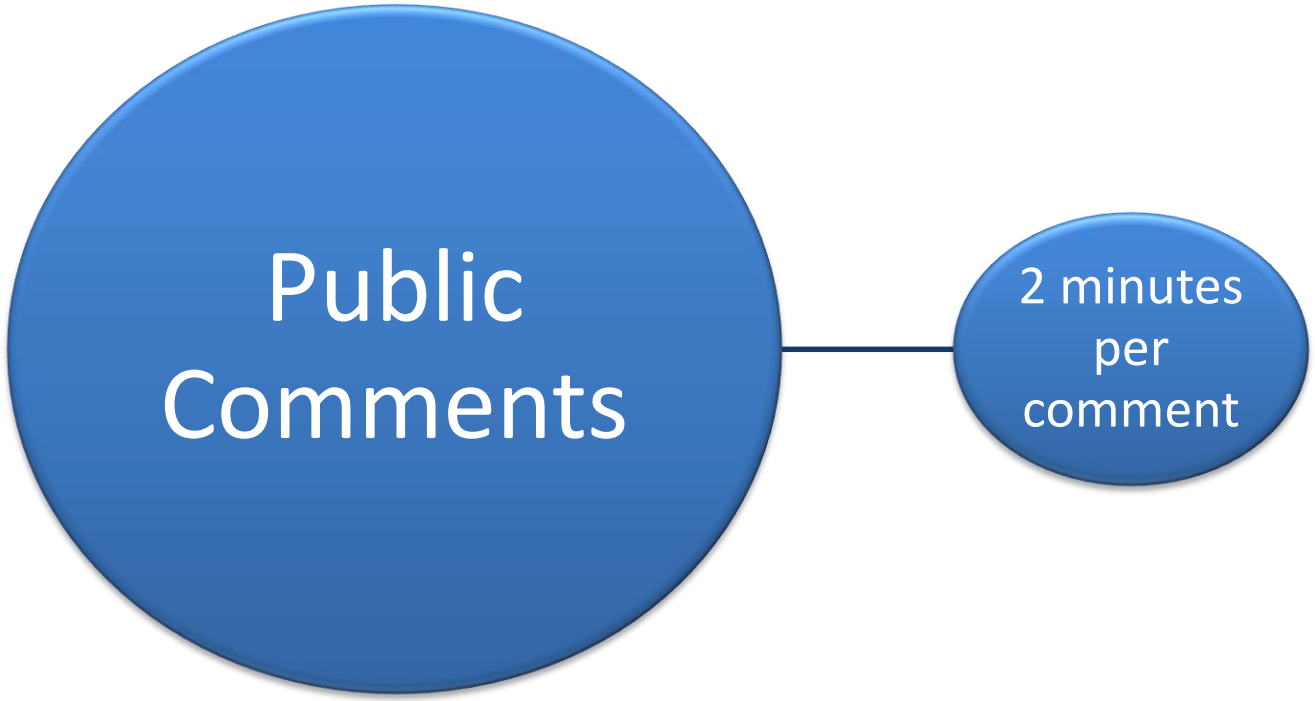
Healthcare Innovation Steering Committee

October 12, 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. VBID Updated Templates	5 min
5. Health Enhancement Communities RFP Update	5 min
6. PCMH+ Participating Entity Presentations	90 min
7. Adjourn	


Public Comments
2 minutes per comment

Approval of the Minutes

VBID Updated Templates

Summary of Key Changes to the VBID Templates

- Purpose: Revise V-BID templates based on feedback from employers and health plans, and current V-BID landscape

- Changes focus on ***format and structure*** rather than content
  - Shortened templates into 1-2 page handouts for employers/plans
    - Employers need easy to consume, digestible information
  - Focused recommendations on core benefits: Preventive Care, Chronic Condition Management, High Value Providers
    - Many employers and health plans incentivize preventive screenings
    - Many employers and health plans have disease management programs
    - Several health plans in CT have incentives for tiered networks and ACOs based on quality and cost metrics

Health Enhancement Communities RFP Update

PCMH+ Participating Entity Presentations

Connecticut HUSKY Health:

Person-Centered Medical Home +

(PCMH+)

Update

SIM Steering Committee

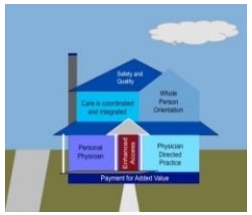
October 12, 2017

Key Messages:

- DSS is hugely proud of the work of the PCMH+ Participating Entities
- To date, important accomplishments include engagement of staff, transition of care management to PEs, uptick in use of the data portal and implementation of provider collaborative meetings
- Extensive information on progress is publicly available and initial indicators are good
- Wave 1 successes and challenges are informing the terms of Wave 2 procurement

PCMH+ in Context

On a foundation of



Person-Centered Medical Homes

ASO-Based Intensive Care Management (ICM)

Pay-for-Performance (PCMH, OB)

Data Analytics/ Risk Stratification

we are building in

Community-based care coordination through expanded care team (health homes, PCMH+)

Supports for social determinants (ICM, transition/tenancy sustaining services, interventions for childhood trauma)

PCMH+

with the desired result of creating

Multi-disciplinary (medical, behavioral health, dental services; social supports) health neighborhoods

Use of Data

One of the most important aspects of PCMH+ is that it is providing PEs with extensive data that equips them to better support attributed members.

- **Provider portal:** attribution lists and PCMH data are being made available to providers through CHN's existing PCMH provider portal, available at this link:

http://www.huskyhealthct.org/providers/providers_login.html

- In the following slide, please see a refresher on what data is being provided

Use of Data (cont.)

- **Panel Reports:**
  - Patient Panel Report
  - PCMH+ Panel Report

- **Utilization Reports:**
  - ED Utilization Report
  - Inpatient Claims Report
  - Daily Admissions and Discharge Report

- **Gaps in Care Reports:**
  - Child Well-Care Visits
  - Child Diabetes Screening Tests
  - Adult Preventive Visits Age 50-64
  - Adult Diabetes Screening Tests

Publicly Available Information

- DSS is making extensive information on PCMH+ publicly available

- Please access these links for two detailed MAPOC presentations on PMCH+:

https://www.cga.ct.gov/med/council/2017/0317/20170317ATTACH_PCMH%20Plus%20Update.pdf

https://www.cga.ct.gov/med/council/2017/0714/20170714ATTACH_PCMH%20Plus%20Update.pdf

- All evaluation materials are posted on a rolling basis on the DSS PCMH+ web page at this link:

http://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Documents

Publicly Available Information (cont.)

- Two examples of reports posted to the web page include the following:

Evaluation Tool	Details	Means and Interval
PCMH+ Monthly PE Compliance Reports	Report on PCMH+ contract compliance, including such elements as staffing, care coordination activities, and community partnerships	PEs submit reports to DSS by the mid-point of each month Reports are posted by the end of each month
PCMH+ Participation Detail Report	Report that tracks member participation	Conduent (formerly, Xerox) and CHNCT are tracking and producing monthly reports

Initial indicators:

- **PE Monthly Compliance Reports:** initial reports indicated that there was a range of experience across PEs that reflected that some had more initial internal capability to handle enhanced care coordination responsibilities and others had more of a lift toward hiring and launching staff, but all PEs have engaged staff and are handling care management functions

- **Opt-out survey findings:** DSS continues to monitor opt-out activity, but there has been none in recent months

Initial Indicators (cont.)

- **Grievances:** there has not been any notable instance of PCMH+-related grievances

- **Eligibility status:** a notable challenge is that a significant number of attributed members have lost eligibility for Medicaid since January 1, 2017 – DSS has adjusted its approach to accommodate situations in which eligibility is restored retroactively, but this has introduced uncertainty for PEs. DSS and PEs are actively working together on means of supporting members in maintaining eligibility during Wave 1. PE input is also providing important insight as DSS refines plans for Wave 2.

Statement on Wave 2

On August 8th, 2017, the Department of Social Services sent this notice to the PCMH+ Participating Entities:

The Department of Social Services remains strongly committed to the success of the PCMH+ initiative. Given the current uncertainty around the General Assembly's adoption of a state budget for the biennium, however, the Department has determined that it is necessary to revisit and revise its original procurement plans for PCMH+ Wave 2. A state budget is needed before the Department can properly plan for, and release, a Request for Proposals for PCMH+ Wave 2. ***For that reason, the Department will be extending Wave 1 contracts with its current PCMH+ Participating Entities for three months, through March 31, 2018.***

We are confident that the record speaks directly to a strong positive launch of PCMH+, and a great deal of potential for good on behalf of Medicaid members.

We are also proud of the open, public, collaborative process that was used to develop and implement PCMH+.

We will continue to encourage everyone involved to get to know, and monitor, our collective progress.

All of that said, we think that the best means of learning about how PEs are fulfilling the aims of PCMH+ is to hear from them.

PCMH+ Participating Entity Presentations

- OPTIMUS Health Care
- Fair Haven Community Health Center
- Value Care Alliance
- Northeast Medical Group

Connecticut HUSKY Health:

Person-Centered Medical Home +

(PCMH+)

Update

October 12th, 2017

Optimus Health Care - Patient-Centered Medical Home

- Our mission is to serve as the patient-centered medical home for our communities to achieve and maintain a positive state of wellness, particularly for the uninsured and underserved.

The Joint Commission
National Quality Approval

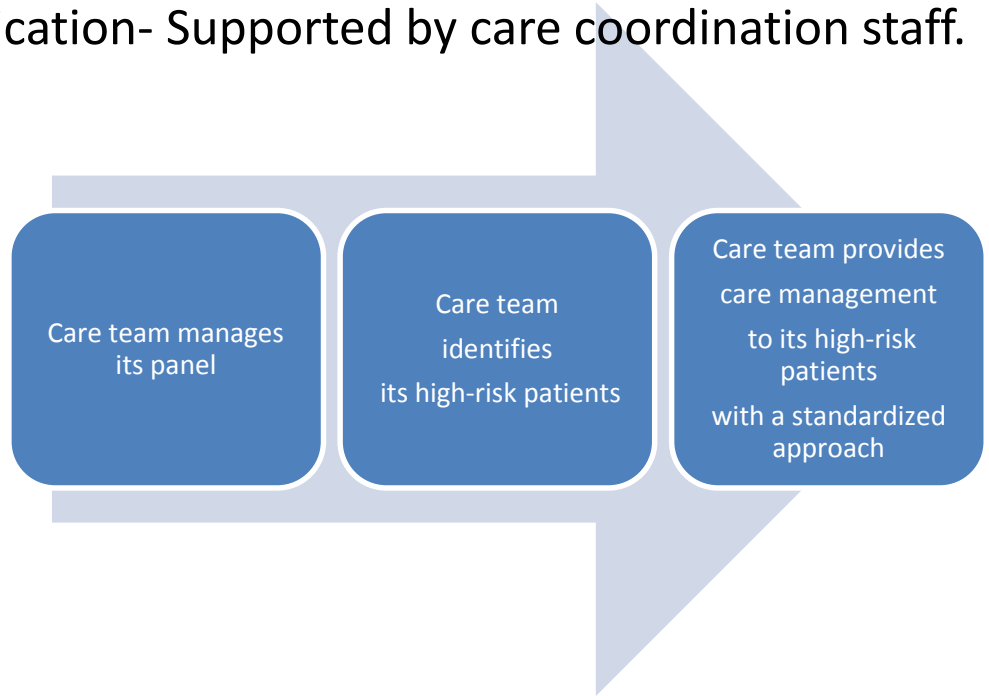
National Committee for
Quality Assurance (NCQA)

What Do We Focus On?

AIM: Achieve better health outcomes / reduce costs / improve patient satisfaction

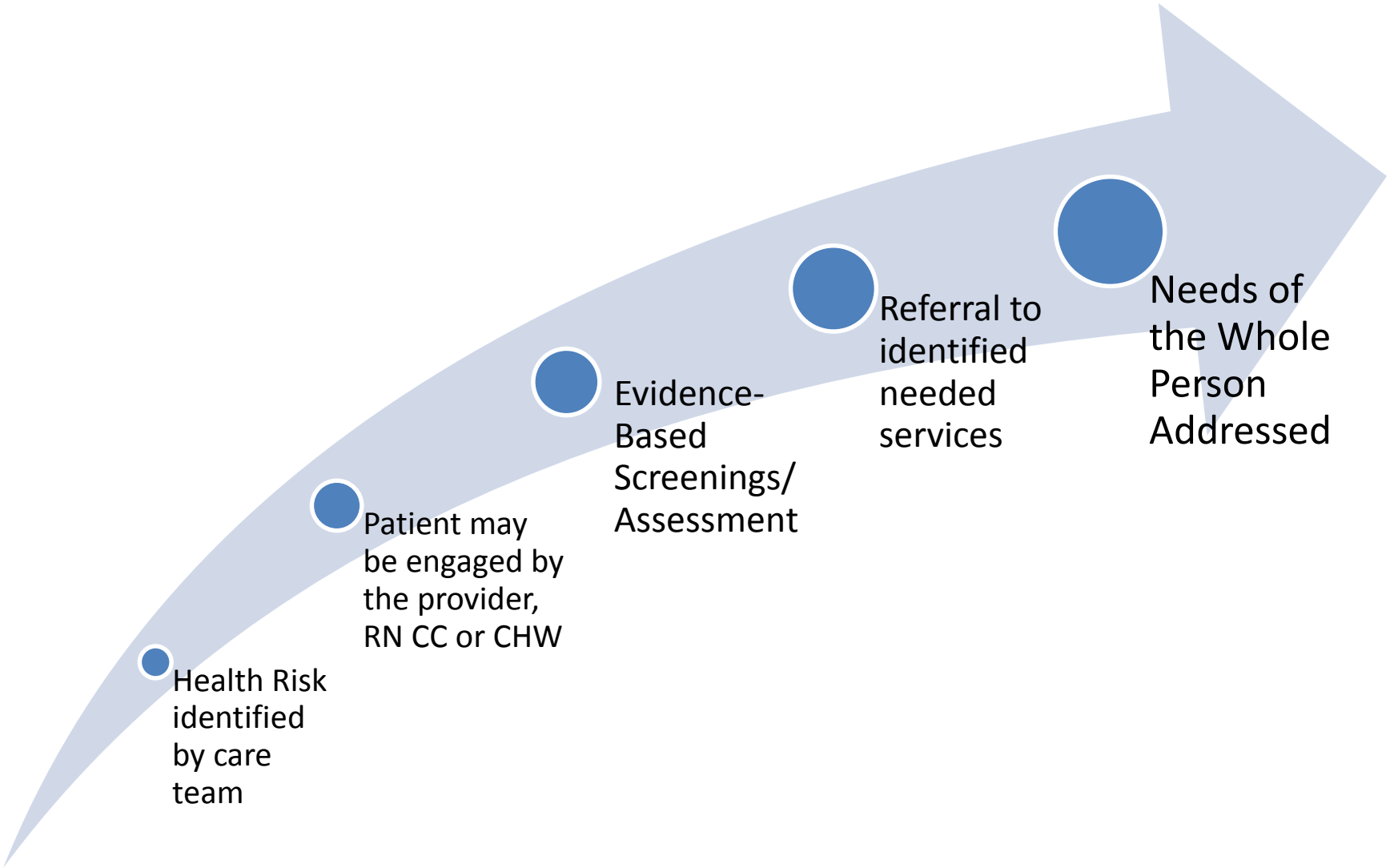
To achieve this we used:

- **Targeted intervention:** with the potential of greatest savings / biggest impact (Husky Provider Reports- Care Analyzer)
- OHC provider driven **population management**: High Risk Patients identification- Supported by care coordination staff.



