Community Health Worker Advisory Committee- Introductory Webinar

March 29, 2016

Meeting Agenda

Item	Allotted Time
1. Welcome/Committee Function	3 min
2. SIM Overview	10 min
3. National CHW Landscape	30 min
4. Connecticut CHW Landscape	5 min
5. Q&A	10 min
6. Closing Remarks	2 min

Welcome/Committee Function

CHW Advisory Committee- Welcome

Migdalia Belliveau
Generations Family Health Center

Ashika Brinkley
Connecticut Associations of Directors of Health

Yolanda Bowes
United Community and Family Services

Thomas Buckley
UConn School of Pharmacy

Juan Carmona
Project Access New Haven

Darcey Cobbs-Lomax
Project Access New Haven

Michael Corjulo
Children's Medical Group

Grace Damio
Hispanic Health Council

Tiffany Donelson
Connecticut Health Foundation

Loretta Ebron
Northeast Medical Group

Peter Ellis
Project Access New Haven

Liza Estevez
UnitedHealthcare

Linda Guzzo
Capitol Community College

Terry Nowakowski
The Connection, Inc.

Chioma Ogazi
CT Department of Public Health

Jacqueline Ortiz Miller
Curtis D Miller Center for Health Equity

Nicholas Peralta
ProHealth Physicians

Milagrosa Seguinot
Southwestern AHEC

Mayce Torres
Planned Parenthood of Southern New England

Robert Zavoski
CT Department of Social Services

DRAFT 2/11/16 Community Health Worker Advisory Committee

Charter

The Community Health Worker Advisory Committee will develop recommendations for the Healthcare Innovation Steering Committee with respect to **the training, promotion, utilization and certification of Community Health Workers** (CHWs), as well as establishing a **framework for sustainable payment models** for compensation. The Committee's work will support the recommendations of the Practice Transformation Task Force with respect to the role of CHWs in care delivery reforms. The Committee will also examine **key success factors for employers of CHWs** including basic understanding of the nature of the workforce, requirements for successful integration of CHWs into clinical operations, distinctive considerations in hiring and supervision, and provision of technical/clinical backup to CHWs in home and community settings. The goal of the Committee is to **support the integration of and effective support for CHWs in the healthcare system and the communities that they serve.**

CHW Advisory Committee charge:

1. Recommend a policy framework that examines a range of issues relevant to establishing a CHW workforce, which may include:
   a) Definition of CHW which properly represents the diversity of individuals who work in the field
   b) Scope of Practice, including practice within a comprehensive care team
   c) Skill requirements, nationally recognized competencies/standards, and criteria and mechanisms for accreditation of training programs
   d) Certification Process
   e) Options for sustainable financing of CHWs, especially as part of the reforms recommended by the Practice Transformation Task Force
2. Propose a toolkit for CHW utilization that will provide strategies for:
   a) Integration of CHWs into health care systems and teams
   b) Supervision and support of CHWs
   c) Inclusion of CHWs in staffing under value-based payment models
   d) Access to CHW assistance for providers and patients: who receives their services and how the services are implemented
   e) CHW Career Ladder
3. Facilitate integration of the Community Health Worker Association of Connecticut into the process of developing the CHW workforce in the state

SIM Overview

Connecticut Healthcare Costs

Connecticut *- healthcare spending = More than $30 billion,* ***fourth highest of all states*** *for healthcare spending per capita*

CMS (2011) Health Spending by State of Residence, 1991-2009.
http://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A03-.pdf

Connecticut: Uneven Quality of Care

Rising rate of Emergency Department utilization

Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2011	195	183	129	40

CT ranking out of 50 states

High Hospital Readmissions

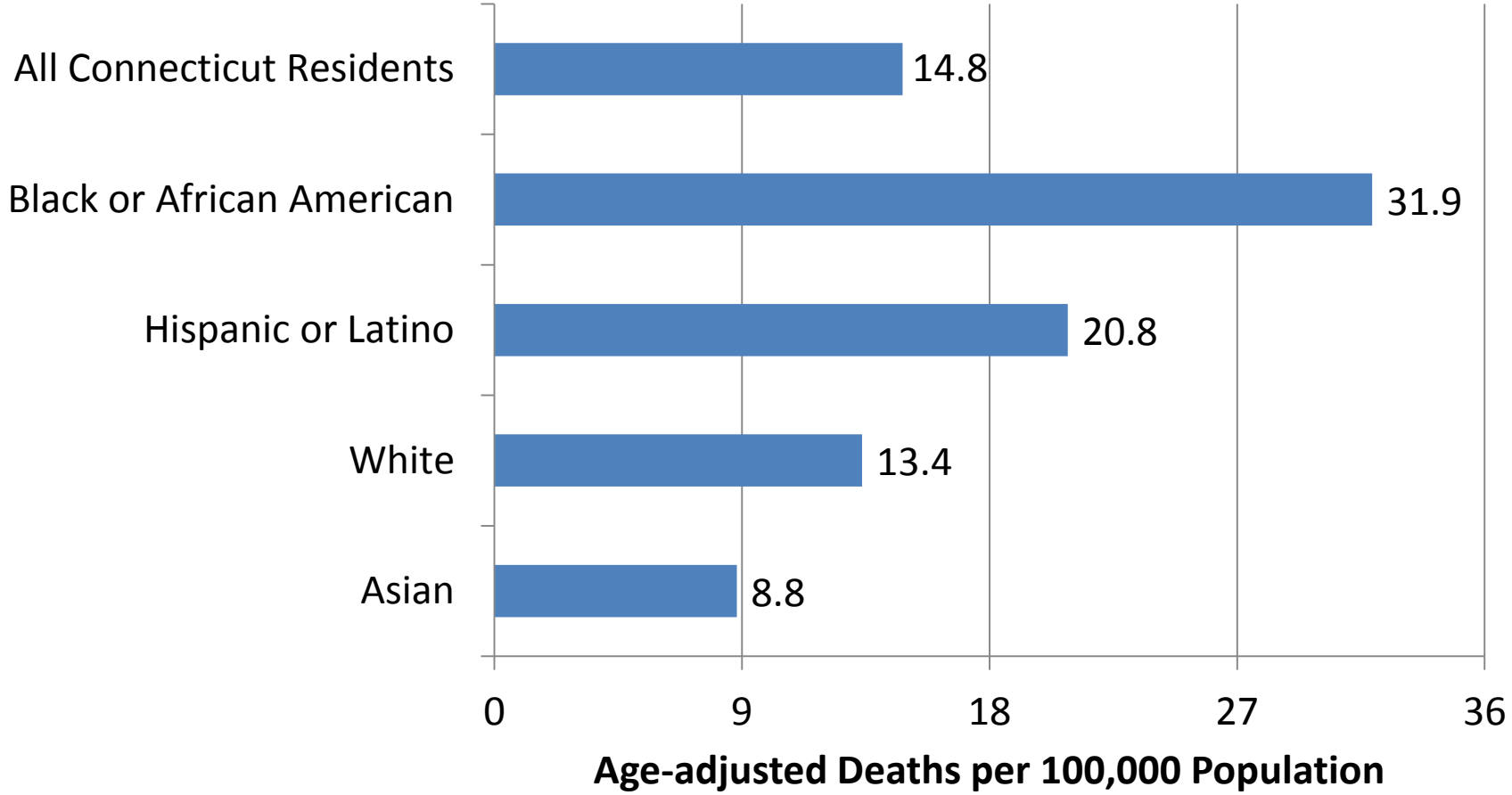
Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	52.0	45	26	36

CT ranks 36th out of 50 states

D.C. Radley, D. McCarthy, J.A. Lippa, S.L. Hayes, and C. Schoen, Results from a Scorecard on State Health System Performance, 2014, The Commonwealth Fund, April 2014.

Health disparities persist in Connecticut

Age-adjusted Death Rate for Diabetes, Connecticut Residents, by Race and Ethnicity, 2008-2012



Data Source: CT DPH, Vital Records Mortality Files, 2008-2012 data.

CT Healthcare Stages of Transformation

Connecticut's Current Health System: "As Is"

Our Vision for the Future: "To Be"

Fee for Service 1.0

Limited accountability

Pays for quantity without regard to quality

Lack of transparency

Unnecessary or avoidable care

Limited data infrastructure

Health inequities

Unsustainable growth in costs

Accountable Care 2.0

Accountable for patient population

Rewards
- better healthcare outcomes
- preventive care processes
- lower cost of healthcare

Competition on healthcare outcomes, experience & cost

Coordination of care across the medical neighborhood

Community integration to address social & environmental factors that affect outcomes

Health Enhancement Communities 3.0

Accountable for all community members

Rewards
- prevention outcomes
- lower cost of healthcare & the cost of poor health

Cooperation to reduce risk and improve health

Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities

Community initiatives to address social-demographic factors that affect health

What is a State Innovation Model Grant?

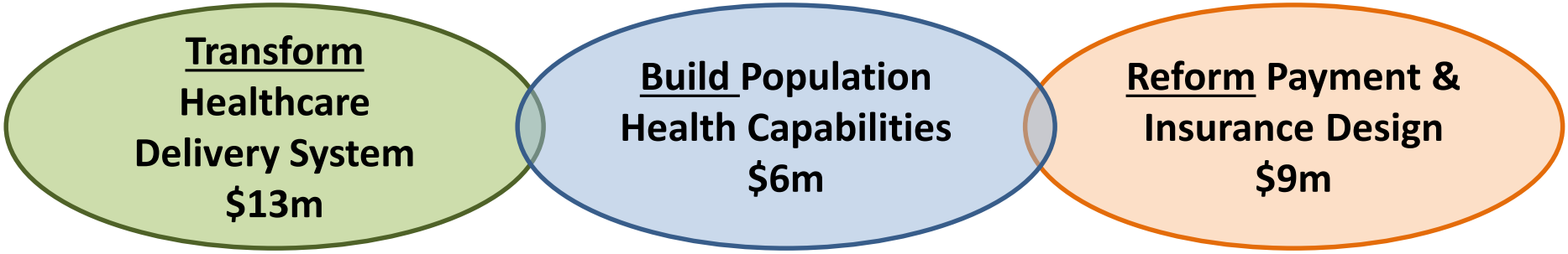
SIM grants are awarded by the federal government through the ***Center for Medicaid and Medicare Services (CMS) Innovation center***. Grants are awarded to states that have demonstrated a commitment to developing and implementing multi-payer health care payment and service delivery models that will:

1. Improve health system performance
2. Increase quality of care
3. Decrease Costs

Connecticut awarded a $45 million test grant in December 2014 which will be implemented over the next five years.

