Health Enhancement Communities: A Pathway to Better Health

Health Care Cabinet Meeting

November 13, 2018

Healthcare Reform in Connecticut

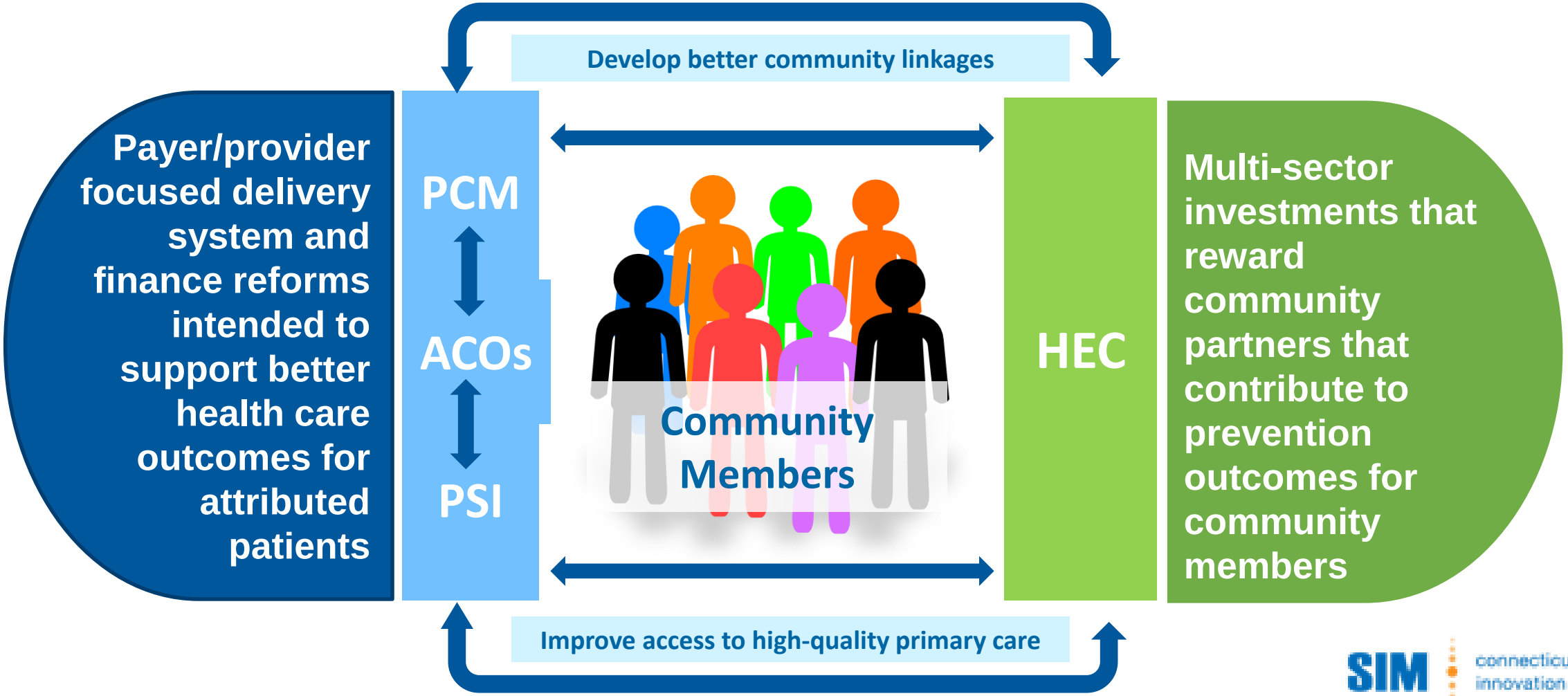
- Achievements…
  - Widespread adoption of the ACO or “shared savings program model”
  - More than 85% of Connecticut’s primary care community in ACO arrangement
  - SIM achievements
    - 180,000+ Medicaid beneficiaries in PCMH+ shared savings program
    - 1,000,000+ beneficiaries (all payer) attributed 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
    - Implementation of information exchange and data analytic solutions underway

