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Empowering Pharmacy Based Community Health Workers

Tripp Logan, PharmD

SEMO Rx Pharmacies & Service

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Financial Disclosures

- **Tripp Logan, PharmD**, declares no relevant financial relationships or commercial interests in any product or service mentioned in this activity, including grants, employment, gifts, stock holdings, honoraria.

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Pharmacist Learning Objectives

At the end of the **knowledge-based** activity, participants will be able to:

1. Define social determinants of health (SDoH).
2. Explain how certain social determinants of health can be barriers to optimizing care.
3. Discuss the tools available that can be employed by pharmacy personnel to improve patient care services in community pharmacies.

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Technician Learning Objectives

At the end of the **knowledge-based** activity, participants will be able to:

1. Define social determinants of health (SDoH).
2. Describe how pharmacy technicians can impact social determinants of health.
3. Recognize the role of Community Health Workers (CHWs) in the pharmacy setting.

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Assessment Question 1

Which scenario highlights how food insecurity can be considered a Social Determinant of Health?

A. *Patients can live in unhealthy food deserts in which they only have access to inexpensive, healthy foods.*
B. *Patients worried about how to get their next meal oftentimes don't prioritize health over food.*
C. *Postal & courier services cannot deliver meal prep subscriptions to a patient's address.*
D. *Patients are hyper aware of the health consequences of their limited access to healthy foods.*

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Assessment Question 2

Which scenario highlights how housing instability can be considered a Social Determinant of Health?

A. *Patient on a fixed income receiving daily meal deliveries.*
B. *Patient living in filthy conditions that cannot navigate in their current home, nor bathe using their current bathroom setup.*
C. *Patient owns their home and has an onsite caregiver.*
D. *None of the above*

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Assessment Question 3

Which is of the following is included in the American Public Health Association's Community Health Worker definition?

A. *CHWs are trusted members of and /or have an unusually close understanding of the community served.*
B. *CHWs use this trusting relationship enables them to serve as a liaison/link/intermediary between health/social services*
C. *CHW's support the community to facilitate access to services*
D. *All of the above*

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Assessment Question 4

Which is not something you would hear from a Community Health Worker?

A. *"What is most important to you?"*
B. *"What are you hoping for?"*
C. *"What are your worries? "*
D. *"What are your personal goals?"*
E. *"Based on your serum creatinine, I've dose adjusted your apixaban to 2.5mg twice daily. "*

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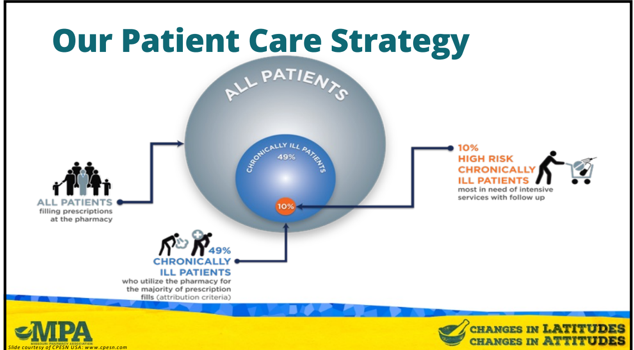

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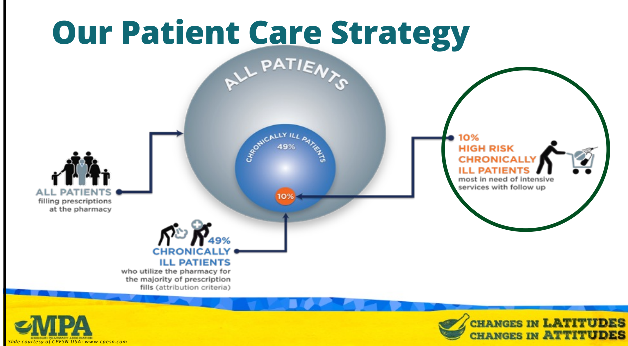

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What Actually Makes Pharmacies Different?

- Local care coordination
- Formulary navigation support
- Out of pocket cost reduction support
- Medication reconciliation support
- Personalized home delivery / visits
- Medication optimization services
- Individualized patient centric support (not population health management)

Targeting Social Determinants of Health

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What Exactly Are Social Determinates of Health (SDH/SDOH)?

"The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."

