Building Community Clinical Linkages

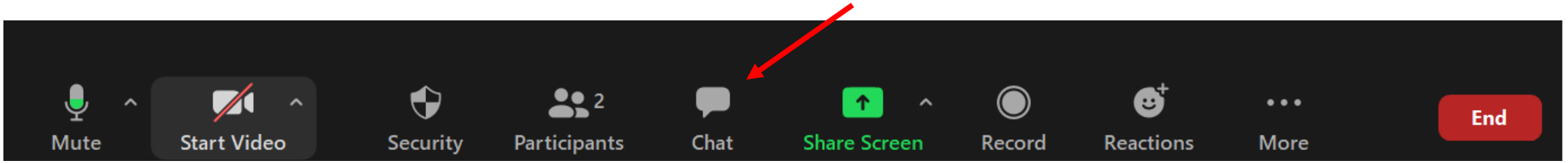
CARE TRANSFORMATION COLLABORATIVE

DECEMBER 4, 2020

Zoom

Welcome! Please Chat in:

- Your Name and Organization



- ***Please mute yourself when not speaking***
- ***Please use the 'Raise Hand' feature***

Community Health Team Spotlight

https://drive.google.com/file/d/1bkK8sCjs7pWsBOftyxmPeSUG5d4bCSTF/view

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Community Health Teams (CHTs)

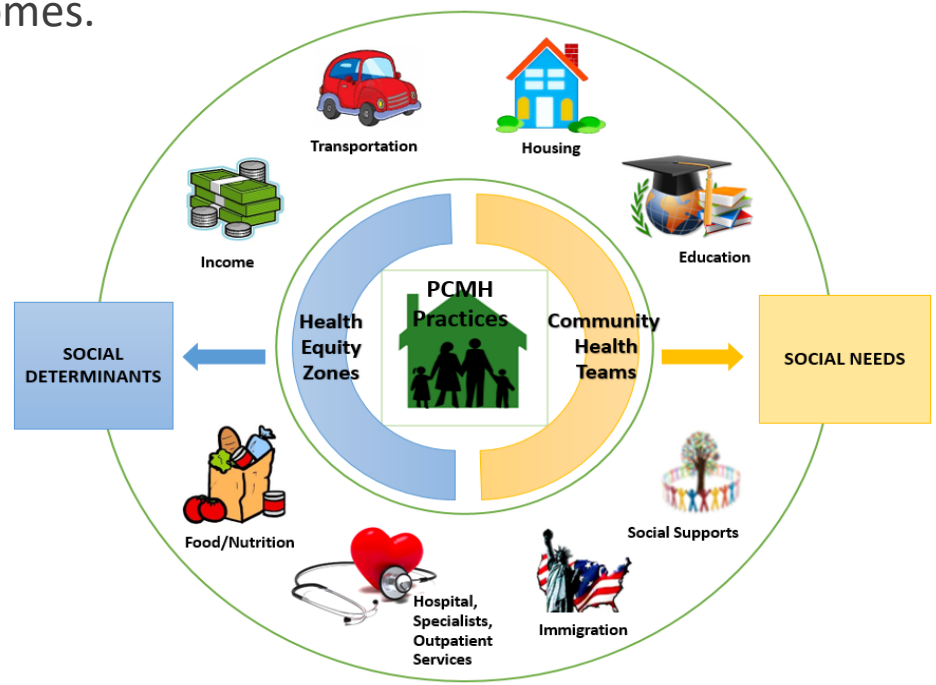
An Integrated Team Model Supporting Community-Clinical Linkages for High Risk Patients & Families

CARE TRANSFORMATION COLLABORATIVE OF R.I.

DECEMBER 4, 2020

PHASE 1- Established the model and evidence

CHT's work as an **extension of primary care** to address the social, behavioral and environmental determinants for high risk/high cost/high impact patients in order to establish healthier living, improved health and total cost outcomes.



Who is on the team?

CORE:

- **Community Health Workers**
- **Behavioral Health Provider**

ADDED:

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screener**
- **Peer Recovery Specialist (SOR)**
- **Family Care Liaison (RIPIN)**
- **Legal Assistance (MLPB)**

PHASE 1- Established the model and evidence

Supported through time limited, multi-payer investments from commercial and Medicare Advantage health plans, Medicaid (HSTP), Rhode Island Foundation; previously SIM and SOR grants

- Payer Blind Program (funding gap for Medicare FFS and uninsured)
- FQHC based and place based teams

Investments since 2015 – over $10M

Piloted projects to:

- Enhance diabetes and hypertension chronic disease management
- Create Multidisciplinary Care Teams with RIDOH Family Home Visiting Programs

