



Saving Lives. Protecting People. Through Prevention.

*“Bridging the Gap: The Role Of Community Health
Workers in Preventing and Controlling Chronic
Diseases”*

Wayne H. Giles, MD, MS
September 5, 2013



Centers for Disease Control and Prevention

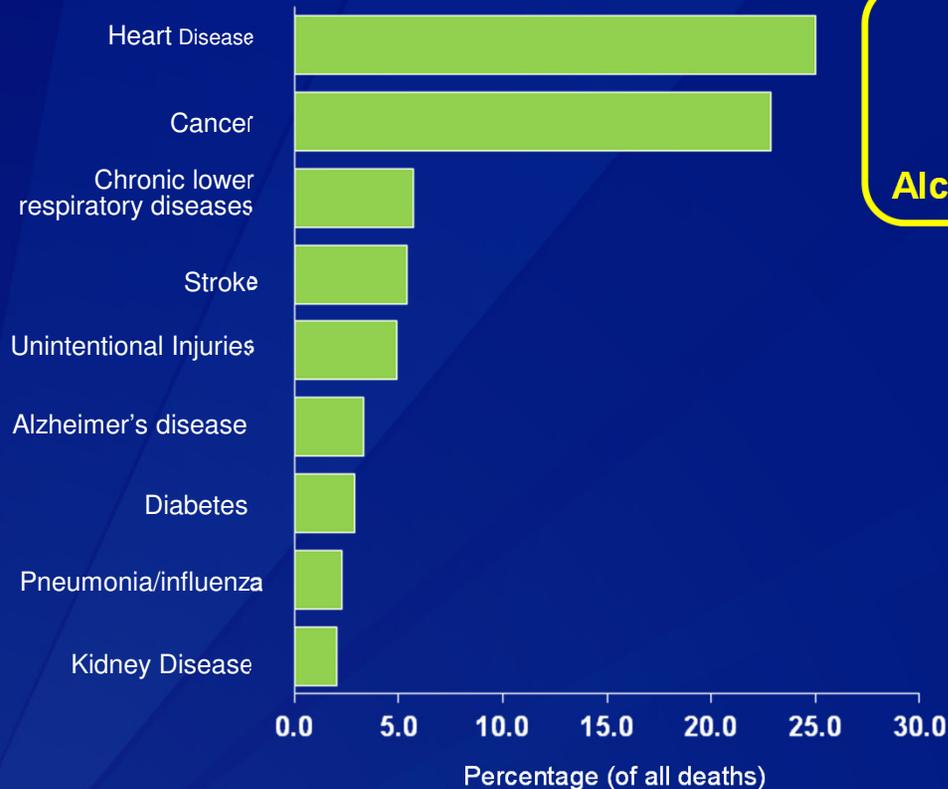
Division of Population Health

Overview

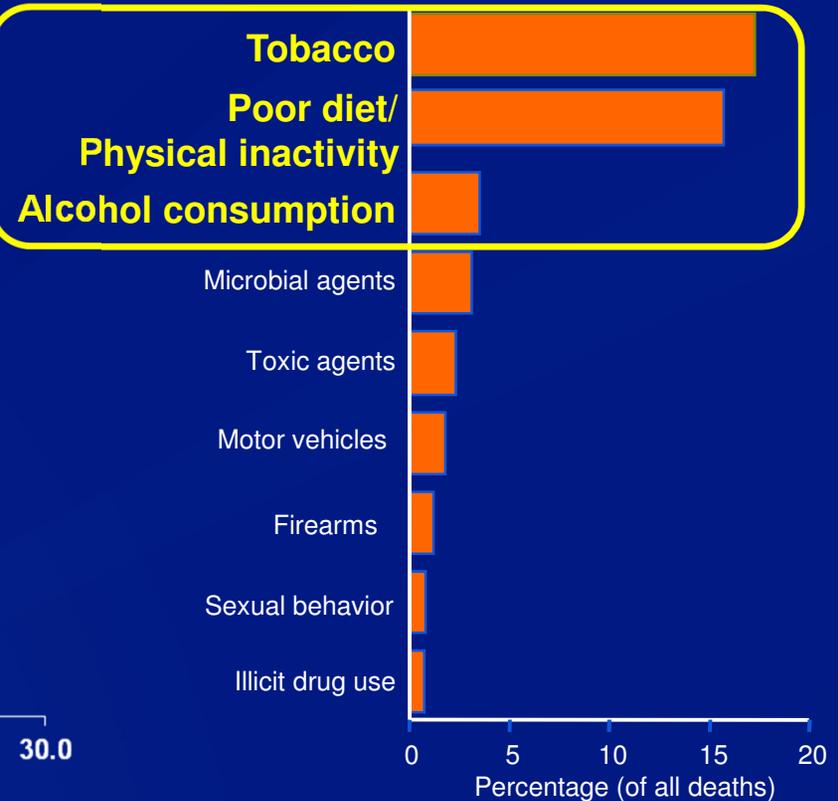
- Why Chronic Disease
- State of health care delivery
- Role of community health workers
- Health disparities
- Current environment
- Resources

What are the Drivers?

Leading Causes of Death[†]
United States, 2008



Actual Causes of Death[†]
United States, 2000



* Minino AM, Murphy SL, Xu J, Kochanek KD. Deaths: Final data for 2008. National vital statistics reports; vol 59 no 10. Hyattsville, MD: National Center for Health Statistics. 2011.

† Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

Disabilities

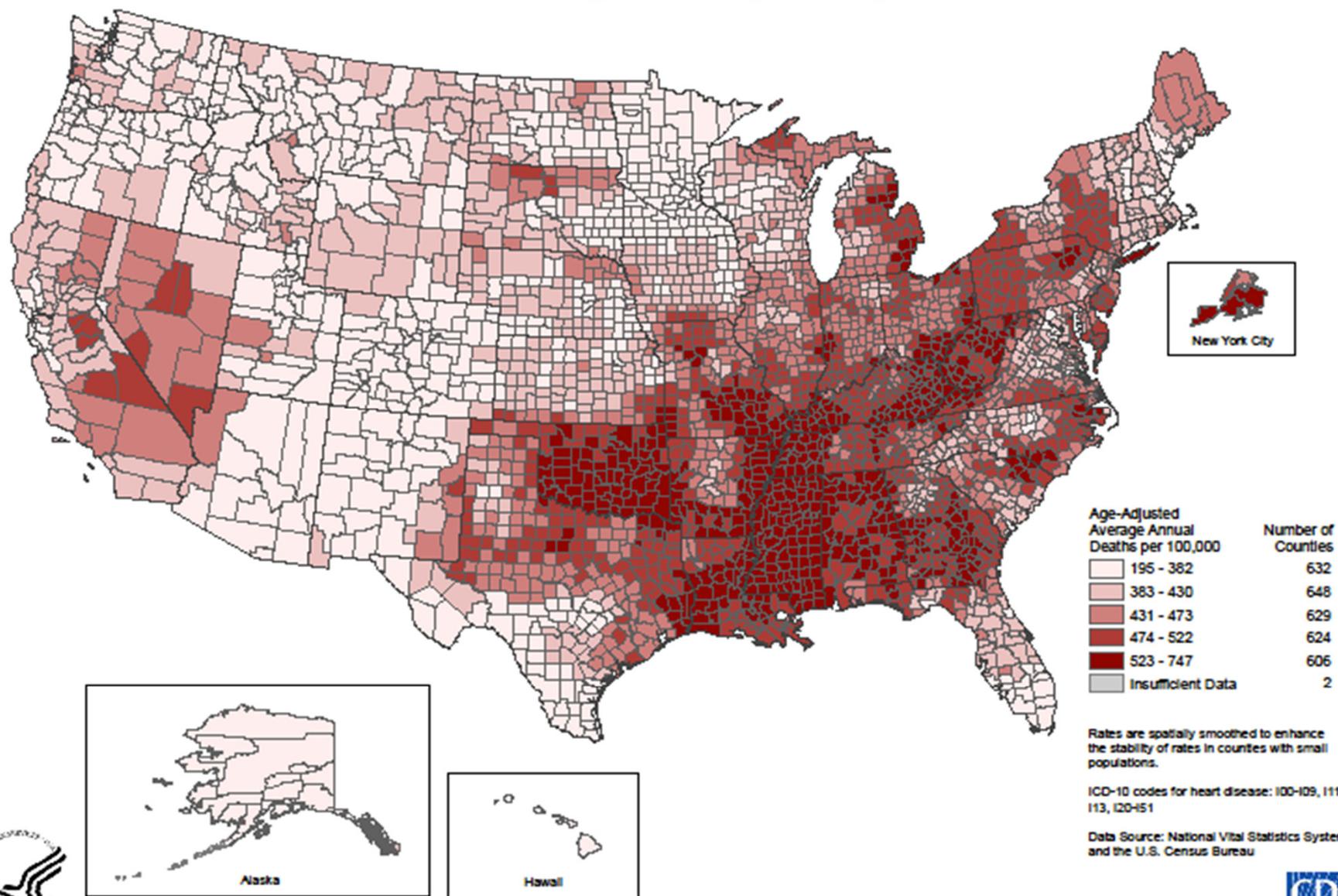
- ❑ **Arthritis** – is the number one cause of disability
- ❑ **Stroke** – has left 1 million Americans with disabilities
- ❑ **Heart Disease** – the leading cause of premature, permanent disability in the U.S. workforce
- ❑ **Diabetes** – the leading cause of kidney failure and new blindness in adults



