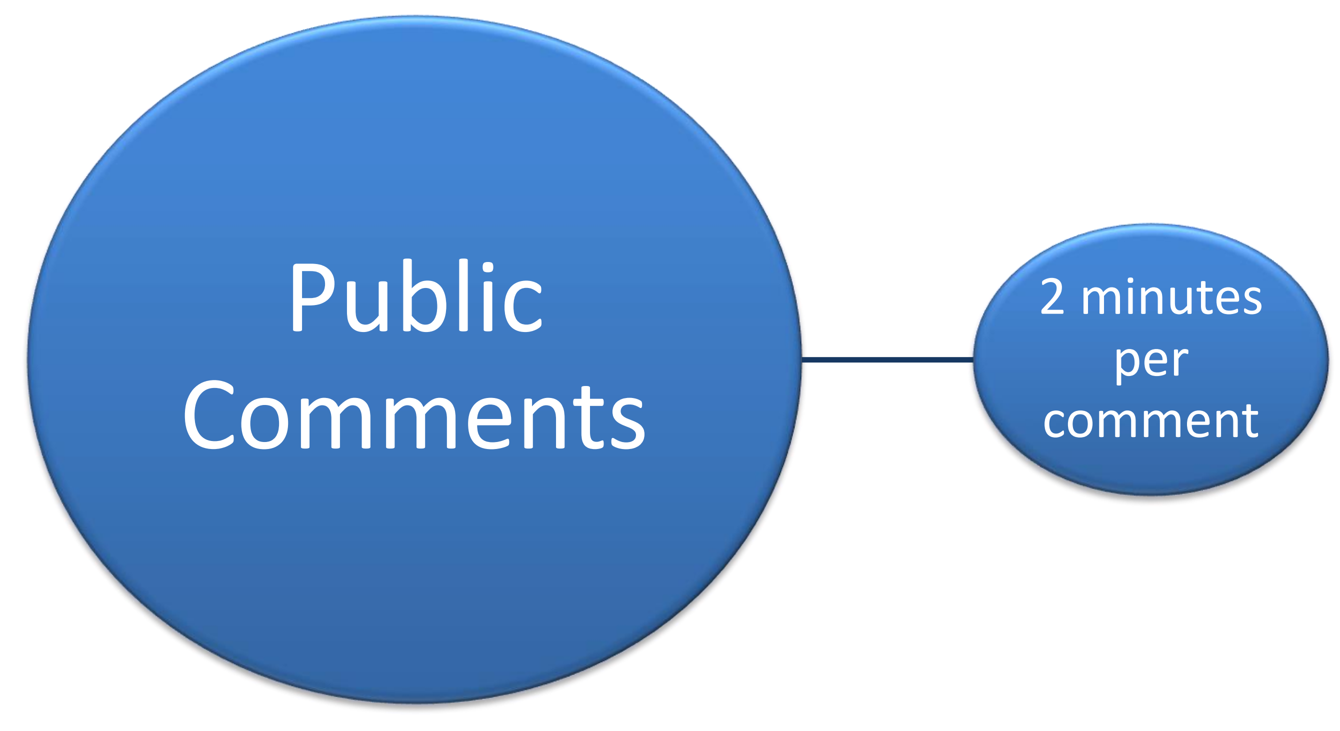
CHW Advisory Committee Webinar

March 21, 2017

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of the Minutes	5 min
4. Certification Recommendation Discussion and Vote	20 min
5. Primary Care Payment Reform Update and Discussion	50 min


Public
Comments
2 minutes
per
comment

Approval of the Minutes

Certification Recommendation and Vote

Question 1: Should certification be granted for 24 months?

