Health Enhancement Community Initiative

Population Health Council Meeting

February 28, 2019

Agenda

1. Approval of the Minutes
2. Meeting Purpose
3. Updates
4. Public Comments Disposition and Timetable
5. Stakeholder Engagement
6. PCM Capabilities - Patient Stories

Meeting Objectives

Purpose of the webinar:

- Review process for addressing public comments
- Provide HEC project updates
- Inform the PHC about the PCM companion project to HEC

HEC Project Updates

1. CMMI – Discussions re: expectations for demonstration
2. Financial impact analyses
    - Seeking to extend analysis to Medicaid/CHIP and state employees
    - Developing model assumptions for child well-being/ACEs reduction
3. Measurement – examining opportunities to:
    - Align with *Well-being in the Nation (WIN) Measurement Framework: Measures for Improving Health, Well-Being and Equity Across Sectors* (see attached)
    - Design and test methods for integrating real-time Patient Reported Outcome Measures (PROMs) and Patient Generated Measures (PGR)

Public Comments Disposition

1. Prepare a compendium (see handout)
2. Prepare a draft response:
    a. Clarification
    b. Adjustment to framework/model design
    c. Consideration in future planning
3. Review select comments/questions with PHC
4. PHC review and approval of complete response

Public Comment Process & Timetable

Step		Timeframe
Milestone:	PHC receives 1st draft HEC Report *(complete)*	**Monday October 22**
	PHC webinars and in-person meeting (November 1) to provide verbal feedback, and opportunity to provide written feedback *(complete)*	**October 23 – November 1**
	HISC meeting to provide input on key topics *(complete)*	**Thursday November 15**
Milestone:	PHC receives 2nd draft: HEC Framework + Technical Report *(complete)*	**Friday November 23**
Milestone:	PHC meeting to determine whether to advance the HEC Framework and Technical Report to the HISC	**Thursday November 29**
	Send the HEC Framework and Technical Report to the HISC	**December 6**
Milestone:	HISC review and approval for public comment	**December 14**
Milestone:	Public Comment period	**January – February**
	PHC reviews select comments and draft public comment response	**March**
Milestone:	Approve to send to HISC	**April or May**
Milestone:	HISC review and approval	**May or June**

Expanded Stakeholder Engagement

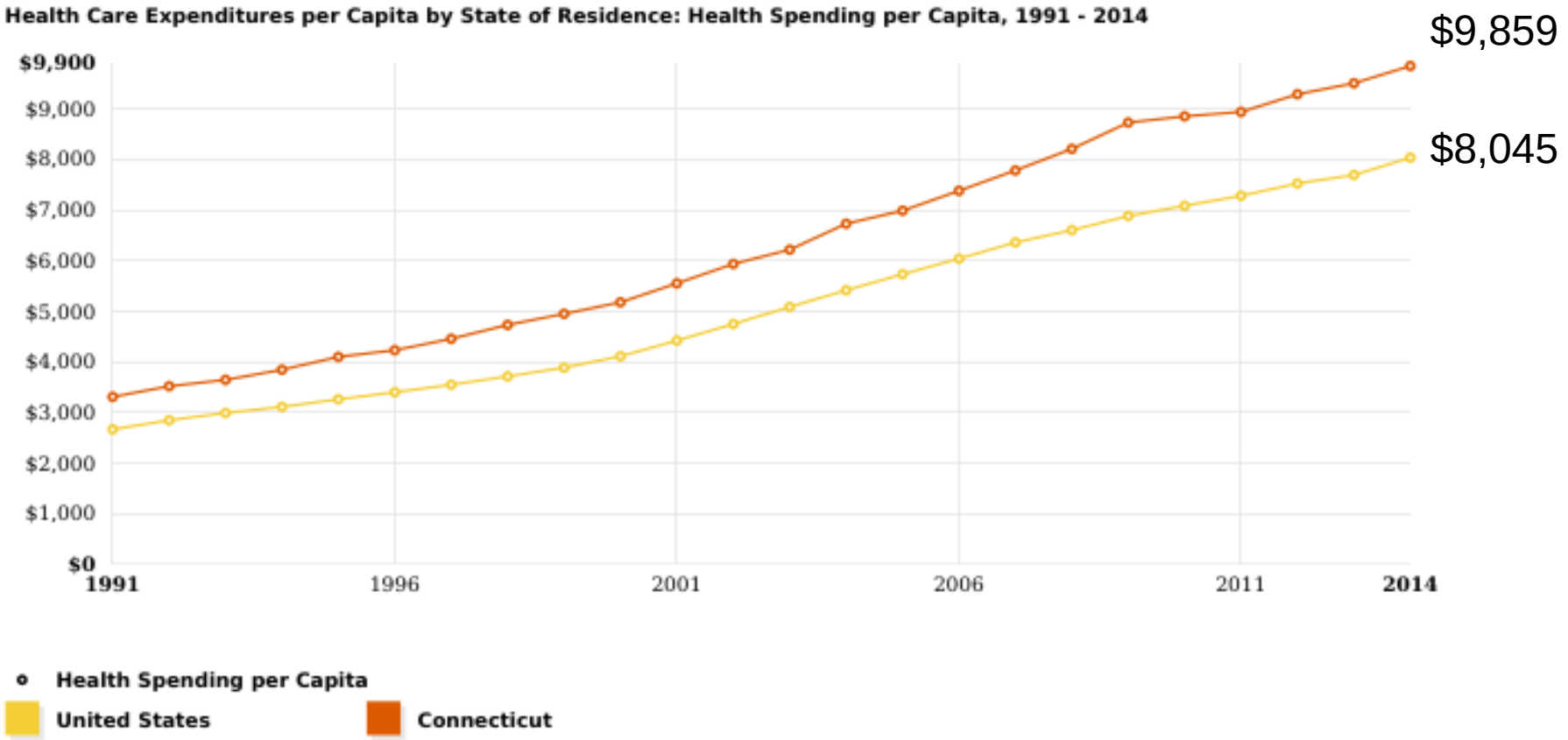
Priorities for the State team are focused on engaging the state government, and regional level entities including municipal governments (LHDs) and nonprofit organizations (collaboratives).
The **Goals** for this level of engagement are to further familiarize these entities with the HEC strategy and discuss how it presents an opportunity for local capacity building, organizational development, and population health impact.

Next steps:

- Five regional meetings with Local Health Directors.
- Revisit Community Health Collaboratives with an update on the HEC proposed framework.
- The State team will also explore other collaboratives and networks that may have fallen off the radar.

