OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

February 13, 2020

Meeting Agenda

Item	Time
1. Introductions/Call to Order	5 min
2. Public Comment	5 min
3. Approval of the Minutes	5 min
4. CHCACT- CCIP Health Equity Improvement	50 min
5. UConn School of Pharmacy –CCIP Pharmacy Integration	50 min
6. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

CHCACT – CCIP Health Equity Improvement

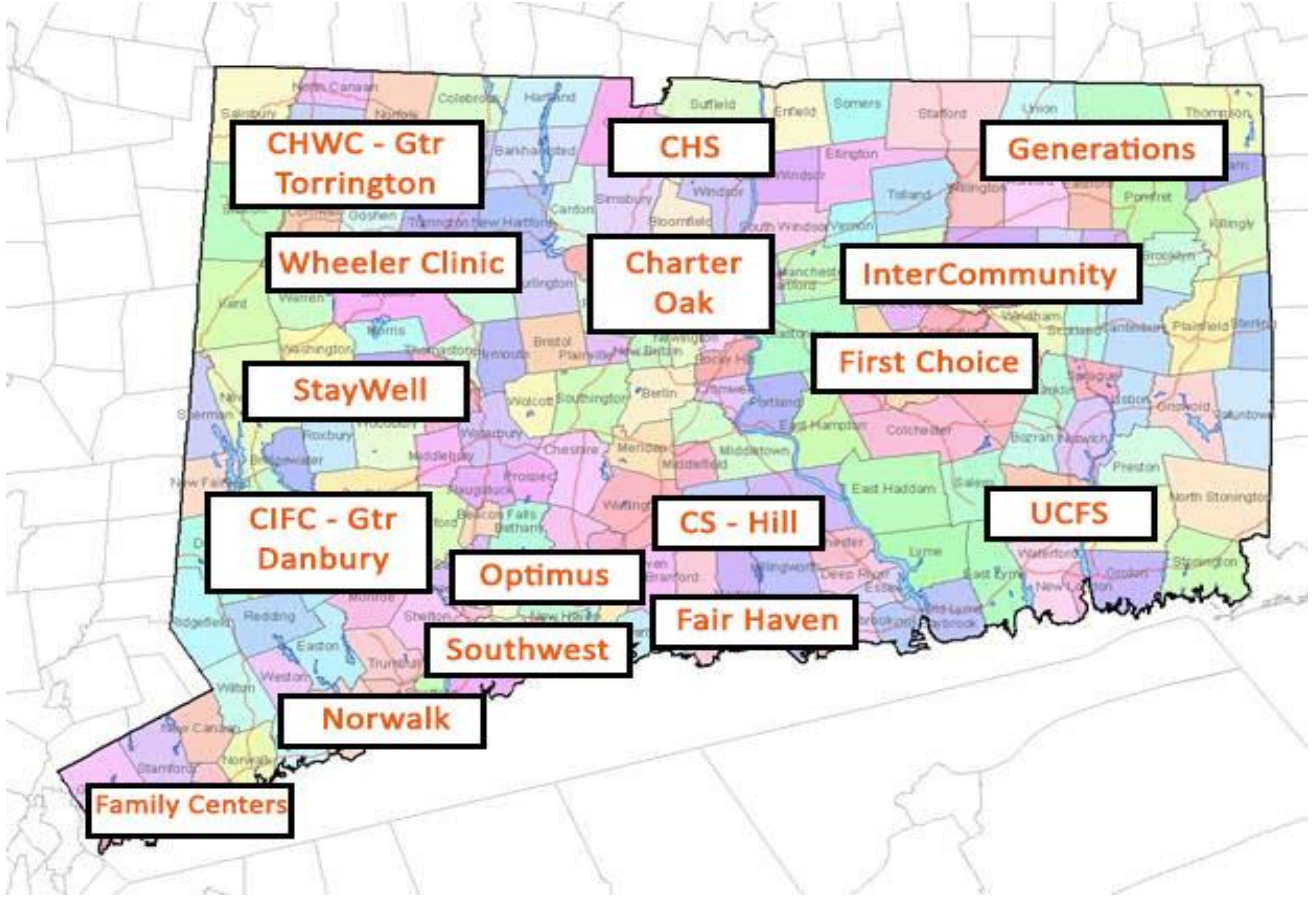
CT Health Centers Work to Reduce Disparities

