NATIONAL ACADEMY
for STATE HEALTH POLICY®

Strategies for Supporting Expanded Roles for Non-Clinicians on Primary Care Teams

Katharine E. Witgert, Sarah Kinsler,
Jennifer Dolatshahi, Catherine Hess

October 2014

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and non-partisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues.

To accomplish our mission we:

- Convene state leaders to solve problems and share solutions
- Conduct policy analyses and research
- Disseminate information on state policies and programs
- Provide technical assistance to states

The responsibility for health care and health care policy does not reside in a single state agency or department. At NASHP, we provide a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.

We work across a broad range of health policy topics including:

- Affordable Care Act and State Health Care Reform
- Coverage and Access
- Medicaid
- Quality, Cost, and Health System Performance
- Long Term and Chronic Care
- Quality and Patient Safety
- Population and Public Health
- Insurance Coverage and Cost Containment

Our strengths and capabilities include:

- Active participation by a large number of volunteer state officials
- Developing consensus reports through active involvement in discussions among people with disparate political views
- Planning and executing large and small conferences and meetings with substantial user input in defining the agenda
- Distilling the literature in language useable and useful for practitioners
- Identifying and describing emerging and promising practices
- Developing leadership capacity within states by enabling communication within and across states

For more information about NASHP and its work, visit www.nashp.org

Portland, Maine Office:
10 Free Street, 2nd Floor
Portland, ME 04101
Phone: [207] 874-6524

Washington, DC Office:
1233 20th Street, NW, Suite 303
Washington, DC 20036
Phone: [202] 903-0101

Follow us @nashphealth on Twitter

Table of Contents

Acknowledgements

The authors would like to thank the Medicaid officials, health center leaders, and training program directors who participated in interviews, shared information about their programs, and reviewed this paper: Michelle Aldrich, Joell Archibald, Denise Chukovich, Chris DeMars, Arthur Garson, Jr., Melanie Giese, Meg Hall, Monica Hammer, Luz Jimenez, Lisa Letourneau, Audrey Lum, Megan Old, Prathiba Pinnamaneni, David Simnitt, Wendy Sturn, and Julie Weinberg. In addition, the authors acknowledge the thoughtful reviews of Lisel Blash and Catherine Dower at the UCSF Center for the Health Professions; NASHP Academy members Nancy Atkins, Katie Dunn, and Maryanne Lindeblad; and Mary Takach at NASHP. We appreciate the assistance of Chiara Corso at NASHP. Finally, we thank our HRSA project officer, Lynnette Araki and her HRSA colleagues for their review and helpful comments. This paper was funded by a cooperative agreement with the Health Resources and Services Administration (HRSA grant number UD3OA22891).

Executive Summary

Many factors catalyze the current trend toward primary care teams: payers' demands for more integrated care and the varied skills such care requires; the complexity of today's health care environment; the cost-effectiveness of using non-physician practitioners for some care; as well as insufficient numbers of primary care physicians in many areas of the country. Delivery system and payment reforms that encourage integrated and patient-centered care also rely on team-based care. In addition to clinicians, primary care teams can include non-clinicians who provide services during a patient visit or in between patient visits with clinicians. These individuals may include medical assistants, health coaches, health educators, care coordinators, patient advocates, peer counselors, community health workers or others who engage with patients and can complement the skills of clinicians.

Evidence from various primary care settings demonstrates the benefits of care teams that include non-clinicians with expanded roles. They can:

- Improve the efficiency of the care team;
- Improve patient care and patient experience;
- Increase job satisfaction for all team members; and
- Extend patient care beyond the clinical visit.

Developing sustainable primary care teams that include non-clinicians requires both a financing mechanism to support their services, and training that both teaches specific skills and facilitates non-clinicians' integration with the rest of the care team. Despite historical challenges, Medicaid payment for services provided by non-clinicians is feasible when properly structured. This paper outlines strategies for and provides examples of Medicaid financing of non-clinician services in fee-for-service, managed care, medical home or health home, and accountable care organization (ACO) settings. The paper also describes different training curricula and methods to help non-clinicians develop new skills as part of a care team and describes the accompanying workflow redesign required for teams to function effectively. The paper suggests strategies for training non-clinicians to improve practice efficiency, manage patients' specific health conditions, and work effectively in a patient-centered medical home.

In today's evolving health care delivery system and payment environment, primary care practices and state Medicaid programs can each play a part in supporting expanded roles for non-clinicians on primary care teams. Primary care practices and Medicaid programs can take advantage of a Medicaid rule change allowing fee-for-service reimbursement of unlicensed practitioners for covered preventive services recommended by a physician or other licensed practitioner.[1] State Medicaid programs that are interested in supporting expanded roles for non-clinicians can help practices understand existing payment options and explore potential new strategies. State Medicaid agencies can review and revise managed care contracting standards to remove barriers and facilitate use of non-clinicians. Medicaid Directors who are interested in supporting expanded roles for non-clinicians on primary care teams can also consider demonstrations, waivers, and State Plan Amendment options that provide the flexible funding that can support expanded roles for non-clinicians as part of broader delivery system transformations. In parallel, states can build training and practice transformation support to help establish and foster team-based care into payment and delivery system reform initiatives, such as patient-centered medical homes, ACOs, or others.

There is strong evidence that team-based primary care has significant benefits for patients and providers, and the appropriate use of non-clinicians as part of a primary care team has the potential to extend the

team's strengths. Non-clinicians can take on expanded roles that include patient engagement and advocacy, health education, and care management. States and practices across the country are already incorporating non-clinicians into primary care teams, and there are opportunities to expand and enhance their integration by taking advantage of flexibilities afforded by health care delivery systems and payment reforms.

Introduction

Many factors catalyze the current trend toward primary care teams: payers' demands for more integrated care and the varied skills such care requires; the complexity of today's health care environment; the cost-effectiveness of using non-physician practitioners for some care; as well as insufficient numbers of primary care physicians in many areas of the country.[2] Delivery system and payment reforms that encourage patient-centered care delivery emphasize the use of primary care teams as one means to achieve the "Triple Aim" of better care for individuals, better health for populations, and lower costs for the health care delivery system. The constellation of professionals and paraprofessionals who make up a primary care team varies by practice setting and patient demographics. A primary care clinical team may include – among others – primary care physicians, nurse practitioners, physician assistants, clinical pharmacists, mental health practitioners or behavioral health specialists, nurses, and social workers[3] who all work together within defined roles to provide care for patients.

In addition to clinicians, primary care teams can also include non-clinicians who provide services to patients during a health care visit or between patients' visits with clinicians. These individuals may include medical assistants (MAs), health coaches, health educators, care coordinators, patient advocates, peer counselors or community health workers (CHWs) who often have skills in interacting with patients that can complement the skills of clinicians. In most states, there are no formal education requirements for non-clinicians working in the health care system. They may receive training at community colleges, through private programs, in employer-run training programs, and/or on the job. Some states offer certification for some types of non-clinicians that documents specific competencies.[4]

Developing sustainable primary care teams that include non-clinicians requires both a financing mechanism to support their services, and training that teaches specific skills and facilitates non-clinicians' integration with the rest of the care team.[5] This paper outlines a set of strategies — based on the literature or on state and local experience — for state Medicaid programs and primary care practices interested in supporting the inclusion of non-clinicians on primary care teams. The paper also includes resources for states or primary care practices to implement such strategies. This paper was developed as part of a National Academy for State Health Policy (NASHP) cooperative agreement with the Health Resources and Services Administration (HRSA) that aims to facilitate collaboration between state Medicaid agencies and health care safety net providers. While the strategies outlined in the paper may be broadly relevant to primary care practices, examples and resources specific to Federally Qualified Health Centers (FQHCs) and other safety net providers are highlighted.

Following a brief discussion of the potential benefits of expanding the use of non-clinicians in primary care teams, the paper focuses on two key types of strategies to support their inclusion. First, the paper provides examples of different Medicaid financing mechanisms that can provide sustainable funding for non-clinicians' services as part of primary care teams. This section includes resources to help additional interested states learn more about implementing these financing mechanisms. Second, the paper describes training programs and practice settings that have successfully used these programs to expand the roles of MAs, CHWs, and front desk staff on primary care teams. This section provides links to curricula for training non-clinicians in new skills, including team-based care. The paper concludes with suggestions for potential actions by practices and state agencies that could support expanded roles for non-clinicians on primary care teams.

