Supporting Primary Care CHW Programs in a Post-COVID Funding Environment

Association of Clinicians for the Underserved, 2023 Conference
Kelly Volkmann, MPH; Northwest Regional Primary Care Association

Your presenter for this session

Kelly Volkmann, MPH, (she/her)

Project Director, CHW Institute
Northwest Regional Primary Care Association

Former:

- Registered Nurse in Oregon and California
- Program Manager for robust CHW program in CHC in Benton County, OR (13 years)

NOTE: Ms. Volkmann has no relevant financial relationships to disclose

Objectives

1. List at least 3 CHW qualities and skills that add value to the care team and their clients

2. Describe the benefits of integrating CHWs into a care team

3. Discuss various ways to potentially support CHW programs in a primary care agency

Who is in the room today?

Please raise your hand if you…

Work as a:

- CHW
- CHW Supervisor
- Provider or clinician
- Medical Director, Administrator, or C-Suite
- HR or Personnel

Have a *clinical* CHW program

Have a CHW program that is completely, sustainably funded…

Who *is* a Community Health Worker?

Trusted member of the community being served

Shares similar characteristics/experience

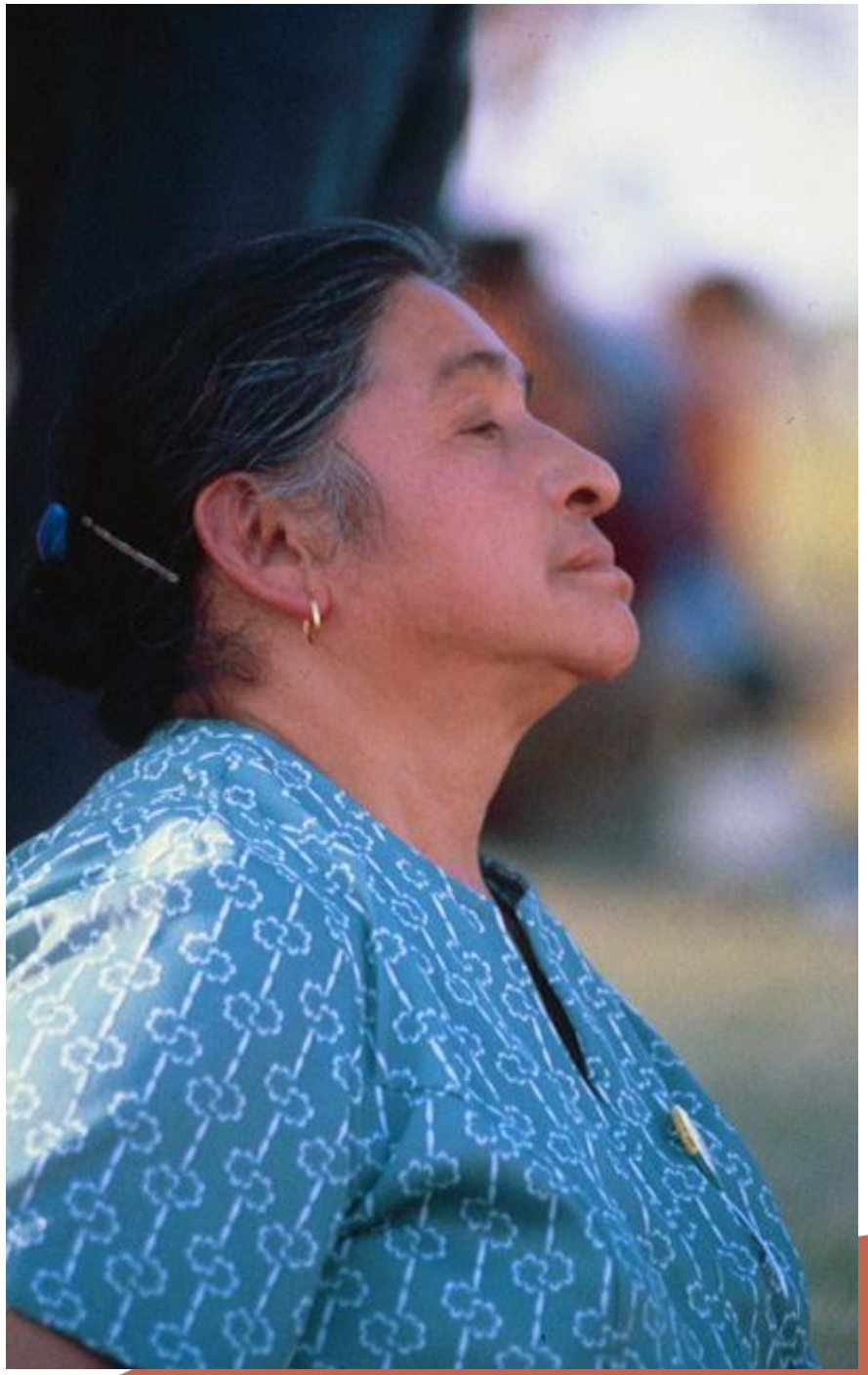
- Language, culture
- Socioeconomic circumstances
- Chronic disease condition
- Mental health consumer

"Someone who looks like me, speaks like me… and *understands* me"

Analuz Torrez-Girón, CHW
Benton County Health Navigation

CHWs have many titles…

- Promotor/a de Salud
- Health promotor
- Health navigator
- Outreach worker
- Lay health educator
- Community health representative
- Patient advocate

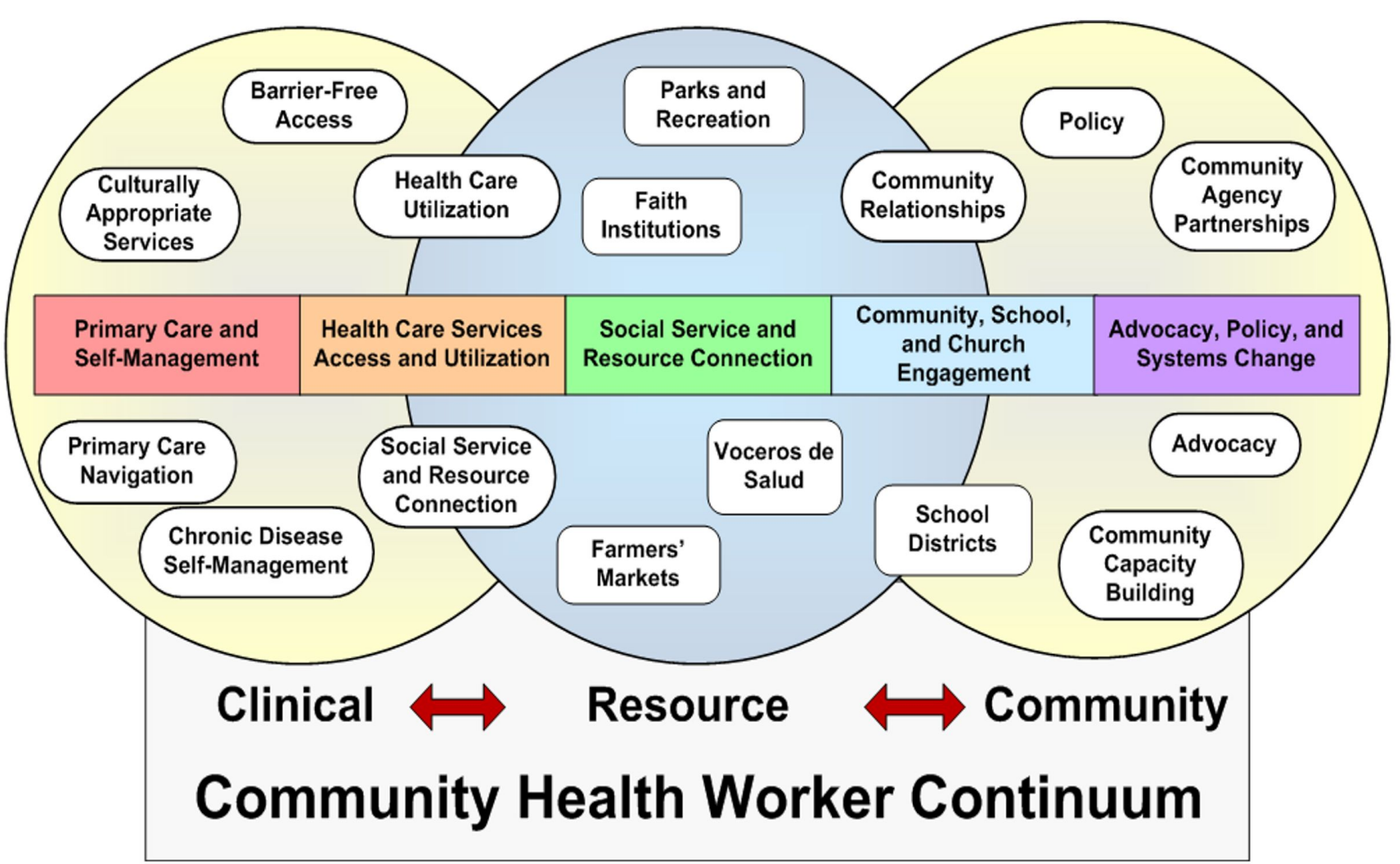


...but share the same core skills

- Communication
- Interpersonal skills
- Service coordination and resource navigation
- Capacity building
- Advocacy
- Community education
- Community organizing

