Systems for Action
National Coordinating Center
Systems and Services Research to Build a Culture of Health

colorado school of public health

The Impact of Global Budgets and Community Health Workers on Health, Health Equity and Cross-Sector Interconnectedness in Vermont

Strategies to Achieve Alignment, Collaboration, and Synergy Across Delivery and Financing Systems

Research-in-Progress Webinar
July 21, 2021
12-1pm ET

Agenda

Welcome: Carrington Lott, Program Manager at Systems for Action

Presenters: Adam Atherly, PhD, Eline van den Broek-Altenburg, PhD & Lisa W. Natkin, PhD

Commentary: Carrie Wulfman, MD

Q&A: Moderated by Carrington Lott, Program Manager at Systems for Action

Adam Atherly, PhD

An expert in health economics and the economics of aging and consumer decisions regarding health plan choice, Dr. Atherly holds a Ph.D. in health services research, policy and administration from the University of Minnesota, and an M.A. in economics from the University of Washington. He joined the Colorado School of Public Health as associate professor and founding chair of the Department of Health Systems, Management and Policy in 2009 and was promoted to full professor in 2016. Consistently funded since 2002 by such agencies as the Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, NIH, Centers for Medicare and Medicaid Services and the Robert Wood Johnson Foundation, Atherly's research targets health economics, with an emphasis on the economics of aging and consumer decisions regarding health plan choice. His research spans numerous methodological and topical areas, including healthcare spending and expenditure modeling, scale development and psychometric analysis, evaluation of efforts to improve quality of care and patient safety and cost-effectiveness analysis. He is the author of more than 70 journal articles and book chapters and has presented his work at more than 75 national professional meetings.

Eline van den Broek-Altenburg, PhD

Dr. van den Broek-Altenburg is an Assistant Professor with the Center for Health Services Research at the University of Vermont College of Medicine. She holds a Ph.D. in Health Services Research with a focus on Economics and Biostatistics from the University of Colorado, a MS degree in Health Services Research & Policy (2014) from Emory University and a MA degree in Political Science (2003) from Leiden University. Her research focuses on patient choice and modelling decisions in healthcare using advanced econometric models and machine learning. She is particularly interested in value-based healthcare from the patient perspective, consumer decisions in health insurance markets, and the effects of decisions and policy reforms on healthcare expenditures. Dr. van den Broek-Altenburg has extensive experience estimating healthcare spending and she has made contributions in further developing standardized quantitative measures to compare health systems and assess health system performance. In Vermont, she has a specific interest in evaluating the effects of recent payment reforms and analyzing patient decisions to predict demand for new health services in the value based context. With fifteen years of experience in health policy and health economics, her aim is to keep providing timely examples of health policy innovation.

In 2005, Dr. van den Broek-Altenburg founded a think tank in The Hague and served as its director until 2017, in charge of its research agenda and winning grants from public and private organizations. Between 2003 and 2012, she also worked as a health policy fellow with leading think tanks and research institutes in the U.S. and Europe; she has been a health policy adviser in the Dutch and European Parliaments; and she worked as an investigative journalist. Dr. van den Broek-Altenburg contributed to the public debate by publishing scholarly papers and op-eds, and she was frequently seen and heard in the media. In 2012, she went back to academia and has since won several awards and grants for her research, including Academy Health's Alice S. Hersh Scholarship which recognizes scholars with commitment to the field of health services research and potential to contribute to health policy.

Lisa W. Natkin, PhD

Lisa is currently part of the team working on the “Integrating Behavioral Health in Primary Care” project. This large pragmatic cluster-randomized control trial is exploring whether integrating behavioral health providers into primary care practices improves patient outcomes. Dr. Natkin is conducting qualitative research to explore the contextual factors supporting or impeding behavioral integration. She is reviewing documents, conducting interviews, visiting sites, analyzing data, and preparing manuscripts. Lisa completed her PhD in Educational Leadership and Policy Studies at the University of Vermont (UVM). Her published dissertation research explored student learning and teaching practices related to UVM’s new sustainability general education requirement.

