Learning Days 2019

April 10th, 2019

Moving beyond grants to sustainable CHW models

Session Objectives

Participants will:

- Understand how community events can reach previously unidentified populations

- Successfully bill (and receive reimbursement from) insurance companies

- Believe that evaluation can be easy and fun

- Laugh along with CHWs as they share their experiences

CHW Solutions
Community Health Worker services made easy

- Owned by Community Health Workers
- Launched in 2016
- Based in St. Paul with a state-wide service area and nation-wide consulting
- Dedicated to developing sustainable models for Community Health Worker (CHW) services
- Service buckets
  - Direct CHW services
  - Clinical oversight and claims submission
  - Technical assistance and consulting

www.chwsolutions.com

Presenters

- Megan Nieto
  - CHW certificate holder since 2017

- LaTrese Vanburen
  - CHW certificate holder since 2018

- Megan Ellingson
  - CHW certificate holder since 2018

- David Rak

Why Community Health Workers (CHWs)?

- Frontline health professionals trained to provide health education and self-management support

- Represent diverse backgrounds and can bridge cultural and linguistic barriers

- Trained to assess and address social determinants that impact health

- In MN, CHWs can obtain a certificate via a standardized 17-credit curriculum offered at several post-secondary schools, including one offered fully online

- MN Health Care Programs, including through managed care organizations, provide reimbursement for CHW services

For a great video on CHWs, see Dr. Rishi Manchanda's TED talk:

"What makes us sick? Look upstream."

https://www.ted.com/talks/rishi_manchanda_what_makes_us_get_sick_look_upstream

Identifying Clients in the Community

- A low-key, friendly way to connect

- Reach new community members who may face significant barriers to traditional clinical care

- Target different geographic areas and patient populations

- Use assessment tools to identify community members at-risk for chronic disease

- Begin delivering educational messages

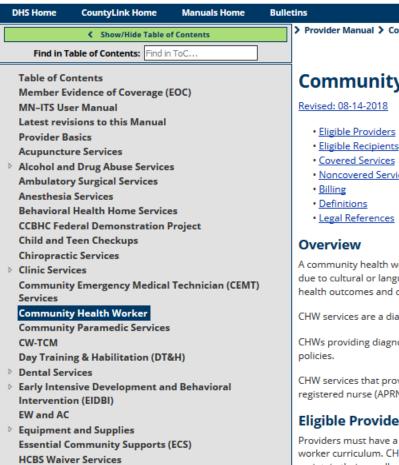- Set up a time to connect with the patient (in-home visit)

Medical Assistance Reimbursement for Sustainability

- Medical assistance covers face-to-face CHW services provided by a certificate-holding community health worker

- Detailed list of possible eligible services developed by the Healthy Communities Taskforce (funded by GTCUW/Medtronic)
  - Understanding diagnosis, treatment, medication, complications, self-management, risk factors, prevention, screening
  - Self-management of health conditions and health education
  - Wellness, prevention, immunizations, nutrition and other health promotion activities
  - Non-disease-specific patient education for prevention and health promotion
  - Culturally appropriate communication, patient engagement and patient education between providers and their patients

- 60% to 70% (on average) of a CHW's time needs to be face-to-face with pts in order to be sustainable

- CHW visits should be scheduled to include time for documentation while still face-to-face

- Scripting can help CHWs become comfortable with using a tablet or laptop while still at a patient's home

- Additional IT and HIPAA considerations when documenting outside of the office

- MHCP does not cover social services such as enrollment assistance, case management or advocacy delivered by a CHW

DHS Provider Manual Basics

- The online MHCP Provider Manual is your primary information source for MHCP coverage policies, rates and billing procedures and is updated on an ongoing basis

- As a provider, you are responsible to check <u>frequently</u> for updates, changes, and additions
  - U9 modifier for groups >8

- Community Health Worker has its own section

- DHS Provider Call Center
  - 651-431-2700
  - 800-366-5411

DEPARTMENT OF HUMAN SERVICES

DHS Home   CountyLink Home   Manuals Home   Bulletins

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Community Health Worker (CHW)

Revised: 08-14-2018

- Eligible Providers
- Eligible Recipients
- Covered Services
- Noncovered Services
- Billing
- Definitions
- Legal References

Overview

A community health worker (CHW) is a trained health educator who works with Minnesota Health Care Prog due to cultural or language barriers. CHWs extend the reach of providers into underserved communities, re health outcomes and overall quality measures. Working in conjunction with primary care providers, CHWs c

CHW services are a diagnosis-related medical intervention, not a social service.

