Sustainable Financing for Community Health Workers: Medicaid and Beyond

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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.
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
  [Link](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
  o Know your audience and be concise!
  o Address Healthcare Quality Measures

• Success might look different than originally envisioned
  o 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®
Advancing Public Health and Medical Research

The “6|18” Initiative

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

6|18 Evidence-based interventions that can improve health and save money

High-burden health conditions

Green & Healthy Homes Initiative®

EPA United States Environmental Protection Agency
The Home Asthma Response Program (HARP)

HARP is an evidence-based asthma intervention designed to reduce preventable asthma emergency department and hospital visits and hospitalizations among high-risk pediatric asthma patients. The model includes a Medicaid Asthma Educator (ACE) 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 services to improve 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 patients had a 70% reduction in asthma-related hospital and ED costs. High utilizers had reductions close to 100%, and much larger savings compared to other participants.

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<thead>
<tr>
<th>PRE</th>
<th>POST</th>
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<tr>
<td>N</td>
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<tr>
<td>156</td>
<td>51</td>
<td>-105</td>
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<tr>
<td>$2,127</td>
<td>$696</td>
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**HIGH UTILIZER**

- N: 51
- PRE: $2,127
- POST: $696

HARP has a positive return on investment. This means that every dollar invested into reducing preventable hospital visits results with electronic savings earned. Overall, HARP participants had a 75% decrease in hospitalization costs & investment returned with extra 33 cents saved. The subset of high utilizers had an ROI of 100%, including overall asthma costs which showed an encouraging increase in medication costs, HARP was still cost-effective (8X investment equal to savings). For high utilizers, the overall asthma cost ROI was 65%.

**Dramatized Outcomes:**

- Quality Improvement: The asthma medication ratio (HEDS) scores for participants increased from 62% to 46%
- Improved Asthma Control: Patient perceptions went from 20% well controlled to 55% well controlled
- Improved Quality of Life: Caregiver quality of life improved 9% on validated surveys
- Reduction of Environmental Triggers: HARP® Community Health Workers observed substantial mold, dust, pets, pets, tobacco smoke, and chemicals
- Reduction in Missed School/Work Days: Caregivers report reduced missing work days due to asthma by 54%
- 54% reduction in episodes requiring an oral systemic corticosteroid
- 70% reduction in asthma-related ED visits
- 82% reduction in asthma-related hospitalizations

**Utah Asthma Home Visiting 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. Since the program began in January 2016, 259 patients have entered the program and 201 have completed it. The program is offered by specialty-trained health educators in Utah and Salt Lake Counties and includes the following:
- **Visit 1:** Learn about asthma symptoms, triggers, medications, and intake 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**

- 90% of participants complete the program.
- 80% of participants had improved asthma control test scores from Visit 1 to Visit 3.
- 85% 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.
- 63% of participants reported increased confidence managing their asthma 6 months after the program.

**Testimonial**

“Ut was used to be a very joy job for our daugther to get sick. But after getting educated on her triggers and having our home inspected, things changed. We are happier! Plans happen, dates occur, friends play. Life is different.”

- Mother in Utah County

**Utah Program Cost**

- Visit 1: $178.65
- Visit 2: $92.54
- Visit 3: $82.64
- Total: $353.83

**ECONOMIC CASE: COST SAVINGS AND RETURN ON INVESTMENT**

- Food assistance received by children is estimated to cost $1 million in savings per year.

- A subset of 265 high utilizers visits, resulting in an estimated cost of $590,000 and average per participant of $2,624.

- The program saves $3,185.73 per participant, with an average savings of $353.83.

- The savings are an average of 6.948 of Utah asthma-related ED visits a year. A total of 64, total asthma-related ED visits cost $262,017,000.

- For every $1 invested, $3.13 is saved.
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

“I can play tag again.”
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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