CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

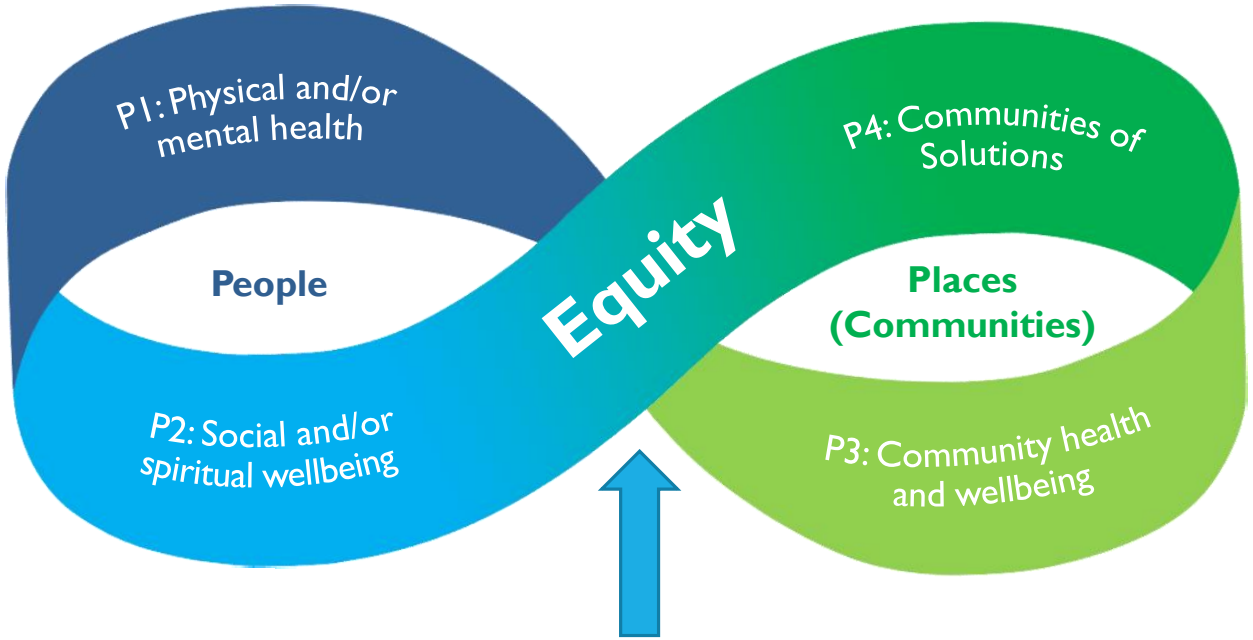
Improving Population Health and Health Equity through CHT Program Design

COMMUNITY CLINICAL LINKAGES MINISERIES

FEBRUARY 26, 2021

From Charity to Equity to Liberation: Pathways to Health Equity

Clinical Care Teams - Improving the health and well-being of **people**



Health Equity Zones (eg. public health, community-based organizations, community development)

Community Health Teams as a Bridge

Questions to Consider

- How do we organize care management services in a geography?
- How do we leverage CHTs to better impact the health and well-being of a population?
- What does it look like to coordinate across sectors?

Community Health Teams- Strengthening Primary Care & Community Linkages

*2021 CPC+ Implementation Guide
Comprehensive Primary Care Functions

- **Practice/SOC Based Teams** – Enhance daily operations and capacity for advanced primary care, including proactive care management and more complete whole person needs
- **Community Based Teams** – Augment and support practice based teams with broader capabilities and services to **address rising risk and complex needs** (e.g. Developmental, BH, MH, SUD, Social, Economic, Safety)
- **Transitions** – Facilitate connections between practices and community based organizations, as well as transitions within and across health systems
- **Adaptable & Fluid** – Adjust to operate most effectively within communities and to meet regional priorities over time. Can supplement practice based operations (e.g. FQHCs, independent practices) as well as provide and connect with community based services (across all primary care settings)

Are these the right program design principles?