CHWs providing diagnosis-related patient education services to enrollees of managed care organizations (M policies.

CHW services that provide patient education for health promotion and disease management are covered if registered nurse (APRN), certified public health nurse (PHN), mental health professional or registered nurse

Eligible Providers

Providers must have a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demons worker curriculum. CHW providers must enroll and be screened following the MHCP provider screening req maintain their enrollment.

Enrollment Criteria

MHCP requires CHWs to enroll so they are represented on a claim as the provider who provided the service

Preparing to Bill

- Provider requirements
  - CHW's must have already completed the certificate course
  - Apply for an NPI number (*"MHCP requires CHWs to enroll so they are represented on a claim as the provider who provided the services. During the enrollment process, Provider Enrollment will assign the CHW worker a Unique Minnesota Provider Identifier (UMPI) if the CHW does not a National Provider Identifier (NPI)." – MHCP Provider Manual*)
  - Complete the following enrollment forms
    - MHCP Provider Agreement (DHS-4138) (PDF)
    - MHCP Enrollment Application (DHS-4016) (PDF)
    - MHCP Applicant Assurance Statement (DHS-5308) (PDF)
  - Fax the forms along with a copy of the CHW certificate to DHS: 651-431-7462
  - If CHW is already enrolled with DHS as a different provider type, complete DHS-3535
- DHS will confirm provider enrollment with a Welcome Letter sent USPS
- If they need more information or to clarify something, they will ask for that information by sending a letter USPS

Billing Basics

- Submit claims electronically using 837p and the "paper" CMS 1500

- Use the hospital's, clinic's, physician's, APRN's, public health nursing organization's or mental health professional's National Provider Identifier (NPI) as the pay to provider

- CPT Codes for CHW reimbursement

  a. 98960 self-management education & training, face-to-face, 1 patient
  b. 98961 self-management education & training, face-to-face, 2–4 patients
  c. 98962 self-management education & training, face-to-face, 5–8 patients
  d. For groups with more than 8 patients, use 98962 with the U9 modifier

- Bill in 30-minute units: limit 4 units per 24 hours; no more than 24 units per calendar month per recipient

- Bill separate lines for each day service is provided (only one calendar month of service per claim)

- Enter appropriate diagnosis code (z71.89 "Other Specified Counseling" very commonly used)

- Enter the NPI of the CHW, who provided the services, as the rendering provider (note: consult each health plan to see who they want as the rendering provider)

Electronic Claims Submission

Use the CMS 1500 when:

- Billing a <u>health plan</u> for a patient who has Medical Assistance or MinnesotaCare as primary

- Billing a <u>health plan</u> for a patient who is Dual Eligible.
  - Medicare is primary
  - Medical Assistance is secondary

- Multiple online clearinghouses available to help process claims
  - MN E-Connect (free)

Use MN-ITS when:

- Billing DHS for a fee-for-service patient who has Medical Assistance as primary

- Billing DHS for a fee-for-service patient who is Dual Eligible

Meeting the Requirements

- Contract with or become an Enrolled Organization with DHS

- Establish contracts with health plans or contract with an organization with existing contracts that can submit claims on your behalf

- Have an order for services signed by an MHCP-enrolled provider
  - Standing order
  - Patient-specific order

- Identify a supervising provider

- Maintain documentation of the best practices, patient education plan or training program used by the CHW

- Documentation of the Data Points
  - Date of service
  - Start and end time of the service
  - Whether the service was group or individual and if group, number of patients present, summary of the session's content, and the CHWs signature and printed name

- Documentation of periodic (at least monthly) assessment of the recipient's progress and need for ongoing CHW services (keep in mind the services must be medically necessary)

Standing Orders

- Standing orders are used to deliver services to an identified population that meet at-risk criteria, without necessarily seeing a clinical provider first.