- *Current Recommendation:* Certification shall be granted for 24 months. Re-certification will require evidence of the completion of continuing education hours and evidence of experience providing CHW services, either through employment or volunteer work as a Community Health Worker in the past 24 months.
- *Question:* Should Recertification be required every 24 months?
- *Rationale:* To maintain an up-to-date and active registry, it is important to require regular recertification.
- *Concern:* Is every 24 months too great of an administrative burden?
- *Potential Change:* Require DPH and the Advisory Committee to determine the appropriate frequency of recertification. However, this could negatively impact the registry.

Question 2: What should be required for grandfathering?

- *Current Recommendation:* For the first two years, DPH shall issue certifications to CHWs who demonstrate knowledge of the core competencies and experience of the CHW field based on either a) completion of a designated number of hours as a CHW and recommendations from current or previous employers or b) passing the standardized competency-based assessment.
- *Question:* Should grand-fathering be allowed solely based on passing of the standardized competency-based assessment?
- *Rationale:* To provide an alternate option to those individuals who completed non-recognized trainings in past years who may in fact have the skills to pass the assessment.
- *Concern:* Would this allow inexperienced CHWs to become certified?
- *Potential Changes:* Require a reduced number of experience hours along with completion of the standardized assessment **OR** remove option B entirely, and only allow grandfathering based on experience.

CHW Certification Principles

The ideal Certification process for CHWs:

- Ensures individual CHWs have achieved core competencies
- Develops a sense of professionalism amongst CHWs
- Can be recognized by employers or payers
- Does not prohibit experienced CHWs from continuing their work
- Does not hold CHWs to unfair standards
- Is not cost-prohibitive for CHWs
- Empowers CHWs to control their own future

CHW Certification Recommendation- Key Elements

The CHW Certification Design Group recommends that DPH establish a CHW certification program. Under this program CHWs will receive an individual 24-month certification from DPH and be placed on a CHW registry if they complete a) an approved training program and b) pass a standardized competency-based assessment.

Key Elements are as follows:

- DPH shall designate CHW training programs as “DPH approved”, based on a standardized curriculum review conducted by agency staff or a contractor.
- DPH shall establish a standardized competency assessment process that assesses both skills and knowledge by June 30, 2018. DPH shall ensure the assessment is reasonably accessible to individuals with language barriers and appropriately assesses cultural competency.
- The standardized competency assessment shall be administered by one or more DPH approved entities.
- DPH shall issue individual certifications to CHWs who have completed an approved training program AND demonstrated proficiency through the standardized competency assessment.

CHW Certification Recommendation- Grand-fathering

- DPH shall allow for grand-fathering: For the first two years, DPH shall issue certifications to CHWs who demonstrate knowledge of the core competencies and experience of the CHW field based on either a) completion of a larger designated number of hours as a CHW and recommendations from current or previous employers or b) a smaller number of hours of experience and passing the standardized competency-based assessment.
- DPH shall assess and determine the need for a pathway to certification based on CHW experience beyond the initial two-year grand-fathering period. Such a process may require completion of a designated number of hours as a CHW, recommendations from current or previous employers, and passing the standardized competency-based assessment.
- Certification shall be voluntary.

CHW Certification Recommendation- Re-Certification and Registry

- Certification shall be granted for 24 months. Re-certification will require evidence of the completion of continuing education hours and evidence of experience providing CHW services, either through employment or volunteer work as a Community Health Worker in the past 24 months.
- The continuing education and experience verification process shall be administered by DPH or its contractor.
- DPH shall establish a Certified CHW registry listing all of the individuals who have ever received certification and the status of such certification. The purpose of the registry is to enable employers to identify certified CHWs and to screen out individuals who may have lost certification for reasons of misconduct

CHW Certification Recommendation- Additional Recommendations

- DPH shall be established as the CHW certification authority under statute. Such statute shall designate a Certified CHW as one who has received an individual certification from DPH. Only CHWs who have received this certification may use the title "Certified CHW"
- DPH shall use the definition and scope of practice developed by the CHW Advisory Committee (based on the National C3 Recommendations for Community Health Workers) as the basis for developing curriculum standards.
- DPH shall establish a CHW Advisory Committee to advise it on development of the training program and competency assessment standards and corresponding certification procedures. At least 50% of the seats on the Advisory Committee should be reserved for CHWs from a range of backgrounds. The Advisory Committee shall also include representatives of DSS, DMHAS, CHWACT, CHW employers, a CHW training program, and a commercial payer.

