

How Community Health Workers and Promotores Can Support Individuals with Complex Needs amid COVID-19

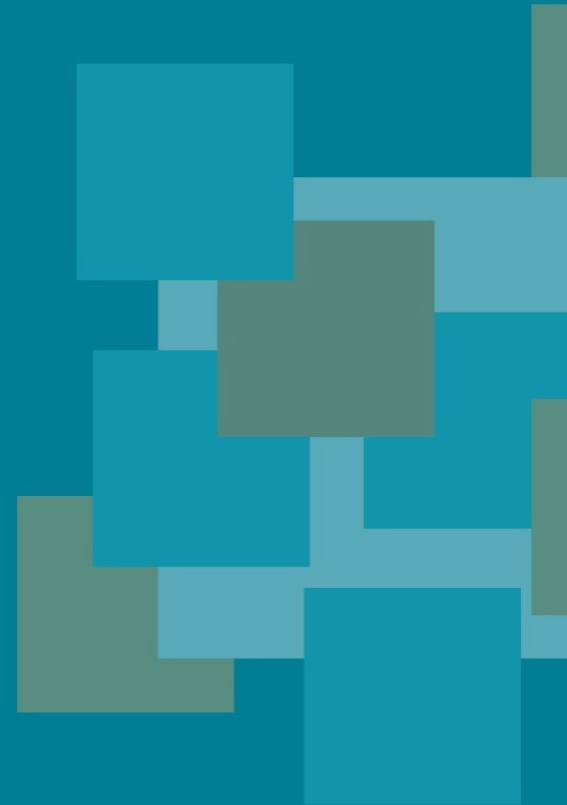
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Welcome & Introductions

Logan Kelly

Senior Program Officer, Center for Health Care Strategies



Agenda



- Welcome and Introductions
- The Role of Community Health Workers and Promotores amid COVID-19
- Implementing Community Health Worker Programs
- Health System Approaches to Building and Expanding Community Health Worker Programs
- Moderated Q&A

Today's Presenters



Logan Kelly, MPH,
Senior Program Officer,
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Robert Fields, MD,
Senior Vice President and Chief
Medical Officer of Population
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Maria Lemus,
Executive Director,
Visión y Compromiso



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Executive Director,
Penn Center for Community
Health Workers

About the Better Care Playbook



Online resource center offering the latest knowledge on evidence-based and promising practices for people with complex health and social needs



Provides practical how-to guidance to inform health system leaders, payers, policymakers and others on strategies to improve care for high-need, high-cost populations

Coordinated by the Center for Health Care Strategies through support from seven leading national health care foundations — **Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.**



www.BetterCarePlaybook.org

Working Definitions

- Frontline public health professionals who have a close understanding of their communities and foster connections between health care, social services, and the community
- Shared lived experience with individuals served, enabling high-quality and culturally relevant service delivery
- Titles may include:
 - » Community health workers (CHWs)
 - » Promotores and community leaders
 - » Community health representatives
 - » Health navigator



CHW/P Roles and Settings

- Roles include:



Care team members



Navigators



Screening and health education providers/coaches



Outreach and enrollment facilitators



Organizers



Preventive services providers

- Programs administered by health systems, clinics, community-based organizations, managed care plans, and government agencies

Sources: Jim Lloyd, Kathy Moses, and Rachel Davis, *Recognizing and Sustaining the Value of Community Health Workers and Promotores*, Center for Health Care Strategies, January 2020, Available at: https://www.chcs.org/media/CHCS-CHCF-CHWP-Brief_010920_FINAL.pdf

Despite Growing Evidence Base, CHW/P Programs Face Barriers to Expansion



- CDC evaluation showed strong evidence that CHW/P programs improve health-related and social outcomes
- Increased evidence from specific programs on reduced hospitalizations, financial return on investment
- Patchwork of funding
 - » Grants
 - » Managed care contracts
 - » Health systems
 - » Medicaid state plan amendments and Section 1115 demonstration waivers
- Only 59,000 individuals currently classified as CHWs

