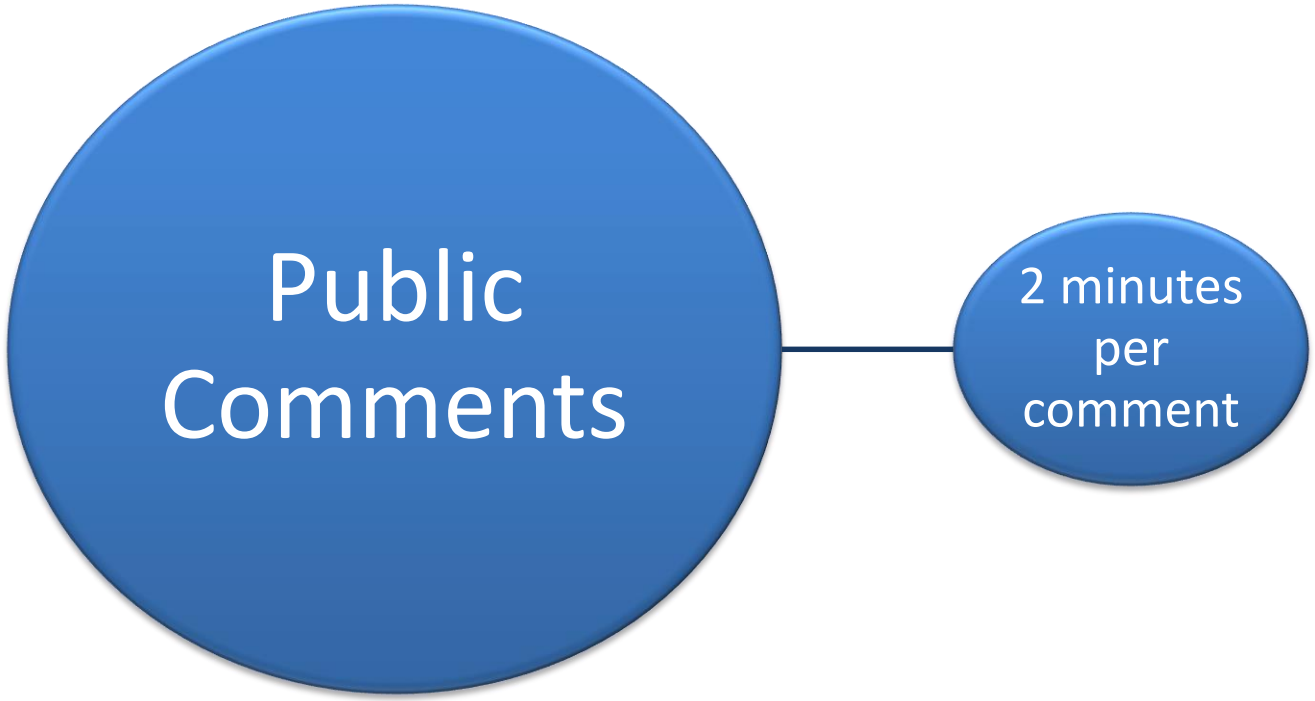
Healthcare Innovation Steering Committee

July 13, 2017

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of the Minutes	5 min
4. Steering Committee Meeting Process	
5. Population Health- Prevention Service Initiative	30 min
6. Report of the CHW Advisory Committee	15 min
7. Public Scorecard	15 min
8. Test Grant Investment Strategy	40 min
9. Adjourn	


