SIM Prevention Service Initiative

Healthcare providers are increasingly being held accountable for healthcare quality and cost through value-based payment. This has created demand for effective prevention services offered by community organizations (CBOs). CBOs that can provide these services efficiently to Advanced Networks and Federally Qualified Health Centers (FQHCs) have an opportunity to take advantage of this potential demand and establish mutually-beneficial formal arrangements.

Gaps that the model aims to address:

1. Individuals have unmet prevention needs related to asthma, hypertension, and diabetes that can be met by *Bucket-2*[1] prevention services delivered in a community setting.
2. Despite the strong evidence of their effectiveness, Bucket-2 prevention services offered by community-based organizations or public health entities are currently under-utilized by Advanced Networks and FQHCs
3. CBOs and public health entities provide evidence based prevention services, but have limited service delivery capacity and need support in marketing and delivering these services to Advanced Networks and FQHCs

Prevention services that the model promotes:

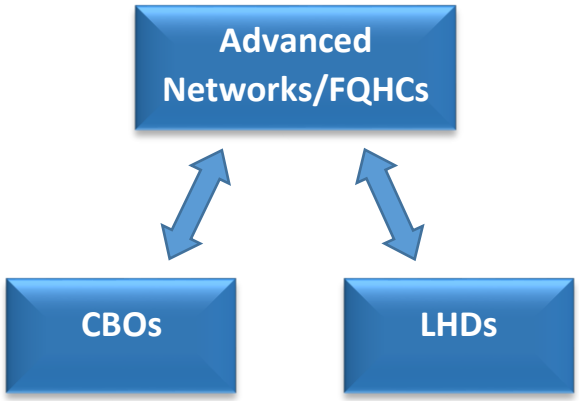
The model promotes prevention services delivered in community settings (CDC "Bucket 2" services):

- Asthma Self-Management and in-Home Environmental Assessment
- Diabetes Self-Management Program

Program goals:

1. Enable CBOs to access sustainable funding to support increased service capacity in the service of their mission.
2. Position CBOs to develop new competencies and align existing ones with opportunities created by value-based payment.
3. Increase the number and quality of formal referral linkages and contractual relationships between the healthcare sector (Advanced Networks/FQHCs) and the community sector (CBOs, public health entities).
4. Increase the number of individuals with unmet prevention needs who complete evidence-based "Bucket 2" prevention services.
5. Improve Advanced Network/FQHC performance on quality measures related to asthma, diabetes, hypertension, ED utilization, and readmissions for a defined attributed population.
6. Enable Advanced Networks/FQHCs to succeed in shared savings programs and other alternative payment models.
7. Open avenues for community integration to address clinical and social determinants of health.

[1] https://nam.edu/wp-content/uploads/2016/05/CDCs-618-Initiative-Accelerating-Evidence-into-Action.pdf

	"CBO Linkage Model"
High-level Overview	This model focuses on **preparing CBOs that can provide effective prevention services to enter into 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. This approach is modeled after similar work done in California, where technical assistance that improved CBOs' competencies related to market success increased the number of formal partnerships and referral pathways between the healthcare and community sectors. This work has been expanded to multiple states.  *Arrows represent contractual linkages

Strategy	"CBO Linkage Model"
1. Improve capabilities of community organizations and public health entities to deliver a specific set of prevention services to the healthcare sector	**Multiple community organizations that provide evidenced-based prevention services are selected in each of three regions to participate in TA. The TA focuses on business processes and operational capabilities necessary to support service delivery agreements with Advanced Networks and FQHCs.**
	15 month TA provided to community based organizations (CBOs) in region by a vendor contracted by the State through SIM. CBOs selected for TA through RFA based on entry level requirements: currently offer one or more of the identified services, and commitment to improve their capabilities to enter into and sustain business agreements with Advanced Networks and FQHCs. TA focus on helping the CBO plan and promote services, establish a sustainable business model to meet demand, a business process for communication and coordination with Advanced Network/FQHC partners, and data collection and reporting. TA will also focus on establishing contractual agreements with Advanced Networks and FQHCs. Funding/grants to CBOs and Advanced Networks/FQHCs support grants to offset costs of TA participation.

