

Community Health Workers: Supporting Diabetes Prevention in Michigan



MICHIGAN DIABETES PREVENTION NETWORK
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March 31, 2016 | Okemos, Michigan

*MiCHWA is supported by grants and contracts and housed at the
University of Michigan School of Social Work.*



Michigan Community Health Worker Alliance (MiCHWA)



The Michigan Community Health Worker Alliance's mission is to promote and sustain the integration of community health workers into Michigan's health and human service systems through coordinated changes in policy and workforce development.

Agenda Overview

- Describe the role Community Health Workers play in promoting health and prevention in Michigan
- Discuss the role of Community Health Workers in addressing prediabetes and diabetes
- Identify roles for CHWs as leaders of evidence-based programs, including the Diabetes Prevention Program



The Community Health Worker Role

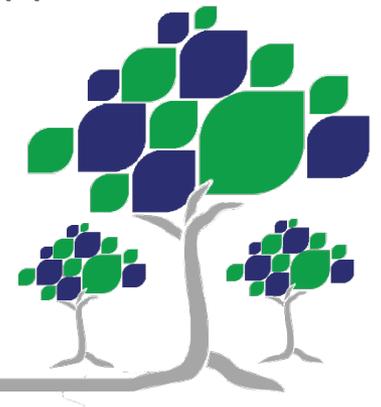


- What is a CHW?
- How does a CHW build relationships with patients?
- What can a CHW do?
- Why are CHWs effective at getting results?

What is a CHW?

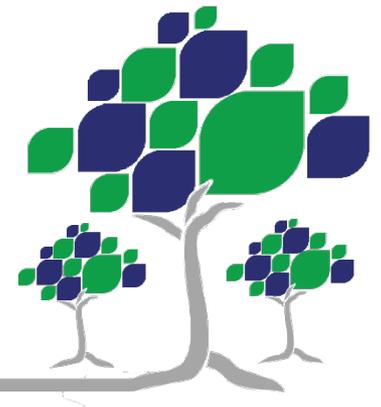
A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.



Who are CHWs in Michigan?

- Community members or residents with an unusually close understanding of the population they are serving
 - Group membership, life/shared experience, geography, etc.
 - Passionate about connecting people
- Education background: high school diploma/GED
 - Trained specifically to be a Community Health Worker
 - Training is core competency-based
- Non-clinical member of the health care team



CHWs in Michigan

How long have they been here?

- First formally trained to provide services in Michigan in the 1960s

Where do they deliver services?

- Community health centers, community events, client homes, non-profit agencies, schools, provider offices

Who employs them?

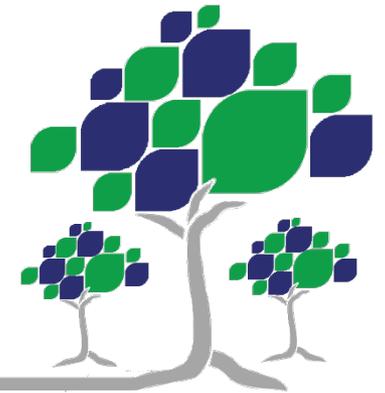
- Community-based service agencies, Federally Qualified Health Centers, health systems, non-profits, academic or research institutions, government agencies, health plans, local health departments



What do CHWs do in Michigan?

CHWs play many roles, including

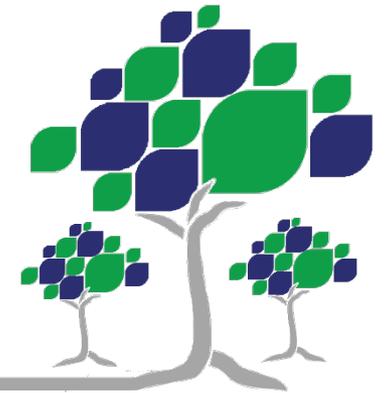
- Case management and care coordination
- Community/cultural liaison
- Health promotion and health coaching
- Home-based support
- Outreach and community mobilization
- Participatory research
- Systems navigation



What do CHWs do in Michigan?