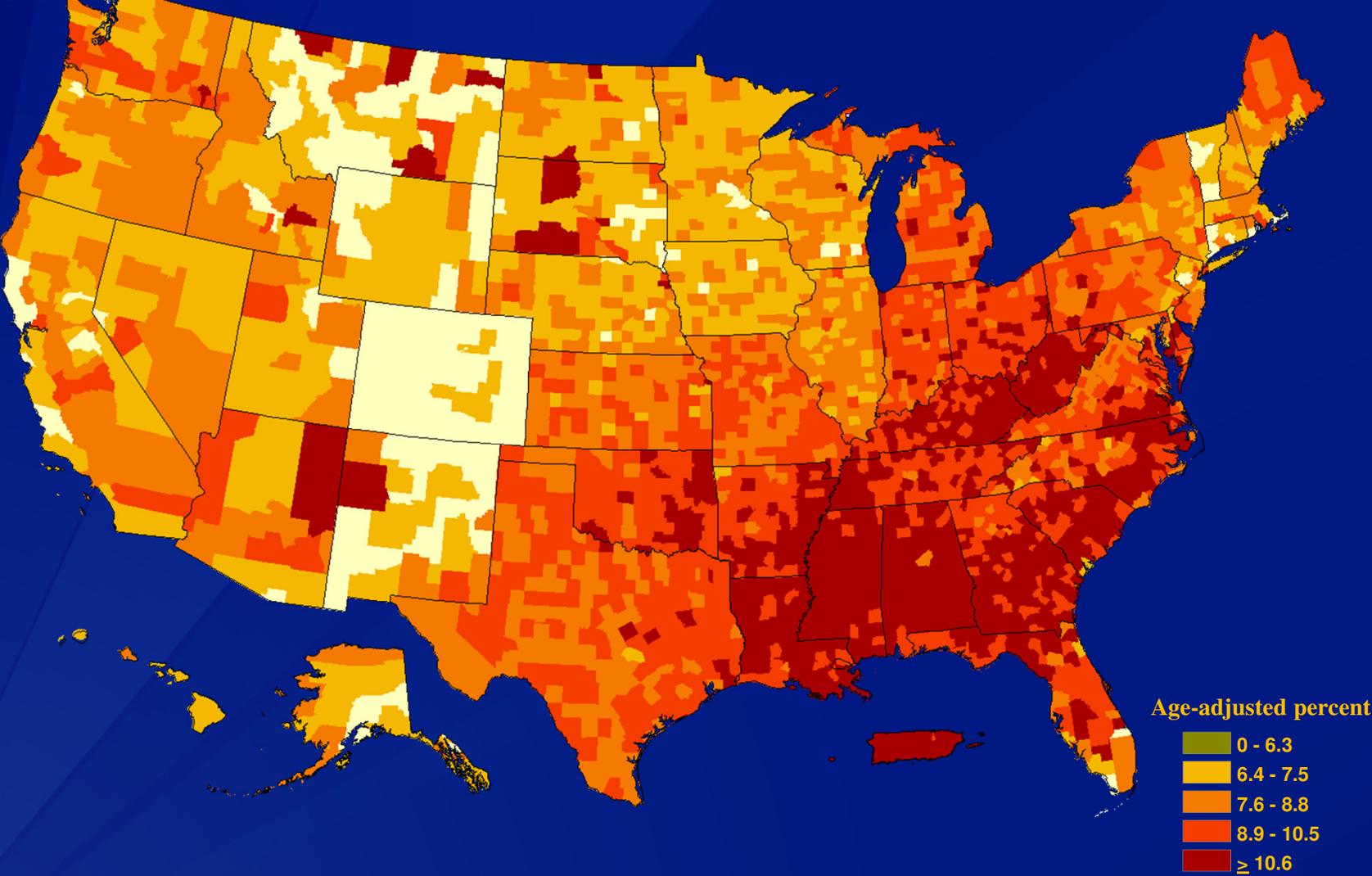
Alarming Health Disparities

- ❑ Heart disease death rates **30% higher** for African-Americans than whites; stroke death rates **41% higher**
- ❑ Diabetes higher among American Indians and Alaska Natives (**2.3 times**), African Americans (**1.6 times**), and Hispanics (**1.5 times**)
- ❑ About **30%** of Hispanics and **20%** of African Americans lack a usual source of health care compared with less than **16%** of whites

Heart Disease Death Rates, 2000-2006 Adults Ages 35+, by County



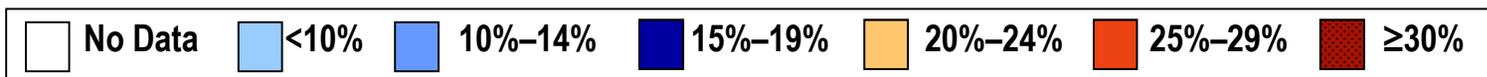
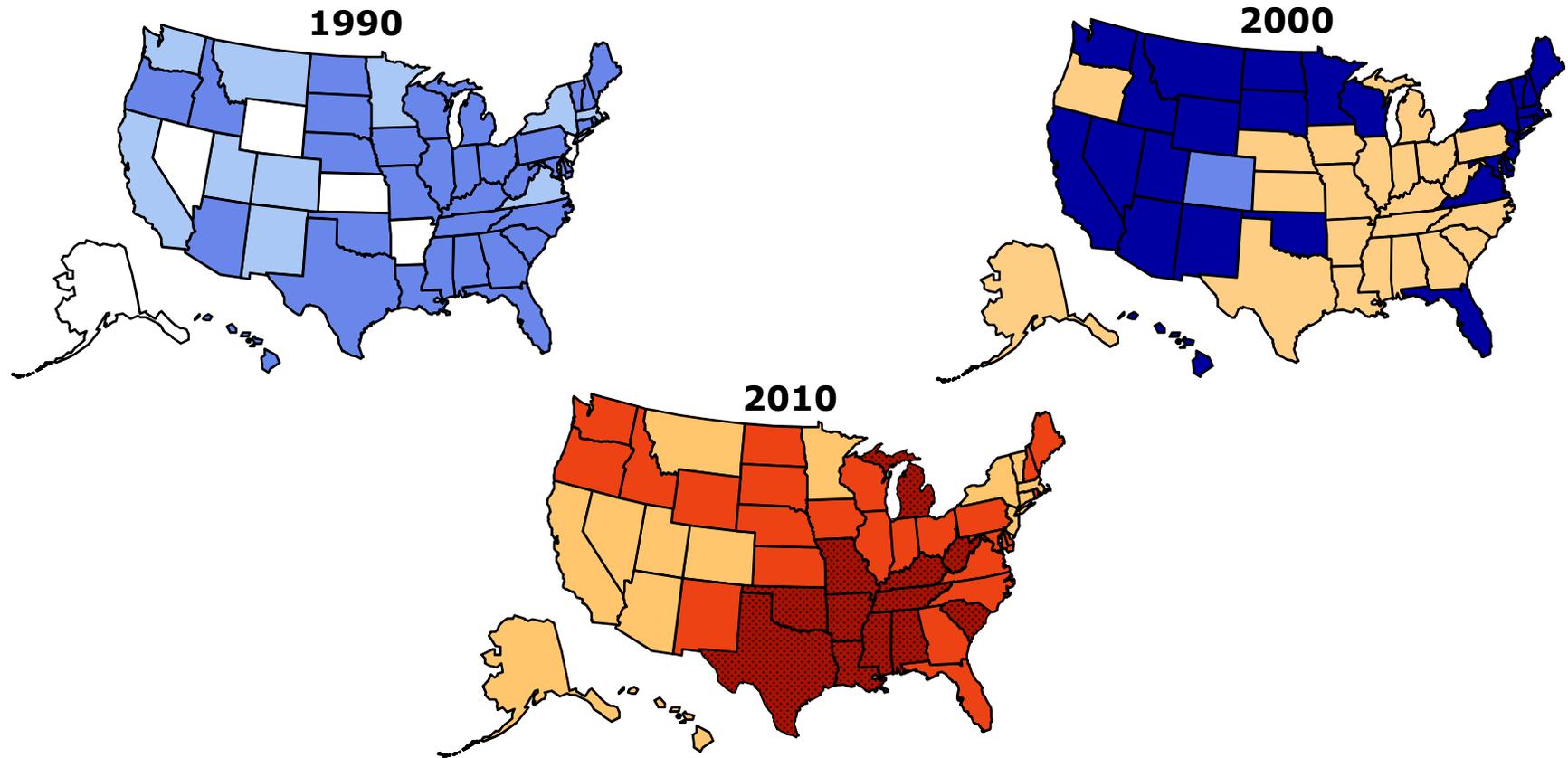
County-level Estimates of Diagnosed Diabetes among Adults aged ≥ 20 years: United States 2009