World Health Organization (WHO) https://www.who.int/social_determinants/sdh_definition/en/

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SDoH……Why Us?

…..because our pharmacies are located in the middle of where people **"are born, grow, work, live and age"**

It's not just a noble cause….it's a national focus

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Why Social Determinates of Health (SDH/SDOH) Now?

Fact sheet

CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F)

Apr 29, 2022 | Affordable Care Act

Social Determinants of Health and Special Needs Plan Health Risk Assessments

"Certain social risk factors can lead to unmet social needs that directly influence an individual's physical, psychosocial, and functional status. Many dually eligible individuals contend with multiple social risk factors such as housing insecurity and homelessness, food insecurity, lack of access to transportation, and low levels of health literacy. All SNPs must complete enrollee health risk assessments (HRAs) at enrollment and annually. We proposed to require that all SNP HRAs include specific standardized questions on housing stability, food security, and access to transportation – all of which we know to be important contributors to overall health. Based on the comments we received, we are finalizing a requirement that all SNP HRAs include at least one question from a list of screening instruments specified by CMS on each of these three domains, but we are not requiring that all SNPs use the same specific standardized questions. The final rule will help better identify the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence and enable MA SNPs to take these risk factors into account in enrollee care plans"

CMS Newsroom CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F) - https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

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How Did We Implement?

- $0.10/hour – Chronic Disease State Management Certificate
  - Additional Incentives: Social Media Recognition, Coursework Covered
- $0.10/hour - Mental Health First Aid Certificate
  - Additional Incentives: Social Media Recognition, Coursework Covered
- $0.15/hour - Motivational Interviewing Certificate
  - Additional Incentives: Social Media Recognition, Coursework Covered
- $1.00/hour - Certified Pharmacy Technician
  - Additional Incentives: Social Media Recognition, Coursework Covered
- $1.00/hour – Technician Immunization Certification
  - Additional Incentives: Social Media Recognition, Coursework Covered
- $1.50/hour - Community Health Workers Certificate
  - Additional Incentives: Social Media Recognition, Coursework Covered

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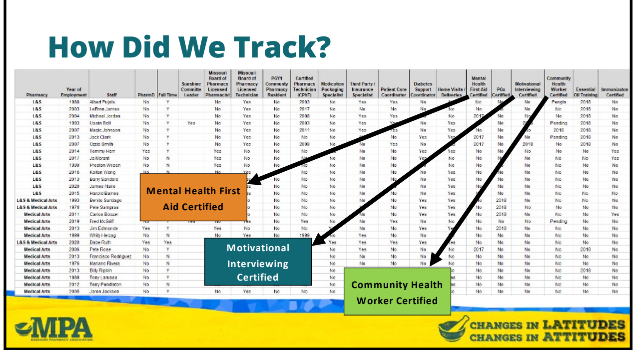

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What's a Community Health Worker?

"Community Health Workers (CHWs) are frontline public health workers who ***are trusted members of and /or have an unusually close understanding of the community served.*** *This trusting relationship enables CHWs to* ***serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services*** *and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."*

...ker Definition; American Public Health Association Policy Statement 20091, Support for Community Health Workers to Increase ... Reduce Health Inequities; 2009

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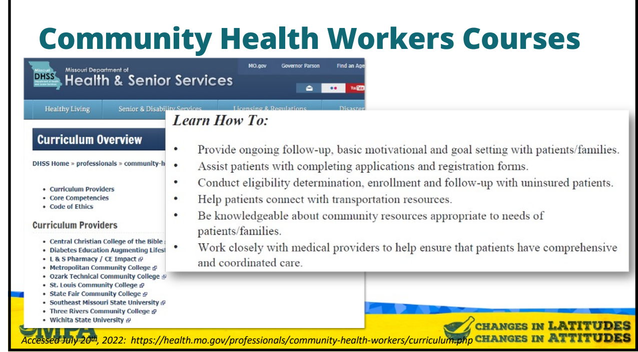

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Community Health Workers

- Help patients and their families navigate the health care system, access LOCAL community services & non-local resources, as well as promote the adoption of healthy behaviors
- Facilitate a LOCAL and ACCESSABLE destination for soft handoffs for patients in transition and/or in need of services beyond standard prescription dispensing
- Serve as a LOCAL liaison for payer and provider partners and become a conduit for information flow and service delivery

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What Does CHW Engagement Look Like?