Healthcare Reform in Connecticut

- Limitations…
  - Primary care remains largely untransformed
  - Limited impact on total cost of care
  - Limited investments in preventing poor health and improving community health and wellbeing

Aligned and Complementary Reforms

Connecticut's augmented strategy to incentivize quality and prevention



SIM connecticut state innovation model

Health Enhancement Community Framework

Proposed Features

- HECs will be multi-sector collaboratives with formal governance structures operating in defined geographic areas that will improve community health, prevention, and health equity and reduce cost and cost trends for select health priorities.
- HECs will implement multiple, interrelated, and cross-sector strategies that address the root causes of poor health, health inequity, and preventable costs.
- HECs will operate in an economic environment that is sustainable, including through financing that rewards communities for prevention, health improvement, and the economic value they produce.

Primary Priorities Across HECs

Improve Child Well-Being

Increase Healthy Weight and Physical Fitness

Improve Health Equity

HECs may also select additional priorities but the intent is to have a statewide focus.

HEC Proposed Health Priorities

HEC Child Well-Being Goal: Assuring safe, stable, nurturing relationships and environments*

HECs would implement interventions to prevent Adverse Childhood Experiences (ACEs) pre-birth to age 8 years and mitigate the impact of ACEs by increasing protective factors that build resilience. Interventions would target one or more ACEs, including:

- Physical, sexual, and emotional abuse
- Emotional and physical neglect
- Mental illness of a household member
- Problematic drinking or alcoholism of a household member
- Illegal street or prescription drug use by a household member
- Divorce or separation of a parent
- Violence in a household and/or in the community
- Incarceration of a household member

HECs may also implement interventions that address other types of trauma or distress such as poverty, food insecurity, poor nutrition, housing instability, or poor housing quality.

HEC interventions may focus on families, children, parents, and expectant parents.

** Source: CDC Essentials for Childhood*

HEC Proposed Health Priorities

HEC Healthy Weight and Physical Fitness Goal: Assuring individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so.

Healthy weight and physical activity are defined as:*

- *Healthy Weight:* Maintaining a healthy body weight (based on CDC BMI guidelines**)
- *Physical Activity:* At least 150 to 300 minutes of moderate-intensity activity per week to prevent weight gain.

HECs would implement interventions to prevent overweight and obesity across the lifespan and the associated risks of developing serious health conditions. Interventions would target:

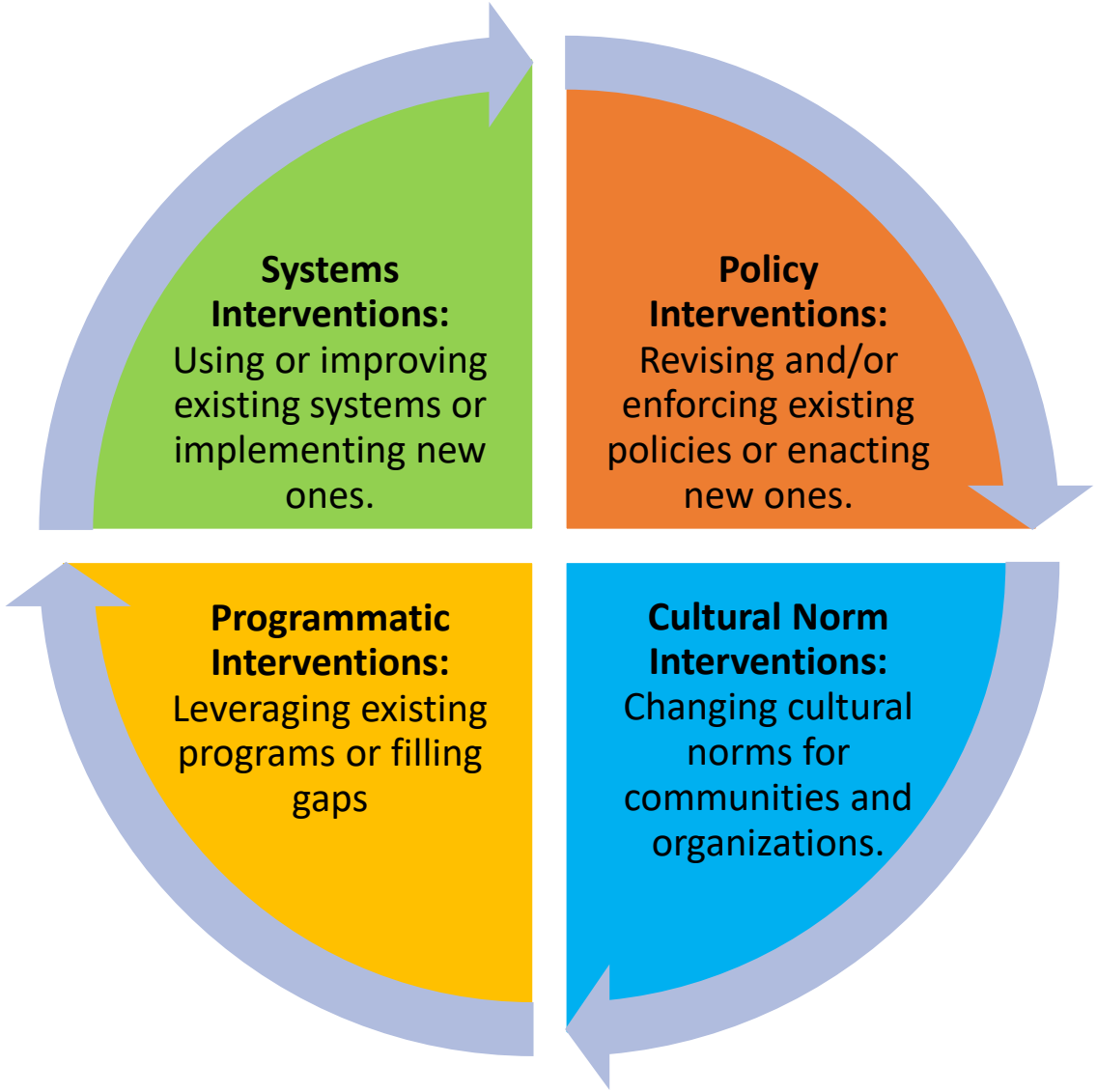
- Access to and consumption of healthy foods and beverages
- Access to safe physical activity space
- Reducing deterrents to healthy behaviors

** CDC*

**** https://www.cdc.gov/obesity/adult/defining.html; https://www.cdc.gov/obesity/childhood/defining.html

Proposed HEC Intervention Framework

HECs will select and implement interventions in these categories.



Geography

HEC Geographies: Proposed Elements and Process

- HECs will have defined geographies for which they are accountable.
- The State hopes to provisionally have 8-12 HECs and wants every geography in Connecticut included in an HEC.
- HEC geographies will be defined during an iterative State process.
  - The process will start by prospective HECs proposing geographies based on criteria defined by the State and providing rationale for their proposed geography.

Governance

HEC Governance

- HECs will need to have a formal governance structure with clearly defined decision-making roles, authorities, and processes.
  - Partner agreements, bylaws, backbone organization(s), contracts for specific services
- The governance structures will need to be effective within each HEC's unique context (e.g., geographies, populations, partners, infrastructures) and be nimble enough to adapt if circumstances change.
- There will need to be a balance between "focus and flexibility" so that HECs can quickly progress from making governance structure decisions to identifying and implementing strategies.

