OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

January 10, 2019

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of the Minutes	5 min
4. Community & Clinical Integration Program Participant Presentations	85 min
a. Community Health Center Inc.	
b. Northeast Medical Group	
c. Value Care Alliance	
5. Primary Care Modernization Update	15 min
6. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

Community & Clinical Integration Program

Purpose of the CCIP & CCIP Standards

- CCIP was designed to support Advanced Networks and FQHCs in the development and implementation of network-wide capabilities to improve primary care
- CCIP was envisioned to complement PCMH+ and other shared savings programs by focusing on capabilities that could lead to improvements in key shared savings program measures

CORE STANDARDS

- Comprehensive Care Management
- Health Equity Improvement
- Behavioral Health Integration

ELECTIVE STANDARDS

- Comprehensive Medication Management
- Oral Health Integration
- E-Consults

CCIP Strategy

During Wave 1, our CCIP Strategy was to provide technical assistance and transformation award funding to the three Participating Entities: Community Health Center, Inc., Northeast Medical Group, and the Value Care Alliance.

Technical Assistance

- Initial Readiness Assessments
- Development of Transformation Plans
- Quarterly Reassessments & Updates to the Transformation Plans
- Regular Meetings with Qualidigm and the SIM PMO
- In-person Learning Collaboratives focused on Core Standards
- Online Learning Management System- Educational Resources

Transformation Awards

- Community Health Workers
- Behavioral Health Specialists (Social Worker & LCSW)
- Program Coordinators
- eConsults Support including CCMC, UConn HDI, and SafetyNet Connect
- HIT Investments
  - PatientPing
  - SymphonyRM
  - Himformatics

Streamlined Standards

CCIP Standards Streamlined mid- 2018

- Right-sized the provisions to focus on the practicable, feasible, verifiable and sustainable within the time available and within the limitations of the current payment environment
- Distinguished the two requirements of the Standards - establishing a network-wide policy and practice-level implementation
- Reinforced requirement that the Comprehensive Care Team include a CHW and a Behavioral Health Specialist
- Require the collection of Sexual Orientation and Gender Identity (SOGI) data, rather than recommend
- Removed anxiety and trauma screening requirement

CCIP Standards

Comprehensive Care Management

Identify and Assess

Identify Individual with complex health care needs

Conduct Person-Centered **Assessment**

Plan and Execute

Develop Individualized **Care Plan**

Establish Comprehensive **Care Team**

Execute Individualized Care Plan

Monitor and Evaluate

Assess individual readiness for **self-directed care**

Monitor individual need to reconnect with care team

Evaluate and improve intervention

CCIP Standards

Health Equity Improvement Part 1

Collect and Analyze

Expand collection, reporting, & analysis of demographic data

Identify and prioritize opportunities to reduce healthcare disparities

Implement

Implement CHW intervention to address identified disparity

Evaluate

Evaluate the intervention

CCIP Standards

Behavioral Health Integration

Identify

Identify individuals with behavioral health needs

Treat

Conduct on-site assessment and treatment

or

Refer to Behavioral Health Specialist

Communicate with Behavioral Health Specialist on treatment status

Evaluate

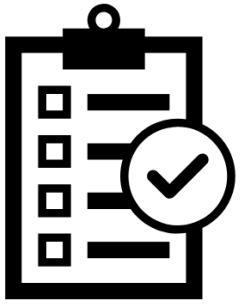
Track outcomes for identified individuals

CCIP Wave 1 Continuation Strategy

Supplemental Awards up to $400,000

Access to Subject Matter Experts

Regular Check-In Calls with the SIM Office



Validation of Progress against the Standards by Island Peer Review Organization (IPRO)

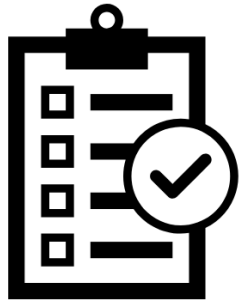
SIM connecticut state innovation model

CCIP Wave 2 Strategy

Transformation Awards up to $750,000

Access to Subject Matter Experts

Regular Check-In Calls with the SIM Office



Validation of Progress against the Standards by Island Peer Review Organization (IPRO)

SIM connecticut state innovation model

Transformation & Supplemental Award Focus Areas

- Staff, including Community Health Workers, Behavioral Health Specialists, PharmDs, Data Analysts
- CHW ECHO Initiative
- EHR Adjustments to enable expanded data collection
- Behavioral Health Referral Platform
- Community Referral Platform
- Reporting/Analytics Tools
- Project Management Technical Assistance

CCIP Participants

Wave 1

Community Health Center, Inc.

Northeast Medical Group

Value Care Alliance

In addition…
The other **8 FQHCs** participating in PCMH+ are required to complete **Core Standard 2: Health Equity Improvement**. We will soon announce a technical assistance vendor to support this effort.

Wave 2

Hartford Healthcare Medical Group

Prospect CT Medical Foundation

Wheeler Clinic/Community Health & Wellness Center of Greater Torrington

CCIP Participant Presentations

Community Health Center, Inc.

Dr. Daren Anderson

Northeast Medical Group

Jeanette Bogdan, Dr. Ohm Deshpande,

& Polly VanderWoude

Value Care Alliance

Dr. Kirsten Anderson

CCIP Participants will share…

- Successes
- Challenges
- Lessons Learned

For Discussion...

How can we continue to advance the CCIP goals through the remainder of SIM and beyond?

Community Health Center Inc.

Presenter: Dr. Daren Anderson

Community Health Center, Inc.

Updates for Community & Clinical Integration Program Steering Committee

January 10, 2019

Dr. Daren Anderson, VP/CQO, CHCI; Director, Weitzman Institute
Adriana Rojas, Project Manager

weitzman institute

A Learning and Innovation Center
Supporting Practice Transformation for Safety Net Practices Nationwide

Community Health Center, Inc.

Profile

- Founding year: 1972
- 14 Primary Care Centers
- Care delivered in 204 sites
- Annual budget: $100m
- Staff: 1,000
- Patients/year: 100,000
- **PCMH+ Panel: 48,000**

Complex Care	Health Equity	Behavioral Health
Identify patients with complex care needs	**Expand stratified data collection** • Preferred language • SDOH • SOGI • Race and ethnicity	Identify BH needs
Conduct Pt-centered assessments	**Health Disparity** • Identify a disparity • Implement intervention • Evaluate	Address BH Needs
Establish a comprehensive care team		Communicate/Collaborate BH-PCP
Care plan • Develop • Execute and monitor • Transition • Reconnect		Track BH Outcomes
Evaluate and improve effectiveness of intervention		

Community & Clinical Integration Program

Improve Complex Care Management
Improve Health Equity
Improve Integration of Behavioral Health and Primary Care

Enhance Data Collection, Measurement and Application

Enhance Primary Care Team

Enhance Engagement with Medical Neighborhood

Community & Clinical Integration Program

Improve Complex Care Management
Improve Health Equity
Improve Integration of Behavioral Health and Primary Care

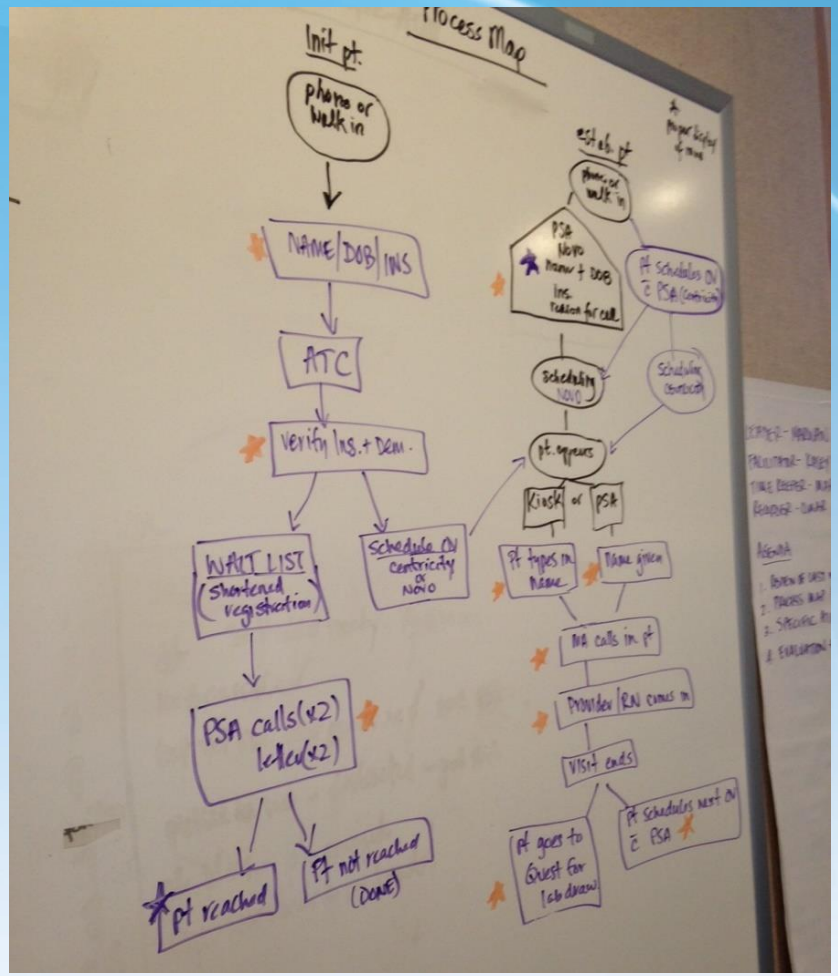
Enhance Data Collection, Measurement and Application

Enhance Primary Care Team

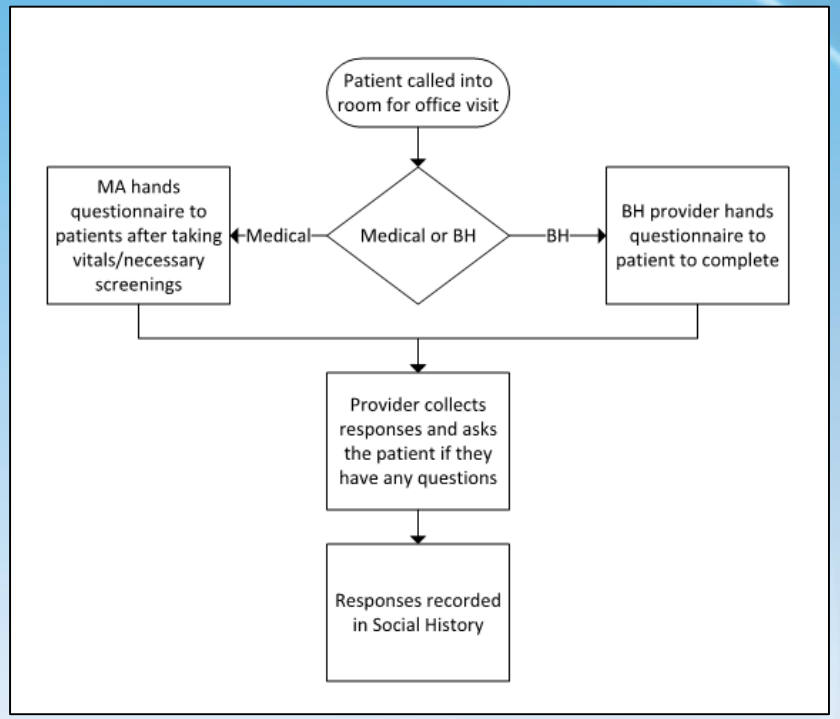
Enhance Engagement with Medical Neighborhood

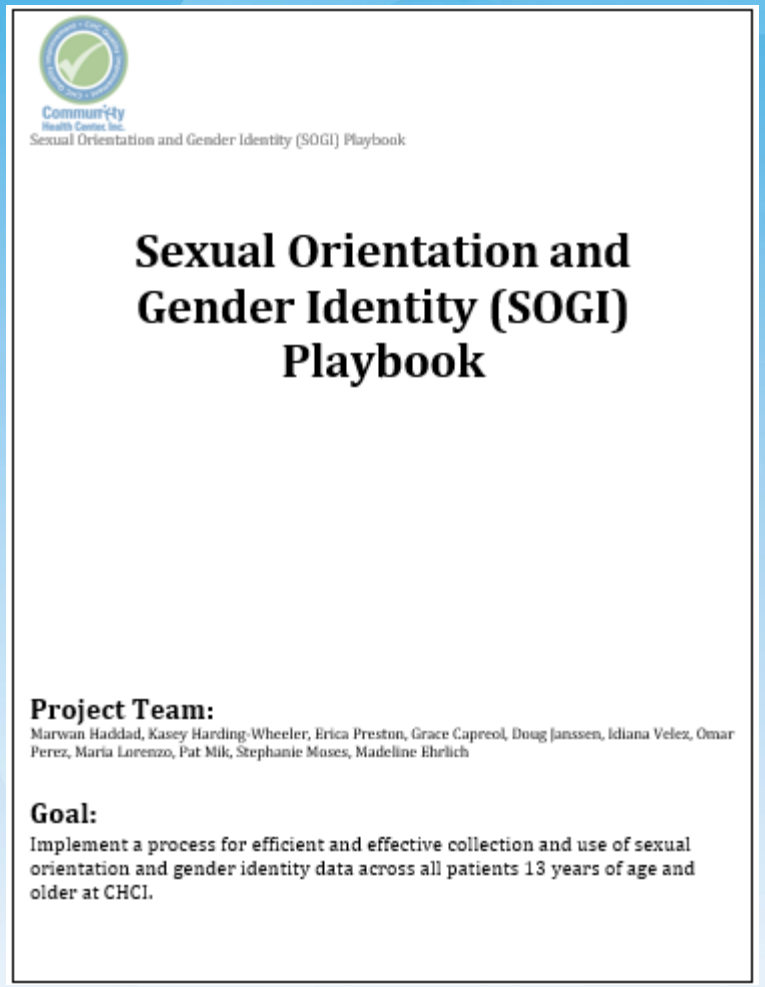
Translating CCIP Core Standards into measurable outcomes

- Step 1:
  - Develop and test workflow for new data collection
    - SDOH
    - PROM
    - Substance abuse screening
    - ACE screening
    - Depression screening
    - Pain screening



- Step 2:
  - Formalize the process and implement





Community Health Center, Inc.