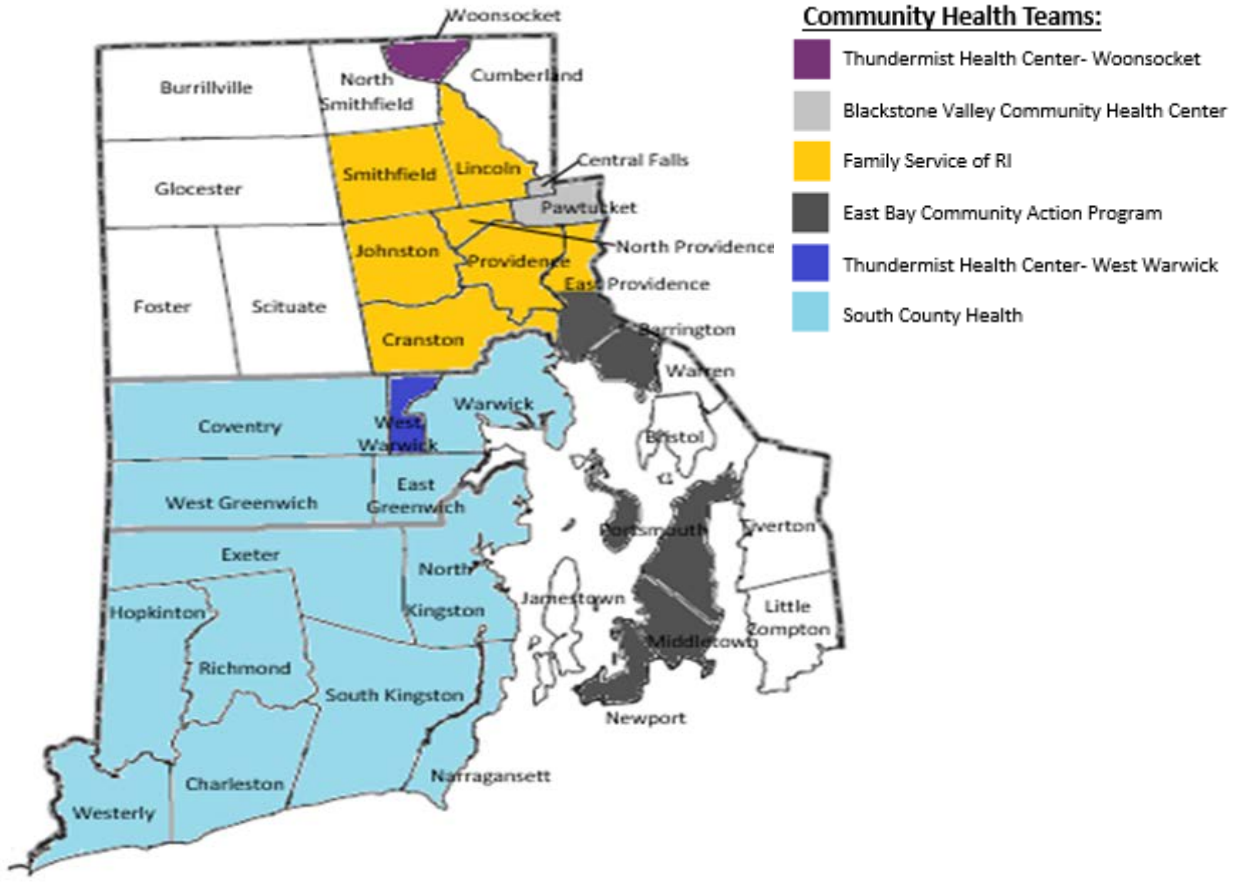
PHASE 1- Established the model and evidence

6 Geographically based teams

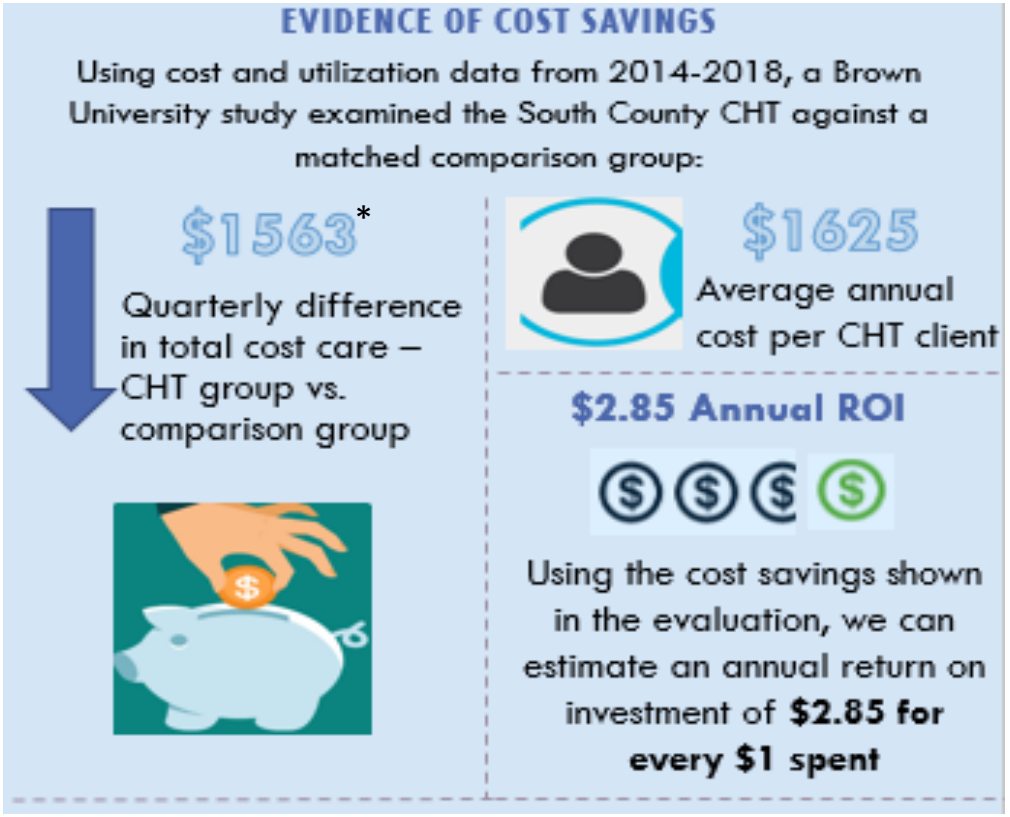
46 practices across the state have referring relationships with Community Health Teams

330 providers across all partnering practices have referring relationships with Community Health Teams

