CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Improving Population Health and Health Equity through CHT Program Design

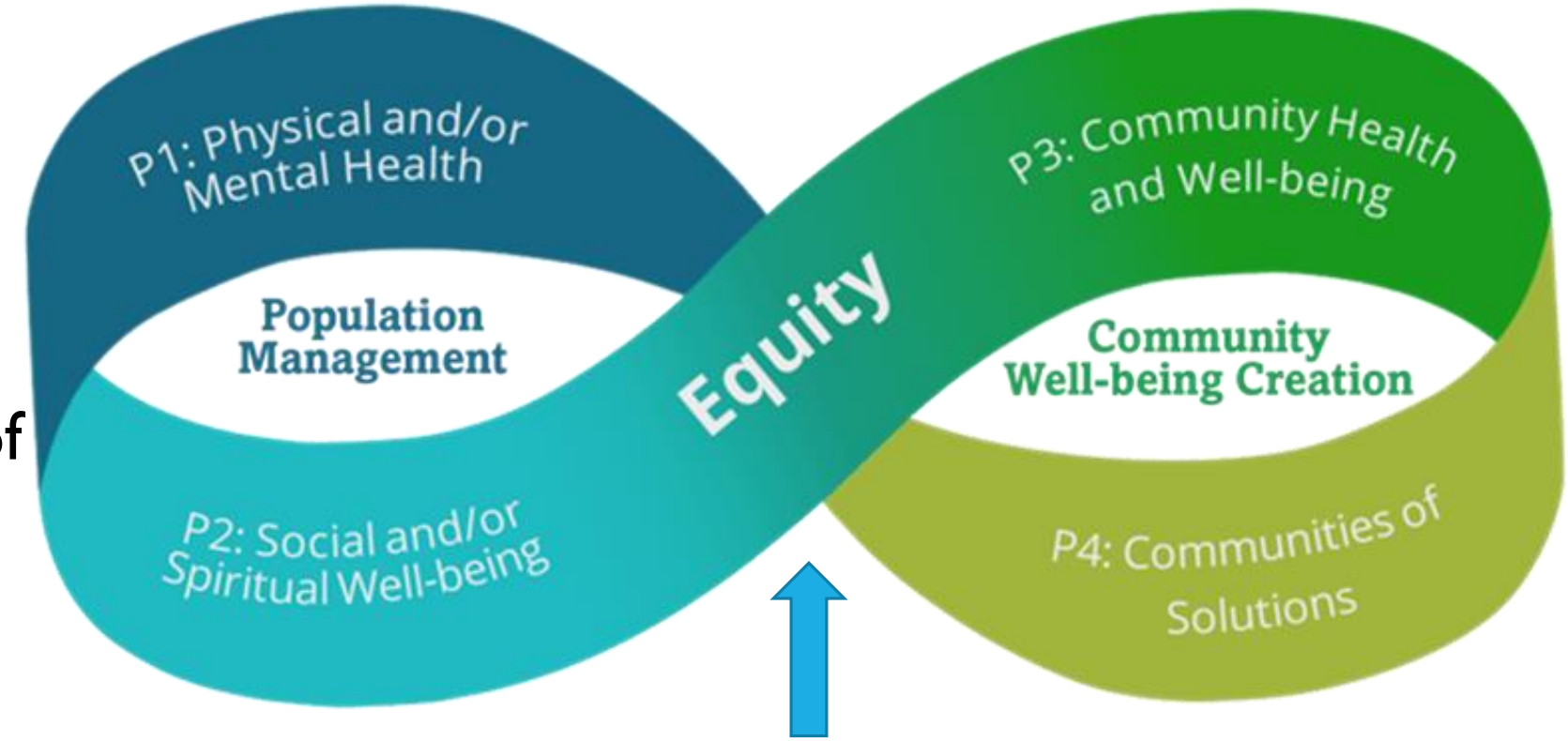
CLINICAL STRATEGY COMMITTEE

FEBRUARY 19, 2021

Four Portfolios of Population Health Action

PATHWAYS TO POPULATION HEALTH

Improving the health and wellbeing of **people**



Improving the health and wellbeing of **places**

Improving the systems that drive (in)equity

Source: Pathways to Population Health, 2018

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

Strong Community-Clinical Linkages Improve Primary Care and Health System Performance: Design Principles

- All Rhode Islanders need access to strong and vibrant comprehensive primary care that engages patients and families, promotes health equity, and contributes to community partnerships where their patients reside.
- Comprehensive primary care and health system transformation aligns with state and federal initiatives and must improve the health of patients, families, and communities.
- Improving health and health equity and strengthening community-clinical linkages requires an organized and data-driven approach to maximize efficiency and effectiveness.
- Sustaining a statewide CHT infrastructure will promote further connections and innovations between all relevant sectors.
- Rather than the payment model determining care delivery and population health, the required structures for successful care delivery design and improved population/community health should be supported by the payment model.

