2022 ANNUAL CONFERENCE

TN PRIMARY CARE ASSOCIATION

UTHSC | Tennessee Population Health Consortium

THANK YOU TO OUR TPCA ANNUAL PARTNERS

Aledade

BlueCare Tennessee

BlueCare Tennessee and BlueCare are Independent Licensees of the BlueCross BlueShield Association.

ena

FORVIS

GBS

AMERICA'S PRODUCTIVITY PARTNER

H3C

i2i

POPULATION HEALTH

Maxor 340B

TN Department of Health

TN AHEC

GROWING GENERATIONS OF HEALTH PROFESSIONALS

United Healthcare Community Plan

Community Health Workers: Strengthening Your Care Team

Susan Butterworth, PhD, MS
Associate Professor
Director of Patient Engagement

Objectives

- Describe the research that supports the integration of CHWs into the primary care team
- Create a helpful checklist for hiring CHWs
- Identify several CPT codes that can be used for CHW services
- Examine the recommended competencies for a CHW in a primary care setting
- Share success stories within your practice in using non-clinical staff to engage patients

Jot down 2-3 words that come to mind when you think of community health workers

The Community Health Worker Core Consensus Project (C3) https://www.c3project.org/

...people will forget what you **said**, people will forget what you **did**, but people will never forget how you made them **feel**.

MAYA ANGELOU

"NEVER BELIEVE THAT A FEW CARING PEOPLE CAN'T CHANGE THE WORLD. FOR, INDEED, THAT'S ALL WHO EVER HAVE."

— MARGARET MEAD

ITSALLYOUBOO.COM

"

I let them know that I have struggles, too. I let them know that they are not alone. I let them talk about their fears. And I offer them encouragement by saying where you see yourself now is not where you will always be.

— Latecia Turner
Spectrum Health Community Health Worker

What is health coaching?

Health coaching is the use of an evidence-based communication approach and strategies to actively engage and guide patients towards a targeted health or lifestyle-related goal; e.g., a health behavior change, adherence to their treatment plan, managing their chronic condition, following through on a referral.

Health coaching is an important role for CHWs

Why Health Coaching?

40-50%

The percentage of overall health determinants that are lifestyle-related

24

The average number of prescription medications for people with 3-4 chronic conditions

55%

The percentage of Tennesseans with multiple chronic conditions

16.5

The average number of minutes PCPs get to spend with their patient

18.6

The average number of minutes for PCP to complete the EMR for each patient

>$5 billion

The direct medical cost associated with treating diabetes, hypertension and cardiovascular disease in Tennessee over a 1-year period

7

The number of established CPT codes that will reimburse different types of lay health coach sessions with patients

CHW Research: Highlights

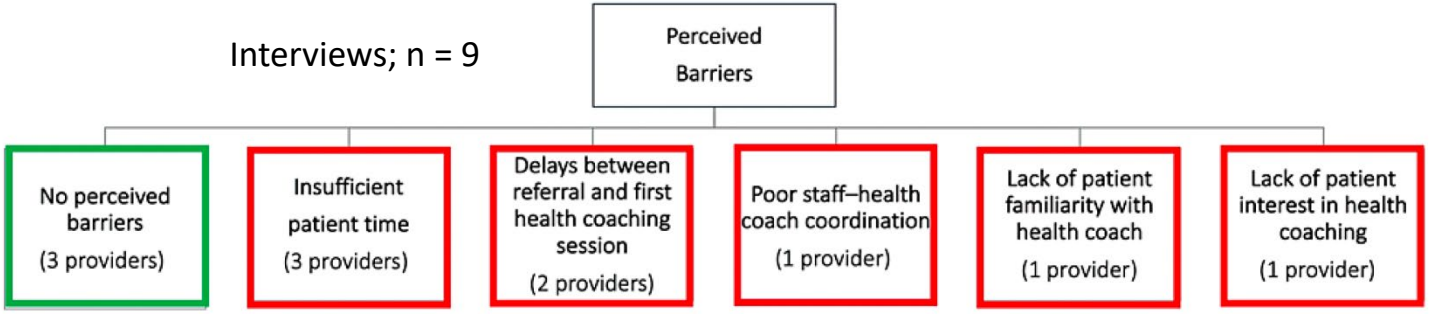
Year and Study	Findings	Citation
2021 Systematic Review	Of the five studies that focused on primary care, all but one noted a significant improvement in use of primary care services among the navigated patients, especially among those with negative SDOH.	Mistry SK, Harris E, Harris M. Community Health Workers as Healthcare Navigators in Primary Care Chronic Disease Management: a Systematic Review. J Gen Intern Med. 2021 Sep;36(9):2755-2771.
2012 Pilot Study	CHWs trained in MI were integrated into mammography navigation program. 71% of the participants scheduled primary care visit to follow-up on their health priorities, and after 30 days, 54% of participants visited their primary care provider.	Battaglia TA, McCloskey L, Caron SE, Murrell SS, Bernstein E, Childs A, et al. Feasibility of chronic disease patient navigation in an urban primary care practice. J Ambul Care Manage 2012;35(1):38-49.
2019 Systematic Review	Thirty-three studies reported positive impacts of CHW interventions on clinical disease risk indicators, screening rates and healthy behaviors.	Sharma N, Harris E, Lloyd J, Mistry SK, Harris M. Community health workers involvement in preventative care in primary healthcare: a systematic scoping review. BMJ Open. 2019 Dec 17;9(12):e031666.
2021 Cohort Study	Comprehensive CHW intervention. Significant reduction in number of readmissions at all timepoints Significant reduction in the number of ER visits at all timepoints. Care with PCP was established in 86.6% of participants. Utilization costs were significantly lower post-intervention.	Ohuabunwa U, Johnson E, Turner J, Jordan Q, Popoola V, Flacker J. An integrated model of care utilizing community health workers to promote safe transitions of care. J Am Geriatr Soc. 2021 Sep;69(9):2638-2647.

