OHS CONNECTICUT Office of Health Strategy

Community Health Worker Advisory Committee

June 18, 2019

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comments	5 min
3. Approval of the Minutes	5 min
4. Opening Remarks	15 min
5. Update on HB 7424 (SB 859)	30 min
6. Presentation on Primary Care Modernization	60 min
7. Adjourn	

Introductions/Call to Order

Public Comments

Approval of the Minutes

Opening Remarks

Update on HB 7424 (SB 859)

https://www.cga.ct.gov/2019/BA/pdf/2019HB-07424-R00-BA.pdf
Pages 50 to 54, section §§ 160 & 161

Fiscal Note
https://www.cga.ct.gov/2019/FN/pdf/2019HB-07424-R00-FN.pdf
Page 23, sections 160 - 182

§§ 160 & 161 - COMMUNITY HEALTH WORKERS

Creates a community health worker certification program and a Community Health Worker Advisory Body

The bill creates a community health worker certification program administered by the Department of Public Health (DPH). Starting January 1, 2020, the bill prohibits anyone from using the title **"Certified Community Health Worker"** unless they obtain this certification.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

1. Establishes certification requirements and sets fees for initial certifications and renewals.

2. Establishes a continuing education requirement.

3. Allows DPH to take certain enforcement actions against a certificate holder who fails to comply with accepted professional standards.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

CHW Advisory Body

The bill also establishes a 14-member Community Health Worker Advisory Body within the Office of Health Strategy (OHS). Among other things, the advisory body must advise OHS and DPH on education and certification requirements for community health worker training programs and provide DPH with a list of approved programs.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

By law, community health workers are public health outreach professionals with an in-depth understanding of a community's experience, language, culture, and socioeconomic needs. Among other things, they (1) serve as liaisons between community members and health care and social service providers and (2) provide a range of services, including outreach, advocacy, and care coordination. EFFECTIVE DATE: January 1, 2020

Requirements for Community Health Worker Certification

The bill requires community health workers to apply to DPH for certification on forms the commissioner provides and pay a **$100 application fee**.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

To obtain certification, an applicant must:
"Path 1"

1. Be at least 16 years old.

2. Be trained or educated as a community health worker by an organization approved by the Community Health Worker Advisory Body the bill establishes.

3. Submit a professional reference from an employer and a reference from a community member each with direct knowledge of the applicant's community health worker experience.

4. Have completed at least 1,000 hours of experience working as a community health worker during the three years before the application date.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

Alternatively, the bill allows an applicant to: *"Path 2"*

(1) Have completed at least 2,000 hours of paid or unpaid experience as a community health worker and

(2) Submit a professional reference from an employer and a reference from a community member each with direct knowledge of the applicant's community health worker experience.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

Renewals

- The bill requires community health workers to renew their certification every three years during their birth month and establishes a $100 renewal fee.

Applicants

- Must have completed at least 30 hours of continuing education, including two hours each on
- (1) cultural competency, systemic racism, or systemic oppression.
- (2) social determinants of health.

Exemption. The bill exempts from the certification requirements community health workers who provide services (e.g., outreach, education, and advocacy) but do not hold themselves out to the public as a certified community health worker.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

Disciplinary Action:

Allows DPH to take disciplinary action against a certified community health worker for failing to conform to accepted professional standards, including:

By law, disciplinary actions available to DPH include license revocation or suspension, censure, a letter of reprimand, probation, or a civil penalty. The department can also order a certificate holder to undergo a reasonable physical or mental examination if there is an investigation of his or her physical or mental capacity to practice safely (CGS § 19a-17).

1. Fraud or deceit in obtaining or seeking reinstatement of a community health worker certification.
2. Fraudulent or deceptive professional services or activities.
3. Negligent, incompetent, or wrongful conduct in professional activities.
4. Aiding or abetting an uncertified person's use of the title "certified community health worker.
5. Physical, mental, or emotional illnesses or disorders that result in his or her inability to conform to accepted professional standards.
6. Abuse or excessive use of drugs including alcohol , narcotics, or chemicals.

The bill allows the DPH commissioner to petition the Hartford Superior Court to enforce any disciplinary action the department takes. DPH must notify the certificate holder of any contemplated disciplinary action and its cause and the hearing date on the action.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

Community Health Worker Advisory Body

The bill establishes a 14-member Community Health Worker Advisory Body within OHS to:

1. Advise OHS and DPH on matters related to education and certification requirements for community health worker training programs, including the minimum number of hours and internship requirements for certification.

2. Conduct a continuous review of these certification and education programs.

3. Provide DPH with a list of approved certification and education programs.

§§ 160 & 161 - COMMUNITY HEALTH WORKERS (Continued)

Creates a community health worker certification program and a Community Health Worker Advisory Body

Community Health Worker Advisory Body (Continued)

The bill establishes a 14-member Community Health Worker Advisory Body within OHS to:

Under the bill, the OHS executive director, or her designee, is the advisory body's chairperson and must appoint the following members:

1. Six members actively practicing as community health workers in the state.
2. One member of the Community Health Workers Association of Connecticut.
3. One representative of a community-based community health worker training organization.
4. One representative of a regional community-technical college.
5. One community health worker employer.
6. One representative of a health care organization that employs community health workers.
7. One health care provider who works directly with community health workers, and
8. The DPH commissioner or her designee.