Primary Care Modernization

Health Care Spending in Connecticut



SOURCE: Kaiser Family Foundation's State Health Facts.

- Among Highest Per Capita in the US
- Steeper Increases than Nation

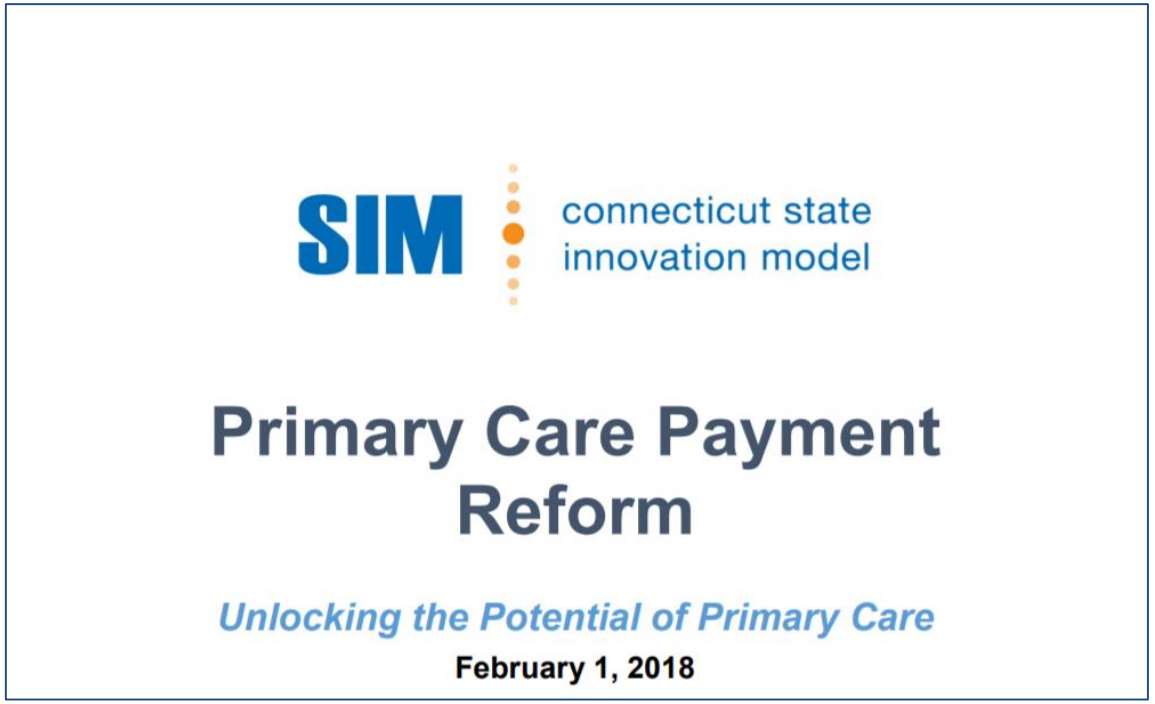
Healthcare Reform in Connecticut

- Widespread adoption of the ACO or “shared savings program model”
- More than 85% of Connecticut’s primary care community in ACO arrangement
- SIM achievements
  - 180,000+ Medicaid beneficiaries in PCMH+ shared savings program
  - 1,000,000+ beneficiaries (all payer) attributed under shared savings arrangements
  - Commercial payers 60% aligned on Core Quality Measure Set
  - 125 practices achieved PCMH recognition through SIM
  - 5 provider organizations representing 735 PCPs and 414,174 attributed lives receiving Community and Clinical Integration Program support
  - 14 provider organizations and CBOs negotiating service agreements under Prevention Service Initiative
  - Value-based Insurance Design – Toolkit and Technical Assistance for Employers

Healthcare Reform in Connecticut

- Limitations…
  - Primary care remains largely untransformed
  - Limited impact on total cost of care
  - Limited investments in preventing avoidable illness and injury

Practice Transformation Task Force Report



Primary Care Modernization Model Design: Advisory Process

Goal - Develop a primary care modernization program model that details:

1) ***new care delivery capabilities for Connecticut's primary care practices***
2) ***payment model options that support those capabilities***

The program model is intended to double primary care spending over a period of five years so that doctors can provide patients with more support. It will also introduce new payment methods that increase flexibility to make care more convenient, community-based and responsive to the needs of patients. Together, these changes must improve outcomes and health equity while reducing the total cost of care and increasing the joy of practice.

Primary Care Modernization Outcomes

Patient Experience	Quality
• Improved communication, convenience, care coordination and self-management. • Increased access to primary and specialty care including behavioral health and dental care. • Increased overall satisfaction with providers, feeling of providers' care and concern. • Shorter wait times • Less time off from work, improved functioning at work	• Improved child development outcomes, improved family engagement, focus on reducing risk and improving protective factors • Earlier identification and treatment of medical and behavioral health conditions; improved outcomes (e.g., depression remission rates) • Improved care plan adherence and chronic illness outcomes (e.g., A1C control) • Reduced preventable admissions for ambulatory care sensitive conditions and all-cause unplanned hospital readmissions • Improved preventive care (e.g., healthy eating and fitness, cancer screening, immunizations, oral health) • Reduced use of opioid painkillers and less opioid addiction; earlier recognition of risk for opioid addiction; improved opioid use disorder treatment outcomes
Access	**Cost**
• Increased access to primary and specialty care including behavioral health and dental care and reduced barriers to access • Reduced wait times to address new diagnoses, changes in condition and response to treatment • Improved access to local, culturally-competent community resources to address social determinant barriers • Easier access to services in the practice, home, and community • Easier access to high quality pain management support from primary care team and medication assisted treatment for substance use disorders	• Lower out of pocket costs for patients when treated in primary care • Reduced avoidable specialty care, urgent care, tests, treatments, procedures • Reduced avoidable emergency department visits and hospital stays • Reduced avoidable physical health utilization related to unmet BH needs • Averted or reduced length of stay in skilled nursing facilities with coordination of home-based supports • Reduced cost associated with time off work