- *"How do you like to get your medication information?"*
- *"Tell me about your situation right now?"*
- *"What is most important to you?"*
- *"What are you hoping for?"*
- *"What are your worries? "*
- *"What are your personal goals?"*
- *"Tell me about you as a person?"*
- *"Tell me about your personal support system"*
- *"Where do you find your strength and your comfort?"*
- Utilize screening tools
- Create peer to peer relationships

Receiving referrals & connecting OUR patient to LOCAL services that meet OUR patient's individualized needs

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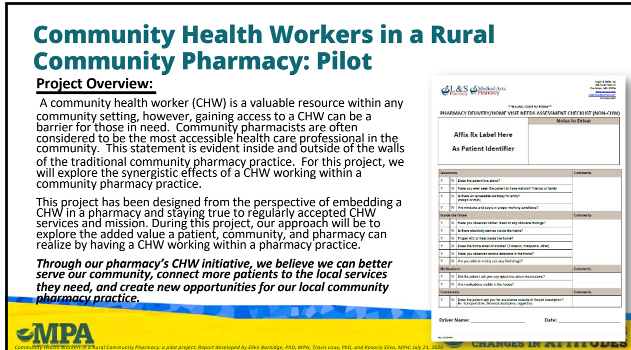

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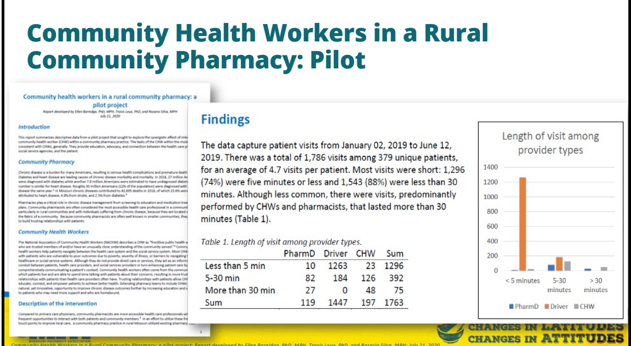

Table 1. Length of visit among provider types.

	PharmD	Driver	CHW	Sum
Less than 5 min	10	1263	23	1296
5-30 min	82	184	126	392
More than 30 min	27	0	48	75
Sum	119	1447	197	1763

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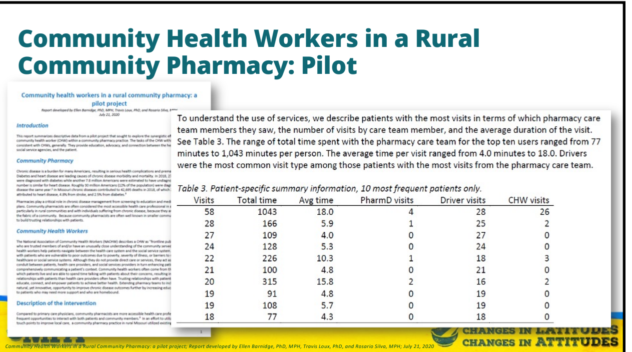

Table 3. Patient-specific summary information, 10 most frequent patients only.

Visits	Total time	Avg time	PharmD visits	Driver visits	CHW visits
58	1043	18.0	4	28	26
28	166	5.9	1	25	2
27	109	4.0	0	27	0
24	128	5.3	0	24	0
22	226	10.3	1	18	3
21	100	4.8	0	21	0
20	315	15.8	2	16	2
19	91	4.8	0	19	0
19	108	5.7	0	19	0
18	77	4.3	0	18	0

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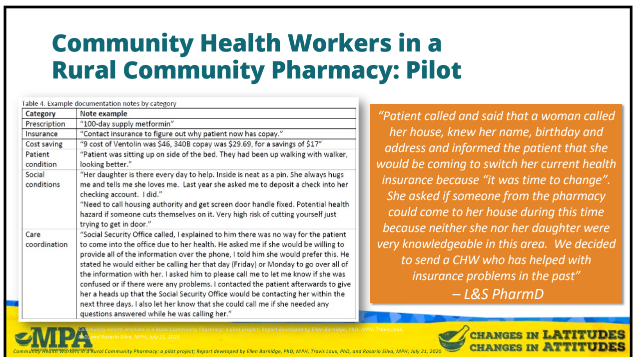