Our Journey from Current to Future: Components

CT SIM Component Areas of Activity



Transform the healthcare delivery system to make it more coordinated, integrate clinical and community services, and distribute services locally in an accessible way.

Build population health capabilities that reorient the healthcare toward a focus on the wellness of the whole person and of the community

Reform payment & insurance design to incent value over volume, engage consumers, and drive investment in community wellness.

Engage Connecticut's consumers throughout	**$376k**
Invest in enabling health IT infrastructure	**$10.7m**
Evaluate the results, learn, and adjust	**$2.7m**

Targeted Initiatives

Statewide Initiatives

SIM Targeted Initiatives

Reform Payment: High percentage of patients in value-based payment arrangements

MQISSP
Medicare SSP
Commercial SSP

+

Transform Care: Resources to develop advanced primary care and organization-wide capabilities

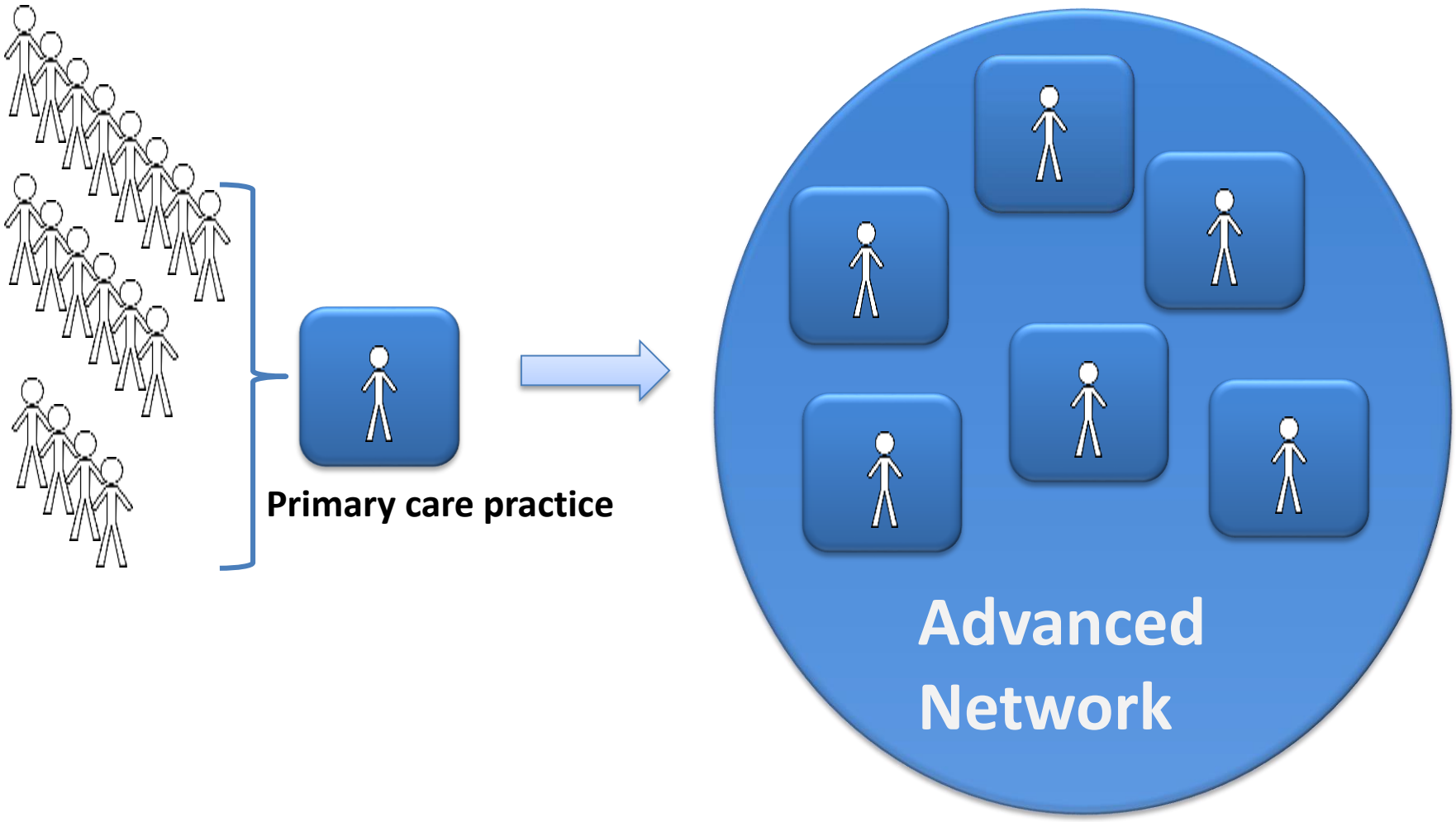
Advanced Medical Home Program (AMH)
&
Community & Clinical Integration Program (CCIP)

=

Build Population Health: Better Quality and Affordability

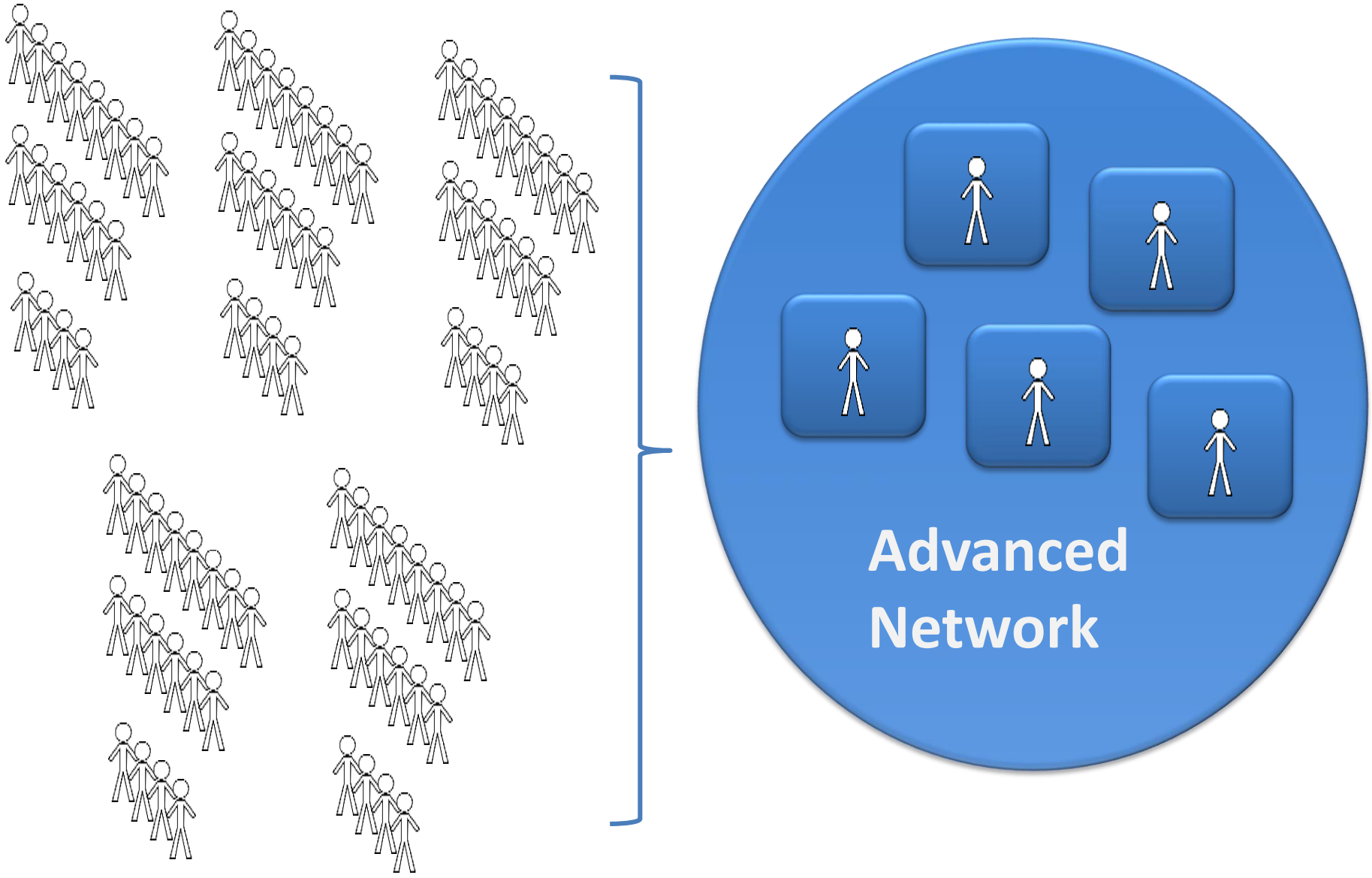
MQISSP is the Medicaid Quality Improvement and Shared Savings Program

