# WELCOME! BIENVENIDXS!

## Today's "Fun Fact"

Please tell us in the chat:
Your name and your
favorite Halloween candy

Mine is Candy Corn...
but not everyone agrees with me!

Northwest Regional Primary Care Association

NATIONAL ASSOCIATION OF Community Health Centers®

# HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

CHW SUPERVISOR TRAINING, POWERED BY Northwest Regional Primary Care Association

## CHW SUPERVISION 201-B: POPULATION HEALTH, RISK STRATIFICATION AND CHW TASK DEVELOPMENT

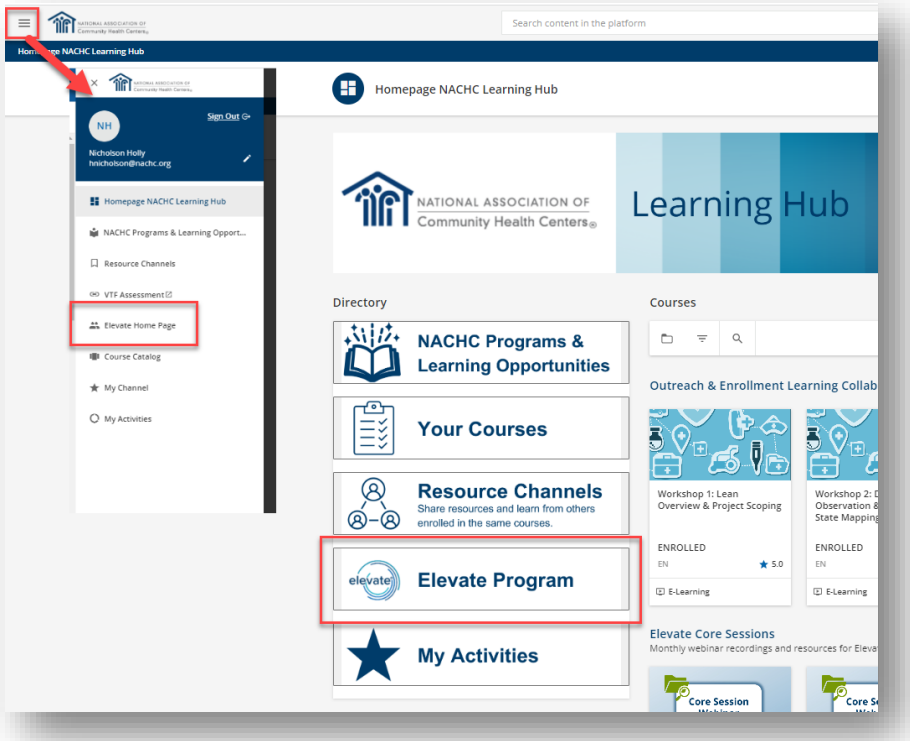
OCTOBER 3, 2023
3:30 PM ET

# NACHC's Online Learning Hub

**Session will be recorded and available in the Learning Hub**

*If you already have a 'NACHC One' login (the login used for NACHC conferences), use this to sign in.*

*If you do not yet have a 'NACHC One' login, **register for free**!*


Access NACHC's Learning Hub at
**https://nachc.docebosaas.com/learn/signin**

# Community Health Worker Supervision 201-B

## Population Health, Risk Stratification, and CHW Task Development

Seth Doyle, NWRPCA
Kelly Volkmann, NWRPCA
Christian Castro, NWRPCA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# Objectives

1. List at least 2 of the components of population health management
2. List at least 2 ways that a CHW can work with a population health manager/care coordinator to improve pop health management
3. Describe at least one way a “risk-stratification matrix” can be used to develop role clarity for CHWs on a care team

# Population health management

- Are you fa r with the term "population health management?"
  - this as PHM going forward…
- ely practice PHM?
- D currently have a role in PHM strategies?

NACHC has amazing resources for this on their Value Transformation Framework website: https://www.nachc.org/about-nachc/our-work/quality-center/value-transformation-framework-vtf/

Please unmute or share your thoughts in the chat box!

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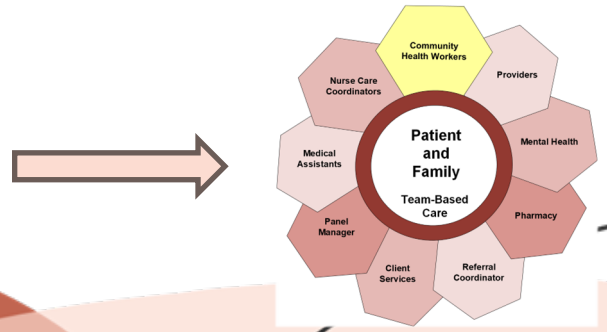
# Population Health Management

- Essential component of value-based care
- Reimbursement is tied to *quality* of care and health outcomes, rather than the *quantity* of care
- A systematic process for managing the health outcomes of different "populations" of patients in your health clinics
  - Ex: Patients living with diabetes, or hypertension, or asthma
- Uses data as an important tool to determine interventions that will help improve health outcomes
- Relies on the work of the *entire* care team

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# Population health strategies

"Top performing health centers segment patients by risk and design models of care tailored to each subgroup." (NACHC, Action of Care Guide)

NACHC's Care Guides are included in your resource toolkit!

Strategies:

- Empanelment
  - Assigning patients to a care team
- Risk stratification
  - Assigning patients to a "risk category" based on risk factors relative to their chronic disease or condition
- Models of care
  - Which members of the care team will be working with a specific patient

# The importance of population health strategies

- Essential to monitoring and meeting metrics for Value-Based Care
- Grouping ("segmenting") patients based on their care needs
  - Grouping by risk levels and needs
  - Creating "populations" within your health center patients
- Increased ability to:
  - Identify and provide appropriate services
  - Tailor care plans and care management for individual patients
    - Instead of "one-size-fits-all…or nobody…"

CHWs can play a vital role in population health management!

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# Strategy #1: Empanelment

- Critical step in managing population health
- Placing every health center patient with a PCP and care team
  - Assumes responsibility for their care
  - Takes patient and family preference into consideration
- Supports:
  - Continuity of care
  - Stability and predictability
  - Proactive health management
  - Patient-centered care

# Empanelment can be challenging

- May lead to large number of patients you are not able to connect with
  - Cultural and linguistic differences, life experiences, trust, relationships
  - Physical / social barriers to coming in for care you may not know about

- Can be difficult to engage patients in preventive services when they feel well

- Payer attribution…definitely challenging!

# CHWs assist with empanelment through outreach

- Many population health managers are NOT bilingual / bicultural
  - May be unable to connect with percentage of patients

- Valuable assistance to pop health managers in knowing best way to reach individuals where they live

- Have the community and outreach experience that population health managers may not have

# CHWs assist in new patient *engagement*

- CHWs are ***experts*** in knowing how to build trust, help patients surmount barriers to care
- Targeted outreach to individuals who are hard to reach or resistant to service
- Provide valuable health education and outreach around preventive services and screening
- Address the need for potentially sensitive or awkward screenings in culturally-appropriate ways
    - Ex: Colorectal cancer screenings, mammograms

Jesus Guzman, CHW
Benton County Health Services

# Strategy #2: Risk stratification

- Another way to manage chronic health populations
- Determining which “risk category” a patient falls into depending on a set of criteria
  - Usually low, rising or medium, high, highly complex
- Useful for deciding
  - Care plans
  - Standing orders
  - Appropriate models of care

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# CHWs improve and extend risk stratification

- Work with care team and care managers across all risk levels
- Care duties and types are spread between all care team members
  - Each team member working at the appropriate level of training and skill
- CHW can focus on the social needs and care gaps
  - Experts on resource navigation, follow-up, identifying and surmounting barriers for high-risk patients
  - Special understanding of the community, the resources, and the barriers involved in accessing them!

