OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

November 14, 2019

Meeting Agenda

Item	Time
1. Introductions/Call to Order	5 min
2. Public Comment	5 min
3. Approval of the Minutes	5 min
4. Prevention Services Initiative	60 min
5. Health Enhancement Communities	45 min
6. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

Prevention Services Initiative

HEALTH MANAGEMENT ASSOCIATES

CT Prevention Services Initiative
HISC Committee Presentation

November 14th, 2019

Hartford, CT

SIM connecticut state innovation model

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

OHS CONNECTICUT Office of Health Strategy

AGENDA

- PROJECT ACCOMPLISHMENTS
- PARTNERSHIP HIGHLIGHTS
  - FAIRFIELD HOSPITAL AND THE MILFORD HEALTH DEPARTMENT
  - WATERBURY HOSPITAL AND THE NAUGATUCK HEALTH DEPARTMENT AND POMPERAUG HEALTH DISTRICT
- WRAP UP
- Q & A

PREVENTION SERVICE INITIATIVE ACCOMPLISHMENTS

HEALTH MANAGEMENT ASSOCIATES

PREVENTION SERVICE INITIATIVE (PSI)

TECHNICAL ASSISTANCE

Year 1

- Organizational assessments
- Site Visits
- TA plans
- Webinars and tools
- Group Learning Sessions
- Regional calls
- 1:1 TA coaching and support
- Peer to peer relationship building
- TA for Business Planning and Contract Development
- SharePoint

Year 2

- Individual TA
- Partner TA
- Group Learning Sessions
- Sharepoint

PARTNERSHIPS

Community Based Organization (CBO)	Health Care Organization (HCO)	Evidence Based Program (EBP)	Geographical Area
CT Community Care	Community Health Center, Inc.	Live Well with Diabetes Plus	Middletown
Hispanic Health Council	Community Health Center, Inc.	DIALBEST	Bridgeport
Hispanic Health Council	Value Care Alliance(VCA) /St. Vincent's Medical Center	DIALBEST	Middletown
Milford Health Department	Fair Haven Community Health Center	Putting on Airs (Asthma)	New Haven
Naugatuck Valley Health District	Prospect Waterbury, Inc.	Diabetes Self-Management Program (DSMP)	New Haven
Southwestern CT Agency on Aging	Optimus Health Care	DSMP	Bridgeport

ACCOMPLISHMENTS

- Enhanced HCO and CBO capacity for chronic disease management
  - HCO capacity to identify populations for chronic disease management
  - provider awareness of EBPs
- Community extenders
  - New workflows for referral and care coordination between HCOs and CBOs
  - CHW integration into care teams
- Enhanced Infrastructure
  - New data collection tools and processes for CBOs
  - array of data sharing arrangements for CBOs and HCOs
- EBPs adapted and enhanced to address patient (and provider) needs
  - Interventions to address SDOH
- Experience with payment for performance
- Retrospective and concurrent evaluation
- Collaborative learning model; network development

PARTNERSHIP HIGHLIGHTS

HEALTH MANAGEMENT ASSOCIATES

FAIR HAVEN COMMUNITY HEALTH CENTER & MILFORD HEALTH DEPARTMENT

- **Project:** Putting On AIRS (POA) for adults and children with recent ED use due to asthma
- **Payment methodology:**
  - Initial payment structure
    - Initial evaluation and up to three follow up visits: $1,000
  - Finalized Payment Structure
    - First Visit: $800
    - Subsequent Visits: $200
- **Patient Identification and Referral:**
  - Engagement
    - Developed an English and Spanish brochure to be shared with patients regarding POA
  - Internal workflows initiated from asthma clinic; screened by an RN with asthma training; standardized referral in EHR (EPIC) with printed form that is faxed from FHCHC to MHD
    - 2-part visit: RN in clinic does initial contact, and asthma/pulmonologist clinician follows up with patient.
    - RN goes through checklist for referral, introduces the program. Referral form in EPIC established criteria; also items such as missed work, school. Handoff to physician, who makes decision and places referral.
    - After referral placed, LPN or CC outreaches to family to confirm willingness to participate; if so, CC prints, faxes, and liaises with Putting on AIRS Program (POA)

Implementation:

- ~101 referrals received by MHD to date, All have received outreach, 38 Initial visits, 21 (twenty-one) 2nd visits, 16 (sixteen) 3rd visits
- As of 9/2019 Fair Haven provides additional triage for referral to ensure they meet program qualifications.
- Have more recently expanded referrals to those with recent ED/hospitalization for asthma-related diagnoses (regardless of involvement in asthma clinic)
  - Intuition and anecdotal evidence is that the sickest patients/those experiencing recent asthma impact on their lives are most motivated to participate OR able to show necessary ED reduction

Communication:

- Communication is open and constant with daily emails and phone calls where needed
- Conference calls are made monthly to discuss referral data and address any outstanding issues that come up such as medication during a home visit.
- Referral faxing process with emails/calls to confirm
- Monthly reconciliation process to review number of referrals that have been sent

FAIR HAVEN COMMUNITY HEALTH CENTER & MILFORD HEALTH DEPARTMENT

+ Successes:

- + Communication (even on Saturdays)
- + Access to EPIC
- + Ability to address and share issues that come up at home visits
- + Finalized Payment Structure
- + Increase in invoicing to Fair Haven