Tennessee-based Intervention

- Management Of Diabetes in Everyday Life (MODEL) study: *PI - Dr. Jim Bailey, UTHSC*
- Clinical arm comparing effects of 3 arms of diabetes management in primary care
  1. Text messaging
  2. Health coaching (lay staff)
  3. Enhanced usual care featuring patient-vetted diabetes educational materials
- Significant Outcomes in HC arm
  - Improved A1c
  - Reduced BMI
  - Improved diet
  - Increased physical activity
  - Increased self-efficacy

Data Summary from Clinic Personnel Surveys n = 46 1 – 5 likert scale			
Question	Question Domain	Mean (N=45)	Standard Deviation
Lay health coaches have helped improve the quality of care my clinic provides to patients with diabetes.	Impact	3.78	1.16
My clinic has been able to integrate lay health coaches as part of the care team without difficulty.	Acceptability	3.78	1.26
Lay health coaches have been able to provide helpful counseling and support to our clinic's patients.	Impact	4.04	1.09
Lay health coaches have been able to help our patients set and achieve their own diabetes self-care goals.	Credibility	3.95	1.07
Having lay health coaches assume some counseling responsibilities has reduced my personal workload.	Impact	3.76	1.19
Our diabetes patients who are working with a lay health coach have more productive visits with our clinic's physicians and nurses.	Credibility	3.71	1.10

Interviews; n = 9



Reich K, Butterworth SW, Coday M, Bailey JE. Integrating Lay Health Coaches Into Primary Care: Acceptability, Credibility, and Effectiveness From the Provider Perspective. Cureus. 2022 May 29;14(5):e25457. doi: 10.7759/cureus.25457. PMID: 35774723; PMCID: PMC9239298.

We Can Move the Needle for Type 2 Diabetes with Lifestyle Interventions

- Lean ME, Leslie WS, Barnes AC, et al. Primary care-led weight management for remission of type 2 diabetes (DiRECT): an open-label, cluster-randomised trial. *Lancet*. 2018;391(10120):541-551. doi:10.1016/S0140-6736(17)33102-1
  - Intensive weight management resulted in 46% ”remission of diabetes” for intervention group
- Dambha-Miller H, Day AJ, Strelitz J, Irving G, Griffin SJ. Behaviour change, weight loss and remission of Type 2 diabetes: a community-based prospective cohort study. *Diabet Med*. 2020;37(4):681-688. doi:10.1111/dme.14122
  - Diabetes remission achieved in 30% participants at 5 yr; weight loss of ≥10 early in disease trajectory associated with doubling of likelihood of remission at 5 years

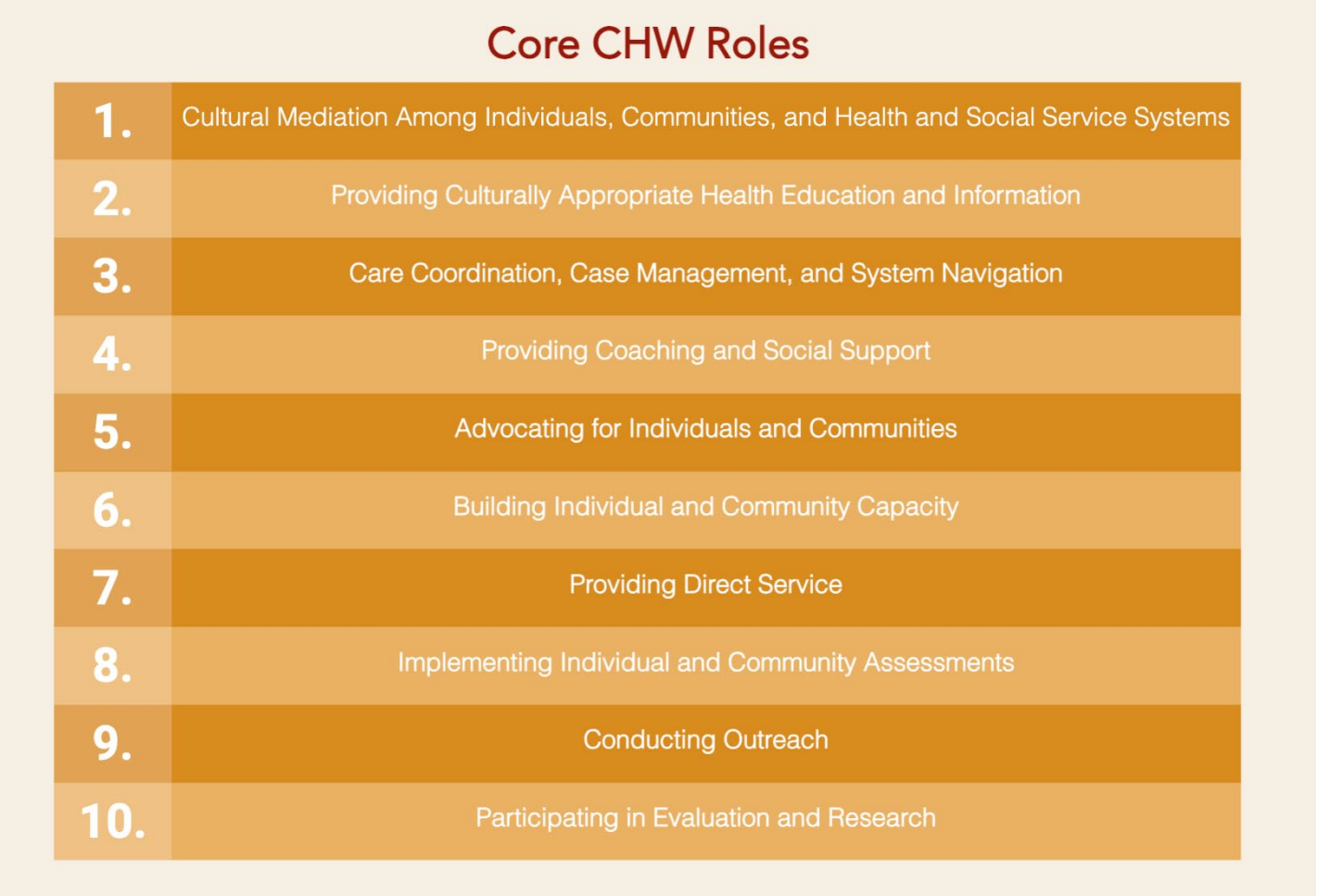
We Can Move the Needle for Type 2 Diabetes with Lifestyle Interventions

