

# PREVENTION SERVICE INITIATIVE: RESPONSE TO HISC COMMENTS

## OVERVIEW

DPH and the PMO have prepared the following summary and FAQ in response to the comments and questions about the Prevention Service Initiative offered by Steering Committee members at the July 13 meeting. The subsequent summary describes the initiative within our overall strategy for health care delivery system reform.

Healthcare providers in new payment models are making unprecedented investments in care delivery improvements. Payment reform (i.e., Shared Savings Programs) is the central tactic in our State Innovation Model (SIM) to spur accountable providers to invest in care improvements. These investments in infrastructure and staff are largely not fee-for-service reimbursable and are being made by providers to improve the quality and efficiency of the services that they provide.

For example, accountable providers are investing in health IT, analytics, care management, and the elimination of gaps in care. They are also investing in care coordination staff, usually nurses and social workers, to reduce avoidable ED and hospital visits for high risk patients. In some cases, they are using certified staff such as registered dietitians or nurses to provide diabetes or asthma self-management guidance. However, they generally have not been investing in community health workers or community partnerships that could help them to deliver better care at a lower cost. The Community & Clinical Integration Program (CCIP) and Prevention Service Initiative (PSI) are our primary means of helping them to do this.

The Community & Clinical Integration Program (CCIP) encourages accountable providers to make investments in community linkages to address social determinants of health. This includes collecting and using race, ethnicity and social determinant data to improve care and building relationships with CBOs to address housing, nutrition, economic, legal, and transportation needs. CCIP also requires that providers hire community health workers to provide more culturally competent care, help patients navigate the health system, and link patients to community supports. CCIP includes transformation grants to offset the near-term costs of making these additional investments and evaluating whether they improve outcomes and generate a return.

The Prevention Service Initiative (PSI) extends the CCIP focus on CBO providers of social services to CBO providers of *evidence-based prevention services* including diabetes and asthma self-management.<sup>1</sup> These services have the ability to improve outcomes and generate a return on investment for eligible patients. The CBOs that provide these services appear to be under-utilized—none of them have written referral agreements with accountable providers--and they lack the resources to expand capacity to meet the need. Accountable providers in new payment models now have a financial interest in extending their investments to services and supports in the community that will enable them to deliver better care at lower cost.

The PSI approach is relatively simple. Accountable providers will be required to execute at least one financial agreement with a CBO provider of *evidence-based diabetes or asthma self-management services*. SIM will fund

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<sup>1</sup> Am J Public Health. 2014 August; 104(8): e25–e31. Published online 2014 August. doi: 10.2105/AJPH.2014.302041; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4103232/>

technical assistance to the CBOs to help them offer high quality services and to be successful in these new agreements. We anticipate that these CBOs will be required to include community health workers as part of their service model in order to qualify.

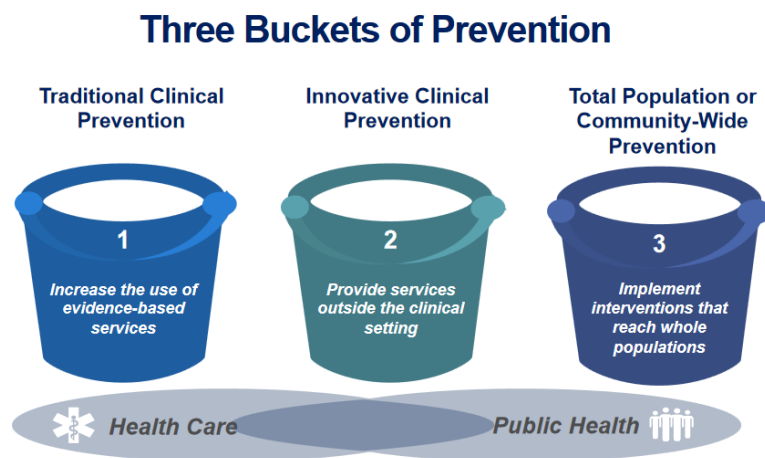
The financial agreement will be expected to have payment terms linked to successful patient engagement and program completion, and perhaps incentives for outcomes. As with the CCIP requirements, the SIM office is proposing to prime the pump by offering grants and technical assistance to accountable providers to enable them to identify appropriate patients, establish referral workflows, negotiate agreements, and to pay for services for the first 12-to-18 months. All parties will carefully evaluate the interventions to validate that they produce a return on investment. *Our plan for sustainability would be continued funding by the accountable providers using their own resources.*