# Level of Risk Stratification Matrix


- Stable and usually healthy
- Minor conditions that are easily managed
- Use of alternate services, such as group visits, telehealth, MyChart
- Goal is to keep healthy and engaged
- Increase / maintain use of screening and preventive services

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# Level of Risk Stratification Matrix


- One or more chronic conditions or risk factors
- Condition is unstable and fragile
- Increased social needs and concerns
- Multiple health risk factors (smoking, obesity, HTN)
- Chronic Disease Self-Management resources important
- Managing risk factors important to decrease movement to high-risk category

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# Level of Risk Stratification Matrix


- Usually < 5-20% of patient population
- Multiple complex illnesses
- Psychosocial concerns and/or barriers
- Requires intensive, proactive care management
- One-on-one support
- Care coordination for medical and social resource needs critical

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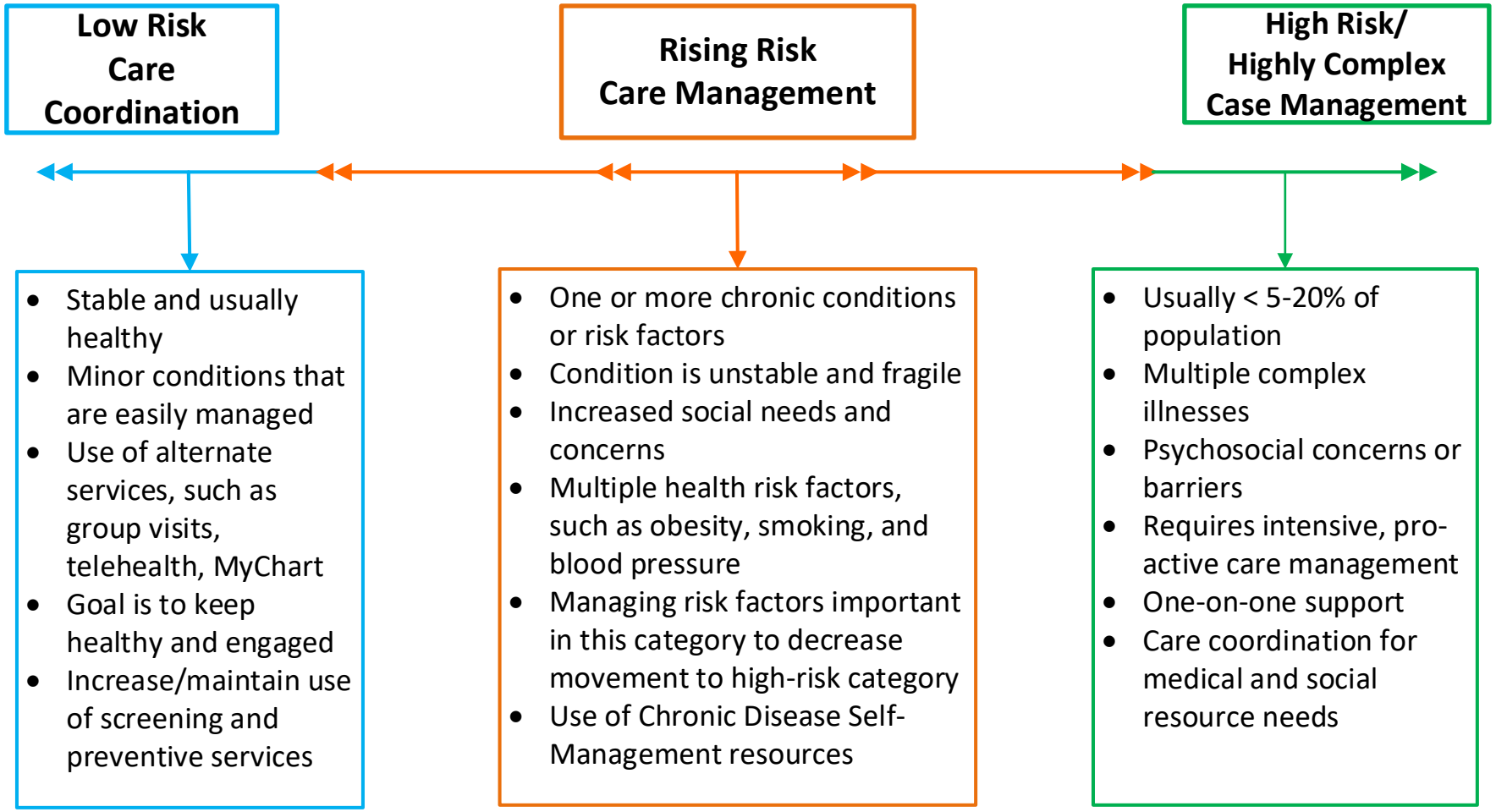
# Level of Risk Stratification Matrix

**This is the "generic" list of risk criteria**

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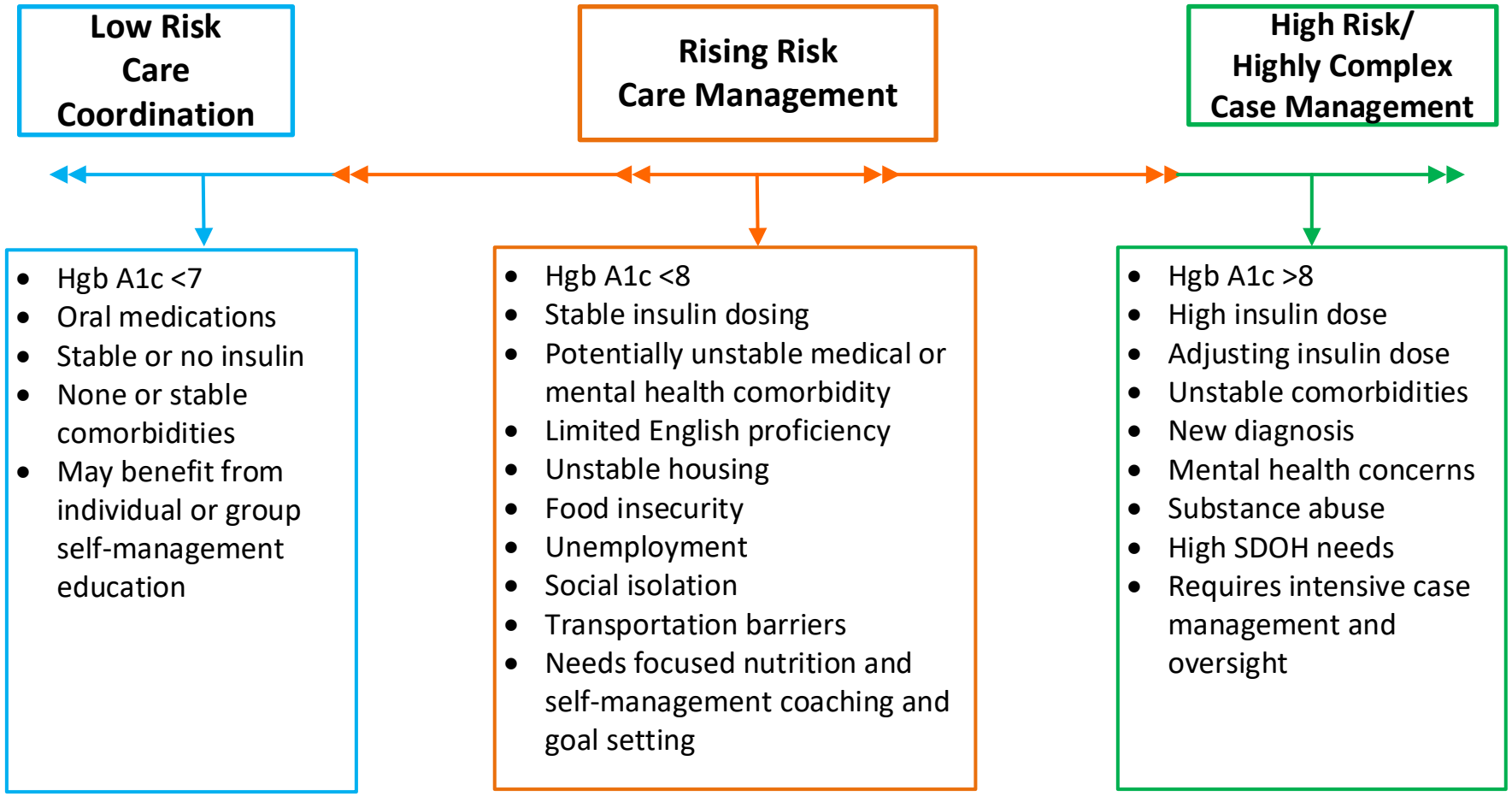
NWRPCA Adapted 2023 from Benton County Health Services

