Project Option 1.2.2 Increase training of primary care workforce: SPH1 Training of Community Health Workers (CHWs)

Unique RHP Project Identification Number: 111810101.1.3
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.2 Increase training of primary care workforce (Option 1.2.2)

This project will aid the reshaping of the health care system in Southeast Texas. The University of Texas School of Public Health (UTSPH) has a rich history of community health worker (CHW) training and is a state recognized training center. The UTSPH will partner with Gateway to Care, Harris Health System, and UT Physicians to increase the number of certified CHWs in the region (currently approximately 500) and respond to specific continuing education needs as identified by providers and CHWs. Additionally, providers and clinic staff will be trained in how to integrate CHWs as members of the health care team.

Clinics implementing this team-based model will be matched with a clinic operating under the current practice model. Comparisons will be made based on: chronic disease management including diabetes, tobacco control, hypertension, prenatal care, and cancer screening and referral; immunization rates; return on investment; and quality of experience as reported by patients.

Goal and Relationship to Regional Goals:
Increase availability and utilization of certified CHWs trained in organized care delivery models, with an emphasis on team-based practice, quality and cost control, that will serve as members of healthcare delivery teams.
CHWs will be invaluable in helping the region achieve its goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system".

Challenges:
Need: 1) Lack of access to culturally appropriate care. 2) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.
Implementation: 1) Willigness of other providers/clinicians to incorporate CHWs in their care team. 2) Retention of trained CHWs. CHWs have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges posed by the fragmented nature of health care delivery on the US. Most CHWs come from the local population, are in touch with the community, and are better able to attend to the needs of patients by helping the system to deliver culturally sensitive care and by facilitating their access to health education and support, thereby providing an important and cost effective service to health care teams and to patients. Providers/clinicians will be trained in the value that CHWs bring to the health care team and in how to incorporate them into the practice. The inclusion of CHWs into care teams in their community and competitive compensation will aid in the retention of trained CHWs.

5-Year Expected Outcome for Provider and Patients:
Several CHWs will have been trained for practice in the region, and more practices will have CHWs employed in team-based management models. Since CHWs are able to provide patients with culturally appropriate assistance, we would expect better health outcomes. For this project, the focus is on reducing admissions for influenza and pneumonia for Hispanic patients.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

CHWs are members of a team of public health professionals who use their unique understanding of the experiences, language and/or culture of the populations they serve to promote health. CHWs have proven to be an important link between healthcare providers, researchers and disadvantaged communities.

As leaders, CHWs bridge the gap between communities and the public health system – they are resource persons who act as liaisons between residents and health and human services. In the United States, CHWs have been a part of the health care delivery system since the 1960s. Their role has evolved over time and varies according to their work setting, which ranges from outreach workers in the community to clinic staff. CHWs have a broad skill set, including communication, leadership, advocacy, and both general and disease or condition-specific health knowledge. Duties performed by CHWs range from counseling and health education to basic clinical tasks (HRSA, 2007). Regardless of their work environment, CHWs are trusted members of the community in which they work and typically reflect the demographic characteristics of the area. Their knowledge of local culture and customs allows them to effectively deliver direct health messages to community members, provide services, connect them to local health and social services, and advocate on their behalf. Nationally and internationally, CHWs are viewed as part of the solution for achieving improved health status in rural and disenfranchised communities.

For many years CHWs have provided an array of health care services in different settings. Recently their role has been elevated, nationally and internationally, as opportunities for integrating CHWs into the health care delivery system are discussed. In 2009, the US Department of Labor recommended the creation of a Standard Occupational Classification for CHWs. This act opened the door for additional integration into the US health system. The 2010 Patient Protection and Affordable Care Act (health reform law) identified community health workers as having major roles in achieving the goals of health care reform. At the International level, the United Nations Millennium Development Goals (MDGs) acknowledge the importance of human capital. In an effort to progress toward meeting health-related MDGs, the World Health Organization recommends CHWs as a part of the health service workforce (Achieving the health-related MDGs. It takes a workforce! 2010).

This project aims to demonstrate improved health outcomes, return-on-investment, and increased patient satisfaction when CHWs are integrated into the health care team in clinics southeast Texas.

Project Components:

Through the Training of Community Health Workers (CHWs) Program, we propose to meet all required project components listed below.

a) Increase the number of community health workers/promotoras being trained and placed with healthcare teams, and

b)Training providers and clinic staff on how to integrate CHWs as members of the health care team.

Process Milestones and Metrics:

For the Training of Community Health Workers (CHWs) Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

- Milestone 1 [P-2]: Expand primary care training for community health workers
- Metric 1 [P-2.1]: Expand other primary care staff (community health workers) training programs
- Milestone 2 [P-3]: Expand positive primary care exposure for residents/trainees
- Metric 1 [P-3.3]: Include trainees/rotations in quality improvement projects

Improvement Milestones and Metrics:

- Milestone 3 [I-11]: Increase primary care training and/or rotations
- Metric 1 [I-11.6]: Improvement in trainee knowledge assessment scores
- Milestone 4 [I-11]: Increase primary care training and/or rotations
- Metric 1 [I-11.5]: Improvement in trainee satisfaction with specific elements of the training program

Unique community need identification numbers the project addresses:
This project addresses community needs CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs) and CN.22 (Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This initiative is an expansion of an existing training program. This initiative proposes increasing the number of CHWs trained and placing more CHWs within health care teams in the area. However, there is a new element being added, which is the training of providers in how to integrate CHWs as members of the health care team.