Next Steps

- Gather questions from CHW Advisory Committee that OHS/DPH should consider in planning
- Continue to educate the public about the passage of the new law, and spread the word about the certification program that will launch next year
- OHS to meet with DPH to formulate a high level project plan, timeline, etc.

Presentation on Primary Care Modernization

OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization:

Unlocking the Potential of Primary Care to Improve Health and Affordability

SIM connecticut state innovation model

AGENDA

- Share information on Primary Care Modernization, including a set of provisional primary care capabilities and flexible payment model options

- Hear your thoughts on the proposed initiative and ways it could support Community Health Workers as part of the healthcare workforce

OUR SHARED CHALLENGE

The highest performing health systems spend 10 to 12% of health care dollars on primary care. In Connecticut, primary care spending is 5% or less. The result is underuse of high value services, overuse of low value services, higher spending and worse outcomes.

Connecticut ranks…

- 32nd worst in the nation in avoidable hospital use and costs, largely driven by avoidable ED use[1]
- 6th highest private health insurance spending per capita and 5th highest for Medicare[2]
- 43rd worst in the nation in health disparities[3]
- 44th worst in the nation in adults with diabetes without a hemoglobin A1c test[2]
- 33rd worst in the nation in adults with mental illness reporting unmet need[2]
- 39th worst in the nation in deaths from drug use[3]

The United States ranks last in primary care providers per 1,000 among developed countries[4]. Connecticut is projected to require a 15% increase in primary care physicians by 2030 to keep pace with current utilization[5].

[1] Commonwealth Fund Scorecard on State Health System Performance, 2018, https://interactives.commonwealthfund.org/2018/state-scorecard/files/Connecticut.pdf
[2] Kaiser Family Foundation State Health Facts, 2017, https://www.kff.org/other/state-indicator/per-capita-state-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[3] America's Health Rankings 2018 Annual Report, https://www.americashealthrankings.org/
[4] Organisation for Economic Cooperation and Development, https://stats.oecd.org/Index.aspx?QueryId=30173
[5] Connecticut: Projecting Primary Care Physician Workforce, https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Connecticut.pdf

TRANSFORM CARE ACROSS THE DELIVERY SYSTEM

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.

GOALS

- BETTER ACCESS
- BETTER PATIENT EXPERIENCE
- BETTER QUALITY
- REVITALIZED PRIMARY CARE
- LOWER COST

INPUTS

- PATIENTS AND FAMILIES
- CARE TEAMS
- PRIMARY CARE CAPABILITIES
- HEALTH NEIGHBORHOOD
- POPULATION HEALTH MANAGEMENT

ENABLERS

- FLEXIBLE PAYMENTS
- COST ACCOUNTABLE PAYMENT
- CONSUMER SAFEGAURDS
- QUALITY MEASUREMENT
- PEFORMANCE ACCOUNTABILITY

IMPACTS

- REDUCED AVOIDABLE HOSPITAL, ED, AND SPECIALTY CARE
- MORE USE OF HIGH VALUE SERVICES
- PREVENTIVE CARE AND CHRONIC CONDITION OUTCOMES IMPROVE
- PROVIDER RECRUITMENT AND RETENTION IMPROVES
- AFFORDABILITY IMPROVES

IMPACT
HEALTH EQUITY

Through capabilities focused on identifying and addressing health disparities and payment model options that recognize social factors impact cost, PCM would improve health equity in Connecticut.

People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. Disparities are largely driven by systemic barriers.