Sexual Orientation and Gender Identity (SOGI) Playbook

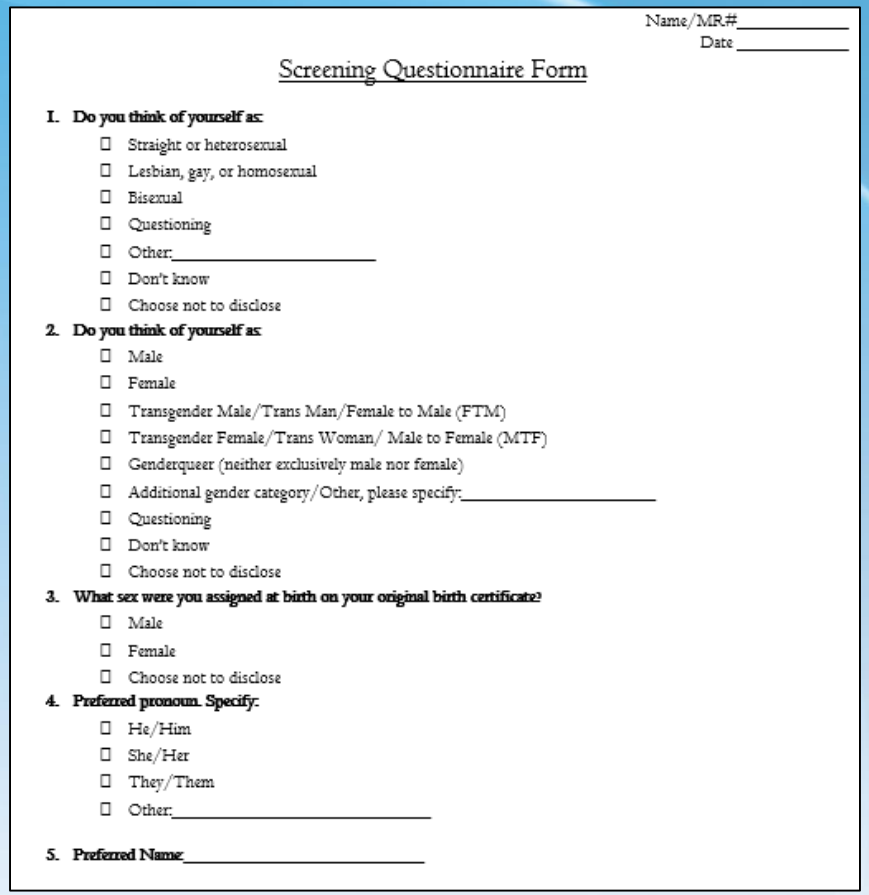
Sexual Orientation and Gender Identity (SOGI) Playbook

Project Team:

Marwan Haddad, Kasey Harding-Wheeler, Erica Preston, Grace Capreol, Doug Janssen, Idiana Velez, Omar Perez, Maria Lorenzo, Pat Mik, Stephanie Moses, Madeline Ehrlich

Goal:

Implement a process for efficient and effective collection and use of sexual orientation and gender identity data across all patients 13 years of age and older at CHCI.



Name/MR#_____

Date _____

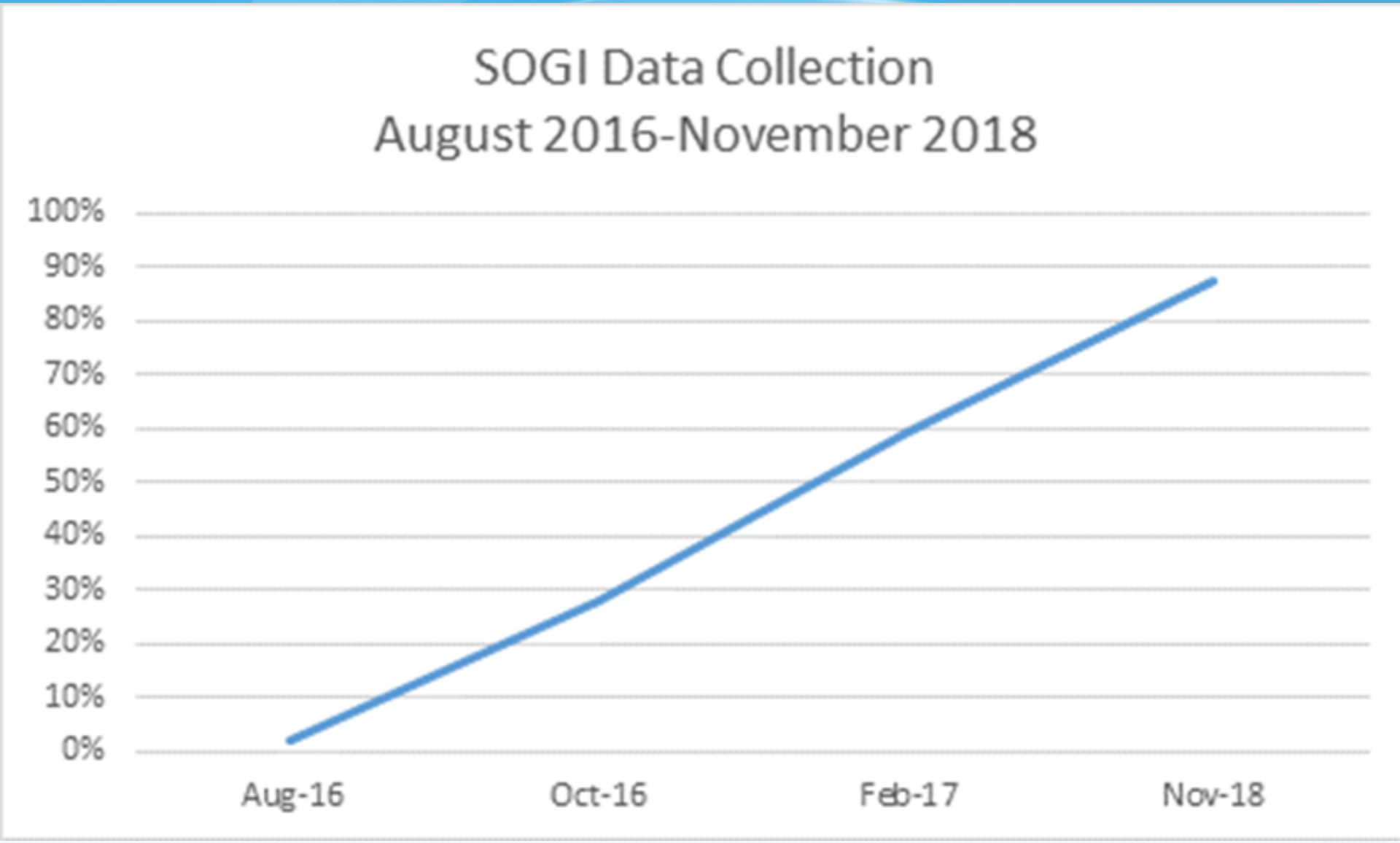
Screening Questionnaire Form

1. **Do you think of yourself as:**
   - ☐ Straight or heterosexual
   - ☐ Lesbian, gay, or homosexual
   - ☐ Bisexual
   - ☐ Questioning
   - ☐ Other:_____
   - ☐ Don't know
   - ☐ Choose not to disclose
2. **Do you think of yourself as:**
   - ☐ Male
   - ☐ Female
   - ☐ Transgender Male/Trans Man/Female to Male (FTM)
   - ☐ Transgender Female/Trans Woman/ Male to Female (MTF)
   - ☐ Genderqueer (neither exclusively male nor female)
   - ☐ Additional gender category/Other, please specify:_____
   - ☐ Questioning
   - ☐ Don't know
   - ☐ Choose not to disclose
3. **What sex were you assigned at birth on your original birth certificate?**
   - ☐ Male
   - ☐ Female
   - ☐ Choose not to disclose
4. **Preferred pronoun. Specify:**
   - ☐ He/Him
   - ☐ She/Her
   - ☐ They/Them
   - ☐ Other:_____
5. **Preferred Name:**_____

- Step 3:
  - Develop a formal measure

Goal	Measurement	Type	*Guidelines*		Description	Value	%
Increase collection of sexual orientation and gender identity (SOGI) data documented in the EHRs	**% of patients with SOGI data documented in the EHRs**	Process	***All patients age 13+ will be asked about sexual orientation and gender identity***	**Numerator**	Patients greater than 13 years of age with SOGI data EVER documented in the EHRs		
				Denominator	Patients age 13 and older as of visit date who had a medical visit 4/1/18-6/30/18		

Goal	Measurement	Type	*Guidelines*		Description	Value	%
Increase collection of sexual orientation and gender identity (SOGI) data documented in the EHRs	**% of patients with SOGI data documented in the EHRs**	Process	***All patients age 13+ will be asked about sexual orientation and gender identity***	**Numerator**	Patients greater than 13 years of age with SOGI data EVER documented in the EHRs		89%
				Denominator	Patients age 13 and older as of visit date who had a medical visit 4/1/18-6/30/18		


SOGI Data Collection
August 2016-November 2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Aug-16
Oct-16
Feb-17
Nov-18

- Step 4:
  - Make data actionable at the point of care

Enhance Data-driven Care

Patient	PCP and Visit Info
[redacted]	[redacted] Next Medical Appointment: 4/23/2018 10:00:00 AM Middletown Medical Last Dental Visit: Never Done Reason for Visit: diarrhea x 5 days, abd cramping, see 4/23 TE

ALERTS	Last Date	Due Date	Value	Notes
Needs Flu Vaccine 2017-2018				
Cervical Cancer Screening	4/15/2013	4/15/2016		
Depression Screening	10/1/2015	10/1/2016		
HIV Screen Needed				Once,13-64 yrs old
SBIRT	Never Done			Yearly,18+ yrs old
HITS	Never Done			Once, Females, 14+ years old

Patient	PCP an
[redacted] Sex: M Age: 51.0	[redacted] Next Me 4/23/201[redacted] Middletown Medical Last Dental Visit: 1/25/2016 Reason for Visit: follow up

Bubbles	#
TE	1
RX	
Doc	1
Lab	

Opioid Alerts	Value
Last Utox	1/30/2018
Last Pain Assessment	4/6/2018
Under Contract	No
CTPMP	No

Figure 1. **Quarterly provider report on opioid prescribing**, page 1 (sample)

Question a: How am I doing compared to other providers at my site and in the agency?

		Average	
Reporting Period	CURRENT	CURRENT	CURRENT
Measure		Site	CHC
Total prescriptions for opioids	115	72	72
Prescriptions with a high pill count	0	2	1
Prescriptions with MME>=90	17	11	10
Prescriptions with MME>=120	10	4	6
Do Not Prescribe Prescriptions*	2	3	1
High Risk Opioids			
Nucynta or Tapentadol	0	0	0
Oxycontin	5	2	3
Opioid & Benzodiazepines	7	9	7

Question b: How am I doing compared to myself over time?