Source: The National Community Health Advisor Study

CHWs work along a continuum of services



Benton County Health Services

CHWs: Community roles

Viviana Gonzalez, CHW
Benton County Health Navigation

Increasing access to needed services for community members

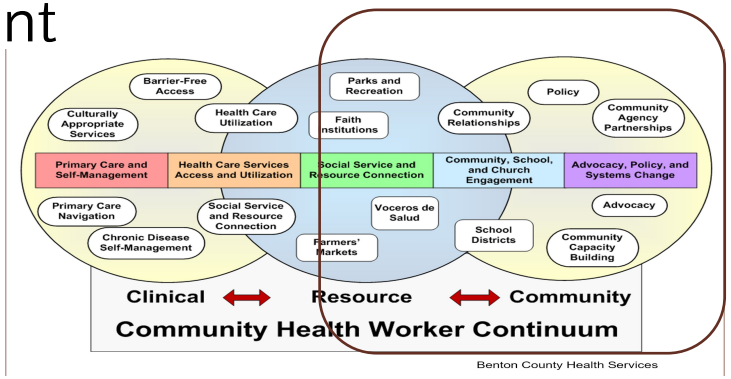
Experts at health care and social system navigation

- Referral to community services & resources

Community advocacy, empowerment

Coordinate community events

- Resource & health fairs
- Vaccine events!



Barrier-busting and cultural mediation between *communities and systems of care*

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CHWs: Clinical roles

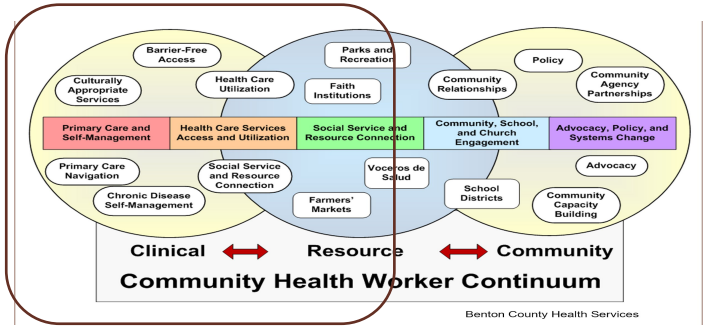
Lizdaly Cancel-Tirado, CHW
Benton County Health Navigation

Integral member of the primary care team

Help clients navigate the healthcare system

Focus on utilization of services

- Clinical system navigation
- Care coordination
- Client advocacy



Provide

- Chronic disease prevention
- Self-management education and support
- Nutrition and exercise coaching

Barrier-busting and cultural mediation between *clients, families, and care teams!*

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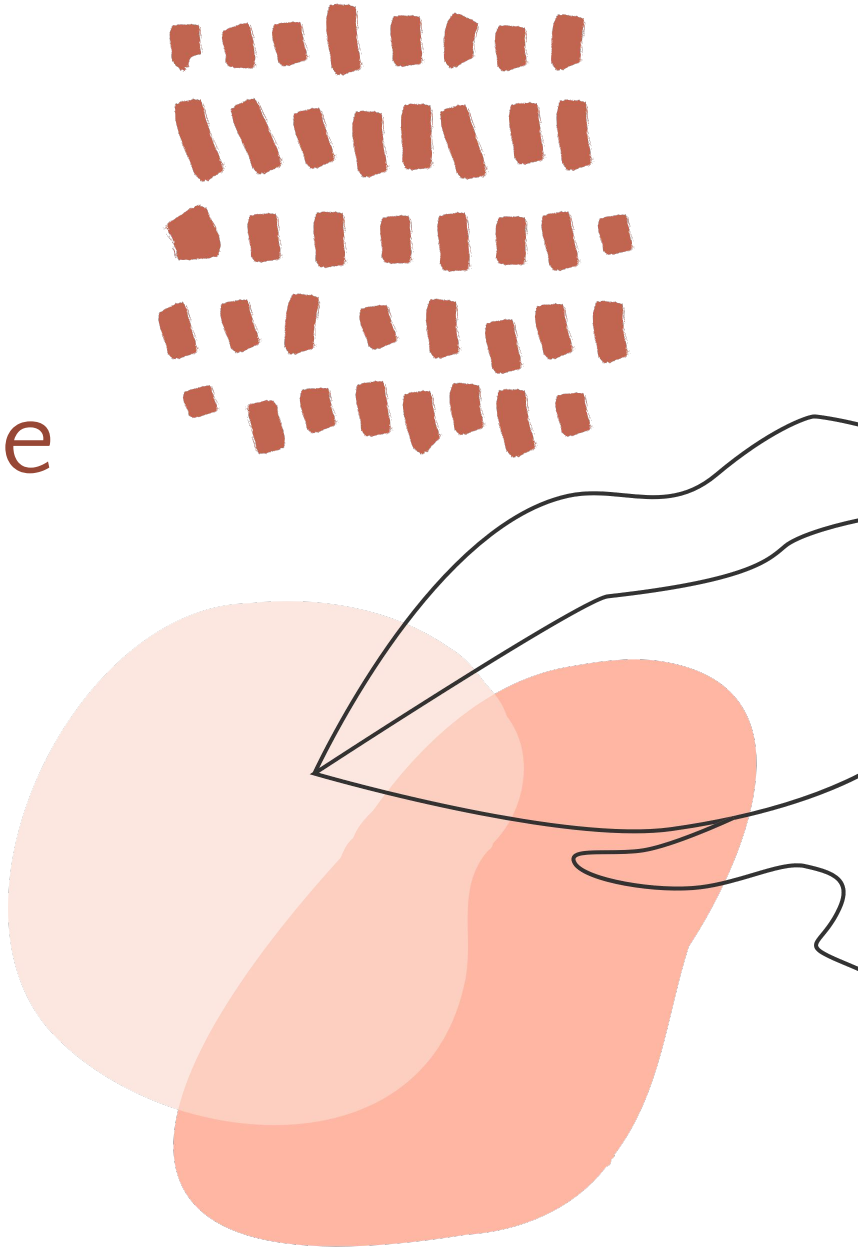
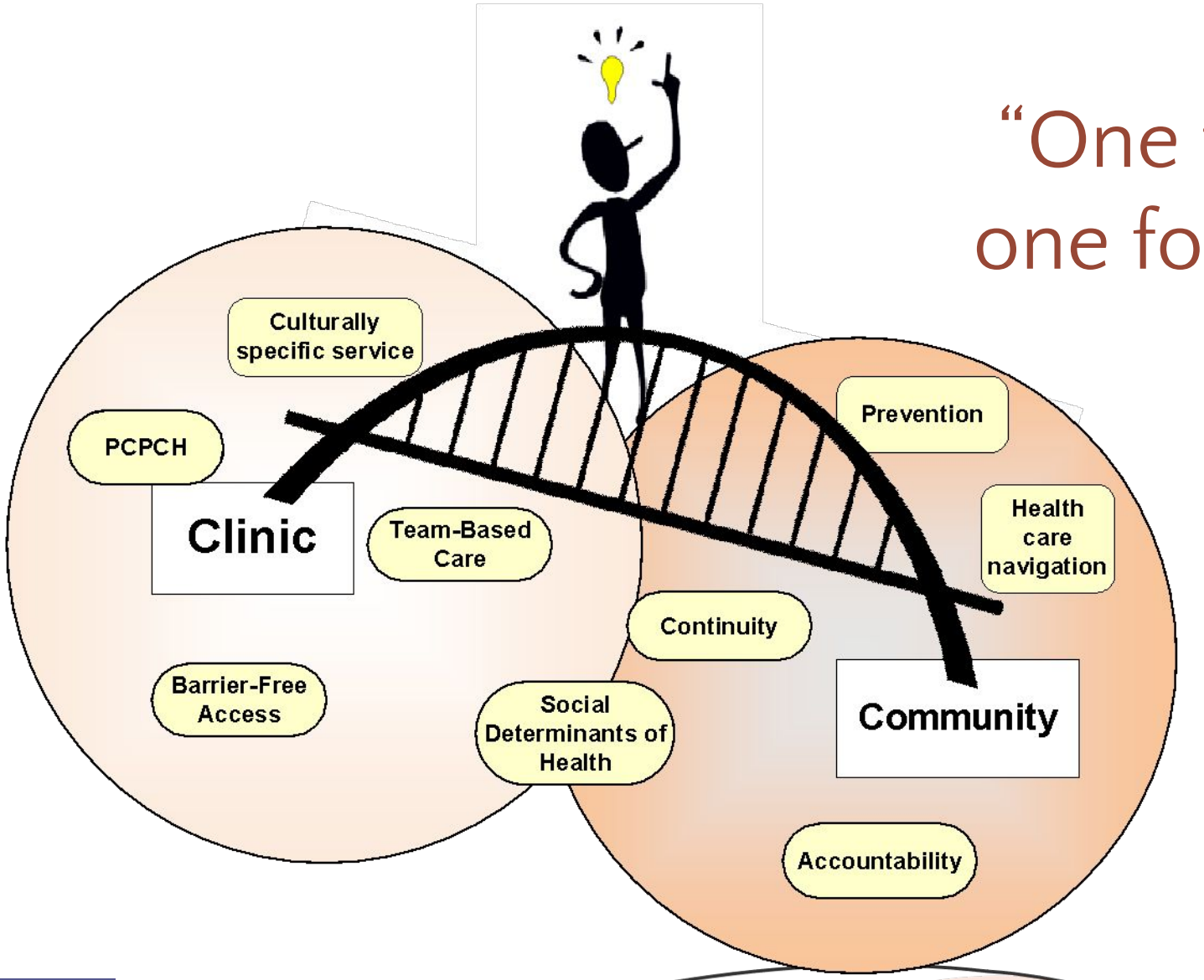
No matter what role they play,
the most important word in the title
“Community Health Worker”
is not *Health…*