+ Challenges:

- + Realized that only the sickest patients/those experiencing recent asthma impact on their lives are motivated to participate OR able to show necessary ED reduction
- + Difficulty sharing info via fax
- + Having complete buy in from both staff and patients

+ Future Projects/Endeavors:

- + Encrypted emails
- + Ability to insert information into EHR for real time
- + Database usage that coincides with EHR

ACCOMPLISHMENTS FOR PSI/SIM PROJECT

Although the traditional evidence-based model (POA) was utilized, additional benefits for this project include but not limited to:

- Implemented and began program using contracted payment methodology – over 30 enrolled
- Identified and worked through patient engagement challenges by refining inclusion criteria (those functionally impacted) and with provider partner
- Read-only access to EHR to
  - Obtain patient demographics
  - Share notes and updates with provider that required response regarding patient
- Additional communication for providers to learn more about patient's challenges such as
  - The ability to obtain and access medication
  - Medication adherence

LESSONS LEARNED

- Obtaining and Maintaining a good relationship with the HCO is key
  - Understanding each other's short and long term goals (long term savings is difficult to quantify into dollars)
- Contract
  - What is flexible/feasible for either party and what is not
- Communication
  - Be open and honest
  - Discussing tough points such as when to recognize when something does not work for either party
  - Discussing what happens at the end of the contract through this project
    - Sustainability of the linkage model
- Acknowledgement
  - Heavy on administration: having the ability to acknowledge and understand each party's efforts and the workload/flow that is being implemented along with other responsibilities
- Data management
  - Understand the outcome indicators that both parties are interested in learning and discuss how to obtain them together
  - Having an agreed upon database that is mutually shared to provide outcome indicators

Naugatuck Valley Health District
Pomperaug Health District
Waterbury Hospital
Chase Outpatient

DSMP

PARTNERSHIPS

CBOs

HCOs

Waterbury Hospital

WaterburyHEALTH

POMPERAUG DISTRICT DEPARTMENT OF HEALTH

+ Waterbury Health Access Program

+ Chase Outpatient Center

SIM connecticut state innovation model

DPH Connecticut Department of Public Health

OHS CONNECTICUT Office of Health Strategy

HEALTH MANAGEMENT ASSOCIATES

DIABETES SELF-MANAGEMENT PROGRAM

+ Evidence-based program developed by Stanford University, managed by Self-Management Resource Center, LLC

+ 6-week program
+ One 2.5-hour session per week
+ Group setting
+ Lay leaders

Topics:
- ✓ Healthy Eating
- ✓ Exercise
- ✓ Stress Management
- ✓ Communication Skills
- ✓ Goal Setting

+ **Incentives offered:**
  + Free 6-week program
  + Class materials, including the book "Living a Healthy Life with Chronic Conditions"
  + $50 gift card (upon completion)
  + Free enrollment in 6-week Cooking Matters class (upon completion)

OHS GRANT

- Part I & Part II Funding from OHS for administrative work
- Oversight of grant by OHS & DPH
- HCO also received funding from OHS for administrative work

DSMP REIMBURSEMENT

- New process for NVHD and PDDH
- CBO bills HCO for service
- Created algorithm that satisfied CMMI requirement
  - Referral Advance Payment
  - Completer Payment
  - 5% Withhold

CALCULATING FEE FOR SERVICE ALGORITHM

+ **Attrition Rate: 37.5%**
  Maximum patients = 64 Maximum (64) – Target (40) = 24
  AR = (24/64)* 100 = 37.5%

+ **Case Rate: $403.15**
  CR = (Fixed Cost ($2508.57) / # of Patients (8)) + Variable Cost per Patient ($89.58) = $403.15

+ **Referral Advanced Payment:**
  Advance ½ Case Rate * # of Patients Referred by WHAP = X
  Withhold 5%: X * 0.05 = Y
  Referral Advanced Payment Net Withhold = X – Y

+ **Completer Payment:**
  Advance ½ Case Rate * # of Completer Patients = X
  Withhold 5%: X * 0.05 = Y
  Completer Payment Net Withhold = X – Y

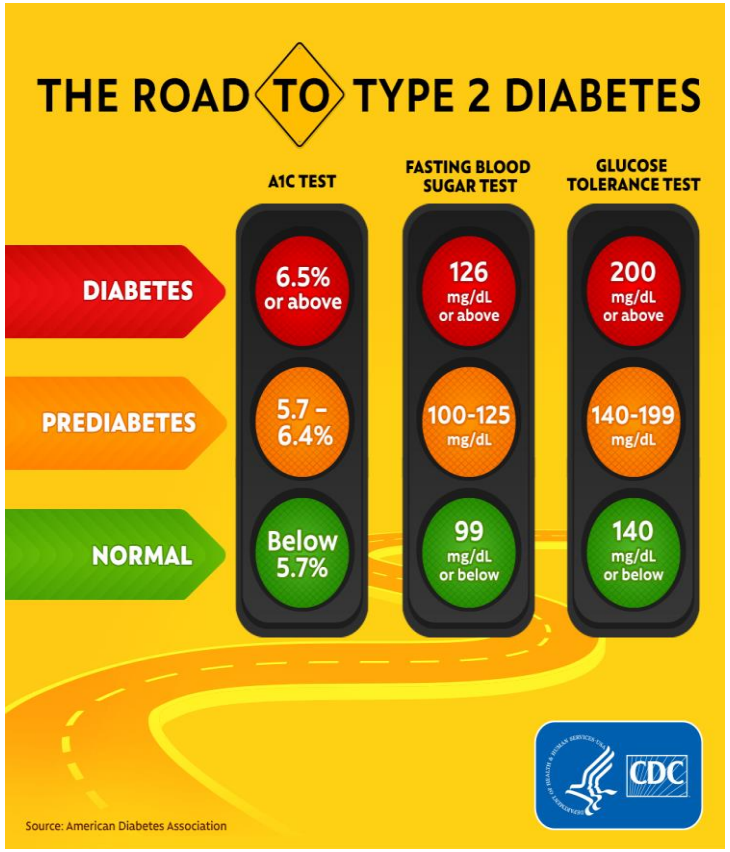
+ **Withhold Payment:**
  Pending A1C Control Performance after 3 Months, Sum of Referral and Completer Withhold