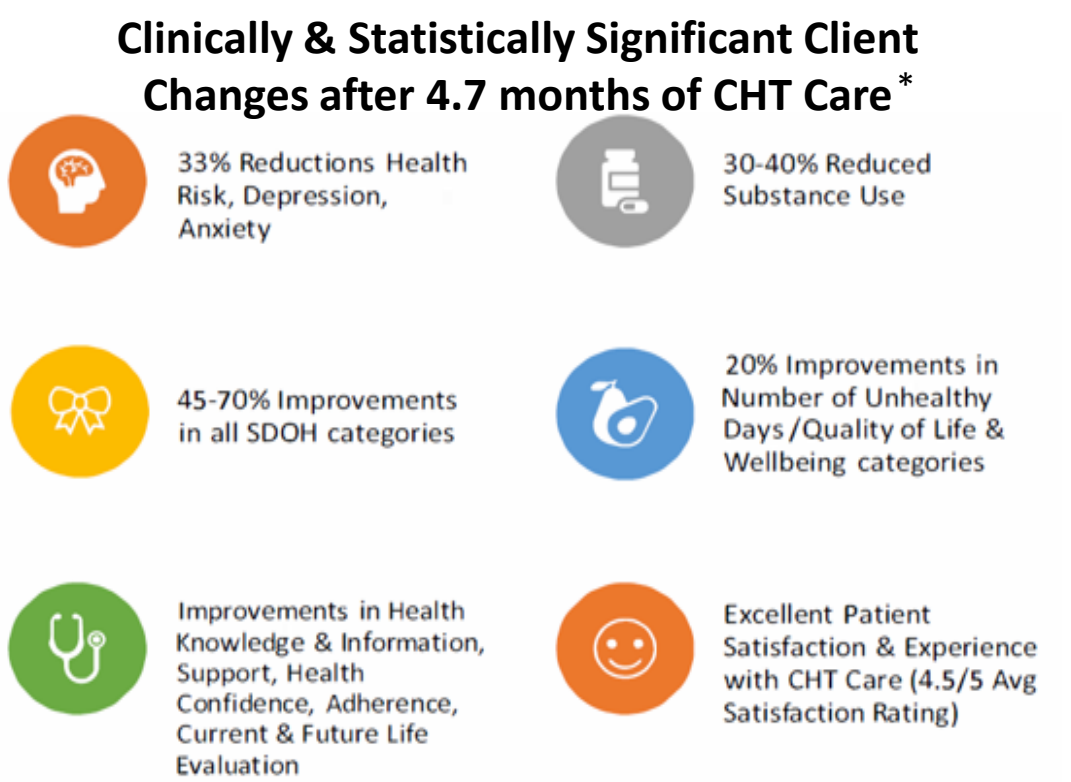
2500 adult patients directly served by CTC-RI Community Health Teams in FY 20



PHASE 1- Established the model and evidence



Galárraga, Li, Thapa (2020, May) *Evaluating the Impact of South County Community Health Team Evaluation Report*. Prepared by Brown University.



*Redding C.A. (2019, August) *SIM Community Health Team Final Evaluation Report*. Prepared by University of Rhode Island State Evaluation Team. Rhode Island State Innovation Model Grant #1G1CMS331405.

Established the model: Importance of community based BH clinician

- Successful patient engagement of high risk patients and families benefits from community-based BH clinicians
- A “must have” for how CTC operationalizes CHTs – enhances work of community health workers
- In most cases, FFS billing for BH clinician does not/will not cover costs

CHT Evolution for Long Term Success

Phase I
2015-2020

- Created the model and established the evidence
- Piloted innovative ways of utilizing CHTs to advance population health goals

Phase II
Next 2-3 Years

- Have a payment model in place for July 1, 2021 that allows CHTs to build on current structures to improve Health Equity and patient and family health
- Continue innovation with evolving model(s):
  - Serve children and families
  - Broaden connections to Hospitals and Health Plans
  - Continue to support Medicaid/RIDOH SODH strategy, and incorporate lessons learned from Rhode to Equity
- Finalize multi payer, multi sector long term payment structure for CHTs