CURRENT	PERIOD 3	PERIOD 2	PERIOD 1
Adjusted data for period comparison (Reference is Period 1)			
101	116	109	121
0	1	1	0
15	17	19	16
9	10	7	10
2	0	2	3
0	0	0	0
4	1	1	3
6	11	N/A	N/A

Definitions

High pill count:
Dispensed 180 or more pills

Do not prescribe prescriptions:
Dilaudid, Soma and Hydromorphone

***Excludes Soma for Periods 1 and 2**

	Begin	End	Days	Working Days
Baseline (PERIOD 1):	6/2/2014	9/15/2014	105	74
PERIOD 2:	7/21/2015	10/20/2015	91	65
PERIOD 3:	12/1/2015	3/29/2015	119	84
CURRENT:	4/1/2016	7/31/2016	121	84

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Community & Clinical Integration Program

Improve Complex Care Management
Improve Health Equity
Improve Integration of Behavioral Health and Primary Care

Enhance Data Collection, Measurement and Application

Enhance Primary Care Team

- **Expanding care teams**
- **Training to a new model**

Enhance Engagement with Medical Neighborhood

Expanded Care Teams

PharmD

CHW

Chiropractor

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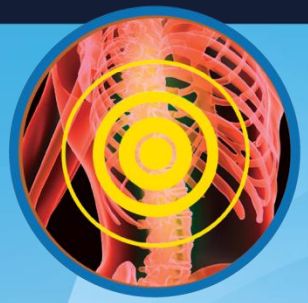
PROJECT ECHO®

weitzman institute inspiring primary care innovation

Using ECHO to "Upskill" and Train Primary Care Teams to a New Model of Care



Pain

HIV / AIDS

Buprenorphine

Hepatitis-C

Pediatric and Adolescent Behavioral Health

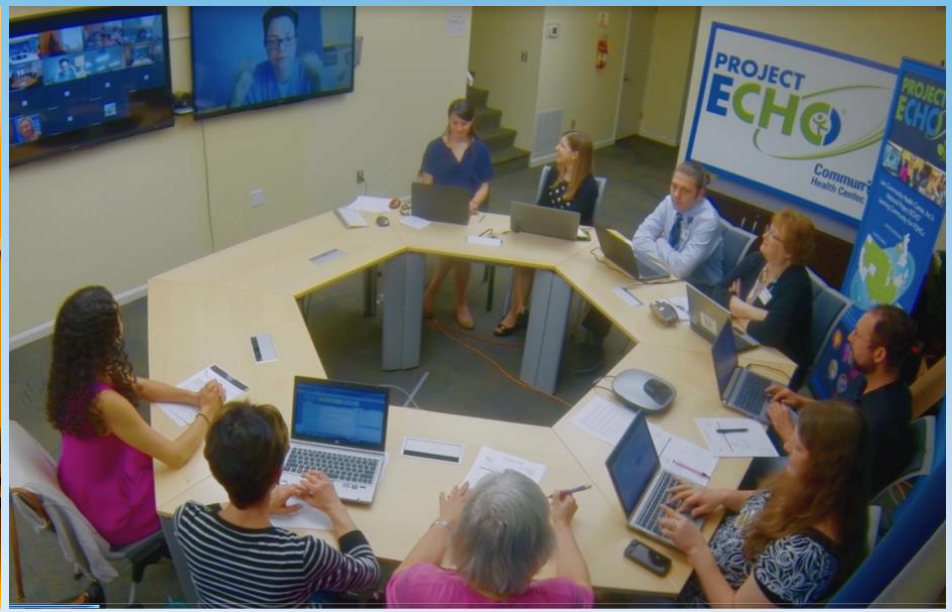
Complex Care Management

LGBT Health

Quality Improvement

Weitzman ECHO®

Coming soon! Project ECHO CHW



Community & Clinical Integration Program

Improve Complex Care Management
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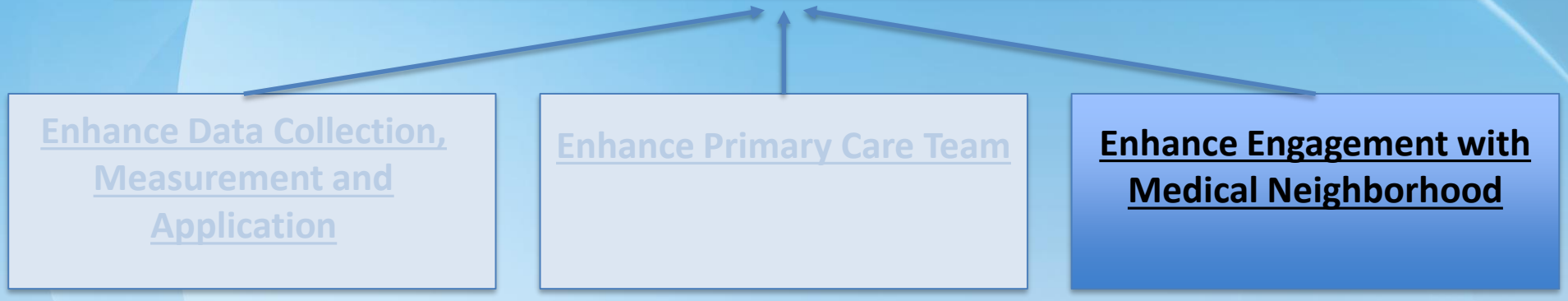

Prevention Services Initiative

- Collaboration with community-based care organizations
- Focus on Diabetes
- CHWs
- Diabetes education and support
- Integration with clinical teams

Hispanic Health Council
Health. Hope. Community.

CONNECTICUT COMMUNITY CARE™
Caring From Every Perspective

Lack of access to specialty care is one of the most pervasive and addressable causes of health inequality

Up to 35%

of all primary care patients are referred to specialists annually

- Wait Times
- Travel
- Time off
- No Shows
- Duplication
- Poor Communication
- Increased Cost
- Health disparities

Electronic Consultations to Improve the Primary Care-Specialty Care Interface for Cardiology in the Medically Underserved: A Cluster-Randomized Controlled Trial

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Daren Anderson, MD[3]
Nicole Jepeal, BA[4]
Robert Aseltine, PhD[3]
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ABSTRACT

PURPOSE Communication between specialists and primary care clinicians is suboptimal, and access to referrals is often limited, which can lead to lower quality, inefficiency, and errors. An electronic consultation (e-consultation) is an asynchronous, non-face-to-face consultation between a primary care clinician and a specialist using a secure electronic communication platform. The purpose of this study was to conduct a randomized controlled trial of e-consultations to test its efficacy and effectiveness in reducing wait times and improving access to specialty care.

METHODS Primary care clinicians were randomized into a control (9 traditional) or an intervention (17 e-consultation) arm for referrals to cardiologists. Primary care clinicians were recruited from 12 practice sites in a community health center in Connecticut with mainly medically underserved patients. Two end points were analyzed with a Cox proportional hazards model where the hazard of either a visit or an e-consultation was linked to study arm, sex, race, and age.

RESULTS Thirty-six primary care clinicians participated in the study, referring 590 patients. In total, 69% of e-consultations were resolved without a visit to a cardiologist. After adjusting for covariates, median days to a review for an electronic consultation vs a visit for control patients were 5 and 24, respectively. A review of 6-month follow-up data found fewer cardiac-related emergency department visits for the intervention group.

CONCLUSION E-consultation referrals improved access to and timeliness of care for an underserved population, reduced overall specialty utilization, and streamlined specialty referrals without any increase in adverse cardiovascular outcomes. e-consultations are a potential solution for improving access to specialty care.

Ann Fam Med 2016;14:133-140. doi: 10.1370/afm.1869.

INTRODUCTION

The number of ambulatory care visits that result in a referral to another health care clinician has doubled during the past decade.[1] Timely access and good communication between clinicians are essential for quality, efficiency, and patient safety. In a national survey, however, only 34% of specialists reported routinely receiving information from referring primary care clinicians, and only 62% of the clinicians reported reliably receiving information back from the specialist.[2] This suboptimal exchange of information leads to an increase in medical errors, wasteful spending, and poor quality of care.[3,4]

In addition, access to subspecialty care is often limited, especially for medically underserved populations. At least 1 in 4 medical encounters at community health centers result in a referral to a specialist.[5] Obtaining appointments for these referrals is challenging because so few specialists are willing to accommodate them.[5,6] This imbalance in supply and demand leads to waiting times for appointments that can be as long as 1

Conflicts of interest: authors report none.

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CLINICAL

A Cost-Effectiveness Analysis of Cardiology eConsults for Medicaid Patients

Daren Anderson, MD; Victor Villagra, MD; Emil N. Coman, PhD; Ianita Zlateva, MPH; Alex Hutchinson, MBA; Jose Villagra, BS; and J. Nwando Olayiwola, MD, MPH

ABSTRACT

OBJECTIVES: To evaluate the cost-effectiveness of electronic consultations (eConsults) for cardiology compared with traditional face-to-face consults.

STUDY DESIGN: Cost-effectiveness analysis for a subset of Medicaid-insured patients in a cluster-randomized trial of eConsults versus the traditional face-to-face consultation process in a statewide federally qualified health center.

METHODS: A total of 369 Medicaid patients were referred for cardiology consultations by primary care providers who were randomly assigned to use either eConsults or their usual face-to-face referral process. Primary care providers in the eConsult arm transmitted consults to cardiologists using a secure peer-to-peer communication platform in an electronic health record. Intention-to-treat analysis was used to assess the total cost of care and cost across 7 categories: inpatient, outpatient, emergency department, pharmacy, labs, cardiac procedures, and "all other." Costs are from the payer's perspective.

RESULTS: Six months after the cardiology consult, patients in the eConsult group had significantly lower mean unadjusted total costs by $655 per patient, or lower mean costs by $466 per patient when adjusted for non-normality, compared with those in the face-to-face arm. The eConsult group had a significantly lower cost by $81 per patient in the outpatient cardiac procedures category.

CONCLUSIONS: These findings suggest that eConsults are associated with total cost savings to payers due principally to reductions in the cost of cardiac outpatient procedures.

Am J Manag Care. 2018;24(1):e294-e301

Many initiatives aimed at transforming primary care have concentrated on the development of patient-centered medical homes, with emphasis on elements including the adoption of electronic health records (EHRs), multidisciplinary team-based care, and care coordination. Fewer efforts have been directed at improving the interface between primary care providers (PCPs) and specialists in the outpatient setting.[1-3] This gap is notable given the significant clinical importance and financial impact of the PCP–specialist relationship. Outpatient specialty visits represent a disproportionate source of year-over-year increases in healthcare expenditures,[4,5] with research suggesting that a typical PCP interacts with more than 200 specialists in a year.[6] Such financial considerations are increasingly important as payment reform gains momentum across the country and stimulates experimentation with novel reimbursement arrangements. Additionally, the proliferation and adoption of new technologies, including EHRs and secure health information exchanges, are creating fertile conditions for improving the interface between specialists and PCPs.

Electronic consultations (eConsults) are non–face-to-face (F2F) consultations between a PCP and a specialist that utilize secure messaging to exchange information. Unlike electronic referral systems that link primary care practices with specialty providers for F2F appointment triage, eConsults provide a virtual consultation by the specialist after clinical information sent by the PCP is reviewed and returned with recommendations, which potentially eliminates the need for the patient to be seen in person by the specialist. Health systems that implemented eConsults have improved specialty access, reduced wait times,[7] and decreased F2F consultations between 9% and 51% depending on setting and specialty.[8-14] However, few studies have evaluated the effects of PCP access to a secure eConsult platform on total healthcare expenditures. Findings using retrospective data from an eConsult program in Canada suggest the potential for cost savings,[15,16] but these studies were not randomized and did not evaluate the impact on total cost of care. The reduction in F2F

TELEHEALTH

By Daren Anderson, Victor G. Villagra, Emil Coman, Tamim Ahmed, Anthony Porto, Nicole Jepeal, Giuseppe Maci, and Bridget Teevan

Reduced Cost Of Specialty Care Using Electronic Consultations For Medicaid Patients

DOI: 10.1377/hlthaff.2018.05124
HEALTH AFFAIRS 37,
NO. 12 (2018): 2031–2036

ABSTRACT **Specialty care accounts for a significant and growing portion of year-over-year Medicaid cost increases. Some referrals to specialists may be avoided and managed more efficiently by using electronic consultations (eConsults). In this study a large, multisite safety-net health center linked its primary care providers with specialists in dermatology, endocrinology, gastroenterology, and orthopedics via an eConsult platform. Many consults were managed without need for a face-to-face visit. Patients who had an eConsult had average specialty-related episode-of-care costs of $82 per patient per month less than those sent directly for a face-to-face visit. Expanding the use of eConsults for Medicaid patients and reimbursing the service could result in substantial savings while improving access to and timeliness of specialty care and strengthening primary care.**

Daren Anderson (Daren@chc1.com) is director of the Weitzman Institute at Community Health Center Inc., in Middletown, Connecticut.