DEFINING THE COHORT

- Hospital Physicians and Residents refer qualifying patients
- Criteria set by Chase Outpatient Center & WHAP
  - Elevated A1C - greater than 10
  - Missed 2 PCP appointments

Patient referral process:

1. Medical Resident/Physician sends task to Chase nurse with patient name and goal A1C
2. Nurse forwards information to WHAP and adds patient name to cohort to be tracked
3. WHAP contacts patients, conducts SDOH, enters patient into database
4. Patient contacted by Health Department staff to confirm registration

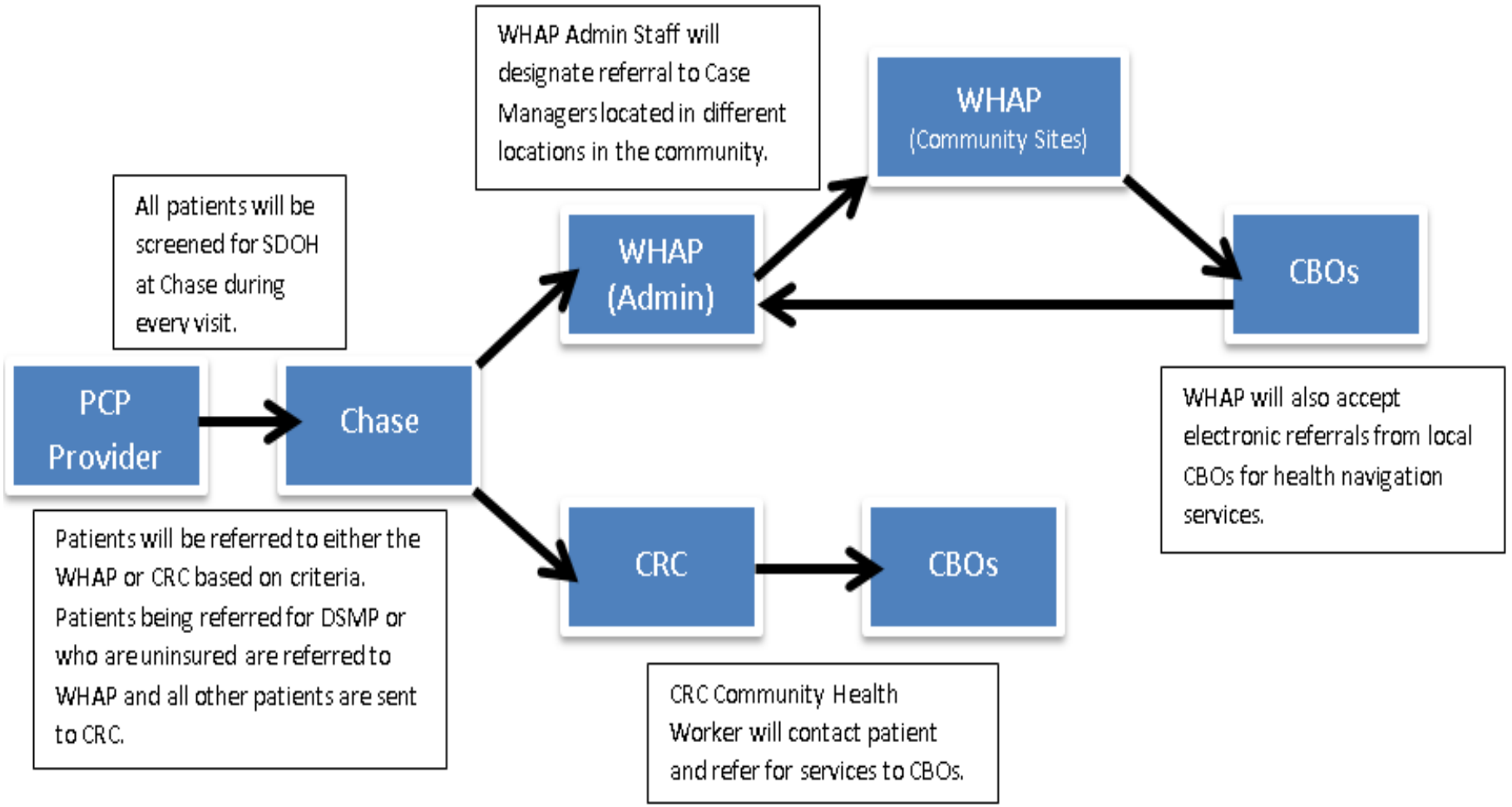


INFORMATION SHARING & IT DATABASE

- Database Workgroup & consultant created a unique DSMP Database utilizing a cloud-based version of FileMaker
  - ✓Accessible by NVHD, PDDH, WHAP, Chase Outpatient Center, Waterbury Hospital
  - ✓HIPAA compliant