Case Management & Care Coordination

- Family engagement
- Assessing individual strengths and needs
- Addressing basic needs
- Promoting health literacy
- Coaching on problem solving
- Developing goals and action plans
- Coordinating referrals and follow-ups
- Providing feedback to medical providers



What do CHWs do in Michigan?

Community-Cultural Liaison

- Community organizing
- Advocacy
- Translation and interpretation of information
- Assessing community strengths and needs



*The opportunity to walk in two worlds at one time:
“We serve as facilitators: we take one message
from one group and we bring it up and we make
those connections work, all for the goal of
seeing improved health outcomes.”*

*Tressa Crosby, CHW
Health Project (Muskegon)*

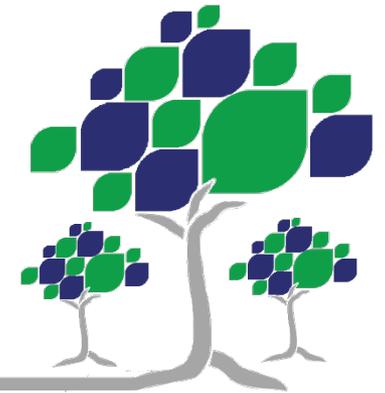


What do CHWs do in Michigan?

Health promotion and health coaching

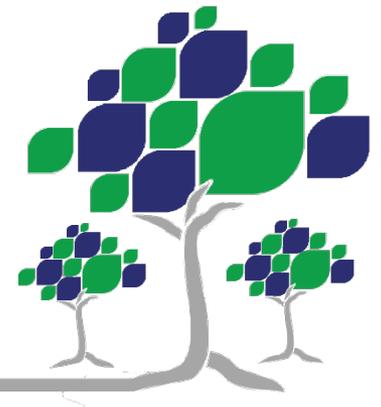
- Translating and interpreting health information
- Teaching health promotion and prevention behaviors
- Coaching on problem solving
- Modeling behavior change
- Promoting health literacy
- Reducing harm
- Promoting treatment adherence
- Leading support groups

Includes evidence-based programs like DPP, PATH



What do CHWs do *on a team*?

- Complement existing team members
 - CHWs do not replace existing care team members
- Bridge between the community and clinic
 - Often based in one location but work in the other
- Address social determinants of health in a unique way from other care team members
 - Convey patient/client backgrounds, constraints and preferences in a culturally appropriate way
 - Identify client barriers including housing, transportation, education, literacy, etc.



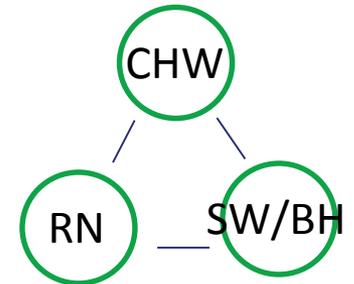
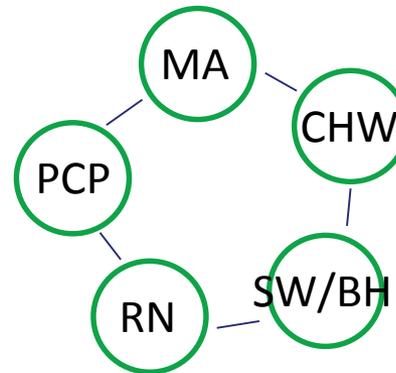
Source: Allen CG, Escoffery C, Satsangi A, Brownstein JN. Strategies to improve the integration of community health workers into health care teams: "A little fish in a big pond." *Preventing Chronic Disease*, 2015;12(E154):1-10.

Findley S, Matos S, Hicks A, Chang J, Reich D. Community health worker integration into the health care team accomplishes the Triple Aim in a patient-centered medical home: a Bronx tale. *J Amb Care Manage*, 2014;37(1):82-91.