- Goldenberg JZ, Day A, Brinkworth GD, et al. Efficacy and safety of low and very low carbohydrate diets for type 2 diabetes remission: systematic review and meta-analysis of published and unpublished randomized trial data. *BMJ*. 2021;372:m4743. Published 2021 Jan 13. doi:10.1136/bmj.m4743
  - Patients adhering to a low carbohydrate diet for six months may experience remission of diabetes without adverse consequences
- Sampath Kumar A, Maiya AG, Shastry BA, et al. Exercise and insulin resistance in type 2 diabetes mellitus: A systematic review and meta-analysis. *Ann Phys Rehabil Med*. 2019;62(2):98-103. doi:10.1016/j.rehab.2018.11.001
  - A systematic review and meta-analysis highlights the effectiveness of a structured exercise intervention program for insulin resistance in T2DM with a moderate level 2 of evidence

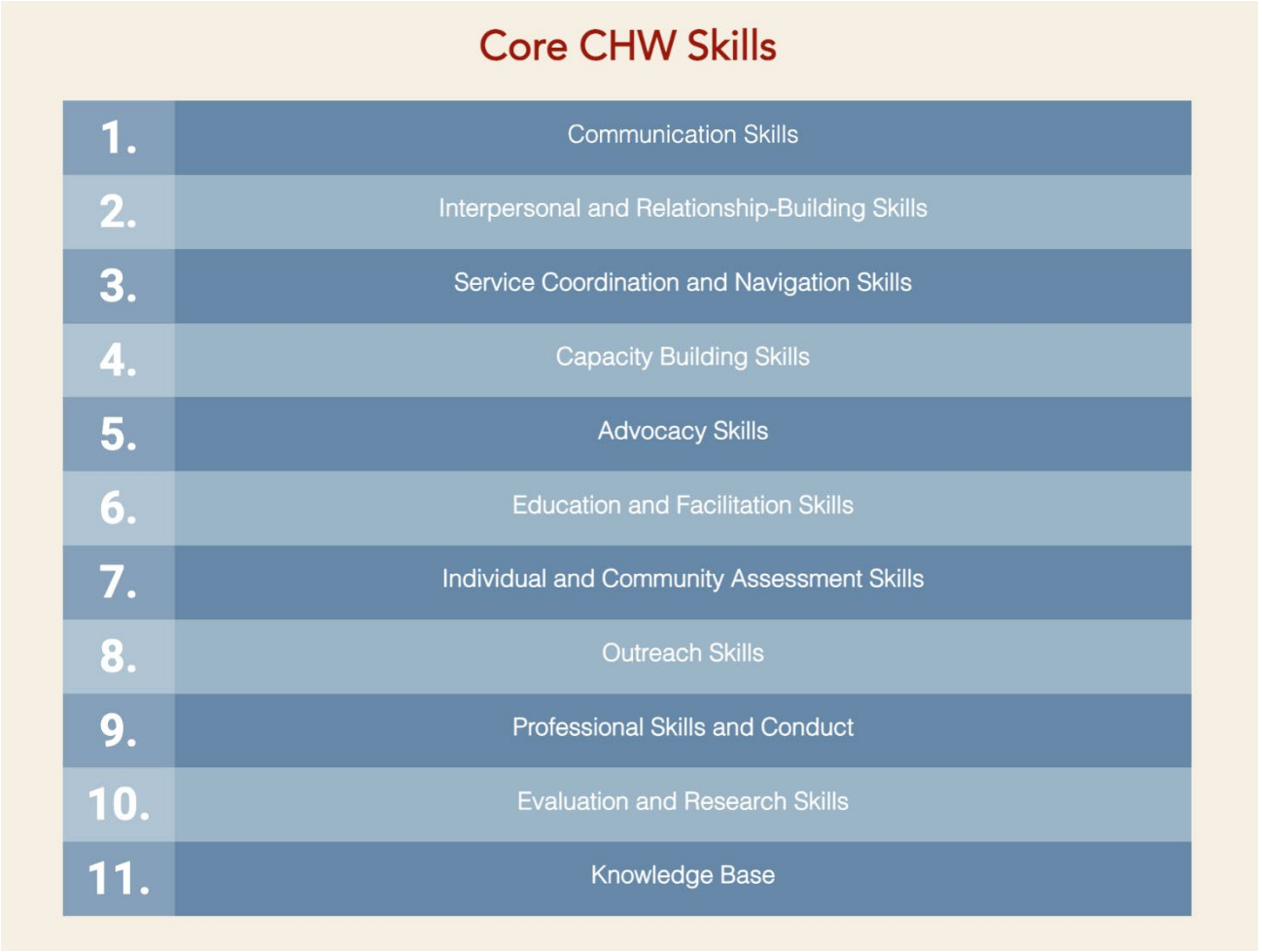
We Can Move the Needle for Type 2 Diabetes with Lifestyle Interventions