Primary Care Modernization Health Equity Impact

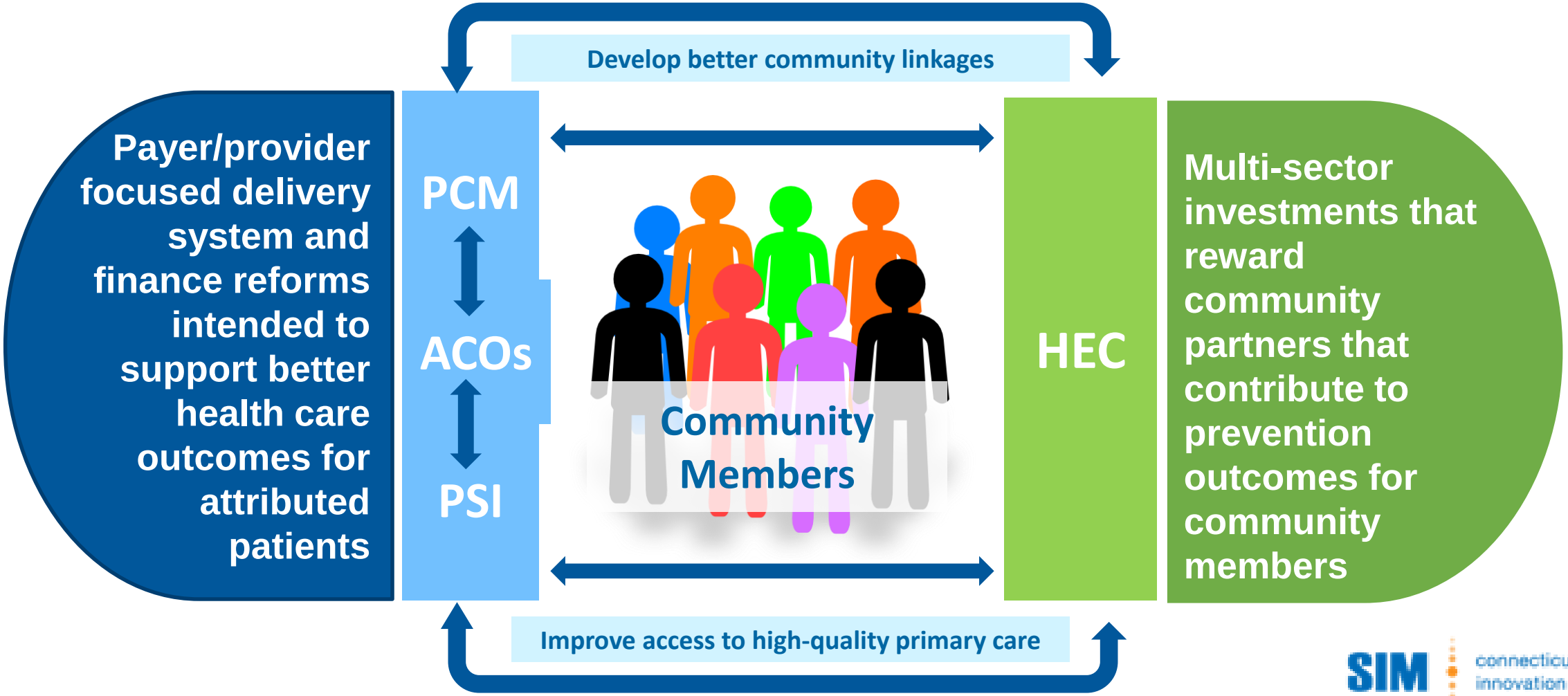
People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. These disparities are largely driven by systemic barriers.

By creating new systems and employing care teams that reflect the patients and communities they serve, PCM capabilities work together to address barriers such as:

- Language differences
- Culture
- Lack of transportation, childcare, food security, housing stability
- Difficulty taking time off work
- Literacy