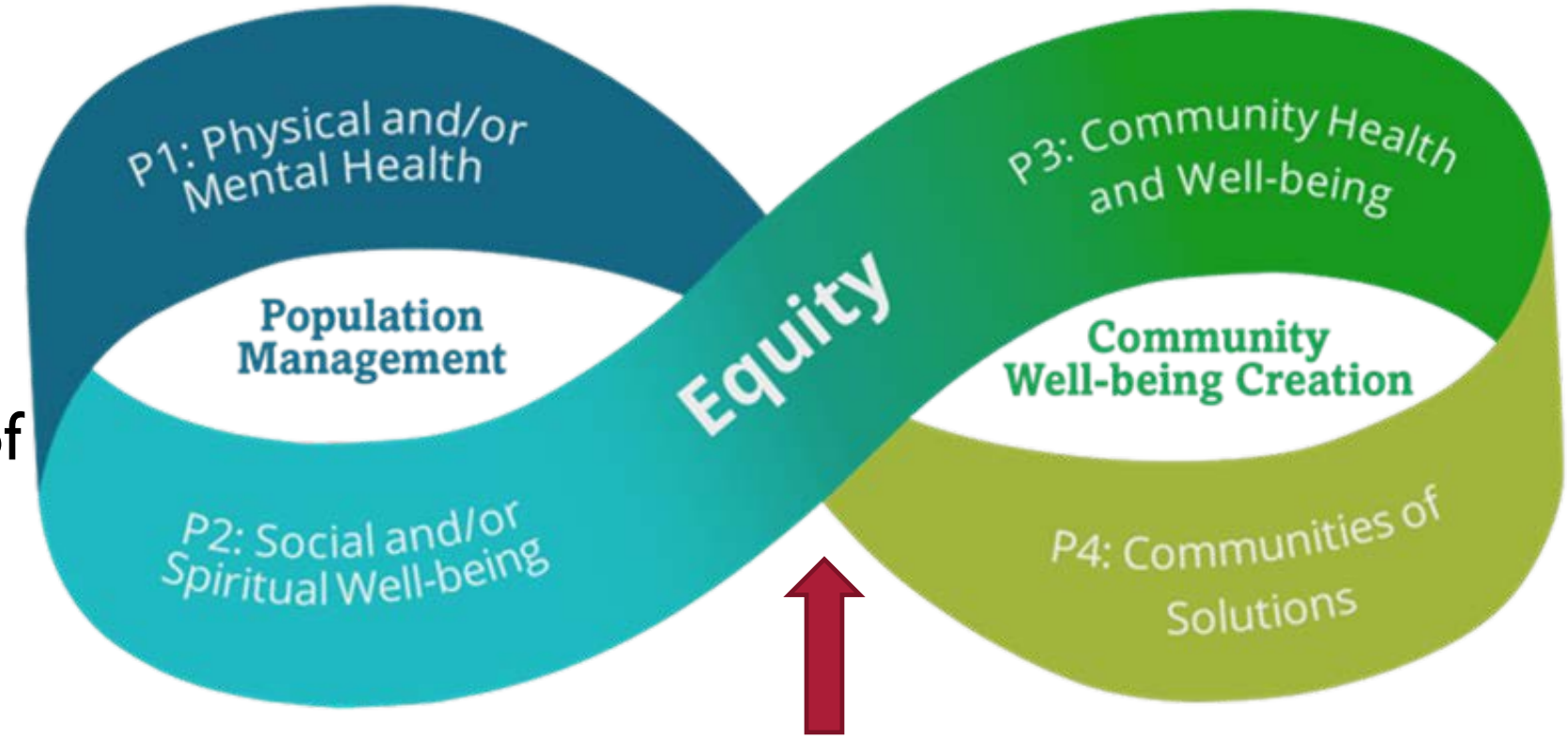
Phase III

- Implementation of long term payment structure based on evolving evidence and model(s) to support Health Equity and Quadruple Aim

IMPROVING POPULATION HEALTH

PATHWAYS TO POPULATION HEALTH

Improving the health and wellbeing of people



Improving the health and wellbeing of places

Improving the systems that drive (in)equity

Source: Pathways to Population Health, 2018

pathways2pophealth.org

KEY ROLES OF COMMUNITY HEALTH TEAMS

- To provide and extend primary health care delivery
- To support care coordination and care management for people at risk of poor health and well-being outcomes and to close social and equity gaps
- To address underlying community needs to address the vital conditions everyone needs to thrive
- To be a trusted intermediary between the community and the larger health system

CHARACTERISTICS OF COMMUNITY HEALTH WORKER SUPPORT SYSTEM

1. **Place-based** - Community health workers that are sourced from and serve a particular geography can do much more than those assigned based solely on a clinical affiliation.
2. **Comprehensive** – Rather than parsing CHW workforce by individual diseases, it is far more efficient and effective to consider them a part of a comprehensive health improvement strategy to address the mental, physical, and social needs of people and communities and organize them based on highest risk, medium/rising risk, and prevention.
3. **Connected** - Community health workers are far more effective when they are part of health teams that are connected with health care and community-based partners across sectors in their geography. This may require access to technology supports, internet and broadband as well as regular processes of connecting with teams..

SUPPORT SYSTEMS

1. **Workforce development and supervision** - A process and policies for workforce development, training, and certification for peer workers, such as community health workers, and their supervisors in both health education and navigator activities and broader community transformation skills needs to be in place.
2. **Support** - There needs to also be training of health care administrative, public health and clinical leaders to effectively engage and mobilize the assets that CHWs bring to communities.
3. **Sustained financing** – When people know something will be around, they can rely on it as part of a health and well-being system.
4. **Support from a broader stewardship group** that is working across sectors to address underlying policy and system changes
5. **Support for data, measurement and evaluation** infrastructure

SUSTAINABLE MULTI-SECTOR PAYMENT STRATEGIES TO SUPPORT COMMUNITY HEALTH TEAMS ACROSS THE NATION

- As part of usual clinical care through Medicaid, MCOs and other payers across sectors
  - Clinical care base payment (fee for service)
  - Quality payments
  - As part of capitation/shared savings payments
  - As part of MCO administrative costs
  - Pay for outcomes payments
- Through grants/demonstration funding, state funding (eg, SIM, public health grants) until shared savings are demonstrated → maintained after that as investments in quality and equity
- Through multi-sector payments (eg, via Pathways hubs)

NEW MEXICO

- Has had a place-based model of community health team deployment for decades, connected with the University of New Mexico. Is particularly developed in Bernalillo county but is scaled across the state.
- Has a certification program in place but certification is not required for payment.
- Payment mechanisms for CHWs services are implemented. For example, Through a Medicaid 1115 Waiver, Centennial Care has leveraged contracts with Medicaid managed care organizations (MCOs) to support the use of CHWs in serving Medicaid enrollees. CHW salaries, training, and service costs are MCO administrative costs and embedded in capitated rates paid to Medicaid managed care organizations.
- Uses Pathways Community Hubs with community health worker teams that reliably connect people with their medical, behavioral health and social needs. Is targeted to comprehensively meet the needs of highest risk people.
- Coordinating entity across the state in place.
- Uses ECHO model with CHWs to support local communities while mitigating the need to travel.
- Shared data infrastructure across sectors.
- Evidence of return on investment across sectors.

MICHIGAN

- In its Medicaid managed care contract, MI requires health plans to maintain a ratio of at least one full-time CHW per 15,000 or 20,000 covered lives; provide or arrange for the provision of CHW or peer-support specialist services to enrollees with behavioral health issues and complex physical co-morbidities; and establish a reimbursement methodology for CHW work that promotes behavioral health integration (https://www.chcs.org/media/PCI-Toolkit-Team-Care-Tool_090319.pdf)
- Pathways HUB models of CHW deployment were scaled in MI through its SIM project across the state as part of its accountable communities for health (https://pchi-hub.com/hubs/map-of-hubs/)
- CHWs are part of the interdisciplinary MI Care Teams under the Section 2703 State Plan Amendment.

