The Life-Changing Impact of Community Health Workers

CICOA Aging & In-Home Solutions – Indiana

RIPIN - Rhode Island

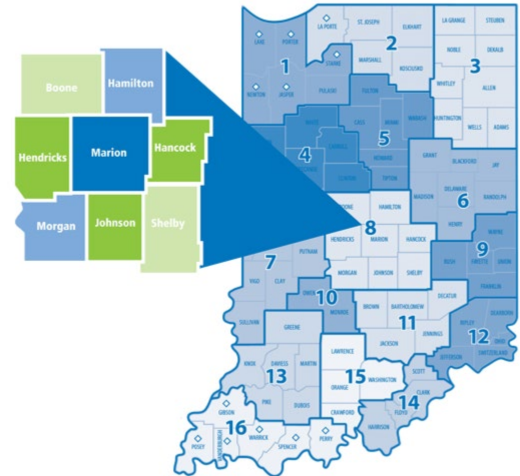
2023 Home and Community-Based Services Conference

HCBS Conference

Erica Seabaugh, Vice President, In-Home Solutions
Kelsey Stinson, Director, Data & Research

Mission

CICOA Aging & In-Home Solutions empowers older adults,
those of any age with a disability, and family caregivers
by providing the innovative answers, services, and support they need
to achieve the greatest possible independence, dignity, and quality of



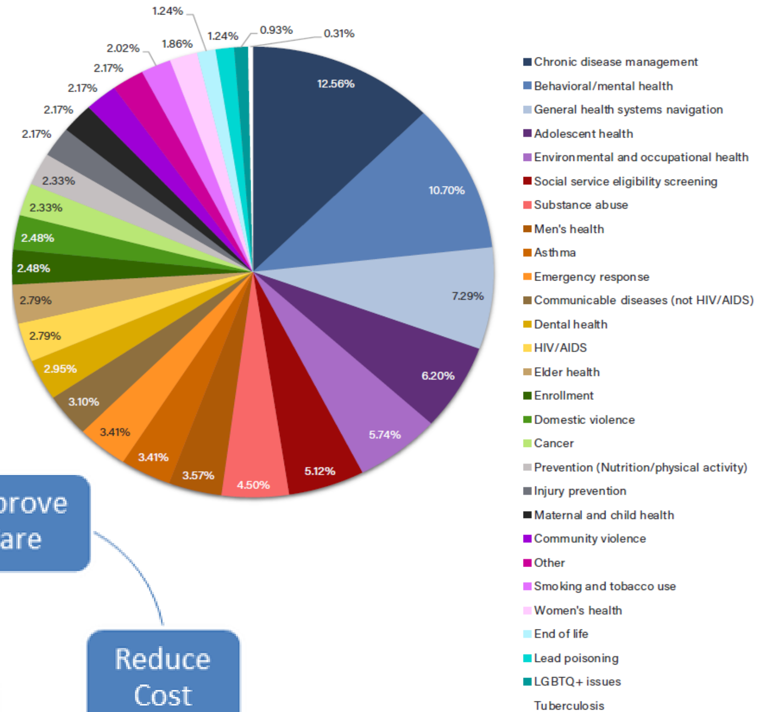
What We Do

Funding Sources:

- Older Americans Act (OAA)
- Social Service Block Grant (SSBG)
- Title III
- Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE)
- Medicaid Aged & Disabled Waiver
- Medicaid Traumatic Brain Injury Waiver

What is a Community Health Worker?

- Frontline health worker
- Link between health/social services and the community
  - Increase access to services
  - Improve quality and cultural competence of service delivery
  - Build individual and community capacity
  - Improve clinical outcomes



(Gonzalvo et al., 2020)

Who are Community Health Workers?

Trusted Community Member

- Shared understanding of lived experiences

Certification

- CHW certification in Indiana open to anyone 18+ with high school diploma/equivalent
- Includes topics & CEUs for ongoing education
- Approx $1200-$1500/certification

ASPIN

Table 3. Community Health Worker Job Title

Job Title (N = 648)	No. (%)
Community health worker	208 (32)
Certified recovery specialist	102 (16)
Certified recovery specialist/Community health worker	90 (14)
Community health advisor	55 (8)
Health educator	55 (8)
Health interpreter or translator	37 (6)
Outreach worker	28 (4)
Enrollment coordinator	16 (2)
Patient navigator	15 (2)
Family advocate	13 (2)
Peer counselor	3 (1)
Other title	24 (4)
No response	2 (1)

(Gonzalvo et al., 2020)

CICOA Community Health Workers: *Development and Implementation*

Collaborative Beginnings

Community Health Workforce Development Institute (CHWDI)

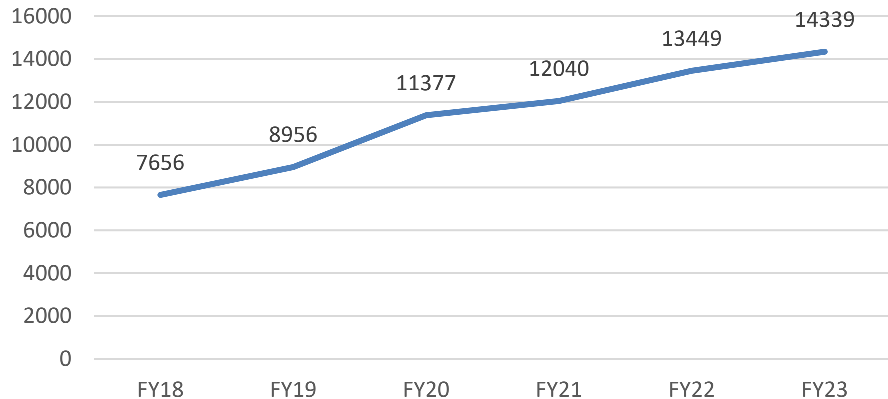
- Indiana CHW Needs Assessment
- Sustainable CHW design & implementation
- Research and evaluation
- Policy and advocacy