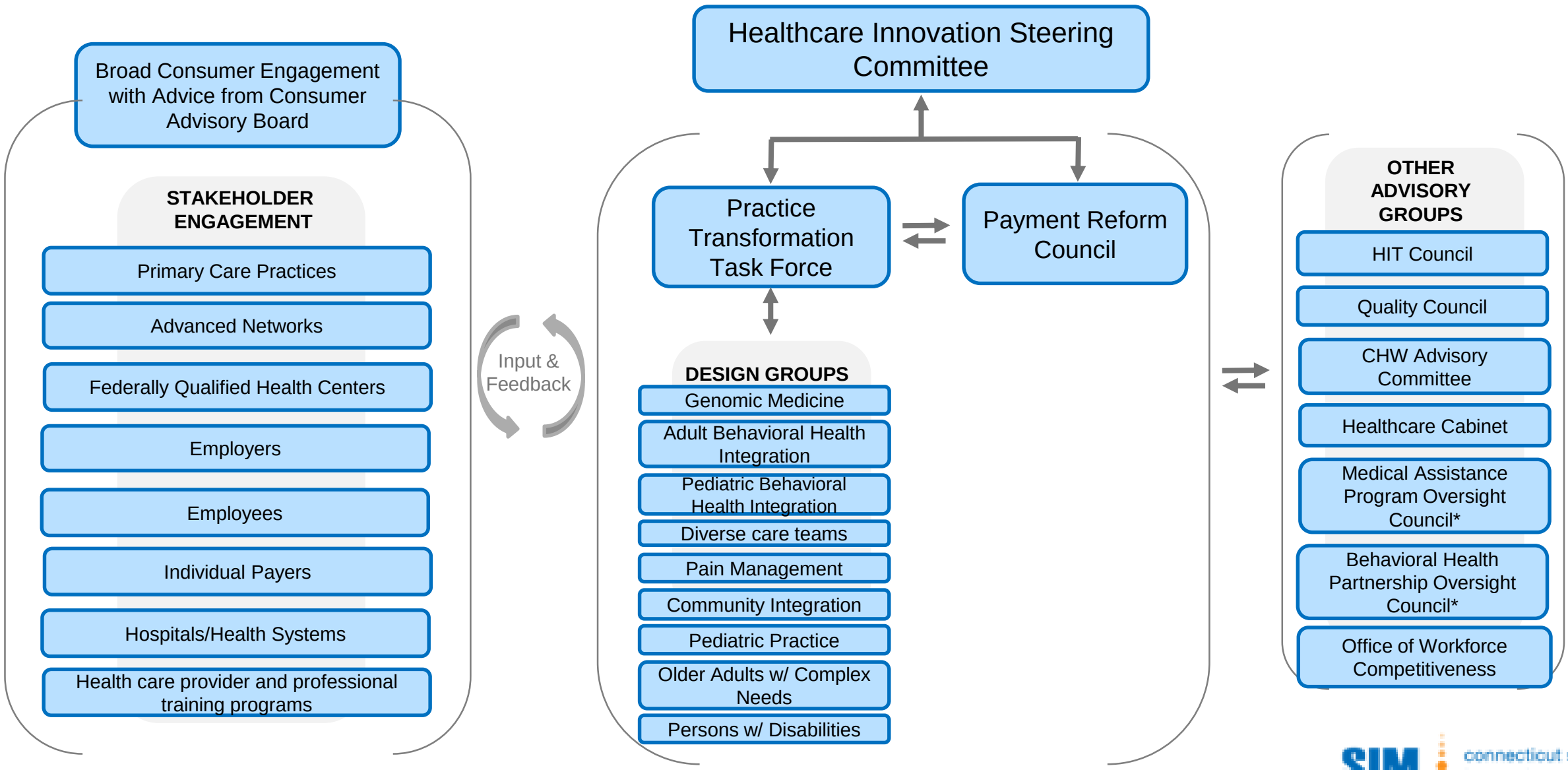
Aligned and Complementary Reforms

Connecticut's augmented strategy to incentivize quality and prevention



SIM connecticut state innovation model

Stakeholder Engagement Progress



SIM connecticut state innovation model

Adult Primary Care Capabilities

Provisional

		Team-Based Care	Alternative Ways to Engage Patients and Their Families	Specialized Practices
Health Equity Improvement	Core	• Diverse Care Teams • Behavioral Health Integration • Community Integration to Address Social Determinants • eConsults and Co-management	• Telemedicine, Phone, Text & Email • Remote Patient Monitoring	• Older Adults w/Complex Needs • Pain Management and Medication Assisted Treatment • Individuals with disabilities
	Elective	• Community Purchasing Partnerships • Oral Health Integration	• Shared Medical Appointments • Integrative/functional medicine	

ADULT DIVERSE CARE TEAMS

CORE

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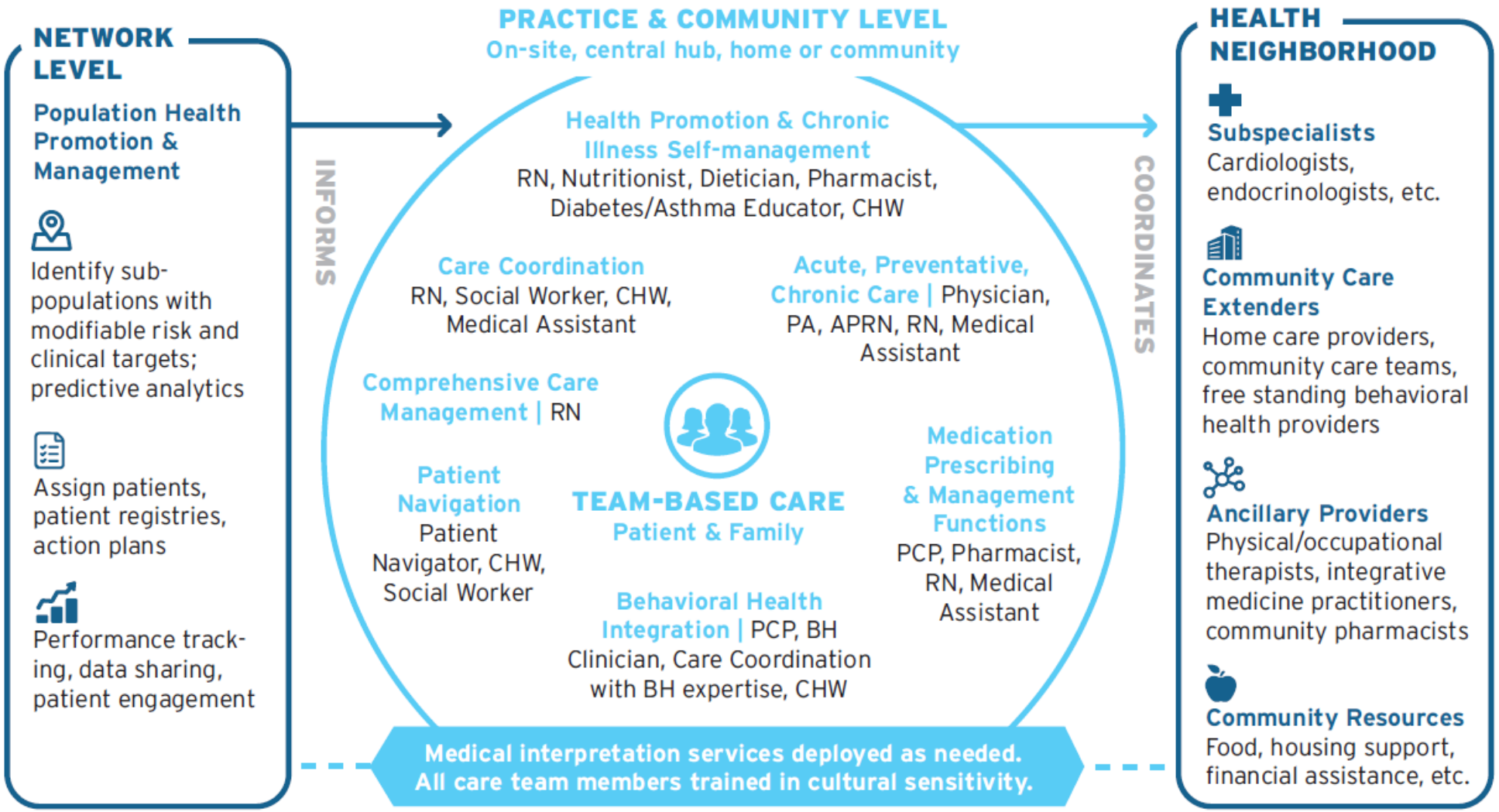

ADULT BEHAVIORAL HEALTH INTEGRATION

CORE

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ALL PRIMARY CARE PROVIDERS TEAM-BASED CARE

Patient & Family

Standard screening for behavioral health and social determinants

Dedicated behavioral health clinician (LCSW or APRN)

- Available on-site or via telemedicine
- Performs assessments, brief treatment services and care team consultation

eConsult arrangement with community-based psychiatrist or advance practice registered nurse (APRN)

Team-based, biopsychosocial approach to care, health promotion, and prevention

Medication management

Practice team training

PRACTICE-BASED CARE COORDINATOR WITH BEHAVIORAL HEALTH EXPERTISE

- Supports referrals and patient navigation to community-based care
- Community resources to support behavioral care
- Works with the primary care team and with behavioral health specialists

HEALTH NEIGHBORHOOD

Connects patients via established relationship with clinics, psychiatrists, psychologists/APRNs/LCSW to provide extended therapy, counseling, and higher level of care

Connects to community-based organizations

Bidirectional communication among primary care team, community-based behavioral health specialist and community support organizations. Access to Electronic Health Record and systematic outcomes tracking.