Sources: Centers for Disease Control and Prevention, "Policy Evidence Assessment Report: Community Health Worker Policy Components," 2014, available at: https://www.cdc.gov/dhds/pubs/docs/chw_evidence_assessment_report.pdf; Johnson et al, "Community Health Workers and Medicaid Managed Care in New Mexico," *Journal of Community Health*, 2011, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3343233/pdf/10900_2011_Article_9484.pdf; U.S. Bureau of Labor Statistics, "Occupational Employment and Wages, May 2019," available at: <https://www.bls.gov/oes/current/oes211094.htm>

Impact of COVID-19 on Individuals with Complex Health and Social Needs



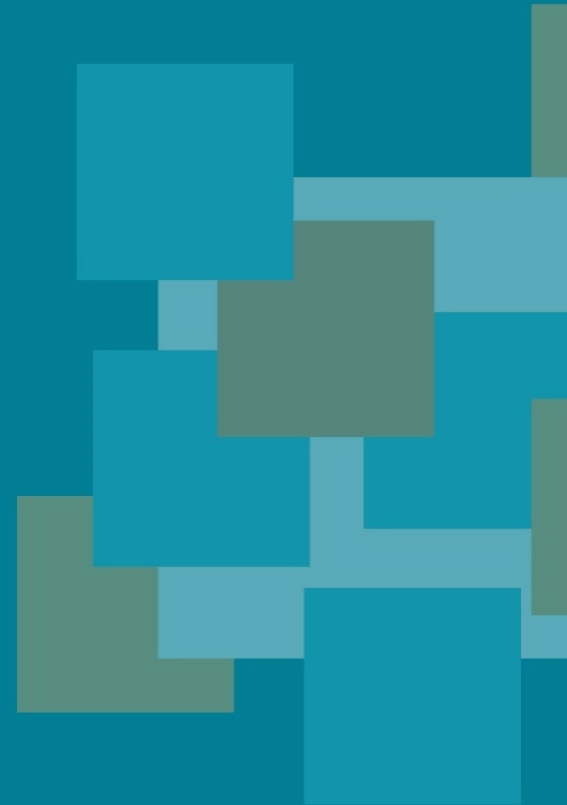
- Multifaceted challenges to supporting individuals with complex needs in the COVID-19 pandemic
 - » Access to physical and behavioral health care and social services
 - » Communication about public health information
 - » Culturally sensitive health education and health coaching
- COVID-19 as “disparities risk multiplier”
- Opportunities for community health workforce to address impacts of COVID-19 and systemic racism

Sources: Denise Smith and Ashley Wennerstrom, “To Strengthen The Public Health Response To COVID-19, We Need Community Health Workers,” Health Affairs Blog, May 2020, available at :<https://www.healthaffairs.org/doi/10.1377/hblog20200504.336184/full/>; David Labby, “Moving Toward Recovery-Oriented Complex Care through COVID-19 Response,” Better Care Playbook Blog, May 2020, available at:

<https://www.bettercareplaybook.org/blog/2020/19/moving-toward-recovery-oriented-complex-care-through-covid-19-response>