# Level of Risk Matrix: Diabetes




NWRPCA Adapted 2023 from Benton County Health Services

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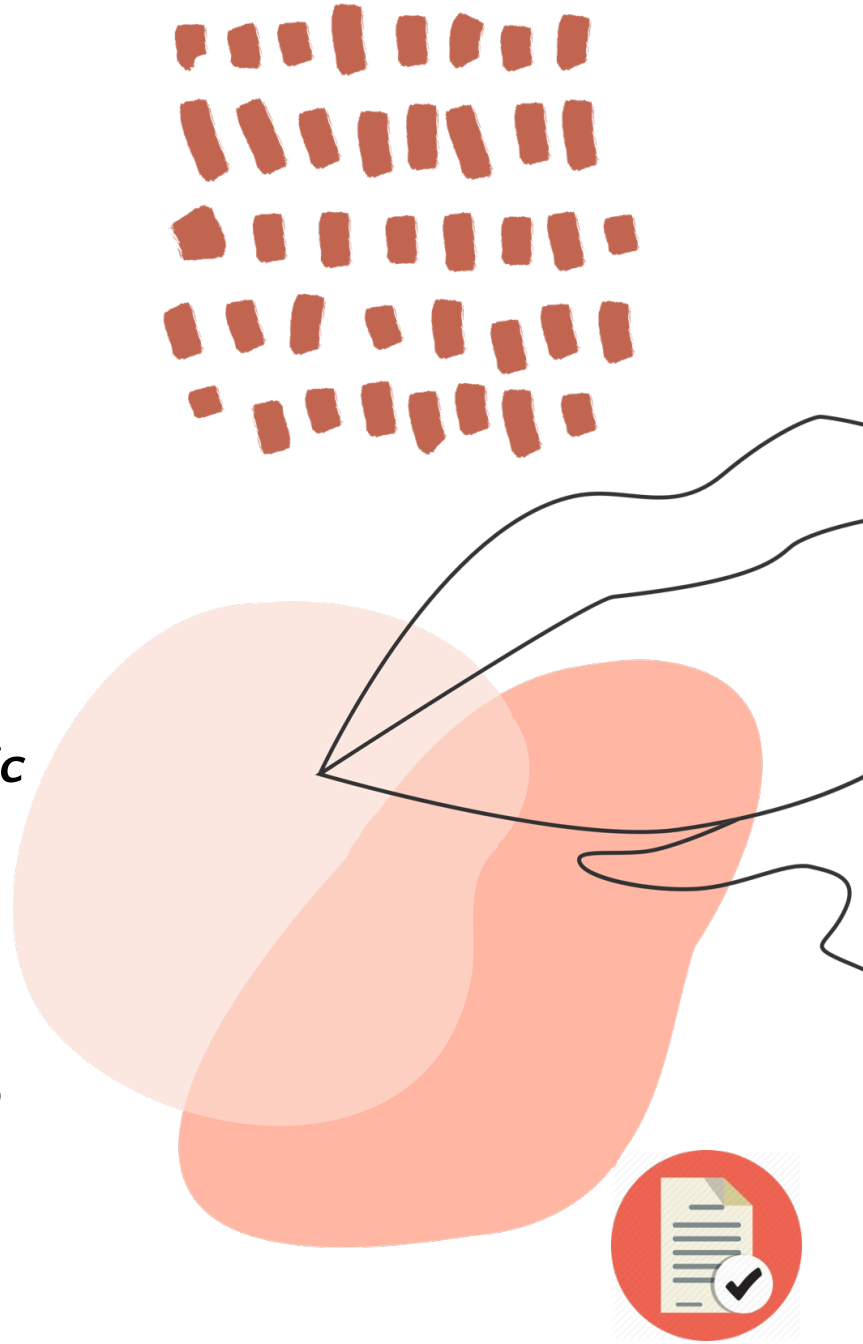
# Using the Risk Stratification Matrix Tool

- Christian will put you into 8 break-out rooms with 5-6 people in each room
    - Assign one person each as **facilitator** (keep the discussion moving), **recorder**, and **time-monitor**
- **Open the Word document labeled "1_Worksheet_RiskStratificationMatrix"**
- Your group will fill in a blank risk stratification matrix with a ***chronic disease the group chooses*** that the group is familiar with
- I will share my screen with each break-out room so you can see the generic risk factors
- You will spend 15 minutes in the breakout room and then return to the main group to share your thoughts and insights on using this tool



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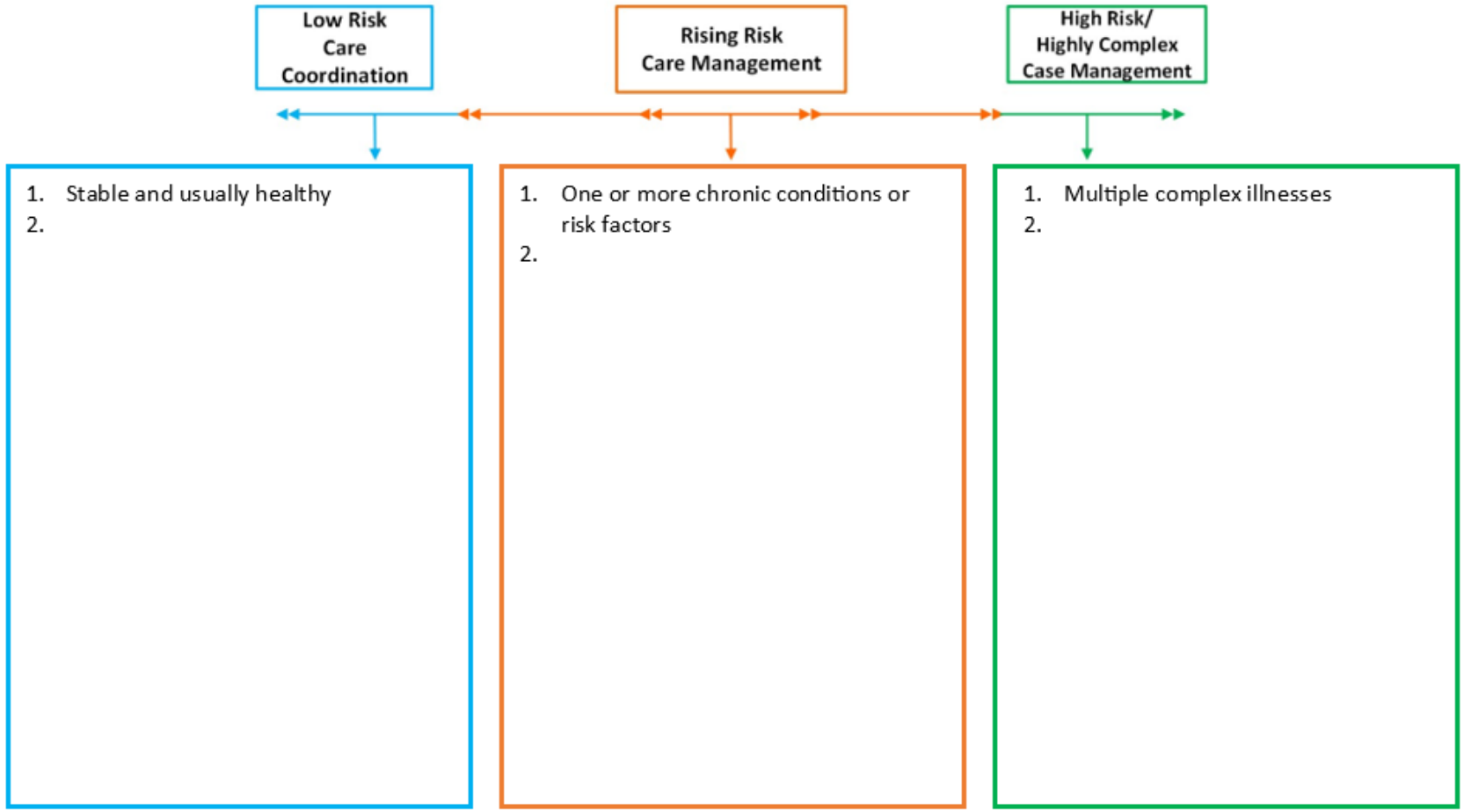
# 1_Worksheet_RiskStratificationMatrix