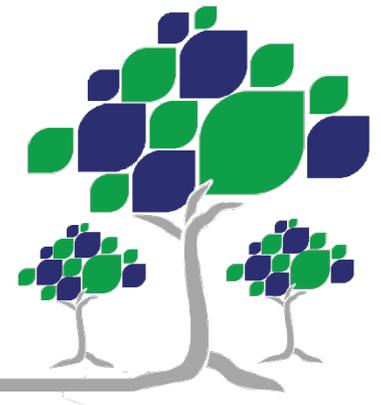
Existing Team Structures

Team Members CHWs Work With

- Registered Nurse
- Social Worker
- Primary Care Provider
- Other CHWs
- Case Manager
- Medical Assistants
- Dietician/Nutritionist
- Health Educator
- Outreach & Enrollment
- Psychologist



*Not inclusive of all teams;
team member composition
varies by site/program*



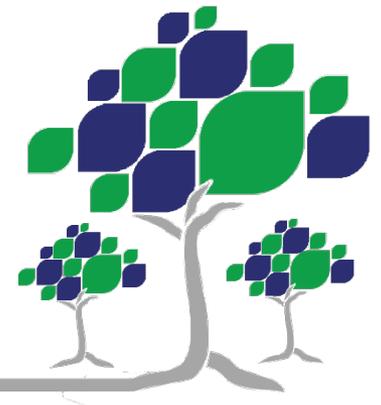
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Why CHWs?

Demonstrated clinical effectiveness

- Decrease in incidence of low birth weight and inadequate prenatal care in women in medically underserved areas
- Increase in prenatal care usage and access
- Decrease in HbA1c levels and improvement in blood glucose testing adherence
- Increase in cervical and breast cancer screenings
- Decrease in depressive symptoms
- Decrease in asthma symptoms



Why CHWs?

Community Impact

- Reduction in unnecessary ED visits
- Increase in appropriate usage of healthcare resources
- Increase in knowledge of cancer and cancer screening among minority populations
- Reduced stress related to neighborhood safety
- Increase in availability of healthy foods and knowledge of those foods and their benefits
- Reduction in number of missed school days



National Support

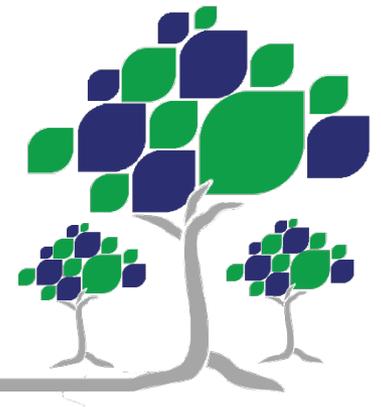
“Scaling up the use of CHWs presents a unique set of obstacles, but it is also possible to chart a roadmap forward. The potential to improve care for vulnerable populations, help achieve the Triple Aim of better care, better health and lower costs, and advance population health is too promising to be deterred.”

Bringing Community Health Workers into the Mainstream of U.S. Health Care

Institute of Medicine Discussion Paper, 2015

Note: IOM is now NAM (National Academy of Medicine)

Source: <http://nam.edu/wp-content/uploads/2015/06/chwpaper3.pdf>



National Support

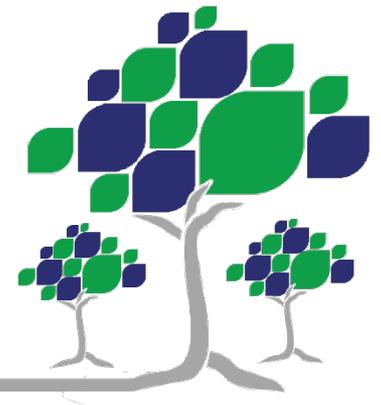
Reports (2014 & 2015)