The Prevention Services Initiative aligns with the central premise of our payment reforms—that the promise of a return on investment will encourage providers to invest in new capabilities and community partnerships to achieve higher value healthcare.

## RESPONSES TO QUESTIONS RAISED BY STEERING COMMITTEE

### 1. The PSI seems to focus on disease management instead of prevention. Is this a change in direction?

There is a longstanding framework for prevention services that categories such services as primary, secondary or tertiary. The services that are the focus of the PSI, specifically diabetes and asthma self-management, are secondary or tertiary prevention activities aimed to arrest the progress of a disease and control its negative consequences.<sup>2 3</sup> PSI services also fall into “Bucket 2 – Innovative Clinical Prevention” of the [CDC framework for prevention](#), because they are provided outside of the clinical setting.



Auerbach J., The 3 Buckets of Prevention. *Journal of Public Health Management and Practice* 2016. [http://journals.lww.com/jphmp/Citation/pubshahead/The\\_3\\_Buckets\\_of\\_Prevention\\_\\_99695.aspx](http://journals.lww.com/jphmp/Citation/pubshahead/The_3_Buckets_of_Prevention__99695.aspx)



<sup>2</sup> Katz, D., & Ather, A. (2009). Preventive Medicine, Integrative Medicine & The Health of The Public. Commissioned for the IOM Summit on Integrative Medicine and the Health of the Public. Retrieved from <http://www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf>

<sup>3</sup> <http://www.emro.who.int/about-who/public-health-functions/health-promotion-disease-prevention.html>

While healthcare organizations in other states, including [California](#) and Massachusetts, are embracing and deploying (and sometimes financing) this approach, it is not widespread in Connecticut. PSI is intended to change that by encouraging providers to contract for these services.

