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

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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

- Heart Disease
- Cancer
- Chronic lower respiratory diseases
- Stroke
- Unintentional Injuries
- Alzheimer’s disease
- Diabetes
- Pneumonia/influenza
- Kidney Disease

Percentage (of all deaths)

Actual Causes of Death†
United States, 2000

- Tobacco
- Poor diet/
  Physical inactivity
- Alcohol consumption
- Microbial agents
- Toxic agents
- Motor vehicles
- Firearms
- Sexual behavior
- Illicit drug use

Percentage (of all deaths)

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
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


Method: Multilevel small area estimation

Classification by Quintiles

State Capital
Cities
Interstates

Percent
14.1 - 21.5
21.6 - 24.7
24.8 - 26.5
26.6 - 29.4
29.5 - 35.3

Map produced by CDC/NCCDPHP/DPHS/ESB/GIS
Date: 8/14/2013
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: Multi-level small area estimation

Classification by Quintiles

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

Date: 8/14/2013
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.

Source: Jane Horvath, “Reining in the Cost of Chronic Illness,” AHRQ, 2003
The Best Opportunity To Maximize Health

Leverage the Far Larger Personal Health System to Achieve Population Health Goals
Expanded Chronic Care Model

- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Action
- Self-Management/Develop Personal Skills
- Delivery System Design/Re-orient Health Services
- Decision Support
- Information Systems

Community

Health System

Activated Community
Informed Activated Patient

Population Health Outcomes/Functional and Clinical Outcomes

Productive Interactions and Relationships
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 burden inversely correlated with income
Goal: Within 24 months, place 10 community health worker to address health disparities

Focus on readiness
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

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

= Community Health Workers

Miles
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

- **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
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.

Source: Nemours, “Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models.” 2013
Resources

A Handbook for Enhancing Community Health Worker Programs: Guidance From the National Breast and Cervical Cancer Early Detection Program
Part 1

Breast and Cervical Cancer Messages for Community Health Worker Programs: A Training Packet
Part 2
Widespread Change...

within our grasp