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

<table>
<thead>
<tr>
<th>TIMEFRAME</th>
<th>FUNDING SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2015</td>
<td>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</td>
</tr>
<tr>
<td>2015-2018</td>
<td>HRSA Rural Health Care Coordination Network Partnership Grant Program: CHW interventions for COPD, CHF and Diabetes</td>
</tr>
<tr>
<td>2019-2020</td>
<td>Partnership with Aetna Better Health includes reimbursement and shared savings for patients referred by Aetna</td>
</tr>
</tbody>
</table>
Community Health Worker Model 2012-2018

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

Clinic Referrals

Clinical Case Management Team
- Provider (NP/PA)
- Nurse(s) CDE
- CHWs
  - Risk Assessment and enrollment
  - Care Plan
  - Weekly Assessment
  - Patient Follow Up

Refer for ancillary and social services

Home Visits

Involve patient in community events (DSMP, DSME, gardening, walks, etc.)
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

<table>
<thead>
<tr>
<th></th>
<th>Start Labs 9/19/17</th>
<th>Current Labs 3/18/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C</td>
<td>13.1%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>267</td>
<td>235</td>
</tr>
<tr>
<td>TRIG</td>
<td>349</td>
<td>217</td>
</tr>
<tr>
<td>HDL</td>
<td>57</td>
<td>45</td>
</tr>
<tr>
<td>LDL</td>
<td>140.20</td>
<td>146.6</td>
</tr>
<tr>
<td>Creatinine</td>
<td>0.71</td>
<td>0.82</td>
</tr>
</tbody>
</table>

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
### ER Visits
**Oct 2018 - Sept 2019**

<table>
<thead>
<tr>
<th></th>
<th>1st 6 Month</th>
<th>2nd 6 Months</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment (n)</td>
<td>37</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Total ER Visits</td>
<td>67</td>
<td>13</td>
<td>-54</td>
</tr>
<tr>
<td>Avg ER Visits per month</td>
<td>11.2</td>
<td>2.2</td>
<td>-9 avg visits/mo.</td>
</tr>
</tbody>
</table>

### Hospital Visits
**Oct 2018 - Sept 2019**

<table>
<thead>
<tr>
<th></th>
<th>1st 6 Month</th>
<th>2nd 6 Months</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment (n)</td>
<td>37</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Total Hospital Visits</td>
<td>70</td>
<td>7</td>
<td>-63</td>
</tr>
<tr>
<td>Avg Hospital Visit per month</td>
<td>11.7</td>
<td>1.2</td>
<td>-10.5 avg visits/mo.</td>
</tr>
</tbody>
</table>
Cumulative Enrollment May 2017 Through September 2019

729
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

NEW! Referrals from Aetna Better Health

NEW! Greater need for Behavioral Health support

Clinical Case Management Team
- Provider (NP/PA)
- Nurse(s) CDE
- CHWs

- Risk Assessment and enrollment
- Care Plan
- Weekly Assessment
- Patient Follow Up

Clinic Referrals

Refer for ancillary and social services

Home Visits

Involve patient in community events (DSMP, DSME, gardening, walks, etc.)

NEW! Aetna nurse joins our care team
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
Jerome Cline, MSN, FNP-C, CDE
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