Community Health Center Association of Connecticut

Community Health Center Association of Connecticut

16 Member Health Centers

State-wide Geographic Coverage



302,465 Patients Served in 2018

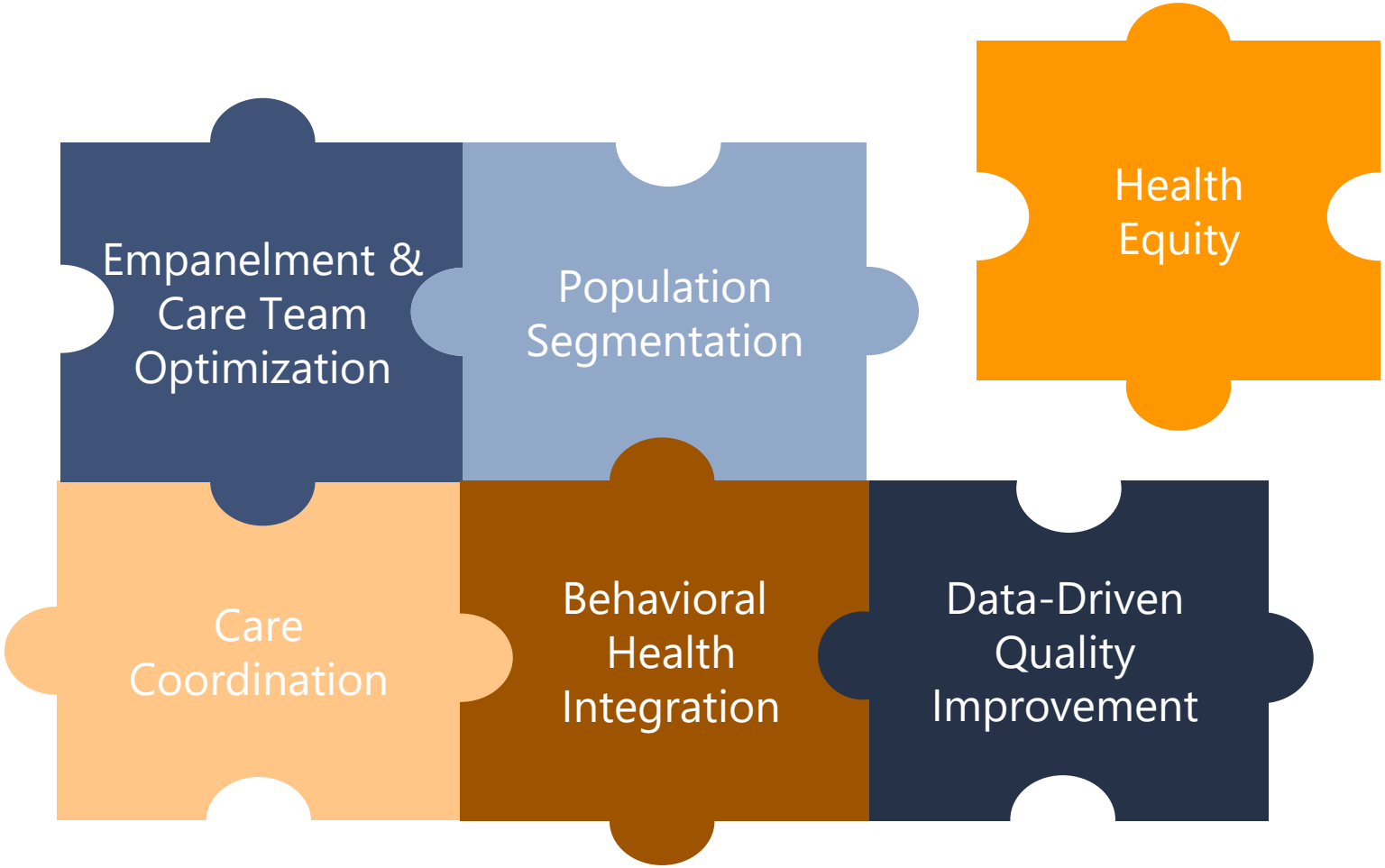
1 in 14 State Residents Impacted

CCIP Health Equity

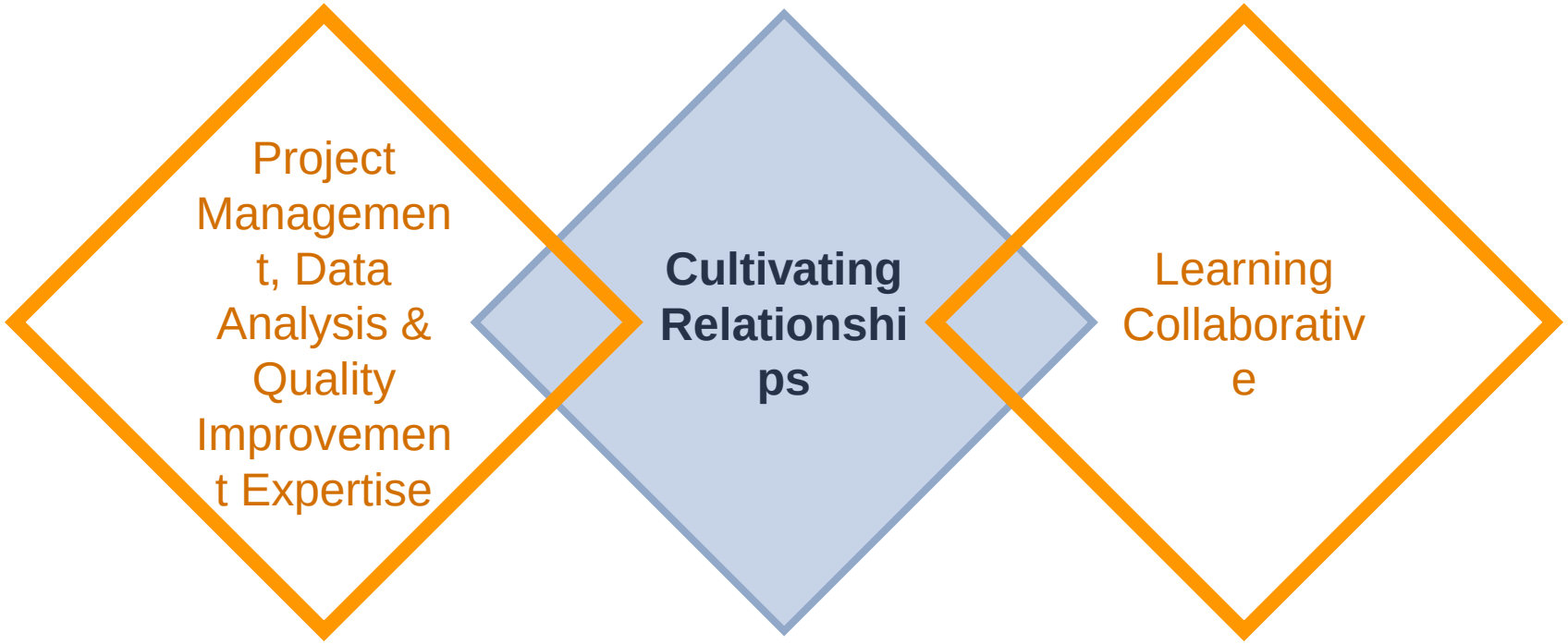
- Required for PCMH+ participants also participating in TCPi
- 8 participating FQHCs supported by CHCACT
- CHCACT selected as technical assistance provider

