COMMUNITY HEALTH TEAMS
A Proposal for the SIM Steering Committee
4.12.2016

Defining the Role of a Community Health Team

Community health teams (CHTs) currently serve as extensions of primary care, helping patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs serve three critical functions:

1. Improving population health by addressing social, behavioral, and environmental needs.
2. Supporting providers in making the transition to value-based systems of care;
3. Transforming primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures; and

CHTs are also specifically focused on the following objectives:

- Help individuals engage consistently in primary care at times, in places, and for costs that are optimal;
- Promote more frequent or active engagement when necessary for the patient;
- Encourage increased use of electronic health records, patient portals, and other communication tools;
- Facilitate adoption of a patient-centric culture and assure continuity of care between providers;
- Access to appropriate community services and resources to address identified health needs;
- Help educate patients, families, or caregivers to improve health/healthcare literary; and
- Empower patients and caregivers to be active voices who advocate for their needs.

Composition of a Community Health Team

All CHTs employ community health workers who are non-licensed generalists serving as peer navigators, care coordinators, or resource specialists. Many teams also include a licensed behavioral health provider and nurse care manager who are considered health coaches. Some CHTs also have other health coaches, such as licensed professionals in pharmacy or nutrition, as well as healthcare professionals serving as clinical educators. CHTs also serve as an educator and resource to healthcare professionals by teaching healthcare workers about the benefits of: CHTS in general, patient-centered care, simultaneous treatment of behavioral and physical health needs, and on how addressing patients' social needs will aid in improving health.

Desired Future State

In order to maximize improvements in Rhode Island's population health, address and improve our social and environmental determinants of health, and make progress in eliminating health disparities within our state, CHTs services should be available to all Rhode Islanders who need that level of multi-disciplinary, community-based services to address the factors that impact our health. Critical to achieving these aims is the solidification of a patient-centered environment that is proven to increase quality and lower costs within our healthcare system. Central to creating this environment is continued investment in practice transformation, workforce development, and integration of care for physical and behavioral health. In 2014, a total of 73 adult practice sites and 433 providers were identified as participating in patient-centered practicing (e.g., such as patient-centered medical homes), providing access to this type of care for an estimated 300,000 Rhode Islanders (CTC-RI, 2014). In 2016, with the introduction of PCMH-Kids, 9 pediatric practices and a new total of 500 providers in 26 cities and towns are supporting patient-centered medical homes. The accessibility for pediatric patients is estimated between 30,000 and 50,000. In the long-term, it is imperative that all Rhode Islanders have access to this type of coordinated care.

Additionally, an estimated 910,000 Rhode Islanders do not currently have access to a CHT should they need these services in a crisis or at a difficult point within their lives. If each CHT were accessible to a catchment area with a total population of 50,000 individuals who might need services at some point, Rhode Island would need approximately 20 CHTs in total to ensure appropriate levels of coverage. This coverage ratio may also depend on criteria (to be defined) that individuals would have to meet to receive services, the true need, and the number of workers employed. CHT are currently working with a ratio of 1 to 50 patients who require a mix of low and high touch.

Existing Community Health Team Models in Rhode Island

Currently in Rhode Island, there are several different models for CHTs. Operating in various parts of the state, current CHTs each have a slightly different area of focus and model for operation. At this time, CHTs fall into one of the following categories:

- A patient-centered medical home practice extension within a specific geographic area (i.e., CTC);
- A general practice-based team (i.e., Thundermist);
- A payer-based team (i.e., NHP, UHC, Medicaid CHT-RI, and Cedar); or
- An accountable care organization-based team (i.e., currently in development).

The CTC and practice-based teams are accessible to an overall population of approximately 75,000 (attributed) Rhode Islanders and focus interventions on high-risk individuals as defined by health plan and practice criteria. Total population estimates for those who have access to NHP and UHC teams are not currently available, but are focused on high-risk individuals. The Medicaid CHT-RI and Cedar teams are accessible to approximately 14,000 Medicaid beneficiaries. These teams focus interventions on high-cost/rising-risk adults, and children/youth with special healthcare needs, respectively. Cedar is the only current team providing such services to children.