The Role of Community Health Workers and Promotores Amid COVID-19

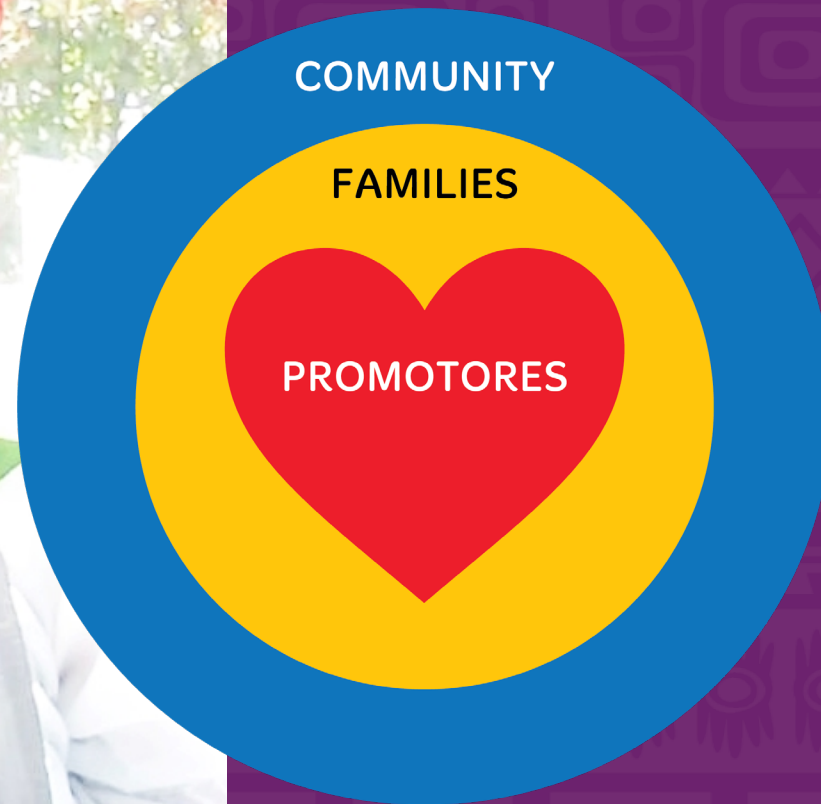
Maria Lemus, Executive Director, Visión y Compromiso





Visión y Compromiso supports the transformational work of promotoras, trusted community leaders who reach our most vulnerable residents.







ME VEO
BIEN
ME SIENTO
BIEN





Avances y respuestas hacia el Covid-19 Episodio 2: Actualizaciones, riesgos y realidades del COVID-19

Avances y respuestas hacia el Covid Episodio 1 Actualiza...

Watch later Share

DESERT HEALTHCARE DISTRICT & FOUNDATION

COVID-19 en California

- Día 28 – 21 de febrero – comienzan las cancelaciones de eventos (se afecta la economía)
- Día 32 – 25 de febrero – San Francisco declara emergencia (sin ningún caso positivo)
- Día 34 – 27 de febrero – (8,400 personas monitoreadas) 200 pruebas en manos del estado
- Día 36 – 29 de febrero – las escuelas comienzan a contemplar la educación a distancia
- Día 40 – 4 de marzo - Gobernador de California declara emergencia
- Día 42 – 6 de marzo – El Presidente firma el primer paquete de ayuda económica (\$8.3B)
- Día 43 – 7 de marzo – 100 casos confirmados en CA. Escuelas comienzan a cerrar
- Día 47 – 11 de marzo – OMS declaración de "Pandemia". Comienza el distanciamiento físico
- Día 49 – 13 de marzo – Declaración de **emergencia nacional**. Cierran las escuelas (8 fallecidos /320+)
- Día 51 – 15 de marzo – Centros de ancianos restringen visitas



Avances y respuestas hacia el Covid-19 Episodio 1: El autocuidado holístico durante estos tiempos

Avances y respuestas hacia el Covid 19 Episodio 2:El Aut...

Watch later Share

La enfermedad del coronavirus Covid-19 desde una perspectiva holística

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HACIA UNA VIDA DIGNA Y SANA



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Implementing CHW/P Programs

*Shreya Kangovi, MD, MSHP, Executive Director, Penn Center for
Community Health Workers*



COMMUNITY HEALTH WORKERS

SOCIAL FIRST RESPONDERS

 IMPACT[®]

PENN CENTER FOR COMMUNITY HEALTH WORKERS



SCIENCE

- Formative: 1,500 patient interviews
- Evaluative: Three RCTS improved primary care access, quality, mental health, reduced hospitalization and \$2.47:1 ROI



PATIENT CARE

- More than 15,000 patients served in Philadelphia



SCALE

- 50 member organizations in 18 states
- Standards, policy and financing initiatives



COMMUNITY HEALTH WORKERS





Job Announcement

COMMUNITY HEALTH WORKER

ARE YOU A TRUSTED MEMBER OF YOUR COMMUNITY?