- "Standing orders are often based on national clinical guidelines, but practices may customize those guidelines based on their own patient population or care environment."*

- Standing orders include:
  - How at-risk clients are identified and criteria for clients to be served (define at-risk population and how clients will be identified)
  - How best practice services will be delivered to at-risk clients
  - Ordering provider signature

- What standing orders are not:
  - Standing orders are NOT a way to deliver general CHW services to everyone

*University of California, San Francisco's Center for Excellence in Primary Care   http://cepc.ucsf.edu/standing-orders

CHW Services Delivered Under Standing Orders

Ordering provider (MD, APRN, PHN, Dentist, Mental Health Professional, RN) develops and signs standing orders

| Defines criteria for at-risk clients to be served | Outlines protocol for CHW service delivery |

Clients identified

| Referral from client's provider | For clients not referred, assessment tool administered to determine if client meets risk criteria in standing orders |

CHW delivers patient education and self-management support services

| Best practices and protocols outlined in the standing orders are followed | CHW communicates with clients' primary care provider about CHW services delivered |

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Best Practices

What are Best Practices?

- Documents summarizing best practices CHWs should follow for clients with specific conditions/needs

- Prediabetes, Diabetes, High Blood Pressure, Blood Pressure Self-Monitoring

- Format: Overview statement of condition, Educational messages, Resources, References

How are Best Practices used?

- Have supervising clinicians review and sign-off on contents of best practices

- Train CHWs on best practices, and set expectation that CHWs will use the messaging and resources with patients

- In-conjunction with specific patient education resources you want your CHWs to use with patients

Examples of success:

- **Public health entity**
  - o Otter Tail County (hypertension and prediabetes)
- **Contracted clinical oversight and claims processing**
  - o Volunteers of America (residents with hypertension and/or prediabetes living in public housing)
  - o YWCA (pediatric obesity groups)
- **CHW Solutions providing direct CHW services**
  - o Minneapolis School Based Clinics (pediatric obesity 1:1)
  - o Neighborhood Health Source (FQHC)
- **Community-based mental health agency**
  - o People Incorporated

Useful Links

- Apply for an NPI number (https://nppes.cms.hhs.gov)

- MN E-Connect (https://mneconnect.healthec.com)

- DHS CHW Provider Manual (https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357)

- Healthy Communities Billing Guide (http://www.mnaap.org/pdf/1804Healthy%20Communities_BillingGuide_Final.pdf)

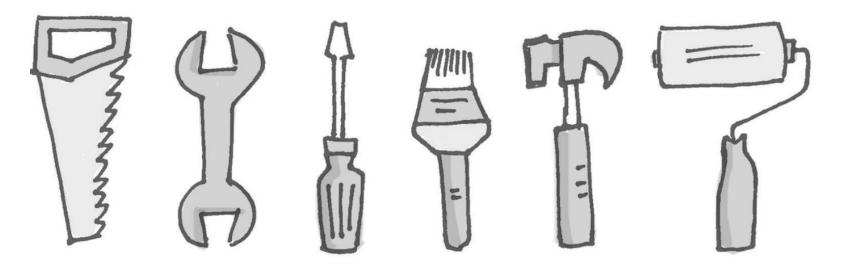- Billing Tip Sheet (http://www.mnaap.org/pdf/1803CHW%20Billing%20TIPS%20Mar%2020%202018.pdf)

Stories from the Field

- Patient Success Stories
- CHW experiences

Tools for managing CHWs and their work

- Ohio Pathways model
- CHW competency tools
- CHW Alliance Supervisor Roundtable advice

Ohio Pathways Overview

- Evidence-based model connecting those at-risk to care

- A guide to CHW practice— keeping CHWs in correct roles (''swim lanes'')

https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf (Pathways on pages 17-40)