- CMS: Equity Plan for Improving Quality in Medicare
- CDC Policy Brief “Addressing Chronic Disease Through Community Health Workers”
- National Health Policy Forum: CHWs & Primary Care

Ongoing Initiatives

- Office of Minority Health (DHHS)
- Office on Women’s Health (DHHS)
- American Public Health Association

Source: <http://www.michwa.org/resources/research-evidence/>
https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf
http://www.cdc.gov/dhdsp/docs/chw_brief.pdf
https://www.nhpf.org/library/forum-sessions/FS_07-31-15_CHWPrimaryCare.pdf



National Policy: PPACA 2010

The Patient Protection & Affordable Care Act cites CHWs:

- §5101: CHWs listed as “health professionals” and as an important part of the health care workforce; a comprehensive CHW definition is included
- §5313: CDC authorized to fund agencies who train and use CHWs to promote positive health behaviors and outcomes for populations in medically underserved communities; CHW functions include outreach, enrollment, and patient education
- §5403: mandates Area Health Education Centers to provide interdisciplinary training of health professionals, including CHWs



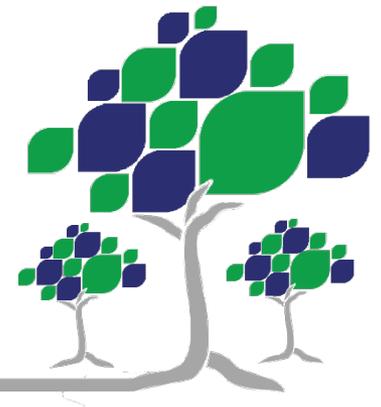
Source: PPACA 2010.

Martinez J, Ro M, Villa NM, Powell W, Knickman JR. Transforming the delivery of care in the post-health reform era: what role will community health workers play? *American Journal of Public Health*. 2011;101(12):e1-e5.

Standard Occupational Classification

Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091).

Bureau of Labor Statistics, 2010
#21-1094



CHWs & Diabetes and Prediabetes



- How do CHWs impact patients with diabetes and prediabetes in Michigan?
- How can CHWs support evidence-based programs, including DPP?
- How can CHWs offer ongoing support to diabetic or prediabetic patients?

Michigan Programs

- Spectrum Health's Core Health Program
- Michigan Pathways to Better Health
- MPCA's Linking Clinical Care to Community Supports (LC3S)
- The REACH Detroit Partnership
- MDHHS' 1422 Efforts

Agencies including county health departments, health systems, FQHCs, and others also utilize CHWs in working with the diabetes and prediabetes populations

Note: additional programs target health and lifestyle behaviors that impact diabetes and prediabetes, including healthy eating, physical activity, etc.



CHWs & Chronic Disease

Evidence

- Significant clinical and cost savings evidence and support for CHWs who work with patients diagnosed with chronic diseases
- Over half of Michigan programs address chronic disease

Opportunities

- Evidence-based programming (DPP, PATH, Enhance Fitness)
- State and federal incentives to address the chronic disease population (dual diagnoses, quality improvement)

Source: CDC http://www.cdc.gov/dhdsp/docs/chw_brief.pdf
Michigan Community Health Worker Alliance Program Survey 2014; Health issues of clients (N=31)
CDC 1422 <http://www.cdc.gov/chronicdisease/about/foa/2014foa/public-health-action.htm>
Million Hearts http://millionhearts.hhs.gov/files/MH_CommHealthWorker_Factsheet_English.pdf



CHWs & Chronic Disease: Evidence

Evidence

- CDC supports the use of CHWs for prevention and intervention among patients with various chronic diseases
- Literature reviews consistently validate the role that CHWs play in diabetes self-management education and diabetes prevention, specifically among minority populations
- AADE recognizes CHWs are valuable supports for patients engaging in diabetes self-management education