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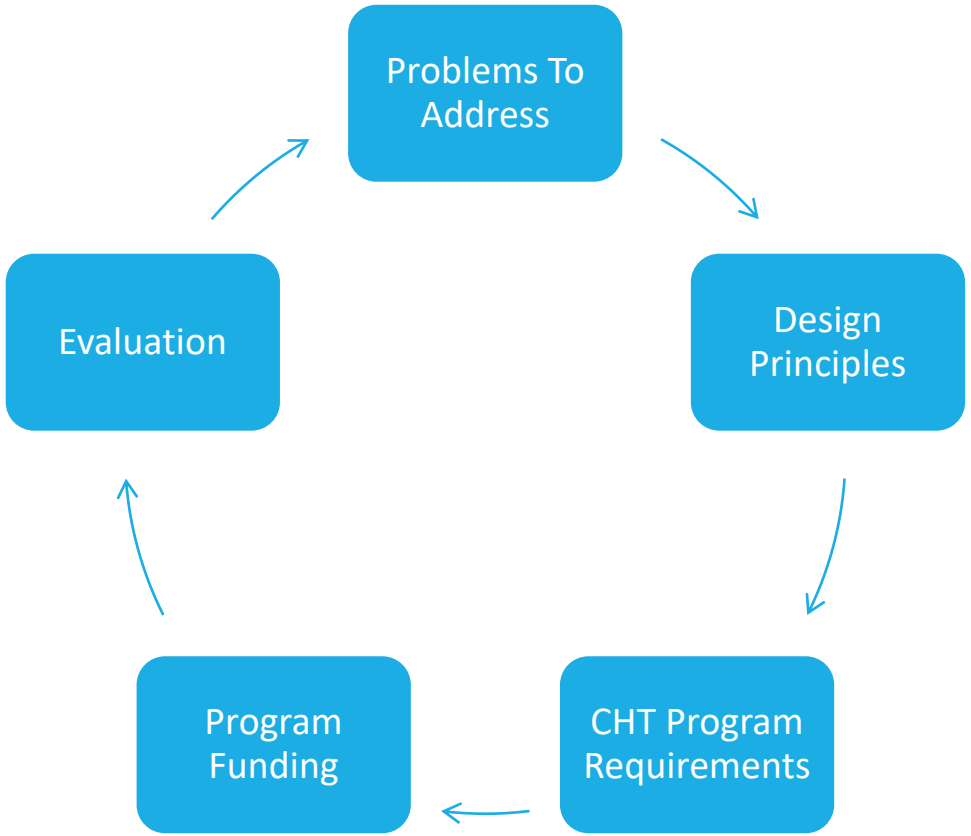
High-Level Overview of CHT Program Development