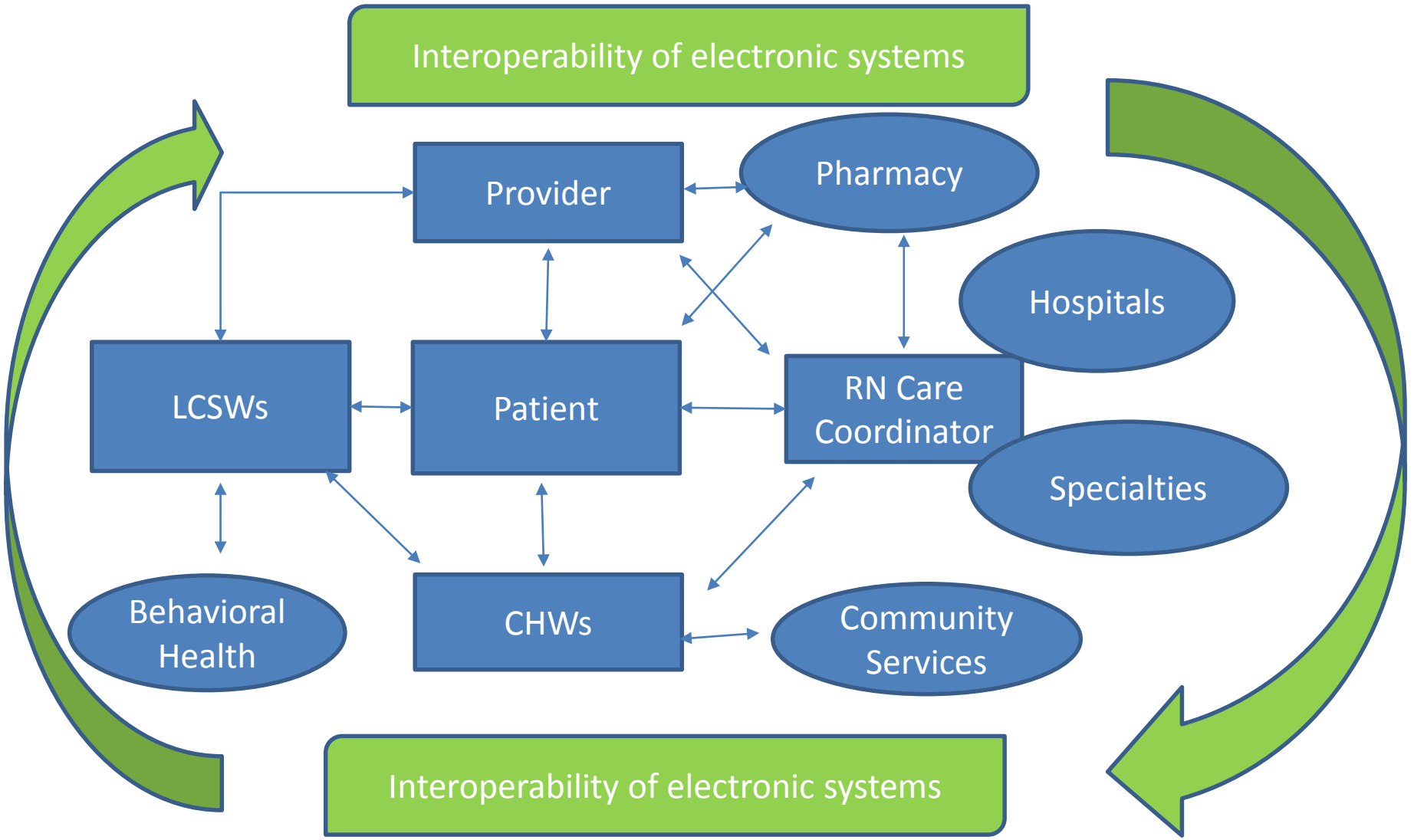
OPTIMUS Health Care

Our Patient Centered Approach…



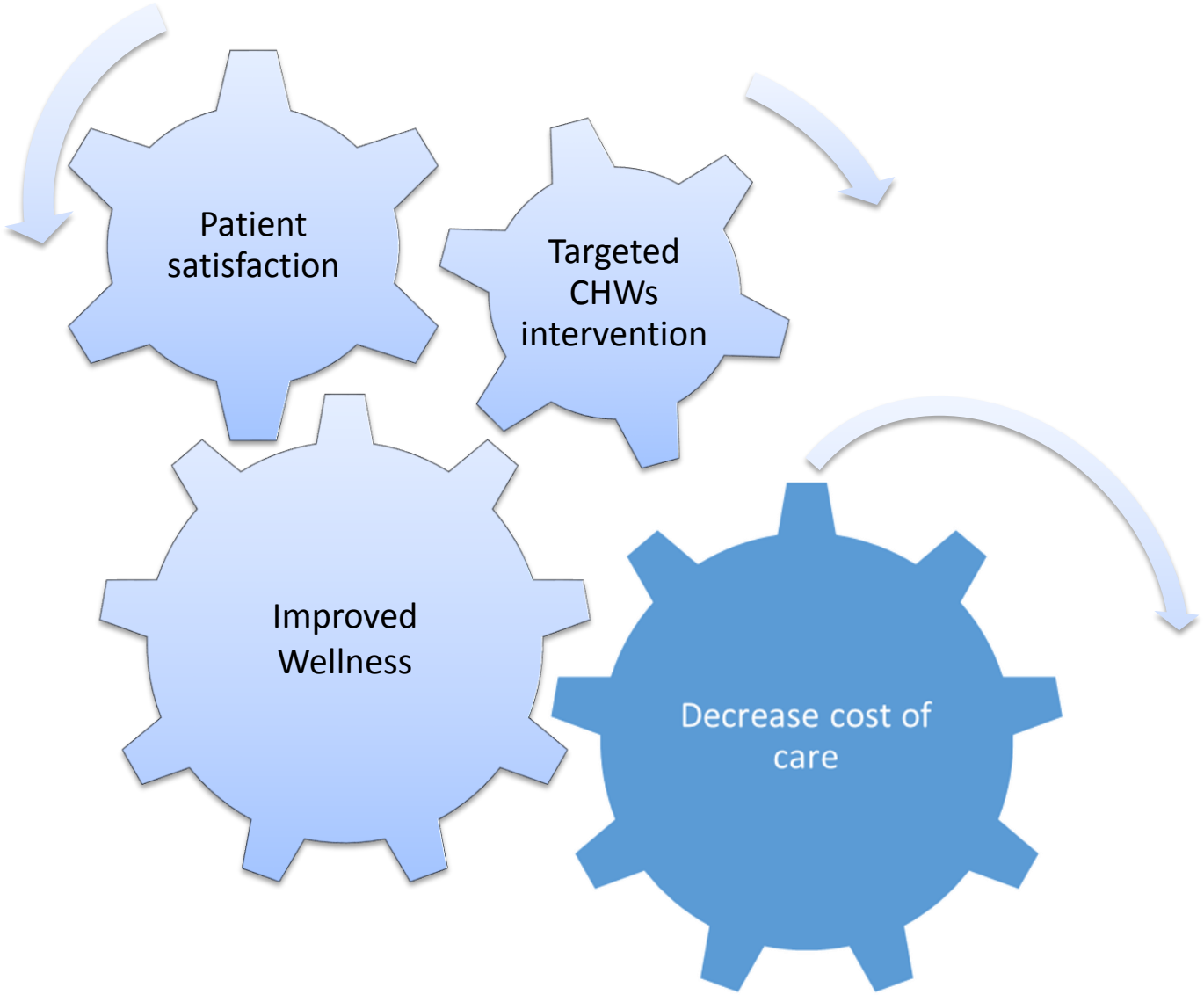
OPTIMUS Health Care

Interconnected Patient-Centered Approach



OPTIMUS Health Care

Actionable Wheels



OPTIMUS Health Care

What Was Done So Far…

- Hired 6 CHWs, 2 RN Care Coordinators.
- Fully implemented the Care Coordination Initiative with the on-boarded CHWs and RN in April 2017.
- Engaged over 500 high-risk PCMH+ members since implementation.
    - 644 ongoing and successful care coordination activities recorded (activities involving other resources within and outside of Optimus)
    - 426 completed/closed community & clinical referrals
    - 500 completed person centered care plans
    - > 180 Hours of Home visits
    - > 150 Hours of Post Hospitalizations Patient Contact Follow Up
    - > 108 Hours of ER Patient Contact Follow Up

OPTIMUS Health Care

Care Coordination Impact

- Care coordination services ensure member success by reducing or eliminating barriers to care and assisting members & providers achieve access & success.

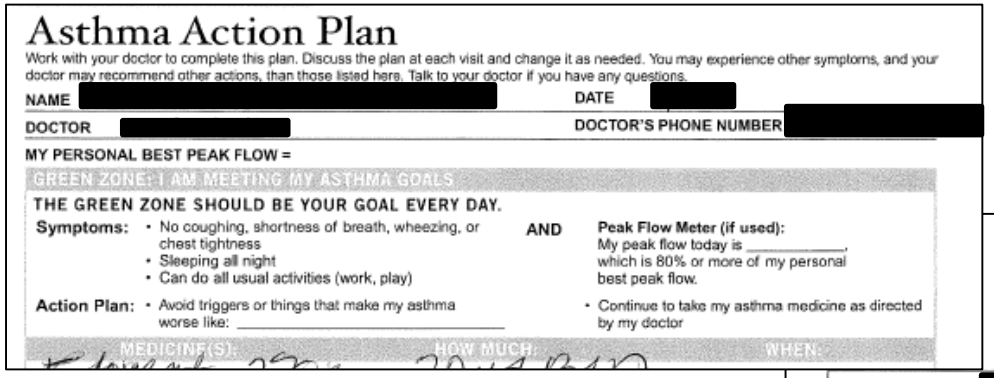
Coordinator	Types of Referrals	Number of referrals-% total
Community Health Worker	Home / Food Issues	229 – 22%
	Medical Access Issues	204 – 19%
	Transportation Issues	192 – 18%
	Benefits/ Eligibility Issues	138 – 13%
	Mental Health Issues	138 – 12%
	Medication Issues	102 – 10%
	Education/Information Issues	43 – 4%
	Durable Medical Equipment Issues	24 – 2%

OPTIMUS Health Care

Community Partnering in action

Close relation with statewide initiatives including the Primary Care Action Group of Bridgeport and CHIP in Stamford, The Council of Churches and the Putting on Airs Stratford Health Department Program.

Ex: Putting on Airs Referral – Asthma Control Test –Asthma Control Plan



Asthma Action Plan

Work with your doctor to complete this plan. Discuss the plan at each visit and change it as needed. You may experience other symptoms, and your doctor may recommend other actions, than those listed here. Talk to your doctor if you have any questions.

NAME [redacted] DATE [redacted]

DOCTOR [redacted] DOCTOR'S PHONE NUMBER [redacted]

MY PERSONAL BEST PEAK FLOW =

GREEN ZONE: I AM MEETING MY ASTHMA GOALS

THE GREEN ZONE SHOULD BE YOUR GOAL EVERY DAY.

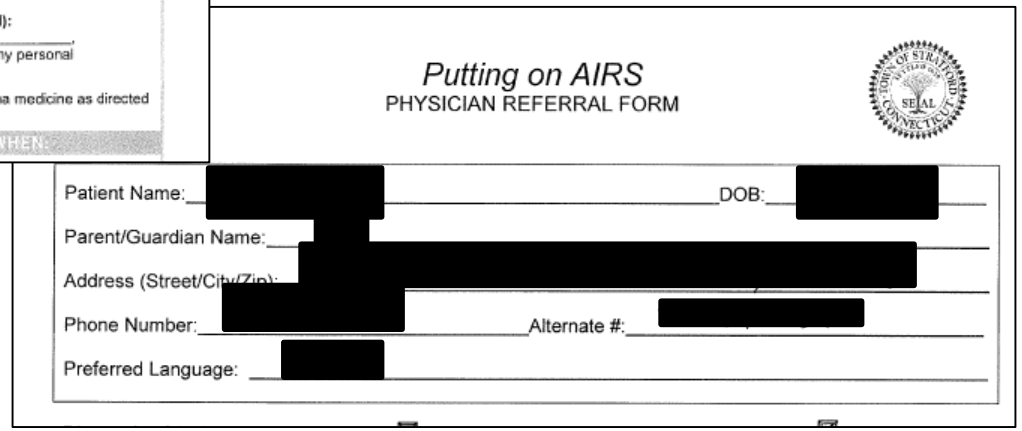
Symptoms: • No coughing, shortness of breath, wheezing, or chest tightness • Sleeping all night • Can do all usual activities (work, play)

AND

Peak Flow Meter (if used): My peak flow today is _____, which is 80% or more of my personal best peak flow.

Action Plan: • Avoid triggers or things that make my asthma worse like: _____ • Continue to take my asthma medicine as directed by my doctor

MEDICINE(S): HOW MUCH: WHEN:



Putting on AIRS

PHYSICIAN REFERRAL FORM

Patient Name: [redacted] DOB: [redacted]

Parent/Guardian Name: [redacted]

Address (Street/City/Zip): [redacted]

Phone Number: [redacted] Alternate #: [redacted]

Preferred Language: [redacted]

Name: _____ Today's Date: _____

ASTHMA CONTROL TEST™

Know your score.

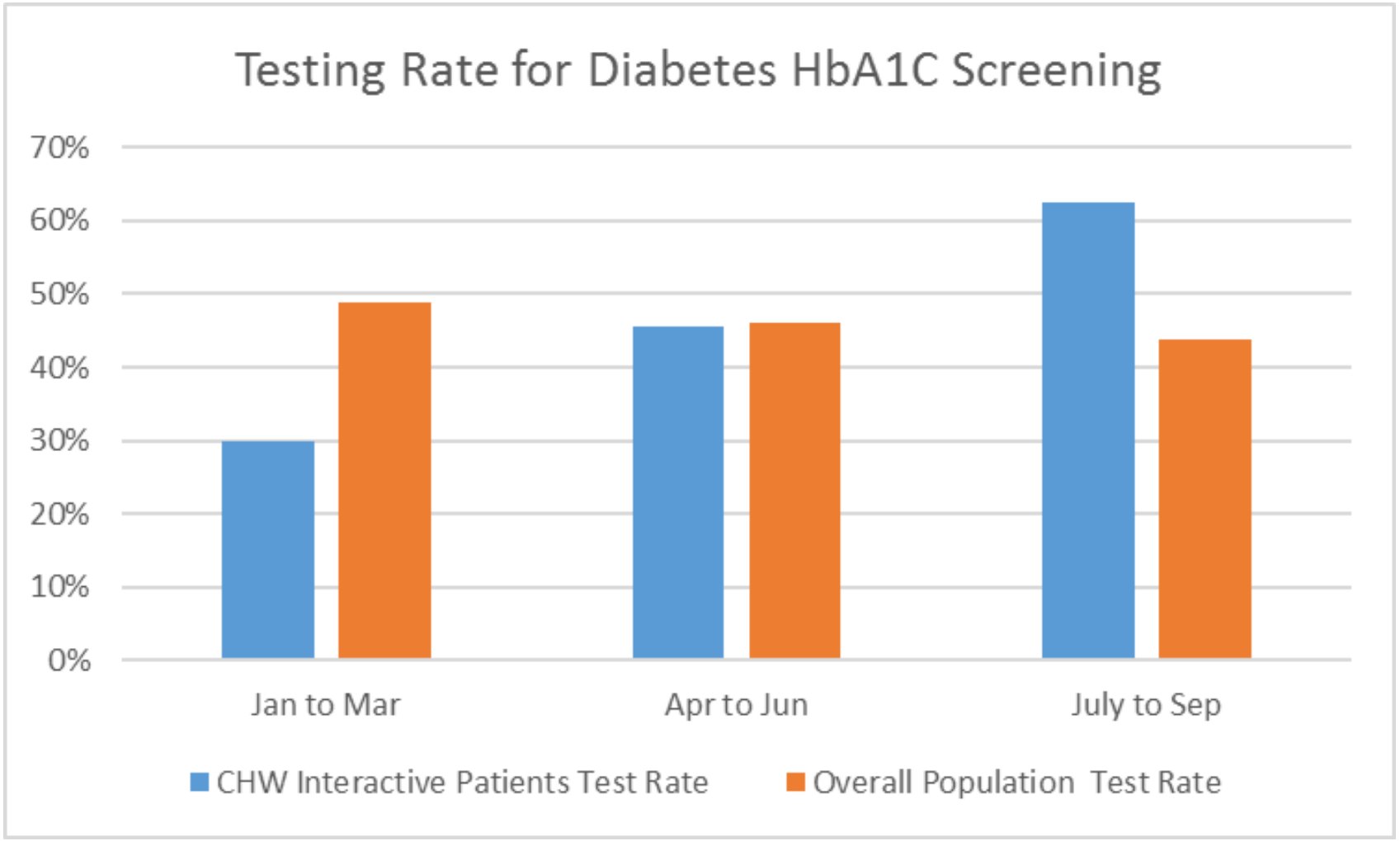
OPTIMUS Health Care

Connection to Patients & Community Providers

- Our patient focus groups is meeting monthly and help us improve the care delivery