Primary care partnerships for accountability

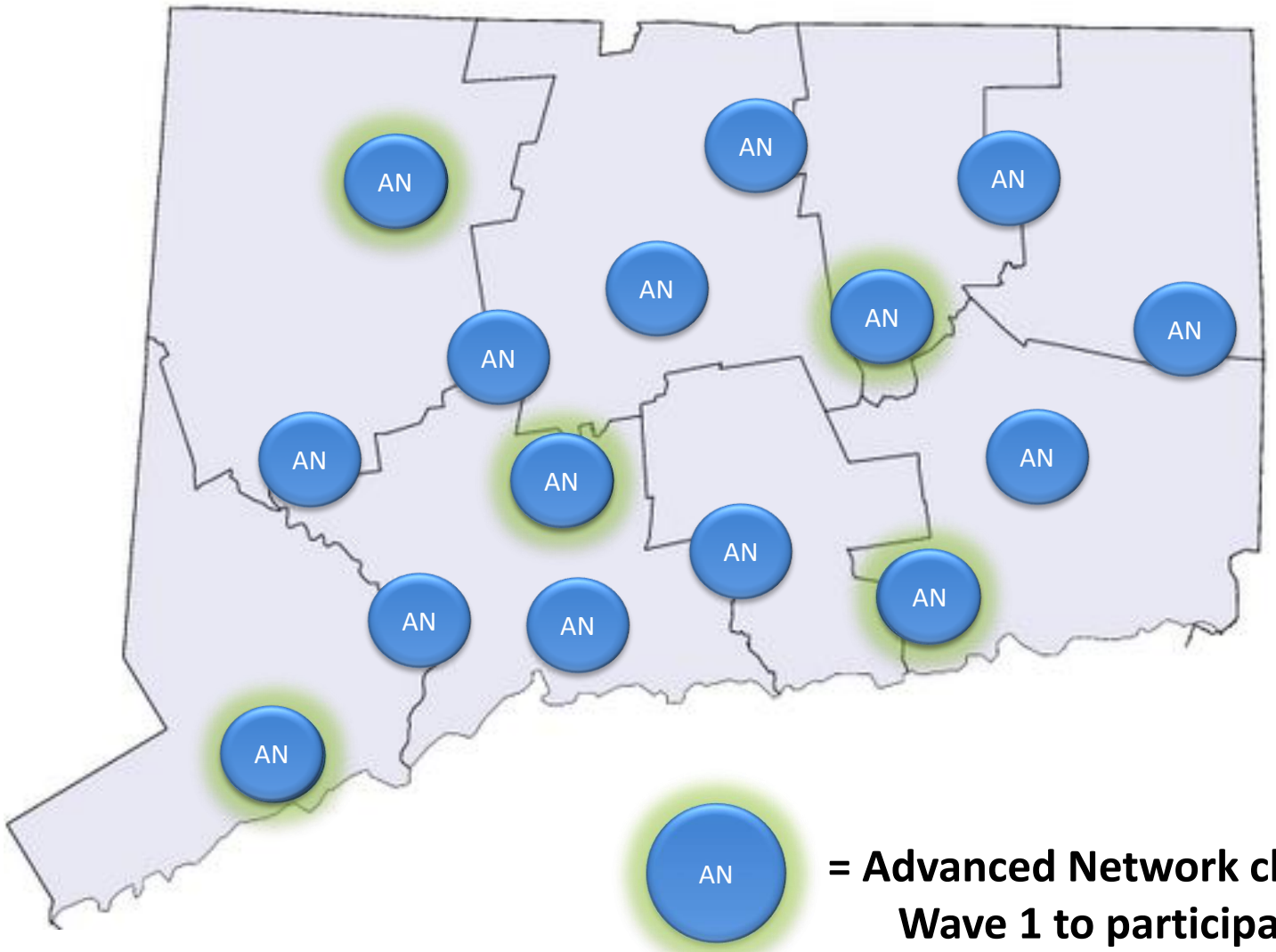


Advanced Network = independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer

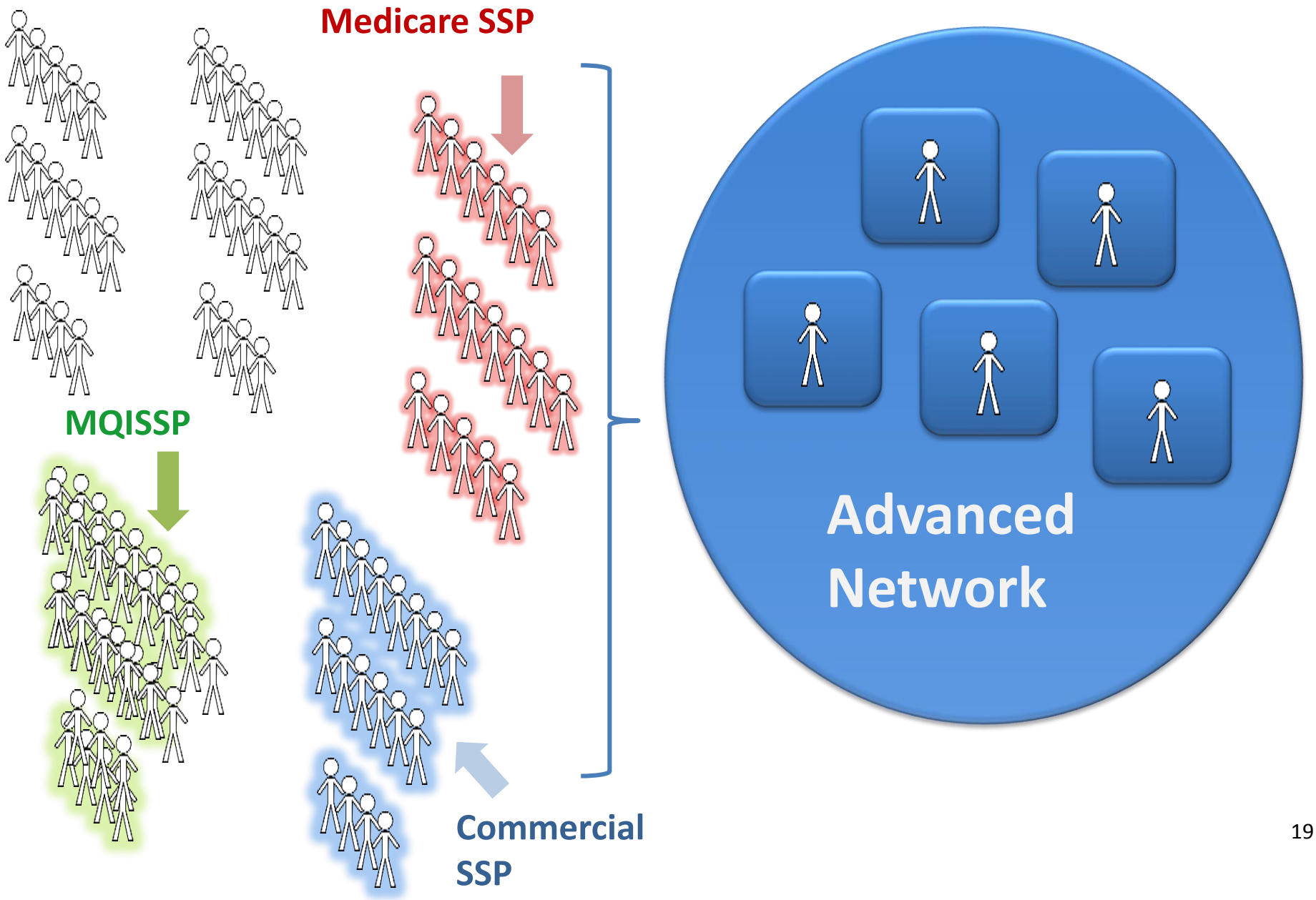
Accountability for quality and total cost