QUALIFICATIONS

Randomized clinical trials



HEALTH



SATISFACTION



QUALITY



HOSPITALIZATION

JAMA
The Journal of the American Medical Association

AJPH
A PUBLICATION OF THE
AMERICAN PUBLIC HEALTH ASSOCIATION

Economic impact

CULTURE OF HEALTH

By Shreya Kangovi, Nandita Mitra, David Grande, Judith A. Long, and David A. Asch

Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment

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ABSTRACT Interventions that address socioeconomic determinants of health are receiving considerable attention from policy makers and health care executives. The interest is fueled in part by expected returns on investment. However, many current estimates of returns on investment are likely overestimated, because they are based on pre-post study designs that are susceptible to regression to the mean. We present a return-on-investment analysis that is based on a randomized controlled trial of Individualized Management for Patient-Centered Targets (IMPACT), a standardized community health worker intervention that addresses unmet social needs for disadvantaged people. We found that every dollar invested in the intervention would return \$2.47 to an average Medicaid payer within the fiscal year.

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Each year the United States spends roughly \$550 billion on care for the nearly sixty-three million Americans covered by Medicaid¹—which accounts for one-sixth of national health care spending.² Some of this spending may be inefficient because it is used to treat illness, disease control,^{7,8} mental health,⁹ quality of care,¹⁰ and hospital use.^{8,10–12} The growing interest in community health worker programs is fueled in part by expected cost savings.¹³ However, with few exceptions,^{12,14,15} these programs have not been subjected to rigorous economic analysis. Two sys-

Standards and scale



Policy and financing



“Improve caregiving and health outcomes in our nation’s most underserved communities by adding 150,000 community health workers ... [Biden] will do this by providing direct grant funding, as well as adding community health worker services as an optional benefit for states under Medicaid....Repeated studies from across the country, including [North Carolina](#) and [Philadelphia](#), have shown that [these] investments can save money by reducing hospitalizations while also improving health and improving career ladders for workers....A recent study revealed that every dollar spent on community health workers would yield [\\$2.47](#) in savings.”

Source: “The Biden Plan for Mobilizing American Talent and Heart to Create a 21st Century Caregiving and Education Workforce,” posted in July 2020 at: <https://medium.com/@JoeBiden/the-biden-plan-for-mobilizing-american-talent-and-heart-to-create-a-21st-century-caregiving-and-af5ba2a2dfef>

THANK YOU

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CHW.UPENN.EDU

Health System Approaches to Building and Expanding CHW/P Programs

Robert Fields, MD, Senior Vice President and Chief Medical Officer of Population Health, Mount Sinai Health System