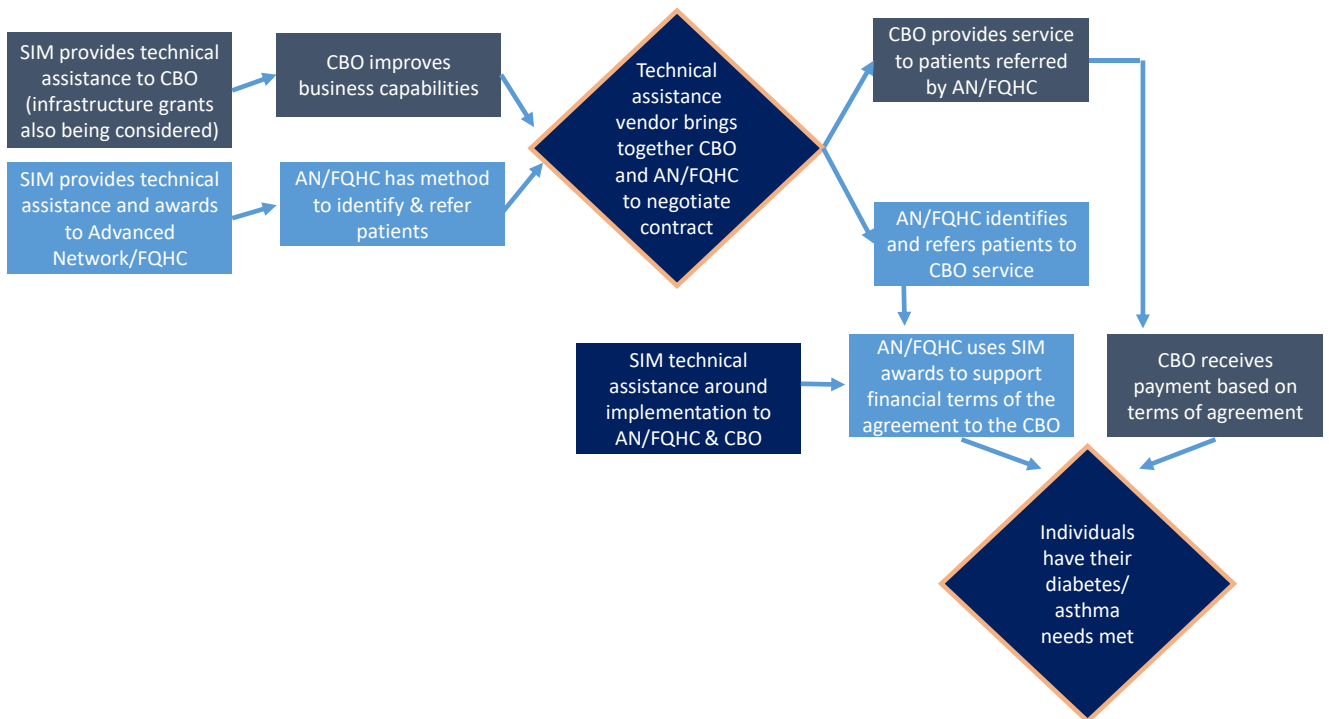
This strategy can work because today’s value-based payment models have created market conditions favorable to some “Bucket 2” prevention services like those included in the PSI. This may not be the case for other primary or secondary prevention services, except where such services are specifically targeted in quality scorecards (e.g., breast and colon cancer screening). Our planning for the Health Enhancement Community initiative will specifically focus on payment or other financing models that will promote cross-sector primary and secondary prevention initiatives and Bucket 3 services.

**2. Will there be sufficient demand from the healthcare sector for community based services?**

Although the healthcare sector in general may not currently demand community based services, one of the aims of the PSI is to strengthen this demand by developing contractual agreements. For example, the Milford Putting on Airs (asthma management home-visiting) program recently establish a direct cooperation with Yale New Haven Health System and now the demand for services is ten times their existing capacity. Therefore, one way to stimulate demand is to build the capabilities of CBOs so that they are strong partners in impacting healthcare outcomes. Another is to require that Advanced Networks/FQHCs invest in these services and then help them evaluate the return on investment.

**3. Can you provide a flow chart of how this initiative will work?**

See below:



**4. How are the CCIP and the PSI similar or different?**

The CCIP initiative requires that Advanced Networks/FQHCs develop referral and linkage arrangements with CBOs to address SDOH needs. In contrast, the PSI initiative focuses on developing referral and linkage arrangements with CBO providers of chronic illness self-management services to address the needs of patients with asthma and diabetes including environmental assessments and remediation interventions. The PSI

initiative will also provide Advanced Networks/FQHCs with grant funding and require that they enter into financial agreements with at least one CBO provider of chronic illness self-management services.

**5. Where is the PSI going to be implemented?**

The PSI targets Advanced Networks and FQHCs that are participating in accountable care arrangements with Medicare, Medicaid and/or commercial payers. The first wave of PSI will be implemented in three areas with high accountable care penetration, using PCMH+ penetration as a proxy. The PMO coordinated with DPH in designating these target communities, so the same communities will be the focus of the CCIP Community Health Collaboratives. The target communities include Bridgeport, New Haven, and Middletown and surrounding areas.

**6. How is the PSI linkage model going to be sustained?**

Recent payment reforms have created a new market for community-based services. Similar models in other states have shown that accountable healthcare organizations are willing to provide financial reimbursement to CBOs for these services.<sup>4</sup> Even so, SIM is proposing initial financial support for Advanced Networks and FQHCs to enable them to pay for CBO services. This will reduce the need to use their own resources for upfront investment and will allow them time to validate the quality and financial returns of such an arrangement. The expectation is that accountable healthcare organizations will continue to fund these services because it helps them to succeed in value-based payment models.