It is ***Community!***



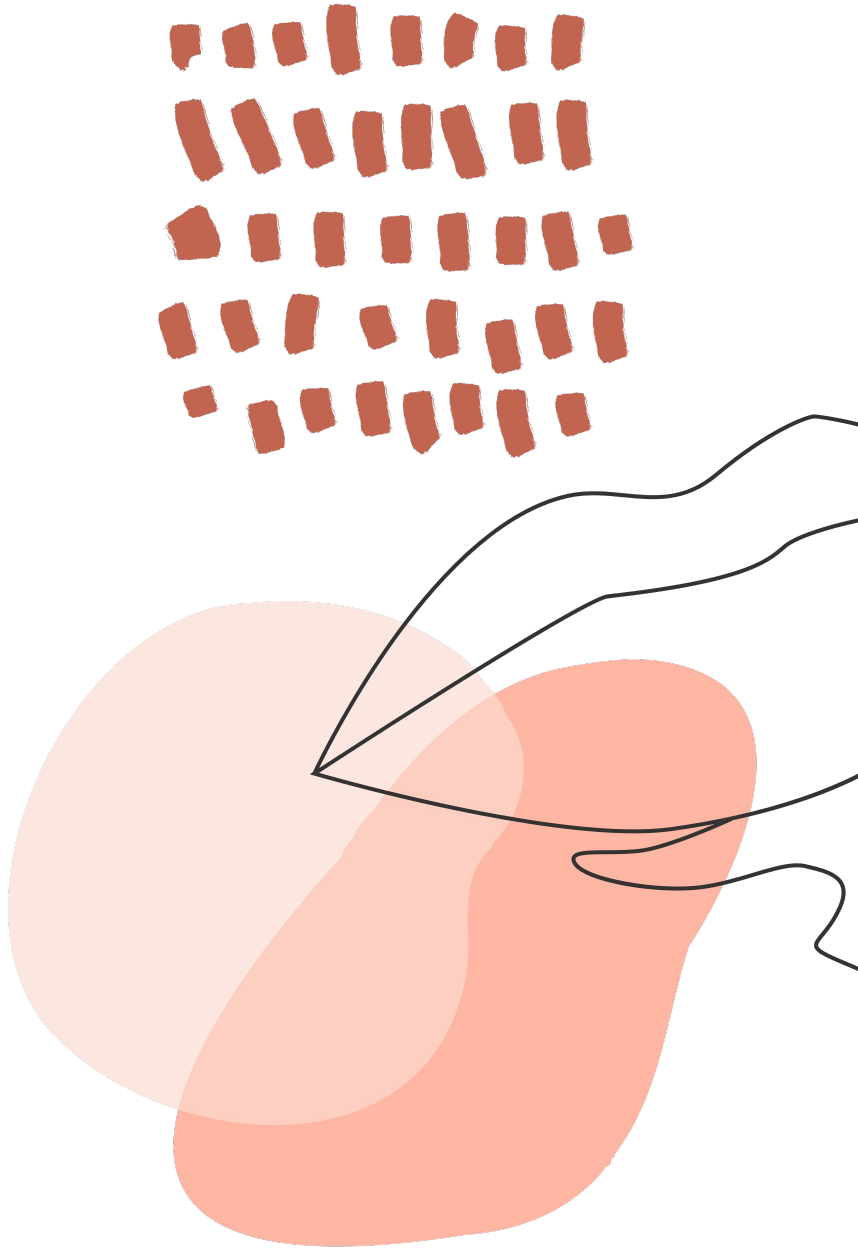


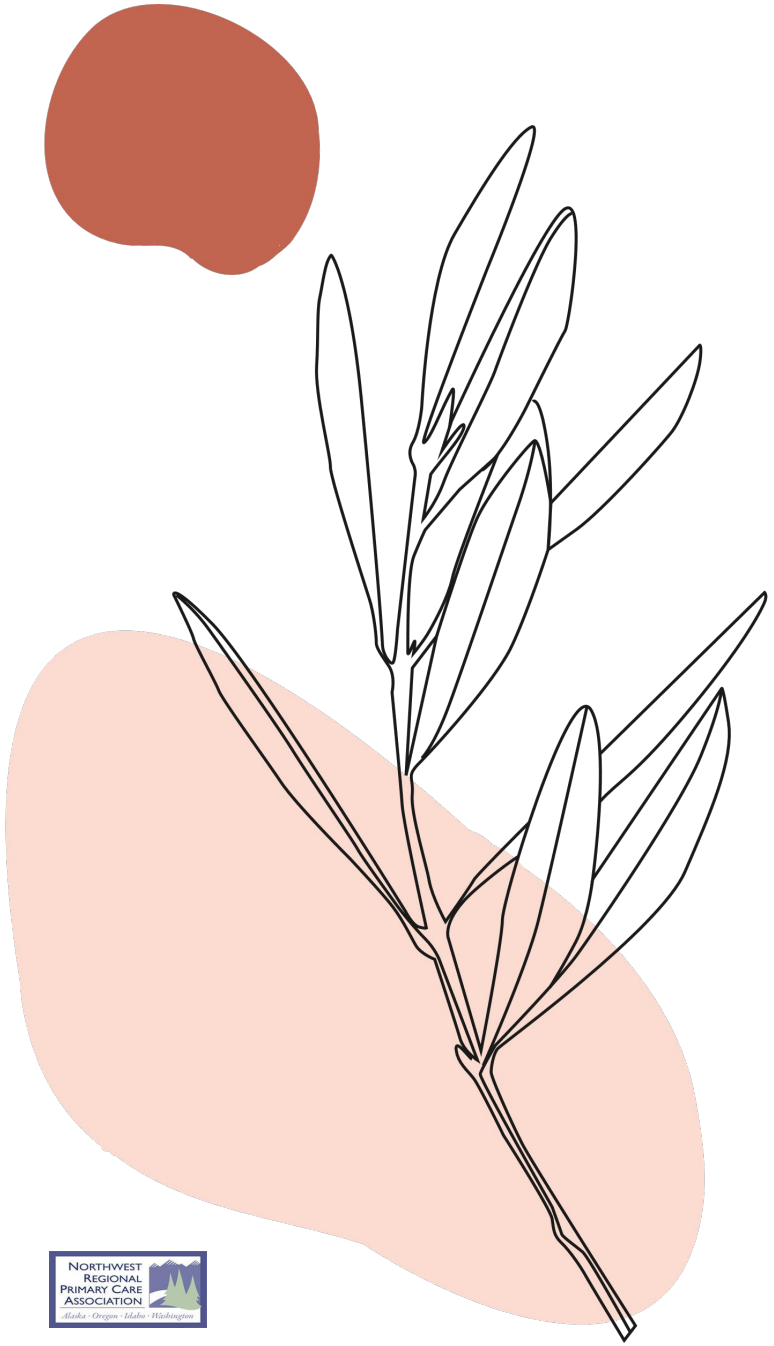
"One foot in the **Clinic** and one foot in the **Community**"