**NOTE: It will be helpful to fill this out – you will use it for the next breakout**

**Instructions for Breakout Session #1:**

1. Choose a chronic disease that you are familiar with
2. Use the "Generic" list of risk criteria as your guidelines (this will be on the shared screen)
3. Fill in the low, rising and high risk boxes with your group's chosen "disease-specific" risk criteria for each risk category
    - Try to fill in at least 3 in each category
4. There is an example provided for you in each category below – it is non-specific but applicable to most chronic diseases

## Level of Risk Matrix for: _____

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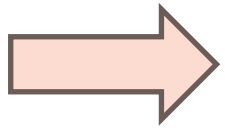
# Level of Risk Stratification Matrix

**Use this "generic" list of risk criteria as a model for *your* worksheet**

NOTE: You will put the risk factors for **the disease your group chooses** into these risk category boxes



## Low Risk Care Coordination

- Stable and usually healthy
- Minor conditions that are easily managed
- Use of alternate services, such as group visits, telehealth, MyChart
- Goal is to keep healthy and engaged
- Increase/maintain use of screening and preventive services

## Rising Risk Care Management

- One or more chronic conditions or risk factors
- Condition is unstable and fragile
- Increased social needs and concerns
- Multiple health risk factors, such as obesity, smoking, and blood pressure
- Managing risk factors important in this category to decrease movement to high-risk category
- Use of Chronic Disease Self-Management resources

## High Risk/ Highly Complex Case Management

- Usually < 5-20% of population
- Multiple complex illnesses
- Psychosocial concerns or barriers
- Requires intensive, pro-active care management
- One-on-one support
- Care coordination for medical and social resource needs

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# Please share your insights and strategies with the group!

1. Was this tool or exercise helpful to think about ways to risk stratify your patients?

2. Do you have another tool that you use at your agency?

Let’s take a 5-minute break to stretch and hydrate!

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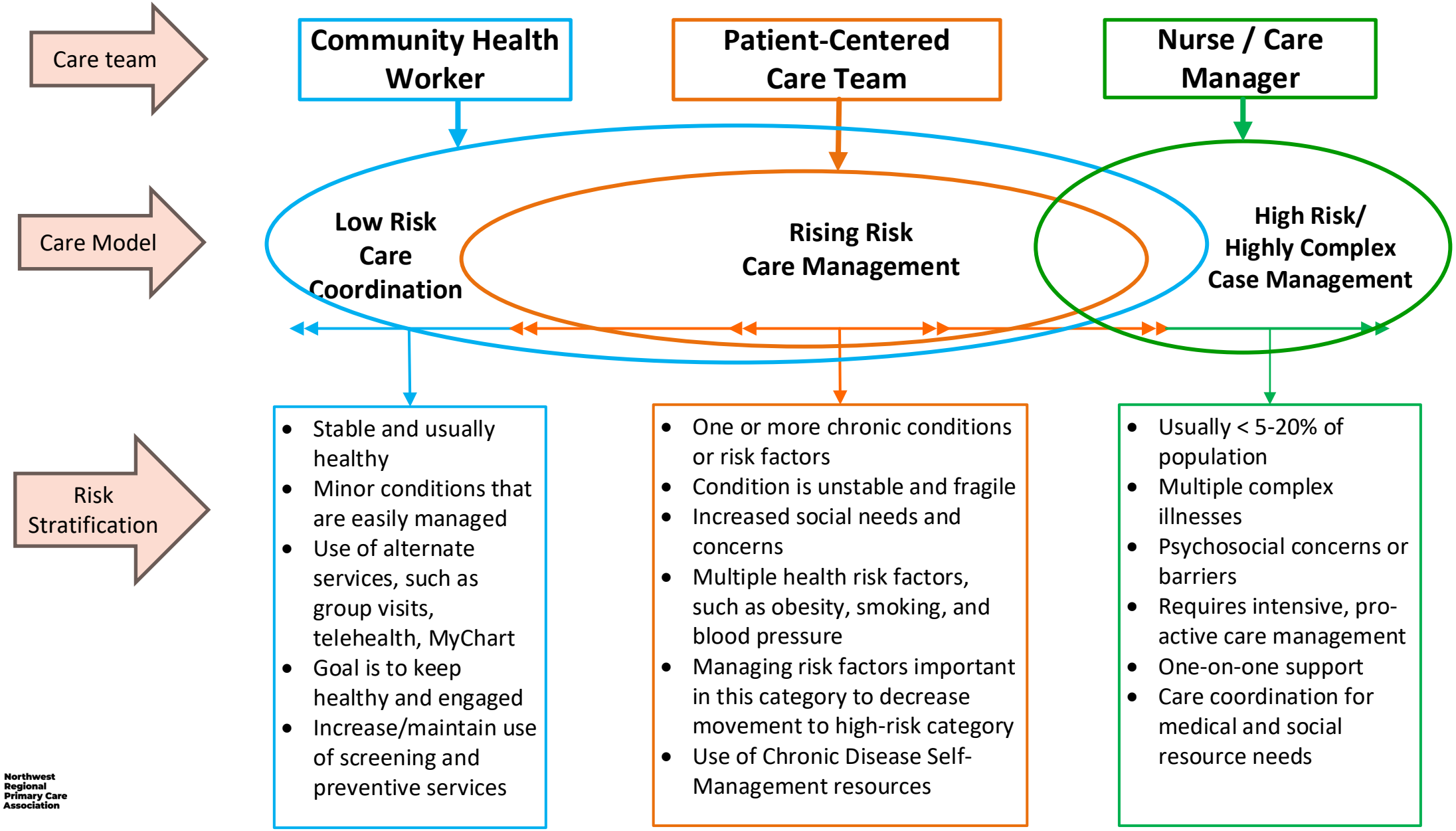
https://www.mountainvacationdeals.com/