Community Input and Engagement in HECs

Stakeholder and Community Input

- Proposed HEC framework is based on stakeholder and community input including:
  - Findings from the SIM Listening Sessions
  - Input from the community members to date
    - Community member engagement done by Reference Communities
    - A parent group affiliated with Clifford Beers Clinic in New Haven
  - Input from the Consumer Advisory Board co-chairs
  - Input from the Population Health Council
  - Input from the Healthcare Innovation Steering Committee (HISC)
  - Input from meetings with community advocates on the HISC

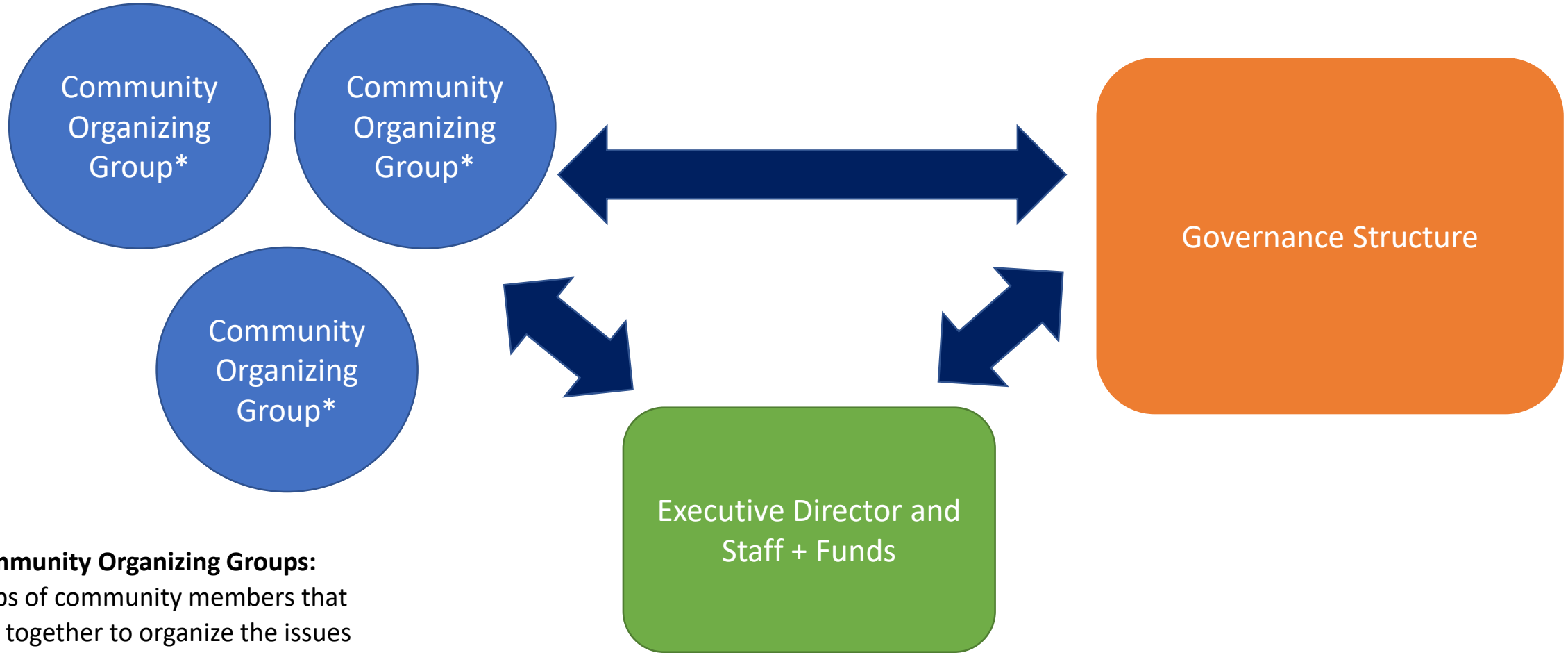
Design Input from Community Collaboratives

- Reference Communities were also selected by the State through an RFP process to provide recommendations on the design of the HEC framework: Hartford, New London, Norwalk, and Waterbury
- Also presented and got input on the proposed framework with collaboratives in New Haven and Bridgeport

The Goals of the Process were to:

- Give the existing community collaboratives and their community members a voice in the design of the HECs
- Get recommendations that are reality-based and actionable in communities