Obesity Trends* Among U.S. Adults

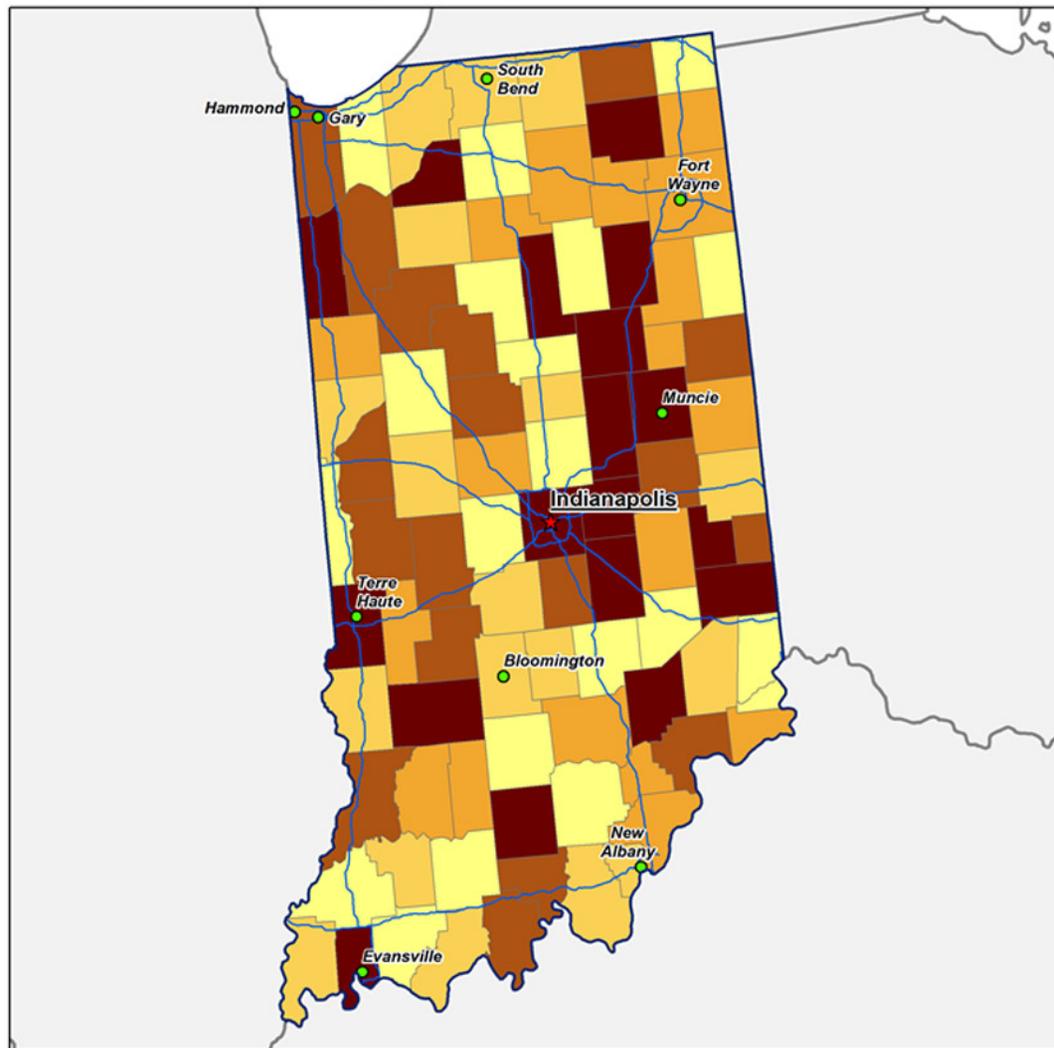
BRFSS, 1990, 2000, 2010

(*BMI ≥ 30 , or about 30 lbs. overweight for 5'4" person)



Source: Behavioral Risk Factor Surveillance System, CDC.

Prevalence of Current Smoking among Adults Aged ≥ 18 Years, by County: 2011



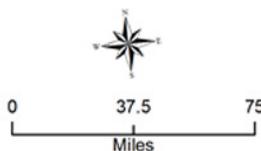
Indiana

Data Source:
Behavioral Risk Factor Surveillance System
(BRFSS) 2011, Census 2010, ACS 2007-2011

Method: Multilevel small area estimation

Classification by Quintiles

Map produced by CDC/NCCDPHP/DPH/ESB-GIS

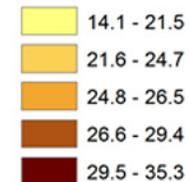


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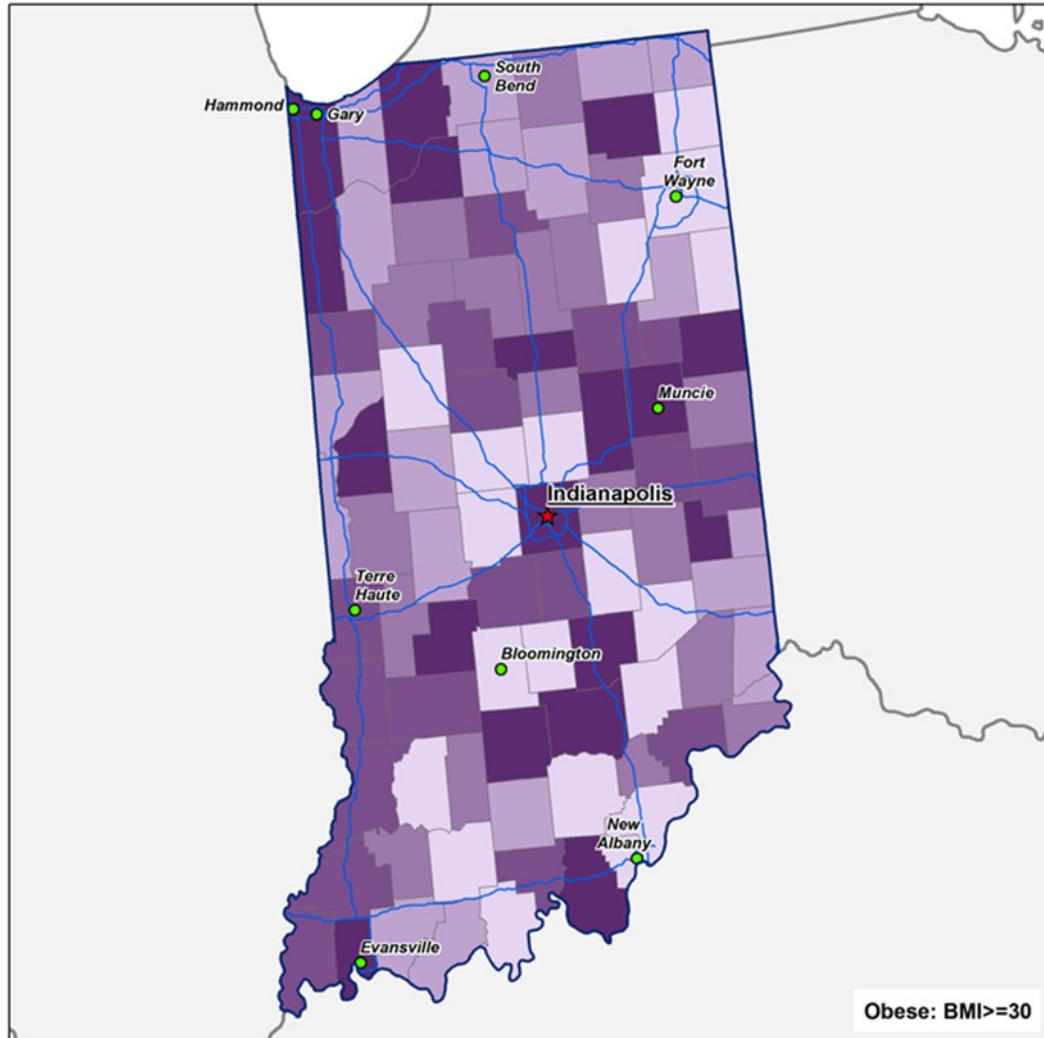
- ★ State Capital
- Cities
- Interstates