To maintain community trust, a ***clinical*** CHW must keep their connection with the ***community***

"I don't feel that community health worker is a job title. And there's no one job description necessarily...and you can call them whatever you want to. But they have to have the *heart* of a health worker."

"Promotoras de salud nacen, no se hacen."





Why integrate a CHW into a primary care clinic?

I'm glad you asked...

CHWs – An integral member of the care team!

Can help care team provide:

Comprehensive care

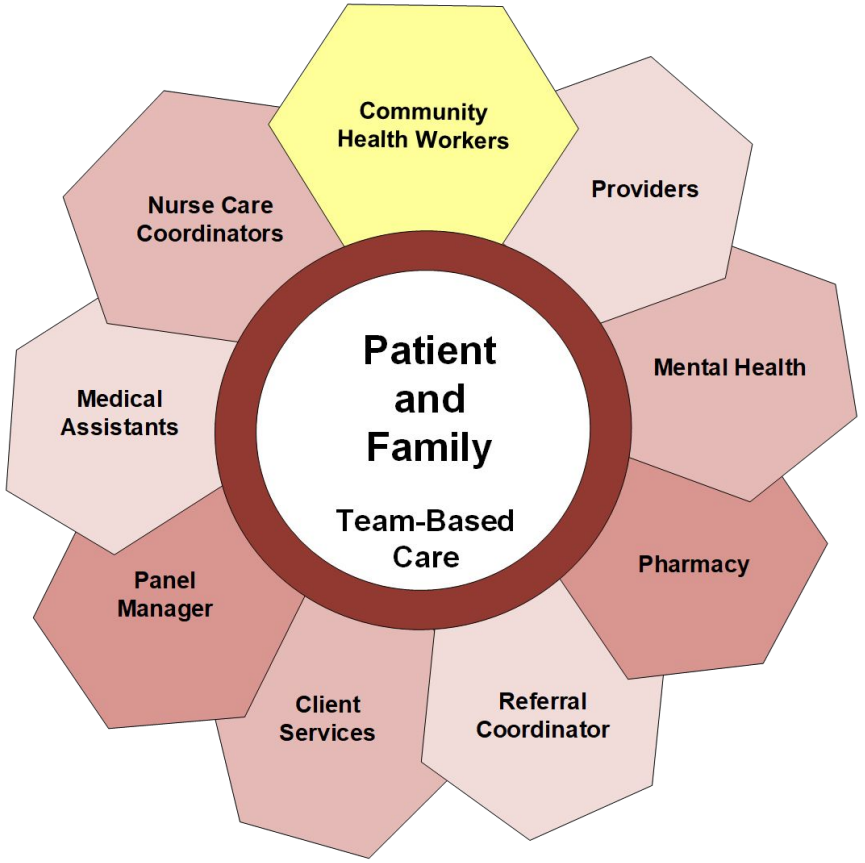
- Enabling services
- Resource navigation

Client-centered care

- Culturally and linguistically specific
- Act as patient advocate

Coordinated care

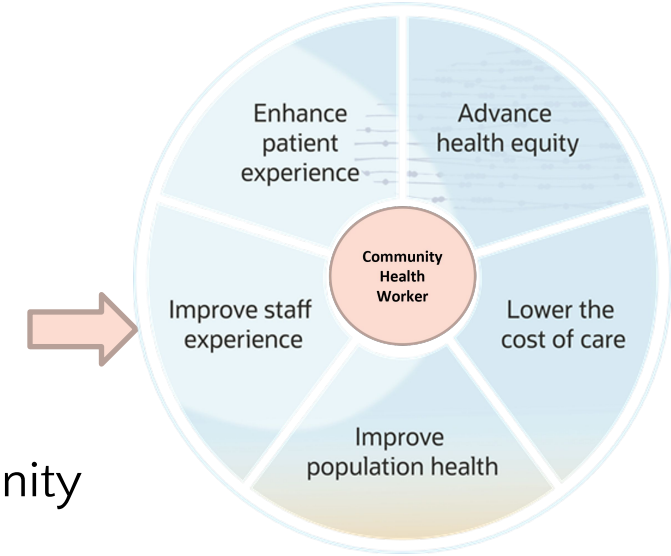
- Help with primary care/specialty care referral
- Connect and coordinate community resources
- Chronic disease education and support



Improve staff experience

Care team members feel less stress when

- They *know* that clients are getting their SDOH needs met
- Clients are receiving coordinated care
- Care is culturally and linguistically-specific and appropriate
  - Especially when care team members are not from the community



The "Quintuple Aim"

Care team members feel more satisfaction when

- Relationships with client, family, and community are strengthened and based on trust
- Clients and families are engaged and involved with the care team and their care plans
- Progress is made and ***health outcomes improve***

"Pretty much every day I'm feeling lucky that we've got the support of CHWs to keep in touch with complex patients between MD visits."

Enhance patient (and family) experience

SDOH (Social Drivers of Health) resource connection

- Connect client/families to food, housing, clothing resources in community

Reduce barriers to care

- Assist with transportation, paperwork, appointments

Communication

- CHW can help client understand medical language, care team interactions, and care plan

Patient engagement

- Increase client and family self efficacy and activation

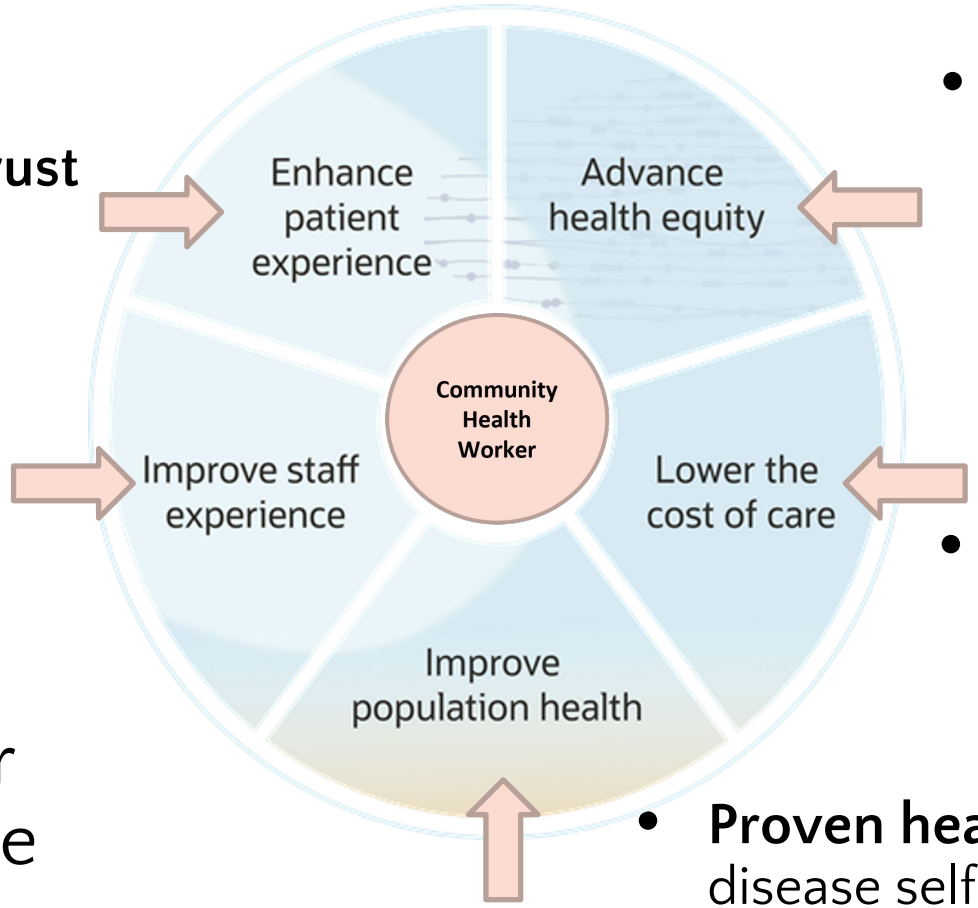
The “Quintuple Aim”