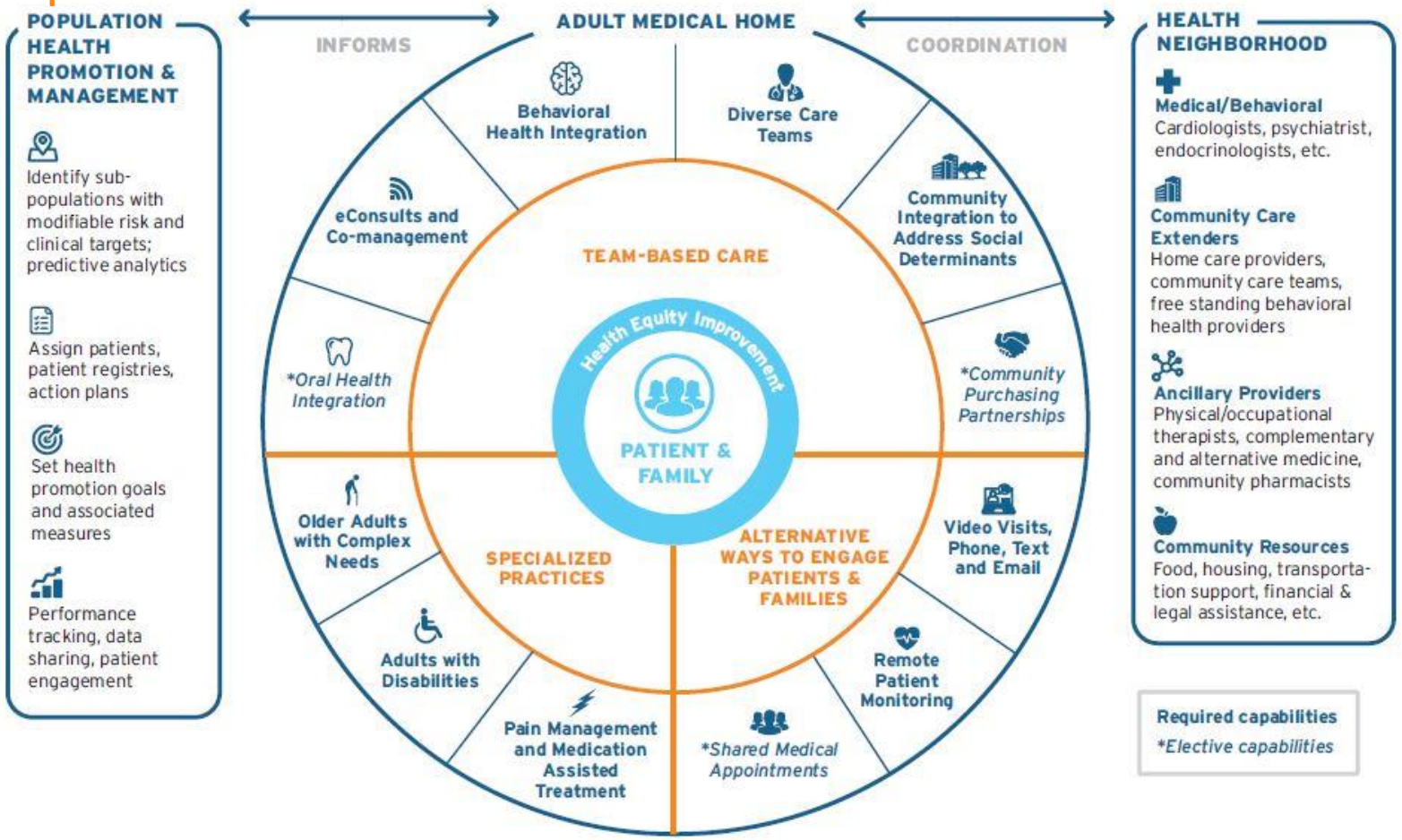
By creating new systems and employing care teams that reflect the patients and communities they serve, PCM capabilities work together to address barriers such as:

- Language differences
- Culture
- Lack of transportation, childcare, food security, housing stability
- Difficulty taking time off work
- Literacy

DRAW SHARED FOCUS TO PROVEN CAPABILITIES

Practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, convenient and responsive to patients' needs while improving health equity.