Percent



Prevalence of Obesity among Adults Aged ≥ 18 Years, by County: 2011



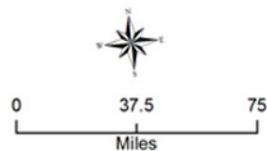
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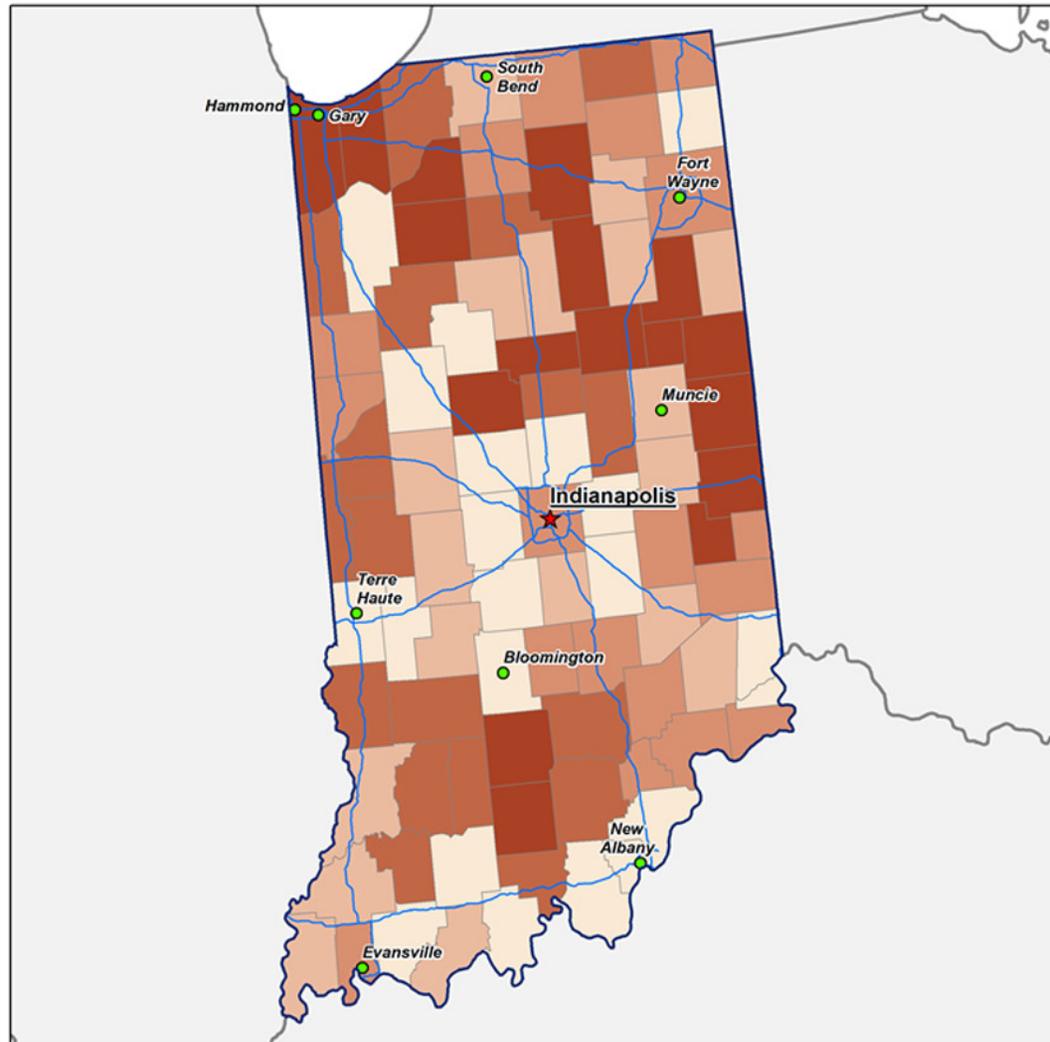
- ★ State Capital
- Cities
- Interstates



Percent

	22.2 - 27.7
	27.8 - 29.4
	29.5 - 31.1
	31.2 - 32.8
	32.9 - 45.8

Percentage of Adults Aged ≥ 18 Years with Diabetes, by County: 2011



Indiana

Data Source:
Behavioral Risk Factor Surveillance System
(BRFSS) 2011, Census 2010, ACS 07-11

Method: Multilevel small area estimation

Classification by Quintiles

Map produced by CDC/NCCDPHP/DPH/ESB-GIS



Date: 8/14/2013

- ★ State Capital
- Cities
- Interstates



Percent

	6.5 - 9.2
	9.3 - 9.8
	9.9 - 10.3
	10.4 - 11.1
	11.2 - 13.3

Chronic Diseases

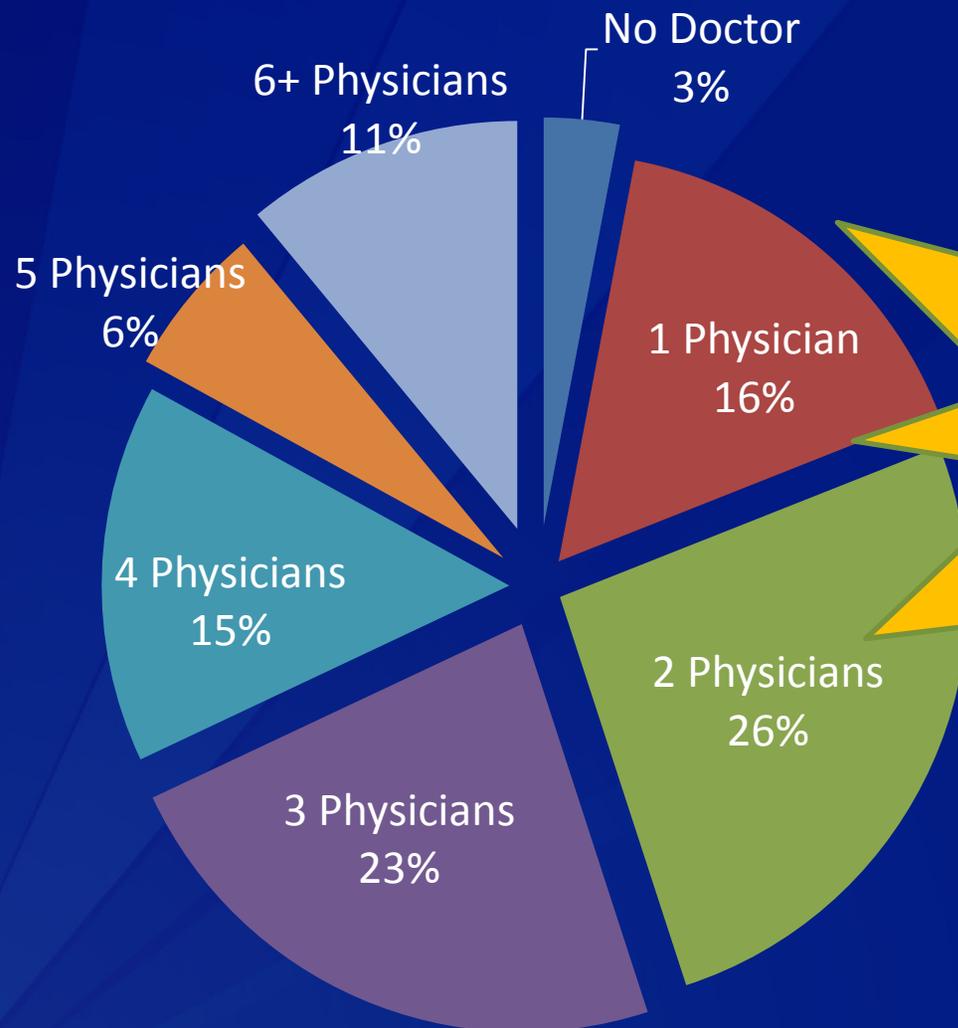
Responsible for 7 of every 10 U.S. deaths

