



CHW Sustainability Collaborative

Community Health Workers in Delivery and Payment Transformation: How New Delivery and Payment Models Can Incentivize and Support the Use of CHWs

Vermont's Blueprint for Health Program

Vermont's delivery and payment transformation program, known as the Blueprint for Health (Blueprint), is designed to improve population health, increase the quality of and access to care, and reduce health care costs.¹ Established through state legislation that also required participation from all payers, the Blueprint began as three pilot projects to test effective methods of chronic care delivery, and is now operating statewide, with most primary care practices participating in the program.^{2,3} The Blueprint has two key components: (1) patient-centered medical homes (PCMHs) that receive enhanced payments for meeting certain standards; and (2) community health teams (CHTs) that receive capitated payments for providing services essential to health, but often not addressed in medical care settings.⁴

Patient-Centered Medical Homes

Patient-centered medical homes are a model of health care delivery characterized by five core elements: comprehensive care, patient-centeredness, coordinated care, accessible services, and quality and safety.⁵ The PCMH model emphasizes whole-person treatment by a team of diverse providers who take into account patients' culture and values to address their physical and mental health needs. Medical homes coordinate care across the health care system to ensure continuity of care, and implement strategies to increase accessibility of services and medical information, such as using alternative communication methods, in addition to committing to quality and safety through

the use of clinical decision-support tools and other improvement activities.⁵

There are a number of existing recognition and accreditation programs for PCMHs, and practices participating in Vermont's Blueprint program are required to achieve and maintain accreditation from the National Committee for Quality Assurance (NCQA).¹ Participating practices continue to be paid on a fee-for-service basis, but also receive per-patient-per-month (PPPM) enhanced payments if they meet performance targets detailed in NCQA's standards.¹ Practices can use these enhanced payments to focus on comprehensive and coordinated care, which can be difficult to do under a traditional fee-for-service system. This focus on more comprehensive and coordinated care includes the use of a range of social, community, behavioral, and medical services to decrease unnecessary visits and improve communication across providers and the health care system to decrease nonessential or duplicative procedures.

Community Health Teams

In addition, the Blueprint established CHTs to serve as a support network for PCMHs and the people they serve. Community health teams provide services that help people better manage their health, including by addressing the social determinants of health. Examples of these services include brief mental health interventions, smoking cessation advice, nutrition counseling, and connecting people to community-based resources like housing, transportation, and substance abuse treatment.^{2,3}

Community health workers (CHWs) have a proven track record of improving health outcomes, reducing health care costs, and addressing health disparities. As trusted members of their communities, CHWs provide linkages to social and community-based services that address nonmedical factors affecting health, help consumers manage their chronic diseases, and break down barriers to care.

The current attention on implementing delivery and payment reforms to improve the quality of care and health outcomes while reducing costs creates an important opportunity for greater integration of CHWs into the health care system and for providing more sustainable financing for CHWs. Health system transformation initiatives implemented in Vermont and Oregon illustrate how the goals of such efforts can align with the value that CHWs provide and can incentivize CHW integration.

Community health teams play an important role in supporting and extending the work of the PCMHs. For example, the standards PCMHs must meet to receive enhanced payment include care management, medication management, and self-care support, and CHTs can help them do so by providing patients with services that align with these standards, such as:

- » Assessing and addressing barriers to health goals.
- » Developing and documenting patient self-management plans and goals.
- » Providing educational resources or referring to educational resources.⁴

The specific team members who make up CHTs is community driven. Local workgroups assess the gaps in health, social, and economic resources in a community and design CHTs to best address those gaps, with consideration of community demographics and the capacity of local partners.² Though CHTs generally include a care coordinator, chronic care coordinator, and behavioral specialist, they may also include social workers, health educators, community health workers (CHWs), dietitians, nutritionists, and other professionals.^{2,6} These teams receive a total payment of \$350,000 per 20,000 people,⁷ an amount paid by all commercial and public payers, with each payer's contribution dependent on the proportion of the people served by that CHT.¹

The Blueprint for Health Aligns with the Value Community Health Workers Can Provide

Given the desired community focus and design of CHTs, CHWs are a natural choice to be included as members of a CHT. Indeed, the purpose of CHTs is to help with services such as individual care coordination, health and wellness counseling, disease self-management, and providing links to social and community-based services, all of which CHWs are effective at providing.^{8,9} Further, the NCQA standards PCMHs must meet to receive enhanced payments include elements that align well with the type of support and services that CHWs provide effectively, and that also align with CHTs, as previously mentioned. In this way, CHWs can contribute to the high performance of PCMHs, and the value-based incentives they receive.