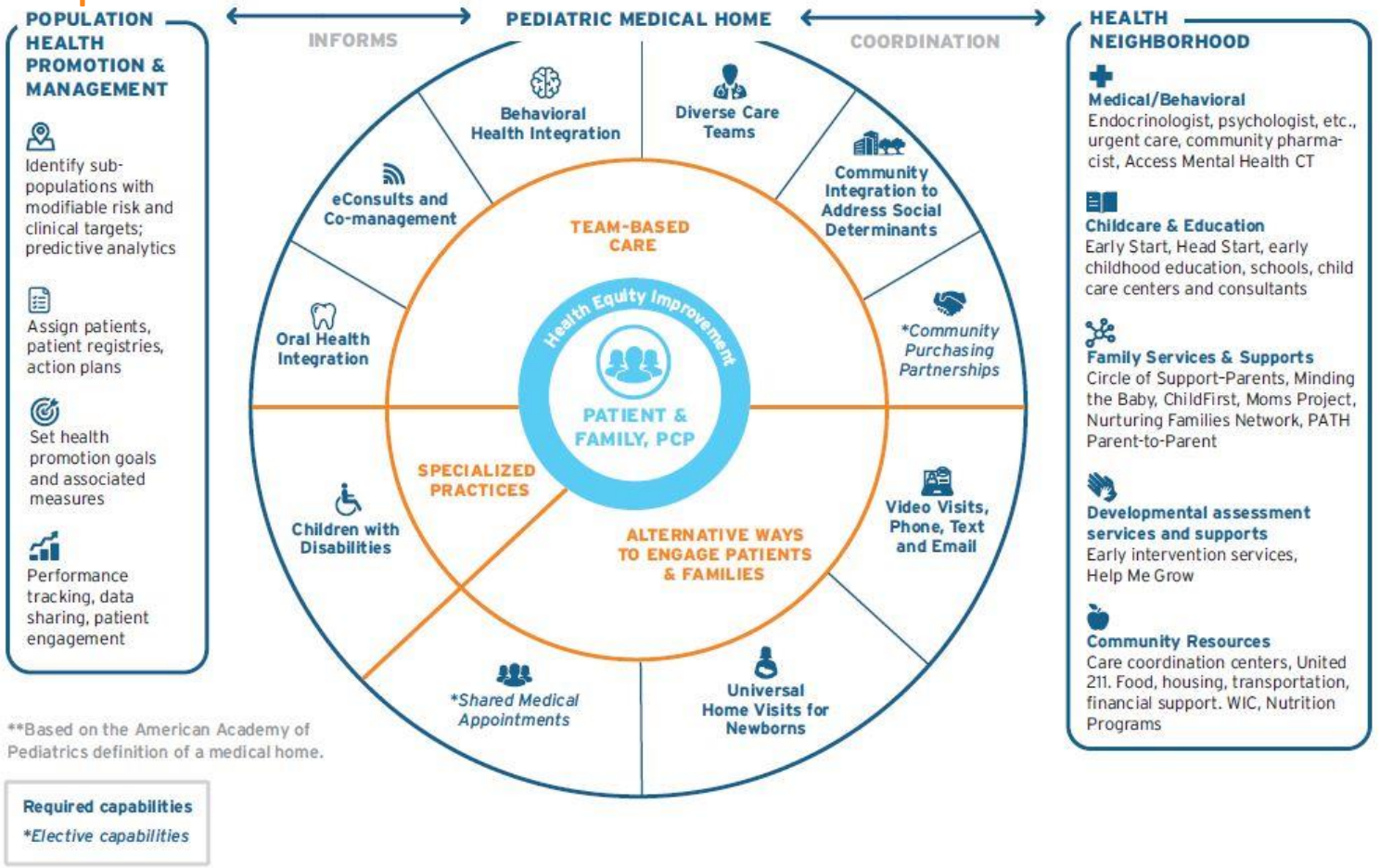
Adult Primary Care Capabilities



ADDRESS SPECIFIC NEEDS OF PEDIATRICS

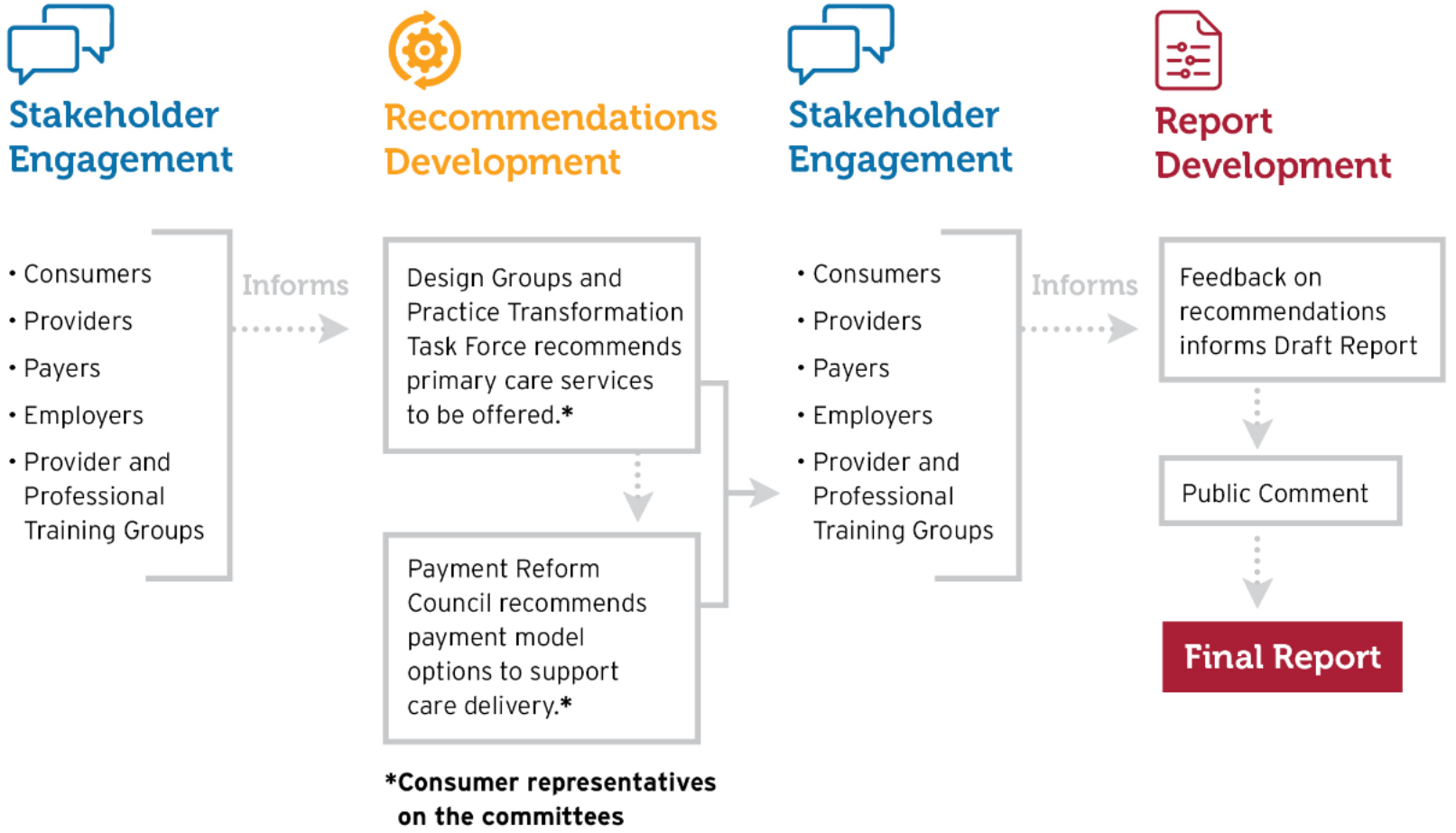
Pediatric practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Pediatric Primary Care Capabilities