Penn Center for Community Health Workers

- IMPaCT – Evidenced-based model
- CHW blueprint design
  - Partner Role
  - Magnet Role

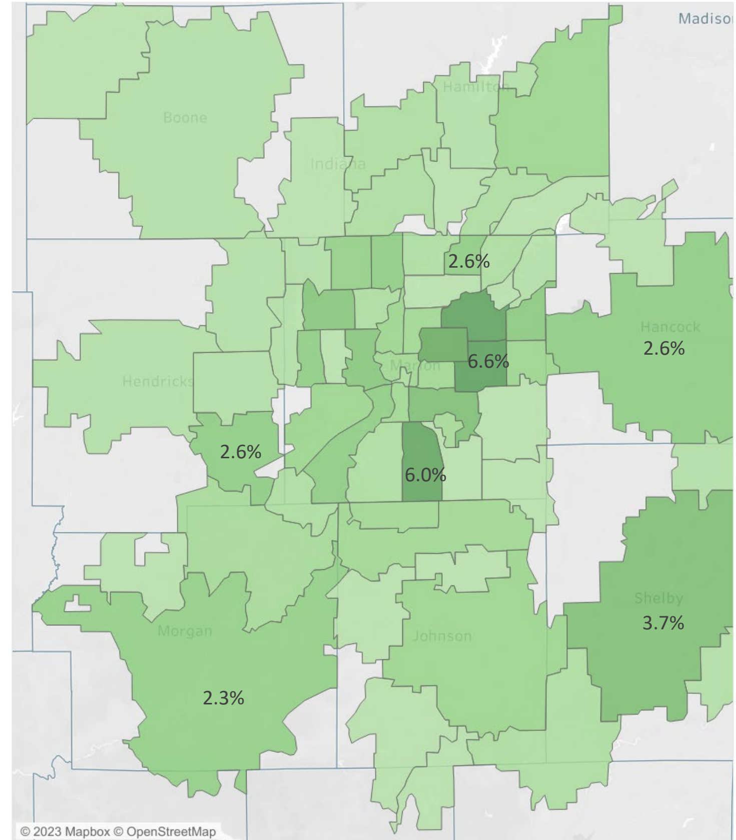
Where to Start – "Partner Role"

- Met most immediate need
- Growing population overall – find new ways to meet needs of consumers at scale.

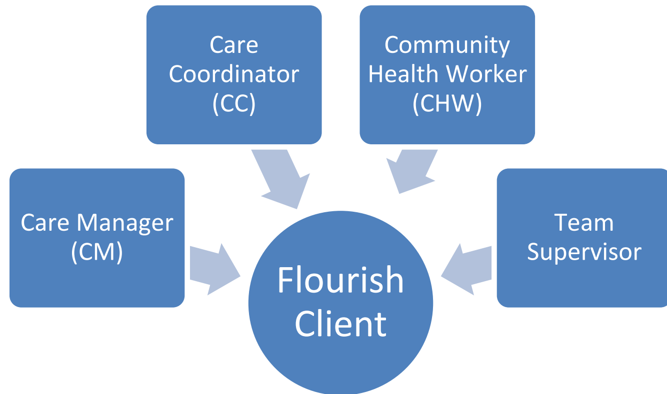


WHERE to start –
Data Driven Approach

- County-Level, Composite SDOH Risk Rankings for Older Adults in Central Indiana
  - Financial Stability, Food Insecurity, Housing, Safety and Abuse, Health Outcomes
- CICOA Client Risk Stratification
  - Demographics
  - Chronic Conditions
  - Hospitalization