ADULT COMMUNITY PURCHASING PARTNERSHIPS

ELECTIVE

DRAFT

CARE TEAM AND NETWORK

Networks use person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services
[See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Secondary Prevention Services	Chronic Illness Self-management Services	Complex Care Coordination for High Risk Patients, Often with SDOH Needs	Support for Patients with Acute or Chronic Medical Risk at Home
EXAMPLES OF MODELS	Health Leads or Project Access	Community Meeting Place Approach	Prevention Services Initiative	Community Care Teams, Leeway Community Living	Mobile Integrated Health/Community Paramedicine

INCREASE EXPERTISE IN PAIN MANAGEMENT

CORE

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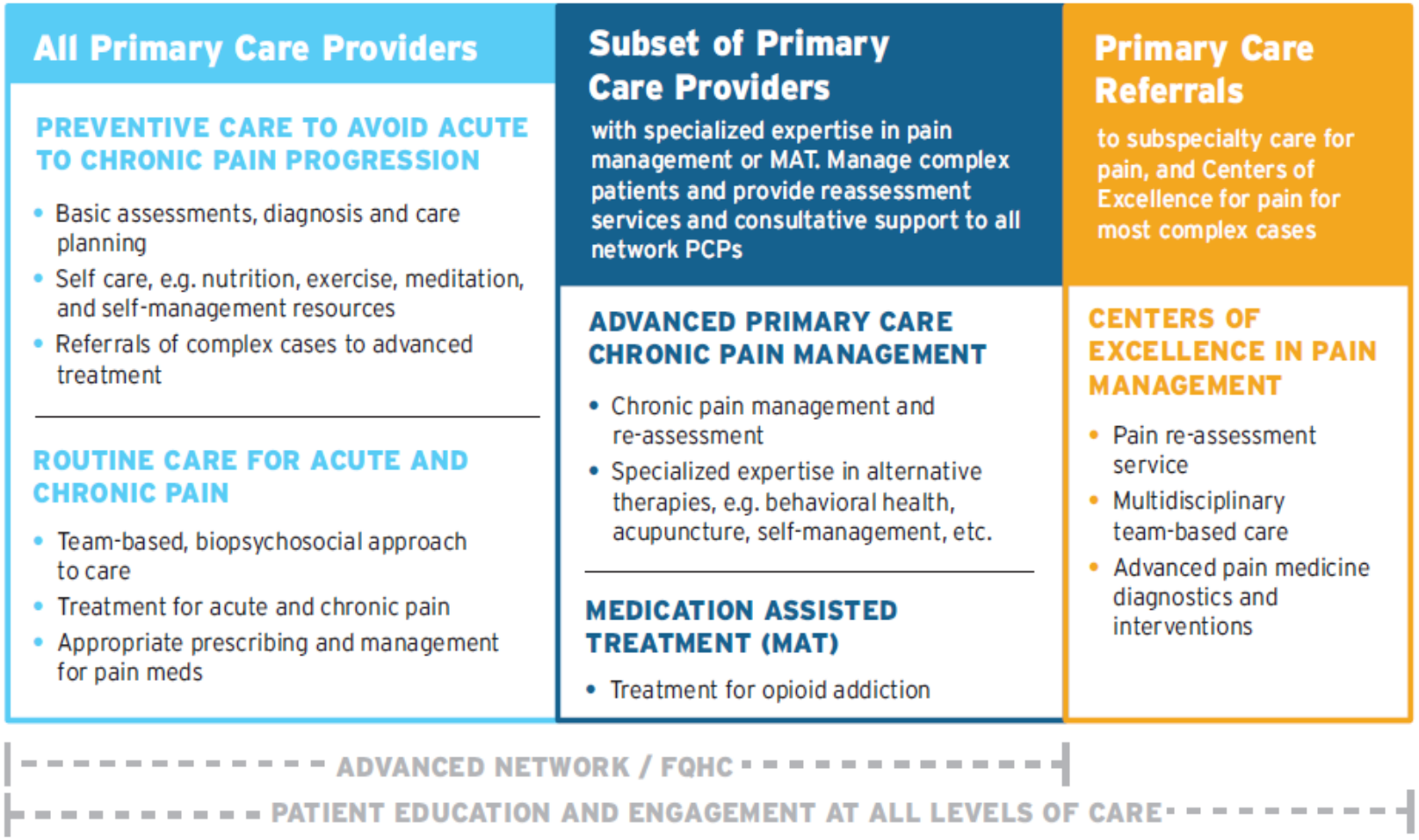

CENTERS OF EXCELLENCE PROVIDE	**All PCPs**: Training and technical assistance in pain assessment and management	**Subset of PCPs**: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management

SPECIALIZED CARE FOR OLDER ADULTS WITH COMPLEX NEEDS

Patients and families choose primary care team based on needs, provider expertise and practice capabilities

CORE

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ADVANCED NETWORK/FQHC TEAM-BASED CARE

Patient & Family

ALL PRIMARY CARE PRACTICES IN AN/FQHC

- Diverse Care Teams (CHWs, pharmacists, care coordinators, BH clinicians, etc.)
- Telemedicine visits
- eConsults between PCPs and specialists
- Remote patient monitoring for CHF, post-acute care
- Phone/text/e-mail encounters

SUBSET OF PRIMARY CARE PRACTICES

Specialize in Geriatrics for Patients with Complex Needs

Specialized expertise supported by Project Echo guided practice, practice experience expertise and technical assistance for Advance Care Planning

- Home-based Primary Care
- Dementia Care
- Palliative Care
- Advance Care Planning (Project Echo)
- Acute care setting rounding & care transitions support

HEALTH NEIGHBORHOOD

Primary care teams link to services and work with other service providers as appropriate, coordinate between PCP and subspecialists

Specialty Care
Subspecialists (e.g. cardiologist, pulmonoglist, etc.), acute care settings

Community & State Services for High Risk Older Adults
Home care/aides, hospice providers, assisted living facilities, Connecticut Community Care support programs

Community Supports for all Older Adults
Meals, transportation, housing, handyman (hand rails, etc.), community centers

Other Adult Capabilities

- Telemedicine, Phone, Text & Email **(CORE)**
- eConsults and Co-management **(CORE)**
- Remote Patient Monitoring **(CORE)**
- Shared Medical Appointments (ELECTIVE)
- Oral Health Integration (ELECTIVE)
- Under Consideration
  - Individuals with Disabilities
  - Integrative/Functional Medicine

Universal Capabilities for Adult and Pediatric Primary Care Practices

CORE

Provisional

All Practices

Health Equity Improvement

This capability identifies key components of an effective Health Equity Improvement strategy. In order to achieve the capability, your network must achieve the goals and demonstrate improvement on the process measures. Your network has a **clear, documented policy and procedure** to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

Community Integration to Address Social Determinants

Every practice and network will identify social determinants of health and other barriers that may affect patents' healthcare outcomes and address those barriers by connecting patients to community resources.