Benefits of Expanded Roles for Non-clinicians on Primary Care Teams

As early as 2001, the Institute of Medicine (IOM) called for primary care teams and emphasized them as a means to ensure patient safety and quality of care in a complex, interconnected health care delivery system.[6,7] Evidence from various primary care settings, including private solo and group practices, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) – which this paper collectively refers to as practices – demonstrates the benefits of care teams that include non-clinicians.

- **Expanded roles for non-clinicians improve the efficiency of the care team.** Care teams that include non-clinicians as well as clinicians who all practice to the "top", or highest skill level of their training, allow each member of the team to contribute optimally—most effectively and efficiently—to patient care. When specific, routine tasks are delegated to non-clinicians, clinical team members can focus on more complex, acute, and chronic concerns that require their skills.[8]
- **Expanded roles for non-clinicians improve patient care and patient experience.** Primary care teams improve care coordination, leading to better outcomes for patients.[9] Non-clinicians can perform key tasks that assist with care coordination, such as completing checklists with patients to assess health status and helping patients set short-term goals for behavior change. Various studies have shown that care teams, including those that include non-clinicians, improve the management of chronic conditions – such as diabetes, hypertension, and asthma – in primary care settings.[10,11] Well-functioning teams also lead to increased patient satisfaction with the health care experience. [12,13]
- **Expanded roles for non-clinicians increase job satisfaction for all team members.** Care teams that include non-clinicians such as medical assistants, health educators and front desk workers have been shown to improve staff satisfaction.[14,15] Care teams decrease the workload for clinicians by freeing them from routine and clerical tasks.[16] At the same time, expanded roles lead to job advancement opportunities for non-clinicians.[17]
- **Expanded roles for non-clinicians extend patient care beyond the clinical visit.** Non-clinicians can play important roles on a care team before and after a patient visit.[18] Prior to an appointment, non-clinicians can help plan the patient visit by determining what services might be needed (for example, immunizations or screenings). After an appointment, non-clinicians can manage referrals or follow up on hospital discharges. Non-clinicians may also visit patients at home or in the community to reinforce health messages or provide supportive services.

Despite these benefits, incorporating non-clinicians onto primary care teams can be challenging. The strategies described in this paper suggest ways to support the inclusion of non-clinicians in various roles on primary care teams.

Medicaid rules have historically presented challenges to payment for non-clinician members of care teams. Non-clinicians usually are not licensed providers with a delineated scope of practice and thus may not be permitted to bill Medicaid for services they provide. However, supervisory arrangements, managed care, and newer payment and delivery system reforms offer opportunities for Medicaid to reimburse or purchase services provided by non-clinicians on primary care teams, thereby establishing a potentially sustainable source of financing. Many FQHCs and other safety net providers serving a high proportion of Medicaid enrollees are active participants in these payment and delivery system models. The strategies and examples in this part of the paper illustrate both traditional and newer payment models that are being used successfully by state Medicaid programs to support the use of non-clinicians on care teams.

Strategy 1: Fee-For-Service Reimbursement for Services Provided by Non-Clinicians on Primary Care Teams

Fee-for-service reimbursement is a common method of reimbursement for primary care services in the United States, including for care delivered to Medicaid enrollees. However, fee-for-service billing can be cumbersome — or even disallowed in some cases — for services provided by non-clinicians operating as part of care teams. Historically, federal Medicaid rules have not recognized many non-clinicians as eligible providers, preventing them from billing directly for services. Some state plan Medicaid benefits, such as physician services or other licensed practitioner services, allow reimbursement for unlicensed practitioners working under the direction of a licensed practitioner who is enrolled as a Medicaid provider. In addition, beginning January 1, 2014, Medicaid rules changed to allow reimbursement of unlicensed providers for preventive services recommended by a physician or other licensed practitioner of the healing arts. States can choose to take up this option by filing a state plan amendment.[19]

South Carolina's Community Health Worker Initiative: Fee-for-service reimbursement for community health workers embedded in primary care pactices

- The South Carolina Department of Health and Human Services (DHHS), which administers the state's Medicaid program, is using its fee-for-service system to pay for services performed by community health workers (CHWs) working with physicians or nurse practitioners on primary care teams. South Carolina launched this initiative with 14 practices in 2013 as part of its Health Access at the Right Time (HeART) project, an initiative to improve chronic disease management, appropriate care utilization, engagement with care, and health outcomes among Medicaid enrollees.[20] The HeART initiative embeds CHWs in primary care teams at selected practices, including at FQHCs

AT-A-GLANCE

Medicaid FFS Payment in South Carolina's CHW Initiative

- Non-clinician type: Community Health Worker (CHW)
- Care setting: Community and home
- Authority: Allowed under existing state plan as a physician service
- Payment mechanism: Specified CPT codes for CHW services, billed by Medicaid-enrolled physician or nurse practitioner

and RHCs. CHWs are directly employed and paid by these participating practices, with practice-based clinical supervisors assigned to oversee CHWs' patient visits and state-mandated reporting on clinical encounters.[21] Each CHW's clinical supervisor reports directly to a physician or nurse practitioner. Much of the CHWs' work is performed in community and home settings; specific functions include supporting patients in navigating the health care system, providing health education and self-management support, and promoting treatment adherence.

- Non-FQHC practices are reimbursed for individual and group visits with CHWs through two CMS-approved CPT codes for patient education.[22] To be eligible for payment, each CHW visit must be associated with a licensed provider's referral for the specific services provided. Because CHWs are not eligible to be Medicaid-enrolled providers, services are billed through the supervising Medicaid-enrolled physician or nurse practitioner. FQHCs are not eligible to receive reimbursement for CHW services; South Carolina DHHS considers these services part of the bundled Prospective Payment System rate that FQHCs receive for each patient visit.[23] South Carolina DHHS also invested state-only funds to support start-up costs, including CHW training and associated administrative costs, for practices participating in the CHW program.[24]
- Though South Carolina's HeART initiative is just ending its first year of implementation, the state sees promise in this approach, and South Carolina DHHS has approved a second year of funding for the initiative. Looking ahead, South Carolina is considering a Medicaid state plan amendment that would allow CHWs to enroll as Medicaid providers and submit claims directly.[25]

Resources: Medicaid FFS Payment in South Carolina's CHW Initiative

Centers for Medicare & Medicaid Services CMCS Informational Bulletin, "Update on Preventive Services Initiatives"

South Carolina Medicaid and the Community Health Worker Program PowerPoint Presentation

Community Health Worker Frequently Asked Questions

Strategy 2: Medicaid Managed Care Payments that Support Non-Clinicians as Members of Care Teams

Since the 1990s, states across the country have implemented managed care within their Medicaid programs with the goals of containing costs and improving care for beneficiaries. As of 2009, 34 states and the District of Columbia had implemented comprehensive risk-based managed care for some portion of Medicaid enrollees; about half of Medicaid enrollees nationwide received benefits through comprehensive risk-based managed care plans that year.[26] Managed care contracting is a key lever that state Medicaid programs can use to transform the primary care workforce.

New Mexico's Centennial Care: Supporting roles for community health workers through managed care contracting

New Mexico's Medicaid program, known as Centennial Care, has leveraged contracts with Medicaid managed care organizations (MCOs) to support the use of community health workers in serving the state's Medicaid enrollees. Centennial Care contracts define CHWs as "lay members of communities who work either for pay or as volunteers in association with the local health care system in Tribal, Urban, Frontier, and Rural areas and usually share ethnicity, language, socioeconomic status and life experiences with the Members they serve. Community health workers include, among others, community health advisors, lay health advocates, *promotoras*, outreach educators, community health representatives, peer health promoters, and peer health educators."[27] Contracts mandate that MCOs encourage the use of

CHWs for care coordination; require MCOs to describe the role of CHWs in providing patient education; and specifically include CHW services in the list of services covered under the state's Medicaid benefit package. State contracts allow MCOs flexibility in implementing these requirements by either embedding CHWs directly in practices or deploying CHWs to provide services to patients outside the practice setting.[28] In either instance, MCOs must ensure that CHWs are available to perform interpretation and translation services, provide culturally relevant health education, help patients navigate the managed care system, connect members to community resources, and counsel members on healthy behaviors.

AT-A-GLANCE

Medicaid Managed Care Contracting in New Mexico

- Non-clinician type: CHW
- Care setting: Varies
- Authority: Medicaid Section 1115 Demonstration Waiver
- Payment mechanism: CHW salaries, training, and service costs are MCO administrative costs and are embedded in capitated rates paid to Medicaid managed care organizations.

