Creating Impact, Surviving Sustainability: Working with Community Health Workers in Public Health

Michigan Premiere Public Health Conference

October 2024

Presenters:

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Healthy People, Healthy Communities

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Presentation Objectives

Describe 2 Health Departments' experiences developing and implementing a Community Health Worker Program

Discuss successes and challenges

Facilitate a discussion around sustainability

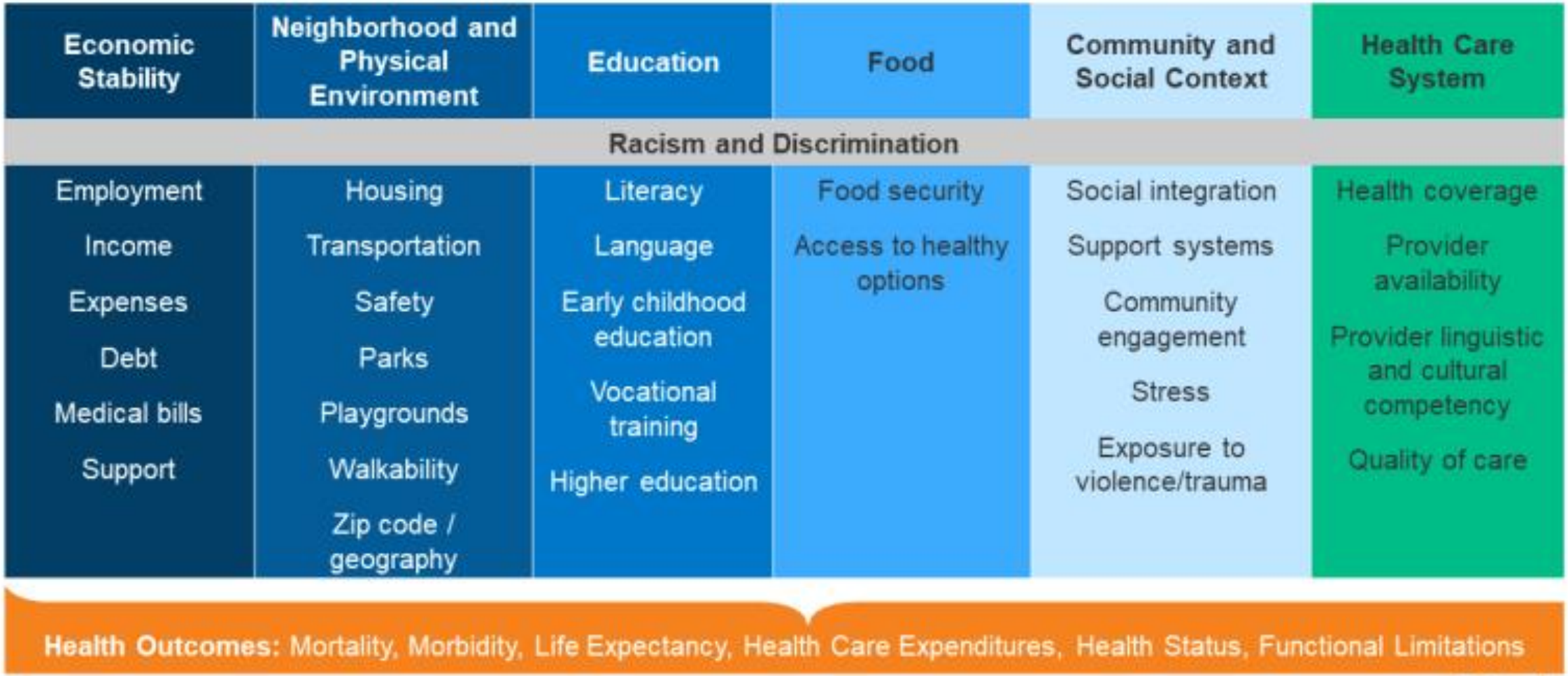
Check-in?

- Who is in the room?
- Who has CHWs?
- Who has worked with CHWS in the past 2 years? 5 years? Longer than that?
- Who is struggling with sustainability?

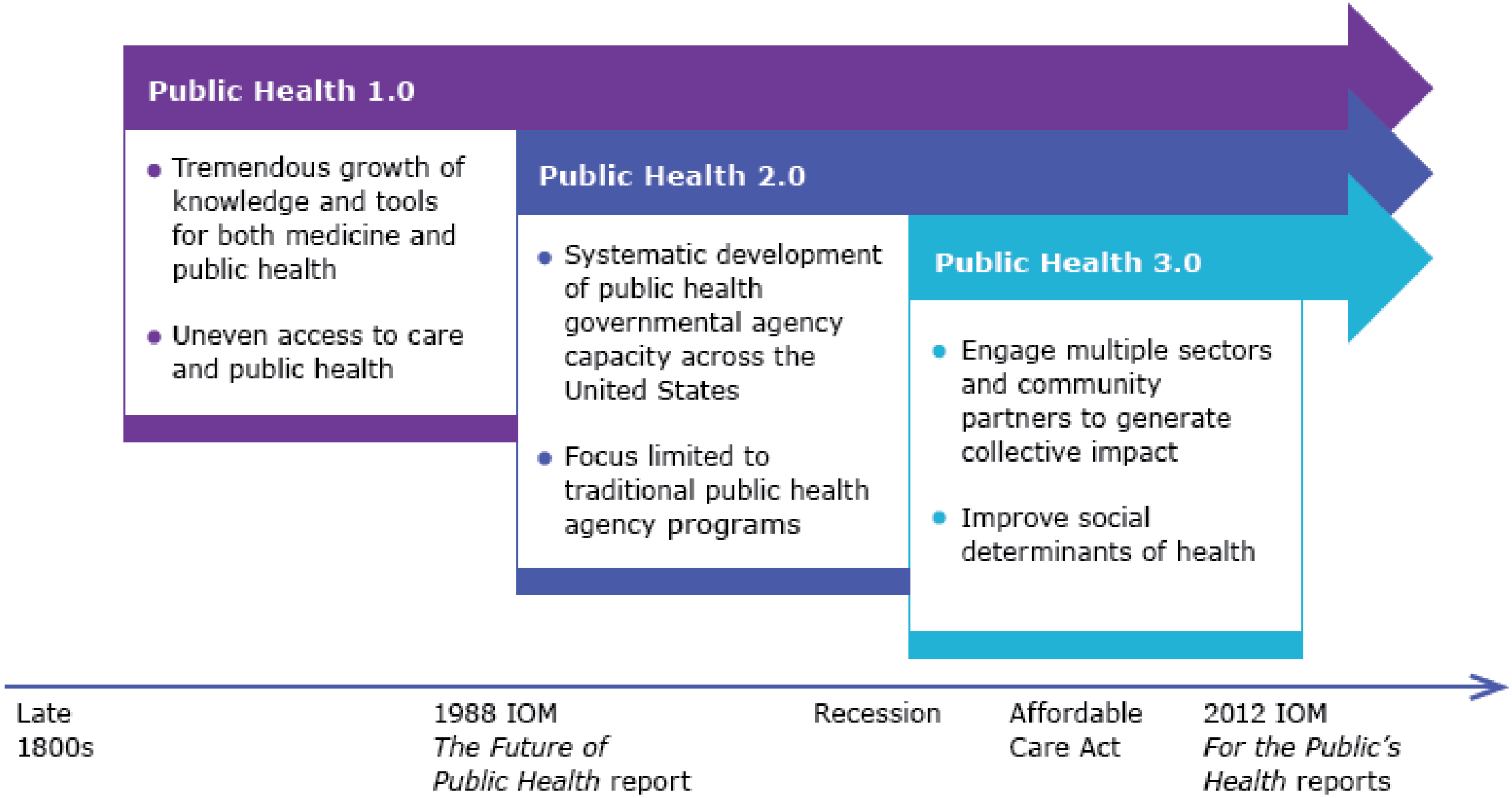
Shifting Priorities: Public Health 3.0 and Health Equity