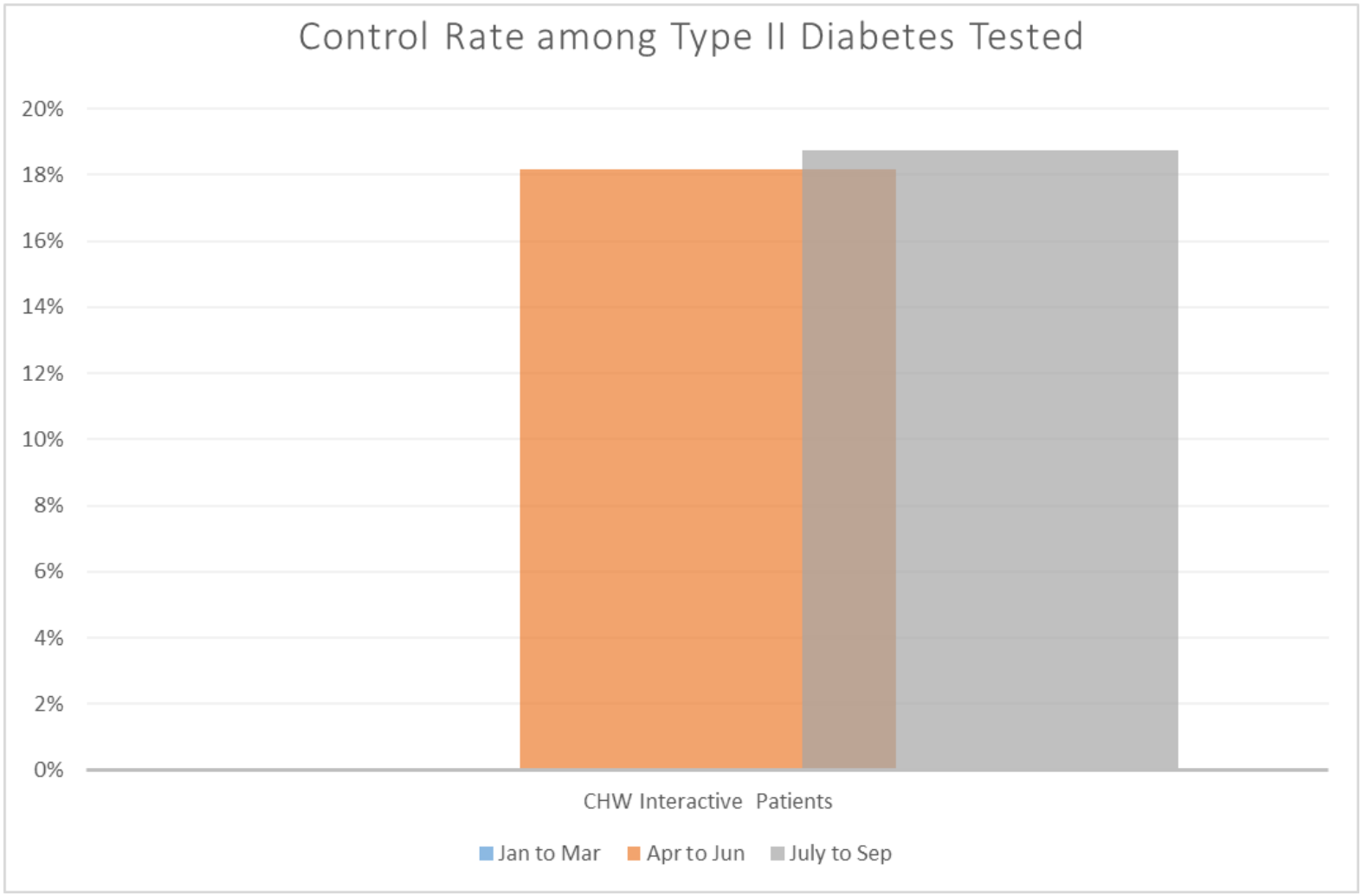
Outcomes for Clinical Metrics

- Diabetes HbA1C Screening



Outcomes for Clinical Metrics

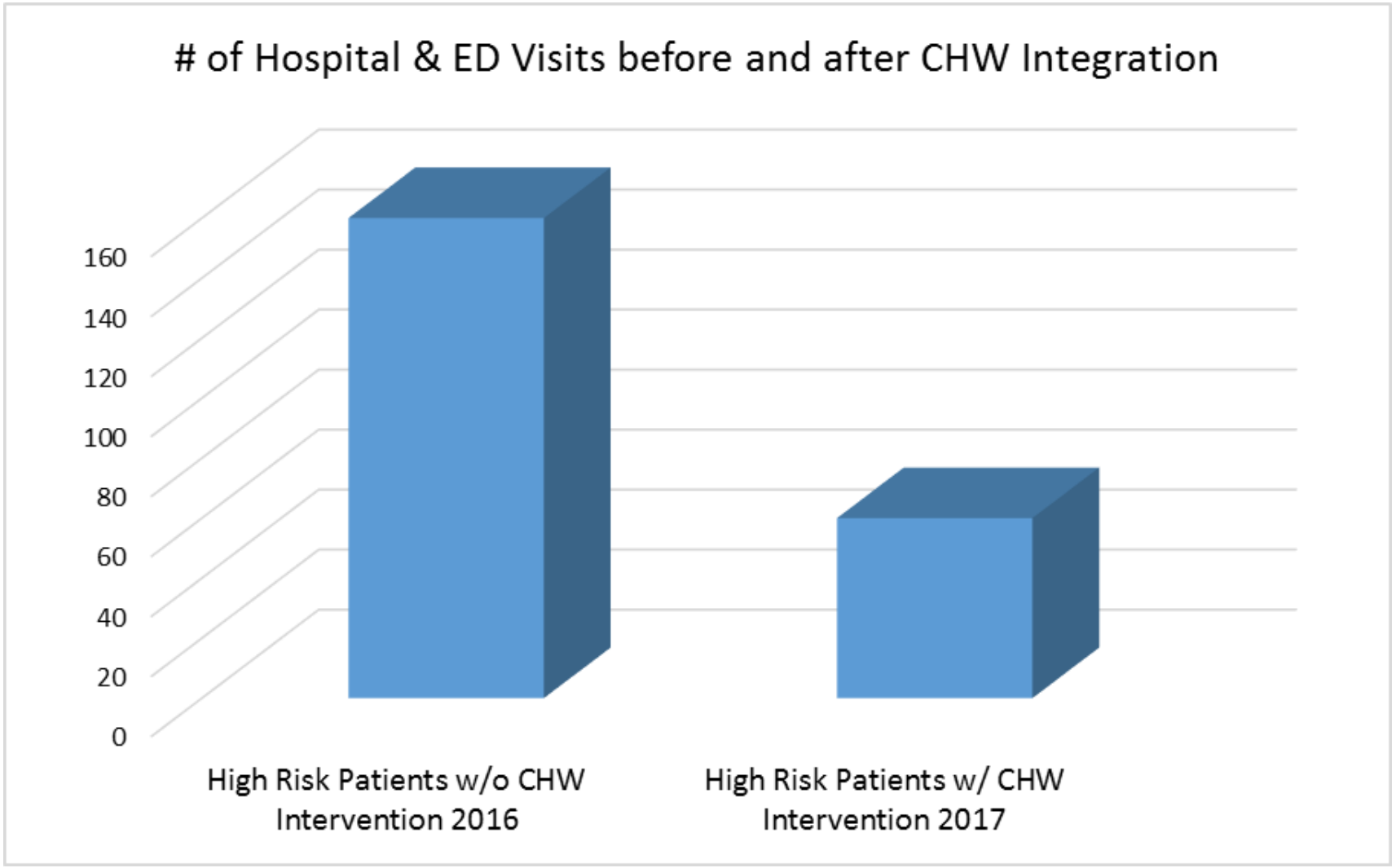
- Diabetes HbA1C Control



OPTIMUS Health Care

Outcomes for Clinical Metrics

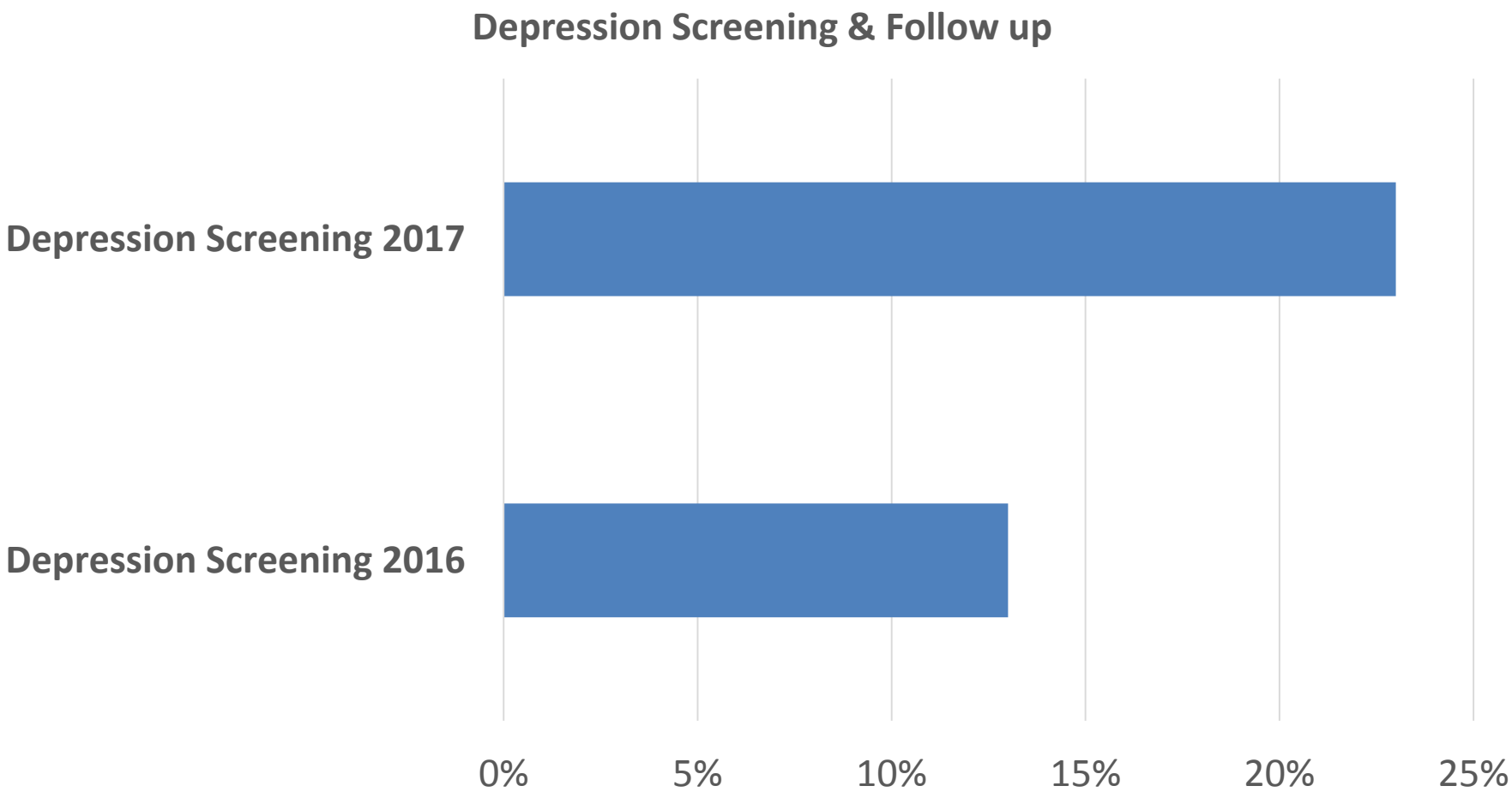
- ED / Post Hospitals Follow Ups



OPTIMUS Health Care

Scoring Measures

- Behavior Health Screening 1-17



Outcome for Financial Metric

- Monthly cost of Community Health Care Workers at Optimus: $26,500 to manage 50,000 patients
- Within a random sample of 10 high-risk patients, the monthly ED/Hospitalization rate for this cohort dropped from 12 to 2 after CHW integration
- Estimated cost spent on CHWs per ED/Hospitalization averted:
- Our data shows that 1 CHW visit averts 1 ED visits,

1 CHW visit cost 25 $ to Optimus

1 ED visit cost $1300

In 2017 The total expected cost saved for Medicaid is $117000

we are expecting to avoid 90 ED visits at $1300 per visit

OPTIMUS Health Care

Our Patient Story

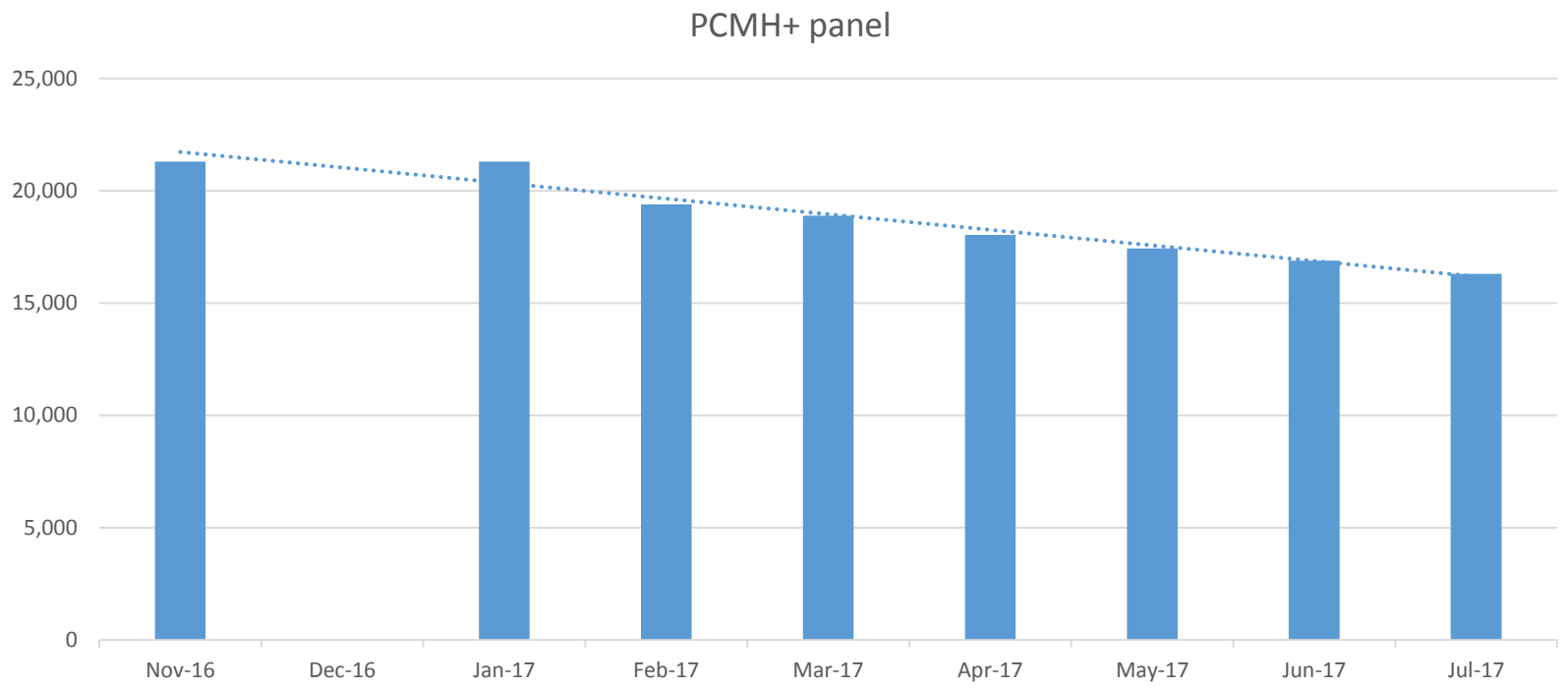
- Mid 40s Hispanic lady:
- screened during a community health fair BP: 210/110
- Sent to the ED (Saturday afternoon)
- Identified as Optimus patient
- CHW coordinated follow-up for Monday at Optimus with PCP and CHW
- Seen at Optimus on Monday for a follow-up
- Was screened by CHW for behavioral Health and SDH needs
- Work done: successful referral to BH – after school program for her children organized to improve her anxiety – Pain management organized, referral to nutritionist and Medication Management
- SUCCESS:

BP controlled, no more ED visits, patient anxiety decreased, PCP happy!