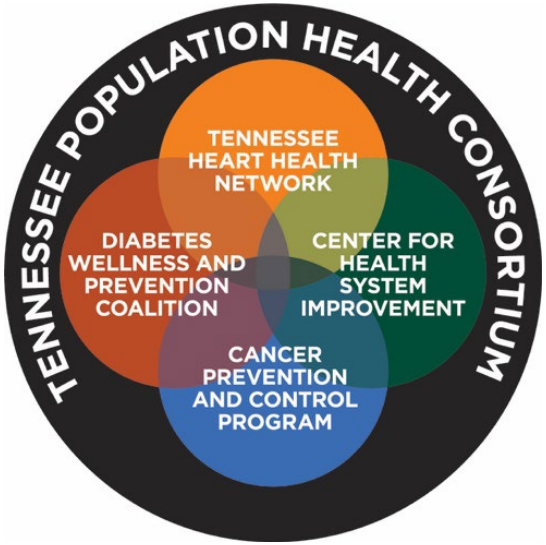
- Zhang Y, Pan XF, Chen J, et al. Combined lifestyle factors and risk of incident type 2 diabetes and prognosis among individuals with type 2 diabetes: a systematic review and meta-analysis of prospective cohort studies. *Diabetologia*. 2020;63(1):21-33. doi:10.1007/s00125-019-04985-9
  - A systematic review and meta-analysis supports evidence that the adoption of a healthy lifestyle is associated with substantial risk reduction in type 2 diabetes and long-term adverse outcomes among diabetic individuals

The Community Health Worker Core Consensus Project (C3) https://www.c3project.org/



The Community Health Worker Core Consensus Project (C3) https://www.c3project.org/