Patricia's Story

Patricia's Needs:

- Support for preventing diabetes
- Support for treating her depression
- Access to healthy foods

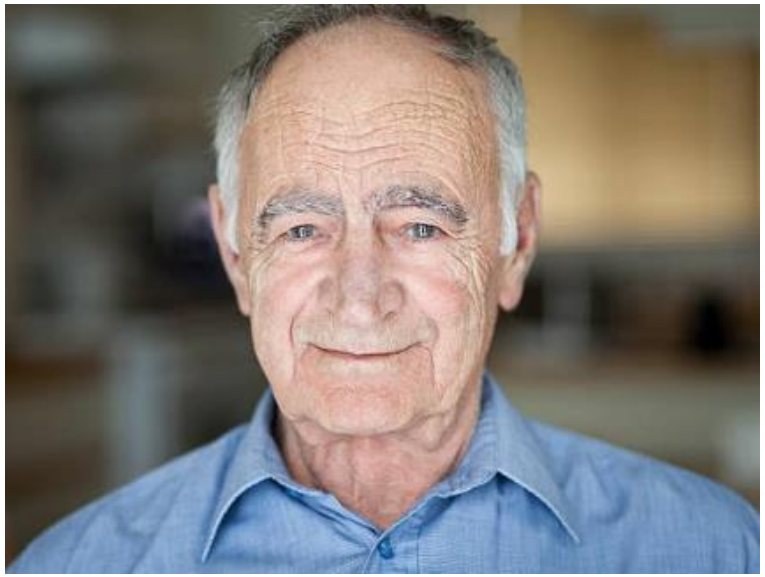
Solutions:

- Assistance enrolling in the health center's Diabetes Prevention Program
- Warm handoff to a behavioral health provider who communicates regularly with Patricia via text messages
- Access to affordable weekly vegetable boxes through a new local urban farming system

Albert's Story

Albert's Needs:

- Assistance preventing becoming overweight
- Support for preventing falls
- Support for enhancing social connections
- Assistance with medications



Solutions:

- Geriatric assessment and care plan
- E-consult with a gerontologist
- Pharmacist for medication assistance
- Health coach to support healthy weight and falls prevention
- Community health worker support for physical activity and social connection