- Database Sections:
  - Patient Entry: Contact Info., cohort assignment, SDOH, etc.
  - Attendance: DSMP Attendance by session date
  - Everyone with Diabetes Counts (EDC) test results (pre- & post-test)
  - Clinical: A1C Values (Goal set by PCP, Highest in 24 mo., 12 months prior – 12 months post class), ED usage, clinical notes
  - Reports: Summary reports for attendance records, clinical outcomes, and EDC tests

UNITE US


WHAP Admin Staff will designate referral to Case Managers located in different locations in the community.
WHAP (Community Sites)
All patients will be screened for SDOH at Chase during every visit.
WHAP (Admin)
CBOs
PCP Provider
Chase
WHAP will also accept electronic referrals from local CBOs for health navigation services.
Patients will be referred to either the WHAP or CRC based on criteria. Patients being referred for DSMP or who are uninsured are referred to WHAP and all other patients are sent to CRC.
CRC
CBOs
CRC Community Health Worker will contact patient and refer for services to CBOs.

LESSONS LEARNED SO FAR

Successes

- Strong multi-agency partnership
- Dedicated staff
- Dedicated PCP involvement throughout the process
  - Resident training
  - Patient tracking during DSMP
  - Post-eval inclusion
- Evidence-based program
- IT Database
- Hospital's ability to provide Be Well Bus tickets/address SDOH
- Received many positive testimonials
- Preliminary results show Cohort 1 may achieve 10% A1C reduction
- EDC Pre- and Post-Evals show knowledge improvement

Challenges

- Specific cohort rather than public class
- Cohort – greater Waterbury area, most outside LHD jurisdiction
- Payment structure reliant upon completers and health outcomes regardless of fixed costs
- Cooking Matters fixed cost but is only reimbursable by algorithm
- Time commitment—great deal of in-kind commitment

Wrap Up: What We Learned

- Good partners take time to build mutual trust, collaborate closely, are solution-focused, and adapt together
- Patient acuity level is an important factor for engagement
- There is much variability in patient characteristics—program adaptations (including hiring) may be necessary
- Identifying outcomes requires consideration of many factors

- Close communication among partners is essential
- Engaging clinical providers is essential; their buy in and encouragement is critical to successful referrals
- Engaging patients is time consuming
- Hiring challenges are common (temp job, specific staffing needs, geographic barriers, language needs, etc.)
- Efficient and streamlined data sharing is important

CONTRACTING AND PAYMENT METHODOLOGY

- Start up requires intense administrative time; requires start-up funds or a flexible payment methodology
- Model adaptation may be necessary to meet patient needs and keep cost contained
- Some CBOs and HCOs are able to leverage existing/separately funded services and resources
- It's hard to finalize the payment methodology before the program methodology is clear
- Payment method needs to consider time involved for referral outreach – "less traditional definition of "service"
- Withholds need to be realistic for the population being served and relate to variables the CBO can control

DATA SHARING AND EVALUATION

- Establishing data collection plans and working through the challenges takes time
- Multiple ways to communicate—faxing (not ideal); secure email, data base development, EHR
- Sharing prior test results, location, acuity is important
- Post-test screens can be hard to obtain
- Continuous improvement, communication and constant adaptation is necessary
- ROI is hard to demonstrate in VBP/FFS combined paradigm. Different per payer.
- Important to share story of the program process and successes with external stakeholders


QUESTIONS?

Health Enhancement Communities

Health Enhancement Community Initiative: HEC Initiative Update

Healthcare Innovation Steering Committee Meeting

November 14, 2019

Meeting Objective

- Provide an update to the HISC on progress with the SIM Health Enhancement Communities (HEC) Initiative in 2019

Note

- While the presentation will highlight HEC Initiative work underway, it is important to note that the new administration and three SIM partner agencies—the Office of Health Strategy, Department of Public Health, the Department of Social Services—are engaged in an assessment process about the future of the HEC Initiative in 2020 and beyond.