Carrie Wulfman, MD

Carrie Wulfman grew up in rural Indiana and graduated from Earlham College and then Indiana Univ. School of Medicine. She completed a residency in Family Medicine at Geisinger Medical Center in 1994. After practicing in South Carolina for four years, she and her family decided to settle in Vermont.

Dr. Wulfman currently serves as Assoc. VP for the Community Practice, UVM HN Medical Group. Other roles include physician liaison between OneCare ACO and the UVMHN Medical Group and Interim Community Vice Chair for the newly-established Family Medicine Network Dept. Dr. Wulfman maintains a passion for clinical family medicine and continues to see patients two days per week at Brandon Primary Care where she has practiced for the last 23 years. Besides seeing her four children through to college graduation, Dr. Wulfman enjoys playing tennis, gardening, skiing, hiking, and raising various animal friends.

Our Team

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Faculty:

- Andrew Wilcock, PhD
- Eline van den Broek-Altenburg, PhD
- Sarah Nowak, PhD
- Jan Carney, MD
- Lisa Natkin, PhD

Staff:

- Chelsey Turley, BS
- Jamie Benson, BA

Partnering Organizations:

- OneCare Vermont – Dr. Norman Ward
- Dept. of Health – Dr. Mark Levine
- Blueprint for Health – Mary Kate Mohlman

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Project Purpose

The purpose of this project is to evaluate the effect of the combining

Global All-Payer Reimbursement

with

Community Health Teams

responsible for

Coordinating Care and Service Delivery

between the medical, social services and public health sectors on system alignment, health, access to healthcare and health equity.

Project Aims

- **Aim 1:** What is the impact of the alignment on formal system linkages between the health care sector and the social services and public health sectors in Vermont?

- **Aim 2:** How do CHTs set priorities for what social, public health and medical services to offer? What are the tradeoffs made between health, health equity and healthcare spending?

- **Aim 3:** What is the impact of Vermont's CHTs and global payment alignment on changes in health risk, health outcome, health equity and access to care?

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Vermont All-Payer Model

- All-Payer Model enables the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance – to pay an Accountable Care Organization (ACO) differently than through fee-for-service reimbursement
    - "Waiver" allows Medicare participation
    - Only 1 ACO -- OneCare
- Standardized population-based payment will predominate
    - Fee-for-service will continue
- Strong focus on socio-economic factors
- Integrated health system able to achieve the Triple Aim
    - –Improve patent experience of care – 70% voluntary enrollment
    - –Improve the health of populations – Reduce chronic illness, avoidable deaths
    - –Reduce per capita cost growth – 3.5% annually over 5 years

Community Health Teams I

- Statewide network of regional community health teams (CHTs).
  - Multi-disciplinary teams
  - Regionally headquartered in each service area's central hospital or federally-qualified health center
- Funded by Medicaid, Medicare, and commercial payer through the Vermont Blueprint for Health initiative ("Blueprint") since 2011
  - Additional capitated payments to additional provider types through the All-Payer ACO Model has created a fundamentally new environment

Community Health Teams II

- CHTs supported activities :
  - Patient-centered medical homes
  - Connect patients to community-based services.
  - Support learning collaboratives
  - Work with medical and community providers to align statewide initiatives with the region’s available resources and priorities
  - Improve quality of services for health and well-being.
- CHTs are relied upon to achieve the goals of the ACO and also the public health goals of Vermont.

Aim 2 Overview

- **RQ:** How do community health teams set priorities for what social, public health and medical services to offer?
- Understand tradeoffs made between health, health equity and healthcare spending
- **Step 1:** Identification of the contextual factors allows development of attributes for the Discrete Choice Analysis
- **Step 2:** Quantitatively estimate how CHTs make trade-offs in priority setting using a DCE / Mixed Logit Model

Step 1: Methods Overview

- *Question: What contextual factors influence Community Health Team Leader's decision-making process for resources allocation and service offerings?*
- Exploratory sequential mixed methods study
- Conducted interviews to identify key factors and processes in decision making and priority setting

- ***This is the focus of today's presentation***

Methods: Sampling Frame

- Community Health Teams (CHTs) are organized and funded by Health Service Areas (13 statewide)
    - Purposively selected Program Managers representing all 13 Health Service Areas
    - Program managers invited to include team members
- Conducted 1-hour semi-structured interviews
    - Interview done via zoom
    - Two UVM team members in each interview
    - Interviews conducted January-February 2021