“With a CHW / HP** present, it helped the patient feel much more comfortable, educated and on the same page with the treatment plan.”

**HP=Health Promoter

Value-add has already been shown…

- **Improved patient communication and trust**
- **Increased staff satisfaction**



- **Increase health equity:** Linguistic, cultural, socio-economic understanding and specific services
- **ROI studies:** Studies show up to $3.00 ROI for $1.00 spent
- **Proven health outcomes:** Chronic disease self-management, SDOH and resource navigation

…not to mention their high profile during the pandemic…

...So why do we STILL have to justify CHW programs??

How do we support and sustain CHW programs?

https://www.nustep.com/community/blog/theres-no-quick-fix-just-hard-work/

Some possible creative funding scenarios

- Medicaid reimbursement
- “Blending and braiding” funding streams
  - Grants, “wrap” funds, CURF (county unrestricted funds); contracts
- Making the case for how your CHW program…
  - Benefits patients *and* care team
  - Helps you meet your Quintuple Aim and Health Equity goals
  - Improves population management
  - Helps your HC meet their metrics

Medicaid reimbursement? YES! Well…maybe?

YES!

- One way to pay – at least partially – for CHW services
- May create a path forward for sustainability
- Although NO national model, some states are working on it
    - As of 7/2022, 29 states allow Medicaid payment for CHW services*

Maybe?

- Current reimbursement unlikely to fully sustain a program –esp if CHW is paid a living wage with full benefits!
- CHW may need approved training or certification for services to be reimbursable
- Only reimbursable for Medicaid patients and/or certain types of services
- Need for certification may exclude valuable, grassroots CHWs

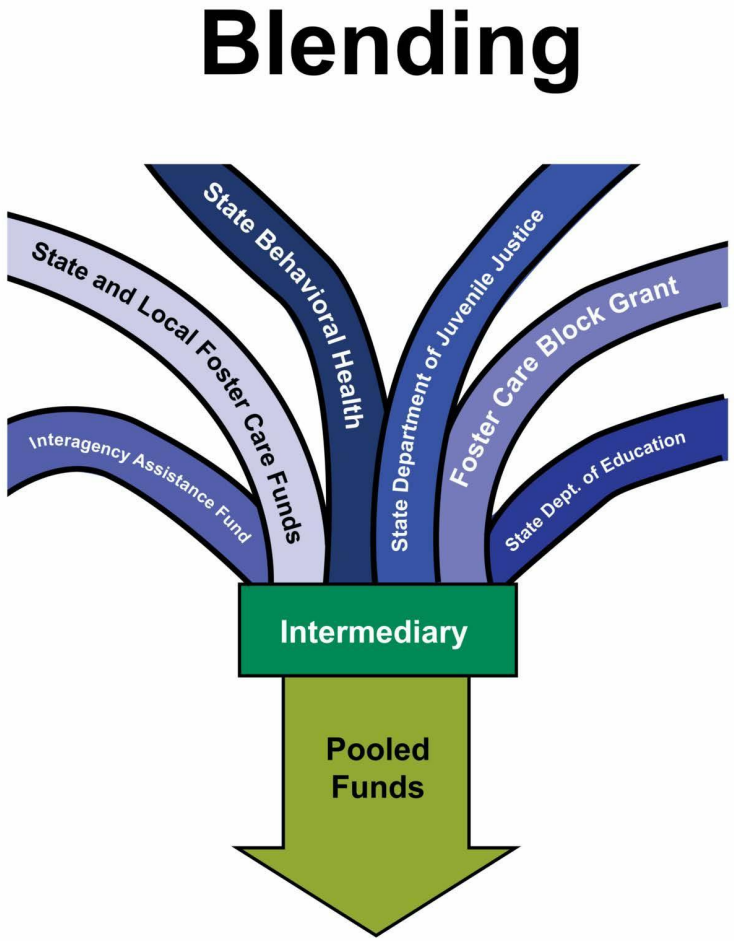
NOTE: CMS reimbursement should only be one 'thread' of your funding strategy

*https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/

Blending funding streams

- Combining or mixing funds from 2 or more funding sources together to support a specific part of a program or initiative

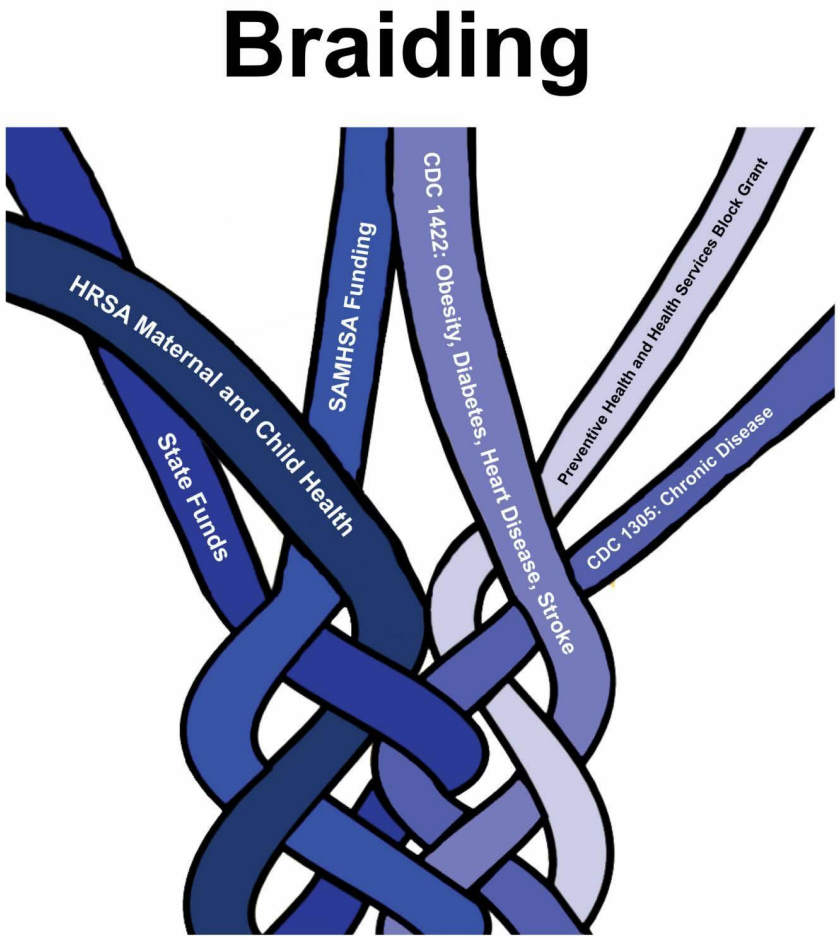
- Costs are not necessarily allocated and tracked by individual funding sources



Adapted from the National Academy for State Health Policy, June 2016.
https://nashp.org/wp-content/uploads/2016/06/CSA-Virginia-Brief-1.pdf

Braiding funding streams

- Two or more funding sources are coordinated to support the total cost of a service
- Revenues and expenditures are tracked by different categories of funding sources
- Cost allocation methods are required to ensure proper accounting (ex – no “double dipping”)



