FIGHTING FOR AMERICA'S FAMILIES

Health Action Conference 2019

Sustainable Financing for Community Health Workers: Medicaid and Beyond

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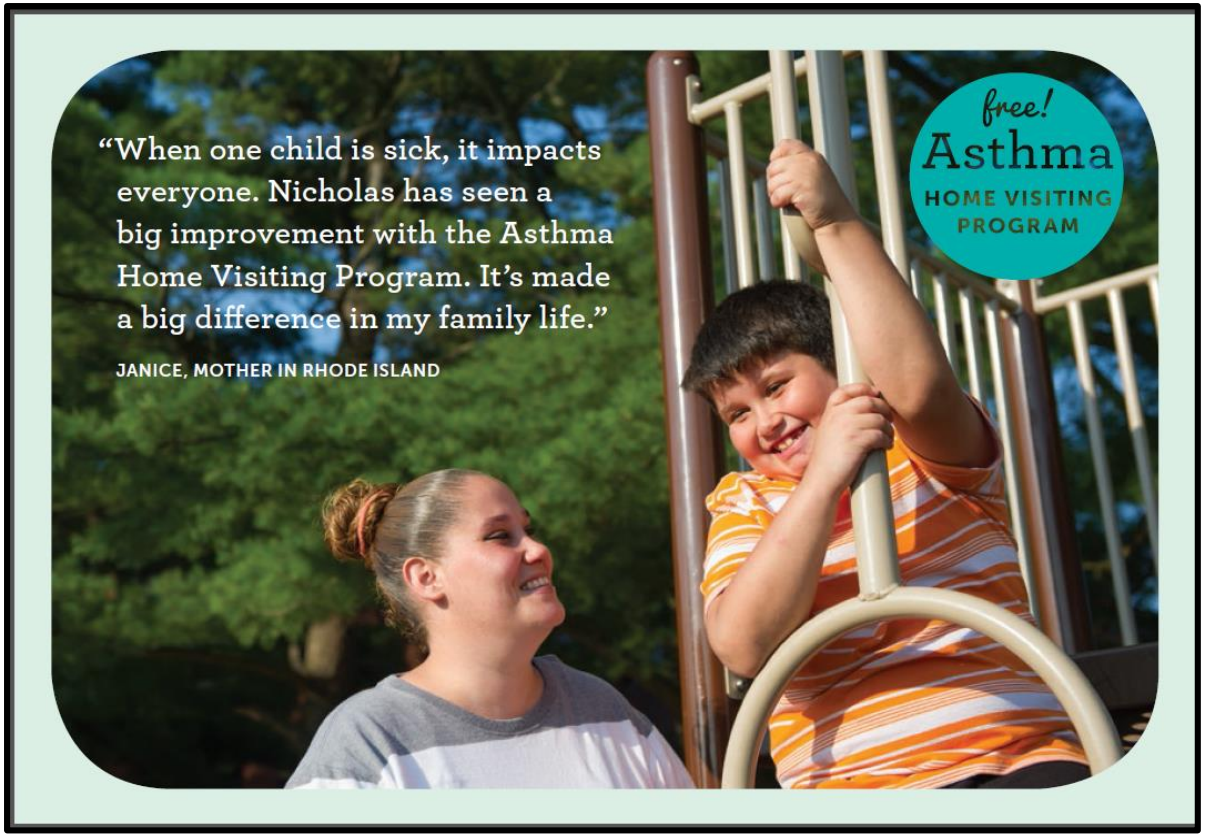
January 22, 2019

Health Resources in Action

Advancing Public Health and Medical Research

CHWs Deliver Asthma Home Visiting Services

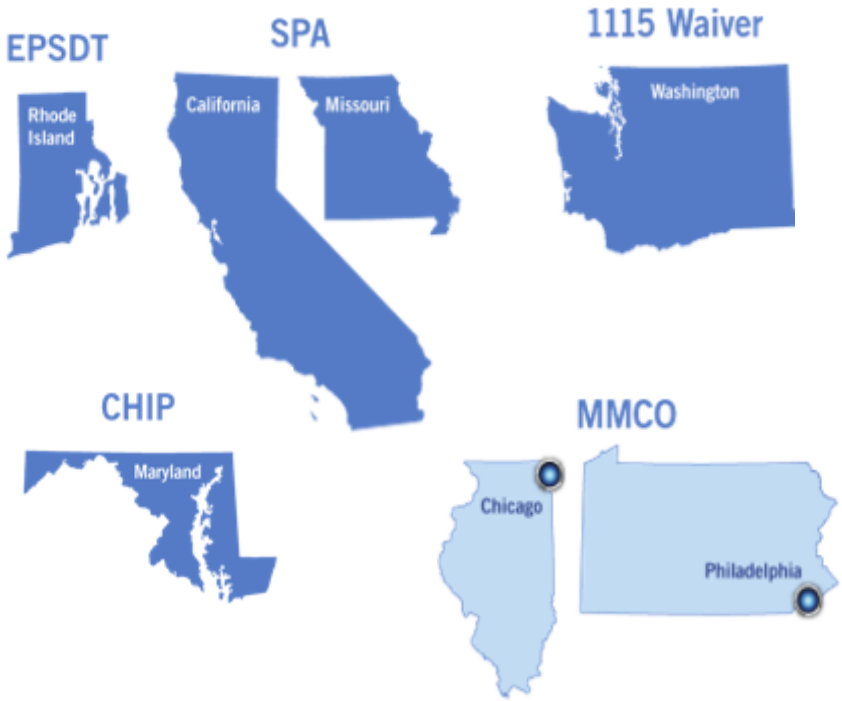


Nicholas used to have asthma symptoms every night and missed several weeks of school in a year.