Connecting Those at Risk to Care

The Quick Start Guide to Developing Community Care Coordination Pathways

Ohio Pathways

- Adult Education
- Behavioral Health
- Developmental Referral
- Developmental Screening
- Education
- Employment
- Family Planning
- Health Insurance
- Housing
- Immunization Referral

- Lead
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Assessment Chart
- Medication Management
- Postpartum
- Pregnancy
- Smoking Cessation
- Social Service Referral

Ohio Pathway: Education

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Education Pathway

Initiation

Education Pathway started by (check only one):

☐ Program-based curriculum
☐ Client requests assistance
☐ Referral from health care provider
☐ Referral from other provider
☐ Community care coordinator initiated

_____
Start date

↓

Document education provided

(Example: educational content—module, section, etc.)

_____
_____
_____
Education

↓

Document educational format used (check only one).

Format:

☐ Handout
☐ Talking points
☐ Video
☐ Other:_____

↓

Completion

Client reports that he/she understands educational information.

Record reason if Finished Incomplete: _____
_____
_____
_____

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Ohio Pathway: Social Service Referral

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Social Service Referral Pathway

Initiation

Client needs a social service referral.

Document type of service needed - use codes. *(Only ONE code per Pathway)*

_____
Start date

_____
Code number

Education provided
☐ Yes   ☐ No

↓

Provide appropriate education and discuss the importance of keeping appointments.

↓

Appointment scheduled with social service provider.

_____
Date of appointment

↓

Completion

Verify that client kept scheduled appointment.

_____
Date of kept appointment

_____
Document how appt. was verified

Code Numbers for Type of Service

1. Child Assistance
2. Family Assistance
3. Food Assistance/WIC
4. Housing Assistance
5. Insurance Assistance
6. Financial Assistance
7. Medication Assistance
8. Transportation Assistance
9. Job/Employment Assistance
10. Education Assistance
11. Medical Debt Assistance
12. Legal Assistance
13. Parent Education Assistance
14. Domestic Violence Assistance
15. Clothing Assistance
16. Utilities Assistance
17. Translation Assistance
18. Help Me Grow
19. Other: _____

Record reason if Finished Incomplete: _____
_____
_____
_____

CHW Competency Tools for CHW Supervisors
(available in our Sharing Library at www.chwsolutions.com)

- CHW Core Competencies
- Appendix A—Hypertension, Prediabetes and Diabetes
- Appendix B—Check-in and Group Supervision Guide
- Appendix C—Example CHW Interview Questions
- Appendix D—Training Resource List
- Appendix E—CHW Best Practice Examples

All are template examples, to be modified by individual service providers to meet their own needs.

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CHW Competency Tools

CHW Core Competencies

- Document CHW knowledge, skills and training needs based on expected skill sets
- Notes topics covered in the MN CHW Certificate curriculum

How to use?

- Supervisor reviews with CHW upon hire, and at regular intervals
- Note gaps and training needs; plan next steps
- Note review dates and observations of client interactions
- Use in addition to organizations' general orientation, on-boarding and policies and procedures

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CHW Competency Tools

Appendix A—Hypertension, Prediabetes and Diabetes

- Same format as the Core Competencies
- Condition-specific CHW competency expectations

How to use?

- Same as core competencies
- Includes sections on training CHWs to support patient blood pressure and blood glucose self-monitoring

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CHW Competency Tools

Appendix B—Check-in and Group Supervision Guide

- Bi-weekly check-ins (minimum) to troubleshoot and support
- Program Goals and Outcomes, Documentation, Barriers/Issues, Client Stories, Training Needs, Other
- Section on Group Supervision with sample question guide

How to use?

- Review check-in questions together and make follow-up notes
- For Group Supervision:
  - Start with a guiding question (for example, "What's worrying you now?" "What's something positive that happened recently?")
  - Conversations will typically develop easily from just one question
  - Ultimately the group assumes leadership of itself in these conversations

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CHW Competency Tools

Appendix C—Example CHW Interview Questions

Appendix D—Training Resource List

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CHW Competency Tools

Appendix E—CHW Best Practice Examples

- Documents summarizing best practices CHWs should follow for clients with specific conditions/needs

- Prediabetes, Diabetes, High Blood Pressure, Blood Pressure Self-Monitoring

- Format: Overview statement of condition, Educational messages, Resources, References

How to use?