The CHT operating out of the Northeastern Vermont Regional Hospital (NVRH) in the St. Johnsbury Health Service Area (HSA) currently integrates six CHWs. These CHWs provide a variety of services, including:

- » Implementing health education classes on chronic disease and pain management and tobacco cessation.
- » Helping with care coordination and management.
- » Providing linkages to community services such as housing assistance and enrollment in the Supplemental Nutrition Assistance Program (food stamps).¹⁰

Although NVRH has used CHWs since 2002, before the Blueprint program began, this program has allowed them to increase the number of CHWs they employ to serve the St. Johnsbury HSA. When the Blueprint was taking shape and St. Johnsbury was selected as one of three sites to pilot the CHT model, there were only three CHWs, one of whom specialized in chronic disease care.³ Although funding from the Blueprint does not fully cover the costs of all six CHWs, it did provide enough support to allow NVRH to double its existing CHW workforce.

Evidence of CHWs' Effectiveness in Vermont's Blueprint for Health

The original Blueprint pilot in St. Johnsbury led to improved outcomes for both providers and consumers.³ Community health teams increased provider satisfaction by helping streamline practices and improve efficiency. Particularly, providers expressed that the CHT model allowed them to use their limited time with patients to deliver more comprehensive care and “less teaching.”³ Teams also helped providers connect patients with community-based services more immediately to mitigate or avert any crises.

Community health workers, specifically, helped improve people's ability to manage their health.³ After two encounters with CHWs, consumers reported increased self-sufficiency with health insurance, prescription drugs, housing, and health education. Further, consumers reported an increased attention to, and better self-management of, their overall health, including increased adherence to recommended treatment.

The Blueprint model has also led to short- and long-term health care cost reductions. The rate of growth in total expenditures was \$322 lower over an 8-year period for a Blueprint patient compared to a person not served by a Blueprint PCMH.² It is interesting to note, however, that there was one type of service that saw increased spending: Special Medicaid Services (SMS). These services target people's social, economic, and rehabilitative needs and offer a range of services that may include: transportation, case management, dental care, residential treatment, and school-based health care.² An increased use of SMS is not necessarily an indication of poor performance; rather, it is an example of “spending in the right places,”² as it may curb future specialized or acute care, which is often more costly. This means that the increased spending in this area may lead to long-term cost savings.

Oregon's Coordinated Care Organizations

In 2012, Oregon instituted a major delivery and payment transformation initiative in its Medicaid program. This model is built on coordinated care organizations (CCOs), which are networks of physical, behavioral, and oral health care providers who work collaboratively to improve health outcomes and reduce health care costs.¹¹ This initiative was approved through an 1115 Medicaid waiver and further supported through a State Innovation Model grant.^{12,13} There are currently 16 CCOs operating in the state, with each CCO using its own approach to improving health and controlling costs, a flexibility that allows it to

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test innovative models of care focused on prevention, chronic illness management, and patient-centered care.¹¹ Each CCO operates in a particular geographic area and is guided by a community advisory council that helps to assess and address the health needs of the CCO's Medicaid eligible population.¹²

Coordinated care organizations have a global budget, which means that they are paid a per-member-per-month amount that grows at a fixed rate to cover the cost of health care (physical, behavioral, and oral), and other operating costs.^{12,14} CCOs can also receive performance-based financial incentives based on how well they do on 17 quality measures that include addressing cigarette smoking prevalence, adequately controlling hypertension, and maintaining healthy levels of HbA1c for patients with diabetes.¹¹ To receive the maximum financial incentives, CCOs must achieve benchmarks or improvement targets on at least 12 of the 17 measures, and must have a minimum of 60 percent of their patients enrolled in a patient-centered primary care home (PCPCH).¹¹

The amount of performance-based financial incentives CCOs can receive is based on a proportion of their annual capitated payments. This amount is collected into a “quality pool” and then distributed to the CCOs who meet the benchmarks or improvement targets.¹¹ In 2017, 14 of 16 CCOs received 100 percent of their incentive award.¹¹ Any funds not distributed because of CCOs not meeting their performance targets are placed in a “challenge pool” and are distributed to CCOs that meet goals for three of the 17 performance

measures: depression screening and follow-up plan, developmental screening, and effective contraceptive use.¹¹ In contrast to a traditional fee-for-service system, where providers are paid based on the services they provide, the use of performance-based financial incentives helps hold CCOs accountable for providing quality care that improves health outcomes.