Primary Care Payment Reform Update and Discussion

Objectives of Today's Discussion

- Review Primary Care Payment Models
- Discuss Stakeholder Interview Findings
- Consider Pros and Cons of the various Payment Models
- Respond to and discuss questions about Primary Care Payment Reform

How does this relate to our Charter?

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

Discussion Preview

1. Is Primary Care Payment reform an option for sustainable financing of Community Health Workers?
2. What are the pros and cons of the Primary Care Payment Models we discussed from the CHW perspective?
3. Should the state pursue a Primary Care Payment model that increases primary care spending and increases flexibility for providers?
4. If the state pursues a Primary Care Payment model, should there be a requirement that providers incorporate Community Health Workers into their practices?

Primary Care Payment Model Review

PCPM Review- Dr. Neil's Primary Care Practice

What does Dr. Neil want to do?

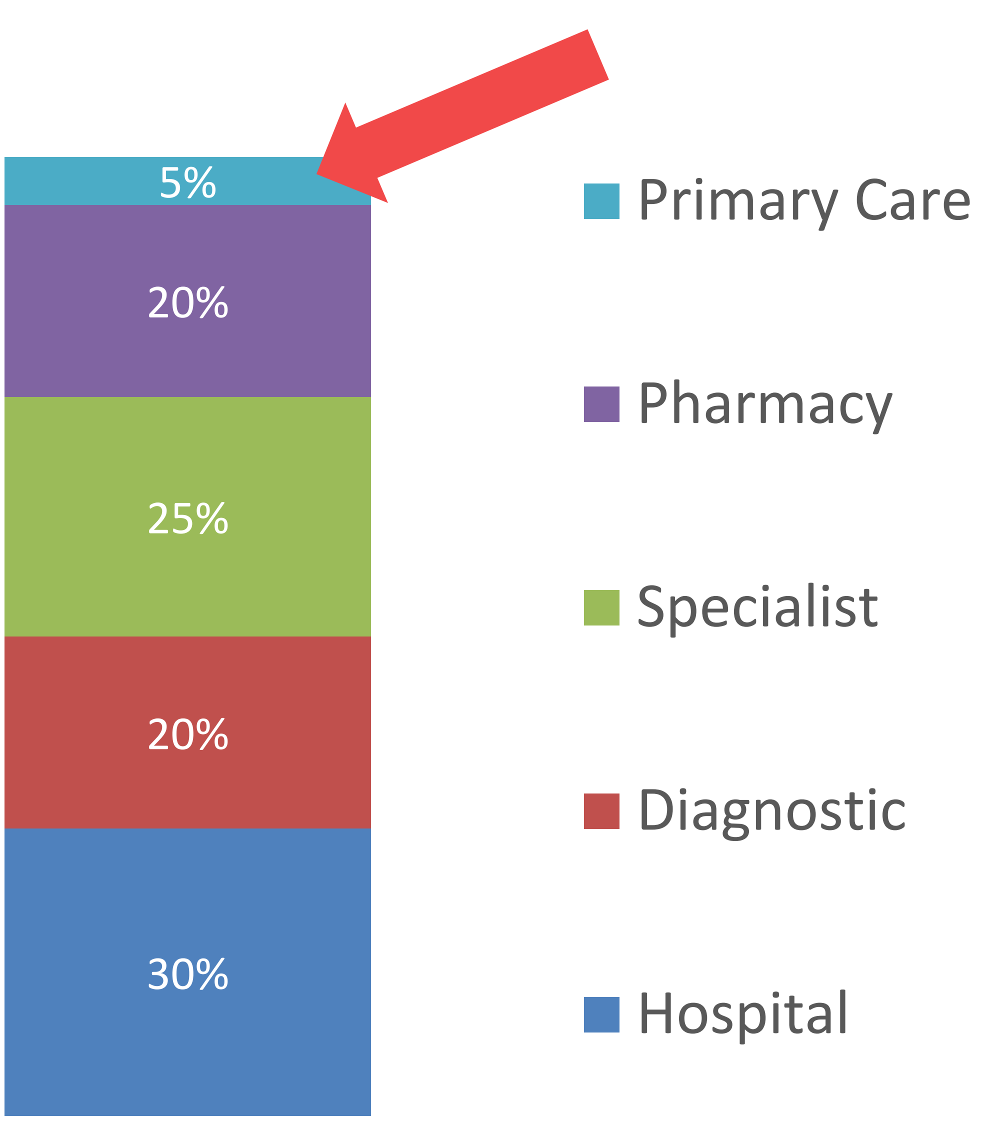
Patient Engagement and Support	Care Team Diversity
Phone contact	Nurse care manager
E-mail/text support	Social Worker
Telemedicine visits	Licensed BH clinician
Home visits	Pharmacists
E-consult	Nutritionist/dietician
Remote monitoring	Care coordinator (community health worker focus on community linkages)
Group visits (illness self-management, prevention, lifestyle enhancement)	Health coach (community health worker)
Tweet/chats/on-line support groups	Patient navigator
Patient/family advisory council	
Communication with child care/school	
Transportation	