SOUTHWEST COMMUNITY HEALTH CENTER
Fair Haven Community Health Care
GENERATIONS FAMILY HEALTH CENTER
UCFS Healthcare
Charter Oak Health Center
OPTIMUS Health Care
First Choice Health Centers For All Your Health Care Needs
Cornell Scott Hill Health Center

Aligning with TCPi

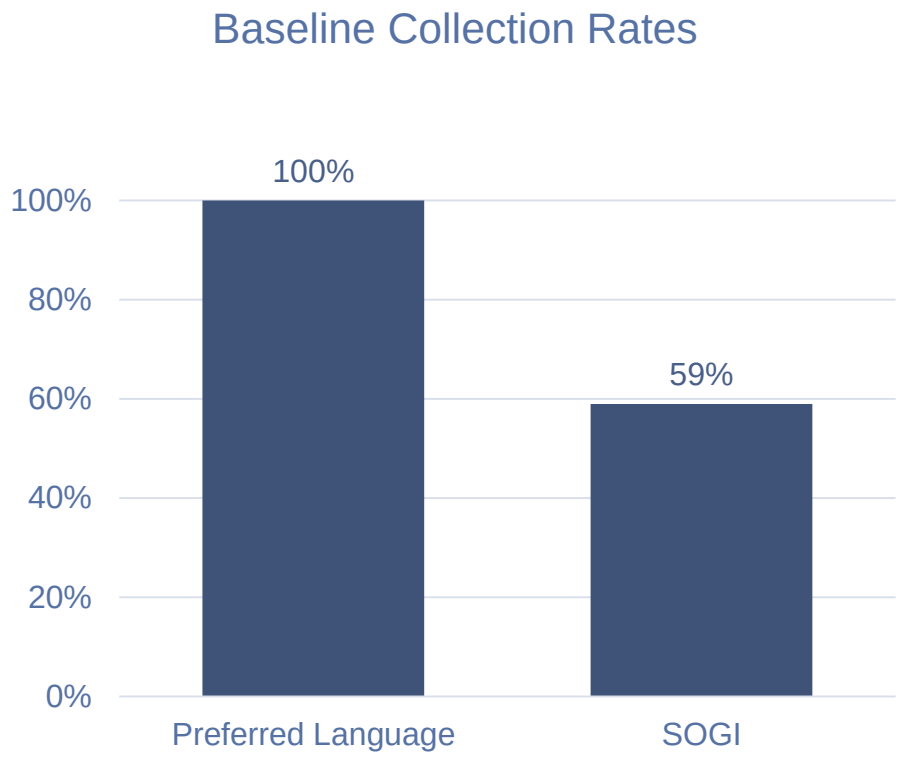


CHCACT's Technical Assistance



SOGI Data Collection & Preferred Language

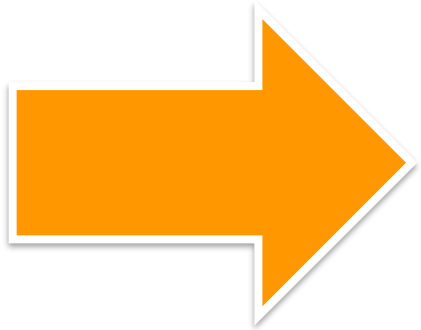
- SOGI: UDS requirement as of 2016
- Preferred Language: PCMH Requirement



Data Analysis

Tiered Approach

- Stratify by general (OMB level) race & ethnicity
- Break down identified group further by gender, age, zip code, language

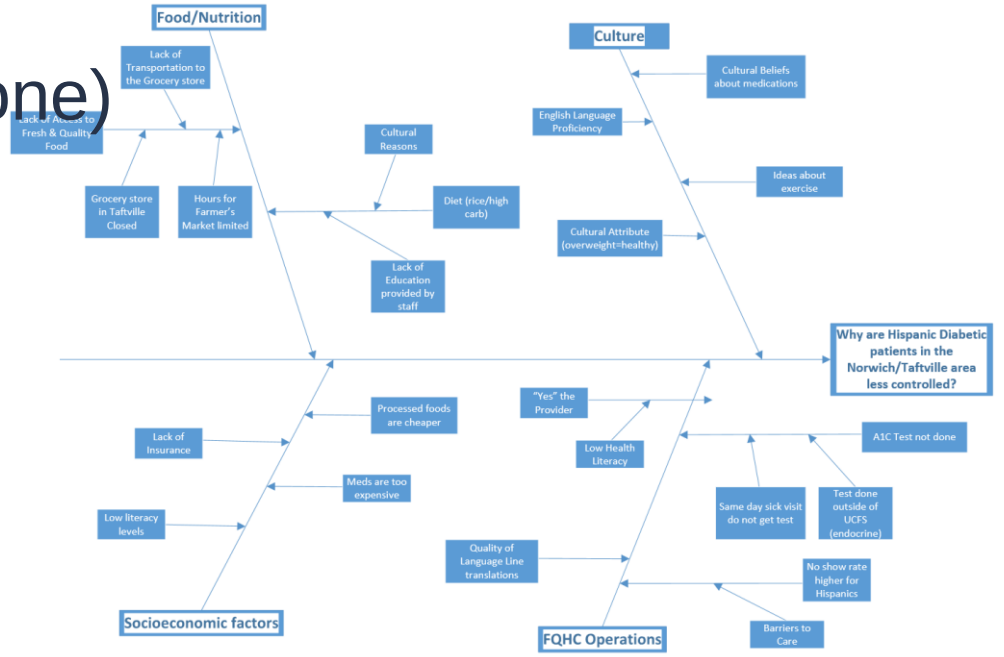


Data Collection

- Analysis by newly collected data
- Analysis of aggregated data

Improvement Work

- Root Cause Analysis (5 Whys, Fishbone)
- Plan-Do-Study-Act
- CHW Interventions
- CHW Cultural Humility Education
- Data collection process development & training