- Have supervising clinicians review and sign-off on contents of best practices

- Training and setting expectations

- In-conjunction with specific patient education resources you want your CHWs to use with patients

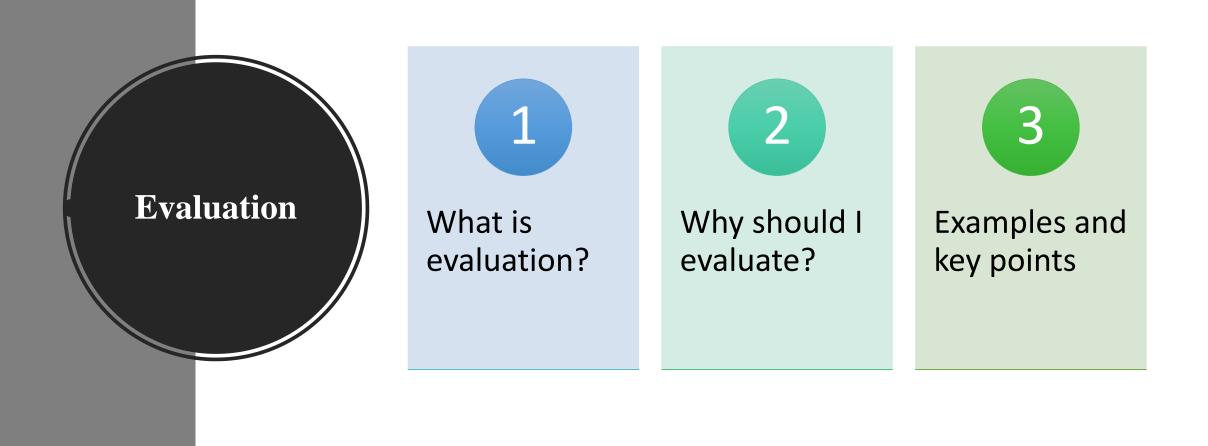# Advice from MN CHW Alliance Supervisors Roundtable

- Set aside <u>time</u> for CHW supervision and development (be patient—it takes time to build CHW teams)

- Promote <u>shadowing</u> experiences for CHWs

- Have <u>informal get-togethers</u> (coffee/lunch) with staff to build internal allies and advocates, and to address concerns

- Allow staff to ask questions about how adding CHWs will <u>impact their own jobs</u>

- Have comprehensive on-site <u>orientation and training</u>

- Have <u>supervisor and peer support</u> at orientation and ongoing

- Clearly <u>define roles</u> as much as possible

Advice from MN CHW Alliance Supervisors Roundtable (continued…)

- Start with a <u>limited number of highly interested providers</u> to develop a successful model that can be built upon with broader stakeholders

- Have CHWs <u>document within the clinical EHR system</u> (as opposed to a peripheral system) to promote understanding of CHW work and communication between CHW and other team members

- Have <u>interdisciplinary daily huddles</u> to discuss patient cases, share ideas and resources

- Assure other roles (RN, PHN, SW, etc.) are <u>receptive to working with CHWs</u> (It helps if people in these roles can have experiences working with a well-trained CHW, and have supervision supportive of CHWs.)

Evaluation

1

What is evaluation?

2

Why should I evaluate?

3

Examples and key points

What is evaluation?

- A process to examine program

- Make judgements about programs – processes and outcomes

- Improve effectiveness

- Make decisions about next steps

Why should I evaluate

Ensure I'm doing what I said I would do

Improve program design and implementation

Demonstrate program impact

Are there times I shouldn't evaluate?