Connecticut has many Advanced Networks



SIM Targeted Initiatives: Value-Based Payment



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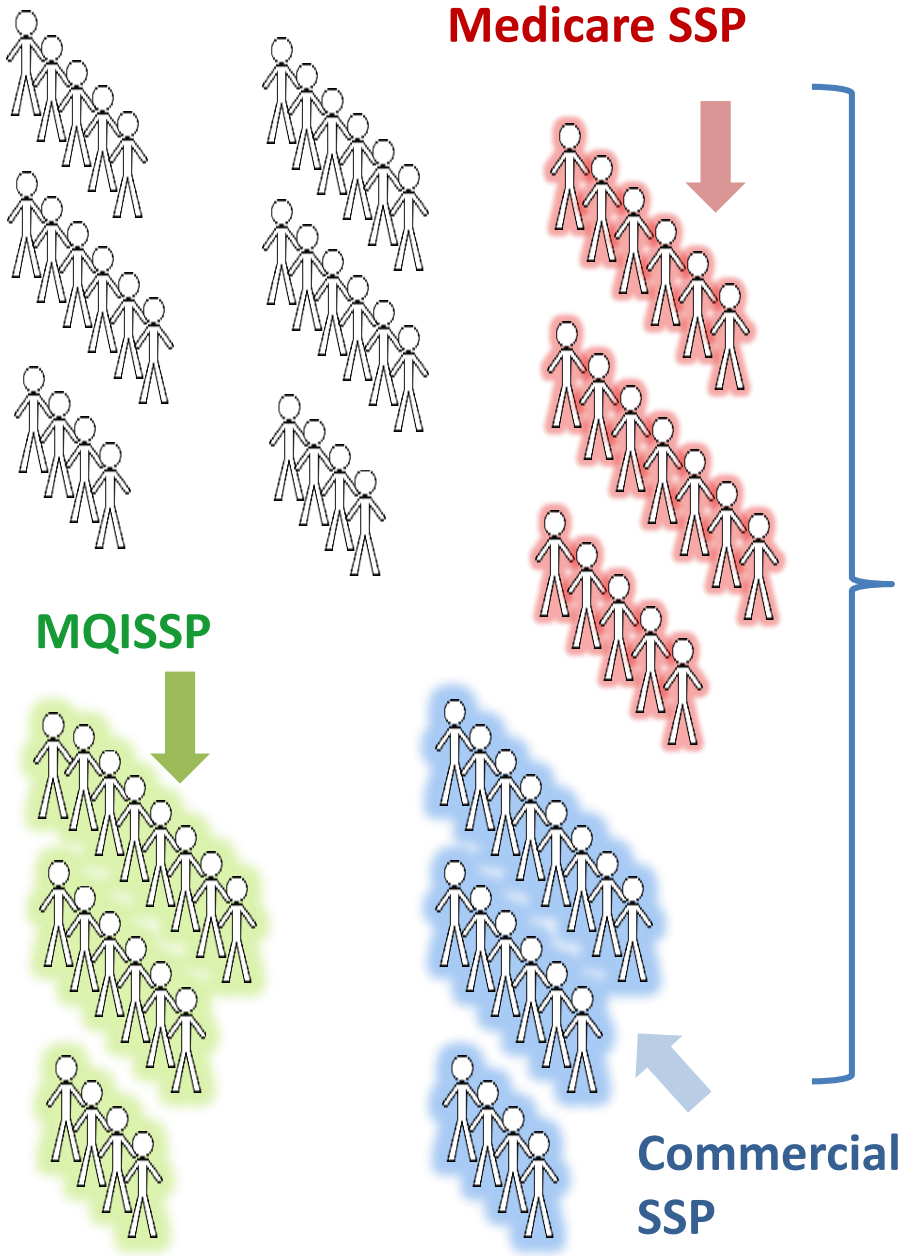
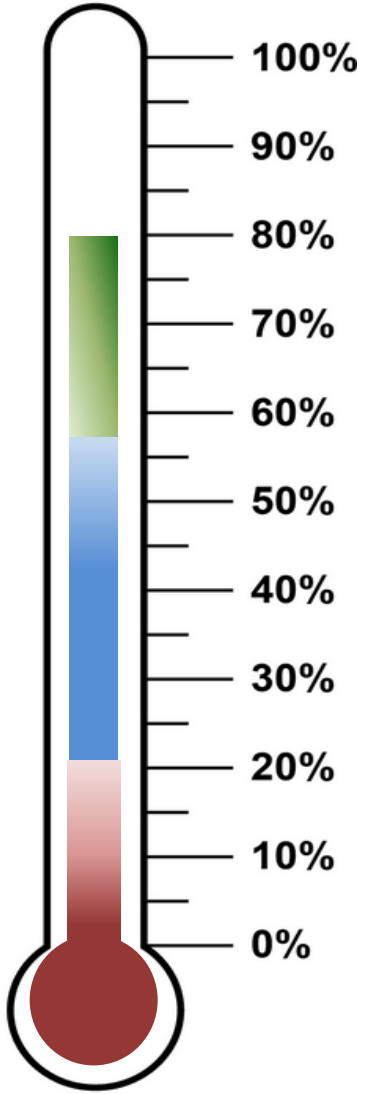
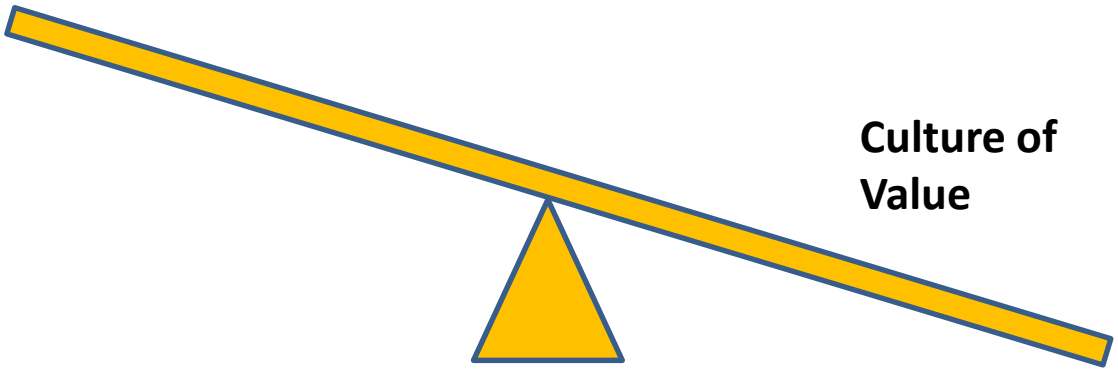
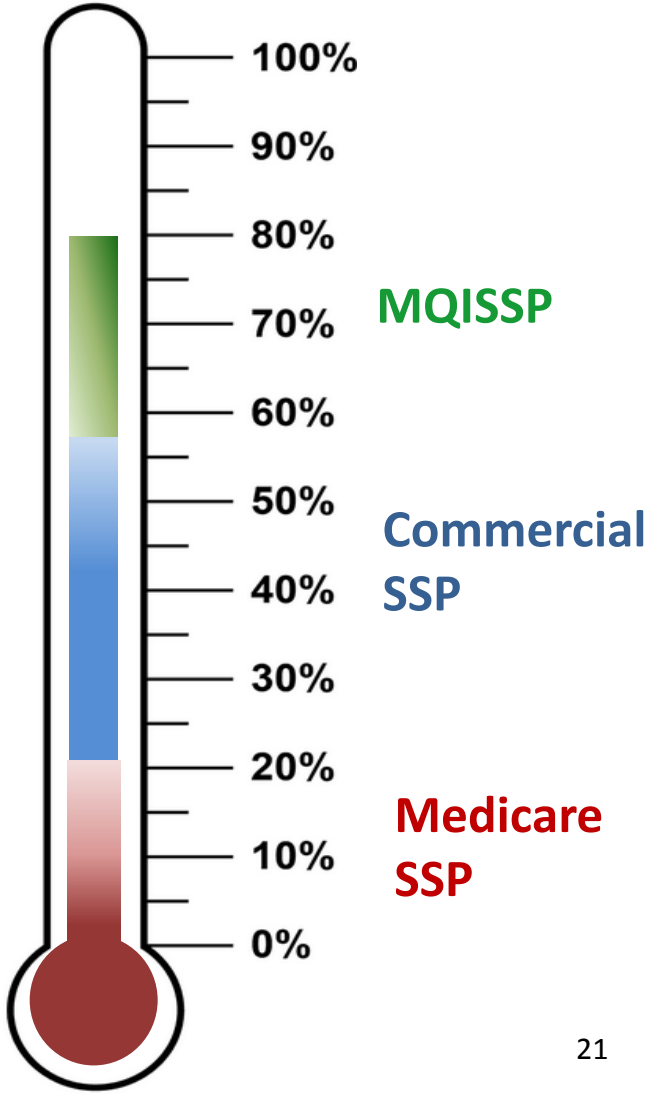




% of consumers in an Advanced Network in value-based payment arrangement

SIM Targeted Initiatives: Value-Based Payment





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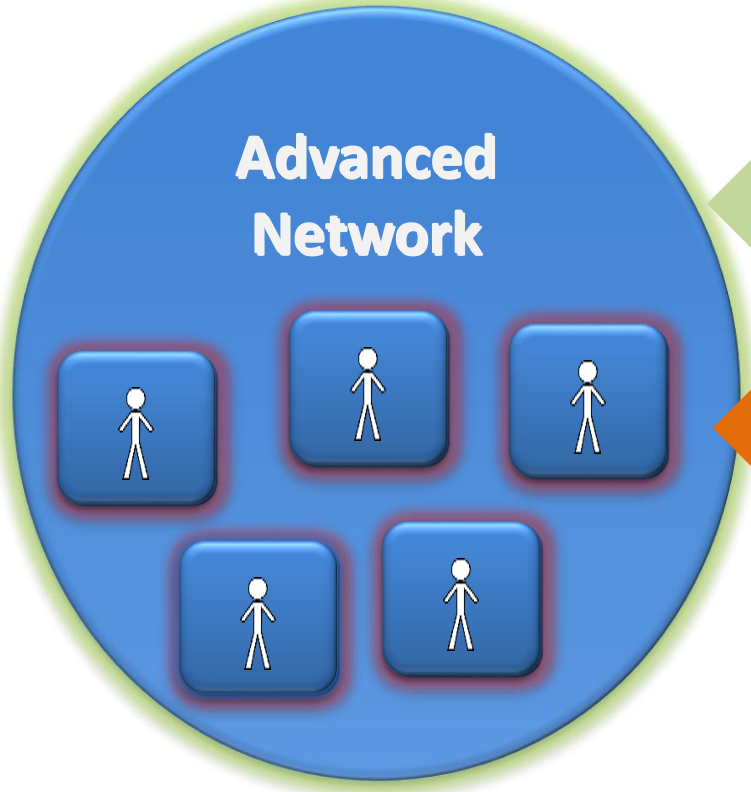
SIM Targeted Initiatives: Transforming the System



Community & Clinical Integration Program (CCIP)

Awards & technical assistance to support Advanced Networks in enhancing their capabilities across the network

Advanced Medical Home (AMH) Program

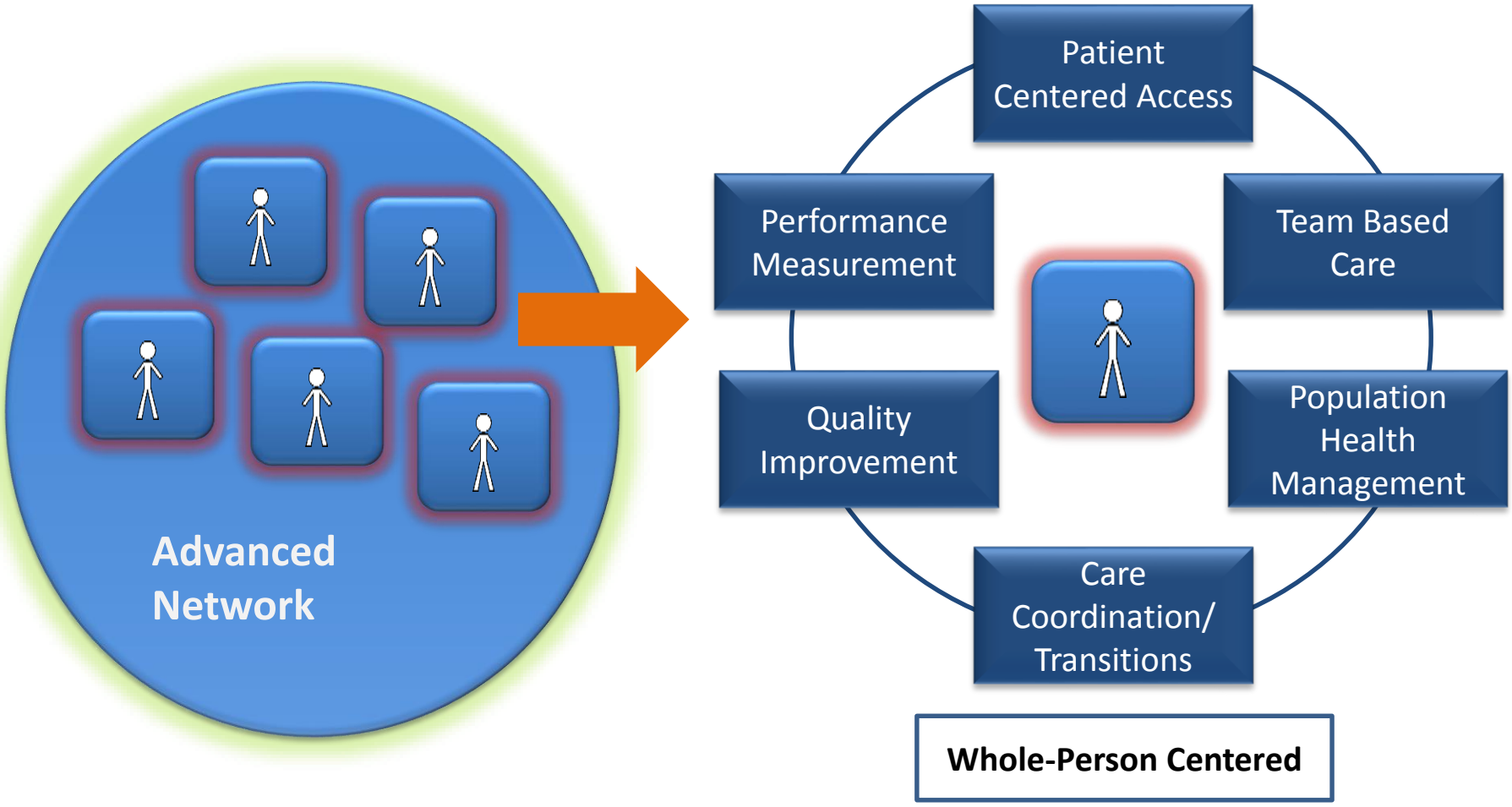
Support for affiliated primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for <u>all</u> populations
Using population health strategies

