
WILLIAMSON HEALTH
AND
WELLNESS CENTER
Our Mission is to create an innovative culture of
health that accelerates positive growth throughout rural communities

AGENDA

- Community Health Worker/Care Coordination Model
- Regional Expansion
- Building Relationships with Payers
- Success and Payer Partnerships

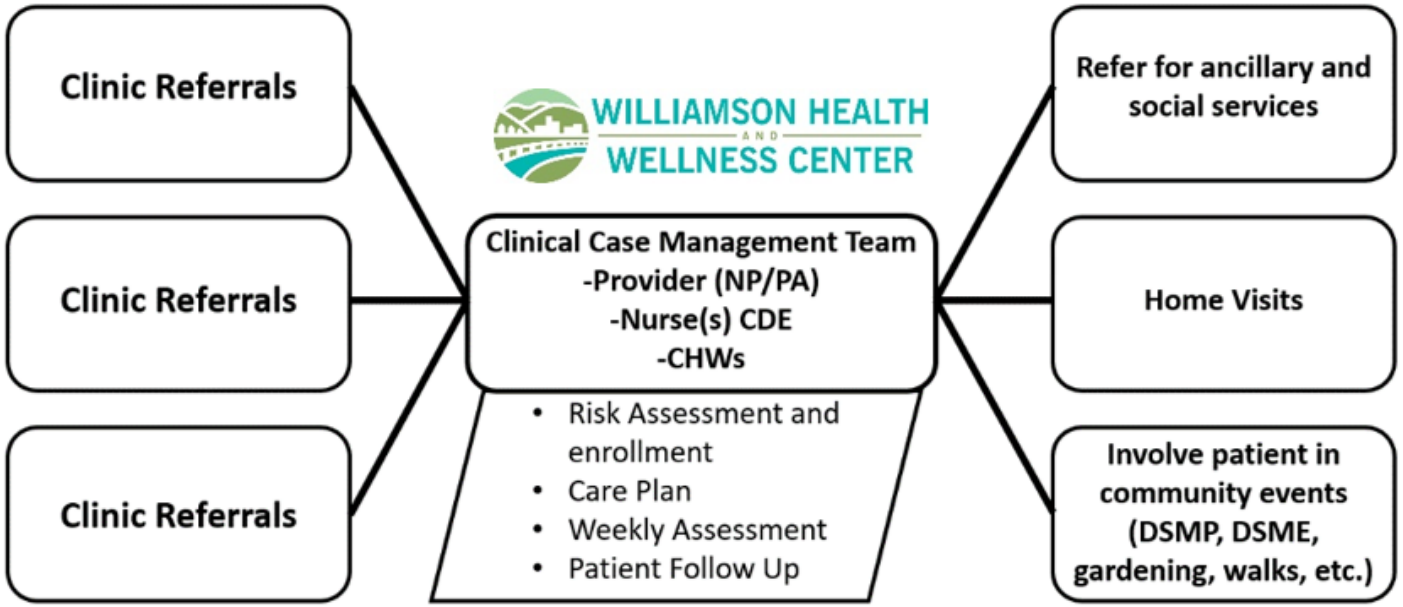
Community Health Worker/ Care Coordination Model

Community Health Worker Model 2012-2020

TIMEFRAME	FUNDING SOURCE
2012-2015	CMS Innovation Award – Subaward from Duke University Southeastern Diabetes Initiative. 600k/year for 11 staff with CHWS guiding clinical and community interventions to address diabetes
2015-2018	HRSA Rural Health Care Coordination Network Partnership Grant Program: CHW interventions for COPD, CHF and Diabetes
2019-2020 NEW!	Partnership with Aetna Better Health includes reimbursement and shared savings for patients referred by Aetna

Community Health Worker Model 2012-2018

- ✓ Reduce Health Care Costs
- ✓ Improve Health Outcomes
- ✓ Strengthen Community Connections



funded by the Federal Office of Rural Health Policy, HRSA

FORHP Grants in *Motion*

RHIhub Rural Health Information Hub | *The* RURAL MONITOR

FEATURES RURAL SPOTLIGHT INTERVIEWS AROUND THE COUNTRY

View the Williamson Health and Wellness Center video on YouTube: https://www.youtube.com/watch?v=W9zKQu8LfLM

M. DILLON

Started seeing her 11/27/2017

- Illiterate and poor family support
- Educated with visual aids/portion control
- Medicines marked monthly with ☀ and ☽
- F/U with podiatry, PCP, and other specialties
- Obtained Diabetic eye exam