New Mexico Medicaid's Managed Care Policy Manual specifies that costs associated with CHWs, including CHW salaries and training, are considered MCO administrative costs for the purposes of rate setting; these costs are included in the capitated rates paid to MCOs.[29] Centennial Care's contracts with MCOs establish a sustainable funding mechanism to continue New Mexico's work with CHWs: New Mexico's Medicaid-enrolled clinicians have engaged CHWs in their work to serve vulnerable and underserved populations for decades, and the state's Medicaid agency sees CHWs as an important part of the path forward in providing high-quality, coordinated care for Medicaid enrollees in the state.[30]

In 2014, New Mexico Governor Susana Martinez signed into law the Community Health Workers Act, which will create a CHW certification program through the New Mexico Department of Health.[31] Medicaid officials expect that this will standardize the position and clarify CHW definitions throughout the state, and that Medicaid contracts will continue to require that MCOs work with CHWs to serve their members.

Resources: Medicaid Managed Care Contracting in New Mexico

Centennial Care Section 1115 Demonstration Waiver

Centennial Care Managed Care Contracts

New Mexico Community Health Workers Act

New Mexico Medical Assistance Division Managed Care Policy Manual

Strategy 3: Coordinated Care Approaches that Support Expanded Roles for Non-Clinicians on Primary Care Teams

Payment reforms that incentivize patient-centered care coordination or care management may lend themselves to including non-clinicians on care teams by providing flexible funding that practices can use to hire new staff, re-purpose existing staff, and cover overhead and technology costs. Patient-centered medical homes and ACA Section 2703 Health Homes are two such models being pursued by state Medicaid programs around the country. As of March 2014, 47 states have adopted policies or programs to advance medical homes or health homes.[32]

Patient-centered medical homes

A patient-centered medical home is a model of primary care delivery that is comprehensive, patient-centered, coordinated, accessible, and committed to quality and safety.[33] As of June 2014, 30 states were making enhanced payments to medical home practices.[34] States use a variety of strategies to provide practices with the financial support they need to provide medical home-caliber care. The most common, a population-based per-member per-month (PMPM) care management fee paid in addition to fee-for-service payments for office visits, tests, or procedures, provides primary care practices with financial flexibility that many use to promote comprehensive team-based care.[35] This can include expanding roles for non-clinicians as part of the care team.

Maine PCMH Pilot: Enhancing practice capacity through expanded use of medical assistants

More than 70 primary care practices across the state participate in the Maine PCMH Pilot, a patient-centered medical home program convened jointly by the state Dirigo Health Agency's Maine Quality Forum, regional non-profit health improvement collaborative Maine Quality Counts, and the employer-led Maine Health Management Coalition.[36] The Maine PCMH Pilot requires that practices obtain National Committee on Quality Assurance (NCQA) PCMH recognition,[37] as well as meet 10 "core expectations" for practice transformation. These expectations include using a team-based care approach that includes expanding the roles of non-physician providers to increase access, improve clinical workflows, and enhance efficiency.[38]

AT-A-GLANCE

PMPM Payments in the Maine PCMH Pilot

- Non-clinician type: Medical assistants
- Care setting: Primary care practices
- Authority: Medicaid Section 1932(a) state plan amendment (2010-2012); Section 2703 health home state plan amendment (2013-current)
- Payment mechanism: Population-based PMPM payments provide flexible, non-visit based funding that can support practice reorganization and staff training

Medicaid, Medicare, and the state's commercial insurers each make per-member per-month (PMPM) payments to participating medical home practices. Though payment amounts vary by payer and fluctuate from month to month based on the number of patients attributed to each practice, these payments provide practices with an enhanced income stream that is not visit-based.[39] Practices can use these medical home payments to develop and support care teams, including hiring new staff and training existing staff. As a result, many PCMH Pilot practices have created structures and systems for training medical assistants to take on new roles. Medical assistants in PCMH pilot practices conduct patient education, care coordination, and population health monitoring.[40]

Resources: PMPM Payments in the Maine PCMH Pilot

Maine Section 1932(a) state plan amendment

Maine PCMH Pilot website

NCQA PPC PCMH Program website

Maine PCMH Pilot Core Expectations

Maine PCMH Pilot Frequently Asked Questions for Primary Care Practices

Health Homes

Section 2703 of the Affordable Care Act (ACA) established the "State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions," a Medicaid state plan option that builds on the medical home model to serve Medicaid beneficiaries with two or more chronic conditions, one chronic condition and risk for another, or a severe and persistent mental health condition. As defined in statute, health homes deliver comprehensive, high-quality care that specifically includes six "core health home services": comprehensive care management; care coordination; health promotion; comprehensive transitional care between inpatient and outpatient setting; patient and family supports; and referral to community resources and social services.[41]

Under the Health Home State Plan Option, states receive an enhanced (90 percent) federal match for health home services for eligible Medicaid enrollees for the first eight quarters of implementation, a significant federal funding boost in most states. As of March 2014, CMS had approved 22 health home state plan amendments in 15 states. In most of these states, health home providers receive PMPM payments for eligible Medicaid enrollees, although some states pay providers a cost-based case rate or use fee-for-service payments without an additional PMPM.[42] The flexible financing afforded by health homes presents an opportunity to include non-clinicians on care teams.

Idaho's Health Home Program: Utilizing non-clinicians to coordinate care for patients with chronic illnesses

- Idaho's Health Home Program launched on January 1, 2013.[43] Idaho requires that health home practices meet minimum standards, including achieving NCQA PCMH recognition.[44] In order to meet these standards, many participating practices have hired or retrained staff to serve as care coordinators. Idaho Medicaid does not require care coordinators to have a particular background or training. Though some are registered nurses or social workers, others are trained as medical assistants or have prior non-clinical experience in a primary care setting. Care coordinators play a variety of roles in health home practices to facilitate coordinated patient-centered care, including panel management, referral tracking and follow up, admission and discharge tracking, and building referral relationships with community resources and social services agencies. Though not all work directly with patients, program leaders consider them critical members of the care team.[45]

AT-A-GLANCE

PMPM Payments in Idaho's Health Home Program

- Non-clinician type: Care coordinators
- Care setting: Primary care practices
- Authority: Section 2703 health home state plan amendment
- Payment mechanism: PMPM payments for eligible patients provide flexible, non-visit based funding source that can support new staff

- Idaho Medicaid pays participating health home practices a PMPM rate of $15.50 for eligible Medicaid enrollees.[46] Idaho Medicaid chose the PMPM payment model with the diverse needs and resources of the state's urban, rural, and frontier practices in mind; PMPM payments allow health homes flexibility to provide otherwise non-billable services, including care coordination, delivered by a variety of clinical and non-clinical staff.[47]

Resources: PMPM Payments in Idaho's Health Home Program

Centers for Medicare & Medicaid Services Health Home Information Resource Center

Idaho Health Home Program website

Idaho Health Home State Plan Amendment

Shared community-based resources to support advanced primary care

Some states are deploying shared resources to support primary care practices in providing medical home services, especially around expectations that they provide team-based services and comprehensive, coordinated care. Shared resources can range in size and composition from a single nurse or care manager who works with multiple practices to coordinate care to large, multi-disciplinary teams, often called community health teams, community care teams, or networks. As of March 2014, 10 of the states working to advance medical homes or health homes provide funding to support shared resources.[48]

Montana's Health Improvement Program: Embedding care managers in health centers to support high-needs patients

In Montana, the state's Medicaid Health Improvement Program (HIP) provides shared resources to better coordinate services for high-risk members of its Medicaid primary care case management (PCCM) program, Passport to Health, across the state's large geographic area. Thirteen participating FQHCs and one tribal health center employ care managers who work with Passport to Health members and their providers in a defined geographic area. Care managers coordinate patient care with primary care providers and specialists, support patient adherence to treatment plans, follow up on emergency department visits and hospital admissions, support patient self-management, and connect patients with community resources and social services.[49] Care managers come from a variety of professional and educational backgrounds; while many are registered nurses or social workers, others are licensed practical nurses or come from non-clinical behavioral health or health coaching backgrounds. All are required to become certified as Chronic Care Professionals through the HealthSciences Institute.[50]

AT-A-GLANCE

PMPM Payments in Montana's Health Improvement Program

- Non-clinician type: Care managers
- Care setting: Thirteen regional FQHCs and one tribal health center
- Authority: Medicaid Section 1915(b) Managed Care Waiver
- Payment mechanism: Population-based PMPM payments fund care manager salaries and services