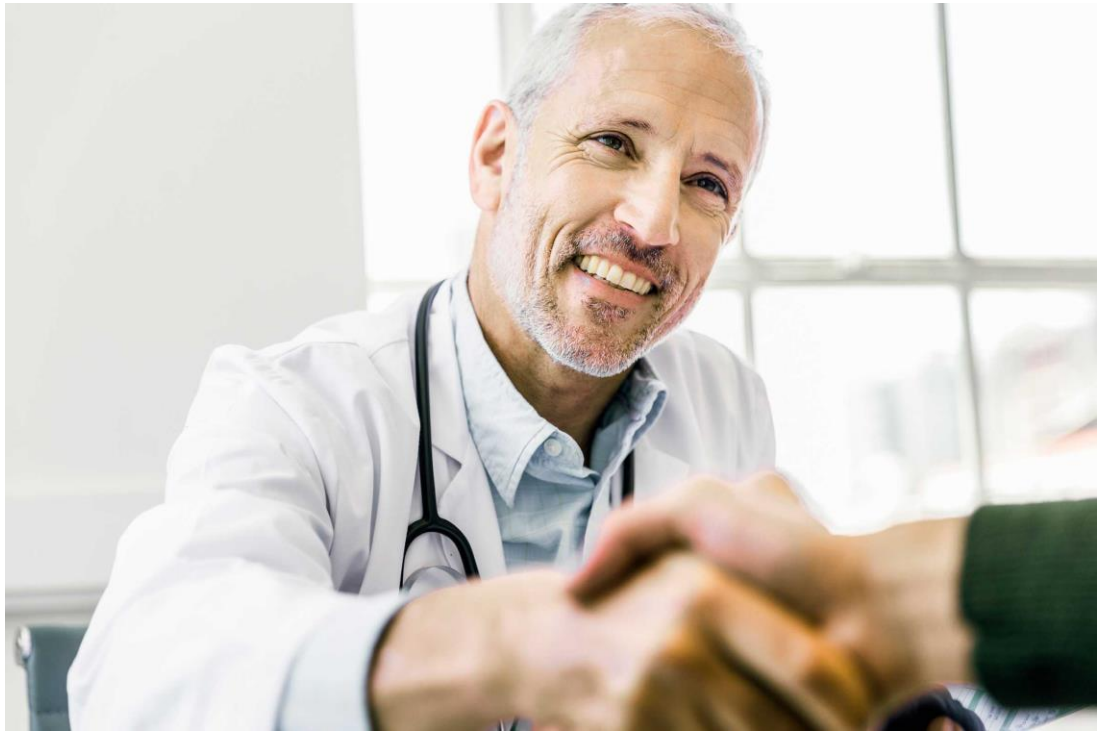
DESIGN SOLUTIONS WITH INPUT FROM ALL STAKEHOLDERS

More than 500 Connecticut stakeholders worked collaboratively to develop provisional recommendations that would drive immediate improvement and long-term transformation.



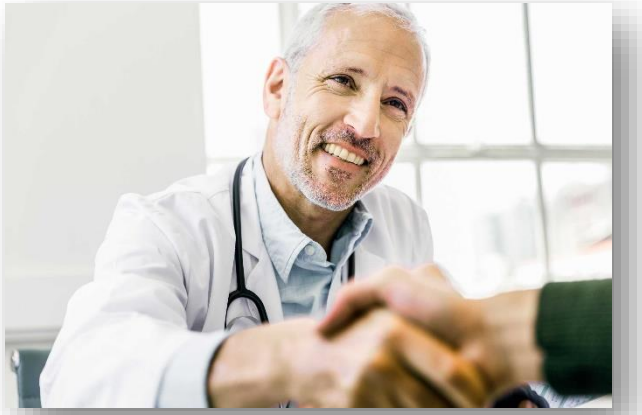
MEET
DR. NEIL AND DR. MOISE

Dr. Neil and Dr. Moise are primary care physicians trying to provide good care. They feel overwhelmed by billing, coding and other administrative hassles. They wish they had more clinical support, too.



MEET DR. NEIL AND DR. MOISE'S PATIENTS

Kahn and Nadia need more support than Dr. Neil and Dr. Moise can provide alone. They are frustrated and worried. They want to feel well again.



KAHN'S STORY

Kahn is a 61-year old Cambodian woman with multiple chronic conditions. She was recently in a car accident, started having problems at work and was laid off.

Kahn's Needs

- Assistance of an interpreter for language and health literacy barriers
- Support for her behavioral health conditions including PTSD and depression
- Help managing her untreated diabetes and hypertension
- Help accessing services like unemployment, transportation and social services

Dr. Neil's Practice Solutions

- Part-time LCSW identifies behavioral health needs, makes referrals, and provides monthly support
- Coordinated care between the PCP and LCSW
- CHW to arrange for interpreter, establish routines of daily living with chronic conditions, and connect patient to resources and social services

NADIA'S STORY

Nadia is a new mother. Her husband works two jobs and she spends most of her time alone with Joseph, her son. Joseph often goes to the doctor due to his coughing.