Victor G. Villagra is an assistant professor at the UCONN Health Disparities Institute, University of Connecticut Health Center, in Farmington.

Emil Coman is a research associate in the Ethel Donaghue Center for Translating Research into Practice and Policy, University of Connecticut Health Center, in Farmington.

Tamim Ahmed is president of Health Analytics LLC, in Glastonbury, Connecticut.

Anthony Porto is a research assistant at the Weitzman Institute, Community Health Center Inc.

Nicole Jepeal is a quality improvement analytics supervisor at CareOregon Inc., in Portland. She was a research associate at the Weitzman Institute, Community Health Center Inc., at the time this work was conducted.

Giuseppe Maci is a research associate at the Weitzman Institute, Community Health Center Inc.

Bridget Teevan is a public health epidemiologist in the Rhode Island Department of Health, in Providence. She was a research associate at the Weitzman Institute, Community Health Center Inc., at the time this work was conducted.

Barbara Starfield described primary care as "the provision of first contact, person-focused, ongoing care over time that meets the health-related needs of people, referring only those too uncommon to maintain proficiency."[1] The number of patients with conditions deemed "too uncommon to maintain proficiency" has shifted over the past two decades, as suggested by a substantial increase in the number of patients referred to specialists from primary care providers. Between 1999 and 2009 the number of visits to specialists in the US increased from 41 million to 105 million.[2] One study found that approximately 25 percent of all visits to a community health center resulted in a referral to a specialist.[3] For such patients who are cared for in the health care safety net, the challenge posed by increased demand for specialty consultations is compounded by limited access, particularly for the uninsured, patients with Medicaid, and those residing in rural locations. Nationally, approximately one-third of specialist providers limited or were unwilling to see patients with Medicaid in 2011.[4]

The increase in specialty referrals for patients with Medicaid makes a substantial contribution to year-over-year health care cost increases and has significant economic consequences for state budgets.[2,5] Specialty care is significantly more expensive than primary care.[6] Limited access compounds the problem by delaying needed treatment and increasing the use of urgent care and emergency departments.[7]

Advanced payment models are rapidly expanding across the country and are providing increased incentives for primary care providers to find ways to increase value and reduce the cost of care. Many cost-saving interventions in primary care have focused on enhancing access in order to reduce unnecessary emergency department visits or on improving care coordination and hospital discharge follow-up to reduce costly hospitalization and rehospitalization. Less attention has been paid to finding strategies to reduce the need for specialty consultation despite the fact that a decision to refer to a specialist is one of the most common, and likely most expensive, decisions made by primary care providers each day.

Differences	Average (PMPM)	95%CI
Total Costs	-$84****	(-$101; -$67)
Dermatology	-$14	(-$27; $0)
Endocrinology	-$63**	(-$102; -$25)
Gastroenterology	-$59***	(-$75; -$42)
Orthopedics	-$85****	(-$105; -$65)

CeCN

Community eConsult Network, Inc.

A Primary Care-Focused
eConsult Network

www.communityeconsults.com

Specialty	Reduction in F2F Visits at CHCI
Cardiology	29%
Dermatology	34%
Endocrinology	38%
Gastroenterology	7%
Infectious Disease	38%
Nephrology	23%
Neurology	26%
Orthopedics	17%
Pain Medicine	9%
Rheumatology	29%
Pediatric Cardiology	8%
Pediatric Dermatology	20%
Pediatric Endocrinology	18%
Pediatric Pulmonology	6%
Total	21%

CeCN Connecticut Payer Contracts

ConnectiCare®
You know us by .

Anthem®

Connecticut Department of Social Services
Making a Difference

Harvard Pilgrim Health Care

CeCN Connecticut Partners

CMG COMMUNITY MEDICAL GROUP

ProHealth PHYSICIANS Part of OptumCare

Starling PHYSICIANS Healthcare the way it should be

The Smarter Choice for Care
MIDDLESEX HOSPITAL PRIMARY CARE

GRIFFIN HEALTH

Connecticut Children's MEDICAL CENTER

ValueCare ALLIANCE

Complex Care	Health Equity	Behavioral Health
Identify patients with complex care needs	**Expand stratified data collection** • Preferred language • SDOH • SOGI • Race and ethnicity	Identify BH needs
Conduct Pt-centered assessments	**Health Disparity** • Identify a disparity • Implement intervention • Evaluate	Address BH Needs
Establish a comprehensive care team		Communicate/Collaborate BH-PCP
Care plan • Develop • Execute and monitor • Transition • Reconnect		Track BH Outcomes
Evaluate and improve effectiveness of intervention		

THANK YOU

www.chc1.com
www.weitzmaninstute.com
www.communityeconsults.com

Northeast Medical Group

Presenters: Jeanette Bogdan, Dr. Ohm Deshpande, & Polly VanderWoude

Yale NewHaven Health

Northeast Medical Group Advanced Network CCIP Progress to Date

SIM Steering Committee

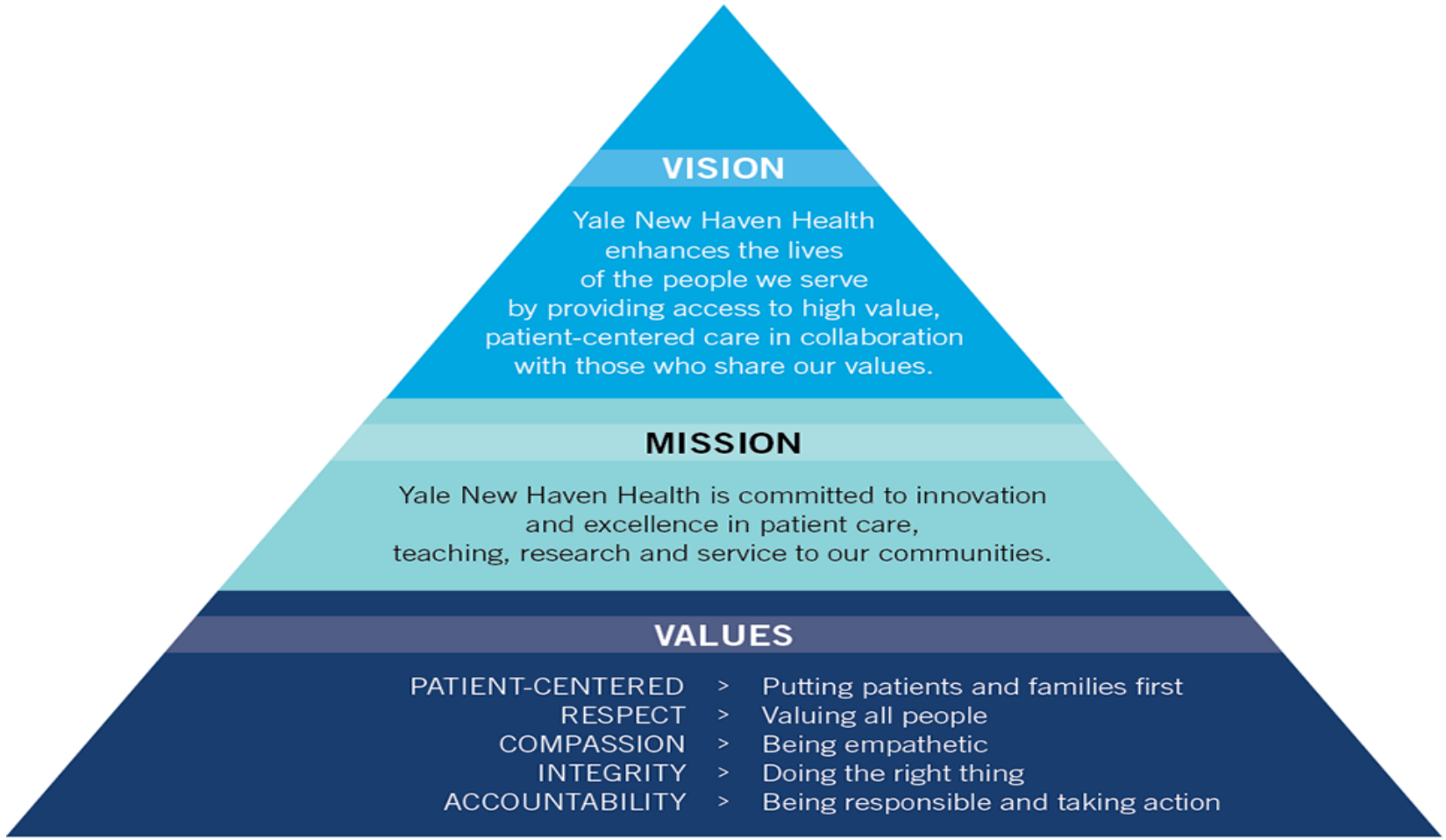
January 10, 2019

Jeanette Bogdan, RN
Director, Ambulatory Care Coordination

Ohm Deshpande, MD
Executive Director, Clinical Operations

Polly VanderWoude, MHSA, FACHE
Director, Clinical Integration & Population Health

VISION, MISSION AND VALUES

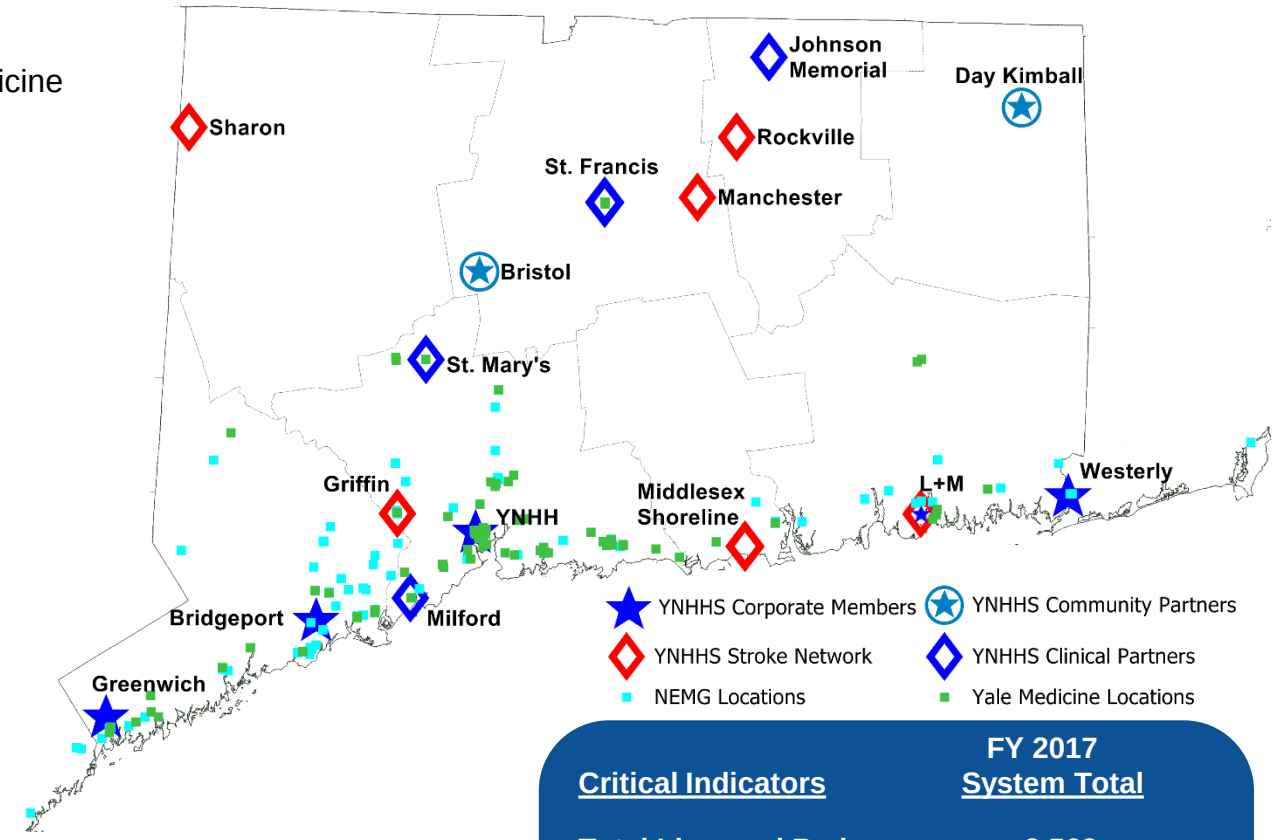


YaleNewHavenHealth

Bridgeport Hospital | Greenwich Hospital | Lawrence + Memorial Hospital | Westerly Hospital | Yale New Haven Hospital | Northeast Medical Group

Yale New Haven Health System - FY 2017

- Founded in 1995
- Affiliated with the Yale School of Medicine
- Corporate Members
  - »Yale New Haven Hospital
  - »Bridgeport Hospital
  - »Greenwich Hospital
  - »Lawrence + Memorial Hospital
  - »The Westerly Hospital, RI
  - »Northeast Medical Group
- YNHHS Community Partners
  - »Bristol Hospital
  - »Day Kimball Hospital
- YNHHS Stroke Network
  - »Griffin Hospital
  - »Manchester Memorial Hospital
  - »Middlesex Shoreline Medical Center
  - »Rockville General Hospital
  - »Sharon Hospital
- YNHHS Clinical Partners
  - »Johnson Memorial Medical Center
  - »Milford Hospital
  - »St. Francis Hospital and Medical Center
  - »St. Mary's Hospital
- »YNHHS Affiliates
  - »PhysicianOne Urgent Care
  - »United Surgical Partners International, Inc.