Why can't Dr. Neil deliver care in the way she would like?

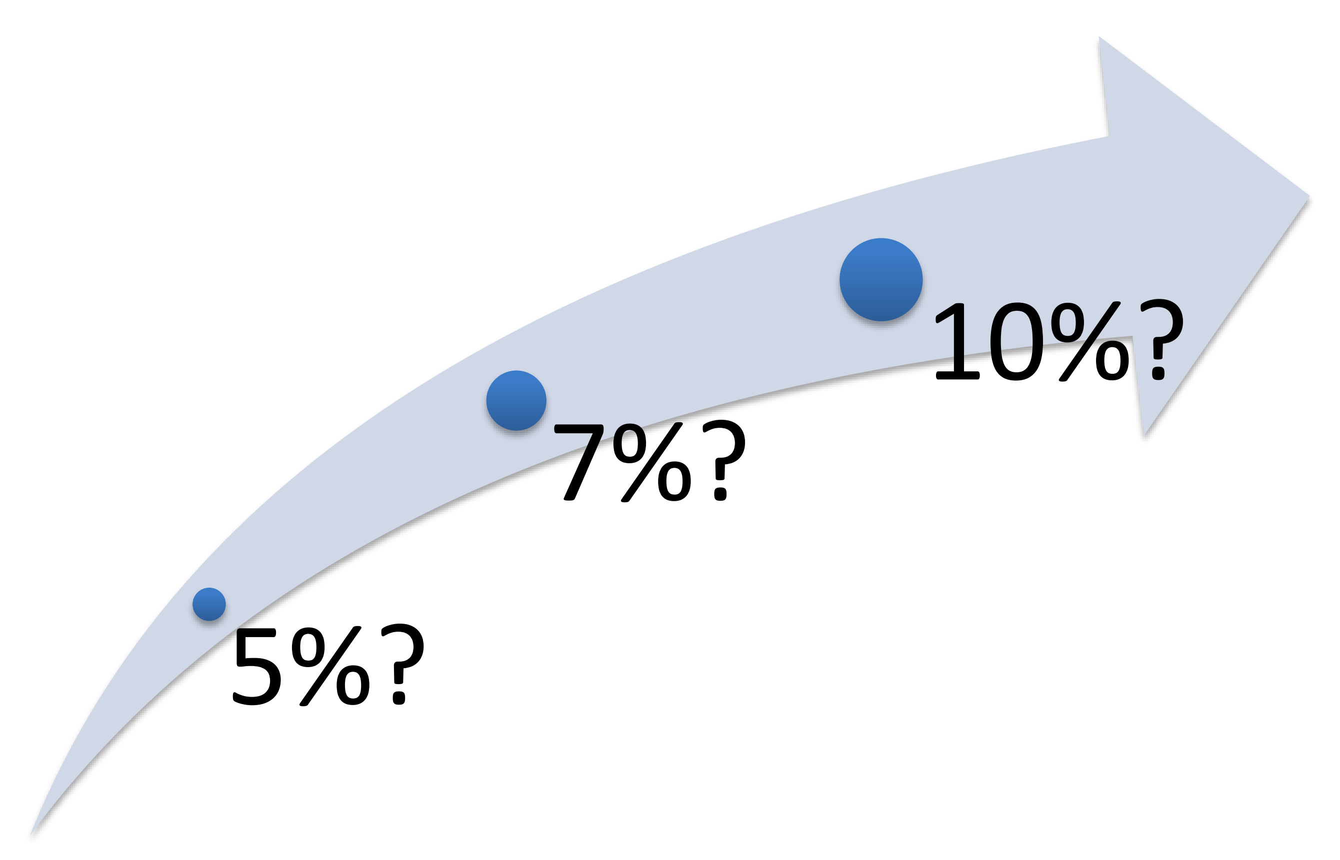
Primary Care Providers are limited in the way they can deliver care due to:

- **Low investment** compared to other areas of healthcare
- **Low flexibility** on how they can use their payments for care delivery

What % of healthcare spending goes into Primary Care?



How much should we be paying for primary care?



How do Primary Care Providers typically get paid?

Segment	Share
(top)	5%
	20%
	25%
	20%
(bottom)	30%

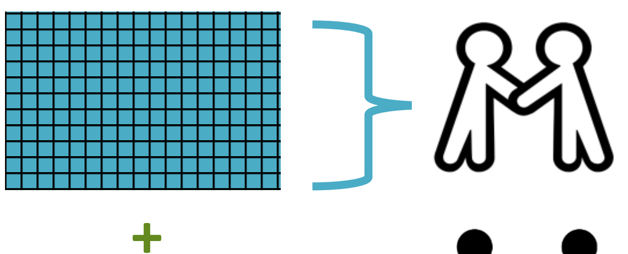
Category	Share
Other Services (e.g. procedures, immunizations, labs)	10%
Sick Visits (Acute and Chronic Visits- E&M)	45%
Wellness Visits (Preventive)	45%

QUALIDIGM

How would Dr. Neil like to get paid?

+Most flexibility through bundled payments
+ Partial payment up front - no need to wait for shared savings or bonuses
+Can be used to increase Primary Care spending as part of primary care bundle
+Increased flexibility
- May be more risk depending on scope (all primary care or only selected services) and amount of bundle

Option 1: Partial E&M (Sick Visit) Bundle



Types of Payment

Care Management Fee– **Up front, flexible**

Other Services like Immunizations

E&M (Sick Visit) Partial Bundle- **Up front, flexible**

E&M- Each Sick Visit- lower amount

Each Wellness Visit

How flexible?

Up-front, flexible payments can support email, telephone, video & group visits; home visits; CHWs, BH specialists, and other staff. Some flexibility to support non-visit based care.