NORTH CAROLINA

- Community health workers are embedded in community health teams supported by Community Care of NC.
- Teams run by the largest Medicaid Managed Care provider operate regionally and include health professionals, hospitals, health departments, social service agencies, and community organizations and serve 1800 primary care practices.
- **Payment**: These teams receive added per member per month care management payments in addition to the fee-for-service payments and work to care manage high risk populations.

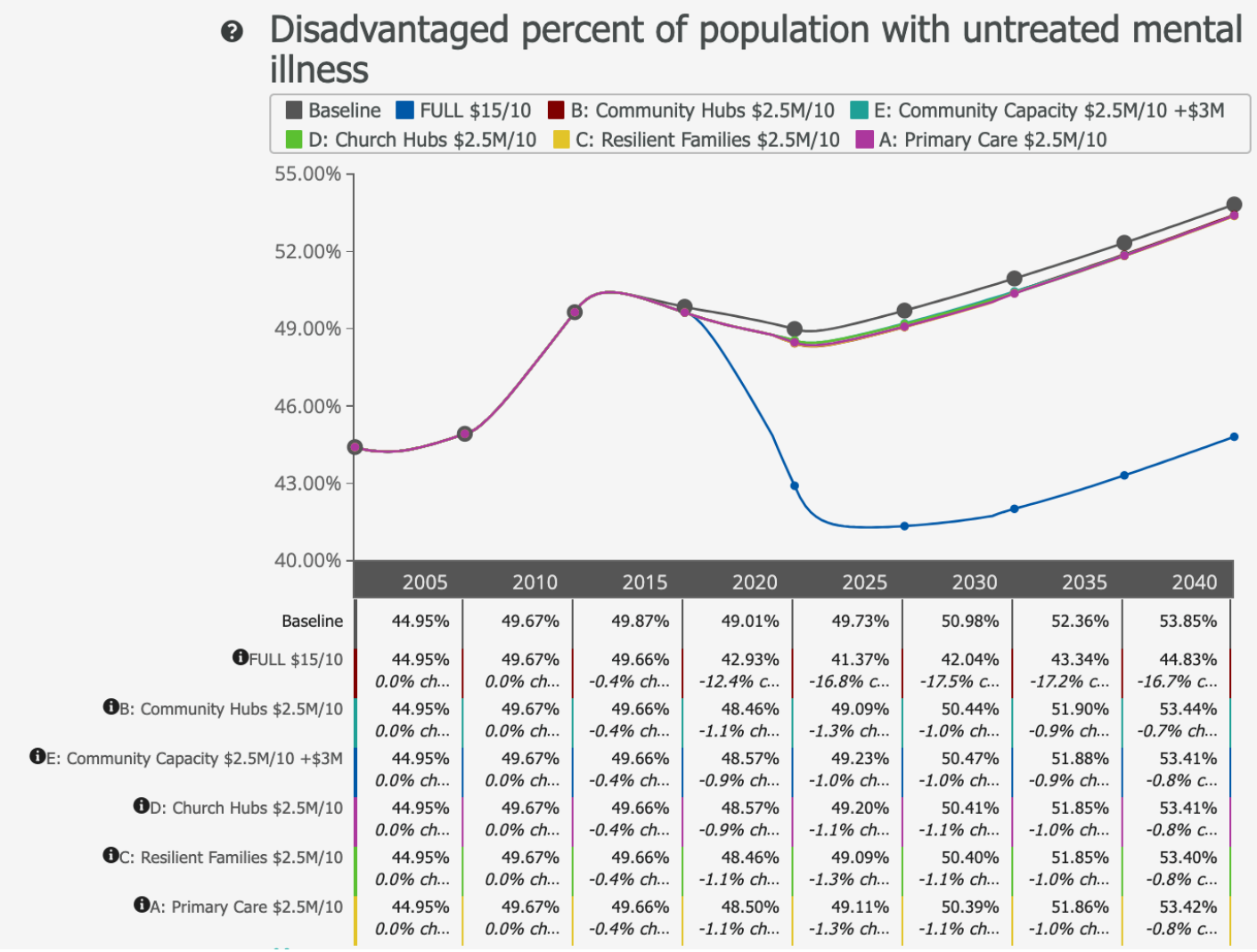
PENNSYLVANIA

- Medicaid is the largest source of funding for CHWs in Pennsylvania, followed by Federal Grant Categorical Funding.
- Medicaid managed care organizations consider CHW expenditures as clinical care costs. Pennsylvania provides Medicaid coverage for Peer Support Specialists (PSS) in the behavioral health field, and some PSS providers are considered CHWs.

- IMPaCT (Individualized Management for Patient-Centered Targets) addresses unmet social needs such as housing and food insecurity and transportation needs in underserved populations with the goal of improving health. The evidence-based program hires, and trains trusted neighborhood residents to become CHWs who carry out culturally appropriate outreach activities, social support, patient advocacy, and health system navigation. Annual return on investment (ROI) of $2.47 for every dollar invested annually by Medicaid.