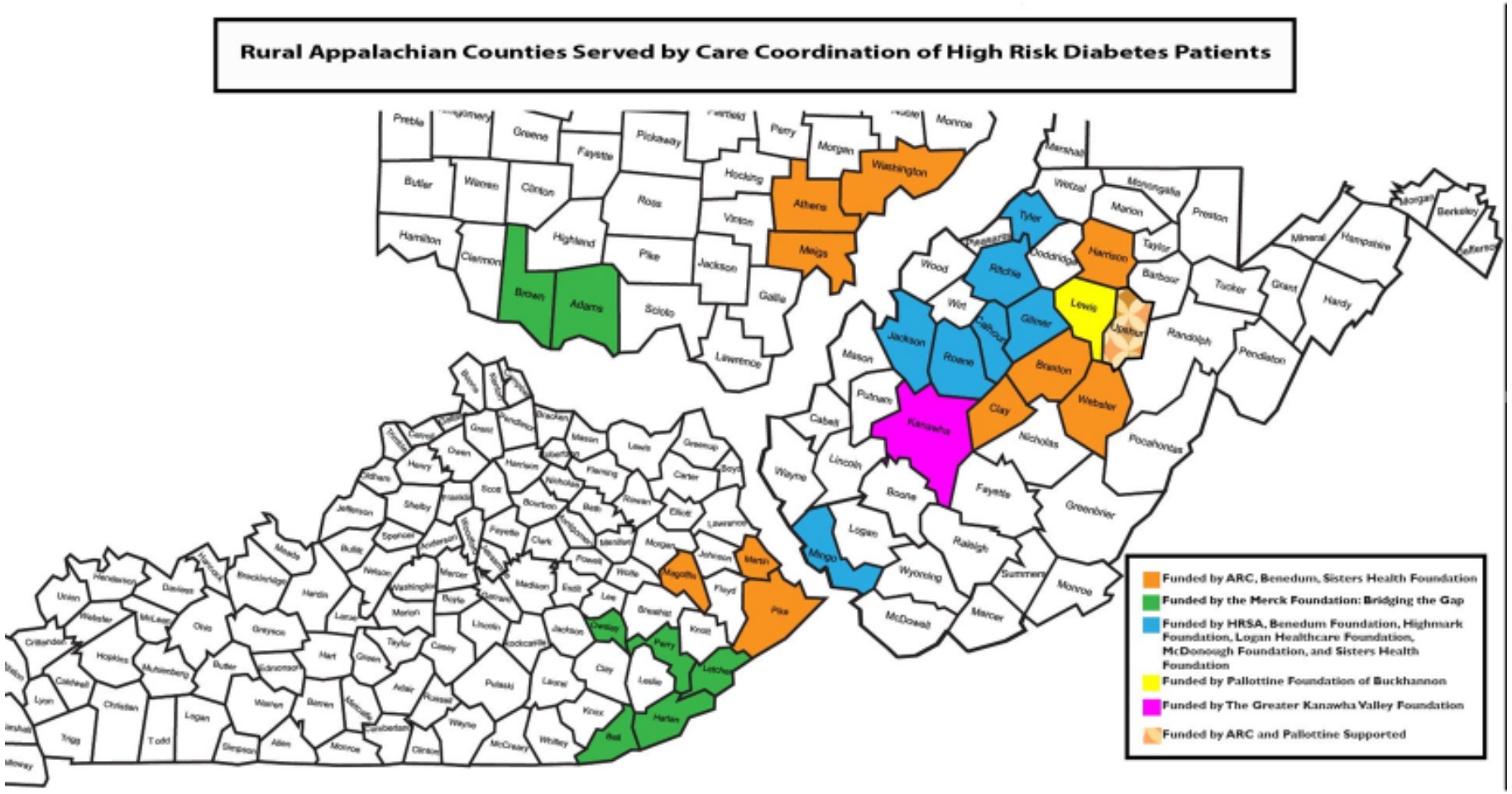
	Start Labs 9/19/17	Current Labs 3/18/18
A1C	13.1%	7.3%
Cholesterol	267	235
TRIG	349	217
HDL	57	45
LDL	140.20	146.6
Creatinine	0.71	0.82

10/28/19

Chol	113
TRIG	102
HDL	44
LDL	49

- Reports less neuropathy and no longer uses cane

Regional Expansion:
In Partnership with Marshall University


Rural Appalachian Counties Served by Care Coordination of High Risk Diabetes Patients
Funded by ARC, Benedum, Sisters Health Foundation
Funded by the Merck Foundation: Bridging the Gap
Funded by HRSA, Benedum Foundation, Highmark Foundation, Logan Healthcare Foundation, McDonough Foundation, and Sisters Health Foundation
Funded by Pallottine Foundation of Buckhannon
Funded by The Greater Kanawha Valley Foundation
Funded by ARC and Pallottine Supported

ER and Hospital Encounters
Time Period: October 2018 to September 2019
Marshall University School of Medicine