Option 2: Full E&M (Sick Visit) Bundle

Types of Payment

Care Management Fee– **Up front, Flexible**

Other Services like Immunizations

E&M (Sick Visit) Bundle- **Up front, Flexible**

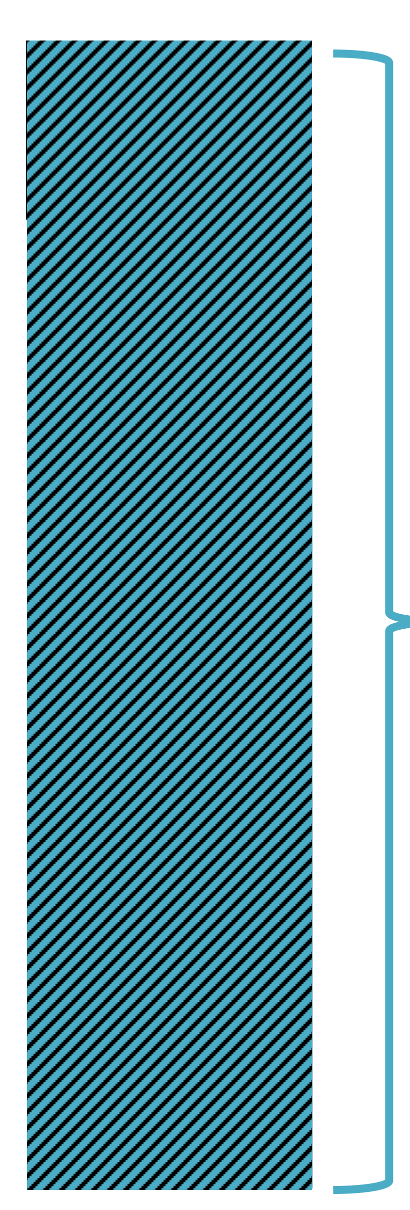
~~E&M Each Sick Visit lower amount~~

Each Wellness Visit

How flexible?

Up-front, flexible payments can support email, telephone, video & group visits; home visits; CHWs, BH specialists, and other staff. Even more flexibility to support non-visit based care. Potential for visit under-service.

Option 3: Full Primary Care Bundle



Types of Payment

Full Primary Care Bundled Payment- Up Front, Most Flexible

How flexible?

Payments can support any services, activities or staff to support patients. This is the most flexible model. Potential for under-service

The Range of Primary Care Payment Reform Models

Increasing Payment

Enhanced Fee for service	Care Management Fee + Partial E*M Bundle	Care Management Fee + Full E*M Bundle	Enhanced Primary Care Bundle
Fee for service	Partial E&M Bundle	Full E&M Bundle	Full Primary Care Bundle

Increasing Flexibility

Comprehensive Primary Care Plus (CPC+)- Where does it fall?

CPC+

Enhanced Fee for service	Care Management Fee + Partial E*M Bundle	Care Management Fee + Full E*M Bundle	Enhanced Primary Care Bundle
Fee for service	Partial E&M Bundle	Full E&M Bundle	Full Primary Care Bundle

Increasing Payment

Increasing Flexibility

New Primary Care Payment Reform Opportunity- CPC+

- CPC+ is a federal opportunity for states or regions of states to participate in a Primary Care Payment Reform model
- CPC+ **includes Medicare participation** (which can often be difficult to get), and encourages **all payers to participate**:
  - Why? Because Primary Care Providers don't want to only provide telephone calls to patients with one type of insurance, or only offer a CHW to a patient with one type of insurance
- Primary Care Payment Models require up-front funding, with the idea that the system will save money over time. **CPC+ could help the state with some of that funding**.
- CPC+ is flexible in its requirements, which could enable us to make **strong recommendations** regarding the model that would **most benefit CT consumers**

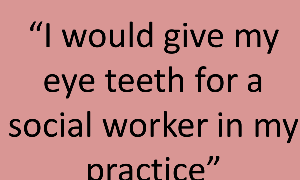
Payer, Provider, Consumer Perspectives

PCPM Perspective: Providers

Provider-identified barriers to improving primary care:

- Size of networks are too broad
- Primary care spending is too low
- Lack of up-front money to invest
- Insufficient data
- No standardized quality measures across payers

What Providers think about Primary Care Payment Reform



"I would give my eye teeth for a social worker in my practice"

"I'm not looking to negotiate fee schedules, I'm looking to get paid for quality care"

"CCIP standards are great and we support them but the grant is insufficient to sustain the standard of care"

"FFS is unsustainable; we must transform payment models and care"

"Adding BH has been transformative for the practices where its embedded"

"Primary care providers should be encouraged to provide non-billable services, (e.g., email, group visits)."