# Models of Care

- Designing different models of care to deliver the right level of care to each risk level
  - Rather than a “one size fits all” approach
- Should allow care team members to work at top of their skill set
- Ability to tailor intervention strategies to meet individuals “where they are” in terms of risk category, life circumstances…
- Example – a patient in the low-risk category wouldn’t need weekly home visits from a CHW…but a patient in the high risk category might…

# Developing Models of Care

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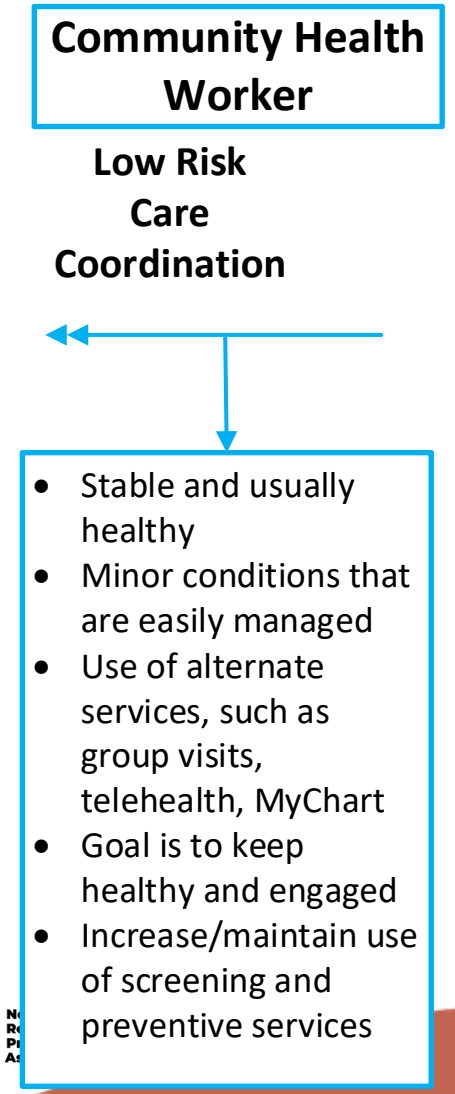
# CHWs and low-risk patients



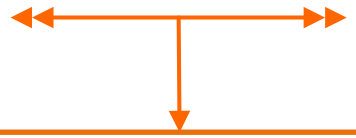

## Generic Tasks:

- Working with care team, but more independently
- Social service care coordination
- Linguistic and culturally-informed and affirming support:
  - Follow up on routine care
  - Ensuring patients have adequate digital and health literacy to access and use telehealth and MyChart services
- Educate and support use of preventive and screening services

# CHWs and rising-risk patients

**Patient-Centered Care Team**

**Rising Risk Care Management**

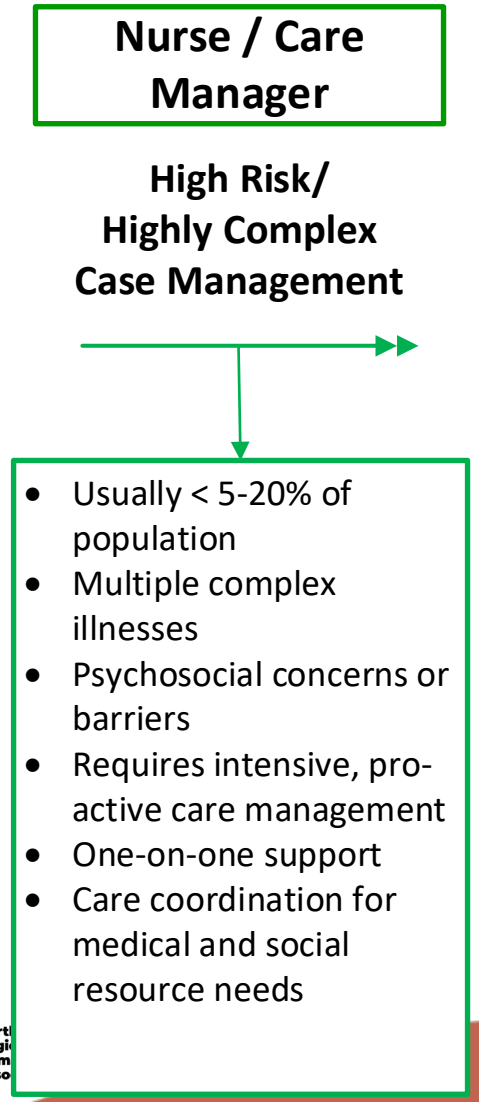


- One or more chronic conditions or risk factors
- Condition is unstable and fragile
- Increased social needs and concerns
- Multiple health risk factors, such as obesity, smoking, and blood pressure
- Managing risk factors important in this category to decrease movement to high-risk category
- Use of Chronic Disease Self-Management resources

## Generic Tasks:

- CHW works more closely with care team and care manager if needed
- Support social service and resource needs and coordination
- Chronic disease self-management education and support
  - Individual or group
  - **Needs additional training and supervision**
  - *Tomando Control de Su Salud,* Living Well With Chronic Disease; Diabetes Prevention Program (DPP)