Community Involvement: Potential Structure for Discussion



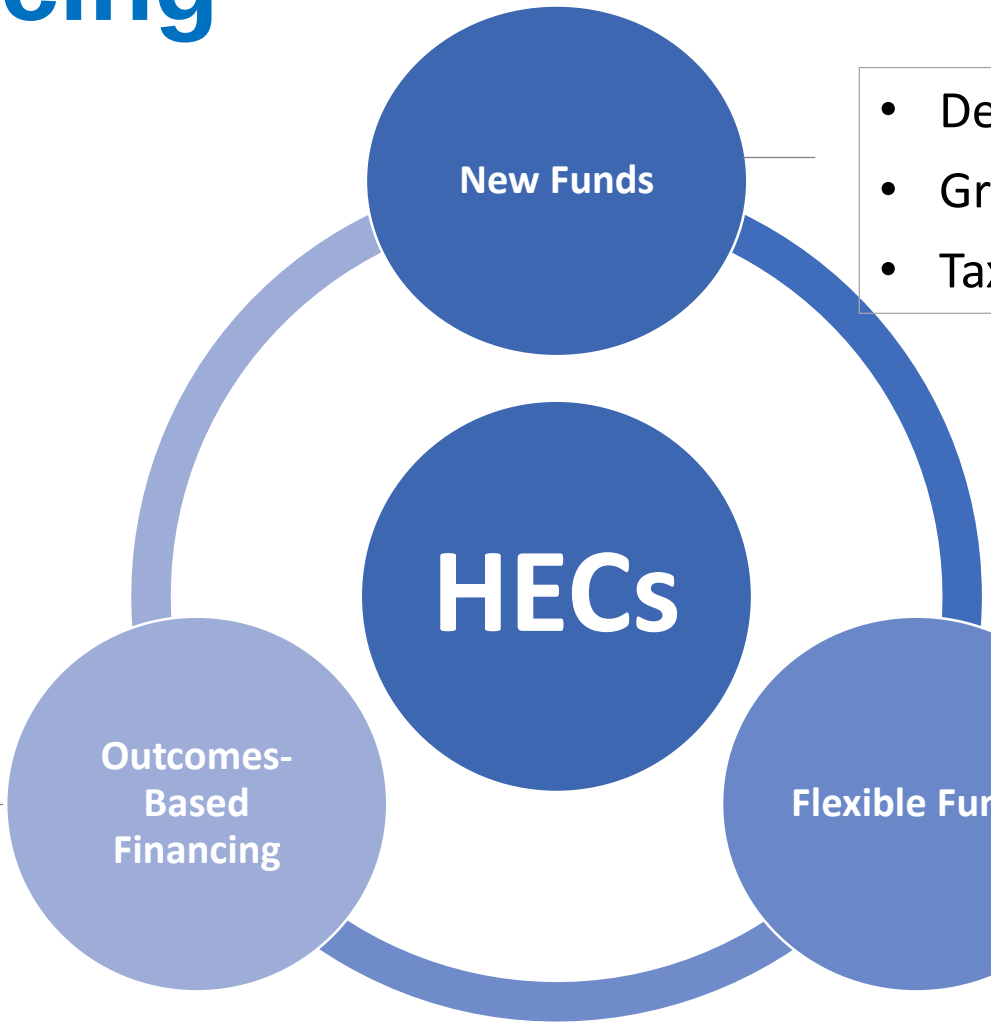
*** Community Organizing Groups:**
Groups of community members that come together to organize the issues and interventions that matter most to them.