Methods: Interview Question Topics & Structure

- Interview guide developed for semi-structured interviews
  - Developed in collaboration with partners and stakeholders
- Key targeted topics included:
  - Current service offerings
  - Decision making process
  - Use of data for decision making
  - Community partners

Methods: Qualitative Analysis

- Review of relevant background documents and Health Service Area (HSA) reports
- Interviews were recorded and transcribed for analysis
- Inductive coding: the list of codes (codebook) was developed by reviewing interview guide and transcripts
- Data was thematically analysis through progressive cycles of coding
    1. At the individual HSA level to identify region-specific contextual factors
    2. Across all regions to identify common themes
- Project team members and partners provided feedback on several iterations of emerging categorizations and themes

Results: Key Contextual Factors that Influence CHT Decision-Making

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Four Major Emergent Themes:

1. Blueprint's stable and flexible structure
2. Commitment to offering high quality care coordination
3. Use of data in program priority setting
4. Leveraging community partnerships and local resources

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Theme 1: Blueprint's Stable & Flexible Structure

- **Blueprint enables local teams to create own structure and services**
  - Each HSA organizational structure and funding arrangements are unique
  - Stability of the Blueprint funding supports staff salaries
  - CHT services are free to all patients
- **Investment in building team capacity**
  - Host trainings to build staff capacity and learn about best practices

*"The beauty of Blueprint is, it is **quite flexible in terms of how we deploy that funding and turn it into staff**. Their emphasis is at a community level, we are **responsive to the community needs**."*

*"I appreciate that we **provide non-billable services**. I think that offers our team flexibility. We r**espond to the needs of the patient**."*

Theme 1: Blueprint's Flexible Structure & Local Team Empowerment

- **Blueprint enables local teams to create own structure and services**
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*"I think that the Blueprint has been the bedrock. There was a **series of learning collaboratives that brought national experts to build capacities and understand best practices in care coordination**. It is being able to work from a grounding of research instead of what just feels good. There has been **a lot of latitude in how you develop who you hire for the staffing through the Blueprint and in the care coordination work.**"*

Theme 2: Commitment to Offering High-Quality Care Coordination

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- **Individualized care coordination for all patients**
  - Working with patients on what is most important to them
  - Providing free care coordination services to all patients
- **Access to supplemental funding for staff and programs**
  - Grants, community partners, primary care practice, and hospital funding supplement
  - Everyone doing care coordination working together as a cohesive team

*"**Engaging them with what they feel is most meaningful to them at that time**. We want to figure out what engages them. What they need in that moment so they can see the value to working with someone and **getting that support to navigate systems.** We can help patients take these next steps of what the provider is asking them to do and really support them getting the resources they need to make that happen."*

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Theme 2: Commitment to Offering High-Quality Care Coordination

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*"The physician that is in the Emergency Department is a **shared position between our FQHC and the hospital.** That position came out of a **community conversation about needing more support** for folks that come to the ED. Maybe patients are really there for social needs or they need support in getting connected to follow-up care. We have positions that were **a decision from the community and responsive to a community need.** That is certainly emphasized in our Blueprint contract."*

Theme 3: Use of Data in Program Priority Setting

- **Needs of the community and patients**
  - CHT assessment of community and patient needs
  - Formal Community Needs Assessment
- **Data driven decision making**
  - Some teams create data reporting systems and dashboards to track progress and inform strategic planning.

*"I was looking at the **Youth Risk Behavior Survey and resiliency was identified as one of the priorities**. The Health Department and our designated agency, came together to spearhead the Okay Resiliency Campaign. Different community partners started getting involved to identify different tools to help parents support resiliency in the household. During the past two years, there has been **a network of volunteers that have helped create a curriculum for parents and in schools**."*

Theme 3: Use of Data in Program Priority Setting

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*"Previously, **we used the Blueprint profiles**. We shared those with the practices. But those profiles have since been retired. That definitely presented this vulnerability for our team, so my team just recently **created this Blueprint Data Brief, where we pulled out our most important information that would attest to the work that we are doing.** We are still refining those measures that we chose because we want it to be reproducible data every month."*