Figure 2

Social and Economic Factors Drive Health Outcomes



KFF
HENRY J KAISER FAMILY FOUNDATION



Evolution of public health practices. Abbreviation: IOM, Institute of Medicine

Source: Northern Arizona University, Center for Health Equity Research

Documented Potential Benefits of CHW Programs

Source: Centers for Medicare & Medicaid Services On the Front Lines of Health Equity: Community Health Workers (cms.gov)

Mission and Vision

- ✓ NMCHIR Mission: Improving population health, increasing health equity, and reducing unnecessary medical costs through partnerships and system change
- ✓ NMCHIR/CCL Vision: Healthy People in Equitable Communities, which includes A “Universally Accessible Comprehensive CHW Navigation System”

BACKBONE ORGANIZATION

NORTHERN MICHIGAN PUBLIC HEALTH ALLIANCE

www.northernmichiganchir.org

- Guides Vision & Strategy
- Supports Aligned Activities
- Establishes Shared Measures
- Builds Public Will
- Advances Policy
- Mobilizes Funding


NORTHWEST COMMUNITY HEALTH INNOVATION REGION
HEALTHY PEOPLE
in Equitable Communities
Our VISION
Our NETWORK
Our MISSION
IMPROVE
Population Health
REDUCE
Unnecessary Medical Expenses
INCREASE
Health Equity
Steering Committee
Clinical Community Linkages Workgroup
MiThrive Workgroup
Learning Community
Behavioral Health Initiative
Residents
Community Partners
Our TOOLS
Our BACKBONE
NORTHERN MICHIGAN PUBLIC HEALTH ALLIANCE
mithrive
COMMUNITY connections
SYSTEMS change
www.northernmichiganchir.org

COMMUNITY connections

A FREE PROGRAM

Connecting adults, children, and families to community resources

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Like food, housing, transportation, physical and mental health

THROUGH MULTIPLE CHANNELS

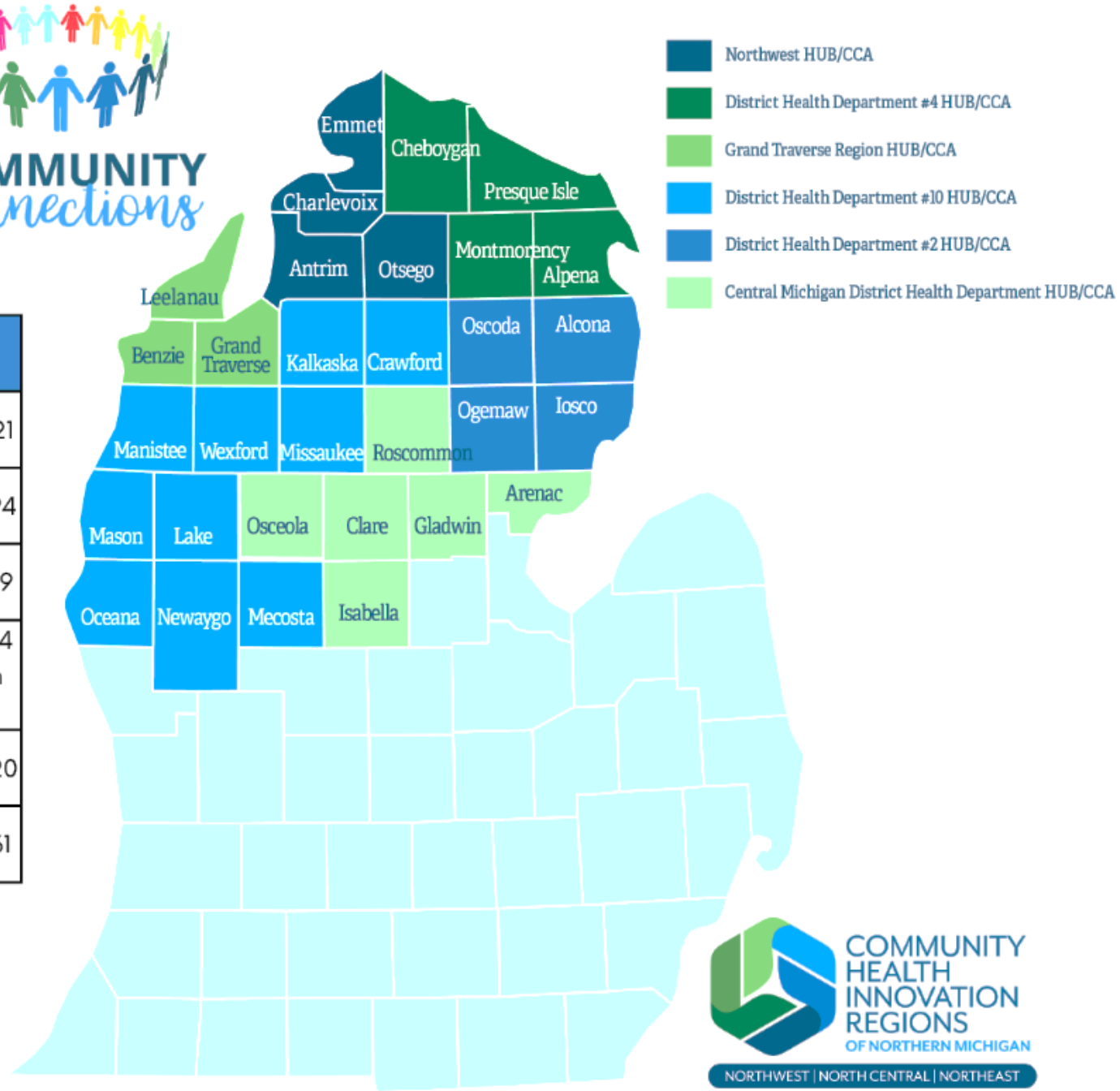
Phone calls, home visits, and office visits