IMPORTANT CONSIDERATIONS

- Measure total return on investment (ROI) across sectors, not just clinical ROI but total ROI
  - Total ROI is the value created across sectors divided by the investment across sectors
- Importance of measuring ROI over short, medium, and long term



	2005	2010	2015	2020	2025	2030	2035	2040
Baseline	44.95%	49.67%	49.87%	49.01%	49.73%	50.98%	52.36%	53.85%
FULL $15/10	44.95% 0.0% ch...	49.67% 0.0% ch...	49.66% -0.4% ch...	42.93% -12.4% c...	41.37% -16.8% c...	42.04% -17.5% c...	43.34% -17.2% c...	44.83% -16.7% c...
B: Community Hubs $2.5M/10	44.95% 0.0% ch...	49.67% 0.0% ch...	49.66% -0.4% ch...	48.46% -1.1% ch...	49.09% -1.3% ch...	50.44% -1.0% ch...	51.90% -0.9% ch...	53.44% -0.7% ch...
E: Community Capacity $2.5M/10 +$3M	44.95% 0.0% ch...	49.67% 0.0% ch...	49.66% -0.4% ch...	48.57% -0.9% ch...	49.23% -1.0% ch...	50.47% -1.0% ch...	51.88% -0.9% ch...	53.41% -0.8% c...
D: Church Hubs $2.5M/10	44.95% 0.0% ch...	49.67% 0.0% ch...	49.66% -0.4% ch...	48.57% -0.9% ch...	49.20% -1.1% ch...	50.41% -1.1% ch...	51.85% -1.0% ch...	53.41% -0.8% c...
C: Resilient Families $2.5M/10	44.95% 0.0% ch...	49.67% 0.0% ch...	49.66% -0.4% ch...	48.46% -1.1% ch...	49.09% -1.3% ch...	50.40% -1.1% ch...	51.85% -1.0% ch...	53.40% -0.8% c...
A: Primary Care $2.5M/10	44.95% 0.0% ch...	49.67% 0.0% ch...	49.66% -0.4% ch...	48.50% -1.1% ch...	49.11% -1.3% ch...	50.39% -1.1% ch...	51.86% -1.0% ch...	53.42% -0.8% c...

Community-Clinical Linkage to Support Comprehensive Primary Care

Vermont's Community Health Teams

CRAIG JONES

DECEMBER 4, 2020

Vermont's Community Health Teams Blueprint Model & Community Linkages

All-Insurer Payment Reforms

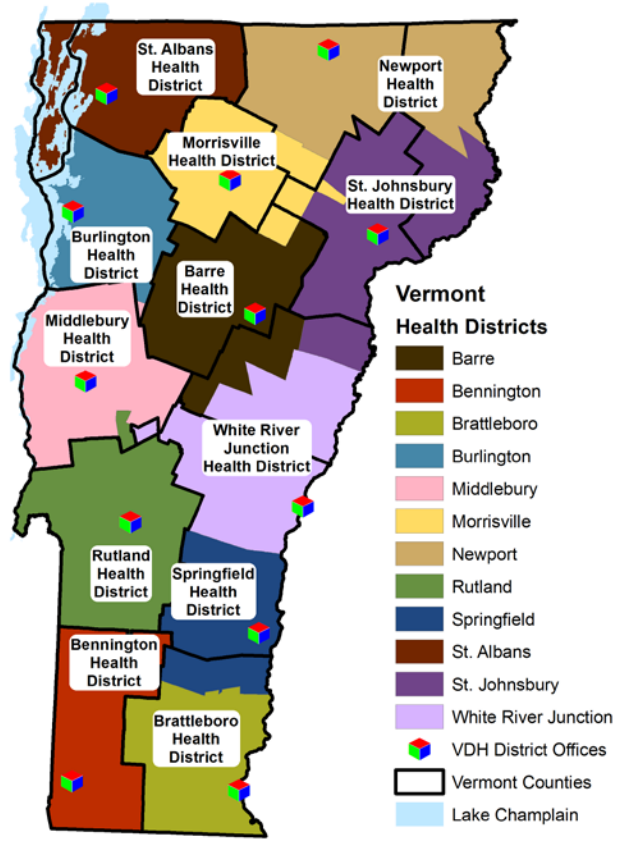
Transformation Network

Service Area & Statewide Collaboratives

Data Infrastructure

Evaluation & Comparative Reporting

Organized at a Health Service Area Level



Vermont's Community Health Teams Health Services Network

Key Components	June, 2015
PCMHs (active PCMHs)	127
PCPs (unique providers)	698
Patients (Onpoint attribution) (Avg. 2014)	334,898
CHT Staff (core)	212 (132 FTEs)
SASH Staff (extenders)	~60 FTEs (54 panels)
Spoke Staff (extenders)	67 (42 FTEs)

Community Health Teams

- 1 core CHT for each HSA
- 5 FTEs per 20,000
- $350,000 for each 5 FTEs
- Scaled to PCMH lives
- Core shared by all payers
- Targeted CHT extenders

