Value Care Alliance CCIP and PSI Initiatives

OHS Legislative Forum

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About the Value Care Alliance

The Value Care Alliance (VCA) is a collaboration of Connecticut health care systems that deliver higher quality and lower cost care. It 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 provides opportunities to exchange best practices among its members with the goal of reducing health care expenses and improving quality. Additionally, the Alliance delivers the data and analytical capability to enable efficient and effective care management and to 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

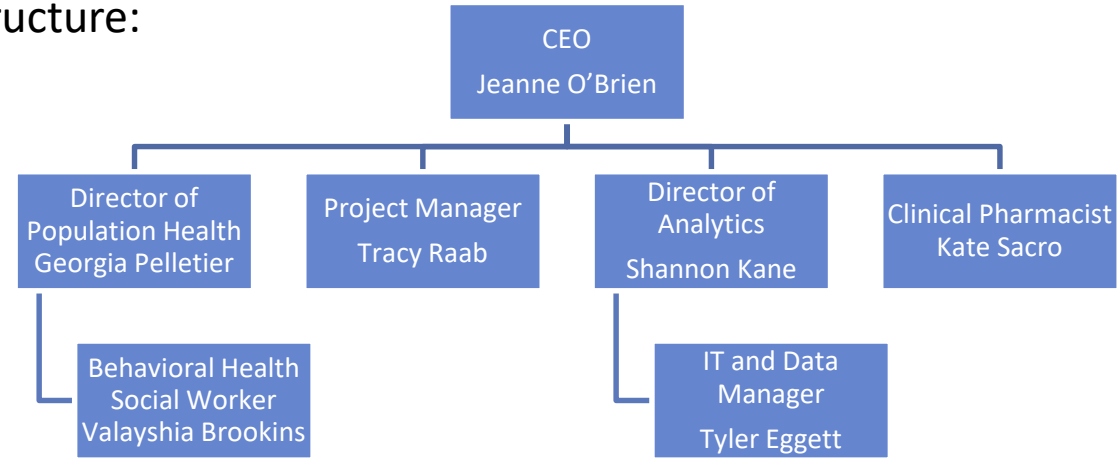
To be an essential partner for patients, employers, payers and providers seeking a competitive integrated system of care that operates at high efficiency and produces outstanding outcomes.

VCA- Who We Are

- Three Independent health systems comprise the VCA
  - *Griffin Health*
  - *Middlesex Health*
  - *Nuvance Health*

- 305 Primary Care Providers and 968 Specialists combine to create this network

- These systems are committed to enhancing the delivery of clinically integrated care and improving population health by increasing quality and reducing cost with the support of VCA infrastructure:



VCA had employed 3 Community Health Workers through CCIP funds and have been integrated into the health systems

Community Clinical Integration Program Overview (CCIP)

- Grant awarded in 2017 to support the efforts of PCMH+ program aimed at providing person-centered, comprehensive and coordinated care to HUSKY members.

What is it?
A SIM initiative to improve care delivery

What will it do?
Provide technical assistance, peer learning, and transformation awards* to provider networks

Who can participate?
Provider networks in the Patient Centered Medical Home+ initiative (formerly called MQISSP)

What will it focus on?
Three key standards:
-Complex Care Management
-Health Equity Improvement
-Behavioral Health Integration

***PCMH+ Track 2 Participants Only**

CCIP- VCA Accomplishments 2017-2019

- Standardized Care Coordination Programs across the VCA network
- Patient Ping Best Practice Workflow: real time notification of facility- based service utilization by attributed patients, including ED visits, inpatient admissions and discharges, observation stays, SNF admissions and discharges, and home health care delivery (urgent care will be incorporated in 2020)
- Expanded the collection of granular race and ethnicity (R/E) data from patients at primary care practices based on recommendations from Health Equity Solutions (hired by OHS)
- Expanded the collection of sexual orientation and gender identity (SOGI) data from patients at primary care practices
- VCA developed, produced and hosted an educational series for VCA providers with the help of the Technical Assistance Vendor provided by OHS
  - ✓ Health Equity and Population Health
  - ✓ The Role of the Community Health Worker
  - ✓ Integrating Behavioral Health into Primary Care

CCIP- VCA Sustainable Accomplishments

- Implemented a Community Health Worker (CHW) program
  - Program included 3 Community Health Workers and 1 Behavioral Health Social Worker
  - ***Sustainable- CHW's integrated into VCA's health systems***

- Implemented embedded Behavioral Health Coordinators in the health systems to close the loop on behavioral health and substance use referrals
  - ***Sustainable- Staff integrated into VCA's health systems***

CCIP-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
  - ***Community Health Workers***
  - ***Behavioral Health Coordinators***
  - ***Standardized Care Coordination***
  - ***Commitment to granular R/E and SOGI data collection***
  - ***Ongoing VCA provider education***

- CCIP Grant has been foundational in helping us understand new ways to administer health care and in educating the network:
  - ***Integrating social determinants of health***
  - ***Being aware of cultural issues that can impact health care***
  - ***Leveraging technology to help patients get the care they need when they need it***

CCIP – Related Initiatives
Accountable Health Communities Grant

- Program Data - Screening Results to Date (7/1/18 – 10/16/19)

- Total Offers to Screen: 47,294

- Screenings Conducted: 28,047 (59.3%)