BY PROFESSIONALS

Community Health Workers, Registered Nurses, or Social Workers

COMMUNITY connections

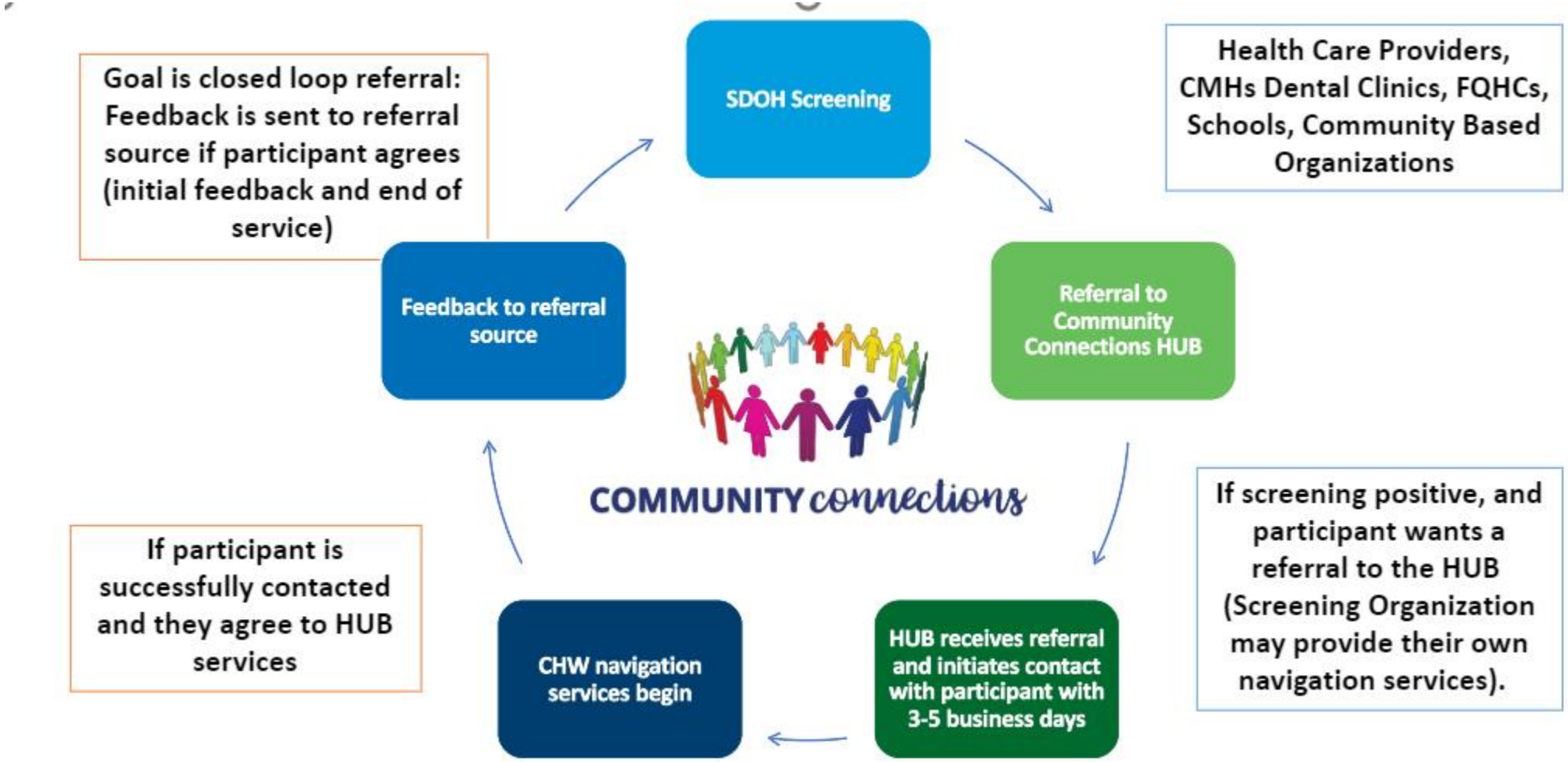
HUB	COUNTIES	NUMBER
Northwest Michigan HUB	Antrim, Charlevoix, Emmet, and Otsego	1-800-432-4121
District Health Department #4 HUB	Alpena, Cheboygan, Montmorency, and Presque Isle	1-800-221-0294
Grand Traverse Regional HUB	Benzie, Grand Traverse, and Leelanau	1-833-674-2159
District Health Department #10 HUB	Crawford, Kalkaska, Lake, Manistee, Mason, Mecosta, Missaukee, Newaygo, Oceana, and Wexford.	1-888-217-3904 (select option #3)
District Health Department #2 HUB	Alcona, Iosco, Ogemaw, and Oscoda	1-989-345-5020
Central Michigan District Health Department HUB	Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon	1-989-539-6731



COMMUNITY HEALTH INNOVATION REGIONS OF NORTHERN MICHIGAN

NORTHWEST | NORTH CENTRAL | NORTHEAST

Community Connection Process



Pathways Community HUB Model

- Adult Learning
- Behavioral Health
- Developmental screening and referral
- Education
- Employment
- Family Planning
- Health Insurance
- Housing
- Immunization Screening/Referral
- Lead
- Medical Home
- Medical Referral
- Medication Assessment/Management
- Pregnancy/Postpartum
- Tobacco Cessation

- Social Services:
  - Childcare
  - Clothing
  - Family Crisis
  - Financial Assistance
  - Food Security
  - Household Items
  - Legal Service
  - Translation
  - Transportation
  - Utilities
  - And more….

REFERRALS

CIE-Electronic Medical Record

(Doctors office only)

https://northernmichiganchir.org

(secure online)

Secure Fax

Phone

(client must call us themselves)

Making A Referral Page 1

Community Connections
Confidential Referral

From/Contact Person:	To: Community Connections
Referring Agency:	District Health Department #10 HUB (Crawford, Kalkaska, Manistee, Missaukee, Wexford Lake, Mason, Mecosta, Newaygo, Oceana Counties) Fax: 1-231-622-7413 Phone: 1-888-217-3904 ext 3
Phone:	Grand Traverse Regional HUB/Benzie-Leelanau District Health Department (Benzie, Grand Traverse, Leelanau Counties) Fax: 1-231-882-0143 Phone: 1-833-674-2159
Fax:	Health Department of Northwest Michigan HUB (Antrim, Charlevoix, Emmet, Otsego Counties) Fax: 1-231-547-6238 Phone: 1-800-432-4121
Date Referred:	District Health Department #4 HUB (Alpena, Cheboygan, Montmorency, and Presque Isle Counties) Fax: 1-989-354-0855 Phone: 1-800-221-0294
Health Care Provider (if known):	Date HUB Received: _____ ID #: _____