Stakeholder Engagement Update

- Multi-sector stakeholder engagement has continued including:
  - A Health Enhancement Community design exercise (charrette) held at the Connecticut Health Foundation on July 11, 2019
    - Over 50 participants representing community residents, advocacy groups healthcare (hospitals, community health centers, and other providers), municipalities, social service agencies, and health plans/payors)
    - Stakeholders identified how an HEC would support families in need and how communities would go about creating an HEC

Stakeholder Engagement Update

- Bridgeport HEC Initiative open public forum on July 23, 2019, hosted in collaboration with the Primary Care Action Group and the Bridgeport Prospers/United Way of Coastal Fairfield County
- Interagency meetings within the State between the Office of Health Strategy, the Department of Public Health, and the Department of Social Services
- Meetings and discussions with potential funders

HEC Pre-Planning

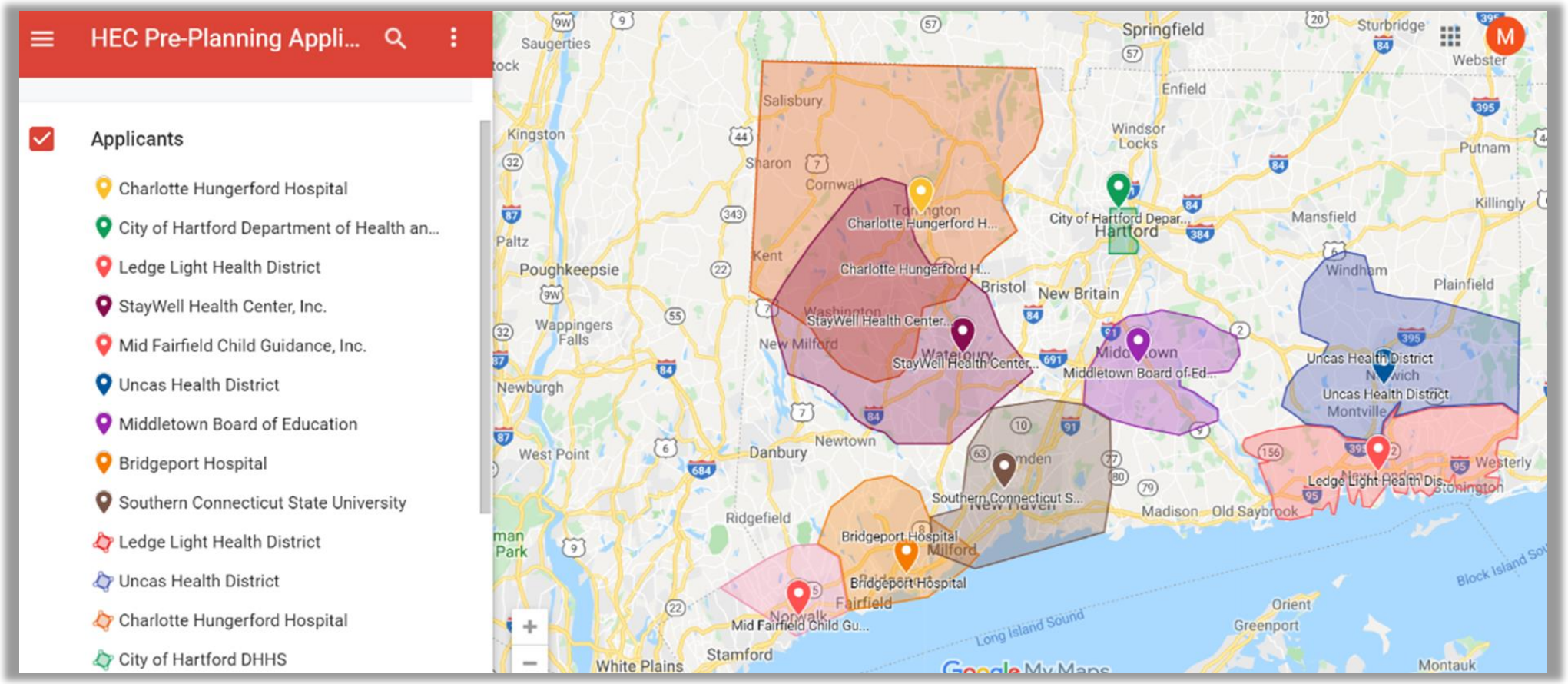
- HEC Pre-Planning RFP issued August 15, 2019; responses were due October 1, 2019.
  - Up to $25,000 to participate in a 90-day HEC pre-planning process to develop key elements of an HEC for their community.
- 9 awardees (participant communities) were selected and contracts have been executed.
- An option to extend for a second 90-day period may be offered dependent upon funding.
- Work to be done by Participant Communities in this RFP are intended to inform a future process to designate HEC.

Awardees

Awardees	Scope of Work*
Bridgeport Hospital (YNHHS)	Scope 1 & 2
Charlotte Hungerford Hospital	Scope 1
City of Hartford, Department of Health and Human Services	Scope 1 & 2
Ledge Light Health District	Scope 1
Middletown Board of Education	Scope 1
Mid Fairfield Child Guidance, Inc.	Scope 1
Southern Connecticut State University	Scope 1 & 2
StayWell Health Center, Inc.	Scope 1
Uncas Health District	Scope 1

* Scope 1 – Main grant; Scope 2 – Rapid Cycle Measures

Awardee Map


HEC Pre-Planning Appli...
Applicants
Charlotte Hungerford Hospital
City of Hartford Department of Health an...
Ledge Light Health District
StayWell Health Center, Inc.
Mid Fairfield Child Guidance, Inc.
Uncas Health District
Middletown Board of Education
Bridgeport Hospital
Southern Connecticut State University
Ledge Light Health District
Uncas Health District
Charlotte Hungerford Hospital
City of Hartford DHHS
Springfield
Sturbridge
Webster
Enfield
Windsor Locks
Putnam
Killingly
Mansfield
Windham
Plainfield
Salisbury
Kingston
Sharon
Cornwall
Paltz
Poughkeepsie
Kent
Bristol
New Britain
Wappingers Falls
New Milford
Newburgh
West Point
Danbury
Newtown
Ridgefield
Bridgeport Hospital
Milford
Fairfield
Norwalk
Mid Fairfield Child Gu...
Stamford
White Plains
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Old Saybrook
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StayWell Health Center...
Middletown Board of Ed...
Uncas Health District
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Southern Connecticut S...
Google My Maps