To support HIP care manager salaries and administrative costs, Montana Medicaid pays participating health centers a PMPM rate of $3.75 for each Passport to Health member in the health center's catchment area, regardless of whether they are being actively managed through the program. Payments are made under the authority of a 1915(b) waiver.[51]

Resources: PMPM Payments in Montana's Health Improvement Program

Montana Health Improvement Program website

Montana Passport to Health 1915(b) Managed Care Waiver

Strategy 4: Medicaid Accountable Care Arrangements

States across the country are pursuing accountable care arrangements within their Medicaid programs as a path to achieving the "Triple Aim" goals of better care, improved health, and lower costs. These models vary broadly across states in scope, governance and authority, and payment methodology, but all seek to hold providers accountable for their performance by linking payment to the cost and quality of care. States have developed a variety of payment models for accountable care initiatives, including upside-only shared savings arrangements, shared savings methodologies that include both upside and downside risk, capitated models that provide a fixed payment per patient, or a global budget.[52] Accountable care models, especially those that utilize capitation or global budgets, provide states and practices with increased flexibility to deliver care in innovative ways. Decreased reliance on fee-for-service reimbursement allows providers to invest in expanded care team models that incorporate non-clinicians or otherwise not directly billable services.

Oregon's Coordinated Care Organizations: Providing flexible funding that supports non-clinicians as members of local care teams

AT-A-GLANCE

Global Budgets in Oregon's Coordinated Care Organizations

- Non-clinician type: Varies
- Care setting: Varies
- Authority: Medicaid Section 1115 Demonstration Waiver
- Payment mechanism: Global budgets provide CCOs with flexibility to pay providers and local organizations for services provided by non-clinicians

In 2011, Oregon embarked on a statewide effort to integrate and coordinate the health care delivery system.[53] A centerpiece of this effort is a statewide network of coordinated care organizations (CCOs). Authorized under a Medicaid Section 1115 Demonstration Waiver,[54] CCOs are locally based organizations that serve Oregon Health Plan (Medicaid) enrollees in the state. CCOs are responsible for providing and coordinating enrollee care across a variety of settings, including primary and acute care, behavioral health, and dental services. They receive a fixed global budget from the state, which includes a PMPM payment for services provided to enrollees, and a transformation incentive payment to support quality and cost reporting and improvement.[55] CCOs must ensure that members receive support navigating the health care system, accessing culturally and linguistically appropriate care, and connecting with social and community services. The Oregon Medicaid program identifies CHWs, peer wellness specialists, and personal health navigators as non-clinicians who might provide these supports.[56]

Yamhill Community Care Organization (YCCO) serves Medicaid enrollees in six counties in northeastern Oregon and uses the flexible funding from its Medicaid global budget to fund local organizations that hire non-clinicians who support high-needs, high-cost enrollees in managing their health and improving connections to primary care. One such organization, Yamhill County's Area Agency on Aging, now employs two CHWs working under the direction of registered nurses. The CHWs work with enrollees who are high utilizers of health care services to improve patient activation, facilitate connections with primary care and other providers, and help patients address non-medical needs. Another local organization, Project ABLE, provides peer support services to enrollees with mental illness. Both programs work in close partnership with primary care providers to help strengthen patient connections to primary care, navigate the health care system, and complete referrals.[57]

RESOURCES: PMPM PAYMENTS IN OREGON'S COORDINATED CARE ORGANIZATIONS

Chapter 602, Oregon Laws of 2011

Oregon Health Plan Waiver Documents

Oregon 1115(a) Waiver Narrative

Working in multidisciplinary teams is a new skill for both clinical and non-clinical providers. Physicians, nurses, and non-clinical providers all need to feel comfortable with their own and each others' roles on a care team. While many training curricula focus on the skills needed by non-clinicians, it is also important that training addresses the needs of physicians, nurse practitioners, physician assistants, registered nurses and others who are learning to work with non-clinicians on a care team.

This part of the paper describes different training curricula and methods developed to help non-clinicians develop new skills as part of a care team and the accompanying workflow redesign required for teams to function effectively. All of these training curricula emphasize the non-clinician's role as an active participant in case management and care coordination as critical to team-based care. The examples include information on how training has been financed and potential roles for states in supporting training. Many of the trainings described below were developed in various practice settings; state PCAs and Medicaid agencies could help spread these models in systematic ways.

Strategy 1: Training for Non-Clinicians to Improve Practice Efficiency

As part of transformations to improve care delivery, practices may find they can provide more effective and efficient care by leveraging the skills of non-clinical staff to take on tasks that would otherwise be completed by clinicians. Non-clinicians can conduct discrete tasks as part of larger care teams, and can often spend more time with patients than is allotted to clinical providers, leading to more efficient care delivery and improved staff and patient satisfaction.

Neighborcare Health: Tasking guidelines to define expanded roles for front desk staff

Neighborcare Health is an FQHC operating 24 medical, dental, and school-based health sites in Seattle, Washington. After implementing a system-wide electronic medical record (EMR) in 2006, Neighborcare realized staffing and flow of tasks were poorly aligned, and satisfaction among nursing staff was low. In response, a redesign team of registered nurses (RNs), medical assistants (MAs), front desk staff, other providers, and clinic managers representing all Neighborcare medical clinics worked with a facilitator to evaluate and redesign the entire clinic workflow. The resulting Medical Clinic Tasking Guidelines outline the roles and responsibilities of each staff member, from a front desk staff person to licensed clinicians. The Guidelines stipulate how patient interactions, information, and paperwork should flow through the clinic.[58]

AT-A-GLANCE

Neighborcare Health Training

- Non-clinician type: Front desk staff; medical assistants (MA)
- Clinicians engaged in training: Nurses
- Care setting: Clinic
- Skills taught: Retrain staff to improve workflows and patient/staff satisfaction
- Length of training: Not standardized
- Assessment: Informal evaluation of skills and need for follow-up training
- Funding: External grants and internal funding for ongoing Guidelines updates

When the Guidelines were introduced, RNs from the redesign team developed group training to better incorporate front desk staff into the care team. Using the Guidelines as a training tool,[59] front desk staff

learned to ask the right questions of patients in the clinic and over the phone to best direct patient requests to the most appropriate member of the care team. Following the group training, RNs shadowed front desk staff and provided informal, one-on-one coaching to assure front desk staff felt comfortable with their new patient-focused responsibilities.[60] Additionally, a "redirect box" was created within the EMR system so that any tasks passed to an incorrect team member could easily be redirected. Clinic managers monitored tasks that were redirected to identify task areas or staff that needed further training.[61] The Guidelines were also used as a training tool for a new MA role of "medical clerk." This position provides clerical support for the back office and initiates the redesigned paperwork flow.[62]

The Tasking Guidelines are updated annually based on staff input. As part of the yearly update, all clinic staff attend a refresher training on the importance and purpose of the Guidelines that also highlights any changes made to the Guidelines. These trainings include staff breakout groups by position and an opportunity to practice roles outlined in the Tasking Guidelines. New hires for all clinic positions are trained on the EMR and Tasking Guidelines as part of their orientation.[63]

The overall redesign and resulting staff trainings were partially funded by a grant from Premera, a local Blue Cross Blue Shield plan, with Neighborcare Health supplying the remaining funds.[64] Ongoing trainings and updates to the Tasking Guidelines are supported through Neighborcare Health's overhead funds. Using surveys, Neighborcare has documented an increase in both staff and patient satisfaction since implementation of the redesign and expanded roles for front desk staff.[65]

Resources: Neighborcare Health Training

Neighborcare Health Presentation – Optimizing the Role of Front Desk Staff

Neighborcare Health Medical Clinic Tasking Guidelines

Strategy 2: Training for Non-Clinicians to Manage Specific Health Conditions

Within every practice, some patients require more intensive care management than others. This could include patients with a chronic health condition, such as diabetes; those who are pregnant; or those with behavioral health concerns. Non-clinicians can work as members of care teams to provide patient screenings, health education, and connections to additional social services for patients with specific health conditions.

