CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Hybrid Model Approach for Community Health Team Services in Rhode Island

Summary Recommendations May 2021

Report by:

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Introduction

The RI statewide Community Health Team pilot supported by CTC-RI has completed phase one after six years. The clinical and financial return has been demonstrated. There is wide agreement among CTC-RI stakeholders that community health team functions are critical to improving the health of patients and families, and that successfully addressing the social needs of patients improves financial performance for the health care system. This has been demonstrated in a Commonwealth Fund Review[1], and has been made even clearer by the COVID-19 pandemic.

As part of its Community Health Team (CHT) sustainability work, CTC-RI sponsored an intensive four-month "Building Community-Clinical Linkages Miniseries" (December 2020 – March 2021). This series highlighted the importance of a short and longer-term approach to help meet the health and social needs of patients and families, and to improve the health of communities. Working with national subject matter experts, the mini-series promoted the following principles around CHTs:

- CHTs are a flexible and fluid resource to meet population health goals
- CHTs are place-based and serve a particular geography allowing them to work with beyond clinical affiliation.
- CHTs are multi-disciplinary, encouraging cross-sector collaboration across providers and care teams
- CHTs effectively identifies and addresses needs of targeted populations, including populations not being served—and works to address the needs directly and supports planning to address those needs at the level of the community

Stakeholder Feedback

Questions arose during the mini-series concerning the role and sustainability of an organized statewide CHT infrastructure vs CHT infrastructure existing within practice/SOC and health plans. As such, following the mini-series, CTC-RI was charged by the OHIC Commissioner and EOHHS Medicaid Director to assess what the consensus was among key stakeholders as to how to best structure CHT services in RI. Nine interviews representing RI AE and health plan leadership were conducted in April/May 2021 that reflected the following:

- It is important to have CHT services close to primary care whenever possible. AEs have built efficiencies in having CHT services within same EMR, workflows, etc.
- There is variability in current practice/AE/ACO capabilities and willingness to offer CHT services to other practices outside of their system

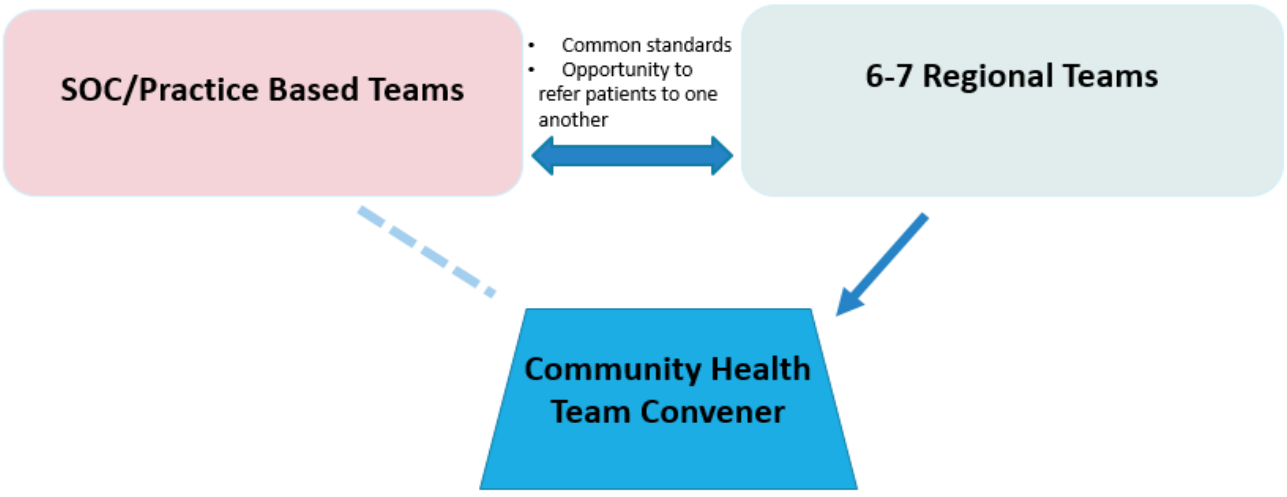
[1] https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-1-19.pdf