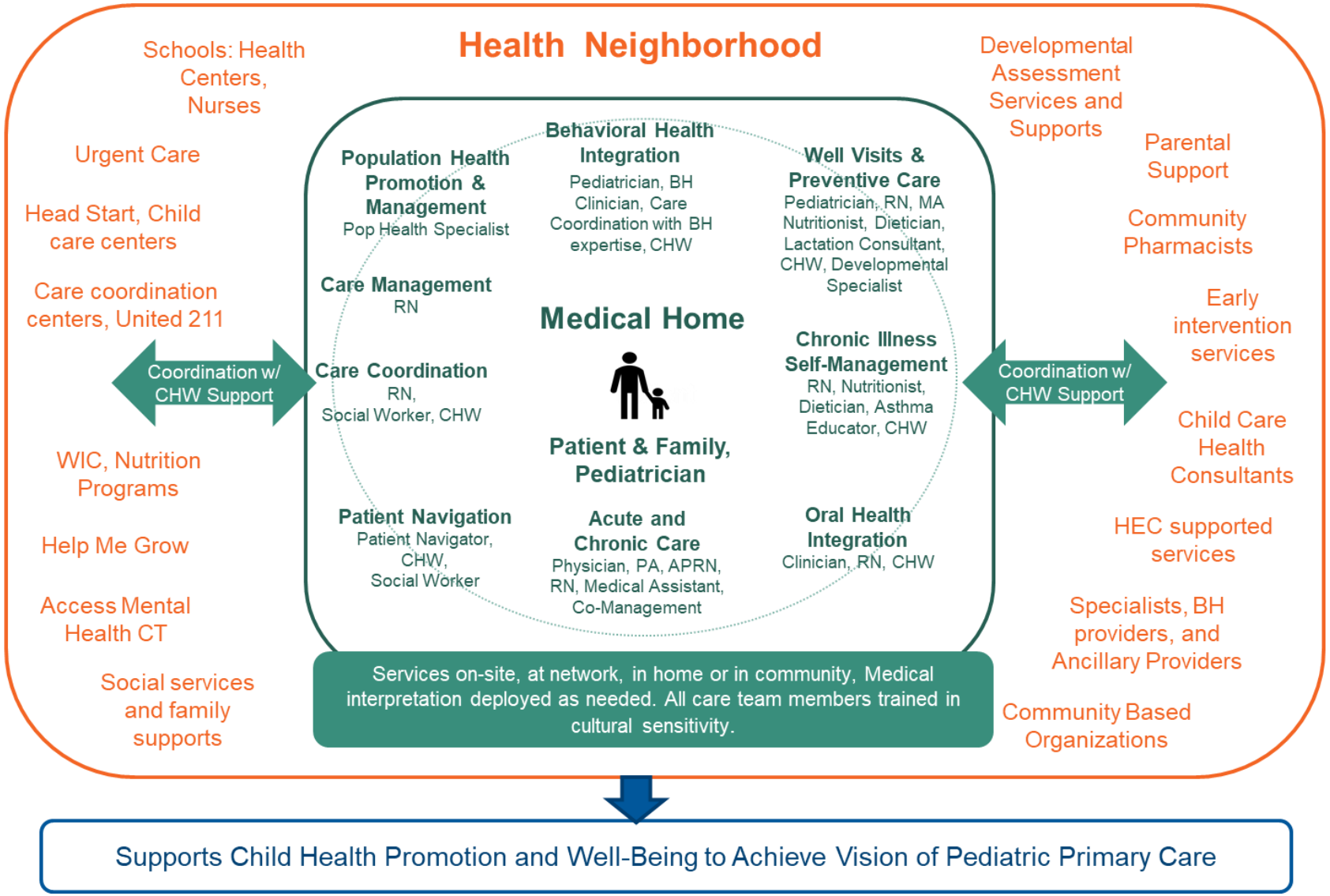
Pediatric Primary Care Capabilities

Provisional

		Team-Based Care	Alternative Ways to Engage Patients and Their Families	Specialized Practices
Health Equity Improvement	Core	• Diverse Care Teams • Behavioral Health Integration • Oral Health Integration • Community Integration to Address Social Determinants • eConsults and Co-management	• Telemedicine, Phone, Text & Email • Universal Home Visits for newborns	• Individuals with disabilities
	Elective	• Community Purchasing Partnerships	• Shared Medical Appointments	

Pediatric Diverse Care teams

CORE



PEDIATRIC DIVERSE CARE TEAMS

Supports Child Health Promotion and Well-Being to Achieve Vision of Pediatric Primary Care

CORE

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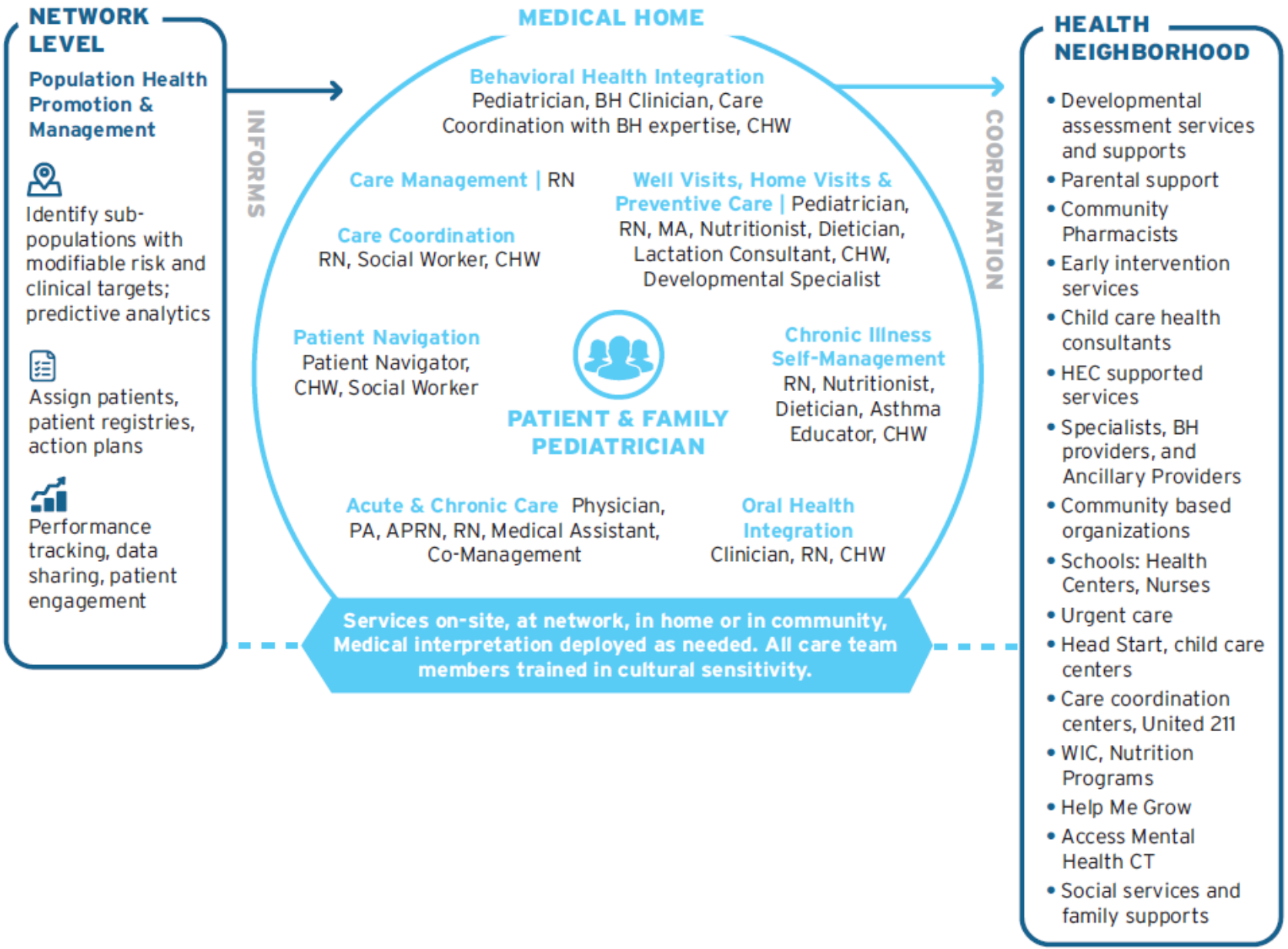

PEDIATRIC BEHAVIORAL HEALTH INTEGRATION

CORE

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ALL PEDIATRIC PRIMARY CARE PROVIDERS TEAM-BASED CARE

Child & Family

- **Standard screening** for behavioral health and social determinants
- **Dedicated pediatric behavioral health clinician (LCSW or APRN)**
  - Available on-site or via telemedicine
  - Performs brief screenings and assessments, brief treatment services and care team consultation
- **eConsult arrangement** with community-based psychiatrist or advance practice registered nurse (APRN)
- **Team-based,** biopsychosocial approach to care, health promotion, and prevention
- **Medication management**
- **Practice team training**

PRACTICE-BASED CARE COORDINATOR WITH BEHAVIORAL HEALTH EXPERTISE

- Supports referrals and patient navigation to community-based care
- Community resources to support behavioral care
- Works with the primary care team and with behavioral health specialist
- Avoids duplication of care coordination services

HEALTH NEIGHBORHOOD

- **Connects patients via established relationships** with pediatric behavioral health clinics, psychologists/APRNs/LCSW to provide extended therapy, counseling, and extensive evaluation
- **Connects to community-based organizations, schools, and child care**

Bidirectional communication among primary care team, community-based behavioral health specialist and community support organizations. Access to Electronic Health Record and systematic outcomes tracking.