Print Name: _____ DOB: ____/____/____ Gender: _____
Parent/Guardian Name *(if a minor)*: _____
Primary Phone: ___ ___ ____ Alt. Phone: ___ ___ ____ County: _____
Address: _____ City: _____ Zip Code: _____
Preferred method of client contact: ☐ Phone ☐ Text _____
Insurance: ☐ Meridian Medicaid ☐ McLaren Medicaid ☐ Molina Medicaid ☐ Priority Health Medicaid ☐ United Healthcare Medicaid ☐ Straight Medicaid ☐ Private ☐ Medicare ☐ Uninsured ☐ Other
Is patient aware of referral? ☐ Yes ☐ No

Reason for Referral:
Medical/Social needs:

- ☐ At risk for dismissal _____
- ☐ Primary care referral/medical home
- ☐ Transportation
- ☐ Utilities
- ☐ Food
- ☐ Health Insurance
- ☐ Child Care/Adult Care
- ☐ Adult Education/Training
- ☐ Financial Assistance/Medical Debt
- ☐ Pregnancy Assistance
- ☐ Developmental Screening/Referral
- ☐ Dental referral
- ☐ Behavioral Health referral
- ☐ Health Education (specify): _____
- ☐ Housing
- ☐ Medication Assessment/Management
- ☐ Basic needs: clothing, shoes, bedding, baby items, etc....
- ☐ Immunizations
- ☐ Employment
- ☐ Translation Assistance
- ☐ Postpartum Assistance
- ☐ Legal Assistance

☐ Other _____

Making A Referral Page 2

Welcome to Community Connections. We can work together to help you and your family stay healthy!

Name _____

Name of Health Care Provider _____

Question	Yes	No
In the past month, did poor physical health keep you from doing your usual activities, like work, school or a hobby?	☐	☐
In the past month did poor mental health keep you from doing your usual activities, like work, school, or a hobby?	☐	☐
In the past 3 months, was there a time when you needed to see a doctor but could not because it cost too much?	☐	☐
In the past 3 months, have you had to eat less than you feel you should because there is not food?	☐	☐
Is it hard to find work or another source of income to meet your basic needs?	☐	☐
Are you worried that in the next few months, you may not have housing?	☐	☐
Has it been difficult to go to work or school because you couldn't find care for a child or older adult?	☐	☐
Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be something you would like to work on in the next 6 months?	☐	☐
Do you have trouble getting to school, work or the store because you don't have a way to get there?	☐	☐
In the past 3 months, have you had a hard time paying your utilities?	☐	☐
Have you been a patient in the Emergency Room 2 or more times in the past 6 months?	☐	☐

You identified some needs today that may make being healthy very difficult. Would you like someone from our team to assist you in person, via phone or text to work on the needs that you identified today? ☐ **Yes** ☐ **No** **If yes, please fill out your contact information below.** Thank you.

Print Name: _____ **DOB:** ___/___/___ **Gender:** _____

Parent/Guardian Name (If a minor): _____ **County:** _____

Address: _____ **City:** _____ **Primary phone:** _____

Preferred method of client contact: ☐ **Phone** ☐ **Text**

Signature _____ **Date:** _____ **Alt.phone:** _____

Responsible Representative Name (Optional): _____ **Phone:** _____

(We will not share any information with the Responsible Representative unless you have signed permission to do so.)

PATIENT CONSENT

REFERRAL CONSENT IS ONLY FOR CONTACTING CLIENT, NOT PROVIDING SERVICES

CLIENT WILL THEN BE ASKED BY OUR STAFF FOR CONSENT FOR SERVICES UPON INITIAL CONTACT

WE CAN PROVIDE FEEDBACK TO OFFICE ONLY WITH CLIENT CONSENT

MOU IS SIGNED BY REFERRING PARTNERS

BAA NEEDED TO SHARE FEEDBACK WITHOUT PATIENT CONSENT

Community Connections Client Quotes

Percent responding "definitely yes" or "mostly yes"

Listened to me 100%

"She was like a great guidance counselor. She helped me with, probably, some questions she's never heard before. It was like I was talking to a friend."

Dependable 98%

"She always followed-up, we were talking once or twice a week. She would set up times to call. I think that was hugely beneficial."

Kept me up to date 88%

"One thing that was special is that she would come to my house and explain things to me and keep me informed on the progress of what we were doing."

Honest 100%

Cared about me 98%

"I felt like I finally had an advocate, some support. I talked to a lot of people before and I felt like I had no support."

Easy to reach 98%

"I was able to contact her by phone, text and e-mail. Really easy to get ahold of her in multiple ways, and that was really nice."

Shared info according to my wishes 78%

Quotes documented from Community Connections Client Satisfaction Interviews conducted Oct – Dec 2019 by the University of Michigan Child Health Evaluation and Research Center

NORTHWEST COMMUNITY HEALTH INNOVATION REGION

POWERFUL IMPACT

COST SAVINGS $3M in Medicaid Health Plan savings Jan 2016 - Jan 2021 by reducing ER visits by 23.5% and inpatient stays by 25.5% [1]

EFFECTIVE COLLABORATION Unprecedented levels of cross-sector collaboration and increased recognition among local leaders of the role of social determinants of health in influencing health and other outcomes [2]

INCREASED SELF-EFFICACY 80% of clients who participated in the NMCHIR's Community Connections CHW Program reported being able to help themselves in the future [3]

COORDINATED SYSTEM Transformation of individual lives and the creation of more responsive & effective organizations and a more acessible, coordinated, service system [4]