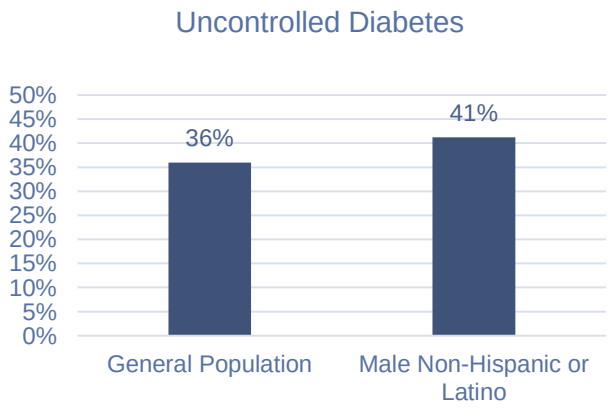


Charter Oak Health Center Addresses Diabetes Disparity

Charter Oak Health Center

Disparity

108 Non Hispanic or Latino males with uncontrolled diabetes (A1c > 9.0%)



Intervention

CHWs educate patients on ABCs of Diabetes

SDOH screening & addressing barriers to care

Integrated diabetes management clinic

Success of program

- 40 patients engaged
- 24 additional patients received SDOH screening
- 10 of 13 of the highest risk patients reengaged in care
- 14.2% increase in timely A1c screen
- 33 new care plans made with resources, education and self management goals

Collecting Granular Race & Ethnicity Data

Charter Oak Health Center

- Pilot on Mobile Van for patients who identify as Black/African American or Hispanic or Latino
- Supplemental form asking for detailed race
- Scaled collection to patients working with CHWs
- Then scaled to additional site, collected at front desk

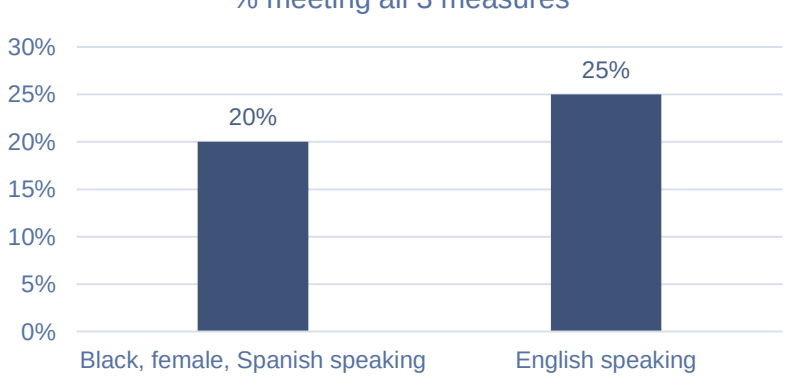
Cornell Scott Hill Health Center Addresses Diabetes Disparity

Cornell Scott Hill Health Center

Disparity

41 Black, female, Spanish speaking patients with uncontrolled diabetes

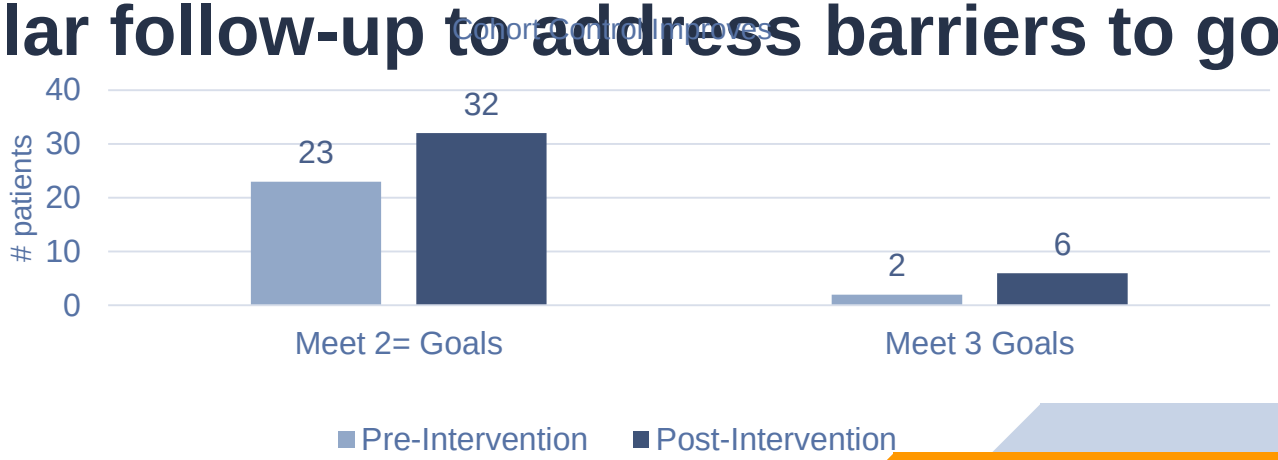
(A1c > 9.0%, LDL > 100 mg/dL, BP > 140/90 mmHg)



Intervention

CHW telephonic outreach to promote self-management goals for medication adherence & nutrition