Table 4. Example documentation notes by category

Category	Note example
Prescription	"100-day supply metformin"
Insurance	"Contact insurance to figure out why patient now has copay."
Cost saving	"9 cost of Ventolin was $46, 340B copay was $29.69, for a savings of $17"
Patient condition	"Patient was sitting up on side of the bed. They had been up walking with walker, looking better."
Social conditions	"Her daughter is there every day to help. Inside is neat as a pin. She always hugs me and tells me she loves me. Last year she asked me to deposit a check into her checking account. I did." "Need to call housing authority and get screen door handle fixed. Potential health hazard if someone cuts themselves on it. Very high risk of cutting yourself just trying to get in door."
Care coordination	"Social Security Office called, I explained to him there was no way for the patient to come into the office due to her health. He asked me if she would be willing to provide all of the information over the phone, I told him she would prefer this. He stated he would either be calling her that day (Friday) or Monday to go over all of the information with her. I asked him to please call me to let me know if she was confused or if there were any problems. I contacted the patient afterwards to give her a heads up that the Social Security Office would be contacting her within the next three days. I also let her know that she could call me if she needed any questions answered while he was calling her."

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Community Health Workers in a Rural Community Pharmacy: Pilot

- >1400 Delivery Driver Home Assessments*
- >275 Unique Sites*
- >200 CHW referrals from Drivers, Pharmacist, Staff, & Other*
- Medication Optimization review led to > $70 PMPM out of pocket savings (CHW PharmD)*
- >$87,000 in estimated annual out of pocket Rx savings*
- Converted 10+ patients to medication packaging*
- Connected patients to ongoing transit services for multiple office visits*
- Connecting patients and caregivers to financial support entities (non-profits, etc)
- Engagement with local payers and providers
- Health fairs, community meetings, pharmacy representation
- Engagement with local Health Departments & School Districts

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Community Health Workers in a Rural Community Pharmacy: a pilot project; Report developed by Ellen Barnidge, PhD, MPH, Travis Loux, PhD, and Rosario Silva, MPH; July 21, 2020

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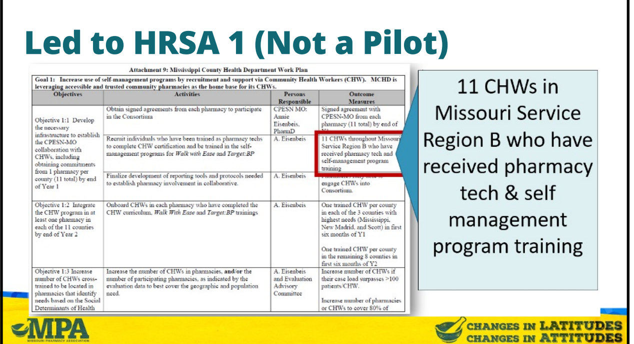

Attachment 9: Mississippi County Health Department Work Plan

Goal 1: Increase use of self-management programs by recruitment and support via Community Health Workers (CHW). MCHD is leveraging accessible and trusted community pharmacies as the home base for its CHWs.

Objectives	Activities	Persons Responsible	Outcome Measures
Objective 1:1 Develop the necessary infrastructure to establish the CPESN-MO collaboration with CHWs, including obtaining commitments from 1 pharmacy per county (11 total) by end of Year 1	Obtain signed agreements from each pharmacy to participate in the Consortium	CPESN MO: Annie Eisenbeis, PharmD	Signed agreement with CPESN-MO from each pharmacy (11 total) by end of
	Recruit individuals who have been trained as pharmacy techs to complete CHW certification and be trained in the self-management programs for *Walk with Ease* and *Target:BP*	A. Eisenbeis	11 CHWs throughout Missouri Service Region B who have received pharmacy tech and self-management program training
	Finalize development of reporting tools and protocols needed to establish pharmacy involvement in collaborative.	A. Eisenbeis	engage CHWs into Consortium.
Objective 1:2 Integrate the CHW program in at least one pharmacy in each of the 11 counties by end of Year 2	Onboard CHWs in each pharmacy who have completed the CHW curriculum, *Walk With Ease* and *Target:BP* trainings	A. Eisenbeis	One trained CHW per county in each of the 3 counties with highest needs (Mississippi, New Madrid, and Scott) in first six months of Y1 One trained CHW per county in the remaining 8 counties in first six months of Y2
Objective 1:3 Increase number of CHWs cross-trained to be located in pharmacies that identify needs based on the Social Determinants of Health	Increase the number of CHWs in pharmacies, **and/or** the number of participating pharmacies, as indicated by the evaluation data to best cover the geographic and population need.	A. Eisenbeis and Evaluation Advisory Committee	Increase number of CHWs if their case load surpasses >100 patients/CHW. Increase number of pharmacies or CHWs to cover 80% of

