed personnel (RN, CDE, SW) handle more complex cases.
- CHW oversight by licensed program manager (RN or SW) and program Medical Director. Patient specific direction taken from PCP.
Statistically Significant Reduction in A1c

Mean Hemoglobin A1c with Standard Deviation by Visit
YR 1 Patients With At Least 2 Visits

Visit 1 (N=696)  Visit 4 (N=769)  Visit 5 (N=769)  Visit 6 (N=693)  Visit 7 (N=556)  Endpoint (N=886)

Hemoglobin A1c Mean (%)

Visit

8.4
7.2
CHW-led Diabetes Intervention IMPACT and Conclusions

- Hospital admission frequency falls by 50%
  - Statistically greater than Control group (-22% decrease)
  - Hospital Length of Stays and Cost per case fall
    - Not statistically greater than Control group
- Hospital ED utilization did not change
  - Lower than Control group throughout study
- Hospital ED Cost per case fall (-19%)
- CHW-led Care Coordination model could have major beneficial impact if scaled further
  - Cost-beneficial solution
  - Leveraging a “new” health care team member embedded with primary health care providers
- Requires innovative health IT support
- Patient activation helps explain positive outcomes
Integrating CHWs Into Baylor Health Care System

Career Path Development:

2005
1 CHW
CoDE
Charitable Program Enrollment

2014
32 CHWs
Chronic Disease Education
Community Care Navigation
Care Connect
DHWI Elder House Calls

2 CHWs
CoDE
Diabetes Equity Project
Community Care Navigation

9 CHWs
Diabetes Equity Project
Community Care Navigation

20 CHWs
Diabetes Equity Project
Community Care Navigation
Care Connect
DHWI Diabetes Elder House Calls

CHW 1
CHW 2
CHW Sup
Our Game Changers…

Contact:
Christine Snead, RN, CPHQ
christine.snead@baylorhealth.edu
The Role for States in Creating and Maintaining Community-Clinical Connections

Marshall H. Chin, MD, MPH
Richard Parrillo Family Professor
University of Chicago

www.alliancefordiabetes.org
Objectives

• Discuss community-clinical connections to improve diabetes care and outcomes in Chicago’s South Side

• Discuss how states can facilitate such partnerships and help patients manage their illnesses
South Side of Chicago

• Challenges:
  - Poverty
  - Social challenges
  - Food deserts
  - Unsafe recreation
  - Mistrust of healthcare
  - Weakened hospital safety net

• Strengths
  - Historical social, political and cultural traditions
  - Community resources and institutions
  - Healthcare institutions
Clinic System Redesign Improvement
Teams in Six Health Centers

Sites
• 4 FQHCs
• 2 Academic Medical
Culturally Tailored Patient Education and Community Partnerships
Public Education; Integration of Health Care and Community Resources
Align Financial Incentives

- Reward improving population health
- Global payments that reward preventive care
- Fund primary care adequately
- Reimburse team-based care, coordination of care, community health workers
- Incentivize reduction of disparities and protect vulnerable populations explicitly
Partnering State Agencies – Be Creative

- Department of Public Health
- Parks and Recreation
- Housing
Contact Information

Marshall H. Chin, MD, MPH
University of Chicago
mchin@medicine.bsd.uchicago.edu
773-702-4769

www.southsidediabetes.org
www.chicagodiabetesresearch.org
www.solvingdisparities.org
The Role of States in Widespread Adoption of Programs That Address the Needs of Vulnerable, High-Risk Patients

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Audience Q & A

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