Public Comments
2 minutes per comment

Approval of the Minutes

Steering Committee Meeting Process

Steering Committee Engagement Strategy

Synergies

Deeper Dive

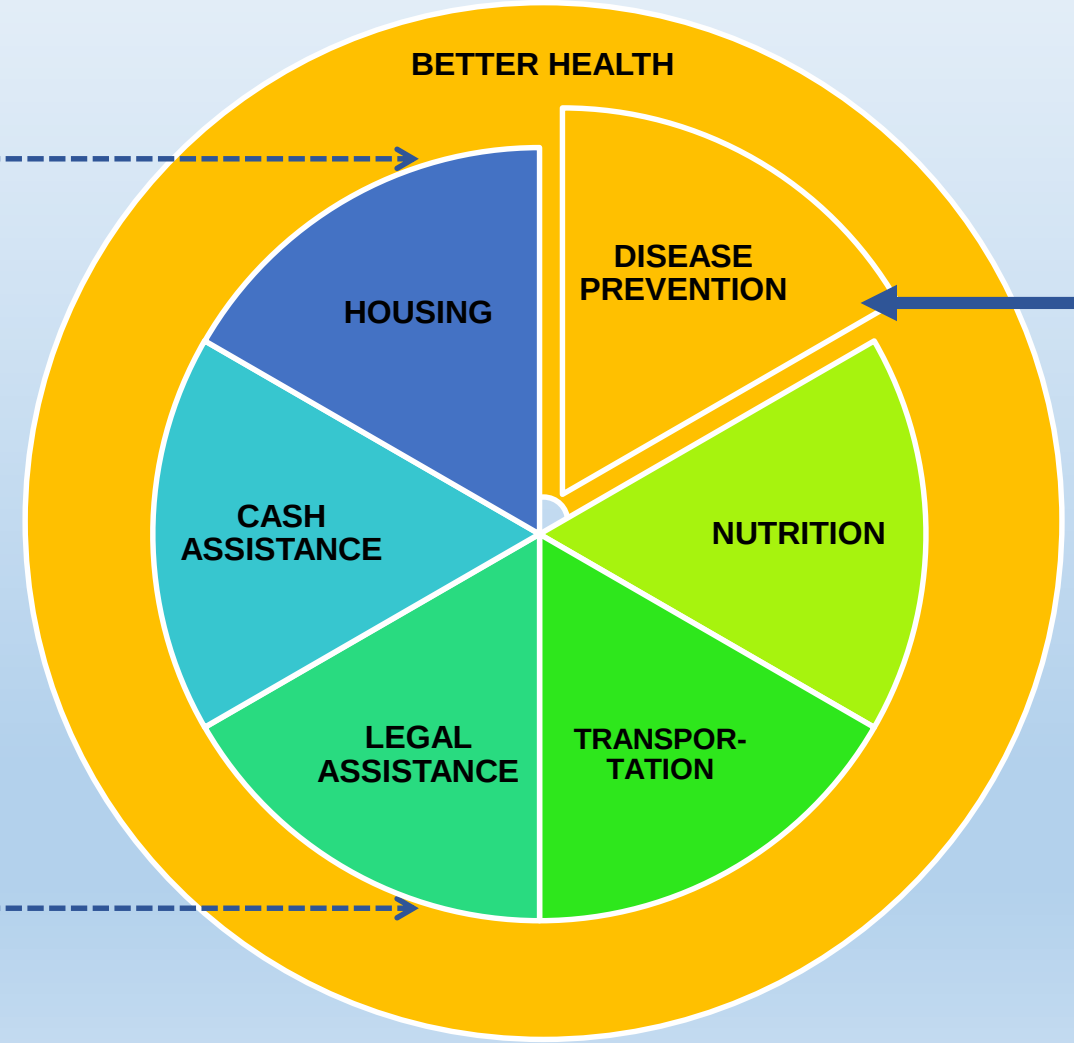
Strategy Questions

Measuring Impact

Population Health-Prevention Service Initiative

Community and Clinical Integration Program (CCIP) & the Prevention Service Initiative (PSI)

CCIP has focused on ***community linkages*** to address social determinants of health



PSI focuses on ***community linkages*** to support chronic illness self-management

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Prevention Service Initiative
Presentation Agenda

Objectives:

- Discuss and solicit final input on PSI and CBO Linkage Model
- Endorse recommendations for the CBO Linkage Model