- Patients/Clients with Health-Related Social Needs (HRSN) identified: 6,078 (21.7%)

    - Food: 2,902 (47.7%)
    - Living Situation: 1,984 (32.6%)
    - Transportation: 2,249 (37.0%)
    - Utilities: 1,426 (23.5%)
    - Interpersonal Violence: 153 (2.5%)

- High Risk Patients/Clients (HRSN & 2+ ED Visits): 3,046
    - 10.9% of all screened Patients/Clients
    - 50.1% of all Patients/Clients with HRSNs identified

CCIP – Related Initiatives – *Unite Us CT*

- Through the Connecticut Hospital Association (CHA), hospitals and health systems are implementing a statewide system of screening and referral that integrates social determinants of health (SDOH) into healthcare practice, effectively addressing social, economic and behavioral health needs on both an individual and a statewide level.

- A core component of the initiative is the ability to exchange SDOH data at a patient level and analyze SDOH data at a statewide level for benchmarking, quality improvement and care coordination.

- CHA is partnering with ***Unite Us CT***, a veteran-owned technology platform provider that will enable Connecticut hospitals to track patients' social determinants and provide closed-loop referrals to community-based organizations (CBO's).

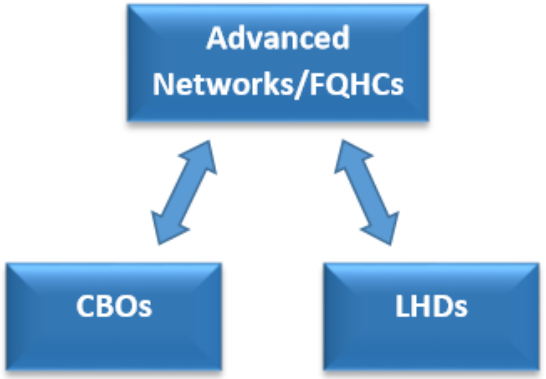
- ***Unite Us CT*** connects health and social service providers into a coordinated, collaborative and accountable network, delivering value and better patient outcomes.

- ***Unite Us CT*** started meeting in September 2019 and launched in November 2019

- Currently the ***Unite US CT*** platform has 38 CBO's that provide 330 services offered throughout the state – these services have supported 45 referrals as of 1/7/2020

Prevention Service Initiative Overview (PSI)

This model focuses on preparing Community Based Organizations (CBOs) that can provide effective prevention services to enter and succeed in formal contractual arrangements with Advanced Networks and FQHCs. Multiple CBOs in three regions will receive SIM-funded technical assistance focusing on developing business strategies and negotiating contracts with Advanced Networks and FQHCs.



*Arrows represent contractual linkages

Program goals:

1. Increase the number and quality of formal referral linkages and contractual relationships between the healthcare sector (ACOs) and the community sector (CBOs, public health entities).
2. Increase the number of individuals with unmet prevention needs who complete evidence-based "Bucket 2" prevention services.
3. Improve ACO performance on quality measures related to asthma, diabetes, hypertension, ED utilization, and readmissions for a defined ACO-attributed population.
4. Enable ACOs to succeed in shared savings programs and other alternative payment models.
5. Open avenues for community integration to address clinical and social determinants of health.

PSI- VCA Accomplishments 2019

VCA contracted with Hispanic Health Council (HHC) - a community-based organization (CBO) to deliver their evidence- based diabetes management program coordinated with a full-time Community Health Worker

- Coordinated CBO services for patients in our Middletown community with Middlesex Health Primary Care and Family Practice

- This intervention addressed the need for a program to provide home-based support for individuals who had elevated HbA1C levels (greater than 9) and who had not proactively engaged in a traditional diabetes chronic care management program/model offered within our system. **Baseline HbA1C average of participants enrolled is 10.8*

- Leadership including a Physician champion was in place to support this initiative

- Established an efficient workflow between HHC and the Middlesex Health provider team including the Physician champion, Population Health Director and Population Health Nurse

PSI- Ongoing Accomplishments 2019

VCA contracted with Hispanic Health Council (HHC) - a community-based organization (CBO) to deliver their evidence- based diabetes management program coordinated with a full-time Community Health Worker

- 30 patients have been enrolled and actively engaged - with 210 home visits to date (June 2019 through December 2019)

- Social Determinants of Health needs are being addressed i.e.
  - ✓ *Several participants connected to SNAP benefits and report seeking healthier food choices*
  - ✓ *Transportation secured for several participants, one participant had not seen ophthalmologist in 4 years, CHW helped to secure appointment with transportation*
  - ✓ *Barriers to clinical care addressed, most participants expressed distrust of clinical services and lack of understanding of how to manage diabetes, CHW reinforced the importance of regular clinical care and educated participants about preparing for clinical visits*

PSI-Conclusion

- The VCA working closely with OHS has established a positive formal contractual relationship with a community- based organization
- A successful workflow has been implemented between a CBO and an Advanced Network
- Social Determinants of Health (SDOH) needs identified and addressed
- Post intervention data will be reviewed to establish sustainability
  - A1C values will be collected 3 months post intervention to determine true impact of the program on this population
  - Review of SDOH needs met during intervention i.e.
    - *Patients connected to eligible benefits*
    - *Patients connected to transportation*
    - *Patients re-engaged with providers*

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