**7. How does the CHW initiative relate to PSI?**

The CCIP initiative incentivizes the healthcare sector to hire CHWs *as part of the healthcare team*. In contrast, the PSI relies on CBOs that utilize CHWs to extend the capacity of their primary care teams to support patients with chronic illnesses. CBOs will receive technical assistance to align their workforce in ways that are compatible with the utilization of CHWs.

**8. Would scarce resources for prevention be better invested within the healthcare sector?**

The goal of the PSI is to catalyze the healthcare sector to invest their own resources in prevention services. Recent payment reforms have made this financially feasible if the services generate sufficient savings. Advanced Networks and FQHCs can do this either by building the services themselves or by purchasing the services from a community organization that currently delivers them. In many cases, it may be more cost-effective and practical to purchase the service. For example, it may not make business sense to build a service tuned to the cultural needs of every sub population. The PSI focuses on the latter approach and provides technical assistance to CBOs to ensure they are ready to take advantage of this opportunity.

**9. Why is the PSI focused on community organizations?**

A basic assumption of the PSI initiative is that healthcare providers can fundamentally improve their performance by incorporating underutilized community services in their strategic approach to quality improvement and cost reduction. The initiative further assumes that a) there are some segments of the population for whom healthcare providers cannot build efficient and effective practice based solutions and b) that community service providers can more flexibly provide services in accessible, non-traditional settings. Community based organizations have proven ability to deliver prevention services, but need additional technical assistance to build their business capabilities and align their service models with the needs of healthcare organizations that are accountable for quality and cost.

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<sup>4</sup><https://www.chcs.org/media/Working-Together-Toward-Better-Health-Outcomes.pdf>

**10. It appears that “accountable providers” are a mainstay of the initiative. Who are they; how will they be recruited; how many will participate? If they are recipients of CCIP Transformation Awards, can new requirements be imposed on them after contracts have been signed?**

Accountable providers are those providers that are participating in a value-based payment initiative (e.g., have Shared Savings contracts with Medicaid, Medicare and/or commercial payers). The initiative targets these providers because value-based payment incentives gives them a financial reason to invest in non-billable services to improve their quality and reduce costs.

We anticipate that entities participating in the PCMH+ program will be required to enter into at least one contract for PSI designated prevention services. In addition, new CCIP award opportunities will offer eligible PCMH+ Participating Entities financial support to do this.

Final numbers regarding how many healthcare organizations will participate have not been determined.

**11. Why are providers of these services under-utilized? Is it the expectation that providers will refer patients to the CBO? What about patient choice? What is the financial incentive for the accountable providers to participate**

CBO providers of these services are under-utilized in part because, in a fee-for-service environment, the healthcare sector has lacked incentives to use them. In addition, CBOs have not developed the business capabilities to succeed in marketing their services and effectively supporting healthcare organizations and their attributed patients. Through PSI, SIM will require that ANs and FQHCs use and pay for these services for a limited period of time. We will also provide the ANs and FQHCs with technical assistance to help them identify patients that will benefit and establish new, efficient referral protocols with their CBO partners.

SIM will also fund technical assistance to increase the CBO’s capabilities. [A similar initiative in California](#) has shown that providing technical assistance to CBOs in this way has resulted in 27 new contracts between healthcare providers and CBOs with potential to serve over 16,000 people annually.

Regarding patient choice, in the past, patients may not have known about these community-placed service options and thus would not have had the opportunity to make the affirmative choice to use them. The PSI will help ensure that patients are aware of the services and fully informed of the opportunity to choose them.

See response to question 1 regarding the financial incentive for providers to participate.

**12. Will CBOs only be paid based on outcomes? Does this place an undue burden on the CBO that is expected to provide the service and hire and pay staff before the outcome is achieved? Most CBO's are operating on very thin margins and cannot afford the upfront costs.**

As has been the case in other states, the financial terms of the contracts are not prescribed by the State. They are negotiated based on both the accountable provider’s and the CBO’s needs. The terms must be acceptable to both parties before the contract is executed. Arrangements based solely on outcomes (versus visits or program “completions”) are usually seen only with CBOs with enhanced readiness, and are not a requirement of the PSI.