Since the program, he hasn't missed school and barely needs to use his rescue inhaler.

Janice, Nicholas' mom,

One Step Forward, Two Steps Back



Seeing efforts to develop sustainable reimbursement policies for in-home asthma visits conducted by licensed, certified, and non-licensed and non-certified professionals, including CHWs.

…and many others

Some Wins and Ongoing Efforts

- State Plan Amendment (SPA) - CHIP Coverage (MD)
- Accountable Care Organization (Pediatric Physicians' Organization at Children's Hospital, Boston) & ACOs
- Medicaid Managed Care (Philadelphia)
- Community Benefits (Rutland Regional Hospital, VT and Boston Children's)
- Medicaid - MoHealthNet

Try Try Again!:

- CA –MediCal

https://docs.google.com/forms/d/e/1FAIpQLSfwKzUsMhubJGwr8IweKsEbGESMqRAasM1EdGZR86b1CichSw/viewform

- NC – negotiating SPA
- UT – Designated State Block Funding
- RI – Pilot with MMCO & State Funds (VW Settlement)
- And many more!

How to Get There?

- Pilot
- Evaluate
- Improve and target
- Build a business case and support
  - Know your audience and be concise!
  - Address Healthcare Quality Measures

- Success might look different than originally envisioned
  - There is no direct path – try multiple approaches, and be flexible

- Relationships are the key to advancement

Partnerships and Support, and Many Pathways

The CMS Innovation Center

The Center for Medicare & Medicaid Innovation (the Innovation Center) with CMS supports the development and testing of innovative health care payment and service delivery models.

Health Resources in Action®
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The "6|18" Initiative

Promote adoption of evidence-based interventions in collaboration with health care purchasers, payers, and providers

High-burden health conditions **6 | 18** Evidence-based interventions that can improve health and save money

Green & Healthy Homes Initiative®

EPA United States Environmental Protection Agency

Examples – Infographic Business Cases

The Home Asthma Response Program (HARP)

HARP is an evidence-based asthma intervention designed to **reduce preventable asthma emergency department visits and hospitalizations** among high risk pediatric asthma patients. The HARP model utilizes a Certified Asthma Educator (AE-C) and a Community Health Worker (CHW) to conduct three intensive sessions that:

- Assess patients' asthma knowledge and trigger exposure
- Provide intensive asthma self-management education
- Deliver cost-effective supplies to reduce home asthma triggers
- Improve quality and experience of care

ECONOMIC CASE: COST SAVINGS AND RETURN ON INVESTMENT

HARP has consistently demonstrated reductions in asthma costs, driven by large decreases in hospital and emergency department asthma claims. Claims data comparing one year pre-HARP to one year post-HARP shows that participants had a 75% reduction in asthma-related hospital and ED costs. High utilizers had reductions close to 80% and much larger average savings compared to other participants.

	N=	PRE	POST	% CHANGE	$ CHANGE
HARP PARTICIPANTS (at least one asthma ED visit or hospitalization)	158	$2,127	$521	-75.5%	-$1,606
HIGH UTILIZER (subset with 2+ prior ED visits)	51	$3,398	$690	-79.7%	-$2,708

ELIGIBLE CHILDREN IN MANAGED CARE

796 children had at least one asthma emergency room visit or hospitalization, costing Medicaid over **$1 million** at an average of **$1,358** per person

A subset of **265 "high utilizers"** had 2+ asthma ER visits at a total cost of **$695,000** and average per person cost of **$2,624**

HARP has a positive return on investment. This means that every dollar invested into reducing preventable ED/hospital visits gets returned, with additional savings earned. Overall, HARP participants had a 33% ROI on ED/hospital costs ($1 investment returned with extra 33 cents saved). The subset of high utilizers had an ROI of 126%. Including overall asthma costs which show an encouraging increase in medication costs, HARP was still cost effective (i.e., investment equal to savings). For high utilizers, the overall asthma cost ROI was positive at 65%.

Demonstrated Outcomes:

Quality Improvement: The asthma medication ratio HEDIS score for participants increased from 32% to 46%.

Improved Asthma Control: Patient population went from 20% well controlled to 51.5% well controlled.

Improved Quality of Life: Caregiver quality of life improved 17% on validated surveys.