Community Health Workers as Partners in Value-Based Care

Rob Fields MD MHA

*SVP CMO Population Health
Mount Sinai Health System*



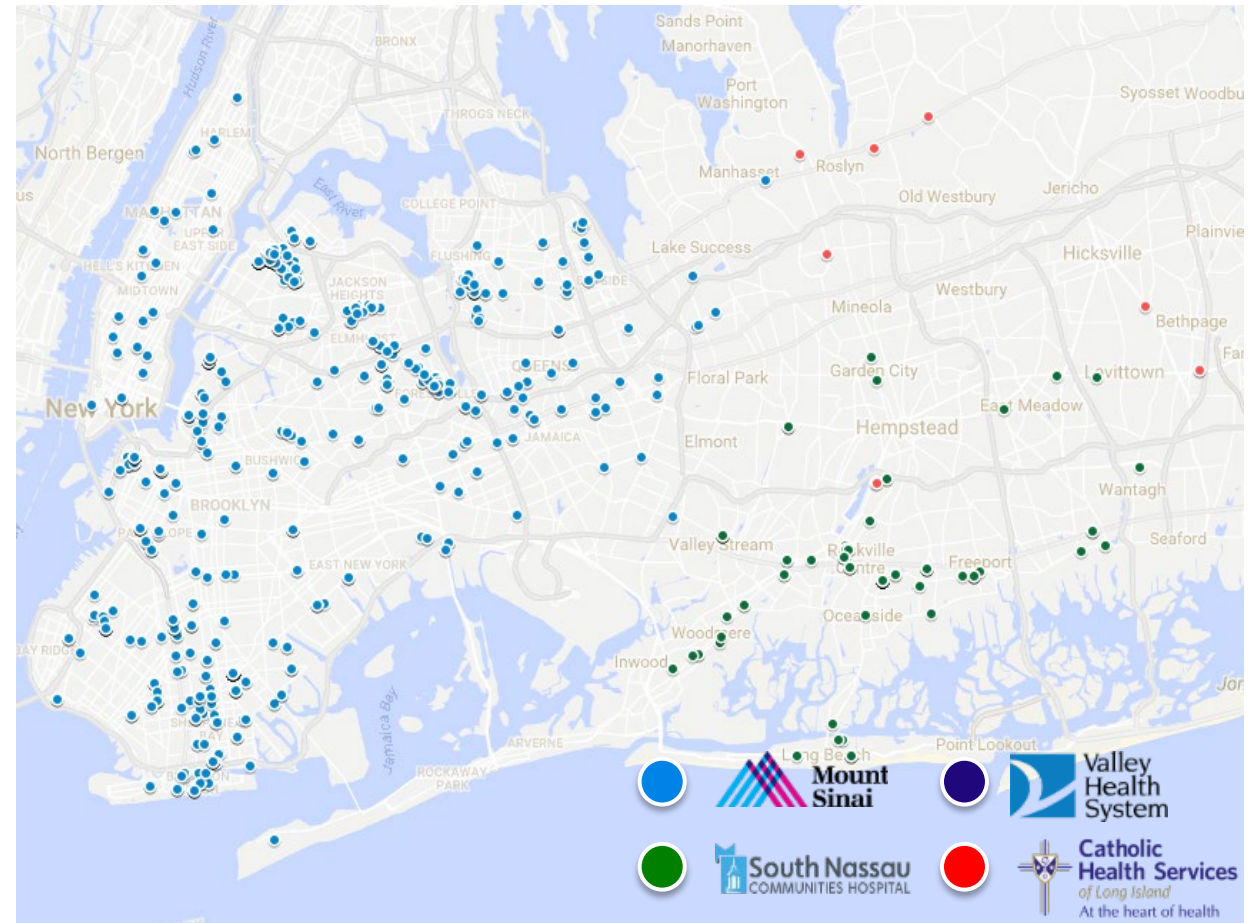
**Mount
Sinai**

Mount Sinai Health System: Positioned for Value

With breadth and depth of assets, Mount Sinai is well positioned as one of the highest-value providers in New York City

Health System Assets

- ▶ Icahn School of Medicine at Mount Sinai
- ▶ Flagship academic hospital + 7 community hospitals
- ▶ >300 community care locations throughout NYC Metro
- ▶ >6,600 physicians on medical staff (~3,500 employed)
- ▶ Clinical affiliations that further our geographic reach



Mount Sinai Health System: Investing in Value

With a focus on value, Mount Sinai has heavily invested in population health solutions, supported by a new business model engaging directly with purchasers of health care

New Business Model

Key goals include:

- ▶ To become the purchaser's partner of choice
- ▶ Align financial incentives around outcomes
- ▶ Earn trust with our patients so that Mount Sinai is their provider of choice
- ▶ Manage outcomes, patient experience, and costs