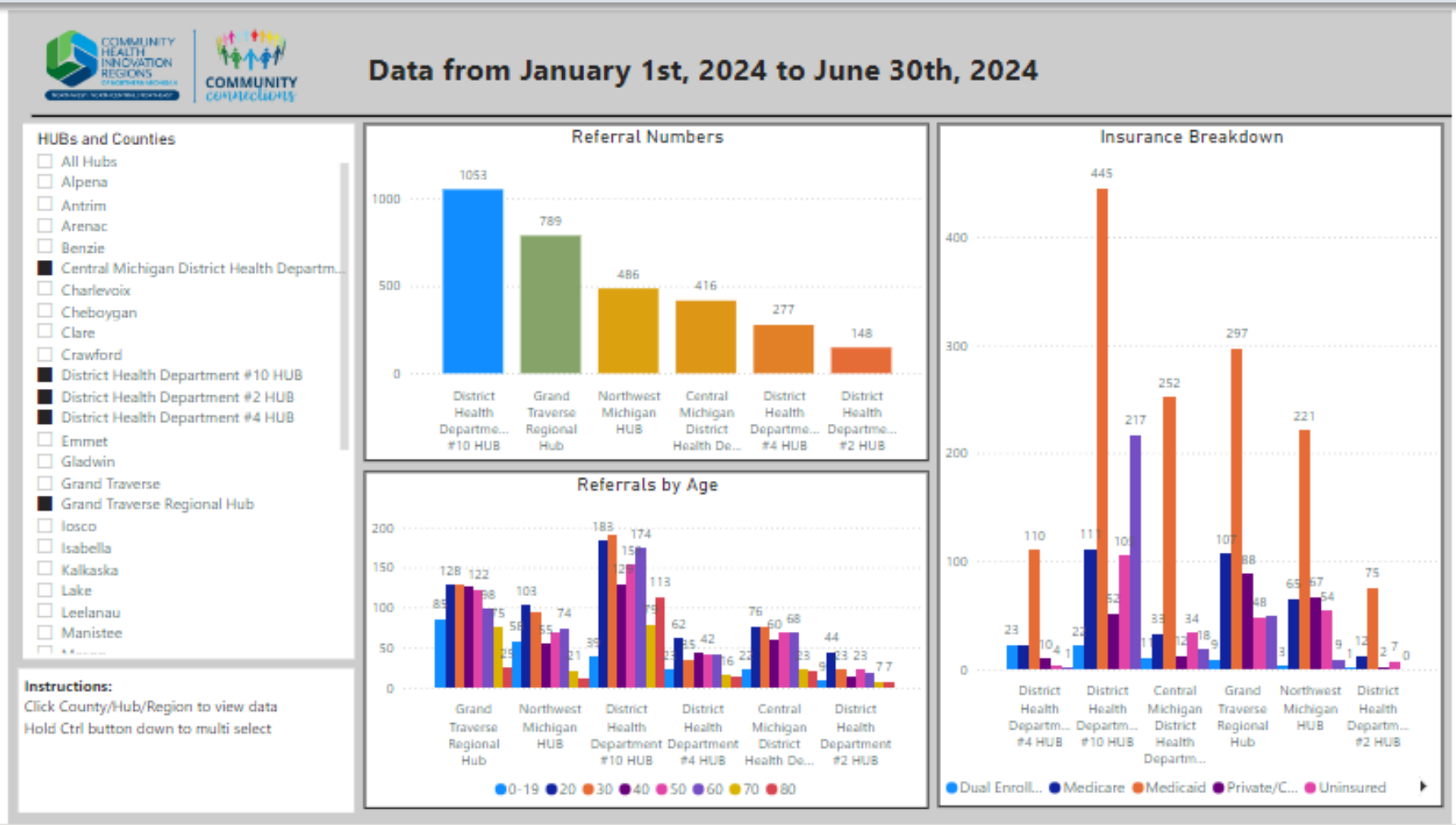
EXPENSE REDUCTION $1.21 in averted medical costs for every $1 of navigation services provided [5]

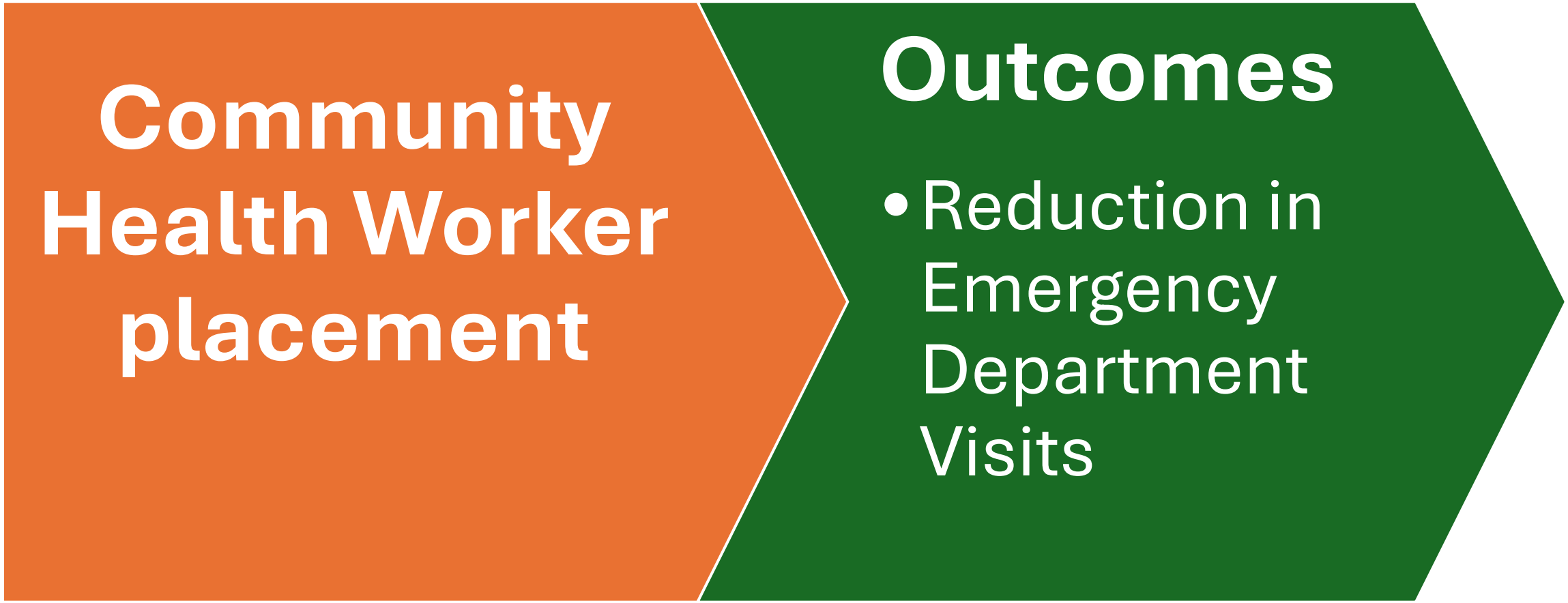
STRONG ROI Partnerships have provided $500K of base funding bringing in an additional $1M to local communities & reimbursement contracts

Sources: 1) MDHHS Analysis 2) 2022 MPHI Analysis 3) 2019 Customer Service Satisfaction Survey by UofM 4) 2019 Collective Impact Evaluation by MSU 5) 2021 MDHHS 2021 Report