To help meet these performance targets, CCOs are encouraged to use their global budgets to provide an array of services that are health-related, but go beyond traditional clinical services.¹⁴ The use of these flexible services varies across CCOs, but some examples include providing blood pressure cuffs, gym or pool memberships, and temporary housing for patients. CCOs also support community-level initiatives, including cooking and parenting classes, abuse prevention, tobacco cessation, and education for pain and other disease management. Because CCOs can provide these flexible services, they can better address social factors that can lead to poorer health and higher health care costs.

Coordinated Care Organizations Align Well with the Value CHWs Can Provide

As CHWs are effective bridges between their communities, social services, and the health care system, they are well-equipped to deliver the health-related flexible services that CCOs can provide. Additionally, because of their trusted relationships with their communities and their ability to address social factors influencing a person's health, CHWs can also help improve health outcomes, which are also

included as performance targets in Oregon’s system transformation initiative. For example, there is ample evidence showing that CHWs help people living with diabetes improve their A1C levels and make other lifestyle changes that improve health,¹⁵ and they can help people with high blood pressure address barriers to their medication adherence.¹⁶

There is also legislative support for the use of CHWs in Oregon, where CHWs are categorized under the broader term of “traditional health workers (THWs),” along with peer wellness specialists, peer support specialists, doulas, and personal health navigators.¹⁷ In 2011, a THW subcommittee was created through legislation to develop criteria, descriptions, and education and training requirements for THWs so they could be used in the state’s health system transformation efforts.¹⁷ The scope of work for THWs that the subcommittee established includes: providing nutrition guidance, enhancing patient-provider communication, monitoring health needs and reinforcing treatment regimens, and identifying and resolving barriers to care. Subsequent legislation in 2012 required the use of THWs in care coordination.^{14,18}

Evidence of CHWs’ Effectiveness in Oregon’s Coordinated Care Organizations

Despite how CHWs can help CCOs meet their performance targets and the legislative support for CHWs, currently only six CCOs report using CHWs.^{19,20} Still, there are several examples of CCOs using CHWs to improve health, while also reducing costs. In particular,

the InterCommunity Health Network, a CCO operating on the western coast of the state, implemented two CHW programs, one in Benton County in 2016 and another in North Lincoln County in 2017.²¹ In Benton County, CHWs improved health by improving disease management for people with diabetes, and increasing enrollment in health insurance and medication assistance programs. Patients weren’t the only ones to benefit, either, as CHWs also increased provider satisfaction by ensuring patients made recommended visits with specialists and reducing physician workload overall. In North Lincoln County, integrating CHWs into PCPCHs and women’s health clinics decreased urgent care visits and missed appointments.²¹

Trillium Community Health Plan also piloted two CHW programs. The first pilot, which began in 2011 but continued after Oregon began its statewide CCO system transformation, embedded CHWs at a community mental health organization, and reduced emergency room (ER) visits from an average of 20 per person per year in 2011, to zero visits in 2013, producing significant savings.¹⁸ The second program, which began in 2015, was launched in partnership with a housing organization. This program also reduced ER visits by having CHWs help patients schedule appointments with primary care providers or other non-emergent providers, and accompanying them to their doctor’s visits.²²

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Lessons from Vermont and Oregon

Delivery and payment transformation efforts in Oregon and Vermont share similarities in how they have pursued improved health outcomes and reduced costs, and the approaches taken by each state are examples of how transformation efforts can help support and incentivize the use of CHWs. In particular, the states' focus on performance-based financial incentives that reward the quality of care and health outcomes, instead of the volume of care, can provide a financial incentive for providers and payers to invest in CHWs, as they can help them meet these performance targets. Although the two states used different sets of measures, both

states used measures that emphasized prevention, patient-centeredness, and the delivery of care by an integrated and coordinated team of providers.

Further, efforts in both states established mechanisms to incorporate local knowledge of the health needs of the communities being served, underscoring the importance of using a community lens in assessing, addressing, and improving health. This, too, is an added value of including CHWs—as trusted members of the communities they serve, they can help bring the strengths and concerns of their communities to health care and social service providers.

Vermont and Oregon are examples of how health care systems can benefit by investing in and integrating CHWs. As more states and private health systems look to implement new payment models that improve health and reduce costs, CHWs should be included as part of these efforts. Not only can they help meet these goals of system transformation, but they can play an important role in ensuring that reforms also help reduce health disparities and reflect the needs of local communities.

For more information about achieving sustainable integration of CHWs into the health system, visit Families USA's **Community Health Workers Collaborative Resource Hub** at <http://www.familiesusa.org>.

Endnotes

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