Awardee Attributes

- All build upon existing collaboratives or community partnerships.
  - Extensive letters of support provided from wide range of partners.
- Diverse set of leads, including hospitals, board of education, health departments, local health districts, behavioral health providers, FQHCs.
- Pre-Planning communities each serve populations ranging from 102,000 to 465,000.
- All outlined plans to engage community residents in all aspects of HEC development and design.

Awardee Attributes

Awardees	Description
Bridgeport Hospital (YNHHS)	Serving the greater Bridgeport urban and suburban area, population of 375,000. Partnership aligned with/ leveraging existing Health Improvement Alliance.
Charlotte Hungerford Hospital	Rural community serving 25 towns in NW corner of state, population of 135,293. Partnering with CT Office of Rural Health.
City of Hartford, DHHS	Serving city of Hartford, population 125,000. Partnership aligned with existing North Hartford Triple Aim Collaborative.
Ledge Light Health District	Serving New London and surrounding area, mix of suburban and rural towns with two urban centers, population 152,429. Partnering with the existing Health Improvement Collaborative of SE CT.

Awardee Attributes

Awardees	Description
Middletown Board of Education	Serving greater Middletown area, population 102,000. Led by Board of Ed. Building upon coalition formed for CHNA.
Mid Fairfield Child Guidance, Inc.	Covers greater Norwalk area, 162,000 residents. Primary partners include the Healthy for Life Project and the Norwalk ACTS Social-Emotional Initiative (pre-existing initiatives).
Southern Connecticut State University	Serving City of New Haven and 12 surrounding municipalities, population 465,633. Building on the 10-year old Healthier Greater New Haven Partnership.
StayWell Health Center, Inc.	Serving Waterbury, including the region's suburban inner and outer ring, population 335,000. Building upon the Greater Waterbury Health Partnership.
Uncas Health District	Serving health district and municipality of Windham, building upon the Eastern Connecticut Health Collaborative.

HEC Pre-Planning Activities

- Awardees expected to:
  - Engage community residents in the planning process
  - Convene participant organization members
  - Identify primary and secondary drivers impacting need related to the HEC health priority aims
  - Identify partners within their geography
  - Identify potential cities or towns outside of their initial geographic boundary with which it would be beneficial to align
- Each awardee has a coach from Health Management Associates to work with them throughout the pre-planning process and provide technical assistance.

HEC Pre-Planning – Rapid Cycle Measures

- Goal: develop an approach in communities to collect measurement information to provide rapid-cycle feedback on the effectiveness of HEC interventions.
- 3 awardees received additional $10,000 to participate.
- Awardees will:
  - Define a set of measures that include information **generated directly by community members.**
  - Create a plan for implementing data collection to measure population outcomes at the local community level.

Pre-Planning Support

Support provided by HMA along three tracks:

Community	Leadership Development	Rapid Cycle Measurement (RCM)
• 9 participating communities • Support to ensure **project work plan** is implemented and grant goals are achieved	• 9 participating communities • Support to **enhance leadership skills** among lead agencies and/or partners	• 3 participating communities • Support to ensure that the **RCM goals and objectives are achieved** within the grant timeframe • Support will be provide in partnership with YaleCORE

Pre-Planning Support

- Each track will receive:
  - **Coaching support** – HMA Coaches will work in a team of 2, with one serving as a Community Coach and the other as a Leadership Development Coach.
  - **Tool, template, and resource development** – Developed based on community input.
  - **Access to Subject Matter Experts** – One-on-one time with HMA expert in area of identified need (e.g., data collection, stakeholder engagement).

Funding Strategies

- Two key resource strategies to move forward:
  - Securing a mix of near-term/upfront funding for implementation and administration.
  - Scaling and/or timing HEC initiative roll out based on availability of resources
    - Because this is a “home-grown” initiative, have flexibility to make decisions about the scale and timing
- Variety of near-term funding sources and mechanisms that could fund HECs and the overall initiative.
  - Including options for new funds, flexible and/or aligned funds, and outcomes-based funding as well as mechanisms that enable aligning or pooling funds

HECs and SHIP

- State Health Improvement Plan (SHIP) 2.0 will be in development in 2020.
- There will be multiple opportunities for community input, including surveys and community forums.
- There will also be opportunities to align the SHIP work with the HECs pre-planning work communities.
  - Participant Communities will be encouraged to participate in the development of the SHIP.