Regular follow-up to address barriers to goals



Collecting Granular Race & Ethnicity Data

Cornell Scott Hill Health Center

- Collecting a subset of granular data via paper form
- Front desk staff gives paper form to patient, transcribed into Epic
- Challenges include patient privacy concerns, transcription, “task creep”, refusal vs. no reply
- Close to 878 patients presented, 581 with responses recorded

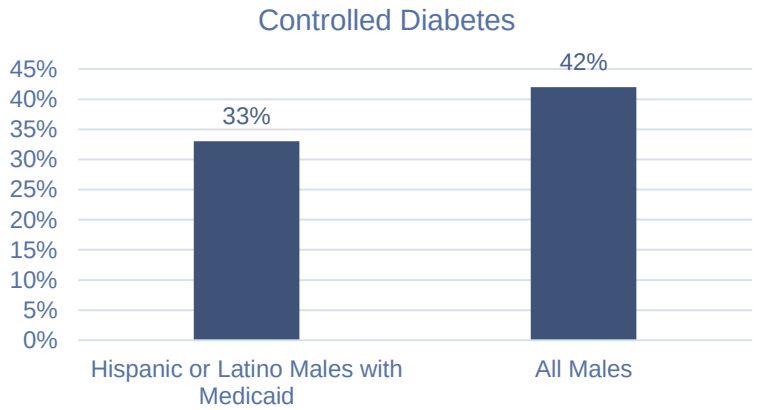
Granular Race/Ethnicity	Patient Count
No response recorded.	297
Black or African American	196
Puerto Rican	142
White	97
Other/Not Listed	29
Mexican, Mexican American, Chicano/a	28
Dominican	17
Ecuadorian	12
Asian Indian	7
Salvadorian	4
Columbian	4
Cuban	4

Fair Haven Community Health Care Addresses Diabetes Disparity

Fair Haven Community Health Care

Disparity

71 Hispanic or Latino male patients with uncontrolled diabetes who have Medicaid
(A1c > 8.0%)



Intervention

Primary Care Diabetes Clinic

Care Coordinator screening & addressing SDOH risk factors

Specific focus on medication affordability and adherence

Collecting Granular Race and Ethnicity Data

Fair Haven Community Health Care

All patients are beginning re-registered at check-in
Start date: August 2019

Percent of Patients with CDC-level Race and Ethnicity Documented

Quarter	Percent
2/1/19 - 4/30/19	0.00%
5/1/19 - 7/31/19	0.00%
8/1/19 - 10/31/19	44.10%
11/1/19 - 1/1/20	63.18%

Collecting Granular Race and Ethnicity Data

Fair Haven Community Health Care

Challenges
- Privacy
- Flow
- Staff turnover/training

Other Insights
- Granular Data needs to be cleaned prior to analysis
- Best practices for verification and cleaning the data

Next Steps
- Yearly staff training (CT State Medical Society Toolkit)
- New check-in area (privacy)
- Continue current process
- Clean data for analysis
- Analyze diabetes control by Hispanic subpopulations

First Choice Health Centers Addresses Diabetes Disparity

Disparity

16 White Hispanic patients with uncontrolled diabetes who live in 06042
(A1c > 9.0%)

Uncontrolled Diabetes Rate	
White Hispanic patients living in 06042	General Population
47%	33%

Intervention

Care Coordination telephonic outreach

Mail patients diabetes education & resource packet

Point-of-care A1c at Manchester site

Success of the Program

Although a small population, we were able to improve both the missing A1c group and those with A1c >9.

We will continue to follow these patients to see if additional improvement comes over time.

Collecting Granular Race and Ethnicity Data

First Choice Health Centers
For All Your Health Care Needs

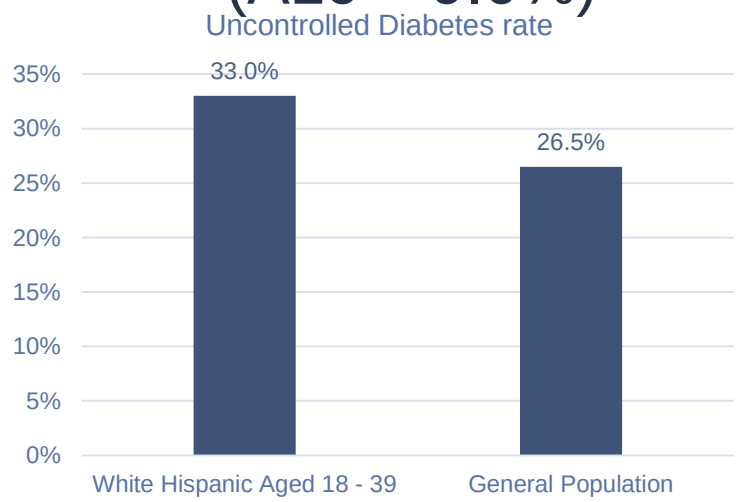
- Collecting at front desk on intake
- Delay due to EMR upgrades
- Challenge with pulling reports from EMR
- Plans to sustain:
- Better understanding of patient population
- Monitor and follow up on cohort

Generations Family Health Center Addresses Diabetes Disparity

Disparity

34 White Hispanic patients with uncontrolled diabetes who are 18 – 39.

(A1c > 9.0%)