Adapted from the National Academy for State Health Policy, December 2017.
https://nashp.org/wp-content/uploads/2017/12/deBeaumont.pdf

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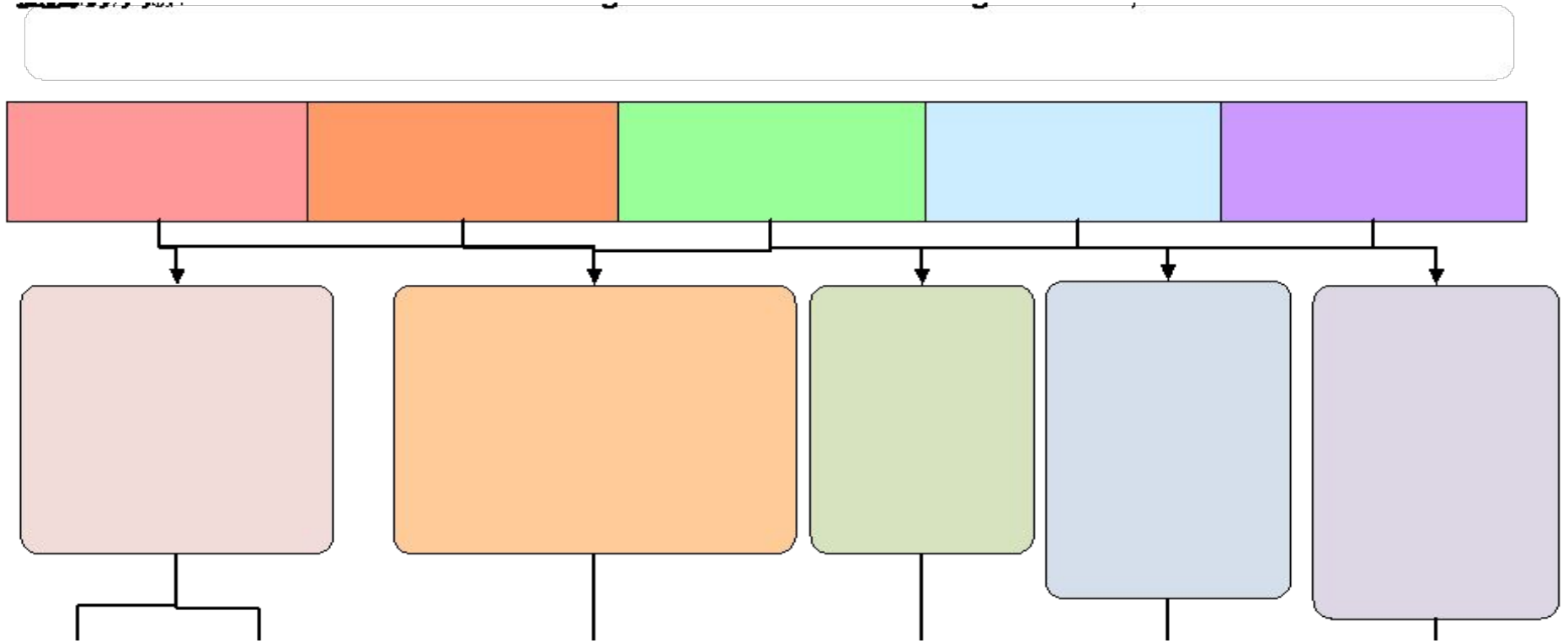
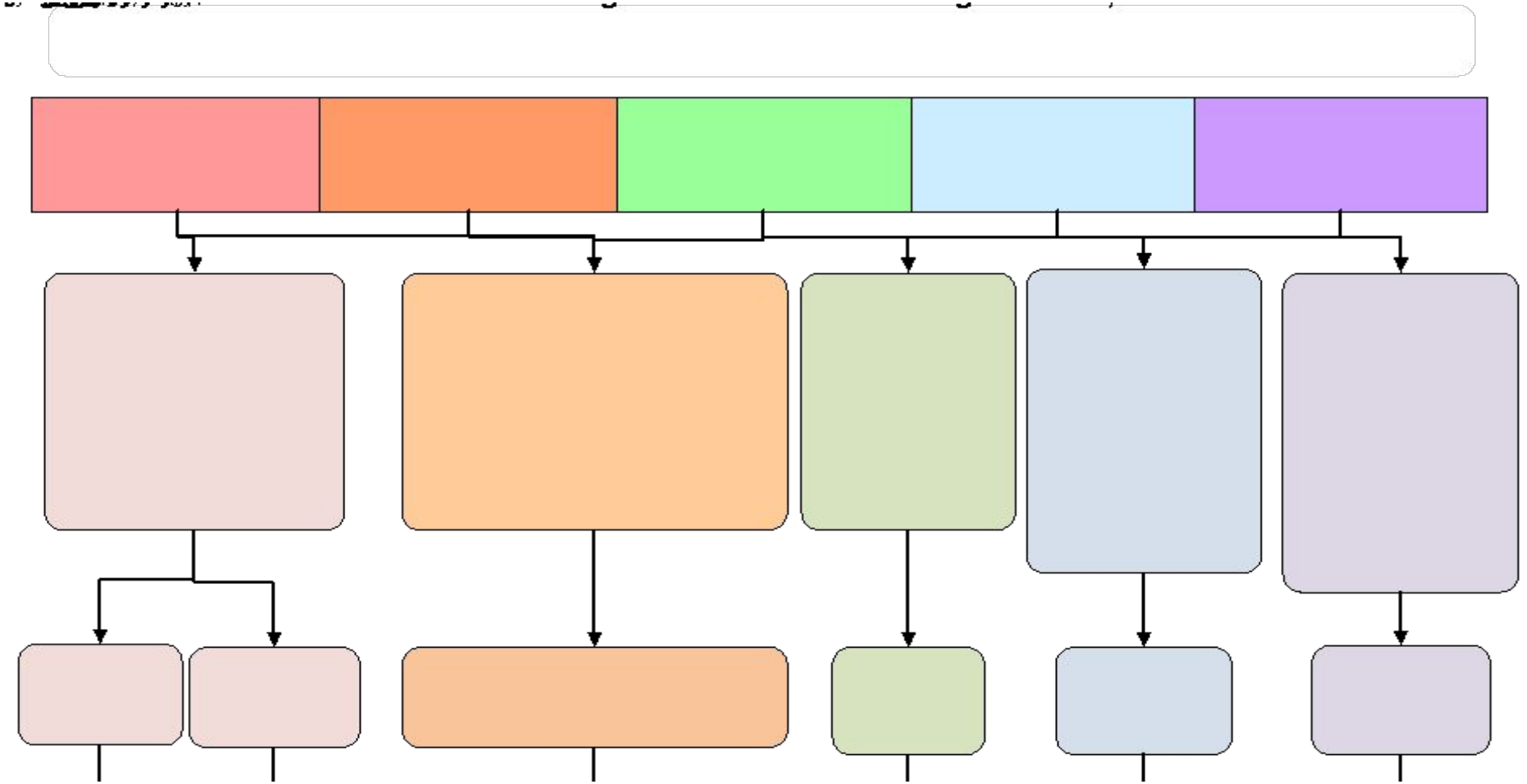
Benton County Health Services, Health Navigation Program