OPTIMUS Health Care

What Has Proved Most Challenging?

- Attribution Loss Average: 500 patients /month



- Barriers: Availability of space, shrinking budget, potential sustainability.

OPTIMUS Health Care

Looking Ahead …

- Challenges?
  - Difficulty in implementing standardized workflows.
  - Explaining the role of the CHWs to the care team and the patients

- What support do we need for PCMH+ at Optimus?
  - Allow time for measurable changes.
  - Increase access for Medicaid members to specialty care via tele-consult
  - Develop interoperability between care sites and community services
  - Transform the CHW position into a billable profession

OPTIMUS Health Care

Patient Centered Medical Home +
SIM Steering Committee

Fair Haven
Community Health Center

October 13, 2017

Organization Accredited
by Joint Commission International

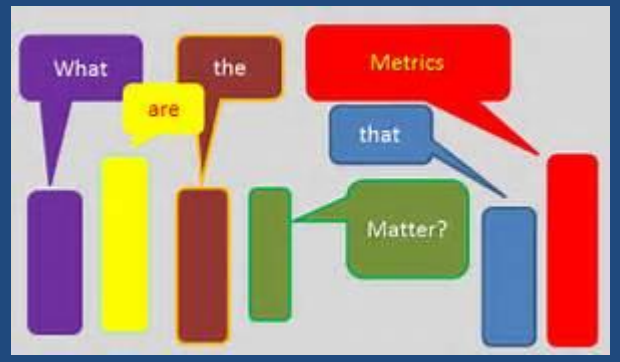
Overall

- PCMH+ has focused the organization on true practice transformation, improved integration and enhanced team-based, person-centered care

Pervasive Challenges and Opportunities

- EHR
  - Biggest Asset, Biggest Challenge

- Choice of metrics



- Strategic alignment of funding
  - Econsult
  - Costs of care, high value care

Examples

- Integration: Developmental Screening
- Quality: Improvements
- “Closing the loop”: 7 day follow up visits
- Efficiency: Access to care and ER utilization
- Coordination: New Care Coordinators
- Standardization: Workflows, data
- Care Experience: Patient advisory groups

Integration, Quality: Developmental Screening

- Before PCMH+
  - Pediatric staff not performing standardized screening routinely
  - Pediatric staff not interpreting similarly
  - Documentation not standardized
  - Different workflows

Developmental screening

- Since PCMH+
  - Clinical protocol for EB, standardized screening
  - MCHAT [Autism] first 3 years of life
  - Training from CHDI – Community linkage
  - Data Reporting – monthly
  - First 7 months of 2017 data, FHCHC:

FHCHC 2015	FHCHC 2016	80th Percentile	FHCHC to date 2017
1.2%	6.7%	46.5%	47.3%

Quality Improvement Data: Operational

- ADT 7 day follow up visit rates[1]
- Prior to PCMH+: No organizational focus on 7 day follow-up

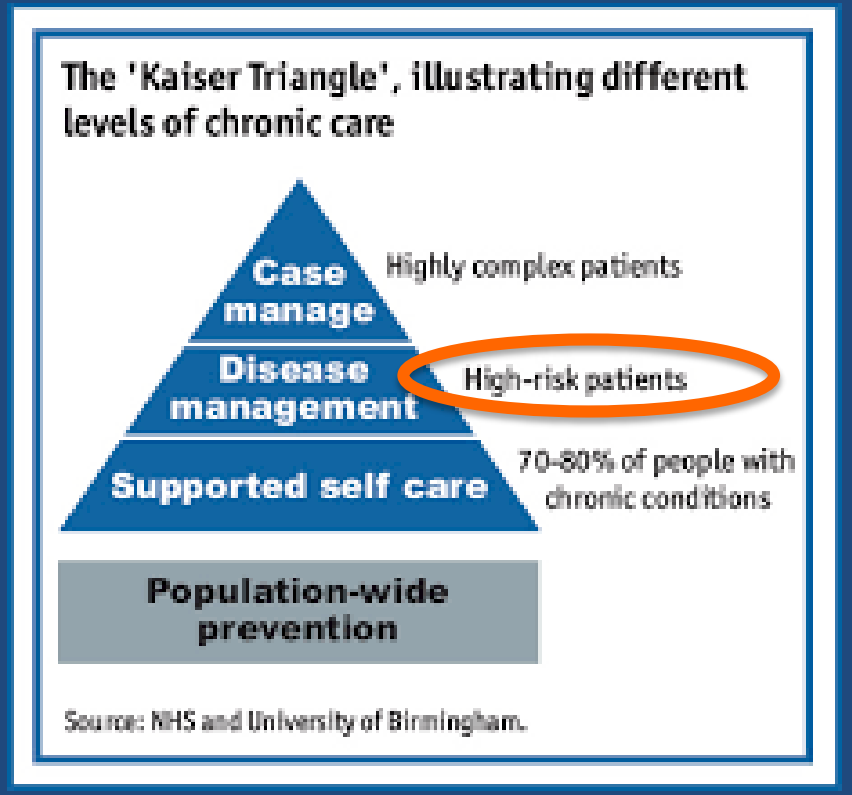
  "Follow-up within 7 days was associated with meaningful reductions in readmission risk for patients with multiple chronic conditions and a greater than 20% baseline risk of readmission, a group that represented 24% of discharged patients"

- 10 →25%

1. Jackson C, et al. Timeliness of Outpatient Follow-up: An Evidence-Based Approach for Planning After Hospital Discharge. Ann Fam Med March/April 2015 vol. 13 no. 2 115-122

Who gets what coordinated?
Hybrid Model: Data, Clinicians

- Community Health Network Data [objective]
  - Hopkins ADG methodology
  - Risk now, risk in future
  - Manage the delta
    - Care team input [subjective]

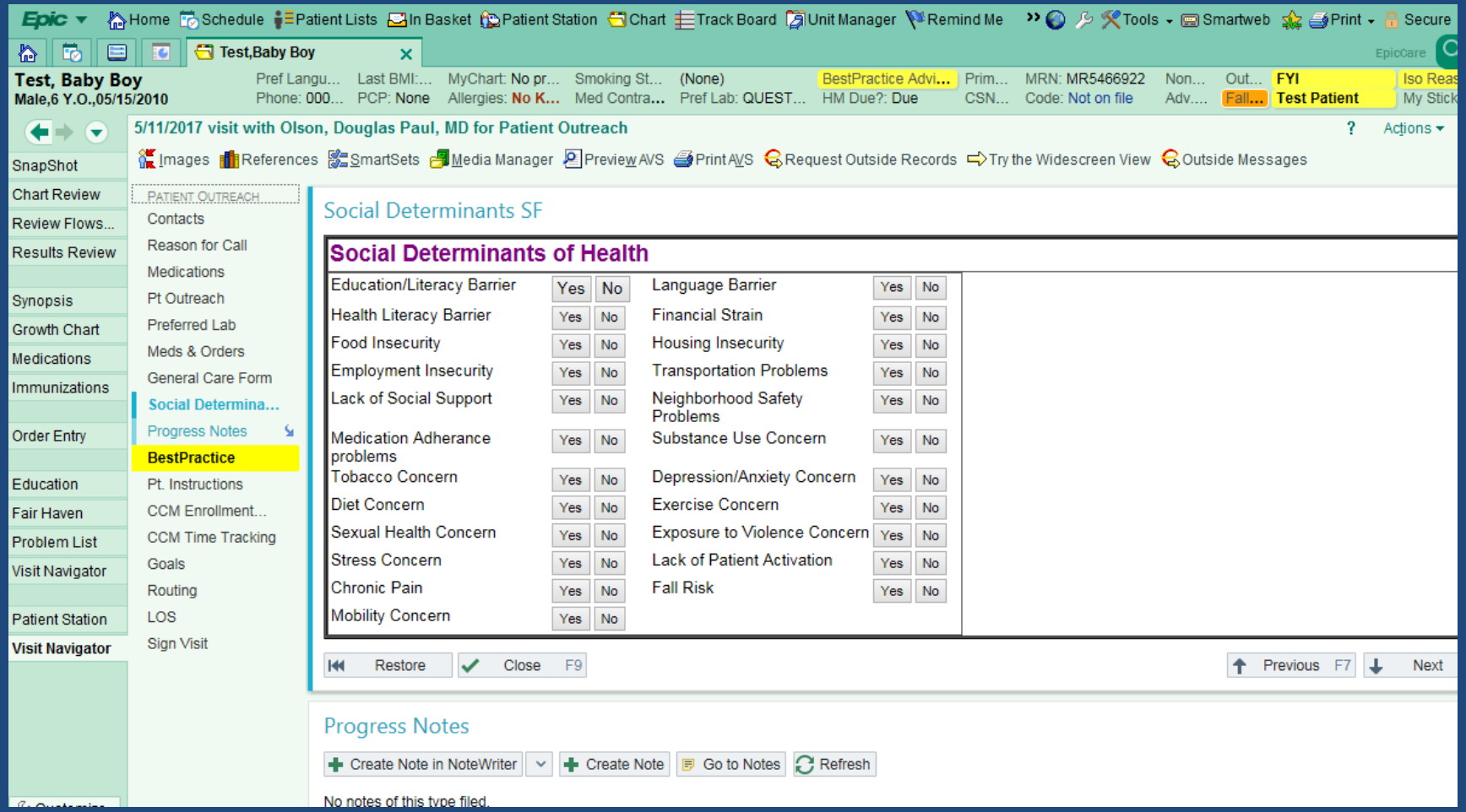


Standardization: SDoH Screening

- Challenges:
  - Choice of screening instrument [1,2]
  - Standardization, comparability, scale-up
  - Data access
  - Reporting

1. National Association of Community Health Centers. The Protocol for Responding to and Assessing Patient's Assets, Risks and Experiences (PRAPARE) accessed online October 10, 2017 at http://www.nachc.org/research-and-data/prapare/
2. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. Making the social determinants of health a routine part of medical care. J Health Care Poor Underserved. 2015;26(2):321-327.

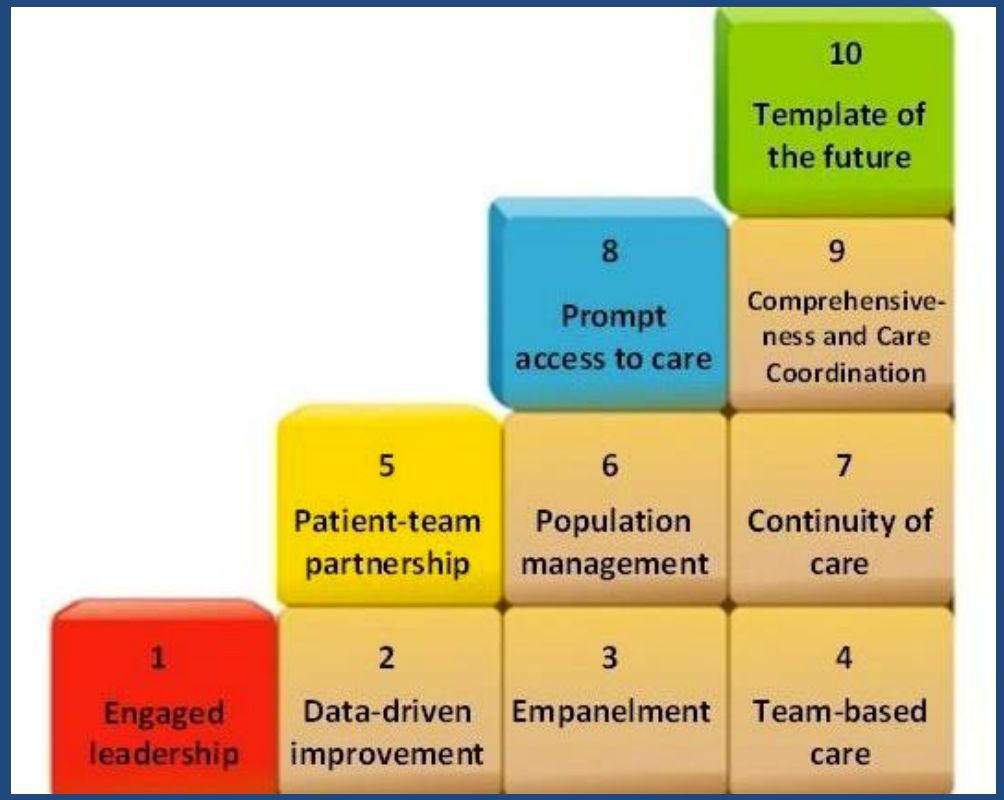
SDoH Screening



Care Experience

- PCMH+ Patient advisory group
- Additional specialty hours requested: now added extra evening HIV sessions
- Increased urgent care slots: 3 per provider per day, *doubled patient satisfaction scores*
- Input about community needs:
  - Services for commercial sex trade, sex work, addiction, eligibility options

Future Opportunities



Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. Ann Fam Med. 2014 Mar-Apr;12(2):166-71.

Shanafelt T, Goh J, Sinsky C. The Business Case for Investing in Physician Well-being. JAMA Intern Med. 2017 Sep 25.