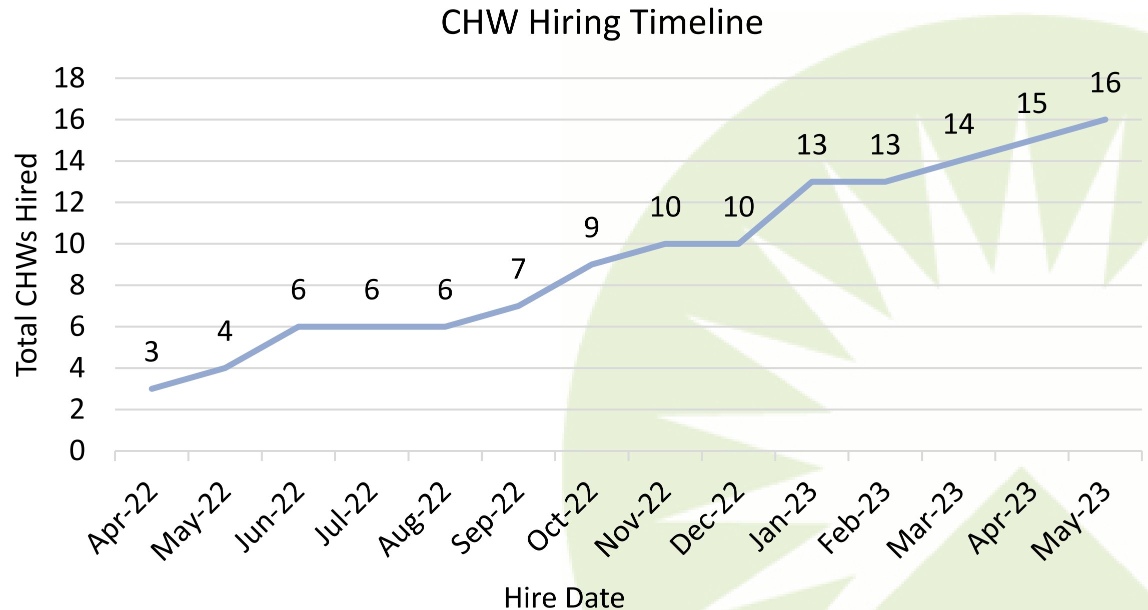
CHW Role at CICOA



- CHWs integrated into Care Management and play important role in providing services and supports
- Implementation plan included a multi-level approach:
  - Supporting care transitions for Dual Special Needs Population (DSNP)
  - Expanding care transition supports for care-managed population
  - Increasing impact on high-risk populations based on population served

Recruitment & Hiring

- Apr 2022: Implementation of the first CHW roles at CICOA
- Sep 2022: Implementation of Lead CHW role
- Apr 2023: 16 CHWs have been hired
- More to come in 2023



CICOA CHWs

Ongoing Training and Partnerships

UNIVERSITY of INDIANAPOLIS®

- Start Aug 2022
- 12 students – two separate semesters
- 2 separate projects:
  - Diabetes Education and Resources
  - Dementia Education and Resources

- Start March 2023; 8-week rotations
- Finalizing partnership to include:
  - Medication Reconciliation at discharge
  - Medication Education (client and CHW) including Opioid use/abuse, infographics and drug access monographs
  - Medication Compliance
  - Medication Access
  - Communication portal between pharmacy students and CHWs

Impact of CHWs

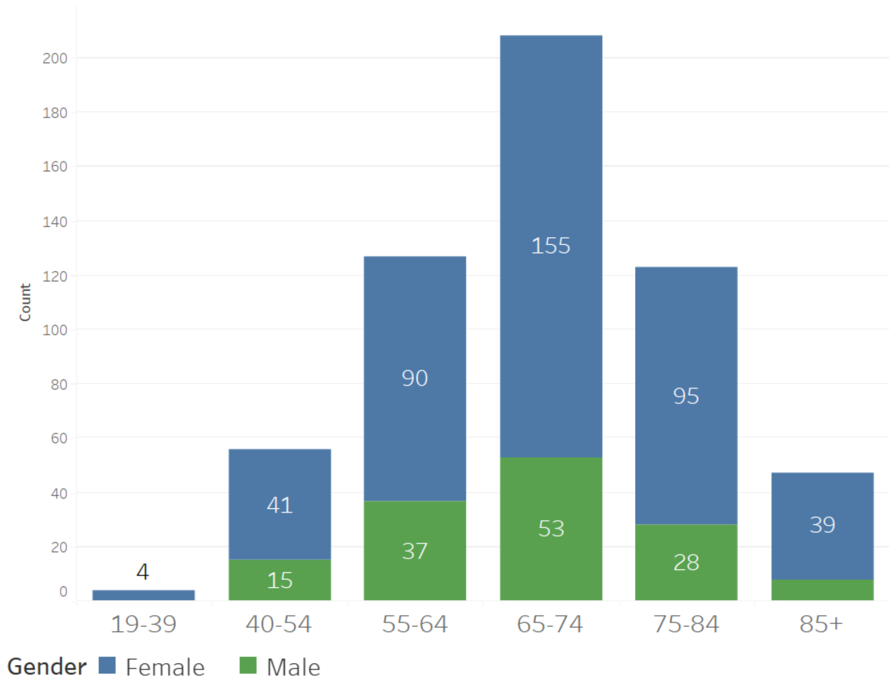
- Reach
- Quality
- Utilization
- Unmet social needs

Client Demographics

Total Clients Served

565

Race	% of DSNP - CHW (n=565)	% CICOA Client (n=12,349)	Central Indiana
American Indian or Alaska Native	0.18%	0.20%	0.10%
Asian	0.18%	1.70%	1.80%
Black or African American	**46.55%**	32.6%	12.40%
Multiracial	**1.06%**	0.90%	1.10%
Native Hawaiian or Other Pacific Islander	0.18%	0.10%	0
Unknown/Missing	6.02%	8.30%	
White	45.84%	56.30%	82.90%