- **5 separate programs**



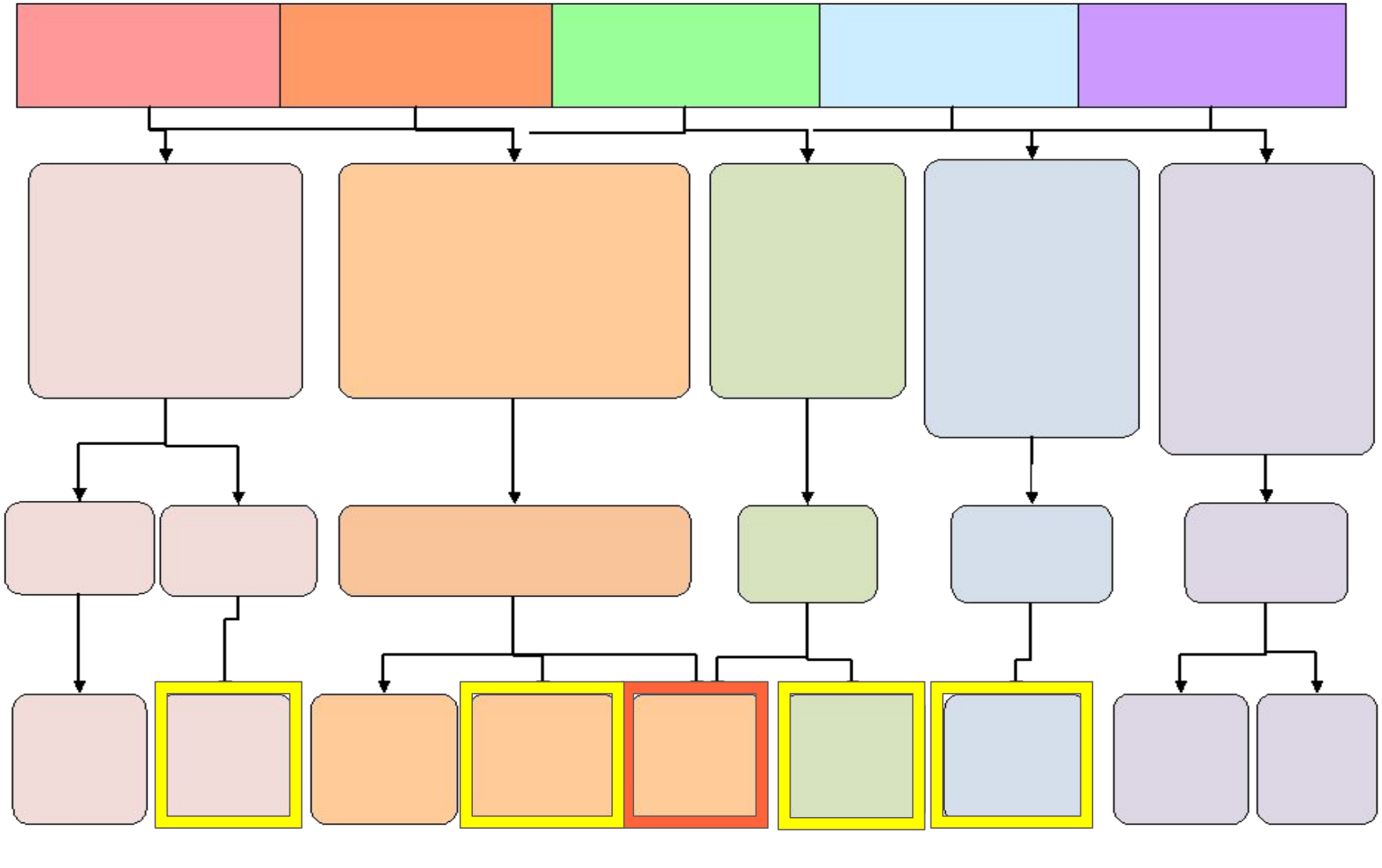
Benton County Health Services, Health Navigation Program

- **5 separate programs**
- **26 CHWs**



Benton County Health Services, Health Navigation Program

- **5 separate programs**
- **26 CHWs**
- **13 funding streams**



Making the case for our CHW program

For sustainability, I needed DATA

- Long before the CCOs…I needed to show the "value-add" of having CHWs on the care team
- Created tracker for CHWs to collect info about what they were doing
- Started counting the "touches" they were providing to clients
  - Referrals, phone calls, tangible assistance (i.e., transportation, paperwork, etc.)
- This didn't completely capture the amount of work being done

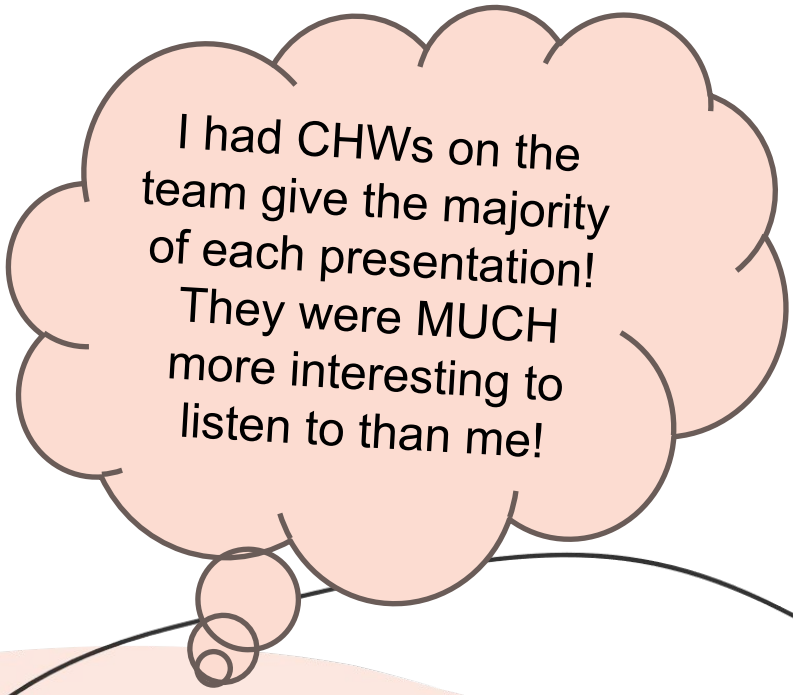
Touch-Time tracking

- Not all touches take the same amount of time
- Needed a way to quantify how much time being spent per touch
- Used Excel spreadsheet
  - Now many programs use the EHR to capture CHW touch/referral data

Referral Data									
# of Referrals **Housing**	# of Time Units (TU) **Housing**	# of Referrals **Food**	# of TU **Food**	# of Referrals **Clothing**	# of TU **Clothing**	# of Referrals **Primary Care**	# of TU **Primary Care**	# of Referrals **Health Insurance**	# of TU **Health Insurance**

Using data to tell the story

- Turned data into a pretty table
- Put table into a presentation about the amazing work the CHWs were doing
- Included a "Story From the Field" – *another great way to show what your CHWs are doing!*
- Gave the presentation to EVERYONE
  - Providers and care teams
  - Clinic Board of Directors (at least twice a year for the first 3 years!)
  - County Board of Commissioners
  - Local CCO
  - Local hospital directors and executives
  - Anyone who asked…and some who didn't!



Telling the story in 2014…

Update: Health Navigation Services

CHC Board of Directors
October 2014

Kelly Volkmann
Health Navigation Program Manager

How HNs help the CHC achieve the "Quadruple Aim"

- **Better Health**
  - Increase client understanding and use of preventive and primary care services
- **Better Care**
  - Increase engagement, treatment adherence, system navigation
- **Lower Costs**
  - Provide team-based services at appropriate "level of license"
- **Health Equity**
  - Culturally and linguistically appropriate services

Resource Health Navigators

- Cover Oregon a success story for us!
  - 9/2013 – 9/2014, Cover Oregon HNs assisted **856 clinic clients** with CO enrollment
- Other numbers
  - 1,535 – number of applications completed
  - 2,547 – number of people who applied
  - 2,194 – number of OHP-eligible
  - 7,300 – estimated number of people CO navigators spoke to at events, meetings, etc

External recognition growing…

- Centers for Disease Control
  - Want to interview us as "an example of an FQHC that effectively utilizes CHWs."
- Oregon Health Authority
  - Asked to participate as a panelist at the Oregon Community Partner Multicultural Summit
  - Recognition of the work we have done engaging diverse communities in Cover Oregon enrollment

Because we had the data…

- I used it to write – and receive – numerous grants
- Our clinic began to understand the value the CHWs were bringing to the patients…and to the care teams and providers
- The local CCO became very interested in learning more about CHWs and how they could support them
  - I received a grant for $174,000 to implement a Clinical CHW program in 4 of their primary care clinics!
- Oregon PCA developed Care STEPs (think of them as "Touches 2.0")
  - I used them to give input to our local CCO about ways to track and count CHW work…and potentially how to pay for their services!