Union Health Center: Training Medical Assistants to be Patient Care Assistants and Health Coaches

Begun in 1914 by the International Ladies' Garment Workers' Union, Union Health Center (UHC) in New York City provides care to members and retirees of several unions and their families.[66] Between 2006 and 2009, UHC developed and implemented the Special Care Center (SCC), a primary care model to manage patients with diabetes and other chronic conditions. The Special Care Center is based on the California HealthCare Foundation's Ambulatory Intensive Caring Unit (A-ICU) model of care,[67] which relies on non-clinicians to teach self-management to patients as part of a care team.[68] UHC uses medical assistants as "patient care assistants" (PCAs) and developed a nine-month training curriculum to train these PCAs as health coaches.[6]

As part of its practice transformation, the SCC defined an expanded role for MAs, determined gaps in training, and identified skills that needed to be strengthened or learned by these staff.[70] The health coach training curriculum content was developed by UHC providers using resources from the American Diabetes Association and the New York City Department of Health and Mental Hygiene clinical guidelines.[71] MAs training to become PCAs participate in a series of two-hour weekly training sessions held during the

workday for nine months. Following this initial training, ongoing training is mandatory for all PCAs and is conducted as a one-hour, bi-weekly session. All training is conducted onsite, primarily by nurses and a staff nutritionist. Topic areas in the curriculum include: basic PCA skills; cognitive impairment; depression screening; self-management support training; chronic diseases; and preventive services.[72] For each topic area, patient handouts and an EMR template were developed with input from PCAs. The handouts and templates help guide PCA and health coach interactions with patients.[73] The training curriculum is overseen by the Clinical Practice Manager and an RN, who also supervise the PCAs.[74]

AT-A-GLANCE

Union Health Center Training

- Non-clinician type: Medical assistants/patient care assistants (PCA); health coaches
- Clinicians engaged in training: Nurses and staff nutritionist
- Care setting: Clinic
- Skills taught: Basic PCA skills, disease assessment and management, preventive services
- Length of training: Nine-month initial training; ongoing education one-hour bi-weekly
- Assessment: Written skills test and assessment of standard PCA skills after initial training
- Funding: Grants funded training development; capitated fee structure supports use of MAs and health coaches

Evaluation includes a written skills test, observation of effectiveness of communication and self-management skills, and an assessment of standard MA skills.[75] PCAs who pass the evaluation can apply to be a health coach and work directly with individual patients.[76] Health coaches can be further promoted to Floor Coordinator, taking on additional duties to manage the flow in the clinic.[77] While only the strongest PCAs advance to these roles, the training prepares all PCAs to assist with patient education and chronic disease management.[78] PCAs and health coaches monitor patient progress with chronic disease management and serve as key members of medical home teams.[79]

UHC received a $75,000 single-year grant from the United Hospital Fund to develop the training curriculum. This grant provided funding for provider and administrator time to develop materials and additional staff time to review materials. An additional $460,000 grant from the New York State Health Foundation supported further development of the curriculum and initial training of some PCAs and health coaches.[80]

UHC's operations are funded by affiliated unions that pay a monthly capitated fee for all services provided to union members, retirees, and their families. As a result, UHC is able to run programs, like the SCC, that provide typically non-billable services and use non-clinicians in expanded roles.[81] Health centers and other practices that are similarly funded with capitated rate structures may also be able to support this type of innovative team care model.

Resources: Union Health Center Training

California HealthCare Foundation's Ambulatory Intensive Caring Unit (A-ICU) model

Union Health Center's MA/PCA and health coach training curriculum and skills assessment

Erie Family Health Center: Training women's health promoters to enhance prenatal care[82]

Erie Family Health Center, an FQHC in Chicago, Illinois, is made up of multiple sites, including six primary care locations and five school-based health centers. In October 2005, as part of an effort to promote early prenatal care entry, Erie Family Health Center created the role of women's health promoter. The position was created as part of the development of the "OB Care Pathways," a set of comprehensive guidelines developed by Erie providers and staff that detail the information, tests, and exams that should be provided to women at every stage of their pregnancies and by whom.

At-a-Glance

Erie Family Health Center Training

- Non-clinician type: Women's health promoter
- Clinicians engaged in training: Physicians, nurses
- Care setting: Women's health clinics
- Skills taught: Collecting basic vitals and health histories, recognizing early warning signs of health concerns
- Length of training: Not standardized
- Assessment: Informal evaluation of skills
- Funding: General operational funds; no reimbursement available

Each Erie facility with a women's health practice has a health promoter onsite who is the first point of contact for women who are or may be pregnant. The women's health promoter collects basic vitals and a health history, describes the midwifery and obstetric services available at the health center, provides health education and prenatal vitamins, and schedules the first prenatal visit. As part of the care team, women's health promoters consult with obstetrics providers and schedule follow-up appointments for any pregnant women assessed as high-risk. The women's health promoter also links patients to case management services, if necessary, and can help connect pregnant women to other important programs, such as oral health services, and assist them with applying for Medicaid. Women's health promoters also meet with women who receive a negative pregnancy test to provide information on family planning services.

No specified educational background is required for women's health promoters, but many are trained health educators with past experience in reproductive or maternal health. Staff hired or reassigned as women's health promoters participate in standardized trainings conducted by a clinician or a more experienced women's health promoter. All women's health promoters are trained to use the OB Care Pathways guidelines, which include protocols to guide patients' visits. The training introduces women's health promoters to the educational materials provided to pregnant women at the health centers. These educational materials include information on the early warning signs of a miscarriage, what women should expect at each stage of their pregnancy, nutrition, allowed medications, and breast feeding. Finally, Erie's director of health promotion and clinical nurse educator train women's health promoters on taking basic vitals, and recording medical, reproductive, and family histories in the EMR system, which is used by the entire care team to coordinate patients' care.

Erie is planning to formalize and standardize this training curriculum and expand the role of women's health promoters. Erie Family Health Center relies on general operations funds to support women's health promoters. None are grant-funded and their services are not reimbursed.

Resources: Erie Family Health Center Women's Health Promoter Training

Education Materials for Pregnant Women

South Carolina: Training Community Health Workers to provide patient education

South Carolina Medicaid began supporting integration of community health workers (CHWs) into 14 primary care practices, including one FQHC, in 2013 through the Health Access at the Right Time (HeART) initiative. Competitively chosen practices were each awarded a $6,000 grant to support training and integration of a CHW into the practice setting. HeART integrates CHWs into the care team to provide education to patients and assist with patient screenings, chronic disease management, and medication and care compliance.[83]

AT-A-GLANCE

South Carolina CHW Demonstration

- Non-clinician type: community health workers (CHWs)
- Clinicians engaged in training: N/A
- Care setting: PCMH clinic
- Skills taught: CHW core competencies, role in health care team, motivational interviewing, facilitating behavior change
- Length of training: 6-week, full-time course at local college
- Assessment: written certification exam
- Funding: $3500 from Medicaid's CHW demonstration grant; practice supports ongoing cost of employing CHW

Approximately $3,500 of each site's CHW grant supported the training of a CHW for the practice.[84] No prior training or experience was required of a CHW candidate beyond a hig school diploma or GED. The full-time, six-week training program was developed by Midlands Technical College in collaboration with the South Carolina Department of Health and Human Services and the Area Health Education Consortium (AHEC).[85] The program was run by Midlands Technical College at three regional training locations. It included a classroom and a hands-on practice and community-based curriculum covering the South Carolina DHHS core competencies for CHWs. These include health coaching and basic medical knowledge.[86] Upon completion of the training, all CHWs were required to take a certification exam assessing the core competencies, which 100 percent of participants passed.[87] Individuals who had been working as a CHW in the community for at least three years could also be "grandfathered" into the CHW initiative.[88] These individuals had the opportunity to take core competency classes before taking the certification exam, but were required to pay for the classes at their own expense if they chose to enroll.[89]

Practices were encouraged to use the remaining grant funds to cover administrative costs necessary to integrating the CHW into the practice. Each practice's clinical supervisor defines the CHW's role, which may include health education as well as assistance with arranging transportation or social services. The clinical supervisor also monitors and reports on services provided by the CHW, and arranges for any necessary supplemental on-site training. AHEC Coordinators also monitor and support the clinical practices and organize meetings for CHWs to communicate with each other and share best practices.[90]

As part of the program's reporting requirements, clinical supervisors are required to document information about CHW-provided services. Interactions between CHWs and AHEC Coordinators are also evaluated, and clinical practices must agree to participate in site visits, report quality data, and undertake evaluation surveys to assess provider and CHW satisfaction, skill development, and lessons learned. After the first year of the initiative, ongoing training will be the responsibility of the individual practices.[91] While grant funding from the state supported training, clinical practices are expected to cover the ongoing costs of employing a CHW.[92]

Resources: South Carolina CHW Initiative

South Carolina Medicaid and the Community Health Worker Program PowerPoint Presentation

Community Health Worker Frequently Asked Questions

Strategy 3: Training for Non-Clinicians to Work in a Patient-Centered Medical Home

Non-clinical staff who will join an interdisciplinary care team practicing in a PCMH need training in collecting and using health information, interacting with patients, and administrative skills specific to medical home settings. The team-based nature of care within a medical home makes it especially important that all care team members – clinicians and non-clinicians – understand how to work together.