Source: CDC http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

CDC 1422 <http://www.cdc.gov/chronicdisease/about/foa/2014foa/public-health-action.htm>

Million Hearts http://millionhearts.hhs.gov/files/MH_CommHealthWorker_Factsheet_English.pdf

2013_Shah, Kaselitz, Heisler_The Role of Community Health Workers in Diabetes-Update on Current Literature

AADE Practice Levels for Diabetes Educators and Diabetes Professionals, 2016



CHWs & Chronic Disease: Opportunities

Diabetes Prevention Program

- CHWs can be trained to serve as lifestyle coaches, teaching or assisting with the DPP classes across the state
- CHWs can also serve as referrers to DPP, working with eligible participants to promote the program, reduce barriers to program participation, and demystifying what the program is
- CHWs can also experience DPP as participants, in conjunction with patients or independently, if they qualify per the clinical guidelines



Profile: DPP Lifestyle Coach



Alice Walker

Outreach Peer Educator (CHW)
Jackson County

Prevention is huge in our county. If you can prevent something from happening, that is great. There are a lot of diabetics here, and my family has been touched with it.

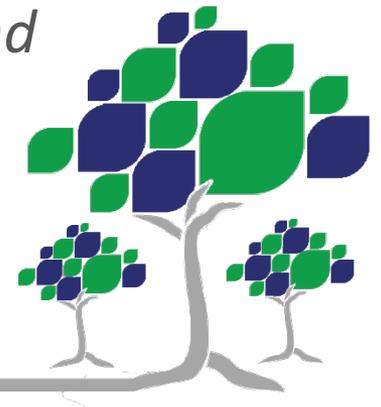


Profile: DPP Lifestyle Coach



What's the most rewarding aspect about being a lifestyle coach?

Participants coming back and sharing about, for example, how they have learned to read food menus, or new ways to prepare food. Participants' faces light up when they have lost 7% of their body fat. That is a huge reward and a huge payoff. As a lifestyle coach, you can't help but to root them on!



CHWs & Chronic Disease: Opportunities

Policy & Systems Changes

Current policy and systems activity directly supports prevention activities and CHW involvement

- CMS Prevention Rule Change (July 2013)
- Michigan Medicaid Managed Care Contracts (May 2015)
- CMS Preventing Readmissions Guidance (September 2015)
- CDC Policy Best Practice (January 2016 / November 2014)
- Health Homes, ACA Section 2703 (July 2016)

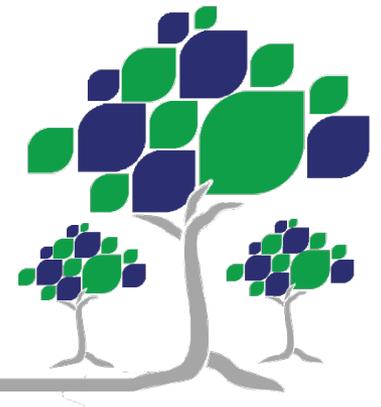


CHWs & Chronic Disease: Opportunities

CMS Prevention Rule Change

Vol. 78 No. 135 Pg. 42306 | July 13, 2013

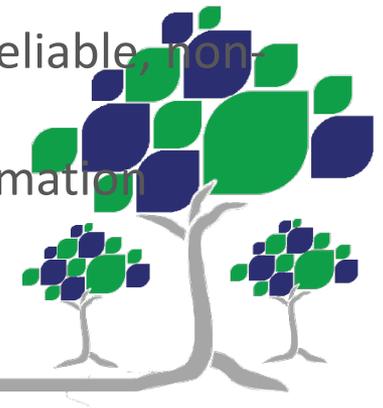
- “...physicians or other licensed practitioners recommend these services but that **preventive services** may be provided, at state option, by practitioners *other than physicians or other licensed practitioners.*”
- §440.130: This final rule “does not dictate who can provide preventive services; it defines who can recommend such services.”
- The person providing services can be a CHW