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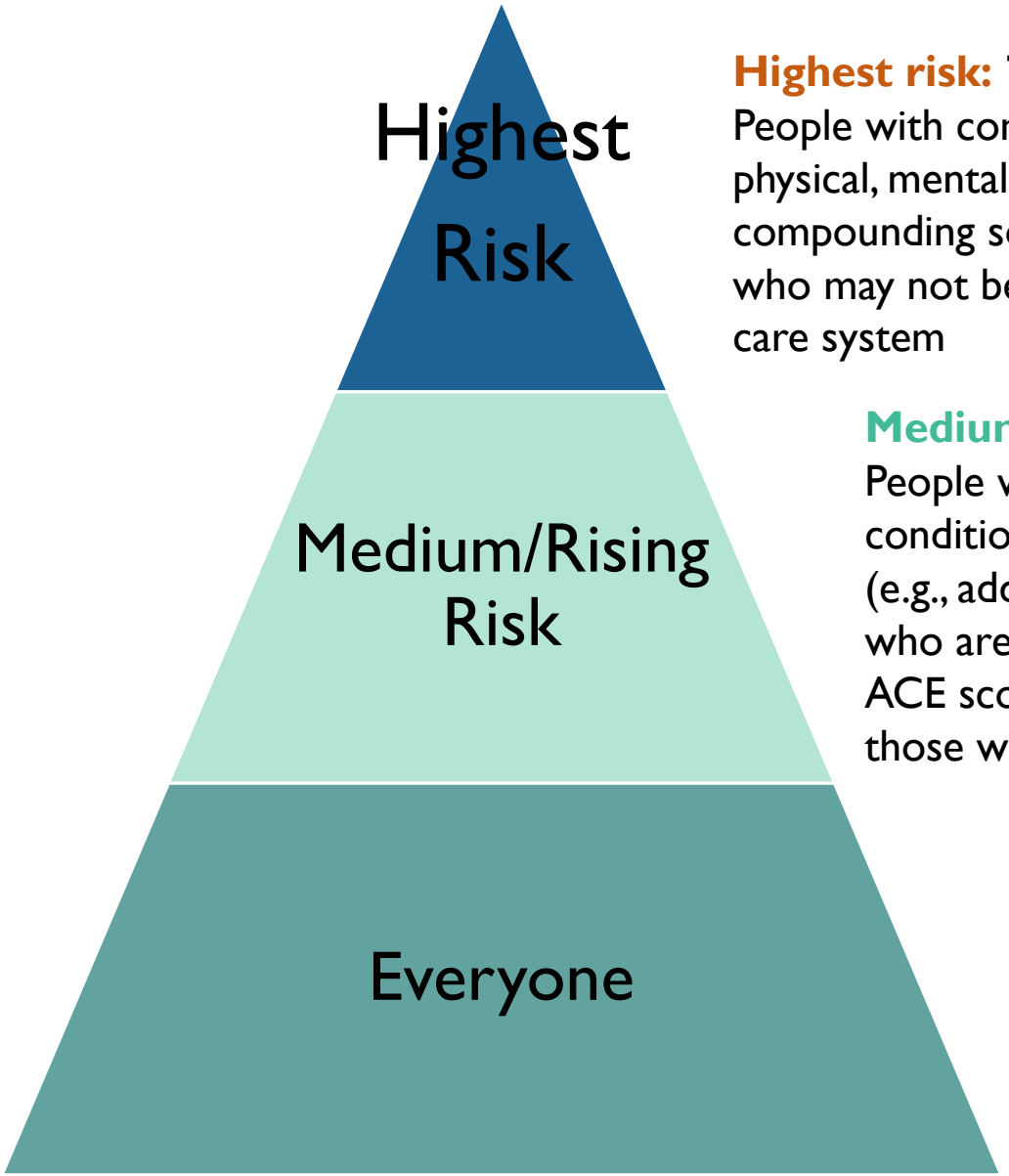

Who is in this group?

Highest risk: Top 5%
People with combined poorly controlled physical, mental health disorders with compounding social needs and equity gaps) who may not be well-connected to primary care system

Medium/Rising Risk:
People with controlled chronic medical conditions, complicating behavioral health (e.g., addiction) OR social/equity gap (people who are housing insecure, kids with high ACE scores, black mothers post-partum), those who are not connected to PC

Everyone:
People who would benefit from navigation for routine care and connection to social/equity needs (eg, immigrants who do not seek COVID testing or vaccination due to fear of public charge)

What is needed to support them?

Community Health Team:
- (CHW, nurse care manager, behavioral health specialist) working in the community in partnership with organizations across sectors).
- **Focus**: engagement and stabilization

Community Health Teams:
embedded in either CHTs or other primary care/AE based care management with ability to reach out into the community or in the community to address needs beyond PC. **Focus: health and life goals**

Navigators / Community Health Workers who can connect people in primary care and navigate people to routine health and social services
Focus: connection

Role of Community Health Teams

- As a primary engager and caregiver of people who are disconnected who are at highest and medium/rising risk
- As an extender and complement to primary care
- As a trusted intermediary between the health system and community
- As a resource for community multi-sector transformation

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Community Health Teams - Strengthening Primary Care & Community Linkages

*2021 CPC+ Implementation Guide
Comprehensive Primary Care Functions

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

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Are these the right design principles?

Community-Based Teams Design Principles to Inform Payment

- **Build Sufficient Capacity –** Assure adequate staffing to address prioritized risk groups within a community. Provide people with real access to services that can impact population health.
- **Embrace Regional Organization –** Local multi-stakeholder guidance to structure and manage team based on community needs and priorities. Community governance and the role of the CHT needs to include engagement with community governance.
- **Establish a Stable Foundation –** Invest in capacity with upfront financing that assures a stable foundation that providers and citizens can rely on. Allow trust relationships to mature.
- **Incentivize Whole Person Health –** Leverage a population-based form of payment (e.g. PMPM) that incentivizes delivery and coordination of more complete and effective services instead of volume (e.g. FFS.)
- **Share Costs – I**ncorporate multi-payer financing to support a whole population approach in each community and in primary care settings. Maintain focus on community, access through many doors, and avoid prioritizing business needs of an individual organization.
- **Invest in Capacity to Address Risks that Impact Health and Costs (ROI)** – Consider priorities and needs across all payers and risk tiers that have substantial impact on population health and avoidable expenditures (i.e. end of life care, poorly controlled co-morbidities, hidden but rising risk).