SDOH data and grant reports

- HRSA Community-Based Workforce grant in 2021
  - Pass-through funding to 3 CHCs and 1 CBO to support CHWs and COVID vaccine education to farmworker communities
- Asked CHW teams to collect SDOH referral information in addition to grant data
- Used this data to create a picture of breadth and scope of CHW services
- Monthly reports back to HRSA and to agencies contained data table
  - Also included “Stories from the Field”

HRSA Grant data table:

Dates	Vaccine Data	Outreach Data		Referral Data					All Totals
9/2021 to 3/2023	vaccine appointments scheduled	outreach events and activities	Individuals reached through outreach	Housing	Food	Clothing	Primary Care/ dental	Health Insurance	All referral Totals
Totals to Date	**1,812**	**1,111**	**56,680**	**1,420**	**6,620**	**1,180**	**2,863**	**3,377**	**75,063**

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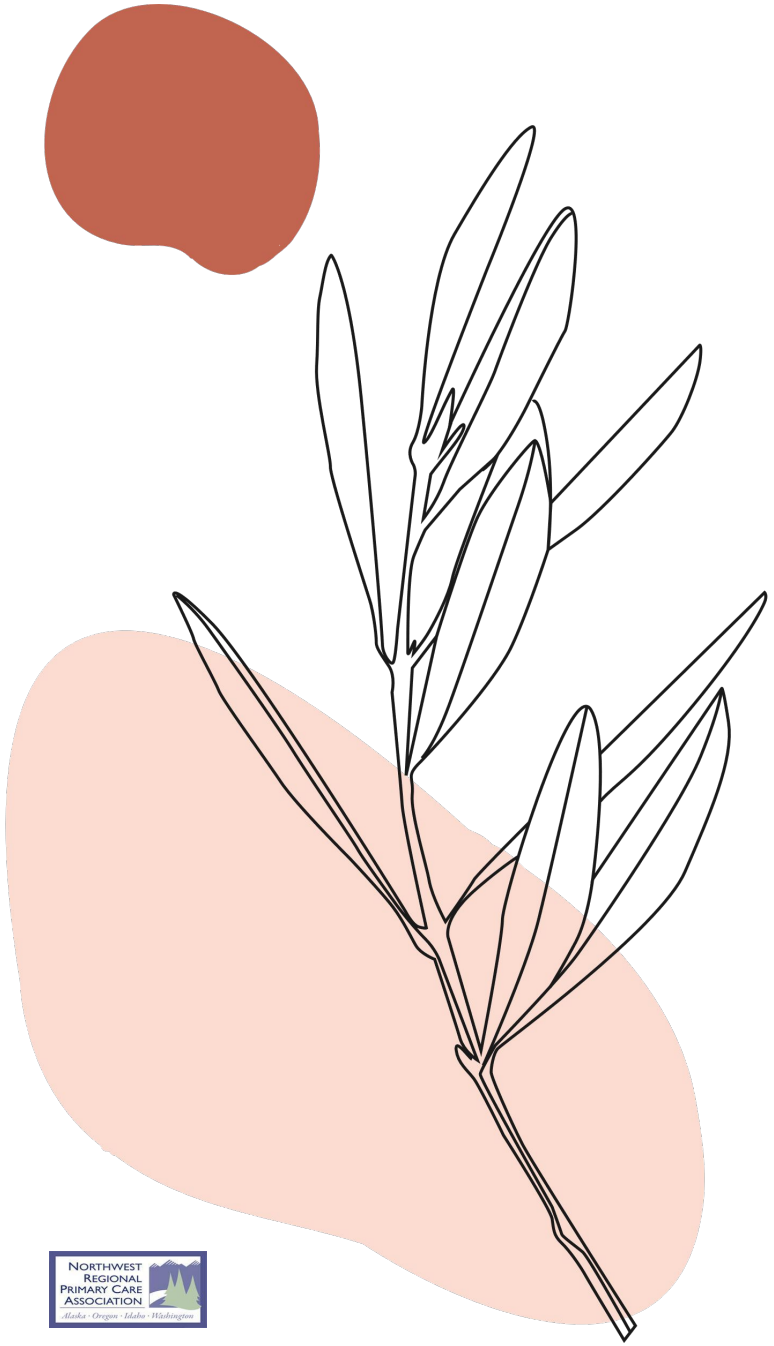
Create a CHW "Story Bank"

- Ask CHWs to collect and de-identify stories of clients/patients they have helped
  - Include the issues, barriers, strategies, and outcomes
- This is a GREAT way to show the difference a CHW makes in the lives of your patients…

"Stories are remembered up to 22 times more than facts alone"

Jennifer Aaker, Stanford Marketing Professor

https://smallbusinessmajority.org/sites/default/files/share-your-story-300.jpg



Your Turn!

What strategies do YOU use to fund your CHW programs?

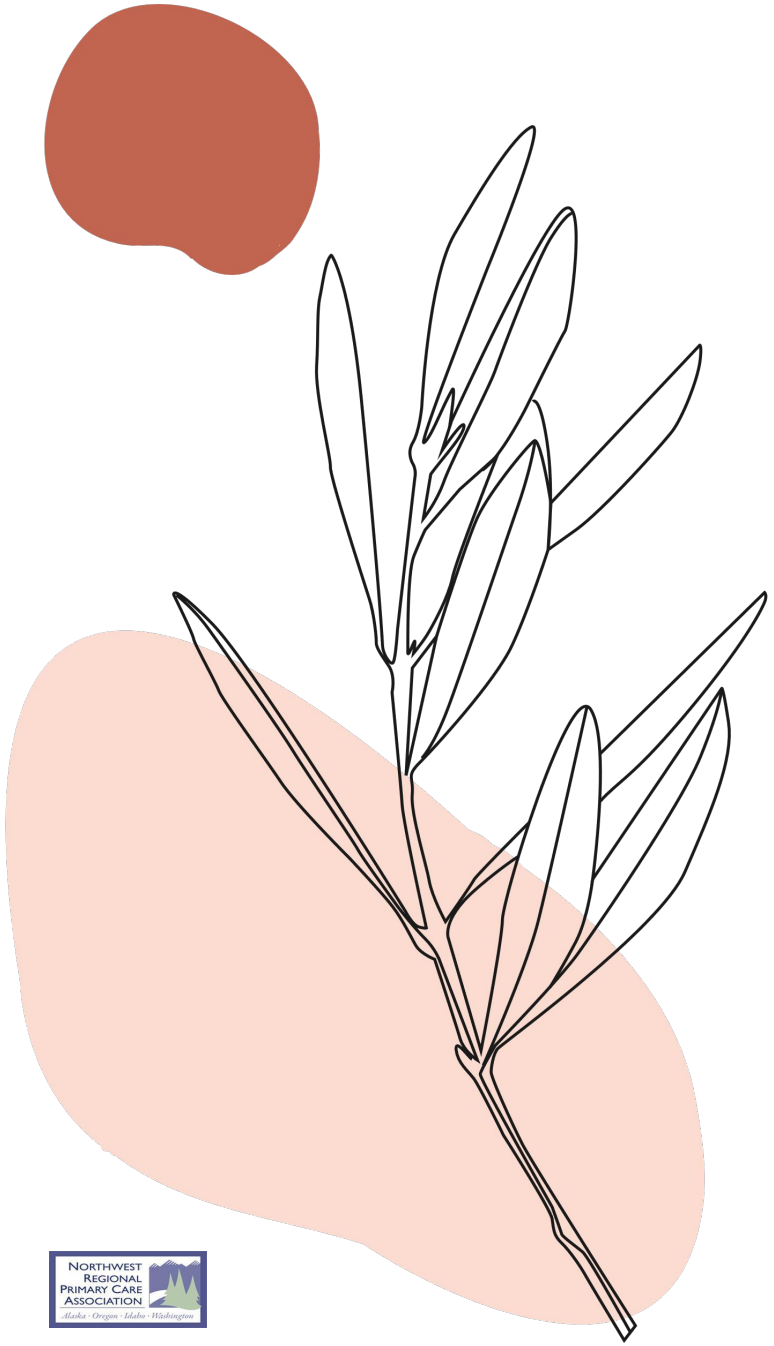
Thoughts?

Questions?

I would love to learn from YOU!

Resources

- “Medicaid Coverage of CHW Services” pdf: https://www.macpac.gov/publication/medicaid-coverage-of-community-health-worker-services/
- ASTHO- “CHWs: Evidence of Their Effectiveness” https://nachw.org/resources/
- Blending/braiding funding streams: https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending
- MARC CHW Toolkit: https://www.marc.org/aging-health/community-health-workers/chw-toolkit



Thank you!

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kvolkmann@nwrpca.org