Strategic Initiatives

- ▶ **New Leadership** – hired new leaders to launch a 400+ FTE team dedicated to population health & value
 - ▶ **Network Development** – launched clinically integrated network of hospitals & >4,000 employed and community-based physicians
 - ▶ **Changing Compensation** – shifted physician compensation to an outcomes-based model
 - ▶ **Investment in Enablement** – \$100M in IT & services to enable care teams for managing populations
 - ▶ **Quality Management** – standardizing & improving care processes for chronic illness & specialty care
- ▶ Value-based contracts with all commercial health plans
- ▶ Full risk-based contracts for Medicare/Medicaid lives

March 17th 2020

The COVID Reality

- ▶ Fragility of safety net
- ▶ Food insecurity
- ▶ Lack of primary care and specialty access
- ▶ Disparities in access to technology
- ▶ Worsening behavioral health concerns
- ▶ Vulnerability of independent primary care practices
- ▶ Lack of hospital capacity at the peak of the virus in NYC

Pandemic Plan of Action

Assessment and Management of COVID Risk and Symptoms

- ▶ New analytics to identify high COVID risk patients
 - ▶ Self-service tool for list distribution for outreach
-

Engagement in Telehealth

- ▶ Outreach efforts included assessment of chronic condition and COVID needs
 - ▶ Education/engagement in telehealth (active engagement and outreach for visits)
-

Focused Themes for Outreach

- ▶ Chronic condition management, medication access, food insecurity, behavioral health, COVID related symptoms
- ▶ Accompanying training guide for practice outreach
- ▶ Use of community health workers, students

Community Partners = Health care Partners

- ▣ Engaging community-based organizations (CBOs) in health care AND health care financing
- ▣ Networks of CBOs to augment “typical” health care
- ▣ Social determinant drivers AND patient engagement
 - technology
 - chronic condition management
 - linkage to standard health services and telehealth
- ▣ Need for CBOs to participate in health care economics
 - improved sustainability
 - “skin in the game”
- ▣ Reimagined processes and technology to facilitate the relationship and the drive towards population health outcomes