Estimation of Current Need

At this time, CHTs define criteria to identify a team's target population. Target populations vary by team but are referred to as those with "highest risk" In general, those who meet any of these criteria are considered "highest risk" by one or more teams:

- Individuals who have three or more known chronic conditions;
- Individuals who have two or more special healthcare needs (i.e., disabilities);
- Individuals who are not accessing primary care regularly;
- Individuals who are unable to access healthcare due to cost; and
- Individuals who have three or more in-patient or emergency department visits within six months.

While exact data that reflects these categories of individuals at "highest-risk" does not currently exist, estimates can be generated. Using data from the Rhode Island Behavioral Risk Factor Surveillance System (RI BRFSS) and HealthFacts RI, the following estimates were calculated:

- A total of 91,444 (11.0%) Rhode Island adults are estimated to have three or more of the following chronic conditions: hypertension, diabetes, CHD, COPD, arthritis, and asthma (RI BRFSS, 2013).
- A total of 76,480 (9.2%) Rhode Island adults have two or more disabilities as defined by five functional components/limitations (RI BRFSS, 2014).
- A total of 164,599 (19.8%) of Rhode Island adults have not visited a doctor for a routine check-up within 12 months (RI BRFSS, 2014).
- A total of 142,153 (17.1%) of Rhode Island adults are unable to access care, meaning see a provider or fill a prescription, due to high costs (RI BRFSS, 2014).
- A total of 16,097 (1.9%) of Rhode Island adults and children within HealthFacts RI have had three or more emergency department visits in a calendar year (HealthFacts RI, 2013; 2014)

While a certain percentage of individuals represented within each data point likely overlap in two or more categories, the likelihood that current teams can address the estimated need is low.

Implications for SIM Planning

Given the current estimated need for those at "highest-risk" and the even larger need for full community access, it is clear that SIM funding is limited in what can be addressed adequately. SIM planning will need to prioritize a portion of these needs. For planning purposes, SIM is proposing to invest the money allocated for CHTs to meet significant, unmet need as determined by our Integrated Population Health Plan (IPHP) and data from relevant state agencies. SIM's investment must also include an evaluation of the CHT we fund, to explore sustainability options and opportunities for expansion over time.

At this time, whichever team receives funding from SIM will be required to participate in a coordinated statewide approach to operation, management, and oversight of CHTs. This approach to a centralized yet collaborative provision of overarching infrastructure aims to maximize alignment with state policy and health reform goals, as well as reduce duplication of effort and operational costs. Within this framework, clinical oversight would appropriately remain at the community-level.

Initial Proposed Budget

As described in the Rhode Island SIM Test Grant proposal, the total investment for CHTs is two million dollars over the course of three years as part of Rhode Island's investment in the healthcare workforce. This funding was prioritized to create new CHTs, investigate the need for more formal community health worker certification, incorporate both community health workers and health coaches into all CHTs, and train providers on how to better incorporate CHTs in their practices. CHTs can be used to support providers in new population-based contracting methods where providers are accountable for their patients' total cost of care and where such contracts prioritize addressing population health and social determinants under these arrangements. To meet these needs, the following budget was proposed:

DESCRIPTION	TOTAL (3 YRS)	PROCUREMENT TIMELINE
CHT Initiative At-Large	**$2,000,000**	---
Focus 1: New CHTs	$1,000,000	June 2016
Focus 2: CHT Capacity	$1,000,000	June 2016

Because SIM dollars are limited, we understand that our investment over the next three years will only go so far toward our estimated need and desired future state. Therefore, we propose investing in infrastructure and enhancements for current CHTs and in the creation of one or two new CHT based on our known needs, IPHP priority areas, and SIM philosophy which have all been informed by stakeholder feedback. Making this type of investment will allow for support of the current CHT teams (e.g., those serving South County and Pawtucket) to continue concentrating on the high-risk populations while creating one or two new teams that would meet similar or new patient criteria. To meet these needs, we are proposing to create some flexibility in SIM's overall budget for CHTs to maximize potential impact:

Revamped Proposed Budget

DESCRIPTION	TOTAL (3 YRS)	PROCUREMENT TIMELINE
CHT Initiative At-Large	**$2,000,000**	---
Focus 1: New CHTs	$1,500,000 to 1,750,000	June 2016 (Yrs. 1-3)
Focus 2: CHT Capacity - Infrastructure and enhancements - Provider Education	$250,000 to $500,000	June 2016 (Yrs. 1-3)

This new budget provides a framework for expenditures related to the proposals located in the section below. These proposals lay out a set of decisions for the SIM Steering Committee to make based upon our conversations with leadership and community stakeholders. The general line of thinking is that two new teams are needed to start making a difference given our estimated need, which ultimately requires more money (appx. S300,000 per year per team is required). Additionally, it has been suggested that investing in some overarching, shared capabilities for all CHTs, including the new CHTs, would allow for cost savings over time, thus the second focus for investment. Perhaps each year a different shared capability (e.g., care management dashboards) may be of focus for capacity building. Third, provider education about available CHTs and benefits for use could be prioritized after Year 1, once new CHTs are established, reducing the need for funding.

SIM Steering Committee approval is requested to allow SIM staff the flexibility to pursue funding for two CHTs, based on the budget above.

Specific Proposal for SIM Investment

The first two sections are strawman proposals that reflect conversations that have happened in workgroups or other forums where we believe that there is some consensus. The third section explores ideas that have had less public conversation – where we believe we need more discussion to get to consensus. In general, SIM hopes that alignment with other projects, such as the Accountable Health Communities, might be able to help support CHTs where SIM cannot.

Enhancing Current Teams

SIM staff held a discussion with approximately 20 leaders of Rhode Island CHTs to determine what specific investments would work to build their capacity to serve more individuals and leverage additional care for Rhode Islanders at "highest-risk." Resulting from these discussions were four areas for investment:

- Centralized, statewide training and professional development—including promotion of community health worker (CHW) certification;
- Platforms for information sharing (e.g., care management dashboards and shared plans of care);
- Development, collection, and sharing of screening/other clinical tools for inter-team implementation; and
- Development and evaluation of a financial model for long-term sustainability.

SIM Steering Committee approval is requested to allow SIM to make funding decisions for current CHT activities that meet the spirit of these suggestions, and other related, creative ideas.

Creating a New Team, or New Teams

SIM is committed to funding one or two new CHTs to bring this model's benefits to more people, particularly those located in underserved areas or areas currently not served in the state. Additional emphasis may be placed on geographic locations where there is evidence that there is an increased need for these types of patient-centered services. SIM has many choices to make in terms of where it can invest dollars for the most benefit, and the following proposal reflects the workgroup meeting reference above, and conversations of the SIM Interagency

team. Here are the general guidelines we are proposing as a strawman for Steering Committee approval. In order to receive funding, a new CHT should meet the following guidelines:

- A new CHT should be multi-disciplinary and consist of both community health workers and health coaches;
    - CHWs are non-licensed generalists with a CHW certification (in the absence of certification, those currently acting as peer navigators/care coordinators/resource specialists are considered CHWs).
    - Health coaches are licensed healthcare professionals with community health focus and/or specialization who provide clinical education and input into clinical decisions related to care.
- The composition of the CHT and the disciplines participating in the teams should reflect the needs and diversity of the community being served;
- The CHT should be accessible to all individuals regardless of insurance (i.e., the CHT funded by SIM should not exclude anyone because of the insurance that they have or because they are uninsured); and
- The CHT should work directly in the home or the community to address factors that impact people's health, including social, behavioral, and environmental determinants of health.

SIM Steering Committee approval is requested to allow SIM to make funding decisions for new CHT activities that meet the spirit of these guidelines and other related principles.

Achieving Procurement Priorities

The following proposals reflect principles that have not yet had adequate discussion. At times, differing methods for ways to most effectively spend limited SIM dollars have been suggested. In general, two approaches have been discussed and considered for procurement. Here is a set of strawman proposals and questions for SIM Steering Committee consideration. The answers to these questions will guide the state's procurement process.