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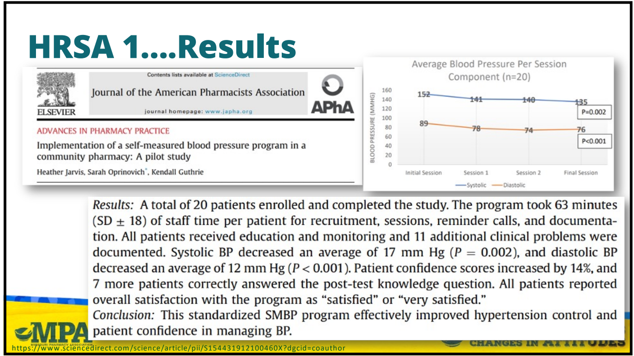

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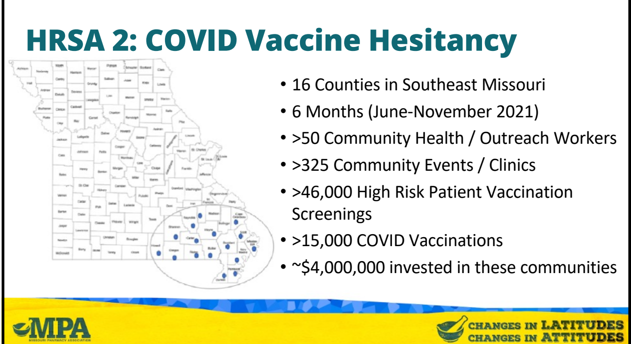

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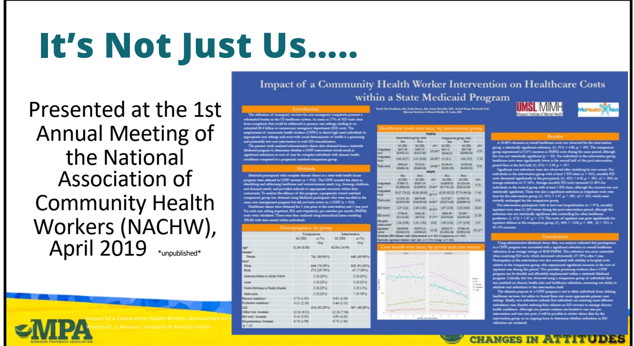

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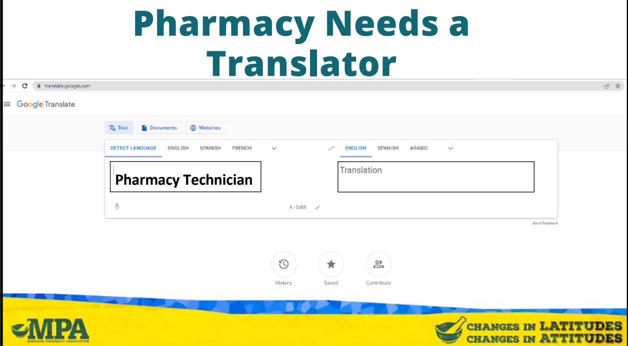

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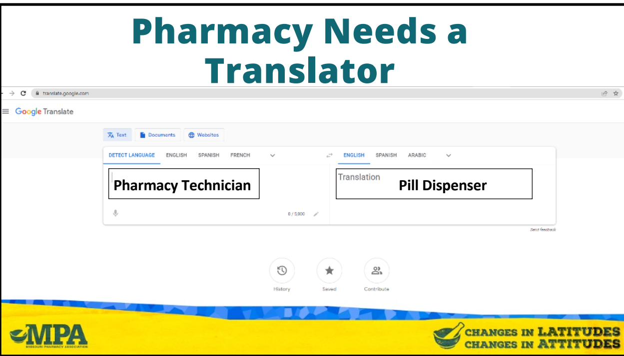