- There is a need for a statewide integrated HIT approach to improve identification of impactable high and rising risk patients, improve care coordination, and improve data and reporting for ongoing performance improvement
- CHT services should be available to all, including "unattributed" patients and uninsured
- It is important to have a more organized system to serve children and families who need intensive community-based services and an opportunity to provide "whole family" care

Elements of Hybrid model

Consensus has shifted towards a "hybrid" approach as the best way to move forward in RI. This proposal includes a system of both regionally-based CHTs as well as CHTs operating within Systems of Care (SOC)/primary care practices to help meet the needs of complex patients and families. This ensures that CHT services are available to all Rhode Islanders. CHT services across both the regionally based teams and the SOC/Practice based teams would consist of a multidisciplinary team of community health workers (CHWs), behavioral health clinicians and other support staff that work as an extension of primary care to connect individuals and families with complex health and social needs to the local, community based supports needed to achieve optimal health and social well-being.

Figure 1: Hybrid Model Organizational Structure



SOC/Practice Based Teams

CHTs operating within a SOC or practice would provide services to targeted patients in their panel and take advantage of the efficiencies of working within in a single system (i.e. same EMR, common workflows). These teams would bill for reimbursable services and could also be supported via value based contracts and other internal funding mechanism. Additionally, these teams have the opportunity to "refer out" to regional teams if needed –(e.g. more specialized services children and family; multi-system involvement; geographic reach; locating and engaging attributed but unengaged patients)

Regional Teams

Having this complementary network ensures that CHT services are available to all Rhode Islanders. Regional CHTs are housed in a clinical/community based backbone organization with the ability to bill for reimbursable services. The teams would be targeted at certain geographic regions and would have capacity to receive referrals from outside of primary care (i.e. health plans, hospitals, First Connections, housing authorities) and from small, unaffiliated primary care practices in that region. This would create capacity to address social needs for uninsured/unaffiliated patients and families in a way that also helps build healthier communities. The teams could also support emergency departments and inpatient discharge planners with complex cases, in order to maximize engagement with needed transitions and care services.

Additionally, these regional teams would be able to provide "whole family care", serving families who might receive care from different primary care practices and services from different child/family systems. They would support connections between primary care and community resources to advance population health goals in their region. We envision close collaboration with HEZs and other important community based partners. These regional teams could serve as places to pilot new care models to reduce health inequities.

Community Health Team Convener

The CHT Convener would have two primary roles. The first role would be to facilitate a statewide Learning Collaborative for regional CHTs and SOC/Practice Based CHTs to promote best practice sharing and alignment common tools and reporting standards. This would ensure coordination of CHT services across teams. The second role of the convener would be to coordinate the regional network by identifying a backbone organization in each region to serve as the regional CHT and ensuring regional CHTs accountability for deliverables and metrics.

Areas for Further Development

Many details still need to be addressed to fully operationalize this new model. In order to facilitate the development of the model, CTC-RI suggests further work in the following areas to develop the business case for the hybrid CHT model.

Financial Model and Payment

Many questions remain about how this hybrid model will be financially supported. EOHHS is pursuing CHW reimbursement as a covered benefit and this will play an important role in supporting the teams. Further work is needed to inform the classification CHT services for payment. CTC-RI believes that the funding CHT services for the regional teams should be approached differently than for the SOC/Practice based teams. We also support a multipayer strategy for supporting the CHT network. Considerations for a workgroup focused on this effort may include:

- Fixed infrastructure support to provide stability to perform non billable work (i.e. outreach/engagement, travel, community collaboration)
- A FFS component that is variable income and aligns with volume of work
- Incentives for innovation/alignment with performance metrics

Child and "Whole Family" Approach

An important component of the regional teams will be to provide "whole family" care. Standards are needed for how the regional teams should engage with child and family systems, including schools, to best ensure an aligned and coordinated approach to care.

Quality Measures, Data Measurement and Reporting and Performance Improvement

Work is needed to identify where we can set common quality measures, data collection and reporting standards across the regional teams and SOC/Practice based teams. It will be important to build off existing standards, rather than create new ones. A workgroup could be established assess how best to identify quality measures, use data for performance improvement/evaluation and how to maximize use of the Community Resource Platform.