Nadia's Needs

- A provider who can address her baby's frequent health issue
- Support for enhancing social interactions
- Assistance addressing housing quality issues
- Fewer days of missed work and fewer trips to the emergency room

Dr. Neil's Practice Solutions

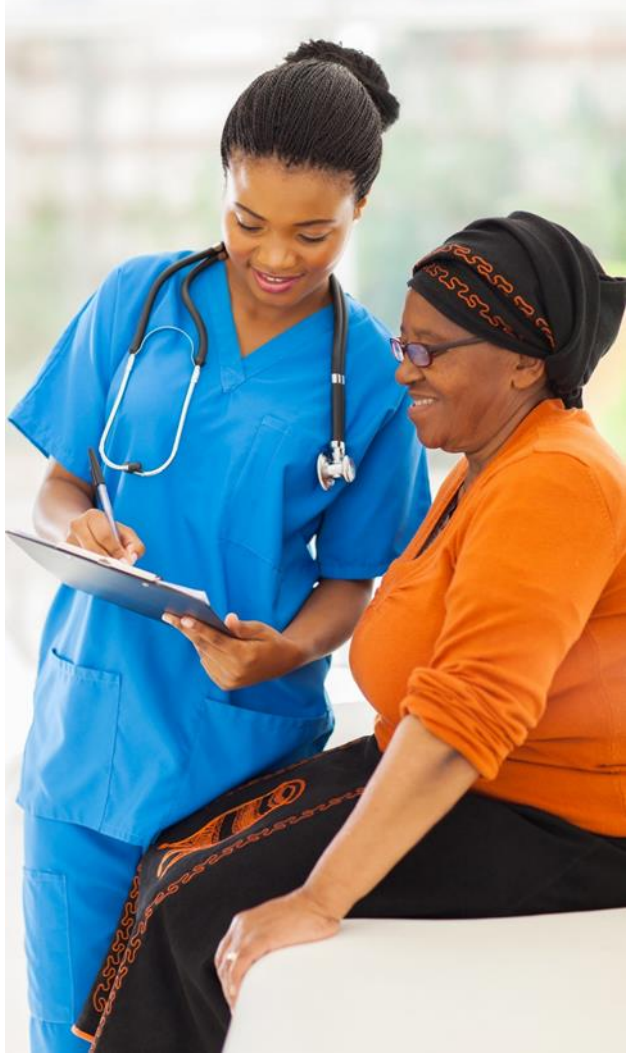
- Create care plan for ongoing health issue with PCP
- CHW to connect patient to:
  - Group visits for moms of newborns
  - Legal aid for housing quality issues
  - Other community based services
  - Transportation to medical visits
- Video check-ins with PCP and/or RN care manager

WHY DR. NEIL AND ABC HEALTHCARE NEED PCM

When ABC Health Partners began MSSP, it hired five community health workers. They immediately saved money. Patients loved the program. Then, ABC Health Partners abruptly ended the CHW pilot.

Why did ABC end the CHW pilot?

- After training and overhead, the five employees cost about $300,000.
- It estimated savings of $450,000 due to avoided ED visits, hospital stays and at least one skilled nursing facility stay. .
- ABC had to split those savings with Medicare, 50/50. Its gain of $150,000 became a loss of -$75,000. For ABC, there is no reward for incremental improvements in efficiency.
- Hiring CHWs highlighted other gaps too. ABC had insufficient data to identify high-needs patients; weak connections to community resources; and lacked certain care team members to address specific needs such as pharmacists to troubleshoot medication problems.
- ABC realized it needed advance funding across its payers to redesign its systems and maximize the shared investment.



THE CASE FOR ADVANCE FUNDING

Today, many care delivery investments are not made due to structure of some shared savings programs. With upfront investment, providers have greater incentive to transform care delivery and lower costs.

THE MATH TODAY

CHW Cost Paid by Provider	$300,000
CHW Savings	$450,000
Provider Share of Savings	$225,000
Provider Loss after Costs	$225,000 - $300,000 **- $75,000**

No Win

THE MATH WITH PCM

CHW Cost Paid with Advance Funding	$300,000
CHW Savings	$450,000
Savings Net of Investment	$150,000
Payer Share of Savings	**+$75,000**
Provider Share of Savings	**+$75,000**

Win-Win

UPFRONT PAYMENTS OFFER FLEXIBILITY

Clinical need and patient preference drives decision-making without the financial and administrative constraints of fee-for-service payments.

Embedded within **shared savings arrangement** that rewards management of total cost of care

Advance Payments to Support Primary Care

Basic Bundle
Time of primary care providers

+

Supplemental Bundle
Other investments to achieve the capabilities.

+

Fee for Service
Services not included in the bundle

UPFRONT PAYMENTS OFFER FLEXIBILITY

Clinical need and patient preference drives decision-making without the financial and administrative constraints of fee-for-service payments.

Embedded within **shared savings arrangement** that rewards management of total cost of care

Attribution

- Prospective
- Prioritize patient choice
- Not standardized across payers

Basic Bundle

Time of primary care providers

- Caring for patients
- Leading care teams
- Learning and peer support

Supplemental Bundle

Other investments to achieve the capabilities

- Care team staff
- Infrastructure and HIT
- Patient incentives
- Patient-specific expenses to address social needs

BASED ON

Historical cost of primary care services included in the bundle

% Primary care spend targets applied consistently across providers

ADJUSTED FOR

- Clinical risk
- Changes in services and use
- Unit cost trend

- Clinical risk
- Social risk
- Conditions with intensive management needs (e.g., dementia)

PAID TO

The same provider or tax ID number receiving today's fee for service payments

Advanced Networks and FQHCs participating in shared savings programs with Medicare and other payers

TRADE OFFS OF THE BASIC BUNDLE

The basic bundle would allow primary care teams to treat patients based on clinical need and patient preference without the constraints of fee-for-service. However, as CMS adds codes and fees for additional services, some wonder if this would be a preferable approach for all payers.