Intervention

Enroll patients in enhanced care coordination program

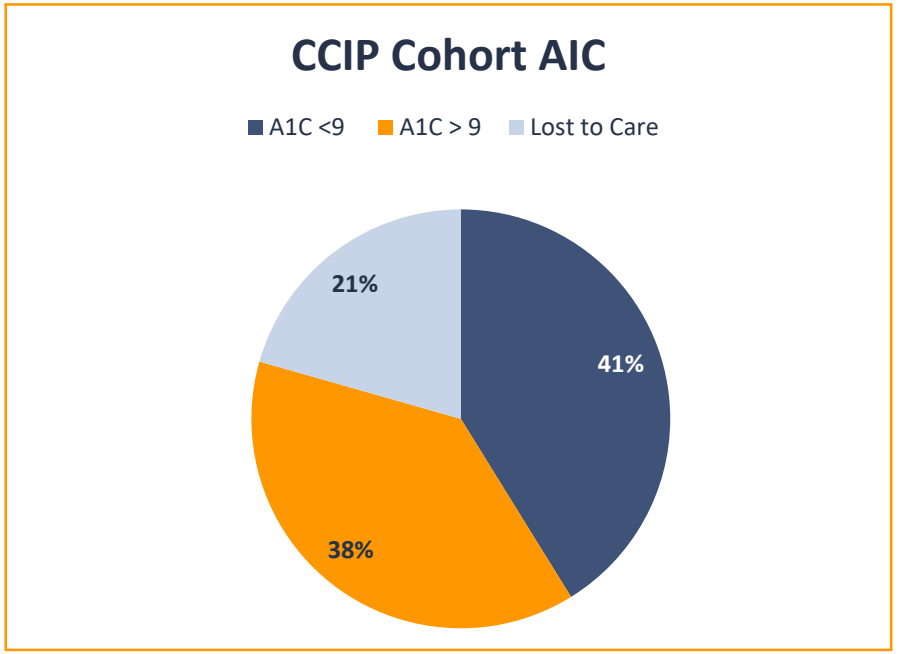
Comprehensive SDOH screen, develop and implement plan

CHW attend PCP visits & coordinate visits with nurse/BH/dental

Success of the Program

GENERATIONS FAMILY HEALTH CENTER

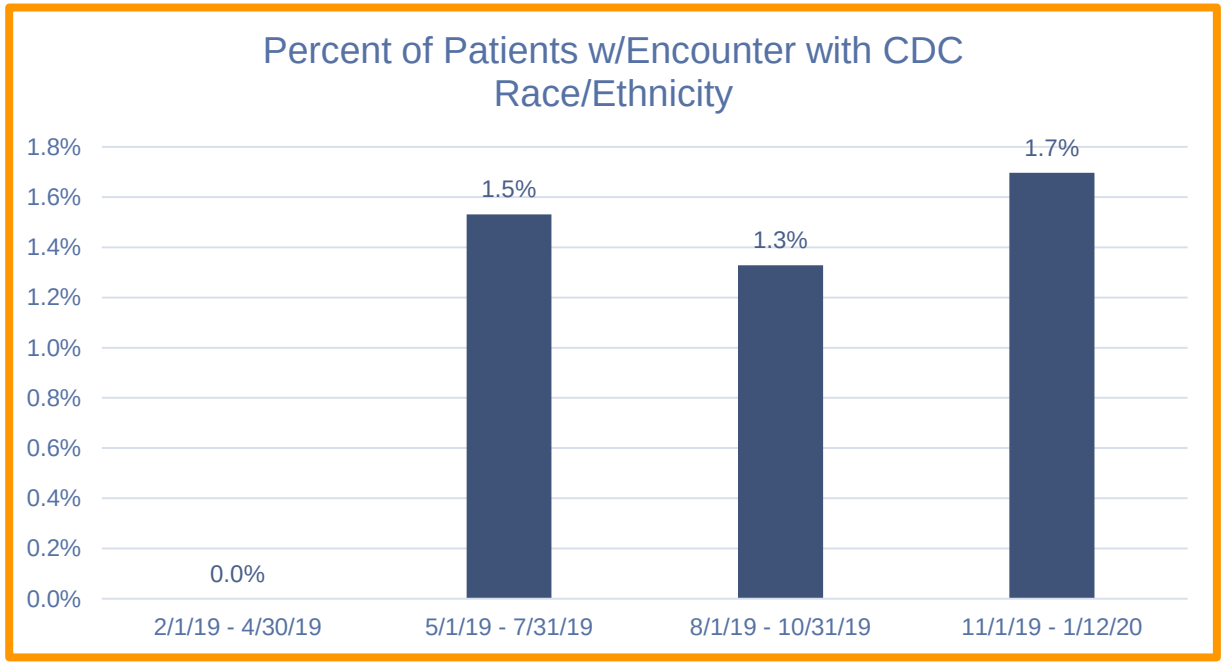
- Improved the A1c of 14 patients
- Screened 41% for SDOH
- 7 patients lost to care (moved, changed providers, etc.)



Lives Improved	**14**	**34**	**41.18%**

Collecting Granular Race and Ethnicity Data

- Initial resistance from patients when collected at front desk
- Stopped collection at front desk, resumed on smaller scale
- Pilot collection with CHWs when completing SDOH screenings, less resistance



Optimus Health Care Addresses Diabetes Disparity

Disparity

93 Black or African American, male patients with diabetes and Medicaid/Medicare

Uncontrolled Diabetes Rate	
Black or African American Males with Medicaid/Medicare	General Population
18.8%	25%