Transforming the System: Advanced Medical Home

Advanced Medical Home Program

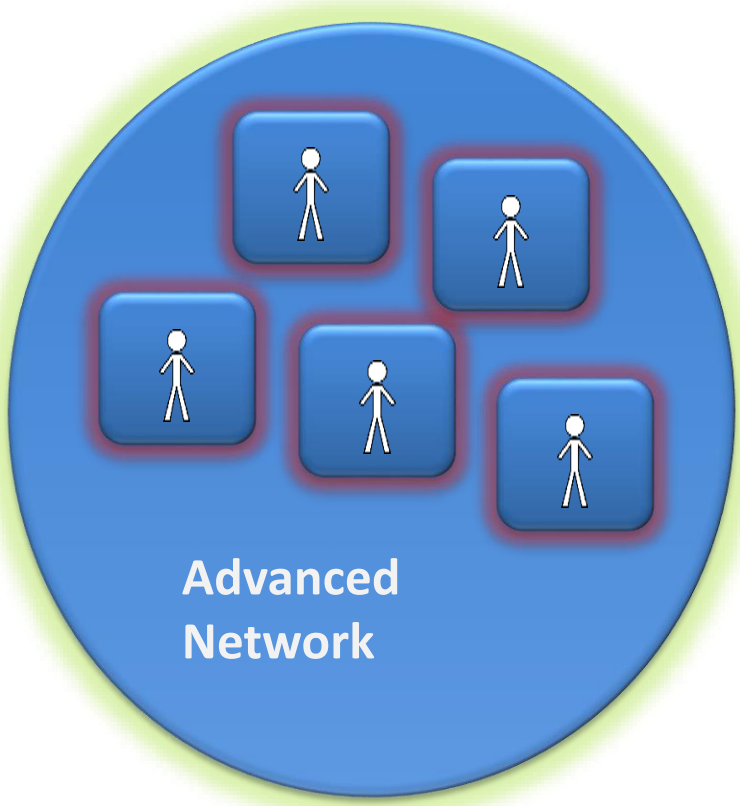
Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 and more



Transforming the System: Community and Clinical Integration Program

Community & Clinical Integration Program

Awards & technical assistance to support Advanced Networks in enhancing their capabilities in the following areas:



Comprehensive Care Management

Comprehensive care team, Community Health Worker , Community linkages

Health Equity Improvement

Analyze gaps & implement custom intervention ✚ CHW & culturally tuned materials

Behavioral Health Integration

Network wide screening tools, assessment, linkage, follow-up

Community Health Collaboratives

Oral health Integration

E-Consult

Comprehensive Medication Management

Transforming the System: Community and Clinical Integration Program

Three core standards focus on populations who have demonstrated health needs that align with SIM goals, align with CT population health goals, and that provide both evidence-based standards for improvement with flexibility in implementation. Their objectives are as follows:

Individuals with complex health needs

- Provide comprehensive care management to individuals who have one or more serious medical conditions, the care for which may be complicated by functional limitations or unmet social needs, and who require care coordination across different providers, community supports and settings to achieve positive healthcare outcomes

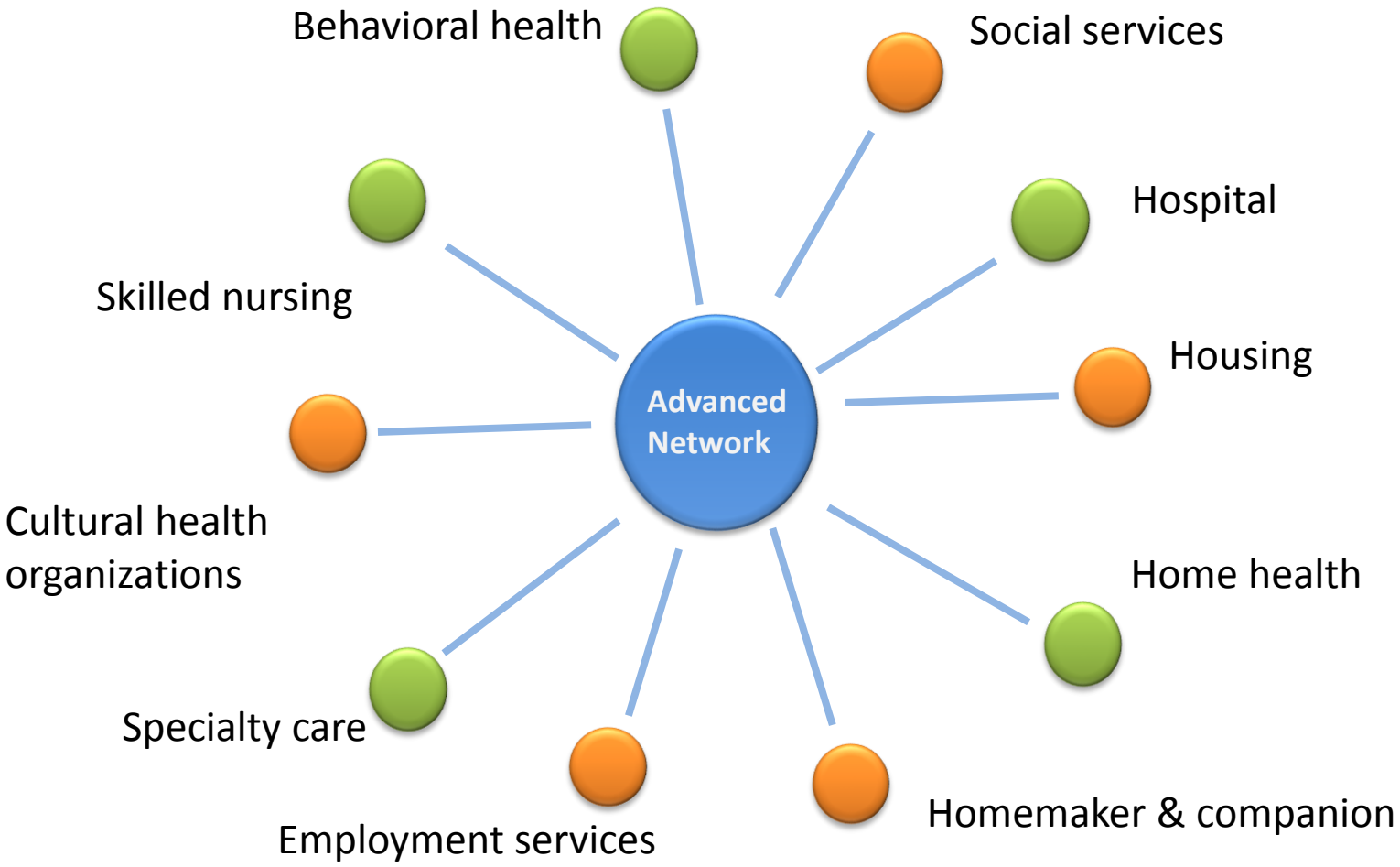
Individuals experiencing health equity gaps

- Part 1: Develop quality improvement processes to address health equity gaps
- Part 2: **Engage a community health worker to provide culturally and linguistically appropriate support to a race/ethnic sub-population that is experiencing poorer health outcomes as compared to the population as a whole**

Individuals with unmet behavioral health needs

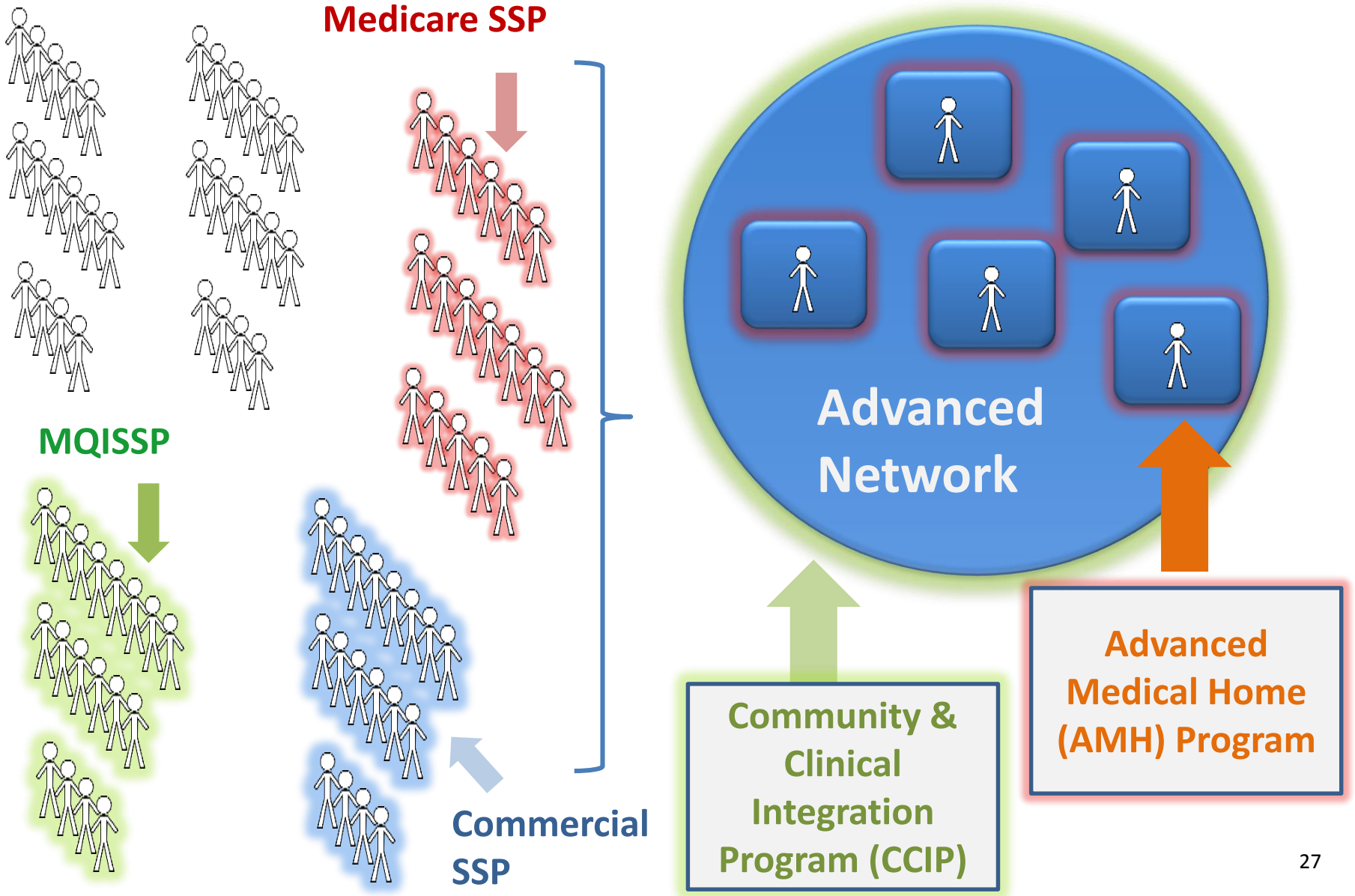
- Help primary care practices identify and treat behavioral health needs within the primary care setting and establish referral, linkage and follow-up for those who require behavioral health specialty care