Cause major limitations in daily living
for 1 of 10 Americans

Account for ~75% of U.S. medical costs

Are inequitably distributed
across the population

Fragmented Care – More than Half of People with Serious Chronic Conditions Have 3 or More Physicians



A third of FFS beneficiaries are treated for 4± chronic conditions yearly. A typical Medicare beneficiary sees 2 primary care physicians and 5 specialists working in 4 different practices.

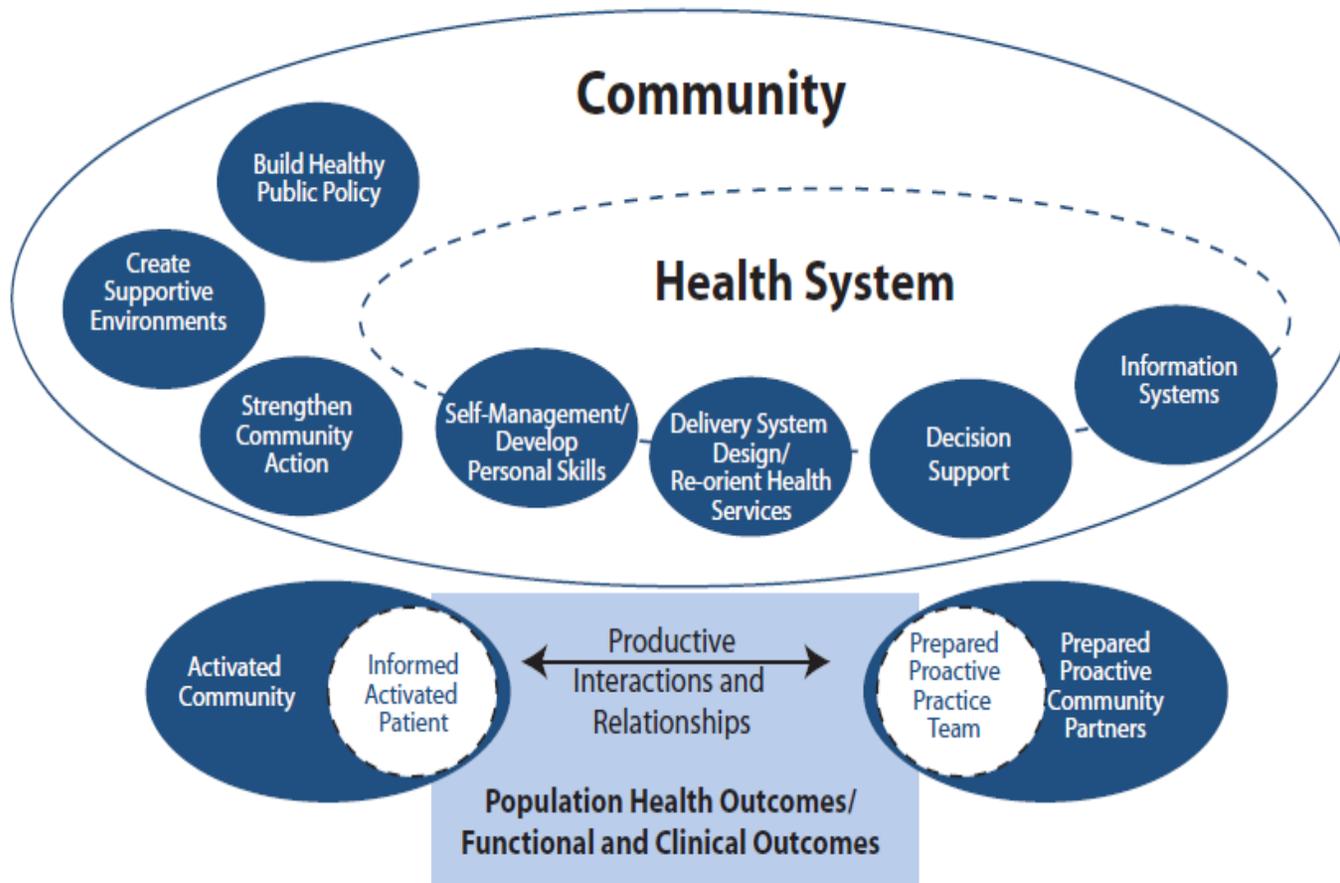
The Best Opportunity To Maximize Health



Leverage the Far Larger Personal Health System to Achieve Population Health Goals