Related Category 3 Outcome Measure(s):
OD-11 Addressing Health Disparities in Minority Populations
IT-11.5 (IT-2.10) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)
For the Hispanic population:
Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
Denominator: Population in Metro Area or county, age 18 years and older.

Relationship to other Projects:
1.1 (C3) - The training of CHWs will increase the availability of support staff for the expansion of primary care capacity.
1.3 (C12) - The disease management registry will help identify patients that need active follow-up, for which CHWs will be uniquely qualified for outreach to non-compliant patients, facilitating their return to appropriate care.
1.7 (A1) - The telemedine technology will also be available for CHWs in their outreach activities and in facilitating patients' interaction with their healthcare team, particularly for those patients with distance/ transportation barriers.
2.1 (C1-2) - The increased training of CHWs competent to work with the 'new primary care' team-based model of care will be an important component of transitioning patients into medical homes.
2.2 (CL3, C5 - C9) - Part of the initiatives in the redesigning of chronic care delivery systems is to make better use of non-physician members of the team, such as the CHWs able to facilitate culturally-appropriate communication, education, and navigation, which are important components of the chronic care model.
2.11 (C10) - Trained CHWs able to facilitate culturally-appropriate communication, education, and navigation will be essential to the care team's medication therapy management for minimizing medication errors.

Relationship to Other Performing Providers' Projects in the RHP: TBD

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be rated on a 10-point scale each project. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds available for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of available funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with a couple of exceptions. First, we did not use two of the criteria and second, we began with a 5-point scale for each criteria rated, then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 2 X 2 = **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. If a significant proportion of the target population is uninsured/Medicaid, add 1 additional point.

   This project's score for this criteria: 2 X 2 = **4**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

   This project's score for this criteria: 2 X 2 = **4**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

   This project's score for this criteria: 5 X 2 = **10**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth plans to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another, so giving the projects the same, or very similar ratings on this criteria would have again had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3.9**

111810101.1.3	***1.2.2***		***SPH1 TRAINING OF COMMUNITY HEALTH WORKERS (CHWS)***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.5*	*IT-11.5 (IT-2.10)*	*Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Expand primary care training for community health workers Metric 1 [P-2.1]: Expand other primary care staff (community health workers) training programs Baseline/Goal: TBD Data Source: Training program documentation Milestone 1 Estimated incentive payment: $ 1,836,957	Milestone 2 [P-3]: Expand positive primary care exposure for residents/trainees Metric 1 [P-3.3]: Include trainees/rotations in quality improvement projects Baseline/Goal: TBD Data Source: Curriculum and/or quality improvement project documentation/data Milestone 2 Estimated incentive payment: $ 2,017,207		Milestone 3 [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.6]: Improvement in trainee knowledge assessment scores Goal: TBD Data Source: Knowledge assessment tool Milestone 3 Estimated incentive payment: $ 2,157,942	Milestone 4 [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.5]: Improvement in trainee satisfaction with specific elements of the training program Goal: TBD Data Source: Trainee satisfaction assessment tool Milestone 4 Estimated incentive payment: $ 2,084,968
Year 2 Estimated Milestone Bundle Amount: $1,836,957	Year 3 Estimated Milestone Bundle Amount: $2,017,207		Year 4 Estimated Milestone Bundle Amount: $2,157,942	Year 5 Estimated Milestone Bundle Amount: $2,084,968
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $8,097,074				

Title of Outcome Measure (Improvement Target): OD-11 Addressing Health Disparities in Minority Populations

Unique RHP outcome identification number(s): 111810101.3.5

Outcome Measure Description:
IT-11.5 (IT-2.10) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)
For the Hispanic population:
Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
Denominator: Population in Metro Area or county, age 18 years and older.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-11.5 (IT-2.10) Reduce by 3% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.
DY5:
IT-11.5 (IT-2.10) Reduce by 5% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.

Rationale:
Hispanics have a high rate of death from influenza and pneumonia (2009 CDC, Minority Health. http://www.cdc.gov/minorityhealth/populations/REMP/hispanic.html#10). Harris County and the UT Physician service areas have considerably more Hispanics (Harris County-40.8%; Bayshore-49.2%; Bellair-46%; Cinco Ranch-26.2%; Sienna Village-23.5%) than the national average (16.3%). (Population race/ethnicity statistics are from the U.S. Census Bureau, 2010 Census Summary File 1, Tables P8, PCT4, PCT5, and PCT8. Note: Derived from 2010 Census Summary File 1 data by the Texas State Data Center.) The delivery of culturally sensitive care is more likely to increase the adoption of preventive services such as influenza vaccinations among Hispanics. CHWs have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges posed by the fragmented nature of health care delivery on the US. Most CHWs come from the local population, are in touch with the community, hence they are able to aid the health system to deliver culturally sensitive care, and by so doing will help address health disparities in minority

populations. Therefore, a reduction in admissions for flu and pneumonia for the Hispanic population served UT Physicians would be an appropriate measure for the success of this program.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.5	*3.IT-11.5 (IT-2.10)*	*Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.3*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 96,682	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 112,067 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 112,067	Outcome Improvement Target 1 [IT-11.5 (IT-2.10)]: Reduce by 3% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 239,771	Outcome Improvement Target 2 [IT-11.5 (IT-2.10)]: Reduce by 5% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 521,242
Year 2 Estimated Outcome Amount: $ 96,682	Year 3 Estimated Outcome Amount: $ 224,134	Year 4 Estimated Outcome Amount: $ 239,771	Year 5 Estimated Outcome Amount: $ 521,242
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 1,081,829			

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