Critical Indicators	FY 2017 System Total
Total Licensed Beds	2,563
NEMG Providers	850
Inpatient Discharges	126,000
Outpatient Encounters	2.0 M
Net Revenue	$4.2 B
Operating Gain	$132.4 M
Total Assets	$5.6 B
Medical Staff	7,200
Employees	24,700

Yale NewHaven Health

NEMG Advanced Network: CCIP Contracting Entity

Northeast Medical Group

- 52 PCMH designated practices
- >200 Clinicians

Bridgeport Primary Care Center

- PCMH designated December 2017
- 6 Attending Physicians
- 42 Resident Physicians

Yale Internal Medicine Associates

- PCMH designated September 2017
- 7 Clinicians

Yale NewHaven Health

Behavioral Health Integration

Yale
NewHaven
Health

Opportunity: Develop and Test New Model of Care

Pilot model

- CCIP-supported Behavioral Health Social Worker embedded in a busy, multi-physician family medicine practice with on-site psychiatrist
- Create resources and workflows that reduce front-line provider burden and enhance early recognition and management of patient mental health issues
- Enhance front line PCP capacity to manage basic mental health conditions, and create standardized escalation workflow
- Enhance speedy access for patients requiring dedicated mental health evaluation

Yale NewHaven Health

Opportunity: Develop and Test New Model of Care

Accomplishments to Date

- Socialized model among diverse PCP group and reduced operational pain points preventing timely and effective front line mental health care
- Standardized depression and anxiety screening and basic medication management
- Warm handoffs and hot handoff process for crises
- Standardized process for same day & same week appointments depending on patient need
- Developed a compendium of behavioral health resources for PCPs
- Changing culture around prescription patterns regarding benzodiazepines for management of anxiety in the geriatric setting

Yale NewHaven Health

Integrated Behavioral Health – Clinician Feedback

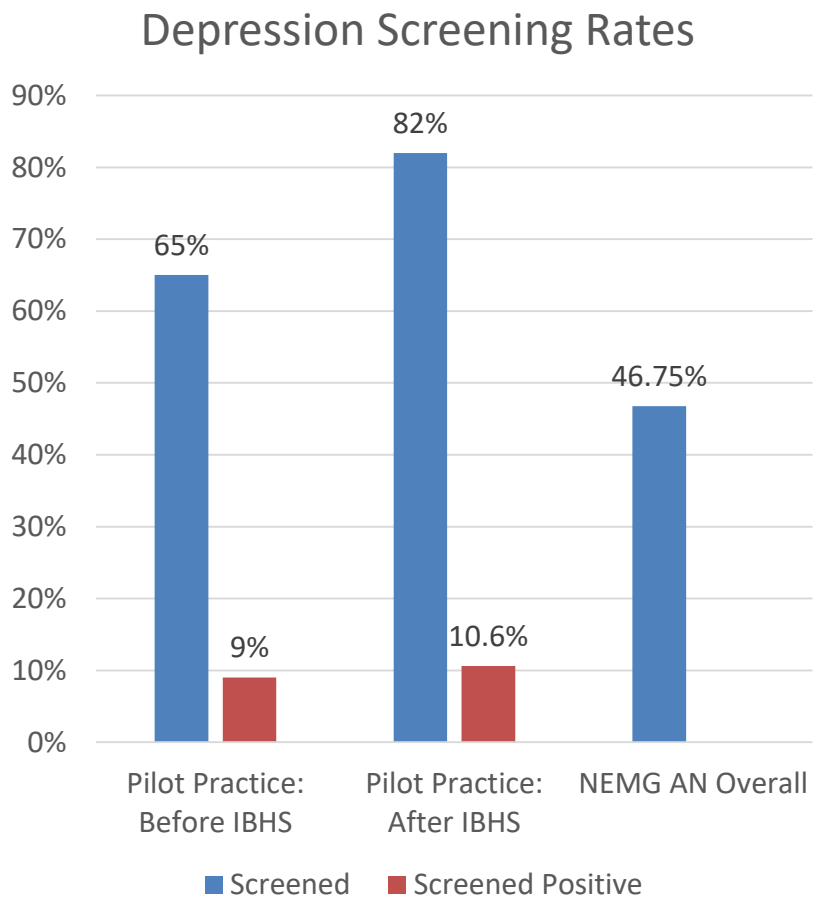
Having our Behavioral Health provider embedded in our office has been a life saver, sometimes literally. With an embedded practitioner, we can link at-risk patients, those who with extreme anxiety, depression and even those with suicidal thoughts with appropriate mental health care, IMMEDIATELY.

Please understand that after 24 years in my position, the greatest lack of resources I have experienced constantly was lack of access to mental health care. I cannot emphasize this enough. Please keep this position funded.

Pamela Gau, APRN

Yale
NewHaven
Health

Behavioral Health Integration - Early Results



After IBS data reflects patients screened from May 1 – December 18, 2018
NEMG AN Overall is Q3 2018 reported data for CCIP.

- After ramp up period, BHSW seeing 3-5 patients per day
- Targeted conditions:
  - Depression based on positive PHQ 9
  - Anxiety based positive GAD-7
  - Diagnostic clarification
  - Suicidal Ideation
  - Suspected behavioral factors influencing medical condition
- Integrated Behavioral Health Model being added to Yale Internal Medicine Associates

Yale NewHaven Health

Opportunity: Develop and Test New Model of Care

Successes:

- Provider satisfaction
- Creation of standardized algorithms to support positive depression screens
- Increased speed to Behavioral Health appointment

Challenges:

- Differences of opinion between what should be managed by PCPs and psychiatry
- Lack of psychiatry access
- Substance abuse workflow part of social history; needs to link to other social determinant factors
- Lack of substance abuse resources for patients of low-socioeconomics

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Comprehensive Care Management

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Health

Framework for Comprehensive Care Model

Source: AHRQ

Yale NewHaven Health

Patient Story

70 y/o male Spanish-speaking male. The patient was non-compliant with medications at time of last visit with PCP in November because of cost. The patient was referred by his primary care physician for navigation to community resources.

Upon screening, the patient identified the cost of prescriptions and access to food as his most important need. Because of the language barrier, the patient failed to enroll in the Medicare part D prescription program. The patient stated that he does not fill his prescription because he does not have prescription insurance. The patient also stated he did not have enough money to buy food. The Patient Navigator contacted New Haven Agency on Aging and arranged for a case manager to assess the patient in his home. The agency coordinator completed a Medicare part D application as well as a SNAP and utility assistance application.

The patient is currently enrolled in a managed Medicare program. The patient also qualified for SNAP assistance and was approved for energy assistance.

Opportunity: Develop and Test New Model of Care

Care management model & goals

- Core team of CCIP-supported Community Health Workers (CHWs) and YNHHS/NEMG supported RN care managers deployed across a disparate group of settings in the Bridgeport area
- Created awareness and referral workflows across ED, inpatient and ambulatory setting to funnel patients to team
- CHW model to connect patients with appropriate resources and enhance outcomes
- Utilize IT infrastructure – Patient Ping – to enhance line of sight across phases of care
- Utilize RN care managers to aid transitions of care and identify and route patients to close gaps

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Opportunity: Develop and Test New Model of Care

Accomplishments to Date

- Developed mechanism to conduct complex case reviews, with capacity to make interventions, with a multidisciplinary team at NEMG
- Created structure that facilitates referrals from inpatient, ED, ambulatory setting to care management team to address high risk needs
- Core team provides menu of services – facilitates navigation of language/comprehension, connection to available services, housing and other key social determinants of health
- CHW team trained in motivational interviewing, mental health first aid, cultural competency and unconscious bias
- Patient Ping has enhanced management of pilot population of CHF patients across inpatient, ambulatory and multiple provider setting. Facilitated reduction in hospitalizations & ED visits
- Transitions of care work has created additional safety net to identify patients requiring additional care management support

Yale NewHaven Health

Comprehensive Care Management – Key Indicators

CHW team was successful in addressing 778 (63%) of the needs for patients choosing to enroll in Navigation.

	Patients	Needs Identified	Needs per Patient
Screened	1691	1781	1.1
Enrolled in Navigation	535 (32%)	1227	2.3

Timeframe: January 1 – November 30, 2018

Nurse Care Coordinators were successful in connecting patients to their PCP post-discharge; outreach included medication adherence, homecare and DME follow-up.

	Medicare Patients	Outreach Complete	PCP Follow Up Complete
Post Acute Transitions	11,000	8,000	6,700 (84%)

Timeframe: January 1 – November 30, 2018

Yale NewHaven Health

Opportunity: Develop and Test New Model of Care

Successes:

- CHF pilot
- Enhanced patient outcomes/increased adherence
- Capacity building across NEMG, BHPCC, and YIMA
- Roadmap for multidisciplinary care management model across traditional barriers
- IT standardization

Challenges:

- Affordable housing
- Access to specialty care for Medicaid patients
- IT standardization

Yale NewHaven Health

Health Equity Improvement

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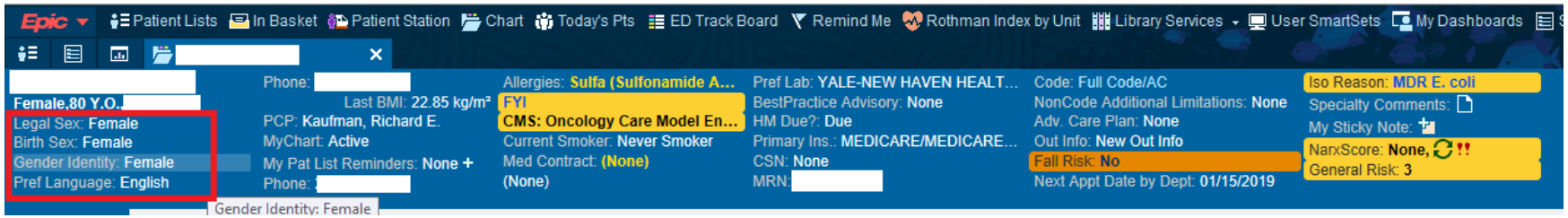
Health

Opportunity: Using Data, Identify Opportunities to Reduce Health Disparities

Accomplishments to Date



- October 2018 launched improved Patient Header with SOGI and Preferred Language information across instance of Epic
- Gender Identity training pilot at 6 NEMG practices with a high PCMH + population
- Gender Identity E-Learn to be released across the network later this year
- REAL data training conducted across the network to improve accuracy of data capture

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Opportunity: Using Data, Identify Opportunities to Reduce Health Disparities

Successes:

- Strong organizational commitment to diversity and inclusion
- New capabilities for SOGI data capture
- >99% preferred language capture

Challenges:

- Creating new process to capture granular country of origin data
- IT Integration across one Epic platform
- Applications / interventions derived from the capture of granular data

Yale NewHaven Health

Future Direction and Lessons Learned

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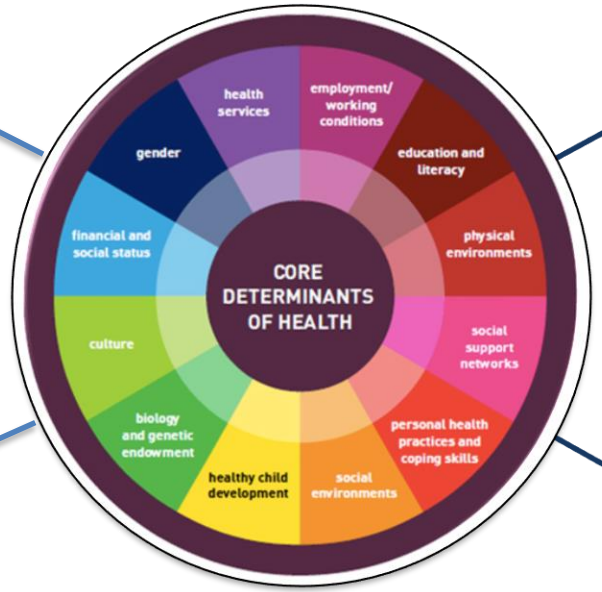
Health