SIM Targeted Initiatives: Community and Clinical Integration Program

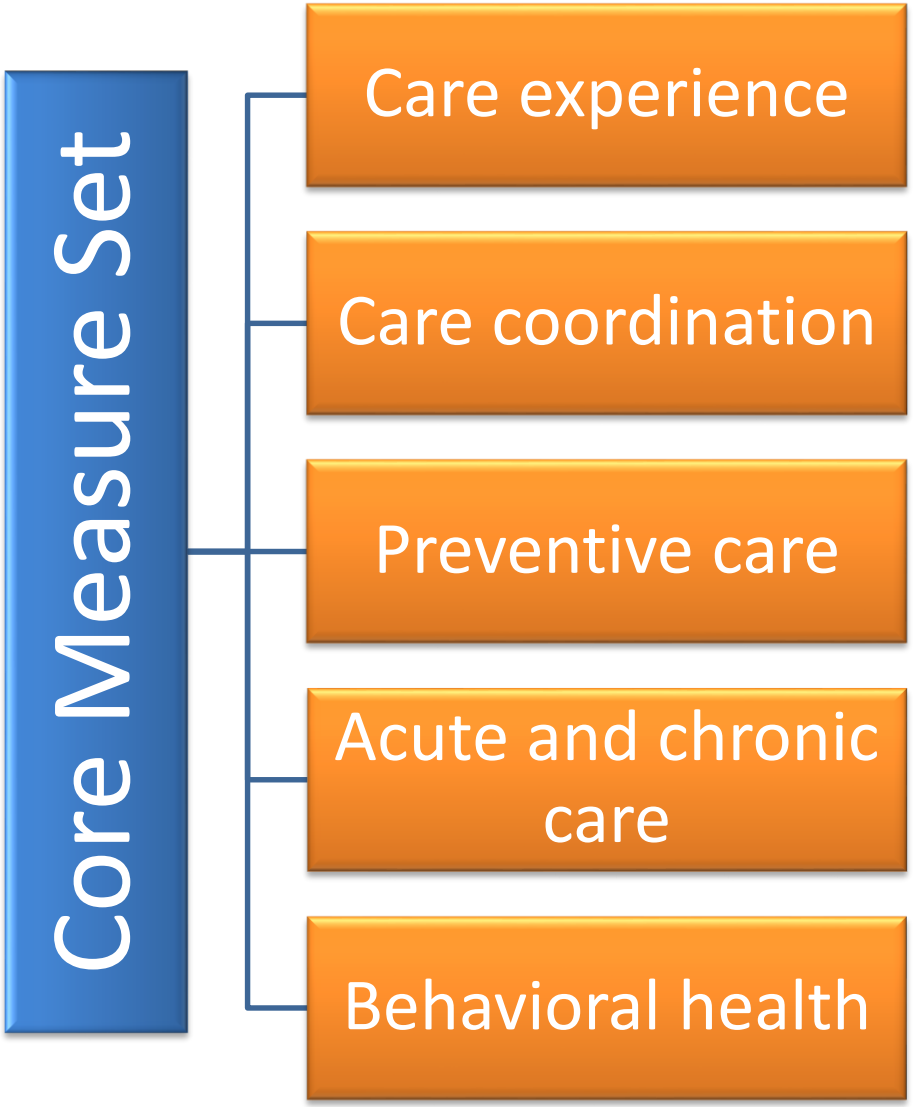


…coordination and communication with key clinical and community partners

SIM Targeted Initiatives: Putting it all together



SIM Statewide Initiatives: Quality Measure Alignment



SIM Statewide Initiatives: Quality Measure Alignment

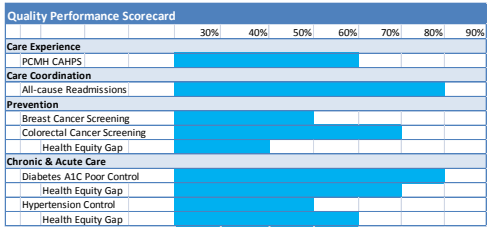
Consumer Engagement
PCMH – Care Experience CAHPS measure
Care Coordination
Plan all-cause readmission
Emergency Department Usage per 1000
Annual monitoring for persistent medications
Prevention
Breast cancer screening
Cervical cancer screening
Chlamydia screening in women
Colorectal cancer screening
Adolescent female immunizations HPV
Weight assessment and counseling for nutrition and physical activity for children/adolescents
BMI screening and follow up
Developmental screening in first 3 years of life
Well-child visits in the first 15 months of life
Adolescent well-care visits
Tobacco use screening and cessation intervention
Prenatal Care & Postpartum care
Screening for clinical depression and follow-up plan
Behavioral health screening (Medicaid only)

Acute & Chronic Care
Medication management for people w/ asthma*
Asthma Medication Ratio*
DM: Hemoglobin A1c Poor Control (>9%)
DM: HbA1c Testing**
DM: Diabetes eye exam
DM: Diabetes: medical attention for nephropathy
HTN: Controlling high blood pressure
Use of imaging studies for low back pain
Avoidance of antibiotic treatment in adults with acute bronchitis
Appropriate treatment for children with upper respiratory infection
Behavioral Health
Follow-up for children prescribed ADHD medication
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid only, custom measure)
Depression Remission at 12 Twelve Months
Child & Adolescent Major Depressive Disorder: Suicide Risk Assessment
Unhealthy Alcohol Use – Screening

SIM Statewide Initiatives: Quality Measure Alignment

Today:

Health Plan → *Claims Data*

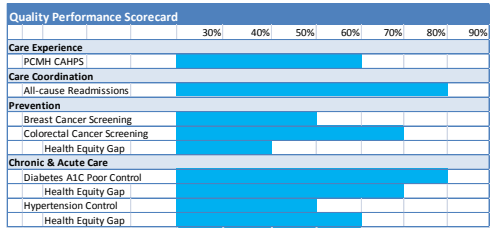


Process Measures

(E.g., Diabetes foot exam, well-care visits, medication adherence)

National consensus to move towards outcomes:

Health Plan → *Claims Data* + *EHR Data*



Process & Outcome Measures

(E.g., diabetes A1C control, blood pressure control, depression remission)

SIM Statewide Initiatives: Value-based Insurance Design

...the use of plan incentives to encourage employee adoption of one or more of the following:

New and innovative approaches

Adopt healthy lifestyles
(e.g. smoking cessation, physical activity)

Use high value services
(e.g., preventative services, certain prescription drugs)

Use high performance providers
Who adhere to evidence-based treatment

Health promotion & disease management

Health coaching & treatment support

SIM Statewide Initiatives: Value-based Insurance Design

- **Employer-led Consortium**: peer-to-peer sharing of best practices

- **Prototype VBID Designs**: using latest evidence, to make it easy for employers to implement

- **Annual Learning Collaborative**: including panel discussions with nationally recognized experts and technical assistance

access health CT
Connecticut's Health Insurance Marketplace

CT's Health Insurance Market Exchange) will implement VBID in Year 2 of the Model Test (subject to Board approval)

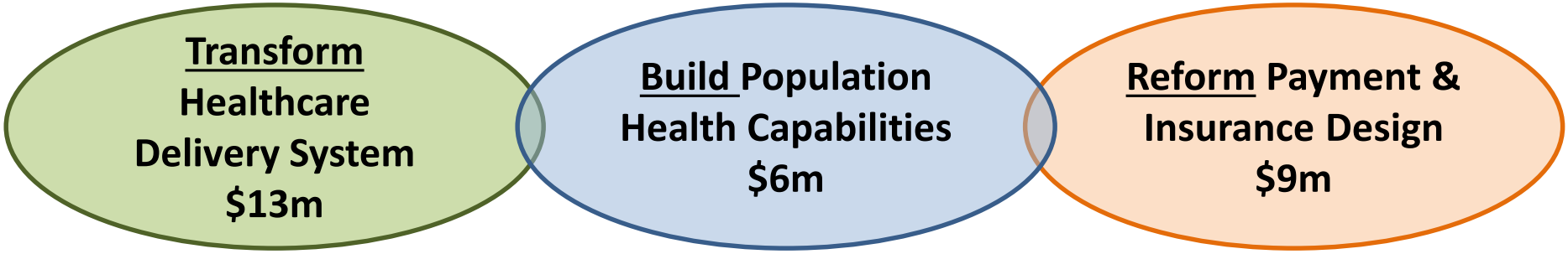
Value-Based Insurance Design - Accountability Metrics

Year	Percent adoption
2016	44%*
2017	53%
2018	65%
2019	74%
2020	87%

*Estimate – will establish empirical baseline 2015

Our Journey from Current to Future: Components

CT SIM Component Areas of Activity



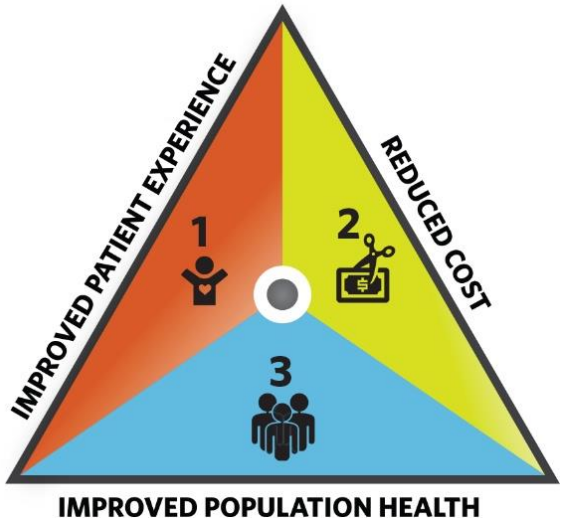
Transform the healthcare delivery system to make it more coordinated, integrate clinical and community services, and distribute services locally in an accessible way.