What will be covered:

- Activities Leading to the CBO-Linkage Model – (level setting)
- CCIP and PSI Alignment
- Patient Story and Case Study Illustration
- CBO Linkage Model Strategies and Recommendations
- Discussion & Approval

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Prevention Service Initiative
Activities Leading to Recommendations

- Discussed Prevention and Population Health Concepts
- Ensured alignment with DPH/SHIP and SIM/CCIP
- Conducted an Environmental Scan
- Designed Criteria and a Menu of Prevention Services
- Selected Priority Regions
- Developed a Lead Agency Straw Model
- Engaged CBOs, ANs/FQHCs, Steering Committee, other states, and CDC to Validate Assumptions and Make Edits
- Revised CBO Linkage Model

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Making it Real – Patient Story

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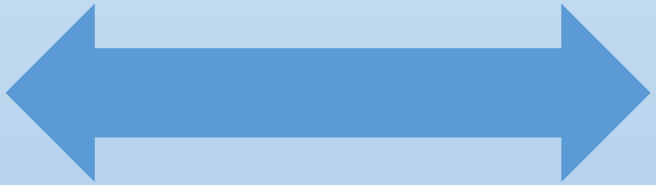
Opportunities

How do you leverage the new incentives healthcare organizations have to facilitate new partnerships between them and community-based organizations and manage patient health better?



Patient

Care Team

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Community Organization

"person just shows up and says my doctor told me I can come here"

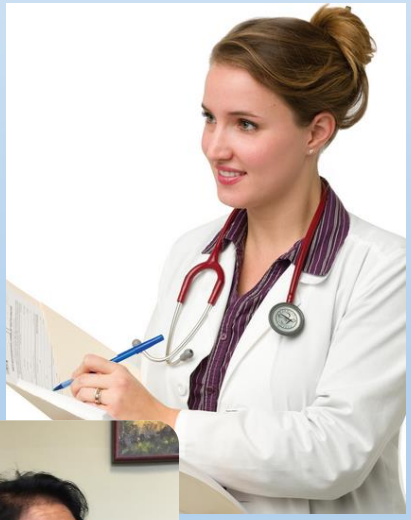
CBO delivers an effective diabetes program staffed by people familiar with community, but referrals from healthcare providers are haphazard and inconsistent

Gaps limiting access to health promotion services

- Individuals have unmet needs related to asthma and diabetes.
- Effective community-based programs are under-utilized by healthcare providers - no warm hand offs.
- CBOs providing evidence based prevention services need support in marketing and delivering these services to health care organizations.

Community Organization

Care Team



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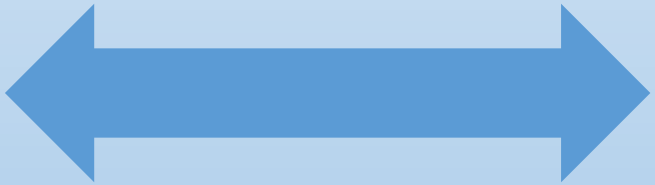

Here's what another state did:

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Case Study
Linkage Lab in California

- ACA created new care delivery opportunities
- Contractual partnerships between the health care sector and CBOs were rare
- Healthcare providers have two options:

Build a service

Buy a service

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Case Study
Linkage Lab in California

Hypothesis:

- Most CBOs rely on grants and may not have the business skills to succeed in selling their services in the healthcare market

Objective:

- Institutionalize core leadership and management competencies
- New skills will permit CBO to enter into at least one contractual relationship with a health care payer or provider

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Case Study
Linkage Lab in California

Results: As of 2015, the first cohort of CBOs signed 27 contracts with healthcare providers with potential to serve over 16,000 clients annually.

Case Study: Linkage Lab in California
Jewish Family Service of LA (JFS)

Services: At-home health and wellness, mental health, meals, transportation, and social and physical activities.