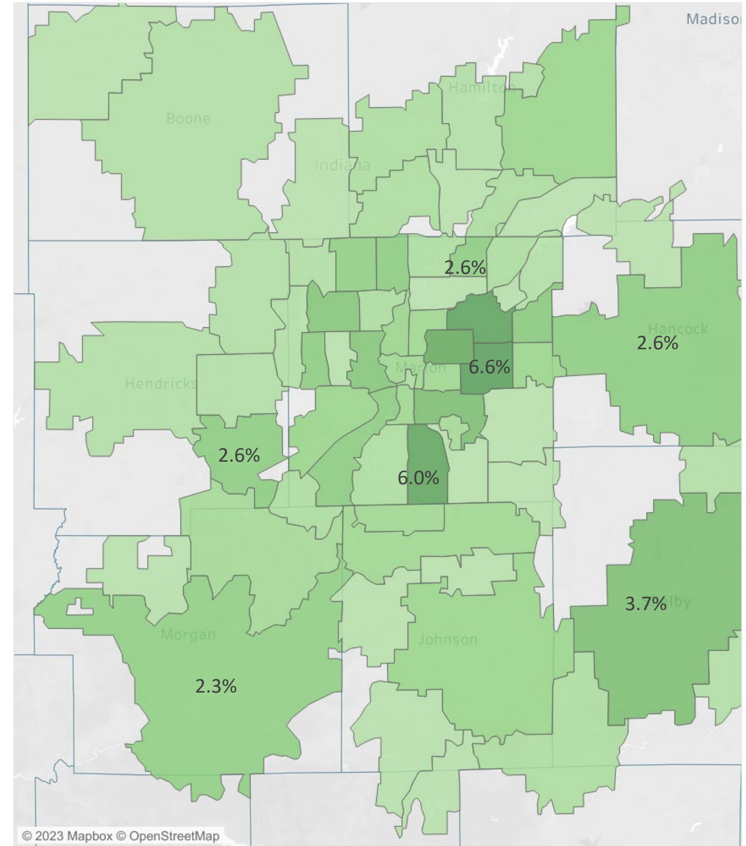
CHW Client Distribution

Indiana
10.6%
4.8%
8.3%
.7%
1.1%
2.1%
1.3%
4.8%
© 2023 Mapbox © OpenStreetMap

% of Total Count of Individual ID

0.18% 10.62%

CICOA CHW Planning: High Risk Distrubition

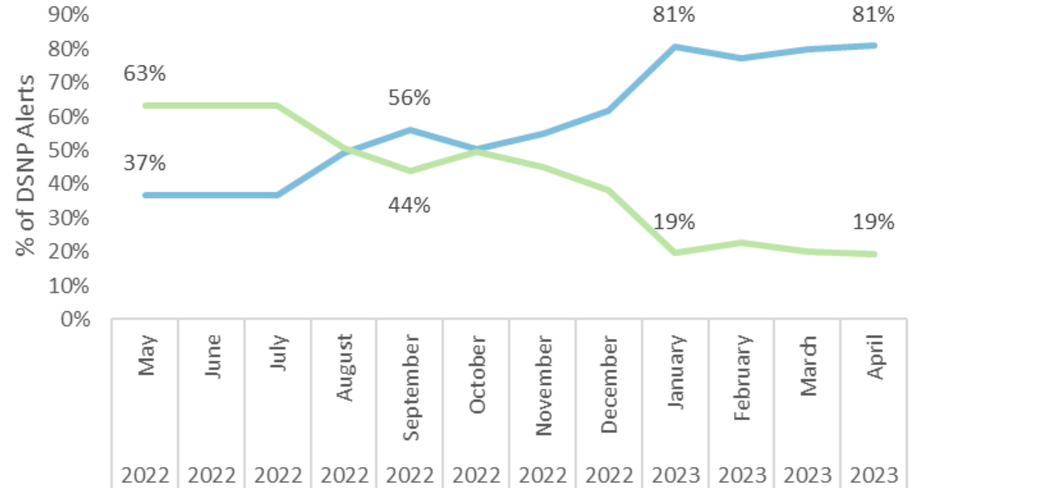


% of Total Count

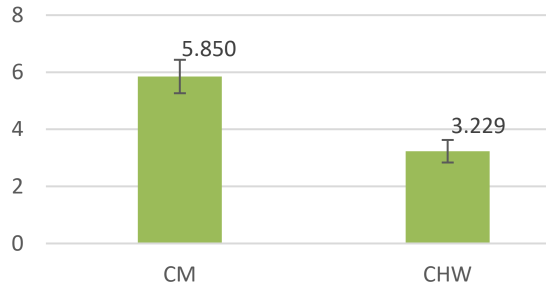
0.3% 10.6%

Workforce Quality - Efficiency

16 CHWs are managing 81% of DSNP activity – compared with 124 Care Managers (CMs).



Workforce Quality - Timeliness



Timeliness of Care Cordination (avg # of days) - CHWs

Year / Month

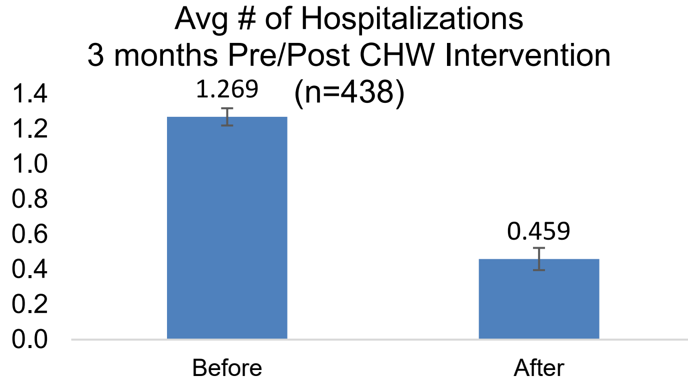
	2022									2023					
	April	May	June	July	August	Septemb..	October	November	December	January	February	March	April	May	June
Avg. Time between notification and coordination start	35	11	7	3	1	2	1	4	2	2	1	1	1	1	