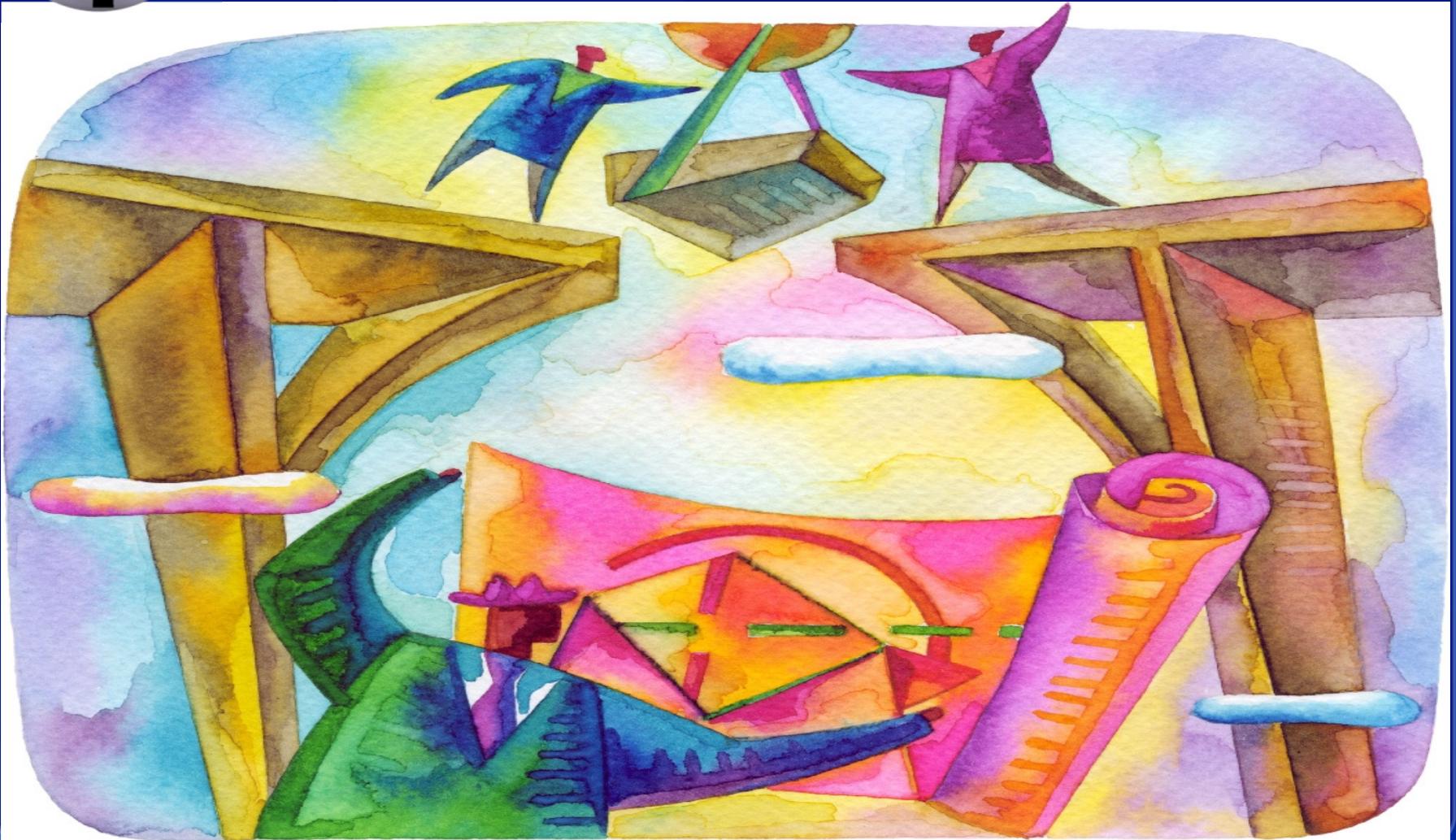
NOT TO SCALE

Expanded Chronic Care Model





Community-Clinical Linkages



Community Health Workers



- ❑ *Liaison between health systems and communities*
- ❑ *Facilitate access to and improve quality and cultural competence of medical care*
- ❑ *Build individual and community capacity for health by:*
 - *Increasing health knowledge and self-sufficiency of the patients*
 - *Serving as community health educators*
 - *Providing social support*
 - *Advocating for the health care needs of patients and communities*

Health issues addressed by CHWs

- Top five issues as reported by CHWs
 - Diabetes (44%)
 - Nutrition (39%)
 - Tobacco Control (37%)
 - Mental Health (31%)
 - High Blood pressure (30%)

Health issues addressed by CHW

- Top five issues reported by employers/payers:
 - Pregnancy & PNC (54%)
 - Diabetes (42%)
 - Nutrition (42%)
 - Breastfeeding (39%)
 - Infant Health (35%)

Most pressing needs of those served as identified by CHWs and employers

- Health information
- Disease management
- Social support
 - Transportation
 - Employment

Chronic Disease Self-Management Program



- ❑ *Low-cost, community-based class for people with chronic diseases developed at Stanford University*
- ❑ *A CDC meta-analysis of CDSMP showed improvements in fatigue, depression, health distress, etc.*
- ❑ *CDC's Arthritis Program funds 12 state arthritis programs that can offer CDSMP as a proven intervention*

Examples of change that works: Children's CAI, Boston, MA

Approaches

Provides case management, training, and education to children with asthma and their families



Outcomes

After 1 year, CAI patients' ED visits at Children's were reduced by 65% and hospital admissions by 81%. Lost schools days were reduced by 39%.

Achieving Health Equity



In theory, policy, systems, and environmental change should affect all equally.

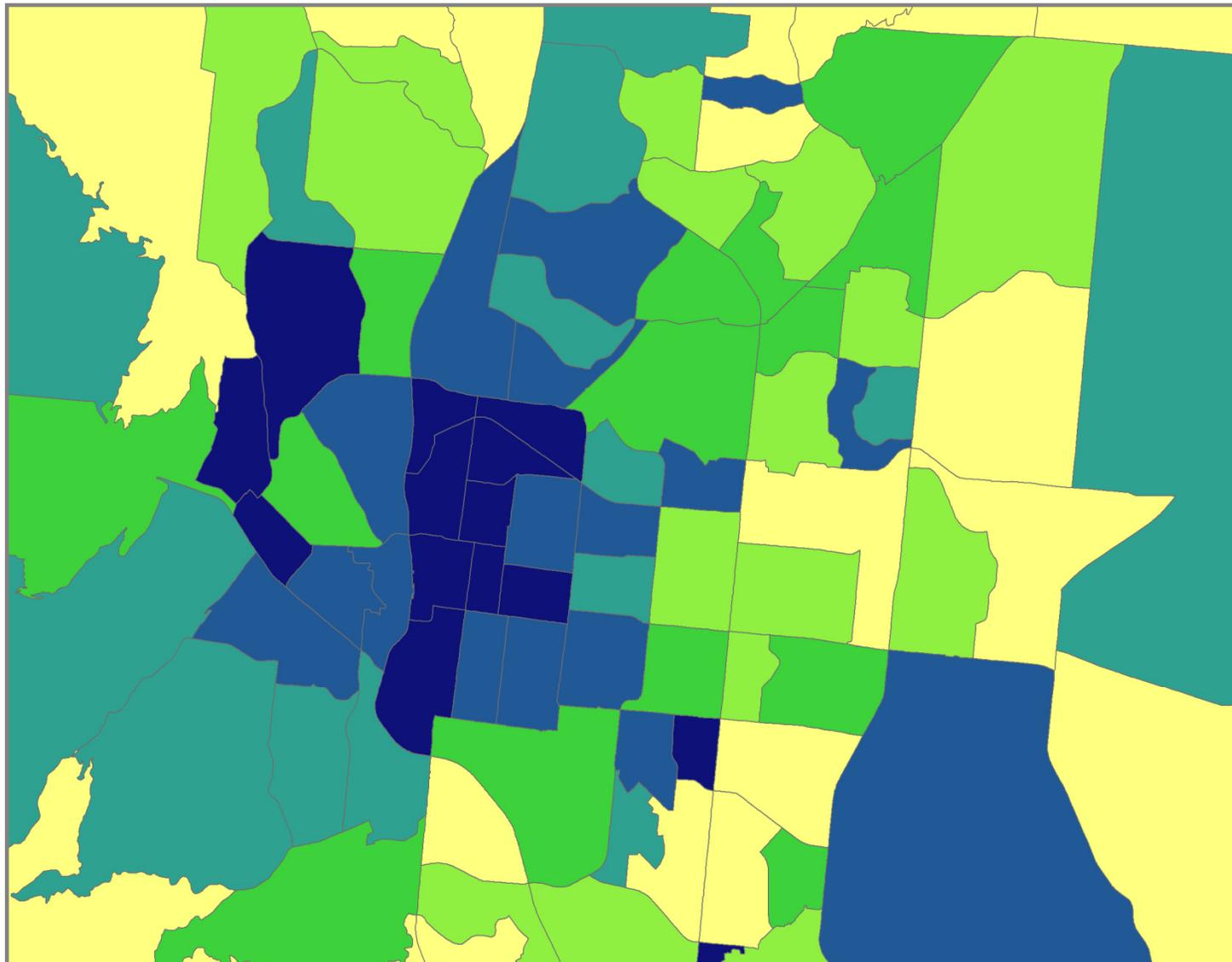
In practice, this may not be the case.

- Varying support
- Differential enforcement
- Selection factors
- Relationships
- Implementation challenges

Goal: Make sure “jurisdiction wide” interventions impact all population equitably