Intervention

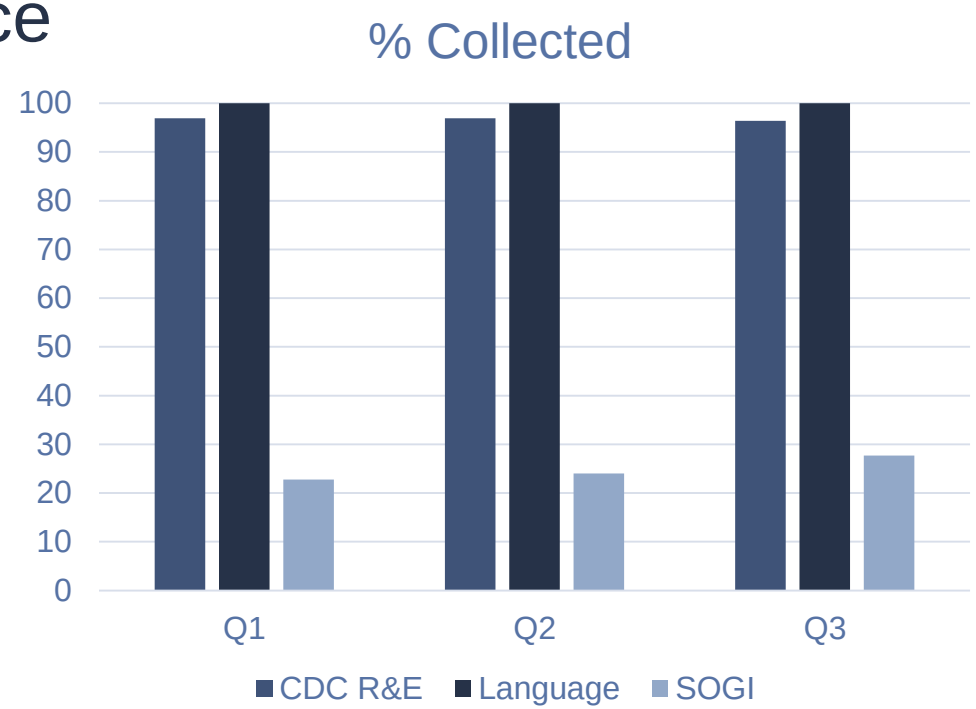
“The Live Well Diabetes Self – Management Workshop”

(Through Southwest Agency on Aging under PSI)

Collecting Granular Race & Ethnicity Data

OPTIMUS Health Care

- Collecting all sub-sets of granular race and ethnicity using HES table
- Collected on separate form during registration and entered in Intergy
- Challenges:
  - Patient willingness to report
  - Verbiage/communication tools to improve collection



Southwest Community Health Center Addresses Diabetes Disparity

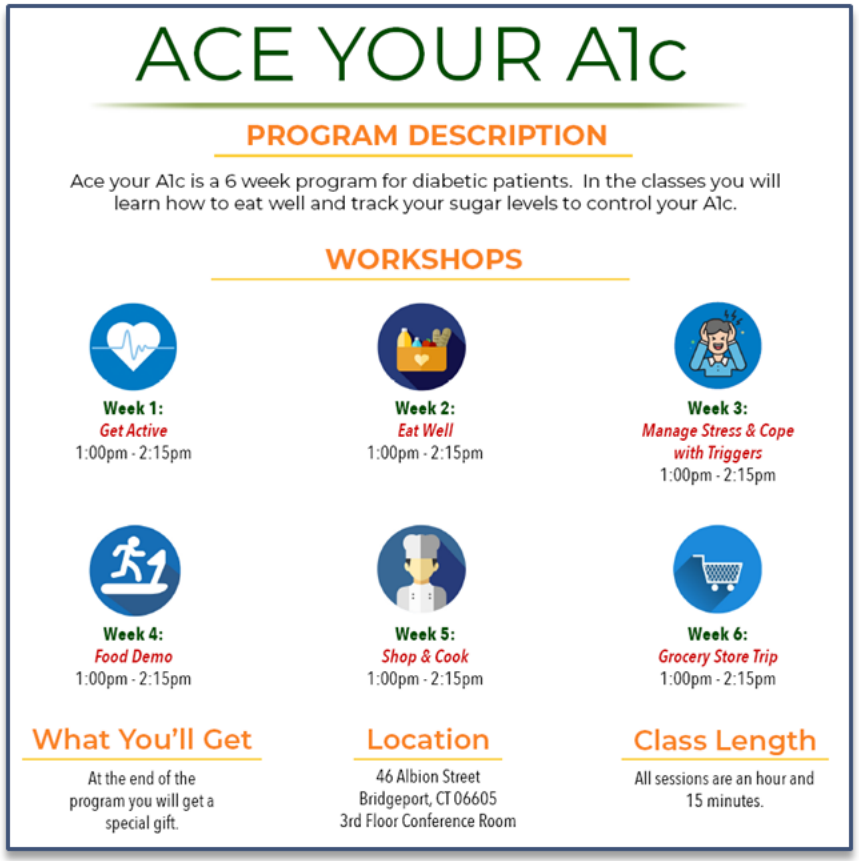
SOUTHWEST COMMUNITY HEALTH CENTER

Disparity

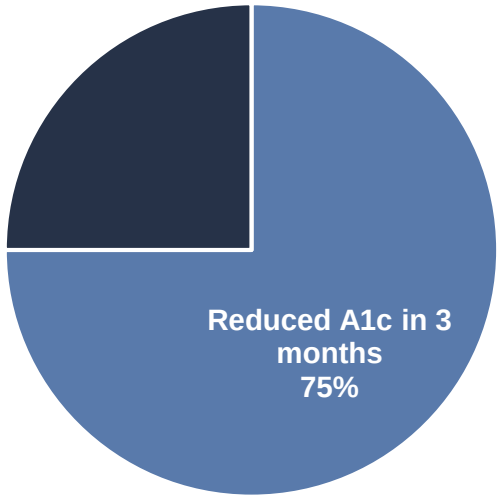
Male Black/African American, Non-Hispanic, > 21 years, living in 06605 with uncontrolled diabetes (A1c > 9.0%)