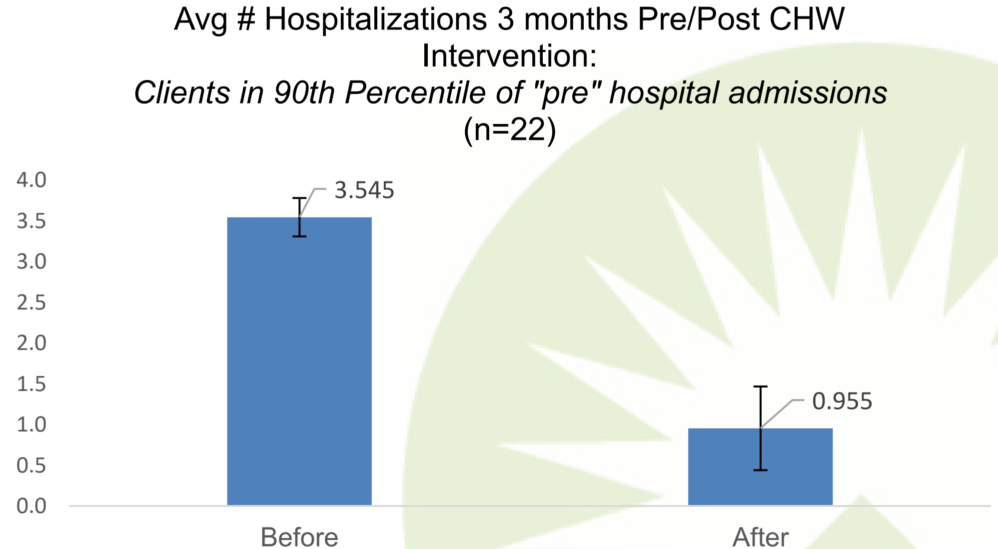
Avg. Time between noti..

35

CHWs provided more timely coordination in response to a client's hospitalization.

Hospital Readmissions





Compared with 3 months prior to CHW interventions, statistically significant reduction in the average number of hospitalizations.

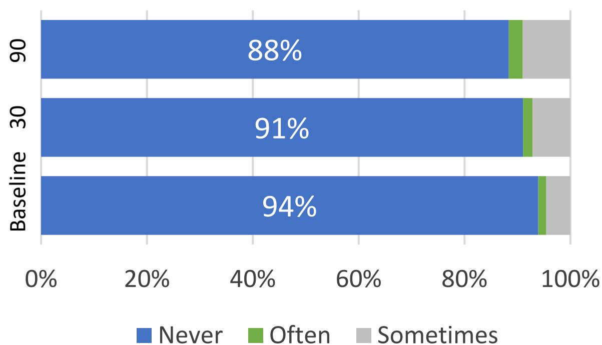
Even greater reduction compared to older adults in the 90th percentile of “pre” admissions.

Addressing Unmet Social Needs

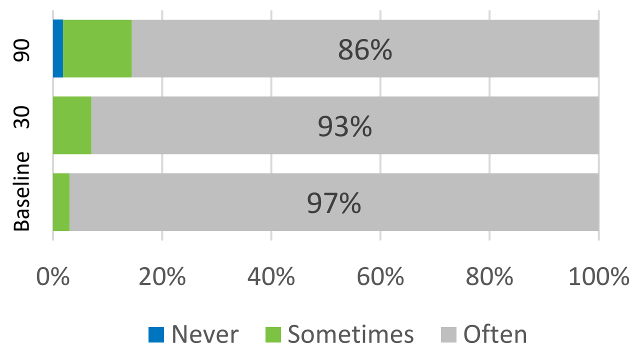
In order of the number of referrals requested:

- Food Pantries
- Transportation
- Housing
- Mental Health
- Medical Equipment/Home Accessibility
- Utility Assistance/Home Repair
- Senior Companions

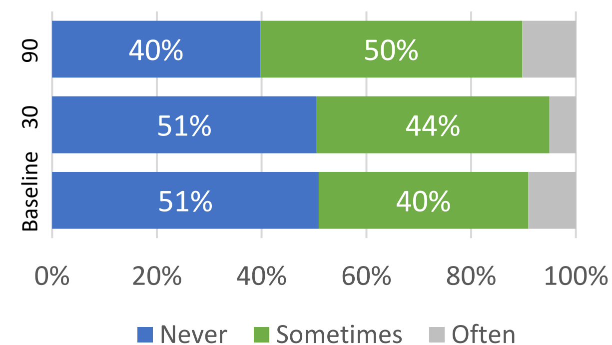
Addressing Unmet Social Needs



Have you run out of food and not have money to get more?



Do you feel confident that your personal needs are met every day?



During the last 30 days, did you often feel unhealthy, or have a lack of energy?

What's Next?