Opportunity: Harmonizing SDOH Data Capture & Community Referral

Technology

Epic
Now Pow
Aunt Bertha
Others

Future:
Connecticut
Hospital
Association



Community Advocates

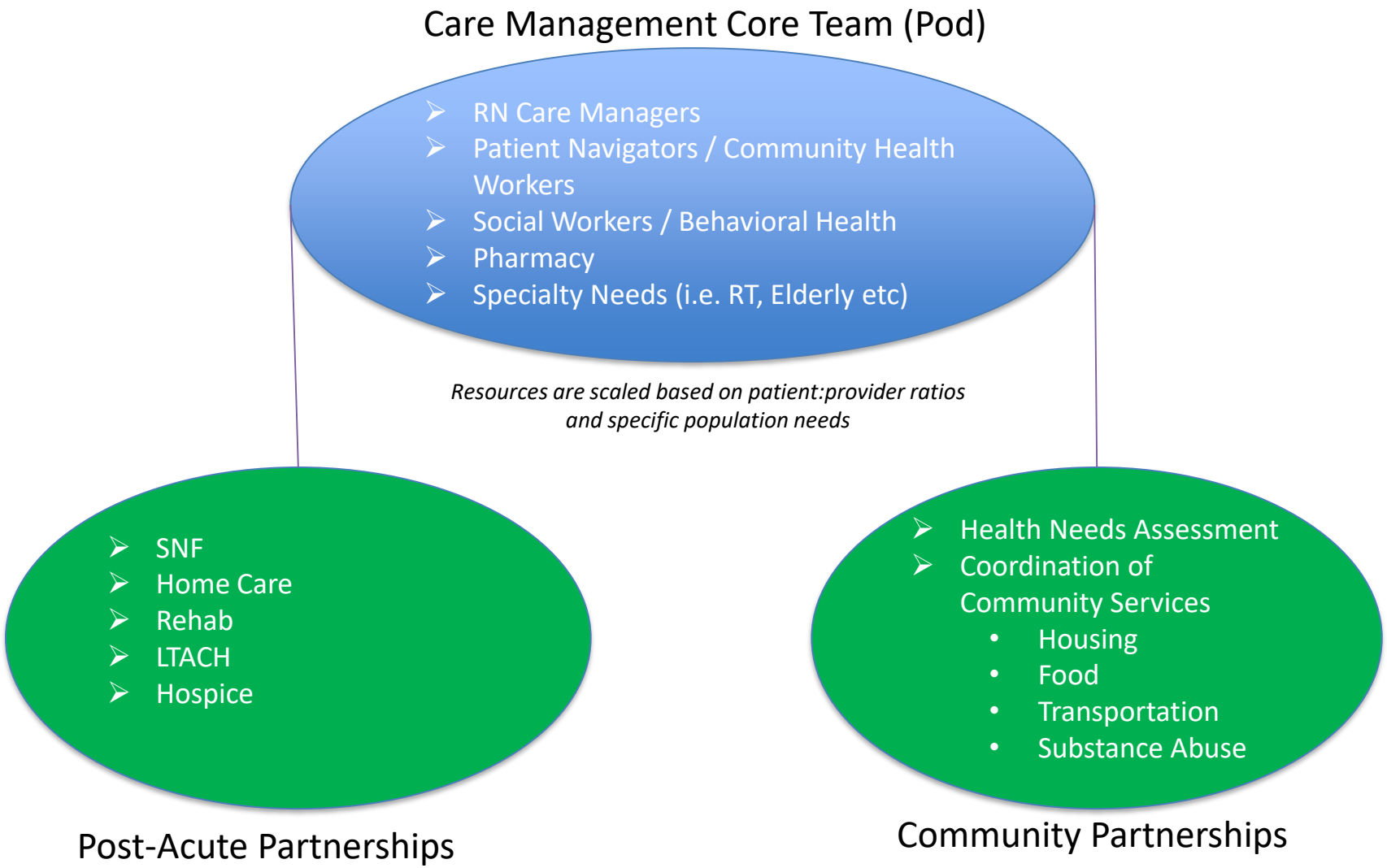
- Bridgeport / NEMG
- Medicaid

CMS / CMMI Accountable Health Communities

- New Haven
- Medicare & Medicaid

Yale NewHaven Health

Opportunity: Creating a Scalable Model



Yale NewHaven Health

Lessons Learned

- Programs like CCIP provide invaluable seed funding to test models
  - Results may lag; spread may be slower without true ROI
  - Continue to innovate with funding models, pilot programs

- Data capture and application
  - What's feasible – for clinicians, for patients
  - Myriad of measures and data sets – prioritize and focus

- Longer Term Impact and Program Design
  - What levers can the healthcare provider influence
  - What levers require state and community resources

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NewHaven
Health

Value Care Alliance

Presenter: Dr. Kirsten Anderson

SIM Steering Committee

Prepared for: SIM Steering Committee

Date: January 10, 2019

About the Value Care Alliance

The Value Care Alliance (VCA) is a collaboration among high quality, low cost Connecticut health care systems. This includes hospitals and organized physician groups working together to enhance efficient, coordinated care and promote local governance with shared leadership in health care decision making.

The Alliance will provide opportunities to exchange best practices among its members with the goal of reducing health care expense and improving quality. Additionally, the Alliance will deliver the data and analytical capability to enable efficient and effective care management and optimize the coordination of care across multiple settings.

The Alliance is the largest collaboration of independent health care providers in the state. Hospital and physician leaders are working together to set the direction for the Alliance and to enhance the delivery of clinically integrated care, as it helps its members and their patients respond to the changing health care environment.

Mission

The mission of the Alliance is to enhance the health and wellness of populations served by delivering exceptional preventative services, acute and non acute care through clinically integrated and connected communities of medical professionals who work together to coordinate patient-centered, high-quality and efficient care.

Vision

To be an essential partner for patients, employers, payers and providers seeking a competitive integrated system of care that operates at high efficiency and produces outstanding outcomes.

Value Care Alliance

The Value Care Alliance (Alliance) is a collaboration among high-quality, cost-efficient Connecticut healthcare systems. This includes hospitals and organized physician groups working together to enhance efficient, coordinated care and promote local governance with shared leadership in healthcare decision making.

Members

Danbury Hospital

Griffin Hospital

Middlesex Hospital

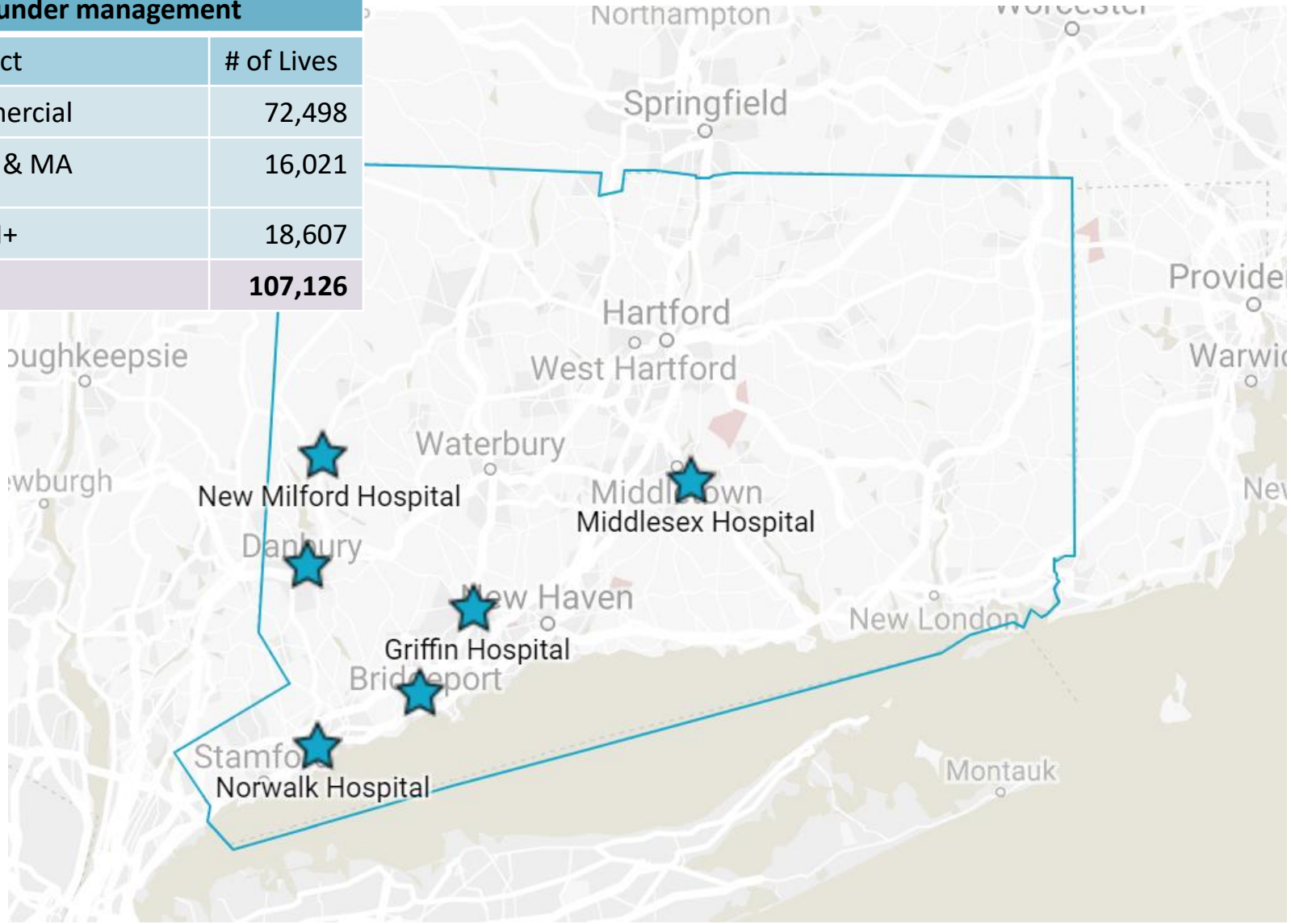
New Milford Hospital

Norwalk Hospital

St. Vincent's Medical Center

Value Care Alliance Geographic Distribution

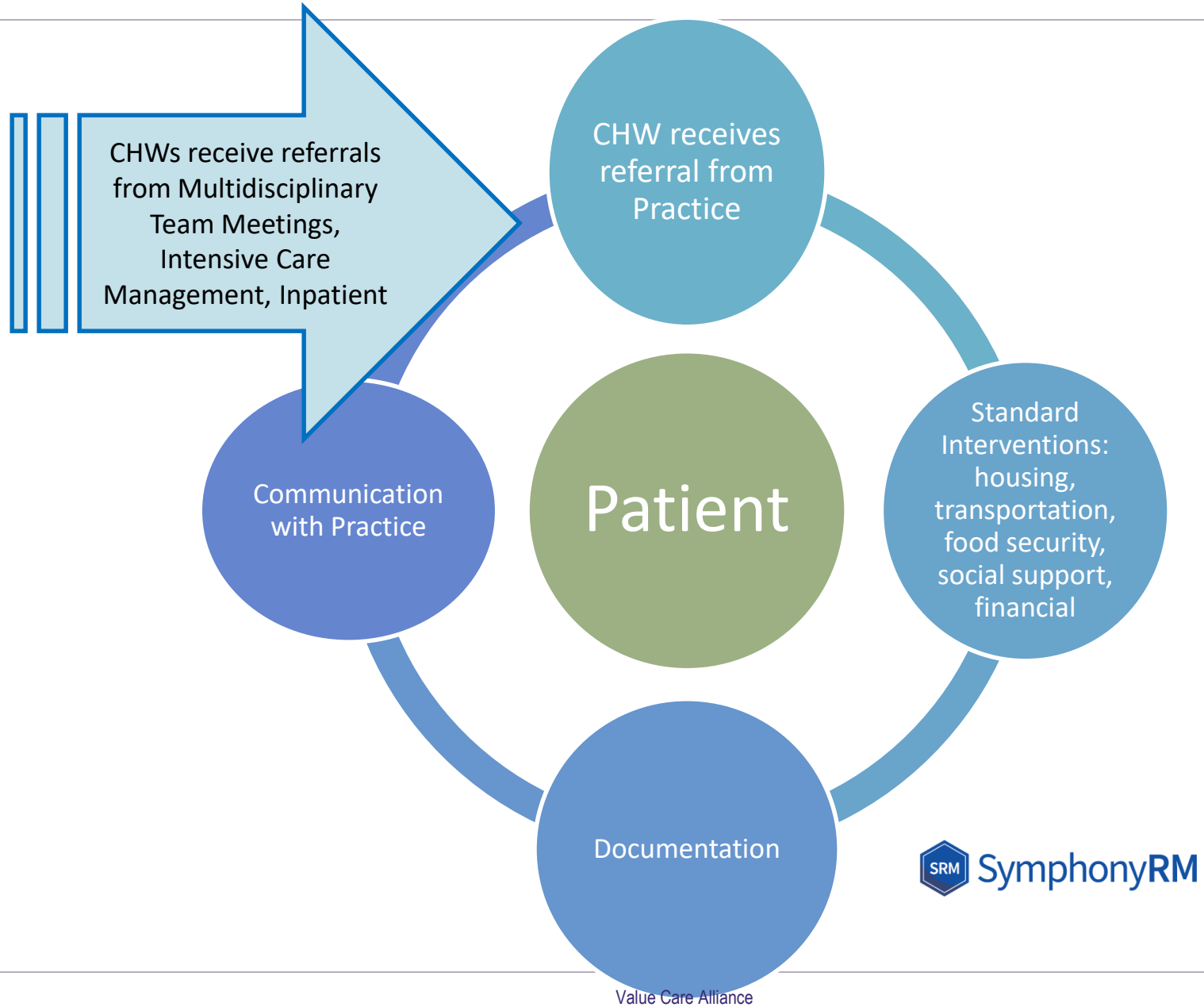
Lives under management	
Product	# of Lives
Commercial	72,498
MSSP & MA	16,021
PCMH+	18,607
Total	**107,126**