Financial Impact Modeling

- Purpose is tell us if the HEC Initiative makes economic sense for Connecticut.
- Also might inform considerations around reinvestment opportunities.
- Two new modelling efforts:
  - Medicaid Impact Model
  - Commercial Impact Model

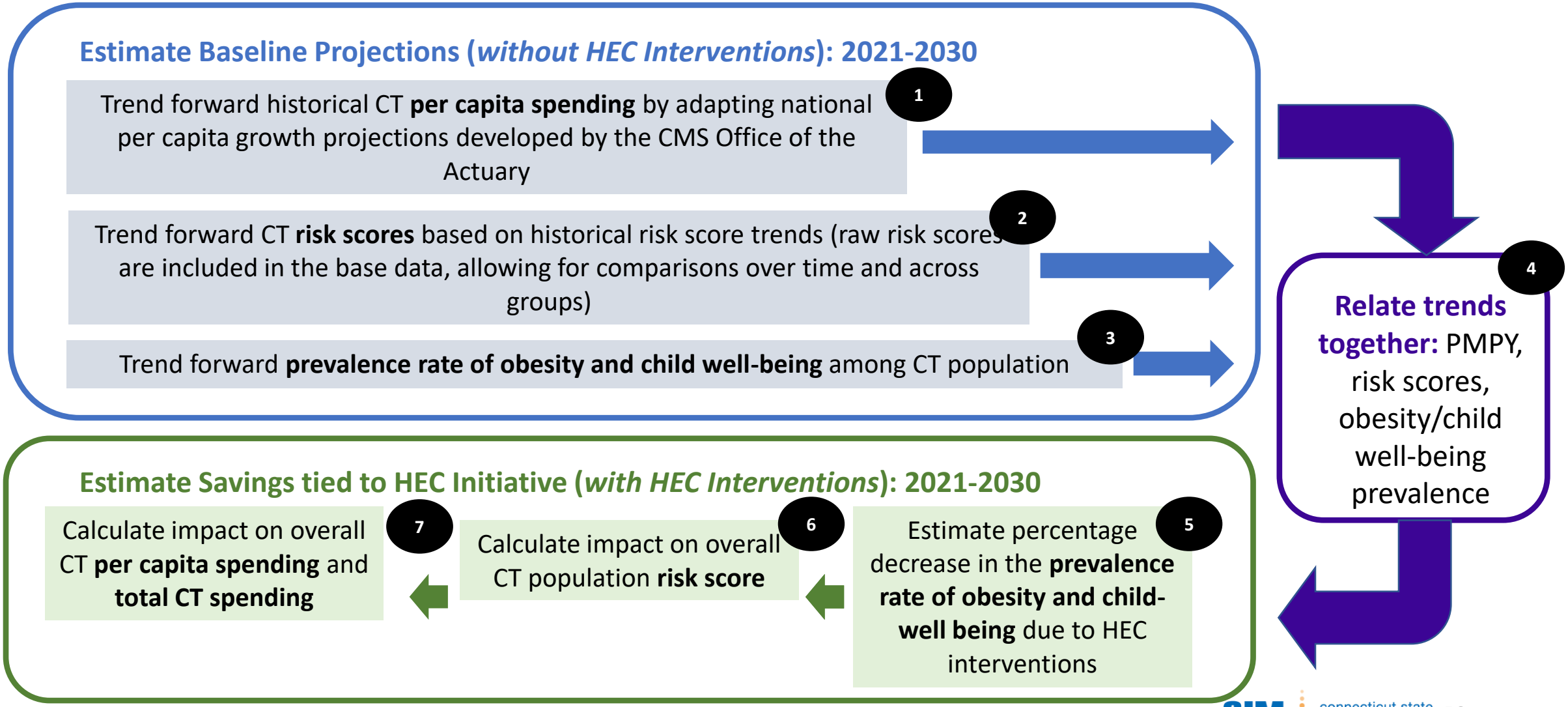
Medicaid Impact Model

- The HEC **Medicaid Impact Model** quantifies the potential short-term and long-term savings impact of the HECs on Medicaid spending, both per capita and total
- Using **Medicaid claims and eligibility data from the Connecticut Department of Social Services**, the model projects per capita costs and risk scores for the Medicaid population without HEC interventions
- **Estimated potential savings** with HEC interventions are based on evidence-based population health interventions associated with reducing obesity and improving child well-being