Current CHWs

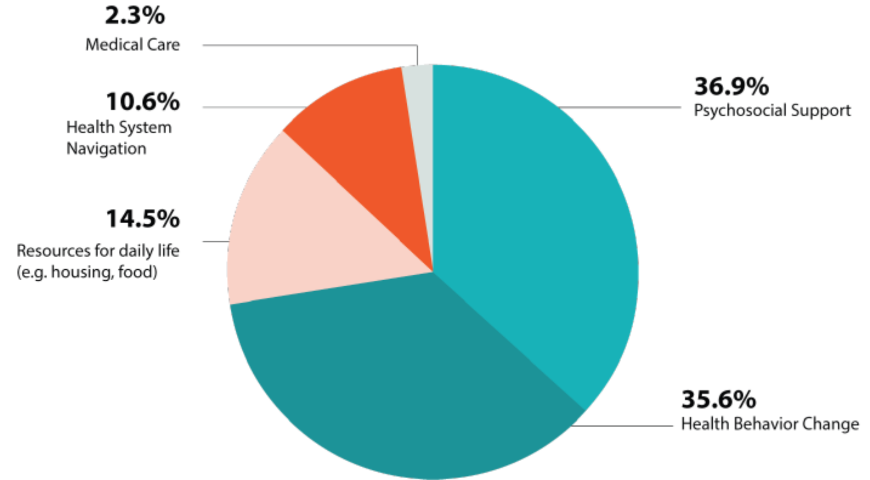
- Continue evaluation – calculate return on investment (ROI)
- Identify long-term reimbursement opportunities
- Streamline processes and analysis of impact
- Expand reach to high-risk clients within current populations

Future CHWs

- Division of Mental Health and Addictions – Targeting older adults with Serious Mental Illness
- "Magnet Role" – Outreach to underserved populations
- SNAP/WIC applications in collaboration with Gleaners Food Bank

How to Incorporate CHWs

- Identify where CHWs can fit in your current workflow
- Explore existing or future reimbursement opportunities
- Lean on partnerships with health systems or Managed Care Organizations



Citations

Gonzalvo, J., Meredith, A., Rodriquez, N., & Ruiz, Y. (2020). *Indiana Community Health Worker Needs Assessment Report.* Purdue Center for Health Equity and Innovation.

RIPIN

Small State Solutions to Big Problems: Evidence-based solutions to supporting Fee-For-Service Medicaid/Medicare recipients and pre-eligibles at risk of long-term institutionalization

Mykahla Gardiner-Higgins

PERSONAL SUPPORT BUILT ON PERSONAL EXPERIENCE

WHO IS RIPIN?

Personal Support Built on Personal Experience.

RIPIN's History

In 1991, a group of parents of children with special learning needs struggled to access special education services for their kids.

Wanting to help other parents facing the same challenges, and improve special education for all students, they founded **RIPIN.**

RIPIN

WHO IS RIPIN?

- Independent 501(c)(3) nonprofit organization
- *Peer Professionals*
- Help Rhode Islanders of all ages, abilities, and backgrounds **access** and **navigate:**
    - Health Care
    - Education
    - Healthy Aging
    - Other services/supports/complex systems

RIPIN

More than ¾ of RIPIN staff are peers

Healthy Aging

- Access to wellness classes to help people manage chronic conditions
- Understanding and navigating Medicare-Medicaid
- Find physicians and providers that accept insurance
- Providing assistance to Rhode Islanders who are dual-eligible for Medicare-Medicaid

What is a Dual?

Medicare: 65+ or disabled

Medicaid: Very low income

High utilization with chronic conditions and high social & economic needs

Rhode Island is home to roughly 37,000 dually eligible individuals

Meet Julia

October 2018

- Unstable housing
- Uncontrolled chronic conditions
- Difficulties establishing boundaries as a caregiver

Duals System Spending and Coverage Options

Coverage Options	Population	Spending & Medicaid Focus
Neighborhood Integrity (fully integrated Medicare-Medicaid Plan)	~15,000	Medicare & Medicaid pay a premium to NHP, who manages and is at risk for all Medicare and Medicaid services
Original Medicare or Medicare Advantage with **Fee-For-Service Medicaid** *RIPIN program serves this population*	~20,000	• Medicare covers most doctors, hospitals, and prescriptions. • Medicare also pays for brief rehab in a SNF - first 20 days in full, and part of days 21-100. • **Medicaid covers most LTSS (both community- and SNF-based)**

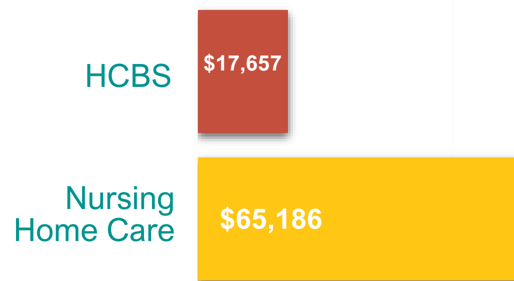
Medicaid spends about $1 bil annually on LTSS, of which about $350 mil is for long term SNF stays. Most of this spending is for Medicare-Medicaid duals.