Supports: Linkage Lab provided seminars, guidance, and technical assistance to:

- Engage payers and providers around potential partnerships;
- Gain a better understanding of business relationships with health care entities;
- Build its management team's skills regarding contract negotiation, business development, data collection, and evaluation; and
- Enhance its ability to provide appropriate, high-quality, cost-effective services.

Case Study: Linkage Lab in California
Jewish Family Service of LA (JFS)

Results: JFS successfully negotiated nine contracts with plans and providers, including:

- Cedars-Sinai Medical Center for behavioral health transitions. Pricing structure: program rate
- Comprehensive Community Health Centers for behavioral health and community social service case management, integration of primary care, behavioral health and social services. Pricing structure: program rate plus additional fee for patients who receive case management.
- St. Francis Medical Center and St. Vincent Medical Center for post discharge services. Pricing structure: hourly rate with a cap on hours.

CT SIM Prevention Service Initiative Recommendations

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Prevention Service Initiative
CBO Linkage Model Goals

- **Enhance business capabilities of CBOs** so that they can enter into at least one contractual relationship with a healthcare provider that is participating in value-based payment.

- **Increase the number of individuals with unmet prevention needs who complete community-placed, evidence-based prevention services** and maintain or improve wellness.

- **Improve Advanced Network/FQHC performance on quality measures** related to asthma or diabetes and associated ED utilization or admissions/readmissions for an attributed population through the use of community-placed and evidence informed preventive services.

Prevention Service Initiative
Key Elements of a Demonstration Project

- **Adopt the Linkage Lab approach by promoting partnerships** between healthcare providers and existing organizations
- Provide **technical expertise and guidance to support CBO's** program development and service delivery
- **Support CBO's in establishing communication protocols, and committing to engage hard-to-reach patients** and address their social determinants of health
- Engage AN/FQHC to **identify target clients, navigate referrals, and track process and outcomes** of community interventions

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Adjustments to Prevention Model from Stakeholder Engagement

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Prevention Service Initiative
Sample Themes from Stakeholder Engagement

Sample Theme	CBOs & Public Health Entities	Advanced Network/ FQHCs	HISC	Pop Health Council
Technical assistance and support is needed to facilitate linkages	✓	✓		✓
Social determinants of health are challenges for patients and clients and should be incorporated into the PSI	✓	✓	✓	✓
Administrative complexity and cost on CBOs should be **minimized**	✓		✓	✓
PSI must offer a **clear value proposition**: better outcomes at lower cost		✓		✓

➢Themes from stakeholder engagement were used to inform model adjustments.

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Prevention Service Initiative
Process to Launch a demonstration Project

Select a TA Vendor for CBOs/ healthcare organizations

Select CBOs who are ready and willing to receive TA and pursue a written agreement

Launch TA to CBOs and healthcare organizations to facilitate written agreements

Technical Assistance
(see handout for detailed activities)

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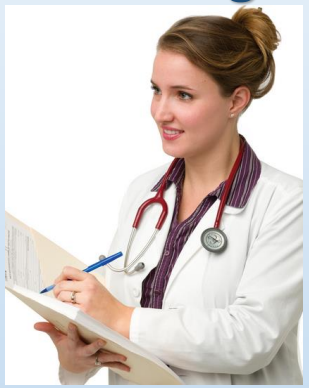
Prevention Service Initiative
Projected Impact

Community Organization

- Receives technical assistance on business strategy, the healthcare market, pricing, and how to develop a partnership
- Develops pricing model and referral process for services
- Formalizes written agreement with healthcare organization

Delivers effective prevention program to a defined population

Healthcare Organization



- Receives technical assistance on identifying eligible individuals with unmet needs and establishing referral pathways
- Formalizes written agreements with CBOs

Improves quality outcomes and costs by improving wellness

Patient

- Benefits from a warm handoff from the care team to a local CBO
- Completes an evidence based diabetes program focusing on her nutrition and fitness.
- Improved communication between clinical and community providers.