# CHWs and high-risk/highly complex patients

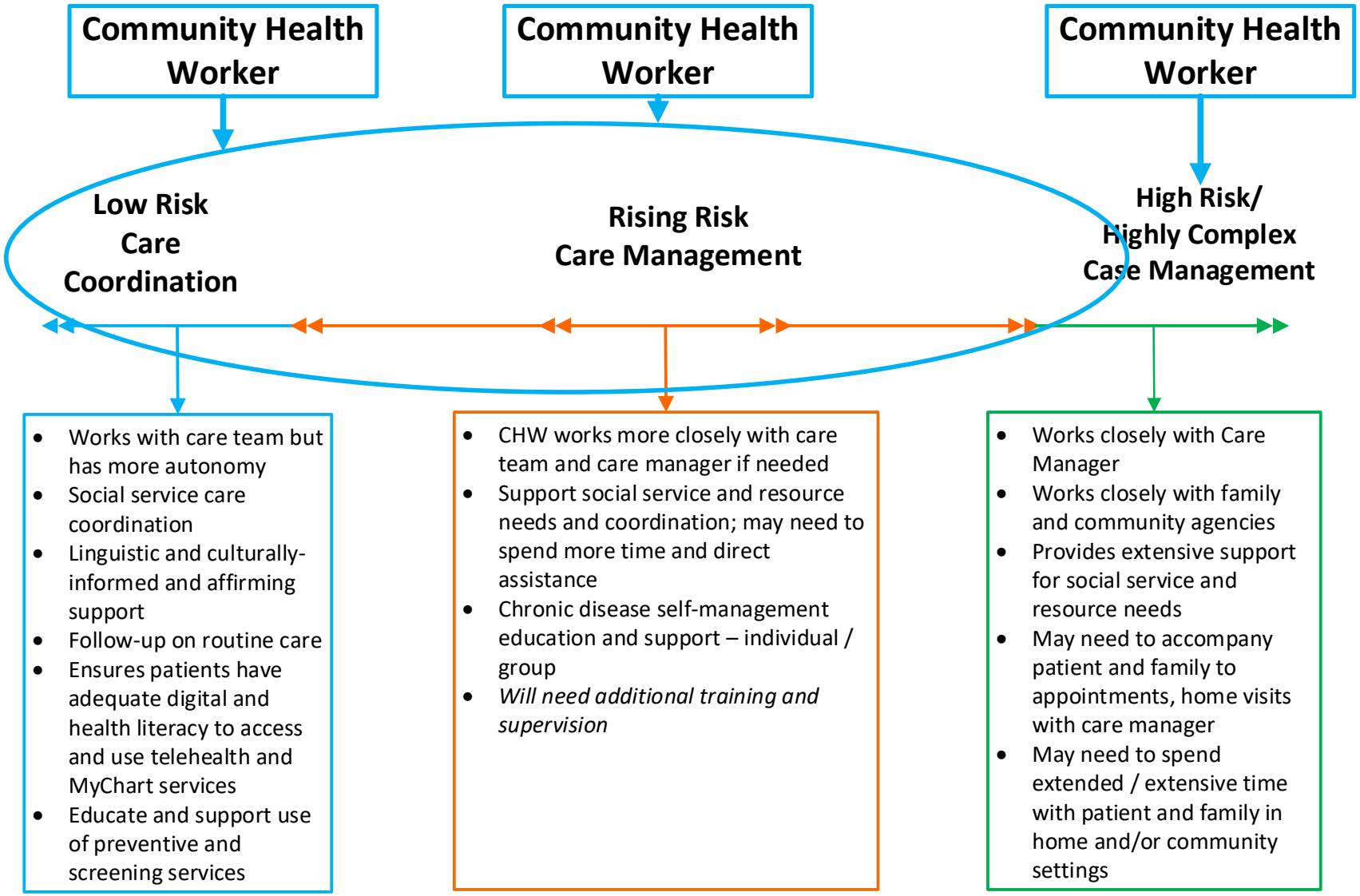



## Generic Tasks:

- CHW works closely with Nurse / Care Manager (NCM)
- Work closely with family and community agencies
- Provides intensive support for social service and resource needs
  - Accompanying family to appointments, home visits with NCM
- May need to spend extended/extensive time with patient and family in home and/or community settings

# CHW tasks specific to each risk category

These are the Generic tasks a CHW might do in each of these risk categories

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# Making the tasks specific…

Now, let's refine the tasks by connecting them to a chronic disease

1. Review the ***generic*** CHW tasks in each risk category

2. Review the risk factors in each category (low – rising – high)

3. Then decide what the CHW tasks would be in each category for a ***specific disease "population"*** that you want to manage

Let's practice using Diabetes as the disease, and Rising risk" as the category:

# Making the tasks Diabetes specific…

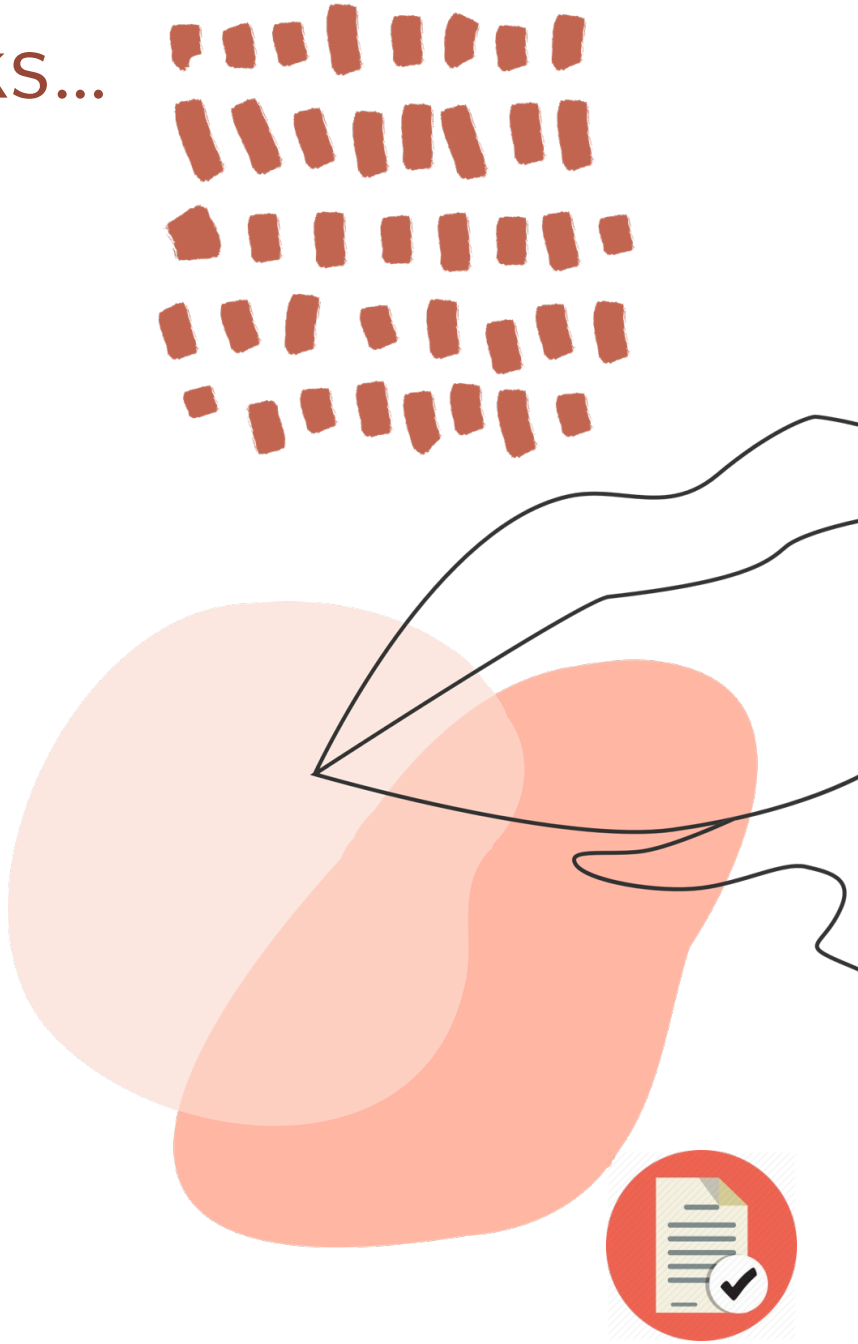
1. Review the generic CHW tasks
2. Review the risk factors
3. Decide what Diabetes-specific tasks your CHW will be doing

## CHW tasks specific to Diabetes "Rising Risk" category

| Generic tasks for rising risk patients | Diabetes rising risk factors | Diabetes-specific tasks for rising risk patients |
|---|---|---|
| • CHW works more closely with care team and care manager if needed<br>• Support social service and resource needs and coordination; may need to spend more time and direct assistance<br>• Chronic disease self-management education and support – individual / group<br>• *Will need additional training and supervision* | • Hgb A1c <8<br>• Stable insulin dosing<br>• Potentially unstable medical or mental health comorbidity<br>• Limited English proficiency<br>• Unstable housing<br>• Food insecurity<br>• Unemployment<br>• Social isolation<br>• Transportation barriers<br>• Needs focused nutrition and self-management coaching and goal setting | • Scrub identified charts for pts who need routine labs<br>• Work with pop health manager to reach out to LEP patients<br>• Spend extra time assisting pts access social service and resource needs<br>• Provide targeted and extensive Diabetes self-management education to pt and family<br>• Take pt/family grocery shopping, meal planning<br>• Assist with pill-management systems, setting goals<br>• Regular follow-up calls for self-management support |

# Developing Disease-specific CHW tasks…

- Christian will put you into 8 break-out rooms with 5-6 people in each room
    - Assign one person each as **facilitator** (keep the discussion moving), **recorder**, and **time-monitor**
- **Open the Word document labeled "2_Worksheet_DiseaseSpecific_CHW-Tasks"**
- Your group will use the chronic disease risk stratification worksheet from the first breakout to complete the worksheet
- I will share my screen with each break-out room so you can see the generic CHW tasks
- After the breakout, we will return to the main room to share thoughts and ideas!