RIPIN

Creation of RIPIN Care Management Program

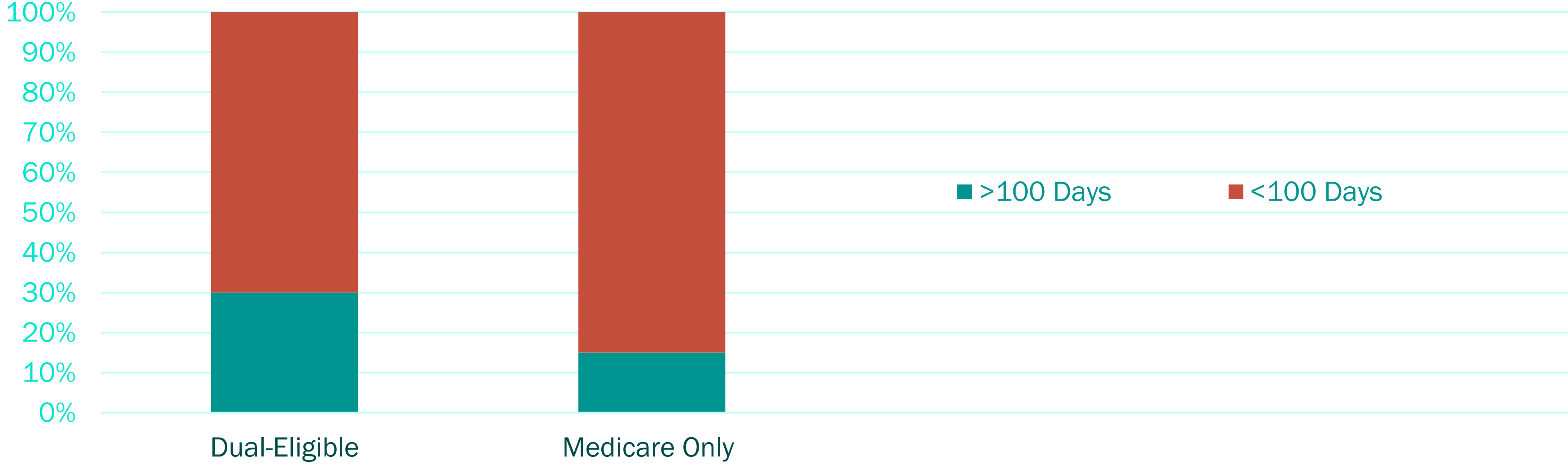
- Created in FY2019 budget as part of sunset of NHP "Unity" program
- FY2019 restructuring saved state $10 mil general revenue (roughly $20 mil all-funds)
- RIPIN program funded at $2.25 mil all-funds
- Primary goal to reduce long term SNF utilization

Long-term care for elderly Medicaid beneficiaries in Rhode Island in FY 2019 costs **3.7 times more**, on average, than spending for home and community-based services



RIPIN

SOURCES: Rhode Island EOHHS, "Long-Term Care Service and Finance Performance Report," April 2020; and A. Houser, W. Fox-Grage, and K. Ujvari, "Across the States 2018: Profiles of Long-Term Services and Supports," AARP Public Policy Institute, August 27, 2018. Rahman, M., Gozalo, P., Tyler, D., Grabowski, D. C., Trivedi, A., & Mor, V. (2014).



Rahman, M., Gozalo, P., Tyler, D., Grabowski, D. C., Trivedi, A., & Mor, V. (2014). Dual Eligibility, Selection of Skilled Nursing Facility, and Length of Medicare Paid Postacute Stay. *Medical care research and review : MCRR*, *71*(4), 384–401. https://doi.org/10.1177/1077558714533824

RIPIN

RIPIN Care Management Program

- Support driven by Community Health Workers and a peer-to-peer model
- Clinical Team of Social Workers and Registered Nurse Care Managers available for consult and care plan reviews
- Housing Specialist
- High-Touch program with monitoring tools in place
- Safely carrying out home and community visits
- Help navigating Medicaid (e.g. home care, DME) and other supports (food, housing, etc.)

RIPIN

Program Evaluation

Rates of Hospitalization

SNF Utilization

ED Use and Preventable ED Admissions

SNF Stays of 20 days or more

- RIPIN Partnered with Brown School of Public Health in 2019 to complete a program evaluation of RIPIN's CMP using All-Payer Claims Data (APCD).
- Principal Investigators were Anya Rader Wallack (former RI Medicaid Director) and David Meyers.
- Key measurements used to evaluate RIPIN's program intervention with reduction in utilization and reduction in state costs.