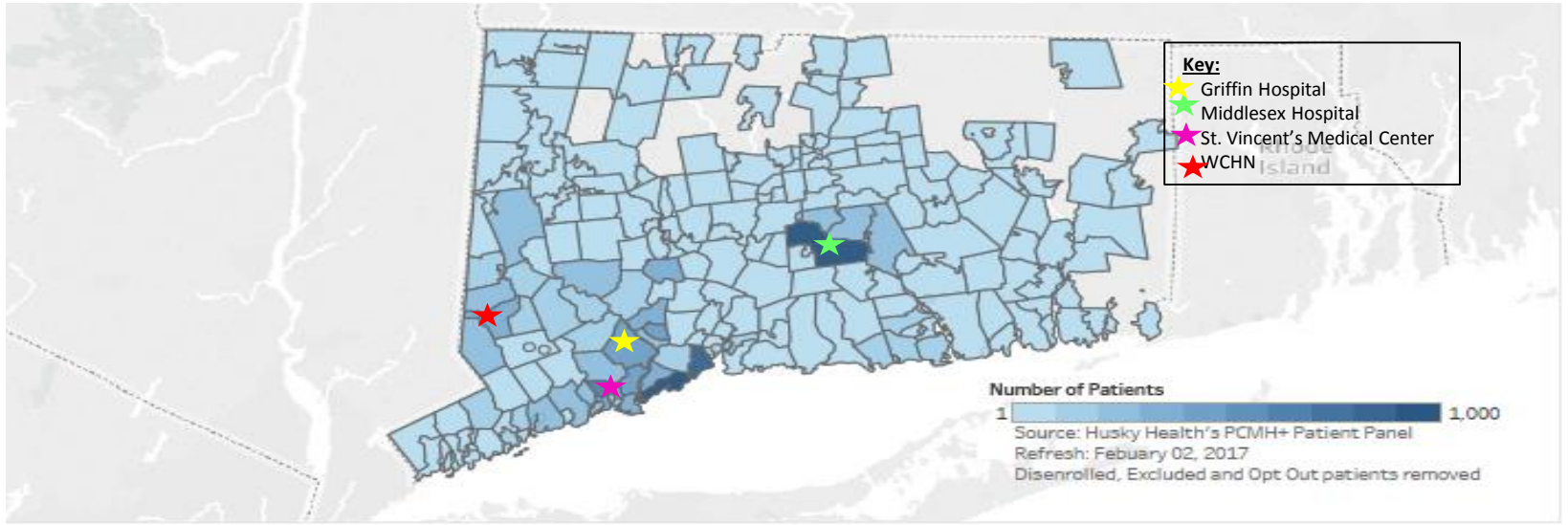
SIM Steering Committee Presentation

Value Care Alliance

Oct 12th Presentation

Value Care Alliance Locations and Populations Served

- There are 8 participating entities in the PCMH+ program spanning across the VCA hospitals
- VCA is managing 16,694 attributed lives



VCA Totals	
Patient Count	16,694
Provider Count	193

Gender	
Female	9,713
Male	6,981

Practice Age Grouping

	Under 4	4-18	18-65	Over 65	Grand Total
DRS GOLDFARB RANNO AND ASSOCIATES	2		243	9	254
GRIFFIN FACULTY PRACTICE	2	7	1,882	34	1,925
MHS PRIMARY CARE	41	343	2,553	46	2,983
MIDDLESEX HOSPITAL	153	498	833	9	1,493
MILFORD PEDIATRIC GROUP	714	2,986	530		4,230
PULMONARY & INTERNAL MEDICINE ASSOCIATES			45	4	49
ST VINCENTS MULTISPECIALTY GROUP INC		6	1,904	40	1,950
WESTERN CONNECTICUT MEDICAL GROUP	79	744	2,943	44	3,810
Grand Total	991	4,584	10,933	186	16,694

PCMH+ Focus on Key Areas

Enhanced Care Coordination

Behavioral Health/Physical Health Integration

Reporting and Communication

Competencies in Care for Individuals with Disabilities

Culturally Competent Services

Children and Youth with Special Health Care Needs

Multidisciplinary Teams to Achieve Key Focus Areas

Broad range of disciplines caring for patients

Development of Comprehensive Care Plans

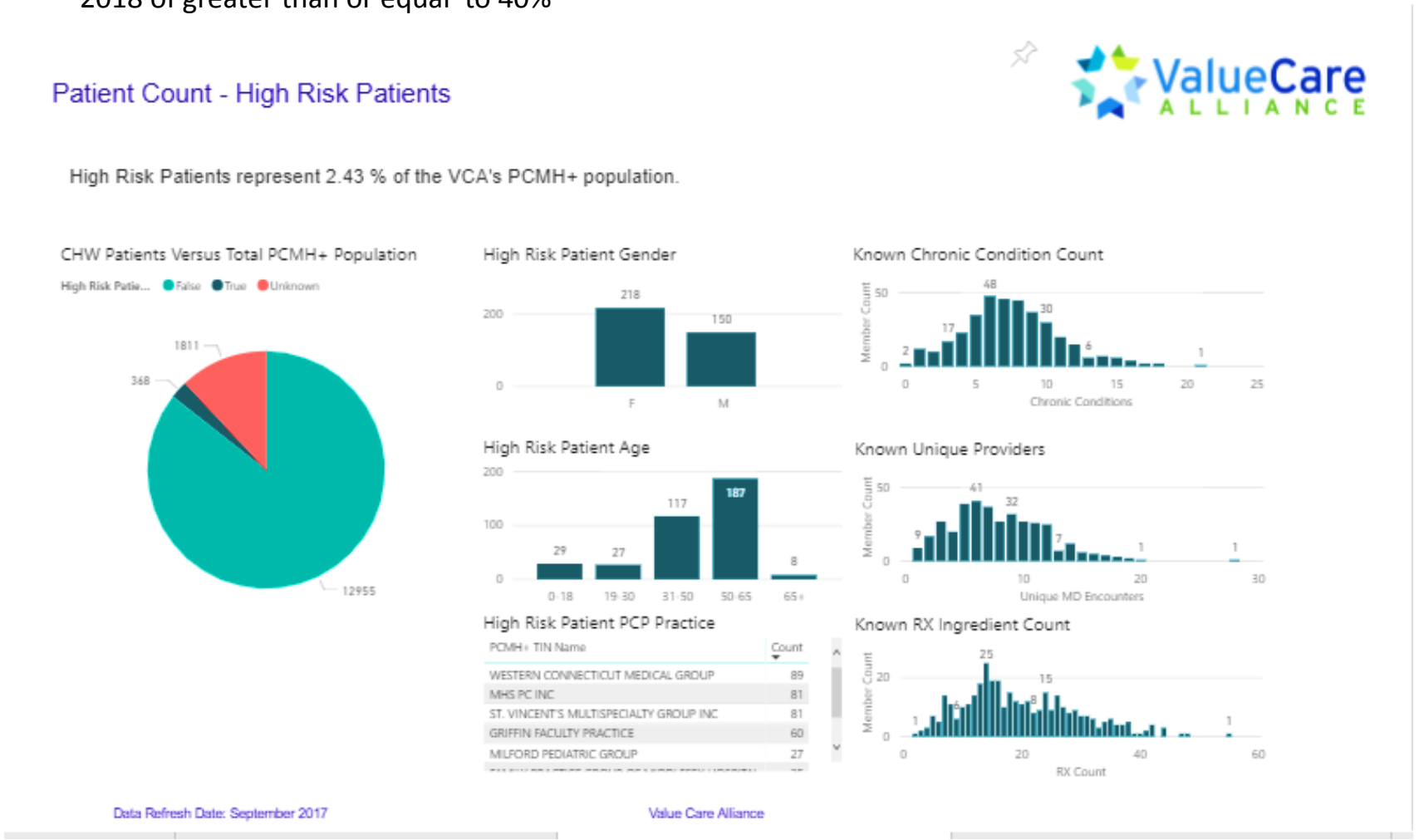
Community Action Teams Address Social Determinants of Health

Individual and Population Based Interventions

Risk Stratification to Identify High Needs

Demographics of High Risk Patients

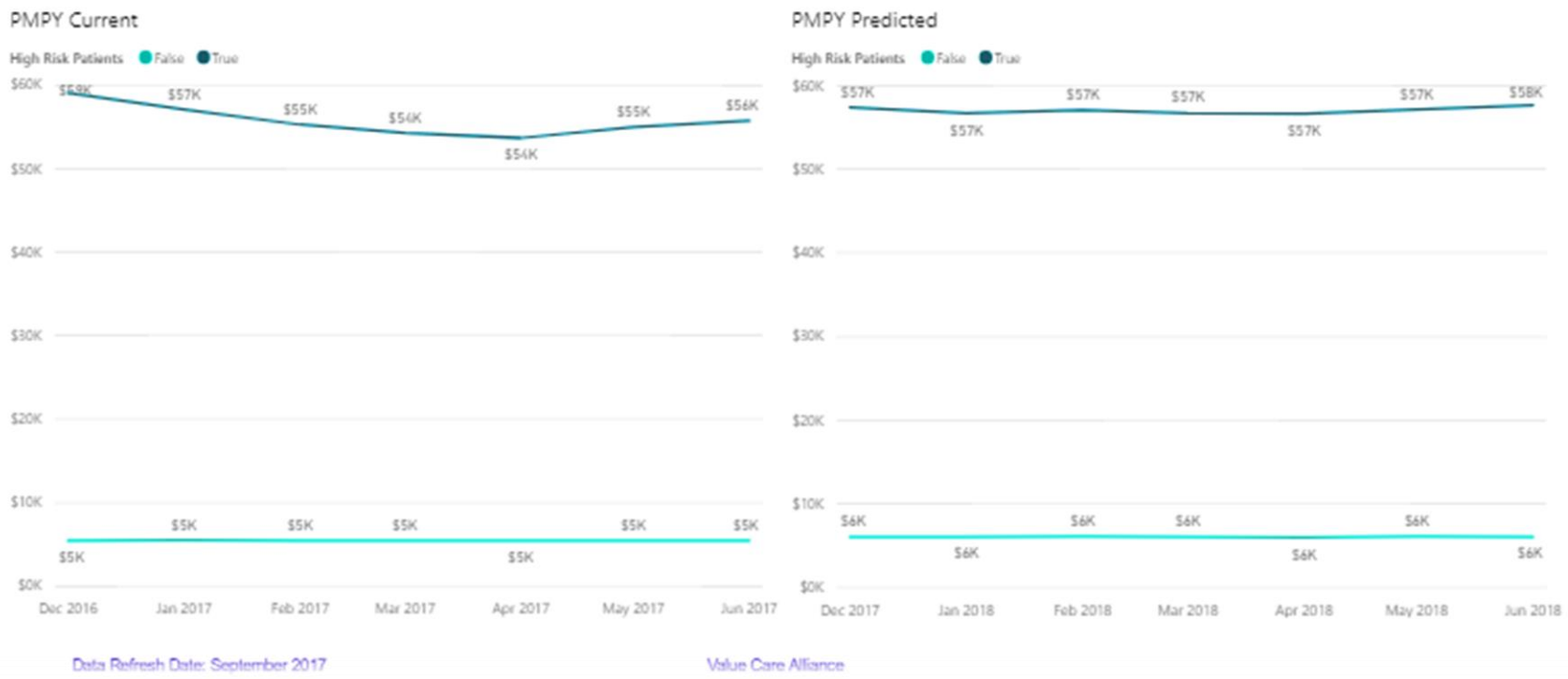
- High Risk Patients Attributed to the VCA are defined as patients with a probability of being high cost in 2018 of greater than or equal to 40%



Current and Predicted Cost – High Risk Patients

Total PMPY Cost Current and Predicted - High Risk Patients

The 2017 cost for these patients is currently 27.5K PMPY. The cost is expected to increase to 29.0K PMPY in 2018.



Data Refresh Date: September 2017

Value Care Alliance

Process – where do we get referrals?

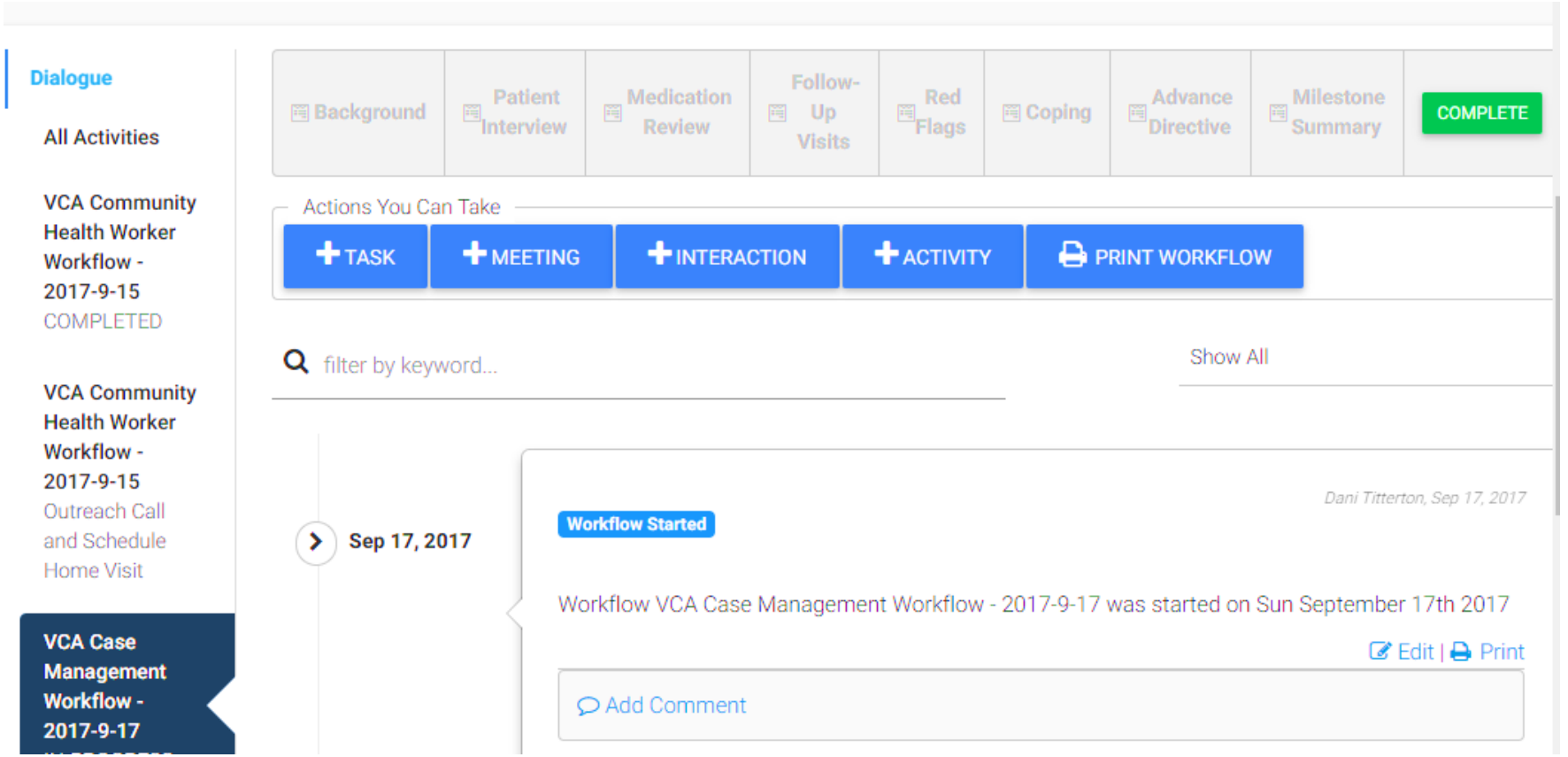
- Examination of top 10% highest risk patients at each VCA member site
- Receiving referrals from CHN, Care Coordinators, and Community Practices
- Launching a set of Health Fairs with health screenings and referrals
- Attending Interdisciplinary Team meetings at health systems to generate referrals
- Creation of a “Circle” meeting every week at Griffin to review specific patients and their needs
- Examination of Data to identify additional patients
  - Gaps needing closure
  - High ED Utilization List
  - Patient Ping – any patient who has been admitted to the hospital, ER, or Skilled Nursing Facility

Multiple Disciplines Involved

1. Clinical interventions: Clinical Care Managers at each VCA member work with patients to create a care plan, and collaborate with the primary care practice to provide input to and refine clinical care plan
2. Interventions related to the social determinants of health: Community Health Workers work with patients to create care plan to address gaps, such as difficulty in getting to office visits or transportation, financial problems, health literacy, or other social issues that may impact health. Care plans are shared with primary care practices.
3. Clinical and social determinants care plans shared across the teams.
4. In the near future: Comprehensive Care Plans and screenings are documented in SymphonyRM to create one view of patient clinical and social needs.
5. Screenings:
    1. Social Determinants of Health.
    2. Behavioral health screening
    3. Barriers to medical care.
    4. Additional items as applicable: Psychiatric advanced directive and Advance Care Planning as needed for Children and Youth with Special Health Care Needs