Obesity Rates in Community X, 2010

Community XXXX Obesity Rate by XXXX, Year xxxx



Legend

Obesity Rate

-  >=30%
-  25-29%
-  20-24%
-  15-19%
-  10-14%

Obesity burden inversely correlated with income



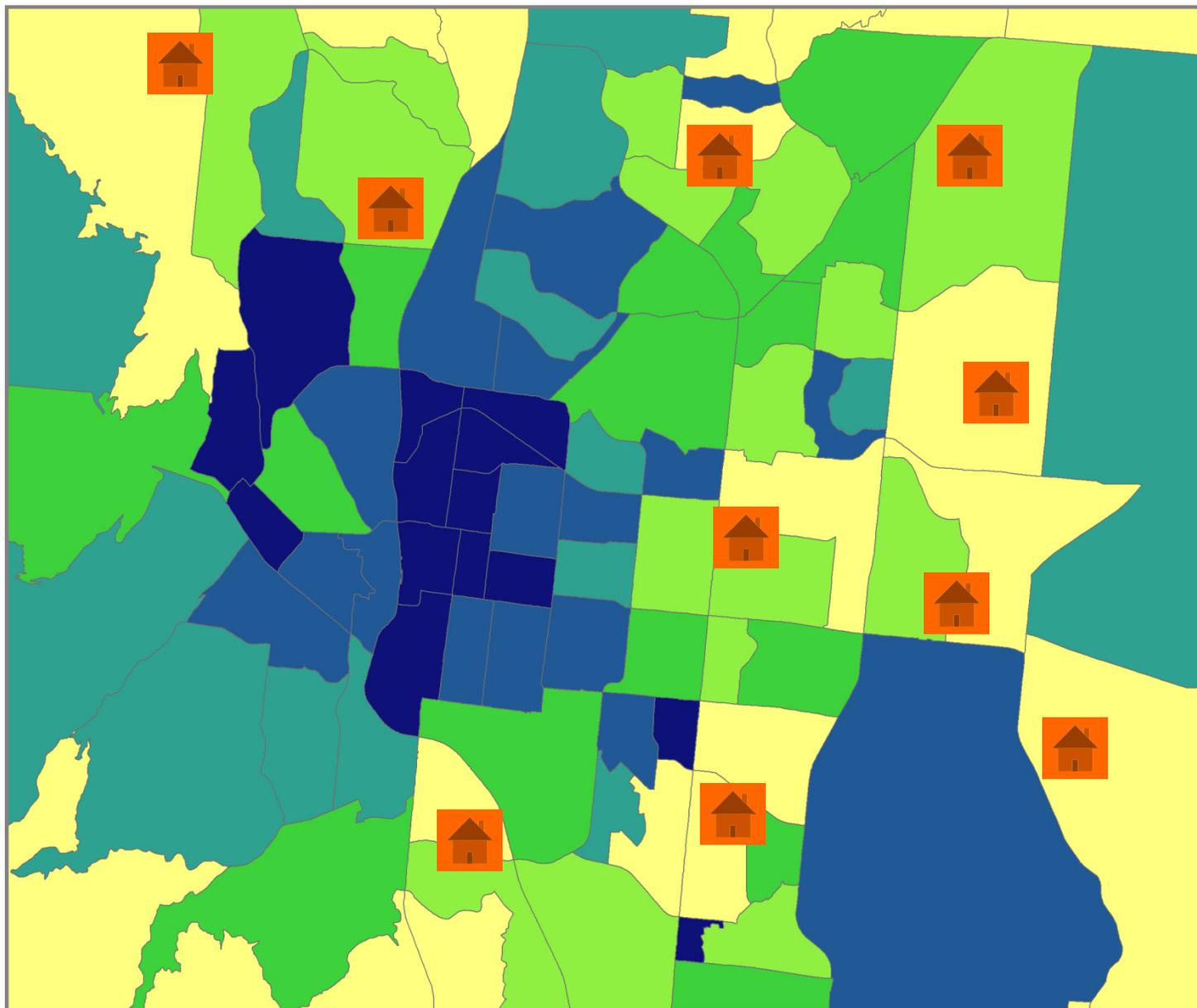
Community X's draft Community Action Plan

Goal: Within 24 months,
place **10** community health
worker to address health
disparities

Focus on readiness

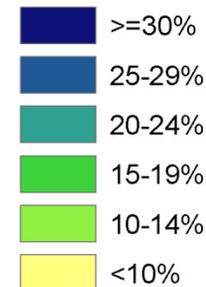


Community Health Workers in Community X's CAP



Legend

Obesity Rate



=

**Community
Health
Workers**



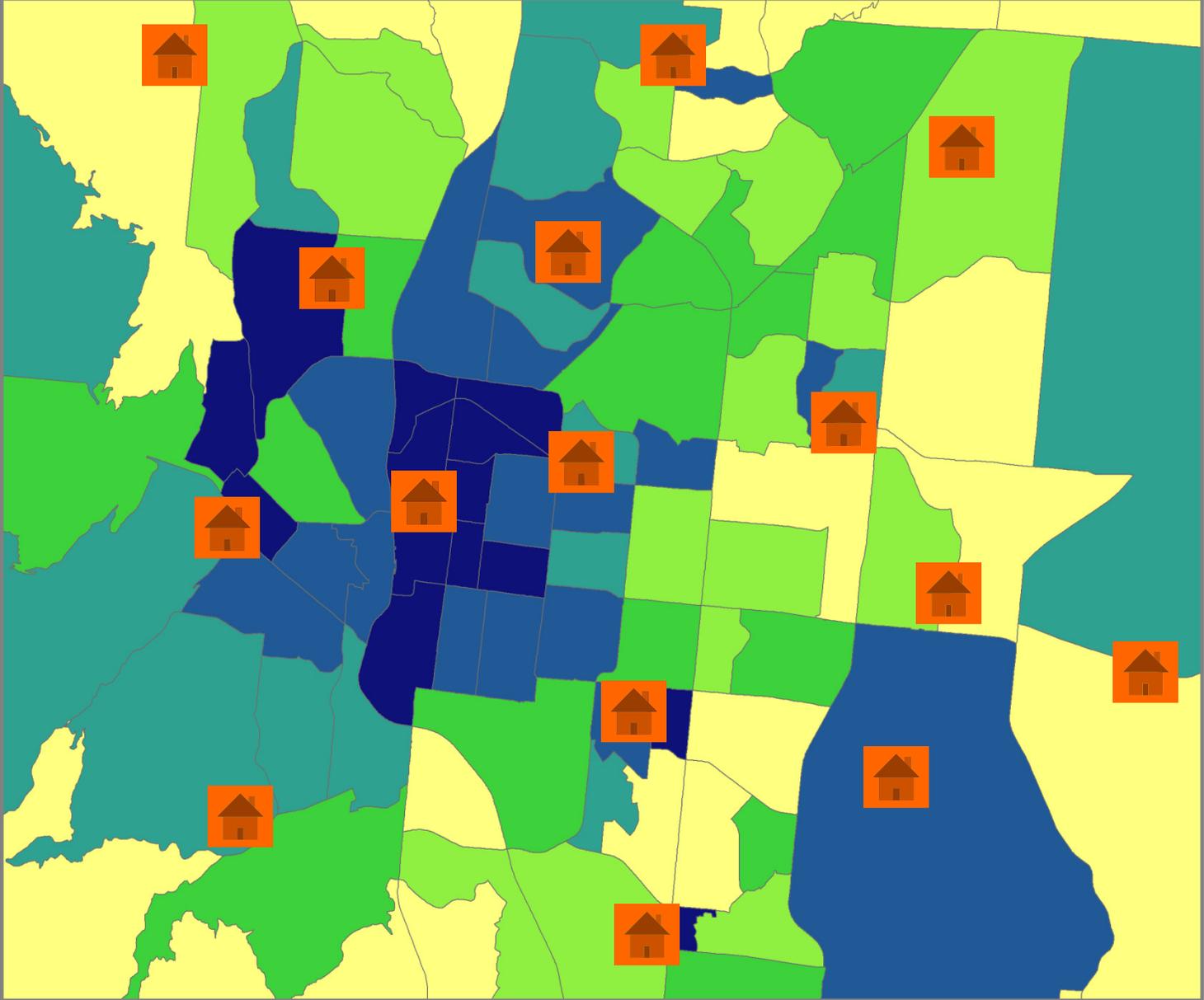
Community X's revised Community Action Plan

Goal: Within 24 months, establish **15** CHW sites, including at least **7** in low-income neighborhoods with greatest obesity burden