**13. How does this fit in the broader public scheme and the allocation of dollars to prevention and to social determinants?**

This initiative prompts healthcare organizations to evaluate their improvement strategy for various segments of their attributed populations and the investments that are necessary to achieve improvement. If the initiative is successful, healthcare organizations will recognize the importance of allocating a portion of their quality improvement investments in community-placed services. This is an important action, one that has

already been taken by health systems across the country, and which builds the case for broader reallocations down the road, including for social determinants and other prevention services.

**14. Should services that are not officially “evidence-based” but that are proving their value locally be included in the PSI?**

In order to ensure that these initial efforts are successful, the Population Health Council has recommended that the State focus on evidence based interventions, including the CDC 6|18 interventions which are nationally recognized as accelerators of the triple aim. The selection of prevention services recommended by the PSI is not closed to interventions that persuasively demonstrate to have health and cost impact in specific communities.

**15. Should other community-placed services that are delivered in, for example, barbershops or led by faith-based organizations be included? For example, the Colorado Black Health Collaborative, the Southeastern San Diego Cardiac Disparities Project, etc.**

The PSI does not restrict the location where the community-placed service is delivered, as long as it is community-placed. We are interested in all community-placed services with an evidence base that improves patient outcomes, with an initial focus on asthma and diabetes. We will encourage our CBO partners to innovate with regard to place of services in order to maximize access and participation.

Our stakeholders advised that we should begin our work with organizations that have a track record of providing the services that we are targeting. With the input of the Steering Committee, we can consider how, in future phases, we can promote the deployment of new and innovative models, of the type that have been undertaken as part of the Colorado Black Health Collaborative and other initiatives. If we are successful with this first phase, we will have identified accountable providers as a potential source of revenue for new initiatives.

**16. Were human and social services agencies included in the PSI planning?**

Close to fifty community based organizations across five regions of the state participated in focus groups sessions. In addition, six Advanced Networks/FQHCs were consulted in a series of in-person interviews. These stakeholder engagements were conducted in a listening session format where the basic PSI assumptions were validated.

**17. How is the SIM process going to implement and launch the PSI demonstration?**

The DPH/PMO teams are working to procure a vendor that will provide technical assistance to both CBOs and Advanced Networks/FQHCs. This procurement will be followed by the identification through an RFA of CBOs that can demonstrate experience with evidence based prevention services and that can articulate how the improvement of organization capabilities would allow them enter and succeed in financial arrangements with the healthcare sector. The CBOs will be selected from the above noted service areas. DSS will be requiring that PCMH+ participating entities enter into at least one contractual agreement with a CBO provider of prevention services. Finally, the DPH and the PMO intend to offer grant support for both CBOs and Advanced Networks/FQHCs to enable their participation in this initiative. The demonstration is scheduled to launch in January 2018 and is expected to last 18 months.

**18. Are hospital Community Benefits considered in the PSI solution?**

Community Benefits funds are independent filings from hospitals and health systems related to their individual contributions, mostly to unreimbursed care and workforce education. Smaller proportions of these funds are dedicated to prevention and other limited solutions to social determinants of health. We anticipate

that hospital anchored Advanced Networks may consider the use of Community Benefit funds as a means to sustain their financial commitments to community-based providers of prevention services.

**19. How does SIM/PSI relate to the CMMI/AHC grant?**

Organizations participating in the CMMI/AHC grant are expected to make investments in screening for social determinants of health (SDOH) needs and referring to community based organizations (CBOs) that can address those needs. They are building systems that support efficient screening, referral and linkage. In contrast, the PSI focuses on identifying patients with asthma or diabetes that they are unable to serve effectively and referring them to CBOs that are better able to engage them in chronic illness self-management. We expect that organizations participating in the CMMI/AHC grant may decide to extend the systems that they develop to support PSI service referral and linkage.