"Providers in other markets are *'swimming in happiness'* with the CPC+ experience"

PCPM Perspective: Payers

Accountability

- Care Management Fees/ Bundles
- Reallocating resources to primary care
  - Shared savings as a means to fund continued improvement in primary care services
- Variability in provider readiness: infrastructure and risk tolerance

PCPM Perspective: Consumers

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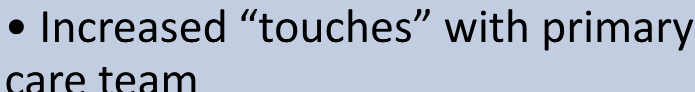

- Increased “touches” with primary care team
- Care team diversity with CHWs
- Easier and more convenient access
- Enhanced care services and coordination
- Prevention focus
  - < E.g., healthy lifestyle focus
- Opportunities for BH integration and care coordination
- Focus on measuring quality

- How will you know the impact on consumers?
- Will consumers pay more?
- What will be the impact on individuals with complex or rare conditions? Pediatric specialty care concerns
- Are providers ready? Won’t they need support?
- Can providers take on financial risk?
  - < Underservice risk?
- What will be the impact on independent practices?

Accountability

Discussion

Discussion

1. Is Primary Care Payment Reform an option for sustainable financing of Community Health Workers?

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Discussion Preview

2. What are the pros and cons of the Primary Care Payment Models we discussed from the CHW perspective?

How might these a Partial E&M bundle affect consumers?

Consumers may experience…

- **More "touches" with primary care team** between office visits
- "Touches" with **CHWs** recruited from their own community
- **Easier communication** with clinician by phone, e-mail and video which reduces missed work and reduces barriers with transportation and child care
- Fewer office visits which means **lower out of pocket costs**
- Care team members may be able to do **home visits** as needed
- Sicker patients do not have to worry about being accepted into care because **Care Management Fee payments are risk-adjusted**
- Better support for **care transitions**
- Because usual primary care services have at least partial FFS reimbursement, there is **no risk of under-service**

How do PCPMs account for sicker and healthier patients?

Risk Stratified Care Management Fees

+

Higher Risk Patients

Care Management Fee

Medium Risk Patients

Lower Risk Patients

Care Management Fee

How can providers be held accountable?

Payer Reviews and Adjusts Payments accordingly

Provider Submits to Payer

Report on Measures like Diabetes A1c and Blood Pressure Control

Report on practice changes like hiring of CHWs, adoption of e-consults

Project a budget and report on actual spending

Quality Measure Reporting

Care Delivery Reform Reporting

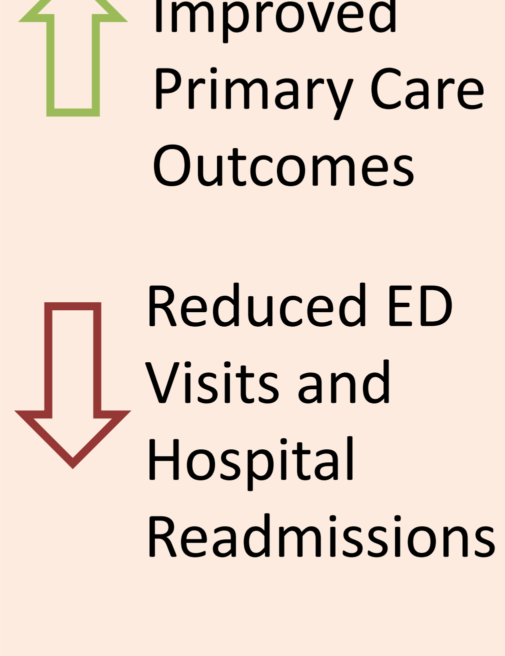
Budget Reporting

Discussion Preview

3. Should the state pursue a Primary Care Payment model that increases primary care spending and increases flexibility for providers?