RIPIN

Evaluation Design and Methods

Treatment Group

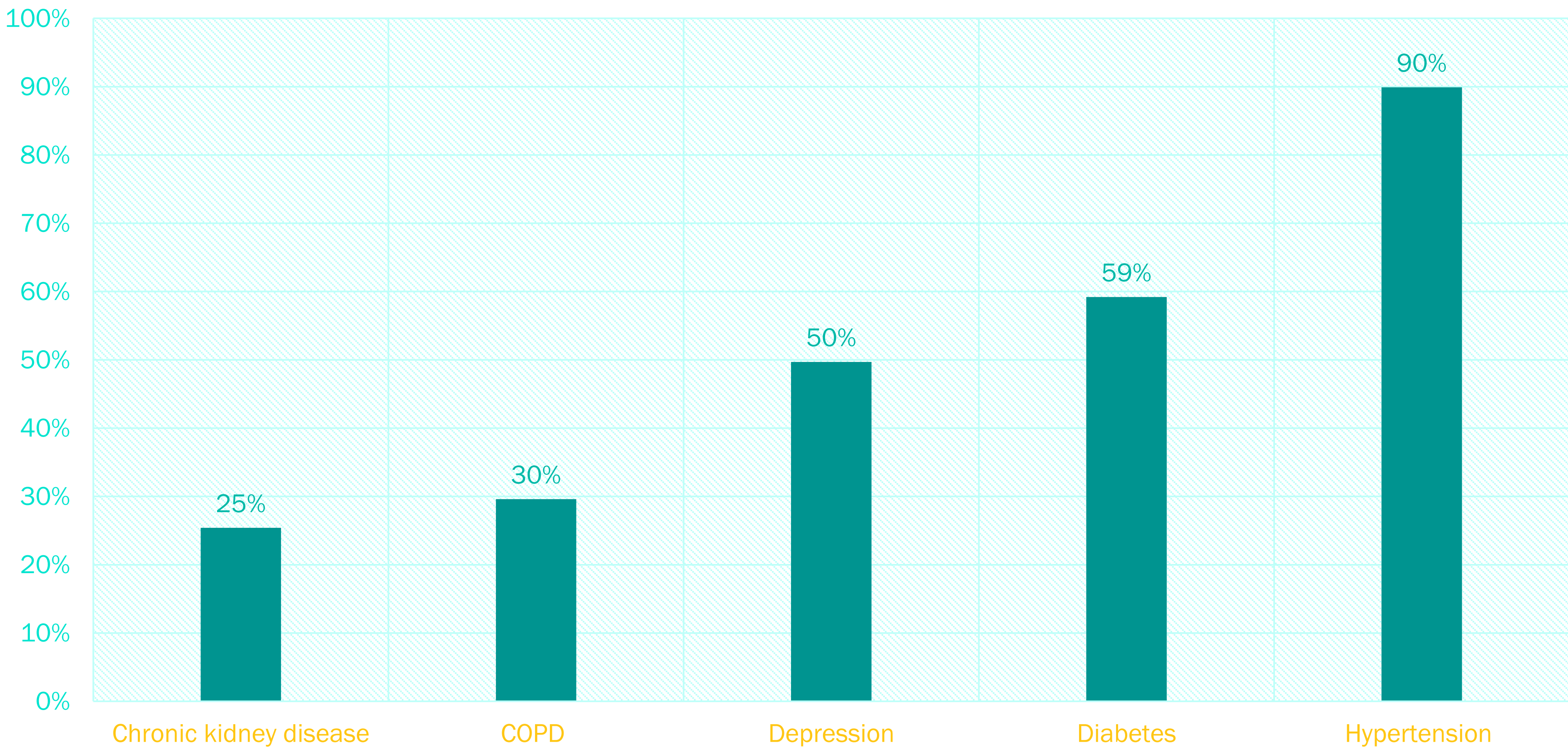
- Actively received care Management
- 169 Participants identified with matching enrollment dates

Quantitative Methods

- Interrupted Time Series
- Pre-treatment 1/1/2017 thru 9/1/2018
- Post-treatment 10/1/2019 thru 9/1/2020
- Adjusted models reflecting the controlled variables of the non-treatment group

Qualitative Methods

- Interviews with EOHHS Leadership, RIPIN staff, and CMP participants


RIPIN CMP Population Characteristics
N= 169
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
25%
30%
50%
59%
90%
Chronic kidney disease
COPD
Depression
Diabetes
Hypertension

Evaluation Results

High Comorbidities	Fewer Hospitalizations	Reduced SNF admissions and Long-Term Stays	Significant Reduction in Medicaid Costs
• RIPIN supporting participants with higher rates of comorbidity	• 118 fewer per 1,000 members per quarter	• 71 fewer SNF admissions per 1,000 members-per quarter • 36 fewer stays of 20 days per 1,000 members-per quarter	• **$7,364 per-member-per-year reduction in Medicaid spending**

RIPIN

Evaluation Results (cont)

Adjusted Analysis‡		
Inpatient Utilization‡ (per 1,000 visits per quarter)		
Admissions	-118 (-226, -11)	0.03
ED Visits	-148 (-335, 39)	0.12
Preventable ED	-30 (-106, 47)	0.45
Skilled-Nursing Facility Utilization‡ (per 1,000 stays per quarter)		
Stays	-71 (-149, 7)	0.08
Stays 20 Days or Longer	-36 (-72, 0)	0.06
Total cost of care, $ (per individual per quarter)		
Medicaid	-1,841 (-2,407, -1,275)	<0.001
Medicare	-729 (-2,741, 1,283)	0.48
All costs	-2,570 (-4,645, -495)	0.02

RIPIN

Hear From Program Participants

- *"She [care manager] has made my health more manageable. I used to have breathing problems, was on oxygen…. She won't stop until I get the help that I need. You know, I don't know what I would do without her."*
- *"My life is easier, I have gotten back some independence. I can get around, I can shop, I am not so dependent on other people."*
- *"My health has improved a lot. Because they found me a device for my leg, I am no longer bothered when I walk. I feel more stable, more confident."*
- *"It is very difficult to communicate with all of the people and departments I need to talk to. She [the RIPIN care manager] communicates with all of them. She is really mindful of my needs and really good at her job."*

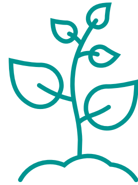
98% of surveyed participants feel respected by their Care Coordinator

RIPIN

Back to Julia

Home and Happy

What’s New / What’s Next

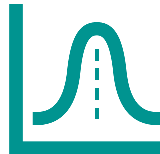


Scaled Program

- Increased program participation to over 600 individuals

Model for Continued Targeted Growth

- Using RIQI tools to monitor eligible population for rising needs



Random Control Trial?

- Scaled program to support RCT analysis, but need funding

Evaluation Citation

Tucher EL, McHugh JP, Thomas KS, Wallack AR, Meyers DJ. Evaluating a Care Management Program for Dual-Eligible Beneficiaries: Evidence from Rhode Island. Popul Health Manag. 2023 Feb;26(1):37-45. doi: 10.1089/pop.2022.0236. Epub 2023 Feb 6. PMID: 36745407.

RIPIN