Build population health capabilities that reorient the healthcare toward a focus on the wellness of the whole person and of the community

Reform payment & insurance design to incent value over volume, engage consumers, and drive investment in community wellness.

Engage Connecticut's consumers throughout	**$376k**
Invest in enabling health IT infrastructure	**$10.7m**
Evaluate the results, learn, and adjust	**$2.7m**

SIM: How will we evaluate our impact?



By 6/30/2020 Connecticut will:

Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

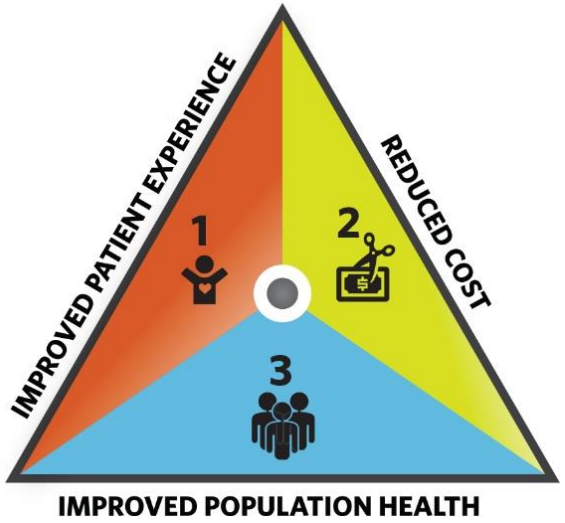
Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

Reduce Healthcare Costs

Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

SIM: What is the role of the CHW?



Improve Population Health

CHWs work across sectors, offering expertise in areas not typically associated with the traditional medical setting, which are crucial to addressing population health

Improve Health Care Outcomes

Acting as members of the healthcare team, CHWs contribute to improved outcomes through an understanding of their communities and how best to help them achieve their healthcare goals

Reduce Health Disparities

The diverse roles and backgrounds of CHWs bring an understanding of the various populations in Connecticut and how best to address their unique healthcare needs

Reduce Healthcare Costs

CHWs can contribute to overall reductions in healthcare costs by providing preventative services, mitigating potentially costly issues within their communities

National CHW Landscape

SIM connecticut state innovation model

Community Health Workers: What's Happening in the States

Carl H. Rush, MRP

University of Texas – Houston, Institute for Health Policy

Topics

- Definitions and distinctive features of the CHW
- Activity at the national and state levels
- Key challenges in CHW policy and workforce sustainability

Community Health Worker Definition American Public Health Association (1)

- The CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

- This trusting relationship enables the CHW 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.

Community Health Worker Definition (2)

- The CHW also builds 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.

APHA Policy Statement 2009-1, November 2009

CHWs are unlike other health-related professions

- Do not provide clinical care
- Generally do not hold another professional license
- Expertise is based on *shared life experience and (usually) culture* with the population served

Distinctive capabilities of CHWs in clinical settings

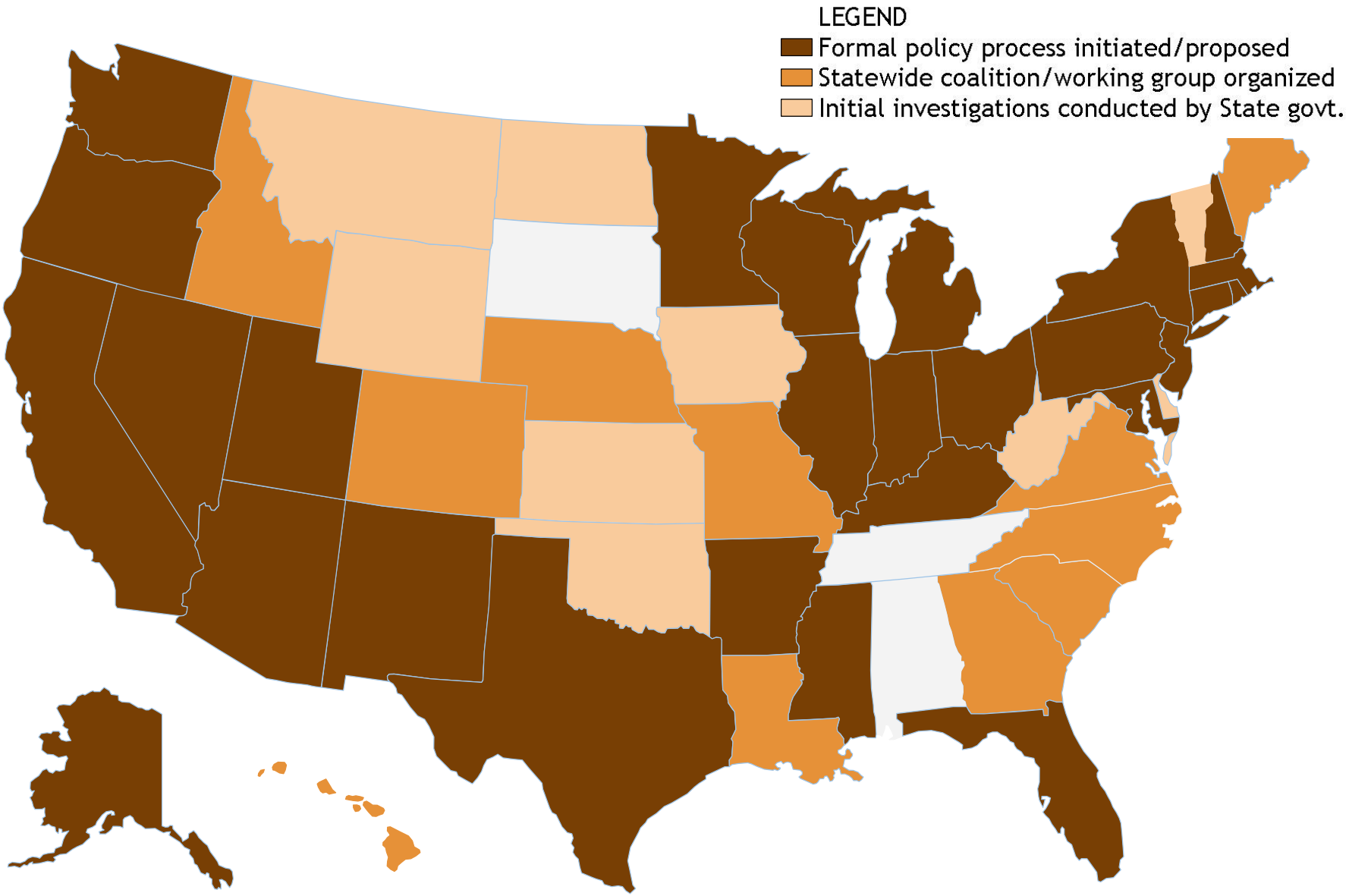
- Establishing close relationships with patients
- Building trust: overcoming power distinctions and historic mistrust of institutions
- Fostering candid and continuous communication

- Managing Social and Behavioral Determinants of Health
  - Providing context to team members on “whole picture” of patient’s life; servings as the “SDOH expert” on the team
  - Assisting patient/family in dealing with non-medical circumstances and issues
  - Mobilizing community to deal with macro issues

What's happening in the States - and at the national level?

UTHealth | School of Public Health
The University of Texas Health Science Center at Houston

CHW Policy Activity by State



Updated 3/28/16

States are pursuing various models in CHW policy innovation

- **Legislative**: Texas, Ohio, Massachusetts, New Mexico, Illinois, Maryland, North Dakota
- **Medicaid rules/SPA**: Minnesota, Wisconsin, DC
- **Policy driven by specific health reform initiatives**: New York, Oregon, South Carolina + SIM states
- **Broad-based coalition process**: Arizona, Florida, Kentucky, Michigan, West Virginia

Recent state innovations with CHWs

- State Innovation Models
- Mass. Prevention and Wellness Trust
- Medicaid 1115 waiver DSRIP grants in TX, NY
- Oregon “CCO” legislation
- South Carolina Medicaid pilot
- Nevada pooled funds pilot
- Apprenticeship training model: MA, WI, AK

Other SIM States

- CHWs on Care Teams: CA, HI, ID, ME, MD, MA, MN, VT
- Major CHW workforce elements in CA, DE, HI, OR, IL, MI
- AR: CHWs as “community reinforcement mechanisms”
- OR: statutory role in Coordinated Care Organizations
- CA: CHWs as one of two workforce “building blocks”
- MD: Community-Integrated Medical Homes
- NY: Medicaid Redesign Team recommendations

Health IT Framework

Evaluation Framework

- A foundation of medical homes and community health teams that supports coordinated care and linkages with a broad range of services
- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams
- A health information infrastructure that includes electronic health records (EHRs), hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