Benefits of Basic Bundle

- Maximum flexibility
- Lightened coding burden
- Option to reduce consumer cost share*

Benefits of Additional Codes and Fees

- Ease of administration for payers
- Certainty regarding services provided
- Familiarity and reliability for providers

Requirements of Both Approaches

- Documentation to ensure patient access and capabilities achieved
- Adaptation of billing systems
- Changes in culture and workflow to maximize effectiveness

** For commercial only*

CAPTURING DATA ON PRIMARY CARE ACCESS

Using a standardized format, practices would document all patient touches by all practice-associated personnel.

Access Tracking Report ABC Healthcare								
Practices included: Acton, Bridgefield, Essex, Marston and Overbrook								
Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).								
Attributed Patients		**Categories**						**Total**
Total Number of Patients Attributed		**PCP**	**Care Manager (RN, MSW)**	**Pharmacist**	**BH Clinician**	**CHW**	**Other (Navigator, Coach, Nutritionist)**	**All Clinical Encounters & Contacts**
RAW TOTALS	6,149	21,390	19,262	18,137	9,827	8,201	7,230	84,047
RAW AVERAGES (PER ENROLLEE PER YEAR)		3.48	3.13	2.95	1.60	1.33	1.18	13.67
RISK ADJUSTED AVERAGES		3.34	3.01	2.84	1.54	1.28	1.13	13.14

CAPTURING DATA ON PRIMARY CARE ACCESS

Types of encounters captured for all practice-associated personnel. This would provide greater insight into care delivery than available today.

Access Tracking Report
ABC Healthcare
April 1, 2018-March 31, 2019 (rolling 12 months)

Practices included: Acton, Bridgefield, Essex, Marston and Overbrook

Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).

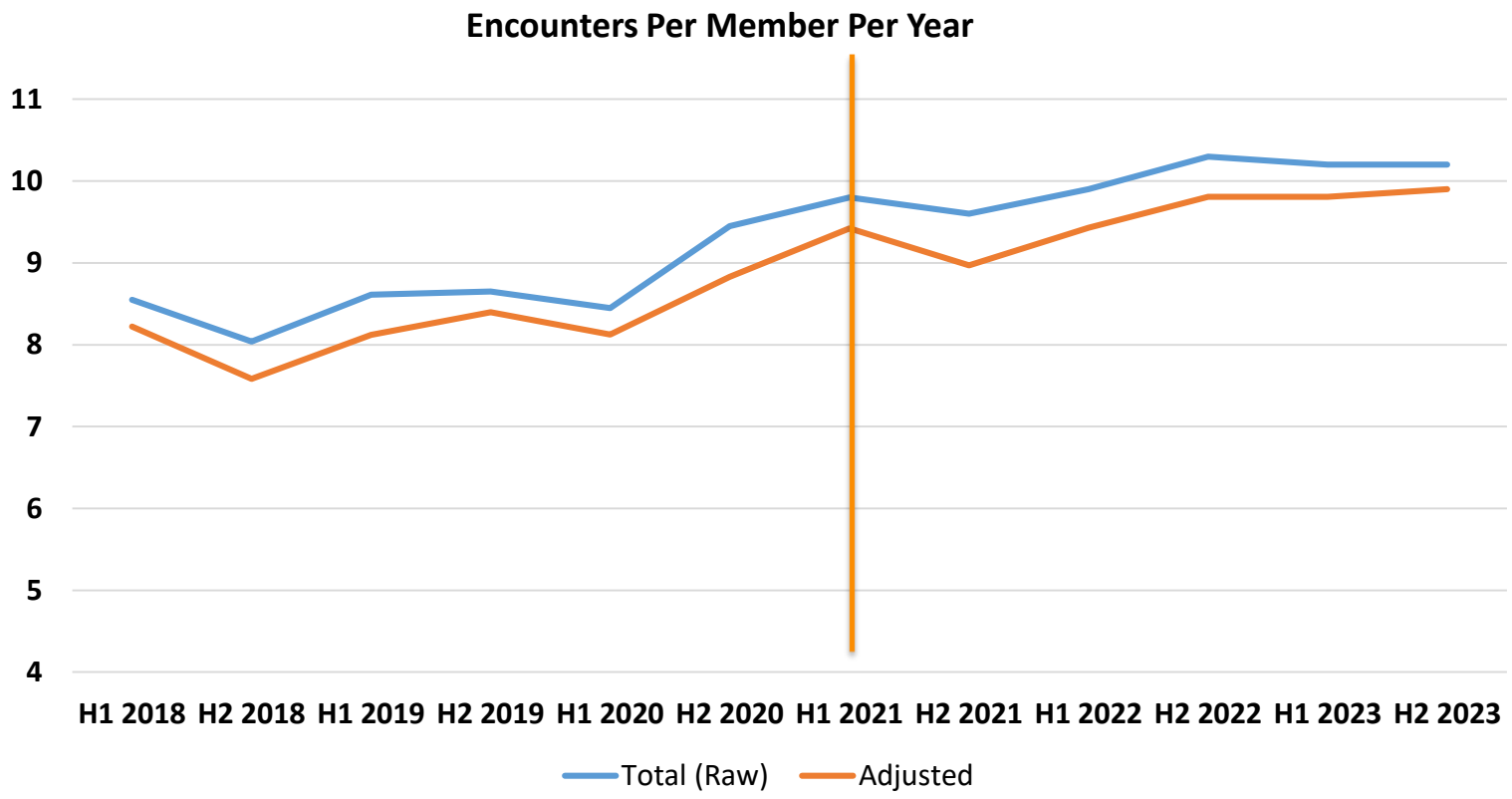
Attributed Patients		PCP				
Total Number of Patients Attributed		Office Visits	Telemedicine Visits	Home Visits	Phone/Text/E-mail contacts	Total Clinical Encounters
RAW TOTALS	6,149	7,230	2,987	1,172	10,001	21,390
RAW AVERAGES (PER ENROLLEE PER YEAR)		1.18	0.49	0.19	1.63	3.48
RISK ADJUSTED AVERAGES		1.13	0.47	0.18	1.56	3.34