Controls Diabetes, adopts healthy lifestyle, eliminates risk factors

Discussion of Recommendations and Approval

Population Health Planning Pathway

- Shared savings or global budget based on up stream SDOH measures
- Wellness fund allows for upstream investments
- Accountability shared with community sector
- Health system provides or partners to provide non-clinical services
- Community-wide measures exist
- Formal collaborative governance exists with clinical and non-clinical partners

Health Enhancement Community

Prevention Service Initiative

Report of the CHW Advisory Committee

Report of the CHW Advisory Committee

The Report includes recommendations for:

- CHW Definition
- Scope of Practice
- Certification
- Sustainable Funding

Senate Bill 126, An Act Concerning Community Health Workers, includes elements of the CHW Definition recommended by the Committee. The bill was signed into law as P.A. 17-74 and will help further the recommendations of the Committee around Certification.

Proposed Timeline:

- Report approved to be released for Public Comment: **7/13/17**
- Public comment summarized and Report edited: **8/31/17**
- Report approved by Steering Committee: **9/14/17**

Public Scorecard Scope of Work and Timeline

Connecticut Healthcare Quality Scorecard

The Connecticut Healthcare Quality Scorecard is a tool for the measurement, evaluation, monitoring and communication of relative performance and quality of healthcare delivery of Advanced Networks and Federally Qualified Health Centers (FQHCs) in Connecticut using key quality and performance indicators.

This valuable resource will guide quality improvement efforts, innovation and policy in the state.

Purpose and Aims

- Display health care quality indicators on a publicly available web-based platform
  - Promote transparency
  - Inform diverse groups of stakeholders: consumers, employers, clinicians, policymakers
- Promote innovation and change in healthcare delivery to improve quality of care and outcomes in the state

How will the scorecard be delivered?

The scorecard will be delivered through:

- A web-based dashboard with individual and composite metrics representing the quality of care delivered at Advanced Network and FQHC level in CT

- An annual report summarizing trends, recommendations and future steps to improve quality of care in CT

Which metrics will be used for the Scorecard?

Provisional Core Measure Set	
Consumer Engagement	**Acute & Chronic Care**
PCMH – CAHPS measure	Medication management for people w/ asthma
Care Coordination	DM: Hemoglobin A1c Poor Control (>9%)*
Plan all-cause readmission	DM: HbA1c Testing
Annual monitoring for persistent medications (roll-up)	DM: Diabetes eye exam*
Prevention	DM: Diabetes: medical attention for nephropathy
Breast cancer screening	HTN: Controlling high blood pressure*
Cervical cancer screening	Use of imaging studies for low back pain
Chlamydia screening in women	Avoidance of antibiotic treatment in adults with acute bronchitis
Colorectal cancer screening*	Appr. treatment for children with upper respiratory infection
Adolescent female immunizations HPV	**Behavioral Health**
Weight assessment and counseling for nutrition and physical activity for children/adolescents*	Follow-up care for children prescribed ADHD medication
Preventative care and screening: BMI screening and follow up*	Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only, custom measure)
Developmental screening in the first three years of life*	Depression Remission at 12 Twelve Months*
Well-child visits in the first 15 months of life	Depression Remission at 12 months – Progress Towards Remission*
Adolescent well-care visits	Child & Adlscnt MDD: Suicide Risk Assessment*
Tobacco use screening and cessation intervention*	Unhealthy Alcohol Use – Screening*
Prenatal Care & Postpartum care*	
Screening for clinical depression and follow-up plan*	
Behavioral health screening (pediatric, Medicaid only, custom measure)	

*Quality Council recommended measures that require EHR or other data for production

Which metrics will be used for the Scorecard? (ctd.)