Financing

Proposed HEC Financing Approach

- Monetizing prevention is at the core of the HEC Initiative
- Will require a mix of:
  - **Near-term**, upfront funding in the first 5 years of implementation
  - Sustainable **long-term** sources of funds beyond 5 years
  - Assumption that near-term financing options will serve as a bridge to longer-term financing
  - Long-term financing will rely upon ongoing collaboration with health care purchasers such as Medicare, Medicaid, and potentially other payers.
- Pursuing multiple strategies
  - Multi-payer demonstration
  - Social finance options

HECs Financing Options



- Debt and Equity
- Grants
- Tax Credits

- Shared savings arrangements
- Pay for Success/ Social Impact Bonds
- Outcomes Rate Cards

- Braided Funds
- Blended Funds
- Wellness Trust

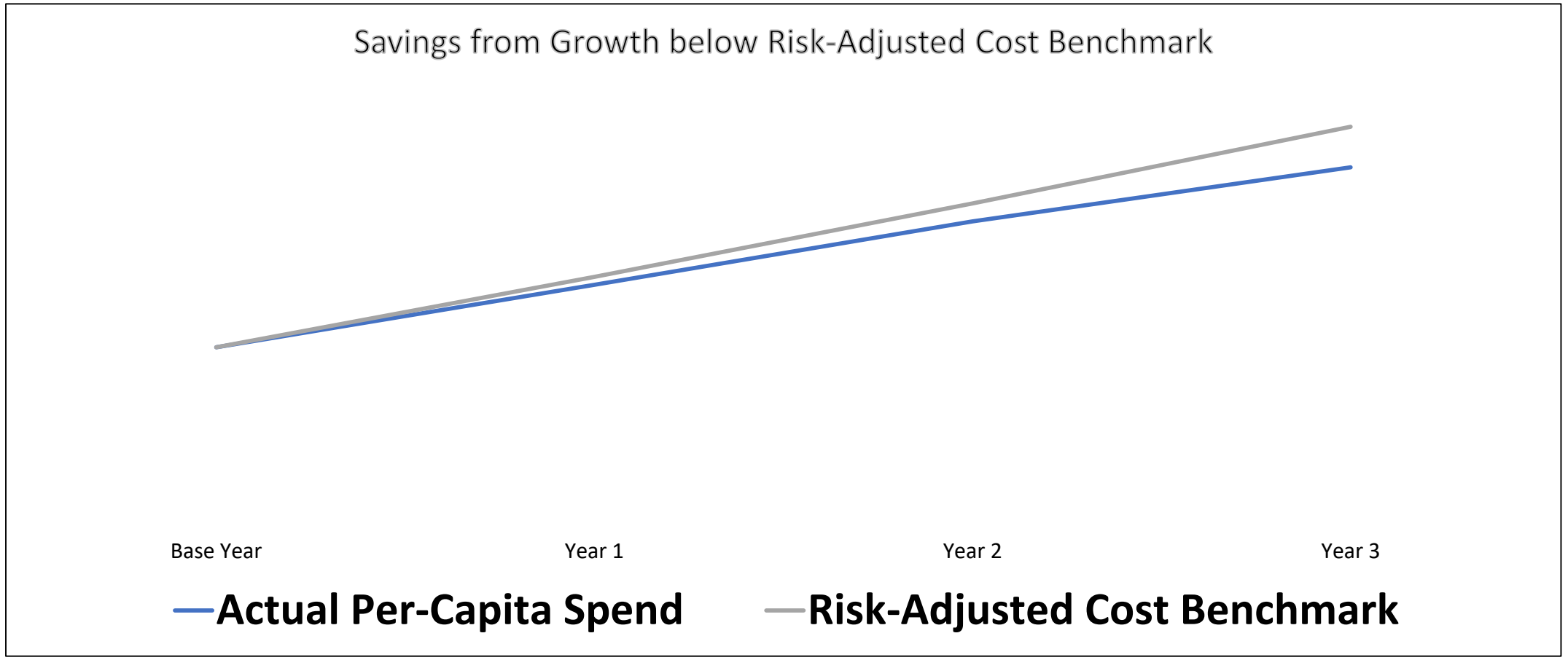
Longer-Term Financing

Outcomes Based-Financing: Reinvestment of Shared Savings

A critical component of securing long-term financing for HECs is developing **prevention-oriented shared savings arrangements with Medicare, Medicaid, and potentially other payers**

- Would complement the existing Medicare Shared Savings Program
- HECs will be measured on success with upstream prevention efforts through reduction in condition-specific prevalence trends
- Longer time horizon to demonstrate impact (5 to 10 years)
- Primary analysis suggests that reducing the prevalence of obesity among the Medicare population (age 65+) by approximately 5 percentage points over a 10-year period (2021 – 2030) could yield cumulative health care cost savings to Medicare of $1 billion or more.