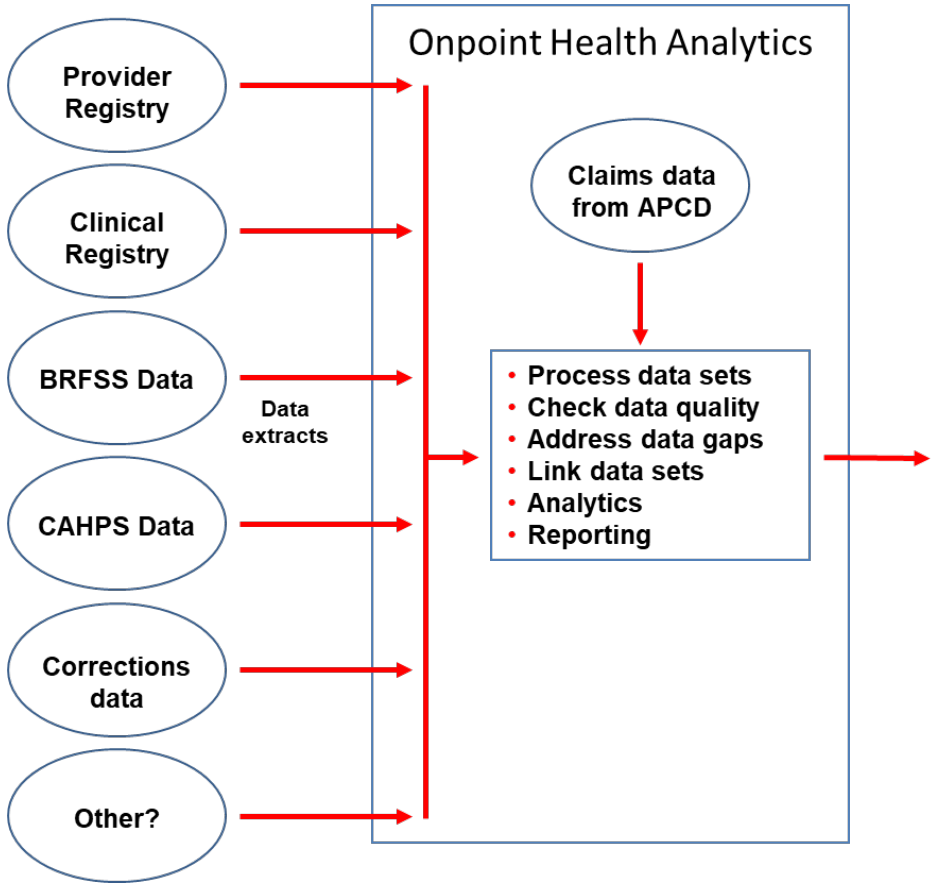
  SASH – Medicare

  Spokes – Medicaid

Vermont's Community Health Teams Statewide Network for Shared Learning

- 31 Community Health Team Leaders
- 19 Blueprint Practice Facilitators
- 14 Blueprint Project Managers
- 4 ACO Clinical Quality Leaders
- 6 ACO Clinical Consultants

Vermont's Community Health Teams Data Use for a Learning Health System

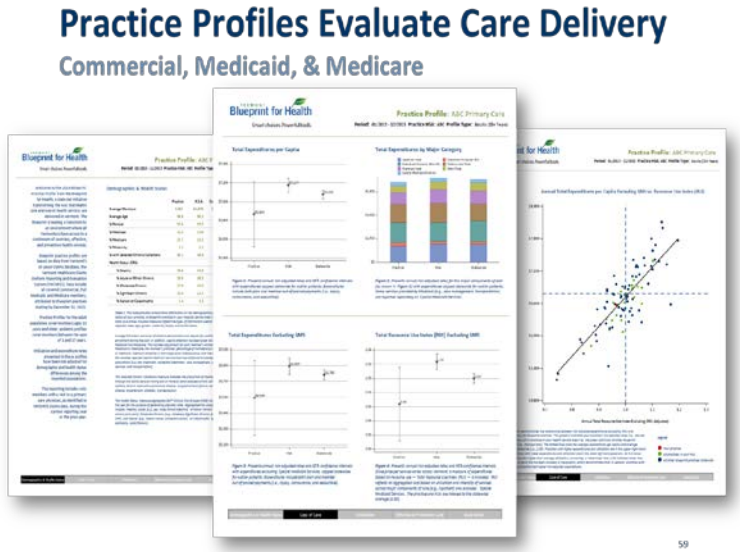


Measurement

- Utilization
- Expenditures
- Unit Costs
- Quality
- Patient Experience
- Social, Economic, Behavioral
- Variation & Associations

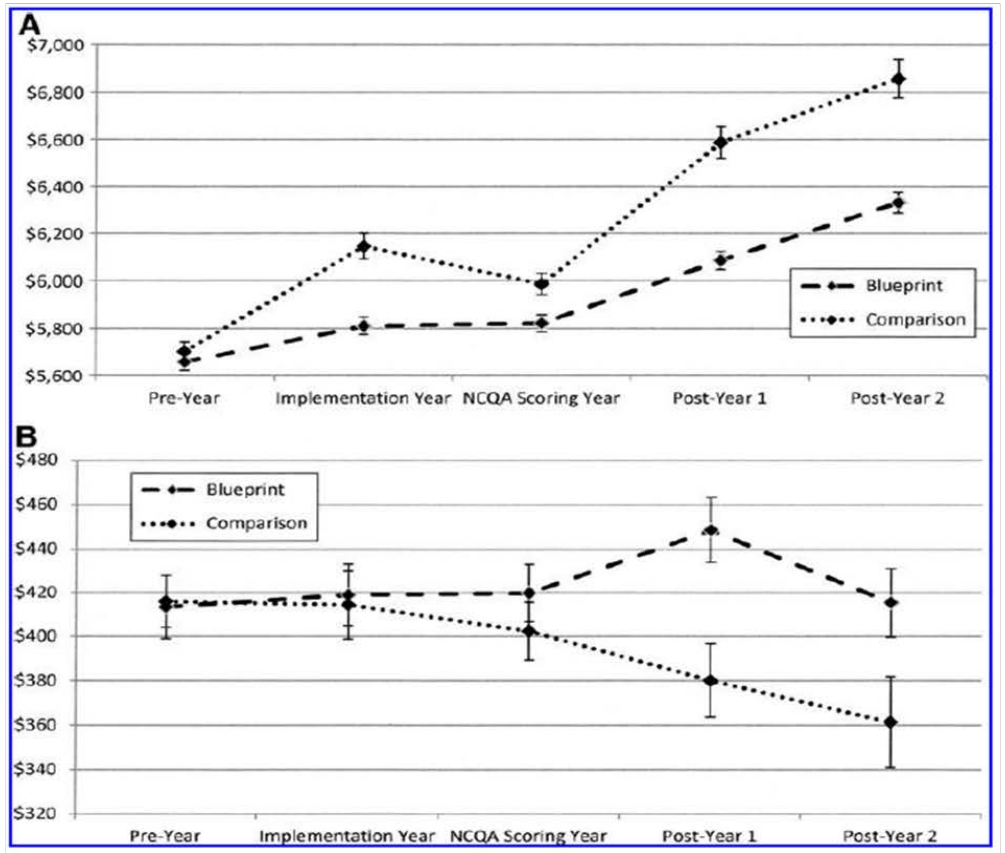
Products

- Practice Profiles
- HSA Profiles
- Learning System Support
- Performance Payments
- Program Impact & Publications
  - PCMH + CHT
  - Opioid Program
- Predictive Models