GENERATING THE REPORT

- AN/FQHC configures EHR to capture all care team contacts, by patient and by type of contact
- PCP and care team personnel record their patient contacts in their daily work flow similar to other visit types
- AN/FQHC runs a quarterly summary report (de-identified) and uploads or transmits the report in a standard format to OHS and participating payers.
- Summary report includes contacts/patient by type of coverage (Medicare, Medicaid and commercial)

SHARING DATA ON PRIMARY CARE ACCESS

As part of program monitoring, the state could report both practice and system performance over time. As an example, the total encounters for one group might appear as shown below, with the vertical line representing the start of bundled payments.



TRANSFORM CARE ACROSS THE DELIVERY SYSTEM

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.

GOALS

BETTER ACCESS
- Convenience
- Timeliness
- Flexibility

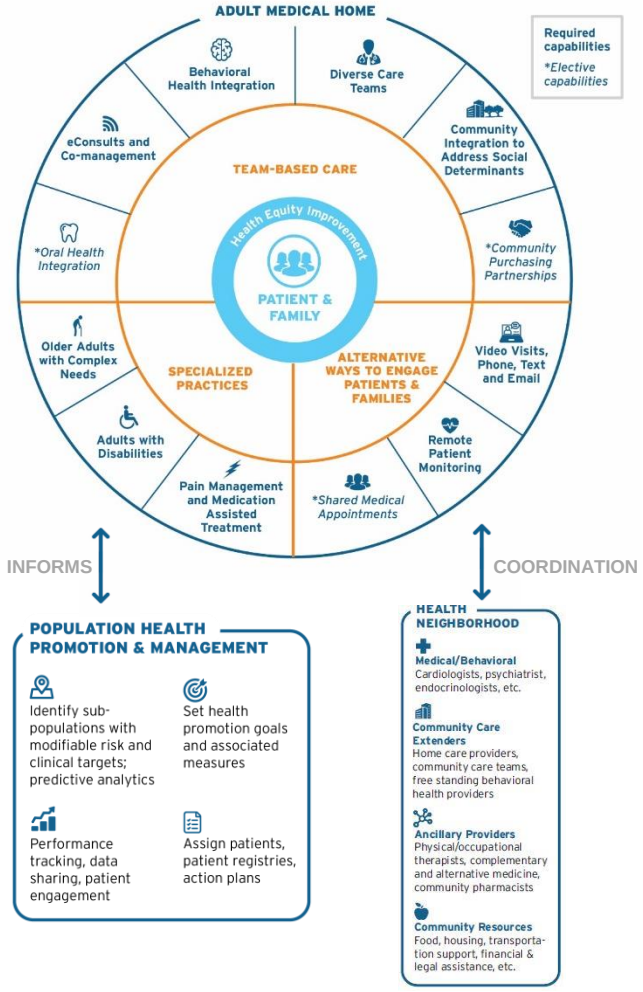
BETTER PATIENT EXPERIENCE
- Courteous and welcoming
- Listens and shares decision-making
- Advises and informs
- Coordinates and navigates

BETTER QUALITY
- Preventive care outcomes
- Chronic care outcomes
- Health equity

REVITALIZE PRIMARY CARE
- PCP and care team satisfaction
- Make primary care a more rewarding profession
- Incent incremental improvements in value

LOWER COST GROWTH
- Reduce cost growth
- Improve affordability for consumers

INPUTS



ENABLERS

BASIC BUNDLE
Advance payment for primary care provider time

SUPPLEMENTAL BUNDLE
Advance payment for primary care team staff and infrastructure

Shared savings program rewards total cost of care management

FLEXIBLE PAYMENTS

CONSUMER SAFEGAURDS
- Payments adjust for clinical and social risk
- Reporting demonstrates higher level of patient service and support

QUALITY MEASUREMENT
Quality and experience scorecard ties performance to shared savings rewards

ACCOUNTABILITY
"Proof of performance" required to qualify for supplemental payment increases

IMPACT

HEALTH OUTCOMES IMPROVE
- Improve diabetes and blood pressure in control rates
- Improve rates of preventive screening (colonoscopy)
- Reduce health inequities (e.g. race, ethnicity, income)
- Reduce percent of residents with risk factors (e.g. weight, tobacco use)
- Improve CAHPS scores
- Increase in physician satisfaction, recruitment and retention (PCPs per 100,000)
- Reduce ED costs by 20%; hospital costs by 10%; Medicare skilled nursing facility use by 16%;
- Reduce commercial outpatient hospital costs by 6%
- Reduce specialty care spend by 3.6% in commercial and 6% in Medicare

AFFORDABILITY IMPROVES
- 2% net reduction in total cost;
- 4.7% of Medicare, 4% commercial spend redeployed to primary care

QUESTIONS?

Adjourn