Theme 4: Leveraging Community Partnerships & Local Resources

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- **Strength of community network**
  - Community collaboratives are important networking vehicles for cultivating partnerships and exchanging information
  - Strength of network varies
- **Availability of local resources and services**
  - Each HSA has a unique make up of staff credentials and FTE based on local needs and other service offerings
  - Each community has different availability of resources that influence their resource allocations

*"It is important for us to also have **a strong infrastructure and Community Health network**. In recognizing that we have limited finances, we **try to maximize the resources of the community working together**. We recognize the strengths of own community partners and have an infrastructure so that we have access to them."*

*"The leaders are at the table who have all decided to **commit to working together in our region to improve health**."*

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Theme 4: Leveraging Community Partnerships & Local Resources

- **Strength of community network**
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- **Availability of local resources and services**
  - Each HSA has a unique make up of staff credentials and FTE based on local needs and other service offerings
  - Each community has different availability of resources that influence their resource allocations

*"**We have no homeless shelter. We have a gap in that area compared to the rest of the state.** Obviously, there are risk factors for people that our care team works with. We have nurses that are highly trained not working to the top of their license because they are **making ride arrangements or filling out their housing application.** It is a crazy use of time for a nurse, but that is the best that we can do with the staffing we have."*

Covid-19 Pandemic's Influence on CHTs

- Covid shifted priorities and roles for CHT workers
- Leveraged existing community partner relationship to support local pandemic response
- Virtual self-management programs and telehealth services have increased access
- Covid has the potential to impact service offerings for the long term

*"The **severity of what is being seen in pediatrics with the pediatric social worker is extremely disturbing**. I am concerned about the **far-reaching implications** of this, especially on our pediatric population. The intensity of referrals, whether it's non-accidental injury, neglect, trauma, exposure, I think we're just seeing a lot more of that. I can not help but **think what this work is going to be look like 5 years from now or 10 year when these kiddos are adults**."*

Conclusions

- Flexibility of Blueprint funding and their empowerment of local teams enables the teams to provide care coordination to all patients and be responsive to community needs
- Blueprint and CHT leaders invest in building their team capacities and work to increase coordination and communication
- Teams consult data available to set priorities and make decisions
- Teams cultivate and leverage community partners to increase their capacity and program offerings

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Global Alignment and CHTs

- Disconnection between Blueprint and OneCare's priorities:
  - OneCare is only for attributed lives
  - OneCare focus on medically high-risk patients vs Blueprint SDH
- OneCare has requirements for care coordination (flexibility)
  - Licensure
  - Working with practices / hospitals
- OneCare funding is after care coordination is documented
  - New Navigator System
  - Through practices / hospitals

"The **bulk of the ACO work falls on the Community Health Team**, which is a new thing. The Care Navigator, which is OneCare's care management platform, is great but it is **essentially double documentation.** There are some expectations around how many touches you have with the high and very high-risk ACO attributed lives. **It is all layered on top of what we were already doing with the same number of FTE's.** We are trying to figure out over time if payments from **OneCare are consistent enough to support additional positions down the road**."

Lessons for the Discrete Choice Experiment

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- Goal: Identify the key attributes used by CHTs in setting priorities
- Preliminary results suggest key attributes:
  - Input from team
  - Priorities from:
    - Community partners
    - Blueprint
    - OneCare
  - Funding Opportunities
  - Availability of appropriate staff
  - Community Resources
  - Availability of data

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Discussion: 4 Major Themes

- Blueprint's stable and flexible structure
  - Blueprint enables local teams to create own structure and services
  - Investment in building team capacity
- Commitment to offering high quality care coordination
  - Individualized care coordination for all patients
  - Access to supplemental funding for staff and programs
- Use of data in program priority setting
  - Needs of the community and patients
  - Data driven decision making
- Leveraging community partnerships and local resources
  - Strength of community network
  - Availability of local resources and services

Commentary

Acknowledgements

Systems for Action is a National Program Office of the Robert Wood Johnson Foundation and a collaborative effort of the Colorado School of Public Health, Health Systems, Management & Policy Department in Aurora, Colorado.

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