Traditional Shared Savings Arrangement



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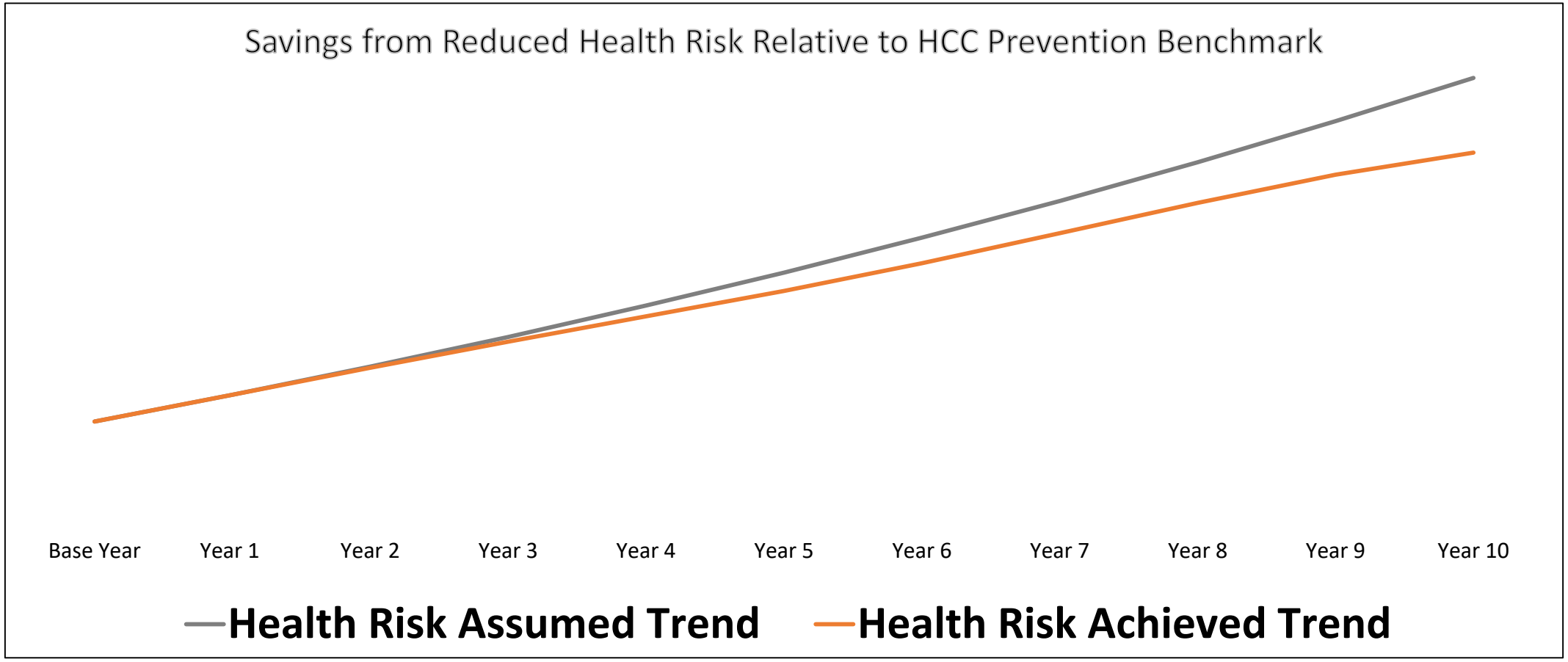
Savings from Community Health Improvements