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**Instructions for Breakout Session #2:**

1. Use the chronic disease risk stratification worksheet from Breakout Session #1
2. Use the "Generic CHW Tasks" list as your guidelines
3. Review the risk factors in the **"Rising Risk"** category (from your risk stratification worksheet, Breakout Session #1)
4. Fill in the CHW tasks for the rising risk category in the disease your group chose

## Instructions:

1. Review the generic CHW tasks
2. Review the risk factors
3. Fill in the disease-specific tasks your CHW will be doing

Chronic disease:_____

| Generic CHW tasks For Rising Risk patients | Disease Rising Risk Factors | Disease-specific CHW tasks for Rising Risk patients |
|---|---|---|
| • CHW works more closely with care team and care manager if needed<br>• Support social service and resource needs and coordination; may need to spend more time and direct assistance<br>• Chronic disease self-management education and support – individual / group<br>• *Will need additional training and supervision* | • | • |

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# Making the tasks Diabetes specific…

1. Review the generic CHW tasks
2. Review the risk factors
3. Decide what Diabetes-specific tasks your CHW will be doing

## CHW tasks specific to Diabetes "Rising Risk" category

| Generic tasks for rising risk patients | Diabetes rising risk factors | Diabetes-specific tasks for rising risk patients |
|---|---|---|
| • CHW works more closely with care team and care manager if needed<br>• Support social service and resource needs and coordination; may need to spend more time and direct assistance<br>• Chronic disease self-management education and support – individual / group<br>• *Will need additional training and supervision* | • Hgb A1c <8<br>• Stable insulin dosing<br>• Potentially unstable medical or mental health comorbidity<br>• Limited English proficiency<br>• Unstable housing<br>• Food insecurity<br>• Unemployment<br>• Social isolation<br>• Transportation barriers<br>• Needs focused nutrition and self-management coaching and goal setting | • Scrub identified charts for pts who need routine labs<br>• Work with pop health manager to reach out to LEP patients<br>• Spend extra time assisting pts access social service and resource needs<br>• Provide targeted and extensive Diabetes self-management education to pt and family<br>• Take pt/family grocery shopping, meal planning<br>• Assist with pill-management systems, setting goals<br>• Regular follow-up calls for self-management support |

# Please share your insights and strategies with the group!

1. Was this tool or exercise helpful to think about ways to develop disease-specific tasks for your CHWs?

2. Do you have another tool that you use at your agency?

# Office Hours #2 – Wednesday, 10/4, 1:00-2:00 PT

- We will discuss developing a panel for your CHWs
  - Deciding the right mix of patients
  - How many is too many?

- The answer is…"It depends on where the patients are on the risk categories."

- Hope to see you there!

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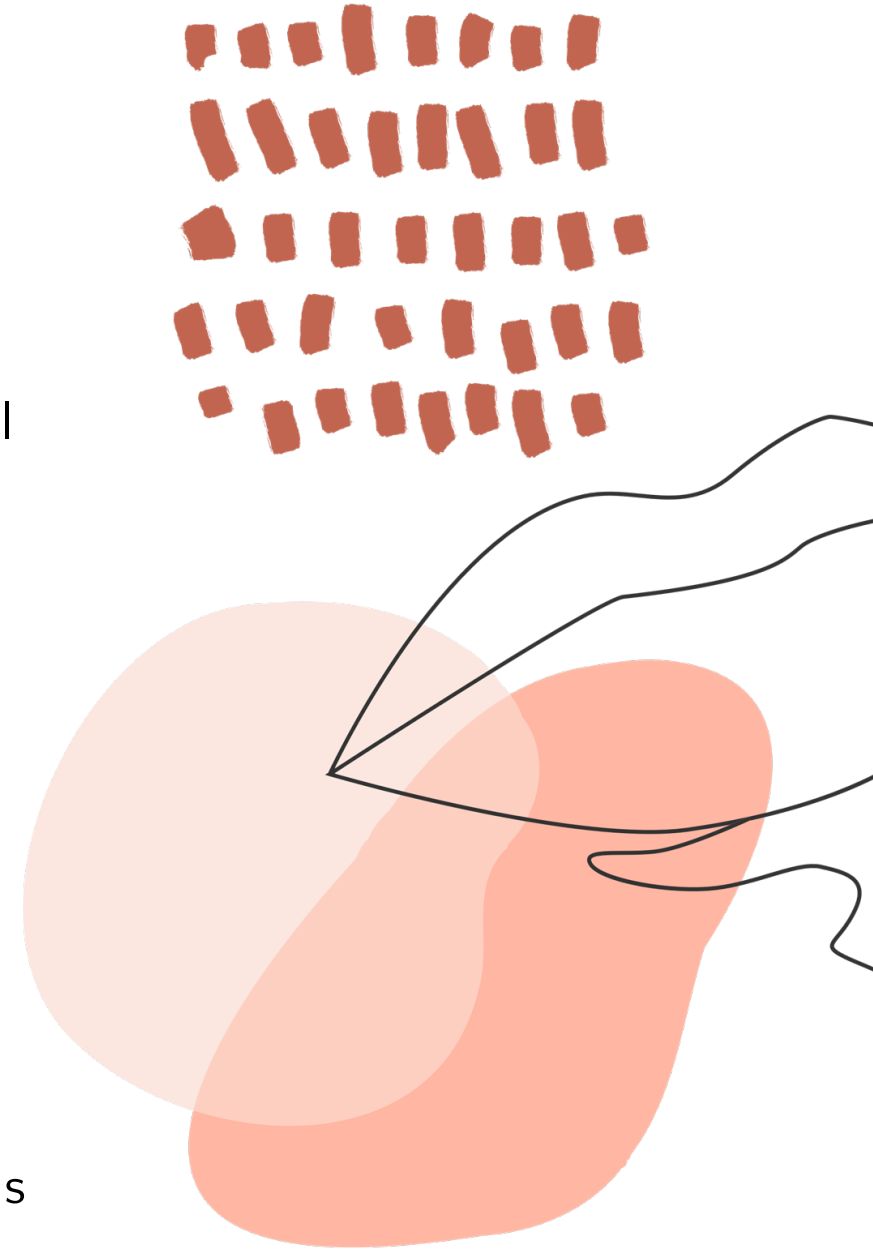
# We would love to hear from you!

- This is an interactive online tool called “Jamboard” that will let you write on “sticky notes” on an online whiteboard
- Christian is going to put the link in the chat – click the link and it will take you to the Jamboard.
- There is a tool bar on the left side of the screen and Christian will talk us through the process

## We would like to know…

- What were your “take-aways” from the series?
- What do you think you can/will share with your teams?
- What resources did you like and think you will use?
- What do you wish we had talked about but didn’t? (This will help us do a better job next time!)



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# Health Center Staff Professional Development Program

This program is made possible through the partnership and support of the CDC.

NACHC's Fall 2023 training opportunities focus on health center staff who support healthy aging and brain health as part of whole-person care.