Partnerships Strategy for CHWs

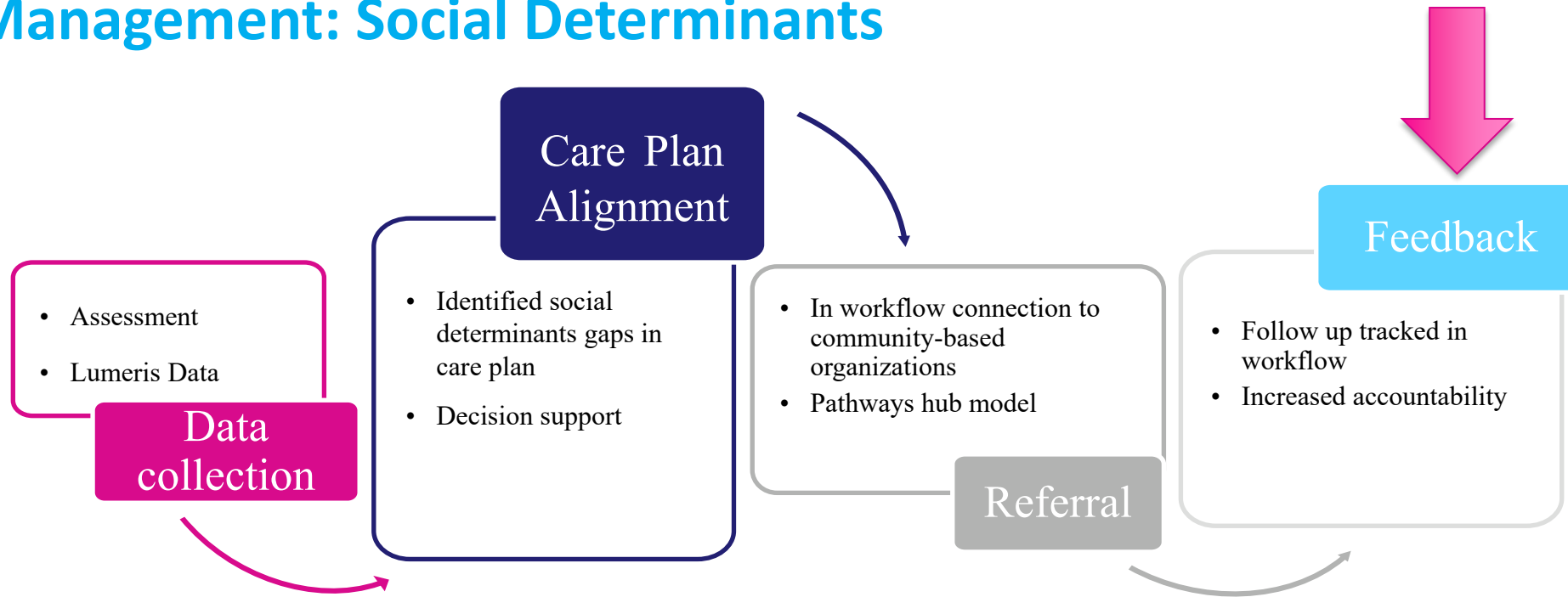
▣ Operational

- Systems struggle at the community level and local partners are key
- Care management resources are often centralized and expensive to scale
- CHW's can serve as a social triage workforce with a community navigation function

▣ Financial

- VBC contract success increasingly important for systems
- CBOs struggle with impact data and how to escape the philanthropy cycle for sustainability

Care Management: Social Determinants



Social Determinants of Health Domains

1. Alcohol Use
2. Depression
3. Financial Resource Strain
4. Food Insecurity
5. Intimate Partner Violence
6. Physical Activity
7. Social Connections
8. Stress
9. Tobacco Use
10. Transportation Needs
11. Housing (coming soon)

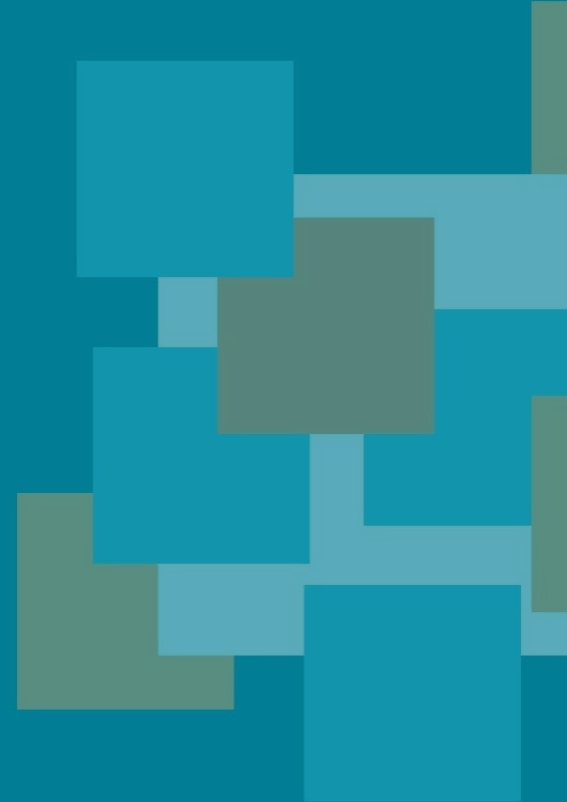
Summary

- ▶ Value-based care has driven systems to think about community-based strategies for care.
- ▶ COVID accelerated Mount Sinai efforts for community engagement and sustainable partnerships.
- ▶ CHW efforts evolved from simple health coaching interventions to more complex social service navigation at scale.
- ▶ The future of our value-based care strategy is to fully integrate CHWs and other CBOs into our network to participate in a share of total cost of care savings and function as true partners in care.