Outline

- Activities
  - CHW Integration into Primary Care
  - Expanded Race and Ethnicity data collection
- Successes/Progress
- Challenges/Lessons Learned
- Next Phase of Work – tracking follow-up

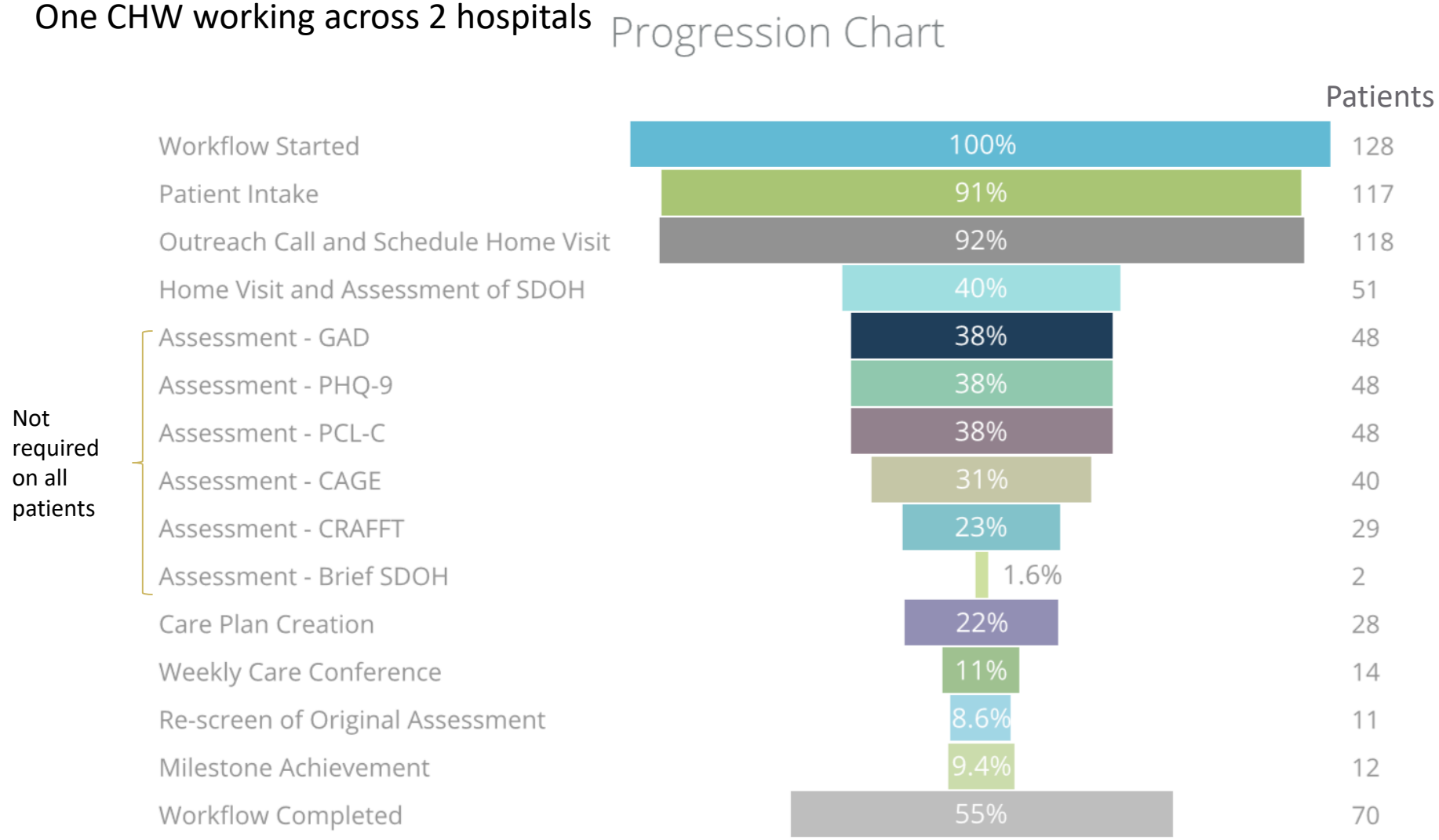
CHW Integration into Primary Care



SymphonyRM

CHW Workflows and Tracking Progress: 2018 Year to Date

One CHW working across 2 hospitals



Successful CHW Requirements

- Operational
  - Hiring the right people: inherent knowledge of the community
  - Excellent onboarding and training: 3 weeks of orientation and shadowing, online training, and Powerpoint presentations
  - Safety mechanisms in place: standard communication intervals with VCA to ensure tracking of CHW location and safety checklists
  - Monitoring performance of CHWs
- Function
  - Working with patients to close gaps in Social Determinants of Health
- Documentation
  - Payer agnostic system for documentation
  - Ability to modify the documentation requirements as we learn more
- Communication with the practices
  - Getting the patient level information to the primary care medical practices electronically or via fax
- Practicing at the top of skillset: VCA CHWs are non-clinical
  - Maximizing clinical vs. non-clinical time with the patient
  - Maximal return for the investment
  - Requires communication between clinical and non-clinical

CHW Challenges

How can CCIP/Office of Healthcare Strategy help provide better job security beyond the scope of the grant?

CHWs would have a better outcome if patients were:

- Willing to engage: high rate of dropout
- Taking the opportunity to follow through with many of the recommendations
- Ideally able to prioritize the CHW partnership in their lives

CHWs:

- *Would be more interested in full time permanent work
  - *Job stability would provide certainty about their career path after the end of the grant
  - *CHWs are new to the health care system and are expected to function at a high level of communication with existing clinical teams

Race and Ethnicity – Expanded Data Collection

- The VCA is 4 health systems with 7 hospitals, 106 primary care practices with 349 Primary Care Physicians and 1490 specialists
- All 4 have undergone or will be undergoing hospital information system conversions with tighter integration between hospital and physician EMRs for inpatient and outpatient between 2018 and 2020
  - WCHN March 2018
  - Griffin October 2018
  - SVHP April 2018
  - Middlesex Spring 2020
- All VCA health systems (inpatient and outpatient) have the capability to collect very granular data and have a care management workflow documentation system as well as customer relationship management (CRM) system
- All health systems use this data to direct their community outreach and wellness efforts
- **2 of the 4 have committed to implementing the recommended race and ethnicity fields**

What we collect today

- Of the potential >900 CDC race and ethnicity categories, Health Equity Solutions recommends that CT implement at least 40, based on census data including the American Community Survey
- The VCA currently collects over 50 categories over our 4 health systems

A sample of what we collect today

Race	F	M	Grand Total
White	8,042	5,734	13,776
Patient Declined	622	459	1,081
Other Race	411	277	688
African American	312	174	486
Black or African American	156	105	261
Asian	128	78	206
Asian Indian	58	30	88
Black	9	6	15
European	11	4	15
American Indian or Alaska Native	6	5	11
Native Hawaiian or Other Pacific Islander	4	2	6
American Indian	3	2	5
Italian	3	1	4
Chinese	1	2	3
Polish	1	2	3
Arab	2	1	3
Irish	2	1	3
Iranian	1	1	2
West Indian	2		2
Vietnamese	1	1	2
Jamaican	2		2
English		1	1
Thai	1		1
Unknown		1	1
Korean		1	1
Middle Eastern or North African		1	1
Laotian	1		1
Other Pacific Islander		1	1
Spanish American Indian	1		1
Cambodian	1		1
Taiwanese	1		1
Grand Total	**9,782**	**6,890**	**16,672**

Note some of these are small numbers

A sample of what we collect today

Race	Count of Enterprise ID	
White	63297	75.40%
Patient Declined	11460	13.65%
Other Race	2492	2.97%
Unknown	1379	1.64%
Black	1351	1.61%
Hispn	1264	1.51%
Asian	1190	1.42%
African American	518	0.62%
American Indian	329	0.39%
Indian	212	0.25%
Black or African American	156	0.19%
European	77	0.09%
Asian Indian	74	0.09%
Dominican	51	0.06%
Chinese	26	0.03%
Filipino	23	0.03%
Pacific Island	16	0.02%
American Indian or Alaska Native	10	0.01%
Cambodian	5	0.01%
Japanese	4	0.00%
Native Hawaiian	4	0.00%
NULL	3	0.00%
West Indian	2	0.00%
Arab	1	0.00%
Chiricahua	1	0.00%
Irish	1	0.00%
Alaska Native	1	0.00%
White Earth	1	0.00%
Indonesian	1	0.00%
Middle Eastern or North African	1	0.00%
Spanish American Indian	1	0.00%
Sri Lankan	1	0.00%
(blank)		
Grand Total	83952	

Ethnicity	Count of Enterprise ID	
Not Hispanic or Latino	63176	75.25%
Patient Declined	17886	21.31%
Hispanic or Latino/Spanish	2442	2.91%
Latin American/Latin, Latino	149	0.18%
NULL	120	0.14%
Puerto Rican	52	0.06%
Central American	34	0.04%
South American	33	0.04%
Mexican	27	0.03%
Spaniard	15	0.02%
Dominican	11	0.01%
Cuban	3	0.00%
Ecuadorian	2	0.00%
Panamanian	1	0.00%
South American Indian	1	0.00%
(blank)		
Grand Total	83952	

Note some of these are small numbers

Expanded Race and Ethnicity Collection: VCA will work with SIM to implement new categories

We have committed to working with SIM to evaluate the new categories, but is the plan going forward to **take action** based on that information?

How will the collection of this data create new information? VCA has a Health Equity Committee whose opinion was that some of the disparities are known, and would like to know how these additional Race and Ethnicity categories will be examined to contribute to the knowledge base regarding disparities.

What is the State of CT planning on doing to help the medical community further study how to address currently unknown disparities?