Vermont's Community Health Teams Model Impact

Total Annual Expenditures Per Person



Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care

Expenditures on healthcare for the whole population

Medicaid expenditures on special services

Population Health Management 2016;19:196–205

Vermont's Community Health Teams Model Impact

Estimated Return on Investment for All Payers in Calendar Year 2014

All-Payer	Investment	Reduction in total expenditures w/ SMS
Reduction in expenditures		$123,142,342
PCMH Payments	$6,590,964	
Core CHT Payments	$8,893,643	
Total Payments	$15,484,607	
Blueprint Program Budget	$5,633,236	
Total investment	$21,117,843	
Return on investment		5.8

Note: Blueprint Program Budget is the average of the FY2014 and FY2015 budgets to estimate the calendar year 2015 budget. Also note the budgeted amount does not reflect actual programmatic expenditures, which may be lower.

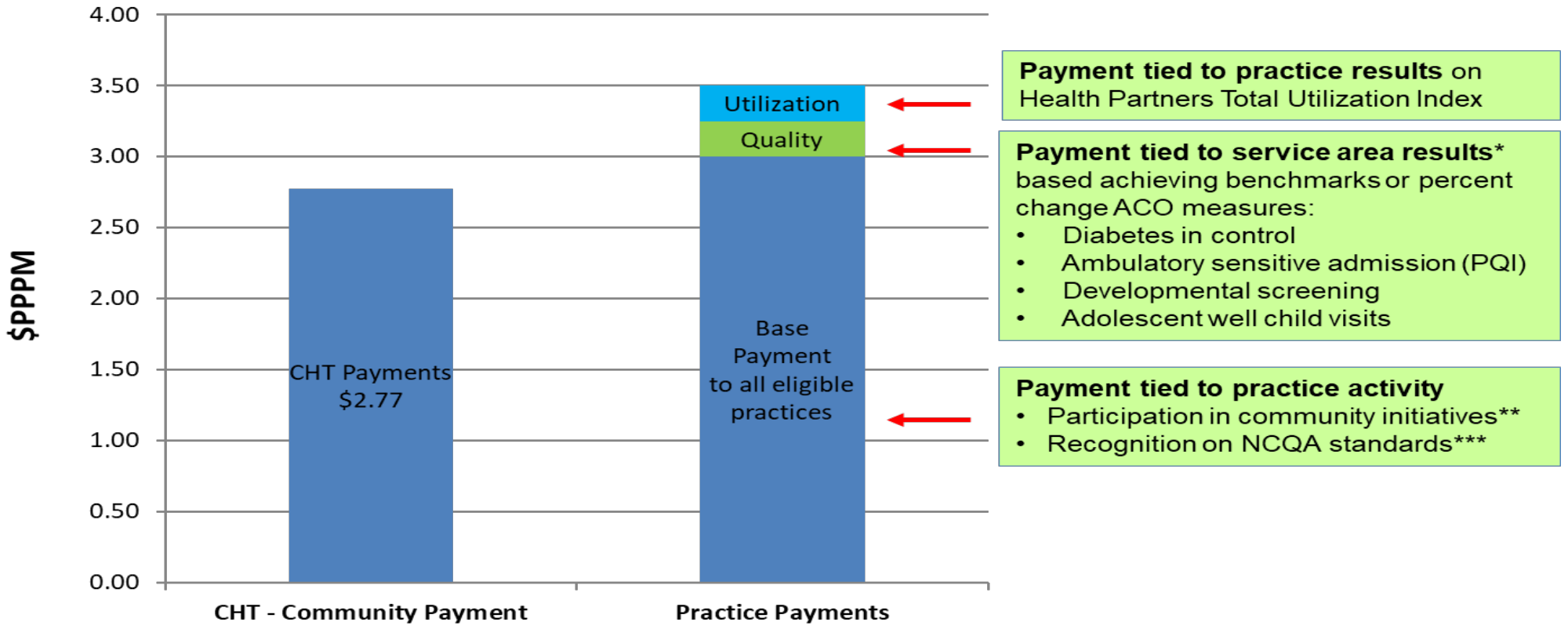
Vermont's Community Health Teams Model Impact

Estimated Return on Investment for Medicaid in Calendar Year 2014

Medicaid	Investment:	Reduction in expenditures w/ SMS	Reduction in expenditures w/o SMS
Reduction in expenditures		$8,644,011	$29,554,703
PCMH Payments	$2,202,342		
Core CHT Payments	$2,172,308		
Total Payments	$4,374,650		
Blueprint Program Budget	$5,633,236		
Total investment	$10,007,886		
Return on investment		0.9	3.0

Note: Blueprint Program Budget is the average of the FY2014 and FY2015 budgets to estimate the calendar year 2015 budget. Also note the budgeted amount does not reflect actual programmatic expenditures, which may be lower.

Vermont's Community Health Teams Payment & Incentives



*Incentive to work with community partners to improve service area results.
**Organize practice and CHT activity as part of at least one community quality initiative per year.
***Payment tied to recognition on NCQA PCMH standards with any qualifying score.
****Payments are for Commercial and Medicaid. Medicare pays a different rate

Vermont's Community Health Teams Blueprint Model & Community Linkages

Questions & Discussion

Future Meetings:

January 22 and Feb 26, 9-10:30

- January meeting focus: What payment strategies should we consider to have in place for July 1, 2021 that allows CHTs to build on current structures to improve health equity and patient and family health?
  - SOC/practice based and place based
  - FQHC and non FQHC