2. Promote collaboration between the community organizations and public health entities that deliver these services	**This model promotes peer-learning and collaboration through joint-learning activities led by the TA vendor.**
	Participants receiving TA will have opportunities to participate in a peer-to-peer learning network, potentially in cohorts organized by service focus (e.g., diabetes management). TA will help CBOs share challenges and solutions related to developing business capabilities and determine whether and what type of formal partnerships (e.g., subcontracts) may be needed to meet demand. CCIP Community Health Collaboratives will include these entities and support the development of consensus protocols related to the use of prevention services.
3. Promote the establishment of formal financial contractual arrangements between these community organizations and Advanced Networks/FQHCs	**This model facilitates formal linkages between Advanced Networks/FQHCs and CBOs that offer services aligned with healthcare sector quality performance priorities.**
	TA will facilitate formal referral and contractual arrangements by coordinating between the Advanced Networks/FQHCs and participating CBOs in the region. Impact will be measured by number of formal arrangements /contracts executed. Such arrangements will establish Advanced Network/FQHC referral processes and procedures for tracking quality measures that correspond to the offered services. In regions where a Bridge Entity (CMS AHC initiative) exists, we will determine whether referrals to these CBOs can be facilitated by them.
4. Formally recognize organizations that deliver these services	**TA participants are recognized as Prevention Service Providers if they are selected to participate in the TA.**
	Participants receiving TA will be referred to as "Prevention Service Providers" for the duration of the 15 month period. Renewable recognition will be considered in the future as Advanced Networks and FQHCs acknowledge value and ROI from prevention interventions.
5. Promote Advanced Networks and FQHCs to measure the impact on attributed populations in order to make the case for sustainability	**Activities for both models are comparable.**
	TA will include support for Advanced Networks and FQHCs to select and track a set of quality measures (e.g., ED utilization, readmissions, A1C control) that reflect CBO performance in serving attributed populations. A Return on Investment analysis will also be undertaken by or in consultation with the participating Advanced Networks, FQHCs and CBOs. Regional population health quality measures will help assess the overall success of this initiative. PCMH+ contract may require PCMH+ Participating Entities to implement contractual relationships with at least one CBO participating in the "SIM Prevention Service Initiative" in a community where such entities exist. CCIP Standards will require linkages with participating CBOs in addition to existing requirements for linkages with providers of social determinant supports.

Exhibit B: Findings from CBO Engagement

Topic Area	Feedback from CBO Focus Groups	Model Adjustments
CURRENT AGENCY RELATIONSHIPS		
Current Community Services	• Emphasis is on coordination and navigation services. • Funding for community services is limited and unstable. • Developing robust infrastructure is challenging. • Keeping continuity of programs and staffing is challenging.	Focus on building organizational capabilities and enhancing collaborative learning.
Relationships with Health Care Entities	• Wide range of relationships range from not existing to informal agreements or sometimes contractual arrangements. • Some agencies receive referrals from health care providers but on-going information-sharing is limited. • There is potential to facilitate information-sharing by accessing EMRs by multiple entities. • Health care entities are either unaware of the existence and value of community services, or they do not know how to work with community service agencies. • Health care entities must screening for social determinants of health and develop processes for referring to community service providers.	Introduced specific goals to support creating formal linkages between community and health care agencies. The model calls for establishing referral pathways and two way communications.
Relationships with Payers	• A few agencies have relationships with payers to obtain reimbursement for flu clinics or programs like "Silver Sneakers". • Services like coordination and navigation are typically not billable.	Model focuses on payment arrangements for evidence-based programs of interest to health care providers only.
Relationships among CBOs and Public Health Entities	• CBOs commonly collaborate with health care entities, public health departments and human services agencies. • Either CBOs or health care entities may take the leading roles in community collaboratives. • Community Care Teams and Coordinated Access Networks are examples of community collaborations. • Although typically sharing information about individuals is a barrier, in some cases agencies have set up Release of Information (ROI) agreements.	Defined a strategy to promote collaboration between community agencies. Introduced technical assistance elements to facilitate peer-to-peer learning activities.
FEEDBACK ON PSC CONCEPT		
Regional Approaches	• Different regions in the state have different strengths and characteristics. • A prevention model should allow for flexibility. • Defining region boundaries could be challenging due to overlaps of service areas and jurisdictions • Identifying a regional convener that serves the entire region may be difficult.	Will work with AN/FQHC to identify their attributed populations to direct and evaluate the impact of prevention interventions.