Four VCA health systems are helping to look at statewide disparities and draw conclusions regarding currently unknown disparities

We need SIM to help us look at data and identify how to better help patients, and provide those resources

Next Phase: CCIP Wave 2: Tracking patient follow-up

- Behavioral Health and Substance Abuse issues are a significant need in all health systems
- VCA is developing a program to track whether patients who have been referred by their Primary Care Physician to BH / SA specialists have kept their appointment
- New Tracking: enabling us to know whether patients have received the care recommended for behavioral health and substance abuse by their primary care physician
  - The VCA is working with SymphonyRM to intercept the electronic referral and will implement processes to follow up with the clinician/patient to ensure completion of the visit
- Goal is to ensure adequate treatment for behavioral health/substance abuse issues

Conclusion

- The VCA has made significant progress in our health systems on integrating community health workers, and emphasizing the importance of race and ethnicity, cultural competency, and behavioral health
- CCIP Grant has been foundational in helping us understand new ways to administer health care:
  - Integrating social determinants of health
  - Being aware of cultural issues that can impact health care
  - Leveraging technology to help make sure patients get the care they need
- Value Care Alliance is looking forward to our continued relationship with the Office of Healthcare Strategy

Primary Care Modernization Update

PCM Work Plan Update – The Work Ahead

PTTF Capability Summaries

- Twelve to fifteen two-page summaries of the proposed adult and pediatric capabilities
- Intended use:
  - SIM advisory bodies (PTTF, PRC, HISC)
  - Approved content will be used to develop stakeholder specific engagement materials for our “Round 2” stakeholder engagement with consumers, employers, health plans, providers, etc.
- Examples of the DRAFT two-page summaries are provided in your packet
- Will include link to concept map, additional detail, including evidence-base

Adults Diverse Care Teams DRAFT Concept Map - Revised

Network Level

Population Health Promotion & Management

Identify sub-populations with modifiable risk and clinical targets; predictive analytics

Assign patients, patient registries, action plans

Performance tracking, data sharing, patient engagement

Informs

Practice & Community Level
On-site, central hub, home or community

Comprehensive Care Management
RN

Acute, Preventive, Chronic Care
Physician, PA, APRN, RN, Medical Assistant

Health Promotion & Chronic Illness Self-management
RN, Nutritionist, Dietician, Pharmacist Diabetes/Asthma Educator, CHW

Care Coordination
RN, Social Worker, CHW, Medical Assistant

Team-based Care

Patient & Family

Medication Prescribing & Management Functions
PCP, Pharmacist, RN, Medical Assistant

Patient Navigation
Patient Navigator, CHW, Social Worker

Behavioral Health Integration
PCP, BH Clinician, Care Coordination with BH expertise, CHW

Medical interpretation services deployed as needed. All care team members trained in cultural sensitivity.

Coordinates

Health Neighborhood

Subspecialists
Cardiologists, endocrinologists, etc.

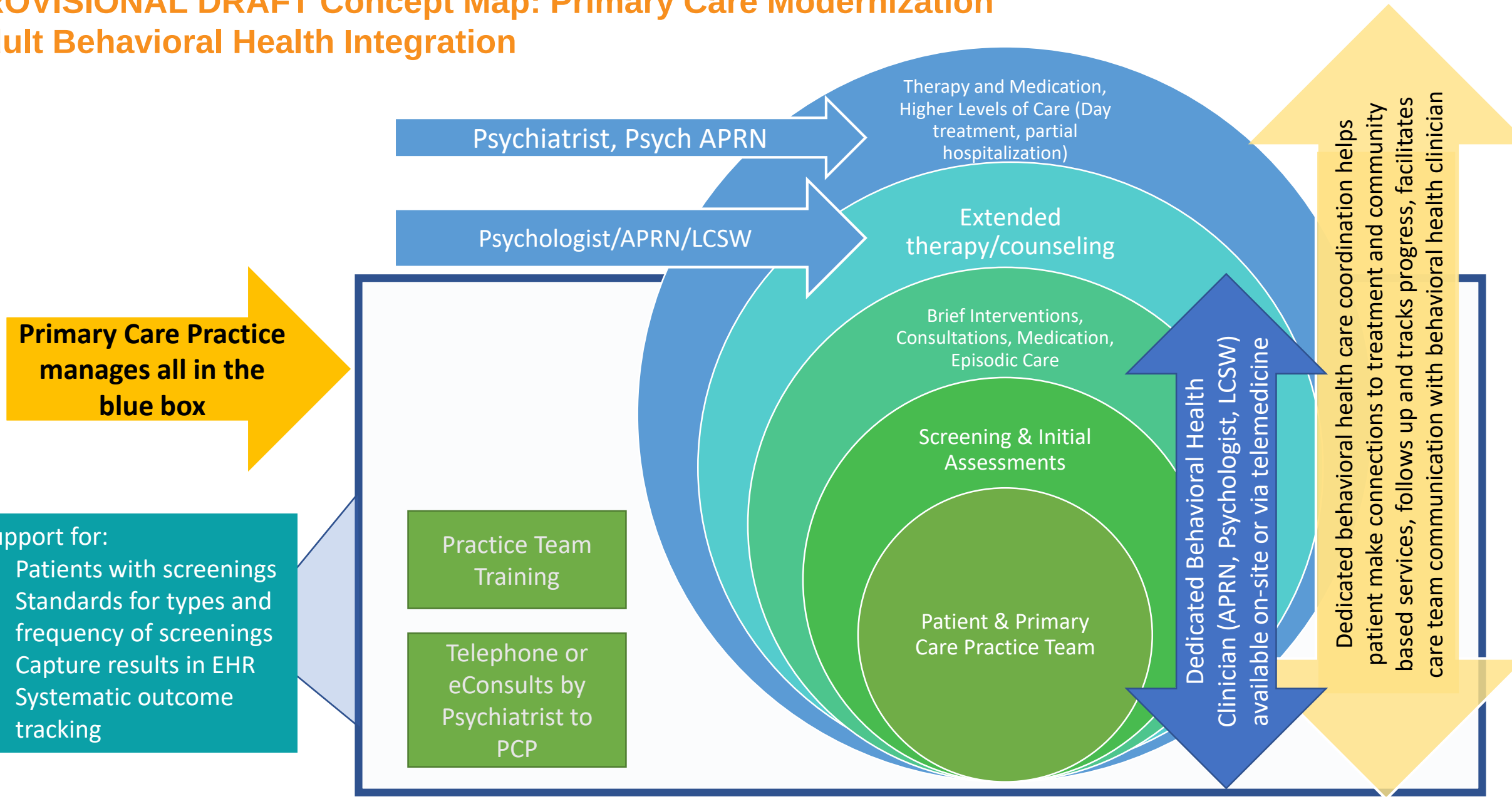
Community Care Extenders
Home care providers, community care teams, free standing free standing behavioral health providers

Ancillary Providers
Physical/occupational therapists, integrative medicine practitioners, community pharmacists

Community Resources
Food, housing support, financial assistance, etc.

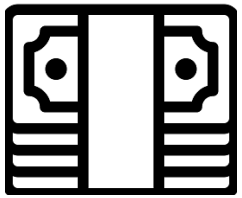
OHS CONNECTICUT Office of Health Strategy

PROVISIONAL DRAFT Concept Map: Primary Care Modernization
Adult Behavioral Health Integration



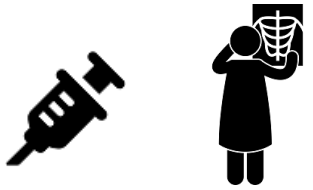
How would care be paid for?

Basic Bundle



Supplemental Bundle

Fee for Service Payments



What is covered in the bundles?

Basic Bundle

PCP's Time
(MD, DO, APRN, PA)

- **Office visits, phone, text, email, telemedicine, home visits, shared visits.**
- Leading care teams.
- Participation in technical assistance to offer more specialized care.
- Supporting e-Consult.

*Medicare will be expanding reimbursement to cover some of these services. PRC and PTTF will reconsider the merits and risks of the basic bundle in light of these reimbursement changes.

Both adjusted to reflect differences in patient needs and expected costs

Supplemental Bundle

New Expenses Necessary to Achieve Capabilities

- **Expanded, diversified care teams that connect with patients through office visits, phone, text, email, telemedicine, home visits, shared visits.**
- Primary care integration with behavioral health services and community-placed resources.
- New investments in technology and infrastructure to support achieving the capabilities.
- Specialist payments for e-Consult.
- Patient-specific expenses to address SDOH needs such as food security/food as medicine, housing instability and transportation.

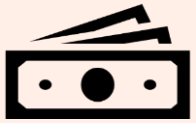
Why don't providers make these investments today?

Under most programs today, providers must generate <u>at least a 2:1 return</u> to share in savings.

Typical Shared Savings Arrangement

Advanced Network **spends** $1 on Community Health Workers

For every $1 invested, total cost of care decreases $1.80



Medicare gives 50% of savings to network ($0.90)

$1.00 (network spend)
- $.90 (shared savings)
= $0.10 (network loss)

Primary Care Modernization

Network **receives** $1 upfront payment to hire Community Health Workers

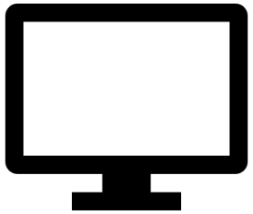
For every $1 invested, total cost of care decreases $1.80.

Medicare gives 50% of <u>net</u> savings to network ($0.40)

$1.00 (payer spend)
$ .80 (net savings)
-$.40 (payer share)
= $0.40 (network gain)

How would consumers be protected?

Protecting Against Underservice:

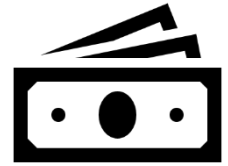


Quarterly claims data and electronic health records capture office and telemedicine visits, other interactions with care team members and hospital stays and readmissions per member

Data is shared publicly through routine provider reports and other sources

Protecting Against Patient Selection:

Patient experience surveys and consumer feedback loop relay patient perspective



Layered risk adjustment recognizes additional cost of social and behavioral needs

Attribution method prioritizes patient selection of provider

Mystery shopper to monitor access

How is underservice monitored?

A Focus on Level of Patient Support and Engagement

Today

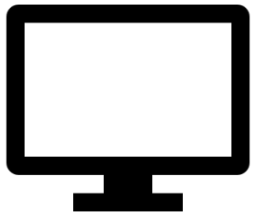
Claims

PCP visits/member

Under PCM

Claims

EHR



PCP visits/member

Other PCP contacts/member

Other Care Team
contacts & visits/member

Strawman PCM Accountability Process

AN/FQHC PCM application details approach to capabilities.

State and payer review and approve application.

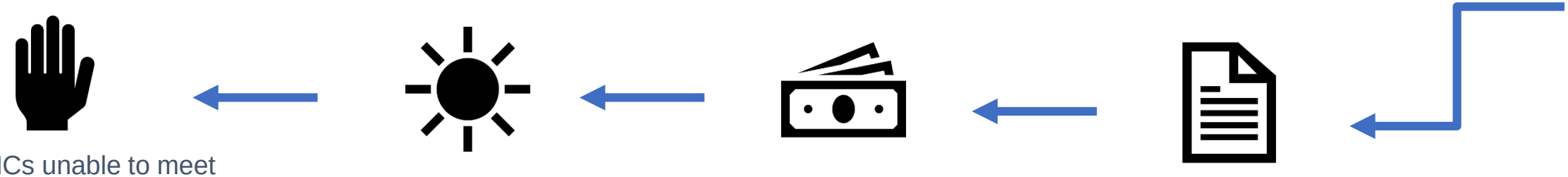
Using state template, ANs/FQHCs develop patient communications.

Claims and EHR data generate utilization and quality metrics.

Patient experience surveys; potentially oversample subpopulations.

Consumer feedback loop answers questions and investigates complaints.

Mystery shoppers call practices to confirm equitable access.



ANs/FQHCs produce periodic reports on investments, process milestones and results.

Payers report percent spending on primary care.

Public reports offer transparency to consumers, advocates and employers.

AN/FQHCs unable to meet requirements or who engage in underservice and/or patient selection will be subject to corrective action plans, financial consequences and termination.

Risk Adjusting the Supplemental Bundle

Proposed Approach

- Since supplemental bundle funds will largely go toward supporting care management and coordination, behavioral health integration and community integration, ideally these payments should be adjusted to align with the patients' needs in those areas.
- To achieve this, supplemental payments would be adjusted using an approach similar to CPC+.
- All beneficiaries are assigned to tiers based on their risk score **but** some beneficiaries default to higher tiers if they have certain conditions or characteristics. We will call this "secondary adjustment."
- Secondary adjustment conditions and characteristics should be meaningful to primary care, able to be defined using available data, and reasonable to isolate despite increased administrative burden.

Example: MassHealth Social Determinants of Care Risk Adjustment Model

- Risk adjustment methodology was augmented to capture the impact of social determinants of health on medical expense.
- The model predicts costs from DxCG relative risk score and age-sex indicators (leveraging commercially available model).
- Then, it adds markers for unstable housing (3 or more addresses/yr or v-code), disability, agency relationships, severe mental illness and substance use disorders.
- The final component is a summary measure of “neighborhood stress” based upon residence in a census block group.

Source: EOHHS
Model is not commercially available

Which populations should receive a secondary adjustment?

During stakeholder meetings, several populations were identified whose clinical, behavioral and social needs may not be fully reflected in a traditional risk adjustment methodology.

Examples included:

- Individuals with unmet social needs such as lack of stable housing
- Individuals with behavioral health conditions and substance use disorder conditions
- Individuals with dementia

Adjourn