VERMONT

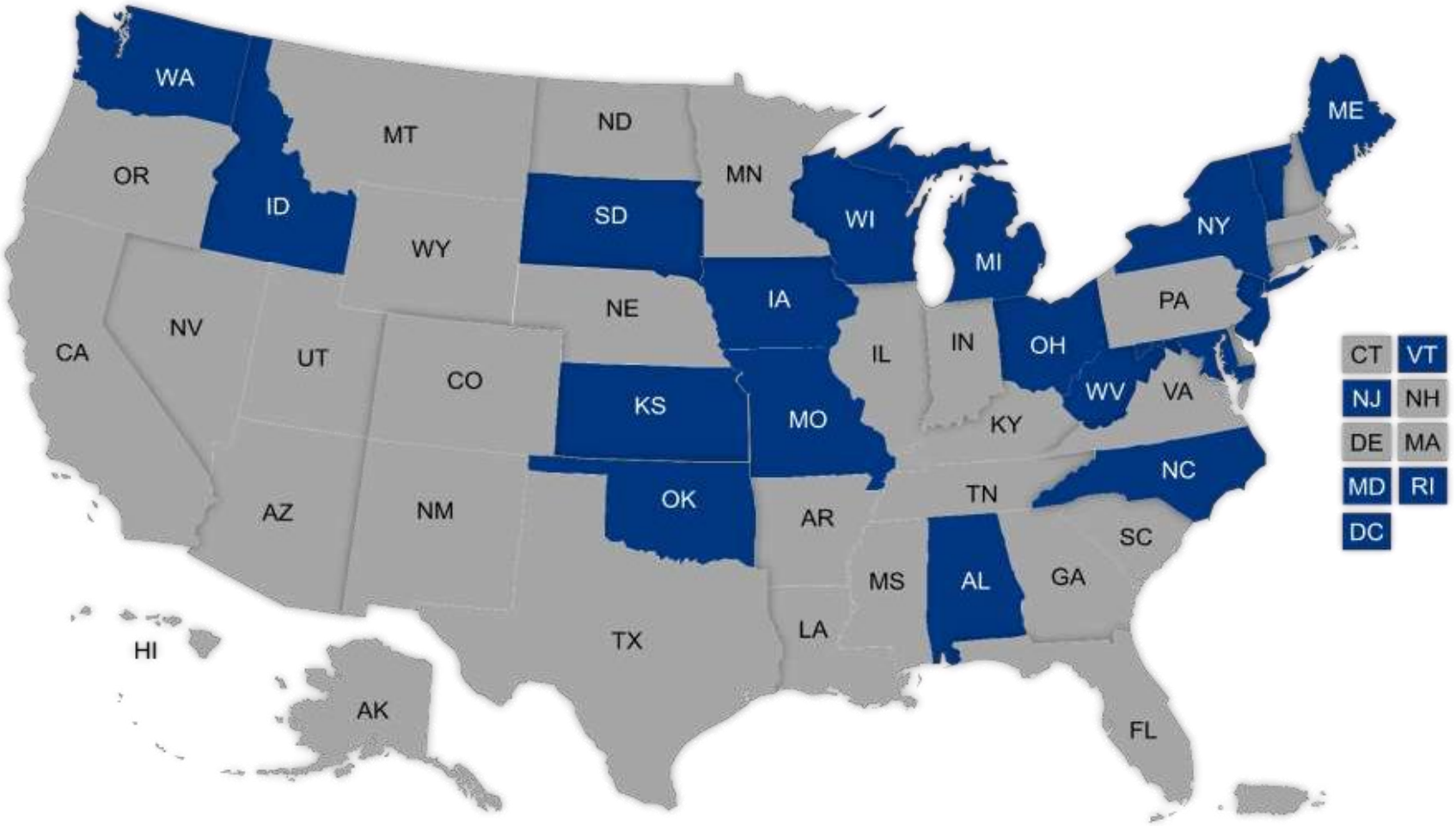
Oregon Health Authority
Medical Assistance Programs

Non-Traditional Health Workers Financing Options

Worker	Direct Care* Care Coordination/ Health Promotion	Population-Based Prevention/ Outreach/ Health Promotion	Payment Options	Reporting
CHW PWS NAV	X X X		PCPCH Payment or CCO-ICM Capitation	Documentation in Medical Record
CHW PWS NAV		X X X	CCO-ICM Capitation Or CCO Sub-Contracted Entity	CCO Reports Expenditures on Financial Report **
Doula	X		Payment to Provider, Hospital or Birthing Center is enhanced when Doula is utilized	FFS Claim for Delivery is billed with modifier CCO reimbursement is dependent on the business practice of the plan

CHW-Community Health Worker; PWS-Peer Wellness Specialist; NAV-Personal Health Navigator
*Direct Care services are provided under the supervision of a Licensed Healthcare Professional
**(Identify the specific report and line item)
***FFS reimbursable for individuals approved for MH 1915(i) Home and Community Based State Plan Option, Discussion currently underway to amend the State Medicaid Plan, Rehabilitative Services Option which will authorize FFS OHP for this HCPCS code.

Approved Medicaid Health Home State Plan Amendments *(effective December 2015)*



As of December 2015, 19 states and the District of Columbia have a total of 27 approved Medicaid health home models.

	States with Approved Health Home SPAs (number of approved health home models)	**Alabama, District of Columbia, Idaho, Iowa (2), Kansas, Maine (2), Maryland, Michigan, Missouri (2), New Jersey (2), New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Vermont, Washington, West Virginia, Wisconsin**

Note that Oregon has withdrawn its Medicaid health home state plan amendment and is no longer providing services under a 2703 SPA.

Federal agencies are increasing support for CHW strategies

- CDC priority on support for policy and systems change
- CDC and HRSA support for TA at state request
- HHS CHW Interagency Work Group
- CMMI Grantee CHW Learning Collaborative
- National Health Care Workforce Commission

Key policy areas for consideration in states that want to advance the CHW workforce

4 key policy areas require attention

1. **Occupational definition** (agreement on scope of practice and skill requirements)
2. **Sustainable financing models**
3. **Documentation, research and data standards** (records, evidence of effectiveness and “ROI”)
4. **Workforce development** (training capacity/resources)

Live poll, NASHP webinar, 2/23/15

What is your biggest challenge or hurdle to integrating community health workers into health care systems?

Project on CHW Policy and Practice
University of Texas Institute for Health Policy
Sustainable Financing of CHW Activities: Three Broad Pathways

	Basic pathways		
	A **Conventional health care**	**B** **Population/community-based public health**	**C** **Patient-centered care systems (emerging hybrid structures)**
1 Promising program models	Emergency room diversion "Hot-spotters" (high cost users) Prenatal/perinatal coaching Primary care based chronic disease management Care transitions Home/community-based long-term care	Specific condition-focused initiatives Community development approach (social determinants)	Patient Centered Medical Homes Accountable Care Organizations Health Homes
2 Specific CHW roles in these models	Care coordination Self-management support for chronic conditions Referral and assistance with non-medical needs and barriers Medication management support Patient/family advocacy Support and extension of health education Patient navigation	Basic outreach and education Community advocacy/organizing	Combination of health care and population-based (as at left)
3 Payment mechanisms for these models	Fee for service Managed care organizations: admin/service dollars; duals Medicaid 1115 waivers Internal financing Prospective payment (FQHCs)	Medicaid waivers Block grants Prevention trust fund (Mass. model) Pooled funds from third-party healthcare payers Social impact bonding	Bundled/global/prospective payment Supplemental capitation payment for specific services
4 Options for third-party payers	CHWs directly employed by payer Health care provider contracts/add-ons to hire CHWs CBO contracts to employ CHWs CHWs as independent contractors		

Four Dilemmas: Special challenges distinctive to policy on CHWs

1. Including non-clinicians in provision of care
2. “Community membership"
3. Professionalism and historical integrity
4. Cost savings: who gains, who loses (including SoP)

Other national action

- Organizing a national CHW association
- Endorsements from AMA and ANA
- CHW Core Consensus (C3) Project

CHW Core Consensus (C3) Project

- Producing recommendations for a common set of Core Roles (scope of practice) and Core Skills
- Seeking consensus in the form of endorsement or adoption across states and stakeholder groups
- Draft recommendations recently reviewed by 25 state/local CHW associations across the U.S.
- Next phase (2016) to seek input and endorsement from state and national stakeholder groups and state governments

Thank you!

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Connecticut CHW Landscape

*Community Health Workers in Connecticut

CT AHEC Network:
Dr. Bruce Gould, William Tootle, Stan Zazula, Meredith Ferraro

Community Health Workers Association of CT:
Millie Seguinot, President

What's Happened with Community Health Workers?

Timeline	CHWs in CT
* 2000	* Dissemination partner for San Francisco CHW Curriculum
* 2001	* 1st Statewide CHW and Employer Survey
* 2002	* Core Competency training developed and implemented
* 2004 - 2007	* www.CHW-NEC.org
* 2009 - 2011	* CHCACT CHIPRA Grant
* 2012 - 2013	* 2nd Statewide CHW and Employer Survey by Yale School of Epidemiology and Public Health
* 2012 - 2013	* CHW Task Force Formed * Workgroups: Definition, Training and Sustainability

AHEC Connecticut Network

What's Happened with Community Health Workers?

CHWs in CT

* Conference: SCSU Dept. of Public Health "Promoting the Public Health Workforce with CHWs"
* **Community Health Workers Association of CT formed**
* **CHWs incorporated into SIM Model**
* **Community Colleges developed CHW Core Competency Course (Gateway, Capital and Housatonic**
* "Community Health Workers in CT" White Paper, authored by Deb Heinrich
* Publication of the "**Business Case for CHWs**"
* Conference: *"The Business Case for Community Health Workers: Employers & the Affordable Care Act"*
* ***SIM GRANT Awarded to CT!***
* Conference: *"COMMUNITY HEALTH WORKERS: Their critical role in addressing health disparities - in health care and in communities*

AHEC Connecticut Network

CHW Advisory Committee Focus for SIM:

- Design
- Certification
- Sustainability

CHW Participants in Bridgeport Focus Group, June 2012

AHEC Connecticut Network

Community Health Workers Association of CT

- **MISSION:** To advance the CHW workforce through policy, education, research and leadership.
- **CORE VALUES:**
  - **CHANGE:** We believe in the effectiveness of CHWs empowerment to transform individuals and communities.
  - **JUSTICE:** We protect the capacity for CHWs to function ethically and with care. We accomplish this with integrity and courage.
  - **LEADERSHIP:** We take steps to advance the CHW workforce and inspire others to join us.

* "WE ARE THE BRIDGE"

Community Health Workers
CHW
Association of Connecticut

Q&A

Closing Remarks