- When program is unstable or has ever-changing protocols

- When people can't tell you what the program is trying to achieve

Example Evaluation Plan

Evaluation questions	Measures	Data collection tools
How many patients with diabetes received services from CHW Solutions?	# of patients referred to CHW Solutions	NowPow
	# of patients visited by CHW Solutions	BestNotes
	# of patient visits completed to each patient	BestNotes
How many patients with diabetes were referred to community services by CHW Solutions personnel? To which community services were patients referred?	# of patients referred to each community services	BestNotes -Resource Referral Template
How many patients had **Ohio Pathways** identified during CHW Solutions visits?	# of patients with Pathways opened (by Pathway)	BestNotes
	# of patients with Pathways [Ongoing] (by Pathway)	BestNotes
	# of patients with Pathways [Finished, Complete](by Pathway) by time frame (start and end date of CHW services)	BestNotes
	# of patients with Pathways [Finished, Incomplete](by Pathway)	BestNotes
	Reasons Pathways [Finished, incomplete] (by Pathway)	BestNotes
What experiences did patients have?	Stories from patients	LaTrese to write up to two stories about patient experiences.
What experiences did patients have?	Opinions from patients	Client satisfaction survey – see **CHWSolutions.com**
What experiences did other staff have?	Opinions from staff	Staff integration survey – see **CHWSolutions.com**

Example Process Measures

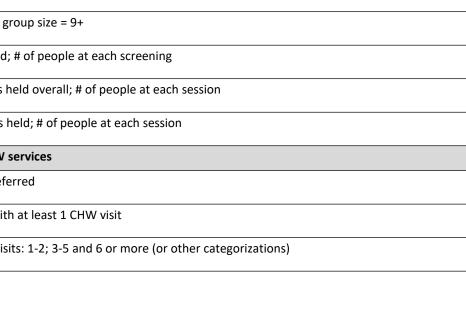| CHWs	
# of CHWs hired/employed	
# and total dollar amount of claims submitted	
# and total dollar amount of claims reimbursed	
Use of services	
# of CHW contacts 1-on-1	
# of CHW contacts group size = 2-4	
# of CHW contacts group size = 5-8	
# of CHW contacts group size = 9+	
# of screenings held; # of people at each screening	
# of group sessions held overall; # of people at each session	
# of TOPIC sessions held; # of people at each session	
Enrollment in CHW services	
# of participants referred	
# of participants with at least 1 CHW visit	
Number of client visits: 1-2; 3-5 and 6 or more (or other categorizations)	

Example Outcome Measures

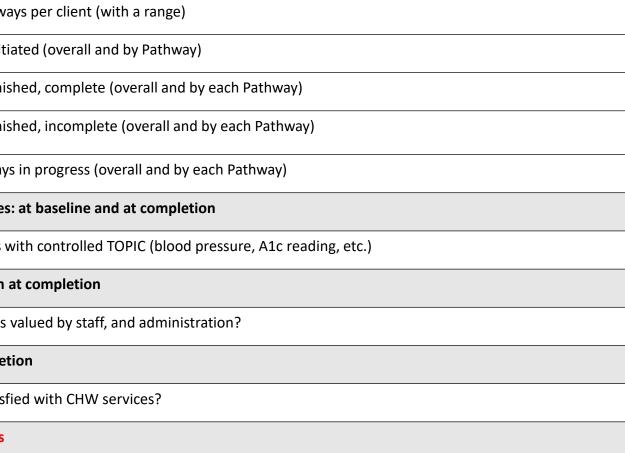|	
Ohio Pathways	
Number of Pathways per client (with a range)	
# of Pathways initiated (overall and by Pathway)	
# of Pathways finished, complete (overall and by each Pathway)	
# of Pathways finished, incomplete (overall and by each Pathway)	
# of goal/Pathways in progress (overall and by each Pathway)	
Clinical Outcomes: at baseline and at completion	
% of participants with controlled TOPIC (blood pressure, A1c reading, etc.)	
Team Integration at completion	
Are CHW services valued by staff, and administration?	
Clients at completion	
Were clients satisfied with CHW services?	
Billing Outcomes	
# and $ of bills submitted / bills reimbursed / bills denied	

Key points to remember

- Tailor to your program

- Be inclusive

- Is honest about findings - both strengths and weaknesses

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