Proposed Model for How a New SIM-Funded CHT Will Connect with Clients

SIM has the money to fully fund one or two teams. We believe that funding a team that aligns with one of the current provider-based CHT models in the state allows us a better opportunity to evaluate the new team's effectiveness rather than trying to evaluate one team in a new model. The latter option's success might be replicable or it might be merely a fluke. Therefore, we are proposing that the new SIM-funded CHT be distinctly connected to a provider – either primary care or community mental healthcare for a population with SMI/SPMI.

We seek SIM Steering Committee approval for this proposal.

We also have additional questions for the implementation of this proposed model that we can address later.

a. How should the SIM-funded team address individuals with commercial insurance who are not connected to primary care/not attributed to a primary care practice but are using urgent care/hospital emergency departments. Would they be able to access this CHT? Do they need to if they can still access payer-based care and if so, would this require a universal triage model?
b. If patients are not distinctly connected with primary care, is there a way that a CHT could ensure continuity of care or long-term strategies for monitoring health? If they have a primary care physician then could they self-refer? How would the primary care practitioner be notified?

Proposed Targets for New Funding

Again, because we are only funding one to two teams, we propose to spend these dollars on focused interventions on "highest-risk" individuals. "Highest-risk" can be defined in myriad ways, but at a minimum should consider the general criteria listed as part of our estimate of need. Particular focus could be placed on an individual's utilization of healthcare services, chronic, complex, and uncontrolled conditions, untreated behavioral health needs, and specific neighborhoods disparately affected by poor social or environmental determinants of health.

We seek SIM Steering Committee approval for this proposal.

We also have additional questions for the implementation of this proposed model that we can address later.

a. There are a number of communities with large numbers of high-risk patients. Does the SIM Steering Committee want to suggest criteria for choosing among these areas?
b. Do any of these possibilities make sense and/or should be prioritized:
    i. Percent of high need residents, from either HealthFacts RI, BRFSS, or another source;
    ii. Some other demographic characteristics, such as age;
    iii. Localities without CHTs currently, or where a current CHT will not exist over the next three years; or
    iv. Some other criteria?

Looking Forward: Developing a Long-Term CHT Model and Strategy

While SIM investments focus predominantly on practice transformation to address population health needs, they also begin to explore addressing social, behavioral, and environmental determinants in a different way. The questions below are likely beyond the short-term strategy of one to two additional SIM-funded CHTs, however we have chosen to share these now because it would be instructive for the SIM Steering Committee to take them up over the next few months.

The following questions provide context for our SIM investments and as a part of the larger state vision for CHTs being led by RIDOH and other key partners:

a. Should CHTs be used as a prevention strategy? How do CHTs monitor a population's health? Does this require analogous build of infrastructure that has been invested in the primary care setting?
b. Is it reasonable to suggest that CHTs could be used to bring preventative resources to individuals and practices (i.e., smoking cessation, diabetes management, cancer navigation) to those of similar, "highest-need"?
c. High risk focus has greater potential to show shorter term return on investment, supporting the sustainability of CHTs. How could Rhode Island use that return on investment to serve people at mid-range risk?
d. If not CHTs—who invests in community prevention efforts that will transform our health system in the longer term?
e. Should alternate settings be considered as part of the overall CHT infrastructure, meaning urgent care, emergency medical services, and emergency departments? Is this duplicative, overly increasing burden, and feasible?
f. If so, could this be done similarly to how Peer Recovery Specialists are being used in emergency departments to connect with substance abusers at a crisis time and how HARP is connecting with children who have asthma through their ED visits?
g. Is now the time to expand to other chronic diseases and health conditions? Are we at a pivotal time for this type of engagement and empowerment?
h. How do we secure long-term investments or funding for current and expanded uses of CHTs? What makes the most sense? Reimbursement? Payment allocation? Other sources? Could a per member per month payment mechanism exist that would be embedded in the primary care practice (so money per patient in the practice) or a different level (like number of residents in a geographic area)?