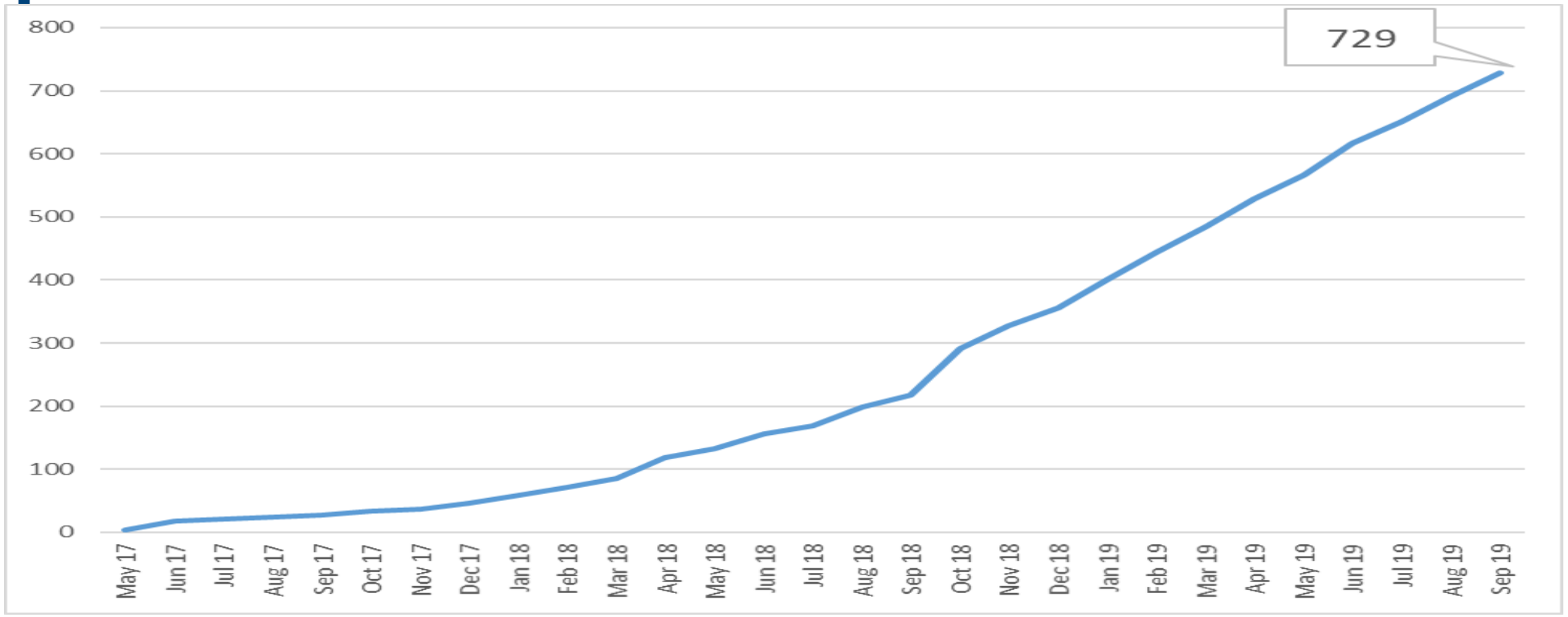
ER Visits
Oct 2018 - Sept 2019

ER Visits Oct 2018 - Sept 2019	1st 6 Month	2nd 6 Months	Difference
Enrollment (n)	37	37	
Total ER Visits	67	13	-54
Avg ER Visits per month	11.2	2.2	-9 avg visits/mo.

Hospital Visits
Oct 2018 - Sept 2019

Hospital Visits Oct 2018 - Sept 2019	1st 6 Month	2nd 6 Months	Difference
Enrollment (n)	37	37	
Total Hospital Visits	70	7	-63
Avg Hospital Visit per month	11.7	1.2	-10.5 avg visits/mo.

Cumulative Enrollment May 2017 Through September 2019



Building Relationships with Payers:
In Partnership with Marshall University

Strategy for Sustainability: Partnership with Medicaid health insurance payers

- Identify the top 10% of high-utilizers
- Partner with health care agencies to set up CHW-Based CCM
- Test and establish a payment model for CHW-Based CCM
- Use an impact investment strategy to minimize the risk to the insurance company for testing payment models
- Use claims data to document cost savings and establish a Win-Win payment system.

Success! NEW Payer Partnerships:
Thanks to Marshall University!

Payer status

- Aetna Better Health WV making payments for CHW-Based CCM with two FQHCs and in planning stage with a third.
- The Health Plan making payments for CHW-Based CCM to one FQHC and in planning stage with a second.
  - Plan will release a 12 month actuarial report in January 2020
- UniCare/Anthem in planning stage with one FQHC.

Preliminary Actuarial Data from The Health Plan

Community Health Worker 4-month enrollment trends for 20 patients:

- ED visits from 2.86 to 2.64
- Prescriptions from 93 to 50
- Reduction in overall average healthcare spend:
  - $20,056 to $15,152
  - **$5,000 saved for 20 patients = $100,000**

NEW Payer Partnerships:
Lessons Learned

Community Health Worker Model

NEW! Changes as of 2019 due to Aetna Better Health Partnership

SUMMARY Lessons Learned in 2019

The CHW model: *Does the model change as we work more with Aetna Better Health and other insurance providers?*

- Increase of # of individuals receiving CHW services who are diagnosed with SUD/behavioral health issues. From 2012-2018 we focused primarily on chronic disease (diabetes, COPD, CHF). **NEW! CHWS need more training for working with a population with behavioral health issues**
- **Increase of wrap around services** provided by Aetna for patients in CHW program
- **Reduced burden of monitoring data separate from the EHR**. Aetna provides data as part of shared savings
- **Increase of time commitments from billing department**
- **New revenue stream for CHW services including reimbursement and shared savings**

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