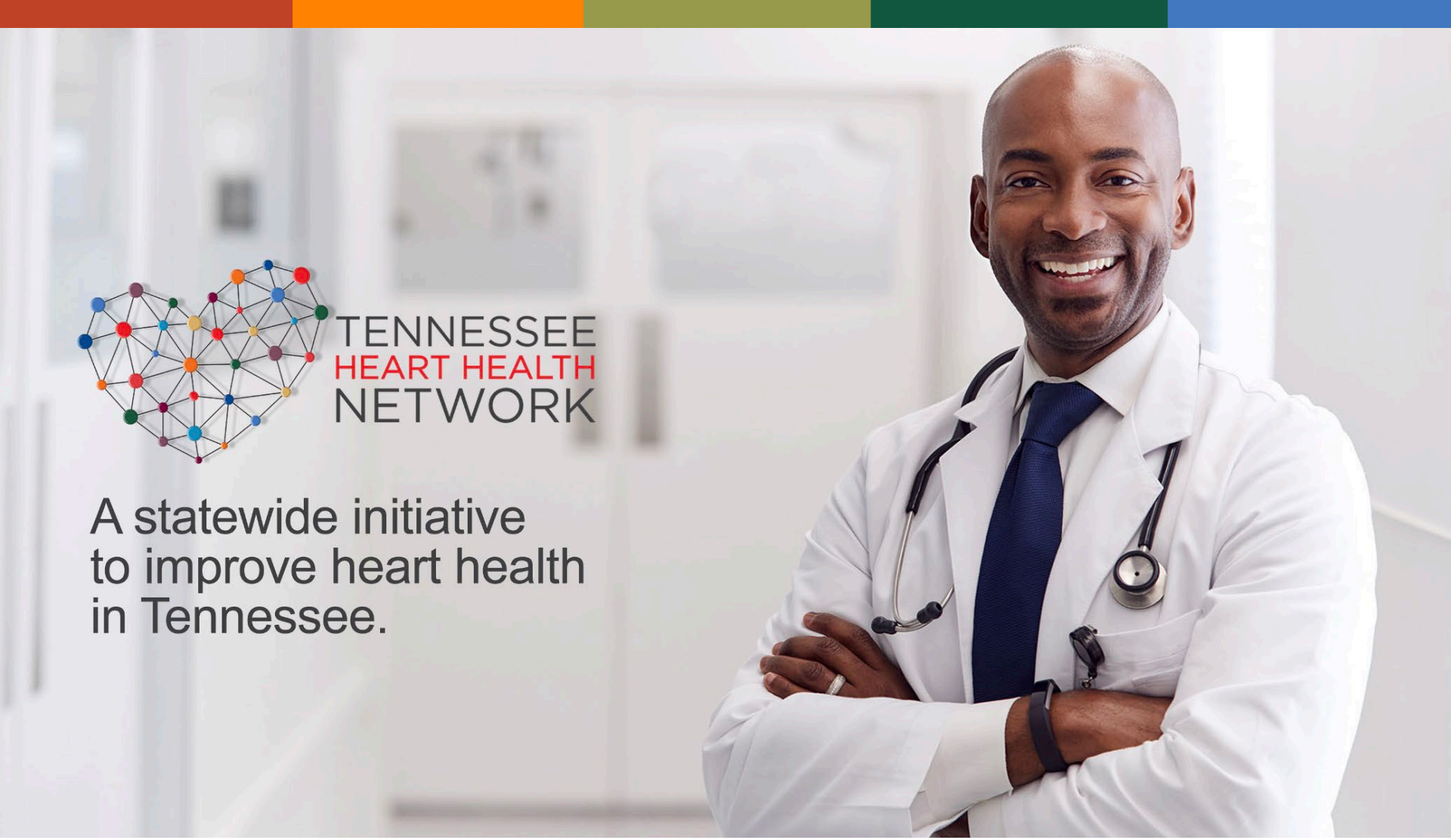




Tennessee Population Health Consortium

Reimagining Primary and Preventive Care for a Healthier Tennessee

Vision: An effective health system that invests strategically in primary and preventive care to measurably improve population health and health equity in Tennessee.



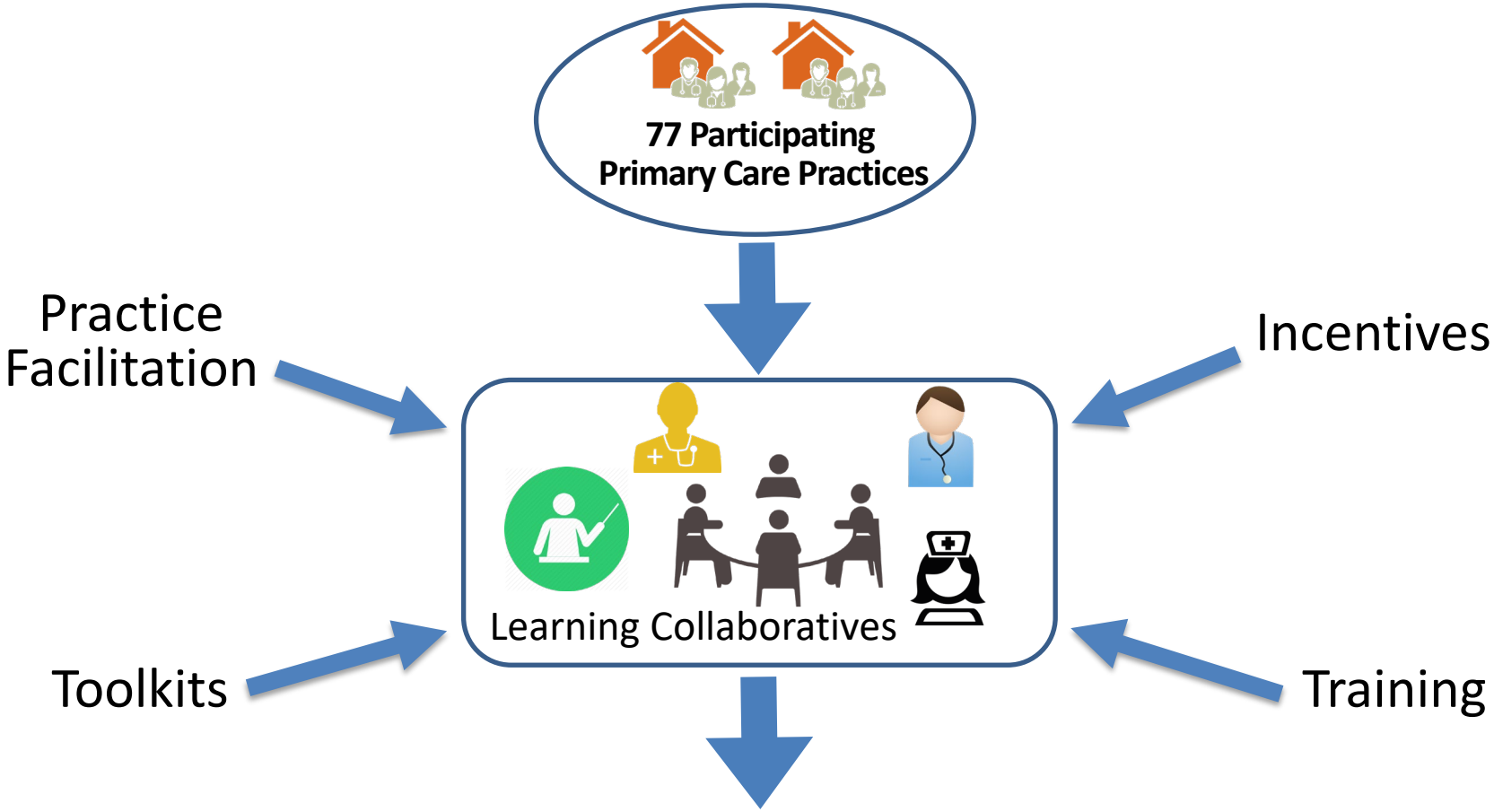
75 Primary Care Practices Across Tennessee Participating in Our Signature Initiative