COMMUNITY CONNECTIONS DATA & TRENDS

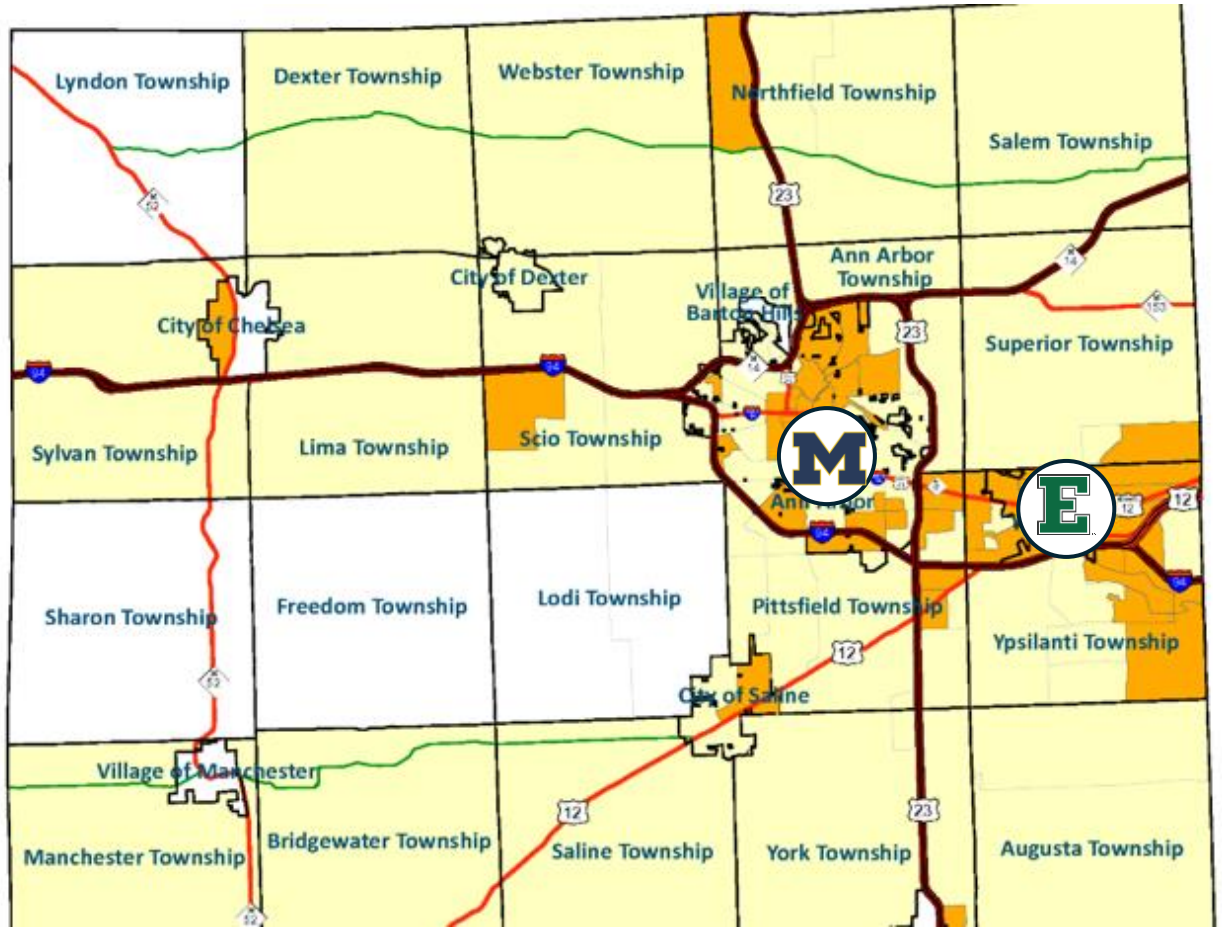
https://northernmichiganchir.org




Community Health Worker placement
Outcomes
• Reduction in Emergency Department Visits

About Washtenaw County

Washtenaw County Health Department

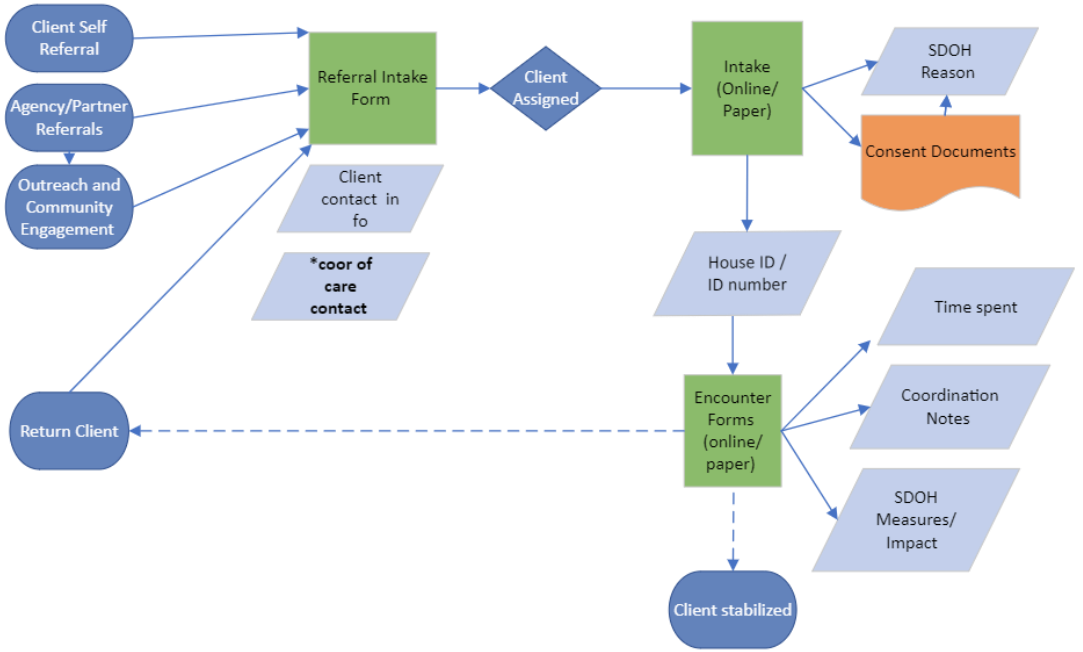


Healthy Neighborhood Team

- Started in July 2022
- Expected to have brief contacts, connections to resources, outreach around chronic health conditions
- Shift into more complex issues, much more need for assistance with housing, food, and mental health, therefore staff need for specialized training. Partners also see the same issues.
- Deepening community connections (community fun days and stop evictions)

Learning As We Go:

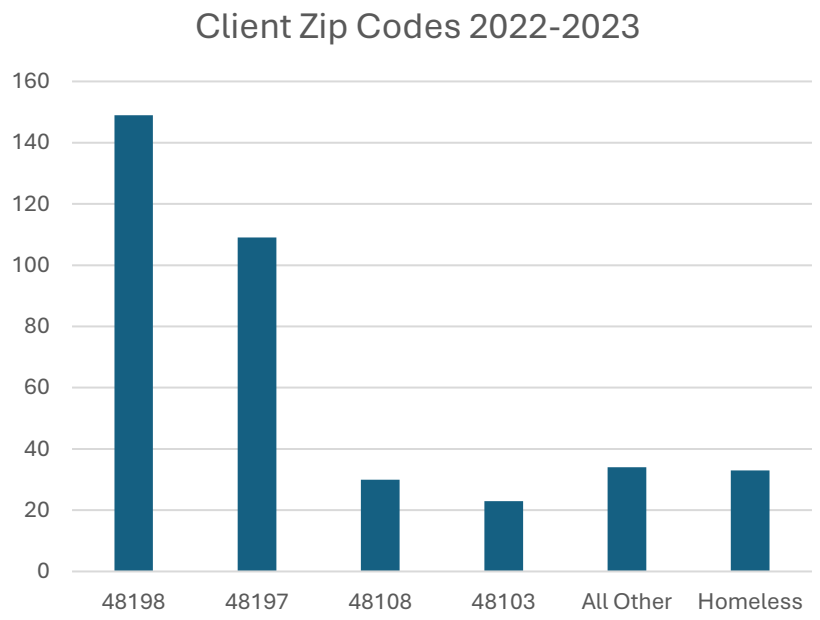
- Training for all staff
  - Certification for CHWs
  - Local services, partners, and resources
  - Knowing local history and stories
- Build client tracking and record keeping
- Build trust with organizations and community partners
- Learning from others
  - MICC/CHIR



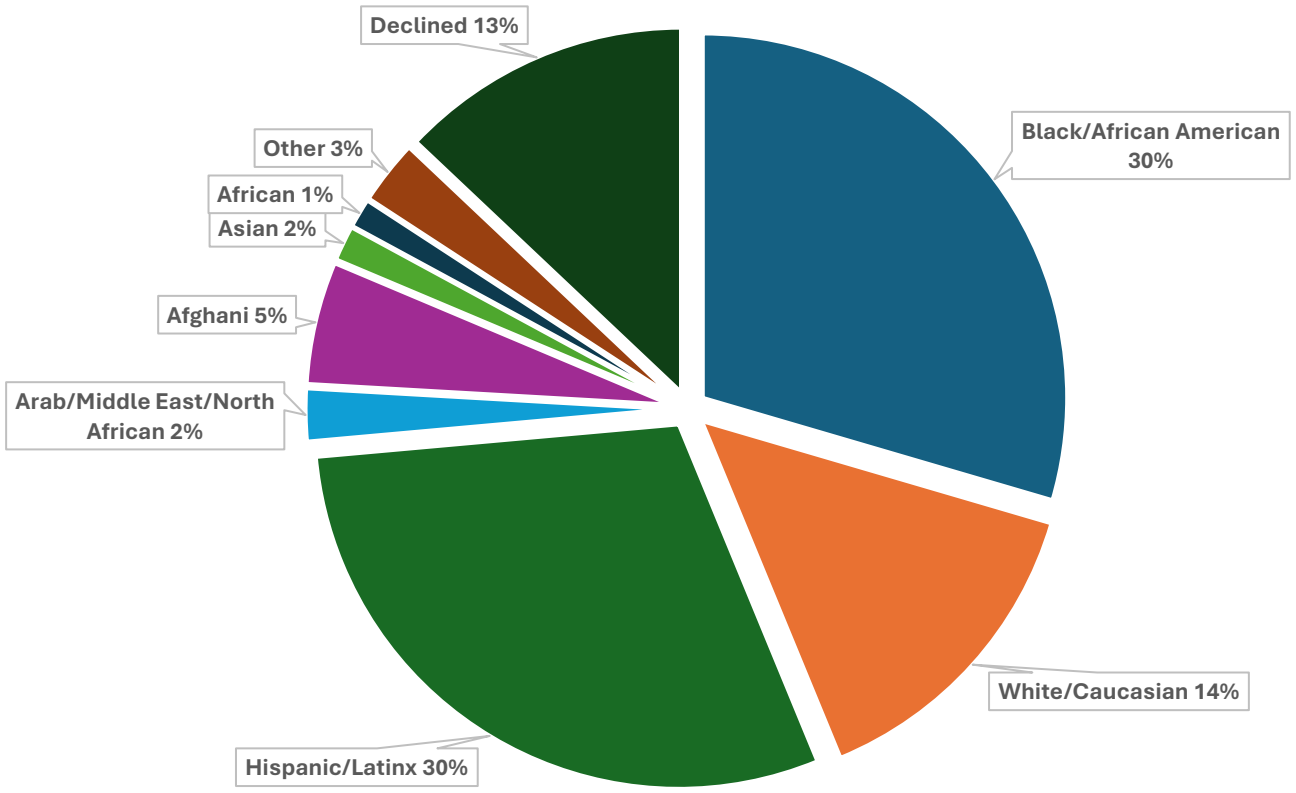
July 2022-September 2024: Intakes

- WIC
- MIHP/CSHCS
- Clinic Clients
- Health Systems
- Non-profit/Schools

About Healthy Neighborhood Clients



More client demographics



Our clients speak many languages!