Commercial Impact Model

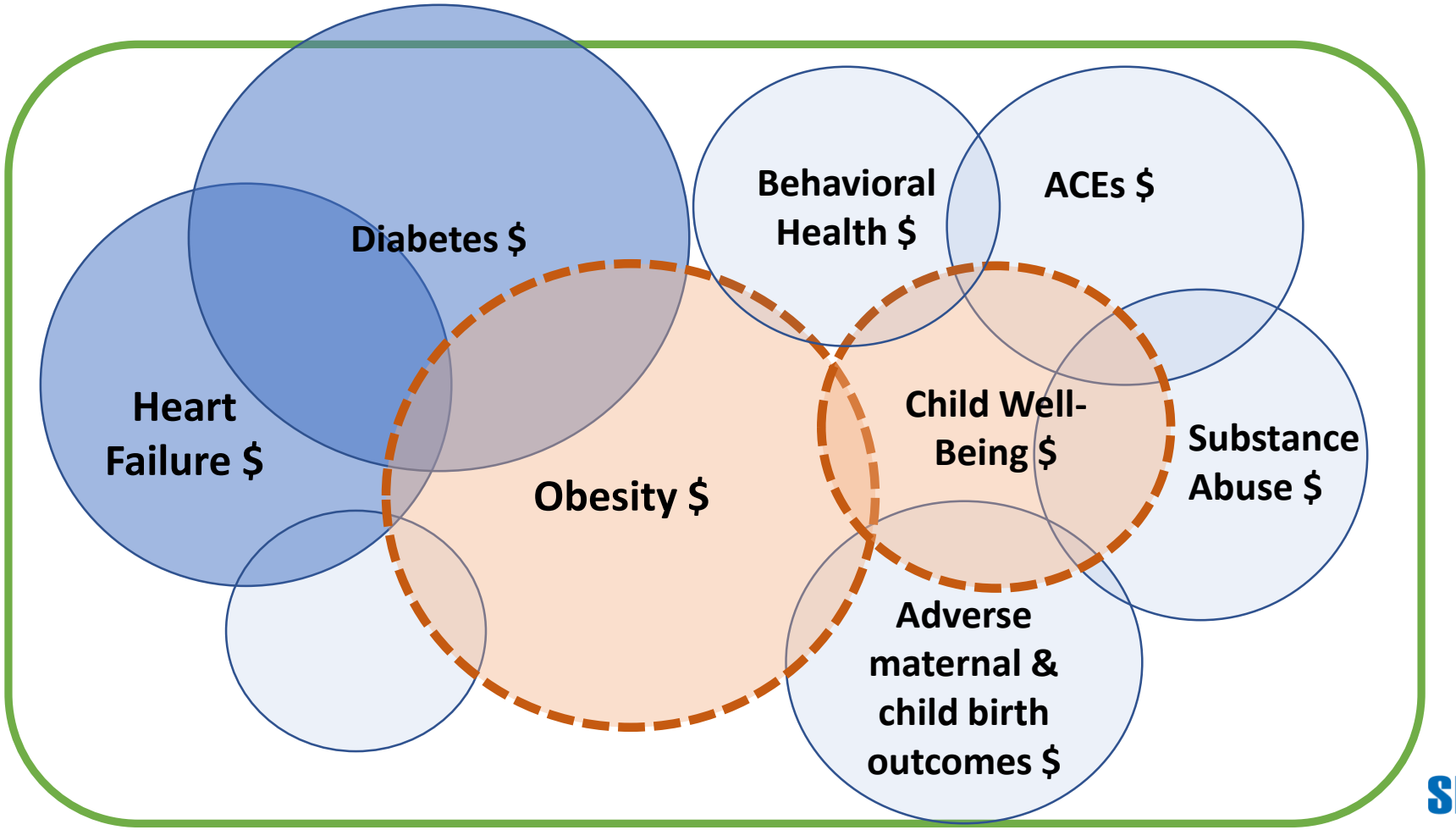
- The HEC **Commercial Impact Model** quantifies the potential short-term and long-term savings impact of the HECs on spending for Employers, both per capita and total
- Using **Employer paid claims and eligibility data from the Connecticut All Payer Claims Database**, the model projects per capita costs and risk scores for the Commercial population without HEC interventions
- **Estimated potential savings** with HEC interventions are based on evidence-based population health interventions associated with reducing obesity and improving child well-being

Analytic Approach: Medicaid/Commercial Impact Model



Connecticut Population Health – Conditions Schematic

Successful efforts to reduce the prevalence of obesity and ACES will reduce the population-level risk score and health care spending.



Questions & Discussion

Adjourn

Appendix

Acronyms

ACO	Accountable Care Organization	**HIE**	Health Information Exchange
ACH	Accountable Communities for Health	**HISC**	Healthcare Innovation Steering Committee
AHCT	Access Health CT	**HIT**	Health Information Technology
AMH	Advanced Medical Home	**ICM**	Intensive Care Management
AN	Advanced Network	**MAPOC**	Medical Assistance Program Oversight
APCD	All-Payers Claims Database	**PCMH+**	Person Centered Medical Home +
ASO	Administrative Services Organization	**MSSP**	Medicare Shared Savings Program
AY	Award Year (AY1, AY2…)	**NCQA**	National Committee for Quality Assurance
BRFSS	Behavioral Risk Factor Surveillance System	**NQF**	National Quality Forum
CAB	Consumer Advisory Board	**OSC**	Office of the State Comptroller
CCIP	Clinical & Community Integration Program	**OHS**	Office of Health Strategy
CAB	Consumer Advisory Board	**PCM**	Primary Care Modernization
CDAS	Core Data Analytics Solution	**PCMH**	Patient Centered Medical Home
CDC	Center for Disease Control and prevention	**PCP**	Primary care provider
CHW	Community Health Worker	**PSI**	Prevention Service Initiative
CMMI	Center for Medicare & Medicaid Innovations	**PTTF**	Practice Transformation Task Force
CMS	Centers for Medicare and Medicaid Services	**QC**	Quality Council
DMHAS	Department of Mental Health and Addiction Services (CT)	**RFP**	Request for Proposals
DPH	Department of Public Health (CT)	**SIM**	State Innovation Model
DSS	Department of Social Services	**SSP**	Shared Savings Program
EHR	Electronic Health Record	**TA**	Technical Assistance
ECQM	Electronic Clinical Quality Measure	**VBID**	Value-based Insurance Design
FQHC	Federally Qualified Health Center	**VBP**	Value-based payment
HEC	Health Enhancement Community		