CHWs & Chronic Disease: Opportunities

Medicaid Managed Care Contracts (May 2015)

- “Contractor must provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to Enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or peer-support specialist services.”
 - Provide clients with training in self-management skills
 - Provide clients with someone they can trust by being reliable, non-judgmental, consistent, open, and accepting
 - Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives



CHWs & Chronic Disease: Opportunities

Medicaid Managed Care Contracts (May 2015)

Within Patient-Centered Medical Homes

- “Improve access to behavioral health, dental care, **community health workers**, patient navigators, and **health promotion and prevention programs** delivered by community-based organizations, or social service programs from the clinical setting.”

Within the population health management section of the contract, there is a section of requirements on disease prevention activities, including support for evidence-based programs



CHWs & Chronic Disease: Opportunities

CMS Preventing Readmissions Guidance (September 2015)

- “Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries”

CHWs are a cited strategy to address readmissions:

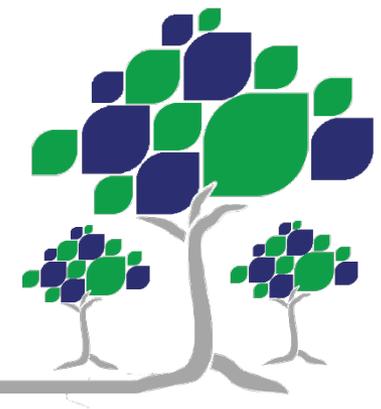
- Counter language barriers and access to interpreter services (culturally competent understanding of community)
- Prevent readmissions by addressing barriers in the inpatient and outpatient setting
- Serve as part of a team to address social supports and social barriers



CHWs & Chronic Disease: Opportunities

CDC Policy Best Practice (January 2016 / November 2014)

Evidence-based policy component (<i>short description</i>)	Evidence Category ^c
➔ CHWs provide chronic disease care services (<i>Chronic Care</i>)	Best
Inclusion of CHWs in team-based care model (<i>Team-based Care</i>)	Best
Core competency CHW certification (<i>Core Certification</i>)	Best
CHWs supervised by health care professionals (<i>Supervision</i>)	Best
Standardized core CHW curriculum (<i>Standard Core Curriculum</i>)	Best
Medicaid payment for CHW services (<i>Medicaid</i>)	Best
Specialty area CHW certification (<i>Specialty Certification</i>)	Best
Inclusion of CHWs in development of their certification requirements (<i>Certification Development</i>)	Best



CHWs & Chronic Disease: Opportunities

Health Homes, ACA Section 2703 SPA (July 2016)

- Launching in 10 FQHCs July 1, 2016
- Criteria for beneficiaries to participate:
- Have depression and/or anxiety
- Have one or more of the following conditions:
 - Heart disease
 - COPD
 - Hypertension
 - Diabetes
 - Asthma
- CHWs mandatory team members

Health Homes: State Medicaid directors letter. Michigan Department of Community Health Web page.
http://www.michigan.gov/documents/mdch/shCMS_Letter_to_Directors_Health_Home_SMD_Final_11-16-10_2_346164_7.pdf. Updated 2013. Accessed August 11, 2015. ; MDHHS Notice of Proposed Policy. 1569-MICT



Addressing Social Determinants

“CHWs become the critical extenders of care beyond clinic walls and between doctor visits that are so needed for patients with medically complex conditions. CHWs also serve as the intermediaries that link clinical services to practical actions in the community to address the social determinants of health. The information they glean about patients’ health status and their unique understanding of patients’ social and cultural barriers to health can be shared with the team, vastly improving care.”

Bringing Community Health Workers into the Mainstream of U.S. Health Care

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CHWs in Michigan



Thank You



For more information about MiCHWA
Please visit our website, www.michwa.org,
or email info@michwa.org

MiCHWA is supported by a grants and contracts to the University of Michigan School of Social Work