English: 59%

Spanish: 28%

Pashto: 4%

Arabic: 2%

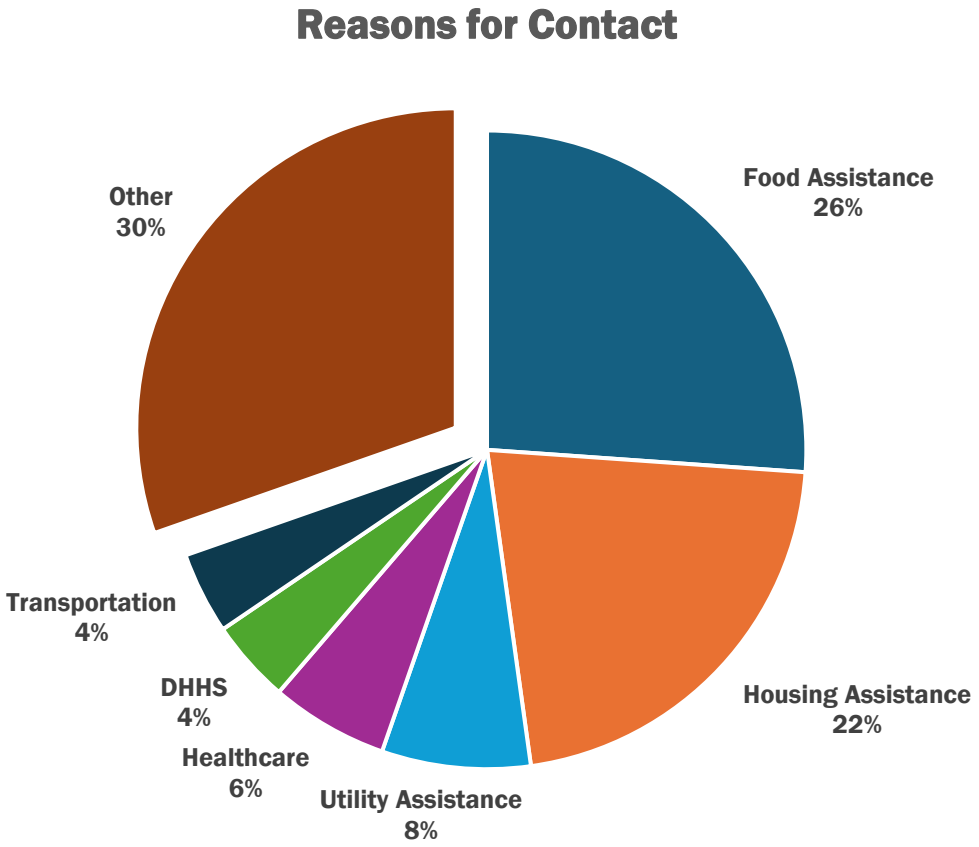
French: 2%

Dari: 1%

All Other 4%

All Other includes Russian, Mandarin, Swahili, Mandinka, Khmer, Farsi and more

Focus of Encounters



- Assistance with accessing food and housing were #1 and #2 reasons for contact.
- Concerns grouped under “other” include:
  - Clothing and household supplies,
  - Health insurance,
  - Social security,
  - Financial assistance,
  - School enrollment/support,
  - Healthcare access/scheduling
  - Legal aid,
  - English as a Second Language support

Client Success Stories

From client we helped with food assistance: "*Mil gracias por toda su ayuda de no aver sido por usted no lo ubiese logrado gracias."*

Connecting a senior facing housing foreclosure to the Housing Bureau for Seniors, who helped her access $12,000 in mortgage assistance, saving her home!

From OCED staffer regarding eviction prevention assistance our CHW provided: "*I am truly impressed with your efforts. Thank you for providing the care and attention that was due to this family. I hope your continued attention will ensure their stability going forward."*

Client Success Stories

Homeless client fleeing violence: Assisted with housing, furniture, medical appointments and mental health support. *"I wanna thank you for all the help you've done for me and my family…"*

Text from landlord of client, family of 9, found rental assistance to avoid eviction: " *I…really appreciate your efforts to help this poor family and other families, you're a very kind woman…"*

Text from client, who has 8 children, helped with FAP and CMH services: "I just wanted to say thank you for following up with me with a phone call. We talked a bit about how difficult it's been getting help for our situation—having someone take the time to get back to me is really meaningful at this point. Thank you again."

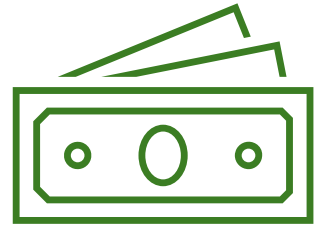
What is the larger success story?

Preventing evictions saves thousands of dollars for the community, stops the disruption of lives, keeps kids in school.

Getting people food, or money for food, allows them to spend more money on housing, utilities, and transportation. It keeps people healthy!

In partnership with other WCHD programs and county-wide programs, through our outreach efforts the Health Department is seen as accessible and a place where people can get problems solved.

If You Ain’t Got The Do-Re-Mi….



That’s a reference to Woody Guthrie’s song “Do Re Mi”

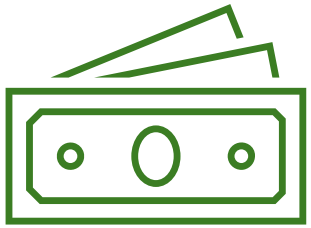
Money changes everything
I said money, money changes everything
We think we know what we're doin'
That don't mean a thing
It's all in the past now
Money changes everything

--Cyndi Lauper, Money Changes Everything

When we dream it, when we dream it, when we dream it
We'll dream it, dream it for free, free money
Free money, free money, free money, free money, free money
Free money
Every night before I go to sleep
Find a ticket, win a lottery
Every night before I rest my head
See those dollar bills go swirling 'round my bed

--Patti Smith, Free Money

Sustainability and Funding



District 10

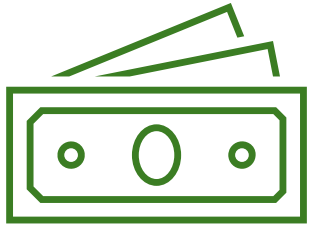
- Growth: 4 to15 CHWs
- 34 CHW's- NM SDOH HUB
- 140% Capacity
- Diversified Funding
  - Medicaid Health Plans
  - Medicaid Reimbursement
  - Medicaid Outreach
  - Grant funding (State/Federal/Local)
  - Local partners (Munson Healthcare, KMHC, Northern Care Partners PHO)
  - Exploration of Medicare billing

WCHD

- Program started with ARPA Funding
- Growth: 4-6 CHWs
- ARPA funding ends 12/31/2024
- Search for sustainability:
  - Grant writing—local and state grants—SDOH, climate change, community violence, etc.
  - Analysis of Medicaid and SNAP Outreach (requires a 50% non-federal match)
  - Medicaid billing limitations
- Reluctance on part of funders to continue long-term funding without "sustainability"

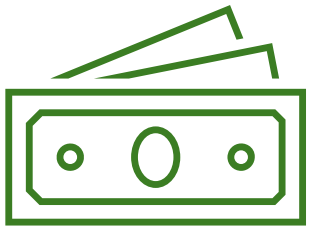
Challenges and Threats to Sustainability

- Billing Medicaid/Medicare
  - Reimbursement rate is insufficient, covers in person work only
- SNAP and Medicaid outreach
  - Matching dollars (Cannot be Federal)
  - Complex formula
- Funders
  - Lack of long term sustainability
- Wrong Pocket Theory
  - SNAP benefits support the client/grocery store, not the health department
  - Getting someone to take their medications correctly may save the health system money, not the health department
- Advocacy of CHW role
  - Who they are and what they can do

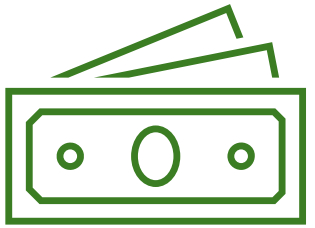


Public Health 3.0 workforce

- Training matters, and takes time. Time=Money
- 6-12 months to fully onboard a CHW
  - New to public health/new to profession
  - Includes understanding the community they are serving
  - Certification (8 week program through MICHWA)
  - Working and trust building relationships with clients
  - Working and trust building with other organizations and partners
  - Record keeping systems (EMR)
- Transition for Coworkers to Public Health 3.0 Mindset
  - Where does CHW work fit?



Ways to Advocate for CHW Sustainability



- Community Health Workers (michigan.gov)
- MICHWA
- Local CHW subgroups
- Conversations with stakeholders about funding needs, the wrong pocket theory, sharing effectiveness and Return On Investment proof

Questions?

Thank you!

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