Community Based Teams Design Principles to Inform Payment

- **Build Sufficient Capacity –** assure adequate staffing to address prioritized risk groups within a community. Provide people with real access to services that can impact population health
- **Embrace Regional Place-Based Organization –** local multi-stakeholder guidance to structure and manage team based on community needs and priorities. Community governance and the role of the CHT needs to include engagement with HEZ and community governance in planning and improving the underlying conditions and root causes of equity
- **Establish a Stable Foundation –** invest in capacity with up front financing that assures a stable foundation that providers and citizens can rely on. Allow trusting relationships to mature
- **Incentivize Whole Person Health and Well-being –** leverage a population based form of payment (e.g. PMPM) that incentivizes delivery and coordination of more complete and effective services instead of volume (e.g. FFS)
- **Share Costs –** incorporate multi-payer financing to support a whole population approach in each community and in primary care settings. Maintain focus on community, access through many doors, and avoid prioritizing business needs of an individual organization
- **Invest in Capacity to Address Risks that Impact Health & Costs and Address Racial and Other Inequities**– Consider priorities and needs across all payers and risk tiers that have substantial impact on population health and avoidable expenditures (eg. end of life care, poorly controlled co-morbidities, hidden but rising risk)

Are these the right principles around payment for community based teams?

Recommended CHT Payment Model

- Core infrastructure support for CHT Network that encourages ongoing innovation, evaluation, best practice sharing, medical-legal services, data reporting, engagement with planning and coordination across a community (including with the HEZ)
- Risk stratified PMPM payment OR modified Case Rate for care management and support services for highest and medium/rising risk
- Performance incentive for people who are stabilized (connected to PC, improved health and well-being outcomes, reduced utilization)
- Include population health PMPM for practices/SOC as part of risk adjusted care management payments; consider payment to OB/GYNs and other sites that engage patients

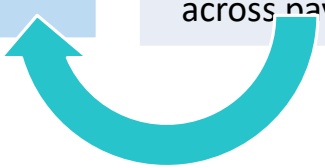
Payment Components for a Community-Oriented Foundation of Primary Care and Health Teams

Primary Care Practice

- **Care Management Fee (PMPM from Health Plans)** - risk adjusted capacity investment based on *practice attribution*
- **Encounter Rate** – motivates access and encounters for beneficiaries. Applies to in-person and remote encounters
- **Quality and Shared Savings Payment** – motivates population health approach based on priority measures. Align across payers where possible

Community Health Teams

- **Capacity Investment (PMPM from Health Plans, cross sector investments)** – risk adjusted capacity investment based on *geographic attribution*
- **Engagement Rate**– motivates access and services for beneficiaries. Supports in-person and remote services
- **Quality and Shared Savings Payment** – motivates population based whole person approach based on priority measures. Align across payers where possible



Care Management + Encounters/Engagement + Quality

- **Care Management and Capacity Investment (PMPM) –** reliable payment that invests in adequate capacity at a practice level (practice attribution) and a community level (geographic attribution). Includes costs needed to collaborate and coordinate with multi-sector partners in a geography
- **Risk Adjustment** – based on proven approach that can be applied to a whole population and all payers (e.g. Hopkins ACGs) + place-based social vulnerability index)
- **Encounter Fees & Engagement Rates** – motivate outreach, access, and active engagement (in-person, remote)
- **Quality Payment** – promotes equity-focused, whole person, whole community approach to improve priority measures. Benefits from alignment across payers and sectors where possible
- **Data & Learning –** separate investments in data aggregation, monitoring, and shared learning to support a continuously improving learning health system

Potential Sources for RI-CHT Investment July, 2022

Source of Funds	Practice/SOC Based Pop Health payments
Health Plans (including Commercial, Medicare Advantage, Medicaid)	Practice/ System of Care (ACO/AE) PMPM payments Medicaid uses Federal Match for CHW/BH/CM payments Primary Care First?
HRSA	FQHC payments that can be used to further support their practice based efforts
Source of Funds	**Community Based CHTs payments**
Health Plans (including Commercial, Medicare Advantage, Medicaid)	Market Based Sustainable Investment for core CHT functions **PLUS** ? PMPM payments or ? modified case rate
Hospitals	Proposed Admissions Based Investment (community benefits or other related payments)
RI Executive Office of Health and Human Services	Innovation Funds, Community Building Funds
Other Sectors	Philanthropy, Other

Next Steps

- Convene state agencies and national consultants for focused conversations on payment methodologies
- Utilize CHT Oversight Committee for advancing strategy for multi-payer approach to CHT financing


THANK
YOU