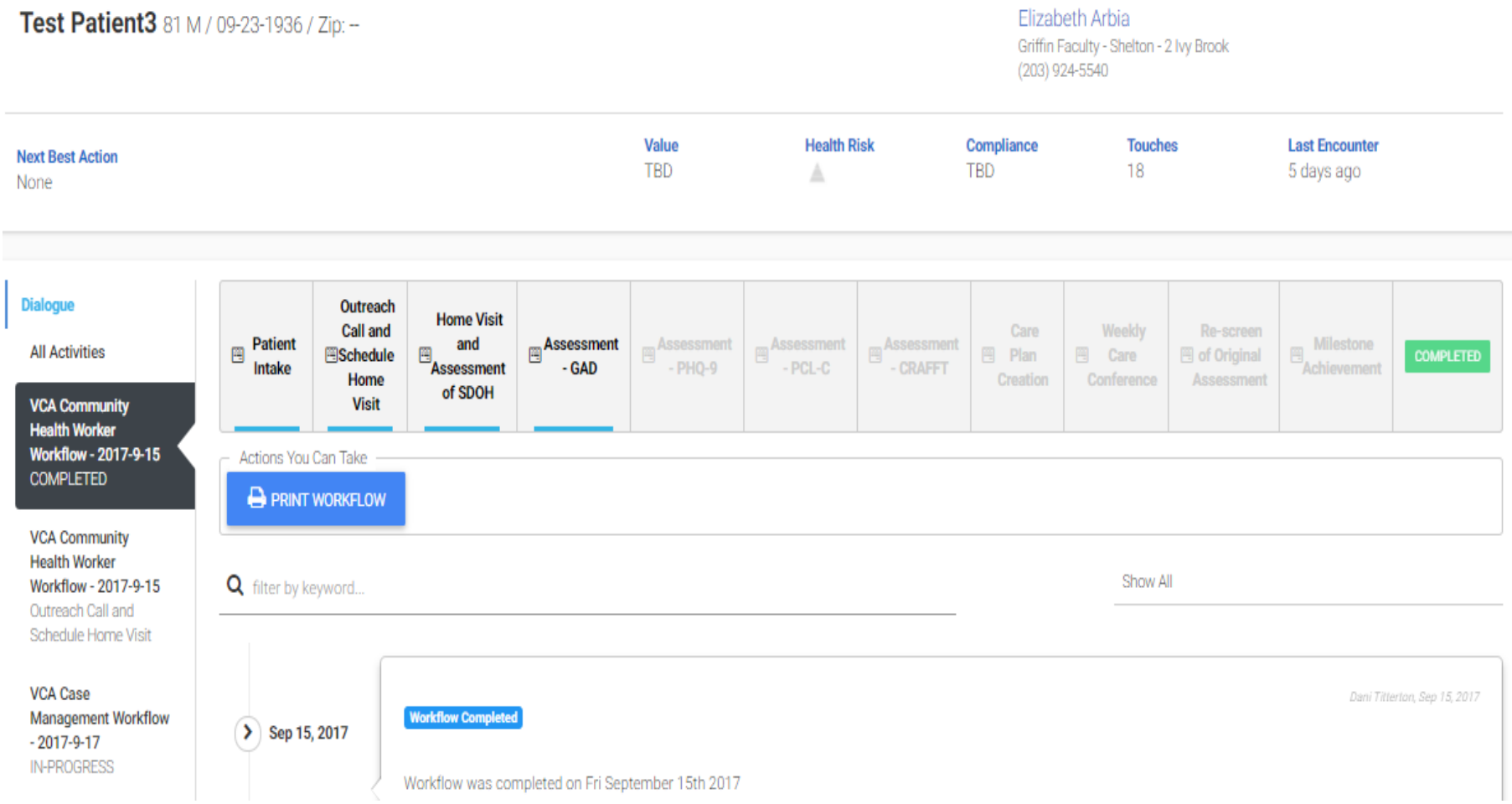
Process – how do we document and track?

Care Manager Workflow



Process – how do we document and track?

Community Health Worker Workflow



Detail: Social Determinants Care Plan

Client Name:

Client Signature: _____

Date: _____

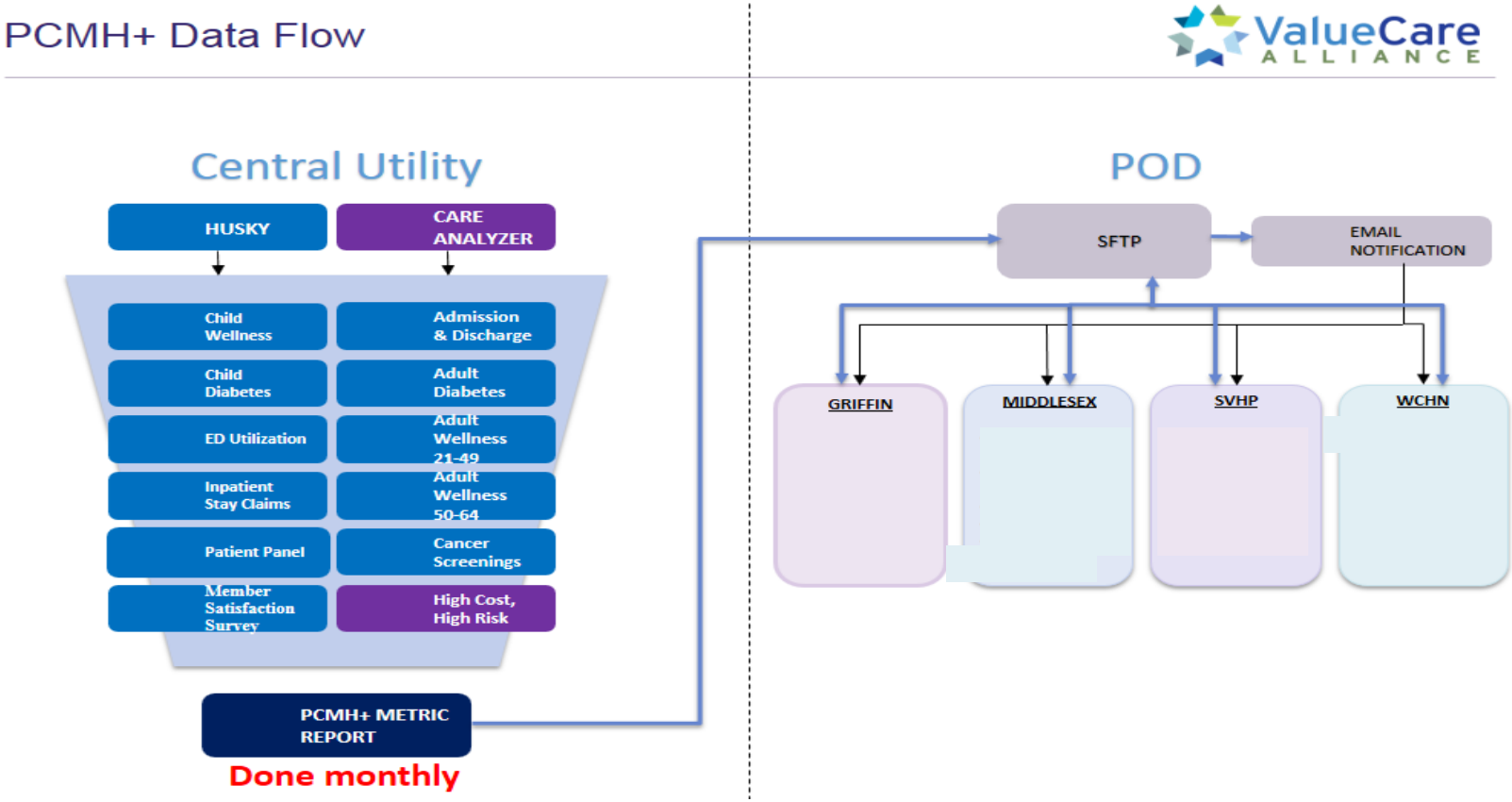
Expected Date of Completion: _____

Concern(s):	Anticipated Result:	Action(s):	Referred To:
Physical Health 1.	•	•	•
Mental Health 1.	•	•	•
Housing 1.			
Food Security 1.	•	•	•
Income 1.	•	• •	• •
Transportation 1.			

Delivering Data in a User-Friendly Way: Utilizing a Monthly Report Package to Manage Patients

Close Gaps in Care

- Monthly PCMH+ report is sent to the Medical Directors, CMO's, and other designated members at each hospital
- Goal to have member enrollment in targeted programs at each VCA member location



Data example: Individual Patients – Gaps in Care Reporting

PCMH+ Gaps Report ST. VINCENT'S MULTISPECIALTY GROUP INC(800458769) Run Date: 7/7/2017															
					Reporting			Other							
				Refreshed:	07/19/2016	07/19/2016	06/17/2017	04/30/2017	06/17/2017	06/17/2017	04/30/2017	04/30/2017	04/30/2017	04/30/2017	06/17/2017
Member ID	Member Name	Member Date of Birth	RBSPredicted	Assignment PCP Name	Breast Cancer Screening	Cervical Cancer Screening	Diabetes - Eye Exam (Adult)	Adult Access To Preventive Services	Adult Wellness 21-49	Adult Wellness 50-64	Annual Dental Visit	Annual Monitoring For Patients On Persistent Medication - ACE/ARB	Annual Monitoring For Patients On Persistent Medication - Diuretics	Medication Management for People with Asthma - 75%	Well Child Visit
			3.785	SWATI JOSHI											
			1.218	ANNA PANKRATOV											
			1.023	CHARLES N BRUCE-TAGOE											
			1.506	CHHAVI RAI											
			1.186	EDWARD TRISTINE											
			0.378	LINETTE Y ROSARIO TEJEDA											
			2.212	YAMITZA CORDERO-FERRER											
			1.396	YAMITZA CORDERO-FERRER											
			0.381	YAMITZA CORDERO-FERRER											
			0.219	YAMITZA CORDERO-FERRER											

Data Analysis

Are we targeting the correct patients?

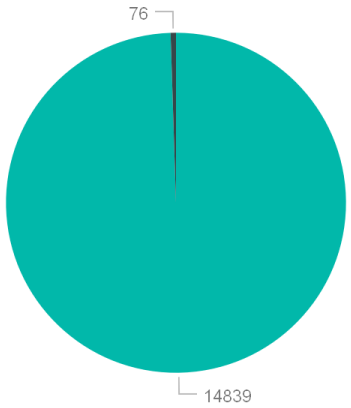
Are we making an impact?

Demographics of Patients Seen by CHWs

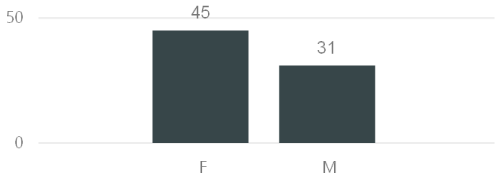
CHW Patient Count

Valuecare Alliance's Community Health Worker's (CHW) currently interact with around 76 patients on a routine basis. This represents 0.56 % of the VCA's PCMH+ population.

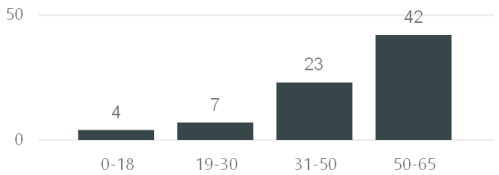
CHW Patients Versus Total PCMH+ Population



CHW Patient Gender



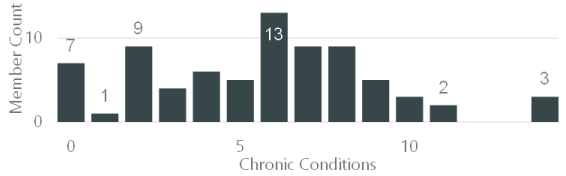
CHW Patient Age



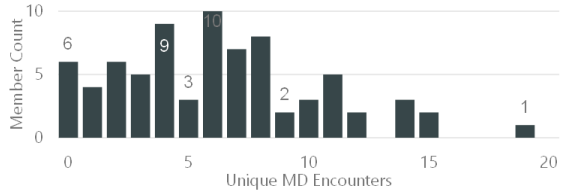
CHW Patient PCP Practice

PCMH+ TIN Name	Count
ST. VINCENT'S MULTISPECIALTY GROUP INC	24
GRIFFIN FACULTY PRACTICE	18
WESTERN CONNECTICUT MEDICAL GROUP	18
MHS PC INC	9
FAMILY PRACTICE GROUP OF MIDDLESEX HOSPITAL	5
MILFORD PEDIATRIC GROUP	2