MaineGeneral Health: Developing a Medical Assistant toolkit for PCMHs

MaineGeneral is a comprehensive non-profit health system that provides primary and specialty care services in the Kennebec Valley area of Maine. In 2011, MaineGeneral convened a workgroup of staff to develop a Medical Assistant Training Toolkit to train MAs to work in Primary Care Medical Home (PCMH) teams. The toolkit focuses on building MAs' skills in prevention, panel management, and controlling chronic diseases. In Maine, MAs are not licensed and their scope of practice is defined by the employer. The MaineGeneral training toolkit aims to standardize documented competencies of MAs to allow them to work to the top of their training as an essential part of the care team.[93]

AT-A-GLANCE

MaineGeneral MA Toolkit

- Non-clinician type: Medical assistants (MA)
- Clinicians engaged in training: Physicians, nurse practitioners, nurses
- Care setting: Hospitals and clinics
- Skills taught: Primary care transformation, panel management, preventive care, treating chronic conditions
- Length of training: 8 sessions totaling 17 hours
- Assessment: Each of 10 modules includes skills evaluation
- Funding: Grant funds used for initial training development. MA services are reimbursable in some practices

The training toolkit consists of 10 modules delivered over eight sessions and 17 total hours. Modules include topics such as primary care transformation and panel management, as well as preventive care and specific chronic conditions. Each module includes a presentation, reviews of important related documents, a classroom activity, and an evaluation of skills.[94] Concurrent learning sessions for practice leaders focus on reconfiguring practice workflows and processes to allow MAs to work at the top of their newly-completed training.[95]

The MA training program at MaineGeneral was supported by grant funds from the Employment and Training Administration of the United States Department of Labor through ARRA.[96] The MaineGeneral toolkit is being disseminated to other practices interested in expanded MA capacity. In late 2012, MaineGeneral provided information on the training to practices in the Maine Patient Centered Medical Home Pilot through the PCMH Learning Collaborative run by Maine Quality Counts.

Resources: Maine General Toolkit

MaineGeneral Medical Center Medical Assistant Training Toolkit

Conclusion: Steps that state agencies and practices can take to Support Expanded Use of Non-Clinicians on Primary Care Teams

As individuals gain coverage and as states, other purchasers, and practices strive to deliver efficient and effective primary care services, care teams that include non-clinicians are one strategy to meet the growing service demand and help achieve the "Triple Aim." Practices, including safety net providers, and their state associations can work with state Medicaid agencies on potential strategies to finance non-clinician services through Medicaid mechanisms already in use or being planned for the state. The following are suggestions—in addition to the strategies outlined in the paper—for how primary care practices and state Medicaid programs can play a part in supporting expanded roles for non-clinicians on primary care teams.

Take advantage of new flexibility to directly pay for non-licensed providers of preventive services. One new payment flexibility in Medicaid is a rule change—effective January 1, 2014—that allows fee-for-service reimbursement of non-licensed providers for covered preventive services recommended by a physician or other licensed provider. The rule change does not affect which services are covered, only who may provide them. That is, preventive services, which are an optional state Medicaid benefit, are those defined in the preventive services benefit category in a state's Medicaid plan where the option is included. States can choose to take up the new option by filing a state plan amendment that must include a summary of the preventive services as well as the qualifications for the non-licensed practitioners who will be eligible to provide those preventive services.[97] Adopting this option may require first establishing qualifications for the non-licensed practitioners if these standards do not already exist.

Clarify what is already possible within state policy. State Medicaid programs interested in supporting expanded roles for non-clinicians can help practices understand existing regulations. For example, state Medicaid programs can clarify for providers what credentialing requirements or billing restrictions may currently apply to different types of non-clinicians, whether in FFS or managed care arrangements.

Review and revise managed care contracting standards to facilitate use of non-clinicians. The growing use of managed care arrangements to serve Medicaid populations, including those with complex conditions, creates a need for increased care management services within Medicaid managed care programs. State Medicaid agencies can consider how to capitalize on the patient engagement and case management skills of non-clinicians on primary care teams serving these populations. State Medicaid Directors can consider ways to structure managed care contracts to allow or incentivize expanded roles for non-clinicians as care coordinators on primary care teams.

Support the expanded use of non-clinicians in medical homes, health homes, and ACOs. Integrated delivery systems and the flexible funding that accompanies medical homes, health homes, and ACOs provide additional opportunities for Medicaid to pay for services provided by non-clinicians. These payment and delivery system reforms prioritize care coordination and patient-centered care delivery, and thus may lend themselves to including non-clinicians on care teams. State Medicaid Directors interested in supporting expanded roles for non-clinicians on primary care teams can consider demonstrations, waivers, and state plan amendment options that provide the flexible funding that can support expanded roles for non-clinicians as part of broader reforms. State Medicaid agencies that have already begun to implement these reforms can clarify for practices what payment options are currently available, or are being planned for future.

Build training for both non-clinicians and clinicians into primary care practice transformation. Practices can evaluate which skills they need to develop or strengthen among both clinicians and non-clinicians to support effective team functioning and facilitate a move toward strong primary care teams. Practice leaders and safety

net associations can assess whether existing training curricula developed in-house or by others[98] can be adopted or adapted to strengthen needed skills that allow all team members to work together effectively.

Support training for both clinicians and non-clinicians to facilitate the inclusion of non-clinicians on primary care teams. States can develop or modify training programs and state certifications to include content related to the benefits of team-based care, and techniques to help teams, including those that incorporate non-clinicians, function effectively. State Medicaid agencies can build training and practice transformation support to help establish and foster team-based care into payment and delivery system reform initiatives, such as patient-centered medical homes, ACOs, or others.

There is strong evidence that team-based primary care has significant benefits for patients and providers, and the appropriate use of non-clinicians as part of a primary care team has the potential to magnify the team's strengths. Non-clinicians can take on expanded roles that include patient engagement and advocacy, health education, and care management. States and practices across the country are already incorporating non-clinicians into primary care teams, and there are opportunities to expand and enhance their integration by taking advantage of flexibilities afforded by health care delivery systems and payment reforms.

Endnotes

1 Diagnostic, Screening, Preventive, and Rehabilitative Services, 42 CFR 440.130 (c). For more information, see Centers for Medicare & Medicaid Services CMCS Informational Bulletin, "Update on Preventive Services Initiatives," November 27, 2013, available at: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf.

2 Grumbach, K.; Bodenheimer, T. "Can Health Care Teams Improve Primary Care Practice?" JAMA. 2004;291:1246-1251.

3 Nielson, M., Langner, B., Zema, C., Hacker, T., Grundy, P. "Benefits of Implementing the Patient-Centered Medical Home: A review of Cost and Quality Results, 2012." Patient-Centered Primary Care Collaborative.

4 Personal communication with Lisel Blash, Senior Research Analyst, Center for the Health Professions, University of California, San Francisco. May 13, 2014.

5 Conference proceedings. "Team-Based Competencies: Building a Shared Foundation for Education and Clinical Practice." Health Resources and Services Administration, Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, ABIM Foundation in collaboration with IPEC. February 16-17, 2011. Washington, DC.

6 Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academy Press; 2001.

7 Institute of Medicine. "Core Principles and Values of Effective Team-Based Care." October 2012.

8 Bodenheimer, T. "Building Teams in Primary Care: Lessons Learned." California Health Care Foundation, Oakland, CA (2007).

9 Bodenheimer, T. "Lessons from the Trenches – A High-functioning Primary Care Clinic." New England Journal of Medicine. 365;1. July 7, 2011.

10 Bodenheimer, T, Wagner, E., Grumbach, K. "Improving Primary Care for Patients with Chronic Illness." JAMA. 2002; 288:1775-1779

11 Brian Schuetz, Erin Mann and Wendy Everett, "Educating Health Professionals Collaboratively For Team-Based Primary Care." Health Affairs, 29, no.8 (2010):1476-1480.