Focus on health equity



Community Health Workers in Community X's Revised Community Action Plan



Legend

Obesity Rate

- $\geq 30\%$
- 25-29%
- 20-24%
- 15-19%
- 10-14%
- $< 10\%$

 =
Community Health Workers





DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

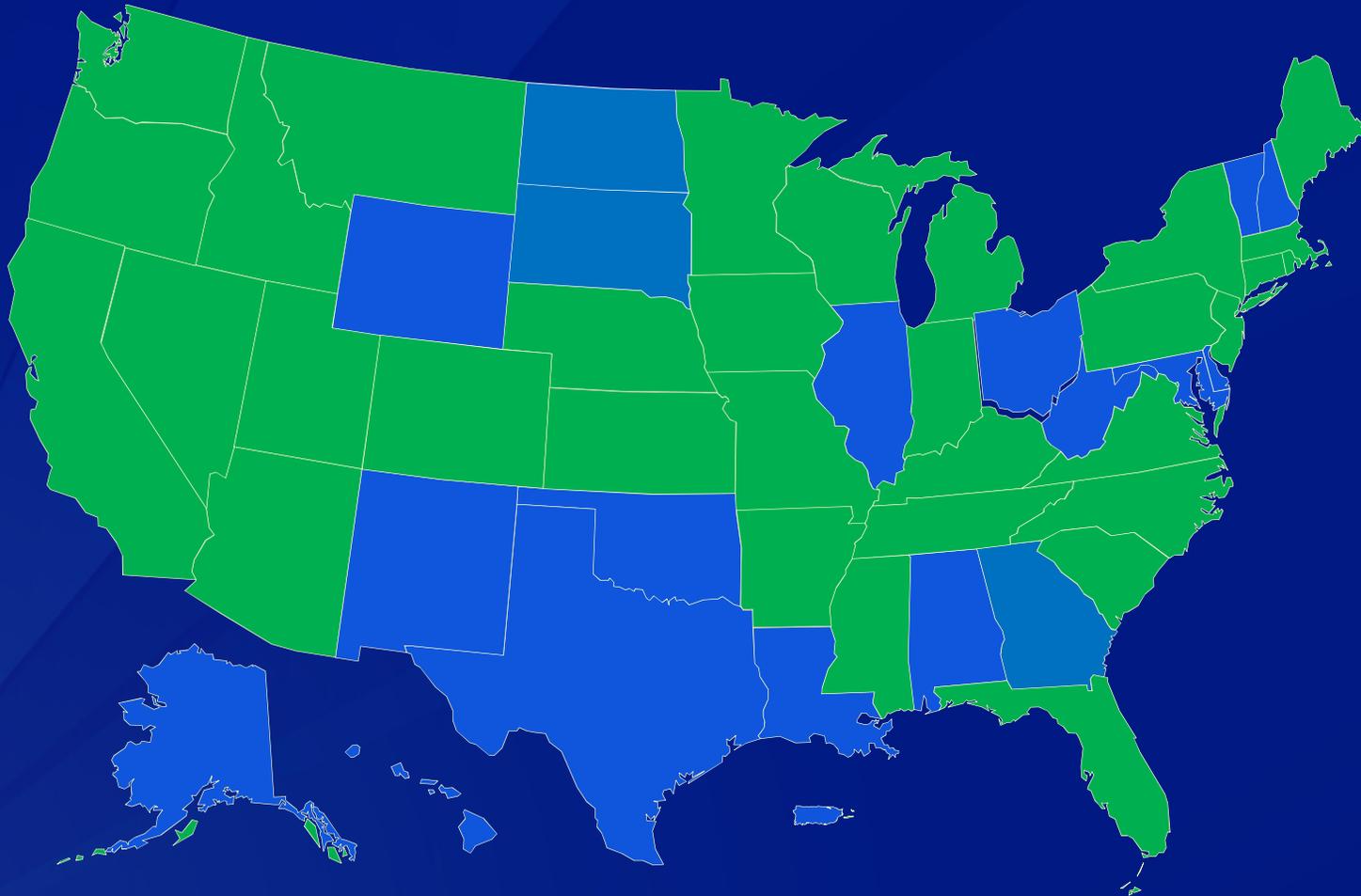


State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health

- Fund public health departments in all 50 states and District of Columbia
- Creates synergies between the school health, diabetes, heart disease and stroke, nutrition, physical activity and obesity prevention programs
- Includes some funding for chronic disease self management education at the enhanced level



32 States funded for Enhanced Initiatives



A reformed delivery system will support and reward those who improve the health of populations

Acute Health Care System

- ✓ High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Coordinated Seamless Health Care System

- High quality acute care
- ✓ Accountable care systems
- ✓ Shared financial risk
- ✓ Case management and preventive care systems
- ✓ Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Community Integrated Health Care System

- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- ✓ Population-based health outcomes
- ✓ Care system integration with community health resources

CMS Innovation Center

Charge: Identify, Test, Evaluate, Scale

“The purpose of the Center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP...while preserving or enhancing the quality of care furnished.”

- ❑ **Resources:** \$10 billion funding for FY2011 through 2019
- ❑ **Opportunity to “scale up”:** The HHS Secretary has the authority to expand successful models to the national level
- ❑ **Building the center:** Status

State Innovation Models

- ❑ \$275 million competitive funding opportunity for States to design and test multi-payer payment and delivery models that deliver high-quality health care and improve health system performance.
- ❑ Only governors from states and U.S. Territories and the mayor of the District of Columbia may submit applications for Model Design and Testing funding.
- ❑ Up to 30 States to design or implement multi-payer payment and service delivery models.

State Innovation Awards

- ❑ Model design and pre-test awards
 - States develop transformative payment and delivery reforms
 - Up to 25 States
 - Up to \$50 million
- ❑ Model testing awards
 - States test and evaluate multi-payer health system transformation models including commercial and employer-sponsored plans.
 - Up \$225 million over three to four years
 - Up to five States

Medicaid Funding

- *Medicaid Coverage of Community Health Workers*

Some prevention initiatives rely on new types of providers (such as Community Health Workers (CHWs)) who have not typically been recognized for purposes of reimbursement by Medicaid, Medicare or commercial insurers. Federal Medicaid statute requires that preventive services be recommended by a physician or other licensed practitioner. Current regulations require that services be provided by or under the direction of a physician or other licensed practitioner; **however, CMS recently proposed revised regulations that would give states the ability to recognize unlicensed practitioners in the delivery of preventive services.** The reality is that while some states have been able to navigate existing Medicaid rules to cover nontraditional providers, it is challenging. Minnesota allows CHWs to reimburse for services through its State Plan, and New Mexico is requiring managed care plans to provide CHW services.

Resources



Addressing Chronic Disease through
Community Health Workers:
A POLICY AND SYSTEMS-LEVEL APPROACH

A POLICY BRIEF ON COMMUNITY HEALTH WORKERS

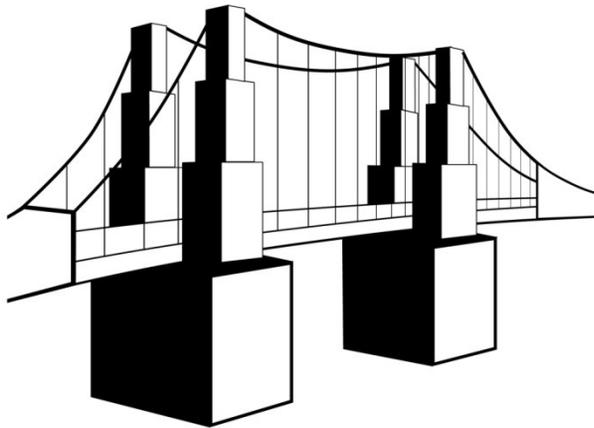
National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention



Resources

A Handbook for Enhancing Community Health Worker Programs: Guidance From the National Breast and Cervical Cancer Early Detection Program

Part 1

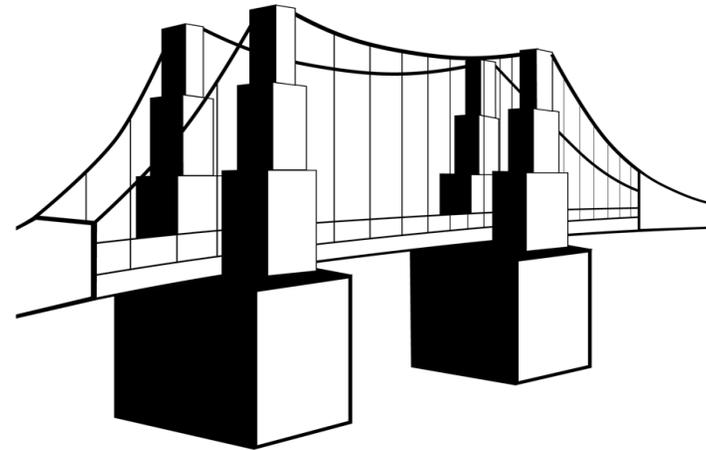


CDC
CENTERS FOR DISEASE CONTROL
AND PREVENTION

NTC Division of Cancer
Prevention and Control
National Training Center

Breast and Cervical Cancer Messages for Community Health Worker Programs: A Training Packet

Part 2



CDC
CENTERS FOR DISEASE CONTROL
AND PREVENTION

NTC Division of Cancer
Prevention and Control
National Training Center

Widespread Change...



within our grasp

Saving Lives. Protecting People. Through Prevention.



For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333

Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348

E-mail: cdcinfo@cdc.gov Web: <http://www.cdc.gov>

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.



Office of the Director

Division of Population Health