Innovative Community Health Worker Strategies:

My Health GPS in Washington, DC, Seeks to Achieve Sustainable Funding and Whole-Person Care

Tina Kartika

Due to mounting evidence that community health workers (CHWs) can improve health outcomes, increase access to health care, and control medical costs,[1] states are increasingly engaging their CHW workforce to replicate those successes at the state level. However, the policies and programs that regulate and pay for CHWs differ dramatically across states,[2] and states facing difficulties advancing CHW initiatives can gain insights from the experiences of other programs across the country.

The National Academy for State Health Policy (NASHP) recently updated its State Community Health Worker Models Map and is currently identifying innovative state strategies that have helped CHW initiatives meet their goals. This case study, which explores My Health GPS in Washington, DC, is the first in a series of NASHP products that highlight those CHW program strategies.

What's innovative about My Health GPS?

- Launched July 1, 2017, My Health GPS is Washington, DC's health home program that coordinates whole-person care for Medicaid beneficiaries with three or more chronic conditions.
- It permits peer navigators to serve on the My Health GPS care teams.
- My Health GPS specifies a minimum staffing ratio of peer navigators based on the severity of beneficiaries' conditions.

My Health GPS Program Overview

Under Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act), states have the option to submit a state plan amendment to create health homes that coordinate whole-person care for Medicaid enrollees with multiple chronic conditions.[3] My Health GPS is DC's health home[4] program designed to "address unmet care management needs" of beneficiaries with three or more qualifying chronic conditions.[5] Eligible conditions include, but are not limited to, asthma, diabetes, chronic renal failure, HIV/AIDS, depression, and substance use disorder.[6] Because the program's members are sicker than the average beneficiary, the program's goals are to improve health outcomes through whole-person care and reduce avoidable hospital and emergency department (ED) utilization. Participation in My Health GPS is voluntary; beneficiaries can opt-out of the program.[7] After the first three months, more than 2,500 beneficiaries had enrolled.

To deliver patient-centered care, multidisciplinary teams integrate and coordinate primary, acute, behavioral health, and long-term services and supports for beneficiaries participating in My Health GPS.[8] The teams of providers—which may include health home directors, nurse care managers, peer navigators (DC uses the terms "peer navigator" and "community health worker" interchangeably), care coordinators, and licensed clinical pharmacists—are categorized into two acuity groups based on the severity of their beneficiaries' conditions. Approximately 80 percent of beneficiaries will be in the lower acuity group (Group 1) and 20 percent of beneficiaries in the higher acuity group (Group 2).[9]

State Plan Amendment approval date: February 6, 2017
Program start date: July 1, 2017

Community Health Workers in My Health GPS

Each care team includes peer navigator(s) regardless of its acuity group. The program defines a peer navigator as:

- A health educator capable of linking beneficiaries with the health and social services they need to achieve wellness;
- Someone who has completed at least 40 hours of training in; or
- Someone with at least six months of experience in community health.[10]

The only other state that requires CHWs to be part of health home care teams is Michigan. In Maine, Missouri, New York, Washington, and West Virginia, CHWs are optional members of health home care teams.

My Health GPS also has a minimum staffing ratio for each type of provider in the program. The program requires at least one full-time peer navigator for every 400 beneficiaries in Group 1, and the equivalent of 3.5 full-time peer navigators per 400 beneficiaries in Group 2.[11]

Reimbursement Model

Per-member, per-month (PMPM) reimbursement for My Health GPS requires that a beneficiary receives at least one My Health GPS service within that calendar month. Providers in Group 1 receive $46 PMPM while Group 2 providers receive $137 PMPM.[12] Starting in fiscal year 2019, My Health GPS will operate on a pay-for-performance model. Providers will be reimbursed for meeting readmissions, preventable hospitalizations, and avoidable ED utilization metrics.[13]

Takeaways

While the program is in its infancy, My Health GPS provides an organizational and funding model for states seeking sustainable CHW programs. States can follow the implementation of DC's program as they consider whether to incorporate CHWs into their health homes and to establish a minimum staffing ratio for their CHWs.

Endnotes

1. Sarah Redding et al., "Pathways Community Care Coordination in Low Birth Weight Prevention," Maternal and Child Health Journal 19, no. 3 (2015): 643–650. http://doi.org/10.1007/s10995-014-1554-4.
   Shreya Kangovi et al., "Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial," *JAMA Internal Medicine* 174, no. 4 (2014):535-543, http://doi.org/ 10.1001/jamainternmed.2013.14327.
   Donald Fedder et al., "The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension," Ethnicity & Disease 13, no. 1 (2003):22-7, http://doi.org/10.1089/heq.2017.0001.
2. While many states adopt or modify the American Public Health Association's definition of CHWs, some states use other definitions. For the purposes of this series, NASHP follows states' definitions. Please visit https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities for APHA's definition.
3. "Health Homes," Medicaid.gov, accessed October 13, 2017, https://www.medicaid.gov/medicaid/ltss/health-homes/index.html
4. For more information on health home programs in different states, please visit http://nashp.org/state-delivery-system-payment-reform-map/
5. My Health GPS is DC's second health home program. DC's first health home program focuses on individuals with Serious Mental Illness (SMI). See also https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/16854.
6. 1. Asthma/COPD
   2. Body Mass Index > than thirty-five (35)
   3. Cerebrovascular disease
   4. Chronic renal failure, indicated by dialysis treatment
   5. Diabetes
   6. Cardiac dysrhythmias

7. Congestive heart failure
8. Myocardial infarction
9. Pulmonary heart disease
10. Hepatitis
11. Human Immunodeficiency Virus
12. Hyperlipidemia
13. Hypertension
14. Malignancies
15. Depression
16. Behavior disorders
17. Personality disorders
18. Paralysis
19. Peripheral atherosclerosis
20. Sickle cell anemia
21. Substance use disorder.

7. Government of the District of Columbia Department of Health Care Finance, My Health GPS *Provider Manual*, July 1, 2017, accessed September 29, 2017, https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/My%20Health%20GPS%20Provider%20Manual_FINAL.pdf.
8. "Health Home for Persons with Multiple Chronic Conditions - My Health GPS," District of Columbia Department of Health Care Finance, accessed October 13, 2017, https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps.
9. My Health GPS *Provider Manual*
10. Ibid.
11. Ibid.
12. "My Health GPS (Health Home 2) Policy Framework," DC State Innovation Model, February 2017, https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Curated%20Slide%20Deck_2017.pptx
13. "Policy Framework." For a full list of pay-for-performance measures, please refer to p. 18-19 of My Health GPS *Provider Manual*.

Acknowledgement:
Any information not cited in this case study was kindly provided by Joe Weissfeld, Project Manager of Health Care Reform and Innovation Administration at the District of Columbia Department of Health Care Finance. The author thanks Mr. Weissfeld, Jill Rosenthal, and Amy Clary for their helpful comments and contribution to this case study. This case study was made possible with funding from the National Center for Healthy Housing, supported through a grant from the W.K. Kellogg Foundation. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the National Center for Healthy Housing or the W.K. Kellogg Foundation.

About the National Academy for State Health Policy:
The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.