Intervention

Ace your A1c workshop



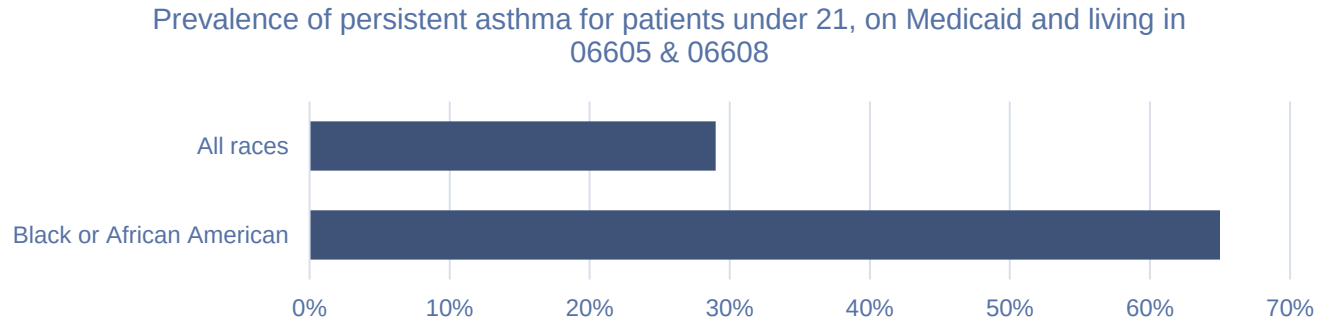
A1c Reduction in 12 tested participants



Southwest Community Health Center Addresses Asthma Disparity

Disparity

82 Black or African American patients with asthma, who are under 21, have Medicaid & live in 06605 or 06608



Intervention

CHWs recruit patients to participating in Putting on Airs

(Partnered with Stratford DPH & Putting on Airs)

Collecting Granular Race & Ethnicity Data

- Granular race and ethnicity data collection began 12/2019 after a successful trial with a Hispanic patient group.
- Patients self-identify at registration. The financial counselor collects form and enters data into EHR.
- Challenges we anticipate:
  - Increase in the number of patient forms to complete at registration
  - Multi-race and “Other” selections not structured data and will hinder our ability to evaluate disparities.

United Community & Family Services Addresses Diabetes Disparity

UCFS Healthcare

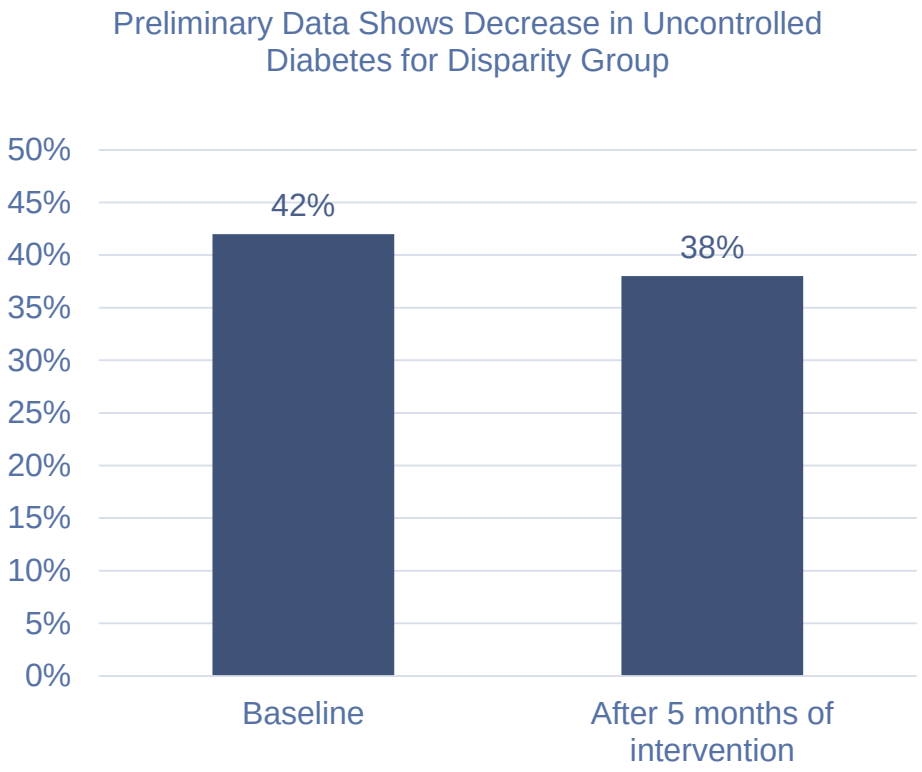
Disparity

80 Hispanic patients with uncontrolled diabetes who live in Norwich or Taftville

(A1c > 9.0%)

Uncontrolled Diabetes Rate	
Hispanic living in Norwich or Taftville	General Population
42%	33%

Identifying and Addressing Disparities



Intervention

- Expanded outreach
- Care management and community relationship building provided by PCMH+ Nurse Care Managers

Collecting Granular Race & Ethnicity Data

UCFS Healthcare

- Used census data in area to identify granular categories to include:
  - Mexican, Puerto Rican, Peruvian, Dominican, Filipino and Chinese
  - CCIP team “gut checked” and added Haitian Creole
- Complete overhaul of form; resulted in a more inclusive process:
    - Staff input of those collecting data
    - Added language to form to explain “why”
    - Decision to only ask new and/or updated patients
- Collection of SOGI data leading to LBGTQ+ Services a strategic focus.

Keys to Future Success

- Collect granular R/E data
- Paradigm shift to look at data through health disparity lens
- APM development that supports health equity improvement

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UConn School of Pharmacy – CCIP Pharmacy Integration

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		