UTHSC | Tennessee Population Health Consortium

Core Interventions

1) **Primary Care Workforce Development**
   - Deploy 50 Community Health Workers/Health Coaches across Tennessee
2) **Motivational *Heart Health Messages***
   - Encourage 150,000 High-Risk Tennesseans to Take Charge of their Health through Telemedicine
3) **Pharmacist–Physician Collaboration**
   - Increase Delivery of Key Population Health Services by Clinical Pharmacists

1) Workforce Development



Deploy 50 CHWs/Health Coaches
in Clinics and Health Hubs Across Tennessee

The Patient-Centered Model is More Effective in Engaging Patients

Traditional Medical Model View of Patient Engagement:

- Patients do what they are told and follow the treatment plan

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

The Patient-Centered Model is More Effective in Engaging Patients

Traditional Medical Model View of Patient Engagement:

- Patients do what they are told and follow the treatment plan

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

Patient-Centered Model View of Patient Engagement:

- I assume that all patients do care about their health
- My approach helps patients become activated or empowered to take charge of their health
- My approach helps patients more successfully navigate the health care system
- My approach helps patients to engage in better chronic care and lifestyle self-management

Motivational Interviewing

"A collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a change goal by eliciting and exploring an individual's own arguments for change."

Rollnick & Miller, 2013

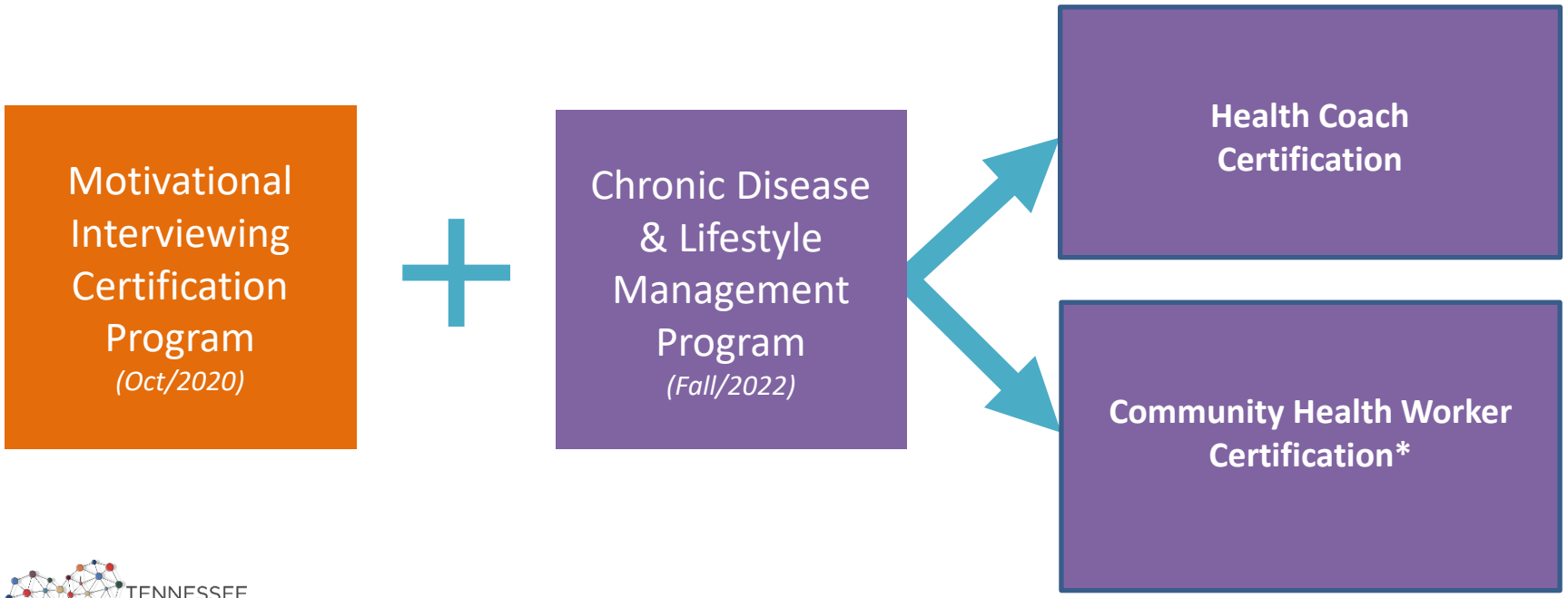
Only health coaching technique to be fully described and consistently demonstrated as causally and independently associated with positive behavioral outcomes.