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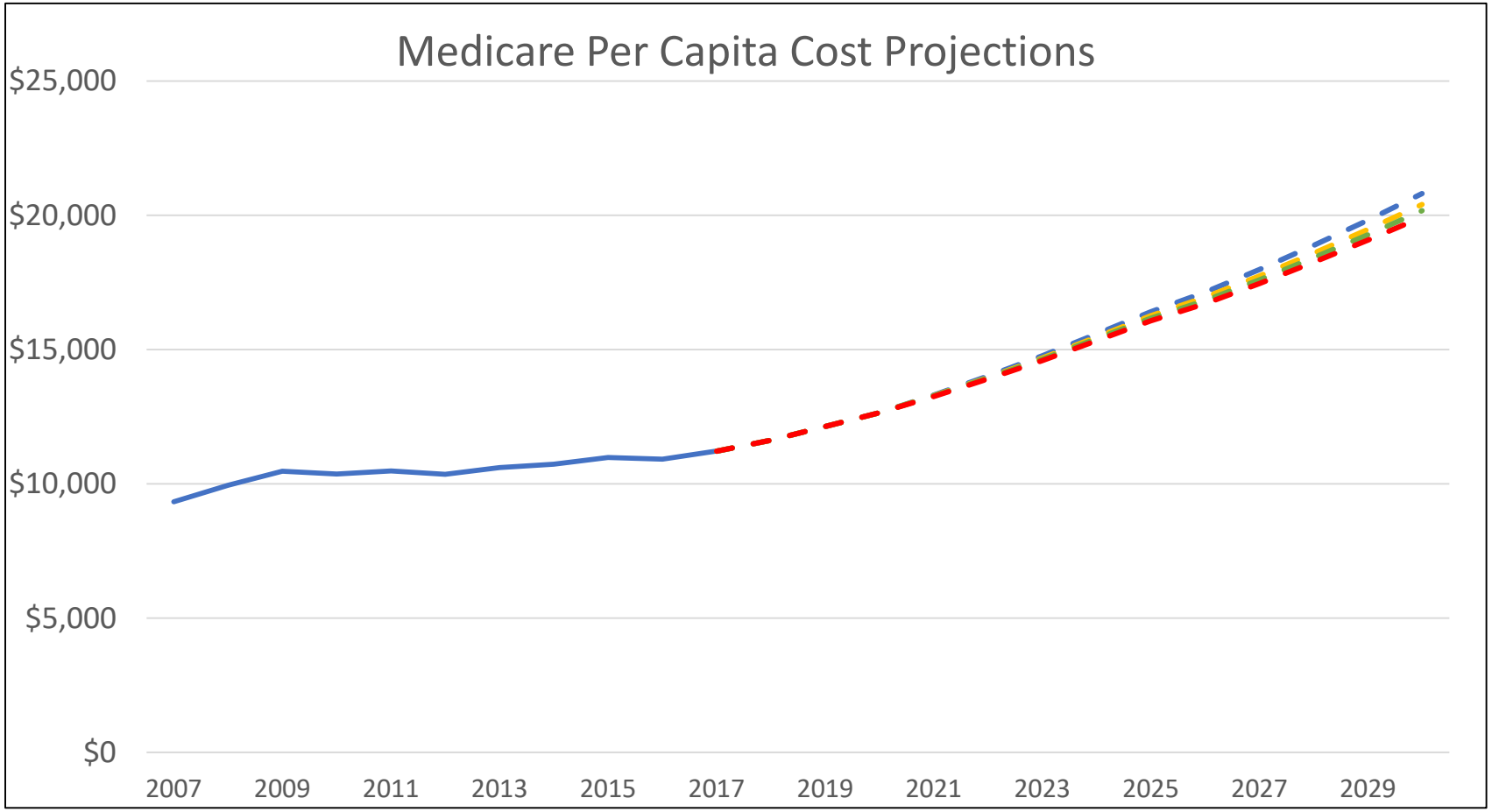
Medicare Expenditure Savings



Preliminary analysis suggests that reducing the trend in obesity prevalence among the Medicare population (age 65+) over a 10-year period (2021 – 2030) could yield cumulative health care cost savings of **$1 to $3 billion**.

Discussion