Key health center roles in brain health and dementia reduction and early detection:

- Community Health Workers (CHWs) and CHW Supervisors
- Care Managers & Care Manager Supervisors
- Quality Improvement Staff

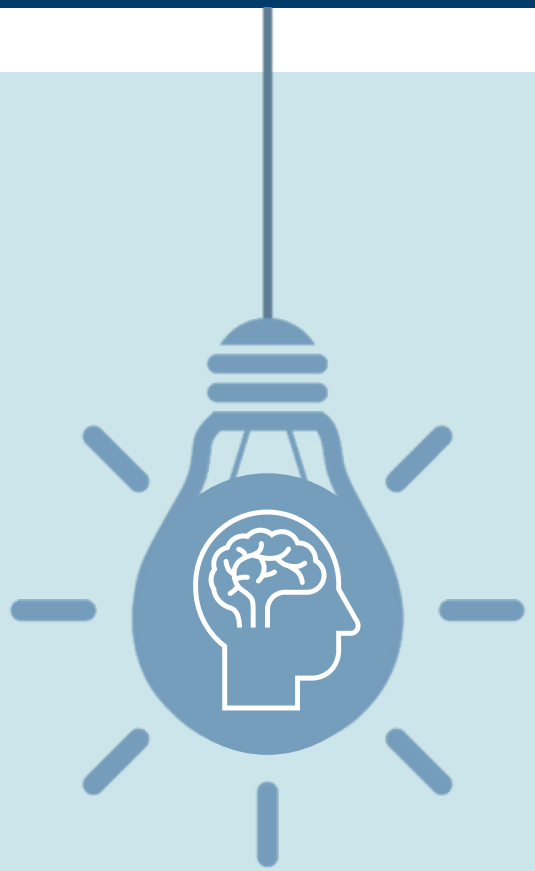
This national professional development series and peer-to-peer professional network included:

**217 health center staff**

**154 health centers**

**36 states, DC, and Puerto Rico**

# The Aging Population: Is Your Health Center Prepared?



65+ years of age fastest growing health center patient population*

36% of health center patients 45+ years of age*

- 11% - 65+ years of age
- 25% - 45-64 years of age

6th leading cause of death in the United States+

Alzheimer's kills more seniors than breast and prostate cancer combined+

Non-Hispanic Black and Hispanic older adults disproportionately more likely than White older adults to have Alzheimer's or other dementias+

* NACHC, Community Health Center Chartbook 2023. https://www.nachc.org/community-health-center-chartbook-2023/

+ Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures. Alzheimer's Dement., 19: 1598-1695. https://doi.org/10.1002/alz.13016

# The Aging Population: Your Health Center is Part of the Solution!

## Primary care providers provide 85% of first diagnosis of dementia; provide 80% of care*

**Providers and care teams:**

- ✓ Can address modifiable risk factors which may slow dementia progression and modify comorbid conditions
- ✓ Address safety and incorporate advanced care planning
- ✓ Achieve cost savings and help reduce rate of hospital admissions in adults 65 years and older (1.78 greater risk of ambulatory care sensitive admissions+)
- ✓ Generate revenue for care management and other Medicare services: Annual Wellness Visits and Advanced Care Planning

+ Phelan EA, et. al., Association of incident dementia with hospitalizations. JAMA. 2012 Jan 11;307(2):165-72. doi: 10.1001/jama.2011.1964.
*Alzheimer's Association. 2023 Alzheimer's disease facts and figures. Alzheimer's Dement., 19: 1598-1695. https://doi.org/10.1002/alz.13016

# The Aging Population: Your Health Center is Part of the Solution!

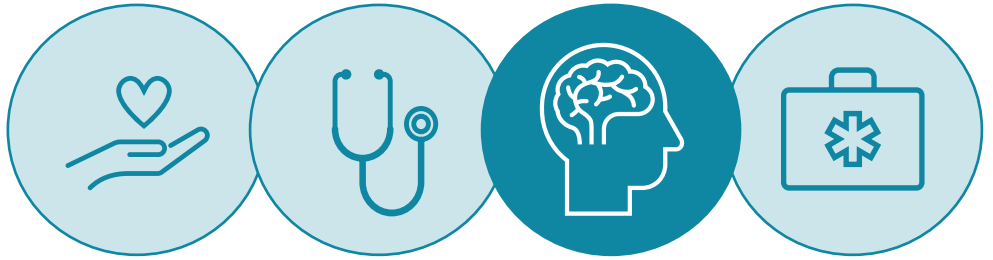
## *HOW to apply new skills to Dementia early detection and risk reduction?*

- ✓ Review resources to understand signs/symptoms of dementia (early detection) – see next slide
- ✓ Update workflows (care management, annual wellness visits, advanced care planning) to include early detection and risk reduction
- ✓ Develop a systems approach to the management of chronic conditions; use tools to assess cognitive function
- ✓ Enhance and expand partnerships and community linkages to support early detection and risk reduction.
- ✓ Incorporate into your health center Improvement Strategy.

# The Aging Population: Your Health Center is Part of the Solution!

## For more information, access the NACHC 3-Part Webinar Series

1. Early Detection of Dementia & Reducing Risk Factors
2. Care Management for Patients with Dementia & Leveraging Reimbursement Opportunities
3. Health Center Partnerships & Community Linkages to care for Patients with/at risk for Dementia



# Aging Population: Leverage the VTF and Elevate

## Sample QI Workplan Activity:


1. **Incorporate** the VTF systems approach within your health center QI strategy, as an organizing approach for all age groups, including older adults
2. **Assess** health center progress in 15 areas of systems change using the VTF Assessment. To access the VTF Assessment go to www.reglantern/vtf.
3. **Join** a national learning community (Elevate) for free training and professional development opportunities. Register for Elevate at https://bit.ly/2023Elevate.
4. **Build** capacity to provide services that provide early detection and risk reduction for dementia in combination with attention to chronic conditions and social risk: Chronic Care Management (CCM) services, Annual Wellness Visits (AWV), Advanced Care Planning (ACP)
5. **Bill** code and bill for additional services (CCM, AWV, ACP)
6. **Improve** patient health outcomes and advance toward Quintuple Aim goals

# Contact Us!

## The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact **QualityCenter@NACHC.org**

*This program is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) under cooperative agreement # NU38OT000310-05-04. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.*

- Please share your "take-aways" from the series...
- What do you think you can/will share with your teams?
- What resources did you like and think you will use?
- What do you wish we had talked about...but didn't?

We will take about 2-3 mins, so we have time for our NACHC colleagues

The series was great - favorite topics - the true definition of a CHW, Qualities of a CHW - teach the skill and not the quality; Developing CHW roles, Does your care team practice PHM; Value based care and its advantages, Population health strategies along with the breakout sessions allowing folks to practice the materials that were being discussed .

Series was excellent!, Matrix also really helpful.

I use the "1 foot in the clinic, 1 foot in the community" quote every day now.

Disease levels tool and what part CHW can play and support the care team at these levels. Enjoyed series

I would like more of admins/providers to utilize and understand CHWs

Will share with the team the collaboration with all these great folks! So many great perspectives from all over the country, the breakouts were really helpful/interesting

I feel like we can do a better job with Population Management. The tools that were given will be helpful.

A lot of good information that I need to go over again

I work for the County and currently we don't have CHW's but subcontract out. So, all the information was new to me and very helpful! I can't wait to share with my upper management.

Maybe on next we could teach CHW safety about Home Visits

I feel like we can do a better job in utilizing our CHW's Skills

love the CHW Tasks Worksheet.

The Matrix sheets will help us further structure the list of what a CHW does and what a CHW does not do.

Wish we had discussed how to support CHWs more on an individual level. Talked a lot support in getting integrated with the care team, how about supervision strategies

take aways- supportive supervision techniques

We will implement the risk stratification tool using the collective mind.

I appreciated the Care Team Member exercise.

I think about "situational leadership" a lot and have been talking to many people on my team about it!

Great to see how others implement tools to assist with the work of CHW's.

Right fit supervision styles to support staff where they are in their work.

I found the onboarding section and scope of practice information to be very helpful. This is something we have struggled with.

Teaching our CHW safety Teaching our CHW boundaries

Today's session was most helpful to me. Thank you!

take-away: investing time upfront to plan and create clear processes to make sure everyone is clear on their roles and how their roles support each other

I really like the CHW Tasks in Primary Care tool to educate providers with

Helpful resource - Home visit safety plan. I'm reviewing our plan against the resource provided

We do not have CHWs right now and it has been great to learn more about what skill sets we should look for

I will be using todays ws

ROI for CHW would be helpful! Sustainability....

I would like to have more specific ideas about training ideas for onboarding CHWs in an organization