How can we increase Primary Care spending?

Upfront Primary Care Investment =



Improved Primary Care Outcomes

Reduced ED Visits and Hospital Readmissions

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Current		→	Future
5%	Primary Care	-->	10%
20%			20%
25%			25%
20%			20%
30%	Hospital		25%

How can we increase Primary Care spending?

Year 1	Year 2	Year 3	Year 4	Year 5
5%	6.6%	7.7%	8.8%	10%
20%	20%	20%	20%	20%
25%	25%	25%	25%	25%
20%	20%	20%	20%	20%
30%	28.4%	27.3%	26.2%	25%

$

-> -> -> ->

Discussion Preview

4. If the state pursues a Primary Care Payment model, should there be a requirement that providers incorporate Community Health Workers into their practices?

Appendix: Primary Care Payment Models

How has Dr. Neil gotten paid for most of her career?

Category 1

Fee for Service – No Link to Quality & Value

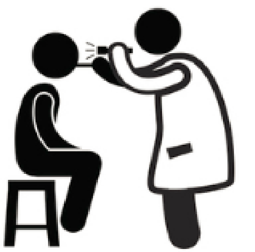
+ Low Risk

- No up front payments

- Only 5% Healthcare spending on Primary Care

- No Flexibility

Types of Payment



Each Sick Visit

Each Wellness Visit

Each service like Immunizations

How flexible?

Only paid for visit-based services

How does Dr. Neil currently get paid?

Category 2

Fee for Service – Link to Quality & Value

+A little flexibility

+ Low Risk

+ May have up front or enhanced payments

+ /- May increase Primary Care spending

- Flexibility limited

Each Sick Visit

Each Wellness Visit

Each service like Immunizations

Bonus Payments for Quality Care- **received after end of the year**

How flexible?

Bonus Payments can support non-visit based activities and care coordination staff, but bonuses typically limited in amount, long wait and not guaranteed

How might Dr. Neil get paid?

Category 3

APMs Built on Fee-for-Service Architecture

+More flexibility

+ Low risk if upside only

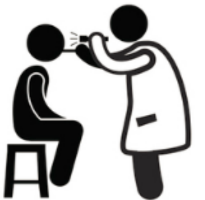
+ May have up front payment

+ Rewards cost control

+ / - May increase Primary Care spending

- Flexibility limited

Types of Payment



Each Sick Visit

Each Wellness Visit

Each service like Immunizations

Shared Savings Payments for Quality & Cost- **Received after end of the year**

How flexible?

Shared Savings can support non-visit based services like email, and staff like care coordinators, CHWs and BH specialists. However, focus on near term ROI, long wait to receive rewards, and not guaranteed

Early Impressions - Current CT Primary Care Environment

Care Team Composition

	MD	APRN	Licensed Behavioral Clinician	Pharmacist	RN Care Coord./ Case Manager	Social Worker	Nutritionist/Dietician	Community Health Worker	Patient Navigator
Multi-Hospital Systems	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓✓	✓			✓
IPAs/PHOs	✓✓✓	✓	✓	✓	✓✓	✓	✓		✓
Solo Practitioners	✓✓	✓							

Non-Visit Based Care

	Predictive Model	Risk Stratification	High Risk Rounds	Proactive outreach to at-risk pop.	Patient Education	Email/text support	In-home CM	E-consult/ Telemedicine	Communication w/Child Care/School	Patient/ Family Advisory Council	Online Support Groups (i.e. tweet/chat)	Group Visit
Multi-Hospital Systems	✓	✓	✓✓	✓	✓✓	✓	✓✓	✓				✓✓
IPAs/PHOs		✓	✓	✓✓	✓✓		✓	✓✓				
Solo Practitioners	✓	✓	✓	✓	✓			✓				