12 Ron Stock. "Teamness." Patient Centered Primary Care Initiative webinar. April 30, 2013.

13 Grumbach, K.; Bodenheimer, T. "Can Health Care Teams Improve Primary Care Practice?" JAMA. 2004; 291:1246-1251.

14 Safety Net Medical Home Initiative. "Continuous and Team-based Healing Relationships: Improving Patient Care Through Teams [executive summary]." May 2013.

15 Lisel Blash, Catherine Dower, and Susan Chapman, "University of Utah Community Clinics—Medical Assistant Teams Enhance Patient-Centered, Physician-Efficient Care." Center for the Health Professions at UCSF. April 2011, Revised November 2011.

16 Bodenheimer, T. "Lessons from the Trenches – A High-functioning Primary Care Clinic." New England Journal of Medicine. 365;1. July 7, 2011.

17 Lisel Blash, Catherine Dower, and Susan Chapman, "Union Health Center: Update 2014." Center for the Health Professions at UCSF. May 2014. http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=gOFIM7K7fro%3d&tabid=161

18 Audio recording from WIHI http://www.ihi.org/knowledge/Pages/AudioandVideo/WIHINewStaffingModelsforPrimaryCare.aspx

19 Diagnostic, Screening, Preventive, and Rehabilitative Services, 42 CFR 440.130 (c). For more information, see Centers for Medicare & Medicaid Services CMCS Informational Bulletin, "Update on Preventive Services Initiatives," November 27, 2013, available at: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf.

20 South Carolina Department of Health and Human Services, "Community Health Worker in Primary Care Practices," news release, December 13, 2012, https://www.scdhhs.gov/sites/default/files/CHW%20Bulletin%20Dec%202012.pdf.

21 South Carolina Department of Health and Human Services, "South Carolina Medicaid and the Community Health Worker Program," (presentation). Available at: https://www.scdhhs.gov/sites/default/files/SC%20Medicaid%20and%20the%20Community%20Health%20Worker%20Program.pdf.

22 South Carolina Medicaid providers may bill for CHW services under two CMS-approved CPT codes: S9445 for individual patient education, and S9446 for group patient education.

23 South Carolina Department of Health and Human Services, "Community Health Worker Frequently Asked Questions," January 17, 2013. Available at: https://www.scdhhs.gov/sites/default/files/Community%20Health%20Worker%20FAQ-%201-17-13.pdf. South Carolina DHHS cites a 2006 HRSA document, *Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs*, as the basis for this decision: "FQHCs are required to provide case management services on site or through arrangements with other case management agencies. FQHCs are also required to provide outreach and translation enabling services." The full text of the document is available here: http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf.

24 South Carolina Department of Health and Human Services, "Community Health Worker Frequently Asked Questions."

25 Personal communication with Melanie Giese, Director, South Carolina Birth Outcomes Initiative, South Carolina Department of Health and Human Services, March 10, 2014.

26 Medicaid and CHIP Payment and Access Commission (MACPAC), "Report to the Congress on Medicaid and CHIP," (Washington, DC: MACPAC, June 2014). Available at http://www.macpac.gov/reports.

27 New Mexico Human Services Department, "Medicaid Managed Care Services Agreement," January 2013.

28 New Mexico Human Services Department, "Medical Assistance Division Managed Care Policy Manual," January 1, 2014. Available at: http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Policy%20Manuals/Managed%20Care%20Policy%20Manual%20Final%201%2010%2014.pdf.

29 New Mexico Human Services Department, "Medical Assistance Division Managed Care Policy Manual." Though CHW services built into the administrative load for the purpose of capitation rate setting, note that costs associated with care coordination, including care coordination provided by CHWs, are considered direct services and count toward MCOs' medical loss ratio.

30 Personal communication with Julie B. Weinberg, Director, New Mexico Department of Human Services Medical Assistance Division, March 13, 2014.

31 The Community Health Workers Act, New Mexico Laws of 2014, Chapter 49. Available at: http://www.sos.state.nm.us/uploads/files/SB%2058.pdf.

32 The National Academy for State Health Policy has been tracking new and ongoing state efforts to implement medical homes and health homes for Medicaid and CHIP enrollees since 2007. National Academy for State Health Policy, "Medical Home & Patient-Centered Care," 2014, http://www.nashp.org/med-home-map.

33 Agency for Healthcare Research and Quality. "PCMH Resource Center: Defining the PCMH," accessed April 17, 2014, available at http://pcmh.ahrq.gov/page/defining-pcmh.

34 National Academy for State Health Policy, "Medical Home & Patient-Centered Care."

35 A 2012 analysis noted that nineteen of the twenty-five states making enhanced payments to medical homes as of June 2012 used a fee-for-service plus PMPM payment methodology. For more information, see: M. Takach, "About Half of the States are Implementing Patient-Centered Medical Homes for Their Medicaid Populations," *Health Affairs* 2012 31 (11): 2432-2440.

36 Maine Quality Counts, "Maine Patient Centered Medical Home," accessed April 17, 2014, available at http://www.mainequalitycounts.org/page/2-659/patient-centered-medical-home

37 NCQA, "Patient-Centered Medical Home Recognition," accessed April 17, 2014, available at http://www.ncqa. org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx.

38 Maine PCMH Pilot, "2014 Core Expectations: Minimum Requirements." Available at: http://www.mainequalitycounts.org/image_upload/Maine%20PCMH%20Pilot%20Practice_Core%20Expectations_Phase%202_02-12.pdf

39 Maine Quality Counts, "Maine PCMH Pilot & Phase 2 Expansion Frequently Asked Questions for Primary Care Practices," March 2013. Available at: http://www.mainequalitycounts.org/image_upload/ME%20PCMH%20Pilot%20%20Expansion%20FAQ_11-12%20%203_2013.pdf.

40 Personal communication with Lisa Letourneau, Executive Director, Maine Quality Counts, April 23, 2014.

41 Centers for Medicare & Medicaid Services, "Health Homes," accessed April 29, 2014, available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html.

42 Charles Townley and Mary Takach, *Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues* (Portland, ME: National Academy for State Health Policy, July 2012).

43 Idaho Department of Health and Welfare, "Idaho Health Home Program," accessed April 17, 2014, available at http://healthandwelfare.idaho.gov/Medical/Medicaid/IdahoHealthHome/tabid/2118/Default.aspx/. Idaho, like many states, has closely linked its Health Home program with broader work to support patient-centered medical homes in the state. The Idaho Medical Home Collaborative (IMHC) launched a two-year 21-practice medical home pilot practices in 2013; in addition to Idaho Medicaid, which participates via the state's Health Home program, the state's three commercial insurers are all participating. For more information on the IMHC Pilot, see: http://imhc.idaho.gov/default.aspx

44 Idaho Department of Health and Welfare, "Idaho Health Home Program."

45 Personal communication with David Simnitt and Meg Hall, Idaho Department of Health and Welfare, March 14, 2014.

46 Idaho Department of Health and Welfare, "Idaho Health Home Program."

47 Personal communication with David Simnitt and Meg Hall, Idaho Department of Health and Welfare.

48 These states are: Alabama, Iowa, Maine, Michigan, Minnesota, Montana, New York, North Carolina, Oklahoma, and Vermont. National Academy for State Health Policy, "Medical Home & Patient-Centered Care."

49 Mary Takach and Jason Buxbaum, *Developing Federally Qualified Health Centers into Community Networks to Improve State Primary Care Delivery Systems* (Portland, ME: National Academy for State Health Policy, May 2011). Available at: http://www.nashp.org/sites/default/files/developing.fqhcs_.community.networks.takach.buxbaum.2.pdf.

50 Personal communication with Wendy Sturn, Health Improvement Program Officer, Montana Department of Public Health and Human Services. For more information on the Chronic Care Professional certification offered by the HealthSciences Institute see http://www.healthsciences.org/Chronic-Care-Professional-Certification.

51 For the full text of the waiver amendment, see: https://www.statereforum.org/system/files/2010_passport_1915b amendment1cmschanges.pdf.

52 For more information on specific states' accountable care models, see NASHP's State Accountable Care Activity map at http://www.nashp.org/state-accountable-care-activity-map.

53 Chapter 602, Oregon Laws of 2011. Available at http://www.oregonlegislature.gov/bills_laws/lawsstatutes/2011orLaw0602.html.

54 The waiver amendment was approved in July 2012. Waiver documents are available at https://cco.health.oregon.gov/DraftDocuments/Pages/CMS-Waiver.aspx.