Exhibit B: Findings from CBO Engagement

Topic Area	Feedback from CBO Focus Groups	Model Adjustments
Backbone or Lead Entity	•A designated entity is needed to drive the work forward and facilitate interagency coordination and collaboration. •A lead entity role could be played by many different types of organizations. •Infrastructure funding and transparency will be required to set up a backbone organization.	Consistent with feedback from other sources, the lead entity model was phased out to favor a collaborative approach based on a technical assistance project.
Processes and Systems	•Model was described by participants as a triage system where a lead entity would make referrals based on identified needs. •Distributing referrals equitably among CBOs may represent a challenge. •Partners must establish clear expectations under written MOUs. •Network is a preferred nomenclature over "Prevention Center".	Technical assistance focus on identifying and formalizing referral pathways with
Accountability & Payment	•Some participants eagerly supported written arrangements to ensure follow-through and to focus on outcomes. •Others that were hesitant noted the need for high level of trust and the difficulties in tracking shared saving across a network. •Reluctance to take risk given challenges delivering services and addressing clients' social determinants of health and "*hierarchy of needs".* •Expectation that savings realized by health care entities should be shared with community providers. •Community services should be reimbursed based on costs. •Community agencies do not have capacity or expertise to track metrics and bill for services.	Introduced a skill building and an organizational process improvement project. Ensure inputs to CBOs to assist with cost/revenue analysis, ROI forecast, and estimations of volume, staffing and pricing.
Data Systems	•Wide range of data access and type of systems available. •Limited (read-only) access to EMRs to few agencies. •Fax referrals are common among agencies without EMR access. •It is important to develop mechanisms to share data on needs and services across providers. •Very few agencies track data on outcomes and they rarely share it with health care entities. •CBOs advocate tracking SDOP indicators and embedding them in EMRs.	Enhanced coordination with health care organizations to create two-way communications.
SUPPORT AND RESOURCES NEEDED		
Capacity and Sustainability	•Some community and prevention services have already maximized their capacity. •Additional funding, staffing, and space would be needed to serve more clients. •If accepting additional referrals, it is important to have services already available to avoid waitlists. •Telehealth is a potential cost-saving option for expanding capacity and reaching more clients. •Because many agencies rely on grant funding, it is noted that alternate funding options such as billing payers directly for services would be required for sustainability.	Ensure a sustainable business plan that meets demand, supports communication and coordination with ANs/FQHCs, and that relies on data collection and reporting. Developing written and accountable business agreements.

Exhibit B: Findings from CBO Engagement

Topic Area	Feedback from CBO Focus Groups	Model Adjustments
Operations	•A variety of evidence-based community and prevention services are available. •Some services are delivered in health care settings while others are delivered only in community settings. Importance of allowing for flexibility of services delivery to accommodate patient and access needs. •Train and certify Community Health Workers on service delivery •Increase credibility with health care entities and payers.	Model primarily considers interventions that are evidence based, delivered in the community and have potential to add value and quality improvement to health care organizations.
Data and Information Technology	•Need systems to share referrals and case management information •Proposed a vision for a common EHR system to access community services. •A two-way information-sharing and real-time referrals would be needed. •CBOs need support around data capture, management, and transfer. •There is value in developing data capabilities and ability to provide evidence of impact and effectiveness •Agencies require assistance on metrics and on how to track, store and analyze data both for internal use and reporting.	Consider potential infrastructure supports to strengthen IT systems and analytical capabilities.
Communication and Collaboration	•Need for assistance with "marketing" or making a service offer to health care providers. •Health care providers are unaware of the services that community agencies provide •Improved awareness of services is needed to ensure that referrals and linkages would be made.	Increase visibility of community services