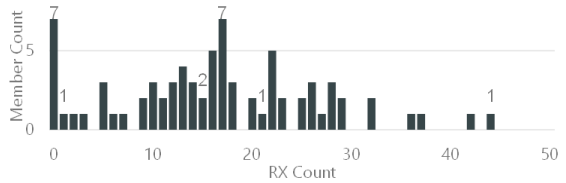
Known Chronic Condition Count



Known Unique Providers



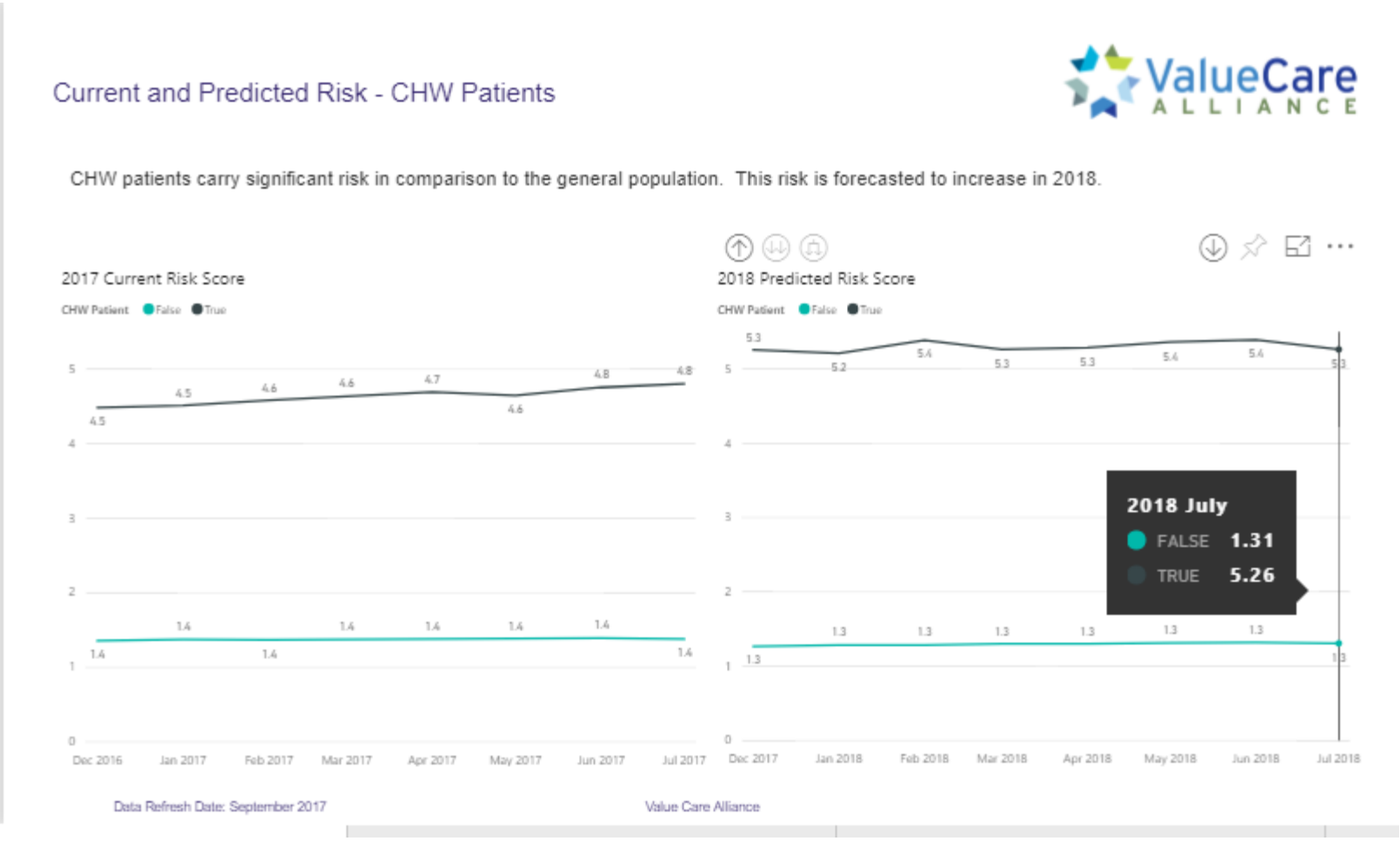
Known RX Ingredient Count



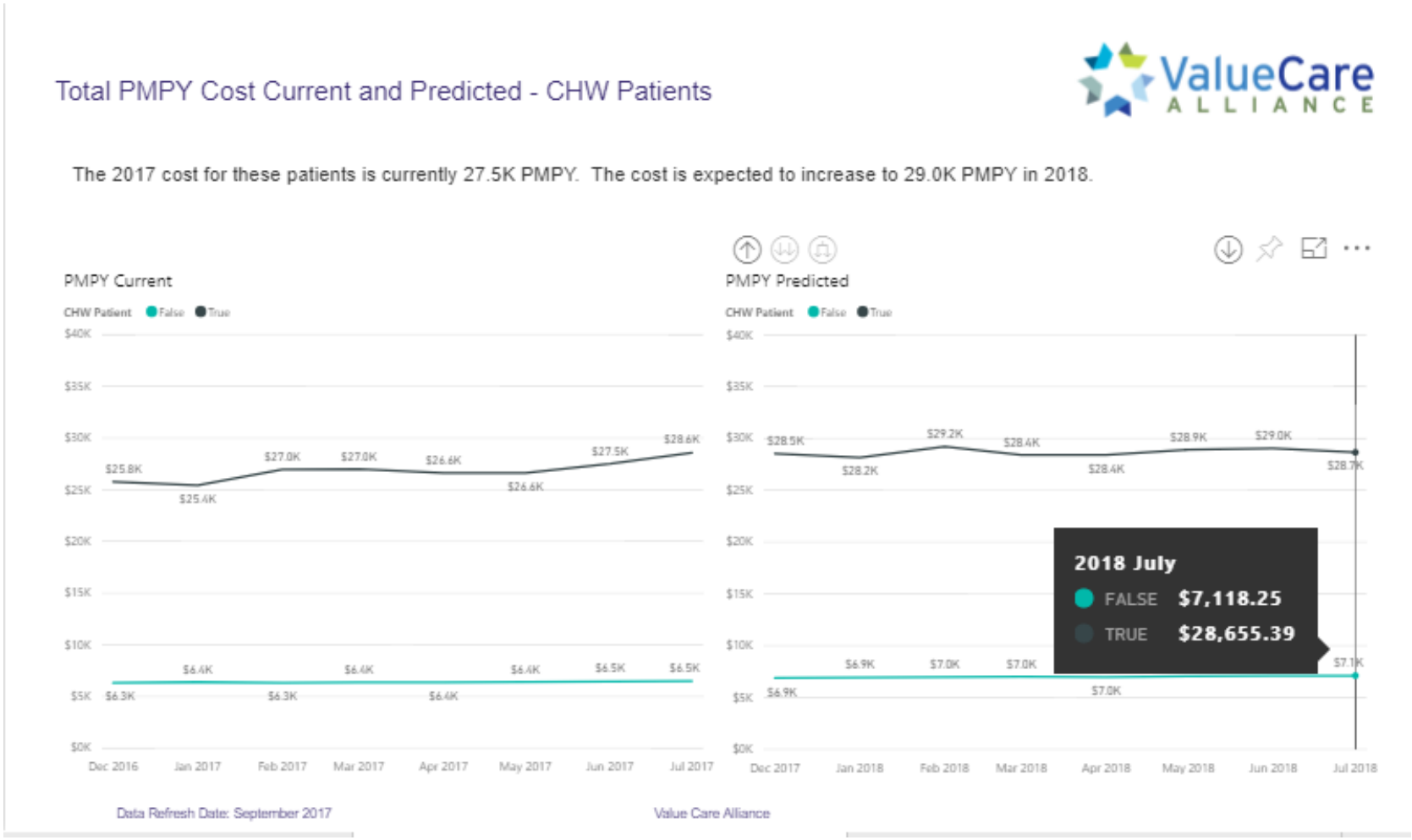
Data Refresh Date: September 2017

Value Care Alliance

Current and Predicted Total Risk – CHW patients vs Total VCA PCMH+ population

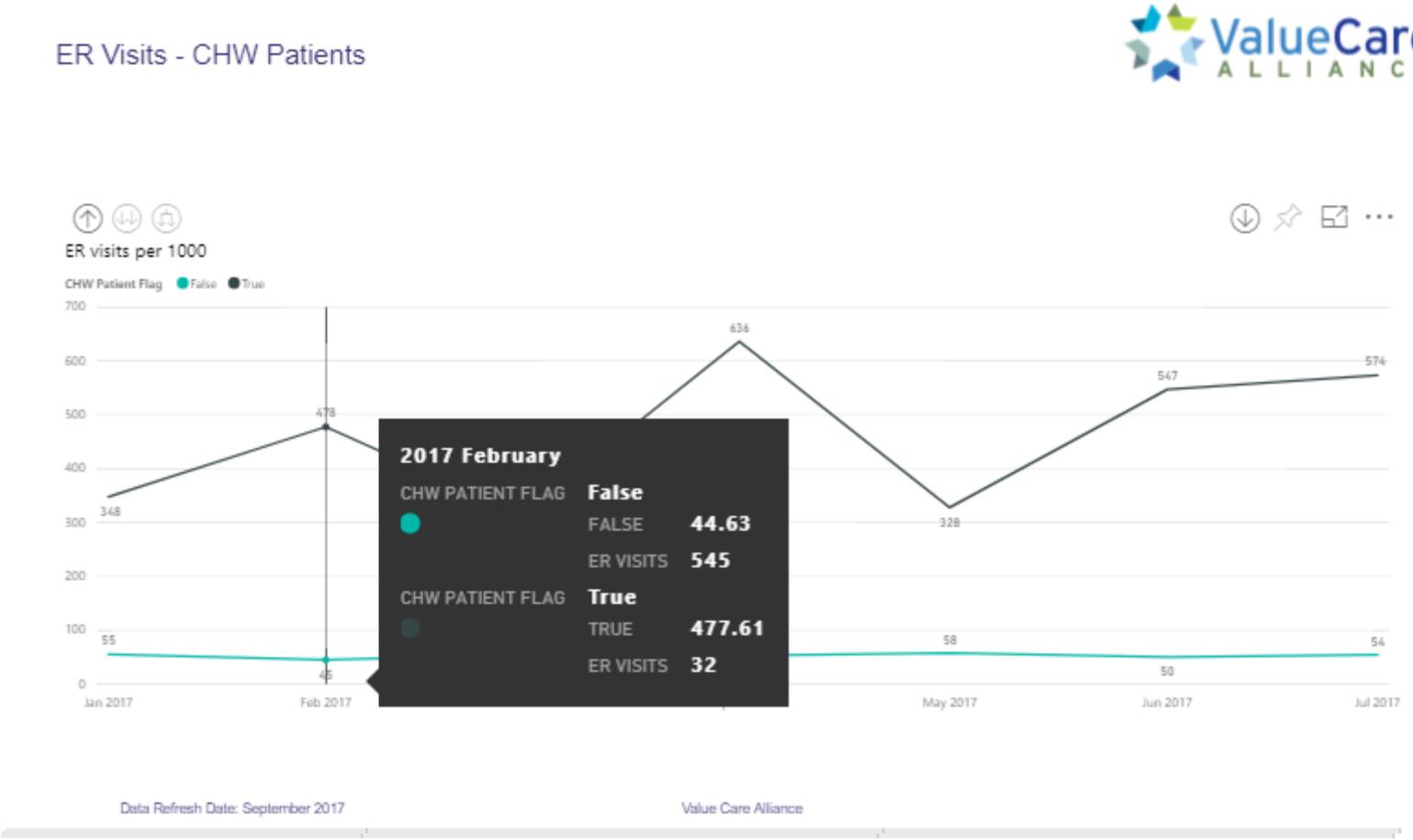


Current and Predicted Total Cost – CHW patients vs Total VCA PCMH+ population



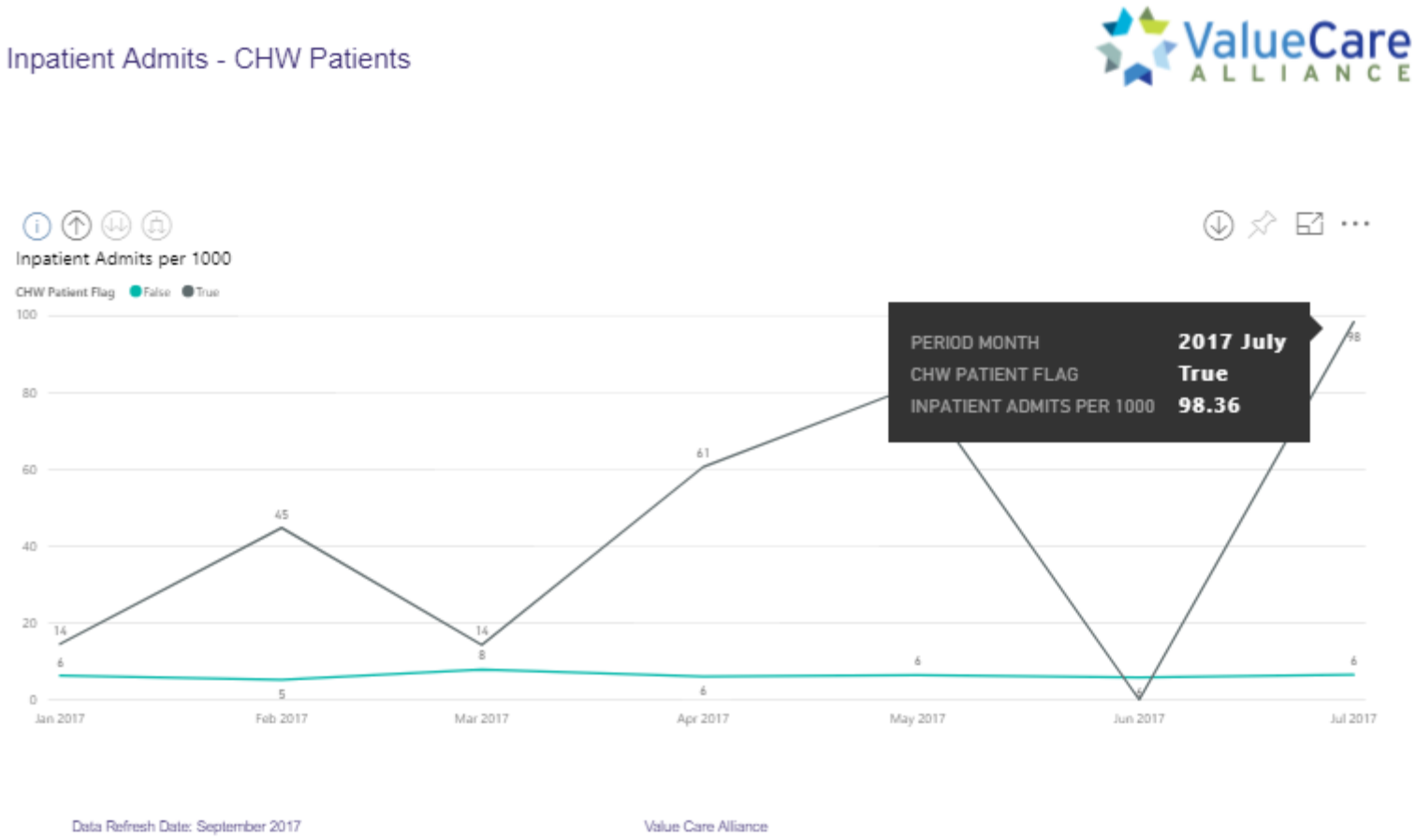
CHW Patients and ER Visits

CHWs started in June/July: Too early to see trend



CHW Patients and Admissions

CHWs started in June/July. This data is through May = pre-intervention
We will continue to track and update progress



Community Health Fair Slides

Community Outreach through Health Fairs and Mission Days

- Community Health Fairs and Mission Days are utilized by VCA health systems
- Opportunities include:
  - Health screenings
  - Lifestyle management
  - Chronic disease management
  - Counseling
  - Social determinants of health screenings
- The Fairs present an opportunity to meet PCMH+ patients and connect them with services offered
- Initiatives by VCA member:
  - **Griffin Faculty Practice**: Community Resource Fairs (held in April/May 2017)
  - **WCHN:** Mission Health Day (10/28)
  - **St. Vincent's:** Medical Mission at Home (11/4)
  - **Middlesex:** Adult and Children's Health Fairs (ongoing)
- Employees donate time and resources to staff these events, and many require participation on weekends

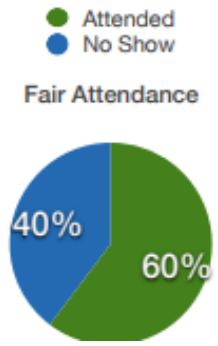
Griffin Hospital Health and Community Resource Fair Report: Statistics, TEAM/GFP/Residency Focus Group Interviews, Next Steps/Future Directions

Victoria C. Costales, MD, MPH

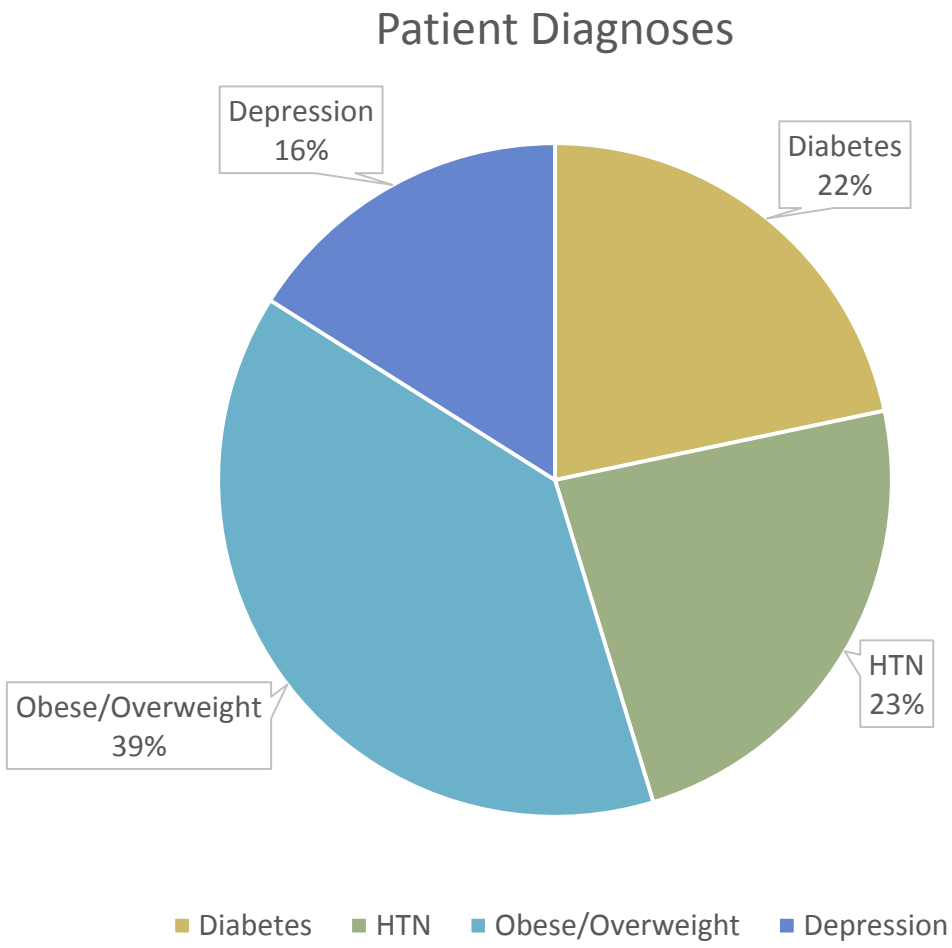
Background

Griffin Hospital conducted 4 Health and Community Resource Fairs in April and May 2017, as part of an outreach campaign to our Medicaid population. These events were a collaboration between Griffin Faculty Physicians, Outreach and Parish Nursing, Internal Medicine and Preventive Medicine Residency Program, and community action agencies, with TEAM Inc, being our main partner. At each fair, patients received a free medical screening administered by the Parish Nurses as well as lifestyle and chronic disease management/prevention counseling from the Parish Nurses and Internal Medicine/Preventive Medicine (IM/PM) and Preventive Medicine (PM) Resident Physicians (new diagnoses of pre-diabetes, diabetes and hypertension). TEAM Inc and other community agencies assessed and offered services related to the social determinants of health (SDOH) to interested patients and family members.