55 More information on Oregon's payment methodology for CCOs is available in the state's 1115 Waiver request narrative, available at https://cco.health.oregon.gov/DraftDocuments/Documents/narrative.pdf.

56 Chapter 602, Oregon Laws of 2011.

57 Personal communication with Chris DeMars, Monica Hammer, and Joell Archibald, Oregon Health Authority Transformation Center, March 12, 2014.

58 Interview with Prathiba Pinnamaneni, Director of Improvement, Neighborcare Health, March 11, 2014.

59 Interview with Prathiba Pinnamaneni, Director of Improvement, Neighborcare Health, March 11, 2014.

60 Interview with Prathiba Pinnamaneni, Director of Improvement, Neighborcare Health, March 11, 2014.

61 Katie Bell and Prathiba Pinnamaneni, Neighborcare Health. PowerPoint Presentation. "Optimizing the Role of the Front Desk Staff." Presented on Safety Net Medical Home Initiative webinar December 15, 2011. Retrieved March 5, 2014. http://www.qualishealth.org/about-us/newsroom/news/neighborcare-presents-optimizing-the-role-of-the-front-desk-staff.

62 Katie Bell and Prathiba Pinnamaneni, Neighborcare Health. PowerPoint Presentation. "Optimizing the Role of the Front Desk Staff." Presented on Safety Net Medical Home Initiative webinar December 15, 2011. Retrieved March 5, 2014. http://www.qualishealth.org/about-us/newsroom/news/neighborcare-presents-optimizing-the-role-of-the-front-desk-staff.

63 Interview with Prathiba Pinnamaneni, Director of Improvement, Neighborcare Health, March 11, 2014.

64 Premera Blue Cross. "Corporate Citizenship 2012 Annual Update." https://www.premera.com/documents/024383.pdf. Interview with Prathiba Pinnamaneni, Director of Improvement, Neighborcare Health, March 11, 2014.

65 Interview with Prathiba Pinnamaneni, Director of Improvement, Neighborcare Health, March 11, 2014.

66 Union Health Center (UHC). PowerPoint Presentation. "Implementing Successful Patient Centered Medical Homes: Transforming Medical Assistant Roles at the Union Health Center" http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=%2bYJ%2fz5Pjm0k%3d&tabid=37.

67 Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum, "Transforming the Role of Medical Assistants in Chronic Disease Management," *Health Affairs* 29, no. 5 (May 2010): 963-965. http://content.healthaffairs.org/content/29/5/963.full?sid=66a69bf0-7843-428e-941a-93781045f770.

68 Mercer Human Resource Counseling, *Redesigning Primary Care for Breakthrough in Health Insurance Affordability* (August 1, 2005). http://www.chcf.org/ /media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20RedesigningPrimaryCareAffordability.pdf.

69 Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum, "Transforming the Role of Medical Assistants in Chronic Disease Management," *Health Affairs* 29, no. 5 (May 2010): 963-965.

70 Union Health Center (UHC). PowerPoint Presentation. "Implementing Successful Patient Centered Medical Homes: Transforming Medical Assistant Roles at the Union Health Center." http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=%2bYJ%2fz5Pjm0k%3d&tabid=37.

71 *Innovative Workforce Models in Health Care: Expanding the Roles of Medical Assistants in Primary Care* (San Francisco, CA: UCSF Center for the Health Professions, February 14, 2014).

72 *Innovative Workforce Models in Health Care: Expanding the Roles of Medical Assistants in Primary Care* (San Francisco, CA: UCSF Center for the Health Professions, February 14, 2014).

73 Union Health Center (UHC). PowerPoint Presentation. "Implementing Successful Patient Centered Medical Homes: Transforming Medical Assistant Roles at the Union Health Center."

74 Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum, "Transforming the Role of Medical Assistants in Chronic Disease Management," *Health Affairs* 29, no. 5 (May 2010): 963-965.

75 Union Health Center (UHC). PowerPoint Presentation. "Implementing Successful Patient Centered Medical Homes: Transforming Medical Assistant Roles at the Union Health Center."

76 *Innovative Workforce Models in Health Care: Expanding the Roles of Medical Assistants in Primary Care* (San Francisco, CA: UCSF Center for the Health Professions, February 14, 2014).

77 Union Health Center (UHC). PowerPoint Presentation. "Implementing Successful Patient Centered Medical Homes: Transforming Medical Assistant Roles at the Union Health Center."

78 *Innovative Workforce Models in Health Care: Expanding the Roles of Medical Assistants in Primary Care* (San Francisco, CA: UCSF Center for the Health Professions, February 14, 2014).

79 Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum, "Transforming the Role of Medical Assistants in Chronic Disease Management," *Health Affairs* 29, no. 5 (May 2010): 963-965.

80 *Innovative Workforce Models in Health Care: Expanding the Roles of Medical Assistants in Primary Care* (San Francisco, CA: UCSF Center for the Health Professions, February 14, 2014). Direct communication with Audrey Lum, April 22, 2014.

81 Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum, "Transforming the Role of Medical Assistants in Chronic Disease Management," *Health Affairs* 29, no. 5 (May 2010): 963-965.

82 Interviews with Luz Jimenez, Senior Vice President for Clinical Operations, Erie Family Health Center. December 6, 2013 and April 25, 2014.

83 South Carolina Department of Health and Human Services. PowerPoint Presentation. "South Carolina Medicaid and the Community Health Worker Program." https://www.scdhhs.gov/sites/default/files/SC%20Medicaid%20and%20the%20Community%20Health%20Worker%20Program.pdf.

84 South Carolina Department of Health and Human Services, "Community Health Worker Frequently Asked Questions," January 17, 2013. https://www.scdhhs.gov/sites/default/files/Community%20Health%20Worker%20FAQ-%201-17-13.pdf.

85 South Carolina Hospital Association, "Community Health Workers in Primary Care Practices," news release, December 13, 2012, http://www.scha.org/news/community-health-workers-in-primary-care-practices.

86 South Carolina Department of Health and Human Services. PowerPoint Presentation. "South Carolina Medicaid and the Community Health Worker Program"; and South Carolina Department of Health and Human Services, "Community Health Worker Frequently Asked Questions."

87 Personal communication with Melanie Giese, Director, SC Birth Outcomes Initiative, South Carolina Department of Health and Human Services. April 23, 2014.

88 South Carolina Department of Health and Human Services. PowerPoint presentation. "South Carolina Medicaid and the Community Health Worker Program"; and South Carolina Department of Health and Human Services, "Community Health Worker Frequently Asked Questions."

89 Personal communication with Melanie Giese, Director, SC Birth Outcomes Initiative, South Carolina Department of Health and Human Services. April 23, 2014.

90 South Carolina Department of Health and Human Services. PowerPoint Presentation. "South Carolina Medicaid and the Community Health Worker Program," (presentation). https://www.scdhhs.gov/sites/default/files/SC%20Medicaid%20and%20the%20Community%20Health%20Worker%20Program.pdf

91 South Carolina Department of Health and Human Services, "South Carolina Medicaid and the Community Health Worker Program," and South Carolina Department of Health and Human Services, "Community Health Worker Frequently Asked Questions."

92 South Carolina Department of Health and Human Services, "South Carolina Medicaid and the Community Health Worker Program," (presentation). https://www.scdhhs.gov/sites/default/files/SC%20Medicaid%20and%20the%20Community%20Health%20Worker%20Program.pdf.

93 MaineGeneral Medical Center. "Medical Assistant Training Toolkit." 2012. http://www.mainequalitycounts.org/page/2-874/medical-assistant-toolkits.

94 MaineGeneral Medical Center. "Medical Assistant Training Toolkit." 2012. http://www.mainequalitycounts.org/page/2-874/medical-assistant-toolkits.

95 Personal communication with Lisa Letourneau, Executive Director, Maine Quality Counts. March 7, 2014.

96 MaineGeneral Medical Center. "Medical Assistant Training Toolkit." 2012. http://www.mainequalitycounts.org/page/2-874/medical-assistant-toolkits.

97 Diagnostic, Screening, Preventive, and Rehabilitative Services, 42 CFR 440.130 (c). For more information, see Centers for Medicare & Medicaid Services CMCS Informational Bulletin, "Update on Preventive Services Initiatives," November 27, 2013, available at: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf.

98 See, for example, TeamSTEPPS, developed by the Agency for Healthcare Research and Quality. Available at: http://teamstepps.ahrq.gov/.