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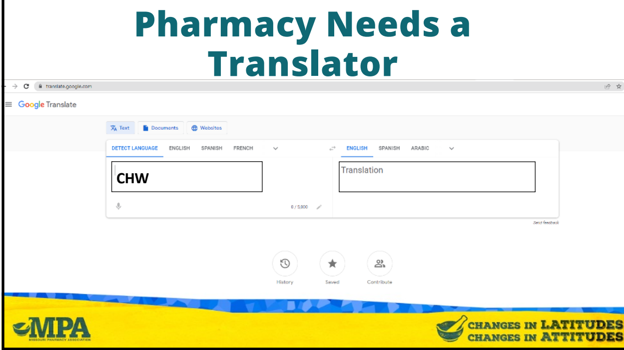

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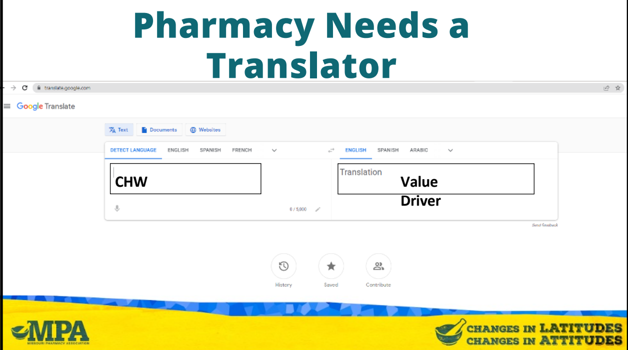

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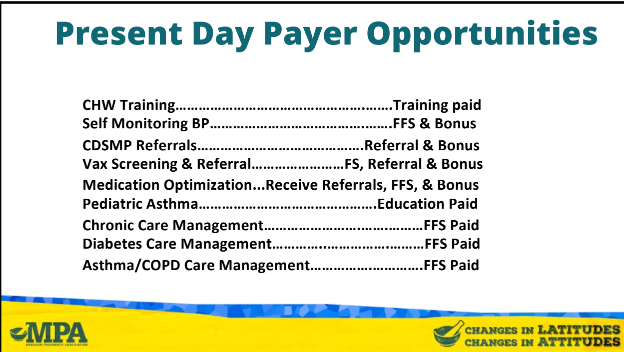

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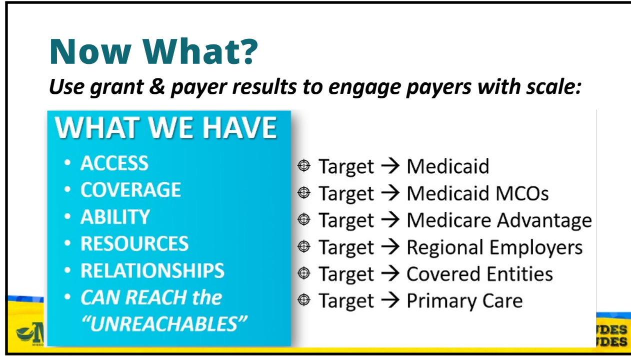

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Assessment Question 1

Which scenario highlights how food insecurity can be considered a Social Determinant of Health?

A. *Patients can live in unhealthy food deserts in which they only have access to inexpensive, healthy foods.*
B. *Patients worried about how to get their next meal oftentimes don't prioritize health over food.*
C. *Postal & courier services cannot deliver meal prep subscriptions to a patient's address.*
D. *Patients are hyper aware of the health consequences of their limited access to healthy foods.*

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Assessment Question 2

Which scenario highlights how housing instability can be considered a Social Determinant of Health?

A. *Patient on a fixed income receiving daily meal deliveries.*
B. *Patient living in filthy conditions that cannot navigate in their current home, nor bathe using their current bathroom setup.*
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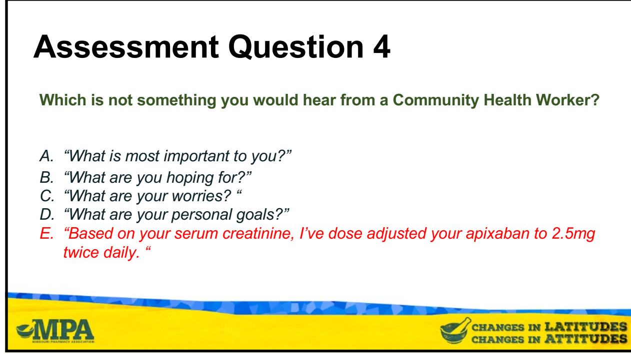

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