Reporting Only
Coordination of Care
30 day readmission
% PCPs that meet Meaningful Use*
Prevention
Non-recommended Cervical Cancer Screening in Adolescent Female
Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)
Frequency of Ongoing Prenatal Care (FPC)*
Oral Evaluation, Dental Services (Medicaid only)
Acute and Chronic Care
Cardiac strss img: Testing in asymptomatic low risk patients
Behavioral Health
Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions*
Anti-Depressant Medication Management
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Follow up after hospitalization for mental illness, 7 & 30 days

*Quality Council recommended measures that require EHR or other data for production

Data Acquisition

- Execute MOAs, Data Use Agreements, and Institutional Review Board applications to acquire data
- Provide secure data transfer mechanism
- Acquire APCD data annually.
- Acquire CAHPS data as available

Data Hosting

- Configure HIPAA compliant servers within the UConn High Performance Computing Facility
- Maintain an initial capacity 2 TB of storage with expansion in subsequent years as necessary
- Set permissions to restrict data access to UConn Health Scorecard team members
- Perform weekly, monthly and annual server maintenance, and comply with all processes and procedures required for HIPAA compliance

Data Processing and Analysis

- Development of data cleaning and validation protocols
- Annual execution of data cleaning and validation protocols
- Exchange of data with Advance Network and FQHC leadership as necessary to examine performance of data validation protocols and results
- Annual calculation of raw and risk-adjusted results for each measure and measure domain; demographic breakdowns; change since previous year; each separately by Advanced Network/FQHC.

Attribution, Risk Adjustment and Benchmarking

- Determine attribution method options after receipt of data and consultation with the CT APCD leadership
- Discuss attribution method options with Quality Council, payers, and representatives of Advanced Networks and FQHCs
- Finalize risk adjustment method after input from Quality Council
- Apply risk adjustment in data analysis
- Research and obtain benchmarks for each scorecard measure
- Review proposed benchmarks with Quality Council and finalize

Review and Validation of Metrics

- Develop a rating validation protocol to get the input from entities about entity specific performance reports
- Provide results to rated entities at least eight weeks prior to public release.
- There will be a four week review and comment period to address entity concerns.

Tasks and Timeline

	2017		2018				2019			
Tasks	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Prepare and maintain analytic environment at UConn	■	■	■	■	■	■	■	■	■	■
Quarterly meetings with QC	■	■	■	■	■	■	■	■	■	■
UI/display tool review and assessment	■									
Acquire APCD data	■		■				■			
Acquire CAHPS data	■			■				■		
Review risk adjustment and patient attribution strategy	■									
Clean & standardize APCD/CAHPS data	■	■		■	■			■	■	
Initial validation with ANs/FQHCs –attribution		■			■				■	
Measure construction and risk adjustment	■	■			■				■	
Measure review and validation with ANs/FQHCs			■			■				■
Review of measures/results with Quality Council			■			■				■
Measure documentation and incorporation of external content	■	■		■	■			■	■	
User support			■	■	■	■	■	■	■	■
Publish scorecard			■			■				■

How will the scorecard be used?

- Health care providers: Transparency drives healthcare quality
- Physicians: Recommending providers for referrals
- Payers: Informing pay for performance reimbursement
- Employers: Informing institutional interventions and policies
- Policymakers: Assessing State performance and informing policy
- Health care consumers: Choosing a health system/network

Test Grant Investment Strategy

Test Grant Investment Strategy- Sample Options

Initiative	Potential scope/budget adjustments
CCIP	Extend Health Equity Improvement standard and transformation awards to FQHCs participating in PCMH+ and PTN
PCMH+	Restore funding for Mercer actuarial and program support services for PY3
QMA	Consultant to facilitate Quality Council meetings
	QM alignment awards for health plans
Pop Health	*TA Vendor to support Prevention Service Initiative*
	Funds to support CBO and AN/FQHC participants in the Prevention Service Initiative
	HEC planning costs – Consulting contract to support Council facilitation and materials development, research, subject matter expertise, stakeholder engagement, preparation of plan and report
VBID	Extend employer engagement activities including individualized employer TA
Evaluation	*Implement public scorecard*

Adjourn