Reduction of Environmental Triggers: HARP Community Health Workers observed reductions in mold, dust, pests, pets, tobacco smoke, and chemicals.

Reduction in Missed School/Work Days: Caregivers report reducing missed work work days due to asthma by 62%. Patients cut missed school days almost in half.

Increased Asthma Action Plans: Availability and patient use of asthma action plans created by providers increased from 20% to 80% of participants.

2015 Medicaid data, Dx asthma

HARP is part of the regional New England Asthma Innovation Collaborative (NEAIC). In Rhode Island, HARP is a partnership between the Rhode Island Department of Health, Hasbro Children's Hospital, Saint Joseph's Health Center, and Thundermist Health Center.

Utah Asthma Home Visiting Program

UTAH DEPARTMENT OF HEALTH – Utah Asthma Program

The Utah Asthma Home Visiting Program is an evidence-based, targeted, high-risk care management intervention designed to reduce preventable asthma emergency department (ED) visits and hospitalizations and improve asthma control.[1,2] Since the program began in January 2016, 250 patients have entered the program and 205 have completed it.[3] The program is offered by specially trained health educators in Utah and Salt Lake Counties and includes the following:

- Visit 1: Learn about asthma symptoms, triggers, medications, and inhaler technique.
- Visit 2: Identify asthma triggers in the home and set goals to reduce these triggers. Refer to home remediation services as needed.
- Visit 3: Discuss progress on controlling asthma and reducing triggers.

Improves Asthma Control and Quality of Life[3]

- 90% of participants complete the program.[4]
- 80% of participants had improved asthma control test scores from Visit 1 to Visit 3.
- 89% of those who achieved control in the program reported having controlled asthma 12 months after the program.
- 75% of participants started using their controller medication more by Visit 3.
- 68% of participants reported increased confidence managing their asthma six months after the program.

Testimonial

"It used to be a way (of life) for our (daughter) to get sick…But after getting educated on her inhalers and having our home inspected, things changed.

We are happier! Plans happen, dates occur, friends play. Life is different."

-Mother in Utah County

Reduces Unwanted and Costly Events[3]

12 Months After Completing the Program

- 75% decline in average missed work days.
- 53% decline in average missed school days.
- 60% reduction in average unplanned doctor visits.
- 53% reduction in episodes requiring an oral systemic corticosteroid.
- 70% reduction in asthma-related ED visits.
- 82% reduction in asthma-related hospitalizations.

September 2018

Current Referral Sources[5]

- Children's
- …intain Healthcare
- …ley Pediatrics
- …nd Healthy …nitiative
- …illey Pediatrics
- Clinic
- Word of Mouth
- Alpine Pediatrics
- Timpanogos Hospital
- Kids on the Move
- WIC
- BeWise
- School Nurses
- Orem Pediatrics (IHC)

Utah Program Cost

Visit 1	$178.65
Visit 2	$92.54
Visit 3	$82.64
Total =	$353.83

Cost includes miles driven, travel time, staff time for two health educators, paper materials, mattress and pillow cover, and spacer.

…onomic Case: Cost Savings and Return on Investment

…a is Common and Costly in Utah

- …2 Utah adults have asthma (8.3%).[6]
- …7 Utah kids have asthma (5.8%).[6]
- …about 48% of those with asthma are …to two or more triggers at home (i.e. dust …and are more likely to miss school, work, …r usual activities.[7]
- …olled asthma in Utah is more prevalent …hose with less education, low income, and …ing in rural areas.[8]
- …ere are on average 6,948[9] Utah …isthma-related ED visits a year.
- …014, total Utah asthma-related ED …visits cost $28.1 million.[10]

The Program Saves Money[3,11]

Number of Participants[12]	82
Program Cost per Participant	$353.83
Average Asthma ED Visit Cost[13]	$1,815.73
% Decrease in Total ED Visits	70%
For Every $1 Invested:	$3.31 saved

1. Asthma Care Quick Reference: Diagnosing and Managing Asthma. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
2. Asthma Home-Based Multi-Trigger, Multicomponent Environmental Interventions. The Community Guide. https://www.thecommunityguide.org/findings/asthma-home-based-multi-trigger-multicomponent-

Challenges/Lessons Learned

- Changes in Leadership (sometimes also an opportunity - CA Governor now)
- If evaluating claims data –
  - make sure race and zip code includes

  Interventions often impact the entire family

- Payers (and Providers)
  - Need information re: CHW field
  - Want assurances of standards in training and qualifications.

Some Resources – Asthma Specific

- MA DPH CHW Protocol Manual and videos
- NCHH - Building Systems to Sustain Home-Based Asthma Services
- The 6|18 Initiative Evidence Summary Control Asthma

Questions for Discussion

- How do we demonstrate the value of CHWs? Can we do so generally, or is a specific intervention necessary?
- Is ROI needed for discussion of sustainable financing or adequate cost-benefit and improved health outcomes?
- How can we demonstrate impact across a lifespan and a family?
- How can we support a fair and livable wage for CHWs (combatting the "CHWs are cheaper")?

Thank you and Contact:

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