PEDIATRIC COMMUNITY PURCHASING PARTNERSHIPS

ELECTIVE

DRAFT

MEDICAL HOME

Uses person-centered assessments (including culturally appropriate SDOH screening) and/or analytics to identify patients and families whose needs are best met through community placed services. [See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Developmental Services	Chronic Illness Prevention and Self-Management Services	Complex Care Coordination for High Risk Patients and Families, Often with SDOH Needs	Parental Support Services	Transition Services for Adolescents
EXAMPLES OF MODELS	Health Leads	The Village Model	DPH Putting on Airs (Prevention Services Initiative), Healthy Me	Clifford Beers ACCORD Model	MOMs Partnership, Minding the Baby	CPAC REACH for Transition

Other Pediatric Capabilities

CORE

- Oral Health Integration **(CORE)**
- eConsults and Co-management **(CORE)**
- Telemedicine, Phone, Text & Email **(CORE)**
- Shared Medical Appointments (ELECTIVE)
- Under consideration
  - Universal Home Visits for Newborns and their Families
  - Individuals with disabilities

The Shaw Family's Story

The Shaw Family's Needs:

- Answers and guidance about their new baby and parenting
- Assistance in developing parenting skills
- Support for finding stable employment

Solutions:

- Universal newborn screening
- Basic review of parenting questions
- Connection to the Minding the Baby program
- Access to employment services

Nadia's Story

Nadia's Needs:

- A provider who can address her baby's frequent health issue
- Support for enhancing social connections
- Assistance addressing housing quality issues
- Access to transportation

Solutions:

- Care plan for ongoing health issue
- Group visits for moms of newborns
- Connection to community-based services
- Legal aid for housing quality issues
- Transportation to medical visits

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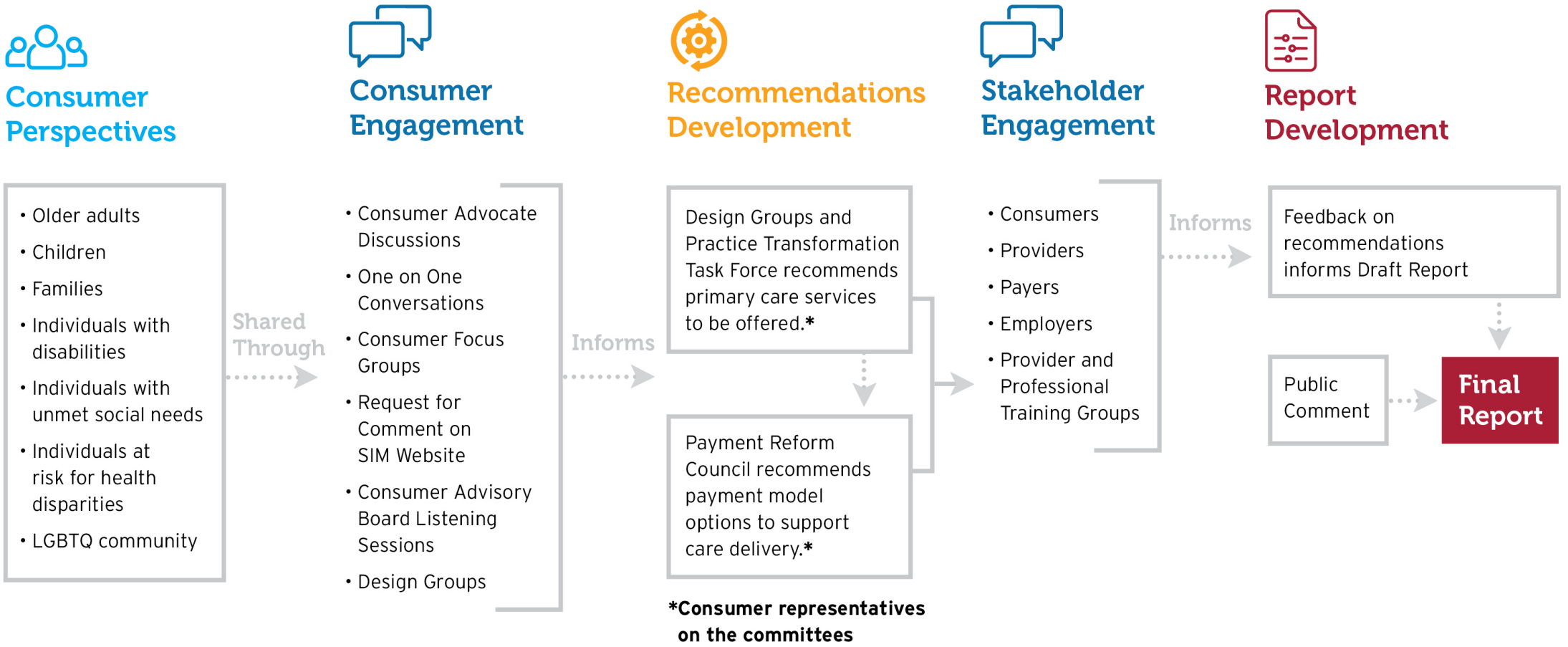
Appendix

Primary Care Modernization Process



Those Who Receive, Provide and Pay for Healthcare Participating in Every Phase of the Work

OHS CONNECTICUT Office of Health Strategy

SIM connecticut state innovation model

New Administration

New Commissioners	
Melissa McCaw	Office of Policy and Management
David Lehman	Economic and Community Development
Vannessa Dorantes	Children and Families
Katie Dykes	Energy and Environmental Protection
Beth Bye	Office Early Childhood Education
James Rovella	Emergency Services and Public Protection
Joseph J. Giulietti	Transportation
Rollin Cook	Correction
Tim Larson	Office of Higher Education
Josh Geballe	Administrative Services
Seila Mosquera-Bruno	Housing
Holdover Commissioners	
Miriam E. Delphin-Rittmon	Mental Health & Addiction Services
Amy Porter	Rehabilitation Services
Michelle H. Seagull	Consumer Protection
Vicki Veltri	Office of Health Strategy
Scott Jackson	Revenue Services
Jorge Perez	Banking
Tom Saadi	Veterans Affairs
Jordan Scheff	Developmental Services
Kurt Westby	Labor
Robert Ross	Office of Military Affairs
Under Review	
TBD	Motor Vehicles
TBD	Social Services
TBD	Education
TBD	Public Health
TBD	Agriculture
TBD	Aging
TBD	Insurance