Exhibit C: Findings from Advanced Network/FQHC Engagement

Prevention Service Initiative (PSI)

Topic Area	Summary of Advanced Network/FQHC Interviews	Key Findings and Implications
Performance	• All acknowledged performance improvement opportunity in diabetes, asthma, hypertension • Not all could quantify this opportunity; • FQHCs can compare to other FQHCs using UDS, but not yet to all PCMH+ peers; Advanced Networks (AN) can compare to other Medicare Shared Savings Program participants • No one could analyze performance by socio-demographic sub-population (e.g., Race/ethnicity/language data)	Opportunity to improve performance exists, which supports potential value of PSI PSI may need to include technical assistance to ANs/FQHCs to ensure that ANs/FQHC can identify, refer and track target population within geographic radius
Current strategy	• All are focused on improving clinical care processes • Using EHR and analytics to drive evidence based medicine, identify gaps and feedback to clinicians/care teams • For diabetes management - most use Certified Diabetes Educators (RNs, RDs, medical assistants). • No one is using Community Health Workers to deliver disease self-management services.	PSI must offer clear value proposition that could not be achieved on-site; better outcomes at lower cost
Challenges/ barriers	• Engaging patients in self-management is a big challenge • Acknowledge that culture/race/ethnicity /language/health literacy may play a role • Analytics do not cut by demographics or neighborhood • Behavioral health comorbidities including depression is an issue • Social determinants of health are an issue	PSI must focus on engagement strategy targeted to the segment that may be more difficult to engage—must add value for this population; PSI should test whether culture/race/ ethnicity / language/ health literacy tuned intervention with integrated SDOH support is effective; need to consider behavioral health

Exhibit C: Findings from Advanced Network/FQHC Engagement

Willingness to use community partners	• Most agreed with the concept of partnering with the community • Most prefer to build rather than buy or partner for essential services • Felt on-site is better for consumer (one stop shopping) • Felt on-site is better for oversight, quality control, and accountability • Off-site introduces additional barrier, which is transportation • All acknowledged that a shared resource prevention service could fill a gap that might not be possible to address on-site	PSI must offer clear value proposition that could not be achieved on-site; better outcomes at lower cost
Written agreements	• ANs/FQHCs do not have written agreements with community-based partners • Some question whether such agreements are needed when referrals are based on collaborative relationships • Written agreements necessary if financial component	Written agreements are uncommon and may be essential only if financial provisions
Expectations for CBO partners	• Should be established organization with infrastructure and capabilities • Need to be able to rely on this service for linkage, follow-through, communication, and quality • Automated referral and communication would be important, e.g., DocuSign or something similar should be standardized across all pilots • Need an agreed upon care plan; however, mixed views on need for CBO access to EHR	Efficient, reliable partnerships are key to success; CBO partners must have mature infrastructure and capabilities
Financing	• Reluctant to pay for services, especially based on limitations of PCMH+ design (loss of attributed members; actuarial projections) • Some willingness to pay on a pilot basis to test the concept • If a paid service, CBO must be accountable for patients referred including acknowledging initial linkage, number of patients who complete the intervention and potentially clinical outcomes	Written agreement with financial terms should be part of the test

TA Scope of Services

1 TECHNICAL ASSISTANCE (TA) TO CBOs

TA shall consist of subject-matter expertise, resources and guidance.

OBJECTIVE 1: CBOs have a clear sense of their strengths, gaps, and goals

1. Conduct organizational assessment/gap analysis with CBOs.
2. Develop a Technical Assistance Plan customized to CBO's strengths, gaps, and goals.