Butterworth, Linden & McClay, 2007; Olsen & Nesbitt, 2010; Noordman et al., 2012; Wolever et al., 2013; Cotterill & Passmore, 2019

Selected Evidence for MI (>1500 clinical trials)

Outcome Variable	References
Patient Engagement/ Activation	Romano & Peters, 2015 (meta-analysis); Seal et al., 2012 (clinical trial); Dean et al., 2016 (clinical trial); Carroll et al., 2005 (clinical trial); Skolasky et al., 2015; Linden, Butterworth, Prochaska, 2010; Linden & Butterworth, 2014 (clinical trial); Hibbard, Greene, Tusler, 2009
Self-Efficacy/Readiness to Change (SOC)	Linden, Butterworth, Prochaska, 2010; Lundahl et al., 2013 (meta-analysis); Chen et al., 2011 (clinical trial); O'Halloran et al., 2016 (clinical trial); Prochaska, Butterworth, Redding, 2008 (clinical trial)
Medication/Treatment Adherence	Zomahoun et al., 2017 (meta-analysis); Palacio et al., 2016 (meta-analysis); Alperstein & Sharpe, 2016 (meta-analysis)
Diabetes Management	McDaniel, Kavookjian, Whitley, 2022 (systematic review); Azami, Soh, Sazlina, et al., 2018 (clinical trial); Soderlund, 2018 (review); Steffen, Mendonca, Meyer, Faustino-Silva, 2020 (clinical trial); Berhe, Gebru, Kahsay, 2020 (meta-analysis); Selcuk-Tosun & Zincir, 2019 (clinical trial); Young, Miyamoto, Dharmar, Tang-Feldman, 2020 (clinical trial)
Physical Activity/Obesity	Suire et al., 2021 (meta-analysis); Pudkasem et al., 2021 (meta-analysis); Barrett et al., 2018 (meta-analysis); Samdal et al., 2017 (meta-regression); Hardcastle et al, 2013 (clinical trial)
Clinical Outcomes & Hospital Readmissions	Carter, Hassan, Walter, et al., 2021 (clinical trial); Long, Howells, Peters, et al., 2019 (systematic review); Magill et al., 2018 (meta-analysis); Benzo, Vickers, Novotny, st al., 2016 (clinical trial); VanBuskirk & Wetherell, 2014 (meta-analysis); Lundahl et al., 2013 (meta-analysis)

Community Health Worker and Health Coach Training & Certification Programs



TENNESSEE HEART HEALTH NETWORK

** Co-sponsored by Lifedoc Health*

Standardized Patient Competency Assessment

Following MI modules and partner activities, each participant:

- Signs up for one-on-one session
- Chooses a patient/client scenario
- Applies MI skills in a role play
- Receives feedback and mentoring
- Receives certificate with competency assessment

95% of participants to date have received “client-centered level” or higher in competency assessment after completing program

Chronic Condition & Lifestyle Management Program: CHW Track

- Overview of health/patient navigation and the community health worker in public health
  - Administration of SDOH assessment
  - Recommendations for screenings/vaccinations
  - Cultural humility
  - Health literacy
  - Outreach and advocacy
  - Care coordination and system navigation
  - Assistance with getting benefits, resources, linking to agencies
- Lifestyle Management
  - Physical activity
  - Nutrition
  - Sleep management
  - Tobacco, alcohol, and drugs
  - Social support
  - Stress management
  - Weight management
  - Protection of mental health
- Chronic Care Management
  - Overview with call-out on social determinants of health and grief/loss
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Diabetes
  - Hypertension
  - COPD
  - CHF
  - Asthma
  - CAD
  - Mental health concerns
  - Other chronic conditions
- Legal, ethical and professional conduct
- Competency Assessment
  - Case study
  - Multiple choice questions
  - Open book; pass/fail

Group Activity & Discussion

- Break into groups of 4-6 participants
  - Be sure to split up if you are a team so you get diverse ideas
- Discuss
  1. Experiences of using lay/non-clinical staff in your clinic
  2. CPT codes that you have billed for using auxiliary/lay staff
  3. How you might get started using lay staff and how your clinic would benefit the most
- Share highlights with larger group

Sustainability: Selected CPT Codes Appropriate for Lay Staff

Service	Code	Notes	Will code pay when billed alone (Yes/No)
Intensive Behavioral Therapy for Cardiovascular Disease	**G0446** -Face to face 15 min	-Encourage aspirin use for the primary prevention of CVD when benefits outweigh the risk, screening for HTN, counseling for healthy diet	Yes
Intensive Behavioral Therapy for Obesity	**G0447** -Face-to-face behavioral counseling for obesity, 15 minutes	-22 sessions allowed in a 12-month period, 1 face-to-face visit every week for the first month, one face to face visit every other week for months 2-6, and one face to face visit every month for months 7-12 if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months	Yes
Smoking and tobacco use cessation counseling	**99406** -intermediate: 3 - 10 minutes	-Patients must be a tobacco user at the time of billing.	Yes
	99407 -> 10 minutes	-TennCare now covers smoking cessation products for all	Yes

Sustainability: Selected CPT Codes Appropriate for Lay Staff

Service	Code	Notes	Will code pay when billed alone (Yes/No)
Counseling/risk factor reduction intervention	**99401** -15 min individual	-Need local CPT to provide in-house smoking cessation, weight management, bp counseling	Yes
	99402 -30 min individual		Yes
	99403 -45 min individual		Yes
	99404 -60 min individual		Yes
Diabetes Self-Management Education	**G0108** -Diabetes outpatient self-management training services, individual, 30 minutes	-Requires ADA or AADE accreditation	Yes
	G0109 -Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Yes