Additionally, all patients were screened for depression and subsequently were asked the complete Patient Health Questionnaire-9 to assess severity of symptoms. These PHQ-9s are a HEDIS requirement typically completed at office visits by providers. All patients with diabetes, when applicable, were screened for diabetic retinopathy, using our portable camera set-up, as well as diabetic foot assessment (monofilament testing). Of the 194 patients scheduled, 117 attended the health and community resources fairs.



GFP Community Resource Fair: 117 participants total, 106 patients with existing medical condition



GFP Community Resource Fair: More Results

- On the spot screening for retinopathy: 87 of Diabetics
- New diagnoses:
  - 1 patient with Diabetes
  - 3 patients with Hypertension
  - 17 patients with pre-diabetes
- 74 patients were scheduled for a PCP office visit while attending the fair; follow-up was conducted to make sure the appointments were kept
- 82 of patients received information regarding availability of social services and agencies
- 7 of patients completed a comprehensive Universal Intake/ Pre-Assessment by TEAM

GFP Community Resource Fair: SDOH Resources Provided by TEAM

Social Determinants of Health area of need	Services Rendered by TEAM (in parenthesis # of patients/clients served)/Follow-up
Emergency Food	Referred to Food bank and assisted in SNAP application (1 client)
Housing	Mediation with landlords (1 client) and affordable apartment searches (3 clients)

Social Determinants of Health area of need	Services Rendered by TEAM (in parenthesis # of patients/clients served)/Follow-up
Training/Employment	Referred to vocational training (GAIN program; 1 client); Resume writing/ employment search and application assistance (2 clients)
Furniture Bank	Referred to Helping Hands, TEAM Inc partner, for discounted furniture (1 client)
Clothing Bank	Referred to My Sister's Place, TEAM Inc partner, for discounted clothing (2 clients' total of 8 vouchers given for clients and their families)
Diaper Bank	TEAM Family Resource Center provides diaper once per month (1 client)
Early Childhood	1 family connected to TEAM's preschool program
Financial Literacy	Connected to an Individual Development Account (1 client - receives $2 for every $1 they save)
LGBTQ	Connected to LGBTQ-specific services (1 client; support group, clinical and legal services)

WCHN Mission Health Day: Scheduled for 10/28

Mission Health Day

Western Connecticut State University • Bill Williams Gym in Berkshire Hall • 181 White Street, Danbury

JOIN US ON OCTOBER 28, 2017 9:00 AM - 3:00 PM

Western Connecticut Health Network colleagues are invited to come together for Mission Health Day – a special event designed to connect community members in need (the uninsured, underinsured and those with housing at risk) with essential health screenings and services, social services, winter clothing, personal care items and refreshments.

SERVICE AND SCREENINGS

- Medical Services
  - General Health Screenings to include 15 minutes with a medical provider
  - General History, Physical Exam, Health Assessment, Vital Signs Measurement, Blood Pressure Screening, Basic Point of Care Testing
- Referrals for Primary Care follow up to a local medical home

- Vaccines, Medication and Essential Prescriptions
  - Flu Vaccinations
  - DTAP Vaccinations
  - Potential Blood Pressure Medication
- Cancer Screening
  - On-site referrals for Mammography
- Spirometry
  - Pulmonary Assessment, early screening for COPD

- Smoking Cessation screening and referrals for assistance
- Podiatry Screening and Foot Washing by faith community nurses and volunteers
- Vision Screenings by Danbury Lions Club
- Behavioral Health Screening, Substance Abuse Screening & Referral

WCHN Mission Health Day: Scheduled for 10/28

ADDITIONAL EVENT OFFERINGS – *ALL COMPLIMENTARY*

Breakfast and Lunch • Kid Zone - supervised child care for participating parents • Winter coats, hats, gloves, boots • Toiletries

HOW YOU CAN HELP

Volunteer

Physicians, nurses and care providers are needed to run the screenings. Come share your time and talent!

Contact: Amy Lionheart at 203-739-7277

Employees are needed to help greet guests, serve food, distribute clothing, etc.

Contact: volunteer@wchn.org

Donate

We will be collecting winter coats, gloves, mittens, socks and boots. Look for donation bins in main hospital entrances and larger offsite locations September 1-October 26.

Spread the word

Help spread the word with your colleagues and distribute flyers to generate awareness and drive participation.

Mission Health Day is being led by a large team of WCHN volunteers representing many departments in collaboration with Western CT State University. As a team, we seek to share our services with those in need. All are invited to join us as we bring our mission to life and connect community members with essential health screenings, services and amenities. Come be part of something special.

To learn more, contact: Event Chair – Dr. Patrick Broderick, Emergency Services 203-739-7405

Western Connecticut Health Network

St. Vincent's Medical Mission at Home: Scheduled for 11/4

Medical Mission at Home is designed to deliver healthcare, social and support services to those who might not otherwise have access to these services and in locations where individuals are physically located like places of worship, schools, community centers, homeless shelters and food pantries.

All services are FREE and NO insurance is needed. We will provide services on a FIRST-COME, FIRST-SERVED basis until the end of the mission day.

https://www.medicalmissionathome.org/success-stories

Middlesex Adult and Children's Health Fairs: Narrative

As part of its Community Benefit program and its commitment to the health and wellbeing of the communities it serves, Middlesex Hospital participates in health fairs and conducts screenings in its service area on an annual basis. Local organizations and community based events depend on hospitals, as the healthcare anchor institution, to help **raise awareness regarding important health and wellbeing information and to disseminate information on local resources**. Health fairs allow community members, often those who are underserved, a means to engage with health professionals through one-on-one conversation, group discussion, and informative educational material in a forum that is comfortable to them.

In FY16, **Middlesex Hospital served 2,506 individuals, including adults, older adults and children,** by participating in health fairs throughout the county. Examples for adults and older adults include: the Middlesex Chamber of Commerce Health Expo; Middletown DCF Dads Matter, Too Fair; CT Partners for Better Health; Senior Center fairs in Middletown and Higganum/Killingworth; the AME Zion Women's Health Conference; the Clinton Chamber of Commerce Expo; the Middlesex Community College Health Fair; the Connecticut Valley Hospital Health & Wellness Fair; and the City of Middletown Employee Wellness Fair. Examples for children and parents include: Middletown's Kids Health & Safety Day; the Middletown High School Wellness Fair; Haddam-Killingworth High School Health Expo; George Hersey Robertson School Kids Eat Right Fair; and the Russell Library Community Preschool Fair.

Preventive services, such as screenings, are a key step in making healthy lifestyle choices and maintaining good health and wellbeing. In the community, **Middlesex Hospital offers flu immunization clinics, often administering free flu immunization for those who are unable to pay; blood pressure clinics; and a lung cancer risk assessment for veterans.** In FY16, a total of **2,540 individuals received community-based screens** conducted by Middlesex Hospital.

Middlesex Hospital understands the benefits that health fairs and screenings can offer: **by bringing health information and health services to our communities, we can help our community members make good health a priority in their lives.**

Middlesex Adult and Children's Health Fairs: Fairs Offered

Adult Health Fairs:

- Pregnancy Fairs
- Health & Safety Fairs
- Chamber of Commerce Health Expo
- Family Advocacy DCF Dads Matter Too Fair
- Veterans Education on Lung Cancer
- CVH Health & Wellness Fair
- Essex Meadows Health Fair

Children's Health Fairs:

- Family Advocacy Kids Health & Safety Fair
- Middletown Kids Health & Safety Day
- George Hersey Robertson School, Kids Eat Right
- Family Advocacy Russell Library Community Preschool Fair

Patient story

- Patient was referred from St. Vincent's Health Partners for transportation issues
- A review of the ER visits from Patient Ping revealed that the patient was a high ER utilizer across the State of CT. She had 16 ER visits in 2016, and 14 in 2017, at 8 different hospitals across the state, for pain from kidney stones
- Patient had been discharged from a medical practice due to missing multiple appointments. The patient stated that she did not feel comfortable at that practice because no referral was made for her to pain management
- Once the BHSW established a relationship, patient was transferred to an Optimus practice where she felt comfortable. She was able to get a referral to Pain Management
- Since establishing the new practice, she has only had 2 ED visits for pain
- Estimated cost per ER visit[1] = $2168

	Incurred ER Visits	Estimated Incurred Cost	Cost/Savings projected
2016	16	$34,688	
2017 pre-CHW	14	$30,352	Projected Cost full year: 28 visits = $60, 704
2017 post-CHW (2 months)	2	$4,336	Projected full year ER visits: 4 additional visits through Dec 2017 , total = 20 **Avoided 22 ER visits = $17,344 saved**

1. https://www.theatlantic.com/health/archive/2013/02/how-much-does-it-cost-to-go-to-the-er/273599/

Support to Benefit Practices

Question: What kind of support would most benefit your practice in the coming year?

- PMPM payment to Advanced Care Networks, similar to what is given to the Community Health Centers
  - Funding to support Care Management
  - Funding for eConsults
- Support for higher than average no-show rates:
  - Physician productivity challenge
  - Continuity of care issue for patients
- Additional Community Health Workers
- Reliable/ accessible transportation assistance
- More community support services embedded within the community, to offer support for behavioral health and substance addiction

Appendix

Notes – data methodology

Notes - Sources

Notes

Sources:

Risk and Cost Data:	CareAnalyzer (Medicaid risk data 2016.12.31 to 2017.06.30)
PCMHPlus Population roster:	Husky Portal (2017.07 roster)
ER and IP admissions:	Patient Ping (2017.09.25 YTD extract)

Assumptions

Multiple patient opted out of CareAnalyzer data collection. Subsequently PMPM may not accurately represent population. As CHW patients were selected via risk scores, this effect is more drastic with regards to the high risk patient reports (note the unknown population under the "Patient Count - High Risk Patient" slide)

Yale NewHaven Health
Northeast Medical Group

State Innovation Model: Steering Committee

Person-Centered Medical Home + (PCMH+)

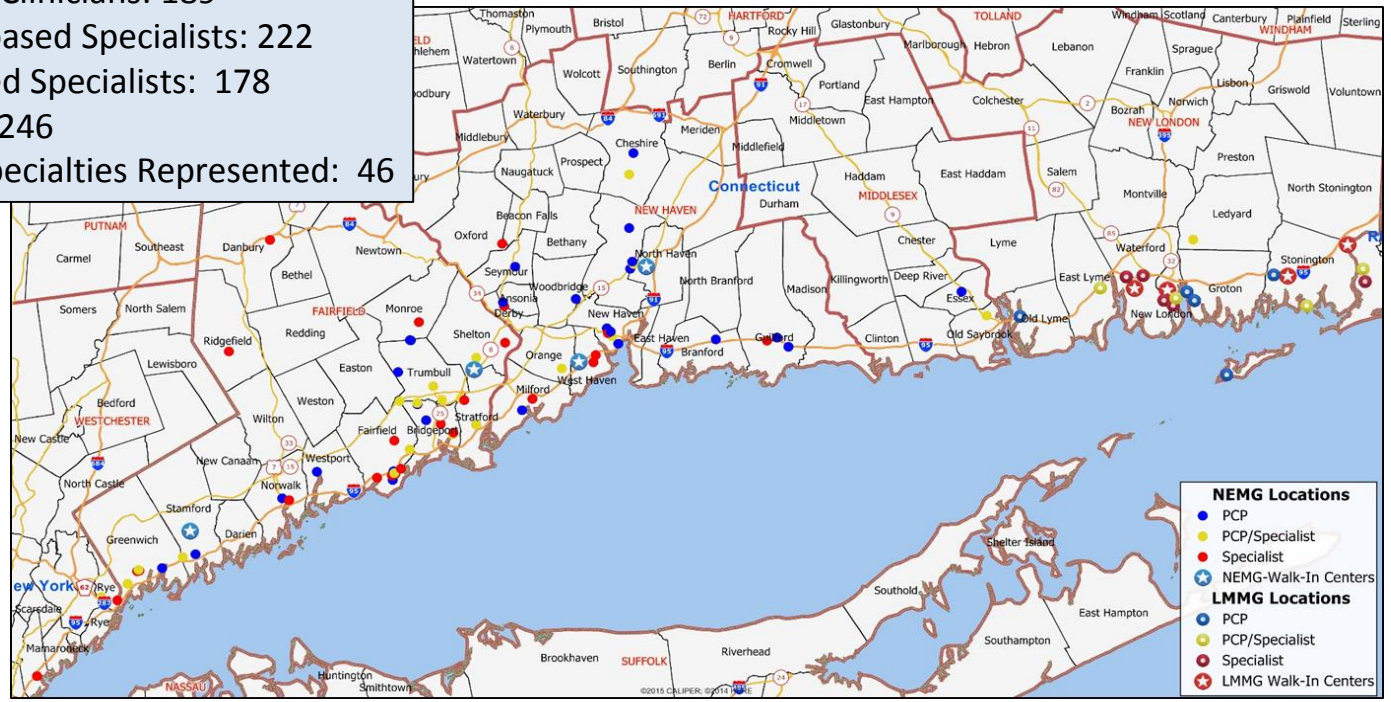
Update

Yale New Haven Health – Northeast Medical Group

October 12th, 2017

NEMG at a Glance

Over 130 Locations in 3 states
Includes Walk-in Sites
Primary Care Clinicians: 189
Community-based Specialists: 222
Hospital-based Specialists: 178
Hospitalists: 246
Number of Specialties Represented: 46



NEMG participates in multiple value-based contracts and currently has attribution for nearly 110,000 lives across these programs.

Yale NewHaven Health Northeast Medical Group

PCMH+ Attribution

Northeast Medical Group Attribution

NEMG PCMH+ Patient Attribution	
1/1/2017	7509
9/30/2017	5328

- Patients attributed to 88 providers across 39 practices, located in Fairfield, New Haven and New London counties
- Attribution by specialty:
  - Pediatrics- 44%
  - Internal Medicine- 48%
  - Family Medicine- 8%

Delivery of Care Improvements

- Improved practice and member outreach.
- Ensured members are navigated to important primary health care services and resources related to social, economic and environmental issues that can adversely impact health.
- Leveraged Care Teams to improve health outcomes by providing comprehensive services in a person-centered manner that meets the member's values and preferences.
- Enhanced focus on transitions of care to ensure coordination and continuity of care.

Practice and Patient Outreach

Practice and Patient Outreach

- Provided program-focused education to patients and PCPs to improve engagement and communication.

- Patient Engagement -EMMIPrevent
  - A tool utilized to conduct recorded calls to patients, on behalf of their physician, to address gaps in care.
  - Offers patients the option to transfer to the practice to schedule an appointment.

Results:	Pediatrics & Adults
Total Patients Outreached	2286
Total Appts Completed	1339
Total Percentage	57%

Enhanced Care Coordination

Member Navigation

- Core focus of member navigation is supported by:
  - 2 patient navigators funded through CCIP grant
  - Community Advocates program modeled after Health Leads, engaging students to link patients with community resources

206 Patients Screened for Social Determinants
112 screened negative
94 screened positive • 16 declined navigation • 78 patients navigated to resources related to: food, housing, transportation and access to health care services and prescriptions

Enhanced Care Coordination

Care Management

- 13 existing care coordinators who support patient care across all populations
  - Support transitions of care
  - Assess health risks/gaps in care
  - Outreach to high risk patients
  - Receive referrals from doctors for coordination of care

Patient Stories

Yale NewHaven Health
Northeast Medical Group

PCMH+ Learning Opportunities

- Opportunity for improvement in comprehensive reporting and analytics to provide improved care management effectiveness
- Per Member Per Month available to FQHCs only
- Member engagement and changing culture toward proactive health management
- Contract: 1 year term
- Social Determinants: Difficulty in addressing certain elements, such as housing

PCMH+ Program Successes

- PCMH+ focus areas resulted in positive outcomes for complex patients
- Focus on wellness: Identifying gaps in care, proactive health management
- Improved patient and physician engagement
- Member engagement within Advisory Committee
- Operationalized screening for social determinants
- Identification of PCMH+ members within EHR to engage patients across care continuum
- Collaboration with other area PCMH+ entities to ensure coordination of care for shared patients

Questions?

Adjourn