OBJECTIVE 2: CBOs have improved capabilities and readiness to implement the Prevention Service Initiative Linkage Model with one or more healthcare provider

1. Provide TA that enables CBOs to:
    a) Conduct a workforce capacity and funding analysis to meet projected healthcare provider demand.
    b) Develop a strong business case/value proposition for their service(s) that includes data and resonates with healthcare providers (speaks to their quality measure goals, Shared Savings initiatives, etc.).
    c) Analyze sites of service in relation to healthcare provider partner sites.
    d) Develop financial contractual agreements (such as by providing templates and examples).
    e) Effectively negotiate.
2. Work with the CBO to develop a CBO-specific Prevention Service Plan. The model should consider:
    a) Intervention fidelity
    b) Market scan, CBO's core offerings/skills
    c) Target population
    d) Strategy for addressing associated social determinant of health
    e) Intake and access process
    f) Two-way communication, information exchange and reporting that anticipates potential data sharing barriers (e.g. HIPPA, access to EHR tools).
    g) Evaluation, data analysis and sharing
    h) Whether partnerships with other CBOs are necessary to meet demand.
    i) Expansion and outreach
    j) Infrastructure for implementation
3. Facilitate peer-to-peer learning activities among CBOs that provide related services or have similar goals/needs.

OBJECTIVE 3: CBOs can deliver effective and financial sound prevention services.

1. Provide TA that enables CBOs to develop a Business Plan that includes:
    a) Performance targets and goals.

b) Projections; strategy / partnership; roles, assigned personnel, tasks and timelines; and marketing approach and materials.
c) Budget and rate structure for the model. This should consider forecasted costs; revenue and cash flow impact of assumed pricing; volume; staffing, wages, and expense assumptions; and a pricing strategy that ensures CBO services are not delivered at a loss and meet revenue generation goals. This may include leveraging other funding streams and accessing sufficient capital to meet capacity demands.
d) Scan of the healthcare market and identify potential interested healthcare providers and develop a positioning strategy.

OBJECTIVE 4: At least one financial contractual agreement is formalized between each CBO and a healthcare provider.

1. Facilitate discussions and joint-activities between CBOs and healthcare providers.
   a) Determine framework for partnership discussions.
   b) Schedule and host meetings; prepare meeting materials.
   c) Determine follow up and communications plan.
2. Facilitate a contractual agreement between the CBO and health care provider.
   a) Develop a contract negotiation strategy.
   b) Disseminate contract/business agreement templates and examples.
   c) Discuss framework for future business planning.

OBJECTIVE 5: CBOs implement and sustain the linkage model

1. TA should enable the CBO and healthcare provider to, at a minimum:
   a) Effectively implement the contracted services/processes.
   b) Monitor progress towards performance targets and conduct mid-course correction activities.
   c) Assess gaps in processes or tools for information collection and communication, including the sharing of their performance indicators with healthcare providers.

2 TECHNICAL ASSISTANCE (TA) TO HEALTHCARE PROVIDERS

The vendor will coordinate the TA provided to CBOs and healthcare organizations.

OBJECTIVE 1: Healthcare organizations understand their strengths, gaps, and goals related to prevention service

1. Conduct organizational assessment and opportunity for use of target community-based prevention services.

OBJECTIVE 2: Improve accountable healthcare provider's readiness and capabilities to implement the Prevention Service Initiative CBO Linkage Model.

1. Provide TA to accountable healthcare providers that enable them to:
    a) Identify the target population and methods for identifying members of the population with unmet prevention service needs.
    b) Develop a formalized referral process and workflow.
    c) Establish methods for two-way communication and information exchange.
    d) Select quality and utilization performance measures associated with the intervention, project performance targets and associated ROI, track and report progress with feedback to clinical team and CBO partner.

OBJECTIVE 3: Healthcare providers implement and sustain the linkage model

1. TA should include, at a minimum, components that enable the healthcare provider to:
    a) Monitor progress towards performance targets and conduct mid-course correction activities jointly with the CBO partner.
    b) Assess quality and reliability of processes or tools for information exchange and communication, including the sharing of performance measures.