Sustainability: Selected CPT Codes Appropriate for Lay Staff

Service	Code	Notes
Diabetes Prevention Program (DPP)[A]	*Core Sessions Months 1-6:*	-Requires CDC accreditation
	G9873 -1st session attended	
	G9874 -4 sessions attended	
	G9875 -9 sessions attended	
	Core Maintenance with 5% weight loss:	
	G9878 -2 sessions attended in months 7-9	
	G9879 -2 sessions attended in months 10-12	
	Core Maintenance without 5% weight loss:	
	G9876 -2 sessions attended in months 7-9	
	G9877 -2 sessions attended in months 10-12	
	Ongoing Maintenance Months 13-24 (Maintained 5% weight loss and attended 2 sessions every 3 months):	
	G9882 -Months 13-15	
	G9883 -Months 16-18	
	G9884 -Months 19-21	
	G9885 -Months 22-24	
	Weight Loss Performance:	
	G9880 -Achieved 5% weight loss OR had absolute reduction of waist circumference by 3.2 cm during months 1-12	
	G9881 -Achieved 9% weight loss during months 1-24	
	Subtotal Maximum Payment Attendance Only:	
	Total Maximum Payment	

Sustainability: Selected CPT Codes Appropriate for Lay Staff

Service	Code	Notes	Will code pay when billed alone (Yes/No)
Administration and interpretation of health risk assessment	**99420** (GO444)		No
Chronic Care Management	**99490**-Non-complex CCM	May be administered under general supervision (not personally performed by the billing practitioner but under overall direction-not under same roof). Patients must be seen by billing provider within 12 months. In Rural Health Clinics or FQHCs must be initiated by provider but may be provided by clinical staff.	Yes
	99439-CCM each additional 20 min		No
	99487-Complex CCM first 60 min		Yes
	99489-Complex CCM each additional 30 min		No

Checklist for CHW Position

- High School Diploma or GED
- Ability to communicate effectively orally and in writing with program participants, health care providers, and community partners.
- Ability to approach/treat all patients and colleagues with respect, acceptance, unconditional positive regard, and a patient-centered, non-judgmental approach regardless of gender, race, religious or other beliefs, sexual orientation, or culture.
- Willingness to engage in a comprehensive training program and work towards competency in a complex skill-set that takes practice, mentoring, and feedback.
- Ability to assess needs of patients and respond appropriately.
- Ability to work in Microsoft Office Suite and other virtual platforms.
- Ability to be self-motivated, responsible, and dependable.
- Ability to be tactful and professional in dress and demeanor both in-person and virtually.
- Ability to relate to individuals working to manage or prevent chronic illnesses who may have negative social determinants of health.
- Two years work experience preferred.
- Prior experience in a health coaching, health clinic, or other health-based organization preferred.
- Current integration in/deep understanding of community they are serving preferred.

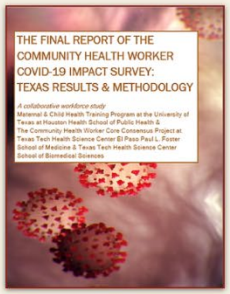
CHW Duties and Responsibilities

- Assist clients/patients in completing forms/applications required to receive needed services or community resources, as required by referral agencies.
- Facilitate referrals for appropriate health information and services as recommended by the provider and health plan.
- Speak with diverse populations about health programs in a sensitive and culturally competent manner.
- Advocate for clients/patients to ensure health care program compliance.
- Provide clients/patients with community resources as needed.
- Maintain data and files for clients'/patients' own records, as well as program reporting.
- Provide one-on-one education on diseases and encourage clients/patients to adopt self-management skills.
- Schedule and/or deliver health education classes in designated communities.
- Teach community groups/organizations to promote healthy lifestyle activities.
- Assist with health screenings in the community.
- Distribute and conduct client/patient and community health assessments.
- Act as a health coach for clients/patients to achieve desired health behaviors.
- Assist clients/patients with navigation of the health care system and processes.
- Fulfill other duties, as assigned.

Resources & Findings from the C3 Project

www.c3project.org

CHW COVID-19 Impact Survey Report - Texas

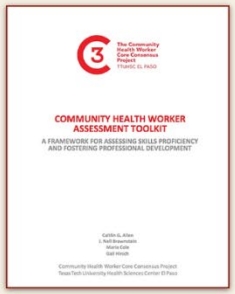


Download

C3 Project Final Report

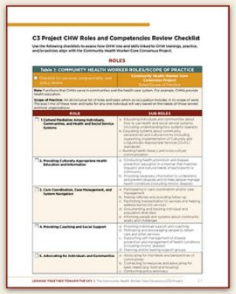
Download

CHW Assessment Toolkit



Download

Roles & Competencies Implementation Checklist



Download

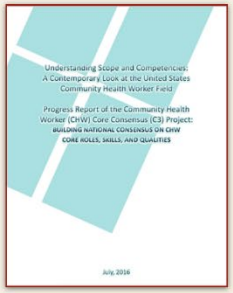
CHWs Are Pivotal Poster

Download

C3 Project Interim Summary Report - 2016

Download

C3 Project Interim Full Report - July 2016



Download

What is a CHW? - English

See Video

Comprehensive CHW Training & Certification

- For more information, go to either:
  - https://tnhearthealth.org/health-coaching/health-coaching-training/
- Or go directly to this link to sign up:
  - https://app.smartsheet.com/b/form/cdae6105a1944d8e8bfd4d5ea15b5d83

Questions & Comments

Please complete our

2022 SESSION EVALUATIONS

2022 ANNUAL CONFERENCE

TN PRIMARY CARE ASSOCIATION

UTHSC | Tennessee Population Health Consortium