Thank You

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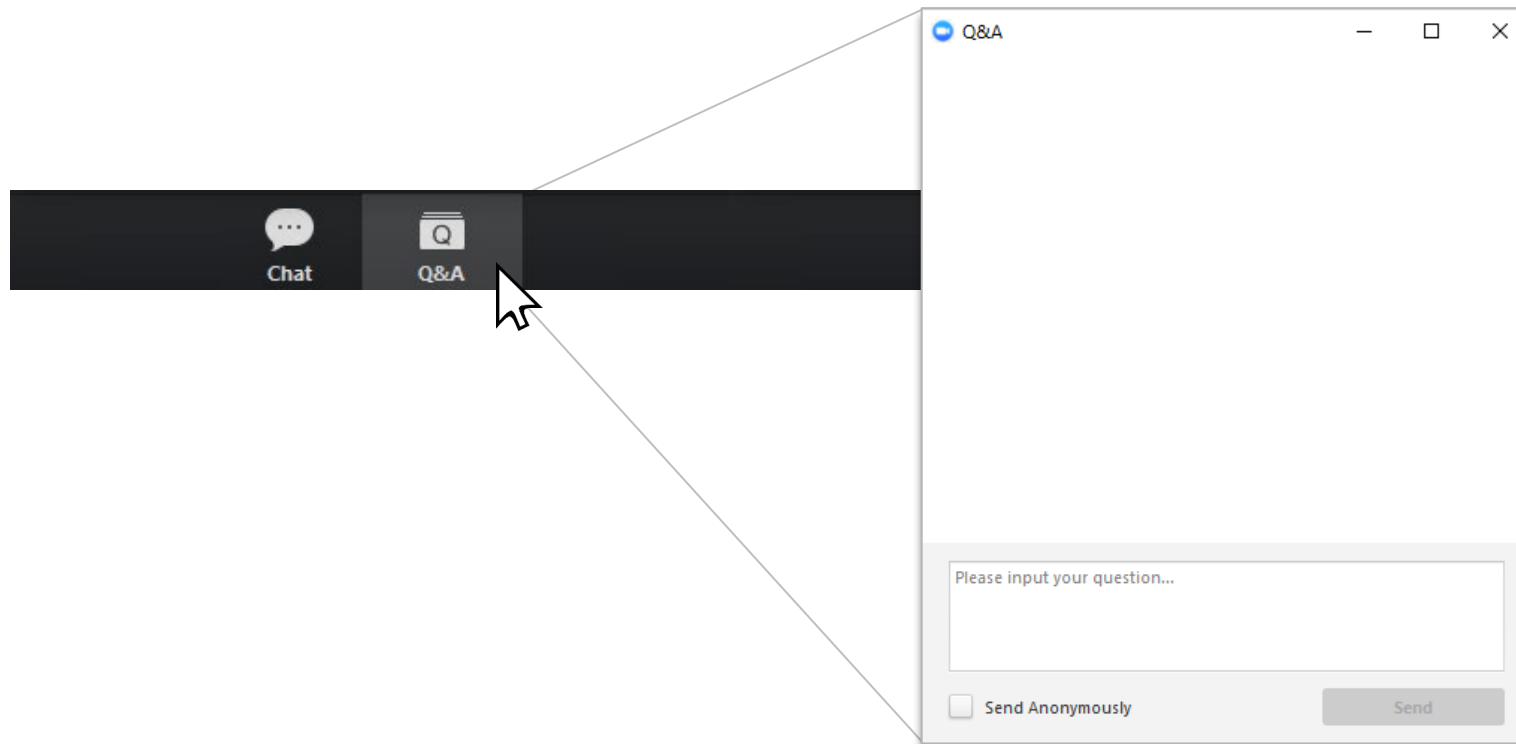
Question & Answer



Questions?



To submit a question, click the Q&A icon located at the bottom of the screen.



Share Your Successes on the Playbook

- **Have you established a promising practice?**
- **Published a study about your complex care program?**

The Playbook welcomes content submissions to help spread best practices in complex care.

www.BetterCarePlaybook.org



Thank you!

Please submit your evaluation survey.

